use of Forum Theatre created an enjoyable and valuable learning experience and that all of the care workers felt more confident communicating with residents with dementia after the session. Thematic analysis of the care worker responses in the ethnographic data recorded demonstrated themes including building meaningful connections with residents and recognising burnout in care workers.

Conclusion: We believe that the use of Forum Theatre to teach Communication in Dementia creates an insightful learning experience for care workers, promoting active involvement in the session. We were disappointed that so few care workers were relieved from duties to attend the session on the day. This may indicate the pressures that the workforce are experiencing. We hope that in sharing the learning from this event, we may promote the use of Forum Theatre in care homes as a means of developing care workers to enhance their skills and ultimately to improve the experience of residents with dementia in care homes.

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USING VIRTUAL REALITY TO EDUCATE HEALTHCARE PROFESSIONALS ON PATIENTS' EXPERIENCE OF DELIRIUM

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10.54531/IQOL1686

Background: Delirium is an acute onset confusion that has fluctuating consciousness symptoms such as hallucinations, mood changes and distractibility. It is experienced by around 2 in 10 patients within the hospital [1]. Amongst these patients, 96% are older adults and their outcomes are consistently worse due to the delirium alone, including increased mortality rates [2]. It can also be extremely frightening and distressing. Hence, the attitudes and knowledge of healthcare professionals surrounding delirium is an important topic to address in order to aid prevention as well as manage delirium. Despite training, delirium is under reported and generally poorly managed. Studies have found that the use of virtual reality in medical education has improved empathy, depth of knowledge, and self-awareness [3]. Using a 360° camera and virtual reality headsets, an in-patient scenario was created whereby the effects of delirium such as hallucinations and disorientation were depicted. The aim of the project was to establish whether virtual reality can be used to improve healthcare professionals understanding and awareness of patients' experience of delirium. The virtual reality video and the interviews can be found on YouTube.

Methods: Eight people were recorded using the VR and five of them were interviewed afterwards. The interviews were conducted using an unstructured approach in which the topics of how the virtual reality tool changed their perception of dementia, what they learnt from the tool, and whether they thought the tool was useful, were discussed. Thematic analysis was carried out retrospectively.

Results: The thematic analysis of the qualitative data highlighted four key themes amongst the healthcare professionals' responses. These themes were education, insight, empathy, and future practice. The most common theme was insight, with comments such as 'having the virtual reality, it breaks that barrier between you and them,' 'you realise how just isolated that person is,' and how the virtual reality made them feel like they are 'in the room,' emphasising this theme.

Conclusion: The outcome has been to prove concept and highlight the usefulness of virtual reality as a method of educating healthcare professionals. We have been emboldened by the feedback received. We are looking to incorporate the VR film as part of a broader simulation-based training. The training is already being adopted by local clinical teams and our local university partners.

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BOOT CAMPS AND ACADEMIA: ODD BEDFELLOWS FOR A NATIONAL COLLABORATIVE APPROACH TO TRAINING NON-MEDICAL CYSTOSCOPISTS

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10.54531/TDRT7263

Background: Scottish cystoscopy service provision faces significant challenges in the years ahead driven by COVID-19's impact on diagnostic waiting times, the development of national treatment centres to expand infrastructure/service delivery, and limited short-term medical capacity to support recovery. These factors have greatly increased demand for the rapid development of a supportive non-medical cystoscopist workforce [1]. There is currently no agreed national approach to non-medical cystoscopy training in Scotland despite clear guidance on competencies from the British Association of Urology Nurses (BAUN). Our proposed solution has been to collaboratively develop and pilot an accelerated learning programme, including a simulation 'bootcamp', that pump primes adaptation to the role and clinical training requirements through technical and non-technical skill rehearsal.

Methods: We invited experts from clinical practice, education, and simulation to form a national short life working group (Figure 1) with two aims: To collaboratively develop a national education programme and oversee implementation, governance, and evaluation. Through an iterative process, the team reviewed current education provision, training frameworks, workforce recruitment and retention data, evidence on simulation accelerated training, existing

academic models, and the Scottish Government guidance on advanced practice. This was used to collaboratively construct the programme.

Figure 1: Diagram of the national short life working group

Results: A unified model for pilot was developed, integrating clinical simulation, theory, and work-based learning (WBL). It focuses on core cystoscopy skills initially, providing the necessary knowledge and 'hands on' ability required for independent practice. The process is primed by a two-day 'cystoscopy bootcamp' using simulation-based education (SBE). This comprises of a variety of methods including high volume cystoscopy skill rehearsal of increasing realism, progressing to cadaver. Non-technical skills are simulated through bespoke scenarios relevant to the role including obtaining informed consent, team communication, and delivering bad news. Expert discussion and debriefing is interwoven throughout. Formal evaluation is ongoing with early reports of increased preparedness and quicker adaptation to the clinical environment. In addition to the anticipated benefits, bootcamp also established early peer support mechanisms and, through the engagement and networking of diverse faculty, fostered integration with the wider community of practice, and a commitment to building a continually improving, user-informed simulation programme.
Conclusion: The method provides a cost-effective collaborative way to explore research, educational models, and the challenges of implementation in real time, through a multi-professional lens. The approach has been crucial to ownership, commitment and acceptance of the programme while fostering integrated cross discipline delivery.

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THE MEDICAL KITCHEN: DEVELOPING CLINICAL SKILLS THROUGH TRANSDISCIPLINARY SIMULATION

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10.54531/BQIZ7246

Background: It is ethically impermissible for medical students to perform invasive procedures on patients before being competent to do so safely [1,2]. Simulation offers obvious benefits, yet established simulation approaches can over-focus on technical tasks and overlook the need for simultaneous communication with patients and colleagues. Transdisciplinary Simulation (TS) addresses these issues by creating a safe, 'low stakes' learning environment based on an apparently unrelated field which in fact offers close parallels with medicine, in this case the kitchen. Expert chefs, like clinicians, must be skilled in preparing and organising their workplace (mise-en-place) [3], constantly attending to hygiene, precision, dexterity, and communication with colleagues and diners.
Activity: The Medical Kitchen is an affordable and scalable instance of TS, developed to help second year medical students acquire psychomotor clinical skills while simultaneously communicating with a patient or colleague. The Medical Kitchen comprises self-guided learning of two new clinically-relevant skills followed by peer assessments; a subsequent whole class synchronous debrief; and individual guided reflections. Our team (clinical educators and a professional chef) selected 'turning' vegetables as a core skill, teaching students to shape courgettes or potatoes into regular and consistent shapes using a suitable knife. This requires dexterity and control, gained through repeated practice, and presents similarities with clinical skills. The knowledge gained from turning vegetables is then applied to the clinical skill of suturing while talking to a colleague, highlighting the need to integrate physical skills with sensitive communication.
Findings: The Medical Kitchen programme has been delivered to over 700 second-year undergraduate medical students at Imperial College London over the course of two years. It is versatile and adaptable, having been delivered in both online and live session formats in response to the COVID-19 pandemic. Student feedback through guided reflections on perceived value has been overwhelmingly positive (though it is too early to establish the long-term effect on students' clinical skills).
Conclusion: The Medical Kitchen offers an innovative approach to clinical skills acquisition, using the world of professional gastronomy to simulate the clinical environment. It is an affordable and scalable programme grounded in theories of psychomotor skills development and has the potential for widespread implementation. As an example of transdisciplinary simulation, it raises wider possibilities for simulation design and innovation within clinical education.

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