The following is a summary of the final recommendations from the Full Scope of Practice Competency Task Force and the COA's actions on the recommendations.

Note: Standards refers to the *Standards for Accreditation of Nurse Anesthesia Programs - Practice Doctorate*, 2015, last revised January 30, 2021.

Recommendation to COA, AANA, and NBCRNA	Action by the COA
1. Adopt the following definitions:	
a. **Full Scope of Practice**: The ability of the nurse anesthetist to practice to the complete extent of their education, skills, and competencies.	**This following definition was approved based on AANA Scope of Practice** 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. Scope of practice is dynamic and evolving.
b. **Autonomous Nurse Anesthesia Practice**: Autonomous nurse anesthesia practice is characterized by independent, self-determined professional judgment and action. Nurse anesthetists have the capability, ability, and responsibility to exercise professional judgment within their scope of practice and to professionally act on that judgment.	**Not approved as a revision in the Standards** While the COA supports the use of the "Autonomous Nurse Anesthesia Practice" definition: the term is not used in the Standards
c. **Competency**: An observable ability of a healthcare professional, integrating multiple components such as knowledge, skills, values, and attributes. Since competencies are observable, they can be measured and assessed to ensure their acquisition.	**Definition approved.** 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.
d. **Competence**: The array of abilities [knowledge, skills, and attributes, 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 state of training. Competence is multidimensional and dynamic. It changes with time, experience, and setting.	**Definition approved.** 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.
e. **Independent CRNA**: An independent CRNA practices without reliance on, or control of, another anesthesia provider.	**Not approved as a revision to the Standards** While the COA supports the use of the "Independent CRNA" definition, the term is not used in the Standards

Recommendations to COA

Recommendations to COA	Resolution
2. The task force strongly recommends to the COA the full implementation of the CCAT requiring its use in all nurse anesthesia programs awarding a doctoral degree for entry into practice.	**Not approved as a revision to the Standards** It is noted the CCAT is on hold due to the impact of COVID-19 on nurse anesthesia programs. Preparations are being made for the rollout of the CCAT in FY2022.

Recommendations to COA	Resolution
3. Increase the required overall case number to 700.	**Approved overall case number increase to 650 cases.** The COA considered several important factors including but not limited to • The accreditation requirements of other anesthesia providers. • The overall case numbers reported by recent graduates per program. • The impact on the types of cases students may obtain (i.e., an increased number of simple less complex cases) and the impact that could have on the quality of the cases students are completing to meet their case numbers. Approved by the COA: Add requirement to the Appendix (Clinical Experiences) of the Doctoral Standards: Increase minimum total case number to 650. Effective for all students matriculating into an accredited program on or after January 1, 2022.

Recommendations to COA	Resolution
4. Establish a minimum requirement for both ultrasound guided regional and vascular access, rather than only having a preferred number. Require 10 cases for ultrasound guided regional and vascular access. Training to perform both procedures may include cadaveric experiences.	**Approved.** Add requirements to the Appendix (Clinical Experiences) of the Doctoral Standards: • Establish a minimum requirement for ultrasound-guided regional and vascular access. o Required total ultrasound guided regional and ultrasound guided vascular: 20. o Required ultrasound guided regional: 10 (total of actual and simulated) o Required ultrasound guided vascular: 10 (total of actual and simulated) Effective for all students matriculating into an accredited program on or after January 1, 2022.

Recommendations to COA	Resolution
5. Add independent CRNA rotations to clinical requirements. Consider non-monetary incentives for practices to take students.	**Not approved as a revision to the Standards** While the COA supports programs adding independent CRNA rotations, concerns were noted regarding establishing an accreditation requirement that is not attainable by all programs at this time. The COA will continue to monitor the availability of independent CRNA rotations via the COA Annual Report and will collect additional data on independent CRNA rotations to clinical sites. The COA supports the work of the AANA in identifying independent CRNA rotations and incentives for practices to take students.

Recommendations to COA	Resolution
6. Develop a mentorship framework including establishment of a mentoring agreement to be agreed upon and signed by a mentor and mentee.	**Not approved as a revision to the Standards** The COA supports mentoring such as through supporting educational offerings. “Requiring” or “assigning” a mentor is not consistent with the principles of mentoring. Mentoring is a mutual agreement, thus it is difficult to assign a mentor. Program proof of compliance, a metric for mentoring, has not been clearly defined. Requirements are high in terms of personnel, time, economic resources in comparison with program effectiveness.

Recommendations to COA	Resolution
7. Use simulation for central line placement and other vascular access.	**Already addressed in the Practice Doctorate Standards**

Recommendations to COA	Resolution
8. Recommend the COA to strongly encourage nurse anesthesia educational programs to explore clinical opportunities in CRNA only and non-medically directed independent practitioner sites. Also, within medically directed settings, explore opportunities for more autonomy for SRNAs.	**Not approved as a revision to the Standards** While the COA supports programs obtaining clinical opportunities in CRNA only and non-medically directed independent practitioner sites it was noted that quality experiences must be obtained in a manner that is fiscally and practically available to the programs. Establishing accreditation requirements that mandate all programs have CRNA independent rotations would place many programs at risk of not meeting accreditation requirements and potential closure. There are currently an inadequate number of CRNA independent clinical sites for all programs to meet such a requirement.

Recommendations to COA	Resolution
9. Recommend the COA to consider incorporating the Point of Care Ultrasound (POCUS) definition: a. **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) and therapeutic (e.g., image-guidance) purposes.	**Approved** Footnote placed: [15]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.

Recommendations to COA	Resolution
10. Recommend COA insert a line between "b. Vascular" and "Intravenous catheter placement" for POCUS diagnostic assessment.	**Approved** POCUS cases, both simulated and actual, are required to be tracked. Effective for all students matriculating into an accredited program on or after January 1, 2022.

Recommendations to COA	Resolution
11. For ultrasound guided techniques, regional and vascular: Under each, add lines to track actual and simulated. Allow use of simulation to meet this requirement (simple models footnote).	**Approved** Actual and simulated techniques tracked. Effective for all students matriculating into an accredited program on or after January 1, 2022.

Recommendations to COA	Resolution
12. Revise the current "radiology" definition to: a. **Radiology**: Didactic curricular content includes the fundamentals of radiologic principles and various techniques, topographic anatomy, contrast agents, radiation safety, basic evaluation of normal and abnormal radiographs of the chest, evaluation of proper positioning	**Approved** 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, basic evaluation of normal and abnormal radiographs of

of various tubes (e.g., endotracheal tubes, chest tubes) and lines (e.g., central venous catheters), and proper techniques of safe fluoroscopic equipment use. Clinical experiences should be provided that support the didactic content.	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. Effective for all students matriculating into an accredited program on or after January 1, 2022.
Recommendations to COA	**Resolution**
13. COA should develop clinical experience requirements that support the didactic content for chest x ray interpretation.	**Approved** Assessment of CXR requirement added (5 required, 10 preferred) A footnote states that this experience can be gained in a healthcare institution, classroom, simulation center, or by using online resources. One case should be counted as the evaluation of one chest x-ray, regardless of the number of items assessed on that x-ray. Effective for all students matriculating into an accredited program on or after January 1, 2022.

Recommendations to COA	**Resolution**
14. Recommend that the COA include 12-lead EKG interpretation as part of the educational curriculum.	**Approved** 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”). 12-lead ECG interpretation - Didactic curricular content in the use of 12-lead ECG to detect cardiac abnormalities having perianesthesia implications Effective for all students matriculating into an accredited program on or after January 1, 2022.

Recommendations to COA	Resolution
15. Add examples to the “Comprehensive history and physical assessment definition: a. 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 (e.g., 12-lead EKG interpretation, point of care ultrasound, etc.), as appropriate. A complete physical assessment should incorporate cultural and developmental variations and needs of the 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 the patient. Specific assessment related to anesthesia should be stressed in the practical experience of SRNAs.	**Approved** 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. Effective for all students matriculating into an accredited program on or after January 1, 2022.

Recommendations to COA	Resolution
16. The COA should establish clinical experiences requirements that specifically focus on a comprehensive history and physical, pre-anesthetic assessment and post-anesthetic assessment and management.	**Approved** Requirements: • Initial preanesthetic assessment: 50 required, 100 preferred. • Postanesthetic assessment: 50 required, 150 preferred. • Comprehensive history and physical: tracked (Actual and simulated). Effective for all students matriculating into an accredited program on or after January 1, 2022.

Recommendations to COA	Resolution
17. The task force supports the COA's clinical experiences requirement of one actual central line placement for students enrolled on or after January 1, 2020.	**Already addressed in the Practice Doctorate Standards**

Recommendations to COA	Resolution
18. COA should develop the following footnote: Footnote for Graduate Standards D9 and D10: Programs are expected to provide students experiences in independently selecting, calculating dosage and administering medications.	**Approved** Instead of adding a footnote to Standards D.9 and D.10, the COA added the following case requirement to the Clinical Experiences table: • Perform a general anesthetic induction with minimal or no assistance† • 50 required/100 preferred. Effective for all students matriculating into an accredited program on or after January 1, 2022.