Guidance for Novice Airway Training

Background

Every year more than 1000 trainees undertake training in anaesthesia and are required to complete the *Initial Assessment of Competence* (IAC). Of these, around 600 come via Core Anaesthetic Training (CAT) or Acute Care Common Stem (ACCS) anaesthetic exit. The remainder are ACCS trainees exiting to Emergency Medicine or Acute Medicine, or ICM trainees. The IAC is a *Critical Progression Point* within the 2021 Anaesthetic Curriculum, and comprises three arenas of professional activity:

1. safe general anaesthesia with spontaneous respiration to ASA 1-2 patients for uncomplicated surgery in the supine position
2. safe rapid sequence induction for ASA 1-2 patients aged 16 or older and failed intubation routine
3. safe perioperative care to ASA 1E – 2E patients requiring uncomplicated emergency surgery.

The IAC will be assessed with *Entrustable Professional Activity* (EPA) 1 and 2:

EPA 1: performing an anaesthetic preoperative assessment
EPA 2: general anaesthesia for an ASA I/II patient having uncomplicated surgery.

As well as the trainee logbook, personal reflection and personal learning activities, assessment will take the form of *Supervised Learning Events* (SLE) and a *Multiple Trainer Report* (MTR). Formative Supervised Learning Events (SLEs) replace Workplace Based Assessments. They should be regarded as formative and should be undertaken during the entire training period to demonstrate progress. When used to assess the IAC, at the end of the relevant training period, they should show a consistent level of supervision/entrustment of 2b (supervisor within hospital for queries, able to provide prompt direction/assistance).

Airway assessment and airway management skills are core components of EPA 1 and 2 respectively. These skills must be assessed as competent (to level 2b) as part of the IAC before work is undertaken without direct supervision. All training required to complete the IAC is undertaken in a supernumerary capacity which can place considerable demands on anaesthetic departments.

Current situation

The COVID pandemic has had a significant impact on airway management and has had a detrimental impact on departments' ability to undertake novice training. There has been an appropriate tendency towards airway management by experienced anaesthetists, restriction of staff in theatre and use of video laryngoscopy. Combined with a reduction in elective surgery within the NHS, this has meant that there have been reduced opportunities for hands-on clinical training in airway management for novice anaesthetists. While things have improved at least to some extent, it could be a long time before restrictions ease completely, and the cohort of doctors in training who are due to undertake the IAC in the coming year will still face challenges in gaining sufficient clinical experience to develop the skills required for successful completion of the assessment. This is particularly important for ACCS trainees, most of whom will only spend 6 months in an anaesthetic attachment. Completion of the IAC is a mandatory requirement for this group and failure to achieve it

within their anaesthetic placements will result in a requirement for additional training time and further impact training capacity in the future. Thus, both trainees and trainers will continue to face challenges in the coming months.

Measures to support training

The RCoA and DAS have worked in partnership to produce a **training package for novice anaesthetists** to support effective training in airway management for those undertaking the IAC. This is available on the DAS website novice airway training material and there is a link at the bottom of the College website simulation page which can be accessed here. The material consists of written material and accompanying videos. It covers the following sections:

- Pre-oxygenation and basic airway management
- Supraglottic airway management
- Intubation
- Extubation
- Unanticipated difficult airway and emergency front of neck airway (eFONA)

We would strongly encourage you to use this material for novice airway training. We also urge departments to:

1. Ensure that appropriate time is available for trainers and trainees. This includes building time into both clinical schedules and allocating sessions to support the use of simulation in the development of airway skills.
2. Establish appropriate training facilities both in terms of accommodation and equipment to support the regular use of simulation as an adjunct to clinical practice.
3. Continue training in direct laryngoscopy. Video laryngoscopy may be used as an alternative to direct laryngoscopy for training and assessment in endotracheal intubation in clinical settings. However, trainees must also be able to demonstrate competence in direct laryngoscopy in simulated settings to achieve successful completion of the IAC.

These measures are essential to support skills development in the current climate. All departments should have a comprehensive plan to ensure that airway training can be optimised for the foreseeable future to ensure successful completion of the assessments that form the IAC.

No Trace, wrong place

In the light of a series of recent tragic events where deaths were associated with undetected oesophageal intubation, we would like to stress the importance of correct interpretation of capnography waveforms to determine endotracheal tube placement. We would also emphasise that during cardiac arrest, if a capnography trace is completely flat, oesophogeal intubation should be assumed until proven otherwise.

The Royal College of Anaesthetists (RCoA) and the Difficult Airway Society (DAS) have collaborated to create the video resource Capnography: No Trace = Wrong Place.

The video can be viewed here

The College recommends that all clinicians involved in the management of airways should take the time to watch this video and help share this important message. The video is accompanied by a slideshow presentation. It is recommended that this presentation is given at your next departmental meeting.