(RCPCH) curriculum [1]. Child Protection (CP) simulation training was commissioned following trainee feedback around unpreparedness when carrying out CPMA. The COVID-19 pandemic forced delivery of online CP simulation. Initial learners were paediatric trainees; with newly qualified school nursing and health visiting colleagues in subsequent delivery; allowing for multi-professional learning in the simulated environment. The session aims were to:
- increase familiarity with professional conversations in the CP context
- formulate an evidence-based opinion in cases of suspected NAI
- rehearse discussing outcomes of CPMA with parents/carers and social workers
Methods: We rehearsed, modified, and then, using Zoom as a synchronous platform, with a trained simulated patient (SP) and faculty as role players created three 10-minute community-based CP scenarios for a twice-yearly programme. Pre-course information and a pre-briefing explained the online limitations and opportunities, including how we co-create psychological safety, the option of a wellbeing 'wobble' room, also outlining the Diamond debriefing model [2]. Pre- and post-course surveys were sent to the 18 participants. Likert scale ratings on confidence and anxiety levels when approaching a CP medical; familiarity with and likelihood of using the HEADSSS tool [3] was analysed using paired T-test probability.
Results: 94% (17/18) had no previous CP simulation experience. Confidence in carrying out CPMA increased post-simulation ($p=0.00418$) Anxiety going into the CPMA decreased post-simulation ($p=0.00624$). 44% were familiar with HEADSSS tool pre-course and 94% were more likely to use it post-course (Likert rating 4or5). Confidence in expressing concerns to parent/carer rose from 11% to 82.3% post-course (Likert rating 4or5). Free text learning points included 'Use what you can agree on (parent and doctor) as a foundation for developing rapport.' '... very useful in preparation for community.' '... very helpful in giving me more confidence in carrying out medicals.' 'Never undertaken a simulation with an actor, it felt real (I was surprised)', 'interesting to share learning... as practitioners have different perspectives.'
Conclusion: Despite sensitivity of the subject and the emotive realism brought by the SP's, psychological safety was achieved in this online interprofessional CP simulation training through detailed preparation in course design and faculty preparedness. The pilot was successful in preparing participants to fulfil their safeguarding role. Online training continues to be a synchronous induction for 2022.

REFERENCES

1. RCPCH. Progress curriculum. Royal College of Paediatrics and Child Health 2018. https://www.rcpch.ac.uk/education-careers/training/progress/curriculum [Accessed on 27/09/2022]
2. Jaye P, Thomas L, Reedy G. The Diamond: a structure for simulation debrief. The Clinical Teacher. 2015; 12(3):171–175.
3. Cohen E, Mackenzie RG, Yates GL. HEADSS, a psychosocial risk assessment instrument: implications for designing effective intervention programs for runaway youth. Journal of Adolescent Health. 1991;12(7):539–44.

AN ALL-WALES VIRTUAL REALITY PROJECT-INNOVATION, DESIGN AND COLLABORATION TO ENHANCE HEALTHCARE EDUCATION

Joanne Davies[1], Paul Twose[2], Sara Cook[2], Craig Dyer[3], Marc Holmes[1]; *[1]Swansea University UK, Swansea University Main Campus, Wales, [2]Cardiff and Vale University Health Board, Cardiff, Wales, [3]University Hospital of Wales, Cardiff, Wales*

10.54531/IEBS2545

Introduction: The potential for immersive technologies to augment healthcare training is gaining significant interest. However, its applicability and effectiveness are yet to be fully understood. This project was a response from a bid released by the Cardiff Capital Region to undertake a rapid innovation project, consisting of 3 main phases: 1) feasibility; 2) development; and 3) testing, across Welsh Health Boards.
Background: Project governance was provided via the Small Business Research Initiative (SBRI) in Clinical Excellence, a project board, and a project team with clinical and educational expertise, alongside Virtual Reality (VR) industry and academic partners. We aim to explore the formation of a virtual reality training package with a multi-centred collaborative project to overcome the current challenges of respiratory education, with a particular focus on tracheostomy care, to meet the challenges of the COVID-19 pandemic and beyond [1].
Methods: Phase 1 focused on the development of minimally viable solutions with a key focus on clinical content accuracy and education standards for single user learners. Phase 2 progressed to further develop the VR-based solutions including a multi-player system and virtual debriefing room, allowing the team to focus on key simulation-based learning best practice standards within the design and build [2]. Phase 3 is when system testing occurred over an 8-week period, across 6 Health Boards in NHS Wales involving over 100 multi-professional clinicians commencing in February 2022.
Results: On site hospital clinical education session feedback regarding use of the system and perceived opportunities were highly favourable in terms of ease of use, potential for VR in practice, and providing flexibility for mass training needs. Multi-user training was particularly well received. The limitations were lack of resource and time to combine a formal research project regarding the educational impact within busy health boards. This is planned for the next phase.
Conclusion: Empirical evidence from other industries demonstrates VR technology is an effective and efficient way of improving training [3]. Developing VR solutions to support healthcare training needs involves a collaborative approach with Health Boards, industry, and academic partners. The design, build, and implementation approach can embed simulation best practice standards to form innovative educational solutions to the challenges seen in the delivery of mass healthcare education. Formal research is required to begin to measure such factors as education transference, patient care impact, and return on investment questions.

REFERENCES

1. Chiang DH, Huang CC, Cheng SC, Cheng JC, Wu CH, Huang SS, Yang YY, Yang LY, Kao SY, Chen CH, Shulruf B. Immersive virtual reality (VR) training increases the self-efficacy of in-hospital healthcare providers and patient families regarding tracheostomy-related knowledge and care skills: A prospective pre–post study. Medicine. 2022;101(2):e28570–e28570.
2. Rossler K, Molloy MA, Pastva AM, Brown M, Xavier N. Healthcare Simulation Standards of Best Practice™ Simulation-Enhanced Interprofessional Education. Clinical Simulation in Nursing. 2021;58:49–53.
3. Manolakis K, Papagiannakis G. Virtual Reality simulation streamlines medical training for healthcare professionals. Journal of dentistry. 2022;121:103987.

A UNIFIED APPROACH TO FACULTY DEVELOPMENT

Lyz Howie[1], Catie Paton[2]; *[1]University of the West of Scotland, Glasgow, United Kingdom, [2]Medical Education Training Centre, Kirklands Hospital, Bothwell, United Kingdom*

10.54531/JPPD3082

Background: Due to the effect of the global pandemic and rising student cohort numbers, simulated practice placements are being implemented into nursing curricula. To deliver simulation-based education (SBE) within the Higher Education Institutions (HEI) staff must be adequately prepared. For SBE to be effective, thoughtful consideration to appropriate staff training is important [1]. A structured unified approach is more beneficial as it sets the same aspirations and contributes to a shared philosophy [2]. This unified approach meant both Health Board and HEI staff were being trained to delivery simulation in the same way, which was new for this HEI. Creating a faculty for simulation emulates a community of practice and also comprises essential networking with other simulationists [2]. It helps support Benner's novice to expert theory as staff start of as novices and subsequently develop emulating that robust educational training for SBE faculty development is essential [3]. Importantly, it addresses quality assurance and governance frameworks in meeting the requirement of the International Nursing Association for Clinical Simulation Learning (INACSL) [3], Association for Simulated Practice in Healthcare (ASPiH), and Nursing and Midwifery Council (NMC) standards. The overall aim of this innovation was to implement a unified approach to faculty development training for academic staff within an HEI.
Methods: Three training sessions were delivered in January and February 2022. HEI staff attended a one-day session. Health Board Simulation Educators facilitated the sessions for the HEI Academic Staff.
Results: Using a unified approach to this faculty development had a positive outcome in supporting HEI staff to be upskilled in the delivery of SBE. It has also resulted in the subsequent development and implementation of a 2-day training course comprising the following sessions: Session 1 – Introduction to clinical skills and simulation and writing learning outcomes and scenarios; Session 2: Technology supporting simulation; Session 3: Preparation, briefing, and debriefing; Session 4: Running an immersive simulation session. This in-house training programme will continue to be delivered to HEI staff undertaking SBE and evaluated.
Conclusion: Using a unified approach enhances the quality and parity of the delivery of SBE within the HEI. A unified approach to faculty development within the HEI will continue to be delivered to upskill staff in SBE. Collaboration with clinical partners in faculty development is crucial in the delivery of SBE to ensure a unified evidence-based approach.

REFERENCES

1. Bryant K, Aebersold ML, Jeffries PR, Kardong-Edgren S. Innovations in simulation: Nursing leaders' exchange of best practices. Clinical Simulation in Nursing. 2020;41:33–40.
2. Peterson DT, Watts PI, Epps CA, White ML. Simulation faculty development: a tiered approach. Simulation in Healthcare. 2017;12(4):254–259.
3. Hallmark BF. Faculty development in simulation education. Nursing Clinics. 2015;50(2):389–397.

EXPLODING SILOS: HACKS IN CREATING NATIONAL SIMULATION NETWORKS

Nathan Oliver[1,2,3], Kirsty Marks[2,3], Siobhan Connolly[2,3], Ashley Meldrum[2,3]; *[1]NHS Lothian, Edinburgh, United Kingdom, [2]NHS Education for Scotland (NES), Edinburgh, United Kingdom, [3]NHS Scotland Academy, Golden Jubilee Hospital, United Kingdom*

10.54531/WGFE8219

Background: Silos of work are a reality in virtually every large organisation and invariably create duplicated workloads, inefficiencies, and in some cases a sense of 'tribalism' which risks the integrity and effectiveness of teams [1]. As simulation-based education gains traction and momentum as a teaching approach across Scotland and the UK, silos of work have emerged and risk the effectiveness and efficiency of programme delivery. Our aim was to create an effective simulation user network across the 14 Health Boards of Scotland to eliminate silos and create a collaboration of work across the country.
Methods: Thanks to an investment from NHS Education for Scotland (NES), insight from the NHS Scotland Academy, and the expertise of the Clinical Skills Managed Education Network (CSMEN), a team of regional Senior Educators were recruited to create a functional regional and national collaborative for simulation in Scotland. The story here is how the team have come together and the lessons learned in networking, negotiating, and establishing a new and growing sense of collegiately across the country. Starting in the East of Scotland, a questionnaire was designed and delivered across simulation teams and stakeholders across four Health Boards. The data collected was used to feed discussion at an East Scotland Simulation Collaborative scoping meeting which was attended by representatives of all four Health Boards and included medics, nurses, physiotherapists, and pharmacist teams delivering simulation to both undergraduate and postgraduate teams.
Results: An East Scotland Simulation Collaborative has been formally established with its inaugural meeting in Autumn 2023. An online space has been established to promote communication and the sharing of resources, and both a quarterly meeting and annual faculty development day designed for the group. Discussions are now ongoing for the development of an East Scotland Simulation Research group to develop new opportunities to conduct multisite studies for the first time. From a national perspective, North and West Scotland Simulation Collaborative groups are now in their formation stages.
Conclusion: Like weeds in a garden, silos of work will grow all by itself. Like roses in a garden, an effective network takes both time and tending, but the investment pays dividends.

REFERENCE

1. Beattie A. War and peace among the health tribes. 1995. In: Soothill K, Mackay L, Webb C (Eds). Interprofessional relations in health care. London: Edward Arnold.

USING ONLINE SIMULATION TO PREPARE MENTAL HEALTH NURSING STUDENTS FOR PRACTICE

Ursula Rolfe[1], Andrea Lacey[1], Marta Ortega-Vega[2], Anita Bignell[2], Aleks Saunders[2]; *[1]Bournemouth University, Bournemouth, United Kingdom, [2]South London and Maudsley Foundation NHS Trust, London, England*

10.54531/OLGF7296

Background: Demand for mental health nursing staff is rising with a drop-in staff of 8% in the last 10 years [1]. Preparing the future NHS healthcare workforce is therefore a vital component of educational delivery for Higher Education Institutions [2]. With funding Health Education England, the aim of this pilot project was to evaluate whether an