

have been on the rise during the last few years in medicine ^[1] and presented an opportunity to produce safe, efficient and flexible inductions for our junior doctors ^[1].

Aim: The aim of the study was to produce a simulation-based departmental induction programme that would be equally effective to the traditional model.

Method/design: We started with identifying the components of a departmental induction and then held a multi-disciplinary team meeting to encourage the addition of topics felt to be important and often overlooked. Stakeholders were involved in a needs analysis on the induction material; previous and current departmental junior doctors, the lead pharmacist, medical registrars, emergency physicians, acute physicians, the clinical lead, the medical director and the director of medical education were all contacted with specific questions on content and junior doctors' needs. Components of the recent General Medical Council surveys were taken into account to allow for a more junior doctor-centred induction. Subsequently, scenarios were designed with input from the directors of simulation and approved by the acute medical unit (AMU) lead. With the help of our colleagues at Hull Institute of Learning & Simulation (HILS) the scenarios were filmed, edited, and filed to produce an educational tool.

Implementation outline: The end-product of our VR360 induction has been checked by the educational lead of AMU against specific variables and standards and was characterized as 'much more flexible and a potentially more effective educational tool for junior doctors' medical induction'. Initial feedback from junior doctors has been very positive; however, further feedback comparing traditional and VR360 induction is needed. Work is ongoing to produce an interactive VR360 induction video with the hope that this could replace face-to-face departmental induction within our hospital.

REFERENCE

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GOING UPSTREAM: KEY CONSIDERATIONS WHEN MOVING A FACE-TO-FACE SIMULATION MODULE AND ASSESSMENT TO VIRTUAL DELIVERY

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Background: 'Preparing for on-call' is a level 6 physiotherapy module delivered face-to-face to enable synthesis of respiratory knowledge and application to real 'on-call scenarios', preparing students for the transition into clinical practice. Due to lockdown, we could not deliver this module face-to-face and changed it to a 'virtual delivery' for teaching and assessment.

Aim: The aim of the study was to deliver a face-to-face SBE module and assessment virtually.

Methods/design: We used the principles of SBE design ^[1] pre-brief, virtual simulation and debrief. We involved simulated patients (SPs) (in their own homes, with blurred background, thereby simulating a hospital environment). They were delivered appropriate props: hospital gown, range of oxygen masks, BP cuff and saturation probe. The SPs were trained online in how to portray respiratory deterioration, a nurse

facilitator was trained to give appropriate information about the patient and a physiotherapy clinical educator supported the students with their A-E assessment and management of the patient. Although normal 'hands-on' could not be achieved, we ensured that the students demonstrated their clinical reasoning using the 'think aloud' technique ^[2].

Implementation: We achieved a 'virtual on-call experience' by involving SPs, confederate nurse facilitators and physiotherapy clinical educators working synchronously with students via Microsoft Teams. With teaching groups of eight, we kept to the principles of SBE by pre-briefing, running a realistic scenario with clear learning outcomes, followed by a debrief facilitated by the nurse and physiotherapy educator. Students were able to rehearse their clinical reasoning by 'thinking out-loud'; these preparatory 'virtual on-call scenarios' enabled them to become familiar with 'performing' on Teams. This 'process-familiarity' led to a preparedness, professionally and psychologically for their subsequent 'virtual on-call assessments'. Four on-call scenarios were delivered in this module, enabling the learning outcomes to be achieved via this method of delivery. The virtual on-call assessment was run in three virtual rooms on Teams, with an SP, a clinical educator as an examiner, a confederate nurse, and one student in each room. The assessment scenario ran for 30 minutes replicating the normal examination time, giving students the opportunity to rehearse the skills they had learnt in the module. Additional supportive information was given to the students by sharing a 'patient monitor' (screenshots from the ALS Laerdal manikin monitors). In total, 28 assessments were achieved in 1 day, with two taken separately for extenuating circumstances. Student feedback has been positive with all students passing, enabling graduation this summer.

REFERENCES

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A SIMULATION WITH NO PARTICIPANTS ONLY CO-FACULTY: USING SIMULATION FOR SYSTEMS INTEGRATION ON THE LARGE SCALE

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Background: The large-scale relocation of a paediatric hospital is a significant undertaking. New environments change the system, and ways of working must adapt to maintain quality healthcare. There are risks to patients and staff well-being, with high anxiety around change. There is evidence for the efficacy of simulation as a tool for safe training and rehearsal of staff and teams ^[1] but less so on such a large scale. Simulation for many is still perceived as a test of performance and a threat. We connected with the international simulation community to design a hospital-wide programme of Patient Environment Simulations for Systems Integration (PESSI). This paper outlines challenges in establishing buy-in from stakeholders and departments, developing a framework for implementation and our reflections on delivery of large-scale simulation activities to assist a hospital move.