Scenario 3: 5-year-old Female with Pertussis

Scenario Set Up	Equipment: gurney, O2, pulse oximeter, stethoscope Parents called 911, extremely concerned and frantic. Pt has been experiencing cold-like symptoms for 2 weeks.
Dispatch	Respond to a 5-year-old female with difficulty breathing
Scene Size Up	5-year-old female crying and sitting with her parents kneeling next to her. Pt is sniffing and experiencing coughing fits.
Pertinent Primary Assessment Findings	AVPU: alert and tracking, AO x 4 A - patent B - labored with coughing, “whoop” upon inhalation C - warm, dry, cap refill < 2
Pertinent Secondary Assessment Findings	S - difficulty breathing, runny nose, coughing fits, “whoop” noise upon inhalation A - Peanuts M - None; has not been vaccinated for pertussis P - None L - Ice cream an hour ago E - Was playing on iPad for 2 hours, cold symptoms have lasted for 2 weeks, has vomited after coughing fits P - Has worsened over 2 weeks, rest makes symptoms better A - None S - Some thick mucus, sometimes vomit after coughing fits T - Very tired after a coughing fit E - More tired than usual, taking more frequent naps Lung sounds - bilateral “whoop” noise upon inhalation
Vitals	BP: 110/76 , HR: 110, RR: 30, SPO2: 94, BGL: 125
Treatments	Administer O2 via nasal cannula at 2 LPM Support/calm parents and child
Key Points	Recognize “whoop” noise and coughing fits as pertussis Pertussis can have deadly complications in babies and young children Vaccine can make symptoms milder

Bonus Questions	What causes pertussis? Bacterial infection causing swelling of the airways

Scenario 2: 18-month-old Male with Febrile Seizure

Scenario Set Up	*Equipment needed: pediatric BVM, O2, suction, glucometer, pulse oximeter* Pt initially postictal and then gradually becomes more responsive. The parents are panicked and crying.
Dispatch	Respond to a child actively seizing.
Scene Size Up	18 month old child lying on the floor, no longer actively seizing upon arrival, bundled up in several layers. Parent states the child had full-body shaking for about 2 minutes. The child feels very warm to the touch.
Pertinent Primary Assessment Findings	AVPU: responds to verbal stimuli (postictal) Airway: patent but may have secretions Breathing: spontaneous, slightly irregular Circulation: pulses present, skin hot Mental status: postictal, gradually improving responsiveness
Pertinent Secondary Assessment Findings	A: none known M: none P: no seizure history L: normal meals today E: child was previously ill with the flu, then suddenly began seizing Parents: O: Sudden onset seizure following previously being ill with the flu P: Seizure stopped on its own; no clear triggers besides fever Q: Generalized full-body shaking R: N/A S: N/A T: Lasted approximately 2 minutes; child currently postictal but improving
Vitals	BP: 90/55, HR: 140, RR: 28, SpO2: 97%, BGL: 89, Temp: 102.9°F
Treatment	Ensure airway is clear, suction as needed Administer O2 if indicated (blow by) Position patient on side (recovery position) Avoid restraining movements if seizure recurs Keep patient cool (remove excess clothing) Provide reassurance to parent Transport
Key Points	Febrile seizures are common in young children and usually self-limiting Focus on airway, breathing, and preventing injury Always rule out other causes of seizure (hypoglycemia, trauma, infection) Blow by O2 is preferred to lessen restriction

Bonus Questions	What age group is most at risk for febrile seizures? ● Typically 6 months to 5 years old (most common around 12-18 months) What differentiates a simple vs complex febrile seizure? ● Simple febrile seizure: ○ Generalized ○ Lasts <15 minutes ○ Occurs once in 24 hours ● Complex febrile seizure: ○ Focal features or ○ Lasts >15 minutes or ○ Occurs more than once in 24 hours When would medication be indicated for seizure control? ● If seizure lasts >5 minutes (status epilepticus concern) ● Recurrent seizures without regaining consciousness ● Per protocol → typically benzodiazepines

Scenario 1: 28 YOF with Abruptio Placentae (Placental abruption)

Scenario Set Up	*Equipment needed: gurney, O2, OB kit, blankets, pulse oximeter, suction* Pt is pregnant and in severe distress. She presents as anxious, clutching their abdomen, and in pain. If the team is calm and reassuring, you provide clearer answers. If they ignore your pain or delay care, become more distressed and less cooperative.
Dispatch	Respond to a pregnant female with severe abdominal pain and vaginal bleeding.
Scene Size Up	28-year-old female. Found lying on her side on the floor at home. Partner reports sudden onset of severe abdominal pain followed by vaginal bleeding. No trauma witnessed.
Pertinent Primary Assessment Findings	AVPU: Alert but anxious Airway: Patent Breathing: Rapid, shallow Circulation: Tachycardic, pale, cool, diaphoretic Mental status: A/Ox3 but distressed
Pertinent Secondary Assessment Findings	S: Severe, constant abdominal pain, Guarding abdomen, Vaginal bleeding (dark red), Uterus feels firm/rigid A: None known M: Prenatal vitamins P: G2P1 (Gravida 2, Para 1) —> pregnant twice, one delivery L: Ate breakfast ~3 hrs ago E: Sudden onset abdominal pain while resting, followed by bleeding O: Sudden onset about 20 minutes ago P: Nothing relieves the pain; movement and palpation make it worse Q: Severe, constant, “tearing” or “sharp” abdominal pain R: Pain may radiate to the lower back S: 10/10 T: Pain has been constant since onset and worsening
Vitals	BP: 92/60, HR: 128, RR: 26, SpO2: 96% BGL: 108
Treatment	Position patient in left lateral recumbent position Administer high-flow O2 Control for shock: keep patient warm, monitor vitals frequently Rapid transport to appropriate facility with OB capability
Key Points	Abruptio placentae presents with painful bleeding and a rigid abdomen High risk for maternal shock and fetal distress Do NOT perform internal vaginal exam

	Rapid transport is critical
Bonus Questions	How does abruptio placentae differ from placenta previa? ● Abruptio placentae: ○ Painful vaginal bleeding ○ Rigid, tender abdomen ○ Blood may be concealed ● Placenta previa: ○ Painless vaginal bleeding ○ Soft, non-tender abdomen ○ Bright red bleeding What signs indicate maternal shock? ● Hypotension (low BP) ● Tachycardia ● Pale, cool, clammy skin ● Altered mental status ● Delayed capillary refill Why should vaginal exams be avoided in the field? ● Can worsen bleeding ● Risk of disrupting the placenta further ● Requires a controlled hospital setting with OB support