By maintaining our in-situ simulation programme we hope to continue enhancing interprofessional learning and training within our department. In situ simulation can be easily setup by other teams to obtain similar rewards.

REFERENCES


SC2 INCORPORATING VIRTUAL REALITY SIMULATIONS INTO UNDERGRADUATE NURSING CURRICULUM

Molly Schleicher*. Oxford Medical Simulation, London, UK

10.1136/bmjstel-2019-aspihconf.36

There are many factors plaguing nursing programs at this time. Clinical sites can be difficult to find or manage; clinical instructors may be difficult to attain, train or retain; large class sizes become cumbersome for clinical faculty and simulation centers; the simulation centers are expensive to create, complete, and control. The research supports the value of simulation in clinical practice, but the resources are not always readily available: enter Virtual Reality (VR).

In a time where nurse educator shortages are affecting nursing programs, new technology can be used to fill the gaps, providing a holistic and effective educational experience to aspiring nurses. VR can be used to simulate patient care, allowing students to practice interviewing, communication, assessment, observation and intervention skills in a controlled and safe environment (Tilton, Tiffany, & Hoglund, 2015; Chia, 2013). Using VR as a supplement to traditional simulation-based education can enhance student motivation and engagement and create a more effective learning experience (Chia 2013, p.21). VR can be designed with relevant reference materials supporting the student’s continued education and likelihood to use resources in the professional or clinical setting (Chia, 2013). Because VR was originally created as a gaming platform (Hebda & Czar, 2012) it is a commonly accepted amongst the current generation of learners. Now, it is regularly thought of as an educational resource (Medical Futurist, 2018) but the question remains: what is the best way to incorporate it into an existing nursing curriculum?

There are many options which include using VR simulation scenarios in place of or along side existing live simulation scenarios or clinical experiences. VR can also used during or after lectures about the corresponding topic. Structured and graded VR scenarios can be used in training, remediation, as an exit exam, as a formative or summative evaluation, as a make-up simulation or clinical option and as a guide for faculty or program improvement.

The purpose of this short communication presentation will be to discuss the different ways in which VR can be incorporated into a nursing curriculum.

REFERENCES


SC3 THE USE OF CHECKLISTS IN SIMULATED SCENARIOS TO SUPPORT SAFE MANAGEMENT OF ACUTE ILLNESS IN PRIMARY CARE

Helen Higham, Anne Maloney, Petronelle Eastwick-Feld, Jo Lawrence, Paul Greig, Miss Rosie Warren. University of Oxford, Oxford, UK; Eastfield House Surgery, Newbury, UK; Royal Berkshire NHS Foundation Trust, Reading, UK; Brighton and Sussex Medical School, Brighton, UK

10.1136/bmjstel-2019-aspihconf.37

Background Evidence suggests that GPs are managing more acutely unwell patients in their practices. The RCGP curriculum for the care of acutely ill people includes:

- Recognising the signs of illness that require urgent intervention
- Acting calmly in emergency situations and following agreed protocols
- Working effectively in teams

Simulation based education (SBE) and the use of checklists in healthcare has been shown to improve outcomes in secondary care settings. It is reasonable to predict that teams in General Practice would benefit from similar training using realistic scenarios, supported by checklists created for primary care.

Summary of project Phase 1:

We designed a training programme for GP settings using three simulated scenarios of recognised emergencies: acute coronary syndrome (ACS); paediatric anaphylaxis and newborn bronchiolitis. The training was delivered in ten practices initially and feedback was collected.

Checklists to accompany the training were devised using a modified Delphi technique with an expert panel comprising GP multidisciplinary teams; consultants in emergency and respiratory medicine, anaesthetics and paediatric intensive care. The process was supported by observations made during the in-situ training and the template for checklists from the quick reference handbook (QRH) developed by the Association of Anaesthetists of Great Britain and Ireland (AAGBI - https://www.aagbi.org/safety/qrh/pdf-version-qrh ).

Phase 2:

Training in the use of the checklists has begun for the next group of 12 practices and a comparison between the training in phase 1 and phase 2 will be made using quantitative and qualitative methods.

Summary of results 172 multidisciplinary staff were trained in 20 practices from October 2018 to May 2019.

The process of developing the checklists was complete after six iterations over three months for three topics: ACS; anaphylaxis and bronchiolitis. The checklist for anaphylaxis is shown in figure 1.

Course feedback:

- 100% of practices reported treating a medical emergency in the past year
- 60% of practices reported a wait >20 mins for an ambulance called to an acutely unwell patient
- 100% of participants thought checklists were helpful and comments from the training have informed additional modifications.
- Free text comments from participants uniformly placed high value on the simulation training

Discussion Our results so far support the use of SBE and checklists as a useful tool to support the delivery of safe care
to acutely unwell patients in primary care settings. Further work is ongoing to complete a QRH for GP practices and to validate its use.

REFERENCES


DEVELOPING A MODULAR PROGRAMME FOR DOCTORS RETURNING TO TRAINING IN THAMES VALLEY

1,2Paul Greig*, 2,3Helen Higham, 4Tina O’Hara, 5Sandra Duncan, 5Andrew Jacques, 4Marc Davison. 1Guy’s And St Thomas’ NHS Foundation Trust, London, UK; 2University of Oxford, Oxford, UK; 3Oxford University Hospitals NHS Foundation Trust, Oxford, UK; 4Buckinghamshire Healthcare NHS Trust, Aylesbury, UK; 5Royal Berkshire Hospital NHS Foundation Trust, Reading, UK

10.1136/bmjstel-2019-aspihconf.38

Background At any moment approximately one in ten doctors in training are taking approved time out of their programme. Returning to training after a break from clinical work can be daunting, with many trainees expressing anxiety about readjusting to the workplace. Recognising this, the Department of Health allocated £10 million nationally to Health Education England to support doctors as they return to training.

Summary of education programme The educational programme in Thames Valley was developed collaboratively by a network of educationalists across our region. Trainees themselves had input into the design of the programme, and the educational materials provided.

We created a modular suite of activities incorporating technical and non-technical skills training orientated towards medicine, surgery, anaesthetics, critical care, paediatrics, and retrieval. Sessions cater to various learning styles, incorporating tutorials, skills workshops, and high-fidelity simulation. Sessions run quarterly throughout the year.

Summary of results To date we have trained 71 doctors; feedback has been excellent. Trainees particularly value the tailored range of educational activities provided, and 93% would recommend the programme to colleagues.

We also collect data from trainees after they have returned to work. Thus far only 5 trainees have returned to work and provided us with feedback. They reported benefit from the training, particularly highlighting the practical aspects such as emergency drills and simulation.

Discussion The training is valued by our participants, but barriers to delivery exist. The main challenge has been identifying eligible trainees to invite. Our most successful publicity has been trainee-driven via social media, as it has been difficult to compile comprehensive contact lists from centrally held data. New communication strategies are in place via Training Programme Directors and Educational Supervisors to better advertise these resources.

Some participants also reported that they found it difficult to arrange childcare to cover these sessions, and Health-education Thames Valley have generously provided additional funding to provide crèches at some modules. This has been highly popular with those returning from maternity leave and this has been a decisive factor in some trainees’ attendance.

Conclusion Targeted, bespoke training designed for returning trainees is a national priority, and highly valued by trainees.