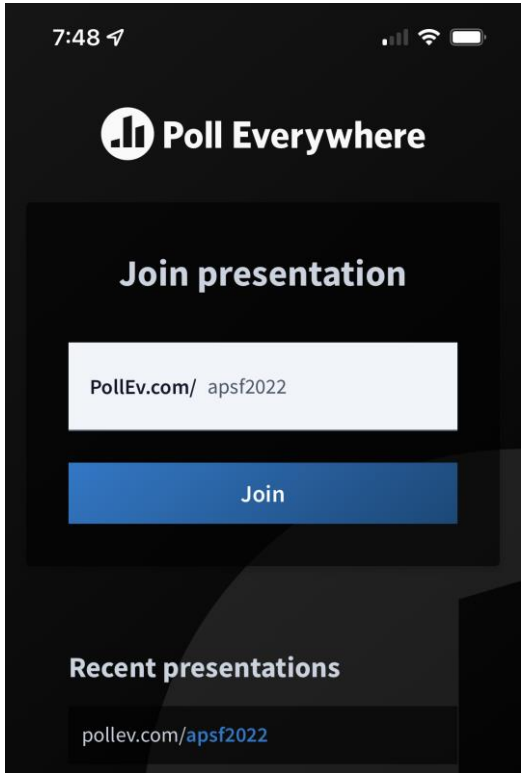
Join Poll Everywhere “apsf2022”

Option 1:
Poll Everywhere app



Option 2:
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Option 3:
Go to PollEv.com/apsf2022

Recommendations and Next Steps

SEPTEMBER 8, 2022

2022 APSF STOELTING CONFERENCE

JW BEARD, MD

Schedule

- ✓ 10:30 – 11:25 Recommendations and next steps
- ✓ 11:25 Closing remarks from Dan Cole
- ✓ 11:30 Conference ends, airport bus arrival
- ✓ 11:45 Airport bus departure

Agenda

1. Join the Poll Everywhere presentation
2. Discuss the recommendations, move towards consensus
3. Let’s not go for perfect, let’s focus on concepts

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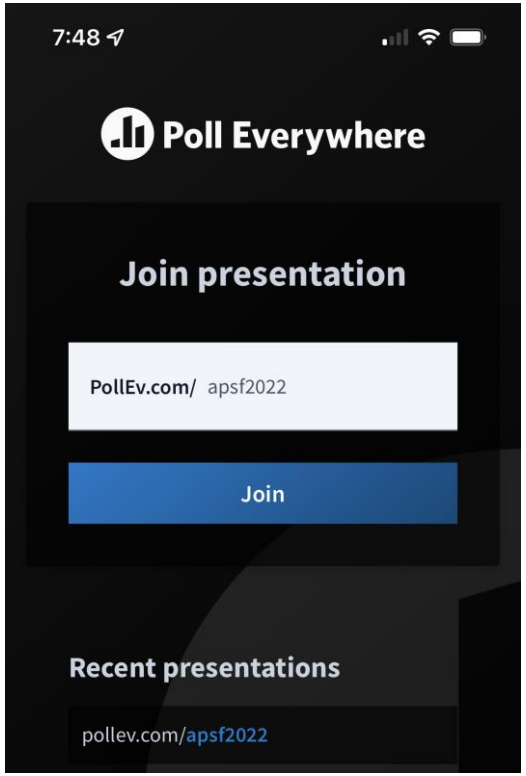

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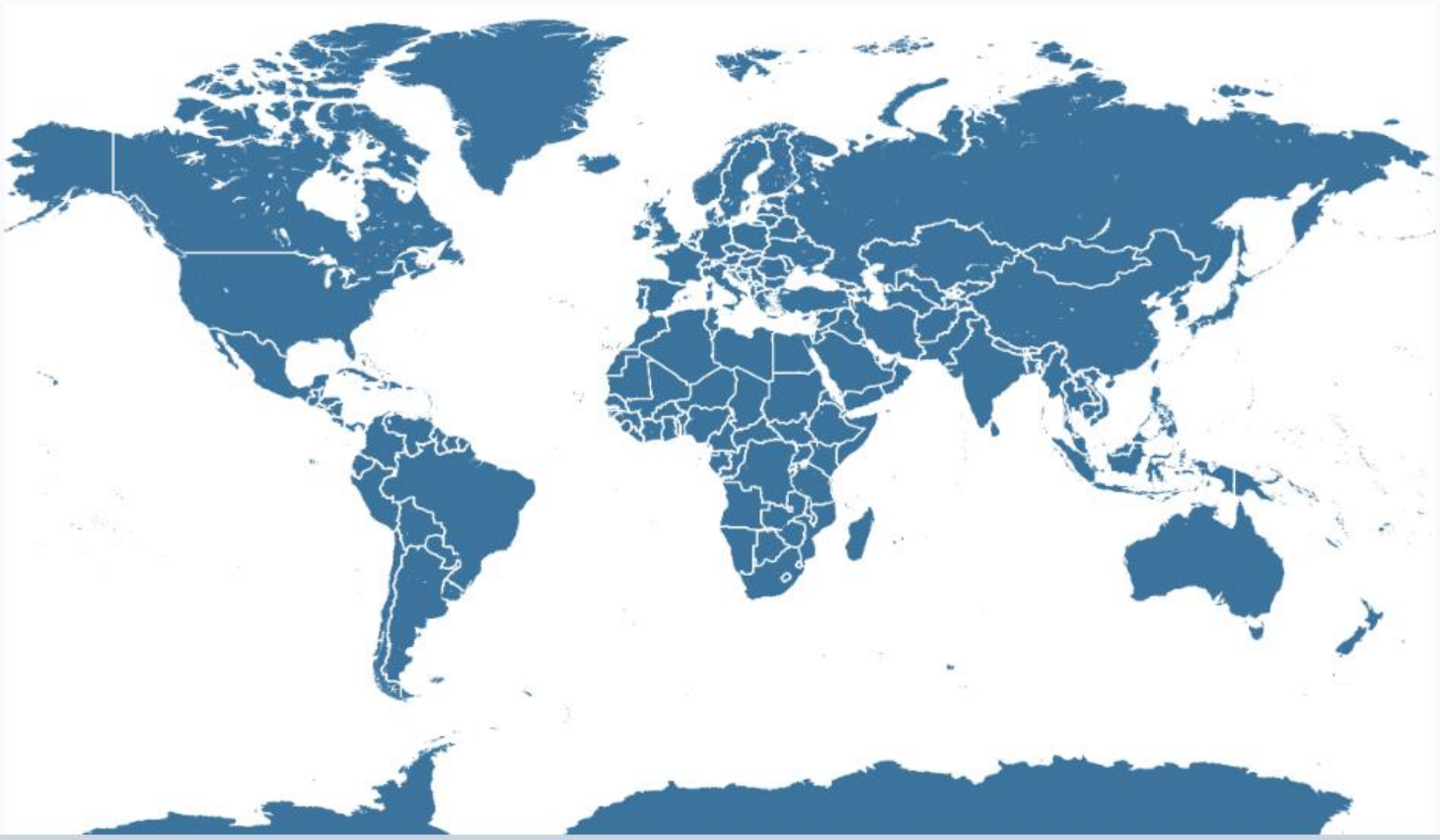
The APSF NORA recommendations poll will be live in a few minutes. Until then, drop a pin on your favorite vacation spot.



What state do you live in?

Are you participating in this poll in-person or virtually?

Live from the Loews Vanderbilt in Nashville, TN

Virtual

We should expect unanimous agreement today.

True

False

The APSF NORA practice recommendations will have a positive impact on patients and clinicians globally.

True

False

Scope 1/2: NORA locations include but are not limited to non-OR procedural areas inside the hospital, procedural centers outside of the hospital, and office-based settings.

Agree

Disagree

Scope 2/2: These recommendations apply to personnel providing, administering, supervising, or monitoring procedural sedation and anesthesia care in NORA locations. These recs are intended to supplement similar existing guidelines/recs.

Agree

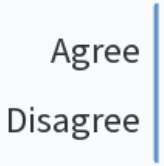
Disagree

Facility (1): Anesthesia personnel should participate in the planning of construction, expansion, or remodeling of NORA locations to ensure the patient safety and anesthetic needs are met.

Agree

Disagree

Facility (2): Anesthesia personnel should encourage facility design to locate NORA suites grouped together, near the OR when applicable, or near the PACU, to bring personnel into closer proximity to respond to requests for assistance.



Facility (3): A reliable source of oxygen adequate for the length of the procedure and an immediately available backup supply are required. A central oxygen supply is encouraged.

Agree

Disagree

Facility (4): In locations where inhaled anesthesia is administered, a scavenging or capture system for anesthetic gas is required.

Agree

Disagree

Facility (5): Electrical outlets shall be sufficient to supply anesthesia equipment and labeled to identify backup power supply. Number of outlets for backup power shall be sufficient to power equipment required to safely care for the patient.

Agree

Disagree

Facility (6): Lighting shall be available to visualize the patient, equipment, supplies, and medications. Battery powered backup lighting shall be available.

Agree

Disagree

Facility (7): There shall be sufficient space to accommodate necessary personnel, clearance from equipment, and expeditious access to the patient, equipment, supplies, and medications.

Agree

Disagree

Facility (8): A source of continuous suction which meets the needs for patient safety shall be available and dedicated for anesthesia personnel.

Agree

Disagree

Facility (9) NEW: A dedicated post-anesthesia recovery room shall be available.

Agree

Disagree

Equipment (1): Anesthesia personnel should participate in capital budget planning for equipment required for setup , maintenance, and improvement of NORA services.

Agree

Disagree

Equipment (2): When volatile anesthetics are administered, an anesthesia machine sufficient for case types and maintained to operating room standards is required.

Agree

Disagree

Equipment (3): Emergency airway equipment, including multiple forms of rescue (supraglottic airway, video laryngoscope, cricothyrotomy kit, etc.) is required for each NORA location and maintained on a regular schedule.

Agree

Disagree

Equipment (4): A self-inflating hand resuscitator bag capable of administering at least 90 percent oxygen to deliver positive pressure ventilation is required.

Agree

Disagree

Equipment (5): Adequate anesthesia medications, supplies and equipment for the intended anesthesia care are required.

Agree

Disagree

Equipment (6): In each NORA location an emergency cart with a defibrillator, emergency drugs and other equipment adequate to provide cardiopulmonary resuscitation are required and maintained daily.

Agree

Disagree

Equipment (7) OUTSIDE STATEMENT REVIEW PENDING: In locations where volatile anesthetics and/or succinylcholine are used, treatment for MH is required.

Agree

Disagree

Equipment (8) PROPOSED DELETE: For patients at elevated risk of cardiac complications, a procedure to obtain a 12-lead ECG shall be established, including a timely read by a cardiologist if indicated.

Delete

Keep

Equipment (9): Infusion pumps with updated drug libraries should be available for the administration of medications including anesthetics and vasopressors.

Agree

Disagree

Equipment (10): At NORA locations where success rates of securing vascular access and placing nerve blocks is not optimal for patient care, point-of-care ultrasound equipment is recommended.

Agree

Disagree

Equipment (11): At NORA locations where patients may be at elevated risk of hemodynamic instability, equipment for establishing intraarterial vascular access and monitoring arterial blood pressure is recommended.

Agree

Disagree

Equipment (12): Timely access to diagnostic or POC testing appropriate for the patient population is required. Tests may include urine pregnancy, complete blood count, blood chemistries, coagulation studies, arterial oxygen content, and blood glucose.

Agree

Disagree

Equipment (13): At NORA locations where procedures may result in clinically significant blood loss, there shall be a procedure for obtaining blood products and the equipment required for administration, such as a fluid warmer.

Agree

Disagree

Equipment (14): When caring for patients in the MRI suite, equipment designated for the MRI environment including airway equipment, infusion pumps, and anesthesia machines should be available and providers trained on their use.

Agree

Disagree

Equipment (15) NEW: At NORA locations where local anesthetic is administered at sufficient dose to cause LAST, lipid emulsion rescue supplies and a crisis checklist shall be available.

Agree

Disagree

Staff and Teamwork (1): Communication, team building, and expectations should be established through a proactive collaborative process driven by anesthesia personnel, nursing, surgical, and proceduralist leadership.

Agree

Disagree

Staff and Teamwork (2): In each NORA location there shall be adequate staff, including a minimum of one registered nurse, trained to support the anesthesia care team and patient.

Agree

Disagree

Staff and Teamwork (3): Anesthesia personnel and one member of the NORA nursing staff shall be ACLS certified (PALS in ped locations), and organized with defined roles and responsibilities during emergencies.

Agree

Disagree

Staff and Teamwork (4): Crisis checklists shall be available and clearly visible in each NORA location. Checklists should address life threatening emergencies including anaphylaxis, asthma, shock, MH, airway emergency, LAST, and arrhythmia.

Agree

Disagree

Staff and Teamwork (5): Interprofessional NORA conferences should be utilized to review and understand near misses and adverse events. These conferences should include a root cause analysis and lead to verified implementation of counter measures.

Agree

Disagree

Staff and Teamwork (6): A dedicated liaison from the Department of Anesthesia should be appointed (e.g. "Director of NORA") to triage and evaluate complex cases, manage scheduling, and optimize quality & safety protocols.

Agree

Disagree

Staff and Teamwork (7): A dedicated NORA anesthesia team should be considered to facilitate communication and adoption of protocols and pathways.

Agree

Disagree

Staff and Teamwork (8) NEW: The Department of Anesthesiology should request designation of representatives from applicable proceduralist departments to serve as the primary points of contact for NORA matters.

Agree

Disagree

Preop Care and Patient Selection (1): A preoperative evaluation process shall be established based on the ASA Practice Advisory for Preanesthesia Evaluation and emerging best practice.

Agree

Disagree

Preop Care and Patient Selection (2): To manage elevated risk procedures, adult and pediatric patient diagnoses should be identified which require specialized preop evaluation or necessitate procedural care in an inpatient facility.

Agree

Disagree

Preop Care and Patient Selection (3): Patient size and weight capacity limits should be established for applicable equipment to confirm patient suitability for the site.

Agree

Disagree

Preop Care and Patient Selection (4): Adult and peds patients with elevated BMIs or the diagnosis or suspected OSA should be evaluated on a case-by-case basis for optimal procedural location and discharge planning.

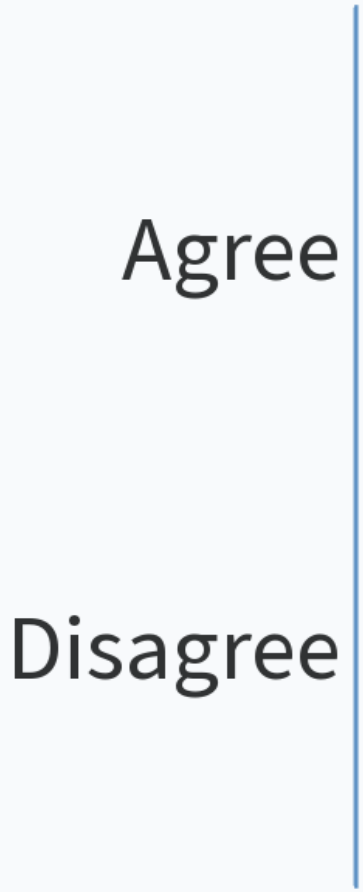
Preop Care and Patient Selection (5): Prior to each procedure, a timeout shall be conducted per The Joint Commission Universal Protocol or according to facility protocol.

Preop Care and Patient Selection (6): For new or unfamiliar procedures or inexperienced staff, specifics of the case shall be reviewed, preferably in a multidisciplinary team meeting, and education provided to team members who require it ahead of time.

Agree

Disagree

Intraoperative Care (1): Intraoperative monitoring shall adhere to ASA Standards of Basic Anesthetic Monitoring.



Intraoperative Care (2): A formal system shall be established to call for assistance and designate personnel to respond.

Intraoperative Care (3): A formal system shall be established to admit a patient from the NORA location to an inpatient facility with contact details and procedure.

Agree

Disagree

Postoperative Care (1): Appropriate post-anesthesia management shall be provided per ASA Standards of Postanesthesia Care.

Agree

Disagree

Postoperative Care (2): Recovery and discharge criteria shall be consistent with those used in Phase I and Phase II of the main Post Anesthesia Care Unit (PACU) as deemed appropriate.

Postoperative Care (3): Discharge guidelines shall enable assessment of home readiness in a simple, clear, reproducible manner.

Agree

Disagree

Postoperative Care (4): NORA practices should establish a patient follow-up procedure, that may involve daily surveys, telemedicine, and other means of communication.

Agree

Disagree

Postoperative Care (5): Post-discharge remote patient monitoring, such as vital signs monitoring or home nursing visits, may be employed for selected indications.

Agree

Disagree

Postoperative Care (6): All patients should be assessed for fall prevention and evaluated whether fall-specific interventions are required.

Agree

Disagree

Postoperative Care (7): VTE risk should be assessed, specific to patient and procedure type. Encourage VTE prophylaxis prescription by surgical or procedural team as appropriate.

Agree

Disagree

Postoperative Care (8): Patients at elevated risk for respiratory depression from opioids should be considered for inpatient monitoring. If discharged home, naloxone prescription as well as instructions to patient and care giver shall be provided.

Agree

Disagree

Postoperative Care (9): Patients who receive sedatives or anesthetics not limited to local anesthetics shall be discharged with a responsible adult. Responsible adults are family or non-family members who can ensure safe transport of the patient to home.

Agree

Disagree

Continuous Quality Improvement (1): Anesthesia personnel should utilize a database of clinical outcomes. Outcome data should be reviewed to identify possible new safety risks and improve care on a regularly scheduled basis.

Agree

Disagree

Continuous Quality Improvement (2): Anesthesia personnel should utilize a database of patient centered outcomes such as comfort, emotional state, and satisfaction with anesthesia care. Data should be reviewed and acted upon on a regular basis.

Agree

Disagree

Summary

1. Recommendations discussed, moved towards consensus
2. Focused on concepts, not perfection
3. Watch for a follow-up recommendations survey later this fall

Thank you!

Closing Comments

Thank you for attending the 2022 APSF Stoelting Conference

Dan Cole, MD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Anesthesia
Patient Safety
Foundation