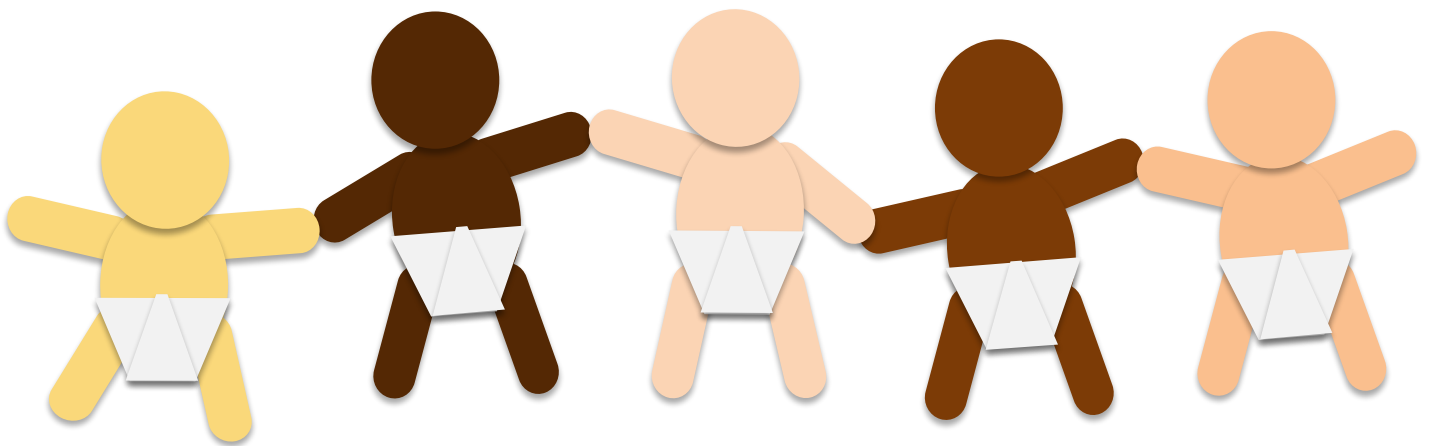


SimBox+ *Tele* SimBox

Pediatric Trauma



EMS



PREPARATION

SimBox Background	Page 3
Tips/Tricks	Page 4
Case Objectives / Summary	Page 5

SCENARIO

Case scenario script and progression	Page 6
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FACILITATION AND DEBRIEFING RESOURCES

Prebriefing Script	Page 10
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CASE SPECIFIC RESOURCES

Teaching content	Page 12
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FEEDBACK

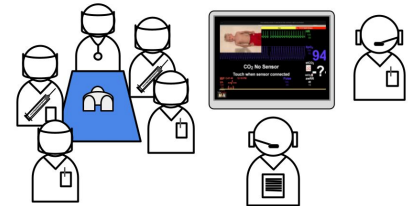
Survey	Page 17
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Thank you for your interest in the SimBox low-technology learning tools!

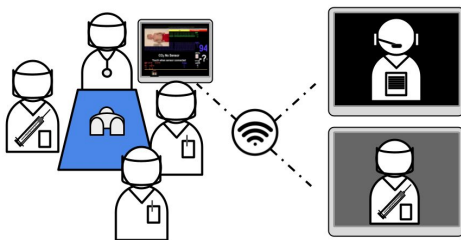
- ❑ Our low-technology simulation series allows your team to engage in the first 5-10 minutes of an emergency scenario.
- ❑ Use your own equipment and resources in your own clinical environment, or in the convenience of a virtual environment to practice non technical skills.

SimBox Original Version

- ❑ Low-technology manikin.
- ❑ + video.
- ❑ + tablet-based resources (*in situ* or sim lab).



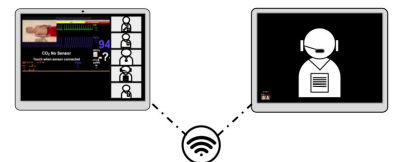
SimBox+ (SimBox Original + tele-facilitator)



- ❑ 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.

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

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 the 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.



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

1. Apply Crisis Resource Management and teamwork in a pediatric trauma resuscitation (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 guide stabilization or escalation of care for a pediatric trauma patient.
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
Parent Liaison	Medications	Recorder

10 mins

Stem: You are called to assess a 7 year old girl who just fell from the monkey bars. She is tachycardic and complains of abdominal pain.

Your team will focus on the resuscitation of a pediatric trauma patient.

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

Scenario script:

"Lets assign roles, including team lead, bedside survey, 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 EMS Pediatric Trauma Video](#)

Video states: "EMS please respond to the scene of a 7 year old girl who fell off the monkey bars about 10 minutes ago. She is crying and says that her belly hurts a lot. You will arrive on scene in 2 minutes."

2 minute warning

- Team assembles + confirms roles
- Asks for equipment: Broselow tape/ app, monitors, IV access
- Dons PPE (hard stop)
- Calls for help

Facilitator states: "You arrive on the scene. The scene is safe and you have put on the appropriate PPE. You find a 7 year old girl who is awake and alert, but complains of diffuse abdominal pain."

Time 0 (min 7)

- Team places patient on monitors
- Estimates weight
- Begins primary survey

"Her saturations are 99% on room air, her heart rate 120 and she has good pulses. You are working on a blood pressure. Her mom says that her weight is 23 kg."

1 (min 8)

HR 130
RR 20
Sats 99% RA
CRT 4 sec
BP -/-

- Team performs the primary survey:
 - A- Airway patent, c-spine immobilized with collar
 - B- Breath sounds and chest wall movement equal bilaterally
 - C- Radial pulses 1+, CRT 4 sec, normal heart sounds
 - D- GCS 15 (or Alert if using AVPU), PERRL, moves all limbs. Asks for POC dextrose
 - E- Normothermic. Bruise to the left flank
- Attempts IV access

SAMPLE history

Signs/ symptoms: "She was climbing on the monkey bars. I turned around to look at my other daughter, and apparently she fell. I did not see her hit the ground, but another parent told me she landed on her stomach with her left hand underneath her. They said that she hit her head too, but cried immediately and did not lose consciousness."

Allergies/ Medications: None

Medical history: None, up to date on immunizations

Last meal: PBJ sandwich and juice approximately 1 hour prior to the incident

2
(min 10)

HR 150
RR 20
Sats 98% RA
CRT 4 sec
BP 80/46
T 36C/ 97 F

- Team performs secondary survey:
 - No scalp/ facial bruising or tenderness
 - No tenderness to palpation of the cervical, thoracic, lumbar spine or clavicles
 - Abdomen is rigid and tender throughout
 - Extremities are cold and slightly mottled
 - No tenderness to palpation of the extremities or the pelvis

“IV placed in the right AC. POC glucose is 90. The patient is still complaining of severe abdominal pain. Is there anything we can give her?”

3
(min 12)

HR 150
RR 20
Sats 99% RA
CRT 4 sec
BP 80/49

- Team verbalizes illness state: Patient in hypovolemic/ hemorrhagic shock; concern for blunt abdominal trauma and splenic laceration
- Orders warm 20 mL/ kg fluid bolus, via push and pull
- Recognizes the need for blood products when they arrive at the hospital
- Attempts second IV
- Asks for POC blood gas with hemoglobin level (if available)
- Draws IV morphine 0.1 mg/kg

“20 mL/kg NS bolus given via push & pull. Repeat blood pressure is 80/49. Second IV is in. Will administer the morphine in a second. POC hemoglobin is 9. What do we think is going on?”

4
(min 14)

HR 130
RR 20
Sat 98% RA
CRT 3 sec
BP 99/63

- Team notes persistent hypotension and low hemoglobin
- Asks for second warm 20 mL/kg fluid bolus
- Makes NPO
- Discusses concern for intra-abdominal bleed with the parents, and the need to be transferred to the Emergency Department for imaging (X Rays, CT abdomen) and consultation with the Pediatric Surgery team

“Second 20 mL/kg NS bolus given via push & pull, her HR and BP seem to be improving. Her pain is better too.”

Wrap up
(min 16)

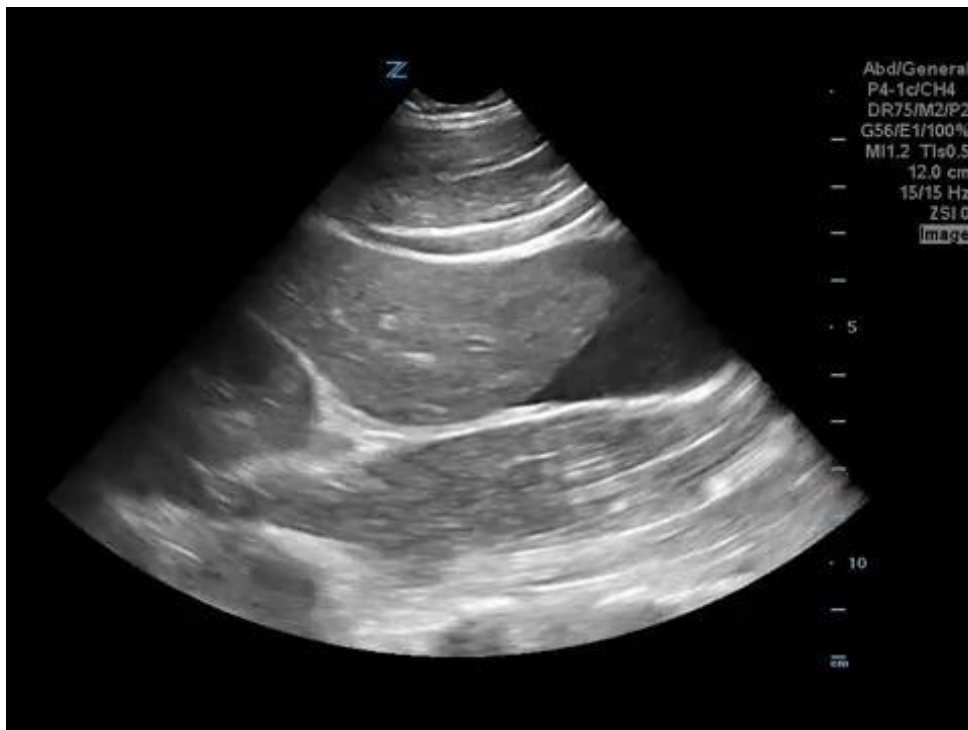
HR 110
RR 20
Sat 98% RA
CRT 2 sec
BP 110/69

- Team notes improving HR and BP
- Considers starting maintenance fluids
- Addresses any parental concerns
- Discusses case with team in the receiving Emergency Department
- Prepares for transfer

After team performs handoff, state “This concludes the simulation” and move to debrief.

[Link to resource page: educational content](#)

FAST:



Video guide

7 min: patient appears
8 min: HR 130
10 min: HR 150, BP 80/46
12 min: HR 150, BP 80/49
14 min: HR 130, BP 99/63
16 min: HR 110, BP 110/69

TASK		DONE CORRECTLY	NOT DONE CORRECTLY	NOT DONE
Team-centered care	Verbally assemble the necessary staff, equipment and resources to care for a pediatric trauma patient.			
	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	Describe how an efficient primary and secondary survey are performed.			
	Verbalize the diagnosis of shock.			
	Demonstrate an organized approach to managing hypovolemic/ hemorrhagic shock.			
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 minutes 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. We are tailoring content for each objective. These questions are not meant to replace your team's discussion, but can help to steer the debriefing session.

PRIORITIZE
SYSTEMATIC
EVALUATION AND
EARLY
INTERVENTION

How did you prioritize the interventions for this tachycardic child with a dropping blood pressure?

- Primary and Secondary surveys with adjuncts.

What is your first priority in this patient?

- As airway and breathing were unremarkable, Circulation perfusion was important in determining stability and an important treatment priority.
- Once identified, deal with a problem BEFORE moving onto the next step of your assessment (i.e "find" and "intervene").

CONSTRUCT A
DIFFERENTIAL
DIAGNOSIS FOR
TACHYCARDIA IN A
PEDIATRIC
CRITICALLY ILL
PATIENT



List the primary determinants of cardiac output:

$CO = HR \times SV$ (preload, afterload, contractility)

List potential causes of tachycardia in pediatric patient:

- Pain/Anxiety
- Fever/Infection
- Hypovolemia
- Hypoxemia
- Metabolic/Endocrinologic (DKA, hypoglycemia or other electrolyte imbalance, thyrotoxicosis)
- Cardiac (arrhythmia, myocarditis)
- Medication/Ingestion

List major areas of internal hemorrhage:

- Chest, Abdomen, Retroperitoneum, Pelvis, Long Bones
- Potentially intracranial in an infant with an open fontanelle

Once tension pneumothorax has been eliminated as a cause of shock, hypotension following injury must be considered to be hypovolemic in origin until proven otherwise (other causes of non-hemorrhagic shock in a trauma patient are cardiac tamponade, cardiogenic shock, neurogenic shock, septic shock)

DEMONSTRATE
FAMILY CENTERED
CARE

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 during resuscitation. This does not lead to increased malpractice.
- A social worker or other provider should be assigned to stay with the family through the difficult time.

PRE-ALERT CHECKLIST

- Activate Trauma Team
- Introduce team + assign key roles
- Don PPE
- Check equipment + monitors: warmed crystalloids + blankets, medications
- Obtain weight + dosages cognitive aid
- Notify CT/ OR and blood bank

HEMODYNAMIC INSTABILITY

HYPOTENSION in pediatric hemorrhagic shock is a LATE FINDING → PEA ARREST.

- poor perfusion, tachycardia
- decreased mental status + pain response

CONSIDER EARLY BLOOD TRANSFUSION
MTP 1:1:1 | Consider TXA

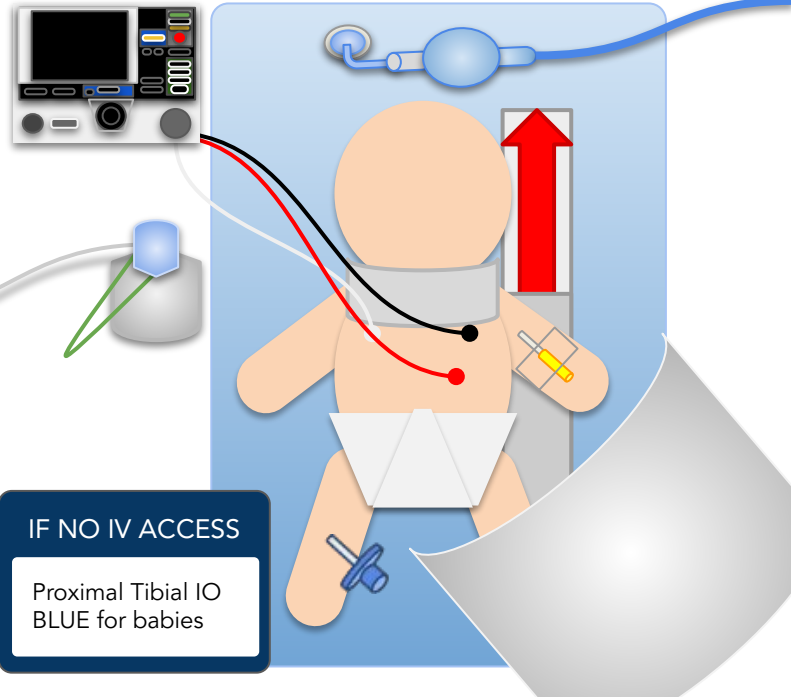
ATLS: ABCDE|FGHI

PRIMARY SURVEY

- A**irway: shoulder roll, c-spine precautions
- B**reathing: oxygenate, ventilate if needed
- C**irculation: access, control hemorrhage
- D**isability: neuro exam, ✓ Dextrose
- E**xpose + control Environment (warmer)

SECONDARY SURVEY

- Full set of vitals + e FAST
- G**lucose + give comfort measures, pain control, allow Child Life presence
- H**ead to toe examination: log roll early and remove backboard/restraints
- H**istory: SAMPLE
- I**maging + labs: +βHcg post menarche



IF NO IV ACCESS

Proximal Tibial IO
BLUE for babies

LEVEL OF CONSCIOUSNESS

AVPU

Alert | Voice | Pain | Unresponsive

KEY ANATOMICAL DIFFERENCES:

Normal vital signs vary with age:

- Larger head, short neck → high c-spine injuries, atlantoaxial instability
- Airway is small and anterior, tongue is relatively large, prone to obstruct
- Larger organs relative to size → solid organ injury with blunt trauma
- Body surface area → hypothermia prone
- Skeletal immaturity → plastic deformities

MULTIPLE BLUNT TRAUMA & INSTABILITY

Perform rapid assessment to r/o hemorrhagic or obstructive shock: consider eFAST.

- extracranial (intracranial in neonates with open skull sutures)
- intrathoracic/intra-abdominal injuries
- femur fractures

ARE PEDIATRIC SUBSPECIALISTS AVAILABLE AT YOUR FACILITY?

Involve consultants early and arrange early transfer if no resources for pediatric care

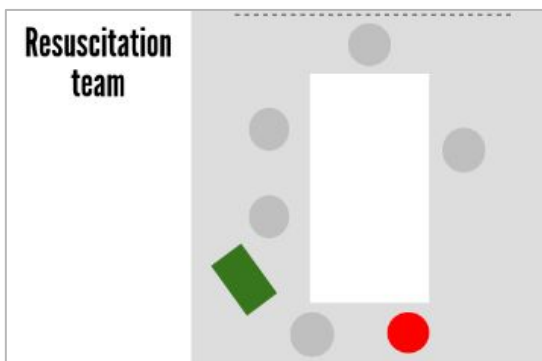
NOT ALL TRAUMA ARRIVES VIA EMS. UPGRADE ACCORDINGLY

COMPONENTS OF EFFECTIVE TEAMS: TEAMSTEPS IN A NUTSHELL

<https://www.ahrq.gov/professionals/education/curriculum-tools/cus toolkit/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" <i>Tool for self evaluation</i> 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			2 CHALLENGE RULE Information conflict regarding patient safety
			DESC Script <i>Tool for personal conflict*</i> 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:



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.



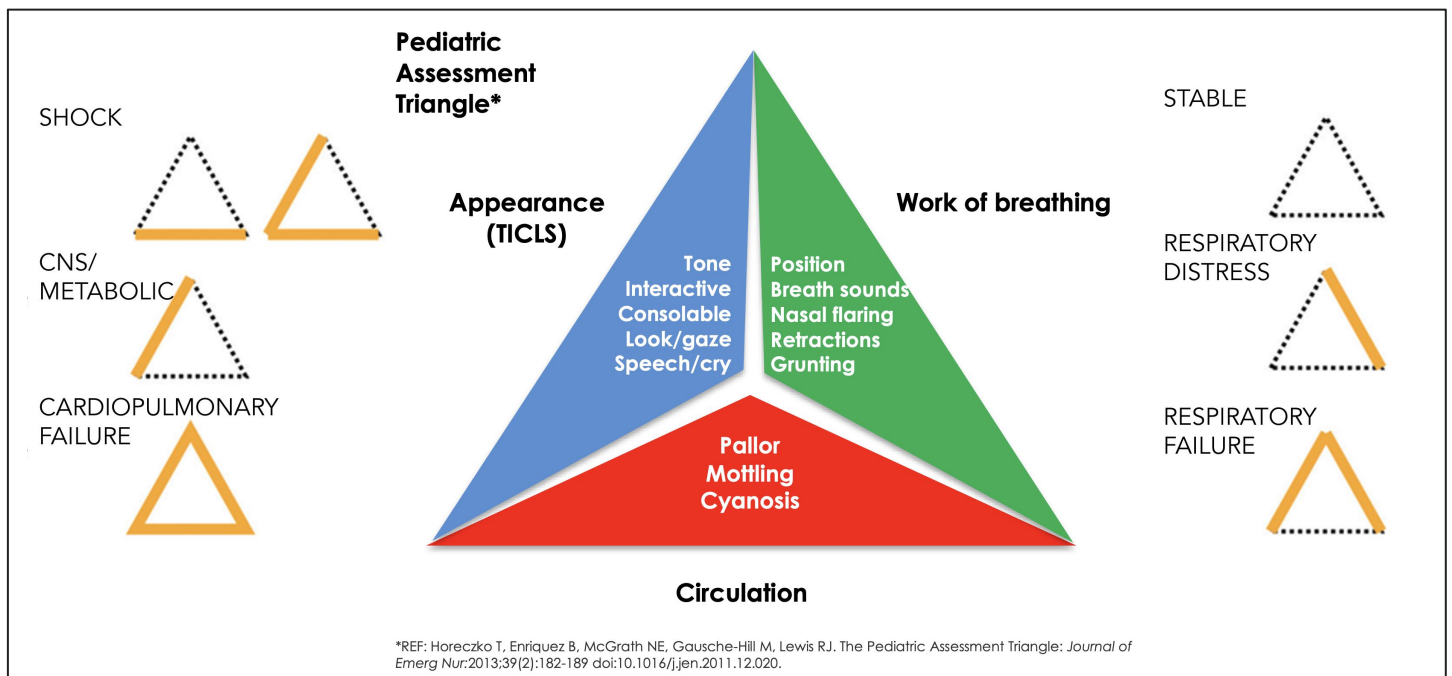
Pediatric Vital Signs/Weight by Age

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

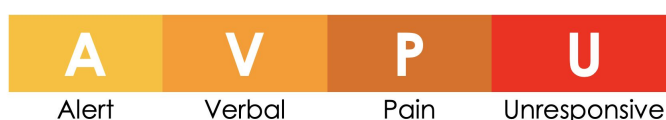
*BP in children is a late and unreliable indicator of shock



Using the Pediatric Assessment Triangle (PAT)



Pediatric Mental Status Assessment: response to stimuli



OVERVIEW

- Saron Henry: [ATLS 10th edition offers new insights into managing trauma patients | The Bulletin](#)
- Jeremiah Smith, Sean Fox. Approach to Pediatric Trauma. Clerkship Directors in Emergency Medicine. Available at: [Trauma](#)
- [I-PASS, a Mnemonic to Standardize Verbal Handoffs](#)
- [Trauma Service : Primary and secondary survey](#) by the Royal Children's Hospital of Melbourne

VIDEOS & PODCASTS

- Breanne Paul, Melissa Chan. Pediatric Trauma. Peds Cases, 2018. Available at: [Pediatric Trauma | PedsCases](#)
- ["Initial Trauma Evaluation"](#) by David Mooney for OPENPediatrics
- [Push-Pull Method for Pediatric Fluid Administration.](#)

ALGORITHMS

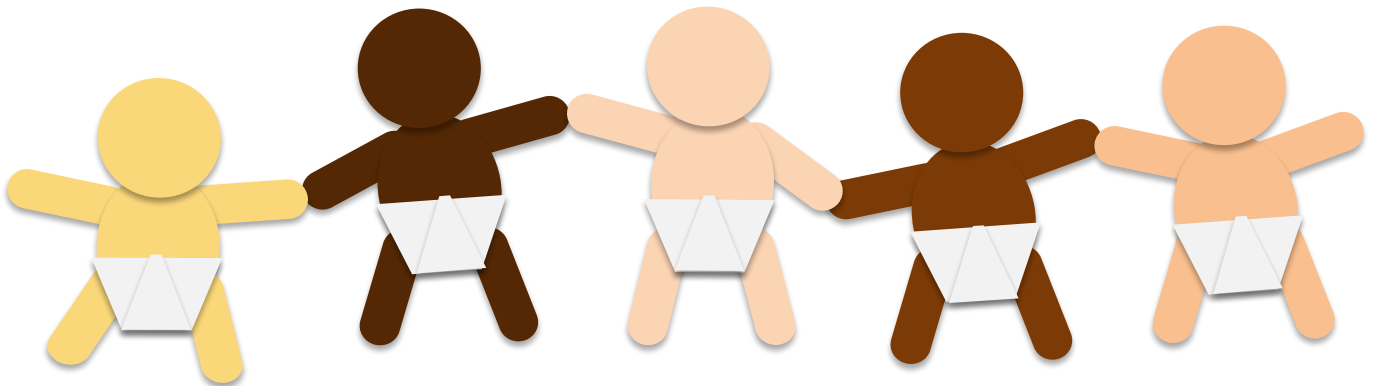
- [Trauma Resuscitation Clinical Pathway — Emergency Department | Children's Hospital of Philadelphia](#)
- TREKK Multiple Trauma, 2020. Available at: [Multiple Trauma](#)

Thank you for participating! We would love to hear your feedback:

Participant Survey:



Or simply click [this link](#) for the participant's survey.



Thank you for participating! We would love to hear your feedback!

We recommend printing the Participant Survey and completing the Facilitator Survey at the end of each session.

Facilitator Survey:



Or simply click [this link](#) for the facilitator's survey.



Posted: Jan 2022

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