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Kia ora Megan

Draft sedation guidance for anaesthetic technicians (ATs)

Thank you for the opportunity to provide preliminary feedback on the draft guidance document (the document) the Council has developed on the use of sedation by anaesthetic technicians. We have consulted with ANZCA's New Zealand National Committee, who recognise and value the unique and considerable skills of ATs in managing sedation, providing the PG09 Guideline on Sedation (2023) (PG09) is closely adhered to, and training and credentialing is robust. The current regulatory environment for health practitioners in Aotearoa, the Health Practitioners Competence Assurance Act (2003) provides assurance of this.

Overall, ANZCA welcomes the document which, in general, appropriately supports supervised practice and training, and a limited scope of practice. The following comments provide specific feedback on aspects of the document we suggest need clarification.

Comments and recommendations

The document cites "PS09" although it links correctly to PG09. The link needs to be correctly named PG09 Procedural sedation (2023).

We suggest the document includes a more explicit statement of support for the principles of PG09, for example: "All sedation carried out must be in accordance with the Medical Sciences Council's competence standards, code of ethics and other relevant standards, *including ANZCA PG09 Procedural sedation*, and other relevant policies and guidance."

Prescribing and administering sedation

"Anaesthetic technicians cannot independently prescribe agents used for general anaesthesia or sedation."
We suggest you delete the adverb 'independently' as it is misleading. Independent prescribing is restricted to authorised prescribers, which do not include ATs.

Types of sedation

"In the presence of an anaesthetist the type of sedation can include deep sedation".

We strongly recommend deleting this sentence, for two reasons:

- "Presence" needs to be defined. It should be clear that the anaesthetist must be immediately available to assist in an emergency. They should not, for example, be performing a procedure they can't immediately abandon at the same time. We suggest expanding all references to the presence of an anaesthetist to: "In the presence of an anaesthetist who is able to immediately assist in an emergency…"

- Deep sedation must not be included in accordance with the guideline which specifically excludes deep sedation, as follows:

> *"This document is not intended to apply to deep sedation, which can rapidly and unpredictably progress to general anaesthesia…. By excluding deep sedation from the scope of PG09 it can readily be applied to all sedationists who have the requisite skills and competencies for their targeted levels of sedation without requiring the necessary advanced skills associated with deep sedation. Each stakeholder can then independently assume responsibility for guidance on deep sedation applicable to their discipline. This may be particularly relevant to critical care disciplines including intensive care and emergency medicine as well as to some specific medical specialties."*

Intentional deep sedation for procedures is managed by anaesthetists (unless in an ICU or ED environment). There is no circumstance where it would be appropriate for ATs to administer deep sedation.

Safety

We recommend that the document should clarify that intravenous anaesthetic agents such as thiopentone are not included, as their use is generally restricted to a medical or dental practitioner. Some models of propofol sedation by non-anaesthetists have been agreed, but non-anaesthetic doses of propofol by non-anaesthetists should occur only under an agreed set of principles as outlined in *Section 4.7 The use of propofol for sedation* in the Sedation background paper (2023) written to support PG09.

Remote monitoring

We have considerable hesitation about remote monitoring which could encompass many scenarios. Most things that can go wrong with sedation happen very quickly and require immediate, hands-on attention. Almost invariably, a physical presence before, during and after anaesthesia is a key safety factor. More specific detail and context are necessary to understand the risk involved.

Requirements for anaesthetic technicians involved in sedation

"Anaesthetic technicians providing sedation must be working within their level of competence and education."
We suggest adding "experience" to this sentence. The technician must be of sufficient experience in the field of sedation to be authorised to take responsibility for sedated patients. ANZCA supports credentialing to allow for this increased scope of practice.

Pre-sedation assessment

An additional point is needed to confirm that "sedation for patients identified as higher-risk should be discussed with an anaesthetist and the presence of an anaesthetist should be considered especially if moderate sedation is planned".

Sedation Administration

We suggest clarifying that the supervisor must NOT be the proceduralist for moderate sedation, as clearly stated in *PG09(G) Appendix III Recommended personnel for procedural sedation.*

Post-sedation care

We recommend clarifying the lead of discharge and issuing of follow-up instructions in consultation with the AT. Although it varies from workplace to workplace, responsibility for this is generally assigned to a senior member of the team.

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We trust this is useful and look forward to further development of the guidance document.

Ngā mihi

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