# Scenario implementation

Scenario implementation for each simulation day based on available ressources. Scenario 5 was omitted from results on days 2, 6 and 10 of the January round due to technical problems with the video equipment.



# Scenario 1: eclampsia

A pregnant (36th week) female found unconscious and intubated by paramedics is en route to A&E. Paramedics will suggest the possible differential diagnosis. After caesarean section, the patient bleeds profusely.



# Scenario 2: kinked chest drain after lung volume reduction surgery

After surgery, the patient is to be extubated immediately and transferred to ICU. On emergence, the patient moves and belts are tightened by the technician, kinking the chest drain. During CPR, the pneumothorax must be found and the chest drain straightened, continuing anaesthesia after resuscitation.



# Scenario 3: laryngospasm

After routine surgery, a neonate develops laryngospasm on extubation. During the hypoxic phase, the heart rate dips under 60, and the neonate should be resuscitated next to the efforts to achieve oxygenation.



# Scenario 4: high spinal

Participants take over from a colleague who needs to rush to an emergency call. Patient has just received spinal anaesthesia; medication and level of the spinal have not been stated and must be requested by the participants. The patient develops PEA due to a high spinal.



# Scenario 5: subdural hemorrhage of neonate

Participants are surprised by the arrival of helicopter carrying an unstable neonate which fell from a highchair. The neonate is agitated and becomes comatose on exit of flight paramedic. CT scan has been performed and the radiologist is examining the images.



# Scenario 6: massive internal hemorrhage

A patient without monitoring (waiting for port surgery in the preoperative area) suddenly feels sick and is rolled into recovery by an anesthesia resident requesting something for nausea to be given. The nausea is due to a massive internal hemorrhage from a previous surgical intervention (whipple) and the patient rapidly becomes pulseless. The ward physician / surgeon immediately suspects this when contacted by participants.



**Scenario 7: intraoperative stroke**

After surgery, the patient is delivered to recovery in deteriorating condition due to an unnoticed intraoperative stroke, becoming increasingly comatose and hypoxic. The stroke must be discovered, the patient referred to neurology and moved to the CT scanner.

