

Patient transfer to CT:

Set-up:	
Lines/access:	RIJ CVC & left radial arterial line
Infusions:	1L crystalloid at 100ml/hr
Airway:	Own
Ventilator:	FM, FiO ₂ 0.4, RR 25, SpO ₂ 94%, crackles bibasally
Other:	Transfer monitor, transfer bag

Clinical Setting:

I: You are the ICU registrar transferring the patient for a CT scan of his abdomen

S: You have just arrived at CT

B: 70M was admitted to HDU post Hartman's procedure for acute large bowel obstruction (20 probable new colonic mass), 5 days ago. He continues to have abdominal pain and persistent inflammatory markers, so the ICU consultant on duty decided he will have a CT CAP to assess the source of ongoing infection. PMHx T2DM, HTN. NKDA Abx to Tazocin. SHx: Independent of ADLs, with ex-tolerance up to 1 mile twice weekly. TEP: Full escalation

A: You are there to as support for the transfer

R: Called for help

Potential Clinical Course:

- Initially **A** own, **B** SpO₂ 94% on FiO₂ 0.4 FM, crackles bibasally **C** HR 120 bpm SR, BP 110/60, CVP 16, **D** GCS 15/15
- Patient starts having a tonic-clonic seizure
- The seizure self-terminates; however, patient's GCS remains E1V1M4, with airway compromise.
- SpO₂ drop 95% -> 75% -> 35% and progresses to respiratory arrest if emergency intubation is delayed.
- (The scenario can be run as a full transfer or as "just arrived in CT" based in a sim suite).

Info Sheet For Faculty

- Initial settings:
 - SpO₂ 94% on FiO₂ 0.4 FM
 - RR 25/min
 - Bilateral air entry, crackles bi-basally
 - HR 120bpm, SR
 - BP 110/60, CVP 16,
 - T 38.8
- Progress to:
 - SpO₂ 75% on FiO₂ 0.4 FM
 - (post-seizure) Obstructing airway
 - HR 130 bpm
 - BP 111/57, CVP 18
- If not intubated:
 - SpO₂ 35%
 - Absent breath sounds
 - Increase HR to 80 bpm SR
 - Progressing to cardiac arrest
- If intubated:
 - SpO₂ 97% on FiO₂ 1.0
 - HR 110bpm SR
 - BP 90/60.

Faculty Roles:

Bedside Nurse 1:

- You are a senior ITU nurse
- You are looking after a 70M post Hartman's procedure for acute large bowel obstruction 5 days ago. He continues to spike temperatures and has abdominal pain. You have come on the transfer to CT for him to have an CT abdo.
- When you are at CT patient has a tonic-clonic seizure and drops his GCS following it.
- You take direction well, and can perform tasks asked of you in a timely fashion.
- You wonder if CT is the most appropriate place to intubate someone.

Radiographer:

- You can put out calls if asked
- Beyond that you do not know how to help

Anaesthetic SpR if called:

- You are experienced, but let the ITU team lead on the situation
- If scenario is not progressing you wonder if intubation needs to happen quicker
- You wonder if CT is the safest place to intubate or perhaps moving to a place of safety is more appropriate

HILLO: 5