4 The practice of clinical supervision of anaesthesia associates

4.1 AAs must work at all times with a clinical supervisor whose name must be recorded in the individual patient's medical notes.

4.2 Overall responsibility for the anaesthesia care of the patient rests with the clinical supervisor.

4.3 It is essential that a clinical supervisor, who has experience of supervising AAs, has direct input into patient selection for lists where AAs are working in a 2:1 model (ASA 1 and 2 patients – see Appendix 1 for ASA classification). Ideally, this selection process should happen early in the patient pathway e.g., when the patient undergoes their preoperative assessment. At this stage a patient can be deemed appropriate for an AA to be involved in their care under close supervision. This should also be reviewed as part of the list planning process and should ensure that the AA can be safely supervised within a 2:1 model.

4.4 Last minute changes to operating lists should trigger a review of the case mix and supervision levels and lists should not commence until appropriate supervision is in place.

4.5 The supervising clinician must take overall responsibility for preoperative patient assessment, suitability of the proposed anaesthetic techniques and patient consent.

4.6 The anaesthesia plan for each patient must be reviewed by the clinical supervisor before anaesthesia begins.

4.7 All staff must introduce themselves and their role clearly, to ensure that patients understand who is caring for them[1]. AAs should introduce themselves using precise language, and (unless the supervisor is present and introduces themself) should explain who is supervising them[2].

4.8 All patients should be supported to understand the role of each healthcare professional they are seeing and not be led to believe that the professional they are seeing has competencies beyond their scope of practice or skill set[3,4].

[1] www.england.nhs.uk/long-read/summary-of-existing-guidance-on-the-deployment-of-medical-associate-professions-in-nhs-healthcare-settings/ (Item 11).
[2] https://rcoa.ac.uk/sites/default/files/documents/2024-08/Principles-guide-HCPs-on-how-to-introduce-themselves-FINAL.pdf
[3] www.england.nhs.uk/long-read/summary-of-existing-guidance-on-the-deployment-of-medical-associate-professions-in-nhs-healthcare-settings/ (Item 12).
[4] www.rcoa.ac.uk/patients/about-anaesthesia-perioperative-care/anaesthesia-team.

4.9 For AAs in Phase 1 it is recommended that the clinical supervisor should meet every patient before anaesthesia begins and should confirm the preoperative assessment.

4.10 In all Phases, and for every case, the clinical supervisor must:

- be present in the theatre suite, easily contactable and available to attend within two minutes
- be present in the anaesthetic room/operating theatre directly supervising induction of anaesthesia
- regularly review the intra-operative anaesthetic management
- be directly available when emergence from anaesthesia is planned (AAs must notify their supervisor when emergence from anaesthesia is due to occur)
- remain in the theatre suite until control of airway reflexes has returned and airway devices have been removed
- remain in the theatre suite until the on-going care of the patient has been handed on or delegated to other appropriately qualified staff.

4.11 When AAs are involved in administering anaesthesia or deep sedation[5] outside of the theatre environment they must be working under 1:1 supervision. This would include (but not exclusively limited to) working in the following sites:

1 endoscopy units
2 interventional radiology
3 interventional cardiology
4 emergency department.

4.12 When AAs are involved in anaesthesia or sedation for surgery which is not planned (for instance on emergency or trauma lists), they must work under 1:1 supervision. 'Planned' in this sense means surgery has been scheduled in advance (not on the same day), and the patient has been through formal anaesthesia pre-assessment or screening, meets starvation criteria for elective surgery and is otherwise fully prepared. Some types of non-acute, minor emergency and planned trauma lists may therefore fit the definition and can be undertaken with a 2:1 supervision model.

4.13 When AAs are involved in administering anaesthesia or sedation to paediatric patients (<16 years of age) they must be directly supervised, working in a 1:1 model. If a clinical supervisor needs to leave the theatre, then another supervisor must take over the case.

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