NON-OPERATING ROOM AIRWAY MANAGEMENT

1. SUMMARY OF MAJOR CHANGES: This directive:

a. **Amendment dated July 3, 2024:**

(1) Updates the implementation schedule, paragraph 6 of the Transmittal Sheet and paragraph 6.a of Appendix B.

(2) Updates the training required, see paragraph 4.

b. **As published:**

(1) Updates the directive title from "Out of Operating Room Airway Management" to "Non-Operating Room Airway Management" to distinguish the language and requirements of this Veterans Health Administration (VHA) directive from other training program requirements of the same name and title which do not fall under the purview of this document.

(2) Delineates the roles of emergency medical technicians and paramedics in the provision of airway management within the Department of Veterans Affairs (VA) system when required to transport a patient to an outside facility with a higher level of care or while in the out of hospital setting. ***NOTE:*** *An outside facility refers to a facility not currently caring for the patient.* See paragraph 2.

(3) Adds responsibilities in paragraph 2 for Assistant Under Secretary for Health for Patient Care Services; Chief Officer, VHA Specialty Care Program Office; National Program Executive Director, National Anesthesia Program; VA medical facility Chief of Staff; Associate Director for Patient Care Services; and Patient Safety Manager.

(4) Adds Health Professions Trainee (HPT) definition in paragraph 7.

(5) Adds Appendix A, introducing training and competency requirements for emergency medical technicians and paramedics; relocates information on clinical staff and HPT airway management to Appendix B.

2. RELATED ISSUES: VHA Directive 1101.14, Emergency Medicine, dated March 20, 2023; VHA Directive 1123, National Anesthesia Program, dated April 2, 2024; VHA Directive 1177, Cardiopulmonary Resuscitation, dated January 4, 2021; VHA Directive 1220(1), Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting, dated May 13, 2019.

3. POLICY OWNER: The Specialty Care Program Office (11SPEC) is responsible for the content of this directive. Questions may be referred to the National Director of Anesthesia at VHANAS@med.va.gov.

4. RESCISSIONS: VHA Directive 1157(1), Out of Operating Room Airway Management, dated June 14, 2018, is rescinded.

5. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of May 2029. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

6. IMPLEMENTATION SCHEDULE: VA medical facilities have 12 months from the date of publication to ensure compliance with this directive.

BY DIRECTION OF THE OFFICE OF THE UNDER SECRETARY FOR HEALTH:

/s/ Erica Scavella, M.D., FACP, FACHE
Assistant Under Secretary for Health
for Clinical Services/CMO

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

DISTRIBUTION: Emailed to the VHA Publications Distribution List on May 8, 2024.

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NON-OPERATING ROOM AIRWAY MANAGEMENT

NON-OPERATING ROOM AIRWAY MANAGEMENT

1. POLICY

It is Veterans Health Administration (VHA) policy that each Department of Veterans Affairs (VA) medical facility ensures the competency of staff performing non-operating room airway management (NORAM) when responding to respiratory compromising events, including cardiopulmonary arrest. NORAM coverage must be available during all hours when inpatient care or sedation and recovery services are provided (moderate sedation, deep sedation or anesthesia and the associated recovery periods), based on the VA medical facility's site classification. ***NOTE:*** *For further information on site classification, see VHA Handbook 1006.02, VHA Site Classifications and Definitions, dated December 30, 2013. See VHA Directive 1220(1), Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting, dated May 13, 2019, regarding invasive procedures and VA medical facility complexity.* **AUTHORITY:** 38 U.S.C. § 7301(b).

2. RESPONSIBILITIES

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

b. **Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer.** The Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer is responsible for:

(1) Supporting the Specialty Care Program Office with implementation and oversight of this directive, including assisting the Executive Director, National Anesthesia Program (NAP) as needed to address non-compliance.

(2) Ensuring the various Integrated Clinical Communities, where moderate sedation is used, have sufficient resources to implement this directive.

c. **Assistant Under Secretary for Health for Patient Care Services.** The Assistant Under Secretary for Health for Patient Care Services is responsible for supporting the program offices within Patient Care Services and collaborating with the Assistant Under Secretary for Health for Clinical Services to support implementation of this directive.

d. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

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

(2) Assisting VISN Directors to resolve implementation and compliance challenges in all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to assure compliance with this directive and its effectiveness.

e. **Chief Officer, Specialty Care Program Office.** The Chief Officer, Specialty Care Program Office is responsible for supporting the National Program Executive Director (NPED), NAP in executing their responsibilities as outlined in this directive.

f. **National Program Executive Director, National Anesthesia Program.** The NPED, NAP is responsible for:

(1) Ensuring compliance and implementation of this directive through appropriate monitoring activities and providing information to VHA leadership including the Assistant Under Secretary for Health for Clinical Services when assistance is needed with compliance.

(2) Developing and approving a uniform training module for NORAM. The uniform training module is available at the VA Talent Management System (TMS) website: https://www.tms.va.gov/SecureAuth35/. See paragraph 3 and Appendix B for additional training information.

(3) Providing guidance to VISNs and VA medical facilities regarding overall conduct of airway management.

g. **Veterans Integrated Service Network Director.** Each VISN Director is responsible for:

(1) Ensuring that all VA medical facilities within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

(2) Ensuring all VA medical facilities within the VISN provide NORAM coverage based upon VHA Directive 1220(1). See paragraph 3.

h. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring overall VA medical facility compliance with this directive and appropriate corrective action is taken if issues with compliance are identified.

(2) Ensuring VA medical facilities have sufficient staff and resources, including:

(a) Determining the number of all Levels of NORAM Providers necessary to adequately respond to respiratory compromise events, including cardiopulmonary arrest, during all hours of patient care as delineated in paragraph 3.a.

(b) Ensuring that a sufficient number of portable video laryngoscopes are always immediately available for use by Level 2 and 3 NORAM Providers.

(c) Ensuring that enough supraglottic airway devices are always immediately available for use by Level 1 NORAM Providers.

(d) Ensuring that 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 (e.g., laryngeal mask airway or other similar supraglottic device) is always available. ***NOTE:*** *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.*

(3) Ensuring implementation of a VA medical facility process for engaging the next level of airway management expertise when required.

(4) Ensuring that a process is in place for managing the known or emergently identified difficult airway. See paragraph 6.c. for additional information.

(5) Ensuring the electronic health record (EHR) based National Difficult Airway Template is used if a Level 3 NORAM Provider has determined that a patient's airway is "difficult" to intubate. The National Difficult Airway Template appears in the patient's posting and problem list for future rapid identification. ***NOTE:*** *When encountering a difficult airway, both anesthesia and non-anesthesia providers must also comply with the requirements in Appendix B, paragraph 5 regarding disclosure to the patient and documentation of this information within the National Difficult Airway Template. See paragraph 6.b. for additional information. Routine airway management provided by an anesthesia provider (see VHA Directive 1123, National Anesthesia Program, dated May 2, 2024) as part of a procedural or surgical intervention within the operating room or procedural setting is beyond the scope of this directive.*

(6) Ensuring that VA medical facilities in extraordinary circumstances, where an individual with the demonstrated competency in airway management in accordance with the requirements of this directive is not available, clinicians (including Health Professions Trainees (HPTs)) can exercise clinical judgment based on education and training to determine an appropriate response, with the overarching goal being the care and safety of the patient.

i. **VA Medical Facility Chief of Staff and Associate Director for Patient Care Services.** The VA medical facility COS and Associate Director for Patient Care Services are responsible for:

(1) Developing the process for assessing and establishing competency for clinicians performing NORAM as defined in paragraph 4. The VA medical facility COS may delegate this to a subject matter expert (SME). ***NOTE:*** *The Chief of Anesthesia, Chief Certified Registered Nurse Anesthetist or equivalent is the preferred SME. The SME must be a provider who performs airway management on a regular basis.*

(2) Ensuring the VA medical facility, under circumstances where there is no provider at the VA medical facility who is appropriately qualified to conduct NORAM competency assessments, either:

(a) Partners with another VA medical facility to oversee the competency assessments and training of local staff; or

(b) Relies upon a co-located non-VA medical facility to oversee the NORAM competency assessments and train local staff, provided that the non-VA medical facility utilizes a similar process and requires documentation as outlined in Appendix B.

(3) If a local NORAM is employed, ensuring that the VA medical facility establishes airway management event quality metrics and has a process for tracking and reviewing these metrics with aggregated morbidity and mortality outcome data that is reported at least quarterly to an executive level committee, such as the Medical Executive Board.

j. **Medical Director, Emergency Ambulance Services.** The Medical Director, Emergency Ambulance Services (EAS) is responsible for:

(1) Ensuring VA EMTs and paramedics are compliant with the requirements of Appendix B.

(2) Ensuring implementation of protocols for airway management by EAS personnel whose provider type is deemed necessary by the VA medical facility Director.

(3) Approving individual VA paramedics to administer medications for the purpose of airway management in accordance with Appendix B.

(4) Reviewing all attempted supraglottic airway insertions and intubations by EAS EMTs or paramedics to ensure the standard of care is met. ***NOTE:*** *See VHA Directive 1695(1), Veterans Transportation Services, dated September 18, 2019, for more information about the role of the Medical Director, EAS to oversee the care provided by Emergency Medical Technicians and Paramedics.*

k. **Service Line Leaders.** ***NOTE:*** *Service Line Leaders are also referred to as Service Chiefs*. Service Line Leaders are responsible for:

(1) Ensuring NORAM Level 2 Providers and NORAM Level 3 Providers have a period of Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation or Competency, specific to airway management.

(2) Ensuring testing and training requirements are in place for prospective NORAM providers based on the VA medical facility needs' assessment.

(3) Ensuring that end-tidal capnography detectors are utilized for every airway management event and that usage is appropriately documented.

l. **Patient Safety Manager.** The Patient Safety Manager is responsible for reviewing and taking appropriate action for NORAM vulnerabilities entered by the clinical staff into the Joint Patient Safety Reporting (JPSR) system and initiating appropriate system modifications to minimize a repeat occurrence.

m. **Level 3 Non-Operating Room Airway Management Providers.** Level 3 NORAM Providers are responsible for clear documentation in the EHR National Difficult Airway Template when substantial difficulty or the inability to manage a patient's airway is encountered in accordance with Appendix B. ***NOTE:*** *See paragraph 2 in Appendix B for descriptions of NORAM Provider levels.*

3. FACILITY PROCEDURE COMPLEXITY DESIGNATION FOR NORAM PROVIDERS

a. VA medical facilities must have a plan for all relevant clinical sites that identifies a safe and efficient process for patients who require urgent or emergent airway management, including support for surgical and invasive procedures. For surgical and invasive procedures performed on an outpatient (same day) basis, practitioners must select appropriate patients in relationship to the services provided at the VA medical facility and the distance and timeliness of back-up services, as outlined in VHA Directive 1220(1).

b. For VA medical facilities with a facility procedure complexity designation of Outpatient Basic, there are no minimum NORAM provider requirements. Emergency services can be provided by activating community EMS, 911.

c. For VA medical facilities with complexity designation of Outpatient Intermediate and Ambulatory Procedure Center (APC) Basic, there must be an adequate number of Level 1 NORAM Providers, as determined by the VA medical facility Director, available during all hours when sedation and recovery care is provided. In addition to the on-site Level 1 NORAM Providers, the facility must have an established back-up plan which must include either:

(1) A plan to call in VA NORAM providers trained to at least Level 2 but preferably Level 3 care if needed, or

(2) Arrangements to ensure immediate request of 911 EMS response system for airway care that is at least Level 2 NORAM.

(3) For VA medical facility designation Inpatient Standard or higher, or when deep sedation, anesthesia, or phase 1 recovery is utilized, VA medical facilities must have:

(a) An adequate number of Level 2 NORAM Providers available to provide care during all hours when patient care is provided and a plan to call in Level 3 NORAM Providers if airway management beyond their level of expertise is identified or anticipated, or

(b) Level 3 NORAM Providers on-site at the VA medical facility during all hours in which patient care is provided.

(c) Inpatient VA medical facilities that do not have a Code Team and do not have an emergency department must provide airway services using one of the established back-up plans outlined in paragraph 3.c.(1) and (2).

4. TRAINING

The following is ***required*** TMS didactic training:

a. For clinical staff seeking Level 1 or Level 2 NORAM Provider certification:

(1) Test-Out Non-Operating Room Airway Management (NORAM): VA 131011471; or

(2) Non-Operating Room Airway Management (NORAM) in the Emergent Setting: 131008717.

b. For HPTs performing NORAM:

(1) HPTs may not be routinely assigned required training beyond the Mandatory Training for Trainees course *VHA Directive 1052, Appropriate and Effective Use of VHA Employee Mandatory and Required Training, dated June 29, 2018.*

(2) For HPTs deemed competent to provide NORAM by their Program Director (PD), no further training is required. (See Appendix B, paragraph 6.b. for attestation of competency form for HPTs.)

(3) Affiliate sponsored HPTs deemed not competent to provide NORAM by their PD must complete the NORAM training requirements at a VA academic affiliate. After successful completion, their PD verifies their competency and completes an annual competency verification form for HPTs, located at https://vaww.va.gov/anesthesia/. ***NOTE:*** *This is an internal VA website that is not available to the public*.

5. RECORDS MANAGEMENT

All records regardless of format (for example, paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management can be addressed to the appropriate Records Officer.

6. BACKGROUND

a. Airway management is often required outside of the operating or procedural room environment. 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 a job title. Specific training and procedural skills are required to meet the NORAM requirements for a 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 an alternative airway device is inserted (i.e., laryngeal mask airway or other supraglottic airway). Continuous waveform capnography is preferred.

c. For some patients, airway management, including insertion of an endotracheal tube, may be difficult due to confounding patient comorbidities. The use of a standardized critical path analysis tool is recommended to help determine when and how additional expertise will be consulted and deployed.

d. The required EHR National Difficult Airway Template standardizes documentation required by Level 3 NORAM Providers that have identified a difficult to intubate airway and must create a clinical warning titled “difficult airway” with a note that may be shared with the patient. The utilization of such documentation can ameliorate future problems by allowing the health care team to adequately plan for future elective or emergent airway management needs.

7. DEFINITIONS

a. **Electronic Health Record.** EHR is the digital collection of patient health information resulting from clinical patient care, medical testing and other care-related activities. Authorized VA health care providers may access EHR to facilitate and document medical care. EHR comprises existing and forthcoming VA software including Computerized Patient Record System (CPRS), Veterans Information Systems and Technology Architecture (VistA) and Cerner platforms. ***NOTE:*** *The purpose of this definition is to adopt a short, general term (EHR) to use in VHA national policy in place of software-specific terms while VA transitions platforms.*

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

c. **General Anesthesia.** 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. **Health Professions Trainee.** An HPT is an individual appointed under 38 U.S.C. §§ 7405 and 7406 who participates in clinical or research training under supervision of their PD to meet program or degree requirements. HPT is a general term to describe a student (undergraduate, graduate, or post-graduate), intern, resident, chief resident, fellow, VA advanced fellow, or pre- or post-doctoral fellow. HPTs can be in a non-clinical, patient care, patient records reviewer, or a data entry training field.

e. **Inpatient Standard.** Inpatient standard invasive procedures are typically performed on a same day basis and require an ICU with the ability to provide hemodynamic monitoring and respiratory support of the patient delayed in recovering

from general anesthesia; pharmacy and blood bank during weekday duty hours; an ED; and a physician call schedule to support the invasive services provided. Examples of inpatient standard invasive procedures are amputation lower extremity, appendectomy, tonsillectomy, cholecystectomy and cardiac pacemaker insertion.

f. **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 usually adequate. Cardiovascular function is usually maintained.

g. **Outpatient Basic.** Outpatient Basic procedures are performed at the bedside or in the clinic or other ambulatory setting. A procedure room is not required. Outpatient Basic procedures can be performed with minimal sedation and/or application of local anesthetics. Examples: arthrocentesis, acupuncture, paracentesis, thoracentesis, laryngoscopy, cystoscopy and cryotherapy for dermatologic purposes.

h. **Outpatient Intermediate.** Outpatient intermediate procedures involve the administration of moderate/conscious sedation but do not require on-site anesthesia support. Examples: colonoscopy, bronchoscopy and upper endoscopy.

i. **Supraglottic Airway**. The supraglottic airway is a group of airway devices that can be inserted into the pharynx to allow ventilation, oxygenation and administration of volatile anesthetic agents if necessary, without the need for endotracheal intubation. Second generation supraglottic airways are defined as those with specific design features intended to reduce the risk of aspiration, either by venting of regurgitant material via a built-in a gastric channel, or by obturating the esophagus so that the tip of the Supraglottic Airway cuff with its position below the laryngeal inlet and just above or inside the upper esophageal sphincter which will occlude the esophagus and prevent regurgitant material from entering the hypopharynx.

j. **Urgent Airway Management.** Urgent airway management is the management of the airway in a patient status is deteriorating and in need of support and eventual intervention (e.g., in need of airway assistance and/or eventual intubation or anticipated respiratory distress).

8. REFERENCES

a. 38 U.S.C. §§ 7301(b), 7405, and 7406.

b. VHA Directive 0320(1), VHA Comprehensive Emergency Management Program, dated July 6, 2020.

c. VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, dated March 24, 2023.

d. VHA Directive 1052, Appropriate and Effective Use of VHA Employee Mandatory and Required Training, dated June 29, 2018.

e. VHA Directive 1073(1), Moderate Sedation by Non-Anesthesia Providers, dated December 20, 2022.

f. VHA Directive 1123, National Anesthesia Program, dated April 2, 2024.

g. VHA Directive 1220(1), Facility Procedure Complexity Designation Requirements to Perform Invasive Procedures in Any Clinical Setting, dated May 13, 2019.

h. VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019.

i. VHA Directive 1695(1), Veterans Transportation Services, dated September 18, 2019.

j. VHA Handbook 1006.02, VHA Site Classifications and Definitions, dated December 30, 2013.

k. VHA Handbook 1400.04(1), Supervision of Associated Health Trainees, dated March 19, 2015.

l. VHA Form 10-0544, Privilege and Competency Verification, https://vaww.va.gov/vaforms/. ***NOTE:*** *This is an internal VA website that is not available to the public.*

m. Clinical Reminders Website, National Difficult Airway Template, https://dvagov.sharepoint.com/:w:/r/sites/VHABHHCSDEPT/Surg/_layouts/15/Doc.aspx?sourcedoc=%7B9C1406F5-6E71-42F4-89FC-8D5EF97703EA%7D&file=VA-Difficult%20Airway%20template.docx&action=default&mobileredirect=true&DefaultItemOpen=1. ***NOTE:*** *This is an internal VA website that is not available to the public*.

n. Emergency Medicine SharePoint, https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/SitePages/Out-of-OR-Airway-Management-Directive.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

o. HPT Annual competency Verification. https://vaww.va.gov/anesthesia/. ***NOTE:*** *This is an internal VA website that is not available to the public.*

EMERGENCY AMBULANCE SERVICES AIRWAY MANAGEMENT TRAINING AND COMPETENCY REQUIREMENTS

1. OVERVIEW

This appendix addresses provision of airway management by Department of Veterans Affairs (VA) emergency medical technicians (EMTs) and paramedics, while under the purview of Emergency Ambulance Services (i.e., when called to transport a patient to an outside facility with a higher level of care or while in the out of hospital setting). If the EMT or paramedic is providing airway management within the VA medical facility outside of Emergency Ambulance Services (EAS), the EMT or paramedic must have obtained a Non-Operating Room Airway Management (NORAM) Provider designation in accordance with Appendix B.

2. EMERGENCY AMBULANCE SERVICES EMERGENCY MEDICAL TECHNICIANS AND PARAMEDICS AIRWAY MANAGEMENT REQUIREMENT

The mandatory airway management competency required for EAS EMTs and paramedics can be found on the Emergency Medicine SharePoint at https://dvagov.sharepoint.com/sites/VHAEmergencyMedicine/SitePages/Out-of-OR-Airway-Management-Directive.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

3. EMERGENCY AMBULANCE SERVICES PARAMEDIC MEDICATION ADMINISTRATION FOR AIRWAY MANAGEMENT REQUIREMENTS

a. EAS paramedics must meet the NORAM Level 2 Provider didactic and procedural requirements.

b. Medications for the purposes of intubation must only be administered by a paramedic if:

(1) No State practice restrictions prohibit paramedic administration of medications to facilitate endotracheal intubation.

(2) A NORAM Level 3 Provider is not present when the paramedic encounters a patient with an unstable airway and is unlikely to be available within the timespan that a definitive airway is clinically indicated.

(3) The paramedic has documented competency in use of video laryngoscopy, direct laryngoscopy and medication-facilitated intubation.

(4) Intubation is performed when called upon to transport a patient to an outside facility with a higher level of care or while in the out of hospital setting.

(5) The paramedic is functioning within protocols approved by the Medical Director of EAS and facility clinical executive committee. Facilities may elect to use the sample medication protocol on the Emergency Medicine SharePoint website (Appendix A paragraph 2) to develop local protocols. ***NOTE:*** *Responsibilities pertaining to EAS can be found in paragraph 2.j. in the body of the directive.*

AIRWAY MANAGEMENT TRAINING AND COMPETENCY ASSESSMENT

1. OVERVIEW

The time and practice necessary for clinical staff to attain procedural competency can be highly variable. It is the responsibility of the designated subject matter expert (SME) to ensure the clinical staff has done enough training on simulators and, when required, on patients to ensure competence before certifying the clinical staff.

2. NORAM PROVIDER DESCRIPTIONS

a. A Level 1 Non-Operating Room Airway Management (NORAM) Provider is clinical staff trained 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 a laryngeal mask airway).

b. A Level 2 NORAM Provider is a clinical staff member trained to be competent in Level 1 airway management that has received further training to perform intubation of the trachea using a video laryngoscope (VL). ***NOTE:*** *VL is also known as an indirect laryngoscopy*.

c. A Level 3 NORAM Provider is a clinician trained according to Appendix B paragraph 3.b.and includes Level 1 and 2 airway management skills as well as the ability and training to manage a patient undergoing sedation deeper than the moderate level and must include expertise in direct laryngoscopy (DL) to secure the airway. A Level 3 NORAM Provider must have privileges, a scope of practice or meet the conditions outlined in Appendix B to use sedation, hypnotic, paralytic, reversal and resuscitation medications.

3. REQUIREMENTS FOR REQUESTING INITIAL PRIVILEGE OR SCOPE OF PRACTICE

a. Level 1 and 2 NORAM Providers must meet the defined didactic and procedural competencies.

b. Clinicians seeking Level 3 NORAM competence must possess:

(1) Privileges, scope of practice or nationally approved protocol to use medications, including, but not limited to, anesthetic agents (sedative-hypnotics) and muscle relaxants (paralytics) to manage a patient requiring urgent or emergent airway management as well as expertise in using DL and VL to secure the airway.

(2) 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, board certified and eligible emergency medicine physicians, Accreditation Council for Graduate Medical Education (ACGME) fellowship trained

pulmonary disease and critical care medicine physicians, ortho maxillary facial surgeons, dental anesthesiologists and other providers as designated by the Veterans Affairs (VA) medical facility)). For those with this education and clinical training, evaluation for privileges or scope of practice will be done locally using normal VA medical facility credentialing and privileging medical staff office processes.

(3) Focused Professional Practice Evaluation (FPPE), Ongoing Professional Practice Evaluation (OPPE) or competency specific to the performance of at least two successful airway management events in each privileging or competency period. If unmet, the clinician must be considered a new applicant. As an alternative, the completion of a dedicated difficult airway simulation course can be utilized. ***NOTE*:** Advanced Cardiac Life Support certification does not fulfill NORAM requirements.

4. REQUIREMENTS FOR REAPPRAISAL AND REASSESSMENT OF PRIVILEGES, SCOPE OF PRACTICE OR FUNCTIONAL STATEMENT

a. **Level 1 NORAM.** FPPE and OPPE or competency specific to a current cognitive understanding of airway management. Consider procedural skills refresher.

b. **Level 2 and 3 NORAM.** FPPE and OPPE or competency specific to the successful performance of at least two successful airway management events and a current cognitive understanding of airway management and intubation requirements in each privileging or competency period is required. If the evaluations are unmet, the clinical staff must be considered a new applicant and demonstrate procedural skills appropriate to the NORAM Level Provider.

(1) FPPE, OPPE or non-privileged competency assessment will be done in accordance with local procedures. 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. ***NOTE:*** *When NORAM competency is verified by airway management care done at a non-VA facility, VHA Form 10-0544, Privilege and Competency Verification must be utilized. The form is available at http://vaww.va.gov/vaforms/medical/pdf/vha-10-0544-fill.pdf. This is an internal VA website not available to the public and may be used for the initial or reappraisal and reassessment process.* It is incumbent on the VA subject matter expert evaluator to ensure that the ongoing NORAM ensures the equivalent of this directive's requirements for reappraisal and reassessment.

5. NATIONAL DIFFICULT AIRWAY DOCUMENTATION

When a Level 3 NORAM Provider encounters substantial difficulty or the inability to manage a patient's airway, clear and timely documentation in the Electronic health record-National Difficult Airway Template with resultant creation of the associated clinical warning communicates this information to other health care professionals and can ameliorate future problems by allowing the health care team to adequately plan for future elective or emergent intubation. Only Level 3 NORAM Providers determine if a patient has a difficult airway and are 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. An example of the National Difficult Airway Template note is available at the Clinical Reminders website, https://dvagov.sharepoint.com/:w:/r/sites/VHABHHCSDEPT/Surg/_layouts/15/Doc.aspx?sourcedoc=%7B9C1406F5-6E71-42F4-89FC-8D5EF97703EA%7D&file=VA-Difficult%20Airway%20template.docx&action=default&mobileredirect=true&DefaultItemOpen=1. ***NOTE:*** *This is an internal VA website that is not available to the public.*

6. HEALTH PROFESSIONS TRAINEES

a. Assignment of Health Professions Trainees (HPTs) to NORAM coverage is exclusively at the discretion of the HPTs’ Program Directors (PDs) (either affiliate or VA-based). HPTs assigned NORAM coverage must be supervised according to VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, dated November 7, 2019, or VHA Handbook 1400.04(1), Supervision of Associated Health Professionals, dated March 19, 2015. An anesthesia or a NORAM Level 3 Provider must be immediately available on-site during the HPT’s assigned NORAM coverage and retains ultimate responsibility for patient care. Facilities have 12 months from the date of publication to ensure compliance with HPT coverage.

b. For the HPT who has not reached the level of expertise in NORAM as required by the ACGME PD (or clinical trainee equivalent program director), NORAM care will be performed under the direct supervision of a Level 3 certified NORAM supervisor who is physically present at the patient bedside when the HPT is providing NORAM care. The Level 3 Provider is ultimately responsible for the management of the patient’s airway. Annual competency verification for HPTs is located at https://vaww.va.gov/anesthesia/. ***NOTE:*** *This is an internal VA website that is not available to the public.*