UVA Health

UVa Health Simulation News

UVAHealth Life Support Learning Center

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Welcome!

Welcome to our Simulation Newsletter!

We continue to walk through the steps of a simulation again, but with a great focus on what this means for you, the person who is asking for the simulations, instead of us, the simulationists.

This month is again Running the simulation, and specifically the Debriefing after the scenario has ended. Even though we talked about this last month, this topic is so important that it gets two months as our focus.

Please send us your feedback! *Our contact information is in the top left corner of the second page.*

Psychosocial Safety

The debriefing is where the participants and the facilitators discuss what happened in the scenario. This is not necessarily a safe place for our participants. What if things didn't go well?

We are highly aware of the difficulties that can occur in a debriefing. The new nurse may not want others to see what he doesn't know. The fellow new to UVa may not want to show she doesn't know UVa's way of doing things. The experienced provider who's been doing this for 20 years may have a lot of their self-image connected to being good at what they do. And no one likes being told they're doing something wrong.

We try to be gentle with our feedback and ensure other participants are, too. If we see something that needs to be fixed, we will bring it up — but calmly, by asking questions, and hopefully guiding the participants to their own answers. It's psychologically more comfortable for someone to make their own decision about what they know than being told it by someone else.

We prefer to have a discussion amongst equals. Let's talk about how we can be better at what we do.

The Basic Assumption

Frequently, participants see a simulation as a test — something they will be graded on. And they're not completely wrong. We won't grade it with numbers, but the whole group (ideally the participants themselves) will critique it.

That's part of the psychological risk to being in a simulation that we describe above. One way we try to mitigate that risk is by using the Basic Assumption. There are different versions of this. Harvard University's Center for Medical Simulation uses "We believe everyone in the simulation is intelligent, capable, cares about doing their best and wants to improve." Our variation is not formally written down but usually is similar to "We believe everyone here is a competent clinician. That's not why we're doing this. We're here simulating with you to help improve the care you already give."

While we describe the Basic Assumption in the briefing, we use it in the debriefing. If someone looks like the debriefing is causing them distress, we'll stop and return to the Basic Assumption. We're not here to grade — we're here to help you improve from where you already are.

Inside this issue:

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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We can use Standardized Patients instead of manikins. This is a new ED RN practicing determining sick vs. not-sick. Your newsletter editor is the patient (which is why we're showing his face).

Another ED picture, this time from the ED Peds ongoing simulations. This newborn simulation was reported to be very useful for them. We wish we could show the participants' faces, so you could see how focused they were.

Debriefing Guidelines

We set our debriefing guidelines in our briefing step (where we also discuss the Basic Assumption) in what we call the Vegas speech: what happens in simulation stays in simulation.

After we discuss that we will run the simulation and then talk about it afterwards, we start the Vegas speech. We ask participants not to discuss what happened in the simulation (including the debriefing) with people outside the simulation for two reasons: we reuse the simulations, but more importantly, because it's not fair to "Monday Morning Quarterback" from outside the simulation. Every simulation and every real-life case runs slightly differently. People who were inside the simulation can discuss the simulation, but no one else.

It's also why we won't report specifics of who did what outside the simulation. If a provider makes a medication error and we believe we have a system fix for it, we'll discuss that, but not who made the mistake. This helps preserve psychosocial safety for the participants.

Using Open-Ended Questions and Silence

The simulation is for the participants. So, when we are debriefing, we try to use open-ended questions as much as possible, inviting participants to share their thought processes, describe their reasoning, or ask a question to the group.

We also are very willing to allow silence. Open-ended questions usually have complicated answers, and people need time to process what they did and how they would describe it. Simulation has the luxury of time, and we make use of that. Participants provide better, more thoughtful answers when we allow silence and reflective thought.

This also goes back to the discussion amongst equals concept. We can all discuss how this went in a deep and thoughtful manner.

Journal Article Spotlight

Since we are using the article from last month to help structure this month's newsletter, we are including it again here. It's a very well-written article on the different types of debriefing and why debriefing is important. It is Abulebda, K. et al. (20). Debriefing techniques utilized in medical simulation. Retrieved from StatPearls July 21, 2022 at the following link: https://pubmed.ncbi.nlm.nih.gov/31536266/.

Extensions

Extensions are our own addition to the debriefing process. In addition to "What went well?" and "What would you like to do differently?" (the Plus-Delta method), we also ask "What if…?" What if your patient's blood pressure was better? Would you still start the vasopressor? What if your patient didn't turn around after your first intervention? What was your next intervention going to be? What if your patient's vital signs were just a little worse?

We use these to help participants clarify where their decision lines are. How bad does the patient have to be for me to want to do X (give a medication, Come Now page the physician, start bagging the patient)? It adds several small clinical situation discussions to the one full simulation.