LOGBOOKS, CONFIDENTIALITY, SECURITY AND DATA PROTECTION

Most anaesthetists in training should now be using some form of logbook to record their experience. This does not prove competence but it does enable trainers and college tutors to see what a trainee has done and if there are any gaps in their training. However, keeping a personal record of details about patients has significant implications. There are both professional and legal obligations regarding clinical records. Anyone keeping a logbook must be aware of these if they are not to fall foul of the GMC or the Courts.

TYPES OF LOGBOOK

Logbooks approved by the RCoA may be kept on paper, on a PDA, smart phone or a USB stick. Approved software can be downloaded via a link from the College’s website. Logbooks kept as part of a theatre and the of logbooks, the Freedom of Information (FoI) Act 2000✱ abbreviated form, these are that personal data shall:

✱ have appropriate technical and organisational measures taken to prevent unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data
✱ be transferred to a country or territory outside the European Economic Area without adequate protection

implications

Firstly, a logbook must be accurate. Significant inaccuracies could be regarded as fraud, which would have serious consequences. That said, it is probably the penultimate principle that causes most difficulty. Everyone will be aware of the news stories about the losses of personal data incurred by various Government departments. When personal data is lost by an organisation it can be very difficult to blame an individual, but if an identifiable anaesthetist loses their logbook and the personal data of one or more identifiable patients gets into the public domain then that anaesthetist could be in serious trouble. The logbook database must therefore be kept physically secure and be regularly backed up to ensure against data loss or corruption. Access must be controlled by at least a password. The use of encryption software is recommended.

Some of this can be difficult in practice. For example, if the database is kept on a US stick it can easily be erased, and encryption software is not always user friendly. One solution is not to record any unique patient identifiers in the logbook so that if the data falls into the hands of a third party it is meaningless.

The Joint Informatics Committee (JIC) of the RCoA and the AAGBI has debated the need to record unique patient identifiers. They have agreed that it must be possible for a college tutor to verify a trainee’s logbook by identifying individual patients beyond all reasonable doubt. The NHS number and date of birth can identify a patient uniquely, but so can a hospital number and age. The former would allow anyone in the NHS to identify the patient, so is inherently less secure than recording hospital number and age, which would only permit someone with access to that hospital’s computer systems to identify the patient. The JIC has received conflicting professional advice from the Information Commissioner and another regulatory body regarding this problem and, in the absence of any legal precedent, currently recommends that the recording of hospital number and age provides sufficient safeguards while meeting the requirements of college tutors.

Finally, anyone keeping a logbook should consider the need to register as a data controller under the DPA.

ACTS OF PARLIAMENT

There are two Acts of Parliament relevant to the keeping of logbooks, the Freedom of Information (Foil) Act 2000 and the Data Protection Act (DPA) 1998. The essence of the FoI Act is that patients have the right to know what is recorded about them. It is important therefore that records are factual and accurate. The provisions of the DPA can be summarised by its eight principles. In abbreviated form, these are that personal data shall:

✱ be processed fairly
✱ be obtained only for one or more specified and lawful purposes
✱ be adequate, relevant and not excessive
✱ be accurate and, where necessary, kept up to date
✱ not be kept for longer than is necessary
✱ be processed in accordance with the rights of data subjects
✱ have appropriate technical and organisational measures taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data
✱ not be transferred to a country or territory outside the European Economic Area without adequate protection

REFERENCES

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LOGBOOKS – A TRAINEE’S OPINION

GasLog 1.2

iPhone/iPod Touch/iPad

This had emerged recently as a real favourite, even for those technophobes amongst us. Its ease of use and speed of data input, coupled with the instant access of the iPhone, has sold it in the majority of anaesthetist’s pockets for this success. It also appears to keep data relatively safe (providing you don’t lose your iPhone) in that it doesn’t crash and lose all the information. On the downside, it is difficult to back-up data onto a PC hard drive. This can be done though (for details see YouTube video). The reports, whilst including all essential information are visually unattractive. There is little flexibility in the programme to allow for specialist areas or custom data collection. However, it is not cheap, at £17.99 (via iTunes Apps).

GasLog 2.0 will have all the good features of the 1.2 version, plus automatic web-based backup, separate data entry fields for pain and ICU cases and even the facility for collecting ‘outcome’ data. The reports should be a bit slicker too as they are generated from the web side rather than the iPhone side. The downside is the cost, which is listed as ‘£10 per annum (first year free to GasLog 1.2 users), although it will be free to download.

HandiBase

For PDAs, iPhones and other smartphones

This ‘generic’ database can be used on many smartphones.
and portable devices. For the enthusiastic logger it provides the flexibility to custom make a logbook with the desired additional information. The LSRA logbook can short-cut a lot of this customising and provide a tidy HanDBase platform fairly easily (see below). It costs between £5 and £15, and is not as pleasant to use as its competitors, but probably provides the most flexibility.

**WEB-BASED LOGBOOKS**

The London School of Regional Anaesthesia (LSORA) logbook, as one would anticipate, the real attraction of this free logbook is the ability to record the detail and outcomes of regional procedures. It can be integrated with HanDBase for use with portable devices. The reports it produces are pleasant, RCoA compatible, and in addition it will construct CUSUM curves for all the procedures. This would be impressive data to produce this free logbook is the ability to record the detail and portable devices. For the enthusiastic logger it can short-cut a lot of this customising and provide a tidy HanDBase platform fairly easily (see below). It costs between £5 and £15, and is not as pleasant to use as its competitors, but probably provides the most flexibility.

**ANNUAL REVIEW OF COMPETENCY PROGRESSION (ARCP)**

The system of assessment for all trainees is called the Annual Review of Competency Progression (ARCP). The ARCP replaces the old RITA system, but the only thing they have in common is that they are annual, taking place towards the end of each year of training. The ‘rules’ and expectations of the assessment process are detailed in the Gold Guide, as are all aspects of training. The most relevant part is section 7, pages 54-85 where assessment is covered. What follows is a summary of the process:

Most regions conduct their ARCPs slightly differently, and interpretation of the Gold Guide varies between deaneries. Over time, I am sure these discrepancies will be ironed out as trainers become more familiar with the process.

ARCP is fundamentally a documentation exercise to show that the trainee is progressing at the appropriate rate through specialty training. The decision of the panel is made based on the evidence provided by the trainer and educational supervisor. The ARCP is easy, and is composed of three elements: appraisal, assessment and annual planning.

The appraisal should be both an educational appraisal and an assessment of the trainee's progress in his/her specialty. It is a summary of the trainee's portfolio, as well as the 'newer' style assessments such as DOPS, Anaes-CEx, ALMAs and CBIs. In addition, evidence of professional development is assessed, to determine the trainee's progress in areas covered in the ARCP: assessment of knowledge and skills. This has a summary of competencies achieved so far, and if unsatisfactory the trainee will be asked to leave the process.

The trainee prepares and submits their evidence, the Specialty School representative, or similarly experienced consultant, and the ARCP panel for consideration. This has a summary of the trainee's portfolio is considered. These are collated and a summary of all of these assessments is usually provided to the ARCP panel for consideration as evidence. The annual planning should take place after the ARCP assessment outcome is known and will involve the trainee, educational supervisor and programme director. This is to provide the trainee with the most appropriate training for the next year.

The ARCP panel will consist usually of at least three members, usually either the Dean, the STC chair, the specialty school representative, or similarly experienced trainers. The possible outcomes from the ARCP have changed compared to RITAs. They are now a numbered outcome and are detailed below. An important part of the process is that the information leading to the outcomes is assessed by an outside agency for 10% of the trainees. This can, for example, be the lead for ARCP in a neighbouring deanery.

**OUTCOMES FROM ARCP**

**Satisfactory outcome:**

1. Achieving progress and development of competencies at expected rate
2. Specific competencies required, no additional time conceded

This is, thankfully, the most common outcome. **Unsatisfactory outcomes:**

1. Specific competencies required, no additional time conceded
2. Unsatisfactory outcomes: Awarded at the final ARCP
3. FISIA or LAT outcome

This has a summary of competencies achieved so far.

4. Out of programme

Issued when out of programme. These outcomes are very prescriptive in nature and offer little in the way of interpretation. Obviously the vast majority of trainees will achieve outcome number 1. However, there will be some that require additional time and/or support, often for failure to obtain the exam at the appropriate time. The section of the Gold Guide for this states, “if there is an unsatisfactory outcome the deanery requires a specific educational agreement to be drawn up to address the deficit in training. The effectiveness of the additional training is assessed by the ARCP panel and if unsatisfactory the trainee will be asked to leave the programme.”

If a trainee is ‘asked’ to leave the programme he/she has the right to appeal before a panel that usually includes the Dean, a consultant from another specialty (with ARCP experience), specialty representative local and one from outside the region and a trainee representative. They are allowed a friend or company them in the meeting, but not legal representation. The trainee prepares and submits their evidence, the Specialty School representative, or similarly experienced trainer. They can short-cut a lot of this customising and provide a tidy HanDBase platform fairly easily (see below). It costs between £5 and £15, and is not as pleasant to use as its competitors, but probably provides the most flexibility.

**LSRA logbook: as one would anticipate, the real attraction of this free logbook is the ability to record the detail and portable devices. For the enthusiastic logger it can short-cut a lot of this customising and provide a tidy HanDBase platform fairly easily (see below). It costs between £5 and £15, and is not as pleasant to use as its competitors, but probably provides the most flexibility.**
Primary FRCA examination and two sittings of the Final FRCA

In each academic year there are three sittings of the Final FRCA examination, set and supervised by the RCoA to obtain eligibility to the Final FRCA examinations. Please note that any FRCA examination you sit will be valid towards the result. Up to two of the stations may be used to introduce and validate new questions; these questions will not be identified to the candidates, but will count towards the final mark. The stations may cover: resuscitation, technical skills, anatomy (general procedure), history taking, physical examination, communication skills, anaesthetic equipment, monitoring equipment, measuring equipment, anaesthetic hazards and the interpretation of medical images (X-rays). One or more of the stations may involve the use of a medium fidelity simulator.

Primary FRCA

The primary MCQ examination consists of up to 18 stations over an hour and a half. There is no negative marking, the aim should be to answer all the questions. The maximum number of attempts is four.

Preparing for the Primary FRCA

The MCQ is a test of knowledge. Preparation for the MCQ is best started by revising the topics in the syllabus, in a standard textbook such as the A to Z or Fundamentals. Examinations are mapped to the RCoA curriculum, so refer to the appropriate part for your current stage of training. MCQ preparation using practice papers is also important. The RCoA produce Primary and Final FRCA practice papers, with example questions which have been known to appear in the exams. Many other MCQ books and CD-ROMs are also available for revision purposes. Reading recent review articles of topics included in the syllabus from the British Journal of Anaesthesia, the British Journal of Anaesthesia Care or the British Journal of Anaesthesia Critical Care & Pain and Anaesthesia can also be useful.

Time constraints are usually not a problem in this section of the exam, it is generally accepted that one can go through the questions at a rate of about one question per minute. Since there is no negative marking, the aim should be to answer all the questions. Ensure adequate time for the transfer of the answer from the question booklet to the optical answer sheet. Allowance will not be made for mistakes made in the transfer process.

The OSCE is an assessment of clinical competence in the context of peri-operative care, communication and clinical skills. The OSCE stations commonly are topics encountered in our daily practice: explaining risks of spinal anaesthesia, pre-operative assessment of a Jehovah's Witness, interpreting an ECG, anaesthesia machine checks. Practice is essential to pass this section of the exam. Practising a list of potential topics from the previous examinations. Have a prepared plan to tackle common clinical scenarios. Practice interpreting ECG, X-rays, machine checks in your daily practice with senior colleagues. Attending a course nearer the exam is a very useful way to focus your thoughts. This is especially useful for candidates without prior exposure to the OSCE. Remember that during the OSCE assessment the examiners want to see a competent and safe clinician in action.

The OSCE consists of up to 20 questions each with a prepared plan to tackle common clinical scenarios. Practice interpreting ECG, X-rays, machine checks in your daily practice with senior colleagues. Attending a course nearer the exam is a very useful way to focus your thoughts. This is especially useful for candidates without prior exposure to the OSCE. Remember that during the OSCE assessment the examiners want to see a competent and safe clinician in action.

The OSCE examination consists of up to 18 stations over an hour and a half, of which only 16 count towards the result. The maximum number of attempts is four.

The SOE

The SOE is conducted as two sessions of 30 minutes each, although these two sessions count as a single SOE examination. Two examiners mark the questions independently and there is no closed marking. The answer to each question is given a numerical score by each examiner (Fail = 0; Borderline = 1; Pass = 2). The candidate’s overall score is the total marks awarded by all the examiners for all the questions. Maximum score 48; pass mark 37.

If a candidate fails either the SOE or OSCE section then they need only to re-sit that section within two years. The maximum number of attempts is four.
The MCQs. This will give you a clear idea of how to approach questions. It is extremely important to be clear and succinct. You will fail the exam if you do not answer the basics, where as you will not if you cannot remember trivia.

THE FINAL FRCR

The Final FRCR consists of two parts, the written and SOE. The SOE is held only in London. Both the written and SOE are pass or fail examinations. If only the written is passed that will stand and only the failed SOE must be re-taken. A maximum of four attempts are allowed at the written exam. A pass in the Primary FRCR permits eligibility to sit the Final for up to 10 years.

THE WRITTEN EXAMINATION

The Final FRCR written examination consists of two parts and stands alone; it must be passed before moving onto the oral parts of the exam. The exam questions are mapped to the RCoA intermediate level curriculum. These written examinations are held in March and September each year, to allow time to apply for the SOE in June or December accordingly. A pass in the written is valid towards the SOE for two years and six attempts at the Final exam are permitted. Both exams carry equal weight and closed marking is not used (e.g. 1, 1, 2, 2+). There are two subsections to the exam: the MCQ paper and the SAQ paper.

THE MCQ PAPER

The MCQ examination consists of 90 multiple-choice questions in three hours: 60 true/false and 30 single best answer questions.

- 20 T/F questions in clinical anaesthesia
- 5 T/F questions in intensive care medicine
- 5 T/F questions in pain management

There is a maximum of six attempts at the SOE. Candidates who fail the SOEs more than once can request a guidance interview. Two examiners mark each part of the SOE and both examiners mark every question independently. There are 12 questions, two marks are given for a pass, one mark for a borderline performance and 0 marks for a fail, giving a maximum total score of 40 marks with a pass mark of 12.

PREPARATION FOR THE FINAL FRCR

The observations made regarding the MCQs and SOEs for the Primary exam are valid for the Final exam, with the caveat that there is an emphasis on clinical medicine, anaesthetic management of patients with co-morbidities and common problems in intensive care. The clinical SOE in the final exam evaluates your clinical judgment based on your knowledge of what an anaesthetist does in everyday medical practice. The emphasis is on safe and competent clinical care of patients undergoing anaesthesia, hence the quote “don’t change your daily practice for the exam” is valid. The clinical science SOE is a scaled-down version of the Primary SOE, with an emphasis on clinical application of the drugs, equipment and anatomy with relevance to regional anaesthesia, and medical statistics.

“Do not answer what has not been asked, and answer all that has been asked.”

The SAQ is an assessment of your ability to organise thoughts and your time management when dealing with scenarios from everyday clinical practice. With 12 SAQs to endure in three hours, the average time for each question is only 15 minutes. It is worth spending a couple of minutes planning the answer – content and layout (tables, labelled diagrams) to achieve decent answers. This leaves you only 10–12 minutes to write an answer, therefore use short and snappy titles, bullet point content with well-spaced text and paragraphs. All questions have to be attempted to pass the exam. The ideal way to prepare for the SAQ is timed practice of the previous year’s questions. The difficulty of the SAQ section of the exam is best appreciated by attempting four SAQs in an hour and having a senior colleague critically assess the answers. As with the other sections in the exam, a comprehensive knowledge base is vital for smooth sailing. A SAQ course nearer the exam will help focus thoughts further and give plenty of chance for improving exam technique.

REFERENCES AND USEFUL WEBSITES

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LIZ SHEWRY
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