Simulation Based Education (SBE) to support IMT development and experience. The benefits of SBE are far beyond traditional skills and drills training (such as resuscitation and procedures), as previously touted. We present our new IMT SIM training programme at the end of its pilot year.

The scenario design and content maps to the IMT curriculum, layering common medical inpatient and outpatient scenarios with varying levels of complex non-technical human factor themes and professional skills.

To date, 17 Core Medical Training (CMT) Doctors have completed the pilot IMT SIM programme. Likert scales (figure 1) and unstructured qualitative questions were assessed from returned surveys, with key quotes and feedback summarised below.

‘This was a great opportunity to experience varied scenarios in a safe environment – the scenarios were extremely relevant to everyday practice.’ – Candidate

‘The scenarios, although difficult, were a good mix of practical and communication skills.’ – Candidate

‘There were different layers to each scenario and it was not straight forward medicine.’ – Candidate

The pilot year of IMT SIM has highlighted the benefit of SBE in providing training in the non-technical aspects of clinical practice, and should not be limited to resuscitation and procedural training only.

Our IMT SIM programme encourages medical leadership and professional development which is fundamental when progressing towards higher specialty training.

As a result of the success of this pilot year, our faculty is now expanding IMT SIM, with separate IMT year 1, 2 and 3 sessions in development, which are to be delivered regionally.

REFERENCES
1. Curriculum for Internal Medicine Stage 1 Training, Joint Royal College of Physicians Training Board, May 2019

EXPERIENCES OF DELIVERING IN-SITU SIMULATIONS IN THE EMERGENCY DEPARTMENT AT NIGHT

Sarah Edwards*, 1Sam Harris, 1,2Damian Roland. 1University Hospitals of Leicester, Leicester, UK; 2Paediatric Emergency Medicine Leicester Academic (PEMLA) group, University of Leicester, Level 2, Jarvis Building RMO, Infirmary Square, UK

10.1136/bmjstel-2019-aspihconf.151

Background In-situ simulation is well established in medical education, being used from everything from assessment to human factors training.1 In emergency medicine, in-situ simulation has been used for many years to try and practice skills relevant to everyday practice – technical and communication skills.

The scenarios, although difficult, were a good mix of practical and communication skills.

‘There were different layers to each scenario and it was not straight forward medicine.’ – Candidate

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Background In-situ simulation is well established in medical education, being used from everything from assessment to human factors training.1 In emergency medicine, in-situ simulation has been used for many years to try and practice skills and understand human factors in teams better.1 With ever increasing patient numbers presenting through the doors of emergency departments, training and learning has become a challenge.2 This will work look at the experiences of doing in-situ simulations with the staff on night shifts.

Summary of work We already have established in-situ simulation training weekly within our department. There are ad-hoc simulations around this as well. The whole team from nursing and medical students, through to senior doctors and nurses get involved. What we have started doing is running simulations at night times to test the systems in place within the emergency department at night. We describe the first two of our simulations that occurred and the challenges of trying to enable them to happen along with strategies to overcome this.

Scenario 1 was a trauma that presented at 6 am in the morning. Scenario 2 was a hanging in the emergency department toilets at 4 am.

Summary of results and discussion Approximately, 15 people were involved between both simulations. Their feedback was collated. The overall feedback was positive. This was seen as a good learning opportunity; it was nice to be learning at night time and ‘I never knew we had a toilet there’. Negatives included people being unsure of the purpose of the simulation. The department learned that at night time it was unclear who was to respond to the emergency bells. It is clear there is an appetite for this type of learning. This is only the initial work and further night time simulations will need to be evaluated.

Recommendations Strategies to enable simulations to happen overnight include senior nurses allocating staff to become available for the simulations, aim for a specific time in the night for it to happen, thus allowing staff to be freed up. Junior doctors will also be allocated for the simulation. It is clear in our early work this can be a valuable learning opportunity even on a night shift.

REFERENCES

SIMULATION TO TACKLE NEVER EVENTS- UTILISING VIDEO AS EDUCATIONAL TOOL AT NORTHERN LINCOLNSHIRE AND GOOLE NHS TRUST NLAG

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Background A nerve block performed on the incorrect side is classified as a Never event.3 As part of the 5 steps to safer surgery ‘Stop Before You Block’ has been incorporated into the WHO check list before the start of any operative procedure. The Development and Simulation Hub, (DaSH) working with Risk and Governance assessed the root cause analyses of two wrong side nerve blocks which had occurred in the last 5 years, examining all the contributing factors, in order to produce a widely accessible training package to prevent this reoccurring.

Method Utilising theatre staff and a simulated patient, we recreated an exact simulation of a patient going a Total Knee Replacement, using authentic theatre equipment, paperwork and in real time. The simulation specifically included all the latent errors and contributing factors which led to the wrong side femoral nerve block. The simulation was filmed and an educational video was created with participants’ consent. In order to emphasise the learning points the video includes a team debrief specifically highlighting the multiple factors which led to the error, and nearly wrong side surgery. The discussion reiterates how the patient’s journey and all checks should be conducted correctly. Is also focusses on the major impact of human factors in this incident.

Results Contributory factors included:

Covering of marked knee with thromboembolic stocking
Stocking applied to incorrect leg

Contributory factors included:
Inexperienced ward staff at theatre handover

Interruptions during handover, with change of staff

6th patient on list

Automatic application of tourniquet, and prepping of femoral area

Failure to stop before block

The video is being shown at medical staff educational and audit and governance meetings across all three trust sites. Theatre educators are ensuring wider rolling out across the theatre teams.

Conclusion and recommendations

In situ simulation is an excellent method of learning for healthcare professionals, however only staff involved benefit from the learning experience. A video of a recreated simulation of a real clinical incident is a powerful method of sharing the lessons learnt, and has access to a much wider audience, and repeat use, re-emphasising the lessons and for new theatre staff and rotating medical staff.

REFERENCES

1. NHS Improvement (January 2018) Never Events List. London NHS Improvement

EFFECTIVENESS OF SIMULATION-BASED MEDICAL EDUCATION IN TEACHING CARDIAC AUSCULTATION: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Introduction

Research suggests that simulation-based medical education (SBME) can benefit teaching cardiac auscultation (McKinney et al., 2013). This systematic review aimed to address the gap in the literature regarding the effectiveness of SBME in cardiac auscultation training for healthcare professionals within randomised controlled trials (RCTs).

Methods

Literature searches were performed on Medline, Embase, PsychInfo and CINahl.

RCTs that compared the effectiveness of A) SBME versus usual/traditional teaching or B) comparing different forms of