Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

Amended on
September 19, 2018

VHA Directive 1157(1)
Transmittal Sheet
June 14, 2018

OUT OF OPERATING ROOM AIRWAY MANAGEMENT

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive addresses the requirements to provide Out of Operating Room Airway Management (OOORAM) care for Veterans.

2. SUMMARY OF MAJOR CHANGES:

a. Amendment dated September 19, 2018, updates The Difficult Airway Algorithm and Rescue Cricothyrotomy (DAARC) training web sites in paragraph 5.f.(2)(b).

b. This update clarifies the appropriate competencies for providers who perform urgent and emergent airway management including intubation outside of VA facility operating rooms, establishes criteria for privileging clinicians, and ensures a training program for those seeking intubation privileges at a VA facility by creating three levels of airway management competency (Level 1, Level 2, and Level 3) and directing that an adjunctive device be used to confirm tube placement. This update also establishes a documentation requirement when a Level 3 OOORAM provider determines the patient has a difficult-to-intubate airway. Documentation must be done using the National Difficult Airway Template in Computerized Patient Record System (CPRS).

3. RELATED ISSUES: None.

4. RESPONSIBLE OFFICE: The Office of Specialty Care Services (10P11) is responsible for the contents of this directive. Questions may be addressed to the Office of Specialty Care Services, National Director of Anesthesia at 202-461-7120.

5. RESCISSIONS: VHA Directive 2012-032, Out of Operating Room Airway Management, dated October 26, 2012, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of June 2023. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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Executive in Charge

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OUT OF OPERATING ROOM AIRWAY MANAGEMENT

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1. PURPOSE

This Veterans Health Administration (VHA) directive addresses the competencies of providers who perform emergent airway management outside of Department of Veterans Affairs (VA) medical facility operating rooms; it addresses required techniques to confirm successful endotracheal tube placement and required documentation when a patient has been determined to have a difficult-to-intubate airway. **AUTHORITY:** Title 38 United States Code (U.S.C.) 7301(b).

2. BACKGROUND

a. Emergent airway management is often required outside of an operating room. It is mandatory that individuals who respond to the airway management needs of the patient are trained and qualified to perform airway management. The ability to manage a patient's airway must be demonstrated and cannot be assumed from the job title. As documented in this directive, specific training and procedural skills are required to meet the airway needs of the patient.

b. Unrecognized esophageal intubation or other failure to appropriately ventilate the patient's lungs will likely result in brain damage or death. The use of a device that detects carbon dioxide must be utilized in concert with auscultation to confirm ventilation in all circumstances when an endotracheal tube or alternative airway device is inserted (i.e., laryngeal mask airway (LMA), King tube™, Combitube™, etc.).

c. For some patients, airway management, including insertion of an endotracheal tube, may be difficult due to prior patient experience, history, or observed anatomic and situational contexts. The use of a standardized critical path analysis tool is recommended to help determine when and how additional expertise will be consulted. An example may be found at the National Center for Patient Safety (NCPS) Web site at http://vaww.ncps.med.va.gov/ in the Guidelines and Directives section. ***NOTE:*** *This is an internal VA Web site that is not available to the public*.

d. When a Level 3 Out of Operating Room Airway Management (OOORAM) provider encounters substantial difficulty or the inability to manage a patient airway, clear and timely documentation in the CPRS-based National Difficult Airway Template and communication of this information to the patient and other health care professionals can prevent future problems by allowing the health care team to adequately plan for future elective intubation and rapidly identify the needed airway expertise for emergent intubations.

3. DEFINITIONS

a. **Deep Sedation.** Regardless of location in the facility, Deep Sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired requiring manipulation of

the airway (for example, jaw thrust, mask ventilation, supraglottic airway insertion or intubation) in order to maintain ventilation. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. However, cardiovascular function may require the use of pharmacologic intervention to support the patient's cardiovascular status. Patients undergoing Deep Sedation may slip into a state of General Anesthesia.

b. **Emergent Airway Management.** Management of the airway in a patient who needs immediate support and intervention (e.g., a code situation).

c. **General Anesthesia.** Regardless of location in the facility, General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

d. **Moderate Sedation.** Moderate Sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

e. **Level 1 OOORAM Provider.** An individual trained according to Section 6 to perform basic airway management which includes mask ventilation, insertion of a nasal airway, insertion of an oral airway and the insertion of a supraglottic device (such as an LMA). After establishing this level of airway assistance, the provider will assess the need to initiate activation of local processes to obtain a higher level of airway expertise (VA Level 2 or 3 provider or 911 Emergency Medical Service (EMS)).

f. **Level 2 OOORAM Provider.** An individual trained according to Section 6 to be competent in Level 1 airway management that has received further training to perform intubation of the trachea using a video laryngoscope (VL) (indirect laryngoscopy). Direct laryngoscopy (DL) is not a required part of Level 2 airway management, however, if an individual has appropriate training and experience in use of DL, DL may be used (for example, a Respiratory Therapist). If laryngoscopy is not possible or fails, a provider with Level 3 airway management skills must be called (or 911 EMS if a Level 3 VA airway provider is not available). Medication management is not part of Level 2 airway management.

g. **Level 3 OOORAM Provider.** This includes Level 1 and 2 airway management skills and the ability and training to manage a patient undergoing sedation deeper than the moderate level and must include expertise in DL to secure the airway. Sedation can be with or without paralytic administration. A Level 3 provider must have privileges or a

scope-of-practice to use sedation/hypnotic/paralytic/reversal and resuscitation medications.

h. **Resident.** An individual who is engaged in an accredited graduate training program for physicians, dentists, optometrists, and podiatrists, and who participates in patient care under the direction of supervising practitioners. ***NOTE:*** *For the purpose of this directive, the term resident includes individuals in approved subspecialty graduate medical education programs, who are also referred to as fellows.*

4. POLICY

It is VHA policy that each facility implements the requirements of this directive no later than 6 months after publication of this directive to ensure the competency of staff performing this task when responding to respiratory compromise events, including cardiopulmonary arrest. OOORAM coverage at the appropriate level must be available during all hours when patient care is provided based on the site classification of the facility as defined in VHA Handbook 1006.02, VHA Site Classifications and Definitions, dated December 30, 2013, or subsequent policy, and the requirements of this directive.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Service Networks (VISNs).

(2) Ensuring that each VISN Director has the sufficient resources to fulfill the terms of this directive in all of the VHA health facilities within that VISN.

(3) Providing oversight of VISNs to assure compliance with this directive, relevant standards, and applicable regulations.

c. **Veterans Integrated Service Network Director.** Each VISN Director is responsible for ensuring that:

(1) Each VISN facility meets all requirements of this directive no later than 6 months after publication of the directive.

(2) Each VISN facility provides OOORAM coverage based on the following:

(a) Extended Care facilities, Community-Based Outpatient Clinics and Health Care Centers where Moderate Sedation is not performed must have an adequate number of Level 1 OOORAM providers available to provide Level 1 OOORAM care during all hours when patient care is provided or must have arrangements in place to ensure

timely 911 EMS response for airway care that is beyond basic life support (BLS) care. If the facility chooses to have Level 1 OOORAM providers available then in addition, the facility must either have:

1. Level 2 OOORAM providers available in-house plus a plan to call in VA providers trained to Level 3 OOORAM care if needed; or

2. Arrangements in place to ensure timely 911 EMS response for airway care that is beyond Level 1 care.

(b) Extended Care facilities, Community-Based Outpatient Clinics and Health Care Centers where Moderate Sedation is performed must have an adequate number of Level 1 OOORAM providers available to provide Level 1 OOORAM care during all hours when Moderate Sedation is administered and throughout the patient's recovery period. In addition, the facility must have:

1. Level 2 OOORAM providers available in-house plus a plan to call in VA providers trained to Level 3 OOORAM care if needed; or

2. Arrangements in place to ensure timely 911 EMS response for airway care that is beyond Level 1 care.

(c) Inpatient Care facilities must have:

1. An adequate number of Level 2 OOORAM providers available to provide Level 2 OOORAM care during all hours when patient care is provided; and

a. A plan to call in Level 3 OOORAM providers if required for patient care; or

b. Arrangements to call 911 EMS if there are no Level 3 OOORAM providers on staff.

2. Alternatively, an Inpatient facility may choose to have Level 3 OOORAM providers in-house during all hours patient care is provided.

3. Inpatient care facilities that do not have a Code team, and do not have an Emergency Department, and do not have functioning Operating Rooms may choose to provide airway services using the 5.c.(2)(a) requirements above.

d. **VA Medical Facility Director.** Each VA medical facility Director is responsible for ensuring:

(1) **Grandfather Considerations.** Implementation of this directive does not require immediate reassessment of those with existing OOORAM privileges, scope of practice or functional statement. Certified OOORAM providers with privileges or scope of practice that include use of the medications listed above in Section 3.g. may be transferred to Level 3 status under this directive. All other current holders of OOORAM privileges, scope of practice or functional statement may be transferred to Level 2 status

under this directive. This directive does not start a new reassessment cycle. All OOORAM providers will need to be reassessed according to their existing cycle.

(2) Facilities have enough individuals deemed competent in airway management per the requirements of this directive to respond to respiratory compromise events, including cardiopulmonary arrest, during all hours when patient care is provided.

(3) Facilities have portable VLs that are always immediately available for use by Level 2 and Level 3 OOORAM providers for OOORAM.

(4) Facilities require the use of a device that detects carbon dioxide in concert with auscultation to confirm ventilation in all circumstances when an endotracheal tube or alternative airway device is inserted (LMA, King tube™, Combitube™, etc.). Portable quantitative waveform capnography is strongly recommended. The use of carbon dioxide detection to confirm ventilation does not preclude other aspects of appropriate care, such as the use of X-ray imaging to verify the position of the tip of the endotracheal tube.

(5) Facilities address the process for engaging the next level of airway management expertise when required, as well as a process for managing the known or emergently identified difficult airway (an example may be found at the NCPS Web site at http://vaww.ncps.med.va.gov/ in the Guidelines and Directives section). ***NOTE:*** *This is an internal VA Web site not that is not available to the public*.

(6) The CPRS-based National Difficult Airway Template is used if a Level 3 provider has determined that a patient's airway is "difficult" to intubate. The National Difficult Airway Template will appear in the patient's posting and problem list for future rapid identification.

(7) Airway management provided by an anesthesia provider as part of a procedural or surgical intervention within the Operating Room or procedural setting is excluded from this directive. However, when an anesthesia provider encounters a difficult airway the anesthesia provider must comply with Section 6 regarding disclosing the issue to the patient and documenting this information within the National Difficult Airway Template.

(8) Facilities include a statement that in extraordinary circumstances, where an individual with the demonstrated competency in airway management per the requirements of this directive is not available, clinicians, including clinical trainees, may exercise their judgment as to the appropriate response with the overarching goal being the care and safety of the patient. If this situation should occur, the facility Chief of Staff (COS), or designee, must conduct a Root Cause Analysis (RCA) as outlined in VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, dated March 4, 2011, or subsequent policy, to why this vulnerability existed and initiate appropriate system fixes to minimize a repeat occurrence.

e. **Chief of Staff.** The Chief of Staff (COS) is responsible for developing the process for assessing and establishing competency for clinicians performing OOORAM as

defined in Section 6 to include the cognitive skills and procedural skills in Section 6. The COS may delegate this to a subject matter expert (SME). The Chief of Anesthesia or equivalent would be the preferred SME. The SME must be a provider who performs airway management on a regular basis.

f. **Service Line Leaders.** Service Line leaders are responsible for:

(1) Ensuring new Level 2 and 3 airway management providers have a period of Focused Professional Practice Evaluation (FPPE), or equivalent, specific to airway management.

(2) Recommending, but not requiring, that experienced airway management providers enhance their airway skills by completing:

(a) The Talent Management System (TMS)-based simulation course titled, Out of Operating Room Airway Management Provider Part II. This training includes six scenarios to simulate real airway challenges.

(b) The Difficult Airway Algorithm and Rescue Cricothyrotomy (DAARC) training. Available on the VA Talent Management System (TMS) web site, https://www.tms.va.gov/SecureAuth35/, (search for TMS course VA #33651), or VHA TRAIN, https://www.train.org/vha/welcome (search for VHA TRAIN course #1071302). The introductory materials in TMS and VHA TRAIN provide the necessary instruction on running the product on Internet Explorer 11 (requires OI&T support in downloading the Unity Web Player to run). The product is also available as an application listed in the VA APP Catalog on a VA iPhone or iPad and in the Apple Store as VHA Difficult Airway.

6. AIRWAY MANAGEMENT COMPETENCY ASSESSMENT

NOTE: The time and practice necessary for an individual to attain procedural competency can be highly variable. It is the responsibility of the designated SME to ensure the individual has done enough training on simulators and, when required, on patients to ensure competence before certifying the individual.

a. If there is no provider at the VA medical facility who is appropriately qualified to conduct the assessments, the COS must:

(1) Partner with another VA facility to oversee the competency assessments and training of staff; or

(2) Rely upon another local or co-located facility (such as an academic affiliate) to oversee the competency assessments and training of staff. If relying on a non-VA facility, the VA must use the same process and require the same documentation as outlined in Section 6.e below.

b. VL equipment is required to be immediately available on a 24-hour-a-day, 7-days-a-week (24/7) basis in all facilities that utilize Level 2 or above OOORAM in-house coverage.

c. **Requirements for Privileging, Scope of Practice or Functional Statement.**

(1) Individuals seeking Level 1 and Level 2 OOORAM status must obtain a passing score on VA's TMS "Out of Operating Room Airway Management - Didactic Exam" test out option (currently TMS Course 19361) or the test at the end of "Out of Operating Room Airway Management Provider Didactic" (currently TMS Course 16087). The passing score (established by TMS) must have been obtained no more than 90 days before the privileging, scope of practice or functional statement action. A verified TMS exam successfully completed at a prior VA is acceptable if it is within the 90-day requirement. A successfully completed exam from an academic affiliate or community hospital is acceptable if the evaluating SME has reviewed the outside exam/training to ensure it covered comparable material to the TMS exam. The SME must document this review and determination and retain said documentation.

(2) For individuals seeking Level 1 OOORAM competence, procedural skills must be demonstrated:

(a) On airway task trainers or patient simulators:

1. Ventilating using a bag and mask;

2. Insertion of an oral or nasopharyngeal airway; and

3. Insertion of an LMA or other equivalent supraglottic airway device.

(b) Procedural skills demonstrated on a patient are not required for Level 1.

(c) Demonstrated knowledge of the local process to obtain a higher level of airway expertise (VA Level 2 or 3 provider or 911 EMS).

(3) For individuals seeking Level 2 OOORAM competence, procedural skills must be demonstrated:

(a) The Level 1 skills described above in 6.c(1)-(2).

(b) Endotracheal intubation(s) utilizing VL on airway task trainers or patient simulators.

(c) Procedural skills demonstrated on a patient:

1. Ventilating using a bag and mask;

2. Insertion of an oral or nasopharyngeal airway; and

3. Endotracheal intubation(s) utilizing VL.

NOTE: *Requirements found in sections 6.c(3)(c)1.-3. may be met with the same patient and at the same time.*

(4) For individuals seeking Level 3 OOORAM competence:

(a) Privileges or scope of practice to use medications, such as muscle relaxants (paralytics), to manage a patient undergoing sedation deeper than Moderate Sedation as well as expertise in using DL and VL to secure the airway.

(b) Significant airway management training as a part of their education and clinical training (examples include, but are not limited to, Anesthesiologists, Certified Registered Nurse Anesthetists (CRNA), board certified/eligible Emergency Medicine physicians, and Accreditation Council for Graduate Medical Education (ACGME) Fellowship trained Pulmonary Disease and Critical Care Medicine physicians). For those with this education and clinical training, evaluation for privileges or scope of practice will be done locally using normal facility credentialing/privileging Medical Staff Office processes. Advanced Cardiac Life Support (ACLS) certification, alone, does not fulfill this requirement.

(5) An alternative process for determining initial Level 2 or Level 3 OOORAM competence may be established through utilization of the form linked in Appendix A in addition to the SME's review of supplemental documentation to be provided by an outside agency to support the recommendation made in the Appendix A form. This alternative process may be used for new employees, transfers, consultants, fee basis, without compensation (WOC) clinicians, or locum tenens. The Appendix A form is required for transfers from another VA and is the recommended form for all others with significant airway experience obtained outside of the currently stationed VA. It is incumbent on the VA SME evaluator to ensure the outside training and skills demonstration was the equivalent of the training and skills demonstration required by this directive.

d. **Requirements for Reappraisal/Reassessment of Privileges, Scope of Practice or Functional Statement.**

Continued competency must be demonstrated at the time of reappraisal of privileges or reappraisal of a scope of practice or functional statement. Continued competency must include the demonstration of airway management skill over the prior time period as well as current cognitive understanding of airway management and intubation requirements. Successful continued competency over time may be documented in the Ongoing Professional Practice Evaluation (OPPE) or annual competency assessment with subsequent reprivileging or updating of a scope of practice or functional statement in accordance with local policy. If the Focused Professional Practice Evaluation (FPPE)/OPPE/competency assessment review does not demonstrate ongoing successful airway practice, then the individual must be considered a new applicant for airway management privileges, scope of practice or functional statement and go through the process defined above for the specific level of airway management sought.

NOTE: *When the continued OOORAM competency can be demonstrated by airway management care done at a non-VA facility, the Appendix A form may be used in the reappraisal/reassessment process. It is incumbent on the VA SME evaluator to ensure*

that the ongoing outside OOORAM care at the non-VA facility was the equivalent of this directive's requirements for reappraisal/reassessment.

e. Only Level 3 OOORAM providers will determine if a patient has a difficult airway and will be responsible for completing the National Difficult Airway Template when the designation of "difficult to intubate" has been determined. After completing the National Difficult Airway Template the provider will print a copy of the note and give it to the patient. The National Difficult Airway Template is available via the Clinical Reminders Web site: http://vista.med.va.gov/reminders/Reminders.html. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

f. Residents (including fellows) and other clinical trainees may perform OOORAM if:

(1) Prior to engaging in any OOORAM patient care, the ACGME Program Directors (or other clinical trainee Program Directors) must require Residents and other clinical trainees to take the TMS-based OOORAM training, "Out of Operating Room Airway Management Provider Didactic" (currently TMS Course 16087) or equivalent training done at an academic affiliate and to perform simulation/airway task trainer-based skills assessment prior to engaging in any VA OOORAM patient care.

(2) After adequate expertise has been gained in a controlled and directly supervised atmosphere the ACGME Program Director (or clinical trainee equivalent Program Director) for a Resident or other clinical trainee may determine that VHA Handbook 1400.01, Resident Supervision, dated December 19, 2012, or subsequent policy, concepts of Graduated Levels of Responsibility (progressive responsibility) are appropriate for the specific Resident/clinical trainee. The ACGME Program Director or clinical trainee equivalent Program Director must document in the individual's training record that this determination for progressive responsibility supervision has been made and provide documentation to the VA facility SME. The form located at the link in Appendix A is encouraged to be utilized. The designated supervisor for a trainee conducting airway management must be a Level 3 OOORAM provider.

(3) Alternatively, when the Resident or fellow has not reached the level of expertise in OOORAM as documented by the ACGME Program Director, OOORAM care will be performed under the direct supervision and control of a Level 3 certified OOORAM supervisor who is physically present at the bedside when the Resident or clinical trainee is providing OOORAM care. The Level 3 provider is ultimately responsible for the management of the patient's airway.

g. The facility OOORAM SME, designee, Code committee or equivalent must review all airway management notes and associated morbidity/mortality/complications with aggregated documentation at the individual level. The aggregated documentation review must be done no less frequently than quarterly.

h. FPPE, OPPE or non-privileged competency assessment will be done as per local policy. The evaluation will be specific to airway management skills and the evaluator

must have the same or higher level of airway competence as the person being evaluated.

7. REFERENCES

a. VHA Handbook 1006.02, VHA Site Classifications and Definitions, dated December 30, 2013, or subsequent policy.

b. VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, dated March 4, 2011, or subsequent policy.

c. VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012, or subsequent policy.

d. VHA Handbook 1400.01, Resident Supervision, dated December 19, 2012, or subsequent policy.

e. American College of Emergency Physicians, Policy #400307, Verification of Endotracheal Tube Placement, Approved April 2009. https://www.acep.org/patient-care/policy-statements/verification-of-endotracheal-tube-placement.

f. American Heart Association, "2015 American Heart Association Guidelines Update for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care," Part 7, Adult Advanced Cardiovascular Life Support, 2015.

g. American Society of Anesthesiologists, "Practice Guidelines for Management of the Difficult Airway: An Updated Report by the American Society of Anesthesiologists Task Force on Management of the Difficult Airway," Anesthesiology. 118:251-270, February 2013. http://anesthesiology.pubs.asahq.org/article.aspx?articleid=1918684.

h. Bishop M. J., Michalowski P., et al. "Recertification of Respiratory Therapists' Intubation Skills One Year After Initial Training: An Analysis of Skill Retention and Retraining," Respiratory Care. 46(3): 234-237, 2001.

i. National Center for Patient Safety Web site Guidance and Directives http://vaww.ncps.med.va.gov. ***NOTE:*** *This is an internal VA Web site that is not available to the public*.

APPENDIX A

DEPARTMENT OF VETERANS AFFAIRS (VA) FORM 10-0544, PRIVILEGE AND COMPETENCY VERIFICATION

VHA Form 10-0544, Privilege and Competency Verification is available at http://vaww.va.gov/vaforms/medical/pdf/vha-10-0544-fill.pdf. ***NOTE:*** *This is an internal VA Web site that is not available to the public*.