

Methods: ML ran two separate simulation days, alongside, members of the research team including a lawyer and facilitator with lived experience.

The initial part of the day included didactic teaching; allowing participants to learn more about ACDs and have a space to ask questions from those with lived experience, clinicians and lawyers. This ensured participants gained a baseline level of knowledge to undertake the scenarios.

There were four simulation scenarios written, but only three took place on both days because of limited time. These revolved around one patient; the participants followed the patient through their ACD journey. The patient was played by an actor. All scenarios were designed to involve a clinician, often with the presence of a carer and service user as well.

The debrief consisted of a modified Pendleton model with feedback from service user, carers and clinicians to allow feedback and learning from all involved.

Results: Participants were asked to complete a pre-course and post-course questionnaire. Paired samples t-tests were conducted to analyse the difference between pre- and post-course questionnaires. Results demonstrated a significant difference in scores for course-specific questions between the pre (M = 3.17, SD = 0.81) and post (M = 4.21, SD = 0.20), $t(5) = -5.26$, $p < .05$, 95% CI [-1.55, -0.53], with a large effect size of $d = -2.15$. 100% of participants would recommend this course.

Conclusion: This was the first simulation that ML has run with a mixed group of learners that included not only clinicians, but also service users and carers taking part in the simulation and debrief. The feedback was positive and helped to improve the knowledge around ACD's. It was also noticeable the positive difference it made having clinicians, service users and carers learning from one another.

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.

REFERENCES

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DESIGN

A82

'SIMULATION FOR FINALS AND REAL LIFE' – IS IT EVER TOO EARLY TO JUMP IN THE DEEP END?

Zoe Shipley¹, Mohamed Azraq Ali Naeem¹; ¹Nottingham University Hospitals (NUH), Nottingham, United Kingdom

Correspondence: zoe.shipley@nhs.net
[10.54531/FQGC6958](tel:10.54531/FQGC6958)

Background and aim: Surveying University of Nottingham (UoN) medical students in their final year with regards to applying an A-E approach in a medical emergency context, we found that they lacked confidence. In order to address this curriculum gap, we designed a low-fidelity simulation-based workshop which has been shown to improve confidence in developing key skills relating to medical emergencies [1].

This consists of a 2-hour session for groups of 6, for all students undertaking their medical placements at Nottingham University Hospitals (NUH).

After successfully implementing this workshop for students in their final year, we asked ourselves 'when is it too early for medical students to cover A-E assessments in medical training?'

Considering this is an essential skill to develop and part of their intended learning outcomes (ILOs) that is also tested in their 3rd year examinations, we introduced an adapted version of this workshop for the more junior cohort.

Activity: We constructed this workshop with alignment to both the final and third year UoN curriculum ILOs. Google forms were used to survey students' confidence pre and post-session.

We used a low-fidelity simulation mannequin, focusing on an otherwise realistic clinical environment using medical notes, a portfolio of investigations and props. This included an observation monitor, a real-time display with altering vital parameters and a fully equipped emergency trolley.

Pre-reading handouts on A-E assessment by the Resuscitation Council UK [2] were provided. We watched a pre-recorded demonstration video of the management of hypoglycaemia prior to students working in pairs on three scenarios.

During the simulation scenarios, faculty members acted as either the patient or team members, including as a nurse and medical registrar.

Results: We showed that participation in our workshop significantly improved student confidence in the specific domains (see [Table 1-A82](#)).

Table 1-A82: Summary of the student questionnaire results

	Pre-session confidence	Post-session confidence	Improvement in confidence
FFP (3rd year medical students)			
Recognizing when to perform an A-E assessment (n=31)	36.6%	100%	+63.3%
Confidence in applying an A-E assessment on an unwell medical patient (n = 31)	6.7%	90.3%	+83.6%
Confidence in managing chest sepsis (n = 31)	3.2%	70.9%	+67.7%
Confidence in managing a STEMI (n = 31)	9.5%	83.9%	+74.4%
Confidence in managing DKA (n = 31)	13%	70.9%	+57.9%
CP3 (5th year medical students)			
Recognizing when to perform an A-E assessment (n=54)	87.3%	100%	+12.7%
Confidence in applying an A-E assessment on an unwell medical patient (n = 54)	29.1%	94.4%	+65.3%
Confidence in managing acute asthma exacerbation (n=36)	13.9%	97.2%	+83.3%
Confidence in managing hyperkalaemia with ECG changes (n=36)	11.1%	88.9%	+77.8%
Confidence in managing SVT (n = 36)	0.0%	83.4%	+83.4%

Written feedback from students suggested active participation in a simulated learning environment together with a detailed debrief and facilitated discussion was a powerful learning experience.

Conclusion: This workshop has now been embedded into the teaching timetable at NUH. A-E assessment is a key template doctors of all grades use when facing the most critical situations.

Considering the feedback, introducing more junior students to the structure of an A-E assessment early is essential for creating a scaffold in their long-term memory, ingraining this into their professional practice. This will prepare them for their OSCEs and the new GMC mandated MLA examinations [3] and, more importantly, for when they start their roles as foundation doctors.

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EDUCATION

A83

ASSESSMENT OF THE USE OF ASSORTED METHODS OF SCENARIO PRESENTATION IN COMMUNICATION SKILLS SIMULATION

Anne McKay¹, Claire Langridge¹, Neil McGowan¹; ¹*Queen Elizabeth University Hospital Glasgow, Glasgow, United Kingdom*

Correspondence: anne.mckay@ggc.scot.nhs.uk

10.54531/CEV7298

Background and aim: FY2 doctors in Greater Glasgow and Clyde (GGC) participate in simulation-based learning [1] to improve communication skills in difficult consultations. COVID-19 pandemic restrictions from 2020 – 2022 meant actors could not be present in person for this. Scenarios were therefore adapted to run as remote consultations - two were conducted using Zoom video calls and one by telephone with professional actors, and one ward-based manikin scenario with faculty as actors. We compared the effectiveness of the session, and of each scenario, in improving confidence in communication.

Methods: Questionnaires were completed before and after simulation. Confidence levels were assessed using a Likert Scale (1 – 5) for each scenario. Participants were also asked to rank each scenario (1 – 4) for engagement, realism and relevance to practice at the end of the session, and for which of the three Intended Learning Objectives (ILOs) for each scenario they had gained most information.

Results: Over 10 days, 126 FY2s (6 – 8 per group) and 23 Faculty members participated. 92 completed questionnaires were obtained. ‘Take Forward Messages’ (TFM) from scenario debriefs from 12 groups were correlated with the ILOs.

Overall, there was a significant improvement in confidence in dealing with difficult communication scenarios after the session; (mean ± SEM) score pre 2.87 ± 0.11, post 3.69 ± 0.08, $p < 0.01$. These values did not differ significantly from 2019 when actors were present in person.

When asked to rank which scenario was most effective in different aspects, the case on how to deal with an angry patient (Zoom video call) performed best overall (Figure 1-A83). The manikin-based scenario was lowest rated, but confidence in being ‘assertive under pressure’, one of its ILOs, did improve by 44% from baseline. Confidence levels improved to a lesser degree in the other scenarios on evidence-based medicine (Zoom) and safeguarding a vulnerable adult (telephone). The ILOs participants rated best achieved best by the session were ‘Managing Confrontation and Anger’ (69%)

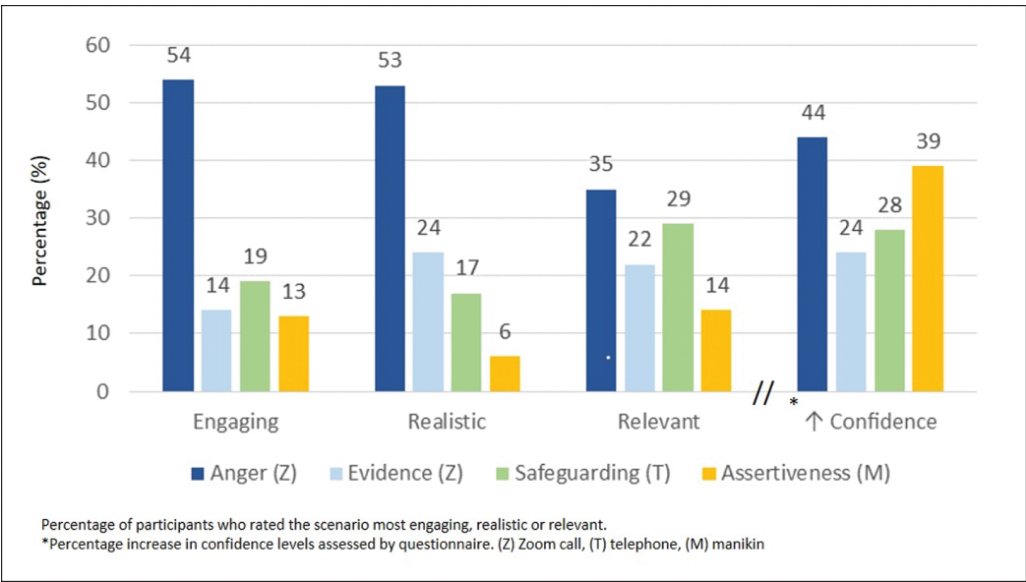


Figure 1-A83: Scenario Quality Assessment and Improvement in Participant Confidence Levels