POLICIES AND PROCEDURES GOVERNING ANESTHESIA PRIVILEGING IN HOSPITALS

***Hospitals must review and revise with legal counsel and ensure compliance with State and federal laws and regulations. ASA intends these documents as references to help hospitals design their own policies and procedures and does not intend, warrant, or hold out these documents as legal advice.*

Purpose

The purpose of these policies and procedures is to establish the standards and expectations for all patients receiving anesthesia services, including but not limited to, topical or local anesthesia, minimal sedation, moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia and general anesthesia, in _____ hospital. These policies and procedures apply to all locations in the hospital where anesthesia services are administered, including but not limited to the Operating room suite (both inpatient and outpatient), Emergency Department, Critical Care areas, Obstetrical Suite, Radiology department, Psychiatry department, Recovery Rooms, Clinics, Outpatient surgery areas, and Special procedure areas, e.g. Endoscopy Suite and Pain Management Clinics, and including all departments in all campuses and off-site locations where anesthesia services are provided (§482.52 and 482.52(a)).

Information

Our hospital is vitally interested in the safe administration of all anesthesia services. Anesthesiology is the practice of medicine. The Department of Anesthesia has the responsibility and authority, through its Director, for developing policies and procedures governing the provision of all categories of anesthesia services, including specifying the minimum qualifications for each category of practitioner who is permitted to provide anesthesia services (§482.52). The hospital's governing body approves the specific anesthesia service privileges, including type and complexity of procedures, for each practitioner who furnishes anesthesia services, addressing the type of supervision required, if applicable.

Hospital anesthesia services policies and procedures will also address the minimum qualifications and supervision requirements for each category of practitioner who is permitted to provide analgesia services, particularly moderate sedation. The hospital is required to assure that any staff administering drugs for analgesia must be appropriately qualified, and that the drugs are administered in accordance with accepted standards of practice (§482.52).

When a hospital permits operating practitioners to supervise a CRNA administering anesthesia, the medical staff bylaws or rules and regulations must specify for each category of operating practitioner, the type and complexity of procedures the practitioner may supervise. However, individual operating practitioners do not need to be granted specific privileges to supervise a CRNA. (§482.52(a) and (c))

Clinical privileges in anesthesiology are granted to physicians and other providers qualified to administer anesthesia* who are qualified by training to render patients insensible to pain and to minimize stress during surgical, obstetrical and certain medical procedures.

*Qualified Anesthesia Professional §482.52(a):

- A qualified anesthesiologist;
- A doctor of medicine or osteopathy (other than an anesthesiologist);
- A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;
- A certified registered nurse anesthetist (CRNA), who, unless exempted in accordance with paragraph (c) of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or
- An anesthesiologist's assistant who is under the supervision of an anesthesiologist who is immediately available if needed

Clinical privileges are also granted to practitioners who are not anesthesia professionals to administer sedative and analgesic drugs to establish a level of moderate or minimal sedation. Analgesia and anesthesia comprise a continuum of states ranging from minimal sedation to general anesthesia; CMS adds the category of topical and local analgesia (§482.52). The following are definitions of various levels of sedation/analgesia and anesthesia as defined by the American Society of Anesthesiologists:

- Minimal Sedation (Anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes and ventilatory and cardiovascular functions are unaffected (§482.52).

- Moderate Sedation/Analgesia is a drug-induced depression of consciousness during which patients respond purposefully (reflex withdrawal from a painful stimulus is NOT considered a purposeful response) to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained (§482.52).

- Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully (reflex withdrawal from a painful stimulus is NOT considered a purposeful response) following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained (§482.52).

- General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression or neuromuscular function. Cardiovascular function may be impaired (§482.52). If the patient loses consciousness and the ability to respond purposefully, the anesthesia care is a general anesthetic, irrespective of whether airway instrumentation if required.

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended. Rescue requires an intervention by a practitioner with expertise in airway management and advanced life support (§482.52). Individuals administering Moderate Sedation/Analgesia should be able to rescue patients who enter a state of Deep Sedation/Analgesia, while those administering Deep Sedation/Analgesia should be able to rescue patients who enter a state of General Anesthesia.

Responsibility for implementation of this policy is assigned to the Director of the Anesthesia Department.

Policy

Minimal Sedation

Pursuant to State scope of practice laws and regulations, minimal sedation and local anesthetics must be administered by a qualified anesthesia provider or a licensed registered nurse, advanced practice nurse or physician assistant (PA) who is trained in compliance with all relevant local, institutional, state and/or national standards, policies or guidelines to administer prescribed sedating and analgesic medications and monitor patients during minimal sedation ("anxiolysis"). Sedation nurses and sedation physician assistants may only work under the direct supervision of a properly trained and privileged medical doctor (M.D. or D.O.).

The supervising doctor is responsible for all aspects involved in the continuum of care – pre-, intra-, and post-procedure. While a patient is sedated, the responsible doctor must be physically present and immediately available in the procedure suite. Although the supervising doctor is primarily responsible for pre-procedure patient evaluation, supervised sedation practitioners must be trained adequately in pre-procedure patient evaluation to recognize when risk may be increased, and related policies and procedures must allow sedation practitioners to decline to participate in specific cases if they feel uncomfortable in terms of any perceived threat to quality of care or patient safety.

Moderate Sedation

Pursuant to State scope of practice laws and regulations, moderate sedation must be administered by a qualified anesthesia provider, or a licensed registered nurse, advanced practice nurse or physician assistant (PA) who is trained in compliance with all relevant local, institutional, state and/or national standards, policies or guidelines to administer prescribed sedating and analgesic medications and monitor patients during moderate sedation. Sedation nurses and sedation physician assistants may only work under the direct supervision of a properly trained and privileged medical doctor (M.D. or D.O.). [If State law allows and hospital chooses] Physicians, dentists and podiatrists who are qualified by education, training and licensure to administer moderate sedation may supervise the administration of moderate sedation. Related policies and procedures must allow supervised sedation practitioners to decline to participate in specific cases if they feel uncomfortable in terms of any perceived threat to quality of care or patient safety.

All providers of moderate sedation are required to have at least the following knowledge and competencies:

- Proper medication dosages, administration techniques, adverse reactions and counter interventions
- Airway management and basic life support techniques
- Ability to assess total patient care, including but not limited to respiratory rate, oxygen saturation, blood pressure, cardiac rate and level of consciousness

Because we have patient safety as our top priority, it is the policy of this organization to follow the ASA's Statement on Granting Privileges for Administration of Moderate Sedation to Practitioners who are not Anesthesia Professionals (Approved by the ASA House of Delegates on October 25, 2005, and last amended on October 19, 2011***). See Appendix A for the policy, which is hereby incorporated and adopted by this organization.***

Deep Sedation

Pursuant to State scope of practice laws and regulations, and due to the significant risk that patients may enter a state of general anesthesia, deep sedation must be administered only by practitioners who are qualified to administer deep sedation or appropriately supervised anesthesia professionals.

Because we have patient safety as our top priority, it is the policy of this organization to follow the ASA's Statement on Granting Privileges to Non-Anesthesiologist Practitioners for Personally Administering Deep Sedation or Supervising Deep Sedation by Individuals who are not Anesthesia Professionals (Approved by the ASA House of Delegates on October 18, 2006 and amended on October 17, 2012). ***See Appendix B for the policy, which is hereby incorporated and adopted by this organization.***

General and Regional Anesthesia

Pursuant to State scope of practice laws and regulations, general anesthesia must be administered only by practitioners who are qualified to administer general anesthesia or under the direct supervision of qualified anesthesia professionals such as CRNAs and anesthesiologist assistants.

Pursuant to State scope of practice laws and regulations, neuraxial regional anesthesia must be administered only by practitioners who are qualified to administer general anesthesia or under the direct supervision of qualified anesthesia professionals such as CRNAs, anesthesiologist assistants and appropriately supervised trainees.

* Facilities should specifically consider the following ASA Statements in the design of policies for establishing privileges for General and Regional Anesthesia

- Guidelines for the Delineation of Clinical Privileges in Anesthesiology (Approved by the ASA House of Delegates on October 15, 2003, and last amended on October 16, 2013). ***See Appendix C.***
- Statement on the Anesthesia Care Team (Approved by the ASA House of Delegates on October 26, 1982, and last amended on October 16, 2013). ***See Appendix D.***

APPENDIX A

STATEMENT ON GRANTING PRIVILEGES FOR ADMINISTRATION OF MODERATE SEDATION TO PRACTITIONERS WHO ARE NOT ANESTHESIA PROFESSIONALS

Committee of Origin: Ad Hoc Committee on Credentialing
(Approved by the ASA House of Delegates on October 25, 2005, and amended on October 18, 2006)
SUBSTITUTE VERSION amended on October 19, 2011)

The American Society of Anesthesiologists is vitally interested in the safe administration of anesthesia. As such, it has concern for any system or set of practices, used either by its members or the members of other disciplines that would adversely affect the safety of anesthesia administration. It has genuine concern that individuals, however well intentioned, who are not anesthesia professionals may not recognize that sedation and general anesthesia are on a continuum and thus deliver levels of sedation that are, in fact, general anesthesia without having the training and experience to recognize this state and respond appropriately.

The intent of this statement is to suggest a framework for granting privileges that will help ensure competence of individuals who administer or supervise the administration of moderate sedation. Only physicians, dentists or podiatrists who are qualified by education, training and licensure to administer moderate sedation should supervise the administration of moderate sedation. This statement can be used by any facility—hospital, ambulatory care or physician's, dentist's or podiatrist's office—in which an internal or external credentialing process is required for administration of sedative and analgesic drugs to establish a level of moderate sedation.

REFERENCES
ASA has produced many documents over the years related to the topic addressed by this statement, among them the following:

Guidelines for Delineation of Clinical Privileges in Anesthesiology (Approved by ASA House of Delegates on October 15, 1975, and last amended on October 15, 2003)

Statement on Qualifications of Anesthesia Providers in the Office-Based Setting (Approved by ASA House of Delegates on October 13, 1999, and last affirmed on October 27, 2004)

Statement on Safe Use of Propofol (Approved by ASA House of Delegates on October 27, 2004)
Guidelines for Office-Based Anesthesia and Surgery (Approved by ASA House of Delegates on October 13, 1999, and last affirmed on October 27, 2004)

*Guidelines for Ambulatory Anesthesia and Surgery (*Approved by ASA House of Delegates on October 11, 1973, and last affirmed on October 15, 2003)

Outcome Indicators for Office-Based and Ambulatory Surgery (ASA Committee on Ambulatory Surgical Care and Task Force on Office-Based Anesthesia, April 2003)

AANA-ASA Joint Statement Regarding Propofol Administration (April 14, 2004) *Practice Guidelines for Sedation and Analgesia by Nonanesthesiologists* (Approved by ASA House of Delegates on October 25, 1995, and last amended on October 17, 2001)

Continuum of Depth of Sedation – Definition of General Anesthesia and Levels of Sedation/Analgesia (Approved by ASA House of Delegates on October 13, 1999, and last amended on October 27, 2004)

Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures (Approved by ASA House of Delegates on October 21, 1998, and effective January 1, 1999)

The Ad Hoc Committee on Sedation Credentialing Guidelines for Nonanesthesiologists took the contents of the above documents into consideration when developing this statement.

DEFINITIONS

Anesthesia Professional: An anesthesiologist, certified registered nurse anesthetist (CRNA) or anesthesiologist assistant (AA).

Nonanesthesiologist Sedation Practitioner: A licensed physician (allopathic or osteopathic), dentist or podiatrist who has not completed postgraduate training in anesthesiology but is specifically trained to personally administer or supervise the administration of moderate sedation.

Supervised Sedation Professional: A licensed registered nurse, advanced practice nurse or physician assistant who is trained to administer medications and monitor patients during moderate sedation **under the direct supervision of a nonanesthesiologist sedation practitioner or an anesthesiologist.**

Credentialing: The process of documenting and reviewing a practitioner's credentials.

Credentials: The professional qualifications of a practitioner including education, training, experience and performance.

Privileges: The clinical activities within a health care organization that a practitioner is permitted to perform based on the practitioner's credentials.

Guidelines: A set of recommended practices that should be considered but permit discretion by the user as to whether they should be applied under any particular set of circumstances.

*** Moderate Sedation**: "Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained."

* **Deep Sedation:** "Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained."

*** Rescue:** "Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiologic consequences of the deeper-than intended level of sedation (such as hypoventilation, hypoxia and hypotension) and returns the patient to the originally intended level of sedation."

*** General Anesthesia**: "General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired."

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*The definitions marked with an asterisk are extracted verbatim from "Continuum of Depth of Sedation – Definition of General Anesthesia and Levels of Sedation/Analgesia (Approved by ASA House of Delegates on October 13, 1999, and amended on October 27, 2004).

STATEMENT

The following statement is designed to assist health care organizations develop a program for the delineation of clinical privileges for practitioners who are not anesthesia professionals to administer sedative and analgesic drugs to establish a level of moderate sedation. (Moderate sedation is also known as "conscious sedation.") The statement is written to apply to every setting in which an internal or external credentialing process is required for granting privileges to administer sedative and analgesic drugs to establish a level of moderate sedation (e.g., hospital, freestanding procedure center, ambulatory surgery center, physician's, dentist's or podiatrist's office, etc.). The statement is not intended nor should it be applied to the granting of privileges to administer deep sedation or general anesthesia.

The granting, reappraisal and revision of clinical privileges should be awarded on a time-limited basis in accordance with rules and regulations of the health care organization, its medical staff, organizations accrediting the health care organization and relevant local, state and federal governmental agencies.

I. NONANESTHESIOLOGIST SEDATION PRACTITIONERS

Only physicians, dentists or podiatrists who are qualified by education, training and licensure to administer moderate sedation should supervise the administration of moderate sedation. Nonanesthesiologist sedation practitioners may directly supervise patient monitoring and the administration of sedative and analgesic medications by a **supervised sedation professional**. Alternatively, they may personally perform these functions, with the proviso that the individual monitoring the patient should be distinct from the individual performing the diagnostic or therapeutic procedure (see *ASA Guidelines for Sedation and Analgesia by Nonanesthesiologists*).

A. Education and Training

The nonanesthesiologist sedation practitioner who is to supervise or personally administer medications for moderate sedation should have satisfactorily completed a formal training program in: (1) the safe administration of sedative and analgesic drugs used to establish a level of moderate sedation, and (2) rescue of patients who exhibit adverse physiologic consequences of a deeper-than-intended level of sedation. This training may be a part of a recently completed residency or fellowship training (e.g., within two years), or may be a separate educational program. A knowledge-based test may be used to verify the practitioner's understanding of these concepts.** The following subject areas should be included:

1. Contents of the following ASA documents that should be understood by practitionerswho administer sedative and analgesic drugs to establish a level of moderate sedation:
   - *Practice Guidelines for Sedation and Analgesia by Nonanesthesiologists*
   - *Continuum of Depth of Sedation – Definition of General Anesthesia and Levels of Sedation/Analgesia*

** The post-test included with the ASA Sedation/Analgesia by Nonanesthesiologists videotape (ASA Document #30503-10PPV) may be considered for this purpose

2. Appropriate methods for obtaining informed consent through pre-procedure counseling of patients regarding risks, benefits and alternatives to the administration of sedative and analgesic drugs to establish a level of moderate sedation

3. Skills for obtaining the patient's medical history and performing a physical examination to assess risks and co-morbidities, including assessment of the airway for anatomic and mobility characteristics suggestive of potentially difficult airway management. The nonanesthesiologist sedation practitioner should be able to recognize those patients whose medical condition suggests that sedation should be provided by an anesthesia professional.

4. Assessment of the patient's risk for aspiration of gastric contents as described in the *ASA Practice Guidelines for Preoperative Fasting*: "In urgent, emergent or other situations where gastric emptying is impaired, the potential for pulmonary aspiration of gastric contents must be considered in determining (1) the target level of sedation, (2) whether the procedure should be delayed or (3) whether the trachea should be protected by intubation."

5. The pharmacology of (1) all sedative and analgesic drugs the practitioner requests privileges to administer to establish a level of moderate sedation, (2) pharmacological antagonists to the sedative and analgesic drugs and (3) vasoactive drugs and antiarrhythmics.

6. The benefits and risks of supplemental oxygen.

7. Proficiency of airway management with facemask and positive pressure ventilation. This training should include appropriately supervised experience in managing the airways of patients, or qualified instruction on an airway simulator (or both).

8. Monitoring of physiologic variables, including the following:
    a. Blood pressure
    b. Respiratory rate
    c. Oxygen saturation by pulse oximetry
    Electrocardiographic monitoring. Education in electrocardiographic (EKG) monitoring should include instruction in the most common arrhythmias seen during sedation and anesthesia, their causes and their potential clinical implications (e.g., hypercapnia), as well as electrocardiographic signs of cardiac ischemia
    d. Depth of sedation. The depth of sedation should be based on the ASA definitions of "moderate sedation" and "deep sedation." (See above)
    e. Capnography–if moderate sedation is to be administered in settings where patients' ventilatory function cannot be directly monitored (e.g., MRI suite).

9. The importance of continuous use of appropriately set audible alarms on physiologic monitoring equipment.

10. Documenting the drugs and fluids administered, the patient's physiologic condition and the depth of sedation at regular intervals throughout the period of sedation and analgesia, using a graphical, tabular or automated record.

11. If moderate sedation is to be administered in a setting where individual(s) with advanced life support skills will not be immediately available (1-5 minutes; e.g., code team), then the nonanesthesiologist sedation practitioner should have advanced life support skills such as those required for American Heart Association certification in Advanced Cardiac Life Support (ACLS). When granting privileges to administer moderate sedation to pediatric patients, the nonanesthesiologist sedation practitioner should have advanced life support skills such as those required for certification in Pediatric Advanced Life Support (PALS).

12. When the practitioner is being granted privileges to administer sedative and analgesic drugs to pediatric patients to establish a level of moderate sedation, the education and training requirements enumerated in #1-9 above should be appropriately tailored to qualify the practitioner to administer sedative and analgesic drugs to pediatric patients.

B. Licensure

1. The nonanesthesiologist sedation practitioner should have a current active, unrestricted medical, osteopathic, dental or podiatric license in the state, district or territory of practice. (Exception: practitioners employed by the federal government may have a current active license in any U.S. state, district or territory.)

2. The nonanesthesiologist sedation practitioner should have a current unrestricted Drug Enforcement Administration (DEA) registration (schedules II-V).

3. The credentialing process should require disclosure of any disciplinary action (final judgments) against any medical, osteopathic or podiatric license by any state, district or territory of practice and of any sanctions by any federal agency, including Medicare/Medicaid, in the last five years.

4. Before granting or renewing privileges to administer or supervise the administration of sedative and analgesic drugs to establish a level of moderate sedation, the health care organization should search for any disciplinary action recorded in the National Practitioner Data Bank (NPDB) and take appropriate action regarding any Adverse Action Reports.

C. Practice Pattern

1. Before granting initial privileges to administer or supervise administration of sedative

and analgesic drugs to establish a level of moderate sedation, a process should be developed to evaluate the practitioner's performance. For recent graduates (e.g., within two years), this may be accomplished through letters of recommendation from directors of residency or fellowship training programs which include moderate sedation as part of the curriculum. For those who have been in practice since completion of their training, this may be accomplished through communication with department heads or supervisors at the institution where the individual holds privileges to administer moderate sedation. Alternatively, the nonanesthesiologist sedation practitioner could be proctored or supervised by a physician, dentist or podiatrist who is currently privileged to administer sedative and analgesic agents to provide moderate sedation. The facility should establish an appropriate number of procedures to be supervised.

2. Before granting ongoing privileges to administer or supervise administration of sedative and analgesic drugs to establish a level of moderate sedation, a process should be developed to re-evaluate the practitioner's performance at regular intervals. For example, the practitioner's performance could be reviewed by an anesthesiologist or a nonanesthesiologist sedation practitioner who is currently privileged to administer sedative and analgesic agents to provide moderate sedation. The facility should establish an appropriate number of procedures that will be reviewed.

D. Performance Improvement

Credentialing in the administration of sedative and analgesic drugs to establish a level of moderate sedation should require active participation in an ongoing process that evaluates the practitioner's clinical performance and patient care outcomes through a formal program of continuous performance improvement.

1. The organization in which the practitioner practices should conduct peer review of its clinicians.

2. The performance improvement process should assess up-to-date knowledge as well as ongoing competence in the skills outlined in the educational and training requirements described above.

3. The performance improvement process should monitor and evaluate patient outcomes and adverse events.

II. SUPERVISED SEDATION PROFESSIONAL

A. Education and Training

The supervised sedation professional who is granted privileges to administer sedative and analgesic drugs under supervision of a nonanesthesiologist sedation practitioner or anesthesiologist and to monitor patients during moderate sedation can be a registered nurse who has graduated from a qualified school of nursing or a physician assistant who has graduated from an accredited physician assistant program. They

may only administer sedative and analgesic medications on the order of an anesthesiologist or nonanesthesiologist sedation practitioner. They should have satisfactorily completed a formal training program in 1) the safe administration of sedative and analgesic drugs used to establish a level of moderate sedation, 2) use of reversal agents for opioids and benzodiazepines, 3) monitoring of patients' physiologic parameters during sedation, and 4) recognition of abnormalities in monitored variables that require intervention by the nonanesthesiologist sedation practitioner or anesthesiologist. Training should include the following:

1. Contents of the following ASA documents:
   - *Practice Guidelines for Sedation and Analgesia by Nonanesthesiologists*
   - *Continuum of Depth of Sedation – Definition of General Anesthesia and Levels of Sedation/Analgesia*

2. The pharmacology of (1) all sedative and analgesic drugs the practitioner requests privileges to administer to establish a level of moderate sedation, and (2) pharmacological antagonists to the sedative and analgesic drugs.

3. The benefits and risks of supplemental oxygen.

4. Airway management with facemask and positive pressure ventilation.

5. Monitoring and recognizing abnormalities of physiologic variables, including the following:
   a. Blood pressure
   b. Respiratory rate
   c. Oxygen saturation by pulse oximetry
   d. Electrocardiographic monitoring
   e. Depth of sedation. The depth of sedation should be based on the ASA definitions of "moderate sedation" and "deep sedation." (See above)
   f. Capnography–if moderate sedation is to be administered in settings where patients' ventilatory function cannot be directly monitored.

6. The importance of continuous use of appropriately set audible alarms on all physiologic monitors.

7. Documenting the drugs administered, the patient's physiologic condition and the depth of sedation at regular intervals throughout the period of sedation and analgesia, using a graphical, tabular or automated record.

B. Licensure

1. The supervised sedation professional should have a current active nursing license or physician assistant license or certification, in the U.S. state, district or territory of practice. (Exception: practitioners employed by the federal government may have a current active license in any U.S. state, district or territory.)

2. Before granting or renewing privileges for a supervised sedation professional to administer sedative and analgesic drugs and to monitor patients during moderate sedation, the health care organization should search for any disciplinary action recorded in the National Practitioner Data Bank (NPDB) and take appropriate action regarding any Adverse Action Reports.

C. Practice Pattern

1. Before granting ongoing privileges to administer sedative and analgesic drugs to establish a level of moderate sedation, a process should be developed to re-evaluate the supervised sedation professional's performance. The facility should establish performance criteria and an appropriate number of procedures to be reviewed.

D. Performance Improvement

Credentialing of supervised sedation professionals in the administration of sedative and analgesic drugs and monitoring patients during moderate sedation should require active participation in an ongoing process that evaluates the health care professional's clinical performance and patient care outcomes through a formal program of continuous performance improvement.

1. The organization in which the practitioner practices should conduct peer review of its supervised sedation professionals.

2. The performance improvement process should assess up-to-date knowledge as well as ongoing competence in the skills outlined in the educational and training requirements described above.

APPENDIX B

STATEMENT ON GRANTING PRIVILEGES TO NONANESTHESIOLOGIST PHYSICIANS FOR PERSONALLY ADMINISTERING OR SUPERVISING DEEP SEDATION

(Approved by the ASA House of Delegates on October 18, 2006, and amended on October 17, 2012)

Because of the significant risk that patients who receive deep sedation may enter a state of general anesthesia, privileges for deep sedation should be granted only to nonanesthesiologist physicians who are qualified and trained in the medical practice of deep sedation and the recognition of and rescue from general anesthesia.

Nonanesthesiologist physicians may neither delegate nor supervise the administration or monitoring of deep sedation by individuals who are not themselves qualified and trained to administer deep sedation, and the recognition of and rescue from general anesthesia.

APPENDIX C

STATEMENT ON GRANTING PRIVILEGES FOR DEEP SEDATION TO NON-ANESTHESIOLOGIST SEDATION PRACTITIONERS

(Approved by the ASA House of Delegates on October 20, 2010)

1. INTRODUCTION

The American Society of Anesthesiologists is vitally interested in the safe administration of all anesthesia services including moderate and deep sedation. As such, it has concern for any system or set of practices, used either by its members or the members of other disciplines that would adversely affect the safety of anesthesia or sedation administration. It has genuine concern that individuals, however well intentioned, who are not anesthesia professionals may not recognize that sedation and general anesthesia are on a continuum, and thus deliver levels of sedation that may, in fact, be general anesthesia without having the training and experience to respond appropriately.

ASA believes that anesthesiologist participation in all deep sedation is the best means to achieve the safest care. ASA acknowledges, however, that Medicare regulations permit some non- anesthesiologists to administer or supervise the administration of deep sedation. This advisory should not be considered as an endorsement, or absolute condemnation, of this practice by ASA but rather to serve as a potential guide to its members who may be called upon by administrators or others to provide input in this process. This document provides a framework to identify those physicians, dentists, oral surgeons or podiatrists who may potentially qualify to administer or supervise the administration of deep sedation.

This document applies only to the care of patients undergoing procedural sedation, and it may not be construed as privileges to intentionally administer general anesthesia. Unrestricted general anesthesia shall only be administered by anesthesia professionals within their scope of practice (anesthesiologists, certified registered nurse anesthetists and anesthesiologist assistants). If the patient loses consciousness and the ability to respond purposefully, the anesthesia care is a general anesthetic, irrespective of whether airway instrumentation is required.

When deep sedation is intended, there is a significant risk that patients may slip into a state of general anesthesia (from which they cannot be aroused by painful or repeated stimulation). Therefore, individuals requesting privileges to administer deep sedation must demonstrate their ability to (1) recognize that a patient has entered a state of general anesthesia and (2) maintain a patient's vital functions until the patient has been returned to an appropriate level of sedation.

Definitions of terms appear at the end of this document. Of special note, for purposes of this document the following definitions are relevant:

1.1 Anesthesia Professional: An anesthesiologist, anesthesiologist assistant (AA), or certified registered nurse anesthetist (CRNA).

1.2 Non-anesthesiologist Sedation Practitioner: A licensed physician (allopathic or osteopathic); or dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law; who has not completed postgraduate training in anesthesiology but is specifically trained to administer personally or to supervise the administration of deep sedation.

2. ADVISORY

This advisory is designed to assist health care facilities in developing a program for the delineation of clinical privileges for practitioners who are not anesthesia professionals to administer sedative and analgesic drugs to establish a level of deep sedation. They are written to apply to every setting in which an internal or external privileging process is required for granting privileges to administer sedative and analgesic drugs to establish a level of deep sedation (e.g., hospital, freestanding procedure center, ambulatory surgery center, physician's or dentist's office, etc.). These recommendations do not lead to the granting of privileges to administer general anesthesia.

The granting, reappraisal and revision of clinical privileges will be awarded on a time-limited basis in accordance with rules and regulations of the health care facility, its medical staff, organizations accrediting the health care facility, and relevant local, state and federal governmental agencies.

NON-ANESTHESIOLOGIST SEDATION PRACTITIONERS

> Note: The *Hospital Anesthesia Services Condition of Participation 42 CFR 482.52(a)* limits the administration of deep sedation to "qualified anesthesia professionals" within their scope of practice. CMS defines these personnel specifically as an anesthesiologist; non- anesthesiologist MD or DO; dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law; CRNA, and AA. See also the *Ambulatory Surgery Center Condition for Coverage 42 CFR 416.42(b).*

Only physicians and other practitioners specifically permitted by CMS, above, who are qualified by education, training and licensure to administer deep sedation may administer deep sedation or supervise the administration of deep sedation when administered by CRNAs. Because training is procedure specific, the type and complexity of procedures for which the practitioner may administer or supervise deep sedation must be specified in the privileges granted.

Any professional who administers and monitors deep sedation must be dedicated to that task. Therefore, the non-anesthesiologist sedation practitioner who administers and monitors deep sedation must be different from the individual performing the diagnostic or therapeutic procedure (see ASA Guidelines for Sedation and Analgesia by Non-anesthesiologists).

3. EDUCATION AND TRAINING

The non-anesthesiologist sedation practitioner will have satisfactorily completed a formal training program in (1) the safe administration of sedative and analgesic drugs used to establish a level of deep sedation, and (2) rescue of patients who exhibit adverse physiologic consequences of a deeper-than-intended level of sedation. This training may be a formally recognized part of a recently completed Accreditation Council for Graduate Medical Education (ACGME) residency or fellowship training (e.g., within two years), or may be a separate deep sedation educational program that is accredited by Accreditation Council for Continuing Medical Education (ACCME) or equivalent providers recognized for dental, oral surgical and podiatric continuing education, and that includes the didactic and performance concepts below. A knowledge-based test is necessary to objectively demonstrate the knowledge of concepts required to obtain privileges. The following subject areas will be included:

3.1 Contents of the following ASA documents (or their more current version if subsequently modified) that will be understood by practitioners who administer sedative and analgesic drugs to establish a level of deep sedation

3.1.1 Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. Anesthesiology 2002: 96; 1004-1017.

3.1.2 Continuum of Depth of Sedation; Definition of General Anesthesia and Levels of Sedation/Analgesia (ASA HOD 2004, amended 2009)

3.1.3 Standards for Basic Anesthetic Monitoring (Approved by the ASA House of Delegates on October 21, 1986, and last amended on October 25, 2005)

3.1.4 Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures (Approved by ASA House of Delegates on October 21, 1998, and effective January 1, 1999)

3.2 Appropriate methods for obtaining informed consent through pre-procedure counseling of patients regarding risks, benefits and alternatives to the administration of sedative and analgesic drugs to establish a level of deep sedation.

3.3 Skills for obtaining the patient's medical history and performing a physical examination to assess risks and co-morbidities, including assessment of the airway for anatomic and mobility characteristics suggestive of potentially difficult airway management. The non-anesthesiologist sedation practitioner will be able to recognize those patients whose medical condition requires that sedation needs to be provided by an anesthesia professional, such as morbidly obese patients, elderly patients, pregnant patients, patients with severe systemic disease, patients with obstructive sleep apnea, or patients with delayed gastric emptying.

3.4 Assessment of the patient's risk for aspiration of gastric contents as described in the ASA Practice Guidelines for Preoperative Fasting. In urgent, emergent or other situations where gastric emptying is impaired, the potential for pulmonary aspiration of gastric contents must be considered in determining:

3.4.1 The target level of sedation

3.4.2 Whether the procedure should be delayed

3.4.3 Whether the sedation care should be transferred to an anesthesia professional for the delivery of general anesthesia with endotracheal intubation.

3.5 The pharmacology of

3.5.1 All sedative and analgesic drugs the practitioner requests privileges to administer to establish a level of deep sedation

3.5.2 Pharmacological antagonists to the sedative and analgesic drugs

3.5.3 Vasoactive drugs and antiarrhythmics

3.6 The benefits and risks of supplemental oxygen.

3.7 Recognition of adequacy of ventilatory function: This will include experience with patients whose ventilatory drive is depressed by sedative and analgesic drugs as well as patients whose airways become obstructed during sedation. This will also include the ability to perform capnography and understand the results of such monitoring. Non-anesthesiologist practitioners will demonstrate competency in managing patients during deep sedation, and understanding of the clinical manifestations of general anesthesia so that they can ascertain when a patient has entered a state of general anesthesia and rescue the patient appropriately.

3.8 Proficiency in advanced airway management for rescue: This training will include appropriately supervised experience to demonstrate competency in managing the airways of patients during deep sedation, and airway management using airway models as well as using high-fidelity patient simulators. The non-anesthesiologist practitioner must demonstrate the ability to reliably perform the following:

3.8.1 Bag-valve-mask ventilation

3.8.2 Insertion and use of oro- and nasopharyngeal airways

3.8.3 Insertion and ventilation through a laryngeal mask airway

3.8.4 Direct laryngoscopy and endotracheal intubation

This will include clinical experience on no less than 35 patients or equivalent simulator experience (See ACGME reference). The facility with oversight by the Director of Anesthesia Services will determine the number of cases needed to demonstrate these competencies, and may increase beyond the minimum recommended.

3.9 Monitoring of physiologic variables, including the following:

3.9.1 Blood pressure.

3.9.2 Respiratory rate.

3.9.3 Oxygen saturation by pulse oximetry with audible variable pitch pulse tone.

3.9.4 Capnographic monitoring. The non-anesthesiologist practitioner shall be familiar with the use and interpretation of capnographic waveforms to determine the adequacy of ventilation during deep sedation.

3.9.5 Electrocardiographic monitoring. Education in electrocardiographic (EKG) monitoring will include instruction in the most common dysrhythmias seen during sedation and anesthesia, their causes and their potential clinical implications (e.g., hypercapnia), as well as electrocardiographic signs of cardiac ischemia.

3.9.6 Depth of sedation. The depth of sedation will be based on the ASA definitions of "deep sedation" and "general anesthesia." (See below).

3.10 The importance of continuous use of appropriately set audible alarms on physiologic monitoring equipment.

3.11 Documenting the drugs administered, the patient's physiologic condition and the depth of

sedation at five-minute intervals throughout the period of sedation and analgesia, using a graphical, tabular or automated record which documents all the monitored parameters including capnographic monitoring.

3.12 The importance of monitoring the patient through the recovery period and the inclusion of specific discharge criteria for the patient receiving sedation.

3.13 Regardless of the availability of a "code team" or the equivalent, the non- anesthesiologist practitioner will have advanced life support skills and current certificate such as those required for Advanced Cardiac Life Support (ACLS). When granting privileges to administer deep sedation to pediatric patients, the non- anesthesiologist practitioner will have advanced life support skills and current certificate such as those required for Pediatric Advanced Life Support (PALS). Initial ACLS and PALS training and subsequent retraining shall be obtained from the American Heart Association or another vendor that includes "hands-on" training and skills demonstration of airway management and automated external defibrillator (AED) use.

3.14 Required participation in a quality assurance system to track adverse outcomes and unusual events including respiratory arrests, use of reversal agents, prolonged sedation in recovery process, larger than expected medication doses, and occurrence of general anesthesia, with oversight by the Director of Anesthesia services or their designee.

3.15 Knowledge of the current CMS Conditions of Participation regulations and their interpretive guidelines pertaining to deep sedation, including requirements for the pre- anesthesia evaluation, anesthesia intra-operative record, and post-anesthesia evaluation.

Separate privileging is required for the care of pediatric patients. When the non-anesthesiologist practitioner is granted privileges to administer sedative and analgesic drugs to pediatric patients to establish a level of deep sedation, the education and training requirements enumerated in #1-15 above will be specifically defined to qualify the practitioner to administer sedative and analgesic drugs to pediatric patients.

4. LICENSURE

4.1 The non-anesthesiologist sedation practitioner will have a current active, unrestricted medical, osteopathic, or dental license in the state, district or territory of practice. (Exception: practitioners employed by the federal government may have a current active license in any U.S. state, district or territory.)

4.2 The non-anesthesiologist sedation practitioner will have a current unrestricted Drug Enforcement Administration (DEA) registration (schedules II-V).

4.3 The privileging process will require disclosure of any disciplinary action (final judgments) against any medical, osteopathic or dental license by any state, district or territory of practice and of any sanctions by any federal agency, including Medicare/Medicaid, in the last five years.

4.4 Before granting or renewing privileges to administer or supervise the administration of sedative and analgesic drugs to establish a level of deep sedation, the health care organization shall search for any disciplinary action recorded in the National Practitioner Data Bank (NPDB) and take appropriate action regarding any Adverse Action Reports.

5. PERFORMANCE EVALUATION

5.1 Before granting initial privileges to administer or supervise administration of sedative and analgesic drugs to establish a level of deep sedation, a process will be developed to evaluate the practitioner's performance and competency. For recent graduates (e.g., within two years), this may be accomplished through letters of recommendation from directors of residency or fellowship training programs that include deep sedation as part of the curriculum. For those who have been in practice since completion of their training, performance evaluation may be accomplished through specific documentation of performance evaluation data transmitted from department heads or supervisors at the institution where the individual previously held privileges to administer deep sedation. Alternatively, the non-anesthesiologist sedation practitioner could be proctored or supervised by a physician or dentist who is currently privileged to administer sedative and analgesic agents to provide deep sedation. The Director of Anesthesia Services with oversight by the facility governing body will determine the number of cases that need to be performed in order to determine independent competency in deep sedation.

5.2 Before granting ongoing privileges to administer or supervise administration of sedative and analgesic drugs to establish a level of deep sedation, a process will be developed to re-evaluate the practitioner's performance at regular intervals. Re- evaluation of competency in airway management will be part of this performance evaluation. For example, the practitioner's performance could be reviewed by an anesthesiologist or a non-anesthesiologist sedation practitioner who is currently privileged to administer deep sedation. The facility will establish an appropriate number of procedures that will be reviewed.

6. PERFORMANCE IMPROVEMENT

Privileging in the administration of sedative and analgesic drugs to establish a level of deep sedation will require active participation in an ongoing process that evaluates the practitioner's clinical performance and patient care outcomes through a formal facility program of continuous performance improvement. The facility's deep sedation performance improvement program will be developed with advice from and with outcome review by the Director of Anesthesia Services.

6.1 The organization in which the practitioner practices will conduct peer review of its clinicians.

6.2 The performance improvement program will assess up-to-date knowledge as well as ongoing competence in the skills outlined in the educational and training requirements described above.

6.3 Continuing medical education in the delivery of anesthesia services is required for renewal of privileges.

6.4 The performance improvement program will monitor and evaluate patient outcomes and adverse or unusual events.

6.5 Any of the following events will be referred to the facility quality assurance committee for evaluation and performance evaluation:

6.5.1 Unplanned admission

6.5.2 Cardiac arrest

6.5.3 Use of reversal agents

6.5.4 Use of assistance with ventilation requiring bag-valve-mask ventilation or laryngeal or endotracheal airways.

6.5.5 Prolonged periods of oxygen desaturation (<85% for 3 minutes)

6.5.6 Failure of the patient to return to 20% of pre-procedure vital signs

7. DEFINITIONS

Anesthesia Professional: An anesthesiologist, anesthesiologist assistant (AA), or certified registered nurse anesthetist (CRNA).

Non-anesthesiologist Sedation Practitioner: A licensed physician (allopathic or osteopathic); or dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law; who has not completed postgraduate training in anesthesiology but is specifically trained to administer personally or to supervise the administration of deep sedation.

Privileges: The clinical activities within a health care organization that a practitioner is permitted to perform.

Privileging: The process of granting permission to perform certain clinical activities based on credentials, experience, and demonstrated performance
Credentials: The professional qualifications of a practitioner including education, training, experience and performance

Credentialing: The process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a healthcare organization.

Procedural sedation: The administration of sedative and analgesic drugs for a non-surgical diagnostic or therapeutic procedure.

Definitions of the continuum of sedation:

* Moderate Sedation: "Moderate Sedation/Analgesia ("Conscious Sedation") is a drug- induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained."

* Deep Sedation: "Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained."

* Rescue: "Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner

corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia and hypotension) and returns the patient to the originally intended level of sedation. It is not appropriate to continue the procedure at an unintended level of sedation."

* General Anesthesia: "General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired."

*The definitions marked with an asterisk are extracted verbatim from "Continuum of Depth of Sedation – Definition of General Anesthesia and Levels of Sedation/Analgesia" (Approved by ASA House of Delegates on October 13, 1999, and amended on October 21, 2009). *Expanded definitions of moderate and deep sedation can be found in the CMS Interpretive Guidelines.*

8. REFERENCES

The American Society of Anesthesiologists has produced many documents over the years related to the topic addressed by this advisory, among them the following (in alphabetical order):

AANA-ASA Joint Statement Regarding Propofol Administration (April 14, 2004)

Continuum of Depth of Sedation – Definition of General Anesthesia and Levels of Sedation/Analgesia (Approved by ASA House of Delegates on October 13, 1999, and last amended on October 21, 2009).

Distinguishing Monitored Anesthesia Care ("MAC") from Moderate Sedation/Analgesia (Conscious Sedation). (Approved by the ASA House of Delegates on October 27, 2004 and last amended on October 21, 2009)

Guidelines for Ambulatory Anesthesia and Surgery (Approved by ASA House of Delegates on October 11, 1973, and last amended on October 22, 2008)

Guidelines for Delineation of Clinical Privileges in Anesthesiology (Approved by ASA House of Delegates on October 15, 1975, and last amended on October 22, 2008)

Guidelines for Office-Based Anesthesia and Surgery (Approved by ASA House of Delegates on October 13, 1999, and last affirmed on October 21, 2009)

Outcome Indicators for Office-Based and Ambulatory Surgery (ASA Committee on Ambulatory Surgical Care and Task Force on Office-Based Anesthesia, April 2003)

Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures. Anesthesiology 1999; 90: 896-905.

Practice Guidelines for Sedation and Analgesia by Non-anesthesiologists. Anesthesiology 2002: 96; 1004-1017.

Standards for Basic Anesthetic Monitoring (Approved by the ASA House of Delegates on October 21, 1986, and last amended on October 20, 2010)

Statement on Granting Privileges for Administration of Moderate Sedation to Practitioners Who Are Not Anesthesia Professionals (Approved by the ASA House of Delegates on October 25, 2005, and last amended on October 18, 2006)

Statement on Qualifications of Anesthesia Providers in the Office-Based Setting (Approved by ASA House of Delegates on October 13, 1999, and last amended on October 21, 2009)

Statement on Safe Use of Propofol (Approved by ASA House of Delegates on October 27, 2004 and amended on October 21, 2009)

In addition the following references may be considered:

ACGME Emergency Medicine residency program guidelines for number of intubations needed:
http://www.acgme.org/acWebsite/RRC_110/110_guidelines.asp#res

American Academy of Pediatrics, American Academy of Pediatric Dentistry, Cote CJ, Wilson S, and the Workgroup on Sedation. Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures: An Update. Pediatrics 2006; 118: 2587-2602.

Centers for Medicare and Medicaid Services Revisions to Interpretive Guidelines for Hospital Condition of Participation, December 11, 2009.
http://www.cms.gov/surveycertificationgeninfo/pmsr/itemdetail.asp?itemid=CMS1231690

Centers for Medicare and Medicaid Services Revisions to Interpretive Guidelines for Ambulatory Surgery Centers Condition for Coverage, December 30, 2009.
https://www.cms.gov/transmittals/downloads/R56SOMA.pdf

APPENDIX D

STATEMENT ON THE ANESTHESIA CARE TEAM

Committee of Origin: Anesthesia Care Team

(Approved by the ASA House of Delegates on October 26, 1982, and last amended on October 16, 2013)

Anesthesiology is the practice of medicine including, but not limited to, preoperative patient evaluation, anesthetic planning, intraoperative and postoperative care and the management of systems and personnel that support these activities. In addition, anesthesiology includes perioperative consultation, the management of coexisting disease, the prevention and management of untoward perioperative patient conditions, the treatment of acute and chronic pain, and the practice of critical care medicine. This care is personally provided by or directed by the anesthesiologist.

In the interests of patient safety and quality of care, the American Society of Anesthesiologists believes that the involvement of an anesthesiologist in the perioperative care of every patient is necessary. Almost all anesthesia care is either provided personally by an anesthesiologist or is provided by a non-physician anesthesia practitioner directed by an anesthesiologist. The latter mode of anesthesia delivery is called the Anesthesia Care Team and involves the delegation of monitoring and appropriate tasks by the physician to non-physicians. Such delegation should be specifically defined by the anesthesiologist and should also be consistent with state law or regulations and medical staff policy. Although selected tasks of overall anesthesia care may be delegated to qualified members of the Anesthesia Care Team, overall responsibility for the Anesthesia Care Team and patients' safety ultimately rests with the anesthesiologist.

Definitions

1. Core Members of the Anesthesia Care Team

The Anesthesia Care Team includes both physicians and non-physicians. All members of the team have an obligation to accurately identify themselves and other team members to patients and families. Anesthesiologists should not permit the misrepresentation of non-physician personnel as resident physicians or practicing physicians. The nomenclature below is appropriate terminology for this purpose.

a. Physicians

ANESTHESIOLOGIST**: Director of the Anesthesia Care Team;** a **physician** licensed to practice medicine who has successfully completed a training program in anesthesiology accredited by the ACGME, the American Osteopathic Association or equivalent organizations.

ANESTHESIOLOGY FELLOW: An **anesthesiologist** enrolled in a training program to obtain additional education in one of the subdisciplines of anesthesiology.

ANESTHESIOLOGY RESIDENT: A **physician** enrolled in an accredited anesthesiology residency program.

b. Non-physicians

ANESTHETIST: A **nurse anesthetist** or **anesthesiologist assistant**, as each is defined below. (Note: In some countries where non-physicians do not participate in the administration of anesthesia, a physician who practices anesthesiology is known as an "anaesthetist" or "anesthetist")

NURSE ANESTHETIST: A **registered nurse** who has satisfactorily completed an accredited nurse anesthesia training program and certifying examination (also, "CRNA").

ANESTHESIOLOGIST ASSISTANT: A **health professional** who has satisfactorily completed an accredited anesthesiologist assistant training program and certifying examination (also, "AA").

STUDENT NURSE ANESTHETIST: A **registered nurse** who is enrolled in an accredited nurse anesthesia training program.

ANESTHESIOLOGIST ASSISTANT STUDENT: A **health profession graduate student** who has satisfied all prerequisite coursework typical of an accredited school of medicine and is enrolled in an accredited anesthesiologist assistant training program.

NON-PHYSICIAN ANESTHESIA STUDENT**:** Student nurse anesthetists, anesthesiologist assistant students, dental anesthesia students and others who are enrolled in accredited anesthesia training programs.

OTHERS: Although not considered core members of the Anesthesia Care Team, other health care professionals make important contributions to the perianesthetic care of the patient (see Addendum A).

2. Additional Terms

ANESTHESIA CARE TEAM: Anesthesiologists supervising resident physicians and/or directing qualified non-physician anesthesia practitioners in the provision of anesthesia care, wherein the physician may delegate monitoring and appropriate tasks while retaining overall responsibility for the patient.

QUALIFIED ANESTHESIA PERSONNEL OR PRACTITIONERS: Anesthesiologists, anesthesiology fellows, anesthesiology residents, oral surgery residents, anesthesiologist assistants, and nurse anesthetists.

MEDICAL SUPERVISION AND MEDICAL DIRECTION: Terms used to describe the physician work required to oversee, manage and guide both residents and non-physician members of the Anesthesia Care Team. For the purposes of this statement, supervision and direction are interchangeable and have no relation to the billing, payment or regulatory definitions that provide distinctions between these two terms (see Addendum B).

SEDATION NURSE AND SEDATION PHYSICIAN ASSISTANT: A licensed registered nurse, advanced practice nurse or physician assistant who is trained in compliance with all relevant local, institutional, state and/or national standards, policies or guidelines to administer prescribed sedating and analgesic medications and monitor

patients during minimal sedation ("anxiolysis") or moderate sedation ("conscious sedation"), but not deeper levels of sedation or general anesthesia. Sedation nurses and sedation physician assistants may only work under the direct supervision of a properly trained and privileged physician (MD or DO).
PROCEDURE ROOM: An operating room or other location where an operation or procedure is performed under anesthesia care.

IMMEDIATELY AVAILABLE: Wherever it appears in this document, the phrase "immediately available" is used as defined in the ASA policy statement "Definition of 'Immediately Available' When Medically Directing" (see Addendum C).

Safe Conduct of the Anesthesia Care Team
In order to achieve optimum patient safety, the anesthesiologist who directs the Anesthesia Care Team is responsible for the following:

1. **Management of personnel**: Anesthesiologists should assure the assignment of appropriately skilled physician and/or non-physician personnel for each patient and procedure.

2. **Preanesthetic evaluation of the patient**: A preanesthetic evaluation allows for the development of an anesthetic plan that considers all conditions and diseases of the patient that may influence the safe outcome of the anesthetic. Although non-physicians may contribute to the preoperative collection and documentation of patient data, the anesthesiologist is responsible for the overall evaluation of each patient.

3. **Prescribing the anesthetic plan**: The anesthesiologist is responsible for prescribing an anesthesia plan aimed at the greatest safety and highest quality for each patient. The anesthesiologist discusses with the patient or guardian, as appropriate, the anesthetic risks, benefits and alternatives, and obtains informed consent. When part of the anesthetic care will be performed by another qualified anesthesia practitioner, the anesthesiologist should inform the patient that delegation of anesthetic duties is included in care provided by the Anesthesia Care Team.

4. **Management of the anesthetic**: The management of an anesthetic is dependent on many factors including the unique medical conditions of individual patients and the procedures being performed. Anesthesiologists will determine which perioperative tasks, if any, may be delegated. The anesthesiologist may delegate specific tasks to qualified non-anesthesiologist members of the Anesthesia Care Team providing that quality of care and patient safety are not compromised, will participate in critical parts of the anesthetic, and will remain immediately available for management of emergencies regardless of the type of anesthetic (see Addendum C).

5. **Postanesthesia care**: Routine postanesthesia care is delegated to postanesthesia nurses. The evaluation and treatment of postanesthetic complications are the responsibility of the anesthesiologist.

6. **Anesthesia consultation**: Like other forms of medical consultation, this is the practice of medicine and should not be delegated to non-physicians.

Safe Conduct of Minimal and Moderate Sedation Utilizing Sedation Nurses and Physician Assistants

The supervising physician is responsible for all aspects of the continuum of care: pre-, intra-, and post-procedure. While a patient is sedated, the responsible physician must be physically present and immediately available in the procedure suite. Although the supervising physician is primarily responsible for pre-procedure patient evaluation, sedation practitioners must be trained adequately in pre-procedure patient evaluation to recognize when risk may be increased, and related policies and procedures must allow sedation practitioners to refuse to participate in specific cases if they perceive a threat to quality of care or patient safety.
The supervising physician is responsible for leading any acute resuscitation needs, including emergency airway management. Therefore, ACLS (PALS or NALS where appropriate) certification must be a standard requirement for sedation practitioners and for credentialing and privileging the non-anesthesiologist physicians who supervise them. However, because non-anesthesia professionals seldom perform controlled mask ventilation or tracheal intubation often enough to remain proficient, their training should emphasize avoidance of excessive sedation over rescue techniques.

Medical Supervision of Nurse Anesthetists by Non-Anesthesiologist Physicians

Note: In this section, the term "surgeon" may refer to any appropriately trained, licensed and credentialed non-anesthesiologist physician who may supervise nurse anesthetists when consistent with applicable law.

General anesthesia, regional anesthesia, and monitored anesthesia care expose patients to risks. Non-anesthesiologist physicians may not possess the expertise that uniquely qualifies and enables anesthesiologists to manage the most clinically challenging medical situations that arise during the perioperative period. While a few surgical training programs (such as oral surgery and maxillofacial surgery) provide some anesthesia-specific education, no non-anesthesiology programs prepare their graduates to provide an anesthesiologist's level of medical supervision and perioperative clinical expertise. However, surgeons and other physicians significantly add to patient safety and quality of care by assuming medical responsibility for perioperative care when an anesthesiologist is not present.

Anesthetic and surgical complications often arise unexpectedly and require immediate medical diagnosis and treatment, even if state law or regulation says a physician is not required to supervise non-physician anesthesia practitioners. The surgeon may be the only physician on site. Whether the need is preoperative medical assessment or intraoperative resuscitation from an unexpected complication, the surgeon may be called upon, as the most highly trained professional present, to provide medical direction of perioperative health care, including nurse anesthesia care. To optimize patient safety, careful consideration is required when a surgeon will be the only physician available, as in some small hospitals, freestanding surgery centers, and surgeons' offices. In the event of an emergency, lack of immediate support from other physicians trained in critical medical management may reduce the likelihood of successful resuscitation. This should be taken into account when deciding which procedures should be performed in settings without an anesthesiologist, and which patients are appropriate candidates.

Medical Supervision of Non-Physician Anesthesia Students

Anesthesiologists who teach non-physician anesthesia students are dedicated to their education and to providing optimal safety and quality of care to every patient. The ASA Standards for

Basic Anesthetic Monitoring define the minimum conditions necessary for the safe conduct of anesthesia. The first standard states, "Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care." This statement does not completely address the issue of safe patient care during the training of non-physician student anesthetists. Further clarification of the issues involved is in the best interests of patients, students, and anesthesia practitioners.

During 1:1 supervision of non-physician anesthesia students, it may become necessary for the supervising anesthesiologist or nurse anesthetist to leave briefly to attend to other urgent needs or duties. This should only occur in circumstances judged to cause no significant increased risk to the patient.

This practice is to be distinguished from that of scheduling a non-physician student as the primary anesthetist, meaning that no fully-trained anesthesia practitioner is also continuously present to monitor the anesthetized patient. Though the brief interruption of 1:1 student supervision may be unavoidable for the efficient and safe functioning of a department of anesthesiology, the use of non-physician students as primary anesthetists in place of fully trained and credentialed anesthesia personnel is not endorsed as a best practice by the ASA. While the education of non-physician anesthesia students is an important goal, patient safety remains paramount. Therefore, the supervision of students at a ratio other than 1:1 must meet criteria designed to protect the safety and rights of patients and students, as well as the best interests of all other parties directly or indirectly involved: anesthesia practitioners, families, and health care institutions.

1. **Delegation**: All delegating anesthesiologists and the department chairperson must deem non-physician student anesthetists fully capable of performing all duties delegated to them, and all students must express agreement with accepting responsibility delegated to them.

2. **Privileging**: An official privileging process must individually deem each student as qualified to be supervised 1:2 by an anesthesiologist who remains immediately available (see Addendum C). Students must not be so privileged until they have completed a significant portion of their didactic and clinical training and have achieved expected levels of safety and quality (if at all, no earlier than the last 3-4 months of training). Privileging must be done under the authority of the chair of anesthesiology and in compliance with all federal, state, and professional organization and institutional requirements.

3. **Case Assignment and Supervision**: Students must be supervised at a 1:1 or 1:2 anesthesiologist to student ratio. Assignment of cases to students must be done in a manner that assures the best possible outcome for patients and the best education of students, and must be commensurate with the skills, training, experience, knowledge and willingness of each individual non-physician student. Care should be taken to avoid placing students in situations beyond their level of skill. It is expected that most students will gain experience caring for high-risk patients under the continuous supervision of qualified anesthesia practitioners. This is in the best interest of education and patient safety. The degree of continuous supervision must be at a higher level than that required for fully credentialed anesthesiologist assistants and nurse anesthetists. If an anesthesiologist is engaged in the supervision of non-physician students, he/she must remain immediately available. This means not leaving the procedure suite to provide other concurrent services or clinical duties that would be considered appropriate if directing fully credentialed anesthesiologist assistants or nurse anesthetists.
4. **Back-up Support**: If an anesthesiologist is concurrently supervising two non-physician students assigned as primary anesthetists (meaning the only anesthesia personnel continuously present with a patient), the anesthesiologist could be needed simultaneously in both rooms. To mitigate this potential risk, one other qualified anesthesia practitioner must also be designated to provide back-up support and must remain immediately available.

5. **Informed Consent**: The chair of anesthesiology is responsible for assuring that every patient (or the patient's guardian) understands through a standardized departmental informed consent process that the patient may be in the procedure room with only a non- physician student physically present, although still directed by the responsible anesthesiologist. In the best interest of all involved parties, documentation of this aspect of informed consent must be included in the informed consent statement**.**

6. **Disclosure to Professional Liability Carrier**: To be assured of reliable professional liability insurance coverage for all involved (qualified anesthesia practitioners, their employers and the institution), the chair of anesthesiology must notify the responsible professional liability carrier(s) of the practice of allowing non-physician anesthesia students to provide care without continuous direct supervision by a fully trained, credentialed and qualified anesthesia practitioner.

ADDENDUM A

1. Other personnel involved in perianesthetic care:

POSTANESTHESIA NURSE: A **registered nurse** who cares for patients recovering from anesthesia.

PERIOPERATIVE NURSE: A **registered nurse** who cares for the patient in the procedure room.

CRITICAL CARE NURSE: A **registered nurse** who cares for patients in a special care area such as an intensive care unit.
OBSTETRIC NURSE: A **registered nurse** who provides care to patients during labor and delivery.

NEONATAL NURSE: A **registered nurse** who provides cares to neonates in special care units.

RESPIRATORY THERAPIST: An **allied health professional** who provides respiratory care to patients.

CARDIOVASCULAR PERFUSIONIST: An **allied health professional** who operates cardiopulmonary bypass machines.

2. Support personnel for technical procedures, equipment, supply and maintenance:

ANESTHESIA TECHNOLOGISTS AND TECHNICIANS
ANESTHESIA AIDES
BLOOD GAS TECHNICIANS
RESPIRATORY TECHNICIANS
MONITORING TECHNICIANS

ADDENDUM B

Commonly Used Payment Rules and Definitions

ASA recognizes the existence of commercial and governmental payer rules applicable to payment for anesthesia services and encourages its members to comply with them. Commonly prescribed duties include:

- Performing a preanesthetic history and physical examination of the patient;
- Prescribing the anesthetic plan;
- Personal participation in the most demanding portions of the anesthetic, including induction and emergence, where applicable;
- Delegation of anesthesia care only to qualified anesthesia practitioners;
- Monitoring the course of anesthesia at frequent intervals;
- Remaining immediately available for diagnosis and treatment while medically responsible;
- Providing indicated postanesthesia care;
- Performing and documenting a post-anesthesia evaluation.

ASA also recognizes the lack of total predictability in anesthesia care and the variability in patient needs. In certain rare circumstances, it may be inappropriate from the viewpoint of overall patient safety and quality to comply with all payment rules at every moment in time. Reporting of services for payment must accurately reflect the services provided. The ability to prioritize duties and patient care needs, moment to moment, is a crucial skill of the anesthesiologist functioning safely within the Anesthesia Care Team. Anesthesiologists must strive to provide the highest quality of care and greatest degree of patient safety to all patients in the perioperative environment at all times.

MEDICAL "DIRECTION" by anesthesiologists: A payment term describing the specific anesthesiologist work required and restrictions involved in billing payers for the management and oversight of non-physician anesthesia practitioners. This pertains to situations where anesthesiologists are involved in not more than four concurrent anesthetics.

MEDICAL "SUPERVISION" by anesthesiologists: Medicare payment policy contains a special payment formula for "medical supervision" which applies "when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures." [Note: The word "supervision" may also be used outside of the Anesthesia Care Team to describe the perioperative medical oversight of non-physician anesthesia practitioners by the operating practitioner/surgeon. Surgeon- provided supervision pertains to general medical management and to the components of anesthesia care that are physician and not nursing functions (e.g., determining medical readiness of patients for anesthesia and surgery, and providing critical medical management of unexpected emergencies).]

See the Medicare Claims Processing Manual (Chapter 12, Section 50.C-D) and individual payer manuals for additional information.

ADDENDUM C

Definition of "Immediately Available" When Medically Directing (HOD 2012)

A medically directing anesthesiologist is immediately available if s/he is in physical proximity that allows the anesthesiologist to return to re-establish direct contact with the patient to meet medical needs and address any urgent or emergent clinical problems. These responsibilities may also be met through coordination among anesthesiologists of the same group or department.

Differences in the design and size of various facilities and demands of the particular surgical procedures make it impossible to define a specific time or distance for physical proximity.