Palliative Simulation for Internal Medicine Trainees

PALL-SIM-IMT

North East Palliative Registrar Research Alliance

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Dear colleagues,

Thank you for taking interest in our project: Delivering Palliative Simulation (SIM) Teaching to Internal Medicine Trainees (IMTs).

Shape of Training commenced in August 2019 and represents a substantial transformation in postgraduate medical education. 'Managing end of life and applying palliative care skills' is one of eight key specialty Capabilities in Practice (CiPs) for all IMTs. As NEPRRA (North East Palliative Registrar Research Alliance), we have developed a Simulation Teaching Package to help IMTs develop the skills that will help them achieve this.

The Package includes eight simulation scenarios that have been carefully mapped to the IMT curriculum. We have piloted this package in a number of Health Education England North East Trusts and have received very positive feedback. Due to the crossover period between Core Medical Training (CMT) and IMT, we have included CMTs in a number of pilot projects and the materials are suitable for use with CMTs.

From pilot work, we are aware of a number of things that must be considered when running this Simulation Teaching Package. The following are mandatory stipulations to use this Package:

1. LEARNERS SHOULD BE IMTs or CMTs

We have designed the scenarios around the requirements of the new IMT curriculum and have tailored the debrief sessions towards the learning outcomes identified. We have delivered the package to groups of IMTs and CMTs and have not designed scenarios to include nursing staff or other professionals.

We therefore request that the majority of learners are IMTs or CMTs, and that a minimum of three scenarios are used in the half or full day to ensure adequate coverage of learning outcomes (see table below).

We have to date delivered packages of half day duration but plan to explore a full day option. The table below also details the minimum and maximum numbers of participants required for each of these options.

	Participants		**Scenarios covered**
	Maximum	Minimum	
Full Day	12	6	6
Half Day	8	4	3-4

2. FACULTY SHOULD INCLUDE PALLIATIVE MEDICINE EXPERTS AND BE APPROPRIATELY TRAINED

We have run pilots as a group of palliative medicine trainees and involved at least one local consultant in palliative medicine at each training site, and local teaching fellows where possible.

Please ensure that faculty includes at least two palliative medicine trainees or consultants, or trust grade doctors with at least six months experience in palliative care. All faculty leading the

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Simulation Teaching Package or running debriefs must have undertaken specific training in SIM teaching and debrief skills.
We would highly recommend basic sim training for all faculty involved.

3. IMT LEADS SHOULD BE INFORMED
We have included the regional IMT Training Programme Director and local IMT Lead Consultants in the planning and approval of the delivery of this Simulation Teaching Package.
We recommend relevant IMT leaders are informed of any training for IMTs in your Trust.
We are also keen to have support from local palliative medicine consultants in your Trust.

4. EVALUATION MUST BE COMPLETED
If you use this Simulation Teaching Package, we would be grateful if you could distribute the attached learner and faculty evaluation forms and return them to us by email (clearly labelling which are IMTs and CMTs).

5. INTELLECTUAL PROPERTY (COPYRIGHT) SHOULD BE RESPECTED
Please note that we are distributing the Simulation Teaching Package for use within your organisation. Accordingly, we are happy for you to use, reproduce, and disseminate components of the Simulation Teaching Package but only within your organisation. If you would like to use, reproduce, and disseminate components of the Simulation Teaching Package outside of your organisation, then please contact us to discuss.

Acknowledgements
We would like to acknowledge the contribution from Epsom and St. Helier University Hospitals NHS Trust in the conceptualisation of this Simulation Training Package
We would also like to thank Dr Deepta Churm, Dr Rowan Walmsley and Dr Jen Vidrine, consultants in palliative medicine whose help and expertise has been invaluable in the production of PALL-SIM-IMT

We would be grateful for any feedback provided during the course of your evaluation or otherwise, but please note that if you would like to submit any suggestions for making improvements to the Simulation Training Package, then we would request that this would be done on the understanding that you would be assigning any copyright associated with the suggested improvements to Northumbria Healthcare NHS Foundation Trust. We would of course nevertheless ensure that you would be given recognition and acknowledgement of your valuable input.

If you have any further questions, please do not hesitate to get in touch.

Yours Sincerely,

NEPRRA
Dr Kate Howorth, Dr Kerry Waterfield, Dr Felicity Dewhurst, Dr Emily Kavanagh, Dr Elizabeth Fleming, Dr Hannah Billett, Dr Max Charles, Dr Lucy Robinson, Dr Amy Huggin, Dr Craig Gouldthorpe, Dr Grace Rowley, Dr Elizabeth Woods, Dr Jo Brown, Dr Donna Wakefield

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Agitation at the end of life

Set up and resources

Simulation Area: Rehabilitation ward

Prepared Documentation:

Documentation	Description/location of document	E-version
Patient notes	MDT summary – physio / unable to engage – no further rehab potential, plan for nursing home care TEP – not for IV abx DNACPR	Need completed TEP and DNACPR
A & E triage	No	
NEWS chart	Require completed NEWS chart	
Medications chart	Present: Simvastatin 40mg Aspirin 75mg Codeine 60mg QDS (for joint pains) Co-amoxiclav 625mg TDS – started 48hrs ago	Completed kardex
Fluid balance chart	Required to show no urine output in last 24 hours	
ECG	Can have one available – sinus tachycardia rhythm	
CXR / Imaging	Recent CXR – aspiration pneumonia	
Blood results	CRP 90, WCC 12, Normal renal function	Require blood results
ABG results	No	
Patient stickers	Need to have on documentation	
GP letter	No	
Trust Guidelines	Palliative Care Guidelines	

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	Care of the dying patient document- if requested	
Screening tools	No	
Video footage	No	

Additional Equipment:

Equipment	**Description of equipment**	**Location of equipment**
Drugs (syringe/ tablets/IV bag)	No IV access (hide venflon on SIMman) Stethoscope	
Equipment	No	
Paperwork	MDT report DNACPR TEP Prescription chart (Further prescription chart for debrief)	
Markings on SimMan	Nil	
Clothing for SimMan	PJs	

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Simulation Teaching Lesson Plan

Duration	15 min scenario 30min feedback
Venue	SIM suite
Participants	Candidate 1 x technician 1 x nurse (plant) 1 x relative on telephone (if requested by IM trainee to speak with them)
Subject	End of life care Agitation at end of life
Aim	To identify the dying patient and assess and manage agitation at end of life
Learning outcomes	1. Identify the dying patient- holistic assessment 2. Consider any reversible causes of agitation 3. Management of agitation including commencement of syringe driver to cover pain 4. Development of individualised care plans including hydration and nutrition at the end of life (possibly using care of the dying patient document) 5. Communicates clearly and sensitively

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Patient Details

NAME:	Rose White	
DOB: 83 yrs	**Gender:** Female	**Weight:** 45kg
Setting:	**Rehabilitation ward**	
HPC:	Rose was admitted to hospital 10 weeks ago having had a dense right TACS. Since then there has been a gradual deterioration. She hasn't had physiotherapy for the past couple of weeks. She has had a poor response to rehabilitation and now felt to have no further rehabilitation potential. She isn't eating. She has been needing to have her fluids thickened. She is bed bound and fully dependent for all ADLs. She has no verbal communication. She was started on oral antibiotic 48 hours ago for an aspiration pneumonia.	
PMH:	IHD Hypertension Osteoarthritis	
DH:	Simvastatin 40mg Aspirin 75mg Codeine 60mg QDS (for joint pains) Co-amoxiclav 625mg TDS – started 48 hrs ago	
SH/FH:	Lives alone NOK niece Sandra who lives in Manchester	
Allergies:	NKDA	

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Candidate Instructions

You are the on-call weekend doctor. You have been asked to come to the rehabilitation ward to review Rose as she is very agitated and has been unable to take her medications. You have not met Rose before. She is an 83-year-old lady admitted to hospital 10 weeks ago having had a dense right TACS. Since then there has been a gradual deterioration. She hasn't had physiotherapy for the past couple of weeks. She isn't eating. She has been needing to have her fluids thickened. She was started on oral antibiotics 48 hours ago for an aspiration pneumonia.

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Nurse instructions

You are a nurse working on a rehabilitation ward. You have been looking after Rose for several weeks. She is an 83-year-old lady admitted to hospital 10 weeks ago having had a dense right TACS. Since then there has been a gradual deterioration. She hasn't had physiotherapy for the past couple of weeks. She has had a poor response to rehabilitation and now felt to have no further rehabilitation potential. She isn't eating. She has been needing to have her fluids thickened. She is bed bound and fully dependent for all ADLs. She was started on oral antibiotics 48 hours ago for an aspiration pneumonia. She is not able to communicate verbally but until the last 24 hours had been able to make her wishes known by nods.

You are very worried about Rose. You have seen her deteriorate rapidly over the past 24 hours and she is now very agitated. You are unable to get her to take any of her medications and she is not managing any oral fluids. She has been moaning in the bed and moving around in a distressed manner. You are worried that she is unsettled and not sure why. You think she might be dying.

You have called her niece Sandra who is her NOK and lives in Manchester. You have explained Rose is less well and Sandra is on her way to visit her now.

Rose has a DNACPR and a TEP which states that she is not for escalation of care past ward level and she is not for IV antibiotics.

You have done some observations before the doctor arrived which are generally normal apart from a tachycardia. Rose had bloods tests two days ago when started on oral antibiotics which were normal apart from CRP 90, WCC 12.

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MDT Summary

Patient: Rose White

Physiotherapy:
Rose has not been able to engage with physiotherapy due to fatigue and challenges with communication. Following assessment it has been felt that she does not have any rehabilitation potential so has been discharged from the physiotherapy service.

Social work:
Following discussions a decision has been made to start looking for a nursing home placement for Rose. An application has been submitted for a CHC assessment.

Speech and Language:
Rose has a poor swallow and is at risk of aspiration. Thickened fluids are recommended. She has no verbal communication. She is sometimes able to communicate by nods but seems to fatigue very quickly.

Medical Handover:
Rose has been commenced on oral antibiotics for an aspiration pneumonia. CXR showed some right sided consolidation. She has a TEP form stating she is for a ward based ceiling of care and not for IV fluids or antibiotics. Rose has a DNACPR. Her background includes ischaemic heart disease, hypertension and osteoarthritis.

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Running script

Scenario section	Patient status	Expected Actions
Initial assessment	HR:115 BP: 106/70 RR: 14 SATS:92 Temp: 36.4 BM 6.6 O/E Creps in right upper lobe Groans on palpation of lower abdomen Patient is drowsy Patient is cool peripherally	Gain a history from the nurse Examine the patient's chest and abdomen looking for reversible signs of agitation Identify and acknowledge that the patient is dying
Nurse prompts if these areas haven't been covered: So what about her pain doctor? Why do you think she is agitated doctor? She hasn't passed urine for a long time Do you think she is dying doctor? She hasn't managed to take any medication this morning.		
Care planning		Identify and acknowledge that the patient is dying Identify that patient is in urinary retention Make a plan to manage the patient's agitation Consider appropriate changes for end of life care: - Informing the family - Anticipatory prescribing - Rationalising medications - Symptom management - Fluids/nutrition - Observations - Documentation - Spiritual care
Nurse prompts if these areas haven't been covered: What is the plan now for her care? Can I give her something to settle her now? Shall I put her NBM? Do you want observations done? She can't drink – should we give her some fluids? What should we do if she becomes agitated again? Do you want me to call the chaplain?		

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Bowel Obstruction

Set up and resources

Simulation Area: Direct admission to Oncology Ward form clinic

Prepared Documentation:

Documentation	**Description/location of document**	**E-version**
Patient notes	**Recent clinic letter stating metastatic ovarian cancer, disease progression, treatment aim is palliative**	
A & E triage	**No**	
NEWS chart	**Slightly hypotensive, otherwise normal**	News chart not necessary as just admitted to the ward
Medications chart	**Metoclopramide 10mg TDS** **Morphine Sulphate MR 20mg BD**	See oncology clinic letter for full medication list Need Kardex with patient stickers
Fluid balance chart	**Not passed urine in last 3 hours**	Need blank fluid chart with patient stickers
ECG	**Normal sinus rhythm**	Required
CXR / Imaging	**CT report- Multilevel bowel obstruction, disease progression**	See most recent clinic letter
Blood results	**Mild AKI**	Need FBC, U&E, LFT, Bone profile, CRP
ABG results	**Not performed**	
Patient stickers	**No**	
GP letter	**No**	
Trust Guidelines	Northern Network guidelines- Management of malignant bowel obstruction TEP form for escalation (with spare) DNACPR form not filled in	Need TEP Need DNACPR

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Additional Equipment:

Equipment	Description of equipment	Location of equipment
Drugs (syringe/ tablets/IV bag)	Cannulated in clinic	Cannula in forearm
Equipment	NG tube available on request	
Paperwork	Clinic letter Fluid balance chart Blood results on sheet TEP and DNACPR Trust guidelines	
Markings on SimMan	Gravid abdomen to be used to demonstrate distension	
Clothing for SimMan	PJs	

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Simulation Teaching Lesson Plan

Duration	10-15 mins scenario, 30 mins debrief
Venue	SIM suite
Participants	Candidate. Manikin Nurse present (plant)
Subject	Admitted from oncology clinic with malignant bowel obstruction- multi-level obstruction secondary to advanced Ovarian Cancer. Patient has previously expressed a wish not to have surgery.
Aim	To identify limited reversibility and manage malignant bowel obstruction
Learning outcomes	1. Identification of limited reversibility to condition with holistic assessment 2. Clear sensitive communication to ascertain wishes of patient and explain plan 3. Able to determine palliative care and potential EOLC needs with advance planning re PPC/ PPD, escalation and resuscitation 4. Indication for syringe driver and appropriate prescribing 5. Management of symptoms including selection of appropriate antiemetic and PRNs

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Patient Details

NAME:	Sandra O'Neill	
DOB: 02/03/1956	**Gender:** Female	**Weight:** 62kg
Setting:	**Medical Admissions Unit - admitted from clinic with uncontrolled vomiting and constipation**	
HPC:	5-day history of constipation, 2 days since passed flatus. Vomiting for the last 48 hours.	
PMH:	Metastatic ovarian cancer- widespread disease throughout abdomen including omental cake and ascites	
DH:	Metoclopramide 10mg TDS PRN Morphine Sulphate 20mg BD Macrogol sachets 1 sachet BD PRN	
SH/FH:	Lives alone, separated from husband several years ago. Daughter Cheryl lives nearby with her husband and children Family history of breast cancer	
Allergies:	NKDA	

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Candidate Instructions

You have been called to the Medical Admissions Unit see a patient who has been admitted from clinic with intractable vomiting for the last 48 hours. The nursing team request a review of the patient and prescription of medications for symptoms.

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Nurse instructions:

Sarah (Nurse)-

You know the patient Sandra and her daughter Cheryl well from previous hospital stays. Sandra has Metastatic Ovarian cancer which progressed despite chemotherapy. She last had chemotherapy 3 months ago.

Sandra appears quite unwell on arrival and you feel her medications need to be reviewed so that she can have something to help stop her vomiting.

You are aware that her disease is widespread and that treatment is with palliative intent. You are an experienced nurse and are aware that it is likely that Sandra has a bowel obstruction which may mean that her life expectancy is as short as days to weeks. You are concerned that her symptoms are not controlled which is impacting on quality time with her family.

You will point out to the candidate that Sandra has colicky pain and vomiting and that her oral medications are not helping.

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Patient instructions:

Patient- (Sandra)-
You are aware that you have metastatic ovarian cancer which is incurable and there are no further chemotherapy/ anti-cancer treatment options.
You attended clinic hoping for a different anti-sickness medication as you have been vomiting for the last 2 days, you feel better after you have vomited and are not particularly nauseated in-between.

You have not opened your bowels for 5 days. You are aware that you have ovarian cancer that has spread throughout your abdomen. You have colicky abdominal pain and your current medications do not seem to be helping your pain or vomiting as they were before.

You would not want surgery if this was offered. Your priorities are your family. You expect that with medications your symptoms will be controlled and that when your symptoms are settled you will be able to return home with your daughter.

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Running script

Scenario section	Patient status (physiology and speech)	Expected Actions
Initial assessment	HR: 88 BP: 110/72 RR: 16 SATS:94% O/E Vomiting Distended abdomen, absent bowel sounds	Diagnosis of obstruction in patient with advanced disease
IF asked for repeat observations they remain the same		
Management plan	As above	Considers alternative route of administration of medications Considers which antiemetic could be considered Considers NG tube for immediate relief of vomiting Clear communication with patient, relative and nurse in attendance
Nurse prompt to consider NG and surgery 'Do you think she needs an operation?' 'The last patient like this we had needed an NG tube" Prompt about antiemetic prescribing Prompt to prescribe,' is there anything I can give her now for her sickness?' If prescribes oral medication asks 'do you think she will keep it down?' If prescribes metoclopramide, asks "Might that make her colic worse? If needs further prompts can say "I think we have some guidelines.." and offers copy of guidelines		

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Oncology Dept
Specialist Hospital

Dear Dr. GP,

Re Sandra O'Neill NHS: 443443443443

Diagnosis: Metastatic Ovarian Cancer (Diagnosed 2016)
Treatment- Previous Carboplatin/ Paclitaxol (progressed on treatment)

Medications:
MST 20mg BD,
IR Oral Morphine 5mg PRN,
Metoclopramide 10mg TDS
Macrogol (laxido) PRN

I reviewed Mrs. O'Neill in clinic today accompanied by her daughter. Mrs. O'Neill remains relatively well, performance status 3.

She describes some difficulty with intermittent constipation for which she has been taking Macrogol with good effect.

We discussed recent CT scan which unfortunately shows further disease progression with extensive peritoneal deposits and moderate ascites. Sandra has progressed on chemotherapy and we have agreed today that the focus of her treatment should be palliative.

Follow up in 8 weeks' time, please do not hesitate to contact me before that if any concerns.

Yours Sincerely,

Dr. Oncologist

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Care after Death

Set up and resources

Simulation Area: Cubicle on ward/ quiet room

Prepared Documentation:

Documentation	**Description/location of document**	**E-version**
Patient notes	**Not required**	
A & E triage	-	
NEWS chart	**Not required**	
Medications chart	**Not required**	
Fluid balance chart	-	
ECG	-	
CXR / Imaging	-	
Blood results	-	
ABG results	-	
Patient stickers	-	
GP letter	-	
Trust Guidelines	Care after death booklet	
Screening tools	-	
Video footage	-	

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Additional Equipment:

Equipment	Description of equipment	Location of equipment
Drugs (syringe/ tablets/IV bag)	None	
Equipment	None	
Paperwork	None	
Markings on SimMan	None	
Clothing for SimMan	Pyjamas	

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Simulation Teaching Lesson Plan

Duration	10 minutes
Venue	SIM suite- remove manikin/ trolley
Participants	Manikin 1x actor (daughter) 1 x newly qualified staff nurse (plant)
Subject	After death care in hospital setting
Aim	Understanding of the practical issues involved in care after death and its importance in total EOLC

Learning outcomes	• How to care for a patient after death
	• Have accurate information about practical arrangements including
	  ○ (last offices),
	  ○ care after death booklet
	  ○ when to contact coroner
	  ○ accurate info about contacting (not going) to the bereavement office
	  ○ Viewing the body
	  ○ Chaplaincy
	  ○ Proper care for transport to mortuary (when body bag needed)
	  ○ Contacting GP
	• Communicate sensitively with family

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Patient Details

NAME:	Jack Wood	
DOB: 05/08/58	**Gender:** Male	**Weight: 68kg**
Setting:	**Mannequin in cubicle on hospital ward (start consultation in quiet room)**	
HPC:	It is 07:15am on a weekday and you are called to the gastroenterology ward where a 62-year-old male with end stage liver disease has died. You are informed that he was admitted with a spontaneous bacterial peritonitis which was successfully drained and treated with IV antibiotics. In the early hours of this morning he acutely deteriorated with a gastrointestinal bleed and died. 30 minutes ago, you confirmed death. His sister and NOK, Rose Wood was contacted via the phone when he deteriorated, she lives an hour away and has just arrived on the ward. The staff nurse has taken her to a side room before she heads to her brother's bed and phoned you to speak to them.	
PMH:	Alcohol abuse Cardiomyopathy – Pacemaker inserted 2016 Regular Surveillance for known Oesophageal Varices No recent operations	
DH:	Not required	
SH/FH:	Divorced. Living independently at home. No children. Close to his Sister and Nephew, who live in Yorkshire.	
Allergies:	NKDA	

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Candidate Instructions:

It's 07:15am on a weekday and you are called to the gastroenterology ward where a 62-year-old male with end stage liver disease has died. You are informed that he was admitted with a spontaneous bacterial peritonitis which was successfully drained and treated with IV antibiotics. In the early hours of this morning he acutely deteriorated clinically with signs of a gastrointestinal bleed and died 30 minutes ago, you confirmed death.

The Gastroenterology Consultant is on the post take ward round but he has spoken to you and informs you that he will speak to you later this morning regarding cause of death for the death certificate, he has reviewed Jack during this admission and knowns him well from previous outpatient clinic attendances.

His sister and Next of Kin, Rose Wood, were contacted via the phone when he deteriorated, she lives an hour away and has just arrived on the ward. The staff nurse has taken her to a side room before she heads to her brother's bed and phoned you to speak to her.

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Nurse instructions:

You are newly qualified and have not been involved in the process of care after death of a patient. You have been looking after Jack today. You have prepared the body after death with the support of your colleagues and are waiting for the doctor to speak to Jack's family.

If asked you will reassure Rose that Jack was peaceful at the time of death. You are aware that Jack is a religious man and have contacted the Chaplaincy Team who have visited Jack after death.

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Daughter instructions: Jack Wood's sister, Rose Wood

You have been phoned at home as your brother's condition has changed again. You arrive on the ward just after he has died.
You are appropriately sad about your brother's death but not overwhelmingly distressed. He has been in and out of hospital for the past few months due to worsening problems with his liver. He has been an alcoholic for many years. This is his 4th admission in 5 months, each time he was admitted medics had told Jack his health was declining and that he may die if he continued drinking. You were both aware that he had a DNACPR form in his notes. You have attended all his appointments with the gastroenterology team and know that he had oesophageal varices which were being monitored.

Over the past few months you had noticed Jack struggling at home- becoming more fatigued and shorter of breath when his ascites worsened. He was admitted to hospital with another infection of the fluid in his abdomen. You were aware that he had it drained and that he was on antibiotics. Yesterday you visited him and although he was brighter you could see he appeared more unwell. You were told over the phone by the nurse that he had deteriorated. He died quickly and peacefully which was what you and the rest of the family had wanted for him. You had asked for the Chaplain to visit Jack on the ward as he often got comfort from his faith – you are reassured when the nurse (plant) tells you that the Chaplaincy team has been informed of Jack's death and have visited. If it is not offered, you can ask for the Chaplain to be called again to see you now.

You want to know what will happen now. Your son (Jack's Nephew) and other members of the family will be coming to the hospital- they live further South so they could arrive late tonight or tomorrow. They will want to see Jack. You want to know where he will be and if they can see him? You ask more questions about how they will move your brother from the ward.

You will be in charge of the practicalities and so need to know how you will obtain the death certificate. If the bereavement office is mentioned you ask if you should go there tomorrow morning first thing to get the certificate You are a medical secretary and have heard about patient's who die sometimes needing to go to the coroner, which, to your knowledge can delay organisation of funeral plans. You want to know if Jack's case will need to be discussed with the coroner and when you would get the death certificate?

You ask how others involved in Jack's care will know what has happened? His gastroenterology consultant and the GP?

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Running script

Scenario section	Relative status	Expected Actions
Microteaching session for 10 mins	**N/A**	**Interactive session covering** -last offices -Viewing the body -Proper care for transport to mortuary (when body bag needed) -Not for coroner discussion- when would coroner be involved?
Breaking bad news	N/A	Appropriate breaking bad news - sensitive setting - ascertain understanding - warning shot - empathy - check if questions
At 3 minutes if not already told, sister to ask directly "has he died" Nurse ask if any questions,		
Answering questions/ seeing body (continue by bedside or back in quiet room)	-Has chaplain been contacted? -Ask to see brother? -Can rest of family see him too? -What about Nephew coming up to see him- may not make it until late tonight or morning. -Where will brother go? How? -Will he need a post mortem or coroner discussion? -How do I get the death certificate? -Should I go to register death first thing? -How will others know? GP? Gastro consultant?	-Suggest calling chaplain to see sister -Answer questions -Offer written information -Explain he does not need coroner input, as cause of death known.
Nurse also suggest written information from ward Nurse suggest calling chaplain		

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Catastrophic Bleed

Set up and resources

Simulation Area: Gastroenterology Ward

Prepared Documentation:

Documentation	Description/location of document	E-version
Patient notes	Patient Emergency Healthcare Plan - Comfort measures in the event of a significant GI bleeds. Does not want endoscopy and to avoid IV therapies. Knows could die as a result of a big bleed. Would want to be made less aware if this were to occur. Advanced Statement - Comfort is a priority - Does not want camera tests or other invasive tests. DNACPR	Need completed EHCP, Advanced Statement and DNACPR
A & E triage	No	
NEWS chart	Require completed NEWS chart	
Medications chart	Present: Lactulose 15ml QDS Rifaximin 550mg BD Multivitamin 1 Daily Thiamine 100mg TDS Spironolactone 200mg daily Propranolol 40mg BD	Completed drug kardex
Fluid balance chart	No	

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ECG	Can have one available taken on hospital admission – sinus rhythm	
CXR / Imaging	If wanted can have normal CXR (taken on admission)	
Blood results	Bilirubin 54 ALP 240 ALT 98 Albumin 19 Potassium 3.0 Sodium 130 Urea 2.5 Creatinine 50 Hb 89 WCC 6.5 Plt 74 PT 20	Require blood results
ABG results	No	
Patient stickers	Need to have on documentation	
GP letter	No	
Trust Guidelines	Northern England Clinical Networks Palliative and End of Life Care Guidelines available on request.	
Screening tools	No	
Video footage	No	

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Additional Equipment:

Equipment	Description of equipment	Location of equipment
Drugs (syringe/ tablets/IV bag)	No IV access (hide venflon on SIMman) Stethoscope	
Equipment	Dark Towels available Vomit bowel full of red fluid	
Paperwork	• Gastro Clinic letter from 2 months earlier. Advanced Liver disease (Child-Pugh C) from alcoholic cirrhosis. Recurrent ascites needing drainage. OGD 6 months ago grade 2 oesophageal varices. Increasingly dependent. Referral to community PC team for support in Advance Care Planning (ACP) and symptom control. • Ward round notes • EHCP- Patient has deteriorated in recent weeks at home, ACP has been done in the community – if deteriorates does not want invasive treatments.	
Markings on SimMan	Nil	
Clothing for SimMan	PJs	

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Simulation Teaching Lesson Plan

Duration	15 min scenario 30min feedback
Venue	Simulation Centre
Participants	Candidate 1 x technician 1 x nurse (+ 1 healthcare assistant available to help if needed) 1 x gastro reg/palliative care reg on phone for advice if needed
Participants level of knowledge	IM trainees
Subject	End of life care Terminal bleed from known oesophageal varices
Aim	To identify the patient is having a catastrophic bleed (from known oesophageal varices) and this is likely to be a terminal event. Manage bleed and associated symptoms. Support end of life care needs in this acute situation. Identify has EHCP and advanced statement about management of such events Offer Team support and remain calm.
Learning outcomes	1. Identify the catastrophic bleed and likely cause (oesophageal varices) from clinical assessment. 2. Identify the patient already has advance care planning documents – to use them to guide decision making. 3. Create a plan to management terminal bleed that is consistent with patient previously stated wishes. (Use of SC anticipatory medications (including crisis order, use of towels, staying calm, someone stays with patient) 4. Offer support to ward nurse who is finding situation difficult. If appropriate checking proposed plan with senior colleagues/palliative care team. 5. Communicate clearly and sensitively.

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Patient Details

NAME:	John Adams	
DOB: 64 yrs	**Gender:** Male	**Weight:** 65kg
Setting:	Gastroenterology Ward	
HPC:	John was admitted to hospital 3 days ago with confusion and increasing abdominal ascites. He has advanced liver disease and is known to community palliative care team. He was found on admission to be constipated due to poor compliance with his lactulose. Since this has been re-established his bowels have been moving and his confusion has resolved. He has been getting increasing discomfort and breathlessness from abdominal ascites and the team are planning to place an ascitic drain tomorrow before making plans to get him home. The hospital palliative care team are due to review him tomorrow. He is already known to the community palliative care team who had been concerned he was deteriorating in recent weeks at home. He has come in with a DNACPR, EHCP and Advanced Statement which were reviewed on admission and confirmed to be consistent with Johns current wishes.	
PMH:	Advanced Liver Disease due to alcoholic liver cirrhosis. Recurrent ascites with previous abdominal paracentesis. OGD 6 months ago grade 2 oesophageal varices. Previous alcohol excess but has not drunk for >2 years.	
DH:	Present: Lactulose 15ml QDS Rifaximin 550mg BD Multivitamin 1 Daily Thiamine 100mg TDS Spironolactone 200mg daily Propranolol 40mg BD	
SH/FH:	Lives alone in ground floor flat. TDS package of care and daughter (Louise) lives locally and visits often. Louise is aware of John's advanced care planning documents and decisions. She has also recognised a general decline in his overall condition in recent weeks.	
Allergies:	None known	

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Candidate Instructions:

You are the evening ward cover doctor on for medicine. While you are on the gastroenterology prescribing fluid for a patient a healthcare assistant grabs you are asks you to go urgently into cubicle 6 to help with a patient who has become acutely unwell.

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Nurse instructions:

You are a nurse on a 12 hour day shift on the gastroenterology ward. You have been looking after John all day today and he seemed to be doing OK. You know he came in with decompensated liver disease due to constipation caused by poor compliance with his lactulose. He has opened his bowels twice on your shift today (soft stool, no melaena). His observations were checked once earlier today and they were ok apart from a low blood pressure which is normal for John.

During your shift John has been reviewed by the gastroenterology who were happy his bowels were opening and that his confusion from admission seemed to be settling. They are planning to drain his abdominal ascites tomorrow and start discharge planning. The hospital palliative care team are also due to review tomorrow to review symptoms and support discharge planning. You are aware that John has been deteriorating generally at home and a few weeks ago undertook some advance care planning at home. There is a copy of his advanced statement and emergency healthcare plan in his notes but you have not had a chance to look at them.

When you attended John to administer his evening medications you noticed he looked awful. He was grey with a clammy/waxy appearance. He told you he felt dizzy and sick and you just have witnessed him vomited up lots of fresh red blood (filling 3 large bowels). John is now less responsive and you have asked the healthcare to urgently get medical help. You are aware that John has a DNACPR. You were wondering about doing some observations while the doctor enters.

You think John is having an upper GI bleed but have never actually witnessed a patient having one before so you are understandably somewhat panicked. When the doctor enters you want to make sure they are aware that how much blood his has vomited.

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Running script

Scenario section	Patient status	Expected Actions
Initial assessment	Patient drowsy but restless Patient groaning/moaning Patient continuing to retch HR: initially 125, pulse weak and thread. Drops significantly during assessment to <30. Patient is cool peripherally. CRP 6 seconds. BP: un-recordable RR: 10 – dropping during assessment SATS: 80% (air) – dropping during assessment. Temp: 36.4 BM – no BM machine available. O/E quiet breath sounds and reduced respiratory effort. Abdo: Distended with ascites, non tender to palpation No other bleeding site apart from haematemesis.	Gain a history from the nurse Recognise acute large volume haematemesis. Identifies acutely unwell patient with rapidly deteriorating status. Identified ACP documents stating his wishes. Identifies that maybe a terminal event.
Nurse prompts if these areas haven't been covered: Why is he vomiting blood doctor? Highlight the large volume and acute change in status. Do you think he is dying doctor? Reminds doctor the patient is known to palliative care team and prompts towards their documentation and advance care planning documents What can I do to help doctor?		
Care planning		- Identify and acknowledge that the patient having an acute upper GI bleed most likely from known oesophageal varices.

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		- Recognised acutely deteriorating situation and that this maybe a terminal event. - Recognises patient's wishes for care set out in ACP documents. Comfort and dignity are priorities, does not want endoscopy of invasive treatments. If having a terminal bleed would want medications to make less aware. Makes plan which is consistent with these wishes. - Prescribe crisis order midazolam 10mg SC/IM and instructs nurse to give (may need prompt to guidelines to support prescribing). Prescribes other anticipatory medications as patient clearly dying. - Identifies dark towels have been left in the room and uses them appropriately. - Recognises support needs to be offered to nurse/healthcare - Stays calms and makes sure someone stays with the patient. - If has time to consider calling daughter ASAP to attend/delegates this to another member of staff. - Consider seeking senior support – which will be provided by the phone (although this not essential)
Nurse prompts if these areas haven't been covered: Should we contact his family? Should we give him some medications? Should I stay with him? Can we use these towels?		

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Supporting documents

SIM Hospital
England

Dear Dr GP:

RE: Mr John Adams, Aged 64

Diagnoses:
Advanced Liver disease (Child-Pugh C) from alcoholic cirrhosis.
Recurrent ascites needing drainage.
OGD 6 months ago grade 2 oesophageal varices.

Medications:
Lactulose 15ml QDS
Rifaximin 550mg BD
Multivitamin 1 Daily
Thiamine 100mg TDS
Spironolactone 200mg daily
Propranolol 40mg BD

I reviewed Mr Adams in clinic today. Unfortunately, he reports that he has been more unwell since our last review. He has not been out of the house except for doctor's appointments and is now spending most of his days in bed. Over the last few weeks he has been unable to care for himself effectively and so now has carers four times a day. I have reviewed Mr Adam's previous endoscopy and we have discussed future options, endoscopic intervention in the future is unlikely to be successful and Mr Adam's expressed that he would not want an endoscopy again even for potentially life sustaining treatment. He has been referral to community palliative care team for support in Advance Care Planning (ACP) and symptom control. I have not arranged to see him again in clinic because his trips to the hospital are becoming too burdensome but would be happy to provide any advice in the future if required,

Kind regards

Dr Gastro

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DEPARTMENT OF GASTROENTEROLOGY

TODAY

WARD ROUND DR GASTRO

64-year-old gentleman with known liver cirrhosis and varices

Admitted with worsening symptomatic ascites and intermittent confusion.

Generally better today, confusion resolving bowels opening
Complaining of discomfort and breathlessness due to abdominal swelling

On Examination
Significant ascites with shifting dullness

Impression

- Decompensated liver cirrhosis due to constipation (non-compliance with lactulose).- improved
- Symptomatic ascites

Plan

- Paracentesis
- Await review hospital palliative care team
- Discharge planning – known to community palliative care team and has EHCP- for FU when home.

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Advance Care Planning Documentation

Regional variation of the forms exists and therefore the local versions, should be completed prior to running the scenario

For the NE of England
https://www.northerncanceralliance.nhs.uk/deciding-right/deciding-right-regional-forms/

For Regions utilising respect
https://www.eolc.co.uk/educational/the-respect-form/
https://www.resus.org.uk/respect/?assetdeta3af2d45-c6ff-4793-84c9-61858f65b520=31453&p=2

The following sentences should be included;

If John experiences bleeding from his stomach or bowel he would like to be managed conservatively. Does not want endoscopy. If is felt to be part of a terminal event would want to be made comfortable and less aware.

To given 10mg SC/IM midazolam in the event of a large bleed
Use of dark towels to minimise appearance of blood
Someone to stay with John and for the environment to be kept calm.

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Opioid Toxicity

Set up and resources

Simulation Area: Inpatient Respiratory Ward

Prepared Documentation:

Documentation	Description/location of document	E-version
Patient notes	Prior instructions Summary sheet – 67 year old gentleman with NSCLC and liver metastases for best supportive care DNACPR TEP – ward based ceiling of care	
A & E triage	Not required	
NEWS chart	Decreased RR and decreased Sats - required	
Medications chart	Morphine 30mg CSCI 2 days ago crossed off and rewritten yesterday as 60mg PRN morphine 10mg po 1 hourly signed for 5-6 times Tazocin 4.5g tds iv	
Fluid balance chart	no	
ECG	Not required as should focus on breathing	
CXR / Imaging	no	
Blood results	Yes demonstrates new onset acute renal failure	
ABG results	no	
Patient stickers	Required for documentation	
GP letter	no	
Trust Guidelines	Palliative Care Guidelines – NECN IF ASK	

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Additional Equipment:

Equipment	Description of equipment	Location of equipment
Drugs (syringe/ tablets/IV bag)	CSCI Morphine 30mg increased to 60mg and running – attached to patient	Kardex
Equipment	CSCI Morphine 60mg running- attached to patient Naloxone in syringe – 400micrograms – in volume 10ml SC cannula IV cannula x1 in situ O2 IVT	
Paperwork	Kardex (with copied front sheet to write stat naloxone on), DNACPR, TEP NEWS chart blood results	
Markings on SimMan	Nil required	
Clothing for SimMan	Nil specific	

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Simulation Teaching Lesson Plan

Duration	10 minutes
Venue	SIM suite
Subject	Opioid Toxicity
Aim	To deliver appropriate and safe opioid toxicity management
Learning outcomes	1. Safe and effective use of a syringe driver 2. Safe and effective use of naloxone 3. Management of non-complex symptoms including pain including appropriate PRN doses 4. Identification of patients with reversible causes of deterioration

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Patient Details

NAME:	Alfred Brown	
DOB: 10/01/54	**Gender:** Male	**Weight:** 82kg
Setting:	**Respiratory ward**	
HPC:	Admitted with pneumonia yesterday Vomiting	
PMH:	Lung cancer, liver metastasis. For best supportive care	
DH:	Zomorph 30mg BD converted on admission to CSCI morphine 30mg then increased to 60mg with 10mg PRN Tazocin No other PRN medications	
SH/FH:	Lives alone	
Allergies:	NKDA	

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Candidate Instructions:

You are the Medical IMT on nights at a busy District General Hospital. You are fast-bleeped to the Respiratory ward. On your arrival the nurse informs you that her patient is drowsy.

The patient is a 67 year old gentleman with metastatic non-small cell lung cancer for best supportive care. He was admitted yesterday with pneumonia and worsening chest pain.

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Nurse instructions:

Your patient has lung cancer and liver metastasis he was admitted yesterday with pneumonia. He has had problematic pain so when he was seen on the ward round his morphine was increased He has been difficult to rouse,

The patient is prescribed a CSCI containing Morphine 60mg/24 hours. It is running to time and there are no concerns about the site. The CSCI was increased last night from 30mg/24 hours. The patient has had pain and so has required 5-6 PRN doses of morphine 10mg SC over the last 12 hours.

You have worked on the respiratory ward for 5 years you have no idea why the patient is drowsy.

You have recently returned from maternity leave and though you can confidently follow instructions you do not feel able to prompt the doctor to carry out investigations or advise on treatment.

If not given naloxone continues to deteriorate nurse to point out that the patient is to point out ward based ceiling of care on TEP and DNACPR

Additional nurse prompts

The patient does not have COPD

If not considered – so what do you want me to do about the CSCI
If ongoing pain management not considered – so what do you want me to do about the pain?
If not considered – how frequently would you like me to do the obs?

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Patient instructions:

The patient is unresponsive to voice initially.
If given a large dose of naloxone patient becomes very distressed and starts screaming in pain.
If given the correct dose of naloxone patient wakes up and is orientated and comfortable

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Running script

Scenario section	Patient status (physiology and speech)	Expected Actions
Initial assessment	HR: 80 BP: 114/86 RR: 7 SATS: 82% (air) BM 7.2 O/E: Eyes half open Pinpoint pupils	• ABC approach • Identifies opioid toxicity. • Maintains patient safety/airway. • Asks for Oxygen to be applied (if sats checked and hypoxia noted). • Asks for BM. • Consults kardex. • Prescribes a titrated dose of naloxone. 400mcirograms titrated up to 10ml. 20micrograms given every 2 minutes titrated to effect
Resulting scenarios		
If 400micrograms or more given of Naloxone as a stat dose	RR 20 Sats 99 HR 130 O/E normal eyes and pupils Screaming +++ Nausea and vomiting Sweating	
No Naloxone	Continues to deteriorate Nurse to acknowledge TEP and DNACPR but to prompt ++	
Correct Management- Stop opioid Dilute 400micrograms naloxone in 10mls 0.9% sodium chloride Give 0.5ml (20micrograms naloxone) every 2 minutes IV until respiratory recovery.	HR: 100 BP: 125/78 RR: 16 SATS: 92% (air) or 100% on O2 BM 7.2 RR and sats Increase over 1 minute O/E normal eyes and pupils Normal conversation Comfortable	• Perform ABCDE re-assessment. • Review drug chart. • Review blood results • Suggest ways to manage pain • Consider reviewing Palliative Care Guidelines and/or asking for help from the Specialist Palliative Care Team if unsure how to proceed.

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Review renal function, pain and analgesic requirements.		• Indicate would discuss changes to prescription with patient/family
Nurse may prompt to consider seeking specialist advice/senior assistance if candidate unsure.		

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Seizure Management

Set up and resources

Simulation Area: Palliative Care Unit

Prepared Documentation:

Documentation	Description/location of document	E-version
Patient notes	Care of dying patient document DNACPR TEP	
A & E triage	No	
NEWS chart	No- stopped routine obs	
Medications chart	Dexamethasone 8mg OM PO (not taken as too sleepy for last 2 days) CSCI Morphine 10mg/24 hours and Buscopan 60mg/24 hours	
Fluid balance chart	No	
ECG	No	
CXR / Imaging	No	
Blood results	From 1 week ago plus contemporaneous BM	
ABG results	No	
Patient stickers	Yes	
GP letter	No	
Trust Guidelines	Palliative Care Guidelines	

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Additional Equipment:

Equipment	Description of equipment	Location of equipment
Drugs (syringe/ tablets/IV bag)	CSCI Morphine 10mg/Buscopan 60mg (in situ and running to time) Midazolam for injection 5mg/ml x 4 vials (x2 10mg doses) Lorazepam for injection 4mg/ml x 2 vials Water for injection 5ml vials x 4	
Equipment	Syringe driver 5ml syringes x4 Subcut needles x4 Short line x2 IV cannula x2, tourniquet, sterile swabs, Tegoderm dressing Gauze or cotton wool Medical tape	
Paperwork	NA	
Markings on SimMan	Nil required	
Clothing for SimMan	Nil specific	

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Simulation Teaching Lesson Plan

Duration	10 minutes with 30min debrief
Venue	SIM suite
Participants	Candidate, SIM-woman, Nurse
Participants level of knowledge	IM trainee
Subject	Seizure management for a dying patient
Aim	To deliver appropriate and safe seizure management for a dying patient,
Learning outcomes	5. Provide appropriate initial management of a seizure for a dying patient. 6. Consider the potential underlying causes of a seizure in a dying patient. 7. Prescribe appropriate ongoing seizure prophylaxis for a dying patient.

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Patient Details

NAME:	Paul O'Brien	
DOB: 10/01/64	**Gender:** Male	**Weight:** 70kg
Setting:	**Palliative Care Unit (On call General Medicine SpR overnight)**	
HPC:	Admitted for end of life care four days ago. Deteriorating daily. Care supported by the care of dying patient document. No oral intake for two days.	
PMH:	Glioblastoma multiforme diagnosed one year ago, progressive despite surgery/chemotherapy/radiotherapy. Neuro-oncology MDT decision for best supportive care four months ago. Previously fit and well.	
DH:	Dexamethasone 8mg OM PO CSCI Morphine 10mg/24 hours and Buscopan 60mg/24 hours	
SH/FH:	Lives with wife and two children – Beth aged 6 years and Simon aged 4 years. Previously worked as a joiner.	
Allergies:	NKDA	

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Candidate Instructions

You are the Medical SpR on nights at a busy District General Hospital. You are fast-bleeped to the Palliative Care Unit. On your arrival the nurse informs you that her patient is having a seizure.

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Nurse instructions:

Your patient has Glioblastoma multiforme and was admitted four days ago for end of life care. His care is supported by the CDP. He is deteriorating daily. He has been difficult to rouse and has not managed food, drink or any oral medication for the last two days.

The patient is prescribed a CSCI containing Morphine 10mg/24 hours and Buscopan 60mg/24 hours. It is running to time and there are no concerns about the site. The CSCI was started the day following admission and has effectively managed headache and secretions. The patient has not required any PRN medication for two days.

You have worked on the Palliative Care Unit for 5 years and have seen several patients have a seizure in the past. You are confident that your patient is having a seizure and have alerted the on-call doctor immediately. The doctor arrives approximately 5 minutes from the onset of the seizure.

You have recently returned from maternity leave and though you can confidently follow instructions you do not feel able to prompt the doctor to carry out investigations or advise on treatment.

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Patient instructions:

The patient is unresponsive to voice throughout and having a seizure.
Will stop within 1 min if given iv lorazepam or 2 mins if given subcut midazolam

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Running script

Scenario section	Patient status (physiology and speech)	Expected Actions
Initial assessment	HR: 110 BP: 114/86 RR: 16 SATS: 86% (air) BM 7.2 O/E: Grand mal seizure activity on arrival of the candidate. This terminates within 1- 2 minutes of administration of a Benzodiazepine.	• Identifies seizure activity. • Maintains patient safety/airway. • Asks for Oxygen to be applied (if sats checked and hypoxia noted). • Asks for BM. • Enquires as to duration of seizure (5 minutes). • Prescribes a stat Benzodiazepine (ideally Midazolam 5-10mg subcut, acceptable to give Lorazepam 2mg/min up to 4mg IV). • Notes time Benzodiazepine given (would need to repeat after 10-20 minutes if not resolved – can be included in Discussion).
Nurse explains seizure has been ongoing for 5 minutes If candidate unsure what to do, offer guidelines Nurse suggests noting time Benzodiazepine administered		
Ongoing management	HR: 100 BP: 105/78 RR: 16 SATS: 92% (air) or 100% on O2 BM 7.2 O/E Unresponsive to voice, no evidence agitation or distress. Airway patent. No further seizure activity. Pupils equal and reactive to light. Longstanding left sided weakness. Upgoing plantars bilaterally. No other focal signs.	• Perform ABCDE re-assessment. • Review drug chart. • Identify patient has not had oral Dexamethasone 8mg for 2 days. • Prescribe subcut Dexamethasone 6.6mg OM. • Identify need for ongoing seizure prophylaxis. • Prescribe Midazolam 20-30mg/24 hours via CSCI. • Prescribe Midazolam 5-10mg subcut PRN for seizures.

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		• Consider reviewing Palliative Care Guidelines and/or asking for help from the Specialist Palliative Care Team if unsure how to proceed. • Indicate would discuss changes to prescription with family.
Nurse may ask 'why do you think this has happened now, he's been fine for weeks' Can go on to prompt, is It because he's not managed his tablets? prompt to consider seeking specialist advice if candidate unsure. Nurse may state 'shall I call his wife?'		

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Shortness of breath at the end of life

Set up and resources

Simulation Area: Respiratory ward

Prepared Documentation:

Documentation	Description/location of document	E-version
Patient notes	TEP – ward based ceiling of care DNACPR	Need completed TEP and DNACPR
A & E triage	No	
NEWS chart	Require completed NEWS chart	
Medications chart	Present: Simvastatin 40mg Aspirin 75mg Tazocin 4.5 grams IV TDS – started 48hrs ago	Completed kardex
Fluid balance chart	No	
ECG	Can have one available – sinus tachycardia rhythm	
CXR / Imaging	Recent CXR – aspiration pneumonia	
Blood results	CRP 90, WCC 12, Normal renal function	Require blood results
ABG results	No	
Patient stickers	Need to have on documentation	
GP letter	No	
Trust Guidelines	Local Palliative Care Guidelines e.g. NECN guidance page 28 'breathlessness at the end of life'. Care of the dying patient document- if requested	
Screening tools	No	
Video footage	No	

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Additional Equipment:

Equipment	Description of equipment	Location of equipment
Drugs (syringe/ tablets/IV bag)	IV access Stethoscope Oxygen via mask	
Equipment	No	
Paperwork	DNACPR TEP Prescription chart (Further prescription chart for debrief)	
Markings on SimMan	Nil	
Clothing for SimMan	PJs	

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Simulation Teaching Lesson Plan

Duration	15 min scenario 30min feedback
Venue	SIM suite
Participants	Candidate 1 x technician 1 x nurse (plant)
Subject	End of life care Breathlessness & agitation at end of life
Aim	To assess and manage breathlessness and agitation at end of life
Learning outcomes	6. Management of breathlessness and agitation including commencement of syringe driver 7. Consider any reversible causes of agitation 8. Development of individualised care plans including hydration at the end of life (possibly using care of the dying patient document) 9. Effective teamwork and communication with colleague (nurse)

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Patient Details

NAME:	Rose White	
DOB: 83 yrs	**Gender:** Female	**Weight:** 45kg
Setting:	**Respiratory ward**	
HPC:	Rose is a frail lady with multiple comorbidities. She had a dense right TACS six months ago with limited improvement with rehabilitation. Since then, she has been living in a nursing home, is bed bound and fully dependent for all ADLs. Rose was admitted to hospital three days ago with SOB, productive cough and fevers. She has been assessed to have an unsafe swallow. She has had 48 hours of IV antibiotics but has deteriorated despite this with increasing oxygen requirements and is no longer responsive.	
PMH:	TACS IHD Hypertension Osteoarthritis Macular degeneration	
DH:	Simvastatin 40mg Aspirin 75mg Tazocin 4.5 grams TDS – started 48hrs ago	
SH/FH:	Lives alone NOK niece Sandra who lives in Manchester	
Allergies:	NKDA	

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Candidate Instructions

You are the on-call weekend doctor. You have been asked to come to the respiratory ward to review Rose as she is very breathless and agitated. You have not met Rose before. She is an 83-year-old frail lady who lives in a nursing home and is dependent for ADLs after a stroke six months ago. She admitted to hospital 48 hours ago with SOB and cough. Despite IV antibiotics, there has been a general deterioration and it is now clear she is dying. You have been asked to review her to review her symptoms.

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Nurse instructions

You are a nurse working on a respiratory ward. You have been looking after Rose since she was admitted. She is an 83-year-old lady who is frail and has multiple comorbidities. She lives in a nursing home after having had a stroke 6 months ago, she is dependent for all ADLs and is bed bound. She came in to hospital because of a fever and breathlessness. Since then there has been a gradual deterioration. She has had her swallow assessed and it is unsafe so she is currently NBM. She was started on IV antibiotics 48 hours ago for an aspiration pneumonia. She is not able to communicate verbally but until the last 24 hours had been able to make her wishes known by nods.

You are very worried about Rose. You have seen her deteriorate rapidly over the past 24 hours and you know she is now dying. She is very agitated and breathless. You are unable to get her to take any of her medications. She has been struggling with breathlessness and is very distressed by this. She keeps pulling her oxygen mask off. You are worried that she is unsettled and not sure why.

You have called her niece Sandra who is her NOK and lives in Manchester. You have explained Rose is less well and Sandra is on her way to visit her now.

Rose has a DNACPR and a TEP which states that she is not for escalation of care past ward level.

You have done some observations before the doctor arrived which show a high respiratory rate, low oxygen levels (82%) and tachycardia. Rose had bloods tests two days ago when started on antibiotics which were normal apart from CRP 90, WCC 12.

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Running script

Scenario section	Patient status	Expected Actions
Initial assessment	HR:115 BP: 106/70 RR: 28 SATS: 82 Temp: 36.4 BM 6.6 O/E Creps in right upper lobe Patient is drowsy Patient is cool peripherally Oxygen mask lying on patient's chest	Gain a history from the nurse Examine the patient's chest and abdomen looking for reversible signs of agitation Identify the patient is breathless and agitated
Nurse prompts if these areas haven't been covered: Can we give her something to help her breathe? Why do you think she is agitated doctor? She hasn't managed to take any medication this morning.		
Care planning		Make a plan to manage the patient's breathlessness and agitation, including commencing syringe driver. Consider appropriate changes for end of life care: - Symptom management - Anticipatory prescribing - Rationalising medications - Fluids - Observations - Documentation - Spiritual care - Oxygen
Nurse prompts if these areas haven't been covered: Can I give her something for her breathing now? Do you think that stop her being so agitated? What will I do if it doesn't? (Consider Midazolam as well as Morphine) How long will the medicine last? What we do when it wears off? Do you want observations done? What shall I do about her oxygen? She can't drink – should we give her some fluids?		

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Stopping Dialysis

Set up and resources

Simulation Area: A and E cubicle

Prepared Documentation:

Documentation	Description/location of document	E-version
Patient notes	**None**	
A & E triage	**Optional**	
NEWS chart	**Not required.**	
Medications chart	**Medications included on letter**	
Fluid balance chart	**Not required**	
ECG	**Not required**	
CXR / Imaging	**-**	
Blood results	**Most recent bloods failed**	
ABG results	**-**	
Patient stickers	**-**	
GP letter	**Renal letter**	
Trust Guidelines	DNACPR form to complete if required NECN guidelines if requested	

Additional Equipment:

Equipment	Description of equipment	Location of equipment
Drugs (syringe/ tablets/IV bag)	-	
Equipment	-	
Paperwork	Renal letter	
Markings on SimMan	No SimMan (move trolley and SimMan out of site)	

North East Palliative Registrar Research Alliance

Simulation Teaching Lesson Plan

Duration	15 minutes with 30mins debrief
Venue	A&E cubicle
Participants	IMT Niece (actor)
Subject	End-stage renal failure Patient's right to refuse treatments
Aim	The aim of this scenario is advance care planning at home. Delegates are expected to: 1. Assess the patient and their mental health. 2. Assess the patient's capacity, and suicide assessment. 3. Discuss options with the patient - whether she wants to die at home or in hospital. 4. Discuss DNACPR status and document accordingly. Refer for urgent palliative care assessment at home.
Learning outcomes	1. Assessing psychological aspects including presence of depression 2. Advance care planning including PPC/PPD and exploring options available with patient 3. Awareness of what services are available in the community for EOL care 4. Consideration of prescribing in organ failure and anticipatory meds 5. Ethical decision making including capacity (MCA) and withdrawal of treatment 6. Communicate clearly with care and compassion

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Patient Details

NAME:	Sylvia Hutchinson	
AGE: 78	**Gender:** Female	**Weight:** 87kg
Setting:	**A&E; Sylvia on bed, niece on chair**	
HPC:	Sylvia Hutchinson, is a 78 year old woman with advanced renal disease on a background of type 2 diabetes and multiple co-morbidities, who has been receiving HD at local renal unit for 5 years. She has been brought into A&E this morning by her niece who is concerned that Sylvia was more breathless and tired.	
PMH:	Hypertension, Type 2 diabetes; retinopathy, Ischaemic heart disease, Peripheral vascular disease, End-stage renal failure on haemodialysis.	
DH:	Dossett box dispensed by local pharmacy	
SH/FH:	Lives alone 3rd floor council flat, divorced with no children, BD package of care via social services. Niece, Janice, is NOK.	
Allergies:	NKDA	

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Candidate Instructions:

You are the medical registrar on call and today are working front of house in A&E seeing medical admissions, it's 1100 on a Monday. Sylvia Hutchinson, is a 78 year old woman with advanced renal disease on a background of type 2 diabetes and multiple co-morbidities, who has been receiving HD at local renal unit for 5 years.
She has been brought into A&E this morning by her niece who is concerned that Sylvia is more breathless and tired. The nurse at triage has tried to take her bloods several times and has failed.
You have 15 minutes to assess the patient, you are not required to examine her. Observations at triage were unremarkable.

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Janice (Niece) instructions:

You live in Portsmouth and came up to visit your Aunt last night. You last saw her 10 months ago and speak on the phone each month. You aren't particularly close but your Aunt doesn't have any children and you are her next of kin. You had been due to visit this week as you are up in Newcastle for a business meeting. Your Aunt didn't sound quite right when you phoned her a couple of nights ago, she seemed quiet and didn't really want to chat. You are now concerned that your Aunt is very tired and seems more breathless than usual. She refused to eat her breakfast as she said she felt nauseous. She didn't want to come to A&E but you have forced her to as you couldn't get a GP appointment for the next two days and you didn't know what else to do. You have a husband and two children at home, and are meant to be back this weekend for your youngest daughter's birthday party (it's Monday today).

You are shocked to hear that your Aunt has stopped dialysis and upset that she didn't feel that she could talk to you about it. However, you are reasonable and listen to what she has to say. You understand why she has come to this decision and accept your Aunts decision. You are keen to do anything you can to help, although you can't really stay up for more than 5 days.

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Sylvia (Patient) instructions: (well-dressed but looks tired)

You are a retired office worker. You have had type 2 diabetes for over 30 years. After your divorce 20 years ago, you struggled to manage your diabetes and your diet and as a result you developed multiple health complications including heart disease. Of note, you have had poor vision for the past 3 years, you suffer from pain in your feet and lower legs most days, and you have been receiving dialysis 3 times a week at your local dialysis unit for 5 years. If asked, you have a fistula (a port made using your blood vessels under the skin) on your left forearm, which is what they use to connect you to the dialysis machine. As a result of your multiple health complications, you can no longer do things you enjoy, such as reading, and you no longer go out except for attending dialysis, and you have become more and more dependent on the carers who visit you daily to assist you with your activities of daily living. You have a DNACPR that your GP completed a couple of months ago.

You have been feeling increasingly fatigued coming up to the hospital for your dialysis appointments and have decided that the time has come to stop dialysis completely- you missed your appointment for the first time last week. You have not discussed this with anybody. You are aware that stopping dialysis will mean that you die more quickly and you have also decided to stop medications (which you have been putting straight in the bin at home) to avoid 'prolonging things'.

You feel a bit less well after missing your dialysis- you know it will make you less well and are accepting of this- you have noticed your ankles are more swollen and you are breathless at rest but you are keen to avoid any further treatment that might prolong life and are happy to put up with any symptoms that result from your decision.

All your friends have already died or are in nursing homes. Dialysis- particularly over the last few months has become more of a burden than a benefit. You have had a good life and you feel you are ready to die and you do not want to be a burden to anyone. You have written a will and a funeral plan. You still enjoying watching your favourite soaps on TV and listening to audiobooks and have had no problems sleeping. You do not feel low in mood or anxious and you fully understand, and are at peace with, the consequences of your decision.

You know that your niece will be upset by your decision, but you didn't want to ring her at home and tell her what was happening. You are worried that she might try to make you re-start dialysis, something that you are not willing to do. You didn't want to come to A&E today but your niece called an ambulance and you felt pressured into coming. Now you just want to go home- you are very sure that you do not want to die in a hospital or hospice.

You do not have a hospital bed or a commode at home. You currently see the DNs once a week and have carers 2 times a day.

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Running Script

Her local dialysis unit are concerned about Joan as she has missed her last dialysis sessions and they have been unable to get hold of her by phone. Janice, Sylvia's niece, will prompt the doctor if required.

Scenario section	Relative status	Expected Actions
Minutes 1-5	If Sylvia doesn't tell the doctor that she has stopped dialysis after 3 minutes, then ask 'But you have still been attending your dialysis sessions haven't you'.	Take a brief history and establish that Sylvia has stopped attending dialysis and wants to stop all active treatment.
Minutes 6-10	If the doctor doesn't assess mood and capacity then this can be prompted by the niece: - are you doing this because you're depressed? (could tie in link to her Mum having an episode of depression and refusing treatment) - Asking the doctor; is she allowed to stop dialysis?	• Assess Sylvia's mental health (that she is not depressed) • Assess that Sylvia fully understand the decision and implications (that she will die more quickly)
Minutes 11-15	If doctor doesn't move on to discuss ACP then niece to prompt with; 'where can be Aunt be looked after?' 'How can she be looked after at home, what happens if she needs someone with her, or has pain/sickness etc' 'Isn't there anywhere else she can go?'	• Assess and acknowledge your end of life wishes Talk about advanced care planning and preferred place of care and overview of services available.
This is a lot to cover, and if when the scenario finishes the doctor hasn't covered services available and symptom control in end stage renal failure then this could be a 10 minute teaching session with whole group after the debrief. Signpost to NECN guidelines for symptom management in renal failure, highlight renal section of PCF and have a summary sheet with an overview of community services.		

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SIM Hospital
England

Dear Dr GP:

RE: Ms Sylvia Hutchinson, Aged 78,

Diagnoses:
Hypertension,
Type 2 diabetes; retinopathy,
Ischaemic heart disease,
Peripheral vascular disease,
End-stage renal failure on haemodialysis for last 5 years

Medications:
Ramipril 2.5mg OD
Insulatard 12 units am, 6 units pm
Simvastatin 20mg OD
Furosmide 20mg OD
Calcichew 1500mg BD
Sevelamer 800mg TDS
Alfacalcidol 1 microgram OD
Cinacalcet 30mg OD
Ferrous sulphate 200mg BD
Sodium bicarbonate 500mg TDS
Paracetamol 1gram QDS

It was a pleasure to see Ms Hutchinson in clinic today. She remains on haemodialysis three times a week via a fistula in her left arm. In recent weeks Ms Hutchinson has had several episodes of hypotension during dialysis, which has limited the amount of fluid that can be removed. We have asked her to start taking her ramipril at night instead of in the morning prior to dialysing and will review her on the dialysis unit over the next couple of sessions. If this remains an issues we will look to admit her for a period of in-patient dialysis to try help with her increasing fluid overload and will trial adjustments to the current dialysis regime.

Kind regards

Dr Renal

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Curriculum mapping IM Palliative Medicine

Generic CiP 8 – managing end of life and applying palliative care skills

It is anticipated that all of these skills will be covered in clinical practice in both specialist and non-specialist settings.

SIM 1 - Agitation at the end of life

SIM 2 - Bowel obstruction

SIM 3 - Care after death

SIM 4 - Catastrophic bleed

SIM 5 - Opioid toxicity

SIM 6 - Seizures

SIM 7 – Shortness of breath at the end of life

SIM 8 - Stopping dialysis

Descriptors	Resources
Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs	SIM 2 – Bowel obstruction - Bowel obstruction in patient with advanced metastatic ovarian cancer -Identify likely irreversible- holistic assessment - explores wishes for treatment - management of symptoms including appropriate antiemetic and commencing syringe driver -Support for carers/family. SIM 8 - Stopping dialysis - considers impact of treatment and implications of stopping and how to manage possible symptoms at home. SIM 4 - Catastrophic bleed - Identify the catastrophic bleed and likely cause and reversibility - Identify the patient already has advance care planning documents – to use them to guide decision making.

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	- Create a plan to management terminal bleed that is consistent with patient previously stated wishes. (Use of SC anticipatory medications)
Identifies the dying patient and develops and individualised care plan, including anticipatory prescribing at end of life	SIM 1 - Agitation at the end of life -Identifying dying, holistic assessment (physical, psychosocial, spiritual). - consider reversible causes of agitation -Prescribing medications for agitation -Anticipatory prescribing in the absence of symptoms (pain, breathlessness, agitation, nausea, respiratory secretions). -Nutrition and hydration including CANH. -Spiritual and cultural needs at the end of life. - debrief to include discussion about titration of opioid and non- opioid in syringe driver SIM 4 - catastrophic bleed - Identify the catastrophic bleed and likely cause (oesophageal varices) from clinical assessment. - Identify the patient already has advance care planning documents – to use them to guide decision making. - Create a plan to management terminal bleed that is consistent with patient previously stated wishes. (Use of SC anticipatory medications) SIM 6 - seizure -Provide appropriate initial management of a seizure in a dying patient. - Consider the potential underlying causes of a seizure in a dying patient. - Prescribe appropriate ongoing seizure prophylaxis for a dying patient. SIM 7 – SOB at the end of life -consider reversible causes of breathlessness -prescribing medication for breathlessness -individualised plan related to hydration at end of life
Demonstrates safe and effective use of syringe pumps in the palliative care population	SIM 1, 2 & 7 (including in debrief) -Indications for a syringe driver. -Prescribing a syringe driver including opioid and non-opioid medications. SIM 5 opioid toxicity - appropriate titration and how to manage toxicity

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	SIM 6 seizure - for ongoing seizure prophylaxis
Able to manage non complex symptom control including pain	SIM 1, 2 and 7: -Prescribing medications for uncontrolled symptoms (pain, breathlessness, agitation, nausea and vomiting, respiratory secretions) -Appropriate prescription and use of PRN medications SIM 5 - Opioid toxicity Know how to manage opioid toxicity in palliative setting SIM 8 - Stopping dialysis - Consideration of prescribing in organ failure -Assessing psychological aspects eg depression, -Ethical decision making e.g. withdrawal of treatment.
Facilitates referrals to specialist palliative care across all settings	SIM 8 - Stopping dialysis -Decision making re need for specialist palliative care input. -Referral pathways including services in hospital, community and hospice.
Demonstrates effective consultation skills in challenging circumstances	SIM 1-7 -Psychological support for carers/families. -Communication with patients and carers/families about dying. SIM 1, 2 & 8 -Advance care planning including PPC/PPD. SIM 3 - How to care for a patient after death - Have accurate information about practical arrangements after death - Communicate sensitively with family SIM 8 -Managing conflicting agendas/priorities including cultural aspects.
Demonstrates compassionate professional behaviour and clinical judgement	SIM1-8 -Identifying dying and/ or holistic assessment (physical, psychosocial, spiritual). -Demonstrating compassion within communication with patients and carers/families. -Non-judgemental approach.

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	-Appropriate professional behaviour in keeping with role of a doctor.

Descriptors	**Level descriptors by training year**		
	IM1	**IM2**	**IM3**
Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs	2	2	3
Identifies the dying patient and develops and individualised care plan, including anticipatory prescribing at end of life	2	2	3
Demonstrates safe and effective use of syringe pumps in the palliative care population	2	2	3
Able to manage non-complex symptom control including pain	2	2	3
Facilitates referrals to specialist palliative care across all settings	2	2	3
Demonstrates effective consultation skills in challenging circumstances	2	2	3
Demonstrates compassionate professional behaviour and clinical judgement	2	2	3

Ref page 42 of IMT stage 1 curriculum

Level descriptors:

Level 1 – entrusted to observe only – no execution

Level 2 – entrusted to act with direct supervision

Level 3 – entrusted to act with indirect supervision

Level 4 – entrusted to act unsupervised

Helpful references

Ambitions for palliative and end of life care: a national framework for local action 2015-2020. http://endoflifecareambitions.org.uk/

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Gold Standards Framework. Prognostic indicator guideline (PIG). Accessed via http://www.goldstandardsframework.org.uk/how-to-use-the-gsf-pig-in-your-practice

Health Education England. E learning for Health Modules: Acute Medicine (ACUMEN knowledge, Palliative Care modules 04_01 to 04_41), Death Certification, End of Life Care (e-ELCA modules 02_01 to 02_19). Accessed via https://portal.e-lfh.org.uk

Leadership alliance for the care of dying people. (2014). One chance to get it right. Accessed via https://www.gov.uk/government/publications/liverpool-care-pathway-review-response-to-recommendations

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Royal College of Physicians, RCP. (2018). Talking about dying: how to begin honest conversations about what lies ahead. Accessed via https://www.rcplondon.ac.uk/projects/outputs/talking-about-dying-how-begin-honest-conversations-about-what-lies-ahead

Silverman, J. Kurtz, S. Draper, J. Skills for Communicating with Patients. 3rd edition. (2013). CRC Press. London UK.

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PALL-SIM-IMT Faculty Evaluation Form

1. **Date of SIM Training: ……..**
2. **Region in the UK that SIM Training was undertaken: ……..**
3. **What was your role in the faculty?**
   - Consultant
   - Palliative Medicine Registrar
   - Teaching Fellow
   - Trust Doctor with experience (please state months experience)
   - SIM Co-ordinator
   - Other
4. **How long was the SIM?**
   - Full Day
   - Half Day
5. **How many participants were present?**
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - >8
6. **Please state the number of participants that were present in each category (If other is selected please state the learner's category).**
   - IMT -
   - CMT -
   - Other -
7. **How many scenarios were used?**
   - 3
   - 4
   - 5
   - 6

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- 7
- 8

8. **Which scenarios were used?**
   - Agitation at end of life
   - SOB at end of life
   - Seizure Management
   - Catastrophic Bleed
   - Stopping Dialysis
   - Care After Death
   - Opioid Toxicity
   - Bowel Obstruction
9. **Of the scenarios that were used on the day, which one provided the best teaching platform and why?**

10. **Of the scenarios that were used on the day, which did you encounter the most difficulties with and why?**

11. **Any other comments on the scenarios used?**

12. **Any other feedback for NEPPRA would be much appreciated in order for us to continue ongoing development and improvements on our SIM package.**

13. **Overall rating of SIM Package. (Please circle)**

Poor **Fair** **Good** **Very Good** **Excellent**

Thank you for your time

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PALL-SIM-IMT Candidate Evaluation Form

Before teaching:

Please rate the following statements by circling the number matching your response:

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I feel confident determining a patient's palliative and end of life care needs.	1	2	3	4	5
I feel confident identifying a dying patient and prescribing anticipatory medications at the end of life.	1	2	3	4	5
I am able to safely and effectively use syringe drivers in palliative care patients.	1	2	3	4	5
I can effectively manage non complex symptoms (e.g. pain, nausea) in palliative care patients.	1	2	3	4	5
I know when to refer patients for specialist palliative care input.	1	2	3	4	5
I have effective communication skills in challenging circumstances.	1	2	3	4	5
I am able to show compassion for palliative care patients and professional behaviour.	1	2	3	4	5

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After teaching

Please rate the following statements by circling the number matching your response:

Statement	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
I feel confident determining a patient's palliative and end of life care needs.	1	2	3	4	5
I feel confident identifying a dying patient and prescribing anticipatory medications at the end of life.	1	2	3	4	5
I am able to safely and effectively use syringe drivers in palliative care patients.	1	2	3	4	5
I can effectively manage non complex symptoms (e.g. pain, nausea) in palliative care patients.	1	2	3	4	5
I know when to refer patients for specialist palliative care input.	1	2	3	4	5
I have effective communication skills in challenging circumstances.	1	2	3	4	5
I am able to show compassion for palliative care patients and professional behaviour.	1	2	3	4	5

What did you think was most useful about the teaching session?

Is there anything you can suggest to improve the teaching?

Any final comments?

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Certificate of Attendance

.....

Attended a simulation training session in Palliative Medicine (PALL-SIM-IMT)

On .....

At.....

This included the following scenarios (please tick):

- **Agitation at the end of life** ☐
- **Bowel obstruction** ☐
- **Care after death** ☐
- **Catastrophic bleed** ☐
- **Opioid toxicity** ☐
- **Seizure management** ☐
- **SOB at the end of life** ☐
- **Stopping dialysis** ☐

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