

10-1

MANAGING EMERGENCIES IN THE COMMUNITY: TAKING SIMULATION OUT OF THE CLASSROOM AND INTO 'REAL-LIFE' ENVIRONMENTS

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Introduction

General Practitioners (GPs) have a responsibility to provide prompt and effective care in an emergency and research has shown this is an area where doctors lack confidence. Primary care staff are currently required to undertake annual Basic Life Support training, which is typically classroom based teaching. We developed a course on 'Managing Emergencies in Primary Care' in which we took medical education out of the classroom and into real-life environments where emergencies actually occur. Clinicians valued the 'real-life' scenarios and their confidence in managing emergencies significantly improved after the workshops (Forde, Bromilow & Wedderburn, 2017). In the current work, we assessed if there was any long term benefit to 'real-life' simulation based teaching.

Method

Workshops were delivered to 118 primary care staff in GP surgeries. Scenarios included the practical management of meningitis, anaphylaxis, hypoglycaemia, convulsions and cardiac arrest. Participants had to find and utilise the equipment in their surgery and were asked to physically draw up the appropriate medication. Participants were asked to rate their confidence in managing emergencies before the workshop, immediately after and 8 weeks later (on a 9 point Likert scale, 9 = very confident). 8 weeks later, participants were asked if they had made any changes to their practice, either personally or within the surgery.

Results

Participants' confidence in managing emergencies increased immediately after the workshop and was sustained 8 weeks later. 98% respondents reported making changes to their practice. This was typically reviewing emergency equipment and/or medication. For example: *"Adjusted the layout of the crash trolley. Printed out algorithms for common emergencies to keep in the crash trolley along with dosing information"; "Lots - I am more confident and feel I can remain calm and act speedily. As a practice, we now have small boxes containing the appropriate drugs for each type of emergency e.g. anaphylaxis, diabetes, chest pain"*.

Conclusions

Training doctors through simulation needs to be taken out of the classroom and into real-life environments, either on hospital wards or in GP surgeries. Doctors need to be confident and competent in using their own equipment and medication. Training in real-life environments highlights the system changes that need to be made. Teaching through 'real-life' simulation can have long-term positive benefits on clinicians' confidence and practice.

10-2

IMPROVING QUALITY OF CHEST COMPRESSIONS AMONGST MEDICAL AND NURSING STAFF THROUGH DELIBERATE IN-SITU PRACTICE WITH FEEDBACK AND THE IMPACT OF REPEATED TRAINING

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Background: quality of chest compressions underpins resuscitation outcomes with poorer performance leading to lower survival rates¹. We aimed to analyse whether deliberate practice of chest compressions with feedback improves quality of compression amongst PICU nursing and medical staff and the impact of repeated training at 2, 4 and 6 months.

Methods: prospective, longitudinal study with in-situ workshops utilising Resusci Baby® QCPR®. Components analysed were hand position, correct & average rate, depth and recoil, a combination of which resulted in overall scores. Study protocol and consent procedure were approved by the Trust's Research Office.

Results: 56 participants (14 doctors, 42 nurses) of which 49 (87.5%) completed all workshops. There was a significant improvement on overall, depth, recoil and rate scores immediately after feedback on all workshops (table 1). A significant improvement was also noted on baseline scores over time: complete recoil from 2nd session (72%, IQR 20-98% vs. 98%, IQR 82-100%, p=0.003); overall, depth, correct and average rate at 4 months in comparison to the first session (84%, IQR 49-94% vs. 95%, IQR 87-98%, p<0.001; 97%, IQR 45-100% vs. 100%, IQR 98-100%, p<0.001; 14%, IQR 1-83% vs. 65%, IQR 30-90%, p=0.002; 119bpm, IQR 113-129bpm vs. 112bpm, IQR 101-118bpm, p=0.01, respectively). Hand position baseline scores did not significantly change over time.

Conclusion: deliberate practice of chest compressions with continuous feedback improves quality of compression amongst PICU nursing and medical staff. This effect is noted immediately and over time with repeated training.

Table 1. Assessment at baseline and after feedback for each workshop

	First workshop (n=56)			Second workshop (n=55)			Third workshop (n=53)			Fourth workshop (n=51)		
	Baseline	After feedback	p	Baseline	After feedback	p	Baseline	After feedback	p	Baseline	After feedback	p
Overall score (%)	84 (49-94)	98 (97-99)	<0.001	93 (43-98)	99 (98-99)	<0.001	95 (87-98)	99 (98-99)	<0.001	98 (86-99)	99 (98-99)	0.001
Correct hand position (%)*	100 (100-100)	100 (100-100)	0.72	100 (94-100)	100 (100-100)	<0.001	100 (100-100)	100 (100-100)	0.07	100 (100-100)	100 (100-100)	0.4
Correct depth (%)	97 (45-100)	100 (99-100)	<0.001	99 (93-100)	100 (100-100)	0.006	100 (98-100)	100 (100-100)	0.001	100 (97-100)	100 (99-100)	0.02
Complete recoil (%)	72 (20-98)	99 (87-100)	<0.001	98 (82-100)	100 (97-100)	<0.001	98 (79-100)	100 (97-100)	<0.001	98 (84-100)	100 (94-100)	0.002
Average rate (bpm)*	119 (113-129)	113 (106-118)	0.03	115 (103-128)	114 (109-117)	0.28	112 (101-118)	111 (107-115)	0.37	112 (107-115)	112 (108-117)	0.68
Correct rate (%)*	14 (1-83)	89 (61-98)	<0.001	60 (3-83)	94 (73-98)	<0.001	65 (30-90)	93 (79-99)	<0.001	81 (51-99)	96 (79-100)	0.01

Values shown as median (IQR). * Missing values on 1st workshop: 2 and 1 for hand position on baseline and after feedback assessment, and 16 for average rate on both assessments.

References:

- 1 - D Yannopoulos, TP Aufderheide, BS Abella, *et al.* Quality of CPR: An important effect modifier in cardiac arrest clinical outcomes and intervention effectiveness trials. Resuscitation 2015;94:106-13.

10-3

USE OF BRIEF MULTIPROFESSIONAL SIMULATION TO IMPROVE CONFIDENCE AND SKILLS IN MANAGING CHILD AND ADOLESCENT MENTAL HEALTH CRISES OUT OF HOURS

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Background: There is well-established evidence for the benefits of using simulation to improve skills and competence in clinical education. An area of learning need was identified in North East London Foundation Trust (NELFT) to improve confidence and skills in managing out-of-hours CAMHS emergencies, for junior medical trainees initially. A pilot simulation session delivered 6 months earlier to 7 junior medical doctors on psychiatric rotation was well received and showed improved confidence in 4 out of 6 domains evaluated, however it was also recognized that the learning could be augmented by widening participation across disciplines and professions.

Aims: To provide and evaluate a multi-professional simulation intended to improve the knowledge and skills of a variety of clinicians working out of hours with young people, including paediatric and mental health doctors, nurses and other allied healthcare professionals.

Method: Clinical staff from NELFT (a Mental Health Trust) and Whipps Cross Hospital, (an acute hospital in Barts Health NHS Trust) collaborated to develop the session, comprising an introductory talk and two simulated scenarios, designed to address issues such as capacity, safeguarding, confidentiality and agitation.

The training was delivered by a team including a Consultant Paediatrician, Consultant CAMHS Psychiatrist, a Fellow in Medical Education from NELFT and two external actors over 3 hours. The session was evaluated through a pre-session focus group, and pre- and post-session questionnaires.

Results: Seven participants attended the session that was delivered; five psychiatry trainees and two paediatric trainees. Different participants were invited to participate in each section of the two scenarios, thereby increasing the number who could have direct experience of the simulation. However, the session had been designed for all participants to learn through observation and discussion.

At the end of the session 100% of participants reported feeling confident in on all the outcomes assessed, which was an improvement in all domains. Five out of seven participants stated they would recommend the course to a colleague, enjoyed the course and found that it met their learning needs. Some free text qualitative feedback identified a need for a wider range of topics to be covered, particularly focusing on paediatric learning needs.

Conclusions: More work needs to be done in advance of future sessions to recruit from acute paediatric services and encourage nurses and AHPs to attend, in order to have more equal representation within the sessions. Despite this, the evidence from this session and the previous pilot demonstrates that this is an effective, engaging and stimulating way to improve skills and knowledge in this area, and that participants benefit from having the opportunity to share knowledge across disciplines and professions and that collaborative working relationships also develop.

10-4

SIMULATION PARTNERSHIP FOR ADVANCING REGIONAL KNOWLEDGE (SPARK); PROGRESS, ONE YEAR ON

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Introduction: The Simulation Partnership for Advancing Regional Knowledge (SPARK) was formed in February 2016 and represents partnership working across North East Yorkshire and North Lincolnshire. The group joined forces to enhance and strengthen simulation partnerships across the region. The group meet quarterly, across Hull, York, Scunthorpe and Scarborough to explore ideas and models to enhance simulation based delivery. SPARK has now approached its first anniversary which provides opportunity to look back on the achievements of the past year.

Methods: The last 12 months have been busy for SPARK as the group have focused on creating its identity and agreeing the priority projects. The first task was to raise the profile of SPARK, our website was created www.spark-neynl.org.uk and Twitter page @SparkNEYNL to enable us to communicate together as a group and with individuals who have an interest in SPARK across the region as well as creating newsletters to keep our followers up to date with latest news and developments. Showcasing our resources and educational capabilities was an important reason for setting up our website. Towards this end we commenced a regional Simulation Audit and gathered information of our regional centres and facilities. This is accessible via the SPARK website. To ensure high quality and consistency of our courses across the region we agreed to standardise the courses to ensure that the same is being delivered in each centre. We are proud to announce that our first SPARK badged course is the Chest Drain. It is hoped that this method will provide better value for our learners and more importantly a greater positive impact for our patients. Encouraged by the positivity of our first collaboration we are now working on the CVC insertion course. The group held its inaugural conference on Tuesday 23rd May 2017, Applying Human Factors for Improved Patient Safety, which was sold out (free event) and attracted national and international speakers.

Results: Website with resource platform, Twitter – 57 Followers, 5 Face to face meetings, SPARK badged Chest Drain Course, Regional Simulation Audit Document, Inaugural Conference
Conclusion- The group have had a successful first year and the quality of our simulation based education is improving through working together. Since the formation of SPARK; information from the partnering organisations is easily accessible through the website such as facilities and resources available in each centre. Our chest drain courses are now being delivered in the same manner which for the first time across our region is ensuring high quality and consistency.

Feedback Scale - 1 Poor, 5 Excellent	
Question	Mean Answer
1. The event was enjoyable	4.5
2. The content was relevant to my particular needs	4.4
3. I was satisfied with the event venue	4.7
4. I was satisfied with the organisation overall? (advertising, registration, reception, catering)	4.7

References

www.spark-neynl.org.uk

@SparkNEYNL (www.twitter.com)

10-5

ANIMAL TISSUE MODELS – A BEGINNER’S PERSPECTIVE

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Introduction-The HILS courses team were tasked with running a wet lab workshop as part of a Regional Tech Themed meeting organised by Health Education England in April 2017. When starting out in 2011 the team were challenged with learning how to create and set up models for the surgical training courses taking place within the centre. Six years on the team have acquired a vast array of skills in the creation of the models through self learning and observing at other centres. The workshop provided opportunity to share the knowledge and resources with other individuals interested in setting up their own models.

Methods-The courses team reflected on the level of expertise required for the animal tissue models. In addition to learning the models themselves the team soon realised that it was equally as important to follow animal tissue policies in terms of purchasing the meat, storage through to disposal. The team developed a presentation for individuals to provide an overview from a beginner’s perspective. Models range from using low fidelity custard abscesses and crushed foxes mints for debris to higher fidelity models dependant on the course. Prepping was discussed in terms of the equipment needed such as sharps bins, gloves, aprons, etc. Individual's were reminded that when prepping, handling and disposing of models, they should wear aprons and gloves themselves. There are many considerations into the safety and regulations of animal tissue, the team purchase from Medical Meats based in Rotherham, which is a trusted provider of meat used for clinical procedures; we are not able to bring in meat from a supermarket or any other source. A log of animal tissue has to be kept to detail where it was purchased from, how it was stored and disposed of, this is to ensure that the meat can be tracked back should there be any issues with it. We work in partnership with the provider who is able to meet our needs in designing more advanced models such as sewing in polyps.

Results-The workshop was well attended and provided opportunity for discussion with other clinical skills centre staff across the region, sharing advice and knowledge as well as meeting new colleagues with whom we could network with to ensure that best practice is adhered to.

Conclusion-The animal tissue models enhance the realism of surgical courses for our surgical trainees. The animal tissue is much more human like than models and manikins. Manikin replacement parts can be quite an expense therefore it is much more economical to use animal tissue for procedures where incisions and dissection is required. The team are now able to provide a beginners guide to animal tissue models and share knowledge/resources/best practice with others. The team aim to set up courses in the future to allow colleagues across the region to attend and learn the required skills.

10-6

IN SITU SIMULATION TO FACILITATE INTRODUCTION OF A NEW OBSTETRIC RAPID SEQUENCE OF ANAESTHESIA GUIDELINE

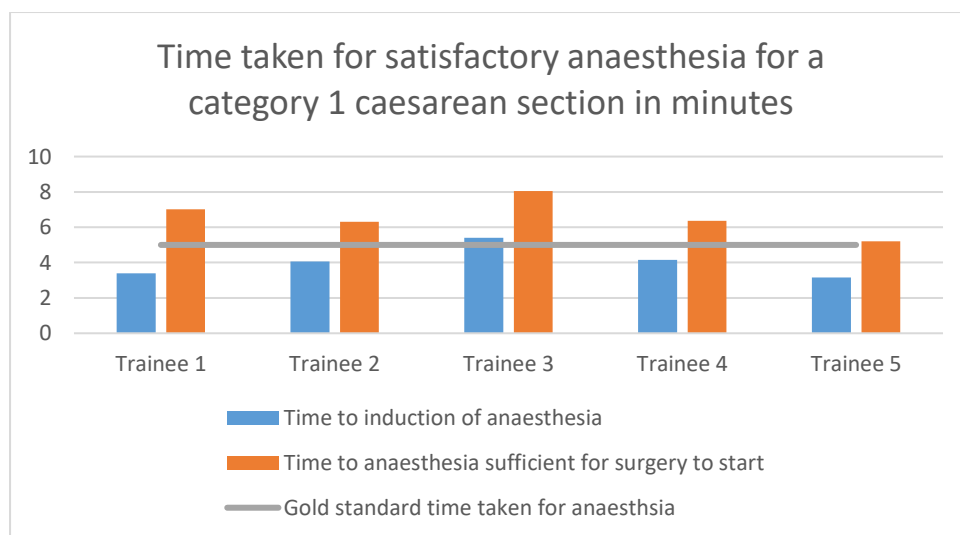
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Introduction: The recent Difficult Airway Society (DAS) guidelines indicated that there is an increased risk of awareness in obstetric patients undergoing general anaesthesia in the emergency setting¹. There is a nationally accepted classification of caesarean sections in terms of their urgency². A category 1 caesarean section means there is an immediate threat to life of the mother and/or foetus, therefore a caesarean section should be performed within 30 minutes of decision to proceed. As such we introduced a new guideline for use in our delivery suite and used in situ simulation to test its practical application, timing of general anaesthesia and highlight any potential risks to patient safety.

Methods: We conducted regional surveys regarding emergency obstetric general anaesthetic and this process was then reviewed at each step to determine how it could be improved. We applied the available evidence base to produce a comprehensive guideline which was widely circulated. Following this we invited trainee anaesthetists to participate in one-to-one in situ simulation scenarios to become familiar with the guideline and improve their skills. A high fidelity manikin was used in a real labour ward theatre and trainees were observed and timed throughout the process. A total of five trainee anaesthetists participated. They completed a pre and post simulation questionnaire feedback form.

Results: In the pre simulation questionnaire 80% of trainees were familiar with the new anaesthesia guideline and all of them expressed concerns about following the guideline, as it differed from their usual practice. The graph shows the time taken for trainees to achieve satisfactory general anaesthesia for surgery to proceed. All trainees failed to achieve satisfactory anaesthesia within 5 minutes, with a range of 5.21 to 8.04 minutes.



Following the simulation all trainees gave the session 100% in terms of usefulness, relevance and teaching.

Conclusions: This in situ simulation provided us with some findings for further development and training. It was useful to discover what aspects of the guideline trainees were apprehensive about so that we can tailor further teaching to address this. With regards to the time for satisfactory anaesthesia this aspect is critical for patient safety. Although all of our trainees failed to achieve anaesthesia in our 'gold standard' time of five minutes, it was the first time they had performed anaesthesia using this guideline and it highlighted areas of their practice they can improve on. We also must bear in mind that they were using a manikin, as opposed to a real patient and did not have a team presence to help them in their actions. Moving forward we aim to

DEMEC 2017 – abstract poster submissions : Category 10: Other

continue to run in situ simulation sessions to aid training, increase the number of trainees for our data collection and fundamentally improve safety for obstetric patients in our hospital.

References

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2. Lucas DN, Yentis SM, Kinsella SM et al. Urgency of caesarean section: a new classification. *J R Soc Med* (2000) **93**:346–50.

10-7

HUMAN ERROR IN PRACTICAL PROCEDURES

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Introduction & Aims: Doctors are required to achieve competency in a set of skills. Traditionally these have been 'learnt' on the job. The introduction of the European Working Time Directive has resulted, for UK doctors in training, in reduced patient exposure and supervision. With patient safety now at the forefront of our practise, the 'see one, do one, teach one' method of acquiring skills is no longer acceptable. The resulting lack of knowledge may then expose patients to harm. Procedural skills competence is important, but so is the knowledge of the impact human factor skills (HFS) has on patient safety. These skills are recognised factors contributing to mistakes (Rodriguez-Paz et al, 2009).

Our course design combines procedural skill teaching with HFS teaching. To our knowledge this is the first programme of its kind in the UK.

The aim is to provide an environment in which skill based competencies are integrated with HFS knowledge to allow skills to be performed without patient safety being affected.

Methods: The course accommodates doctors at any stage of their training. The morning consists of four practical procedures– chest drain, lumbar puncture, central line and nasogastric tube insertion, taught by an expert instructor providing real-time feedback to trainees. The skills chosen are based on Serious Untoward Incidences (SUI's) at our trust alongside consideration of emergency procedures. Consent processes, guidelines and identity checking are explored prior to practising each procedure. A maximum of 12 trainees per course ensures adequate time for hands-on practise.

The afternoon is spent understanding and exploring the impact of human factors on performing the procedures. Trainees are then encouraged to apply the human factor skills learnt to the procedural skills practised earlier in the day in order to explore ways to reduce error in practice.

Results: Data collection involves feedback from participants, asking specifically about whether the skills stations improved their knowledge and whether the afternoon session added to learning. Thematic analysis of the results show a self-assessed improved confidence in knowledge on performing practical procedures, with a greater understanding of the impact of human factors.

Conclusion: Combining procedural skills training and HFS learning improves trainee confidence in performing procedures and increases understanding about the human factors that contribute to procedural error and patient harm. This has the potential to improve patient safety. Our aim would be to run this course in the future. We hope to be able to perform a comparison study in order to fully assess any additional impact that this combined course has on reducing patient harm compared to a procedural course alone. In addition we hope to be able to collect in-situ data in order to conduct a level 3 Kirkpatrick evaluation.

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- Kirkpatrick, D. L. *Evaluating training programs: the four levels*. 3rd Edition. Williston: Berrett-Koehler, 2005.

10-8

FOUNDATION YEAR SIMULATION (FYSIM): FEEDBACK FROM COURSE PILOT AND BARRIERS TO PARTICIPATION

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Introduction: Simulation provides an effective means of delivering medical education within a safe learning environment, and it is increasingly included within postgraduate training programmes. We have developed a new medical simulation course for doctors at the end of Foundation Year 1 (FY1) in response to local demand. We have collected feedback from FY1 attendees at our pilot course and investigated barriers limiting attendance.

Methods: We have designed a simulation course (FYSim) based around the management of medical emergencies to assist FY1 doctors in achieving their learning outcomes as specified in the foundation curriculum, and to prepare them for their second foundation year (FY2). We collected written questionnaires from attendees at our pilot course in June 2016. As attendance was limited, we collected data on barriers to participation amongst the FY1 cohort.

Results: One course participant described FYSim as being “very useful in getting more practice of tricky scenarios before we begin FY2” and felt they particularly developed their ability to manage tachyarrhythmias, major haemorrhages and seizures. Attendees rated the course between 4/5 and 5/5 on Likert scales in helping them develop a range of non-technical skills. In summary, one participant describes a “superb course” and that “all should come” in order to best prepare for FY2.

We had 26 responses to the barriers questionnaire from a total cohort of 67 FY1s. The major barriers listed were in relation to service pressures and not having formal study leave:

Barrier to Attendance	Percentage of FY1s
Perceived difficulty taking time off wards	69.2%
No study leave	57.7%
Travel difficulties	34.6%
Other	19.2%
Lack of information	15.4%
Lack of interest in simulation	11.5%
Actual difficulty taking time off wards	11.5%
Not relevant to learning needs	7.7%
Fear of peer judgement	7.7%
Other non-clinical commitments	3.8%
Fear of faculty judgement	3.8%

Motivation was an issue, one FY1 describing themselves as “tired/jaded from unfulfilling ward work”. However, others regretted not being able to attend, stating “I would have loved the opportunity to do this”.

Conclusion: We have received positive feedback from our pilot course from FY1s who feel it fulfils its role of increasing preparation for FY2. A larger study will help to confirm this, and we have identified a range of barriers limiting attendance. These will be discussed within the medical education department to design a strategy to maximise attendance in the following year.

10-9

CHALLENGING SCENARIOS IN PRIMARY CARE – LEARNING OPPORTUNITIES FOR NURSES AND ALLIED HEALTHCARE PROFESSIONALS

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Background

The GP Education Unit secured funds to provide professional development and education sessions for qualified nurses, healthcare assistants and primary care allied healthcare professionals to develop or improve their skills in dealing with challenging encounters in the workplace. There is good evidence that simulated scenarios for clinical staff provide effective learning experiences. Our sessions focused on healthcare scenarios that were uncommon but challenging personally and/or ethically; for these reasons clinical staff may find them uncomfortable.

Summary of work

Session participants experienced simulated workplace scenarios such as: dealing with aggressive patients, safeguarding issues, staff bullying, whistle blowing and the collapsed patient. The sessions took place on site and were co-facilitated by two GP ST4 fellows from the Southampton GPEU and the Simulated Patient Team.

Summary of results

Bi-monthly sessions were planned from Spring 2016. Sessions were evaluated from the perspectives of all participants. Feedback from the Southampton City CCG area where we have run sessions to date, has been extremely positive and the facilitators have been asked to provide further sessions in the same practices for staff who were unable to attend. Bookings are also being taken from practices in the neighboring West Hampshire CCG region.

Conclusions

The sessions were found to provide a safe environment for staff to think through challenging situations and test out their reactions, in order to help them feel better equipped to deal with them when they do arise. Results will be shared in the poster and placed in the context of the literature.

Take home messages

Excellent healthcare depends on developing a caring, compassionate, highly-skilled and educated workforce, working in a supportive culture. This simulation pilot contributes to these aims by building on individual as well as team skill-sets, and promoting confidence in dealing with challenging scenarios in primary care.

10-10

SIMULATED INTERVIEWS: PREPARATION FOR GENERAL PRACTICE (GP)

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Background

Preparation for work is integral to a GP training programme. Almost all newly qualified GPs interview for a job just before or after completing training. Since 2012 we have run an annual, three-stage (written applications, short listing and interviews) simulated-skills interview process for a variety of primary care jobs.

Method

GPs and practice managers provide realistic simulated interviews. Constructive candidate feedback is provided for each stage. Candidates also act as peer-observers giving feedback on interviews.

We analysed feedback from 42 trainees from 5 interview simulations (2012-2017)

92% GP trainees report their last interview was between 3-8 years ago.

100% of all participants report the session as highly relevant and valuable

100% of ST3 trainees identify skills they would use in future interviews

GP Trainee participants:

- Value simulated interviews from Practice Managers and GPs who recruit regularly
- Learn how to adapt CV /covering letter for a range of jobs
- Discover the interview as a 2 way process *“you are selecting them, as well as they selecting you”*
- Recommend peer observers for sharing of skills and tips

Interview simulators:

- Feel hopeful seeing the talents of exiting GP trainees
- Value practising their shortlisting and interviewing skills
- Desire newly qualified GPs to contribute to local health workforce
- Envision new job roles through sharing of hopes and aspirations

Conclusion

Small group simulation is helpful in preparing trainees for the interview process

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10-11

IMPROVING SIMULATION DEBRIEFING FOR AN EFFECTIVE LEARNING EXPERIENCE

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Introduction: Simulation is widely regarded as a crucial part of learning development. Through creating experiences that mimic everyday events, participants are able to reflect on their actions within a safe environment. Debriefing is a guided reflection in the cycle of experiential learning. It is a powerful tool which is "the heart and soul" of the simulated experience.

The Dynamic Debriefing Course was introduced at Medway Maritime Hospital and designed to focus specifically on the debriefing aspect of facilitating a simulation. Our aim was to assess the experience of simulation facilitators within the Trust and how the course could aid in effectively running future simulation debriefing sessions.

Methods: We analysed demographic data, previous simulation experience and participants' expectations of the debriefing course by providing pre- and post- course questionnaires. This was followed by an interval questionnaire to assess the impact of the course one month later after having implemented the newly learnt debriefing skills. We collated the data and presented it using descriptive statistics.

Results: Fifteen participants undertook the Dynamic Debriefing course in March 2016 at Medway Maritime Hospital. All those who attended had run prior simulation sessions. 73% had attended a previous training course. The results showed an increase in confidence level in debriefing after the course. Overall the participants felt that their expectations of the course had been met. The interval questionnaire results demonstrated that participants felt debriefing was important in the clinical setting as well as after simulation and that the skills they had acquired would be beneficial for both. 80% expressed an interest in a Trust Wide debriefing tool to facilitate debriefing in the clinical setting.

Conclusion: Following our findings and a literature review on existing debriefing models, we created the 'STARS Dynamic Debriefing Tool' (see Figure 1) which was piloted at the second Dynamic Debriefing Course in February 2017. Participants reported that the tool was beneficial in providing structure and delivery to debriefing sessions.

The results show that the course gave participants more confidence to debrief effectively in future simulation sessions and provided them with skills that would be beneficial in the clinical setting. We plan to make the STARS Dynamic Debriefing Tool available on the intranet for use in simulation debriefing sessions throughout the Trust.

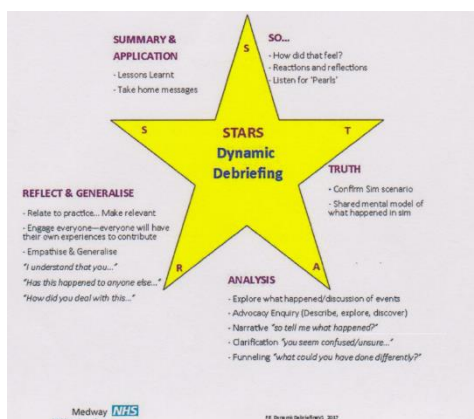


Figure 1. STARS Dynamic Debriefing Tool

Acknowledgements: We would like to thank Dr Felicity Brokke (Neonatal Consultant, Medway Maritime Hospital) for her guidance and support.

10-12

TELEPHONE TRIAGE: A WORKSHOP FOR THE GP TRAINEES

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Background

In recent years there has been a significant shift in consultation patterns which has seen more moving from face-to-face to telephone; this is both in practices and in OOH services which are designed around triage. Registrars need to have a sound and confident approach to consulting in potentially high risk working circumstances. There is variable opportunity for teaching and supervision in this area for registrars, and with the likely introduction of the Audio-COT, it is becoming more important to encourage development in this type of consulting.

Summary of work

To address this need an educational a day long session was designed for the ST3s with a specific focus on telephone triage (TT). The poster will give an overview of the session and evaluation: the morning explored the context of telephone triage and the afternoon comprised a 'mock' 6 case surgery specifically chosen to ensure the trainees were required to manage risk and demonstrate their awareness of the particular pressures of telephone triage. To add authenticity to the session simulated patients who were based at home were used. They were called back as would happen for telephone consultations, and the conversation relayed to the group of trainees and the facilitator.

Summary of results

The workshop was evaluated: post-session feedback was collected from trainees and again a month later. Consent was also given for the facilitator to access their reflective log entries written in follow-up. Trainees felt more confident to 'have a go' with a 'more positive attitude'. They found the session realistic. It was noticeable that the feedback one month later was qualitatively different. It changed from lists of skills to experiences; impersonal entries to personal and from using jargon to describing behaviour.

Conclusions

Telephone triage is becoming more widely used in primary care, thus would benefit from more research and education development.

Take home messages

Simulated telephone triage is a valued way of learning the skills and issues of telephone consultation.

10-13

'A DAY IN THE LIFE OF...' AN OPPORTUNITY FOR STUDENTS TO EXPERIENCE A HEALTHCARE CAREER

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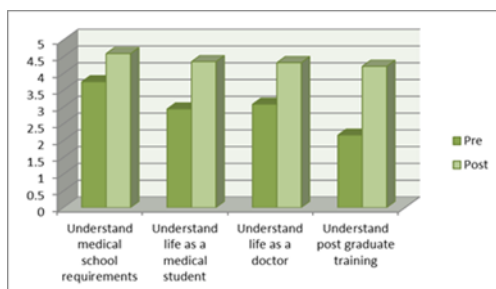
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Introduction: There is an increasing demand for work experience placements in the NHS for school students which often exceeds available limits (Hillage et al, 2001). Research has also found that work experience prior to entry into nursing was a stimulus to them pursuing a career in nursing (Wells et al, 2000). Therefore the HILS team created two separate courses, A Day in the Life of a Doctor and Midwife which gave students the opportunity to increase their knowledge of their chosen career from medical student level through to fully qualified staff. The aim of these courses was to give students a valuable insight into the healthcare career they were considering and enable them to make the decision of it is a career they want to pursue.

Methods: The one day courses were broken up into lectures in the morning and small group workshops in the afternoon. 57 students in total attended one of the two courses from 2014 – 2016. The course associated with doctors spent the first half of the day discussing medical school requirements, life as medical student, life as a junior doctor and simulation fellowship roles; bringing in doctors currently in these roles to share their experiences with the students. Day in the life of a midwife discussed university requirements, what to expect at interview and brought current student, community and hospital midwives in to expand on their roles. Some of the many workshops included airway/ ultrasound, auscultation of the heart and resuscitation. Each course finished with a simulated scenario, using SimMan/ SimMom as the patient and had students play roles such as student midwife or student anaesthetist. This allowed the students to practice some skills they had been shown in the workshops and assist the fully qualified staff while the rest of the students watched via video link.

Results:

- 56 from 57 students agreed that by attending the course it helped them make the decision regarding their career.
- All pre/ post course questions showed an increase in understanding on the Likert scale.



Conclusion: The course has demonstrated a great balance between informative lectures and engaging workshops to help students make informed choices regarding their future careers; and this is supported by the significant improvement shown for each question asked on the pre/post course questionnaires. Further courses will be added this year to cover the demand but also to prevent over crowdedness which would negatively impact the students learning. There are plans in the future to expand our courses to cover other specialities such as Physiotherapy.

References:

1. Hillage et al, 2001, Pre-16 Work Experience Practice in England: An Evaluation (Research Report RR263), Department for Education and Employment, London.
2. Wells et al, 2000, Journal of Psychiatric and Mental Health Nursing, Vol 7, Issue 1, 79-87.

10-14

IMPROVING ACTOR/ PATIENT RECRUITMENT FOR HILS COURSES WITH SUPPORT OF THE PIONEER TEAM ACADEMY

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Aim:

Our aim was to increase our patient and actor database for the training courses we run at HILS and define a recruitment process. We planned to do this through the trust funded Pioneer Team Academy as they gave expert knowledgeable advice with each step of our project, as well as financial support.

Method:

We attempted to build interest in the following ways: Created posters, flyers and a pull-up, then distributed them throughout the hospital and local colleges.

Visited medical outpatients and spoke with those visiting the clinics.

Visited school careers fairs to discuss the project with prospective students.

For those who signed up we created a basic induction which included a presentation, tour of the facility and an introduction to SimMan. Once completed, they were allowed to observe scenarios until they felt ready to act for HILS.

Results:

Working as the Pioneer Project team we have been very successful in achieving the majority of our objectives so far. Not only have we been able to recruit a sufficient number of actors and nurses to fill all the courses we are hosting this year, we are also oversubscribed with interest and continue to receive enquiries on a regular basis from prospective actors. This highlights the success of the promotional materials used for our campaign. We have attracted a higher calibre of actors through this programme as we recruited already professional actors, and have a much larger pool from which to select the most appropriate actor depending upon the course running. In order to continue to engage the actors we have implemented a policy of awarding certificates of recognition which we feel makes the programme mutually beneficial. Overall, not only has the project helped with actor and patient recruitment but it has also heightened the level of interest in what we offer as a department as a whole and the courses which we run.

Conclusion:

In order to develop and extend the project we have set objectives for the future. For the actor recruitment we aim to devise a full and comprehensive training programme which can be implemented. Within this programme we would like to design and develop the characters for each scenario so that the actors themselves are able to have input and are familiar with the roles they will undertake. For patient recruitment we wish to continue expanding the database so that we have sufficient numbers of patients available to allow us to take on extra courses and exams. To do this, we are working to establish a contact with a Consultant or Registrar within each of the main departments who will be able to help push recruitment in clinics and also triage the suitability of the patients being recruited.

DEMEC 2017 – abstract poster submissions : Category 10: Other

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10-15

HIGH-FIDELITY SIMULATION IN INTER-PROFESSIONAL EDUCATION WITH MEDICAL, NURSING AND PHYSIOTHERAPY UNDERGRADUATE STUDENTS

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Introduction:

High-fidelity simulation (HFS) is frequently used to develop the clinical and communication skills of undergraduate medical students. With the increasing emphasis on multi-disciplinary teamwork in healthcare, HFS has been identified as an ideal means by which students from different specialities can practise working together. Previous studies have demonstrated the educational benefits of combining medical and nursing students. However, despite evidence indicating a positive role for HFS in undergraduate physiotherapy education, limited research has evaluated simulation combining medical, nursing and physiotherapy students.

Methods:

145 undergraduate students (26 physiotherapy, 54 medical, 65 nursing) at King's College London participated in a HFS interprofessional (IPE) programme. Each session involved students from at least two specialities undertaking a simulated clinical scenario whilst being observed by their peers via video link. To assess student perceptions, students completed the previously validated KidSIM ATTITUDES questionnaire before and after their session. A 5-point Likert scale was used to rate 30 statements related to five domains. Results were analysed using a mixed 2-way ANOVA.

Results:

Physiotherapy students reported less prior simulation experience (11.5%) compared to medical (32.1%) and nursing (48.4%) students. There was a significant difference in pre and post questionnaire responses for each speciality with students more strongly agreeing with statements following simulation (each domain; $p < 0.001$). However, compared to medical and nursing students, physiotherapy students had significantly less positive perceptions of the relevance of simulation (medical $p < 0.001$; nursing $p < 0.01$) and the importance of effective communication (medical $p < 0.01$; nursing $p < 0.001$). They were also significantly less positive regarding opportunities in IPE ($p < 0.05$), roles and responsibilities ($p < 0.01$) and situation awareness ($p < 0.01$) compared to nursing students only.

Conclusion:

Following participation in HFS, undergraduates from all three disciplines reported more positive perceptions regarding the role of simulation as a teaching modality. The less positive views expressed by physiotherapy students may partly reflect their reduced prior exposure to simulation. The results of this study highlight HFS as a valuable means of delivering IPE and support an increased exposure to simulation for all three specialities especially physiotherapy students.