

Table 1: Student evaluation data from the simulated home environment assessment activity

Quality assessed	Mean Likert score (1 – strongly disagree, 5 – strongly agree)
Improve confidence	4.32
Improve communication skills	4.34
Improve reasoning skills	4.41
Improve decision-making skills	4.41
Helpful for professional development	4.46
More comfortable in completing home assessment to identify safety hazards and concerns	4.48
More comfortable to identify team members to meet the immediate and long-term needs of a patient with pain and limited mobility	4.48
The activity demonstrated the value of providing team-based home assessment education	4.54
Overall was a valuable educational activity	4.48
Simulation video portrayed the simulated environment well	4.5
Simulation video gave constructive indicators to identify patient characteristics and behaviours	4.53
Simulation provided an effective mechanism to learn home assessment using the INHOMES tool	4.52

Implications for practice: Our results demonstrate that a video-recorded simulated home environment event is successful in supporting the development of an inter-professional action plan for a home assessment using the INHOMES assessment tool. The collaborative creation of this event was essential due to the COVID-19 pandemic, but the efficacy for learning demonstrates the utility of this approach in the post-pandemic area. Virtual simulations increase accessibility for inter-professional learners to learn from, with and about each other for the benefit of our patients.

REFERENCE

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CAN 'POP-UP' STYLE SIMULATION TEACHING IMPROVE THE CARE THAT OUR CHILDREN AND YOUNG PEOPLE'S EMERGENCY DEPARTMENT TEAM PROVIDE FOR CHILDREN PRESENTING WITH FEVER?

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Background: We wanted to use simulation teaching to improve our multi-disciplinary team's (MDT) management of children who presented to our Children and Young People's ED (CYPED) with fever.

Aims: The aims of the study were: first, to use simulation teaching to train the MDT in our CYPED, to improve the care delivered to children presenting with fever, measured as an improvement in our compliance with the Royal College of Emergency Medicine's (RCEM) standards [1]. Secondly, to carry out the simulation teaching in a 'pop-up' style that can be

delivered to staff within their clinical shifts on the shopfloor, without disturbing their work or the functioning of the CYPED.

Method: For cycle one of our audits, we looked at a sample of 136 children who presented to our CYPED with fever; 61 patients met the inclusion criteria and were included. To improve compliance to the RCEM standards [1], we designed a 10-min, low-fidelity, simulation-based teaching session, requiring minimal resources. When staffing and acuity in the department allowed, we carried out 'pop-up' teaching in a spare CYPED cubicle. We ran four sessions, each lasting 1 to 3 h. Within these sessions, we ran the simulation 20 times, to 40 members of the MDT. To aid flexibility, we started each teaching session as and when staff attended. Following the teaching, staff self-rated their knowledge and ability to adhere to the RCEM standards on a 10-point Likert scale. To complete our PDSA cycle [2], we repeated the audit. We looked at a sample of 192 children, 87 met the inclusion criteria and were included.

Results: Staff's self-rated knowledge of the RCEM standards [1] improved from 4.4 to 9.3 and their self-rated adherence to the standards improved from 5.4 to 9.3, on a 10-point Likert scale. This was reflected in improved compliance to the RCEM standards 1–6 [1] in the second audit cycle. The compliance with RCEM standards (1) from cycle 1 to cycle 2 was as follows: standard 1; 71% to 79%, standard 2; 59% to 78%, standard 3; 38% to 92%, standard 4; 74% to 66% and standard 5; 100% both cycles. Standard 6 is that the CYPED should provide training in sepsis recognition, which was achieved through our simulation sessions.

Implications for practice: 'Pop-up' style simulation teaching can be used to improve the care that we offer our patients, as reflected by an improvement in staff's confidence and in the department's compliance with RCEM standards [1]. We endeavour to continue to use pop-up style simulation sessions within clinical shifts to continue to learn and strengthen as an MDT. In turn, we hope that this will improve the care that we offer our patients.

REFERENCES

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GENITAL EXAMINATION EDUCATION AND INSTRUCTION: LOWERING ANXIETY AND RAISING COMPETENCE

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Background: Gynaecologic Teaching Associate (GTA) and Male Urogenital Teaching Associate (MUTA) methodology have been utilized for decades in effective breast, pelvic and urogenital examination clinical skill instruction. This methodology is recognized as the gold standard of instruction when educating learners on the sensitive, invasive clinical skills techniques associated with a genital examination. While research shows it is the most effective way to learn these procedures, outside of the USA and Canada, there are few GTA/MUTA programmes at medical learning institutions.

Aim: This methodology aims to provide hands-on, standardized instruction in an anxiety-free environment where learners safely practice the clinical skills techniques of breast, pelvic and urogenital examinations and have the unique experience of learning these techniques from the patient's perspective.

Method: The GTA/MUTA is both instructor and live simulated patient, using their own bodies as teaching tools, guiding learners through examination techniques and providing instant feedback. With this unique opportunity for skills acquisition, learners receive step-by-step instruction on an actual person in a quality-controlled environment. In addition to correct palpation techniques, this patient-centred form of instruction addresses the emotional reaction patients may have to these examinations. GTA/MUTA instruction also includes patient education and communication and relaxation techniques. The GTA/MUTA patient empowerment methodology is designed to provide an anxiety-free atmosphere for the learner so that the sensitive nature of the genital examination and the embarrassment often accompanying the examination do not become an obstacle to acquiring safe, effective clinical technique.

Results: Decades of research prove that this method lowers learner anxiety and provides exceptional outcomes for learners in a multiplicity of learning criteria, including higher overall scores; superior communication skills; better ability to identify pathology; 'better interpersonal skills than physician trained with lasting effects that can be demonstrated after clinical exposure'^[1]; ability to conduct safe, genital examination techniques on patients after exposure to a GTA/MUTA instructor^[2].

Implications for practice: The methodology has far-reaching implications. The specialized skills of these individuals mean that the teaching method can be brought outside of the well-patient experience; sexual assault providers can practice the trauma examination on live simulated patients; remediation can be provided to practitioners who must relearn techniques to maintain licensure; learners are more empathetic to their patients and more inclined to include their patients in the examination process thus improving patient care. This methodology can be utilized in any setting where invasive examination procedures, patient education and communication must be mastered.

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ENHANCED RECOVERY AFTER SURGERY: MULTI-DISCIPLINARY HEALTHCARE SIMULATION TRAINING FOR PERIOPERATIVE TEAMS

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Background: Enhanced recovery after surgery (ERAS) is an evidence-based approach in perioperative care allowing patients to recover more quickly after surgery. The ultimate aim of this programme is to optimize organ function pre-operatively

and reduce the stress response from major surgery to aid in early recovery^[1]. The multimodal pathways utilize a wide range of staff from the multi-disciplinary healthcare team. Although medical staff such as senior anaesthetists and surgeons may be confident in implementing ERAS protocols and troubleshooting post-operative problems, this may not be the case for more junior medical, theatre and nursing staff. This is of particular relevance in smaller surgical units across the UK.

Aim: We aimed to provide structured and interactive simulation (SIM) training for staff involved in the management of colorectal surgery patients on the ERAS programme. Staff included operating department practitioners (ODPs), surgical staff nurses and anaesthetics senior house officers (SHOs). This was based at a small district general hospital (DGH) in the West Midlands.

Method: Staff were given hypothetical post-operative scenarios of commonly encountered surgical problems on the ward. These included hypotensive patients and the management of regional analgesic techniques such as epidurals. Sessions were commenced with a brief and targeted outline of relevant physiology, followed by a series of SIM moulages. A longer period of time was made available at the end of each SIM for debrief.

Results: Staff were more confident after SIM sessions in managing the acutely ill ERAS surgical patient. The multi-disciplinary nature of the scenarios was highly commended. Feedback from staff was encouraging, in particular, about how 'real' the scenarios felt. There was also increased awareness about the rationale behind the principles of the ERAS programme and healthcare staff felt it would change their practice. Feedback was measured through a series of pre- and post-SIM questionnaires.

Implications for practice: Through a series of SIM sessions and theatre shadowing, we aim to create an ERAS team and ERAS unit at the hospital. SIM will play a major role in addressing the learning objectives of junior medical staff, ODPs and nurses. The long-term goal is to safely manage these patients on a dedicated unit. We aim to create a safe environment where invasive monitoring can be used, and treatments such as vasopressors prescribed under the supervision of anaesthetists. This will ultimately improve patient care and help fulfil the core objectives of the ERAS approach.

REFERENCE

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EFFICACY OF A VIRTUAL MOCK TRIAL FOR INTER-PROFESSIONAL LEARNING

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Background: A medical negligence trial can be stressful for all involved and may be the first time in a courtroom for many health professionals. To provide students with the opportunity to learn from, with and about each other, the Mock Trial was established as an annual collaborative learning event between a local law school and our university-affiliated Office for IPE (Inter-professional Education). In 2021, Mock Trial was conducted virtually to continue high-quality IPE throughout the COVID-19 pandemic.