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 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
Sindhu Cyril*, Aeh Bu*, Ian Donaldson, Valerie Dimmock. Homerton University Hospital NHS Trust, Hackney, UK
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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
STORIES OF SUCCESS: DEMONSTRATING IMPROVED PERFORMANCE IN JUNIOR DOCTORS AFTER SIMULATION: A 12 MONTH FOLLOW UP NARRATIVE STUDY

Nathan Oliver*, Heather Stirling, NHS Lothian, Edinburgh, UK

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Introduction and aims A large amount of the credibility of immersive simulation rests on the assumption that the experience of simulation positively impacts on clinical behaviour. Research has shown a positive relationship between simulation and the development of skills and confidence but it is often stated that more research is required to demonstrate transfer of learning to the workplace, impact on patient outcomes and to demonstrate the longitudinal effects of behaviour change.

In fact, many studies demonstrated that postgraduate continuing professional education had a lack of effect on physicians performance of current practice guidelines.

Simulation has been highlighted as an important tool in improving safe delivery of medical care but medicine is lagging behind due to financial limitations, therefore it is essential that we can evidence an improvement in clinical competence and patient safety to justify this cost.

In 2013, a simulation programme was set up for first year junior doctors, to respond to areas of the curriculum which they were finding hard to evidence. This programme consists of three sessions that run over the year, focusing on technical and non-technical elements of patient care.

This study sought to look for what impact, if any, did the programme have on the performance and behaviour of first year junior doctors a year after they attended their first simulation teaching.

Methods This was a qualitative study utilising a narrative enquiry approach. Between 2013 and 2018, a voluntary questionnaire was sent to all junior doctors at completion of their first year of training. This questionnaire asked them to briefly describe, if possible, two specific accounts of when they were able to apply what they had learned during their simulation experience into their clinical setting. Questionnaires were coded and analysed using thematic analysis.

Results and discussion 264 junior doctors (n=264) returned their completed questionnaire for a total of 528 narrative accounts for analysis. The narratives draw strong, contextualised links from what was learned in simulation to direct positive impacts on their performance. The following five themes were identified: situational awareness, teamwork, communication, legal decision making, and the acute management of the unwell patient. Whilst acknowledging that the responses received in this study are inherently subjective in nature, it is asserted that the large sample size, along with the five year span of data collection year, add a level of validity in responding to the question at the centre of this enquiry.

REFERENCES

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USING SIMULATION-BASED LEARNING TO PROVIDE AN INTRODUCTION TO HUMAN FACTORS

1. Prateek Nalwaya*, 1Gregory Oxenham*, 1Luke McGeoch, 1Philippa Clery, 1Emma Sewart, 1Kajan Kamalanathan. 1University Hospitals Bristol, Bristol, UK, 2University of Bristol, Bristol, UK

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Background In 2016, a report by Health Education England advocated using simulation based-learning and placing a greater emphasis on human factors (HF) training to improve patient safety across the NHS. 3 HF have been incorporated into several post-graduate training programmes, in particular anaesthesia, where potential risk to patient safety is high. Our innovative, simulation-based, one-day course sought to expand this training to final year medical students.

Summary of work In this pilot, we organised two training days and a total of 33 students attended. The course began with a brief introductory lecture about HF concepts. Following this, six scenarios were simulated; these scenarios were based on real experiences that illustrated different aspects of HF.

Both before and after the course, the students completed a modified version of a 14-part questionnaire developed by Reedy et al. 2 to evaluate learning outcomes in HF training.

Summary of results The response rate was 100%. With respect to questions developed by Reedy et al. 2, using an ordinal Likert scale, we found that students’ greatest mean improvement in confidence (2.27) was in ‘monitoring the ‘big picture’ during a clinical scenario’ and the least improvement (1.24) was seen in ‘involving colleagues in your decision making’. With respect to our own questions, the greatest mean improvement in confidence was seen in ‘reporting a system error or critical incident’ (2.42). Pre-teaching and post-teaching feedback was analysed using a paired t-test and showed a significant improvement in human factor(s) skills (p<0.000001).

Qualitative feedback revealed that students appreciated opportunities to practice dealing with problems commonly encountered in foundation training, such as dealing with challenging colleagues and system errors. Negative feedback was largely directed at only being able to participate in one scenario.

Discussion and conclusions Simulation-based learning improved the confidence of our final year medical students in criteria relating to HF. Evaluating whether increased confidence leads to behavioural change is, however, fraught with difficulty. We plan to organise this training day for the next cohort of final year medical students, and in our future study design plan to include follow-up to assess if there has been an impact on their clinical practice.

Recommendations We believe that a major strength of our design was in having the faculty member who developed the simulation scenario - based on their own clinical experiences - also leading the ‘debrief’ for that session. This grounding in