along with a 'seal broken' table. The process, procedures and innovation were discussed and approved by the Drugs and Therapeutics group.

Implementation outline: Each emergency scenario was tested *in situ* on the AMU using the simulation doll and trainer (see Table 1 for results). To test each drawer a corresponding scenario was created and each intervention timed. The scenario was run twice, firstly without the trolley and then again with the trolley using two sets of nursing staff. The time was recorded from when the ward team responded to the patient to when the last step of emergency drug treatment was administered.

Table 1: Results from testing the enhanced care drug trolley

Emergency	Time taken (*without* trolley) (min)	Time taken (*with* trolley) (min)	Total time saving (min)
Anaphylaxis	16:00	07:20	08:40
Hypoglycaemia (severe)	07:40	03:45	03:55
Diabetic Ketoacidosis (DKA)	26:02	08:05	17:57
Hyperkalaemia	31:10	13:06	18:04
Status Epilepticus	18:56	13:08	05:48

Simulation testing led to modifications of the contents of the trolley after feedback from the users. To embed practice, education of the nursing staff and clinicians was commenced to ensure familiarity and confidence to use the trolley, and to ensure governance adhered to.

REFERENCE

1. Royal College of Physicians. Acute Medical Care: the Right Person, in the Right Setting – First Time. Report of the Acute Medicine Taskforce. London: RCP, 2007.

161 ABSENT IN BODY BUT PRESENT IN SPIRIT: BATTLING ON WHEN BOTH LEARNERS AND FACULTY ARE REMOTE FROM THE SIMULATION CENTRE

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Background: Over the last year, COVID-19 has constrained the capacity of education centres to deliver face-to-face simulation-based education (SBE). Restrictions on travel between NHS trusts necessitated development of remote simulation to allow learners to participate in training safely. The challenge to maintain training provision was increased due to the imposition of shielding requirements on a member of the education faculty requiring them to isolate at home over a 2-month period (February–April 2021).

Aim: The aim of the study was to allow educators isolating at home to continue to support SBE, despite their physical absence from the training centre, by:

1. Simulating the patient role remotely.
2. Facilitating debrief from home. Observing SBE within the simulation suite and supporting subsequent discussions using video conferencing platforms.
3. Supporting delivery of human factors teaching sessions to Trust staff remotely.

Method/design: To deliver SBE remotely for learners with remote faculty rested on three key requirements:

1. Collaborative and iterative development of scenarios that could be delivered effectively for learners remotely utilizing expertise from the simulation centres education and technical teams. The creation of scenarios optimized for remote delivery.
2. Effective communication and observation between remote faculty, centre-based staff and remote participants over Microsoft Teams (MST) to allow remote facilitation of debrief
3. Controlling and voicing the patient simulator from isolation at home via a desktop PC linked with simulation centre systems via a virtual private network (VPN) and utilizing the Zoom platform.

Implementation outline: Faculty member shielding requirements lasted for approximately 8 weeks and during that period they were able to support a range of SBE courses;

1. Foundation years doctors (supported 14 courses)
2. Final-year medical students (supported 6 courses)
3. Surgical nurses (supported 1 course)
4. Burns speciality (supported 1 course)
5. Acute care skills: Nurse OSCE provision (supported 4 courses)
6. Human Factors teaching to trust staff (delivered 5 lectures)

Key equipment:

1. PC with dual screens to allow MST and Zoom software to be managed simultaneously to allow response to participant communication and interactions in real time.
2. Headset-Microphone to support effective fidelity within audio exchanges.

The facility to contribute to educational provision was mutually advantageous to all members of the educational faculty:

1. Off-loading some of the burden of training from those within the centre.
2. A positive influence on the mental health for the isolated.

Making remote simulation work possible was through whole team collaborative working.

30 SHIFTING AN IN-PERSON SIMULATION FACILITATION TRAINING PROGRAM FOR NEW NURSE EDUCATORS TO A VIRTUAL CONTEXT

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Background: Best practices indicate simulation sessions should be facilitated by a trained instructor to maintain a safe environment for learners. We developed and implemented a successful simulation facilitation training curriculum for nurse educators at our organization in 2018 [1], but as the COVID-19 pandemic was declared worldwide in March 2020 the program was put on hold. This pandemic has led to many innovations in health professions' education, including nursing, to meet the ongoing need for prelicensure training