7th & 8th March 2025
Academic General Practice Ireland, ASM
"Renewing Vision"

5A Poster – Theme: Education and Workforce

Chair: Dr Sian-Lee Ewan

The Attitudes of Healthcare Students to Mindfulness-Based Interventions

Dr Shane Dunlea, Dr Anne Doherty

Background

- **Mindfulness**: *"awareness that arises through paying attention, on purpose, in the present moment, non-judgementally"* [1]
- Mindfulness Based Interventions (MBIs) associated with a number of psychological and physiological health benefits [2]
- Variety of MBI programmes developed since 1970's
  - In recent years programmes specifically tailored for healthcare students/workers
  - Healthcare students/workers: higher rates of depression/ anxiety/burnout
- Literature demonstrates positive outcomes with MBIs in healthcare students/ professionals [3]
  - Decreasing measures of stress, depression and anxiety,
  - increasing measures of mood, self-efficacy, empathy and mindful attention scores
- This study aimed to assess the attitudes, knowledge and experiences of healthcare students towards MBIs and to examine perceived barriers/ facilitators.

Methodology

- Cross-sectional survey of UCD Medical and Nursing students (3,320)
- Questionnaire gathered anonymised demographic information and data regarding the participants' attitudes, knowledge and previous experience of MBIs
- Developed from a number of previous similarly themed surveys and consisted of 17 stems containing mix of simple binary questions, Likert scales and open-ended free text questions
- Simple statistical univariate analysis methods were used to examine the characteristics of the group – using as appropriate mean/median, range, standard deviations (SD) to examine the characteristics of the participants and their perspectives on various aspects of MBIs.

Results

Demographics
- 83 students (response rate 2.5%)
  - Age: 53% 18-22, M:F (24.1%:75.9%), Med: Nur (49:34), Undergrad: Postgrad (61:17)

Knowledge, Attitudes and Experiences of HealthCare Students towards MBIs
- 51 (61.4%) prior knowledge of MBI's,
  - 39 (76.5%) had Positive/Very Positive attitudes towards MBI's
- 44 (86.3%) had prior experience of MBIs
  - 37 (84.1%) found it to be beneficial (Fig. 1)
    - 32 (72.8%) had ongoing practice of MBIs
      - most use online resources/ apps

Attitudes of Healthcare Students towards MBI in Healthcare Educational Settings
- 79 (95.1%) of participants felt a need for the inclusion of a student well-being programme
  - 74 (88%) saw a role for MBIs / indicated interest in taking part in such a course

Perceived Role of MBI's for Healthcare students/workers

A Role for MBI's (n=74)	No role for MBIs (n=9)
- Stress-reduction tool (73.2%)	- Prioritise working conditions (33.3%)
- Student/ Staff Well-being (29.3%)	- Not practical (22.2%)
- Increasing efficiency (12.2%)	- Poor uptake (11.1%)
- Fostering Compassion (4.4%)	- Religious/Scientific concerns (22.2%)

Preferred MBI Course format (Fig 2, Fig 3, Fig 4)

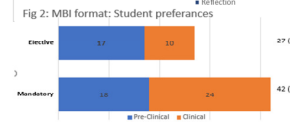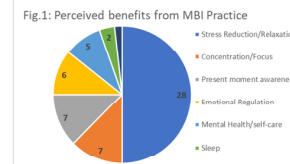| Barriers to MBI practice	Facilitators to MBI practice:
-Time pressure 26 (74.3%)	- Designated spaces: 52 (70.3%)
-Academic priority 12 (34.4%)	- Lunchtime session 48 (64.8%)
-Privacy concerns 6 (17.15)	- Mobile Apps 43(58.1%)

Results

Fig.1: Perceived benefits from MBI Practice
- Stress Reduction/Relaxation
- Concentration/Focus
- Present moment awareness
- Emotional Regulation
- Mental Health/self-care
- Sleep
- Reflection

Fig 3:Preferred Duration (weeks) of MBI Course
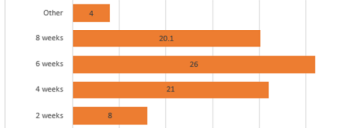
Fig 2: MBI format: Student preferences

Fig 4:Preferred Duration (mins) of MBI Session

Please briefly describe your previous MBI practice:
"…beneficial as it helps me to relax more, and prevents me becoming too overwhelmed"

"…makes me anxious, not being productive…"

Please briefly describe why you see/don't see a role for MBI amongst healthcare students/ healthcare workers?
"I think there is such a need for it with healthcare students. Training and working in healthcare is so overwhelming and stressful, that I really believe you need some coping strategies in place to help you get through your training."

"In a stressful career that requires us to be compassionate and caring towards others it's important to take note of our needs mentally also. You can't be your best self for others if you're not treating yourself with similar compassion"

"Although MBIs might help some, in my opinion the only way to improve healthcare students/workers conditions…must occur to the whole educational system/work environment rather than individualism"

Please briefly describe (if applicable) any barriers that might prevent you from participating in mindfulness practice
"Busy environment, busy clinical and academic schedules = poor participation"

"Over-worked...too much to do, no time..."

Conclusion & the Future

- High levels of knowledge and experience amongst students
- Largely positive attitudes/experiences of MBIs
- Barriers to engaging with MBI centred on time and academic pressures,
- Potential facilitators included designated spaces, lunch time session and access to apps
- Clear consensus on need for student well-being initiative and role for MBI's in this
- Study suggests MBIs may be a valuable tool for healthcare students in their academic and professional journeys

References:
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Exploring experiences of Less-Than-Full-Time postgraduate medical training and options for future improvement in Ireland: a qualitative study

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Introduction

International demand for less-than-full-time (LTFT) postgraduate medical training is rising (1). In Ireland, applicants for LTFT postgraduate training must have 'well-founded individual reasons' for applying for one of the 32 funded flexible training places available each year, with the most common reasons listed including caring responsibilities, health reasons and personal family circumstances. Participation is restricted to a maximum of 2 years working at 50% WTE. (2)

LTFT training offers benefits such as cost savings, staff retention, reduced burnout and patient safety (3, 4). Promoting LTFT training may prevent trainee attrition and promote workforce sustainability (5). UK studies have explored solutions to implementation challenges, but Irish data remain scarce (3, 6).

There is a comparative lack of focus in literature on logistical and governance challenges associated with LTFT training, or the impact on working environment. This study aimed to explore how best to support LTFT training in Ireland and internationally.

Methods

This prospective qualitative study used semi-structured interviews. Ethical approval was granted by the ICGP (ICGP_REC_22_006).

Recruitment
Sample size was determined by coding saturation. Interview participants were selected by purposeful sampling. Recruitment targeted NCHDs, consultants and administrators. Factors such as gender, training status, medical specialty, parenthood and future plans for training were considered.

Data collection
Four researchers, (CM, GB, GJ, MA) conducted the interviews, either online using video-conference software (Zoom) or face-to-face. The interviews took place between May 2022 and December 2022, ranged from 20-45 minutes in duration, and were recorded and transcribed by hand or using online software (Otter). A total of 29 interviewees took part.

Data analysis
Thematic analysis was used to identify themes and patterned meanings. Five researchers familiarised themselves with the transcript data through line-by-line open coding of each transcript using NVivo 12. 246 codes were then condensed to four overarching themes.

Results

There was poor awareness of LTFT training amongst trainees. Key themes, highlighted in Figure 1, included flexibility, work–life balance, burn-out, institutional support and attitudes to LTFT. Some quotes are illustrated in Table 2. Awareness surrounding LTFT training options was poor. Current working structures were seen as inflexible, with a preference for 70-80% whole-time-equivalent options. LTFT training was felt to increase administrative workload and create human resourcing difficulties, and there was a perceived lack of support in this area. While LTFT felt they met competencies, concerns about negative perceptions remained.

Strengths and limitations

- A qualitative approach provided deep insights into participant challenges.
- A diverse cohort, including medical, governance, and management perspectives, ensured a broad range of views.
- Ethics restrictions limited direct recruitment of NCHDs in formal training to avoid coercion.
- The sample size (29) may have influenced theme frequency, but thematic saturation was achieved, making additional interviews unlikely to yield new findings.

Figure 1 Thematic code tree. LTFT, less than full time.

Discussion

Recent international literature discussing the 'quadruple aim' to optimise healthcare by improving staff well-being, indicates an urgent need to address NCHD welfare in Ireland, with LTFT training as a potentially cost-effective strategy (7-10). Current work structures were seen as inflexible, with parental leave difficult to access. Most trainees preferred higher WTE options such as 80% WTE hours (or 4 days/week rather than 5), to balance training duration and career progression, echoing UK experiences (11). Concerns included logistical difficulties, and administrative burden, but UK solutions, such as LTFT liaison officers, may help (11,12). Despite challenges, administrative staff viewed LTFT training as crucial for workforce sustainability.
Trainees were concerned about the effect that working lower WTEs may have on career progression and competency. In UK and Australian literature, LTFT trainees perform as well as, or better than, full-time peers. These sentiments were supported by LTFT trainees in this study (3,11).

Conclusions

LTFT training appears to be a viable strategy to aid in reducing burn-out and attrition, and improving the training experience, without major reported adverse effects on service provision. LTFT training cannot be shoehorned into inflexible structures. This study integrates qualitative Irish data with international literature and contributes to evidence that increased administrative support and dedicated variable-percentage LTFT posts are necessary. LTFT liaison officers may assist in bridging the gap between hospitals and PGTBs; active promotion of LTFT training among NCHDs and PGTBs could help to ensure stakeholders are well informed; and practical and financial supports such as review of payroll methods, and training and resourcing for manpower departments may also facilitate the practical aspects of these important system changes.

Table 2 Flexibility of working structures

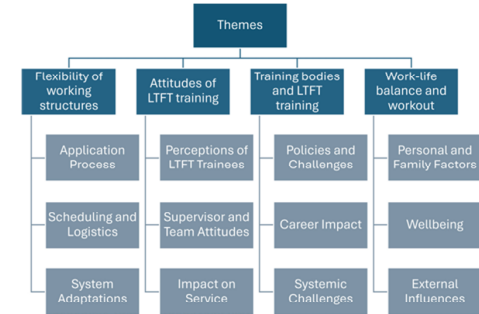| Respondent characteristics	Quote
Respondent 5/consultant EM/F	Basically, just take the brunt, just get through it and stop rocking the boat. So, I think, looking back, that the parental leave that I wanted was actually, probably—if I knew what LTFT was, that's exactly what I would have wanted.
Respondent 19/consultant anaesthesiology/F	What if one of them goes off sick, then what happens to the other half of the slot? Whose responsibility is it to fill that slot? … I think that wouldn't be appropriate to put the responsibility on the trainee to find that. I know historically because I did a job like this, where if you're sharing a job, when one person's away, the other one has to do all the on-call, essentially. And I don't think that's really fair. I think it's the system should sort that out, rather than the individual.
Respondent 3/FT registrar psychiatry/F	[There is] the financial aspect, and the fact that you're only working 50%, which is going to significantly extend your training, and you're financially going to be worse off than you would be if you're working full-time.
Respondent 17/FT registrar intensive care/M	I'd say ideally 40 [hours] seems appropriate, given you spend 40 hours asleep, give or take 40 hours at work, 40 hours with regards to yourself. I'd say I'd be happy with up to 50 hours. Ideally, I actually think the best thing would be working four day weeks and having three days off.
Respondent 15/medical manpower manager/F	My experience in other areas would be that service provision is fine, as long as you have enough of the less-than-full-time people to make up the whole-time equivalent that you need. And actually, it can add richness to the service as well, as long as there's flexibility with the people who are doing the less-than-full-time work.
Respondent 15/medical manpower manager/F	It doesn't matter whether a doctor was recruited to work 12 hours a week or 39 hours a week, you still have to go through the same compliance. Pre-employment, you know. And extra contracts have to go out … So, for example, if you normally have 20 NCHDs, then because of less-than-full-time working it's 35 people you're bringing in, that's an extra 15 contracts, compliance, setups, for the same number of full-time equivalent.
Respondent 15/medical manpower manager/F	Healthcare isn't a nine-to-five Monday-to-Friday job. And you know, somebody who, for example, is a flexible trainee in orthopaedics can't go home in the middle of a trauma list because the hours are finished … They have to be paid for those hours, irrespective of who's paying for the hours. But we have the core time and attendance system configured for full-time people. So, then it has to be manually adjusted for part-time people, because obviously if somebody's working hours are 19 and a half, even if they work up to 30 hours, it's still paid at time, it's not paid at time and a half.

Presenter details

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Assessing the influence of game creation on adolescents' health knowledge, attitudes and behaviors: Protocol for a Scoping Review

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Introduction

Game-based learning, the WHO's new focus on health promotion and disease prevention underscore the need to explore game creation's potential in adolescents' health education. This scoping review aims to assess evidence on the impact of game creation on adolescents' health knowledge, attitudes, and behaviors, identifying relevant research gaps based on analysing current

Methods

JBI's Population, Concept, and Context framework guided this scoping review protocol, adhering to the PRISMA- ScR guidelines. A library specialist supported the development of a search strategy, & PubMed, ScienceDirect, SCOPUS, & JSTOR were the selected search databases for inputting search strings using developed MeSH terms in accordance to the search strategy, to collect quantitative data on relevant literature in accordance to the exclusion and inclusion criteria.

Table 2. Keyword and Medical Subject Headings (MeSH) terms for the population, context, & concept framework

Population		Context		Concept	
MeSH terms	Keywords	MeSH terms	Keywords	MeSH terms	Keywords
Adolescents	School students	Gamification	Electronic game creation	Health promotion	Health knowledge, attitudes, and practices
Children	Adolescent		Co-creation of games	Health education	Healthy Habits
Minor	Children		Knowledge implementation		Health promotion
Student			Competition		Healthy lifestyle

Table 3. Search strings

Search strings	Database	Number of results
"adolescent OR children OR minors OR school students OR adolescent OR children AND gamification OR Education AND electronic game creation OR co-creation of games OR gamification AND health promotion OR health education OR health knowledge attitudes practice OR health promotion" Filters applied: social sciences, Education	SCOPUS	58

An example of a search string and MeSh/Keywords used.

Discussion & Limitations

- Clarification of research gaps in health promotion through game creation
- Does not report on all available evidence
- Niche explored domain, limiting the amount of relevant studies found
- JBI's principles for scoping reviews preventing/mitigating publication bias
- Exclusion of analysis of methodological practices of the interventions

Results

Initial database searches revealed 597 studies,(July 2023), the duplicates are being eliminated before the extracted studies' abstract & title screening. Studies will be presented according to the scoping review's research questions & aims.Results of the database searches will be presented as so, with significant findings presented in the 2nd part of the flow chart.

Figure 1. Flowchart of PRISMA for the scoping review.
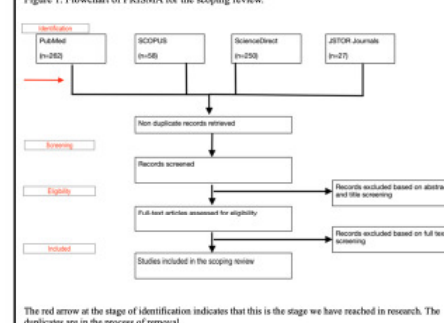
The red arrow at the stage of identification indicates that this is the stage we have reached in research. The duplicates are in the process of removal.

Conclusions

This protocol will guide the scoping review on relevant present data while outlining challenges throughout the search strategy.

The scoping review will contribute to the field of health promotion & improvement by providing a preliminary understanding of:
- The extent of current research on game creation for adolescent health promotion
- Impacts of a game creation competition on adolescents' health knowledge, attitudes, and behaviors

Practitioners' Perspective on Implementation of Acute Virtual Wards: A Scoping Review

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BACKGROUND

Virtual wards (VWs) provide a promising alternative to traditional 'bedded care' by facilitating early discharges and delivering acute care at home[1]. They focus specifically on patients needing acute care, which would traditionally necessitate an in-hospital stay.
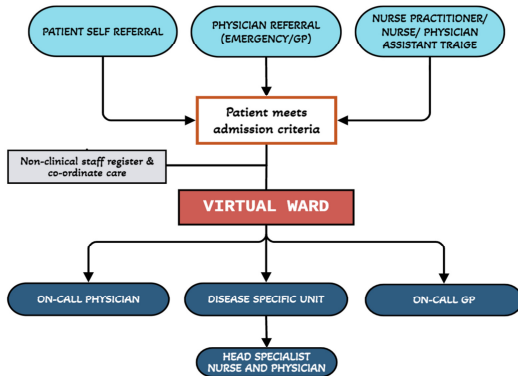
OBJECTIVE

Explore and synthesise practitioners' perspectives on the challenges, considerations, and effectiveness of implementing VWs.

METHODS

A scoping review was conducted between May and July 2024, following PRISMA Extension for Scoping Reviews (PRISMA-ScR) guidelines and Arksey and O'Malley's six-step methodological framework with additional recommendations provided by Levac et al (2010) [2,3]. A comprehensive search of PubMed, Cochrane, CINAHL, and Embase databases was conducted (2015–2024). Thematic analysis, using Braun and Clarke's framework, was performed to identify key insights related to VW implementation.
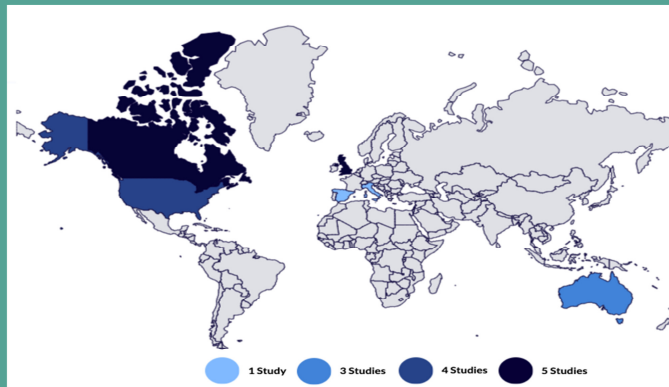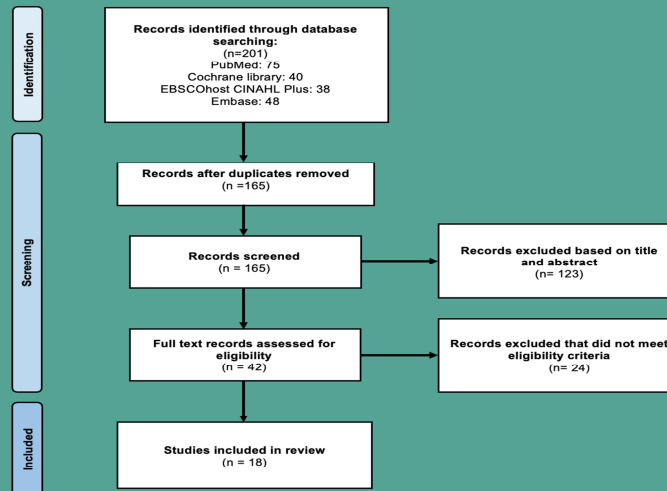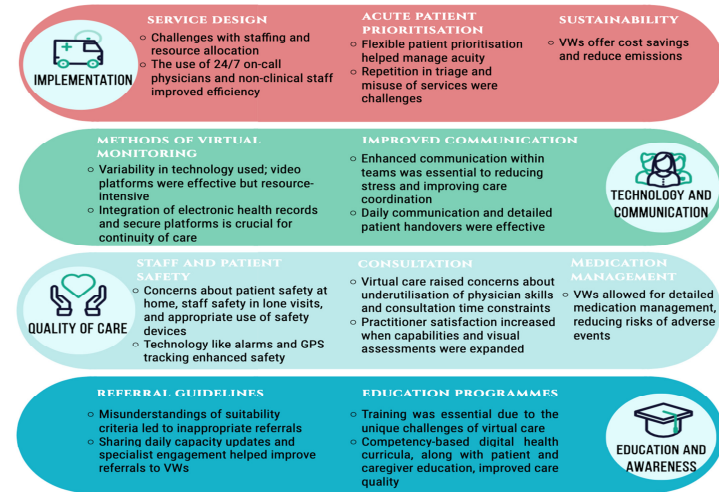
RESULTS

Fig 1. Locations of study populations

1 Study   3 Studies   4 Studies   5 Studies

Fig 2. PRISMA-guided flowchart of identification, screening, and inclusion

Identification

Records identified through database searching:
(n=201)
PubMed: 75
Cochrane library: 40
EBSCOhost CINAHL Plus: 38
Embase: 48

Screening

Records after duplicates removed
(n =165)

Records screened
(n = 165)

Records excluded based on title and abstract
(n= 123)

Full text records assessed for eligibility
(n = 42)

Records excluded that did not meet eligibility criteria
(n= 24)

Included

Studies included in review
(n = 18)

References:
1. Norman, G., P. Bennett, and E. Vardy, Virtual wards: a rapid evidence synthesis and implications for the care of older people. Age Ageing, 2023. 52(1).
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Table 1. Summary of key findings from thematic analysis

IMPLEMENTATION

SERVICE DESIGN
○ Challenges with staffing and resource allocation
○ The use of 24/7 on-call physicians and non-clinical staff improved efficiency

ACUTE PATIENT PRIORITISATION
○ Flexible patient prioritisation helped manage acuity
○ Repetition in triage and misuse of services were challenges

SUSTAINABILITY
○ VWs offer cost savings and reduce emissions

METHODS OF VIRTUAL MONITORING
○ Variability in technology used; video platforms were effective but resource-intensive
○ Integration of electronic health records and secure platforms is crucial for continuity of care

IMPROVED COMMUNICATION
○ Enhanced communication within teams was essential to reducing stress and improving care coordination
○ Daily communication and detailed patient handovers were effective

TECHNOLOGY AND COMMUNICATION

QUALITY OF CARE

STAFF AND PATIENT SAFETY
○ Concerns about patient safety at home, staff safety in lone visits, and appropriate use of safety devices
○ Technology like alarms and GPS tracking enhanced safety

CONSULTATION
○ Virtual care raised concerns about underutilisation of physician skills and consultation time constraints
○ Practitioner satisfaction increased when capabilities and visual assessments were expanded

MEDICATION MANAGEMENT
○ VWs allowed for detailed medication management, reducing risks of adverse events

REFERRAL GUIDELINES
○ Misunderstandings of suitability criteria led to inappropriate referrals
○ Sharing daily capacity updates and specialist engagement helped improve referrals to VWs

EDUCATION PROGRAMMES
○ Training was essential due to the unique challenges of virtual care
○ Competency-based digital health curricula, along with patient and caregiver education, improved care quality

EDUCATION AND AWARENESS

CONCLUSIONS

VWs present a viable, efficient, and sustainable model for delivering acute care outside traditional hospital settings. However, successful implementation requires addressing key challenges, including:

- Service design and workforce planning
- Ensuring patient safety through monitoring and protocols
- Improving digital infrastructure and inter-operability
- Enhancing clinician training and awareness

Continuous evaluation and adaptation are essential to optimise VWs for long-term success in modern healthcare systems

ACKNOWLEDGEMENTS

Preparing Tomorrow's Doctors: A Migrant Health Module For Undergraduates

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RCSI
UNIVERSITY
OF MEDICINE
AND HEALTH
SCIENCES

Background

With increasing migration globally, medical students need training in cross cultural care

Only 20% of medical students in Ireland felt they had received adequate training

Student choice 1-week modules: flexible, student centred, wider society

Module Development And Aims

Aim: describe health issues and discuss challenges facing migrants

Based on postgraduate module developed by NDCGP, Crosscare and Cairde

Delivered by GP faculty members

Content and Delivery

Safetynet PRIMARY CARE — Migration patterns, health conditions and right to health
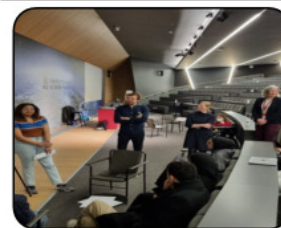
Workshop on accessing GP care Cairde/Crosscare

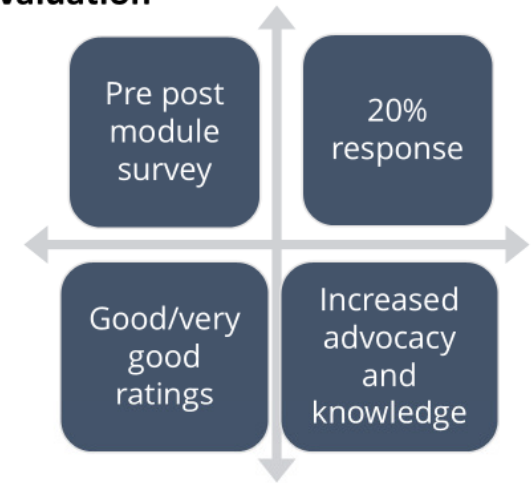Interpreted consultation role plays. Interpreter presentations

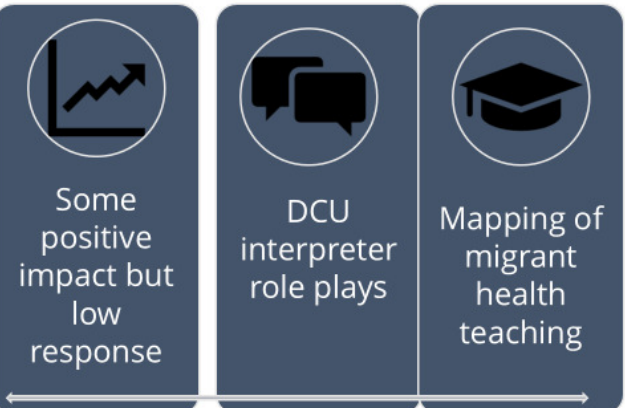Trauma. Cultural awareness workshop. Film club

Presentations

Evaluation

Pre post module survey

20% response

Good/very good ratings

Increased advocacy and knowledge

Conclusions And Future Work

Some positive impact but low response

DCU interpreter role plays

Mapping of migrant health teaching

The increasing need for specialists in primary care cancer research

Cancer and NCDs pose major public health challenges, with primary care playing a key role in early detection.
GPs occupy a unique position due to
- Continuity of care,
- High patient volume,
- Distinct population characteristics.

To advance primary care research, we are training future leaders through the student-led PRiCAN Scholars Network (PSN) curriculum.
- This cancer research framework builds transferable research skills for NCDs and integrates evidence-based training, mentorship, and projects on screening, prevention, and early detection in primary care.

Curriculum Development:

Most medical curricula emphasize hospital-based research, leaving a gap in primary care–oriented cancer research training. The PSN Curriculum will use Kern's Six-Step Approach:
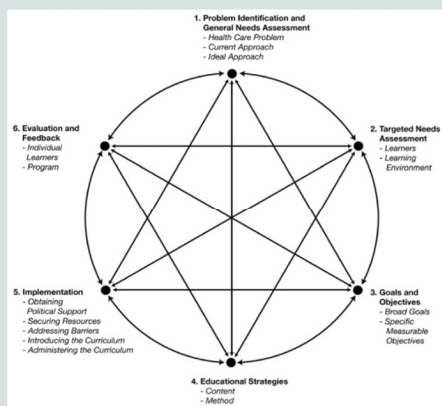
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Developing a specialised curriculum in primary care cancer research in an Irish medical school

Logan Verlaque, Joshua Graham, Benjamin Jacob, Kurdo Araz, Aileen Barrett, Syed Muhammad Sherdil Sherazi, Conor Murphy, Fiona Kent, Professor Patrick Redmond.

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Step 1: General Needs Assessment

1a. Scoping Review Search Terms & Preliminary Findings:
- Shortage of structured training for primary care cancer research.
- Need for multi-level engagement and capacity building among practitioners.

(("Primary care" AND "cancer research" AND "curriculum") OR ("Primary care training" AND "oncology curriculum") OR ("Cancer education" AND "primary care integration") OR ("Medical curriculum" AND "cancer research") OR ("Primary care" AND "cancer prevention education") OR ("Primary Health Care"[MeSH] AND "Neoplasms"[MeSH] AND "Education, Medical"[MeSH]) OR ("Family Practice"[MeSH] AND "Oncology"[MeSH] AND "Curriculum"[MeSH])) AND (2010[PDAT] : 2025[PDAT])

1b. Survey
Format: Anonymous Online Survey
Content:
- Demographics (e.g., role, background)
- Current training or gaps in GP cancer research
- Priorities for curriculum content
- Open-ended questions about barriers, facilitators, and ideas for integration into existing curricula

Recruitment:
- Distributed through institutional email lists

Target Sample:
- Over 200 Survey requests sent

Finalizing Step1:
1. Scoping review & Survey completion
2. Targeted Needs Assessment: Findings from Step 1 will help identify competencies, challenges, and gaps in primary care cancer research training.

TABLE 1: Preliminary literature review after returning 903 articles

Impact of Cancer Survivorship Care Training on Rural Primary Care Practice Teams: A Mixed Methods Approach Risendal B et al. (2022)
- Assesses a survivorship education program for rural PCP teams and its long-term effects.

Increasing Primary Care Physician Support for and Promotion of Cancer Clinical Trials Robinson MK et al. (2014)
- Details strategies to boost PCP participation in clinical trials using targeted curriculum interventions.

The Cancer Prevention and Control Research Network (CPCRN): Advancing Public Health and Implementation Science White A et al. (2019)
- Describes CPCRN's role in disseminating evidence-based cancer prevention through primary care networks.

The Cancer Prevention and Control Research Network: An Interactive Systems Approach to Advancing Cancer Control Implementation Research and Practice Fernández ME et al. (2014)
- Outlines strategies to integrate cancer prevention research into primary care using evidence-based methods.

Next Steps:

1. **Develop** an educational curriculum that addresses identified needs using effective teaching strategies.

2. **Implement** the curriculum within the PRiCAN Scholars Network and evaluate its feasibility.

3. **Assess** its impact on student research competencies and engagement in primary care cancer research.

4. **Ensure** quality assurance to keep the curriculum relevant, up-to-date, and aligned with primary care cancer research standards in Ireland.

What Isn't Counted Doesn't Count
Irish GP workforce analysis

Irish College of GPs

GP

Highly Rural GP

The North-Northwest and Midwest have the highest proportion of GPs who work in "Highly Rural / Remote" areas.

% GPs working in Highly Rural areas		
	D-NE	2 %
	D-ML	2 %
	D-SE	5 %
	SW	5 %
	MW	**10 %**
	N-NW	**21 %**
	National	7 %

The North-Northwest and Midwest also have the highest proportion of GPs who work in solo practices.

% GPs working solo		
	D-NE	11 %
	D-ML	11 %
	D-SE	10 %
	SW	10 %
	MW	**20 %**
	N-NW	**17 %**
	National	13 %

N-NW

D-NE

D-ML

MW

D-SE

SW
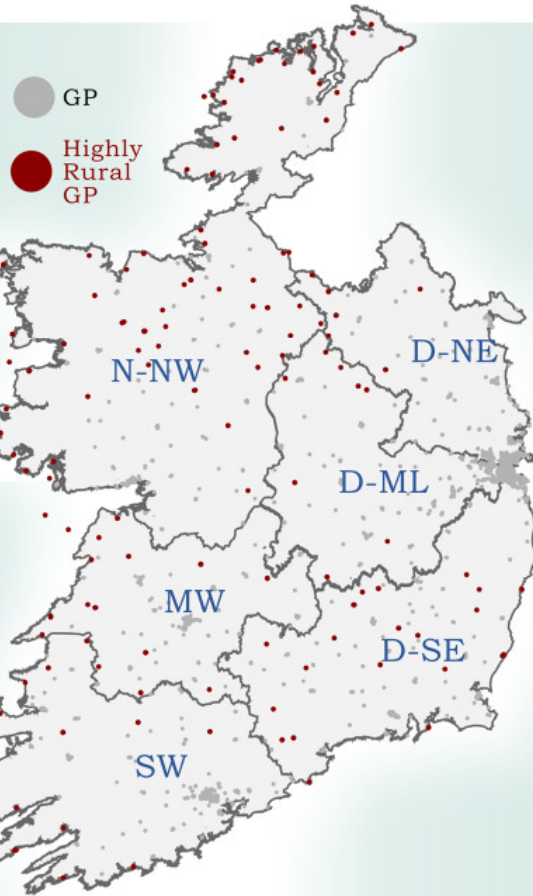
GPs working in Dublin-Northeast and Dublin-Midlands have the lowest proportion of GPs over 60.

% GPs over 60 years old		
	D-NE	**18 %**
	D-ML	**18 %**
	D-SE	21 %
	SW	20 %
	MW	22 %
	N-NW	20 %
	National	21 %

The Southwest and Dublin-Southeast have the highest GP per capita estimates.

|	GP per 10k	pop.
D-NE	8.2	1.2 m
D-ML	8.4	1.0 m
D-SE	**10**	1.1 m
SW	**9.8**	0.7 m
MW	8.9	0.4 m
N-NW	9.5	0.8 m
National	9.0	5.2 m

Also developing much more localised analysis of access to GP based on travel distance estimates.

Below is a draft of that analysis in Mayo

Higher Access

Lower Access
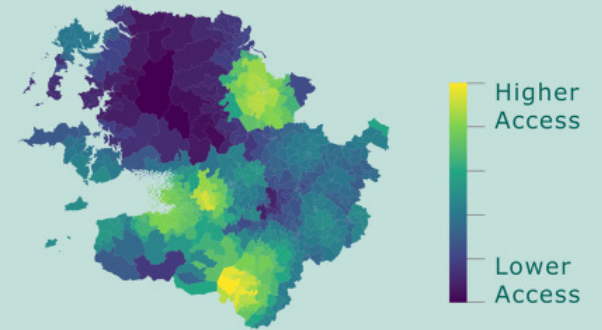
Percise mapping also allows us to pull in other detailed metrics like Deprivations or the CSO Rurality Index and cross-tab these with GP workforce data.

Below is GP age data combined with the CSO rurality index.

Under 50   Over 50

Rural   Over 60

Town

City

60   40   20   %   20   40
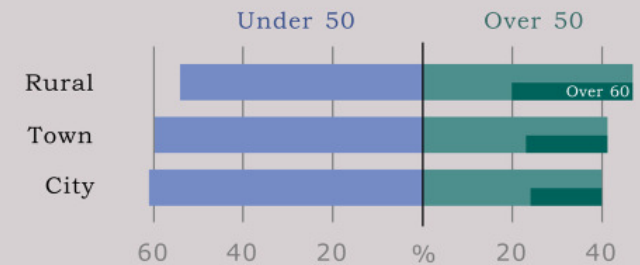
Feedback, comments & questions welcome!

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Developing a Complex Intervention to Integrate Community Paramedics in GP Out-of-Hours Care in Ireland

Dr Colette Cunningham[1], Dr Siobhan Masterson[2], Assoc Prof Alan Batt[3], Mr J.D. Heffern[4], Prof Shane Knox[2], Dr. Diarmuid Quinlan[5], Prof Cathal O' Donnell[2], Dr Deirdre O' Donnell[1], Assoc Prof Tomas Barry[1]
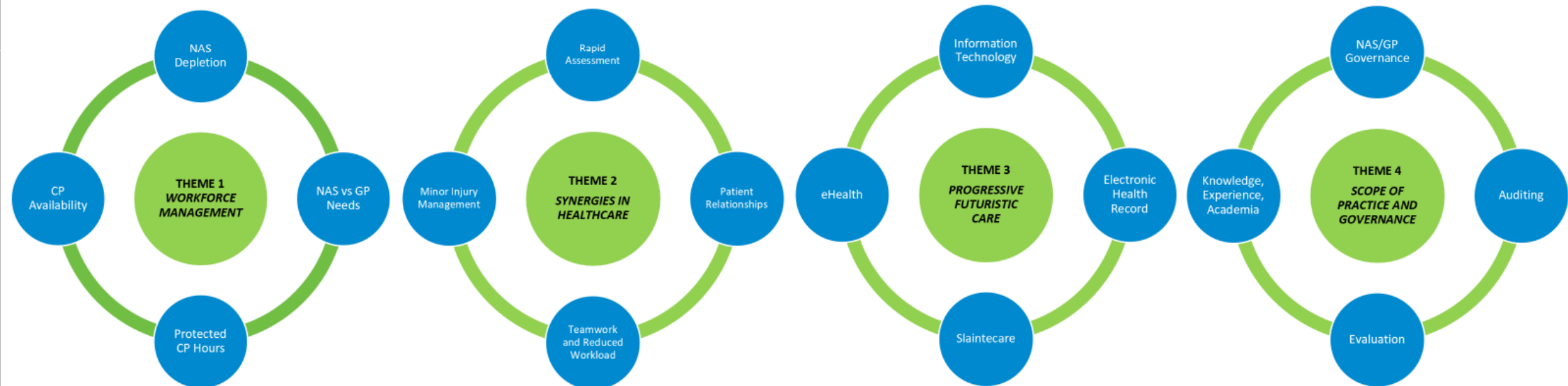
University College Dublin, Ireland, National Ambulance Service, Ireland, Monash University, Australia, Chief Paramedic for Indigenous Services, Canada, Irish College of General Practitioners

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