Scenario Run Sheet

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| Scenario Overview | |
| Estimated scenario time: | 15-30mins |
| Estimated guided reflection time: | 30mins |
| Target group: | ED Drs and Nurses |
| Brief summary: | Severe Asthma- requiring maximal medical therapy and intubation followed by post intubation hypotension and ventilation difficulties |

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| Learning Objectives | |
| General: | To improve teamwork behaviours in critical incidents by introducing participants to the key points of Resus Room Management:   * Environment – self, patient and team * Leadership – role delegation and managing the mob * Planning – anticipate, share and review the plan * Cognitive resilience – managing stress * Communication techniques – closed loop and graded assertiveness * Limitations – knowing when to call for help |
| Scenario Specific: | * Medical Mx of Acute Asthma * RSI in Asthma * Ventilation strategies in Asthma * Advanced: Mx of post-intubation ventilation difficulties and hypotension |

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| Equipment Checklist | |
| Equipment   * SIM Mannequin * SIM IPAD and defibrillator * NIV-BiPAP machine | **Medications and Fluids**   * Salbutamol , Atrovent, Hydrocortisone, MgSO4, theophylline, Adrenaline * RSI drugs: Sux/Roc, Ketamine |
| **Documents and Forms**   * ED documentation- Nurse scribe sheet |
| **Diagnostics available**   * Venous Gas- Resp alkalosis then acidosis * CXR * ECG: Sinus Tachycardia |

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| Scenario Preparation / Baseline Simulator Parameters | | | |
| Commencement *(i.e. pre-hospital, triage presentation)* | | **Proposed treads during scenario** | |
| Temp –  Pulse –  Resp –  BP –  SpO2 –  GCS –  BSL – | **37.8**  **110**  **30**  **150/80**  **92% on 15L O2**  **15**  **7.5** | Temp –  Pulse –  Resp –  BP –  SpO2 –  GCS-  VBG | **160bpm**  **8**  **160/85**  **Low 80’s**  **13**  **Resp Acidosis forcing intubation** |

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| Number of Participants | |
| Student Roles  Nursing Staff   * Scribe, Airway, Circulation   Medical Staff   * 2 doctors minimum | **Instructor Roles**     * Kev: SIM IPAD * Nicola/Kerrie: Observe, patient voice, ICU consult |

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| Additional Information / Medical History | |
| Patient Demographics: | Jessie Breathless age 30 years |
| History of Presenting Complaint: | BIBA with severe Asthma, self discharged yesterday from medical ward following admission with same, given salbutamol neb x2 by SJA. |
| Previous Medical History: | Asthma- previous intubation and ICU stay required  Social: Smoker 10/day |

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| Proposed Correct Treatment (Outline) |
| * Resus Area with non-invasive monitoring * Obtain full vital signs on arrival: Temp  PR  RR  BP  SpO2  GCS + pupils  BSL  * Obtain IV access: Yes  No  * Initiate IVF: Yes  No  * Medical Tx: * High flow Oxygen\_\_ Beta agonists: Salbutamol Spacer/nebs/infusion\_\_ Anticholinergics: Atrovent spacer/nebs\_\_ * Steroids: Prednisolone/Hydrocortisone\_\_ * Magnesium Sulphate IV\_\_ * Theophylline: IV Aminophylline\_\_ * Adrenaline\_\_ * Consider NIV\_\_ * RSI + drugs used: Fluid Bolus prior to intubation/Sux/Roc/ketamine/other * Ventilation strategy: Aim permissive Hypocapnia, Volume controlled ventilation, FiO2 100% then titrate,RR 6-8, Low TV 5-6mls/kg, Long expiratory time: I:E ratio >1:2, minimal PEEP * Post intubation Ventilation difficulty and Hypotension: Consideration of causes and correction: Dynamic hyperinflation, Tension Pneumothorax, Hypovolaemia, Drugs * Pathology: Pathology requested: FBC  U+E  LFT  Coags  CK/TnI  VBG  ABG  Other \_\_ * Investigations / Treatment: ECG  ARTline  Central Line  IDC  Other \_\_ * Radiology: CXR\_\_ * Referrals: Med\_\_ ICU\_\_ |

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| Debriefing / Guided Reflection Overview |
| Reflection and Self Appraisal:   * *What went well?* * *What else happened?* * *How did the team function?* |
| Situational Awareness questions):   * Global *i.e. was suctioning available?* * Physiological *i.e. what was the heart rate at the completion of the scenario?* * Comprehension a*sk one of the nurses – test clear communication through the team i.e. what do you think is wrong with the patient?* * Projection *ask one of the junior medical staff i.e. what do you think will happen now?* |
| Conclusion:   * *These are the things you identified as going well…* * *These are the things you identified as needing to work on…* * *I saw the following positive things throughout this session…* |

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| Resus Room Management Considerations |
| * Environment – *self, patient and team*   Situational awareness – do you have enough space, light? Can you access and utilise your equipment? Exercise crowd control and minimise disruptive noise.  Don’t be helpless when it counts – do you know how to set up the ventilator, run through an arterial line   * Leadership – *look, act and sound like a leader…*   Leadership is critical in the emergency department  If resources allow – stay hands of to maintain your situational awareness, when you get involved in tasks (i.e. managing the defib) you become blind to what’s happening around you.  Manage to mob – get everyone on the same page by keeping the team with you. This can be achieved by periodically announcing clinical findings and progress, share your mental model of what is going on and state the goals.  Task specific individuals and not the room – learn people’s names   * Planning – *use your mind’s eye…*   The five to ten minutes before the patient is wheeled into your resus room is just as important as the primary survey – use this time effectively to delegate roles, brief the team and share expected outcomes. When the team shares the same mental model they work more effectively to achieve common goals. This shared understanding of team goals, tasks, environment and individual roles and expertise is critical to effective teamwork.   * Cognitive Resilience –   Know your human cognitive limitations – stress can impair memory, attention and judgment. No one is immune to this – build a system to reduce your cognitive load  Encourage the team to challenge, question, and remind  Use checklists (i.e. for RSI)  Stress management can be enhanced through high stress and high fidelity simulation   * Communication techniques – *Never get personal*   Assertive and polite – state the facts and what outcomes you want to achieve.  Never directly judge other individuals  Graded assertiveness is a essential skill to learn  Never threaten someone’s competence; this can disrupt the entire team. If you must disagree or override someone, always give them face saving options. But ultimately remember it’s not about you or them, it’s about the patient.   * Limitations – *don’t let pride disrupt patient outcomes*   It is essential that all team members know their limitations and call for help early when these are reached. |