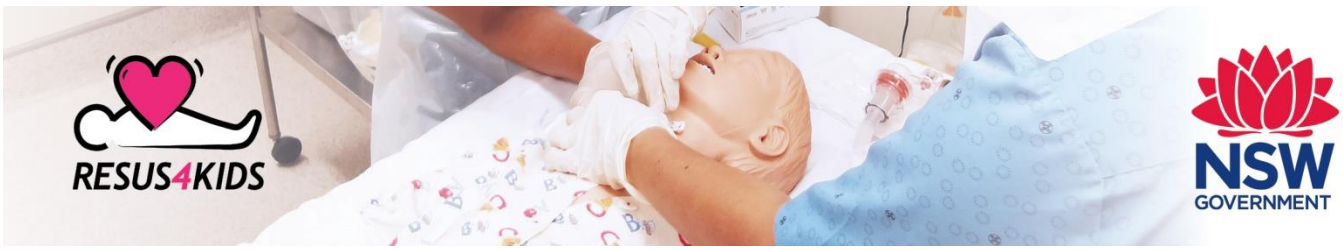
RESUS4KIDS

Allied and Community Health Short Practical Course

Instructors Manual



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With extensive contributions from the Phase 1 and Phase 2 RESUS4KIDS Steering Committees and NSW Child Health Network CNCs.

Disclaimer

TRAIN THE TRAINER

The 4 hour train the trainer workshop has been designed to provide new RESUS4KIDS (R4K) instructors with the information and resources required to teach the scenario based education. These workshops are targeted towards practitioners who display a keen interest in delivering paediatric resuscitation in a multidisciplinary training environment.

On completion of the train the trainer workshop the learner will be able to:

- Confidently teach each session including communication and teamwork and the scenario based education session.
- Understand the resources, obligations and requirements needed to conduct the RESUS4KIDS course.
- Recognise potential barriers and challenges that may occur while teaching the course and be aware of different ways to troubleshoot these problems**.**

Pre requisites for becoming a RESUS4KIDS instructor

Please refer to the current governance document available online at: www.resus4kids.com.au.

Requirements and resources for running the short practical course

- Instructors are responsible for ensuring that all participants meet the course participant prerequisites, including recommendation by their line manager if required.
- Instructors must follow the course format unless prior approval has been obtained from the RESUS4KIDS executive.
- The instructor to student ratio must not exceed 1:6 unless prior approval has been obtained from the RESUS4KIDS executive. Participant numbers may be less than 6 at the instructor's discretion. A minimum of 4 participants are recommended to allow participants to demonstrate effective teamwork in the scenarios.
- Instructors may use a working AED or other simulator in place of the laminated cards. Instructors should be familiar with the safe use of a live working AED in a simulation environment and have permission from their line manger to use a live device.
- Resources for setting up, running, evaluating and reporting courses are available at www.resus4kids.com.au under 'Allied and Community Health Instructor' resources. These include:
    - RESUS4KIDS Governance Document.
    - Course record of attendance form.
    - Algorithm – Paediatric Life Support for Healthcare Rescuers and Choking Child.
    - Training videos
    - List of equipment required for the practical course.
    - Instructor Manual with Scenario Lesson Plans.
- Registered instructors will be emailed the password to access the secure page when they complete the train the trainer course. Please note that the password will change periodically, and the instructors will be notified of this change by email.

EQUIPMENT REQUIRED

Room (1 room per instructor to run the scenarios separately, communication and teamwork can be run in a larger group).

Infant / Child ALS Manikin (1 per instructor). Participants must be able to perform a chin lift and jaw thrust to open the airway of the manikin.

Computer and projector – ensure sound volume is adequate beforehand, you may need to purchase an external speaker.

Access to the videos – suggest download beforehand

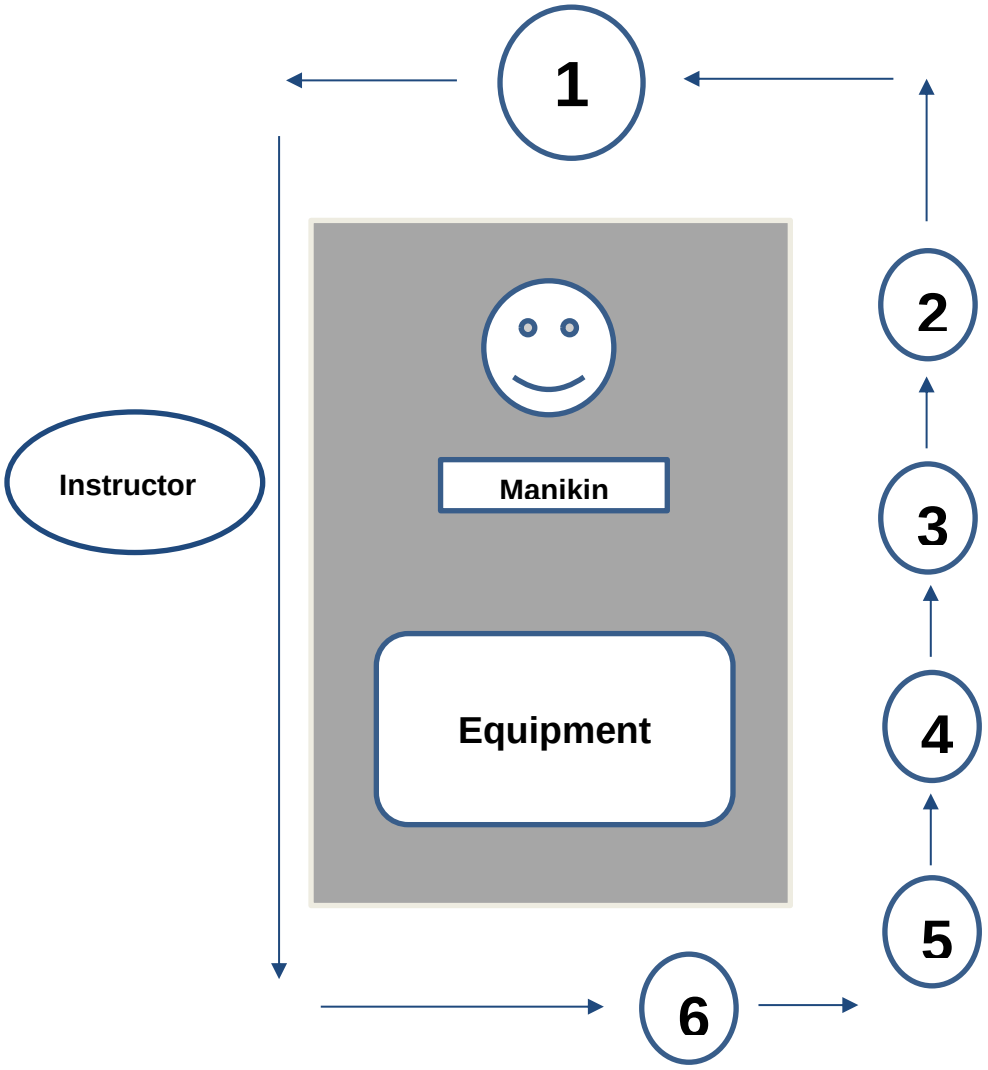
Attendance Record Sheet

Instructors need to ensure that all equipment is in working order prior to commencing the session e.g. check that lungs inflate on manikin, teamwork videos play etc.

- 1 x Laerdal adult pocket mask
- 1 x paediatric self-inflating resuscitation bag *(this will be determined by the availability and the specific learning needs of the participants)*
- 2 - 3 x masks to demonstrate correct sizing / placement of mask
- Laminated Cards
    - RESUS4KIDS paediatric life support flowchart
    - Managing the choking child Algorithm
- 12 x tennis balls
- Sheet of blank labels for names of participants

Table set up for ‘Round the Table’ Teaching

Teach the first scenario using the ‘Round the Table’ method. It is an effective way to teach the first scenario as every member of the group has an opportunity to demonstrate a different part of the DRSABCD algorithm, which makes the process less threatening and means that every member of the group has a turn of participating. Set the table or bed up as shown below. The numbered circles represent where the 6 participants stand.



Steps performed by the different participants

Participant 1: Assess for danger.

Participant 2: Check for a response.

Participant 3: Send for help.

Participant 4: Chin lift, jaw thrust, all participants now do this in turn.

Participant 5: Assess for breathing, give rescue breath. All participants now do this in turn.

Participant 6: Compressions, with participant 5 ventilating. All participants now do this in pairs with a 15:2 ratio.

1. Participant 1 identifies different ‘Dangers’ to be aware of when you approach a collapsed or unwell child. Once they have done this and the instructor is happy to move on participant 1 moves around the table to where participant 6 was standing and all group members move up a place. This now places participant 2 at the head of the bed to check for a ‘Response’.
2. This process continues until the participants reach ‘Airway’. Once the participant at the head of the bed has demonstrated the different components of ‘Airway’ each member of the group moves around the table, and all demonstrate the different clinical skills. When every member has demonstrated these skills the participant who was next to have a turn at the head of the bed steps up and demonstrates ‘Breathing’.
3. When the participants reach ‘Circulation’ and need to demonstrate compressions the group now works in pairs with one person demonstrating compressions while the other gives rescue breaths. Once both participants have demonstrated both sets of skills another pair then has a go. The last pair demonstrating compressions and rescue breaths continue doing so and the rest of the group now work as a team to care for the patient in real time.

COMMUNICATION AND TEAMWORK

Human factors

Human factors are issues that affect a person's performance (human performance). Human factors involve non-technical skills (NTS) that are required to deal with a crisis such as communication, language, tone of voice, leadership and role identification. Non-technical skills refer to attitudes and behaviours, not directly related to system management or standard operating procedures which influence patient safety.

Crisis Resource Management

Crisis Resource Management (CRM) training addresses the non-technical skills necessary for effective teamwork (Carne, Kennedy & Gray, 2012). CRM was developed after it was identified that human error caused by teamwork failure led to unnecessary deaths or patient complications (Carne, Kennedy & Gray, 2012). There are 5 principles of CRM used in RESUS4KIDS.

- Establish a leadership role.
- Communicate effectively.
- Appropriate resource utilisation.
- Anticipate and plan.
- Maintain situational awareness.

The information below can be used to enhance your group discussion during the teamwork and communication section of the RESUS4KIDS short practical course.

Establish a leadership role.

- Leads and coordinates patient care.
- Maintain situational awareness.
- Leadership style should employ the least confrontational approach. Awareness that leadership style can influence team dynamics.
- Encourage a shared sense of purpose, a focus on results and a collaborative environment.
- Ensure clearly defined roles for team members. This reduces role confusion.
- Establish priorities for the team.
- Verbalise priorities, goals, and clinical findings as they change so that all team members are aware of the patient's condition. Leaders can also summarise the patient's condition to allow the team to review progress.
- Does not necessarily have to be the most experienced clinician, however, must be able to coordinate the team.
- All decisions need to flow through the team leader.

Communicate effectively.

- Effective communication distributes important information to other team members and facilitates continuous updating of the patient's condition Using team members names to gain their attention.
- Being specific when requesting a task to be completed. A good way to do this is closed loop communication. It is an effective tool to facilitate information exchange and confirm task completion.

It involves:

- The sender initiating a message.
- The receiver receiving the message, interpreting it and acknowledging its receipt.
- The sender ensuring the intended message was received.

Appropriate resource utilisation.

- This applies to staff, equipment, and your environment.
- Assigning the right role to the right person. This can be done by understanding different people's roles, skills, and level of experience.
- It is the team leader's responsibility to ensure the workload is being distributed evenly amongst the team. In turn it is the team member's responsibility to feed back to the team leader if they have too many tasks.
- Regular training to ensure clinicians familiarity with critical care equipment and its appropriate use.

Anticipate and plan.

- Relevant at all levels of performance.
- Focused on forward planning and preparation.
- Thinking ahead to what might happen and developing a plan for that contingency: plan A, plan B.
- Call for help early. It is easier to send people away if not required.
- Practical examples.
- The use of checklists.
- Training: mandatory training, simulation.
- Allocation of roles at the start of a shift.
- Know your environment. Regularly checking your resuscitation equipment. This will ensure that it is all in date and working order as well as ensuring that you know where equipment is stored. This is the opportunity to ask if you are unfamiliar.

Maintain situational awareness.

- It is very easy to become tasked focused or focused on one abnormality in a stressful situation. Task focus is not a bad thing, concentrating on the different tasks is important however it is important for one person to see the 'big picture'.
- Allows for awareness of the big picture. This helps to ensure that important changes in the patient's condition are not missed.
- Appropriate delegation of tasks and involvement of other team members is a necessary step to maximizing situational awareness.
- Awareness of potential dangers/ risks to staff e.g., defibrillation, possible infectious causes, crowd control.

Achieving high situational awareness can be achieved by:

- Going through a checklist (e.g., routine equipment checks)
- Having standard procedures / policy and procedural guidelines.
- Announcing procedural steps.
- Involving the whole team.
- Alerting self or others to unusual events which have caused error in the past.
- Stopping for any red flag.

Graded Assertiveness

When caring for a patient as part of a team it may come to a clinician's attention that by an **action** (such as initiating treatment on the incorrect patient) or an **omission** (such as failing to confirm a patient's allergies), one of their colleagues may potentially be causing harm to a patient.

It's very unlikely that this is deliberate. Most mistakes are accidental and happen to clinicians who are intending to do the best for the patient at the time. Therefore, in most circumstances raising an issue politely to the person concerned will result in a positive discussion and resolution to their concerns.

Occasionally raising a concern may be difficult. This may be due to a lack of confidence, a lack of certainty or a hostile environment. Raising concerns to a more senior clinician can be challenging.

Being able to raise concerns, and advocate for the patient, is a skill that needs to be practised as failing to do this may have a severe impact on the patient. An example is the case of a patient who had the wrong kidney removed in 2000 in the UK, despite a medical student in the operating theatre being aware what was happening (http://www.telegraph.co.uk/news/uknews/1398408/Surgeons-who-removed-the-wrong-kidney-are-cleared.html).

Graded assertiveness is a well described method of escalating a concern, starting with a non-threatening question. It is important to realise that the clinician who is making the potential mistake may feel embarrassed or upset by their actions or inactions and raising the concern gently at first is essential. The aim of graded assertiveness is to start at the lowest level possible and increase your level of assertiveness if the situation demands it. You should only move up a grade if you get an unsatisfactory response from your previous attempt to raise your concern.

One method of Graded Assertiveness is the PACE approach.

PACE approach

Probe	"do you know that…?" or express your concern using an 'I' statement, "I am concerned about . . . "
Alert	(offer an alternative) – "Can we re-assess the situation…?" or "Would you like me to . . ."
Challenge	"Please stop what you are doing while…" or ask for an explanation, "It would help me to understand . . ."
Emergency	"STOP what you are doing!" or "For the safety of the patient we need to .....now."

Example:
A clinician is about to begin a procedure on a patient

Probe: "Have we confirmed that this procedure is following the updated Policy and Procedure Guidelines?"
Alert: "We need to ensure that the procedure is done according to the updated guidelines as there have been significant changes."
Challenge: "I am concerned that if the procedure does not align with the updated guidelines, we may cause potential harm to the patient leading to the need for more treatment options."
Emergency: "Please stop the procedure immediately. I am concerned this may harm the patient. I am going to call for help".

SCENARIO BASED TEACHING

Scenario based teaching creates a highly engaging learning opportunity, placing learners in a situation that mirrors reality and requests the learner to make behavioural choices. It represents a pulling together of knowledge and skills and involves aspects of cognitive, affective, psychomotor, and interpersonal training.

Objectives of scenario-based teaching include:

- Clinical focus.
- Situational factors / situational awareness.
- Multi-professional and cross-sectional target audience.

Types of scenario-based teaching include:

- Pause and discuss.
- Simulated problem-based learning.
- Immersive scenario.

Barriers to effective communication with your participants

- Using long words and / or jargon.
- Language differences.
- Boring presentations.
- Equipment failure.
- Having preconceptions.

Feedback

Feedback needs to be accurate and will assist the learner in making progress. Learners cannot improve unless they know where improvement is necessary and how the improvement may be made.

Feedback should be:

- Descriptive.
- Supportive.
- Positive and constructive.
- Specific and accurate.
- Realistic.
- Timely.

There is no formal practical skills assessment during the R4K short practical course. Participants' skills are instead continually observed during the first scenario and continual feedback is provided to participants.

Discussions and debriefing

A successful discussion or debrief:

- Spirited discussion within the group.
- The instructor didn't talk too much and facilitated discussion rather than lectured.
- Everyone in the group was involved in discussion.
- Everyone, including quieter participants feel safe contributing.
- Vocal participants were managed courteously.
- Participants learnt from each other, and the session promoted interdisciplinary awareness.

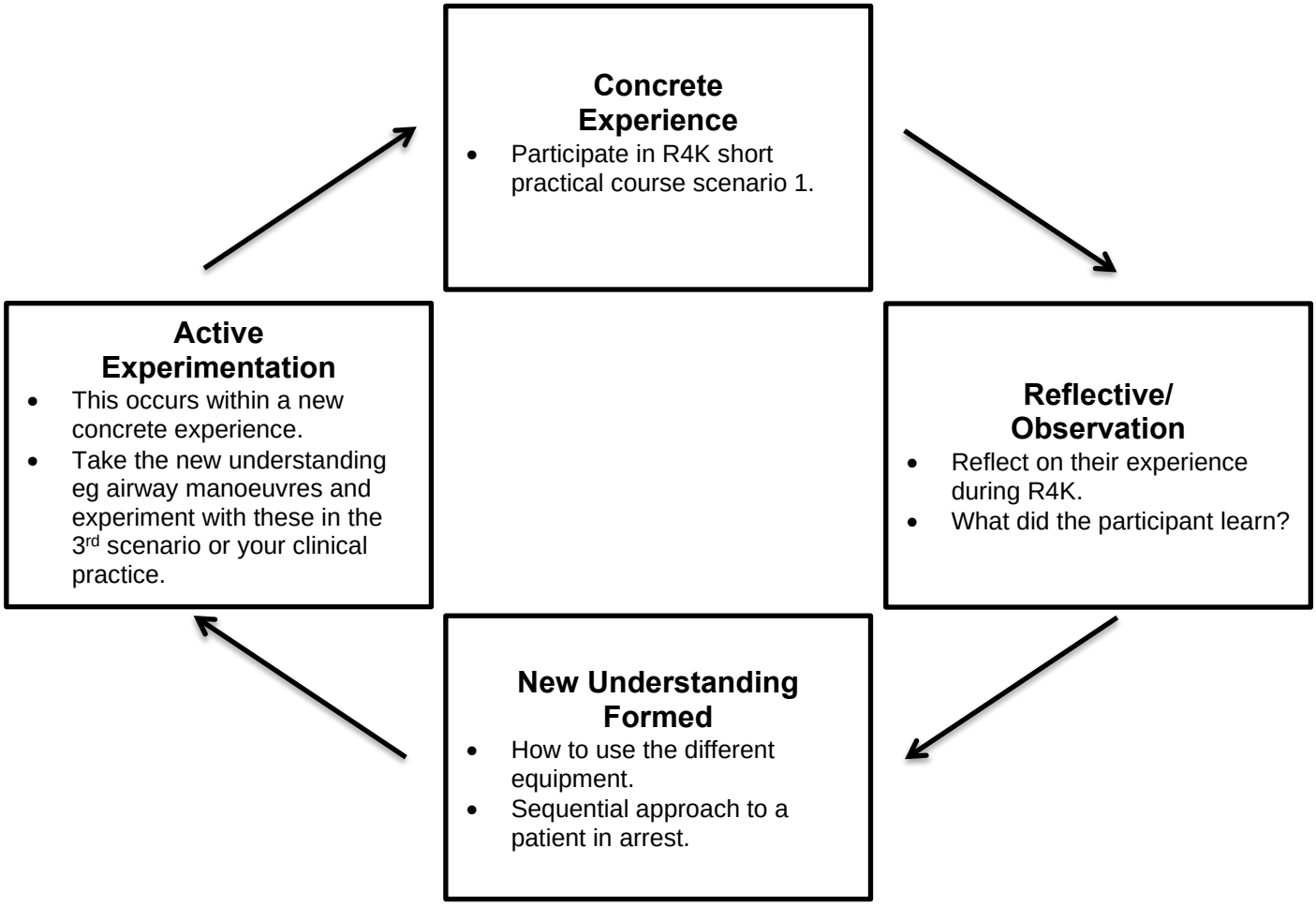
(Mackway-Jones and Walker, 1999)

Adult Learning Principles – overview (Knowles, 1990)

- Adults are internally motivated and self-directed.

- Adults bring life experience and knowledge to learning experiences.
- Adults are goal orientated.
- Adults are relevancy orientated.
- Adults are practical.
- Adult learners like to be respected.
- Adults have their own individual style of learning.

Kolb's Learning Cycle (Kaufman, 2010)



Reflective practice is important as it enables individuals to learn from experiences through reflecting on what has been learnt. This forms the basis of new ideas which in turn impacts on how we practice as clinicians. Kolb's learning cycle shows the learning process that participants need to go through to transform the knowledge and skills learnt from the R4K program into clinical practice.

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RESUS4KIDS SHORT PRACTICAL COURSE - LESSON PLAN

Topic	**RESUS4KIDS** **Basic Life Support for Allied and Community Healthcare Rescuers**	
Trainers	Trainers who have undertaken the RESUS4KIDS Train the Trainer course.	
Participants	Allied Healthcare workers caring for acutely unwell adult and paediatric clients within the Community setting **Maximum 6 participants per trainer.**	
Timeframe	90 minutes.	
Training objectives	By the end of the 90 minute practical course participants will be able to: • Explain why good **TEAMWORK AND COMMUNICATION** are essential for optimal outcomes in resuscitation (use names, allocate and accept roles). • Manage an infant or child's/adult's **AIRWAY** (open and clear the airway and maintain it open). • Perform effective **BREATHING** (slow breaths with chest rise). • Demonstrate effective minimal interruption cardiac **COMPRESSIONS** (push hard, push fast, allow full chest recoil).	
Prerequisites	**All participants at the short practical course will be expected to have undertaken all the RESUS4KIDS Basic Life Support for Allied and Community Healthcare Rescuers E-learning modules prior to attending the session. This requires that they have completed the post course test with a pass mark. When this is achieved the participant will be able to print a certificate. Instructors must site this certificate.**	
Preparation	1. Assemble all equipment and ensure that it is in working order. 2. Arrange equipment and manikins on the tables.	
Welcome & introduction	Brief overview of RESUS4KIDS Basic Life Support for Allied and Community Healthcare Rescuers State the learning objectives. Toilets and fire exits.	**5 minutes**
Confidentiality	At the beginning of the course it is important to talk to all participants about the importance of confidentiality. You need to try and create a safe learning environment for your participants and it is important to explain to them that it is inappropriate to discuss other participant's performance after the course has finished.	
Teamwork component	Use ball game and videos for facilitated discussion and feedback.	**25 minutes**
Scenario based teaching	Pause and discuss format, scenario based teaching.	**60 minutes**

Teamwork component

2 minutes

There are several teamwork, leadership and communication activities that you can now choose from when teaching the first 30 minutes of the Resus4Kids program. All the games and videos are designed to be used across all levels of experience.

The Ball Game followed by the videos 'MET Call in Focus' or 'Paediatric Anaphylaxis' are all designed to explore the concepts of Teamwork, Leadership and Communication. The 'Sea Patrol' videos are designed as a stand-alone tool exploring the concept of Graded Assertiveness and can be used during this session.

Specific learning points to bring out during the 30 minute session.

- Display and use names wherever possible.
- Recognisable team leader.
- Team members' participation.
- Allocate / accept roles.
- Concise, clear communication / closed loop communication.

Introduce session objectives and learning points and make the link with effective delivery of care to patients.

Suggested introduction for the first 30 minutes of the Resus4Kids program.

Introduction when using the videos, 'MET Call in Focus' and 'Paediatric Anaphylaxis'

'For the first part of today's session we are going to explore the concepts of teamwork, leadership and communication. We are going to do this by playing a game and watching a couple of short videos. The reason that we include teamwork, leadership and communication training in the Resus4Kids program is that a number of adverse events happen in hospitals around the world each year because of a breakdown in these elements.'

Introduction for groups that the instructor has chosen Sea Patrol as the teaching tool:

'For the first part of today's session we are going to explore the concepts of teamwork, leadership and communication. These are all essential skills required by healthcare professionals as a breakdown in any of these elements can lead to an adverse events for patients.. We will watch 3 short videos from the TV show Sea Patrol and then practise graded assertiveness using clinical scenarios.'

	Tennis Ball Game: Works best with 6 participants. Participants stand in a semicircle (clear chairs). **Learning objectives:** 1. Understand the importance of communication and the use of **names** during a resuscitation. 2. Identify the importance of having an identifiable **team leader.** 3. Understand the importance of appropriate **task allocation** in a resuscitation. Choose the right person for the right job. **Rules**: Introduce the game: We are going to play a ball game. Everyone needs to stand up and form a semi-circle. Make sure everyone is wearing a name badge that is easily visible. Catch the ball and throw it to someone else in the group, they then need to throw it to another person, and so on. • The ball needs to keep moving amongst the team. • Don't drop the ball! • Don't throw the ball back to the Instructor. • Don't hurt anyone else in the group. • Don't break any equipment. As participants get more confident with passing one ball start to add in more balls adding them quicker as time passes. **Facilitated feedback:** Note initial performance and how it improved as the game went on and comment on: What do the tennis balls represent? *Facilitator discussion points* • *Tennis balls represent the different tasks that happen during a resuscitation. When there is only one ball (task) it is easy to keep the ball moving without dropping it as the group is able to focus on the one ball. The more tennis balls (tasks/ people) the harder the task became as there were more balls to focus on.* What strategies can you or did you apply to this games that could also be applied to a resuscitation to help you manage a chaotic situation? *Facilitator discussion points.* • *Using names: There is ownership of a task when allocated using a person's name. The task is more likely to be completed. The danger of saying 'someone' is that no one takes owner ship of the task and it may not get completed.* • *Team leader: A team leader can bring order to the chaos by offering a solution such as passing the ball to the person on the left. In a resuscitation they are in charge of moving the group through the DRSABCD approach to a collapsed patient.*	**10 minutes**

	Is it enough to say someone's name and then throw them the ball? *Facilitator discussion points.* • *Closed loop communication. Need to wait for the person to respond and let you know that they are ready to catch the ball. By allowing them to respond you are also able to determine if they have understood the task they have been given.* Who caught the first ball of the game? Was this a reasonable task? *Facilitator discussion points.* • *Appropriate task allocation: You need to ensure that the person given the task has the clinical skills to perform the given task. It is the team leaders responsibility to allocate what they believe to be a reasonable task for a team members role however if the team member does not have that skill they need to speak up. Patient safety is important and we should not be working outside of our scope of practice in a resuscitation.* Did anybody think about any of these ideas during the game? If yes why did you choose to/ choose not to vocalise these ideas? *Facilitator discussion points.* • *If ideas were vocalised: discuss why the person offered the solution that they did. It may be that they have played the game before. Relate this to the clinical environment by discussing how we learn from previous experiences and these experiences influence how we approach future resuscitations. Discuss with the team why they chose to follow the suggestions e.g. They seemed reasonable, made sense. Relate this back to the clinical environment as we see the same thing happen.* • *If ideas were not vocalised and people thought of them: Discuss this in relation to the clinical environment. If you see your team struggling to care for a patient and you have either an idea or solution are you going to keep it to yourself?* There are several ways to play this tennis ball game and it can be adapted well to individual teams. The game will play out differently every time depending on the group and be successful if the facilitator picks up on the feedback from the participants and relates the game to an emergency situation using previous discussion points.	
	Leadership and Teamwork in Medical Emergency Teams: MET Call in Focus **NB: If you use this resource the videos are longer and you should allow an extra 10 minutes to deliver the content.** **Acknowledgements** This resource has been adopted and modified with the permission of Professor Cobie Rudd, Pro-Vice-Chancellor (Health Advancement) at Edith Cowan University. This resource was developed by the Interprofessional Ambulatory Care Program at Edith Cowan University in collaboration with the ECU Health	**20 minutes**

Simulation Centre with funding provided by the Australian Government under the Increased Clinical Training Capacity Program.

Office of the Pro-Vice-Chancellor (Health Advancement) from Edith Cowan University (Perth). (2012). *Interprofessional Learning through Simulation. Leadership and teamwork in Medical Emergency Teams: MET call in Focus*. Retrieved 6th March 2013, from http://www.ecu.edu.au/community/health-advancement/interprofessional-ambulatory-care-program/interprofessional-learning/ipl-through-simulation/leadership-and-teamwork-in-medical-emergency-teams

Further information on this resource is available from the link above, including a detailed facilitators manual and literature review.

Background

Mr Keane is a 78 year old man with a history of congestive heart failure who had been admitted to hospital with an episode of Acute Pulmonary Oedema (APO) for which he initially required Bi-level Positive Airway Pressure (BiPAP). The original problem has been resolved but he has developed hospital-acquired pneumonia as a result of a left lower lobe lung infection. He requires daily chest physiotherapy for this. Around midday on day five of his hospital stay Mr Keane has got out of the shower and is attending his scheduled physiotherapy session.

The videos

Met Call in Focus consists of two video scenarios, the first demonstrating sub-optimal performance of the healthcare team, with the second demonstrating more effective performance, improving the patient experience and outcome.

These videos like 'MET Call in Focus' are shown to identify the importance of Communication, Leadership and Teamwork, with specific areas addressed in this scenario including:

- Interprofessional communication.
- Client centred care.
- Leadership characteristics.
- Role clarification.
- The expected response to a clinical deterioration.

An example of an introduction:

'I am going to show you 2 short videos that have been provided to RESUS4KIDS by Edith Cowan University called Met Call in Focus. The people in this video are all actors. I'm showing them to you to emphasis the important of teamwork, leadership and communication.'

Show the first video of 'Met Call in Focus' (3min, 51 secs).

Suggested Questions for part one:

What are your initial thoughts on this video from a teamwork, leadership and communication point of view?

Facilitator discussion points.

- *Use this question to gauge what your participants are thinking about after watching the video.*

What was the communication like in this video?

Facilitator discussion points.

- *The language was negative, blaming and belittling. This created a negative team environment and hindered the team working together to care for Mr Keane.*
- *Patient centred care: No one spoke to or listened to the patient who was scared but also giving important clinical information to the team. Relate this to the patience confidence in the team caring for him. When relating this to a paediatric scenario you need to explain things to the parents as well as the child at an age appropriate level.*

Did this video demonstrate effective teamwork? Why or why not?

Facilitator discussion points.

- *Discuss that while there were a group of people in the room they were not working as a team. They were each focused on their own task and were not communicating with each other. The team were not working as a team but rather as a group of individuals.*
- *Allied health worker: discuss with the group the roll of allied health professionals. They can be a part of the team if one is available and at least they should stay and assist until further help arrives.*

Was there a clear team leader? If yes, were they an effective team leader?

Facilitator discussion points.

- *No clear allocation of a team leader: In this video there was no clear team and it could be seen as multiple people competing for the role of the team leader. Highlight the importance of clearly identifying who the team leader is in a resuscitation.*
- *There was no team leader that had situational awareness – one was busy reading notes, another trying to get an IVC in and the other drawing up medications.* Discuss with the group the impact of task focused vs. situational awareness in this scenario. No one in the team had situational awareness. They were all performing different tasks and became task focused. This resulted in the patient becoming unresponsive for a period of time before the team became aware that the patient had arrested.

What response would you like to see from the Physiotherapist and the Enrolled Nurse?

Facilitator discussion points.

- This is an opportunity to reinforce your organisation's deteriorating patient protocol (DETECT or DETECT Jnr in NSW).
- Recognition of **D**eterioration.
- Systematic **E**valuation of the patient.
- Immediate **T**reatment.
- **E**scalation of care (Call for help).
- **C**ommunicating in **T**eams.

Show the second video (5 mins 45 secs).

	Suggested Questions for part two:
	What was the communication like in this video? What impact did this have on the teamwork in this scenario?
	Facilitator discussion points.
	The team were communicating with each other and Mr Keane. This resulted in the team working as a team and a better outcome for the patient.
	What where the key differences in relation to communication, teamwork and leadership in this video? How did these affect the team dynamic and ultimately the patient's outcome?
	Facilitator discussion points.
	• *There was no blaming of each other.*
	• *People were finishing their sentence, 'No I can't give that medication as I am an enrolled nurse.'*
	• *They listened to the patient and informed him of what was happening as they cared for him. Instilled confidence in their patient.*
	Outline how care was delivered differently.
	Facilitator discussion points.
	• Listening to the patient meant treating the patient, preventing his cardiac arrest.
	• Talking to patient about MET team arriving.
	• Talking to patient about what is wrong and care given
	• DETECT approach.
	  ○ Recognising this is clinically important deterioration.
	  ○ Systematic assessment including physiology.
	  ○ Recognition that assessment is abnormal and activation of MET team.
	  ○ Provision of immediate treatment – Oxygen and patient positioning.
	Encourage participants to reflect on their practice and how the issues identified may apply to themselves and their workplaces.	

	## 'Paediatric Anaphylaxis' video: ### Acknowledgements This resource has been developed by Kids Simulation Australia at the Sydney Children's Hospitals Network for use by Resus4Kids Education and Training Program. It is a dramatization using a simulated scenario of a deteriorating child in a ward within a hospital. It does not portray real clinical practice or policy in any NSW Health organisation. **Background** Storm is a 7 year old boy who has been an inpatient receiving treatment for an infection. His father has been at the bedside for the entire admission. Storm has a history of anaphylaxis to peanuts. Following administration of his medication for the infection, Storm begins to deteriorate. **The Videos** Paediatric Anaphylaxis consists of 2 video scenarios, the first demonstrating sub-optimal performance from the healthcare team, with	**30 minutes**

the second demonstrating a more effective performance, improving the patient experience and outcome.
These videos are shown to identify the importance of Communication, Leadership and Teamwork with specific areas addressed in this scenario including:

- Interprofessional communication
- Family centred care
- Leadership characteristics
- The use of names
- The expected response from a healthcare team to a clinical deterioration.

An example of an introduction
'I am going to show you 2 short videos that have been provided to Resus4Kids by Sydney Children's Hospitals Network called Paediatric Anaphylaxis. It is a simulated scenario depicting real events. These are teaching videos with the aim to emphasise the importance of Teamwork, Leadership and Communication'

Show 'Paediatric Anaphylaxis' Part 1 (2min and 30 secs)

Suggested questions for part one;

What did this team do well?

Facilitator discussion points:

- *Recognised the arrest and started CPR*
- *Recognised they needed help and called for the arrest team*

What was the team's communication like?

Facilitator discussion points;

- *The tone was negative, the language was blaming and belittling. This created an ineffective team environment*
- *No one explained the situation to the parent, he was dismissed and told to move out of the way*
- *No one spoke to the child, he would have been scared and upset*
- *The team members spoke over one another and not listening to each other*

What was the communication with the parent like?

Facilitator discussion points

- *The team members were dismissive of the parent*
- *Nothing was explained to the parent which led to him becoming quite obstructive*
- *The nurse wanted the parent out of the way but did not explain anything to him*

How did this type of communication contribute to the actions of the team members?

Facilitator discussion points

- *Frustrations around not having the necessary equipment at the bedside and blaming each other*

- *Anger at the parent for trying to care for his child when he thought no one else was*
- *Not listening to the parent or the child and then the child deteriorated quite quickly*
- *The teams performance during the arrest was not conducive of effective teamwork*

Who was the team leader?

Facilitator discussion points

- *No clear team leader*
- *Lots of shouting*
- *No clear instructions to anyone in particular*
- *'orders' were given*

If you were involved in this situation, what could you do to improve the management of this patient?

Facilitator discussion points

- *Participants to identify what elements of teamwork, leadership and communication they would change*
- *Specific points to consider are:*
  - *Call for help early and prioritise care appropriately until help arrives*
  - *Work within your scope of practice*
  - *Inform the parent and the child of the situation*

Show 'Paediatric Anaphylaxis' Part 2 (5mins and 15 sec)

Suggested questions for part two;

When we look at the elements of Communication, Teamwork and Leadership, how was this portrayed differently when compared to the first video?

Facilitator discussion points

- *Tone of the language was calm*
- *The was a clear team leader who used names to ask for specific tasks to be done*
- *The parent was included and involved in the discussion and plan of care*
- *Team members worked together and there was no blame*

What was the communication between the team and the parent like?

Facilitator discussion points

- *Team leader introduced herself to the parent*
- *She spoke with the parent about the child's past history*
- *The Dr spoke with the child and directed some questions to him*
- *The parent was reassured by the team and the Dr and was informed of the diagnosis made by the Dr and what treatment was necessary*

- *The team incorporated Family Centred Care principles by including the parent and the child on all the processes and the plan following*

How did the improved communication with the patient and the parent improve the outcomes of the patient?

Facilitator discussion pints

- *By talking to the parent the Dr was able to determine that the patient has significant allergies*
- *The Dr could then focus on what may have caused the child to begin to deteriorate*
- *The team was able to initiate treatment to the child quickly which halted the deterioration*
- *The calm approach to the situation helped keep the parent involved in the care of his child which in turn kept the child calm*

What was the communication within the team like?

Facilitator discussion points

- *The team communicated well with each other*
- *The communication was polite and calm using the closed loop technique*
- *The team members listened to each other and there was no talking simultaneously*

Was there an effective team leader?

Facilitation discussion points

- *Yes, there was an identified team leader, this was established shortly after the team arrived*
- *The team leader spoke calmly and clearly*
- *The team leader used names to ask for tasks to be done*
- *The team leader listened to other members of the team*
- *The team leader communicated with and listened to the parent*

How did this influence the outcome of the child?

Facilitator discussion points

- *A quick diagnosis was made and treatment initiated before the child deteriorated further*
- *The child and the father were aware of the process and what treatment was being initiated*
- *The child and the parent were reassured throughout the whole process which then allowed for them to remain calm and well informed*
- *The child and the parent were aware of the plan following the event*

Sea Patrol – A Brilliant Career

25 minutes

Acknowledgements

These videos are taken from a commercial television series called ‘Sea Patrol’.

The segments are edited and distributed with the permission of McElroy All Media.

Questions to ask prior to watching the videos.

What do you remember learning from previous RESUS4KIDS courses on teamwork, leadership and communication?

- Communication: use of names, closed loop communication, the impact that language can have on a team.
- Team Leader: roles and responsibilities, impact of task focus vs situational awareness.
- Teamwork: we are all responsible for each other, task allocation.
- Patient centred care.

This year in RESUS4KIDS we are going to explore the concept of graded assertiveness.

Learning Objectives

By the end of the 30 minute session participants will be able to:

- Understand the importance of ‘speaking up’ in order to ensure patient safety.
- Identify the 4 stage approach to graded assertiveness
- Demonstrate the use of graded assertiveness using a clinical scenario.

Graded Assertiveness

Question to ask participants: What do you understand about Graded Assertiveness?

Facilitator discussion points.

- *It can be challenging to speak up if you identify a patient safety issues especially if it is a senior member of staff that you are challenging.*
- *Graded assertiveness is a process that can be used to help you speak up if you are concerned about the care of a patient or identify a potential mistake.*
- *There are four elements to graded assertiveness and the aim is to start at the lowest level possible and then work your way up the chain based on the response received.*

PACE approach to Graded Assertiveness

PACE approach

Probe	"do you know that…?" or express your concern using an 'I' statement, "I am concerned about . . . "
Alert	(offer an alternative) – "Can we re-assess the situation…?" "Would you like me to . . ."
Challenge	"Please stop what you are doing while..." or ask for an explanation, "It would help me to understand . . ."
Emergency	"STOP what you are doing!" or "For the safety of the patient we need to .....now."

Example:

A clinician is about to begin a procedure on a patient

Probe: "Have we confirmed that this procedure is following the updated Policy and Procedure Guidelines?"

Alert: "We need to ensure that the procedure is done according to the updated guidelines as there have been significant changes."

Challenge: "I am concerned that if the procedure does not align with the updated guidelines, we may cause potential harm to the patient leading to the need for more treatment options."

Emergency: "Please stop the procedure immediately. I am concerned this may harm the patient. I am going to call for help"

Introduction to videos: ***"****You are now going to watch 3 short videos taken from the TV show Sea Patrol. These videos demonstrate the different stages of graded assertiveness as well as a number of teamwork, leadership and communication points. After each video we are going to discuss what you have seen and how this applies to the clinical environment."*

Show the first section of the sea patrol video.

Questions to ask after the first video.

How did you see graded assertiveness demonstrated in this video?

Facilitator discussion points.

- *The captain of the boat suggested that the crew take the boat through uncharted waters.*

- *Probe: A concern was raised by the navigator saying that the course requested went through uncharted waters. Formal protest was recorded in the ships log.*
- *Alert: An alternative was provided that extra crew would be put on the lookout.*

How could this scenario relate to the clinical environment?

Facilitator discussion points.

- *A team leader could suggest an unprecedented procedure or course of treatment for a patient that goes against the organisations policies and guidelines.*

What was the communication like in this video?

Facilitator discussion points.

- *Communication was sarcastic, belittling and loud which can create an intimidating environment to speak up in.*
- ***Clinical Relevance:** communication including language, tone and volume can have significant influence on the team environment and how 'safe' a team member feels to raise their concerns. These elements can intimidate the team. To ensure we create a 'safe' team environment in a resuscitation we need to be aware of how we communicate with our team members, especially our non-verbal cues.*

How was teamwork demonstrated in this video?

Facilitator discussion points.

- The co-captain supported the navigator by also recording her formal protest in the ships log.
- **Clinical Relevance:** If you agree with a concern raised by one of your team members in the clinical environment speak up and back them up as this will increase their confidence to know that they have support of other team members. You should also document your concerns in the patient note's if relevant.

Questions to ask after the second video

How did you see graded assertiveness demonstrated in this video?

Facilitator discussion points.

- *The previous attempts to raise the crew's concerns over the course requested by the captain were ignored.*
- *Challenge: The captions orders to fire the guns were directly challenged by the first officer who told the gunman, 'do not touch that trigger.'*

How did the first officer try and talk with the captain at first?

Facilitator discussion points.

- *Asked the captain to talk privately. This shows that the first officer still tried to show respect to the captain and tried to move the conversation away from the rest of the crew to a more appropriate place.*
- ***Clinical Relevance**: If you do need to progress to this level of graded assertiveness if it possible try and talk with the person one on one as this is not a conversation to have in front of a group if it can be avoided.*

What was the communication like in this video?

Facilitator discussion points.

- *Loud, demanding, assertive, degrading.*
- ***Clinical Relevance:** Reinforce that communication including language, tone and volume can have significant influence on the team environment and how 'safe' a team member feels to raise their concerns. These elements can intimidate the team. To ensure we create a 'safe' team environment in a resuscitation we need to be aware of how we communicate with our team members.*

Questions to ask after the third video

How did you see graded assertiveness demonstrated in this video?

Facilitator discussion points.

- Emergency: The first officer took control of the ship and relieved the captain of his duties.

How was teamwork demonstrated in this video?

Facilitator discussion points.

- *The crew support the first officer and stood beside her. It was once that the first officer realised that she had the support of the crew she was then confident to step forward and directly challenge the captain.*
- ***Clinical Relevance:** Reinforce the importance of supporting your team member if you agree with the concern that they have raised. It may give them the courage they need to step up and take control of a dangerous situation.*

Practical Exercise

Now that participants have seen an example of how to use graded assertiveness, they now have an opportunity to practise the levels of graded assertiveness using a scenario.

Feel free to make up a scenario relevant to your own working environment or use one of the provided scenarios below:

Scenario 1

You are working with another clinician caring for a patient with a fractured neck of femur. They are about to stand the patient without checking the patients weight bearing status.'

Instructor: Ask a different member of the group to respond to this scenario using the different levels of graded assertiveness. Example responses are provided.

Using the different stages of graded assertiveness identify your concern to the other clinician starting with stage 1: Probe

Example of a response for level 1: I am concerned that you have not checked the patient's weight bearing status and are about to stand this patient up.

Instructor to state: The other clinician dismisses your concerns saying that they have cared for patients with fractured NOF's before and know what they are doing. What is an example of a response for grade 2?

Example of a response for level 2: Before we stand this patient up should we check the patient's weight baring status with the medical team?'

Instructor to state: The other clinician responds that you are both busy and doesn't want to waste their or the admitting doctor's time with checking the patient's weight baring status. They continue to prepare to stand the patient. What is the next thing you could say?

Example of a response for level 3: Please stop preparing to stand this patient until we have confirmed their weight baring status.

Instructor to state: The other clinician still does not want to check the patients weigh baring status and continues to prepare the patient to stand. What is the next thing you could say?

Example of a response for level 4: Stop what you are doing. For the safety of this patient I am going to contact the admitting team to confirm the patient's weight baring status before we stand this patient.

Wrap up

Emphasise that the attributes discussed in these activities are applicable to health care / resuscitation events. Identify to the participants that in the clinical scenarios that they are about to participate in they will have the opportunity to put into practise these different teamwork, leadership and communication activities.

Summarise the objectives of the teamwork & communication component of the course.

	Scenario based teaching Move participants into groups of six people. Each pre-assigned group will ideally have an interdisciplinary component as well as a varied experience level.	
Introduction to scenario-based teaching	Suggested introduction *'For the 60 minutes we are going to run through 3 clinical scenarios. In these scenarios you are going to have the opportunity to put into practice all of the clinical skills that you were introduced to or refreshed with in the e-Learning. In these scenarios we will be following the DRSABCD approach to a collapsed patient. All of the equipment that you need for the scenarios is on the table so please don't tell me that you are going to do something rather pick up the equipment and show me using the manikin. There is no test today. Today is about practise.'*	
Introduction to the scenario	Instructor will: • Outline the **pause-and-discuss** format, Real time may be suspended, slowed or fast tracked at appropriate intervals as we pause to discuss learning points. • **GREY SHADED AREAS IN THE LESSON PLAN ARE TO BE PAUSED AND DISCUSSED WHITE BOXES ARE SKILLS TO BE DEMONSTRATED AS INDICATED.** • Remind participants that this is a chance to consolidate what they have learnt in their e-learning, it is not new information. • Discuss that there will be three scenarios, the first taking around 45 minutes as everyone will demonstrate the life support skills. • Provide responses to the learner's questions about the case scenario. • Provide specific information about the case as it progresses. Participants must follow DRSABCD: D Danger R Response S Send for Help A Airway B Breathing C Circulation / compressions D Monitor / defibrillation As the instructor, you will state: 'I will describe a scenario of a patient who is critically ill. As you assess the patient and evaluate interventions, I will give you additional information'. Use the expression 'OK, the patient is not going to get better or worse….' When you pause to discuss a point. This is a manikin, it is plastic, it can be ventilated using a pocket mask or bag and mask and compressions can be done. You will need to ask for other clinical signs associated with the scenario.	**4 minutes**

	For the purpose of this scenario I want you to suspend disbelief and treat the manikin as a real patient.	
Suggested technique for small group skill practice	Round the table teaching method which is described in detail above in this manual.	
Note for instructors	It is important that, by the end of the session at least, every participant has met the learning objectives and demonstrated: • Managing a patient's airway. • Performing effective breathing. • Performing effective cardiac compressions. • Demonstrate knowledge of safe pad placement and the use of an AED. **None of the 'patients' in the RESUS4KIDS practical course die, they all recover after receiving treatment!**	

Scenario One

Adam an 8 year old boy has come into your clinic for a review of a minor problem, he is otherwise well. You are half way through your appointment with Adam when he suddenly appears to lose consciousness.

Or

You have been asked to review Adam an 8 year old boy who has been admitted to the ward. You are part way through your assessment of Adam when he becomes unresponsive.

Or

Adam, 42 year old male is recovering from surgery at home, as a community health worker, you are required to perform an assessment. During your assessment Adam becomes short of breath and becomes unresponsive.

NOTE: *The aim of this scenario is to identify with the group the difference between a paediatric and an adult arrest. The scenario combines discussion around the differences in paediatric and adult arrests as well as providing participants with the opportunity to practise the different techniques required to respond to a paediatric arrest.*

DRSABCD Step	Expected steps by participants	Instructor Prompt	Time
Participant 1 **Action Step** **DANGER**	Participant to assess for danger.	What type of dangers may you come across is your work environment? • Thinking about external dangers e.g. cords, spills, equipment, other people. • Tight places eg: bathroom	1 min
Participant 1 **Discussion** **DANGER**	**Questions to ask the participants.** **Instructor discuss:** What dangers do patients pose to health care rescuers? What do we do to minimise these risks?	• Blood. • Respiratory secretions (PPE). Health care rescuers who are managing the patient's airway should be wearing a mask and goggles to protect them from airborne viruses. All other members of the team should at least be wearing gloves. **THERE IS NO DANGER**	
Participant 2 **Action Step** **RESPONSE**	Assess for response.	**A participant to demonstrate assessing response**: "Talk and Touch" – gently touch the child and call their name, e.g. 'Adam can you hear me?' Trapezium squeeze is acceptable for an adult patient	1 min

Participant 2 **Discussion** **RESPONSE**	**Questions to ask the participants.** What type of response would you expect from an infant or child? What type of response would you expect from an adult?	• Eye opening. • Cry. • Verbal response. • Movement. **THE PATIENT IS UNRESPONSIVE.**	
Participant 3 **Action Step** **SEND FOR HELP**	Send or call for help.	Participant to state hospital emergency response number and other methods of calling for help specific to their work area.	2 mins
Participant 3 **Discussion** **SEND FOR HELP**	**Questions to ask the participants.** How do you send for help **in your setting?** Do you need to provide any specific information when calling a paediatric arrest? When do I call for help if I witness the patient arrest?	• Emergency Number. • MET team. • Buzzers / call bell. • Phone by bedside • 000 Stating that it is a paediatric arrest, location of the arrest. A rescuer responding to a sudden collapse should obtain help immediately and then start CPR. . **Note:** If you have people from different clinical areas in the same group that have different methods for calling for help discuss this with the group. **HELP IS ON THE WAY.**	
Participant 4 **Action Step** **AIRWAY**	Assess the airway. Clear the Airway. Open/Maintain airway. Demonstrate manual manoeuvres and airway positions to open the airway.	**THE AIRWAY IS OBSTRUCTED.** Roll the patient to drain secretions Place the infant in the neutral position. Place the child in the sniffing position and the adult with backward head tilt. • Chin lift. • Jaw thrust. • Backward head tilt in the adult patient	2 mins

Participant 4 **Discussion** **AIRWAY**	**Questions to ask the participants.** How would you clear the airway? What position do you place an infant in to maintain an open airway? What position do you place a child in to maintain an open airway? What position do you place an adult in to maintain an open airway? **Further information that can be used if the discussion points arise.** What is different about infant's airways?	• Roll to drain secretions • Do not do blind finger sweeps because a young child's airway is funnel-shaped and there is a risk of pushing an object further down the airway. Neutral position: a good way to achieve this is to place a towel or thin blanket (approximately 1.5cm in thickness) under the infant's shoulders. Do not delay CPR if you are unable to easily locate a towel of blanket. Sniffing position: tilt the head back until the nose is pointing to the ceiling / sky Backward head tilt to open the airway Obligate nasal breathers in the first several months of life therefore may need to clear nose as well.	
All participants **Action step** **AIRWAY**	Neutral position (infant) Sniffing position (child) Backward Head tilt (adult) Chin lift. Jaw thrust.	Each participant now takes it in turn to demonstrate each of these skills.	8 mins
Participant 5 **Action Step**	Assess for breathing : • Look / listen / feel.	Participant to demonstrate assessing breathing by placing their ear over the patient's mouth and nose while looking for adequate rise and fall of the chest	2 mins

BREATHING		for 10 seconds. It is vital that participants maintain an airway opening manoeuvre while assessing and giving breaths. Failure to maintain head tilt and chin lift is the most common cause of obstruction during resuscitation. **THE PATIENT IS UNRESPONSIVE AND NOT BREATHING NORMALLY.**	
	Demonstrate how to use a pocket mask or an adult sized face mask for an infant.	For an infant or child a pocket/ face mask is used 'upside down' to ensure a proper seal. Note: Ensure that participant doesn't actually blow into the mask	
	Demonstrate how to bag mask ventilation. ***If a self-inflating bag is not used within the clinical field of your participants, you may wish to just talk about it's use and a quick demonstration only***	Ensure participants choose the correct size mask to ensure an adequate seal and the lungs are inflated.	
Participant 5 **Discussion** **Breathing**	**Questions to ask the participants.** How do you know the breath delivered is adequate?	Good chest rise and fall	
	What factors do we need to ensure when using the self-inflating resuscitation bag?	• Good seal. • C grip.	
	How much do you ventilate the lungs?	Just enough to make the chest rise.	
	What do I do if I don't have equipment to give breaths to the patient?	If you do not have access to a pocket mask or bag and mask to give the patient breaths and you are not comfortable delivering mouth to mouth ventilations, you should start compressions until help arrives with the appropriate equipment.	

All Participants **Action Step** **BREATHING**	Give two effective rescue breaths. Rescue breaths **are not** required in adult resuscitation	Each participant is to now take it in turn to demonstrate giving two effective rescue breaths using a self-inflating bag and / or pocket mask. **Instructor note: Once each of the participants have demonstrated giving two rescue breaths ask participant 5 to return to giving rescue breaths as participants will now work in pairs to ensure the correct ration of 15:2 for an infant and/or child.**	5 mins
Participant 6 **Action Step** **CIRCULATION**	Assess for signs of life. Participant to commence cardiac compressions.	Participant to recognise the patient is unresponsive and not breathing normally. **THERE ARE NO SIGNS OF LIFE.** Participant should start cardiac compressions at a ratio of 15:2 working with participant 5 who is providing ventilations. Assess participant for • Correct rate. • Correct depth. • Allow full recoil. • Correct landmarks. • Correct hand positioning. • Correct ratio. ***NOTE: chest compressions should be commenced in an infant if a pulse is not palpable or is less than 60 beats per mins or cannot be identified within 10 seconds and the***	2 mins

		patient is unresponsive and not breathing normally. ***If the Healthcare rescuer is unable to palpate a pulse and the patient remains unresponsive and not breathing, it is appropriate to commence compressions.***	
Participant 6 **Discussion** **CIRCULATION**	**Questions to ask the participants** How do you assess for signs of life?	Patient is unresponsive and not breathing normally If appropriate, assessing for an infant / child pulse for no longer than 10 seconds • Brachial. • Femoral. • Carotid (not appropriate for infants due to chubby neck). **Note**: Suggest to participants that they should practice feeling femoral and brachial pulses in infants in their clinical practice. If they are unable to feel pulses in children who are obviously alive, then they should not rely on a pulse check in a collapsed child.	
	How far down do you compress the chest?	1/3 of the depth of the chest	
	Where do you position your hands on the chest?	Lower half of the sternum equates to the centre of the chest.	
	What are the different techniques you can use to deliver cardiac compressions?	Two hands encircling / two fingers, one hand / two hands. **Infant/Child:** 15 compressions: 2 ventilations **Adult:** 30 compressions: 2 breaths in adult resuscitation	
	How often should we change over?	Recommended to change rescuer every two minutes (at the rhythm check) to reduce fatigue and maintain efficacy of compressions. ***Remember:*** *It is essential to provide effective cardiac compressions so push hard, push fast, release and don't interrupt.*	

		Note: Instructors should consider recording beat at 100-120 BPM off the e-learning to reinforce compression rate.	
All Participants **Action Step** **CIRCULATION**	Demonstrate effective cardiac compressions and ventilations.	Participants are to now work in pairs taking it in turn to demonstrate effective cardiac compressions and ventilations at the ratio of 15:2.in the infant / child and 30:2 in the adult	6 mins
All Participants **Action Step** **DEFIBRILLATION / MONITOR**	Attach the defibrillator pads from the AED while CPR continues and follow the voice prompts to deliver a shock. Instructors will need to be familiar with how to use your organisations training AED or use an iSimulate device to mimic an AED. Alternatively, you can use the laminated cards provided in the resources.	Place pads using the front-back position (anterior-posterior) or in the conventional anterior position on an older child or adult The AED has been bought to the patient. Steps the participants are to follow: 1. Turn on the AED 2. Prepare the patient's chest (remove clothing) 3. Retrieve AED pads 4. Position the first pad on the patient 5. Position the second pad on the patient 6. Stop CPR when instructed to do so by the AED 7. Deliver shock or recommence CPR as instructed 8. Continue CPR and follow AED instructions until help arrives	3 mins
All Participants **Discussion Step** **DEFIBRILLATION**	**Questions to ask the participants.** Before placing the AED pads on the patient's chest how should you prepare the patient's chest?	- Remove all items of clothing from the chest - Remove all jewellery from the patient's chest (eg necklaces) - Ensure that the chest is clean and dry	

	Where do you place the AED pads? Do you remove the AED pads between shocks? What are the safety considerations when using an AED?	For an adult or older child place at AED pads as shown on the pads themselves (anterior-lateral position) if using the adult sized pads on a child you can place one pad on the child's front in the centre of their chest and the other on the child's back. No, once the AED pads are in place they are kept in place. - No one is touching the patient at the time of defibrillation - If the patient is in a wet area move the patient to a dry area and dry their chest (water is a conductor of electricity) Always commence compressions immediately following defibrillation and / or follow the AED prompts. **Remember:** have knowledge of safe defibrillation because defibrillation is everybody's business and early defibrillation saves lives! The ARC recommends the first option for defibrillation of a child is a manual defibrillator. If one is not available, the second option is an AED with attenuated paediatric pads for children under the age of 8. Children over the age of 8 can be defibrillated using a standard AED. If there is only a standard AED available this can be used on a child under the age of 8.	
All Participants **Action Steps** **SCENARIO Continue**	**Immediate Recommence CPR.**	Immediately after the first shock has been given the participants are to return to providing CPR – Start with the chest compressions. Note: The person giving compressions should be changed every 2 minutes. Follow the voice prompts from the AED to initiate a second rhythm check, the patient is in a non-shockable rhythm and is starting to respond.	3 mins

All Participants **Action Steps** **SCENARIO Continue** **Coming up to 2 minutes Prepare for rhythm check**	Assess for signs of life	**The patient is now becoming responsive and demonstrating signs of life. The patient is now starting to breathe on its own.** **END SCENARIO.**	3 mins

END OF SCENARIO

Scenario Two

Choking Child

You are picking up your lunch at a café. A small child is sitting with his family near where you are waiting for your meal. He is eating a lolly. He waves at you, you smile and turn away.
You feel a tap on the shoulder and turn - Instructor holds manikin in own arms gives manikin to participant's stating –"I think he has inhaled a lolly. Can you help him?"

Step	Expected steps by participant	Instructor Prompt	Time
Effective cough management	Encourage coughing.	Instructor to make or play downloaded coughing noises, ie effective cough. Alternatively say 'the patient has an effective cough'.	1 min
Ineffective cough management	5 Back blows. 5 Chest thrusts. Call for help.	Instructor now makes or play downloaded stridulous noises in between coughing, ie ineffective cough Alternatively say 'the patient now has an ineffective cough'.	2 min
Unresponsive cough management	DRSABCD approach.	Instructor now goes quiet – patient now unresponsive. Emphasise not to get stuck on breathing: if unable to ventilate move onto circulation in an unresponsive infant.	2 min
Instructor is to now talk and demonstrate to the group through the different steps of the choking child algorithm. Back blows – aiming between the child's shoulder blades. Chest thrusts – exactly the same as a chest compression just at a slower rate. 1 per second. When to call for help – sooner rather than later. It is better to have help and not need it than to not have help and need it.			
All participants Discussion	How do you encourage a one year old to cough effectively? Back blows/ chest thrusts. What is the difference between an effective and an ineffective cough?	There is no correct way to encourage a one year old to cough effectively. The main thing to ensure if the child is kept as calm and comfortable as possible. When giving the child back blows and chest thrust ensure that you use gravity. To do this hold the infant over your knee with their head facing downwards. For an older child or adult back blows can be administered by placing them over a chair, bed, table or bend their head towards their knees. Chest thrusts can be administered by placing them against a wall or firm surface.	

	Further information that can be used if the discussion points arise. How many attempts at back blows/ chest thrust will it take to clear the object.	<table><tr><th>Effective</th><th>Ineffective</th></tr><tr><td> - Crying or talking in response to questions. - Loud cough. - Able to take a breath before coughing. - Fully responsive. </td><td> - Unable to cry or talk. - Quiet or silent cough. - Unable to breath. - A bluish colour to skin. - Decreasing level of consciousness. </td></tr></table> This will depend on each individual circumstance. Some people have reported having to do the back blows, chest thrust set multiple times before the object clears. The take home message is while the children is still conscious with an ineffective cough keep performing the back blows, chest thrusts and ensure help is on the way.	

END OF SCENARIO

At the end of this scenario spend a few minutes emphasising the three stages in the management of a choking child.
You can demonstrate the correct management if the participant failed to correctly manage the patient and answer any questions the participant may have.

Scenario Three

Infant Scenario – Real time

Molly an 11 month old girl (10kgs) has come into your clinic for a review, she is otherwise well. You are half way through your appointment with Molly when she suddenly becomes unresponsive.

Or

You have been asked to review Molly an 11 month old girl (10kgs) who has been admitted to the ward. You are part way through your assessment of Molly when she becomes unresponsive.

***NOTE**: Start this scenario with one participant and when they send for help slowly add the others. It is important to make sure that at least one other participant has arrived before compressions to ensure that the correct CPR ratio of 15:2 is maintained.*

DRSABCD Step	Expected steps by participants	Instructor Prompt	Time
DANGER	Assess for danger	THERE IS NO DANGER	1 mins
RESPONSE	Assess for response	THE INFANT IS UNRESPONSIVE	
SEND FOR HELP	Send or call for help	HELP IS ON THE WAY	
AIRWAY	Assess airway. Open, clear, maintain	Chin lift, Jaw thrust. Suction if available	5 mins
BREATHING	Assess breathing. Look, Listen, Feel. Give two effective breaths	IF INFANT IS UNRESPONSIVE AND NOT BREATHING NORMALLY	
CIRCULATION	Assess for signs of life and / or the need for compressions	THERE IS NO SIGNS OF LIFE, COMMENCE COMPRESSIONS **Ensure the 2nd participant has arrived to help*	
COMPRESSIONS AND BREATHS	Start compressions. • Correct rate • Correct depth • Allow full recoil • Correct positioning • Correct hands • Correct ratio	15 compressions: 2 ventilations. Rate 100-120 compressions per minute 1/3 depth of the chest Two thumbs encircling / two fingers. **The rest of the participants have arrived to help* ***Optional end of scenario 'when help arrives' for sites without an AED.*** ***For sites with an AED, continue with the scenario.***	5 mins

AED	Correctly attach the AED to the patient and follow the voice prompts. Commence the next 2min cycle of CPR and follow the AED prompts.	Step the participant is to follow: 1. Turn on the AED. 2. Prepare the patient's chest (remove clothing.) 3. Retrieve AED pads. 4. Position the first pad on the patient. 5. Position the second pad on the patient. 6. Stop CPR when instructed to do so by the AED. 7. Deliver shock or recommence CPR as instructed. 8. Continue CPR and follow AED instructions until help arrives.	6 mins
WHEN HELP ARRIVES **DISCUSSION** **ALL PARTICIPANTS**	Discuss with the group that when the hospital arrest team or ambulance arrives to help, as an allied or community health worker you can continue to assist with breaths and compressions.		1 min

END OF SCENARIO

Wrap up: Spend a couple of minutes summarising the key teaching points from the course.

By the end of the 90 minute practical course participants will be able to:

- Explain why good TEAMWORK AND COMMUNICATION are essential for optimal outcomes in resuscitation (use names, allocate and accept roles).
- Manage an infant and child/adults AIRWAY (open and maintain it open).
- Perform effective BREATHING (slow breaths with chest rise).
- Demonstrate effective minimal interruption cardiac COMPRESSIONS (push hard, push fast, allow full chest recoil).

SPECIFIC CHALLENGES FOR INSTRUCTORS

The delivery of this training incorporates principles ensuring that:

- The content is relevant.
- The learner is actively involved.
- Objectives are clearly set.
- Positive feedback is given.
- Reflection on experience is encouraged.

A participant who may present challenges during the course includes:

Non Talker

'Non-talker' does not necessarily equate to 'non-learner', however some candidates may need additional support. Learners feel more comfortable in familiar situations and if asking direct questions it may be worth relating the question to their individual clinical environment and role for example 'how would you activate an emergency response in your own clinical area'. During scenario allocation consider allocating a less threatening role initially to allow the learner to become more familiar with the expectation. Take turns at asking each person questions or to demonstrate so that one individual does not feel picked on.

Talkers

These learners are usually enthusiastic and keen to show that they have sound core knowledge and as such tend to monopolise the discussion. Approaches that can be used to influence this type of candidate include summarising or asking the candidate to summarise what has been said. Following the summary the discussion can be directed towards another candidate.

It may be difficult to interject while learners like these are talking. To overcome this wait until the talker has to breathe, thank them for their response, rephrase the question and redirect the discussion.
Participants from acute clinical areas may bring in more complex questioning or advanced scenario questioning, this can confuse those participants who do not need this additional knowledge and may also challenge an inexperienced instructor. To manage these groups determine if the questions or comments are relevant to the session objectives and if they are not advise that this session is designed to refresh core knowledge and skills within the allocated time. Specific questions or scenarios related to more advanced life support training whilst relevant are managed back within their clinical area training programs.

Reluctant Learner

Traditionally healthcare providers have been taught within their own disciplines in both the undergraduate and post graduate programs. During medical emergencies these disciplines are brought together and required to work as a team when roles are unfamiliar and the stakes are high. During these emergencies these teams are working towards a common goal with each team member's contribution progressing the team toward this goal.

The multidisciplinary approach of RESUS4KIDS is a relatively new concept and some individuals may find this challenging to engage in. Often these individuals have good core knowledge and sharing this knowledge would benefit all participants. It is important that the instructor attempts to help these learners use their knowledge constructively.

Satellite discussions between participants rather than with the group as a whole

This can be a disrupting influence and the instructor may choose to stop the main discussion, listen to the satellite one, and link this with the main discussion to bring the group back together. Alternatively use a direct approach and call the individual by name to draw attention back into the discussion.

The Learner with a previous real life experience

These learners have either recently being involved in a paediatric arrest or have in the past been involved in a paediatric arrest and are still affected by their experience. These participants may present as any of the above mentioned challenging learners. These participants may have had a positive experience and can add to the group's discussion. Others may find the content taught in RESUS4KIDS too confronting as it brings back difficult memories. If the course content becomes too much for these people allow them to leave and inform their manager so they can follow up with them.

Participants that struggle during the scenario based teaching

There is no formal assessment during the RESUS4KIDS short practical course however there is process of continuous assessment and feedback by the RESUS4KIDS instructor during the course.
If a member of the group is significantly struggling with the essential skills of RESUS4KIDS (airway manoeuvres, bag mask ventilation and cardiac compressions) this needs to be fed back to the participant with a suggestion that they obtain further training.

Local health districts should establish policies for instructors to follow for poorly performing candidates.