

Welcome!

Welcome to our simulation newsletter!

The Life Support Learning Center has been performing simulations since 2012. We've created this newsletter to increase awareness of what simulation is, how we perform simulations, and the benefits of simulation.

We believe simulations should be used to help clinicians and students develop and improve their clinical judgment and teamwork skills. We want to do this in a non-judgmental way, by practicing patient care with a pretend patient, and then having a specific, dedicated time to talk about that care.

We will focus on how we

do simulations in the Life Support Learning Center. There are lots of potential ways to run simulations, and we won't pretend to be the final say in anything. But we will explain how we do simulation and why we choose to do it that way.

We plan to include an article relevant to the theme of each issue for additional reading and a more in-depth look.

We'll also have features about our simulationists and our manikins. We're proud of all of them and look forward to introducing them to you!

As we go with this newsletter, please send us your comments, suggestions, and



PICU procedural sedation simulation, January 2020

questions! We appreciate all feedback! Our contact information is in the top left corner of the second page.

Simulation Overview

Simulations can be run in multiple ways, but here's a general overview of how we do the simulation process.

GOALS: We need to know the educational goals of the simulation before we can do anything else.

CREATION: We create the scenario (the plan for the simulation) based on the educational goals.

PREPARATION: Once the scenario is written, we need to collect all the equipment we will need.

RUNNING THE SIMULATION: At the date and time chosen, we use the scenario as a guide to run the simulation. We brief the participants to prepare them for the simulation (if possible). We actually perform the simulation, which is when the participants treat their patient(s). Then we debrief the participants, discussing what went well and what they might want to do differently next time. Each of those three parts is immensely important.

One more thing should be

discussed: safety. The simulation should be a safe place physically and emotionally for the participants and the facilitators.

RESET: Once the simulation is done, we bring everything back to be cleaned and reset. Props and manikins are delicate and need to be cared for.

ASSESSMENT: We ask the participants for their feedback about the simulation. We also do our own debriefing about the simulation.

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Steps of a Simulation:

- Goals
- Creation
- Preparation
- Running the Simulation
 - Briefing
 - Run
 - Debriefing
- Reset
- Assessment

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We create simulation-based experiences for current staff and students to maintain and improve their clinical judgment and teamwork skills during medical emergencies.

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Meet Our Staff!

Meet Laerdal 3G, our primary manikin for adult simulations!

3G, as he's known, is the top of line of Laerdal simulators. He has been with the Life Support Learning Center for more than four years now.

3G is flexible, being able to represent both men and women. 3G is wireless, so no cords or wires are present during simulations. He can be transported from one area to another during a simulation without loss of control.

3G can represent many levels of acuity, from a fami-

ly member who was thought to be fine to a fragile ICU patient.

He has chest rise and fall, breath sounds, pulses in multiple places, heart sounds, pupillary reaction, and bowel sounds. He is very close to an actual human for most aspects of assessment.

3G can be used with our new Zoll defibrillators. We use training pads with him so that no power actually goes to the manikin even though it appears that it did. This allows us an extra level of safety in our simulations.

We have prop IVs and

central lines that we use with 3G, so that participants can give IV medications and fluids.

There are some things that 3G can't simulate. Anything neurological (other than pupils) is problematic, as well as talking to him to assess level of consciousness. 3G's voice is usually done by the simulation facilitator working with him.

In addition, we cannot yet push 3G's vital signs into an actual monitor, so we bring our own monitor to replace the usual one in the simulation's area.

3G is a cool person to

Safety

There are several types of safety that have to be considered in simulations.

The physical safety of the participants is most important. No needlesticks and no participant is defibrillated! We design our simulations to protect physical safety.

Emotional safety is important to the participants. Having others watch you care for a patient can be disconcerting. We mitigate this by discussing at the start that simulation is a safe place, even if the care is not perfect. The manikin is plastic, and nothing bad happens in simulation — but the simulation can help improve the participants' care of actual patients.

Finally, the manikin also needs to be protected. Our manikins represent considerable investment by the Health System, and we need them to function as long as possible.

Journal Article Spotlight

We've chosen our journal article for this issue because it's a good implementation-level overview of a simulation process. In future months, we'll do a higher-level overview of simulation, and then go into more details of the various parts of simulation.

Our article is Herbers, M.D. & Heaser, J.A. (2016). Implementing an In Situ Mock Code Quality Improvement Program. *American Journal of Critical Care*, 25(5), 393-398. From a HealthSystem computer, the following link should get you the entire article:

[Click here for article](#)



work with. He never complains and is happy to do all that we ask of him. If you haven't met 3G yet, we hope you can soon!