

Day 2 — Recognise Before Collapse

Case simulation cards — facilitator pack (3 scenarios)

How to run these simulations

- Each scenario runs 10–15 minutes plus a 10-minute debrief. The focus is RECOGNITION and ESCALATION, not resuscitation.
- Use a live actor (staff member) as the patient where possible — coach them on symptoms beforehand. A manikin works for the deteriorating stages.
- Prepare vital-sign cards for each stage; hand them over only when the team actually measures that parameter.
- Participants must verbalise ABCDE findings aloud and calculate NEWS2 on the centre's chart in real time.
- One observer completes the Day 2 Audit Tool; time the triage decision and the escalation call with a stopwatch.
- If the team fails to escalate, let the patient deteriorate per the progression table — do not rescue the scenario.

Standard debrief structure (after every case)

- **Reactions** — one word from each participant on how it felt.
- **Description** — what was the case? Confirm the clinical facts.
- **Analysis** — what went well, what would we do differently? Use the audit checklist findings.
- **Summary** — each participant states one thing they will do differently in a real emergency.

Case 1: The Quiet Deterioration — Sepsis in an Elderly Patient

NEWS2 scoring • trends over snapshots • escalation discipline

Scenario brief — read aloud to the team

A 78-year-old woman is brought by her son for 'weakness and poor appetite' for two days. She had a urinary infection treated last month. She is sitting quietly in the queue, looking tired. The son says she was 'a bit muddled' this morning, which is new.

Setting, roles & equipment

Location	Waiting area → consultation room → treatment room.
Participants	Triage nurse, doctor, second nurse. Patient played by staff actor.
Equipment	Vital-sign monitor or cards, thermometer, NEWS2 chart, IV trainer arm, fluid bag prop, mock antibiotic.
Facilitator controls	Release stage 2 vitals only after 15 simulated minutes or if the team re-checks. Deterioration continues until fluids started and escalation call made.

Initial patient status

Stage	RR	SpO2	BP	HR	Temp	ACVPU	NEWS2
Arrival	22	95% air	108/64	104	38.4	Alert (son reports new confusion)	= 7 if confusion counted; 4 if missed
+15 min	24	93% air	96/58	118	38.9	Confused	10
If untreated	28	91% air	84/50	128	39.2	Voice	14 — peri-arrest

Facilitator progression — how the case unfolds

Stage / trigger	Patient state	Expected team response
Arrival	Looks tired, quiet in queue	Visual triage flags her as unwell; vitals + NEWS2 within 5 min; NOT left in the queue
Assessment	Stage 1 vitals	Full ABCDE verbalised; new confusion identified and scored 3; NEWS2 calculated = 7 → emergency response
Recognition	Sepsis suspected (fever + confusion + tachycardia + source)	Doctor called to patient immediately; moved to treatment room; oxygen if SpO2 < 94%
Treatment	Stage 2 vitals if delayed	IV access + bloods/glucose, crystalloid 500 mL bolus, first-dose antibiotic per protocol, urine dip
Escalation	Improving BP if fluids given	Transfer decision verbalised, SBAR call made stating NEWS2 and sepsis concern, monitoring continued

Expected critical actions — observer ticks each

- Patient identified as unwell at visual triage and prioritised out of the queue within 5 minutes
- Complete set of vitals including temperature and respiratory rate (counted, not estimated)
- New confusion elicited from the son and scored as 3 on NEWS2
- NEWS2 total calculated correctly at every stage
- Score ≥ 7 triggers immediate doctor review and continuous monitoring — verbalised as an emergency
- Sepsis named as the working diagnosis with a source considered
- IV fluids started within 15 minutes of recognition
- Escalation/transfer call made with NEWS2 stated explicitly
- Observations repeated after every intervention — trend recognised, not just single values

Debrief points

- What was her NEWS2 at arrival — and what response did that mandate?
- What made the confusion easy to miss, and who held that information?
- How would this patient present differently at 30 years old?

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Case 2: Chest Pain at Reception

Triage red flags • ACS pathway • the cost of queueing an emergency

Scenario brief — read aloud to the team

A 52-year-old man walks up to reception asking for 'something for indigestion'. He is pale and sweaty, rubbing the centre of his chest. He drove himself in. He is a smoker with diabetes. If sent to the queue, he will collapse in 10 minutes.

Setting, roles & equipment

Location	Reception desk → treatment room.
Participants	Receptionist (scripted), triage nurse, doctor, second nurse.
Equipment	12-lead ECG machine or printed ECG showing inferior STEMI, monitor, aspirin prop, GTN prop, oxygen, AED nearby (in case of arrest per Day 1).
Facilitator controls	If triaged and treated promptly, he remains stable with ongoing pain. If queued: collapses into VF arrest at 10 min — the scenario becomes a Day 1 code.

Initial patient status

Stage	RR	SpO2	BP	HR	Pain	Other
At reception	20	96% air	138/86	92	6/10 central, heavy, radiating to jaw	Pale, sweaty, nauseated
In treatment room	18	97% air	132/84	88	4/10 after aspirin/GTN	ECG: inferior ST elevation

Facilitator progression — how the case unfolds

Stage / trigger	Patient state	Expected team response
0–3 min	Asks for antacid at reception	Receptionist recognises red flags (chest pain + sweating) and calls the nurse immediately — no registration first
3–6 min	Moved to treatment room	ABCDE, monitor + defibrillator pads nearby, 12-lead ECG within 10 minutes of arrival
6–10 min	ECG shows inferior STEMI	Aspirin 300 mg chewed; GTN if systolic >100 and no contraindication; analgesia; IV access
10–15 min	Stable but ongoing pain	Urgent transfer activated for reperfusion — time-critical; SBAR includes 'STEMI' and ECG findings; escort with AED

Expected critical actions — observer ticks each

- Reception escalates chest pain + autonomic signs immediately (no queueing, no paperwork first)
- Patient never left alone; moved by wheelchair/trolley, not walked
- 12-lead ECG performed and reviewed by the doctor within 10 minutes
- Aspirin 300 mg given (chewed) after allergy check
- Defibrillator/AED placed at the bedside — arrest anticipated
- GTN withheld or given correctly according to BP

- Transfer for reperfusion activated as time-critical with door-in door-out target verbalised
- SBAR handover includes ECG findings, times, and drugs given

Debrief points

- What exactly should a receptionist be trained to recognise and say?
- Why does this patient need the defibrillator beside him, not in the cupboard?
- What is our centre's realistic door-in door-out time — and what delays it?

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Case 3: The Asthmatic Who Stops Wheezing

Severity grading • treat-reassess cycles • silent chest = pre-arrest

Scenario brief — read aloud to the team

A 24-year-old woman attends with 4 hours of worsening breathlessness despite using her salbutamol inhaler repeatedly at home. She has been hospitalised for asthma before, once in ICU. She can speak only in short phrases.

Setting, roles & equipment

Location	Treatment room.
Participants	Nurse, doctor, second nurse. Patient played by staff actor (coach the speech pattern).
Equipment	Nebuliser + masks, salbutamol/ipratropium props, oxygen, monitor, mock steroids, IV trainer, peak flow meter.
Facilitator controls	Improvement ONLY if back-to-back nebulisers + steroids given and oxygen titrated. If reassessment is skipped, progress to silent chest stage — the team must recognise pre-arrest and escalate.

Initial patient status

Stage	RR	SpO2	HR	Speech	Chest	PEFR
Arrival	28	92% air	118	Phrases only	Widespread wheeze	40% predicted
If treated	22	95% on O2	105	Sentences	Wheeze reducing	55% predicted
If neglected	12 and tiring	88% on O2	132	Single words	SILENT	Unable

Facilitator progression — how the case unfolds

Stage / trigger	Patient state	Expected team response
0–2 min	Severe attack (phrases, RR 28, SpO2 92%)	Severity graded aloud as SEVERE; sat upright; oxygen to target 94–98%; nebulised salbutamol 5 mg driven by oxygen
2–10 min	Partial response	Reassess after EVERY nebuliser; add ipratropium; repeat salbutamol back-to-back; oral/IV steroid early
10–15 min	Improving OR deteriorating per treatment quality	If improving: continue, plan observation + transfer decision. If deteriorating: recognise life-threatening features
Deterioration	Quiet chest, tiring, SpO2 falling, bradycardia developing	Verbalised as LIFE-THREATENING/pre-arrest; urgent transfer activated; BVM ready; senior help called; do NOT sedate; prepare for Day 1 response

Expected critical actions — observer ticks each

- Severity graded using objective criteria (speech, RR, HR, SpO2, PEFR) and stated aloud
- Oxygen-driven nebulisation started within 5 minutes of arrival

- Steroid given within 15 minutes
- Reassessment after every intervention, restarting from A
- ICU history recognised as a risk factor for fatal asthma
- Silent chest / falling RR recognised as pre-arrest, NOT improvement
- Escalation and transfer activated at the right stage with SBAR
- Patient never left unattended; monitoring continuous

Debrief points

- Why is a quiet chest in a tiring asthmatic more alarming than loud wheeze?
- Which features made her high-risk from the first minute?
- What does 'reassess after every intervention' look like in practice — who, what, when?

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