

QUICK SOLUTION GUIDE

CONFUSION AND SPEECH IMPAIRMENT



SCENARIO

#648

NAME

MARY BOYLE

SPECIALTY

Neurology

DIFFICULTY LEVEL

INTERMEDIATE

SIMULATION ENVIRONMENT

PRE HOSPITAL - LIVING ROOM

BODY INTERACT™
VIRTUAL PATIENTS

This patient is not a real patient, and the clinical scenario, while clinically plausible, is fictional.

Dialogues

Ask the following questions to the patient:

SAMPLE

Symptoms

- Can you tell me your name and your age?
- What happened to you?
- Are you feeling any pain?
- Do you feel any weakness in your limbs?

Medications

- Are you currently taking any medication?

Last oral intake

- When was the last time that you had something to eat?

Events

- When did you last feel well?

Physical examination

Perform the following physical examinations:

Breathing

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

Circulation

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

Disability

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

Exposure

- Temperature (°C)

Medical tests

Request the following medical tests:

Decision aids

- FAST scale
- FAST-ED scale
- Race scale

Treatments

Administer the following treatments:

Call - Stroke Ready Hospital

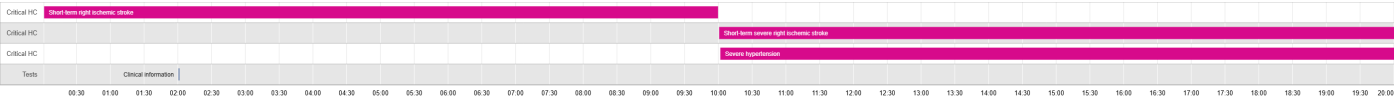
- Call | Stroke Ready Hospital

Interventions - Oxygen therapy. One of the following:

- Interventions | Oxygen | High flow mask
- Interventions | Oxygen | Non-rebreathing mask
- Interventions | Oxygen | Nasal cannula

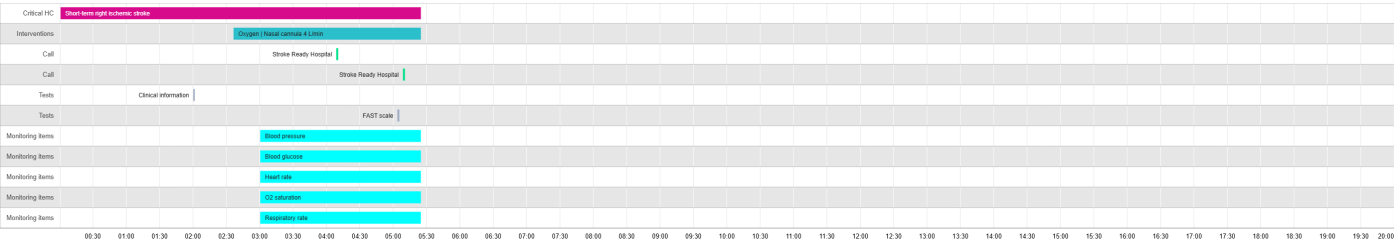
Baseline

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



Optimal approach

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

Acute ischemic stroke

3 Incorrect answer(s)

Hypoglycemia

Epileptic fit

Drug intoxication

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.