

simulation, educational tools have been created, extending their reach to both clinical and non-clinical staff.

## REFERENCE

1. Kaba A, Barnes S. Commissioning simulations to test new healthcare facilities: a proactive and innovative approach to healthcare system safety. *Adv Simul.* 2019;4(1). doi: 10.1186/s41077-019-0107-8

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## DEBRIEFING THE DEBRIEFER; DEVELOPING AN INTER-PROFESSIONAL FACULTY FOR EMERGENCY MEDICINE SIMULATION

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**Background:** Previous research has described the importance of debriefing in Simulation-Based Medical Education; it is considered the most critical part of the teaching experience<sup>[1]</sup>. It is a skill requiring practice and poorly structured debriefs can harm candidates<sup>[1]</sup>. There are few formal debriefing courses available to aspiring faculty members; they are often oversubscribed.

**Aim:** The aim of this work was to develop an inter-professional faculty with a variety of backgrounds to assist on an inter-professional nursing-medical simulation course in Emergency Medicine. A further aim was to develop a novel formal debrief for the debriefer to help improve confidence in this skill.

**Method:** A variety of professionals were invited to attend the course as faculty. Following their debrief of the scenario, the debriefer was invited to discuss their opinion on how they managed the debrief, from room set up to structure used. Troubleshooting advice was offered and an action plan was put in place for next steps of development. Faculty members were asked to complete a formal feedback form at the end of the session.

**Results:** Inter-professional faculty members included Emergency Medicine consultants, trainees and clinical fellows, simulation technicians, emergency medicine nursing staff and resuscitation officers. 75% of faculty members had attended <5 simulation courses as faculty prior to this session. 81% of faculty members scored 4 and 5/5 for feeling confident at debriefing as a result of the session. 100% scored 4 and 5/5 for feeling supported during their debrief. 100% felt that the session had improved their debriefing skills. 87.5% felt appropriately challenged as a faculty member. 100% were willing to attend the course again in the future. Free-text comments included the best part of the day was 'Personally observing and practicing debrief, brief and debrief of my debrief', 'Supportive atmosphere for faculty' and 'Debrief learning points'.

**Implications for practice:** Overall, faculty members from varying clinical and simulation backgrounds were supported throughout the day and as a result were more confident in their debriefing abilities following the session. Future work aims to continue this incremental learning to allow all faculty members to feel confident and able to 'debrief the debriefer'. This will ensure the quality of the debrief for learners, maximizing the impact of simulation-based medical education.

## REFERENCE

1. Rall M, Manser T, Howard S. Key elements of debriefing for simulator training. *Eur J Anaesth.* 2000;17(8):516-517.

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## INFANT ABDUCTION: LIVE SIMULATION DRILLS EXPLORE THE RISK IN THE MATERNITY UNIT

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**Background:** Child abduction is poorly defined in the UK. Legislation varies, defining offences of child abduction, kidnapping and child stealing/plagium. Rabun<sup>[1]</sup> reports that 45% of infant abductions occur from healthcare facilities and the remainder occur from homes (40%) and other places (15%). The rise in child abduction in recent years may be related to easier access to hospital units, previously open only to fathers during strict visiting hours<sup>[2]</sup>. Modern, family-centred units allow many visitors, posing further concerns around abduction. **Aim:** Proactive planning, security and staff training are required to reduce this risk, and a live simulation was utilized to test these elements, identify risks and provide solutions.

**Method:** A staff member, unknown to the maternity team, was admitted to the ward and gave birth (simulated to a baby girl). Ward staff were informed that there was a restraining order on her partner who was not permitted to visit. An educator from the Clinical Simulation team was tasked with gaining access to the maternity unit, abduct the baby and make their way to a hospital exit and to the car. With the support of Clinical and Governance Midwives, an unannounced live drill was conducted to analyse:

- Security of the unit
- Staff adherence to local policy – proactive planning
- Conflict management and challenge

**Results:** Observation analysis identified:

- Access to the maternal unit was gained through tailgating with no challenge from staff.
- Access to the mother's room, despite being in close proximity to the midwives' station, went unchallenged.
- Staff did not engage or challenge abductor despite a team member identifying concern.
- Activation of local policy was slowed due to handover time. Lack of awareness of who has called who.
- Communications between staff members occurred through non-secure social media applications.
- Security cameras ineffective due to relay of images to a different location
- Escape from the unit made easy by unlocked corridors.
- Certain staff groups unsure of their role.

**Implications for practice:** The identification of latent risks in resources and staffing alongside having confidence with protocols and decision-making has illustrated potential serious risks to both mother and baby. This clinical simulation has allowed us to address and provide recommendations to resolve these by highlighting urgent reassessments of security, proactive planning and staff development to ensure the reality of abduction is minimized.

## REFERENCES

1. Rabun JB. For Healthcare Professionals: Guidelines on Preventing Infant Abductions. 3rd edn. Arlington, VA: National Centre for Missing and Exploited Children; 1993.
2. Lowenstein LF. Parental child abduction: a literature review. *Police J.* 2002;75(3):234-244.