

Simulation training for clinicians returning to practice

Abstract

Many doctors take time out of clinical practice, and then have decreased confidence and poor performance ratings on their return. Simulation training provides a safe and effective learning platform for healthcare professionals to become immersed in realistic scenarios that provide an opportunity to develop technical and non-technical skills. A standardised, 1-day, multi-fidelity, interprofessional, simulation training course was developed and delivered at four sites, focusing on human factors, patient safety and acute clinical scenarios relevant for clinicians returning to practice in internal medicine. A total of 56 participants, with a median time out of training of 3.6 years, attended seven courses. Quantitative and qualitative analysis showed a significant pre/post-course increase in candidates' self-reported confidence in returning to practice along with learning in non-technical skills. The carefully designed standardised format may facilitate wider expansion of such training.

Key words: Medical education; Return to practice; Simulation training

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Introduction

Physicians commonly take time out of clinical practice for a number of reasons including parental leave, health-related absence and approved training opportunities in research, education, leadership or other disciplines that nurture personal development (Grace et al, 2010). The longer a clinician is out of programme, the more likely they are to have poor performance ratings on their return. They may feel a loss of momentum with regard to career progression and/or a sense of professional isolation and, on returning to practice, may feel 'out of touch' (Gowland et al, 2016).

Simulation training provides an education platform for healthcare professionals to become immersed in realistic scenarios with experiential learning and a focus on improving non-technical as well as technical skills (Ross et al, 2015). It affords situational learning without compromising patient safety and has been demonstrated to improve clinician competence and confidence in a number of specialities (Blackmore et al, 2014; Ross et al, 2015; Quick, 2018; Satin, 2018). Simulation training has been trialled previously at times of career transition but such programmes have been single site, with small numbers of participants, and mostly focused on surgical skills (Bruce et al, 2005). Previous research has demonstrated the value of simulation training in medicine but no studies have assessed its role in supporting trainees returning to practice with qualitative and quantitative analysis. This study outlines the development of a multi-centre simulation programme for doctors and nurses returning to clinical training and practice in internal medicine.

Methods

Course structure and evaluation

A standardised, 1-day, multi-fidelity, interprofessional, simulation training course was developed by a project group (comprising educationalists, trainees and trainers from a variety of specialities) to address the needs of clinicians returning to training and practice in internal medicine. The aims of the course were to support returning clinicians through exploration of technical (recognition of clinical deterioration, the acutely ill patient, atypical presentation of medical emergencies, clinical interpretation of abnormal physiology, competence with resuscitation protocols) and non-technical (situational awareness, calling for help, teamwork,

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communication, decision-making, leadership/followership, dealing with conflict) skills. The course was delivered by experienced clinicians and educationalists at one of four sites across London (one per quadrant) (Simulation and Interactive Learning Centre, St Thomas' Hospital; Education Centre, King's College Hospital; Simulation Centre, Homerton University Hospital; Simulation Training and Resource Centre, Harefield Hospital). Course faculty and sites were recruited by the project group based on their track record in the delivery of multi-centre simulation training. Course faculty facilitated courses on all sites to achieve consistency of scenarios and learning objectives. The course included five scenarios chosen to develop assessment and management in a broad range of acute clinical situations, incorporate key non-technical skills and be relevant for clinicians returning to practice (Table 1). The scenarios, exemplified in Appendix 1, had been validated in previous postgraduate simulation training programmes for physicians (Mehdi et al, 2014; Braude et al, 2015).

Each course started with a facilitated exercise to glean the hopes and fears of attendees and an introduction to simulation. Scenarios used Gaumard SUSIE S2000 high-fidelity human patient manikins (with computer-controlled vital signs allowing changes in patient characteristics to be simulated) and role-play exercises. Attendees directly participated in one or more scenarios and watched others via a live video-feed. Each scenario lasted up to 20 minutes and was followed by a group debriefing session lasting approximately 40 minutes using a validated 'diamond' model of description, analysis and application (Braude et al, 2015). Participants were given validated pre- and post-course paper questionnaires to rate their confidence (on a 0–10 scale) in managing clinical scenarios and key non-technical skills such as leadership and communication, and provide free-text feedback about what they learned and appreciated from the course (Appendix 2) (Gaba et al, 2001; Braude et al, 2015). Health Education England funded costs associated with the running of the programme (£4000/course) that was advertised via educational networks in London.

Data analysis

Records of anonymised pre- and post-course questionnaire free-text feedback were transcribed into Microsoft Excel spreadsheets. Each response was kept as a separate datum point. All text was thematically analysed by authors AHM and JB. A single response could be coded against multiple themes. Quantitative data were tested for normality using the Kolmogorov–Smirnov test and were found to be not normally distributed. Therefore, non-parametric tests (Wilcoxon signed-rank test) were used for data analysis. All candidates gave written informed consent for data to be aggregated for research purposes in accordance with the terms of the Data Protection Act 1998. Ethical approval was given by the Hospital Research Ethics Committee (South London REC 3; approval ref. 09/28), under the terms of the UK NHS Research Ethics Service.

Results

Fifty six candidates (25% core medical trainees, 52% specialist registrars training to be consultant physicians, 23% band 3–7 nurses) attended seven courses (two each at St Thomas' Hospital, King's College Hospital and Harefield Hospital, and one at Homerton University Hospital) between August 2018 and August 2019. Median (interquartile range) time out of training was 3.6 years (2.6 years). Reasons for time out of clinical practice included parental leave, research, health-related absence and career breaks.

The pre-simulation exercise generated 61 hopes and 72 fears, which were coded into five and seven themes respectively (Table 2). For both hopes and fears, the top two themes accounted for $\geq 50\%$ of the responses. Free-text post-course questionnaire feedback yielded 159 responses. Thematic analysis of what was learned by course attendees generated seven themes, mostly related to non-technical skills (Table 3). Candidates documented their enjoyment of the course with thematic analysis demonstrating four themes (each accounting for 25% of responses):

- Valuing high-fidelity simulation as a training modality
- Choice of scenarios
- Debriefing model
- Supportive faculty.

Table 1. Standardised scenarios and skills		
Scenario	Simulation technique	Skills aimed to be incorporated into the training
Management of delirium	High-fidelity life-size manikins	<ul style="list-style-type: none"> Situational awareness Calling for help Leadership Teamwork Effective communication Using available resources Decision making Recognition of atypical presentation of medical emergencies Clinical interpretation of abnormal physiology
Assessment of sepsis	High-fidelity life-size manikins	<ul style="list-style-type: none"> Situational awareness Calling for help Teamwork Effective communication Using available resources Decision making Recognition of clinical deterioration Competence with resuscitation protocols
Complex discharge planning	Role play exercises	<ul style="list-style-type: none"> Leadership and followership Teamwork Effective communication Decision-making Dealing with conflict Using all available information Patient as central focus of care Patient safety
End of life care	High-fidelity life-size manikins and relative actor	<ul style="list-style-type: none"> Decision making Calling for help Situational awareness Setting priorities dynamically Exercising leadership Effective communication Dealing with conflict Patient as central focus of care
Management of the acutely ill patient	High-fidelity life-size manikins	<ul style="list-style-type: none"> Teamwork Effective communication Leadership Situational awareness Decision making Calling for help Setting priorities dynamically Recognition of acutely ill patient

Table 2. Thematic analysis of hopes and fears of course attendees

Theme with examples			% of responses accounted for by theme
Hopes	Confidence	‘I would like to come away with increased confidence in my abilities’ ‘Develop confidence in my assessment skills’	38
	Clinical refresher	‘To feel familiar again with thinking through acute situations’ ‘Learn any changes in emergency management’	25
	Non-technical management skills	‘To explore my leadership potential’ ‘Practise prioritising’	23
	Reflection and reassurance	‘To think about ... skills I’ve retained’ ‘Hope to be reassured I haven’t actually forgotten everything’	10
	Return to practice training	‘I hope to gain better understanding of the process of return to practice’ ‘Gain confidence in getting back into practice’	4
Fears	Insufficient knowledge/skills/out of date	‘Loss of skills ... not being up to date’ ‘Lack of knowledge’	34
	Leadership	‘Being in charge’ ‘Concern of returning to ... role with ... responsibilities’	31
	Making mistakes	‘Don’t recognise what I have forgotten ... will be unsafe’ ‘Making mistakes’	9
	Managing emergencies	‘Reacting to an emergency’ ‘That my mind will go blank under pressure!’	9
	Fear of simulation training/course benefit	‘Scared of being compared to other participants’ ‘Will the course be relevant to me?’	8
	New clinical environment/situational awareness	‘My concern is to work in a new environment’ ‘Not worked in hospital for a long time’	5
	Work–life balance	‘Managing when sleep deprived’ ‘I won’t cope with it all (work, family, childcare)’	4

Quantitative analysis demonstrated significant improvement in all domains assessed with the greatest change referring to dealing with uncertainty (Table 4).

Discussion

Returning to practice can be stressful with clinicians feeling potentially out of date and deficient in their capabilities. Despite this many are expected to return directly to the same intensity of work. This study demonstrated a dedicated simulation training programme to be effective in increasing candidates’ confidence in returning to clinical practice along with learning in non-technical skills.

The question remains whether the positive results obtained from this training result in improved patient outcomes. Previous studies have shown correlation between simulation training and improved patient care and sustained effects of such training with ongoing reflective practice (Brydges et al, 2015; Ross et al, 2015). Furthermore, based on the principle of motivation theory, learners’ self-efficacy ratings (eg confidence levels) have

Table 3. Thematic analysis of post-course questionnaire free-text feedback

Theme with examples		% of responses accounted for by theme
Improved confidence	‘Feel more confident ... can be a medic again’ ‘My skills aren’t as rusty as I thought’	28
Communication	‘Being specific in instructions’ ‘Importance of closed loop communication ... speak up’	22
Reflection	‘I would be more open and build a safe environment for myself’ ‘Reflection on self-care ... being flawed’	14
Coping with working under pressure and uncertainty	‘Dealing with anxiety/stress in an emergency situation’ ‘Confidence that ... normal to feel uncertain...’	13
Clinical refresher	‘Knowledge ... opportunity of using the skills centre facility’ ‘Think simple ... ABCDE’	9
Team working and asking for help	‘You are never alone - help is always there!’ ‘It is okay not to know everything and ask for help’	8
Leadership	‘I feel more confident in a leadership role as a registrar’ ‘Assessment of leadership in scenarios’	6

Table 4. Comparison between pre-and post-course confidence ratings

	Median (interquartile range) pre-course score	Median (interquartile range) post-course score	P value
Managing negative emotions	7 (3)	8 (3)	<0.001
Requesting help	8 (3)	9 (2)	<0.001
Communicating effectively	7 (2)	8 (2)	<0.001
Prioritising	7 (3)	8 (2)	<0.001
Speaking up	7 (3)	8 (4)	<0.001
Dealing with uncertainty	6 (3)	8 (3)	<0.001
Asking for information	7 (2)	8 (2)	<0.001
Recognising when to take on a leadership role	7 (3)	8 (2)	<0.001
Monitoring the ‘big picture’ during a complex clinical situation	7 (3)	8 (4)	<0.001
Anticipating in clinical situations	7 (2)	8 (1)	<0.001
Working effectively with a new team	7 (3)	8 (2)	<0.001

been shown to have a good correlation with real-world ability. This underpins the social cognitive approaches to the learning theory used within simulation that cannot replace real-life work-based experience but may be used to augment knowledge and competencies (Braude et al, 2015). Follow-up studies in individuals returning to clinical practice would be helpful to address these issues, particularly focussing on patient safety issues in internal medicine; assessing whether the positive self-reported changes in behaviour noted provide tangible results.

The strengths of this study include the successful delivery of a training programme across four centres. Efforts were taken to achieve standardisation of course structure with prescriptive scenario outlines and cross-site faculty working. The scenarios were carefully developed by an interdisciplinary project group and were shown to meet the situational,

Key points

- Many doctors take time out of clinical practice with decreased confidence and poor performance ratings on their return.
- Simulation training affords an opportunity for doctors to improve technical and non-technical skills.
- Simulation training provides a safe and effective learning platform to increase confidence in returning to clinical practice, particularly in dealing with uncertain situations.
- A standardised, multi-centre, simulation training course to support physicians returning to practice is a feasible educational initiative.

technical and non-technical needs of participants, as evidenced by analysis of their pre-course hopes and fears. Considerable coordination and dedication from cross-site faculty was required and previous experience from the project lead (JB) in delivering simulation programmes in stroke and geriatrics across London facilitated the success of this study (Braude et al, 2015; Ross et al, 2015).

This study is limited by a lack of a control group who did not receive the simulation training and it would be interesting to see how the beneficial effects of the training would compare against such a control group in terms of short-term and long-term outcomes. In addition, there is a selection bias of the individuals who attended the course and their self-reporting. It could be postulated that the attendees might be deficient in self-evaluation skills and believe that they are actually worse than they are, such that the effect of the course is not a specific one of training but rather a reminder that their skills are better than they thought. The limited numbers of participants also precluded meaningful analysis of differences in results between doctors and nurses and between doctors and nurses of different grades.

Conclusions

As more healthcare professionals are taking time out of clinical practice, educators and employers need to look at ways in which to support this vulnerable group on their return. This novel, carefully designed, standardised simulation programme facilitates the format to be transferable to multiple centres and future courses. Despite clinicians' major fear of technical limitations, an appreciation of non-technical skills is crucial. Participants mainly felt better improvement in their preparedness in non-technical skills that would be hoped to translate to enhanced clinical performance and patient outcomes.

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Conflicts of interest

The authors declare that there are no conflicts of interest.

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Appendix 1. Example of scenario used: assessment of sepsis

Patient's name: Albert Adams

Patient's demographics: 80-year-old male

Narrative description	<p>Albert Adams, an 80-year-old male, was admitted from home 3 days ago acutely confused and 'off legs'. He was found to be in urinary retention with a urinary tract infection. He is now on oral antibiotics with a foley catheter in-situ, and has been transferred to the elderly care unit for ongoing treatment and a complete geriatric assessment.</p> <p>Past medical history: Atrial fibrillation and hypertension</p> <p>Drug history: Digoxin, ramipril, no known drug allergies</p> <p>Social history: Lives with his wife and independent with activities of daily living</p> <p>Resus status: Full</p> <p>Day 1: Blood pressure 165/95 mmHg, heart rate 90/minute irregularly irregular in rhythm, oxygen saturations 94% on air.</p> <p>Day 2: Made good progress initially and was transferring with one carer at lunchtime. Catheter became displaced and was reinserted that afternoon. That night he became disorientated and required a dose of haloperidol.</p> <p>Day 3: He has become increasingly disorientated. Blood pressure 110/75 mmHg, heart rate 110/minute atrial fibrillation, oxygen saturations 96% on air. Decreased urine output noted overnight. The nurse is concerned and calls for help.</p>	
Staffing	<p>Faculty control room:</p> <p>1 × technician</p> <p>1 × patient voice</p> <p>>1 × debriefer</p>	<p>Faculty role players:</p> <p>1 × health care assistant plant</p>
Case briefing	<p>To all candidates</p> <p>Albert Adams, an 80 year old male, was admitted from home 3 days ago acutely confused and 'off legs'. He was found to be in urinary retention with a urinary tract infection. Initially improving, he is now on oral antibiotics with a foley catheter in-situ, and has been transferred to the elderly care unit for ongoing treatment and a complete geriatric assessment. Last night he became disorientated and required haloperidol. Today the nurse is worried and has called you to see her.</p>	
Manikin preparation	<p>Patient not attached to any monitoring with intravenous access: 24 gauge (pink) cannula</p> <p>Catheter in-situ, ideally with urometer which is empty</p>	
Room set up	<p>As per elderly care ward</p>	
Simulator operation	<p>Patient initially talking but confused and disorientated (abbreviated mental test score 3/10)</p> <p>He becomes less responsive as he deteriorates</p> <p>Improves if given fluids, antibiotics, oxygen, and hyperkalaemia treated</p> <p>If hyperkalaemia not recognised and treated, patient will develop multiple ventricular ectopics, then pulsed ventricular tachycardia, then pulseless ventricular tachycardia and ventricular fibrillation</p>	
Props needed	<p>Foley catheter, urometer, dark stained urine, intravenous fluids</p> <p>2 × large bore cannulae, resus trolley and defibrillator, hyperkalaemic electrocardiogram</p> <p>Drugs: Antibiotics, paracetamol, calcium gluconate, insulin/glucose, resus drugs</p>	

Observations

Initial

Heart rate	110/minute, atrial fibrillation
Oxygen saturations	96% on air
Blood pressure	95/55 mmHg
Temperature	37.9°C
Respiratory rate	22
Glasgow Coma Score (GCS)	E(Eyes)=4 V(Verbal)=4 M(Motor)=5 Total=13 Talking but confused

Abbreviated mental test score 3/10

Patient able to correctly identify name, date of birth and monarch

In the first 5–10 minutes if untreated

Heart rate	135/minute, atrial fibrillation
Oxygen saturations	97% (100% with oxygen)
Blood pressure	74/46 mmHg
Temperature	37.9°C
Respiratory rate	27
GCS	E=3 V=3 M=5 Total=11 Less responsive

Routine bloods and arterial blood gas (ABG) available if asked

In the next 5 minutes with treatment (intravenous fluids and antibiotics)

Heart rate	98/minute, atrial fibrillation
Oxygen saturations	99% (100% with oxygen)
Blood pressure	105/64 mmHg
Temperature	37.9°C
Respiratory rate	18
GCS	E=4 V=4 M=5 Total=13

If candidates fail to recognise and treat the hyperkalaemia then the patient will develop multiple ventricular ectopics.

Newly qualified staff nurse plant role

Scenario

Albert Adams, an 80-year-old male, was admitted from home 3 days ago acutely confused and 'off legs'. He was found to be in urinary retention with a urinary tract infection. He is now on oral antibiotics with a foley catheter in-situ, and has been transferred to the elderly care unit for ongoing treatment and a complete geriatric assessment.

Past medical history: Atrial fibrillation and hypertension

Drug history: Digoxin, ramipril

No known drug allergies

Social history: Lives with his wife, independent with activities of daily living, non-smoker, non-drinker

Resuscitation status: full

Day 1: Blood pressure 165/95 mmHg, heart rate 90/minute irregularly irregular, oxygen saturations 94% on air.

Day 2: Made good progress initially and was transferring with one carer at lunchtime. Catheter became displaced and was reinserted that afternoon. That night he became disorientated and required a dose of haloperidol.

Day 3: He has become increasingly disorientated. Blood pressure 110/75 mmHg, Heart rate 110/minute, atrial fibrillation, oxygen saturations 96% on air. Decreased urine output noted overnight. The nurse is concerned and calls for help.

On routine observations, you note the patient appears to be increasing unwell and confused. You have called for help.

Underlying diagnosis

Urinary sepsis/Systemic inflammatory response syndrome

Hyperkalaemia secondary to acute renal failure

Instructions

You are a newly qualified staff nurse who can do things if you are told exactly what to do, and you can contact anyone if told who and how.

Patient role

Albert Adams, 80-year-old male

Scenario

You were admitted from home 3 days ago acutely confused and 'off legs'. You were found to be in urinary retention with a urinary tract infection. You are now on oral antibiotics with a catheter in-situ, and you have been transferred to the elderly care ward for ongoing treatment and a complete geriatric assessment.

Past medical history: Atrial fibrillation and hypertension

Drug history: Digoxin, amlodipine

No known drug allergies

Social history: Lives with his wife, independent with activities of daily living, non-smoker, non-drinker.

Resuscitation status: full

You initially made good progress and you were able to transfer with one carer yesterday lunchtime. Your catheter became displaced and was reinserted that afternoon. Overnight you have become increasingly disorientated and confused.

Underlying diagnosis

Urinary sepsis/Systemic inflammatory response syndrome

Hyperkalaemia secondary to acute renal failure

Instructions

You are scared and confused as you can see and hear everyone start to panic and run around. You know ‘who you are’ but not where you are, what year it is or why you are in hospital.

If given a mini-mental test, you answer correctly your name, date of birth and the Queen’s name only.

You are breathless with a sore ‘tummy’ and you want to go home to your wife and dog.

You can only give a vague history and need constant reiteration of where you are and why.

You know you are on a little white tablet for blood pressure.

If not treated appropriately, you become more drowsy and confused and can’t give any useful information.

Arterial blood gas result

Albert Adams, 80-year-old male

pH	7.31
pCO ₂	3.8
pO ₂	8.9 on air
BE	-5
HCO ₃	20

Blood results (from earlier in the day)

Albert Adams, 80-year-old male

Hb	10.2	Na	147
WCC	14.5	K	7.8
Plts	460	Ur	11
		Cr	135

Appendix 2. Pre-and post-course questionnaires

Pre-course questionnaire

Dear participant

To help us make sure you get the most out of your Return to Practice Simulation course, please answer the following questions so we know a little more about you. This is to help us tailor the day to your learning needs as much as possible and to help us inform future Return to Practice activities.

1. Current stage of training or banding:

.....

2. Length of gap in practice:

.....

3. Date of return to practice (if known):

.....

4. Reason for gap in practice (eg maternity leave, research, career break) if happy to share:

.....

5. What job will you be/have you been working in *after* your return to practice?

.....

6. What job were you working in last *before* your gap in practice?

.....

7. Have you got any particular concerns about returning to practice that you hope this day might address?

.....
.....
.....
.....
.....

Please circle your preferred response

On a scale of 0–10, how confident do you feel in:

Managing negative emotions	0	1	2	3	4	5	6	7	8	9	10
Requesting help	0	1	2	3	4	5	6	7	8	9	10
Communicating effectively	0	1	2	3	4	5	6	7	8	9	10
Prioritising	0	1	2	3	4	5	6	7	8	9	10
Speaking up	0	1	2	3	4	5	6	7	8	9	10
Dealing with uncertainty	0	1	2	3	4	5	6	7	8	9	10
Asking for information	0	1	2	3	4	5	6	7	8	9	10
Recognising when to take on a leadership role	0	1	2	3	4	5	6	7	8	9	10
Monitoring the 'big picture' during a complex clinical situation	0	1	2	3	4	5	6	7	8	9	10
Anticipating in clinical situations	0	1	2	3	4	5	6	7	8	9	10
Working effectively with a new team	0	1	2	3	4	5	6	7	8	9	10

Post-course questionnaire

Please circle your preferred response

On a scale of 0–10, how confident do you feel in:

Managing negative emotions	0	1	2	3	4	5	6	7	8	9	10
Requesting help	0	1	2	3	4	5	6	7	8	9	10
Communicating effectively	0	1	2	3	4	5	6	7	8	9	10
Prioritising	0	1	2	3	4	5	6	7	8	9	10
Speaking up	0	1	2	3	4	5	6	7	8	9	10
Dealing with uncertainty	0	1	2	3	4	5	6	7	8	9	10
Asking for information	0	1	2	3	4	5	6	7	8	9	10
Recognising when to take on a leadership role	0	1	2	3	4	5	6	7	8	9	10
Monitoring the 'big picture' during a complex clinical situation	0	1	2	3	4	5	6	7	8	9	10
Anticipating in clinical situations	0	1	2	3	4	5	6	7	8	9	10
Working effectively with a new team	0	1	2	3	4	5	6	7	8	9	10

Please list what you learned and appreciated from the course

.....

Please let us know if you enjoyed the course and anything you particularly liked:

.....

