0828: NON-CONSULTANT HOSPITAL DOCTORS IN IRELAND: A SURVEY OF SATISFACTION IN TRAINING

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Aim: Assessing Irish NCHDs satisfaction, at different training levels, regarding the quality of training.

Methods: A questionnaire was sent to NCHDs in four major hospital (Dublin, Cork, Galway and Drogheda) assessing NCHD’s satisfaction during training year 2013–2014. (SPSS)

Results: 678 emails were sent with 117 (17.25%) response rate. 74 (63.2%) males and 43 (36.8%) females responded. 49.6% (n = 58) were Irish graduates. 15.4% were interns, 33.3% SHOs, 0.9% lecturers, 30.8% registrars and 19.7% SPRs. 57.3% (n = 67) were on a formal training scheme.

56.1% (32/57) Interns and SHOs either disagreed or strongly disagreed that their training helped improve the acquisition of higher skills, compared to 22.2% (8/36) registrars and 13/23 SPRs (p = 0.001).

52.6% (30/57) Interns and SHOs either disagreed or strongly disagreed that their training helped improve the acquisition of higher skills, compared to 36.1% (13/36) registrars and 30.4% (7/23) SPRs (p = 0.271).

22.8% (13/57) Interns and SHOs either agreed or strongly agreed that implementation of European Working Time Directive (EWTD) negatively impacted on their training, compared to 38.6% (14/36) registrars and 26/6 (23) SPRs (p = 0.008).

Majority of NCHDs (62%, n = 31/50 non-training and 73.1%, n = 49/67 training scheme) preferred to change current training model (p = 0.200).

Conclusion: Interns and SHOs were apprehensive that their training was not helping improve their clinical and research skills. Registrars and SPRs felt that EWTD was negatively affecting training.

0874: THE EFFECTIVENESS OF NEW LAPAROSCOPIC TASKS TO ACQUIRE SKILLS IN THREE DIMENSIONAL LAPAROSCOPY

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Aim: To establish validity of novel 3-D models using McGill inanimate System for Training and Evaluation of Laparoscopic Skills (MISTELS) criteria for training of laparoscopic skills in 3D.

Methods: Total 23 subjects [18 non-competent (novices, intermediates) and 5 experts] followed the training flow comprises of three sets of repetitions of an improved FLS tasks (Peg transfers, Ligating Endoloop, Intracorporeal suture, Pattern-cutting) and an additional new task (Creating Zig-zag loop). The tasks were performed under 3D and 2D visual modalities. Overall performances (Total scores, total errors) were measured. Student’s t test used to compare the data.

Results: Each group performed significantly better in 3D. Statistically significant differences found between skilled and non-skilled groups’ overall performances (p < 0.05) in both visual modalities. Using Likert scale (1–5) candidates favoured (face validity) the use of models in 3D (4.3).

Conclusion: We have effectively established the face and construct validity of novel models for both visual modalities. Hence, models can be successfully used for simulation training in both visual modalities. 3D vision allows remarkable improvement in performance and error rates.

0875: OBSTRUCTION OR OBSTRUCTIVE-ARE WE CAUSING MORE HARM THAN GOOD? Audit the use of the abdominal X-ray (AXR) in patients presenting with an acute abdomen

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Aim: AXR is the most commonly ordered radiograph for patients presenting with an acute abdomen, however, is of low diagnostic yield. A previous audit in 2011 showed 43% of patients were unnecessarily exposed. Our aims is to determine whether AXR use is in keeping with Royal College of Radiology2 (RCR) standards and whether unnecessary radiation exposure has reduced.

Methods: Retrospective study of patients presenting with an acute abdomen to A&E over a 4 week period in Autumn 2013.

AXR: appropriate indications as per RCR guidelines:
- acute abdominal pain where perforation or obstruction suspected
- acute small or large bowel obstruction
- IBD: acute exacerbation
- acute and chronic pancreatitis

Results: 33% patients were exposed unnecessarily, however reasons for investigation highlight AXR used defensively to exclude serious pathology.

Conclusion: Osler’s classic quote reminds us the art of history taking is paramount in establishing the correct diagnosis. Therefore it is essential doctors hone these skills to develop their clinical acumen and avoid unnecessary harm. In the era of defensive medicine and increasing life expectancy we must ensure we limit unnecessary investigations to protect not only patients but also scarce financial resources; safeguarding the future of the NHS. Junior Doctors, thus play a key role.

0884: INTRAVENOUS FLUID PRESCRIBING IN ACUTE GENERAL SURGICAL PATIENTS WITHIN FIRST 24 HOURS OF ADMISSION AT THE ROYAL BRIGHTON AND SUSSEX HOSPITAL

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Aim: To evaluate the accuracy of intravenous fluid prescribing in acute surgical patients at a busy teaching hospital.

Methods: Data was retrospectively collected from 27 general surgical inpatients who received intravenous fluids for either maintenance or replacement within the first 24 hours of admission. Standards were set by pre-existing guidelines from the National Institute of Clinical Excellence (CG174).

Results: Of the 15 patient’s requiring fluid maintenance alone 60% (n = 9) received greater than the maximum advised fluid requirement (average 638 ml) based on individual weight. 26.6% (n = 4) received less than the advised minimal fluid requirement (average 933 ml). 13.3% were prescribed the appropriate volume of fluid.

10 patients required fluid replacement alone and 100% appropriately received crystalloids with daily urea and electrolyte monitoring.

No (n = 27) patients received the recommended quantities of glucose, potassium, chloride or sodium.

Conclusion: A large proportion of acute general surgical patients are receiving inadequate quantities of glucose and electrolytes as well as volumes of fluid. Patients are potentially at risk of fluid overload, starvation ketosis and electrolyte imbalance. In response to these findings we recommend early access to patients weight, inclusion of NICE guidelines in the surgical clerking proforma and further local education.

0905: REPRESENTATION OF SURGEONS AS FOUNDATION TRAINING PROGRAMME DIRECTORS IN THE UNITED KINGDOM

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Aim: The Foundation Training Programme Director (FTPD) oversees the junior Doctor when most will decide their career speciality and has a strong role in inspiring and assisting future surgical trainees in career progression. In this study we aimed to assess the representation of surgeons as FTPDs in the UK.

Methods: A list of Deanery’s in the UK FTPD’s was made from deanery website, e-mail or telephone call (n = 21). Deanery’s not supplying a list were excluded (n = 4). FTPD specialty was determined by internet search or telephone call. Definition of ‘surgeons’ included all sub specialties of general surgery, Urology, Vascular, ENT, plastics, Paediatric, Orthopaedics.

Results: The quality of data received from each deanery was of varying quality. Overall in the data we received (FTPD n = 278) 41% were Physicians, 16.5% of FTPD’s were surgeons. Other specialties represented were Anaesthetics (13%), ED (11%), Obstetrics and Gynaecology and Paediatrics (5%) The proportion of FTPD’s that were surgeons varied widely between Deanery’s from 36% (East Anglia) to 0% (West Midlands).

Conclusion: Surgeons are the second most represented specialty in the role of FTPD. There is large variation between deanery’s in specialty
representation. Surgeons must continue to participate as FTPD’s to facilitate trainees choosing a surgical career.

0909: WORK-BASED ASSESSMENTS AMONGST SURGEONS: A COMPARISON IN PRACTICE BETWEEN THE UNITED KINGDOM AND NEW ZEALAND

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Aim: Work-based assessments (WBAs) including DOPs, CEX and CBD are considered the highest form of assessing clinical competence. However, trainees and trainers in the UK and NZ are often inadequately trained, complete WBAs without feedback and trainers fail to be present; mandatory requirements for validation.

Methods: Experiences of surgical first and second year trainees completing WBAs at London and NZ teaching hospitals were collated through a Likert-scale graded questionnaire.

Results: Response rate was 100% UK (FY1 = 11, FY2 = 16) and NZ (FY2 = 14).
Most UK trainees; 72.5% (n = 19) have completed > 50% of DOPs with an assessor present, 77.1% (n = 19) have completed > 50% of CEX with an assessor present and 89.3% (n = 24) have filled in > 50% CBD with an assessor present compared with just 14.2% (n = 2), 28.6% (n = 4) and 14.2% (n = 2) of NZ trainees respectively.
37% UK trainees (n = 10) and 14.2% of NZ trainees (n = 2) have > 50% WBAs completed by non-assessor trained.

Conclusion: In both countries there is a need for improvement in current practice. Fewer WBAs are supervised by trainers in NZ compared with UK.
Most NZ trainees have received formal training in providing feedback. These differences in practice need to be taken into account for UK surgical trainees wishing to train abroad.

0934: USING THE 5F’S AS A DIAGNOSTIC AID FOR GALLSTONE DISEASE

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Aim: Undergraduates use mnemonics. The 5F’s – female, fat, forty, fertile and fair, is used for predicting patients with gallstones. This project aims to elucidate the usefulness of the 5F’s to identify patients with gallstones.

Methods: Female patients presenting acutely to general surgery with right upper quadrant pain (n = 206) over a six month period were included.
‘Fertility’ was not attainable hence only 4 of the 5Fs were measured. Data were retrospectively collected from electronic records. Patients were considered to fit the 4F profile if: female, > 40 years old, Caucasian, BMI > 25.

Results: 122/206 had image-proven gallstones and were older than those without (56.4 years range vs 47.8 years range, p = 0.03).
There was no significant difference in BMI between the 2 populations (p = 0.07).
96% with gallstones were Caucasian (80.2% of local population of this ethnicity). Application of the 4Fs in identifying patients with gallstone disease was calculated to have sensitivity of 0.54 and specificity of 0.55.
The positive predictive value of the 4F tool was 0.71 and the negative predictive value was 0.38.

Conclusion: The application of the 4/5Fs is a poor method of identifying patients with gallstones. It should no longer be taught as an aid to diagnosis of gallstones.

0956: IMPROVING MEDICAL STUDENT EDUCATION IN THE OPERATING THEATRE THROUGH A NOVEL, MULTIDISCIPLINARY THEATRE INDUCTION COURSE

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Aim: Transitioning from pre-clinical studies to being a clinical medical student can be a challenging. Operating theatres present multiple learning opportunities beyond simply observing an operation, however students are often unaware of this. Moreover, patient safety risks exist if students are unclear on the behaviours and procedures expected in theatre. We introduced a multidisciplinary theatre induction course aiming to educate new third year medical students on the various learning opportunities available in the operating theatre environment.

Methods: A single day covering: behaviour in theatre; principles of anaesthesia; patient positioning and handling; suturing; gloving and gowning; airway skills; and a patient simulation, facilitated by surgical and anaesthetic trainees. Anonymous feedback forms were collected prospectively for analysis.

Results: 25 students to date have undertaken the course. 100% of students felt the course made them more confident in theatre. All felt the course should be mandatory part of the third year curriculum. 44% would consider a surgical career after attending the course.

Conclusion: An immersive theatre induction course improves medical student confidence, patient safety and awareness of learning opportunities available in the theatre environment. Students undertaking the course unanimously agree that it should be part of the third year curriculum.

1000: ESTABLISHING AN EFFECTIVE SURGICAL HANDOVER PROCESS – SENIOR NURSE LED ENFORCEMENT USING A CHECKLIST OF STANDARDS WORK

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Aim: To measure proceedings at General Surgical handover meetings and improve the process for continuity of patient care and prevent adverse events RCS, BMA and RCP guidelines on handover were combined to establish comprehensive standards of practice.

Methods: A covert prospective audit was performed over a 2 week period of twice daily General Surgery handover meetings. Findings were presented followed by intervention of recruiting named senior nurses to enforce handover proceedings using a checklist of all standards.

Results: Eighty per cent of handovers were multidisciplinary, 100% were in a timely manner in a suitable venue. Patients with anticipated problems and deteriorating early warning scores were mentioned at 25% of meetings during weekdays and 100% over weekends. Identifying and introducing new or unknown team members was done 0% of the time. Re-audit following implementation of checklist showed improved compliance in all domains.

Conclusion: Surgical Handovers are crucial to patient-care, particularly sick patients under the care of an out-of hours team. Optimal environment, conduct and content of a handover meeting is multi-faceted and a checklist of standards is useful tool. In our experience a senior nursing staff member enforcing these standards was effective.