Negative learning: the invisible outcomes
Research students collaborate to innovate
So you want to be a SimCo...
Celebrating errors
Interviews with Darren Lawrence and Joseph Sharpe
Executive address

2015 has proven to be a monumental year for the Clinical Skills Development Service (CSDS). Whether it is has been through our involvement in the delivery of national and international level events, supporting the ever-increasing numbers of simulation providers, or the addition of new courses into our program, CSDS has not stopped supporting clinicians, at the state, national and international levels.

This edition provides some food for thought on where education and research in healthcare is going and also identifies some of the highlights that CSDS will progress as we all move into 2016.

On behalf of all of the team here at CSDS, I would like to wish you all a safe and merry festive season and invite you to continue your patronage to CSDS and this magazine.

A/Prof Marcus Watson / Executive Director, CSDS
Do you celebrate your errors? Your first reaction to that question is most likely a resounding ‘no’. Why would you? In general, we are not taught to. We are encouraged to own up to them, to rectify them, to not repeat them, but are rarely told that we should see our failures as a good thing. However, there is a growing body of research that suggests that we should celebrate our errors, and in this article I am going to suggest that there are three reasons why. I am also going to link these reasons back to what we do here at the Clinical Skills Development Service (CSDS).

Reason one: when we make a mistake, work through that mistake, and move on, we develop resilience and make it more likely that we will achieve success later on. In the New York Times article ‘What if the secret to success is failure?’ Paul Tough explores how it is important for children to fail a few times early in life. If children do not face set backs early on, they may not build resilience and strength and then the first major set back or challenge they face (often at College) may cause them to have a major crisis1.

For clinicians, having the opportunity to make errors and ‘fail’ in a safe learning environment, like the one at CSDS, develops resilience for future practice, and reinforces skill in the very areas that provide the greatest challenge.

Reason two: the very fact that you are making errors suggests (perhaps) that you are attempting to break new ground; that you are trying new things. You can be sure that before any innovation is successful, there is a string of failures and errors that have led to that success. The flipside of this is that if you are so frightened to make an error that you do not try anything new...that is a great loss.

At CSDS we are constantly trying new things. There are errors and failures along the way, but we are encouraged to air them and learn from them, and most importantly move on and progress, and the innovation does eventuate, and how many errors it took to get there does not dampen that success.

Reason three: this is perhaps the most important one, if we do not celebrate our errors, we perhaps do the opposite: we ignore them, we disregard them, and we overlook them. In a learning environment, such as CSDS, we address errors or failings because if we were to ignore them or disregard them, the participant would not learn, and they would take that practice into their workplace, and this would have real world consequences. Of course, addressing errors or failures is always done sensitively, and participants are always supported in the process of working on their deficits.

If you take this further and think about the clinicians back in their workplaces, it gets even more serious. If a clinician makes a clinical error and conceals, it can have dire consequences for patient safety. If they, instead, admit to their mistake, it means that something can be done. The situation itself may not be redeemable, but talking about what has happened and highlighting it can ensure it does not happen again.

In Joseph Loscalzo’s editorial ‘A Celebration of Failure’ he says that failure has ‘at least as important a role in our experience, education, and professional development as success, if we would only learn from it’2. This is a sentiment that CSDS also holds.

So, do you celebrate your errors? You should.

By Gemma Collett, Instructional Designer, CSDS

References
**What’s new at CSDS?**

In this edition the STaR magazine is introducing a section titled: ‘What’s new at CSDS?’.
This section will describe some of the exciting changes and developments that are happening at the service.

---

1. **Honorary fellowship**
   - The CSDS Honorary Fellowship Program provides an opportunity for healthcare professionals to learn about the use of simulation-based education in healthcare. Dr Caroline Heggie, Registrar Emergency Medicine at the QEII Hospital, was the first to successfully complete the Honorary Fellowship Program on 9 July 2015. Registrar Emergency Medicine Dr Cherie Watts, our second fellow, is also from Queen Elizabeth II Jubilee Hospital. She will pursue her fellowship at CSDS from August until December 2015.

2. **Audiovisual installations**
   - Our audiovisual technicians have been busy ensuring our Pocket Centres are kept up to date with custom-built systems to suit individual site needs. In order to provide support across Queensland, the technicians are required to travel great distances.

   Recent trips include installations at:
   - Ingham: High-definition (HD) mobile system
   - Cooktown: Fixed standard-definition system
   - Gold Coast: HD mobile system
   - Redland: HD fixed system in the emergency department and an HD mobile system in the anaesthetic department
   - Prince Charles: HD fixed system
   - Carins: HD fixed system (x3).

   The technicians assemble all audiovisual products in house at CSDS before they are shipped to the location. Once the system and technicians are on site, they will finish the installation and provide training for the Pocket Centre staff.

3. **The Clinical Preparation Program moves to eLearning**
   - The Clinical Preparation Program has utilised video conferencing successfully for many years. Later this year it will improve delivery by moving to a new eLearning format. This will provide rural and remote clinicians with flexible access to the program via the internet.

4. **CSDS Central resources for Pocket Centres**
   - One of the applications of CSDS Central is an interactive curriculum system. It supports the sharing of learning materials across the Pocket Centre network.

   Recent additions to the database are:
   - an updated scenario template featuring a wider variety of patients (male, female, adult, child)
   - an updated skills station template
   - an improved simulation event report template.

   CSDS Central includes a range of educational resources from clinical scenarios to manuals and guides. Anyone who is associated with a Pocket Centre and has completed the CSDS Simulation Coordinator Training Program has access to these resources. There is also an option to upload educational resources that have been developed in the Pocket Centres to the system so that all the sites can benefit. The person submitting a resource will get author credit for the submission on the site. For more info contact CSDS-Admin@health.qld.gov.au or +61 7 3646 6500.

5. **CSDS blog updates**
   - Over the coming months we will be adding more resources to CSDS Central. We recommend you check our blog regularly for updates.
CSDS is proud to announce the latest addition to the curriculum brood. And it’s a... maternity course!

CSDS’s new maternity course will be the first in a suite of new courses that couple an interactive eLearning module with a simulation-based face-to-face module. We have designed this course in response to feedback from our stakeholders; you provide feedback, we listen!

This course will be aimed at maternity specialists, midwives and any other clinicians who may be exposed to the birthing process as part of their work.

To commence the course participants enrol and complete a self-paced eLearning module. This will prepare participants for the face-to-face module and expose them to crisis resource management principles, that will be discussed during the face-to-face debriefs. This eLearning module can be completed anywhere, anytime, and participants can stop and start as needed.

The four-hour face-to-face module focuses on maternity-based crisis scenarios. The scenarios are based on real crises that have occurred, and are run in a simulated clinical setting. After each scenario, the team will participate in a debrief. The debrief consists of a guided reflection and a focused discussion. It is an open forum for discussion around what has occurred during the scenario, how everyone felt about it, and related thought processes. The debrief provides the opportunity to identify areas of positive performance as well as areas for improvement. These debriefs will be led by clinical and simulation experts.

This maternity course will also embrace new technology by incorporating the Laerdal SimMom and the new Automatic Delivery Module. The latest modifications to SimMom allow for wireless connectivity and either manual or automatic delivery of the baby; there is also increased fidelity with more life-like anatomy of the mother and baby. This increased fidelity is sure to create a more immersive environment and offer more options around the variety of scenarios that can be run; it provides the perfect opportunity for participants to practise critical events with no danger to real mothers and babies.

For more information on this great new course from CSDS please visit our website at www.sdc.qld.edu.au

Since opening in 2004, the Clinical Skills Development Service (CSDS) has gained plenty of valuable experience in developing eLearning. We have transitioned through a number of changes in a continuous quest to meet both training and business needs.

Up until now, CSDS has focused on developing custom-built educational solutions. By doing this, CSDS have been able to create highly-interactive eLearning with high-quality assets developed to consolidate learning and assess participants. Unfortunately, this custom approach was generally expensive and time consuming, both in creation and in maintenance and a standardised approach to development couldn’t be achieved.

As this custom-built model was not sustainable, CSDS ventured into the environment of rapid development in January 2015.

Rapid development, as its name suggests, means a shorter development time frame. CSDS purchased an off-the-shelf platform, and have used this to develop eLearning packages, allowing templates to be created and a standardised approach to be utilised. The flow-on effect of this is that courses cost less to develop. An eLearning course developed in this manner can also be easily and quickly maintained.

As technology and the needs of a highly-mobile workforce continue to change, CSDS is prepared to be agile and evolve to support this growing trend, and to support those who seek to develop their own courses. In 2016 we will release a new eLearning development environment to provide those at the point of care with the ability to design, develop and deliver eLearning and blended courses quickly. This rollout will initially target those in Pocket Centres, but will then have a broader reach.

How great would it be if you had the ability to develop your own training, using a rapid development eLearning tool not dissimilar to PowerPoint? What if you could also access a library of existing images and interactions configured for eLearning and clinical environments? Well, this will all be possible next year. With these resources at your fingertips, you will be able to create an eLearning package for your course participants, and if you have technical problems, or need some advice, a team of experienced CSDS eLearning developers will be available to assist you by taking photos, capturing videos, creating animations, or building learning interactions.
Darren Lawrence interview
Queensland Ambulance Service

Darren Lawrence has lived in Brisbane for 15 years and has been a paramedic for nine and a half of those years. Prior to working with the Queensland Ambulance Service (QAS), Darren was a chef and then a manager. He has worked across the world in different locations such as the UK and Korea, and has worked for 12 months in a two Michelin star awarded restaurant. Darren is married with three children; two daughters and one son.

What first drew you to be a paramedic?
I have always loved helping people, and this is where my drive to become a paramedic came from. I couldn’t think of a better job than one that involves helping people each and every day. The autonomy of the job also appealed to me, as well as the variety of work.

And then, what prompted your transition into education?
The foundations of a paramedic’s skill set come from their training. Culture change also starts with how you learn the basics. Education enables me to train and assist staff from the novice to the experienced practitioner.

You are a clinical support officer with the QAS. Can you explain what this role entails?
As a clinical support officer (CSO) I am fortunate to have a varied and challenging role within the Metro North Clinical Education Unit. I am a frontline supervisor whilst still being an operational paramedic, primarily responding to emergencies as a single response. I also provide real-time coaching to paramedics, where I attend cases either as a single response or part of a crew, and provide coaching, feedback and assistance as required, which is part of QAS’s clinical governance model. I might be called upon to assist with mass casualty incidents, or debrief crews who have had a difficult case. Another component of being a CSO is education delivery. One day I might be teaching the new digital clinical practice manual to a classroom of paramedics, the next day I might be completing a guided competency validation. A lot of our hands-on training revolves around using manikins and part-task trainers. I could be involved with simulating a car accident scene with our first responders, or I could be training at the hospital ramp whilst our paramedics are waiting to offload patients.

You recently attended the SimGHOSTS conference here at CSDS. Did you find this conference to be relevant to you and your role with QAS?
SimGHOSTS was a valuable opportunity for me to meet new contacts, and find out what training other simulation coordinators do on a day-to-day basis, as part of their job. Each session was structured well and I was able to get a lot of answers to the questions I had. The moulage workshop was sensational and I have been using those skills with the new equipment we purchased after SimGHOSTS.

After SimGHOSTS I made a presentation from what I had learnt and delivered it to the clinical education unit. I also suggested some ideas we could implement.

Do you think simulation-based training has an important role to play in clinical education?
Simulation-based education (SBE) most definitely plays an important role in clinical education. We can replicate just about any condition, without causing any harm to a real patient. Experiences can be tailored to the individual’s requirements, ensuring the participant has the most valuable experience. Learning in the SBE environment allows for mistakes to be made, so that hopefully those same mistakes are not made in the field. SBE also allows for practice of skills that are not performed very often, such as inserting an LMA. With SBE, once you get buy-in from the participants, it can be a very valuable learning experience.

What are the greatest challenges in providing education to clinicians in the pre-hospital field?
The pre-hospital field has so many variables. Most simulation centres have a hospital bed as their training environment mainly caters for hospital staff and related situations. As our environment is always different, this in itself is a major challenge. We have to try and replicate situations to get the staff to buy-in to the scenarios, and this can be difficult. We have to try and replicate the patient being located beside the bed, or replicate a car accident on a motorway. Then there are scenarios like a patient who is intoxicated and wants to fight, or CPR needing to be performed in the back of an ambulance.

In the Metro North Local Ambulance Service Network we are taking education to the emergency departments. Recently we took a Quality CPR (QCPR) manikin to a hospital ramp, and whilst the officers were waiting to offload patients, we coordinated one-on-one time for CPR practice. We also have put part-task trainers into an ambulance and provided short education sessions in the field. The paramedics’ feedback from these sessions was positive.

When you reflect on your own education and clinical practice, can you see a link between scenario-based training you have done and how this has improved your response in a real-life situation?
SBE has proven to be an invaluable part of my education and practice as a paramedic. It is paramount for me to be able to practise the skills that I do not use every day; it gives me the confidence I need when I have to perform the procedure in the real world. One example is CPR practice; those skills degrade quite quickly if they are not regularly practised. I recently attended a cardiac arrest and because I had been practising on the QCPR manikin, I didn’t have to concentrate on getting the metrics correct, which allowed me to concentrate on other aspects, such as managing extrication and other important procedures.

What are your interests outside of work?
I have an interest in aviculture (breeding of birds) and take the kids camping and to the beach. I also love four-wheel driving and drag racing.
A key focus for the Clinical Skills Development Service (CSDS) is facilitating simulation training at Pocket Centres and external locations. In order to successfully make this happen, we consistently loan out equipment all over Australia. Up until now, the process of lending out equipment was primarily paper based. While effective, it was also inefficient and made it very difficult to obtain accurate reporting when required.

The CSDS Systems Team strives to make everyday work easier by improving work processes through technology. For this reason, about a year ago the team began to completely overhaul the processes of loaning, tracking and maintaining equipment. In early 2015 this came to fruition when the team released CSDS Central Earth, a new version of CSDS’s internal bookings, resources, and learning management system. This updated version of CSDS Central gave staff the ability to create equipment templates, record assets and their condition, track equipment and product orders, and manage the return of loaned equipment. The release of CSDS Central Earth also meant the introduction of CSDS’s new SimShop. The SimShop is a one-stop shop for loaning equipment and purchasing products/consumables for simulation training. Anyone can now view a full inventory of CSDS’s loanable equipment, which will ideally encourage more external training.

This newly introduced system means CSDS can view a piece of equipment’s complete location history or just find out where it is right now, at a click of a button.

The new process of hiring equipment is easy and streamlined. The steps are as follows:

1. The facilitator makes an order for equipment through the SimShop.
2. Staff at CSDS are alerted and endorse or decline the order.
3. The facilitator makes payment for the equipment and shipping.
4. Staff at CSDS organise pick up or send the equipment out via courier.
5. The system alerts staff and the loaner when the equipment is due for return.
6. Staff at CSDS organise a courier to pick up the equipment.
7. Staff at CSDS receive the equipment and complete a maintenance inspection before (a) returning the equipment to inventory or (b) passing it on to the Simulation Team for repair.

Every step of the process is recorded in the system, which means the loaner has access to their own loan/payment history and some helpful functions like reminders and return labels.

The CSDS Systems Team has also recently been working on updating the digital signage throughout the centre in order to make it more user-friendly and informative. By improving the design and replacing the current system with Raspberry Pi technology, the screens will be more accurate and easier to use. This update is currently in the testing phase and will be rolled out very soon. Make sure you check them out if you come to visit the centre!

If you'd like to check out the new SimShop or make an order, simply go to: www.sdc.qld.edu.au/simshop

“SimShop is becoming a very comprehensive database that’s practical and functional for all, including the novice user. As a tool I utilise most weeks, even just to browse through, I find it much more “useable” and informative than the previous equipment lists. Can I also say that the follow up and service has also been spectacular?”

Rachel Wayne, Simulation Coordinator, Mackay Base Hospital.

“Although we don’t use them a lot we have found the systems user friendly, and response times are very quick.”

Mark Kelly, Nurse Educator, Commedia dell’Arte.
SimHealth 2015 was the eleventh annual conference for the Australian Society for Simulation in Healthcare (ASSH). Hosted by Simulation Australasia, this was the third year that SimHealth was run jointly with the SimTecT Conference. The conference, which took place from 17 to 21 August at the Adelaide Convention Centre, focused on the idea of ‘Finding the Balance’ and encouraged collaboration and discussion around how education can improve patient safety and clinical outcomes.

The Clinical Skills Development Service (CSDS) attended SimHealth 2015 in various capacities. Associate Professor Marcus Watson, CSDS Executive Director and Chair of Simulation Australasia, represented CSDS through high-level networking. Marcus welcomed conference attendees during the Opening Plenary session, and again at the Welcome Reception event. Marcus also chaired the SimHealth Plenary session ‘Simulation - A Tool for the Training of Organisations?’ and was a panellist on the SimTecT Panel ‘Creative and Cultural Applications: Making Sense of Sense-Making’. Luke Wainwright, CSDS Simulation Manager and Technology Special Interest Group (SIG) Lead for ASSH, chaired the SimHealth free papers ‘Technology and Innovation’ session. At the SimHealth poster hub, CSDS Simulation Educator Tracey McLean presented ‘Intubation Impossible’ and CSDS Simulation Coordinator Clinton Henderson presented ‘Tissued Drip’ and ‘A Standardised Approach to the Evaluation of Simulation Equipment’. CSDS also hosted a conference booth at the event, showcasing face-to-face and elearning courses as well as tools for curriculum development.

Another exciting addition to this year’s conference was the research on avatars, with Dr Teresa Crea, Convenor of SimTecT, chairing a session titled ‘Expressive Intelligence - Simulation for the Next Generation of Interactive Avatars’. There is a growing body of work on intelligent systems for simulation and it will be interesting to see how these exciting new technologies will be blended with traditional educational delivery methods. This will be a space to watch over the next five years and CSDS will continue to strive to remain current.

Being an active presence at SimHealth 2015 has been beneficial for CSDS, providing opportunities for staff to network with delegates from a range of simulation backgrounds. Attending conferences such as these allows CSDS to maintain relevance in the fast-moving industry that is clinical simulation.
Intubation impossible

Intubation impossible, a poster presented at this year’s SimHealth, highlights a specific technique the Clinical Skills Development Service (CSDS) have used to create a difficult airway, which can be used in high-fidelity healthcare simulations. The poster was presented by CSDS Simulation Educator Tracey McLean, on behalf of the Simulation Team. Tracey McLean; Kim Heaslip; Daniel Host. Simulation Team. Clinical Skills Development Service, Brisbane

Aim

To outline a specific technique used to create a difficult airway (grade four view), to use in high-fidelity healthcare simulations.

Background

Delivering simulation in a high-fidelity mode has been well validated as an educational tool in healthcare training. However, the ability to suspend disbelief and engage in simulation often still presents as a significant obstacle for individuals. This has been attributed to the mindset that it is ‘not the real thing’ (DeCarlo, et. al., 2008:94). A number of authors make the reasonable assumption that simulation is likely to be most effective when individuals perceive it to be legitimate and authentic (Dinker and Singh, 2012; Hotchkiss, et. al., 2002). Developing and applying a difficult airway tourniquet is one method of achieving an elevated level of realism in viewing a difficult airway in a SimMan 3G or essential manikin.

Methods

1. To create a difficult airway in a Simman 3G, or essential manikin, you will need a Velcro strap, two clinical airway adjuncts, and some cutting equipment.
2. Cut back the clinical airway adjuncts to remove the flanges and then slide them onto the Velcro strap.
3. Mark out the placement of the first clinical airway adjunct so that when the strap is tightened, the rough end of the Velcro meets the smooth side.
4. Feed the Velcro strap behind the manikin’s neck, ensuring that the tubing from the fluid system is not crushed.
5. Use the two clinical airway adjuncts to help guide the tourniquet up and over the thyroid shroud. This will allow clear access to the carotid pulses and increase the resistance to the pharynx.
6. Pull the strap tight and feed it back behind the neck.
7. Finish by securing the Velcro to itself.
8. You can now use a laryngoscope to check the airway. Once you activate the pharyngeal obstruction feature you should get a grade four view.

Results

The difficult airway tourniquet has been incorporated into multiple immersive scenarios within the Clinical Skills Development Service. Simulation staff have observed that the immersive simulations were successful on each occasion. This has been primarily due to the tourniquet providing the appropriate clinical and physical cues which allowed participants to rapidly and accurately assess the patient’s condition and plan their care accordingly.

Conclusion

An individual who is able to apply a difficult airway tourniquet can be expected to have a greater perception of realism within the simulated learning environment. As a result of this, they are more engaged and subsequently have a learning experience which aligns more with the planned objective. In this instance, two easily-sourced products were able to be creatively applied to achieve a realistic grade four difficult airway view.

References


View our video here.
Since 2011 Proserpine Hospital has provided simulation training to local staff. This has given rural staff the opportunity to enhance their clinical skills, by being able to access training easily. This Pocket Centre provides many opportunities for skill development, providing training programs such as:

- Advanced Life Support (ALS)
- Paediatric Life Support (PLS)
- Recognition and Management of the Deteriorating Patient (RMDP) - Adult
- Recognition and Management of the Deteriorating Paediatric Patient (RMDPP)
- Paediatric Advanced Life Support (PALS)
- Advanced Neonatal Resus Program (ANRP)
- Practical Obstetric Multi-professional (PROMPT) Program.

The regular running of these programs ensures mandatory education and skills are maintained and increases the multi-disciplinary teams’ experience with routine and unusual experiences that they do not see everyday, building team confidence and clinical expertise.

The Pocket Centre is currently occupying a ward room, with future plans to develop a standalone locked laboratory, with a dedicated simulation room, a viewing room, and a debrief room. Anne Eaton, Midwifery Manager/Simulation Team member explains that, ‘this will enable education to take place away from the hustle and bustle of the ward environment and enable participants to truly immerse in this high-fidelity world’.

Debbie McConnel, Educator and Simulation Leader, further explains that ‘spot scenarios and programs such as PROMPT will also continue to run in the clinical environment, but the dedicated room gives us the best of both worlds to provide education and training’. Debbie also explains that everyone has a role in supporting this Pocket Centre: ‘The whole facility has to support the development of this program, by releasing staff, taking on extra roles and being opportunistic in providing education during periods of lower acuity’.

In a rural pocket hub there is generally no dedicated simulation coordinator and the voluntary team have to perform this role over and above their normal job description. At this Pocket Centre there is a dedicated team of seven staff: two senior medical officers and five nursing/midwifery staff. The enthusiastic team see the potential and opportunities in the simulation learning that they provide locally. ‘It has been challenging and rewarding to incorporate simulation into our existing roles, to enable simulation to become a normal part of our everyday work life,’ says Leigh Ironside, Clinical Nurse/Simulation Team member. As a team they provide realistic scenarios that foster teamwork and build staff confidence in maintaining skills, networking with each other, and improving services they provide locally. As Debbie Simmonds Medical Doctor/Simulation Team member states, ‘the dedication and motivation of the Simulation Team enables the staff to buy into the realism of simulation and see its worth in their growth and delivery of safe clinical practice’.

Anne Eaton is optimistic that the positive effects of the Pocket Centre will soon become clear, saying: ‘next year will hopefully show the benefits of running our own Pocket Centre with an increase in staff confidence, teamwork and skills development’.

Debbie McConnel, Educator and Simulation Leader, further explains that ‘spot scenarios and programs such as PROMPT will also continue to run in the clinical environment, but the dedicated room gives us the best of both worlds to provide education and training’. Debbie also explains that everyone has a role in supporting this Pocket Centre: ‘The whole facility has to support the development of this program, by releasing staff, taking on extra roles and being opportunistic in providing education during periods of lower acuity’.

In a rural pocket hub there is generally no dedicated simulation coordinator and the voluntary team have to perform this role over and above their normal job description. At this Pocket Centre there is a dedicated team of seven staff: two senior medical officers and five nursing/midwifery staff. The enthusiastic team see the potential and opportunities in the simulation learning that they provide locally. ‘It has been challenging and rewarding to incorporate simulation into our existing roles, to enable simulation to become a normal part of our everyday work life,’ says Leigh Ironside, Clinical Nurse/Simulation Team member. As a team they provide realistic scenarios that foster teamwork and build staff confidence in maintaining skills, networking with each other, and improving services they provide locally. As Debbie Simmonds Medical Doctor/Simulation Team member states, ‘the dedication and motivation of the Simulation Team enables the staff to buy into the realism of simulation and see its worth in their growth and delivery of safe clinical practice’.

Anne Eaton is optimistic that the positive effects of the Pocket Centre will soon become clear, saying: ‘next year will hopefully show the benefits of running our own Pocket Centre with an increase in staff confidence, teamwork and skills development’.

Debbie McConnel, Educator and Simulation Leader, further explains that ‘spot scenarios and programs such as PROMPT will also continue to run in the clinical environment, but the dedicated room gives us the best of both worlds to provide education and training’. Debbie also explains that everyone has a role in supporting this Pocket Centre: ‘The whole facility has to support the development of this program, by releasing staff, taking on extra roles and being opportunistic in providing education during periods of lower acuity’.

In a rural pocket hub there is generally no dedicated simulation coordinator and the voluntary team have to perform this role over and above their normal job description. At this Pocket Centre there is a dedicated team of seven staff: two senior medical officers and five nursing/midwifery staff. The enthusiastic team see the potential and opportunities in the simulation learning that they provide locally. ‘It has been challenging and rewarding to incorporate simulation into our existing roles, to enable simulation to become a normal part of our everyday work life,’ says Leigh Ironside, Clinical Nurse/Simulation Team member. As a team they provide realistic scenarios that foster teamwork and build staff confidence in maintaining skills, networking with each other, and improving services they provide locally. As Debbie Simmonds Medical Doctor/Simulation Team member states, ‘the dedication and motivation of the Simulation Team enables the staff to buy into the realism of simulation and see its worth in their growth and delivery of safe clinical practice’.

Anne Eaton is optimistic that the positive effects of the Pocket Centre will soon become clear, saying: ‘next year will hopefully show the benefits of running our own Pocket Centre with an increase in staff confidence, teamwork and skills development’.
I am a new simulation coordinator at the Clinical Skills Development Service (CSDS). I’m one of the lucky ones who can say I have found my ‘dream job’.

Don’t get me wrong: the days start early and can be long and demanding, but who wouldn’t want to do something different each day? Something challenging, rewarding, and sometimes out of your comfort zone.

As a simulation coordinator I work closely alongside the simulation educators. Our aim is to deliver realistic scenarios that engage participants in realistic clinical situations, all within a safe learning environment.

Although there is no ‘typical day’ in simulation, most weeks we deliver a variety of courses to doctors, nurses, paramedics and even the armed forces. We cover anything from basic life support to critical care and emergency trauma. We love a challenge; if it can happen in real life we can make it happen in simulation. When we aren’t running courses we are researching, road testing, preparing and improving our scenarios to enhance your learning experience.

Setting up may begin days, weeks, or even months before the course itself, depending on the learning objectives and equipment required. Preparation and forward planning are a crucial part of ensuring our scenarios are realistic and run to their full potential. Scenarios are tailored to the ability and knowledge base of each participant who attends, ensuring that we educate, but do not intimidate.

A lot of work goes on behind the scenes and after each team meeting we fire up the audiovisual (AV) system, turn on the manikins, check the equipment and troubleshoot any problems. The general rule is ‘just because something worked yesterday, doesn’t mean it will work today’.

And when we talk about our AV system, we don’t mean your everyday home theatre system: we have HDMI cables, scan converters, monitors, VGA cables, quad processors, black cables, cameras, sim pads, brown cables, speakers, mixers and did I mention more cables? We are able to view and record all scenarios from the control room and can send a live feed or recorded play back into any of the debriefing rooms in the centre (of course we are careful to maintain the confidentiality of the participants). This for me is by far the most complex part of my job but I am lucky enough to work with some pretty impressive technology specialists.

A simulation coordinator’s role is multifaceted: we run the AV console and the manikins themselves, but we also play any role that is required. We can be the patient’s voice or the voice from switchboard or the blood bank. We can act as any person the scenario requires. As the fidelity of the scenario is extremely significant we set the scene with sights, sounds, smells, and equipment. Once the scenario is set up and ready, this is where the fun really begins. Everyone takes their places, ‘Live in 5’ and GO.

As most of our courses start by familiarising participants with the manikins and the environment, application of the moulage (simulated-injury make up) is either prepared prior or left to the last minute. Applying moulage is one of my favourite parts of the job; you are only limited by your imagination and of course, time itself. We can create blood, cuts, abrasions, burns, compound fractures, amputations, and more. We say on some occasions less is best, just enough to give the desired effect, especially if cleaning up time between scenarios is limited. However, it’s the big trauma moulage we all live for: gunshot wounds, bomb blasts, stabblings, and multi-trauma accidents will take hours of work to perfect, but when it results in full immersion for the participants, we know it’s all been worth it.

Each day, after the last scenario and debrief are done, and we have cleaned up and set up for the next day, we get to go home, and think about what’s in store for the next dynamic day of simulation. There’s certainly no place I’d rather be.

By Kate Fagg, Simulation Coordinator, CSDS
The primary role of the Clinical Skills Development Service (CSDS) Research Team is to conduct high-quality research projects related to clinical skills and Human Factors. Some common themes in our research include:

(a) investigating the Human Factors, cognitive and perceptual aspects of medical tasks, procedures, equipment and simulations and
(b) investigating the efficacy of various educational techniques (including simulation, eLearning, and blended learning) in specific clinical contexts.

Each of our research projects is designed to generate new knowledge that can be used to improve or demonstrate the quality of the training offered by CSDS, and/or to improve patient safety more generally by making the safety of medical systems and tools less reliant on training.

As the smallest team within CSDS, the Research Team relies on collaborations with universities and other research organisations to advance its research agenda. Student research projects represent an important subset of these collaborations, and CSDS staff supervise or otherwise collaborate with students at both the PhD and Honours levels. As well as generating useful research data, these projects offer students an opportunity to work in an interdisciplinary team addressing important real-world problems.

Some of these projects have tested unproven assumptions that have guided clinical training and practice for decades, sometimes showing them to be ‘strong but wrong’ beliefs. These include long-held beliefs about how vital sign data should be arranged on patient observation charts to facilitate recognition of the deteriorating patient (see STaR edition 1, pp.20-21 available at https://www.sdc.qld.edu.au/about/blogpreview), and in relation to the interpretation of vital sign data.

Other projects have investigated the limitations and affordances of key clinical equipment and their potential impacts on clinical performance and training. One researcher whose work falls into this category is Shin Sakata, who is a trainee in general surgery currently completing a PhD at The University of Queensland (UQ) in collaboration with researchers from UQ, The Royal Brisbane and Women’s Hospital and CSDS. Shin describes his PhD project as follows:

‘My research is on the positive and negative effects of new surgical technology used in colorectal surgery. In particular, I am studying the effects of two- and three-dimensional laparoscopic and robotic technologies on the performance of expert and novice surgeons, in both the operating theatre and in the simulation lab.’

We asked Shin what he values most about collaborating with the CSDS. After waxing lyrical about the ‘world class simulation facilities and excellent organisational support from intelligent and long-sighted directors and managers,’ he adds: ‘above all, I value and cherish the many friendships that I have made here’.

As for where Shin’s research might lead him, he says, ‘in the future, my goals are to be a colorectal surgeon, a clinical researcher in a dynamic surgical research group, and an editorial member of a surgical and colorectal journal. I am interested in clinical trial design and would like to participate in multicentre clinical research, investigating various aspects of core elective and emergency colorectal surgery.’

For other students, research in collaboration with the CSDS could potentially lead to careers in academia, Human Factors consulting or healthcare systems design, to name but a few possibilities. Shin offers this advice for prospective students interested in working with us: ‘At the CSDS, you are only limited by your own imagination and determination to succeed’.

Research students collaborate to innovate

The primary role of the Clinical Skills Development Service (CSDS) Research Team is to conduct high-quality research projects related to clinical skills and Human Factors. Some common themes in our research include:

(a) investigating the Human Factors, cognitive and perceptual aspects of medical tasks, procedures, equipment and simulations and
(b) investigating the efficacy of various educational techniques (including simulation, eLearning, and blended learning) in specific clinical contexts.

Each of our research projects is designed to generate new knowledge that can be used to improve or demonstrate the quality of the training offered by CSDS, and/or to improve patient safety more generally by making the safety of medical systems and tools less reliant on training.

As the smallest team within CSDS, the Research Team relies on collaborations with universities and other research organisations to advance its research agenda. Student research projects represent an important subset of these collaborations, and CSDS staff supervise or otherwise collaborate with students at both the PhD and Honours levels. As well as generating useful research data, these projects offer students an opportunity to work in an interdisciplinary team addressing important real-world problems.

Some of these projects have tested unproven assumptions that have guided clinical training and practice for decades, sometimes showing them to be ‘strong but wrong’ beliefs. These include long-held beliefs about how vital sign data should be arranged on patient observation charts to facilitate recognition of the deteriorating patient (see STaR edition 1, pp.20-21 available at https://www.sdc.qld.edu.au/about/blogpreview), and in relation to the interpretation of vital sign data.

Other projects have investigated the limitations and affordances of key clinical equipment and their potential impacts on clinical performance and training. One researcher whose work falls into this category is Shin Sakata, who is a trainee in general surgery currently completing a PhD at The University of Queensland (UQ) in collaboration with researchers from UQ, The Royal Brisbane and Women’s Hospital and CSDS. Shin describes his PhD project as follows:

‘My research is on the positive and negative effects of new surgical technology used in colorectal surgery. In particular, I am studying the effects of two- and three-dimensional laparoscopic and robotic technologies on the performance of expert and novice surgeons, in both the operating theatre and in the simulation lab.’

We asked Shin what he values most about collaborating with the CSDS. After waxing lyrical about the ‘world class simulation facilities and excellent organisational support from intelligent and long-sighted directors and managers,’ he adds: ‘above all, I value and cherish the many friendships that I have made here’.

As for where Shin’s research might lead him, he says, ‘in the future, my goals are to be a colorectal surgeon, a clinical researcher in a dynamic surgical research group, and an editorial member of a surgical and colorectal journal. I am interested in clinical trial design and would like to participate in multicentre clinical research, investigating various aspects of core elective and emergency colorectal surgery.’

For other students, research in collaboration with the CSDS could potentially lead to careers in academia, Human Factors consulting or healthcare systems design, to name but a few possibilities. Shin offers this advice for prospective students interested in working with us: ‘At the CSDS, you are only limited by your own imagination and determination to succeed’.

Research students collaborate to innovate

The primary role of the Clinical Skills Development Service (CSDS) Research Team is to conduct high-quality research projects related to clinical skills and Human Factors. Some common themes in our research include:

(a) investigating the Human Factors, cognitive and perceptual aspects of medical tasks, procedures, equipment and simulations and
(b) investigating the efficacy of various educational techniques (including simulation, eLearning, and blended learning) in specific clinical contexts.

Each of our research projects is designed to generate new knowledge that can be used to improve or demonstrate the quality of the training offered by CSDS, and/or to improve patient safety more generally by making the safety of medical systems and tools less reliant on training.

As the smallest team within CSDS, the Research Team relies on collaborations with universities and other research organisations to advance its research agenda. Student research projects represent an important subset of these collaborations, and CSDS staff supervise or otherwise collaborate with students at both the PhD and Honours levels. As well as generating useful research data, these projects offer students an opportunity to work in an interdisciplinary team addressing important real-world problems.

Some of these projects have tested unproven assumptions that have guided clinical training and practice for decades, sometimes showing them to be ‘strong but wrong’ beliefs. These include long-held beliefs about how vital sign data should be arranged on patient observation charts to facilitate recognition of the deteriorating patient (see STaR edition 1, pp.20-21 available at https://www.sdc.qld.edu.au/about/blogpreview), and in relation to the interpretation of vital sign data.

Other projects have investigated the limitations and affordances of key clinical equipment and their potential impacts on clinical performance and training. One researcher whose work falls into this category is Shin Sakata, who is a trainee in general surgery currently completing a PhD at The University of Queensland (UQ) in collaboration with researchers from UQ, The Royal Brisbane and Women’s Hospital and CSDS. Shin describes his PhD project as follows:

‘My research is on the positive and negative effects of new surgical technology used in colorectal surgery. In particular, I am studying the effects of two- and three-dimensional laparoscopic and robotic technologies on the performance of expert and novice surgeons, in both the operating theatre and in the simulation lab.’

We asked Shin what he values most about collaborating with the CSDS. After waxing lyrical about the ‘world class simulation facilities and excellent organisational support from intelligent and long-sighted directors and managers,’ he adds: ‘above all, I value and cherish the many friendships that I have made here’.

As for where Shin’s research might lead him, he says, ‘in the future, my goals are to be a colorectal surgeon, a clinical researcher in a dynamic surgical research group, and an editorial member of a surgical and colorectal journal. I am interested in clinical trial design and would like to participate in multicentre clinical research, investigating various aspects of core elective and emergency colorectal surgery.’

For other students, research in collaboration with the CSDS could potentially lead to careers in academia, Human Factors consulting or healthcare systems design, to name but a few possibilities. Shin offers this advice for prospective students interested in working with us: ‘At the CSDS, you are only limited by your own imagination and determination to succeed’.

Research students collaborate to innovate

The primary role of the Clinical Skills Development Service (CSDS) Research Team is to conduct high-quality research projects related to clinical skills and Human Factors. Some common themes in our research include:

(a) investigating the Human Factors, cognitive and perceptual aspects of medical tasks, procedures, equipment and simulations and
(b) investigating the efficacy of various educational techniques (including simulation, eLearning, and blended learning) in specific clinical contexts.

Each of our research projects is designed to generate new knowledge that can be used to improve or demonstrate the quality of the training offered by CSDS, and/or to improve patient safety more generally by making the safety of medical systems and tools less reliant on training.

As the smallest team within CSDS, the Research Team relies on collaborations with universities and other research organisations to advance its research agenda. Student research projects represent an important subset of these collaborations, and CSDS staff supervise or otherwise collaborate with students at both the PhD and Honours levels. As well as generating useful research data, these projects offer students an opportunity to work in an interdisciplinary team addressing important real-world problems.

Some of these projects have tested unproven assumptions that have guided clinical training and practice for decades, sometimes showing them to be ‘strong but wrong’ beliefs. These include long-held beliefs about how vital sign data should be arranged on patient observation charts to facilitate recognition of the deteriorating patient (see STaR edition 1, pp.20-21 available at https://www.sdc.qld.edu.au/about/blogpreview), and in relation to the interpretation of vital sign data.

Other projects have investigated the limitations and affordances of key clinical equipment and their potential impacts on clinical performance and training. One researcher whose work falls into this category is Shin Sakata, who is a trainee in general surgery currently completing a PhD at The University of Queensland (UQ) in collaboration with researchers from UQ, The Royal Brisbane and Women’s Hospital and CSDS. Shin describes his PhD project as follows:

‘My research is on the positive and negative effects of new surgical technology used in colorectal surgery. In particular, I am studying the effects of two- and three-dimensional laparoscopic and robotic technologies on the performance of expert and novice surgeons, in both the operating theatre and in the simulation lab.’

We asked Shin what he values most about collaborating with the CSDS. After waxing lyrical about the ‘world class simulation facilities and excellent organisational support from intelligent and long-sighted directors and managers,’ he adds: ‘above all, I value and cherish the many friendships that I have made here’.

As for where Shin’s research might lead him, he says, ‘in the future, my goals are to be a colorectal surgeon, a clinical researcher in a dynamic surgical research group, and an editorial member of a surgical and colorectal journal. I am interested in clinical trial design and would like to participate in multicentre clinical research, investigating various aspects of core elective and emergency colorectal surgery.’

For other students, research in collaboration with the CSDS could potentially lead to careers in academia, Human Factors consulting or healthcare systems design, to name but a few possibilities. Shin offers this advice for prospective students interested in working with us: ‘At the CSDS, you are only limited by your own imagination and determination to succeed’.
In each edition of STaR magazine we have an equipment spotlight, where we focus on a new and exciting piece of equipment that is currently in use at the Clinical Skills Development Service (CSDS), and explore what its uses are. In this edition we are looking at CAE Healthcare’s Vimedix ultrasound training platform.

The Vimedix ultrasound trainer provides a ground-breaking ultrasound and echocardiography training platform that offers on-demand learning without risk to live patients, which makes it one of the most comprehensive and versatile ultrasound simulators.

Using computer-generated echo simulation, Vimedix teaches learners how to perform cardiac echo imaging as well as FAST scan procedures, and how to interpret the scanned ultrasound images through more than 50 pathologies, for both cardiac and abdominal ultrasound assessment, such as:

- myocardial infarction
- pleural effusion
- tamponade
- aortic aneurysm.

Vimedix consists of a manikin, mock ultrasound transducer and graphic representation of both the 3D patient anatomy and the ultrasound scan in real time, offering an immersive ultrasound simulation learning environment. The Vimedix manikin’s realistic tactile features, including a depressible abdomen, ribs and sternum allow the student to practise fine motor skills associated with performing cardiac ultrasound exams.

Vimedix allows users to perform colour Doppler imaging on a normal heart and on all valvular cardiac pathologies with standard curvilinear and trans oesophageal echocardiography probes.

If you would like to know more about the Vimedix and how it could benefit your education, or would like to loan one, contact us directly at CSDS-Equipment@health.qld.gov.au or visit our sim shop on www.sdc.qld.edu.au

The following are colour Doppler-enabled pathologies:

- normal heart
- dilated cardiomyopathy – severe biventricular systolic dysfunction
- hyperdynamic left ventricular systolic function
- recent anterior myocardial infarction with pericardial effusion
- dilated cardiomyopathy – very severe left ventricular systolic dysfunction in a COPD patient
- dilated cardiomyopathy – mild left ventricular systolic dysfunction
- anterior myocardial infarction in a COPD patient
- biologic prosthetic valve in aortic position
- dilated cardiomyopathy – very severe left ventricular systolic dysfunction
- pulmonary hypertension in a COPD patient
- pulmonary hypertension
- bicuspid aortic valve
- atrial septal defect - small
- dilated cardiomyopathy – moderate biventricular systolic dysfunction
- coronary artery disease – wall motion abnormalities in the 3 coronary territories
- left pleural effusion
- normal heart in a COPD patient
- tamponade
- left ventricular apical aneurysm with thrombus
- fine ventricular fibrillation
- dilated cardiomyopathy - mild left ventricular systolic dysfunction in a COPD patient
- acute lateral myocardial Infarction in a COPD patient
- acute anterior myocardial infarction
- tamponade
- aortic aneurysm.

Vimedix consists of a manikin, mock ultrasound transducer and graphic representation of both the 3D patient anatomy and the ultrasound scan in real time, offering an immersive ultrasound simulation learning environment. The Vimedix manikin’s realistic tactile features, including a depressible abdomen, ribs and sternum allow the student to practise fine motor skills associated with performing cardiac ultrasound exams.

Vimedix allows users to perform colour Doppler imaging on a normal heart and on all valvular cardiac pathologies with standard curvilinear and trans oesophageal echocardiography probes.

If you would like to know more about the Vimedix and how it could benefit your education, or would like to loan one, contact us directly at CSDS-Equipment@health.qld.gov.au or visit our sim shop on www.sdc.qld.edu.au
Joseph Sharpe graduated as a registered nurse in 1991 from Edith Cowan University in Western Australia and worked in several regional- and district-sized hospitals prior to taking leave to travel around Australia in 1998. In 2001 Joseph commenced work at The Townsville Hospital as a registered nurse in emergency and was also commissioned as a nursing officer in the Australian Army Reserve. Over the next seven years Joseph obtained a clinical nurse position, undertook multiple Australian Defence Force (ADF) courses, obtained a Masters of Critical Care – Emergency, and deployed briefly overseas with the ADF.

Joseph is currently the national director for PHTLS Australia, a member of the Clinical Reference Group and an active PHTLS instructor. Joseph has instructed on over 60 courses throughout rural and remote Australia and two in Brunei.

Since March 2008, Joseph has worked as the clinical nurse consultant for the Trauma Service at The Townsville Hospital. In this role, Joseph is a member of the Statewide Nursing Officer in the Australian Army Reserve. Over the next seven years Joseph obtained a clinical nurse position, undertook multiple Australian Defence Force (ADF) courses, obtained a Masters of Critical Care – Emergency, and deployed briefly overseas with the ADF.

Joseph is currently the national director for PHTLS Australia, a member of the Clinical Reference Group and an active PHTLS instructor. Joseph has instructed on over 60 courses throughout rural and remote Australia and two in Brunei.

Since March 2008, Joseph has worked as the clinical nurse consultant for the Trauma Service at The Townsville Hospital. In this role, Joseph is a member of the Statewide Trauma Clinical Network.

You are currently a clinical nurse consultant: trauma at The Townsville Hospital. What does this role entail, and how has previous experience prepared you for it?

Following the release of a Trauma Plan for Queensland in 2006, The Townsville Hospital (TTH) was listed as a Major Trauma Service for adult patient care in the North. The Trauma Service commenced in 2008 and I have been in the role since the beginning. My core role is to perform ‘Trauma reviews’ on patients admitted with trauma or injury to TTH, which includes adult and paediatric patients. From the outset it became evident that every injury matters to the patient. The beauty of my role is that a review takes as long as it takes and can easily vary from 45 minutes to several hours dependent upon patient complexity and requirements. The Trauma review is more than just a standard tertiary survey and I am confident that the role brings care forward.

I have always been interested in emergency and trauma care and the natural evolution of my nursing career has provided exposure to general ward care, theatre, critical care, and emergency. In 2001 I joined the Army Reserve as a nursing officer and enjoyed the advanced roles and clinical autonomy that is seldom available in the civilian system. In 2002 I completed the Field Nursing Course and the combination of real world and simulated trauma decision making hooked me. I attended the Pre Hospital Trauma Life Support (PHTLS) course in 2003 and embraced its principles. I completed my instructor course in December 2003 and have been involved through three edition changes.

In 2005 I deployed to the Middle East with the ADF and we worked extensively with coalition specialists and trauma surgeons. We cared for many trauma patients, suffering trauma from a multitude of causes including: motor vehicle crashes, blasts, burns, and penetrating mechanisms. I witnessed the benefits of an efficient primary retrieval system with short transport times and the effective application of adjuncts such as tourniquets.

How important is it to teach clinical nursing staff ‘soft skills’ like communication and teamwork, and how can this best be done?

Communication is key - some can do it naturally, whilst others may benefit from coaching. Ineffective communication results in delays in patient care, and in some cases, less than optimal outcomes. This is evident when patient referral for either admission or consult are required - those clinicians who are able deliver their message in a structured manner facilitate the patient’s journey whereas a ‘poorly sold’ patient often languishes with delays.

One of the more valuable learning experiences I had as an ED nurse was in attending a crisis resource management – emergency department (CRM – ED) course. This is where I really witnessed the benefits of clear communication facilitated by simply using people’s names when assigning tasks versus the tendency to address everyone in the hope that ‘someone’ will do it.

Most of your nursing experience has been in the emergency department. What drew you to emergency over other clinical specialities?

I am a driver, a type A, and therefore the dynamic nature of ED was a natural attractant. It can be very rewarding to know that you have done everything you can to ensure that patients receive optimal care within the constraints of a busy department. The clinical care is extremely varied and the ED offers a multitude of roles and clinical exposure unattainable in other clinical areas. Traiging, re-triging and the required multitasking also keeps the mind active.

There is a downside to the 100% tempo and that is stress and finding it difficult to wind down. Restful sleep between a late/early shift was rare as I would regularly re-process the shift in my sleep as my mind would still be active.

A large draw card in Queensland used to be the prospect of conducting aeromedical retrievals out of the department. This was both a motivator to stay in the department and to undertake additional training. I only got to fly for about nine months prior to the current arrangements coming into play, but it was a great experience.

The transition to Trauma CNC was a natural extension of the clinical exposure and skill sets obtained from working in ED, defence, and retrievals.

What are your interests outside of work?

I am married with two sons, aged three and five. I am currently inactive from the ADF.

At the moment we are renovating a house and prepping our current house for sale.
Negative learning: the invisible outcomes

When you write a scenario, a module, or a whole course, you know what you want to teach. You write learning objectives and outcomes, and they guide your course design. You use these objectives and outcomes to measure your course too. If the learners demonstrate the outcomes, you figure you’ve done a good job.

But what about the knowledge, or practices, that you never meant to teach, but inadvertently taught anyway?

When a learner walks away from an education experience with knowledge that is incorrect, even dangerous - that is negative learning. The scary thing for any educator is that negative learning can be sitting rather innocuously in one of the courses they are teaching, and they may not even realise it. However, if educators understand what negative learning is, and where it is most likely to lurk, they can begin to address it.

Educators working in simulation-based training need to be particularly aware of negative learning, and this was addressed by Dr. Kenneth Gilpin when he spoke to all who attended SimGHOSTS Australia 2015, at the Clinical Skills Development Service. Gilpin argued that negative learning is a problem in healthcare simulation, and pinpointed three areas that can create negative feedback:

- scenarios being accelerated in time to show the effect of treatment (without clear notice of this being given)
- simulators requiring physical action from learners that real patients do not (such as particular intubation techniques)
- simulations that generalise archetypal disease symptoms - suggesting a classic presentation, which is not always the case in reality.

While research in this area is relatively new, there is some out there, which is highly beneficial to any educator working with simulation, and any clinician participating in simulation-based education. Weller et al identified that using a simulator and or simulation can lead to misdirection in the following ways:

- if physical signs such as sweating and changes in skin colour are not apparent, learners may ignore these signs in real-life situations or consider them not important
- if steps like seeking patient consent and undertaking safety procedures are not carried out in simulations, this may lead to habitual unsafe behaviour
- learners may learn to communicate in an artificial manner if they are frequently interacting with simulated patients.

Simply being aware of potential areas for negative learning is a good place for any educator to start. The next step is to go through any scenarios and identify any possible negative learnings and address them. For instance, if you need to accelerate time in a scenario, make sure you acknowledge this, and inform learners approximately how long they would have to wait for this response in reality.

So, to any educators who are mapping out scenarios, or any other education; up top with the objectives, make sure you list any possible negative learnings, and address these. Also, take the opportunity to talk to your learners about what negative learning is, so that they can seek to actively identify negative learnings, rather than passively carrying them into clinical practice.

Reference
Metro North Hospital and Health Service warmly welcomes Dr Kira-Lee Thiele and Dr Matthew Rawlins who migrated from South Africa in January 2015; they have worked here since this time. After attending the Communication Program Team’s Clinical Preparation Program, both doctors passed the Australian Medical Council (AMC) Clinical Examination in July 2015. They are currently working in the paediatric emergency department at The Prince Charles Hospital, Metro North Hospital and Health Service. Kira-Lee and Matthew intend specialising in emergency medicine, with dual fellowships in paediatric and adult emergency medicine. Kira-Lee said ‘Coming from South Africa we have experience in emergency and trauma medicine so ED suits us in this regard and we both really enjoy it. The team at Prince Charles is great and I really love my job!’

Kira-Lee and Matthew graduated from The University of Pretoria, South Africa and after completing two years of internship in the Pietermaritzburg Hospital in South Africa, they worked in Isilimela, a small rural hospital near Port St Johns, on the South Eastern coast of South Africa. There, they managed a wide variety of trauma-related injuries, as well as obstetric and paediatric patients, especially children with malnutrition. The majority of their patients required assistance for HIV and TB. They worked with minimal supervision and resources, but believed they were able to make a considerable difference to communities who have very little. After their time in Isilimela, they were separated for the first time in their professional careers, in the town of East London. Matthew worked in a small department of orthopaedics, which catered to a large population heavily burdened by trauma-related orthopedic injuries. Although resources were scarce, and this included waiting up to two weeks for a plain film X-ray or an urgent operation, Matthew believed that they always did the best they could to manage their patients appropriately. Kira-Lee said that she had the pleasure of working in the department of paediatric surgery, East London, which serviced an area of approximately 500kms. The department consisted of a total of 11 to 12 doctors who worked between two hospitals to maximise bed space. Kira-Lee said that as a result of her time there, she gained excellent experience in the acute management of very ill children, and was able to perform and assist in a wide variety of surgeries.

They both agreed that despite only being in Australia for seven months, they’ve really enjoyed their time here. Matthew said: ‘Our consultants are very approachable and everyone is very friendly and tries to help in any way possible’.

Kira-Lee and Matthew intended to settle permanently in Queensland and for this reason needed to gain general registration with the Australian Health Practitioner Regulation Agency (AHPRA). They were put in contact with Jennifer Young and her Communication Program Team at the Clinical Skills Development Service by other doctors who had already passed the AMC Clinical Examination.

Kira-Lee said: ‘The team prepared us for the AMC Clinical Examination, which we passed in July this year. The team helps you understand what is expected of you during the AMC Clinical Examination. They will make you realise that the exam is multi-faceted. It's about your clinical knowledge, and knowledge of the Australian healthcare system and Australian culture. The team helps you link all these aspects together in such a way that you can communicate your knowledge effectively to the 'Australian' patient. They cleverly showed us how communication and culture affects your history taking and your treatment and management plans.

Time management is an important consideration in the AMC Clinical Examination, in any exam and importantly when we work. When we started to practise the clinical scenarios, we could not finish all the tasks in the designated eight minutes. With the help of Jennifer and her team we were able to find a smooth way to create rapport with a patient, take a detailed history and complete all tasks in the given time. Being able to communicate using everyday English that patients understand in a limited time is vital to be able to pass the exam.

English is our first language, but being able to perfect our communication skills and strategies was one of the most beneficial aspects of the program. Australian medical students are fortunate in that there is a huge emphasis during their medical degrees on learning medical communication. This did not happen when we studied medicine in South Africa. This was a big gap for us coming to Australia.’

Matthew summarised by saying: ‘All that we learnt on the Clinical Preparation Program is not only vital for the AMC Clinical Exam, but prepares you for your working career, future exams and life in Australia. We are indebted for this huge opportunity.’
How do I pay for a course?

Once you have registered for a course, a Clinical Skills Development Service (CSDS) staff member will approve you for that course. Once you have been approved, you will receive an automated email requesting payment or you can complete the following steps:

1. Login to your CSDS account.
2. Find the course you wish to pay for in your ‘Pending Courses’ list.
3. Click on ‘Pay Now’ next to the course, which will take you to a credit card payment form.
4. Fill out the form and click ‘Process Payment’. You will receive a message to let you know if the payment was successful or not.
5. If the payment was successful, you will be emailed your receipt.

Alternatively, you can call us with your details to pay by credit card over the phone or we can email you a fax payment page.

Can I transfer to another course?

Yes, depending on the reason for the transfer; always refer to our terms and conditions which can be found on the second page of your invoice. We understand that things can change or that the dates you originally selected may no longer be suitable due to extenuating circumstances or roster changes. The best way to go about transferring is to have a look on our website: www.sdc.qld.edu.au for an alternative course date. Once you have found a course date that is more suitable, call our reception and we will be happy to transfer you to the new preferred course date. Please keep in mind that the sooner you let us know, the sooner you can confirm your arrangements, keeping in mind that last minute changes could potentially mean that we have to cancel a course.

What do I do if I am running late for a course?

If you are running late for one of our courses, call us at reception, which is open from 7:30 am–4:30 pm and we will let the relevant people know. That way we can also ensure all participants share the same learning experience when attending our courses.

How do I get a refund?

To acquire a refund, firstly you will need to refer to our terms and conditions (found on the second page of your invoice) to make sure that you are eligible to receive one. Then all you need to do is call (+61 7 3646 6500) or email (csds-admin@health.qld.gov.au) and we will process this for you and have the funds deposited back into your account.

If you’ve got a question you’d like to ask Simon, please email CSDS-Admin@health.qld.gov.au and we’ll address it in future publications.

Accreditation

CSDS courses are accredited through:

- Australian College of Emergency Medicine
- Australian College of Rural Medicine
- Australian College of Anaesthetists
- College of Intensive Care Medicine of Australia and New Zealand
- Australian Physiotherapy Council
- Royal Australian College of Physicians
- Royal College of Nursing Australia
- College of Emergency Nursing

Simon says

Hi! I’m back with the answers to some great questions you’ve been sending in. Please do continue to send them through.
Brain teasers

A) Stephen, an eLearning expert who was only days away from developing a world first, never before seen, eLearning course has suddenly gone missing. While inspecting his last-known location, you find a note: 5/18/9/14, 9/19, 7/21/9/12/20/25, 1/13, 9/14, 19/20/15/18/17/5, 3/21/16/2/15/1/4. Currently there are three suspects: Erin, Richard and David. Can you break the eLearning expert’s code and find the culprit’s name?

B) At the CSDS, four simulation coordinators were talking about their manikins. There are a total of eight manikins, two in each colour: red, green, blue and yellow. Each simulation coordinator owns two manikins. No simulation coordinator has two manikins of the same colour. Clinton doesn’t have a yellow manikin. Davin doesn’t have a red manikin, but does have a green one. One of the simulation coordinators has a yellow manikin and a blue manikin and another simulation coordinator has a green manikin and a blue manikin. Sandra has a yellow manikin. Colin has a blue manikin, but doesn’t have a green one. Can you work out which manikins Clinton has?

ACROSS
1. therapy that uses physical agents such as exercise, massage and other modalities
2. a time of intense difficulty or danger
3. relating to the heart
4. operations that are performed through small incisions
5. the necessary items for a particular purpose

DOWN
1. substance that induces insensitiveness to pain
2. representation of the operation or features of one process or system
3. relating to a particular subject, art, or craft, or its techniques
4. situation requiring immediate medical action
5. medical speciality dealing with children
6. a very young child or baby
7. the passage by which air reaches a person’s lungs

To generate your own crossword or word search visit http://edtools.mankindforward.com | See page 31 for answers

CSDS CONTACT INFORMATION
Phone (07) 3646 6500
Fax (07) 3646 6501
Email CSDS-Admin@health.qld.gov.au
Website www.sdc.qld.edu.au
Street address Level 4 Block 6 Royal Brisbane and Women’s Hospital Herston, Queensland, 4006
Business hours Monday - Friday: 7:30am - 4:30pm Saturday and Sunday: Closed
Mailing address PO Box 470 Herston Queensland, 4029 Australia
Nega/g415ve learning: the invisible outcomes
Research students collaborate to innovate
So you want to be a SimCo...
Celebrating errors
Interviews with Darren Lawrence and Joseph Sharp e