

Guidelines for the Management of the Obstetrical Patient for the Certified Registered Nurse Anesthetist



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Introduction

CRNAs have been the predominant providers of anesthesia services to obstetrical patients.¹ CRNAs provide obstetrical anesthesia services with physicians such as anesthesiologists, obstetricians and family practitioners, and with nurses such as nurse midwives and nurse practitioners. In recognition of that role, the AANA advocates establishing clinical guidelines that promote quality patient care.

While pregnancy and childbirth are normal physiologic processes, many variables have the potential to complicate overall patient management.^{2,3} The American Association of Nurse Anesthetists (AANA) developed the “Guidelines for Anesthesia Management of the Obstetrical Patient”⁴ to (1) promote safe and effective anesthesia care for obstetrical patients, and (2) provide guidance for Certified Registered Nurse Anesthetists (CRNAs) and healthcare institutions.

In the context of these guidelines, anesthesia is the care provided for surgical intervention (i.e., cesarean section), and labor analgesia is the care provided for pain management (i.e., labor epidural). The AANA *Scope and Standards for Nurse Anesthesia Practice*⁵ shall apply to all patients who undergo anesthesia in the obstetrical setting (see Appendix).

Guideline 1

Possess the appropriate skills and credentials to initiate and/or manage regional (intrathecal, spinal, epidural or caudal epidural) labor analgesia and anesthesia and general anesthesia for the obstetric patient.

Interpretation

The CRNA shall be able to develop and implement a plan of patient care specific to the needs and predispositions of the obstetric patient and based on current anesthesia principles.

Guideline 2

The CRNA shall be aware of fetal status prior to each analgesia/anesthesia intervention.

Interpretation

Fetal status is monitored and documented in the patient’s record.

Guideline 3

Insure that anesthesia equipment is consistent with other anesthetizing locations in the facility. Emergency airway management equipment and drugs for resuscitation of the neonate shall be available.

Interpretation

Departmental policies should define the anesthesia equipment required to provide high quality anesthesia care to the parturient and the neonate.

Guideline 4

The CRNA shall be immediately available, as defined by institutional policy, when analgesia and anesthesia is administered.

Interpretation

During the conduct of a continuous epidural infusion for analgesia, the CRNA must be immediately available to assess the level of analgesia and adjust the plan of care as appropriate. Following bolus epidural or intrathecal injection for analgesia, the CRNA must be immediately available to assess the level of analgesia until that level has stabilized.

Guideline 5

During the conduct of an anesthetic, a qualified healthcare provider, other than the CRNA, shall be available in the event neonatal assessment and resuscitation are required.

Interpretation

The primary responsibility of the CRNA is to the patient receiving anesthesia for the obstetrical procedure.

Guideline 6

Initiate, in the event of an emergency, anesthesia care in accordance with institutional policy.

Interpretation

At a minimum, the policy should be congruent with the American College of Obstetrics and Gynecology (ACOG) guidelines. *“Local circumstances must dictate the way in which these guidelines are best interpreted to meet the needs of the particular hospital, community or system. The nursing, anesthesia, neonatal resuscitation and obstetric personnel should be in the hospital or readily available. Readily available should be defined by each institution within the context of its resources and geographic location.”*

Guideline 7

Insure that postanesthesia care for the obstetrical patient is consistent with institutional policies.

Interpretation

Departmental policies should define the resources required to provide high quality postanesthesia care to the parturient.

REFERENCES

- (1) Hawkins J, Gibbs G, Orleans M, Martin-Salvi G, Beaty B. Obstetric anesthesia work force survey, 1981 versus 1992. *Anesthesiology*. 1997;87:135-143.
- (2) Fiedler M, Shaw B. Obstetric anesthesia. In Nagelhout J, Zaglaniczny K, eds. *Nurse Anesthesia*. Philadelphia: WB Saunders. 1997:292-332.
- (3) Santos A, Pederson H, Finster M. Obstetric anesthesia. In: Barash PG et al, eds. *Clinical Anesthesia*. Philadelphia: Lippincott-Raven. 1992:1061-1090.
- (4) AANA Guidelines for Anesthesia Management of the Obstetrical Patient. In: *Professional Practice Manual for the Certified Registered Nurse Anesthetist*. Park Ridge, Illinois: American Association of Nurse Anesthetists. 1991.
- (5) Scope and Standards of Nurse Anesthesia Practice. In: *Professional Practice Manual for the Certified Registered Nurse Anesthetist*. Park Ridge, Illinois: American Association of Nurse Anesthetists. 1996.
- (6) *American Academy of Pediatrics, American College of Obstetricians and Gynecologists Guidelines for Perinatal Care*. 3rd ed. Elk Grove Village, Illinois: American Academy of Pediatrics. 1992.

Appendix:

Scope and Standards for Nurse Anesthesia Practice

- Standard I** *Perform a thorough and complete preanesthesia assessment.*
- Standard II** *Obtain informed consent for the planned anesthetic intervention from the patient or legal guardian.*
- Standard III** *Formulate a patient-specific plan for anesthesia care.*
- Standard IV** *Implement and adjust the anesthesia care plan based on the patient's physiologic responses.*
- Standard V** *Monitor the patient's physiologic condition as appropriate for the type of anesthesia and specific patient needs.*
 - A. **Monitor ventilation continuously.** Verify intubation of the trachea by auscultation, chest excursion, and confirmation of carbon dioxide in the expired gas. Continuously monitor end-tidal carbon dioxide during controlled or assisted ventilation including any anesthesia or sedation technique requiring artificial airway support. Use spirometry and ventilatory pressure monitors as indicated.

- B. **Monitor oxygenation continuously** by clinical observation, pulse oximetry, and if indicated, arterial blood gas analysis.
- C. **Monitor cardiovascular status continuously** via electrocardiogram and heart sounds. Record blood pressure and heart rate at least every five minutes.
- D. **Monitor body temperature continuously** on all pediatric patients receiving general anesthesia and when indicated, on all other patients.
- E. **Monitor neuromuscular function and status** when neuromuscular blocking agents are administered.
- F. **Monitor and assess the patient positioning** and protective measures except for those aspects that are performed exclusively by one or more other providers.

Standard VI *There shall be a complete, accurate, and timely documentation of pertinent information on the patient's medical record.*

Standard VII *Transfer the responsibility for care of the patient to other qualified providers in a manner which assures continuity of care and patient safety.*

Standard VIII *Adhere to appropriate safety precautions, as established within the institution, to minimize risks of fire, explosions, electric shock and equipment malfunction. Document on the patient's medical record that the anesthesia machine and equipment were checked.*

Standard IX *Precautions shall be taken to minimize the risk of infection to the patient, the CRNA, and other healthcare providers.*

Standard X *Anesthesia care shall be assessed to assure its quality and contribution to positive patient outcomes.*

Standard XI *The CRNA shall respect and maintain the basic rights of patients.*

The AANA Board of Directors adopted "Guidelines for the Management of the Obstetrical Patient for the Certified Registered Nurse Anesthetist" at the 1998 Preconvention Board Meeting. The Guidelines are effective January 1, 1999.