organization. The programme's global scope, with five regions, highlights its relevance and applicability to a diverse range of workplaces. There is potential for replication in other organizations facing similar challenges, ultimately impacting on our society as a whole.

Ethics statement: Authors confirm that all relevant ethical standards for research conduct and dissemination have been met. The submitting author confirms that relevant ethical approval was granted, if applicable.

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DESIGN

A57

SIMULATED PRACTICE AS A METHOD TO PROMOTE LEGITIMATE PERIPHERAL PARTICIPATION

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Background and aim: Simulated sessions are widely used within medical education. Despite the potential benefits of simulated learning, it suffers from a narrow scope of practice; acute, emergency presentations and procedural skills. There is less research for its utility in sub-acute and chronic disease management.

To develop expertise in medical practice, learners require sufficient foundational knowledge to facilitate more complex behaviours [1]. Within ward environments, lack of foundational knowledge in both 'hard' (knowledge) skills, and 'soft' (organizational) skills can limit learners' potential for development. Considering legitimate peripheral participation theory, learners require 'enculturing' into an institution to develop 'soft' skills. Examples of 'soft' skills include understanding problem solving approaches, language, values and norms of the profession [2].

Aim: To design and assess the educational impact of simulated ward round teaching sessions on medical students in semi-acute settings, focussing on 'enculturing' skills.

Methods: This was a prospective study. We created a ward round-based simulation session, with six simulated patient scenarios, designed for clinical placement level medical students. Ten students were included in the study.

We utilized an induction exercise to familiarize students with medical documentation, a simulated ward round, and a consolidation exercise reviewing discharge paperwork and prescriptions. A simulated patient was present in each scenario, with a member of faculty facilitating. Simulated ward round entries, nursing handover queries and investigations were provided to students. Scenarios were 20 minutes; with objectives to produce ward round documentation and generate holistic clinical management decisions. Students participated in a 'board round', which served as a forum for station specific feedback.

Enculturing values were assessed via a 40-point, knowledge based formative assessment, covering the main themes of the session: appropriate documentation, medical abbreviations, and clinical decision-making. Assessment was administered both pre- and post-session. Qualitative feedback of the session was obtained from learners to identify themes for further development.

Results: There was a significant improvement in knowledge following the session (see Table 1-A57). The results were analysed with a two tailed paired t test, with statistical significance reached (p = 0.0018). Positive qualitative feedback was given. The main themes of student feedback indicated improved confidence in the ward environment, with medical documentation and clinical decision-making.

Table 1-A57: Results of pre- and post-intervention knowledge assessment

Student	Scores				
	Pre test raw score (/40)	Pre test standardized score	Post test raw score (/40)	Post test standardized score	Absolute difference
1	16	**0.40**	36	**0.90**	**+0.50**
2	17	**0.43**	37	**0.93**	**+0.50**
3	28.5	**0.71**	37	**0.93**	**+0.22**
4	24.5	**0.61**	36	**0.90**	**+0.29**
5	16	**0.40**	29	**0.73**	**+0.33**
6	29	**0.73**	38	**0.95**	**+0.22**
7	30.5	**0.76**	36	**0.90**	**+0.14**
8	28	**0.70**	36	**0.90**	**+0.20**
9	33	**0.83**	36	**0.90**	**+0.07**
10	26	**0.65**	35	**0.88**	**+0.23**
		Mean Raw score Difference			10.75
		Mean Standardized Score change			**+0.27**
		p value (at 95% CI)			0.00018

Conclusion: Our results demonstrate an increased sense of empowerment in the study population.

Simulated practice can be used effectively to enhance learning in sub-acute medical situations. Enculturing skills were particularly enhanced; promoting future learning through orientation within zones of legitimate peripheral participation.

Ethics statement: Authors confirm that all relevant ethical standards for research conduct and dissemination have been met. The submitting author confirms that relevant ethical approval was granted, if applicable.

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SYSTEM

A58 **MASTERY BASED SIMULATION APPROACH ENABLING SOCIAL CARE TEAMS TO RAPIDLY ORDER SMALL PIECES OF EQUIPMENT TO A PERSON IN THEIR HOME**

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Background and aim: Traditionally small pieces of equipment (e.g. Zimmer frame, commode, toilet frame and raise and walking sticks) required for frail older people in their home environment are ordered by Allied Health Professionals who are highly skilled in ensuring safety and functionality of the chosen item. However, the problem is that this process can sometimes take up to six months due to backlogs in the system. This means the person is living with unacceptable risk within their own home and losing the ability to perform activities of daily living (ADLs). This could also potentially result in falls and hospital admissions with the subsequent increase in morbidity and mortality.

The team working within social care are often the referrers into this service and we wondered if the use of simulation-based mastery learning which has been shown to allow safe successful dissemination of skills in other areas of health and social care could be used to enable home care teams to safely, timeously and appropriately order small pieces of equipment autonomously [1]?

Activity: Using the 7-stage approach to SBML, Checklists allowing the safe acquisition of small pieces of equipment aiding ADLs were developed by our trained mastery learning facilitators (senior AHPs). Sessions were delivered to a wide range home care team members. The training was delivered using mastery-based learning approach.

We believe that this is the only example of the use of SBML in the social care environment and are really excited about the safety benefits and the way SBML enables a person-centred approach to social care [2]. The SBML training and the train the trainers will be continued to be disseminated and we will continue to evaluate the impact both on practitioners, the time it takes to get a piece of equipment and also rates of falls and admissions to hospital.

Findings: The feedback from the sessions reflects the massive benefit perceived from the participants in the way their new ability will transform the way they can support people in their homes:

● We can't believe this is happening it will make such a difference to our practice and the care we can deliver to our clients in their own home
● I never thought the day would come

Conclusion: We will continue to assess impact on home care teams especially whether this added enhanced role aids joy at work.

Ethics statement: Authors confirm that all relevant ethical standards for research conduct and dissemination have been met. The submitting author confirms that relevant ethical approval was granted, if applicable.

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QUALITY

A59 **MIDLANDS SIMULATION AND IMMERSIVE LEARNING CENSUS 2023: A CROSS-SECTIONAL STUDY TO INFORM REGIONAL TEL STRATEGY**

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Background and aim: National Health Service England (NHSE) is committed to providing the highest quality, evidence-based and sustainable Technology Enhanced Learning (TEL) to the workforce of tomorrow [1]. Over the past 20 years, simulation-based education (SBE) facilities have developed across many NHS trusts, universities, and training programmes using different models of delivery and funding to match their local needs. More recently, technological advances and a pandemic-driven need for remote and supplementary training experiences has expanded the remit of TEL.

Our objective was to complete a wide-ranging census to map simulation and immersive learning (SimImm) resources across an entire NHSE region and how these are delivered. Most importantly, we aim to gather stakeholder opinions on the perceived challenges faced by the SimImm community in the coming 3-5 years.

Methods: In December 2022, we launched a multi-phased regional online survey of SimImm providers. Phase one distribution included members of the two regional simulation networks. Phase two was distributed to simulation leads for postgraduate schools, training programmes and higher education institutions. Throughout, other stakeholders in the SimImm community had the opportunity to complete the 'future challenges' section only.

Results: 35 organizations had completed the full census, with a further 47 stakeholders completing the 'future challenges' section. Of the full census, 14 were secondary care simulation centres, 18 training programmes and 3 universities. The most common resources used were High-fidelity simulation ($n = 28$), simulated patients ($n = 21$) and advanced part-task simulators ($n = 20$). 15 organizations were delivering extended reality (XR) resources, with 6 delivering cadaveric simulation. Only 47% reported representation on regional simulation