



### 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 discussed the preparation work and we've Briefed the participants. This month, we'll talk about the Run of the simulation.

This is what people think of when they think "simulation" — we have participants actively caring

for our plastic patient. How do we make that go well?

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

### What Is the Simulation Run?

A simulation is a chance for participants to care for a patient who isn't a real patient. This is the Run: participants caring for the pretend patient.

So what does the simulation team do during the simulation? From the outside, it will look like we are doing as little as possible. We are the stage crew, running things in the background. We run the manikin, showing the participants how the patient is changing. We push information to the participants that the manikin can't provide, such as skin

color, grip strength, and voice responses. We will add props (such as a new IV line) as the participants continue their care. As the participants request additional friends, we portray those friends or give their responses. As much as possible, though, we blend into the background.

What the participants don't see is the work we are doing to ensure the simulation continues to run in a useful way.

If the participants are getting off track, we use the

patient's monitor and other responses to help steer the participants. If we have an ally in the room, the ally may give hints or even suggestions to redirect the participants. We can also make time be flexible to give the participants more time to think.

Our job is to make the simulation flow with the lightest touch that is effective to help the participants make new and correct treatment pathways in their minds.

### What Is the Run Not?

It's important to realize the Run is for the participants to care for the patient themselves, with as little outside help as possible. That means the simulation is not teaching, lecturing, or a presentation. It's not a class — it's a "putting it all together" chance for them

to handle the whole situation on their own.

As a result, we don't answer questions during the simulation (other than providing information the manikin can't). The participants need to make their decision in the moment. If it's the wrong decision (or

the right decision), we'll discuss it in the Debriefing.

Most of our participants are clinicians here at UVa, not students. They should already know lots of stuff. This is the chance to apply their knowledge in a safe environment.

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### Steps of a Simulation:

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

**UVAHealth  
Life Support Learning Center**

1222 Jefferson Park Ave  
Fifth Floor, Room 5603  
Box 800309  
Charlottesville, VA 22903

Phone: (434) 924-1765  
Email: [jph5z@uvahealth.org](mailto:jph5z@uvahealth.org)

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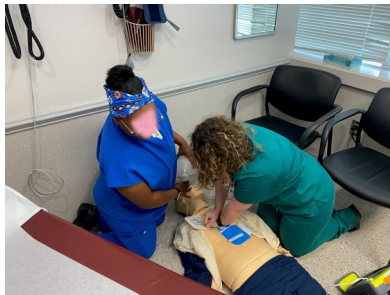
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## Pictures!



Northridge Internal Medicine staff treat a patient after solving the “patient coding in a chair” problem by bringing the patient to the floor. They’re using a practice AED.



Two ED nurses are treating an MCI of several patients. See how many patients you can find! (The adult patient under the blue sheet is not one of them.)

## Stepping Back

One of the hardest things to do as a simulationist is to step back and not interfere in the simulation. The simulation is for the participants to make their own choices. We should allow them to see their actions either help the patient to improve or see their actions make the patient worse (though we won’t do a punitive death of the simulated patient).

To clarify, we can certainly show them patient deterioration if they are choosing sub-optimal interventions. However, we can also allow them time to recognize the deterioration and figure out how to recover themselves if they’re going down a wrong pathway. This is really important and something we can’t do with a real patient. A plastic patient is the safest patient on which to practice recovery from a previous decision.

In addition, it allows the team to work together to make their own decisions without having an instructor tell them what to do.

## Stepping In, Rarely

It is very rare, but occasionally we do need to step in as the simulationists and create a time-out in the simulation. It’s happened perhaps six times in the twelve years we’ve been doing simulations. It’s most often a situation where the simulation (not the patient) has gone so sideways that it’s unrecoverable.

When that happens, we will step in a stop the simulation. We then usually ask questions: ‘What’s going on, what do you think is happening, why do you think that, what would you like to do about it?’ And then we back the simulation up to a spot before it went sideways and restart the simulation from there.

Again, we prefer discussion to lecture, allowing the participants to have time to think so they can figure out what they should be doing.

## Journal Article

Our article this month is from Behrens, CC, et al. (2023). ‘Dancing with Emotions’: An Interpretive Descriptive Study of Facilitators Recognition and Response to Students’ Emotions During Simulation. *Medical Education*, 59(40); p 439-448, April 2025. This article discusses how simulationists react and adjust to the participants during the Run.

We have a link for this that should work from any UVa computer:

<https://asme-publications-onlinelibrary-wiley-com.proxy1.library.virginia.edu/doi/epdf/10.1111/medu.15554>

## Editorial

This month’s editorial is not going to be a surprise, as this month’s issue topic is running a simulation. We should do more of them!

There is now plenty of evidence, both in the literature as well as our anecdotal reports and simulation surveys, that says that simulation helps health care providers give better care.

In addition to clinical improvement, there is also a lot of evidence saying that simulations can help with process and system improvements. We have an excellent example of that which will appear in a future issue.

We should do more simulations!