model was created in the RCSI Simulation & Clinical Skills Department. The model was further developed for use on alternative parts of the body.

Summary of education program or project

The model provides a visual aid for learners to interact with the basic principles of NPWT. The model was created mainly using low cost items, black/coloured foam, liquid latex, silicone, zip-lock bags, oxygen supply tubing, suction machine, wattright dressing and moldable splint material to form the desired shape of the body part. Step by step photos and notes were taken of each stage of development. These stages will make up the main body of the presentation.

Summary of results

This model can be used for various scenarios and creates a relatively realistic simulation of the NPWT in practice for a low cost and effort. This model can be adapted for use on various parts of the body as required. The adaptability of the model allows for it to be used in other courses, both within RCSI and externally. Costing comparisons between this model and the leading brand single use version will be included in the presentation.

Discussion

The model can be evolved to replicate NPWT on various body parts. RCSI used the model on its SimMan mannequin, but this model could be easily be used on a human surface model or as a stand-alone item.

Conclusion

This short presentation will discuss the method of producing a multi-usage NPWT simulator for educational and demonstrative scenarios.

Description of the model

With the input and expertise from the surgical faculty, important steps were taken to maximize the fidelity of this biological model. The model was created in the RCSI Simulation & Clinical Skills Centre and has recently been introduced for the Core Surgical Training Year 2 blended OSCE assessments.

Introduction

This model was designed and created to allow postgraduate trainee specialists and interventional radiologists to practice chest drain insertion. This model allows trainees to use the surgical technique, but also the Seldinger approach. Seldinger, also known as wire technique under ultrasound guidance can be performed on the model. This adds more fidelity to this biological model. The model can be used on various parts of the body as required. The adaptability of the model allows for it to be used in other courses, both within RCSI and externally. Costing comparisons between this model and the leading brand single use version will be included in the presentation.

Conclusion

This short presentation will discuss the method of producing a multi-usage NPWT simulator for educational and demonstrative scenarios.

Conclusion

The chest drain model has 6 intercostal spaces that allow for the 12 incisions. The sweeping technique gives the trainee assurance that they entered the correct space between the chest wall and visceral pleura. Trainees can also palpate the simulated lung. The drain is sutured in by the trainees to practice their skills in full potential. This model is used during the Core Surgical Training year 1 in our National Surgical & Clinical Skills Centre and has recently been introduced for the Core Surgical Training Year 2 blended OSCE assessments.

SC10 DEVELOPING A BIOLOGICAL CHEST DRAIN MODEL FOR CLINICAL PRACTICE

Miroslav Voborsky*. Royal College Of Surgeons Dublin, Ireland, 26 York Street, Ireland

Introduction

This model was designed and created to allow postgraduate trainee specialists and interventional radiologists to practice chest drain insertion. This model allows trainees to use the surgical technique, but also the Seldinger approach. Seldinger, also known as wire technique under ultrasound guidance can be performed on the model. This adds more fidelity to this biological model. The model can be used on various parts of the body as required. The adaptability of the model allows for it to be used in other courses, both within RCSI and externally. Costing comparisons between this model and the leading brand single use version will be included in the presentation.

Conclusion

This short presentation will discuss the method of producing a multi-usage NPWT simulator for educational and demonstrative scenarios.

Description of the model

With the input and expertise from the surgical faculty, important steps were taken to maximize the fidelity of this model. The steps taken to get the most realistic feel of the procedure were:

- Debridement of the subcutaneous fat layer from the pork ribs allows trainees better intercostal space definition.
- Ribs are placed on the jig under the 40-degree angle, which is then placed into the plastic box specially carved for this model.
- Ioban drape is placed onto the plastic jig. Ioban drape, due to its perfect elasticity simulates the visceral pleura.
- Surgical glove filled with water is placed onto the plastic jig, right under the Ioban drape. The glove simulates the lung.
- Once the model is completed a surgical drape is placed over the ribs and the square shape window is cut out into the drape. This defines the operative field for the procedure.

Conclusion

The chest drain model has 6 intercostal spaces that allow for the 12 incisions. The sweeping technique gives the trainee assurance that they entered the correct space between the chest wall and visceral pleura. Trainees can also palpate the simulated lung. The drain is sutured in by the trainees to practice their skills in full potential. This model is used during the Core Surgical Training year 1 in our National Surgical & Clinical Skills Centre and has recently been introduced for the Core Surgical Training Year 2 blended OSCE assessments.

SC50 MALEFICENCE VERSUS BENEFICENCE: YOUNG ADULTS' PERSPECTIVES OF BEING CHILD SIMULATED PATIENTS

Scarlet Herbertson*. StComm Academy, UK

Background

There is increasing engagement with real people within simulation based education (SBE), as simulated patients (SPs), including child SPs (cSPs). An ethical framework of engaging with cSPs has developed organically by educators and clinicians, with some input, latterly, from children (Hamilton 2017). There is a paucity of information from young adults about the personal repercussions of their involvement, as children, in SBE, hence broad judgements have been made regarding ‘maleficence and beneficence’ with limited consultation with the SPs themselves. The ASPiH standards specifically state that ‘the patient perspective is considered and demonstrated within educational planning’ - consulting with the SPs is vital.

Project description

We undertook a qualitative study exploring young adults’ views on involvement in SBE as cSPs. Inclusion criteria was for the participants to be 16 or over and to have been involved as a SP as a child (aged 15 and younger). Twelve people were now young adults, two cited lack of time, ten took part. Two focus groups were conducted which then directed the content of four skype interviews. The principles of autonomy, non-maleficence, beneficence and justice provided the context for the overall domains and the areas of discussion were informed by lived experience.

Summary of results

Participants ranged from 16–24 years and had worked as cSPs from 8–15 years. The breadth of roles: trauma, mental health, bullying, anxiety, depression, self-harm, anger management, sexual health (early pregnancy, STD), domestic violence, child carer, HPV vaccine and Gillick competence. The range of organisations equated to 3 HEIs, 5 Trusts, 2 fire and rescue facilities and a Royal College. The domains, with semi-structured prompts enabled detailed information about personal and group perceptions and opinions, to be collected. Initial analysis identifies an overwhelming positivity and weight towards beneficence. 7/10 have chosen to enter health professions (nursing, medicine, psychology). Confidence (with adults and peers), knowledge of health professions, ability to support others experiencing illness, a knowledge of safety and safe practices, were consistently cited, as too was being a voice for children.

Conclusions and recommendations

A unique feature of this study has been focussing on the young adults who have been cSPs. The ethics of working with cSPs has been questioned (Gamble 2016). Undue anxiety by faculty and educators, and the perceived potential of ‘maleficence’, can override the
realism and the ‘beneficence’ from the perspective of the SP involved; a well governed programme is an essential element.

REFERENCES


Tuesday 5th November, 14.30–15.30

THE IMPACT OF VIDEO VS ORAL DEBRIEF ON EXPERIENTIAL LEARNING AND SKILLS TRANSFERENCE; AN ACTION RESEARCH STUDY

Lisa Toft*. Portsmouth Hospitals NHS Trust; Cosham, Portsmouth, UK

Background Portsmouth Hospitals Simulation Centre is located in a busy district general hospital, employing over 7,000 staff. The centre recently upgraded its audio-visual equipment, creating opportunities to introduce video debrief into practice.

Project As part of an ongoing Master’s Dissertation, a qualitative action research study will be carried out in July and August 2019, exploring the use of video debrief in comparison to oral debrief when applied to a session for newly employed overseas nurses, as part of a transition programme. Literature supporting the use of video debriefing compared with oral found minimal evidence to support either method was superior. A study from Ostovar et al (2018) concluded that although improvements had been seen in specific skills and confidence, there was no evidence that oral verses video debrief was superior over another. Despite the evidence, the exploration of video debrief is available for educators to enhance specific scenarios or courses.

The aim of the study is to:
1. Analyse how video debrief and tradition oral debrief supports the reflection and analysis of events through experiential learning.
2. A Comparison of the exploration of technical and non-technical skills between two different debrief approaches, against the learning objectives.
3. Evaluation of the transference of knowledge and skills learned in simulation to real practice.

The study participants will be separated into 2 control groups; oral and video debrief. Each group will undertake the same 3 scenarios, either as participant or observer during the simulation. All the candidates will complete a semi-structured qualitative questionnaire, reflecting on the key skills taken from the session and experience of debrief. Zigmont et al (2011) describes the use of simulation as a method to allow learners to move from comprehension to application, analysis and synthesis, which can be an indicator of competence in practice. A follow up semi-structures qualitative questionnaire will be sent 4 weeks post training to explore the skills transference to practice, as part of the experiential learning cycle. A thematic analysis will be completed in August 2019, analysing the reflection when compared to each debrief with conclusions and recommendations being drawn.

REFERENCE


MENTAL HEALTH DETENTION IN THE COMMUNITY: DEVELOPING A MEANINGFUL SIMULATION-BASED EDUCATIONAL INTERVENTION

Paula Houton*, Helen Reid, Gerry Gormley. Queens University Belfast, Belfast, UK

Background Simulation-based education in the area of mental health is under-utilized. One of the most challenging tasks a doctor can be faced with is deciding whether or not an unwell patient requires detention for assessment under relevant mental health legislation. This can be a highly emotional and difficult process for all involved during, before and after the event itself. General Practitioners are faced with this medical emergency in the community but despite this they get limited training and exposure to prepare themselves as they would for other medical emergencies. Other professionals involved also reported formal training. There is therefore a need for the development of a simulation-based teaching intervention which can bridge this knowledge gap. This is a complex and sensitive clinical encounter and careful consideration must be given to ensure simulation content is authentic and meaningful.

Summary of project In this research, we are using a method to explore mental health detention processes in primary care settings. We are particularly interested in learning more about unmet training needs and experiences of doctors and key stakeholders involved in this process. We have identified key stakeholders as the patient, the patient’s wider support circle, GPs, social workers, the ambulance team, police-service, community mental health team and secondary care colleagues in psychiatry. Importantly, our approach includes input from and consultation with stakeholder representatives throughout the project.

Summary of results We will present findings from our study. Literature review indicates that there is very limited formal training in this area for any of the professionals involved. Despite this, there is widespread acknowledgment of the challenges associated with these situations in the community and of the potential benefits of interdisciplinary training. It is apparent that there is much we can learn from patients and families who have already been through this process. These findings will be augmented with results of our stakeholder consultation.

Discussion, conclusions and recommendations Our findings will help identify unmet training needs and will also provide key information that should be taken into consideration when developing simulation-based educational interventions to bridge this knowledge gap. It is anticipated that this work will be a foundation for the development of multidisciplinary, simulation-based learning activities in this area. Increasing the knowledge and experience of stakeholders will improve patient care and potentially lead to a reduction in associated stress and anxiety for all involved in this complex clinical encounter.