



### Welcome!

Welcome to our Simulation Newsletter!

We are going to start this year by going through the steps of a simulation, as we have in previous years. Each month will be one of the steps.

We've done Goals, Creation, and Preparation. This month, we'll discuss Briefing (part of running the simulation).

Briefing (also called a Prebrief) sets up our participants for success. It gives them clear expectations, a

broad view of what will happen, establishes the fiction contract, and helps the simulationist set the scene for psychological safety.

Please send us your feedback! *Our contact information is in the top left cor-*

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### Briefing Defines Clear Expectations

As much as we'd like it to be, a simulation is not reality. Therefore, it has its own rules. For a real patient, we can place an IV. With most manikins, we don't want them to pierce the skin, so we need to clarify the "rules."

We need to tell participants how they will receive information and what the manikin's capabilities are. Does this manikin have pulses everywhere, in just a few locations, or none at all? How does the participant assess information beyond the manikin's means?

Is this information we feed to them?

We also discuss who will be in the simulation. Will we have multiple disciplines involved? If not, will other roles need to be played by someone (often the simulationist)? Who will voice the manikin? If the scenario needs a family member, who will play that role?

Another important piece to include is how time will flow. For most simulations, we try not to manipulate time. Simulating in real time allows for more realistic expectations when car-

ing for our patients. It allows us to work through processes in a more credible fashion. Occasionally, to meet the objectives of the simulation within our timeframe, we need to perform a time jump (such as taking the patient to CT and having the CT read).

Lastly, we need to provide the overarching structure of simulation: We will do a briefing, we will run the simulation, and then we will debrief the simulation, asking what went well and what they would like to do differently next time.

### Why We Might Not Do a Briefing

There are a few simulations that are run without warning. We have run In-House Adult Mock Codes where there is no advance notice. These simply occur. Typically, these simulations test our system (not individuals). When we call a code,

who arrives? How many people? Do we have the correct team members for the code? Are there processes that impede the code?

With this type of no-warning simulation, we cannot do a briefing. It means that as simulationists, we

have to help the participants with the events of the simulation more than we would otherwise. We may have to step into the simulation to place an IV, for instance. A no-warning simulation is more difficult for both the participants and simulationists.

### 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 improve their clinical judgment and teamwork skills during medical emergencies.

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**Our newsletter repository:**

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

## Pictures!

An ED nurse inserts a single lumen trach after troubleshooting other trach issues.



ED staff cares for a complex trauma patient in hypovolemic shock with an open book pelvic fracture. They assessed the patient with the ATLS and TNCC surveys to find and treat lethal issues. They transfused using Whole Blood, a new process in the ED.

## Simulation Details

We have a range of manikins and monitors with varying capabilities. Many of our manikins can be intubated but only one can have a chest tube inserted. Depending upon the manikin, we set up our Zoll differently for defibrillation purposes.

Even with participants that we do simulation with frequently, we ensure participants have an understanding of how the manikin/monitor will give them information upon which to act. This includes patient assessment details, how to do procedures, and how to give medications. In one infant simulation, the LIP asks for intranasal midazolam. Unlike medications in our rigged IVs, we don't want participants to instill fluid in the manikin's nose. This needs to be spelled out prior to simulation to protect the manikin. With in situ sims, we try to place items where they would normally be found, such as an Ambu bag at the head of the bed. Understanding these details with the Briefing helps the flow of the simulation.

## Psychological Safety in Vegas

"What happens in Vegas, stays in Vegas" is a mainstay of the Briefing. Simulation is solely for the participants. Whether or not they do "well" is not the point of simulation. Our goal is to develop pathways for clinical judgement to develop that will change future patient outcomes positively. We don't talk about how the simulation went with others outside the walls of that particular simulation. We don't grade them. We often write down things for the debriefing or to tweak our sims but not for grading.

We espouse the Harvard Basic Assumption: We believe that everyone participating in sim is intelligent, capable, and cares about doing their best and wants to improve. Our participants are competent clinicians. Our role is to give them practice with a situation we know is difficult. We are trying to protect their psychological safety in that situation.

## Journal Article

Our article this month is from Rudolph, JW, et al. (2014). Establishing a Safe Container for Learning in Simulation: The Role of the Presimulation Briefing. *Simulation in Healthcare: Journal of the Society for Simulation in Healthcare*. 9 (6); p 339-349, December 2014. This article expounds upon each component of a Briefing: (1) clarifying expectations, (2) establishing a "fiction contract," (3) logistics, and (4) psychological safety.

We have a link for this that should work from any computer:  
[https://journals-lww-com.proxy1.library.virginia.edu/simulationinhealthcare/fulltext/2014/12000/establishing\\_a\\_safe\\_container\\_for\\_learning\\_in.2.aspx](https://journals-lww-com.proxy1.library.virginia.edu/simulationinhealthcare/fulltext/2014/12000/establishing_a_safe_container_for_learning_in.2.aspx)

## Editorial

Although all components of the Briefing are important, establishing psychological safety is the most critical component to me. This can't just be stated; it must be demonstrated by the simulationist during the entire simulation run. There is a plethora of research that positively correlates psychological safety with information learned. Participants are more likely to be engaged through the run and debrief. They are willing to "work at the edge of their expertise or capacity where mistakes are likely" (Rudolph), knowing it is OK to be make mistakes. Psychological safety provides the safety net—not to rescue, but to allow the willingness to try. When we stretch, we grow.