Conclusion The co-production and delivery of the training of those with ID and experts is a unique training modality which has a powerful and important impact on learner’s experience and memory. The current research contributes to the growing literature around the effectiveness of simulation training on ID however future research, is needed on a larger scale to support the current findings.

Background In November 2018 the Hull Institute of Learning and Simulation (HILS) became the first centre within the United Kingdom to be awarded the ASPiH Accreditation. Here we share the experience of that journey with intentions of helping others with their applications.

Summary of work The initial stage was ensuring that HILS fulfilled the criteria for the organisation accreditation. The standards framework and guidance from the ASPiH website lists the criteria - four modules;

1. Faculty,
2. Technical Personnel,
3. Activity,
4. Resources

Once confident that the requirements could be met, the application form was completed. The application requires the organisation to justify how they meet the criteria for each area, backed up with evidence. Some evidence included with the application is listed below:

- 2 Years of Activity
- Course Programmes
- Scenario Design Templates
- Sample Scenarios
- Faculty Training
- Statistical Reports–Footfall, Usage

Following submission of the application, it was reviewed by ASPiH panel members before arranging an audit of the centre. HILS were tasked with arranging a room for the visit. The panel ask that the centre arranges delegates, faculty and staff members who could be interviewed by the panel, this was really experience a situation, rather than just reading about it. The positive response to simulation may be, in part, due to limited opportunities in the real clinical setting, as the Obs

Recommendations The process is very much formative. HILS are now working on the recommendations from the report and are accredited for 3 years.

Conclusions The accreditation, application and audit was a rigorous process but the panel were very supportive and helpful throughout the process.

Discussion The process is very much formative. HILS are now working on the recommendations from the report and are accredited for 3 years.

Conclusions The accreditation, application and audit was a rigorous process but the panel were very supportive and helpful throughout the process.

Recommendations To ensure a smooth process we would recommend checking off the guidance criteria and start collecting evidence required to support the application as that can be time consuming.

REFERENCES
1. HILS www.heyhils.co.uk
2. ASPiH www.aspih.co.uk

P60 'FILLING THE GAP': A SIMULATION COURSE FOR FOURTH YEAR MEDICAL STUDENTS TO ENHANCE UNDERSTANDING OF OBSTETRIC EMERGENCIES
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Introduction Obstetrics is a team-based high-risk speciality, where litigation is high. Teamwork failings contribute to adverse outcomes for mothers and babies, therefore, good multiprofessional teamwork is essential. Furthermore, team simulation training in obstetrics has been shown to improve neonatal outcomes following obstetric complications. Simulation training is used increasingly for training undergraduates as it allows students to consolidate their learning and use their skills and knowledge in practice. Although specialised, the clinical and non-technical skills required for the management of obstetric emergencies including post-partum haemorrhage (PPH) and sepsis are transferable to any emergency.

Methods/Project description An obstetric simulation was designed for 4th year medical students at the end of their Obstetrics and Gynaecology placement. Groups of 3–5 students underwent simulated scenarios (lasting 10–20 minutes) with a high-fidelity, integrated mannequin (CAE systems Lucina©) covering PPH, sepsis and eclampsia. Following the scenarios, students participated in a debrief focusing on clinical aspects and the non-technical skills required in each situation. An anonymous online feedback questionnaire was sent out to students at the end of the academic year to gain an insight into opinions on the simulation and how it may be improved.

Results Students were extremely positive about the simulation, and felt strongly that it helped consolidate knowledge, helped with non-technical skills, and students felt they would use the knowledge gained from the simulation in their future practice. Students appreciated ‘actually putting into practice theoretical learning’ and felt that ‘it [simulation] gives you the chance to really experience a situation, rather than just reading about it. And in a safe environment’. Students expressed that the simulation component of the Obs and Gynae placement should be increased to at least two sessions over the four-week placement and gave other useful suggestions of how the simulation may be improved.

Discussion Overall, the simulation sessions were a success. Student’s feedback was positive, and they demonstrated improved self-reported knowledge and confidence following the sessions. The positive response to simulation may be, in part, due to limited opportunities in the real clinical setting, as the Obs
and Gynae placement is only four weeks, making it very difficult for students to experience all that the specialty has to offer. Furthermore, it would be difficult for students to be involved in management of obstetric emergencies in practice. Further work on improving and expanding the simulation training is planned for the next academic year.

REFERENCES
1. MBRRACE-UK. Saving Lives, Improving Mothers’ Care Surveillance of maternal deaths in the UK 2012–14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–14. 16.

P61 MULTIDISCIPLINARY TEAM DEBRIEFING AFTER IN-SITU SIMULATION
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Background Debriefing is well acknowledged to be one of the most important parts of simulation. There appears to be limited literature into debriefs of multidisciplinary team (MDT) simulations. At Leeds Teaching Hospitals Trust (LTHT) Emergency Department (ED) we run twice weekly MDT in-situ simulations (some involving ED staff only – including doctors, nurses, Advanced Care Practitioners, health care support workers – and others involving multiple specialties and departments). These are some pointers that we have learned and questions we have asked ourselves (some answered and some not!) from our experiences of multidisciplinary simulation debriefing after in-situ simulation in the ED in LTHT.

Summary of work/results Environment:
- Is it big enough?
- Is it private; should it be away from a clinical area?
- Will you need to move?
- Are there distractions?

Timing:
Learners need to go back to work. Attention can wander. We have had feedback that shortening the debrief may help with both of these. We aim to keep to 20–30 mins max. This can be easier said than done which leads to the next section – technique.

Technique:
- Is there a right answer? A structure seems to help but there are many around – does it matter which one? We find highlighting 3–4 focused topics to discuss at the start of the debrief seems to help structure the debrief and keep the time down. Ensuring that all team members are involved, in particular empowering the least confident or experienced early in the debrief, helps with team debriefing as well as each individual’s learning experience.
- How many debriefers should there be?

There is no clear answer to this with pros and cons to having multiple debriefers. Having a debriefer from each specialty & profession can help increase buy-in and supports credibility. However, we have found that having more debriefers can increase the length of the debrief and it can become overly focused on a specific clinical element related to a specialty. Having a lead debriefer with planned input from others in specific topic areas has worked well for us – this maximises multiple specialty faculty participation whilst keeping the debrief shorter and structured.

Conclusion Our tips that we have learnt from our MDT in-situ simulation debriefing process are largely around a credible, balanced faculty and structure to the debrief.
We do not have all the answers on this topic (and neither does the literature). More research needs to be done!

P62 'REVIVING, SURVIVING, THRIVING': ASSESSING THE IMPACT OF IN-SITU SIMULATION ON RESPONSE TO DETERIORATING PATIENTS
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Introduction Ensuring that patients who deteriorate receive appropriate and timely care is a key safety and quality challenge and a national priority. All patients should receive comprehensive care regardless of their location in the hospital or the time of day. Nurses who have the most frequent patient contact and responsibility for ongoing monitoring of patients play a crucial role in recognising and responding to clinical deterioration. The importance of education in supporting nurses to enhance their Acute Care Skills (ACS) and improve management of deteriorating patients is paramount.

Methods Explore the educational strategies to ensure qualified nurses are competent in accurately assess patients and recognise clinical deterioration; appreciate the urgency of a situation; can communicate effectively to escalate care and provide immediate appropriate interventions.

Design Phase 1:
- Tailored, classroom based teaching session for all nurses on ACS Study Day followed by an Objective Structured Clinical Examination to assess competencies.
- Facilitated learning and implementation of the National Early Warning Score (NEWS) 2.

Phase 2:
- In-situ simulation focusing on deteriorating patients, human factors, situation awareness, structured communication and detection of latent errors.
- Feedback post teaching sessions and simulation for educational improvement.

Preliminary results Post phase 1,
- Identified that nurses have adequate theoretical knowledge but fail to respond to deterioration in a consistent and timely manner as evidenced by clinical documentation.

Post phase 2,
- Clinical response and review, speed of response and seniority review were measured and remained the same between September 2018 and December 2018 (data collection):
- From January 2019, monthly ward based in-situ simulation program are planned and feedback will be collected quantitatively and qualitatively.

Conclusion The educational strategies have highlighted important aspects of patient safety in clinical deterioration and the role of qualified nurses. The program has assisted nurses to have the knowledge and skills needed to recognise and respond to patient deterioration in a more timely and effective way.

These strategies include:
- utilising clinical decision-making models; developing a standardised tool for systematic nursing assessment and management of clinical deterioration and conducting more