

**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

- Kendrick D, Young B, Mason-Jones AJ, et al. Home safety education and provision of safety equipment for injury prevention (Review). *Evid Based Child Health*. 2013;8(3):761–939.

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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

- Royal College of Emergency Medicine, Feverish Children Information Pack. National Quality Improvement Project, 2018/2019. Available from: <https://www.rcem.ac.uk/docs/QI%20+%20Clinical%20Audit/Feverish%20Child%20information%20pack%202018-19.pdf>
- NHS, Online Library of Quality, Service Improvement and Redesign Tools; Plan, Do, Study, Act (PDSA) cycles and the model for improvement, NHS England and NHS Improvement, 2021. Available from: <https://www.england.nhs.uk/wp-content/uploads/2021/03/qsir-plan-do-study-act.pdf>

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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.