

Scenario Development Worksheet-Group # 1

Scenario Title Trauma-Closed Head Injury

Scenario Goal - Perform a patient assessment to identify and treat life threats while packaging and transporting a trauma patient

Scenario Objectives: During this scenario the participants will be expected to:

1. Perform a trauma patient assessment and identify life threats.
2. Treat life threats
3. Determine how to package the patient
4. Make appropriate transport decisions

Prerequisite Competencies

Cognitive Trauma patient assessment, s/s of head injuries, trauma response and transport guidelines

Psychomotor Trauma Patient assessment, managing traumatic injuries, patient packaging techniques

Affective Understanding the importance of patient reassurance, teamwork effectiveness, personal safety to EMT and Patient

Performance Expectations

Novice versus Expert

Skill Focus versus Management

Bloom Level

(Cognitive, Psychomotor, Affective) Manipulation

Scenario Roles (Describe and Assign)

Bystander/Family Member N/A

Patient responding to verbal stimuli -

Lead Provider Performs appropriate assessment for patient

Assistant Provider(s) Participates in treatment, packaging as necessary

Other (Recorder, Medical Control, PD, etc) NA

Higher Level (Critical) Thinking Issues

Cognitive Signs and Symptoms: head and spinal injury; Pt. packaging techniques
A: Airway assessment and management; LOC Assessment; Shock treatment

Psychomotor Pt. Packaging techniques; Airway Management;

Affective Patient Reassurance, good teamwork, personal safety

Required Materials

Moulage/Props wound (bump) on head, pale skin, mister for moist skin

Medical Equipment Oxygen, Trauma kit, Spinal immobilization equipment, Airway management equipment

Other ATV, props, Extra help.

Assessment and Management Scenario Template

Dispatch: 36 year old male who fell from a tree stand.

Arrive to find: Scene is safe. Man fell to ground and landed on wood. He is responsive to verbal stimuli. Arrival at the scene will be facilitated by the use of ATVs and additional help. Was hunting with Cheney.

Assessment should reveal:

- Airway -Patent Airway
- Breathing-rapid and shallow @ 20 breaths per minutes
- Pulse - 64 and regular
- Blood pressure-160/90
- Pupils -dilated and equal
- Lung sounds –present and clear bilaterally
- Skin pale-pale, cool, clammy
- History
 - S-head hurts, disoriented,
 - A-medic alert indicates penicillin
 - M-na
 - P-na
 - L-na
 - E-tree stand broke
 - O-time of call-to unknown
 - P-na
 - Q-na
 - R-na
 - S-na
 - T-na
- Injuries-bump on head

Moulage: wound on head, pale skin, mister to provide moist skin

Treatment:

Basic: ABC's, C-Spine Control, O2, patient packaging and transport to destination

Patient Response: unchanged

ALS: Ground ALS intervention to hospital

Higher Level Questions or Affective Issues: Questions relating to progress of patient with altered LOC , potential changes that may be experienced.

Scenario Development Worksheet # 3

Scenario Title Cardiac Episode

Scenario Goal-Manage patient with cardiac chest pain

Scenario Objectives: During this scenario the participants will be expected to:

1. ID signs and symptoms of cardiac chest pain (origin)
2. Select appropriate interventions
3. Consider the need for ALS Intercept

Prerequisite Competencies

Cognitive Patient Assessment for cardiac

Psychomotor Skills:communication through medical module

Affective Personal and Family Concerns

Performance Expectations

Novice versus Expert

Skill Focus versus Management

Bloom Level

(Cognitive, Psychomotor, Affective) Applications

Scenario Roles (Describe and Assign)

Bystander/Family Member Concern for pat., “help them” “hurry up”, asking questions

Patient Alert and oriented x 3, 8 of 10 on pain scale, SOB, pale/cyanotic/clammy

Lead Provider Decided by team members, lead in assessing patient and directing treatment for patient.

Assistant Provider(s) partner

Other (Recorder, Medical Control, PD, etc) first responder, police

Higher Level (Critical) Thinking Issues

Cognitive Do a complete cardiac history assessment, JVD, pedal edema, family history, smoker, etc., What if your patient already took NTG or ASA. What would you do if your patient’s BP dropped after you gave NTG. What would you expect the position of comfort to be? Should ALS be notified to transport?

Psychomotor how much O2? Mask vs. nasal

Affectively responds to high priority appropriately

Required Materials

Moulage/Props _____ White make-up, blue for cyanosis, spray, sweating _____

Medical Equipment _____ O2, aspirin, nitro? Medication bag, D-fib, stretcher, suction, scope and BP cuff _____

Other _____

Assessment and Management Scenario Template

Dispatch: 58 yo female with chest pain

Arrive to find: female seated at kitchen table, SOB, pale, cool, clammy, radiating down left arm.

Assessment should reveal:

- Airway-patent
- Breathing-SOB
- Pulse- 100
- Blood pressure-148/90
- Pupils - PERRL
- Lung sounds - clear
- Skin pale- pale
- History-
 - S-
 - A-NKA
 - M-nitro, lipitor, high BP meds
 - P-angina, hypertension, stents
 - L-2 hours ago
 - E-watching TV
 - O-2 hours
 - P-movement makes it worse
 - Q-crushing
 - R-left are
 - S-8 on 10 scale
 - T-worse in last 30 minutes
- Injuries NA

Moulage: pale, cool, clammy make-up

Treatment:

Basic: O2, aspirin, vitals, AED (or monitor), assist with nitro? Pain goes away

Patient Response: no response to 3 nitro administration

ALS: Consideration

**Higher Level Questions or Affective Issues: What's the effect of aspirin? Nitro?
Which first? What did you do for family members?**

Scenario Development Worksheet

Scenario Title Trauma-C-Spine Injuries # 3

Scenario Goal-Proper C-Spine Management

Scenario Objectives: During this scenario the participants will be expected to:

1. Recognize possible injuries, based on mechanism of injury.
2. Use appropriate C-Spine immobilization
3. Select appropriate equipment to immobilize.

Prerequisite Competencies

Cognitive_ Patient Assessment, communication, Trauma/spinal assessment and treatment

Psychomotor C-Spine immobilization devices, patient movement

Affective Make patient aware of treatment, reassurance, honesty

Performance Expectations

Novice versus Expert

Skill Focus versus Management

Bloom Level

(Cognitive, Psychomotor, Affective) C=Application P=Precision
S=Valuing

Scenario Roles (Describe and Assign)

Bystander/Family Member Neighbor across street

Patient Conscious, bleeding R arm and L ankle fracture

Lead Provider _____

Assistant Provider(s) _____

Other (Recorder, Medical Control, PD, etc) dispatch

Higher Level (Critical) Thinking Issues

Cognitive Signs and symptoms of spinal “shock” /why do these s/s occur?
Which is priority-C-Spine, bleeding arm or fx ankle? Why? How does a patient’s
medical conditions (i.e. diabetes) affect your decisions? Seizure prior to your arrival?
What if the wind chill factor is -20 degrees F?

Psychomotor Immobilization (immediate c-spine) What if the patient doesn’t fit
into a conventional c-collar or if patient’s head will not align into a neutral position?
How would the situation change if your patient is a 10-month old?

Affective valuing-how would you handle a patient that wouldn’t tolerate
immobilization?

Required Materials

Moulage/Props minor arm bleeding, obvious ankle fracture

Medical Equipment c-collars, KED, long board, straps, jump kit with O2, BP cuff, blankets, splinting equipment, bandaging materials

Other _____

Assessment and Management Scenario Template

Dispatch: 57-year old male “man laying on the ground”, early afternoon

Arrive to find: outside in summer, ladder propped against house, pt. is supine, obvious deformity to left ankle, bleeding from right forearm

Assessment should reveal:

- Airway-patent
- Breathing-rapid, 24/minute, shallow
- Pulse-108 and regular
- Blood pressure – 100/60
- Pupils - PERRL
- Lung sounds clear and diminished in the bases
- Skin- pale and diaphoretic
- History
 - S-pain in R arm, paresthesia from nipple line down
 - A-morphine
 - M-high cholesterol meds, HCTZ
 - P-hypertension, high cholesterol
 - L-lunch 2.5 hours ago
 - E-cleaning gutters, started down the ladder to get more tools
 - O-at time of call
 - P-nothing
 - Q-none
 - R-none
 - S-2 for right arm
 - T-constant
- Injuries-abrasion to R forearm-minor bleeding, obvious deformity to L ankle

Pain on palpation @ C-5 and 6

Moulage: consistent with injuries listed above

Treatment

Basic: Manual c-spine, O2, vitals, complete immobilization to long board, load and go, consider ALS, bandage forearm and splint ankle

Patient Response: no change 2nd vitals: BP 90/60, P112, R 24

ALS: Not available

Higher Level Questions or Affective Issues:

Why was patient hypotensive? What are the difference between spinal shock and hypovolemia?

Medical Equipment inhalers/medications/neb sets, BP cuff, stethoscope, pulse oximeter.

Other Breath sound simulator, if available

Assessment and Management Scenario Template

Dispatch: Elderly male with shortness of breath

Arrive to find: Male seated in recliner complaining of shortness of breath, has increased his home oxygen with no relief.

Assessment should reveal:

- Airway -patent
- Breathing-rapid, shallow, labored, 28 BPM
- Pulse –rapid and thready-110/minute
- Blood pressure – 110/64, controlled by medication
- Pupils - PERRL
- Lung sounds –poor air exchange, inaudible lungs sounds bilaterally
- Skin pale-cyanotic, cool, sweaty
- History-
 - S-difficulty breathing, pain in lower right rib area
 - A-Penicillin
 - M-Blood Pressure pill, cholesterol medication, water pill, heart pills, inhalers
 - P-COPD, hi cholesterol, Hypertension, heart disease
 - L-Breakfast 0600
 - E-Bent over, sudden onset of pain
 - O-1 day ago and increased dyspnea since-minimal exertion adults inability to breath normally
 - P-position change
 - Q-dull
 - R-none
 - S-10 of 10
 - T-1 day
- Injuries-none found

Moulage: Cyanosis, diaphoretic

Treatment

Basic: O2 by non-rebreather
Nebulizer (Albuterol)

Patient Response: Slight relief, wheezing with poor air exchange

ALS: intercept requested.

**Higher Level Questions or Affective Issues: Why did wheezing start after neb RX?
Are there any other meds you can give? How are albuterol and atrovent different?**

Scenario Development Worksheet

Scenario Title Trauma-Open Chest Injury

Scenario Goal- Manage open chest injury

Scenario Objectives: During this scenario the participants will be expected to:

1. Perform assessment to reveal open chest injury
2. Manage an open chest injury
3. Treat an open chest injury

Prerequisite Competencies

Cognitive Pt. Assessment, trauma, chest injury and communications lessons

Psychomotor C-Spine Management , application of occlusive dressing

Affective emotional well being of patient, educate patient

Performance Expectations

Novice versus Expert

Skill Focus versus Management

Bloom Level C=analytical, P=precision, A=Organizing

(Cognitive, Psychomotor, Affective) _____

Scenario Roles (Describe and Assign)

Bystander/Family Member Friend-concerned

Patient conscious, verbal, agitated, excited

Lead Provider Assess and history taking

Assistant Provider(s) Manage wound

Other (Recorder, Medical Control, PD, etc) gopher, communicator-documenting vitals

Higher Level (Critical) Thinking Issues

Cognitive pathophysiology of chest wound including organs that could be involved; major bleeding from from vessels, level of diaphragm

Psychomotor complications in bandaging

Affective organized fashion

Required Materials

Moulage/Props grease paint in red, blue, white, torn and bloody shirt _____

Medical Equipment O2, bandages, occlusive dressing, jump kit

Other beer/liquor bottles, simulated broken glad overturned table / chairs

Assessment and Management Scenario Template chest injury

Dispatch: Called to local establishment for bar fight, perpetrator under arrest, safe scene

Arrive to find: 28 year old male patient sitting in chair, holding R lower ribs. Verbal, excited , agitated

Assessment should reveal:

- Airway - open
- Breathing- 24 and shallow, slightly labored
- Pulse – 98, full and regular
- Blood pressure – 128/84
- Pupils- PERRL
- Lung sounds-clear x 4
- Skin-pale, cold, clammy
- History
 - S-puncture wound R lower
 - A-none
 - M-none
 - P-none
 - L-just had 4 beers and jalapeno peppers
 - E-visiting with old female classmate and her boyfriend came in a started a fight “He stabbed me”
 - O-
 - P-hurts to breath
 - Q-sharp, stabbing pain at trauma site
 - R-no radiation
 - S-pain 6 of 10 scale, respiratory distress 4 of 10 sclae
 - T-15 minutes ago
- Injuries-R lower ribs, puncture wound with minimal bleeding

Moulage: grease paint- white, red, blue, blood- stained t- shirt

Treatment

Basic: O2, management of wound with gloved hand, treatment with occlusive, treatment of shock position of comfort

Patient Response: responds appropriately to treatment. Vitals remain stable, patient remains alert

ALS: Consider ALS for possible complications

Higher Level Questions or Affective Issues: Development of tension pneumothorax: signs and symptoms? Treatment? Appearance if managed properly?

Scenario Development Worksheet

Scenario Title Medical-Diabetic # 6

Scenario Goal- Determine when it is warranted to administer oral glucose.

Scenario Objectives: During this scenario the participants will be expected to:

1. Differentiate between high and low blood sugar based on s/s of patient
2. Identify any contraindication to the administration of oral glucose.
3. Demonstrate administration of oral glucose.

Prerequisite Competencies

Cognitive- Medical history taking, understanding of diabetes, communications for obtaining medical control orders if indicated

Psychomotor glucose check, administration of glucose

Affective how they interact with patient with altered mental status

Performance Expectations

Novice versus Expert

Skill Focus versus Management

Bloom Level

(Cognitive, Psychomotor, Affective) C=application P=precision

A=valuing

Scenario Roles (Describe and Assign)

Bystander/Family Member roommate

Patient slightly shaky and confused

Lead Provider Choose students to perform assessment

Assistant Provider(s) _____

Other (Recorder, Medical Control, PD, etc) _____

Higher Level (Critical) Thinking Issues

Cognitive- relationship between glucose and insulin levels-why they have an altered mental status when sugar levels are low.

Psychomotor during skills, ask questions as to why you chose oral glucose over glucagon

Affective patient stated improper words or exhibited improper actions during altered mental status and remembered it when levels became closer to normal

Required Materials

Moulage/Props pale skins

Medical Equipment _____ jump kit, oral glucose, O2 and delivery devices
Other _____

Assessment and Management Scenario Template

Dispatch: Unknown medical problem-patient confused

Arrive to find: 28 year-old female sitting in living room recliner

Assessment should reveal:

- Airway - open
- Breathing-14/ non-labored
- Pulse – 90 BPM
- Blood pressure – 136/72
- Pupils -PERRL
- Lung sounds – present, clear bilaterally
- Skin-pale, dry
- History
 - S-confused, slightly shaky
 - A-NKDA
 - M-metformin
 - P-diabetic, cardiac
 - L-last night, 1800 hours
 - E-dusting house, ½ hour ago
 - O-roommate ran to store, came home and found patient glassy-eyed and “not normal”
- P-NA
- Q-NA
- R-NA
- S-NA
- T-within last ½ hour
- Injuries

Moulage: Pale skin

Treatment

Basic: Patient assessment, O2, oral glucose, no glucometer available,

Patient Response: Alert after one tube of glucose

ALS: none needed

Higher Level Questions or Affective Issues: What do you do when your patient refuses transport? What treatments and concerns do you have if patient's LOC decreases? What are the s/s of hypoglycemia? Hyperglycemia?

Scenario Development Worksheet

Scenario Title: Acute Abdominal Pain

Scenario Goal: To assess and treat abdominal pain

Scenario Objectives: During this scenario the participants will be expected to:

1. Perform medical and trauma patient assessment.
2. Develop a treatment plan based on assessment findings.
3. Provide treatment based on assessment findings and treatment plans.

Prerequisite Competencies

Cognitive Medical and Trauma Assessment, Acute Abdomen, OB/Gyn Emergencies

Psychomotor Assess the abdominal quadrants, monitor VS, identify MOI, control bleeding

Affective Communications with patient and hospital, empathy for miscarriage

Performance Expectations

Novice versus **Expert**

Skill Focus versus **Management**

Bloom Level

(Cognitive, Psychomotor, Affective) Analyze, Precision, Valuing

Scenario Roles (Describe and Assign)

Bystander/Family Member Boyfriend

Patient Female, tearful, upset

Lead Provider _____

Assistant Provider(s) _____

Other (Recorder, Medical Control, PD, etc) _____

Higher Level (Critical) Thinking Issues

Cognitive Potential miscarriage vs. internal bleeding

Psychomotor Full assessment while explaining procedure to patient, care of pelvic fracture, care for miscarriage

Affective Paint a good picture to the hospital, balance your emotional feelings against the patient's distress

Required Materials

Moulage/Props Snowmobile suit, confined space/bathroom stall, cutable clothing, fake blood, pale and clammy skin

Medical Equipment Oxygen tank and supplies, back board, scoop stretcher, jump kit, blankets, bandaging and splinting supplies

Other _____

Assessment and Management Scenario Template

Dispatch: Snowmobile vs. tree accident. The patient has been taken into the local tavern.

Arrive to find: A 24 y/o female in the one stall bathroom. She is complaining of abdominal pain and vaginal bleeding.

Assessment should reveal:

- Airway is open; patient is talking and crying.
- Breathing at 26 times/minute and shallow.
- Pulse is 110, weak and regular.
- Blood pressure 112/88
- Pupils equal
- Lung sounds clear, equal bilaterally
- Skin is pale, cool and clammy.
- History
- S- abdominal pain, vaginal bleeding, nausea
- A- PCN
- M- prenatal vitamins
- P- miscarriage 2 years ago, currently 12 weeks pregnant
- L- pizza and soda 1 hour ago
- E- Lost control of snowmobile going around a corner about 15 MPH.
- O- snowmobile hit the tree; she may have hit handle bars; she has been having cramping and spotting since yesterday

- P- worse when she extends her legs
- Q- cramping abdominal pain
- R- down to pelvis
- S- 6/10 scale; she states “I’m not a baby.”
- T- accident happened ½ hour ago; cramping and spotting since yesterday
- Injuries – Bruise to umbilicus area, gross red blood from vaginal area. Denies neck or back pain.

Moulage: Bloody pants, pale/cool/clammy skin, messy clothes

Treatment

Basic: Oxygen, prevent further heat loss with blankets. Trauma dressings to genital area for vaginal bleeding. Spinal immobilization with legs flexed. Talk to and calm patient and boyfriend. Monitor patient for hypovolemic shock.

Patient Response: Patient feels better when treated for shock. Nausea continues. Patient continues to compensate: pulse 118, respirations 30, BP 110/84.

ALS: Start an IV and titrate to maintain BP. Analgesia for pain if within protocols.

Higher Level Questions or Affective Issues:

B: When and if would you call ALS?

B/A: Would you address the previous miscarriage?

B/A: Would you expose and examine the genital area?

B/A: Would you transport patient on backboard?

B/A: Would you tilt the patient to one side? Which one?

B/A: How would you address the patient’s response to possible miscarriage?

A: What gauge catheter and IV tubing would you use?

A: What rate would you run the IV?

A: What analgesia would you choose to give? Why?

Scenario Development Worksheet

Scenario Title: Obstetric – Supine Hypotension Syndrome

Scenario Goal: To identify supine hypotension syndrome

Scenario Objectives: During this scenario the participants will be expected to:

1. Identify signs and symptoms of supine hypotension.
2. Identify causes of supine hypotension.
3. Identify treatment for supine hypotension.

Prerequisite Competencies

Cognitive Medical Assessment, OB/Gyn Emergencies

Psychomotor Assess the patient and treat supine hypotension

Affective Seeks opportunity to educate patient on supine hypotension

Performance Expectations

Novice versus Expert

Skill Focus versus **Management**

Bloom Level

(Cognitive, Psychomotor, Affective) Analyze, Precision, Valuing

Scenario Roles (Describe and Assign)

Bystander/Family Member Husband

Patient Female, dizzy

Lead Provider _____

Assistant Provider(s) _____

Other (Recorder, Medical Control, PD, etc) _____

Higher Level (Critical) Thinking Issues

Cognitive Understand the A&P of patient's condition

Psychomotor Assessment of patient and treatment of supine hypotension

Affective Relate signs and symptoms to prevention

Required Materials

Moulage/Props Pregnancy simulator or pillow, pale/sweaty skin, lawn chair

Medical Equipment Oxygen tank and supplies, jump kit, blankets

Other _____

Assessment and Management Scenario Template

Dispatch: Female in the backyard on a warm summer day complaining of feeling light headed and dizzy.

Arrive to find: A 32 y/o female in her third trimester of pregnancy, lying supine in a lawn chair.

Assessment should reveal:

- Airway is open.
- Breathing at 18 times/minute, labored and shallow.
- Pulse is 110, thready and regular.
- Blood pressure 80/60
- Pupils equal
- Lung sounds clear, equal bilaterally
- Skin is pale, cool and clammy.
- History
- S- "feeling woozy", light headed and dizzy
- A- Sulfa
- M- prenatal vitamins
- P- currently 38 weeks pregnant; first pregnancy
- L- sandwich and lemonade 1 hour ago
- E- Lying in the sun since eating an hour ago.
- O- started feeling a little funny about 30 minutes ago, continued to rest then felt very lightheaded when she stood up to go in. She laid back down to await your arrival.
- P- nothing
- Q- feels lightheaded, not spinning
- R- none
- S- rates dizziness 6/10 scale
- T- 30-40 minutes ago

- Injuries – none

Moulage: Pillow to simulate pregnancy, pale/cool/clammy skin

Treatment

Basic: Assessment with vital signs, oxygen, transport patient tilted to her left side

Patient Response: Patient feels better and dizziness is gone. Vitals improve - pulse 94, respirations 18 and normal depth, BP 110/84.

ALS: none

Higher Level Questions or Affective Issues:

B: Would you check for crowning? Would you examine the genital area?

B: Would you take this opportunity to discuss supine hypotension with the patient and her husband?

B: How would you explain supine hypotension syndrome to the patient and her husband?

Scenario Development Worksheet

Scenario Title: Gunshot Wound to the Genitalia

Scenario Goal: To assess and treat genitalia injuries

Scenario Objectives: During this scenario the participants will be expected to:

1. Identify additional resources that may be needed.
2. Perform trauma patient assessment.
3. Provide physical and emotional patient care.

Prerequisite Competencies

Cognitive Trauma Assessment, Trauma Module

Psychomotor Bandaging, bleeding control, care for soft tissue injury

Affective Communications with patient and hospital

Performance Expectations

Novice versus Expert

Skill Focus versus **Management**

Bloom Level

(Cognitive, Psychomotor, Affective) Analyze, Precision, Organizing

Scenario Roles (Describe and Assign)

Bystander/Family Member Brother-in-law

Patient Alert and anxious

Lead Provider Ambulance personnel

Assistant Provider(s) First responder

Other (Recorder, Medical Control, PD, etc) Police department, fire department

Higher Level (Critical) Thinking Issues

Cognitive Elements of shock

Psychomotor ALS support

Affective Emotional support for future physical function

Required Materials

Moulage/Props Hunting clothes that can be cut, simulated weapon, fake blood, pale skin

Medical Equipment Oxygen tank and supplies, back board, jump kit, blankets, bandaging supplies

Other _____

Assessment and Management Scenario Template

Dispatch: Hunting accident in a secluded wooded area.

Arrive to find: A 37 y/o male at the bottom of a tree with profuse bleeding from the groin area.

Assessment should reveal:

- Airway is open.
- Breathing at 16 times/minute and shallow.
- Pulse is 96, strong and regular.
- Blood pressure 150/92
- Pupils equal
- Lung sounds clear, equal bilaterally
- Skin is pale, cool and dry.
- History
- S- pain and bleeding from the groin
- A- none
- M- atenolol
- P- hypertension
- L- breakfast early this morning
- E- was hunting from tree stand; slipped off stand and accidentally shot self in the groin
- O- as above
- P- bleeds more with movement, nothing changes pain
- Q- sharp pain
- R- throughout groin
- S- 10/10 scale
- T- accident happened ½ hour ago

- Injuries – Large amount of blood to groin, penis and scrotum. Denies neck or back pain.

Moulage: Bloody pants, pale/cool skin, simulated weapon

Treatment

Basic: Oxygen, prevent further heat loss with blankets. Trauma dressings to genital area to control bleeding. Spinal immobilization. Talk to and calm patient. Monitor patient for hypovolemic shock.

Patient Response: Patient feels better when treated for shock and bleeding controlled but remains very anxious due to the location of the wound. Patient continues to compensate: pulse 92, respirations 18 and deeper, BP 162/88.

ALS: Start an IV and titrate to maintain BP. Analgesia for pain.

Higher Level Questions or Affective Issues:

B/A: How do you make the scene safe?

B/A: What obstacles do you have for moving the patient to your ambulance? How do you overcome these obstacles?

B/A: How should you address the patient's fear of being permanently disabled or non-functional sexual response?

A: What gauge catheter and IV tubing would you use?

A: What rate would you run the IV?

Scenario Development Worksheet

Scenario Title: Differentiating psychological emergencies from other problems

Scenario Goal: To differentiate between normal and abnormal behavior.

Scenario Objectives: During this scenario the participants will be expected to:

1. Recognize safety issues at a scene.
2. Recognize signs and symptoms of mental illness or disorders.
3. Provide treatment for psychological emergencies.

Prerequisite Competencies

Cognitive Medical Assessment and Medial Emergencies Modules, Communication

Psychomotor Patient assessment and use of restraints

Affective Interpersonal communication skills, empathy for the patient

Performance Expectations

Novice versus Expert

Skill Focus versus Management

Bloom Level

(Cognitive, Psychomotor, Affective) Comprehension, Manipulation, Valuing

Scenario Roles (Describe and Assign)

Bystander/Family Member 68 y/o wife who is the primary caregiver

Patient 70y/o male who is agitated

Lead Provider EMT1

Assistant Provider(s) EMT2

Other (Recorder, Medical Control, PD, etc) Police officer, medical direction for on-line medical control

Higher Level (Critical) Thinking Issues

Cognitive Safe vs. unsafe scene; psych vs. medical problem

Psychomotor Use of restraints and body language

Affective Interpersonal communication, developing trust

Required Materials

Moulage/Props Weapon, pill bottles

Medical Equipment Oxygen tank and supplies, jump kit, blankets, restraints

Other Ambulance cot, radios for contacting medical control

Assessment and Management Scenario Template

Dispatch: To a home for an elderly man who is suicidal.

Arrive to find: A typical residence, in the evening. You are first on scene.

Assessment should reveal:

- Airway is open; patient is screaming, “Leave me alone.”
- Breathing rapid and deep – appropriate for the situation.
- Pulse is 110, strong and irregular.
- Blood pressure 160/96
- Pupils equal
- Lung sounds clear, equal bilaterally
- Skin is flushed and moist.
- History
- S- agitated, pacing, escalating anger
- A- PCN
- M- Aricept, Accupril
- P- HTN, Sun-downer’s syndrome (recent checkup and tests show patient’s condition is deteriorating)
- L- Lunch – soup, sandwich and coffee
- E- According to wife he has been agitated throughout the day; he is worse than usual with his Sun-downer’s syndrome.
- O- As above
- P- nothing makes him better; talking to him makes it worse
- Q- irrational
- R- N/A
- S- more upset than usual
- T- 1 hour

- Injuries – none

Moulage: Moist, flushed skin

Treatment

Basic: Communication skills in conjunction with assessment. Oxygen. Monitor/evaluate patient for medical problems. Soft restraints. Check blood sugar (101).

Patient Response: Initially uncooperative. Responds to communication from one responder.

ALS: Start an IV and consider sedation and/or chemical restraints.

Higher Level Questions or Affective Issues:

B/A: Is this a medical or psychological problem?

B/A: What would you do if patient remains uncooperative?

B/A: What medical problems mimic or contribute to this situation?

B/A: Explain effective communication skills.

Scenario Development Worksheet

Scenario Title: Right Hip Fracture

Scenario Goal: To assess, treat and transport a patient with a hip injury

Scenario Objectives: During this scenario the participants will be expected to:

1. Assess for scene safety.
2. Recognize the signs and symptoms of a hip injury and shock.
3. Provide stabilization and splinting of a hip injury.

Prerequisite Competencies

Cognitive Patient Assessment, Trauma, Environmental Emergencies

Psychomotor Splinting and spinal immobilization

Affective Communications with patient and hospital

Performance Expectations

Novice versus Expert

Skill Focus versus Management

Bloom Level

(Cognitive, Psychomotor, Affective) Psychomotor

Scenario Roles (Describe and Assign)

Bystander/Family Member Friend

Patient Female

Lead Provider _____

Assistant Provider(s) _____

Other (Recorder, Medical Control, PD, etc) _____

Higher Level (Critical) Thinking Issues

Cognitive 50% mortality rate, decreased pain sensation and denial of seriousness of injury

Psychomotor Should a Hare traction splint used? What are the potential complications of using a traction splint?

Affective Recognize the need for a traction splint, consider hypothermia as a possible complication

Required Materials

Moulage/Props Pale, cool and clammy skin

Medical Equipment Oxygen tank and supplies, back board, collars, straps, scoop stretcher, jump kit, blankets, bandaging, traction splint and splinting supplies

Other Blanket

Assessment and Management Scenario Template

Dispatch: Dispatched to a residence for a fall.

Arrive to find: A 82 y/o female laying in the driveway. She is A/Ox3. She is complaining that she cannot get up.

Assessment should reveal:

- Airway is open.
- Breathing at 26 times/minute and shallow.
- Pulse is 120, weak and regular.
- Blood pressure 120/90
- Pupils equal
- Lung sounds clear, equal bilaterally
- Skin is pale, cool and clammy.
- History
- S- cold and cannot get up
- A- None
- M- Atenolol, Lasix, HCTZ
- P- CHF, HTN
- L- Lunch 2 hours ago
- E- Out walking and slipped on the ice.
- O- No medical problem preceding fall
- P- nothing
- Q- None
- R- None
- S- None

- T- About ½ hour ago
- Injuries – right hip pain on palpation

Moulage: Pale/cool/clammy skin

Treatment

Basic: Assessment with vital signs. Oxygen. Prevent further heat loss with blankets. Reassure patient. Splint hip injury. Provide spinal immobilization. Monitor patient for hypothermia and treat as needed.

Patient Response: Patient remains pain free. She is warmer. She is argumentative.

ALS: none

Higher Level Questions or Affective Issues:

- B: Is patient stable or unstable?
- B: When and if would you call ALS?
- B: Why doesn't the patient have pain?
- B: What environmental concerns do you have?
- B: Is the scene safe?

Scenario Development Worksheet

Scenario Title: Hyperthermia during Winter and Fall

Scenario Goal: To cool a patient with hyperthermia without putting the patient into hypothermia

Scenario Objectives: During this scenario the participants will be expected to:

1. Recognize signs and symptoms of hyperthermia.
2. Identify the different levels of hyperthermia.
3. Demonstrate how to take care of hyperthermia according to the patient's signs and symptoms.

Prerequisite Competencies

Cognitive Patient Assessment, Environmental Emergencies, Communications

Psychomotor Check temperature and other vital signs, caring for hyperthermic patient

Affective Communications with patient to inform them of the treatment and the reasons for selected treatment

Performance Expectations

Novice versus Expert

Skill Focus versus **Management**

Bloom Level

(Cognitive, Psychomotor, Affective) Application, Precision and Articulation, Organizing

Scenario Roles (Describe and Assign)

Bystander/Family Member Wife

Patient Not feeling well, headache

Lead Provider Rapid assessment and oversee patient assessment

Assistant Provider(s) C-spine, SAMPLE, vital signs

Other (Recorder, Medical Control, PD, etc) Giving patient report and update to the ED

Higher Level (Critical) Thinking Issues

Cognitive Analysis of different levels of hyperthermia

Psychomotor Ability to perform skills without thinking about them

Affective Organizing

Required Materials

Moulage/Props Winter clothing/heavy clothing, flushed and moist skin

Medical Equipment Oxygen tank and supplies, back board and straps, jump kit, blankets

Other _____

Assessment and Management Scenario Template

Dispatch: Man has fallen off the roof.

Arrive to find: A 45 y/o male lying in the snow. He is alert and oriented x4. He tells you he fell from the roof where he was shoveling snow from the roof

Assessment should reveal:

- Airway is open.
- Breathing at 28 times/minute and labored.
- Pulse is 110, strong and regular.
- Blood pressure 160/90
- Pupils dilated but equal
- Lung sounds clear, equal bilaterally
- Skin is flushed, moist and warm.
- History
- S- diaphoretic and warm
- A- None
- M- None
- P- None
- L- drinking about midnight the night before
- E- shoveling snow from the roof
- O- was a little dizzy and slipped when he fell
- P- nothing hurts
- Q- None
- R- None

- S- None
- T- fell 15 minutes prior to call
- Injuries – No obvious injuries

Moulage: Heavy clothes, flushed and moist skin

Treatment

Basic: Passive cooling while removing from environment. Check temperature. Spinal stabilization.

Patient Response: Patient feels better when cooled. Patient's vitals are pulse 90, respirations 20, BP 134/78.

ALS: None

Higher Level Questions or Affective Issues:

B: Would you call ALS?

B: How can you find out how much he had been drinking the night before? Is it important?

B: What could be some problems or contributing factors we have not identified yet?

Scenario Development Worksheet

Scenario Title: Extremity Fracture

Scenario Goal: To splint a humerus

Scenario Objectives: During this scenario the participants will be expected to:

1. Perform patient assessment.
2. Demonstrate stabilization of a fractured humerus.
3. Select and apply the appropriate splint for a humeral injury.

Prerequisite Competencies

Cognitive Patient Assessment, Protocols, Splinting

Psychomotor Apply splint, radio report

Affective Communications with patient and family

Performance Expectations

Novice versus **Expert**

Skill Focus versus Management

Bloom Level

(Cognitive, Psychomotor, Affective) Evaluation, Naturalization, Characterizing

Scenario Roles (Describe and Assign)

Bystander/Family Member _____

Patient Conscious, alert, oriented

Lead Provider 1

Assistant Provider(s) 1

Other (Recorder, Medical Control, PD, etc) dispatch, radio contact

Higher Level (Critical) Thinking Issues

Cognitive Incorporate patient's medical history into considerations for seriousness of this event

Psychomotor Splint arm while talking with patient

Affective_

Required Materials

Moulage/Props Arm deformity

Medical Equipment Radios, oxygen tank and supplies, jump kit, blankets, splinting supplies

Other _____

Assessment and Management Scenario Template

Dispatch: Called to a residence for a man who fell and possibly broke his arm.

Arrive to find: A 66 y/o male sitting in chair and holding his arm. He is alert and oriented with a pained expression on his face.

Assessment should reveal:

- Airway is open.
- Breathing at 18 times/minute and even.
- Pulse is 110 and regular; gradually returns to normal.
- Blood pressure 160/90
- Pupils equal
- Lung sounds clear, equal bilaterally
- Skin is pale; gradually returns to normal.
- History
- S- holding arm, c/o pain
- A- None
- M- Nitro as needed, lasix, aspirin, lopressor
- P- heart attack last year
- L- lunch
- E- slipped on carpet and arm hit door jam
- O- when he slipped and hit door jam
- P- increases with movement
- Q- continuous and throbbing
- R- mid shaft humerus is the most pain but the whole arm hurts
- S- 7/10 scale
- T- 20 minutes ago
- Injuries – Deformity in upper arm

Moulage: deformity for upper arm, pale skin

Treatment

Basic: Introduction, ABC's, initial and focused assessment, splinting (check CMS before and after)

Patient Response: Patient feels better when treated. Pain decreases to 4 after splinting. Color improves. Repeat vitals are pulse 88, respirations 16, BP 132/76.

ALS: Not at this time

Higher Level Questions or Affective Issues:

B: How does the cardiac history affect this patient and this injury?

B: What would you do if there is no distal pulse before splinting? After splinting

B: What if pain increased with splinting?

B: How does the patient respond to your actions?

Scenario Development Worksheet

Scenario Title: CVA

Scenario Goal: To recognize signs and symptoms of a stroke in a rapid manner

Scenario Objectives: During this scenario the participants will be expected to:

1. Identify signs and symptoms of a stroke with the time of onset.
2. Administer proper treatment.
3. Determine proper transport and destination.

Prerequisite Competencies

Cognitive Medical Assessment, Altered Mental Status, Communication, Medical Emergencies with Prehospital Treatment of for CVA, Knowledge of CVA Risk Factors

Psychomotor Glucometer, Stroke Scale, Oxygen Administration, Airway Control, Suctioning

Affective Communications with patient and family

Performance Expectations

Novice versus Expert

Skill Focus versus Management

Bloom Level

(Cognitive, Psychomotor, Affective) Application, Precision, Valuing

Scenario Roles (Describe and Assign)

Bystander/Family Member Wife

Patient Male who is drooling, slurred speech and has right sided weakness, responds to environment but not able to verbalize thoughts completely

Lead Provider 1

Assistant Provider(s) 1

Other (Recorder, Medical Control, PD, etc)___

Higher Level (Critical) Thinking Issues

Cognitive Ability to differentiate between CVA and diabetic emergency

Psychomotor Managing airway with advanced means

Affective Communicating with a patient who has impaired communication skills

Required Materials

Moulage/Props Dilated pupil with a contact lens, patient able to demonstrate one-sided weakness and slurred speech

Medical Equipment Oxygen tank and supplies, jump kit, glucometer

Other_____

Assessment and Management Scenario Template

Dispatch: Time is 0800 when you are dispatched for a 60 y/o male who is unable to get out of bed.

Arrive to find: A 60 y/o male in bed. He is alert and responding to the surroundings. His ABC's are okay but he is drooling.

Assessment should reveal:

- Airway is open.
- Breathing at 14 times/minute and shallow.
- Pulse is 50 and regular.
- Blood pressure 190/100
- Pupils unequal; left is dilated
- Lung sounds clear, equal bilaterally
- Skin is warm and dry.
- History
- S- right sided weakness, drooling, right arm drift, headache
- A- None
- M- Atenolol
- P- Hypertension
- L- 14 hours ago
- E- woke up with a headache and weakness
- O- woke up with it
- P- nothing changes it

- Q- worst headache ever
- R- none
- S- 10/10 scale
- T- came on upon wakening
- Injuries – None

Moulage: None

Treatment

Basic: Oxygen, suctioning as needed. Positioning for managing secretions.

Patient Response: Patient's blood sugar is 86. His vitals remain unchanged and his headache persists.

ALS: None.

Higher Level Questions or Affective Issues:

B: What do you think the problem is if the patient improves rapidly?

B: What types of CVA are there?

B: What would you do differently if the patient were hypoglycemic?

B: What do you check in the stroke scale? Why does the patient need to close their eyes while checking for arm drift?

B: How would you describe the patient's orientation?

B: What is the patient's Glasgow Come Scale number?

Scenario Development Worksheet

Scenario Title: Massive Bleeding due to Trauma

Scenario Goal: To provide bleeding control and treat for shock

Scenario Objectives: During this scenario the participants will be expected to:

1. Recognize signs and symptoms of hypoperfusion.
2. Demonstrate treatment for hypoperfusion.
3. Provide treatment for massive bleeding.

Prerequisite Competencies

Cognitive Trauma Assessment, Shock

Psychomotor Bandaging, Care for shock, Spinal immobilization

Affective Patient interaction

Performance Expectations

Novice versus Expert

Skill Focus versus **Management**

Bloom Level

(Cognitive, Psychomotor, Affective) Application, Precision, Valuing

Scenario Roles (Describe and Assign)

Bystander/Family Member Witness to the MVC

Patient c/o pain to right thigh, nausea, SOB, altered mental status

Lead Provider Perform trauma assessment

Assistant Provider(s) Manage and treat life threats

Other (Recorder, Medical Control, PD, etc) Law enforcement for traffic control, Fire for extrication and hazards

Higher Level (Critical) Thinking Issues

Cognitive Identify need for ALS intercept, Early identification of hypoperfusion

Psychomotor Management of bleeding control, application of traction splint

Affective Demonstrate patient empathy, Communication with patient

Required Materials

Moulage/Props Make-up for cyanosis, cutable clothing, fake blood, pale and clammy skin, deformity for femur fracture

Medical Equipment Oxygen tank and supplies, back board and immobilization supplies, traction splint, jump kit, blankets, bandaging and splinting supplies

Other Vehicle for extrication

Assessment and Management Scenario Template

Dispatch: Two car accident at city speed.

Arrive to find: Two vehicles with moderate damage. One car is empty and a 40 y/o male is walking around. In the second vehicle there is a 35 y/o female seated in the driver's seat of the second vehicle. She is complaining of pain to right thigh.

Assessment should reveal:

- Airway is open.
- Breathing at 26 times/minute and shallow.
- Pulse is 124, weak and regular.
- Blood pressure 92/68
- Pupils dilated
- Lung sounds clear, equal bilaterally
- Skin is pale, cool and clammy.
- History
- S- pain to right thigh, deformity/obvious fracture with a bleeding wound
- A- NKA
- M- Coumadin (warfarin)
- P- Blood clots, Hepatitis B
- L- 2 hours ago
- E- T-bone collision – Your patient hit the other vehicle when he did not stop at a stop sign.
- O- time of accident
- P- worse with any movement
- Q- severe, sharp pain

- R- none
- S- 10/10 scale
- T- accident happened 8-10 minutes ago
- Injuries – fractured right femur

Moulage: Bloody pants, pale/cool/clammy skin, cuttable clothes, fractured femur

Treatment

Basic: Oxygen, prevent further heat loss with blankets. Trauma dressings after bleeding is controlled. Spinal immobilization and traction splint. Monitor patient for hypovolemic shock.

Patient Response: Patient feels better. Patient's repeat vitals pulse 100, respirations 22, BP 104/74.

ALS: Start an IV and titrate to maintain BP. Analgesia for pain.

Higher Level Questions or Affective Issues:

B: Should you call ALS? When?

B/A: What should you do if direct pressure does not control the bleeding?

B/A: When should you apply a traction splint?

B/A: Identify one other way to splint the leg.

A: What gauge catheter and IV tubing would you use?

A: What rate would you run the IV?

A: What analgesia would you choose to give? Why?