P11 SIMPALL AN IN-SITU SIMULATION COURSE ON PALLIATIVE CARE FOR THE EMERGENCY DEPARTMENT

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Introduction Emergency Medicine (EM) is a unique specialty often meeting people at the worse moments of their life. Death is an everyday occurrence, and with that comes the skills needed to talk to patients and families about when their end of life may be nearing. The Royal College of Emergency Medicine’s guidelines suggest doctors need to have the skills to talk to these patients. We developed a full day course called SimPall which incorporates some lecture-based teaching, and then an afternoon of in-situ simulation within the emergency department (ED). Our aim was to gather feedback to see what educational benefit this brought to our EM staff.

Methods Following some teaching around difficult conversations, do not attempt cardio pulmonary resuscitation and managing palliative emergencies we gave the participants all 3 of our in-situ simulations, in two groups. The participants were not aware of what simulations they got. The three simulations based on realistic ED patients were; Scenario 1 was the end stage COPD patient who is not for any further interventions. Scenario 2 is of a very frail patient, with pneumonia who has multiple comorbidities. Scenario 3 was a massive upper gastrointestinal bleed with known oesophageal cancer. All participants were debriefed, and feedback recorded. All participants were offered the chance to discuss with a senior if they had any worries about the scenarios.

Results/Outcomes This teaching day was in April 2019. 13 people including doctors and advanced nurse practitioners attended the day. All were involved in each of the scenarios and their feedback was collated. Overall the feedback for all the simulations was positive. 76% of participants felt their knowledge had improved from lacking confidence to being fairly confident or very confident after the simulations. Written comments suggest that participants feel they would benefit from more teaching and exposure of this. Comments given at the end of the day mentioned that this had been some of the best teaching they had had, with the simulations being very realistic.

Conclusion The feedback was overwhelmingly positive, and suggests this work needs to continue. The SimPall course, will continue to be developed and its roll out will take on board the feedback.

REFERENCES

P12 USING IN-SITU SIMULATION TO ENHANCE THE KNOWLEDGE OF UNEXPECTED DIFFICULT AIRWAY MANAGEMENT IN THE INTENSIVE CARE UNIT

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Background An unexpected Difficult Airway (DA) is a recognized emergency in anesthesia for which protocols exist (Frerk, Mitchell et al. 2015). It is a rare but potentially fatal emergency for the patient. Within the Intensive Care Unit (ICU) this is an even rarer event. The possibility of latent safety threats (LST) is high and potentially fatal. Prior to the simulated scenario there have been changes made to the local protocol for managing an unexpected difficult airway and a new algorithm has also been introduced to more junior members of the Multi-Disciplinary Team (MDT).

Summary of work We designed an in situ simulation scenario to address the unexpected difficult airway. We asked the participants to use all the equipment which they are familiar with and use the protocols which they are aware of.

This scenario was first tested at the ICU Odense University Hospital Denmark. Then adjusted and run at ICU at Guy’s and St Thomas Hospital London United Kingdom.

There was a post simulation questionnaire to assess the knowledge gained in both Non Technical, and Technical Skills. To capture the LSTs, the scenario was observed by an anesthetist with expertise in DA.

Results A total of 12 participated in the scenario, 8 Nurses, 2 Registrars and 2 others. They had an average of 3.42 years of ICU experience.

Participant described an overall gain in knowledge off the difficult airway from an average of 4.66 to an average of 5.58 (table 1). Furthermore there was a slight tendency towards a gain in self-confidence when doing intubation. Do to the low amount of participants we did not calculate a P value.

13 latent safety threats were documented doing the scenario.

Discussion Our study suggests that the use of in situ simulation to train rare and potentially lethal situation will help
increase the staff’s self-confidence. This correlates with the finding of Patterson et al. (Patterson et al., 2013). Furthermore, a number of LST was emerged. However the number of participants and the number of repetitions are too small to generalize.

**Conclusion** This data indicates that it is possible to use In situ simulation to implement new protocols and guidelines for procedures, and to increase self-confidence, knowledge and skills. It also indicates that In situ simulation is a valuable tool to emerge latent safety without any patient coming to harm.

Further studies are needed to support this.

**REFERENCES**


**P13 MISST: MICRO IN-SITU SIMULATION TRAINING**

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**Background** In-situ simulation (ISS) has benefits on an organisational level including highlighting patient safety concerns and economical use of resources. For individuals, it negates the need for travel to a simulation centre and enhances team working. However, stakeholders may feel that in-situ education can distract clinical staff thereby reducing efficiency and patient flow. We respond to this by developing a novel tool of ‘micro’ simulation sessions.

**Summary of work** In order to create ‘learning in context’ for emergency department (ED) staff, a dynamic team of interprofessional clinical educators developed ‘micro’ ISS. This could be delivered to ED staff without removing them from clinical duty for more than 15 minutes. This allows for rapid education without disruption to departmental flow. Each scenario was adaptable to a multiprofessional team with one-on-one teaching for participants. Scenario flexibility allowed for a balance between debrief, teaching and practical skills. Scenarios were designed in response to near-misses and critical incidents logged via the datix reporting system, responding directly to patient safety concerns.

**Summary of results** A package of scenarios was delivered (Management of diabetic emergencies; Phentoyin administration; Trauma/head injury; Sepsis/preparation for transfer; Management of hyperkalaemia; Starting non-invasive ventilation). Key stakeholders from ED, pharmacy, physiotherapy, outreach, intensive care and anaesthetics were involved in the development and delivery of the sessions. 14–25 participants attended every session: a mixture of nurses, doctors (foundation to consultant), health care assistants and students (medical, nursing and physician associates). The interprofessional faculty each taught a diverse group and peer-to-peer learning was encouraged. The scenarios were adaptable to the training needs of the individual. Participants all reported increased confidence levels pre and post-session, their feedback of current learning needs shaped future sessions. Findings from each scenario were collated and a standardised proforma was disseminated to the ED with global learning outcomes and required departmental actions such as equipment orders or change in stock drug concentrations.

**Discussion and conclusions** Our programme was well received, allowed for departmental training in addition to addressing patient safety concerns. We have shown that ISS does not require large scale scenarios; targeted clinical skills can be addressed in a ‘micro’ session whilst still allowing overall functioning of a busy ED.

**Recommendations** This model is easily replicable throughout a hospital setting. Key stakeholder involvement as well as an enthusiastic and adaptable clinical education team ensure well managed and received education.

**REFERENCES**


**P14 FIRST STEPS INTO IN-SITU SIMULATION: OUR EXPERIENCES AND LESSONS LEARNED**

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**Background** Simulation is widespread in UK medical education and improves knowledge, skills, behaviour and patient-related outcomes. The transition from student to doctor can be stressful, but this can be improved by clinical exposure to the junior doctor role. Our objective was to deliver a form of in situ simulation which replicated a ‘medical emergency call’ for final year medical students in the period prior to commencing Foundation Training.

**Summary of work** 90 final year medical students were invited to take part. Those who signed up were given a beep for a week during which they were bleeped, without warning, to attend a medical emergency in the Clinical Skills Room (situated within the hospital). Here, a ward was simulated with 3 staff members acting as patient, nurse and observer. Students had to manage an acutely ill patient and escalate to a senior (a volunteer Medical Registrar available on a beep). Debrief followed.

**Summary of Results** 19 students signed up, of which 12 attended a simulation. Five simulations were set up; four ran successfully with between 2 and 4 students (none attended the fifth simulation). Clinical scenarios used were hypoglycaemia and sepsis. The simulations lasted between 18 and 22 minutes. Debrief lasted between 17 and 26 minutes.

Within the debrief both technical and non-technical skills were discussed. 9 students provided written feedback. All agreed the session was ‘Extremely Useful’ in preparing for Foundation Training and that they would recommend the session to other students. All reported improved confidence in managing an emergency (7 significantly improved, 2 slightly improved). They all found the simulations ‘Extremely Useful’ to prepare for prioritising tasks, team work and communication.

**Discussion, Conclusions and Recommendations** The faculty felt the simulation was useful to students. However, it was time intensive to deliver due to low uptake, possibly due to: