

An interprofessional day of hi-fi simulation of Family and Domestic Violence with Midwifery students and Social Work students.

Abstract

An interprofessional simulated learning day with standardised patients (hired actors) was held for student midwives and student social workers in a simulated hospital ward in response to a situation involving Family and Domestic Violence (FDV). Two scenes were pre-written and an unplanned scene was also improvised.

Initial evaluation of the session was conducted by questionnaire, with capacity for quantitative responses using a five point Likert Scale and qualitative replies to questions via textbox. A focus group with the six midwifery students offered an opportunity to provide feedback the following week. Overall findings suggest that students found the simulation a realistic, valuable and safe experience. Student midwives felt less prepared than the social work students and some were confronted by the realism when faced with a scene of FDV; all valued the interprofessional experience and found it useful to discover the role of their professional counterparts in responding to FDV.

Keywords: Simulation, interprofessional, Family & Domestic Violence

Format

Hi-fidelity simulation using simulated patients, held on a simulated a hospital ward.

Target audience

Second year undergraduate midwifery and social work (SW) students. All SW students had completed some study related to biopsychosocial assessments in the context of risk situations and were enrolled in a counselling unit. None of the SW students had been on field placement at the time of the simulation. All midwifery students had been on clinical placement for 18 months but none had any work experience with FDV.

Objectives

The scenarios were developed to meet the following learning objectives: 1) Increase awareness of FDV in hospital settings. 2) Understand the interprofessional roles of social work and midwifery. 3)

Understand the screening tool and risk assessment application. 4) Develop interprofessional communication skills. 5) Reflect upon processes used to make decisions in the context of FDV.

Activity Description

Interprofessional education (IPE) continues to be considered an important focus in health care training (1) and enables health care professionals to develop understanding of different roles (2) which enhances positive, collaborative, working relationships (3). When this is introduced at an undergraduate level it is associated with interprofessional awareness and collegiality (4).

One method of interprofessional education is simulation, used in the health care setting across numerous allied health professionals, including midwives and social workers. It is widespread in undergraduate study and varies in complexity from the use of task trainers to hi-fidelity (closely representing real-life), simulation with standardised patients (actors) (5). Integration of simulation into the current healthcare curricula is evidenced by enhancement of student confidence and clinical skills (6, 7) and has developed over the last decade to provide a safe environment in which learners are also able to develop an understanding of different colleagues' roles (4).

A high fidelity interprofessional simulation using actors was planned for midwifery and SW students in order to allow them to practice skills by collaboratively responding to a situation of FDV in a safe environment.

Second year midwifery and SW students were recruited via an email announcement. All students were volunteers and participation was based on availability, willingness to join an interprofessional simulation activity, and an interest in the subject of FDV. Most of the students had previous experience with simulation, but not all with standardised patients. A total of 15 students were recruited but only 13 (6 midwifery and 7 SW) were able to participate.

All of the students received pre-brief instructions and reading material to prepare for the activity, which consisted of articles regarding pregnancy and partner violence (8, 9). They were also given access to screening and assessment tools; a basic biopsychosocial assessment form for the SW students developed specifically for the simulation session. The SW assessment form included prompts such as family history details, social history, risk factors, strengths (consider her ability to care well for child/bond with the child; willingness to be protective; self-belief; problem solving abilities): and plan to address any notes risks (consider safety planning; outside agency support; family support). The screening tool used by the student midwives was the Edinburgh Postnatal Depression Scoring (EPDS) system (10).

A simulation laboratory comprising of 4 teaching suites replicating a hospital ward was the setting including a waiting room, which was modified to facilitate professional consultations. All rooms were equipped with cameras that allowed the facilitators and non-participating students to watch the scenes unfold in real time in an adjacent room. Actors were employed to play the role of the abused woman and her partner, to enhance the realism in order to optimise learning outcomes (11, 12). The actors were briefed about their characters and given scripts with scene descriptors, but there was no scripted dialogue. The actors were experts at improvisation, which was encouraged.

The simulation scenarios were developed through collaboration between the social work and midwifery unit coordinators. The two scenes were chosen to reflect a clinical experience that both social work and midwifery students were likely to encounter in their clinical practice. Students were informed that at any stage of the simulation the scenario could be stopped if anyone felt unsafe (13). The students were also advised that they would be offered an opportunity to participate in some scenarios and observe other scenarios to vary their experience (14).

The students were given background to the first scenario prior to the simulation. They were told that the scene would involve a young mother (20 years old), financially and emotionally dependent on her older partner (30 years old) and recently having given birth to her unplanned first baby. Her partner had been unsupportive, angry and aggressive towards her and staff members. Following this background information students were offered the opportunity to choose whether to participate in or observe the first scenario. They were then advised to work inter-professionally in planning the best approach for helping the new mother.

Two midwifery students and two social work students volunteered to participate in the first scene, which started in the ward tea room. They were on break but discussing concerns about the partner's aggressive behaviour in labour. The SW student was considering risk assessment and referral when the conversation was disrupted by them overhearing the father being verbally abusive to the mother. The simulation continued (after prompting by facilitator) with the student midwife entering the hospital room. The father continued to be abusive to both the mother and midwife before leaving the room angrily. The student midwife commenced the FDV screen (EPDS) with the mother and when completed, returned to have a discussion with the SW. This allowed an opportunity to discuss the FDV screen and risk factors for FDV which included the young age of the mother, financial dependence and verbal abuse (9), and arrange a referral.

In the second scene the SW was introduced to the mother and used the SW assessment tool to discuss her history, problems, future plans and the father's anger. The actor playing the mother was told beforehand to continue to defend her partner. The SW explained her role regarding safety assessment and then discussed the situation.

The scenarios were run with flexibility, allowing students to stop the scenario to ask for advice from peers and facilitators. After each key scene interaction, students were rotated so that they all had an opportunity to participate. Students in the observation room were advised to take notes to aid participation in the mini debrief sessions between scenarios. On one occasion this resulted in the addition of an impromptu scene, because observing students suggested that it could be beneficial for a SW student to speak with the father alone. This resulted in a discussion between the SW and father in which it was explained that his behaviour was not acceptable but there were strategies available to help.

Debriefing occurred at the end of key points/parts of scenarios and conclusion of each main scene because inter-simulation reflective debrief is key to simulated learning (15).

Meaningful discussion was given sufficient time to allow feedback and reflection, with the identification of performance gaps, strategies for future improvement, and strengths in performance (16), following Garden, Le Fevre, Waddington and Weller's (2015) suggested method of three phases. Emotional venting, the first phase, allows participants to 'cool down' and vent strong feelings; analysis, the second, determines what happened and why, and third, generalisation, integrates the simulation experience into "real world clinical practice" (p 307) to improve future clinical care.

After the final scene, the last debrief included discussion around the personal impact to the students enabling personal reflection and insight, known to be linked to professional resilience (17). The standardised patients participated in the final debrief which gave students awareness to their 'patient view' of the care they had received (18).

Assessment and Evaluation

Following the final debrief the students were asked to complete a post evaluation questionnaire, which all agreed to, in order to analyse achievement of the objectives. The generic (not discipline specific) questionnaire was developed by the simulation team for all

activities within the simulation facility. The questionnaire comprised of 11 questions, some with radio button responses, some asking for numerical order of importance and some with free text answers. Demographic data, such as age and gender were obtained, specific questions about level of simulation experience were asked, benefits of the day and level of agreement with a list of statements around learning objectives were requested (See Table 1.). The data were analysed with SPSS via frequencies and percentages and NVivo10 was used for the qualitative free text results. There was no missing data.

Questionnaire responses (see Table 1.)

Of the 13 students who participated, a strong positive reaction to the simulation was found. The pre-reading was considered to be adequate preparation for all but one of the students, however students were not assessed regarding completion or quality of the pre-assignment reading materials. All strongly agreed that the simulation was a realistic portrayal of the FDV scenario, that it was a supportive process and that debrief was effective. Regarding the learning outcomes, all students agreed or strongly agreed that they were clear and that the simulation activity supported the achievement of the learning outcomes. When rating the importance of the learning outcomes of communication skills; professionalism; problem-solving; teamwork; client-patient practice and client-patient assessment, communication skills was rated the most important outcome (n=5) with client-patient assessment rating second (n=4). Realism was a feature of the students' qualitative comments when asked what was the most beneficial aspect of the activity, including: *Having the experience of seeing an actual scene that I could potentially face in the future.*, *Having a realistic experience.*, *The realistic environment.*, *Was very professional and realistic,* and *Made me feel like I was out in the field practicing* (SW student).

The midwifery student comments referred to gaining insight to the role of the social worker, the interprofessional experience and the benefits of being able to practice in a safe environment, for example: *The interprofessional element and feeling in a safe place to try to deal with the situation but knowing it would be okay if you didn't get it all right* (MW student).

Focus Group

In addition a focus group was held with the midwifery students the following week to add further understanding to the students' narratives of their experiences (19). A focus group for SW students was not carried out due to assessment commitments. The focus group was opened with the question: "What are your feelings and thoughts about the way the FDV simulation day unfolded?" This allowed openness of discussion which resulted in detailed reflection of the simulation.

Much of the discussion reflected the findings from the questionnaire which included a perceived lack of preparation. The midwifery students discussed whether they would prefer total cognizance of the simulation session ahead or whether it was a better learning experience to 'go in cold'. The students had given little thought to the reality of the simulation and some commented that they were not expecting actors, or for the scenarios to be so dramatic and true to life. During the simulation all students felt nervous about playing the part of a midwife, in front of their own student midwife peers plus SW students, at the same time as managing an FDV situation for the first time. There was appreciation of the frequent and in-depth debrief sessions after each scenario.

The focus group discussion revealed recognition of the value of the interprofessional context, especially the new knowledge gained from watching and working with social work students.

Impact

The value of the FDV simulation was expressed by all students but various issues were raised which require further consideration. Pre-simulation preparation has been widely reported as being integral to a successful simulation experience for students (20). In this situation, some students did not engage in the pre-reading, and some who did felt it was inadequate. It is recommended that more detail is included in pre-reading, including the level of simulation, for example whether actors, volunteers, or manikins would be used so that students feel fully prepared.

Participating in simulation, especially when being simultaneously filmed and observed can cause anxiety for students (21), as found here, and could subsequently reduce learning outcomes. More exposure to simulation, in other words more practice, may prove to mitigate these effects. Students in this study expressed a wish for more simulation practice to help reduce performance fear. The SW students in this activity had engaged in more simulation (known to them as role playing) and this may correlate with the study findings that they felt less discomfort during the simulation. In contrast the midwifery students' previous involvement in simulation was to play the patient in emergency scenarios for more senior colleagues, which does not require the same level of responsibility.

The importance of debrief during simulation education is well known and enables students to make sense of the scenario (22). The students in this study corroborated these findings and suggested that the feedback from coordinators and peers helped build strategies for the future. Peer review was a valuable part of debrief as it encouraged student observation skills in order to give constructive feedback.

When the students reflected on the experience they appreciated the range of emotions that had been evoked. One such emotion that was discussed extensively within the midwifery focus group was the experience of FDV. Two students had previously been subject to FDV

and found the scenarios very challenging with the scenes serving as an unwelcome reminder. Being a victim of FDV may increase participation interest; it is therefore necessary to consider strategies to minimise harm. However, it has previously been reported that inter-simulation and immediate post-simulation debrief is not the time to unpack previous issues (20). It is therefore recommended that students are given the opportunity beforehand to discuss the possible repercussions and local services available to deal with issues raised. Conducting simulations that are likely to trigger negative personal experiences for students is challenging for educators and requires them to operate as ‘practitioner-teachers’ (23), thus requiring a greater emphasis on the pre-brief and post-simulation debrief. The benefits of simulation have been reported internationally (24) and the students in this study confirmed that their learning was enhanced in this safe but realistic environment. As it is now accepted that simulation is a demonstrated beneficial pedagogical method, increasing student exposure should be considered in curriculum design (25). Without exception, all students in this study requested more simulation within their course.

Offering an interprofessional experience in health professional education prepares students for future practice by giving them an understanding of the roles of their counterparts (4).

Required materials

There were no required materials for this simulation apart from the screening tools which were used, as described above. The two standardised patients were hired for 3 hours (at \$35 per hour) but these could be played by volunteer actors.

Table 1. Questionnaire Results

		Student Midwives					Student Social Workers				
1	Which course are you enrolled in?	6 x midwifery					7 x social work				
2	Age Group	15-19	20-24	25-29	30-34	40-44	15-19		25-29	40-44	0-54
			2	1	2	1	1		4	1	1
3	Gender	M			F		M			F	

			6				1			6			
4	Have you had any previous experience of simulation?	Yes			No			Yes			No		
5	Please expand (qual responses)	4			2						7		
6	Overall, do you feel that simulation was a positive learning strategy for you?	SD	D	N	A	SA	SD	D	N	A	SA		
					1	5					7		
7	Please indicate your level of agreement with the following statements//questions:	SD	D	N	A	SA	SD	D	N	A	SA		
a	Did the simulated setting create a realistic environment?				1	5				1	6		
b	Did the actors/volunteers portray a realistic patient/client during the simulation activity?					6					7		
c	Did the pre-brief provide you with enough preparation for the simulation?		1		3	2				2	5		
d	Did your experience create a positive learning environment for this activity?				2	4				2	5		
e	Were you satisfied with the support provided by your educator?		1			5					7		
f	Were you clear about the learning outcomes of the simulation activity?			1	3	2				1	6		
g	Did the simulation activity support the achievement of the learning outcomes?				2	4				1	6		
h	Were you satisfied that the debrief session supported the activities that simulation activity?		1			5					7		
8	Please arrange the following skills in order of priority according to what you think simulation activities are most suited to helping you develop in your role as a health professional (1 being the most suited, 6 being the least suited):	1	2	3	4	5	6	1	2	3	4	5	6
	Communication Skills	2	2		2			3		1	2	1	
	Client/Patient practice	1	2		1	2			4	2	1		
	Problem-solving	1		2	1	2				1	2	1	3
	Team work	1	1	2	1		1		3		2	2	
	Professionalism			1	1	2	2	1		2		1	3
	Client/patient assessment	1	1	1			3	3		1	1	1	1
9	What was the most beneficial aspect of the simulation activity for you?	Qual responses					Qual responses						
10	Would you like to make any other comments about the simulation activity that you participated in?	Qual responses					Qual responses						

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