Abstract P30 Table 1  Latent threats and actions taken

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Latent errors identified</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Anaphylaxis/site 1</td>
<td>1. Adrenaline 1:1000 was found to be missing from live box 2. Team also identified that Resusc Council UK guidance was not in the box</td>
<td>Immediately rectified by the team and stocked in a way that would reduce the risk of wrong use (adrenaline vials in one bag and Chlorpheniramine in a separate bag within the box but also separate from what would be used by an anaesthetist if using AAGBI guidelines).</td>
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<tr>
<td>2 Deteriorating patient in a post-operative ward</td>
<td>On the ward only simple face mask, for use in the immediate post op phase of care, was available and no Venturi oxygen valves/Non Re-breath masks available. This is contrary to the BTS guidelines 2017. 2. Knowledge gaps with the NEWS Scores and sepsis were noticed in some staff members.</td>
<td>Masks are now available on the ward. 2. Training and education of both NEWS score and the escalation plans for sepsis were covered during debrief.</td>
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<tr>
<td>3 Anaphylaxis/site 2</td>
<td>The anaphylaxis box held the primary and secondary line medication for non-medical response in a single bag leading to potential error</td>
<td>This has been split into separate bags to avoid error</td>
</tr>
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</table>

Background: 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 what they what for their end of life. These conversations can be very challenging for all concerned, including junior doctors. The Royal College of Emergency Medicine’s guidelines suggest doctors need to have the skills to talk to these patients. Therefore, we felt we needed to develop a series of realistic EM in-situ simulations for our staff to learn and practice on. A review of published literature suggests this has been tried in the US only, and nothing currently in UK.

Summary of work: We created 3 simulations designed to enable junior doctors to have difficult conversations with patients who are approaching the end of life in the ED. Scenario 1 was a patient with end stage COPD. Scenario 2 is of a very frail patient with pneumonia again who has multiple comorbidities. Scenario 3 revolves around a patient with a massive upper gastrointestinal bleed with known oesophageal cancer. These simulations were tested in-situ in the ED over the course of several months and the feedback collected from all team members.

Summary of results: These simulations were trialed over January – March 2019 as part of our weekly in-situ simulation. 20 people took part in the above simulations, 5 people in scenario 1, 9 people in scenario 2 and 6 people in scenario 3. Simulations were run more than once, with different participants in each. All had a doctor plus nursing support. Feedback was obtained from all those involved. The data was pooled from all the simulation sessions. 80% of people moved from being not confident or lacking in confidence to fairly confident or confident after doing the simulations. All participants felt their knowledge had increased significantly following the simulations. Positives described by participants include ‘Learning to recognise when CPR may be futile in patients and balancing delivering treatment and assessing futility of discussing this with patients’.

Discussion and conclusion: This work suggests that people’s confidence with these difficult conversations has improved. How this will translate into clinical practice is not known, but the feedback suggests these simulations will have an impact. We will look to incorporate this into a day long course.

REFERENCES

P32 USING SIMULATION TO PREPARE MEDICAL STUDENTS TO ASSESS AND MANAGE AN ACUTELY UNWELL AND SUICIDAL PATIENT

Ella Mcgowan*, Helen Leach. Sandwell And West Birmingham NHS Trust, Birmingham, UK 10.1136/bmjstel-2019-aspihconf.136

Background: Simulation in undergraduate medical education often focuses on the assessment and management of an acutely unwell patient, whilst communication skills needed to assess a mentally unwell patient tends to be taught through role player. We wanted to combine the two presentations to

P31 EXPERIENCES OF DEVELOPING IN-SITU PALLIATIVE SIMULATIONS IN THE EMERGENCY DEPARTMENT

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sessions ranging from increased confidence in clinical management of common post-operative cases to awareness of practice limitation and impact of human factor in our clinical environment. Patient safety threats were also identified and appropriate corrections made as highlighted in the table below.

Conclusion: Simulation is a valuable tool in staff training especially in challenging environments like theatre. It exposes latent threats or errors in the system and offers the opportunity for actions to be taken before it becomes a safety risk to the patients. It also increases the confidence of staff in the management of common post-operative emergencies.

Above all, it is a quality improvement project and leads to an improved quality of care offered to our patients and improves patients experience and safety.

The theatre Staff are keen to participate, but there is a challenge of how to balance the need for training and education with the huge clinical commitment and service delivery.

REFERENCES
2. Gaba M Th. future vision of simulation in health care. Quality and safety in Healthcare 2004; 13(Suppl 1); i2-i10.