of departmental opening. The participants were instructed to treat the scenarios as real, including the manner in which they called for help. Any equipment required came from the department and if single use, it was exchanged for training equipment. The participants then undertook a hot debriefing before feedback was gathered about both the educational value of the scenarios as well as any issues identified within the new department.

Results: In total there were 38 multidisciplinary participants including nurses, operating department practitioners, and doctors from 6 different specialties. The feedback from the sessions was positive with an average ranking of >4 out of 5 in 8 out of the 9 measured domains, including; realism, enhancement of knowledge, and usefulness of in-situ simulation in a new environment. We also identified greater than 50 problems spanning all 5 of the categories from the 'SHEEP' model [3]. Approximately 60% of issues were resolved within the 8 weeks, whilst the remaining are on the risk register and awaiting review at a stakeholder level.

Conclusion: In-situ simulation is an excellent mechanism for carrying out clinical systems testing of new environments due to the fact that it simulates realistic events which are prone to the same errors as the real events, without the risk of patient harm. Once the source of an error is exposed the debriefing can help to identify methods to minimise the risk of future reoccurrences. At the same time, with appropriate planning, the scenarios can also provide an opportunity to deliver multidisciplinary training.

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JUST-IN-TIME IN-SITU SIMULATION FOR HIGH STAKES SUCCESS IN VIRAL HAEMORRHAGIC FEVER (VHF)

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Background: Success of just-in-time in-situ simulation to find new ways of working, test processes, and uncover latent error to promote patient and staff safety is well documented from the COVID-19 pandemic [1,2]. We used just-in-time simulation in a unique situation where imminent transfer of a critically unwell patient with VHF was required to our high-level isolation unit (HLIU). The Trexler isolator tent is custom made for treating high consequence infectious diseases (HCID), requires specific training. Staff provide care by 'stepping' into 'suits' in the plastic walls. Transfers into the tent are time-critical to reduce potential exposure risk to staff. This was the first time ever an intubated, ventilated patient was to be transferred into the tent.

Methods: Simulation, Infectious Diseases, and Intensive Care teams collaborated within a few hours' notice to simulate in-situ the mechanism of transferring a patient (using a Laerdal SimMan 3G) intubated and ventilated with multiple drug infusions running, headfirst from a transport trolley into the foot end of the isolator tent. This was repeated subsequently in several Plan-Do-Study-Act (PDSA) cycles to refine the process and reduce transfer time taken. There were multiple pauses as problems, latent threats, and potential failure points were identified, and time outs to discuss solutions.

Results: Transfer teams informally reported increased confidence being able to troubleshoot and rehearse the transfer process before patient arrival. Key learning related to leadership, communication, highlighting safety steps, and sharing mental models between teams such as airway management, significance during transfer and ergonomics of airway-trained personnel positioning in the tent. This was written up as a visual aid for the transfer team. Environmental latent threats found included safe ventilator mounting, IV pump management, emergency drug preparation, and allowed for enhanced consideration of the practicalities of caring for an intensive care patient in the HLIU tent. The actual transfer of the patient went smoothly and without incident. Further simulations were run during the patient care episode to rehearse and potential anticipate airway and ventilation management issues.

Conclusion: Just-in-time in-situ simulation provided a valuable opportunity to rehearse a high-stakes, never done before activity, and facilitated identification of environmental latent threats before patient arrival. It created a shared mental model between different specialities of patient needs contributing towards an increased situational awareness and ability to forward plan and project, ultimately increasing patient and staff safety.

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SUCCESSFULLY DELIVERING A NEW, TRUST-WIDE IN-SITU SIMULATION TRAINING PROGRAMME TO MULTIDISCIPLINARY TEAMS IN THE CLINICAL ENVIRONMENT

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Background: Simulation-based education is well established as a teaching strategy but is often taught in dedicated simulation centres. In-situ simulation had previously been less prominent as a teaching tool within the Trust due to lack of awareness of its benefits and versatility. The aim of