DEVELOPING DNACPR SIMULATION SESSIONS FOR SENIOR DOCTORS

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Background Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) discussions and decisions form an integral part of advance care planning. Although DNACPR is a medical decision, doctors have a legal duty to involve patients and relatives. However such conversations can be difficult, requiring good communication skills and an understanding of the legal position. We recognised a lack of training and clarity regarding DNACPR and the law amongst physicians and looked at ways to bridge this gap.

Summary of work Simulation has been well recognised as an effective method to teach communication skills.1 The aim was to develop a simulation-based education session for senior doctors, to clarify the legal position regarding DNACPR and to give them an opportunity to practise discussions in a safe, supported environment. The sessions were developed following a successful bid for network Multi-Professional Education and Training funding.

5–8 candidates participate in a 3 hour session. A pre-briefing clarifies the legalities around DNACPR. Each session comprises 3 bespoke scenarios using patient actors, with candidates playing the part of the doctor. Video-playback is used to assist the debrief process. As a result of the success of the initial programme the training has been rolled out to a first cohort of 13 senior community nursing staff who have completed advanced communication skills training.

Summary of Results Since 2015, 21 sessions have taken place with a total of 85 attendees, including a wide range of medical and nursing staff. Evaluation has been extremely positive. 99% of candidates agreed or strongly agreed that they felt more confident about the legal position regarding DNACPR. 70% strongly agreed that they felt more confident undertaking DNACPR discussions with patients and relatives and 89% strongly agreed that they would recommend the course to colleagues.

Qualitative feedback includes comments such as ‘Excellent! ‘should be mandatory’ and ‘everyone should do this.’ Feedback from the initial nursing cohort was also overwhelmingly positive and following their training all have held DNACPR conversations with patients and completed DNACPR forms.

Discussion, conclusions and recommendations Having a dedicated simulation centre at the trust has been invaluable. The main challenge has been encouraging attendance and several sessions have been cancelled because of lack of candidates. We are currently exploring the feasibility for the program to become part of mandatory training. Following the successful roll out to community nursing staff we will be looking at extending the training to nursing staff within the acute trust.

REFERENCES

P9 CAN MULTIDISCIPLINARY SIMULATION ENHANCE DELIVERY OF CARE AND TEAM WORKING IN THE MANAGEMENT OF A PATIENT WITH NEUTROPENIC SEPSIS?

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Background Given the high morbidity and mortality associated with neutropenic sepsis, there is a move towards finding innovative ways to improve patient care. Simulation is becoming a widely accepted method of supporting learning and is increasingly used in medical education. However, its role in facilitating the learning of a multidisciplinary team in the management of neutropenic sepsis is yet to be clearly established. This project is aimed at assessing whether simulation can be used to:

1. Highlight the significance of prompt management in patients with febrile neutropenia
2. Support the importance of multidisciplinary team working to improve patient safety

Summary of work Five, sixty-minute courses, each consisting of 2–3 participants including nurses and junior doctors were conducted. All participants completed a pre-course questionnaire and were then exposed to a 15 minute scripted case of a patient presenting with neutropenic sepsis in the simulation lab using a high-fidelity mannequin. The scenario was followed by a 10 minute debrief, a 10 minute presentation that emphasised current definitions and guidelines to facilitate discussion and lastly a post-course questionnaire. Thematic analysis of the qualitative pre-course and post-course questionnaire results was undertaken.

Summary of results Synthesised results from 24 attendees demonstrated that all participants agreed or strongly agreed that the course was interesting, relevant and would positively impact patient safety. More participants felt confident in assessing and managing a patient with febrile neutropenia after the course, with 91% agreeing or strongly agreeing that the course would improve their multidisciplinary team working skills. The participants found the greatest value in understanding the importance of recognition of neutropenic sepsis, finding a source of infection and carrying out the ‘sepsis six’. A variety of specific learning points as well as helpful suggestions on how the educational experience may be improved were raised.

Discussion and conclusions This study suggests value in using simulation to facilitate the understanding of the prompt assessment and management of patients with neutropenic sepsis. Furthermore, there are interesting insights into communication styles used to escalate patient care- from concise handovers to request a review through to being assertive in indicating urgency of the situation- allowing for the development of effective multidisciplinary team working ensuring patient safety.

Recommendations This study helps medical educators consider the value of investing in this pedagogical approach to support learning requirements. There is a need to further explore direct effects on practice and the feasibility of delivering such simulation.

P10 WHO WATCHES THE WATCHMEN? AN AUDIT OF SIMULATION ACTIVITY ACROSS A LARGE ACUTE HOSPITAL TRUST IN THE SOUTH WEST OF ENGLAND

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Background The ASPiH Standards Framework for Simulation Based Education (SBE) in Healthcare was launched almost three years ago1 2, with the aim of defining the appropriate structures and processes required to deliver effective SBE. The new Post-Graduate Medical Education (PGME) ‘SimSpace’ at North Bristol NHS Trust was designed from the outset with reference to these standards, with programmes and activities mapped to the four key themes defined by ASPiH.

Nevertheless, as a large regional trauma and tertiary referral centre, in a city with an established culture of SBE delivery, we were aware of multiple groups across our organisation also undertaking SBE on a regular basis. In order to better understand the extent and quality of SBE outside of PGME’s immediate control, we used the ASPiH Standards Framework to inform an audit of these activities.

Summary of work We undertook an on-line survey of departmental educational leads to ascertain what (if any) and how frequently SBE activities are delivered, how topics and learning objectives are identified and selected, the composition and training of faculty, and who provides overall leadership for SBE within their department. We also explored their awareness of guidelines for the delivery of SBE and how these informed their departmental practices.

Summary of results We found a large variation across the organisation, with some departments undertaking frequent and organised activities and others with little or no programmed SBE. There was also variation in the nature and training of the faculties used to deliver these activities, and in the design and development of SBE programmes. In departments where SBE was most established, named individuals were often identified as having overall responsibility for its delivery.

Discussion and conclusions The ASPiH Standards Framework proved a useful tool for designing and implementing SBE programmes within our bespoke SimSpace environment, but variation in knowledge and implementation of this guidance across the established activities of our organisation impacted on our ability to effectively audit the quality of SBE delivered outside of our immediate circle of influence.

Recommendations In an environment in which SBE is widely practiced by individuals with varying degrees of engagement with existing validated standards, structures must be developed to educate the educators and ensure the uniform high quality of SBE delivery. One solution might be the creation and adoption of ‘Simulation Registries’, mapped to the ASPiH Standards Framework, in which all SBE activities across an organisation could be catalogued for future audit purposes.

REFERENCES