Dementia Training Design and Delivery Audit Tool (DeTDAT) v4.0

Auditor's Manual

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It was conducted by Leeds Beckett University, the University of Bradford and the University of Leeds.

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Introduction

Background to the DeTDAT

The DeTDAT was developed as part of the outcomes from the *What Works? in dementia training and education* study. The research was commissioned by the Department of Health Policy Research Programme (DH PRP) on behalf of Health Education England (HEE) and carried out by Leeds Beckett University, the University of Bradford and University of Leeds. The audit items are based on evidence arising from a review of the international literature on effective approach to dementia education and training.[1] They therefore reflect the best practice guidance based on what is currently known about the conditions most likely to lead to effective dementia education and training for the health and social care workforce.

The literature review upon which the DeTDAT is based has been published as an open access journal paper a link to that and a download of the full report are available via the study web-site http://www.leedsbeckett.ac.uk/school-of-health-and-community-studies/what-works/

Using the DeTDAT

The DeTDAT is designed to be used by those who deliver, commission or purchase dementia training to:

- assess whether the training they deliver/commission complies with current best practice guidance;
- review and update existing training in line with best practice guidelines;
- help inform the design and delivery of new training programmes to increase likelihood of successful outcomes;
- inform decisions around the commissioning of future training to ensure this is in line with best practice guidance around likely qualities for successful outcomes and thus represents good value for money.

Using this DeTDAT auditor's guide

Please make sure you carefully read this auditor's guide before undertaking an audit of a training or education programme using DeTDAT. It is important each of the audit items is understood adequately before making a decision about whether it has been met. The guide will help you to consider what the item means and how this might be evidenced.

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[1] **Surr, C.,** Gates, C., Irving, D., Oyebode, J., Smith, S.J., Parveen, S., Drury-Payne, M. and Dennison, A. (2017) Effective dementia education and training for the health and social care workforce: A systematic review of the literature. *Review of Educational Research.* DOI: 10.3102/0034654317723305 available to download for free from www.bit.ly/2hYYkJB

Choosing the evidence to audit

Training is usually comprised of a number of different elements including the aims and learning outcomes, teaching plan, written materials, PowerPoint or other visual aids, audio-visual materials, exercises and activities, handouts and how these are delivered. Ideally an audit should include all components of the training. Experience indicates for example that what is in a teaching plan, or on PowerPoint slides might not be what is actually delivered in the training room. Therefore, observation of delivery is essential in assessing whether the intended training is what is actually received.

It may be that some audit items are either not applicable to the package being reviewed (for example the 'facilitator qualities' section will not be applicable to an e-learning only package) or the auditor may unable to assess the item due to the evidence available. In such cases record either n/a if the item is not applicable or ? if the item is applicable but the auditor is unable to make a judgement based on the available evidence. The auditor may wish to access further evidence for items marked ? ahead of making further judgment about the outcome for the programme under review.

What the DeTDAT score means

Ideally all training programmes should be compliant with or meet all audit items. However, we recognise that programmes will vary in their design and delivery. Therefore, the DeTDAT is designed to be used to identify areas where a training programme could be improved to give greater likelihood of having successful outcomes. An auditor might use this tool on a number of occasions to monitor development of a programme over time. It can also be used in the planning and commissioning of dementia training to ensure, where possible, programmes are designed or commissioned, which meet current best practice guidance. The score gives the auditor an overall idea of how close the training programme is to what we currently understand to be best practice in dementia training design and delivery. However, careful review of the audit items that have and have not been met is required to understand if and how a programme might be enhanced or improved.

The DeTDAT is not a research tool or a validated measure of training. Therefore, the scores should not be used to conduct, for example, statistical analyses comparing one training programme to another. While a score is obtained at the end of completing the audit, the tool is intended to be used more qualitatively to help identify strengths and areas for improvement within the design and delivery of dementia training.

Informing continued development of the audit tool

We are keen to hear about your experiences of using the tool so that these can be used to inform its continual development. Please do provide us with feedback about how you have used it, what works well and if you have any suggestions for improvement via the following e-mail address dementia@leedsbeckett.ac.uk

Design, Content and Materials

The items in this section are relevant to all training or education programmes.

General

1. **Training has been designed for/tailored to the specific service setting and job role of learners who will attend**

The content of the training including case studies, vignettes and other materials need to be targeted specifically to the service setting and role of the staff attending. Staff are unlikely to make efforts to implement training if they feel it is not relevant to their role or the realities of day-to-day practice.

The training design also needs to take into account the learning needs and previous educational experience of learners. The way the training is structured and delivered needs to take into account these learning needs to ensure it is accessible and relevant. For example, you should consider the content, language and delivery methods, particularly if attendees may have low literacy skills or English as a second or additional language. One-size-fits-all training does not meet the criteria of this audit item.

2. **Training maps onto the intended, relevant Dementia Training Standards or Framework[2] Tier, subject areas and associated learning outcomes[3]**

Learning outcomes are what a learner should know or be able to do at the end of completing a session or programme of learning. They should be demonstrable, measurable or testable. Sometimes the terms learning outcomes and learning objectives are used interchangeably. However, the term learning objective is usually used as a statement of intention of learning, whilst a learning outcome is a measure of achievement of learning.[4]

In England Skills for Health, Health Education England and Skills for Care in 2015 jointly launched a framework for dementia training education that is the accepted gold standard for content and learning outcomes. It has subsequently been renamed and updated in 2018.

The Framework covers all depths of dementia education and training, split into three tiers from basic awareness (Tier 1), to knowledge and skills for all staff with regular contact with people with dementia (Tier 2) through to knowledge and skills required of leaders and managers in the field (Tier 3). This document supersedes all previous frameworks or standards and it should be used to inform all current dementia education and training

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[2] Skills for Health, Health Education England and Skills for Care (2015) Dementia Core Skills Education and Training Framework. http://www.skillsforhealth.org.uk/images/projects/dementia/Dementia%20Core%20Skills%20Education%20and%20Training%20Framework.pdf?s=cw2

[3] Refer to the accompanying What Works study Dementia Education and Training Framework Learning Outcome Mapping Tool.

[4] Higher Education Academy (2015) *Learning objectives and outcomes.* Available on-line: https://www.heacademy.ac.uk/knowledge-hub/learning-objectives-and-outcomes

across health and social care. You can download a copy of the Framework from https://hee.nhs.uk/our-work/dementia

The Framework includes 14 subject areas, each with a set of learning outcomes. A single training programme is not expected to cover all learning outcomes across the 14 subject areas. However, it might be expected that a dementia awareness training course should cover all 11 learning outcomes under the subject 'Dementia Awareness' within the framework. The learning outcomes associated with each subject area may not all be relevant for all staff roles/groups and therefore careful consideration needs to be made of the subject areas a training programme is being designed to cover and the specific learning outcomes associated with that topic that are relevant to the target staff group.

To work in conjunction with this audit tool, we have developed an Excel based mapping tool that can help trainers, commissioners and managers to map which learning outcomes are covered within single and across multiple dementia training programmes offered within an organisation. This can help to identify overlap and gaps. The tool can be downloaded from the What Works study web-site http://www.leedsbeckett.ac.uk/school-of-health-and-community-studies/what-works/

There are equivalent standards or frameworks for the other countries of the United Kingdom as follow;.

Scotland: Scottish Government (2011). *Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers* http://www.gov.scot/Publications/2011/05/31085332/0;

Wales: Care Council for Wales, NHS Wales, Public Health Wales & Welsh Government (2016). *Good Work: A dementia learning and development framework for Wales*. https://socialcare.wales/resources/good-work-dementia-learning-and-development-framework;

Northern Ireland: Health and Social Care Board (2016). *The dementia learning and development framework* http://www.hscboard.hscni.net/download/PUBLICATIONS/dementia/26092016_Learning_Development_Framework.pdf

3. Training content covers all learning outcomes in a depth that is relevant to the Tier and learners' job roles

In addition to which learning outcomes are covered, consideration also needs to be given to the depth in which these are covered within a particular education or training programme. It may be, for example, a programme focussing on person-centred dementia care could touch on a range of broader issues that feature within other subject areas of the Framework e.g. needs of carers, or promoting independence. In such cases it may be appropriate for these outcomes to not be covered in depth because they are not the primary focus of the programme. If this is the case the programme should not be stated to cover these learning outcomes.

What is important is that staff have the opportunity, across a portfolio of training they can access, to cover all of the learning outcomes relevant to their role, in the required depth /at the required Tier. Different staff roles will require coverage of different outcomes in more or less depth, for example those working in memory assessment services will require greater knowledge of dementia assessment and diagnosis than someone working in a hospice. This is where consideration of the specific needs of the staff groups to be trained is essential.

The length of a training course or programme will determine how many learning outcomes can realistically be covered in sufficient depth for adequate learning to take place. For example, it would be highly unlikely that a course lasting 1 hour could adequately cover 15+ learning outcomes in the depth required to ensure adequate learning.

There are no hard and fast rules about how long should be spent on a learning outcome for it to be covered adequately. However, it is logical that simply mentioning a topic or including one slide with a few bullet points about it within a training session does not constitute covering a learning outcome in the required depth for adequate learning. Different learning outcomes have different degrees of complexity and potential content so what is adequate needs to be considered carefully for each outcome and each staff group.

Therefore, within the training audit both the breadth and depth of learning outcome coverage need to be carefully considered.

4. Training includes interactive learning activities

Training should be interactive. Predominantly didactic training, where the trainer spends the majority or all of the session talking at/to the group, often using a set of slides, has been found to leave learners dissatisfied with the training. Short periods of didactic content, interspersed with interactive learning activities appears to work best in terms of learner satisfaction. Studies examining dementia training have also found that learning via a written resource alone (paper or web-based), is ineffective in improving staff knowledge.

Interactive learning activities might include discussion, group work, practical activities, experiential exercises, simulation, viewing videos, talks by carers and people with dementia, multi-media on-line content etc. Careful consideration should be given as to the most appropriate method for teaching each component of a training programme, as some methods will be more or less suitable or useful for teaching different aspects.

5. Training includes group discussion

Group discussion should be a core component of every training programme. Theory on how we learn indicates that discussion is helpful in aiding individuals to assimilate or accommodate new information into what they already know. It is particularly important when learning complex and cognitively challenging topics, such as those associated with delivery of dementia care. Discussion allows people to work through complexities, ask questions and to discuss potential barriers to taking on board the information.

6. Training includes knowledge-based/theoretical content

Training should provide knowledge-based or theoretical content alongside other learning methods. Therefore, in-service or practice-based learning should be accompanied by taught content as evidence suggests it is not successful if used as the sole learning method (see also items on in-service/practice learning below). How this is delivered may vary and should bear in mind the other audit criteria around successful delivery e.g. interactive and discursive, face-to-face teaching etc.

Examples of knowledge-based or theoretical content includes: an overview of what person-centred care is; effective communication approaches to apply when working with people with dementia; content on what an advanced care plan is and how to write one; the different types of drugs that can be prescribed to treat the cognitive symptoms of dementia. Knowledge or theory-based content provides the basis for practical skills.

7. Training includes use of written, video or in-person case examples/vignettes/ scenarios as a basis for discussion

Training should use realistic scenarios or vignettes to present elements of dementia care and to support discussion around key issues. Vignettes or scenarios are particularly valuable because they can provide realistic case examples that can provide opportunities to apply learning to practice through discussion. Video or film-based scenarios are preferred by learners over written examples. Training that includes talks or discussions delivered by or including people with dementia and family carers has been reported to be particularly impactful for learners. However, recognising this may not always be practically possible, other methods of including people's lived experiences, such as video clips are an accessible alternative.

8. Training includes learning activities that involve the application of what is learnt in a practice-based situation

Training should include opportunities to apply learning in practice. The method of application may vary and can include practice activities carried out in-between training sessions or the use of exercises, simulated scenarios or role play during the training itself. Careful consideration of the approach that will be most useful and appropriate to the learners, structure of the training programme and skills to be practised is required.

For example, in some studies researchers found that staff felt uncomfortable initially undertaking role-plays or video recording their practice in order to view it, gain feedback and reflect. Building trust and confidence in use of these methods was required, over a period of a number of weeks. (See audit criteria below on use of simulation, experiential learning or role play techniques in training.)

Likewise, to gain greatest benefit from application of learning in day-to-day practice, running training over a number of consecutive weeks permits learners to bring experiences and reflections on this process back into the training room during the next session, which is important for the learning process. This can support identification of barriers or issues and support problem solving. This isn't achievable in single session training or education, where use of practical activities in the session itself may be more appropriate.

Supporting learners to identify and implement learning in practice in a supported and structured manner can help with longer term implementation and also learner satisfaction and morale. Research following up learner experiences over time, following training course attendance, found that personal stress and frustration can result if learners are unable to meet their own, or organisational expectations about application of learning in practice.

9. Training includes introduction of structured tools, methods or approaches to care delivery

Teaching the use of structured tools, methods or approaches included within learning programmes are more likely to lead to staff behaviour change. Examples of structured tools, methods or approaches include things such as pain assessment tools, behaviour recording tools that help staff to look for causes and solutions, structured care planning documents, etc.

10. Training materials are clear and easy to follow e.g. are jargon free, clearly laid out, take into account educational background of learners etc

Materials need to be clear, easy to follow, jargon free and written with their audience in mind. Materials that are seen to be too complex can reduce confidence and cause disengagement with the learning process. Materials should avoid jargon, technical language and should consider the prior educational experience and literacy levels of learners, which may be varied.

For example, this explanation of the way that one type of medication works to address changes associated with Alzheimer's disease is not suitable for care support workers, but may be appropriate for individuals with medical or pharmaceutical training.

The development of acetylcholinesterase (AChe) inhibitor drugs followed the finding that cholinergic pathways in the cerebral cortex and basal forebrain are compromised in Alzheimer's disease and the resultant cholinergic deficit contributes to cognitive impairments. Acetylcholine (ACh) is rapidly inactivated by acetylcholinesterase to acetate and choline. The acetylcholinesterase inhibitors (AChEIs) prevent this breakdown to increase ACh at the synapse.

The following may be more appropriate for care support workers.

Messages in the brain are passed from one cell to another by "Neurotransmitters". The brain uses neurotransmitters for passing on messages for all bodily functions; from making your heart beat to thinking. There is an important neurotransmitter for memory function called acetylcholine. Unfortunately people with some forms of dementia have low levels of this neurotransmitter in their brain. One type of drug designed to help people with Alzheimer's disease works by stopping enzymes (proteins that are found in the) from destroying the neurotransmitter as it travels from one cell to another. This means that the neurotransmitter acetylcholine, which is in short supply in people with Alzheimer's disease, is not destroyed so quickly.

Materials should be tailored to specific staff groups who have similar educational, linguistic or knowledge profiles or if delivery is within groups with a broad mix of staff attending, then the materials need to be written in a manner that is accessible to all. Materials such as handouts, booklets or manuals to take away from the training course and to use later as reference also need to be written in a clear and easy to follow format.

11. Training materials are succinctly written, are an appropriate length for their mode and purpose and can be completed in the allocated time

Training materials need to be succinct. This includes written materials such as handouts or workbooks as well as other visual aids such as PowerPoint slides. Training needs to be carefully planned so it can be delivered at a suitable pace, within the allotted time.

Materials that are seen to be lengthy or over wordy can be overwhelming and inaccessible, particularly if learners struggle to navigate them or find the information they need easily. Also materials that are perceived to, or do, require a significant time investment to complete are unlikely to be successful.

12. Learners are able to bring their own practice examples and problems for discussion

Training needs to be practical and support staff to apply learning in practice. One method for achieving this is to provide learners with the opportunity to bring examples and challenges from their own practice, which can be discussed within the training programme. This supports specific learning to take place that will be directly relevant to a learner's practice, alongside broader problem solving and peer learning that is gained from discussing others' practice. This requires a flexible approach from training facilitators and for them to have a good knowledge-base in order to be able to confidently and competently support such an approach.

13. Training includes opportunities for learners to engage in practice-based problem solving

Training should include problem-solving opportunities. The care of people with dementia is complex and there are no right and wrong answers or specific approaches that will always work with every individual with dementia in every situation. Therefore, good dementia care requires staff to be able to problem solve in their day to day practice and to have the confidence to try different approaches. This might for example be in the form of exercises and activities, or the programme could use specific methods such as simulation or problem-based learning to achieve this. The methods will depend upon the topic of learning and learner group and their needs.

14. Consideration has been given to the full costs of developing and delivering the training and the potential benefits

There are different models of training commissioning and delivery, including; in-house development and delivery; the purchase of external training; or, purchase of a train-the-trainer programme that can then be delivered onwards, or rolled-out by in-house staff. There are pros and cons of each approach and also associated immediate and ongoing costs. The model that is right for each organisation will be different based on their size, budget and specific training needs. Calculating training development and delivery costs can be complex.

As an output of the *What Works in Dementia Training and Education? study* we have, therefore, developed a costing tool that organisations can use to calculate initial development and ongoing delivery costs of any training programme. This is available to download from the What Works study web-site http://www.leedsbeckett.ac.uk/school-of-health-and-community-studies/what-works/.

Training length

15. Training is at least 3.5 hours in total

Training programmes that are longer in duration (8-12 hours) are more likely to lead to positive outcomes for people with dementia (e.g. in supporting reduced use of antipsychotics, reduced agitation) and for staff (e.g. reduced burnout, greater job satisfactiono. However, those of at least 3.5 hours or half a day also demonstrated benefits. Shorter programmes of less than 3.5 hours were less likely to have impact on outcomes. The training programme could be delivered as a half, one or multiple day programme or in a number of shorter sessions delivered over a number of weeks. However, individual session length is also important (see item 17 below).

16. Training is at least 8 hours in total

See above.

17. Individual training sessions are at least 2-hours duration

Training involving individual training sessions of less than two-hours (even if the total programme length combining the sessions is longer), is unlikely to be effective in changing learner attitudes towards dementia. Researchers across a number of studies found that programmes with sessions of half a day or longer were more likely to significantly change learner attitudes on a validated measure. In particular staff with lower qualifications were less likely to show attitude change following shorter duration training sessions. Two-hours or more appeared to be the optimal session length for greatest impact.

Practical issues

18. Learners are provided with detailed information about the format of and commitment(s) the training involves ahead of attendance

Learners should be provided with clear information about what attending a training programme will involve including the time required and the format of delivery. Not understanding the time and level of engagement required of a programme of training, ahead of commencement can lead to stress and reduced satisfaction for those attending. This is particularly the case for longer, more involved programmes that might for example run over a number of weeks or months. It is also equally important that learners have all the required information about what the training will entail and expectations of them ahead of time. It is particularly important for learner morale and engagement that programmes are not longer, more time consuming or onerous than they had anticipated.

19. Training can be delivered flexibly to meet the needs of an individual group or service

Training needs to be delivered flexibly based on the needs and reactions of a particular group of learners. Training delivered to a set script or which offers limited or no opportunity for learners to discuss their own experiences, or raise issues pertinent to them is unlikely to meet learner needs. This requires a skilled facilitator (see below).

Facilitator qualities

The trainer facilitator has an impact on learner experiences and training outcomes. Therefore, selection of a facilitator who has the right qualities can have an impact on training effectiveness.

20. Facilitator is experienced in the delivery/facilitation of training

Training should be delivered by an experienced facilitator who is skilled in the delivery of training. Building training experience requires time. Training facilitators who are new to the role need to be given time and the opportunity to develop skills alongside someone who is more experienced.

21. Facilitator is knowledgeable about the subject area and/or has clinical experience of working with people with dementia

Facilitators need to have experience of working with people with dementia. This ensures they are able to speak from experience during training and are seen as credible and understanding of the challenges of delivering dementia care by learners. Learners recognise when a facilitator is and is not knowledgeable about the subject area.

22. Facilitator creates a safe environment for discussion and asking of questions

Learners need to be enabled to feel comfortable, should be encouraged to ask questions and should be listened to by the facilitator and not just talked at, or judged or belittled for their input This can lead to the creation of a 'safe' learning environment where challenging issues can be raised and addressed.

23. Facilitator is able to adapt the training to meet the needs, issues and concerns of a learner group

Facilitators need to be skilled and confident in their role so they are able to adapt training to meet the needs of a specific group of learners. A skilled, flexible facilitator can use responsive delivery to challenge particular viewpoints or perceived barriers to changing practice or implementing learning, in a safe and supportive manner. Balancing this in a programme where there is also a need to deliver some standardised or required content needs careful consideration.

In-service or practice-based learning

The items in this section are relevant to training that includes in-service or practice-based learning methods.

In-service or practice-based learning is learning that takes place entirely within a service setting. It can include shadowing or working alongside a more experienced colleague, being observed in day-to-day practice and receiving feedback, mentoring or coaching or taking part in a placement in a service setting other than a learner's usual workplace (this list is not exhaustive). In-service or practice-based learning appears to be effective in helping learners embed learning into practice when used alongside classroom-based theoretical/knowledge based teaching.

IS1: In-service/practice-based learning is accompanied by face-to-face theory/knowledge-based learning

In-service learning when used as the sole method for training is consistently reported to not lead to positive outcomes for learning or attitude change. However, training programmes that combine classroom-based theoretical and knowledge-based content with in-service/practice learning are most likely to lead to positive outcomes for staff behaviour change, knowledge gains and feelings of self-efficacy.

IS2: In-service mentor/facilitator is allocated dedicated time to support in-service learning

Where in-service learning fails this is often in part from a lack of time or engagement by the learning mentor/facilitator to support the in-service learning due to work pressures. Careful consideration needs to be given to if and how in-practice mentors can be assured the time they need to support learners during in-service learning.

IS3: Learner is allocated dedicated time to engage in in-service learning activities

Another reason commonly cited for failure of in-service learning is a lack of dedicated learner time. Many learners reported that work pressures and staff shortages meant that in-service time they should have spent learning or gaining support from a mentor, was not able to be devoted to this and had to be spent engaging in usual on day-to-day work activities.

IS4: In-service learning takes place in care environments where practice is supportive to learning and is at least of adequate quality

A further challenge for those undertaking in-service learning is the sometimes limited opportunity for good quality in-service learning. This can be due to the general low quality care in the individual's work environment or lack of openness of other staff to work in person-centred ways.

IS5: In-service learning takes place in care environments suitable for the planned learning activities

A further challenge experienced with in-service learning was the physical and care environment available to learners and mentors. They may not always be conducive to being able to deliver best practice care, and in some types of service setting, for example acute hospitals, there were not always people with dementia on the ward on scheduled learning days and therefore no-one to work with.

IS6: In-service learning is facilitated by an experienced mentor who is able to effectively support learning of required skills

Mentors' skills, or lack of appropriate skills are cited as a difficulty encountered during in-service learning. Therefore, as with in-classroom training facilitators, in-service learning mentors need a range of facilitation skills and practice experiences in order to be able to appropriately support people.

Online, web-based or e-learning

The items in this section are relevant to training that is delivered either partly or fully online or using web-based resources. On-line or web-based learning can be useful for implementation with some groups of staff and for some content, but should be used with careful consideration as to whether this is appropriate for the content and learners. Self-directed learning is at high risk of non-completion and so while often seen as an easy or cost effective method for staff training, its ability to effect learning can be limited.

OL1. Training includes the opportunity for learners to engage in classroom-based group learning and discussion with a facilitator and other learners

Training most likely to be effective uses small or large group face-to-face learning either alone or in addition to another learning approach. Opportunities for discussion and interaction are important facilitators of learning.

Therefore, on-line/web-based learning should not be used as the sole learning method. Web-based learning should be supplemented by a significant amount of workshop or group based activities, allowing opportunity for discussion. Face-to-face learning to support online or web-based learning must be prioritised, as without this, full engagement with all learning activities cannot be achieved.

Practice-based learning should be structured and underpinned by theoretical or knowledge based content, to allow learners to apply learning into practice and to gain the most from their web-based learning.

OL2. Training materials are interactive

On-line learning materials should be interactive rather than largely a written resource. Interactive materials include things such as video clips, quizzes, exercises and activities that learners complete. On-line interactive materials can also utilize case examples and vignettes to provide a basis for discussion with other learners and the facilitator either on-line or in additional classroom/face-to-face sessions. Video based scenarios are a particularly valuable resource to use.

Particularly when training draws heavily on written materials, for example in booklets or online sources, simple straightforward language should be used. Written materials need to be concise and easy to understand.

Making on-line materials interactive does not take away the need to include face-to-face learning with opportunity for group discussion.

OL3. Specialist IT support is available to all learners at point of need

Specialist IT support needs to be available, particularly when learners are first commencing their studies since learners who fail to overcome IT difficulties quickly are likely to drop-out

and many learners lack IT skills and confidence. This support needs to be readily and easily available.

OL4. Web-based learning is appropriate for the skills and IT literacy of the targeted learners

The design of online modules should be easy to navigate, active and engaging especially for individuals who may not favour electronic methods. Learning should be supported by a user-friendly virtual learning environment in order to facilitate learning.

This form of learning requires considerable investment of time from learners to engage with content and where necessary, learn new IT skills.

Simulation, experiential learning and role play

The terms simulation, experiential learning and role play cover a broad range of learning activities from high fidelity work using simulation suites, scenarios and equipment, through to low fidelity reflective exercises. In this section the term 'simulation' will be used to represent these full range of teaching and learning approaches.

Simulation and experiential learning can be hugely powerful, particularly in engaging learners and supporting attitude and behaviour change. However, used poorly simulation can be ineffective, or at worst emotionally damaging for learners. This may lead to learners not wishing to engage in future learning activities. Therefore, with the use of simulation, experiential or role play activities comes a responsibility to use them in a safe and supportive manner.

SL1: Simulation/experiential learning or role play is accompanied by classroom-based based learning and discussion

As with the general training recommendations, simulation needs to provide learners with an opportunity to discuss the issues that arise and to assimilate the learning. This needs to occur in a small group, face-to-face setting.

SL2: Learners have an opportunity to build trust and rapport with facilitator and other learners ahead of use of simulation/role play/experiential learning activities

Engaging fully and freely with simulation requires learners to engage at an emotional level with the scenario. This requires a degree of trust and rapport to exist between the learners and the facilitator and each other. Therefore, simulation is unlikely to work well, or may be a less positive experience for learners if the simulation is the first learning activity they engage with. It is also important that facilitators get to know learners in order to assess if everyone is able to take full part in the simulation (see item SL4 below).

SL3: Simulation/experiential learning/role-play is used alongside knowledge/theory-based teaching

It is important that simulation is embedded within a learning cycle that includes theoretical or knowledge-based content as well as the practical application of this within the simulated, experiential or role play activities.

SL4: Learning experience includes time for learner preparation ahead of the simulation/experiential activity/role-play

It is important that learners are adequately prepared for the simulation activity, particularly if a high fidelity simulation is being used. This requires adequate briefing so learners know

what will happen and that the can agree to take part. In some cases, learners may not wish to engage in a simulation activity for a variety of personal reasons. For example, a recent family bereavement might make engaging in an end of life planning simulation too emotionally difficult. In other cases, learners may be caring for a family member with dementia or may have a family member who has been recently diagnosed. Again their current circumstances may mean they may find taking direct part could be too emotionally difficult. It is important a facilitator does not force anyone to engage in a simulation activity. The degree of involvement can be negotiated, for example the learner may be happy and able to observe and feedback. It is also important that provision is made for support during and after the simulation in case individuals become distressed. Therefore, at least two facilitators may be involved with simulation in order that one can provide immediate support if required.

SL5: Learning experience includes formal debriefing

Formal debriefing and discussion is an integral part of any simulation activity. Failure to adequately debrief and result in lack of learning or incorrect learning. It can also leave learners feeling upset, distressed, angry etc.

SL6: Learning experience includes opportunity for discussion of emergent issues and implications post simulation/experiential activity/role-play

Learners are likely to have many questions and thoughts after a successful simulation activity. Therefore, time needs to be allocated for informed discussion where these can be discussed and resolved. This completes the learning cycle and supports learners to turn the simulation experience into positive knowledge gains and behaviour change. As each simulation will be different, dependent on how learners react and engage, a discussion of key issues ensures that all learning points can be drawn out appropriately within each session.

SL7: Learning experience includes the opportunity for learners to engage in positive or best practice simulation/experiential/role play activities where they are able to identify, experience and apply desired practice(s)

Simulation should not be focussed on negative experiences or care. While experiencing what negative or poor quality care can feel like may help develop empathy and a positive attitude it may provide little opportunity for learning. Simulation activities most likely to lead to an effective learning experience are those where learners are encouraged to identify, implement and experience good care. This builds knowledge and skills in the type of care staff are being encouraged to deliver. This should be supported with theoretical and knowledge based in-classroom learning as well as effective debriefing and group discussion of emergent issues.