

principles informed the design of a GP Quick Reference Handbook (QRH) [1,2] and a review of the literature ensured we had the most up to date treatment protocols. Guidance from GPs informed pragmatic recommendations for treatment where limited resources are available. We used in-situ, low-fidelity simulation to train primary care teams to use the QRH. Sessions (lasting 3 hours) were delivered by experienced faculty at 15 practices. Feedback was collected on the design and content of the checklists and the simulation training.

**Results:** Seventeen checklists were produced: 14 to guide clinical actions in acute conditions (e.g. croup, anaphylaxis); one 'key basic plan' to be used when the diagnosis is unclear; a checklist to aid non-clinical staff; and an SBAR (Situation/Background/Assessment/Recommendation) guide for handover of key details to ambulance retrieval teams. The complete QRH can be printed in hard copy or accessed on an electronic device. Feedback on the QRH from multidisciplinary teams in primary care was universally positive. The simulation-based training was extremely popular with 100% agreeing they would like it embedded as normal practice in primary care.

**Conclusion:** Checklists are a vital component of safe work processes in high reliability organisations and, more recently, in secondary care settings in healthcare. Emergency presentations are not easy to manage in GP environments and checklists could enhance team performance in rapidly evolving, uncertain circumstances [3]. We have developed the first QRH for primary care and used it in simulation-based training in 15 GP practices, but further work is required to analyse any improvements in team performance. In order to ensure sustainability of the project, we are working with regional 'learning hubs' for primary care to embed a train the trainer programme and share the QRH nationally.

## REFERENCES

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## THE DOUBLE DEBRIEFING ROOM: A PILOT TO CHALLENGE THE ISSUE OF CAPACITY WHILST ENHANCING EFFICIENCY

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**Background:** Immersive simulation is an expensive education modality with a high faculty requirement, for which its cost effectiveness can come under scrutiny [1]. Physical distancing during the COVID-19 pandemic necessitated decreased participant numbers on simulation courses, leading to significant training implications including an onus on remote learning [2]. We postulated a novel approach to increase course capacity, while maintaining quality, would be to facilitate a 'double debriefing'. When compared with other strategies,

such as online simulation or a hybrid model, this approach could improve effectiveness and engagement, which can be challenging with a 'remote' group of participants.

**Methods:** Two simulation days, involving 28 foundation doctors, were chosen for the pilot study. Participants were randomly allocated to one of two debriefing rooms. Simulations were completed in pairs, with one participant from each room. Following the simulation, the participants returned to their respective debriefing rooms. The debriefing structure was standardised across both rooms through a 3-phase model (Description, Analysis, and Application) with clearly defined learning objectives. Debriefing facilitators rotated between each room. A post-course questionnaire was used to collect qualitative and quantitative data. Five questions explored: Overall course rating; positive aspects of the course; areas for improvement; perceptions of double debriefing; and comparison to previous foundation simulation days. The qualitative data then underwent thematic analysis.

**Results:** All participants rated the courses as excellent or very good (17 and 11 respectively). 19 participants agreed or strongly agreed that double debriefing worked well. 5 neither agreed nor disagreed, 1 disagreed, and 3 did not answer. When compared to previous foundation simulation days, 14 participants stated the experience was better, 9 thought it was equivalent, 1 thought it was worse, 2 did not answer, and 2 had not previously attended. Smaller debriefing groups were seen as a positive, however participants also wanted a smaller overall group size to ensure everyone had the opportunity to participate in a simulation.

**Conclusion:** A 'double debrief' approach to Foundation doctor simulation training is perceived as an acceptable and potentially desirable method to increase course capacity whilst controlling group sizes. This has implications for both increasing access to simulation-based education, but also in delivering more high-quality simulation-based education at minimally increased cost. Moreover, this could enhance the delivery of interprofessional simulation, which often involves larger groups [3]. Larger studies involving more diverse groups of healthcare professionals will be conducted to ascertain wider applicability.

## REFERENCES

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## MAKING REAL DECISIONS: DOES VIRTUAL REALITY MEASURE UP IN THE SIMULATED ENVIRONMENT? – INTERIM RESULTS

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**Background:** Virtual reality (VR) is an expanding area within medical education, accelerated by the COVID-19 pandemic. Use of VR has been explored within multiple areas but there is limited evidence relating its use in teaching clinical decision-making (medical 'expert-thinking') to medical students