

**Implementation outline:** The pilot course in June was a resounding success; candidate confidence scores increased significantly across both skills and knowledge surrounding capacity, consent and DNACPR. All attending candidates have recommended the course to their peers and suggested integration into the Foundation training curriculum. However, identifying and implementing courses appropriate for all foundation doctors with such a specialized course would be challenging. Most foundation doctors have at least one placement in a surgical specialty. Therefore, it is more realistic to adjust the course to become less specialized, encompassing all the surgical specialities, to target all foundation doctors initially instead of juniors in each speciality. Following the capture of foundation doctors, the second phase of implementation will return to speciality-specific courses to address the learning needs of non-medical practitioners, such as Physician Associates and Advanced Nurse Practitioners, working in surgical departments.

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171

## SAFE PATIENT TRANSFER: GETTING EVERYONE IN ON THE ACCT

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**Background:** Optimal patient care frequently requires the safe inter-hospital transfer of critically ill patients for time-sensitive treatments, often outside of normal working hours. Safe transfer requires a multi-disciplinary approach including doctors (typically anaesthesiologists), nurses and paramedics. In a 2018 survey of anaesthesiology trainees in Ireland, 81% agreed that specific training in this area was 'deficient' or 'absent' <sup>[1]</sup>.

**Aim** Recognizing the lack of formal training, we identified the need for training in the transport of critically ill patients including familiarization with the ambulance environment and common critical transfer scenarios <sup>[2]</sup>. Supported by national health and education bodies, we assembled a multi-disciplinary team of clinical experts and simulation educators to develop, implement and evaluate an Adult Critical Care Transport programme (ACCT) for key healthcare professionals involved in transferring critically ill patients. Our aims were: (1) to support a shared approach across multi-disciplinary teams; (2) to provide clinical training promoting safe, efficient transfer of patients; (3) to address gaps in training of anaesthesiologists involved in transporting critically ill patients; (4) to design a course acknowledging the challenges of COVID-19, and difficulties with releasing clinical staff and faculty from work for face-to-face training.

**Method/design:** The ACCT methodology consists of (1) comprehensive Video-Assisted Learning (VAL) material for pre-course completion; (2) on-site face-to-face simulation;

(3) an ACCT Train the Trainer (ACCT-TTT) for trainers to subsequently deliver the programme.

**Implementation outline:** The VAL material includes lectures (e.g. transport physiology), clinical skills demonstrations (e.g. transport and ambulance equipment) and simulation (e.g. safe packaging for transfer). There is an accompanying multiple-choice questionnaire (MCQ) to ensure full engagement and testing of core knowledge prior to the on-site component. On-site, small multispecialty delegate groups comprising of doctors, nurses and paramedics rotate through three simulations, allowing for enhanced experiential learning. Two take place in high-fidelity simulation laboratories, and one occurs in a fully operational ambulance. Delegates assume their real work roles and deal with common transport scenarios and adverse incidents. Debriefing focuses on reinforcing prescribed learning objectives. A post-course MCQ is used to validate learning, with feedback forms used for course evaluation. We plan to pilot the course and subsequently conduct ACCT-TTT courses. We aim to implement and expand ACCT nationwide, making it a mandatory component of anaesthesiology training.

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48

## USE OF SIMULATION TO INTRODUCE DELIVERY ROOM CUDDLES AS STANDARD PRACTICE IN A NEONATAL INTENSIVE CARE UNIT

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**Background:** Kangaroo Mother Care (KMC) was introduced in the 1970s to keep premature babies warm after birth. There has been growing evidence of multiple benefits including physiological autoregulation, reduced stress, positive attachment, enhanced neurocognitive development, breastfeeding and psychological well-being. Delivery Room Cuddles (DRC) was introduced 15 years ago in Norfolk and Norwich University Hospitals as an extension of KMC. Other units have since reported the successful introduction of the process <sup>[1]</sup>. Anecdotally in our Neonatal Intensive Care Unit (NICU) parents were not routinely offered skin-to-skin contact with their infant early in their neonatal journey.

**Aim:** The aim of the study was to safely introduce DRC as standard practice in our NICU.

**Method/design:** We obtained feedback on parental and staff experience with DRC. A Failure Mode and Effects Analysis (Figure 1) was then carried out to break down the DRC process into steps, highlight potential risks and mitigation strategies. Information was synthesized into a standard operating procedure (SOP) and checklist. The use of a transport incubator to mobilize premature infants was not common practice in our NICU at the start of the project; therefore, a parallel SOP was developed for this. Staff training was then