Methods the following data about endoscopists in screening programs between 201–017 were collected: age, sex, years as physician, specialization, annual colonoscopy volume. During 201–014, younger endoscopists (<40 yr) underwent four meetings with a senior endoscopist (Christopher Williams), to improve general endoscopic ability and, in particular, the sensitivity to detect adenomatous lesions. ADR was calculated for each operator. Data were analyzed with SPSS program.

Results During the three year period, 191 endoscopists performed a total of 42,706 first colonoscopies after FIT positivity. One hundred forty with at least 20 colonoscopies after FIT positivity/yr, (mean age $48.2\text{yr} \pm 10.8\text{yr}$ ($M \pm SD$), Male 53.9%) were selected. Three hundred eight-two ADRs were collected during the observation period. Overall ADR was $43.7 \pm 9.5\%$. Ninety-six of the endoscopists were specialized in gastroenterology, 35 in general surgery, and 8 in other specialities. ADR was $44.1 \pm 9.7\%$ for the gastroenterologists, $42.7 \pm 9.6\%$ for the surgeons ($p = \text{ns}$) and $39.5 \pm 7\%$ for those with other specialities ($p = 0.033$). ADR was significantly higher for the younger endoscopists (3–9yr 47.5%; 4–9yr 44.6%; >50yr 41.4%, with $p < 0.001$). The ADRs over the three year period were similar (44.2% vs 42.9% vs 43.3%, $p = \text{ns}$). No significant association between ADR and number of screening colonoscopies performed weew found. When the ADR in 2017 of 81 endoscopists was analyzed depending on the cumulative number of total colonoscopies/yr, it was found that the those with > 300 colonoscopies/yr had higher ADRs ($35.5 \pm 21.4\%$ vs $43.5 \pm 11.5\%$, $p = 0.04$) in colonoscopies after FIT positivity/yr.

Conclusions Study findings demonstrated that junior endoscopists and those specialized in gastroenterology were more effective in identifying adenomas during screening colonoscopy procedures. High annual colonoscopy volumes and working exclusively as endoscopists but not years of experience or being older were associated with higher ADRs. Educational interventions seemed to be effective in improving sensitivity and performance.

OWE-35 MULTIPROFESSIONAL IN SITU SIMULATION IS AN EFFECTIVE METHOD OF IDENTIFYING LATENT PATIENT SAFETY THREATS

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Introduction Identifying errors in the ward environment, healthcare organisation or interaction between the multiprofessional team members is crucial. Such identification may prevent serious mistakes that can occur in high pressure gastroenterology emergencies. Unannounced multiprofessional in situ simulation can be an effective means of identifying latent patient safety threats before they occur. We set up a standardised in situ simulation programme centred around speciality specific emergency scenarios not only to improve skills, team working and communication but also to identify and address latent errors. The in situ faculty consisted of a consultant gastroenterologist; skills tutor; education fellow and director of medical education.

Methods We identified key learning objectives for several different emergency scenarios including: massive upper gastrointestinal haemorrhage; septic shock; post-procedure

complications and cardiac arrest. Using a wireless high fidelity simulation manikin we ran 15 unannounced sessions between February 2017 and January 2019. There was a minimum of three faculty in attendance in each of the sessions and an overall total of 67 participants representing the spectrum of different professions including: doctors; nurses; health care assistants and students from nursing, medical, and physician associate backgrounds. Following completion of the scenario a structured debrief was conducted. Latent errors affecting patient safety at an individual, team or organisational level were identified and discussed. Following the scenarios, actions were put in place designed to address the identified errors in a timely fashion.

Results During the 15 unannounced sessions between February 2017 and January 2019 we identified the following latent errors: shortage of Sengstaken-Blakemore tubes, Bair Hugger and a step for CPR on the ward; lack of awareness as to how to activate the major haemorrhage protocol; junior doctors without working pagers; deficiencies in resuscitation skills amongst non-training grade doctors; members of the multiprofessional team forgetting each others' names and parts of the ALS algorithm; not knowing where the oral glucose gel is kept on the ward. Since the identification of these errors corrective measures have included: laminated ALS algorithms attached to the resuscitation trolleys and dedicated major haemorrhage protocol training at junior doctor induction. Equipment shortages including sourcing the relevant equipment has been undertaken by ward management. Dedicated training days for the non-training grade doctors has also been undertaken.

Conclusions In situ simulation is highly effective in identifying latent errors that could have potentially deleterious consequences on patient safety. This allows corrective measures to be undertaken in advance of real-life emergencies.

Posters

PWE-100 ENDOSCOPY TRAINING IN SIERRA LEONE – SUCCESSFUL REMOTE SUPERVISION LEADING TO A SUSTAINABLE OGD SERVICE

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Introduction Sierra Leone is a poor country in Africa; population 7 million. Medical services are rudimentary. Until 2016 there was no established endoscopy service within the country. We describe a successful novel model of direct and remote supervision to train and mentor 3 doctors to competence in diagnostic Gastroscopy (OGD).

Methods A team of UK doctors developed and delivered a modified JAG OGD basic skills course during a week-long visit to Sierra Leone in 2016 to 3 doctors at Choithram Memorial Hospital, Freetown. Training involved group discussion of pre and post procedural aspects of OGD, intense procedural visual conceptualisation, hands-on model training and OGD on 12 volunteer patients under direct supervision. Trainees were trained to give feedback using the JAG DOPS form. Over the subsequent 12 months, the UK team offered regular

weekly feedback and support via WhatsApp. Trainees were required to perform procedures with all 3 present: one carrying out the OGD, the 2nd supporting with vocal prompts and the 3rd recording the procedure via mobile technology. DOPS feedback took place on each case locally and supplementary feedback was delivered by UK faculty following video review. In 2017 the UK team revisited Freetown and provided further training on live cases. Each trainee underwent an oral viva examination and were assessed by 2 trainers over an OGD case by summative DOPS. In 2018 at the time of a third visit, the 3 trainees were again assessed with a focus on report writing and pathology recognition.

Results To date 290 OGDs have been performed by Freetown doctors without complication. At the time of the second visit in 2017, all trainees satisfied DOPS criteria demonstrating competent, safe practice and were awarded “provisional certification” and continued to practice in pairs. In 2018, all trainees demonstrated additional periprocedural competence and knowledge and were granted “full certification” to practice alone, with the proviso that they continued to provide videos of pathology as part of ongoing remote support. 250 procedures had been performed by the team at this point in time with high quality KPIs of D2 intubation and retroflexion occurring in >90% of cases. Train the Trainer training was delivered to Freetown endoscopists in 2018 and utilised in training 3 new trainees.

Conclusion A sustainable OGD service can be developed using intermittent direct supervision and remote mentoring. The use of intense procedural visualisation, trainee to trainee feedback and highly supportive trainers are identified as critical elements to achieve this. Similar models could be applied in other developing countries.

PWE-101 AN INNOVATIVE MODEL OF INTERPROFESSIONAL EDUCATION TO IMPROVE STAFF CONFIDENCE, COMPETENCE, AND MULTIDISCIPLINARY COMMUNICATION

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Introduction We have introduced an innovative model of interprofessional education on the gastroenterology ward at Homerton University Hospital NHS Foundation Trust, United Kingdom (UK). The purpose of this model is to improve self-reported confidence and clinical competence of staff and to promote multidisciplinary communication.

Methodology There are five phases of the education model.

In phase one (1), reflective sessions were conducted for all ward nurses with an aim to develop a better understanding of the concept and to incorporate reflection into everyday clinical practice. Questionnaires pre and post-session were distributed.

In phase two (2), once-monthly medical teaching sessions were organised for junior doctors and nurses over a one-year period (December 2017- November 2018).

In phase three (3), a staff survey was conducted (June 2018), mid-way through the medical teachings to assess confidence in skills gained through attendance at these sessions.

In phase four (4), five-minute poster reading sessions were introduced for nurses. These sessions were conducted once weekly over a five-month period (August 2018- December 2018). The poster was generated from preceding month's medical teaching session.

Qualitative semi-structured interviews were conducted to assess the quality of these sessions in phase five (5).

Results

1. Reflective sessions were arranged for 85% of the ward nurses (n=14 nurses). Pre and post-session questionnaires demonstrated good understanding of reflection and all nurses agreed that it enhanced thinking and analytical skills.
2. Eleven medical teaching sessions were conducted over a one-year period (December 2017- November 2018). The total number of attendees was 79, 42% were doctors and 38% were nurses. All staff agreed that the sessions made them more confident in the management of particular cases. The majority also agreed that these sessions would change their practice.
3. Staff survey results at six months (mid-way) were gathered from 36% of staff that had attended one or more of the teaching sessions. All agreed that they have been more confident in applying the skills taught and that the sessions promoted multidisciplinary communication.
4. The total number of Poster reading sessions was 18 over the five-month period (August 2018- December 2018).
5. Semi-structured interviews were conducted after five months of running the Poster reading sessions. All nurses agreed that the sessions enhanced confidence and clinical skills.

Conclusions Implementing an interprofessional education model within a clinical area was challenging due to busy clinical commitments. However, these sessions have provided staff with an efficient way of learning within a clinical environment. These sessions have improved self-reported confidence and clinical skills, and promoted multi-disciplinary communication.

PWE-102 AN EDUCATIONAL INTERVENTION IMPROVES FOUNDATION DOCTORS' CONFIDENCE IN THE MANAGEMENT OF PATIENTS WITH ASCITES

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Introduction Cirrhosis is the most common cause of ascites, with ascites occurring in 50% of patients with cirrhosis over 10 years of follow-up¹. Cirrhosis is responsible for ~% of all deaths in most European countries, and is increasing in incidence in the UK and Ireland².

Ascites has a mortality rate of 48% at one year, and can have acutely life-threatening complications such as spontaneous bacterial peritonitis³.

Direct observation in our unit suggested that Foundation doctors were often not confident in the management of patients with ascites.

Methods 19 Foundation doctors (14 Foundation year one (F1), and 5 Foundation year two (F2)) in a district general hospital completed a 13-question survey to assess their confidence in the management of patients with ascites. Each