

# DAS Interprofessional Simulation Scenario – Plan B



## Scenario: Unanticipated Difficult Tracheal Intubation (Plan B)

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**Version:** 1.0

**Learners:** Anaesthetists – all grades, Airway Assistants and any other staff normally present at induction.

This scenario is designed so that all members of the airway team, regardless of profession, can practice the anaesthetic non-technical (ANTS) and communication skills required during unexpected airway difficulty, following the DAS 2025 algorithm.

### Intended Learning Outcomes (ILO's):

By the end of the session the learners should be able to:

1. Demonstrate clear and timely **declaration of failed intubation**, ensuring the whole team shares an understanding of the evolving risk, urgency, and the need to transition in the DAS algorithm.  
(ANTS domains: *Situation Awareness; Teamwork*)
2. Demonstrate forward planning (“priming”) by **preparing for potential emergency front-of-neck airway (eFONA)** while progressing through Plan B, coordinating team actions to reduce the risk of task fixation.  
(ANTS domains: *Situation Awareness; Task Management*)
3. Establish a structured **“stop, think and communicate” moment** once SAD ventilation is achieved, consolidating information about oxygenation, patient status and surgical context to consider safe next steps.  
(ANTS domains: *Decision-Making; Balancing risk*)
4. **Communicate assertively and collaboratively** when external pressure to continue surgery arises, ensuring concerns are voiced clearly, risks are articulated, and a shared, safe airway plan is agreed.  
(ANTS domains: *Teamwork; Communication*)

**Faculty:** Experienced in immersive simulation for learning and airway management. Embedded faculty member to guide scenario; role could be changed based on composition of learners. Authentic interprofessional learning will benefit from a multidisciplinary faculty.

**Recommended timing:** 10 min scenario + 30 min debrief

### Background & Setup

**Background to Scenario (for faculty):** This scenario is an unanticipated difficult airway in an ASA 2 patient undergoing an *elective diagnostic laparoscopy*\*. Learners will encounter an unanticipated difficult tracheal intubation, and they will fail to intubate on 3 (+1) attempts. They will proceed to successfully ventilate via a Supraglottic Airway Device (SAD) before deciding next step (aim to wake the patient up).

### Specific Setup:

- Intubatable mannikin
- Trolley/patient bed
- Anaesthetic machine including Suction
- Pre and peroxygenation equipment including nasal cannula and high-flow nasal oxygen (HFNO) if available

- Videolaryngoscope (VL) with Macintosh and hyperangulated blades
- Airway equipment (ETT, syringe, bougie, stylet, facemask, OPA (Guedel), 2<sup>nd</sup> generation SAD, anglepiece, catheter mount)
- eFONA kit (size 10 scalpel, size 6.0 ETT, caudé tip bougie)
- Labelled syringes (induction agent, opioid, muscle relaxant, emergency drugs)
- IV cannula and IV fluids
- Copy of DAS 2025 Guidelines for Unanticipated Difficult Airway
- Initial observations: SpO<sub>2</sub> 100% RA, HR 70 bpm, BP 110/78 mmHg

#### **Required Roles / Participants:**

- Anaesthetist(s) (learners or embedded faculty)
- Anaesthetic Assistant (learner or embedded faculty)
- Clinical Support Worker (learner or embedded faculty)
- Surgeon (embedded faculty)

#### **Briefing for Learners:**

##### **Brief to Learners:**

You are the anaesthetist on an elective gynaecology list: (+/- with distant supervision – this can be adjusted depending on the grade of the learner). Your next patient is a 52-year-old woman who is booked for an elective diagnostic laparoscopy\*. She has been pre-assessed by your colleague and is appropriately fasted. She is in the anaesthetic room with monitoring applied, checklist completed and ready to start induction.

##### **Anaesthetic Assessment:**

- BMI 30
- ASA 2; Hypothyroidism
- Airway: MP2, good mouth opening and neck extension, jaw slide A.
- No previous anaesthetics

##### **Drug history:**

- Levothyroxine 50mcg OD
- NKDA

#### **Guidance to Faculty:**

##### **Guidance for Embedded faculty**

You are available to support the learners to achieve the ILOs, keep the scenario on track and overcome any difficulties with simulation artefact. There are some example prompts in the template below.

##### **Guidance for Surgeon role:**

You are keen to get this operation done, as they have been cancelled before, however upon discussion at the ‘Stop, Think and Communicate’ moment, the patient is clinically stable from a surgical perspective, therefore she could be woken up and surgery postponed.

##### **Simulating difficult intubation:**

Ideally, we would like the participants to be able to insert the videolaryngoscope they have chosen and not be able to get a clear view of the cords. This can be difficult to achieve with most manikins, so it is important to brief them beforehand that they will be told what intubation grade they are achieving in the scenario, and to go with this (or even use a picture of the grade they are achieving).

ILO	Scenario State and team actions	Transition Trigger (actions that will give you the material for the debrief)	Faculty Prompts (if needed)	Additional notes/debrief points
<b>1: Declaration of failed intubation</b>	Patient Induced <b>SpO<sub>2</sub> 100%, HR 80bpm, BP 124/88, ETCO<sub>2</sub> 2.8</b> Can't intubate but can ventilate with facemask.  3+1 max attempts at intubation, if help arrives ( <i>each attempt has poor view or unable to pass ETT</i> )	Declaration of unable to intubate, with some sharing of level of urgency amongst the team.  Declaration for transition to Plan B and get eFONA kit.	<i>"Are we getting any ventilation with the facemask at all?"</i>  <i>"Is there anything we can do to get a better view?"</i>  <i>"Sats still look ok at the moment (said calmly)"</i>	Aiming to uncover strategies that keep the team on the same page that this is a critical situation but maintain calm.  Failure of Plan A can be declared at any time, even after the first attempt at tracheal intubation.  Appropriate assistance must be summoned.
<b>2: Plan B and priming for eFONA</b>	Sats slowly dropping. <b>SpO<sub>2</sub> 94%, HR 80bpm, BP 124/88</b>  Team start inserting SAD – no ETCO <sub>2</sub> on first attempt. <b>ETCO<sub>2</sub> 0</b>  Success on achieving ETCO <sub>2</sub> on second attempt with different SAD (size or type). <b>ETCO<sub>2</sub> 3.0</b>	Team to get out eFONA kit while SAD is being inserted.  Team aware of sats dropping.	<b>If eFONA kit not requested:</b> <i>"shall we get the FONA kit out, just in case?"</i>  <b>If failed intubation not declared:</b> Pointing to algorithm- <i>"Are we now moving to plan B?"</i>	Importance of priming for eFONA early. Role of airway assistant in prompting this, if not already declared/requested.  Importance of how the whole team knowing the algorithm can help avoid task fixation and prompt transition down the algorithm.
<b>3: Stop and think moment</b>	With second attempt of SAD, can ventilate and sats improve.  <b>SpO<sub>2</sub> 100%, HR 90bpm, BP 124/88 ETCO<sub>2</sub> 4.0</b>  Guide the team towards the decision to wake up the patient, before moving on to the next section.	Clarification amongst team that we now <b>can</b> ventilate and oxygenate - confirmed with waveform capnography and pulse oximetry.  Discussion and consideration of options	<i>"Shall we stop for a second and work out the plan next?"</i>  <i>"I don't think the surgery was that urgent - should we wake the patient up?"</i>	Aim to highlight how we no longer have such a time critical situation and balanced decision making is now possible (i.e. switching from rules-based decision making to analytical).  The default decision here should be to discontinue anaesthesia. Other options are high-risk and should only be considered with senior input.

		eg wake up, intubate via SAD.		
<b>4: Assertive and collaborative communication</b>	<p>Obs remain stable  <b>SpO<sub>2</sub> 97%, HR 90bpm, BP 124/88 ETCO<sub>2</sub> 4.0</b></p> <p>Depending on experience and seniority of learner Embedded surgeon/faculty can challenge the decision making i.e. <i>"This patient's been cancelled twice now, is there any way we can keep them asleep and continue with operation?"</i></p>	Clarification of seriousness of situation with surgeon, and priority to wake up.	<b>If learner agrees with surgeon to continue:</b> <i>"They did drop their sats and things were looking a bit serious a couple of minutes ago"</i>	Doesn't need to be done perfectly, but in this section aim is to create a scenario to consider the challenge of these conversations. If novice/junior learner can leave this out of scenario but discuss as a 'what if' in debrief.  Reference to 'continuation bias'
<b>End scenario</b>	Obs as above	<p>Team start to prepare to wake patient up</p> <p>Recognition of potential risk of airway complications on emergence.</p>	"Shall I get the sugammadex?"	Thank participants and end scenario there.

**Suggested questions for “analysis” section of debrief:**

**ILO1: Declaring difficulty**

- *How did we keep everyone on the same page that this was a critical situation, but also keep the calm in the room?*
- *How can we keep track of time and oxygen saturations during the intubation attempts?*

**ILO2: Priming to getting eFONA kit out**

- *How comfortable do people feel about getting the FONA kit out when we’re still on plan B?*
- *Do people feel that the anaesthetist would have to ask for it, or that the team could do this without being asked?*

**ILO3: Stop and think moment**

- *When the SAD was in and sats were better, what options were people thinking about?*
- *What types of situations might change the risk vs benefit of these different options? (encouragement to think about patient, team and surgical factors)*
- *Despite discontinuation of anaesthesia being recommended as the default option, it is not without risk. What are these risks and how can they be mitigated? (Situational awareness and vigilance for risks such as laryngospasm – and how to prepare for this safely – assistance/drugs/equipment required)*

**ILO4: Assertive and collaborative communication**

- *When there is pressure to continue, what language do people find effective to express concern, or to keep everyone on the same page*
- *What graded assertiveness tools are available? (CUSS or PACE)*
- *Thinking about real clinical practice: what systemic or cultural factors influence speaking up?*

**References / Feedback QR**

- DAS 2025 guidelines
- AirSim Facilitators User Guide
- Human Factors Appendix, DAS 2025
- QR code for facilitator and learner feedback

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