

reading on my own this helps me feel I am doing some keeping up. Please continue!

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### INTERIM EVALUATION OF A CLINICAL EDUCATORS PILOT STUDY VIA A MULTI-STAKEHOLDER ONLINE SURVEY

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**Aims/Objectives/Background** In England, the demand for emergency care is increasing, confounded by challenges with recruitment and retention of multi-professional teams in Emergency Departments (ED). The intense working environment that clinical ED staff face is recognised as a cause of staff dissatisfaction, attrition and premature career 'burnout.' A new 'shop floor' Clinical Educator (CE) role may improve the retention and wellbeing of multi-professional ED teams. A Health Education England pilot developed and recruited CEs across 54 acute trust EDs in England, from 2017. Aston University and the Royal College of Emergency Medicine were jointly commissioned to undertake a service benefit evaluation. **Methods/Design** An online survey was circulated to CEs, learners and managers across the 54 study sites. Each group answered questions relating to experiences, opinions and reflections. Topics included impact of a CE on patient flow, confidence and competence of staff, as well as sustainability and any impact on staff wellbeing.

#### Results/Conclusions

**Results** 314 individuals accessed the survey and 291 eligible respondents completed it, including: 187 learners, 65 CEs and 39 ED Clinical Directors/Managers.

- Learners (169/187), CE (63/65) and managers (39/39) saw no change/an improvement in patient flow.
- 100% of CEs felt that a CE in the ED improved competence and confidence of staff (88.2% of learners, 89.7% of managers).
- 7% (61/65) of CEs and 87.2% (34/39) managers agree that CEs have improved wellbeing of staff.
- 8% of managers (26/39) were unsure whether the CE role would be funded beyond the pilot, but 66.7% (26/39) strongly supported continuation of the CE role.

**Conclusion** Interim evidence suggests that CEs positively impact the multi-professional ED workforce.

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### EVALUATION OF THE USE OF TELE-SIM IN THE EXAMINATION SETTING FOR FINAL YEAR EMERGENCY MEDICINE RESIDENTS IN INDIA

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**Aims/Objectives/Background** Travel restrictions during this Covid-19 pandemic created a barrier to bringing external examiners to conduct simulation assessments, a crucial component of emergency medicine examinations in India. Indefinite postponement would prevent several final year trainees from progressing and would have added to their stress and frustration during an already challenging time.

We conducted these evaluation via tele-simulation and sought to evaluate the feasibility and effectiveness of tele-simulation as tool for assessing the management of critically ill or injured patients by emergency medicine (EM) trainees. Our secondary outcome was a survey evaluating the attitudes and perceptions of fairness of this remote simulation modality for both faculty and trainees.

**Methods/Design** 104 residents from 14 separate hospitals across India were evaluated in pairs by a local facilitator and a remote examiner via Zoom. There were 14 local facilitators and 10 remote examiners based in the US, UK and India. All residents examined were given the same simulation case he examination over the course of 7 hours. Real time online structured evaluation forms were completed by both evaluators and each candidate was discussed after every pair to agree a pass/fail grade. The external examiners were blinded to the students overall 3 year performance, theory and thesis results. The tele-simulation evaluation was triangulated with the final examination theory and thesis exam grades and overall clinical performance and feedback over 3 yrs from their local supervisor. We surveyed local faculty, remote examiners and trainees.

**Results/Conclusions** 52 paired tele-simulation examinations were conducted by 24 local and remote examiners from India, United Kingdom and USA over 7 hours. Of the 14 candidates who failed, their tele-simulation grades correlated with overall performance. The interim data analysis of the survey results show that 96.7% thought the exam was fair Tele-simulation is a feasible and effective way to evaluate EM trainees.

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### ULTRASOUND DIRECTED REDUCTION OF COLLES' TYPE DISTAL RADIAL FRACTURES IN ED (UDIRECT): A FEASIBILITY RANDOMIZED CONTROLLED TRIAL

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**Aims/Objectives/Background** Wrist fractures are among the commonest injuries seen in the emergency department (ED). Around 25% of these injuries have Colles' type fracture displacement and undergo manipulation in the ED. In the UK, these manipulations are typically done 'blind' without real time imaging and recent observational studies show that over 40% of the injuries go on to require surgical fixation (due to inadequate initial reduction or re-displacement). Point of care ultrasound has been used to guide and improve wrist fracture reductions but it's effect on subsequent outcome is not established. We set up and ran the UK's first randomised controlled feasibility trial comparing standard and ultrasound guided ED wrist fracture manipulations to test a definitive trial protocol, data collection and estimate recruitment rate towards a future definitive trial.

**Methods/Design** We conducted a 1:1, single blind, parallel group, randomised controlled feasibility trial in two UK hospitals. Adults with Colles' type distal radial fractures requiring manipulation in the ED were recruited by supervising emergency physicians supported by network research nurses. Participants were randomised to ultrasound directed fracture manipulation (intervention) or standard care with sham ultrasound (controls). The trial was run through Exeter Clinical Trials Unit and consent, randomisation and data collection conducted electronically in REDCap cloud. All participants were followed up at 6 weeks to record any surgical intervention and also underwent baseline and 3 month quality of life (EQ-5D-5L) and wrist function (Patient Rated Wrist Evaluation (PRWE) assessments.

**Results/Conclusions** We recruited 47 patients in total, with 23 randomised to the interventional arm and 24 randomised to

the control arm. We were able to follow up 100% of the patients for the 6 week follow up. Data analysis and results will be presented at the time of the conference.

**292 EMERGENCY AIRWAY MANAGEMENT OUTSIDE THE OPERATING ROOM; A THREE YEAR PROSPECTIVE SERVICE EVALUATION AND QUALITY IMPROVEMENT PROJECT**

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**Aims/Objectives/Background** Emergency airway management outside a controlled theatre environment has been previously

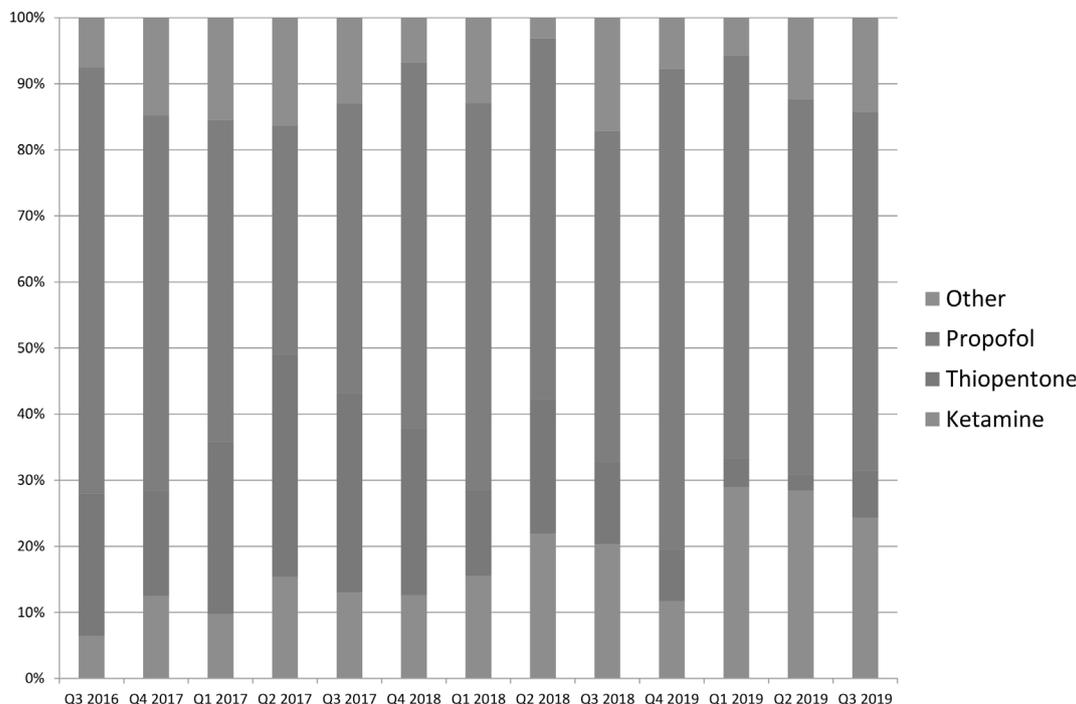
**TRAUMA ANAESTHESIA GUIDANCE FOR TRAINEES**  
 The primary anaesthetic responder should be ST4 or above as per RCOA GPAS guidance\*  
 Introduce yourself early and communicate often with the Trauma Team Leader  
 Remember the importance of human factors, early haemorrhage control and spinal immobilisation

**Deciding to Intubate:**  
 Call for help early: 2nd on 61852 / Trauma Cons. 65556 / ODP 61851 / Out of hours ICU 48751 and ICU Consultant often resident overnight  
 Ask for opiates and ketamine early (need to be signed out and prepared)

**Preparing to Intubate:**  
 Anticipate difficulty & use the B@EASE checklist for cognitive offload  
**AVOID CRYSTALLOID** in haemorrhage  
**WARM** Blood Products in a 1:1 ratio are the resuscitation fluid of choice  
 Use O<sub>2</sub> in resus, then activate the MHP using the red phone or on 4444  
 If unfamiliar with trauma anaesthesia **ASK FOR HELP**  
 Consider analgesic doses of ketamine to facilitate pre-oxygenation and preparation in the agitated patient (10-20mg boluses)  
 Prepare an endotracheal tube with subglottic suction port as default  
 Communicate any use of vasopressor agents to the TTL

**Intubation for Intubation:**  
 Rapid sequence induction: Ketamine 1-2mg/kg, Propofol 1-2mg/kg, Suxamethonium 1-2mg/kg, Rocuronium 0.6-1.2mg/kg  
 Give ALL blood products **WARMED** through the level II filter at all times  
**THINK ABOUT YOUR INDUCTION:**  
 Ketamine 1-2mg/kg, Propofol 1-2mg/kg, Suxamethonium 1-2mg/kg, Rocuronium 0.6-1.2mg/kg  
 Propofol with significant dose reduction if any suspicion of bleeding or CVS instability  
 Opioids should be given in total IV only  
**SUSPENDENCY** is advised in the ED Oropharynx for airway emergencies or analgesia in non-emergencies only

Abstract 292 Figure 1



Abstract 292 Figure 2 Primary induction agents selected throughout the study period