Simulation Training in Psychiatry

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Aims of workshop

- To explain what is meant by clinical simulation training (CST) in medical education
- To describe and discuss the multifactorial reasons for using CST in medical (indeed all health professionals) training
- To showcase two examples of CST in core training in psychiatry, successfully, in use
  - Formative Assessment of Communication Skills
  - Recognising and Assessing Medical Problems in a Psychiatric Setting
• 10.30 or 12.45 Introduction and setting scene to clinical simulation training
• 10.45 or 13.00 Formative Assessment of Communication Skills (FACS)
• 11.15 or 13.30 Recognising and Assessing Medical Problems in a Psychiatric Setting (RAMPPS)- scenario and staged debrief
• It is an interactive session and questions welcomed and encouraged throughout
What is simulation?

• ‘Simulation is a technique—not a technology—to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner.’ Prof D Gaba

• ‘Simulation offers a safe environment within which learners can repeatedly practise a range of clinical skills without endangering patients. Comprehensive simulated environments allow a move away from isolated tasks to more complex clinical situations, recreating many of the challenges of real life.’ Prof R Kneebone

• Various types of simulated experiences, in psychiatry usually:
  – Simulated individual patient scenarios, using either actors or volunteers
  – Simulated situations, e.g. MHA tribunals
  – Manikins and models of varying complexity
Why use simulation training?

• Learning from aviation industry
• Patient expectation
• “Safer Medical Practice” -importance of simulator training to improve performance and protect patients (CMO annual report 2008)
• Skills acquisition, maintenance and assessment in a reduced training time
How we learning and develop from simulation

The Personal Competence Development Cycle

- Smart Habit
- Unconscious incompetence
- Conscious incompetence
- Practice/Application
- Conscious competence
- Learning/Coaching
- Feedback
Fitts & Posner (1967): 3 phase model of skill acquisition

**Cognitive phase** - learner engages in cognitive activity listening to instructions and receiving feedback. Many errors, variable performance, little insight into how to improve

**Associative phase** - when performance is becoming skilled. It is a refining stage in which errors are identified and reduced

**Autonomous phase** - when the skill has become entirely automatic
Training conditions: variables that influence skill learning

- Explanations/Instructions: quality/timing
- Demonstrations: real/video; before/after
- Fractionation: part-task/whole task practice
- Simulation: high/low fidelity
- Feedback: during/after
- Motivation: intrinsic/extrinsic
- Amount of practice
- Support
Mastery Learning and 4/10: How to become an expert (Ericsson, 2006)

• Geniuses/Experts are made not born
  – Supportive environments
  – Important mentors
  – High investment of effort

‘The more I practise the luckier I get’ (Gary Player)

• High IQ not a predictor

• 4/10 rule: to become an ‘expert’ you practise/work 4hrs/day for 10 years (~10,000 hrs)
Some Experts
(From ‘Outliers’ by Malcolm Gladwell)

• **Bill Gates (Microsoft):**
  – at 14 starts programming (20-30 hrs/wk) for 7 years, drops out of Harvard and starts Microsoft

• **Average time to become chess-grandmaster ~ 10 years.**

• **The Beatles (founded 1957):**
    • 1 (106 nights),
    • 2 (92 nights)
    • 3 (48 nights)
    • 4 (10 nights)
    • 5 (10 nights)
  – By 1963 they had performed live 1,200 times
  – Sgt Pepper (1967) after 10 years together
Teaching with simulators
Advantages of using simulation

• Individual and on demand training
• Different situations (including uncommon presentations can be tried as can different techniques in same situation
• Learners can focus on whole or part of procedure
• Improves trainee confidence, reduces risk to patient and undesired interference
• Multiple sources of feedback may improve educational result
• Simulators give objective evidence of performance
Disadvantages

- Cost
- Infrastructure
- Technical difficulties
- Educational theory
- Attitudes of learner
- Evidence
Educational issues

- Feedback is the most important feature of simulation.
- Repetitive practice is a key feature in successful simulation.
- Simulation should be integrated into an educational curriculum for effective use.
- A range of task difficulty is important as was adaptability of the simulator for multiple learning strategies.
- Simulators are more useful if they could capture a wide variety of clinical conditions rather than a narrow range.
- Simulation should occur in a controlled environment to allow errors to be made without adverse consequences.
- Simulation should include individualisation i.e. everyone has a chance to be an active participant rather than passive bystander.
- Learning outcomes are more likely to lead to mastery of a skill.
- Simulation should be valid or it is unlikely to produce effective learning.
Simulated Patients
Using CST in Psychiatry

• Communication & clinical interview skills can be taught
• These are essential competency in psychiatry for patient centred care (Good Medical Practice, MRCPsych, Francis)
• Practice of these skills safest in a clinical simulation environment
• Can be as informal as role play between trainees and trainers to full MDT training courses in a clinical simulation centre
• CASC pass rate remains low (51.8% in Jan 13)
• CASC examines process and content of clinical interview
• Majority failing do not demonstrate process of interviewing
• CST from CT1 to identify and monitor strengths and developmental needs in communication & clinical interview skills should improve competencies in process of interviewing before considering CASC application
• Most deaneries will have a Clinical Simulation Strategy
Yorkshire School of Psychiatry Strategy for CST in Core Training

• Quality assured and progressed via School Working Group, including clinical SIM fellow reporting to School management committee

• CT1
  clinical interview skills
  Formative Assessment of Communication Skills (Yorkshire modified version)
  ST mentor scheme

• CT2
  Recognising and Assessing Medical Problems in a Psychiatric Setting
  CASC training
  Repeat of FACS if required

• CT3
  CASC training
FACS - Pilot 2012, Summary

- Held at end CT1
- 4 sites (EMHWD, Wessex, Yorks, NE)
- 3 patient simulation scenario (upset colleague, sexual dysfunction, grief)
- 2 assessors
- 10 minutes task
- 10 minutes immediate feedback
- Written feedback tool to take away
- Post assessment reflection and PDP
Assessment Tool

Key features:
- 3 competency areas – ES, VC, NVC
- Mix of checklist (derived from CC) and observed behaviour recorded
- Anchor descriptors of desirable\undesirable behaviours
- 6 Outcomes
  - Minimal\No demonstration
  - Needs improvement – significant, moderate, minor
  - Competent for end CT1
  - Exceeds expectations for CT1
Key Findings

• Highly valued by trainees and assessors/trainers
• Overall positive comments for validity and feasibility
• Question of reliability which needs further evaluation (but similar to other assessment of this kind)
• Trainees wanted more training and more assessments
• Initial findings suggest differences in performance depending on place of qualification and that communication skills for psychiatrists can be taught
Key Recommendations

• In current format
  – Should remain formative
  – Session should be videotaped – including the feedback
  – Some adjustments to the assessment tool
  – Include in core curriculum

• Need to incorporate communication skills programmes into MRCPsych courses
What has been taken forward......

• Yorkshire
• East Midlands
2013 FACS Yorkshire

- 2 successive observed scenarios using patient simulators each totalling 30 minutes.
- 10 minutes to read the instructions and complete the task.
- 20 minutes face to face immediate feedback
- Assessor and trainee to complete an agreed PDP
- Video and PDP kept by trainee
- ST mentor referral
‘Very helpful to look at my strengths and weaknesses.’ Attending CT

‘Knowledge of this at an early stage in training is vital.’ Attending CT

‘THANK YOU all for the excellent work towards helping us improve our skills.’ Attending CT

‘Very helpful at this level of training to identify weak areas. Should be offered to everyone.’ Attending CT

‘I just wanted to say that I thought the FACS event which you organised was really excellent! Apart from the superb planning and smooth running of the event, I thought it was really valuable and clearly revealed an eyewateringly wide variety of communication skills.’ TPD for CT East locality

‘So much improved on last year with the forms and feedback, I really think we should make it mandatory next year.’ College Tutor West locality

‘Any chance you could let me have a copy of the FACS feedback form? Would like to incorporate some of it into an undergrad equivalent if poss. All will of course be gratefully attributed!’ Senior Lecturer in Liaison Psychiatry of Old Age University of Leeds
FACs 2013 East Midlands (North)......

- Re-organised and incorporated communication skills training courses into the new EM LETB MRCPsych Course
- Not been easy........
- Negotiations ongoing
Course Outline

- Year 1 – Basic consultation skills for psychiatrists
- Year 2 – Advanced consultation skills for psychiatrists

Approx 18 sessions each year. Across both years:
- Some theoretical background
- Use exercises to highlight and demonstrate a certain skill\features
- Use role play
- Use simulated clinical scenarios
- Use video feedback
Course Objectives

- To improve participants clinical consultation skills
- To enable the participants to use their range of communication skills techniques across a more diverse and challenging set of circumstances
- Encourage adaptability and improve confidence
- Improve with practice
- (Improve performance at CASC)
The 3+T model

- **Beginning**
  - Suss things out
  - Rapport building

- **Middle**
  - Eliciting
  - Explaining
  - Influencing and negotiating

- **End**
  - Forward planning
  - Appropriate ending

- **+ Toolkit**
  - Calibration & Pacing
  - Mirroring or Matching
  - Moving up and down the question tree
  - Chunking and checking
  - Summarising
  - Reflecting
  - Leading
  - Anti-Pacing or Breaking Rapport
FACS 2013

- Re run April 2013
- Same 3 scenarios – some adjustments to scenarios is response to feedback
- Whole session videotaped – task and feedback
- 1 assessor only – less reliance on written feedback form for both
- Each trainee given a CD of their personal circuit to help develop their PDP
Giving Feedback – Advocacy with Enquiry

Advocacy

▪ State what you observed

Enquiry

▪ Ask why they did that

▪ Ask how that might be perceived by others
  If not able to express help out ie

▪ Describe how you perceived it or how others might)
Recognising and Assessing Medical Problems in Psychiatric Settings: The RAMPPS Course

Royal College of Psychiatrists
PGME Conference, Edinburgh, 27th September 2013
Mortality rate for mental illness is three times the population average

28 JUNE, 2012 | BY SHAUN LINTERN

People who suffer with a serious mental illness have a mortality rate three times as high as those in the general population, according to new research.
PHYSICAL DISORDER IN 164 CONSECUTIVE ADMISSIONS TO A MENTAL HOSPITAL

THE incidence AND SIGNIFICANCE

BY

ROBERT J. PHILLIPS, M.B., B.Ch., B.Sc.

Late Assistant Medical Officer, Glamorgan County Mental Hospital
There is, indeed, an obvious need for a miniature general hospital, with all its numerous departments, within the organization of each mental hospital, and consequently a real necessity for a resident house-physician whose sole function would be the care of the bodily ailments of the patients. It is only when such a burden is removed from the shoulders of the resident mental medical officers that the problems of mental disorders, uncomplicated by other factors, can be fruitfully investigated.
Call for mental health nurses to recognise patients' poor physical health

21 March, 2011

Poor physical health is common among people with serious mental illness in the UK, recent research has revealed.

High levels of diabetes, heart disease and obesity were uncovered among 782 patients who had conditions such as bipolar disorder and schizophrenia.

This explains why their life expectancy is significantly reduced, according to the researchers from the University of East Anglia.
Student Editor Blog

‘Why isn’t physical assessment a bigger part of mental health nurse training?’

4 June, 2013

I’ve come to realise that your nursing training is what you make of it and everybody’s experience will be different.

**One thing that does concern me is the lack of physical assessment skills that student mental health nurses are taught at university**

Just because you don’t cover something at university, you might encounter it on placement, and vice versa.

But one thing that does concern me is the lack of
We need to develop bands 1-4 staff. They are 40% of our workforce and have 60% of patient contact - @hee_ian #francis #HEE
The Annual London Deanery Trainee Survey 2012 – On call shift

How confident did you feel on your first ever on-call shift?

- Not at all confident
- Not very confident
- Quite confident
- Very confident
- Not applicable

Bar chart showing the distribution of responses.
The Annual London Deanery Trainee Survey 2012 - Confidence

- Write a clinical report: 39.7% (Not Very confident), 16.4% (Not at all confident)
- Prescribe including rapid tranquillisation: 44% (Not Very confident), 25% (Not at all confident)
- Make a basic management plan: 49.1% (Not Very confident), 9.5% (Not at all confident)
- Perform a physical examination: 4.6% (Not Very confident), 4% (Not at all confident)
- Perform a risk assessment: 42.2% (Not Very confident), 12.9% (Not at all confident)
- Perform a cognitive screening assessment: 45.7% (Not Very confident), 7.8% (Not at all confident)
- Perform a mental state examination: 29.3% (Not Very confident), 1.7% (Not at all confident)
- Elicit a clinical history: 23.3% (Not Very confident), 1.7% (Not at all confident)
No health without mental health

A cross-government mental health outcomes strategy for people of all ages
NHS Outcomes Framework

- **Domain 1**: Preventing people from dying prematurely
- **Domain 2**: Enhancing quality of life for people with long-term conditions
- **Domain 3**: Helping people to recover from episodes of ill health or following injury
- **Domain 4**: Ensuring that people have a positive experience of care
- **Domain 5**: Treating and caring for people in a safe environment and protecting them from avoidable harm

- **Effectiveness**
- **Patient experience**
- **Safety**
# Domain 1: Preventing people from dying prematurely

## Overarching indicators

1a Mortality from causes considered amenable to healthcare  
(The NHS Commissioning Board would be expected to focus on improving mortality in all the components of amenable mortality as well as the overall rate)  
1b Life expectancy at 75

## Improvement areas

### Reducing premature mortality from the major causes of death

1.1 Under 75 mortality rate from cardiovascular disease*
1.2 Under 75 mortality rate from respiratory disease*
1.3 Under 75 mortality rate from liver disease*
1.4 Cancer survival  
   i One- and ii five-year survival from colorectal cancer  
   iii One- and iv five-year survival from breast cancer  
   v One- and vi five-year survival from lung cancer

### Reducing premature death in people with serious mental illness

1.5 Under 75 mortality rate in people with serious mental illness*

### Reducing deaths in babies and young children

1.6.i Infant mortality*  
1.6.ii Perinatal mortality (including stillbirths)

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*Shared responsibility with Public Health England  
Note: Indicators in italics are placeholders, pending development or identification of a suitable indicator
## Domain 4: Ensuring that people have a positive experience of care

### Overarching indicators

<table>
<thead>
<tr>
<th>4a</th>
<th>Patient experience of primary care</th>
</tr>
</thead>
<tbody>
<tr>
<td>4b</td>
<td>Patient experience of hospital care</td>
</tr>
</tbody>
</table>

### Improvement areas

- **Improving people’s experience of outpatient care**
  - 4.1 Patient experience of outpatient services

- **Improving hospitals’ responsiveness to personal needs**
  - 4.2 Responsiveness to inpatients’ personal needs

- **Improving people’s experience of accident and emergency services**
  - 4.3 Patient experience of A&E services

- **Improving access to primary care services**
  - 4.4 Access to GP services and dental services

- **Improving women and their families’ experience of maternity services**
  - 4.5 Women’s experience of maternity services

- **Improving the experience of care for people at the end of their lives**
  - 4.6 *An indicator needs to be developed based on the survey of bereaved carers.*

- **Improving experience of healthcare for people with mental illness**
  - 4.7 Patient experience of community mental health services

- **Improving children and young people’s experience of healthcare**
  - 4.8 *An indicator needs to be developed.*
Introduction

- **My Background** (Mental Health Nurse, Humber Foundation Trust)

- **Project Background** **SCSA**
  - Deliver the CS Strategy
  - Liberating the NHS
  - Developing the Healthcare Workforce
  - Framework for Technology Enhanced Learning
  - Delivering High Quality, Effective, Compassionate Care
  - SCSA Work-streams

- **Physical Health Agenda for MHLD**

- **Conferences**
Regional group formulated

Raised lots of questions?

- Is simulation possible with MHLD?
- Do we have any simulation centres?
- What types of scenarios?
- Who would run them (faculty)?
- What equipment would be needed?
- Must it be inter-professional?
- Debriefing?

Dr Paul Rowlands (Head of School of Psychiatry for the Y&H Deanery)

Recognising and Assessing Medical Problems in Psychiatric Settings (RAMPPS) created and piloted at Leeds CPC

Appointment of psychiatry simulation fellow – Dr Mike Akroyd
A Competency Based Curriculum for Specialist Core Training in Psychiatry

CORE TRAINING IN PSYCHIATRY CT1 – CT3

Royal College of Psychiatrists

February 2010

© Royal College of Psychiatrists 2010
Essential skills clusters (2010) and guidance for their use (guidance G7.1.5b)

The essential skills clusters (ESCs) are to be used as guidance and should be incorporated into all pre-registration nursing programmes. How they are incorporated into programmes is left to local determination. Programme providers can use them to develop learning outcomes at different levels or to map them against existing programme learning outcomes. Some programme providers may wish to map them to specific competencies within the domains or use them to develop practice assessment tools. All the ESCs apply to all fields of nursing.
First Steps for health care assistants
online induction programme

Competence checklist pack

February 2011
Recognising and Assessing Medical Problems in Psychiatric Settings:
The RAMPPS Course

Clinical Simulation Scenarios

The RAMPPS Development Team
June 2013

DRAFT
1. Brain Tumour
2. Chest Infection
3. Hypoglycaemia
4. Substance Abuse, Respiratory Depression
5. Complications of Rapid Tranquilisation
6. Neuroleptic Malignant Syndrome
7. Wernicke’s Encephalopathy
8…
RAMPPS

- Delegate team
  - Health Care Assistants, Nursing staff, Core trainees
- 10–15min scenario
  - Handover of information
  - Decision-making
  - ABCDE approach
- c.45 min debrief
  - Use of video
  - Reflection
RAMPPS
RAMPPS
RAMPPS
<table>
<thead>
<tr>
<th>RCNHCA First Steps Curriculum “I am confident in…” (n=8)</th>
<th>Mean pre-course</th>
<th>Mean post-course</th>
<th>Mean difference</th>
<th>Wilcoxon Signed Rank: z score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Communicating information clearly, accurately, in a timely fashion</td>
<td>3.0</td>
<td>1.9</td>
<td>-1.1</td>
<td>0</td>
</tr>
<tr>
<td>2. Taking action to address any misunderstandings</td>
<td>2.9</td>
<td>1.6</td>
<td>-1.3</td>
<td>-0.6</td>
</tr>
<tr>
<td>3. Presenting suggestions and offering ideas to the MDT</td>
<td>2.5</td>
<td>2.4</td>
<td>-0.1</td>
<td>1.1</td>
</tr>
<tr>
<td>4. Taking action to deal with health and environmental emergencies</td>
<td>3.1</td>
<td>2.0</td>
<td>-1.1</td>
<td>-0.8</td>
</tr>
<tr>
<td>5. Summoning assistance appropriate to emergencies</td>
<td>3.1</td>
<td>1.6</td>
<td>-1.5</td>
<td>0</td>
</tr>
<tr>
<td>6. Working with individuals to identify situations that may result in danger</td>
<td>3.3</td>
<td>1.4</td>
<td>-1.9</td>
<td>-1.3</td>
</tr>
<tr>
<td>7. Identifying and acting when behaviour changes may lead to danger</td>
<td>3.1</td>
<td>1.4</td>
<td>-1.8</td>
<td>-1.4</td>
</tr>
</tbody>
</table>

9-point Likert item: 1 = strongly agree; 9 = strongly disagree; 5 = neutral
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<tbody>
<tr>
<td>8. Collaborating when situations require close team working</td>
<td>3.1</td>
<td>1.5</td>
<td>-1.6</td>
<td>-0.9</td>
</tr>
<tr>
<td>9. Ensuring behaviour towards others supports team function</td>
<td>2.9</td>
<td>1.4</td>
<td>-1.5</td>
<td>-1.3</td>
</tr>
<tr>
<td>10. Ensuring no action makes other individuals feel inferior</td>
<td>2.8</td>
<td>1.5</td>
<td>-1.3</td>
<td>-0.8</td>
</tr>
<tr>
<td>11. Providing ongoing support within my own competence</td>
<td>2.6</td>
<td>1.5</td>
<td>-1.1</td>
<td>-1.0</td>
</tr>
<tr>
<td>12. Recognising the boundary of my own role and responsibility</td>
<td>2.6</td>
<td>1.1</td>
<td>-1.5</td>
<td>-0.8</td>
</tr>
<tr>
<td>13. Taking measurements at the prescribed time, in sequence</td>
<td>2.6</td>
<td>1.5</td>
<td>-1.1</td>
<td>-0.3</td>
</tr>
<tr>
<td>14. Using appropriate equipment to obtain accurate measurements</td>
<td>2.6</td>
<td>1.5</td>
<td>-1.1</td>
<td>-0.3</td>
</tr>
</tbody>
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<tr>
<th>NMC Essential Skills Clusters “I am confident in...” (n=19)</th>
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<th>Mean post-course</th>
<th>Mean difference</th>
<th>Wilcoxon Signed Rank: z score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstration of sound knowledge, skills and understanding</td>
<td>2.4</td>
<td>2.2</td>
<td>-0.2</td>
<td>-0.7</td>
</tr>
<tr>
<td>2. Knowledge of own limitations and taking appropriate action</td>
<td>2.4</td>
<td>1.9</td>
<td>-0.5</td>
<td>-2.3*</td>
</tr>
<tr>
<td>3. Listening to, watching for and responding to verbal/non-verbal cues</td>
<td>2.4</td>
<td>2.0</td>
<td>-0.4</td>
<td>-1.4</td>
</tr>
<tr>
<td>4. Communicating effectively and sensitively in different settings</td>
<td>2.4</td>
<td>2.1</td>
<td>-0.4</td>
<td>-1.7</td>
</tr>
<tr>
<td>5. Actively consulting and exploring ideas and solutions with others</td>
<td>2.5</td>
<td>1.9</td>
<td>-0.6</td>
<td>-1.9</td>
</tr>
<tr>
<td>6. Working within requirements of the Code in delegation/being delegated to</td>
<td>2.2</td>
<td>1.7</td>
<td>-0.5</td>
<td>-2.0*</td>
</tr>
<tr>
<td>7. Inspiring confidence and providing clear direction to others</td>
<td>2.6</td>
<td>2.1</td>
<td>-0.5</td>
<td>-2.3*</td>
</tr>
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* denotes p < 0.05
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<tr>
<td>“I am confident in...”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(n=19)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Managing my time effectively</td>
<td>3.0</td>
<td>2.2</td>
<td>-0.7</td>
<td>-2.6*</td>
</tr>
<tr>
<td>9. Prioritising my own workload and managing conflicting priorities</td>
<td>2.8</td>
<td>2.3</td>
<td>-0.5</td>
<td>-1.9</td>
</tr>
<tr>
<td>10. Assessing and implementing measures to manage risk</td>
<td>2.5</td>
<td>2.0</td>
<td>-0.6</td>
<td>-2.0</td>
</tr>
<tr>
<td>11. Applying appropriate measures for conflict resolution and de-escalation</td>
<td>2.6</td>
<td>2.3</td>
<td>-0.4</td>
<td>-1.0</td>
</tr>
<tr>
<td>12. Working in and leading teams to develop treatment options</td>
<td>2.3</td>
<td>2.0</td>
<td>-0.3</td>
<td>-1.6</td>
</tr>
<tr>
<td>13. Administering medicines via routes commonly used, maintaining records</td>
<td>2.1</td>
<td>1.9</td>
<td>-0.4</td>
<td>-0.5</td>
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<th>RCPsych Core Curriculum “I am confident in...” (n=13)</th>
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<tbody>
<tr>
<td>1. Assessing for the presence of general medical illness</td>
<td>3.3</td>
<td>2.5</td>
<td>-0.9</td>
<td>-2.7*</td>
</tr>
<tr>
<td>2. Interpreting the results of investigations</td>
<td>3.6</td>
<td>2.8</td>
<td>-0.8</td>
<td>-2.4*</td>
</tr>
<tr>
<td>3. Applying knowledge of the implications of coexisting illnesses</td>
<td>3.4</td>
<td>2.5</td>
<td>-0.9</td>
<td>-2.7*</td>
</tr>
<tr>
<td>4. Supervision and management of challenging behaviour and medical complications</td>
<td>4.9</td>
<td>2.8</td>
<td>-2.2</td>
<td>-3.1*</td>
</tr>
<tr>
<td>5. Ability to stay within limits of my expertise</td>
<td>2.2</td>
<td>1.6</td>
<td>-0.6</td>
<td>-1.2</td>
</tr>
</tbody>
</table>

* denotes p < 0.05

9-point Likert item: 1 = strongly agree; 9 = strongly disagree; 5 = neutral
<table>
<thead>
<tr>
<th>RCPsych Core Curriculum</th>
<th>Mean pre-course</th>
<th>Mean post-course</th>
<th>Mean difference</th>
<th>Wilcoxon Signed Rank: z score</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;I am confident in...&quot; (n=13)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Demonstration of respect, empathy, responsiveness and concern</td>
<td>2.5</td>
<td>1.5</td>
<td>-1.0</td>
<td>-2.4*</td>
</tr>
<tr>
<td>7. Ability to communicate and work effectively with team members</td>
<td>2.9</td>
<td>1.7</td>
<td>-1.2</td>
<td>-2.7*</td>
</tr>
<tr>
<td>8. Demonstration of respect for skills, contributions and opinions of others</td>
<td>2.5</td>
<td>1.5</td>
<td>-0.9</td>
<td>-2.2*</td>
</tr>
<tr>
<td>9. Demonstration of a good understanding of clinical priorities</td>
<td>2.9</td>
<td>1.7</td>
<td>-1.2</td>
<td>-2.4*</td>
</tr>
<tr>
<td>10. Responding appropriately to requests when on call</td>
<td>3.1</td>
<td>1.7</td>
<td>-1.4</td>
<td>-2.4*</td>
</tr>
<tr>
<td>11. My behaviour, in accordance with contemporary standards of practice</td>
<td>2.5</td>
<td>1.5</td>
<td>-1.0</td>
<td>-2.1*</td>
</tr>
</tbody>
</table>

* denotes p < 0.05
9-point Likert item: 1 = strongly agree; 9 = strongly disagree; 5 = neutral
### Questions relating to RAMPPS course (n=43)

<table>
<thead>
<tr>
<th>Question</th>
<th>HCA Mean</th>
<th>NS Mean</th>
<th>CT Mean</th>
<th>Whole Group Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>The scenarios reflected situations that I have been in</td>
<td>1.4</td>
<td>2.0</td>
<td>2.6</td>
<td>2.1</td>
</tr>
<tr>
<td>I found the use of video intimidating</td>
<td>5.0</td>
<td>4.7</td>
<td>6.3</td>
<td>5.2</td>
</tr>
<tr>
<td>I performed better in the scenarios than I would in real life</td>
<td>4.8</td>
<td>6.5</td>
<td>6.6</td>
<td>6.2</td>
</tr>
<tr>
<td>I found it hard to give feedback to colleagues</td>
<td>6.6</td>
<td>6.2</td>
<td>7.3</td>
<td>6.6</td>
</tr>
<tr>
<td>I received some useful feedback about my own performance</td>
<td>3.1</td>
<td>2.1</td>
<td>2.7</td>
<td>2.5</td>
</tr>
<tr>
<td>I think that other colleagues at my training level would benefit from this type of course</td>
<td>2.1</td>
<td>1.5</td>
<td>2.6</td>
<td>1.8</td>
</tr>
<tr>
<td>I think that everyone should have to take part in RAMPPS</td>
<td>1.9</td>
<td>1.2</td>
<td>1.9</td>
<td>1.7</td>
</tr>
<tr>
<td>I will now feel more able to assess and manage medical problems that arise in psychiatric settings</td>
<td>2.1</td>
<td>2.3</td>
<td>2.3</td>
<td>2.3</td>
</tr>
</tbody>
</table>

**9-point Likert item: 1 = strongly agree; 9 = strongly disagree; 5 = neutral**
Overall RAMPPS course

Course organisation

- “All of it was fab, including working in an MDT with Doctors, Nurses and Nursing Assistants. Hearing others’ views and opinions in MDT” NSR2

- “Well-structured and organised” CTR1
Overall RAMPPS course

- Usefulness of RAMPPS
  - “Very useful” HCAR1, HCAR3, NSD5
  - “Thank you for a day of learning. I enjoyed it” HCAD2
  - “Excellent. More, more, more! Everyone should do this” NSD6
MDT, Team–working

“All of it was fab, including working in an MDT with Doctors, Nurses and Nursing Assistants. Hearing others’ views and opinions in MDT” NSR2

“The communication between different members of MDT was something which was highlighted during the sessions” CTD1

“Working in a real life like scenario with other members” CTD1
Scenarios
Jane Collins is a lady with a history of psychosis and previous heroin dependence.

She has been receiving treatment on the ward for the last 4 weeks, and is detained under Section 3 MHA.

She has just been returned by the Police, having taken some unauthorised leave.
Special thanks to:

- Dr. Priya Thaker
  - CT2 Trainee, Yorkshire & the Humber Training Scheme
- Ms. Kazia Gamble
  - Actor
Thank-you and questions

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