

group activities maximise participation and consolidate learning, whilst sharing service users' words powerfully demonstrates relevance.

Table 1: How service users' lived experiences inform CCST through simulation

<p>Updating a relative on the phone</p> <p>• "When I rang the ward on the day mum died the person who answered the phone said "she is fine". I later learnt that meant she was comfortable. It gave me false hope. Staff need to realise how their words can be interpreted."</p> <p>• Son</p>	<p>Escalating concerns using SBAR communication model</p> <p>• "Contact was made between the nursing and medical team, however this communication was not clear and the reason for contact was ambiguous. This resulted in the ward staff assuming the patient would be reviewed and hence no efforts were made to make further contact. Due to miscommunication the junior medic did not understand that an immediate clinical review of the patient was expected of them. Consequently the patient did not receive a timely medical review and subsequently deteriorated."</p> <p>• Case review</p>	<p>Challenging a colleague & upholding Trust values</p> <p>• "Dad was a really smart man. He used to own his own company and employ lots of staff. He would do the crossword every day until his stroke. Some of the nurses were lovely and would talk to him, but others talked over him as they washed him as though he was just "a task". They would talk about their holidays to each other or the poor staffing. He felt so invisible and when they talked about how bad work was, it made him scared. I wish they had realised they get to go home at the end of the shift. He was stuck there with his life in their hands."</p> <p>• Daughter</p>
<p>Supporting Compassionate Conversations</p> <p>• "I asked the nurse how long we had left. She couldn't tell me of course but she allowed me to ramble on and offload about what a long journey this had been. She allowed me to admit for the first time that it would be a bit of a relief. I hadn't been able to say this to anyone before. I felt so much guilt but just the touch of a hand made such a difference. She was telling me it was ok."</p> <p>• Husband</p>	<p>De-escalating conflict using empathy & active listening</p> <p>• "I could never get through to the ward on the phone. When I visited, the ward was noisy and I never saw the same nurse twice. They told me he wouldn't last the weekend but here we were 30 days later. You wouldn't let an animal suffer like this. I was really angry he'd been moved out of the side room but then the EOLC nurse asked me how I was. Everyone kept asking me how I thought he was but no one had asked how I was before. He was comfortable, he seemed settled, but me? I was a mess. I realised then that it was me that needed help."</p> <p>• Wife</p>	<p>Breaking bad news over the phone</p> <p>• "The nurse who phoned me in the middle of the night was so kind. It can't be easy to make that call. She gave me time, and didn't rush me at all. However, by the time my daughter arrived I'd completely forgotten what we needed to do next. We couldn't get back through to the ward – it was constantly engaged but my daughter finally found it on the hospital website. It was such useful information. It just would have helped if we'd been told where to find it rather than spend ages trying to get through on the phone."</p> <p>• Wife</p>

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Findings: The initial four courses have received universal praise from participants, ARP, and accreditors:

- 100% participants reported increased confidence
- Content relevant and comprehensive
- Key learning: Escalating concerns, Power of silence, Active listening
- Self-reflection and peer support positively supported
- High energy levels maintained throughout day
- Service users' experiences extremely powerful
- Use of ARP provides realism and invaluable insight into user experience

Conclusion: CST is as important as clinical skills training. Using ARP to simulate situations based on service user feedback, provides powerful learning opportunities through participation and observation. The lived experiences of service users and clinical review findings directly influence course content and impact on future care. Establishing an accredited CCST course with standardised content will ensure quality, deliverability and assurance of training. This has the potential to improve communication skills and consequently user experience of care provision.

REFERENCE

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USING A SYSTEMS-BASED APPROACH TO EXPLORE THE ENABLERS AND BARRIERS TO EQUALITY, DIVERSITY, AND INCLUSION WITHIN A SIMULATION-BASED EDUCATION SERVICE

Jessica Wadsworth¹, Jennifer Blair¹, Ruth Millett¹, Kristine Damberg¹, Maria Esposito¹, Eloise Van Vuren¹, Emily Marshall¹; ¹*Epsom and St Helier NHS Trust, Dorking Road, United Kingdom*

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Background: Equality, diversity, and inclusion (EDI) are high on the national agenda within healthcare. As an acute Trust based in London, we believe it is important to explore our simulation service provision through this lens, and make appropriate improvements. We have noted EDI interventions typically focused on single or isolated actions that often have minimal impact. The Safety Engineering Initiative for Patient Safety (SEIPS) [1] is a systems-based approach that considers the dual outcomes of system performance and human wellbeing. SEIPS is often described as the 'Swiss army knife' of human factors or systems-based models and can be used both retrospectively and prospectively to look at a defined work system, and its related processes. We utilise the SEIPS framework, to evaluate current barriers and enablers to EDI within our simulation service, and use the findings to design appropriate improvements.

Methods: The SEIPS framework guided our thinking across all stages of the project and we considered the wider context of EDI within our simulation service. Interactions between different work system factors that produce both wanted and unwanted outcomes, and feedback loops were explored. Information gathered from a number of sources allowed for triangulation and a review of emergent themes. Data sources included: Optional online post-course survey, including quantitative and qualitative EDI questions relating to an experience on a recent simulation course. All participants and faculty that attended relevant simulation courses since November 2021 were included. Review of feedback from November 2021 of all relevant simulation courses. Qualitative data themes were mapped to the SEIPS framework. A patient representative shared common EDI experience themes that Trust patients had reported whilst interacting with our hospitals and healthcare services. Relevant scenario and course documentation was reviewed for EDI themes using CORE20PLUS5 [2] as guidance. Frequency of both implied and explicit references were measured.

Findings: Stage one (evaluation) findings so far, suggest three key themes of accessibility, default gaze, and Work-As-Imagined versus Work-As-Done have emerged. Stage two (improvement) is to design system level improvements and assess them using the Inequality, Feasibility, Acceptability, Cost, Efficiency, and Sustainability (IFACES) criteria. Suitable improvement ideas will then be tested using a Plan/Do/Study/Act (PDSA) cycle.

Conclusion: We reflect on the utility of SEIPS as a systems-based tool to support an EDI service evaluation and improvement project and share our journey so others may learn from this process.

REFERENCES

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