

# Managing the expanded role of anaesthetists in response to COVID-19

This document provides guiding principles and key considerations to support health facilities plan for the expanded role of specialist anaesthetists in response to the COVID-19 pandemic.

## Background

People infected with the Delta variant of COVID-19 have approximately double the risk of hospital admission, when compared with the Alpha variant. Approximately 20% of adult patients hospitalised with Delta will require admission to the intensive care unit (ICU).

Modelling from various sources has predicted a likely need for supplementation of staff in ICUs from other specialists.<sup>1,2</sup> This could include specialist anaesthetists.<sup>3</sup>

Anaesthetists have skills that are transferable to the acute care of patients with COVID-19. The role of anaesthetists has been successfully expanded in other countries which have had large numbers of COVID-19 patients in hospitals, leading to overwhelmed ICU resources.

## Guiding principles

When planning for the expanded role of specialist anaesthetists, health services should be guided by the these overarching principles:

1. Maximising access to care for the greatest number of patients.
2. Maintaining patient safety.
3. Preserving staff safety and wellbeing.

With these principles in mind, the following key elements should be considered.

## Key considerations

### Credentialing, scope and indemnity provisions

The NSW Ministry of Health has outlined the requirements for senior and junior medical officers working in roles that are different to their usual clinical roles in NSW public hospitals during the pandemic.<sup>4</sup>

Where a medical practitioner is working outside their usual clinical role, a local assessment should be undertaken that considers the suitability of the officer working in that role.

For junior medical officers, the local assessment must be undertaken by a senior medical officer (e.g. Director of Training, Head of Department) with an understanding of the individual's skills, experience and qualifications, as well as an understanding of the clinical duties the junior medical officer is being required to undertake.

Local assessments should be appropriately documented, and consider:

- the practitioner's qualifications, skills, training and experience
- the transferability of skills to deliver safe care
- the conditions in which the practitioner will be working, including facilities, supervision and training.

For senior medical officers (specialists), the local assessment should be undertaken by the Executive Director of Medical Services (or other senior medical officer delegate of the Chief Executive) with knowledge in the specialty area, which should be appropriately documented.

It should consider whether the practitioner's existing clinical privileges already allow them to work in that different clinical role, because those privileges are applicable to that different role. In such a case, the practitioner may be deployed to that role within the LHD/SN without a further re-credentialing process.

If the local assessment determines that there needs to be an amendment to the senior medical officer's existing clinical privileges in order for them to undertake a different role, then the existing mechanisms of the Medical and Dental Appointment Advisory Committee (MDAAC) should be used as far as practicable to amend those clinical privileges. The existing mechanisms can be streamlined, if required.

Anaesthetists may have varying experience and training to contribute to the care of patients in intensive care, emergency departments and resuscitation of patients with COVID-19. The additional roles should be suited to the individual's qualifications, training, experience and expertise (see [Medical Board of Australia's statement 2020](#)).<sup>5</sup>

## Scope

Scope of practice for medical practitioners is not determined by the Australian Health Practitioner Regulation Agency (AHPRA). [AHPRA](#) states that it is the responsibility of the individual practitioners to determine their own competency for their scope of practice.<sup>6</sup> Hospitals will often specify the scope of practice of clinicians in their employment contract (refer to the section on 'Mutual agreement').

Generally, medical practitioners who have trained in Australia have both general and specialist training registration.<sup>5</sup> The AHPRA statement applies equally to those with 'specialist only' and 'specialist and general' registration.

From a registration point of view, AHPRA's concerns are around anaesthetists using false titles. For example, although they may be doing the work of an intensivist, anaesthetists are not to claim they are intensivists.

The health service must have a process in place to arrange individuals according to their health risk factors when considering/requesting redeployment.

## Medical indemnity

When anaesthetists are asked to perform duties outside their scope of practice, such as taking on an intensive care role, they will be indemnified by NSW Health 'where they act professionally and in accordance with the mandated guidelines, policy or lawful directions of their employer'.<sup>7</sup>

## Mutual agreement

For individual anaesthetists to undertake roles outside of their normal practice of anaesthesia, a mutual agreement between the anaesthetist and the healthcare organisation must be agreed to first.

## Clinical support and training while undertaking additional roles

When an anaesthetist is undertaking expanded roles, clear lines of support are needed. This support could be from a nominated specialist intensive care physician. Similarly, there will need to be the usual support from trainee medical staff, nursing and allied health. A formal clinical governance structure and escalation pathway is also important.

A suitable process for additional training should be implemented. Refer to [Adult intensive care workforce report in COVID-19 pandemic - Appendix 2](#) for suggested training.

For anaesthetic trainees, any secondments should not be to the detriment of their training accreditation. This will require ongoing communication between the trainee, employer and the accrediting college (e.g. Australian and New Zealand College of Anaesthetists).

## Infection prevention and control

Anaesthetists are at particular risk of acquiring COVID-19 due to their routine practice of aerosol-generating procedures (AGPs) in their normal clinical practice.<sup>8</sup>

The key components of protection are:

- the use of a P2/N95 respirator when performing AGPs on a patient that is known or suspected of having COVID-19
- fit-testing to a suitable device in accordance with national standards (Standard AS/NZS 1715: 2009)

- a user-performed fit check should be undertaken every time a P2/N95 mask is used.
- training and simulation (such as donning and doffing) should occur beforehand.

Further resources and educational materials are available via the [Clinical Excellence Commission \(CEC\) website](#).<sup>9</sup> The [COVID-19 Infection Prevention and Control Manual](#) also provides further detailed guidance on infection prevention and control requirements for the management of patients or clients with suspected, probable or confirmed COVID-19.<sup>10</sup>

The preferential use of regional anaesthesia, when appropriate, can minimise the use of general anaesthesia with the associated AGP risk.<sup>11</sup>

## Vaccination

The NSW government has passed a [public health order](#) that mandates all healthcare staff working in healthcare facilities (public and private) be vaccinated against COVID-19 (first dose by 30 September 2021).<sup>12</sup>

## Managing exposure of a healthcare worker to a person with COVID-19

The [Health Care Worker COVID-19 Risk Assessment Matrix](#) details how healthcare facilities should assess staff who have been exposed to COVID-19.<sup>13</sup> Please refer to the matrix for [vaccinated](#) and [unvaccinated](#) staff.

## Examples of expanded clinical roles of anaesthetists in the critical care of patients with COVID-19

More detail about expanded clinical roles can be found in the related [Adult intensive care workforce report in COVID-19 pandemic](#).<sup>3</sup>

### Intensive care

- Anaesthetists have skills in resuscitation and care of patients with respiratory failure due to COVID-19. These include endotracheal intubation, ventilator management, placement of intravascular lines and transport of critically ill patients within the hospital. In this model, the anaesthetist would not have sole responsibility for patient care but would provide support through task-based care.

- Direct supervision of ICU patients with low-level ICU requirements. Possible examples could include non-ventilated post-surgical patients needing close observation, such as invasive monitoring and inotrope support for a short time (e.g. up to 24 hours). Patient care may occur in an alternative location, such as the post anaesthetic care unit (PACU). Ideally, this should be closely located near the ICU. As per the [NSW Health Role Delineation of Clinical Services](#), this level of care is often referred to as ICU Level 4.<sup>14</sup>

### Close observation units

As per the [NSW Health Role Delineation of Clinical Services](#), close observation units (Level 3) are a dedicated unit in adult health facilities with no intensive care service. These units provide higher levels of monitoring and observation than standard ward-based care, such as cardiac monitoring and additional staff.<sup>14</sup>

### Rapid response and intubation/airway management team

The literature and international experience supports that endotracheal intubation should be performed by the most experienced person available. This approach helps to minimise time to successful intubation in the hypoxic patient and potentially reduces staff exposure to airborne transmission during an AGP.<sup>15</sup>

### Supervision and management of patients on respiratory support wards having non-invasive ventilation (NIV)

This type of respiratory support helps to relieve the caseload on available ICU beds. It should be recognised that NIV poses a special risk of aerosolisation and spread of COVID-19 within the patient care environment. Appropriate infection control measures, including engineering (ventilation) measures, must be implemented. For further details, see [Care of adult patients with COVID-19 in acute inpatient wards](#).<sup>16</sup>

### Additional options

- Providing advice on equipment and health care infrastructure.
- Teaching and simulation for testing and training.
- Providing advice on disaster management (i.e. those with disaster, military or aid experience).

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