

involving trainees working with Foundation Year Doctors over 5 scenarios where they are escalated to as the senior on call. The focus is developing skills such as prioritisation, leadership and communication. All candidates take part in the debriefing. The IMT3B course is a day of 5 extremely challenging scenarios in difficult settings such as out of hours or with limited senior presence. These scenarios are devised to push the IMT3 candidates in order to help prepare them for working under pressure. Scenarios include difficult ethical decision-making, litigation issues, and complex patients (e.g. pregnancy).

Results: The sessions were positively evaluated by the IMT who expressed how they will help change their practice and enhance patient safety (see Table 1). All aspects of the course are devised to help and progress with the trainee introducing best practice and quality assurance. Debriefings are effective with discussions between peers being both positive as well as informative. We have kept class sizes to 6 participants as we have found this gives the right amount of support without being too overwhelming.

Table 1: Feedback from the internal medical trainees

Course	Learner Feedback (what did you appreciate?)
Internal Medical Trainee Year 1	Proper communication and debriefing. Feedback with learning objectives discussed. Great faculty. Very good scenarios. The training staff was very cooperative and it was a wonderful learning experience for me.
Internal Medical Trainee Year 2	Strenuous scenarios – clinically stretching and very helpful to reflect on. Engaging and active participation. A lot of thinkings and reflections for not just the scenarios I have directly involved, but also in colleagues' scenarios. Technical skills – Brady/tachycardia, ALS, pacing.
Internal Medical Trainee Year 3	Multiple different scenarios, structure of the scenarios meaning I was realistically called in without prior knowledge of the situation. Put in stressful but safe situations where I was the most senior person, having to make decisions and delegate – very true to life. Constructive feedback in a safe environment with opportunity to lead adult emergency call and response to referrals from junior member of the team.

Conclusion: We feel that as the IMT work through the programme prepares them for what is a difficult transition. Over their IMT simulation training they will take part in 18 scenarios either as a candidate or in the debriefing. It has given the IMT the chance to have high quality training in a high-fidelity environment thus promoting enhanced care and patient safety.

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ENDOSCOPIC SUBMUCOSAL DISSECTION (ESD) TRAINING SESSIONS ON EX-VIVO PORCINE MODELS

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Background: Endoscopic Submucosal Dissection (ESD) is a technique for removing lesions in the gastro-intestinal tract. It involves precise cutting into the submucosal layer, allowing

for the lesion to be removed in one piece, and has been shown to have a high curative resection rate [1]. It is a technically challenging endoscopy technique that requires experience and practice. As one of the common complications from ESD is perforation [2], training on ex-vivo models is becoming popular with 84% of surveyed centres in the UK requiring Endoscopists to complete a number of ESDs on animal models before progressing to train on patients [3]. While training was accessible at other centres, this was infrequent and less accessible.

Methods: Sessions were created at the hospital training centre. This was done using decommissioned endoscopy stacks and endoscopes, so that these were always available and designated for ex-vivo use only. The animal model was a porcine oesophagus, stomach, and start of duodenum prepared in a box with a hole for endoscope insertion. The duodenum was clamped to ensure inflation would be possible. The days ran from 0830-1530 with a drop-in option. After 7 sessions were run over 5 months, a survey was sent out to the 8 people that had participated to assess the benefits of the service (including faculty doing the training and trainees).

Results: 8 responses (100%) were collected. 62% (n=5) of responders had used ex-vivo models before. 83.3% of trainees (n=5) said they had come to our hospital specifically to train in ESD technique. Responders attended between 1 and 10 sessions at our centre. All trainees and faculty said they found the training extremely beneficial and that they thought the ex-vivo model work well the way it was set up. All responders said they would recommend the sessions to a colleague. All trainees said that training with an experienced Endoscopist was more beneficial than training alone. Suggestions for improvement included a more consistent timetable of when they could access sessions, more accessibility and wider range of endoscopy kit, and involving the wider nursing team in the sessions.

Conclusion: The ex-vivo ESD training sessions were well received by both faculty and trainees and were said to be very beneficial to their training. We will therefore be putting on more of these sessions, taking into account the suggestion for a regular accessible timetable.

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USING SIMULATION TO SUPPORT A NEW THEATRE SETUP

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Background: Following the redevelopment of the day case theatre complex at Chorley District General Hospital it was identified that new ways of working were required, and changes to patient processes would need to be made. Some of these were normal, expected, adaptations to be made when moving to a new working environment, such as the location and storage of equipment.

Methods: The Resuscitation and Simulation Team, led by the associate Clinical Lead for Simulation, modelled the theatre list for the first day using simulated patients and in line with the ASPIH standards [1]. This gave the theatre staff the opportunity to run through cases in real time and gauge when patients needed to be sent for, how long was needed for setting up, and at what time they could safely call for the next patient without causing unnecessary delays or having patients waiting in corridors. Each step in the process was followed by a debriefing so that the actions could be discussed and any changes made.

Results: The feedback was positive and team members found it extremely useful to simulate their upcoming lists. As expected, there were several patient flow related issues raised, mainly around timings and logistics (Table 1). The day also allowed teams to anticipate other minor issues such as kit storage, stocking and availability to ensure the theatre lists ran smoothly on the day.

Table 1: Issues identified following simulation of a theatre list

Problem	Effect	Solution
Lack of anaesthetic room meaning that patients needed to be anaesthetised in the theatre.	The theatre must be set up and ready to go prior to the patient arriving as the noise during induction must be minimal.	Times were mapped out from sending for the patient, pre-op checklist, to arrival in theatre so that staff could plan set-up accordingly.
During joint replacement operations the doors cannot be opened due to infection risk.	All equipment must be inside the theatre prior to the patient arriving.	A simulated 'walk through' of the theatre list allowed staff to collate a list of all possible equipment that may be needed so it could be inside the theatre.

Conclusion: Simulation of normal business can be successfully used to improve patient safety and the confidence of clinical staff when developing new clinical areas.

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DEVELOPING A NEW SIMULATION-BASED DECISION-MAKING AND TEAM-WORKING COURSE FOR ADVANCED CLINICAL PRACTITIONERS

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Background: The development of the Advanced Clinical Practitioner (ACP) framework at Lancashire Teaching Hospitals began in 2017. There are now 13 non-medical consultants, 73 Qualified Advanced and Specialist Clinical Practitioners, and 25 trainee ACP's across the organisation. Part of the competency framework included the ability to manage common medical emergencies that are not necessarily a routine part of that ACP's case load, for example managing a patient with chest pain on a surgical ward or assessing a ward patient following a fall.

Methods: A one-day simulation-based course was developed to allow ACP's to manage patients with these conditions in a safe and supportive environment. The day includes a

lecture introducing human factors and decision-making theories, followed by six scenarios with debriefing facilitated by senior faculty to discuss learning points with the group. Scenarios were designed in line with ASPIH standards [1] to include clinical competencies which are not commonplace in the trainee's current working environments, giving them a chance to undertake the management of these rarer occurrences in a safe and controlled environment.

Results: Feedback was collected using anonymous self-scoring feedback forms and was overwhelmingly positive, with candidates feeling more confident in managing these clinical scenarios in practice. All candidates felt the scenarios were pitched to the correct level. Written feedback also highlighted how beneficial it was to get together as a group for shared learning across different directorates.

Conclusion: Simulation-based learning can improve the confidence of ACP's in managing unfamiliar clinical emergencies. In future courses will be advertised and opened to ACP's from other Trust's to allow further discussion.

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BRIDGING THE REALISM GAP: USING 'LOW-FIDELITY' SIMULATION FOR HIGH QUALITY TRAINING

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Background: The Royal College of Anaesthetists recommends use of simulation-based-education (SBE) during the initial 12-week novice placement for new anaesthetic trainees [1]. For many UK anaesthetic departments, the complexity and cost of patient simulators [2] may reduce opportunities for SBE during novice training. However, avoiding the physical fidelity trap [3] and utilising both conceptual and psychological fidelity to good effect might mitigate this issue. As novice trainees are already familiar with the theatre environment from day-to-day clinical practice, the learning outcomes from SBE generally cover rarer emergencies which can still be covered during SBE outside of the theatre environment. We aimed to assess the feasibility of running weekly low physical fidelity SBE across the entire 12-week novice period instead of the smaller number of ad-hoc sessions delivered previously.

Methods: Our new SBE programme consisted of 30-minute sessions held in the anaesthetic department conference room to minimise impact on stretched theatre capacity and educator availability. To further maximise efficiency, we created a portable simulation set-up using a basic resuscitation manikin on a patient trolley, a disused anaesthetic machine, and a tablet device with a simulated monitor application. This could all be set-up and stored away in under 5 minutes. Our focus on conceptual and psychological fidelity led to the creation of a new scenario bank which identified common issues encountered by new anaesthetic trainees, rather than emergencies rarely encountered by even an experienced anaesthetist. Scenarios needed to be highly plausible and solvable by the novice trainee. Learners were then asked to complete a feedback survey after each session.