Conclusions: The GreenLight Simulator is a useful training tool for PVP training. It is hoped that by using the training curriculum produced, novice trainees can acquire skills and knowledge to a predetermined level of proficiency.

0223: COMPLIANCE WITH GMC GUIDELINES FOR CHAPERONE USE IN INTIMATE EXAMINATIONS AND THE INFLUENCE OF JUNIOR DOCTOR EDUCATION ON PRACTICE


Introduction: The GMC recommends chaperone use during all intimate examinations. This study audited self-reported practice and documented chaperone use in an NHS Trust Acute Surgical Admissions Unit.

Methods: The study comprised four phases; 1. Prospective audit of documented chaperone use during intimate examinations over a 10-day period of acute admissions. 2. Anonymous online survey of clinician self-reported chaperone practice. 3. Junior doctor education sessions and information posters displayed on surgical wards. 4. Re-audit of documented chaperone use 3 weeks later.

Results: During the initial audit period, 89 patients were admitted, with 29 intimate examinations performed (2 male genital, 2 female breast, 13 male per rectum (PR) and 12 female PR) in 28 patients. Chaperone use was documented in 4 cases (14%). Of 50 clinicians emailed, 19 completed the survey (9 male 10 female). Although 77.8% reported regular chaperone use, only 52.6% admitted documenting this in the patient notes. The re-audit period included 72 admissions. Of these, 23 underwent PR examinations (8 male, 15 female). Chaperone use was recorded in 18 cases (78.3%).

Conclusions: Chaperone use in clinical practice at our hospital does not comply with GMC recommendations, but education increases awareness and improves documentation, most notably amongst F1 doctors.

0243: "IS GENERAL SURGERY STILL RELEVANT TO THE SUB SPECIALISED TRAINEE?" A 10 YEAR COMPARISON OF GENERAL VS. SPECIALITY SURGICAL PRACTICE


Introduction: The splintering of general surgery (GS) into subspecialties has brought into question the relevance of a continued emphasis on traditional general surgical training. With surgical trainees now expressing a clear preference to sub-specialise, this study sought to determine the changes in general surgical practice in a specialist centre over the past decade.

Methods: A retrospective review of surgical admissions at Cork University Hospital, Republic of Ireland was performed at three individual time points: 2002, 2007 & 2012. Basic demographic details of both elective & emergency admissions were tabulated & analysed.

Results: 11,288 surgical admissions were recorded (2002:2773, 2007:3498 & 2012:5017), showing an increase of 81% over the total ten year period. Average length of stay reduced significantly in both elective (3.62 to 2.58 bed days) & emergency admissions (7.36 to 5.65, p=0.013). While growth in overall service provision was seen, the practice of general emergency surgery versus specialty relevant emergency surgery showed no statistically significant change in practice from 2002-2012 (p=0.87). While emergency surgery steadily increased, elective general surgery dropped from 27% to 18% of elective workload during study duration.

Conclusions: The results emphasise the importance of general surgical training even for those trainees committed to sub specialisation.

0266: SURGICAL TRAINING IN SOUTH AFRICA – A PRACTICAL GUIDE TO GETTING A JOB

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Introduction: Increasingly, UK trainees are pursuing postgraduate training abroad to gain extensive and varied operative experience. South Africa (SA) has a world-renowned reputation for surgical training, driven by its infamous abundance of trauma and philosophy of ‘hands on’ experience. Currently there are no published articles to guide the prospective foreign applicant and many may be deterred by the complexity in securing SA employment.

Methods: Information was collected regarding the experience of five surgeons who applied to SA during 2013. All successfully secured paid employment.

Results: Application took 9-12 months and cost approximately £500. The most challenging step was obtaining Health Professions Council of South Africa (HPSCA) registration (GMC equivalent) following which a work permit was granted. However several endorsements were required prior to this. Difficultly arose due to the failure of our foundation training to match the broad competencies required of SA junior doctors.

Conclusions: This step-by-step guide integrates all component parts of the median admission process and is a helpful resource. Surgical trainees working in SA benefit from varied experience and substantial theatre time. Obtaining a post is an arduous process but we argue it is incredibly worthwhile, with eventual rewards to both the surgeon and the NHS.

0284: THE DELIVERY OF ACUTE SURGICAL CARE; IS THE TRADITIONAL MODEL ACCEPTABLE?

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Introduction: Recently, new models for delivering acute surgical care have emerged. The traditional “supra-elective” model, consisting of an on-call service to the Emergency Department (ED) while balancing daily elective work, is still widely practiced. We aim to assess the efficiency of this model in a regional district hospital.

Methods: A retrospective study between July 2009-March 2010 was conducted. The primary outcome was to assess the time taken for initial surgeon-patient consultation after ED referrals. Secondly we assessed whether the time of day, day of week or case-mix aetiology impacts on time to consultation.

Results: 860 patients were included in the analysis. The overall median time to consultation was 30 minutes (P<0.001). Daytime (08.00-17.00) median consultation time was 60 minutes, 30 minutes for evening (17.00-24.00) and 20 minutes for night time (00.00-08.00), p<0.001. The median consultation time for trauma was 15 minutes, vascular 45 minutes, while other categories (upper & lower gastroenterology, & skin related) 30 minutes (* P = 0.025).

Conclusions: The emergence of newer acute surgical care models has advantageous results. However, regional and economical consequences impact the practicality at a local level. We acknowledge that the traditional “supra-elective” model though not ideal, still remains achievable in a moderate sized tertiary referral unit.

0294: PREPARING JUNIOR DOCTORS FOR THEIR SURGICAL ROTATION USING SIMULATION TRAINING

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Introduction: Junior doctors often feel underprepared before commencing their surgical rotation. Simulation can provide a means of addressing this real or perceived performance gap. Existing simulation courses are usually run at a site distant to their place of work, are over-populated and focus on medical emergencies. This project aims to establish a novel in-house surgical ward simulation course for new FY1 doctors.

Methods: A departmental critical events analysis and a survey of common FY1 complications were used to generate surgical scenario topics. Local systems and protocols were built into the scenarios to improve realism. Four participants attend the course fortnightly; each gets the opportunity to act as team lead.

Results: 16 participants have attended so far. Participants rate perceived confidence relating to four domains pre and post simulation. Following simulation, the proportion of individuals strongly agreeing that they felt confident in each domain increased. Confidence in patient assessment rose by 73%, initial management by 66%, handing over information by 67% and team working by 13%.

Conclusions: Simulation improves perceived confidence particularly in relation to patient assessment/management and handing over information. The course will be delivered to ‘preparation for practice’ doctors who join us for a shadowing period prior to commencing work.