

SCRIPT

FALL AT THE STREET



SCENARIO

#649

NAME

CHARLES HAMILTON

SPECIALTY

Neurology

DIFFICULTY LEVEL

INTERMEDIATE

SIMULATION ENVIRONMENT

PRE HOSPITAL - STREET

BODY INTERACT™
VIRTUAL PATIENTS

This patient is not a real patient, and the clinical scenario, while clinically plausible, is fictional.

Scenario

General description of the scenario info. Corresponds to the initial information presented to the trainee when selecting this scenario.

Title

Fall at the street

Context

Mr. Hamilton was taking his trash out this morning when suddenly felt ill and collapsed on the floor. His daughter tried to talk to him but he couldn't express himself.

Briefing

Male, 75 years old, has a medical history of diabetes type 2, hypertension, and dyslipidemia. His daughter found him collapsed on the floor in front of his house, with facial droop, speech impairment, and unable to move the right side of his body. She immediately called Emergency Medical Services.

General learning objectives

In this scenario, the learner should:

Recognize acute stroke.

Perform neurological assessments using stroke screening (FAST, FAST-ED, or race scale).

Evaluate eligibility for transport to a stroke center.

Specific learning objectives

Important when questioning the patient:

Characterize the main complaints (facial droop, speech impairment, and hemiparesis), and determine the onset time

Ask about similar situations in the past, further co-morbidities, regular medication, and alcohol or smoking habits

Fundamental in ABCDE:

Perform vital signs vigilance in acute care (blood glucose, blood pressure, oxygen saturation)

Evaluate the presence of stroke mimics

Apply stroke screening (FAST, FAST-ED, race scale) and search for neurological deficits

About the treatment:

Pre-notify stroke unit

Employ the correct decision for transportation (hospital, stroke ready hospital, or comprehensive hospital)

Pre-simulation notes

-

Environment

Pre Hospital

Specialty

Neurology

Difficulty Level

Intermediate

Reviewers

Angels Initiative

Patient characteristics

Characterization of the patient's demographic, habits, behavior and specific status effects.

Avatar



Patient Name

Charles Hamilton

Age

75 years

Race/Ethnicity

European/Caucasian

Smoker

No

Sedated

No

Agitated

No

Facial palsy

100

Eyelid closure

40

Gender

Male

Eye color

Brown

Conscious

Yes

Confused

Yes

Last meal over 2h

Yes

Speech impairment

Yes

Renal metabolic compensation

Auto

Patient parameters

These parameter values are used by the simulator to initialize this scenario.

Systolic arterial blood pressure (mmHg)

Diastolic arterial blood pressure (mmHg)

185

Heart rate (bpm)

80

Respiratory rate (/min)

23

Temperature (°C)

36.7

Urinary output (mL/kg/h)

0.5

Height (cm)

175

Potassium (mEq/L)

4.1

110

O2 saturation (%)

93

Blood glucose (mg/dL)

85

Hemoglobin (g/dL)

12

Weight (kg)

69

BMI

22.5

Sodium (mEq/L)

139

Other character

Characterization of the other character included in the scenario can be healthcare professional, relative, friend or other.

Non-Player Character

Patient's daughter

Physical examination

The items below characterize the patient's physical examination and monitoring findings on admission.

Airway

Airway observation

1st Priority

Airway is open, not obstructed and safe.

Breathing

Chest palpation

Not a priority

2L - normal; 2R - normal

O2 Sat (%)

1st Priority

93 %

Pulmonary auscultation

2nd Priority

Clear to auscultation.

Respiratory rate (/min)

1st Priority

23 /min

Circulation

Blood pressure (mmHg)

1st Priority

185/110 mmHg

Capillary refill time (s)

1st Priority

1 second

Cardiac auscultation

2nd Priority

Regular rate and rhythm.

Heart rate (bpm)

1st Priority

80 bpm

Pulse palpation

Not a priority

Central - Amplitude: strong; Rhythmic;
Peripheral - Amplitude: strong;
Rhythmic.

Disability

Blood glucose (mg/dL)

1st Priority

85 mg/dL

Glasgow Coma Scale

1st Priority

11 (E-3; V-3; M-5)

Pupil light reflex

2nd Priority

Right eye: 4 mm; Right eye light: 2 mm;
Left eye light: 7 mm
Left eye: 7 mm; Right eye light: 2 mm;
Left eye light: 7 mm

Exposure

Abdominal palpation

Not a priority

No rigidity. No pain. No guarding or
signs of peritoneal irritation. No masses
or palpable organomegalies.

Skin observation - Lower body

Not a priority

Temperature (°C)

1st Priority

36.7°

Dialogues

This is a complete list of all the possible dialogue lines by both the health practitioner (on the left) and the respective responses from the patient (on the right).

SAMPLE

Symptoms

01. Can you tell me your
name and your age?

1st Priority

Patient: Thii... boo.

02. Can you tell me what
happened to him?

1st Priority

Patient's daughter: We were outside and
suddenly his gaze was odd and fell on the
floor.

03. Do you know where you
are right now?

Patient: Haaf... weeaak...

1st Priority

04. Does he smoke?

Patient's daughter: Only when he was younger.

2nd Priority

Allergies

05. Does he have any allergies?

Patient's daughter: Yes, penicillin, gives him a skin rash.

2nd Priority

Medications

06. Does he take any medication?

Patient's daughter: Yes, he takes simvastatin, losartan, and metformin.

1st Priority

07. Has he been taking his medication properly?

Patient's daughter: I'm not sure, I just came yesterday for a weekend visit. He is normally independent with his medication.

After question "Does he take any medication?" is asked

2nd Priority

Past medical history

08. Does he have any health issues?

Patient's daughter: He has hypertension, type 2 diabetes, and high cholesterol.

1st Priority

Last oral intake

09. When was the last time he had something to eat?

Patient's daughter: It was at breakfast, maybe an hour ago.

1st Priority

10. How often does he drink alcohol?

Patient's daughter: He has a few glasses of wine at meals, nothing else.

2nd Priority

Events

11. When was the last time you saw him well?

1st Priority

Patient's daughter: It was just before we came outside, around half an hour ago.

12. Was he doing any effort when this happened?

2nd Priority

Patient's daughter: No, we were just taking the trash outside.

Diagnostic strategies

The items below characterize the possible test results during this scenario, including rules that may condition test results.

Decision aids

FAST scale

1st Priority

i.1

Facial droop: One side of the face doesn't move at all

Arm drift: One arm drifts compared to the other

Speech: Slurred and inappropriate words

FAST-ED scale

1st Priority

i.1

Facial droop: 1 - One side of the face droops

Arm weakness: 2 - One or both arms falls rapidly

Speech: 1 - Speech content clearly abnormal or names 1-2 items correctly

Receptive aphasia: 1 - Patient does not understand e.g does not show two fingers

Gaze deviation: 1 - Patient has clearly difficulty when looking to one side

Denial: 1 - Patient is weak and does not recognize it

Neglect: 1 - Patient does not recognize his/her weak arm

Total score: 8 - Immediate transport to the closest Comprehensive Hospital

Race scale

1st Priority

i.1

Facial palsy: 2 - Facial gesture is completely asymmetrical

Arm motor function: 2 - Cannot

maintain the arm and drops immediately
Leg motor function: 2 - Cannot
maintain the leg and drops immediately
Head and gaze deviation: 1 - Present
Agnosia/Negligente: 2 - There is
asomatognosia and anosognosia
Aphasia/ Language: 1 - Perform one task
correctly
Total score: 10

Electrophysiology

12-Lead ECG 2nd Priority

Sinus rhythm.

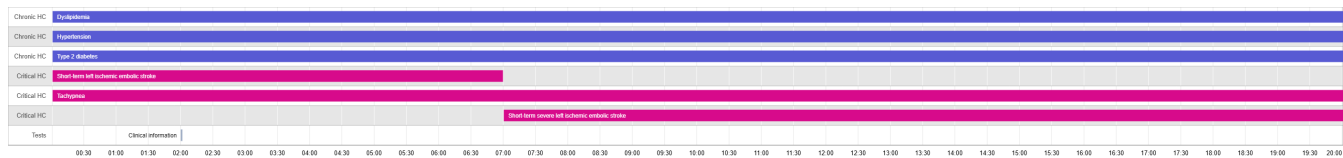
Initial notifications

Initial notifications presented to the trainee after a specified amount of time after starting the simulation

Medical test	Time	
Clinical information	02:00	Comprehensive Stroke Center 15 minutes away Hospital 10 minutes away Stroke Ready Hospital 25 minutes away

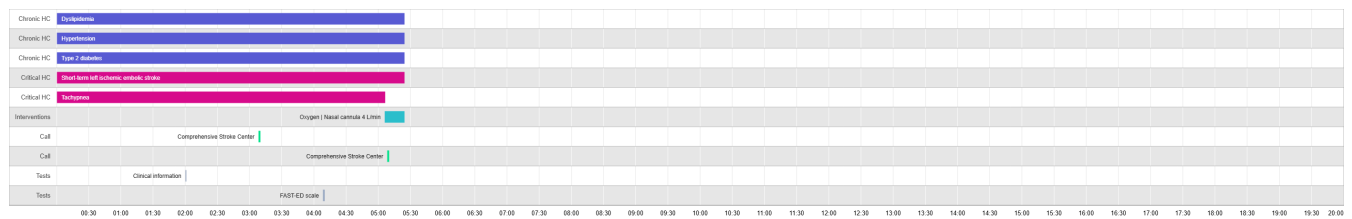
Baseline

This section is automatically generated and predicts scenario behavior assuming no actions by the trainee, which usually represents the worst-case scenario.



Optimal clinical approach

This section previews how the optimal approach resolves the scenario successfully. Comparison with Baseline may be useful to understand the scenario behavior.



Treatment priorities

Treatment items that are considered necessary or adequate to solve this clinical scenario are listed below. Notes: 1st Priority - mandatory items to solve the scenario successfully. 2nd Priority - optional items that are considered adequate, but are not essential. Not a Priority - unnecessary items that are considered inadequate or a waste of time.

i.2 - Call - Comprehensive Stroke Center

1st Priority

Initial: Please gather more information regarding the patient's status and contact again.

Call | Comprehensive Stroke Center

After stroke screening: The stroke team was notified.

i.3 - Interventions - Oxygen therapy

1st Priority

Due to sats lower than 95%

Interventions | Oxygen | Nasal cannula

Interventions | Oxygen | High flow mask

Interventions | Oxygen | Non-rebreathing mask

i.33 - Call - Hospital

Not a priority

We are not ready to receive and treat stroke patients.

Call | Hospital

i.34 - Catheters & tubes - IV peripheral catheter

2nd Priority

Interventions | Catheters & tubes | IV peripheral catheter

i.35 - Fluids & Electrolytes

2nd Priority

Medications | Fluids & Electrolytes | Fluids IV - Crystalloid

i.36 - Call - Stroke Ready Hospital

Not a priority

The Stroke Ready Hospital is too far away to receive this patient.

Call | Stroke Ready Hospital

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

Acute ischemic stroke

3 Incorrect answer(s)

Hypoglycemia

Epileptic fit

Drug intoxication

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.

Ending messages

Feedback messages presented to trainees for particular successful or failed approaches and the respective conditional rules that trigger these messages.

Title	Type	Message	Conditional
Send patient to Hospital OR Stroke Ready Hospital	Failure	This is the end of your virtual simulation scenario. Following the suspected stroke, the patient should have been transferred to the nearest stroke center.	If Call Hospital OR Stroke Ready Hospital is requested, the case will end in failure.
Stroke screening and send patient to Comprehensive Stroke Center	Success	Your practice meets the guidelines' requirements.	

References

1. Powers WJ, Rabinstein AA, Ackerson T, et al. 2018 Guidelines for the Early Management of Patients With Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the

American Heart Association/American Stroke Association. *Stroke*. March 2018.

2. Lima Fabricio O., Silva Gisele S., Furie Karen L., et al. Field Assessment Stroke Triage for Emergency Destination. *Stroke*. 2016;47(8):1997-2002.

3. Pérez de la Ossa Natalia, Carrera David, Gorchs Montse, et al. Design and Validation of a Prehospital Stroke Scale to Predict Large Arterial Occlusion. *Stroke*. 2014;45(1):87-91.