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Background and aim: The new Speciality Training curriculum for Palliative Medicine from August 2022 identifies key procedural skills that, for the first time, can be performed in a simulation (SIM) skills lab to demonstrate proficiency [1]. These include tracheostomy care, managing non-invasive ventilation (NIV) and the management of indwelling ascitic drains. These skills can be difficult to acquire in non-hospital settings like hospices and in the community. A bespoke, pilot palliative care skills day was organized to assess the suitability for theory, skills training and subsequent opportunity to demonstrate proficiency by sign off against curriculum competencies.
Methods: A total of 11 palliative care trainees from the Northern Deanery attended a pilot SIM study day in March 2023. Three parallel workshops were planned – tracheostomy care, the insertion and management of ascitic drains and managing NIV. Each workshop was delivered by local experts in the area (non- palliative care professionals) with experience of teaching and training other professionals. assessing internal medicine trainees. Trainers were briefed on learning outcomes prior to the session by two palliative care consultants, and the clinical context of each session was set within relevant palliative care environments for e.g. the care of a patient in a hospice, in the community or in a hospital.
Trainee confidence was assessed before and after SIM training with the use of 10-point Likert scales and free text comments.
Results: Overall self-reported trainee confidence and competence scores increased for all three workshops (Paracentesis 7 to 8.8 out of 10, NIV 4.5 to 8.6, tracheostomy care 3.8 to 8.9). All trainees agreed it was an effective and educational way of addressing curriculum objectives; and agreed it should be a rolling programme offered regionally. Trainees commented on the positive learning environment, the small group sizes, the benefit of being taught by experts and having the opportunity to be assessed for curriculum requirements. Trainees who had previously achieved competencies commented on the benefit of refreshing skills. One area for development identified was the lack of standardization on DOPs forms about the level of proficiency required. This will be fed back to the regional training committee for the future. Trainees identified further clinical skills that could be addressed in a skills lab and hence, a second skills day will be organized.
Conclusion: SIM training is an effective tool for delivering training around procedural skills for palliative care registrars. It also brings opportunity to demonstrate proficiency in specific practical skills.
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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EDUCATION

A43 MAGIC – THE MANAGEMENT OF ACUTE EMERGENCIES IN GP SURGERIES USING *IN SITU* SIMULATION AND CHECKLISTS, PROJECT FINAL PHASE: COMPLETED QUICK REFERENCE HANDBOOK AND PLANS FOR SUSTAINABILITY

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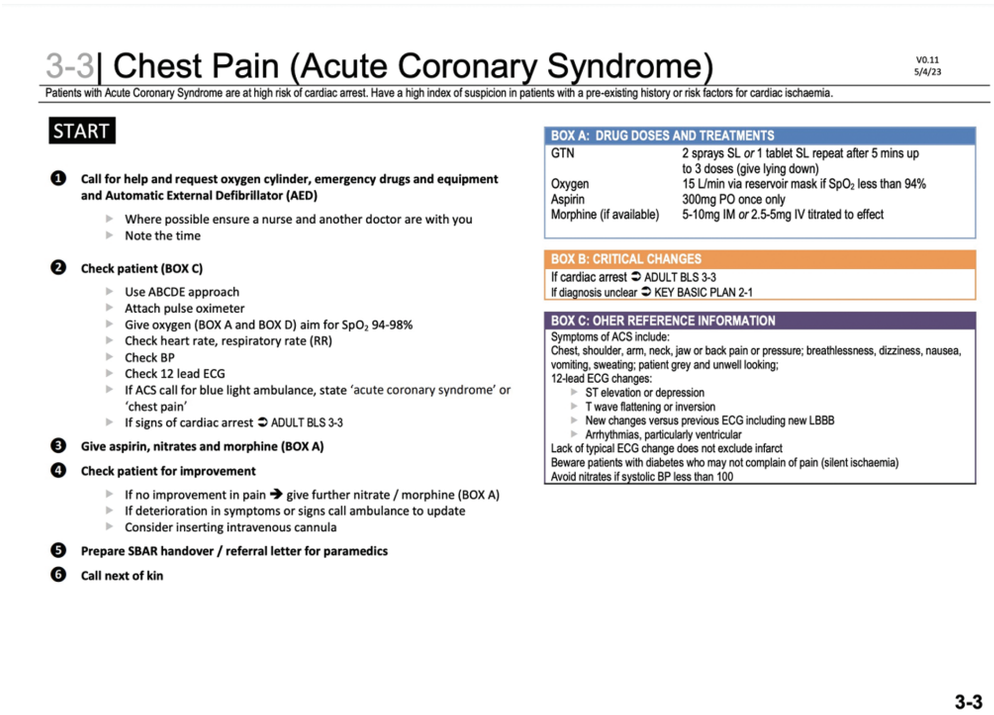
Background and aim: GP teams manage a wide spectrum of acutely unwell and deteriorating patients, these are unexpected, high risk, low frequency events. Ambulance delays mean patients may need prolonged input prior to transfer. There is little best practice guidance for many emergencies seen in primary care. Evidence from secondary care shows improved non-technical skills when checklists are used in emergency simulations.
We have previously presented early phases of the MAGIC project to design a Quick Reference Handbook (QRH) for GP teams and now present the final handbook along with plans for embedding it in primary care.
Activity: Previous presentations at scientific conferences (ASPiH) covered the Delphi process used to develop the QRH and the pilot training programme incorporating in-situ simulation. We incorporated feedback from 14 GP teams who used the checklists in the context of in situ simulations and used a round of tabletop simulations at six GP practices to finalize the checklists in the handbook.
The development process was guided by the 'CLEAR' principles proposed by Greig et al [1] and the design of the QRH for anaesthetic emergencies [2] which followed human factors principles.
Since completing the GP QRH we have been focusing on plans for sustainability. The QRH will be incorporated into in situ simulation or tabletop exercises [3]. We have written standardized 'MiniSim' scenarios using low fidelity techniques and accompanied by the relevant checklist. They will be uploaded on the iRIS platform to ensure ease of access. We are working with colleagues in GP training hubs around the HEE South-East and South-West regions to embed the QRH and then share the work nationally.
Findings: We have completed a GP QRH including 16 checklists: fourteen to guide clinical actions in acute conditions (Figure 1-A43), one to be used when the diagnosis is unclear, and one to aid non-clinical staff. Additionally, we have included guidance on the use of equipment (e.g. oxygen cylinders and AED) and supporting documents including emergency scoring systems (e.g. NEWS), normal physiological values in children, and a recommended medication and equipment list. These checklists will be made freely available. Feedback on the QRH and in-situ training to date has been universally positive.
Conclusion: Checklists improve non-technical skills and team performance in emergency situations. We have developed the world's first GP QRH to support safer care of emergencies in primary care. The GP QRH will be freely available together with training materials to embed it in practice.



3-3| Chest Pain (Acute Coronary Syndrome)

V0.11
5/4/23

Patients with Acute Coronary Syndrome are at high risk of cardiac arrest. Have a high index of suspicion in patients with a pre-existing history or risk factors for cardiac ischaemia.

START

1. **Call for help and request oxygen cylinder, emergency drugs and equipment and Automatic External Defibrillator (AED)**
   - Where possible ensure a nurse and another doctor are with you
   - Note the time
2. **Check patient (BOX C)**
   - Use ABCDE approach
   - Attach pulse oximeter
   - Give oxygen (BOX A and BOX D) aim for SpO_2 94-98%
   - Check heart rate, respiratory rate (RR)
   - Check BP
   - Check 12 lead ECG
   - If ACS call for blue light ambulance, state 'acute coronary syndrome' or 'chest pain'
   - If signs of cardiac arrest ➲ ADULT BLS 3-3
3. **Give aspirin, nitrates and morphine (BOX A)**
4. **Check patient for improvement**
   - If no improvement in pain ➔ give further nitrate / morphine (BOX A)
   - If deterioration in symptoms or signs call ambulance to update
   - Consider inserting intravenous cannula
5. **Prepare SBAR handover / referral letter for paramedics**
6. **Call next of kin**

BOX A: DRUG DOSES AND TREATMENTS

GTN	2 sprays SL *or* 1 tablet SL repeat after 5 mins up to 3 doses (give lying down)
Oxygen	15 L/min via reservoir mask if SpO_2 less than 94%
Aspirin	300mg PO once only
Morphine (if available)	5-10mg IM *or* 2.5-5mg IV titrated to effect

BOX B: CRITICAL CHANGES

If cardiac arrest ➲ ADULT BLS 3-3
If diagnosis unclear ➲ KEY BASIC PLAN 2-1

BOX C: OHER REFERENCE INFORMATION

Symptoms of ACS include:
Chest, shoulder, arm, neck, jaw or back pain or pressure; breathlessness, dizziness, nausea, vomiting, sweating; patient grey and unwell looking;
12-lead ECG changes:
- ST elevation or depression
- T wave flattening or inversion
- New changes versus previous ECG including new LBBB
- Arrhythmias, particularly ventricular

Lack of typical ECG change does not exclude infarct
Beware patients with diabetes who may not complain of pain (silent ischaemia)
Avoid nitrates if systolic BP less than 100

3-3

Figure 1-A43: An example of a checklist from the GP quick reference handbook

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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DESIGN

A44

SIMULATED PLACEMENT PREPARATION: PHYSIOTHERAPY STUDENT ACCEPTABILITY OF A MULTI-LEVEL SIMULATED PLACEMENT PREPARATION WEEK

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Background and aim: Practice based learning (PBL) remains a universal mandatory experience for physiotherapy students. Challenges of placement capacity were heightened by the impact of COVID 19 as well as growing demand in response to the NHS long term plan/interim people plan for growth in AHP workforce. These challenges provided opportunity to rapidly progress sustainable PBL capacity utilizing simulation as replacement and enhancement of PBL.

Having established simulation as placement replacement within the Faculty of Health & Wellbeing at University of Winchester [1], the simulated placement preparation (SPP) project aimed to explore the acceptability of simulation as preparatory enhancement of PBL, delivering a week of multilevel peer assisted simulated PBL; two primary objectives of reducing demand on capacity and optimizing students' success in PBL through preparatory simulated activities.

Activity: Simulation and learning focused on the development of digital capabilities in recognition of the Topol review that reflected the requirements of NHS workforce to be digitally capable [2]. Additionally, the KNOWSBEST study [3] recommended digital capability and simulation within PBL, thus simulated activities were designed to promote core digital capabilities including training and simulation in remote consultations and presenting simulated scenarios accessed via electronic patient records.

Collaborative learning in practice (CLiP) model of supervision was used to promote peer assisted learning with learning outcomes focused on communication and MDT domains of the common placement assessment form (CPAF), familiarization with digital technologies and orientation and management of scenarios in high acuity environments and enhancement of digital capabilities. The SPP week utilized mixed modality and fidelity simulated activities including 'real play' remote consultations, simulated patients, manikins/ventilators and virtual simulations.

Students completed faculty developed questionnaires pre and post SPP relating to self-assessed communication and telehealth capability and specific clinical competence in musculoskeletal and cardiorespiratory physiotherapy. A convenience sample of students participated in focus group interviews following subsequent completion of PBL to explore their perceived impact of SPP on subsequent PBL. Thematic analysis was used to analyse focus group interviews and pre-post anaylsis conducted using repeated measures ANOVA.

Findings: Results demonstrated increased capabilities in teleconsultation and appreciation of digital technologies