

INTRODUCING SSTORCC: SIMULATION FOR STRESS TESTING AND OPERATIONAL READINESS IN CRITICAL CARE

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Background: Hospitals are dynamic healthcare environments, adapting to challenges including increasing demand through the design and construction of new clinical areas. In-situ simulation has been used effectively in clinical settings to assess the strength and suitability of these clinical environments prior to their use [1]. Additionally, simulation has been more recently used in critical care settings to evaluate adaptations required in response to new challenges, including the COVID-19 pandemic [2]. We ran a one day in-situ simulation-based session called Simulation for Stress Testing and Operational Readiness in Critical Care (SSTORCC) to evaluate the operational readiness of a new twenty-four bedded critical care unit built at our hospital prior to its official opening to patients and staff. The aim was to assess the operational readiness of the new critical care unit and evaluate its safety for patients, with the objective being to identify problems that would affect this. The attendees were key members of the team and stakeholders so that issues that arose from the session were addressed in a timely fashion.

Methods: This in-situ simulation session followed a patient's journey from admittance to the new critical care unit and incorporated all aspects of patient care, including accessing the unit, the ergonomics of the bed space, and equipment availability. We simulated several emergency situations including emergency intubation and cardiac arrest, and a transfer from the unit to another area of the hospital.

Results: The session identified key areas of development and modifications required prior to the move of patients and staff to the new critical care unit. These included ensuring access to the unit for relevant staff at the hospital, clear labelling on each equipment trolley, assembly of emergency drug boxes for each of the four areas of the unit, and raising awareness about the location and opening of the new unit to the wider hospital.

Conclusion: In-situ simulation is a constructive tool to use in stress testing a new critical care unit and allows for efficient recognition of areas which require immediate action prior to being considered ready for operational use.

REFERENCES

1. Frommelt J, Noeller T. In situ Simulation to Evaluate the Readiness of a New Clinical Space. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2022.
2. Fregene TE, Nadarajah P, Buckley JF, Bigham S, Nangalia V. Use of in situ simulation to evaluate the operational readiness of a high-consequence infectious disease intensive care unit. *Anaesthesia*. 2020;75(6):733–738.

MEDICS FOR MEDICS: INTRODUCTION OF A SIMULATION COURSE DESIGNED FOR INTERNAL MEDICINE TRAINEES PROGRESSING TO REGISTRAR TRAINING

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Background: The Curriculum for Internal Medicine Training [IMT] outlines that simulation should be used as a teaching

tool during the three years of training to consolidate clinical knowledge and incorporate the importance of human factors in the clinical workplace [1]. Although simulation is used as the mainstay of teaching procedural skills for IMT trainees, we identified that there was no immersive simulation beyond this offered to these trainees at our Trust. This inspired us to design an immersive one-day simulation course, which we called MEDICS [Managing Emergency Decisions and Interventions in Critical Situations]. This course, aimed at IMT year 2 and 3 trainees, gives them the opportunity to lead in common medical emergencies, practise task prioritisation, and prepare for the role of medical registrar, with human factors integrated into these immersive scenarios.

Methods: We used the IMT curriculum and our discussions with IMT trainees to design seven scenarios with emergencies from each core speciality, which were highlighted as areas where IMT trainees felt less confident. Following each scenario, we held a 30-minute debriefing to highlight key clinical learning points and discuss the impact of human factors in the delivery of care.

Results: Post-course feedback for both pilot courses were overwhelmingly positive, with all candidates feeling that the course improved their confidence in dealing with these medical emergencies and enhanced their preparation for the role of medical registrar.

Conclusion: Immersive simulation is an effective means of giving IMT trainees the opportunity to practise leadership, delegation, and task prioritisation to improve their preparation for the step up to medical registrar.

REFERENCE

1. Joint Royal Colleges of Physicians Training Board, Curriculum for Internal Medicine Training Stage 1 Training, Federation of Royal College of Physicians 2019. https://www.jrcptb.org.uk/sites/default/files/IM_Curriculum_Sept2519.pdf [Accessed on 24/06/2022]

'WHO YOU GONNA CALL?': TRAINING MEDICAL STUDENTS IN TELEPHONE COMMUNICATION SKILLS THROUGH SIMULATION

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Background: Effective communication in the healthcare setting is essential for safe clinical practice and providing good patient care. Doctors frequently request and receive clinical tasks and information over the telephone, a skill which became even more important during the COVID-19 pandemic [1]. However, these skills are rarely incorporated into the medical school curriculum and new Foundation Year 1 (FY1) doctors lack the confidence and ability to effectively communicate over the telephone [2]. The aim of this project was to improve the confidence of medical students in communicating over the telephone in a clinical context using scenarios.

Methods: A team of post-foundation doctors created seven telephone-based scenarios representative of what a FY1 doctor could commonly experience on a ward. Each patient scenario involved two telephone calls to healthcare professionals (e.g.: doctors, nurses, pharmacists, allied health professionals) and/or patient relatives who were role-played by clinical teaching fellows (CTFs). Tasks included making requests and referrals,