Ethics statement: Authors confirm that all relevant ethical standards for research conduct and dissemination have been met. The submitting author confirms that relevant ethical approval was granted, if applicable.

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QUALITY

A30	**SAFE INTERDEPARTMENTAL LEARNING FROM CLINICAL INCIDENTS USING A QUALITY IMPROVEMENT FRAMEWORK**

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10.54531/TOUD6953

Background and aim: Mistakes are an inherent learning opportunity within healthcare that can be used to prevent future loss of lives and reduce suffering. We aim to create a safe learning space within our organization that can be embedded within our quality improvement (QI) process.

Methods: We have designed a bespoke framework (Figure 1-A30) to integrate our organizational QI process [1] with a 6-month iterative simulation programme. This utilizes multidisciplinary co-creation, embedded faculty development, and reflective practice to facilitate learning from each other.

Our tertiary hospital clinical governance team in collaboration with the multi-professional education, simulation, and patient safety departments has identified 5 topics based on the root cause analysis of serious clinical incidents. This description from our recent cohort involves the recruitment of 5 different specialty teams, each consisting of 1 experienced consultant faculty and 3 other facilitating clinicians with different levels of experience in healthcare simulation.

The teams prepared and designed the most suitable clinical scenario progression to address the learning objectives based on their allocated topics. Learner and peer feedback along with reflections on the session, highlighted possible change ideas to modify the subsequent scenario running. Over a period of 6 months, different learner sets were involved in the same simulation exercise with 2 further iterative modifications.

Results: The 5 teams have generated a total of 15 hours of simulation sessions using standard pre-briefing, debriefing, and evidence-based simulation techniques. The level of independent facilitation and mentoring by more advanced debriefers has been adjusted to fit the individual pace of experiential learning. To further enhance the embedded faculty development a total of 270 minutes of online discussion, reflections, and 15 topics
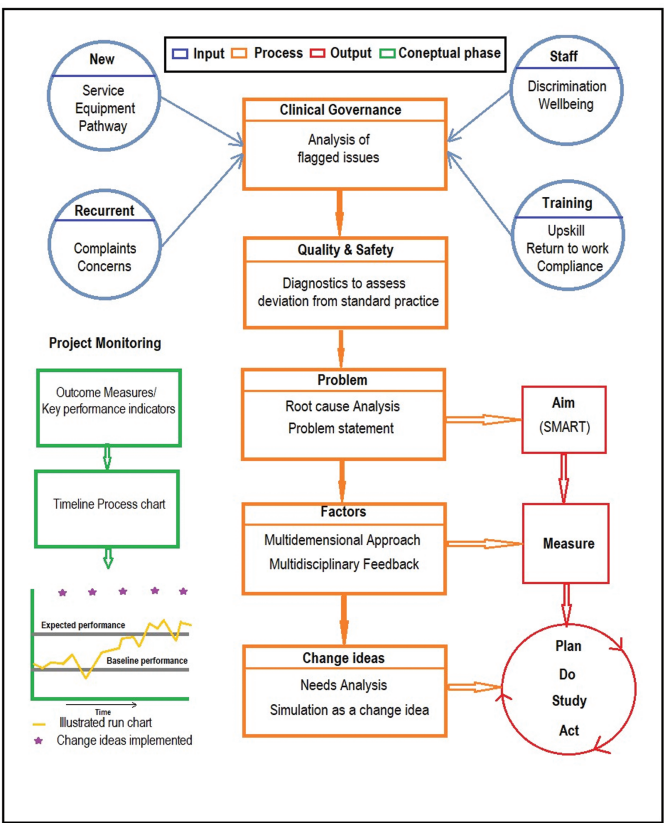

Figure 1-A30: Safe Interdepartmental Learning with a Quality Improvement Framework

were presented by the facilitators to create a multi-professional learning experience. The content was structured to reflect the national outcome's framework for faculty development and the ASPIH standards guidance for simulation-based education. The recorded simulation sessions, debriefing, and topic discussions have generated a useful asynchronous online reference for the current and future cohorts.

Conclusion: The feasibility of implementing this simulation programme integrated with a QI framework is a major step for our future prospective evaluation of the impact of translational simulation as theorized in the current literature [2] on patient outcomes and healthcare performance indicators.

Ethics statement: Authors confirm that all relevant ethical standards for research conduct and dissemination have been met. The submitting author confirms that relevant ethical approval was granted, if applicable.

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DESIGN

A31	**SKILLS2U – USING WARD-BASED TOOLKIT TRAINING TO ADDRESS FREQUENTLY IDENTIFIED TECHNICAL SKILLS PERFORMANCE ERRORS DURING *IN SITU* SIMULATION**

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10.54531/EODS9506

Background and aim: Delayed airway management was identified in 70% (9 of 13) of Insitu simulation (ISS) with an average time of 3.42 minutes from identification of the problem to management. The resuscitation council UK suggest that in most patients presenting with a compromised airway, simple actions are sufficient to stabilize them, failing to do so increases the risk of hypoxia and multi-organ failure [1]. To address this trust wide training was initiated through the 'skills2u' programme, where toolbox teaching was taken to the wards.

Methods: Across a two-week period, a multiprofessional team comprising of the simulation faculty, anaesthetists, and advanced clinical practitioners, visited all clinical areas and delivered a short 10–15-minute practical ward-based interactive session to the interprofessional team. The session covered airway assessment, airway opening manoeuvres and opportunity to practice inserting basic airway adjuncts.

Results: 412 clinical staff, of all grades and disciplines, were taught in basic airway management of the deteriorating and arrested patient. Evaluation of the teaching revealed 95.5% of staff agreed it was relevant to their role and 98% agreed they now felt better prepared to respond to changes in a patient's condition. In the subsequent three months, technical skills performance errors for airway management were identified in 15% of 10 ISS completed. In these simulations the average time taken to manage the airway from identification of the problem reduced to 1.39 minutes.

Conclusion: Using ISS to identify technical skills performance errors followed by a trust wide ward-based education programme is an effective way to enhance patient safety.

Ethics statement: Authors confirm that all relevant ethical standards for research conduct and dissemination have been met. The submitting author confirms that relevant ethical approval was granted, if applicable.

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EDUCATION

A32	**TOWARDS A TAXONOMY OF SCALE: A SUSTAINABLE APPROACH**

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10.54531/CEUN6931

Background and aim: Taking simulation from concept through to scalable delivery is complex, contested and an under-theorized process. The traditional approaches to scaling innovations, proposed by Everett Rogers in the 1960s is the notion of diffusion of innovation; we argue that this is of limited use in our context of working with NHS health professionals supporting their learning post-covid. Our approach to scaling draws the upon the well-tested seminal works on taxonomies by Coburn (2003) [1] and her dimensional framework, Dede et al (2007) [2], with

their educational scaling model, plus the systematic review of Greenhalgh et al (2004) [3] in health services.

Activity: By considering the ways in which our eight Health Education England (HEE) simulation projects have been delivered, this work presents an emerging framework, designed to enable the orchestration of team discourse about theory, the production of simulation artefacts as tools for design discourse and the identification of scalable systemic pain points. We pay particular attention to scaling innovations in practice and organizational change, which are in our view enabling factors in the sustainable adoption of learning technologies by end users in the workplace.

Findings: Successful scaling is more than just being about the number of users we can reach. It requires underpinning by an understanding about the changes in practice an innovation can bring about, and how valuable these changes are to stakeholders. Challenges remain as to whether such changes can be sustained over time, and the extent to which users and stakeholders are involved in co-creating the innovation. Individuals within the organizations – and their attitudes, beliefs, and habits – play an equally important role in exploring new technologies and practices with an open mind and perceiving these as an added value in their work environment and daily routines.

Conclusion: This work illustrates the need to strategically involve the 'missing middle' and starts to identify the key role these people play in that space between where scaling factors reside between top-down strategy and bottom-up initiatives.

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DESIGN

A33	**A NOVEL FORM OF COMMUNICATION TRAINING FOR MEDICAL SUPPORT WORKERS AT A LARGE TEACHING HOSPITAL**

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10.54531/VABK6137

Background and aim: The Medical Support Worker (MSW) Programme, funded by NHSEI, enables International Medical Graduates (IMG) and refugee doctors to work in the NHS, whilst acquiring General Medical Council (GMC) registration [1]. MSWs and IMGs have a recognized set of learning needs, with communication difficulties the most reported challenge amongst IMGs [2]. North Bristol Trust (NBT) employed a second cohort of 30 MSWs in July 2022, all of whom previously practiced medicine in Myanmar. NBT enlisted the assistance of a local Community Theatre to create and deliver a novel training programme with an emphasis on improving confidence in communication.