**EDITORIAL VIEW**

# Anesthesia Clinical Services Accreditation by Royal College of Anaesthetists UK: An example to follow

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## ABSTRACT

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There has been an increasing awareness about the need of a system of quality assurance in the healthcare services throughout the world. Many of the advanced countries have developed meticulous guidelines and checklists to assure quality and safety, and prevent medical errors at every step of the healthcare and minimise the iatrogenic mortality and morbidity, and have introduced accreditation systems to offer incentives to the best of the institutions. A system of awarding a certificate of 'Anesthesia Clinical Services Accreditation' (ACSA) has been evolved by Royal College of Anaesthetists UK (RCoA) to be awarded to the suitable healthcare institutions. This editorial offers an outline of this system to introduce the need of such a system in every country with the aim of enhancing quality of the care being provided by the healthcare institutions.

**Key words:** Accreditation; Anesthesia; Medical Errors/prevention & control; Safety Management/standards; Quality Improvement

Royal College of Anaesthetists UK (RCoA) has a system of awarding a certificate of Anesthesia Clinical Services Accreditation (ACSA) to the suitable healthcare institutions, who apply for this certificate. At the time of writing this editorial, there have been only 20 departments of anesthesiology in UK, which were judged eligible to obtain this prestigious award. As part of the process, the applicant department is required to demonstrate to the RCOA, that it meets all of the 155-quality standards within 5- main domains being tested, including patient safety training and teaching. The quality control teams of RCOA visit the hospital every year to monitor progress in the improvement of anesthetic services as per the standards of ACSA.

Most recently the anesthetic department of The Royal Derby Hospital in the East Midlands UK has been granted the RCoA accreditation in anesthesia services. The application for the accreditation had been submitted four years back and the accreditation process was completed according to the standards of accreditation laid down by the RCoA. The standards committee visited the hospital every year to monitor the progress in improving the standards of care and the measures taken by the anesthetic department to fulfil the mandatory requirements. The accreditation was awarded only after the whole process of the setting of the standards and demonstration of the successful implications of all domains recommended by the College were completed and the standards committee was fully satisfied.

A summary of the 51-page comprehensive document for accreditation by the Royal College and the salient points of the process to fulfil the criteria for a successful accreditation is presented here.

The process of Anaesthesia Clinical Services Accreditation (ACSA) has five main Domains:

1- The Care Pathway
2- Equipment, Facilities and Staffing
3- Patient Experience
4- Clinical Governance

5- Subspecialties

All domains are divided into subdomains;

**The Care Pathway:**

Includes preoperative care. Preoperative assessment clinics need to be run by appropriately trained staff, trainee anesthesiologists with input from senior anesthesiologists. Any investigations required and support provided by other medical specialities in preoptimization of the patients and for the post-op care of patients is ensured.

Speciality specific anesthesiologists as appropriate should be assigned elective surgical lists. All lists have named anesthesiologists and the lists are compiled 24 hrs preop.

Post-op care of patient includes the provision of adequate pain relief and risk stratification is discussed and documented clearly in the pre-op notes. Patients and their careers are given adequate information upon which to base their decision regarding anesthesia, post-operative care and pain relief

All patients should have a named and documented supervisory anesthesiologist who has overall responsibility for the care of the patient. This should be visible on the anesthetic record, on the rota and on display in the department. Named senior anesthesiologists supervising trainees in all areas of anesthetic services is documented and published on weekly working rota.

There are policies and documentation for the handover of care of patients from one team to another throughout the perioperative pathway. A copy of policies and protocols should be provided. Handovers should be visible on the anesthetic record. A rolling audit of handover quality, would be useful to demonstrate compliance with this standard.

Current guidelines for the management of anesthetic emergencies are appropriately displayed and immediately and reliably available in sites where anesthesia and sedation is provided and include guidelines for children. Copies of policies which are required for emergencies that may occur (based on the services being provided) should be appropriately displayed and immediately and reliably available.

There are policies for the management of acute pain and post-operative nausea and vomiting, including for those with special requirements, e.g. chronic pain, drug dependency. There is a policy for the management of morbidly obese patients. A copy of the policy should be provided.

An appropriate early warning score is in use for all patients including emergencies, obstetric patients and children. Early warning scores should be visible on patient observation charts. Arrangements are in place for the multidisciplinary management of patients with significant comorbidities. Pediatrics early warning scores should be visible on all age-specific observation charts. Charts should be modified for the obstetric patients.

Policies for children's surgical services are formulated and reviewed by a multidisciplinary team- including leads from the following specialties; pediatrics, anesthesia, surgery and nursing.

There is a documented policy for the interdisciplinary management of critically ill children including short term admission to a general ICU. There are clear criteria and standards for pediatric day surgery with regards the children attending, discharge pathway and also about the environment and staff where it is delivered. When a child undergoes anesthesia, all staff (operating department / practitioners / assistants / anesthetic nurses / recovery) have pediatric competencies and experience, including basic as well as advanced life support competency.

Where there are elective cesarean section lists, there needs to be dedicated obstetric, anesthesia, theatre and midwifery staff.

Arrangements are in place for the multidisciplinary management of vulnerable older patients.

There should be policies for the 24-hour cover of emergency surgery, prioritization of emergency cases according to clinical urgency, and seniority of clinical staff according to patient risk. The local arrangements should be verbally relayed by staff members and clearly visible on duty charts.

There is a policy to address the airway management of adults and children in the emergency department.

**Equipment, Facilities and Staffing levels:**

All anesthetic equipment is checked before use according to published guidelines and the checks are documented. These guidelines can be published by the local competent authority.

A copy of documented checks should be provided Equipment for monitoring including capnography, ventilation and resuscitation including defibrillation must be available at all sites where patients are anesthetized or sedated and on the delivery suite.

In areas that treat children, this must include equipment specifically designed for children.

Defibrillators, bag and masks and capnography should be available, including in remote locations.

Trained anesthetic assistance / nurse should be present to help anesthesiologist where patients are being anesthetized. Staff should be proficient in using the available equipment models and frequently asked if they encounter any difficulties with equipment in any sites; specifically at all situations where a patient will be intubated, including the ward. Equipment must be available to administer oxygen to all patients undergoing procedures under sedation by an anesthesiologist. There must be the ability to monitor continuous $CO_2$ output.

Devices for monitoring and maintaining or raising the temperature of the patient should be available throughout the perioperative pathway including control of theatre temperature.

There is either a fully equipped obstetric theatre in the delivery suite or an adjacent theatre that is always available for this purpose

After general or regional anesthesia, or sedation, all patients recover in a specially designated recovery areas equipped with appropriate monitoring facilities / emergency drugs and intubating equipment. The recovery area should have oxygen delivery system and suction. The recovery room staff must be appropriately trained in all relevant aspects of post-operative care. A written policy should be provided describing which members of staff, based on their qualifications, should be present in recovery for each of the procedures being undertaken. Until patients can maintain their airway, breathing and circulation they are cared for on a one-to-one basis by an appropriately trained member of staff, with an additional member of staff available at all times. Critically ill patients in the recovery area are cared for by appropriately trained staff and have appropriate monitoring and support

A written policy should be provided and this should be seen in the recovery area.

There is a recognized process in place for the referral of patients requiring critical care, including pediatric and obstetric patients, to an appropriate facility. A written policy should be provided for adults and children.

There are agreed criteria for discharge from recovery. After these criteria have been met, an appropriately trained member of staff accompanies patients during transfer

A written policy should be provided for adults and children.

Specialist acute pain management advice and intervention is available at all times including

escalation plans. A system by which anesthesiologists can be called at any time for advice should be relayed verbally by any member of staff, including nursing staff, for adults and children. There is a dedicated acute pain nurse specialist service which also covers the needs of children.

There is a trained resuscitation team for adults, including pregnant women, children and neonates as appropriate.

There are anesthetic clinical leads with responsibility in the following areas: pre-operative assessment, emergency anesthesia, remote sites, pediatrics, obstetrics, day surgery, acute pain management, perioperative medicine, resuscitation, ICM, anesthetic equipment, governance, simulation/human factors training, research, airway management, and safety and others as appropriate. This list is not exhaustive. PSA must work with the higher authorities to start fellowship programs of adequate duration in these disciplines at well-suited centers of excellence.

Trainees have specific training and demonstrated competence in relevant areas before working with or without distant supervision. They have unimpeded access to a nominated consultant for advice and supervision at all times.

A duty anesthesiologist is available for the obstetric unit 24 hours a day, where there is a 24-hour epidural service, the anesthesiologist is immediately available to the delivery suite.

**Patient Experience:**

Evidence be provided for appropriate pre-op assessment times and clinics. Anesthetic notes must include the explanation of anesthesia, risk stratification and the anesthesia including the provision of post-op pain relief discussed and recorded clearly in pre-operative notes.

The patients given the choice between the general and regional anesthesia as appropriate and informed consent obtained from the patient.

Any support needed for patients with individual or special requirements including children must be mentioned in the records.

Information given to patients and/or advocates includes what to expect in the anesthetic room, operating theatre and recovery room and obstetrics department, as appropriate

Copies of written information should be provided.

Procedure specific leaflets that cover a variety of ages and levels of understanding appropriate to the patient are produced by the administration and provided in

the pre-op period.

**Clinical Governance:**

Accurate, contemporaneous, clear and complete information about operating lists is printed and displayed and any changes to lists are agreed by all relevant parties.

Written documentation should be provided and displayed

The whole theatre team engage in the use of the WHO surgical check list including team brief and debrief in all settings where anesthesia is administered.

Patient's identification including the surgical process and surgical site marked checked and confirmed with patient and the published list. "Stop before Block "is carried out in order to avoid wrong side block.

Where relevant there must be adequate number of doctors available to simultaneously cover commitments in obstetrics, critical care and emergency theatres.

There is a formal handover process between shifts, multidisciplinary where appropriate.

There is a system in place to allow reporting and regular presentation of: audit projects, complaints, critical incidents and other untoward incidents and near misses, with demonstrated learning and improved outcomes. The department has evidence of engagement with, and implementation of national audit projects and quality improvement programs, including obstetrics.

Continuous measurements of the outcome of elective and emergency anesthesia is undertaken.

The emergency surgery workload is continually monitored and reviewed and is used to plan future demand. Rolling audit data should be available.

Continuity of high quality of anesthesia care and safety for patients is demonstrated in the specialized surgical services supported by audits / studies with measurable outcomes.

An understanding and review of the information regarding this accreditation can be helpful towards standardisation of services and to improve quality of care of the anaesthetic services in other countries as well.

The guidelines and the requirements can be modified as appropriate to best fit for the local anaesthesia services in other countries. It is suggested that a steering group be formed by 6/8 senior anesthesiologists, who could review the standards and put together a document akin to the one used by the RCOA. This document can be used to guide the anesthetic departments in the country who would wish to apply for the accreditation.

A Quality control teams comprising of 10/12 senior anesthesiologists could be formed. They are prepared to visit the anesthesia departments striving to achieve accreditation. The quality control team monitors the improvement in anesthesia services and provides feedback on the drawbacks and areas of services that needed enhancement. A certificate of accreditation is awarded to the department that successfully demonstrates and fulfils all criteria of standards of care.

# REFERENCES

1.  Royal college of Anaesthetists UK, Documents on application for The An- aesthesia Clinical Services Accredita- tion (ACSA). Available at https://www. rcoa.ac.uk/acsa/acsa-standards

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