Scope of Practice for Anaesthesia Associates 2024

3 Principles underpinning the clinical supervision of anaesthesia associates

3.1 AAs must only work under the supervision of a consultant or autonomously practising anaesthetist.

3.2 AAs must not be supervised by an anaesthetist who requires supervision themselves, e.g. anaesthetists in training, non-autonomously practising SAS or locally employed doctors.

3.3 AAs must not be supervised by another AA.

3.4 Whilst responsible for supervising AAs and anaesthetists (under a 2:1 model), the clinical supervisor must not provide solo anaesthesia for another patient or undertake any duties they cannot leave immediately.

3.5 The clinical supervisor must not be responsible for more than two anaesthetised patients simultaneously, where one or both involve supervision of an AA. When supervising within a 2:1 model it is essential that the clinical complexity of the anaesthetic management is appropriate, and the cases should be within the same theatre suite.

3.6 Every AA must have immediate access to a clinical supervisor who must always be in the same theatre suite and available within two minutes.

3.7 An AA should always know where their clinical supervisor is and how to contact them. Equally the supervisor should always know where their supervisees are and have detailed knowledge of the clinical activity they are responsible for. This can be assessed by a department through use of the Cappuccini Test[1].

3.8 If the clinical supervisor needs to leave the theatre suite for any reason, deputising arrangements must be made. A formal handover of the case to the new clinical supervisor must take place.

3.9 Where a clinical supervisor is responsible for more than one anaesthetised patient (2:1 supervision model), and they become involved in closely supporting one supervisee (e.g. managing a critical incident requiring conversion to 1:1 supervision), another clinical supervisor must be mobilised to be available for the other supervisee. The local implementation for the supervision of AAs must take this into account and must explicitly plan for it.

[1] www.rcoa.ac.uk/safety-standards-quality/patient-safety/cappuccini-test.

3.10 Levels of Supervision

The levels of supervision listed below relate to AAs working in clinical practice post qualification. They are different to those used during AA training which are listed within the curriculum and AARA. This is to provide clarity for clinical supervisors.

Level of Supervision	Descriptor
1 (Direct)	Direct supervisor involvement – present in the same theatre and available to assist when needed (1:1 working)
2a (Close)	Supervisor in theatre suite, available to guide aspects of activity through monitoring at regular intervals and available within two minutes of being called (1:1 or 2:1 working)
2b (Local)	Supervisor within hospital for queries, able to provide prompt direction/assistance **NB: this level of supervision is not to be used the delivery of anaesthesia or deep sedation – it can be used for procedures such as fascia-iliaca block (FIB) placement or midline/PICC line insertion**

3.11 In addition to a clinical supervisor, there must be a dedicated trained assistant, i.e. an operating department practitioner (ODP) or equivalent, in every theatre in which anaesthesia care is being delivered, whether this is by an anaesthetist or AA.

3.12 AAs can undertake clinical activity during daytime, evenings, weekends or overnight. However, any clinical activity undertaken by AAs must occur under the same level of clinical supervision and by the same grade of supervisor outlined within this scope of practice.