

QUICK SOLUTION GUIDE

ENDOVASCULAR ACUTE STROKE



SCENARIO

#70

NAME

BETHANY LARSON

SPECIALTY

Neurology

DIFFICULTY LEVEL

INTERMEDIATE

SIMULATION ENVIRONMENT

INTRA HOSPITAL - EMERGENCY ROOM

Dialogues

Ask the following questions to the patient:

History Taking

Chief Complaint

- What happened to you?

History of Present Illness

- When did your symptoms start?

Past Medical/Surgical History

- Have you had any operations recently?

Medications and Allergies

- Are you currently taking any medication?

Physical examination

Perform the following physical examinations:

Airway

- Airway observation

Breathing

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

Circulation

- Blood pressure (mmHg)
- Capillary refill time (s)
- Cardiac auscultation
- Heart rate (bpm)
- Pulse palpation
- Urinary output (mL/kg/h)

Disability

- Blood glucose (mg/dL)
- Pupil light reflex

Exposure

- Temperature (°C)

Medical tests

Request the following medical tests:

Decision aids

- Stroke scale (NIHSS)

Imaging

- Cerebral angiography
- Head CT

Lab tests

- Coagulation tests

Treatments

Administer the following treatments:

To treat: Acute ischemic stroke/Severe acute ischemic stroke

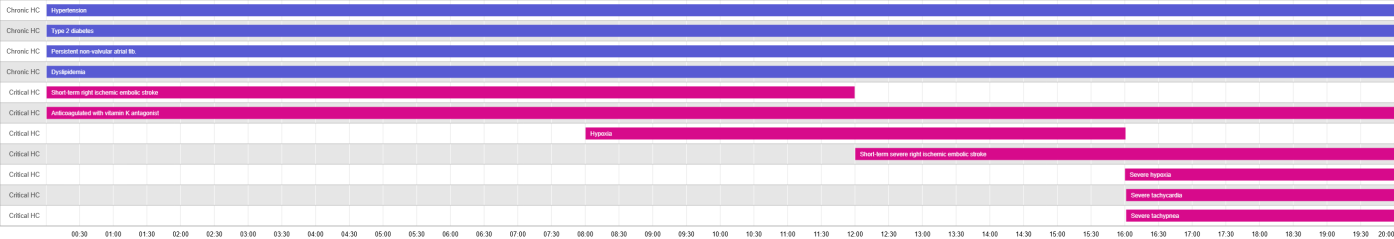
- Call | Thrombectomy

To treat: Acute ischemic stroke/Severe acute ischemic stroke

- Call | Stroke unit

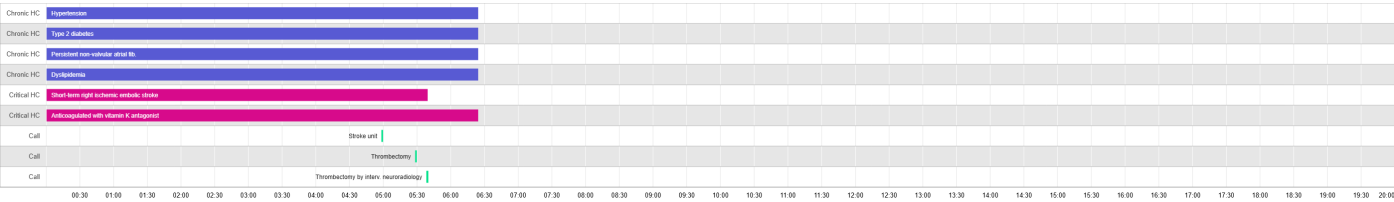
Baseline

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

Ischemic stroke

3 Incorrect answer(s)

Multiple sclerosis

Brain tumor

Epileptic fit

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.