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## Safe Interfacility Transport of Pediatric Patients: Medical Control Training, an Interdisciplinary Approach



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### ABSTRACT

*Introduction:* Critically ill children who require transfer to tertiary care centers often require transport by specialized transport teams (TT). These interfacility transports require a medical control physician (MCP). Traditionally this role is assigned to fellows who are taught "on-the-job", but achieving competency in communication for those trained this way may not be optimal. We sought to close this curriculum gap by developing a MCP training program immersing emergency medicine (EM) and critical care (CC) fellows together with TT members to manage a simulated patient.

*Methods:* Pilot curriculum from 2014-2016 involving 1st year fellows. A case is presented initially with a referral call. By phone the fellow is to communicate with and guide the TT, who is in a separate room managing the "sick" patient using high-fidelity simulation. Each MCP and TT communication is evaluated by faculty and peers. An immediate debriefing session provided formative feedback.

*Results:* 11 fellows participated and 10 completed a post-simulation survey (91%). The fellows and TT members rated the curriculum as "highly important" and positively viewed the interprofessional collaboration. Respondents were neutral when asked if communication skills improved.

*Conclusion:* The MCP training curriculum was viewed favorably and participants reported that this formalized training is needed.

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Emergency medicine and critical care physicians often serve as the medical control physician (MCP) for pediatric patients who require interfacility transport. Traditionally, this "skill" of managing a patient sight unseen is taught to fellows informally "on the job." This "see one, do one, teach one" approach may not be the most optimal to learn how to manage a critically ill patient.<sup>1,2</sup> In addition, entrusting an inexperienced physician to effectively communicate plans to an unfamiliar transport team in the field could be problematic.<sup>3</sup> Moreover, at our institution, the role of MCP falls under the "entrustable professional activity" umbrella, and evaluation of an individual's performance with this task is often inconsistent and informal.<sup>4</sup>

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Nonetheless, the Accreditation Council for Graduate Medical Education has performance expectations for the following milestones: patient care, medical knowledge, professionalism, interpersonal communication skills, practice-based learning, and systems-based practice. Recognizing that our emergency medicine and critical care fellows were not receiving formal education and evaluation in assuming medical control for patients during interfacility transfer, we sought to close this curriculum gap by developing a formal program.

This structured training combines an interdisciplinary approach, high-fidelity simulation, and immediate feedback on performance by peers, faculty attending physicians (faculty), and experienced transport clinicians. This curriculum is very similar to already successful training simulation programs that focus on safety and communication in the nursing, surgical, military, and aviation fields.<sup>5-13</sup> Moreover, the curriculum's interdisciplinary aspect makes it versatile for other programs to adapt. A similar communication training curriculum could easily address the Accreditation Council for Graduate Medical Education's expectation that all accredited training programs must assess each trainee's professionalism, interpersonal communication skills, and ability to show leadership

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while "working in interprofessional teams to enhance patient safety."<sup>14-16</sup>

#### Methods

This study was exempt from review by our institution's institutional review board. Participation by transport clinicians and fellows was voluntary. Each training session was held during scheduled afternoon transport team education days during the 2014 to 2016 academic years.

After an introduction of the MCP role by faculty, the common barriers to telephone communication were discussed with the fellows. Fellows in groups of 2 were then assigned teams and assumed the role of their respective disciplines. One attending physician played the role of the referring physician and made an initial call to the fellow from a different room, reading from a scripted scenario of a pediatric patient in respiratory distress. The "referring" did not volunteer vitals nor report any physical examination findings unless prompted by the "receiving" fellow. Fellows were presented the option to use a template for information gathering or were allowed to record information by their own methods (Supplementary Fig. S1). The total length of calls and the types of information collected were recorded by another faculty attending observing the fellow's conversation with the "referring." After collecting the patient's information, the fellow offered recommendations to the referring and then called the transport team (TT) to provide a succinct report and "mobilize" them. Although our institution uses a much more efficient "1-call" system to mobilize our transport team, the exercise was completed in this way to provide yet another opportunity to practice communication. The non-MCP fellow observed and rated both phone calls (Supplementary Fig. S2).

In teams of 2 to 3, transport clinicians were asked to participate in a high-fidelity simulation using the same case scenario in another room. Continuing with the scenario, the transport team "arrives" at the outside facility to find the patient in moderate respiratory distress. After assessing the patient and deciding on an initial plan of care based on protocol, the TT then called the MCP with a report, and plans for the next steps were discussed.

However, during the MCP call, the case scenario abruptly proceeds to respiratory failure with severe hemodynamic instability requiring the TT to hang up with the MCP. As in real life, TT interventions are made when the patient's status changes. This dramatic interruption was done to highlight the complexities of transport for the fellow. Once the team made the appropriate interventions, the transport team proceeded to call the MCP back with an update. This second call to the MCP by the transport team was designed to challenge the fellow in their MCP role, as the scenario forces the fellow to co-manage the patient and work collaboratively with the team in "real time."

Immediately after the case scenario, there is a debriefing with faculty. The "MCP" reflected on his or her performance first and was encouraged to volunteer the realized barriers to communication over the phone. Peer feedback by the other fellow was also



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