Aim

Since the British Thoracic Society published their national emergency oxygen guidelines and the national wide audits this has shown generally poor adherence to oxygen prescription. To test our adherence to these guidelines we looked at the effect of a simple oxygen prescribing induction session on the ability to prescribe oxygen appropriately. A total of 15 foundation year 1 doctors, 13 foundation year 2 doctors and 11 health care professionals of different backgrounds on a respiratory ward were assessed.

Method

1. 10 mcq’s taken from a sample of 60 based on BTS guidance on oxygen prescription. Pass mark set at 70% - negatively marked. Question format - specify target oxygen saturation, device and flow rate - all components required.

2. 15 minute tutorial on the basics of oxygen prescription.

3. Repeat 10 mcq’s taken from a sample of 60 mcq’s. Before and after marks compared.

Results

The average number of questions answered correctly was 5.8 for FY1 doctors. The score post tutorial rose to 7.7 with fewer number of questions omitted. The average number of questions answered correctly for FY2 doctors was 6.5 pre and 8.1 post tutorial with fewer number of questions omitted. When looking at health care professionals working in the respiratory department (FY1, FY2, core medical trainees and nurse practitioners) they scored 7.9 pre and 9.2 post tutorial with no questions omitted pre or post assessment.

<table>
<thead>
<tr>
<th></th>
<th>Foundation year 1 doctors</th>
<th>Foundation year 2 doctors</th>
<th>Respiratory department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre tutorial score</td>
<td>5.8 (58%)</td>
<td>6.5 (65%)</td>
<td>7.9 (79%)</td>
</tr>
<tr>
<td>Post tutorial score</td>
<td>7.7 (77%)</td>
<td>8.1 (81%)</td>
<td>9.2 (92%)</td>
</tr>
<tr>
<td>Average number of omitted questions pre tutorial</td>
<td>2.6 (26%)</td>
<td>1.7 (17%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------</td>
<td>-----------</td>
<td>-------</td>
</tr>
<tr>
<td>Average number of questions omitted post tutorial</td>
<td>1.6 (16%)</td>
<td>0.8 (8%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

Conclusions

The results suggest that there is a relatively poor level of knowledge with regards to oxygen prescription in particular in health care professionals at the start of their careers. A simple oxygen tutorial substantially increased knowledge with regards to appropriate oxygen prescription. An oxygen tutorial should become a mandatory part of hospital induction for all health care professionals involved.
Title: Do junior doctors document a working diagnosis when clerking patients on the acute medical take?

Topic: Education

Author: Dr Deborah Smith

Co-Authors:

Aim

To identify whether doctors (from F1 to SpR) formulate differential diagnoses when clerking acute medical admissions. Anecdotal evidence in our hospital had suggested that junior doctors were failing to record a working diagnosis in the notes. A review of the literature revealed that this is a common finding, one article citing that “junior doctors did not routinely document a clinical diagnosis or differential diagnosis at the conclusion of their clerking, regardless of experience”.

Methods

A single centre retrospective review of acute medical admissions was undertaken. Over a 4 day period 249 admissions took place. 176 sets of notes were available (70.7%) and formed the final sample. Each set of patient notes was analysed for grade of doctor and existence of one or more differential diagnoses.

Results

· Very few cases were clerked by FY1 doctors – 2.3% (n=4/176)

· Doctors who did not identify themselves in the notes had the highest incidence of not proposing a diagnosis

· The incidence of a lack of working diagnosis did not reduce with experience

· In 5.7% (n=10/176) of cases no diagnosis existed by the time of the post take ward round

Conclusion

The results suggest that there is insufficient emphasis in undergraduate training on the importance of proper documentation in patient records, and on the development of skills that allow the formulation of working diagnoses. Greater exposure of FY1’s to the acute medical take could help support earlier development of diagnostic skills. Induction days should include the importance of patient notes as a legal record.
References

Aim

In this presentation I will highlight the use of bed side ultrasound at the point of care ,in a safe, accurate, rapid and noninvasive approach.

Methods

To outline the components and rationale for various ultrasound protocols in critically ill patient.

Initially a brief review of:

- FEEL (Focused Echo in Emergency Life support).
- FICE (Focused Intensive Care Echo).
- ACES (Abdominal and Cardiac Evaluation with sonography in Shock).
- RUSH scan (Rapid Ultrasound for Shock).
- Level 1 Thoracic Ultrasound as per BTS.

Last section is an interactive case scenarios, loaded with with CXRs and ultrasound pictures and videos.

All these cases are true patients of mine, I encountered on oncall days, where bed side ultrasound affected patient management positively and improved outcome.

OUTCOME

FAST (Focused Assessment Sonography in Trauma) is the standard of care in the evaluation of a sick trauma patient. However there seems to be far less urgency to use ultrasound to evaluate the medical sick patient with hypotension or shock. Part of the reason is the lack of a standardized protocol of bed side ultrasound in medically ill patient.

The College of Emergency Medicine includes Ultrasound training in the curriculum for their trainees.Is it
the time for SAM to lead the way in emergency ultrasound for Acute Physicians.

CONCLUSION

I sincerely believe in the clinical utility and improved patient care offered by emergency ultrasound, I would like to share my passion about ultrasound with my colleague trainees in Acute Medicine.
Feedfront?

*Feedback on the feedback*…

George Morris, Siyum Strait, Shiva Sreenivasan

Gloucestershire Royal Hospital, Gloucester

**Introduction**

Acute medicine units (AMUs) are rich in educational opportunities for trainee doctors. Trainers aim to balance service provision with high quality education. Apart from collating individual teaching feedback and an annual Deanery report, the overall educational experience of our trainees in acute medicine had not previously been formally assessed. We developed and implemented standards from national guidelines to capture trainees’ core educational requirements.

**Method**

The Trainee Doctor\(^1\) provides guidance on education and training of doctors during foundation and specialty training. Recommendations relevant to AMU trainees were identified and categorised into five domains: Teaching, procedures, assessments, feedback and professional development. Junior and senior team members agreed on the standard for each. To trial these, a questionnaire (Figure 1) was distributed to all trainees during the final 2 weeks of their attachment (n=12).

**Results**

Of the five domains, in-house teaching attendance was considerably less than the mandatory foundation/specialty teaching sessions (25% vs. 58%). 43% of all trainees completed a personal development plan. Feedback on work based on post-take ward rounds was substantially limited by inability of trainees to attend regular post-take ward rounds. Standards were met for procedures and work-based
assessments.

Conclusion

We have developed a tool to aid contemporaneous constructive feedback to trainers in acute medicine, and have identified gaps in trainees’ education requiring further action. These devised standards can be adapted to any clinical teaching environment, and provide a foundation for assessment and development of core elements of medical education.

References

Aim:

To review cardiopulmonary resuscitation skills amongst medical trainees participating in the acute medical take.

Methods:

We conducted a written survey of all medical trainees working at Chelsea and Westminster Hospital to ascertain their training, clinical exposure, confidence and competence to perform basic airway skills (BAS), DC cardioversion (DCCV) and cardiopulmonary resuscitation (CPR).

Results:

113 junior doctors completed the survey (86% response rate) – 36 FY1s, 36 FY2s, 12 ST1/2s, 10 ST3/4s and 14 ST5+. Clinical exposure and confidence increased with year of training for all procedures. By ST5+ most trainees had been signed off for BAS (57%) and CPR (64%), but not DCCV (36%). There was evidence of trainees being signed off for procedures performed fewer than ten times. The majority of FY1s, FY2s and ST1/2s reported no clinical exposure to DCCV and confidence was less than for the other skills. Simulation training was more prevalent for BAS (81%) and CPR (84%) than DCCV (35%), which was primarily taught at the bedside (39%).

Discussion/Conclusion:

It is mandated that FY1 doctors are trained in Immediate Life Support and FY2 doctors are trained in Advanced Life Support. There is limited clinical exposure to re-enforce this training, yet specialty trainees are expected to be independent in advanced CPR on completion of Core Medical Training. Simulation training may have a role in increasing exposure and confidence, particularly amongst Foundation Year doctors. Simulation may also aid validation of competency sign off by E-Portfolio.
Aim

‘Ward rounds in medicine’\(^1\) highlighted significant variability in practice and recommended structured review and training for those taking part in rounds. Junior doctors play a pivotal role and in return are offered significant learning opportunities\(^2\) yet the Foundation training curriculum\(^3\) makes no specific reference to the competencies needed for ‘good’ rounds.

Method

A survey issued to final year medical students (37) and juniors doctors (73) showed lack of confidence levels in leading ward rounds (21% doctors, 3% students) and few had previous training (15% and 24% respectively). A simulation session was then developed with 3 clinical patient (actors) encounters. Participants were assigned roles including leading and documentation. Feedback was obtained after the training session.

Results

The session was run for 37 final year medical students and 97% rated the session as ‘excellent’. Self rated confidence in leading and documenting rounds improved to 43% and 68 % respectively. 92% of students felt that further sessions would be useful prior to foundation training. All students felt that training should be incorporated into medical school curricula.

Conclusion

Junior doctors provide the majority of daily patient contact and are essential to the ward round process, yet many lack in confidence. Ward round simulation training was well received and showed improved confidence levels in medical students. Just as ‘signing off’ the ability to site a cannula, surely being able to perform a structured patient review is equally important if we are to ensure the safety of patients in the hands of these future doctors?

References:


Title: Providing junior trainees on the Acute Medical Unit a more varied clinical experience - Is sessions in ambulatory and medical clinics the answer?

Topic: Education

Author: Nithin Narayan
Co-Authors: Stephen Gulliford

AIM
The Acute Medical Unit (AMU) junior doctor team at Royal Albert Edward Infirmary, Wigan, consists of six Core Trainees and Foundation Doctors. We recognised at times multiple trainees were doing similar duties on the AMU, and struggled to attain mandatory attendances in medical clinics. We implemented an AMU rota, aiming to incorporate on-call commitments and local teaching sessions, with additional fixed sessions on the Ambulatory Unit and Medical Clinics.

METHODS
A six week pilot AMU rota was designed, on MS Word, using the template of the on-call medical rota. A minimum of two junior trainees were placed to the AMU, and additional trainees were then allocated to the Ambulatory Unit or Medical Clinics in Gastroenterology, Diabetes & Endocrinology and General Medicine. Each trainee, during the six weeks, attended four sessions in the ambulatory unit, and three medical clinics. Following the pilot, anonymous feedback from junior trainees and AMU consultants was collected using SurveyMonkey.com.

OUTCOMES/RESULTS
5 of 6 juniors and 5 of 7 consultants supplied feedback online (Figure 1). Both consultants and junior trainees agreed that they attended an adequate number of extra sessions, which were educationally beneficial. Feedback indicated that at times there was unsatisfactory cover on the AMU, as the rota did not accommodate unexpected leave due to sickness. All ten agreed that they would like the rota to continue, and would prefer an online live rota.

CONCLUSION
A rota with timetabled sessions in ambulatory and medical clinics provides trainees with a more varied and enhanced learning environment.