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Chapter 2 : ASA Refresher Course in Anesthesiology : Alan Jay Schwartz :

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Anesthesiology and Critical Care Medicine Dr. Kalsi ; Department of Emergency Medicine Mr. Brust ; Department of Respiratory Care Ms. Tyler ; Department of Emergency Medicine Dr. Boulet Address correspondence to: Maintenance of competence in orotracheal intubation skills is challenging for non-anesthesiologists who do not practice intubation routinely. We hypothesized that discipline, recent training, and experience would affect immediate skill improvement during refresher training. Experienced pediatric providers refreshed intubation skills in six simulated infant trauma scenarios with cervical spine protection. Time T to successful intubation in seconds was used to calculate refresher training immediate effectiveness as a function of time to success at second vs. Twenty-six providers performed intubations. Time to successful intubation T1 was The number of intubation attempts and the number of tracheal intubation-associated events were not different in recent training, discipline, or clinical experience. Recent tracheal intubation training, but not years of experience or discipline, is associated with immediate refresher training effectiveness. Introduction High-reliability organization theory supports a high number of operations, intensive training of personnel and teams, and intensive critiques of performance during operations and training in order to maintain a very low failure rate in high-hazard organizations. For better allocation of resources to improve patient safety in organizations, it would be helpful to know which factors are associated with the learning effect of refresher training to maintain clinical competence. Many tasks required to maintain competence in clinical settings involve psychomotor skills with appropriate-level medical knowledge. Several studies have revealed that psychomotor skills required for crisis management, such as cardiopulmonary arrest, rapidly decay over time, 4 , 5 , 6 , 7 , 8 and do so faster than cognitive skills medical knowledge. Furthermore, maintaining competence may require frequent refresher training, 15 since non-anesthesiology pediatric practitioners and trainees practice this psychomotor skill infrequently in actual clinical settings. Medical simulation has been recognized as an effective tool to improve patient safety. Recently, several studies found that simulation-based training effectively improved clinical operational performance with fewer adverse events. Food and Drug Administration FDA now requires simulation-based training for a certain intravascular surgery device. Since pediatric intubation is a complex, risky procedure that does not occur on a regular basis for most non-anesthesiology practitioners, medical simulation was determined to be the best technique for this intubation training study. A high fidelity simulator was used in a simulated clinical setting to maximize the realism, to accurately reflect competence, and to maximize the learning effect. Non-anesthesiology pediatric practitioners who are credentialed in tracheal intubation in our institution were asked to participate voluntarily in this study from October to February Pediatric residents were not enrolled in this study, since their intubation rate and success rate have been low in the local airway registry data, and they are not the primary intubators on our transport team. A written consent was obtained from each subject. A priori-defined pretraining dataâ€”including discipline, date of prior training involving pediatric intubation, years of experience performing pediatric intubations, and basic demographics age, sex, and ethnicity â€”were collected using a questionnaire at the time of training. Each subject was asked to participate in six simulation sessions with identical objectives, all of which required pediatric advanced airway management, including orotracheal intubation for an infant trauma patient with C-spine stabilization. In each session, a subject performed as the primary airway provider. The team leader asked the subject to perform orotracheal intubation, randomized to one of three different cervical spine protection techniques: The order was randomized. Each session was designed to last approximately 5 minutes, and the entire simulation evaluation consisted of six consecutive sessions and lasted approximately 1 hour in total. Scenario Briefly, the scenario was as follows: A 6-month-old infant is involved in a motor vehicle crash. She appears obtunded, with oxygen saturation of 93 percent, despite percent oxygen via a properly fitted face mask. She has been moved to a stretcher for primary evaluation and advanced airway management. Minor, prospectively configured variations of this same scenario were repeated identically six times. The simulator was preprogrammed to demonstrate saturation and

heart rate changes during advanced airway management, with realistic timelines and triggers for response Appendix 1. For orotracheal intubation, a standard Miller 1 blade and a 3. The key actions were prospectively identified and defined as follows: Time of initiation of tracheal intubation was cessation of bag-valve-mask ventilation. Initiation of direct laryngoscopy was defined when the laryngoscope was inserted into the oral cavity of the simulator; initiation of tracheal tube insertion was defined when the tracheal tube visibly entered beyond the gum inside the oral cavity. As used in the procedural definitions for the National Emergency Airway Registry NEAR , 30 duration of an intubation attempt was prospectively defined by the process starting at the cessation of bag-mask ventilation to time of confirmation of successful tracheal tube placement. A successful orotracheal intubation was defined as tracheal intubation with confirmed endotracheal tube position with primary chest rise and auscultation and secondary confirmation positive end-tidal CO2. This was later reviewed to document the lowest saturation during each scenario and any tracheal intubation-associated event s that occurred during the scenario. Tracheal intubation-associated events were prospectively defined as: No intubation success within 15 minutes. Esophageal intubation with immediate recognition prior to removal of laryngoscope. Esophageal intubation with delayed recognition after removal of laryngoscope, but recognized by a subject. Missed esophageal intubation never recognized by a subject. Mainstem intubation with immediate recognition prior to removal of laryngoscope. Mainstem intubation, with delayed recognition after removal of laryngoscope, but recognized by a subject. Missed mainstem intubation never recognized by a subject. Statistical Analysis The immediate effectiveness of refresher training was prospectively defined as the ratio of time required for successful intubation at the second vs. The time to successful intubation in seconds and immediate effectiveness of refresher training were considered as continuous parametric variables. To avoid confounding by intermittent periods of time required for appropriate rescue bag-mask ventilation, the sessions where subjects required more than one intubation attempt for success were analyzed separately. As safety practice indicators, the number of intubation attempts required for intubation success and the number of predefined tracheal intubation-associated events were also analyzed as a secondary outcome. Nonparametric variables were analyzed with Wilcoxon rank-sum test or the Kruskal-Wallis test. Multivariable linear regression analysis was conducted to evaluate the impact of a priori selected independent variables. The median length of pediatric intubation experience was 3. Table 1 Demographics of participants. All participants were successful at the first attempt in the second session. The largest improvement was seen between the first T1 and second sessions T2. Univariate analysis revealed the immediate effectiveness of refresher training was significantly associated with recent pediatric advanced airway training with recent training 0. The number of intubation attempts for a total of six sessions did not differ significantly among disciplines transport nurse: Table 3 Number of intubation attempts and tracheal intubation-associated events. The frequency of tracheal intubation-associated events did not differ significantly among disciplines transport nurse: The most common intubation-associated event was mainstem bronchus intubation without immediate recognition, which was observed in 42 sessions. Discussion Psychomotor skill is a critical component for crisis management in clinical settings. Those studies showed that both cognitive and psychomotor skills decay over time, but psychomotor skill decays faster. Although under some circumstances the initial training effect can be augmented by initial intensive overtraining, 33 the intensity of refresher training required to maintain competence is still unknown. It is also unclear what factors influence the effectiveness of refresher training. Tracheal intubation is a complex psychomotor skill, similar to cardiopulmonary resuscitation; there is a learning curve to acquire intubation skills, and it usually requires significant practice. Since multiple attempts at intubation may be harmful, the immediate refresher effect is critically important. Therefore, we chose this as a primary outcome of our study design. This study showed that the effectiveness of immediate refresher training was significantly associated with recent psychomotor training. Unlike many studies in cardiopulmonary resuscitation training with volunteer lay rescuers, all participants in this study were credentialed in pediatric advanced airway trainingâ€”including orotracheal intubationâ€”and many had received training relatively recently Table 1. The transport team members participated in bi-annual intubation training in the operation room. The pediatric emergency medicine fellows and pediatric critical care fellows perform advanced airway management as a part of their fellowship training, although it is less frequent,

compared to that of anesthesiologists. Our local airway registry data in Pediatric Intensive Care Unit showed that tracheal intubation occurs every 3 to 7 days in a busy tertiary PICU with 45 beds data not published. Despite that training, the intubation in the first session took significantly longer compared to other sessions. This study finding was similar to the recent report on chest compression refresher training for pediatric in-hospital staff. The first session serves as refresher training and the second as a competence measurement. The second session needs to be repeated for those judged not sufficiently competent. Therefore, this goal is achievable. However, skill reacquisition did not differ between a group that received training 7 months earlier compared with a group that had previous training as much as 12 months earlier. This finding is different from our study, in which the recent training was positively associated with an immediate learning effect. Although the reason for this difference is not entirely clear, it is possible to speculate that: They then randomized participants to three groups: They found that the group with feedback and subsequent practice sessions maintained their airway skills without decay and performed significantly better than the other two groups. The score of the airway skills dropped significantly at the first followup test 16 weeks and stayed at similar levels in the control group the first and the third group. The study by Kovacs, et al. Based on those findings, we conclude that previous training effect still exists up to 3 months later, and that frequent pediatric intubation refresher training every 3 months can be brief, since practitioners regain the skill quickly. Future study in pediatric intubation refresher training at various intervals with immediate training effectiveness measurement is warranted to further quantify the effectiveness of refresher training. This study has some limitations. It was conducted with each participant performing tracheal intubation without feedback using any of three different C-spine stabilization techniques. Although this was randomized, this technique might have biased the results. The reason for this is unclear. Their performance was eliminated in T1, since they required more than one attempt for intubation success, but it was included in T4, since they no longer required more than one attempt.

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