NATIONAL ANESTHESIA SERVICE

1. PURPOSE

This Veterans Health Administration (VHA) directive provides the policy, procedures, and responsibilities for the management of the Department of Veterans Affairs (VA) Anesthesia services. AUTHORITY: Title 38 United States Code (U.S.C.) 7301(b).

2. BACKGROUND

The medical specialty of anesthesiology has evolved over the years, and VHA now provides a wide range of anesthesia services to Veterans, including the assessment of, consultation for, and preparation of patients for anesthesia and acute pain management as well as the management of homeostasis in the critically ill, injured, or otherwise seriously ill patient. The practice of anesthesiology includes the full continuum of anesthesia from minimal sedation through general anesthesia, including moderate sedation, deep sedation, and emergency airway management when not performed by anesthesia professionals. VA adheres to the Joint Commission standards and considers guidelines developed by the American Society of Anesthesiologists and the American Association of Nurse Anesthetists. National Anesthesia Service (NAS) supports VHA's mission by providing the highest quality of care.

3. DEFINITIONS

a. American Society of Anesthesiologists Physical Status. American Society of Anesthesiologists (ASA) physical status is defined by the American Society of Anesthesiologists. See: http://www.asahq.org/quality-and-practice-management/standards-guidelines-and-related-resources/asa-physical-status-classification-system. NOTE: This linked document is outside of VA control and may or may not be conformant with Section 508 of the Americans with Disabilities Act.

b. Anesthesia Professional. An anesthesia professional is a fully trained anesthesiologist, Certified Registered Nurse Anesthetist (CRNA), or anesthesiologist assistant (AA).

c. Anesthesia Team. An anesthesia team is a team that may contain a combination of anesthesiologists, CRNAs, anesthesia residents or AAs. The anesthesia team model states a preference that no anesthesia professional is regularly working alone, however, VA recognizes that not all facilities have the staffing to support the team concept at all times. The team leader should be the professional with the most advanced training and must be an anesthesiologist, when available. In the absence of an anesthesiologist, the operating surgeon serves as the team leader. The team leader will provide guidance, instruction, direction, and leadership to ensure optimal perioperative patient care. The team leader will always take into consideration the input and opinions of the other team members in decision making. The conceptualization may include

a daily facilitator/board runner who is available for consultation. The collaborative delivery of anesthesia in a team concept has been shown to reduce mortality and morbidity when compared to an anesthesia professional working outside a team concept. When constituting the anesthesia team for each case, the facility must be aware of any State license or resident supervision requirements.

d. CRNA Experience. Determined by Locality Pay Survey Grade assignment as determined by the CRNA Qualification Standards (see VA Handbook 5005, Part II, Chapter 3, Appendix II-G7) and based upon education, training, professional experience and the individual's clinical competence as determined by a Nurse Anesthetist Professional Standards Board.

e. Drug Enforcement Agency (DEA) Through Schedule 2. The possession of a DEA Controlled Substance Registration Certificate allowing use of controlled substances through Schedule 2. Suitability as determined by the DEA demonstrating practice supported by State licensure. See the Controlled Substances Act, 21 U.S.C. 801 et seq.

f. Operation/Procedural Complexity. The delineation of Ambulatory Basic, Ambulatory Advanced, Inpatient Standard, Inpatient Intermediate and Inpatient Complex surgeries as determined by the Operative and Ambulatory Complexity Directive definitions found in VHA Directive 2010-018, Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures, dated March 6, 2010, and VHA Directive 2011-037, Facility Infrastructure Requirements to Perform Invasive Procedures in an Ambulatory Surgery Center, dated October 14, 2011.

4. POLICY

It is VHA policy that eligible Veterans will be provided anesthesia care when required as part of the Veteran's treatment. National Anesthesia Service (NAS) will be the oversight function for anesthesia care.

5. RESPONSIBILITIES

a. Under Secretary for Health. The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b.Deputy Under Secretary for Health for Operations and Management. The Deputy Under Secretary of Health for Operations and Management is responsible for:

(1) Communicating the contents of this directive to each Veterans Integrated Services Network (VISN),

(2) Ensuring that each VISN Director has the sufficient resources to fulfill the terms of this directive in all VA medical facilities within that VISN; and

(3) Providing oversight of VISNs to assure compliance with this directive.

c. Veterans Integrated Service Network (VISN) Director. The Veterans Integrated Service Network (VISN) Director is responsible for ensuring that the VA medical facility Director implements this directive.

d. Director, National Anesthesia Service (NAS). The Director, NAS, must be a Board-Certified Anesthesiologist. The Director, NAS is responsible for:

(1) Providing national leadership to and has advisory and consultative responsibility for all VA anesthesia services programs and initiatives,

(2) Coordinating NAS activities with other services in VHA Central Office and other federal agencies on issues pertaining to the practice of anesthesiology in VHA,

(3) Working closely with the Deputy Director, NAS, and other valuable staff to ensure effective communication to the field, and affiliate programs and services,

(4) Drafting and recommending plans, procedures, and professional standards pertaining to the practice of anesthesiology in VHA for higher level management review,

(5) Developing programs, including quality indicator benchmarks, to promote ongoing quality improvement and measure the quality of anesthesia care provided by VHA with focus on data analysis of continuous physiological data from electronic Anesthesia Record Keepers or a linked analytical database,

(6) Developing plans and processes for interacting with external review organizations,

(7) Advising VHA Central Office and the Veterans Integrated Service Networks (VISNs) regarding the collection workload, productivity, staffing, and other pertinent data related to anesthesia care,

(8) Assisting the Office of Productivity, Efficiency and Staffing (OPES) with the establishment of anesthesia productivity targets (see http://opes.vssc.med.va.gov/Pages/Default.aspx for links to anesthesia productivity targets.) Note: This is an internal VA Web site and is not available to the general public.

(9) Assisting VA medical facilities in improvement efforts to achieve established productivity benchmarks, and quality benchmarks when established

(10) Assisting, local VA medical facilities in recruiting anesthesia health care staff,

(11) Providing input to the appointments of anesthesia service or section chiefs as required by VA Handbook 5005, Staffing, Part 2, Chapter 3, Appendix II-H1,

(12) Developing educational programs relevant to anesthesiology and patient care,

(13) Serving on VHA Central Office Professional Standards Board,

(14) Providing liaison with professional organizations,

(15) Regularly communicating with anesthesia service/section chiefs,

(16) Leading meetings with Anesthesia Chiefs and Chief CRNAs to discuss topics to include, but not limited to, trends, opportunities for improvement, sharing lessons learned, to help foster culture of safety where anesthesia is delivered. Create an environment where anesthesia of the highest quality can be delivered safely; and

(17) Whenever feasible, appoint a VISN Chief Anesthesia Consultant among the anesthesia chiefs in the VISN.

e. Deputy Director, NAS. The Deputy Director, NAS, must be a CRNA with a minimum of a Master's degree. The Deputy Director is responsible for:

(1) Supporting the Director, NAS in the accomplishment of the Director's duties,

(2) Coordinating CRNAs activities through the Director, NAS,

(3) Recommending and preparing policies, plans and professional standards,

(4) Recommending long-range programs of continuous quality improvement to the Director NAS,

(5) Assisting field facilities, when requested, in recruitment of anesthesia health care staff and suggesting scope of practice or privileging parameters for CRNAs,

(6) Advising, providing assistance, and professional expertise to field VA medical facilities and VHA Central Office concerning CRNAs and the practice of anesthesia,

(7) Serving on the VHA CRNA Professional Standards Board, or other Professional Standards Boards as delegated by Director, NAS,

(8) Providing liaison with professional organizations on matters pertaining to CRNAs, and

(9) Providing input to the appointments of anesthesia service or section chief CRNA as required by in VA Handbook 5005, Staffing, Part II, Appendix H6 which requires contact with the Deputy Director, NAS.

f. VISN Chief Anesthesia Consultant. When possible, a VISN Chief Anesthesia Consultant (VCAC) is selected and appointed by the Network Director, after consultation with the Director, NAS.

(1) The VCAC must have the following qualifications:

(a) A physician actively engaged in the practice of anesthesiology at a VHA facility;

(b) Evidence of leadership by VHA appointment (e.g., Chief of Anesthesia);

(c) A history of productive relationships with academic affiliates, including but not limited to, graduate medical education activities, programmatic relationships, and sharing of medical staff;

(d) Ability to work collaboratively and effectively with the NAS.

(2) The duties and responsibilities of the VCAC include, but are not limited to:

(a) Facilitating development and implementation of a strategic plan for anesthesia services within the VISN;

(b) Overseeing clinical outcomes, standards of care, and best practices of VISN facilities engaged in the delivery of anesthesia services;

(c) Assessing current and future needs for anesthesia care;

(d) Leading regular VISN Chiefs of Anesthesia conference calls;

(e) Immediately evaluating critical anesthesia events at time of VHA facility report. Such critical events include but are not limited to:

1. Wrong site regional blocks;

2. Deaths in OR or within 24 hours of end of anesthesia;

3. Operating room fires.

(f) Supporting graduate medical education programs and promoting relationships between VISN facilities and academic affiliates;

(g) Ensuring educational and supporting research activities of all anesthesia programs within the VISN;

(h) Ensuring ongoing review of pertinent data for each VISN anesthesia program.

g. VA Medical Facility Director. The VA medical facility Director is responsible for:

(1) Working with the Chief of Staff to determine the structure of the Anesthesia Service within that medical facility. Consideration will be given to the Medical Center Group assignment of the facility, the operative/procedural complexity assignment of the facility and the number of anesthesia staff at the facility. A separate Anesthesia Service reporting directly to the Chief of Staff is the preferred organizational model to ensure adequate resources are available to provide the highest quality of anesthesia care for Veterans,

(2) Ensuring that an Anesthesia Service or Section meets the requirements of this directive,

(3) Ensuring that the Chief of Staff discusses the proposed selection for the facility Chief of Anesthesia Service or Section with the Director of NAS before a final selection is made (VA Handbook 5005, Part 2, Chapter 3, Appendix II-H1), and

(4) Determining if a CRNA will work under privileges or a scope of practice. If working under a scope of practice, CRNAs will practice under the concepts of progressive levels of responsibility as defined in Appendix B. This determination will be based on the specific CRNA's State license and recommendations from the VA Medical Facility Chief of Staff and the Facility Chief of Anesthesia Service or Section.

h. VA Medical Facility Chief of Staff. The VA medical facility Chief of Staff is responsible for:

(1) Working with the VA Medical Facility Director and the Chief/Lead of Anesthesia to determine the structure of the Anesthesia department within that medical facility. Either as a separate Anesthesia Service reporting to the Chief of Staff or as an Anesthesia Section reporting through another clinical Service. Consideration will be given to the Medical Center Group assignment of the facility, the operative/procedural complexity assignment of the facility and the number of anesthesia staff at the facility,

(2) Ensuring that adequate resources are available to provide the highest quality of anesthesia care for Veterans, and

(3) Recommending to the VA Medical Facility Director whether the facility should use privileges or a scope of practice to define CRNA responsibilities and duties.

i. Facility Chief, Anesthesia Service or Section. The Medical Facility Anesthesia Service, or Section, Chief is responsible for:

(1) Working with the VA Medical Facility Director and the Chief of Staff to determine the structure of the Anesthesia Service, reporting directly to the Chief of Staff, or as an Anesthesia Section reporting through another clinical Service,

(2) Ensuring that patient-oriented anesthesia services are consistently provided in accordance with this Directive describing required anesthesia practices in the VA,

(3) Determining departmental policy,

(4) Developing a peer-review process to critically evaluate the delivery of anesthesia and its related services on a regular basis. Departmental Anesthesia Morbidity and Mortality Indicators (AMMI) (see Appendix A) will be reviewed by an Anesthesia Committee at least quarterly. The Anesthesia Committee will include members from all the different types of anesthesia providers at the VA medical facility. Committee minutes will reflect the cases reviewed and select cases with the potential for process improvement will be presented at required monthly collegial departmental conferences to enhance departmental practice. Departmental and individual AMMI trends will be monitored by the Facility Chief, Anesthesia Service (or Section) and be included in the anesthesia professionals' Ongoing Professional Practice Evaluation (OPPE),

(5) Assigning a clinical mentor to new VA anesthesia professionals for three months and ensuring the new hire undergoes a Focused Professional Practice Evaluation (FPPE) required in VHA Handbook 1100.19, Credentialing and Privileging. Required core FPPE elements for anesthesia professionals are defined in Appendix C,

(6) Recommending to the VA Medical Facility Chief of Staff and Director whether the facility should use privileges or a scope of practice to define CRNA responsibilities and duties.

j. NAS Field Advisory Committee: The Anesthesia Service Field Advisory Committee (FAC) is composed of field-based VA-employed Anesthesiologists, ~~and~~ CRNAs, and CAAs. It is responsible for providing timely advice and recommendations to the NAS Director regarding:

(1) Program development,

(2) New clinical techniques and procedures,

(3) Clinical policy,

(4) Program performance for anesthesia care,

(5) Feedback on matters of importance to field-based practitioners, and

(6) Formation of subspecialty subcommittees as necessary. The Anesthesia Service FAC will meet annually in person, subject to VHA Central Office funding availability, and on a regular basis by electronic means.

6. TRAINING

None.

7. RECORDS MANAGEMENT

All records, regardless of format (paper, electronic, electronic systems), created by this directive will be managed according to the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. If you have any questions regarding any aspect of records management you should contact your facility Records Manager or your Records Liaison.

8. REFERENCES

a. 21 U.S.C 801.

b. 38 U.S.C 7301(b).

c. CRNA Qualification Standards, VA Handbook 5005, Staffing, Part II, Chapter 3, Appendix II-G7.

d. VHA Handbook 1004.01, Informed Consent for Clinical Treatments or Procedures, dated August 14, 2009.

e. VHA Directive 1039, Ensuring Correct Surgery and Invasive Procedures, dated July 26, 2013.

f. VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012.

g. VHA Handbook 1400.01, Resident Supervision Handbook, dated December 19, 2012.

h. VHA Handbook 1907.01, Health Information Management and Health Records, dated March 19, 2015.

i. VHA Directive 2010-018, Facility Infrastructure Requirements to Perform Standard, Intermediate, Or Complex Surgical Procedures, dated March 6, 2010.

j. VHA Directive 2011-037, Facility Infrastructure Requirements to Perform Invasive Procedures In An Ambulatory Surgery Center, dated October 14, 2011.

k. Mulroy M.F., Weller R.S., LiguoriG.A.; A Checklist for Performing Regional Nerve Blocks, Regional Anesthesia and Pain Medicine, May-Jun 2014, 39(3); 195-199. NOTE: This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.

l. American Society of Anesthesiologists ASA Physical Status Classification System, updated October 2014. Available from: http://www.asahq.org/~/media/sites/asahq/files/public/resources/standards-guidelines/asa-physical-status-classification-system.pdf#search=%22asa%22. NOTE: This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.

m. The Joint Commission, Comprehensive Accreditation Manual for Hospitals (CAMH). NOTE: This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.

n. Office of Productivity, Efficiency and Staffing (OPES). http://opes.vssc.med.va.gov/Pages/Default.aspx. NOTE: This is an internal VA Web site and is not available to the general public.

o. Scope and Standards for Nurse Anesthesia Practice, American Association of Nurse Anesthetists. Available from: https://www.aana.com/practice/practice-manual NOTE: This linked document is outside of VA control and may or may not be conformant with Section 508 of the Americans with Disabilities Act.

p. Standards, Guidelines, and Statements, American Society of Anesthesiologists. Available from: https://www.asahq.org/quality-and-practice-management/standards-and-guidelines.

q. Standards for Basic Anesthetic Monitoring, American Society of Anesthesiologists. Available from: http://www.asahq.org/~/media/sites/asahq/files/public/resources/standards-guidelines/standards-for-basic-anesthetic-monitoring.pdf. NOTE: This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.

r. Human Resources Management Letter 05-06-12, Qualification Guidelines for the Position of Anesthesiologist Assistant, GS-0601, dated December 22, 2006.

9. APPENDIX A: ANESTHESIA MORBIDITY AND MORTALITY INDICATORS (AMMI)

1. RESPIRATORY

a. Airway Trauma/Dental Damage,

b. *Aspiration Pneumonitis,*

c. *Re-intubation,*

d. Unrecognized difficult airway,

e. Laryngospasm requiring succinylcholine, and

f. *Negative pressure pulmonary edema.*

2. CARDIOVASCULAR

a. Arrhythmia requiring unanticipated therapy,

b. Cardiac arrest,

c. Inappropriate hypotension,

d. Inappropriate hypertension, and

e. Inadequate/Inappropriate fluid therapy.

3. CNS

a. *Stroke,*

b. Agitation requiring treatment,

c. Seizure, and

d. *New neurologic injury.*

4. REGIONAL

a. Failed block,

b. High spinal/epidural,

c. Unintended dural puncture,

d. Unintended vascular injection, and

e. Local Anesthetic Systemic Toxicity.

5. OTHER

a. *Awareness/Recall,*

b. *Eye injury,*

c. *Wrong Dose/Wrong Drug,*

d. Inadequate monitoring,

e. Unplanned escalation of care,

(1) *Prolonged intubation,*

(2) Prolonged PACU stay,

(3) *Unplanned ICU admission,*

(4) *Unplanned admission, and*

(5) *Rule Out Myocardial Infarction.*

NOTE: Items in italics, bold and underlined are triggers for a AMMI review and Peer Review

10. APPENDIX B: VA CERTIFIED REGISTERED NURSE ANESTHETIST PRACTICE GUIDELINES

1. The possible maximum breadth of Certified Registered Nurse Anesthetist (CRNA) practice is controlled by the individual's State license. As allowed by the State license and the local VA medical facility, a CRNA may practice as a Licensed Independent Practitioner (LIP), in collaboration with a physician, or under physician supervision. To be considered for LIP status, the CRNA must possess a DEA License through Schedule 2 Controlled Substances. The individual CRNA must also be granted privileges by the local VA medical facility under the recommendation of the Chief of Anesthesia. The team approach should still be the preferred model even when a CRNA has LIP status. Changes to existing CRNA Privileges are controlled by the process outlined in VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012 and are beyond the scope of this directive. NOTE: The possession of a DEA Controlled Substance Registration Certificate grants a health care provider the authority to prescribe or administer controlled substances through Schedule 2. This certificate is part of a health care provider's state license. Some facilities may require approval from the credentialing committee before the provider may exercise this authority. See the Controlled Substances Act, 21 U.S.C. 801.

2. In the model of physician supervision, CRNAs and Residents earn progressive responsibility for the care of the patient as part of their professional development. In the case of CRNAs, progressive responsibility determinations will be made based on documented evaluation of the CRNA's clinical experience, judgment, knowledge, and technical skill. In VA, CRNAs working under physician supervision will be granted the broadest responsibilities consistent with documented clinical experience, judgment, knowledge, and technical skill. ~~This includes administration of regional anesthesia and use of ultrasound.~~ CRNA experience,

surgical/procedural complexity as well as the ASA physical status of the patient should be considered when determining the level of responsibility and supervision with the ultimate goals being the efficient, effective, and safe care of the patient.

3. When physician supervision or involvement of a CRNA is required by the CRNA's State license and the supervision or involvement is provided by an Anesthesiologist, supervision or involvement requires meaningful clinical input that adds value to the care being provided as well as facilitation of the effectiveness and productivity of the team. Supervision or involvement will be at a ratio consistent with safe patient care. Rarely, if ever, will a 1:1 supervision ratio of a CRNA be warranted unless the procedure or patient acuity indicates otherwise. Supervision is not controlling minute to minute decisions, it is collegial interactions that respect the training and skills of the parties involved. After collegial discussions among the parties, the supervising anesthesiologist has the final authority regarding the anesthesia management. Disagreements regarding the planned anesthesia care will be referred to the Chief of the Department after the case for review.

11. APPENDIX C: ANESTHESIA PROVIDER FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) STANDARDS

Anesthesia Provider Focused Professional Practice Evaluation Standards (FPPE) for each core focused review include but not limited to the following list (must use at least 2 methods of evaluation):

1. Chart review (minimum 20 encounters if using this method. Evaluator must determine whether community standards have been achieved),

2. Continuing medical education/training completed,

3. Direct Observation,

4. Discussion with other individuals involved in the care of patients,

5. Monitoring of clinical practice patterns,

6. Proctoring, or

7. Review of performance data from external sources.

12. APPENDIX D: SCOPE OF ANESTHESIA SERVICES

1. Assessment of, consultation for, and preparation of patients for anesthesia and the management of homeostasis in the critically ill, injured, or otherwise seriously ill patient.

2. Provision of various degrees of sedation, comfort, and insensibility to pain during surgical, non-surgical therapeutic, palliative, and diagnostic procedures and the management of patients so affected in a patient-centered health care environment.

3. Monitoring and restoration of homeostasis during the perioperative/periprocedural period.

4. Diagnosis and treatment of acute and chronic painful conditions and syndromes.

5. Clinical management and training of airway management.

6. Assisting in the clinical management of cardiac and pulmonary resuscitation.

7. Evaluation of respiratory function and application of respiratory therapy in all its forms.

8. Supervision, teaching, and evaluation of the performance of medical, nursing, and allied health care personnel in anesthesia, pain medicine, respiratory, and critical care.

9. Conducting and collaborating in research at the clinical and basic science level to proactively identify gaps in evidence and practice, performing gap analysis, and linking evidence to practice.

10. Administrative and leadership involvement in hospital activities and committees, medical, and nursing school affiliations.

11. Perioperative data collection and monitoring of quality indicators, and

12. Collaborates with other stakeholders to continuously improve patient access, satisfaction, safety, and quality of care.

13. APPENDIX E: REQUIREMENTS FOR ANESTHESIA PROFESSIONALS

1. ORGANIZATION

a. VA Medical Facility anesthesia professionals will be organizationally assigned to an Anesthesia Service or Section. If there is no formal Anesthesia Service or Section, Anesthesia professionals will be assigned to or managed by Surgery Service.

b. Members of the Anesthesia Service/section will be under the overall supervision of the Chief of Anesthesia Service or Section, or a designee. If a facility has not appointed an anesthesiologist as Chief of Anesthesia, the facility will informally name a section chief or lead anesthesiologist. In facilities without an anesthesiologist, a Chief or lead CRNA

will be designated. In facilities without an anesthesiologist, the Chief of Surgery will serve jointly as the Chief of the Anesthesia Service.

c. The VA health care system incorporates different types of facilities with differing levels of complexity of anesthetic care. An Anesthesia Team model is preferred however we recognize that different models of anesthesiology practice may exist including medical facilities with:

(1) A team consisting of a combination of anesthesia professionals as defined in this directive,

(2) Only Anesthesiologists, and

(3) Only CRNAs.

d. Anesthesia professionals must meet the licensure requirements defined in their respective VHA qualification standards. Local medical facilities must adhere to the requirements of the Federal Controlled Substances Act, 21 U.S.C. 801, relative to the specific State license of the anesthesia professional. A State license establishes the maximum breadth of practice allowable for an anesthesia professional unless otherwise stated in VA regulation. Because a provider can maintain more than one State license, the facility should look to the license permitting the highest or broadest scope of practice. Facilities are responsible for determining the specific privileges or scope of practice for the individual. The privileges or scope of practice the facility grants may be narrower than the maximum allowed in a State license.

e. In facilities where there are only anesthesiologists or only CRNAs, there is an expectation that the facility will migrate anesthesia care to a team-based concept for improved productivity and quality of care. In the team concept, there is rarely ever a need to have a routine 1:1 supervision of a CRNA. The objective is to have an appropriate supervising ratio of CRNAs to obtain the highest level of productivity.

f. In facilities where there are only CRNAs, the responsibility for intra-operative anesthesia choice is determined by the CRNA. In those cases, as the anesthesia practitioner of record, only the CRNA's signature is required on the anesthetic record for purposes of authentication.

g. Resident Physician Practice/Supervision Guidelines:

(1) Resident anesthesia physician training supervision will conform to the requirements of the VA's Resident Supervision Handbook (VHA Handbook 1400.01, Resident Supervision Handbook, dated December 19, 2012) as well as requirements set by the national body for anesthesiologist training programs, seehttp://www.acgme.org/Specialties/Overview/pfcatid/6,

(2) Resident anesthesia physicians require supervision by an anesthesiologist, and

(3) Postgraduate year 2 resident anesthesia physicians will be assigned emergency airway management duties only after the Accreditation Council for Graduate Medical Education (ACGME) Program Director or clinical trainee equivalent program director has certified them to be competent in airway management. The ACGME Program Director or clinical trainee equivalent program director must document in the individual's training record that this determination for progressive responsibility supervision has been made and provide documentation to the VA medical facility subject matter expert.

2. VA MEDICAL FACILITY CHIEF, ANESTHESIA SERVICE OR SECTION:

The Chief, Anesthesia Service or Section must meet the requirements for a staff anesthesiologist and must be Board Certified in the practice of Anesthesiology. Current Chiefs of Anesthesia that are not Board Certified in the practice of Anesthesiology on the publication date of this Directive may continue to serve as Chief of Anesthesia if the individual remains a VA employee without a break in service in the Chief of Anesthesia position. For new appointments who are not Board Certified in the practice of Anesthesiology, but still in the Board Examination eligibility period, a waiver of the Board Certification requirement may be obtained through a process of discussion between the VA Medical Facility Chief of Staff and the Director of NAS. Formal appointment will be as outlined in VA Handbook 5005, Staffing, Part II, Appendix H1 which requires contact with the Director, NAS. Credentialing and Privileging will be as required by VHA Handbook 1100.19, Credentialing and Privileging. The recommendation for privileges or a scope of practice for all anesthesia professionals will originate from the Chief of Anesthesia. If the facility has not appointed a Chief of Anesthesia, the Chief of Surgery will consult with NAS before making a recommendation for anesthesia privileges or a scope of practice.

3. VA MEDICAL FACILITY CHIEF CRNA:

The Chief CRNA is selected by the Chief, Anesthesiology Service or Section. The Chief CRNA must meet the requirements for a staff CRNA, must be Certified and must possess a minimum of a Master's degree. The Master's degree requirement is waived for VA employees already in the Chief CRNA position on the publication date of this Directive if the individual maintains continuous VA employment as a Chief CRNA. Formal appointment will be as outlined in VA Handbook 5005, Staffing, Part II, Appendix H6 which requires contact with the Deputy Director, NAS. Credentialing will be as required by VHA Handbook 1100.19., Credentialing and Privileging. Privileging or Scope of Practice will be determined locally within the limits of the individual's State license and the local medical facility bylaws.

4. VA MEDICAL FACILITY STAFF ANESTHESIOLOGIST:

Overall qualifications will be as required in the VA Physician Qualification Standard in VA Handbook 5005. In addition, all physicians requesting anesthesiology privileges must be Board Certified in the practice of Anesthesiology or still in in the Anesthesiology Board Examination eligibility period. VA employed Physicians not meeting these criteria on the publication date of this Directive may be allowed to work in Anesthesiology if they have appropriate credentials,

knowledge, and experience and are recommended by the local Chief of Anesthesia. If there is no local Chief of Anesthesia, the individual considering recommending privileges for the proposed staff anesthesiologist must contact the Director, NAS for input. Credentialing and Privileging will be as required by VHA Handbook 1100.19, Credentialing and Privileging.

5. VA MEDICAL FACILITY STAFF CRNA:

Overall qualifications will be as required in the VA Nurse Anesthetist Qualification Standard in VA Handbook 5005. Credentialing will be as required by VHA Handbook 1100.19, Credentialing and Privileging. Privileging or Scope of Practice will be determined locally within the limits of the individual's State license and the local medical facility bylaws. A minimum of a Master's degree educational preparation is required. The Master's degree requirement is waived for VA employees already in the staff CRNA position on the publication date of this Directive if the individual maintains continuous VA employment as a staff CRNA. For new appointments, the Deputy Director, NAS, may authorize a waiver of experience and/or the degree requirements for individuals whose professional accomplishments, performance, and qualifications warrant such consideration. Waivers of degree requirements are not authorized for Nurse IV and Nurse V.

6. VA MEDICAL FACILITY ANESTHESIOLOGIST ASSISTANTS:

Overall qualifications will be as required in Human Resources Management Letter 05-06-12, Qualification Guidelines for the Position of Anesthesiologist Assistant, GS-0601, dated December 22, 2006. Anesthesiologist Assistants require medical direction and the immediate physical availability of an anesthesiologist at all times. Immediate physical availability may include a nearby care area or immediately adjoining office space.

14. APPENDIX F: PATIENT CARE AND DOCUMENTATION

1. Anesthesia professionals must use an automated Anesthesia Record Keeper (ARK). Hand prepared, paper Anesthesia Records will be used only if the ARK malfunctions.

2. Pre-anesthesia care requirements, including documentation requirements, are outlined in VHA Handbook 1907.01, Health Information Management and Health Records, dated March 19, 2015. This process must include documentation that the risks and benefits of anesthesia were discussed and the patient has agreed to the planned anesthetic and procedures, as required by VHA Handbook 1004.01, Informed Consent for Clinical Treatments or Procedures, dated August 14, 2009. Other elements include:

a. Reviewing the medical record,

b. Interviewing and examining the patient,

c. Obtaining or reviewing tests and consultations necessary to the conduct of anesthesia; and

d. Determining the appropriate prescription of pre-operative medications as necessary to the conduct of anesthesia.

3. Time Out Before Regional Anesthesia. Performing a time out before regional anesthesia is a mandatory part of safe, high quality patient care (see VHA Directive 1039, Ensuring Correct Surgery and Invasive Procedures, dated July 26, 2013).

4. Basic Anesthetic Monitoring

a. Qualified anesthesia health care personnel must be present in the room throughout the conduct of all general anesthetics, regional anesthetics, and monitored anesthesia care.

b. During all anesthetics, the patient's oxygenation, ventilation, circulation, and temperature must be continually evaluated. For body temperature, this means continual monitoring when clinically significant changes in body temperature are intended, anticipated, or suspected.

c. Documentation (time-based record of events, either paper or electronic), to include:

(1) Reviewing the pre-operative evaluation immediately prior to initiation of anesthetic procedures,

(2) Monitoring of the patient (e.g., recording of vital signs with documentation every 5 minutes at a minimum),

(3) Amounts of all medications and agents used, and times administered,

(4) The type and amounts of all intravenous fluids used, including blood and blood products, and times administered,

(5) The anesthetic technique(s) used, and

(6) Unusual events during the peri-procedure anesthesia period.

5. Post-anesthesia.

a. All patients who have received general anesthesia, regional anesthesia, or monitored anesthesia care must receive appropriate post-anesthesia management.

(1) Phase 1 recovery (e.g. PACU or ICU):

(a) A patient transported to the Phase 1 recovery must be accompanied by a member of the anesthesia team who is knowledgeable about the patient's condition and qualified to monitor the patient during transport. The patient must be continually evaluated and treated during transport with observation or electronic monitoring and support appropriate to the patient's condition.

(b) Upon arrival in Phase 1 recovery, the patient must be re-evaluated and a verbal report, preferably using a hand off communication tool or checklist, provided to the responsible RN staff by the member of the anesthesia team who accompanies the patient.

(c) The patient's condition must be evaluated continually in Phase 1 and potential or apparent complications reported and managed appropriately.

(2) Phase 1 recovery bypass (Direct transfer to Phase 2 e.g. Ambulatory Surgery Unit or floor) may be authorized by an anesthesia professional, or when, at a minimum, the VA Post Anesthesia Score (VA-PAS) or other standardized discharge criteria from Phase 1 are met.

b. Post-anesthesia care documentation is outlined in VHA Handbook 1907.01, Health Information Management and Health Records, dated March 19, 2015.