INSTRUCTION MANUAL

MULTIPURPOSE PATIENT CARE AND CPR INFANT SIMULATOR

MODEL S117

Gaumard Scientific
14700 SW 136 Street
Miami, FL 33196-5691
e-mail: sima@gaumard.com

PLEASE READ THE FOLLOWING INSTRUCTIONS PRIOR TO COMMENCING TRAINING EXERCISES ON YOUR NEW SIMULATOR

HANDLE YOUR SIMULATOR IN THE SAME MANNER AS YOU WOULD HANDLE YOUR PATIENT - WITH CARE AND CONSIDERATION.

SHOULD YOU HAVE ANY QUESTIONS AFTER READING THIS INSTRUCTIONAL MANUAL, PLEASE CONTACT GAUMARD

TABLE OF CONTENTS

*Available Option

SECTION I – OUTLINE OF FEATURES AND CAPABILITIES

The size of this model is designed to simulate a one year child. It may be an effective training tool for CPR, intubation, suctioning, intensive care, trauma care, and general patient care exercises. It is to be used only as part of an approved training program for pediatric patient care. It features:

- Realistic intubatable airway
- Tracheostomy care
- Heart, lungs, ribs, stomach, and liver
- Arterial sites in the arms and legs
- Intraosseous infusion site
- Injection training arm for intravenous, subcutaneous, and intramuscular injections
- G-tube site
- Custom carrying bag

Training elements include:

INTUBATION AND CPR

- Realistic mouth, tongue, vocal cords, trachea, and esophagus
- Fully articulating head, neck, and jaw
- Oral and nasal intubation plus suctioning
- Suction either airway or esophagus
- Crico prominence facilitates Sellick maneuver
- Endoscopically examine airway to level of bronchi
- Easily accessible chest cavity
- Chest compliance achieved through realistic heart, lungs, and ribcage
- Look, listen, and feel for bilateral lung expansion
- Palpable and visual landmarks for CPR
- Realistic chest rise
- Simulated brachial, radial, and femoral pulse

TRACHEOSTOMY CARE

- Access port
- Insert Shiley through replaceable membrane
- Positive pressure ventilation produces chest rise

INTRAOSSEOUS INFUSION (I/O)

- Venous access of choice in trauma care of children
- Tibial bone in right leg
- Palpable landmarks include tibial tuberosity, tibia, and patella
- Sixteen (16) interchangeable bones with anatomic landmarks
- Pressurized system provides realistic pop when needle enters bone marrow cavity
- Pull fluid through needle, verifying correct position

ARTERIAL SYSTEM

- Pulse may be determined at the left or right brachial or at either the right radial or the right femoral artery.
- The brachial pulse is normally taken during CPR. The available femoral arterial site in the right leg may be cannulated to ascertain blood gas levels without interfering with the CPR effort.

FEMORAL VENOUS ACCESS

- Simulated blood can be supplied in the right femoral vein
- The right femoral vein may be infused, since it is relatively easy to cannulate without interfering with the CPR effort.
- Two quick venous sticks are recommended prior to attempting intraosseous techniques. Therefore, both intravenous and intraosseous techniques can be practiced.

INJECTION TRAINING ARM

- For intravenous training on arm and hand
- Palpable brachial and radial arteries
- Simulated blood supplied to arm and hand
- Veins stand out or collapse
- Easily replaceable skin, veins, and arteries

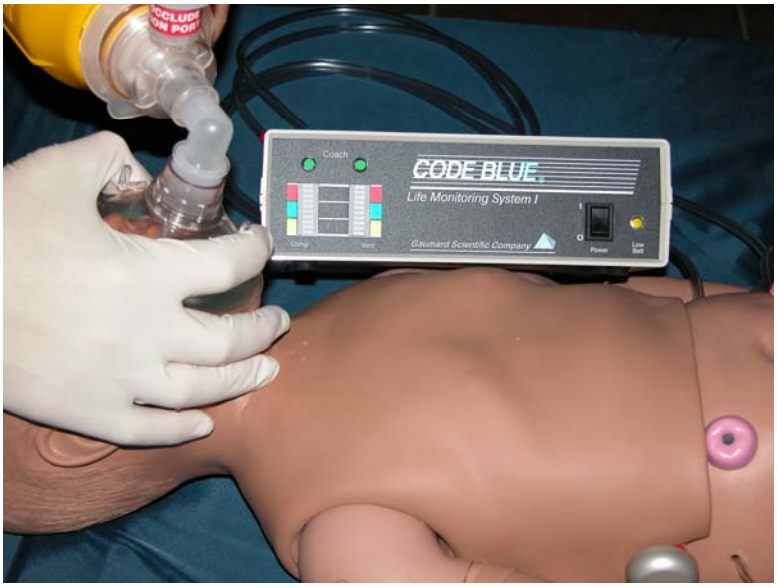
PATIENT CARE

- Bandaging
- Eyes and Ophthalmologic exercises
- Nasogastric and Orogastric exercises
- Enema Administration
- Other Injection sites

SECTION II - INTUBATION AND CPR

1. Respiratory and Cardiovascular System

The degree of pulmonary ventilation and cardiac compression achieved by the trainee can be judged by connecting the optional **Code Blue Life Monitoring System**. Attach the blue tube from the lungs to the **ventilation** port at the rear of the monitor. Attach the red tube from the heart to the **compression** port at the rear of the monitor. Both tubes are located at the left side of the upper torso.



2. Code Blue Life Monitoring System - Instructions for Use

The **Code Blue Life Monitoring System** is to be used with a GAUMARD CPR/Patient Care Simulator only. It was designed to help teach CPR simply and effectively. It coaches the student through CPR training. A manual from the American Heart Association is provided by GAUMARD with your CPR simulator. This system is to be used as a part of an approved CPR training program.

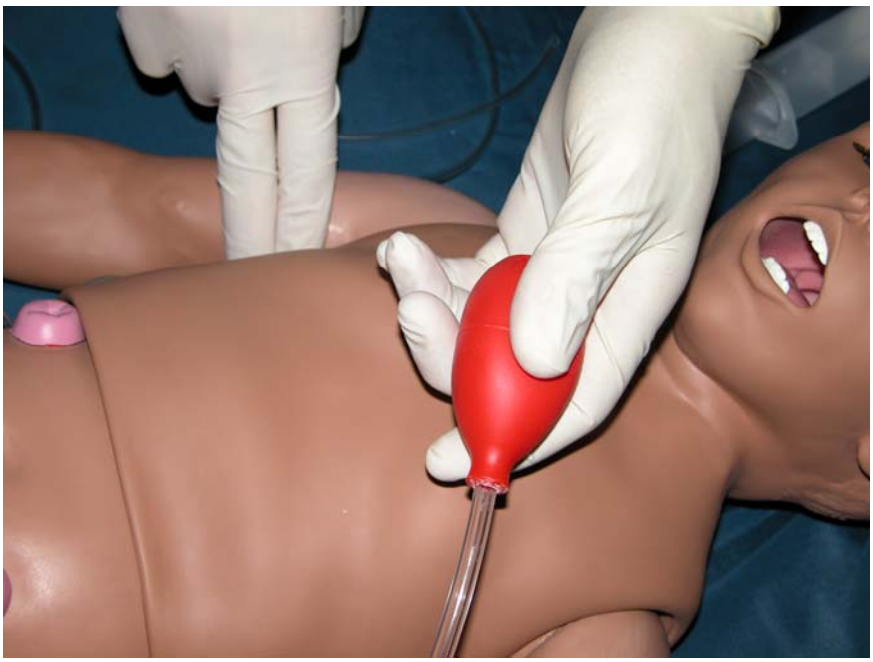
Connect the color-coded red and blue tubes to the compression and ventilation ports on the rear of the monitor. Select the infant mode, set the Coach/Reset switch to Coach, and turn on the monitor. The student will immediately see coaching lights and hear pitched tones. The pitched tones and lights are synchronized. The low tones indicate timing of ventilations; the higher tones indicate the timing of chest compressions.

3. CPR: Ventilation – Compression - Pulses

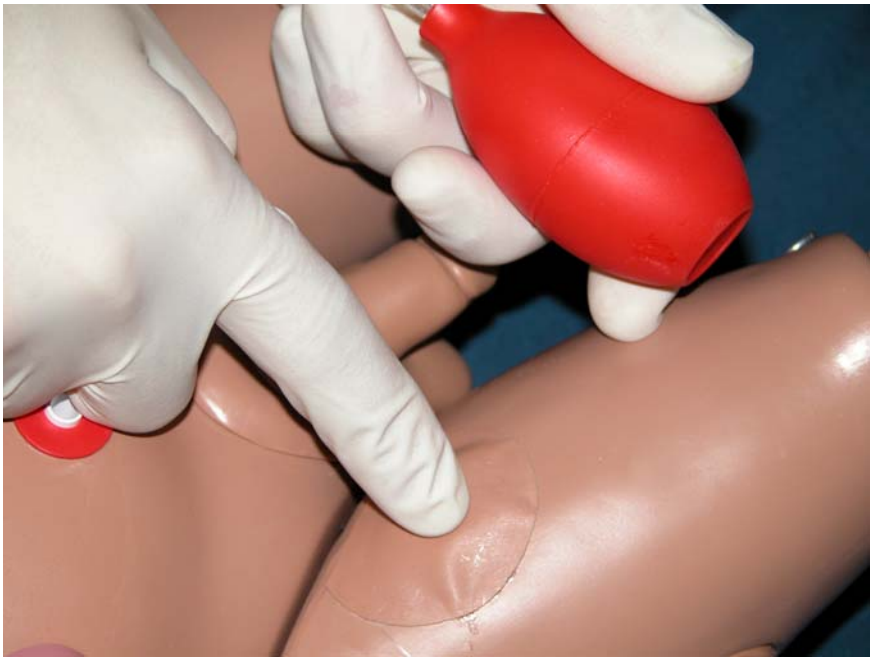
Select Toddler sized BVM with thick flexible seal fitting well over the mouth and nose

BVM shown with mask sealed over the mouth and nose minimizing leakage of air

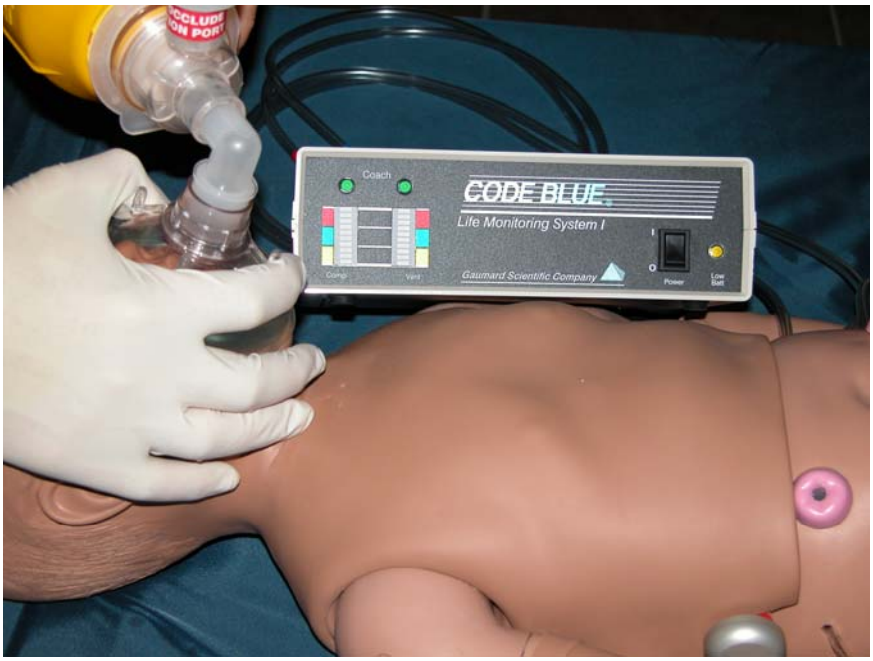
One rescuer uses two-finger method of cardiac compression while the other provides air or oxygen through a positive pressure ventilation device.



Brachial and radial pulses may be checked by the student as the instructor generates pulse pressure using squeeze bulb



Femoral pulse may be checked using squeeze bulb. Note that the femoral vein lies medially.



Ask the student to ventilate the lungs using a positive pressure device designed for an infant. Note that too little ventilation will cause the bar graph to illuminate only the yellow range. Correct ventilation is in the green range. Too much ventilation is in the red range. Now ask the student to compress the chest. Insufficient chest compression will cause the bar graph to illuminate only in the yellow range. Correct compression is in the green range. Too much compression is in the red range and may damage the ribs. Stay in the green range for both ventilations and compressions.

Depending upon the mode selected, the monitor will adjust for the differences in both the timing cycle and the amount of ventilation/compression required.

NOTES:

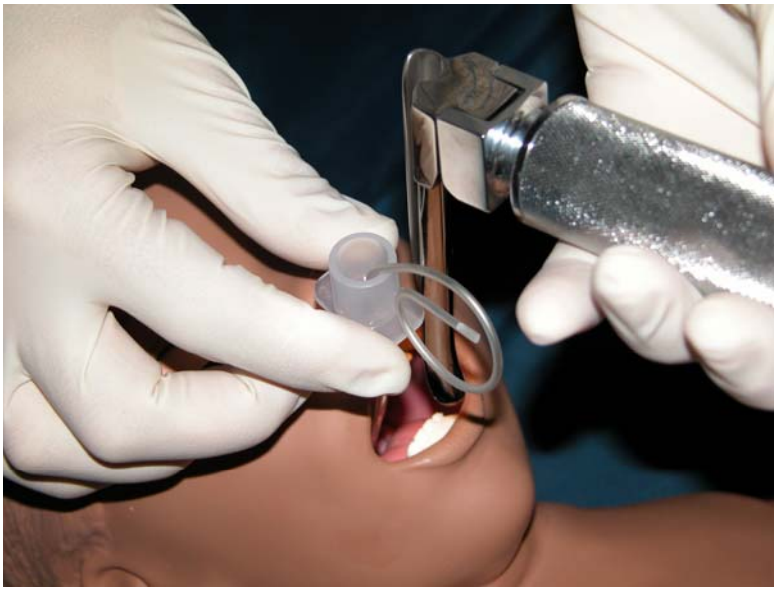
A. The **Code Blue Life Monitoring System** available with this simulator may be used for both toddler and infant modes. For the newborn, normally select the INFANT setting. When changing modes, always switch from coach to Reset and back to Coach. This resets the electronics and starts the timing sequence.
B. While teaching the correct amount of lung inflation or chest compression, the instructor may elect to turn off the Tone and Light Option by switching to Reset. In this mode, the student can practice proper ventilation or chest compression by monitoring progress on the bar graph. Remember to stay in the green range.
C. The **Code Blue Life Monitoring System** is powered by a conventional 9-volt battery. Note that the Low Battery indicator is next to the Power switch.

For CPR instructions, refer to the enclosed manual prepared by the American Heart Association. For additional information, refer to the course book offered by your organization.

4. Intubation

NOTE: Your simulator is equipped with a realistic airway having a soft, floppy epiglottis and vocal cords. In order to avoid damage to the airway, thoroughly lubricate the distal tip of the endotracheal tube with water based silicone prior to insertion.

A laryngoscope has been fitted with a Miller 1 blade in order to insert a 3.0 mm endotrachial tube which is stiffened with an appropriately sized stylette.



Once the ETT is inserted through the vocal folds and into the trachea, the ETT must be held in place while the blade of the laryngoscope is withdrawn. The ETT is then fixed into place and oxygen supplied.

OPENING THE AIRWAY

During your BLS training the ABC's of resuscitation were emphasized again and again. Recall the "A" stands for airway and "B" stands for breathing. Therefore, the mechanics of properly opening the airway are essential.

Remember the following during pediatric Intubation:

- Children require more oxygen per amount of body weight than adults.
- The airway of a typical newborn child is only 3.8 millimeters in diameter at its narrowest point, located below the vocal cords. An adult's airway may be 20 millimeters in diameter.
- The tongue occupies a relatively larger portion of the mouth.
- A towel placed under the shoulders is essential to extend the infant's neck.

Intubation may be indicated in the unconscious patient or when the patient is not breathing properly. Successful Intubation provides:

- means for oxygen and positive pressure ventilation
- alternative route for providing certain medications if IV is not available
- access for suctioning the trachea and bronchi

The **KEYS** to successful Intubation are:

- Hyperventilation before Intubation
- Patient position
- Using laryngoscope to visualize the vocal cords
- Passing the endotracheal tube between vocal cords
- Practice, practice, practice

HYPERVENTILATION BEFORE INTUBATION

During Intubation attempts, the patient will **NOT** receive adequate oxygen. Therefore, the rescuer must provide 100% oxygen before attempting Intubation, **AND MUST HYPERVENTILATE BETWEEN EACH ATTEMPT.**

PATIENT POSITION

The objective is to position the patient so that the rescuer will have the **BEST VIEW OF THE VOCAL CORDS.** Inserting an endotracheal tube (ET tube) must be a well-rehearsed procedure. Each **CORRECT** step makes the **NEXT STEP** that much easier.

Remember to ventilate the patient **BEFORE** and **BETWEEN** each Intubation attempt.

Place the patient on his back. Use the **"SNIFFING POSITION"** or **JAW THRUST** shown below. A towel must be placed under the infant's shoulders. This places the patient in the so-called **"SNIFFING"** position. This provides the rescuer with the **BEST VIEW** of the vocal cords. **HEAD TILT/CHIN LIFT** is to be avoided in the newborn.

VISUALIZING THE VOCAL CORDS

The rescuer is normally positioned above and behind the head of the patient so that the line of sight is across the forehead, over the nose and along the axis of the patient's airway. The laryngoscope is used to lift the tongue and epiglottis out of the line of sight so that the vocal cords may be **CLEARLY** seen.

The laryngoscope may be fitted with two types of blades; the straight Miller or the curved Macintosh. The Miller traps the top edge of the epiglottis against the tongue while the Macintosh lifts the epiglottis by lifting the tongue at the vallecula. The **straight** blade is widely **preferred** for pediatric Intubation.

In the event that you can **STILL** not see the vocal cords, use the **SELLICK** maneuver as follows: have an associate depress the crico cartilage - this forces the airway posteriorly, providing a better view of the vocal cords; locate the cricoid by finding the "Adam's Apple" or thyroid cartilage; move the hand lower and feel the crico-thyroid membrane; move further below and locate the cricoid cartilage.

POSITIONING THE ENDOTRACHEAL TUBE

With the patient in the sniffing position, and the rescuer behind the patient, place an uncuffed ET tube approximately 3.0 mm I.D. by 10 to 12 centimeters in length as follows:

1. Use the left hand to insert the blade along the right side of the mouth, sweeping the tongue to the LEFT until the blade is midline.
2. Lift the tongue and the epiglottis up and away.
3. Keep low behind the patient and observe the vocal cords.
4. It is a good idea to have 2 ET tubes ready for use; one WITH A GUIDE WIRE in place and the other without the guide wire.
5. Use Sellick maneuver and/or guide wire if necessary.
6. Slide ET tube along the right side of the blade and between the vocal cords.
7. Position the tip of the ET tube midway between the vocal cords and carina.
8. Carefully withdraw the guide wire as the ET tube moves through the trachea.
9. Carefully withdraw the laryngoscope blade.
10. Attach oxygen supply and check for bilateral lung expansion

CONFIRMING CORRECT PLACEMENT

- Look, listen and feel for bilateral lung expansion.
- In a patient:
  Auscultate for chest sounds and air entry.
  Observe ET tube - note fogging of the expelled air - you should NOT see the gastric contents.

- Check the patient:
  for **COLOR**
  for the **EFFORT** of breathing
  is the **RESPIRATION RATE** reasonable?
  for **BLOOD PRESSURE** and **HEART RATE**.

FOR ADDED REALISM:

- Gastric contents and other fluids may be added to the stomach.
- Suctioning may be practiced in either/or the esophagus/trachea.
- Placement of the ET tube should also be attempted while fluids are present in the vicinity of the vocal folds.
- Placement of the ET tube using the naso-tracheal route should also be demonstrated using an ET tube several centimeters LONGER.

SECTION III – INTEGRATED SKILLS

1. Intraosseous Infusion

The Intraosseous Trainer may be an effective tool for instruction in intraosseous infusion. This model also contains a simulated femoral artery and vein in the upper thigh so that the student can appreciate both the femoral entry and the intraosseous entry into the venous system. This dual system design is useful since the intraosseous entry is recommended after two quick unsuccessful attempts at peripheral venous cannulation. This simulator is to be used only as a part of an approved program for the care of pediatric patients. The Intraosseous Trainer includes a set of sixteen (16) modified tibial bones, a fluid dispensing syringe, synthetic blood concentrate, and two (2) spare skin covers.

CAUTION:

The tibia bones supplied with your simulator are made from hard plastic that can be pierced by an intraosseous needle. Once holes have been made in the tibia it CAN leak. We have minimized leakage by controlling fluid pressure in the bone using inlet and drain valves. Proceed as follows:

1. Fill syringe with water, open the drain valve and allow water to flow thru the system into a catch basin.

2. The water will displace entrapped air in the line.

3. Perform IO exercises

4. After about 10-20 sticks you may need to add water to the tibia bone. To do so, remove the syringe and refill.

5. Continue your IO exercises.

6. To change the tibia bone, drain the fluid, remove the skin cover and remove the bone. Replace the tibia bone and re-attach the skin. Return to step 2.

7. When the training session is completed, open the outlet and drain the fluid.

8. Remove the syringe.

9. Replace the bones and dry them for next session.

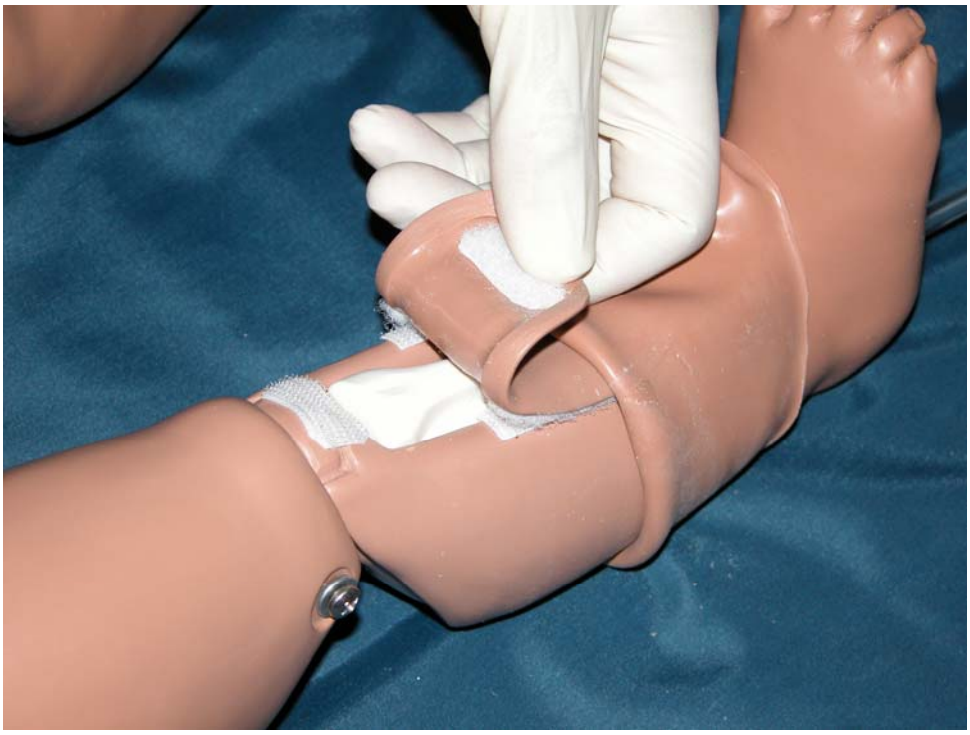
10. Instructor may seal the holes in the bone(s) that are made by the IO needle with "Super Glue".

INTRAOSSEOUS INFUSION (continued)

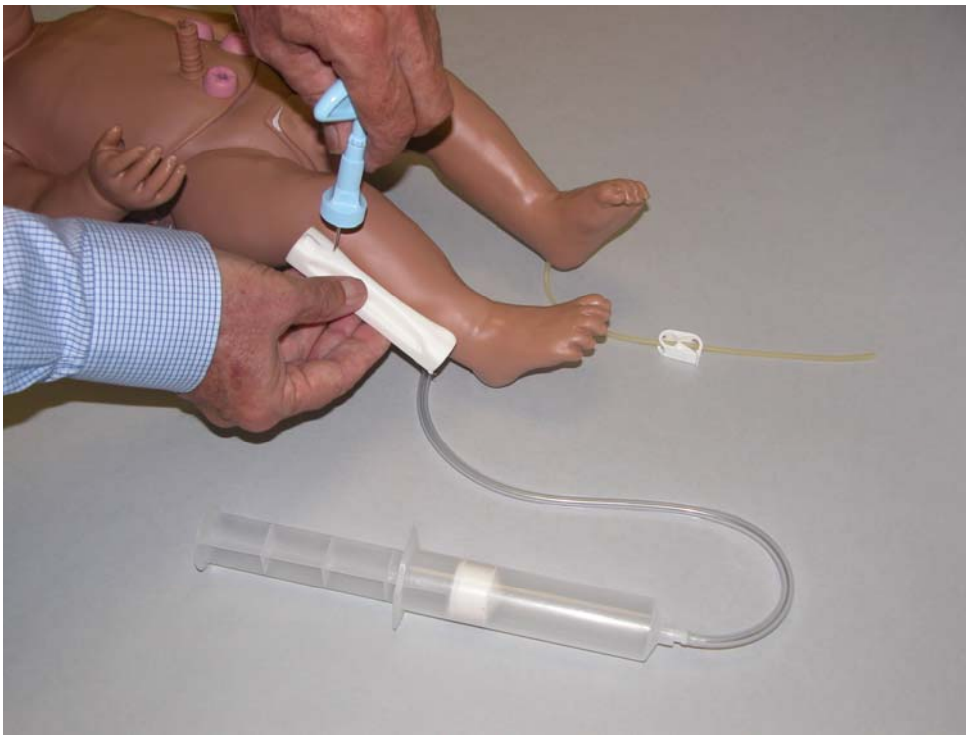
Intraosseous infusion is the infusion of fluids, blood and/or drugs directly into the bone marrow of the tibia or other large bone. It is a quick, simple solution to venous access in children when the alternate peripheral veins are barely visible or palpable. Contraindications to intraosseous access include bone disorders, infected burns, cellulitis, or recent fractures.

THE TIBIA ACCESS IS THE CHOICE IN THE EVENT THE VICTIM ALSO REQUIRES CPR INTERVENTION. THE HUMERAL ACCESS IS ONE CHOICE IN THE EVEN SEVERE ABDOMINAL TRAUMA OR BILATERAL FRACTURES ARE EVIDENT.

Setting up an intraosseous access line is an invasive procedure requiring an aseptic technique. The site most recommended for the tibia is the anterior medial aspect of the tibia. Although any portion of the tibia can be used, the preferred site for properly locating the point of insertion of the needle is two (2) to three (3) centimeters below, and one (1) centimeter medial to the tibial tuberosity (the tibial tuberosity is the bump below the kneecap). Note that each tibial bone provided is modified, having a tibial tuberosity at the top and bottom of the tibial bone. This allows the bone to be rotated after repeated needle sticks. You may wish to apply conventional "SuperGlue" or PVC sealant to the holes created by the needle sticks to prevent fluid leakage from the needle sticks.



Removable tibia bone is placed beneath skin. Fluid can be inserted through syringe and into bone marrow cavity. The fluid passes through the femoral venous return and out the drain in the foot.



A 16 gauge bone marrow aspiration needle is placed below the tibial tuberosity

Note the needle is aimed away from the knee and worked through bone with a slight clockwise and counterclockwise motion

Locate the tibial site and clean the area with alcohol. Avoid the use of povidone-iodine, as this will discolor the simulator. Simulate anesthetization of the area if needed. The needle recommended for this procedure is a 16 gauge disposable bone marrow aspiration needle.

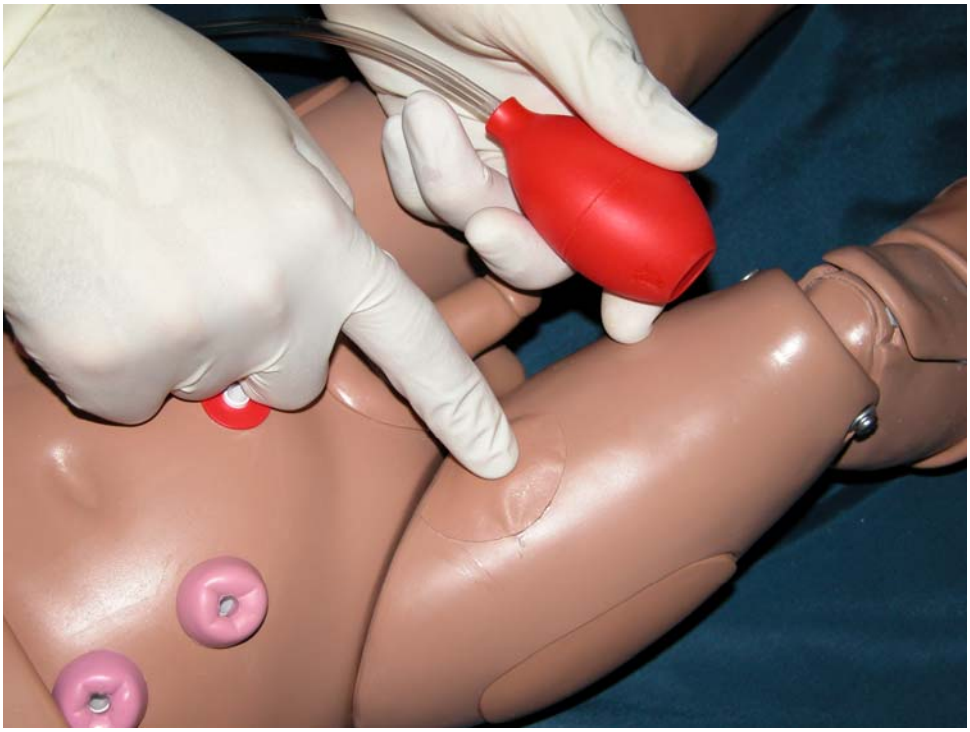
Caution must be used when inserting the needle. Once the insertion point is located, insert the needle and cannula by applying downwards pressure while rotating the needle back and forth until the bony cortex has been penetrated. A "pop," or sudden decrease in resistance signal entrance into the cavity. Now remove the central needle, leaving the cannula in place. If the needle/cannula has been properly inserted, fluid may be withdrawn using a standard syringe. In the event "blood" return is not observed, the student may not have penetrated the bone marrow cavity. The intraosseous access is only marginally stable and is easily dislodged from the pediatric patient. Therefore the student should practice stabilizing the needle using, for example, a hemostat clamped to the needle hub and taped to the leg of the patient.

Once stabilized, the intraosseous access may be used to infuse fluids, drugs, and blood products. Be sure to flush the cannula with saline after each use.

It is recommended in the literature that the intraosseous infusion be conducted for the briefest amount of time, usually an hour or two, until a more secure intravenous line has been established.

2. Femoral Venous Access

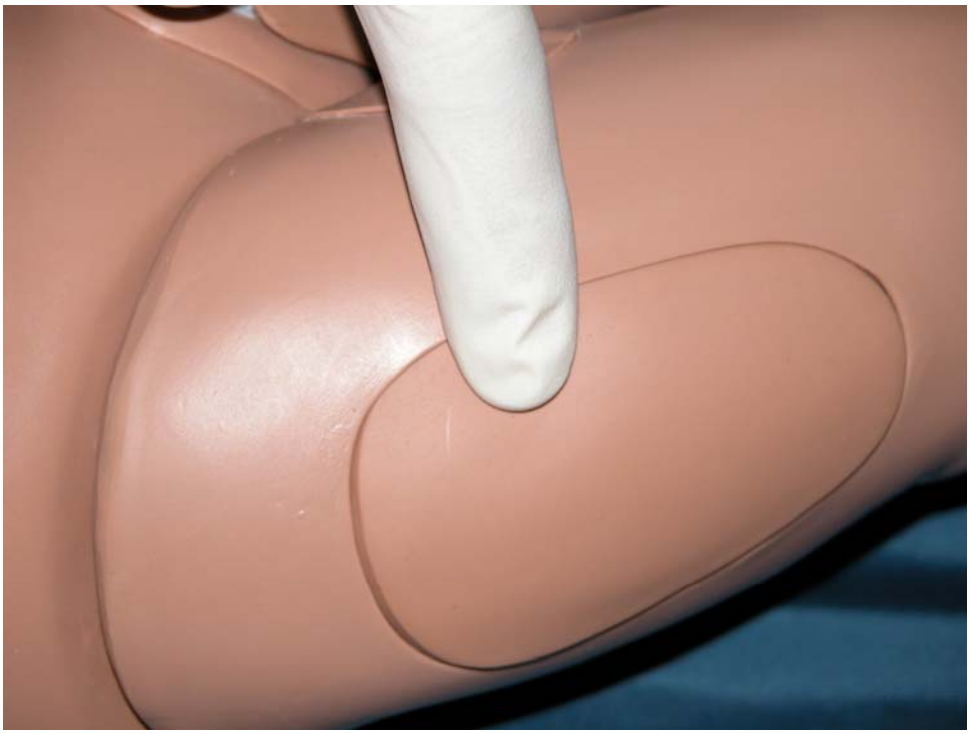
During CPR, the preferred access site is the largest and most accessible site that does not interrupt resuscitation of the victim. Venous access can be obtained through the intraosseous route discussed previously, o the femoral , internal jugular, external jugular, or subclavian veins. Of the latter four sites, the femoral is preferred because like the intraosseous site, it provides less interference with the resuscitation efforts. To cannulate the femoral vein, a suggested procedure is shown below:



Accessing the femoral veins:

1. Restrain the right leg with slight external rotation.
2. Identify the femoral artery by palpation or, if pulsations are absent, by finding the midpoint between the anterior superior iliac spine and the symphysis pubis.
3. Scrub the area thoroughly with an antiseptic solution.
4. Wash hands and wear sterile gloves.
5. Anesthetize the skin with 1% lidocaine.
6. Puncture the skin with a hollow needle **one finger breadth below the inguinal ligament, and just medial to the femoral artery**. During chest compressions, pulsations in the femoral area are as likely to originate from the femoral vein as from the artery, and needle puncture should be attempted at the point of pulsation. Direct the needle toward the head at a 45N angle and advance it slowly until a free flow of blood is obtained. Insert the through-the-needle catheter or catheter- introducing sheath. Remove the needle, or guide wire and dilator and secure.

3. Intramuscular I/M Sites

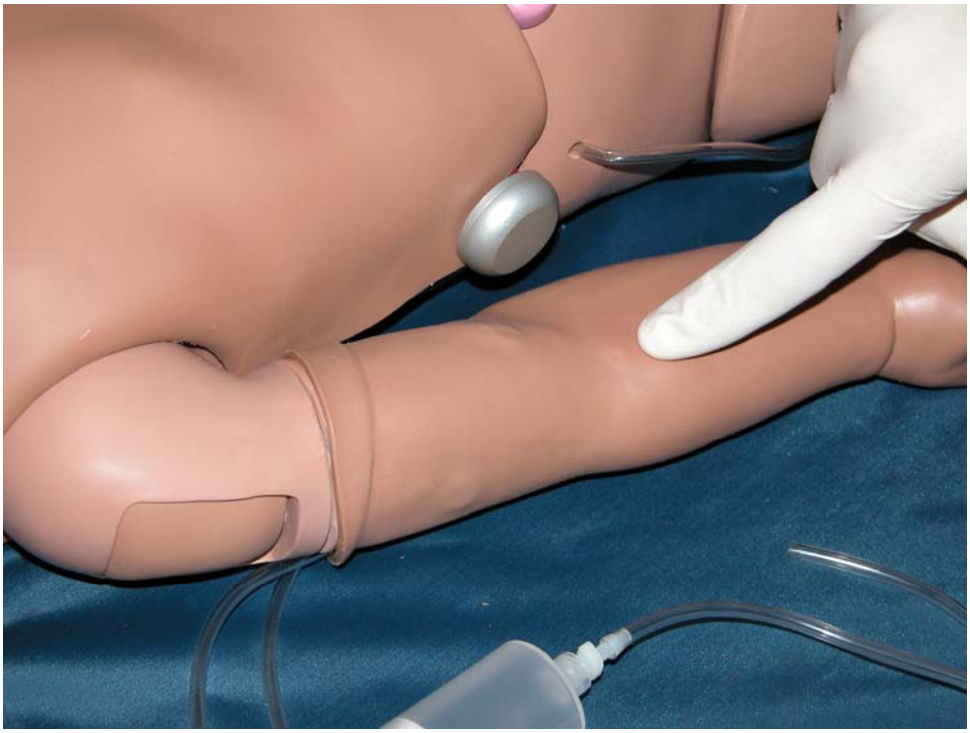


IM sites are located are located bilaterally at the thighs and on the right shoulder

4. Pediatric Injection Training Arm

The Pediatric Injection Training Arm simulates the arm of a newborn child. It is an effective training tool for intravenous and certain arterial exercises. It is only to be used as part of an approved program for patient care.

The Injection Arm includes a blood dispensing syringe, synthetic blood concentrate, and a spare arm skin. The training arm contains anatomically located venous and arterial grooves which are fitted with soft latex tubes closely simulating the consistency of the veins. A translucent, pliable latex skin, which is removable and washable, is stretched over the training arm.



The IV arm provides:

1. A medial venous antecubital vein for IV exercises
2. Radial and brachial pulse points
3. Two vein in the dorsum of the hand for additional intravenous training techniques

Applying pressure via the syringe permits the veins to stand out, simulating a clenched fist or a tourniquet situation. Release of the pressure simulates collapsed veins. Use of the syringe permits the palpability of the veins to be varied as seen in routine hospital or emergency situation.

The instructor may ask the student to access the veins initially using a 23 guage needle set without

the use of fluids. Once the student is more skilled, water can be added to the syringe. Later one may elect to use the synthetic blood. Remember to flush the arm following each training session.

INTRAVENOUS EXERCISES

Setting up an IV line is an invasive procedure requiring an aseptic technique. The normal procedure for setting up an IV line using the simulator is as follows:

1. Apply desired pressure to the veins.

2. Squeeze the appropriate vein site and clean the skin with alcohol. Avoid use of povidone-iodine, as this will cause the skin to become discolored and brittle.

3. Omit tourniquet use if possible. If required, apply the tourniquet a few inches above the selected site.

4. Simulate anesthetization of the skin if needed.

5. Select a 22 gauge cannula and 23 gauge needle. Large needles will damage the veins.

6. Apply finger pressure to the vein distal to the puncture site.

7. Puncture the skin and the underlying vein with the needle. The bevel of the needle should be up and the needle should be angled at a 20-30 degree angle. You can feel a Apop@ as the needle enters the veins and you can note the blood return.

8. Stabilize the entry site as desired.

9. Apply ointment and dressing and remove tourniquet, if used.

DISASSEMBLY AND RE-ASSEMBLY

1. Remove the skin starting with either the hand or shoulder. Use talcum powder on the skin to ease movement. Remove the skin, exposing veins and arteries.

2. Remove the veins and arteries from the grooves in the simulator. Replace the veins and arteries as required. See sketch on following page.

3. Assemble in reverse order, being certain to powder the inside of the skin before rolling it on.

CLEANING AND REPAIR

1. The skin of the simulator can be cleaned with mild detergent, or with soap and water. After drying the arm, lightly dust it with talcum powder. This will keep the training arm supple and easy to use. Note: dust the inside and outside of the skin lightly with talcum powder for ease in assembly.

2. If the venous system is blocked, first check that the tubes are not kinked. If blockage persists, remove the fist and flush the veins with water.

3. Marks made with ballpoint pens, ink, or markers will remain.

5. TRACHEOSTOMY CARE

Trachea care site shown. One may pass a Shiley tube through to the trachea and pierce the replaceable septum. Once the bulb at the distal end of the Shiley is inflated, students may attach a positive pressure device and observe chest rise. Be sure to replace the septum with the tape provided after each exercise otherwise oral devices will leak air into the chest cavity and the chest will not rise.

SECTION IV - PATIENT CARE

1. Bandaging

The fingers and toes of this simulator are separated to permit bandaging exercises. The surface of the manikin is smooth and resistant to water, oil, and liniments.

2. Heel Stick Exercises

Both legs are molded from a very soft, lifelike material, permitting heel stick exercises.

3. Eyes/Ophthalmologic Exercises

The head has separately inset eyes, permitting the following exercises:

- Administration of orbital medicines, including instillation of drops or ointment into the conjunctival sac.
- Removal of foreign bodies.
- Eye irrigation.

4. Tongue

The simulator is supplied with a soft tongue.

5. Hygienic Care

The head has molded hair for cleanliness. The manikin surface is water resistant so that bathing exercises may be practiced.

6. Range of Movement

The arms and legs are soft and rotate within the torso body. The head, neck, and jaw articulate.

7. Nasogastric and Orogastric Exercises

Nasal and oral openings are connected to the stomach reservoir, so that an appropriately-sized catheter may be used to demonstrate tube feeding and gastric suction. The stomach is provided with an opening for gastrostomy. **ALWAYS USE A LUBRICANT WHEN INTRODUCING ANY CATHETER.** The reservoirs/tanks may be cleansed by introducing a solution of soap and water, or a mild detergent with a large syringe.

8. Ears, Nose, and Throat

Ear - The left ear contains a simulated ear canal, allowing simulated temperature measurement, or syringing exercises.

Nasal/Oral - Both the nasal and the oral openings are connected to the stomach tank, as discussed earlier.

9. Enema Administration

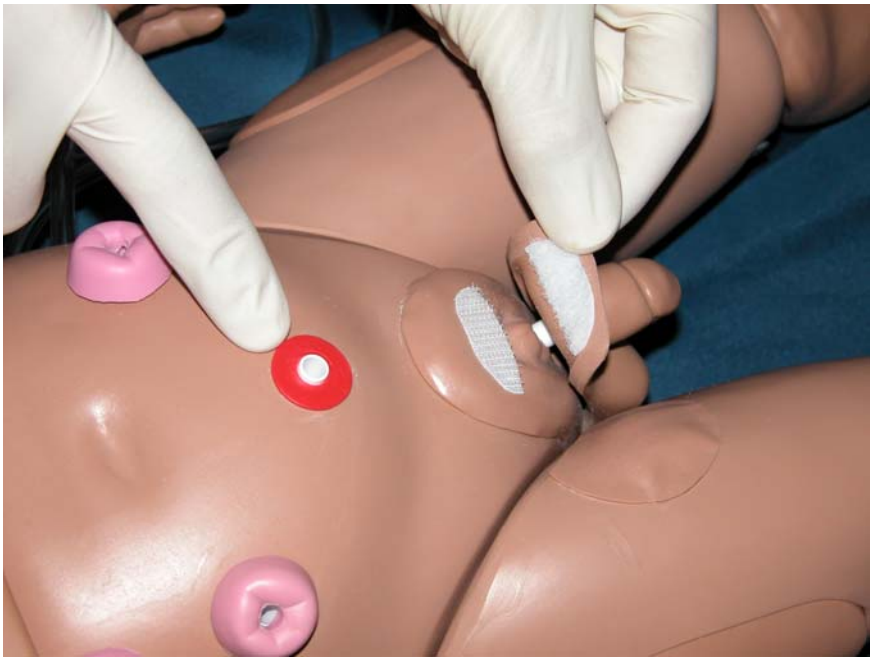
Administration of an enema may be performed on this manikin. The simulator should be placed on its side, and the enema introduced with an anal nozzle of **small diameter**. Please note that a non-return valve is built into the anal passage to prevent fluid spillage during instillation.

10. Urinary System

The urethral passage and the bladder are connected by a double diaphragm valve to make catheterization exercises more lifelike. Fluid may be withdrawn from the bladder after the insertion of an appropriately-sized catheter. **CAUTION - ALWAYS USE A WATER-SOLUBLE LUBRICANT, WHEN PERFORMING CATHETERIZATION ON THE SIMULATOR.**

11. Male and Female Organs

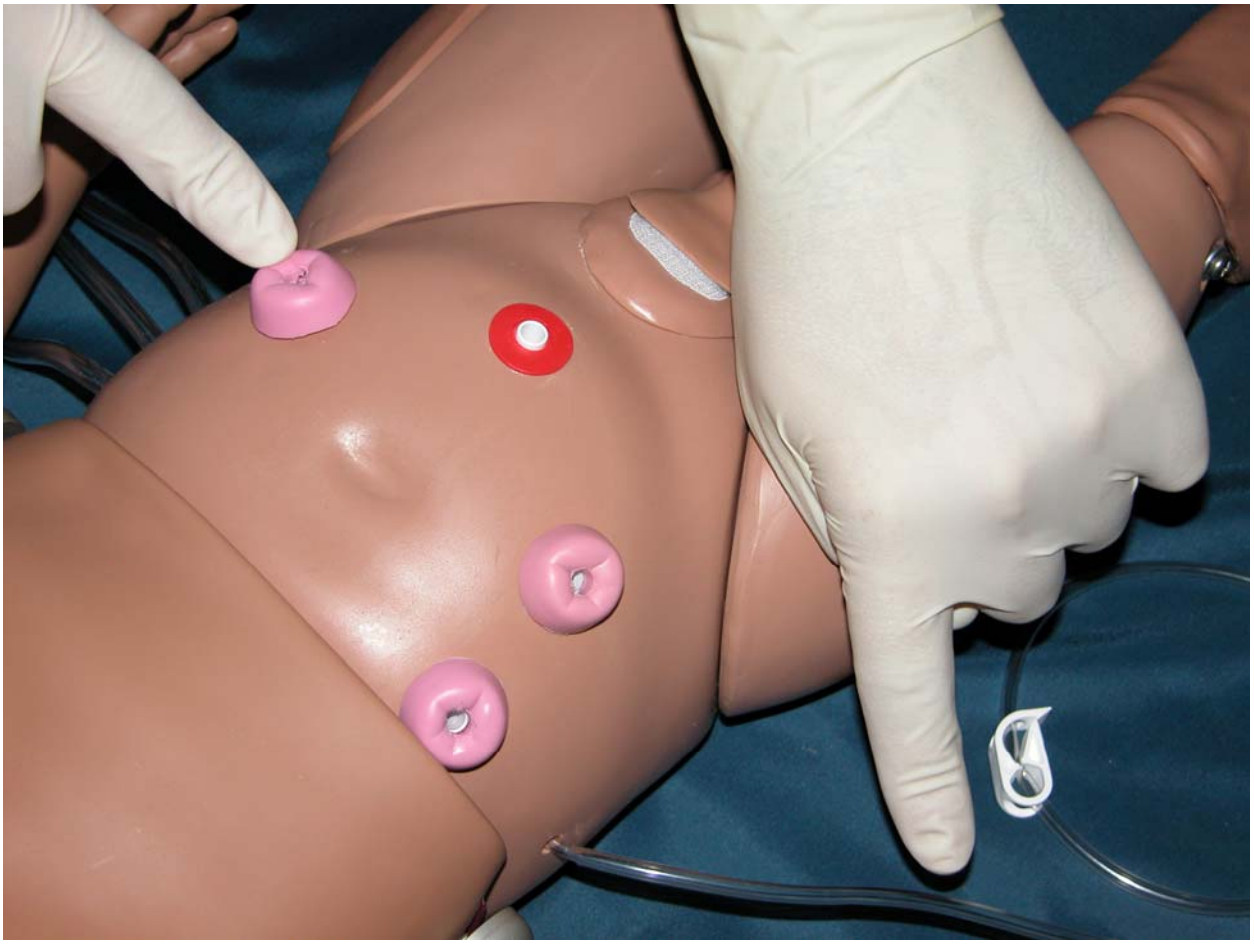
The male and female organs are molded of soft vinyl. The male organ attachment simulates the external genitalia, complete with scrotum. The vaginal passage is closed at the introitus. Both male and female catheterization can be practiced.



Add fluid to the internal tank accessed through this suprapubic stoma. Male and female catheterization may be practiced.

12. Ostomy Care

The S117 is equipped with ostomies for care of the rectum and intestines.



Fluid may be added through an ostomy connected to the rectal tank. Stomach fluids can be drained through the click valve shown. The port at the center fills the bladder for catheterization exercises. The ostomies on the right side of the torso, connect to an internal tank simulating a portion of the intestine.

SECTION V - GENERAL NOTES

1. Catheters - Troubleshooting

There may not be an immediate outflow of water on introduction of the catheter, especially if catheterization is performed with the manikin in the supine position. Should an airlock/ blockage occur, simply inject air through the catheter. This should cause the reservoir to function normally.

Gaumard simulators are designed to simulate the sensitivity of the human urinary system. For this reason, the bladder tank will disengage internally from the flange in the event that a catheter is inserted with excessive force. In this case, remove the catheter, reattach the bladder tank, and reinsert the catheter more gently, applying lubricant as necessary.

2. Emptying the Reservoir System

A. To remove the remaining fluid from the bladder reservoir after catheterization exercises are complete, sit the model up over a bedpan with the catheter in place.

B. Purging the entire system of fluid may be accomplished by "squeezing" out the fluid.

3. Filling the Bladder

The bladder should be filled through the suprapubic opening. This may be done in one of two ways. Instillation of water through introduction of an appropriate funnel at the suprapubic site; or, by using a catheter with a large syringe.

4. Internal Cleaning

All internal reservoirs may be removed for cleaning. GENTLY disengage each tank by firmly grasping the tank at the base of the red flange that connects the tank to the torso, and easing the red flanges away from the body until the tank is completely disengaged

5. Lubrication

When introducing any invasive device, always use a lubricant, such as one of the following:

- a drop of soap with water
- water soluble lubricant
- silicone spray

6. Cleaning

- The skin of the manikin may be cleaned with a mild detergent, or with soap and water.
- Do not clean with harsh abrasives.
- Indelible marks made with ballpoint pens, ink, or markers will remain.
- Do not wrap the manikin or any **Gaumard** product in newsprint.
- Do not use povidone-iodine on this manikin or any **Gaumard** simulator.
- Improper storage may damage the manikin - keep the manikin stored in the box provided.
- Do not stack or keep heavy materials on top of the box.
- Keep the manikin in a cool area.

Should you have any questions after reading this instruction manual, please contact our customer service department 8AM until 430 PM Miami time (GMT -5) for further assistance:

800.882.6655 (Toll Free USA)
305.971.3790 (Worldwide)
305.667.6085 (Fax)
www.gaumard.com
sales@gaumard.com