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CP01 Listing of standard abbreviations and definitions for professional documents 2024

Short title: Definitions and abbreviations

1. Purpose

This document is to provide a repository of standard abbreviations and definitions of terms used in ANZCA professional documents.

2. Scope

The terms in this listing are primarily intended to apply to ANZCA professional documents. Use in other areas of college documents is optional but desirable.

Where regulatory authorities provide definitions that are clear and distinct these are deferred to for clarity and to ensure avoidance of any conflict and potential risk.

3. Background

ANZCA has a wide range of professional documents with new ones arising based on needs using the processes found in *CP24 Policy for development and review of professional documents*. A number of these documents contain abbreviations and. definitions of terms that may not be consistent and would benefit from a single point of reference. There is also the emergence of new definitions, or modifications of them, over time that requires resources to track for consistency. This document contains, and replaces, the terms originally included in *Appendix 2 of the ANZCA Document Framework Policy*.

4. Process for update of this document

It is recognised that these terms will require updating as new terms arise or where there is a need for clarification. Hence this document is considered a 'Living document' with the oversight group being the DPAs Policy and the Policy Officer – Professional Documents. Recommendations for inclusion of new terms may come from ANZCA committees or document development groups. The oversight group will update this document as it is considered necessary.

New definitions will be added CP01 following approval of professional documents to pilot. The date will be inserted after most recent definitions.

5. Structure

For ease of access, this document lists terms in two sections in the following glossary:

a. Document Development terms
   - These are terms which relate to professional documents themselves.
   - Acronyms and abbreviations for college use (eg committee names) are not considered in this document and are available from the Policy Unit.

b. Clinical terms
   - These are terms that relate to clinical content and clinically used abbreviations.

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Glossary

Section 1: Document development terms

Corporate documents: Sometimes referred to within the college as business records, contain information relevant to the operation of the college as a corporation.

Digital records: Refers to any records stored in computers or other digital storage devices irrespective of whether they were generated manually, electronically, or by imaging.

Document: A piece of written, printed, or electronic matter that provides information or evidence or that serves as an official record.

Document custodians: Individuals within a role who are responsible for preparing and managing the creation, review process, and withdrawal of any document. The custodian is responsible for ensuring that documents have been authorised by the designated body of the college or its delegate. Document custodians are formally accountable to the document owner.

Document management: Describes the processes involved with creating, developing, reviewing, indexing, retrieving, depositing, storing and disposing (withdrawal) of college documents.

Document owners: The body or role that has the ultimate legal or regulatory responsibility for a document. Examples of document owners are ANZCA Council, FPM Board, the CEO or their delegates.

Governance documents: Corporate documents that relate to the "framework of rules, relationships, systems and processes within which authority is exercised and controlled"5 within the college.

Guidelines: Advice on a particular subject, ideally based on best practice recommendations and information, available evidence and/or expert consensus.6 Guidelines are not prescriptive. Note that, in contrast to policies, guidelines use "should" (advises) and avoid "must" (mandates).

These documents may be developed by the college or may be developed by external bodies. Externally developed guidelines satisfying the process defined in *CP25(G) Policy on Endorsement of Externally Developed Guidelines* may be **endorsed** by the college.

Where the college may not have been invited to endorse a guideline, or did not have representation in its development, or where the final document was promulgated with some opinions that did not entirely align with the college's position, the college may decide to **support** the guideline.

Policies: Documents that formally state principle, plan and/or course of action that is prescriptive and mandatory. These documents are generally (although not exclusively) produced by the college for internal use but may also be accessed by external stakeholders.

Position statements: Authoritative statements that describe where the college stands on a particular issue. This may include areas that lack clarity or where opinions vary. Position statements are not prescriptive.

These documents may be developed solely by the college or may be developed with other organisations (in which case they are "Joint statements").

Professional documents: Documents that contain information relevant to the clinical, administrative and ethical practice of anaesthesia and/or pain medicine. Professional documents may be developed as either a policy, position statement, or guideline.

Standards: Documents that define levels of quality or achievement against which activities or behaviours can be measured.

Stakeholders:

> **External stakeholder:** Any person(s), group or institution that is not internal to the college. Examples include the community (including community representatives), the Australian Society of Anaesthetists (ASA) and the New Zealand Society of Anaesthetists (NZSA), noting individual members may also be internal stakeholders as ANZCA fellows and trainees, as well as healthcare facilities, jurisdictions, regulatory bodies, training sites, universities and other colleges.
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> **Internal stakeholders:** May include college staff, fellows, trainees, specialist international medical graduates (SIMGs), regional/national committees, specialist interest groups (noting these may also have individual external stakeholder members of the ASA, the NZSA or others).

Statements: See "Position statements"

Section 2: Clinical terms

Adult: For clinical purposes, a person who is aged over 16 years (ie from their 17th birthday onwards). This varies between institutions and jurisdictions.

Airway lead: A role to facilitate an administrative process to assist various aspects of airway management within individual local departments.

Anaesthesia: Includes general anaesthesia, sedation, and regional analgesia/anaesthesia.

> **General anaesthesia:** A drug-induced state of unconsciousness characterised by absence of purposeful response to any stimulus, loss of protective airway reflexes, depression of respiration and disturbance of circulatory reflexes.

> **Regional anaesthesia:** Refers to administration of local anaesthetic agent(s) in order to render a select region of the body insensate without inducing unconsciousness.

Anaesthetist: A registered medical practitioner who provides anaesthesia services working within their scope of clinical practice. This includes vocationally registered anaesthetists in New Zealand, SIMGs supported by ANZCA, specialists in training, and non-specialists including FANZCA trainees, and general practitioner anaesthetists.

> **Specialist anaesthetist:** A protected title that refers to practitioners who are registered as specialists in anaesthesia with the Medical Board of Australia (MBA) or in the vocational register (anaesthesia) of the Medical Council of New Zealand (MCNZ).

Asepsis: The prevention of microbial contamination of living tissues or sterile materials.

Behavioural disturbance: Defined as the combination of observed bodily and verbal actions made by an individual that are in excess of those considered contextually appropriate and are judged to have the potential to result in significant harm to the individual themselves, other individuals or property. Acute behavioural disturbance is characterised by a rapid onset and severe intensity. The aetiology is commonly a mental disorder, physical illness or intoxication with alcohol and/or other substances. Often the behaviour is considered not to be under the voluntary or legally competent control of the individual.

Clinical support time: The time spent performing duties or fulfilling roles (other than the provision of direct individual patient care) aimed at improving quality of patient care and ensuring compliance with training requirements

Clinical time: The time spent in the direct provision of patient care.

Consultation: A meeting with an expert or professional person to get advice or to discuss a problem, especially a meeting with a doctor.

Credentialling: The formal process used to verify the qualifications, experience and professional standing of practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.

Cultural competence: The ability to ensure that the clinical environment is inclusive of the cultural needs of the patient and their family/support network. Cultural competence also involves doctors navigating the health system for patients to ensure they receive the best clinical care.

Day-stay procedure: Any procedure following which it is expected that the patient will be discharged on the same day as, or within 24 hours of, its performance. Day-stay procedure encompasses terms such as “day surgery”, “day-stay surgery”, “day-care surgery”, “ambulatory surgery”, “same-day discharge”, as well as procedures performed on an outpatient basis.

Disinfection: The inactivation of non-sporing organisms using either thermal or chemical means.

Education: The process of facilitating learning and building a body of knowledge related to the specialty.

Fatigue: A sensation of weariness from bodily or mental exertion.

Healthcare facility: Refers to hospitals, clinics and office-based facilities where patients receive medical treatment or procedures are performed under anaesthesia (as defined above). The delivery of anaesthesia services at such facilities must comply with the regulatory licensing authority standards.

Paediatric patient: Includes the neonate, infant, child and adolescent.

> **Premature infant:** A child born before 37 weeks gestation.

Neonate: Child aged up to and including 28 days (for ex-premature babies, use expected date of delivery plus 28 days).

Infant: Child aged one to 12 months (inclusive).

Post-menstrual age: The gestational age plus post-natal age in weeks.

Adolescent: a person between the ages of 10 and 19 (WHO definition). For clinical anaesthesia purposes the upper age limit often used is from 10 years up to the date of the 17th birthday

Post-anaesthesia care units (PACU): may also be referred to as recovery units. They may be further classified into “first stage” recovery units where initial higher acuity care is provided and “second stage” recovery areas provided for observation of ambulant patients prior to discharge from the healthcare facility.

Post-anaesthesia nurse: The specialty or practice of nursing in the care of patients in PACU following surgery and/or anaesthesia. The requirements to be able to practice in this area is defined by the Australian College of Perianaesthesia Nurses in Australia and New Zealand Nurses Organisation in New Zealand.

Pre-anaesthesia consultation: A meeting with an anaesthetist for the purposes of discussion and advice prior to anaesthesia. This is to be distinguished from pre-anaesthesia assessment, elements of which may be carried out by a range of other practitioners including medical and nursing.

Prolonged absence from practice: Any absence from clinical anaesthesia or pain medicine practice exceeding 12 months, which will trigger the need for a return to anaesthesia practice program or a return to pain medicine practice program.

Scope of clinical practice: The delineation of the extent of an individual practitioner’s clinical practice within a particular organisation, based on their qualifications, competence, performance and professional suitability, and the needs and capability of the organisation to support such clinical practice. This is not to be confused with the term “scopes of practice” used by the MCNZ to differentiate between general, vocational and special purpose scopes under the Health Practitioners Competence Assurance Act (2003) NZ legislation.

Sedation:

Minimal: A drug-induced state, during which patients respond purposefully to verbal commands or light tactile stimulation.

Features of minimal sedation include maintenance of airway patency and reflexes, as well as ventilatory and cardiovascular function, although there may be some reduction in cognition and physical dexterity.

Moderate: A drug-induced state of depressed consciousness during which patients retain the ability to respond purposefully to verbal commands and tactile stimulation.

Features of moderate sedation include maintenance of airway patency and reflexes, as well as ventilation and cardiovascular function. However, minimal interventions to maintain airway patency, spontaneous ventilation or cardiovascular function may, be required. Moderate sedation offers a margin of safety that is wide enough to render loss of consciousness unlikely.

This level of sedation is normally not used for children due to the heightened risk of laryngospasm associated with this plane.

Deep: A drug-induced state of depressed consciousness during which patients are not easily roused and may respond only to noxious stimulation.

Features of deep sedation may be difficult to distinguish from general anaesthesia and include impaired ability to maintain an airway, inadequate spontaneous ventilation and/or impaired cardiovascular function. Deep sedation can readily and rapidly progress to general anaesthesia with onset of unconsciousness and inability to maintain an airway. For this reason, providers of deep sedation should possess a level of skill and training commensurate with these risks. Advanced airway and life support skills are necessary when deep sedation is practised. Similarly, the environment in which deep sedation is administered should be suitable for the management of the inherent risks of this technique.

Procedural sedation: A state of drug-induced relief of anxiety or tolerance of discomfort in the context of interventional diagnostic or therapeutic medical, dental or surgical procedures. Lack of memory of distressing events and/or analgesia may be desired outcomes, but lack of response to painful stimulation is not assured.

Sedationist: Any practitioner or dentist or dental specialist registered with their jurisdictional regulatory registration authority, responsible for the administration, management, and conduct of sedation working within their scope of practice.

This practitioner is expected to have completed training relevant to sedation and have attained and maintained the competencies outlined in Appendix 4 of PG09(G).

While sedation lies on the spectrum of anaesthesia, non-anaesthetist sedationists are restricted to procedural sedation as they are not anaesthetists.

Shared decision making: An approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences.

Specialist pain medicine physician: A protected title that refers to medical specialists who have completed an additional specialist qualification in pain medicine, namely fellowship of the Faculty of Pain Medicine, ANZCA.

Sterilisation: The complete destruction of all micro-organisms, including spores.

Training: Refers to teaching a particular skill or type of behaviour within the specialty or to staff.

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Professional documents of the Australian and New Zealand College of Anaesthetists (ANZCA) are intended to apply wherever anaesthesia is administered and perioperative medicine practised within Australia and New Zealand. It is the responsibility of each practitioner to have express regard to the particular circumstances of each case, and the application of these ANZCA documents in each case. It is recognised that there may be exceptional situations (for example, some emergencies) in which the interests of patients override the requirement for compliance with some or all of these ANZCA documents. Each document is prepared in the context of the entire body of the college's professional documents, and should be interpreted in this way.

ANZCA professional documents are reviewed from time to time, and it is the responsibility of each practitioner to ensure that he or she has obtained the current version which is available from the college website (www.anzca.edu.au). The professional documents have been prepared having regard to the information available at the time of their preparation, and practitioners should therefore take into account any information that may have been published or has become available subsequently.

Whilst ANZCA endeavours to ensure that its professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

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* Glossary originally included in Appendix 2 of the ANZCA Policy for Professional Document Framework.

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