Out of Hours

No more tick box resuscitation training:

simulation in the surgery

RELEVANT TRAINING WHERE IT MATTERS

I have been training GPs in life support for 20 years and have always striven to deliver relevant and resonant training. Over the past 2 years I have been applying some new techniques underpinned by the simulation teaching I have received as a Resuscitation Officer and found that these have transferred naturally into the GP treatment room.

It is clear that traditional classroom-style training for GPs is outdated. My practice now is to take full-body manikins of adult, child, and baby sizes into surgeries. Then, after a refresher lecture, I run scenario-style teaching and debriefs in the areas where medical emergencies would be managed, such as the treatment room. I'm aiming not just to test the medical practice but also how the space works as a whole — including the human-factor element — and the results have been interesting. The resuscitation attempt may be hampered by the poor positioning of the trolley and other furniture in the treatment room. Clinical staff can struggle with tasks such as accessing oxygen from a cylinder or assembling and operating bag valve masks. Staff may also have scanty knowledge of the contents of emergency equipment boxes.

These problems only come to light when scenarios are run with the staff, space, and equipment that the practice already has in place. By simulating a critical incident, nurses and medical staff handle and develop a familiarity with rarely used equipment and deficiencies come to light. I bring duplicates of disposable items so no practice equipment has to be opened. The training is of an equivalent length to classroom training, but more focused and relevant to the needs of the individual practice. All the scenarios that I run in the practice are written up and returned to those who have attended the simulation, along with comments and key learning points.

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RETHINKING SYSTEMS AND PROCESSES

The feedback I have received has been consistently positive. All the practices I have visited have been initially apprehensive but have welcomed the new method. Practices have rethought their systems and processes to the satisfaction of the staff involved, and used them to enhance their approach to patients who are deteriorating.

I have also explored the role of non-clinical practice staff and, alongside a GP colleague, have developed a checklist for them to be able to assist with important non-clinical tasks such as making 999 calls, contacting relatives, and printing off patient summaries, as well as supporting the clinical team. This practical preparedness gives confidence and encourages staff to unite to manage critical incidents.

SMARTER TRAINING

Mandatory Resuscitation Training, which can often be a quick hour of training in a classroom to 'tick a box', should no longer be acceptable. Events where patients require basic life support and resuscitation are rare but can be distressing for staff even when handled efficiently. However, training time does not need to be significantly longer than it is: it simply needs to be smarter and in line with modern educational practice.

Through relevant situated learning, practice staff can manage these infrequent but challenging events admirably. Scenario- and simulation-based teaching should therefore form the backbone of GP resuscitation training.

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DOI: 10.3399/bjgp17X688621