had received training, 21.5% had been ad hoc, 2.5% as planned ward based teaching, 11% online via e-learning and 65% in a classroom with a presentation. 40.5% of participants who had undergone some sort of CXR training (with between 1 and 20 images to review) but no standardised competency assessment.

Despite this, 77% of participants felt competent in reviewing CXRs for the purpose of confirming NGT position. 63% of those reported feeling competent as an FY1, 30.5% reported competence at FY2. 3.3% of participants have signed others off as competent at reviewing CXRs for NGTs.

Upon delivery of training and competency assessment, 63% passed, highlighting a discrepancy between perceived and actual competence (77% vs 59%) which is concerning. The results by training grade are shown in the table below. Those who passed received a competency certificate to link with the national portfolio for training and future training was provided to those who failed, for reassessment. Written feedback for the session was positive.

Grade	FY1	FY2	CT1	CT2
Pass	10/13 (77%)	7/15 (47%)	11/18 (61%)	10/14 (79%)
Fail	3/13 (23%)	8/15 (53%)	7/18 (39%)	4/14 (21%)

Conclusions Despite NPSA recommendations, there is no standardisation in practice, and over one-third of doctors receiving no formal training. Where training exists it is varied. The delivery of a standardised training and assessment programme led to 63% of doctors achieving competency and we believe ongoing utilisation of this training will increase doctor confidence when interpreting CXR and reduce the risk of NGT related never events.

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PWE-106 'DOCUMENTING THE DRAIN': INTRODUCTION OF A PROFORMA TO IMPROVE THE DOCUMENTATION OF ABDOMINAL PARACENTESIS

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Introduction Abdominal paracentesis is a common procedure in the inpatient and Ambulatory Care setting. It is 'desirable' to attain competence during Core Medical training (CMT), but mandatory in Gastroenterology and General Internal Medicine training. Trainees performing this procedure must be capable in both its practicalities and documentation.

However, in the absence of a standardised approach there can be significant variability in the extent of procedural documentation. We therefore aimed to evaluate the quality of abdominal paracentesis documentation as well as trainees' confidence in this, before introducing a proforma to improve both aspects.

Methods We determined 16 key elements for 'gold standard' documentation, informed by guidelines and consultant consensus. These formed the basis of the proposed 'Abdominal Paracentesis Proforma' [Figure 1].

We collected baseline documentation data on 15 procedures, scored out of 16 points based on how many 'key elements' were included. Qualitative data was collected from trainees (<CMT grade) regarding their experience with abdominal paracentesis and its documentation. The Abdominal Paracentesis Proforma was then introduced and promoted. Repeat quantitative data was collected from a further 10 procedures, as well as preliminary repeat qualitative data from the trainee cohort.

Results Scores for the initial 15 pre-proforma procedures ranged from -2/16, meaning compliance with the 16 'key elements' ranged from 12.5%-75%. The mean score was 7/16 (43.8% compliance) and mode score was 8/16 (50% compliance). Following introduction of the proforma, scores ranged from -6/16, with compliance therefore improving to 56.3%-100%. The mean score doubled to 14/16 (87.5% compliance) and the mode score was 16/16 (as all elements of the proforma were documented in 60% of cases).

In terms of qualitative data, 52 juniors were surveyed. 30 (57.7%) had performed at least one abdominal paracentesis before. Only 5/52 (9.62%) had formal training regarding documentation, whilst 27/52 (51.9%) had received informal advice. Almost a third (32.7%) reported zero confidence in documentation, with only 18/52 (34.6%) reporting above average confidence. 46/52 (88.5%) felt that a proforma would benefit them.

Data collection is ongoing at the time of abstract submission, but preliminary post-proforma qualitative data includes CMT trainees. 5/5 (100%) now reported above average confidence and felt the proforma benefitted them.

Conclusion We have demonstrated that existing documentation of abdominal paracentesis was insufficient and that trainees lacked confidence in this process. However, provisional data has determined improvement in both aspects following the

Abdominal Paracentesis Proforma

Great Western Hospital NHS Foundation Trust

COMPLETE THIS PROFORMA FOR ALL PATIENTS UNDERGOING ABDOMINAL PARACENTESIS

- Affix patient identification sticker here if available -

PATIENT NAME : _____

MRN : _____

DOB : _____

INDICATIONS FOR ABDOMINAL PARACENTESIS:

Therapeutic benefit ☐

Refractory ascites ☐

Diuretic resistant ascites ☐

Malignant ascites ☐

1. PRE-DRAIN

✓ Ensure there is an appropriate indication necessitating abdominal paracentesis (see above) ☐

✓ Check relevant pre-procedure medications (i.e. aspirin, clopidogrel, warfarin, DOAC, heparin) ☐

✓ Check pre-procedure INR (discuss with Gastro SpR if >1.7) ☐

✓ Check pre-procedure platelets (discuss with Gastro SpR if <50) ☐

✓ Consent (including discussion of complications : bleeding, perforation, infection, failed procedure) ☐

✓ Assess the need for USS-guidance (i.e. in the instance of a 'dry tap') ☐

2. DRAIN INSERTION

✓ Time of drain insertion: _____ Number of attempts required: _____

✓ Additional information: (i.e. which sterile measures were used, development of any complications, any investigations that ascitic fluid was sent for etc.)

3. DRAIN MANAGEMENT

✓ Volume expansion requested from Blood Bank (20% Human Albumin Solution, 'HAS') ☐

✓ Volume expansion prescribed (100mls HAS for every 3 litres of ascites drained) ☐

✓ Nursing staff instructed to remove drain after 6 hours ☐

✓ Total volume of ascites drained: _____ Volume of HAS required: _____

NAME: _____ **SIGNATURE :** _____ **BLEEP :** _____ **DATE :** _____

Abstract PWE-106 Figure 1

introduction of a dedicated proforma. There remains further scope to develop this, ideally supported by practical training.

PWE-107 DIRECT OBSERVATION OF PROCEDURAL SKILLS (DOPS) ASSESSMENT IN GASTROSCOPY: VALIDITY AND COMPETENCY DEVELOPMENT DURING TRAINING

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Introduction Validated competency assessment tools and the data supporting milestone development during gastroscopy training are lacking. We aimed to assess the validity of a novel formative direct observation of procedural skills (DOPS) assessment tool in gastroscopy, and study competency development using DOPS.

Methods This was a prospective multicentre analysis of formative gastroscopy DOPS assessments. Internal structure validity was tested using exploratory factor analysis and reliability estimated using generalisability theory. Item and global DOPS scores were stratified by lifetime procedure count to define learning curves, using a threshold determined from receiver operator characteristics (ROC) analysis. Multivariable binary logistic regression analysis was performed to identify independent predictors of DOPS competence.