

could perceive themselves as confident and competent but still perform incorrectly. Fast track SBEs should not be used to confirm full competence due to the inability to provide repetition of skills practice.

#### REFERENCE

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#### LEARNING FROM COVID-19 AND SUPPORTING STAFF USING HUMAN FACTORS AND SIMULATION

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**Background:** The full impact of working in the COVID-19 pandemic surge on NHS staff is yet to be understood. Simulations were run to explore the staff experience following the second COVID surge. From these, it was clear that the staff had powerful stories to tell. A series of further simulation sessions were then delivered, designed to allow staff to explore their experiences and assist with organizational learning within the trust debrief strategy.

**Aims:** Firstly, to use simulation to recreate working with uncertainty and unfamiliar staff as a platform within the debrief to explore their experiences of working during the pandemic surges. Secondly, to employ a human factors framework, SEIPS model <sup>[1]</sup>, within a simulation debrief to build a system picture of work-as-done <sup>[2]</sup> by staff throughout the organization. This was then used to feed back to leadership to influence care processes and staff and patient well-being for potential future surges.

**Method:** Simulation sessions, open to all staff, were advertised throughout the organization. In total, 8 sessions were delivered for 38 staff. Multi-disciplinary attendance was encouraged, and a wide range of staff groups participated. During the session, staff were given a brief presentation on human factors, a simulation pre-brief and a pre- and post-simulation questionnaire. A simple patient deterioration scenario unrelated to COVID-19 was used to maintain psychological safety. A system-focussed debrief using the PEARLS model took place after the scenario. Insights shared by candidates were captured by a facilitator and anonymously grouped into the six SEIPS themes.

**Results:** Pre- and post-questionnaires show a general theme of improved confidence post-simulation. Findings were reviewed and the impact on care processes and staff, patient and organizational outcomes were summarized. Information captured within the SEIPS framework showed recurring themes that were condensed into four main categories: psychological trauma and burnout, communication, re-deployment and training, and infection control and PPE.

**Implications for practice:** It was clear from facilitating sessions that staff were concerned about patient experience but were also suffering their own trauma from working through the surge. Feedback from participants was positive, emphasizing their sense of validation in sharing their experiences and of feeling part of the hospital community. Staff also had experiences to share about what had helped them and where things could be improved. These insights were synthesized into practical recommendations for managing future pandemic surges that were fed back to the wider organization.

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#### NO TIME TO TRAIN? THE USE OF SIMULATION TO DEVELOP A PATHWAY AND DELIVER TRAINING FOR EMERGENCY SURGERY IN MATERNITY DURING THE COVID-19 PANDEMIC

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**Background:** The COVID-19 pandemic presented healthcare workers with a challenge to provide safe clinical care while protecting staff and coping with an evolving situation. The use of simulation to devise and test emergency pathways is well recognized in the literature <sup>[1]</sup>. However, this pandemic presented the world with a very tight timeline to deliver, let alone test potential pathways. This was further complicated in maternity units where workload remained the same during the preparatory phase.

**Aim:** Recognizing the need to test a safe pathway, with a limited evidence base, we sought to test the hypothesis that a combination of table-top and *in situ* simulation could be used to devise a protocol and train teams in a tertiary maternity unit during the first phase of the pandemic.

**Methods:** This programme involved three phases: pathway development, safety testing and team training. The initial phase was a simulated table-top scenario of a parturient requiring a Category 1 Caesarean delivery under general anaesthetic. This pathway was then used to create a structured simulation scenario to test its suitability. The debrief sessions for each explored three themes: (1) pathway feasibility; (2) timing and (3) feedback.

**Results:** The table-top simulation took place on 11 March. Team-specific outcomes highlighted the logistics of early senior escalation and the rationalization of staff and equipment in theatre. We also recognized deficits in the amount and correct use of personal protective equipment (PPE). Staffing levels and limitations in communication were also key findings. The subsequent *in situ* simulation took place 2 days later. The baby was delivered within the 30-min guideline (28 min) and overall, the pathway was safe to use. It was then modified and used to train teams over the subsequent weeks, reaching 151 staff. Feedback from candidates was powerful: 'I feel safer coming to work'.

**Implications for practice:** The initial phases of the COVID-19 pandemic provided a fertile ground for team consolidation and planning that promoted collaboration in one of the most multi-professional areas of any hospital: the maternity unit. Involvement of all teams meant that deficits in training could be identified early, and changes could be adapted rapidly. The simulations also demonstrated to staff that it was possible to safely deliver a baby within the timeframe. Recognizing that this was not an isolated problem, we shared our resources publicly helping teams in the USA, Laos, Australia and UK to develop their own protocols. Importantly, it improved our response to the second wave.