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The James Lind Alliance & setting research priorities

Jury summons: an anaesthetist’s reflection on the legal system

Old, new, borrowed and blue: tranexamic acid

Photograph: Wellcome Library London
ULTRASOUND TRAINING COURSES

2014 COURSE DATES:

Introductory Ultrasound Guided Regional Anaesthesia
27–28 April
2–3 May
28 May
21 June
3–4 July
6-7 July
13–14 July
21–22 July
25–26 July
28–29 July

ULTRASOUND GUIDED REGIONAL ANAESTHESIA
This two-day introductory course is designed to teach those who have little or no experience in the use of ultrasound in their normal practice. The course comprises of didactic lectures on the physics of ultrasound, ultrasound anatomy and regional anaesthesia techniques. The lectures and hands-on sessions will concentrate on the brachial plexus, upper and lower limb blocks.

ULTRASOUND GUIDED VENOUS ACCESS
This one-day course is aimed at physicians and nurses involved in line placement and comprises didactic lectures, ultrasound of the neck, hands-on training with live models, in-vitro training in ultrasound guided puncture and demonstration of ultrasound guided central venous access. The emphasis is on jugular venous access, but femoral, subclavian and arm vein access will also be discussed.

ULTRASOUND GUIDED PÆDIATRIC VENOUS ACCESS
This one-day course is designed to teach delegates the techniques of ultrasound-guided venous access in children. The course is aimed at physicians, nurses and healthcare professionals and comprises didactic lectures, hands-on ultrasound of the neck, in-vitro training in ultrasound guided puncture and demonstration of ultrasound guided central venous access. Areas covered will include jugular femoral, subclavian venous access and arm venous access will also be discussed.

PROGRAMME

Day 1
- Ultrasound appearance of the nerves
- Machine characteristics and set-up
- Imaging and needle-tipping techniques
- Common approaches to the brachial plexus / upper / lower limb
- Workshops – using phantoms / models / cadaveric sections (A)

Day 2
- Consent / training and image storage
- Upper / lower limb techniques
- Abdominal / thoracic techniques
- Cervical spine / gatlin / epidural / pain procedures
- Workshops – using phantoms / models / cadaveric procedures (A)

All courses qualify for CPD Accreditation.
Venue: SonoSite Education Centre, Unit 10, The Village, Bunkersfield, Great Maltings, Luton, Bedfordshire LU2 4XL.
Contact: Louise Smith
Tel: 040 3759 5435
Email: education@sono.com
For the full listing of SonoSite training and educational courses, dates and to register go to: www.sonositeeducation.co.uk

Fees: £375 (two-day courses) includes VAT, lunch, refreshments and course materials, £260 (one-day courses) includes VAT, lunch, refreshments and course materials.

ULTRASOUND GUIDED REGIONAL ANAESTHESIA – BEYOND INTRODUCTORY

These courses are organised by Regional Anaesthesia UK (RA-UK) in conjunction with SonoSite Ltd for training in ultrasound guided regional anaesthetic techniques. Previous experience in regional anaesthesia is essential.

2014 Course Dates
14–15 July
21–22 July
28–29 July

Location
Brighton (A)
Liverpool
Nottingham (A)

Organisers
Dr Susanne Krone
Dr Steve Roberts
Dr Nigel Bedforth

The aim of Anaesthesia News is to inform and entertain; preferably at the same time. How? By providing Association members with news, views, and a forum for discussion and, perhaps, challenge. Members submit many articles (and all the letters) and the most interesting news comes from members. So budding authors, get writing and tell us what you are doing and want to share with others and send it to anaews@aagbi.org. We can’t promise to accept every article and letter we receive, but we’ll do our best. We have appointed an Editorial Assistant (Rona Glog – anaews@aagbi.org) who works alongside Chris Steer, our Publications and Website Officer; between them they run the submission, review and production processes, while the editors decide which articles to accept.

In this month’s issue there are contributions about international work, jury service, and a report from a trainee in a project management post about his work to create a simulation network in the South West. We receive many articles on overseas work, reflecting the importance the Association’s members place on supporting healthcare in the developing world.

As I write, there is an article on the BBC News website that a major trial has been halted due to the difference finding it impossible to find baristers prepared to work at new (reduced) legal aid rates. At a time when the BMA are enduring difficult times as they try to negotiate a new consultant contract, I wonder whether we will read similar stories about the NHS in the future?

There is also an article on a new research priorities setting development run by the Japan Lind Alliance and the NIAA. The Association is a major funder of the NIAA and of this particular project, which is noticeably different in that as well as professionals, it includes carers and patients. This will be your chance to contribute to guiding the funding of research into anaesthesia and perioperative care.

Finally, summertime is bracketed by AAGBI conferences – GAT in June and Annual Congress in September. I’m looking forward to the Annual Congress in Harrogate. As ever, the scientific programme looks great, and there is the added attraction of Betty’s Tea Rooms. Just don’t tell Mrs N what happens to my diet that week! Following the success of this year’s venue. Please watch out for details in an e-newsletter very soon. You can either support the riders by donating or, better still, you can join them. The Association’s conferences continue to grow and grow: WSSM London 2014 had a record attendance. We assume this is because we are providing what delegates want – good scientific content in a convivial atmosphere and at an attractive location? See you there.

Mike Nathanson
Council member

Anaesthesia meets July 2014 • Issue 324

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A full-day’s educational meeting, presenting the Fifth National Audit Project from The Royal College of Anaesthetists and The Association of Anaesthetists of Great Britain and Ireland. The day will present the largest ever study of Accidental Awareness during General Anaesthesia.

Open to all anaesthetists and others with an interest. NAP5 Local Co-ordinators are especially invited to attend.

The presentations will be delivered by the NAP5 Steering Panel: anaesthetists, psychologists and patient representatives.

Organisers: Professor Jaideep J Pandit & Professor Tim M Cook
Fee: £150
CPD Credits anticipated: 5

Topics to be covered will include:
- Overview of findings
- Baseline survey results
- Activity survey results
- Incidence(s) of awareness
- Depth of anaesthesia monitoring
- Patient experiences
- Consequences of awareness
- Awareness during induction, maintenance and emergence
- Awareness and anaesthetic techniques - TIVA, muscle relaxation etc.
- Awareness and sub-specialties - Obstetrics, Cardiac, Airway, ICU, Paediatrics etc.
- Reports of awareness following sedation
- Depth of anaesthesia monitoring and NAP5
- Medico-legal and consent issues
- The Irish experience
- Case presentations
- Question and answer session
- Recommendations
- Future steps

James Lind was an 18th century Scottish naval surgeon who discovered by careful analysis and exclusion of other factors, and against contemporary medical wisdom, the cause of scurvy in sailors. His methodology is reported to have included the first ever clinical trial. He campaigned for better ventilation and improved personal cleanliness on naval vessels and his MD thesis was on venereal disease. He spent part of his career as Chief Physician at the Royal Hospital at Haslar, where his son John succeeded him. The James Lind Alliance (JLA) (www.lindalliance.org) is a not-for-profit organisation created in 2004 and now part of the National Institute for Health Research’s NIHR Evaluation, Trials and Studies Coordinating Centre (NETSCC). The JLA facilitates partnerships of patients, carers and clinicians to develop a list of possible treatment uncertainties, discover which are truly unanswered, and then prioritise into a top 10. There are currently 19 completed partnerships listed on the JLA website and others are in progress. The completed top 10s include stroke, asthma and dementia. While some uncertainties are (perhaps) clear, others, for example ‘What are the benefits of breathing exercises as a form of physical therapy for asthma?’, might not be so obvious to clinicians.

The NIAA undertook a research priority setting exercise in 2009.1 A list, generated by clinicians, of research topics was published and some have gone on to be the subject of research projects. The difference between that exercise and the current JLA-guided project is the addition of carers and patient groups in both the survey and the project steering group. The output (expected in 2015) will be used to guide the awarding of research grants by the funding partners and may be used by other funders when deciding how to prioritise research in our areas of interest. For example, it might be helpful to colleagues who apply for a grant from one of the larger funders such as the Wellcome Trust or the MRC.

As I write this piece, the exact question and survey are being finalised, and by the time this article is published the survey should be live and responses will have been invited. You know what comes next - please take part! This is a great opportunity to raise awareness of your ideas and your own priorities.
The date on which I was required was during the ESRA congress in Glasgow which I had booked in advance. So I asked for a deferral, listed the dates when I could attend and hoped the Bureau would forget all about me. No such luck. A fortnight later I received another letter informing me that because I had deferred once I couldn’t defer again and was now required to attend.

I was relieved to find I did not have to do any on-call swaps and the next two weeks away was going to impact on my training. I was supported by the College Tutor and a deferral, listed the dates when I could attend and hoped the Bureau would forget all about me. No such luck. A fortnight later I received another letter informing me that because I had deferred once I couldn’t defer again and was now required to attend.

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One gift springs to mind which, it can be argued, satisfies all criteria at once: tranexamic acid.

Great Britain and Ireland will receive a discount GBI14 to attend the ANESTHESIOLOGY™ 2014 annual anesthesiology specialty.

Not all weddings will end with happiness forever after. Every day in the UK and worldwide, countless unsuitable weddings are taking place: asphalt with bare skin, cold metal with blood vessels, and glass with taut muscle. What gift would a wise doctor bring to such traumatic marriages, to ensure the best chance of a happy outcome following these ill-fated pairings? Superstition dictates brides wear something old, something new, something borrowed and something blue to avoid misfortune.

One gift springs to mind which, it can be argued, satisfies all criteria at once: tranexamic acid.
Tranexamic acid is a gift steadily becoming more fashionable; often initiated by UK paramedics pre-hospital, subject of the first NICE off-label evidence summary, part of UK military ballistic trauma protocols10 and a WHO ‘essential drug’.11 Before its adoption into many UK trauma protocols, hospital surveys showed it was probably underutilised – auditing current practice may well be useful.12 As with any new drug or off-label use, unanswered questions remain following the first trials. Despite this, there is enough evidence to suggest it can become an important part of trauma management. It’s not a heroic intervention – the benefit will be seen through widespread use rather than saving the most severely injured. It’s not an expensive or ostentatious gift – there certainly isn’t much commercial interest in promoting it. Unlike a expensive and dazzling white gown, tranexamic acid may be the quiet, unassuming wedding present which survives over the years with its usefulness. Hopefully this old, new, borrowed and blue gift will bring luck as the old wives’ tale says, and keep more victims of traumatic bleeding and transfusions in primary coronary bypass operations: a double-blind, randomised, placebo-controlled trial.17

Robert J, Pearson J, Rice E. A practical guide to the prehospital use of tranexamic acid.18

Maitani E, Tsuzuki T, Sakurai M, et al. Antifibrinolytic agents in current anesthetic practice.19


18. Robert J, Pearson J, Rice E. A practical guide to the prehospital use of tranexamic acid.18


Creating a South West simulation network through HIEC

What is HIEC? What are you up to? I forget the number of times these questions were asked over the course of my secondment. The first was easy enough to answer; you just Google the description, but you’re not really left any the wiser with what it actually does. The second is somewhat more difficult and I’m still trying to bring it all into focus.

According to the HIEC website, Health Innovation and Education Clusters are ‘collaborative partnerships between NHS organisations, academia and industry’. There is mention of transforming healthcare, driving up quality, developing the workforce. The mantra of progressive, innovative thinking no doubt, but what does it all mean?

Putting this into context, I’m an anaesthetic registrar with two years training to go. On a normal day I head to work, I am given a list of patients to anaesthetise, patients are provided, a team is present, the surgeon operates, patients are woken up and I go home. By 8.30am I’ve planned my day and follow it as long as the patients and staff behave themselves. Ideal for creatures of habit who enjoy the comfort of routine.

The next year would be very different. The offer of a project management secondment to South West HIEC was unexpected. I had registered interest in management experience over 18 months previously but nothing had materialised. The initial proposition left me somewhat bewildered, with an uncomfortable lack of specificity. I had to propose a project and run with it. I had to be ‘innovative’. A few initiatives were mooted and I was strongly in favour of developing simulation in the region. I had experience with simulation training, understood its limitations and some of its potential. The timing was fortuitous as there had been a large Deanery capital investment in equipment and there were fears of under-utilisation. The Chief Medical Officer’s 2008 report emphasised the importance of building simulation into future workforce training.1 The Framework for Technology Enhanced Learning was in draft and would raise the bar for workforce skills education.2 This was a ‘hot potato’.

Making progress

The next few months were spent touring the simulation centres, the Deaneries and the SHA. I spent time talking to providers, commissioners, managers and learners to understand the level of management interest and the challenges faced and proposals for future delivery of care. Themes emerged and through the use of qualitative research methodology - grounded theory - these ideas were coded and distilled.3 This formed the backbone to a South West simulation strategy.

Simulation provision within the region was entrenched, there were large pockets of expertise, enthusiasm was palpable, and some had been using it for years. The existing Peninsula Simulation Network provided an excellent forum for idea sharing amongst providers and hosted a number of regional simulation programmes. The Bristol Medical Simulation Centre was internationally renowned, providing an array of multidisciplinary educational initiatives. Despite this there was a palpable lack of structure, cohesion and accountability. Many providers lacked financial and technical support to provide sustainable future training programmes.

The main purpose of the strategy was to provide a vision for the future. We wanted to build high quality simulation training, fully integrated into the workforce and to promote safe and excellent clinical care. Effective collaboration across the region was a key element. The Peninsula and Severn Deaneries were brought together, formal and informal meetings were held to discuss joint

ventures in education and research, share best practice, and widen the participation of simulation and faculty development. Raising and maintaining skills of simulation were essential to drive up quality. A formal quality assurance framework was devised with benchmarks for organisational structure, courses, resources and facilities.

We formed a steering group to take the newly coined ‘South West Technology Enhanced Education and Research’ (STEER) strategy forward. This group was fundamental to successful implementation. As a trainee in anaesthetics, I felt I neither had the necessary credibility or indeed wisdom to make this project work alone. The STEER committee comprised providers including doctors, nurses, midwives, the Deaneries and the SHA, LETB (Local Education & Training Board). The purpose was not only to drive forward implementation of the STEER strategy but also to provide a vital link between providers and commissioners.

Depending on your view, the timing of this project was either fortunate or poor. Poor, in terms of the pending demise of the SHA meant that financial commitment was absent. Fortunately, in that the evolution of the LETB provided an opportunity to reframe the relationship between commissioners and trusts or educational providers. We took the opportunity to influence the content of the Learning and Development Agreements with trusts to raise the profile of simulation in the region.

In terms of lessons learned there are many, but a few key ones are:

1. Develop clear and achievable outcomes from the outset, even if you don’t know how to get there. Though these may evolve with time, those who have a clear vision will be more effective.
2. Undertake early project management training (e.g. Prince2). These tools would have been invaluable at the start. I could have saved myself a lot of time and angst.
3. Early commitment planning is vital. Find out who the movers and the shakers are early on and get them on board.
4. Building the need is essential. If people can’t understand what you want to achieve and why it’s important they won’t support it.
5. Understanding people, insight and reflection is important. If you want people to change their practice and their behaviour, understand why they don’t want to and why they think their way of doing things is better than yours.

The South West simulation strategy can be found at http://workforce.southwest.nhs.uk/simulation/

Conclusion

While the natural life of HIEC is coming to an end, it has spawned a number of initiatives of which STEER is one. The new Academic Health Science Networks must be embraced and help to ensure that these initiatives are sustained for the future.

References


"It's still trying to bring it all into focus."

"I'm still trying to bring it all into focus."

Figure 1 The interdependence of individual and team training is integral to providing a high quality service.

The South West simulation strategy can be found at http://workforce.southwest.nhs.uk/simulation/

Alex Mills
Specialist Registrar, Derndafy Hospital, Plymouth

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A novel approach to exam preparation

E-learning and improved technology such as video calling from smartphones and tablets presents another option for examination practice. Video calling using such applications as Skype and FaceTime provide ideal mediums for this. Outlined below is one method that has been employed to prepare a candidate for the examination, which may encourage a more widespread use of the technique.

Pros

SOE practice via the internet may sound like an easier option than remaining behind after a long day at work and, providing you own the required technology, is cheaper than attending a course. However, this method requires as much dedication as the traditional route. Ground rules must be in place to ensure maximum benefit and minimise non-work chat! If done effectively the online viva sessions can be productive for both involved.

Set-up and format

Both parties require access to an internet connection and video calling technology. Transmitted images must include the candidate’s upper body to allow assessment of both verbal and non-verbal communication. For example, fidgeting hands are as much a distraction during online practice as they are in real life.

The technique requires an agreed format. An example would be breaking the session into sections, separating the clinical and science aspects of the exam. There are a few huddles compared to a face-to-face technique. For the clinical part of the exam, information (including clinical material) needs to be emailed to the candidate at the start of the session and 10 minutes allocated for its assimilation. After this assimilation time, questioning can begin in the same format as in the exam (20 minutes of clinical material questions followed by 20 minutes of clinical anaesthesia questions unrelated to the material provided). The examiner must be prepared. Questions are pre-printed with the answers included. This enables marking whilst the candidate speaks, maintenance of eye contact during questioning and evaluation of non-verbal communication.

The clinical science portion is divided into two sections of 15 minutes. Each section covers two questions on the application of basic science to anaesthesia, intensive care medicine and pain management. Again pre-printed question sheets containing the answer points are invaluable here.

A feedback debriefing session is taken at the end of each component rather than ploughing on through all questions, as ability to retain suggestions and tips diminishes if delivered in one large chunk at the end of the session.

Limitations

One limitation is the reliability of internet connectivity but the advent of more capable broadband will alleviate this.

Candidates may wish to draw diagrams to illustrate a point and time can be lost holding these up to the camera. This can be overcome by using diagrams annotated with letters, which are part of the prior information emailed to the candidate. This then allows demonstration of understanding by identification of parts of the diagram, without the time-consuming process of drawing and then attempting to show to the examiner.

This technique will not suit everyone, but it presents another option for preparation and is preferable to no practice at all. It can be adapted to fit the formats of other postgraduate bodies, both within the UK and beyond, and may ultimately lead to a faculty of virtual world remote examiners assisting in exam preparation.

Rex Kinnear-Mellor
ST5 Anaesthesia, Nottingham City Hospital

The Fellowship of The Royal College of Anaesthetists
Final examination has a structured oral examination (SOE) component. Success at this examination requires extensive practice of oral examination technique. Traditionally the preparation for this is done face to face within the hospital or at a specifically designed course.

8 CPD points from the Royal College of Anaesthetists applied for
Putting this in perspective, the UK has roughly one doctor for every 1000 people. This is one of the problems faced by the northern Ghana health service and is often work completely on their own in isolated areas with few resources in terms of drugs and equipment. Further training is frequent, and, to attend, they usually have to travel 600 km south to the capital Accra, where they will be taught in a lecture theatre with over 400 other students. The SAFE course aims to provide up-to-date learning in small groups with a more hands-on approach.

Currenty there is only one anaesthetic doctor in this region, Dr Thomas Anabah (who joined us teaching on the courses), with anaesthetics in the regional hospitals being delivered by nurse anaesthetists. After their initial training these nurse anaesthetists often work completely on their own in isolated areas with few resources in terms of drugs and equipment. Further training is frequent, and, to attend, they usually have to travel 600 km south to the capital Accra, where they will be taught in a lecture theatre with over 400 other students. The SAFE course aims to provide up-to-date learning in small groups with a more hands-on approach.

On the first course, 23 nurse anaesthetists from the upper east, upper west and northern regions of Ghana attended, some of whom had travelled incredibly long distances to attend the course, and a further 16 attended in September. The reason for the lower number on the second course was due to transport logistics across water-logged terrain during the rainy season, which some of the difficulties local staff have to contend with on a regular basis.

The courses were taught in the local complex of the nursing council. The first evening was spent registering candidates, handing out copies of Obstetric Anaesthesia for Developing Countries, which all candidates received, and completing pre-course MCQs. A sub-group undertook a skill station assessment which was repeated at the end of the course. Once this had been completed and the candidates left we continued to set up our teaching rooms ready for the next day.

On the next three days we delivered a series of lectures, small group teaching sessions and discussion groups, and ran scenarios with manikins. This was a new style of teaching for many of the students but, once the course started, each candidate was immersed in the programme and tuned up to each teaching session with impressive enthusiasm, although keeping to schedule with candidates more used to running on ‘Ghanaian time’ was challenging! Teaching was complemented by several videos prepared by AAGBI members, including Dr OllieRoss from Southampton who joined the second faculty teaching in September. These videos demonstrated how to perform spinal anaesthesia, rapid sequence inductions and how to approach common complications such as a high spinal. On the final day we ran an essay competition with the title ‘What inspired you to be a nurse anaesthetist?’ Many of the stories were deeply moving and showed how tough it is to work in such poorly resourced and demanding environments.

The course faculty set out from Southampton carrying an assortment of adult and neonatal manikins, kindly loaned by Southampton Hospital’s resuscitation department, and a collection of teaching aids ranging from laryngoscopes to bougies and IV fluid bags. After arriving in Accra for a brief overnight stop we flew north to Tamale, a city in the northern region with a rapidly expanding population of over 500,000.

The course was very enjoyable and rewarding to teach on and we have rarely seen such eager, enthusiastic and grateful students. Days were often long, with early starts preparing teaching rooms and learning how to cope with challenges such as frequent power cuts leaving us bereft of projection facilities, lighting and much-needed air conditioning. Each evening ended with a faculty meeting (supplemented by an ice cold beer). We were well looked after by the local team and well fed with Ghanaian dishes.

The SAFE Obstetric Course has been designed by the AAGBI and it is hoped it will be delivered by UK healthcare volunteers throughout sub-Saharan Africa and south Asia; prior to our work in Ghana it has already been run in Liberia and Uganda. It comprises a generic guide to the teaching methods used and comes ready made with lectures, workshops, discussion groups and teaching sessions for the teaching faculty to run. This follows a similar framework to the Resuscitation Council life support courses which medical staff from the UK will be familiar with. The course covers basic and advanced airway techniques, general and spinal anaesthesia, how to approach setting up an HDU, and management of specific conditions such as pre-eclampsia, haemorrhage and sepsis.

The country, the reality differs when these newly qualified doctors find reasons to stay in the more prosperous southern areas. The long-term aspiration is to set up a self-sustaining healthcare training programme which will both improve the health of the local population and act as a strong incentive to those Ghanaian doctors who may have originally come from these regions, but previously have not seen the long-term attraction of staying there.

Currently there is only one anaesthetic doctor in this region, Dr Thomas Anabah (who joined us teaching on the courses), with anaesthetics in the regional hospitals being delivered by nurse anaesthetists. After their initial training these nurse anaesthetists often work completely on their own in isolated areas with few resources in terms of drugs and equipment. Further training is frequent, and, to attend, they usually have to travel 600 km south to the capital Accra, where they will be taught in a lecture theatre with over 400 other students. The SAFE course aims to provide up-to-date learning in small groups with a more hands-on approach.

Benefits of teaching on SAFE

We would highly recommend teaching on the SAFE course to other trainees. It is a very different experience to teaching in the UK and you feel like you are really teaching skills and knowledge which will be put to use to save lives and improve care. It’s a great way to get overseas experience with just a week away from the UK and add something a bit different to your CV. We all learnt how to be much more flexible and prepare for any eventuality while running the course and all of the faculty found their teaching skills were the best they had seen. We also learnt how tough it is to work in such poorly resourced and demanding environments.

To finish, each candidate repeated the MCQs and a post-course skill station assessment. Almost without exception scores rose significantly. It is hoped that we will be able to evaluate retention of knowledge and skills during subsequent trips to the area. At the end of the course, a few candidates who were felt to have shown the greatest enthusiasm and potential to go back to their respective hospitals and pass on the skills they had learned were offered the opportunity to stay and attend a ‘Training the Trainers’ course following on from SAFE. Here candidates were taught how to prepare and deliver a lecture, demonstrate and teach a skill and run a scenario using a manikin.

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tested as we learnt to adapt and overcome the various problems associated with running a course in a new environment. And never underestimate the value of a bag of sweets in ensuring your candidates turn up to your teaching session on time!

We were very fortunate and grateful to benefit from funding from the AAGBI, the Tropical Health and Education Trust and the G.A.S. Partnership, which kept costs relatively low. We are also indebted to Dr Alison Carling from Newport who joined us and prepared us well for our first course having previously taught SAFE in Uganda and Liberia. It is hoped that staff from Southampton will return to Ghana to deliver the SAFE course again and improve training for more nurse anaesthetists in the region.

Dr Paul Stevens
Dr Laura Tarry
Dr Malvena Stuart-Taylor
Consultant Anaesthetist, Queen Elizabeth Hospital, Kings Lynn
Specialist Registrars, University Hospital Southampton
Consultant Anaesthetist, University Hospital Southampton

References
5. W: WWW.PRE-OP.ORG  /  T: 020 7631 8896

2015 AAGBI Innovation in Anaesthesia, Critical Care, and Pain Award

It is with great excitement and anticipation that we launch our fourth annual AAGBI Innovation in Anaesthesia, Critical Care and Pain Award to support and reward receiving new entries in this ever more popular competition.

The previous winners were: a new, safe intravenous fluids drip chamber; a universal, portable ECG monitor and an infusion pump test for performance of ultrasound guided regional anaesthesia. All these winning entries will potentially enhance patient safety.

Throughout our medical careers we are all inventors and innovators to some degree, sometimes we do not even notice it. The old cliché, ‘necessity is the mother of invention’, still stands and you can try to apply it in your everyday hospital setting. It is often something that repeatedly does not function or perform as it should, as far as equipment or techniques are concerned and you may find new, better solutions. The same applies to our everyday IT issues. The road to success with a new idea is not easy: as part of the AAGBI Innovation Initiative we hope to be able to offer useful advice to help new innovators, for instance through sessions at the main conferences and future seminars at the AAGBI annual meeting.

Apart from well established, already on the market products, well described techniques and well known if solutions, we welcome new innovations at various stages of development where winning the award can financially and otherwise enhance progress of the project. Please make sure that you have the necessary intellectual property protection, if applicable, before you enter the competition.

So please fill in your award application form today! We are looking forward to receiving your entry!

For more information visit www.aagbi.org/research/innovation

Dr J Bernard Liban
AAGBI Innovation Lead

SAFIRA – Safe Injection System for Regional Anaesthesia

SAFIRA is a new device for regional anaesthesia, invented by Emad Fawzy, Dr Peter Young and Dr John Gibson (Consultant Anaesthetists, Queen Elizabeth Hospital, Kings Lynn) and Dr Joseph Carter (Consultant Anaesthetist, York Teaching Hospital, York).

SAFIRA is a new device allowing anaesthetists to safely perform nerve blockade single-handed. It is a safe single use regional anaesthetic injection system controlled by buttons attached to the hub of the regional anaesthetic needle. SAFIRA enables precise speed, time, pressure and volume control of the injectate and is designed to minimise the risk of intraneural injection and nerve injury, and allows you to record the whole anaesthetic injection procedure.

Due to confidentiality, only basic features can be disclosed; however there are five intellectual property applications so far.

SAFIRA has been developed as a NHS innovation device and is managed by Health Enterprise East (NHS innovation agency) and was awarded the NHS Innovation Award for Best Medical Technology 2013 by Health Enterprise East, and also the AAGBI Innovation Award 2014 at WSM London 2014.

Winning the AAGBI award was invaluable for the SAFIRA project as it added huge value and credit to SAFIRA. After winning such a prestigious award we received huge interest from different groups of investors and major companies in the field of regional anaesthesia. The AAGBI award represents the recognition of the potential of SAFIRA from a panel of world experts acknowledged as one of the most prestigious organisations in the field of anaesthesia and this was fully appreciated by the various investment groups who approached us.

Winning this award has raised awareness among anaesthetists about the existence of inventions and promoting the culture of innovation. Following on from WSM 2014, I received many calls from anaesthetists across the UK who had bright ideas but required guidance on how to take their ideas forward. After winning the AAGBI Innovation Award, we received an offer from an investment group to fund the SAFIRA project over the next two years and build prototypes up to the required standards. We have built three prototypes so far, and are currently planning to build a prototype up to the standard of FDA and CE marking. We expect to have this prototype ready by the end of this year, when we will start our first animal and cadaveric studies.

We aim to start out first patient study in early 2015 and, by the end of 2015, SAFIRA should be ready to be marketed.

Dr Emad Fawzy
Consultant Anaesthetists, Queen Elizabeth Hospital, Kings Lynn

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Less Than Full Time training demystified


to Z Guide to LTFT training.

Less Than Full Time (LTFT) training: even the title feels something of a mouthful. However, it’s nothing compared with actually navigating the complexity of training LFT. The way it’s administered varies between regions; there are multiple different models; no two trainees work the same pattern of days; and the scope for wrangles over pay, days off, on-call cover, and indeed almost any other aspect of working life seems endless.

There is no doubt that LTFT training, badly managed, can cause headaches for all concerned. However, like any employee, the NHS has a clear interest in retaining employees. Furthermore, the NHS has an obligation to taxpayers, whose taxes fund medical school and postgraduate training, to get value for money from its investment in medical training. Offering flexible employment allows several trainees, who might be unable or unwilling to work full-time, to continue their training and subsequent careers. This is clearly preferable to losing a proportion of trainees who might otherwise provide decades of experience to the profession.

The key to making LTFT work, for employees and employer, is communication, understanding and flexibility. The overall goal is to avoid workforce shortages or labour investigations, where trainees have to provide evidence of the complexity of training LFT. For the trainee, to allow them to fulfil commitments during the ‘ST’ year. However they’ll be a whole lot less tidy if you discover belatedly that you haven’t got the requisite documentary evidence to get sign off for the competencies or completed stages of training that you were expecting to work and which days they can’t. It’s also important for College Tutors to ensure that LTFT trainees are actually working the correct number of hours for the proportion of whole-time equivalent they’ve had approved. This may need some planning if your department hasn’t had LTFT trainees before (or if you’ve got more LTFT trainees than usual, or two trainees wanting the same day off, etc.)

Tip for trainers

You should also contact the relevant people (the anaesthetics secretaries, the rota writers, the College Tutor) in advance at the hospital where you’ll be working to let them know your specific LTFT requirements and make sure they can accommodate them. You don’t want to be called to a roster meeting before you start that they can’t let you have every Friday off for childcare, and you won’t win friends by presuming that your specific LTFT needs are common knowledge.

In addition to local support, the AAGBI, the RCoA and the British Medical Association have LTFT resources available online and the RCoA has a Bernard Johnson Advisor with responsibility for LTFT training who can be contacted for advice. The GAT Handbook 2013-14 has chapters on ‘LTFT Training’. ‘Returning to Practice’ and ‘The Pregnant Anaesthetist’, while the GAT (and RCoA) websites host an A to Z Guide to LTFT Training in Anaesthesia. These explain more about the practicalities and logistics of training part-time such as eligibility criteria, pay and banding and working patterns and include a comprehensive list of useful references.

Finally, once you’ve started LTFT, be vigilant about keeping on top of workplace-based assessments (WPBAs), the requirements of the curriculum and what you need to get signed off. Annual review of competency progressions are generally untidy because you can take one step forward (rather than at the end of a specific ‘ST’ year). However they’ll be a whole lot less tidy if you discover belatedly that you haven’t got the requisite documentary evidence to get sign off for the competencies or completed stages of training that you were expecting.

Tips for trainees

If this appears more like a scrutiny of the things that can go wrong with LTFT training than a celebration of the opportunities and advantages it can bring, we sincerely apologise and let us reiterate that, in the vast majority of cases, it works to the mutual benefit of all. To find out more on how to make the most of LTFT join us at the Making Part-Time Work Symposium. As well as sessions on the practicalities of training part-time there will be a series of workshops, tailored to both trainees and trainers, exploring the opportunities LTFT presents and what to do when things aren’t going quite as expected. The General Medical Council has recommended that doctors seek out a trained mentor at times of change and one of the workshops will focus on the role of mentoring in helping you make the most of the opportunities, and negotiate the dilemmas, that part-time training presents.

You can find the meeting programme and registration details at http://www.rcoa.ac.uk/education-and-events/making-part-time-work-2014-%E2%80%93-the-2nd-national-ltft-day. We look forward to seeing you there.

Dr Oliver Boney
ST7, London Deanery

Dr Sarah Gibb
SpEq, North Deanery

References

Confirmed Faculty includes:
Dr Jean-Pierre van Besouw, London
Lt Col Michael Butler, Truro
Prof Martin Cowie, London
Dr Tomas Drabek, Pittsburgh
Dr Michel van Dyck, Brussels
Prof Gebrine El Khoury, Brussels
Dr Conn Russell, Belfast
Prof Justiaan Swanevelder, Cape Town

For all enquiries please contact Jane Heppenstall on 0114 2455423 or email actasheffield2014@gmail.com

Early bird registration closes 10th October 2014

The July edition of Anaesthesia includes a number of articles regarding the airway. Two of these specifically explore insertion techniques of airway devices. Anaesthesia is often described as a ‘craft’ specialty. Occasionally the choice of anaesthetic technique is based on personal experience, an ‘it is safe in my hands’ approach. These two articles help us understand the evidence base that can be used to influence the choices made in performing specific tasks, whilst acknowledging a study only gives us part of the answer to this difficult question.

A prospective randomised comparison of two insertion methods for i-gel™ placement in anaesthetised paralysed patients: standard vs rotational technique

Kim HC, Yoo DH, Kim HJ, Jeon YT, Hwang JW, Park HP

To rotate or not to rotate, that is the question? The i-gel is a commonly used supraglottic airway device. Unfortunately multiple insertion attempts can lead to airway trauma and the incidence of failure with insertion on first attempt is reported as anywhere between 7% and 22%. This failure is mostly a consequence of impaction at the back of the mouth by tongue folding. Previous work from this group showed a higher success rate for first insertion with ProSeal™ laryngeal mask airways when using a rotational technique. Here the authors evaluate the efficacy of this technique for i-gel insertion.

One hundred and eighty-one paralysed patients were randomly allocated to receive i-gel insertion by either the standard or rotational technique following induction of general anaesthesia. The rotational technique showed a higher success rate and shorter time of insertion on first attempt. In addition it was associated with a better airway seal and less airway trauma to the patient. In this regard the evidence suggests the rotation technique for i-gel placement may improve specific insertion outcomes.

A randomised comparison of free-handed vs air-Q™ assisted fibreoptic-guided tracheal intubation in children <2 years of age

Sohn LE, Jagannathan N, Sequera-Ramos I, Sawaiedar A, Schaldenbrand K, De Oliveira GS

The second paper on airway insertion techniques investigates whether using a specific supraglottic airway device, the Air-Q, as a conduit shortens the time to fibreoptic-guided tracheal intubation compared with the traditional free-hand fibreoptic technique in both experienced and inexperienced operators. Whilst fibreoptic-guided tracheal intubation is an important skill, some practising anaesthetists report limited experience and it is likely that this proportion is increased in those inexperienced with fibreoptic-guided tracheal intubation. Therefore any method to improve success, especially in the inexperienced, seems useful to evaluate.

This prospective randomised study looked at 80 healthy children with normal airways, aged between 1 month and 24 months, undergoing elective surgery that required tracheal intubation. They were randomised into four groups depending on operator experience and whether a free-handed or Air-Q assisted fibreoptic-guided tracheal intubation occurred. No differences were observed between groups for time to tracheal intubation, number of attempts, manoeuvres required for tracheal tube passage or complication rates. The Air-Q group did require fewer manoeuvres to obtain an adequate laryngeal view. Fibreoptic-guided tracheal intubation times were similar with or without the Air-Q, irrespective of the operator’s experience. Therefore, based on this study, should everyone use a free-hand approach? The authors suggest that, in deciding on insertion technique, there may be possible advantages with the Air-Q that were not evaluated, such as help with scope positioning, relieving upper airway obstruction and allowing continuous oxygenation during fibreoptic-guided tracheal intubation. In this regard the evidence of no difference is useful; however, when considering individual patients, certain circumstances exist where it seems likely the Air-Q would appear to be helpful.

Helen Laycock
Editor, Anaesthesia

NB. the articles referred to can be found either in a print issue or on Early View (ePub ahead of print)
Learn@AAGBI
Providing lifelong learning in anaesthesia

The AAGBI online learning zone offers a wealth of educational, learning and CPD resources for its members. Use this new facility to reflect on lectures at AAGBI conferences and seminars.

Step-by-step guide on how to reflect using the site:

Step 1. Go to www.aagbi.org/education
Step 2. Click on the ‘Learn@AAGBI’ box
Step 3. Log in note: you will need your AAGBI membership number and password
Step 4. Click on ‘My CPD Area’
Step 5. Click on ‘Register a reflective activity’ at the top of the page
Step 6. Complete the reflective feedback form. All boxes must be completed
Step 7. If you are happy with what you have written, click on ‘Submit form’; or if you would like to add more later on, click ‘Save Draft’. This will appear in your My CPD Area as either draft or a completed ‘Submitted Reflective Note’.

The template is easy to use allowing you to reflect on the conference as a whole or on individual lectures.

Go to www.aagbi.org/education and use Learn@AAGBI for your reflection and learning at our meetings and seminars.
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Or email: RACourse@sowra.org.uk

The Evelyn Baker award was instigated by Dr Margaret Branthwaite in 1998, dedicated to the memory of one of her former patients at the Royal Brompton Hospital. The award is made for outstanding clinical competence, recognising the ‘unsung heroes’ of clinical anaesthesia and related practice. The defining characteristics of clinical competence are deemed to be technical proficiency, consistently reliable clinical judgement, and wisdom and skill in communicating with patients, their relatives and colleagues. The ability to train and enthuse trainee colleagues is seen as an integral part of communication skill, extending beyond formal teaching of academic presentation. Nominees should normally still be in clinical practice.

Dr John Cole (Sheffield) was the first winner of the Evelyn Baker medal in 1998, followed by Dr Meena Choksi (Pontyporrid) in 1999, Dr Neil Schofield (Oxford) in 2000, Dr Brian Steer (Eastbourne) in 2001, Dr Mark Crosse (Southampton) in 2002, Dr Paul Monks (London) in 2003, Dr Margo Lewis (Birmingham) in 2004, Dr Douglas Turner (Leicester) in 2005, Dr Martin Coates (Plymouth) in 2006, Dr Gareth Charlton (Southampton) in 2007, Dr Neville Robinson (London) in 2008, Dr Fred Roberts (Exeter) in 2009, Dr Sudheer Medakkar (Torquay) in 2010, Dr Keith Clayton (Coventry) in 2011, Dr John Windsor (London) in 2012, and Drs Amanda Blackburn (Rotherham), Michael Donaldson (Hull), Andrew Kliner (Newcastle) and Chris Vallis (Newcastle) in 2013.

Nominations are now invited for the award, which will be presented at WSM London in January 2015. Members of the AAGBI can nominate any practising anaesthetist who is also a member of the Association. Examples of successful previous nominations are available on request. Nominations should include an indication that the nominee has broad support within their department.

The nomination, accompanied by a citation of up to 1000 words, should be sent to the Honorary Secretary at HonSecretary@aagbi.org by 17:00 on Monday 22 September 2014.
Particles

Myocardial injury after noncardiac surgery: a large, international, prospective cohort study establishing diagnostic criteria, characteristics, predictors, and 30-day outcomes

Anesthesiology 2014; 120: 564-578

Background
Myocardial ischemia is a frequent cause of death within 30 days of non-cardiac surgery.1,2 Minor postoperative increases in serum troponin levels have, in the past, been dismissed as less relevant cases of supply/demand mismatch. Emerging evidence3 suggests many patients sustain myocardial injury in the perioperative period, which does not satisfy the diagnostic criteria for myocardial infarction.4 This shows that a new diagnosis of myocardial injury after non-cardiac surgery (MINS) may be useful to clinicians. MINS was defined in this paper as clinically relevant myocardial injury due to ischaemia (that may or may not result in necrosis), which occurs during or within 30 days after non-cardiac surgery.

Methods
Investigations prospectively looked at a cohort of 10 805 patients aged 45 or older who underwent elective (inpatient and emergency) non-cardiac surgery (under GA and/or RA) and had troponin T measured during the first 6 postoperative days. Patients with a history of severe acute myocardial infarction, previous open thoracic surgery, or a cut-off value for TnT of 0.01 were excluded. The authors used regression analysis to validate the cut-off value for TnT of 0.01.

Results
The difference in gastric emptying times as assessed using ultrasound was not significant either. The geometric mean T1/2 after drinking tea with and without milk was 15.1 minutes and 22.7 minutes respectively. In all, 60 minutes, measurements show the stomach had returned to a pre-drink size.

Discussion
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Conclusion
The trial revealed that a moderate volume of milk or tea does not delay gastric emptying. Its limitations are that it is a small study and involves only healthy volunteers. Further studies are required to investigate this in surgical patients. The results of this study suggest that current fasting guidelines could be modified to allow the addition of milk to tea and coffee. This would improve cancellation rates and increase patient comfort.

Dr N Patel and Dr K Shelley
Gloucestershire Hospitals NHS Foundation Trust

References

Hillard S, Cooman S, Ramasundaram R, Sweet PT, O’Sullivan G

Does adding milk to tea delay gastric emptying?

British Journal of Anaesthesia 2014; 112: 65-71

Background
To minimise the risk of aspiration of gastric contents during anaesthesia, patients are fasted prior to surgery. Standard guidelines suggest clear liquids are permitted until 2 hours pre-operatively but that milk should be regarded as similar to solids, delaying a 6-hour interval.1 However there is very little evidence to support this. This study attempts to establish whether the addition of a modest volume of milk to tea results in delayed gastric emptying.

Methods
Ten healthy volunteers were enrolled into this randomised controlled crossover trial. Participants with a predisposition to delayed gastric emptying such as diabetes were excluded. Gastric emptying was determined by the para-amino absorption technique and by serial real-time ultrasound measurements of the gastric antral cross-sectional area.

Results
Mean plasma para-amino concentrations plotted against time showed little difference in gastric emptying regardless of whether milk was added. In fact the study showed the mean difference in time to reach peak para-amino concentration (tmax) was +8 min (95% confidence interval -23.1 to 7) in favour of tea with milk.

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Discussion
The study found that a high proportion of ICU admissions were associated with iatrogenic events.2-5 These studies in the UK have found high levels of sub-optimal care prior to admission using a modified Global Trigger Tool. The cause of the admission was categorised as an ‘iatrogenic event’ (medical event or iatrogenic event). Iatrogenic events included potentially harmful acts of commission or omission as confirmed by the investigations answering ‘no’ to the question ‘would this standard of care be acceptable for a relative’. Cases were then reviewed by four consultants and recorded as iatrogenic if consensus was reached. Further meetings were held to review the case with specialist input (e.g. radiology) as required. If there was still no consensus the case was discarded. Events were graded by severity of harm caused between A (no harm to E (contributed to patients death).

Results
The notes of 280 patients were reviewed. In 68/28 patients, 149 potential iatrogenic events were identified. On review it was agreed that 76/280 patients had experienced 104 (27%) events. Eighty-three events either directly caused (28) or contributed (50) to the ICU admission. 27 events were possibly iatrogenic, 24 caused or contributed to prolonged ICU stay and none caused or contributed to permanent harm or death.

Discussion
The study found that a high proportion of ICU admissions were associated with iatrogenic events. These events were then compared with the current literature (1–20%). These results were deemed largely preventative (77%). The nature of the events included delays seeking advice, inadequate resuscitation and mismanagement of the early warning score. The authors suggest a new approach may be required to critically appraise identification, such as continuous telemetry to detect the onset of severe shock and risk of acute deterioration. Further studies are required to identify and prevent adverse events in all patients, including those not admitted to ICU.

Dr Emile Hodzic
CTU Weston General Hospital

References

Garry DA, McKeech SN, Calif et al.

A prospective multi-centre observational study of adverse iatrogenic events and substantial care preceding intensive care unit admission (PREVENT)

Anaesthesia 2014; 69: 137-142

Introduction
Iatrogenic events are those adverse clinical events caused by medical professionals and not related to underlying pathology. They are one of the factors contributing to intensive care unit (ICU) admissions and can cause severe harm to the patient. Importantly, they are potentially avoidable. Previous studies in the UK have found high levels of sub-optimal care prior to admission to ICU.7-8 International studies within the last 20 years have had varied results, showing that between 1 and 20% of ICU admissions were associated with iatrogenic events.2-5 This study aimed to assess the incidence of iatrogenic events associated with ICU admission in five hospitals in the UK.

Methods
All unscheduled adult admissions to ICU in a six-week period in 2011 were included. The notes were reviewed for the seven days prior to admission using a modified Global Trigger Tool. The cause of the admission was categorised as an ‘iatrogenic event’ (medical event or iatrogenic event). Iatrogenic events included potentially harmful acts of commission or omission as confirmed by the investigations answering ‘no’ to the question ‘would this standard of care be acceptable for a relative’. Cases were then reviewed by four consultants and recorded as iatrogenic if consensus was reached. Further meetings were held to review the case with specialist input (e.g. radiology) as required. If there was still there was no consensus the case was discarded. Events were graded by severity of harm caused between A (no harm to E (contributed to patients death).

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References
New AAGBI Member Benefit
Discounted rates and a special introductory offer

The AAGBI has partnered with Heartweb to offer AAGBI members a discount on distance learning online echocardiography and clinical ultrasound courses. For more information on the course, please visit www.aagbi.org/ultrascan.

19th ANNUAL SCIENTIFIC MEETING
Friday 7th November 2014
Nottingham Conference Centre

10 years of conflict: Lessons learnt in pain management
Dr Dominic Aldington

Surgery & Anaesthesia talked
Professor Chris Moran

Damage limitation & timing of orthopaedic surgery
Dr Nick Reynolds

Anaesthesia for the bigger bone
Dr Nick Reynolds

Orthopaedics Enhanced Recovery: What's new & what works?
Dr David McDonald

Orthopaedics Enhanced Recovery: Fine tuning the process
Dr Tom Wainwright

Comprehensive Geriatric Assessment in Orthopaedics: Panacea or Pandora’s Box
Dr Adam Gordon

Hip Fracture Anaesthesia: Art or Science
Dr Iain Moppett

(31st) Abstract Closing date Wednesday 17th September

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Approved by the Royal College of Anaesthetists for 5 CPA credits

The Association of Anaesthetists of Great Britain & Ireland & Anaesthesia will be awarding new research grants in September 2014.

Priority will be given to proposals that support the Associations' research aims:

• Patient safety
• Innovation
• Clinical outcomes
• Education and training
• Related professional issues (e.g. standards and guidelines, working conditions, medico-legal issues)
• The environment

Applications must describe how the proposed project meets the above aims. Suitable projects may be large research studies, small clinical/benchtop projects, ideas (innovation) development, observational studies/data collection, quality improvements or clinical audits (although the latter are unlikely to receive AAGBI funding if they are small, 'routine' local audits).

Any amount of funding may be sought, but applications will be judged on 'value-for-money' as well as scientific credibility. Awards will be made via the NIAA and, if appropriate, will be eligible for NIHR portfolio status.

The deadline for applications is 5pm Friday 08 August 2014

For further information and to apply please visit the NIAA website http://www.niaa.org.uk

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