

which recommends in-situ simulation in obstetric units to promote safety [2]. With the recent change of speciality training curricula, especially in anaesthetics, there has been an increased requirement for simulation-based training. However, the COVID-19 pandemic has had a significant negative impact on medical training, both in terms of clinical breadth and opportunities for educational activities [3]. In order to tackle all these requirements, we developed an in-situ multidisciplinary obstetric simulation programme.

Methods: This was supported by the anaesthetic simulation fellow, obstetric anaesthetic lead and fellow and obstetric safety fellow, together with senior midwifery input. This allowed simulation development, running and debriefing to benefit from the skill and experience of a multidisciplinary team. The local simulation centre provided technical support which allowed us to take the simulation to multiple locations on the labour ward. Learners were from anaesthetic, midwifery, theatre, and operating department practitioner backgrounds and we conducted this simulation programme as three-monthly sessions corresponding with trainees' rotations. The scenarios were based around previous critical incidents while ensuring the psychological safety of the candidates. This demonstrates an open learning culture where lessons learnt can be shared and patient safety prioritised. It was also useful in applying a systems approach to understanding how errors occurred.

Results: Feedback confirmed the in-situ aspect of this session provided experiential learning and improved familiarity of the environment. This was especially pertinent as the sessions were conducted with trainees new to the department. It also allowed midwifery and theatre staff to take part in the session who otherwise may not have. A multidisciplinary approach allowed flattening of team hierarchy as shown by feedback. We ensured challenges associated with in-situ simulation were met with the team ready to respond to clinical needs in the department. No simulated equipment or medication was used and all documentation was labelled appropriately.

Conclusion: Obstetric emergencies can be life changing and can significantly affect those involved. This simulation session addressed several learning needs while rising to the challenges of in-situ simulations. We hope to continue developing this programme with more specialities represented and integrating learning from critical incidents while ensuring psychological safety.

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RESPIRATORY EMERGENCY SIMULATION TEACHING (REST) IN A MULTIDISCIPLINARY TEAM (MDT)

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Background: During the COVID-19 pandemic our respiratory high dependency unit (RH DU) increased bed capacity by 200%,

recruited new staff to provide high flow nasal oxygen (HFNO) and continuous positive airway pressure (CPAP) support, and was relocated within the hospital. This created the need to upskill new staff to provide level 2 care to sick patients in a new environment [1]. We aimed to provide training to nurses, healthcare assistants (HCA), and junior doctors on RH DU via a multidisciplinary (MDT) simulation programme to manage deteriorating respiratory patients. We also aimed to identify gaps in learning, policy, and procedures due to the relocation of RH DU.

Methods: The pilot included 22 sessions of in-situ simulation, run weekly by a core faculty including a respiratory consultant, ward sister, senior HCA, and clinical educator. All scenarios focused on MDT working with effective assessments and handovers.

Results: All staff members on the ward wore the same scrubs making it challenging to identify the job role or seniority of staff, and this was noticeable during the simulations. Coloured lanyards identifying job role were purchased and are now worn by all RH DU staff. An anaphylaxis simulation identified a time delay in finding the key to access emergency medication. A key safe has been purchased by the ward to house this key, ensuring it is always available in an emergency. The themes identified were: an increase in the confidence, competence, and knowledge of the MDT in recognising, responding, and treating medical emergencies. It also developed the working relationships between MDT members by highlighting the skill set of different professions, allowing for an exchange of knowledge across all working levels.

Conclusion: Simulation is an excellent resource in problem solving and teaching. It provides a safe place to practise new skills and breaks down the barriers to effective communication within the MDT by creating a cohesive learning environment. Simulation must be an ongoing development for staff to ensure that skills are honed resulting in the best outcomes for our patients in an acute emergency. A monthly training programme has been developed consisting of four hours of simulation-based training using different levels of fidelity. We will continue to employ the use of MDT working to reflect real life working conditions based on the success of this pilot.

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SIMULATION FOR PRECEPTEE PHYSIOTHERAPISTS READINESS TO PRACTISE

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Background: The COVID-19 pandemic has significantly impacted the clinical placement experiences of undergraduate Physiotherapists [1], many of whom started working as preceptee Physiotherapists shortly after qualifying in 2021. Consequently, it was important to provide training in the key skills required to work within an acute inpatient setting to preceptee Physiotherapists starting at an acute NHS Trust in 2021.

A one-day simulation course was developed to expose preceptees to common scenarios occurring in clinical practice to increase their confidence in managing these situations.

Methods: Six simulation courses were delivered with 22 preceptees each attending a single course. The course started with a group tactical decision exercise to develop caseload management skills. Participants took part in a simulated multidisciplinary team (MDT) ward handover and were provided the opportunity to gather more information from MDT colleagues, simulated medical notes, and admission systems to help them prioritise their simulated caseload. Participants then used this information to make decisions regarding the prioritisation of their simulated workload. The influence of information on participants' decision-making was then discussed. Participants subsequently undertook five high-fidelity scenarios in pairs; examining themes of discharge planning, managing an unwitnessed fall, the acutely unwell patient, conflict resolution, and acute confusion management. Each scenario was followed by a faculty-led debriefing to facilitate learning through discussion and reflection.

Findings: Participants completed a self-rating questionnaire based on the 5-point perceived self-efficacy scale before and after course attendance. It evaluated confidence and competence in aspects of inpatient care. Overall self-rated confidence and competence improved post-course in all question categories.

Significant differences ($R > 0.5$) were seen for self-rated confidence in managing a ward handover (1.2), prioritising daily workload (0.6), communicating with the multidisciplinary team (0.6), communicating with patients and relatives (0.6), and responding to unpredictable workload and environments (1.2).

Significant differences were also seen for self-rated competence in managing a ward handover (0.9), prioritising a daily workload (0.5), and responding to unpredictable workload and environments (0.8).

Free text analysis of participants' course key learning points identified themes surrounding confidence in own abilities, escalation, and communication.

Conclusion: Simulation-based training was effective in enhancing confidence for preceptee Physiotherapists in managing aspects of acute inpatient care. Further work is required to establish its utility in addressing competence. The development of preceptee simulation training for multi-professional groups is also required. For 2022, a joint Physiotherapy and Occupational Therapy preceptee induction simulation course is planned.

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WHERE DO I START? INTRODUCING SIMULATION IN A HOSPICE ENVIRONMENT

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Background: Simulation is widely recognised as a safe, valuable learning modality [1]. However, it is greatly

underutilised in End of Life (EoL) care [2] where the majority of learning has been theoretical. A plethora of challenges exist around introducing a simulation programme in a hospice environment, both organisational and psychological [3], including implementing a new idea at a time when healthcare workers are experiencing unprecedented levels of burnout following a pandemic. As part of a one-year project funded by Health Education England, we sought to create and introduce a comprehensive simulation-based programme for rollout across the Hospice with clear benefits and relevant subject matter that engages our wide range of MDTs as well as non-clinical staff.

Methods: Posters were used to begin to introduce the concept of simulation. A mixture of questionnaires, interviews and online sessions were held to establish current knowledge and views of staff on simulation-based learning. Time was set aside to thoroughly outline the project and its benefits to teams throughout the Hospice, clinical and non-clinical staff.

Results: Questionnaire results from 52 respondents show that 35% of staff had no knowledge of simulation prior to the information given as part of this project. Despite this, when simulation was explained more clearly, all respondents felt that they would be able to gain something positive from introduction of a simulation-based programme as shown in Figure 1. There was very little in the way of negativity towards the introduction of simulation, with only 1.9% of respondents citing that they felt 'disinterested' by the project.

Figure 1

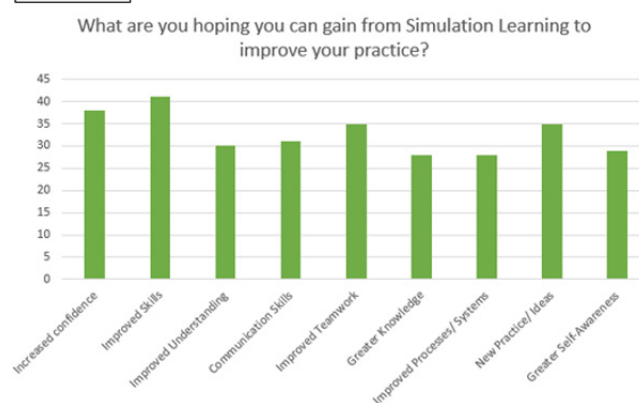


Figure 1: Participants' response to the question: What participants expect simulation-based learning to improve in their practice?

Conclusion: Teams amongst the hospice recognise that simulation provides a valuable learning opportunity. By ensuring understanding of the project, encouraging involvement of all teams, and recognising their unique concerns, thoughts and pressures, it is possible to implement a successful simulation-based programme in the Hospice environment leading to quality improvement in End-of-Life care.

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