REFERENCES


SC15 MCA/DOLS – SIMULATION AN ALTERNATIVE TO CLASSROOM?

Emma Williams*, Lisa Toft*, Sarah Thompson, Carole Moss, Paula Reynolds. Portsmouth Hospitals NHS Trust, Portsmouth, UK

Background The TEAMS simulation centre was approached in September 2018 to assist with MCA/DOLS training after the CQC enforced a section 29a to the hospital. With immediate effect the TEAMS simulation educators and the safeguarding team collaborated to try a different way of educating staff surrounding MCA/DOLS which hadn’t been implemented before.

Summary of educational programme/project The Simulation scenarios were provided using live actor and used experiential learning with detailed debrief using specific learning outcomes. Triola et al (2006) showed that live actors were a valid comparable model to high fidelity manikins. Gillett (2008) agrees showing that live actors are equivalent to using manikins during simulation exercises but that both have limitations, advantages and disadvantages. We provided 2 hour sessions, four times during the day to capture all senior staff members (over 100) to feed information back to their teams and then ‘frontline’ staff attended which has led on to interest for bespoke simulation for other departments.

Pre and post confidence questionnaires were provided to assess whether the candidates felt more confident after the simulation with areas such as assessing capacity and managing challenging patients. It is important to know whether it had improved practice in the workplace using both Quantitative and qualitative data. Simulation evaluations showed positive qualitative data with most candidates expressing thoughts such as it was ‘realistic, interactive’ ‘it demystified the process’ ’open and relevant discussions’

A Comparison with classroom based teaching and feedback using powerpoint and discussions/table top exercises showed that despite this rolling programme of face to face training staff were still unsure of processes and procedures surrounding MCA/DOLS when CQC inspectors questioned staff. It was then that MCA and DOLS simulation was introduced in September 2018 to compliment the delivery method to improve staffs confidence and knowledge. Stakeholder involvement included the safeguarding team and was piloted in September with support from the chief executive and board members with an alternative way of delivering education to staff.

Discussion, conclusions and recommendations Over a period of 8 months and 141 members of staff attending the simulation sessions the pre and post confidence questionnaires showed a 100% raise in confidence post simulation.

This is an Ongoing project to see whether the simulation changes practice in the workplace and if possible remove section 29a from CQC in the future.

REFERENCES


SC16 USE OF SIMULATION TO IMPROVE TEAM PREPAREDNESS FOR VERTICAL EVACUATION OF A CRITICAL CARE PATIENT DURING LIFT FAILURE

Hannah Davis*, Clinton Jones, Aintree University Hospital NHS Trust, Liverpool, UK

Project description Many hospitals have clinical areas accessible by lifts: in the event of fire or lift failure evacuation via stairs becomes necessary. Management of critical care patients during a lift failure offers challenges associated with a requirement for continuous monitoring, resuscitation and organ support using specialist equipment. Reviews of mass patient evacuations highlight the benefits of frequent simulation and involvement of external organisations on their success. Aintree University Hospital has developed a standard operating procedure (SOP) for the vertical transfer of critical care patients in the event of lift failure. Through an in-situ simulation exercise the aim was to test effectiveness of the new SOP and assess for latent errors in addition to offering a collaborative training opportunity for the hospital medical emergency team (MET) and external support agencies. Two simulations took place in locations vulnerable to lift failure. The MET were required to stabilise an unwell simulator patient and perform a vertical evacuation utilising the SOP. In each simulation an external emergency retrieval team assisted: North West Ambulance Service (NWAS) in scenario 1 and Liverpool Tactical Response Unit (TRU) in scenario 2. A debrief followed and participants provided feedback on perceived challenges.

Summary of results Successful evacuations were achieved in scenario 1 and 2: 38 minutes and 37 minutes respectively. Table 1 outlines the human factors and system errors identified with recommendations for prevention.

Discussion, conclusions and recommendations This project demonstrates safe resuscitation and efficient vertical evacuation of critical care patients is achievable, the SOP triggers the appropriate actions and recruitment of external support. However, the major barrier to its use is the lack of awareness amongst staff of its existence. This exercise revealed latent errors relating to equipment, staff training and our SOP was

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<td><strong>Factor identified</strong></td>
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<td>Human factor</td>
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<td>Loss of situational awareness:</td>
<td>• Frequent simulation training.</td>
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<td>Delayed identification of lift failure resulting in delayed request for external support.</td>
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<tr>
<td>System error</td>
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<td>Staff not trained for manual handling of patient for vertical evacuation.</td>
<td>• Targeted staff training.</td>
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<td>Inadequate staff awareness of SOP.</td>
<td>• Adjust SOP: only high priority equipment to be mobilized whilst resource limited for staff.</td>
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<td>Physical demand of ascending stairs with equipment.</td>
<td>• Cautious admission of bariatric patients to vulnerable wards.</td>
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<td>Bariatric equipment not available.</td>
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rectified, whilst also providing excellent educational opportunities, as success in this critical event is achieved through a well-rehearsed, coordinated team response.

REFERENCES

SC17 DEBRIEFING A MAJOR INCIDENT EXERCISE
1Andrew Blackmore*, 2Reuben Griscti, 1Dave Wright, 1Makani Purva. 1Hull Institute of Learning and Simulation, Hull, UK; 2Hull University Teaching Hospitals, Hull, UK

Background The Civil Contingencies Act (2004) requires organisations such as the emergency services, councils and hospital trusts to prepare for emergencies by undertaking ‘live’ Major Incident exercises every three years. In the summer of 2017 our organisation took part in ‘Operation Orange Falcon,’ a multi-agency live Major Incident Exercise. This involved teams from Hull and East Yorkshire Hospitals, Yorkshire Ambulance Service, Humberside Fire and Rescue, Humberside Police and the Royal Logistics Corps and more than 60 casualty volunteers. Hull Institute of Learning and Simulation (HILS) led the debriefing element of the exercise.

Project summary The challenge in debriefing such a large-scale exercise came in providing meaningful immediate feedback to participants while also providing useful feedback to the involved organisations as a whole.

We approached this by using two forms of debriefing; a ‘hot debrief’ on closing the exercise and a ‘cold debrief’ several weeks later.

It was impractical to deliver a hot debrief to all of the participants in the exercise together. We agreed within the participating organisations to establish key areas of focus and placed debriefing teams in each of those key areas. They could then provide immediate feedback to participants on close of exercise.

The debriefing teams consisted of a content expert, with expertise in the particular area being observed and an experienced debriefer from HILS.

The agreed areas of focus included:
- Decontamination at the scene of the incident.
- The incident command team on-site.
- Decontamination at the hospital.
- Triage at the Hospital.
- Hospital control room.

Casualty volunteers were debriefed separately by a team that included a psychologist from the Humber Mental Health Trust.

The cold debrief was held eight weeks after the exercise and all participants were invited to attend. It focused on the same key areas, with the addition of video footage of the day to illustrate key points and revisited the issues raised in the hot debriefings.

Results The feedback from the other agencies was very positive. They reported that the standard debriefings they had attended before focused on finding fault or assigning blame.

Use of on-site hot debriefing provided a deeper understanding of how the Trust’s Major Incident Plan worked in practice.

Discussion The skills of debriefers from a healthcare background can be transferred outside of the healthcare environment when paired up with content experts in the field. Debriefing teams improved the experience of participants in a multiagency Major Incident Exercise.

REFERENCES

SC18 TEA AND TRACHEOSTOMIES – USING TRANSPORTABLE, LOW-FIDELITY SIMULATION TO MAINTAIN KEY COMPETENCIES IN AN ICU ENVIRONMENT

Clare Pickering*, Christopher Gough, Surabhi Ramsundar, Kapil Savjani, Jasmine McAuley, Oxford University Hospitals Trust, Headington, UK

Background Tracheostomy displacement is a life-threatening airway emergency. The 4th National Audit Project found that ‘tracheostomy dislodgement occurred in 14 patients and led to half of all cases of death and brain damage’ in the Intensive Care Unit (ICU). As such, it recommended further training and protocol use in the care of ICU patients with tracheostomies.1

Our current practice for training staff in tracheostomy emergencies includes high fidelity simulation, both in-situ and within a simulation centre. Challenges to this, however, include high resource requirements and limited reach to staff. This project attempts to assess the feasibility of utilising low-fidelity simulation via a ‘tea trolley’ method, to refresh multidisciplinary Intensive Care staff in the management of a displaced tracheostomy.

Summary of education programme or project This is the first program in our unit to utilise the Bath ‘tea trolley’ method of training. Educational material and refreshments are set up on a trolley which can be moved to a variety of locations within the ICU.2 Teachers on non-clinical days provide short 10-minute educational sessions, at a time that suits learners. This allows teaching to occur with minimal disruption to patient care, while maximising the potential audience.

Our training was based on local algorithms, and resources from the National Tracheostomy Safety Project. We utilised small group teaching and a concise, low fidelity simulation with an airway mannequin. This allowed staff to have a hands-on refresher of the management of a tracheostomy emergency, guided by the displaced tracheostomy algorithm. The small group and low fidelity nature of this teaching allows for increased replicability, and a low-stress and supportive environment for learners.

Summary of results This project is ongoing, with further teaching sessions planned. Preliminary results showed that participants’ confidence in managing a tracheostomy emergency improved by an average of 1.2 points on a five-point Likert scale. All participants strongly agreed that this training was relevant, helpful, and in an appropriate format. They also strongly agreed that it was likely to improve patient safety, and that further similar sessions would be useful. By using