Cappuccini Audit – An Audit of Supervision

CP Hebbes[1], F Guinness[2], R Assaf[2], C Collins[3]

[1]Specialty trainee, [2]Core trainee, [3]Consultant in Anaesthesia, University Hospitals of Leicester NHS Trust

Background

The GMC places a duty on all doctors to work within their competence and to seek advice from colleagues where needed[1]. The Royal College of Anaesthetists (RCoA) has produced standards (Box 1) for consultant supervision of all anaesthetists in training and non-consultant career grade doctors (NASG) in the Guidelines for the Provision of Anaesthesia Services (GPAS)[2, 3]. The importance of appropriate supervision of junior doctors was highlighted as a key factor for patient safety in the Francis report[4].

The Cappuccini test examines the robustness of supervision by applying a two stage test[5]

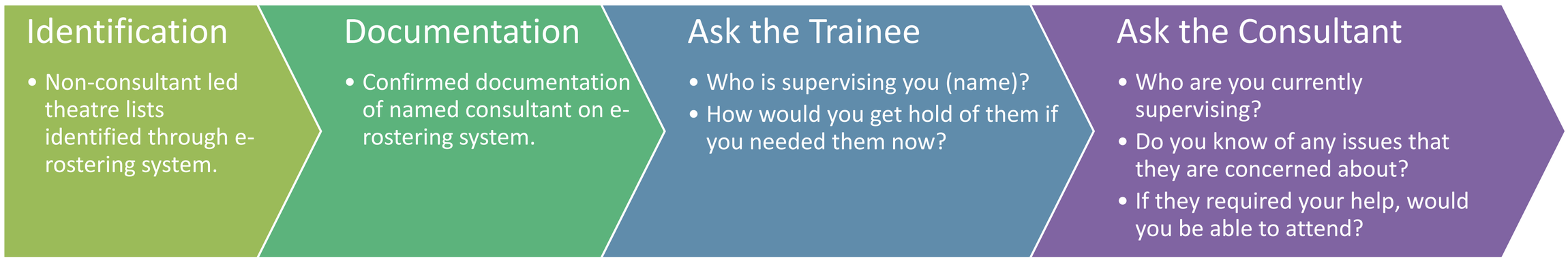
1. The non-consultant anaesthetist is asked who their supervising consultant is, and how to contact them.
2. The supervising consultant is then contacted (using the method stated), asked about their knowledge of their supervisee and whether they were free to attend if required.

Box 1: RCoA Guidelines for the Provision of Anaesthesia Services for intraoperative care – staffing requirements[2]

- All trainees must be appropriately clinically supervised at all times.
- All patients should have a named and documented supervisory consultant anaesthetist.
- Non-consultant anaesthetists should have unimpeded access to a nominated consultant.
- Where an anaesthetist is supervised by a consultant, they should be aware of their supervisor's identity, location and how to contact them.

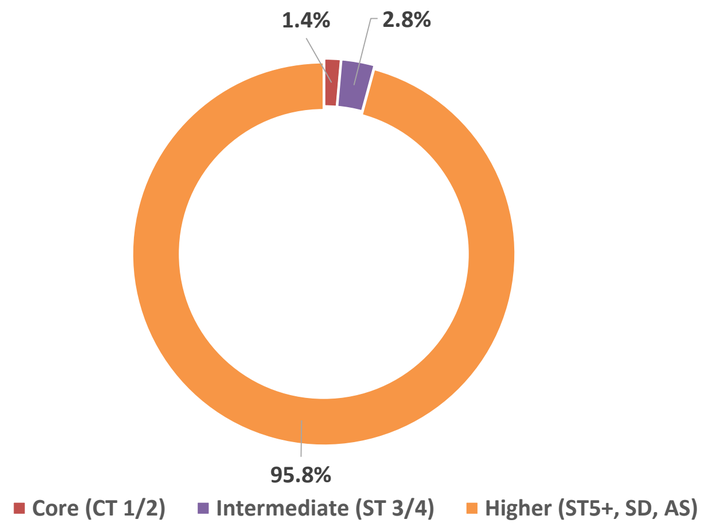
Method

During October 2019, 71 non-consultant led theatre lists at the Leicester Royal Infirmary were identified using the anaesthetic e-rostering system, and the Cappuccini test applied to 29 of these lists. Additionally, trainees were asked about the quality of supervision, and any problems.



Results

Grade of non-consultant leading operating lists



Cappuccini Test

The Cappuccini test was applied to 29 non-consultant led lists

	Number of operating lists (%)
Supervising consultant allocated	26 (90.0%)
If allocated - Non-consultant aware of supervisor	26 (100%)
If allocated - Supervisor contactable	26 (100%)
If allocated - Contact method	
Phone	16 (61.54%)
In person	10 (38.46%)
If allocated - Supervisor aware of mentee	26 (100%)
If allocated - Supervisor available to attend	26 (100%)

Trainee Comments

"(my supervisor) had checked if there were any issues – there were none"

"List had been changed at last minute – help available in adjacent theatre but no named consultant mentor"

"Supervisor available plus additional floating consultant. Present at briefing"

Discussion

- Overall there was high proportion of non-consultant led lists which had consultant supervisors allocated (90.0%). Where a consultant is allocated, both non-consultants and supervisors were aware. Comments suggests that consultants are proactive in offering support in accordance with good supervisory and educational practices.
- All supervisors for allocated lists were accessible and available to attend if required. Contact was either by telephone (61.54%), or directly (38.46%). Neither method is perfect for all areas (for example if telephone reception is poor), and methods to mitigate (such as highlighting the mentor, location and contact details to the theatre team, or using a quick dial number) may be useful to ensure that help is available in a timely manner.
- For lists that did not have an assigned mentor, the informal comments from the trainees highlighted help in adjacent theatres. However, with no designated mentor, it would be impossible to ensure that help was always available, nor a nominated consultant for the list as per RCoA standards.
- Within a main theatre suite, it is likely that help is available nearby – however, for some remote sites, this may not be the case. Non-consultants are unlikely to be placed without direct supervision in such sites – however, a robust method for monitoring this is important. This project has not focused on remote sites, nor on out of hours supervision, although this could be a target for further work.

Conclusion

This project demonstrated high compliance with the relevant RCoA standards for supervision.

- All patients should have a named and documented supervisory consultant anaesthetist and unimpeded access to a nominated consultant (90.0%)
- Where an anaesthetist is supervised by a consultant, they should be aware of their supervisor's identity, location and how to contact them (100%).

This project demonstrated a number of instances where non-consultant anaesthetists did not have an assigned consultant supervisor, and this was not always highlighted via the anaesthetic e-rostering system.

Action Points:

- Work with the CLW Rota e-rostering team to highlight non-consultant led lists without a named supervisor to allow easy identification.
- Ensure that the theatre team are aware of the location of the allocated supervising anaesthetic consultant with their contact details and location prior to surgery.
- Disseminate audit results to ensure that unmentored staff alert anaesthetic office prior to list start.
- Disseminate audit results to ensure that the named consultant is recorded on anaesthetic chart, theatre system and e-rostering system.
- Re-audit to assess continued compliance and improvement.

References

1) Good Medical Practice. GMC, London 2013 (bit.ly/2qbU8Jd)
2) Guidelines for the Provision of Anaesthetic Services (GPAS), Royal College of Anaesthetists. London, 2019
3) Royal College of Anaesthetists. Supervision of SAS and other non-consultant anaesthetists in NHS hospitals, 2015
4) Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery Office.
5) Cappuccini test, RCoA 2019 (bit.ly/2Df7Pfg) 5 Coding work to SAS doctors, NHS Employers 2017 (bit.ly/2r4gw9l)