EVALUATING THE ROLE OF PEER FEEDBACK AND IMPLEMENTATION OF A PEER FEEDBACK TOOL IN MEDICAL STUDENT SIMULATION TRAINING

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Introduction: Feedback is integral to simulation-based teaching to ensure effective learning [1]. Peer feedback is the process of providing assessment to students who have a similar level of competence [2]. Peer feedback has been shown to both aid in the development of the assessor's knowledge and skills as well as the student who is being assessed [2]. However, it has been shown that without guidance students have found peer feedback a difficult process [2]. The aims of this study were to assess students' self-perceived abilities at providing peer feedback at a high-fidelity simulation training day and whether the use of a peer feedback tool would improve their ability to provide peer feedback.
Methods: 12 students attended a high-fidelity medical emergencies simulation training day. The students completed a pre-course questionnaire evaluating their comfort at providing peer feedback and whether a peer feedback tool with guidance would improve their confidence and ability in providing peer feedback. 11 students subsequently piloted the peer feedback tool, which contained a combination of tick boxes and free text spaces. The tool aimed to help the students evaluate their peer's scenario and provide feedback. The 11 students who piloted the peer feedback tool completed a post-course questionnaire to evaluate the usefulness of the tool.
Results: The pre-course questionnaire was completed by 12 students. 11 students answered that a tool would help to provide peer feedback. The post-course questionnaire was completed by 11 students. 100% of the students found the peer feedback tool useful and that it improved their ability to provide feedback. 91% of the students found that providing feedback enhanced their learning. 91% of the students found that providing feedback helped to retain their interest in the scenario. 100% of the students found receiving peer feedback useful and improved their understanding of the scenario.
Conclusion: The students felt that giving and receiving peer feedback is beneficial to their learning. The use of a peer feedback tool improved the students' confidence in providing useful feedback to their peers. Going forward the peer feedback tool will be used at future simulation training days to enhance learning for the students. The effectiveness of the tool will be further evaluated by future students completing the post-course questionnaire.

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MAGIC – MANAGEMENT OF ACUTE EMERGENCIES IN GENERAL PRACTICE USING IN-SITU SIMULATION AND CHECKLISTS

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Background: Emergency presentations in General Practice (GP) are increasing, however teams may go months without having to manage one. While guidelines exist for emergency management, most are written for hospital practice, and applicability to primary care is limited. Similarly, simulation training to support teams in the management of emergencies is common in hospital but not in family medicine. An audit of GPs in the Thames Valley revealed significant concerns about providing care for acutely unwell patients and highlighted the conditions they were most worried about.
Methods: We used a Delphi process with a panel of experts to design novel checklists for treating emergency conditions in primary care (Figure 1). Human factors

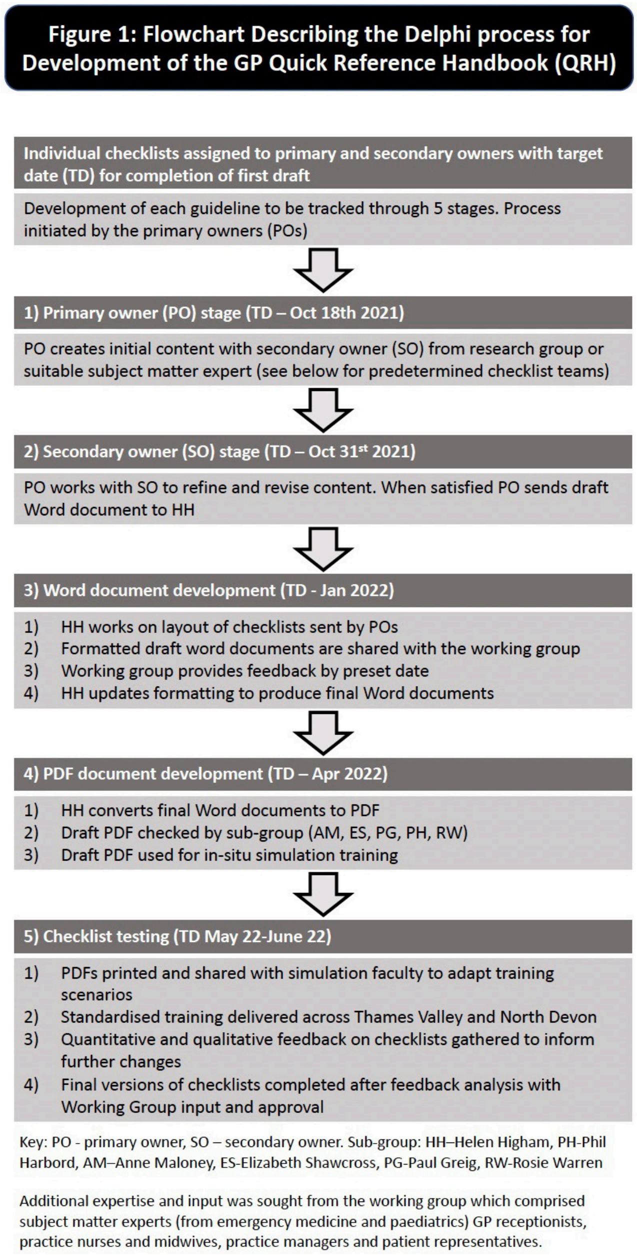

Figure 1: Flowchart describing the Delphi process for the development of the GP Quick Reference Handbook (QRH). Additional expertise and input was thought from the working group which comprised subject matter experts (from emergency medicine and paediatrics), GP receptionists, practice nurses and midwives, practice managers and patient representatives.

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.

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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.

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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