Abstracts

Similar means and confidence intervals were demonstrated for improved awareness of patient safety, communication skills and awareness of MDT working (full values available at conference).

When asked whether they felt confident to contribute in the debrief (measured 1–5), participants mean equalled 4.53 (95% CI 4.37–4.69). Doctors felt most able to contribute (mean = 4.6, 95% CI 4.4–4.83), followed by nurses (mean = 4.5, 95% CI 4.2–4.9). The students felt least able to contribute.

Thematic analysis is underway on free text concerning the most useful things learnt, potential changes in practice and suggested improvements.

Conclusions The programme achieved our aims as the sessions were well received and feedback demonstrated many positives. The participants reflected the multi-professional team in the department. Psychological safety was maintained as measured by confidence in speaking up.

Our approach is an example of how regular high quality in-situ simulation can be embedded into a busy department through attention to resourcing, inclusivity, incentivisation and fun!

Wednesday 6th November, 12.35–13.35

SC36 TEACHING NEW STAFF TO RAISE CONCERNS USING THE PACE APPROACH AND HIGH FIDELITY SIMULATION

1Ben McNaughten, 1Carol Junk*, 1Catherine Diamond, 2Thomas Bourke, 1Andrew Thompson. 1Royal Belfast Hospital For Sick Children, Belfast, UK; 2Centre for Medical Education, Queen’s University Belfast, Belfast, UK

Background Hierarchy and leadership are essential within any multidisciplinary team. However, team leaders can make mistakes irrespective of seniority. It is essential that everyone within the team feels confident in raising concerns to ensure patient safety. This can be particularly challenging for new staff joining established healthcare teams. We aimed to improve the confidence of new children’s nursing staff in raising concerns by introducing teaching on a structured method for raising concerns into their induction simulation session.

Summary of education programme New nurses undertook a simulated clinical scenario in which the doctor was deliberately hesitant and reluctant to administer appropriate emergency treatment. Teaching was then provided on the PACE approach for raising concerns. Each nurse then participated again in a similar scenario. Each of the 23 participants completed pre and post questionnaires.

Summary of results There was no difference in participants’ confidence between challenging a nurse or doctor (3.4/5) prior to training. Following the initial scenario the nurses reported feeling ‘frustrated’ and ‘scared’. After the session they stated that their confidence in challenging nurses and doctors had increased to 4.3/5 and 4.2/5 respectively. Free text comments included:

- ‘Hearing from doctors that they would rather be challenged was reassuring.’
- ‘Improved my confidence to speak up when querying a decision’

Conclusions/Discussion Nursing staff reported improved confidence in their ability to raise concerns. This can only serve to improve patient safety. We believe that similar training would also benefit new medical staff. Consequently, we plan to incorporate PACE training into all future medical and nursing induction programmes.

SC37 IN-SITU SIMULATION-BASED TEAM TRAINING IN TRANSCATHETER AORTIC VALVE IMPLANTATION (TAVI) EMERGENCIES

1Gillian Hardman*, 1Neil Berrigan, 1Gillian Liddle, 2Mark Hatch, 2Mike Dickinson, 1Antony H Walker. 1Department of Cardiothoracic Surgery, Lancashire Cardiac Centre, Blackpool, UK; 2Simulation and Skills, Blackpool Victoria Hospital, Blackpool, UK

Background Transcatheter Aortic Valve Implantation (TAVI) represents a complex procedure, performed in high risk patients, by a multidisciplinary team (MDT), in the catheter lab. When emergencies occur, they present significant Human Factors challenges. The importance of team training to the recovery of patients following TAVI emergencies is recognised.

Following a TAVI emergency, a Serious Incident (SI) was raised. In response, we extended our existing Cardiac Surgery in-situ simulation programme to the catheter lab, with the aim of improving team performance, using interprofessional learning, in-situ simulation and deliberate practice with a Human Factors (HF) and non-technical skills (NTS) approach to debriefing.

Summary of project An introduction to the session was followed by a 40-minute simulated scenario of cardiac arrest in a patient at the end of a transfemoral TAVI procedure. This was performed in-situ in the cardiac catheter lab (Figure 1). An emergency theatre, perfusion and surgical team were made aware of the session and briefed that they should attend if contacted.

Fourteen team members, representative of the MDT, participated in the scenario. The remaining 10 learners observed and actively contributed to the one-hour facilitated debrief. The final 30-minutes of the session was used for deliberate practice of specific emergency steps.

Summary of results A post-session online questionnaire using a 5-part Likert scale was used to evaluate the session. The questionnaire was completed by 19 individuals (response rate 79%). Results of the questionnaire are outlined in Table 1.

All participants expressed a desire for further simulation-based education sessions.

Practice development areas identified during the debriefing were escalated to the management teams and quality improvement plans have been implemented.

Discussion In-situ simulation-based team training is now well established within our Cardiothoracic team at the Lancashire Cardiac Centre, with monthly in-situ team training.

An SI has prompted us to extend this education approach and successfully adapt it to a related working environment, providing real-time identification of practice development areas, fostering improved team working across disciplines and improving departmental patient safety culture.

Conclusions and recommendations Further work is required to assess the impact of this session on behaviour, patient safety and outcomes following emergency complications after TAVI.