SCENARIO 1: 3 YOM with barking cough and stridor (Croup)

3 YOM w/ Croup

Scenario Set Up	Peds BVM, blow-by O_2, suction, peds NC/NRB, thermometer, stethoscope **PROCTOR:** Caregiver is anxious, describes barking cough. The child worsens when agitated.
Dispatch	"3-year-old male with noisy breathing and barking cough."
Scene Size up	Child in living room on parent's lap; no hazards; humidifier running
Pertinent Primary Assessment Findings	Airway patent; inspiratory stridor when crying; moderate WOB; intercostal retractions; tachycardic; warm skin. **A:** Patent; inspiratory stridor when crying **B:** RR elevated, moderate WOB, intercostal retractions, barking cough, lungs clear **C:** Tachycardic; warm/pink skin; cap refill ~2 sec; no major bleeding **AVPU:** Responds to verbal; age-appropriate → **V**
Pertinent Primary Assessment Findings	Low-grade fever, no history of asthma, no choking; vaccines up to date **S:** Barking cough, stridor, mild fever **A:** NKDA **M:** Acetaminophen earlier **P:** Full-term, vaccines up to date, no asthma **L:** Sipped water 1 hour ago **E:** Woke suddenly with barking cough; no choking episode **O:** Sudden onset during sleep **P:** Worse with crying/agitation **Q:** Upper airway noise; barking cough **R:** No radiation **S:** Moderate respiratory distress **T:** ~30 minutes
Vitals	HR 140, RR 30, BP 96/60, SpO_2 94%, Temp 100.9°F, BGL 98 mg/dL 2nd set: HR 148, RR 34, BP 98/62, SpO_2 92%,

	Temp 101.2°F, BGL 92 mg/dL
Treatments	Calm/minimal stimulation, position of comfort, blow-by O_2, avoid upsetting procedures, rapid transport.
Key Points	Viral upper airway obstruction → barking cough + inspiratory stridor Agitation worsens obstruction → keep child calm, avoid stimulation Airway interventions can worsen swelling; minimal handling is crucial Blow-by O_2 preferred; do NOT force mask Sudden nighttime onset is common Stridor = narrowing at level of larynx/trachea
Bonus Questions	How do you distinguish croup from epiglottitis? Why avoid agitation in upper airway obstruction?

SCENARIO 2: 5-month-old with apnea during cough fits (Pertussis)

5 YOM w/ Pertussis/ALTE

Scenario Set Up	Infant BVM, blow-by O_2, suction, infant stethoscope **PROCTOR:** Mother reports paroxysmal cough, vomiting after cough, brief apnea.
Dispatch	"An infant not breathing well after coughing fits."
Scene Size up	Infant in crib, fatigued, pale, vomit on towel.
Pertinent Primary Assessment Findings	Airway patent w/ mucus; RR 50 irregular w/ apnea; rhonchi; pale, delayed cap refill. **A:** Patent but full of mucus; gagging after cough **B:** Tachypneic (RR 50), irregular breathing, brief apnea episodes, rhonchi **C:** Pale/mottled skin, delayed cap refill (~3 sec), tachycardic **AVPU:** Responds to painful stimulus + crying → **P**
Pertinent Primary Assessment Findings	Not fully vaccinated; post-tussive vomiting; symptoms worsening. **S:** Coughing fits, post-tussive vomit, apnea **A:** NKDA **M:** None **P:** Only first round of vaccines **L:** Last fed 2 hours ago; vomiting after cough **E:** Worsening cough 1 week; apnea tonight **O:** Gradual over a week; tonight sudden worsening **P:** Fits triggered by coughing/crying **Q:** "Whoop" sound, gagging **R:** No radiation **S:** Severe episodes **T:** 1 week duration; acute episode tonight
Vitals	HR 170, RR 50 (irregular), BP ~80 systolic, SpO_2 91%, Temp 100.2°F, BGL 82 mg/dL 2nd set: HR 180, RR 56 (irregular), BP ~78 systolic, SpO_2 88%, Temp 100.5°F, BGL 78 mg/dL

Treatments	Gentle suctioning, blow-by O_2, BVM if apnea, minimize stimulation, rapid transport.
Key Points	Infants with pertussis often have apnea, not the classic “whoop” Post-tussive vomiting is common High risk for hypoxia and respiratory arrest Suction, O_2, and readiness for BVM are essential Avoid agitation; coughing fits worsen with stress Consider ALTE/BRUE if cyanosis or apnea present
Bonus Questions	Why are pertussis infants high-risk? What indicates the need for BVM?

SCENARIO 3: 34-week pregnant female with painless bright red bleeding

32 YOF, 34 wks w/ Placenta Previa

Scenario Set Up	OB kit, pads, O_2, monitor, stretcher w/ left tilt capability **PROCTOR:** The patient is anxious, reports sudden bright red bleeding, no pain.
Dispatch	"34-week pregnant female with vaginal bleeding."
Scene Size up	Blood on bedding, patient seated, no trauma.
Pertinent Primary Assessment Findings	Airway/breathing normal; mild tachycardia; bright red bleeding **A:** Patent **B:** Normal effort, clear breath sounds **C:** Mild tachycardia, bright red bleeding, skin slightly pale **AVPU:** Alert and oriented → **A**
Pertinent Primary Assessment Findings	G2P1, known low-lying placenta, fetal movement present, mild cramping **S:** Painless bright red bleeding **A:** NKDA **M:** Prenatal vitamins, iron **P:** G2P1; low-lying placenta previously noted **L:** Ate 3 hours ago **E:** Bleeding started suddenly while resting **O:** Sudden onset **P:** Nothing makes it better/worse **Q:** Bright red bleeding **R:** N/A **S:** Moderate amount **T:** ~20–30 minutes
Vitals	HR 110, RR 18, BP 108/68, SpO_2 98%, BGL 94 mg/dL 2nd set: HR 122, RR 20, BP 102/64, SpO_2 98%, Temp 98.6°F, BGL 96 mg/dL
Treatments	Left-lateral tilt, pads externally, no vaginal exam, O_2 if needed, rapid transport.
Key Points	Painless bright red bleeding = previa until proven

	otherwise NEVER perform a vaginal exam Maternal hypotension can develop quickly → monitor closely Left-lateral tilt improves maternal and fetal perfusion Transport to OB-capable hospital is time-sensitive Distinguish from abruption (which involves pain + darker blood)
Bonus Questions	How does placenta previa differ from abruption? Why avoid vaginal exams?

SCENARIO 4: 38-week pregnant female w/ seizure (Eclampsia)

26 YOF, 38 wks w/ Eclampsia

Scenario Set Up	BVM, O_2, suction, padding, monitor, OB kit **PROCTOR:** Patient finishing generalized seizure; post-ictal with headache, vision changes.
Dispatch	"Pregnant female actively seizing."
Scene Size up	Living room, blankets around patient, family present.
Pertinent Primary Assessment Findings	Post-ictal, airway patent but at risk; tachycardic; shallow breathing. **A:** Patent but at risk (post-ictal, vomiting) **B:** RR elevated, shallow; lungs clear **C:** Tachycardic; BP severely elevated; skin clammy **AVPU:** Post-ictal confusion → **V** (responds to verbal, not oriented)
Pertinent Primary Assessment Findings	Recent high BP, swelling in hands/feet, severe headache, visual disturbances. **S:** Headache, swelling, seizure, visual "spots" **A:** NKDA **M:** Prenatal vitamins; possible BP meds **P:** First pregnancy; known high BP **L:** Dinner 3 hours ago **E:** Worsening headache → collapse → seizure **O:** Gradual over 2 days **P:** Worsened today **Q:** Pressure/throbbing **R:** No radiation **S:** Severe **T:** Hours–days
Vitals	HR 120, RR 24, BP 180/110, SpO_2 94%, BGL 108 mg/dL 2nd set: HR 128, RR 28 (shallow), BP 190/114, SpO_2 92%, Temp 98.8°F, BGL 112 mg/dL
Treatments	Left-side positioning, airway protection, O_2,

	suction, protect from further injury, rapid transport, follow protocol for eclampsia.
Key Points	Any seizure in pregnancy = eclampsia until proven otherwise Severe hypertension + headache + vision changes are red flags Protect airway: suction, left-side position, O_2 High risk for repeat seizures Maternal status directly affects fetal status Rapid transport is critical; ALS if available
Bonus Questions	What are warning signs of preeclampsia? Why is this dangerous for the fetus/mother?