and disseminate the research findings of this six step approach (Arksey and O’Malley, 2005).

Summary of project A search strategy was developed and refined in order to answer the research question ‘What is known about how individuals, and their experiences of illness/healthcare are represented by Simulated Participants (SPs) in Healthcare Professional Education (HPE)?’

The search strategy was entered into five electronic databases – MEDLINE, EMBASE, Scopus, Web of Science and CINAHL. Initial citations were 9,795. Databases were modified, limiters applied to reflect <10 yrs, English, Article, Journal and Reviews.

All 5,437 citations were imported into Covidence a review software. Once the duplicates were removed, 2,948 articles were independently screened by title and abstract. Disagreements were discussed until consensus was reached. Finally, full texts were reviewed to determine the articles eligible for inclusion in the review.

In an iterative process key elements from articles were charted and a data extraction template was developed. To ensure that all relevant data is extracted according to the research question, all articles were assessed, and charted by the research team.

Summary of results A summary of the information found will be shared, and results will be categorized by how patients are being represented by SP in the different articles. Finally, the results will be discussed and implications for further research, practice, and policy will be described.

Discussion The implications of these findings will be discussed. Conclusions and recommendations Reviewers will consider how health professions educators can guarantee that authentic patient voices, and their experiences, are not lost or devalued in the Simulation Based Education (SBE) process; and will identify recommendations.

REFERENCES

SC48 DEVELOPING A SIMULATION-BASED EDUCATION WORKSHOP FOR PSYCHIATRIC EMERGENCIES FOR NATIONAL ROLL-OUT

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Background The use of simulation-based education in psychiatry has been increasing in recent years outside of Ireland. Its use has been demonstrated to be an effective means of training in management of acute agitation1, and advancing communication skills amongst psychiatrists2. However, adoption of simulation has been slow in psychiatry training in Ireland.

A need was identified for the development of a simulation-based education workshop to improve management of psychiatric emergencies, for trainees new to psychiatry, such as Foundation Year trainees and GP trainees.

Summary of project Four scenarios were identified and developed using an iterative collaborative process involving a consultant psychiatrist, psychiatry trainees, psychiatry nurses and simulation staff. The scenarios were: the difficult discharge of a patient; completing an involuntary admission under the Mental Health Act, 2001; management of an acutely agitated patient in the Emergency Department; and risk assessment of a suicidal young man.

The scenarios were scripted and actors were trained as simulated persons, and a detailed dry run took place in advance of the workshop.

Workshop participants ranged from Foundation Year trainees to Higher Specialist Trainees. Debriefing was led by consultant psychiatrists and the actors. Post workshop satisfaction surveys were circulated and semi-structured reflective interviews were conducted after 3–4 weeks to examine impact on clinical practice.

Summary of results Post evaluation data (n=12) was positive with 100% agreeing that the workshop addressed their learning needs. Participants highlighted the benefits of reflection with consultant feedback after each scenario, and an improvement in communication skills. Participants also enjoyed the social aspect of the workshop, and more senior trainees found it a beneficial refresher of basic skills. All wanted further training with suggestions for other scenarios including psychiatry-specific medical emergencies, and assessment of emergency presentations of children and adolescents. Delayed interviews (n=3) showed that participants had applied their learning to their practice in the domains of situational awareness and communication.

A handbook was developed following the workshop, detailing the scenarios and including all paperwork relevant to the scenarios, for implementation in other training sites.

Discussion, conclusions and recommendations Simulation-based education is a suitable method of training for psychiatric emergencies. The design of a workshop requires detailed scenario development and training of actors in playing simulated persons. There is scope for a roll-out of simulation-based education in post-graduate psychiatry training nationally, supported by the handbook developed from this workshop.

REFERENCES

SC49 ‘WE DON’T FEEL SAFE HERE’ – EDUCATIONAL MAPPING TO DEVELOP, CHALLENGE AND MAINTAIN A MULTIDISCIPLINARY NETWORK OF PROFESSIONALS WHO IMPROVE EDUCATION IN A NEUROSURGICAL WARD

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Background A 12 month educational program was co-developed by a multidisciplinary teaching team for nurses within a busy Neurosurgical ward at a large teaching hospital in...
London. This was prompted by poor outcomes from hospital safety audits, lack of staff engagement with educational activities, low staff retention and generally low morale. Complaints from staff included:

1. Lack of an integrated, well signposted and resourced educational pathway
2. Professional silos among teachers with few educational opportunities to learn across professional boundaries
3. Perception of feeling unsafe and poor care to patients
4. Workplace design and ergonomic issues (iClip/WoWs) which are time consuming
5. Unstable leadership on the ward

**Summary of education programme** We surveyed subject specialists and staff to identify key educational topics. Twelve key clinical topics were identified. Drawing on Bigg’s (2004) model of ‘constructive alignment’ - matching learning objectives, teaching/learning activities and success criteria - we began a process of educational mapping. This was developed iteratively month by month for each topic. The multidisciplinary team generated a variety of activities – e-learning, WhatsApp groups, in-situ simulations, peer-to-peer teaching, formative knowledge tests - and these became templates for on going topics to supplement routine formal educational events.

**Process measures of success included:**
- Documentation of Individual needs assessment and attainment on the ward database.
- Progressive completion of individual competency sign offs –
- Diversification of sources of feedback for staff – e.g. portfolio reflection; feedback online; peer feedback; teacher engagement with feedback activities (e.g. monitoring online discussion groups)
- Percentage of teaching team participating in teacher development activities; peer support networks, resources development
- Outcome measure of success comprised:
  - Percentage of RN engaging systematically with education offer
  - Percentage of competency attainment over course of 12 months (compared to current)
- Staff satisfaction and retention
- Centralised learning resources and Neuro–education map of activities bank

**Summary of results** A 12-month educational curriculum was produced. A senior leadership team was essential to create, maintain and monitor the teaching network. Collaboration was embedded in everyday rituals and the process of educational mapping alerted teachers to a common sense of mutual awareness and appreciation for the importance of education. A senior leadership team was essential to create, maintain and monitor the teaching network. Collaboration was embedded in everyday rituals and the process of educational mapping alerted teachers to a common sense of mutual awareness and appreciation for the importance of education.

**Discussion/Conclusion** Networked faculty development multiplied opportunities for staff to engage in learning, feel supported and to improve perceptions of safe practice. Its effects on longer term staff retention are still unclear.

**REFERENCES**


**SC51** ‘MIND THE GAP’: AVOIDING ‘TRAINING SCARS’ IN PARAMEDIC UNDERGRADUATE EDUCATION TO PROMOTE PREPAREDNESS FOR AND RESILIENCE IN CLINICAL PRACTICE

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Simulation based education is a core aspect of the BSc Paramedic Science at St George’s University of London. The dedicated simulation centre includes state of the art facilities, which allow for increased authenticity with the view to increasing students’ technical and non-technical skills.

Historically, paramedic education has centred upon traditional classroom-based learning and the use of standardised manikins which demanded the imagination of students to envisage diverse clinical working environments and patient presentations. The risks associated with the discord between this and real working environments have been widely documented (Lamé & Dixon-Woods 2018) and as such the need to move to more realistic methods of educational delivery has been advocated.

Despite this drive towards achieving high fidelity simulation in prehospital education through the use of resources including professional actors, audio-visual media and imitation clinical equipment, it is not without its own potential for harm through the causing of ‘training scars’.

‘Training scars’ relate to unintentional malpractice and bias acquired through teaching that can pose a latent threat to patient safety. Opportunities for these adverse events can relate to any discipline, however research upon this predominately relates to firearms and police service education (Hall 2013). These can be related to both unrealistic situations, inauthenticity and disproportionate blocks to clinician intervention and patient interaction.

In order to minimise the occurrence of these ‘training scars’, the Department of Paramedics ensure that students not only have access to high fidelity environmental resources and appropriate equipment needed to fulfil their role, but also that as educators we are mindful of the importance of cognitive and emotional safety within simulated education.

We have devised a number of strategies within our paramedic programme to ensure the safety of our learners through thorough briefing and debriefing of students, faculty and actors, in situ resources to stop the simulation process and the presence of on-site pastoral care.

Furthermore, we have recognised the need to strike a balance between ‘training scars’ and the counterproductivity of assumed invincibility through the provision of a ‘magic solution’ (Boal, 2002) which neither represents real working environments or the complexity of holistic patient management.

This short presentation will discuss the importance of vigilance to this complex issue within simulated prehospital education and propose strategies to ensuring the confidence, preparedness and emotional resilience of our clinicians of the future.

**REFERENCES**
