Paediatric safeguarding simulation (PaSS) training: a novel approach to teaching child protection

Anna Woodman, Phil J Peacock, Rebecca E Holman, James E Hambidge, Joanne Smith, Janet King

Department of Paediatrics, Great Western Hospitals NHS Foundation Trust, Swindon, UK

Correspondence to
Dr Phil J Peacock, Great Western Hospital, Swindon, SN3 6BB, UK; phil.peacock@bristol.ac.uk

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INTRODUCTION

Child safeguarding is the responsibility of all healthcare professionals and in the UK, 'Level 3 Safeguarding Children' is a national requirement for clinical staff working with children, young people, their parents or carers.[1] These professionals have a key role in identifying, assessing and reporting safeguarding concerns. This report describes the development and delivery of a new simulation programme, within a UK District General Hospital, to help increase staff confidence in managing child safeguarding in the clinical environment.

Serious case reviews following safeguarding incidents in the UK have demonstrated that opportunities are often missed by front-line healthcare professionals during routine clinical encounters.[2] Similar concerns have been raised in other countries, including the USA, Canada and Australia.[3–5] Safeguarding concerns may arise in a number of healthcare settings: a child may present to hospital or their general practitioner with injuries or a medical emergency, during routine appointments, or during an encounter with a family member. It is important that healthcare professionals are trained in recognising and confidently managing these unexpected safeguarding presentations.

In the UK, safeguarding is currently largely taught in an e-learning format with higher level training involving more face-to-face time in lecture/seminar sessions. These methods are useful for teaching the knowledge required, but are not as well suited to the affective elements and communication skills which are essential to effectively manage safeguarding cases. There is some evidence that simulation training may be effective at teaching these aspects of child safeguarding,[6] as well as giving opportunity to practise skills that are infrequently used.[7]

METHODS

Since 2015, safeguarding simulation has been included in the medical student paediatric placement in Swindon,[8] a District General Hospital linked to the University of Bristol.

Undergraduate (AW, REH, JEH) and postgraduate (PJP) teaching fellows have collaborated with the named nurse for safeguarding (JS) and designated doctor for the local authority (JK) to develop 'paediatric safeguarding simulation' (PaSS) training for Trust staff.

Simulation scenarios include a scalded infant, a domestic violence disclosure on the neonatal unit, an accidental paracetamol overdose, child sexual exploitation and non-accidental injury. Scenarios were developed in advance using a standardised simulation template which includes a written brief for participants to standardise the scripts. To increase the realism and enhance learning, high-fidelity simulators as well as adult and child actors have been used where appropriate (figure 1). This was approved by the Trust simulation lead and safeguarding team. All child actors were accompanied by their parents, who consented for their child to act and were fully briefed prior to participation. The well-being of children was ensured throughout and there were plans for the scenarios to be stopped if the child became upset at any point. Suitable toys and refreshments were provided. Props and moulage make-up helped increase authenticity.

Six half-day sessions were delivered, each with three or four scenarios for a maximum of seven participants. Participants signed up on a voluntary basis, with attendance recorded in their safeguarding training passports.

When not directly taking part in a scenario, participants observed via a live video link into a debrief room with a faculty member. This footage was not recorded and all participants were aware of the cameras. Each scenario was followed by an extensive debrief using the advocacy-inquiry model to encourage individual reflection. Participants discussed how the scenario went and reflected on emotions and their performance, with feedback from observers and facilitators. The debrief addressed key learning points and concepts and allowed for review of local safeguarding procedures.

Feedback was collected on the training and the approach to teaching safeguarding through simulation. Attendees completed Likert scales to measure their confidence in managing safeguarding situations before and after the simulation session. Presession and postsession scores were compared using a Wilcoxon signed-rank test. Attendees also provided free-text comments. Completion of the feedback questionnaires was voluntary, and responses were anonymous.

RESULTS

Six sessions have been delivered, with a total of 33 participants. The participants were multidisciplinary and included nursery nurses, midwives, health visitors, play specialists, junior doctors, paediatric registrars and nursing staff. They worked in a range of settings including the emergency department, neonatal unit, children's ward and

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Figure 1 Simulation scenario (unexplained bruising) using a baby simulator and an actor.

surgical department. All participants returned feedback forms and each gave the session an overall rating of 'excellent' or 'good'.

Confidence in managing child safeguarding was measured using a Likert Scale from 0 to 10. The median reported confidence increased from 6 (range 0–8) to 8 (range 6–10) following the simulation teaching ($p<0.0001$). Free-text comments included 'exciting and engaging way to learn safeguarding' and 'really good to put me in the simulation and think "what would I do?"'.

DISCUSSION

PaSS training has been successfully introduced in a District General Hospital as part of the Safeguarding Children training programme. Training is well received by participants and leads to an increase in reported confidence in managing child safeguarding cases. Simulation training can complement the taught safeguarding courses, allowing front-line healthcare professionals to maintain their level 3 competencies and develop essential clinical and communication skills in the recognition and initial management of a child at risk.

The strengths of this simulation programme are the multiprofessional faculty and attendees, the high faculty to participant ratio and the realistic simulation scenarios. The use of live actors, as well as props and moulage, has helped increase realism and thus enhanced the learning experience.

There is potential bias with self-reported confidence scores, and these may not accurately reflect competence in the clinical setting. However, the anonymous nature of the feedback sought to minimise this and the free-text comments were in keeping with the confidence scores given. Confirmation bias could be further minimised in the future by recording anonymous participant confidence scores directly before and after the scenarios.

At present, there is no formal assessment of skills or competence during the simulation sessions, as it was felt this might deter people from attending. However, the authors are considering incorporation of objective assessment of skills and competence presimulation and postsimulation training in the future. The programme will continue to be adapted and developed on the basis of faculty and participant feedback. Safeguarding and simulation faculty from nearby hospitals have observed sessions, and it is hoped that this programme will be rolled out beyond this local hospital.

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