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Development of a simulated program in a new HWA-funded Integrated Student Supervised Clinic

The Interprofessional Simulation Project at Latrobe Community Health Service (LCHS) in partnership with Monash Department of Rural and Indigenous Health (MUDRIH) was completed over eighteen-months from January 2012 to 30 June 30 2013 in the Gippsland Region (RA2). The aim of the project was to establish rural interprofessional clinics as part of a normal community health clinic practice, that would provide students an opportunity to “learn with from and about each other” to improve quality of client care (CAIPE 2009). This project established an innovative model of simulated interprofessional supervised student clinic where learners from two different health care disciplines collaborated to interview a simulated client (SC) with complex chronic conditions.

The project funding supplied the salary (0.4 EFT) for an administrative officer, who commenced in January 2012.The project also provided capital equipment, to be installed in the LCHS Moe site where it was anticipated that planned major renovations would be completed in early 2012. Once construction was complete, the installed multimedia capturing equipment would record the students’ interviews in podiatry, physiotherapy and consulting rooms, with live viewing for the supervisor available from a dedicated student training room.

There were educational challenges in developing the model, because there was no one precedent to follow to provide a simulation environment appropriate to the community health context. While the educational principles of the simulations were deeply embedded in experiential, situated and social learning, the protocols and scenarios had to be adapted to suit the community health context. In addition, a raft of simulation tools needed to be developed in order to deliver the project.

Firstly there was a need to provide appropriate SCs. To achieve this aim it was necessary to develop character templates based on real client stories from community health and adapt a program to train volunteers to represent these characters and be interviewed as SCs. The next step was to develop materials for learners, including a detailed pre reading package and scenario observation templates to guide learners through the simulation and feedback session. Finally, the learners needed a generic interview tool to encompass a holistic client centred approach. To fulfil this purpose it was decided to use the Interprofessional Referral Tool (IRT) previously devised by health care practitioners (HCPs) at LCHS.

Simulation sessions lasted three to four hours. Learners commenced with pre-briefing from the interprofessional supervisor. Discussion covered basic interprofessional competencies, communication skills, features of client-centred interviewing and care planning. The questions on the IRT were revised. There were usually two simulations in each session, with two SCs booked for interview, usually an hour apart. Learners formed interprofessional teams of two and each team interviewed a different SC while the others observed. Learners were deeply immersed in a highly realistic context where they greeted the SC in the normal waiting room and brought the SC to be interviewed in consulting rooms amongst the other working HCP’s who were consulting with actual clients. The multimedia capture enabled live viewing from another room without intruding on the interview. It also provided the facility to record and replay parts of the interview to enhance the learning experience. The simulation session was subsequently completed with the use of multilayered post briefing including analysis of the video replay which usually lasted more than an hour. All learners completed a questionnaire immediately at the end of the session.

The project was not without challenges, all of which were mitigated as the project progressed. The difficulty of scheduling students from different disciplines (and institutions) was overcome by opportunistic selection of students whose placements overlapped, while ensuring they were always paired with a student from a different discipline. The funding did not cover the expenditure required if we were to employ actors, therefore, the solution was to train volunteers, and provide them with a $20 gift voucher to cover transport expenses to attend each time. A major obstacle external to the project occurred when the planned renovations at the LCHS Moe site were beset by unexpected delays due to major changes in architects’ plans and subsequent postponement in tendering for builders. Despite this delay in construction, the ability to increase the simulation hours for students was protected by developing alternate mechanisms to undertake project activities. The installation of the audio-visual equipment was revised and carried out in an alternate setting, and a substitute temporary mechanism was initiated that allowed continued delivery of simulation hours with multimedia capture and live viewing at the LCHS Moe site.

Key outcomes included an increase in quantity of simulation hours along with an increase in the number of disciplines participating. The project also delivered high quality learning as evidenced by the learners’ responses to in-depth questionnaires which indicated they learnt more about each other’s disciplines and perceived the simulations to be a highly realistic and authentic learning experience.

This interprofessional simulation model could provide a template for a replicable package where clinicians from any health service could be trained as interprofessional facilitators to supervise simulated interview sessions. The model could certainly be transplanted to either acute or community health care settings and could be expanded to include interprofessional education for health care practitioners/clinicians.

For further information

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