Paediatric laryngospasm

Paediatric Simulation

Name:	T Brown	**Observations at start**		**CRT:**	2s
D.O.B.	31/12 (Any age to match available mannequin)	**RR:**	struggling	**Temp:**	36.5
Address:	(Insert local address)	**ETCO2:**	dropping	**BM:**	6.2
		Sats:	95%	**Weight:**	Age appropriate
Hospital ID:	441 364 9942	**Heart rate:**	High for age	**Allergy**	NKDA
Ward:	Paediatric admissions unit	**BP:**	High for age		

Background to scenario	Specific set up
This scenario can be simulated with an adult or paediatric mannequin as either 1. Intra-operative laryngospasm 2. Post-operative laryngospasm in recovery	Mannequin on trolley Either in theatre or recovery area (Theatre – supraglottic airway and ventilator, used anaesthetic induction drugs, draped for surgery) Recovery – oxygen mask) Cannulated Anaesthetic chart
Required embedded faculty/actors	**Required participants**
Junior anaesthetist and surgeon (If in theatre) Recovery nurse (if in recovery)	Anaesthetist ODP

Past Medical History

F&W, normal development, vaccinations up to date, no recent LRTI
Admitted for elective grommet insertion (or any other operation performed in your department)
No previous anaesthetics, no airway concerns

Drugs Home	Drugs Hospital
Nil reg	Anaesthetic induction drugs

Brief to participants

Intra-op – you have been called to support an anaesthetist in ENT theatres
Handover – ? year old having insertion of grommets. Induction was uneventful, a size ? LMA was inserted.
Brought to theatre and surgery has just begun when patient started making odd airway noises, I have only just finished my novice period and the consultant stepped out for a coffee and I can't find them
Post-op – you have been called to support a patient that has just been transferred to recovery.
They had grommets inserted under GA (LMA) which was uneventful. The LMA has just been removed in recovery and the patient is making stridulous noises.

Scenario Direction

	If in theatre
A	Stridor, (coughed as initial incision made)
B	RR high, Sats gradually drop to 85% unless treated, ETCO2 trace – obstructive, ↓ to 2.4
C	HR high for age ( ) and rising, BP high for age ( ) and rising (unless treated)
DE	At point of surgery starting anaesthetised with inhalational agent (MAC 0.9) Surgeon continues surgery unless Laryngospasm can be relieved by an appropriate manoeuvre/treatment at any point in the scenario
Rx	Identify cause of stridor, declare incident, call for appropriate help Follow QRH handbook stepwise approach to treating laryngospasm Discussion regarding continuation of surgery and strategy for extubation

	In recovery
A	Stridor, patient semi awake
B	RR high, chest seesaw movements, sats drop to 85% unless treated
C	HR high for age ( ) and rising, BP high for age ( ) and rising
DE	Semi awake Laryngospasm can be relieved by an appropriate manoeuvre/treatment at any point in the scenario
Rx	Identify larungospasm, call for appropriate help including ODP Follow QRH handbook approach to treating laryngoscpasm Discussion regarding location and support for waking patient up

Guidelines

AoA QRH Handbook laryngospasm and Stridor https://anaesthetists.org/Portals/0/PDFs/QRH/QRH_3-6_Laryngospasm_and_stridor_v1.pdf?ver=2018-07-25-112714-407

Guidance for Patient Role

Opening lines/questions/cues/key responses
Semi-awake/not actively involved in scenario

Guidance for ODP role	Guidance for surgeon
Actions Support as necessary depending on level of participant	Notices patient is coughing/moving toes as surgery is begun, unaware of anaesthetic issue until alerted
Guidance for Role e.g. ITU/Anaesthetic Senior	**Additional challenges**
Expectations/actions Support as necessary depending on level of participant	Patient's cannula has come out during the struggle, requiring consideration of IM suxamethonium or IO access

Session Objectives	
Clinical	Treatment of laryngospasm
Non-technical skills	
Teamworking	Coordinating activities of team (ODP/recovery team), exchanging information at handover, assessing capabilities of team and utilising these appropriately (eg: drawing drugs up in emergency)
Task management	Planning/preparing and anticipating next steps, following guidelines
Situational awareness	Gathering information on arrival to aid decision making, recognising critical incident
Decision making	Identifying treatment options and choosing appropriate options, continuous re-evaluation

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