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Chest drain insertion— training is the key, Seldinger or otherwise

We welcome Maskell *et al*'s timely editorial highlighting the shortfalls of safe chest drain insertion.[1] Modernising Medical Careers states that competence in chest drain insertion should be achieved as a part of core medical training but does not set out how this might be practically achieved. The authors suggest that chest drain insertion should not be a generic skill but be confined to respiratory teams. Where there is a large presence of chest physicians, this may be possible. Few hospitals can achieve this. Where all chest drains cannot be inserted by the chest team, all registrars who take part in unselected acute medical take service should be trained.

Our trust, with seven chest physicians, has over the past 3 years addressed training by developing and validating a training module for chest drain insertion using a Porcine—Resin model. The module focuses on decision making and simulation training using the model with assessment using a direct observation of procedural skills; a session takes 4 h. Before proceeding to perform independently on patients, close supervision with feedback is provided until the trainee is deemed competent and confident. The West Midlands Deanery recognising the importance of training has funded a Teaching Fellow to train all Core Medical Trainees in the region using the module. We also run a training day for newly appointed Respiratory Registrars (ST3) as they lack experience and feel vulnerable.

The National Patient Safety Agency (NPSA) report[2] in May 2008 highlighted the risks associated with chest drain insertion. We conducted a postal survey of Lead Chest Physicians in all acute hospitals in England and Wales in August 2009, which showed training sessions and competency assessment were established in only 58 of the 110 hospitals that responded to the survey. There was no register of competent trainees in 76% of the departments. The NPSA's recommendation on pleural procedures audits has only been implemented by 55% of the hospitals, 1 year on.

As we uphold the mantra 'It is not the gun that is dangerous, it's the person holding it', regular training courses need to be a formal part of the training curriculum and respiratory consultants' time should be recognised in their job plans.

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