QUICK SOLUTION GUIDE

SUDDEN DIFFICULTY MOVING HER RIGHT ARM

SCENARIO #1366

NAME
EVELYN ADAMS

SPECIALTY
Neurology

DIFFICULTY LEVEL
ADVANCED

SIMULATION ENVIRONMENT
INTRA HOSPITAL - EMERGENCY ROOM

BODY INTERACT™ VIRTUAL PATIENTS

Dialogues

Ask the following questions to the patient:

History Taking

Chief Complaint

- How are you feeling?
- Can you tell me what happened to her?

History of Present Illness

- Did she mention any other symptoms?
- How long has it been since the symptoms started?

Past Medical/Surgical History

- Does she have any chronic illness?

Medications and Allergies

- Does she take any medication?
- Does she take any anticoagulants orally?
- Does she have any allergies?

Physical examination

Perform the following physical examinations:

Airway

- Airway observation

Breathing

- O2 Sat (%)
- Respiratory rate (/min)

Circulation

- Blood pressure (mmHg)
- Heart rate (bpm)

Disability

- Blood glucose (mg/dL)
- Glasgow Coma Scale

Medical tests

Request the following medical tests:

Decision aids

- FAST scale
- Stroke scale (NIHSS)

Imaging

- Cerebral angiography
- Head CT

Treatments

Administer the following treatments:

Call - Neurology

- Call | Neurology

Call - Thrombectomy

- Call | Thrombectomy

Call - Thrombectomy by interv. neuroradiology

- Call | Thrombectomy by interv. neuroradiology

Interventions - Nasal cannula

- Interventions | Oxygen | Nasal cannula = 4 L/min

Interventions - IV peripheral catheter (R/L)

- Interventions | Catheters & tubes | IV peripheral catheter (R/L)

Medications - Alteplase

- Medications | Fibrinolytics | Alteplase Intravenous bolus - Left = 7 mg

Medications - Alteplase

- Medications | Fibrinolytics | Alteplase Intravenous infusion - Left = 65 mg/h

Medications - Labetalol

- Medications | Antihypertensives | Labetalol Intravenous bolus - Left = 20 mg

Tomography/CT room

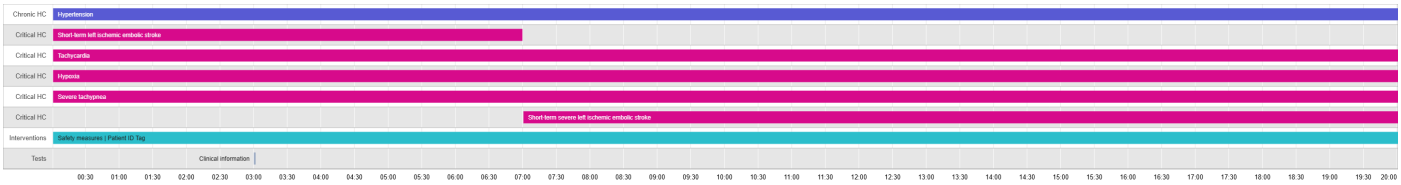
- Call | Tomography/CT room

Send to Tomography/CT room

- Call | Send to Tomography/CT room

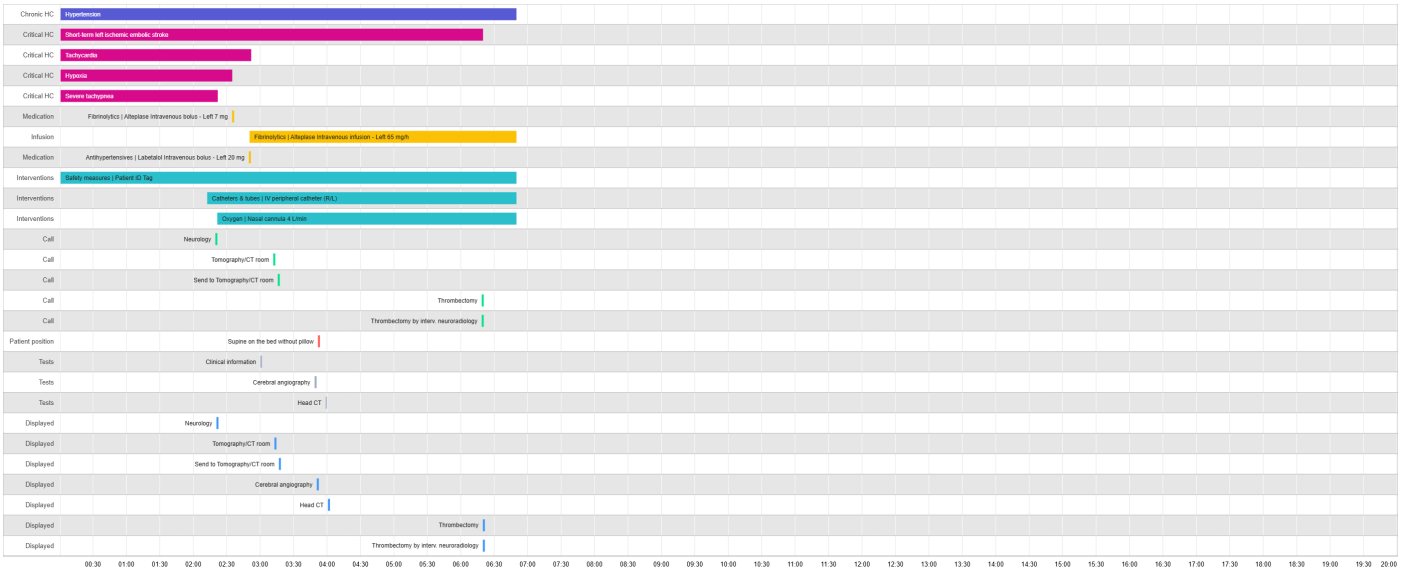
Baseline

Visualize the baseline approach. The baseline predicts scenario behavior assuming no actions by the trainee, which usually represents the worst-case scenario.



Optimal approach - International

Visualize the optimal approach to end your simulation successfully.



Assessment question(s) after simulation

Questions presented to the trainee in order to have a more detailed evaluation of the use of the clinical scenario.

Summative Multiple Choice Question:	
Question	What is the most likely diagnosis?
Correct answer	Ischemic stroke
3 Incorrect answer(s)	Migraine headache
	Hemorrhagic stroke
	Meningitis
Formative Multiple Choice Question:	
Question	When you activate the code stroke, what information should you provide?
Correct answer	All the options are correct.
3 Incorrect answer(s)	Inform stroke team of patient's estimated arrival time.
	Inform radiology to prepare CT scanner for stroke patient.
	Inform clinical laboratory of stroke code.
Formative Multiple Choice Question:	
Question	What information needs to be collected within 5 minutes?
Correct answer	Check blood sugar by finger

	prick, point of care INR, check blood pressure, determine patient's weight, time from symptom onset, patient’s age.
3 Incorrect answer(s)	Check blood sugar by finger prick, point of care INR, check blood pressure.
	Determine patient's weight, time from symptom onset, patient’s age.
	Check blood sugar by finger prick, determine patient's weight, patient’s age

Handoff question

Question presented to the trainee to assess their ability to effectively communicate patient information during a transition of care. This question is optional.

Question	Summarize this Body Interact scenario using a structured handoff pattern.
Review handoff pattern	SBAR (Situation, Background, Assessment, Recommendation): Includes current condition and reason for handoff, relevant history and context, assessment details, and recommended actions.
	SOAP (Subjective, Objective, Assessment, Plan): Covers patient-reported symptoms and history, measurable data and findings, clinical impressions and diagnoses, and the treatment plan.

I-PASS (Illness Severity, Patient Summary, Action List, Situation Awareness and Contingency Planning, Synthesis by Receiver): Encompasses illness status, patient background, tasks and actions, potential changes and plans, and confirmation of understanding.

AT-MIST (Age, Time of incident or onset of symptoms, Mechanism of injury/Medical Complaint, Injuries or Inspections head-to-toe, vital Signs, and Treatments): Describes the cause of injury or medical complaint, findings from head-to-toe inspection, vital signs, and treatments provided.