rectified, whilst also providing excellent educational opportunities, as success in this critical event is achieved through a well-rehearsed, coordinated team response.

REFERENCES

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 years1. In the summer of 2017 our organisation took part in ‘Operation Orange Falcon,’ a multiagency 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

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

Claire Pickering*, Christopher Gough, Surabhi Ramsundar, Kapil Sawjani, 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 damage2 in the Intensive Care Unit (ICU). As such, it recommended further training and protocol use in the care of ICU patients with tracheostomies.

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
staff already rostered onto non-clinical days, once established, the resource requirements were minimal.

**Discussion, conclusions and recommendations** ‘Tea trolley’ training is a feasible method of improving confidence in the management of tracheostomy emergencies in the ICU. Further research is required to analyse the comparative benefits and costs between low-fidelity ‘tea trolley’ training and high-fidelity simulation.

**REFERENCES**

**Tuesday 5th November, 16.00–17.20**

**Abstract SC19**

**WORK TOGETHER, LEARN TOGETHER: THE BENEFITS OF INITIATING IN-SITU SIMULATION IN AN ACUTE MEDICINE DEPARTMENT**

Stephanie Oade*, Kimberly Schoen*, James Storey, Charlotte Timme. Leeds Teaching Hospitals’ Trust, Leeds, UK

Background Simulation teaching in the Leeds Teaching Hospitals’ Trust Acute Medicine department began as sessions in a dedicated, non-clinical, sim suite however we quickly recognised limitations with authenticity and attendance, with people often struggling to leave their respective wards. The concept of the teaching was well received, which spurred on our desire to develop the programme. Following reconfiguration of an acute medicine ward to include a High Observation Area, we seized the opportunity to trial in-situ simulation in a clinical space. A significant barrier to overcome was the constant bed pressures of an acute admissions ward - something that has always been a limitation to simulation in Acute Medicine previously. This was achieved by clinical leaders and patient flow coordinators agreeing with the importance of a protected space and recognising the potential to reduce team anxiety when caring for higher acuity patients.

**Summary of education programme** Our in-situ SIM programme is a once weekly afternoon session involving medics (predominantly Core Medical Trainees), nursing staff and allied health care professionals. It follows a format of pre-brief, handover and real time clinical practice. The session is completed with a detailed debrief, focussing on areas of good practice and human factors education.

**Summary of result** The programme is in the early stages of development, however initial results are promising, particularly relating to MDT involvement. There is a greater feeling of empowerment to voice concerns and ideas in real time, improved communication amongst team members, with better understanding of each others’ skill sets and limitations to practice. This results in a more collaborative approach to enhance patient care. Additionally, all participants have reported feeling more confident in managing a wider range of medical emergencies, and trainee clinicians describe feeling more prepared for the transition into a leadership role in high acuity circumstances.

**Recommendation** Future development includes enhancing realism to improve immersion in the clinical scenario. We hope to instigate this by removing observing delegates and faculty and live streaming the session to a neighbouring room. We believe this will help to alleviate anxieties of the active participants and thereby decrease the cognitive load to achieve better learning outcomes.

**Conclusion** To date, moving simulation teaching to an in-situ setting has been well received, allowing a more realistic teaching platform for all healthcare professionals. It has promoted an attitude of ‘work together, learn together’ and created a greater sense of team in a fast-paced, high-stress environment.

**Abstract SC20**

**THE INTRODUCTION OF A WEEKLY SIMULATED SKILLS PROGRAMME TO INCREASE CONFIDENCE OF 3RD YEAR MEDICAL STUDENTS IN THE CLINICAL SETTING**

Abigail Nelson*, Kathy McCann, Anand Gidwani. Altnagelvin Hospital, Western Health and Social Care Trust, Derry/Londonderry

**Background** Not all clinical skills are easy for medical students to practice during hospital attachments, especially those requiring specialist equipment. However it is crucial that the next generation of doctors are trained in a manner that gives them confidence in the clinical setting.

Our aim was to increase student confidence in clinical skills during their 3rd year General Surgery attachment in Altnagelvin Area Hospital, a Northern Irish DGH.

**Summary of education programme/project** A 5 week clinical skills simulation programme was developed, beginning in October 2018. Each session took place in the virtual ward at the Clinical Education Centre and comprised 4-5 OSCE style stations mirroring common scenarios faced by junior doctors.

Each week was themed around a different skill – history taking, examination, communication and procedures. The final session included elements from each of the four domains.

A team of surgical doctors participated each week, taking the role of simulated patient, assessor and/or assistant. Simulator equipment was used as appropriate, and resources such as observation charts and prescription charts promoted realistic clinical scenarios. Both individual and group feedback was provided to course participants.

Students rated their overall confidence with regard to their OSCE examinations using a Likert type scale from 1 – 5 (table 1). Students were asked to answer this question after each session, allowing average confidence changes to be assessed weekly.

All students were also asked to provide scores pre and post programme regarding confidence in each of the 4 broad skill area the course covered.

**Summary of results** Data was collected from the first two groups who participated in the course. (n = 14). Primary measured outcome was self-rated confidence with regard to