

 Lakeridge Health	Anaesthesia Assistants – Medical Directive	
	Manual: Medical Directives & Delegated Controlled Acts	Original Date: 24MAY2011
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Authorizing Prescribers

All Lakeridge Health Department Chiefs for the following sections:

- Anesthesia

Authorized to Whom

Anaesthesia Assistants who work within the Surgical Program throughout Lakeridge Health and who have the following qualifications:

- Registration with the College of Respiratory Therapists of Ontario (CRTO) or registration with the College of Nurses of Ontario (CNO).
- Completion of the Post Graduate Anaesthesia Assistant Certificate Program.
- Current in Advanced Cardiovascular Life Support (ACLS) (i.e., certification within the last 2 years)
- Competent to perform intravenous and arterial line insertions.
- Competent to perform endotracheal intubation, laryngeal mask insertion, and extubation.

Patient Description/Population

This medical directive applies to patient's aged 16 years and older undergoing general, regional, local anaesthesia, or conscious sedation.

Order and/or Procedure

The procedures are not presented in sequential order; any one of or combination of the procedures in the [Order Table Form](#) may be selected by the Anaesthesia Assistant. The Anaesthesia Assistant will review the patient's diagnosis and medical history.

Indications to the Implementation of the Directive

Any hemodynamically stable patient receiving general, regional, local anaesthesia, or conscious sedation with an American Society of Anesthesiologists (ASA) class score of I-IV (Appendix A) as determined by the attending Anaesthesiologist and meets the procedure-specific indications listed in the [Order Table Form](#).

The attending anesthesiologist retains overall responsibility for the patient's anesthetic care. All controlled acts performed under this medical directive are carried out through physician delegation.

Contraindications to the Implementation of the Directive

This medical directive must not be implemented under any of the following circumstances:

- Patient under 16 years old
- Patient who is deemed to be unstable by the Anaesthesiologist
- Existence of procedure-specific contraindications listed in the [Order Table Form](#)

Consent

Consent is obtained by the Anaesthesiologist prior to surgery and according to the *Consent to Treatment – Policy and Procedures*.

Documentation Requirements

In addition to standard documentation practices, the Anaesthesia Assistant implementing this medical directive must document the following in the patient's electronic health record:

- The procedure performed on the patient
- The name of this medical directive by attesting

The order mode “per medical directive” must be selected and the Anaesthesia Assistant must enter their name as the ordering provider. The authorizing provider selected is the attending Anaesthesiologist.

During downtime, the Anaesthesia Assistant must document the following in the Anaesthesia Record Sheet:

- The procedure performed on the patient
- The name of this medical directive
- The name of the implementer
- Legible signature of the implementer, including credentials
- Date and time

Review/Evaluation Process

This directive will be reviewed by Surgical Program every 2 years.

References

College of Respiratory Therapists of Ontario. (1999). *Interpretation of authorized acts*.

College of Respiratory Therapists of Ontario. (2025). *Delegation of Controlled Acts: Professional Practice Guideline*. [Home - Delegation of Controlled Acts](#)

Dobson, G.R., Bak, A.B., Chau, A., Denomme, J., Fuda, G., Mc Donnell, C., Milkovich R., Milne, A.D., Murdoch, J., Sparrow, K., Subramani, Y., Young, C. (2026). Guidelines to the Practice of Anesthesia—Revised Edition 2026. *Canadian Journal of Anesthesia* 73 (1), 13–60. <https://doi.org/10.1007/s12630-026-03075-w>

Gaba, D. M., Fish, K.J., Steven, K. H. (1994). *Crisis Management in Anesthesiology*. Churchill Livingstone.

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Ontario Government. (2000). *A guide to the substitute decisions act*.
<http://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/pgtsda.pdf>

Public Hospital Act, RRO, 1990.

Regulated Health Progression Act, 1991, SO 1991 C18

Respiratory Therapy Act, 1991, SO 1991, c 39

Substitute Decisions Act, 1992, SO 1992, c 30

Appendix A – American Society of Anesthesiologists

ASA PS Classification	Definition	Adult Examples, Including, but not Limited to:	Pediatric Examples, Including but not Limited to:	Obstetric Examples, Including but not Limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use	Healthy (no acute or chronic disease), normal BMI percentile for age	
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations or end organ involvement. Current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40), well-controlled DM or HTN, mild lung disease, CHF NYHA Class 1, mild cognitive dysfunction, isolated mild/moderate obstructive sleep apnea with compliance with CPAP as prescribed.	Asymptomatic non-cyanotic congenital cardiac disease, well controlled dysrhythmias, asthma without exacerbation, well controlled epilepsy, non-insulin dependent DM, abnormal BMI percentile for age, mild/moderate OSA, oncologic state in remission, autism with mild limitations, malignant hyperthermia risk (family history or patient with history)	Normal pregnancy, well controlled gestational HTN, diet-controlled gestational DM
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. COPD, morbid obesity (BMI ≥40), active hepatitis, compensated cirrhosis, alcohol	Uncorrected stable congenital cardiac abnormality, asthma with exacerbation, poorly controlled epilepsy, insulin dependent diabetes mellitus, morbid obesity,	Preeclampsia with or without severe features, gestational diabetes poorly controlled or with complications or high insulin requirements, a thrombophilic disease requiring anticoagulation.

ASA PS Classification	Definition	Adult Examples, Including, but not Limited to:	Pediatric Examples, Including but not Limited to:	Obstetric Examples, Including but not Limited to:
		dependence or abuse, functional implanted pacemaker, moderate reduction of ejection fraction or CHF NYHA class 2 or 3, ESRD undergoing regularly scheduled dialysis, history (>3 months) of MI, CVA, TIA, PE, or CAD/stents, significant cognitive dysfunction, isolated severe OSA regardless of CPAP compliance or any severity of obstructive sleep apnea with CPAP noncompliance. Poorly controlled DM or HTN with or without end organ dysfunction.	malnutrition, severe OSA, oncologic state, renal failure, muscular dystrophy, cystic fibrosis, history of organ transplantation, brain/spinal cord malformation, symptomatic hydrocephalus, premature infant PCA <60 weeks, autism with severe limitations, metabolic disease, difficult airway, long term parenteral nutrition. Full term infants <6 weeks of age.	
ASA IV	A patient with severe systemic disease that is a constant threat to life	Recent (<3 months) MI, CVA, TIA or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction or CHF NYHA class 4,	Symptomatic congenital cardiac abnormality, congestive heart failure, active sequelae of prematurity, acute hypoxic-ischemic encephalopathy, shock, sepsis, disseminated intravascular	Preeclampsia with severe features complicated by HELLP or other adverse event, peripartum cardiomyopathy, uncorrected/decompensated heart disease.

ASA PS Classification	Definition	Adult Examples, Including, but not Limited to:	Pediatric Examples, Including but not Limited to:	Obstetric Examples, Including but not Limited to:
ASA V	A moribund patient who is not expected to survive without the operation	shock, sepsis, DIC, ARDS, ESRD not undergoing regularly scheduled dialysis, uncompensated cirrhosis, severe cognitive dysfunction Ruptured abdominal or thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction	coagulation, automatic implantable cardioverter-defibrillator, ventilator dependence, endocrinopathy, severe trauma, severe respiratory distress, advanced oncologic state. Massive trauma, intracranial hemorrhage with mass effect, patient requiring ECMO, respiratory failure or arrest, malignant hypertension with hypertensive crisis, decompensated congestive heart failure, hepatic encephalopathy, ischemic bowel or multiple organ/system dysfunction.	Uterine rupture, amniotic fluid embolism
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes			

This table must **not** be used independently apart from the Medical Directive

Order Table Form

Management of Neuromuscular Block			
Order	Indications	Contraindications	Notes (Optional)
Non-depolarizing neuromuscular blocking agent administration Rocuronium 10 - 20mg IV x 1 dose	Train of Four (TOF) not adequate for the procedure	TOF adequate for the procedure	Rocuronium 10mg IV x 1 dose may be given in 5 minutes if required, as per attending Anaesthesiologist
Reversal agent administration - Neostigmine 2.5mg x 1 dose with Glycopyrrolate 0.4mg IV x 1 dose or - Sugammadex 2.0mg/kg IV - or 4.0mg/kg IV	Time for reversal of non-depolarizing neuromuscular blocking agent		Maximum dose of 300 mg

Management of Hypertension			
Order	Indications	Contraindications	Notes (Optional)
Deepen anaesthesia • Increase level of vapour concentration up to 50% of set baseline and/or • Titrate IV Propofol infusion rate between 0 – 200 mcg/kg/min and/or • Titrate IV Remifentanil infusion rate between 0 – 0.1 mcg/kg/min	• Hypertensive with a rise in baseline blood pressure by more than 20% above the baseline and • Inadequate level of anaesthesia (increased heart rate and blood pressure)	Monitor artifact – patient not truly hypertensive, or adequate level of anaesthesia	Important: If patient is not responsive to increase in anaesthesia, call attending Anaesthesiologist to inform of patient's response.

Management of Hypotension			
Order	Indications	Contraindications	Notes (Optional)
Administer fluid bolus • 250mL Ringers Lactate or 0.9% Saline IV x 1 dose ○ May repeat x 1 if blood pressure not responsive	• Hypotensive with less than 20% drop from baseline (baseline rhythm unchanged)	Monitor artifact – patient not truly hypotensive	Important: If patient not responsive to fluid boluses, call attending Anaesthesiologist and administer EPHEDrine or Phenylephrine as indicated in the row below.
• EPHEDrine 5 – 10 mg IV x 1 dose and repeat measurement or • Phenylephrine 50 – 100 mcg IV x 1 dose and repeat measurement	• Hypotensive with 20 – 40% drop from baseline (baseline rhythm unchanged) or • Blood pressure less than 20% drop from baseline and unresponsive to fluid boluses		Important: Call attending Anaesthesiologist.
• Phenylephrine 100 – 200 mcg IV x 1 dose or • Norepinephrine (16mcg/ml) 16 – 24 mcg IV x 1 dose or • EPINEPHrine 10 – 20 mcg IV x 1 dose plus EPHEDrine 10 – 20 mcg IV x 1 dose Ensure IVs are fully opened.	• Hypotensive with greater than 40% drop from baseline (baseline rhythm unchanged)		Important: Call attending Anaesthesiologist stat.

Management of Hypopnea and/or Apnea			
Order	Indications	Contraindications	Notes (Optional)
• Insert Oral or Nasal airway and or adjust head position • Decrease level of vapour concentration by as much as 50 - 80 % of set baseline ○ Or turn off - and/or • Titrate IV Propofol infusion rate between 0 – 200 mcg/kg/min - and/or • Titrate IV Remifentanil infusion rate between 0 – 0.1 mcg/kg/min	• Spontaneously breathing non-intubated patient, • intubated patient Hypopnea with a respiratory rate of less than 6 breaths per minute or ○ Apnea with a cessation in breathing for greater than 20 seconds • Non-responsive to intervention(s)	Artifact – patient not truly apneic or experiencing hypopnea	

Management of Intravenous Fluid Replacement Therapy			
Order	Indications	Contraindications	Notes (Optional)
BOLUS 250 mL of Isotonic Crystalloids IV x 1 dose	Monitor reveals Tachycardia and decreased BP (Monitored Urine output is less than 0.5 mL/hr)	Use ½ the calculated deficit with the elderly and patients with renal, cardiac and hepatic disorders.	IV Fluid Maintenance - 4:2:1 rule: 4 mL/kg for the first 10 kg 2 mL/kg for next 10 kg 1 mL/kg for each additional 10 kg IV FLUID SHIFT Third space loss (shift due to evaporation and internal redistribution of body fluid) Minor shift 2 - 4 mL/kg/hr Moderate shift 4 – 8 mL/kg/hr Major shift 8 – 12 mL/kg/hr
See Management of Tachycardia and Management of Hypotension	Tachycardia and decreased BP persist		Call Attending Anesthesiologist

Management of Acute Onset of Bradycardia			
Order	Indications	Contraindications	Notes (Optional)
• EPHEDrine 5 – 10 mg IV x 1 dose, may repeat in 5 minutes - or • Glycopyrrolate 0.2 mg IV bolus, may repeat 0.2 mg IV bolus after 2 minutes after the first bolus ○ Maximum cumulative dose is 0.4 mg	• Heart rate 40 – 60 bpm with decreased blood pressure	Monitor artifact – patient not truly bradycardic	Important: If patient not responsive to medication, call attending Anaesthesiologist stat, and give EPINEPHrine 10 mcg IV x 1 dose.
• Atropine 0.3 mg IV bolus, may repeat 0.3 mg IV bolus in 1 minute after the first dose ○ Maximum cumulative dose is 0.6 mg	• Heart rate less than 40 bpm, profound low blood pressure		Important: If patient not responsive to medication, call attending Anaesthesiologist stat, and give EPINEPHrine 10 mcg IV x 1 dose.

Management of Acute Onset of Tachycardia			
Order	Indications	Contraindications	Notes (Optional)
Deepen anaesthesia • Increase level of vapour concentration up to 50% And or • Bolus IV narcotic as per order And or • Bolus IV anaesthetic - See Management of Hypertension	• Tachycardia with normal blood pressure	Monitor artifact – patient not truly tachycardic	Important: Consider pain or anxiety. Call attending Anaesthesiologist.
IV fluid bolus administration – See Management of Hypotension	• Tachycardia with decreased blood pressure	Monitor artifact – patient not truly tachycardic	Important: Call attending Anaesthesiologist and consider hypovolemia.
See Management of Hypertension	• Tachycardia with increased blood pressure	Monitor artifact – patient not truly tachycardic	