resources were available on an online platform and students had foundational knowledge of legislation and clinical therapeutics from other parts of the degree programme. Learning outcomes were that students should have clinical and legal knowledge and skills to competently dispense health service and private prescriptions, including providing pertinent advice about the items(s) being supplied. Role-play interactions promoted active learning and occurred in a simulated pharmacy (with authentic medicinal products, labelling software and decision-making tools).1 2 Mock prescriptions were linked to a different clinical area each week. Students assumed the role of the pharmacist while staff acted as healthcare practitioners and patients (or representatives). Students dispensed health service and private prescriptions written by various healthcare practitioners (which had deliberate errors embedded) and provided verbal advice. Marking rubrics were used for assessment with mark deductions linked to potential level of harm (pass mark was 70%).1 2 Alongside grades, students received individual and class feedback.1 Reflection was encouraged through error logs and discussion about mistakes that had occurred in practice.1 2 Students’ opinions were gained using a standardised module questionnaire.

Summary of results Mean grade was 73.5 ± 13.2. Students considered it would ‘help a lot in the future’ and ‘built confidence’. It was ranked as their preferred method assessment as it allowed them to ‘demonstrate skills that had been learnt, and it is what pharmacists actually do.’ All students ‘strongly agreed’ or ‘agreed’ that the learning outcomes had been met, and that problem-solving skills had been developed. Staff considered it valuable but time-intensive.

Discussion and conclusions This seems to be an effective way for students to learn and be assessed, and has been well received by students.

Recommendations A case should be made for using a simulated approach to teach other roles such as pharmacist prescribing while being cognisant of the high levels of resources required.

REFERENCES

P29 TRIALLING A HIGH-FIDELITY SIMULATION COURSE ON THE MANAGEMENT OF GENERAL SURGICAL EMERGENCIES
Ananyo Bagchi*, Timothy Parr, Toni Shanahan, Simon Mercer. Aintree University Hospital, Liverpool, Liverpool, UK

10.1136/bmjstel-2019-asphiconf.133

Background Simulation based teaching is an increasingly valuable tool in both undergraduate and postgraduate medical education, helping candidates develop both clinical and non-technical skills. High fidelity simulations can help postgraduate doctors learn about the management of clinical emergencies in an immersive, yet safe environment.

Doctors in the equivalent of surgical senior house officer (SHO) posts have an increased exposure to acute general surgical presentations compared to at Foundation Year 1 (FY1) level, and are expected to be able to commence management of those conditions and escalate to senior clinicians appropriately. A high-fidelity ENT emergencies course has been successfully run in the Mersey deanery since 2014, with participating specialty trainees reporting a significant improvement in their confidence in the management of emergencies in head and neck surgery. However, there is no equivalent course in the region to help foundation doctors develop similar skills for general surgical emergencies.

Summary of work This 1-day course is to be piloted on 11 June 2019, with 6 FY1 candidates. The course will consist of six high-fidelity simulated scenarios, lasting for 20 minutes each, followed by video-assisted debrief. The debrief will focus on both the clinical management of each scenario and non-technical skills such as leadership, communication with other members of the team and appropriate escalation. There will also be a brief didactic session after the debrief which will summarise the main clinical learning points from each scenario. Candidates will be issued pre and post course questionnaires to assess the impact of the course on their confidence in recognising and commencing management of common acute general surgical conditions.

Summary of results Currently unavailable, pending the piloting of the course.

Discussion and Conclusions Conclusions drawn will be based on collated feedback from the candidates after the course has been piloted. If the feedback is positive, this course will be run regularly as a regional course for foundation doctors. In addition, a modified version of the course will be aimed at core surgical trainees.

Recommendations As above.

REFERENCES

P30 IMPROVING PATIENT SAFETY, IDENTIFICATION OF LATENT THREATS AND SYSTEMS TESTING IN THEATRE RECOVERY USING SIMULATION AT DISTRICT GENERAL HOSPITALS

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10.1136/bmjstel-2019-asphiconf.134

Introduction Simulation has been shown to be an effective method of improving patient safety, increasing staff performance by analysing multidisciplinary team working and caring for post-operative patients.1 We embarked on in situ simulation in theatre recovery of Darent Valley Hospital and Queen Mary’s Hospital Sidcup to deliver simulation for common post-operative emergencies across both sites monthly. We also aimed to use simulation to test our systems thereby identifying latent threats and errors in clinical environment.

Methods Common clinical problems from critical incidence were drawn and scenarios were selected in collaboration with different stakeholders from both sites.

Sessions started 8am, at time of minimal disruption to service delivery and staff availability, lasted for 10–15 minutes in an unused recovery bay with 45 minutes of debrief.

Results The simulation training had a total of 28 Participants across both sites in a 4 month period. There was great enthusiasm and positive feedbacks from each of the
Abstract P30 Table 1 Latent threats and actions taken

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Latent errors identified</th>
<th>Action taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Anaphylaxis/site 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Adrenaline 1:1000 was found to be missing from live box</td>
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<tr>
<td>2. Team also identified that Resuscitation UK guidance was not in the box</td>
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<tr>
<td>Immediately rectified by the team and stock in a way that would reduce the risk of wrong use (adrenaline vials in one bag and Chlorpheniramine in a separate bag within the box but also separate from what would be used by an anaesthetist if using AAGBI guidelines).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Deteriorating patient in a post-operative ward</td>
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<tr>
<td>On the ward only simple face mask, for use in the immediate post op phase of care, was available and no Venturi oxygen valves/Non Re-breath masks available. This is contrary to the BTS guidelines 2017. 2. Knowledge gaps with the NEWS Scores and sepsis were noticed in some staff members.</td>
<td></td>
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</tr>
<tr>
<td>Masks are now available on the ward. 2. Training and education of both NEWS score and the escalation plans for sepsis were covered during debrief.</td>
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<td></td>
</tr>
<tr>
<td>3 Anaphylaxis/site 2</td>
<td></td>
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<tr>
<td>The anaphylaxis box held the primary and secondary line medication for non-medical response in a single bag leading to potential for error</td>
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<tr>
<td>This has been split into separate bags to avoid error</td>
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</tbody>
</table>

Background Emergency Medicine (EM) is a unique speciality often meeting people at the worse moments of their life. Death is an everyday occurrence, and with that comes the skills needed to talk to patients and families about what they what for their end of life. These conversations can be very challenging for all concerned, including junior doctors. The Royal College of Emergency Medicine’s guidelines suggest doctors need to have the skills to talk to these patients. Therefore, we felt we needed to develop a series of realistic EM in-situ simulations for our staff to learn and practice on. A review of published literature suggests this has been tried in the US only, and nothing currently in UK.

Summary of work We created 3 simulations designed to enable junior doctors to have difficult conversations with patients who are approaching the end of life in the ED. Scenario 1 was a patient with end stage COPD. Scenario 2 is of a very frail patient with pneumonia again who has multiple comorbidities. Scenario 3 revolves around a patient with a massive upper gastrointestinal bleed with known oesophageal cancer. These simulations were tested in-situ in the ED over the course of several months and the feedback collected from all team members.

Summary of results These simulations were trailed over January – March 2019 as part of our weekly in-situ simulation. 20 people took part in the above simulations, 5 people in scenario 1, 9 people in scenario 2 and 6 people in scenario 3. Simulations were run more than once, with different participants in each. All had a doctor plus nursing support. Feedback was obtained from all those involved. The data was pooled from all the simulation sessions. 80% of people moved from being not confident or lacking in confidence to fairly confident or confident after doing the simulations. All participants felt their knowledge had increased significantly following the simulations. Positives described by participants include ‘Learning to recognise when CPR may be futile in patients and balancing delivering treatment and assessing futility of discussing this with patients’.

Discussion and conclusion This work suggests that people’s confidence with these difficult conversations has improved. How this will translate into clinical practice is not known, but the feedback suggests these simulations will have an impact. We will look to incorporate this into a day long course.

REFERENCES

P32 USING SIMULATION TO PREPARE MEDICAL STUDENTS TO ASSESS AND MANAGE AN ACUTELY UNWELL AND SUICIDAL PATIENT

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10.1136/bmjstel-2019-aspihconf.136

Background Simulation in undergraduate medical education often focuses on the assessment and management of an acutely unwell patient, whilst communication skills needed to assess a mentally unwell patient tends to be taught through role play. We wanted to combine the two presentations to sessions ranging from increased confidence in clinical management of common post-operative cases to awareness of practice limitation and impact of human factor in our clinical environment. Patient safety threats were also identified and appropriate corrections made as highlighted in the table below.

Conclusion Simulation is a valuable tool in staff training especially in challenging environments like theatre. It exposes latent threats or errors in the system and offers the opportunity for actions to be taken before it becomes a safety risk to the patients. It also increases the confidence of staff in the management of common post-operative emergencies.

Above all, it is a quality improvement project and leads to an improved quality of care offered to our patients and improves patients experience and safety.

The theatre Staff are keen to participate, but there is a challenge of how to balance the need for training and education with the huge clinical commitment and service delivery.

REFERENCES