

Implementation outline: The pilot course in June was a resounding success; candidate confidence scores increased significantly across both skills and knowledge surrounding capacity, consent and DNACPR. All attending candidates have recommended the course to their peers and suggested integration into the Foundation training curriculum. However, identifying and implementing courses appropriate for all foundation doctors with such a specialized course would be challenging. Most foundation doctors have at least one placement in a surgical specialty. Therefore, it is more realistic to adjust the course to become less specialized, encompassing all the surgical specialities, to target all foundation doctors initially instead of juniors in each specialty. Following the capture of foundation doctors, the second phase of implementation will return to speciality-specific courses to address the learning needs of non-medical practitioners, such as Physician Associates and Advanced Nurse Practitioners, working in surgical departments.

REFERENCES

1. Non-Technical Skills for Surgeons (NOTSS). The Royal College of Surgeons of Edinburgh [Internet]. The Royal College of Surgeons of Edinburgh. 2021 [cited 19 June 2021]. Available from: <https://www.rcsed.ac.uk/professional-support-development-resources/learning-resources/non-technical-skills-for-surgeons-notss>
2. Wood T, Raison N, Halder S, et al. Training tools for nontechnical skills for surgeons – a systematic review. *J Surg Educ.* 2017;74(4):548–578.

171

SAFE PATIENT TRANSFER: GETTING EVERYONE IN ON THE ACCT

Peter McCauley¹, Crina Burlacu¹, Nick Wall¹, Anna Marie Murphy², Peter Moran³, Brian Kinirons³, Dermot Doherty⁴, Karl Knapman⁵, David Menzie²; ¹College of Anaesthesiologists of Ireland, Ireland²National Ambulance Service/Mobile Intensive Care Ambulance Service, Ireland³University Hospital Galway, Ireland⁴National Ambulance Service – Critical Care Retrieval Service, Ireland⁵Cork University Hospital, Ireland

10.54531/YLRL2252

Background: Optimal patient care frequently requires the safe inter-hospital transfer of critically ill patients for time-sensitive treatments, often outside of normal working hours. Safe transfer requires a multi-disciplinary approach including doctors (typically anaesthesiologists), nurses and paramedics. In a 2018 survey of anaesthesiology trainees in Ireland, 81% agreed that specific training in this area was 'deficient' or 'absent' ^[1].

Aim Recognizing the lack of formal training, we identified the need for training in the transport of critically ill patients including familiarization with the ambulance environment and common critical transfer scenarios ^[2]. Supported by national health and education bodies, we assembled a multi-disciplinary team of clinical experts and simulation educators to develop, implement and evaluate an Adult Critical Care Transport programme (ACCT) for key healthcare professionals involved in transferring critically ill patients. Our aims were: (1) to support a shared approach across multi-disciplinary teams; (2) to provide clinical training promoting safe, efficient transfer of patients; (3) to address gaps in training of anaesthesiologists involved in transporting critically ill patients; (4) to design a course acknowledging the challenges of COVID-19, and difficulties with releasing clinical staff and faculty from work for face-to-face training.

Method/design: The ACCT methodology consists of (1) comprehensive Video-Assisted Learning (VAL) material for pre-course completion; (2) on-site face-to-face simulation;

(3) an ACCT Train the Trainer (ACCT-TTT) for trainers to subsequently deliver the programme.

Implementation outline: The VAL material includes lectures (e.g. transport physiology), clinical skills demonstrations (e.g. transport and ambulance equipment) and simulation (e.g. safe packaging for transfer). There is an accompanying multiple-choice questionnaire (MCQ) to ensure full engagement and testing of core knowledge prior to the on-site component. On-site, small multispecialty delegate groups comprising of doctors, nurses and paramedics rotate through three simulations, allowing for enhanced experiential learning. Two take place in high-fidelity simulation laboratories, and one occurs in a fully operational ambulance. Delegates assume their real work roles and deal with common transport scenarios and adverse incidents. Debriefing focuses on reinforcing prescribed learning objectives. A post-course MCQ is used to validate learning, with feedback forms used for course evaluation. We plan to pilot the course and subsequently conduct ACCT-TTT courses. We aim to implement and expand ACCT nationwide, making it a mandatory component of anaesthesiology training.

REFERENCES

1. Kelleher E, Bailey K, Doherty D, Jonker W. The current state of inter-hospital transfer of the critically ill adult in Ireland. *Anaesthesia News* [online]. 2020;393:14–15. Available from: <https://anaesthetists.org/Home/Resources-publications/Anaesthesia-News-magazine/Anaesthesia-News-Back-Copies>
2. The Association of Anaesthetists of Great Britain and Ireland. AAGBI Safety Guideline: Inter Hospital Transfer [online]. Association of Anaesthetists 2009. [cited 19 June 2021]. Available from: <https://anaesthetists.org/Home/Resources-publications/Guidelines/Interhospital-transfer-AAGBI-safety-guideline>

48

USE OF SIMULATION TO INTRODUCE DELIVERY ROOM CUDDLES AS STANDARD PRACTICE IN A NEONATAL INTENSIVE CARE UNIT

Diana Aguirre¹, Amy Henderson¹, Helen Cornes¹, Gemma Holder¹, Cecilia Perez Fernandez¹, Emma Cawsey¹; ¹Birmingham Women's and Children's NHS Foundation Trust, Birmingham, UK

10.54531/NRWC9112

Background: Kangaroo Mother Care (KMC) was introduced in the 1970s to keep premature babies warm after birth. There has been growing evidence of multiple benefits including physiological autoregulation, reduced stress, positive attachment, enhanced neurocognitive development, breastfeeding and psychological well-being. Delivery Room Cuddles (DRC) was introduced 15 years ago in Norfolk and Norwich University Hospitals as an extension of KMC. Other units have since reported the successful introduction of the process ^[1]. Anecdotally in our Neonatal Intensive Care Unit (NICU) parents were not routinely offered skin-to-skin contact with their infant early in their neonatal journey.

Aim: The aim of the study was to safely introduce DRC as standard practice in our NICU.

Method/design: We obtained feedback on parental and staff experience with DRC. A Failure Mode and Effects Analysis (Figure 1) was then carried out to break down the DRC process into steps, highlight potential risks and mitigation strategies. Information was synthesized into a standard operating procedure (SOP) and checklist. The use of a transport incubator to mobilize premature infants was not common practice in our NICU at the start of the project; therefore, a parallel SOP was developed for this. Staff training was then

carried out using a video simulation and workshops. DRC was formally introduced in April 2021 (Figure 1).

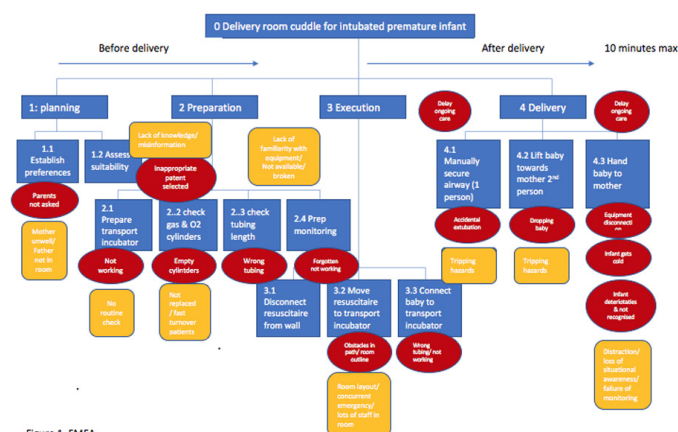


Figure 1: FMEA

Figure 1: FMEA

Implementation outline: Before implementation, 54 medical and nursing staff completed the survey, rating statements on confidence from 1 'strongly disagree' to 5 'strongly agree'. Confidence was higher in non-intubated infants 32–34 weeks' gestation (33/54 rated 5) and lowest in intubated infants <27 weeks' gestation (10/54 rated 5). Staff reported anxieties around equipment failure, delaying care and adverse events. Thirty-nine parents completed the questionnaire. Thirty-four babies were born locally. Only five babies had DRC, of which four had no respiratory support. Time to first skin-to-skin contact ranged from 2 hours to 17 days (mean of 5 days). DRC is becoming routine practice in our NICU with no adverse events to date. Anecdotally staff and parents report great satisfaction with DRC, although formal outcome assessment is outstanding. Introducing DRC is feasible with adequate process planning and staff training using video simulation and workshops. DRC is cherished by families, rewarding for staff and sets infants up for a positive start in the neonatal journey. With examples of successful DRC practice and emerging safety outcome data, DRC is likely to become routine practice. Using this model of process design and training, other units will also be able to safely introduce DRC.

REFERENCE

- Clarke P, Allen E, Atuona S, Cawley P. Delivery room cuddles for extremely preterm babies and parents: concept, practice, safety, parental feedback. *Acta Paediatrica* 2021;110(5):1439–1449.

96

A VIRTUAL MOCK TRIAL FOR INTER-PROFESSIONAL LEARNING

Karen J. Dickinson ¹, Wendy L. Ward ¹, Robert Minarcin ², Christopher Trudeau ², Kathryn Neill ¹; ¹University of Arkansas for Medical Sciences, Little Rock, USA ²William H. Bowen School of Law, Little Rock, USA

10.54531/LOVW1916

Background: As a healthcare professional, participating in a medical negligence trial is an intimidating and stressful prospect, exacerbated by the fact that many have never been in a courtroom. To meet this learning need, our institution runs a Mock Trial inter-professional learning event (IPE) designed to give law students and medical, nursing, pharmacy, public health and other healthcare professions students exposure to a medical negligence trial and the opportunity to learn about, from and with each other as they collaborate as a jury to reach a verdict. To continue to deliver high-quality inter-professional education during the

COVID-19 pandemic, transition to the virtual platform was required. Important lessons learnt from this process can be applied to the effective planning of similar virtual events.

Aim: The aim of the study was to effectively transition a large-scale in-person inter-professional Mock Trial simulation to the virtual platform to increase the accessibility of simulation education during social distancing and beyond.

Methods/design: Subject matter experts from the local law school and a university-affiliated Office of Inter-Professional education (IPE) jointly developed content for the Mock Trial. Students enrolled in the virtual Mock Trial were given pre-course jury instructions, IPE objectives and technical connection information 2 weeks before the trial. Law students, the judge and simulated witnesses received script materials 1 month prior to preparing. Facilitators participated in a virtual 'crash course' training 1 week before and a 15-minute pre-huddle just prior. Jurors (the students) watched the trial via Zoom and then were put into inter-professional breakout rooms with a facilitator to deliberate. All returned to the main room and verdicts were delivered followed by a debriefing session. Facilitators also debriefed after the event conclusion. Pre- and post-assessments were completed by students.

Implementation outline: The in-person Mock Trial event was conducted in 2018 and 2019, but was cancelled in 2020 due to the pandemic. In the 2021 learning event, 11 individuals were in person in the courtroom with the remaining students (143) participating via zoom. These 11 individuals comprised: one judge, four law students (two defense, two prosecution), five witnesses and one administrator. Social distancing/masking rules were obeyed. One witness participated via Zoom. Student and facilitator evaluation data, including assessment of IPEC competencies, were comparable to previous in-person events. This effective translation of a large-scale simulation event to the virtual platform demonstrates the utility and increased access to learners of this modality and will form a useful part of our simulation education toolkit post-pandemic.

142

THE COLLEGE OF ANAESTHESIOLOGISTS OF IRELAND RETURN TO WORK PROGRAMME: AN INNOVATIVE APPROACH TO SUPPORT TRAINEES' WELL-BEING AND PATIENT SAFETY ON RETURN TO WORK

Vincent Wall¹, Aisling McMahon¹, Louise Moran¹, Eilis Condon¹, Crina Burlacu¹; ¹College of Anaesthesiologists of Ireland, 22 Merrion Square, Ireland

10.54531/QCYF5806

Background: Within the 6-year Specialist Anaesthesiology Training (SAT) programme overseen by the College of Anaesthesiologists of Ireland (CAI), there is now an option for trainees to take up to 12-month unaccredited professional or personal leave after years 2 and 4. There is also a cohort of trainees taking academic leave, maternity leave or other leave. There is growing recognition in the CAI and among other Training Bodies that returning to work following a period of absence can be daunting. It requires a comprehensive support package to help with the readjustment to the clinical and training environment, and rebuild confidence^[1]. The CAI Committee of Anaesthesiology Trainees (CAT) has also made this recommendation after running a voluntary survey among its members.

Aims: A CAI steering group was convened to design a Return to Programme (RTP) support package, with the following objectives: