

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 focusing on Resetting. This is not the flashiest topic. So, we will also discuss a specific example of a process simulation in the articles on the sec-

ond page.

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

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Removal from the Simulation Area

Once the debriefing is done, we can start resetting and removing ourselves from the simulation area. We don't start cleaning up until after the debriefing is done — if we do, the participants will assume the debriefing is finished.

Most times, we have plenty of time for removing our equipment, such as when we're in the Educational Resource Center's Sim Room or in one of our own

rooms in the LSLC. However, when we do *in situ* simulations, we need to be able to clear the room in five minutes, such as during our last ED simulation in one of the trauma bays when they had an actual patient coming in.

The biggest thing here is that we need to ensure all of our equipment leaves with us. We especially cannot leave any of our fake medicines. There are rare

but scary stories from elsewhere of simulated medications getting into the real world. We work to prevent this by hand-labelling our medications and having a red "Not for Human Use" sticker on all of them.

We also need to make sure we don't take any of the real world's equipment and that the room is basically clean and ready to go.

Resetting in Our Area

Once we're out of the simulation area, we can take a little more time — which we'll need.

Everything should be reset as soon as possible after our simulation. This prevents us from bringing props that aren't ready to our next simulation (which may be later that day).

We clean the manikin. We use paper tape for a lot of our props because it's easier to remove. Tape

residue can be hard to get off the manikins!

Our manikins and their controllers need to be recharged. It's a very bad feeling to show up at a simulation with a dead manikin.

Our various props need to be cleaned, emptied, and/or refilled. The IV drain lines need to be emptied and have new IV covers stocked with them. The IV medications that were used need to be refilled (with normal

saline — we don't use actual medications). Other props, such as nasal cannulas, need to be reset.

If we do have another simulation coming up soon, we need to ensure the props from this simulation roll forward to the next simulation.

While resetting isn't the most exciting part of simulation, it is important.

Steps of a Simulation:

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

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Ivy Orthopedics staff working with their simulated patient. Notice the different style bed and the bedside monitor that has more capabilities than a Dynamap (including capnography).



The patient is being transferred to the Medical Transport Network stretcher. A question that arose: if the nurses are physically present and a physician is on a telemedicine call into the room, who gives report to the EMS providers?

Ivy Orthopedics Process Simulation

We were fortunate to be invited to help the new Ivy Orthopedics facility with a simulation. This was a process simulation to help them and their team understand how to run the overnight unit in the building. Some of their patients will stay overnight in patient rooms with nurses on site and a physician available by telemedicine link.

Any time a new unit opens up, a new process is instituted, or a new type of patient is coming into an area, process simulations can be helpful. They are not designed to practice clinical care but rather try out the thing that is new. In this case, the simulation was designed to use the new types of equipment in the building, the telemedicine link with a physician, and the interaction with EMS providers for transport to the ED.

We had actual providers performing their own roles: two night-shift nurses, a physician, and a paramedic and AEMT from Medical Transport Network. Everyone did what they would do in real life, in real time, to see what would really happen.

Results of the Simulation

The simulation found seven major topics of interest: Dynamap vs. bedside monitor, emergency equipment location, telemedicine use, iSTAT use, the use of capnography, report to EMS, and the EMS report sheet. Some of these had been considered previously, but this simulation helped highlight the benefits and still-remaining difficulties.

The largest benefit is that all of these topics were brought up before any actual patients came into the area. We found issues before they made it to the patients.

We are happy and grateful to have been part of this and would recommend this type of simulation to anyone who will be starting something new!

Journal Article Spotlight

We've found multiple examples of process simulations in the literature. This month, we'll include links to four of them here:
https://journals.lww.com/pec-online/Fulltext/2021/05000/Simulation_as_a_Dynamic_Tool_to_Reorganize.10.aspx (pediatric resuscitation in the ED);
<https://pubmed.ncbi.nlm.nih.gov/34309137/> (CT scheduling in the ED);
<https://www.sciencedirect.com/science/article/pii/S1553725021002464?via%3Dihub> (new helipad testing);
<https://www.sciencedirect.com/science/article/pii/S0099176722000125?via%3Dihub> (removing patients from their cars emergently in the ED).



Our New HAL manikin getting a ride to Ivy Orthopedics for her simulation job. Notice the seat belt — they're good for everyone!