Background Simulated participants (SPs) play an increasing role in Health Professions Education (HPE) in simulated learning environments. Whilst some are actively involved in teaching intimate examinations in some parts of the world, most SPs are involved in more ‘mundane’ or everyday simulated examinations. We argue that even these ‘mundane’ examinations, such as a chest examination in a female patient, may also be perceived as intrusive and involve unacknowledged sexual undertones. We were interested in power dynamics in such simulated encounters which, unlike in clinical contexts with patients, are less well known. This research looked at SPs’ perceptions of boundary crossing in all examinations on the intimacy continuum, particularly where power dynamics led to subjugation of SPs to clinical tools.

Methods Data was collected from 22 SPs in five focus groups and analysed using thematic analysis, sensitised by Foucault’s concept of the clinical gaze. Data collection and analysis continued iteratively under themes were fully developed, with input from the research team.

Results As students and SPs navigated boundary crossing in simulated examinations, issues of power were apparent. The simulated learning environment permitted SPs themselves, perhaps unintentionally, to further propagate the clinical gaze. Discourses of sexuality were prominent, exemplified by the strong sexual metaphors that the SPs often called on to reflect their feelings of subjugation and even, at times, violation.

Discussion and conclusion In simulated learning environments, the clinical gaze and power dynamics are very important with potentially detrimental consequences. Any simulated examination, however mundane, can be considered ‘intimate’; underpinned by discourses of sexuality, SPs have an important role in guiding students to reflectively navigate the blurred lines between contact that is caring and contact that is sexual, and to acknowledge power relations in such encounters. Simulated learning spaces must no longer permit enactment of the clinical gaze.

REFERENCES

O31 CRITICAL CARE SIMULATION IN UNDERGRADUATE OBSTETRICS & GYNAECOLOGY AT TRINITY COLLEGE DUBLIN: HOW THIS EARLY APPLICATION CAN MAKE A DIFFERENCE
1,2Claire Thompson*, 1Ronan Daly*, 3Gareth Morrison, 2,4Richard Deane, 2,4Professor Deirdre Murphy, 1St James’s Hospital Dublin, James’s Street, Ireland; 2Trinity College Dublin, Dublin, Ireland; 3Antrim Area Hospital, Antrim, Ireland; 4Coombe Women and Infants University Hospital, Dublin, Ireland

Introduction Undergraduate critical care training is often suboptimal. Poor recognition combined with lack of knowledge, failure to appreciate clinical urgency or seek advice and poor communication have been identified as contributory factors. In a recent Year 4 student evaluation conducted by Trinity College Dublin (TCD), only 23% stated that current undergraduate training would prepare them adequately to care for acutely ill patients. To address this, a 2-hour simulation training session on critical care in Obstetrics and Gynaecology was designed.

Methods Observational study comparing student performance managing a critical care scenario before and following a new critical care simulation training session. This applied a systematic ABCDE approach with an Assess, Intervene and Review (AIR) strategy. Students then applied this in simulated cases.

Results 27 students took part. On pre-simulation questionnaire on their confidence in assessing/starting basic management of Airway/Breathing/Circulation/Disability/Exposure. Rated as 1 (no confidence) till 5 (very confident). Participation was voluntary and assurance that this study would not impact final examination results. Students within the last rotation of the academic year were invited. They completed an anonymised Pre- and Post-simulation session questionnaire on their confidence in assessing/starting basic management of Airway/Breathing/Circulation/Disability/Exposure. Rated as 1 (no confidence) till 5 (very confident).

Two 8-minute OSCE structured assessments were designed (First held at the beginning of the rotation/pre-simulation and then at the end of rotation/post-simulation). Clinical scenarios were marked against a standardised proforma by trained TCD staff. Statistical analysis was performed via 2 tailed T-test.

Discussion and conclusion In simulated learning environments, the clinical gaze and power dynamics are very important with potentially detrimental consequences. Any simulated examination, however mundane, can be considered ‘intimate’; underpinned by discourses of sexuality, SPs have an important role in guiding students to reflectively navigate the blurred lines between contact that is caring and contact that is sexual, and to acknowledge power relations in such encounters. Simulated learning spaces must no longer permit enactment of the clinical gaze.

REFERENCES
Discussion/Conclusions Despite the small study number, a clear statistical improvement in performance was seen following the new simulation session. Feedback from the entire year group has been positive.

Early application of simulation is now essential in medical training. This includes undergraduate level, in order to prepare students adequately to provide effective and safe patient care. We therefore fully recommend this approach to expand in undergraduate training.

**Abstract O32 Figure 1**

---

**Discussion/Conclusions** Despite the small study number, a clear statistical improvement in performance was seen following the new simulation session. Feedback from the entire year group has been positive.

Early application of simulation is now essential in medical training. This includes undergraduate level, in order to prepare students adequately to provide effective and safe patient care. We therefore fully recommend this approach to expand in undergraduate training.

**Introduction** Major Haemorrhage carries a high mortality of 32%¹ and requires a co-ordinated response from bloodbank, clinical areas and porters. In-situ simulation can reveal latent threats which are not shown by Patient Safety Incident reporting.² Repeated simulations allow iterative Quality Improvement (QI) to mitigate latent threats. In this tertiary hospital specialising in adult and paediatric cardiac surgery we experience on average 17 Major Haemorrhage cases a year. We report our experiences of SPRinT (Simulated interPRofessional Team Training) in-situ simulations of Major Haemorrhage between 2012 and 2018. We discuss the latent threats identified and arising QI projects.

**Methods** Repeated SPRinT courses were planned cross-departmentally on the ward and in bloodbank to deliver simulated major haemorrhage events. The ‘Plan-Do-Study-Act’ tool was applied to the Massive Blood Loss (MBL) guideline to identify latent threats and deliver QI. Observer checklists measured compliance with any new changes. Systems errors responsible for poor outcomes were identified and staff trained. This process was repeated in multiple PDSA cycles with the aim to reduce latent threats to zero. Time to start transfusion of both the first unit of blood, and subsequent cross-matched blood, were...