Name:	C Matthews	**Observation at start**		**CRT:**	2s
D.O.B.	18/09 (63Y)	**RR:**	18	**Temp:**	36.5
Address:	(Insert local address)	**ETCO2:**	-	**BM:**	7.2
		Sats:	98% on A	**Weight:**	65Kg
Hospital ID:	971 647 3258	**Heart Rate:**	60	**Allergy**	NKDA
Ward:	Urology	**BP:**	90/45		

Background to scenario	Specific set up
A patient has a spinal anaesthetic for a JJ stent insertion for a ureteric stone causing hydronephrosis. This develops into a high/total spinal requiring resuscitation/GA	Mannequin or simulated patient On theatre table Cannulated, IV fluids connected Anaesthetic drugs, airway trolley available Anaesthetic chart
Required embedded faculty/actors	**Required participants**
Patient ODP Surgical/scrub team	Anaesthetist ODP/theatre team/surgeon – can be participants in MDT sim

Past Medical History

PMH: hypertension
Presented with a 3 day history of loin to groin pain and a 2mm ureteric stone causing hydronephrosis on CT
They are booked for a JJ stent insertion. The patient preferred to have the procedure under spinal anaesthetic
No airway concerns, no reflux, fasted

Drugs Home	Drugs Hospital
Amlodipine	Spinal anaesthetic – drugs of choice (slightly high dose)

Brief to participants

You have just placed a spinal anaesthetic for a patient undergoing a JJ stent insertion for a ureteric stone.
They are cannulated, fluids are being infused, they have just been transferred to theatre.
You have just been asked to perform the WHO stop moment

Scenario Direction

Stage 1, 0– 5 minutes Deteriorating patient	
A	Awake and talking
B	RR 18, sats 98% on A
C	HR 60, BP 90/45
DE	Feeling dizzy and nauseous Block height C5/T1if tested
Rx	Structured approach to assessing a patient with hypotension, consider differentials (LA toxicity, anaphylaxis, high spinal) including block check Call for help Resuscitation – ABCDE (oxygen, fluid, vasopressor, treat bradycardia, patient positioning (head up tilt?))
Stage 2, 5–10 minutes Cardiovascular collapse	
A	Intermittent snoring
B	Sats 92% on RA or oxygen. RR 10
C	HR 50 BP 80/38
DE	Fluctuating GCS – drowsy with slurred speech/distressed by difficulty in breathing and moving arms Unable to grip bilaterally Surgeons keen to carry on (not understanding anaesthetic ongoing anaesthetic concerns until communicated with) Block height T2/3 (if checked)
Rx	Declaration of critical incident 'high/total spinal', communication with other teams Resuscitation – simple airway manoeuvres, management of cardiovascular collapse Call for appropriate help Communicates with patient Preparation for GA – Scenario can end when first induction drug is given Discussion re continuation of surgery and post-op destination

Guidelines

Obstetric Anaesthetists Association – High Spinal Block
https://www.oaa-anaes.ac.uk/ui/content/content.aspx?ID=60

Guidance for Patient Role

Opening lines/questions/cues/key responses	Relevant HPC / PMH
Why do I feel so dizzy	Well controlled hypertension, otherwise active and well
Actions	**Actions**
Distressed/anxious as scenario progresses and shows increasing signs of high spinal	

Guidance for ODP role	Guidance for surgeon role
Opening lines/questions/cues/responses/Concerns That blood pressure is quite low, do you need to give something for it? Do you need some more hands in theatre?	Keen to start surgery When directly communicated with/incident declared, support within capacity of surgical team
Actions Depending on level of participant can suggest next steps, suggest additional staff or equipment that might be needed	

Guidance for Role e.g. ITU/Anaesthetic Senior	Guidance for theatre team role
Expectations/actions Able to support by phone/in person depending on level of participant Support with decision making	Support in their capacity Call for help – but ensure specific team is specified by participant
	Additional challenges
	Degree of cardiovascular instability leading to arrest

Session Objectives	
Clinical	Management of patient with high/total spinal
Non-technical skills	
Teamworking	Coordinating activities in emergency (assessing and preparing for GA), exchanging information with MDT, assertiveness in emergency, assessing capabilities of team
Task management	Planning and preparing for further deterioration/next steps, maintaining standards – using guidelines, identifying and utilising resources – using team to do tasks such as call for help, resuscitation
Situational awareness	Gathering information as patient deteriorates, anticipating changes
Decision making	Identifying and balancing cause for deteriorating patient, continuous re-evaluation

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