

programmes were provided by the academic health centre and IP educational activities were crafted around these. Such programmes included: a 1-800 COVID-19 hotline providing rapid access to health screening to assist the community in understanding when and where they should access the healthcare system for testing or care; a Contact Tracing Call Center to identify those with exposure and risk and counsel next steps; and provision of public health information regarding the virus and the vaccine. IP Faculty developed a series of IP simulations to provide students with the knowledge and skills necessary to serve in these public health support areas. These simulations were all structured utilizing an initial brief (detailing Interprofessional Education Collaborative (IPEC) domains and Patient- and Family-Centered Care principles), followed by scenario-specific education such as IP team review of screening algorithm and decision tree for hotline and call centre work, with subsequent standardized patient (SP) interaction, and finally IP debriefing. Five simulations involving 190 students occurred. Evaluation metrics collected included pre-/post-Interprofessional Collaborative Competencies Attainment Survey (ICCAS), evaluation of learning objectives, SP interaction and simulation methodology via Likert scale, and identification of themes from qualitative response items. **Implementation outline:** Inter-professional simulation training activity via an online platform supported student learning for COVID-19 disease information, screening algorithm and decision tree tools and telemedicine delivery. The rapidly implemented virtual training prepares students to graduate whilst also supporting the state during this public health crisis. This work provides a template by which curricula can pivot to meet the needs of all key stakeholders during a time of global crisis.

60 TALKING UNDER COVER: A VIRTUAL WORKSHOP TO IMPROVE COMMUNICATION IN PPE

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Background: Since 15 June 2020, all hospital staff were mandated by the government to wear a facemask in hospital and it looks like they will remain a permanent feature in healthcare for the foreseeable future. There is a significant body of research about the plethora of adverse effects that wearing masks can have on verbal communication ^[1] and we have evidence that effective communication is a common root cause of clinical error that affects patient safety ^[2]. However, despite the mounting evidence about the detrimental effects, there is little out there in the way of solutions to these problems. **Aim:** The aim of the study was to develop an interactive virtual workshop aims to improve the verbal communication of healthcare staff whilst wearing Personal Protective Equipment (PPE).

Method/design: We delivered 14 workshops from March 2021 to May 2021 to 80 participants. First, we discussed the barriers that healthcare workers are up against when they are working in Personal Protective Equipment (PPE) and then speak about vocal anatomy and how speech is created. The workshop then focusses on how to make speech clearer whilst also advising healthcare staff on how to look after their voice. To ensure the workshop is interactive, there are a number of

exercises that the participants perform and videos of COVID cardiac arrest simulations are used to discuss the potential speech and communication errors in PPE which could affect patient safety in an emergency. Finally, we also incorporated a patient's perspective in designing this course. They offered very helpful suggestions regarding verbal and non-verbal communication when communicating with patients in PPE, which are often overlooked by healthcare professionals but immensely valuable to improve patients' and staff experience. **Implementation outline:** We invited hospital departments to book on to the virtual training and collected electronic feedback from participants. As a result of this feedback, we hope to be able to provide face-to-face training in the future and incorporate simulation in the workshops so that participants can practice what they have learnt with higher fidelity and we are better able to understand how the added burden of cognitive bandwidth will influence people's communication.

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82 SURGEONS DON'T JUST OPERATE: IMPROVING JUNIOR SURGICAL PRACTITIONERS' NON-TECHNICAL SKILLS OUTSIDE OF THE OPERATING THEATRE USING HIGH-FIDELITY SIMULATION

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Background: The non-technical skills of surgeons play a significant role in patient confidence, experience and safety ^[1]. Courses, such as NOTSS, have been successful in advancing senior surgeons' abilities in situational awareness, decision-making, communication and teamwork, and leadership. These courses focus on non-technical skills intraoperatively ^[1]; however, the work of a surgeon is far from limited to the operating theatre. Often, critical events take place in A&E or the ward environment involving junior surgical practitioners potentially unsupervised. Still, there remains no required human factors training at the junior stage or surrounding surgical care outside of the operating theatre at any stage of practice. We are establishing a course for junior surgical practitioners encompassing two areas where non-technical skills are frequently tested outside of the theatre environment; DNACPR and consent.

Aims: The aim of the study was to improve non-technical skills and confidence of junior surgical practitioners regarding DNACPR conversations and obtaining operative consent.

Method: We have developed a speciality-specific course to address the educational deficit surrounding non-technical skills outside of the operating theatre, focussing on DNACPR and consent, for junior surgical practitioners. It was piloted at Aintree University Hospital with their Orthopaedic Department. We combined lectures and workshops delivered by subject matter specialists with simulated scenarios. The simulated scenarios were debriefed by human factors specialists using the gold standard validated NOTSS tool ^[2]. Anonymized candidate data were collected using electronic forms.

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.

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SAFE PATIENT TRANSFER: GETTING EVERYONE IN ON THE ACCT

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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.

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

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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