effectiveness of patient-delivered training in the short and medium term.

Results During the clinical rotation, when compared with the control group, there was no difference in the number of examinations performed by participants in the experimental group.

At the end of the clinical rotation, when compared with the control intervention, the experimental intervention had a moderate effect on knowledge [difference 29.9% (95% CI 11.2%–48.6%)] and participant confidence [difference 1 (95% CI 0–2)], and a large effect on participant comfort [difference 1.8 (95% CI 0.6–3.0)].

At the end of the academic year, the experimental intervention had a small effect on technical and interpersonal skills when compared with the control intervention. Median values were 24 (IQR 21–27) and 20 (IQR 17–24) in the experimental group compared with 24 (IQR 20–26) and 19 (IQR 17–22) in the control group, respectively.

Lessons learnt Among medical students taught the female pelvic examination by low-fidelity simulation, additional training by trained patients improved student, knowledge, comfort, and confidence at the end of the clinical rotation but did not improve examination skills at end of the academic year.

Messages for others Medical schools considering new or continuing investment in patient-delivered pelvic examination training should carefully consider its cost effectiveness, as it did not appear to produce any gains in summative assessments.

Leading innovation and improvement

46 DNACPR DOCUMENTATION & TREATMENT ESCALATION PLANS IN ELDERLY PATIENTS WITH A NECK OF FEMUR FRACTURE

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Aim To improve the documentation of DNACPR decisions and Treatment Escalation Plans (TEPs) in elderly patients (>75 year) presenting with a neck of femur fracture.

Methods Initial Audit (January 2018) + Re audit (March 2018)

- Inclusion Criteria: 20 consecutive patients over the age of 75 years, presenting with a neck of femur fracture (AO–31 A–C)
- To assess:
 - Was a DNACPR decision made during the admission?
 - Was discussion of this decision with the patient documented in the medical notes?
 - Was discussion with the NOK documented in the medical notes?
 - Was the DNACPR form countersigned by the responsible orthopaedic/orthogeriatric consultant?
 - Was a TEP clearly documented in the medical notes?
 - AMTS, ASA and PRISMA7 score to assess frailty

Interventions

- Staff education sessions (junior doctors + nursing staff)

- Improved availability of DNACPR and treatment escalation plan paperwork
- Posters within the doctors' office

Results Comparison of the two audit cycles shows an improvement in all aspects measured. The percentage of a documented DNACPR decision increased from 40% to 70%, and in the re-audit 100% of DNACPR forms were countersigned by a consultant. TEPs were also seen to increase by 100% in the re-audit.

Conclusion Fractured neck of femur has a high mortality rate. Therefore these discussions should be had early, ideally on admission and prior to surgery. As such, we have targeted our interventions towards reminding the admitting doctor, when appropriate, to have the resuscitation conversations. We acknowledge that it is not appropriate for every patient with a fractured neck of femur to have a DNACPR form signed, and as such we have concentrated on improving the documentation of DNACPR decisions, rather than the proportion of DNACPR forms signed.

The staff education sessions, the improved availability of DNACPR paperwork and visual reminders around the doctors' office clearly improved the documentation of DNACPR decisions.

Quality improvement project

48 STREAMLINING FOLLOW UP PROCESS IN OBSTETRIC ANAESTHESIA

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A problem with follow up was identified in our Obstetric anaesthetic department at UHCW (Coventry). The follow up process was conducted on paper, and had a lot of steps in the process, which added to unnecessary waste, and ultimately frustration with the anaesthetists. It also meant a unified patient record was not possible. There are a lot of different methods employed in different hospitals, including commercial electronic products, which were suggested. Due to cost constraints as well as practicality issues, this was not feasible.

An alternative method was needed. The idea was to modify our existing patient portal to incorporate anaesthetic follow up onto, so that it doesn't add to any costs, the infrastructure is already in place and the system was familiar to everyone.

This QI project was very ambitious to start with but received a lot of support from colleagues. Eventually after 8 months of collaboration with the ICT department a potential solution was found.

We have implemented a new electronic follow up system which is incorporated into the existing patient portal and has replaced the previous paper system. The feedback has been excellent, with the 18 anaesthetists who completed the questionnaire, all of them found the new system to be easier to use. Over 90% of them found every element of the new follow up process to be easier. This has eliminated steps that added waste and improve the time we spend with our patients, and ultimately adding value to them.