

neonatal unit nurses to the course affected the postgraduate doctors in training feedback (which has always been consistently positive); and to assess if the nurses felt it was beneficial for their training.

Methods: We invited four nurses to SHINE who were about to complete their Neonatal Qualified in Specialty (QIS) Course. They took the nursing role in the scenarios either caring for the baby (a manikin) in the neonatal unit or carrying the labour ward delivery nursing bleep. We evaluated the relevance, confidence levels, and the learning environment for both the doctors and nurses attending the course via a written anonymous survey.

Results: The doctor's feedback was very positive and comparable to previous courses ran with all of them recommending the course to their colleagues, and they felt they had enough opportunity to interact. The nurses felt sessions were very relevant to their current practice and all of them improved their level of confidence. They felt there was the correct number of scenarios and workshops; that the debriefings were well structured and educational; the learning environment was safe and supportive; and all would recommend the course to a colleague. Comments included 'Really enjoyed the day and it has definitely helped me to feel more confident – especially as I've only just started holding the bleep.'

Conclusion: SHINE is a well-established sought-after course shown to be effective and highly valued by paediatric postgraduate doctors in training. Given the positive feedback, we will be inviting four nurses to each SHINE course and integrating it in to Qualified in Specialty training.

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TESTING THE SYSTEM: INFANT 'ABDUCTION'

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Background: Infant abductions from hospital are rare events but make headline news. A US study examined 247 infant abductions between 1983–2006 and found nearly half were abducted from healthcare settings [1]. Abduction risk reduction strategies are also considered during the Care Quality Commission's inspection of each maternity unit [2]. The baby tagging system was updated in our hospital in April 2020, training undertaken and subsequently reinforced with e-learning. In our hospital, many families have safeguarding concerns. These are considered the highest potential risk for infant abduction so it is essential the system and processes provide protection. The aim of this simulation was to test the processes currently in place for a tagged baby abduction from an inpatient ward to highlight good practices and identify system failures.

Methods: An activated tag was assigned to a manikin on the transitional care unit. The manikin was removed, in a carrier bag, by a faculty member ('the abductor') tailgating a leaving staff member thus preventing the ward doors from automatically locking when the tag is near the sensor. The 'abductor' took the lift to the ground floor and walked out of the main entrance within three minutes. Faculty members

were placed in transitional care (TC), the main entrance, and another tracking the tag's location. A timeline of events was recorded and analysed. Simulation participants were debriefed, including staff directly involved, parents on TC, front of house staff, and senior managers.

Results: It was evident from the debriefing that this caused significant distress to some staff members who felt helpless and uncertain when faced with this scenario. It highlighted how quick and easy it is to leave the hospital with a baby. Important human factors were identified including discrepancies between emergency call requests and responses, and poor knowledge about the abduction of baby policy. System problems were found: hospital 'lockdown' locked internal doors preventing responder actions but not all external doors; and the tagging system did not respond as expected – locking the doors to the ward and an inaccurate final tag location.

Conclusion: Multiple deficiencies in the system were found so an action plan has subsequently commenced. New external doors have been added to automatic lockdown and a new main entrance door system proposed. Tagging engineers are addressing the automatic locking of internal doors and tag location, switchboard calls are to be standardised, and the standard operating procedure is being reviewed and recirculated.

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THE IMPORTANCE OF SIMULATION TECHNICIANS' INVOLVEMENT IN EDUCATORS' CONFERENCES AND EDUCATIONAL EVENTS

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Background: Simulation technicians are a vital part of simulation teams and facilitating simulation sessions. Additionally, they help to materialize the educators' vision [1]. There is a gap between what educators expect from technicians and how well technical staff perform based on the instructions given. To support simulation-based education understanding of the educational philosophy underpinning simulation processes used by educators would improve and enhance the abilities of the technician. A survey-based review recommended exploring opportunities that simulation technicians have and to create more opportunities for technicians to get involved [2]. Not having sufficient knowledge and understanding can impact on the overall preparation and requirements from the technician. Full understanding between instructional and educational principles will close the gap and allow simulation technicians to have a deeper role and active part of simulation-based education. This allows simulation technicians to go beyond the technical skills and technical terminology especially for those whose background is non-clinical. The overall aim is to explore what opportunities simulation technicians have to participate in educational simulation events to enhance their knowledge, skills, and effectiveness of their role.

Methods: Interestingly the Society in Europe for Simulation Applied to Medicine (SESAM) 2022 conference was attended by 607 delegates from 51 countries with only 36 simulation technicians attending. This meant that only 6% of the delegates were Simulation Technicians compared to other professionals, which is a small number. This data was never previously collected by SESAM so we do not know if this number has changed over the years [3].

Results: The study is presently being submitted for ethical approval. It is the expectation that the data will be collected and analysed upon receiving the ethical approval.

Conclusion: We will gain new understanding from the technicians' perspective on the attendance at simulation-based educational events from the Simulation Technicians network across the United Kingdom. It will help us identify how often simulation technicians attend and what benefits there were to this continual professional development opportunity. Simulation technicians should have more opportunities to participate in conferences and educational events. This will close the technicians-educators' educational gap and allow them to have a more meaningful part within the simulation community, resulting in more equity, parity, and diversity.

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HUMAN FACTORS SIMULATION TAKES FLIGHT: COLLABORATIVE WORKING WITH THE AVIATION INDUSTRY TO IMPROVE THE 'HOW' DURING EMERGENCY DEPARTMENT IN-SITU SIMULATIONS

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Background: Working in Emergency Departments (ED) can, at times, be challenging for staff who are expected to work as a team, manage a wide range of conditions, and respond rapidly in a changeable environment [1]. Simulation has been proven to be a psychologically safe approach allowing staff to practise and explore Human Factors (HF) skills [2]. WingFactors, HF trained pilots, joined the faculty to collaborate and run in-situ simulation [3]. Our aim was to integrate HF-focused simulation with application into clinical practice, utilising the novel and fresh aviation perspective.

Methods: Simulations were designed by clinicians with both technical and non-technical learning outcomes. Patients were played with either a manikin, a pre-briefed actor, or both. The participants were mainly doctors and nurses but have included the wider multidisciplinary team. Senior doctors were embedded and briefed to be able to offer support as part of a staggered entry. After debriefing, each participant completed a feedback form evaluating their experience, confidence levels, and take-home messages.

Results: Seven different scenarios were run gathering 65 responses. Participants' agreement with five questions using 5-point Likert scales and free text thematic analysis allowed evaluation of the simulation experience. They were asked to consider the usefulness, understanding, and relevance of topics, as well as confidence gained. In addition, participants were asked how they felt the experience would change or enhance their clinical practice. High satisfaction and clinical relevance of the simulations were reported with a mean score of 4.85 across all domains (Table 1). Qualitative feedback showed participants had learnt both technical and specific non-technical learning objectives. Thematic analysis demonstrated that participants had gained skills such as improved emotional intelligence and confidence, ability to challenge authority gradients safely, team motivation, and shared decision-making. Some of the key themes from the feedback offered by the pilots include the importance of 'read-back' communication, pressure testing decision-making, and the power of pre-briefing.

Table 1: Scenarios with participant numbers and average scores/5

Scenario / HF Focus	Participants	Average score/5
1 – Cold sepsis / decision making / communication	6	4.8
2 – Agitated patient / capacity assessment / working with the MDT	13	4.16
3 – Fractured femur / challenging extrication outside the ED / anticipation of clinical course	9	4.9
4 – Paediatric cardiac arrest / managing a parent who wouldn't leave	7	4.76
5 – Adult cardiac arrest / non verbal communication skills	7	4.76
6 – Toxicology / active management of distractions	5	4.88
7 – Silver trauma / challenging upwards	18	4.84

Conclusion: The involvement of the pilots added value to the teaching by bringing a new perspective, experience, and application of HF. Individuals have walked away with a better understanding of they can practically implement HF skills into everyday clinical practice, improve patient care and mitigate risk. We hope to progress this collaboration, trialling new HF concepts (e.g. managing error) involving more members, not only the multidisciplinary team, but service users as well and to explore the potential learning in offering more clinicians the patient's perspective.

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