Blank Scenario Template and Guide

Psychotic 22 YOF

Scenario Set Up	*Equipment: gurney, soft restraints, blanket, glucometer, pulse oximeter, O2* Pt presents as terrified, frantic, sweaty, and extremely agitated. She believes there are bugs crawling under her skin. She repeatedly scratches at her forearms, claws at her neck, yanks at her hair, and slaps at her shoulders and chest as if trying to kill or remove things crawling on her. Do not be easy to interview. You are distracted, paranoid, and convinced no one believes you. If the team crowds you, argues with you, or grabs you suddenly, escalate. If they reduce stimulation, use one calm speaker, and give simple commands, become slightly more redirectable. If you are bandaged/treated but not restrained, remove the bandages and continue on with your day.
Dispatch	Respond to an agitated female in her apartment complex courtyard, reportedly trying to tear at her own skin.
Scene Size Up	22 year old female. She is pacing barefoot on the sidewalk, sweating heavily, scratching at both arms, and slapping at her shirt and neck. A friend says she has been awake "for maybe two days" and suddenly started screaming that bugs were inside her skin. There are several bystanders watching.
Pertinent Primary Assessment Findings	AVPU - Alert Airway - patent Breathing - rapid, shallow but effective Circulation - radial pulses very rapid, skin hot, flushed, diaphoretic, cap refill 2 Mental status - alert to person, inconsistently oriented to place, not reliable on time or event A/Ox1

	Behavior - pacing, hypervigilant, repeatedly clawing at arms/scalp, trying to rub skin against nearby surfaces, shouting at unseen insects Speech - rapid, fragmented, fearful, sometimes incoherent Pt is actively endangering self through frantic self-injurious behavior and inability to follow commands consistently.
Pertinent Secondary Assessment Findings	*A - none known* *M - no prescribed medications per friend* *P - history of anxiety, no known formal psych diagnosis, friend unsure about prior substance use history* *L - energy drinks, "a little vodka," no real food since yesterday* *E - had been out at a party the night before, has not slept, became increasingly paranoid and then began insisting bugs were under her skin and in her hair. Unknown if she has taken any substances at the party.*
Vitals	*Multiple superficial red scratch marks on forearms and neck* *Hair disheveled from repeated pulling* *No major bleeding* *Pupils dilated* *No obvious focal neurologic deficit on quick exam, but full exam limited by agitation* *Possible dehydration*

	BP: 156/98 *HR: 155* *RR: 30* *BGL: 108* *SpO2: 97%*
Treatments	*Treatments:* *Request PD early for scene safety and assistance if needed per protocol* *Reduce stimulation:* ● *move bystanders back* ● *use one calm communicator* ● *keep directions short and simple* *Perform full primary assessment and rule out physical causes of altered mental status:* ● *hypoxia* ● *hypoglycemia* ● *head trauma* ● *intoxication or excited delirium* ● *stroke* ● *hyperthermia or other environmental causes* *Attempt verbal de-escalation first:* *If pt continues active self-harm or becomes unsafe,* ***restrain*** *per protocol with adequate personnel and continuous reassessment* *Treat superficial skin injuries* ***AFTER*** *behavior is controlled* *Transport for medical and psychiatric evaluation*
Key Points	*It is important for EMTS to consider possible drug effects from the night before, and consider possible stimulant intoxication. Symptoms like not sleeping, pacing, sweating, all point towards abuse of stimulants*

Bonus Questions	*What findings suggest stimulant intoxication versus primary psychiatric illness?* *What medical causes of altered mental status still need to be ruled out here?* *At what point is this pt a danger to self?* *Does this pt appear to have decision-making capacity?* *When would restraints be appropriate?*

Example Scenario

4 YOF w/ Epiglottitis

Scenario Set Up	Equipment needed: NRB, O2 PROCTOR: You are a 4 year old child and are also having trouble breathing so you don't give many answers but rather the mother (proctor #2) does. Be shy towards the EMTs unless they make a real effort to distract or entertain.
Dispatch	Respond C2 to a child w/respiratory problems.
Scene Size Up	Pt sitting on chair, presenting in tripoding position
Pertinent Primary Assessment Findings	A- stridor, salivating B- dyspneic C- skin is pink, dry, hot to touch
Pertinent Secondary Assessment Findings	(SAMPLE provided by parent), pt unable to speak A- peanuts M- none, never even been vaccinated P - none L - 2 hour ago E - pt was fine a few hours ago at school, mother just noticed
Vitals	HR: 150, RR: 28, BP:110/70, SPO2: 91%, T: 104 degrees F
Treatments	Keep pt in tripod position, administer O2 via NRB @ 15 LPM

Key Points	Keep pt as still as possible, and do not inspect airway. Administer O2 if tolerated. Do not lay the pt down.
Bonus Questions	What is epiglottitis usually caused by? (A: bacterial infection that causes swelling of the epiglottitis and partial airway obstruction) What signs and symptoms differentiate croup from epiglottitis? What signs and symptoms would indicate impending respiratory failure? (retractions of muscles between ribs, bradycardia, hypoxia, decreased respiratory effort)

22 YOF w/ Panic Attack

Brief Title Explaining (Age, Gender, Chief Complaint)

Scenario Set Up	*Equipment: Gloves, stethoscope, blood pressure cuff, pulse oximeter, glucometer, watch, oxygen setup available if needed, stretcher, radio/phone for transport decision making* *PROCTOR: Patient is a 23-year-old college student sitting on the floor against a wall in a library study area. She is crying, breathing rapidly, trembling, and repeatedly saying, "I can't breathe" and "I think I'm dying." A friend nearby called 911 after the patient suddenly became overwhelmed while studying for exams. The patient is frightened but cooperative if EMTs are calm. The proctor should look visibly anxious, speak in short sentences at first, and improve gradually if EMTs use reassurance and guided breathing. If EMTs are dismissive or rush her, she should become more panicked.*
Dispatch	*Respond Code 2 for a 23-year-old female with difficulty breathing, chest tightness, and anxiety at a college library.*
Scene Size Up	*Patient found seated on the floor leaning against a bookshelf. No trauma noted. Friend present as bystander. Scene is safe. No immediate life-threatening injuries seen. Patient has rapid respirations and is shaking.*
Pertinent Primary Assessment Findings	*AVPU - How alert is the patient - indicate which part of AVPU they are? A&O X __4____ (Indicate what they are A&O to)* *A - describe their airway (Is it patent?) - Airway patent; patient able to speak in short, broken sentences.* *B - describe their breathing (Is it normal? Rate, rhythm,* *quality?) - Breathing rapid and shallow; RR elevated; lungs* *clear bilaterally; no wheezing or stridor; SpO2 normal on* *room air.* *C - describe their circulation (Skin signs? Pulse? Cap Refill?) -* *Radial pulse rapid but present and regular; skin warm, slightly*

	pale and sweaty; cap refill less than 2 seconds
Pertinent Secondary Assessment Findings	*Indicate here the patient/proctors answers to SAMPLE questions, along with any pertinent further assessments (focused or complete physical assessments, AEIOUTIPS, OPQRST, etc.)* A - *Does the patient have allergies? - No known allergies* M - *What medicine is the patient taking? - No daily medication, denies taking drugs today.* P - *Does the patient have any relevant past pertinent medical history? - History of panic attacks* L - *What was the patient's last oral intake? - coffee and granola bar an hour ago* E - *What events led up to the call? - Symptoms started suddenly while studying for exams. Patient felt overwhelmed, then developed chest tightness, tingling in hands, dizziness, and fear that she was dying*
Vitals	*Indicate the patient's vital signs-> add a second set if necessary for after initial treatment* *BP:138/84 , HR: 118, RR:32 shallow/rapid, BGL: 96, SPO2:99% , Any other relevant vitals*
Treatments	*calm verbal reassurance; reduce crowd and noise; primary assessment with airway-breathing-circulation focus; obtain full set of vitals and blood glucose; coach slow controlled breathing (for example, in through nose and out through mouth); place patient in position of comfort; continue reassessment; oxygen only if indicated by distress, hypoxia, or protocol; transport for further evaluation, especially if first episode, persistent chest pain, abnormal findings, or concern for another medical cause.*
Key Points	*Do not assume "just anxiety" until dangerous causes are considered. Panic attacks can mimic asthma, hypoglycemia, stimulant effects, arrhythmia, pulmonary embolism, or cardiac problems. Strong EMT performance includes scene calming, ruling out life threats, obtaining objective vitals, and using nonjudgmental communication. Avoid saying "calm down" or using a paper bag. Patient should improve if EMTs slow the environment and guide breathing*
Bonus Questions	*What medical conditions can look similar to a panic attack?* - *Hypoglycemia* - *Asthma* - *Pulmonary embolism*

	What communication techniques help de-escalate an anxious patient? - *Calm verbal reassurance* - *Reducing noise level* - *Guided slow, controlled breathing* - *Not rushing the patient*