

included understanding one-self, how teams interact, processes/systems of change and conflict resolution. There was also inspiring and experienced speakers including Dame Clare Marx (ex-president of Royal College of Surgeons), to provide case studies and real life practice experience.

I approached this project initially with evidence to provide confidence the changes were appropriate, and performed an open meeting with the urology department to discuss planning and in particular engaging the experiences of the specialist nurses who would be effecting the change. This final step would be most important as they already had knowledge the difficulties of such clinics but also had the most invested in the change. We came to a combined template of future plans which included updating standard letters, clinic timings, patient opinion but also a plan to any we flagged as a concern.

Pre-operative fasting practice

91 NIL BY MOUTH MEANS WHAT? PUTTING EVIDENCE INTO PRACTICE, A PROSPECTIVE PRE-OPERATIVE FASTING AUDIT

S Rehman, S Habib*, K Erskine, T Pelly, R Blunstone. *Department of Digestive Diseases, Brighton and Sussex University Hospital Trust, UK*

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An audit was conducted to assess the duration patients are fasted for and patient understanding of pre-operative fasting instruction.

Pre-operative fasting is a pre-requisite for every surgical procedure done under general anaesthesia. This is important as it decreased gastric acid content, gastric reflux, and reduces risk of aspiration. It was observed in the general surgical department that patients were fasting for longer than necessary. This could lead to dehydration affecting the ability to cope with surgical stress response and potentially delaying or complicating postoperative recovery. The aims of this audit were to assess pre-operative fasting times and patient understanding of pre-operative fasting instructions.

A prospective audit was conducted over a 4 week period. Adult patients on both CEPOD and elective lists were included. Patients on total parenteral nutrition were excluded. Data was retrieved from a comprehensive patient questionnaire, anaesthetic pre-operative document and drug charts. Questionnaires included last time patient consumed solids or liquids and pre-operative information provided.

Total sample population was 47 patients, 23 elective and 24 CEPOD patients. Mean duration patients fasted for solids was 20 hours (standard of 6 hours) and for liquids 8 hours (standard of 2 hours). CEPOD patients are fasted for longer compared to elective patients. 23% of patients were encouraged to drink until 2 hours before surgery. 21% of patients were given pre-operative advice on chewing gum and smoking, of which one patient received correct advice. Common pre-operative fasting instructions include nil by mouth from midnight, to only have sips of water after midnight, and only take water 2 hours before operation. Incorrect information was found to be stated on the trust patient advice leaflet.

Results of this audit were discussed at the general surgical, as well as, anaesthetic departmental meeting. Training on pre-operative fasting to frontline healthcare professionals was provided, and an information poster for the ward developed to raise awareness of up to date pre-operative fasting guidelines. Fluid fasting policy is in the process of being changed to 1 hour for patients admitted electively to the assessment unit. A re-audit will be performed using similar methodology, in addition to assessment of aspiration events post-policy change. A reduction in pre-operative fasting times is anticipated.

Staff well being in UK emergency care

92 GRIT AND BURNOUT IN UK EMERGENCY MEDICINE TRAINEES

¹Jon Bailey*, ¹Carrie Thomas, ²Almuth McDowall. *¹Emergency Medicine Trainees' Association, UK; ²Department of Organizational Psychology, Birkbeck University of London, UK*

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Objective 'Grit' can be defined as the passion and perseverance for long term goals, and it can be measured using a validated 12 item scale. Grit has been shown to correlate with seniority amongst ENT surgeons in the UK. Emergency Medicine trainees consistently report high levels of burnout, and amongst UK trainees, doctors working in Emergency Medicine posts are more likely to rate the intensity of their work in these posts as 'very heavy' than other medical training posts. As is the case with ENT surgeons, it might be expected that grit is necessary to progress through training. This study aimed to examine the relationship between grit and progression through training years in Emergency Medicine, and the relationship between grit, burnout, anxiety and depression.

Design This was a prospective, survey based study, using four validated tools: the Short Grit Scale; the Oldenburg Burnout Inventory, the Generalised Anxiety Disorder Assessment (GAD7), and the Patient Health Questionnaire (PHQ-9).

Setting UK based trainees in Emergency Medicine, working as part of a nationally recruited training programme leading to the award of a CCT in Emergency Medicine.

Participants A total of 432 trainees completed the study, split across 6 years of training from ST1 to ST6, the normal endpoint of UK Emergency Medicine training. Progression through training by grade is associated with increased grit scores ($r=0.49$, $p<0.05$). Burnout scores were high in all stages of training with no respondent scoring low risk of burnout, and all grades averaged 'high or very high' risk of burnout. Trainees who undertook additional locum work alongside training had significantly lower burnout scores than those who didn't ($p<0.05$), but no significant difference in grit scores. There was no significant correlation between grit and PHQ9 or GAD7 scores, nor between burnout and PHQ9 or GAD7 scores.

Conclusion Grit is an important feature in progression through training in Emergency Medicine. Burnout in Emergency Medicine is so prevalent that the inventory used to detect it may no longer discriminate effectively in this cohort.