

The Difficult Airway Society
Projects Update
Nottingham 2011



www.das.uk.com



Nottingham 2011

From the editors

Welcome to this special edition of the DAS Newsletter, *the Projects Edition*.

As the Society grows, the Annual Scientific Meeting gets busier and busier. And as the Society grows the number of projects it is involved with also grows- to the extent that there simply isn't time to discuss them all in the detail they deserve.

This newsletter is a trial edition that attempts to redress the lack of detail. It carries reports from all the DAS Projects we could locate, coordinated by our ever watchful Scientific Officer Jaideep Pandit, who works tirelessly on the Society's behalf.

Whether, then, you are reading this during a coffee break in Nottingham or online thereafter please do email us and let us know what you think- the reception this Projects Edition receives will probably determine the likelihood of repeating the exercise

As ever email us

newsletter@das.uk.com

Or if you are in Nottingham come and speak to us, the worst that might happen is we invite you to write something for the Newsletter!

*Ravi
Bhagrath
London*

*Alistair
McNarry
Edinburgh*

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Please note that Project Reports have been accepted largely unedited (except where issues of space/ style etc have required changes). As such the responsibility for content lies with the Authors not the Society.

From the President



I am delighted to announce that 2011 has been our busiest year yet with many projects reaching completion and a few commencing. As one of our main functions is to set standards in the area of airway management it is indeed gratifying to see the Extubation Guidelines have been completed and accepted for publication in *Anaesthesia*. I would like to thank the whole team who worked extremely hard to complete this task. In addition the paediatric guidelines are reaching completion. On the horizon we are putting together a team to revise the DAS Difficult Airway Guidelines which were published in 2004. We are also finalising plans to work with the OAA on guidelines for Management of the Difficult Airway in obstetric anaesthesia.

Other initiatives include ADEPT which is being led by Jaideep Pandit . We hope that this will lead to improvement in the process by which new devices reach us and lead to increased patient safety as a consequence. We are all aware of the role of human factors in adverse outcomes following difficult airway management events and the SMART course is an attempt to increase the awareness of this and teach teams to work together more effectively.

The publication of NAP4 has focused the DAS committee on it's future strategy. The results has given us a direction in which we feel we should develop our research and teaching from the lessons learnt. To this end we are working with the RCoA to help deliver this strategy.

I would like to thank the DAS committee for all their hard work over the past year and especially our Scientific Officer lead Jaideep Pandit for his co-ordination of this aspect of our work. If you wish to be involved in any aspect of these exciting initiatives please contact me at president@das.uk.org

Ellen O'Sullivan

DAS AGM

Thursday

3rd November 2011

1700

DAS Projects

This has been a busy year for DAS-sponsored projects and this newsletter supplement provides an update.



NAP4 was launched earlier this year by Drs Cook, Woodall and Frerk and accompanied by editorials in both the main anaesthetic journals, *BJA* and *Anaesthesia*. Containing important messages, it is now incumbent upon specialist societies, Trusts and individual anaesthetists (led, we hope by active members of DAS) to implement its recommendations. So NAP4 is far from being a ‘closed’ DAS project – its true success will be measured by how effectively its recommendations are implemented. Nick Woodall reports on the next page.

ADEPT: DAS’ guidance to members on the purchase of airway equipment has been published in *Anaesthesia* (accompanied by an editorial) and this policy is being disseminated to industry, Trusts and individual anaesthetists alike. Dr Pandit will make this a main focus of his lecture at Nottingham and readers are also asked to watch developments on the DAS website that incorporate many of ADEPT’s recommendations. Want to be involved—see the job adverts on pages 16-18.

Anaesthesia Airway Supplement: a special supplement of *Anaesthesia* is planned for later this year. Guest-edited by Drs Pandit and Cook with >30 international contributors, it will contain much of value to DAS members and the articles will likely echo many of the conclusions of NAP4 and ADEPT.

iDAS: has been downloaded by many times. See the figures on page 13

ADAM: The project team was successful in its application for £10,000 of DAS grant funding offered in the 2010 NIAA grant round. See the report on page 15.

SMART course: Ravi Dravid reports on Page 7

NIAA: DAS Multi-centre grant: DAS sponsored a consortium of 7 centres in application for the recently-advertised £750K NIAA-RCA multi-centre grant. There were a total of 6 applications from across the subspecialties and 5 (including ours) were shortlisted to a second round. However, after considerable paperwork and effort on the part of all applicants, the NIAA decided not to make any awards. Nonetheless, DAS considers the application sufficiently robust as to submit the proposal for funding elsewhere. DAS continues to be an active participant in NIAA through regular offers for grant funding and has a seat on NIAA Research Council.

Guidelines: Three sets of guidelines are being actively developed at present. The **Extubation Guidelines** are provisionally accepted– read the report on page 12

The **Paediatric Difficult Airway Guidelines** are under development see page 11

The **Tracheostomy Guidelines** are led by Dr McGrath in Manchester and consist of a multi-disciplinary team (with DAS representation). See page 9.

Finally, the original DAS **Intubation Guidelines** need revision/update and a committee is being formed to oversee this.

Dr Jaideep J Pandit
Consultant Anaesthetist, Oxford
DAS Scientific Officer

NAP4 Unfinished business.



The papers have been written, and the report is available on-line, as are the PowerPoint presentations from the RCoA launch, along with the podcasts which were beautifully prepared by our colleagues in Leeds. Editorials in the BJA and in Anaesthesia followed the NAP4 report and presentations have been given by review panel members up and down the country. Much has been done to reveal the findings of NAP4 but we are left to wonder will anything change? Some individuals may discount the scientific basis for NAP4 as weak, amounting to a series of case reports with informed opinion but this response should not be accepted as an excuse for inaction. Examination of adverse events is central to the investigation of rare and unusual disasters in other industries. NAP4 data were carefully collected and cautiously reviewed, the information provided on current airway management and how to tackle the problems in the UK is as good as we are likely to be able to achieve now or in the foreseeable future.

The output of NAP4 has been voluminous and daunting, the report runs to over 200 pages and contains more than 160 recommendations. The NAP4 report should be used as a tool to empower anaesthetists to make the changes we need to help us to provide better care for our patients. The recommendations are conveniently grouped together and presented in appendix 5 at the end of the report. They are downloadable separately from the DAS web-site and are intended to be easily accessible so that all groups can use them to improve airway management. Action is required at a number of levels throughout the NHS, at an individual level, departmental level, Trust level, and nationally.

Individual actions

What can be done at an individual level? A thorough personal assessment and review of the recommendations is a useful exercise, this may identify individual deficiencies of knowledge. NAP4 panel members found the review process to be highly educational as we learned from each other. Most anaesthetists will learn something new simply by reviewing the recommendations. Furthermore examination of the recom-

mendations will provide the stimulus to reflect on the training given to ODPs, nursing staff, or trainee anaesthetists. Organisational deficiencies such as absent equipment, unsafe staffing levels or inadequate admission practices may be identified, these will need to be raised at a departmental or Trust management level.

Departmental Actions

The necessary changes for the application of NAP4 recommendations fall largely at a departmental level. The identification and appointment of an airway lead anaesthetist with the role of implementing the NAP4 findings would make this process easier by providing authority and a point of reference. It is likely many DAS members will take up this role but in the absence of such an appointment responsibility for responding to the challenges of NAP4 will lie with the chairman or lead anaesthetist. The selection and provision of training in the use of equipment to be deployed on airway trolleys throughout the hospital is a vital responsibility. Many of the specific recommendations (on airway assessment, or assessment of aspiration risk for example) could be incorporated into, or form the basis of local guidelines.

Trust level actions

The RCoA President, Dr Peter Nightingale wrote to all UK Hospital Trust chief executives and informed them of the NAP4 report. There can be no doubt that senior Trust management will be interested in improving patient safety and to this end it might be anticipated that senior management will evaluate the level of preparedness within their Trust to manage these events. Nevertheless changes in staffing levels, additional equipment such as capnography, the introduction of multidisciplinary training and the development of safer pathways for patients with morbid obesity or airway obstruction may all have significant financial and organisational implications. The Trust senior management need to be kept informed of what is needed to meet the recommendations of the report.

National organisations

The Difficult Airway Society has a vital role to play at a national level to improve patient safety. The development of guidelines in the management of anticipated difficulty with tracheal intubation has made a huge contribution to airway management in the UK. It is likely that the extubation guidelines will be similarly useful. It would simplify the responsibilities of departments of anaesthesia if further national standards and guidelines were available (on airway assessment, and assessment of aspiration risk for example) these could then be adopted or modified to suit the needs of individual departments. If a core set of techniques and airway devices to be deployed could be agreed nationally, this would greatly improve ease of training, maintenance of skills and patient safety, particularly where anaesthetists move between hospitals. National training courses might then be developed for the equipment selected and training could subsequently be devolved to a local level. However the contents of

airway trolleys need to be selected based on guidelines for the management of the most common airway problems at the start and at the end of anaesthesia, in ICU and in the Emergency Department.

The role of DAS goes further, in future the selection of devices may be aided by ADEPT and national bodies such as DAS and the RCoA can direct research into safer airway management techniques and devices as highlighted by the report.

Airway management in the ED and ICU were notable in NAP4 as particularly high risk. This document is not the place to re-iterate those at length but issues of staffing, staff training, standardised equipment, anaesthetic assistance, development and implementation of standard operating procedures +/- checklists and interdepartmental liaison are all issues raised by NAP4 for these areas. It *is* worth re-iterating that capnography, should now be available and used for intubation of all critically ill patients irrespective of where that procedure takes place.

It is clear that there is still much to do, NAP4 is very much a work in progress.

NW

SMART Anaesthesia Course

Only a few of adverse events that occur in the operating room are associated with technical error. Human error accounts for up to 80% of accidents in anaesthesia. This could happen to the ‘most experienced’ and ‘good doctors’ due to inadequate non-technical skills (NTS) such as communication, team working, leadership, situation awareness and decision making.



A theatre team with awareness of pre-designated roles is better equipped and more effective in managing airway crisis, which lead to the conceptualisation of SMART (Structured Management Airway Response Team). Although recognised that “most (medical) care delivered today is done by teams of people / professionals working in increasingly complex environment and situations, the training often remains focussed on individual responsibilities, leaving practitioners inadequately equipped to enter these complex settings. ...the ‘silos’ created through training and organisation of care impede safety improvements. NAP4 has highlighted these issues in a chapter dedicated to Human Factors.

DAS difficult airway guidelines (2004) changed the landscape of airway training in the UK. Many courses are available in the country which focus on teaching anaesthetists the technical skills (TECHS) of airway management. Anaesthetists are highly skilled and confident in these skills and yet mistakes happen. Even experienced anaesthetists find it challenging to draw on this technical expertise, get structured / effective help/contribution from their team and take appropriate decisions when faced with airway difficulty.

DAS has been smart in recognising these major issues of NTS deficiency and ‘compartmentalisation’ of training being provided to anaesthetists only. It therefore initiated efforts to integrate TECHS and NTS and provide training to ‘teams’. The ethos: “train together those who work together”. SMART Anaesthesia course was envisaged to address above issues.

The course consists of interactive classroom based teaching of Human Factors by Ex-aviation faculty who give an insight into its development and integration into aviation and a provocative and interactive discussion into its role and adaptation to healthcare. Technical airway workstation provides an opportunity to practice DAS difficult intubation guidelines skills and their integration with NTS as a team. Practical stations/modules then provide an opportunity to the delegate teams to practice NTS techniques and participate in a difficult airway scenario on simulator. There is particular emphasis on developing ‘behaviours’ aimed at *‘error avoidance and how not to get into a crisis’*.

Nine courses have been conducted to date in Oxford, Coventry, Bangor and Medway, Kent with the intention of making the course easily accessible in different regions. Simulation facilities and local coordinator involvement and support is integral to it. In total, 216 delegates (108 anaesthetist-ODP teams) have attended the courses. Special invitees and observers are included on the course for feedback and comments. All the lectures were marked individually for their content, presentation and relevance on a scale of 1 (lowest) to 5 (highest). All the lectures consistently scored >80% for content, presentation and relevance. Delegates consistently reported high scores (>75%) for briefing, simulator and debriefing workshops. They also overwhelmingly supported concept of training in technical + SMART + non technical skills. It also revealed differences in various hospitals regarding training (or lack of it) of anaesthetic staff and the rest of theatre staff in management of an airway emergency. There is a lack of uniform availability of DAS algorithm training even for anaesthetists (including consultants) and they felt technical stations in the form of series of plans – what to do next was crucial. ODPs felt they got a clear idea of how DAS algorithm should work so they could effectively help / felt empowered to challenge the anaesthetist if needed.

The Course has been successful in promoting the concept of ‘team building, team working and effective role delegation’ within operating theatre teams to enhance patient safety in case of an airway emergency. We have formally evaluated the course with pre and post-course questionnaires to see if the NTS learning objectives have been achieved at the end of the course. A significant change has been noticed in NTS behaviours at the end of the course. A positive significant change has also been observed in participants’ attitudes to simulator training.

The SMART protocol provides a clinical model in airway management which integrates both TECHS (of DAS intubation guidelines) and NTS. SMART Anaesthesia course provides training to team in these skills and may improve ‘error avoidance and crisis management’ and thus patient safety.

RD

National Tracheostomy Safety Project

A multi-disciplinary initiative improving the management of routine and emergency care for patients with tracheostomies and laryngectomies. The project was prompted by local and national reviews of tracheostomy critical incidents in critical care and on hospital wards, working with the NPSA. Recurrent themes were identified including equipment, staff training and infrastructure deficiencies. In response we devised the following:



- Emergency algorithms to manage tracheostomy & laryngectomy emergencies

- Bedhead signs detailing essential information about the patients' airway

- Supported these innovations with a comprehensive web-based resource. The resource includes hyper-links to videos and animations describing important aspects of routine and emergency care along with draft policies and competencies.

Since the publication of NAP4, the need for these resources has been further highlighted, in critical care, anaesthesia and beyond.

This is the first comprehensive resource aimed at tracheostomy/laryngectomy management. We have collaborated with key national stakeholders to develop consensus guidelines for the first time, involving DAS, the RCoA, ICS, ENT UK, BAOMS, RCN, CSP, CEM, RCSLT, the Resuscitation Council UK and patient groups. The resources we have developed put together the different pieces of the jigsaw that exist around the multidisciplinary care of these patients. Instead of reading text though, the resources are web-based and include links to videos, animations and demonstrations of the key elements of emergency and routine care. On-line resources can be freely accessed by nursing, medical and allied health staff at the bedside. Update of the website with smartphone apps and YouTube videos are currently underway.

We have demonstrated that the resources are practical to teach and implement and can improve safety of this vulnerable patient group. The teaching resources are all housed on our website and are freely available to use.

Other initiatives include cohorting patients with tracheostomies or laryngectomies in defined clinical areas together with ensuring that essential equipment is both standardized and immediately available at the bedside. This ensures staff are trained and equipped to safely manage routine care and deal with emergencies. We have also worked with industry to start to agree standards for colours and types of speaking valves, cuffs and inner tubes. Future research is required to identify the best types and dimensions of tracheostomy tubes and how the clinician at the bedside can be informed as to which tube to choose – another area in which we have been able to challenge and feedback to industry.

We have finalized the algorithms after a huge collaborative effort, incorporating the views of the stakeholder committees, national and international experts, DAS mem-

bers and open feedback via the ICS, DAS and our own website. We expect these to be published shortly (and they are currently available on the web).

This Summer has also been spent designing 3 e-learning for health modules through the RCoA's e-LA initiative. These will shortly be available to update your tracheostomy related CPD and describe in detail the anatomy, physiology, problems and routine and emergency management of tracheostomy and laryngectomy patients.

The project is truly multidisciplinary and brings together a wide range of people from different backgrounds with an interest in airway and tracheostomy management: For example, we have recently started developing resources specifically for the paediatric tracheostomy patient in partnership with colleagues at Great Ormond Street Hospital. If you want to get involved, have something to share or want to use any of our resources, go to www.tracheostomy.org.uk

BMcG

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NOTTINGHAM?
IN 2012
DAS GOES
TO
CARDIFF
PUT THE DATES IN YOUR DIARY NOW
21ST -23RD NOVEMBER 2012**

APA/DAS Paediatric Difficult Airway Guidelines



On behalf of APA/DAS Paediatric Airway Guidelines Group

Unexpected airway difficulties in paediatric patients are rare and many departments have developed their own guidelines, mainly based on the adult guidelines but a nationally agreed guideline would be useful. With the support of the APA and DAS a group was set up to develop a national guideline some three years ago. The group: Drs Ann Black (Chair), Paul Flynn, Helen Smith, Mark Thomas, Kathy Wilkinson and Mansukh Popat (DAS).

Currently available international paediatric airway management guidelines were formally evaluated using the AGREE guidelines evaluation process ⁽¹⁾. As there is limited evidence based data available from published paediatric airway research the Delphi methodology was used to gain consensus opinions on which to develop the guidelines. A panel of volunteer paediatric anaesthetists agreed to assist in the development. E mail links to a web based survey using QuestionPro were used. Three Delphi rounds were completed. Consensus was sought for each step of the guideline. Results were analysed and a consensus level of 70% was accepted as evidence of agreement for or against each question. Areas of agreement were acknowledged and used in the guideline. Areas of contention or disagreement were further scrutinised by a second expert panel made up of a volunteer group of paediatric experts and the results of this review were incorporated into the respective guidelines. Using this information three flow charts were developed as follows:

- **Difficult mask ventilation in a child aged 1-8 years.**
- **Unanticipated difficult intubation during routine induction of anaesthesia in a child aged 1-8 years.**
- **Failure to intubate and failure to adequately ventilate in a paralysed, anaesthetised child aged 1-8 years.**

The draft guideline flowcharts were displayed on the APA website for wider consultation. Anaesthetists, who do not have a regular paediatric practice, nevertheless need to maintain their skills in paediatric airway management. We hope that by developing specific, evidence based guidelines we will enhance this area of anaesthetic care. We hope to publish the guidelines soon.

MP

Reference: 1. AGREE Collaboration 2011 www.agreetrust.org

Extubation Guidelines

Difficult intubation is widely discussed by anaesthetists and appears in every training syllabus and textbook. The DAS difficult intubation guidelines introduced into clinical practice in 2004 have been widely adopted by UK anaesthetists and have set standards for good clinical practice. Extubation, an equally important and risky aspect of anaesthesia has been overlooked. The subject has been addressed in some International airway guidelines, and in a small number of textbooks but has not had the same attention as difficult intubation, the Royal College of Anaesthetists Syllabus contains very little on extubation. Several studies, most recently NAP4 have highlighted extubation as a high risk phase of anaesthesia.

The DAS extubation group was formed in 2007 in order to produce guidelines on behalf of the society. The group was composed of Dr Mansukh Popat, Dr Ravi Dravid, Dr Viki Mitchell, Dr Anil Patel, Dr Andy Higgs and myself, at that time I was the airway fellow at University College London Hospital

We carried out an English Language literature search in order to determine the evidence base for the guidelines. The initial search yielded 6215 articles of which 327 were considered relevant. These were categorised according to the Oxford Centre for Evidence Based Medicine criteria and all articles were forwarded to all members of the group. There was a lack of high grade scientific evidence; the majority of the papers were case reports, case series or smaller randomised control trials. This was discussed at the DAS Annual General meetings in 2008 and 2009 and a decision was made to write simple, practical guidelines that were of use in daily practice.

During our initial meetings each member was allocated a section to write. Prior to the next meeting those sections were reviewed by each of us individually and then any changes were made to the master document as a group. The initial structure of the guidelines, including the algorithms was determined after much debate and reflection by the group. The article was then refined over a four year period until we felt we had something that we could submit to our expert panel for their opinion. Each suggestion, modification or correction was considered and if appropriate, incorporated into the document. The algorithms were put on the DAS website for members to comment upon before the finalisation. Even a few weeks prior to submitting the article fundamental changes were made. The article was then submitted to “Anaesthesia” for publication and it has now been provisionally accepted.

Currently there are no international guidelines focusing solely on the process of extubation. Following the publication of the ASA guidelines for the management of the difficult airway there was a significant reduction in the incidence of claims relating to injury at the induction of anaesthesia. We hope that our guidelines will

help to reduce to incidence of problems at the extubation phase by providing a framework around which extubation can be carried out and taught. We have tried to emulate the simple stepwise approach which has worked so well with previous DAS guidelines. These guidelines are not intended to be a didactic approach to this subject but are simply there to provide information and guidance and to encourage anaesthetists to plan the process of extubation.

Christene Swampillai on behalf of the DAS extubation Group
 Clinical Fellow in Patient Safety and Anaesthesia
 The Royal Marsden NHS Foundation Trust

iDAS

iDAS has been provided by the company iMobileMedic. By August 2011 4130 different devices had accessed the server (3491 of which since January).

Of these 2403 have registered (1535 since January)

We are hoping to be able to bring you breaking news about the availability of a version on the android platform during the ASM.

value	count(value)
United Kingdom	1587
Australia	296
New Zealand	66
Other - Asia	61
USA	45
Other - South America	37
Other - Europe	36
Republic Of Ireland	33
Germany	32
Denmark	31
Spain	28
India	23
Canada	18
South Africa	16
Portugal	15
Italy	13
Netherlands	12
Other - North America	11
China	7
Other - Africa	6
France	5
Sweden	5
Norway	5
Japan	4
Hungary	3
Austria	3
Other - Australian Continent	2
Belgium	2
Luxembourg	1
Pakistan	1

Videolaryngoscopy Project

Videoscopes; you either love ‘em (and you’re a DAS member) or you can’t work out what all the fuss is about cos you’ve got a strong left arm (and perhaps a failing memory!)



There’s lots of papers out there about videoscopes and October’s “Anaesthesia” has an editorial from Ahmed Nusrath on the subject, meanwhile in the background the DAS videolaryngoscopy project has been collating data from a number of anaesthetists who are using these devices regularly, both in their own practice and for teaching colleagues. There’s a poster at this year’s DAS conference in Nottingham showing the results of the project to date and without reproducing it here what can I tell you?

First off, in terms of data collection we’ve learnt a lot which will help us in the future and so far, clinically, interestingly there’s not obviously a great deal of difference in performance of the various scopes being used in terms of median time to intubation. There are small differences in overall success rates and “reasons for failure” between the different manufacturers’ scopes and we’ve gathered together a summary of useful tips and hints from the clinicians who have contributed to the site available in the form of a “user guide” on the website www.videoscope.das.uk.com. We hope this will help future users shorten their learning curves (whilst not negating the need for formal instruction in the necessary techniques).

Where Next? We hope to trap Jaideep Pandit in a corner at the DAS meeting and find out how we can best collaborate in the light of the ADEPT report to provide more robust evidence to support clinicians in their choice of videolaryngoscope, the data collection system (devised by Dr Simon Scott) evidently works well, we need to maintain the enthusiasm of the anaesthetists who have contributed data to date, we need to formulate the right questions to ask next about videolaryngoscopy and also recruit new colleagues to help us find out the answers.... in the real world.

Look out for us as you saunter round the poster exhibition in Nottingham and come and say hello – we look forward to seeing you there.

Chris Frerk/ Simon Scott

ADAM <http://adam.liv.ac.uk>



The ADAM website went live 9th May 2009. All applications are checked for professional standing and there are currently nearly 450 registrants from a total of 22 countries. Up to 18th September 2011 the website had had >4,000 unique IP visitors and an average of 6 visitors per day. The server is maintained by the University of Liverpool and I know of only one serious shut down – last weekend (7-8th October) when most of the university servers were down for 12-18 hours.

The DAS grant (£4,000) has helped to bring on Version 2 of the website which was released on 18th September 2011. DAS had requested the possibility to include reports of cases where no difficulty had been anticipated and council has approved a local initiative by Dr Seema Charters to initiate an “ADAM Airway Alert Card”. This is an attempt to pass on information to other anaesthetists firstly by issuing the patient with a card which records the data currently on the DAS website but, with the patient’s consent allows more details to be made available to the ADAM website which can be looked up by an anaesthetist on the website using the number on the ADAM Airway Alert Card.

In response to user requests the “Devices” presented as alternative managements for any patient or test case can be customised to what the user has in the local hospital. A number of new “Scenarios” have been added and “Surgical Tracheostomy under LA” has also been incorporated as a full management option which may be of interest to surgical trainees.

The patient information side of the website has been extended slightly but as there is so little information for patients we plan to take this further working with our senior Head and Neck cancer nursing staff.

An airway wiki is at a late stage of development and it was hoped to release this at the same time as version 2 of ADAM. Once a security issue is dealt with this should be fully implemented prior to the DAS meeting in Nottingham. This will be in two parts – an airway wiki proper for all things airway and a manual for users of the ADAM website. We were very aware in releasing the ADAM website that it was ideally suited for people attending one of our ADAM workshop courses. The manual should therefore go some way to providing additional information that the website on its own lacks.

“Wikitext” is the “Word” text processor equivalent used in wikis. Although this is not necessarily intuitive there should be enough help for anyone interested in contributing to the wiki rather than just reading it as most folk do on Wikipedia! Once the wiki is under way we plan to then release a blog site to complement both ADAM and the AdamWiki.

PC, PG and the ADAM Team

CALL FOR DAS 'ADEPT OFFICER'

ADEPT Guidance from DAS-

The minimum evidence required to select or purchase airway-related equipment

A paper in Anaesthesia [<http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2044.2011.06787.x/full>] describes the conclusions of the Difficult Airway Society's Airway Device Evaluation Project Team (ADEPT), to establish a process by which the airway-management community within the profession could itself lead a process of formal device/equipment evaluation.

The full paper describes how widespread adoption of this professional standard can act as a driver to create an infrastructure in which the required evidence can be obtained.

In order to implement the DAS ADEPT policy, DAS Committee wishes to appoint an ADEPT Officer for an initial term of 1 year, renewable on an annual basis. The duties of the role and person specification are set out below.

DUTIES

1. To work with and assist the DAS Scientific Officer (currently Dr Jaideep J Pandit) and focus on developing the ADEPT strategy for airway device evaluation;
2. To foster and create links with industry to promote the funded trialling the airway related devices;
3. To maintain the ADEPT part of the DAS website, which will include the update of evidence supporting the devices listed and updating the information received from DAS Device Feedback Forms [[link](#)];
4. To maintain a register of Local ADEPT Leads and to assist them in the design and start-up of industry-sponsored clinical trials
5. To help develop templates for ethics forms, trial registration and costings;
6. Strategic development and refinement of the ADEPT policy;
7. Where required, reporting to DAS Committee and to DAS AGM.

Although there are no additional PAs for this role, DAS would expect that this activity can be justified within the typical allowance for 2.5 SPAs as exists within the 2003 Consultant Contract, and DAS is prepared to write to Trusts in support of this.

To apply for this role, please send a **full CV and a maximum 2-page cover letter** outlining your qualifications for the post and how you see ADEPT developing to **adept@das.uk.com**

Specification	Essential	Desirable
Substantive consultant anaesthetist	✓	
Member of DAS	✓	
Evidence of published research in airway management	✓	
Experience of clinical trial of an airway device	✓	
Experience of completing an ethics form	✓	
Excellent communication and interpersonal skills	✓	
Wordprocessing and skills, IT and website management	✓	
Experience of fundraising, applying for or managing a grant		✓
Awareness of key strategic reports in academic anaesthesia and of relevant publications in airway research strategy	✓	

ADEPT Officer Criteria

*The preliminary closing date will be the 31st January 2012
For informal discussions please email adept@das.uk.com*

CALL FOR LOCAL ‘ADEPT LEADS’

ADEPT Guidance from DAS- The minimum evidence required to select or purchase airway-related equipment

A paper in *Anaesthesia* [<http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2044.2011.06787.x/full>] describes the conclusions of the Difficult Airway Society’s Airway Device Evaluation Project Team (ADEPT), to establish a process by which the airway-management community within the profession could itself lead a process of formal device/equipment evaluation.

The full paper describes how widespread adoption of this professional standard can act as a driver to create an infrastructure in which the required evidence can be obtained.

One important recommendation was that, when Trusts make their purchasing decision(s), they feedback to DAS to enable us to develop a database of decisions and the evidence upon which they were made. This will form a useful and growing resource for others faced with similar decisions.

DAS is now calling on its members to volunteer as an ‘ADEPT Lead’ for their Trust. Ideally we would like each Trust to have an ADEPT Lead.

The role and duties of the Lead will be:

1. To act as the primary point of contact for communication about matters relating to the ADEPT project and airway device evaluation
2. To feed back information on local device purchasing decisions to DAS on the DAS feedback form [*see the DAS Website*]
3. To lead a local team of interested consultants to form a ‘research unit’ that can become involved in the clinical trials of airway devices. This will in turn involve (with DAS support and guidance) the design of a clinical trial in partnership with industry, the completion of relevant ethics forms, trial registration, calculating relevant costs and managing the funding with DAS.

Although there are no additional PAs for this role, DAS would expect that this activity can be justified within the typical allowance for 2.5 SPAs as exists within the 2003 Consultant Contract, and DAS is prepared to write to Trusts in support of this.

To register as a local ADEPT Lead please email your details to adept@das.uk.com

Note: all registrants must be substantive consultant anaesthetists
Only one registrant per Trust

Difficult Airway Society Annual General Meeting

3rd November 2011 17:00 Nottingham

Agenda

- 1 Apologies
- 2 Minutes of the AGM held in Cheltenham on 25th November 2010 for approval
- 3 Matters arising from minutes
- 4 Honorary President's report – Dr Ellen O'Sullivan
- 5 Honorary Secretary's Report – Dr Atul Kapila
- 6 Honorary Treasurer's Report – Dr Peter Groom
- 7 Constitutional changes
- 8 DAS Newsletter – Dr Alistair McNarry
- 9 Nominations for DAS medal
- 10 Future Meetings

2012: Cardiff - Dr Iljaz Hodzovic

2013: Wexham Park/Slough - Drs Jairaj Rangasami / Mridula Rai

2014: Coventry - Dr Subrahmanyam Radhakrishna

2015: DAS 20th Anniversary Meeting (venue TBA)

- joint meeting with society abroad - Dr Bernie Liban

- 11 ACCEA awards
- 12 Election of honorary treasurer
- 13 Any other business
- 14 Date of next meeting
- 15 AOCB



C-MAC® from KARL STORZ

More than a Videolaryngoscope: this is the end of a standalone philosophy



Welcome to the C-MAC® system which keeps evolving and moving forward.

The C-MAC® family now has new tools for airway management;

- MACINTOSH blades
- D-BLADE for the difficult airway
- Neonate and Paediatric MILLER blade
- C-CAM™ for the use with intubation fibrescopes
- C-HUB™ for use with patient monitors, large flat screens and Laptops
- New add-on devices are currently in development

***The Videolaryngoscope on its own does not manage the difficult airway.
We understand what airway management means.***

Should you require further information, an evaluation trial or a presentation please contact Steve Guerrini, Anaesthetic Business Manager, KARL STORZ Endoscopy UK Ltd. Head Office: 01753 503500 Mobile: 07771773603 email: sguerrini@karlstorz-uk.com

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