Guidelines for supervision of patients during peripheral regional anaesthesia (2023)

1. Summary

If a specific set of criteria are met, patients having procedures under regional anaesthesia alone do not require the continuous presence of an anaesthetist. However, the anaesthetist must be contactable until the procedure is completed and it is deemed good practice to regularly review the patient.

2. Introduction:

Ultrasound guided peripheral regional anaesthesia nerve blocks can be used to deliver safe and effective care, two key pillars of quality in healthcare. A safe and efficacious block allows parallel processing using either an anaesthetic room or block room/block area whereby the anaesthetist may be blocking one patient whilst the other patient is being operated upon. This enables efficient provision of anaesthesia, and allows more time for training.

RA-UK produced guidelines for the supervision of patients having procedures under regional anaesthesia (RA) in 2015[1]. Prior to this many block rooms ran using local guidelines which did not require the direct presence of an anaesthetist in theatre. This practice was not supported by the Association of Anaesthetists (AoA) guidance at the time, but precedents of delegated direct anaesthetic responsibility were already being commonly utilised in practice (i.e. epidurals on labour ward, critical care patients and theatre recovery). The 2015 guidelines recommended that in certain well-defined circumstances, continuous presence of an anaesthetist is not required throughout surgery performed under peripheral nerve block, provided that they are immediately accessible. This has since been recognised in the recent AoA monitoring guideline[2]. This RA-UK guideline updates and supersedes the previous 2015 guidance.

3. Recommendations: 3.1 Inclusion Criteria

These guidelines relate to adult patients undergoing peripheral anaesthesia only.

3.2 Exclusions

Patients having procedures under neuraxial anaesthesia are excluded from these recommendations as well as those having procedures in the ‘beach chair’ or ‘deck chair’ operating positions. This is due to the potential for haemodynamic changes which require the continuous presence of an anaesthetist.

The patient should be systemically well and be free from acute or chronic pathology, which might reasonably be expected to decompensate during the surgical procedure.

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3.3 Consent

All patients undergoing anaesthesia should be appropriately informed and consented in accordance with Royal College of Anaesthetists (RCoA) and General Medical Council (GMC) guidance[3,4]. This includes providing information on rationale, conduct, common side effects, serious complications and alternatives.

Patients should be informed that they will be awake during the procedure, that a trained healthcare will be present throughout and the anaesthetist will be available if required. They should be aware of possible events during the procedure (i.e. tourniquet pain, inadequate anaesthesia), and the individual to whom responsibility has been delegated.

It is best practice to provide this information as early as possible.

3.4 Monitoring

Regional anaesthesia should be performed in an appropriate area with a competent assistant, AoA minimum standard monitoring (i.e. NIBP, pulse oximetry and ECG) and resuscitation equipment[2].

Monitoring should be continued for at least 30 minutes following the peripheral nerve block and until the cessation of surgery.

Monitoring requires interpretation by an anaesthetist or delegated to an appropriately trained assistant.

3.5 Documentation

An accurate record of the anaesthetic should be documented in the patient notes. This can be completed by the anaesthetist, a delegated deputy or an electronic record system. An electronic record is recommended by the AoA[2]. International consensus guidelines exist for the standards of documentation for regional anaesthesia[6].

3.6 Delegated Responsibility

The anaesthetist may delegate responsibility for in theatre supervision and monitoring to an appropriately trained healthcare worker provided that 15 minutes have elapsed since the provision of regional anaesthesia and, the block has been tested and deemed to be effective.

An appropriately trained healthcare worker is defined in accordance with AoA requirements for Post Anaesthetic Care Unit (PACU) nursing[5]. This may include other doctors, ODPs and anaesthetic/recovery nurses.

The individual with delegated responsibility must be able to recognise signs and symptoms of local anaesthetic toxicity.

The surgical team should receive appropriate handover, including dose limit on further doses of local anaesthetic, and the anaesthetist should be present for safety checklists.

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The surgeon and surgical team must be content to start surgery and continue without the presence of an anaesthetist. The surgical team should be familiar with performing procedures on conscious patients.

The anaesthetist should be immediately available for verbal advice and able to attend theatre within 2 minutes of request for assistance. The anaesthetist therefore must have competent assistance (as defined above) in the block area, sufficient to maintain the safety of other patients there, should the anaesthetist be called back to theatre.

The anaesthetist is ultimately responsible for the care during the duration of delegated responsibility. It is good practice to review patients in theatre, particularly if the duration of surgery is prolonged.

3.7 Sedation

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If sedation is administered during the block, the patient must be conscious and communicating effectively when responsibility is handed over.

If further doses of sedation are required, or a continuous infusion is provided, this necessitates the continuous presence of an appropriately trained individual.

References:

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