EMERGENCY CARE READINESS CAMPAIGN

# Day 5 — Stabilise, Communicate & Transfer

**Case simulation cards — facilitator pack (3 scenarios)**

## How to run these simulations

- Each scenario runs 15 minutes plus a 10-minute debrief. These are LOGISTICS-heavy scenarios: the clinical care is deliberately familiar (from Days 1–4) so the focus falls on preparation, documentation, communication and the journey.
- Provide real blank HP-218/HP-249 forms (or the centre's current transfer forms), the actual escort bag, and a phone for simulated SBAR calls — a facilitator plays the receiving hospital and scores the call.
- Set up a 'vehicle/boat' area (chairs + stretcher) at a distance from the treatment room; moving the patient is part of the exercise.
- Inject one deterioration mid-journey in every scenario (facilitator hands a card to the escort).
- One observer completes the Day 5 Audit Tool; a second can peer-audit the completed transfer form against the checklist.
- For the sea-transfer scenario, a facilitator plays the boat skipper with a scripted weather report.

## 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.

EMERGENCY CARE READINESS CAMPAIGN — DAY 5 SIMULATION

# Case 1: STEMI to the Cath Lab — Time-Critical Transfer

**Door-in door-out • SBAR call • HP-218/HP-249 under pressure • arrest risk en route**

## Scenario brief — read aloud to the team

The 52-year-old man from Day 2 — inferior STEMI diagnosed on ECG at 10:50 — has received aspirin, and pain is controlled. The receiving hospital has a cath lab 45 minutes away (boat + ambulance). It is now 10:58. The clock is running: every minute of delay costs myocardium.

## Setting, roles & equipment

| | |
|---|---|
| **Location** | Treatment room → transfer vehicle area. |
| **Participants** | Doctor (escort decision-maker), 2 nurses, driver/crew actor; facilitator on phone as receiving cardiologist. |
| **Equipment** | Escort bag, AED/defibrillator, oxygen cylinder (half-full — trap), monitor, blank HP-218/HP-249, printed STEMI ECG, phone. |
| **Facilitator controls** | Half-empty oxygen cylinder must be noticed at bag check. Mid-journey card: patient becomes clammy with BP 84/50 → team must reassess, treat, and update hospital. If forms incomplete at handover, receiving clinician refuses to sign and asks for missing items. |

## Initial patient status

| Stage | HR | BP | SpO2 | Pain | Other |
|---|---|---|---|---|---|
| Pre-departure | 88 | 128/82 | 97% air | 2/10 post GTN | Pads on, 2 IV lines, ECG done |
| Mid-journey event | 104 | 84/50 | 95% | Increasing | Clammy — inferior STEMI hypotension (GTN + RV involvement) |
| After correct response | 96 | 102/64 | 96% | 3/10 | Legs raised, fluids running, GTN withheld, hospital updated |

## Facilitator progression — how the case unfolds

| Stage / trigger | Patient state | Expected team response |
|---|---|---|
| 0–3 min | Stable, decision made | Transfer declared time-critical; roles split: clinical stabilisation vs logistics (vehicle, escort, documents, receiving call) |
| 3–8 min | Preparation | Escort bag checked — oxygen deficiency found and replaced; defibrillator with patient; next-dose drugs drawn; forms completed in parallel |
| 8–12 min | SBAR call | Structured SBAR to cardiologist with ECG findings, times, drugs; ETA given; cath lab activation requested; call-back number confirmed |

| | | |
|---|---|---|
| Departure + journey | Deterioration card at 'sea/road' | ABCDE en route; hypotension recognised (GTN held, fluids, legs raised); receiving hospital UPDATED with new SBAR |
| Arrival | Handover | Monitoring continues during verbal SBAR; forms and ECG handed over; acceptance signed; times documented; bag retrieval plan stated |

## Expected critical actions — observer ticks each

- ■ Door-in–door-out target verbalised and tracked (≤30 min from decision)
- ■ Logistics owner assigned separately from clinical care within 3 minutes
- ■ Escort bag physically checked before departure — planted oxygen deficiency detected and corrected
- ■ Oxygen requirement calculated for twice the journey time
- ■ Defibrillator/AED travels WITH this patient (arrest risk verbalised)
- ■ HP-218/HP-249 complete: identifiers, ECG findings, drugs with times, vitals series, signatures
- ■ Pre-departure SBAR call complete, structured, with loop closure
- ■ Mid-journey deterioration managed with ABCDE and hospital updated
- ■ Handover at destination structured; original documents handed over; acceptance confirmed and signed

## Debrief points

- Where did minutes leak between decision and departure?
- What would an arrest 10 minutes offshore have required — and were you ready?
- Which box on the form would have been empty without the checklist?

EMERGENCY CARE READINESS CAMPAIGN — DAY 5 SIMULATION

# Case 2: Deteriorating Pneumonia and a Rough Sea

**Go/no-go decision • stabilise harder before a rough crossing • securing patient & kit**

## Scenario brief — read aloud to the team

A 67-year-old woman with pneumonia has been on oxygen in your centre for two hours. Despite fluids and the first antibiotic dose, her NEWS2 has climbed from 5 to 8. She needs hospital care. The boat crew reports a strong afternoon wind: the crossing is possible now with moderate swell, but conditions will worsen towards evening. The helicopter is unavailable for at least 3 hours.

## Setting, roles & equipment

| | |
|---|---|
| **Location** | Treatment room → jetty/boat area (simulated). |
| **Participants** | Doctor, nurse escort, second nurse; facilitator as boat skipper with scripted weather; facilitator as receiving hospital. |
| **Equipment** | Escort bag, oxygen cylinders ×2, portable suction, stretcher + straps, monitor, antiemetic prop, blankets, forms, phone/radio props. |
| **Facilitator controls** | Skipper offers a 40-minute window now or uncertainty later. Mid-crossing card: vomiting episode while supine in swell. If patient/equipment not secured, facilitator narrates equipment sliding and an interrupted assessment. |

## Initial patient status

| Stage | RR | SpO2 | BP | HR | Temp | NEWS2 |
|---|---|---|---|---|---|---|
| Decision point | 26 | 91% on 4 L | 102/60 | 112 | 38.6 | 8 |
| Pre-departure (optimised) | 24 | 94% on 10 L | 108/64 | 104 | 38.2 | 6–7 |
| Mid-crossing event | 28 | 88% transient | 100/58 | 118 | — | Vomiting, needs suction + repositioning |

## Facilitator progression — how the case unfolds

| Stage / trigger | Patient state | Expected team response |
|---|---|---|
| 0–5 min | NEWS2 8, worsening | Transfer need confirmed; skipper consulted EARLY; weather window and alternatives discussed as a shared go/no-go decision |
| 5–12 min | Window chosen: go now | Aggressive pre-departure optimisation: oxygen up-titrated, second IV secured, antiemetic given, suction placed at head end, everything strapped |
| 12–15 min | Loading | Patient strapped on stretcher, cylinders upright and fixed, bags lashed, crew briefed on roles if she deteriorates; SBAR call with ETA |
| Crossing | Vomiting card | Escort suctions/repositions safely (lateral tilt within straps), oxygen maintained, vitals recorded, event written on the form |

| | | |
|---|---|---|
| Arrival | Handover | Updated SBAR including the vomiting episode and oxygen requirement trend; documents transferred; acceptance signed |

## Expected critical actions — observer ticks each

- ■ Escalating NEWS2 trend recognised as 'transfer now', not 'observe longer'
- ■ Go/no-go made JOINTLY with the boat crew using the weather window — decision and reasoning verbalised
- ■ Contingency stated aloud (what if conditions worsen mid-crossing / turn-back criteria)
- ■ Patient optimised harder BECAUSE of the rough crossing (oxygen, antiemetic, second line)
- ■ Oxygen calculated: two cylinders for twice the crossing time
- ■ Patient, cylinders, monitor and bags all physically secured; crew briefed
- ■ Suction immediately available and used correctly at the vomiting event, with safe repositioning
- ■ Vitals recorded en route at correct frequency despite conditions
- ■ Complete documentation and updated SBAR at handover

## Debrief points

- What made 'go now' better than 'wait for calm seas' — and when would the answer flip?
- What did the swell change about your airway plan?
- Who owns the go/no-go decision — doctor, skipper, or both? Why?

EMERGENCY CARE READINESS CAMPAIGN — DAY 5 SIMULATION

# Case 3: Child in Status Epilepticus — Transfer with Drugs Running

**Paediatric transfer • drugs prepared for the journey • parent on board • two SBARs**

## Scenario brief — read aloud to the team

The 2-year-old from Day 3 (12 kg) seized for 14 minutes and needed two doses of midazolam. He is now post-ictal, drowsy but protecting his airway, on oxygen. Two doses means hospital — the paediatric ward is 50 minutes away. His grandmother will travel with him. Risk of further seizures en route is real.

## Setting, roles & equipment

| | |
|---|---|
| **Location** | Treatment room → transfer vehicle area. |
| **Participants** | Doctor, nurse escort, grandmother actor; facilitator as receiving paediatrician. |
| **Equipment** | Child manikin, escort bag with paediatric insert, oxygen, suction, prepared midazolam 'next dose' (2.4 mg labelled), glucometer, dose card, forms, phone. |
| **Facilitator controls** | Mid-journey card at 20 min: brief 2-minute seizure. Correct response = timed, positioned, oxygen, prepared dose considered per protocol, hospital updated. If next dose was NOT drawn up pre-departure, narrate the delay and scoring consequence. |

## Initial patient status

| Stage | ACVPU | RR | SpO2 | HR | Glucose | Temp |
|---|---|---|---|---|---|---|
| Pre-departure | V — drowsy, airway protected | 26 | 96% on O2 | 138 | 5.1 | 38.9 |
| Mid-journey seizure | Seizing 2 min | Irregular | 93% | 150 | — | — |
| Post-event | P→V improving | 28 | 95% on O2 | 144 | Recheck 4.9 | 38.6 |

## Facilitator progression — how the case unfolds

| Stage / trigger | Patient state | Expected team response |
|---|---|---|
| 0–5 min | Post-ictal, stable-ish | Transfer triggered by the two-dose rule; paediatric insert of escort bag checked; weight (12 kg) and dose card WITH the patient |
| 5–10 min | Preparation | NEXT midazolam dose calculated (2.4 mg), drawn up, labelled; suction and correctly sized airway adjuncts placed at head end; antipyretic given |
| 10–13 min | SBAR + family | SBAR to paediatrician: doses WITH TIMES, seizure durations, glucose, weight; grandmother briefed on the plan and her role (sit, comfort, don't obstruct) |
| Journey | Seizure card at 20 min | Timed, lateral position within restraints, oxygen, suction ready; protocol decision on the prepared dose verbalised; hospital updated with new ETA info |

| | | |
|---|---|---|
| Arrival | Handover | Two-part handover: clinical SBAR including the en-route seizure + document transfer; grandmother introduced to the receiving team |

## Expected critical actions — observer ticks each

- ■ 'Two doses of benzodiazepine = transfer' rule stated and acted on
- ■ Paediatric insert checked; weight and dose card travel with the patient
- ■ Next benzodiazepine dose pre-calculated, drawn up and LABELLED before departure
- ■ Suction and paediatric airway adjuncts immediately accessible at the head end
- ■ Pre-departure SBAR includes weight, all doses with times, seizure durations and glucose
- ■ Family member briefed, seated safely, and used as a comfort resource
- ■ En-route seizure: timed, positioned, oxygenated; drug decision per protocol verbalised
- ■ Receiving hospital updated after the en-route event
- ■ Handover complete with en-route events documented on the form

## Debrief points

- What would have happened at minute 20 if the next dose hadn't been prepared?
- How did having the grandmother aboard help — and complicate — the transfer?
- Which Day 3 skills did this transfer silently depend on?