

# **CRUMPET FACULTY GUIDE**

## **Cross-specialty Multidisciplinary Paediatric Emergency Training**

**1<sup>st</sup> Edition, 2013**



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## Contents

<b>Introduction</b>	<b>4</b>
<b>Non-technical Skills</b>	<b>6</b>
<b>Candidates</b>	<b>8</b>
<b>Faculty</b>	<b>10</b>
<b>Facilities</b>	<b>12</b>
<b>Course Structure and Scenarios</b>	<b>13</b>
<b>Debrief</b>	<b>16</b>
<b>Feedback</b>	<b>20</b>
<b>References</b>	<b>20</b>
<b>Appendix: Curriculum Mapping</b>	<b>21</b>

## **Introduction**

The CRUMPET course was started in Rotherham Hospital in 2007. Paediatrician Sanjay Suri contacted his emergency medicine and anaesthetic colleagues with an idea for a course involving doctors, nurses and ODPs from the three specialties. The course was run with a basic life support manikin for the first 3 years before being replaced with a medium fidelity simulation manikin. From the beginning, the course was run in the style of a simulation course. The aim was to concentrate on the non-technical skills or human factors involved in a resuscitation team scenario, although the terms were not in such wide use at the time.

In paediatric resuscitation, the staff may be experienced and have usually been trained on life support courses focussing on technical skills. However, when things go wrong, failings in non-technical skills are more common than technical errors <sup>1</sup>. Life support courses train individuals, whereas paediatric resuscitation is usually carried out by large and potentially unwieldy multidisciplinary teams. The CRUMPET course aims to bridge the gap between staff knowing what to do as individuals and being able to work well in a team. This is done by focussing on non-technical skills. At the time the course started there was little coverage of non-technical skills in life support courses and trainee curricula. This situation is beginning to change at the time of writing.

For many staff real-life paediatric resuscitation scenarios are relatively few and far between. The course therefore also provides a useful opportunity to practice the technical skills of paediatric resuscitation. As the scenarios include an actor in the parent or grandparent role, this allows training on the often neglected subject of care of relatives during resuscitation.

Two positive unintended consequences of the course have occurred. One is that team building has occurred between the three specialties involved, by working together as candidates and faculty on the course. Greater links, more discussion and better understanding of each other's roles has resulted. Secondly, discussion during the courses on the best way to deal with particular scenarios has led to reflection and improvement of real-life working practices.

### **CRUMPET course objectives:**

- Non-technical skills training, in particular teamwork, leadership and communication.
- Practice of resuscitation technical skills in 2 scenarios.
- Training on care of relatives during resuscitation.
- Team building.

The course is not intended to provide comprehensive coverage of a paediatric resuscitation curriculum. It does not replace the need for life support courses or paediatric simulation courses focussing on technical skills.

The purpose of this manual is to provide the necessary information to run a CRUMPET course, along with some of the learning from several years of running the course. The scenarios are provided separately. Please contact us if you require further information.

## **Non-technical Skills**

The purpose of the CRUMPET course is to go beyond the teaching of technical resuscitation skills to individuals, for example in life support courses. The focus of CRUMPET is on the non-technical skills necessary for the application of technical skills in the real world, such as teamwork, leadership and communication. Whilst most simulation courses cover non-technical skills to a greater or lesser extent, CRUMPET has a particularly high emphasis on these skills. This is partly because of the large multidisciplinary team involved in paediatric resuscitation. It seems that the larger and more varied the team, the more important advanced non-technical skills become.

There have been a number of attempts to determine the non-technical skills required in different clinical settings<sup>2-4</sup>. The matrix currently being used by the College of Emergency Medicine<sup>2</sup> is probably the most relevant framework for the CRUMPET scenarios, as they are based in the Emergency Department.

### **Emergency Medicine Non-technical Skills Matrix**



This framework was developed for middle grade doctors, and there is therefore an emphasis on leadership. The non-technical skills required by each different staff group vary slightly. For example, the skills for more junior doctors and nurses would have more of an emphasis on followership skills. Nevertheless, non-technical skills are generic skills and best

considered as such in the course. This is because it is beneficial for leaders to understand the position of followers and vice-versa. Differences in the emphasis or application of the different skills for different staff groups can be brought out in the debrief where relevant. The debrief section covers the common non-technical skills issues that arise in the course with suggestions on how to debrief them.

## **Candidates**

The candidates should reflect the personnel who attend paediatric emergencies in the ED in your hospital. This may vary a little at different centres, but the core personnel are likely to be similar. Each specialty lead selects candidates based on their availability on the day, rather than by advertising for applicants. Priority is given to trainees in EM and paediatrics who intend to pursue a career in those specialties. An example is given:

**Emergency Medicine:** 1 SHO

1 Middle Grade

1 Junior Nurse

1 Senior Nurse

**Paediatrics:** 1 SHO

1 Middle Grade

1-2 Nurses (if they attend emergencies in your ED)

**Anaesthetics:** 1 SHO

1 Middle Grade

1 ODP

### **Variations**

The term SHO is used to cover F2, GP VTS and ST1-3 doctors working in each specialty. Middle Grade includes Specialty Registrars (ST4-7) and Specialty Doctors. Specialty Doctors have limited training opportunities and a lot to gain from the course, so it is well worth their attending, potentially on a recurrent basis. Where Paediatric Advanced Nurse Practitioners are involved in resuscitation in the ED, they should also be included. Consultant involvement in the scenarios has so far been limited to faculty members offering consultant advice on the phone. However, having consultant candidates in addition to or instead of the middle grade would be very worthwhile.



## Absences

Due to sickness and workload pressure, the course may be left without some of the personnel listed, often at the last minute. A certain amount of absence can be coped with and can reflect real-life situations. The dynamics of the course will be altered by any absences. For example, if there is no ED Middle Grade, the SHO is likely to call for paediatric and anaesthetic help at an earlier stage. SHOs who have no MG in their specialty can also be supported by telephone advice from a faculty member playing the role of consultant.

However, there are certain personnel essentials for the course to run:

- There must be at least one nurse. If there is only one, he or she will be put under a lot of pressure and may find the situation stressful. A nursing faculty member could role play to support a single nurse or if there were no nurses available.
- There must be at least one doctor from each specialty.
- Anaesthetists can be expected to cope without an ODP in an emergency. However, it is not reasonable to expect an anaesthetist with no paediatric experience to take part without MG support. Again a faculty member may be able to step in and role play.

The Course Director will need to make the final decision as to whether to go ahead or cancel based on which personnel are absent and any measures that can be taken to replace them with role-playing faculty or phone advice. If at all possible, the show must go on!

## **Faculty**

One of the founding principles of CRUMPET as a multidisciplinary course, is that the faculty should also be multidisciplinary. It is important to have a representative for each of the specialties involved if at all possible. This ensures the best and most appropriate debrief for each specialty and also ensures maximum credibility in the eyes of the candidates.

The ideal faculty involved in the debrief is as follows:

**Consultant in Emergency Medicine**

**Consultant Paediatrician**

**Consultant Anaesthetist/Intensivist**

**Senior Nurse in Emergency Medicine** (e.g. Clinical Educator, senior RCN)

Resuscitation Training Officers can also be useful team members. We have not had ODPs on the faculty as yet, although this would be possible. A special interest in paediatrics may be desirable for the non-paediatric faculty. Conversely, involvement in the course can also be a useful way of maintaining and developing paediatric skills in faculty who are not paediatric sub-specialists.

### **Faculty Training**

There are currently a number of different courses for simulation faculty training, run through simulation centres or colleges. There are currently no accepted content or common standards. Some courses focus mainly on debriefing, others also cover scenario writing and technical aspects. There is also currently a lack of capacity in these courses. Because of this, the ideal of all faculty being trained on a recognised course may be difficult to achieve in the short term. At an absolute minimum the course director must be trained and experienced in simulation teaching. He or she may need to offer guidance to faculty members who do not have this training. Faculty who do not have simulation training must have at least some relevant teaching experience such as instructor on life support course. In the longer term, simulation faculty training should be an objective for all faculty members. The Debriefing Assessment for Simulation in Healthcare (DASH) Handbook<sup>5</sup> is a useful source of guidance for faculty members and can also be used to perform assessments on debriefs to enhance faculty development.

### **Size**

A faculty of four is already quite large. With aspirant faculty and observers added on, the faculty can become unwieldy and intimidating for the candidates, especially if they are outnumbered! It may help to keep those who are primarily observing to the back or in the

control room to minimize this effect. The course director needs to strike a balance between inclusiveness and creating an excessively large faculty.

### **Absences**

As with the candidates, the course may be left with a sub-optimal faculty list, often at the last minute. A bare minimum debriefing faculty would be 2 individuals from different specialties. This is not ideal and reduces the educational potential, particularly for the candidates who do not have representative faculty from their specialty.

### **Technical Faculty**

One faculty member will be required to control the manikin. Ideally this will be a simulation centre staff member, but if this is not possible, one of the debriefing faculty can take this role, provided they have the necessary training and experience. Another vital role is preparing and stocking the simulation environment, turnaround between scenarios and clearing up.

### **Actors**

All scenarios include a parent role. Trained actors can transform a scenario by adding amazing levels of realism and emotional intensity to the scenario. Faculty members or education centre staff can be used if trained actors are not available, but are usually less realistic. If all else fails, it is possible to run the scenarios without a parent role, but this misses some valuable educational opportunities.

## **Facilities**

### **Manikin**

The course was originally run with a basic life support training manikin. However, the use of a medium-fidelity simulator such as Sim Baby or Meti Baby adds considerable realism and should be regarded as essential. The course can be run with just a baby manikin, but if a paediatric manikin is also available, this could be used for one of the scenarios, with appropriate changes to the scenario details.

### **Rooms**

The minimum is a simulation room for the active candidates, a separate waiting room for candidates waiting to be called and a debriefing room. There is no need for audiovisual feed to candidates during the scenario, as they are either participating or waiting blind to events. A separate control room with one-way mirror adds realism by removing the controls and technical faculty. In an ideal world, the simulation room would be the paediatric resuscitation bay in the ED. However for many departments that see both adults and children, this may be difficult due to high bed occupancy rates in the resuscitation room.

### **Audiovisual equipment**

Video recording of scenarios is difficult due to the large number of participants involved and the amount of simultaneous communication. We have not achieved satisfactory results, and hence do not currently use video in the debrief. However, it is likely to be possible with an advanced set up involving multiple microphones and cameras.

### **Equipment**

Assuming the simulation room is not the actual ED resuscitation bay, the set up should be as similar as possible. If necessary, easy location of equipment can be facilitated by putting core equipment in trays on top of trolleys where it can be readily seen.

### **Drugs**

Real, out of date or mock up drugs may be used depending on the local set up and policy. The closer the resemblance between mock drugs and the real product, the better. Real antibiotics should not be used because of the risk of encouraging antibiotic resistance.

## **Course Structure**

The CRUMPET course evolved as a half-day course for pragmatic reasons. There can be considerable difficulty in securing the release of candidates (and faculty) for a whole day's training, but if all that is being asked is 3 hours within a shift, success is much more likely. A whole day course would be a possibility if release of staff could be achieved. However, we have found that the course objectives can be reached effectively in just 3 hours. The example timetable requires a prompt start and good timekeeping. Allowing an extra 30 minutes would make it easier to keep to time.

### **Example Timetable**

13.20	Arrival
13.30	Introduction and meet the manikin
13.50	Scenario 1 (ED Team start)
14.20	Debrief 1
15.00	Coffee
15.30	Scenario 2 (Group Start)
16.50	Debrief 2
16.30	Close and Completion of Feedback

### **Arrival**

Starting promptly can be difficult, especially when staff have come from other duties, hence asking candidates to assemble 10 minutes before the starting time. It is helpful if the specialty leads liaise with their departments just prior to the starting time to ensure that handovers are completed, staff are released promptly and bleeps covered etc.

### **Introduction**

The introductory lecture provided on PowerPoint is essential to set the scene, allay candidates' fears and create a relaxed atmosphere that will promote discussion and learning. It is important to emphasize that the course is a learning exercise, not an assessment and that performance will not be discussed outside the room or with Educational Supervisors unless there are exceptional circumstances. The faculty introduce themselves. A point is made of the candidates not introducing themselves to each other.

The aim is for the candidates, if they do not already know each other, to meet and introduce for the first time during the scenario, as they would in the real-life situation.

Following this the candidates are given a few minutes to familiarize themselves with the manikin, by feeling pulses, listening to heart and lung sounds etc. They should be told what the manikin can and cannot do, and that they are expected to mix up and inject/infuse drugs and fluids as they would in a real scenario. They should also be shown the location of equipment, drugs and fluids. Any unfamiliar details regarding defibrillators, monitors and ventilators should be covered. If these steps are skipped or rushed, candidates may become very anxious and fixated on equipment issues and unable to concentrate on the scenario. The most important point to make to guide and reassure candidates is:

*'Do exactly what you would do in a real scenario!'*

## Scenarios

Scenarios can be run in two ways: with only the ED team at the start or with the whole group at the start. Both approaches should be used, to increase learning and because only using the ED team start can leave the other teams feeling left out and peripheral.

### ED Team Start

The ED team assemble for a pre-alert and start by managing the case themselves. They then call paediatric and anaesthetic staff as and when they feel necessary. The paediatric and anaesthetic staff must wait in another room until called, in order that when they are called they have no knowledge of what has happened so far, as in reality. The faculty decide how quickly a call for help is responded to. In reality, help does not arrive immediately, and faculty may wish to delay the response in order to see more of how the team copes on its own. Scenarios using the ED team start generally take longer than the group start, and this is reflected in the timetable. The ED Team start has the advantage of creating several occasions for staff introductions, handovers and changes of leadership.

### Whole Group Start

All the candidates are called to the ED for a pre-alert. This ensures that all are fully included from the beginning and is appropriate for scenarios that appear more serious from the onset. This approach leads to a shorter scenario and less complicated team dynamics as a single stable team is usually formed at the beginning, which does not keep changing and handing over with the arrival of new personnel.

## **Scenario Choice and Order**

The status epilepticus scenario works best as an ED team start, as the situation gradually increases in seriousness. The bronchiolitis, meningococcal sepsis and shaken baby scenarios are more serious at the onset and work well as whole group start. They can also be used for ED team start, in which case they are likely to lead to more rapid escalation than the status epileptic scenario. It is suggested that the best approach is for the first scenario to be an ED team start and the second a group start. This gives everyone an equal opportunity to put what they have learned in the first debrief into practice in the second scenario.

## **Debrief timing**

The scenario alone has little educational benefit, so it is important to stop the scenario at a point that allows sufficient time for the debrief. Occasionally, it may be necessary to stop before the scenario has reached the intended end point. As the learning takes place in the debrief, this should last longer than the scenario, as reflected in the timetable.

## **The Debrief**

General approaches to debriefing are covered elsewhere<sup>5</sup>. The purpose of this section is to highlight the areas that commonly arise in CRUMPET debriefs.

### **Technical skills**

Most of the participants have been trained on life support courses and the team contains several highly experienced members. Despite this, technical errors relating to drug doses or treatment guidelines are relatively common. In general these errors are relatively minor and not life-threatening. However, it is a very important principle that

*Technical errors must be addressed in the debrief.*

The debriefer may be more interested in discussing the non-technical skills, but ignoring technical errors misses an important learning opportunity, sets a bad example regarding accepting low standards and may lead to the debriefer and the course losing credibility in the eyes of the candidates. In cases where there are no technical issues to discuss, the debriefer can, after acknowledging this, move straight to the non-technical skills.

### **Non-technical skills**

The following are some of the common areas of interest that arise in the CRUMPET course. Key questions are given, followed by areas of discussion. Suggested good approaches and behaviours for the candidates are given for guidance.

#### **Introductions and Handover**

*Did people introduce themselves? If not, why not?*

*How was the handover? Was any important information missing?*

The ED-only start scenario maximises the opportunity for introductions and handover. The number can be further increased by making the paediatric and anaesthetic teams arrive individually (e.g. junior first followed by senior) rather than together. Worthwhile areas of discussion:

People often don't introduce themselves or wear a name badge. This results in assumptions and guesses which are often wrong e.g. 'Is he an ODP or consultant anaesthetist? Theatre scrubs, no badge, looks experienced – how can I tell??' Although introductions are made difficult and rushed by the need to continue resuscitation, there is no excuse for not doing it at all. Name, specialty and grade is required.

Handover in this context means handover of clinical information and not all responsibility for the patient. The SBAR (situation, background, assessment and recommendation) format can be used. Whilst the recommendation is by implication to join the team, it can be useful



to state or discuss what the new team member should do first. New team members need to know what has been done so far, so this should be part of the handover. It allows the new arrival to consider if there is anything else they think should be done. It also avoids the tenth person arriving at a meningococcal scenario being the tenth person to ask 'have you given any antibiotics?' The whiteboard can be a very useful adjunct to handover if used to document times of interventions and drugs given.

### **Leadership and Followership**

*Who was in charge?*

*Did the leader stand back and not get involved in technical tasks?*

*How did you decide who would lead?*

*Who should lead the team in a paediatric resus?*

*What was it like to be a follower in this team?*

A team with a clear leader performs better than one without. A good leader sets goals and priorities in a timely fashion and makes the job of followership easier. Leaders are more successful when they stand back and do not get involved in technical tasks. It is very difficult to lead the team whilst intubating the patient, for example.

Followers can be overloaded with tasks, often given in the order that they are thought of rather than the order of priority. They should be prioritised by the leader.

There is no clear answer to who should lead. It should be whoever is best equipped to do so. In some scenarios it will be natural for the paediatric middle grade to lead, as they would in an emergency on the paediatric ward. In others, it may be natural for the EM middle grade to lead or continue to lead. The leader does not have to be the most knowledgeable person. A leader with good leadership skills may fare better than a leader who is the most knowledgeable individual, provided they consult the whole team. Anaesthetic middle grades may sometimes lead the scenario, usually reluctantly, when no one else is doing so effectively. This is usually less ideal, as they have complex technical task such as intubation to complete and cannot stand back.

### **Teamwork, Communication and Situational Awareness**

*What did each individual/the team think was going on (at a certain point)?*

*Was everyone aware of (a certain event, result, decision etc)? If not why not?*

*What was the team's goal? How did you make decisions?*

*How could the communication/teamwork/handover be improved?*

*Did the team feel they could ask questions and make suggestions?*

*How steep was the hierarchy? (this will need explanation)*

Information should ideally go to the team leader and then be disseminated to the team. Without clear leadership, the overall team can break into ‘teams within the team’ – such as a nursing team and anaesthetic team. This leads to communication breakdown and loss of coordination.

It can be instructive to look at who was and was not told the blood gas or other results when they arrived, as an indicator of the effectiveness of group communication. Ideally the whole team should find out at the earliest possible opportunity, but often results and other important information spread by ‘Chinese whispers’ and do not reach all team members.

Frequent reviews by the team leader are a good way of ensuring nothing has been missed, updating the team on progress and then moving on to decision making and forward planning. This can be done using an ABC (i.e. airway, breathing and circulation) format. This helps the team to have a shared mental model of the scenario and goals. Where this does not happen it is valuable to use questioning to illustrate the lack of a shared mental model and common goals.

Some leaders may need to actively raise their voices to gain the attention of the whole team and communicate effectively in the scenario of a large, often noisy group.

It can be worth exploring whether the hierarchy was steep or flat and explaining this concept to the candidates. To summarise, a steeper hierarchy means didactic leadership and obedient, unquestioning followers. A flatter hierarchy encourages input from all team members, but does not mean there is no leader. A flatter hierarchy is generally accepted as being safer and more effective in resuscitation scenarios. This is with the caveat that at very critical moments, a more didactic approach may be more appropriate and lead to quicker action. Even in this situation, however, team members should still be able to input on crucial matters, for example to point out that the oxygen has become disconnected. Leaders can influence the steepness of the hierarchy by either actively encouraging any questions, ideas or suggestions from team members, or by being negative, critical or dismissive towards input from others. Followers can influence the hierarchy by being assertive with their input.

### **Care of relatives**

*To the actor: How did you feel you were treated?*

The ideal for dealing with relatives is to have a nurse dedicated to looking after them, explaining what is happening and keeping them informed. This is often not possible with two or fewer nurses, but it helps if one nurse can take the lead on this task and keep returning to it when possible. Sometimes the paediatric or EM SHO may be free to take on

this role. What often happens is that many different team members speak briefly to the relative at different times potentially giving an inconsistent message.

## General Tips for the Debrief

Include **all** team members in the debrief. There can be a tendency to focus on the team leader, but this must be avoided to ensure all candidates benefit from the debrief.

One of the faculty should lead the debrief for each scenario. They aim to produce a structured overall debrief of the scenario. This can be based on input from the rest of the faculty before starting. The rest of the faculty are invited for any further points at the end of the debrief. They may also come in during the main debrief to pick up on any points of particular expertise related to their specialty or otherwise. For example, the anaesthetist faculty member is likely to be brought in to comment on issues relating to intubation, during the body of the debrief. Conducting a well constructed debrief that incorporates views from all faculty members, includes all the candidates *and* runs to time is a true challenge!


Some questions are focussed at the individuals involved. However, there is much benefit in asking questions not of the 'actor', but the person on the receiving end of the action. For example: how did the paediatric team find the ED team handover? What did the nurses think of the leadership? Who did the group think was leading? (ensuring answers from as many individuals as possible, sometimes all different!) What did the person acting the relative think about how they were treated? This approach aims to utilise the feedback that exists within the group, which may be seen as more valid than feedback from an external debriefer.

As discussed above, if there have been multiple technical errors, they must be covered in the debrief. However, if care is not taken the group can feel criticised and demoralised by this and as a result stop listening and engaging with the debrief on non-technical skills. This is a difficult debrief scenario, the solution may be to try to provide some early balance with good points, rather than cover all the technical errors first.

## **Feedback**

Feedback is collected from all candidates at the end of the course on the provided feedback form. Numerous changes to the course have been made as a result of the feedback. The feedback from each course should be collated and distributed to all faculty members. Informal discussion on the shop floor a few days after the course can also reveal further interesting viewpoints which may not appear in the written feedback.

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## **Appendix**

### **Curriculum Mapping**

The course has been mapped to the College of Emergency Medicine Curriculum (2010).

<http://www.collemergencymed.ac.uk/Training-Exams/Curriculum/Curriculum%20from%20August%202010/>

Each scenario has been mapped to the Paediatric section of the General Curriculum. These items are listed in the scenario itself. Listed below is a mapping of the course to the generic skills or Common Competencies.

CC1 History taking  
CC3 Therapeutics and safe prescribing  
CC4 Time management and decision making  
CC5 Decision making and clinical reasoning  
CC7 Prioritisation of patient safety in clinical practice  
CC8 Team working and patient safety  
CC15 Communication with colleagues and cooperation  
CC21 Evidence and guidelines

Mapping to the Paediatric, Anaesthetic and Nursing curricula has yet to be completed.