CASE SCENARIO – FACILITATOR INFORMATION

The purpose of this activity is for the participant to demonstrate their knowledge of COMPASS principles in a simulated patient case scenario.

LEARNING OUTCOMES:
• Recognise the deteriorating Paediatric patient
• Initiate appropriate and timely interventions
• Demonstrate effective communication (ISBAR)

EXPLANATION OF HOW TO RUN CASE SCENARIO:

Prior to beginning the scenario explain to the participants that this is a low fidelity simulation/role play. The participants should try as much as possible to simulate (verbally) what they would really do on the ward.

Allocation of roles.
• There is one “Actor” card. This participant will interact with the “players” as directed on the “Actor” card
• There are several “player” cards
• Start by allocating the RN1 player card

You can allocate further roles and hand out appropriate player cards as the scenario progresses:
• Registrar

Try to include all participants in the role play.

The first “player” card has information that the participant should read out to the group at the beginning of the scenario. When each new “player” joins the role play they should read out their “player card”.

The facilitator may prompt and direct the participants as required. Note that all participant contributions are valuable and should be heard within the group.

Other useful materials that can help to guide participants:
• Oxygen delivery chain (recognise deteriorating patient and understand why observations have changed)
• ISBAR chart/forms (for communication during role play)
• PEWS escalation process (appropriate and timely interventions)

Materials required for this scenario:
• Observation chart and Fluid Balance Chart
• Frequent Nebuliser Record
• Medication chart

The facilitator can hand these materials out to participants as the role play progresses.
SCENARIO: Case study 1 (Paeds)
Andrew White
UR 12233445

Scenario overview: facilitator reads out the following (in bold) to the group

Andrew White is a 6-year-old male admitted to the Paeds Medical Ward from ED at 1630, with an acute exacerbation of asthma.

**PMHx-**
Asthma – admission last winter
Normal growth and developmental milestones achieved
NKA
Wt 24kg

*Invite the Actor and Player One to read out their cards to start the scenario.*
*Explain to the participants that they may ask the “patient’s carer/guardian” or the facilitator questions to try and work out what is going on*

**During the scenario:**

If Player 1 needs prompting:

1. **What assessments would do on this patient?**
   - Vital Signs *(what do you think vital signs indicate?)*
   - Respiratory effort – wheeze, recession and accessory muscle use
   - Respiratory efficacy (How well are they breathing?)
   - Respiratory effect (What effect is respiratory status having on circulatory status?) *(pale, cool fingers and feet)*
   - Chest auscultation – *expiratory wheeze*
   - Can Andrew speak in full sentences? *no*
   - General assessment - What does Andrew look like?
     - *Pale, sitting upright, not engaging in conversation with you, he is tachypnoeic, SaO₂ have dropped despite O₂ @ 2L/NP*
   - Level of consciousness
     - *Alert*

2. **What questions would you ask this patient/patient’s carer?**
   - How does Andrew seem to you?
• Has Andrews’s condition changed since he arrived on the ward?
• What other sources of information do you have (family, pathways, medication chart, fluid balance chart, progress notes)

3. **Who would you notify? Why?**
   - PEWS 7 – Registrar to review, notify Consultant
   - Team leader or CNC

   **The RN should discuss the case face-to-face with the Registrar**
   **Communication should be clear expressing concerns and what he/she would like the Registrar to do (use ISBAR)**

   Registrar (player 2) enters the role play – read from card

4. **What information do you require from the RN?**
   - Vital Signs
   - Medication chart
   - Frequent nebuliser chart
   - Brief history

5. **What assessment would you do? (Prioritise)**
   - ABC
   - Respiratory examination (look, listen, feel)

6. **What is your management plan for this patient?**
   - Oxygen
   - Increase frequency of bronchodilators
   - IV access
   - Steroids
   - Investigations- (*bloods*, ? *ABG*, CXR)

7. **What would you do if the patient does not respond?**
   - Seek help
   - Nursing team leader or CNC
   - Contact Registrar and/or Consultant
   - Consider HDU
   - Consider CPAP

**During the role play the facilitator may ask the participants** –
   - How often should observations be done?
What do you think may be going on with this patient?

Explain the observations using the oxygen delivery chain

Group discussion/reflection at the end of the scenario

The important things to get across in this case are:

**CASE 1 (Asthma)**

- 6 year old boy transferred to the ward from ED with acute asthma and is now deteriorating.

**Physiological changes reflected in the vital sign readings:**

- Arterial saturation has fallen due to airway constriction limiting the oxygen entering the lungs
- Respiratory Rate ↑ because he has become hypoxic which stimulates the respiratory centre to increase the respiratory rate
- With a ↓ in arterial saturation (and therefore arterial O2 content) there is an ↑ in heart rate to ↑ Cardiac Output and ↑ Oxygen delivery (from stimulation of sympathetic nervous system)
- Effort of breathing ↑, wheeze and recession
- Andrew is at risk of tiring

**Management should include:**

- Bronchodilators to dilate airways and therefore ↑ SaO2
- Steroids – reduces inflammation in the airways therefore allowing ↑ airflow and ↑ arterial SaO2
- ½ hrly obs with high PEWS, 1/24 obs if on oxygen

Information noted from patient charts and results:

- Increased respiratory rate
- Increased effort of breathing
- Increased heart rate
- Decreased SpO2
• Increasing PEWS score
• Last salbutamol at 2100hrs - not due until 2300hrs
• Last Iprabropium Bromide at 1800hrs – due at 2200hrs
• Has not had any steroids

Player Card 1 - RN (case 1 Paeds)

Please read out the wording in **bold** when scenario commences.

I am an RN on night duty on the Paediatric Medical Ward. I have approached Andrew at the beginning of my shift to perform regular observations.

What I know about Andrew:

• He is 6 year-old boy admitted from ED at 1630hrs, with an acute exacerbation of asthma earlier this afternoon

What do you do next?

• Talk to patient/carer
• Perform observations
• Assessment (look at vital signs, do you need any other information? Ask patient/carer)
• Do you need to refer this patient for review?
Actor Card - Patient’s mother – Gloria White (case 1 Paeds)

Please read out the wording in bold when scenario commences.

I am Gloria White, Andrew’s mum.

If asked:

• **When was Andrew admitted?** I brought Andrew to the ED this morning after he became ‘wheezy’. He has had a cold (runny nose) for a couple of days, and has been coughing a lot at night

• **Has Andrew been in hospital with asthma before?** Andrew had his first admission to hospital with asthma last winter. He was in for 3 days. He has been fine since, only needing the blue puffer every now and then.

• **Is Andrew on a preventer medication?** No

• **How do think Andrew is going?** His breathing seemed to improve when we first arrived on the ward, but he is breathing faster and not his usual active self now. He is wheezing

• **What does Andrew look like?** Pale. Not interested in playing on the I pad. He is sitting forward and looks a bit out of it.
You are the Paediatric Registrar working nights. You are admitting a child in ED when you are called to review this patient.

The RN will try to discuss the case with you using ISBAR. Allow the RN to finish before responding.

THEN

How do you respond?

What do you do next?

**ROLE-PLAY YOUR NEXT ACTIONS.**
Case 1

The Canberra Hospital
Frequent Nebuliser Record Sheet

Weight: 20KG  Allergies: NKA

Date | Time | Drug      | Dose | Frequency | O2 / Air | R.M.O.'s Signature
-----|------|-----------|------|-----------|----------|---------------------
11/6 | 1000 | Salbutamol| 4-6  | 2/3/4     |          |                     
11/6 | 1000 | Ipratropium| Puffs| 4/8/24   |          |                     
11/6 | 1000 | Bromhexine| 4-6  |          |          |                     

Medication Administration Record

Date | Time | Given by | Checked by | O2 Therapy | O2 Saturation | Pre | Post
-----|------|----------|------------|------------|---------------|-----|-----
11/6 | 1800 | D.D.     | Vx6        |            |               |     |     
11/6 | 1800 | D.D.     | Vx6        | Ax4        |               |     |     
11/6 | 1800 | A.M.     | Vx6        |            |               |     |     

Ur 123457.
White, Andrew
DOB 2/10/2003  Male
<table>
<thead>
<tr>
<th>Period</th>
<th>Medication</th>
<th>Dose</th>
<th>Route</th>
<th>Administered</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Week 1</td>
<td>Propranolol</td>
<td>10mg</td>
<td>PO</td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Metoprolol</td>
<td>50mg</td>
<td>PO</td>
<td>Daily</td>
<td></td>
</tr>
<tr>
<td>Week 2</td>
<td>Amiodarone</td>
<td>200mg</td>
<td>IV</td>
<td>Once</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Verapamil</td>
<td>120mg</td>
<td>PO</td>
<td>Daily</td>
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</table>

**Case 1 – Paediatrics – Andrew White**
Case 1 – Paediatrics – Andrew White

**GENERAL OBSERVATION CHART**

**PEDIATRIC**

6 - 11 YEARS

Complete details or add label

**URN:** [URN]

**Family Name:** WHITE

**Given Names:** ANOREN

**DOB:** 2/1/2003

**Sex:** Male

**Alarms to calling criteria**

Document reasons for Attention to calling criteria below and urgent review parameters over page. Patient must be reviewed within 24 hours (written in clinically indicated). Register non-alarm Alerts after discussion with Consultant. Consultant to sign chart within 24 hours. Further Attention to calling criteria required circumstances new chart.

**Date/Time:**

**Reason for Attention:**

**Next review date/time:**

**Observation frequency:**

**Alerts to calling criteria documented over page?**

- [ ] Yes
- [ ] No

**Additional instructions and comments:**

- Call if clinical concern

**RMO/Registrar name (print):**

**RMO/Registrar signature:**

**Consultant name (print):**

**Consultant signature:**

**Additional observations**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pain Score – FLACC Pain Scale (behavioural)**

<table>
<thead>
<tr>
<th>FACE</th>
<th>No particular expression or smile</th>
</tr>
</thead>
<tbody>
<tr>
<td>SCORE 1</td>
<td>Occasional grimaces or frown,</td>
</tr>
<tr>
<td></td>
<td>watery, red, eyes,</td>
</tr>
<tr>
<td>LEGS</td>
<td>Abnormal position or relaxed</td>
</tr>
<tr>
<td>SCORE 1</td>
<td>Upright, relaxed, tall</td>
</tr>
<tr>
<td></td>
<td>Kneeling or leg drawn up</td>
</tr>
<tr>
<td>ACTIVITY</td>
<td>Lying quietly normal position</td>
</tr>
<tr>
<td>SCORE 1</td>
<td>Squeezing, shifting back/forth</td>
</tr>
<tr>
<td></td>
<td>Torso</td>
</tr>
<tr>
<td>CRY</td>
<td>No cry (tears or wailing)</td>
</tr>
<tr>
<td>SCORE 1</td>
<td>Whispering or Complains</td>
</tr>
<tr>
<td></td>
<td>Crying, steady, loud or echo</td>
</tr>
<tr>
<td>CONSOLABILITY</td>
<td>Content, Relaxed</td>
</tr>
<tr>
<td>SCORE 1</td>
<td>Reassured by occasional</td>
</tr>
<tr>
<td></td>
<td>Touching, hugging or talking</td>
</tr>
</tbody>
</table>

This score chart is used for the following children: adding the score of each of the five points together from 1 – 10

**Facial Pain Scale – Revised**

![Facial Pain Scale](image)

"These faces show how much something can hurt. The left face (pain to this area) shows no pain. The faces show more and more pain up to the one on the right which shows very much pain. Point to the faces that show how much you hurt right now."

**PPS © International Association of the Study of Pain © 2003**

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Case 1 – Paediatrics – Andrew White

### Paediatric Early Warning Scores (PEWS)

<table>
<thead>
<tr>
<th>PEWS</th>
<th>Escalate</th>
<th>Index</th>
<th>Hospital alert</th>
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</thead>
<tbody>
<tr>
<td>4MET</td>
<td>Team Leader</td>
<td>RN and RMO</td>
<td></td>
</tr>
<tr>
<td>PEWS 3-4</td>
<td>Team Leader</td>
<td>RN and RMO</td>
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</tr>
<tr>
<td>PEWS 2-3</td>
<td>Team Leader</td>
<td>RN and RMO</td>
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</tr>
<tr>
<td>PEWS 1-1</td>
<td>Team Leader</td>
<td>RN and RMO</td>
<td></td>
</tr>
</tbody>
</table>

- Notify: Oncall, Radiology, Pathology, Pharmacy, IT, Fluids
- Escalate: Nursing, Medical, ICU
- Index: Pedi, RMO, RDST
- Hospital alert: Aldo, RMO, Radiology

### PEWS Escalation Table

#### Vital sign frequency and actions for PEWS ≥ 4:
- ½ hour for 1 hour
- Commence fluid balance chart
- IF PEWS ≥ 4 DI must be measured with each set of vital signs

#### Initials
- If patient improves decrease frequency of vital signs to:
  - 1 hour for 4 hours
  - 4 hours for 24 hours

### MET Criteria (Dial “A” for MET)

- Neonatal/MET II < 3 months or > 15 kg
- Paediatric/MET II > 3 months or > 15 kg
- Pedi/MET II > 3 months or > 15 kg

**Symptoms**
- Any observation ≥ KET score
- SaO2 < 90% on any O2
- SaO2 < 90% in patients with Cystic Fibrosis
- Severe or worsening respiratory distress, exhaustion, agitation or cyanosis
- Abnormal heart rate
- Insensitive to cardiac arrest

**Clinical Indicators**
- New or worsening clinical condition, postoperative or post procedure, medical orders, signs of clinical deterioration and/or PEWS ≥ 4

Refer to Vital Signs Procedure for clarification.