

a chest x-ray, whilst 27% of trainees stated they would not investigate further. Treatment options included oxygen, salbutamol, ipratropium, 0.9% saline drops or nebulisers, 3% saline nebulisers or not doing anything at all.

It appears that trainees are less confident at differentiating episodic viral wheeze from multi-trigger wheeze. 49% of trainees stated they would be give prednisolone to children with a first episode of viral wheeze. Trainees used different cut-off levels of oxygen saturations to initiate oxygen therapy. 69% of trainees felt that recurrent episodes of multi-trigger wheeze warranted regular inhaled beclomethasone, whilst 15% felt that montelukast was more appropriate. The need for an asthma action plan and asthma clinic follow up was raised by 85% and 76% of trainees respectively.

We sought to assess the knowledge of trainees on predisposing factors for early-onset multi-trigger wheeze. The two most predictive risk factors are a personal history of eczema, and a family history of asthma in mum or dad, which were identified by 78% and 59% of trainees respectively.

Conclusions There is a marked variation in how paediatric trainees deal with childhood wheeze. Rationalising investigations and therapeutic measures in bronchiolitis is associated with cost savings. Commonly used steroids are well known to have side-effects and should only be used where indicated. Local and national guidelines on childhood wheeze should aim to standardise practice across the UK for paediatric trainees, and reduce the financial burden on the NHS.

M28 RESPIRATORY CLINICIANS' EXPERIENCES OF END-OF-LIFE CARE IN IDIOPATHIC PULMONARY FIBROSIS

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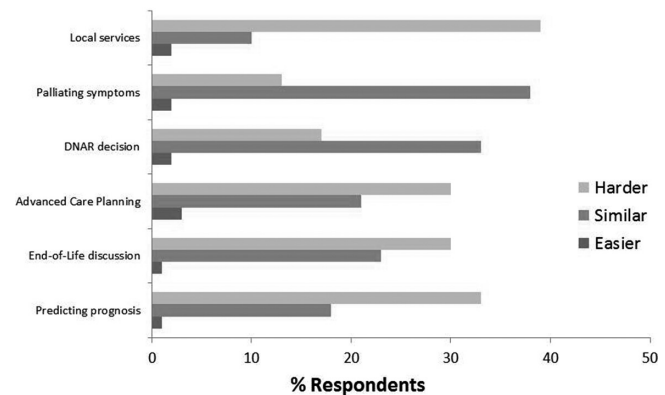
Introduction Referral rates to Specialist Palliative Care are low in Idiopathic Pulmonary Fibrosis (IPF) despite mean survival of 3 years,¹ and a high symptom burden in the final year, in particular dyspnoea, chest pain, anxiety and depression, and fatigue.² This study aimed to explore chest clinicians' experiences in delivering care in advanced IPF.

Methods Questionnaires were distributed at a regional Respiratory meeting, focussing on initiating End-of-Life discussions, predicting prognosis, training, and reasons for low palliative care referrals.

Results 57 completed questionnaires - 17 chest consultants, 28 chest registrars, 11 physiotherapists, and 1 nurse clinician. 23 (40%) initiated End-of-Life discussions in severe IPF frequently or very frequently, and 47 (84%) felt it was a very important or important part of their role, but 42% felt predicting prognosis in advanced IPF was difficult or very difficult. More consultants felt End-of-Life discussions were an important part of their role than registrars.

Several aspects of End-of-Life care were felt to be harder in severe IPF than advanced malignancy (Figure 1), although similar to advanced COPD. 22 (42%) referred patients with severe IPF to hospital palliative care services very frequently or frequently, and 19 (37%) to community palliative care very frequently or frequently. Less than 10% of all respondents felt they had significant training in initiating End-of-Life discussions, palliating symptoms, or services available.

Clinicians' difficulty in IPF compared to Advanced Malignancy



Abstract M28 Figure 1

The three symptoms perceived to be experienced most in patients dying with IPF were breathlessness, anxiety and fatigue (cohort data supports this²). The three commonest reasons for low palliative care referrals were healthcare team perceptions that palliative care services focussed on cancer, patient's lack of awareness of prognosis, and difficulty clinicians have in predicting prognosis.

Conclusion Chest clinicians find predicting prognosis in ILD difficult, and this contributes to low palliative care referrals. They have minimal training in End-of-Life issues in IPF and there is a lack of local services for such patients. Respiratory training, and commissioning groups, are challenged to develop better End-of-Life services for a condition carrying a high symptom burden and often distressing death.

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M29 TRYING TO CAUSE LESS PAIN FOR OUR PATIENTS! USING LOCAL ANAESTHESIA FOR ARTERIAL BLOOD GAS SAMPLING

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Background Direct radial artery puncture (DRAP) is considered the gold standard procedure for arterial blood gas (ABG) sampling, but it is associated with significant pain. The current 'BTS guidelines for oxygen use in adult patients' recommend using local anaesthesia (LA) for all ABG sampling except in emergency situations. LA can be administered subcutaneously or topically.

Aims

1. To assess the attitudes towards LA for ABG sampling in a population of medical junior doctors (JD).
2. To assess the effectiveness of topical lidocaine cream for ABG sampling by DRAP for respiratory inpatients.

Methods

1. Firstly, we surveyed a population of JD working in our Hospital using an electronic survey platform (SurveyMonkey®).
2. Secondly, a group of inpatients requiring ABG sampling were surveyed over two months whereby half received topical LA and half did not. The LA used was Denela® 5% cream (Lidocaine 2.5% + Prilocaine 2.5%) applied 10 to 15 min prior to DRAP. Pain associated with DRAP was assessed using a combination of the Wong-Baker FACES pain rating visual scale¹ and a visual analogue pain scale, both scoring the pain from 1 (“no pain”) to 6 (“worst pain”).

Results

1. 68 JD were contacted and 26 responses were received (shown in Table 1).
2. 56 DRAP were performed for ABG sampling, 50% received topical LA. The median (inter-quartile range) pain score was reduced with LA prior to DRAP (2.0 [1.8] “moderate pain”) compared to performing DRAP without LA (3.0 [4.0] “severe pain”), $p < 0.008$. The doctors reported insignificant interruption to their ward duties by using topical LA.

Abstract M29 Table 1 Results of electronic survey: Use of local anaesthesia in arterial blood gas sampling

1. Do you take arterial blood sampling regularly?		
Yes: 100%		No: 0
2. If answered "yes" to Q1, how often do you estimate you perform ABG sampling?		
Practically every day: 34.6%	At least once weekly: 50.0%	Less than once weekly: 15.4%
3. Have you ever used local anaesthesia for radial arterial blood sampling? (excluding arterial lines)		
Yes: 26.9%		No: 73.1%
4. If answered "no" to Q3, what's the reason for it?		
I have never heard about this practice before.		31.6%
I have not been taught how to do it.		47.4%
I usually don't have time to do it.		31.6%
I do not think it would reduce the pain associated with the procedure significantly		26.3%
5. Are you aware of the 'BTS guidelines for emergency oxygen use in adult patients' recommend the use of local anaesthesia for all arterial blood gas specimens except in emergencies or if the patient is unconscious or anaesthetised?		
Yes: 19.2%		No: 80.8%

Conclusions Currently, LA is not used routinely as part of the ABG sampling by DRAP in our centre. Pain was significantly reduced with the use of LA when performing DRAP.

These data will help inform quality improvement projects designed to implement the usage of LA for ABG sampling using DRAP as per BTS recommendations.

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M30

RESPIRATORY SKILLS COURSE FOR POST-GRADUATE MEDICAL TRAINEES; INSPIRING FUTURE RESPIRATORY TRAINEESR Young, T McLellan, C Walters. *Barts Health NHS Trust, London, UK*

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Introduction/objectives Respiratory medicine curriculum requires medical registrars to be competent in procedural skills such as intercostal chest drain (ICD) insertion, non-invasive ventilation (NIV) and thoracic ultrasound.¹ Previous research² has shown that medical registrars do not feel confident in performing respiratory related procedural skills and required further training in these skills.

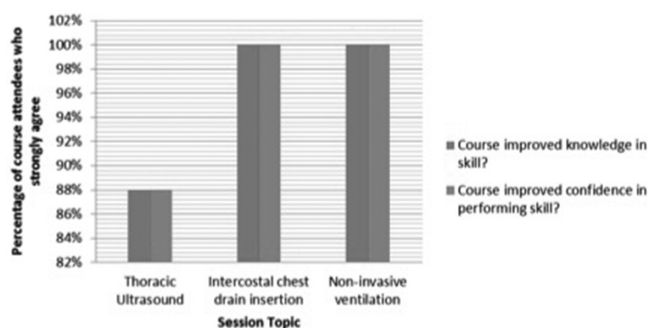
The aim of this research was to assess medical trainees' experience and confidence in performing respiratory procedural skills and the influence a respiratory skills course had on trainees' career aspirations and their confidence to perform these skills.

Methods A respiratory skills course consisting of three evening sessions was designed and delivered to medical trainees'. Teaching was delivered through small group tutorial, simulation and practice on real patients.

A pre- and post-course survey was designed, consisting of closed, Likert style and free-text response questions. This was distributed to eleven attendees at the course.

Results 50% of course attendees had received previous teaching on NIV and thoracic ultrasound whilst 70% had previous teaching on ICD insertion. The majority of candidates did not feel confident in performing the procedural skills prior to the course.

Following the course, all attendees felt that the course had improved their confidence and knowledge in performing all three procedural skills (Figure 1). One candidate stated that the course had 'made me more enthusiastic about my career choice in respiratory medicine.'

**Abstract M30 Figure 1**

Conclusion Although this study was small, the results are positive. There are however, implications to running further courses due to the willingness of faculty to facilitate sessions in their own time. This research does show that medical trainees do not feel confident in performing procedural skills, highlighting the need for more sustainable teaching in these areas to improve confidence and thus inspire trainees in medical careers.

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M31

INTRODUCTION OF EBUS INTO A RESPIRATORY DEPARTMENT – A REFLECTION ON EXPERIENCE REQUIREDAL Chapman, M Cornere. *Waitemata District Health Board, Auckland, New Zealand*

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