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| Standard Operational Policy for Physicians' Assistant in Anaesthesia PA(A) |  |
| **Classification:** Policy/SOP**Lead Author:**

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**Unique ID:** **Issue number:**  2**Date approved:**  |

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**Who should read this document?**

* Physicians’ Assistants (Anaesthesia)
* Consultant Anaesthetists

**Key Points**

Physician’s Assistants in Anaesthesia, PA(A)s, are trained and employed at INSERT TRUST NAME HERE. This policy details the role, the training and the current practice of these individuals.

This document outlines the scope of practice and levels of supervision for PA(A)s.

Executive Summary

* There are 3 qualified PA(A)s working in INSERT TRUST NAME HERE. One is registered with the NMC, the other 2 are science graduates. There is 1 due to complete training in January 2014. There are a further 2 trainee PA(A)s in their first year of training.
* Planned PA(A) registration with the HPC has halted following the enactment of the Health and Social Care Act 2012. All PA(A)s working at INSERT TRUST NAME HERE are on the voluntary register held by Association of Physicians’ Assistants in Anaesthesia.
* The role of the PA(A) is described together with possible roles envisaged by the DoH and roles currently undertaken at other UK hospitals
* PA(A) training is managed at the University of Birmingham, it has full Royal College of Anaesthetists and Department of Health support.
* The 2 year University lead Training of the PA(A) is described.
* PA(A)s work along side a Anaesthetic Consultants, who will always be present at induction and extubation. The Anaesthetist may leave the PA(A) for short periods providing indirect supervision criteria are met. A Patient Specific Directive (PSD) will prescribe the drugs the PA(A) may administer.
* Trust Grade Anaesthetists and Senior Trainee Anaesthetists (ST6 & 7) may supervise PA(A)s if deemed competent to do so by the Clinical Director Anaesthesia.
* PA(A)s are accountable to the Department of Anaesthesia and the Division of Surgery.
* Continuing Professional Development, Mandatory Training and Maintenance of Competencies are provided and monitored by the Department of Anaesthesia.
* It was estimated that, last year (2012), whilst we had 3 PA(A)s in post, we made an annual saving of over £180,000.

**Background/ Scope/ Definitions**

**Summary for Consultant Anaesthetists working with Physicians’ Assistants (Anaesthesia) at INSERT TRUST NAME HERE**

‘For every case the **supervising consultant anaesthetist** must:

* be present in the theatre suite, must be easily contactable and must be available to attend within two minutes of being requested to attend by the PA(A)
* be present in the anaesthetic room/operating theatre during induction of anaesthesia
* regularly review the intra-operative anaesthetic management
* be present during emergence from anaesthesia until the patient has been handed over safely to the recovery staff
* remain in the theatre suite until control of airway reflexes has returned and artificial airway devices have been removed, or the ongoing care of the patient has been handed on to other appropriately qualified staff, e.g. in the intensive care unit.’

**RCoA, Physicians’ Assistants (Anaesthesia) [(PA(A)s]**

Supervision and limitation of scope of practice (May 2011 revision)

* At INSERT TRUST NAME HERE a qualified PA(A) is competent to manage routine emergence of anaesthesia with indirect supervision except for intubated patients.
* The supervising anaesthetist be present during extubation of endotracheal tubes, unless the PA(A) has completed the extubation training package.
* Under direct consultant supervision PA(A)’s may perform spinal and regional anaesthesia, unless the PA(A) has completed the training package.

Qualified PA(A)s may be indirectly supervised

* The supervising anaesthetist must be available within 2 minutes of being called by the PA(A), must maintain a means of communication (bleep, mobile) or inform of exact location to PA(A)
* If the supervising anaesthetist is going to be >2 mins away, another named consultant should be immediately available to provide assistance to the PA(A)
* Under indirect supervision PA(A)s may perform preoperative assessment, check anaesthetic equipment, draw up anaesthetic and emergency drugs, maintain anaesthesia (administer anaesthetic drugs using PSD), insert venous cannulae, arterial lines and CVP lines
* Patient Specific Directive must be signed by the consultant when indirectly supervising the PA(A).

Trainee PA(A)s must be directly supervised at all times

* May carry out preoperative assessments
* May carry out procedures such as Arterial Line and CVP line insertion under direct supervision
* May administer anaesthetic and emergency drugs under direct supervision.
* Cannot use Patient Specific Directives
* Must have read out and confirm drug name and dose with 2nd qualified person.

**Policy/ Guideline/ Protocol**

1. **Accountability**

PA(A)s are accountable, under the Division of Surgery, to the Clinical Director of Anaesthesia for Job Planning, Appraisal, Clinical Competence and Continuing Professional Development. The CD for Anaesthesia will also be responsible for pay, pay progression and disciplinary issues.

For a PA(A) who is also registered with the NMC and maintains a nursing function within their job specification, clinical supervision is a requirement and should be facilitated by the Divisional Director of Nursing. It is recommended that the ADNS maintains regular 1 to 1 contact with all PA(A)s and supports the PA(A)s and the Clinical Director of Anaesthesia.

During PA(A) training, they are accountable to the Clinical Lead for PA(A)’s who is a Consultant Anaesthetist.

In the work place the PA(A) is always supervised by a Consultant\* Anaesthetist. Levels of supervision are detailed in section 5.1.

\* Consultant Anaesthetist includes Speciality Doctors who are deemed to be trainers or with senior anaesthetic trainees where a supervising consultant is identified. Consultant Anaesthetic support is always available through the starred anaesthetist system.

**2.0 Legal status**

The development of the role of PA(A) was the result of extensive consultations by the Department of Health by the 'New ways of working in anaesthesia stakeholder board' chaired by Neil McKeller. (referenced)

The Royal College of Anaesthetists are closely involved and the Anaesthesia Related Professions Committee continues to oversee the training and the scope of practice of PA(A)s. The RCoA reviews and publishes the 'Supervision and Limitation of the Scope of Practice of PA(A)s'.

Following the publication of the Government Command Paper "Enabling Excellence - Autonomy and Accountability for Health Workers, Social Workers and Social Care Workers - The Health and Social Care Bill", registration of PA(A)s with the Health Professions Council has stalled.

The governments positions is not to statutorily regulate any new professions. The governments preferred method of regulation is through the Professionals Standards Authority, which would accredit voluntary registers. The Association of Physicians’ Assistants does not currently believe the significant costs of gaining accreditations will increase patient safety and will therefore not pursue this route. This decision will be readdressed when any new information or evidence emerges.

All PA(A)S at INSERT TRUST NAME HERE are voluntarily registered with the Association of Physicians' Assistants in Anaesthesia. The APA(A) maintains a voluntary register of PA(A)s, ensures highest standards of patient care, advises on education and continuing professional development and represents PA(A)s at the RCoA and other national bodies.

A Clinical Leads Forum of Consultant Anaesthetists involved in the training and supervision of PA(A)s meets twice a year and acts as a responsible body of opinion especially in the development of extended roles for PA(A)s.

**3.0 Who are Physicians’ Assistants (Anaesthesia) (PA(A) and Their Role Once Trained?**

PA(A) are practitioners trained to care for patients undergoing surgery and/or anaesthesia under the supervision of a senior Anaesthetist. PA(A)s undergo an intensive 2 year training program, coordinated by Birmingham University and supported by the Royal College of Anaesthetists.

**3.1 Qualified PA(A)s are competent in the following activities:**

* **Pre-operative assessment of elective and urgent surgical patients,**

Taking relevant medical/surgical histories

Interpretation of relevant investigations

Current medication review

Medical examination, particularly of respiratory and cardiovascular systems

Airway Assessment.

Gaining informed consent: for anaesthesia and for common anaesthetic interventions - following the Association of Anaesthetists 'you and your anaesthetic' document. The Supervising Consultant will gain consent for any intervention that the PAA is unfamiliar with.

Agreeing anaesthetic plan with supervising Anaesthetist.

* **Preparation of anaesthetic environment;**

Checking of anaesthetic equipment/machine.

Preparing emergency drugs

Preparing anaesthetic drugs

* **Conduct anaesthesia**

Gaining peripheral intravenous access.

Arterial cannulation and central intravenous access if indicated.

Induction of anaesthesia – under supervision of Anaesthetist.

Securing of airway utilising advanced airway skills

Monitoring and documentation of patient vital signs

Maintenance of anaesthesia with supervision with Anaesthetist

Acting in response to patient vital signs to maintain them within appropriate limits

Administration of IV fluids as required.

Immediate management of emergencies until senior help arrives

Safe emergence from anaesthesia – currently under direct supervision from the Consultant.

Immediate post-op/anaesthetic management in the PACU.

**3.3 Roles of the PA(A) identified by the DoH in the 2005 paper**

Support for solo consultant - providing rest breaks and managing same day admissions

Support for solo consultant - complex patients, very long operations

Support for an operating list to free up the consultant to undertake competency based training of anaesthetic trainees

1 consultant supervising 2 theatres

Flexible support for 2 or more theatres

Non theatre Roles

Pre-op clinic, peri-op procedures, sedation, scanning, patient transfer.

Reconfiguration of theatre teams

**3.4 Roles of the PA(A) in other UK hospitals (Clinical Leads Forum)**

Upper limb blocks

Lower limb blocks

Spinal / Epidural anaesthesia

TAP blocks

Sedation (TIVA for radiological investigation)

Arterial line and CVP line insertion prior to anaesthesia

Crash team

Trauma and Emergency pre-op assessment

Pre-op Clinic

Emergence from GA - indirect supervision

Extubation in recovery - indirect supervision

Proposal rights - electronic prescribing

**3.5 Areas being considered for expansion of the PA(A) role**

**Spinals (extended role) Approved**

would help improve turnaround particularly if two ODPs were available..

**Extubation** **(extended role) Approved**

would help improve turnaround particularly if two ODPs were available..

**Upper Limb blocks (extended role) Approved**

Upper limb blocks are known to reduce inpatient stay, particularly in recovery. Minimal stay needed on DSU, as no GA

Would allow the setting up of a block room with the PA(A) putting in blocks.

The PA(A) could act as a training resource for trainee anaesthetists in the future..

**Sedation lists (unutilised skill)** - could be done safely with indirect supervision.

**1 consultant supervising 2 theatres**

**3.6 Impact of extended roles**

**Upper Limb** blocks have been successfully and safely performed, allowing PA(A)s to provide the skill where it might not otherwise be available. The PA(A)s act as a training resource for doctors in training and consultants unpractised in the skill.

This has allowed the planning and future role out of the block room. This will improve the patient experience allowing more procedures to be performed under regional anaesthesia, as well as reducing costs and theatre down time.

**Spinals** – allowed preparation for spinal anaesthesia and quicker administration as the PA(A) is able to begin preparation for administration of the spinal while the supervising consultant is occupied elsewhere, with administration as soon as the consultant arrives in theatre. Greater satisfaction, understanding and management of spinal anaesthesia by the PA(A).

**3.7 Further Extension of role**

As part of the successful expansion of the role into upper limb regional anaesthesia, it is envisaged that the role with the regional anaesthesia skills will play an important role in the running of a successful ‘block room’.

It is expected that the majority of patients will have procedures performed under regional anaesthesia with no sedation.

The PA(A) will be involved and responsible for performing nerve blocks with indirect/proximal supervision and continuing patient care through the peri-operative period.

A minority of patients may request or require sedation. The anaesthetic department believe PA(A)s could safely provide **conscious sedation with indirect supervision**. Before commencing sedation the PA(A) will discuss and inform the supervising anaesthetist of the sedation plan.

**5.0 Guidelines and Scope of Practice**

Guidelines on scope and limitations of practice are available from the RCoA and Associations of Physicians’ Assistant website. ‘Physiicians Assistants (Anaesthesia) (PA(A)) Supervision and limitations of scope of practice (May 2011 Revision)

**5.1 Levels of supervision**

**Direct Supervision: The Supervising Anaesthetist is present in the anaesthetic room or operating theatre.**

The PA(A) supports the Anaesthetist and may undertake appropriate tasks that aids the running of the theatre list or aids the care of the patient. The PA(A) may:

* Perform preoperative assessment
* Prepare the anaesthetic room and theatre
* Draw up drugs
* Induce anaesthesia
* Intubate
* Insert arterial and CVP lines
* Maintain anaesthesia
* Perform spinal anaesthesia
* Perform regional analgesia

Trainee PA(A)s may only operate under direct supervision.

**Indirect Supervision: The supervising anaesthetist may leave a qualified PA(A) for short periods during maintenance of general or Neuraxial anaesthesia.**

*The consultant* must

* be present in the theatre suite, must be easily contactable and must be available to attend within two minutes of being requested to attend by the PA(A)
* be present in the anaesthetic room/operating theatre during induction of anaesthesia
* regularly review the intra-operative anaesthetic management
* be present during extubation; unless the PA(A) has achieved competency for unsupervised extubation
* remain in the theatre suite until control of airway reflexes has returned and artificial airway devices have been removed
* hand supervision to a second supervising consultant if (s)he leaves the theatre complex

*Patient Specific Directives* will be used for all patients on these lists so that PA(A)s are able to administer drugs

**Explanation of terms**

Multiple specialists terms relating to anaesthesia practice. Please contact author with any queries.

**Roles and responsibilities**

PA(A)s will be responsible for following the guidelines in the policy and directed others towards it as required.

Consultant anaesthetists will be able to refer to the document with queries as to the Trusts position on PA(A)s and the scope of practice at INSERT TRUST NAME HERE.

The Clinical Director of Anaesthesia and Clinical Lead of PA(A)s will ensure that practice is in line with the guidelines of this document.

Anticipated changes in practice are to be documented and sent for review to relevants governance committee for approval, this will be done via the clinical director.

Clinical Effectiveness Committee ensure that policy and scope of practice for PA(A)s is safe and appropriate at an executive level.

**References and Supporting Documents**

Anaesthesia Practitioner Curriculum Framework (Note name change from Anaesthesia Practitioner to Physicians’ Assistant (Anaesthesia) [http://www.dh.gov.uk/prod\_consum\_dh/groups/dh\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\_123011.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/%40dh/%40en/%40ps/documents/digitalasset/dh_123011.pdf)

Tool kit to support the Planning and Introduction of Training for Anaesthesia Practitioners (Including examples of models of practice)

[http://www.dh.gov.uk/prod\_consum\_dh/groups/dh\_digitalassets/@dh/@en/documents/digitalasset/dh\_074708.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/%40dh/%40en/documents/digitalasset/dh_074708.pdf)

Physicians’ Assistants (Anaesthesia) [(PA(A)s] Supervision and limitation of scope of practice (May 2011 revision)

<http://www.rcoa.ac.uk/docs/RCoA_PAA%20supervision_May%202011.pdf>

Scope of Practice – Association of Physicians’ Assistant (Anaesthesia) <http://www.anaesthesiateam.com/index.php/scope-of-practice>

Position statement on extended roles for qualified PA(A)s – APA(A) http://www.anaesthesiateam.com/index.php/latest-news/12-position-statement-on-extended-roles-for-qualified-paas

**Policy Implementation Plan**

E-mail to PA(A)s and consultant anaesthetist directing them to the policy on the intranet.

**Monitoring and Review**

Compliance with the policy will be monitored through AIR form reporting. These will be discussed by the Clinical lead for PA(A)s and the Clinical Director of Anaesthesia. Where required any issues raised will be discussed at departmental clinical audit/governance days. Issues or changes in practice will be escalated to the relevant committee as and when required.

Policy will be reviewed after 2 years (or earlier if required) with PA(A)s, their clinical lead and the clinical director, discussion of any policy changes will take place.

**Endorsement**

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| --- |
| **Endorsed by:** |
| **Name of Lead Clinician/Manager or Committee Chair** | **Position of Endorser or Name of Endorsing Committee** | **Date** |
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