performed. Subjective comparison reported increased confidence, lower stress levels, good preparation of left-hand skills, and passive learning of surgical theory and technicalities (Table 1).

Table 1: Comparison of virtual reality and real surgery experience

Objective Comparison		
	Virtual reality simulation data	**Real surgery logbook**
Time duration	10 months	8 months
Logged time	45.7 hours	Limited (unable to measure)
Intraocular lens injected	74	30
Intraocular tasks	1581	86
Capsulorhexis	772	31
Injured corneal area	679 mm2	Unable to measure
Injured lens area	113 mm2	Unable to measure
Posterior capsule rupture	862	1
Subjective Comparison		
	Virtual reality simulation	**Real surgery**
Stress	Negligible	Significant
Margin of error	Unlimited	Zero
Environment	Safe learning	Real consequences
Time	Unlimited	Significantly constraint
Mentorship	Optional, limited	Direct supervision
Viewers	Optional, negligible	Supervisor, OR staff, students

Conclusion: Despite challenges of affordability and traditional surgical culture in a low middle-income country, simulation training provides safe learning alternatives to trainees which are effective and should be widely adopted. Although the learning curve is slightly longer, but skills acquired are replicable in operation theatre and significantly reduce the complication rate in the interest of patient safety.

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DEVELOPING A SIMULATED GENERAL PRACTICE ENVIRONMENT TO IMPROVE CLINICAL REASONING AND NON-TECHNICAL SKILLS IN JUNIOR MEDICAL STUDENTS

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Background: Simulation in medical education is often associated with acute specialities, however there is evidence in the literature to suggest exposing medical students to a simulated General Practice (GP) environment can be beneficial to their clinical reasoning and non-technical skills [1] and that this may even be superior to that gained from a GP practice placement [2].

Methods: 22 junior medical students participated in a simulated GP clinic where they reviewed 4 simulated patients. Patients were faculty members who also acted as assessors to ask 3 pre-defined questions and provide feedback after each station, rotating between candidates. The session was concluded with a presentation to clarify correct diagnoses and management for each case. Candidates completed a feedback form to evaluate the session.

Results: In terms of clinical reasoning, >85% of students reported the session greatly improved their history taking, recognition of red flags, and ability to formulate management plans in the community. For non-technical skills, >75% reported a great improvement in their professionalism, communication, and decision-making ability. However, 2 students (~10%) reported their professionalism had not been affected at all. Individual feedback after each station and the concluding presentation were reported as useful aspects of the session. 3 students (~14%) requested to include examination practice in future sessions.

Discussion: The majority of students felt that they benefited significantly from participating in the simulated GP clinic, both with respect to their clinical reasoning and non-technical skills. This may be due to the combined immersive nature of the simulation and the psychological safety provided by the absence of formal assessment [1]. The aspect which candidates felt least improved by the session was their professionalism, which may be in part due to an inability to suspend their disbelief. The benefit of adding clinical examination to this activity is not clear.

Conclusion: A simulated GP surgery environment can be used to improve history taking ability, recognition of red flags, and formulation of management plans in primary care, as well as non-technical skills in junior medical students. However, more research is required to establish whether this is transferable to clinical practice.

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CREATING A SUSTAINABLE WEEKLY INTERPROFESSIONAL SIMULATION FOR THE EMERGENCY DEPARTMENT (ED) CLINICIANS

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Background: Simulation-based education has been shown to improve clinical practice [1]. It offers an environment whereby complex real world situations can safely be practised facilitating learning through immersion, reflection, and feedback [2].There has been an increasing awareness amongst the medical profession as to the importance of simulation, we therefore created a sustainable simulation programme for the multidisciplinary team (MDT) at the Horton General Hospital (HGH) Emergency Department (ED) – Oxford University Hospitals NHS Foundation Trust.

Methods: Several simulations were designed involving trauma, airway management, and acute adult and acute paediatric presentations. The focus of the simulations was based on identifying errors due to human factors. The simulations were designed utilising feedback forms as well as analysing

information from clinical incident forms. These provided a platform to understand areas of improvement and targeted scenarios were created. A weekly simulation programme was then created involving the ED MDT (doctors, nurses, allied healthcare professionals) as well as other specialities (Paediatrics, Trauma and Orthopaedics, Anaesthetics and Acute General Medicine). The session was run every week for 2 hours in the ED as an 'in-situ' educational activity to provide a higher level of fidelity and provide an immersive environment for the participants. These scenarios were then debriefed by senior members of the team including speciality registrars and consultants trained on debriefing and human factors.

Results: The debriefings involved the discussion of human factors pertaining to the simulations and were learner-led. The feedback from the MDT was grossly positive; nursing staff and healthcare professionals in particular felt more empowered after the sessions to raise concern. Feedback was collected using an online survey which was sent to the participants following the session. Feedback obtained from participants aided improvement of targeted learning points and therefore aided debriefing.

Conclusion: Our simulation programme has been run over 18 months and has had excellent feedback. We continue to improve our simulations and increase the participant numbers through the use of video links for the sessions; thereby engaging a wider audience. This has been crucial throughout the pandemic due to various reasons (room constraints, staff isolation).

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BREAKING BAD NEWS: A MULTIPLE COHORT STUDENT PARAMEDIC SIMULATION EVENT WITH INTEGRATED SERVICE USERS

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10.54531/TBTJ1706

Background: This simulation aimed to meet the indicative content of a communication module, which focused on breaking bad news. The aim of this session was for first year paramedic students to observe bad news being given in a simulated environment. The objectives were for students to understand the emotive realism [1] behind breaking bad news, highlight the importance of integrating service users into simulated healthcare education, and to recognise the impact of observation and feedback.

Methods: The first-year paramedic students were introduced to the SPIKES [2] model prior to the event being commended due to its ability to allow patients and relatives to have their own reaction to bad news. The first year students then observed the second and third year students undertake two simulations and used the SPIKES tool to structure feedback on how they broke the bad news. One of the simulations was a cardiac arrest case in which the patient was pronounced deceased by the paramedics, and the second was the treatment of a patient that was suffering from a myocardial infarction. Within both simulations the students were expected to treat the patient utilising best practice and then break the bad news. The final element to this simulation was the inclusion of service users who acted as patients and relatives, and were given the opportunity to feedback as to how they felt during the communication [3].

Results: We gathered feedback via a Microsoft form from all parties with a total of 23 responses: 11 first year students, five 2nd and 3rd year students, and four service users. 17/23 of the participants 'strongly agreed' that the day was beneficial to their clinical practice. All participants stated they would want to take part in this educational intervention event again. Service users reported that there was a collegiate atmosphere that was developed between them and the staff. They also appreciated the opportunity to feedback to the students. The main feedback from the observing students was the realistic nature of the day and that they learnt by watching the more experienced students doing the simulation. Students involved in the simulation highlighted that they learnt a lot from the feedback they received and being involved in a realistic simulated environment.

Conclusion: Overall, this simulation-based activity brought together the theoretical subject matter of communication and created an inclusive learning space for a variety of people to learn.

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DOES SIMULATION HELP MEDICAL SUPPORT WORKERS TRANSITION INTO WORKING IN THE NHS?

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10.54531/SSCG9628

Background: A simulation-based programme was developed for the Medical Support Workers (MSW) within the Trust. The MSW role was created in response to the COVID-19 pandemic, providing an opportunity for doctors seeking GMC registration to gain clinical experience within a supervised NHS placement [1]. This project explored the MSWs' perceptions and previous experience of simulation and their overall confidence working within the NHS before and after the teaching programme. The aim was to assess if simulation is a useful tool to help international medical graduates transition into working in the NHS.

Methods: 29 MSWs (28 of whom were from Myanmar) worked in acute and medical specialties across the Trust, performing roles including: writing in medical notes, taking collateral histories, examining patients under supervision, procedures such as venepuncture and writing discharge summaries. Each MSW was invited to attend three training days between January and March 2022. We provided a programme incorporating medical and surgical simulation, communication workshops, and procedural skills, supported by human factors teaching. We delivered the sessions in our learning and research building, including our simulation suite. We collated data by sending out pre- and post-training surveys. There were 22 and 18 responses to the two initial surveys and 20 responses to the post-training survey.