

Background: Debriefing is a form of “reflective practice” and provides a means of reflection-on-action in the process of continuous learning [1]. Debriefing and feedback have been recognized as the most important aspects of healthcare simulation [2]. It is necessary for simulation, and educators have reported that debriefing increases learners’ knowledge, skill performance, satisfaction, and self-reflection [3]. The ‘Advancing simulation debriefing’ course was delivered in April 2022. The participants were healthcare professionals who had experience in debriefing.

Methods: The full-day course included reviewing the facilitators’ experience and knowledge of debriefing frameworks and skills, and how these can be adapted and built upon to facilitate more demanding debriefings. During this engaging and interactive course, the attendees were invited to reflect on their own experiences and challenges, and build on active involvement in practising these skills live via tailored exercises. Participants were asked to complete a pre-course and post-course questionnaire rating their knowledge, confidence, and attitudes towards debriefing skills. The learning objectives covered a range of skills, such as learning different strategies for uncovering biases within debriefings and how to address these, how to maintain core psychological safety through challenging debriefings, and how psychologically informed debriefing principles, can enhance debriefing practice, for scenarios with a mental health focus as well as many others. Ethical approval was given by the Psychiatry Nursing and Midwifery Research Ethics Subcommittee at King’s College London (PNM 13/14–179).

Results: Paired samples t-tests were conducted to analyze the difference in ratings between the pre- and post-course questionnaires. Of the 18 participants within the course, 11 provided eligible responses. They were healthcare professionals who were regularly involved in simulation-based education and debriefing. Results demonstrated a significant difference in the scores for all course-specific questions between pre- and post-score answers (pre-course MD=70.81, SD=9.24, post-course MD=96.82, SD=6.35) $t(10)$ test=-7.41, $p<0.0001$, with an average increase of 37% in the total score. Open-text responses reflected improved confidence in the usage of different debriefing models, considering emotional factors, and taking the lead while debriefing.

Conclusion: The course had an impact on improving debriefing skills, especially by improving the facilitators’ confidence in debriefing skills, ability to debrief, and understanding of how debriefing is related to simulation-based learning. These results demonstrate a profound benefit of the use of advanced debriefing skills as a better way to standardize participant experience across different sites to improve healthcare practice.

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SEQUENTIAL SIMULATION AROUND ONCOLOGICAL EMERGENCIES AND COMPASSIONATE CONVERSATIONS IN CANCER CARE FOR PRIMARY CARE HEALTH CARE PROFESSIONALS (HCPS)

Jane Roome¹; ¹*Health Education England Kent Surrey Sussex, Tunbridge Wells, United Kingdom*

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Background: Between 2016–2018, 375,400 people were diagnosed with cancer and between 2017–2019 167,142 people died from cancer in the United Kingdom [1]. 64% of patients with a cancer diagnosis express a wish to die at home although currently only 30% manage to do so [2]. The Primary Care team who look after a person with cancer remains the same unless they move or change practice. Their household will also, in most circumstances, be looked after by the same team. It is therefore vital for healthcare practitioners (HCP) in primary care to be able to recognise different stages in a patient’s disease trajectory and be able to manage this effectively. Integral to this is a need for exemplary communication with the person and their household, in order that a therapeutic relationship with all is maintained [3].

Methods: We worked with the local Macmillan team to develop four different scenarios involving the same 44-year-old woman with a diagnosis of breast cancer. The scenarios were: neutropenic sepsis during chemotherapy, agitation caused by metastatic disease, conversations around completing a ReSPECT form and preferred place of death, and lastly end of life care and recognition of dying. Before each scenario participants were told how much time had elapsed since the patient had last been ‘seen.’ The simulation suite was set up as a consulting room for the first two scenarios and the patient’s home for the remaining two. We used an experienced Simulated Patient with the patient’s wife being played by one of the faculty.

The session was delivered to an interprofessional group of eight participants and comprised of four different HCP roles. It was jointly facilitated by the author and a member of the Macmillan team.

Results: 87.5% of attendees felt that their awareness of oncological emergencies and how they can present in primary care had increased because of the training, with 100% feeling it was relevant to their developmental needs and that it met the learning objectives for the day. There was appreciation of the value of being able to simulate breaking bad news and that the sequential nature of the day made it feel realistic to participants.

Conclusion: Sequential style simulations work well for primary care HCPs who recognise the value of simulation that replicates their own practice. We recommend exploration of further scenarios around end-of-life care and communication.

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PREPARATION FOR PRACTICE: ‘WE DON’T PRACTICE IN ISOLATION, SO LET’S TRAIN TOGETHER’

Kathryn Sharp¹, Stephen Paterson¹, Elizabeth Simpson¹, Ciara King¹, Claire Stark¹, Neil McGowan¹; ¹*NHSGGC, Department of Medical Education, Glasgow, United Kingdom*

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Background: Historically, simulation-based education (SBE) has been delivered to unprofessional groups by unprofessional faculty. This does not reflect the way we