



Welcome!

Welcome to our Simulation Newsletter!

We're going to discuss some of the secondary gains that simulation can provide, not only to the participants, but their areas as well.

This month's secondary gain will be in discovering your ideal state. When we do simulations, we need to know what you want you participants to see and hopefully do in the situation. That requires you to

know what you want them to do. Sometimes, that's not an easy question to answer.

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

Educational Goals

As we've said before, when you come to us and say, "We'd like to do some simulations," we'll say yes (because we're nice people) and ask what you want to do. The next question will be "What do you want your people to get from it?"

The educational goals drive everything. We do simulations for a reason, not just because they're cool (even

though they are). If you ask us to simulate a code, we'll ask what parts you want to focus on and why. Are you looking for practice with compressions, team communication, or trying to figure out why the patient is coding?

If you ask us to simulate a deteriorating patient (one of our favorite topics!), we'll ask what you what

your team to practice: nurses using protocol orders, physicians making a differential diagnosis, or PCTs/PCAs knowing what's in their scope to help with?

To answer these questions, you'll need to know what you want your ideal response to look like. We'll go into that more in the next article.

Ideal Response

Let's go deeper into the deteriorating patient scenario. We'll need a starting condition — let's use a patient with pneumonia — and then what is making the patient deteriorate — in this case, they're becoming septic.

After that, we'll need to know how you want your people to respond. Different areas will have different responses.

If the patient is in a clinic, the participants should rec-

ognize possible sepsis, notify an LIP, call for transport to the Emergency Department, and support the patient. Should your people start an IV? Give a fluid bolus? Give oxygen? These all depend on the capabilities of your area.

The same patient in the Emergency Department should get a Sepsis Alert workup, which is a specific local area response. What should be in that response?

A floor simulation may

need an LIP notification as well as a MET call, with cultures, labs, a fluid bolus, and transfer to an ICU as some of the needed care will be outside what the floor can do.

An ICU team may need to do what the floor does plus possibly add vasoactive agents.

Each area will respond differently. You will need to know what your area's ideal response is.

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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

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!



Adult Code Team residents participate in a mock code. Everyone's first code should be on a plastic patient.



PICU nurses caring for an infant in an RN Clin I scenario.

Actual Examples

We were invited to do simulations for the Battle Building Dentistry area for the sedations they do there. Our scenario was going to be a patient who coded while in sedation. Some of the questions we asked were: How would you sedate the patient? Do you have IV access? How would you try to reverse the sedation without IV access? The dentistry clinic does not have nurses — who would give meds during a code? What should the dental technicians be expected to do during the code?

The Emergency Department will soon start using a LUCAS chest compression device during codes. Our questions about that for simulations included: Who would put the device on? What is the process for putting the device on? What are your training materials for this new device rollout, so we can make sure our simulation agrees with them?

When the Emergency Department went to the new South Tower space several years ago, we did various simulations with them to help them decide how they wanted to design physician and nursing coverage of the space. In this case, the simulations helped create the ideal state.

Ideal Response 2

Asking those questions helps you figure out what your ideal response is. It's correct to say, "If the patient codes, we should run a code," but what does that mean for your area? Our asking about the equipment and people you have, and then asking what you want them to do, can help you be more specific and detailed about how your area responds to an actual emergency.

Journal Article

This month, our article reports on simulations for ECMO practice and latent safety threat discovery. It's sort of old, but it shows that we've been using simulations to find latent safety threats for a while. The article is: Burton, KS et al. (2011). Impact of Simulation-Based Extracorporeal Membrane Oxygenation Training in the Simulation Laboratory and Clinical Environment. *Simulation in Healthcare: The Journal of the Society for Simulation in Healthcare*, 6(5), 284-291.

We have a link for this that should work on any UVa computer: <https://oce-ovid-com.proxy1.library.virginia.edu/article/01266021-201110000-00005/HTML>

Editorial

This month's editorial is related to the Ideal Response 2 article and the theme of this month. In addition to helping providers practice their patient care, we strongly believe that the process of preparing for a simulation can improve patient outcomes by helping areas refine their responses to various emergencies. Deciding how you want to simulate an emergency helps you decide how you want to respond to a real emergency.