Policy for the development and review of professional documents

1. Introduction

1.1 The professional documents (hereafter "the documents") of the Australian and New Zealand College of Anaesthetists (ANZCA) promote quality and safety in all domains of anaesthesia practice. They define the college's requirements for training and for hospitals providing such training, they provide guidance on standards of anaesthesia practice, and convey the college's position on particular matters.

1.2 The following terminology applies to the documents:

1.2.1 "Policy" deals with matters within the authority and control of the college. It formally states principle, plan and/or course of action that is prescriptive and mandatory.

1.2.2 "Statement" defines the position of the college. It describes where the college stands on a particular issue in areas that lack clarity or where opinions vary. A statement is not prescriptive.

1.2.3 "Guideline" offers advice on a particular subject, ideally based on best practice recommendations and information, but may be based on evidence and/or expert consensus. A guideline is not prescriptive.

2. Purpose

To ensure that ANZCA professional documents are relevant and contemporaneous, which requires a rigorous, standardised process. This policy provides the framework to meet these requirements in an efficient manner.

3. Scope

This policy is intended to apply to the development and review of all ANZCA professional documents. It is not intended to apply to endorsement of externally produced guidelines, which are governed by *CP25(G) Policy on endorsement of externally developed guidelines*, nor to endorsement of externally produced educational material and apps, nor to the development of corporate policies.

4. Principles

4.1 ANZCA Council oversees the process by which the documents are developed and reviewed. This includes consultation with stakeholders, including regional/national committees, the Faculty of Pain Medicine (FPM) Board, the ANZCA Trainee Committee, special interest groups and other experts and organisations as relevant. Co-badged documents are developed and reviewed with input from the relevant organisations, with the process determined by the Executive Committee.

4.2 The college promotes the highest standards of perioperative care, based on available evidence, consultation, and expert consensus. Whilst ANZCA professional documents follow the process

outlined in this policy, on occasion the college identifies areas where a more detailed, systematic guideline is desirable and strong supporting evidence is available. The resources required for development and revision of such documents are considerable. The process outlined in this policy can be tailored to the development of these more exhaustive documents.

4.3 The college promulgates documents on only those issues for which there is a clear need and sufficient grounds to support a guideline, policy or statement. Where other relevant authorities have promulgated adequately specific documents (for example, in the case of the codes of conduct of the Medical Board of Australia and the Medical Council of New Zealand), there may be no need for duplication. In these cases, endorsement is possible and may be appropriate.

4.4 The documents are the responsibility of ANZCA Council and no assurance is given that any particular opinion elucidated through consultation will be reflected in the final version.

4.5 Documents are supported by a background paper explaining the basis for conclusions made.

4.6 For most purposes, reference solely to the document, available on the college website, should be adequate. However, reference to available background papers, where relevant, is encouraged.

5. Process of development

5.1 Support is provided by the ANZCA Safety and Advocacy Unit throughout the development (and review) process. The Director of Professional Affairs (Professional Documents) [DPA (PDs)] in their advisory role to ANZCA Council supports the development of the documents by:

5.1.1 Assessing requests for new documents and discussing them with the President.

5.1.2 Editing each document to ensure alignment with the college's mission statement, clarity of intent, and consistency within and between documents. Such editing should also ensure that the document is applicable, wherever possible, to all jurisdictions in Australia and New Zealand.

5.1.3 Liaising with ANZCA Council and other relevant individuals and groups.

5.1.4 Being a member of each document development group (DDG).

5.1.5 Reviewing feedback about each document.

5.1.6 Ensuring that ownership of the document is assigned to the relevant unit or committee.

5.1.7 Ensuring that each document is assigned a code that complies with the applicable ANZCA classification.

5.2 A request for development of a new professional document, including an explanation of need and benefit, should be directed to the DPA (PDs) in the first instance. The DPA (PDs) will evaluate the request in liaison with the President and then relevant committees. From the request it should be clear whether the professional document is applicable to ANZCA, FPM, or both.

The decision to develop a new professional document should include consideration of the following criteria:

- Alignment with mission, strategic priorities and vision.
- Potential to make a significant positive impact.

- Importance across the college.
- Potential to increase safety and/or lead to improved outcomes for patients and the community.

5.3 Approval pathways. The committees reporting directly to Council that have a delegated responsibility from Council for development or review of professional documents, referred to as oversight committees within this document, include the Safety and Quality Committee (SQC), and the Professional Affairs Executive Committee (PAEC). Usually, professional documents related to matters of clinical safety and quality are referred to SQC, while those pertaining to other matters are referred to PAEC. Where these committees are not appointed by Council as DDGs they will serve as the committee to which the DDG must report.

5.3.1 For new professional documents, Council approval is required prior to publication during the pilot phase, and for release of the final version. Any professional document that is considered to be controversial or contains material that presents a higher risk to the college will be subjected to a greater oversight by Council, including requiring Council approval prior to 'initial' consultation. Determination of the level of required oversight is made by the President.

5.3.2 For review of existing professional documents Council approval is generally required only for the release of the final version. SQC and PAEC assume the Council-delegated task of reviewing, editing and circulating the documents prior to that stage.

Where the development of a new document is supported, the President or nominee will present a recommendation to ANZCA Council, along with a proposal for a DDG. DDG membership will usually include an experienced Fellow with recognised relevant expertise (not necessarily a councillor) who will be the DDG Lead, the DPA (PDs) to support the process and additional individuals as appropriate. One of the above college committees is usually nominated, either as the DDG or as the group to which the DDG reports. Subsequently, additional individuals may be co-opted to the DDG, subject to the approval of ANZCA Council or committee to which the DDG reports.

5.4 Where necessary, the DDG will convene an expert group to:

5.4.1 Identify relevant evidence.

5.4.2 Critically review this evidence, reflecting expert group members' experience and expertise, and taking into account the wider economic and medico-political environment in Australia and New Zealand.

5.4.3 Identify other relevant experts for consultation.

5.4.4 Develop expert consensus.

5.5 Using the ANZCA template, terms of reference of the expert group will be developed by the DDG and approved by ANZCA Council or the oversight committee. The expert group includes all DDG members and may include other fellows along with one or more community representatives with relevant expertise (for example, an ethicist or a technical expert). Administrative support will be provided, usually by staff members supporting the relevant committee. The expert group will conduct as much of its work as possible by electronic means and teleconference. If a face to face meeting is deemed necessary by the DDG Lead then this is to be included in the terms of reference and would usually need to occur only once, typically for one day. Funding for such a meeting requires prior approval by the chief executive officer.

5.6 The document must be concise, provide clear direction and be referenced.

5.6.1 Some documents contain one or more appendices consisting of tools or content that is subject to change. These may be edited without the need for a full comprehensive review of the entire document.

5.7 The background paper should include:

5.7.1 A justification for the document (purpose and benefit).

5.7.2 A concise review of the issues considered, with sufficient discussion to allow readers to understand the basis for and limitations of all recommendations. Importantly it should indicate any relevant issue or information considered but not included.

5.7.3 Documentation of literature search strategies and/or methods of expert consensus development.

5.7.4 Lists of publications and other evidence reviewed.

5.7.5 Names of all those consulted or otherwise involved in document development.

5.7.6 Other information as appropriate.

5.8 Logic control, broader environmental analysis and editorial support is provided by the Safety and Advocacy Unit to ensure that all professional documents and background papers comply with the ANZCA style guide. The DDG is responsible for ensuring none of the proposed content conflicts with regulations, college policies, or other professional documents.

5.9 The draft document: The DDG is responsible for ensuring appropriate consultation at each stage of development. This may at times include relevant external stakeholders such as other societies or colleges, community representative groups, manufacturers, and jurisdictional authorities. Once prepared, the draft professional document and background paper should be submitted to ANZCA Council or the relevant oversight committee, for consideration as per item 5.3 above. ANZCA Council may approve these drafts for the next stage of development, return them with an indication of areas requiring further work or withdraw them.

5.10 Initial post-draft consultation: After acceptance by ANZCA Council (or the relevant oversight committee in the case of a review), the Safety and Advocacy Unit will circulate the draft professional document to regional/national committees, the FPM Board, ANZCA Trainee Committee and relevant special interest groups for comment and feedback, accompanied by the background paper for information. Feedback will be collated by the Safety and Advocacy Unit and forwarded to the DDG Lead for review and revision of the draft as required, in consultation with the expert group as necessary. While integral to the drafting process, verbatim feedback whether de-identified or otherwise, is not to be included in the background paper. Should any significant or sensitive issues arise during the consultation phase, further liaison with relevant oversight committees and/or Council is encouraged, prior to submission of final drafts to ANZCA Council or oversight committees, with changes arising from the consultation phase tracked.

5.11 Pilot Draft: Following acceptance of the results of the initial post-draft consultation by ANZCA Council or the relevant oversight committee, the Safety and Advocacy Unit will coordinate dissemination of the final draft (“pilot”) document via the college’s website, accompanied by the background paper. The professional document will be considered operational for a pilot period of approximately six months.

5.11.1 Feedback on any document is welcome at any time and should be directed to the DPA (PDs) after which it will be retained on file until scheduled review. Documents are reviewed at the end of the pilot period, with feedback invited from regional/national

committees, the FPM Board, ANZCA Trainee Committee and relevant special interest groups.

5.12 Final version: The DDG and oversight committee (if relevant), will consider all feedback received during the pilot period. This will inform drafting of the definitive versions of all professional documents and background papers submitted to ANZCA Council for final approval.

5.13 Following approval, the Safety and Advocacy Unit will provide the CEO with copies of the document and background paper to ensure that operational requirements are in place, following which it will coordinate dissemination of those documents via the college's website. The usual timeframe for developing a new professional document to the pilot stage is between six to twelve months.

6. Process of review

6.1 Where documents remain relevant they are reviewed approximately every five years, but this period may vary at the discretion of ANZCA Council. Where a document is no longer relevant (e.g. its content has been superseded) the DPA (PDs), after liaison with the President, may recommend to Council that the document is withdrawn.

6.2 The document review process should align with the development process outlined in Section 5 (above), except that ANZCA Council may determine that a pilot period is not required. Where it is considered that there has been very little change since the current version the oversight committee may suggest a preliminary review to determine whether a comprehensive or abbreviated review is to be performed.

6.3 Where possible, the review group should include at least one member of the preceding DDG.

6.4 Proposed changes to existing documents must be tracked when presented for consideration to ANZCA Council or relevant oversight committee, unless a major rewrite is undertaken.

6.5 Minor typographical and editing changes that do not change the intent or meaning of the document are accepted to be the responsibility of the Safety and Advocacy Unit prior to dissemination.

This document is accompanied by a background paper (CP24(G)BP) which provides more detailed information regarding the rationale and interpretation of the Policy.

Related ANZCA documents

CP24(G)BP Policy for the development and review of professional documents Background Paper

Professional documents of the Australian and New Zealand College of Anaesthetists (ANZCA) are intended to apply wherever anaesthesia is administered and perioperative medicine practised within Australia and New Zealand. It is the responsibility of each practitioner to have express regard to the particular circumstances of each case, and the application of these ANZCA documents in each case. It is recognised that there may be exceptional situations (for example, some emergencies) in which the interests of patients override the requirement for compliance with some or all of these ANZCA documents. Each document is prepared in the context of the entire body of the College's professional documents, and should be interpreted in this way.

ANZCA professional documents are reviewed from time to time, and it is the responsibility of each practitioner to ensure that he or she has obtained the current version which is available from the College website (www.anzca.edu.au). The professional documents have been prepared having regard to the information available at the time of their preparation, and practitioners should

therefore take into account any information that may have been published or has become available subsequently.

Whilst ANZCA endeavours to ensure that its professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

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Interim review:	2012
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Owner:	Policy Officer, Safety and Advocacy Unit

ANZCA website: www.anzca.edu.au

Appendix 1: Glossary of terms

1. Document development terms

Corporate documents: Sometimes referred to within the college as business records, contain information relevant to the operation of the college as a corporation.

Digital records: Refers to any records stored in computers or other digital storage devices irrespective of whether they were generated manually, electronically, or by imaging.

Document: A piece of written, printed, or electronic matter that provides information or evidence or that serves as an official record.

Document custodians: Individuals within a role who are responsible for preparing and managing the creation, review process, and withdrawal of any document. The custodian is responsible for ensuring that documents have been authorised by the designated body of the college or its delegate. Document custodians are formally accountable to the document owner.

Document management: Describes the processes involved with creating, developing, reviewing, indexing, retrieving, depositing, storing and disposing (withdrawal) of college documents.

Document owners: The body or role that has the ultimate legal or regulatory responsibility for a document. Examples of document owners are ANZCA Council, FPM Board, the CEO or their delegates.

Governance documents: Corporate documents that relate to the "framework of rules, relationships, systems and processes within which authority is exercised and controlled"[5] within the college.

Guidelines: Advice on a particular subject, ideally based on best practice recommendations and information, available evidence and/or expert consensus.[6] Guidelines are not prescriptive. Note that, in contrast to policies, guidelines use "should" (advises) and avoid "must" (mandates).

For example: *PG03(A) Guideline for the management of major regional analgesia.*

These documents may be developed by the college or may be developed by external bodies. Externally developed guidelines satisfying the process defined in *CP25(G) Policy on endorsement of externally developed guidelines* may be **endorsed** by the college.

Where the college may not have been invited to endorse a guideline, or did not have representation in its development, or where the final document was promulgated with some opinions that did not entirely align with the college's position, the college may decide to **support** the guideline.

Policies: Documents that formally state principle, plan and/or course of action that is prescriptive and mandatory. These documents are generally (although not exclusively) produced by the college for internal use but may also be accessed by external stakeholders.

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[5] Australian Institute of Company Directors (AICD) definition of "corporate governance"; with the word "corporate" is removed (as it may confuse given it is used elsewhere in the glossary). From AICD. Director tools. Role of the board. Governance relations. 2016. Accessed 8 March 2019. Available at: https://aicd.companydirectors.com.au/-/media/cd2/resources/director-resources/director-tools/pdf/05446-3-11-mem-director-gr-role-of-board_a4-v3.ashx

[6] The process for achieving consensus involves seeking input from those recognised as experts in the relevant area. Their advice is used to inform oversight committees responsible for development/review with their decisions.

Position statements: Authoritative statements that describe where the college stands on a particular issue. This may include areas that lack clarity or where opinions vary. Position statements are not prescriptive.

For example, *PS10(PM) Statement on "Medicinal Cannabis" with particular reference to its use in the management of patients with chronic non-cancer pain - 2019.*

These documents may be developed solely by the college or may be developed with other organisations (in which case they are "Joint statements").

Professional documents: Documents that contain information relevant to the clinical, administrative and ethical practice of anaesthesia and/or pain medicine. Professional documents may be developed as either a policy, position statement, or guideline.

Standards: Documents that define levels of quality or achievement against which activities or behaviours can be measured.

These levels can be considered as:

- Minimum, in which case they represent minimum standards and consequently, are mandatory.
- A range of acceptable performance.
- Excellence, in which case they are aspirational and not prescriptive.

Stakeholders:

External stakeholder: Any person(s), group or institution that is not internal to the college. Examples include the community (including community representatives), the Australian Society of Anaesthetists (ASA) and the New Zealand Society of Anaesthetists (NZSA), noting individual members may also be internal stakeholders as ANZCA fellows and trainees, as well as healthcare facilities, jurisdictions, regulatory bodies, training sites, universities and other colleges.

Internal stakeholders: May include college staff, fellows, trainees, specialist international medical graduates (SIMGs), regional/national committees, specialist interest groups (noting these may also have individual external stakeholder members of the ASA, the NZSA or others).

Statements: See "Position statements".

2. Clinical terms

Airway lead: A role to facilitate an administrative process to assist various aspects of airway management within individual local departments.

Anaesthesia: Includes general anaesthesia, sedation[7], and regional analgesia/anaesthesia.

General anaesthesia: A drug-induced state of unconsciousness characterised by absence of purposeful response to any stimulus, loss of protective airway reflexes, depression of respiration and disturbance of circulatory reflexes.

Regional anaesthesia: Refers to administration of local anaesthetic agent(s) in order to render a select region of the body insensate without inducing unconsciousness.

[7] This excludes conscious sedation as defined below.

Anaesthetist: A registered medical practitioner who provides anaesthesia services working within their scope of clinical practice. This includes vocationally registered anaesthetists in New Zealand, SIMGs supported by ANZCA, specialists in training, and non-specialists including FANZCA trainees, and general practitioner anaesthetists.

Specialist anaesthetist: A protected title that refers to practitioners who are registered as specialists in anaesthesia with the Medical Board of Australia (MBA) or in the vocational register (anaesthesia) of the Medical Council of New Zealand (MCNZ).

Asepsis: The prevention of microbial contamination of living tissues or sterile materials.

Behavioural disturbance: Defined as the combination of observed bodily and verbal actions made by an individual that are in excess of those considered contextually appropriate and are judged to have the potential to result in significant harm to the individual themselves, other individuals or property. Acute behavioural disturbance is characterised by a rapid onset and severe intensity. The aetiology is commonly a mental disorder, physical illness or intoxication with alcohol and/or other substances. Often the behaviour is considered not to be under the voluntary or legally competent control of the individual.

Clinical support time: The time spent performing duties or fulfilling roles (other than the provision of direct individual patient care) aimed at improving quality of patient care and ensuring compliance with training requirements.

Clinical time: The time spent in the direct provision of patient care.

Consultation: A meeting with an expert or professional person to get advice or to discuss a problem, especially a meeting with a doctor.

Credentialling: The formal process used to verify the qualifications, experience and professional standing of practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.

Cultural competence: The ability to ensure that the clinical environment is inclusive of the cultural needs of the patient and their family/support network. Cultural competence also involves doctors navigating the health system for patients to ensure they receive the best clinical care.

Day-stay procedure: Any procedure following which it is expected that the patient will be discharged on the same day as, or within 24 hours of, its performance. Day-stay procedure encompasses terms such as “day surgery”, “day-stay surgery”, “day-care surgery”, “ambulatory surgery”, “same-day discharge”, as well as procedures performed on an outpatient basis.

Disinfection: The inactivation of non-sporing organisms using either thermal or chemical means.

Education: The process of facilitating learning and building a body of knowledge related to the specialty.

Fatigue: A sensation of weariness from bodily or mental exertion.

Healthcare facility: Refers to hospitals, clinics and office-based facilities where patients receive medical treatment or procedures are performed under anaesthesia (as defined above). The delivery of anaesthesia services at such facilities must comply with the regulatory licensing authority standards.

Paediatric patient: Includes the neonate, infant, child and adolescent.

> **Infant:** Child aged one to 12 months.
>
> **Neonate:** Child aged less than 28 days (for ex-premature babies, use expected date of delivery plus 28 days).

Post-menstrual age: The gestational age plus post-natal age in weeks.

Premature infant: A child born before 37 weeks gestation.

Post-anaesthesia care units (PACU): may also be referred to as recovery units. They may be further classified into "first stage" recovery units where initial higher acuity care is provided and "second stage" recovery areas provided for observation of ambulant patients prior to discharge from the healthcare facility.

Post-anaesthesia nurse: The specialty or practice of nursing in the care of patients in PACU following surgery and/or anaesthesia. The requirements to be able to practice in this area is defined by the Australian College of Perianaesthesia Nurses in Australia and New Zealand Nurses Organisation in New Zealand.

Pre-anaesthesia consultation: A meeting with an anaesthetist for the purposes of discussion and advice prior to anaesthesia. This is to be distinguished from pre- anaesthesia assessment, elements of which may be carried out by a range of other practitioners including medical and nursing.

Prolonged absence from practice: Any absence from clinical anaesthesia or pain medicine practice exceeding 12 months, which will trigger the need for a return to anaesthesia practice program or a return to pain medicine practice program.

Scope of clinical practice: The delineation of the extent of an individual practitioner's clinical practice within a particular organisation, based on their qualifications, competence, performance and professional suitability, and the needs and capability of the organisation to support such clinical practice. This is not to be confused with the term "scopes of practice" used by the MCNZ to differentiate between general, vocational and special purpose scopes under the Health Practitioners Competence Assurance Act (2003) NZ legislation.

Sedation:

Conscious sedation: A drug-induced alteration of consciousness during which patients are able to respond purposefully to verbal commands or light tactile stimulation. It constitutes the lightest level on the spectrum of procedural sedation.

Deep sedation: A state characterised by the alteration of consciousness that may progress to the point where unconsciousness ensues, defined as the patient responding only to noxious stimulation. Deep sedation constitutes the moderate to heavy level of the spectrum of procedural sedation. It may be associated with loss of ability to maintain a patent airway, inadequate spontaneous ventilation and/or impaired cardiovascular function, and has similar risks to general anaesthesia, requiring an equivalent level of care.

Procedural sedation: A state of drug-induced relief of anxiety or tolerance of discomfort in the context of interventional diagnostic or therapeutic medical, dental or surgical procedures. Lack of memory of distressing events and/or analgesia may be desired outcomes, but lack of response to painful stimulation is not assured.

Sedationist: Refers to any registered healthcare practitioner providing sedation and working within their clinical scope of practice.

Specialist pain medicine physician: A protected title that refers to medical specialists who have completed an additional specialist qualification in pain medicine, namely fellowship of the Faculty of Pain Medicine, ANZCA.

Sterilisation: The complete destruction of all micro-organisms, including spores.

Training: Refers to teaching a particular skill or type of behaviour within the specialty or to staff.

Appendix 2

Disclaimer for professional documents:

It is the responsibility of each practitioner to have express regard to the particular circumstances of each case, and the application of ANZCA professional documents in each case. It is recognised that there may be exceptional situations (for example, some emergencies) in which the interests of patients override the requirement for compliance with some or all of these documents. Where anaesthetists, in good faith endeavour to comply with these documents but are prevented from doing so due to factors beyond their control then they should not be held accountable. Each document is prepared in the context of the entire body of the college's professional documents and should be interpreted in this way.

ANZCA professional documents are reviewed from time to time, and it is the responsibility of each practitioner to ensure that they have obtained the current version which is available from the college website (www.anzca.edu.au). The professional documents have been prepared having regard to the information available at the time of their preparation, and practitioners should therefore take into account any information that may have been published or has become available subsequently.

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