
Great Survey
French
Nurse-Anesthetists
2018

RESTITUTION OF RESULTS

OCTOBER 2018

SNIA
157 rue Legendre – 75 017 Paris

1. INTRODUCTION - PRESENTATION OF THE SURVEY

It is the responsibility of the national IADE union to regularly review the demographics and practices of IADE. The objective of this work consists in a photograph of the professional body, its current practices in France, but also its expectations in order to extract concrete data for the promotion and defense of the profession.

This survey was conducted by closed computer questionnaire upon personal invitation from March 15 to May 6, 2018.

The technical solution used is the Lime Survey software (version 2.73.1) hosted on our server.

The inaugural personal invitations were sent to all our IADE contacts (merging of our member files, professional contacts and respondents from our previous surveys).

In a second step, we set up a secure registration system to generate personal invitations to the survey, the registration link was distributed on private groups and social networks exclusively composed of IADE. Anonymity was perfectly respected, only a collective processing of the responses was carried out.

Balance sheet:

- Generation of 6143 invitations

- Number of responses: 2435 or 23.6% of the IADE professional population.

- Complete and usable answers: 1830 or 17.75% of the IADE professional population.

- Response rate: 39.64 %.

- Usable response rate: 29.8%.

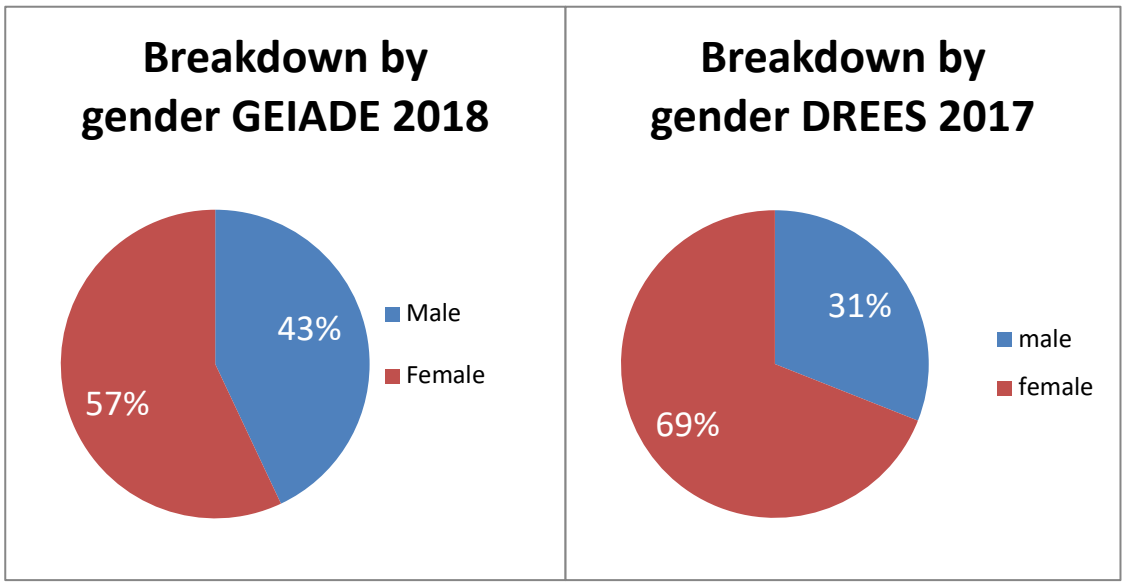
The questions were varied and were written to cover all the specificities of IADE practice. In addition to these declarative answers, we took advantage of this survey to consult professionals on a significant number of questions related to current events in the sector.

The answers to these questions of opinion serve us to refine the basis of our demands in order to enable us to argue our positionings and best represent the IADE sector.

2. DEMOGRAPHIC AND SOCIAL DATA

The GEIADE 2018 sample is composed as follows:

A. Gender :



Findings in brief:

Respondents were divided between 57% women (1043) and 43% men (787).

Reminder: The data of the Directorate of Research, Studies, Evaluation and Statistics (DREES) for the year 2017 show 10,311 IADEs, 69% of which are women (7114) and 31% men (3197)

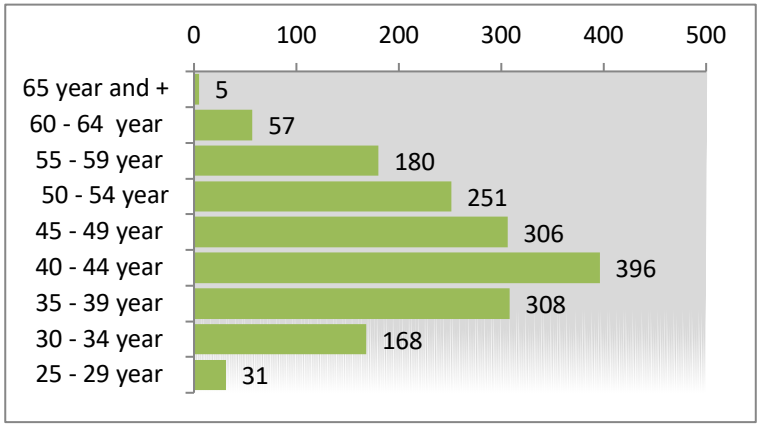
Commentary and interpretation:

A characteristic male over-representation (+12%) is observed in each professional survey. However, the gender ratio is not reversed and we considered that it was sufficiently representative of the factual female majority of the professional corpus. No weighting was applied to the analysis of the survey.

B. Family situation:

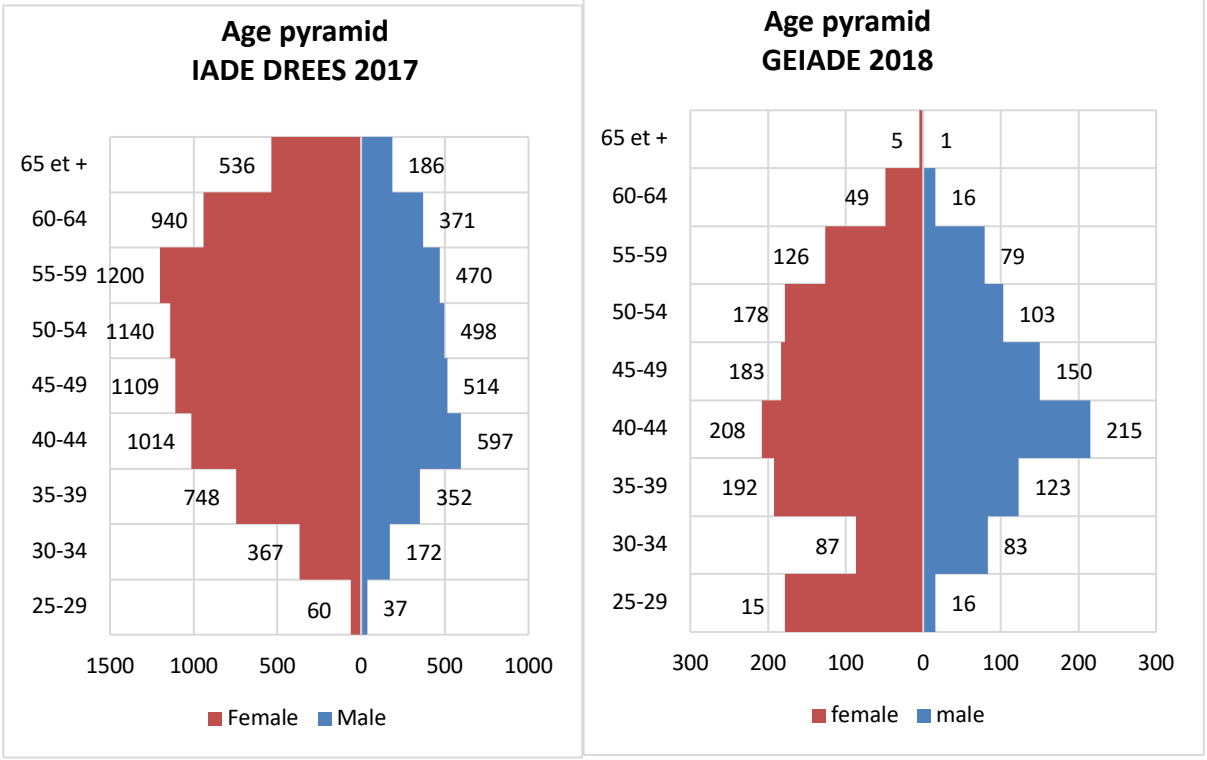
75% live in a couple (65% in a couple with children), 10% in a single-parent family, 15% as single people.

C. Ages :

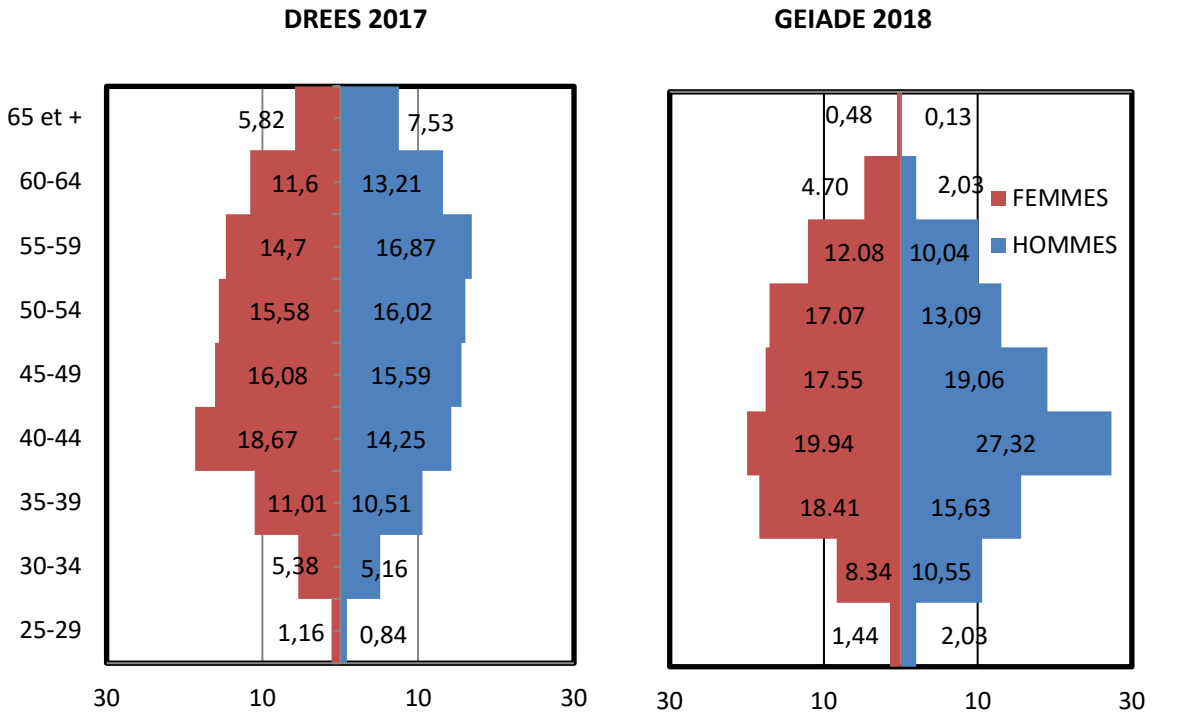


Age	Number	%
25 - 29 year	31	1.82 %
30 - 34 year	168	9.86 %
35 - 39 year	308	18.09 %
40 - 44 year	396	23.25 %
45 - 49 year	306	17.97 %
50 - 54 year	251	14.74 %
55 - 59 year	180	10.57 %
60 - 64 year	57	3.35 %
65 year and +	5	0.29 %

Comparisons of age pyramids between DREES 2017 data and GEIADE 2018 data



Comparisons of age pyramids between DREES 2017[1] Data and GEIADE 2018 Data (Data expressed as a percentage of the same sex population))



[1] Datas issues de le Direction de la Recherche, des Etudes, de l'Evaluation et des Statistiques (DREES) https://drees.solidarites-sante.gouv.fr/etudes-et-statistiques/open-data/data-drees/article/data-drees
Et de la Statistiques Annuelle des Etablissements de santé (SAE) https://www.sae-diffusion.sante.gouv.fr/

Findings in brief:

We note:

- a significant over-representation of MEN aged 40-44 (+13 points)

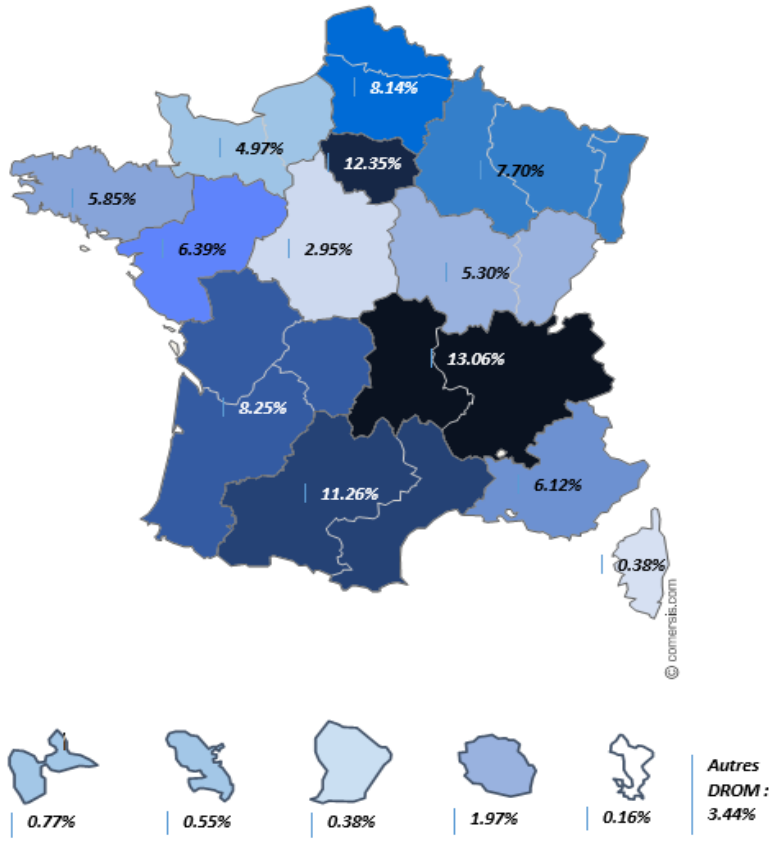
- an under-representation of professionals over 60 years of age

Comments and interpretations:

The male over-representation, common to any IADE survey, cannot be explained precisely.

The under-representation of our former employees (relying on an efficient update of the ADELI files when they retire) can be explained in several ways: a blunt interest in professional surveys for professionals close to retirement, difficulties in mastering the technical aspects of IT tools, a reduced presence on social networks inviting them to participate in the survey....

Apart from these reservations, we considered that the panel (in particular the 30-59 age groups representing the majority of practising professionals) was superimposable on the referenced ages of the professional corpus to affirm its validity.



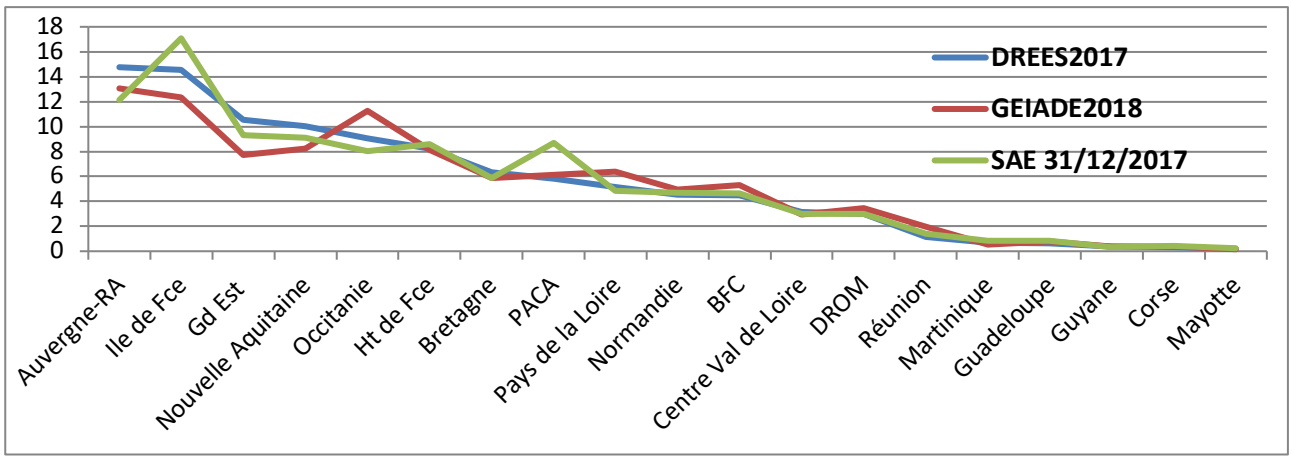
Auvergne Rhône Alpes	239	**13.06 %**
Bourgogne Franche Comte	97	5.30 %
Bretagne	107	5.85 %
Centre Val de Loire	54	2.95 %
Corse	7	0.38 %
Grand Est	141	**7.70 %**
Guadeloupe	14	0.77 %
Guyane	7	0.38 %
Hauts de France	149	**8.14 %**
Ile de France	226	**12.35 %**
Martinique	10	0.55 %
Mayotte	3	0.16 %
Normandie	91	4.97 %
Nouvelle Aquitaine	151	**8.25 %**
Occitanie	206	**11.26 %**
Pays de la Loire	117	**6.39 %**
PACA	112	**6.12 %**
Réunion	36	1.97 %

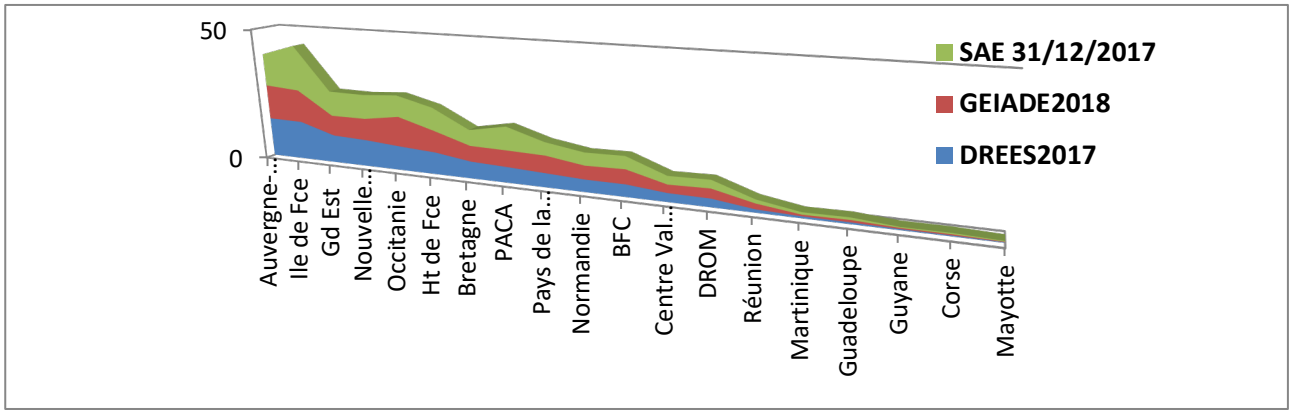
DROM (Nouvelle Calédonie, Polynésie Française, étranger)	63	3.44 %

D. Geographical situation: regional distribution of the panel:

Comparison of regional demographic data between official statistics (DREES and SAE) and the panel of the Great IADE 2018 Survey..

Rang	DREES 2017 (%)		GEIADE 2018 (%)		SAE au 31/12/2017 (%)	
1	Auvergne-Rhône-Alpes	14.76	Auvergne-Rhône Alpes	13.06	Ile de France	17,08
2	Ile de France	14 .55	Ile de France	12.35	Auvergne-Rhône Alpes	12,13
3	Grand Est	10 .54	Occitanie	11.26	Grand Est	9,33
4	Nouvelle Aquitaine	10.04	Nouvelle Aquitaine	8.25	Nouvelle Aquitaine	9,11
5	Occitanie	9.04	Hauts de France	8.14	PACA	8,68
6	Hauts de France	8.25	Grand Est	7.70	Hauts de France	8,57
7	Bretagne	6.31	Pays de la Loire	6.39	Occitanie	8,04
8	PACA	5.8	PACA	6.12	Bretagne	5,86
9	Pays de la Loire	5.16	Bretagne	5.85	Pays de la Loire	4,84
10	Normandie	4.52	Bourgogne Fr-Comté	5.30	Normandie	4,68
11	Bourgogne Fr-Comté	4.48	Normandie	4.97	Bourgogne Fr-Comté	4,65
12	Centre Val de Loire	3.15	AUTRES DROM	3.44	Centre Val de Loire	3,01
13	DROM	3 .0	Centre Val de Loire	2.95	AUTRES DROM	NR
14	Réunion	1.14	Réunion	1.97	Réunion	1,38
15	Martinique	0.66	Guadeloupe	0.77	Guadeloupe	0,85
16	Guadeloupe	0.61	Martinique	0.55	Martinique	0,83
17	Guyane	0.37	Guyane	0.38	Corse	0,42
18	Corse	0.33	Corse	0.38	Guyane	0,32
19	Mayotte	0.20	Mayotte	0.16	Mayotte	0,24





Comparative stacked areas of regional DREES and SAE staff with GEIADE staff (%)

Findings in brief:

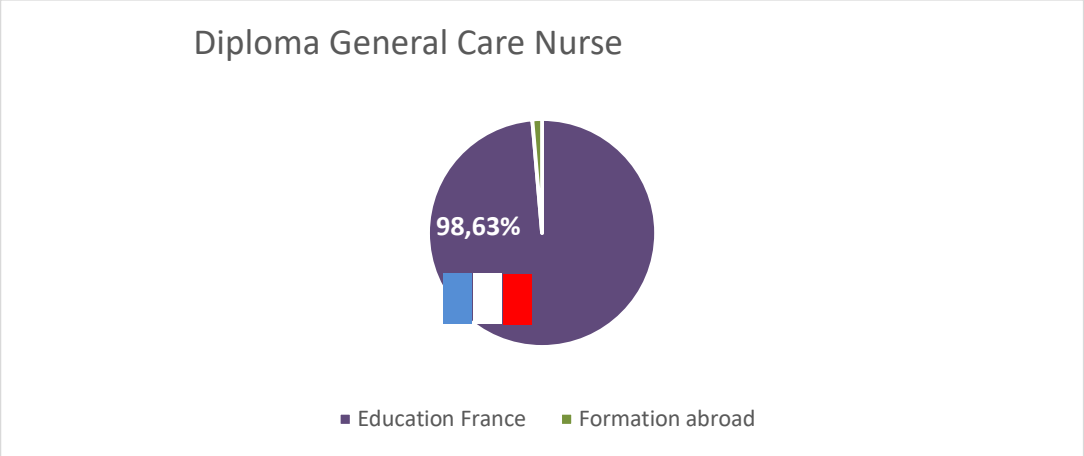
The panel's geographical origin generally respects the geographical classification extracted from the recent DREES and SAE data (2017). There is an over-representation of the Occitanie region and an under-representation of the Grand Est and Ile de France. We do not explain the differences between the official data, particularly concerning the number of employees in the Ile de France and Provence Alpes Côte d'Azur regions.

Comments and interpretations:

Despite some discrepancies, we considered that the panel's geographical distribution was sufficiently validated in terms of territorial distribution.

3. EDUCATION :

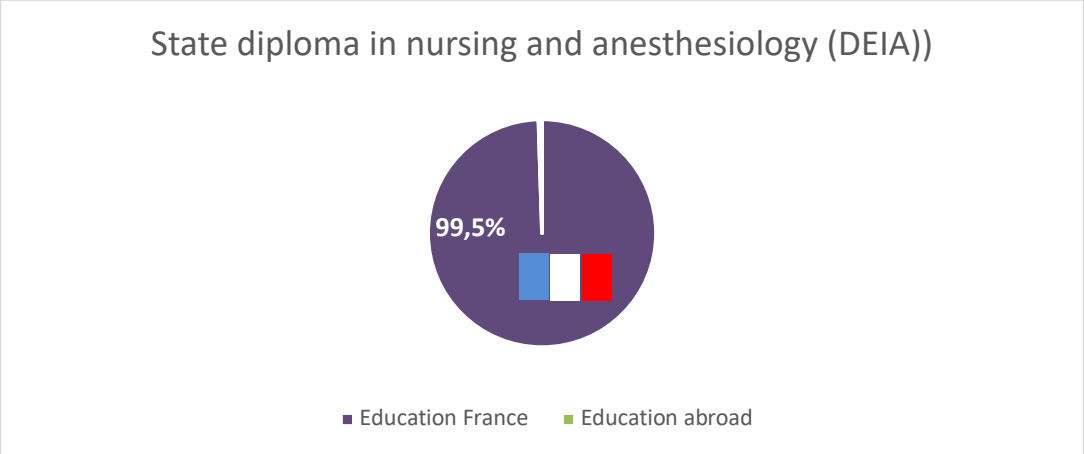
A. Initial education :



Findings in brief:

The French state nursing diploma represents: 98.63% of respondents, 1.37% come from a foreign education (23 respondents: 11 Belgium, 4 Spain, 2 Switzerland, 2 Luxembourg, 2 Luxembourg, 1 USA, 1 Armenia, 1 Romania, 1 Italy). The overwhelming majority of IADEs operating in France have a French initial training (IFSI)

B. Specialized training :



Concerning the IADE specialty diploma, 99.5% are French trained, 0.5% foreign (3 Luxembourg, 4 Switzerland). The overwhelming majority of IADEs operating in France have specialized French training.

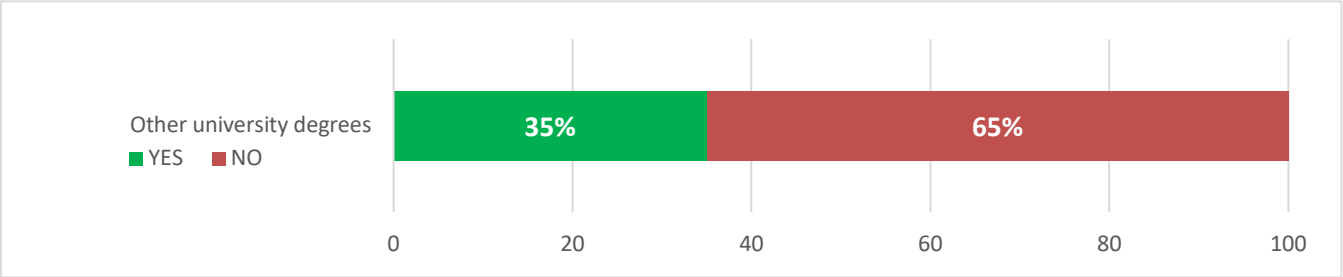
16.2% of respondents (295/1830) benefited from the new Master's degree course set up since the beginning of the academic year in October 2012 (2012-2014 and following promotions) following the reengineering of the course.

Comments and interpretations:

This quasi-exclusivity of French training can be explained by the great differences in the levels of requirement of European diplomas between them. In the international ranking of requirements for paramedical training in anaesthesia, France ranks second after the United States curriculum and professional practices (CRNA).

It appears that few European training courses meet the requirements expected to enable Community professionals to practice within the framework of medically supervised autonomy regulated in France.

C. University degrees:



35% of respondents have other university degrees **(this ratio is reversed for IADE Health managers who are 67% holders of other university degrees)**

22.25% of respondents have one or more university degrees (DU or IUD)

9.275% hold one or more national university degrees (L-M-D excluding DEIA degree Master):

- 4.73% hold a master's degree (excluding DEIA Master's degree)

- 3.2% of a License,

- 0.046% of a doctorate,

- 1.3% from another university degree (DEUG, Master's degree)

D. University degree fields (DU /DIU)

Algology/pain care is at the top of the D.U. titles (the integration of DU pain into some IADE school curricula has increased the rate of graduates). Other recurring themes (in descending order) are: Emergencies, Hypnosis, Resuscitation, Disaster, Medical Repatriation, Management, Pedagogy, Law...

E. Domains of national university degrees (L-M-D)

The main fields found are: Educational Sciences, Health and Social Sciences, Management, Biology, Management, Law, Psychology, STAPS, Training Engineering...

F. First Aid Trainer Training:

26.83% (491) of respondents have an official diploma as a first aid trainer (National Monitorat...).

Comments and interpretations:

We suspected a significant number in response to this question, but we didn't think we would find such a high number! More than a quarter of the professional population is a first aid trainer, which clearly shows the appetite of our professional body for adult training and emergency medicine / first aid / disaster.

G. Hypnosedation / hypnoanalgesia training

23.88% (437) of respondents are trained in hypnosis.

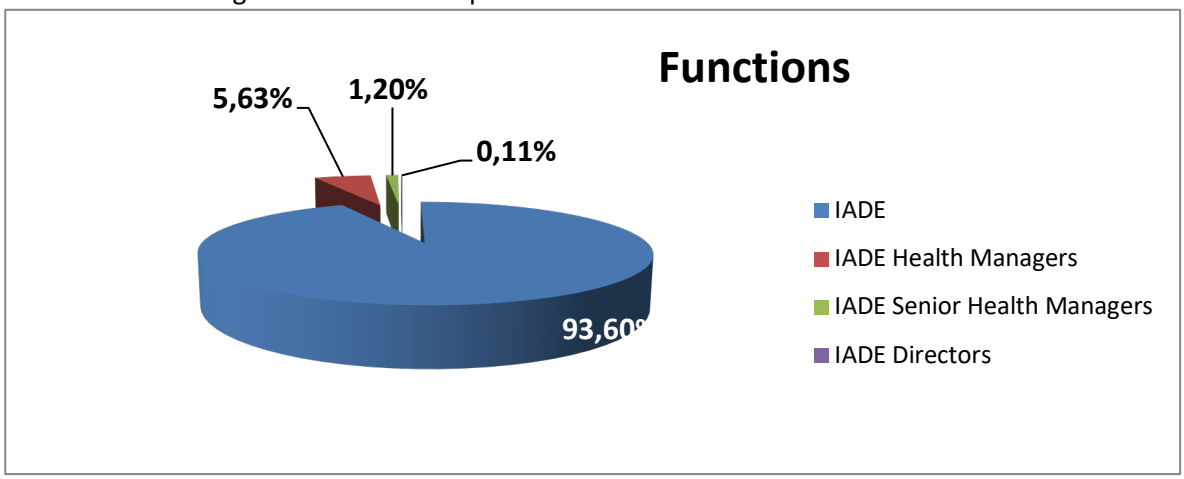
The latter are 80.55% to practice these techniques or 19.23% of IADE practitioners of hypno-analgesic techniques**.**

4. PROFESSIONAL AND EXTRA-PROFESSIONAL DATA

A. Functions held:

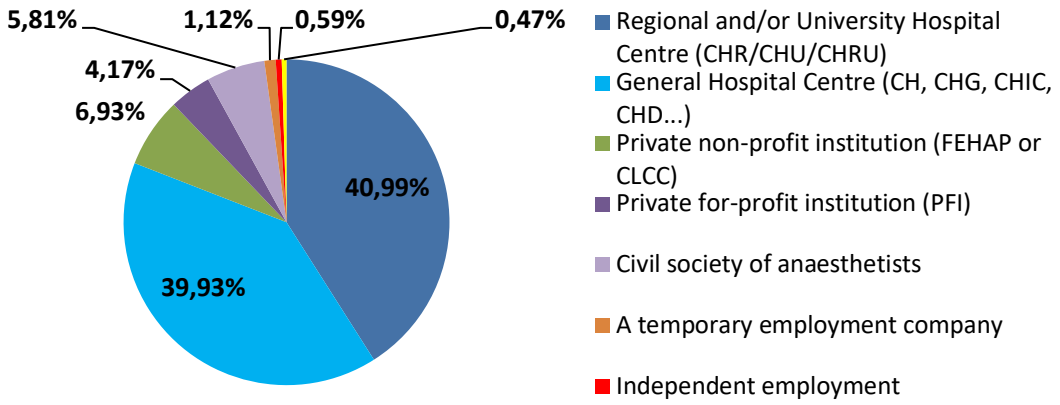
The distribution of the panel according to the functions performed is as follows:

- 1703 IADE or 93.06% of respondents
- 103 IADE Health Managers or 5.63% of respondents
- 22 IADE Senior Health Executives or 1.20% of respondents
- 2 IADE Care Managers or 0.11% of respondents.



B. Main employer :

The breakdown of the panel by main employer is as follows:

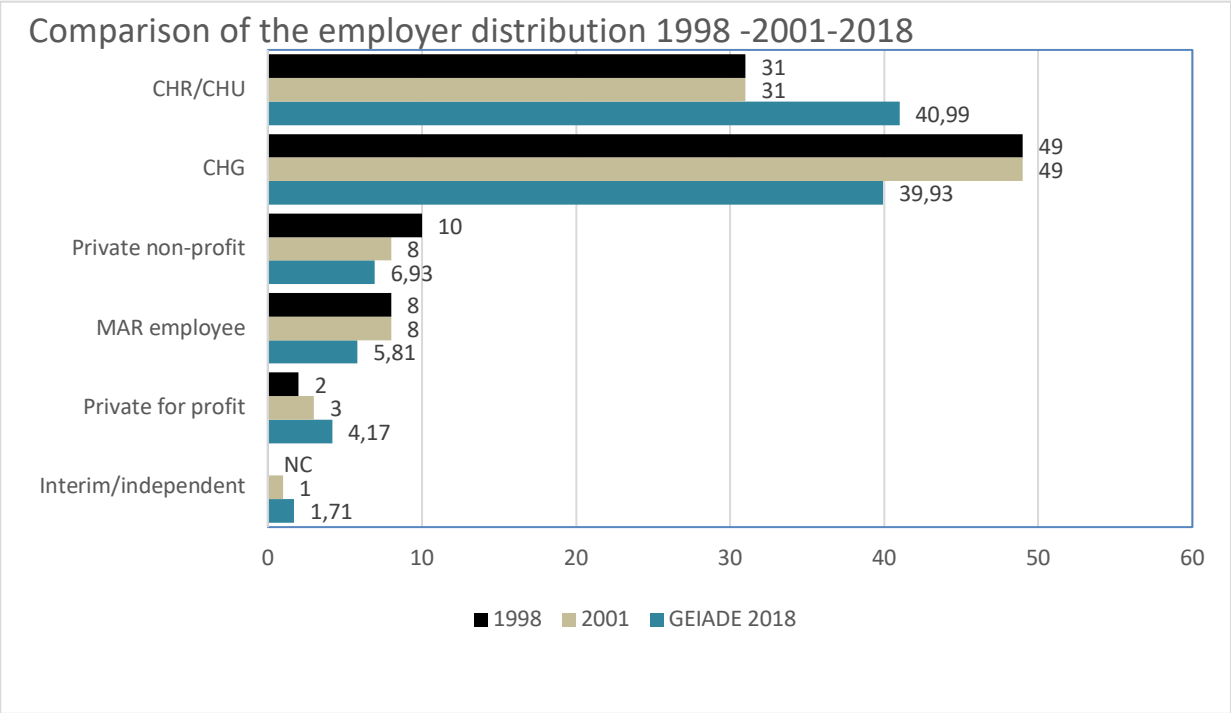


	Regional and/or University Hospital Centre (CHR/CHU/CHRU)	**40.99 %**
	General Hospital Centre (CH, CHG, CHIC, CHD...)	**39.93 %**
	Private non-profit institution (FEHAP or CLCC)	**6.93 %**
	Private for-profit institution (PFI)	**5.81 %**
	Civil society of anaesthetists	**4.17 %**
	A temporary employment company	**1.12 %**
	Independent employment	**0.59 %**
	Army Training Hospital (HIA)	**0.47 %**

The IADE Health managers are divided into 45.67% in university hospitals, 44.09% in university hospitals and around 8% in private institutions.

Attempt to compare the survey results with statistics from DREES and SAE

	GEIADE	SAE 31/12/2017	DREES 2017
Public	81,39 %	87,94 % (9347)	91,4 % (9425)
Private non-profit	6,93 %	8,55 % (909)	4,52 % (465) Other sectors 4,08 % (421) Freelance or mixtes
Private for profit	4,17 %	3,51 % (373)	
MAR Salaried employees	5,81 %		
Interim/Independent	1,7 %		
Number of employees TOTAL	100 %	10629	10311



Findings in brief:

The distribution of IADEs by employer corresponds to 81.39% of public employees, 6.93% of non-profit private employees, 9.98% of profit private employees (including 5.81% of employees of anaesthetist companies and 4.17% of employees of private sector for-profit clinics). Comparison with previous SNIA survey data (1998, 2001)[2] shows that in 20 years, the proportion of IADE employed by CHG has fallen by almost 10 points, while those of CH(R)U have gained 10 points, but in 20 years, the proportion of IADE working in the hospital public service seems not to have changed proportionally, between 80 and 90 %.

The proportion of IADE working in private non-profit institutions (FEHAP, CLCC) and IADE employed in MAR seems to have decreased proportionally in 20 years (-2 to -3%).

[2] Previous SNIA surveys (including the 2001 survey) on the demography and reported practices of IADE available in the "SNIA Publications" section of the website: www.snia.net/publications-snia.html

The share of IADE employed by private for-profit institutions and the independent/interim financial year seem to have increased proportionally, respectively by +2.17% and +0.71%.

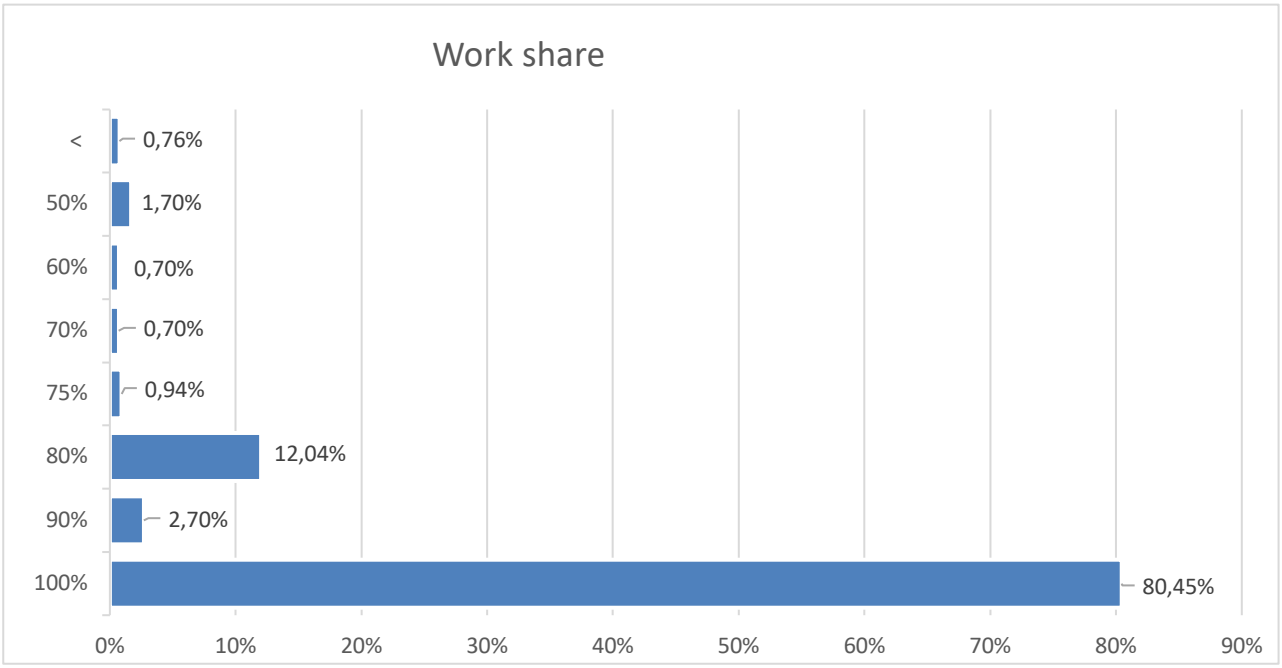
Comments and interpretations:

Despite discrepancies with the official statistics of the DREES and the SAE (which do not agree with each other), the profile of the respondents to the survey corresponds to the distribution of employers of IADE in France, i. e. the vast majority of the professional body is located within public hospitals. There is a good participation of private sector professionals in this national consultation, which may explain the difference. The method of enumeration (ADELI file for DREES and declaration of establishments for SAE) and the multi-activity or cumulative employment of some IADEs (see later in the survey) can also explain the differences between official statistics.

The proportional changes observed in the hospital public service between CH(R)U and CH compared to previous data (1998, 2001) could be explained by the decrease in public health coverage in 20 years, the closure of operating theatres by the transformation of hospitals into SRH, EHPAD establishments, or even their closure and the concentration of technical platforms within CH(R)U.

In view of these results, we believe that the panel's "employer" distribution corresponds overall to the distribution of the professional body of IADEs in France.

C. Work share :



Findings in brief:

80.45% of IADEs work full-time. The most common form of part-time work is 80% (12.4% of respondents). 93.14% of men and 72.86% of women work full-time. 17% of women IADEs are 80% active.

The part-time rate is therefore 19.55% in the IADE population, which should be compared with the 2016 DARES statistics, which show a part-time rate in the civil service (state, local authorities and hospitals) of 20.5% and 19.2% for all employees.

6.86% of IADE Men work part-time, compared with 7.6% of all male employees in France.27.14% of IADE Women work part-time, compared with 30.7% of all female employees in France.

Comments and interpretations:
The working time units and part-time proportions are comparable with the rest of the general population.

D. Vacations for another employer or establishment:

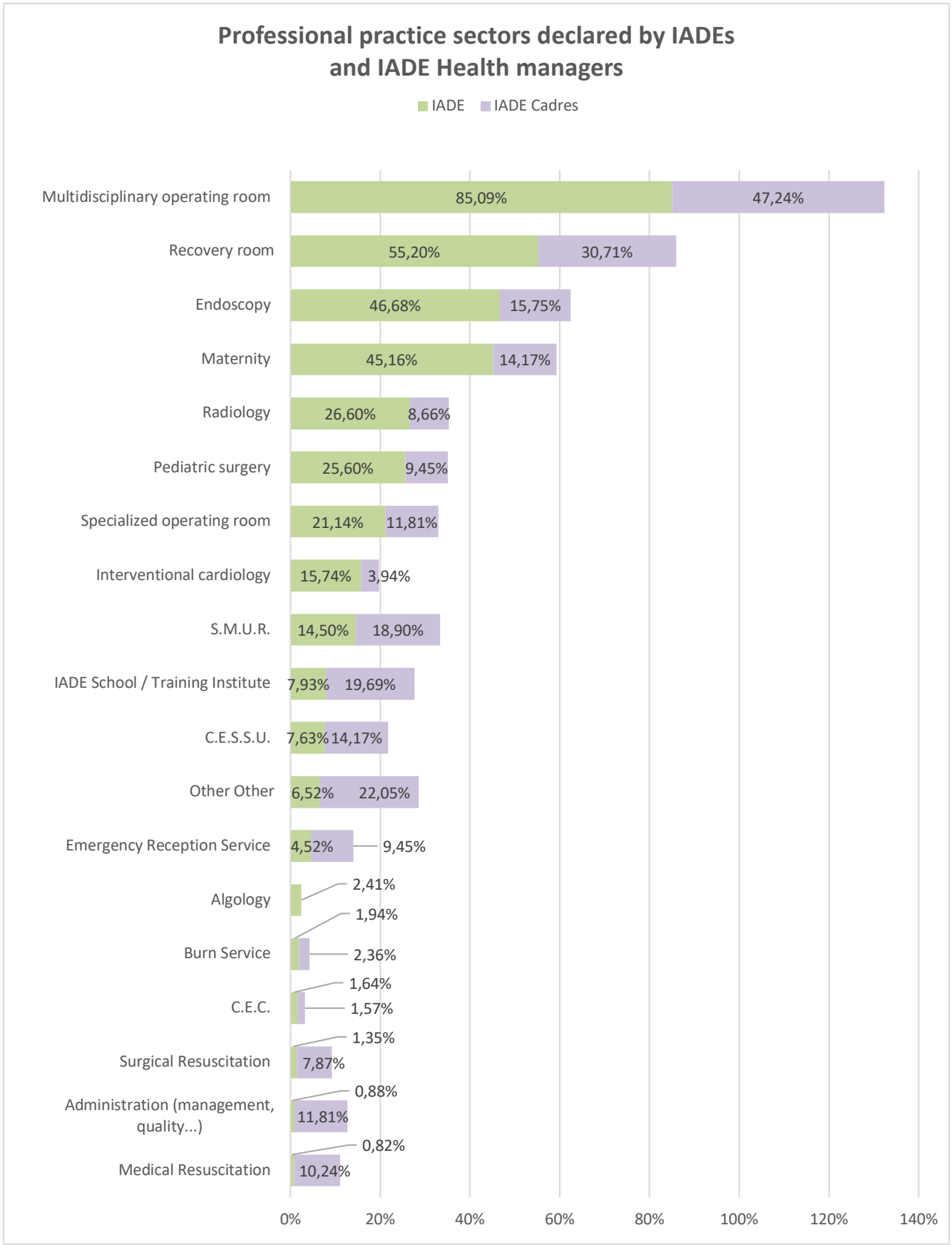
A brief observation:
20.31% of IADEs report working shifts for another employer.
The proportion of public sector IADEs reporting that they perform their duties for another employer is 14.1% for IADEs operating in CH(R)U and 19.57% for IADEs operating in CH; an average for the hospital civil service of 16.82%.

The cumulative employment rate for IADEs identified by the 2011 IGAS survey reported 19.6% of FPH IADE in cumulative employment.

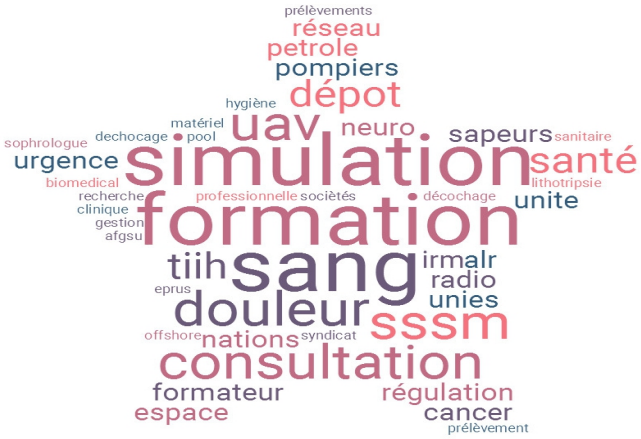
Commentary and interpretation:
This 2.8% decrease in the cumulative activity of the FPH's IADEs can be explained by the "hunting" triggered in the regions by certain branches in order to ensure compliance with the current rules prohibiting multiple employment.
From trade union sources, it appears that this desire to bring these staff into compliance is carried out in a variable geometry according to the territories. It should be recalled that the IGAS in its report explained that these cumulations of employment, although illegal, "could have a social utility by allowing the maintenance or continuity of the service that is provided for the benefit of the patient. Cumulation can prevent, for example, the postponement of scheduled activities.

E. Sectors of activity of IADE and IADE Health Manager:

Answerss	IADE	IADE HM
Multidisciplinary operating room	85,09 %	47,24 %
Recovery room.	55,20 %	30,71 %
Endoscopy	46,68 %	15,75 %
Maternity	45,16 %	14,17 %
Radiology	26,60 %	8,66 %
Pediatric surgery	25,60 %	9,45 %
Specialized operating room	21,14 %	11,81 %
Interventional cardiology	15,74 %	3,94 %
C.E.C.	1,64 %	1,57 %
S.M.U.R.	14,50 %	18,90 %
Emergency Response Service	4,52 %	9,45 %
Surgical Resuscitation	1,35 %	7,87 %
Medical Resuscitation	0,82 %	10,24 %
Burn Service	1,94 %	2,36 %
IADE School / Institute for Training in Health Professions (IFSI, IFAS.)	7,93 %	19,69 %
C.E.S.U.	7,63 %	14,17 %
Algology	2,41 %	0,00 %
Administration (Direction of care, quality, IT systems...)	0,88 %	11,81 %
Others	6,52 %	22,05 %


Professional practice sectors declared by IADEs and IADE Health managers
IADE
IADE Cadres
Multidisciplinary operating room
85,09%
47,24%
Recovery room
55,20%
30,71%
Endoscopy
46,68%
15,75%
Maternity
45,16%
14,17%
Radiology
26,60%
8,66%
Pediatric surgery
25,60%
9,45%
Specialized operating room
21,14%
11,81%
Interventional cardiology
15,74%
3,94%
S.M.U.R.
14,50%
18,90%
IADE School / Training Institute
7,93%
19,69%
C.E.S.S.U.
7,63%
14,17%
Other Other
6,52%
22,05%
Emergency Reception Service
4,52%
9,45%
Algology
2,41%
Burn Service
1,94%
2,36%
C.E.C.
1,64%
1,57%
Surgical Resuscitation
1,35%
7,87%
Administration (management, quality...)
0,88%
11,81%
Medical Resuscitation
0,82%
10,24%
0%
20%
40%
60%
80%
100%
120%
140%

Other sectors of professional activity: 6.52% for IADEs and 22.05% for IADEs Health managers



Findings and interpretations in brief:

The distribution of the sectors of activity in which IADEs work speaks for itself in terms of the diversity of the positions and functions they perform. Many joint exercises are demonstrated without being precisely defined by the survey. Few IADEs are assigned to a single workstation or a single activity/specialty. These figures demonstrate the versatility of these professionals. Of course, the anaesthesia activities in the operating room and in the interventional sectors are at the top of the list.

It should be noted that the SMUR exercise remains at 14.5%, the 2001 SNIA survey showed that this rate was 16.54%, including 15.5% in mixed exercise (OR/emergency care or Intensive care/emergency care).

Intervention in intra-hospital emergencies represents 4.52% of professionals. The combined shares of IADE operating in the intensive care/burn sectors reach 4.11%.

It is also noted that intervention at training sites (IADE schools, training institutes, CESU) concerns between 7 and 8% of IADEs.

The main areas of practice of the IADE Health Frameworks are logically superimposed on the places of practice most represented by the IADE (anaesthesia activities). However, it should be noted that the supervision of SMURs represents nearly 19 % of management professionals and 9.45% of the supervision of emergency reception services. It should be noted that in these two disciplines the percentage of IADE health professionals is higher than that of IADE. This result shows the interest that health institutions have in the specific expertise held by the IADE health framework to facilitate and organize the activity of these services.

Training activity is obviously the other field of activity in which the IADE Health Executives are found (20% in schools and training institutes and 14% in emergency care teaching centres). 8% of IADE Executives manage surgical intensive care services and it is noted that more than 10% work in medical intensive care. Nearly 12 % declare that they work within administrative entities with the departments (care, quality, HR, etc.). Finally, we note the high proportion of IADE Executives (22.5%) working outside the sectors proposed by the survey. The analysis of the 20 written responses describing an exercise outside the scope of the survey mentions various functions: supervision of sterilization services, surgical and ambulatory anaesthesia services, organ retrieval coordination, simulation centres and other care services (including 2 in residential facilities for dependent elderly people).

F. Local supervision of IADEs:

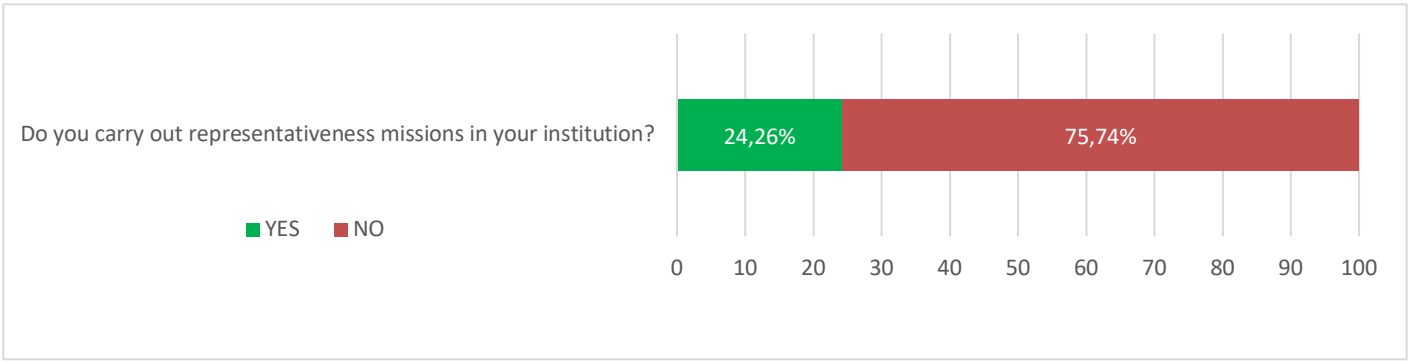
Answers	Public hospitals	Private clinics	Employed by MAR
Nurse Care Manager	7.86 %	8.99 %	0
Functioning Nurse Care Manager	4.47 %	9.52 %	0
IADE Health Manager	**60.39 %**	**21.69 %**	**0**
Functioning IADE Health Manager	**11.76 %**	17.46 %	0
OR nurse Health Manager	7.72 %	16.93 %	0
Functioning OR nurse Health Manager	2.09 %	6.88 %	0
Senior Health manager	2.24 %	2.65 %	0
Functioning Senior Health Manager	0.22 %	1.06 %	0
Health manager or Functioning Health Manager from other specialties	1.23 %	0.53 %	0
Direction of care	0.94 %	0.00 %	0
General management	0.07 %	0.00 %	
Others	1.01 %	14.29 %	100 % MAR

In the public hospital sector, 72.15% of IADEs report being supervised by staff in their NA speciality.

In private sector clinics, it appears that the ratio is strongly reversed, as it can be observed that only 39.15% claim to benefit from IADE supervision.

85% of the professionals surveyed state that the management delegates part of its activities to one (e) or more IADEs for the management of the IADE team (planning, equipment, etc.). There is no significant difference depending on whether the management IADE or not IADE skilled.

5. REPRESENTATIVENESS of FUNCTIONS IN INSTITUTIONS



24.26% of IADE respondents perform representative functions in their institution, broken down as follows

Nursing, Rehabilitation and Medico-Technical Care Commission	11.71 %
Operating room Council	**43.02 %**
Hospital department Council	**13.06 %**
Material vigilance commission	4.73 %
Pain care committee	**27.25 %**
Committee for the Control of Nosocomial Infections	9.68 %
Transfusion Safety and Hemovigilance Committee)	**12.84 %**
Technical committee or Work Council	10.81 %
Health, Safety and Working Conditions Committee)	8.56 %
Board of Directors	2.48 %

58.27% of IADE Health Managers carry out representative missions.

Others: 27.93 %.

68 % declare that they can easily/relatively easily exercise their mandates in these representative bodies. 32% have difficulty/impossibility to exercise them.

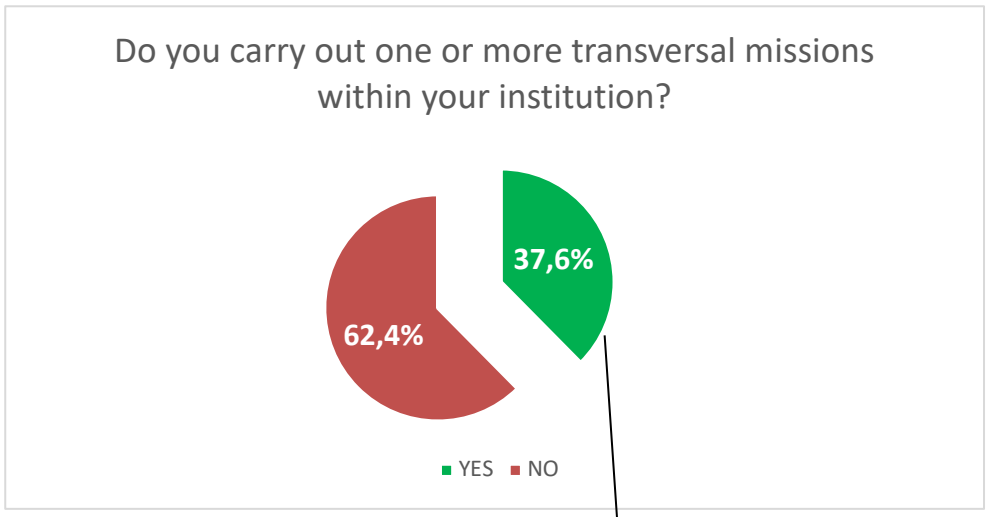
Comments and interpretations:

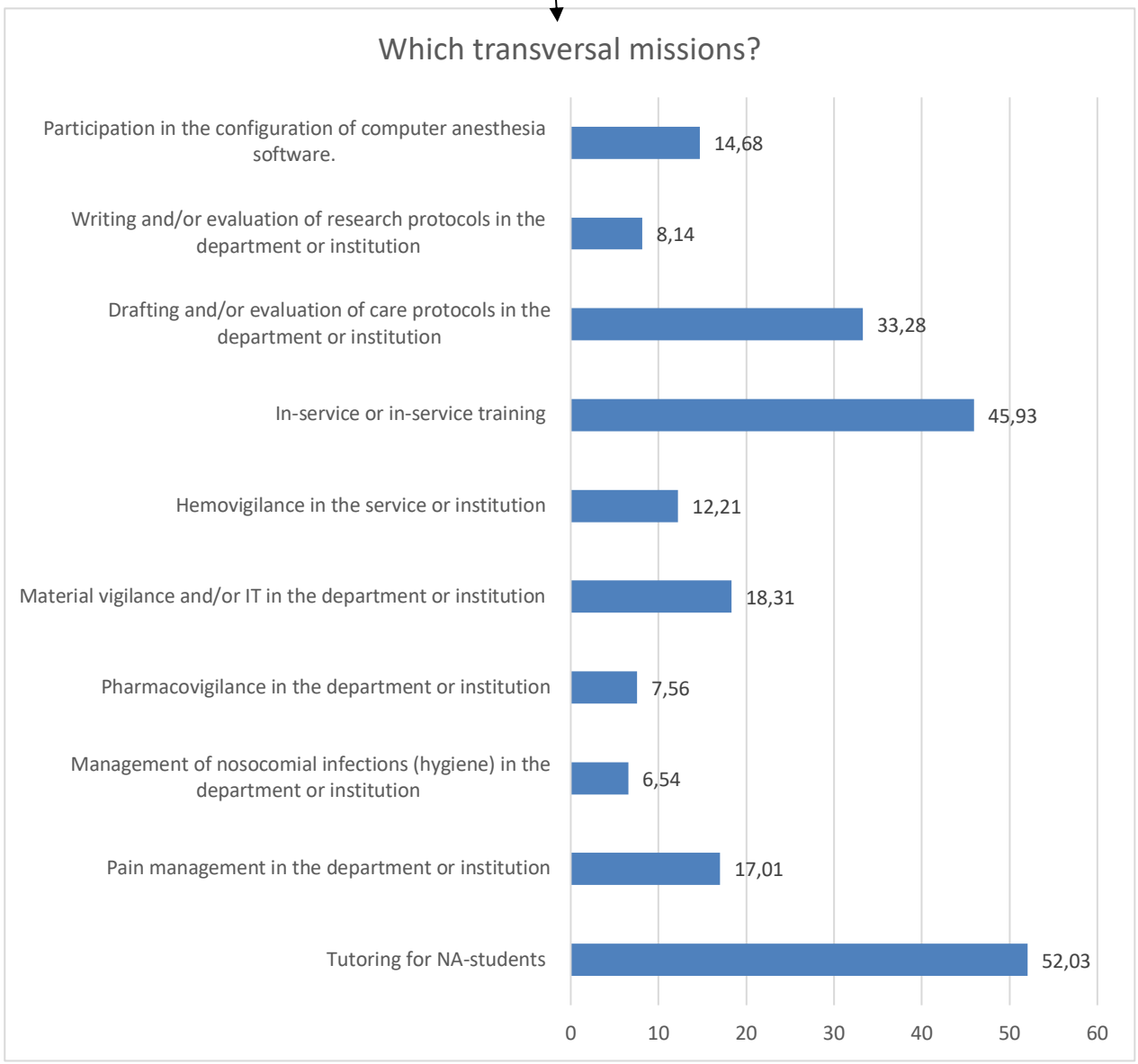
This commitment rate (1/4 of the professional population) is a credit to our profession and demonstrates its involvement in the operation of services and establishments.

The commitment concerns primarily the operating room councils (43%) followed by the pain care committees (27.25%).

IADEs take part in all existing representative bodies (Nursing Commission, Transfusion Safety Committee, Employee representative committees etc.) at high rates with regard to what the NA profession represents within the French health landscape (reminder: IADEs represent 1.4% of nurses in France). The rate of NA engaged in these representative functions, which declare that they have difficulties (or even impossibilities) in fulfilling these missions, is questionable by its importance (almost a third of them!) The reasons for these difficulties have not been explored in this survey, but it is suspected that the time factor (detached or not) is the main factor.

6. TRANSVERSAL MISSIONS IN THE INSTITUTION

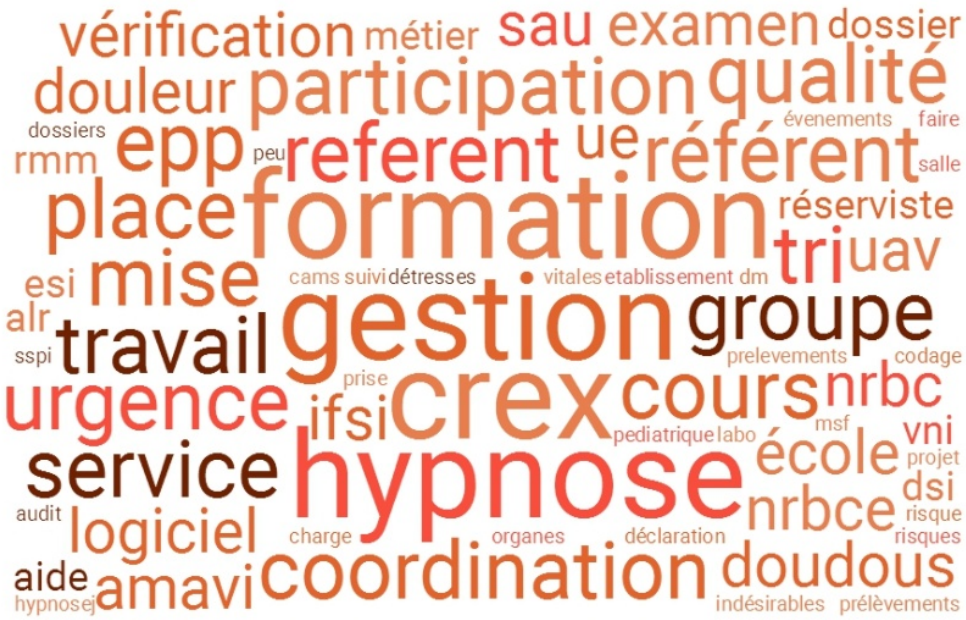




The NA Health Managers, for their part, are 66.93% to carry out transversal missions.

Roles	**%**	Description and distribution
Internship tutoring for NA students	52.03 %	
Pain management in the department or facility	17.01 %	Half of them are service referees and/or members of the pain care committee. ¼ are referents of the institution, ¼ work in the pain unit, trainer, hypno analgesia, etc...
Management of nosocomial infections (hygiene) in the department or institution	6.54 %	Mostly service referrers (>80%), members of the pain care committee, 1 referent of the institution.2/3 are unit referents and for 1/3 members of their institution's working groups
Pharmacovigilance in the department or institution	7.56 %	¾ unit referents, 1/3 are members of their institution's working groups, 7 are referents of their institution.
Material vigilance and/or IT in the department or institution	18.31 %	60% are unit referents, 16.5% are institution referents, 33% are working group members in their institution, 7 are institution referents.
Hemovigilance in the service or institution	12.21 %	20% Management and training at the Blood Depot
In-service or in-service training	45.93 %	Half are unit referees, 28% hospital referees, 28% work in schools, 22% in NA School, 4% in OR nurse School and 20% work in CESU/Simulation/Training
Drafting and/or evaluation of care protocols in the department or facility	33.28 %	The majority are unit referees (>70%), 10% are referents of their institution, 20% participate in working groups.
Writing and/or evaluation of research protocols in the department or institution	8.14 %	59% are referents of the unit
Participation in the configuration of computer anesthesia software.	14.68 %	
Director/Master of Student Thesis (paramedical...)	16.13 %	

Other areas concerned by transversal missions:



Findings in brief:

37.6% of IADEs and 67% of IADE managers declare that they carry out transversal missions in their institution.
51.44% of IADEs carrying out transversal missions report having difficulties in carrying out their functions.

Comments and interpretations:

As with the representativeness missions, NAs (and even more managers) participate in large numbers in the institution's transversal missions (nearly 38% of them). Training is the first mission (internship tutoring, training in the department and/or institution, thesis director), then the writing and/or evaluation of service protocols, Material vigilance, Pain, IT. This commitment rate demonstrates the involvement and leadership of NAs in staff training, but also in all missions contributing to the proper functioning of the system in which they operate. As with representativeness missions, the rate of difficulty in being able to carry out these transversal missions (more than half!) is questionable.

A. Humanitarian missions :

6,39% of respondents participate in humanitarian missions, 1/3 of them say they can carry out these missions easily. For the remaining 2/3 this seems very difficult (50%) or even impossible (17%), which raises questions about the possibilities offered to employers to enable them to carry out these tasks, despite legislation that is supposed to facilitate.

B. Additional activities related to care/rescue :

18% of NAs participate in extra-curricular activities related to health and social issues (care, relief)
7.69% of NA respondents are Fire Brigade Nurses (see focus IADE ISP below)
4.5% of respondents are EPRUS Reservists
1.75% are Reservists in the Army Health Service
2.13% are members of an NGO (MSF/MDM/...)

C. Focus IADE Fire Brigade Nurse (ISP)

Based on the results of the survey, the engagement rate of NAs in the Health and Medical Rescue Services (SSSM) of the Departmental Fire and Rescue Services (SDIS) is 7.7%, i.e. by extrapolation a corps of about 790 NAs committed in France on these assignments. Considering the number of fire brigade nurses in France, which would be 6922 professionals, the IADE would represent 11.4% of the Fire brigade nurses.

It should be recalled that this rate of citizen engagement, compared to the general population of nursing professionals (1.4%), demonstrates the clear involvement of our specialty in this activity of personal assistance and emergency medicine.

67% of IADE ISPs declare that they work with specific IADE emergency care nursing protocols (PISU) in their department, enabling them to apply their skills. On the basis of this declaration, we were able to draft the following map, which must be taken with all the necessary precautions:

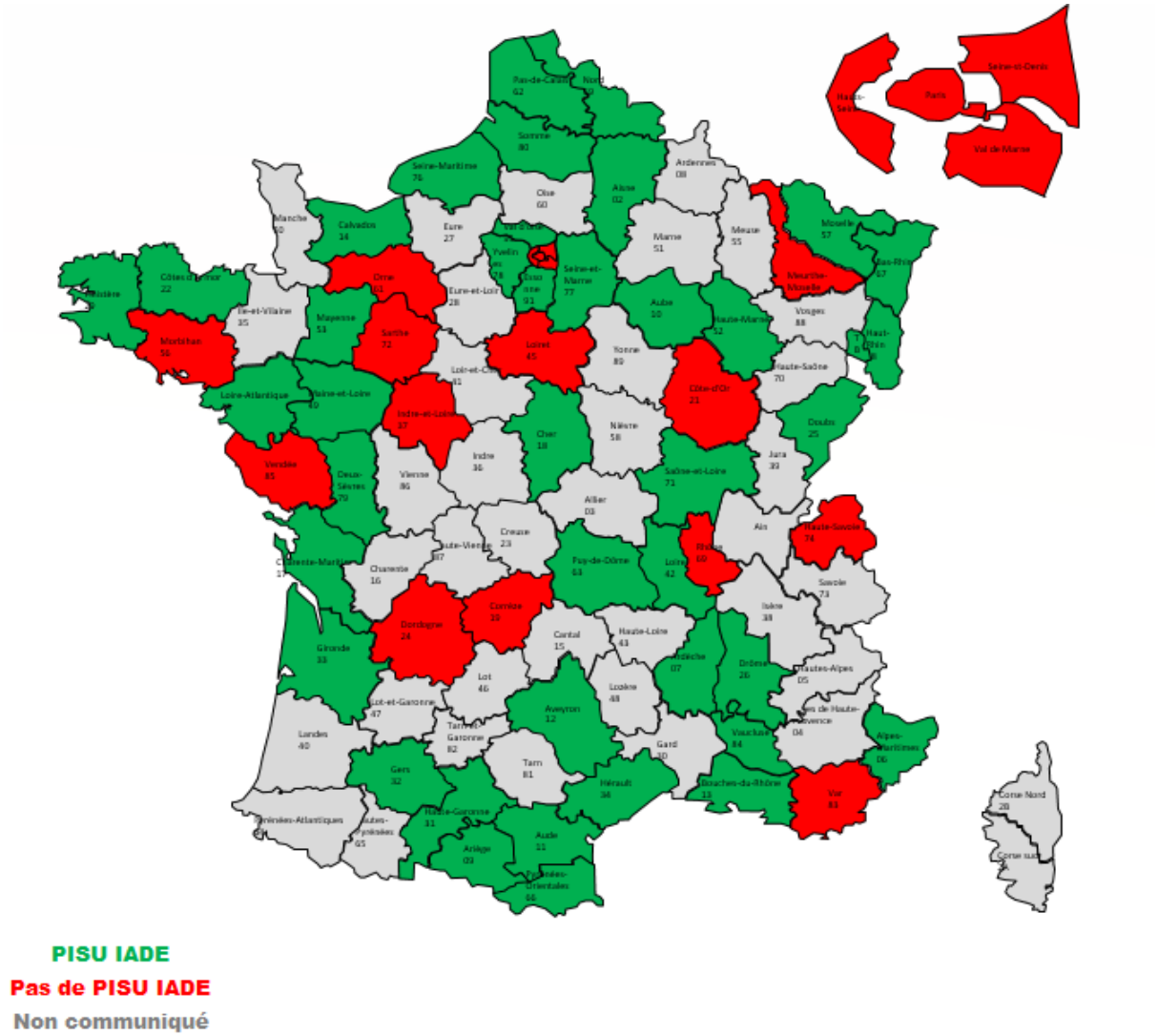


Figure 1: SDIS departmental map according to the existence or not of a specific IADE PISU

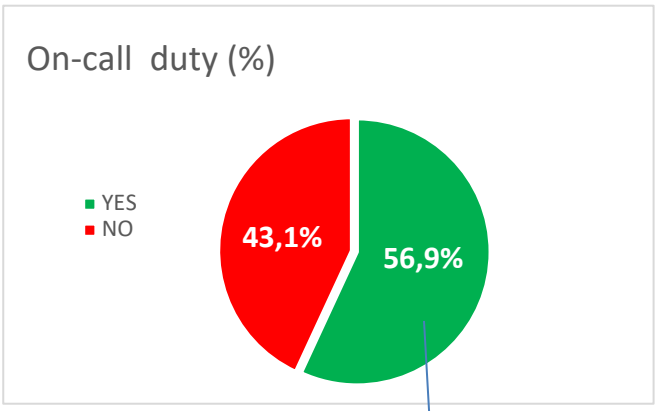
The GREEN departments would have specific IADE PISU

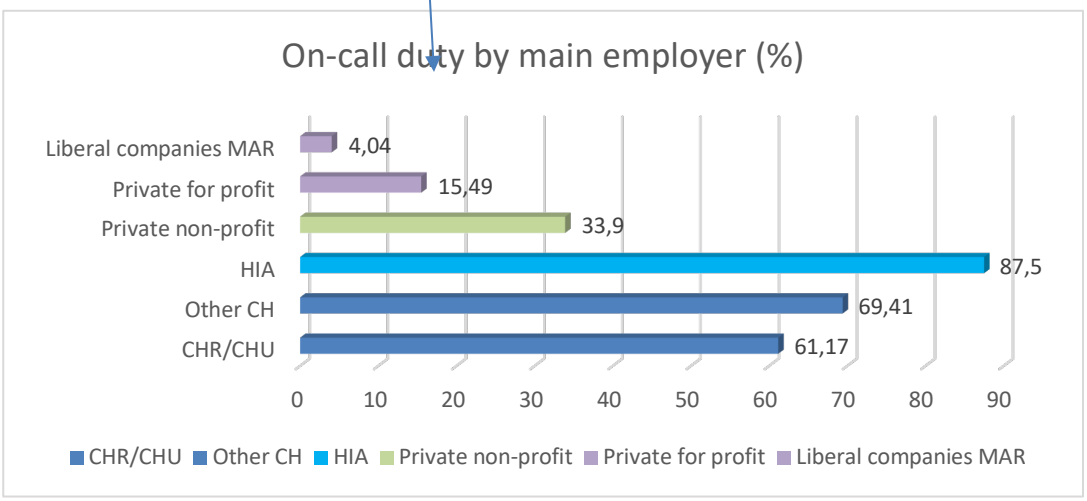
The departments in RED would not have a specific IADE PISU

We do not have information on greyed out departments.

7. CONTINUOUS CARE

A. On duty:





Findings in brief and interpretation:

57% of IADEs have on-call duty. In 1998, 52% of them reported doing so, which shows a slight increase in this device to allow continuity of care.

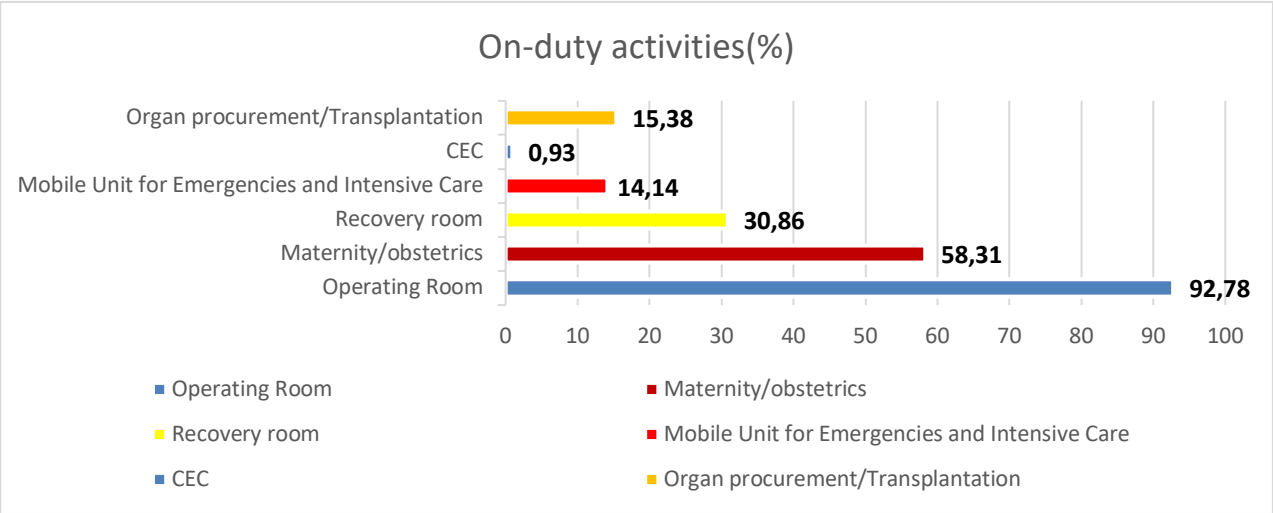
The results confirm that the majority of on-call constraints related to the permanence of care concern public sector workers with an average of 65.39%.

The particular involvement of the private non-profit sector PSPH (33.9%) in this scheme is noteworthy.

68.11% of these guards are included in the weekly working time, while 65% were included in the 2001 SNIA survey. They are paid overtime for 62%.

The NA Health managers perform administrative guards for 57.48% of them.

i. Sectors concerned by the guards:



ii. 24-hour shifts:

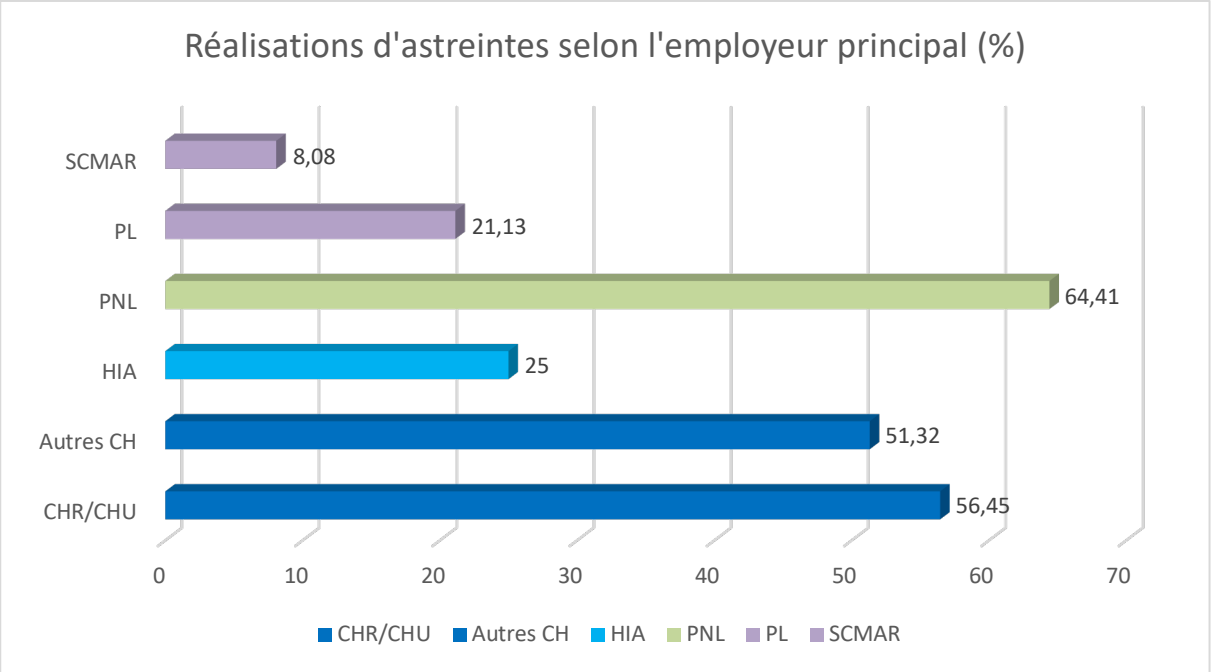
22.5% of IADEs work 24-hour duty periods [39.6% of IADEs who work on duty (56.9%)].

The IADEs on duty for 24 hours are proportionally and respectively the IADEs in CH-CHG (58.69%), the IADEs in the private non-profit sector (47.5%), the IADEs in CHR-CHU (18.5%).

They have rooms in 91.5% of cases.

It can be seen that this system, although legally unenforced, still exists and allows institutions to ensure continuity and safety of care.

B. On-call duty :



Findings and interpretations:

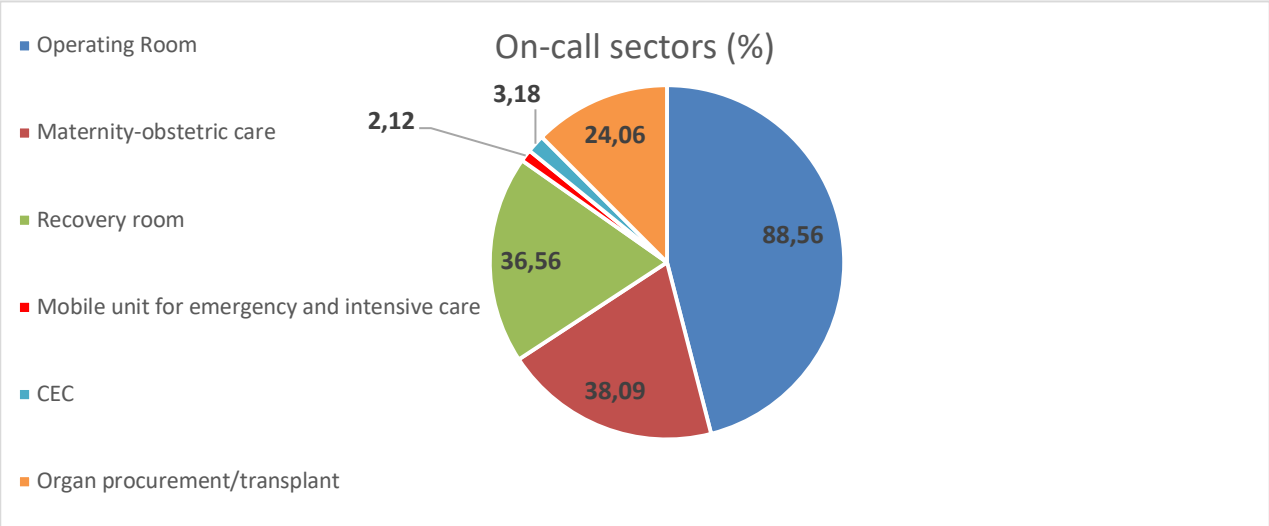
49.79% of IADEs are on call at home, compared to 37% in 2001. This tends to show that this approach has become more widespread.

Half of hospitals IADEs do so, with significant use of the on-call system in the private non-profit sector (64.4%) and low use in the private for-profit system (21.13%)

All sectors combined, 75% of respondents are on call on a voluntary basis. (This volunteer rate was 71.2% in 1998). For 74% of IADEs on call, the latter are not counted in weekly working time, they are paid for 90.57% in overtime.

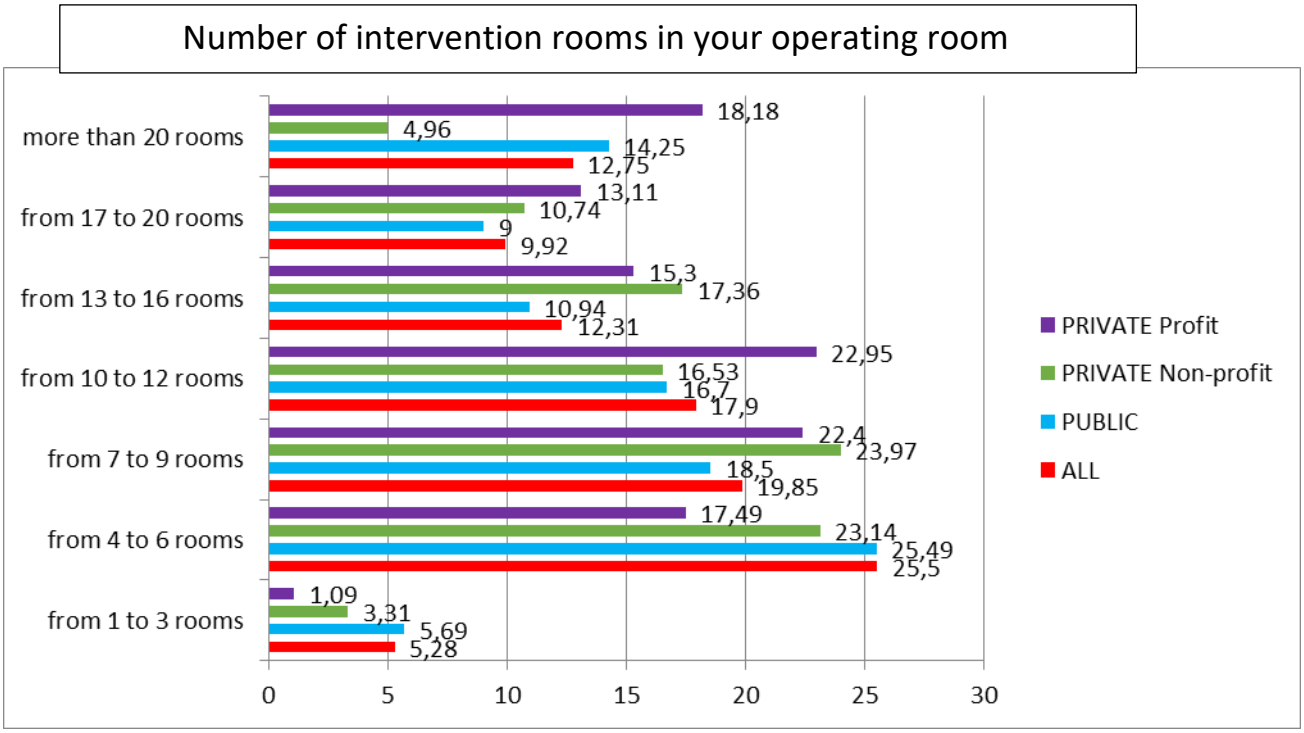
37.8% of IADE Health Managers work on administrative duty, compared with 16.2% in 2001. This increase in the use of on-call duty for a management body surprised us without finding any precise explanations.

Sectors concerned by on-call duty



8. ANESTHETIC ACTIVITIES

A. Working environment in the operating room:



It should be recalled that the statistics of the DREES 2014 report a total number of 7416 operating rooms in all establishments (1021 establishments). Public hospitals (454 facilities) had 3338 rooms, private non-profit facilities (98 facilities) had 640 rooms and private for-profit facilities (469 facilities) had 3438 rooms

A brief observation:

Public sector: just under 1/3 (31%) of NAs work in small blocks (1 to 6 rooms), 1/3 (35%) in medium-sized blocks (7 to 12 rooms) and the last third (34%) in large blocks (13 to +20 rooms).

Non-profit private sector: ¼ (26.45%) of NAs operate in small blocks (1 to 6 rooms), 40.5% in medium-sized blocks (7 to 12 rooms) and the remaining third (33.05%) in large blocks (13 to over 20 rooms)

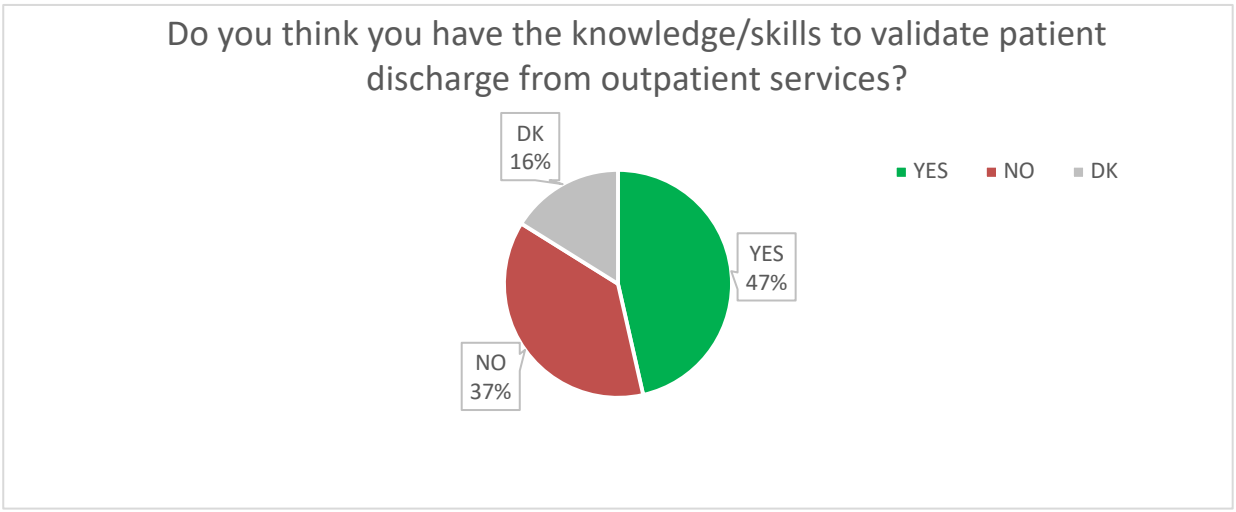
For-profit private sector: 18.58% in small blocks, 45.35% in medium blocks, 46.59% in large blocks. The percentage exceeds 110%, which can be explained by an exercise on several institutions of different sizes (multiple responses possible).

B. Ambulatory:

87.69 % of the IADEs surveyed (1446) declare that they participate in the outpatient activity.

This data confirms the commitment and role of the NA profession in the "ambulatory shift".

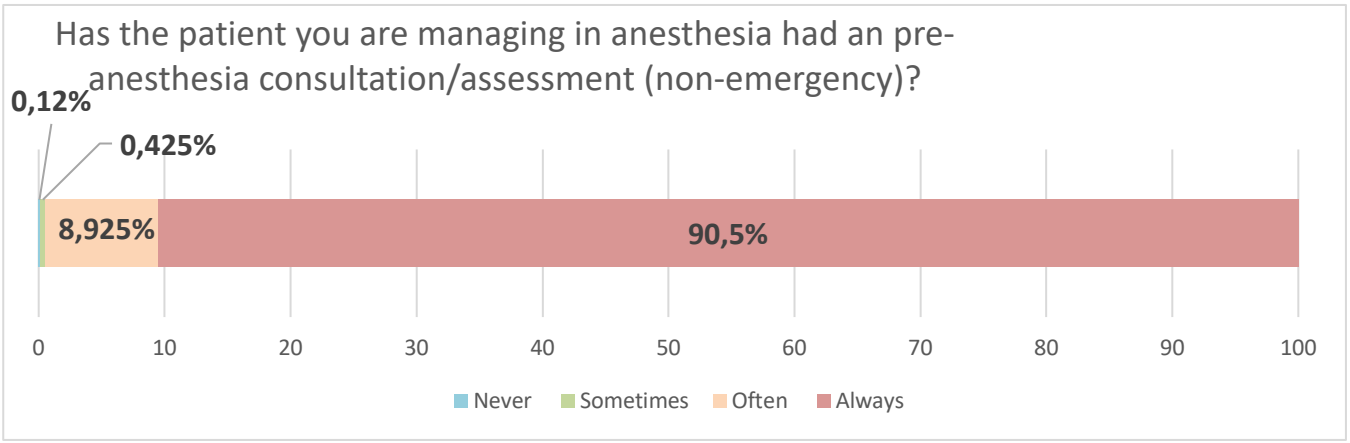
OPINION QUESTION Validation of discharge from outpatient service by the IADE

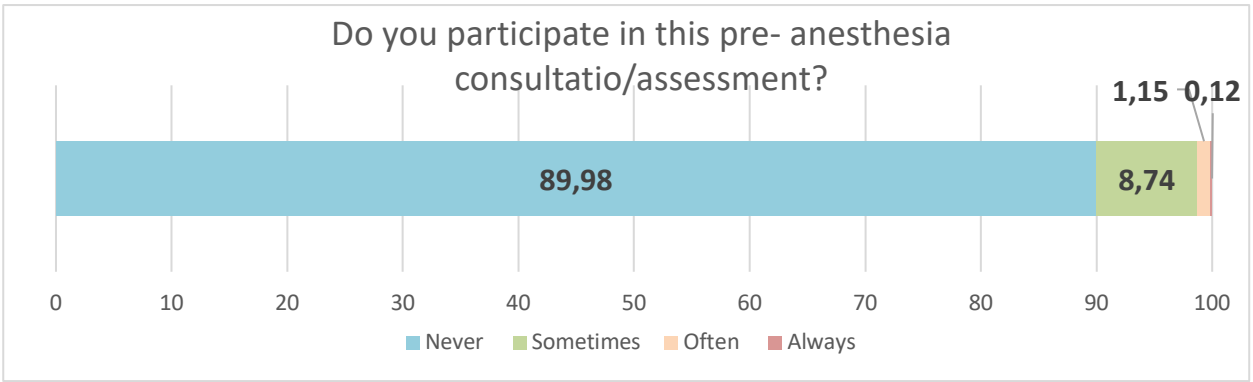


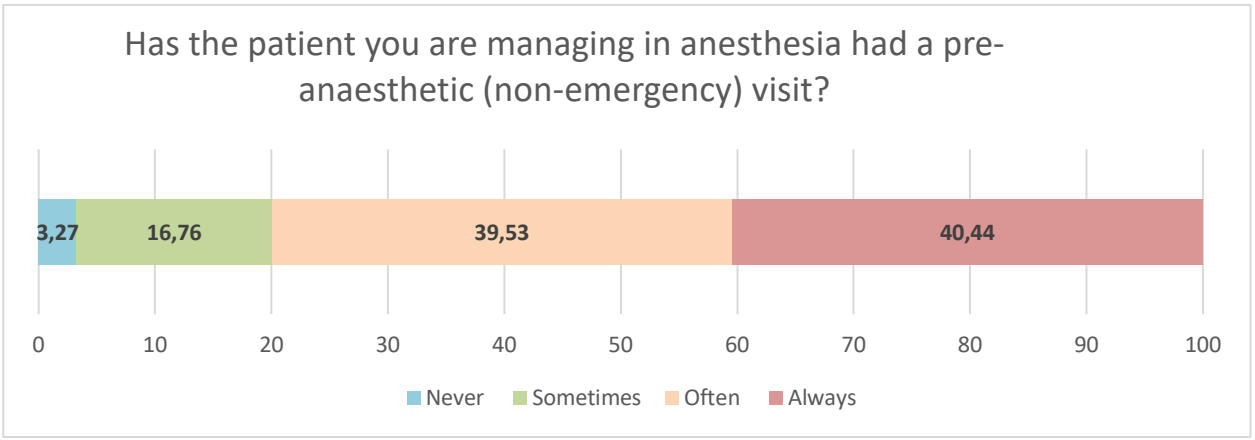
Comment:

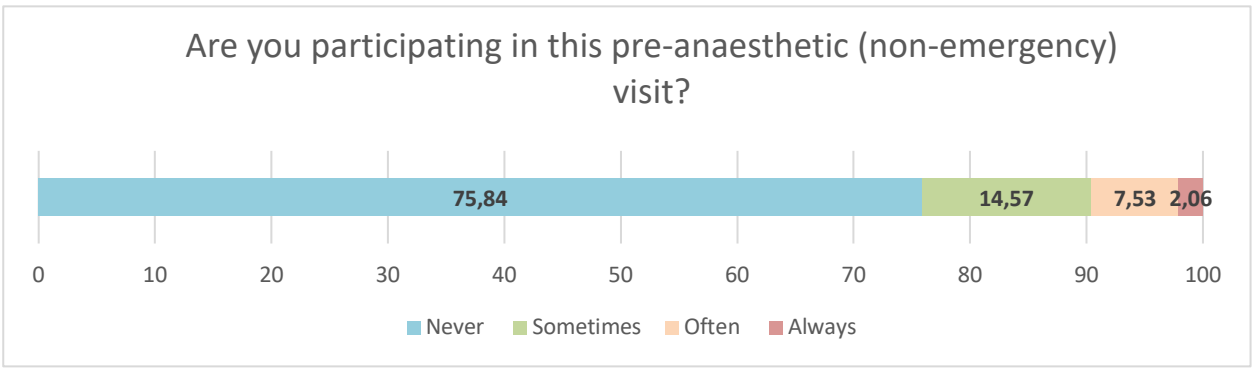
The SNIA's proposal to open a role for IADEs in the context of validating the discharge of patients from surgery and outpatient anaesthesia units is intended to be proactive. The criteria for "putting patients back on the street" are in fact part of the skills taught at NA. This role, which can be added to post-operative pain management and/or consultation/visit activity (see later in the survey), would support a new job profile. This role would free up medical time and make the patient's journey more fluid.

Pre-operative time (Anesthesia consultation - Pre-anesthetic visits): Commentaire :

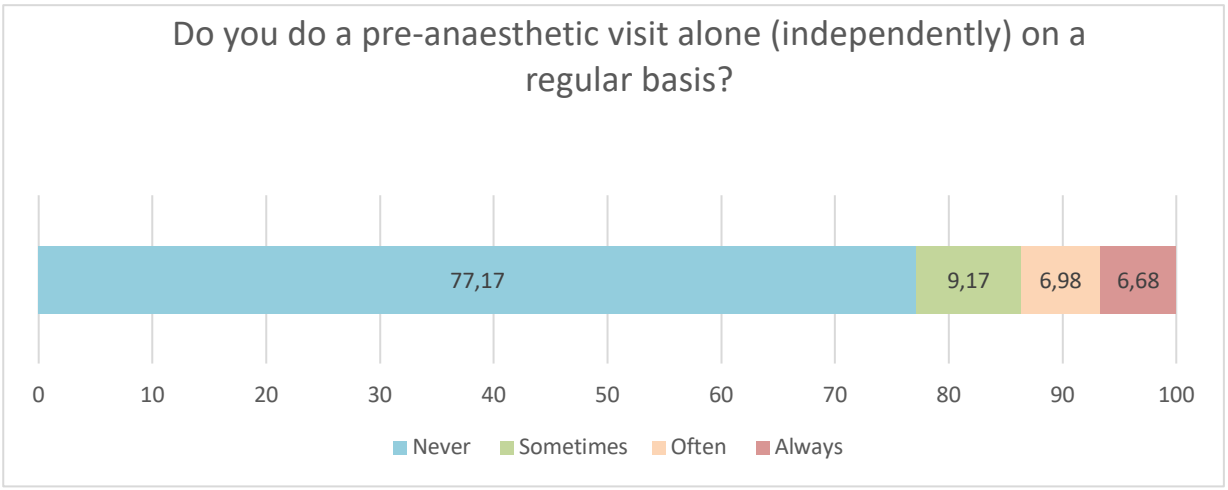




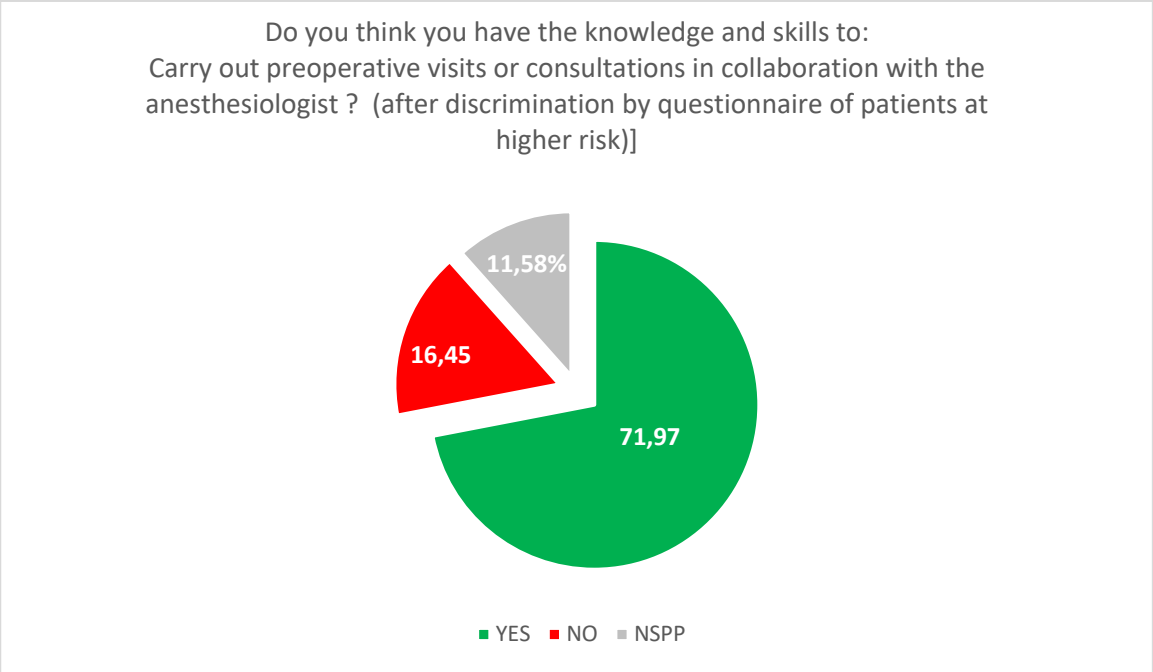




C. Realization of the pre-anesthesia assessment by IADE



OPINION QUESTION Implementation of PAA/PAVs by IADE



Findings in brief:

The absence of an- preanaesthesia assessment (outside the emergency department) appears to be exceptional. IADE's participation in the anaesthesia consultation is also exceptional (sometimes 8.74%).

PAV is always performed in 40% of cases and often in 39.5%. (Sometimes 16.76% and Never 3.27%).

Contrary to the consultation, nearly 10% of NAs report that they frequently (often/always) participate in the implementation of the PAA with the anesthesiologistes. 13.66% of NAs report that they frequently carry out these PAVs independently.

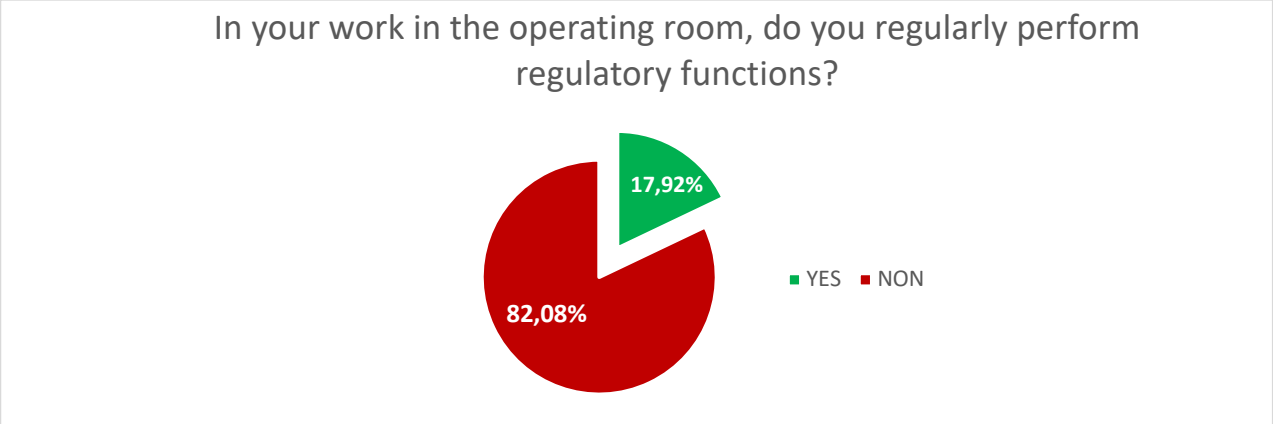
71.97% of NAs report having the necessary knowledge and skills to carry out preoperative/pre-interventional consultations/visits, in collaboration with the anesthesiologists and after discrimination of patients by questionnaire. (16.45% No and 11.58% DK)

Comments and interpretations:

Despite the limited space available to NAs for PAA and PAV activities, it appears that IADEs feel ready to take on new roles in the system. A collaboration allowing the NA to carry out pre-anaesthetic visits or even consultations with patients without a significant history, in the context of outpatient care for example, would be meaningful and relevant. These new activities could allow the redistribution of medical time on "complex" consultation activities while allowing patients with no history to benefit from complete information on the anesthetic procedure delivered by an anesthesia professional, an IADE.

It remains to create the regulatory and organisational conditions for these new practices by going beyond the compartmentalization of tasks associated with this activity.

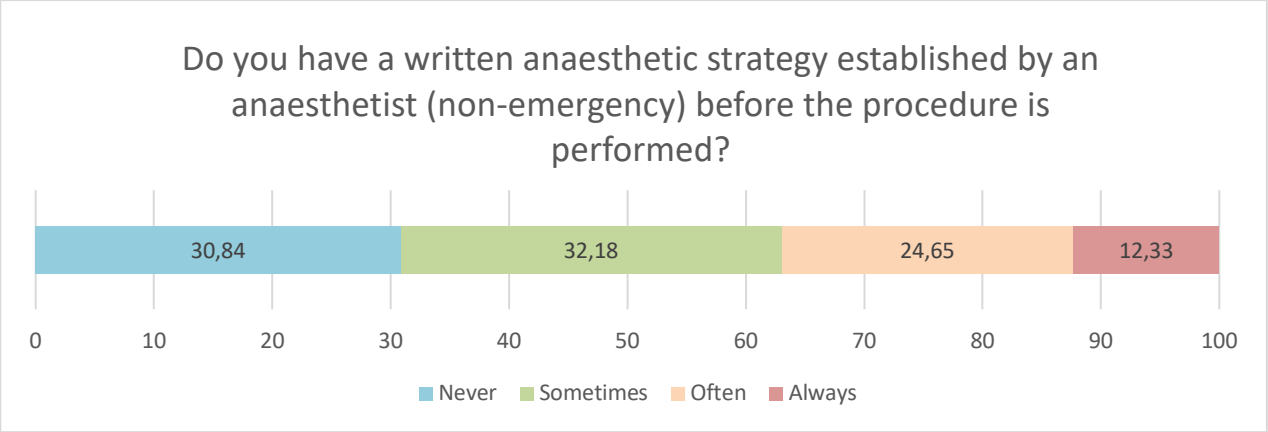
D. Operating room activity regulation functions:



***A brief observation**:*
Nearly 18% of IADEs perform regulatory functions within their operating rooms.
80.88% of IADE Health Managers working in operating theatres perform regulatory functions.

Comments and interpretations:
This 18% rate of IADE is not insignificant and also shows the proportion of IADE developing other skills within the operating room organization. The rate of IADE Managers to fulfil these regulatory missions also demonstrates their strong involvement in this core activity.

E. Anesthetic strategy:

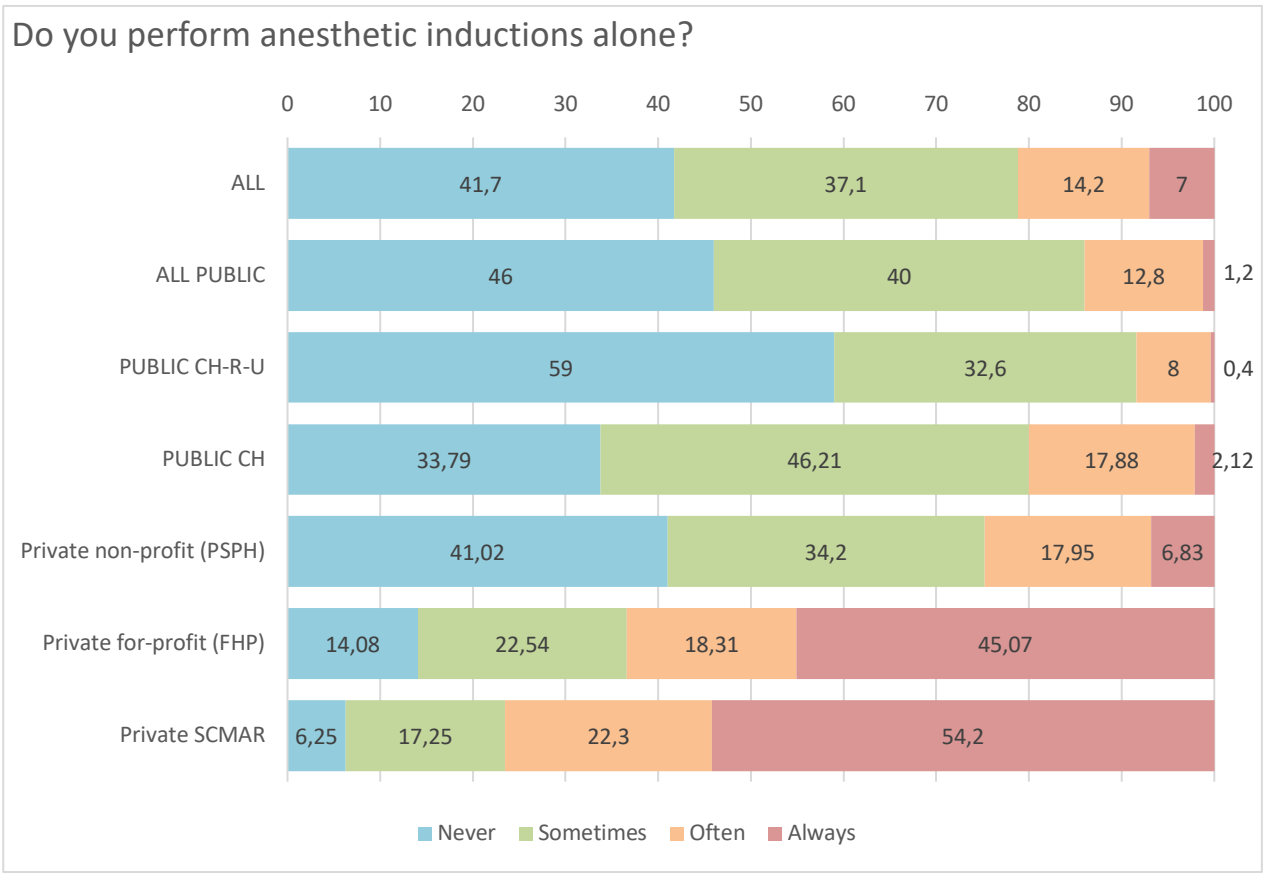


Findings in brief:
The anaesthetic strategy (formerly protocol) established by the MAR is still only present in 12%, often 25%. It is never present in 31% of cases and only sometimes in 32%.

Comments and interpretations:
This absence raises questions about the legal fact of the IADE practice in the absence of a written strategy. This can be explained by the fact that IADEs have always used their clinical knowledge and skills to deduce a large amount of information from the anaesthesia consultation report, but also that many of the exchanges between MAR and IADE are still oral. By the absence of a written strategy and/or prescription, the MAR implicitly recognize clinical analysis skills in IADE, skills already recognized by the IADE training, skills and activities repositories. Indeed, the choices and conditions of implementation of anesthesia are mainly deduced after analysis of the results of the anesthesia consultation performed by the MAR. While the profession worked on the rewriting of

article 4311-12 in 2016-2017, it remains a concern that the notion of an anesthesia strategy has not become part of the practice of anesthesia teams. It seems that the regulatory framework is not yet in line with the skills developed by the IADEs on the ground.

F. Anesthetic induction phases :



Findings and comments in brief:

On average, 21% of IADEs frequently (often/always) perform anesthetic inductions alone, sometimes 37.13%, never 41.76%). The results for private non-profit sector IADEs are superimposed on this overall average.
If we look more closely, we can see great disparities in the autonomous practice of induction by IADE alone according to the employer.

In the public sector, the activity reported in large hospitals (CHR, CHU) compared to that of small establishments shows that 20% of them regularly perform inductions alone, compared to 8% in CH(R)U.

It is in the private for-profit sector that autonomous induction is most frequent, regularly practiced by IADEs employed in FHP clinics at 63.38% (often: 18.31% and always 45.07%). These practices are even more common for IADEs employed by liberal MAR companies (often: 22%; always: 54%).

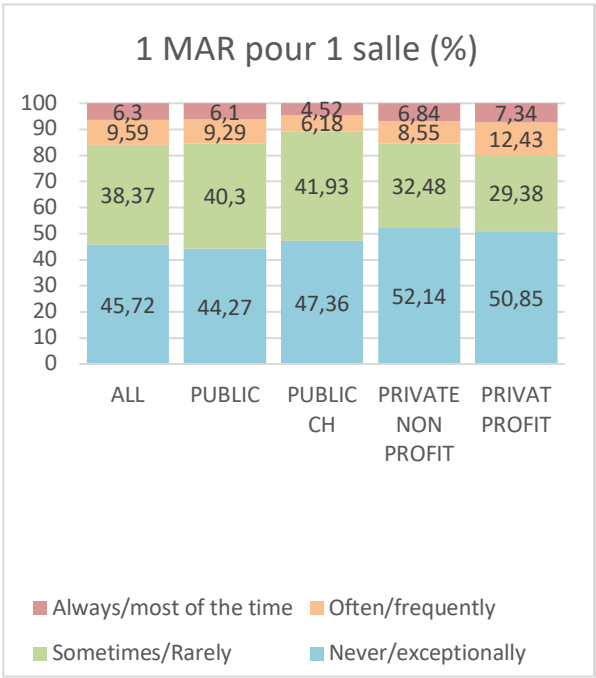
The MAR is always present on the site (which can allow rapid intervention) where inductions are carried out in 85.37%, Often 12.87%, Rarely 1.27%, Never 0.04%)

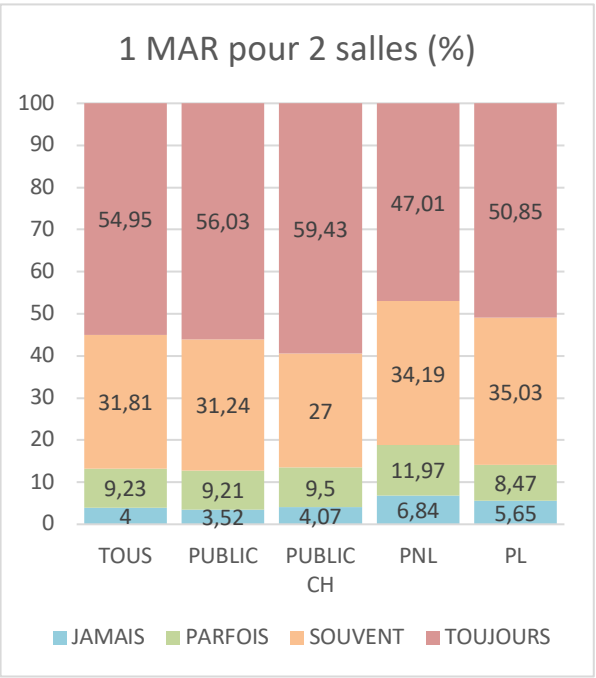
G. Intervention/Supervision by Anesthesiologist Resuscitator:

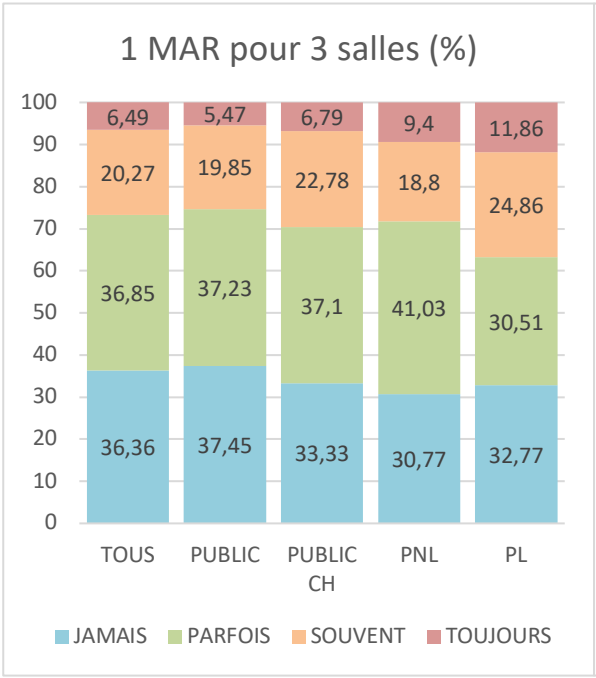
The anesthetist can intervene at any time in 97.99% of the organizations set up.

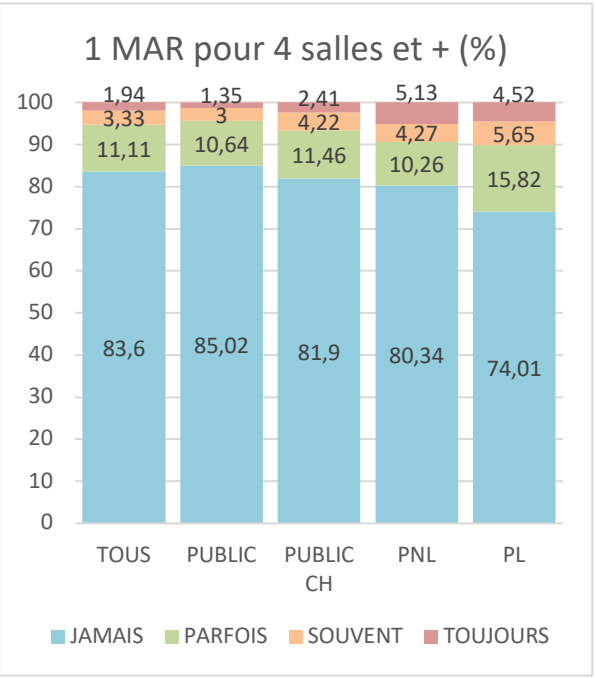
The MAR is always present on site (allowing it to intervene quickly) during the maintenance phase in 85.14% of the declarations.

Number of rooms supervised by 1 MAR, 1 IADE in each room









Findings in brief:

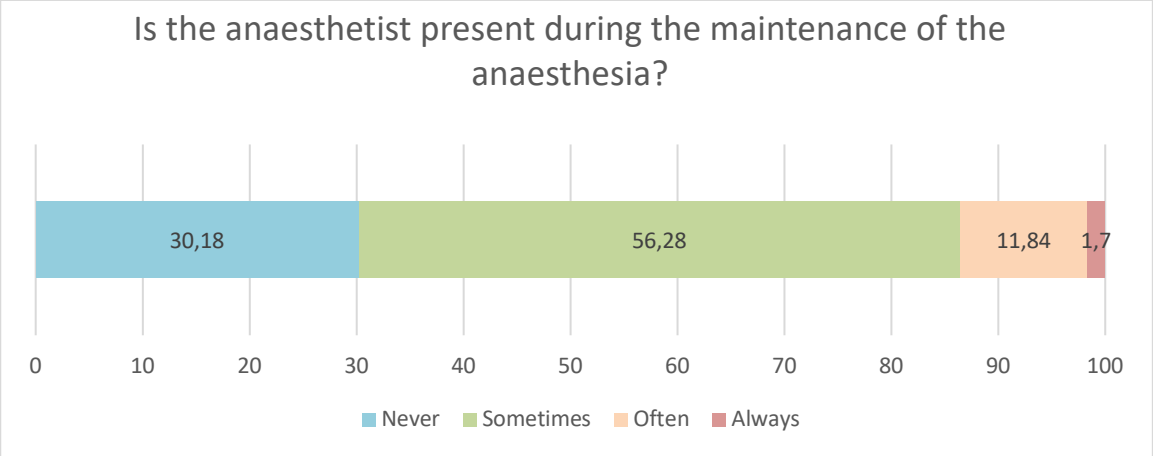
It can be seen that the number of rooms supervised by the MAR is approximately the same, regardless of the establishments or the type of employer. The most common operation remains the supervision of 2 rooms by the MAR, which corresponds to the recommendations of the learned medical society. The supervision by the MAR of

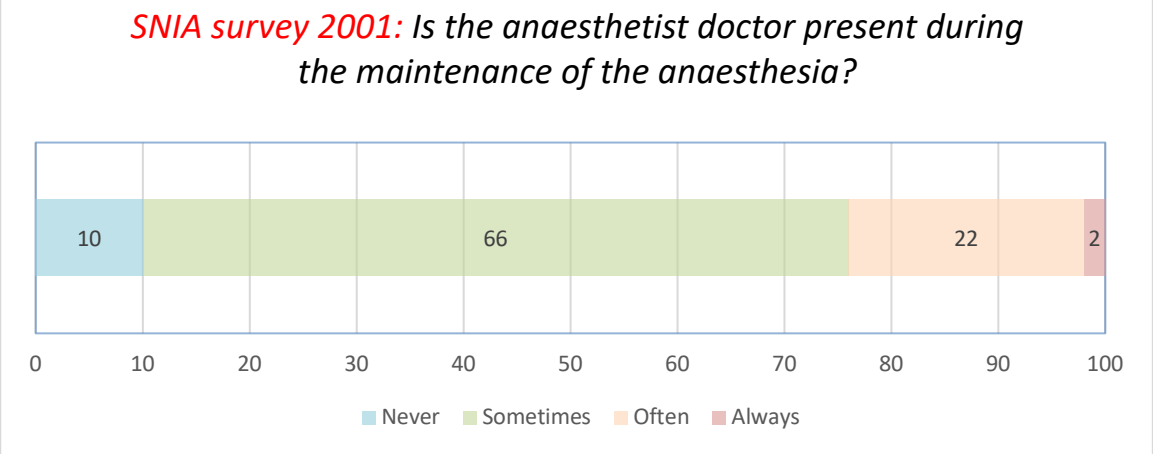
3 rooms is also widespread in all types of establishments. The supervision of 4 rooms by the MAR remains uncommon, but more often in the private sector.

Comments and interpretations:

With the increasing recognition of IADE skills in anaesthesia practice in recent years, it is questionable whether the recommendations of 2 rooms for one MAR (one IADE in each room) should not evolve.

H. Maintenance phase :

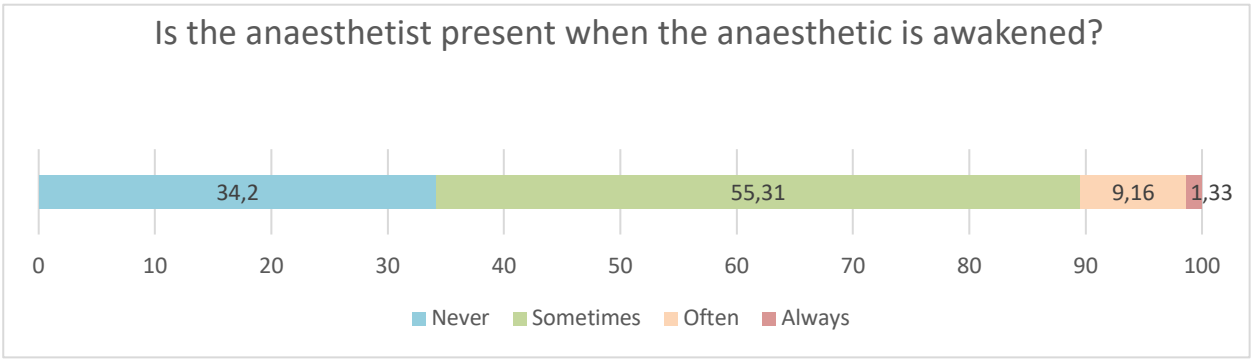


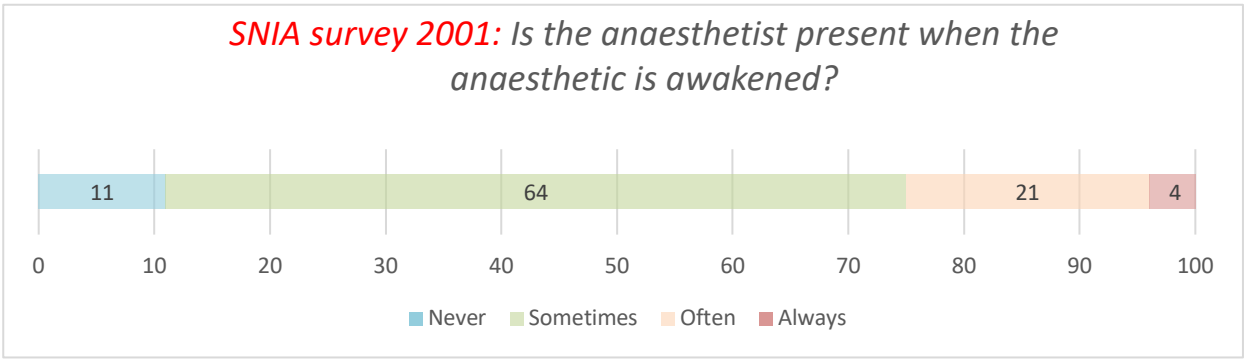


Interpretation:

The recurrent physical absence of MAR noted in these results indirectly demonstrates the autonomy of IADE during the intraoperative phase in the conduct of anesthesia and the maintenance of homeostasis. Autonomy has clearly increased since 2001.

I. Awakening phase :





Interpretation:

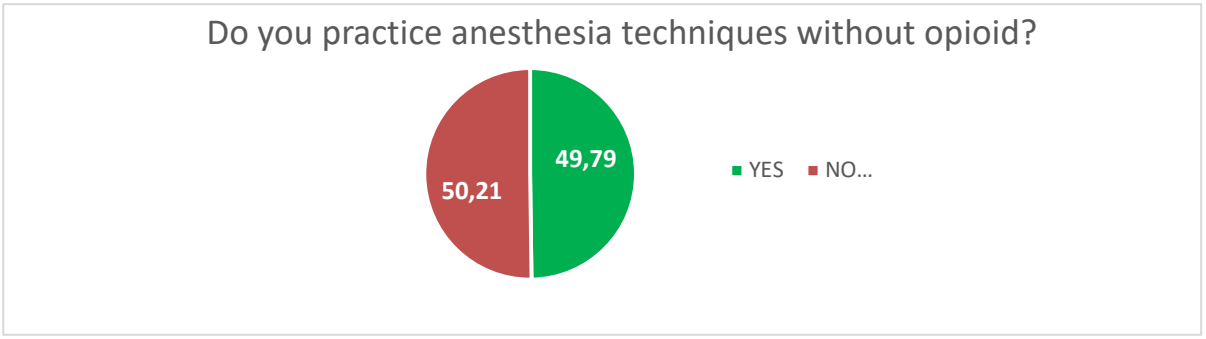
These results demonstrate autonomy in anesthetic reversion and ventilatory and hemodynamic weaning. Autonomy has increased since 2001.

J. Pediatric anesthesia :

In 89.67% of cases, IADEs never induce children alone (8.94% sometimes), the recommendations for 4-handed induction are generally strictly respected.

79.81% of IADEs practicing pediatric anesthesia report that collaboration with the MAR and its supervision are closer than in the adult sector, 18.8% do not see any difference and only 1.37% report less close supervision.

K. Opioid Free Anesthesia :

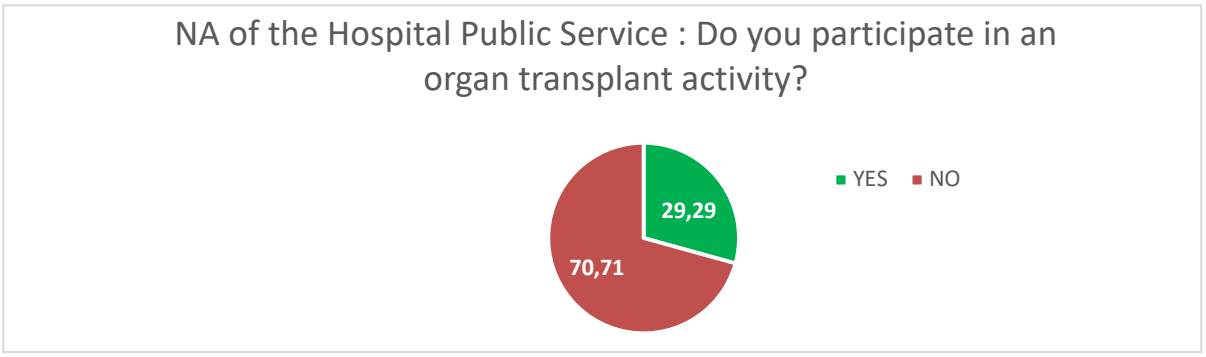


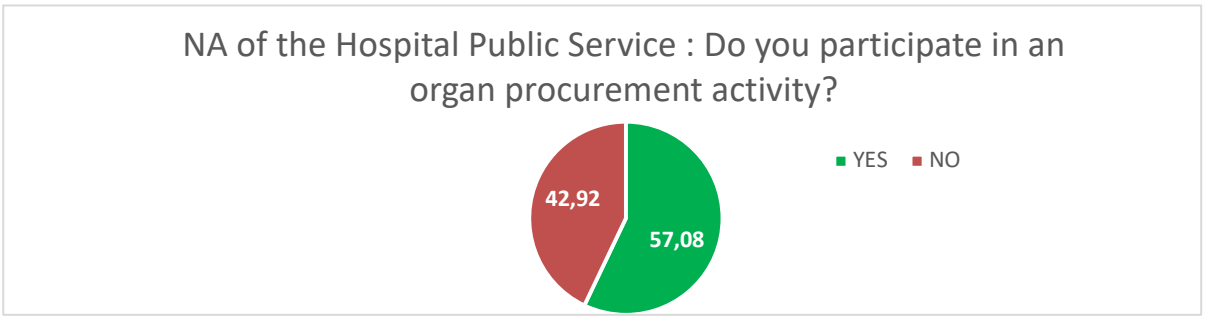
Comments and interpretations:

Nearly a half of the professionals interviewed practice opioid-free anesthesia techniques, a technique that is currently being generalized in our country. This data provides information on the progress of this promising process with regard to the requirements for improved recovery after surgery (RAAC) and early rehabilitation as part of the "ambulatory shift". IADEs demonstrate their ability to adapt.

L. Organ harvesting and transplant activities:

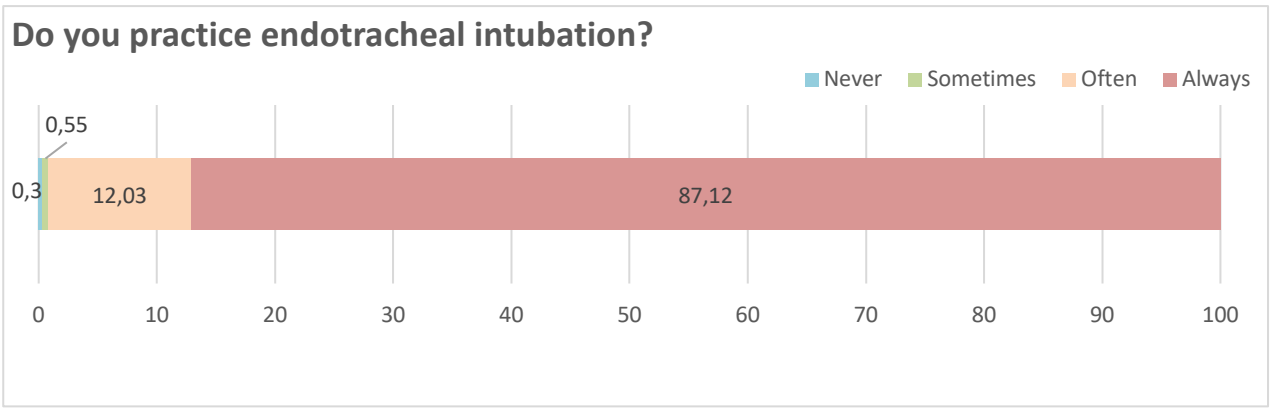
Questions asked only to public sector IADEs.



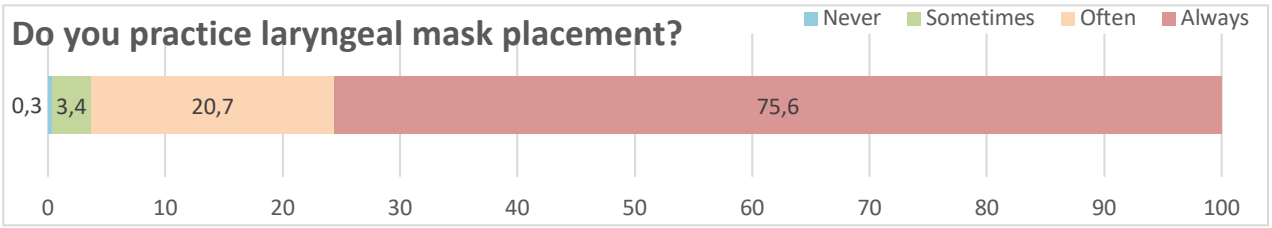


M. Ventilation procedures :

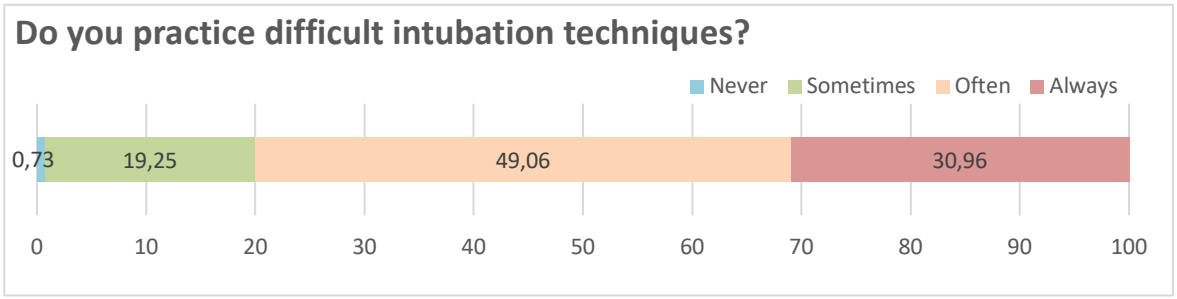
i. Endotracheal intubation:

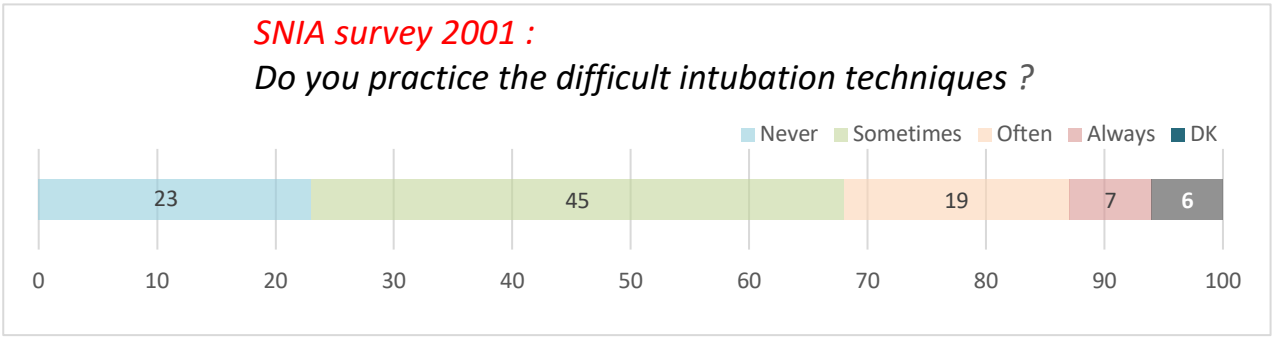


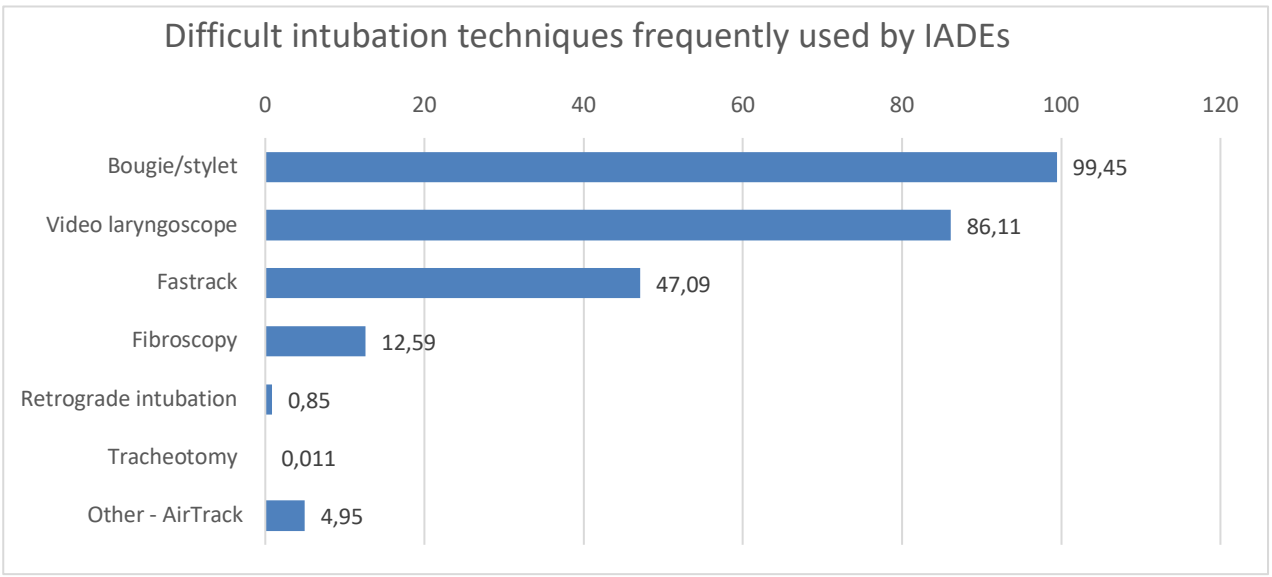
ii. Supraglottic devices :



iii. Difficult intubation techniques :





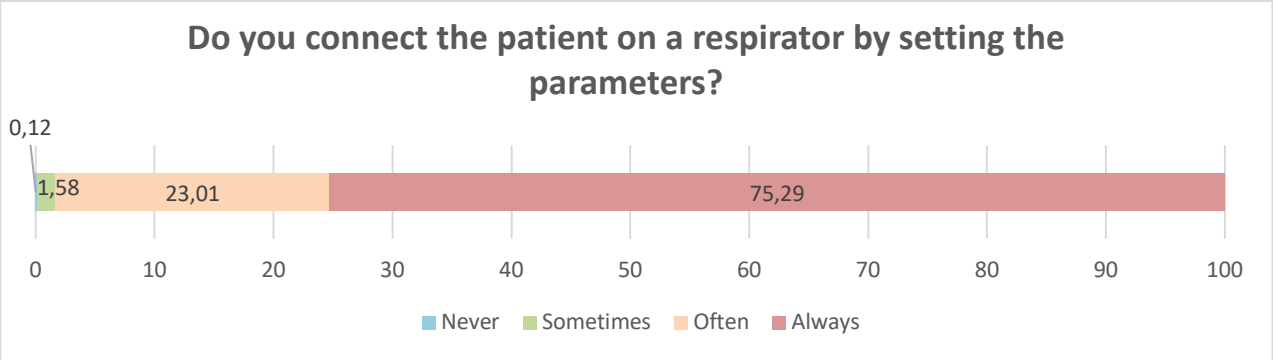


Findings in brief:

Bougie and videolaryngoscopy techniques are the most commonly used by IADE for difficult intubation. Fibroscopy is performed by only 12.6% of professionals and the AirTrack solution by 5%.

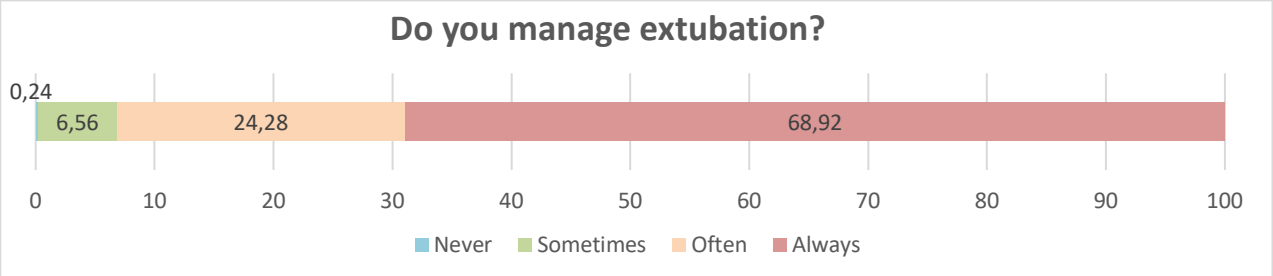
Comments and interpretations:

These data confirm the daily practice and recognized expertise of IADEs in upper airway management. Comparison with the 2001 data on the practice of difficult intubation techniques clearly shows the increase in IADE expertise in this field, due in particular to technical innovations.



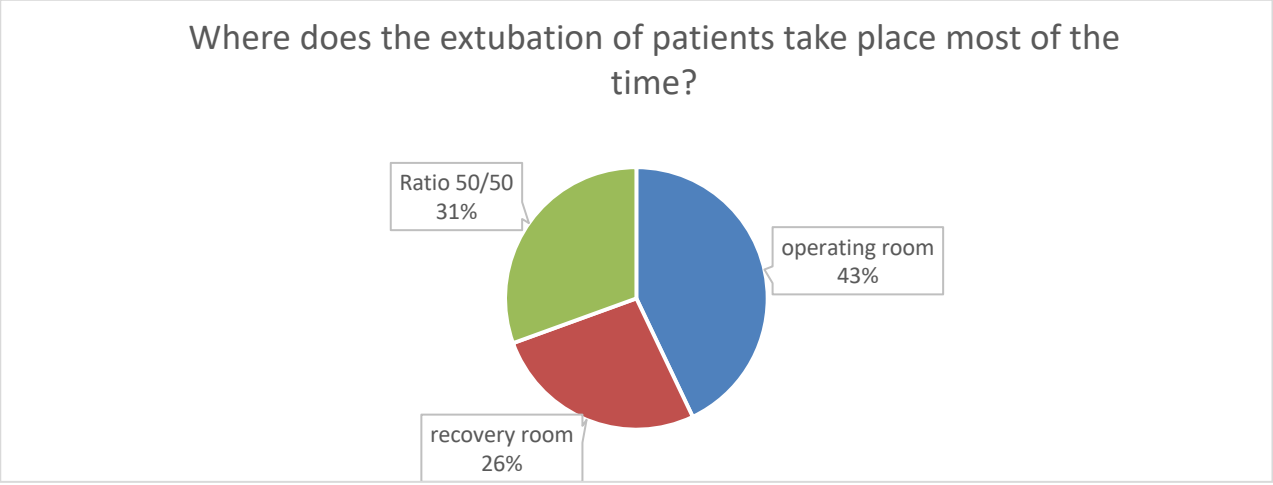
Interpretation:

These results confirm the autonomy in the adjustment and adaptation of ventilatory supplementation equipment.



Interpretation :

These results confirm the IADE autonomy in the reversion and weaning of patients.



Findings in brief:

It should be noted that a significant proportion of patients appear to be extubated directly in the intervention room (43% and a ratio 50/50 for 30% compared to a percentage of extubation in recovery rooms of 26.5%).

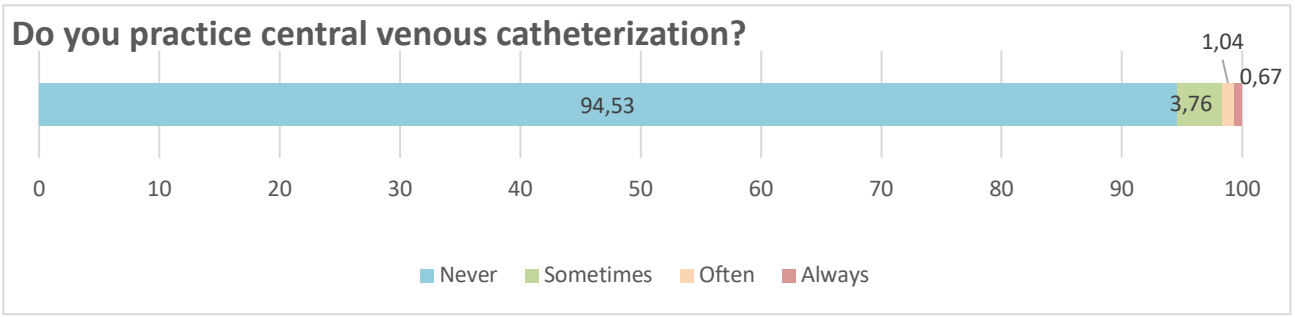
Comments and interpretations:

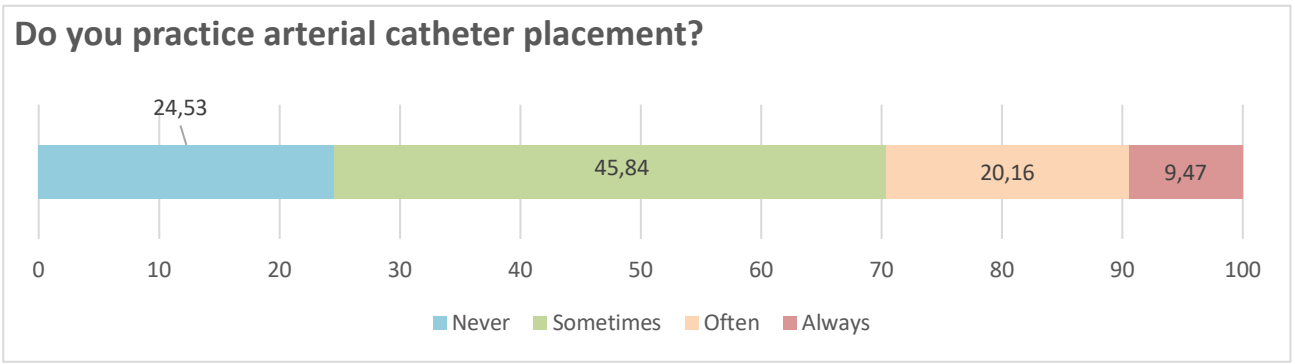
These so-called "on table" extubations indicate the significant effort of professionals in anticipating drug and physiological reversions, which make it possible to moderate the workload of recovery rooms.

The responses demonstrate and confirm the daily practice and skill of all medical techniques used by NA to manage the upper airways and maintain hematosis.

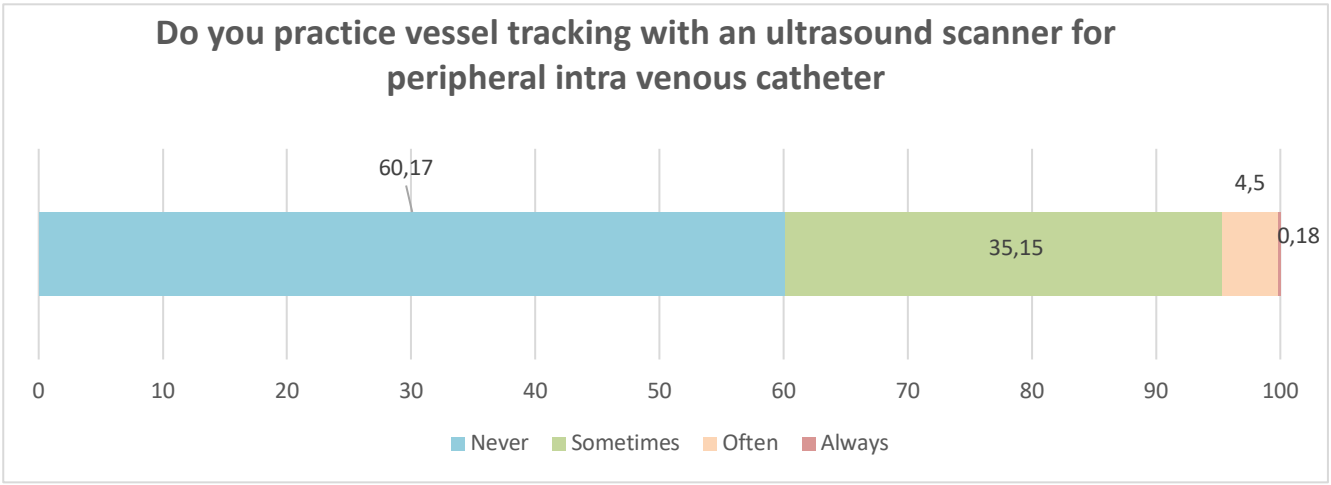
N. Vascular access:

i. Central venous approaches and arterial catheterization:

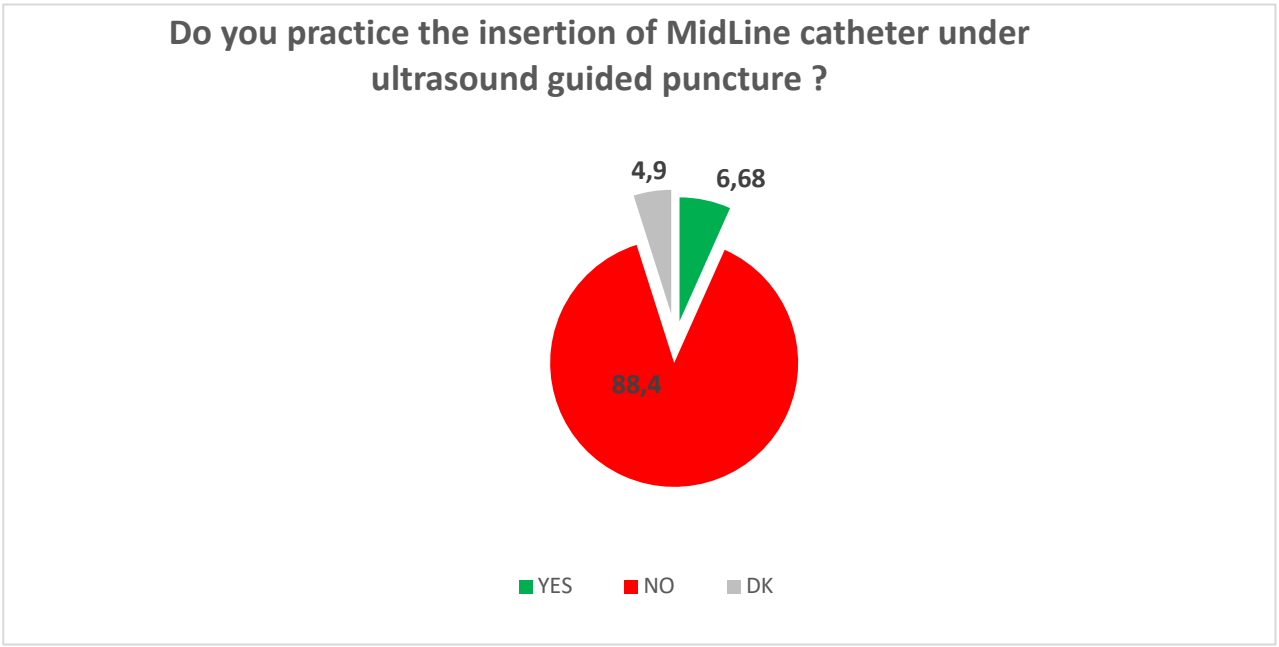




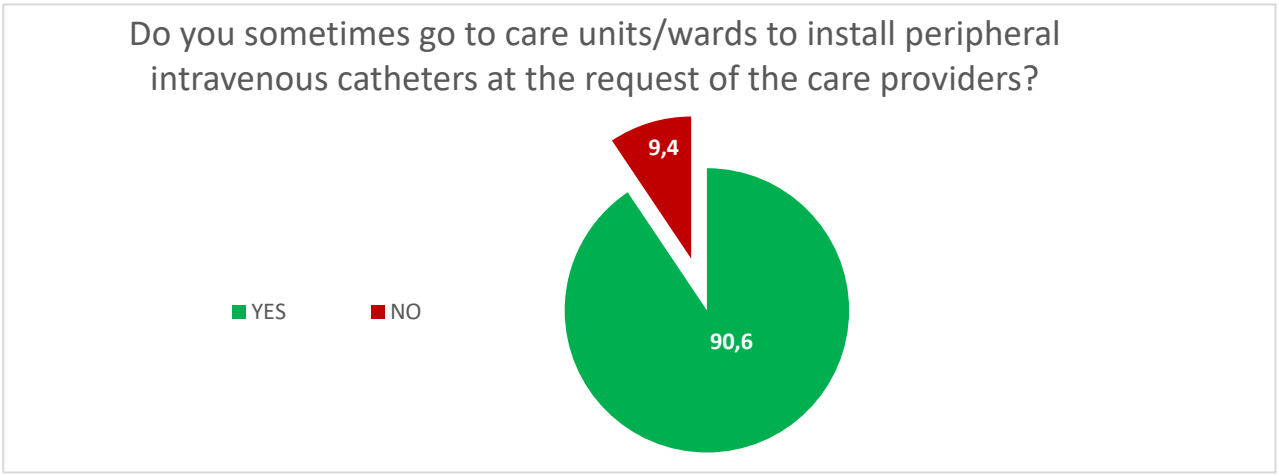
ii. *Ultrasound for peripheral venous approaches:*

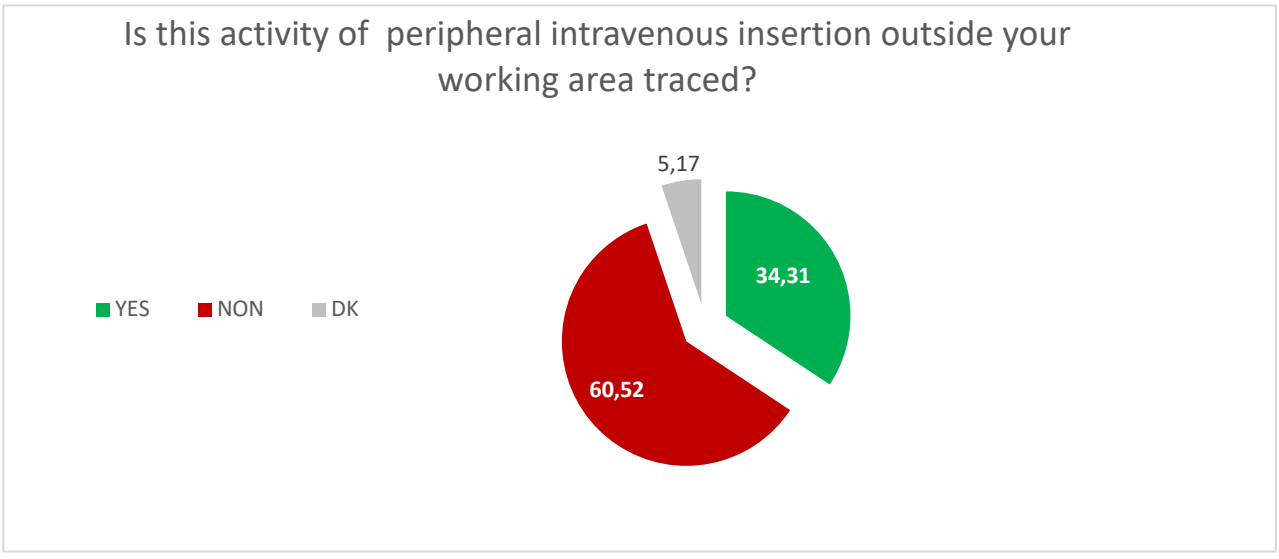


Midline devices



iii. *Skills for difficult peripheral venous access:*



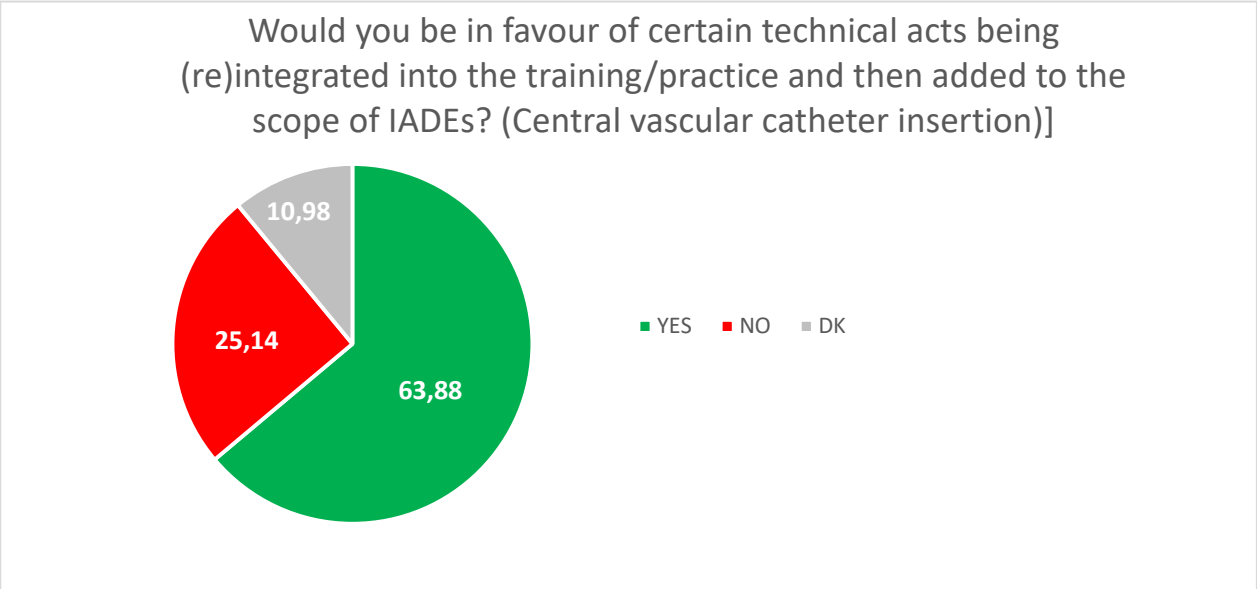


Observations and comments in brief:

An overwhelming majority of NAs (>90%) report that they are leaving their units to infuse "difficult" patients at the request of *care units.*

This expertise in the peripheral intravenous insertion is certainly only traced in 34.31% of cases.

OPINION QUESTION: CVC insertion by IADE



Comments and interpretations:

The insertion of central venous catheters has become very marginal among IADEs (5.47%). Since 2001, when nearly 19% of them declared that they practise these techniques (Never 78%, Sometimes 15%, Often 2%, Always 2%, Always 2%), the advent of activity-based pricing has most certainly played against a pose by anesthesia nurses.

Arterial catheters are frequently placed (often/always) by 30% of IADEs. It should be noted that the insertion of arterial catheters only concerns certain major surgeries and/or patients with a proven cardiac history, which may explain this relatively low rate for an activity totally authorized for IADE.

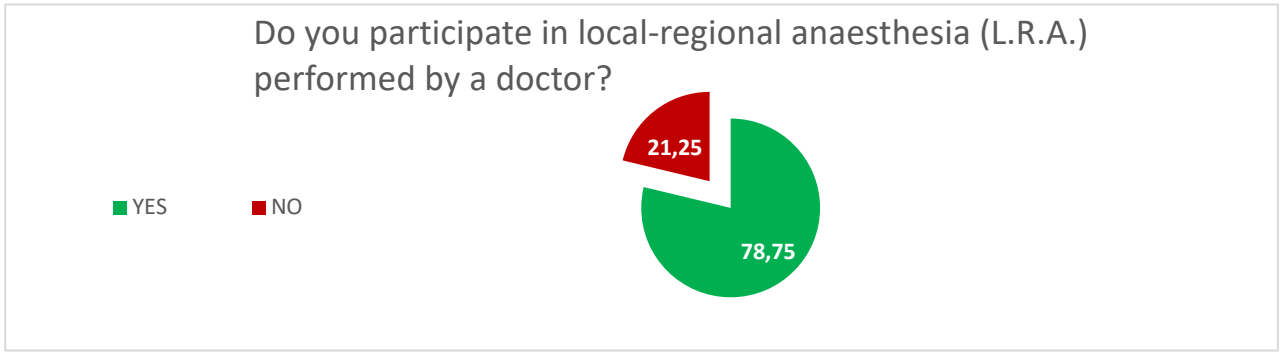
A majority of IADE (64%) would support the insertion of central vascular catheter as a (re-) technique integrated into their activity/training.

The activity of difficult peripheral intravenous catheter insertion by IADEs outside their working sectors had never been quantified. It should be noted that this activity is extremely widespread, but not highly rated or valued.

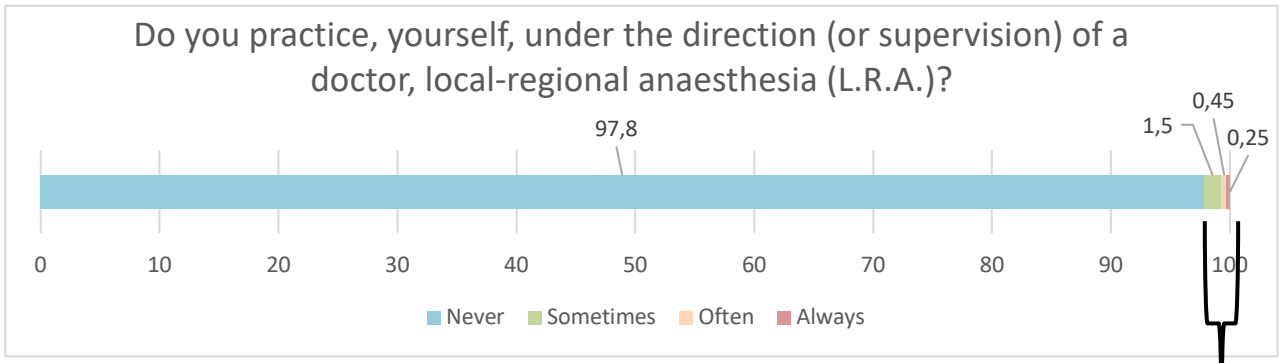
All these data are in favour of recognition of the IADE expertise in the insertion of intravascular catheter that only needs to be increased. The development of new devices (Midlines/PiccLines) and the effective participation of IADEs in protocols of cooperation for the insertion of CVCs illustrate the need to change the settlement and to allow modifying the regulation of educational program leading to the state diploma of nurse-anesthesist on these practices.

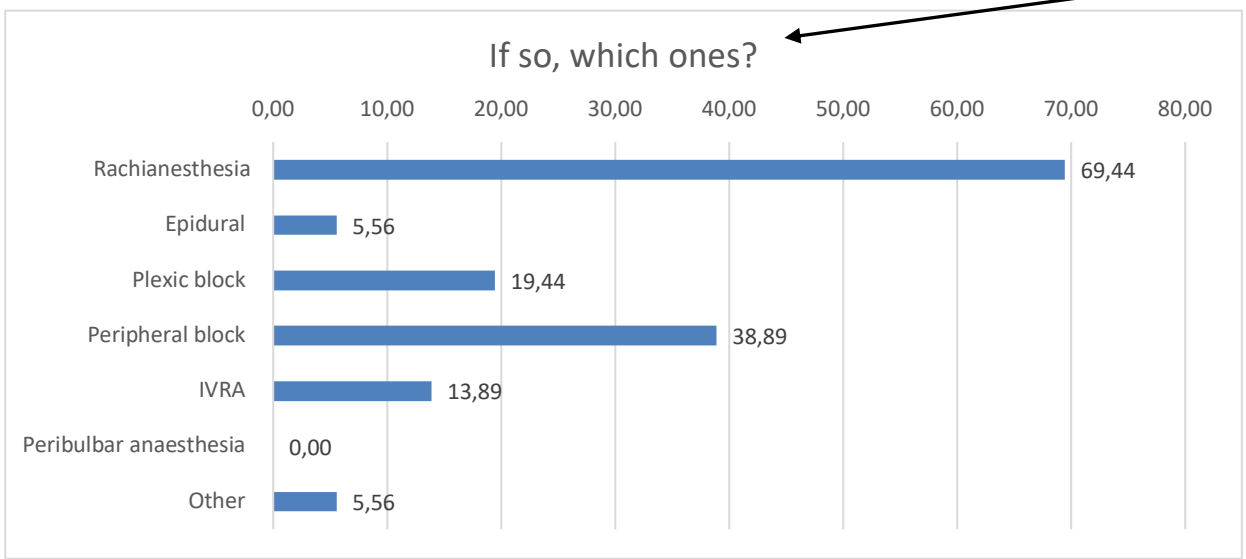
O. Local and regional anesthesia:

i. *Participation in techniques :*

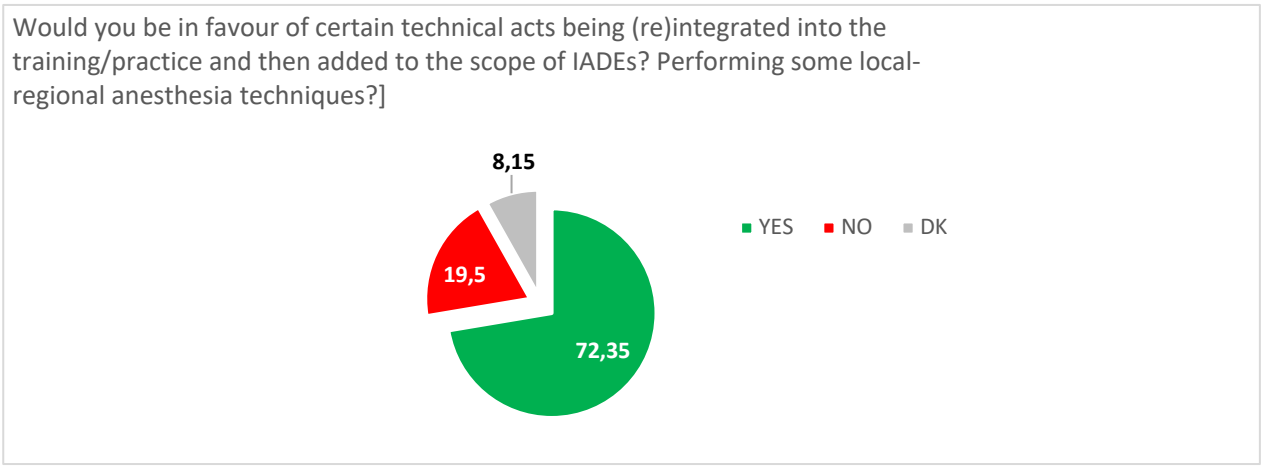


ii. *Practice of techniques:*





OPINION QUESTION: Conduct of LRA by IADE



Findings in brief:

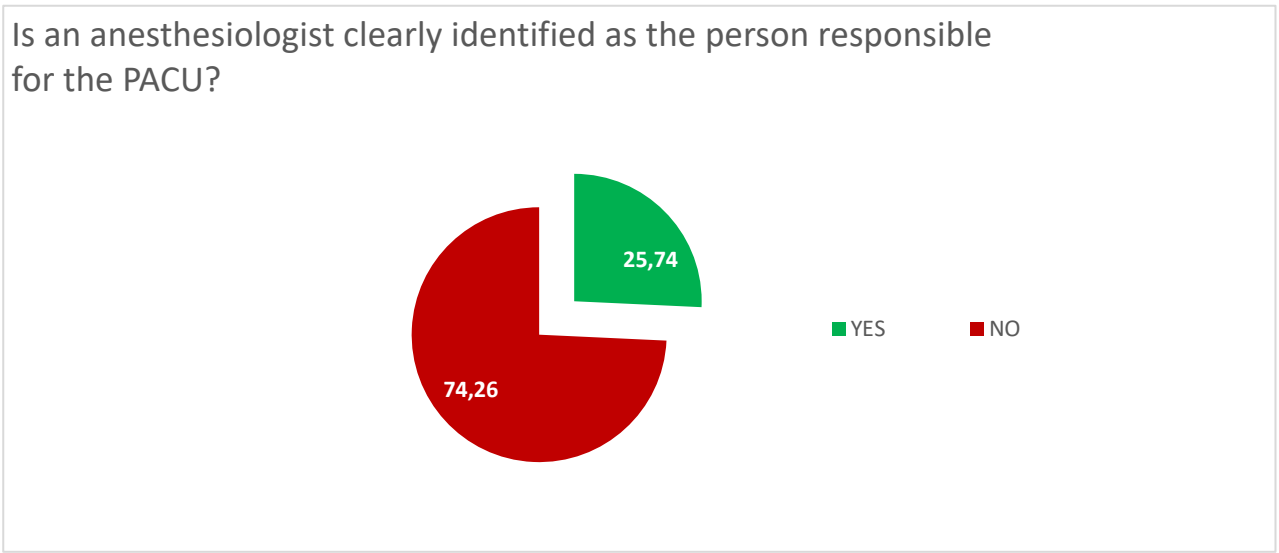
A majority of IADE (79%) participates with the MAR in local and regional anesthesia.
The autonomous practice of LRA techniques by the IADE remains highly confidential (<3%).

It is noted that a majority of IADE (72.34%) would be in favor of LRA techniques being fully integrated into their activity/training.

Comment:

As in the central venous catheter insertion we would like to enrich our training, skills and activities in the field of local and regional anesthesia.

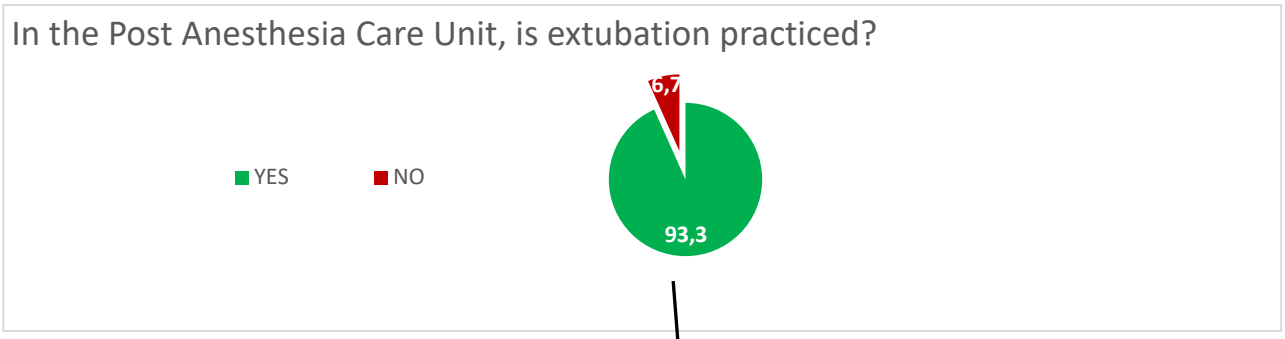
P. Recovery room (PACU)

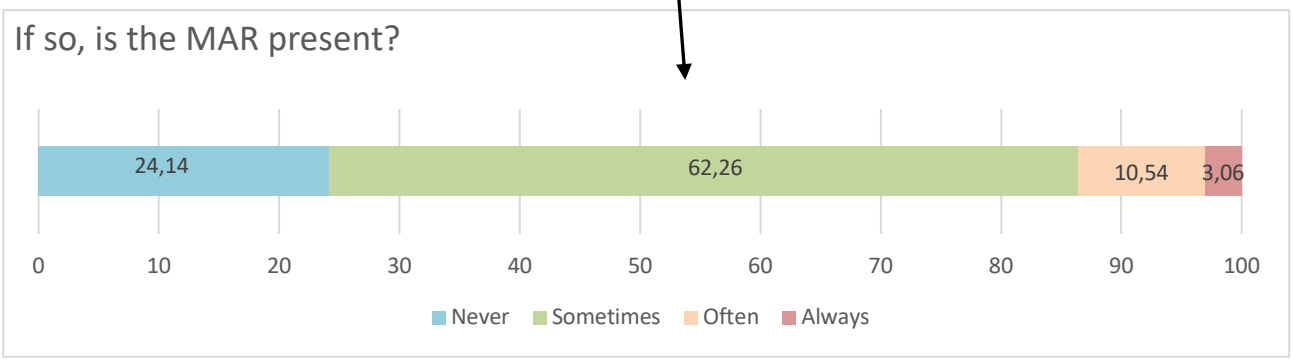


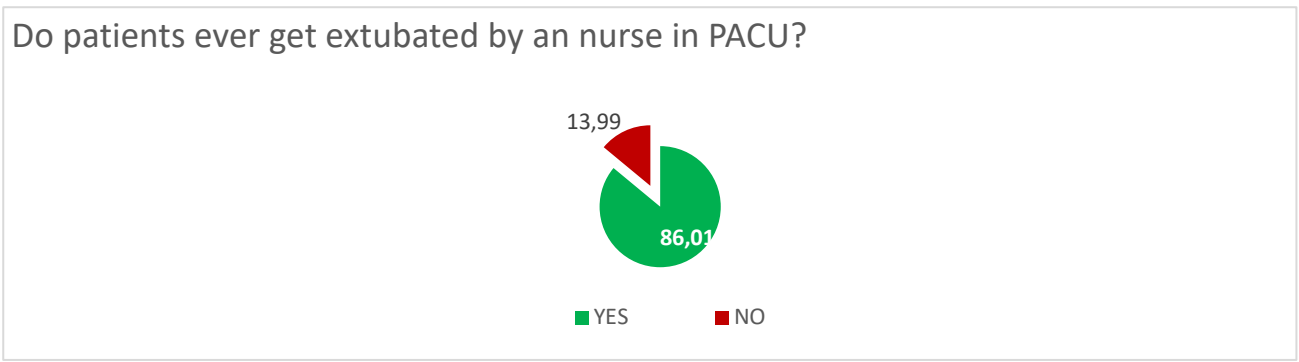
A brief observation:

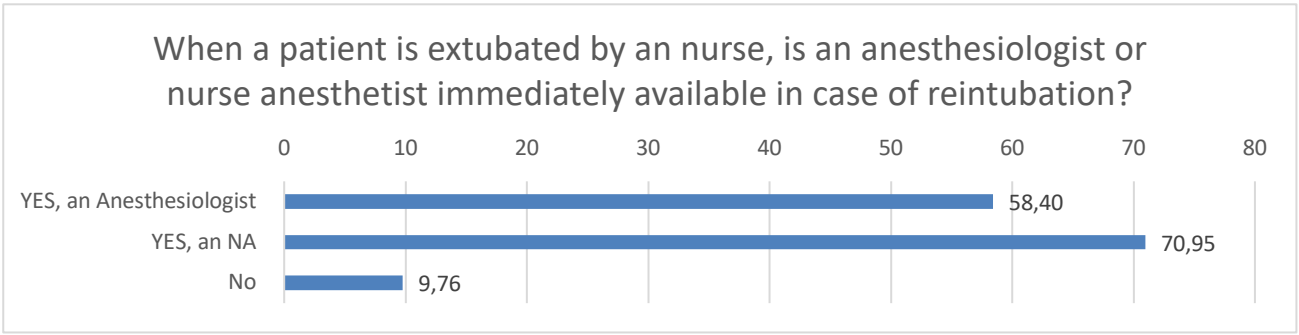
In 75% of the responses, no physician was identified as responsible for the PACU.

Extubations in PACU





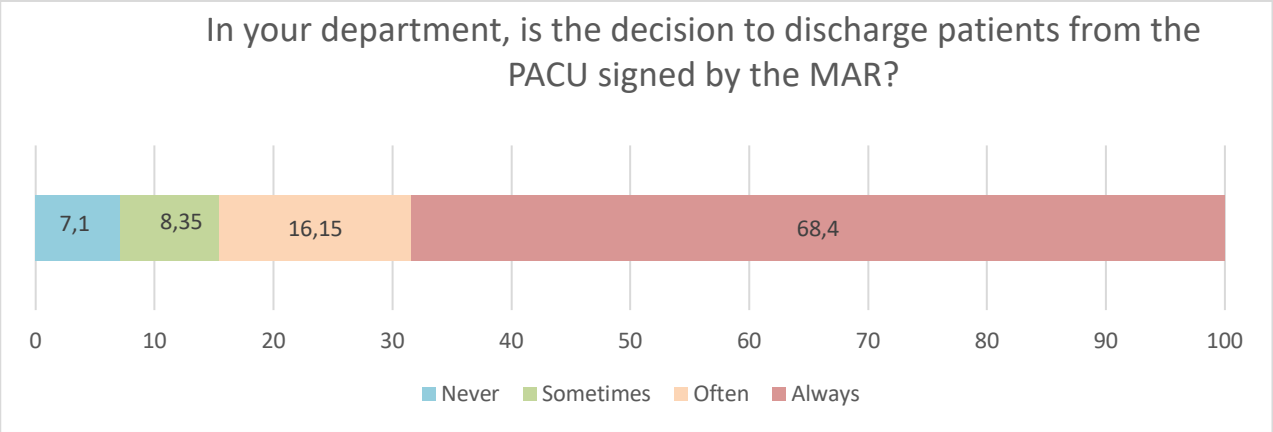


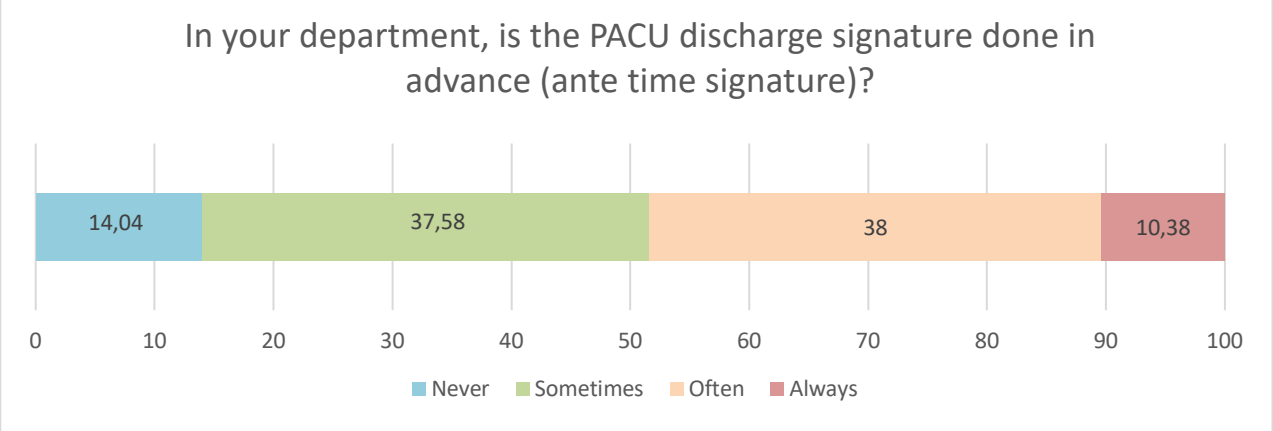


A brief observation:

Extubation of patients in a recovery room is a common practice (93%), an anesthesiologist is never or sometimes present in 86.4% at the time of this procedure.

Patient extubation is a common practice by nurses in PACUs (86.01%). In the event of an incident during this phase, it appears that the IADE (71%) is the most available resource person to solve the problem.





A brief observation:

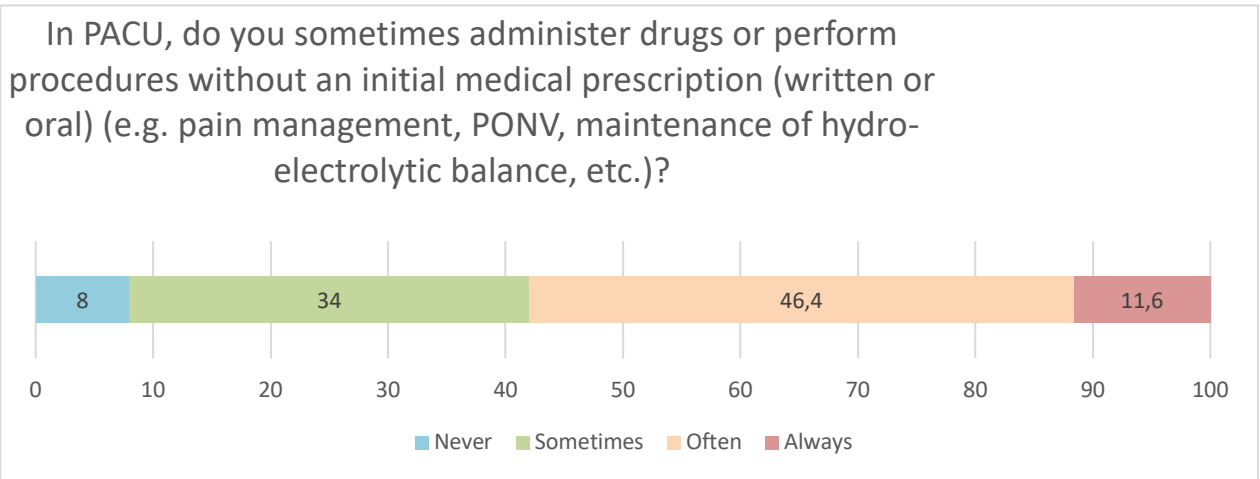
It appears that the decision to discharge from PACU is always signed by the anaesthesiologist in 68.4% of cases, but that this signature is often ante time in 38% of cases and always in 10.4%.

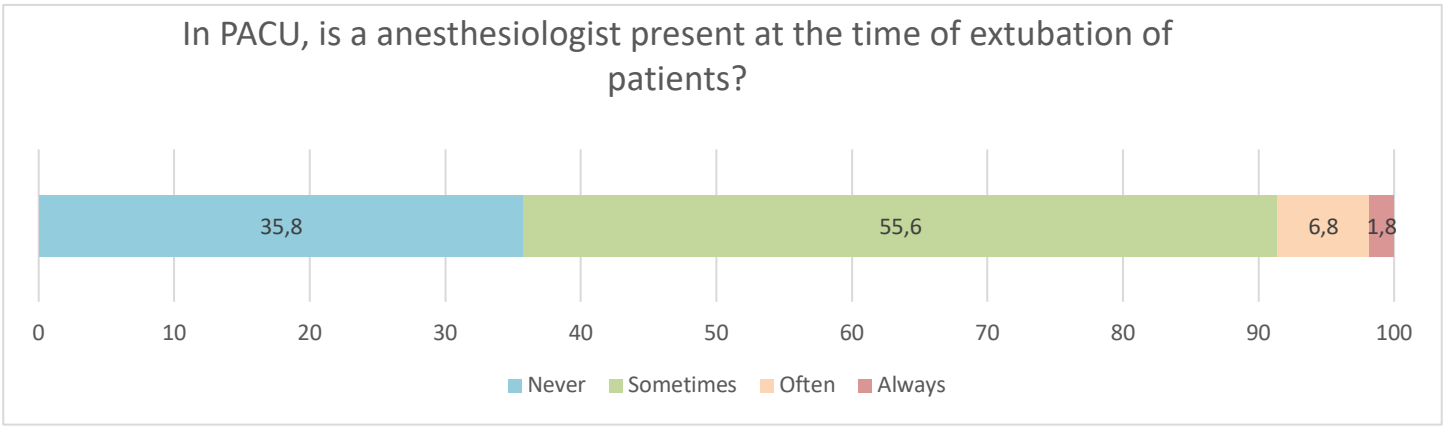
Commentary and interpretation:

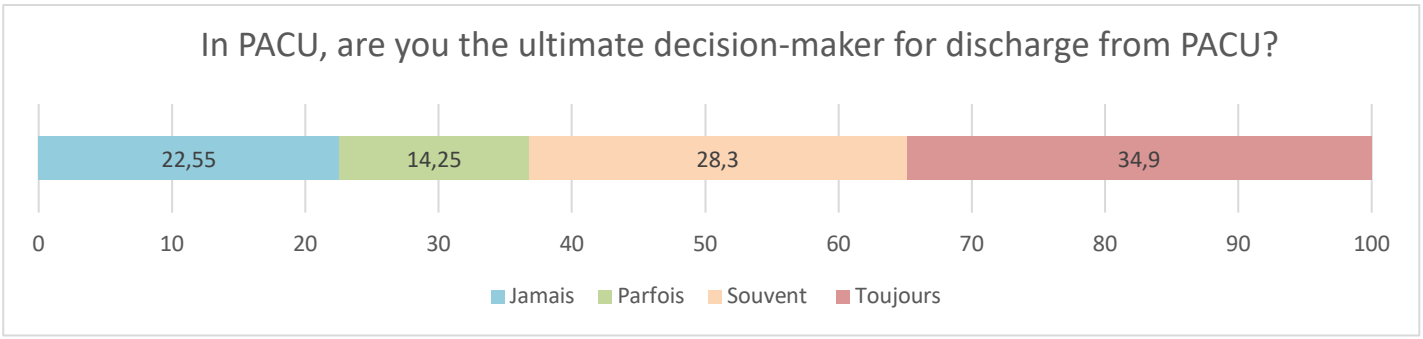
This frequent practice of ante timestamping is used to try to comply with current legislation and shows that the final evaluation is based on the expertise of SSPI paramedics.

IADE in post-anesthesia care unit - PACU

(940 /1703 or 55.2% of IADE respondents)







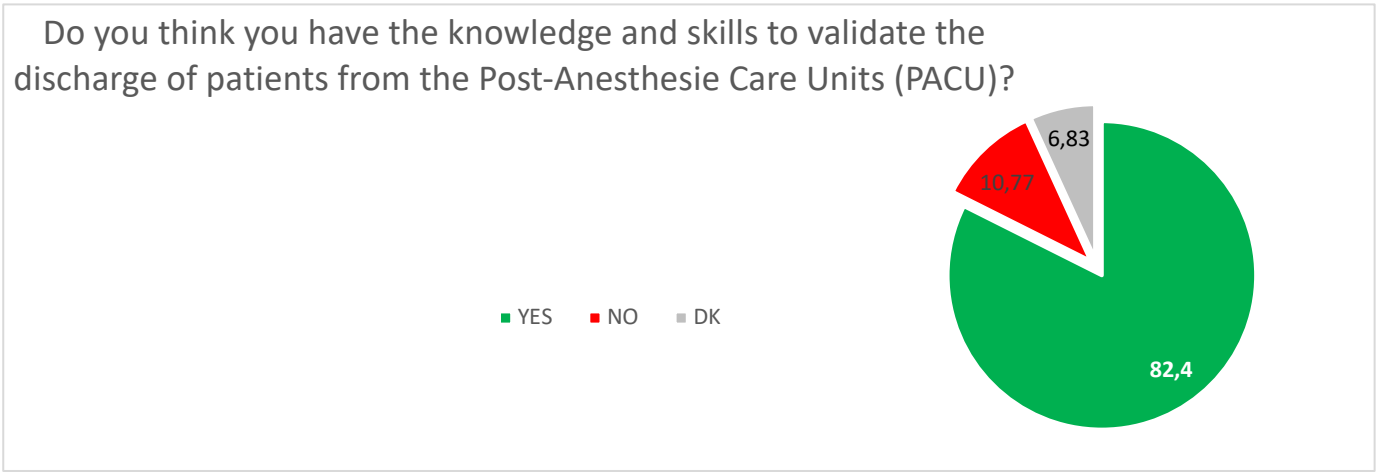
Findings in brief:

92% of IADEs working in PACU report administering drugs and performing procedures without an initial prescription (often: 46.4%, always 11.6%, sometimes 34% and never 8%).

In PACU, the MAR is never or rarely present at the extubation of patients in 91% of reports (Never: 35.8%, Sometimes: 55.6%, Often: 6.8%, Always: 1.8%). Compared to previous responses on this subject, it appears that MAR is even less present at the time of extubation when IADEs are posted in SSPI.

63.2% of IADEs working in SSPI report that they are frequently or systematically decision-makers in the discharge of patients from PACU (Often: 28.3%, Always: 34.9%) Sometimes: 14.25%, Never: 22.55%.

OPINION QUESTION: Validation for discharge from PACU by the IADE



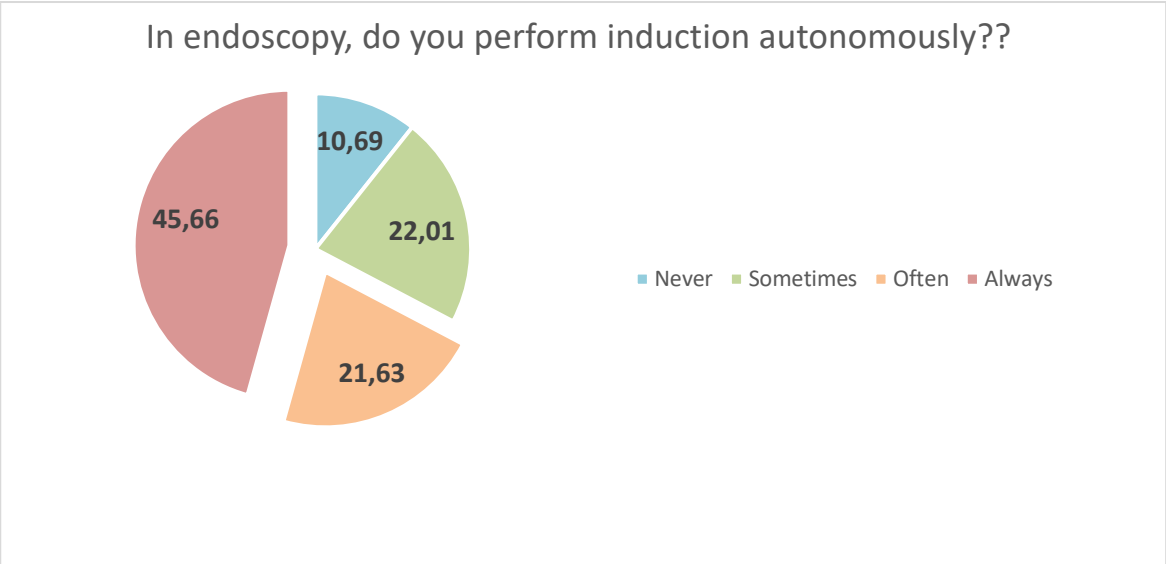
Comments and interpretation:

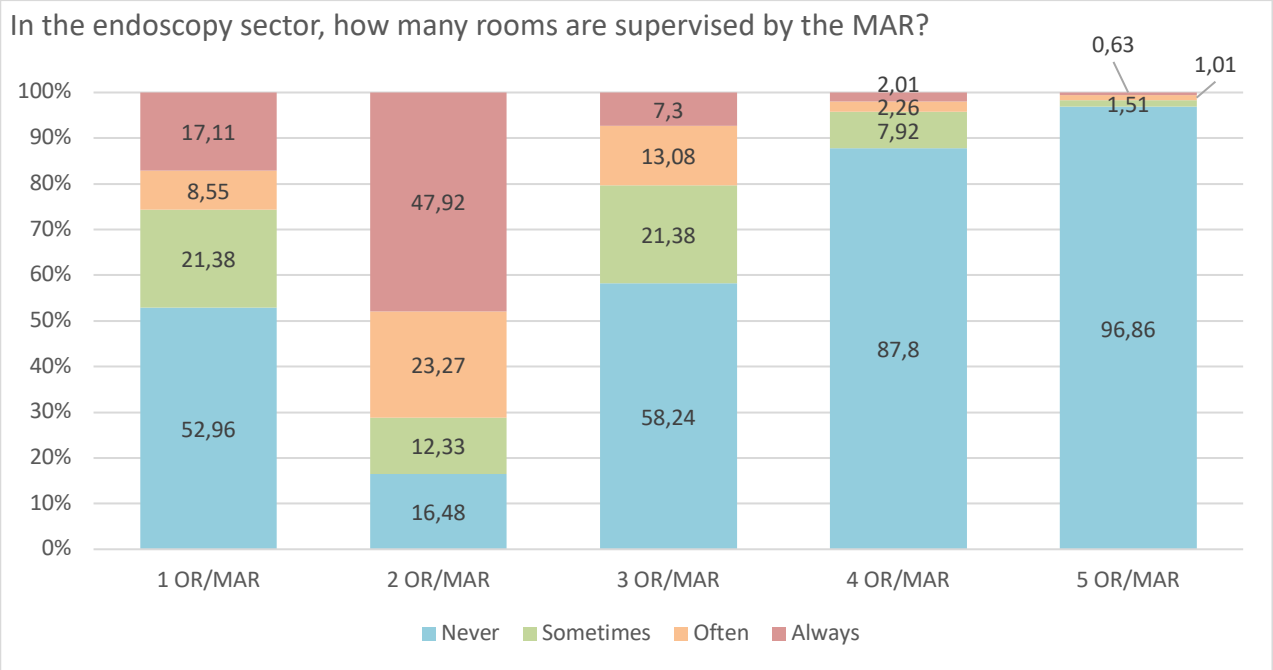
The administration of therapies and the performance of non-prescription procedures appears to be the daily routine of many IADEs in PACU. It seems natural for these care providers authorized to practice anesthesia independently in the operating room in order their post-operative skills (Analgesia, correction of side effects related to anesthesia, maintenance of hemodynamics and hematosis...).

IADEs rightly believe (since this practice is factual) that they have the necessary skills to validate the discharge of operated patients from SSPI. The legislation still needs to be amended and finally this exclusive responsibility must be recognized by the IADE.

Q. IADE in the Endoscopy sector:

(n 795 /1703 or 46.68% of IADE respondents):





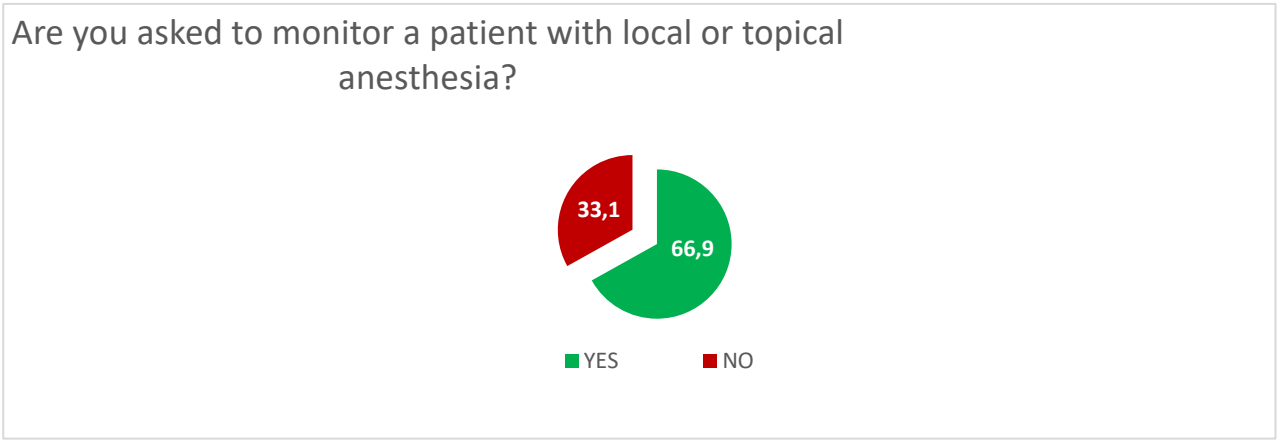
A brief observation:

67% of IADEs working in the endoscopy sector report that they frequently perform inductions alone. (Always: 45.66%, Often 21.63%, Sometimes: 22.01%, Never 10.69%). Medical supervision of endoscopy rooms does not seem to differ from other operating areas, it is the operation of 2 rooms for a MAR that is the most common. It should be noted that the three-room operation is frequently implemented for nearly 20% of respondents.

Commentary and interpretation:

In view of the other data from this survey, the endoscopy technical platform seems to be a place where the autonomy of anaesthesia practice by the IADE is most expressed. Despite the fact that digestive and pulmonary endoscopy is an activity where anaesthesia must be as fine as possible (injecting the right doses to maintain spontaneous ventilation and rapid reversibility) and where sequencing is the fastest in terms of programs, we can see that IADEs are fully fulfilling their role. The very low claims rate tends to demonstrate that this mode of operation is without prejudice to the patient.

R. Topical anesthesia:

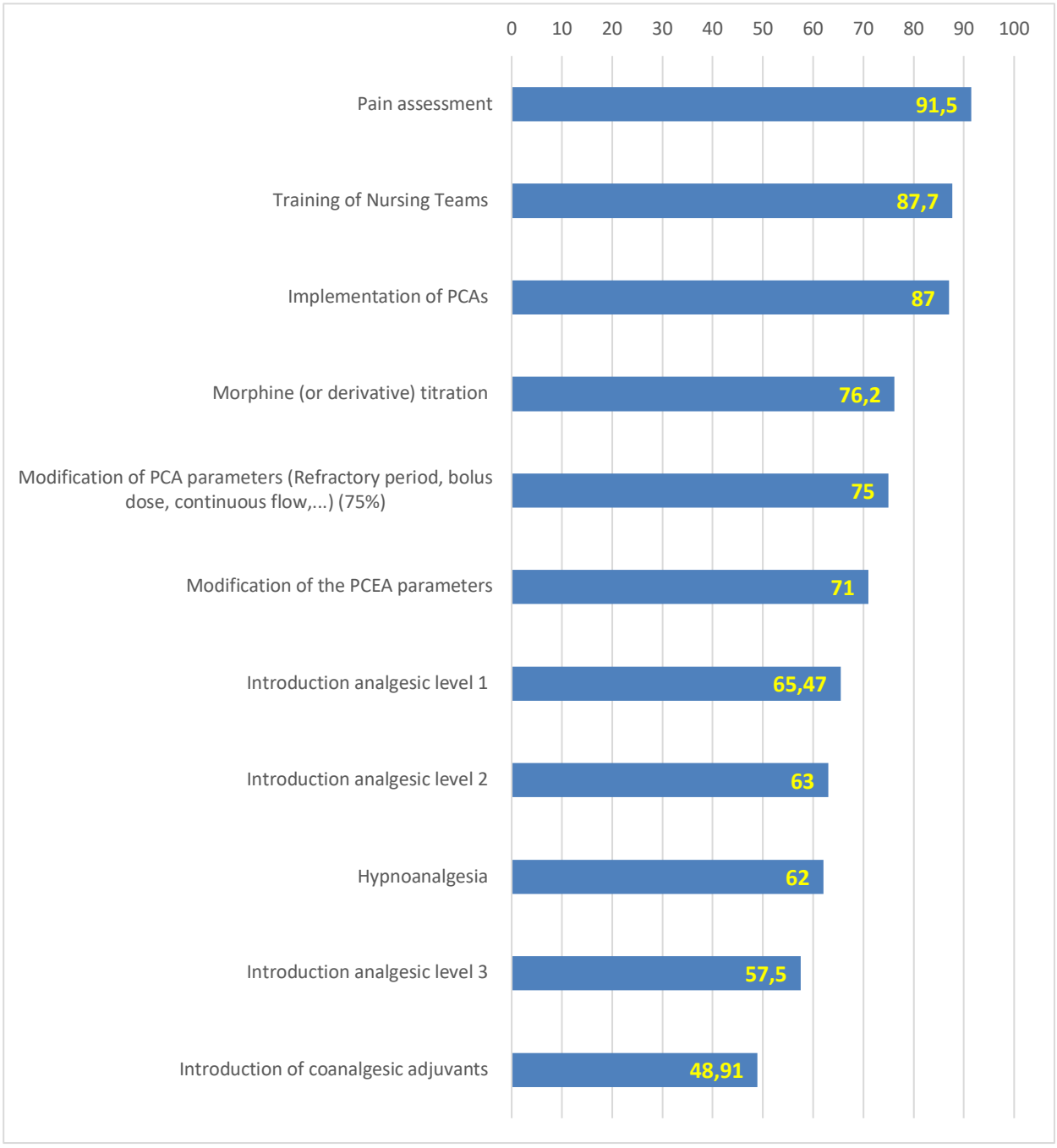


S. Post-operative pain management:

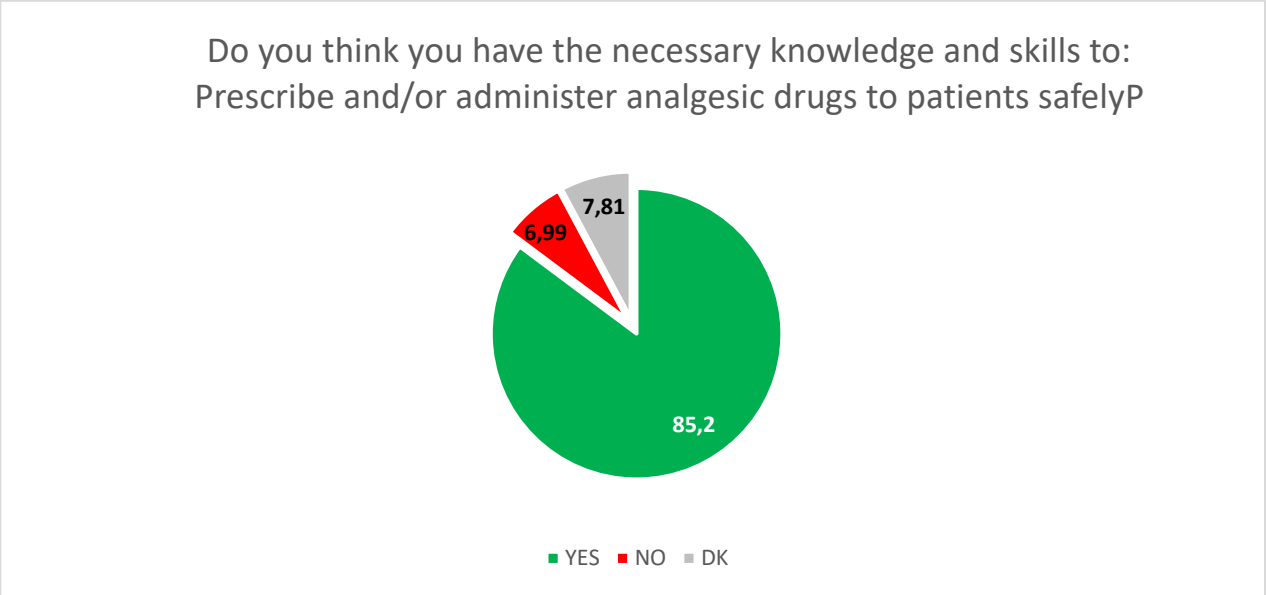
An organization set up for the management of postoperative pain in hospitalization units is effective in the practice areas of 52% of the surveyed IADEs (No for 38%, 10% DK).

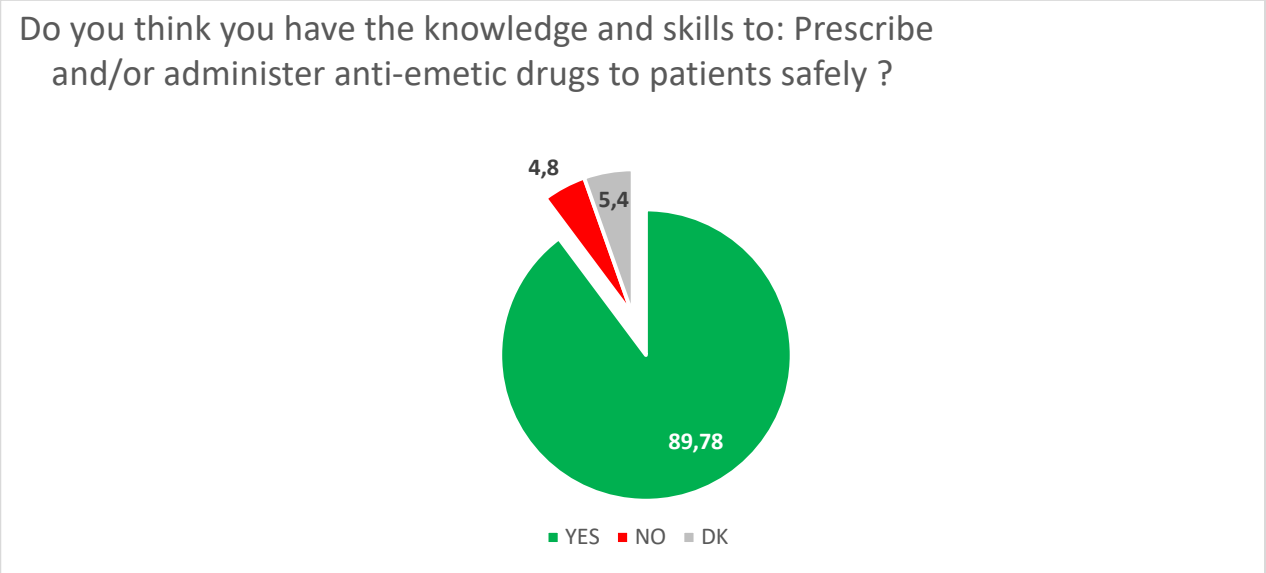
IADE participates in 39% of the declarations to these organizations or transversal services for post-operative pain management.

The prerogatives of these " pain IADE " have been researched: *In what way(s) do IADEs participate in this organization of post-operative pain management in hospitalization services? (%)*


0
10
20
30
40
50
60
70
80
90
100
Pain assessment
91,5
Training of Nursing Teams
87,7
Implementation of PCAs
87
Morphine (or derivative) titration
76,2
Modification of PCA parameters (Refractory period, bolus dose, continuous flow,...) (75%)
75
Modification of the PCEA parameters
71
Introduction analgesic level 1
65,47
Introduction analgesic level 2
63
Hypnoanalgesia
62
Introduction analgesic level 3
57,5
Introduction of coanalgesic adjuvants
48,91

OPINION QUESTIONS Prescribing/professional use of drugs





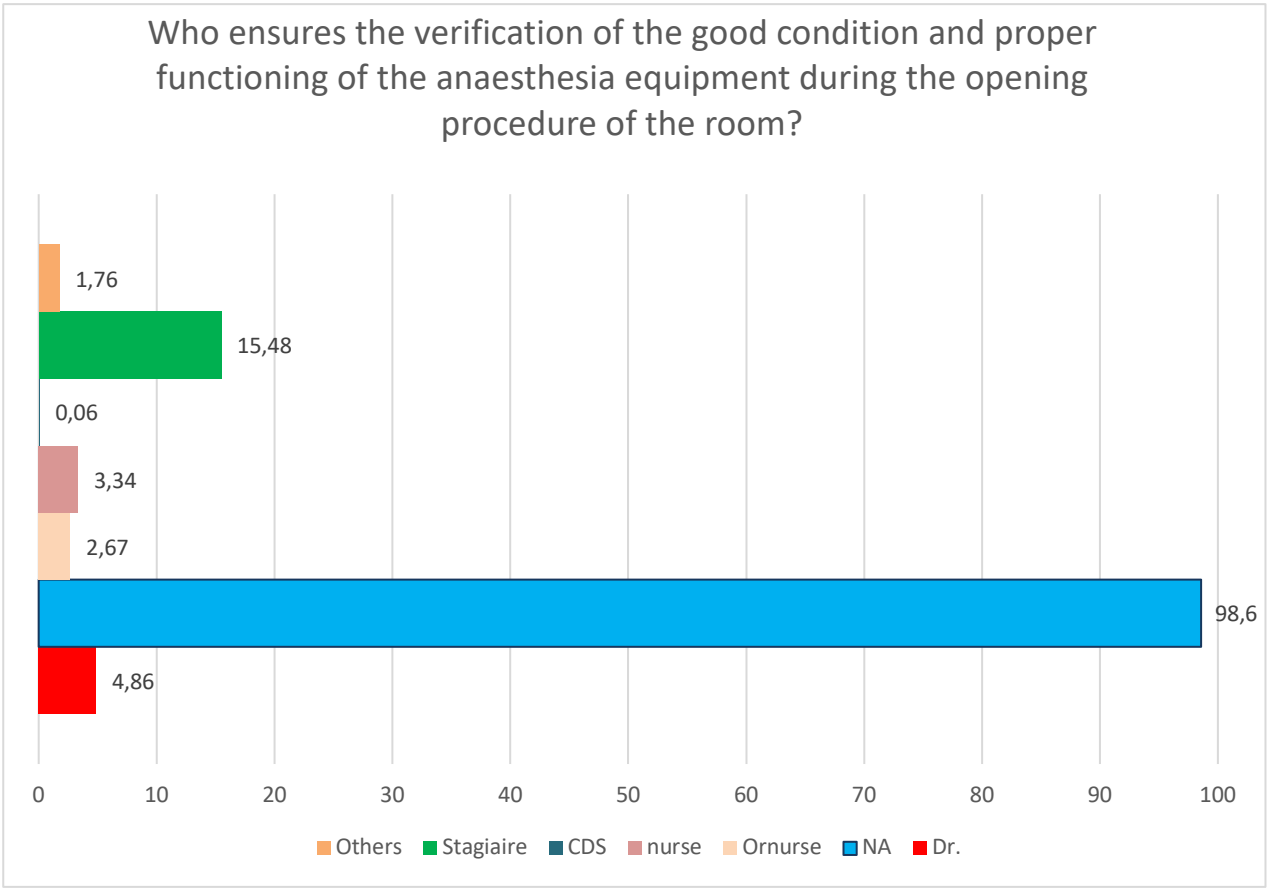
Findings in brief:

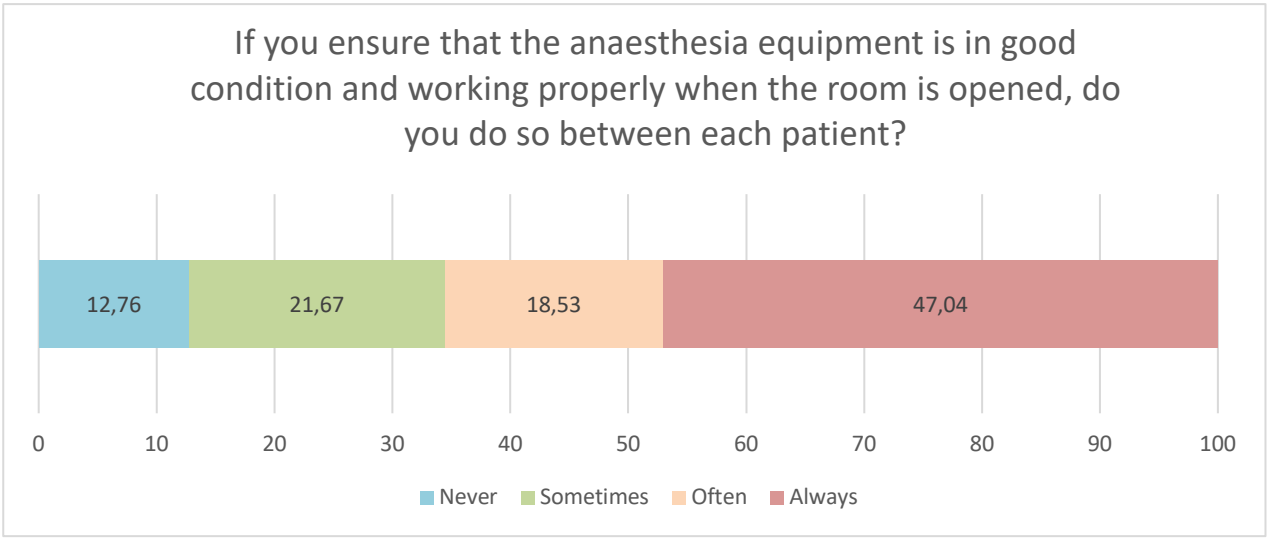
An overwhelming majority of IADE believes they have sufficient knowledge to prescribe and administer drugs, particularly for analgesic or antiemetic purposes. We have also seen in the section "IADE in SSPI" that professional already report administering and/or performing care without an initial medical prescription.

Comments and interpretations:

These results were expected as these skills are evident in personnel already performing these intraoperative procedures without formal prescription. It seems urgent to secure practices, to have this limited right of prescription (or professional use) already included in the reference framework recognized, but which is neither effective nor legalized despite the fact that the "continuation of intraoperative resuscitation" in PACU is included in the text of the law governing IADE practice. Limited prescribing rights are already held by midwives anaesthetists.

9. MATERIOVIGILANCE, ANESTHESIA SAFETY and PROCEDURES

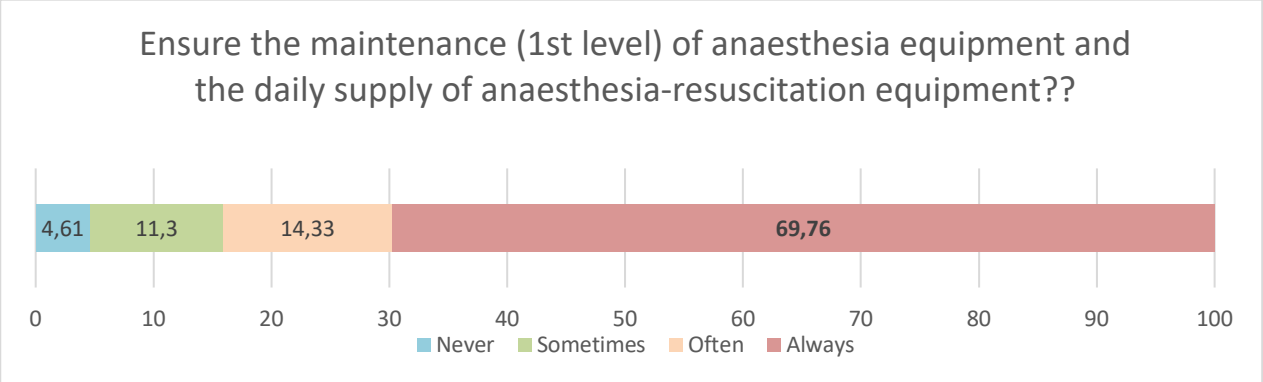


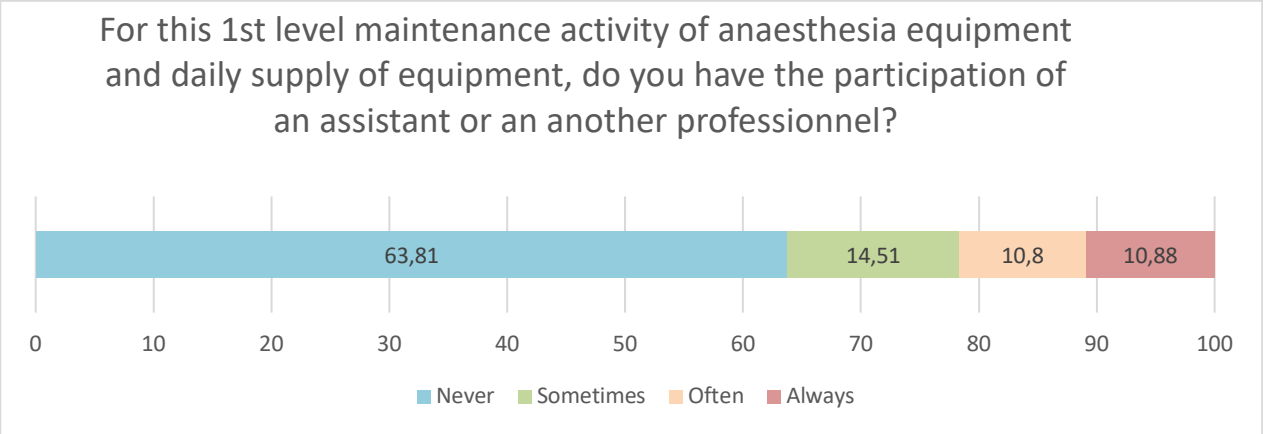


Comments and interpretations:

The IADE always appears as the professional guarantor of anaesthetic safety, particularly through the daily verification of the equipment and its proper functioning. It should be recalled that the HAS Checklist clearly stipulates that the verification of the equipment required for anaesthesia must be carried out by qualified anaesthesia personnel (thus excluding any other "paramedical").

A. Support activities :





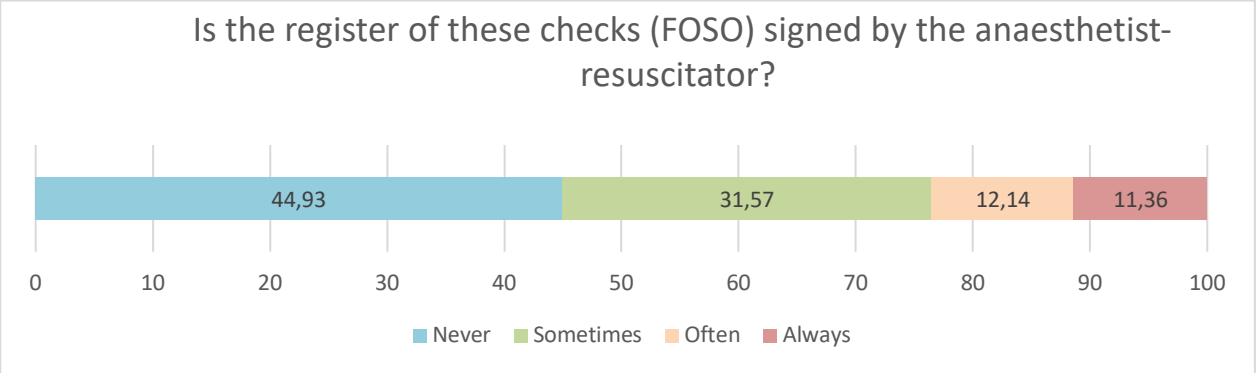
Findings in brief:

The logistical activity of restocking the equipment in the operating rooms remains mainly the responsibility of IADE professionals. Only 21.7% of IADEs are assisted in this role by another agent (AS or ASH)

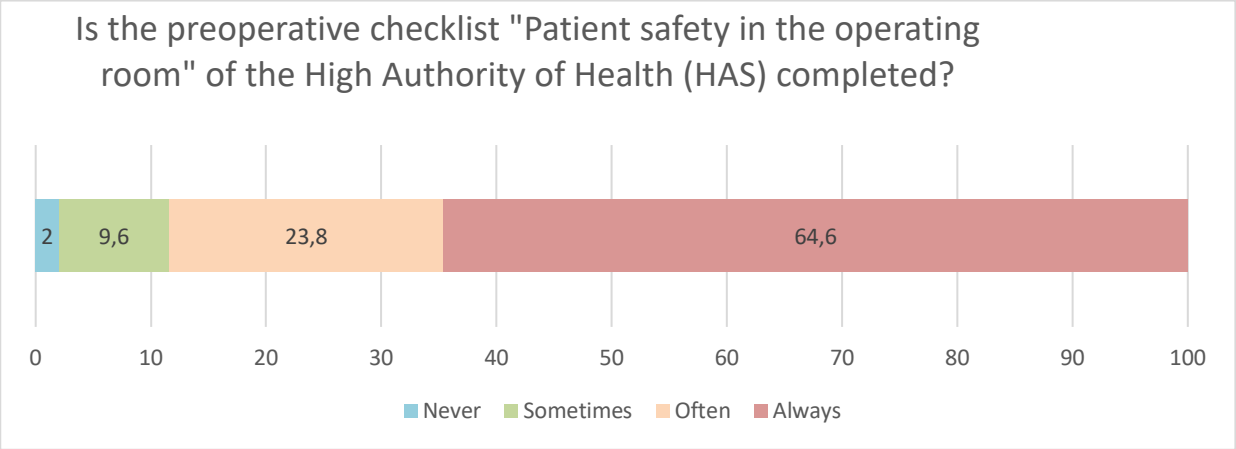
Comments and interpretations:

These activities could, if clinical time is to be made available for the practice of anesthesia, be delegated to logistical staff

B. Anesthesia check Procedure (register of checklist before opening OR)



C. Check-list safety surgery HAS (WHO safety checklist) :



Findings in brief:

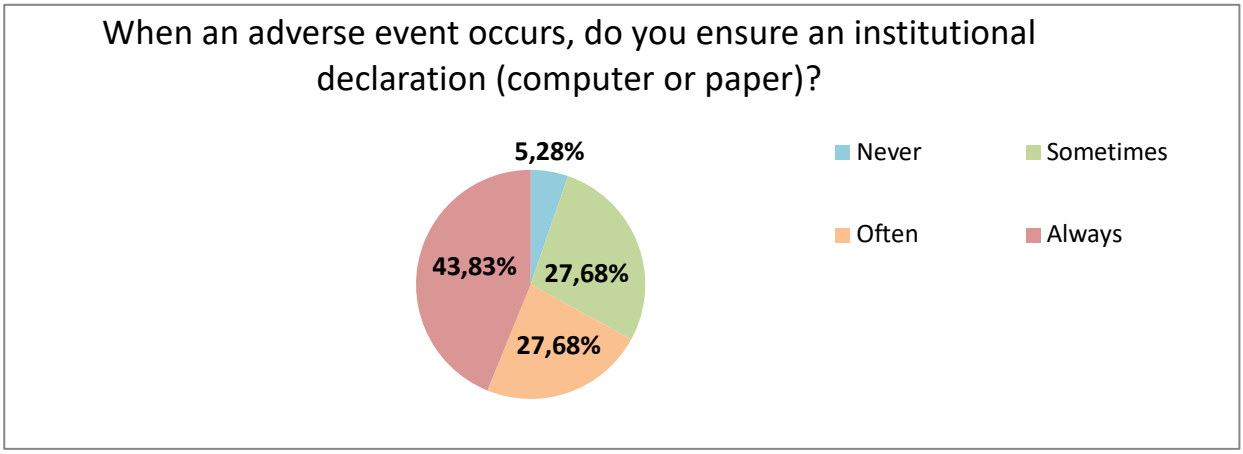
The FOSO is always signed by the MAR in only 11.36% of cases and never in 45%.

The HAS checklist is always performed in 64.6% of cases and never in 2% of cases

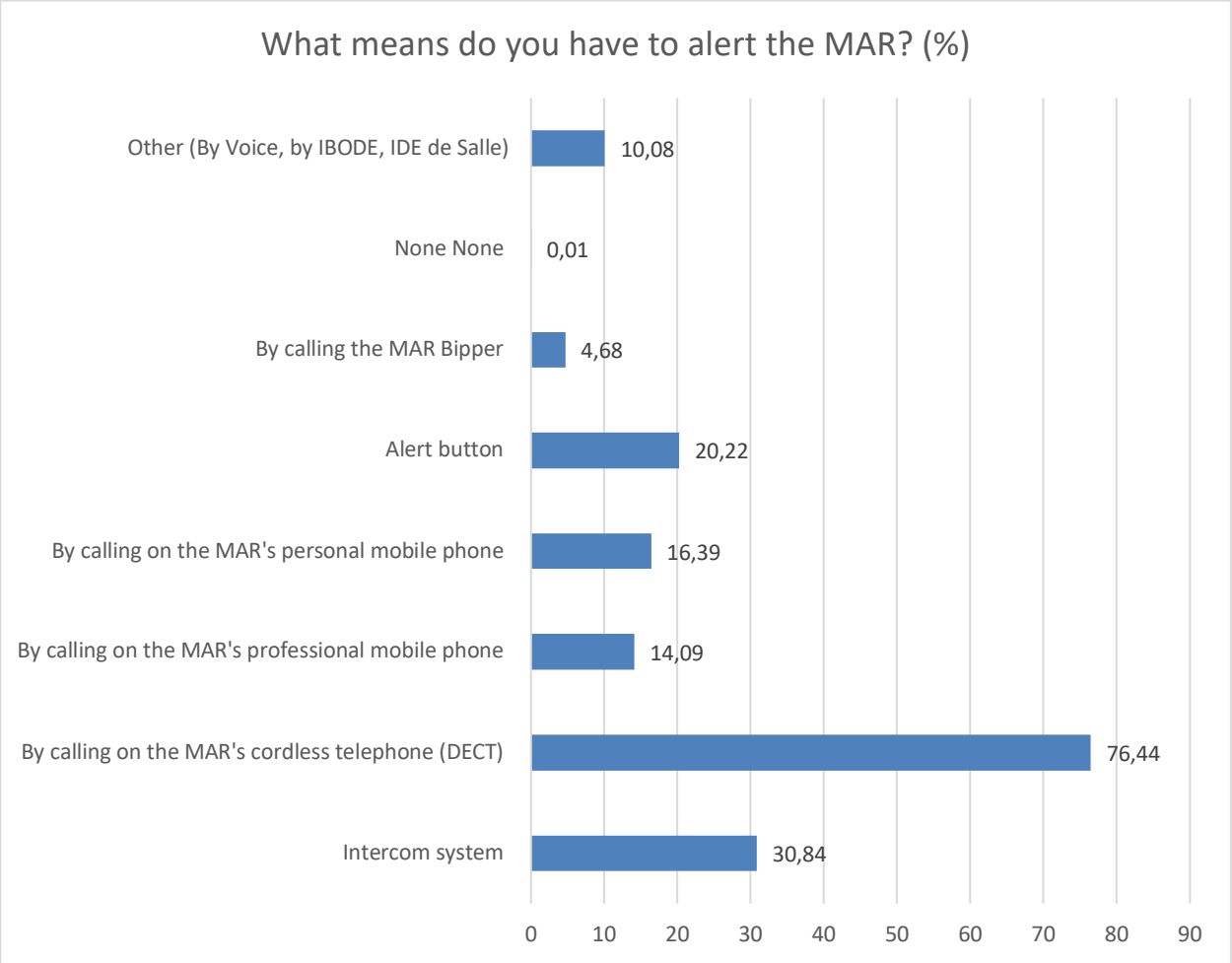
Comments and interpretations:

It seems that the implementation of the HAS checklist as a priority practice since 2010 tends to supplant FOSO regarding the traceability of the proper preparation of the surgical procedure. It should be noted that this checklist does not include all the items of the FOSO and that the latter remains due under the legislation.

D. Reporting of adverse events (ARs):



E. Raisons of alerting the MAR in Per-operative period:



A brief observation:

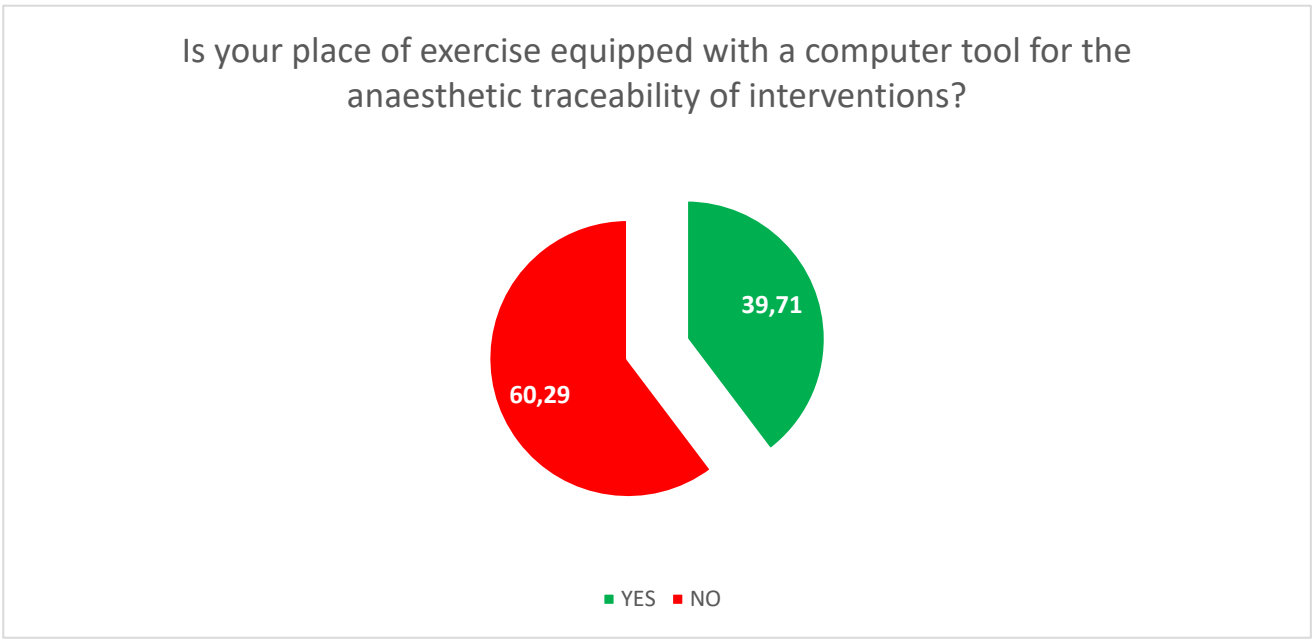
The most common means of alerting the MAR in the event of a changeover to a patient's medical condition is the cordless telephone (DECT) (76.5%). It is also pointed out that the MAR is within direct call range in only 10% of the responses and via an intercom in 31% of the cases. The installation of an alert button represents 20% of the responses.

Comments and interpretations:

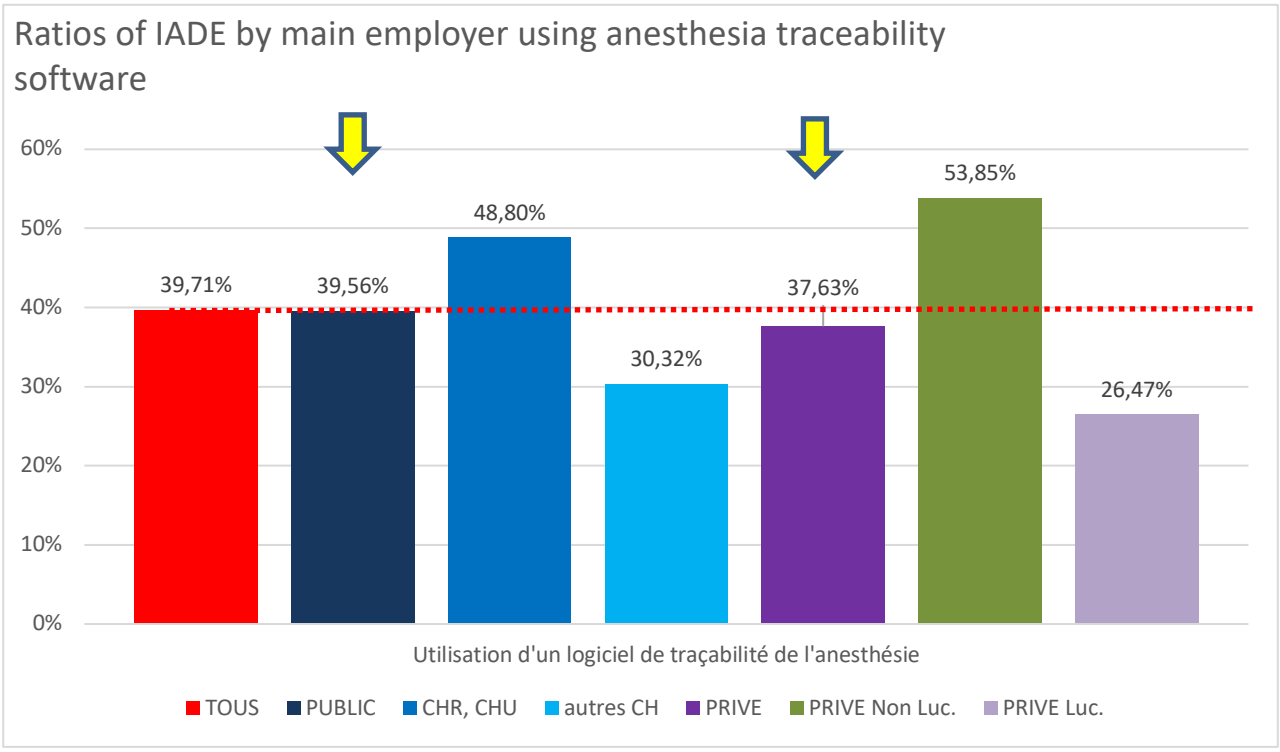
The most common means of alert involving dialing a number and waiting for the MAR's response clearly demonstrates that the MAR's response to a problem cannot be immediate. The implementation of such a system demonstrates that it is clearly the IADE's responsibility to implement appropriate corrective and protective measures pending the arrival of the MAR. The claims rate tends to prove that this system guarantees patient safety and rapid intervention of the MAR without prejudice to the patient.

F. Computerization of the anesthesia sheet:

i. Use of anesthesia traceability software:



Nearly 40% (39.71%) of respondents benefit from the computer tool for the anaesthetic traceability of interventions



A brief observation:

The averages of public (39.56%) and private (37.63%) sector users seem comparable with the overall average (39.71%).

It should be noted that within the public sector, IADEs operating in large establishments (CH-R-U) are better equipped compared to IADEs in other hospitals and exceed the overall rate of users by nearly 10 points. The IADEs of the other CHs are therefore below 10 points of the overall average.

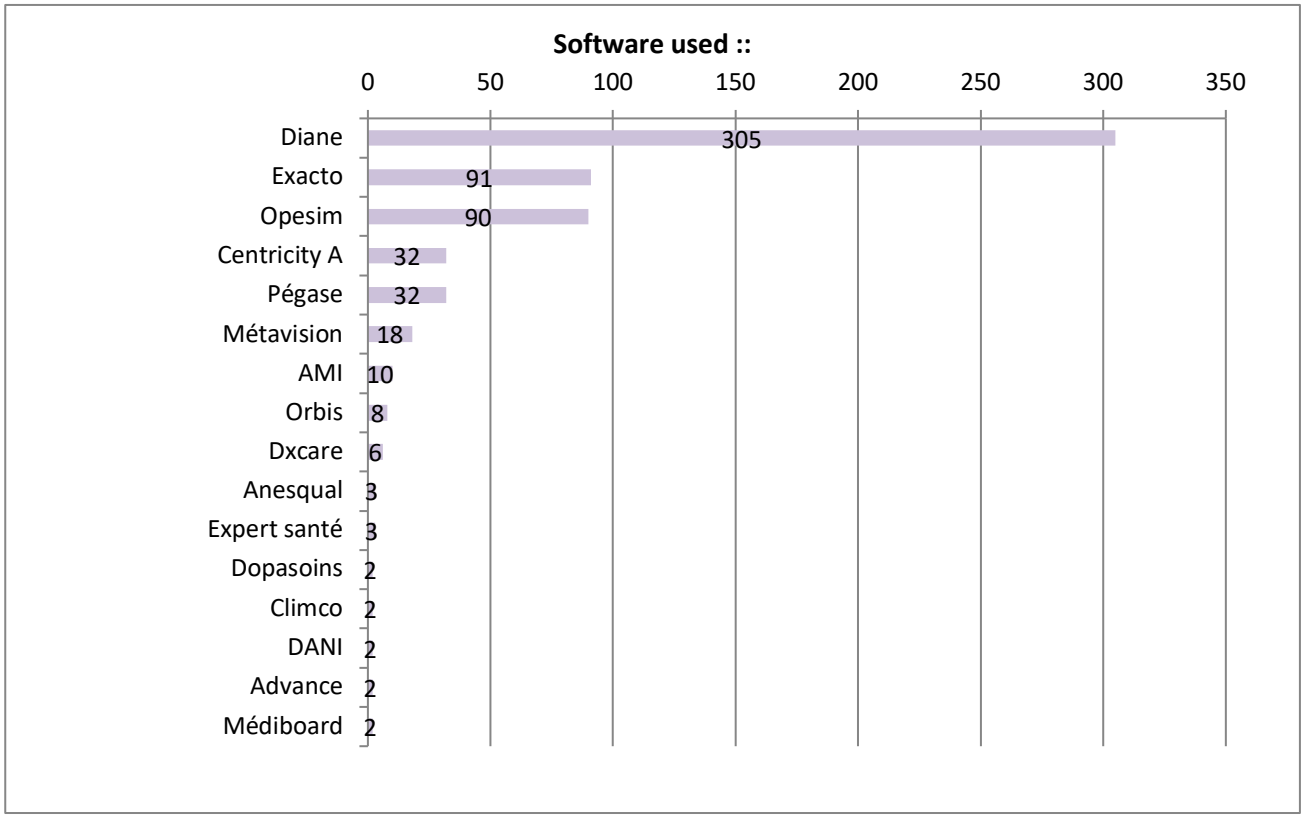
Within the private sector, it appears that IADEs operating in private non-profit establishments are the best equipped, exceeding the overall average of users by more than 14 points and are twice as well equipped as IADEs operating in private profit-making establishments (including IADE employed in the MAR), which appear to be the least equipped with more than 13 points less than the overall average of users.

Commentary and interpretation:

The graph above gives an idea of the rate of equipment according to the status of the establishment in anesthesia traceability software. It illustrates the room of manoeuvre that institutions and IT companies must have to allow professionals to benefit from this system.

ii. Software used :

What software is used?		
Réponse	N	%
Diane	305	46,63
Exacto	91	13,91
Centricity Anaesthesia	32	4,89
Autres	226	34,55
Détails Autres : *Opesim*	*90*	*13.76*
Pegase	*32*	*4.89*
Metavision	*18*	*2.75*
AMI	*10*	*1.53*
Orbis	*8*	*1.22*
DxCare	*6*	*0.91*
Anesqual	*3*	*0.459*
Expert Santé	*3*	*0.459*
Dopasoins	*2*	*0.31*
Climco	*2*	*0.31*
DANI	*2*	*0.31*
Advance	*2*	*0.31*
Médiboard	2	*0.31*

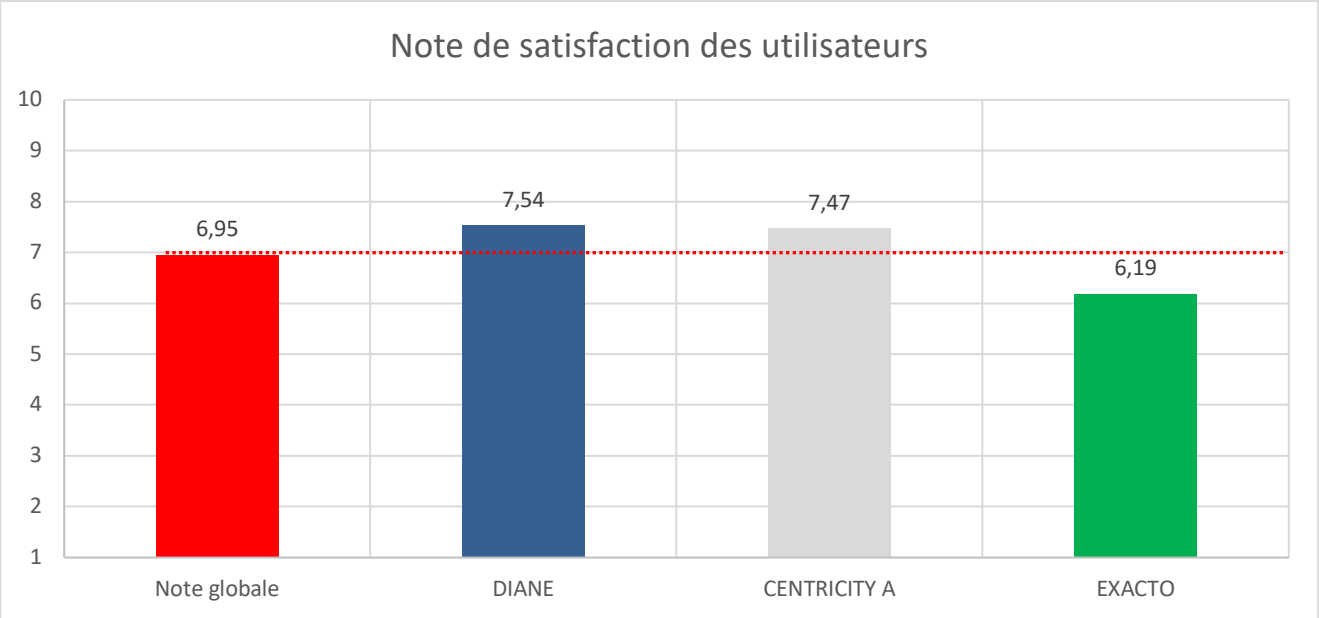


Level of software satisfaction:

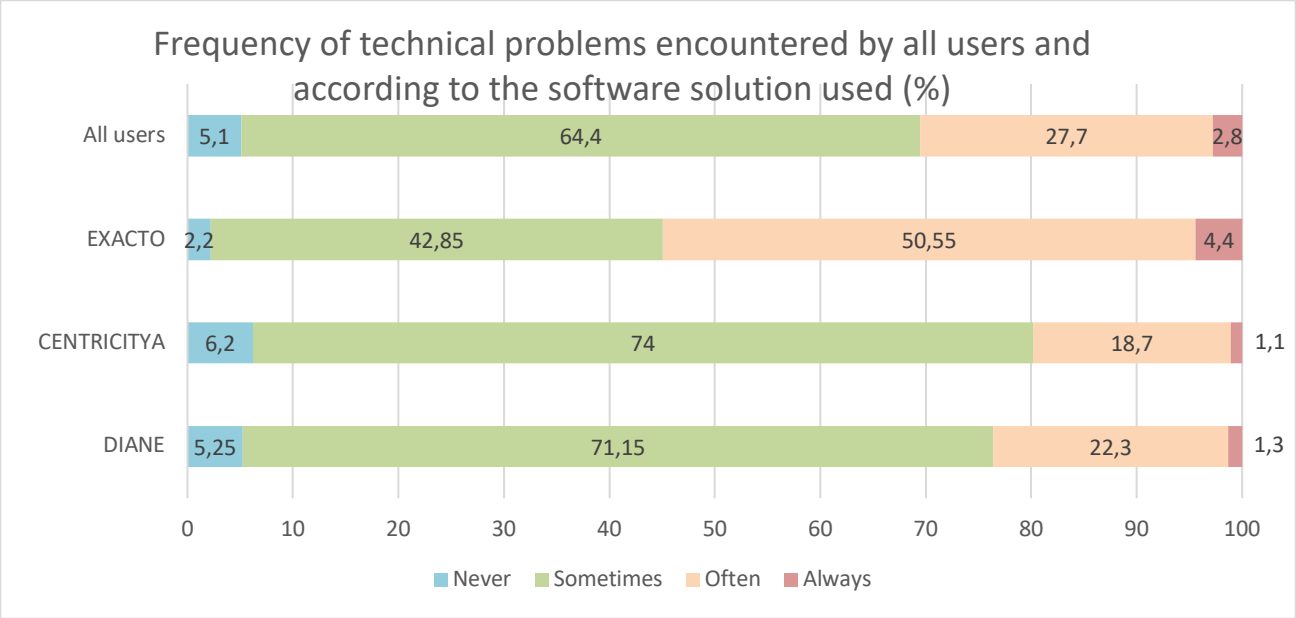
How satisfied are you with the use of the software? [Rate from 1 (very dissatisfied) to 10 (very satisfied)]		
Réponse	Décompte	%
1	12	1,834862
2	24	3,669725
3	29	4,434251
4	33	5,045872
5	43	6,574924
6	50	7,64526
7	134	20,489297
8	194	29,663609
9	88	13,455657
10	47	7,186544

User satisfaction rating on the main anaesthesia traceability software used on a scale from 1 to 10.

The overall average score of users on IT solutions is 6.95
The average score given by **Diane**'s (305) users is : 7,54
The average score given by the (32) users of **Centricity anaesthesia** is : 7,47
The average score given by the (91) **Exacto** users is : 6,19



iv. Technical difficulties in using the computer system:



Findings in brief:

30.72% of IADEs report regular technical difficulties in using the computer system. (Often 27.7% and Always 2.8%)

Comments and interpretations:

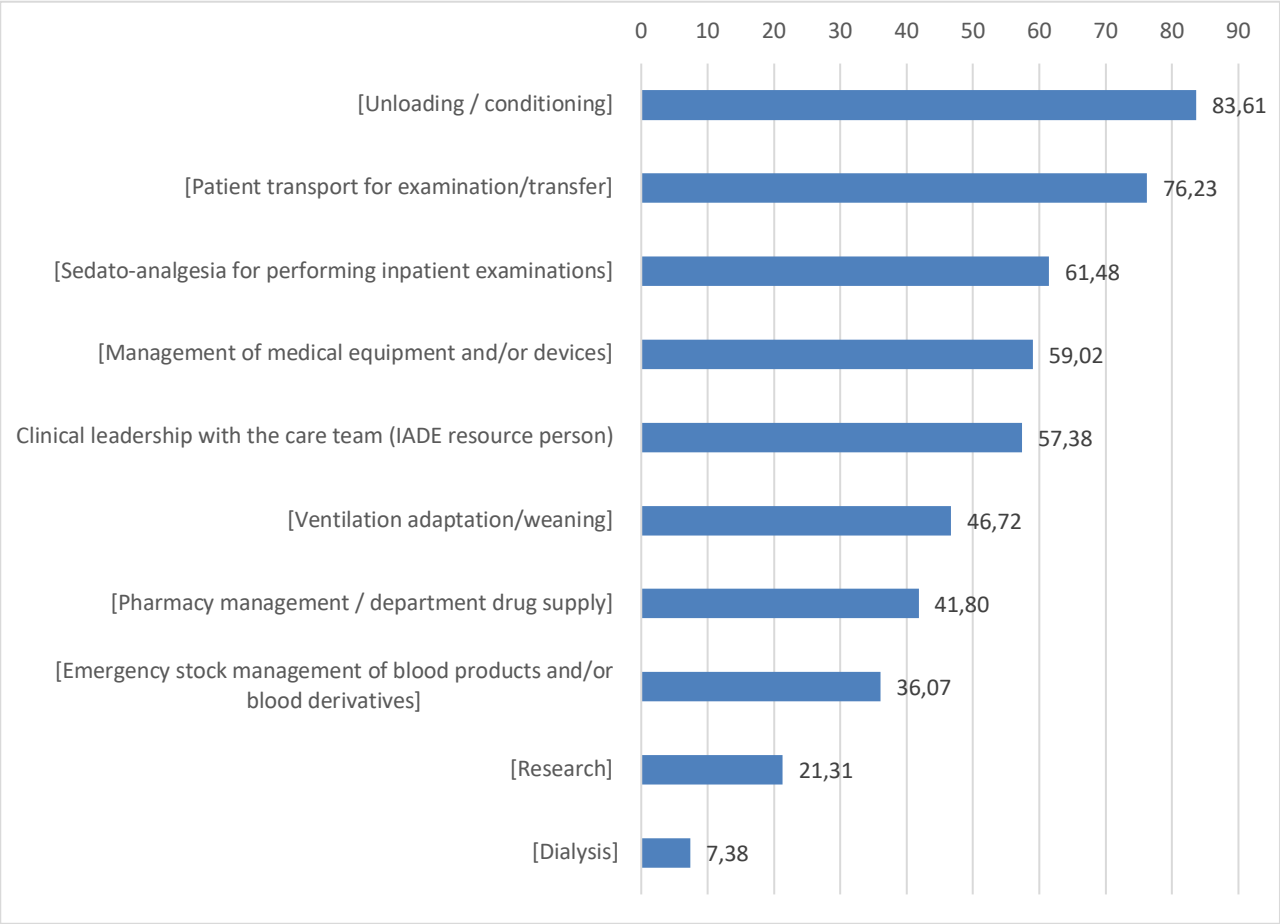
These problems can be related to hardware solutions (stations, connectors...), network environments and/or software solutions (configuration, server connection...). These recurring problems can lead to task interruptions (increasing the risk of error), slowdown of activity, loss of anaesthesia traceability, etc. As this question is related to the previous one on the questionnaire, we have isolated the answers of the users of the first three software programs. It appears that the software with the lowest score (Exacto) is the one that suffers the most from technical problems (disconnection, communication between biomedical devices, etc.). 54.95% of exacto users complain of recurring problems compared to 30.5% of all users. On the other hand, it is the Centricity Anesthesia solution, followed by Diane, that has the least technical problems in their use.

10. IADE in Resuscitation Service, Burned, Emergency Services

(122/1703 or 7.16% of IADE surveyed)

22.95% have their own work rotation within the nursing team; 77.5% have their own.

Targeted prerogatives of the IADE in intensive care unit, Burn center, UAS:

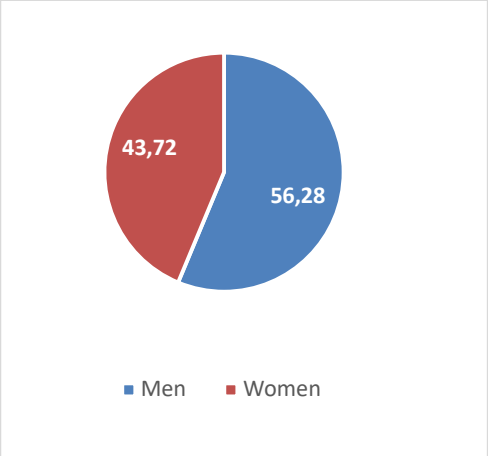


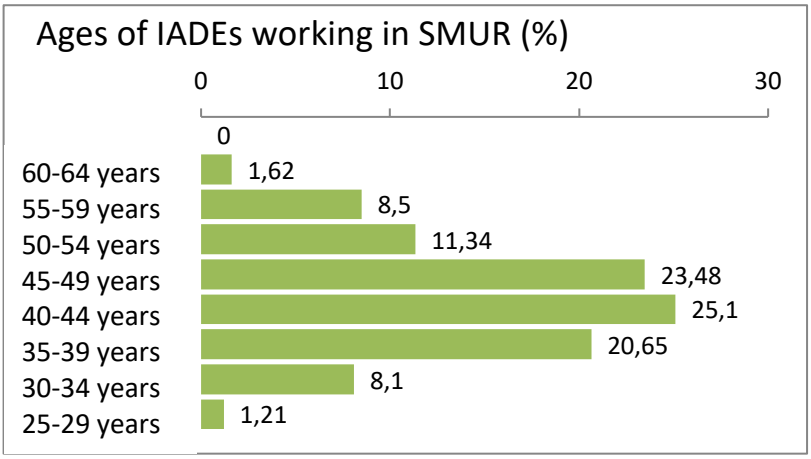
To the question: "Is your activity/position in the intensive care unit and/or UAS and/or burn unit in question? ": 27.87% answer in the affirmative and specify "in the short or medium term".

11. IADE in Mobile Emergency and Resuscitation Service (SMUR):

i. Demographic data IADE in SMUR :

IADEs working in SMUR represent 14.50% of the panel.





43.72% women and 56.28% men.

ii. Training :

28.3% of IADEs practicing in SMUR have a DU or IUD mainly related to oxyology, (emergency medicine, disaster, repatriation) and pain management. 43.7% have a diploma as a first aid trainer.

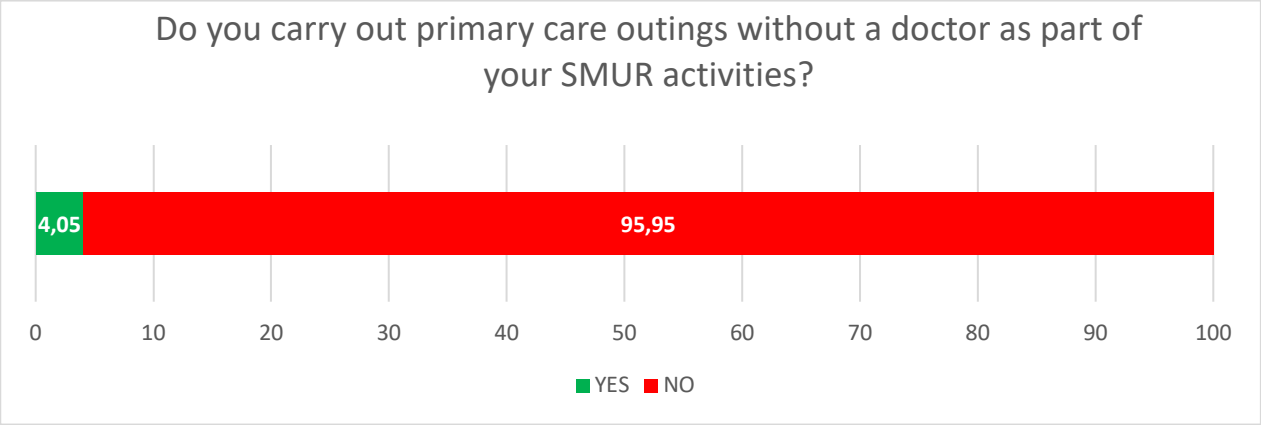
iii. Exercise :

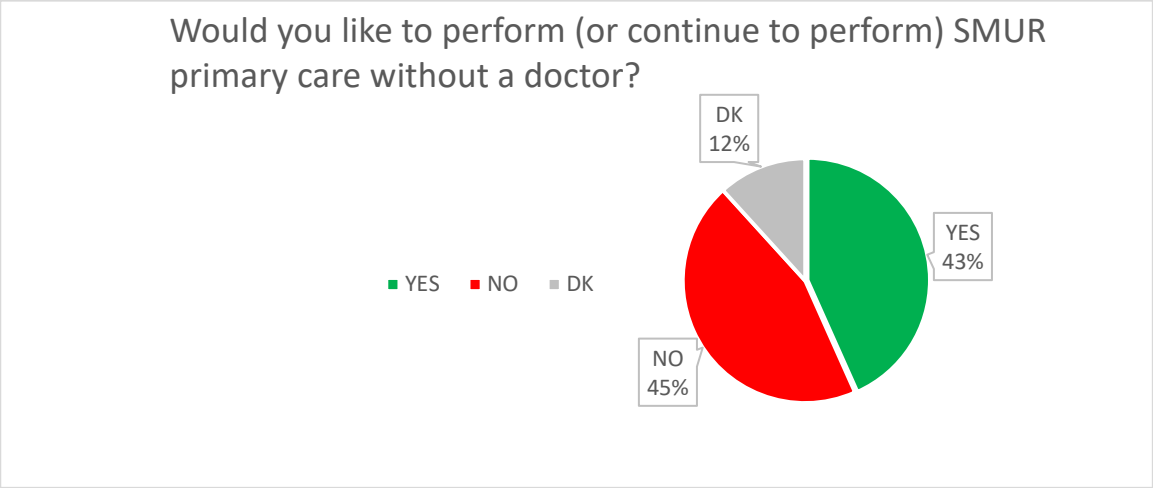
33% work in CHR / CHU; 67% work in CH. 89.86% work full-time. Mixed exercise is very common. In addition to the functions performed in SMUR, the IADEs concerned also operate in the various other sectors:

Sectors shared with the SMUR exercise.	**IADE SMUR**
Multidisciplinary operating room	80,97%
Specialized block	14,98%
PACU	55,06%
Maternity	56,68%
Pediatric surgery	23,89%
Endoscopy	47,37%
Radiology	17,81%
Interventional cardiology	10,93%
Surgical ICU	3,24%
Medical ICU	2,83%
Burn center	0,81%
UAA	20,24%
CEC	0,81%
School IADE / IFSI / IFAS ...	11,74%
CESU	24,29%
Algology	2,83%
Administration	0,81%
Others	7,29%

In addition to their main professional activities, 18.22% of IADEs working in SMUR are also employed as fire brigades and 9.72% as EPRUS reservists.

A. Emergency paramedicalization/graduated response:





Findings in brief:

4% of IADEs practicing in SMUR perform primary care without a doctor.

When asked whether they would like to carry out (or continue to carry out) primary outings without a doctor (with triggered medical support), there is no clear majority.

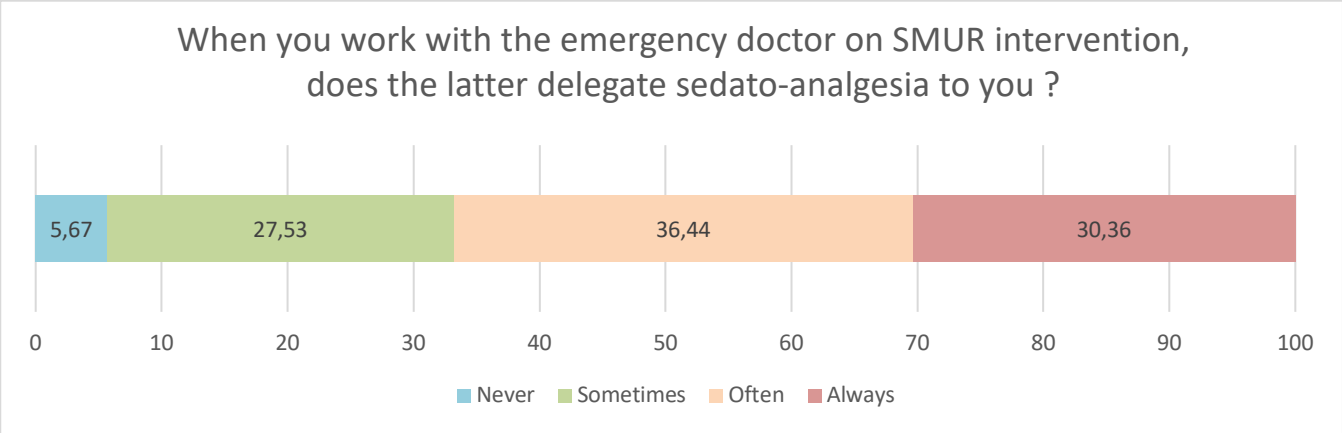
Comments and interpretations:

Contrary to the statements made by some medical representatives, some IADEs (4%) already carry out primaries without a doctor in SMUR, triggered on certain reasons for leaving or in the event of a lack of a complete team in order to optimize medical time and provide a graduated response to the pre-hospital emergency.

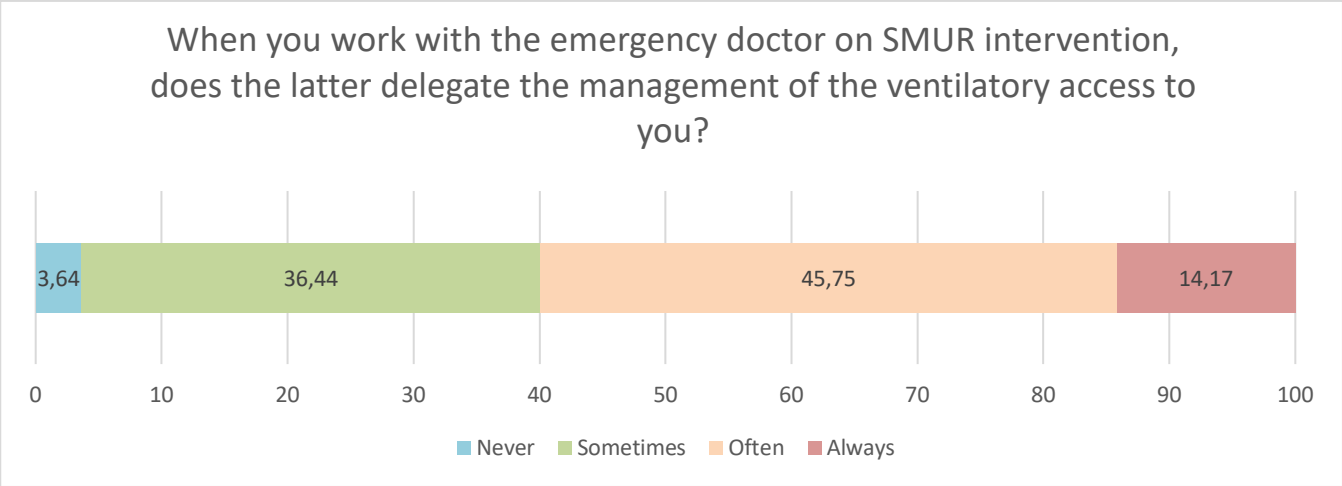
Apart from a proportion who does not wish to express an opinion on this wish (12%), the rest of the professionals are almost perfectly divided on the question. The reluctance of some may be explained by the risk that they may make such claims in view of the threats already weighing on their eviction from these services (see below), and on the regulatory context and liability in the event of an adverse event.

B. Prerogatives delegated by the emergency doctor to the IADE in SMUR:

i. Management of sedato-analgesia :



ii. Management of the ventilatory access :

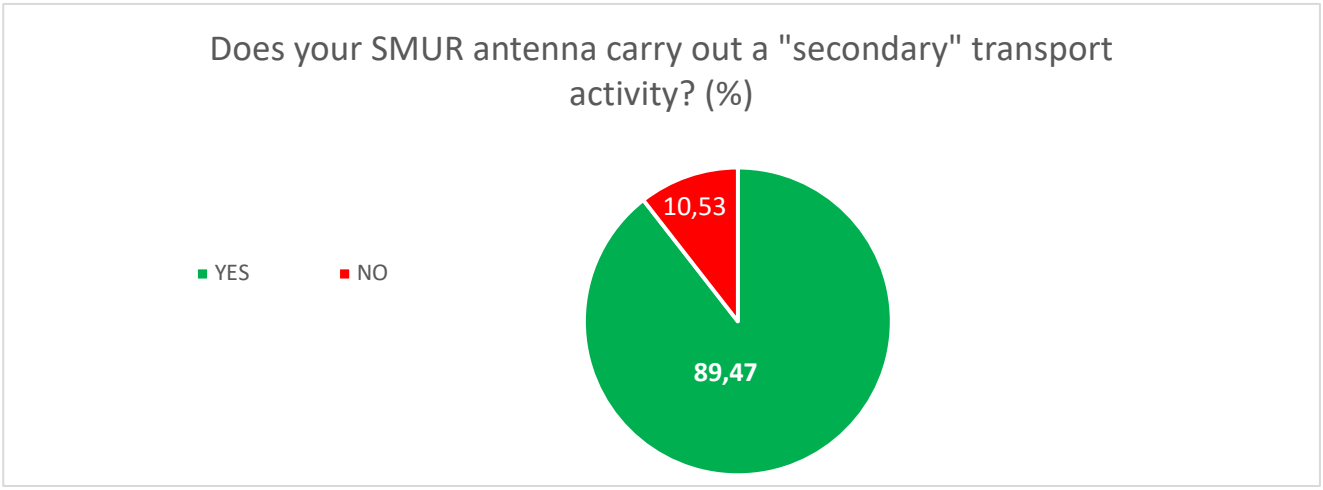


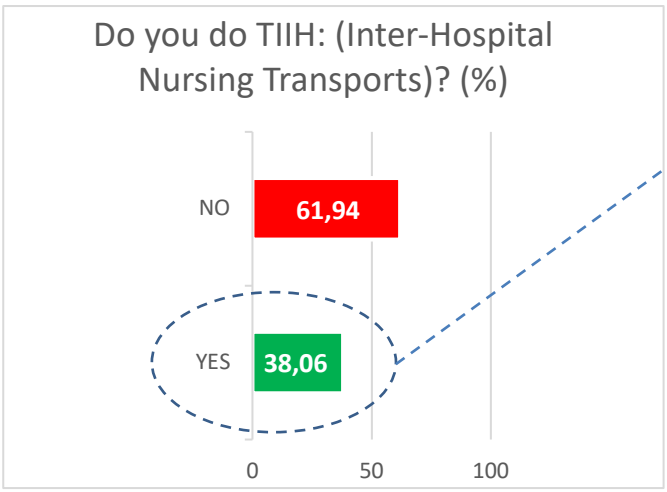
Findings in brief:

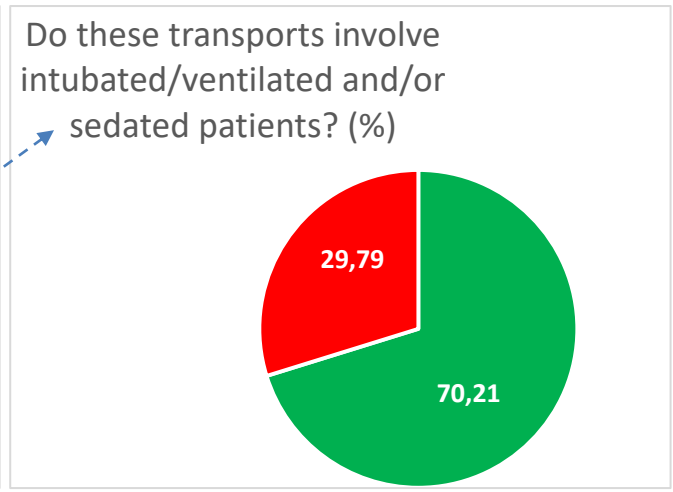
Emergency physicians with IADE on SMUR crews seem to rely mainly on their skills in the management of sedato-analgesia and upper airway.

Nevertheless, there remain a significant proportion of emergency physicians who do not fully exploit the prerogatives that can be delegated to IADE in the context of these activities.

iii. Secondary transport, Inter-hospital nursing transport:







A brief observation:

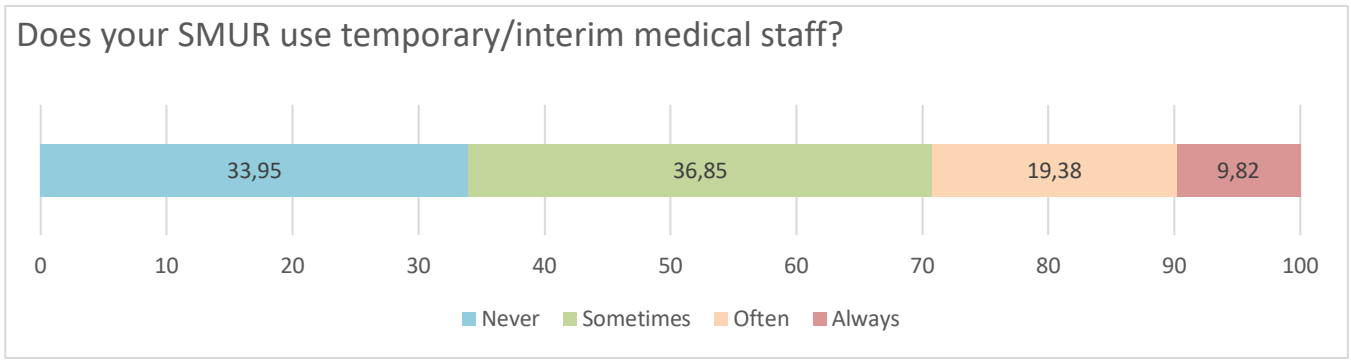
89.47% carry out secondary transport.

38.06 % achieve TIIH. 70.21% of the latter are used to perform TIIH of "reanimatory" patients (intubated/ventilated and/or sedated).

Commentary and interpretation:

We can therefore deduce that 24% of the IADEs operating in SMUR perform TIIHs as part of their new exclusivity obtained in 2017. These transports of "intensive care" patients by the IADE allow a significant release of medical time. With regard to the creation of territorial hospital groups, it is expected that these inter-hospital transfers of critical patients will increase.

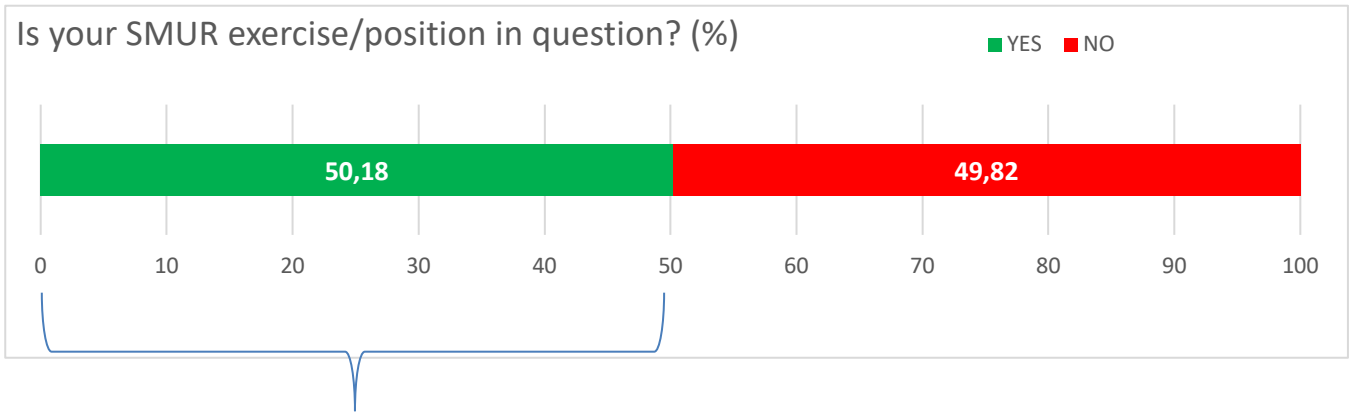
iv. Collaboration with temporary emergency physicians:

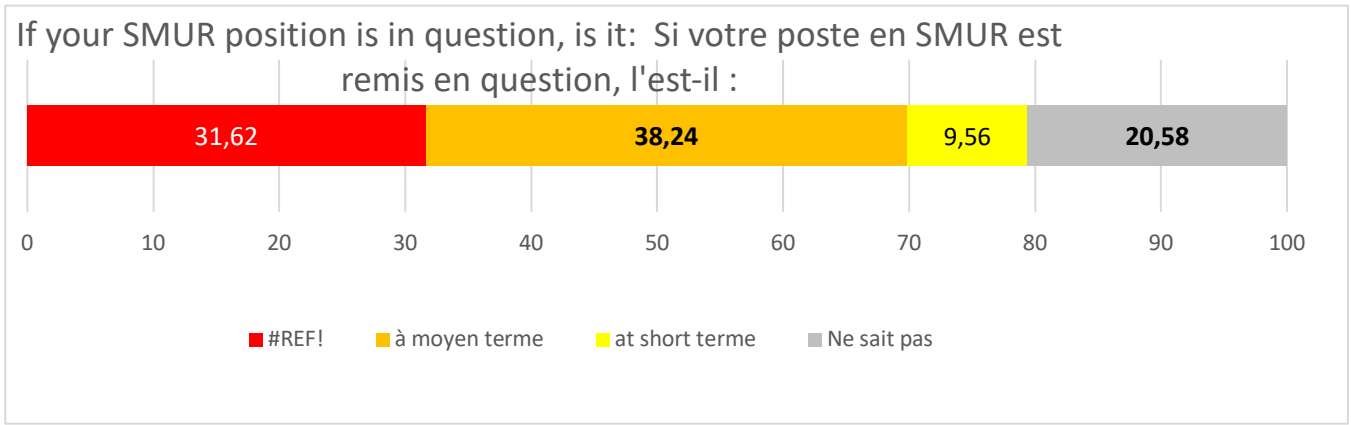


A brief observation:

29.2% of IADEs practicing in SMUR report working frequently (often/always) with temporary/interim doctors.

v. Durability of IADE positions in SMUR





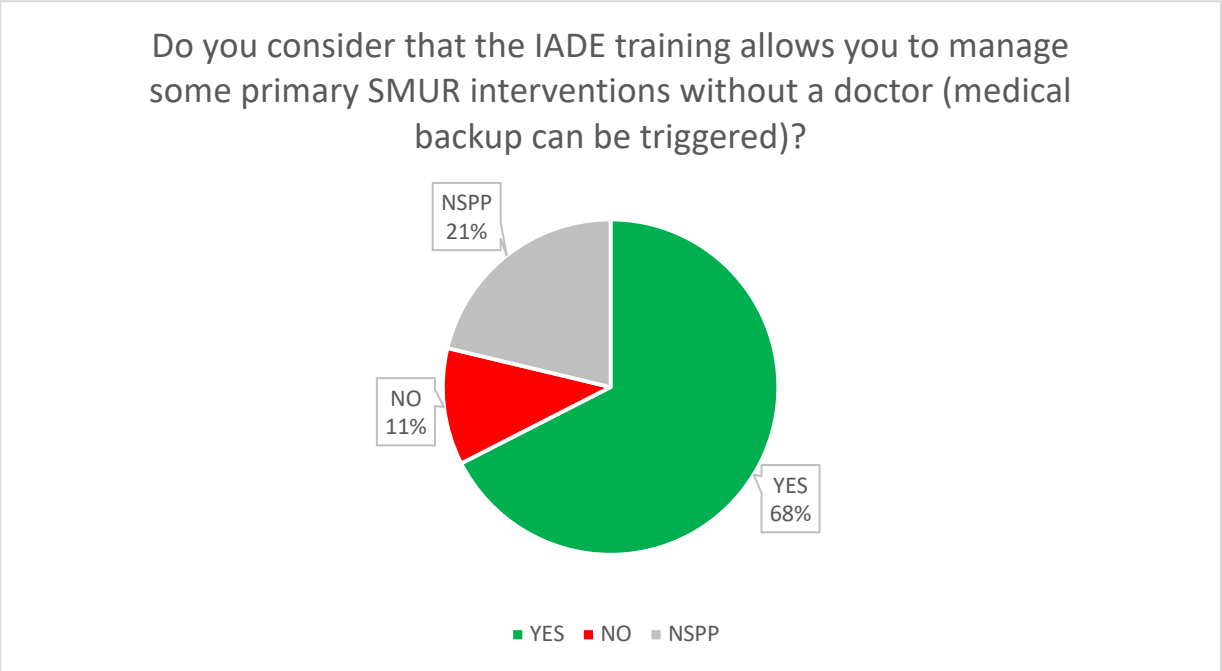
***A brief observation**:*

50.18% say that their position in SMUR is in question, 70% of them in the short-/medium term.

Commentary and interpretation:

These results are based on the current atmosphere experienced by IADE staff working in SMUR. Under the pretext of savings, some administrations tend to remove IADEs from SMUR teams. Our professional organization regularly denounces the de-qualification of SMURs by replacing non-specialized personnel for these activities.
OPINION QUESTION: SMUR and Graduated Response IADE

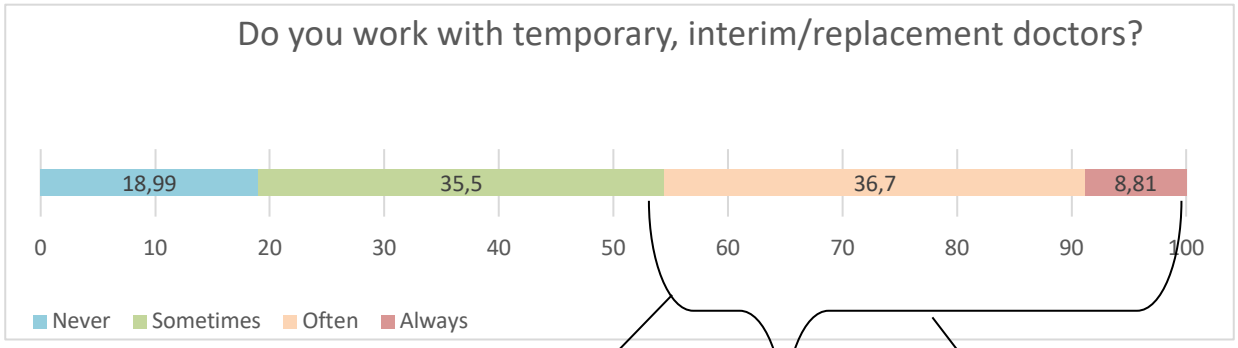
Question asked to the whole panel:

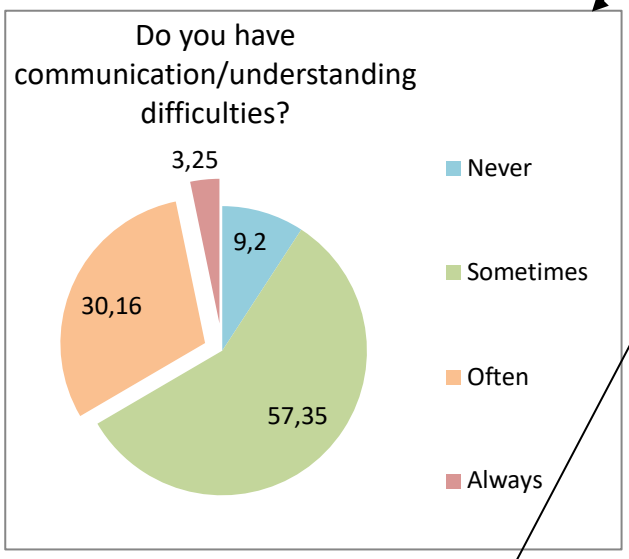


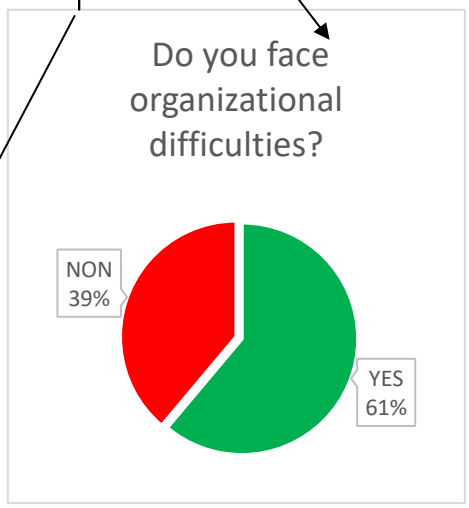
Comments :

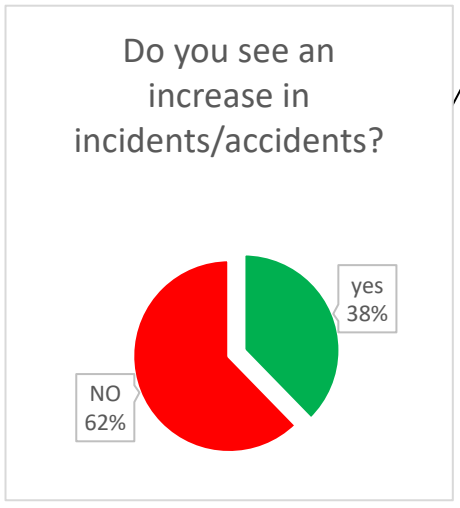
The concept of a graduated response to pre-hospital emergency is a concept that has been defended for many years by the IADE network, which is positioned as a priority for these activities. In addition to the numerous training contributions in pathophysiology, pharmacology and emergency medicine, the training, activity and skills standards annexed to the training order of 23 July 2012 have been enriched in this spirit with the injury and vital assessment of a victim by the IADE and anaesthesia with a non-specialised doctor.

12. COLLABORATION WITH TEMPORARY MEDICAL STAFF IN THE OPERATING ROOM









A brief observation:

45.5% of IADEs frequently collaborate with interim/vacation doctors. Of these, 1/3 (33.41%) report frequent communication and comprehension difficulties. 61% of them frequently encounter organizational difficulties in this collaboration.

37.7% noted an increase in the occurrence of incidents/accidents in this collaboration.

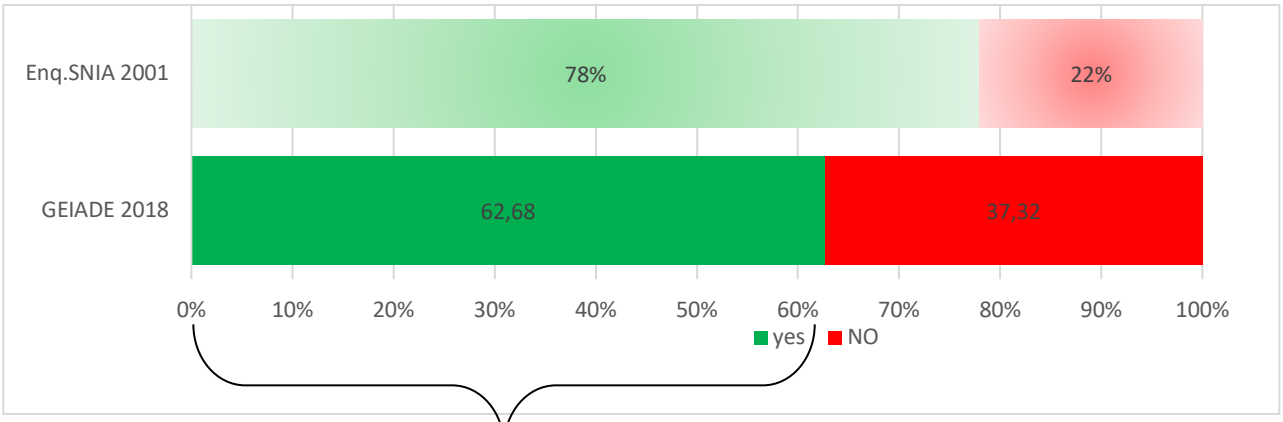
Comments and Interpretations:

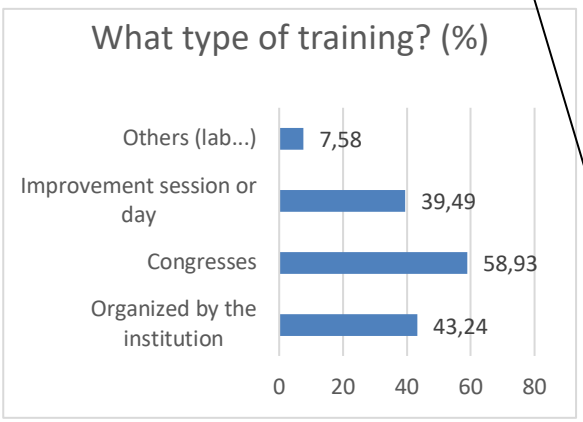
The role of IADEs in these services is to try to maintain a team structure, practices and functioning to overcome medical demographic difficulties. Many reports to the SNIA report complex professional situations by IADE professionals in these structures.

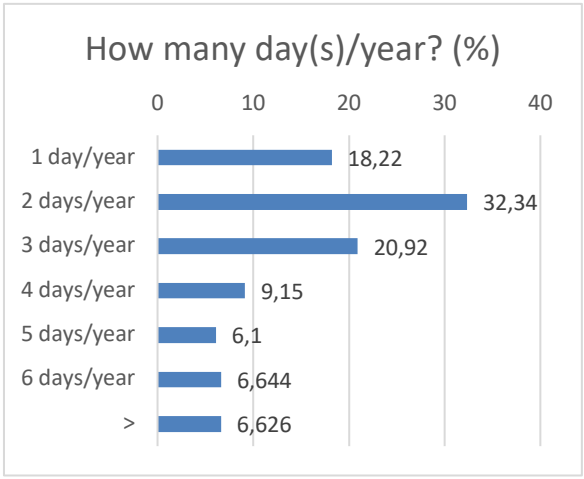
13. CONTINUOUS TRAINING

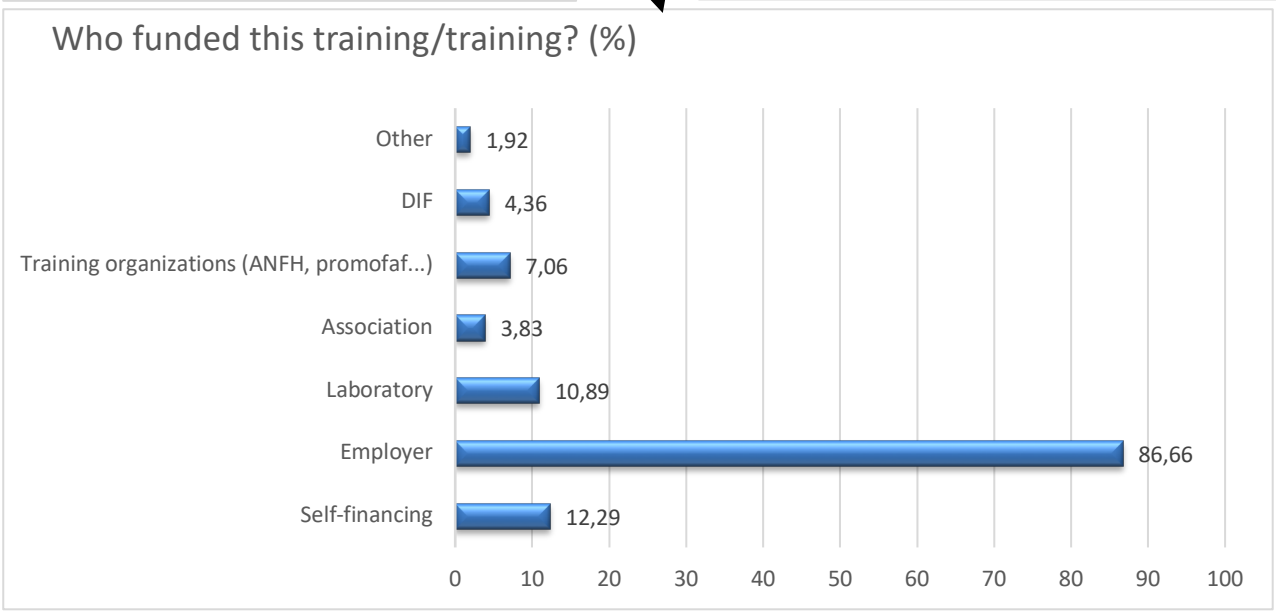
Frequencies, types and duration of training courses:

Did you participate in continuing training activities in 2016/2017 (institutional training, congresses...)?









77.95% of IADE Health Managers were able to benefit from continuous training during this period.

Reading, brief observations, comments and interpretations:

62.68% of IADEs received training in the last year, almost 15% less than in 2001. It should be noted that our professional population has doubled since this study and even if the proportion is declining, it can be noted that the rate of access to continuing training remains high compared to our workforce. With regard to the hospital civil service, this access rate is 65.13%, as a point of comparison, we can mention the recent ANFH publication which reports that 58.5% of staff left for training at least once in 2017. It should be noted that the high rate of IADE Health Managers who were able to benefit from training during the survey period (78%) should be noted.

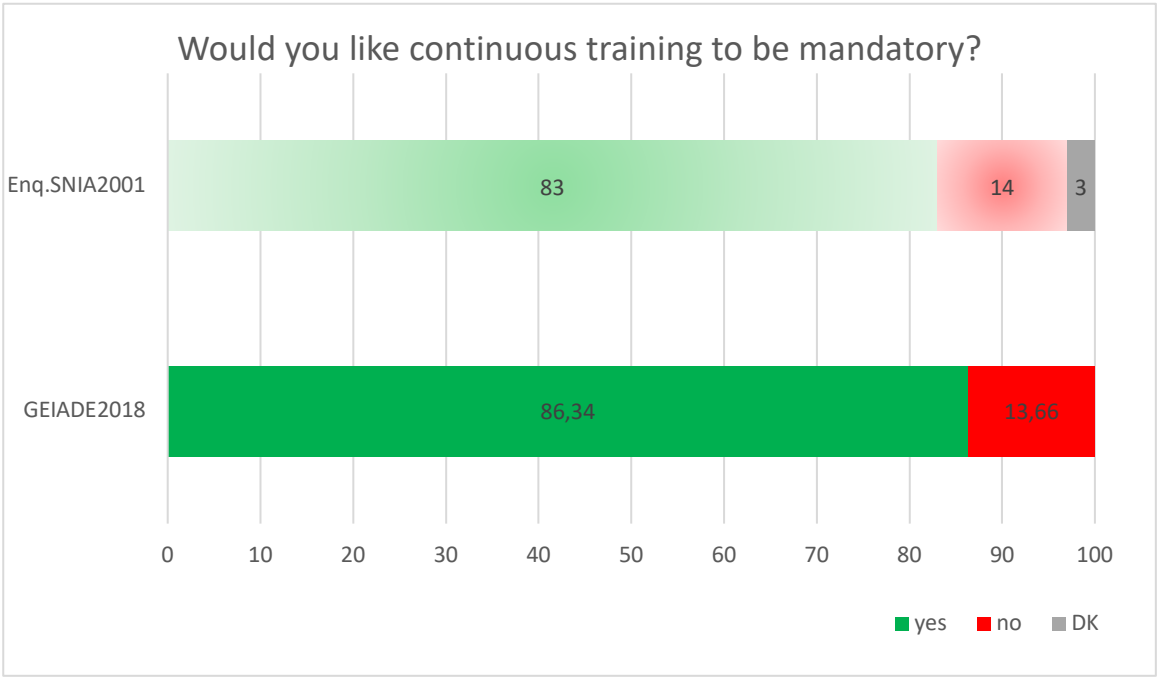
The congresses of the specialty (JEPU, SFAR, MAPAR, JMARU,...) are acclaimed by 58.93% of IADEs who have received training during the past year, followed by the training organized by the institutions

The congresses of the specialty (JEPU, SFAR, MAPAR, JMARU,...) are acclaimed by 58.93% of IADEs who have received training during the past year, followed by training organized by institutions (43.24%) and refresher sessions or days (39.49%). It should be noted that the training provided by the laboratories represents only 7.58%.

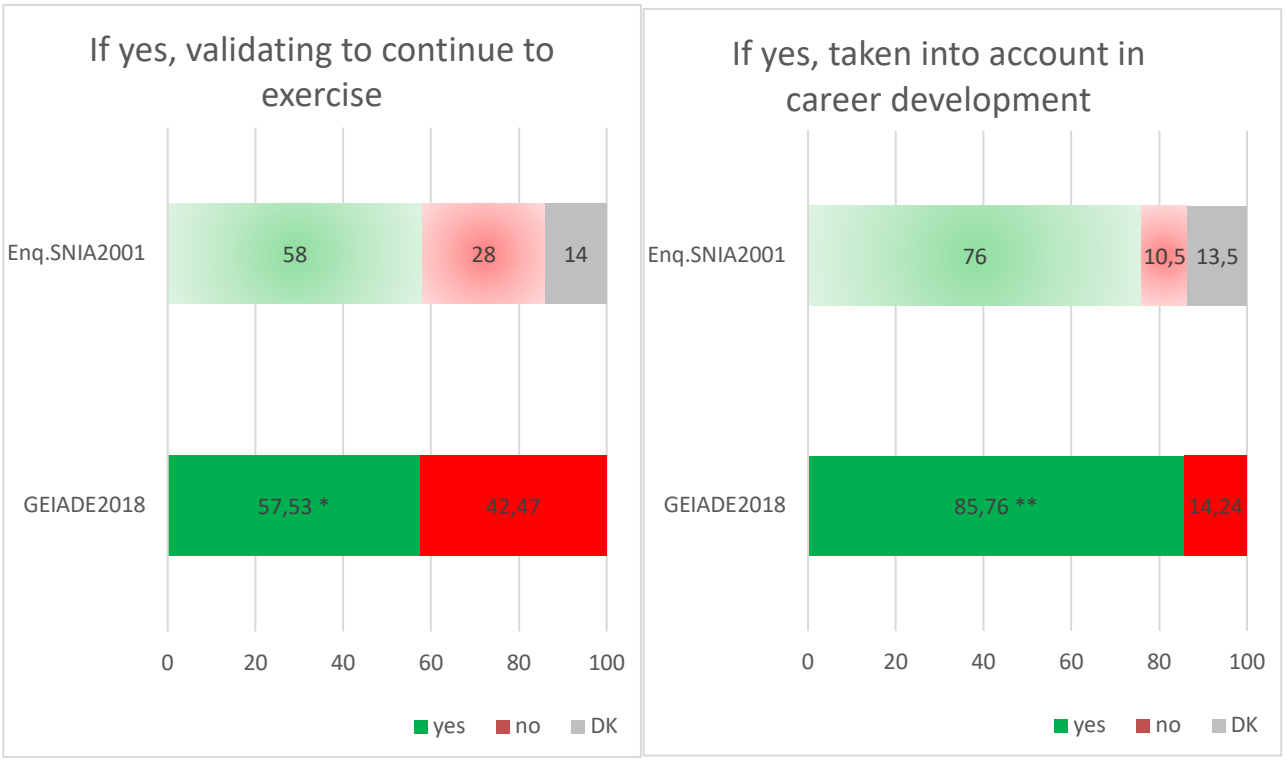
The median indicates that nearly 50% of the training courses provided by IADEs were of a duration of 3 days or more in 2017.

These training courses are mainly financed by the employer (86.66%), Self-financing concerns 12.29%, while financial support by laboratories represents 10.89%.

Legal obligations of continuing training and re-certification:



The 86.34% in favor of the obligation of continuous training is broken down as follows:



* 57.53% of 86.34% or 49.67% of the total panel

** 85.76% of 86.34% or 74.04% of the total panel

Findings in brief:

86% of IADEs are in favor of the obligation of continuous training.
57.5% of them, or 49.67% of the panel, say they want these certifications to be valid for continued practice.
71.43% of IADE Health Managers are in favor of these certifications.

85.7% of them, or 74.04% of the panel, want them to be considered in order of career development.

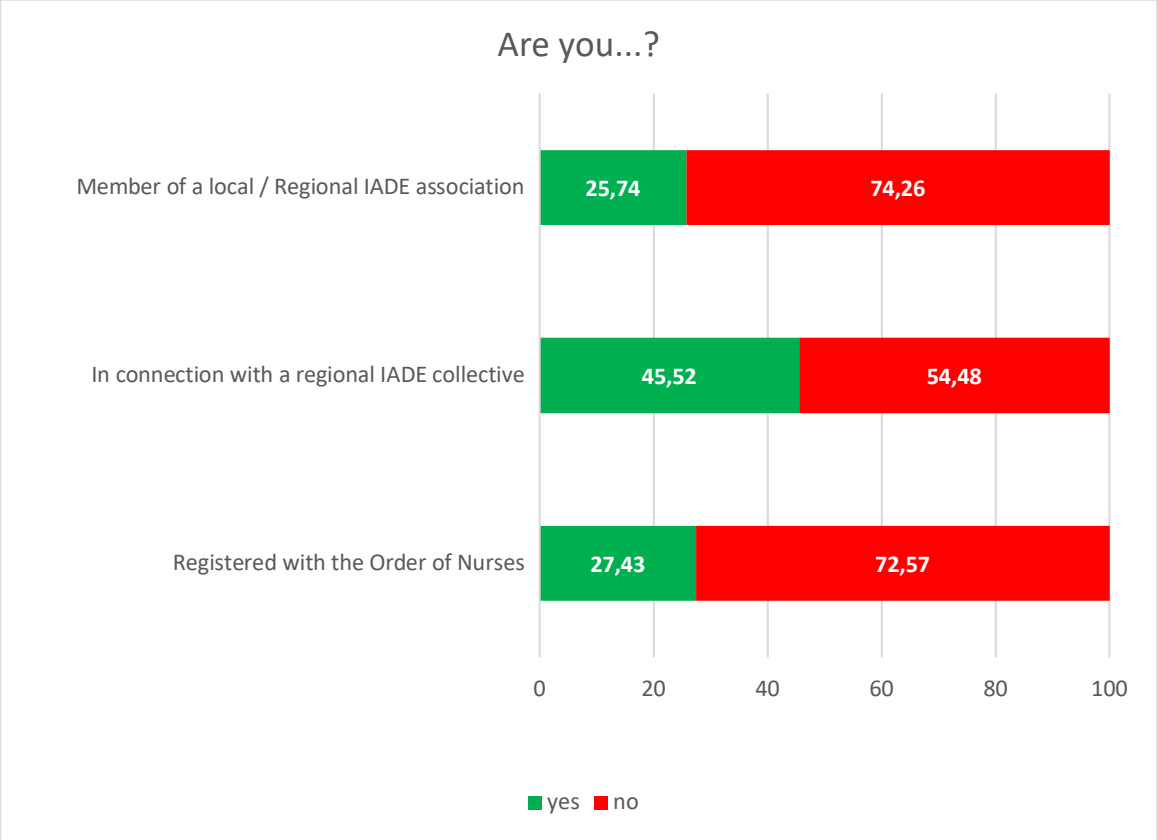
Comments and interpretations:

These results differ only slightly from the results obtained in the 2001 SNIA survey, demonstrating a stability of opinion on these subjects.

The subject of a validating re-certification, and all that it would imply, almost perfectly divides the professionals questioned (49.67%/50.33%), yet the three-year obligation to follow a CPD course could already be assimilated to the beginning of re-certification and requires that these training courses be adapted and relevant for our IADE specialty.

14. IADE COMMUNITY NETWORK

A. Professional associations, regional collectives, Order of Nurses:



Findings in brief:

¼ of the IADE respondents are members of a local or regional IADE association

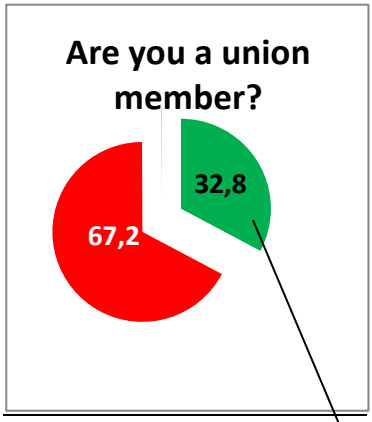
45.51% of IADEs are linked to a local or regional IADE collective

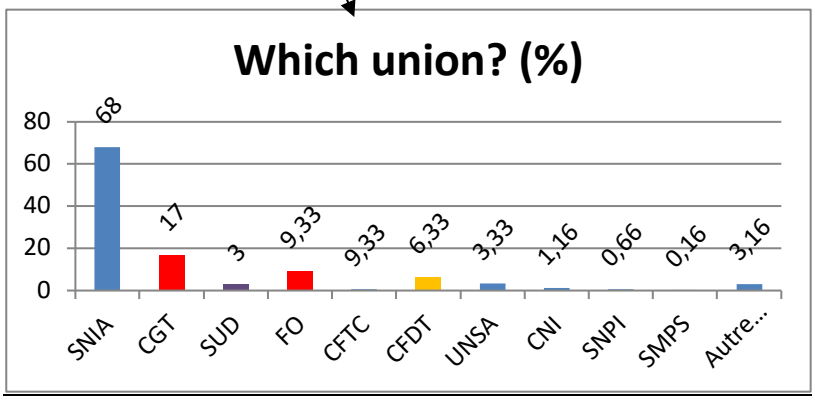
Only 27.4% of IADEs are registered with the National Order of Nurses (73.70% of those registered are up to date with their ordinal contribution at the time of answering the GEIADE2018 questionnaire).

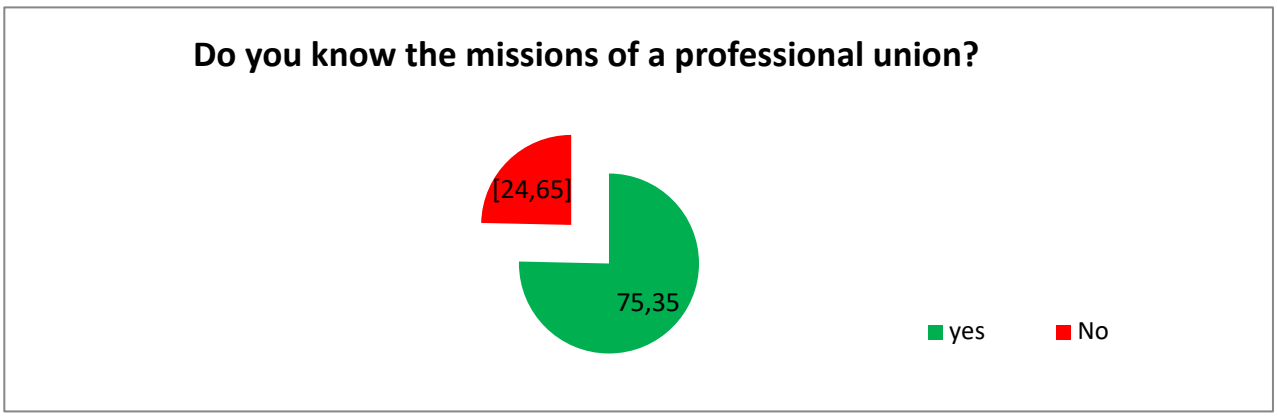
A majority of IADEs (55.4%) believe that it is necessary for IADEs to be properly represented in the ONI.

61% of IADEs admit that they do not know the missions of the National Order of Nurses.

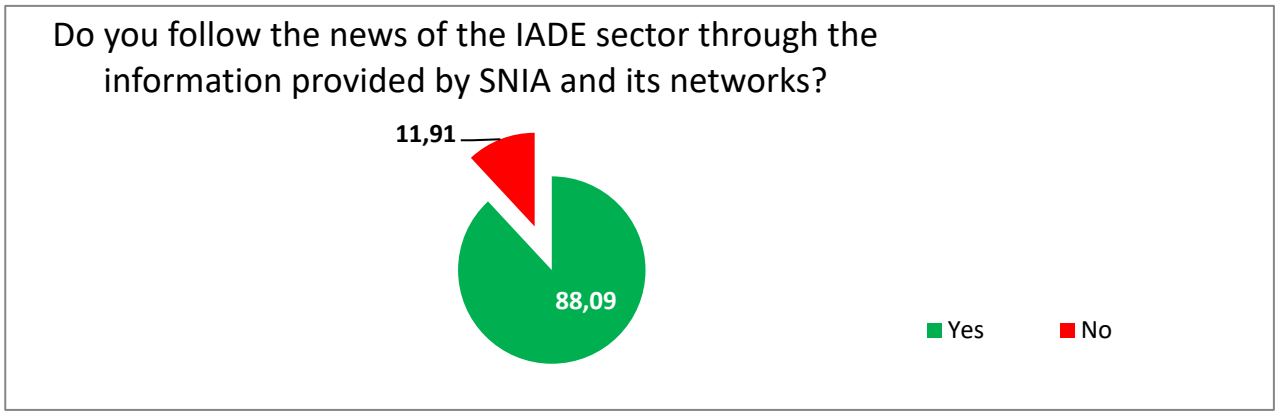
B. Union :







Visibility of the SNIA



A brief observation:

33% of the panel reported that they were unionized.

The share of SNIA union members represents the majority of IADEs reporting that they are union members.

The missions of the professional union are known and understood by nearly 75 % of the respondents.

Nearly 90 % of the IADE population is informed via SNIA networks.

Comments and interpretations:

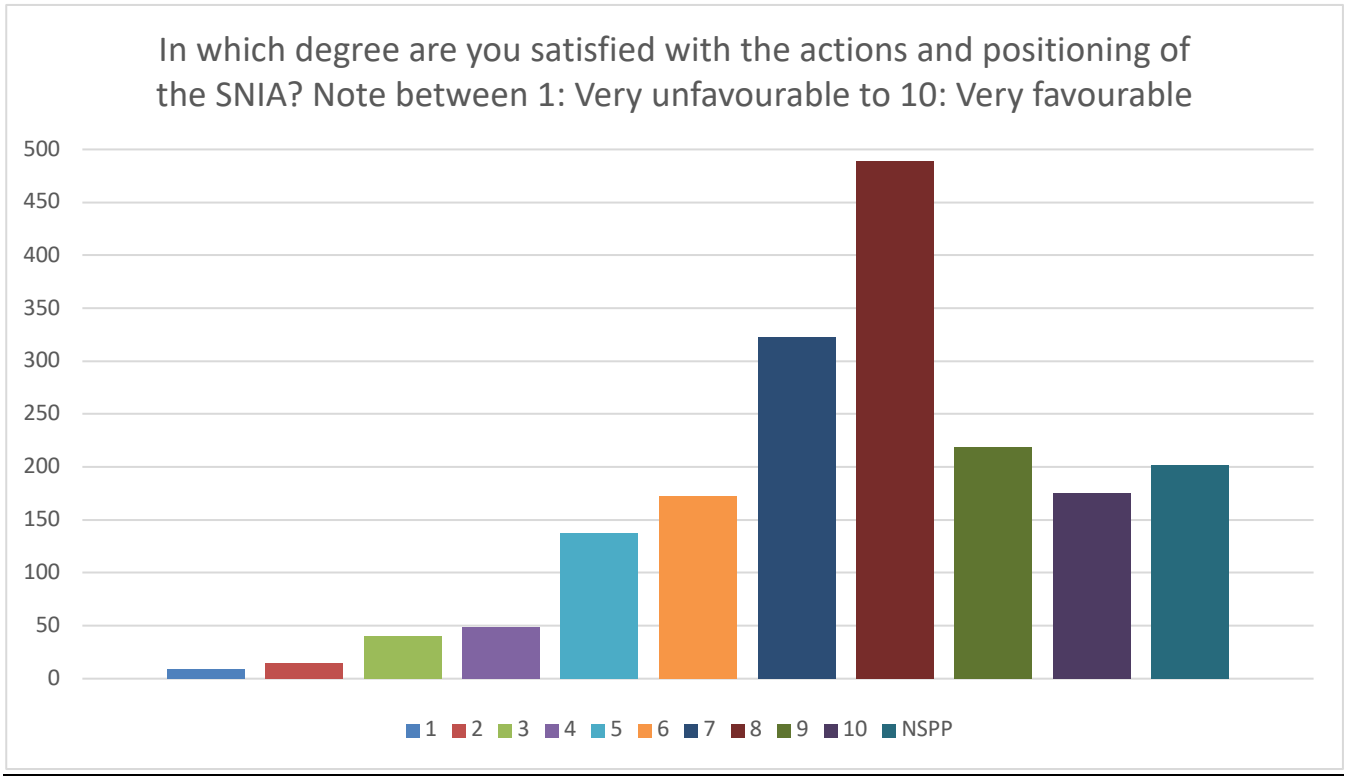
The unionization rate is very high in view of the unionization rate of employees in France (11%)

The SNIA appears to be a union favoured by the IADEs, but these results are still to be weighted because the secure personal invitations were (only partially) sent via our member file.

The rate of people reporting knowledge of the missions of the trade union suggests that the communication aimed at professionals is bearing fruit.

The SNIA appears to be a popular information channel for the IADE sector.

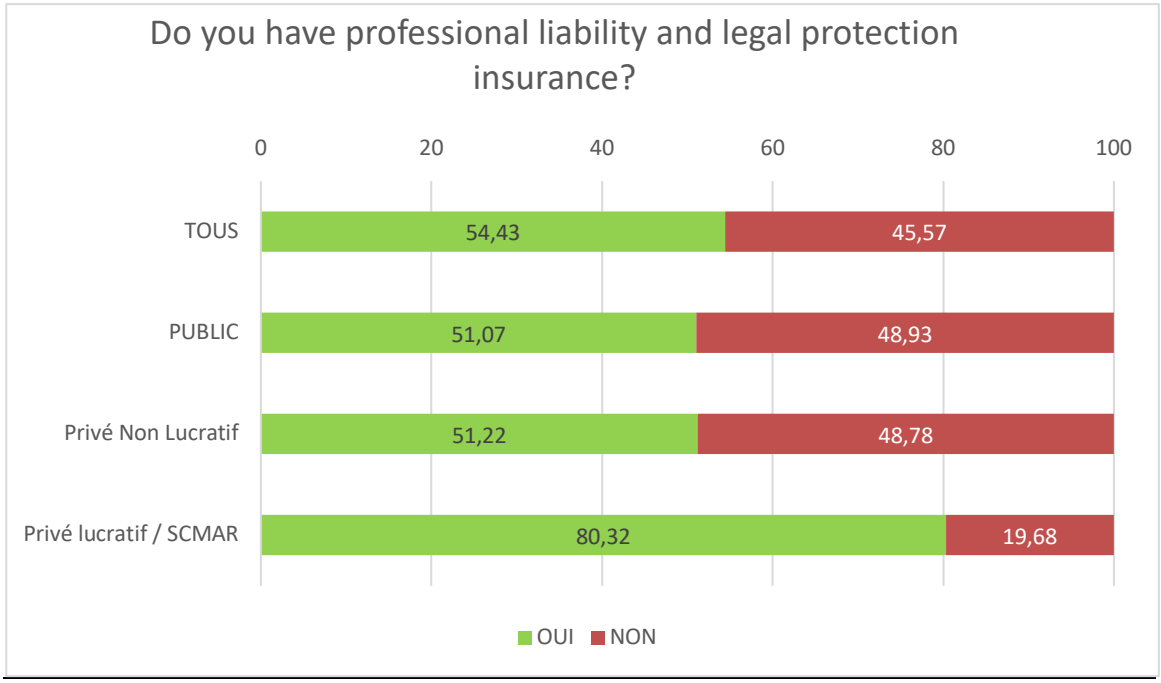
Appreciation of the profession towards its professional union SNIA



Interpretation :

The overall average rating of SNIA's actions and positioning amounts to 7.35 on a scale from 1 to 10.

C. Insurance coverage :

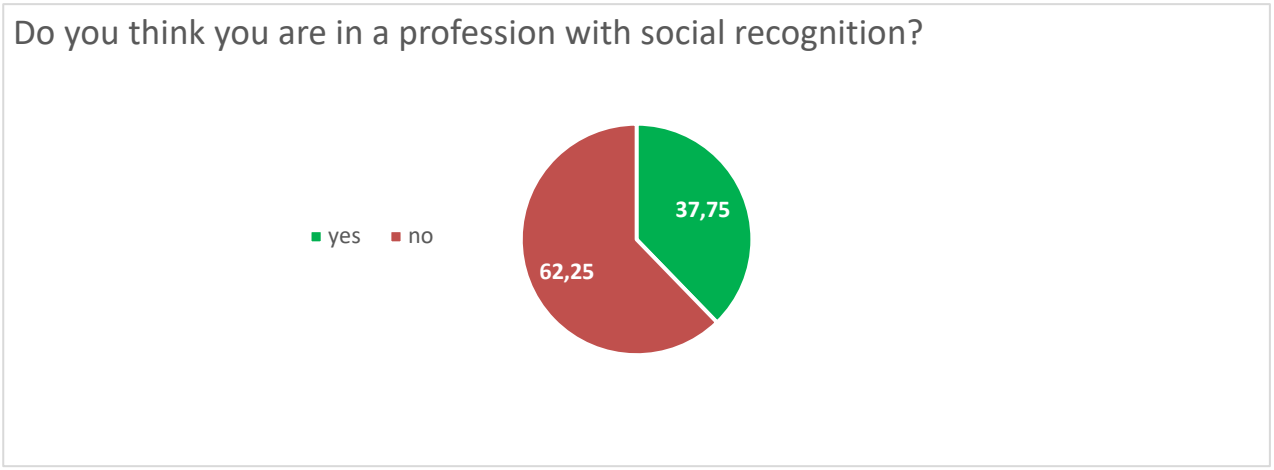


Findings and comments:

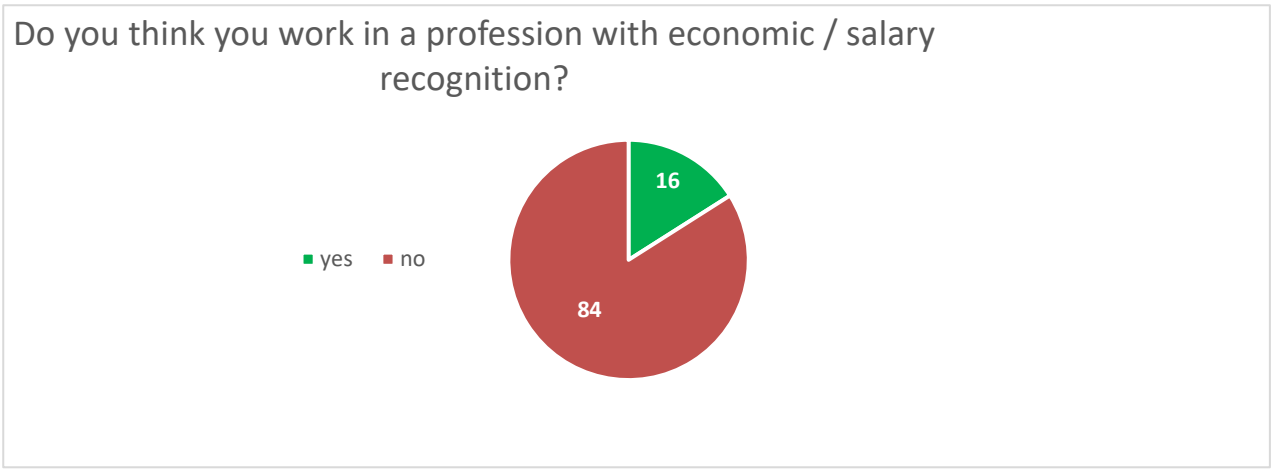
54.4% of IADEs have professional insurance.

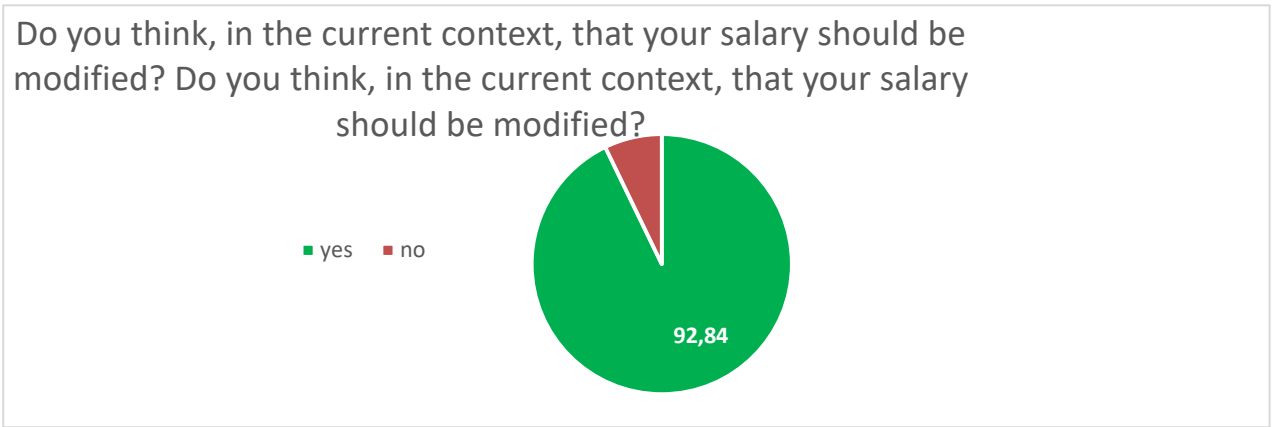
It is obviously the IADEs in the private for-profit sector that hold the highest rate (80.32%) in terms of their more autonomous practices and more risk-taking due to the way they operate. Public sector IADEs are partly covered by the insurance of their establishments if the fault or error committed is not detachable from the service.

15. CONSIDERATION, RECOGNITION, MISCELLANEOUS ISSUES



48.82% of IADE Health Managers estimate that they work in a profession with social recognition, 10 points higher than all IADEs (37.75%).

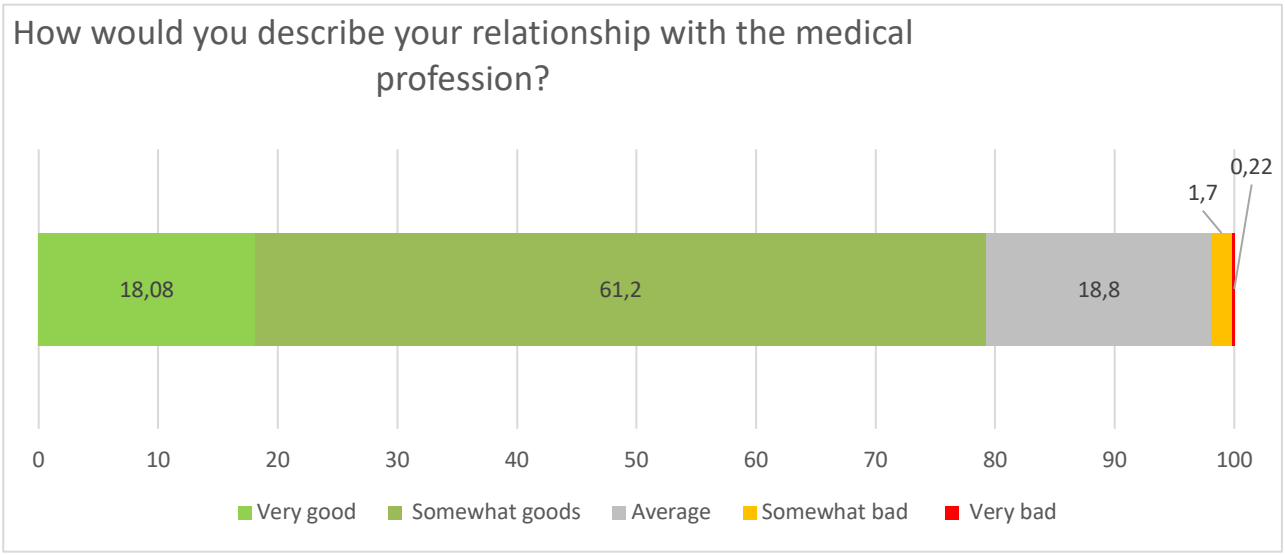




Comments and interpretations:

These results demonstrate the persistent dissatisfaction on the themes of salary recognition in the IADE sector. In view of the university level, the real responsibilities exercised and the constraints of exercise, it appears that the IADE and IADE Cadres professional bodies will naturally pursue their efforts to achieve a higher status and a higher salary.

A. MAR/IADE relations :



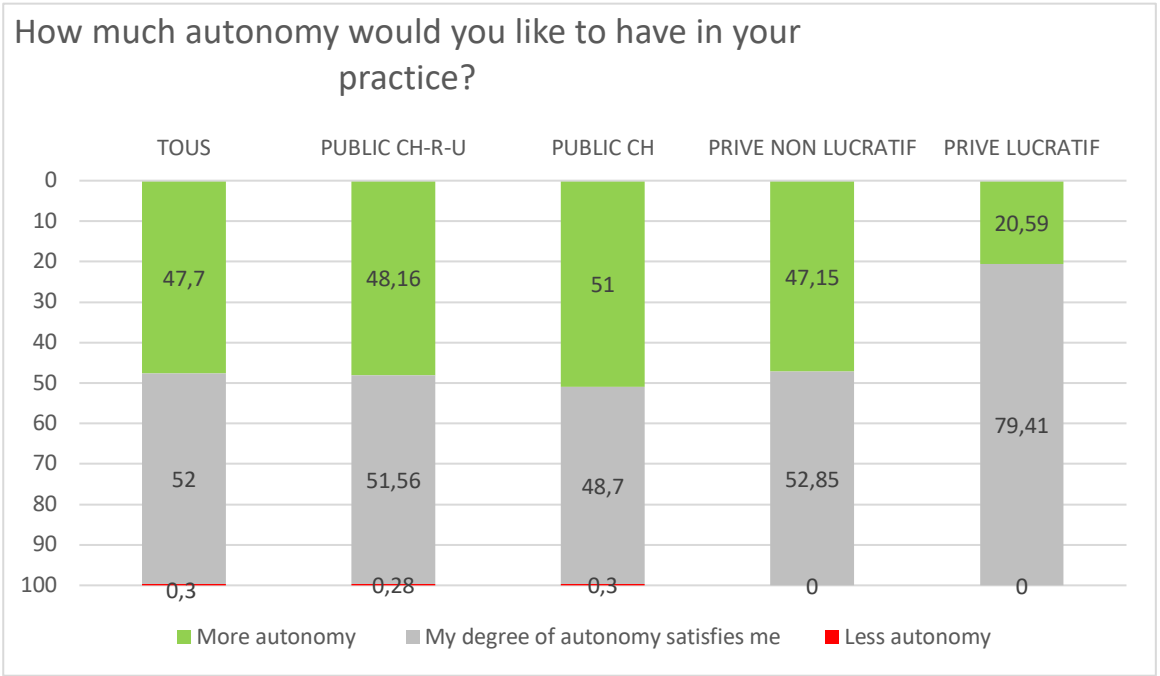
Findings in brief:

MAR/IADE professional relations are good for more than 79% of respondents (Very good 18%, rather good 61.2%). They are average for 18.8% of IADEs and poor for 1.9% of respondents (Somewhat poor 1.69%, Very poor 0.2%). 24.41% of IADE Executives describe their relations with the medical profession as very good, 60.63% as rather good, 13.39% as average, 0.79% as rather bad and 0.79% as very bad.

Comments and interpretations:

These results reflect the good interprofessional understanding between the actors of French anaesthesia.

B. Autonomy in the practice of anesthesia:

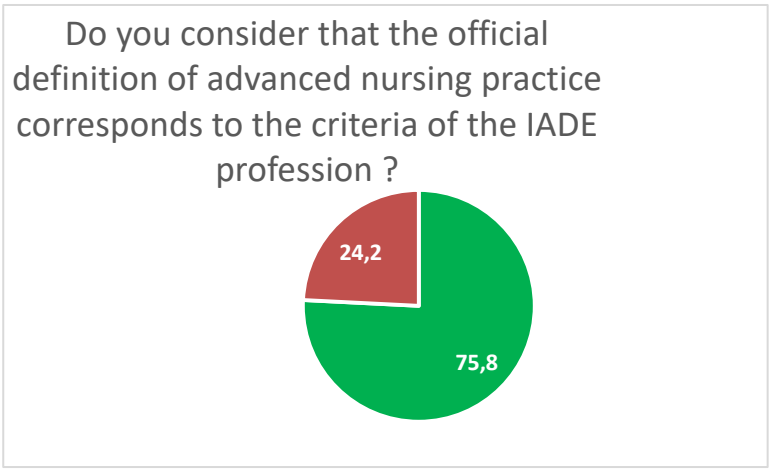


Comments and interpretations:

The desire for greater autonomy of practice is expressed mainly by public sector IADEs. Concerning IADEs working in the private for-profit sector employed by clinics or liberal MAR companies, they are logically less in search of an autonomy of practice that is already more effective for them.

There is a clear division on the desire for a more autonomous practice. The IADE autonomy left by the medical profession varies greatly from one establishment, or even from one service to another. This may explain why professionals who already have a satisfactory autonomy of practice do not feel the desire to see it grow. Others may not want to leave a comfort zone or admit to new responsibilities until a satisfactory statutory and salary framework emerges.

C. Advanced practice:

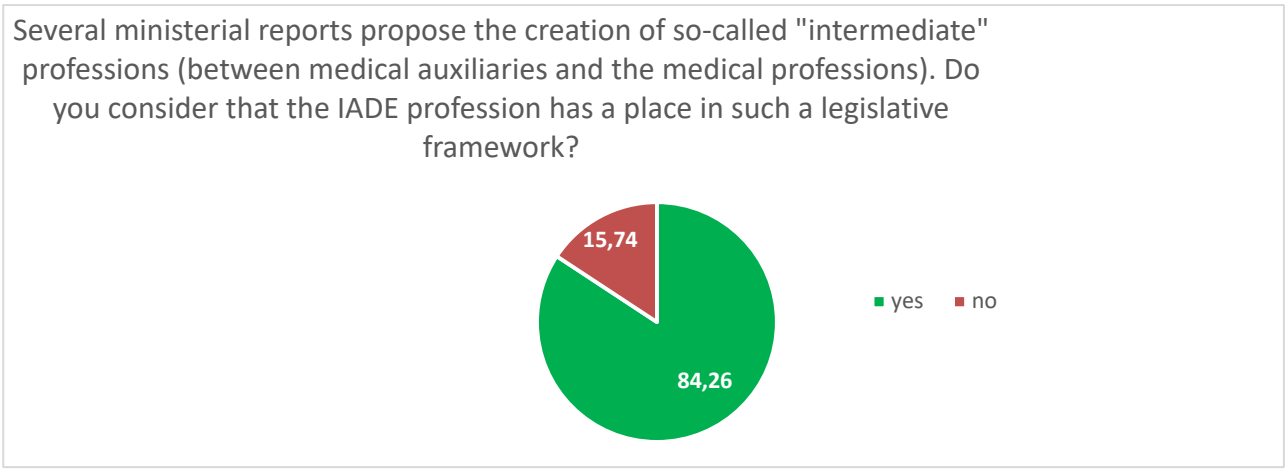


"A Nurse Practitioner/Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A master's degree is recommended for entry level. . (ICN APN Network)

A brief observation:

More than ¾ respondents believe that the official international definition of advanced practice corresponds to the IADE profession. For IADE Health Executives, this rate is 80.31%.

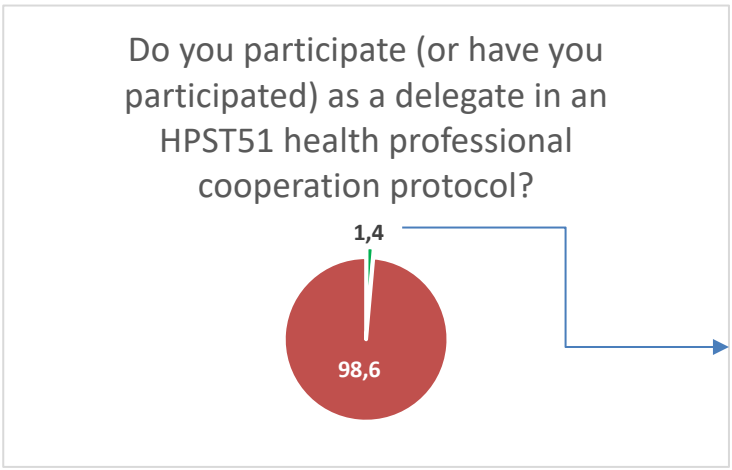
D. Intermediate health care provider :



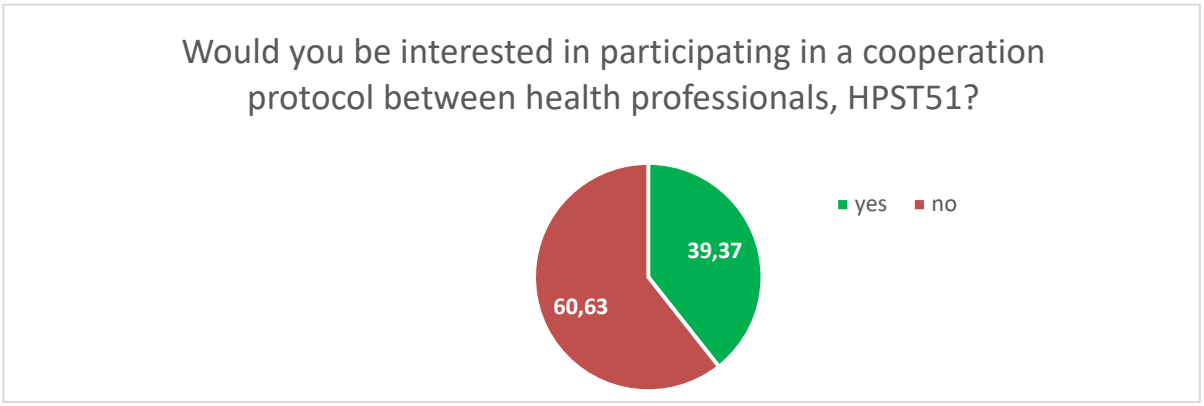
A brief observation:

An overwhelming majority (84.26%) believe that access to intermediate professional status is legitimate for the IADE profession. This rate stands at 88.19% of IADE Health Managers.

E. Cooperation Protocols between health professionals HPST51



The areas covered by these protocols concern the insertion of central vascular catheters for 57.7%, the realization of ALR for 11.53% and other areas for 30.7% (not investigated in this survey.



The cooperation protocols currently authorized by the HAS and in which the IADEs have been involved concern the " insertion of central venous lines by the IDE ". These protocols are not specifically reserved for the IADE although from certain sources we are able to argue that it is most of the time IADEs who are the delegated staff. This protocol is currently in force in 8 regions in France according to the government website listing all cooperation.

Nouvelle Aquitaine	Transfert de compétence : pose de voies veineuses centrales par l'infirmière	22/01/2015		Autorisé	
Bourgogne-Franche Comté	Transfert de compétence : pose de voies veineuses centrales par l'infirmière	11/12/2014		Autorisé	
Grand Est	Transfert de compétence : pose de voies veineuses centrales par l'infirmière	17/12/2013		Autorisé	
Auvergne-Rhône-Alpes	Transfert de compétence : pose de voies veineuses centrales par l'infirmière	12/05/2016		Autorisé	
Pays de la Loire	Transfert de compétence : pose de voies veineuses centrales par l'infirmière	22/02/2018		Autorisé	
Ile-de-France	Transfert de compétence : pose de voies veineuses centrales par l'infirmière	11/06/2014		Autorisé	
Provence-Alpes-Côte d'Azur	Transfert de compétence : pose de voies veineuses centrales par l'infirmière	10/04/2018		Autorisé	
Normandie	Transfert de compétence : pose de voies veineuses centrales par l'infirmière	19/08/2016		Autorisé	

Résultats : 7

Région	Intitulé	Statut	Date de dépôt	Voir
Ocean Indien	Protocole de pose de Picc Line au Bloc Central	Complété	21/09/2016	
Ile-de-France	Consultation de pré anéthésie conduite par une IADE	A compléter	16/12/2013	
Ile-de-France	pose de midline	Nouveau	05/09/2018	
Bourgogne-Franche Comté	pose de voie veineuse centrale par un IADE	Nouveau	07/09/2018	
Pays de la Loire	Coopération médico-soignante pour la pose des voies veineuses difficiles (PICC line et Midline) au CHU de Nantes	Nouveau	26/12/2017	
Nouvelle Aquitaine	protocole de coopération entre anesthésistes-réanimateurs et infirmiers anesthésistes pour la pose de PICCline	Nouveau	26/02/2018	
Provence-Alpes-Côte d'Azur	réalisation par l'infirmier anesthésiste des blocs nerveux analgésiques du membre inférieur sous échographie, dans la chirurgie de la prothèse de genou, de hanche et de la ligamentoplastie du genou, dans le cadre de la prise en charge de la douleur.	En attente HAS	27/07/2014	

It can be noted that 7 requests for cooperation protocols specifically relevant to IADE remain pending, 5 concern the venous access ("PiccLine", "MidLines", "VVC"), 1 concerns the conduct of pre-anaesthetic consultations by IADE, 1 concerns the performance of local and regional anaesthetic procedures for analgesic purposes by IADE.

Findings in brief:

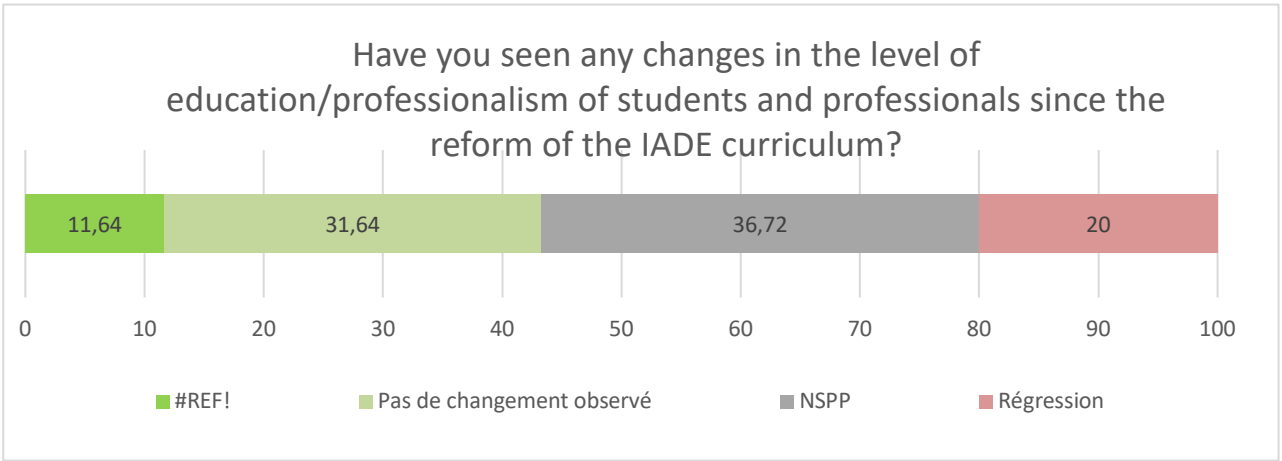
Less than 1.5% of IADEs participate or have participated in a cooperation protocol between health professionals. The majority of them (57.7%) concern the installation of central vascular approaches. 11.5% carry out ALRs. 30% are carrying out other cooperation protocols that unfortunately were not researched in this survey.

Nearly 40 % of the IADEs surveyed are interested in participating in an HPST protocol 51. The requests for protocols specifically relevant to IADEs are all awaiting validation and some have been waiting for almost 5 years!

Comments and interpretation:

When the cooperation protocols between health professionals introduced by the HPST law in 2009 arrived, the IADE sector took a very negative view of this legislative mechanism, which could potentially have jeopardized the exclusive right to practice IADE. A great mistrust persisted during its launch. Today, a significant part of the IADE population (40%) seems willing to use this system to access new prerogatives. We are entitled to question the reasons why the HAS does not validate the specific IADE protocols. We know that some have received negative opinions from medical entities.

F. New training, New professionals:



The IADE Health Managers are 27.56% to observe a positive trend, 32.28% to have not observed any change, 25.98% to have no opinion and 14.17% to estimate that there has been a regression.

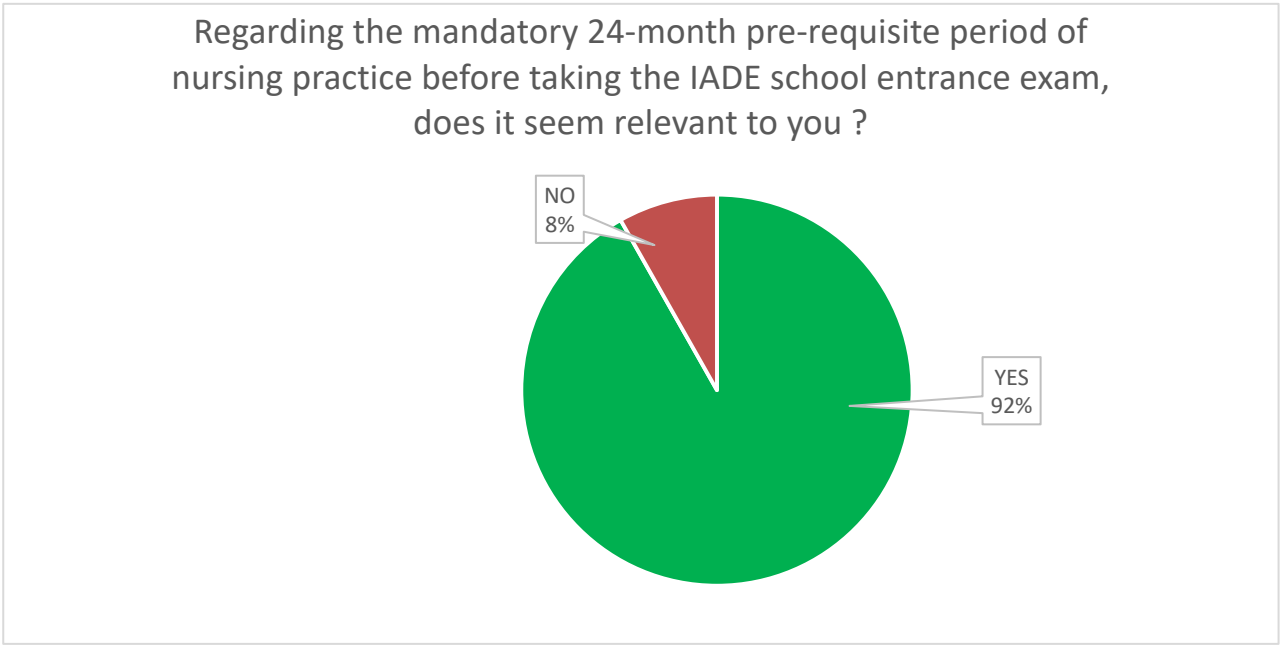
A brief observation:

37% of IADE respondents did not comment on this question, 31.6% stated that they had not observed any change, 20% saw it as a decline in professionalism and only 11.64% conceded a positive trend.

Comments and interpretations:

IADEs have difficulty perceiving the changes brought about by the reengineering of training. As this re-engineering is still recent (inaugural promotions in 2012-2014), it is possible that the professionals interviewed may have difficulty forming a clear opinion on this issue. It should be noted that the IADE Executives notice a much more positive evolution (more than 15 points compared to the IADE with 27.5% positive opinions and 10 points less uncertainty)

OPINION QUESTION: Professional period required for entry into training



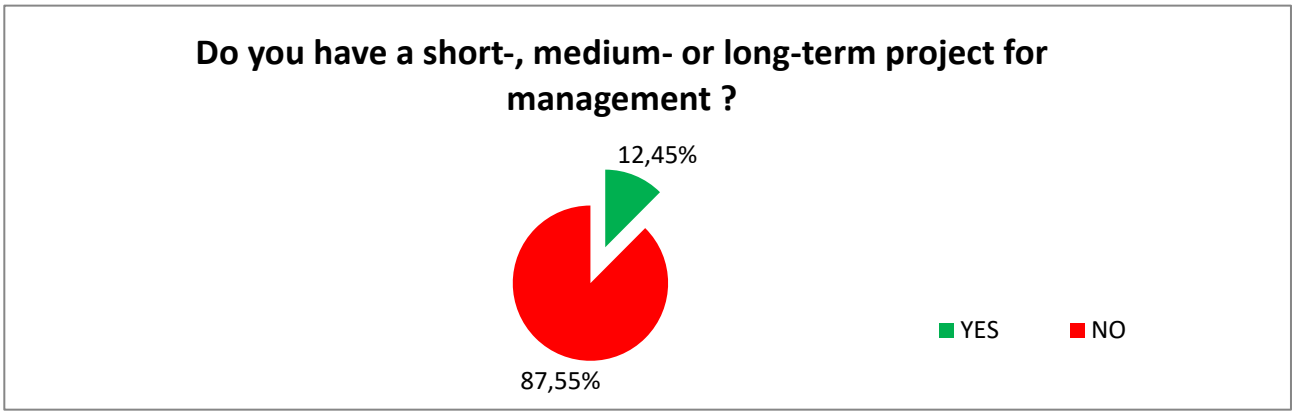
Findings in brief:

An overwhelming majority of respondents (92%) maintain the relevance of a pre-requisite professional period before entering IADE training.

Comments and interpretations:

The professional period is necessary for the acquisition of field skills in the field of nursing and the confrontation with different care situations before further study and future IADE clinical functions. The IADEs are very attached to this prerequisite, which is, in a way, part of the training.

G. Career project towards the management functions



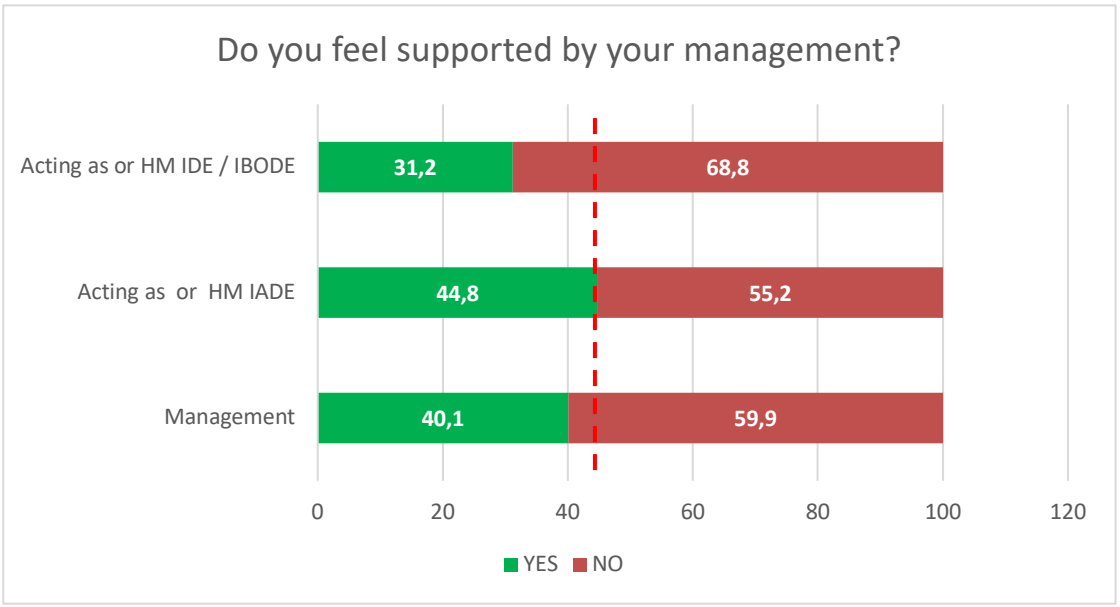
A brief observation:

Only 12.45% of IADE respondents reported having a project to become health manager.

Comments and interpretations:

The lack of salary attractiveness of the IADE executive profession, induced by the exclusion of any financial compensation on the last movements, could be an explanation ... The attraction for clinical practice can also represent a barrier to the desire to evolve towards a full management career.

H. Support from management



A brief observation:

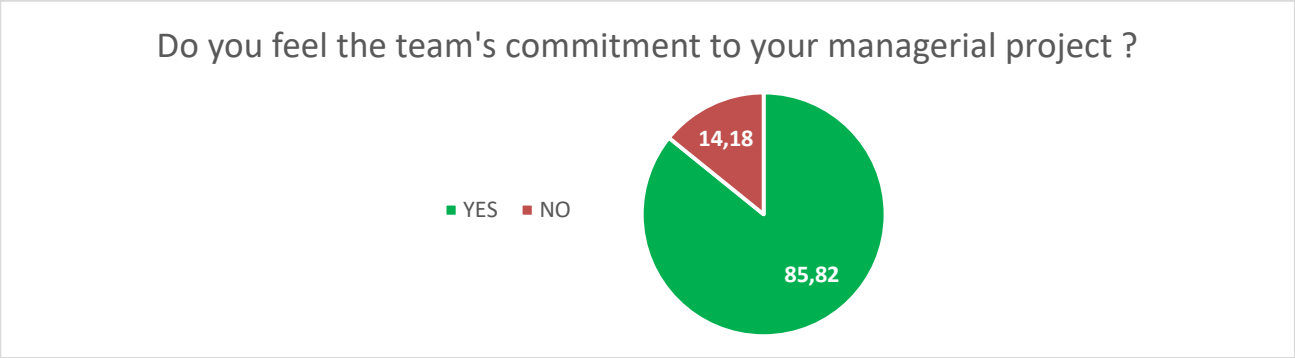
40% of IADEs feel the support of their managers, regardless of the profile of the manager. This rate approaches 45% when the supervisor has a diploma in nurse anesthesia and falls to 31% when the supervisor has an OR nurse or nurse training.

Commentary and interpretation:

There is therefore a correlation between the teams' feeling of support by the managers and the professional profile of the manager. An IADE manager will naturally have a better understanding of the constraints of the profession and will respond to the team commitment on projects of IADE Managers:

I. Team commitment to project of IADE Managers:

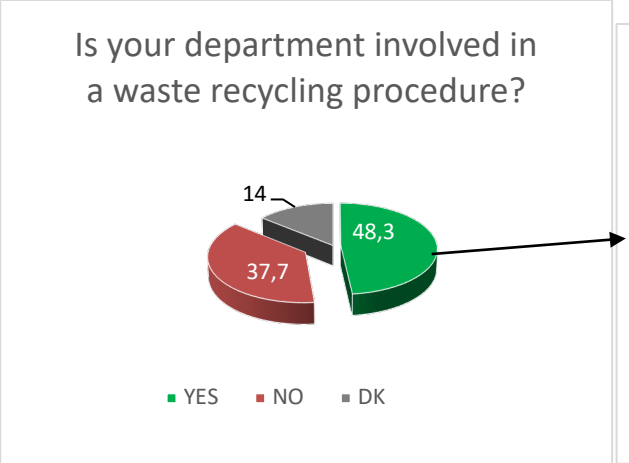
Question asked only to IADE health managers.

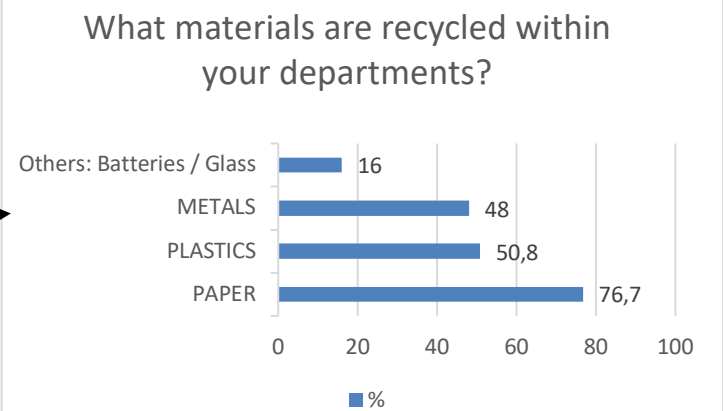


A brief observation:

A large majority of IADE Health Executives (85.8%) say they feel their team's commitment to their project

J. Environmental measures - waste recycling:





Observation and commentary in brief:

The reading of the results concerning the recycling of materials within the services shows the existing margin of manoeuvre in this field. The recovery of waste set up by local associations or partnerships also promotes awareness. These initiatives are often the result of the commitment of staff (including IADEs) to set up a sustainable development circuit with humanitarian or charitable aims. The example of the association "Les p'tits doudous" perfectly illustrates the initiatives undertaken and engageable in the country.

16. CONCLUSION

This major IADE survey carried out by the SNIA is a true photograph of the nursing anaesthetists' body, which will make it possible to delimit, in 2018, the real outlines of their professional practices, but also to highlight organisations' aspirations both for progress and for recognition.

These results demonstrate the predominant place of these professionals in the activities of anaesthesia-intensive care, emergency medicine and pain management on one hand, but also prove the involvement of these personnel in the entire healthcare system through their transversal and representative functions. It is therefore a profession that is engaged and participates in the evolution of hospital health policy.

The IADE corps appears to be a proactive professional population within healthcare institutions. Versatile professionals who participate in the bodies open to them, training in new techniques, new materials and pharmacological innovations. They support the progress of their specialties.

Many responses demonstrate the pivotal role that IADEs can play in the proper functioning of the patient pathway, in its safety and in the quality of provided care. They also reveal a massive investment by this profession in the initial and continuing training of other health professionals.

The results of the survey confirm the clinical and technical expertise of the IADEs in their fields as well as their autonomy of practice which, in several fields of competence, has increased since the last surveys carried out by the SNIA (practice of anaesthesia and maintenance of homeostasis, intraoperative resuscitation, perioperative pain management, vascular and ventilatory procedures,...).

The survey also highlights professional practices that do not comply with current regulations. These practices seem to be used to improve the fluidity of the patient pathway, the quality and safety of care. These are therefore not task transfers but rather the use of necessary skills in the field that do not currently appear to be regulatory (examples: validation of PACU discharge, administration of therapeutics, and performing procedures without a medical prescription during the extra-operative period).

It also tends to show the need for the profession to obtain a secure real practice as well as a legislative evolution in response to work as prescribed by the institution. The various questions of opinion on possible new prerogatives make it clear that a majority is willing to move the IADE profession forward towards even greater excellence.

IADEs support the recognition of responsibilities already exercised, but often ignored by decision-makers because of the lack of visibility or ignorance of their activities, as well as the possibility of new attributions in their dedicated fields (acts, prescription, consultation, autonomy,...), without calling into question a medical supervision of these activities.

IADEs require statutory and salary recognition based on their level of education, skills, responsibilities and constraints.

It is in this sense that, beyond the regulatory advances, that are expected to validate all their current and future practices. It is their positioning within the public health code which would seem relevant to redefine them towards an intermediate profession status.

17. ANNEXES

A. VERBATIM –

free expression: **307 people decided to respond to the free field set up at the end of the survey. In respect of anonymity, responses are not published.**

B. FRENCH ACRONYMS:

ALR : Anesthésie Loco-Régionale
ANFH : Association Nationale pour la Formation des Hospitaliers
AS : Aide-soignant
ASH : Agent des services hospitaliers
CDS : Cadre de Santé
CEC : Circulation Extra-Corporelle
CESU : Centre d'Enseignement des Soins d'Urgence
CH : Centre Hospitalier
CHG : Centre Hospitalier Général
CHIC : Centre Hospitalier Intercommunal
CHR : Centre Hospitalier Régional
CHU : Centre Hospitalier Universitaire
CPA : Consultation pré-anesthésique
DARES : Direction de l'Animation de la Rescherche des Etudes et des Statistiques (Ministère du travail)
DECT : Digital Enhanced Cordless Telephone : Téléphonie sans fil.
DREES : Direction de la Recherche, de l'Evaluation des Etudes et des Statistiques (Ministère de la santé)
DGOS : Direction Générale de l'Offre de Soins
EPRUS : Établissement de préparation et de réponse à l'urgence sanitaire
FF : faisant fonction
FHP : Fédération de l'Hospitalisation Privée (secteur privé lucratif)
FPH : Fonction Publique Hospitalière
GEIADE : Grande Enquête IADE 2018
HPST51 : référence à l'article 51 de la loi Hopital Patients Santé et Territoires (2009) instituant des protocoles de coopération entre professionnels de santé.
HIA : Hôpital d'Instruction des Armées
IADE : Infirmier.e-Anesthésiste Diplômé.e d'Etat
IBODE : Infirmier.e de Bloc Opératoire Diplômé.e d'Etat
IDE : Infirmier.e Diplômé.e d'Etat
IPA : Infirmier.e de Pratique Avancées
MAR : Médecin Anesthésiste-Réanimateur
MDM : Médecins Du Monde
MSF : Médecins Sans Frontières
ONG : Organisation Non Gouvernementale
PISU : Protocoles Infirmiers de Soins d'Urgence (Sapeurs-pompiers)
PL : Privé lucratif
PMO : Prélèvement multi-organes
PNL : Privé non-lucratif
PSPH : Participant au Service Public Hospitalier (Établissement privés non-lucratifs)
SAE : Statistique Annuelle des Etablissements de santé
SDIS : Service Départemental d'Incendie et de Secours
SMUR : Service Mobile d'Urgence et de Réanimation
SNIA : Syndicat National des Infirmier.e.s-Anesthésistes
SSPI : Salle de Surveillance Post-Interventionnelle (salle de réveil)
SSSM ou 3SM : Service de Santé et de Secours Médical (Sapeurs-pompiers)
TIIH ou T2IH : Transport Infirmier Inter-Hospitalier
VPA : Visite pré-anesthésique
VVC : Voie Veineuse Centrale

C. ACRONYMS in english

ALR: Local-Regional Anesthesia
ANFH: National Association for the Training of Hospitallers
AS: nursing auxiliaire
ASH: Hospital cleaner
CDS: Health Manager
CEC: Extra-Corporal Circulation
CESU: Emergency Care Education Centre
CH: Hospital Centre
CHG: General Hospital Centre
CHIC: Intercommunal Hospital Centre
CHR: Regional Hospital Centre
CHU: University Hospital Centre
CPA: Pre-anesthesia assessment
DARES: Board of Animation for Research, Study and Statistics (Ministry of Labour)
DECT : Digital Enhanced Cordless Telephone: Wireless telephony.
DREES: Directorate of Research, Evaluation, Studies and Statistics (Ministry of Health)
DGOS: General Direction of Health Care
EPRUS: Health Emergency Preparedness and Response Facility
FF: acting as an agent
FHP: Federation of Private Hospitalisation (private for-profit sector)
FPH: Hospital Public Service
GEIADE : Great IADE 2018 Survey
HPST51: reference to article 51 of the Hospitals, Patients, Health and Territories Act (2009) establishing protocols for cooperation between health professionals.
HIA: Army Training Hospital
IADE : State Diploma Qualified Nurse e-Anesthesist
IBODE: State Diploma Qualified Operating Room Nurse
IDE: State Diploma Qualified Nurse
IPA: Advanced Practice Nurse
MAR: Anesthesiologist and Intensive Care Doctor
MDM: Doctors of the World
MSF: Doctors without Frontiers
NGO: Non-Governmental Organization
PISU: Emergency Care Nursing Protocols (Fire Brigade)
PL: Private for profit
PMO: Multi-organ procurement
PNL: Private non-profit
PSPH: Participant in the Public Hospital Service (Private non-profit institutions)
SAE : Annual Statistics of Health Establishments
SDIS: Departmental Fire and Rescue Service
SMUR: Mobile Emergency and Resuscitation Service
SNIA: National Union of Nurses-Anesthesists
SSPI: Post-Anesthesia Care Unit (recovery room)
SSSM or 3SM: Health and Medical Rescue Service (Fire Brigade)
TIIH or T2IH: Inter-Hospital Nurse Transport
VPA: Pre-anesthesia visit
VVC: Central Venous Acces

Great Survey IADE 2018 carried out by the National Union of Nurses-Anesthetists: Steering: Simon TALAND (Secretary General); Support function: Raphaël LAGARDE (National Councilor); Analysis, comments, interpretations and review: SNIA National Council; Translation: Nico DECOCK (National Councilor)

Syndicat National des Infirmier(e)s-Anesthésistes (SNIA)

157 rue Legendre 75017 Paris
Tel : 01.40.35.31.98

Fax : 01.40.35.31.95

Email : contact@snia.net

Web : www.snia.net

Twitter: @SNIA75 https://twitter.com/snia75

Facebook: Snia Iade https://fr-fr.facebook.com/iade.snia