

DESIGN

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MANAGING TRANSITIONS FROM CAMHS FOR PEOPLE WITH AUTISM SPECTRUM DISORDER (ASD) – INTERACTIVE SIMULATION TRAINING COURSE

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Background and aim: Transitions from CAMHS services to adult mental health care present a challenge to patients, carers, and professionals alike and are often managed poorly by services, leading to avoidable anxiety and adverse experiences for service users [1]. For patients with autism, transitions can be extremely distressing and require careful consideration and planning to ensure continuity of care. There is a lack of clarity for professionals and services users about what resources are available and appropriate for people with autism. This course is designed to provide professionals working in both CAMHS and adult mental health with a better understanding of autism and introduce strategies to improve the management of transitions and care of individuals with autism.

Methods: Maudsley Learning, in collaboration with the ESTIA Centre, offered an online simulation training program on two occasions. The course aimed to provide participants with a clinical understanding of autism and autistic persons' lived experiences, to equip participants with person-centred strategies to support individuals with autism, address the challenges faced by autistic individuals during child-to-adult transitions, and implement strategies to improve the care of individuals with autism who have co-morbid mental and physical illnesses.

The training began with group icebreakers and a didactic introduction to simulation training to establish psychological safety followed by five scenarios covering different aspects of ASD and the challenges faced by individuals with ASD during transition. To add higher fidelity and better learning experience, we involved actors with autism and intellectual disability. The Maudsley debrief model was used to provide constructive feedback to participants on their contributions and facilitate positive learning experiences.

Participants completed a questionnaire before and after the course assessing their confidence in skills related to the course. They also provided qualitative feedback on their experience and their willingness to apply their learning.

Results: Paired samples t-tests did not find a significant difference in scores for course-specific questions between pre-course (M =16.75 SD = 2.50) and post-course (M = 20.25, SD =.50), $t(2.64)=3$ $p >.005$, 95% CI [-7.70,.70]. 100% of the participants reported that they would recommend the course.

Conclusion: This course was co-produced and involved actors with autism and intellectual disability for better learning. The score improved slightly, but not significantly due to a small number of participants. All participants found the course helpful for their clinical practice and would recommend it. The course is best conducted in-person for optimal learning experiences.

Ethics statement: Authors confirm that all relevant ethical standards for research conduct and dissemination have been met. The submitting author confirms that relevant ethical approval was granted, if applicable.

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CONTENT

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THE IMPORTANCE OF HUMAN FACTORS AND THE IMPLEMENTATION OF THE 'SOCIAL GRACES' IN SIMULATION TRAINING: A 6-MONTH REVIEW OF FOUNDATION SIMULATION TRAINING AT GUYS AND ST THOMAS' (GSTT) NHS FOUNDATION TRUST

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Background and aim: Traditionally the focus of simulation has been centred on clinical management. More recently there has been a drive to enhance training on 'human factors' [1]. In simulation, human factors can be challenging to replicate, particularly with regards to how individuals interact within a system.

At GSTT we introduced a concept known as 'social GRACES' into simulation training. Social GRACES, first described by John Burnham in 1992 [2], outline a framework to understand an individual's personal and social identity.

An abundance of research into the development of human factors skills exists in the literature. Our aim was to integrate social GRACES into our simulation programme as a novel approach to engage trainees with human factors.

Methods: Between October 2022- April 2023, there were 23 full-day simulation training days. The course started with an introduction on human factors and the social GRACES. This was followed by a 'lost at sea' activity where trainees worked individually and in teams to prioritize the items they would take if lost at sea. This was followed by 4 clinical scenarios with debriefs related to clinical management, human factors and social GRACES. Pre and post course questionnaires were disseminated, and delegates were consented for data being used for quality improvement. Unique identifiers allowed for paired data analysis.

Results: 101 pre-course and 138 post-course feedback forms were received. To allow for paired analysis, only completion of both questionnaires was included, leaving 83 responses. There was a statistically significant increase in the percentage of responders who strongly agreed they felt confident in recognizing (7.2%-35.2%), assessing (15.7%-43.4%), managing (3.6%-20.5%) and escalating care (15.7%-35%), in acutely unwell patients. Additionally, confidence improved in understanding the impact of human factors in delivering care (9.6%-35%) and the performance of healthcare professionals (9.6%-39.8%). We explored confidence with regards to the practical implementation of human factors in healthcare (Table 1-A40).

Conclusion: The results demonstrate that the interplay between managing acute clinical scenarios & human factors can effectively be taught through simulation and enhanced with an understanding of social GRACES.

An increased understanding of human factors and simulation training was useful in improving 3 crucial skills; teamwork,

communication and leadership, which are instrumental in improving clinician confidence and patient outcomes. Future direction should look to include awareness and implementation of human factors within mainstream simulation to effectively replicate real time clinical scenarios & pressures.

Table 1-A40: 10 questions were devised to assess confidence relating to practical aspects of human factors in healthcare with regards to teamwork, communication, and leadership. Following paired data analysis, we found a statistically significant improvement in confidence in all areas investigated.

Question – On a scale of 1-10 rate your confidence in: -	Pre course	Post course	p value
Constructively managing others' negative emotions at work	6.1	7.8	<0.001
Requesting help from colleagues in other professions	8.0	8.6	<0.001
Communicating effectively with a colleague with whom you disagree	5.9	7.6	<0.001
Prioritizing when many things are happening at once	6.2	7.9	<0.001
Speaking up as part of a team to convey what you think is going on	6.2	8.2	<0.001
Involving colleagues in your decision-making process	7.4	8.3	<0.001
Dealing with uncertainty in your decision-making process	6.0	7.5	<0.001
Asking other team members for the information I need during a busy ward environment	6.8	8.0	<0.001
Recognizing when you should take on a leadership role	6.0	7.9	<0.001
Monitoring the 'big picture' during a complex clinical situation	5.8	7.7	<0.001
Anticipating what will happen next in clinical situations	5.7	7.6	<0.001
Working effectively with a new team in clinical situations	6.6	8.1	<0.001

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TECHNOLOGY

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IMPLEMENTATION OF VIRTUAL CLINICAL EXPERIENCES FOR MYANMAR MEDICAL STUDENTS: A PILOT ROLLOUT OF REMOTE-SYNCHRONOUS SIMULATION

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Background and aim: Severe disruptions have plagued Myanmar's undergraduate and postgraduate medical education – firstly with the Covid-19 pandemic and later with a military coup d'état in February 2021. In the wake of the current humanitarian and political crisis, many medical students partaking in civil disobedience have been driven underground for fear of retribution. Foregoing bedside teaching and crucial clinical learning opportunities in hospitals – for online education through teleconferencing and live broadcast via social media. To scale up these efforts the Global Health Education Group's (GHEG) novel XR platform was piloted to provide remote clinical experiences streamed to Myanmar students with the help of diaspora doctors and virtual patients in the UK [1].

Methods: The pilot held over a 4-day period in February comprised 4 Virtual Clinical Experience (VCE) sessions each covering two simulated patient scenarios related to the following disciplines: Medicine, Surgery, Obstetrics and Gynaecology, and Paediatrics. Each session had an introductory, consultation, and debrief phase that ran for 1.5 – 2 hours altogether. This was held on GHEG's newly developed Virtual CP platform [2], which enabled the students to view a live stream of the consultation with the patient-actor through the clinician's smart glasses and provided the opportunity for real-time interaction.

Results: The sessions were successfully delivered to 400 students from across 5 Myanmar Universities. The student's satisfaction was assessed using an anonymous feedback form that was disseminated; a total of 38 responses was obtained which was overwhelmingly positive. 76.3% of the respondents rated the session to be 'helpful' or 'extremely helpful' and 68.4% rated the session to be representative of a real clinical experience. On a scale out of 10, 57.8% of respondents rated the VCE platform a 6 and above on ease of use. Technical difficulties did arise affecting 68.4% of respondents, although free text feedback purported they were promptly addressed in subsequent sessions.

Conclusion: Synchronous remote learning through virtual clinical experiences can be used to address the dearth of clinical opportunities afforded to medical students in Myanmar.

Ethics statement: Authors confirm that all relevant ethical standards for research conduct and dissemination have been met. The submitting author confirms that relevant ethical approval was granted, if applicable.

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2. <https://www.gheg.org/virtual-clinical-experiences>

DESIGN

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A PALLIATIVE CARE SKILLS STUDY DAY IS AN EFFECTIVE WAY OF MEETING PALLIATIVE CARE REGISTRAR CURRICULUM DIRECT OBSERVATION OF PROCEDURAL SKILLS (DOPS) REQUIREMENTS

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