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**Training 26th November 2013**

**Thoughts after delivering the first training session – Ellie, Richard, Chris, Rebecca, Julia, Claire**

**Plus discussion at steering group meeting 5th Dec 2013**

1. The session felt rushed. Although we had run through and timed everything, those delivering the session were aware of how much there was to get in and this resulted in a rushed delivery. There was less time spent in discussion groups than had been planned for.
2. It would be better to nominate one person to ‘host’ the session, and for all others who are contributing to the delivery to sit down unless they are speaking.
3. All of the hand outs need to be delivered at the beginning or the end of the session; handing them out during the training contributed to the chaos
4. The Yes/No game was a good start, but there needed to be more time for reflection and discussion about how people found this.

It might have worked better to ask everyone to stand up while they were playing the game and sit down when they had finished; this would make it easier to identify when everyone had finished.

1. Video clips

* The clips worked well and people appeared to engage in hearing directly from parents
* The discussion (‘what do you think were the key messages from the video’) was too simple and people quickly worked out what the messages were.
* Questions about the videos might work better, with each group taking one question and then feeding back to everyone. For example, we could ask about the skills that the clinician would have needed in each situation, or we could reorganise the video so that it stopped before the ‘what would have made the experience better’ section, and ask this question.
* Discussion after the videos could also include a chance for reflection on real experiences and how staff feel they could have handled past experiences better.
* We need to write and print out transcripts of the videos in case the technology fails!
* The sound on the video clips fades out a bit too soon so you lose the last bit of what is being said; this needs to be amended

1. Role play

* Too simplistic, however, this can be rectified by making the situation more complex.
* The message about waiting 30 seconds for a child to respond was lost; need to make this clearer
* We discussed ideas in the steering group meeting around adding in asking the parent/child about dietary requirements, whether the food needs cutting/pureeing etc. Sheri Ostler and Julia Melluish may be able to advise about this.
* We could also use the role play to lead into a discussion about how the three people (staff/parent/child) might have been feeling during the interaction
* The role play element of the training session requires extra people delivering the session which we need to think about – should the role play be retained?

1. Key Messages

* Slide: It might be better to display each key message separately and then amalgamate them at the end. This will allow explanation of each message and a chance for discussion
* The key messages could be used in communication booklets when they are developed, so that for each child there is a reminder of what the messages are. They could be personalised so that the headings appear and leave space for each child/parent to complete the appropriate thing for them. For example ‘just ask’, and then a space for individual info about how to do this for the child in question.

1. We could include more information about phase 2 (qualitative work). This could be used to highlight that communication is everyone’s responsibility and that our research has shown that it does not always happen effectively on the ward.
2. The local information about the aids that are available was useful but we need to make it deliverable elsewhere. We could have the general training package and then a section for ‘local input’ where whoever was delivering the training could invite an appropriate local person to deliver this bit of it.
3. Feedback

* We asked everyone for feedback and had some very positive comments.
* It would be useful to email everyone who came to the training in 4/6 weeks to see whether they think attending the training has had any impact on their practice.
* This could just be a few simple questions or survey monkey.
* We could use this feedback in future training sessions/to inform roleplay/in advertising the training
* We might want to ask about any barriers that staff have thought of since the training which might prevent them from putting the key messages into practice.

1. Doctors seemed less engaged than others. This might have been because of the timing of the training; they are still holding their bleeps and so not fully engaged. This might be helped by increasing the amount of time for discussion and engaging in the training.
2. We might want to limit numbers in the future; smaller groups would have been better for discussion
3. We need to think about how to handle latecomers. We could consider having a sign on the door once the session has started.

Next steps:

* Claire will no longer be working on the project, but it is intended that another training session will run
* It has been suggested that the training session could be delivered to medical students as part of their training, surgical teams/those members of staff who visit the children’s ward.
* We also received a request after the training to deliver it in the Emergency Department, which Rebecca will follow up.