

National Ambulance Resilience Unit to create handover videos involving assessing casualties to create videos for other healthcare professionals. Follow-up videos were then filmed on the 360° cameras in the simulation suites to represent an accident and emergency environment as this is where mental health crisis assessments can take place. The adult psychosis presentation was filmed and shows 'psychiatric liaison nurses' played by second-year MSc and BSc mental health students assessing the person with suspected psychosis and making clinical decisions. The scenario mental state examination and the case study were scripted. Students could view the 360° videos using virtual reality headsets such as the Oculus Rift [3]. The student feedback evaluation data was collected via an online survey and focus group discussions (FGDs).

Results: A survey was completed with n=30 students across all fields of nursing students and paramedic students. The student FGD evaluations were very positive about alternative simulated learning styles with one student quoting 'It will make an assessment of mental health patients a lot easier for students using appropriate tools and models'.

Conclusion: Students found that simulation-based learning experience is an excellent addition to traditional learning approaches as it met the requirements for different learning styles. This research project brought together academics and practitioners from across practice and university. Future work should build on these resources based on feedback from students and service users.

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PROMOTING THE USE OF SIMULATION-BASED EDUCATION IN GP SURGERIES THROUGH THE DEVELOPMENT OF A NEW LOCAL NETWORK OF PRIMARY CARE SIMULATION EDUCATORS

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Background: Simulation-Based Education (SBE) is a widely used educational tool in healthcare, but with a skew to secondary care. Our work is part of a growing movement to bring the benefits of SBE into primary care [1]. There is an expanding and diversifying number of staff groups in general practice, with the potential to bring additional expertise and experience to benefit primary care patients; notably the Additional Roles Reimbursement Scheme is bringing new paramedics, pharmacists, physiotherapists, physician's associates, and social prescribers, among others, into the traditional primary care workforce. There have been significant challenges in embedding these new roles, creating a sense of belonging, forming new ways of multi-disciplinary working, as well as understanding of their strengths and training needs [2]. The aim of the programme is to build a sustainable local network

of simulation practitioners to continue to deliver in-situ simulations to the general practice teams. This will contribute to the training and education of clinicians, improving patient experience and safety, and embracing the broadening and expanding primary care workforce.

Methods: We are training a network of 'Simulation Ambassadors' to work in local Primary Care Networks – clusters of practices serving up to 100,000 patients – to bring SBE to primary care teams, enabling training and education targeted to local needs, in multidisciplinary settings, including established and new staff groups. This has the intended benefit of allowing focused training sessions in GP practices, fostering closer working relationships between members of different staff groups while sharing knowledge and learning between these different groups.

Results: 6 'Simulation Ambassadors' have received training to deliver and debrief simulation sessions and are further supported by a Primary Care Simulation Fellow, who provides resources, mentoring, and fosters a community of practice. The simulation sessions cover a range of topics including 'acute' scenarios (e.g. the unwell patient in a waiting room), as well as scenarios focused on consultation and communication skills (e.g. safeguarding, explanations and diagnoses of chronic pain conditions, paediatric asthma management).

Conclusion: We have encountered several challenges during this process, including the novelty and unfamiliarity of simulation in primary care, and the difficulty of asking already stretched staff to dedicate time, either as educators or learners, away from direct clinical care. As the programme rolls out, we intend to demonstrate the value of simulation as an educational medium and will encourage wider use locally within Primary Care.

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A STUDY INTO THE PERCEPTIONS OF PRE-REGISTRATION NURSES' USE OF MENTAL SIMULATION FOR LEARNING CARDIAC ARREST SKILLS

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Background: Pre-registration nurses (students) must be prepared to be part of a cardiac arrest team at a moment's notice. Basic Life Support (BLS) must be performed proficiently and accurately. Proficient performance relies on repetitive practice, but time without practice results in skill decay [1]. Mental simulation offers the opportunity for repetitive, solitary, deliberate practice. Mental simulation is a quasi-perceptual experience in the absence of stimuli and overt physical movement [2]. Mental simulation has been well researched within healthcare education with promising results. Mental simulation has previously been shown to objectively improve performance of cardiopulmonary resuscitation (CPR) skills [3]. We aim to: 1) understand how participants integrate mental simulation into their busy lives over several weeks; 2) understand how the participants experience imagining a cardiac arrest and what this means

to them; 3) and understand the value that students place on experiencing cardiac arrest and life-support education through mental simulation.

Methods: Phase-1 was the design of a mental simulation script. The protocol was engineered to assist the students in creating functionally equivalent, high-fidelity images. Phase-2 was a qualitative interview study undertaken from a constructionist perspective. Eleven pre-registration nurses were asked to use the mental simulation protocol for 4-weeks. At the end of this period, semi-structured interviews and thematic analysis were employed to co-construct an understanding of student perceptions.

Findings: Several themes were identified (Table 1). The participants were motivated to undertake the mental simulations mainly due to feelings of low self-efficacy. These motivations created the volition required to problem-solve and make decisions that overcame environmental and time management challenges. The scripts assisted participants in coding images evoked from the language within the script narration. Unique to the participants, these images created individualised, emotionally laden, authentic scenarios high in psychological fidelity. This generated a realistic scenario akin to a real-world practice experience. Mental simulation acted as a reflective tool, and reflective practice allowed the participants to demystify the complexities of cardiac arrest life-support processes, leading to increased self-efficacy. Whilst CPR practice has been objectively shown to increase skill, these findings show the processes that occurred during learning (Figure 1).

Table 1: Theme and subtheme definitions

Theme/ subthemes	Definition
'Motivation'	Participants were underconfident about undertaking real-world BLS and life-support, creating strong motivational drivers. These motivational drivers (along with others) were strong enough for participants to enact mental simulation.
'Picture perfect.' (subtheme)	The participants had to fit mental simulation into their busy life schedules, creating the time and space necessary to undertake it. The participants all created a sanctuary that allowed them the space to create high-fidelity images.
'High-fidelity' (theme)	The script narration and cues of the audio-guided mental simulation script created the basis for creating a high-fidelity simulated experience.
'Imagination' (subtheme)	The participants tended to produce visual images evoked by the language within a script, but they significantly individualised them. The participant created these images from past memories unique to them.
'Hang on to your emotions' (subtheme)	The narration and the sound effects within the script evoked high-arousal states that are akin to those felt in a real-world cardiac arrest.
'I can't imagine.' (subtheme)	Most participants found the kinaesthetic (haptic) imagery challenging. The script did not tend to evoke high-fidelity kinaesthetic images, perhaps due to a lack of real-world experience.
'Harmony' (theme)	Mental simulation created periods of reflective practice, which illuminated gaps in skill and knowledge, demystifying the cardiac arrest structure and processes. This reflective period helped to fill in skill and knowledge gaps.
'Coping' (sub-theme)	Mental simulation gave participants greater self-efficacy towards their ability to perform clinically, meaning they felt ready to cope with real-world life-support practice.

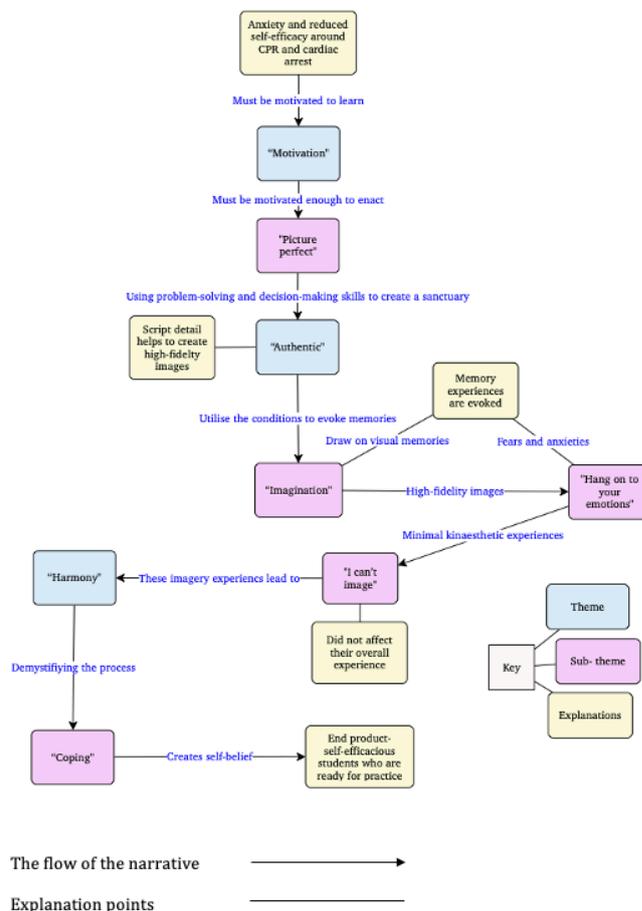


Figure 1: Representation of the learning process during mental simulation

Conclusion: Using mental simulation creates an authentic cardiac arrest learning experience. It creates self-efficacious, knowledgeable students who are ready for clinical practice. The author recommends mental simulation adjuncts mandatory BLS training within their organisation. Mental simulation could be rolled out to other staff groups, however, more mental simulation research into its efficacy is required.

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THE USE OF MULTIMODAL EDUCATIONAL TOOLS FOR LARGE SCALE SIMULATED PRACTICE

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Background: Due to the current placement capacity issues for nursing students [1] within the West Midlands and the continuation of the Nursing and Midwifery recovery standards [2], this enabled academic institutions to utilise up to 300hours of practice learning utilising a range of innovative practice-based simulations. At Birmingham City