

**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'<sup>[1]</sup>; ability to conduct safe, genital examination techniques on patients after exposure to a GTA/MUTA instructor<sup>[2]</sup>.

**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.

## REFERENCES

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2. Smith PP, et al. The effectiveness of gynaecological teaching associates in teaching pelvic examination: a systematic review and meta-analysis. *Med Educ*. 2015;49(12);1197-1206.

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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<sup>[1]</sup>. 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.

**Aim:** The aims of the study were to establish the efficacy of translation of a large-scale inter-professional malpractice Mock Trial simulation to the virtual platform and to determine whether this will be a useful modality once social distancing restrictions ease.

**Method:** The virtual simulation was structured using the brief-simulation-debrief model. Students participated as jury members via Zoom. A simulated courtroom held 11 participants of the trial (one judge, four law students [two defence, two prosecutions], five witnesses and one administrator) and was broadcast in real time to students. The learners first heard the case (opening statements, Plaintiff's case, Defendant's case, closing statements and jury instructions) before moving to IP jury break-out rooms with facilitator supervision to deliberate a verdict. Verdicts were delivered in the main room, followed by a debriefing. All students completed a pre-/post-questionnaire, including the Interprofessional Collaborative Competency Attainment Survey (ICCAS) and evaluation of simulation methodology, Mock Trial structure/content and overall impression. To assess efficacy, we compared student evaluations from 2018 and 2019 (in-person events) to those from 2021 (virtual).

**Results:** A total of 179 learners participated in three in-person Mock Trials; 143 attended the virtual offering. The virtual event included learners from 19 professions from 4 institutions and 12 facilitators. Evaluations assessed IPEC competencies. For the virtual Mock Trial, learners (96%) strongly agreed/agreed that 'this activity demonstrated the value of IP collaborative practice to prevent malpractice lawsuits' and 97% felt that this was a valuable educational activity. Representative qualitative data include: 'as a law student it was interesting to see what laypeople take away from evidence...'; 'watching the process provided insight into the litigation process'; 'the most valuable experience is hearing other people's perspective'.

**Implications for practice:** Large-scale virtual simulation events such as a Mock Trial are feasible and provide a valuable inter-professional learning experience. Student feedback demonstrates that gaining insight from different perspectives is a meaningful part of the experience. Incorporation of large-scale simulation events post-pandemic can increase accessibility to foster IP learning on a wider scale.

## REFERENCE

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### IMPROVING TECHNICAL AND HUMAN FACTORS SKILLS ON THE OLDER PERSON UNIT: AN *IN SITU* FRAILTY SIMULATION PROGRAMME

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**Background:** Awareness of symptoms associated with frailty is uneven across acute hospital staff <sup>[1]</sup>. Frail patients are more likely to suffer adverse outcomes; managing frailty requires an inter-professional, multi-disciplinary approach – for which simulation has been identified as beneficial in delivering education <sup>[2]</sup>. Given this, in addition to multiple incidents on wards highlighting a deficiency in both technical

and human factors skills, an *in situ* frailty simulation project was undertaken at a London teaching hospital.

**Aim:** The aim of the study was to evaluate the efficacy of *in situ* frailty simulation in improving both technical and human factors skills for ward staff.

**Method:** *In situ* simulation was selected to increase accessibility for staff and promote ward team learning. Sessions started in October 2020 on one ward, before moving across other wards. These 1-hour sessions have been delivered weekly with a hiatus due to the second wave of the COVID-19 pandemic. A bank of frailty-based scenarios has been created, ranging from acutely unwell patients to communication with families. Participants have been from across the multi-disciplinary team. Data were collected using pre- and post-session questionnaires – containing the Human Factors Skills for Healthcare Instrument (HuFSHI) and frailty-based knowledge questions with Likert scales. Learning has been disseminated through the department via newsletters.

**Results:** Thirteen sessions have been delivered with 59 participants (23 nurses, 20 doctors, 9 physiotherapists, 6 nursing assistants, 1 occupational therapist). Forty-nine surveys were completed – 100% of participants found the sessions useful. Post-training, staff demonstrated improvement of self-efficacy in 11/12 HuFSHI questions and all frailty questions (Table 1). The most common learning themes were communication (51%), teamwork (43%) and escalation (24%), as well as management of frail patients (35%). Working with the team (47%), the scenarios (18%) and debriefing (12%) were aspects learners most liked about the sessions.

**Implications for practice:** An *in situ* frailty simulation programme has been successfully implemented, leading to improved learner self-efficacy in both technical and human factors skills when managing frail patients. This has been well received amongst staff. In particular, the sessions have promoted interaction and teamwork within the multi-disciplinary team, which was liked by participants. The *in situ* delivery has allowed learning to occur without the need for staff release, widening access. Latent threats – such as missing airway equipment – have been identified during sessions and addressed. Moving forwards, funding has been secured for a departmental manikin alongside expanding our multi-disciplinary faculty.

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### ESTABLISHING AN INTER-PROFESSIONAL *IN SITU* SIMULATION (ISS) PROGRAMME IN DISTRICT GENERAL HOSPITAL EMERGENCY DEPARTMENTS (EDS)

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**Background:** *In situ* simulation (ISS) is an effective educational tool that improves patient safety outcomes <sup>[1]</sup>. It has been trialled previously in this trust but not regularly and many staff members had never participated. Anticipated challenges included freeing staff from clinical duties, scepticism about simulation training and technical issues.