3. Personalized Learning
4. Expert driven feedback

Official ASPE Affiliate Presentation Submission.

This workshop is designed for those without a medical background, but all are welcome.

REFERENCES
1. Bates’ Guide to Physical Examination and History Taking; Bickley, Lynn S.; Walters
2. Training Standardized Patients to Have Physical Findings; Barrows, Howard S.;
   Southern Illinois University School of Medicine Press, Springfield, Illinois; copyright

W12  BUILD YOUR OWN META-DEBRIEF CLUB: AN IMPACTFUL WAY TO DEBRIEF YOUR DEBRIEF
Nathan Oliver*, Ed Mellanby, Chris Schnieke-Kind*, NHS Lothian, Edinburgh, UK

Abstract Structure: Who should attend; Level (please select from Introductory/Intermediate/Advanced) Background, Intended Learning Outcomes, Structure of workshop Educational Methods to be used.

The application of simulation as an educational tool within medicine is increasing. In immersive simulation, it is widely accepted that the post-scenario debrief is a critical component for learning. Effective faculty development is therefore required to preserve the quality of debriefing. Though clear standards have been set out by the Association of Simulated Practice in Healthcare (ASPiH), there is little in published literature describing faculty development. NHS Lothian has established a ‘debriefing the debrief’ programme, called ‘The Meta-Debrief Club’ or ‘MDC’. It is available to staff from all backgrounds and levels of experience. Through group reflection, debriefers take part in regular evaluation of their practice, with constructive feedback from peers. The purpose of this workshop is to share the story of how the MDC emerged, and to provide the structure, tools, and support to others who are interested in forming their own process of meta-debriefing.

Who Should Attend:
Simulation educators with experience in debriefing immersive simulation.
Level: All.
ILOs:
1. Discuss the benefits of meta–debriefing as a tool to increase proficiency in debriefing immersive simulation.
2. Demonstrate a facilitated meta–debrief process in the simulated environment.
3. Formulate a plan in creating an meta–debrief club in the learner’s department or simulation centre.

Structure/methods of Workshop (This is TBC depending on time offered.)
The structure of the workshop utilises a facilitated workshop style of small group discussions and activities.

Activity one: A presentation of the current literature around the importance of meta-debriefing to practice and the story of how the MDC was formed. Tools and structure of the MDC are then distributed across tables, explored and explained.

Activity two: Groups are then invited to watch pre-recorded debriefs (the number and time dependant on time offered) and learners are asked engage with a facilitated meta-debrief process. A reflective group discussion on this will follow.

Activity three: Groups are invited to work together to formulate their own MDC plans, including a critique the presented MDC process, and invited to add alternative tools, ideas, and structure, and present their plans back to the group.

Evaluations and email addresses are be collected to continue the conversation after the conference.

REFERENCES

W13  MAKING SIMULATION IN THE WORKPLACE SAFE
Colette Laws-Chapman*, Gabriel Reedy*, Guys and St Thomas’ NHS Foundation Trust, 1st Floor, St Thomas House, UK

Workshop In-situ simulation is fast becoming the panacea of Simulation Based Education (SBE). In-situ simulation is used because it can produce highly realistic training with opportunities for team and systems testing while remaining embedded in the clinical setting. With a diversity of theoretical underpinnings, there is limited evidence in the public domain as to what practical procedures can enhance safety in the design and delivery of SBE in the clinical workplace. Especially significant risks include disruption of service and more importantly, physical safety for patients and staff.

Basic safeguarding procedures in place at a large London teaching hospital, including a traffic light checklist and a system to sign equipment in and out, seem to have prevented any errors resulting in harm. However, the possibility of simulation-related mishaps resulting in patient, participant, or staff harm is real and significant. Despite clear procedures and standards being in place, other seemingly less dangerous errors have been reported: a simulated blood gas syringe and lab result being left in a clinical area, a simulated handover sheet and used defib pads on a resuscitation trolley, an unused shock box for defibrillation.

In addition, annual staff turnover means institutional memory—knowledge of our incidents and safeguarding principles (checklists)—have been lost in handover and information transfer. A recent podcast on Simulcast http://simulationpodcast.com/simulcast-journal-club-february-2019/ inspired our centre to review its practice.

This workshop aims to discuss the core components of SBE safety standards, both from the national, international and locally applied perspectives from the authors place of work. From there the workshop will act as a focus group to discuss common practices with the purpose of surfacing best practice that may contribute to the beginnings of a consensus for future guidelines. It is aimed at Introductory, Intermediate and Expert educators working in the simulation community.
Poster Presentations
Tuesday 5th November, 11.15–12.35

P1 THE IMPACT OF UNANNOUNCED PAEDIATRIC IN SITU SIMULATION IN AN EMERGENCY DEPARTMENT OF A DISTRICT GENERAL HOSPITAL

Uduakobong Ndiiyo*, Darent Valley Hospital, Dartford, UK
10.1136/bmjstel-2019-aspihconf.107

Introduction This project aims to

- Demonstrate the effectiveness of unannounced Paediatrics in situ simulation to increase knowledge of rare paediatric cases, identify patient safety issues and reinforce teamwork training in a paediatric emergency department (ED) especially with the current shortage of paediatric trained staff in ED.
- To evaluate feasibility and the perception of learning and stress especially when unannounced in situ simulation, has been described as stressful and stress can adversely affect learning.

Methods Unannounced simulation was limited to 15 minutes with 30–45 minutes of debrief within the emergency department. The participants were nurses, students, healthcare assistants and doctors working in ED. To minimise disruption to service delivery, the simulation sessions were held early in the morning at 08.30am to 09.30am.

The primary outcome measured using questionnaires was to compare the impact of an announced verse unannounced simulation on stress and learning.

Also to address patient safety concerns highlighted by Care quality commission (CQC), cases were selected from major incidence or near misses in the department.

Results 100% of the participants reported that their stress level increased as it was an unplanned simulation but 100% of these participants also recorded that they preferred in situ unannounced simulation to an announced simulation. A strong theme that emerged from the feedback was reflected in this participant’s statement.....‘In AE we don’t often know what is coming through our doors so we need more unannounced simulations as it presents like real life’.95% reported that they gained useful learning in the unannounced simulation even though it was stressful.

Conclusion In situ simulation is a practical method to reinforce team training behaviours, improve staff knowledge and skills thereby improving patient care. Embedding in situ unannounced simulation as a routine expectation in a high risk clinical setting has shown to be a valuable asset to test clinical systems, improve patient safety and overall patient experience. It was observed from the feedback that though unannounced simulation increased participant’s stress level on the day but that didn’t impact on their learning. Infact they preferred it to a planned or announced simulation as it made simulation experience feel ‘real’ with little or no opportunity to self-select into the simulation or decline participation.

Recommendation It would have been more beneficial to involve a multidisciplinary team of anaesthetic and Paediatric

Abstracts

Intended learning outcomes
- Present the reasoning underpinning the principles of making in-situ simulation practice safe
- List the core components that ensure simulation safety for in-situ (and lab-based) simulation
- Identify the different approaches undertaken in healthcare simulation to ensure patients & staff do not come to harm
- Create the beginnings of a consensus for practice to be considered as part of the National Standards Framework

Timeline:
- Minutes 0–5 Workshop introduction
- Minutes 05–20 Overview of existing standards
- Minutes 20–40 Group Discussion: core components of approaches
- Minutes 40–55 consensus for practice
- Minutes 55–60 Summary & close

Methods Didactic introduction with visual aids, group work and nominal group technique.

REFERENCE