

and inter-professional training, and have funded the appointment of an ICU Simulation Fellow to continue to lead and enhance future *in situ* simulation teaching on the ICU.

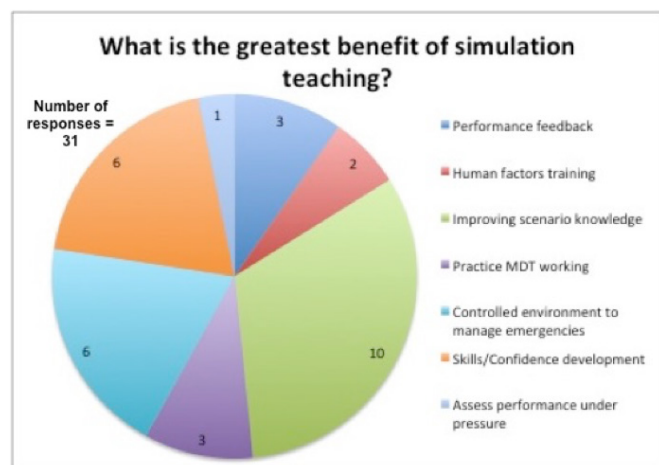


Figure 1:

20 SPECIAL DELIVERY: SKILLS@HOME

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Background: Due to the sudden shift in online learning at the start of the pandemic, an innovative idea was identified to encourage a student-centred approach for continuing the development of their essential skills whilst learning from home. Taking inspiration from other healthcare programmes, we developed, and risk assessed 'Skills@Home' packages to embed a mastery learning approach towards dexterous skills. These comprehensive packages included access to virtual resources and e-learning as well as practical and safety equipment. Implementation of these packages allowed students to maximize their exposure, experience and understanding of a range of skills that could be accessed at a time and pace to suit their needs. The pilot 'Skills@Home' package focussed upon the development of suturing, which is a traditional and essential midwifery skill.

Aim: A collaborative approach between the midwifery team and the clinical simulation and skills education team ensured a robust approach to the risk assessment, procurement and delivery of packages to students' home addresses. A prerequisite for receiving a pack was the completion and return of a detailed student agreement form which outlined safety considerations and their responsibilities. The package was piloted with a cohort of 29 third-year student midwives, as a priority group, to facilitate and increase confidence and application in the clinical area and to ensure enough opportunities for progression on the programme.

Method/design: Students completed an online evaluation form after receiving their packs, which showed overwhelming support for this approach. Students identified that having the opportunity to learn in this manner at home not only enhanced their confidence and skills technique but also helped them to relate theory to practice. Additionally, students identified that they would like to see the 'Skills@

Home' approach sustained and enhanced once on-campus learning has resumed.

Implementation outline: This has inspired the clinical simulation and skills education team to identify other Skills@Home packages that can be used within healthcare learning. Ensuring that thorough risk assessments are completed along with the packages being created and delivered to the students in the most cost-effective way. Following the pilot study, ethics approval is currently being sought to explore, using focus groups, the midwifery students' experiences and view of using the Skills@Home initiative.

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REDUCING RISK: SIMULATION-BASED CLINICAL SYSTEMS TESTING TO DETERMINE NEW HOSPITAL READINESS FOR ANAESTHESIA SERVICES

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Background: The newly built Women's Wellness and Research Center (WWRC) replaced the pre-existing Women's Hospital (WH) as the only provider of tertiary maternity care for the residents of Qatar. The pre-existing WH was smaller, with a 12-bay emergency department, 3 operating theatres, 12 delivery rooms and 220 beds, in shared rooms. The new WWRC facility is significantly bigger, with a 28-bay emergency department, 7 operating theatres over two floors, 26 delivery rooms and 240 private inpatient rooms catering for around 18,000 deliveries per year. New systems, designed over only a few months, would need to promote that same level of high-quality patient care but in a newer, larger and unfamiliar facility.

Aim: The aim of the study was to identify and mitigate clinical systems risks, relevant to anaesthesia services, by running *in situ* simulations.

Method: The 'WWRC Anesthesia Activation Team' was established to conduct *in situ* simulations, testing clinical systems. We hypothesized that, despite meticulous planning, numerous process gaps would be discovered, and that improvements derived from testing sessions would reduce risk^[1]. Well-planned scripted 'everyday' scenarios were prepared. Relevant multi-disciplinary groups of participants were involved, and the scenarios were kept flexible. After the simulation, facilitated debriefing highlighted problem areas and suggested improvements.

Implementation outline: Approximately 110 hours of simulation were conducted in sites relevant to anaesthesia. Many of the participants had never experienced simulation before but nearly everybody complimented its usefulness and debriefing was unanimously constructive. Testing identified 143 discrete latent safety threats (LST) and were categorized under Facility, Workflow, Personnel, Process, Equipment and Technology (Table 1). Fifty-four LSTs were due to systems that were incomplete at the time of testing but would be completed by the time services commenced. The remaining 89 were significant LSTs which could have resulted in significant clinical incidents. After mitigation of LSTs, the areas were simulation tested again to confirm threat elimination. WWRC was opened only after all areas of concern were addressed. A year after moving, a review of all the changes recommended from the simulation-based systems testing was conducted. It showed that there were no anaesthesia-related clinical incidents in those areas.