

strikingly, 65% of the doctors surveyed did not consider starting enteral feed prior to or alongside correcting any electrolyte imbalances. Delaying the onset of enteral feed may put patients at greater risk of malnutrition. Further education and training about RS are necessary for all grades, particularly junior doctors.

Disclosure of Interest None Declared

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PTU-002 LARGE VOLUME PARACENTESIS (LVP) CAN BE SAFELY PERFORMED BY JUNIOR DOCTORS WITHOUT ULTRASOUND GUIDANCE

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Introduction The introduction of the European Working Time Directive has led to concerns about reduction in exposure to practical procedures for junior doctors¹.

Ultrasound is now considered essential for pleural aspiration and chest drain insertion². Its use for LVP has also been suggested³.

Our aim was to assess the safety of LVP performed at our centre according to the clinical grade of the operator.

Methods We identified patients who had undergone LVP at our hospital during a 12 month period from October 2010 by reviewing the admission book of our department and by reviewing a list of all the ascitic fluid samples sent to our microbiology department. Case notes for these patients were reviewed and data were collected on patient demographics, method of insertion (blind vs. ultrasound guided), grade of operator, adequacy of albumin replacement and the occurrence of any complications.

Results 56 LVP were performed on 28 patients.

53 drains were successfully inserted blindly, 3 required ultrasound guidance.

2 drains were inserted by consultants (both ultrasound guided) and 9 by registrars. 15 were inserted by core training doctors (1 procedure was supervised) and 28 by foundation doctors (19 supervised).

Ascites was sent for white cell count after 53 (95%) procedures.

No major procedure related complications occurred; 1 patient required a stitch for a minor cutaneous bleed after drain removal.

6 received < 6g albumin per litre of ascites drained. 3 LVP were carried out with no albumin replacement, in 2 of these the drain had been inserted under ultrasound guidance. For 2 procedures (performed on surgical wards) the drain was not removed after 6 hours.

Conclusion LVP can be safely performed without ultrasound guidance by adequately trained or supervised junior doctors. Some failings occurred with regard to albumin replacement, timely drain removal and request for ascitic white cell count. However, none of these would have been prevented by performing drain insertion under ultrasound guidance. Patients who had their drain inserted under ultrasound guidance were in fact more likely to receive sub-optimal post-procedure care.

Protocols are required for the management of ascitic drains and clear communication with nursing staff is essential.

Disclosure of Interest None Declared

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PTU-003 PARACENTESIS: UK TRAINEES' PRACTICE, EXPERIENCE AND ATTITUDES

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Introduction Abdominal paracentesis is considered a relatively safe procedure¹ but serious life threatening complications are known to occur² and practise guidelines often differ between centres. Moreover, in many European countries gastroenterologists are trained in the use of abdominal ultrasound and utilise this when inserting paracentesis catheters.

Aim :To obtain a snapshot of current UK trainee practise and experience of paracentesis and its complications.

Methods A cross sectional survey of current UK gastroenterology trainees was conducted over a 3 week period (Dec 2012-Jan 2013).

Results 88 trainees completed the survey. 75% (76/88) of respondents have more than 3 yrs' experience in gastroenterology at registrar level. 42% (37/88) report having performed or supervised > 100 procedures and a further 42% have performed > 50 procedures. 28.7% (26/88) have witnessed serious complications; 14.9% (13/88) report significant haemorrhage requiring blood transfusion, 16.1% (14/88) have encountered bowel perforation and 9%(6/88) attribute a patient's death to a paracentesis. Only 10.2% (9/88) of trainees routinely take informed written consent. 22.7% (20/88) state that their unit has no formal consent policy for paracentesis. 63% (48/88) of trainees exclusively use suprapubic 'Bonnano' catheters despite the fact that this product is unlicensed for use as a paracentesis catheter.

The majority of trainees (78.4%) estimate a failure rate requiring ultrasound guided catheter placement of < 10%. However, 23.9% (21/88) state that when this is required patients routinely wait longer than 2 days. 73.9% (65/88) report that radiology colleagues are unwilling to insert catheters in patients with INR > 1.5 without administration of fresh frozen plasma. 80.7% (71/88) of trainees believe training in abdominal ultrasonography should be part of the gastroenterology curriculum and 62.5% (55/88) feel that this would improve the safety and efficiency of paracentesis.

Conclusion The number of UK trainees reporting serious adverse events due to paracentesis is higher than expected. It is therefore of concern that few trainees are taking written consent for this procedure. The majority of trainees are still using the unlicensed 'Bonnano' catheter despite the availability of licenced products such as the 'Safe-T-Centesis' and 'Neo-Hydro' drainage kits. The majority of UK gastroenterology trainees express a desire to be trained in abdominal ultrasonography and believe this would improve the safety of paracentesis.

Disclosure of Interest None Declared

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PTU-004 THE USE OF A "MOODLE" VIRTUAL LEARNING ENVIRONMENT (VLE) IN GASTROENTEROLOGY TRAINING

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Introduction The East Midlands Healthcare Workforce Deanery launched a VLE pilot in 2009 and subsequently rolled out the "Moodle" based platform to all Postgraduate schools. Some schools have used the VLE as an information repository only, but The School of Gastroenterology South was keen to exploit the full potential by developing interactive activities and evaluating their acceptability to trainees.

Methods In addition to using our “Moodle” page as a repository for training information, rotation and teaching event details and Journal club records we have also developed Endoscopy and Gastro-radiology atlases.

Forums for Case, Endoscopy and Radiology Presentations have also been developed, and these are “Question and Answer” forums in which trainees post a short introduction and others reply with their thoughts. Other trainee’s postings become visible once an individual has posted themselves, thus removing the chance that all replies will mirror that of the first reply. As the discussion progresses the case is updated by the original poster to mirror how the case developed in real life.

To augment the learning during regional teaching, quizzes are placed on the VLE following each session and immediate feedback is given. Teaching evaluation is also obtained through the VLE which simplifies the analysis of this feedback.

We have surveyed how the trainee’s use the VLE and which areas they find most useful via a questionnaire in order to guide further development.

Results Pleasingly all trainees were aware of the existence of a VLE for Gastroenterology and have accessed it at some stage. The case discussion forums are used most and found useful by all trainees. All those who have used the Endoscopy and Radiology libraries find them useful, and all trainees report finding the Journal Club records and the single point of access for training information, e-learning resources and rotation details useful. The quizzes following teaching sessions were seen as less helpful, but two thirds still found them to be useful. The medical apps area is not used by any trainees and this may relate more to the ready access to medical apps available on smart phones.

Conclusion The interactive use of the VLE has been accepted by most trainees and has led to evidence based discussion around cases and consolidation of learning together with providing a repository for the storage of information and resources. The “moodle” platform requires only simple IT skills and material can be developed by anybody with basic word processor skills. Further development is planned that will include blueprinting of the curriculum to the rotation and learning material available, together with further interactive case discussions.

Disclosure of Interest None Declared

PTU-005 AGREEING ENDOSCOPY TRAINER ATTRIBUTES – A DELPHI STUDY TO DEVELOP A TRAINER EVALUATION TOOLKIT

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Introduction Recent advances have been made to improve the skills of the UK’s endoscopists but currently endoscopy trainers have no validated method by which to receive formative feedback regarding their training. Previous research has developed a list of attributes that describe the high quality trainer and could be used to deliver frequent feedback¹. This study uses the Delphi technique to select and refine attributes to be included in an evaluation toolkit. The Delphi technique is a group consensus technique that involves asking a panel to take part in a series of rounds to clarify, refine and finally gain consensus on an issue.

Methods Four sub-groups (experts, trainers, nurse endoscopists and trainees) reviewed the list of attributes that describe good endoscopy trainers derived from previous work¹. Participants were asked to suggest additions or modifications and rate the suitability of each attribute for two types of evaluation instrument: a single session (DOTS: directly observed teaching skills) or a rotation (LETS: long-term evaluation of teaching skills). After round one free text comments were analysed, additional items added and suggested modifications were made; attributes which scored less than

77% agreement were excluded; those that scored above 77% and had significantly different scores for the LETS and DOTS were allocated to the appropriate instrument. The remaining attributes were resubmitted to the panel in round 2

Results 62 participants completed the process. Following free-text analysis it was apparent that the panel wanted tools that were as short as possible. The attributes were therefore re-grouped and similar attributes amalgamated. Remaining comments were reviewed and subsequent modifications made, 17 attributes were excluded in round 1; 8 were allocated to the DOTS and 9 to the LETS. In round 2 a further 12 attributes were allocated to the DOTS and 6 to the LETS and one new item added

Conclusion By conducting this study it has been possible to develop a usable evaluation toolkit by which trainers could gain formative feedback on their performance. The Delphi process has enabled us to reduce the number of attributes included in the toolkit and refine these attributes. It has also enabled us to gain and amalgamate the opinions of a large panel of experts. Due to suggestions made by the panel, the original wording of 13 of the attributes was refined. Five attributes have resulted from an amalgamation of attributes

Disclosure of Interest None Declared

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PTU-006 USING DIGISTORIES TO CHALLENGE STUDENT ATTITUDES TO ADDICTION

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Introduction Addiction to both alcohol and other drugs creates a large health burden within the NHS. Undergraduate exposure to these patients tends to be opportunistic and sporadic; we wanted to create a learning experience for large groups of 30+ students using a real patient storey. Patients with drug and alcohol dependence can lead chaotic lives and may feel threatened by a large group teaching encounter, they may struggle to talk about their often highly personal experiences. Moreover patients with addictions may only volunteer for teaching once they have been abstinent and consequently their storey whilst relevant is no longer current.

Methods A transdisciplinary group of Gastrointestinal and Mental Health teachers elected to produce a digital storey (digistory) of a patient currently dependent on both alcohol and opiates. A digistory is a personal narrative normally set to still images which change in reference to the person’s storey. Typically it is recorded using a Dictaphone and embedded within a PowerPoint picture presentation. The advantage of a digistory over conventional video is that the patient’s anonymity is preserved whilst the patient retains their own voice; the addition of appropriate images makes the storey more powerful and creates a focus whilst listening to the audio.

A patient known to a regional addictions service was approached, consented and recorded. The digistory was shown to the patient prior being shown to the students.

In groups students discussed their previous experiences of addiction and then watched the digistory. To enhance knowledge transfer they were asked to consider a biopsychosocial problem list for the patient. They then reflected on their own preconceived ideas about addictions, reaction to the storey and developed a patient problem list.

Students completed a written evaluation of the session.

Results There was consensus that the digistory was a powerful learning tool and that the session was thought provoking. Furthermore they stated that the storey’s power arose from the fact the