SEAUK

Summer 2020

Summer 2020 Newsletter

President Address

Full of great articles

Information on FREE Webinars, ASM 2021 and exciting grant announcement!

Contents

SEAUK

Letter from the Editors

Welcome to the summer newsletter from SEA-UK. A slightly different newsletter this time crammed with interesting thoughts, experiences and learning points from 2020 so far.

What a few months it has been for the NHS. Phrases and words such as “unprecedented times”, “furlough”, “pandemic”, “PPE” and “shielding” to name but a few are now part of our everyday language. Even in our wildest dreams we could not have imagined how much our daily lives have changed and the challenges we have all faced both personally and professionally. As a health service we have done our nation proud and it has been a privilege to be a small part of it. However, to use another favourite phrase, now we have this ‘new normal’ how do we as educators ensure as a profession we continue to thrive, and the quality (and quantity) of training does not lessen?

This newsletter is filled with a variety of articles written by different members of our multidisciplinary team, which we hope you will find thought-provoking and interesting.

The annual scientific meeting (do not forget your abstract submissions!) has been rescheduled to 22nd March 2021 in Stratford-upon-Avon and has a great line up planned -we hope to see you there!

We hope the rest of 2020 brings back some normality and of course “Stay Safe!”

Dr Claire Halligan

Consultant Anaesthetist

Royal Glamorgan Hospital

Dr Emily Murphy

CT3 Anaesthetics

Royal Glamorgan Hospital

SEAUK

Letter from the President

Our spring newsletter has been delayed by circumstances beyond our control. It has been transformed from a record of the ASM and a brief account of the programme, to a deeply personal account of the educational learning associated with pandemics. We have moving stories from staff moved to cover Intensive care to reflections from guardians and articles from ex-SEA UK presidents. Despite being a small society we have still managed to maintain a presence in educational events, publications and an input at the specialist societies.

Please look out for the ASM in March and register for our webinar later in the year.

Dr Sue Walwyn

Congratulations

Professor Cyprian Mendonca has now taken over as treasurer and we know he'll do a fabulous job just as Dr Sarah Wimlett has done for the past couple of years!

SEA -UK

ASM Summer 2021

21st SEAUK ASM

The Society for Education in Anaesthesia

Monday 22nd March 2021

Hilton Warwick/ Stratford-upon-Avon

- Current GMC priorities for Postgraduate medical education
- Simulation in Assessment
- Assessment: Priorities and pitfalls
- Second Victim
- Higher qualification for Educational supervisors
- ARCP for non-trainee doctors

Keep an eye out for upcoming Webinars…

ASM 2021 Programme

SEA UK

Society for Education in Anaesthesia (UK)
Registered Charity No. 1091996
21st ANNUAL SCIENTIFIC MEETING
Monday 22nd March 2021
Provisional Programme

09:00	**Registration**	
09:20	Introduction and Welcome	Dr Sue Walwyn President SEA UK
09:30-10:10	**Keynote 1** Assessment: Priorities and pitfalls	Dr Anne Taylor
10:10-10:30	Annual General Meeting	
10:30-10:55	**Refreshments**	
11:00-11:45	**Workshops**	
1	Supporting the returning trainee	Dr Victoria Bower
2	Simulation in Assessment	Dr Carl Hillermann
3	Second Victim	Dr Shirley Remington
4	ARCP for non-trainee doctors	Dr Dipesh Odedra
11:45-13:00	**Free Papers**	Chair: Dr Peeyush Kumar
13:00-13:40	**LUNCH**	
13:40-14:20	**Key note 2** Current GMC priorities for postgraduate medical education	Russel Professor Sue Carr Deputy Medical Director, GMC
14:25- 15:10	**Workshops (as above)**	
15:10- 15:30	**Refreshments**	
		Cyprian Mendonca
15:30 –16:30	**Debate** This house believes that every ES should have higher educational qualification	
	Proposer	Dr Shireen Edmunds Head of School HEE West Midlands
	Opposer	Dr Chris Carry Associate Postgraduate Dean HEE Kent Surrey Sussex
16:30-16:45	Presentation of prizes and closing address	Dr Sue Walwyn

Training and Safe Practice

Time is of the essence!

As reality dawned on us, both of the magnitude of the pandemic arriving at our shores and the sheer scale of change in practice that needed implementing, it became clear that we required a robust training strategy to ensure the safety of our most exposed staff. This article looks at the approach that we took at a large teaching hospital to overcome the challenges of training anaesthetists and theatre staff to safely deliver care during the COVID-19 pandemic.

Planning and preparation

The first challenge that we were faced with was understanding the subject and formulating a strategy for training in donning, doffing and airway management, for more than 200 staff within a short time frame of 48 hours. Planning provided structure and context to both the learners and teachers and an opportunity to reflect and prepare for the pandemic. In a crisis, it is imperative that there is a standard operating procedure, one that everyone is familiar with and one that is easy to follow. Adequate planning and preparation is of immense importance for any clinical teaching [1].

Training resource

Improving efficiency of training was essential to deliver effective training within a short time frame. It was important that the standards were reviewed by the trainers, to ensure learners could mentally rehearse them. We devised a set of videos that showed the equipment, the setting and the correct sequence of steps needed to safely don and doff. The videos were recorded in-situ (in the theatre environment) to enable visualisation of where the processes would take place and how the systems worked. This enabled learners to use the visual cues they saw in the video to recall the actions during the training. We utilised visual aids in the form of posters to help outline the steps for donning and doffing. Visual aids are an essential tool for making teaching effective and for the best dissemination of knowledge [2]. The faculty highlighted the key pitfalls with each step to encourage learners to reflect on the process and rehearse the techniques correctly. Within a short time period of 72 hours training package was developed, faculty recruited, and training had begun. The initial stage was training the trainers to ensure a robust system to deliver training for over 200 staff within two weeks. Time really was of the essence!

Checklists

Another aspect of team building was the use of a checklist. Checklists are useful in an emergency situation to reduce cognitive overload [3]. The national checklist was modified for local use by intubating team members. These were then piloted in stages and further improvements made. These were process driven checklists and feedback from learners was incorporated in helping to make them flow more succinctly.

Adaptation to new Equipment

A significant adaptation was required to airway equipment to comply with Infection Prevention and Control guidelines. The majority of equipment used was single use and disposable. It was ensured that only essential equipment was made available on the airway trolley. A McGrath® videolaryngoscope with Mac blade was introduced as the default videolaryngoscope. During the training session it was realised that many were not familiar with this device.

Organisation

A google® forms sheet was produced that allowed all members of the department access to time slots and dates which they could sign up to. This enabled the educators to plan faculty numbers and resources required to continue the training. As the training progressed operating department practitioners (ODPs) were also recruited as trainers to train those who only needed donning and doffing training (theatre staff).

Learning in phases

To enable learning of a new procedural skill, training sessions were divided into three sections: use of the checklist, donning and doffing and airway simulation. As anaesthetists are familiar with World Health Organisation (WHO) Safe Surgical checklist, it was ensured that the COVID-19 airway checklist resembled a similar format. This familiar layout and run-through ensured decreased cognitive load on the learners, leaving them to focus on learning new skills in donning and doffing. Deliberate practice using simulation and teaching skills at stages has been shown to be more effective for learning than traditional teaching [4, 5].

Pre-delegation of roles

A key part of the training programme was to ensure that everything was taught in-situ. This meant that we could pilot our processes, ensure logistical compatibility with the environment, refine ergonomics and instil confidence in the staff that they were well prepared for any eventuality. For the training to be successful, it was important to emphasise teamworking and delegate tasks effectively to defined roles. This was, in effect, utilising crisis resource management tools to best prepare teams to work to their full potential [6].

The allocation of roles was one of the first tasks on the airway management checklist. This encourages the team to get to know each other, define a leader and delegate skill sensitive tasks to each member.

We encouraged a ‘buddy system’ where a team of four staff members was grouped into two pairs. This system enabled crosschecking of vital steps in the donning and doffing process to be done to a high standard with the probability of steps missed or skipped becoming ever less likely. This also aided team building and rapport amongst the team members. The buddy system was designed to mitigate the risk of incorrect PPE donning and doffing.

The airway training simulation was the second part and the final part was the doffing procedure. This meant that three teams could be trained simultaneously in a conveyor belt fashion, ensuring that the process was very efficient. The key to being able to develop, pilot and implement this ‘fast track’ training package was developing the checklist, a scenario for airway training and donning and doffing training as a team.

The airway simulation was designed to reinforce a realistic situation of dealing with a COVID-19 patient. The participants were presented with a critically ill patient requiring emergency airway management. As with any simulation, the key learning points were discussed, and ideas reinforced during the debrief once the simulation had ended. The debrief used a promoting excellence and reflective learning in simulation (PEARLS) model. The PEARLS model is a well-established medical debriefing tool for simulation and includes 4 phases: reactions, description, analysis and summary [7].

In conclusion, we designed, piloted and ran an in-situ simulation airway scenario to aid learning for COVID-19. We used various techniques to help disseminate information to our learners and organise teaching. A PEARLS model was used to aid debriefing after an in-situ simulation for airway management for COVID-19. The feedback from the teaching has been overwhelmingly positive with staff relieved they had the opportunity to learn in a safe environment prior to dealing with COVID-19 patients.

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COVID 19 Pandemic: A Trainee's Perspective

In early February 2020, the outbreak of Coronavirus in China continued to evolve, and news of it spreading worldwide was impossible to ignore. Hospitals across the UK started to prepare for an inevitable intake of critically unwell patients, involving drastic changes to working patterns; job roles and responsibilities; and potential consequences for doctors in training. As the 'R' number in the UK now continues to fall, and lockdown measures are eased, we reflect on the last few months, and focus of the impact it had on anaesthetists in training.

In the Royal Glamorgan Hospital, prior to our first confirmed COVID-19 patient, we had two weeks of 'COVID preparation'. This involved significantly reducing elective lists, which would eventually stop altogether, and multiple teaching sessions. As an Anaesthetic/Critical Care department, we led teaching to the other specialties across the hospital, anticipating that they would be required to assist us in the management of critically unwell ventilated patients. Many predictions, based on admissions elsewhere, were used and our 'anticipated' rate of admissions to ITU at one point was 18 patients/day. Which as a small DGH seemed an insurmountable prospect. We focused our teaching sessions on PPE ('doffing and donning'); proning; ventilator settings; and we ran regular COVID intubation simulations, involving staff from theatres, A&E and paediatrics. Understandably, we were all anxious about what was ahead, and many meetings were held discussing increasing ITU capacity and emergency staffing. Unlike London, it felt like we had a 'heads up', and the ability to make attempts at preparation. However, as more time elapsed, the fear of the first COVID-19 intubation intensified.

Inevitably, the COVID-19 admissions began, and we immediately moved onto our emergency rota. This rota involved predominantly antisocial hours; Critical Care cover; no normal working days; and no teaching/SPA. It also meant that the CT1 trainees, who are usually supernumerary, were required to fill rota slots independently. We were split into teams and worked alongside two resident consultants. Despite the challenging rota, and unpredictable working pattern, morale in general was high, and teams worked fantastically together. However, as the first nurse (from another hospital) was admitted to ITU, the unspoken fear of looking after friends/colleagues began.

As time progressed, the management of the patients changed drastically, and we were learning new information every week. Every 'success' in the unit, would be followed by an unexpected death and it was often difficult to process. We are fortunate in our department to have a cohort of incredibly supportive consultants; however, many trainees were isolating from their friends and families, and often had limited 'down-time' or normality outside of work. Life became, work, eat, sleep, work. Knowledge and experience gained during the pandemic was exponential, however, any form of formal training was a distant memory. This obviously had consequences for trainees, but almost felt insignificant compared with what was going on.

Many of our anaesthetic trainees had limited ITU experience, and many consultants had not covered an ITU rota in years. Therefore, this involved staff to be very adaptive and flexible, and more experienced staff took on invaluable teaching roles. During our peak, we had theatre staff acting as ITU nurses, and ventilated patients on anaesthetic machines in Coronary Care. With no definitive end point in sight, each shift would start with anxiety of what was to come and how many admissions there would be. We were

fortunate that despite being incredibly busy, we never breached our surge capacity, and ITU admissions started to decrease.

As we start to establish some normality with elective cases, we look back on the impact COVID-19 has had on training. ST3 applications were interrupted across many specialities, and interviews did not take place in Anaesthetics, leading to unappointed trainees who had weaker self-scores on their applications. Many exams during this time were cancelled, and the upcoming Primary MCQ in September is due to be online, which is causing obvious concern for trainees. Also, recent ARCP's have led to disappointing outcomes for some trainees who were unable to complete certain modules during the pandemic. Trainees' work-life balance will have also suffered, with demanding rotas; fear of a 'second peak'; and no chance of foreign holidays on the horizon. Nevertheless, it is important that we reflect on the wealth of experience that has been gained during this time, and how as departments we have all worked together, despite challenging and unfamiliar circumstances, to step up and provide fantastic care to the best of our abilities. Disappointment with exams and career progression is inevitable, but this is a unique and rewarding time to be working in the NHS, and will have undoubtably changed the way we work, adapt, and will have increased our resilience for the future.

Dr Emily Murphy

CT3 Anaesthetics

Royal Glamorgan Hospital, South Wales

Becoming a Consultant in the Time of Coronavirus…

I am currently three months into a permanent consultant post at Royal Oldham Hospital, a large DGH in the northwest of England. Starting my job during the biggest global pandemic for a century has been far from ideal but I hope my experience can still be of use to those currently approaching application.

"You're a consultant now, so you know everything right?" – Anaesthetic Trainee c. 2016

A misconception that I, and possibly many others, have possessed during their training is that consultants are omniscient, omnipresent beings immune to the stresses and pressures of complex clinical situations and emergencies. This could, of course, not be further from the truth. On the first day of my consultant job I was exactly the same person I was the day before and knew just as much (or little) as I did then. And I felt no small amount of stress at being where the buck stops in terms of decision-making for the first time in my career.

Or so I thought. One of the most refreshing things I immediately discovered about being a consultant is that it is still and always ok to ask for help. This may seem obvious to some but it came as a huge relief to see that my colleagues were so approachable and willing to help each other out with advice or an extra pair of hands. The friendly culture within the department was a huge draw to me when applying for jobs and I would highly recommend prioritising this when contemplating working somewhere for twenty-plus years.

Job planning and On-calls

Around two weeks after my start date and having just agreed a potential job plan with my clinical director we were thrust into the middle of a global pandemic and accompanying emergency Covid rota. Rolling 12 hour shifts were back on the menu and I found myself doing ICU daily reviews again! Thankfully I had been working as a locum at the trust for a few months prior to my permanent post and so already had a reasonably firm grasp of how the hospital worked.

I have found that job planning is something of a negotiation and needs to be treated as such. My approach was to have one thing that I wanted to regularly at all costs (paediatrics) and one thing I absolutely didn't want to do at all on pain of death (eyes). With everything else in between there is room for compromise and I'm happy knowing that if I get stuck with a regularly overrunning list or want to cut back on a certain specialty, these things are not permanent and can be renegotiated.

One of the biggest changes from trainee to consultant is the on-call work and being on-call from home. I live just under 30 mins drive from my hospital and so took the initial decision to stay resident in hospital accommodation during my first on-call shifts. Giving out advice and making decisions from information over the phone has taken some getting used to. However, as I've grown in confidence I undertake more of these shifts from home but they are still rather unsettled nights involving waking every hour in fear of missing a phone call!

Management roles

As with all UK hospitals the Covid-19 crisis has obviously created many headaches within the department. With new guidance emerging week to week or even day to day this has made the task of getting to grips with a new job even more difficult. My current working week bears little resemblance to that job plan initially discussed back in March but it is still my hope that it will again one day.

Once the peak of Covid-19 admissions had ended offers began to trickle in to take over or assist with management duties. This is clearly an important aspect of the work of a consultant and another difference from trainee life. I have endeavoured to only agree to roles that align at least partly with my own interests and strengths e.g. education, paediatrics and trainee mentorship. While it can be difficult being a new member of staff wanting to immediately become a valued part of the team I believe it is important to recognise my own strengths and weaknesses even if it means politely saying no to an approach from a senior colleague.

Take home message

I am loving life as an anaesthetic consultant and even with the country under lockdown I am feeling the benefits of the improved work-life balance it affords. I feel I have more time on my hands and have more energy and enthusiasm for my clinical days now I am free of trainee rotas. I find the freedom of decision-making rewarding and S.P.A time means that those late evenings spent completing audits or filing ARCP paperwork are things of the past. Life is good at the end of the rainbow and the feeling of having finally reached this position is one of great pride and fulfilment.

Dr Matthew Bowker

Consultant Anaesthetist

Royal Oldham Hospital

Rejoining the NHS: a Snapshot

Coronavirus triggered the biggest one-off recruitment drives in NHS history (NHS England, 2020a). Following prominent media coverage of the "Your NHS Needs You" campaign in March, tens of thousands of retired doctors and healthcare professionals volunteered to re-join the workforce to assist during the pandemic (NHS England, 2020b).

The GMC reportedly granted temporary registration to 15,500 doctors who had given up their registration or license to practice within the last three years; 6,800 doctors who gave up registration three to six years ago; and 12,000 doctors who did not hold a license to practice (BMA, 2020).

However, reports soon came forward that those volunteering got caught up in "red tape," and were unsuccessful in rejoining the workforce (Philpotts, 2020).

I conducted a short survey and undertook focussed discussions with a small group of retired hospital doctors and GPs to understand the following:

- Motivations for volunteering to rejoin the NHS
- Concerns surrounding returning to work
- Challenges faced when attempting to return to the NHS
- Attitudes to learning tools and methods when considering retraining

All of the participants volunteered for non-patient facing roles and contact tracing roles. Other areas that were volunteered for included patient-facing roles, triage support, and educational roles.

None of the participants have been able to start any shifts with the NHS or Health Education England, with the majority awaiting further communication regarding future needs.

Motivating factors

There were clear themes on display – namely supporting the NHS, colleagues and offering help to the public. Even if there were health concerns or reasons for shielding, there was a clear drive to do anything possible to help the NHS in this time of need. Some examples of feedback include:

- "The service needed help."
- "I wanted to be of use [and] support colleagues…I felt I had skills that could be useful"
- "Wish to assist NHS staff facing such a pandemic in any way that would be of help."

Interestingly, some of the feedback expressed concern at the management of the pandemic at a national level, and a subsequent drive to therefore to contribute as an individual.

Challenges or concerns included the following:

All participants felt the following were challenges or concerns when volunteering to rejoin the NHS:

- Receiving appropriate training/education for the new role
- Receiving appropriate support whilst undertaking the new role
- Access to appropriate resources to work from home (such as remote access to IT systems and equipment)
- Medical indemnity cover

The majority of participants also felt health and wellbeing were a concern, with 100% of participants concerned that they were at risk of contracting COVID-19 in a patient-facing role.

The majority of participants also had some contractual concerns. On further discussion, there was a degree of uncertainty regarding pay, with some colleagues who had returned to work reportedly having not been paid since starting in April. There are also numerous reports of retired colleagues being asked to pay for GMC registration, even during the pandemic, which goes against the agreement suggested when the recruitment drive was announced.

Challenges associated with working outside their parent specialty split the group – some felt this was a concern, whereas others did not.

In terms of attempting to return to the workforce, many participants found the process slow, inefficient and ultimately unsuccessful. Despite completing online training in their free time and contacting the teams organising recruitment, there seemed to be a general theme of being unable to progress and return to work. Those who have returned to work have found the shift patterns and payments chaotic.

Returning to the NHS: attitudes to learning methods and tools to assist with retraining

When considering methods of learning new skill sets and being retrained to return to the workforce, there were a number of common tools that participants would be keen to use. These include:

- E-modules
- Interactive tutorials via a video platform
- Online discussion forums
- A clear set of protocols
- Virtual, interactive lectures
- A combination of all of the above.

Interestingly, the use of protocols was highlighted as a key component for ensuring patient safety. Protocols often provide reassurance that best practice is being delivered, particularly in such an evolving clinical environment.

Attitudes to face-to-face lectures were mixed, with some participants considering it a useful way to learn, whereas others strongly disagreed. Similarly, interactive tutorials using video conferencing platforms split the group.

This snapshot of medical volunteers provides a useful insight into the pertinent problems and common challenges experienced. Every participant was sympathetic towards the recruiters they communicated with, despite often fragmented communication. They appreciated clinical demand is changing on a daily basis and this recruitment drive remains in its infancy, however there are clearly areas that could be improved. Communication and organisation were often cited as areas for development.

Motivating factors largely focussed around an overwhelming drive to help the NHS and the public with this healthcare crisis. The participants were open to a variety of learning tools to assist with retraining. This highlights how there is likely to be a shift away from face-to-face training in the future, moving towards virtual learning platforms and tools.

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Dr Elizabeth Smithson

Mid Yorkshire Hospitals NHS Trust

Guardian of Safe Working: Lessons Learnt

I would like to share my experiences of the current crisis from the point of view of the Guardian of safe working hours in our trust. On the whole the junior doctors were keen to play their part in the current crisis and willing to be flexible and accommodating. There were, however, a few issues that were raised.

An important lesson is the importance of safe guarding autonomy and the necessity of involvement of junior doctors in decisions that will potentially affect them. As with many situations clear communication with stakeholders is crucial, with problems being identified early and solutions agreed.

A major source of complaints was the rota patterns changes. I believe that the underlying problem was the lack of time for proper consultation given the emergency nature of the Covid situation. The consequential lack of opportunity for consultation meant lack of junior doctor involvement in the decision making process, leading to a perceived lack of control and autonomy with subsequent disquiet. The junior doctors felt like they had no say in what was happening, that their views were not valued nor taken into account. The rotas were designed by human resources, following contractual requirements with an awareness of the potential for fatigue. For this reason shorter shifts were introduced, meaning a greater frequency of shifts; a source of contention. If there had been sufficient time we may have been able to follow a formal consultation process, but due to time constraints this was not possible, which I believe contributed to the dissatisfaction.

Another concern raised was the difficulty experienced in completing relevant training and work placed based assessments necessary for upcoming ARCPs. All formal training was also suspended causing anxiety as junior doctors were of the opinion that they were not receiving any training. I would argue that this situation has offered a variety of training and educational opportunities, if only they had been highlighted and used as such. This is a situation that will, hopefully, only happen once in our lifetimes and has resulted in people working in situations they would not otherwise have, and has offered ample opportunities for enhanced teamwork, working alongside professionals with whom the doctors would not normally have interacted. I believe it is up to us as educators to signpost these opportunities to our trainees and to help them understand the importance of using this as an educational experience.

Lastly the question of correct pay was another stumbling block. The new rotas were implemented at the very end of March and when the junior doctors did not receive the correct pay at the end of April this was seen as a lack of appreciation of their hard work and dedication, which could not have been further from the truth. Again this can be attributed to difficulties with communication as an email had been sent, stating that it would take some time to amend payslips, but no specific date was mentioned. Had this been the case it would have said, that the changes would not be reflected in the April pay, but only by the end of May. For those who know the processes, it was clear that there had not been enough time before the deadline for payroll to implement changes by April, the mistake was assuming that this would be obvious to everyone.

Whilst relatively new in the post I have come to realise the importance of the guardian of safe working in maintaining balance within the organisation and giving junior doctors a voice. The most important lesson I learnt from this pandemic is to ensure that there is junior doctor involvement in decision making processes involving them as a group, and that for this to occur, clear and transparent communication is essential.

Dr Tracy Langcake

SAS Doctor Anaesthetics

Mid Yorkshire NHS Trust

One Paediatric ICU's Approach to Promoting Staff Wellbeing During the COVID-19 Pandemic

The increased importance of well-being at work had been recognised by our unit in the past 2 years. Following research studies and a number of staff having an interest in the topic, a well-being team began taking shape at the beginning of last year.

Prior to this there were existing initiatives that had been established to promote staff wellbeing and teamwork, such as Learning From Excellence (learning from what works well), appreciative inquiry, debriefs, prepare and support (simulations) , support groups, socials, PICU wellbeing facebook page, boot camp for new medics and many more. More recently 2 psychologists joined our team and although they have only been in post for 2 months their input has been invaluable.

At the start of the pandemic it was recognised that staff well-being needed to be a top priority. Both physical and emotional/ psychological safety were given huge importance by our leaders.

Below is a table of initiatives we carried out during corona virus.

What was done	Why	Staff targeted
Zoom supportive team chats	Peer support, staff engagement, connection, themes coping mechanisms/tips	All staff
Face book wellbeing page	Keep people informed	All staff
Recharge room	Time out from PPE	All staff
Virtual social events	Connection	All staff
Shared information on how to manage anxiety	Practical tips	All Staff
Staff pictures on PPE	Connection	All staff
Teaching	Shared learning, support for new staff, redeployed staff	All staff
Hug vouchers	Connection	All staff
909 Zoom every morning	Connection, information sharing, engagement even a photo competition.	Initially for staff shielding but became open to all staff very quickly, manly taken up by new medical staff

The Experience of an Anaesthetist Redeployed to PICU During the Pandemic

I was one of a few anaesthetists redeployed from theatres to PICU at the start of the pandemic. PICU can be a daunting place for an anaesthetist and it certainly felt a little like this to me. Having never done a paediatric medicine job I was both excited and a little nervous that I was going to be working with paediatricians at the top of their game.

During our induction I remember feeling grateful for the educational lectures designed to help us hit the ground running; but also impressed with the focus on staff wellbeing and open discussions of coping strategies and support sources.

What did I find most difficult during my time on PICU? Undoubtedly the delayed presentation and non-accidental injury cases. These seemed worsened by the lockdown measures and reduction in community support. Thankfully the 9:09 meetings, recharge room and shared teaching sessions served as opportunities for me to let my proverbial bucket overspill.

In this new world of coronavirus in which we find ourselves working; from my time on PICU I will take away the simple strategies I have seen make a difference to team spirit and morale. More-over I will remember to regularly check in with colleagues whose professional and personal lives may be changing unpredictably from one day to the next.

Dr Sarah Webb

PICU Lead

Birmingham Children's Hospital

Dr Natasha Santana-Vaz

Anaesthetic Registrar

Warwick School of Anaesthesia

Generational Response Towards the Pandemic

COVID 19 and its response has resulted in an unprecedented change in the workplace for medical professionals. Redeployment in extended roles has required the rapid acquisition of new skills, working extended hours in 'Teams" that challenge traditional hierarchical structure. Some of these changes are likely to bring long-standing transformations to our traditional workplace and education such as web-based learning and remote assessment.

The NHS relies on a multi-generational workforce spanning baby boomers, generation X, and generation Y with each generation displaying a distinct value system and learning style. It would be interesting to explore the generational response to changing circumstances in the light of these established stereotypes.

Remote web-based learning and willingness to embrace permanent change:

The response to COVID 19 has ushered in a new age of global co-operation in the field of medical education as witnessed by the proliferation of web-based teaching platforms and free access to acclaimed medical journals (Apuzzo and Kirkpatrick, 2020). Medical Educators now face the challenge of adapting to the virtual classroom and adopting virtual assessments. From the perspective of the technologically adept generation Y with experience in distant collaborative learning, it is but a small step into the future. For the technologically conservative baby-boomers with conventional medical training, this is a seismic paradigm shift. For the computer-savvy life-long learners belonging to the generation X the response is likely to be more nuanced **(**Whitney Gibson, Greenwood and Murphy, Jr., 2009).

Reliance on Social Media

During the pandemic social media has proved a valuable resource for the dissemination of information. 'Connectivism' through the Internet has now become the dominant learning tool leading to the democratisation of knowledge empowering learners and disrupting traditional constructivist hierarchical medical teaching models. However, there is a distinct generational divide in the perception of the impact of social media (Hillman and Sherbino, 2015).

While generally viewed as a force for the good by the *social network native* younger generations, the advanced generations are likely to be justifiably more sceptical of unformed ideas expressed through Twitter and WhatsApp(Whyte and Hennessy, 2017).

The Human Element

Traditional generational stereotypes suggest that the younger generation would intuitively warm to the challenges of team-working and learning new skills while the baby-boomers are likely to be more ambivalent. With the disease showing a disproportionate predilection for adverse outcomes with advancing age and a natural cynicism for the powers to be the risk of exposure without adequate PPE is also more likely to affect the baby-boomers (Richardson et al., 2020). The baby-boomers also have a reputation for greater resilience and rely primarily on family for emotional support while the younger generations look to friends and peer groups(De Maeyer and Schoenmakers, 2019). on family as the primary source of emotional support The loss of human contact may affect these generational groups differently.

So what next?

Across the generational divide, there is an acceptance that this change is inevitable. It would be interesting to explore the change in generational attitudes towards this new normal through a survey.

The advanced generations face the mighty challenge of navigating a new course where social media and remote learning is recognised as a valid element of professional practice. However, it is imperative that the human element of education is not lost in the process.

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How Medical School Prepared Me for Life as an FY1 on ICU During COVID

As anaesthetists, we become accustomed to the apprehension and excitement of moving between departments, and adapting to the needs of different clinical areas. Even during a global pandemic, there's a familiarity to the fast pace change in learning and acceptance that working with an ever changing clinical situation entails. However, other integral staff to our department may not have the skills or experience to adapt as such a quick and effective rate. Here, two foundation doctor year 1's working in the ICU during the peak of COVID-19 explain how the skills they learnt from medical school, prepared them for the new working unprecedented working conditions.

Situational awareness

Throughout university, I undertook modules in leadership and safety, which promoted situational awareness, a new concept to me. I realised how important this was in the COVID-19 pandemic. My ICU department ran at double capacity, with multiple ventilated patients and staff that had not working in ICU before. I became an accessible resource for new staff on how to use the different IT systems and ICU protocols, ensuring the unit still ran smoothly despite the daily changes to normal practice. I was keen for new members of staff to see that although I was familiar with our ICU, I was not a trained anaesthetist. I had skills and man-power to offer, but my familiarity shouldn't get confused with seniority and clinical skills.

Communication skills

At medical school, there was a strong emphasis on developing communication skills in the form of workshops with simulated patients, group seminars and inter-professional teaching days. At the time it was easy to underestimate the value in this. However, since starting FY1 it has been striking to see how much of an impact timely, clear and effective communication can have. This was especially paramount during the Covid-19 pandemic, where high stress levels and a hot bustling, work environment become the new norm. Our communication styles had to adapt over a very short period of time, chiefly because of the lack of facial gestures due to visor and mask wearing! I realized how much these non-verbal cues influenced our day to day interactions with colleagues, patients and relatives, and how difficult life was without them.

Knowledge base

Having studied for 5 years with continuous assessment and rigorous examinations, I was well aware of the broad knowledge base required to work safely and effectively as a foundation doctor. Not only did medical school emphasize the importance of basic physiology, anatomy and biochemistry, but it taught me how to build on the solid base of clinical knowledge whilst working full-time, by using multimedia resources, journals, and opportunistic teaching moments. Whilst formal teaching was postponed during the pandemic, I took to listening to Podcasts and using Twitter handles to keep up to date with the latest scientific evidence.

Clinical assessment

During the final years at medical school, there was a strong emphasis on the ABCDE assessment approach. When I first started working on ICU, I was encouraged to perform this "quick ABCDE assessment" to identify a patient's current issues and work out what needs to happen next to manage their pathology. Whilst knowledge of medical conditions is obviously beneficial, in situations where the diagnosis is uncertain and the route to finding the cause also hazy, approaching the case a structured assessment of the patient is invaluable. As our ICU department adapted to accepting and treating more and more patients, I was given greater clinical responsibilities in reviewing these patients alone. With a new pathology and increasing clinical duties, it was comforting and helpful to remember the simple ABCDE assessment and structure to allow me to prioritise deteriorating signs and escalate my findings effectively to a busy senior clinical team.

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Amy's Song

Around 8 years ago when I was choosing which medical pathway to take, I narrowed it down to two choices: should I be apply for Nursing, or to be an Operating Department Practitioner?
I decided on the latter. The airways, the surgery, and the scrubs, for some strange reason. Who doesn't want to wear pyjamas to work constantly?
So I completed the course, the placements and qualified, becoming part of the hidden organisation that helps to run the theatre department.
Sidekick to the anaesthetist, control-drug key-keeper, surgical jack of all trades but master of none.
There are roughly 14,000 ODPs registered in the UK, and yet the only people who know who we are either work with us or are married to us.
Three years passed, and I became a band six, specialising in managing difficult airways.
Three years later, the pandemic hit.
My jobs changed overnight.
Our secret safe-haven in theatres became a fraught with risk as we handled potentially contagious airways, fighting even harder to manage the breathing of patients with the virus that fought against us.
We watched theatre lists be cancelled, our anaesthetic trainees and consultants disappearing to where they were needed most: Intensive Care.
Unless it was an emergency, there was nobody left to run a theatre.
Then the same was asked of us, the staff remaining.
Who would be willing to go?
Who would be happy to help?
What they were really asking was this:
Who will move into another department - for the foreseeable future - to face a virus we still don't fully understand, that can kill perfectly healthy people indiscriminately?

So I went; I had signed up help people, so this was still within my remit.
Pre-pandemic, I had always found Intensive Care to be an odd place. Strange but fascinating. A twilight zone where all but the staff are asleep, CPAP hoods and humming machines, nurses who hate the tangle of wires that seem to come with every patient we bring from theatre.
But the second something changes, everyone mobilises. The nurses react faster to resolve an issue than it would normally take me to find a Doctor or surgeon to ask for help.
How was I ever going to be able to keep up with that? My role is always paired with another - Goose and Maverick, as one of the doctors affectionally calls us. We're never alone.
But these nurses thrive on their abilities to work independently, without relying on the skill set of another to complete their jobs.

My first shift came quickly, a night shift, and I shared it with some colleagues.
We were all doubled up with ICU nurses who were as unsettled as we were by the pandemic - and probably even more so by the strangers they had been paired with.
For twelve hours I sat with a patient.
Terrified.
Trying to make head or tail of the various pumps, alarms and paper work.

I'm usually better thrown in the deep end, I know that from my ODP career so far. Jetting down to A&E to assist with the challenging intubation of a belligerent patient was my kind of diving in.
But this was a whole different type of sea.

I remembered that decision I had made when applying to university, and realised that regardless of which path I had chosen, both of them would've likely brought me here, to this room.
At university, nurses and ODPs both do a drugs course, with the same dose calculations, best practice for administering, and so on.
There's an exam you have to pass, but the difference is that once the PIN number comes through, Nurses can administer (once they've preformed local trust training), and ODPs cannot. We have all of the knowledge, but it doesn't come into practice.
The same goes for the rest of the shared course content: cannulations, taking bloods, catheter insertion, intermediate life support, advanced life support.
All of these things were once studied but not included in the daily duties of an ODP. Pre-pandemic, this wasn't such an issue.
So I drew up my first ever antibiotics that night. I took blood gas samples, changed over drugs in PK pumps that I had drawn up myself, and managed to reduce my patient's oxygen requirement from 65% to 60%, all under the careful eye of the nurse who had been lumped with me.
The same nurse who, at the end of the night, was very complimentary and told me I'd made his night easier.
Regardless, I left exhausted and feeling useless. This was not my space - I felt like an intruder.

My next shifts went by in a blur of painful PPE and stupid questions, asking things that I'm sure the guys on ICU will laugh about one day. It's an eye-opening position to be in: to watch the world fall apart on the news, and then go to work and stand at the bottom of a hospital bed and stare down the thing that was causing it.
Roughly three weeks into my stay in ICU, I found my feet. Changing drugs, slowly beginning to understand the various pumps, using e-meds (an electronic prescribing system, that ODP's has to be fast-tracked through to access), steadily holding our own during ward rounds with the doctors and acting on their plans.
Until I was involved in withdrawing care on a patient I'd looked after.

You see, death in theatre is incredibly uncommon.
Sometimes we know it's coming, as the patients are so poorly that surgery is their last chance, or the patient is an organ donation.
Patients dying outside of these situations in theatres is extremely rare.
In ICU, in a pandemic, it isn't so rare.
It was sobering and I'm not ashamed to say I went home and cried.
In total I spent eight weeks in intensive care. Eventually the patients in ICU were at such a low number that we could return to theatres. My last shift was on a Thursday night, so I had the pleasure of standing by an open window to hear the 8pm clap with the nurses.
Those guys deserve so much more than clapping. But it was nice to be with them as it happened.

Returning to theatres was as scary as my first day there. It felt like everything had changed but at the

same time nothing had, I suppose I had a locker and everyone knew my name at least! The one thing that did remain was that the people I work with are as much my family as my real family, and that they too have felt the fear and worry of how Covid has affected us. Everyday could be an uphill struggle, but together we work through it as a department and a trust.

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SEAUK

Summer 2020

Thank you again to all of our contributors- especially during such a busy time!

We hope to see you all at the upcoming ASM!

21st SEAUK ASM

The Society for Education in Anaesthesia

Monday 22nd March 2021

Hilton Warwick/ Stratford-upon-Avon

- Current GMC priorities for Postgraduate medical education
- Simulation in Assessment
- Assessment: Priorities and pitfalls
- Second Victim
- Higher qualification for Educational supervisors
- ARCP for non-trainee doctors