



### 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 Run of the simulation itself.

This is the thing we've been preparing for. Let's

have the participants take care of the patient and see what happens. There's a lot happening during this.

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

### How to Say Go

We've finished the briefing and now it's time to start the simulation. How do we say go?

Well, just say, "go", right?

There's more to it than that. We want to help immerse the participants in the simulation by making it clear the simulation has started.

We can have an ally or a simulationist be the "charge nurse" and start describing the patient coming in.

We can describe where the group is in a procedure, giving them enough information to imagine themselves in the procedure, and then say, "And here we go."

We can have an ally give them report from the off-

going provider.

In each case, we are using the "go" process to help the participants suspend disbelief and come into the simulation.

We need you to help us understand how your area deals with patient flow and provider handoffs to make this start realistic.

### What to Watch For

So much to do during the simulation run! Everyone is so busy!

What should the simulationists and allies look for?

It all goes back to the goals. What do you want your providers to get from the simulation?

We're taking notes (on paper or in your head) about what should be discussed in the debriefing. The participants will do much of the debriefing, but we can also choose some of the topics. Sometimes we

have incidental findings that we can discuss, but most of the discussion will be structured by the goals.

If a goal relates to patient assessment, how are they assessing the patient? Are they assessing everything they need to? If they're missed something, what is it, and why? Are they going back later to catch it?

If a goal relates to communication, how are they communicating? Is there good closed-loop communication? Who is the Team

Leader? Who is the actual Team Leader (not always the same person)?

If a goal relates to choosing interventions, how are they intervening for their patient? Are those interventions reasonable? What are their decision processes behind their interventions?

We need to know what you'd want them to do so we can look to see if they're doing it.

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### Steps of a Simulation:

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

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Only one picture this time, but we'll discuss it in detail.

This is from the ED 500s simulation in June. It's a trauma alert which has come into the ED. The patient is being logrolled to assess his back (they should look, even in a simulation — we've taped props to the back of manikins before).

In the picture is a resident, a nurse, a paramedic, and two ED Techs. ED simulations involve the entire patient care team.

Around the manikin's right elbow, you can see the drain line for the rigged IV that the team started. We have props that allow the team to perform procedures, and then use those props for other things. In this case, the patient was given medications, IV fluids, and blood products.

## The Technical Side of the Run

While the simulation is running, the simulationists are controlling the manikin and other props (such as the patient monitor) to show the participants what we want them to see. We're also adding or removing props from the simulation. Depending on the scenario, this can keep us hopping!

We're also looking to see how we need to change the scenario. Do the participants need a few extra moments to make a decision before going to the next step? Can we change the vital signs a bit to nudge them in the right direction? Are they going on the path we expected, or are they going a different way — and, if so, do we need to help them back to our path or not? We don't necessarily need to "fix" every variation. The scenario is a guide, not a script.

We try to make the scenario show them what we wanted them to see when we made the goals. Sometimes, we ad-lib a bit to make that happen by tweaking vital signs or making time be flexible. We are constantly adjusting to give the participants the best experience.

## When to Step Inside

The participants should be the actors in the simulation. The simulationists are the stage crew who stay offstage. Usually. Occasionally, we step "inside" the simulation.

If there is a manikin or a prop failure, we step in with an apology, a quick fix of some sort, and get the simulation running again.

If this is a "no-look" simulation, we may need to help participants understand what they can and can't do.

We try to stay inside as little as possible. The simulation belongs to the participants, not us.

## Journal Article Spotlight

This month's journal article is on in-situ simulations gives details about how the simulations were run. Also, it has a CT scan of a manikin! The article is Schofield, L. et al. (2018). In-situ simulation. *Trauma (20)*4. The following link should work from any UVa computer:  
<https://journals.sagepub.com/doi/full/10.1177/1460408617711729>.

## When to Stop a Simulation

It is quite rare to actually stop a simulation midway through. If we do, it's usually because the simulation has gone completely sideways and not remotely near where we wanted it to be. This is different than the participants simply going a different way than what we expected — we won't stop if they're providing care that is reasonable. We will stop if they are going into care that is totally not related to the simulation or is dangerous.

If we do stop a simulation, we'll take a moment to see where people are and what they believe is happening. If we didn't deliver information well, we'll correct it. If the patient would die from their actions or inactions, we won't do a punitive death — we'll help them figure it out. Then we'll go back into the simulation.