



2015=9

Overview

Casey Paediatrics Teaching

Scenario 1 – Stephanie King

Scenario Name: Stephanie King– Status

### Format: Fully immersive scenario

### Course: Casey Emergency Paediatric teaching

### Last Revised: 10th November 2015

### File Location:

### Aim:

* To enable participants to practice an effective systematic approach to the management of a patient with Seziures/status

### Duration of Session 10-15 minutes & debrief 10mins

### Type of Learners: Nursing and Medical staff

### Number of Learners: 10

### Number of Staff: 2-3

Learning Objectives:

1. Demonstrate a structured approach to a change in patient status
2. Recognise the need escalation of management
3. Demonstrate the correct use of Midazolam/diazepam/phenytoin/phenobarbitone, propofol
4. Demonstrate the appropriate Ix – hypoglycaemia excluded, consideration of CT
5. Anticipation and planning for RSI – use of checklist, calling for help.
6. Appropriate allocation of roles with multiple tasks needing to be performed
7. Demonstrate the ability to prioritise needs & call for help early
8. Practice effective communication when managing the unstable patient

# Plot

## Outline:

Stephanie is a 5yo who is brought into emergency by a distressed mother for seizure. Seizure continues despite intervention requiring preparation for intubation.

## Patient Details:

### Patient Name: Stephanie King

### Age: 5 years of age

Presenting Complaint:Stephanie is brought in by mother, was at home playing and then collapsed and had seizure, mother lives only 4 min form hospital so places child in car and brought in immediately - Having ongoing seizure on arrival.
No recent infective Sx.

### Past History:

* Born at term, nil Cx
* Nil significant medical history
* NKA

# Setup

## Room & Equipment:

Sign on door: Resuscitation 1

Posters on wall: ISBAR, ACLS, MET criteria

Resus Trolley outside room

## Patient:

Mannequin as “Stephanie”

* 2L NP
* Male wig
* Patient gown
* Covered with blankets
* Cardiac monitoring available
* Oxygen saturation monitoring
* Non-invasive BP monitoring
* Intubating Equipment

## Props:

* Triage nursing chart at end of bed with presenting problem completed as “SOB/wheeze – excacc Asthma”
* Bi-PAP mask - small +/- ventilator
* Intubation equipment checked and available
* 6 cm endotracheal tube (ETT)
* 20 ml syringe
* ETCO2 monitoring
* Lubricant
* McGill’s forceps
* Laryngoscope
* Size 3 McIntosh blades (light source checked and functioning)
* Tape to secure ETT
* Drugs available for rapid sequence intubation (RSI) and potential complications/side effects
* Suxamethonium 100mg in 2ml
* Ketamine 200mg in 2ml
* Propofol 200mg in 20ml
* Midazolam 5mg in 5ml, 5mg in 1ml, 15mg in 3ml, 50mg in 10ml
* Fentanyl 100 micrograms in 2ml, 500 micrograms in 10ml
* Rocuronium 50mg in 5ml, 100mg in 10ml
* Vecuronium 4mg or 10mg powder for reconstitution
* Metaraminol 10mg in 1ml
* Adrenaline 1mg in 1ml, 1mg in 10ml
* Atropine 1200 micrograms in 1ml, 600 micrograms in 1ml
* Crash Cart stocked with
	+ Premixed Adrenaline infusion 6mg/100ml
	+ Premixed Isoprenaline infusion

**Primary Participant:** Handover

# Conduct of Scenario

## Stem

“Stephanie is brought in by mother, was at home playing and then collapsed and had seizure, mother lives only 4 min form hospital so places child in car and brought in immediately”

## Actors’ Instructions

Actors: Nurse confederate

Patient: see control room table

## console

**Control Room:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***System*** | **Patient** | ***Mannequin Settings*** | ***Sam*** | **Ix Results** |
| General  |  | Seizing  |  |  |
| Airway | Snoring - responding to postioning |  | Airway Clear of secretion |  |
| Breathing | earratic | ***RR***16/min | ***SaO2*** 96% on 15L/min  | ***Chest sounds:****Normal* |  |  |
| *Evolution of patient state:* |
| Circulation | A little dizzy | ***HR****135/min* | ***BP*** *120/70mmHg* | ***ECG:*** | JVP |  |
| *Evolution of patient state:*  |
| Disability | GCS 3  | * *Evolution of patient state:*

*Status Epilepticus** Ongoing seizure activity. Until set up for intubation then post ictal.

*Post Ictal* * Slowly improving GCS.

*Treatment of Status** IV access
* 2 doses of Benzodiazepine 5min apart
* IV phenytoin/phenobarbital
* Setup for RSI

*Treatment post ictal state** Reassess A/B/C
* Determination of cause.
* Consideration of Ix i.e CT/MRI

  | Pupils - NormalMotor responses - Normal | BSL 6.5Initial Venous GasespH 7.20 HCO3 20pO2 85 Lactate 4.2pCO2 45 BSL 5.6K 4.5 |
|  |  |  |  |  |
|  |  | Scenario ends when patient referred PIPA for transport and Further Ix discussed, |  |  |

**Discussion Points:**

* Algorithm for Active seizures.
* Remembering to check for hypoglycaemia
* Anticipation of next step in algorithm
* Phenytoin VS Keperra
* Complications of phenytoin
* Calling for help early
* Appropriate allocation of roles
* Disposition and further Ix