

P111 PROCEDURAL EXPERIENCE, TRAINING OPPORTUNITIES AND ATTITUDES TOWARDS INTERCOSTAL CHEST DRAIN INSERTION: VARIATIONS BETWEEN CONSULTANTS, TRAINEES AND MEDICAL SUB-SPECIALTIES

¹JP Corcoran, ²RJ Hallifax, ³A Talwar, ¹I Psallidas, ¹A Sykes, ¹NM Rahman. ¹Oxford Centre for Respiratory Medicine, Oxford University Hospitals NHS Trust, Oxford, UK; ²Department of Respiratory Medicine, Buckinghamshire Healthcare NHS Trust, Aylesbury, UK; ³Department of Respiratory Medicine, Royal Berkshire NHS Foundation Trust, Reading, UK

10.1136/thoraxjnl-2014-206260.252

Background and method Intercostal chest drain (ICD) insertion has long been considered a core skill for the general physician to master. The NPSA alert in 2008 highlighted potential hazards associated with this procedure, whilst recent guidelines¹ advocate the use of thoracic ultrasound to reduce complications. These developments have occurred at a time when trainees report a growing lack of confidence in their clinical experience and procedural capabilities, alongside a decline in training opportunities² that might address the latter concern. Nonetheless, competence in ICD insertion remains a compulsory or highly desirable procedural skill to acquire on a number of UK specialty training curricula including that for general (internal) medicine.

We carried out a survey of consultants and trainees who contribute to general medical services in hospitals across the Thames Valley region. This survey assessed factors including physicians' attitudes towards ICD insertion; prior and recent procedural experience; training opportunities; and clinical knowledge.

Results 90 clinicians (26 consultants; 41 registrars (ST3+); 23 core medical trainees (CT1/2)) responded to the survey. Most clinicians (94% of responses) felt that placing >5 ICDs was necessary to attain initial competence at the procedure; before continuing to place >5 ICDs on an annual basis in order to maintain that competence (78% of responses). However, only 17% of medical registrars surveyed reached this basic combined standard. Other key findings are summarised in Table 1.

Conclusion Our findings demonstrate a disparity between clinical reality and the expectations junior doctors and consultants

have of the physician in training with regards to ICD competence. Most trainees cannot achieve the number of procedures they feel are required to attain independence, nor maintain that independence on an annual basis; whilst access to training in thoracic ultrasound is limited outside certain specialties. This inexperience is manifest in variable clinical understanding and procedural confidence.

Consideration needs to be given as to how medical training programmes might address these issues, and whether ICD insertion is even a skill that all general physicians can maintain competence in performing in the modern clinical environment.

REFERENCES

- 1 Thorax 2010;65 Suppl 2:ii61-76
- 2 Clin Med 2013;13(5):434-9

P112 SPEECH AND LANGUAGE THERAPY BY SKYPE™ FOR VOCAL CORD DYSFUNCTION AND CHRONIC COUGH

SF Lillie, J Haines, A Vyas, SJ Fowler. Lancashire Teaching Hospitals Trust, Preston, UK

10.1136/thoraxjnl-2014-206260.253

Introduction The Airways Service at Royal Preston Hospital receives tertiary referrals from across the UK. When a diagnosis of vocal cord dysfunction (VCD) or chronic cough is made and speech and language therapy (SLT) required, patients undergo weekly therapy (minimum four sessions), which some may struggle to attend due to pre-existing commitments and/or travel time. As SLT typically does not require 'hands-on' therapy we felt that Skype™ videoconferencing may be a useful mode of treatment delivery. We present our initial experience of this service.

Methods A six-month pilot was completed whereby patients were offered SLT over Skype. Prior to therapy all patients were seen by the respiratory consultant and speech and language therapist for assessment and flexible laryngoscopy. Patients required confidential webcam access and proficiency. Symptom questionnaires were completed pre and post therapy (for VCD

Abstract P111 Table 1 Sample of key findings from a survey of 90 clinicians relating to intercostal chest drain (ICD) insertion. Answers to clinical questions were derived using BTS Pleural Disease Guidelines (2010) and consensus between three respiratory physicians specialising in pleural disease

ATTITUDES (answers on a Likert-type scale, 1 = strongly agree to 5 = strongly disagree)	Consultants	SpRs	SHOs
		(ST3+)	(CT1/2)
"ICD insertion is a core skill that all general medical registrars should be able to perform"	1.9 ± 1.3(SD)	2.3 ± 1.2	2.2 ± 1.1
"ICD insertion is a specialist skill only a select group of physicians should perform in future"	3.5 ± 1.2(SD)	3.1 ± 1.2	3.5 ± 0.8
TRAINING and EXPERIENCE (trainees only)		SpRs	SHOs
		(ST3+)	(CT1/2)
"How many ICDs have you inserted in the last 12 months of your training?"	None	20 (49%)	5 (22%)
	<5	14 (34%)	12 (52%)
	5 to 10	5 (12%)	5 (22%)
	10 to 20	1 (2%)	1 (4%)
	>20	1 (2%)	0 (0%)
"Have you had access to simulation training in ICD insertion?"	Yes	22 (54%)	12 (52%)
	No	19 (46%)	11 (48%)
	Yes + qualification	5 (12%)	0 (0%)
	Yes, not qualified	13 (32%)	5 (22%)
"Have you had any access to training in the use of thoracic ultrasound?"	No	23 (56%)	18 (78%)
CLINICAL KNOWLEDGE (best of 5 questions, trainees only)		SpRs	SHOs
		(ST3+)	(CT1/2)
Scenario 1: Small (<2cm) asymptomatic 1° pneumothorax in 22yo male	Correct	11 (27%)	2 (9%)
Best answer: observation only	Incorrect	30 (73%)	21 (91%)
Scenario 2: Patient with suspected pleural infection and "x" marked in radiology as site for aspiration by medical team on ward.	Correct	25 (61%)	19 (83%)
Best answer: repeat USS to identify safe site and immediate aspiration +/- ICD	Incorrect	16 (39%)	4 (17%)

the 12 item VCDQ; for chronic cough the 19-item LCQ), and patient satisfaction questionnaires and flexible laryngoscopy performed post therapy.

Results Eleven people have completed SLT over Skype™ to date, and all demonstrated improvement in symptoms following therapy. Patients with VCD showed a decrease in score on the VCDQ from median (range) 48 (12–53) pre therapy to 40 (7–42) post therapy [minimal clinical important difference (MCID) 5]. Patients with chronic cough showed an increase on the LCQ from median (range) 6.4 (4.6–8.2) pre therapy to 12.2 (10–14.6) post therapy (MCID 1.3). Improvements in laryngeal tension and sensitivity were noted in all cases. All patients gave positive feedback in their patient satisfaction questionnaire scoring “very satisfied” or greater. On three occasions Skype connection problems delayed sessions by a few days.

Conclusions Virtual consultations provide the opportunity to treat patients in a more time efficient and practical way, and improvements in patient-reported symptoms and laryngeal appearances were similar to those of patients attending therapy sessions in chest clinic. This data gives support to pursue formalised tariffs for a specialised telehealth service. We feel that Skype should continue as a regular therapy option for patients and other members of the multi-disciplinary team (MDT) should consider this method of therapy delivery.

P113 THE USE OF LOCAL ANAESTHESIA IN IMPROVING THE PATIENT EXPERIENCE OF ARTERIAL BLOOD GASES: STUDENTS AND TRAINERS ARE STILL NOT GETTING THE MESSAGE

¹Z Magera, ¹C Gunasekera, ¹J Kinley, ²J King, ¹B Walker, ³O Cohen, ⁴P Dilworth. ¹University College London Medical School, London, UK; ²The Whittington Hospital, London, UK; ³University College Hospital, London, UK; ⁴Royal Free Hospital, London, UK

10.1136/thoraxjnl-2014-206260.254

Background BTS guidelines (2008) states that “local anaesthesia (LA) should be used for all arterial blood gas (ABG) specimens except in emergencies¹ as it improves the patient experience. A survey conducted in 2012 revealed only 5% of junior doctors regularly use LA with ABGs.² We were interested to determine if this has improved and establish whether medical students are being orientated to this practice.

Methodology This is a multicentre prospective study. A questionnaire survey was distributed to 4th year medical students and junior doctors affiliated with UCL Medical School. Questions related to their actual experiences of using LA with ABGs and barriers to using LA.

Results 94 medical students completed the questionnaire. Students used LA 17% of the time out of 54 supervised procedures. 29% were actively discouraged from using LA by their supervising doctor. 10% felt the general culture amongst supervising doctors was resistant to using LA.

Amongst the 86 surveyed doctors, 91% never or rarely (<10% of the time) used LA, 5% sometimes (<25% of the time) and 3% used it regularly (>75% of the time). 65% of doctors were not aware that LA was advised in national guidance. 40% of respondents felt it would not reduce the pain of the procedure and 38% did not know the technique involved of using LA.

Conclusion The use of LA is extremely poor as has been found previously.¹ The reasons reflect a lack of awareness and a culture that is experienced from the moment the enter the clinical environment as medical students. In order to improve the

patient experience we have introduced an intervention at the level of the medical school and junior doctor teaching which includes mandatory training and encouraging affiliated trusts to help create a culture where giving LA is the norm.

We will fully report on the results and success of our interventions.

REFERENCES

- 1 O'Driscoll, Howard LS, Davison AG. BTS guideline for emergency oxygen use in adult patients. *Thorax*. 2008; 63 (Suppl VI):vi1–vi73
- 2 Khan F *et al.* The Use of Local Anaesthesia For Arterial Blood Gas Sampling – A Multicentre Survey. *Thorax* 2012;67:A167-A168

P114 WHAT SKILLS, EXPERIENCE AND TRAINING ARE NEEDED TO WORK IN INTEGRATED RESPIRATORY SPECIALIST ROLES AND HOW CAN WE ROLL THESE POSTS OUT IN THE UK?

¹NJ Roberts, ²M Ward, ³IS Patel, ⁴J Yorke, ⁵J Williams, ⁶R Walters, ⁷M McKeivitt, ⁸S Edwards. ¹Glasgow Caledonian University, Glasgow, UK; ²Sherwood Forest Hospitals, Sutton in Ashfield, UK; ³Kings College Hospital London, London, UK; ⁴University of Manchester, Manchester, UK; ⁵Halton General Hospital, Runcorn, UK; ⁶Mansfield Community Hospital, Mansfield, UK; ⁷British Lung Foundation, London, UK; ⁸British Thoracic Society, London, UK

10.1136/thoraxjnl-2014-206260.255

Aims There is an increased drive towards healthcare integration in the UK (UK) to adapt to new health care needs. In response to this, new ways of delivering care have been developed such as the provision of integrated respiratory specialists. This project set out to describe these roles, the key skills needed and how junior staff can aspire to these roles.

Methods Semi-structured telephone interviews with 12 integrated care specialists or those currently working with integrated respiratory care teams were undertaken to explore and discuss the role of integrated respiratory specialists.

Results Nine integrated specialists were interviewed (6 physicians, 2 nurses, 1 physiotherapist). One Specialist Trainee (StR), a general practitioner (GP) and a pharmacist were also interviewed. The integrated role was variable for participants; most were involved in MDTs, education for staff and developing guidance, with some involved in community or virtual clinics. Physicians were more likely to be involved in Acute Medical Unit reviews. Five interviewees had two joint leads with either two physicians, or a physician and a nurse.

Key skills identified by the interviewees included respiratory specialist knowledge, prior primary care experience as well as knowledge of the NHS, commissioning and social services processes. Specific training included conflict management, advanced communication and research and evaluation skills (health economics and service evaluation). Three areas were highlighted to support the establishment of new posts: clear details about the posts and standards of care; embedding integrated care into training; increasing visibility of this new area and gaining support from appropriate organisations.

Conclusions Interviewees highlighted that existing posts should be used as exemplars to provide junior staff with more information about these roles. Greater collaboration with professional societies such as the BTS, ERS and PCRS for education as well as to promote and advance these new potential career pathways should be undertaken.

Funded by the British Thoracic Society.