5. THE ANAESTHETIC PERIOD

Consideration of principles of safe anaesthesia care provision is given elsewhere in the document as it pertains to professionalism, equipment and monitoring, medication, etc. The following are guidelines on issues not addressed elsewhere.

5.1 Delegation of care

2022 review by A de Goede and T Hlongwane

The anaesthetist's primary responsibility is to the patient currently under their care. **The anaesthetist shall always remain with the patient throughout the conduct of all general anaesthesia, major regional anaesthesia, and procedural sedation and analgesia (PSA) until the patient is transferred to the care of personnel in an appropriate care unit.**

If the attending anaesthetist leaves the operating room temporarily, care of the patient must be delegated to another anaesthesia provider. When the attending anaesthetist delegates care to an anaesthesia assistant (untrained physician, nurse, technician, etc.), the attending anaesthetist always remains responsible for the management of the patient under anaesthesia. Before delegating the patient's care to an anaesthesia assistant, the anaesthetist must ensure that the patient's condition is stable, and that the anaesthesia assistant is competent, experienced, and familiar with the operative procedure and the operating room environment and equipment. The attending anaesthetist must remain immediately available when care is delegated to an anaesthesia assistant.

An anaesthetist may briefly delegate routine care of a stable patient to a competent person who is not a trained anaesthesia provider only under the most exceptional circumstances, e.g., to provide lifesaving emergency care to another patient. That person's only responsibility would be to monitor the patient during the anaesthetist's absence and to keep the anaesthetist informed until returning to the theatre. In this situation, the anaesthetist remains responsible for the patient's care and must inform the operating room team.

An intraoperative handover of care between two anaesthetists should be documented in the anaesthesia record and follow a structured protocol. **It is unacceptable for one anaesthetist to simultaneously administer general anaesthesia, major regional anaesthesia, or moderate to deep procedural sedation (as classified in the SASA Guidelines for the safe use of procedural sedation and analgesia for diagnostic and therapeutic procedures in adults: 2020–2025 and the SASA paediatric guidelines for the safe use of procedural sedation and analgesia for diagnostic and therapeutic procedures in children: 2021–2026) on more than one patient.**

Where only mild procedural sedation is administered, and provided an additional appropriately trained, qualified, and accredited individual, approved by the healthcare institution, is in constant attendance with each patient receiving care, it may be acceptable under these specific circumstances for one anaesthesia provider to supervise more than one patient.

In an obstetric unit, it is acceptable for one anaesthesia provider to supervise more than one patient receiving regional analgesia for labour, but only once the patient has been assessed to be stable and handed over to a qualified and experienced registered maternity unit nurse for monitoring.

The anaesthetist remains primarily responsible for extubation of the patient

5.2 Perioperative temperature management

To be reviewed in 2026

Monitoring patient core temperature is strongly recommended during cases of general and neuraxial regional anaesthesia lasting 30 min or longer. In the absence of surgical or patient indications for intraoperative hypothermia, active patient warming systems, control of the operating room ambient temperature, and other methods, should be used to target a central core temperature of 36–37 °C.

Monitoring patient core temperature is strongly recommended during cases of general and neuraxial regional anaesthesia lasting 30 min or longer.

5.3 Guidelines on the use of ultrasound in anaesthesia

To be reviewed in 2026

The use of ultrasound (US) has significantly improved patient safety. It is sufficiently pervasive in both the training of anaesthetists and usage among SASA members to warrant the drafting of some guidance.

Vascular access

Based on available evidence, using real-time US during internal jugular (IJ) cannulation improves success and reduces the incidence of complications associated with the insertion of central venous catheters (CVC).

In adults, complications during performance of femoral vein (FV) cannulation are less severe than those that occur with subclavian (SC) and IJ vein cannulation. US guidance for FV access may improve the success rate and reduce complications for FV cannulation. However, this benefit may be more important with novice operators, paediatric patients, or patients with difficult anatomical landmarks. It should be noted that prolonged FV cannulation is associated with a higher incidence of DVT. An individualised and holistic patient risk-benefit assessment for site and type of line should always be considered.

Obese and coagulopathic patients should have US screening of the SC vein before attempted cannulation to identify vessel location and patency. If real-time US is not used as the initial technique for SC vein cannulation, it should be used as a rescue device.

Static US with skin marking is useful for identifying vessel anatomy and thrombosis but may not improve cannulation success or reduce complications as real-time US needle guidance does.