[students] in imagining performing cardiac arrest skills. The protocol had to be designed to increase the mental simulation exercise's functional equivalence and increase the possibility that learning would take place.

Methods: The protocol had several elements to improve functional equivalence, and these were: i) a narrated audio script with embedded sound effects that described the scenario. The script was based on PETTLEP mental simulation framework (physical, environment, task, timing, learning, emotion and perspective) [3]. The author used a tripartite script design. The scripts were designed between 1) the [first] author, 2) the [2015] BLS and ALS guidelines, and 3) students with real-world cardiac arrest experience; ii) a first-person [1-P] film of a cardiac arrest to assist in evoking high-fidelity images from a 1-P perspective; iii) a patient back story; iv) resuscitation algorithms, and v) a glossary of terms to help inexperienced students to understand cardiac arrest terminology. The glossary would assist students in turning language into images.

Findings: This novel approach to creating a mental simulation protocol created a scenario rich in detail and rich in stimulus, response and meaning cues that could help students learn cardiac arrest skills outside the simulation laboratory.

Conclusion: This is a new and novel way to design mental simulation protocols for learning cardiac arrest skills outside the simulation laboratory.

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A BESPOKE TRAIN THE TRAINERS COURSE TO MAKE HEALTHCARE MORE INCLUSIVE FOR PEOPLE WITH LEARNING DISABILITY

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Background: People with Learning Disability (LD) often receive inequitable care within the NHS, something Mencap has described as 'institutional discrimination' [1]. The NHS Long Term Plan states the need to improve the care of patients with LD [2]. Simulation with debriefing is a useful approach for improving patient care with Human Factors teaching. To improve education around LD, we created a de novo course with concurrent LD theme for nursing educators to become trained in debriefing and simulation, to allow them to become champions in facilitating learning, especially in relation to LD.

Methods: To establish the current educational needs of our organisation around LD, we conducted a staff survey to further understand the educational needs of our colleagues. 108 professionals from a variety of disciplinary backgrounds (including nurses, dietitians, and doctors) across 4 sites within our Trust responded. Thematic analysis highlighted the need for further education, with anxiety about inequitable treatment of LD patients, and staff and patient physical safety when looking after a patient with LD. We subsequently ran a 2-day 'Train the Trainers' course for nursing educators, which used communication scenarios (online videos and actors) and games to develop generic debriefing skills. Day 2 focused on simulation design and incorporating LD into simulation design, and at the end of the course participants facilitated a high-fidelity simulation to the rest of the group. Throughout the course, patient feedback, serious incidents, staff survey, and our Trust LD specialist nurse's expertise were incorporated.

Results: 8 nurses attended our course, taught by a diverse multidisciplinary faculty. Before the course, confidence in debriefing was on average 2.8/5 (5 being most confident). Afterwards they rated their confidence 3.8/5. Learners were asked about their confidence raising awareness of LD within their department. The rating was improved from the initial 2.6/5 to 3.6/5 after the course. To date, 1 participant has delivered LD-related teaching to their department using debriefing skills following an online LD video used on the course.

Conclusion: Our staff survey highlighted the need for further education within our organisation. The course was successful in increasing nursing educators' confidence in debriefing and their confidence in raising awareness of LD during teaching sessions. We are currently creating further resources to aid teaching, including videos with service users. We will further signpost to existing resources and request delayed feedback to assess if our nursing educators have become LD Champions.

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HOW TO INTRODUCE INTERPROFESSIONAL EDUCATION (IPE) TO CARDIAC ARREST SIMULATIONS FOR FINAL YEAR UNDERGRADUATE MEDICAL AND NURSING STUDENTS

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Background: Healthcare professionals work in a diverse community of different specialities and skills. However, most healthcare professional courses are insular and isolating in their training methods. This results in highly trained individuals, who are unfamiliar with the true multidisciplinary team (MDT) approach in health services [1], leaving them unprepared for working in the NHS. One specific area where teamwork, good communication and appreciation of others' skills sets are crucial is during medical emergencies and cardiac arrests, where multiple professions (including: Doctors, Nurses, Resuscitation officers, Operating Department Practitioners) work together to achieve the best outcome patients. We aimed to introduce Interprofessional Education (IPE) to cardiac arrest simulations for final year undergraduate medical and nursing students to improve their understanding of working as part of a MDT, to enhance their confidence in dealing with cardiac arrests and prepare them for work in the NHS.

Methods: Reviewing the literature, there are several key components required to successfully instil IPE including:

commitment to IPE, expert facilitation, understanding of roles in different professions, and positive role modelling [2]. When designing the course, we obtained each profession's learning outcomes for cardiac arrest and planned them into the course; paying particular attention to equal weighting of learning outcomes for both professions and mutual learning outcomes. Furthermore, we identified key skills which we wanted students to demonstrate and designed simulations to incorporate these. For example, nursing students using the defibrillator in manual mode independently and medical students to independently use the defibrillator in automatic mode. To add value to the course we wanted high quality role modelling and profession specific feedback. To do this, we ensured both qualified nurses and doctors with experience in delivering feedback and real-life cardiac arrest cases were present for all sessions.

Results: Feedback collated from students and faculty positively supported the introduction of IPE in cardiac arrest simulation, with students specifically commenting on the benefits of teamwork, understanding each other's competencies, and benefits of workings as an MDT.

Conclusion: Due to these simple changes and keeping IPE at the centre of our design and implementation of the cardiac arrest simulation course, we were able to successfully introduce IPE to final year undergraduate medical and nursing students.

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PREPARING FINAL YEAR MEDICAL STUDENTS FOR THEIR TRANSITION TO FOUNDATION YEAR 1 USING SIMULATION

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Background: The transition from medical student to Foundation Year 1 (FY1) doctor represents a vital stage in the development of a newly qualified doctor. It is well established that medical students struggle with this transition [1]. There is evidence that simulation-based education (SBE) improves competence and confidence [2]. At our Trust, medical students undergo a Transition to Foundation Year 1 (TTF1) placement to prepare them for their upcoming roles. This study's aim was to improve the confidence of final year medical students beginning their FY1 jobs in August 2022 by introducing them to common FY1 situations like prioritising tasks, handing over, being part of the on-call team, and practising clinical skills to improve patient safety as per the General Medical Council (GMC) outcomes for graduates [3]. We designed and implemented a simulation-based training day during their TTF1 placement.

Methods: We collected feedback from a focus group of nine final year medical students regarding what would help best prepare them. We mapped these against their medical school's curriculum and the GMC's framework [3]. They reported they were inadequately prepared for FY1 and all agreed to have a training day covering different domains to increase their confidence. We designed a TTF1 training day that included lecture-based teaching on how to survive FY1, three scenarios based on common FY1 situations and a teaching session on ultrasound guided cannulation. The training day was delivered to five cohorts (29 medical students) during their TTF1 placements in 2022. During this training day, medical students completed a pre- and post-programme questionnaire which measured self-reported changes in confidence levels via a 5-point Likert scale across domains: verifying deaths, prioritising tasks, cannulation, handing over, and being part of the on-call team. The questionnaire also explored their expectations of the day and what they had learnt from the day. This was analysed using the framework analysis.

Results: Quantitative results revealed: increased preparedness for their FY1 role (+24%; <0.001) and being part of the on-call team (+58.7%; p<0.001), increased confidence in prioritising tasks (+28.6%; <0.001), verifying deaths (+131.5%: <0.001), and cannulation (+50%; <0.001). Analysis of qualitative results revealed common themes of improved confidence in ultrasound guided cannulation, increased knowledge-base, clearer understanding of handling common FY1 situations, and 100% of participants agreed that this training day was useful.

Conclusion: The implementation of a TTF1 training day proved to increase the students' confidence and levels of preparedness for their upcoming jobs.

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GAMIFICATION IN OPHTHALMIC SURGERY SIMULATION

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Background: Recent advances in simulation have yielded great outcomes in training ophthalmology residents worldwide [1]. However, repetitive tasks may lead to burnout and loss of interest. The safe learning environments provided by surgical simulation create space for exploring creative practices and the introduction of gamification [2]. We held one such tournament for ophthalmology residents to compare and compete on their cataract surgery skills [3]. The aim was to generate interest and sportsmanship amongst the residents, and engage senior surgeons on the utility of simulation.

Methods: We designed a knockout tournament with 3 rounds, for 8 participants (Figure 1). Specific tasks for each round were selected on the EyeSi course software (V3.0.6). Round 1 was 'Capsulorhexis-high tension', round 2 'Capsulorhexis-errant tear', and round 3 'Milky-White Cataract'. Rules were displayed to the participants before the event and the highest score of three consecutive attempts was considered a passing score. A live performance was projected on a screen with an audience, along with a scoreboard display keeping track of scores and progression of participants.