Scope of Practice for Anaesthesia Associates 2024

1 Phases post qualification for anaesthesia associates

Experience and capabilities, both clinical and non-clinical, are expected to develop over time. It is vital that AAs are provided with the support needed to ensure safe practice and the appropriate development of skills. The 2024 Anaesthesia Associate Scope of Practice has been written based on the following phases post qualification.

Phase 1: Scope of practice in first year post qualification (year 1).
Phase 2: Scope of practice for years 2, 3 and 4 post qualification.
Phase 3: Scope of practice year 5 post qualification and beyond.

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Phase 1 Scope of Practice (year 1) The following roles/activities are included within the scope of practice for anaesthesia associates in Phase 1	
Preoperative Assessment	
Under supervision level 1 progressing to level 2a	▪ Taking a focussed medical/surgical history. ▪ Interpretation of relevant investigations. ▪ Current medication review. ▪ Respiratory and cardiovascular examination. ▪ Airway assessment. ▪ Consenting patients for anaesthesia and common anaesthetic interventions*. ▪ Agreeing the anaesthesia plan with the supervising anaesthetist.
Preparation for Anaesthesia	
Under supervision level 2a	▪ Anaesthetic equipment and machine check. ▪ Preparation of anaesthetic drugs. ▪ Preparation of IV fluids.
Delivery of Anaesthesia	
Under supervision level 1	▪ Induction of anaesthesia. ▪ Securing of the airway. ▪ Insertion of spinal anaesthesia. ▪ Emergence from anaesthesia.
Under supervision level 1 progressing to level 2a	▪ Monitoring/documentation of patient vital signs. ▪ Maintenance of anaesthesia. ▪ Monitoring of patients during surgery under general, neuraxial or regional anaesthesia. ▪ Administration of IV fluids as required. ▪ Immediate post-operative care in recovery.
Under supervision level 2b	▪ Infra-inguinal fascia-iliaca block (FIB) to provide analgesia. ▪ Ultrasound guided peripheral venous cannulation.
Extended roles which can be considered for development in Phase 1**	
Under supervision level 1 progressing to level 2b	▪ Ultrasound guided insertion of midline and peripherally inserted central catheter (PICC) lines following appropriate locally agreed additional training.

Exclusions from Scope of Practice at Phase 1	

	▪ Induction of anaesthesia and airway management without direct supervision.
	▪ Regional anaesthesia other than spinal and FIB.
	▪ Insertion of central venous lines (excluding PICC).
	▪ Insertion of arterial lines.
	▪ Subspecialty anaesthesia including:
	  ▪ paediatrics (patient <16 years) – see 4.12
	  ▪ obstetric anaesthesia
	  ▪ cardiothoracic anaesthesia
	  ▪ neuro anaesthesia.

*AAs are able to take consent for procedures for which they are suitably trained/qualified to undertake and where they have sufficient knowledge of the proposed investigation or treatment, and the risks involved.

**To enable the development of extended roles it is essential that there is a demonstrated clinical need for AAs to undertake this role within the employing organisation. It must also be confirmed that there are sufficient training opportunities for the physician anaesthetists within the department to have received this training if required[1].

Notes to accompany Phase1 Scope of Practice

Progression from level 1 to level 2 supervision during Phase 1

It is expected that in the first three to six months post qualification an AA will be working with 1:1 (level 1) supervision for their clinical activity. During this time clinical confidence and competence will develop and it will be appropriate for this level of supervision to move from direct (level 1) to close (level 2a) supervision. With increasing experience in the delivery of general anaesthesia an assessment should be made by the clinical lead for AAs in conjunction with the clinical director that the level of supervision can move towards 2:1 working. This review should take into consideration the AA's logbook of cases/procedures, case mix, reflections on any critical incidents and feedback from their clinical supervisors (e.g. via a Multiple Trainer Report).

General

1 Any clinical activity involving AAs in the delivery of general anaesthesia outside of the operating theatre complex will require 1:1 supervision by a clinical supervisor. This relates to all remote sites within a hospital.

2 It is expected that, within Phase 1 working, AAs can maintain anaesthesia in ASA 1 and 2 patients under 1:1 (level 1) or 2:1 (level 2a) supervision. Where a patient is deemed by the clinical supervisor to be ASA 3 or above then any anaesthesia delivered by an AA should be supervised through 1:1 working under either direct (level 1) or local (level 2a) supervision. See Appendix 1 for ASA classification.

[1] www.aomrc.org.uk/wp-content/uploads/2024/03/Consensus_statement_High_level_principles_concerning_PAs_040324.pdf.

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Sedation

3 Where deep sedation[2] is required, an AA should be directly supervised (level 1).

Extended roles

4 Extended roles as highlighted within the Phase 1 scope of practice can be considered where required by the organisation. All extended roles within Phase 1 will need to be performed under direct supervision unless otherwise stated.

5 Development of extended roles will require the department to clearly define the training support required and the governance in place to ensure safe delivery of patient care.

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[2] www.aomrc.org.uk/publication/safe-sedation-practice-for-healthcare-procedures-standards-and-guidance/.

Phase 2 Scope of Practice (years 2-4) The following roles/activities are included within the scope of practice for anaesthesia associates in Phase 2	
Preoperative Assessment	
Under supervision level 1 or 2a	▪ As per Phase 1.
Preparation for Anaesthesia	
Under supervision level 2a	▪ As per Phase 1.
Delivery of Anaesthesia	
Under supervision level 1*	▪ Induction of anaesthesia. ▪ Securing of the airway. ▪ Insertion of spinal anaesthesia.
Under supervision level 1 or 2a	▪ Monitoring/documentation of patient vital signs. ▪ Maintenance of anaesthesia. ▪ Monitoring of patients during surgery under spinal, neuraxial or regional anaesthesia. ▪ Administration of IV fluids as required. ▪ Emergence from anaesthesia. ▪ Immediate post-operative care in recovery.
Additional Procedures	
Under supervision level 2a or 2b	▪ Infra-inguinal fascia-iliaca block (FIB) to provide analgesia. ▪ Ultrasound guided peripheral venous cannulation to include midline and peripherally inserted central catheter (PICC) lines following appropriate locally agreed additional training.
Extended roles which can be considered for development in Phase 2**	
Under supervision level 1	▪ Insertion of arterial lines.

Exclusions from Scope at Phase 2	

	▪ Induction of anaesthesia and airway management without direct supervision.
	▪ Regional anaesthesia other than spinal and FIB.
	▪ Insertion of central venous lines (excluding PICC).
	▪ Subspecialty anaesthesia including:
	  ▪ paediatrics (patient <16 years) –– see 4.12
	  ▪ obstetric anaesthesia
	  ▪ cardiothoracic anaesthesia
	  ▪ neuro anaesthesia.

*__Induction of anaesthesia and insertion of spinal anaesthesia:__ It is expected that as an AA gains experience, whilst still directly supervised for induction of anaesthesia and insertion of spinal anaesthesia, their clinical supervisor may be able to reduce their level of involvement in the procedure.

**To enable the development of extended roles it is essential that there is a demonstrated clinical need for AAs to undertake this role within the employing organisation. It must also be confirmed that there are sufficient training opportunities for the physician anaesthetists within the department to have received this training if required.

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Notes to accompany Phase 2 Scope of Practice

Progression from Phase 1 to Phase 2

Following the completion of the first-year post qualification an AA should move into Phase 2. With increasing experience in the delivery of general anaesthesia an assessment should be made by the clinical lead for AAs in conjunction with the clinical director that the AA is able to progress into the next Phase. This review should take into consideration the AA's logbook of cases/procedures, case mix, reflections on any critical incidents and feedback from their clinical supervisors (e.g. via a Multiple Trainer Report).

General

1 It is anticipated that after one year of clinical practice AAs may be working more regularly under 2:1(level 2) supervision.

2 It is expected that, within Phase 2 working, AAs can maintain anaesthesia in ASA 1 and 2 patients under 2:1 (level 2a) supervision. Where a patient is deemed by the clinical supervisor to be ASA 3 or above then any anaesthesia delivered by an AA should be supervised through 1:1 working under either direct (level 1) or local (level 2a) supervision. See Appendix 1 for ASA classification.

Sedation

3 Where deep[3] sedation is required, an AA should be directly supervised (level 1).

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[19]https://www.aomrc.org.uk/publication/safe-sedation-practice-for-healthcare-procedures-standards-and-guidance/

Extended roles

4 Extended roles as highlighted within the Phase 2 scope of practice can be considered where required by an organisation. All extended roles within Phase 2 will need to be performed under direct supervision unless otherwise stated.

5 Development of extended roles will require the department to clearly define the training required and the governance in place to ensure safe delivery of patient care.

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Phase 3 Scope of Practice (>4 years)

The following roles/activities are included within the SoP for anaesthesia associates in Phase 3

Preoperative Assessment and Preparation for Anaesthesia	
Under supervision level 2a	▪ As per Phase 1 and 2.
Delivery of Anaesthesia	
Under supervision level 1*	▪ Induction of anaesthesia. ▪ Securing of the airway. ▪ Insertion of spinal anaesthesia.
Under supervision level 2a	▪ As per Phase 1 and 2. ▪ Emergence from anaesthesia.
Additional Procedures	
Under supervision level 2b	▪ Infra-inguinal fascia-iliaca block (FIB) to provide analgesia. ▪ Ultrasound guided peripheral venous cannulation to include midline and peripherally inserted central catheter (PICC) lines once appropriately trained
Extended roles which can be considered for development in Phase 3**	
Under supervision level 2a	▪ Insertion of arterial lines ▪ Insertion of central venous lines following additional locally agreed training and assessment
Exclusions from Scope at Phase 3	

	▪ Induction of anaesthesia and airway management without direct supervision.
	▪ Regional anaesthesia other than spinal and FIB.
	▪ Subspecialty anaesthesia including:
	  ▪ paediatrics (patient <16 years) – see 4.12
	  ▪ obstetric anaesthesia
	  ▪ cardiothoracic anaesthesia
	  ▪ neuro anaesthesia.

Induction of anaesthesia and insertion of spinal anaesthesia: It is expected that as an AA gains experience, whist still directly supervised for induction of anaesthesia and insertion of spinal anaesthesia, their clinical supervisor will be able to reduce their level of involvement in the procedure.

**To enable the development of extended roles it is essential that there is a demonstrated clinical need for AAs to undertake this role within the employing organisation. It must also be confirmed that there are sufficient training opportunities for the physician anaesthetists within the department to have received this training if required.

Notes to accompany Phase 3 Scope of Practice

Progression from Phase 2 to Phase 3

Following the completion of four years post qualification an AA should move into Phase 3. With increasing experience in the delivery of general anaesthesia an assessment should be made by the clinical lead for AAs in conjunction with the clinical director that the AA is able to progress into the next Phase. This review should take into consideration the AA's logbook of cases/procedures, case mix, reflections on any critical incidents and feedback from their clinical supervisors (e.g. via a Multiple Trainer Report).

General

1 It is anticipated that after four years of clinical practice as an AA a significant proportion of their clinical work will be under the 2:1 supervision model.

2 It is expected that, within Phase 3 working, AAs can maintain anaesthesia in ASA 1 and 2 patients under 2:1 (level 2a) supervision. Where a patient is deemed by the clinical supervisor to be ASA 3 or above then any anaesthesia delivered by an AA should be supervised through 1:1 working under either direct (level 1) or local (level 2a) supervision. See Appendix 1 for ASA classification.

Sedation

3 Where deep sedation is required, an AA should be directly supervised (level 1)

Extended Roles

4 Extended roles as highlighted within the Phase 3 SoP can be considered where required by the organisation. It may now be reasonable for extended roles within Phase 3 to be performed under level 2 supervision.

5 Development of Phase 3 extended roles will require the department to clearly outline the training required and the governance in place to ensure safe delivery of patient care.

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Additional notes covering the scope of practice in all phases

Sub-tenon block for ophthalmic surgery:
Sub-tenon blocks for eye surgery are administered by a range of trained practitioners including AAs. Where AAs are providing this service, they must be appropriately trained and supervised under either a 1:1 or a 2:1 model.

Prescribing and administration of medicines:
Within the operating theatre, any administration of drugs by AAs is regarded as being on the order of the clinical supervisor. AAs can administer medicines but are not able to act as independent or supplementary prescribers. A robust mechanism for regulating this arrangement should be devised locally. Many hospitals have adopted a route of generating patient-specific directions (PSD) as evidence of prescription by the supervising anaesthetist.

Robust governance utilising PSD's for drug authorisation and administration by AA's should be in place. Non-medical prescribing (NMP) for AAs cannot be established until statutory regulation has been completed because it is subject to separate legislation that can pertain only to professions that are statutorily regulated. The GMC will clarify their view on AAs who have gained NMP status through other professions (nursing etc) and their ability to use that qualification while working as an AA.

Please note that the clinical supervisor remains responsible and accountable for all medicines administered by the AA.

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