and Gynae placement is only four weeks, making it very difficult for students to experience all that the speciality 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

P61 MULTIDISCIPLINARY TEAM DEBRIEFING AFTER IN-SITU SIMULATION
Catherine Holmes*, Andrew Davies. Leeds General Infirmary, Leeds, UK
10.1136/bmjstel-2019-aspihconf.162

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 to 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