

University (BCU) we were faced with providing simulation to large cohorts of students in excess of 500, reduced staffing and resources. The aim was to provide simulation based on the Nursing and Midwifery Council annexes A and B proficiencies [3] in large groups and still maintain an element of clinical realism and immersion.

Methods: The skills and simulation team developed several simulations which incorporated films, live actors, low-fidelity simulation, and problem-solving activities for students within the Future Nurse Course. Each simulation had pre- and post-work to be completed which was monitored and recorded via our online learning platform. The simulations developed and tested were:

- Breaking bad news- A traumatic below knee amputation of a young farm worker which looks at issues with partner/autistic child/overprotective mother.
- Hypoglycaemia- Adult hypoglycaemic patient within a General Practice setting with Paramedic input/Child hypoglycaemia/digital healthcare through use of Libre sensor.
- Conflict Resolution- Case study around the care of a patient with dementia who keeps falling and a Matron who does not have time.
- Pre-operative simulation- A 13-year-old high functioning Autistic child with torte teste requiring surgery and preoperative checking and Practice Assessor input.
- Allergies and Sensitivities- Management of allergies and sensitivities, Use of EpiPen for anaphylaxis.
- Hygiene- Shaving oral care/eyecare/female and male genitalia cleansing.
- The deteriorating patient- A to E assessment.
- Mobility and access- Use of equipment simulating frailty and disability.
- Assistance dogs for medical and neurodevelopmental conditions.
- Safeguarding- Looking at Trans/same sex couples/heterosexual domestic violence.
- Female genital mutilation.

Results: The simulations were evaluated by the students (N=550) and conclusions drawn from the feedback received. The large size of the groups being around 60 students is an issue both with staff and students, but it was recognised that this was beyond our control and that the large-scale sessions were 'immersive in nature' and reproduced substantial aspects of the real world interactively. Several students highlighted in their evaluation that they found the simulation content relevant to their clinical practice due to it demonstrating difficult situations that allowed them to practise their skills in a safe environment, promoting patient safety, and enhancing their situational awareness through guided experience.

Conclusion: Learners appreciate the relevance of the simulations to their developing clinical skills and recognised that the learning could be more targeted than within the practice setting although did not recognise it as clinical practice time.

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MEDICAL PROCEDURES INITIATIVE FROM SIMULATION LABORATORY TO MEDICAL WARDS

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10.54531/YLNK6076

Background: Historically, attaining medical procedural competency during training has been challenging [1–3]. At a small district general hospital, initiatives were implemented to address these mandatory curriculum components.

Methods: 1) Ten skill-sessions were organized, to encompass all mandatory procedures such as skills in central venous catheter, chest drain, ascitic drain, lumbar puncture, DC cardioversion, pacing, and interosseous access. Doctors, advanced clinical and nurse practitioners were invited to attend a face-to-face procedure session. Manikins alongside medical procedure toolkits were provided to assist in simulation training. Pre- and post-Likert Scale questionnaire was used to assess skill-specific confidence levels.

2) A specific WhatsApp group was used to alert doctors of procedural training opportunities within the hospital. Terms of reference and clear clinical governance guidance were provided prior to sign-up. To assess the effectiveness of this method, a questionnaire was distributed amongst the users.

Results: Thirty-eight professionals in training attended the sessions. The cumulative rating of all skills revealed an improvement in skill confidence from 15% to 80%. This was most marked in the interosseous access (17% to 100%) and abdominal paracentesis (27% to 100%). However, aptitude in central venous catheter was identified as having the lowest confidence skill level both pre- and post-sessions (0% to 60%). 86% of trainees found the WhatsApp group to be effective or very effective to communicate procedural training opportunities within the hospital. Within six-months, bedside training in DC cardioversion, ascitic drains, interosseous access, pleural aspiration, and drains were achieved.

Conclusion: The training sessions improved skill-specific confidence. Equally, the more challenging procedural skills were identified for more training. Further plans for this Quality Improvement Programme will include utilizing the hospital's online communication platform, organizing procedure-specific human factors teaching, and extending training sessions to consultants to evidence the upkeep of procedural competency.

Acknowledgement: We would like to thank and acknowledge the contribution of the Dinwoodie Charity Company of Physicians. The medical registrar: Empowering the unsung heroes of patient care. RCP, 2013.

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