

P94

**DO HEALTHCARE PROFESSIONALS HAVE SUFFICIENT KNOWLEDGE OF INHALER TECHNIQUES IN ORDER TO EDUCATE THEIR PATIENTS EFFECTIVELY IN THEIR USE?**

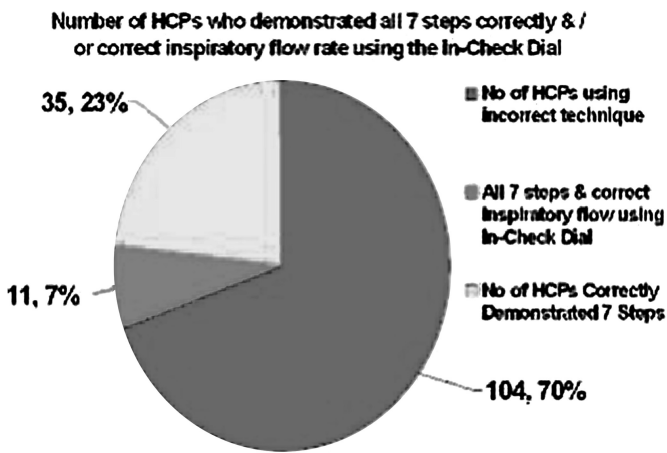
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**Introduction and objectives** Inhalers are widely used in the treatment of asthma and chronic obstructive pulmonary disease (COPD). For patients to gain maximum benefit they need to be educated by competent healthcare professionals (HCPs) whose own competence meets accepted standards. This study looked at HCPs ability to use the commonly prescribed metered dose inhaler (pMDI).

**Methods** 150 Healthcare professionals (74 Primary Care Trust; 76 Acute Trust) were asked to demonstrate how they would self-administer a pMDI placebo Inhaler. The Group included hospital doctors, hospital nurses, general practitioners, practice nurses, hospital and community pharmacy staff. Each professional was marked against a standard set by the manufacturer and Education for Health UK.<sup>1</sup> They were also asked to demonstrate the correct inspiratory flow rate using the In-check dial device.<sup>2</sup>

**Results** Of the 150 HCPs assessed only 11 (7%) could demonstrate all the recognised steps in administration including assessment of inspiratory flow using the in-check device (Abstract P94 Figure 1). 113 (75%) of the HCPs said they were involved in the teaching of inhaler technique. Of these 113, 11(9%) could demonstrate all the recognised Steps (n=10 PCT n=1 acute trust). Of the 150, 72 (48%) were prescribers or were involved in prescribing. 94 (63%) had received some training on Inhaler technique in the past of which 64 (67%) said the training took place more than a year before.



Abstract P94 Figure 1 Number of HCP's who demonstrated all 7 steps correctly & / or correct inspiratory flow rate using the In-Check Dial.

**Conclusion** If we are going to adequately educate our patients with regard to their inhaler usage we as HCPs need to be competent in how each device works. Incorrect teaching and assessment will increase use of healthcare resources, waste medication, and mean worsening symptoms and poor control of airways disease for our patients.

**REFERENCES**

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P95

**OXYGEN DELIVERY IN AN ACUTE HOSPITAL SETTING**

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**Background** Oxygen is one of the most widely used drugs in secondary care. The National Patient Safety Agency (NPSA), UK issued guidance<sup>1</sup> ensuring safer management of oxygen delivery. Many individuals do not see oxygen as a drug and hence prescribing oxygen within most Trusts has been poor. This study assesses Health Care Professionals (HCPs) knowledge of the basic principles of oxygen delivery in an acute medical setting, to ensure the safe use of oxygen and to inform a Trust Oxygen Steering Group in order to target educational sessions appropriately.

**Method** A questionnaire listing 10 common scenarios, based on the BTS guidelines<sup>2</sup> was administered to a random selection of doctors and nurses (Abstract P95 Table 1). Responses were evaluated by a panel of Respiratory Physicians. For each scenario respondents indicated whether they would give oxygen, appropriate target saturations, delivery device to be used and the flow rate.

**Results** 139 HCPs completed the questionnaire (41% junior doctors, 59% nurses). The results are summarised below. Common mistakes included

1. The use of non-rebreather mask instead of bag and mask in cardiac arrest situations
2. Failing to identify the use of high flow oxygen in the conservative management of patients with a pneumothorax and
3. Failing to recognize the use of Venturi masks in COPD patients.

Abstract P95 Table 1 Correct responses (%) to oxygen delivery, target saturations, delivery devices and flow rate

Scenario	D-doctor	O2 delivery	Target Sats	Device	Flow rate
Cardiac arrest (GI bleed)	D	100	60	46	91
	N	98	45	39	84
Severe COPD, LTOT, Cardiac arrest	D	96	7	53	86
	N	95	2	33	79
Primary pneumothorax managed conservatively	D	54	35	7	7
	N	40	21	1	2
Severe COPD, rim of pneumothorax, conservative Rx, Sats 94%RA	D	81	11	81	81
	N	80	7	80	80
Acute exacerbation of asthma, Sats 89% on room air	D	100	42	91	88
	N	98	37	99	82
Severe community acquired pneumonia, Sats 87% on room air	D	100	33	79	79
	N	96	9	85	82
COPD, Carcinoma bronchus, Sats 90% on room air	D	100	11	40	91
	N	98	7	27	95
Exacerbation COPD, LTOT, Sats 98% on a non-rebreather	D	77	32	58	47
	N	74	17	30	21
Exacerbation COPD, Sats 86% (2l/min), usual Sats 88%(LTOT)	D	88	46	28	19
	N	84	50	20	18
Infective exacerbation of COPD, Sats 84% on room air	D	98	32	61	44
	N	94	24	44	35