UPSTATE MEDICAL UNIVERSITY
SIMULATION CENTER
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# Terminology

Below is a list of common terms and words we used in the Center. These are adapted from the Healthcare Simulation Dictionary. The complete dictionary can be found on the Society for Simulation in HealthCare's webpage: https://www.ssih.org/Dictionary

| Term | Definition |
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| Co-Debriefer | An individual with specific training in debriefing methodology who assists the lead Debriefer in the debriefing. |
| Content Expert | An individual with clinical expertise related to the simulation case who does not necessarily have specific training in simulation. The content expert attends the debriefing and answers any clinical questions that arise during the discussion. The content expert follows the lead debriefers' structure for the debriefing. |
| Debrief (Debriefing) | A formal, collaborative, reflective process within the simulation learning activity. To explore with participants their emotions and to question, reflect, and provide feedback to one another (i.e., guided reflection). Debriefing should foster the development of clinical judgment and critical thinking skills (Johnson-Russell & Bailey, 2010). |
| Debriefer | A person who leads participants through the debriefing session and is knowledgeable and skilled in performing appropriate, structured, and psychologically safe debriefing sessions (Fanning & Gaba, 2007). Debriefing by competent instructors and subject matter experts is considered important to maximize the opportunities arising from simulation (Raemer et al, 2011). The Debriefer may be the Lead Instructor or another staff member trained in debriefing. |
| Embedded Simulated Person | Also called known as a confederate. This is a person who portrays a simulated family member or healthcare provider in order to |

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| | facilitate or help meet the objectives of the simulation. |
| Embedded Simulation Person vs. Standardized Person (SP) | A standardized patient is one form of a simulated person. At times, a standardized person is used in a scenario to simulate someone besides the patient.<br>An individual trained to portray a patient with a specific condition in a realistic, standardized, and repeatable way and where portrayal/presentation varies based only on learner performance; this strict standardization of performance in a simulated session is what can distinguish standardized patients from simulatedpatients.SPs can be used for teaching and assessment of learners including but not limited to history/consultation, physical examination, and other clinical skills in simulated clinical environments (ASPE). SPs can also be used to give feedback and evaluate learner performance (ASPE).<br>SPs participate in high stakes assessments in which SP responses to the learner were standardized; in recent years as SPs have been included in more formative teaching scenarios, its meaning has become interchangeable with the term simulated patient |
| Feedback | Information transferred between participants, facilitator, simulator, or peer with the intention of improving the understanding of concepts or aspects of performance (INACSL, 2013).<br>Feedback can be delivered by an instructor, a machine, a computer, a patient (or a simulated person), or by other learners as long as it is part of the learning process.<br>Feedback should be constructive, address specific aspects of the learner's performance, and be focused on the learning objectives (SSH). |

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| Fiction Contract | A concept which implies that an engagement in simulation is a contract between the instructor and the learner: each has to do his or her part to make the simulation worthwhile (Rudolph, Dieckmann, et al.). The degree of engagement that healthcare trainees are willing to give the simulated event; also known as the "suspension of disbelief," it is a literary and theatrical concept that encourages participants to put aside their disbelief and accept the simulated exercise as being real for the duration of the scenario. |
| Fidelity | The level of realism associated with a particular simulation activity. It is not constrained to a certain type of simulation modality, and higher levels of fidelity are not required for a simulation to be successful.<br>Fidelity can involve a variety of dimensions such as:<br>• physical factors such as environment, equipment, and related tools<br>• psychological factors such as emotions, beliefs, and self-awareness of participants<br>• social factors such as participant and instructor motivation and goals;<br>• culture of the group<br>• degree of openness and trust, as well as participants' modes of thinking (INACSL, 2013). |
| Frame(s) | The perspectives through which individuals interpret new information and experiences for the purpose of decision-making; frames are formed through previous experiences and can be based on knowledge, thoughts, feelings, actions (speech/body language), attitudes (verbal/non-verbal), and perceptions (adapted from Rudolph, J.W. et al.). |
| High-Fidelity Simulation | In healthcare simulation, high-fidelity refers to simulation experiences that are extremely realistic and provide a high level of interactivity and realism for the learner (INACSL, 2013); Can apply to any mode or method of simulation; for example: human, manikin, task trainer, or virtual reality. |

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| Immersive Simulation | A real-life situation that deeply involves the participants' senses, emotions, thinking, and behavior; creating an immersive simulation depends on the alignment with learning objectives, the fidelity of the simulation (physical, conceptual and emotional), and participant´s perception of realism. |
| In Situ/ In Situ Simulation | Taking place in the actual patient care setting/environment in an effort to achieve a high level of fidelity and realism; this training is particularly suitable for difficult work environments, due to space constraints or noise. This training is valuable to assess, troubleshoot, or develop new system processes. |
| Interprofessional | Collaborating as a team with a shared purpose, goal, and mutual respect to deliver safe, quality health care (World Health Organization (WHO), 2010). |
| Interprofessional Education /Training/Learning (IPE) | An educational environment where students from two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes (Interprofessional Education and Collaborative Expert Panel, WHO 2011). |
| Lead Simulation Instructor (LSI) | The person responsible for the overall development and delivery of the simulation activity on behalf of the requesting program. Typically, this is a program director, lead facilitator, curriculum designer, or similar role. |
| Pilot/Dry Run | Scheduled meeting to walk through the simulation scenario, piloting the session as a participant would experience it. This is a critical step to ensure the alignment of case design, learning objectives, script, and use of equipment. |

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| Prebrief | An activity immediately preceding the start of a simulation activity. The purpose of the prebriefing is to set the stage for a scenario, and assist participants in achieving scenario objectives.<br>Prebriefing can include orientation to equipment, environment, manikin, roles, time allotment, objectives, and patient situation. Essential information about the simulation scenario such as background information, vital signs, instructions, or guidelines can be given. For example, at the start of the simulation scenario, participants receive a notification from ambulance personnel regarding a patient being transported to their facility with a gunshot wound. (Alinier, 2011; Husebo et al., 2012). |
| Pre-Program Walk Through | Before a scheduled session begins, LSI should meet with Center staff approximately 30 minutes before to review roles, case flow, and any other critical details. This is separate from a 'dry run' which is done when the simulation scenario is being developed. |
| Psychological Safety | A feeling (explicit or implicit) within a simulation-based activity that participants are comfortable participating, speaking up, sharing thoughts, and asking for help as needed without concern for retribution or embarrassment.<br>The perception of members of the team that the team is safe for risk taking, and mistakes will be considered learning opportunities rather than there being embarrassment or punitive consequences (Edmondson, 1999; Higgins et al, 2012). |
| Safe Learning Environment | A learning environment of mutual respect, support, and respectful communication among leaders and learners; open communication and mutual respect for thought and action encouraged and practiced. |

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| Shared Mental Model | A framework whereby an individual team member develops a perception of the situation, it is shared, allowing the team to reflect on the information and revise their situational awareness and their own mental model based on new information; for example, sharing can be done by vocalizing observations, calling out information, using a structured time-out to communicate new information and thinking out loud to allow others to relate and appreciate the associations, assessments, and plans.<br>Shared mental models facilitate collaboration, and are crucial when team communication in a situation is difficult (due to time pressure, etc.). |
| Simulation | An educational technique that replaces or amplifies real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner (Gaba Future Vision Qual Saf Health Care 2004). |
| Simulation Planning Meeting | Will Review:<br>• Proposed Program<br>• Potential Schedule<br>• Objectives and further simulation scenario development if needed<br>• Appropriate Simulation Modalities and testing of case<br>• Staff and equipment needed<br>• Learner assessment plan |