**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**

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**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 CEX and CBdDs, 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)**

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**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.**

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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**

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**Introduction:** Head and neck cancer patients have a significant risk of refeeding syndrome (RfS) due to their often poor nutritional status and co-morbidities. 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, chemoradiotherapy, for their risk of developing RfS.

**Results:** 79/71 (52.1%) patients were determined to be at risk, and 14/71 (19.7%) went on to develop RfS. 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.