Background: Between November 2020 and May 2021, 61 simulation sessions were run either face-to-face or remotely for foundation-level doctors and pre-registration pharmacists. A total of 346 participants attended. Thirty-three sessions were face-to-face (185 participants) and 28 were remotely via Microsoft Teams (161 participants). The content was the same for both modalities.
Aim: The aim of the study was to discern whether there was a difference in learning points and confidence scores between face-to-face and remote participants.
Methods: Participants were asked to rate their confidence (see Table 1) before and after the course. They were asked to provide their main learning points and what they gained from the course. Confidence scores were compared and assessed for change. Responses were compared between face-to-face and remote.

Table 1: Confidence score change on Likert scale 1–5.

Q. no.	How confident do you feel...	Change	
		F2F	REM
1	...that your clinical knowledge is appropriate for your role	+0.67	+0.89
2	... to manage a patient who is peri-arrest	+1.03	+1.27
3	...to manage a patient with a NEWS2 >7 and/or is deteriorating	+0.93	+1.23
4	...that you possess the skills required to communicate information to the rest of the MPT	+0.81	+0.83
5	... that you possess sufficient strategies to raise concerns when necessary	+0.51	+0.64

Results: All participants reported increased confidence. Table 1 shows that the changes were comparable, with the changes in the remote participants all being marginally higher than in face-to-face. The distribution of learning points for remote and face-to-face participants was identical. For both modalities, the top two points were communication and escalation. The dominant theme in remote was escalation and communication in face-to-face. Remote participants were positive about the course, in their free-text responses, 'most innovative use of technology I have seen during COVID' and 'My hands are sweating, I can't believe how real that felt' a common theme in the comments was that they would rather do the course face-to-face.
Implications for practice: While not preferred, remote simulation appears to deliver equivalent learning and is a suitable alternative when face-to-face is impossible. The main difference seen was in communication skills, which is concurrent with Cheng et al. [1] related to the difficulties of communication in a virtual debriefing.

REFERENCE

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55 INTRODUCTION OF A CARDIAC ARREST PROFORMA THROUGH *IN SITU* SIMULATION TRAINING

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Background: The use of *in situ* simulation (ISS) within the Emergency Department (ED) has been widely accepted and has shown to be a valuable teaching tool [1]. At Mid-Yorkshire NHS Trust, we have been running weekly ISS since October 2020. Within the ED, systems and protocols are frequently audited, guidelines often change, and it can be challenging to disseminate this information. After identifying a clinical need for a cardiac arrest proforma, we considered how best to introduce it. We decided to utilize our weekly ISS to provide a valuable learning opportunity.
Aim: The aim of the study was to evaluate the effectiveness of using ISS as a learning opportunity to disseminate and trial the introduction of a new cardiac arrest proforma.
Method: We ran the scenario on two separate occasions involving 11 participants. The simulation involved a low-fidelity manikin and a simulated monitor app. Real equipment is used and the simulation is run in real-time – learners were encouraged to manage the patient as they would in real life. Learners include doctors, nurses, healthcare assistants and student nurses/doctors. Learners are briefed prior to the simulation; in this particular case, the learners were informed that we would be utilizing a cardiac arrest proforma and encouraged to use this. The learners are then debriefed using a promoting excellence and reflective learning (PEARLs) framework and discussion amongst themselves is central to the debrief framework [2]. The purpose of this simulation was multi-faceted; firstly, to discuss the team's management of cardiac arrest and learning around this and, secondly, to discuss the use of the proforma to improve teamwork and patient care. Learners were asked to complete a feedback form.
Results: Feedback obtained from this simulation concluded that it was a valuable learning opportunity. Figure 1 shows the results of learner responses (n = 11). The scale included was 5 (strongly agree) to 1 (strongly disagree) – an average of responses is included within the graph.
Implications for practice: Using ISS to trial our proforma allowed us to implement it within the ED. Collating feedback allowed us to make amendments to our proforma based on multi-disciplinary opinions. As well as recognizing that ISS can be used to achieve this purpose, it also provided a valuable learning opportunity. ISS can be used in future to introduce new guidelines, distribute vital information and provide learning.

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6 ASSESSMENT OF THE CREATION OF A NEW COURSE

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Background: Although commonly used in the clinical environment, insertion of peripherally inserted central catheters (PICC) is not routinely taught to clinical staff. As the procedure requires knowledge in relevant anatomy, sonography skills, and understanding of complications management, it requires dedicated time for teaching. In 2018 no PICC line insertion courses were found in London County.