and communication skills with only one paper mentioning this. Frequently simulation focuses on the acquisition of individual procedures and skill acquisition. Alongside this simulation is also reported to be used to test responses to rare or complicated cases or high-pressured scenarios such as resuscitation.

**Conclusion:** This scoping review reveals that the extent to which simulation is used within PEM is largely unknown and requires further investigation.

**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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# IN PRACTICE

## QUALITY

### A23 WRAPPING A GASTROSCHISIS BABY: AN MDT SIMULATION PROGRAMME


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10.54531/KSOO3436

**Background and aim:** Gastroschisis is a congenital defect of the anterior abdominal wall characterized by the herniation of abdominal contents through a defect usually located to the right-side of the umbilical cord [1]. Team-working, collaboration and clear communication between the obstetric, neonatal, and paediatric surgical teams are critical to achieving optimal outcomes in gastrochisis [2]. A national cohort study of all surgical units in the UK and Ireland identified primary closure as the optimal surgical management for antenatally detected cases of simple gastroschisis [3].

A local retrospective audit in RBHSC identified a higher rate of staged gastroschisis repair in the last 10 years with 66% of patients requiring initial silo placement, when compared to 45% national average. Data also demonstrated that patient with silo placement took longer to achieve full feeds, prolonged TPN, delayed discharge, and increased complications rates.

**Aims:** To create an interprofessional simulation programme for the preparation and management of a gastroschisis delivery, resuscitation, and initial stabilization. Aims of this project are to improve awareness of optimal stabilization management, efficiency of bowel wrapping and clear communication amongst the MDT with the overall goal of improving the rate of primary closure and outcomes in our unit.

**Methods:** A gastroschisis simulation model was created using vegan-sausage casings, jelly, and food colouring to create the bowel. The simulation programme focused on; team education of optimal gastroschisis management, team and delivery room preparation, primary resuscitation and bowel wrapping with clingfilm. Following a lecture of gastroschisis management and demonstration of delivery room stabilization participants were divided into teams of five, given a scenario, asked to prepare equipment, allocate roles and work in sync to achieve effective resuscitation and stabilization of the new-born. Pre and Post simulation feedback was collected and course adapted using a PDSA cycle. For continued learning a post-course video for delivery room management of gastroschisis was created and available for everyone to reference at any time in any location.

**Results:** Pre-simulation: 56% of participants had no previous training or clinical experience of the management of gastroschisis and 78% didn't feel confident in providing delivery suite management and stabilization. 100% of attendees felt the simulation training improved their confidence of initial management and stabilization of gastroschisis and all would recommend this course to their peers.

**Conclusion:** Simulation-based interdisciplinary team training can serve as a channel for the acquisition and maintenance of clinical skills. It is crucial to improving the management of complex neonatal conditions.

**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

### A24 CALCULATING THE COST OF SIMULATION BASED EDUCATION. WHAT TO INCLUDE?


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**Background and aim:** The cost of developing simulation-based education (SBE) facilities is high. However, the cost of sustaining SBE activities is often not considered in the initial outlay and facilities and centres can find themselves in financial difficulty early on. In addition to the cost of the initial capital and technology costs, there are many other costs incurred when running and sustaining SBE programmes. These are often not apparent or considered by simulationists when establishing new programmes. Research to date has focused on cost effectiveness and a return on investment [1]. However, the sustainability of a SBE programme is related to the ability to meet these costs. The aim of this work is to develop a simulation cost calculator that considered all costs incurred in skills programme development.

**Methods:** Following consultation with experienced simulation faculty, the finance office, human resources and

buildings office and equipment providers, a cost calculator template was devised to categorize the items required for SBE. The template allows for the calculation of the cost of teaching a procedural skill per person based on the total cost of all of the items in the template plus the number of attempts required for teaching and/or assessment.

**Results:** The cost calculator categories for procedural skills teaching in a simulated environment included recurrent costs such as heating, light and cleaning of the simulation space/facility, consumables, single use simulators, fixed equipment/initial outlay, waste disposal, depreciation costs and staff costs. To illustrate, the calculated cost for a bowel anastomosis workshop using biological materials is approx. €235 per person while the equipment cost for a basic skill such as venepuncture is €161.17.

**Conclusion:** Adequate resourcing is critical to establish, run and sustain SBE programmes. A cost calculator template will help new facilities to project their budget requirements and to decide what skills education they can support and sustain long term.

**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

### A25 GUIDING UK EDUCATED NURSES, MIDWIVES AND ALLIED HEALTH PROFESSIONALS WITH THE SKILLS TO BE ALLIES TO INTERNATIONALLY EDUCATED REGISTRANTS

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10.54531/RXMN5350

**Background and aim:** As international migration continues to shape the healthcare workforce globally, the United Kingdom (UK) has seen a significant increase in internationally educated (IE) nurses, midwives and allied health professionals (AHPs) [1]. These healthcare workers are vital to maintaining healthcare services, yet they face multiple challenges including language pronunciation, culture shock, and lack of social support [2]. The aim of this NHSE funded project was to identify the experiences of IE registrants, then develop and deliver a sustainable set of simulation-based workshops equipping established nurses, midwives and AHPs with the necessary skills to be allies [3].

**Activity:** The project design involved a mixed-method approach. Qualitative data was collected from across the region through focus group discussions and semi-structured interviews with IE registrants and with Trust leads for inclusivity and diversity. The findings were analysed and authentic story boards and scripts for scenarios were developed, cross checking back to source. These then became the core of a 're-usable' workshop with skilled actor role players and facilitators. Allyship is introduced, advantage and privilege discussed, pre-recorded films analysed, and simulation is through live face to face encounters and forum theatre. The workshop centres on cultural allyship and the four pillars of allyship, which include awareness, empathy, action, and sustainability.

**Findings:** Face to face simulation-based experiential learning has enabled participants to explore different scenarios and gain insights into the challenges faced by IE registrants. Workshops have been delivered on 20 occasions to groups of around 20, predominantly UK educated, nurses, midwives and AHPs. The impact has been significant; over 400 participants have benefitted, with evaluations of the workshop comprehensively positive. The participants reported increased awareness of their own biases and privilege, improved empathy towards IE registrants, and increased confidence in taking action to support them. The workshop ends with each participant making a pledge, showing their commitment to being an ally to IE registrants.

**Conclusion:** Equipping UK educated nurses, midwives and AHPs with the skills to be allies to IE registrants is essential, not least because this is about being respectful and compassionate to one another, but also retaining our recruited workforce helps us all deliver safe healthcare. These repeated workshops, adaptable for different professional groups, are an effective way to achieve the goal of being active as an ally. The workshops have the potential to be replicated in other healthcare settings to promote cultural allyship, and improve healthcare outcomes for all.

**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

### A26 EMPATHIC SIMULATION: A NOVEL SIMULATION DESIGN TO DEVELOP EMPATHY IN HEALTHCARE STUDENTS

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10.54531/XJCK3778

**Background and aim:** It is well established that simulation is a powerful tool for developing empathy in healthcare students [1]. Previous simulation designs surrounding the