consultations. We provided educational recordings of virtual model consultations for reference. Trainees were provided with the videos to complete a self-paced didactic educational session. Subsequently, a group session was held virtually in groups of six involving simulated clinical scenarios with a faculty-led debrief. Avatars were used to simulate patients and patient medical records were simulated in the 'chat' function. These simulation sessions allowed the transfer of knowledge into practice whilst using SBE methods to debrief on human factors skills, specifically focussing on human factors in a virtual world.

Method/design: The purposely developed 'Remote Consultation Self-Assessment Tool' was completed immediately prior to and after the training. This tool provided Likert responses to 10 statements relating to the course content and consequent quantitative analysis was based on the percentage change in participant self-assessment. The General Self Efficacy Scale (GSE) was also used to gather information from participants prior to and after the training. The GSE measures participant self-efficacy via a 5-point Likert scale.

Implementation outline: A total of 29 participants attended the course. There was a high failure to attend rate of 40%, with covering the COVID-19 vaccine clinics a commonly stated reason for failure to attend. Primary care workers made up 60% (n = 18) of participants, 26% (n = 9) worked in secondary care and 6% (n = 2) worked in other settings. Most participants (85%) were naive to SBE. There was a significant improvement in both the remote consultation self-assessment tool (mean difference 12.08 [95% CI 5.31 to 18.83] p = 0.001) and the GSE (mean difference 3.54 [95% CI 1.81 to 5.27] p < 0.0001). This model of delivering SBE has improved access for staff working in primary care and other areas who have not been able to access SBE previously. The use of avatars is a feasible method of delivering SBE. Consideration to improving attendance rates at courses should be a priority for those delivering SBE.

158 THE INTRODUCTION OF VIRTUAL SIMULATION INTO A PRE-REGISTRATION NURSING COURSE DURING THE COVID-19 PANDEMIC

Lewis Newton [1,2], Debbie Clark [1]; [1]*Sheffield Hallam University, Sheffield, UK*[2]*Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, Doncaster, UK*

10.54531/BTYS4786

Background: The COVID-19 Pandemic changed the way teaching and learning could be delivered at Sheffield Hallam University; the use of virtual simulation was explored to enhance the student experience and prepare students for placement.

Aim: The aim of the study was to evaluate the application of virtual simulation for pre-registration nursing students.

Method/design: Oxford Medical Simulation (OMS) is an immersive, interactive, virtual healthcare simulation platform that allows participants to engage in a wide range of clinical scenarios. The environment, patient and other team members are fully interactive, with conversation and physiology adapting to students' actions and treatment. The educational focus is on decision-making, clinical reasoning and critical thinking to improve patient care.

Implementation outline: A programme was developed to allow students to take part in lecturer-led sessions where OMS was used to practise the assessment and management of an unwell patient. Virtual scenarios lasting 15–20 minutes were managed by the lecturer, with students offering their contributions to determine the steps they wanted to take to manage the patient. Screen sharing of the virtual simulation via Zoom allowed students to take part in the scenarios from home. Learning outcomes predominantly focussed on A to E assessment, encouraging students who had never encountered a 'real' patient before in a clinical setting to begin to develop a structured approach. Evaluation of introduction of OMS to Nursing Course. This evaluation describes the benefits realized between the launch of OMS in November 2020 and 1 January 2021. The data presented include qualitative and quantitative data collated and analysed from student online survey responses. Data from 188 purposively sampled student participants were collated and analysed. The qualitative data demonstrated improvements in the student experience, under the following themes: (a) preparing students for placement, helping to apply knowledge to practice and improve decision-making; (b) developing confidence, providing a safe learning space – able to make mistakes without patients coming to harm. Students were also asked to rate their level of satisfaction on a 5-point scale (where 5 was most satisfied). The median rating for the 55.9% (n = 105) student responses was 5.0 with no statistical difference between identifiable fields of nursing (X^2 (2)=1.882; p = 0.390). As Ingrassia et al. [1] point out, 'there is great uncertainty about how COVID-19 will impact future training in simulation facilities' (p = 0.2), and moving forward, in the altered climate in which we find ourselves, OMS might be considered an important complement to the future teaching and learning experience.

REFERENCE

1. Ingrassia PL, Capogna G, Diaz-Navarro C, Szyld D, Tomola S, Leon-Castelao E. COVID-19 crisis, safe reopening of simulation centres and the new normal: food for thought. Adv Simul. 2020;5(13). Available from: https://doi.org/10.1186/s41077-020-00131-3

18 SP TRAINING FOR TRANSGENDER HEALTHCARE STATIONS: WHAT SPS AND PROGRAM DIRECTORS NEED TO KNOW

Erik Simon[1,3], Isle Polonko[2]; [1]*Clinical Practice Resources for Training and Education, Astoria, NY, USA*[2]*Clinical Practice Resources for Training and Education, Hardwick, NJ, USA*[3]*Clinical Practice Resources for Training and Education, New York, NY, USA*

10.54531/KIAH2695

Background: Recent interest in the United States addressing Lesbian, Gay, Bisexual, Transgender (LGBT) healthcare issues, particularly obstacles faced by transgender individuals, has resulted in newly developed programming addressing these concerns. Training students and faculty on nuances of LGBT patients, with a specific focus on transgender patients, is critical if outcomes for this population are to improve. Data show 23% of survey respondents avoided seeing a doctor when needed, fearing mistreatment as a transgender person [1]. This programming also addresses the anxiety of healthcare practitioners when interacting with members of a marginalized community which frequently stems from inadequate training and infrequent direct experience with patients from that community.

Aim: The aims of the study were to increase empathy and awareness of LGBT healthcare needs and to improve communication and patient/practitioner relationships

through experiential learning with live transgender standardized patients.

Method/design: The programmes developed address fundamentals for healthcare professionals about serving LGBT patients: inclusivity, rapport, effective communication without creating anxiety or offense, language to avoid, and other practical knowledge including various surgeries and gender-affirming care available to transgender individuals. Initial panel discussions with members of the LGBT community have proved very effective in covering realities faced by transgender patients. Implementation of Teaching OSCEs (Objective Structured Clinical Exams) utilizing transgender individuals applies gained knowledge from lectures and discussions. It is critical for learners to experience working with an actual transgender standardized patient to effectively simulate encounters. Only a person from a marginalized community can accurately portray unique experiences affecting that particular community. Advanced medical training has also been developed including training for forensic examiners.

Implementation outline: These programmes include an LGBT didactic presentation, followed by a moderated panel (conducted virtually or in-person) of transgender individuals from varied backgrounds to share personal experiences receiving healthcare. Trainees are encouraged to ask panellists questions regarding concerns on proper communication, inquire about experiences in receiving gender-affirming care and discuss how to improve healthcare for transgender patients. Subsequently, trainees have the opportunity to participate in scenarios scripted and led by transgender standardized patients (SPs) or Trans Teaching Associates (TTAs). These scenarios can be conducted virtually, focussing on interview/history taking and communication skills, which makes global reach possible. In-person hands-on OSCEs can further assist trainees by providing opportunities to visualize trans anatomy. Learner feedback on improved understanding and empathy has been overwhelmingly positive, proving the necessity of providing training for learners in the care and treatment of transgender patients.

REFERENCE

1. The Report of the 2015 U.S. Transgender Survey [Internet]. Washington, DC: National Center for Transgender Equality. 2016. Available from: https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

116 DEVELOPING A FRAMEWORK FOR THE INTEGRATION OF SKILLS AND SIMULATION: THE 5-STAGE APPROACH

Emily Browne[1], Mike Phillips[1]; [1]*Staffordshire University, Stafford, UK*

10.54531/KYBT8535

Background: In recent years, there have been many publications providing guidance on simulation-based education and frameworks for development of faculty and delivery of simulation. However, there is not a framework for the integration and delivery of skills and simulation within a pre-registration curriculum. In 2017, Woda [1] referred to a need for a 'sequenced' integration of simulation into programmes with increasing complexity, knowledge, and exposure to simulation. Furguson [2] also found that there was a gap in how a simulation strategy becomes effectively implemented and embedded within an existing curriculum.

Aim: The aim of the study was to create a framework that integrates clinical skills and simulation increasing in complexity that can be used for any pre-registration healthcare curriculum. Ability to effectively implement and embed within an existing or new curriculum.

Method/design: We developed a framework using a five-stage approach to scaffold learning. Bringing simulation into the curriculum from the very start with the early introduction of consolidation and simulation allowing for a gradual cognitive load. Our approach builds on technical and non-technical skills alongside an understanding and exposure to simulation, by their final-year students will be debriefing their own teams in simulation and understand the use of simulation debriefing tools. This integration of skills and simulation and move away from 'task training' skills teaching aims to create both competence and confidence in students enhancing practice placements and ultimately improving the safety of patients. The approach consists of five stages: (1) online learning; (2) facilitated practical (task training); (3) simulation consolidation (facilitated simulation); (4) simulation days (remote facilitation); (5) clinical practice.

Implementation outline: The framework is being applied to the 2-year Master's programmes and nursing associate programmes as well as the standard 3-year pre-registration nursing, midwifery, operating department practitioner and paramedic programmes. Skills both technical and non-technical are introduced in years 1 and 2. In year 3, the focus is on knowledge review with a higher expectation of understanding and assimilation into the simulated environments expected. Over the 3 years, facilitation will lessen until students are leading on the simulation delivery and debrief by the end of their course. The same principle is applied to the 2-year programmes. This framework has been applied to all our healthcare courses by mapping the required skills curriculum and using the framework to build the content and set the delivery. The framework has now been adopted by another university.

REFERENCES

1. Woda A, Hansen J, Paquette M, Topp R. The impact of simulation sequencing on perceived clinical decision making. Nurse Educ Practice. 2017;26:33–38.
2 .Furguson J, Astbury J, Willis S, Silverthorne J, Schafheurne E. Implementing, embedding and sustaining simulation-based education: what helps, what hinders. Med Educ. 2020;54(10):915–924.

64 360 SIMULATION: ASSESSING BABY ROBIN

Jo Staples[1], Rose Edwards[2], Sam Pask[2], Heidi Singleton[1], John Moran[1], Debbie Holley[1], Ursula Rolfe[1]; [1]*Bournemouth University, Bournemouth, UK*[2]*Poole Hospital, University Hospitals Dorset, Poole, UK*

10.54531/MKXW2760

Background: Within a rural county, student placement locations are geographically scattered. Student feedback revealed that only students in one placement were able to benefit from the high-fidelity simulation suite resources situated at the lead hospital. Research shows students value co-created and personalized resources. Working with our practice partners we identified a cost-effective, accessible and inclusive solution, using 360 videos. Clinical simulation has been found to be effective [1] for teaching nursing skills. One limitation is the number of participants who can be involved at one time and in one place. A pilot study [2], with