SIMulatED RDH Emergency Department - Author:

# Scenario Run Sheet: Neuro Call

## Learning Objectives

**Target Group:** ED nursing and medical staff

**General**

Introduction of the draft “Neuro Call” protocol to ED registrars and nurses

**Scenario Specific**

Demonstration of the key decision points in ED for a “Neuro Alert” and “Neuro Call”

Indications and contraindications to thrombolysis in acute stroke

Demonstration of the NIHSS using a live simulated patient and “expert examiner”

Briefing (MDS): see powerpoint

* Goals:
  + Practice, not assessment.
  + Sim is good for rehearsing in “high stakes” situations
  + We want you to work on the edge of your capacity. I’s normal to have “adrenaline surge”, this will be less in the real clinical situation.
  + THIS WEEK: Testing first half of new protocol TPA In stroke. Not yet live.
  + Stroke workup more complex than STEMI
  + 2 phases: Neuro Alert and Neuro Call, “whole of hospital approach”
  + We know this is unfamiliar – looking for your insight for final tweaks
* Roles/Environment:
  + Front end focus: From CIA to resus; ends before thrombolysis
  + Nurses: some confederates. Doctors: play RAT, Majors consultant and reg, joined by Neuro registrar
  + SIM Switch: call usual number except: Haematol and DPH CT: call directly
  + Patient is a live standardised patient – no needles!
  + Videoconf with Gove ED: sound check
  + In SIM: feel safe enough to take risks for the sake of learning: includes accepting and managing uncertainty, sharing your thinking out loud, asking for help, maybe even changing your usual clinical practice.
  + Fiction contract: “ We have done our best to make things as real as possible for the purposes of achieving the learning objectives. We rely on you acting as though it is real even though you notice lapses in reality”.
* Expectations
* Fiction contract
  + We attempt to make things as real as possible – act as if it is real even if you notice there are lapses in reality
* Confidentiality – not recorded; not for discussion after end of session. GDH
* Scenario 20 mins
* Debrief 20 mins
* Soundbite: draft Neuro Call protocol 10mins

## Scenario Overview

**Brief Summary:** Patient presents within 30 mins of onset of Dominant Left MCA territory infarction, undergoes rapid screening in CIA with Neuro Alert followed by triggering of Neuro call. Patient assessed by Stroke Team in resus. Scenario ends with patient’s departure to CT scan.

|  |  |  |  |
| --- | --- | --- | --- |
| Intro Time | Scenario Time | Debrief Time | Soundbite |
| 5 | 20-25 | 20 | 10 |

## Observers’ Engagement Task

What processes facilitated the patient’s assessment? Did any processes hinder assessment?

## Equipment Checklist

|  |  |
| --- | --- |
| **Patient:** | Live Actor |
| **Monitoring:** | ISim |
| **Docs and Forms** | EDNA, Green sheet, Neuro Call Box (SM): Neuro alert, Neuro Call, NIHSS |
| **Equipment** | Glucometer, 12-lead ECG electrodes, Patient scales, IV cannulation, Safety pin, tendon hammer |
| **Consumables** |  |
| **Medications** |  |

|  |  |
| --- | --- |
| **Sim Prompts** | 12 Lead ECG, VBG, Neuro Alert and Neuro Call printed protocols; JPEGs for audience |
| **Sim Equipment** |  |
| **Same day prep** | MDS phone DPH CT 8928 9821/Haematol 28014 / Neuro reg. to confirm / GDH re VC |

## Participants

**Staff**

Triage nurse, CIN Nurse, 2 Resus Nurses

RAT Consultant: Reg1

Majors Consultant: Reg 2

Majors Registrar: Reg 3

**Instructor Roles:**

In room: MDS

Phone handler: RD : Med consultant; Neurology consultant not avail: at conference

**Confederates**

Patient: Lizanne

FETL: Sam

CIA nurse becomes resus scribe

Resus nurse2

Resus nurse3

Neurology registrar: Steve Evans (Med Reg in a code blue upstairs; Neuro consultant at a conference; Med consultant in Clinic

## Additional Information/Medical History

**Demographics**

58yo female, works as a Centrelink Manager, lives Palmerston, divorced with grown children, Right handed.

Workmate:

**HPC (workmate)** We were eating lunch around 1.30 or 1.40pm when she suddenly started behaving weirdly: kept dropping her knife and couldn’t pick it up again. Sounded like she was drunk like she couldn’t talk properly: Right side of the face not moving properly. She burst into tears out of the blue a couple of times. We were just down in casuarina club and thought it would be faster to drive than wait for an ambulance. In the car she was saying the wrong words sometimes. She needed help to get out of the car- she said her right arm and leg were heavy.

NO seizure, fall, choking, collapse

**HPC (Patient)** “Woke up fine”around 7am, went to work as usual at Centrelink. Had just started eating lunch at the pub maybe 1.30: felt pins and needles to Right face and couldn’t properly out of the right eye. Couldn’t hold my knife properly – kept falling out of my hand. Side of face felt heavy and couldn’t talk properly “like after the dentist”. Felt really scared. Couldn’t find my words to say what was going on. Friend decided to drive me to hospital as only 5 minutes away. Had to help me to the car. Noticed Right leg starting to feel numb and heavy.. Couldn’t get out of car by myself– needed wheelchair to get in to ED.

No headache, vomiting, double vision or vertigo. Well recently. No previous events

**PMH** (Workmate has no details but knows she smokes at work)

HT on Ramipril 10mg for years

High cholesterol “GP just started me on lipitor 40mg”

No DM

“Cutting down” cigarettes – now 10/day

Never had IHD or CVA before

Penicillin allergy: swollen face

Thrombolysis exclusion discussion: answers “no” to bleeding risk questions

**FHx:** Father had a stroke at 70 and 2 brothers “have heart problems”

**When being examined:**

**GCS 14** (E3: closes eyes unless spoken to)

**CNS:**

I normal

II Right homonymous hemianopia

III, IV, IV normal

V reduced R facial sensation

VII Dysarthria: R sided lower facial droop (UMNL)

VIII normal

IX, X – reduced R sided gag

XI reduced SCM/traps power

XII tongue weak R side

PNS: Increased tone (clasp knife) Right side

3/5 weakness Right side.

Coordination: poor finger-nose and heel-shin

If reflexes checked – attempt to feign Right hyperreflexia and Right upgoing plantar

Sensation: reduced LT and PP Right side

**Higher centres:**

Expressive dysphasia but able to communicate with team verbally and with gestures

Difficulty repeating words and describing events in NIHS diagrams

## Proposed Scenario Progression

Orientation: This is the CIA; majors/resus will be the Ben O’Connor room.

STEM: It is 2pm on a Wednesday, this is the current state of Majors. This is the CIA. The FETL has just wheeled a 58yo woman into the CIA in a wheelchair. “This patient has just arrived by private car complaining of Right side weakness and slurred speech. Her friend is registering her at Triage, and says it began while eating lunch about 20-30 minutes ago. I’ve called a NEURO ALERT”.

.

**Starts in audience roo: “CIA” Triage activates “Neuro Alert”**

CIA nurse performs initial obs + alerts RAT consultant (ideally simultaneous assessment)

RAT consultant performs ROSIER, Independence/QOL check and Onset < 4h: **triggers “Neuro Call”** (calls SIM SWITCH for \*\*\* plus requests Triage RN to activate ED tanoy)

**Patient moved to resus by wheelchair** (FETL –NTL-resus nurse+Majors TL; considers options for ED disposition: sim MAP)

RAT consultant hands over to Majors Consultant

Stroke team conducts pre-CT checklist: Vitals, 2xIV,VBG, urgent lab bloods (phones lab 28014: “THIS IS A SIMULATION ONLY”, gives patient referral details, states “END SIMULATION”.). Pt weight, ECG, PCA for transport, head up 30degrees, NBM. Phones DPH CT scanner **8928 9821** and states “THIS IS A SIMULATION ONLY”, gives patient referral details, states “END SIMULATION”.

Neuro registrar arrives: takes handover by Majors Consultant

Neuro registrar conducts NIHSS, confirms 3-phase CT.

Neuro reg attempts to call consultant Medical Consultant (knows Neuro cons is away; via sim switch)

Unable to contact Med Consultant initially. Proceeds with CT.

No BP or resuscitation issues during scenario

Scenario ends as PCA prepares to move patient to CT

## Scenario Preparation/Baseline Parameters

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Stage 1** | Progression Trigger | **Stage 2** | Progression Trigger | **Stage 3** |
| **RR** | 22 | similar |  |
| **SpO2** | 96 RA | 98 RA |  |
| **HR/Rhythm** | 110 SR | 90 SR |  |
| **BP** | 160/95 | 150/90 |  |
| **T** | 37.4 |  |  |
| **Other** | BSL 5.4 |  |  |
|  |  |  |  |

## Debriefing/Guided Reflection Overview

|  |  |
| --- | --- |
| **Opening Gambit**  So who was hoping to thrombolyse him during the scenario? | **Anticipated themes:** |
| **Exploration with key players**  -In this instance the patient arrived by private car.  What do you think would have happened differently if SJA had transported him? What P/H transport priority do you think would have been appropriate?  -What aspects of the protocol did you feel hindered/facilitated patient workup?  -What communication loops were required to facilitate transfer to a monitored cubicle? What difficulties did the nurse TL have in allocating a bed?  -What barriers might there be to calling a Neuro Alert?/Neuro Call?  The Neurology registrar was readily available today; what might need to happen if he/she were absent? | SJA pre-notification  Triage nurse education/prompt sheet  No RRAT doctor in CIA? Options?  Pt aphasic and no RDH record/ID/collaborator  Judgement of “premorbid function” |
| **Engaging the general group** |  |
| **Sharing facilitator’s thoughts** |  |
| **Any other questions or issues to discuss?**  Where else might pt assessment take place during access block?  What might be different if the patient presented after hours? |  |
| **Summary** |  |

## The Soundbite

Powerpoint

General Feedback Prompts/Examples:

Opening Gambit:

* What did you feel were your specific challenges there?
* Let’s talk.
* Can you describe to me what was happening to the patient during that scenario?
* Can you describe to me what was going on?
* What was important to you in choosing to manage that situation?
* Can you tell me what your plan was and to what extent that went according to plan?
* That seemed to me to go smoothly, what was your impression?
* That looked pretty tough. Shall we see if we can work out together what was going on there so that you can find a way to avoid that situation in the future?

Exploration with key players

* Questions to deepen thinking
* Questions to widen conversation
* Introduce new concepts; challenge perceptions; listen and build
* So what you’re saying is…
* Can you expand on…
* Can you explain what you meant by…
* When you said…
* I noticed that you…

Engaging the general group

* Let’s check with the rest of the group how they reacted to you saying that.
* Did you [scenario participants/observers] feel the same?
* What did you [scenario participants/observers] want from [scenario participant] at that point?
* What ideas or suggestions has anyone else got for how to deal with that situation?

Sharing facilitator’s thoughts

* Use advocacy with inquiry to share your observations and explore their perception
* What does the protocol say on…..
* What do you think was happening ….?
* How do you think … would respond to…. ?
* What about next time…..?
* Do you think there’s anything to be gained from…?

Any other questions or issues to discuss?

Summary