PROPOSED REVISIONS TO COA STANDARDS

These items will be discussed during the COA Hearing
AANA Virtual Annual Meeting

The proposed revisions approved at the June COA meeting will also be distributed to the community of interest in a Call for Comment.

Updated 081220

Addition of glossary definition of "competency" – approved for distribution January 2020 COA meeting

Proposed Change	Key Points
• Add the following glossary definition to Doctoral Standards and Accreditation Policies and Procedures: **Competency**: An observable ability of a health professional, integrating multiple components such as knowledge, skills, values, and attitudes. Since competencies are observable, they can be measured and assessed to ensure their acquisition.	• Currently the COA does not have a glossary definition of "competency." • Well-supported generic definition and the source of the definition is the same as used by the COA's Common Clinical Assessment Tool.

Addition of glossary definition of "competence" – approved for distribution January 2020 COA meeting

Proposed Change	Key Points
• Add the following glossary definition to Master's and Doctoral Standards, and Accreditation Policies and Procedures: **Competence**: The array of abilities [knowledge, skills, and attitudes, or KSA] across multiple domains or aspects of performance in a certain context. Statements about competence require descriptive qualifiers to define the relevant abilities, context, and stage of training. Competence is multi-dimensional and dynamic. It changes with time, experience, and setting.	• This term appears in both the master's and doctoral Standards. • Currently the COA does not have a glossary definition of "competence." • This is a well-supported generic definition and the source of the definition is the same as used by the COA's Common Clinical Assessment Tool.

Change in total case number requirement – approved for distribution January 2020 COA meeting

Proposed Standard Change	Key Points
• Add the following requirement to the Appendix (Clinical Experiences) of the Doctoral Standards: Increase minimum total case number to 650. • Implementation date: All students matriculating into an accredited program on or after January 1, 2022.	• Minimal impact on programs and students. • Supported by benchmarking against requirements of other anesthesia providers' accreditors. • Minimal impact on programs and students assessed by analyzing 2018 NBCRNA data.

Establish a minimum number of cases for ultrasound-guided regional and vascular access – approved for distribution January 2020 COA meeting

Proposed Standard Change	Key Points
• Add the following requirements to the Appendix (Clinical Experiences) of the Doctoral Standards: Establish a minimum requirement for ultrasound-guided regional (10 cases) and vascular access (10 cases) rather than only having a preferred number. For ultrasound guided techniques, regional and vascular: under each, add lines to track actual and simulated. Allow use of simulation to meet this requirement. • Implementation date: All students matriculating into an accredited program on or after January 1, 2022.	• Making this a requirement versus preferred will help ensure that CRNA programs stay on the forefront of anesthesia practice. • According to the latest NBCRNA data, it appears that the numbers of regional anesthesia cases are increasing. This may be due to simulation. • Type of vascular access not specified (central, peripheral or arterial) and should be easy to obtain.

Standards Appendix
Other

	Minimum Required Cases	Preferred Number of Cases
Ultrasound-guided techniques (total of a & b)	20	
a. Regional[footnote]	10	
1. Actual regional		
2. Simulated regional		
b. Vascular[footnote]	10	
1. Actual vascular		
2. Simulated vascular		

Regional footnote: Regional includes neuraxial, truncal, and peripheral nerve blocks. No clinical experiences can be obtained by simulation alone.

Vascular footnote: Vascular includes arterial, peripherally inserted central catheters, central venous, and peripheral access. No clinical experiences can be obtained by simulation alone.

Changes related to point of care ultrasound – approved for distribution January 2020 COA meeting

Proposed Change	Key Points
• Add the following glossary definition to Doctoral Standards: **Point of Care Ultrasound (POCUS)**: Refers to the use of portable ultrasonography at a patient's bedside for diagnostic (e.g., symptom or sign-based examination) purposes. This is exclusive of using ultrasound for image-guidance purposes such as for regional anesthesia or vascular access. • Add the following In the Appendix (Clinical Experiences) of the Doctoral Standards: Add POCUS with no case number requirement but require students to track. • Implementation date: All students matriculating into an accredited program on or after January 1, 2022.	• There has been a rapid escalation in the use of POCUS for assessment and diagnosis as well as vascular and regional access. • Currently POCUS does not appear in the Standards for curriculum. • This proposed Standard change addresses the use of ultrasound for more than vascular access and regional guidance.

Standards Appendix

	Number
Point of Care Ultrasound (POCUS)*	
a. Actual	
b. Simulated	

*Definition of POCUS: **Point of Care Ultrasound (POCUS)**: Refers to the use of portable ultrasonography at a patient's bedside for diagnostic (e.g., symptom or sign-based examination) purposes. This is exclusive of using ultrasound for image-guidance purposes such as for regional anesthesia or vascular access.

Add glossary definition of "full scope of practice" – approved for distribution June 2020 COA meeting

Proposed Change	Key Points
• Add the following glossary definition to Master's and Practice Doctorate Standards, and Accreditation Policies and Procedures: **Full scope of nurse anesthesia practice** - Preparation of graduates who can administer anesthesia and anesthesia-related care in five general categories: (1) preanesthetic/preprocedure; (2) intraoperative/intraprocedure; (3) postoperative/ postprocedure; (4) pain management; and (5) other services. These are general categories. CRNA scope of practice is dynamic and evolving. CRNA clinical privileges should reflect the full scope of CRNA practice evidenced by individual credentials and performance. (Reference "Scope of Nurse Anesthesia Practice", available from AANA, Park Ridge, IL. Approved by the AANA Board of Directors, January 2020)	• There was a disconnect between the generic, one-sentence definition proposed by the Full Scope of Practice Competency Task Force and the AANA definition which addresses categories of care. • The COA should ensure the "full scope of practice" definition references the AANA Scope of Practice document.

Revise radiology definition and establish a clinical experiences requirement to support the didactic content for chest x-ray interpretation – approved for distribution June 2020 COA meeting

Proposed Standard Change	Key Points
• Revise the glossary definition of radiology in the Practice Doctorate Standards: **Radiology** - Didactic curricular content includes the fundamentals of radiologic principles and various techniques, topographic anatomy, contrast agents, radiation safety, proper techniques of safe fluoroscopic equipment use, evaluation of normal and abnormal radiographs of the chest where findings may have perianesthetic considerations, evaluation of proper positioning of various devices (e.g., endotracheal tubes, chest tubes) and invasive vascular access catheters (e.g., central venous catheters). Experiences in chest X-ray interpretation are offered.	• The proposed definition incorporates the recommendation to add clinical experiences to support the didactic content.

Establish a minimum and preferred requirement for interpretation of chest x-rays to support the didactic content

Proposed Standard Change	Key Points
• Add the following requirements to the Appendix (Clinical Experiences) of the Master's and Doctoral Standards: Establish a minimum and preferred requirement for interpretation of chest x-rays to support the didactic content. • Add the following interpretation to the Guidelines for Counting Clinical Experiences: The expectation is that the student accurately interprets a chest x-ray including recognizing normal and abnormal findings on chest x-rays that may have immediate perianesthetic implications (e.g., pneumothorax, pulmonary edema) along with evaluating proper positioning of various tubes (e.g., endotracheal tubes, chest tubes) and invasive vascular access lines (e.g., central venous catheters). One "case" should be counted as the interpretation of one chest x-ray and student's interpretation is evaluated. The chest x-ray source can be a current or past patient or from an institutional or commercial library of chest x-rays. This experience can be gained in a healthcare institution, classroom, simulation center, or by using online resources.	• The proposed definition incorporates the recommendation to add clinical experiences to support the didactic content. • Programs indicated a formal radiology rotation is not an option. • Simulation has effectively bridged the gap between the classroom and the clinical setting. • Radiology operates on a mostly virtual platform (clinician "reading" image in remote location to patient).

Standards Appendix
Other

	Minimum Required Cases	Preferred Number of Cases
Interpretation of chest X-ray[footnote]	5	10

Footnote
This experience can be gained in a healthcare institution, classroom, simulation center, or by using online resources.

Add 12-lead ECG interpretation to the curriculum – approved for distribution June 2020 COA meeting

Proposed Standard Change	Key Points
• Revise the Practice Doctorate Standards to incorporate 12-lead ECG interpretation: **Standard E.2.2.** Content: Advanced Physiology/Pathophysiology (120 contact hours), advanced pharmacology (90 contact hours), basic and advanced principles in nurse anesthesia (120 contact hours), research (75 contact hours), advanced health assessment (45 contact hours), human anatomy, chemistry, biochemistry, physics, genetics, acute and chronic pain management, 12-lead ECG interpretation, radiology, ultrasound, anesthesia equipment, professional role development, wellness and substance use disorder, informatics, ethical and multicultural healthcare, leadership and management, business of anesthesia/practice management, health policy, healthcare finance, integration/clinical correlation (see Glossary, "Wellness and substance use disorder," "Pain management, acute," "Pain management, chronic," "Professional role development," "12-lead ECG interpretation," and "Radiology"). • Add a glossary definition of 12-lead ECG interpretation: 12-lead ECG interpretation - Didactic curricular content in the use of 12-lead ECG to detect cardiac abnormalities having perianesthesia implications.	• Safe care can be contingent on the CRNA being able to interpret a 12-lead ECG to detect such conditions as myocardial ischemia and infarction in emergency situations and when the patient is being monitored using properly-placed ECG electrodes.

Add examples to the "comprehensive history and physical assessment" definition – approved for distribution June 2020 COA meeting

Proposed Standard Change	Key Points
• Revise the glossary definition of comprehensive history and physical assessment in the Practice Doctorate Standards: **Comprehensive history and physical assessment** - Comprehensive history and physical assessment includes the history, physical, and psychological assessment of signs and symptoms, pathophysiologic changes, and psychosocial variations of a patient. The assessment includes an evaluation of the body and its functions using inspection, palpation, percussion, auscultation, and advanced assessment techniques, including but not limited to laboratory, radiologic, and other diagnostic studies (e.g., chest x-ray, 12-lead ECG, point-of-care ultrasound), as appropriate. A complete physical assessment incorporates cultural and developmental variations and needs of a patient. The results of a comprehensive history and physical assessment are used to establish a differential diagnosis based on assessment data and develop an effective and appropriate plan of care for a patient. Specific assessment related to anesthesia should be stressed in the practical experience of nurse anesthesia students.	• Expanding the definition of comprehensive history and physical assessment with specific examples emphasizes the importance of these skills and techniques to independent CRNA practice. • The proposed changes are aligned with the AANA Scope of Practice documents: "Order, evaluate, and interpret diagnostic laboratory and radiological studies (e.g., chest x-ray, 12-lead EKG, TEE)"

Establish clinical experience requirements that specifically focus on pre-anesthetic assessment, post-anesthetic assessment and management, and a comprehensive history and physical – approved for distribution June 2020 COA meeting

Standards Appendix
Other

	Minimum Required Cases	Preferred Number of Cases
Initial preanesthetic assessment	50	100

Proposed Guidelines Change	Key Points
• Add the following interpretation to the Guidelines for Counting Clinical Experiences: The initial preanesthetic assessment is one in which the student personally conducts the assessment by reviewing the patient's medical history, conducting an anesthesia-focused physical assessment, and evaluating pertinent laboratory findings/diagnostic testing. This is an original assessment, not a review of or reference to a preanesthetic assessment previously conducted by another anesthesia provider. The preanesthetic assessment is evaluated by a faculty member. Clinical experiences **cannot** be obtained by simulation alone.	• Preanesthetic assessment is part of the AANA Scope of Practice. • Thorough preanesthetic assessment is fundamental for the independent practitioner. • Adding this component to the Clinical Experiences log will allow the COA to track data for compliance and make future adjustment to requirements if necessary.

Standards Appendix
Other

	Minimum Required Cases	Preferred Number of Cases
Postanesthetic assessment	50	150

Proposed Guidelines Change	Key Points
• Add the following interpretation to the Guidelines for Counting Clinical Experiences: A postanesthetic assessment is the review by the student of all pertinent patient data and evaluation of anesthesia outcomes. This may occur anytime during the post-operative period. The student implements needed interventions or makes appropriate referrals, if indicated, based on the assessment. This is not the postanesthetic assessment required by health care facility accreditors. Due to many factors beyond the control of the student, each patient the student anesthetizes is not required to have a postanesthetic assessment performed by the student. Documentation may be solely the student case log, recognizing the fact that the student may not be able to document the encounter in the patient's medical record. The postanesthetic assessment can be accomplished telephonically. The program must have a process of validating postanesthetic assessments if not documented in the patient's medical record (such as documentation on anesthetic care plan or in case logs.). Clinical experiences **cannot** be obtained by simulation.	• Comprehensive postanesthetic assessment is fundamental for the independent practitioner.

Standards Appendix
Other

	Minimum Required Cases	Preferred Number of Cases
Comprehensive history and physical	10	20

Proposed Guidelines Change	Key Points
• Add the following interpretation to the Guidelines for Counting Clinical Experiences: Comprehensive history and physical assessment includes the history, physical, and psychological assessment of signs and symptoms, pathophysiologic changes, and psychosocial variations of a patient. The assessment includes an evaluation of the body and its functions using inspection, palpation, percussion, auscultation, and advanced assessment techniques, including diagnostic testing, as appropriate. A complete physical assessment should incorporate cultural and developmental variations and needs of a patient. The results of a comprehensive history and physical assessment are used to establish a differential diagnosis based on assessment data and develop an effective and appropriate plan of care for a patient. Specific assessment related to anesthesia should be stressed in the practical experience of nurse anesthesia students. This experience **can** be obtained by simulation alone.	• Simulation for the comprehensive history and physical should be an effective option for clinical experience, can be accomplished in low-fidelity, and should require minimum investment.

Students have experiences in independently selecting, calculating dosage and administering medications – approved for distribution June 2020 COA meeting

Standards Appendix
Other

note: "Emergence from anesthesia" moved from "Methods of Anesthesia" to the "Other" category

	Minimum Required Cases	Preferred Number of Cases
Perform a general anesthetic induction with minimal or no assistance	150	300
Emergence from anesthesia	300	

Proposed Guidelines Change	Key Points
• Add the following interpretation to the Guidelines for Counting Clinical Experiences: The student conducts a general anesthetic induction by selecting medications, calculating dosage, administering medications and managing the patient's airway with minimal or no assistance from the supervising CRNA or anesthesiologist. The plan of care is always approved by the supervising CRNA and/or anesthesiologist.	• Students may graduate never having done an induction without the supervising provider selecting and administering the medications. • The Guidelines statement assures that the supervisor approves the plan of care.