SimBox+
Tele SimBox

Infant Seizure

Emergency Department/Hospitalist/Resident

SimBox Toolkit

PREPARATION

SCENARIO

FACILITATION AND DEBRIEFING RESOURCES

CASE SPECIFIC RESOURCES

FEEDBACK

Thank you for your interest in SimBox low-technology learning tools!

❏ Our low-technology simulation series allows your team to engage in the first 10 minutes of an emergency scenario.

❏ Use your own equipment and resources in your own clinical environment, or in the convenience of a virtual environment to practice non technical skills.

SimBox Original Version

❏ Low-technology manikin.
❏ + video.
❏ + tablet-based resources (*in situ* or sim lab).
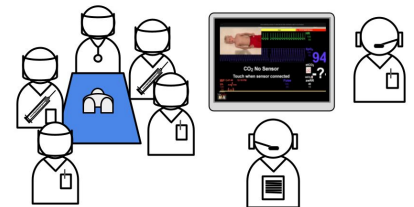
SimBox✚ (SimBox Original + tele-facilitator)
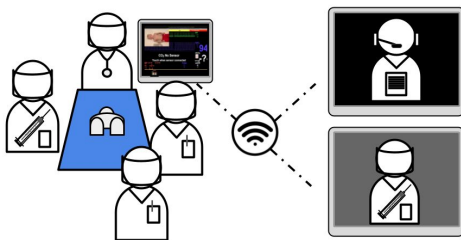
❏ SimBox Original PLUS.
❏ Learners in remote or underserved areas +/- limited access to content or simulation experts.
❏ Remote facilitator.

Tele SimBox:

❏ Non-technical skills all remote version.
❏ Meets post-pandemic demands for virtual learning and continuous education for learners of all levels.
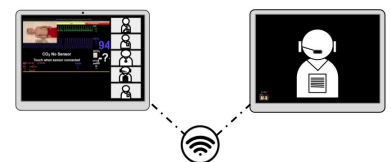
How to use these resources

SimBox or SimBox✚
● Review this document + run a session in your ED with a doll/manikin/pillow.

Tele SimBox
● Reference: Tips / Tricks.
● Watch a sample recording of the telesimulation to see how it is run.

*If using this resource for EM / PEM trainees see Resource page at end of booklet with suggested case augmentation to meet Milestones.

**For additional questions or concerns, arrange a one-on-one tutorial with the project team.

3

Guide

This guide is for facilitators of all backgrounds in how best to use these didactic resources.

Novice Facilitator

❏ Review this entire guide and watch video *prior to* first session.
❏ Utilize the Prebriefing / Debriefing Scripts, Prompts and Resources.
❏ Review the Checklist.
❏ Encourage all participants to complete the Survey.

Intermediate to Advanced Facilitators

❏ Review the case summary and progression.
❏ Use the Prebrief / Debrief scripts or use your own.
❏ Review Educational Resources or use your own.
❏ Review this Checklist *or modify* to your specific learner group.

Tele Tips / Tricks

❏ Trial sharing the video *prior to* the session.
❏ Use *Gallery View*.
❏ Have participants *name themselves* with assigned *role*.
❏ Ask *observers to mute audio* and *turn off video* for simulation.
❏ Both participants and facilitators can use a *"Time Out"* whenever necessary to pause and regroup.
❏ An *embedded participant* can help move the scenario along.
❏ During the simulation, scroll through the monitor video based on the participants' actions.

For example, if the participants quickly stabilize the patient, you can "skip through" to the part of the video where the vital signs have normalized.

Conversely, if the necessary interventions, e.g. giving the patient oxygen, have not been performed, you can "scroll back" and spend more time in the part of the video where the vital signs are abnormal.

4

After this activity, the team will be able to manage a seizing pediatric patient with emphasis on the following objectives:

1. Apply Crisis Resource Management and teamwork in the care of a patient with a seizure (with attention to role designation, directed orders, sharing mental model and closed loop communication with team and family members).

2. Prioritize treatment of potential etiologies to the guide stabilization or escalation of care for a patient with a seizure.

3. Determine the appropriate destination for transfer.

Overall Scenario Schema

Prebrief: Use narrated video + sample script or your own script

2 mins	Assign or Coach them to allocate roles. Adapt roles based on the participating team:

Team Leader	Airway	Bedside Survey
Respiratory Tx	Bedside Nurse	Medication Nurse
Parent Liaison	Pharmacy	Recorder

10 mins

Stem: You are called to a assess an infant who is actively seizing and desaturating.

Your team will focus on the resuscitation of a child in status epilepticus.

Telesim Co-facilitator prompts are indicated in these boxes

15 mins

Debrief: Use the narrated video + sample script or pause the video and use your own script

10 mins

Option: re-run scenario

5

Scenario script:

"Lets assign roles, including team lead, bedside survey and airway provider and parent liaison. You will hear a brief EMS patch and then see a two minute countdown clock as you prepare for the arrival of the patient. You will now hear the EMS dispatch."

Link to ED Infant Seizure Video

Video states: "ED, this is EMS, we are coming in with a one year old girl who is actively seizing. She has no history of any recent illness, trauma or prior seizures. She has been seizing for the past 5 minutes and we are about to give her intranasal midazolam. We will arrive in 2 minutes."

2 minute warning

- Team assembles + confirms roles
- Asks for equipment: monitor, temperature, oxygen, breathing (BVM/CPAP), access (IV), Broselow tape/app, medications
- Dons PPE (hard stop)
- Calls for help

Facilitator states: "The patient has arrived. You have put on the appropriate PPE. EMS administered intranasal midazolam 2 minutes ago and placed her on 100% FiO2 via a non-rebreather en route. She is still seizing."

Time 0 min 7

- Team places the cardiac monitors, pulse oximeter, BP cuff, temperature probe
- Performs ABCDEs
- Uses Broselow tape/ app for weight and/ or asks parents
- Starts timer

"Airway is patent. Breath sounds are equal bilaterally, but she is saturating 80% on 100% O2 via a NRB. Pulses are 2+ and CRT is brisk. She is unresponsive with tonic- clonic movements of his arms and legs. Pupils are equal, small and reactive. No obvious injuries or rashes."

1 min 8

HR 160
BP 90/50
RR 30
Sat 80%
ETCO2 50

- Team notes hypoxia
- Performs airway repositioning maneuvers, suctions any oral secretions, and begins bag-valve-mask ventilation
- Requests temperature and POC glucose
- Asks RN for IV and istat/ gas, CBC, PT/PTT, CMP, iCa/ Mag/ Phos

"Saturations are improving with airway repositioning and BVM. POC glucose is 120. Working on the IV. Temperature is 36.5 C. Weight is 10 kg."

2 min 10

HR 160
BP 95/53
RR 40
Sat 95%
ETCO2 46

- Team notes improvement in oxygen saturation with BVM
- Notes normal glucose level and temperature
- Orders 0.1 mg/kg of IV lorazepam if IV efforts successful
- Orders PR diazepam or IN/ BC/ IM midazolam as alternative
- Mentions using IO if IV unsuccessful after 90'

SAMPLE history

Signs/Symptoms: Generalized seizure began at home a few minutes prior to EMS arrival, has never done this before. No recent fevers or infectious symptoms.
Allergies/meds: None.
Medical history: Uneventful perinatal and past medical history. Vaccines up to date. No known family history of seizures or neurologic, vascular, hematologic, or biliary diseases. Single child, lives with mom and dad.
Last meal: Usual cereal for breakfast ~2 hrs prior.
Events: No obvious triggering events. No trauma.

"IV successful on 3rd attempt. It has been 5 minutes since she received the IN midazolam and 10 minutes since she started seizing. Administering 0.1 mg/kg of lorazepam IV now (min 10)."

3
min 12

HR 160
BP 89/48
RR 40
Sat 100%
ETCO2 40

- Team verbalizes illness state: Patient in status epilepticus s/p second benzodiazepine administration
- Trials off BVM and places back on NRB
- Checks ETCO2
- Orders 60 mg/kg of IV levetiracetam to be ready at bedside
- Verbalizes the need for advanced airway if the seizure persists

"Blood gas results are 7.45/70/45/22 BE 1. The patient is still seizing. Is there anything else we should be thinking about?"

4
min 14

HR 140
BP 94/50
RR 40
Sat 98%
ETCO2 36

- Team discusses the differential for status epilepticus: vascular emergency (stroke), CNS infection, head injury, toxidrome, metabolic, neoplasm/ mass
- Asks for a second IV and serum toxicology
- Verbalizes the need to administer the IV levetiracetam if the seizure persists after min 15'
- Prepares equipment for intubation/ advanced airway

"The tonic clonic movements stop and she appears to be more alert and responsive. She is maintaining her airway and breathing well on her own."

Advanced learner option: "It has been 5 minutes since the IV lorazepam (min 15') and she is still seizing. IV levetiracetam going in now. The seizure seems to be slowing down but the patient is desaturating, despite BVM." Team performs endotracheal intubation.

Wrap
min 16

HR 130
BP 88/48
RR 40
Sat 100%
ETCO2 38

- Team notes that the seizure has stopped
- Reassesses ABCDE and repeats istat/ gas
- Updates the family and addresses any questions and concerns
- Consults pediatric neurology (if available)
- Discusses the need for head imaging and cEEG
- Hands off to the admitting/ PICU team

Video guide

0 min: Seizure starts
5 min: EMS administers 1st BZ
7 min: Patient appears
8 min: SpO2 80%, HR 160s
10 min: SpO2 high 90s, HR 160s, 2nd BZ
16 min: SpO2 100%, HR 130s

After team performs handoff, state "This concludes the simulation" and move to debrief.
Link to educational content

7

TASK		NOT DONE	NOT DONE CORRECTLY	DONE CORRECTLY
Team-centered care	Verbally assemble the necessary staff, equipment and resources to care for a seizing pediatric patient in the ED.			
	Demonstrate effective teamwork and communication (i.e. designate leader/roles, directed orders, closed-loop communication, sharing mental model).			
	Demonstrate appropriate PPE.			
Family-centered care	Obtain an appropriate history from the family member (SAMPLE).			
	Address family concerns, update on care (translate medical aspects of care in plain language).			
Medical knowledge	Verbalize the initial management of an acutely ill pediatric patient (airway, breathing, circulation).			
	Verbalize the first line diagnostic tests of a seizing patient (monitors, dextrose, electrolytes).			
	Discuss the first line therapeutic interventions of a seizing patient (benzodiazepines).			
	Form a broad differential for status epilepticus in pediatric patients.			
Communication	Demonstrate handoff of care at the end of the case.			

Best practices for establishing psychological safety in simulation

Basic Assumption: "we believe that everyone participating in our activities is intelligent, capable, cares about doing their best and wants to improve" *Center for Medical Simulation, Boston MA*

Prebrief

Welcome your team, make introductions:

"This simulated resuscitation is to practice our team's response to an emergency. We will spend about 15' in simulation, then we will debrief for 20' to discuss what went well and what could be improved with input from the team. Even though it is not real, and the manikin can't be harmed, everyone will get the most out of this scenario if we take it as seriously as possible."

Describe

Describe simulator capabilities, equipment and how to participate:

"Act as you would within your role. You will not get monitor feedback unless your equipment is attached to the patient. Airway equipment should be attached to oxygen, etc. Try to make tasks realistic and timely using your equipment. Please ask for clarifications."

Demo

DEMO: Closed loop communication:
Know your role and task designation. Use closed loop communication to verify and complete.
    Leader: Tech, we need an EKG.
    Tech: OK going to get the machine.
    Tech: OK, I've got the EKG machine here.

Disclose

If a safety concern arises during the simulation, I will state:
    "Let's take a safety pause."
If a real event happens that is not part of the simulation, I will state:
    "This is not a simulation."
Disclose if video recording, privacy and permission.

Components of a Debrief (Based on 3Ds + PEARLS)

"The purpose of this debrief is to discuss areas of great performance and discover areas for improvement. It is not a blame session- everyone is here to do their best."

Defuse
1-2 min

Solicit emotions and reactions.
"Reactions?"; "Let's take a moment to gather our thoughts."

Discover
7-8 min

Clarify facts.
"Can a teammate share a short summary of the case?";
"Were there other thoughts?"

Explore Performance.
"What went well?"
"What could be improved?"

Use observations of learner experiences to highlight strengths of the team and individuals, while asking learners for their thoughts, observations and reflections.

Deepen
1-2 min

Identify patient care priorities. Then provide focused feedback and specific areas of opportunity for improvement. Elicit any other outstanding issues or concerns.

Summary
1-2 min

Identify take-home points to apply to future practice : Round the room reflections and thanks for participation.

This page provides possible questions to elicit teaching points during the debrief. These questions are not meant to replace your team's discussion, but can help to steer the debriefing session.

PERFORM A SYSTEMATIC ASSESSMENT/ REASSESSMENT OF A SEIZING PATIENT

How does your team perform a systematic assessment of an ill pediatric patient?
PAT Pediatric Assessment Triangle:
- Appearance TICLS: tone, interactivity, consolability, look/gaze, speech/cry
- Work of breathing: Important to undress visualize WOB
- Circulation/capillary refill: Where and how is this assessed in the pediatric patient?

Airway Breathing Circulation Caveats: Consider pediatric anatomical differences.
ABC vs CAB (in adult patient)
SAMPLE mnemonic: signs/symptoms, allergies, medications, last meal, events preceding

PRIORITIZE EARLY ADMINISTRATION OF APPROPRIATE MANEUVERS AND MEDICATIONS

How did you prioritize the interventions for this seizing patient?
ABCDs, Monitors, AEDs, Access Always reassess - monitor for apnea side effect (of both seizure and AEDs). Call for help.

What is your first priority in this patient? The Airway.
When the breathing was slow and irregular and the patient was hypoxic on 100% NRB, what maneuvers worked? Performing BVM (rate 30-50).

What are ways to give benzodiazepine medication without IV/IO access? Intranasal, buccal, intramuscular, per rectum.

How did you get access? PALS recommends 3 PIV attempts in 90 secs prior to getting IO. Proximal tibia is preferred location for IO.

DESCRIBE COMMON SEIZURE ACTIVITY IN KIDS AND GENERATE A DIFFERENTIAL DIAGNOSIS FOR A SEIZURE

How do you recognize a seizure in a pediatric patient?
- There are various clinical manifestations including: unresponsiveness, apnea, tremulousness, tonic-clonic activity, fixed eye deviation, etc.

What mnemonic is useful in remembering seizure etiologies?
- VITAMINS: Vascular, Infection, Cerebral malaria, Trauma/Toxicology, Autoimmune, Metabolic, Idiopathic, Neoplasm, Syndromes

DEMONSTRATE FAMILY CENTERED CARE INTERACTIONS

How does the team manage the reactions of family members while you are caring for a seriously ill child?
- A large body of literature supports family presence. This does not lead to increased malpractice.
- A social worker or other provider should be assigned to stay with the family through this difficult time.
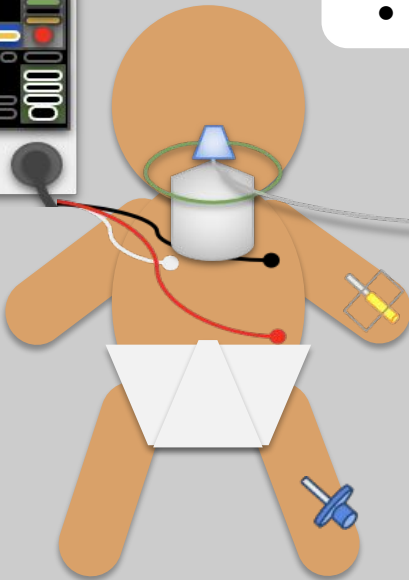
ABCDE's
- Airway
- Breathing
- Circulation
- Disability/Dextrose
- (Anti)Epileptic drugs

Airway Management
- Jaw thrust, Chin lift, Shoulder roll
- Suction PRN
- Accessories: NP/OP airway

Assist breathing
- Bag mask ventilation (BVM)
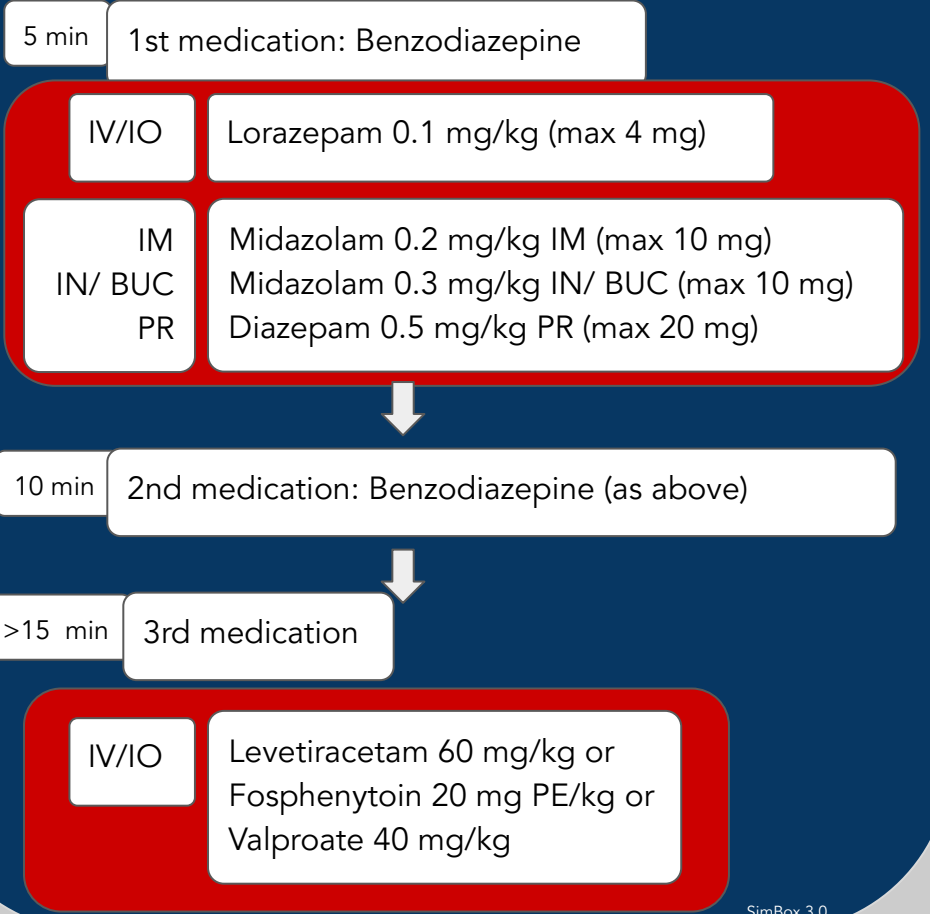- Continuous positive airway pressure(CPAP)
- Consider definitive airway

PEDIATRIC STATUS EPILEPTICUS

| 5 min | 1st medication: Benzodiazepine |

| IV/IO | Lorazepam 0.1 mg/kg (max 4 mg) |

| IM
IN/ BUC
PR | Midazolam 0.2 mg/kg IM (max 10 mg)
Midazolam 0.3 mg/kg IN/ BUC (max 10 mg)
Diazepam 0.5 mg/kg PR (max 20 mg) |

| 10 min | 2nd medication: Benzodiazepine (as above) |

| >15 min | 3rd medication |

| IV/IO | Levetiracetam 60 mg/kg or Fosphenytoin 20 mg PE/kg or Valproate 40 mg/kg |

SimBox 3.0

Consider Nonconvulsive status epilepticus NCSE if prolonged "seizure" or postictal period

VITAMINS
Seizure Etiology ⚠️

V VASCULAR
Stroke, post stroke, AV malformations

I INFECTION
Meningoencephalitis, Lyme disease, TB meningitis, brain abscess, HIV related, cerebral malaria

T TRAUMA / TOXICOLOGY
Non-accidental trauma, brain injury (hemorrhage), toxicologic (prescription and non-prescription, recreational drugs, opioid withdrawal)

A AUTOIMMUNE
SLE, CNS vasculitis

M METABOLIC
Hepatic encephalopathy, uremia, hypoglycemia, low Na, Ca, Mg, porphyria

I IDIOPATHIC
Epilepsy

N NEOPLASM
Primary or secondary brain tumor

S SYNDROMES
Tuberous sclerosis, Down syndrome, Sturge Weber syndrome, Von Hipple Lindau syndrome, other neurodevelopmental syndromes

ELIZABETH SANSEAU MD, MAYBELLE KOU MD, ILENE CLAUDIUS MD

COMMONS.WIKIMEDIA.ORG/WIKI/FILE:VITAMIN_B12_CAPSULE.JPG

12

PEDIATRIC SEIZURES

MANAGING CONVULSIVE STATUS EPILEPTICUS

Defined as:

1) Seizure >5 min and/or ongoing seizure upon arrival to ED
2) 2+ seizures without full recovery of consciousness between them

ETIOLOGY

V ascular: stroke, AV malformation

I nfection: meningitis, Lyme, TB, brain abscess, HIV-related

T rauma: hemorrhage, toxicologic

A utoimmune: SLE, CNS vasculitis

M etabolic: hypoglycemia, low Na|Ca|Mg encephalopathy

I diopathic

N eoplasm

S yndromes: Tuberous sclerosis, Rhetts, Sturge Weber, VHL

SYMPTOMS

Convulsions

Incontinence (urine or stool)

Clenched Teeth

Irregular breathing or apnea

Trouble Speaking

Staring or eye rolling

OPTIMIZING THE PEDIATRIC AIRWAY

Airway Differences: Short, anterior airway, large tongue and epiglottis, prominent occiput. Neonatal seizures are non focal: watch for lipsmacking or blinking

Position Head

Jaw Thrust

Use index/middle fingers to push back of jaw up, thumbs on chin

Shoulder Roll

Use rolled towel under shoulders to achieve neutral neck

Chin LIft

Use two fingers under chin to lift

Suction

Suction secretions from nose and oral cavity

Assist Breathing

1) Airway adjuncts: NP/OP
2) Bag Mask Assist if RR <20
4) Consider supraglottic device or tracheal intubation if apneic and unconscious

13

EMERGENCY MANAGEMENT

5 min

IV Access
- Lorazepam (0.1 mg/kg) over 2 min **OR**
- Midazolam (0.1 mg/kg)
- Diazepam (0.2 mg/kg)

No IV Access
- Midazolam **IM** (0.15 mg/kg) **OR**
- Intranasal / Buccal Midazolam (0.2 mg/kg)　　(0.5 mg/kg)
- Rectal Diazepam (0.5 mg/kg)

10 min

Repeat Benzodiazepine
- Obtain intraossesous (IO) access if failed IV attempts x2
- Prepare second line agent

15 min

Administer 2nd line agent
- **Fosphenytoin 20 mg/kg IV/IO over 10 min OR**
- **Levetiracetam 20-60 mg/kg IV/IO over 15 min OR**
- Phenytoin 20 mg/kg IV/IO over 20 min OR
- Phenobarbital 20 mg/kg IV/IO over 20 min

30 min

Administer alternative 2nd line agent e.g. if fosphenytoin used, give levetiracetam or phenobarbital.
- Consider 3rd line agent

TESTING

- Perform STAT blood glucose and electrolytes. Consider sepsis workup if febrile.
- Treat hypoglycemia/hyponatremia/hypocalcemia
- Consider neuroimaging if first time seizure with prolonged post-ictal period, R/O NAT

ANTIEPILEPTIC MEDICATIONS

FIRST LINE Benzodiazepines	Levetiracetam	**SECOND LINE** Phenytoin Fosphenytoin	Phenobarbital
Bind inhibitory GABA(A) receptor to facilitate GABA attachment	may bind synaptic vesicle protein SV2A that alters vesicle fusion; indirectly modulates GABA	blocks voltage-dependent neuronal sodium channels; watch PR interval	bind GABA(A) receptor, extending duration of GABA-mediated chloride channel opening

Please refer to your insititutional seizure algorithm for further direction*

COMPONENTS OF EFFECTIVE TEAMS: TEAMSTEPPS IN A NUTSHELL
https://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/modules/implement/teamworknotes.html

COMMUNICATION	LEADERSHIP	SITUATION MONITORING	MUTUAL SUPPORT
SBAR Situation Background Assessment Recommendation	**BRIEF** Planning, setting the tone	**STEP** Status of pt Team Members Environment Progress toward goal	**TASK ASSISTANCE** Awareness of team work load
CALL OUT Sharing critical information with the team	**HUDDLE** Ad-hoc planning or updates	**"I'M SAFE"** *Tool for self evaluation* Illness Medication	**FEEDBACK** Providing information for purpose of team improvement
CHECK BACK Loop Closure**	**DEBRIEF** Exchange of information to inform team of performance and effectiveness	Stress Alcohol/Drugs Fatigue Eating + Elimination	**ADVOCACY & ASSERTION** Advocating for patient in case of a disagreement with decision maker

HANDOFF
I PASS the BATON

Introduction

Patient
Assessment
Situation
Safety Concern

Background
Actions
Timing
Ownership
Next

Cognitive Aid @DrM_Kou

PERFORMANCE

Leadership

Communication — Situation Monitoring

Mutual Support

SKILLS

KNOWLEDGE — PATIENT CARE TEAM — ATTITUDES

2 CHALLENGE RULE
Information conflict
regarding patient safety

DESC Script
*Tool for personal conflict**
Describe situation
Express your concern
Suggest an alternative
Consensus statement

CUS STATEMENT
I'm concerned
I'm uncomfortable
This is a safety issue

COLLABORATION
Working toward
a common mission

CRISIS RESOURCE MANAGEMENT: CRM and the Shared Mental Model:

Resuscitation team
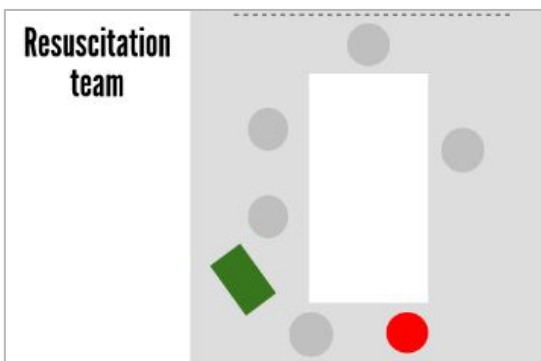
CRM (established by the airline industry) is based upon team leadership and defining clear roles for team members.
Closed loop communication when used by all team members reduces errors and improves safety through:
- Addressing team members by name when assigning tasks.
- Giving confirmation when tasks are acknowledged or completed.

A shared mental model allows a team to anticipate the plan for patient care and what equipment or medications might be needed.
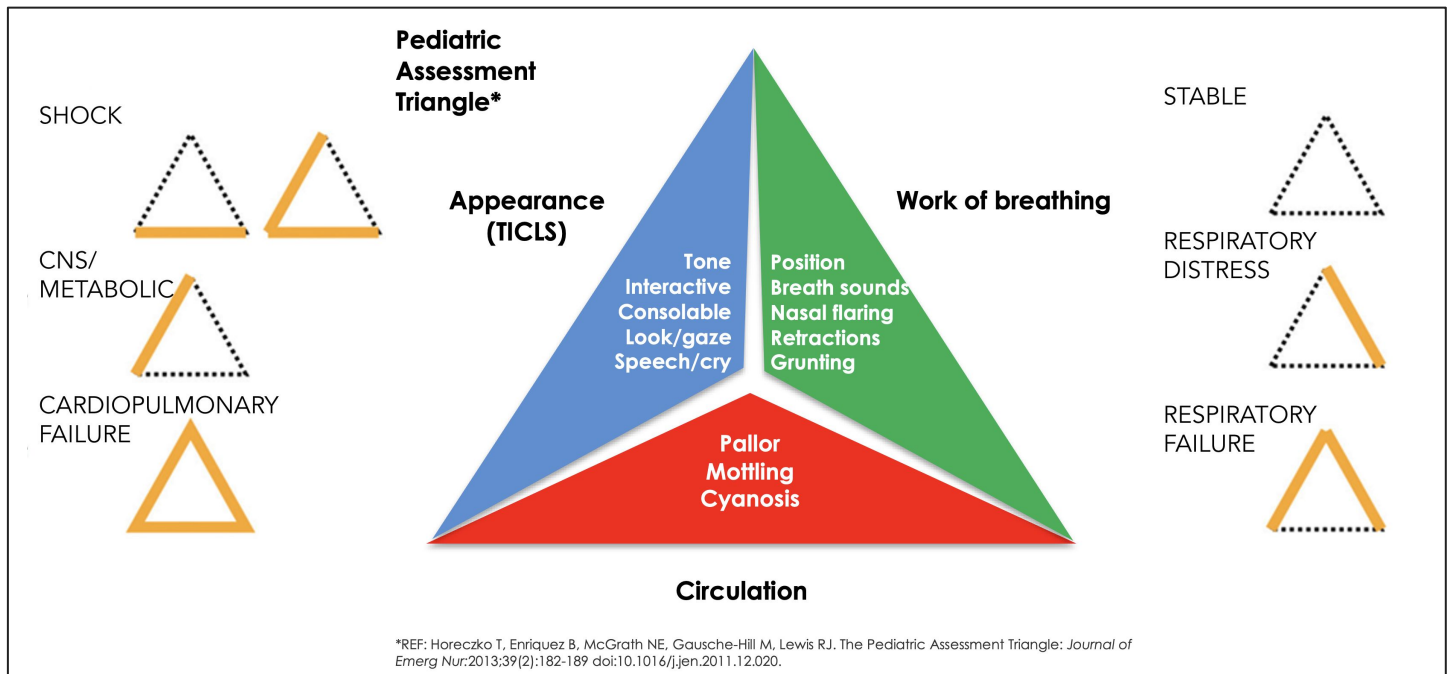
Pediatric Vital Signs/Weight by Age

Age	Weight (kg)	Pulse	Resp	Systolic BP*
Newborn	3	100-180	30-60	60-70
6 mos	7	100-160	30-60	70-80
1 yr	10	100-140	24-40	72-107
2	12	80-130	24-40	74-110
3	15	80-130	24-40	76-113
4	16	80-120	22-34	78-115
5	18	80-120	22-34	80-116
6	20	70-110	18-30	82-117
8	25	70-110	18-30	86-120
10	35	60-100	16-24	90-123
12-15+	40-55	60-100	16-24	90-135

*BP in children is a late and unreliable indicator of shock

Using the Pediatric Assessment Triangle (PAT)

Pediatric Assessment Triangle*

SHOCK

CNS/ METABOLIC

CARDIOPULMONARY FAILURE

Appearance (TICLS)

Tone
Interactive
Consolable
Look/gaze
Speech/cry

Work of breathing

Position
Breath sounds
Nasal flaring
Retractions
Grunting

**Pallor
Mottling
Cyanosis**

Circulation

STABLE

RESPIRATORY DISTRESS

RESPIRATORY FAILURE

*REF: Horeczko T, Enriquez B, McGrath NE, Gausche-Hill M, Lewis RJ. The Pediatric Assessment Triangle: *Journal of Emerg Nur:*2013;39(2):182-189 doi:10.1016/j.jen.2011.12.020.

Pediatric Mental Status Assessment: response to stimuli

A	V	P	U
Alert	Verbal	Pain	Unresponsive

Family-centered care:

- Obtain appropriate history from family member (SAMPLE).

- Address family concerns and update on care.

- Manage the expectations of those who receive care in the ED and use communication methods that minimize the potential for stress, conflict, and misunderstanding [Assess via their communication to prep family for intubation and then for transfer, Patient Centered Communication (EM Milestone ICS1) Level 3:].

Medical knowledge:

- Verbalize the initial management of an acutely ill pediatric patient (ABC's.
- Verbalize first line diagnostic tests of a seizing patient.
- Verbalize the first line therapeutic interventions of a seizing child.
- Demonstrate handoff of care at the end of the case .
- Integrate hospital support services into a management strategy for a problematic stabilization situation [Trainee should request transfer early, Emergency Stabilization (EM milestone PC1) Level 4], Performs rapid sequence intubation in patients using airway adjuncts Employs appropriate methods of mechanical ventilation based on specific patient physiology [Airway Management (EM milestone PC10) Level 3/Pediatric ACGME intubation procedure requirement].

OVERVIEW

Ben Lawton. The First Afebrile Seizure, Don't Forget the Bubbles, 2014. Available at:
The First Afebrile Seizure - Don't Forget the Bubbles

Thanos Konstantinidis. Febrile seizures, Don't Forget the Bubbles, 2014. Available at:
Febrile seizures - Don't Forget the Bubbles

Dalziel, Stuart R., et al. "Levetiracetam versus phenytoin for second-line treatment of convulsive status epilepticus in children (ConSEPT): an open-label, multicentre, randomised controlled trial." *The Lancet* 393.10186 (2019): 2135-2145.

VIDEOS & PODCASTS

Elma Raissi. Febrile Seizure. Peds Cases, 2015. Available at: Febrile Seizures | PedsCases

Michelle Bischoff. Status Epilepticus in Children. Peds Cases, 2010. Available at: Status Epilepticus in Children | PedsCases

Michelle Bischoff. Seizure Types and Epilepsy. Peds Cases, 2010. Available at: Seizure Types and Epilepsy | PedsCases

Anand Swaminathan, "REBEL Core Cast 9.0 – Pediatric Status Epilepticus", REBEL EM blog, April 17, 2019. Available at:
https://rebelem.com/rebel-core-cast-9-0-pediatric-status-epilepticus/

ALGORITHMS

TREKK Status Epilepticus PedsPac, 2018. Available at:
Search results for 'status epilepticus'

18

Thank you for participating in the simulation.
Please complete the facilitator and participant surveys by clicking on the links or scanning the QR codes below:

Facilitator Survey

Participant Survey

Posted: May 2020

Revised: Feb 2022

Authors: Sofia Athanasopoulou, MD, Shruti Kant, MD, Mukuka Kangwa, MD, Sonia Mehta, MD, Marc Auerbach, MD; Maybelle Kou, MD; Ilene Claudius, MD; Keyuree Satam, Elizabeth Sanseau, MD