

EMT-PARAMEDIC AND BEYOND

FINAL EXAM SCENARIOS

SCENARIO ONE

A 34 year old female fell down a flight of stairs, striking her head on a concrete floor.

SCENE SAFETY:	Scene is safe.
GENERAL IMPRESSION:	The patient is lying at the base of the stairs, not moving. The patient's arms are held to her chest in a flexed position.
LOC:	Unresponsive to painful stimuli.
CHIEF COMPLAINT:	No verbal complaints.
AIRWAY:	Open.
BREATHING:	Shallow and regular. She appears to be breathing only with her belly.
CIRCULATION:	Radial pulses are weak but seem to be within normal ranges and regular. Skin is warm and dry.
HEAD, FACE, NECK:	There is a deep 1 inch laceration to the patient's forehead. There is no obvious deformity, spasm, or tenderness of the neck. Trachea is midline. -JVD.
CHEST:	No obvious signs of trauma. Breath sounds are present bilaterally with no rales, rhonchi, or wheezing. Movement of the chest wall during breathing seems to be diminished.
ABDOMEN:	No obvious signs of trauma.
PELVIS:	No obvious signs of trauma. Pelvis stable.
LEGS:	No obvious signs of trauma. +PM -S.
BACK:	Spine clear of deformity of tenderness.
UPPER EXTREMITIES:	No obvious signs of trauma. +P -M -S. However, her arms are flexed tightly to her chest. If the student attempts to straighten one and release it, it returns to the flexed position.
GCS:	3
VITAL SIGNS:	BP: 76/50, P: 72 and weak, R 28 and shallow but regular. O2 sat is 92 %.
BLOOD GLUCOSE:	104 mg/dL
SAMPLE:	No history available.

When endotracheal intubation is attempted, the student is unable to visualize the cord in 2 attempts.

HEAD TO TOE:	Assessment is all as above except now patient has blood draining from the right ear.
GOALS:	Immediate airway control with BVM and 100% O2 while maintaining C-spine. Full spinal precautions. Recognition of spinal shock with recognition for need for prompt transport to Trauma Center. Treatment of spinal shock with blanket and consider elevating foot of stretcher. MAST. Intubation orally and when attempts fail, the student should recognize need for Combitube, which will be successful. IV's. Contact Medical Control for Solu Medrol IVPB.

SCENARIO TWO

You respond to a 1 vehicle accident involving an elderly man who ran off the road and ran his car head on into a tree at an unknown speed.

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SCENE SAFETY:	Scene appears to be safe. The car has significant front end damage and the driver's door is crumpled into the frame. It looks as if both it and the passenger door will be hard to open.
GENERAL IMPRESSION:	The patient is still in the drivers seat, moaning, with blood oozing from a cut on his cheek.
LOC:	Patient responds to loud verbal stimuli with moaning. He won't open his eyes or follow commands.
CHIEF COMPLAINT:	Patient only moans.
AIRWAY:	Open.
BREATHING:	Respirations are somewhat fast and labored.
CIRCULATION:	Radial pulses are weak and irregular.
HEAD, FACE, NECK:	There is a very small laceration to the patient's right cheek area, with no obvious deformity. There is no obvious deformity, spasm, or tenderness of the neck. Trachea is midline. +JVD
CHEST:	No obvious signs of trauma. Breath sounds are wet with diffuse rales and rhonchi bilaterally. Long scar noted down center of chest from suprasternal notch about 8 inches down.
ABDOMEN:	No obvious signs of trauma.
PELVIS:	No obvious signs of trauma. Pelvis stable.
LEGS:	No obvious signs of trauma. +PM S
BACK:	Spine clear of deformity of tenderness.
UPPER EXTREMITIES:	No obvious signs of trauma. +PMS.
GCS:	4
VITAL SIGNS:	BP: 90/60, P 132 and weak and irregular, R: 38 and labored. O2 sat 86%. ECG Sinus tach with multifocal PVC's and runs of Vtach – there is also a noticeable ST segment depression
SAMPLE:	Patient is wearing a medic alert tag that states he is a cardiac patient and is allergic to HCTZ.
BLOOD GLUCOSE:	150 mg/dL
HEAD TO TOE:	All is still the same except the breath sounds are more congested and the patient's breathing is more labored
VITAL SIGNS:	BP: 112/80, P 140 and still irregular, R:42 and labored. O2 sat 87%. ECG still the same.
GOALS:	Immediate recognition that this trauma patient may have other complicating factors. Immediate identification for need for rapid extrication with full spinal restriction and administration of O2 with BVM. Intubation early. Recognition of AMI. IV therapy. Potential need for consultation with MC concerning use of ASA, vasodilators and diuretics in this trauma patient.

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SCENARIO THREE

You are working today in the local clinic in Big Bend National Park. Your closest ambulance for transport is Terlingua, about 30 miles away. The closest hospital is 120 miles away in Alpine. Helicopter service is out of El Paso or Midland. Your doctor has a good case of food poisoning and can't get away from the bathroom, so she told you to handle things. If you need something, you can call her on the radio – but she trusts you to make good judgments.

The clerk tells you that a 40-year-old male is in the waiting room complaining of weakness and dizziness.

SCENE SAFETY: Secure
GENERAL IMPRESSION: The patient is awake and alert, sitting in the waiting room in a chair. He appears to be a little anxious, but in no apparent distress otherwise.
LOC: Alert and Oriented x 4 and able to answer all questions.
CHIEF COMPLAINT: "I don't feel good today. I have been so dizzy I almost fall down."
AIRWAY: Open
BREATHING: Rate seems to be normal with normal depth.
CIRCULATION: Radial pulses are present, rapid and weak. Capillary refill < 2 sec. Skin is warm and pale – a little moist.
HEAD, FACE, NECK: Neck veins visible but not distended. Pupils at 3 and reactive to light. Nothing further to be noted.
CHEST: Equal rise and fall of the chest with breathing. No accessory muscle use. Heart tones normal – S1 and S2 noted. Breath sounds clear and equal bilaterally.
ABDOMEN: No pulsating masses or other.
PELVIS: Normal.
LEGS: No pedal edema. Equal pulses present – weak.
UPPER EXTREMITIES: Equal pulses but weak. No edema.
BACK: Breath sounds clear and equal bilaterally.
GCS: 15

VITAL SIGNS: BP: 108/50, P: too fast to count, R 26 regular. O2 sat 95% . ECG **V-tach.**

SAMPLE: Patient's symptoms began when he got up this morning and was preparing breakfast. He says this has never happened this bad before, but it has been happening more and more frequently over the last couple of weeks. He has never been seen by a Dr. for it though. He is allergic to Amitriptyline and Atenolol. He currently takes propranolol. His only history includes migraine headaches. He ate breakfast about an hour ago.

(Critical interventions include high flow oxygen, IV. Early consideration of rapid transport to major facility. Ambulance is on a call and won't be available for at least another 30 minutes over their normal response time. Consider helo. Amiodorone - Amiodorone is 150 mg over 10 min - in either order is to be used. Pt will not convert unless Cordorone is used. A maintenance infusion should then be hung at 0.5 mg/min.)

REASSESSMENT: Patient's dizziness will disappear when the rhythm changes. BP 130/82, P is in the 90's with **Sinus tach**, R 20 clear and equal. Pulses are now much stronger. Skin is warm, dry and pink.

GOALS: Immediate application of O2 early in ABC's.
Early recognition of need to call for help. Helo is most likely transport mechanism due to times for ground transport vehicle to arrive.
IV therapy.
Use of appropriate ventricular antidysrhythmics.

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SCENARIO FOUR

Dispatch tones you out to a difficulty breathing call at a private residence.

SCENE SAFETY:	Secure
GENERAL IMPRESSION:	The adult patient is sitting in a chair, leaning forward, having obvious trouble breathing.
LOC:	Alert and Oriented x 4 but having difficulty answering questions between breaths.
CHIEF COMPLAINT:	“I can’t breathe...”
AIRWAY:	Open
BREATHING:	Rate seems to be tachypneic and extremely labored.
CIRCULATION:	Radial pulses are present, rapid and weak. Capillary refill > 2 sec. Skin is cool, pale and wet.
HEAD, FACE, NECK:	Neck veins visible but not distended. Pupils at 5 and reactive to light. The patient has nasal flaring and is using accessory muscles to breathe.
CHEST:	Equal rise and fall of the chest with breathing. Accessory muscle use. Heart tones normal – S1 gallop. Breath sounds noted to have diffuse rales (crackles) throughout all lung fields.
ABDOMEN:	No pulsating masses or other.
PELVIS:	Normal.
LEGS:	No pedal edema. Equal pulses present – weak.
UPPER EXTREMITIES:	Equal pulses but weak. No edema.
BACK:	Breath sounds with significant rales heard.
GCS:	15
VITAL SIGNS:	BP: 82/40, P: 138 and irregular, R 40 and labored. O2 sat 87% . ECG Sinus tach with PVC’s.
SAMPLE:	Patient’s symptoms began about 2 hours ago and have been getting progressively worse. He was watching TV when it started. He denies chest pain or nausea. Pt is allergic to sulpha drugs. He has a history of MI x 2 with CABG x 4 5 years ago. His meds include Digoxin and Cardizem. He says he hasn’t eaten today because he hasn’t felt like it.
	(Critical interventions include high flow oxygen, IV TKO. Early consideration of rapid transport to major cardiac facility. Fluid challenge not indicated due to wet lungs. Dopamine is preferred to increase BP due to s/s of shock. Used in conjunction with Nitro, Lasix, and Morphine.
REASSESSMENT:	Patient’s BP will improve with Dopamine to 100/systolic allowing use of other agents. Pt’s respiratory status and s/s will improve if all agents used. If not, pt will deteriorate into respiratory arrest.
GOALS:	Immediate application of high flow O2 early in ABC’s. Early recognition of need for rapid transport to cardiac facility. Position patient in High Fowler’s as pt allows. IV line TKO – preferably 2 lines. One line is to be used for piggyback for Dopamine drip. Students should recognize need to increase BP to approximately 100/systolic as target and then give vasodilators and diuretic.

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SCENARIO FIVE

It is an extremely frigid, wintry day. All the lakes have been frozen for about 2 days. You are called to a local pond on a report of a drowning. Bystanders tell you that a 19-year-old female was sliding around, playing, on the ice and then fell through about 30 minutes ago. The fire department just located her and is bringing her ashore with CPR in progress.

SCENE SAFETY: Secure as long as the crew stays on the shore.
GENERAL IMPRESSION: The patient is pulseless and apneic.
LOC: Unresponsive
CHIEF COMPLAINT: The patient is unresponsive.
AIRWAY: Open
BREATHING: None
CIRCULATION: Pulses are absent. Skin is pale, bluish and extremely cold and a little hard.
HEAD, FACE, NECK: Neck veins are not scene. Pupils at 8 and non-reactive.
CHEST: Equal rise and fall of the chest with ventilations with BVM. Heart tones not heard. Breath sounds hard to hear with ventilations..
ABDOMEN: No pulsating masses or other.
PELVIS: Normal.
LEGS: No pedal edema. Cold and blue.
UPPER EXTREMITIES: Cold and blue. No pulses. No edema.
BACK: No obvious trauma
GCS: 3

VITAL SIGNS: BP: 0, P: absent without compressions, R 0. O2 sat 90%. ECG **fine Vfib.**

SAMPLE: bystanders know nothing else about the pt.

(Critical intervention starts with spinal immobilization with continued ventilations – preferably with a pocket mask until can get into ambulance and use warm, humidified O2. Keep pt level and handle gently. Remove all wet clothing and wrap in warm blankets. Defib x 1 – no change. Establish IV with warmed NS using increased rates. No heat packs due to afterdrop and resultant vasodilation and release of toxins to central circulation. Continue CPR.)

LOC/GCS: Still unresponsive.

AIRWAY: Still open

BREATHING: No breathing.

CIRCULATION: No change.

VITAL SIGNS: No change.

REASSESSMENT: Patient's condition will remain unchanged unless meds are given or more shocks are given. Then patient will deteriorate to asystole and not change.

GOALS: Recognition of potentially resuscitatable situation.
Recognition of indication for spinal immobilization – quickly.
Removes all wet clothing inside ambulance and wraps in blankets – unless further out – then must quickly be done in field.
Ventilations with pocket mask for warmth and humidification until warmed, humidified O2 is available.
Defib x 3 only with no further shocks.
IV with warmed IV fluids.
No meds due to build up of toxic levels.
Handle gently and keep patient level at all times.

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CPR is mainstay with warming using warm blankets, warm environment, warm O2 and warm IV fluids.