Using BLOGS as a formative assessment tool
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Adele Nightingale
What is a BLOG?

• A frequently updated online journal or diary
• A combination of links, commentary, personal thoughts and essays
• A regularly updated website or webpage
• A website containing the writer’s own experiences, observations and opinions with links and images to other websites
Common themes....

- On the Web
- Regularly updated
- Writers’ own thoughts and opinions
- Selected audience
- Links to other websites or images etc.....
How and why use it in education?

• Constructivist Theory- “convert experience into knowledge through action, imagery and symbols” (Aubrey and Riley 2016: 48)

• Idea based on Vygotsky work of constructing knowledge by developing a process of learning (from interacting with others more knowledgeable)

• Internalisation- make sense of the problem so they can solve a similar problem

• Challenge the student so that they will build and refine their understanding
Bruner (1966)- Scaffolding

• Help is offered – problem not solved
• Develop a deeper understanding and help them discover on their own
• Learning is an active and constructive process
• New information linked to prior knowledge
### Perioperative Student Demographic

| Level 6 pre registration Operating Department Practitioners (Case study 1) |
|-----------------------------|-------------|
| Aged between 18-55          |
| No previous experience of Operating Theatres |
| Academic qualifications & recent study |
| 3 year programme leading to registration |
Case Study 1: pre-reg ODP students

• Discussion Board versus Blog
• Limited engagement of discussion board by student:
  • Limited engagement on discussion board by staff
  • Poor instructions to students
  • Inappropriate use of discussion board
# Discussion Board

Forums are made up of individual discussion threads that can be organised around a particular subject. Create Forums to organise discussions. [More Help](#)

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Displaying 1 to 2 of 2 items
Thread: What not to put on facebook hahahaha. End of 1152

STUDENT
What not to put on facebook hahahaha. End of 1152

Good luck to you all xx
20141030_135031.jpg (1.958 MB)

STUDENT
RE: What not to put on facebook hahahaha. End of 1152

Great picture that. Good luck to everyone x

STUDENT
RE: What not to put on facebook hahahaha. End of 1152

Good luck for you all.
Thread: Polytrauma Activity

Using the Template provided in the discussion board please do the following:

1. Using the template below complete the anaesthetic, surgical and recovery care for this patient
2. Please give a brief review of how difficult you found this exercise on the discussion board, which section you found the most difficult i.e. anaesthetics, surgery or recovery and why
3. Email your completed template to me.

Polytrauma Scenario Template.doc (78 KB)

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STUDENT

RE: Polytrauma Activity

On completing the Polytrauma activity, I found that the surgical phase of Gary's care was the most challenging to plan. I feel that my rationale for this is my lack of exposure to these specialities, in particular these procedures, thus I could only hazard a guess as to what instrumentation, sets and supplantives might be required. However, having completed the activity I now feel more confident in my own knowledge of these procedures - resources like YouTube are really helpful for explaining the procedure and the anatomy, and I will refer to practice when we start back next week about the list. I will make it a priority to at last double scrub for one or all of these procedures before completing my scrub placement. Moreover I feel that I was able to offer a more thorough and indepth explanation of my planned anaesthetic and recovery phase of care, as this is the part which we discussed together as a group in class.
**Forum: Assignment activities**

Organise Forum Threads on this page and apply settings to several or all threads. Threads are listed in a tabular format. The Threads can be sorted by clicking the column title or the caret at the top of each column. More Help

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Displaying 1 to 4 of 4 Items  Edit Pages
So what did this tell me...?

- WIIFM - If the students saw that there was a purpose to the activity they engaged...alignment!
- Not all lecturers utilise the discussion board optimally
  - ...are we sharing best practice?
- Not all students understand the difference between discussion board and Social area
  - ...are we setting the boundaries and etiquette from the outset?
- After having a focus group with one cohort the feedback suggested:
  a) They do not like others viewing their work
  b) They feel that people copy their work
  c) It created a sense of unhappiness, especially when some students had contributed more than others.
Lets try a BLOG...

• The overriding reason for doing the BLOG was for engagement and alignment

• Setting up the BLOG
  • There needed to be a definite focus
  • Need to consider etiquette, ethics, risk and resources
  • Need for concise instructions on how to access and use
  • A clear explanation of expectations
  • Clearly explain how and when they would receive feedback
  • Explain how students should act and respond to feedback
The differences......
Instructions for Anaesthetic Scenario Blog

The junior anaesthetist has anaesthetised a man for a laparotomy using Fentanyl/Propofol/Atracurium. He has performed a laryngoscopy and says to you ‘Oh dear... I can’t see a flipping thing’. It is the middle of the night, the on call consultant is at home and the senior anaesthetist is caring for a patient in Maternity. The junior anaesthetist looks up at you and says ‘OMG! What am I going to do now?’

Give me a step by step plan of what you are going to do as the ODP. For each step provide a rationale for your decision and critically analyse why you made that decision.

Click [Add Entry] to submit your answer to the difficult airway scenario. You will receive feedback from me via the Viewer Comments section (below).

Edited by: [Name] 8 months ago
Tags: None Edit

< Previous Page; New Entry >
New Entry

The anaesthetist should try maneuvering the patient to get a better view, head tilt chin lift or try adjusting the pillow underneath the patient. The anaesthetist and ODP could try using the difficult intubation trolley in here they could try using a ILMA, this is a blind view of putting an ET tube in.

The DAS guidelines should be followed in any situation. If the anaesthetist cannot see anything and airway adjuncts have been used to try and aid the view such as a bougie and McGrath, this should be tried 3-4 times before moving to plan B. If the anaesthetist can manually ventilate the patient this should be done whilst the ODP can set up any equipment that might help the anaesthetist. Plan B of the DAS guidelines state that the next port of call should be using an LMA which can provide good ventilation for the patient. If this still doesn’t help the anaesthetist view and the anaesthetist has failed attempts of intubating the patient the patient may need to be woken up.

Edited by: 8 months ago
Tags: None

Viewer Comments (1)

Edited by: 8 months ago

Thanks however you need to consider getting help from anaesthetist and maybe another pair of hands to help you as the ODP. You could also consider using BURP to help bring the chords into view. Unfortunately if the patient has been given a muscle relaxant and the patient cannot intubate and ventilate, waking the patient up is not an option! You also need to consider the action plan that the DAS describe for a cannot intubate, cannot ventilate scenario.

Cheers: 

Reply  Edit  Delete
Anaesthetics Scenario

1. Advise the Anaesthetist to return to bag and mask ventilation. If the patient is able to be ventilated using a face mask and a basic airway adjunct such as an oropharyngeal or nasopharyngeal then this can be conducted by the anaesthetist or ODP indefinitely while a plan of action can be created. This process of ventilation also allows for oxygen reserves in the Functional Residual Capacity to be at a high level allowing for more time during intubation as hypoxia is less likely.

2. Use of a basic airway adjunct prevents the tongue from occluding the upper airway, therefore ensuring that mask ventilation is effective at all times.

3. Call for help. It is essential that help is obtained from other experienced staff members as they can get further equipment if required such as the difficult airway trolley if this is not readily available in the anaesthetic room. They can also assist in creating a plan of the further difficult intubation technique.

4. Advise the Anaesthetist about the various difficult airway equipment available which will assist in the creation of a plan for how to deal with the difficult intubation; this should include informing the Anaesthetist of the laryngoscope blades available and different methods of intubation such as fiberoptic laryngeal mask or Intubating LMA.

5. Optimize patient position to ‘framing the morning air’ as this allows for optimal visualization of the upper airway anatomy in the majority of patients with varying Cormack-Lehane scores compared to just head extension. This ensures that the Anaesthetist has the best chance of being able to use the vocal cords for intubation. I would also advise the anaesthetist on the use of laryngeal manipulation which may allow the vocal cords to be more visible.

6. 2nd Attempt. During this attempt I would advise the anaesthetist to use a Size 4 Macintosh blade as this laryngoscope blade can be used like the standard Macintosh blade with the added ability to further move the epiglottis using the hoarding lever. A size 4 would be more adequate compared to a size 3 as it can be placed further in or retracted if needed. At this point I would also advise the Anaesthetist to use a bougie to assist with intubation; this would be used as a guide through the vocal cords and allow for the endotracheal tube to be railroaded over to bougie for an increased chance of successful placement.

7. If still Failed: bag and mask ventilation. As before, if necessary, the anaesthetists can develop an action plan whilst building up FRC and reducing the risk of hypoxia.

8. 3rd attempt of intubation. I would advise the anaesthetist to use a Macintosh video Laryngoscope as this will further improve the view of the upper airway anatomy and vocal cords due to the presence of a camera on the end of the laryngoscope providing a live feed to the screen. I would remind the ET tube on a sheet to allow the anaesthetist to shape the tube to the anatomy of the trachea therefore increasing the likelihood of intubation whilst still having a restricted view of the vocal cords.

9. If failed again, bag and mask ventilation.

10. Last attempt of intubation; during this attempt a fiberoptic scope could be placed past the larynx and through the vocal cords for optimal view; this allows the anaesthetist to determine if there were any obstructive or anatomical differences which were restricting the view and allow for a more accurate intubation due to the tube being railroaded over the fiberoptic scope.

11. If failed. Bag and mask ventilation while further airway adjuncts are prepared.

12. Insertion of IGL or Laryngeal Mask. Although the risk of aspiration is greater due to the LMA or IGL sitting above the vocal cords it is still possible to use these adjuncts to maintain a patent airway and to assist ventilation. I would advise the anaesthetist to use an IGL instead of a LMA as the IGL moulds to the shape of the larynx creating a more secure fit. It is also possible to pass a suction catheter through an IGL if regurgitation and aspiration should occur.


14. Final attempt of intubation of IGL or LMA. As before, reinsert the IGL if possible as this would allow the surgery to still take place.

If a can’t intubate, can’t ventilate situation occurs then help buzzer should be pressed for more help. At this time the emergency airway kit should be made available or, if not available, a 14-gauge cannula with jet intubation should be used to create an emergency airway through the oesophageal cavity followed by the insertion of a tracheostomy.


What did I see in the BLOG...?

• The BLOG supported the students in developing the ability to critically analyse and synthesis:
  • They write, I give them feedback and ask further questions, they reflect, rewrite.
  • It’s a cyclical process as opposed to linear
  • Any changes they make are in a different colour. This highlights to them what analysis and critical analysis is
Focus Group

• “Once I got on it I loved it”
• “Helped structure and write assignments”
• “Made me think at a deeper level”
• “Helped me write and reference”
• “Liked the interaction with lecturer”
• “Nobody else could see it and laugh at my mistakes”
What’s missing…?

• Interaction and collaboration.....or is it?
  • Interaction is with the lecturer; however students then go on to discuss in the clinical area with Mentor and Anaesthetists.
• They use the BLOG as part of their summative practice assessment.
• They use a screen shot in their portfolio to demonstrate their knowledge
• Decided to take the next step...sharing the BLOG with others.
The next step...sharing the BLOG

• Not quite as easy to set up and manage in Campus pack
• Student led: let them decide who to share it with; had to share with at least 3 others
• Lecturer: everybody had to share with lecturer
• The results were very significant
Difficult Intubation

If the patient had been preoxygenated effectively then I would firstly suggest that a possible position change of the patient's head and neck could allow for a better view when carrying out a laryngoscopy as this may reveal the vocal cords and epiglottis. The optimal position for intubation is known as the 'Sniffing Position' when the neck of the patient is extended and the chin is elevated to create an open airway which can be seen easier in this position during a laryngoscopy (Cattano, 2011). If the patient has a relatively short or wide neck achieving this position may seem difficult and the use of a folded pillow or neck pads may be needed to help with the extension of the neck (Cattano, 2011). I would recommend changing the patient's position before calling a failed intubation as sometimes the Junior anaesthetists may forget about this method when intubating or perhaps are physically strong enough to be able to achieve this position effectively to help with intubation. Furthermore, changing the position of the patient only takes a matter of seconds so the SP02 of the patient shouldn't drop too much whilst doing this allow for more time to look again to see if the airway is visible.

If the 'Sniffing Air' position is not adequate to provide the optimal view of the larynx then I would also suggest elevating the patient even higher to allow the anaesthetist to look down the patient's throat (Rao, 2008). This position can be obtained by elevating the top half of the trolley allowing the patients torso to be elevated with the support of the trolley. This position can also be obtained with use of sheets, blankets and manual support in emergency situations. By putting the patient in this position any added weight or pressures on the chest or neck can be relieved with a change in gravitational pull (Rao, 2008). This may allow for the anaesthetist to open the oral cavity and gain a much better view of the pharynx and trachea possibly allowing for a successful intubation.

Working as the ODP in this situation the priority is always ensuring the delivery of oxygen to the patient until a plan can be made of what is going to be done next to achieve a sufficient maintained airway. The junior anaesthetist must ensure that the patient is continuously oxygenated via face mask with sufficient seal to provide enough oxygen to maintain the patient's O2 saturation above 90% (O'Driscoll, 2008). The Difficult Airway Society (DAS) also suggest the use of airway adjuncts such as a Guedel to help deliver sufficient oxygen to the patient (DAS, 2015). I personally would advise the anaesthetist to use a Guedel airway when manually ventilating the patient just to ensure the patient is having the best possible amount of oxygen during this procedure as the Guedel prevents the tongue of the patient falling back and restricting the patient's airway.

Following the DAS guidelines of difficult tracheal intubation in adults the next step would be to call for help, whether that be for a trained practitioner or another junior Anaesthetist as having an extra pair of hands and another train of thought is always appreciated in this type of circumstance (DAS, 2015). Having an extra pair of hands is a massive help as there can be many extra things to think about and set up during this critical time. Extra equipment, more or different drugs may be needed to be prepared and just having the extra experience can help in the situation allowing for the Junior Anaesthetist not to panic and cause further problems (Shanmuga, 2015).

Due to the fact that modern medicine is constantly changing a range of different laryngoscopes have been developed in order to deal with situations like this. For example, a McCoy blade is a long curved blade similar to the regular McIntosh blade used for standard intubation however the McCoy blade has a laryngoscope-controlled hinged portion just proximal to the tip which can be helpful in situations (Lavery, 2008). The hinged tip allows for the epiglottis to be manipulated if it is blocking the entrance of the trachea allowing the anaesthetist to obtain a better visual of the airway and possibly allow access to insert a tube (DAS, 2015). The use of different blades allows you to perform laryngoscopies with the advantage of accessing the trachea from different angles and depths creating a solution for any visual problem you may have whilst performing a laryngoscopy.
If the use of a different laryngoscope does not work then I would advise the anaesthetist of the use of a fibre optic scope or camera scope. At my local trust we use the GlideScope™ for difficult intubations as this device allows the anaesthetist to perform a blind laryngoscopy as the scope has a camera on the end allowing the anaesthetist to visually see what’s in the patient’s oral cavity and pharynx (Aziz, 2011). The image is displayed on a screen and is easy to use which makes it less stressful in this type of situation. The display can allow the anaesthetist to see if something is blocking the trachea or just to see the trachea if the patient isn’t correctly positioned or has a high intubation grade (Aziz, 2011). More often than not the anaesthetist is able to obtain the patient’s airway with the use of the GlideScope™ as they can see exactly where the tube is needed to be inserted.

The DAS guidelines state that only 3 attempts should be made when performing intubation to prevent trauma and stress to the patient. Once the third and final attempt has been made, I would recommend a supraglottic airway device (SAD) to gain some type of maintained airway (DAS, 2015). The use of a Laryngeal Mask Airway (LMA) would be efficient enough to obtain the patients airway and help deliver sufficient oxygen to the patient. However, the patient may still be paralysed from the Atracurium given and unable to spontaneously breathe for themselves so manual ventilation will be needed to supply the patient with enough oxygen. Another risk of using these airways is that the patient may aspirate causing any gastric contents to pass down the trachea and into the lungs causing many other problems for the patient.

If the patient then became impossible to ventilate there are numerous ways to try and tackle this issue. The DAS suggest that mask ventilation is needed with maximum neck extension and maximum jaw thrust to try and open the airway as best as possible. By doing it allows for the airway to become more open and without any bends or concluded allowing for possible laryngospasm to relax (DAS, 2015). Another way of supplying oxygen to a ‘cannula ventilate’ patient is by inserting a nasal airway as this sits at the back of the oral cavity and supplies oxygen to the larynx via a different angle, one which may not be blocked or occluded. The use of an LMA can help by applying positive pressure which may open the Larynx and allow the patient to breathe again (DAS, 2015). If all else fails a cannula or surgical Cricothyroidotomy may be necessary to enable anaesthetist to give the patient some amount of oxygen to prevent hypoxia. These are usually last resort but by cutting into the cricothyroid enables a high pressure of oxygen to enter the trachea and into the lungs (AAGBI, 2013).

References


Adele Nightingale 14 days ago

Thanks for this. It's very well written and methodical. Do you think there are any other basic manoeuvres that you could do to help optimise the anaesthetists view? What would you do differently if you then failed to ventilate your patient? Any additions to your blog please put in a different colour so that you can see have you have started to analyse your answers.

Well done, Adele

Reply | Edit | Delete

Adele Nightingale 14 days ago

Great addition.

Excellent work, you should be proud to share this.

Cheers, Adele

Reply | Edit | Delete

[Anonymous] 3 days ago

Your step by step plan is very similar to mine when it comes to the first failed intubation and what I'd do eg positioning. At your trust do you see the Glidescope commonly used? I don't see it very much but if someone pulls the emergency alarm and I hear on the intercom that it's a difficult intubation I will normally grab the difficult intubation trolley which has a few sizes on.

What you have wrote about failed ventilation is very similar to mine, however I have never come across a difficult intubation at that level yet.

Our plan is very similar but it would be interesting to see the difference between our trusts regarding the equipment (quality and cost) comparing NHS and private sector.

Reply

[Anonymous] 5 days ago

Hey,

I think your work is brilliant.
New Entry

Working as a Operating Department Practitioner (ODP) out of hours. Knowing that there is a Junior Anaesthetist on call and the senior anaesthetist is busy, I would ensure that I am aware of the Consultant on call and the whereabouts of the Senior Anaesthetist. It is important to follow standard anaesthetic practice to ensure safe and effective anaesthetic care.

In the event of difficulty, that was not predicted in the surgical plan, an anaesthetist should immediately call for help, following the Good Medical Practice (GMC) Standards of Conduct, Performance and Ethics (2018). I would declare the surgical team that we have a difficult intubation situation and require them in the anaesthetic room and call a member to contact the Consultant on call. This follows the Health and Care Professions Council Standards of Conduct, Performance and Ethics (2018). Working in partnership with colleagues, we can ensure that the patient receives the best possible care.

Upon being informed by the anaesthetist that the patient is uncooperative, I would take steps to ensure ongoing ventilation and oxygenation, to increase functional residual capacity (FRC) by exceeding the baseline respiratory rate. I would also attempt to improve ventilation and oxygenation by giving a small dose of a muscle relaxant, such as vecuronium, to facilitate ventilation and oxygenation during the intubation process. If this fails, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation. If these methods fail, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation. If these methods fail, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation. If these methods fail, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation.

Plan 1. Initial tracheal intubation plan:
- Plan A: SAD insertion plan, if plan A fails.
- Plan B: SAD insertion plan, if plan A fails.
- Plan C: Oropharyngeal airway and postoperative recovery plan, if plan A fails.

Plan 2. Rescue techniques for "can't breathe, can't ventilate" situations:
- Early plan A: SAD insertion plan, if plan A fails.
- Early plan B: SAD insertion plan, if plan A fails.
- Early plan C: Oropharyngeal airway and postoperative recovery plan, if plan A fails.

All anaesthetists have their own preferences, according to capabilities and experience. I would follow the advice of the SRMCS guidelines for airway management. If the patient is unable to be intubated within 30 seconds, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation. If these methods fail, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation. If these methods fail, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation. If these methods fail, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation.

Plan 3: Oropharyngeal airway and postoperative recovery plan, if plan A fails.
- Plan A: SAD insertion plan, if plan A fails.
- Plan B: SAD insertion plan, if plan A fails.
- Plan C: Oropharyngeal airway and postoperative recovery plan, if plan A fails.

All anaesthetists have their own preferences, according to capabilities and experience. I would follow the advice of the SRMCS guidelines for airway management. If the patient is unable to be intubated within 30 seconds, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation. If these methods fail, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation. If these methods fail, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation. If these methods fail, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation.

Plan 4: Oropharyngeal airway and postoperative recovery plan, if plan A fails.
- Plan A: SAD insertion plan, if plan A fails.
- Plan B: SAD insertion plan, if plan A fails.
- Plan C: Oropharyngeal airway and postoperative recovery plan, if plan A fails.

All anaesthetists have their own preferences, according to capabilities and experience. I would follow the advice of the SRMCS guidelines for airway management. If the patient is unable to be intubated within 30 seconds, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation. If these methods fail, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation. If these methods fail, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation. If these methods fail, I would consider using a laryngeal mask airway (LMA) or a fiberoptic bronchoscope (FOB) to facilitate intubation.
What would I do!!!

As there is not much background information I am going to assume this patient is normally fit and healthy, and was deemed to be a non difficult airway during the pre-op assessment.

The first thing I would do as an Operating Department Practitioner (ODP) in this situation is to ask the anaesthetist WHO I should call to help and not IF I should call someone. Because he is a junior he may become overwhelmed quickly if things were to go pear shaped. If he said not to bother I would still get another member of staff to call the senior anaesthetist to alert them to the fact that this may become a difficult airway and to find out what he would suggest should happen if it doesn’t, should the on call consultant be alerted now so he has enough time to arrive before anything untoward were to happen. The Good Medical Practice guidelines (General Medical Council, 2015) say to communicate with other more senior team members to acquire assistance. Although there tends to only be a skeleton team on during night shifts the on call consultant is available for such incidents and may not be required to leave his home because just talking to the junior anaesthetist could calm their nerves and bring him back into focusing on the job at hand calmly.

Next I would suggest to the junior anaesthetist that if he could not see anything that he should cease what he is doing and begin manually ventilating the patient with the aid of a mask which prevents the tongue folding back on itself and allows for a more patent airway. I would then calmly but quickly reach for the diffcult airway tray which would have been parked outside the emergency theatre door and proceed to point out the next steps as outlined in the DIFFICULT AIRWAY SOCIETY (DAS) 2015 DIFFICULT airway guidelines of which step 4 is to manually ventilate.

Once the junior anaesthetist has calmed down and gathered himself and we have laid out the plan of action in line with the DAS guidelines we would then proceed. Step 8b to maintain an airway using a Supraglottic Airway Device (SAD). Most difficult airway trays have SADs which are second generation laryngeal mask airway (LMA) device (Intersurgical, 2016). Sads are preferred over 1st generation LMAs in these circumstances because they are much easier to use, no cuff needs to be inflated, they provide a superior seal pressure, there is reduced trauma, an integral bite block and gastric aspiration if required (Intersurgical, 2016).

If this was again unsuccessful I would then request a member of my team (either DCC or scrub practitioner) calls for assistance in the form of the senior anaesthetist if possible or the on call consultant. I would then lead the junior anaesthetist into beginning step C which is the final attempt at face mask ventilation (DAS, 2015). Once the junior anaesthetist is ready I would offer him the option of an endotracheal tube and a bougie or suggest that he may prefer to use fiberoptic assisted tracheal intubation. The junior anaesthetist would probably prefer this second option as the images are magnified in the eye piece or into a screen allowing for a more successful intubation (Verma, 2015). Fiberoptic intubation is when an endotracheal tube (ETT) over the body of a flexible fiberoptic scope. This scope is passed through the mouth into the pharynx and will show the vocal folds and then the scope carries into the patient’s trachea. Once the tracheal rings and carina are in view the ETT is slid down the body of the scope and placed and the scope is carefully removed and the ETT is secured (Verma, 2015). In the unfortunate case that this is not successful step D calls for front of neck ventilation but by this stage the emergency buzzer would be called and specialist help would be required.

Once the situation is resolved and safe I would reflect with with junior anaesthetist whom I would make buy me a strong drink for holding my nerves.

References:


Student feedback

Evaluation Data
Student feedback

Four questions:

1. Did you enjoy the BLOG?
2. What did you like about the BLOG?
3. How could the BLOG be improved?
4. Did you feel the BLOG enhanced your knowledge and understanding?
Did you enjoy the BLOG?

- YES: 17
- NO: 1
What did you like about the BLOG?

- Choose who to share with: 14
- Interactive: 3
- Builds on existing knowledge: 3
- Freedom: 3
- My level: 4
- Helped me with referencing: 3
How could the BLOG be improved?

- Ease of access: 6
- Start in year 1: 1
- Alerts for comments: 1
Did you feel the BLOG enhanced your knowledge and understanding?

- YES: 17
- NO: 1

[Diagram showing 17 YES and 1 NO]
Future consideration....

- Starting a pre-reg airway management BLOG in the 1st year and updating with experiences in practice.
- Student led versus Lecturer led?
- Utilise journals and hyperlinks to add depth and breadth to their knowledge.
  - They will be encouraged to analyse and critique.
- This will provide construction of knowledge and aid them in reflecting on practice.
- Make them public????
  - Need to consider the associated risk.
Thank You
References
