# OMFS Top Tips 2019 – new top tips on page 3

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## Contents

## Why do we need to keep a logbook? (Griffiths, G et al Bulletin of the RCS Edin)

- Competence in a procedure does not confirm that a trainee can manage all clinical presentations in which that procedure is indicated
- EXPERIENCE is therefore a core component in determining readiness for independent practice
- Logbook and indicative numbers are a surrogate for experience
- Experience is a stick to lean on when encountering unusual cases
- Flying hours in aviation is probably not an unreasonable analogy

A logbook is therefore a means of demonstrating that you have experience.  It is imperative that logbooks are an honest account of your operative experience.  Overall competence is assessed based on your practice as observed by your supervisors, but that is informed by the amount of exposure you have had.  So, if your logbook shows a large number of procedures, a supervisor will assess your surgical competence with this is mind.  Thus if you have entered operations as having been completed by you but actually you had a small part of play there is a risk that you will appear less competent for your level of experience than is actually the case.

A logbook that shows evidence of exposure to all areas of the curriculum is a means of demonstrating that you have experience of the WHOLE breadth of the specialty of OMFS – work with your TPD/supervisor to ensure this happens.

**Logbooks are a powerful tool for trainees to ensure they gain exposure to procedures so they can develop their surgical skill.**

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# Top Tips for 2019

I will add a new top-tip with each edition of these notes. If you have read the previous versions, you only need to read this update. That said, you should probably have a look all the way through.

## Validation of logbooks still recommended but no longer officially required

Whilst this is the official stance of the JCST after long and difficult debate curricula and requirements are shifting all the time.  A validated logbook might be something  you require for future hospital roles/private practice so the SAC in OMFS strongly recommends that you validate all entries with your supervisor in real time.

## Change in SAC codes for Orthognathic Surgery – Again

### Assisting

If you only assist an orthognathic procedure you put in the procedure code for the bits of the operation you assisted on. Assists do not count toward indicative numbers.

### Performed

This is the highest level of participation e.g. one side of a sag split or undertaking more than 75% of a maxilla. If you perform both sides of a sagittal split, this counts as one procedure only. However, it may then be appropriate for you to also add an SAC extra-code as lead surgeon. You should, of course, always add the Extra-Code either way.

### SAC Extra-codes for Orthognathic Surgery

These SAC 'extra-codes' are IN ADDITION to the procedure code and give those assessing your training an indication of leadership role in the operation. Senior trainees will have a lot of cases which could be retrospectively updated. ***If you have only used the SAC extra code, you should make sure there are procedure codes to go with this extra code.***

**If you only observe or assist, do not use the 'SAC extra-codes'**.  Just detail the operation, and select assist/observe. All surgical activity which is not assisting or 'partial', should be coded twice with the original procedure codes, and the SAC extra-code.

The SAC is no longer concerned about lead surgeons or second surgeon categories. However because there is no code within the eLogbook for a Bimaxillary osteotomy, to record a Bimax you need to include this code with the individual codes for mandible and maxillary procedures. For a maxilla only or mandible only case, add the single jaw SAC code.

*What happens to my previous SAC lead and second surgeon codes?*
Don't worry, these will be converted to Bimax and single jaw codes.

## New Codes added

There a number of new codes added in the last 12 months. Platelet rich plasma (PRP) in the Oral Surgery – Other sub-section, internal mammary artery perforator flap in Free Flaps, codes for severe facial wounds, debridement for MRONJ and others. These have been suggested by trainees and consultants.

BEFORE YOU SUGGEST A NEW CODE – please have a good look and use the search function. About 3 out of 4 requests for new codes are people asking for codes to be added that are already there.

## Introduction

The eLogbook is the official logbook for OMFS training in the UK. Using it carefully and efficiently will document your training experience.

## Official eLogbook Link on ISCP does not work effectively - you must upload PDF reports

The eLogbook does not link easily to ISCP. The logbook tab shows a simple list of all your procedures in numerical order. This is impractical to use for the ARCP panel including the SAC Liaison Member.

This is why you must upload an SAC summary and Grouped Report for each of your training rotations/blocks, for each year of your training and one for your total ST training to date. You might want to also include a total logbook (including experience outside ST training) but make sure this is marked as such. There is detailed advice about this elsewhere in this document.

Please **contact me if you have any problems.**

## Logbook Trainee Representative - Contact Me If You Are Interested

**If there** are any trainees interested in becoming an eLogbook trainee rep, I am always much happier to assemble a team rather than work on my own.

## What should I do when I start my ST post?

### Check your profile – make sure you are verified as an OMFS trainee (by your TPD or me)?

If you are not a verified OMFS trainee, your TPD will not be able to view your eLogbook records. Check your profile tonight.

### Find out and set-up all my trainers with the official training rotation trainer password

If there is not one yet, you should make it so.

### Get into the habit of recording your eLogbook records as they happen

Op note and eLogbook go together like a horse and carriage (ask Frank Sinatra and Cole Porter).

## What should I upload onto ISCP?

The eLogbook does not speak to ISCP. There is what appears to be a link, but it is useless. This lack of facility is unlikely to change. So you need to actively upload reports to document your training.

### SAC Summary Report and a Group Report for your total SpR training

Make sure you enter the start date of your training to filter out your pre-ST experience.

### SAC and Group Reports for previous 12 months (and each complete year of training).

ARCP is an annual review. It is useful for the panel to see the activity recorded in your previous year.

### Keep your eLogbook up-to-date

Some Liaison Members will generate an eLogbook report for the month prior to your ARCP - to see if you are keeping a contemporaneous record. If this report is blank (and you have not been on leave), it looks very bad.

### SAC and Group Summary for Each Training Rotation

At the end of each block/rotation, you should upload an SAC summary and grouped summary report for that block. Before your ARCP, you should also upload the same two summaries for the preceding year, and for your total training to date. This should go into the additional evidence part of ISCP.

Use the Pre-ARCP and Pre-CCT checklist to remind you to upload the correct data.

### Give your reports a clear file name and heading on ISCP

These reports are much easier to review if they have a name which makes their contents clear. A good example of names would be:

SAC Summary 2015-2017 - All ST training to date.

Group Report 2017 - Activity Since last ARCP

SAC Summary - 6 months trauma block St X DGH Jan-July 2017

Bad names I have seen include

eLogbook Report

Last rotation

Blank i.e. no reports uploaded at all = ARCP 5

### Percentage Validated On-Line

This is a quality indicator for your logbook. If some trainers are not validating your records, it will often be obvious on your training rotation reports. See top tips and below for strategies to improve your eLogbook validation.

### Upload Clearly Labelled SAC and Group Summaries of your Pre-ST Experience

Officially the GMC says you cannot use experience prior to your ST training towards your indicative numbers or as evidence of training. However, the OMFS SAC and ARCP panels are more pragmatic. If you have good WBA evidence during your ST training and lots of eLogbook records prior to ST (especially if supported by WBAs or letters from trainers during this period), then this may be considered by the panel. Of course, it will help if all your eLogbook records are validated.

## How much do I have to do for it to count as a procedure I have performed.

The general guidance is >70% but this does beg the question, what is 70% of a neck dissection? Common sense, and getting your trainer to advise you in theatre before you create an entry in the eLogbook is my advice.

## Upload Correct Reports onto ISCP Or Risk an ARCP Outcome 5 (or worse!)

The Gold Guide says at the bottom of page 56

*ARCP: Collecting the evidence*

*7.44 HEE, NES, the Wales Deanery and NIMDTA will make local arrangements to receive the educational portfolio from trainees, and they will give them and their trainers at least six weeks' notice of the date by which it is required so that trainees can obtain all necessary components. **The educational portfolio must be made available to HEE, NES, the Wales Deanery or NIMDTA at least two weeks before the date of the ARCP (my bold).***

The eLogbook reports, detailed later in this Handbook, are key pieces of evidence in your ARCP. If you do not upload the appropriate reports (in nature, number and level of validation) then your portfolio may be viewed as incomplete.

Do not take this risk. Make sure your eLogbook evidence on ISCP is complete, up-to-date, validated and correctly labelled.

## Penultimate Year and CCT Checklists - Indicative Numbers

From the first year of your training, you should be aware of the indicative numbers. Each year, with your AES, you should track your trajectory. The penultimate year checklist is an important way-marker towards your CCT. Indicative numbers are not mandated, but rather are viewed in the context of other documentation of training. When you completed your Penultimate Year and Pre-CCT self-assessments, where you are low against indicative numbers you should discuss this at the earliest opportunity with your AES (and possibly your TPD). The SAC stresses that indictive numbers are 'indicative' and if your numbers are low you should ensure you have Workplace Based Assessments (PBAs, DOPS) at an appropriate level, and note low numbers and the dates and level of these on your checklist so they can be reviewed by your Liaison Member/TPD.

## If you follow our advice and wish to validate your logbook the following advice is offered - Use a Common Trainer Password in your region

If all the trainees in a training rotation use an agreed trainer password, it makes validation of the eLogbook record much easier. Pick and agree a password. A short, simple password is fine - the purpose of this password it to stop patient details being sent to someone not involved in the case (when a trainee clicks the wrong trainer name). As the wrong trainer will not know the agreed regional password, there will be no compromise of patient data. Make sure new SpRs and DCTs know the agreed password.

## Validation

The OMFS SAC still recommends that you should have your eLogbook records validated contemporaneously. The easiest way is to enter your data whilst the list is taking place, and have your trainer validate them before they leave the room. Adding to your eLogbook contemporaneously avoids losing records and having them validated contemporaneously avoids the risk of your trainer not being able to remember the operation and not validating it. An accurate logbook is essential for your ARCP or CCT. SO THIS IS SERIOUS.

A top tip, from the Liverpool trainees, is to agree within a region your trainer password and keep it constant across all training grades (ST DCT Fellows). This does not put your eLogbook data at risk, as a trainer will only gain access to activity allocated to them.

On your eLogbook reports the number of validated records will be displayed, so please do not leave this until the last minute.

## Help your trainers use validation to populate their eLogbook

If, when your trainers validate your activity, if you encourage them to use 'copy and validate', the process will populate their own eLogbook. This will give them documentation for their annual appraisal.

### When is the best time to add eLogbook Records? In theatre

The evidence from other specialties is that, if you don't add to your eLogbook whilst you are in theatre, you will fail to record between 5% and 30% of your actual experience.

Sometime it is not possible to get access to the eLogbook on hospital computers. With ISCP, GMC and BNF, the eLogbook should be accessible from every workstation in your hospital. I am very happy to liaise with your hospital IT department if they are reluctant to co-operate.

## Sub-specialty Specific Advice

### Skin Surgery

Thanks to the trainee who pointed the lack of clarity on these codes out to me.

*Excision and Primary Closure*
If you do a simple excision and primary closure, you can pick this as a single code and the procedure will be added to your indicative numbers in both the excision AND the primary closure. So it will be a single code in your total logbook, but will be counted twice in your indicative numbers.

*For all other skin operations code the excision and the closure separately*
So you code excision and flap closure, or excision and skin graft. Use the 'another procedure on the same patient' button to do this without re-entering patient data.

*Can I add two codes one for Simple Excision and the other for primary closure?*
Yes, of course. Either do this as two codes (each of which will be added to their appropriate accumulator) or, as mentioned above, use the double code excision & primary closure.

*What should I do if I have only used one code for these procedures (either the excision code or the primary closure code but not both?*
Don't worry too much, unless your numbers are low because of this hiccup. If they are low, you can add the other code retrospectively. This will be easy if the record is not yet validated just add another procedure on the same patient. If it is validated, you will need to just add another procedure.

### Trauma

Shared operating is trickier in trauma than it is in orthognathic surgery where two surgeons will often work together. The 70% rule applies here also, and it would include decision making which is often important in trauma operations.

Complex mid-face fractures should have their components coded separately e.g. and zygoma where the orbital floor is explored and repaired should have been coded.

### Dentoalveolar Surgery

Whilst you are collecting numbers toward your indicative numbers, it would seem foolish to use the 'multiple extractions' or 'dental clearance' codes and they could cover a series of surgical procedures including removal of wisdom teeth.

### One wisdom tooth or two?

This is a question I have been asked – if you are removing two lower wisdom teeth, how should this be coded as a single case of 'surgical removal of 8' or should each tooth be coded? As per the

previous paragraph, each wisdom tooth should be coded individually and as accurately as you can. So this could be two simple extractions, or one extraction of 8 and one disto-angular wisdom tooth. Each will count as a single procedure i.e. two will be added to your indicative numbers.

### Simulation

Simulation should not be recorded in the eLogbook. Logbook records need to have a date of birth and hospital number – which would be unusual in a chicken leg. Details of simulated surgery can be recorded in ISCP with WBAs or other documentation in other evidence.

# Indicative Numbers

Indicative numbers refer to the experience expected to be obtained during your ST training. Officially, the GMC says that experience prior to higher training cannot be counted. When they were introduced they were set at the 25 centile of trainees applying for their CCT. These have been relatively unchanged since 2012. They are not mandatory (as ENT are where the numbers are part of their curriculum), so there is some flexibility, but most trainees should aim to exceed them.

### Check the latest Version of OMFS Indicative Numbers on the JCST Website

All trainees should be aware if they are on trajectory to get to the year 4 (FRCS application) targets, and especially their CCT targets. If you have a zero, particularly in activity which can be 'observed' rather than performed, then you may be given an ARCP outcome other than a 1 which will preclude you being able to take the exam.

### Take Responsibility for your Indicative Number Trajectory

Do not count on anyone else to know what the numbers are, and where you are in relation to them. If you need activity which is not available in your rotation, then don't leave it to the last minute to address this. Your AES and TPD will help, but you need to take responsibility yourself.

### SAC Summary Report – Auto-sum don't generate the 'indicative number'

The SAC Report generates a summary of your experience in the format preferred by the OMFS SAC. It will be used at your ARCPs and when you apply for a CCT compare your training experience against the 'indicative numbers'. There are two types of experience listed on the indicative numbers, those where competency is expected, and those where experience of (including Observation and Assisting) is sufficient.

For those in the latter group (marked O), all experience counts and so the auto-sum will generate the correct number.

For those where performance of the procedure is needed, **the auto-sum DOES NOT GENERATE THE CORRECT NUMBER**. **You have to subtract your observed and assisted experience** to generate the right number to compare to the indicative numbers.

So in the example below, although at a glance the indicative numbers are exceeded, once the A (assisted) cases are removed, the numbers are a little short and so additional evidence with WBAs at level 4 would be useful to support an application for CCT.

| | Total | A | S-TS | S-TU | P | T | O | PPT |
|---|---|---|---|---|---|---|---|---|
| **Mandibular osteotomy (40)** | 42 | 10 | 28 | 3 | 1 | 0 | 0 | 0 |
| **Maxillary osteotomy (30)** | 46 | 6 | 36 | 3 | 1 | 0 | 0 | 0 |
| **Genioplasty (5)** | 7 | 2 | 5 | 0 | 0 | 0 | 0 | 0 |
| **Malar / orbital osteotomy (4)** | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| **Total :** | 107 | 25 | 73 | 7 | 2 | 0 | 0 | 0 |

This is clunky, but whilst there is no money to update the running of the eLogbook there are issues which you just have to work around.

I would strongly suggest that you always check the most current version of the OMFS Indicative Numbers by downloading them from the JCST website. If they differ from the eLogbook report, please let me know. https://www.jcst.org/quality-assurance/certification-guidelines-and-checklists/

## New codes – you just need to ask.

Do have a good look before you ask for a new code, most procedures should be there already. That said, don't be afraid to ask. Particularly if you would like to record a specific variation on an existing operation. This is why we changed from fractured mandible without much detail, to the multiple codes we have now. Those with interest in trauma wanted to recorded more detail.

If you would like to record 'activity' on the eLogbook – like joint clinics or grand rounds – if you think where the activity would be best held/found in the hierarchy, and let me know, I would be happy to add it. Remember to mention this to your junior staff who might want to log ward activity.

Usually a new code will be added within a day or two (so you can record your operation before you forget what it was). You can use the official form, or just send me an e-mail. If you can find out the ICD or other official code for the operation let me know.

## Useful links

Help and Support – within eLogbook click the link at the top of the page or go to https://www.elogbook.org/site/1293/default.aspx

eLogbook Message Board https://www.elogbook.org/site/1261/default.aspx

FAQ for Trainees on Message Board https://www.elogbook.org/site/CMD=SUBJECT/SUBJECTID=38599dbc-5148-43d4-9c8a-04d590712688/1261/default.aspx - There is one Oral and Max message – dated 2013!!!

Providing Trainer Access for Validation https://www.elogbook.org/site/1306/default.aspx

Indicative Numbers - http://www.jcst.org/quality-assurance/documents/certification-guidelines/indicative-logbook-numbers-omfs-2015

CCT Checklist - http://www.jcst.org/quality-assurance/documents/certification-guidelines/CertificationguidelinesOMFS2016FINAL.pdf