

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).

REFERENCES

1. Al-Elq AH. Simulation-based medical teaching and learning. *Journal of Family & Community Medicine*. 2010;17(1):35-40.
2. Datta R, Upadhyay KK, Jaideep CN. Simulation and its role in medical education. *Medical Journal of the Armed forces India*. 2012;68(2):167-72

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

Emma Geis¹; ¹Staffordshire University, Stafford, United Kingdom

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.

REFERENCES

1. Buckman R. How to break bad news: a guide for health care professionals. University of Toronto Press; 1992 Aug 8
2. Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES – a six-step protocol for delivering bad news: application to the patient with cancer. *The oncologist*. 2000;5(4):302-11.
3. Orr F, Kellehear K, Armari E, Pearson A, Holmes D. The distress of voice-hearing: The use of simulation for awareness, understanding and communication skill development in undergraduate nursing education. *Nurse Education in Practice*. 2013;13(6):529-35.

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

Hope Thomas¹, Ygraine Clarke¹, Paul Karamura¹, Revathi Whittaker-Jain¹, Kitt Waring¹, Abigail Nye¹; ¹North Bristol NHS Trust, Bristol, United Kingdom

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.