



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 Running the simulation, and specifically the Debriefing after the scenario has ended.

This is the most important part of the simulation. It

allows the participants to discuss what happened, critique themselves, and lock in new knowledge.

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

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Steps of a Simulation:

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

Types of Debriefing

The debriefing is where the participants and the facilitators discuss what happened in the scenario. How should we structure that?

We could have a teacher talk, describing what the team did well and what they need to improve next time. All of our participants have been in classes at some point, so they know how that works. But we don't do that.

Instead, we look for the participants to critique themselves. We do Plus-Delta with Extensions debriefings. The Plus is asking what went well. The Delta is asking what could be done differently next time. Extensions are when we ask what-ifs — what if your patient was sicker? Or not quite as sick? Would you do the same thing?

We feel teacher-led debriefings are good in classes

with new information. In our simulations, we have the time to have the participants reason things out themselves.

By asking the participants the Plus and Delta questions, they need to focus on what they did and why. This allows them to assess their actions in the simulation and improve their actions next time with actual patients.

Connections

We want the debriefing to be participant-run as much as possible for several reasons. One of them is that participant-run debriefings help the participants make real-life (well, almost real-life) connections to what they've learned before.

As the facilitators, we can see what topics the participants are bringing up. If they aren't bringing up areas related to the goals of the simulation, we can. Either

way, as they think through the topics, they are making connections in their minds that are reinforcements of what they learned in classes or trainings.

Those classes and trainings make the initial thought pathways ("a patient in shock may have a high heart rate") while the simulation reinforces that ("my patient had a high heart rate *bing* and a high respiratory rate *bing* and her blood pres-

sure was drifting down *bing* — I think she was in shock"). In this example, the participant is taking several things learned in classes and putting them together in one case. It's inductive reasoning instead of the deductive reasoning frequently done in classes, and the type of reasoning clinicians need to use at the bedside.

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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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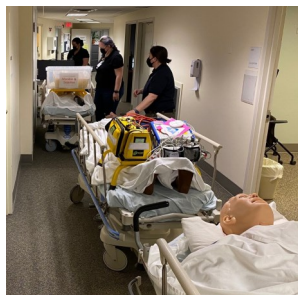
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Our newsletter repository:

<https://www.medicalcenter.virginia.edu/medicalcenter/simulation-newsletters>



From the Anesthesiology Boot Camp this summer. Our manikins can be intubated. Notice our monitor in the foreground in yellow, but also notice the actual anesthesia machine on the left. We do not anesthetize the manikins (it's hard to get anesthesia gases back out of their lungs), but we can have the actual anesthesia machine give the participants certain alarms.



A parade of manikins going to Endoscopy. There are four in all (one Resusci-Anne at the front of the line).

Concrete Examples

Let's use the patient in shock as an example again. In the debriefing, the participant walks through their reasons for believing the patient was in shock: tachycardia, tachypnea, cool skin, blood pressure falling. This participant now has a specific, concrete example of what a patient in shock might look like.

As a different example, we know that lack of breath sounds on one side might indicate a pneumothorax. How many people have found that on a real patient? We can make the manikin show that, as well as lack of chest wall motion and bad vital signs that all connect to a pneumothorax. Now the participant has a specific, concrete example of a pneumothorax.

This idea of giving a concrete example is really useful for simulations about new patient types, new procedures, or working in new areas. We can talk about these all we want, but it helps to actually see them and be able to discuss them before having them with real patients.

Ability to Self-Critique

We believe the participants should critique themselves as much as possible, with occasional guidance or support from the facilitator. In addition to being useful in the simulation, this debriefing style allows the participants to critique themselves after actual events. In the real world, we often don't hold a debriefing after major events (though we should!) and so our simulations give the participants a way to debrief themselves after such events throughout their careers.

Journal Article Spotlight

This month's journal article is from StatPearls. 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/>.

We like this article so much we're going to use it to structure next month's newsletter, which will be a continuation of discussing debriefing.

When to Step In

This question, when to step in to be more active in a debriefing, is not as clear-cut as when to stop the run of a simulation (discussed last month). The scenario, the run of the simulation, is for the students, but the debriefing is where we want to solidify the goals of the simulation. We may need to be a little more directive to make that happen.

Even so, we try to use a light touch. We ask questions that help the participants get to our goals. We won't say, "Why didn't you notice the patient was in shock?", but rather ask questions to help the participants get to recognizing shock and understanding it better.

Occasionally, the participants won't get there — the topic is too new to them, or we didn't build the scenario well enough, or it just didn't happen. In those cases, we may need to become more of a teacher than a facilitator. This does happen sometimes, and when it does that's OK, but even here we are trying to help the participants connect this new information back to things they already know.