Nursing Aid Specialized in Anesthesia-Resuscitation (NASAR)
What will be the NASAR’s role in 2012?

Society for Anesthesia and Resuscitation of Belgium and Belgian Professional Association of Specialists in Anesthesia and Resuscitation

Preliminary statement

Anesthesia is a medical act and is the exclusive responsibility of a medical doctor specialized in anesthesia and resuscitation (SAR). The present document does not alter the existing prescriptions gathered in the guidelines known as ‘Safety First’.

– Under the term ‘nursing aid specialized in anesthesia and resuscitation’ (NASAR), one should understand a registered nurse who has followed an additional training focusing upon anesthesia (and resuscitation) organized in Belgium.

– The motivation to include an aid is not discussed here. Although there is not yet a clear Belgian general agreement, an undeniable interest is expressed by a significant number of SAR to obtain in some circumstances more specialized nursing aid. However, due to differences in working conditions of anesthetic practice across Belgium, it is understandable that nursing aid may be very desirable in one institution while less so in another one. Despite the absence of a consensus, a clear definition is mandatory with respect to the framework of professional activities of the NASAR. This manuscript provides that framework for the NASARs and will not interfere with or modify the role of the nursing staff already dedicated to support the anesthesiologists.

– The financing of a NASAR is not the purpose of the present document.

Modalities of interactions between the SAR and the NASAR

General framework

– The NASAR will work at all times under the direct responsibility of a SAR. The former will not perform any activity without the permission of the latter. The responsible SAR must be clearly identified and the communication between the two health care providers must be codified ranging from verbal orders (lower tasks) to written orders (preparation of medication to be injected).

– The SAR is at all times responsible of the actions of the NASAR except for those particular situations where they were performed in non-compliance with the specific orders given.

– The NASAR will never work under the responsibility of a resident in training.

– As mentioned above, the guidelines of “Safety First” are not modified; this means that despite the presence of a NASAR, the SAR is not allowed to perform simultaneous anesthesia and/or be responsible for more than one NASAR under these circumstances.

Special circumstances

1. The pre-anesthetic consultation

The NASAR contributes to the collection of the systematic patient history and medical treatments specific to the anesthetic practice. He/she determines the risk classifications and scoring systems (1-3). He/she prepares the patient for the clinical examination by the SAR (recording of weight, systemic blood pressures, heart rate, breathing frequency). He/she completes the pre-anesthetic file after having collected the different technical exams ordered by the SAR (ECG, imaging, …)

The NASAR contributes to provide information to the patient with respect to the preoperative precautions and instructions, the anesthetic and/or analgesic techniques available, postoperative care, etc. These interventions complete but replace neither the preoperative visit by the SAR nor the discussion between a patient and the SAR.

2. The pre-anesthetic period

The NASAR prepares and checks all necessary anesthetic drugs and equipment, such as ventilator, breathing circuit, perfusion…according to
the written orders of the SAR. The SAR supervises and takes responsibility of all acts performed by the NASAR.

The NASAR takes part in the reception and installation of the patient in the operating or procedure room. He/she will check the patient’s identity, the pre-anesthetic file, the type, site and side of the intervention, compatibility with the preoperative instructions (information, availability of blood units ordered...). These interventions complement but never replace the direct contact between the patient and the SAR.

3. During anesthesia

During general anesthesia within or outside the confines of the operating theatre:

During induction of anesthesia the NASAR carries out all actions requested by the SAR, responsible for the patient, and under direct supervision and responsibility of the SAR who must be present in the room. During maintenance of anesthesia, the monitoring of the patient can be delegated to the NASAR only for limited periods of time and under the following conditions:

- Stable anesthetic course, i.e. the anesthetic depth, the hemodynamic and respiratory variables are stable as evidenced by a complete record of monitored variables.
- Stable surgical course, i.e. periods during which the patient will not be at risk of any instability induced by surgery, such as placement of a prosthesis, deflation of a tourniquet, release of vascular clamps, etc.
- The NASAR’s activity will be restricted exclusively to monitoring the patient under anesthesia. Consequently, this excludes any other task in the operating or examination room.
- The SAR must be immediately available without delay.
- The NASAR may adjust the anesthetic conditions (depth, muscle relaxation...), ventilation and volume status according to the monitoring values to be followed and consistent with written orders provided in advance by the SAR. The NASAR must immediately inform the SAR about all modifications to be performed during the course of anesthesia.
- In case of an unforeseen critical situation and after having alerted the SAR, the NASAR, however, may start all necessary therapeutic support provided that its use was covered by an algorithm clearly defined in accordance with the SAR.

- During the recovery period, the NASAR carries out all tasks ordered by the SAR and this under the direct supervision and responsibility of the SAR, who must be present in the operating room.

During regional anesthesia:

During performance of regional techniques, the NASAR carries out all tasks judged necessary by the SAR and this under direct supervision and responsibility of the SAR. The periods covering the installation of the block and the surgical incision must not be considered as a stable condition and therefore require the presence of the SAR in the room.

The intraoperative monitoring of the patient may be delegated to the NASAR under similar conditions as defined for general anesthesia. In case of patient discomfort or unsatisfactory block, the NASAR may never administer any sedative or analgesic medication upon his/her personal initiative. A previous evaluation by the SAR is mandatory. A patient operated under regional anesthesia but requiring a supplement to provide sufficient comfort cannot be considered to be in a stable anesthetic situation. Hence, the SAR must be present in the room.

In case of an unforeseen critical situation, the same principles should be applied as described for general anesthesia.

4. The post-anesthetic period

a) The immediate post-anesthetic period:

Anesthetic and postoperative analgesic techniques are diverse and often complex. In the recovery room, patients must be closely monitored by nursing personnel specifically educated in anesthetic techniques and knowledgeable about postoperative problems. In this respect, the usefulness and necessity of the NASAR in the recovery room must be stressed.

b) The postoperative patient at the peripheral ward:

The NASAR, consistent with his/her education, can participate in an ‘acute pain service’ team under the responsibility of a SAR. Hence, the NASAR evaluates the analgesic techniques applied in the postoperative period, reports to the responsible SAR and adapts or completes analgesia according to the written medical orders and/or the pre-existing analgesic protocols and algorithms.
References