Section 14: Training

Edited by
Dr Ian Barker

14.1 Consultant supervision of trainees in operating lists
14.2 Trainee logbooks – are they up to date?
14.3 Study leave for trainees, including attendance at FRCA courses
14.4 Continuing Professional Development (CPD)
14.5 ICU training
14.6 Training in day surgery anaesthesia
14.7 Airway management training for novice anaesthetists
14.8 Delivery, timing and quality of pain training for anaesthetists
# Consultant supervision of trainees in operating lists

**Dr J Clarke, Dr P Keeling, Dr P Radford**

## Why do this audit?
To ensure compliance with Royal College of Anaesthetists (RCoA) guidelines[^1][^2] and to see that all trainees are receiving this most fundamental aspect of training.

## Best practice: research evidence or authoritative opinion
The RCoA has issued guidance on the appropriate supervision of trainees[^1][^2].

## Suggested indicators
% trainees with the correct proportion of accompanied lists, as stated in the RCoA guidelines.

## Proposed standard or target for best practice
- 100% Senior House Officers (SHOs) in their first 12 weeks of anaesthesia should have all time-tabled lists directly supervised by a consultant or a post-fellowship anaesthetist[^1].
- 100% other SHOs and 1st or 2nd year Specialist Registrars (SpRs) should have at least three operating sessions per week supervised by a consultant or a post-fellowship anaesthetist[^1][^2].
- 100% 3rd or 4th year SpRs should have at least one list per week supervised by a consultant.

## Suggested data to be collected
A survey may be carried out over a 1- or 2-month period. This may be done using departmental records, or preferably from trainee logbooks. Trainee logbooks should be a more accurate source of information, as they will indicate actual supervision, rather than planned supervision which may not have occurred due to a crisis elsewhere. The supervisor should be present throughout the session and not doing another list at the same time. An out-of-theatre session such as a labour ward session counts as a list.

## Common reasons for failure to reach standards
- Service commitment.
- Poor departmental planning.

## References
1. Royal College of Anaesthetists. The CCST in Anaesthesia II: Competency based Senior House Officer training and assessment. RCoA, London April 2003 (see: [www.rcoa.ac.uk/docs/ccstptiied2.pdf](http://www.rcoa.ac.uk/docs/ccstptiied2.pdf))
2. Royal College of Anaesthetists. The CCST in Anaesthesia III: Competency based Specialist Registrar years 1 and 2 training and assessment. RCoA, London April 2003 (see: [www.rcoa.ac.uk/docs/ccstptiiied2.pdf](http://www.rcoa.ac.uk/docs/ccstptiiied2.pdf)).
Trainee logbooks – are they up to date?

Dr J Clarke, Dr P Keeling, Dr P Radford

Why do this audit?

To ensure that all trainees are keeping a logbook as recommended,1,2 and that it is up to date. This will also pick up trainees who are failing to keep an adequate logbook at an early stage. They will find it essential if they wish to progress up the career ladder.

Best practice: research evidence or authoritative opinion

The Royal College of Anaesthetists (RCoA) recommends that all trainees maintain a logbook.1,2

Suggested indicators

% trainees whose logbook:
- begins when they started anaesthesia, or when logbooks were introduced, whichever is the later.
- is completed and up to a date no more than 7 days prior to the date of the audit.
- includes ASA grades for most cases.
- includes supervision level for most cases.
- includes a record of critical incidents.

Proposed standard or target for best practice

100% trainees should have logbooks as above in a form that contains the minimum recommended data set.2

Suggested data to be collected

Review of trainee logbooks as above. If trainees are relying on computerised theatre records, then this audit may not be appropriate. However, the record must include the data recommended by the RCoA, including ASA grade and supervision level as above.

Common reasons for failure to reach standards

Lack of enthusiasm or understanding by the trainee or College Tutor.

References

2 Royal College of Anaesthetists. Electronic logbook (see: www.logbook.org.uk/).
# Study leave for trainees, including attendance at FRCA courses

Dr J Clarke, Dr P Keeling, Dr P Radford

**Why do this audit?**

It is important that trainees have study leave, including, where appropriate, access to a recognised FRCA course. Factors that prevent this should be identified at an early stage and corrected.

**Best practice: research evidence or authoritative opinion**

The NHS terms and conditions of service outline the recommended study leave for trainees.

**Suggested indicators**

- % trainees who have taken at least 75% of their study leave entitlement in the year prior to the date of the audit.
- % candidates for the primary and final FRCA who have attended a recognised course prior to taking the examination.

**Proposed standard or target for best practice**

- 75% of trainees should have used at least 75% of their study leave entitlement in the year prior to the date of the audit.
- 100% candidates for the primary or final FRCA should have attended a recognised course before their first attempt at the exam.

**Suggested data to be collected**

This data could be collected at the end of year Record of In-training Assessment (RITA), or the audit may be done as a survey within a department. The number of days of study leave, the names of any courses attended and attempts at the examination should be noted. If the standards are not met, the trainee should be asked the reasons for this. This audit could be extended to correlate specific courses with examination results.

**Common reasons for failure to reach standards**

- Lack of knowledge of study leave entitlement.
- Service commitment does not allow for full entitlement.
- Trainee may not wish to attend a recognised course.
- Not enough places on local course, or hospital unable to release all trainees at one time.

**References**

1. Study leave guidelines for hospital doctors and dentists in training. South Thames Department of Postgraduate Medical & Dental Education, 1997 (and corresponding guides for each deanery).
# Continuing Professional Development (CPD)

**Dr J Clarke, Dr P Keeling, Dr P Radford**

## Why do this audit?
It is a Royal College of Anaesthetists (RCoA) requirement that non-consultant career grade anaesthetists and consultants provide satisfactory records of their CPD activities to maintain recognition for training. Satisfactory CPD is now also required as part of consultant appraisal. An audit would provide feedback that the current proposals for CPD are being followed. It would also demonstrate a commitment by anaesthetists in these grades to continuing education.

## Best practice: research evidence or authoritative opinion
The RCoA considers that all non-consultant and consultant grades should demonstrate their continued education and professional development.

## Suggested indicators
% of non-trainee staff who achieve the RCoA requirements as follows:
- There was previously a minimum requirement of 25 internal credits and 25 external points in a 5-year period, with an expectation that this would be achieved on a pro rata basis annually. Currently the actual totals per year must be agreed with the appraiser, though the previously recommended levels would appear to be generally acceptable in most situations.

## Proposed standard or target for best practice
100% of consultants and non-consultant career grades (including clinical assistants, staff grades, associate specialists and ‘Trust’ doctors) should achieve the RCoA requirements or other agreed requirement as above.

## Suggested data to be collected
CPD points acquired, as described in the RCoA document. The local CPD co-ordinator should be able to provide this information.
As a supplementary investigation, it may be helpful to ask for views as to why it was not possible to achieve the goals.

## Common reasons for failure to reach standards
- Lack of funding.
- Service commitments.
- Failure of individual to appreciate importance of CPD.

## References
ICU training
Dr J Clarke, Dr P Keeling, Dr P Radford

Why do this audit?
To ensure that proper training occurs during ICU modules.

Best practice: research evidence or authoritative opinion
The Intercollegiate Board for Training in Intensive Care Medicine (IBTICM) and the Royal College of Anaesthetists (RCoA) recommend standards of training during ICU modules. It is recommended that clinical training in ICU should be in blocks of at least 1 month for SHOs and 3 months for SpRs years 1 and 2.

Suggested indicators
% appropriately timed blocks of training for SHO and SpR trainees.
% days when a consultant ward round occurs.
% weeks when a trainee has attended at least one teaching session with an ICU consultant.

Proposed standard or target for best practice
100% training blocks should meet above stipulations.
100% days there should be a consultant ward round on the ICU.
100% trainees on the ICU module should attend at least one teaching session with an ICU consultant each week.

Suggested data to be collected
Trainee portfolio and programme director’s records on ICU and anaesthesia rotations
It is suggested that data collection is for 1 month by trainees on the ICU module.

Common reasons for failure to reach standards
Consultants on leave.
Other calls on consultants’ time taking priority.
Difficulties with timing of a session to enable all trainees to attend.
ICU emergencies taking priority.

References
1 Royal College of Anaesthetists. The CCST in Anaesthesia II: Competency based Senior House Officer training and assessment. RCoA, London April 2003 (see: www.rcoa.ac.uk/docs/ccstptied2.pdf)
2 Royal College of Anaesthetists. The CCST in Anaesthesia III: Competency based Specialist Registrar years 1 and 2 training and assessment. RCoA, London April 2003 (see: www.rcoa.ac.uk/docs/ccstptiiied2.pdf).
# Training in day surgery anaesthesia

**Dr L Rowe**

## Why do this audit?
Most consultant anaesthetists will have sessions involving day case patients. It is vital that all new consultants have received adequate training in this field.

## Best practice: evidence

The Royal College of Anaesthetists has laid down the syllabus for training in day surgery in section 16 of the intermediate level training manual for year 1 and 2 Specialist Registrars (SpRs). Day surgery is one of six general units of training, in which it would be expected that all SpR 1 and 2 trainees will receive appropriate training followed by a workplace assessment.

## Suggested indicators
Compliance with section 16 of the RCoA Competency Based training manual for year 1 and 2 SpRs.

## Proposed standard or target for best practice

1. 100% SpR years 1 and 2 trainees will have completed a day surgery training module in a designated day surgery unit.
2. 100% SpR years 1 and 2 trainees will have satisfactorily completed a workplace assessment in day surgery.

## Suggested data to be collected
Evidence from workplace assessment records.

*See also the example questionnaire on the accompanying CD-ROM.*

## Common reasons for failure to reach standards
Day surgery may be given a low priority in some centres compared with other training modules.

Service commitments may lead to trainees being seconded to cover in-patient lists.

## References
1 Royal College of Anaesthetists. The CCST in Anaesthesia III: Competency based Specialist Registrar years 1 and 2 training and assessment. **RCoA**, London April 2003 (see: [www.rcoa.ac.uk/docs/ccstptisied2.pdf](http://www.rcoa.ac.uk/docs/ccstptisied2.pdf)).
Airway management training for novice anaesthetists

Dr C Whymark

**Why do this audit?**

Airway management is a fundamental skill in anaesthetic practice. Airway management techniques include use of the face mask, laryngeal mask airway (LMA) and tracheal intubation. In the initial 3 months of training it is important that new-start anaesthetists gain adequate experience in all these techniques as these skills will form the basis of all airway management, whether routine or difficult, expected or unexpected. While these three aspects are formally assessed at the initial test of competency the RCoA does not currently recommend minimum case numbers.¹

Recent concerns about reduced competence in basic airway management have been raised in relation to reductions in training time and case-load that are apparent in recent years.

**Best practice: research evidence or authoritative opinion**

There is evidence that for practical procedures, 50 attempts will confer a degree of competence.²,³ This number is also achievable in the context of early training in anaesthesia.

**Suggested indicators**

The emphasis of this audit is on the ability of a training rotation to deliver a satisfactory volume of airway management experience to the novice trainee, rather than to determine airway competency in individual trainees per se.

- % novice trainees with logbook documentation of all cases including a record of airway management during the initial 3-month period of training.
- % trainees achieving experience of 50 cases of each of three categories of basic airway management, i.e. face mask, LMA, tracheal intubation.

**Proposed standard or target for best practice**

100% of new-start trainees should have a complete record of the airway management technique used for every case carried out in the first 3 months.

100% should have achieved 50 cases in each category.

**Suggested data to be collected**

The number of cases carried out using:
- face mask alone or with oropharyngeal airway
- LMA
- tracheal intubation.
Common reasons for failure to reach standards

Case mix: trainees may not be exposed to a sufficient number or appropriate balance of cases to achieve the broad range of experience necessary. This should be taken into account when compiling weekly departmental rotas.

Trainers need to monitor the progress of trainees on a month by month basis to address such deficiencies as soon as possible.

Trainees should be discouraged from taking leave during this initial period of intensive training.

Poor compliance with completion of logbooks.

References

1. Royal College of Anaesthetists. The CCST in Anaesthesia II: Competency based Senior House Officer training and assessment. RCoA, London April 2003 (see: www.rcoa.ac.uk/docs/ccstptied2.pdf)


Delivery, timing and quality of pain training for anaesthetists

Dr J Francis, Dr D Graham

Why do this audit?

To determine how effectively key elements of pain training (duration, delivery and supervision) are delivered at each stage of training from SHO to advanced trainee level. Emphasis is placed on training for advanced trainees. This audit should provide evidence of current training, but in addition the template can be used repeatedly for tracking change nationally on a region by region basis.

Best practice: research evidence or authoritative opinion

The Royal College of Anaesthetists (RCoA) requirements for pain training at each stage are as follows:1

1 SHOs: exposure to pain training opportunities.
2 SpRs (years 1 and 2): 1–3 months pain training over 2 years.
3 Higher training in pain management builds upon earlier SpR training.
4 Advanced training: 1 year training ideally unbroken in RCoA approved training centres.

There is some evidence from regional trainee surveys that this is not always consistently achieved:

- 97% of SHOs think more training in pain management is necessary.2
- only 55% of SHO and SpR trainees consider training adequate for acute pain, with correspondingly low numbers satisfied with chronic pain (approximately 25%) and cancer pain (approximately 22%) training.3

Suggested indicators

Part 1: SHOs, junior SpRs and higher trainees as defined above
Structure of training.
Delivery and duration of training.
Quality of training.
Monitoring: adequacy of the system used.

Part 2: Advanced trainees
Structure of training.
Delivery and duration of training.
How adequate is clinical training?
Non-clinical commitments.
The level of supervision.

Proposed standard or target for best practice

Training should meet RCoA requirements at each stage.
Suggested data to be collected

Data to be collected on a school or regional basis.

**Data fields to be completed ONLY by the Regional Advisor in Pain, data to be collected with respect to ALL trainees**

- Is training modular in structure?
- The duration of training and what % is actually delivered.
- Where the training occurs.

**Additional fields for SHOs, junior SpR and higher trainees**

- Broadly identify the content of training with respect to recommended training objectives.
- Is the monitoring system (e.g. logbook) for pain training adequate?

**Additional fields for advanced trainees**

- Is the clinical workload adequate (out-patients, in-patients, interventions and availability of out of region training)?
- The level of supervision and opportunity for non-clinical involvement.

**Numbers**

- Are advanced trainee posts available?
- Number of trainees having successfully completed training (within the last 3 years).
- Is there opportunity for trainees to undertake training out of region if required?

Common reasons for failure to reach standards

- **There is a lack of training opportunities due to rota structure or pressure from anaesthesia and other specialties.**
- **There is a lack of emphasis on pain training due to competition from more traditional sub-specialty areas of anaesthesia.**
- **Service commitment to anaesthesia.**

References


New topic template

See also the editable Word version of this template on the accompanying CD-ROM

Why do this audit?

Best practice: research evidence or authoritative opinion

Suggested indicators

Proposed standard or target for best practice

Suggested data to be collected

Common reasons for failure to reach standards

References