**MOCK ARREST SCENARIO- ADULT**

**VT / PEA arrest**

**Scenario:**

Jane is a 65yo female patient seen in ED with a small bowel obstruction. She is to be transferred to a private hospital under the care of her private surgeon. She has been admitted to SSU in the interim.

She has been unwell for 24/24 with generalized abdominal pain, nausea and vomiting. She has not passed a bowel motion or flatus for 24/24

She complains to the nurse of abdominal pain and dizziness and immediately become unconscious.

The emergency buzzer is pressed and the participants arrive.

Facilitator #1:

Operates console and observes scenario

Facilitator #3

Observes scenario

**Actors:**

Grad Nurse 1: “I do not know what happened! She was fine 15 minutes ago. She buzzed and complained of chest pain and dizziness and then she passed out “

It is important that as soon other nurses +/-medical staff arrive junior nurse steps into the back ground. She is helpful when given direct instructions but does not show initiative. Also she cannot perform any tasks beyond her usual role.

**Room Set Up**

“MOCK SCENARIO” Sign on Door

nursing chart at end of bed with observations

medication chart

1 18G IV cannula insitu

Patient in hospital gown

Covered with two blankets

Oxygen saturation monitoring

Non invasive BP monitoring

Crash trolley

Defibrilator

Intubation equipment checked and available

* 7.5 cm endotracheal tube (ETT)
* 20 ml syringe
* Satin slip introducer
* ETCO2 monitoring
* Lubricant
* McGill’s forceps
* Laryngoscope
* Size 3 & 4 McIntosh blades (light source checked and functioning)
* Tape to secure ETT

Drugs available for rapid sequence intubation (RSI) and potential complications/side effects

* Thiopentone 500mg powder for reconstitution
* 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

Other: 3 ECGs – VT / SR ( PEA)

**Learning objectives**

1. Recognise need for BLS / ACLS
2. Recognise VT rhythm and need for DCR (pulse
3. Recognise PEA rhythm and need for CPR
4. Demonstrate administration of BLS / ACLS
5. Follow CPR algorythm
6. DCR
7. Intubation

* Demonstrate preparation for rapid sequence intubation using a systematic approach as per 7P’s of safe RSI especially;
* Safety check and preparation of required equipment including:
* Selection of drugs
* Allocation of roles and appropriate use of equipment and drugs

1. Leader

* leader appointed – leader stands back and leads , if possible without being involved in CPR / procedures/ intubation
* Once The ED doctor arrived he/she should resume the leader role.
* Note if it has been a leader before ED doctor arrives.
* What distinguishes them as a leader and how was the leadership passed from this person to the ED doctor
* In this case as the ED doctor may be the only person that has airway skills may have to do both. Aknowledge this and the inherit difficulties

1. Team work
   1. Communication

* How do you deligate tasks effectively i.e. ask specific person to do specific task
* How do you get their attention : call them by name , touch them , get eye contact
* Closing the loop ( leader ask person “A” to give adrenaline🡪 person “A” gives adrenaline-🡪 person “A” states 1mg adrenaline given)
  1. Roles:
     + Who is the leader- what made them the leader? Did they announce it? Verbal and non verbal communication ( how they stand , what they say , what they are wearing etc)
     + Who is the scribe nurse
     + Who is who- do people introduce themselves and state their position when they arrive?

5. If time permits briefly discuss sedation / paralysis and induced hypothermia/ disposition

**5. Distracters**

Nil.

**6. Control Instructions**

Initial obs set up:

GCS 3

No output

Once patient is connected to the defib/AED: wide complex tachycardia 🡪 VT with no output

If DCR early - continue with VT and no output

After two cycles of CPR the rhythm become PEA

Allow at least another 3 cycles of CPR before output and SR returns 🡪 monitor shows HR 80 BP 100/60 O2 Sats 98% on 15 L O2

Troubleshooting : if participants choose to do a 12 lead ECG during the resus provide them with one of VT/SR ( PEA) after they have brought and connected the ECG machine – however this has to be addressed during debriefing as an inappropriate action   
Have an SR for post arrest

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