Background: In November 2020, the first COVID-19 vaccine for the UK had been approved. We were subsequently tasked with the rapid development of vaccination clinics. Two COVID-19 vaccination clinics in suitable spaces within the University Hospitals Bristol and Weston NHS Ft were planned, across two different hospital sites (25 miles apart), to be operational within 7 days. Changes to both pharmaceutical and national guidelines were altering by the hour.
Aims: The key driver for this fast-paced change was to ensure vaccines were delivered as soon as available to Bristol-based health and social care staff.
Methods: A process map outlining the vaccination journey established in the local public vaccination site was the starting point to understand how to efficiently, effectively and safely deliver vaccines. Hospital sites for both clinics were identified, and work began immediately to vacate those rooms and establish both the infrastructure and personnel to run the large-scale clinics. Simulation Lead Educator involvement during the first days of planning was essential and at each stage of the process mapping.
Simulation Round 1:

- full-scale simulated vaccine clinic in the newly designed rooms on one site
- standardized patients (actors) briefed as receiving the simulated vaccine
- key staff in roles – administrators, pharmacy, vaccinators
- debrief focussed on latent threats, agreeing immediate changes to be tested in the next round
- patient experience feedback from the standardized patients

Simulation round 2:

- immediate re-run of the simulated clinic
- solutions identified in Round 1 were applied and tested
- rapid improvements to the process mapping, ergonomics, clarity of roles and timings for clinic appointments were able to be made

Simulation round 3:

- Round 3 took place on the second site a few days later
- lessons learnt from the first two stages being shared and translated within the new site
- essential safety and efficiency issues were explored and lessons learnt applied to the clinic

Results: The three rounds of simulation systems testing identified a number of latent threats and process mapping alterations which were implemented immediately, with solutions being tested on the spot. The vaccination clinics opened, administering over 500 vaccines per day across a 4-month period. The team involved continued to adapt processes and environment to suit the constantly changing guidelines and ensure safe practice.
Implications for practice: Simulation is an adaptive and responsive tool in systems testing, process mapping and implementing solutions within a high-pressured and time-restricted environment.

67 EVEN BETTER THAN THE REAL THING? COMPARING IN-PERSON AND ONLINE DELIVERY OF SIMULATION-BASED TRAINING FOR EARLY-STAGE PSYCHIATRIC DOCTORS

Divija Bansal[1], Nilesh Tribhowan[2], Owen P. O'Sullivan[3], Hannah Iannelli[1]; [1]*Maudsley Learning, South London and Maudsley NHS Foundation Trust, London, UK*[2]*Hull York Medical School, Hull, UK*[3]*Maudsley Simulation, South London and Maudsley NHS Foundation Trust, London, UK*

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Background: COVID-19 required many simulation faculties to provide online alternatives to in-person training. Over this period, our organization pivoted fully to online delivery of mental health simulation-based education (SBE), defined as delivery entirely via a videoconferencing platform to participants remote from one another and the simulation team. SBE can help early-stage psychiatric doctors to bridge educational and clinical practice by providing exposure to a variety of presentations and a safe space to hone communication and de-escalation techniques while encouraging reflective practice [1,2]. There is, however, limited research comparing the efficacy of in-person and online mental health SBE.
Aim: We assessed for any significant differences across several course evaluation measures in a comparison between groups attending in-person and online versions of a simulation course for early-stage psychiatric doctors.
Method: An existing full-day course was adapted for online delivery over a half-day period. It focuses on developing confidence and skills in psychiatric history-taking, mental state examination, risk assessment and formulation, meeting the relevant learning outcomes set by the Royal College of Psychiatrists. It encourages participants to explore consultation dynamics with a key emphasis on communication and human factors skills. Participants for in-person (n = 228) and online deliveries (n = 90) comprised of early-stage psychiatric doctors (core psychiatric trainee, or GP trainee level) based in mental health trusts in South London. Pre- and post-course quantitative data (assessing learners' confidence, situational awareness, and course satisfaction) using the Human Factors Skills for Healthcare Instrument (HuFSHI) and Course-specific Questions (CSQ) measures were collected and compared across the two delivery formats, that is, in-person and online. Data previously collected from participants attending in-person deliveries were used in the comparison.
Results: Paired-samples t-tests were conducted to determine whether there were any changes in HuFSHI and CSQ scores pre- and post-course. Results indicated that there were significant improvements in HuFSHI scores as well as CSQ scores for both digital delivery and in-person delivery. Large and very large effect sizes were also observed for HuFSHI and CSQ scores, respectively, in both delivery formats. Our data suggest that participants benefited more from in-person delivery across CSQ measures and from digital delivery across HuFSHI measures.
Implications for practice: Our understanding of the educational differences between in-person and online mental health SBE is at an early stage. Our data suggest that online mental health SBE potentially represents an effective alternative to in-person delivery. Further research is required to better understand these differences.

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129 USING SIMULATION TO IDENTIFY SYSTEM ISSUES IN THE EMERGENCY DEPARTMENT

Clare Mulqueen, Catherine Holmes[1], Demi Thompson[1], Andy Matson[1]; [1]*Mid Yorkshire Hospital Trust, Wakefield, UK*