

This pilot has demonstrated that SSOF can be incorporated into an EM simulation curriculum to engage observers and can be beneficial to simulation participants by facilitating peer feedback. The SSOF can be applied more broadly to both graduate and undergraduate simulation curricula to leverage the observer role for benefit of observers and participants alike.

Student Simulation Observer Form

Was there a clear team leader in the group?

Did team members communicate effectively
 With each other?
 With the patient?
 With consultants?
 With the nurse?

List 2 things that the team did very well:

List 2 things that the team could have improved on:

List 5 items in your differential diagnosis for this patient:

- 1.
- 2.
- 3.
- 4.
- 5.

List at least 2 questions that you have regarding clinical management for this particular patient:

13 Talk It Out: A Novel Use of Training Groups with Emergency Medicine Residents

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Background: In response to the alarming rates of physician burnout, in July 2016 the ACGME updated the Common Program Requirements and now mandate residency programs provide services and resources to support resident well-being. To address this requirement, we developed training group sessions for Emergency Medicine (EM) residents to mitigate burnout and enhance resilience. Training groups are small groups in which participants learn through their interaction with each other while processing mutual experiences. Training groups have traditionally been used in Psychiatry residency

programs to help residents process secondary traumatic experiences and emotions. To the best of our knowledge, this is the first use of training groups for EM residents.

Educational Objectives:

- Provide a confidential and safe environment to discuss stressors
- Reduce burnout through normalization and shared experience
- Enhance resilience by learning and practicing coping techniques

Curricular Design: We collaborated with the Department of Psychiatry to design 12 60-minute sessions over the academic year during weekly resident conference. Residents are divided into groups by PGY level. Each training group is led by one psychiatrist and one psychologist who remain with that group for the entire year. All discussions are confidential and no information is shared with the residency leadership unless a risk of harm is identified. The faculty pair initiate each session and then 1) continue discussion from prior sessions, 2) prompt new discussion, or 3) allow residents to determine the content. Through targeted discussion grounded in the fundamentals of cognitive behavioral theory, faculty help residents to identify stressors and sources of burnout specific to each class year’s specific needs. Once stressors are identified, the group works to develop approaches that build resilience. We will assess the effectiveness of the training groups by using two validated tools, single item-measures of emotional exhaustion and depersonalization to measure burnout and the Connor-Davidson Resilience Scale.

Impact/Effectiveness: Integrating training groups into an EM resident curriculum has not previously been described in the literature. This innovation allows EM residents, under the guidance of trained psychiatrists and psychologists, to fight burnout and to develop resilience to stressors during residency training.

14 Teaching the Art of a Great Hand Off in the Emergency Department

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Background: Transfer of patient care, “sign-outs,” is recognized as an area within medical practice where errors occur and patient safety is at risk. As with all medical practice, the act of transfer of patient care, or “sign-out,” should be taught to residents to ensure their competency, and thus help to decrease errors during training and beyond. A sign-out curriculum and retention of this skill has been identified as a priority and requirement in resident training by the ACGME. Unfortunately there is no established curriculum or validated method to guide teaching this skill in Emergency Medicine. Using IPASS as a guide, we developed a curriculum that addresses this lack of training and can be easily integrated into

the regular conference didactic.

Educational Objectives:

- Create a curriculum that can be easily integrated into the conference didactic time for Emergency Medicine.
- Use OPAs as assessment tools for improvement
- Integrate IPASS into an EM environment
- Train residents to give competent sign outs consistently

Curricular Design: A “sign out” method for the residents to was adapted from IPASS to Emergency Medicine.

The curriculum was created to teach the residents to incorporate this new EM IPASS method while in the ED. The curriculum is simple and has three parts; lecture, simulation, and small group discussion. Two two-hour sessions are taught a year. First part: The lecture includes a literature review of errors related to sign outs is, our EM IPASS sign-out system is introduced.

The second part takes in small groups consisting of a faculty mentor, senior and junior residents. The faculty mentor provides a written case that is given to one of the residents. The resident has ten minutes to review it, then “signs” the patient out to the group. After the provided case is signed out, the group has a discussion on the sign-out and whether they felt they could assume care with the information given, using the EM IPASS tool as a guide. The third part consists of faculty directly observing residents during sign-out and filling out a real-time assessment tool (OPA) of the Emergency Department hand-off using a pre-prepared checklist.

For the future, there will be ongoing sessions with small group practice with simulated sign-out, as well as ongoing assessment of resident performance during their clinical shifts. The goal is to use the assessment tool to validate that residents’ sign-outs can be standardized after a comprehensive teaching curriculum. Residents complete a pre and post curriculum survey for feedback. Observations of sign-out will continue through the first three years of the residency program (a four year program) to assess retention if the curriculum.

Impact/Effectiveness: The data points that reflect the Effectiveness of the curriculum are as follows:

- OPA data: Marked improvement in flow of the sign out, thoroughness, and comprehensive understanding of the patient care after sign out
- Time of Sign Out: an unexpected data point (documented) was the amount of time sign out took after shifts.
- Resident survey data: Data questions that consistently received 5 on a Leikert scale;
- Safety of sign out has improved
- Does the curriculum give you the tools to give a comprehensive sign out
- Is a curriculum important to teach residents sign out
- ACGME data point:

The question stating Do you think pertinent data is not lost during sign out? response from our residents. Our program consistently scored between 73-78 %. Six months after the curriculum and new sign out tool was implemented, our score was 95% for the first time.

- Illness severity
- Patient summary
- Action list
- Situation awareness/contingency planning
- Synthesis by the receiver

Illness Severity
-includes illness severity (stable, unstable, watch) / working diagnosis
-disposition
-vital signs

Patient Summary
-pertinent past med hx
-H&P – pertinent
-PE - pertinent
-labs / radiology initial

Action List
-active issues
-interventions
-outcomes (corrected vital signs, new lab values)

Situational Awareness / Contingency Plan
-Current plan
-Active issues that require follow up
-contingency plan (BP does not respond to appropriate IVF resus, start pressors)

Synthesis by the Receiver
-able to accurately summarize illness, active issues, and plan

JH ED Resident Sign Out

New format – definition of scale on second page

Resident name: _____ Faculty: _____

****MUST BE IN THIS ORDER**** (not that the below was eventually stated)

1. Did the resident sign out the “working” diagnosis/ stable vs unstable?
Please circle one: 1 2 3 4 5
2. Did the resident sign out the disposition? (Pending is an appropriate option)
Please circle one: 1 2 3 4 5
-if pending dispo, was a working differential signed out?
Please circle one: 1 2 3 4 5
3. Did the resident sign out a focused History of the patient’s present concern?
Please circle one: 1 2 3 4 5
4. Did the resident sign out a focused past medical history?
Please circle one: 1 2 3 4 5
5. Did the resident sign out focused physical exam?
Please circle one: 1 2 3 4 5
6. Did the resident sign out pertinent lab /radiology findings?
Please circle one: 1 2 3 4 5
7. Did the resident sign out active issues with interventions / outcomes?
Please circle one: 1 2 3 4 5
8. Did the resident sign out the active plan and pending issues?
Please circle one: 1 2 3 4 5
9. Did the receiving resident acknowledge pending issues / plan?
Please circle one: 1 2 3 4 5