The Cappuccini Test - a QIP on Supervision

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Introduction:

The guidelines for the provision of anaesthetic services (GPAS) recommend consultant supervision for all non-consultant anaesthetists working solo, with exceptions for locally approved SAS doctors[1].

These guidelines were set out after a patient who returned to theatre three hours after an emergency caesarean section having lost two litres of blood, died as a result of under-resuscitation. The supervision levels provided were deemed inappropriate on this occasion. The coroner's verdict in this case was as follows: "The supervision arrangements in respect of *[the anaesthetist]* were undefined and inadequate and no-one was aware who was supervising him and their availability."

This project aimed to assess adherence to supervision guidelines as set out by RCoA, over a 14-day period covering all elective work involving doctors working under remote supervision. Additionally, we aimed to identify areas for improvement, and implement change.

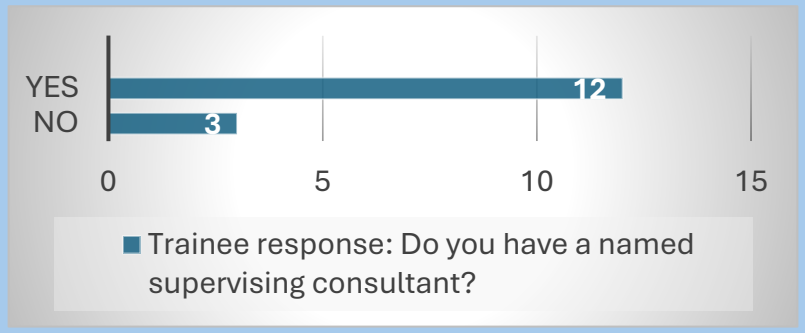
Methods:

Data was collected from 15 elective theatre lists. Questionnaires were distributed to non-consultant anaesthetists and their supervising consultants. Trainees were asked whether they had a named supervising consultant; if help was available when needed and suggestions for improvement were incorporated. Supervisors were asked whether they were aware of who they were supervising; if communication was appropriate and if they were holding a bleep which they could be contacted on.

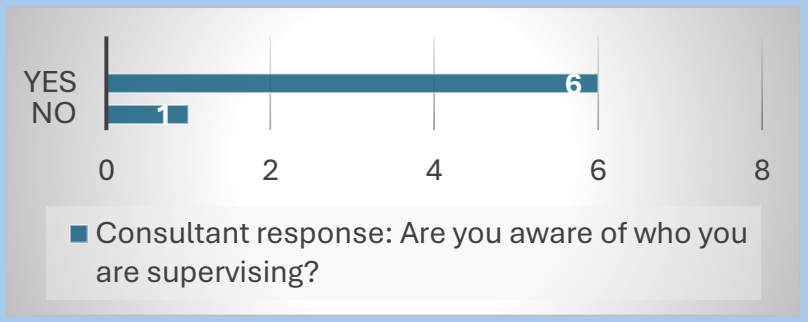
QR code linking to RCoA Guidance on supervision levels[1]

QR code linking to AoA solo working guidance[2]

Key highlights:



- 80% of solo lists were led by ST5+ or SAS doctors.
- All supervisees knew how to contact their supervisors.
- All, except one, were able to contact their supervisor when needed.



- Confidence and workflow were better when a named consultant was assigned.
- On-call (duty) anaesthetists felt unable to safely supervise due to emergency bleep responsibilities.
- 87% of supervising consultants carried a personal bleep on the day

Conclusions and discussion:

- Scope for improvement to align current practice with GPAS guidelines.
- 'Named consultant' supervision clearly enhances support and efficiency.
- Supervision by the on-call consultant anaesthetist may delay timely assistance in critical situations due to competing clinical responsibilities.

Next steps:

- Introduce a policy of assigning a named consultant anaesthetist for all solo lists.
- Display and communicate supervision details clearly using CLWrota (departmental rota app).
- Re-audit following intervention to assess impact.

References:
1. RCoA – Guidelines for the Provision of Anaesthetic Services
2. Association of Anaesthetists – Solo Working Guidance