**Supplemental Table 1**. Consensus summary for the safe conduct of anesthetic care in NORA locations

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| Facility | 1. Anesthesiology personnel should participate in planning, construction, expansion, or remodeling of NORA locations to ensure that patient safety and anesthetic needs are met. 2. Anesthesiology personnel should encourage facility design teams to group NORA suites together, near the OR, or the PACU, to facilitate rapid access to additional personnel and equipment when needed. 3. A reliable source of oxygen adequate for the length of the procedure and an immediately available backup supply are required. A central oxygen supply is ideal. 4. A scavenging or capture system for anesthetic gas is required in locations where inhaled anesthesia is used. 5. Electrical outlets shall be sufficient to supply anesthesia equipment and labeled to identify the backup power supply. The number of outlets available for backup power shall be sufficient to power equipment required to safely care for patients. 6. Lighting shall be available to visualize the patient, equipment, supplies, and medications. Battery-powered backup lighting shall be available. 7. There should be sufficient space to accommodate personnel with adequate clearance and expeditious access to the patient, equipment, supplies, and medications. Sufficient space shall be available to bring emergency equipment into the room. 8. A source of continuous suction shall be available and dedicated for use by anesthesiology personnel. 9. Pre- and post-procedural areas shall be available for preparing and recovering the patient. |
| Equipment, Medications, and Supplies | 1. Anesthesiology personnel should participate in capital budget planning for equipment required to set up, maintain, and improve NORA services. 2. When volatile anesthetics are administered, an anesthesia machine sufficient for case types and maintained to facility standards is required. 3. Emergency airway equipment, including multiple forms of rescue (e.g., supraglottic airways, video laryngoscope, cricothyrotomy kit, etc.) is required for each NORA location. 4. A self-inflating hand resuscitator bag capable of delivering positive pressure ventilation while administering at least 90 percent oxygen is required. 5. In each NORA location, emergency supplies including a defibrillator, medications, and other equipment to provide cardiopulmonary resuscitation are required. 6. Equipment and medication for treatment of MH shall be present in all locations where volatile anesthetics are used. 7. Succinylcholine or other equivalent rapid acting paralytic medications should be immediately available for emergency airway management in all NORA locations. When succinylcholine is present, staff shall be educated on MH and prepared to provide and aid treatment. 8. Infusion pumps should incorporate dose error reduction systems (DERS). 9. Diagnostic testing capability appropriate for the patient population and planned procedures is required. 10. Appropriate blood products and the equipment required for administration, such as a fluid warmer, shall be available for procedures that may have clinically significant blood loss. 11. MRI-safe equipment, including airway equipment, infusion pumps, monitors, and anesthesia machines shall be available for MRI, and providers trained on their use. Patient monitoring consistent with operating room standards should be displayed in the MRI control room. 12. Intralipid for treatment of local anesthetic systemic toxicity (LAST) shall be available at NORA locations where local anesthetic is used for purposes other than local skin infiltration. 13. Patient size and weight capacity limits should be established for each NORA site to confirm patient suitability based on equipment and other available resources. 14. Crisis manuals appropriate for the patient population, procedures, and potential therapeutic complications shall be available to staff and clearly visible in each NORA location to serve as cognitive aids during emergencies. 15. Protective equipment, including, but not limited to lead aprons, goggles and radiation shields shall be made available to all anesthesia personnel where radiation exposure may occur. 16. Equipment, such as inflatable mattresses, for patient transfer to and from procedure table shall be available to avoid injury to patient and personnel. |
| Staff and Teamwork | 1. Communication, team building, expectations, and training should be established through a proactive collaborative process driven by anesthesiology personnel, nursing, surgical, and proceduralist leadership. 2. In each NORA location adequate staff shall be trained to support the patient and the anesthesiology care team. The NORA team shall include at least two individuals with appropriate certification (ACLS, BLS, or PALS) and defined responsibilities to provide patient care during emergencies. 3. Anesthesiology personnel should triage and evaluate complex cases, assist with scheduling, and optimize quality and safety protocols. A dedicated NORA anesthesiology team should be considered to facilitate communication and the adoption of protocols and pathways. 4. Team members names and roles should be posted in the NORA location to facilitate communication during patient care. |
| Preprocedural Care and Patient Selection | 1. A pre-procedural evaluation process shall be established based on the ASA Practice Advisory for Preanesthesia Evaluation and emerging best practice. 2. Adult and pediatric patient comorbidities should be identified which require specialized preoperative evaluation or necessitate procedural care in an inpatient facility. 3. Adult and pediatric patients with elevated BMI or a diagnosis or suspected diagnosis of OSA should be evaluated on a case-by-case basis for suitability for the planned procedural location and management plan. 4. Before each procedure, a timeout shall be conducted per The Joint Commission Universal Protocol or according to the facility protocol including site marking and laterality as indicated. 5. Appropriate education shall be provided to team members for new or unfamiliar procedure types, and specific aspects of the case shall be reviewed with NORA staff. 6. All patients should be assessed for fall and venous thromboembolism risk and treated appropriately. |
| Intra-procedure Care | 1. Intra-procedural monitoring shall adhere to ASA Standards for Basic Anesthetic Monitoring with additional monitoring based on patient co-morbidities and/or the nature of the procedure. 2. A formal system to call for assistance, designate personnel to respond, and transport a patient with appropriate monitoring from the NORA location to an in-patient facility shall be established. |
| Post-procedure Care | 1. Appropriate post-anesthesia management shall be provided per ASA Standards for Post-anesthesia Care. 2. Recovery and discharge guidelines shall enable patient assessment in a simple, clear, and reproducible manner. 3. Patients who receive medications for sedation or anesthesia (but not local anesthetics alone) shall be discharged with a responsible individual who can ensure the safe transport of the patient to their home. |
| Continuous Quality Improvement | 1. Anesthesia personnel should establish a quality review process to identify possible new safety risks and improve care on a regular basis. 2. Periodic emergency response simulations should be performed to review system, communication, equipment, and educational infrastructure. |

NORA, non-operating room anesthesia; OR, operating room; PACU, post-anesthesia care unit; MH, malignant hyperthermia; MRI, magnetic resonance imaging; ACLS, advanced cardiovascular life support; BLS, basic life support; PALS, pediatric advanced life support; BMI, body mass index; OSA, obstructive sleep apnea; ASA, American Society of Anesthesiologists