A14.ISS. Even better than the real thing? Using video assisted structured reflection in Simulated Clinical Scenarios and Real-Life Clinical Experiences in the Flipped Classroom.

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Background: This paper explores the attitudes of practitioners to the use of video assisted structured reflection in simulated clinical scenarios and real-life clinical experiences in the context of a Flipped Classroom to encourage and support reflection and reflective practice among pre-hospital emergency care practitioners in Ireland. It also examines the experiences of practitioners who participated in this process. **Methodologies:** This paper is part of a larger project which consisted of three cycles of action research. Data was collected via an online survey questionnaire, and by conducting a series of semi-structured interviews with various stake-holders. These included all three clinical levels of pre-hospital emergency care practitioners and educators from emergency service providers, private ambulance services, and voluntary organisations. **Findings:** When combined, a simulation experience with audio-visual recording and a structured model of reflection in the context of a Flipped Classroom has become a powerful learning experience. The process of a simulation experience with audio-visual recording, and a structured model of reflection appears to dovetail very nicely with the concept of the Flipped Classroom. The review of footage from audio-visual recording in the real-life clinical context provides a reliable and accurate means of evaluating clinical performance. Concerns were raised about the potential for abuse and misuse of audio-visual recordings. There are perceptions that audio-visual footage of real-life clinical experiences could potentially be used for unintended purposes such as, disciplinary procedures. **Recommendations:** Since the process of combining a simulation experience with audio-visual recording and a structured model of reflection in the context of a Flipped Classroom has shown great promise as a learning experience, a larger scale pilot study is proposed. Develop a pilot programme with student practitioners during their undergraduate internship, and evaluate its findings. Develop a policy which clearly defines the use of audio-visual recording footage prior to the commencement of the pilot programme. A learning contract for all participants and faculty, including a confidentiality agreement, must be in place prior to the establishment of the process.

A15.ISS. Refusal to travel in the National Ambulance Service: A retrospective examination of calls from 2017.

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Introduction: When a member of the public calls for an ambulance through the 999/112 system, the only permitted course of action for the responding National Ambulance Service (NAS) staff is to convey the patient to an emergency department. Regardless of the clinical level, NAS staff do not have the authority or scope of practice to discharge the patient from the scene or make any other arrangements for the treatment of that person.(1) The patient, meeting certain criteria, can refuse treatment or transport (RTT) of their own volition.(1) Mortality rates for non-conveyed patients vary from 0.2%-3.5% within 24 hours and are twice those of patients discharged from an emergency department.(2, 3) In 2017, the refusal to travel rate in Ireland jumped from 7-8% of calls (2012-2014) to a national average of 11.3% (24,735) of total AS1 calls.(4) Although this level of non-conveyance would still be below international norms the rate of increase was concerning.(3) **Aim:** A quality improvement initiative necessitated identification of baseline RTT information. **Methods:** Retrospective data collection was conducted on all calls closed with a 'refusal to travel' or 'refusal of treatment' occurring between 1st Jan 2017 and 9th Nov 2017 and was gathered from the National Emergency Operations Centre (NEOC). **Results:** The top three dispatch classification that resulted in RTT were falls, unconsciousness or near fainting, and generally unwell patients. This was followed by chest pain, seizures, traffic incidents and breathing problems. It was noted that the time at which RTT calls occurred peaked nationally between 2000 and 2059. In the Southern area, peak RTT occurred between 2000-2059h and 0000-0100. 33.6% of RTT calls in the Southern Area were designated as Delta calls. This designation requires an advanced life support and a blue light response and is the call level with the second highest acuity below an Echo call, the designation for cardiac or respiratory arrest. **Conclusions:** The NAS specifically utilises a risk adverse triage system. Examination of dispatch priorities may be warranted. The peak close of RTT calls between 2000-2059 may align with a shift changeover at 2000. Further study is required.

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