

national 7.1%). Following this, an electronic alert was incorporated into a bespoke prescribing system to remind doctors to prescribe oxygen. This alert was triggered whenever the oxygen saturations of a patient were recorded on supplemental oxygen without an oxygen prescription.

Method Data was collected using the standard BTS oxygen prescribing audit proforma in October 2011 and October 2012. In 2012, 215 patients from six medical and respiratory wards were included; 40 were on supplemental oxygen. We used Fisher exact test to analyse our data.

Results The number of patients using oxygen with a valid prescription increased significantly from 42.9% in 2011 to 72.5% in 2012 ($p = 0.023$). The national average for oxygen prescriptions in 2012 was 52.3%. Oxygen is being signed for on drug rounds more often, 64.1% of the time compared with 13.5% the previous year. Despite the number of oxygen prescriptions increasing significantly, the proportion of patients with saturations in their target range actually decreased.

Conclusions The number of oxygen prescriptions have increased significantly with the introduction of an electronic alert system. Potential developments for the future would include an automatic prescription with 'opt out' facility and an alert for nursing staff when oxygen saturations are out of range to allow better titration of oxygen. This study shows that use of information technology and prescribing alerts and reminders can have a significant effect on number of prescriptions. What remains to be seen is if this will have an effect on patient outcomes.

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CONVENTIONAL AND INTERVENTIONAL BRONCHOSCOPY TRAINEE PRACTICE AND CHALLENGES

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Introduction Bronchoscopy, an integral skill for respiratory registrar training, has been challenged by changing work patterns. Exposure to interventional bronchoscopy has posed further challenges to trainees.

Objective To assess if UK respiratory trainee bronchoscopy practice and skills are in keeping with guidelines and whether their curriculum is being adhered to. We also gauged trainee attitudes and exposure to interventional bronchoscopy.

Methods A survey was designed by us to assess training opportunities, exposure, competency and practice in conventional bronchoscopy with a section dedicated to interventional bronchoscopy. This was piloted locally then expanded nationally with 15 deaneries participating.

Results 144 replies represented 24% of potential survey recipients. 13% had bronchoscopy experience outside specialist training such as fellowships or overseas experience.

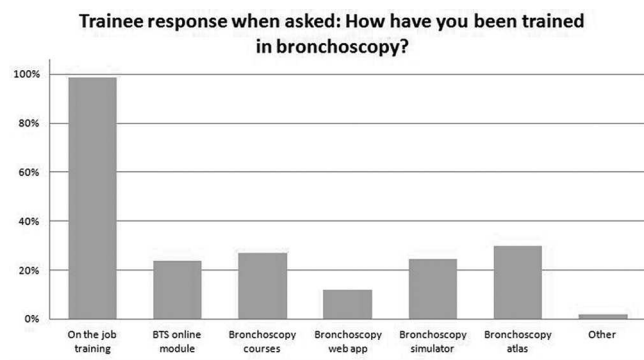
53% were scheduled to attend bronchoscopy lists at least weekly although 27% achieved this (mainly due to on-call commitments). Just 70% of trainees had performed >200 bronchoscopies by their final training year. 97% kept a logbook, though only 62% recorded 'hit-rates'.

More scope via nose than mouth (53% vs 14%) and from the front than behind (44% vs 15%). Most right-handed (68%) and left-handed (73%) trainees preferred handling the control-lever with their dominant hand, 58% were influenced by their first trainer. 98% used midazolam and 52% opioids for sedation with 8% routinely using no sedation. Trainees tend use midazolam rather than opioids first when using both (61% vs 24%).

By the final year of training, not everyone was completely independent with common diagnostic procedures, e.g. only 30% were for transbronchial biopsy. Almost all were trained on-the-job (figure). 62% of trainees rated flexible bronchoscopy training *excellent* or *good*.

Unfortunately most interventional bronchoscopy techniques weren't experienced by the vast majority. Only TBNA (36%) and EBUS-TBNA (22%) were performed by significant numbers of trainees. 24% had a definite interest in interventional bronchoscopy and of those 54% rated training *poor* or *very poor*.

Discussion The results have highlighted bronchoscopy training deficiencies and a substantial number of trainee's desire for exposure to interventional bronchoscopy techniques. Using e-portfolio akin to that already used for endoscopy and creating separate training pathways for interventional bronchoscopy may help in remedying this.



Abstract P68 Figure 1.

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THE USE OF ASSESSMENT IN THE DELIVERY OF BRONCHOSCOPY SIMULATION- ARE SKILLS RETAINED AT ASSESSMENT?

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Introduction Bronchoscopy simulation is becoming increasingly used as a tool to improve the confidence and knowledge of trainees, with the intention of increasing the speed of skill acquisition. Although this training has been shown to be effective, little research has been conducted into whether retention of skills occurs. Health Education Yorkshire and The Humber (HEYH) previously designed a mandatory programme to support the education of trainees and this has been extended to involve Anaesthetic trainees who often perform bronchoscopy.

Methods 8 Respiratory, 8 Anaesthetic and 8 bronchoscopy naive trainees underwent the simulation course. They participated in an assessment two months later. All trainees had access to the simulator to practice in the two-month period. Pre/post course and post assessment Likert scale questionnaires were carried out to assess confidence. Dexterity was assessed with data generated from the Simbionix Simulator including: final navigation scores, bronchial segments identified correctly and number wall hits in