

NEUROANAESTHESIA ACCREDITATION STANDARDS 2023

Notes to Provide Clarification of ACSA Standards

Please be advised that:

- only certain parts of the cited GPAS reference text may be applicable to the ACSA standard
- the term 'appropriately trained' refers to someone who has had specific training in the knowledge and skills required to undertake their designated role
- areas that do not have any anaesthetic input will not be assessed during the onsite review visit
- the obstetric unit only refers to units led by an obstetrician: midwife-led units are not reviewed by ACSA.

Note 1	On the prioritisation of standards	Every ACSA standard has been assigned a priority. Standards are assigned priority 1 if they must be achieved in order for accreditation to be awarded. Priority 2 standards should be achievable by most departments. Priority 3 standards will be aspirational for most; however, they will provide targets for the highest performing departments to achieve.
		All new standards are assigned to Priority 2 in their first year but may become Priority 1 after that.
Note 2	On the use of the term 'policies'	Whilst the ACSA standards utilise the term 'policies', it should be noted that the term is used as an umbrella to refer to a form of locally agreed process that is maintained, kept up to date, can be used as a reference and is used during staff induction. This could be in the form of a policy document, practice document or even a piece of software that fulfils the function of the standard. The important criteria are that everyone knows the reference point exists and where to find it, and that the reference point is kept up to date in accordance with the trust/board policies. Policy documents should be standardised in format, have clear review dates and have been ratified in accordance with trust/board policies.
Note 3	For hospitals that do not provide services for patients under 18 years of age (or, in Scotland, under 16 years of age).	<p>If your department does not treat patients under 18 years of age (or, in Scotland, under 16 years of age) routinely it is acceptable to mark paediatric specific standards as 'N/A'. Where the standard refers to both patients under 18 years of age (or, in Scotland, under 16 years of age) and adults, you may disregard the paediatric aspect and mark the standard as 'met' if you feel you meet that standard for adult care, or 'not met' if that isn't the case.</p> <p>If you have an emergency department but do not routinely treat patients under 18 years of age (or, in Scotland, under 16 years of age) or only occasionally treat patients of 16 or 17 years of age, then the paediatric standards are still considered applicable to a certain degree. In this instance, you will be required to provide further information on the pathway for these patients to determine a view of how those particular standards will apply to you.</p>

<p>Note 4</p>	<p>On anaesthetists in training, SAS doctors who are not autonomously practising and anaesthesia associates (collectively referred to as 'supervisee').</p>	<p>The diverse nature of these posts means that the standards of education, training and experience that can be expected from post holders can vary quite widely. To ensure the safety of patients, anaesthetists in training, SAS doctors who are not autonomously practising and anaesthesia associates must be subject to an appropriate level of supervision of all their clinical practice and follow the 2021 RCoA guidance on 'Supervision arrangements for anaesthetists'.</p>
<p>Note 5</p>	<p>On terminology</p>	<p>Please use the following definitions and explanation to facilitate your understanding of the ACSA standards:</p> <p>Immediate Without any appreciable delay, within a matter of seconds or minutes. Unless otherwise specified, this should be no more than five minutes.</p> <p>Remote sites A remote site is any location where general or regional anaesthesia or sedation is administered away from the main theatre suite and/or anaesthetic department. This may be within or away from the base hospital. Common examples include MR or CT scanners, maternity units or dental sedation suites.</p> <p>Supervision The "Guidance on the supervision of anaesthetists 2021" comprehensively outlines arrangements for supervision and the different levels of supervision. Audit data based on the Cappuccini Test should be used to provide evidence for supervision arrangements.</p> <p>Sedation Unless otherwise specified, sedation refers to sedation delivered by an anaesthetist.</p> <p>Lead There should be anaesthetic clinical leads with clear and agreed responsibilities for different areas or specialties. The number of leads will depend on the size of the anaesthetic department, their areas of specialisation, workload and any ongoing areas of special focus. Where appropriate a named 'lead' can be a non-anaesthetist.</p> <p>Multidisciplinary This will have different meaning in respect of which healthcare professionals are referred to according to context and clinical situation. It is referred to as an integral part of perioperative care; 'the practice of patient-centred, multidisciplinary and integrated clinical care for patients from contemplation of surgery until full recovery.'</p>

Autonomously practicing anaesthetists are SAS Doctors who can function autonomously to a level of defined competencies, as agreed within local clinical governance Frameworks.

SAS Doctors* are Speciality Doctors, SAS Specialists, Associate Specialists, Staff Grades and other closed SAS Grades.

Locally-employed Doctors (LEDs)* are doctors on local, employer-based contracts, commonly based on a current or historical version of the trainee contract. Examples of these roles include Trust Doctors, Trust Grades, Clinical Fellows, and Medical Training Initiative doctors. Some doctors are in this position short-term, between stages of training, or before becoming SAS doctors or consultants. Others are now in this position longer-term.

*These definitions are taken from the Association of Anaesthetists style guide:

<https://anaesthetists.org/Portals/0/PDFs/Wellbeing/Association%20style%20guide%20for%20describing%20types%20of%20anaesthetist%20and%20staff%20groups.pdf?ver=2022-12-21-122110-427>

STANDARD

5.1.1.1 Neuroscience Centres have specific pathways based on expert consensus in place for the management of brain injury including; stroke, STBI, SAH and other common neurological/neurosurgical diseases requiring critical care support.

EVIDENCE REQUIRED

Copies of the relevant guidelines and audits to show compliance should be seen.

PRIORITY

1

CQC KLoEs

Safe, Effective

HIW Domains

Safe & effective care

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES

- 14.5.11** For standalone neuroscience centres, local arrangements should be in place for specialist opinion and review of patients by other disciplines. A named consultant neuroanaesthetist should be identified to facilitate such liaison.
- 14.7.2** Audit programmes should be developed locally but should include continuous audit of transfer of brain injured patients, neurocritical care capacity and demand, rates of unplanned admission and readmission to the intensive care unit, and the caseload of trainees. In general, local practice should be audited against compliance rates with national and expert consensus guidelines.

STANDARD

5.1.1.2 Protocols and appropriate facilities are in place for transfer of critically ill neuroscience patients between hospitals, and within neuroscience units.

EVIDENCE REQUIRED

Protocols and presence of equipment which conforms to the guidance in Association of Anaesthetists' document 'Safe transfer of the brain-injured patient: trauma and stroke, 2019'. Protocols should include guidelines on how to deal with referrals when the neuro unit is full.

PRIORITY

1

CQC KLoEs

Safe, Effective

HIW Domains

Safe & effective care

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES

- 14.1.3** There should be designated consultants in referring hospitals and neuroscience units with overall responsibility for the organisation, infrastructure and processes to enable safe transfer of patients with a brain injury
- 14.2.4** Consideration should be given to continuing as much clinically indicated neuromonitoring as safely as possible when the patient is transferred between critical care unit, theatres, interventional suite, MRI and CT scanners..
- 14.5.13** Local guidance should be developed for the intrahospital transfer of neuroscience patients, based on guidance from the Neuroanaesthesia and Neurocritical Care Society (NACCS), Association of Anaesthetists and the Intensive Care Society.
- 14.5.14** Each department should appoint a designated liaison consultant responsible for identifying the strategic pathways and logistical pitfalls of the intra-hospital transfer of neurosurgical patients. The appointment should ensure any identified problems are either removed or mitigated.

HELPNOTE

Guidance in the Association of Anaesthetists document ['Safe transfer of the brain-injured patient: trauma and stroke, 2019'](#) should be followed.

STANDARD

5.1.1.3 Local guidelines are agreed between clinicians in the neuroscience unit and referring hospitals within their critical care operational delivery network for the transfer and repatriation of patients.

EVIDENCE REQUIRED

Transfer protocols, named consultant or autonomously practising anaesthetist within the department responsible for transfers, and transfer audits including regional with feedback. To include protocols for those ventilated patients being transferred only for specialist tests (e.g. GA MRI and neurophysiology) and then immediately returned. Transfers between the referring hospitals and the regional neuroscience unit should be audited and the results of the audit should be presented and discussed within the neuroscience unit as well as the operational delivery network.

PRIORITY

1

CQC KLoEs

Effective, well led

HIW Domains

Safe & effective care; Management & leadership

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

14.5.4 Consultants in neuroanaesthesia should be involved in the local and regional planning of any novel neuroscience services e.g. thrombectomy

14.5.8 Hospitals should have systems in place to facilitate multidisciplinary meetings for neuroscience services.

14.5.11 For standalone neuroscience centres, local arrangements should be in place for specialist opinion and review of patients by other disciplines. A named consultant neuroanaesthetist should be identified to facilitate such liaison.

STANDARD

5.1.1.4 There is a named consultant or autonomously practising anaesthetist within the neuroscience unit with responsibility for patient transfers.

EVIDENCE REQUIRED

Departmental document listing individual consultants' or autonomously practising anaesthetists' responsibilities.

PRIORITY

1

CQC KLoEs

Well led

HIW Domains

Management & leadership

HIS Domains

Workforce management and support; Quality improvement-focused leadership

GPAS REFERENCES

14.5.14 Each department should appoint a designated liaison consultant responsible for identifying the strategic pathways and logistical pitfalls of the intra-hospital transfer of neurosurgical patients. The appointment should ensure any identified problems are either removed or mitigated.

STANDARD

5.1.1.5 In neuroscience units associated with an emergency department but without onsite paediatric neurosurgical services, specific consideration is given to the provision of anaesthetic services for paediatric imaging and neurosurgery, to allow lifesaving emergency procedures to be performed in an adult unit prior to transfer.

EVIDENCE REQUIRED

Protocols and guidelines, plus availability of paediatric equipment within the neurosurgical theatre suite.

PRIORITY

1

CQC KLoEs

Safe, Effective

HIW Domains

Safe & effective care

HIS Domains

Safe, effective and person-centred care delivery; Policies, planning and governance

GPAS REFERENCES

14.3.3 Paediatric and neuroscience centres should consider partnering to help each maintain expertise of the other area.

14.3.4 In a true emergency situation involving a child requiring urgent neurosurgery for a deteriorating condition admitted to an 'adult-only' neurosurgical service, the most appropriate surgeon, anaesthetist and intensivist available would be expected to provide lifesaving care, including emergency resuscitation and surgery.

STANDARD

5.1.1.6 There is a policy to ensure that all cases requiring immediately lifesaving neurosurgery are admitted to the local neurosurgical centre irrespective of the initial availability of neurocritical care beds.

EVIDENCE REQUIRED

A policy should be provided. Staff should confirm that it happens in practice

PRIORITY

1

CQC KLoEs

Safe, Effective

HIW Domains

Safe & effective care

HIS Domains

Safe, effective and person-centred care delivery

REFERENCES

Management of Perceived Devastating Brain Injury After Hospital Admission – A Consensus Statement' <https://ficm.ac.uk/sites/ficm/files/documents/2021-10/Management%20of%20Perceived%20Devastating%20Brain%20Injury%20After%20Hospital%20Admission.pdf>

Courts and Tribunals Judiciary. Regulation 28: Report to Prevent Future Deaths January 2017 <https://www.judiciary.gov.uk/wp-content/uploads/2017/02/Dennett-2017-0026.pdf>

STANDARD

5.1.2.1 A neuroanaesthetic department should be able to provide elective and emergency care for all neurosurgical and neuroradiology subspecialities within their neuroscience centre and be able to manage these patients appropriately in a critical care area as required.

EVIDENCE REQUIRED

Operating lists, list of facilities and case mix supported by the department, staff rotas and confirmation by the Clinical Director.

PRIORITY

1

CQC KLoEs

Safe, Effective

HIW Domains

Safe & effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

14 Introduction

- 14.1.4** An appropriately trained and experienced anaesthetist should be present for all neurosurgical operating lists and interventional neuroradiology sessions, with sufficient consultant-programmed activities to provide adequate supervision and support to trainee anaesthetists and SAS anaesthetists.
- 14.1.5** Adequate anaesthetic cover should be available to provide general anaesthesia and sedation for diagnostic radiology sessions, including computed tomography (CT) and magnetic resonance imaging (MRI) scans.
- 14.1.8** An appropriately skilled and experienced resident anaesthetist should be available at all times to care for postoperative and emergency patients. The experience and skills necessary to provide this cover are not usually found in training grades below ST3.
- 14.1.13** All post anaesthetic recovery staff looking after neuroscience patients should be able to recognise and describe complications following neuroanaesthesia and possess skills to obtain multidisciplinary assistance and escalate treatment according to departmental protocols and guidance.

STANDARD

5.1.2.2 A specific group of consultant anaesthetists or autonomously practising anaesthetists (neuroanaesthetists) who may be part of, or closely affiliated with, a general department of anaesthesia and intensive care unit, is available for cover for neuroanaesthesia.

EVIDENCE REQUIRED

Evidence of a specific group of named consultants or autonomously practising anaesthetists who cover all the neuro-services within the trust. List displayed in the department (with any subspecialty interests, e.g. spinal, skull base), theatre rotas.

PRIORITY

1

CQC KLoEs

Effective

HIW Domains

Safe & effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

14.1.2 There should be a specified and therefore identifiable group of neuroanaesthetists who cover the neuroanaesthesia service and have sufficient programmed activities to deliver the elective and emergency service.

STANDARD

5.1.2.3 Sufficient numbers of clinical programmed activities are in consultants' or autonomously practising anaesthetists' job plans to provide cover for all elective neurosurgical operating lists and interventional neuroradiology sessions, including appropriate pre and postoperative assessment, and also to provide adequate emergency cover for neurosurgery and interventional radiology (including thrombectomy).

EVIDENCE REQUIRED

Theatre rotas and normal theatre allocation plan to show that such cover exists.

PRIORITY

1

CQC KLoEs

Safe, Effective

HIW Domains

Safe & effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

- 14.1.2** There should be a specified and therefore identifiable group of neuroanaesthetists who cover the neuroanaesthesia service and have sufficient programmed activities to deliver the elective and emergency service.
- 14.1.5** Adequate anaesthetic cover should be available to provide general anaesthesia and sedation for diagnostic neuroradiology sessions (i.e. brain and spine imaging) sessions, including computed tomography (CT) and MRI.
- 14.5.2** There should be sufficient numbers of clinical programmed activities in consultants' job plans to provide cover for all elective neurosurgical operating lists and to provide adequate emergency cover.

STANDARD

5.1.2.4 Consultants or autonomously practising anaesthetists in anaesthesia working in neuroanaesthesia and/or neurocritical care have sufficient regular programmed activities within this field to ensure that their specific skills and experience are maintained.

EVIDENCE REQUIRED

Evidenced by rotas and job plans.

PRIORITY

1

CQC KLoEs

Well led

HIW Domains

Management & leadership

HIS Domains

Workforce management and support; Quality improvement-focused leadership

GPAS REFERENCES

- 14.4.1** Any autonomously practising anaesthetist working in neuroanaesthesia must undertake continuing professional development (CPD) in neuroanaesthesia and must have sufficient regular programmed activities within this field to ensure that their specific skills and experience are maintained.
- 14.4.2** Departments should consider providing newly appointed consultants with a mentor to facilitate their development especially in a sub-speciality they may have limited experience.
- 14.4.3** Consultant anaesthetists who provide out of hours cover to the neuroscience unit, but do not provide neuroanaesthesia in working hours, should be able to demonstrate the maintenance of appropriate skills and knowledge through regular clinical involvement and continuing professional development (CPD).
- 14 Glossary**
Neuroanaesthetist – Neuroanaesthetists will have regular neuroscience sessions (most often at least two sessions per week), be involved in neuroscience morbidity and mortality conferences and carry out regular CPD in this area.

STANDARD

5.1.2.5 All neuroanaesthetists have evidence of case mix and CPD to maintain relevant skills, including the management of the difficult airway, as required for appraisal and revalidation in neuroanaesthesia.

EVIDENCE REQUIRED

Confirmation from consultants or autonomously practising anaesthetists, ideally, including personal theatre logs and CPD record. The majority of consultants undertaking neuroanaesthesia have membership of an appropriate national specialist body. Evidence of regular multidisciplinary simulation training for neuroemergencies is desirable.

PRIORITY

1

CQC KLoEs

Safe, well led

HIW Domains

Safe & effective care; Management & leadership

HIS Domains

Safe, effective and person-centred care delivery; Quality improvement-focussed leadership

GPAS REFERENCES

- 14.1.2** There should be a specified and therefore identifiable group of neuroanaesthetists who cover the neuroanaesthesia service and have sufficient programmed activities to deliver the elective and emergency service.
- 14.4.1** Any autonomously practising anaesthetist working in neuroanaesthesia must undertake continuing professional development (CPD) in neuroanaesthesia and must have sufficient regular programmed activities within this field to ensure that their specific skills and experience are maintained.

STANDARD

5.1.2.6 There should be a nominated Clinical Lead for Neuroanaesthesia and/or Neurocritical care who should have adequate programmed activities allocated to this function.

EVIDENCE REQUIRED

Lead consultants' or autonomously practising anaesthetists' agreed job plan.

PRIORITY

1

CQC KLoEs

Well led

HIW Domains

Management & leadership

HIS Domains

Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

14.1.1 In each hospital providing neuroanaesthesia, a neuroanaesthetist should be appointed as the clinical lead (see glossary) to manage service delivery. Adequate time for this role should be included in the lead's job plan.

14 Glossary

Clinical lead - doctors undertaking lead roles should be autonomously practising doctors who have competence, experience and communication skills in the specialist area equivalent to consultant colleagues. They should usually have experience in teaching and education relevant to the role and they should participate in quality improvement and CPD activities. Individuals should be fully supported by their clinical director and should be provided with adequate time and resources to allow them to effectively undertake the lead role.

STANDARD

5.1.2.7 24/7 neuroradiology support is provided for interpretation of neuroimaging. Online review of CT scans from referring hospitals and within the neuroscience centre are available locally.

EVIDENCE REQUIRED

Neuroradiology on call rota or evidence of SLA to provide the support. PACS system linked in to referring hospitals.

PRIORITY

1

CQC KLoEs

Effective

HIW Domains

Safe & effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

14.2.12 Neuroradiology support should be available 24/7 for interpretation of neuroimaging.

14.2.14 Online imaging results from referring hospitals and within the neuroscience centre should be available locally, and consideration should be given to the provision of remote access for all consultants who provide cover to neuroanaesthesia out of hours.

14.5.1 Much of neurosurgery involves acute work with a high degree of urgency. The provision of associated services should recognise this need and inappropriate delay should not be allowed to occur as a result of lack of key personnel or facilities. Laboratory services, neuroradiology, availability of operating theatre time and sufficient Level 1–3 bed provision should all be organised to cope with these demands.

STANDARD

5.1.2.8 Appropriate telemedicine access, e.g. PACS access, is provided in the homes of consultants or autonomously practising anaesthetists who provide cover to neurocritical care out of hours.

EVIDENCE REQUIRED

Consultants or autonomously practising anaesthetists confirm that they can view images at home.

PRIORITY

1

CQC KLoEs

Caring

HIW Domains

Management & leadership

HIS Domains

Workforce management and support

GPAS REFERENCES

14.2.14 Online imaging results from referring hospitals and within the neuroscience centre should be available locally, and consideration should be given to the provision of remote access for all consultants who provide cover to neuroanaesthesia out of hours.

STANDARD

5.1.2.9 Neurotheatres, PACU, ICU and radiological facilities are co-located, ideally on the same floor, to allow for easy transfer of ventilated patients with neurosurgical problems between these three areas.

EVIDENCE REQUIRED

Floor plan of hospital.

PRIORITY

2

CQC KLoEs

Effective

HIW Domains

Safe & effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

14.2.17 Transfer times between the procedure room and intensive care should be minimised. In new buildings, this may be achieved by having theatres, the intensive care unit and radiological facilities within close proximity and preferably on the same floor. An integrated approach should be taken when planning new facilities.

STANDARD

5.1.2.10 Anaesthetic staffing levels in the operating theatre are sufficient to allow neuroanaesthetists to work in teams during long and complex operations.

EVIDENCE REQUIRED

Theatre rotas and verbal explanation should be given of arrangements to cover planned and unplanned over-runs

PRIORITY

1

CQC KLoEs

Safe, Caring

HIW Domains

Safe & effective care; Management & leadership

HIS Domains

Safe, effective and person-centred care delivery; Workforce management and support

GPAS REFERENCES

14.1.6 Hospitals should have well integrated arrangements that ensure anaesthetists covering long neurosurgical procedures or overrunning lists are regularly relieved by an appropriate colleague for refreshment and comfort breaks. If a case is expected to run over three sessions, consideration should be given to organising a second anaesthetist.

STANDARD

5.1.2.11 There should be a dedicated resident anaesthetist for out of hours neurosurgical workload with a clear process for advice and escalation to a designated oncall consultant/specialist neuroanaesthetist if required.

EVIDENCE REQUIRED

On call rotas.

PRIORITY

1 (standalone neuroscience units) 2 (neuroscience units embedded within larger trusts)

CQC KLoEs

Effective

HIW Domains

Safe & effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

- 14.1.8** An appropriately skilled and experienced resident anaesthetist should be available at all times to care for postoperative and emergency patients. The experience and skills necessary to provide this cover are not usually found in anaesthetists in training in stage 1.
- 14.1.9** Out of hours, consultants should be immediately available by telephone for advice and be able to attend the hospital within 30 minutes. Suitably skilled and experienced theatre staff should also be available.
- 14.2.18** Postoperative recovery facilities, with appropriately trained staff and equipment, should be available for elective and non-elective procedures.
- 14.5.2** There should be sufficient numbers of clinical programmed activities in consultants' job plans to provide cover for all elective neurosurgical operating lists and to provide adequate emergency cover.

STANDARD

5.1.2.12 Specific equipment to manage the difficult airway, including the provision of sufficient numbers of fiberoptic laryngoscopes, is available.

EVIDENCE REQUIRED

Equipment should be seen.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe & effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

14.2.1 Specific equipment for difficult airway management should be available in a clearly labelled trolley.

STANDARD

5.1.2.13a In hospitals with a separate neurocritical care unit there is a designated consultant or autonomously practising anaesthetist lead for NICU within the critical care area.

EVIDENCE REQUIRED

Consultant's or autonomously practising anaesthetists' CPD records, daily work rotas, case mix and training records. The same as would be required for appraisal and revalidation.

PRIORITY

1

CQC KLoEs

Well led

HIW Domains

Management & leadership

HIS Domains

Workforce management and support; Quality improvement-focussed leadership

REFERENCES

['Guidelines for the Provision of Intensive Care Services 2022'](#). The Faculty of Intensive Care Medicine and the Intensive Care Society.

STANDARD

5.1.2.13b In a neurosciences centre with a separate neurocritical care unit, any consultant or autonomously practising anaesthetist covering the neurocritical care unit out of hours should also have daytime sessions in the neurocritical care unit during the working week.

EVIDENCE REQUIRED

Consultants' or autonomously practising anaesthetists' CPD records, daily work rotas, case mix and training records. The same as would be required for appraisal and revalidation.

PRIORITY

1

CQC KLoEs

Well led

HIW Domains

Management & leadership

HIS Domains

Workforce management and support; Quality improvement-focussed leadership

REFERENCES

['Guidelines for the Provision of Intensive Care Services 2022'](#). The Faculty of Intensive Care Medicine and the Intensive Care Society.

STANDARD

5.1.2.14 Consultant or autonomously practising anaesthetists responsible for the care of neuroscience patients requiring critical care support have the knowledge, skills and experience needed to treat this group of patients, irrespective of whether the services are provided in a recovery ward, dedicated neurocritical care unit or within the context of a general intensive care unit.

EVIDENCE REQUIRED

Consultants' or autonomously practising anaesthetists' CPD records, case mix and training records. The same as would be required for appraisal and revalidation.

PRIORITY

1

CQC KLoEs

Well led

HIW Domains

Management & leadership

HIS Domains

Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

14.1.14 Where departments use post-anaesthetic recovery units for extended recovery, the post-anaesthetic recovery staff caring for those patients should have a registered nurse or operating department practitioner: patient patient ratio of 1:2, as in a level 2 critical care unit.. However, the care of an individual patient should be delivered on a one to one basis until the patient is able to maintain their own airway, has respiratory and cardiovascular stability and is able to communicate (where applicable). Departments should have procedures in place to demonstrate the adequacy of medical cover for such extended recovery units.

STANDARD

5.1.2.15 In neuroscience centres with a separate critical care unit there must be a doctor with appropriate skills and competencies immediately available for the neurocritical care unit 24/7.

EVIDENCE REQUIRED

Trainee and consultant or autonomously practising anaesthetist on call rotas.

PRIORITY

1

CQC KLoEs

Safe, Effective

HIW Domains

Safe & effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

14.1.2 There should be a specified and therefore identifiable group of neuroanaesthetists who cover the neuroanaesthesia service and have sufficient programmed activities to deliver the elective and emergency service.

STANDARD

5.1.2.16 Neurophysiological support is available seven days a week to support the management of patients requiring continuous EEG monitoring to manage their treatment.

EVIDENCE REQUIRED

Neurophysiological SLA/rotas demonstrating the service exists.

PRIORITY

2

CQC KLoEs

Safe

HIW Domains

Safe & effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

14.2.6 Those units conducting functional neurosurgery or surgery for correction of scoliosis, other relevant spinal surgery, or surgery for some cranial lesions (e.g. cerebellopontine angle tumours) should have the appropriate equipment and adequate numbers of trained staff for intraoperative neurophysiological testing. Neuroanaesthetists should be aware of the implications of this testing for anaesthesia including blood pressure management, use of neuromuscular blockade, and the use of total intravenous anaesthesia.

STANDARD

5.1.2.17 Fellowship posts suitable for those who wish to follow a career in neuroanaesthesia or neurocritical care are available that provide enhanced levels of teaching and training and with access to study leave.

EVIDENCE REQUIRED

Details of training offered, trainee feedback and evidence of research or audit undertaken by fellows.

PRIORITY

2

CQC KLoEs

Well led

HIW Domains

Management & leadership

HIS Domains

Workforce management and support; Quality improvement-focused leadership

GPAS REFERENCES

14.4.8 Fellowship posts should be identified to allow additional training for those who wish to follow a career in neuroanaesthesia or neurocritical care. Such posts should provide similar or enhanced levels of teaching, training and access to study leave as regular training posts.

STANDARD

5.1.2.18 There needs to be a named consultant or autonomously practising anaesthetist who has responsibility for emergency neuroanaesthesia 24/7.

EVIDENCE REQUIRED

Rota should be seen.

PRIORITY

1

CQC KLoEs

Effective

HIW Domains

Safe & effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

- 14.1.4** An appropriately trained and experienced anaesthetist should be present for all neurosurgical operating lists and interventional neuroradiology sessions, with sufficient consultant-programmed activities to provide adequate supervision and support to trainee anaesthetists and SAS anaesthetists.
- 14.1.8** An appropriately skilled and experienced resident anaesthetist should be available at all times to care for postoperative and emergency patients. The experience and skills necessary to provide this cover are not usually found in anaesthetists in training in stage 1.

STANDARD

5.1.2.19 There is an inpatient pain service available 7 days a week with staff that are trained to deal with the complex pain requirements of some patients following neurosurgical and complex spine surgery.

EVIDENCE REQUIRED

Verbal confirmation should be given of pain service and staffing. On call anaesthetists who cover requests for pain management should be appropriately trained with guidelines they can follow.

PRIORITY

1

CQC KLoEs

Safe

HIW Domains

Safe & effective care

HIS Domains

Safe, effective and person-centred care delivery

GPAS REFERENCES

14.5.17 The 24/7 acute pain service should be available for neurosurgical patients and staff should be trained to address the specific needs of neurosurgical patients, such as those with impaired communication.

14.5.18 Pain is a useful outcome measure for audit. The utility of specific local and regional techniques for neurosurgical patients is established and pain teams should be aware of these techniques.

STANDARD

5.1.2.20 There should be provision within the department for consultants or autonomously practising neuroanaesthetist to familiarise themselves and update their skills for highly specialised procedures done in limited numbers such as neurosurgery in the interventional MRI suite, awake neurosurgery, craniofacial procedures, deep brain stimulation, and anaesthesia for complex base of skull surgery.

EVIDENCE REQUIRED

Consultants' or autonomously practising anaesthetists' CPD records, case mix and training records. The same as would be required for appraisal and revalidation.

PRIORITY

1

CQC KLoEs

Safe, Well led

HIW Domains

Safe and effective care; Management & leadership

HIS Domains

Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

14.4.4 Elective neuroanaesthesia for highly specialised procedures that have limited case numbers (e.g. craniofacial procedures, awake neurosurgery, and deep brain stimulation) should be provided by a dedicated subgroup of neuroanaesthetists within the department to ensure that they are able to treat sufficient numbers in order to maintain their competence in these areas.

STANDARD

5.1.3.1 Patient information specific to neurosurgical procedures is provided to patients, including relevant risks. This should be in a format of the patient's choice.

EVIDENCE REQUIRED

Patient information should be provided in a wide range of formats and styles relevant to the patient population, e.g. large print, Braille, easy-reading, QR codes, videos or other media. This should be available in clinic and on neurosurgical wards.

PRIORITY

1

CQC KLoEs

Caring

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

- 14.9.1** Patients should be provided written information (in a format of their choice) specific to the neurosurgical procedure they are planned to undergo, which explains the procedure, any preoperative preparation required, the risks, benefits and relevant advice in an easy to understand language.
- 14.9.2** All patients (and relatives where appropriate and relevant) should be fully informed about the planned procedure and be encouraged to be active participants in decisions about their care, including the option of doing nothing.

STANDARD

5.1.3.2 Information for relatives of patients requiring neurocritical care is available, including contact details of relevant charities and helplines.

EVIDENCE REQUIRED

Relatives and patients' information on critical care is available.

PRIORITY

1

CQC KLoEs

Caring

HIW Domains

Quality of patient experience

HIS Domains

Impact on patients, service users, carers and families

GPAS REFERENCES

14.9.2 All patients (and relatives where appropriate and relevant) should be fully informed about the planned procedure and be encouraged to be active participants in decisions about their care, including the option of doing nothing.

STANDARD

5.1.4.1 There should be evidence of MDT working both in Neurotheatres and neurocritical care unit which includes regular MDT rounds, inputs into development of protocols and involvement in clinical governance of the service.

EVIDENCE REQUIRED

List of documents and authorship showing wide input and consultation within the multidisciplinary team. Clear information as to where they can be found (e.g. intranet). The protocols and guidelines available for inspection, and which are up to date and with specified review dates.

PRIORITY

1

CQC KLoEs

Well led

HIW Domains

Management & leadership

HIS Domains

Quality improvement-focussed leadership

GPAS REFERENCES

- 14.1.1** In each hospital providing neuroanaesthesia, a neuroanaesthetist should be appointed as the clinical lead to manage service delivery. Adequate time for this role should be included in the lead's job plan
- 14.5.8** Hospitals should have systems in place to facilitate multidisciplinary meetings for neuroscience services.
- 14.5.12** Hospitals should review their local standards to ensure that they are harmonised with the relevant national safety standards (e.g. National Safety Standards for Invasive Procedures in England or the Scottish Patient Safety Programme in Scotland).

STANDARD

5.1.4.2 Departments of neuroanaesthesia and neurocritical care engage in research relevant to the practice of neuroscience.

EVIDENCE REQUIRED

Evidence of engagement in national projects such as RAIN and RescueICP and, where appropriate, a portfolio of local projects. There should be a named research lead.

PRIORITY

1

CQC KLoEs

Well led

HIW Domains

Management & leadership

HIS Domains

Quality improvement-focussed leadership

GPAS REFERENCES

14.7.1 Departments of neuroanaesthesia should be encouraged to develop research interests, even if not part of an academic department. Research collaboration with other neuroscience disciplines is good practice. Taking part in national anaesthesia and critical care projects is to be encouraged.

STANDARD

5.1.4.3 Audit programmes are developed locally including continuous audit of relevant neuro related issues. Collaborative audit with the other neuroscience disciplines should also be encouraged, and some M&M meetings should be joint with neurosurgeons, neuroradiologists and the stroke team.

EVIDENCE REQUIRED

Audit records and minutes of audit and M&M meetings. Named audit lead.

PRIORITY

1

CQC KLoEs

Effective Well led

HIW Domains

Management & leadership

HIS Domains

Quality improvement-focussed leadership

GPAS REFERENCES

14.7.2 Audit programmes should be developed locally but should include continuous audit of transfer of brain injured patients, neurocritical care capacity and demand, rates of unplanned admission and readmission to the intensive care unit, and the caseload of anaesthetists in training, among others. In general, local practice should be audited against compliance rates with national and expert consensus guidelines.

14.7.3 Collaborative audit with the other neuroscience disciplines should be encouraged as well as close liaison and joint transfer audits with referring hospitals.

STANDARD

5.1.4.4 Local practice is audited against national and expert consensus guidelines.

EVIDENCE REQUIRED

Evidence of participation in NAP projects, NCEPOD), TARN data should be seen.

PRIORITY

1

CQC KLoEs

Effective Well led

HIW Domains

Management & leadership

HIS Domains

Quality improvement-focused leadership

GPAS REFERENCES

- 14.7.2** Audit programmes should be developed locally but should include continuous audit of transfer of brain injured patients, neurocritical care capacity and demand, rates of unplanned admission and readmission to the intensive care unit, and the caseload of anaesthetists in training, among others. In general, local practice should be audited against compliance rates with national and expert consensus guidelines.
- 14.7.3** Collaborative audit with the other neuroscience disciplines should be encouraged as well as close liaison and joint transfer audits with referring hospitals.
- 14.7.5** All departments should maintain active links to national bodies and societies (e.g. [NACCS Doctor Scheme](#)) to facilitate national audit and dissemination of information.

STANDARD

5.1.4.5 The department should monitor any changes in clinical workload both during hours and out of hours for e.g. development of 24/7 thrombectomy service and ensure that they have adequate resources including staffing to cover increased workload.

EVIDENCE REQUIRED

Clearly defined written lines of escalation with management. Verbal confirmation of managerial support should be given and staff should relay anecdotal evidence of times that this has been handled appropriately.

Priority

1

CQC KLoEs

Safe; Well led

HIW Domains

Safe and effective care; Management & leadership

HIS Domains

Workforce management and support; Quality improvement-focussed leadership

GPAS REFERENCES

14.1.11 Departments that participate in national initiatives (e.g. services for thrombectomy) should review their staffing arrangements to ensure timely emergency cover. Thrombectomy should have a protocol-led service, ideally staffed by neuroanaesthetists.



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