

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 the final item of the process: Assessment. Assessment is different than grading. We'll talk about assessment on Page 1. As a different

topic, we'll discuss some particular types of scenarios on Page 2.

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

Formal and Informal Feedback

Assessment is different from the debriefing and is different from grading (which we rarely do). Assessment is looking at the scenario and the simulation to see how well they helped the participants reach the educational goals of the simulation. In other words, we're looking at us.

We send out an anonymous survey through Qualtrics after our simulations asking for feedback. In the survey invitation, we describe things we saw and discussed, as a way to extend the debriefing. The

survey itself, however, is designed to allow the participants to tell us about the simulation. Unsurprisingly, the first two questions are "What went well?" and "What needs improvement?" which should sound like our debriefings. We also ask how they will change their practice, if they have any suggestions for us, and if they would recommend simulation to others. In the more than one thousand responses we've received, less than ten said "No". We share this anonymous feedback with you.

We also sometimes verbally ask one question right after a debriefing: "Was it worth your time?" Most answers are some version of "Yes".

Sometimes, we'll touch base with you to see if you have received any feedback directly from the participants.

We are also occasionally lucky enough to hear back from participants or even non-participants about how our simulations helped with an actual patient. That is our best thing to hear!

Updating and Refining

We also try to have a quick huddle with you, called a hot wash, right after the simulation ends. This is also a version of "What went well, and what could we do differently next time?" What could be tweaked or changed to improve the next time we run this simulation or any simu-

lation?

We do this even for scenarios we don't plan to run again. We want to constantly improve what we do.

This is also a great way for you to affect how we do simulations. Did we achieve your educational goals? Did

we build what you wanted your participants to see? Was this valuable to you?

We'll also update our Things Needed lists — what do we need to bring to run a simulation like this?

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



And sometimes, the manikin does code.
It is a useful simulation.

PICU above, ED below.



Sims Don't Have to Be Codes

Like last month with Ivy Orthopedics, we were fortunate to participate in amazing Emergency Medicine simulations with the Palliative Care team with the goal of improving resident performance of death disclosures.

Telling someone that their family member has died is obviously a difficult thing to do. The Palliative Care team members did a fantastic job of portraying different types of family members (as Standardized Patients) and then participating in the debriefing.

It was an honor and a joy to work with them!

It's also a reminder that simulations can be about more than just clinical care. We can simulate just about any part of health care. Death disclosures can be a particularly difficult area that thankfully doesn't happen very often. Let's allow residents to do their first death disclosure with a pretend family member.

High-Acuity Low-Frequency Sims

There are a wide range of non-code simulations that we can run. Many of these are high-acuity low-frequency scenarios — the situations that make providers nervous. Some we've run recently were an euglycemic DKA scenario on a floor for MET, a newborn child for the Emergency Department, and a postpartum preeclampsia for Family Medicine.

These high-acuity low-frequency scenarios are perfect for custom simulations. Every area has the thing it does that others don't do: TCV opens chests, 6C has patients with epilepsy, 4C TX has transplants, and so on. Each of these special patients is simulatable. Some areas are already doing simulations with these kinds of patients (ED, PICU, IR, STICU, ...) — you could, too!

Journal Article Spotlight

This month's journal article is related to the Emergency Medicine/Palliative Care simulation described above. It describes an end-of-life simulation for pediatric ICU nurses which brought up some of the same topics that UVA's simulations did. The article is Hillier, M. M., et al. (2021). Utilizing high-fidelity simulation to improve newly licensed pediatric intensive care unit nurses' experiences with end-of-life care. *Journal for Specialists in Pediatric Nursing* (27)1. The following link should work from any UVA computer:

<https://onlinelibrary.wiley.com/doi/epdf/10.1111/jspn.12360>.

Skill Simulations

Simulations don't have to be just practicing codes. We can do various types of deteriorating patients, and we can do process simulations. We can also do skill simulations. For instance, the STICU, the ED, and the PICU use simulations to check their staff off on procedural sedations.

Over the course of a few hours, the participants will see four different procedural sedation patients with varying complexity. They likely will see more with our manikins than they would with four actual patients. Feedback for these simulations has been excellent!