response to the 69 recommendations were: already usual practice (no cause for concern) \( [n = 51] \), already usual practice (cause for concern) \( [n = 15] \) and no plans to implement \( [n = 3] \). The audit did not support the favourable BA response in 3 out of the 69 recommendations: use of endoscopic ultrasound, staging laparoscopy and preoperative nutrition assessment.

**Conclusions:** Audit, and not benchmark assessments, should be used to allow a more detailed and accurate record of current practice for patients with potentially curative OG cancers.

**DOCUMENTATION OF FACIAL NERVE MORBIDITY FOLLOWING PAROTIDECTOMY: A 5 YEAR RETROSPECTIVE AUDIT OF 53 CASES**

David Houghton, Iain McVicar. Nottingham University Hospital NHS Trust

We retrospectively evaluated the documentation of post operative facial nerve function of all patients who underwent parotidectomy by a single consultant surgeon. Grade of operator, operation performed, histopathology, documentation of sensory nerve deficit as well as incidence of freys syndrome, haematomata, tumour spillage and recurrence were also addressed in the audit. In the audit, 53 patients (average age = 53.8, range 14-83) underwent parotidectomy between 2003 and 2007 with a minimum of 1 year follow-up. Of these 53 patients, 45 (85%) had their facial nerve function fully documented post operatively and at every subsequent follow-up appointment until normal function was recorded. Incomplete documentation was observed in 7 patients (13%) and in only 1 patient (2%) was facial nerve function not documented at all. Of the 45 patients whose facial nerve function was fully documented, 24 (53%) had some immediate post operative weakness of the facial nerve. After 1 month 17 (38%) had some facial nerve weakness. After 3 months 35 (78%) had fully recovered and 10 (22%) had some remaining weakness. After 6 months 38 (84%) had normal nerve function and 7 had minor nerve paresis. After 1 year, 42 (94%) had fully recovered and 3 (6%) had some facial nerve weakness.

**TAKE NOTE, SURGICAL DOCUMENTATION IS IMPROVING: A 5 YEAR REVIEW**

P. Burns, C. O'Donnell, L. Thorpe, R. Kennedy. Altnagelvin Area Hospital

**Introduction:** Accurate, timely and legible note keeping supports the safe and effective delivery of surgical services. We aimed to establish a quality standard for surgical documentation in a teaching hospital and ascertain if standards are improving.

**Methods:** Multiple case notes were randomly selected for each general surgical consultant at 2 time points in 2004 and 2009. The CRABEL score was chosen to ascertain the quality of note keeping. The initial clerk-in, 5 subsequent entries and the discharge letter were examined and a percentage score obtained. The tool examines the quality of the information recorded and its legibility. It has been widely validated and used in NCEPOD reports. Researchers collated a mean score for each consultant at 2004 and 2009.

**Results:** 11 sets of notes at the 2 time points were examined. The mean CRABEL score at 2009 was significantly higher than at 2004, 74% (66-83) versus 63% (61.1-65.8) \( p = 0.03 \). Most points were lost at both time points due to poor documentation of date and time (43% points lost) and illegible signature (28%).

**Conclusions:** The quality of surgical documentation has improved from 2004 to 2009 as measured using the CRABEL score. The most frequent errors are poor recording of date and time and illegibility of signature.

**AN ‘OPEN SOURCE’, SELF- BUILT, CONVENTIONAL AND SINGLE INCISION LAPAROSCOPIC SURGERY (SILS) SIMULATOR**

R.W. Partridge, A.J. Sahbarwal. Department of Paediatric Surgery, Royal Hospital for Sick Children, Yorkhill, Glasgow, UK

**Introduction:** A presentation of the AcesoSim - an ‘open source’ laparoscopic and SILS simulator. It’s unique feature is that the details of how to make it are published on a web-site (AcesoSim.org) and it can be built for less than £100.

**Methods:** Video clips demonstrate the AcesoSim. A 10-point face validity questionnaire was performed comparing intracorporeal suturing on the AcesoSim with the virtual reality LapSim (Surgical Science, Sweden).

**Results:** Both conventional laparoscopic and SILS procedures are demonstrated. The face validity questionnaire, scoring from 1-10, demonstrated a significant \( p < 0.001 \) advantage to the AcesoSim over the LapSim regarding: mean(SD): overall usefulness as a training tool 9.22 (0.83) vs 5.11 (3.01), value for money 9.77 (0.44) vs 1.88 (1.69), realism of suturing 8.77 (0.97) vs 2.22 (1.56) and realism of tactile feedback 8.88 (0.93) vs 2.33 (1.41). Realism of anatomical representation was better in the LapSim: 6.37 (2.31) vs AcesoSim 3.75 (1.48) \( p < 0.01 \). Camera and instrument simulation and user interface were considered equal. \( n = 9: 3 \) consultants, 6 trainees).

**Conclusions:** The video is a clear presentation of this novel and exciting ‘open source’ and SILS enabled concept. The face validity questionnaire supports its potential as a useful training tool.

**WORK PLACE BASED SURGICAL ASSESSMENTS: ASSESSMENT FOR LEARNING OR ASSESSMENT OF LEARNING?**

Anjana Satpathy, Roger Kneebone. St Mary’s Hospital, London

**Introduction:** Work place based assessment system is an integral part of the new surgical curriculum. Although designed to serve both formative and summative functions, the real benefit is yet to be established.

**Method:** This is an interview based qualitative study. Surgical trainees (n = 14) and trainers (n = 4) were invited to participate in this study. Semi-structured interviews were performed and participants were asked about their perception of current surgical assessment system, rigour of the process, feedback, experience and opinion about the learning benefit of assessments in surgical training. Key themes were identified from the interview data and compared across the database.

**Result:** In a general overview, most of the participants expressed doubt about the effectiveness of work place based assessments. The major challenges to undertake these assessments were lack of sufficient time and enthusiasm. Most of them felt that these assessments are mostly subjective without any benefit in teaching and learning.

**Conclusion:** The current shift in focus from experience to competence based system has affected the quality as well as the quantity of the surgical training by overburdening the faculties and trainees with the administrative work. Participants in this study suggest that there should be a balance between training and assessment.

**USE OF A DEDICATED TEACHING SESSION FOR IMPROVING STANDARDS OF SURGICAL WARD ROUND DOCUMENTATION.**

R. Fish, C. Garnsey, S. Morcos, S. Ellenbogen. Tameside Hospital NHS Foundation Trust
The Association of Surgeons in Training

**Introduction**: Accurate documentation of the ward round is crucial for continuity of care and is medico-legally mandatory. It is commonly undertaken by inexperienced doctors and standards vary. The aim of the study was to assess whether a teaching session for foundation doctors improved surgical ward round documentation.

**Materials and methods**: A tutorial on ward round documentation was given to all foundation doctors. Ward round entries for all surgical patients were assessed before, 2 weeks after and 8 weeks after the teaching. Data collectors were blinded to the dates of the entries. Entries were given a numerical score based on criteria derived from GMC and RCS guidance.

**Results**: The mean score before teaching was 65%, increasing to 76% (p<0.05) 2 weeks after teaching but falling to 70% at 8 weeks. The greatest improvements were seen in areas that were initially the poorest. There was short term improvement in 6 criteria. 3 criteria showed sustained improvement: time of entry documented (31% to 60%); entry signed (77% to 93%); pager number of author documented (68% to 97%).

**Conclusion**: A dedicated teaching session can improve ward round documentation. To make sustained improvement it may be necessary to repeat the teaching session at regular intervals.

**ARE FOUNDATION YEAR ASSESSORS ADEQUATELY TRAINED**

J.M.L. Williamson. Weston General Hospital

**Introduction**: A new system of Work Based Assessments (WBAs) is being used to assess Foundation Year (FY) doctors. Current recommendations are that ‘senior doctors’ (senior SHOs and above) are used to assess CEXs and CbDs, while DOPS may be assessed by other senior healthcare professionals. In 2007 approximately 1/3 of ‘senior doctors’ had formal training in the use of WBAs. The grade of SHO ceased to exist in 2007.

**Method**: All WBAs performed at our hospital (from 21 FY1s and 18 FY2s) were analysed to reveal who performed them and what training they had undertaken. Results 790 mini-PATS and 765 WBAs were submitted. The Registrar grade performed 290 of these assessments, Consultants/GPs 192 and SHOs 160 (38%, 25% and 21% respectively). Of these senior professionals, 239 (37%) had formal training in the use of WBAs, compared to 67% of FYs 62% of nurses.

**Conclusion**: Registrar grades performed most WBAs. FY1s tended to use more junior assessors, while FY2s used more senior assessors. The majority of senior assessors had not had formal training in the assessment tools. The recording of SHO, a now obsolete grade, as an assessor causes ambiguity.

**SHO (CT2) TRAINING EXPERIENCE – THEN AND NOW (72 HOURS VS 48 HOURS WORKING WEEK)**

K. Futaba, H. Tafazal, J. Francombe. Department of General Surgery, Warwick Hospital

**Introduction**: Current surgical consultants worked approximately 72 hours per week as an SHO and were in training for at least 3 years before obtaining registrar grade. Current trainees now work a maximum 48 hours and are expected to obtain registrar grade after 2 years at SHO level.

**Methods**: Logbook records were analysed for index operations performed by two SHOs in the final 9 months of their Basic Surgical Training: SHO1 in 1995 (1-in-4 on call prospective rota) and SHO2 in 2009 (48hour full shift rota).

**Results**: SHO1 performed 351 operations independently and performed supervised / assisted in 116 operations, compared to 25 operations performed and 96 performed supervised / assisted by SHO2. Old-fashioned training on 1-in-4 on call rota provided a four-fold increase in exposure to index operations and surgical experience than a 48hour full shift pattern.

**Conclusion**: There is a shift to more procedures being performed under supervision, which reflects improvement in quality of training. The SHOs of today will need to work the equivalent of 12 years before they achieve the same level of experience of their predecessors before reaching registrar grade. Focused training alone may not compensate for the reduction in exposure to the variety of cases.

**OUTPATIENT SATISFACTION IN ENT: CENTRAL VS. PERIPHERAL CLINICS.**

Alexander Moore 1, Natarajan Balaji 2. 1 University of Glasgow; 2 Monklands Hospital

This study aims to assess the differences in patient satisfaction between a central and peripheral ENT outpatient clinic and determine the factors contributing to patient satisfaction. Patients attending a surgeon’s clinic were randomised to the central or peripheral group. The central clinic was conducted at a large hospital; the peripheral clinic was conducted at a small, outlying facility. Patient satisfaction was assessed with the Improving Practice Questionnaire. N = 143. The groups were comparable, however the peripheral clinic was significantly further away from the patients’ homes (p = 0.018). Overall satisfaction was not significantly different between the two groups. Eight variables related to housekeeping aspects were significantly (p<0.05) in favour of the peripheral clinic: hours, time, comfort, wait, etc. There was no significant difference (p>0.05) between variables related to the doctor-patient consultation: ability, reassurance, warmth, etc. Ordinal logistic regression found the most powerful predictors of overall satisfaction to be related to the doctor-patient consultation: (Kruskal’s Gamma) warmth, listening, explanation, respect, reassurance and ability (0.94-0.97). Conversely variables related to housekeeping were poor predictors of overall satisfaction: comfort and waiting time (0.41-0.44). This demonstrates the relative importance of aspects of the doctor-patient relationship as a reflection of quality compared to the widely exposed waiting time statistic.

**PROGNOSTIC FACTORS FOR REFEEDING SYNDROME IN HEAD AND NECK CANCER PATIENTS**

Hare James 1, Skelly Rachel 2, Ghosh Samit 3, Jones Terry 2. 1 Faculty of Medicine, University of Liverpool; 2 Aintree University Hospitals NHS Foundation Trust; 3 Calderdale and Huddersfield NHS Foundation Trust

**Introduction**: Head and neck cancer patients have a significant risk of refeeding syndrome (RfS) due to their often poor nutritional status and comorbidities. This is a severe condition comprising of metabolic and electrolyte abnormalities with systemic effects. We prospectively assessed 189 consecutive head and neck oncology patients, admitted for surgery or chemoradiotherapy, for their risk of developing RfS.

**Methods**: 189 patients were assessed on admission for nutritional status, electrolyte abnormalities with systemic effects. We prospectively assessed 189 consecutive head and neck oncology patients, admitted for surgery or chemoradiotherapy, for their risk of developing RfS.

**Results**: Overall, 104 (55%) were found to be at risk of RfS, according to institutional guidelines. 18 (9.5%) patients went on to develop RfS, 16 of which had been found to be at risk: 28 (14.8%) patients had >15% weight loss in the last 3 months. When looking at specific tumour sites, the site with the highest proportion of patients developing RfS was the oral cavity; 37/71 (52.1%) patients were determined to be at risk, and 14/71 (19.7%) went on to develop RfS.