

Aim: Surgical checklists are used to reduce errors, however, the best method of administering the checklists is still unknown. We aimed to compare the effects of trainee self-administered versus trainer-administered checklist on the laparoscopic task performance of novices.

Method: We formulated a standardised checklist among master surgeons by consensus. Ten consented novices were randomised into 2 equal groups. Both groups performed double square knots in two separate stages (3 minutes per stage).

Stage 1: no checklist applied by either groups. Stage 2: The study group with a trainee self-administered checklist and the control group with a trainer-administered checklist.

The unedited video-recorded laparoscopic tasks were assessed by a blind assessor using the human reliability assessment technique. Non-parametric statistics were used for data analysis.

Result: Unlike the control group, the study group showed highly significant improvement in the laparoscopic task performance as measured by the number of errors committed in stage 2 vs stage 1 (control group: 131 vs 106 errors, study group: 154 vs 84 errors, $p < 0.01$).

Conclusion: The trainee self-administered method of applying a surgical checklist had a significant accelerating effect on the acquisition of technical skills during a standardised lab-based laparoscopic task when compared to the trainer administered method.

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0213: MENTORSHIP IN HIGHER SURGICAL TRAINING – WHAT DO TRAINEES REALLY WANT?

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Introduction: The benefits of mentorship to surgical trainees are well documented. Previous research undertaken by the Association of Surgeons in Training showed disparity between the high demand for mentorship and the low uptake of mentorship schemes. We analysed feedback from higher surgical trainees (ST3-8) to ascertain what they really want from mentoring to address this disparity.

Method: An online questionnaire was distributed to three UK higher surgical training cohorts. Results were analysed by speciality and training-grade.

Result: A 68% survey response rate was achieved (N=45). 93% of respondents felt formal mentorship would be beneficial and 80% felt they lacked suitable mentorship opportunities.

Trainees felt a mentor of close training-grade, within the same speciality, but not at their own level would provide the best mentorship. The choice of mentor was equally important to non-training grades.

No trainee felt their current Educational Supervisor was a suitable choice of mentor.

Further perceived benefits included the consensus that if mentorship is to be effective it should be formally recognised for revalidation.

Conclusion: Our findings provide insight into what the higher surgical trainee really wants from mentorship. We make recommendations to facilitate improved engagement and discuss the development of a sustainable higher surgical mentorship scheme.

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0236: LAPAROSCOPIC SURGERY ISN'T SIGNIFICANTLY REDUCING TRAINEES' EXPOSURE TO THE 'EMERGENCY LAPAROTOMY'

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Background: General surgical trainees are required to undertake 100 'Emergency laparotomies' to meet the JCST criteria for CCT (Certificate of Completion of Training). Anecdotal evidence suggested that operations traditionally undertaken as laparotomies were being done laparoscopically. There was concern that this would mean these would not count towards the requisite number for CCT.

Method: Trainees, from a single deanery, were asked to prospectively record all emergency laparotomies and laparoscopic cases over a 3-month period. Trainees were asked to exclude paediatric cases and appendicectomy. Trainees recorded the operation name, whether the case was open or laparoscopic and the level of supervision.

Result: Data was received from 18 trainees and 137 operations. 21% of operations were recorded as the trainee 'assisting'. The majority, 86%, were undertaken as open operations. The median number of cases over the 3-month period was 6.5. Based on the JCST list just 1 of the laparoscopic cases would not have been counted as a 'laparotomy'.

Conclusion: The volume of emergency cases does allow trainees to meet the criteria for CCT. Laparoscopy is still predominantly used for post-operative complications following elective laparoscopic surgery, and perforated DU. Assisting in an operation was the main reason that cases were not counted.

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0245: LAPAROSCOPY TRAINER WORKSHOPS: TAKING SURGERY INTO THE TRAINEE'S HOME

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Aim: Due to time constraints in theatre opportunities for trainees to learn and develop new skills have been limited. Simulation has been increasingly seen as a valid tool for improving technical skills outside the theatre environment, but purchasing commercially available trainers is prohibitively expensive whilst access to simulation equipment in hospitals is highly variable.

Method: We organised the first "Build Your Own Laparoscopic Trainer" workshop in conjunction with The Academy of Surgical Education and with funding support from ASIT. This one day course was open to candidates nationally, who were each provided with all the required equipment and expertise in order to build their own laparoscopic trainer.

Result: Fifteen delegates attended the course, with backgrounds varying from medical students to registrars. Once the trainers were built, trainees had the opportunity to work through a series of tasks and had a session on laparoscopic suturing and knot tying led by a consultant surgeon. Following the course delegates were able to take their trainers home to continue their learning.

Conclusion: The course illustrated that building your own laparoscopic trainer is possible with easily obtainable materials, and helped remove some of the barriers trainees face in furthering their development as future laparoscopic surgeons.

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0310: MULTIDISCIPLINARY SIMULATION TRAINING: ACUTE MANAGEMENT OF LARYNGECTOMY AND TRACHEOSTOMY PATIENTS

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Aim: Following a serious incident at a cardiac arrest call for a laryngectomy patient, our simulation faculty was approached to provide multidisciplinary training to doctors and nurses involved in the care of laryngectomy and tracheostomy patients.

Method: Six multidisciplinary simulation sessions were organised using the Laerdal Essential patient simulator and Laerdal Learning Application software. Scenarios involved acutely deteriorating laryngectomy or tracheostomy patients and were followed by a group debrief. Participants completed pre-session and post-session questionnaires and multiple choice questions in order to evaluate the effectiveness of our training.

Result: We ran a total of 21 scenarios, catering for 25 doctors and 19 nurses. Our data indicates that our training increases participants' knowledge of the differences between laryngectomy and tracheostomy patients, and improves participants' confidence to assess and manage these patients, including those in respiratory distress (Mann-Whitney U test, $p < 0.05$). Participants found the scenarios to be realistic (mean five-point Likert score 4.7/5).