Recommendations Continue to strengthen the programme, recruiting a manageable number of fellows for supervision. Continue to look for other faculty programmes.

REFERENCES
1. HILS - www.heyhils.co.uk
2. HEE - https://www.yorksandhumberdeanery.nhs.uk/education/future_leaders_programme

P89 TRAIN-THE-TRAINER SIMULATION COURSE WITH A TWIST
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Background
The simulation center at Landspitali-University Hospital, accredited by ASPiH in 2018, was established in late 2016. In the beginning, increasing the number of trained facilitators was necessary, as only a handful worked at Landspitali at the time. To meet the growing demand Train-the-Trainer (TTT) courses were offered, in English, in Iceland by SAFER. After the last of three courses SAFER suggested that the next TTT should be conducted by the hospital’s team itself.

Summary of work
Preparation for the 2-day TTT course conducted by the Landspitali team started nearly a year before the course set date. Preparation was thoroughly planned with workshops, discussions and run-throughs. The course structure followed that of courses at SAFER and CAMES(2), but with an increased emphasis on using best evidence in all aspects of the course, diverse teaching methods and more focus on the facilitators’ role. This meant: 1. Assigned readings only from peer-reviewed journals, 2. Standardized cases with mounting challenges, 3. Continuous evaluation of participants, instructors and the course plan and content, 4. The participants, 10 RNs, seven physicians and one paramedic, were required to practice the role of facilitator and debriefer for 4–6 sessions with an experienced facilitator following the course completion, 5. Reflective discussions by instructors at the end of each day, as well as peer-reviewed evaluations (anonymous) of lectures, teaching and facilitation.

Summary of results
The over-all grade for the course was 8.9 out of 10. The participants found the course challenging, the learning experience positive and had a clear sense of the knowledge and qualities facilitators must possess. They were quite satisfied with the course content and structure. After five months, 84% had completed the requirements of further training. The instructors were satisfied with the rigorous preparation, and were fair yet critical in their evaluations.

Discussion and conclusions; recommendations
The learning objectives of the course were met according to both participants’ and instructors’ evaluations. The participants were well prepared and ready to facilitate and debrief after the course finished.

When taking on new assignments and making changes to successful projects such as previous TTT courses, clearly defined objectives, sharply delineated preparation, well-reasoned and documented changes, based on evidence when available, as well as close monitoring and assessment of outcomes is imperative.

Further results from participants’ and instructors’ evaluation at 6 months after the course finished will be presented.

REFERENCES
1. SAFER (e.d.) Stavanger Acute Medicine Foundation for Education and Research. https://www.safer.net/
2. CAMES (e.d). Copenhagen Academy for Medical Education and Simulation. https://www.regionh.dk/CAMES/Sider/default.aspx

P90 (C)CCU – CRITICAL AND CORONARY CARE UNIT MDT SIMULATION
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Background
Patients are frequently taken to the ‘cath lab’, both acutely and electively, for various procedures. Given its nature, emergencies also frequently occur here, both scenarios requiring the joint input and team work between Critical Care staff and cardiology staff. It is often felt that both teams do not always understand the requirements of the other to perform their roles to the best of their ability. This has potential to prevent treatment being delivered as well as desired.

Summary of work
A half-day session was organised in the cardiac catheterisation laboratory, inviting cardiology consultants, nurses, radiographers and allied staff, along with an intensive care consultant and two registrars, who would attend this location on transfers or in emergencies. Four scenarios were run covering elective angiography, PCI, cardiac tamponade during elective angiography and a VF cardiac arrest during angiography. These were run in as close to real time as possible.

Summary of results
The session was well received and all staff felt more comfortable with how to act in emergency situations following it. Positive findings included communication remaining clear throughout, succinct handovers during emergencies between both specialties were high quality, and the benefit of adding visual aids in the laboratory was highlighted. The allied staff also became more familiar with the complexities of handling an anaesthetised/intubated patient. There were moments when the clinician leading a particular scenario was not clear, and discussions held between the cardiologist and anaesthetist allowed clarification of what was felt to be a priority in those instances. An important learning point for both teams was that otherwise isolated anaesthetist required assistance of an allocated staff member to help them perform their role proficiently.

Conclusion and discussion
The session was felt to be helpful for all involved, and lead to local changes that are believed will have a positive impact on patient care in these settings. Discussions are taking place to broaden the audience attending these sessions and to increase their frequency.

Recommendations
We recommend that similar simulation programmes be run in other centres to help improve familiarity and team working between their critical care and cardiology departments.

REFERENCES