Course Title	IMT3 simulation	Scenario Title	Bowel perforation in a frail elderly patient
Patient	Name: Miriam Hoffman Age: 89 years old Hospital number: MB920459		

Disclaimer	This scenario has been written by palliative care specialists but intended for delivery by generalist doctors for the simulation training of IMT3 level doctors. **Please adapt the scenario based on your local needs.** We strongly recommend that given the sensitive nature of the content, that faculty have sufficient formal training and faculty development prior to delivery of this sim.	
Learning Outcomes	Technical	Non-Technical
	• Limited/no reversibility – recognising dying • Absence of treatment escalation plan/DNACPR • Communication with (challenging) family member • Symptom control of pain: recognise on a background opioid and unable to swallow – safe initiation of syringe driver, SC PRNs with proportionate doses • Initiate an individualised care plan (5 priorities of care of the dying patient) • Escalate (specialist or from seniors) as appropriate using SBAR	• Appropriate escalation • Decision making • Managing uncertainty • Communication in challenging circumstances • Team working • Situational awareness • Supporting other colleagues during difficult conversations
Scenario Overview	89 year old nursing home resident, Miriam Hoffman, was admitted via A&E with new onset abdominal pain. CT abdomen showed a perforated bowel and surgeons have advised that there is no surgical option and to manage conservatively. They have recommended IV fluids but no one can cannulate Miriam. Miriam has been taken over by medics and seen by the medical F1 earlier who prescribed some PRN morphine immediate release oral solution (insufficient dose to background opioid, PO route no longer appropriate) and PRN PO/IV paracetamol and continued all other oral medications. Miriam was given paracetamol PO earlier for her pain but she struggled to swallow it and now is too drowsy to attempt it again. She is groaning in pain. The nurses report that she is “looking worse than earlier”. She has no agreed treatment escalation plan or CPR decision. Her family member will arrive partway through the sim and require an update of the situation. Requires urgent symptom control, treatment escalation plan, communication/breaking bad news to family	
Set Up	Setting: medical ward environment Patient: adult manikin Relative: **ideally an actor is used for this role**, less ideal would be a faculty member	

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Prop List	Paperwork: drug chart, patient notes including blood results (see below) Guidelines: local palliative care guidelines on anticipatory prescribing Telephone to call seniors

Console		Initial obs			
	RR	26			
	SpO_2	96% (on air)			
	HR	109			
	BP	87/55			
	Rhythm	Sinus			
	Temp	37.3			
	Eyes	Pupils equal and reactive			
Expected Actions	The participants will receive initial obs. They may attempt to give a fluid bolus but this will not alter the observations or clinical state of the patient. The obs will not deteriorate further but should remain static throughout Participants should complete an initial A to E assessment (some may wish to take bloods or give IV fluids), they will realise that this patient is rapidly deteriorating from an irreversible problem and seek senior support (either medical registrar/consultant, surgeons or palliative care team), they will need to communicate the bad news to the patient's relative				
End Point	Roughly 15 minutes for the scenario Participants should reach the stage of speaking to the patient's relative and breaking the bad news.				

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Participant briefing	You are the IMT3 doctor on the medical wards and have just received handover before your **NIGHT** shift. Mrs Miriam Hoffman has recently arrived on the medical wards following a long wait in A&E. Miriam is an 89 year old nursing home resident. She was admitted with new onset abdominal pain and diagnosed with a perforated bowel, confirmed on CT scan. The surgeons say she is not a surgical candidate and should receive conservative management. They have asked for the medical team to take over her care. The medical F1 saw Miriam during the day shift and prescribed some PRN pain killers. The nurse is just about to go home from the day shift and is worried about Miriam's pain control and her escalating distress. *Allow candidates time to ask questions if needing clarity on the case* *Please remember to give or point out the notes and drug chart for Miriam*
Patient Briefing	Groaning and drowsy with limited/no response to questioning

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Patient PMHx	**Past medical history:** Frailty, IHD, T2DM, AF, HTN, mild cognitive impairment, recurrent falls, osteoporosis, low BMI, osteoarthritis, chronic back pain, severe diverticular disease, reflux **Drug history:** • Amlodipine 10 mg OD • Warfarin – recently stopped due to repeated falls • Bisoprolol 5 mg BD • Pregabalin 75 mg BD • **Morphine modified release tablets 10 mg BD** • Furosemide 20 mg OM • Simvastatin 40 mg ON • Aspirin 75 mg OM • Metformin 500 mg BD • Gliclazide 80 mg OM • Lansoprazole 30 mg OM • Paracetamol 500 mg QDS PRN • Lactulose 10 mls BD • Macrogol 1 sachet BD **Allergies:** none **Social history:** Non-smoker, non-drinker Nursing home resident Global deterioration over months and now bedbound Hoist transfer Double incontinence Fully dependent for all care Has only 1 daughter/son who lives nearby **Treatment escalation plan:** none made

Investigations & results	**Blood results from ED yesterday**: Hb 90, WCC 14, Plts 90, INR 1.2 Na 132, K 5.1, Creatinine 40, eGFR >90 Bilirubin 12, ALP 50, ALT 45 CRP 112 **ABG now**: pH 7.25, pCO2 5, pO2 8, HCO3 26, BE -3, Lactate 7

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Plant (**nurse**) briefing	You are a proactive nurse and aware of the handover information above. You were on the day shift so have seen the changes across the daytime and express that Miriam keeps looking worse and worse. Earlier today Miriam was still moaning and able to answer simple yes/no regarding pain. Since this morning, she has been too drowsy to take her oral tablets. You are worried about how much pain Miriam appears to be in. **Prompt participants to give something for pain** **If they ask for a cannula, explain that no one can get one in. Plenty have tried and it causes Miriam great distress.** **If asked**, no one has mentioned end of life care verbally or in the notes. **If asked**, no family have been in today but you know that Miriam's son/daughter lives nearby and wants an update.
	Family member (actor/actress) briefing:

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Plant (**relative**) briefing	You live nearby, and your mum is the only family you have left. You have an estranged brother whom you haven't spoken to in years. The nursing home told you she was admitted to hospital overnight but you hadn't heard much more, and you have tried calling the ward for an update but no one answered or returned your calls. This upset you greatly. You haven't been able to see her in person for many months (due to COVID nursing home visiting restrictions) but you are aware of her general/global deterioration. 9 months ago, she was still walking with her Zimmer frame but she has gradually gotten weaker, fallen more often and in the last few months you are aware she has been unable to get out of bed at all. You admit she looked thin and frail when you last saw her (2 months ago) and you know she has lots of medical problems. Your primary concern right now is her **pain control** (as you are aware she was admitted with abdominal pain). **Push for pain relief to be given** **You ask what is happening** – participants should explain in layman's terms what a bowel perforation is (do not accept medical jargon), and they should relay the seriousness of the situation and that there is unfortunately no reversibility likely. Unfortunately your mum is sick enough to die and it is very likely she will die soon (potentially hours to short days). They should explain their approach which is to focus on symptoms and comfort, the role of anticipatory medications at the end of life and they should offer you support. Ideally they should explore any other individual needs you or your mum may have and sensitively enquire whether anyone else should visit her here to say goodbye. **"What are you doing for her pain?"** **"Are you telling me she is going to die? There's no chance she could recover from this?"** **"Why don't you just operate if she is going to die anyway without it?" "Is there nothing else you can do?"**
	With appropriate empathy and explanation, you should calm down and accept the bad news given. You agree to the DNACPR if it is explained compassionately. **Only if very specifically asked,** your mum is Jewish and she would want all Jewish rituals at the end of life to be observed. You, yourself, do not know much of the specifics however.

On Examination

	A	B	C	D
Colour	Pale			
Skin	Cool			
CRT	Prolonged			
GCS	E3 V2 M5			
Pain Score	Groaning, grimacing			

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	Abdomen	Diffusely tender			
Life Savers	**Highlight absence of DNACPR/TEP decision** (if this is not noticed or asked about by candidates) Prompt them to call for help/escalate if struggling Prompt them to address patient's severe pain				
Telephone Assistance					
	SURGICAL registrar SpR Salvatore (telephone):				
	You saw the patient in A&E and you've seen the scan. The perforation is large and unlikely to seal over and the mortality rate is expected to be very high. Miriam is not a surgical candidate due to her frailty and multi-morbidity. An operation would carry a high mortality rate, is unlikely to be successful and would not be in her best interests. You have not had time to communicate this to Miriam's next of kin. You think it is likely she will die in the next few hours to short days. As such, you feel she should not be under surgeons but to go under medicine. You are in theatre so you cannot assist in any further instructions or conversations with family or otherwise.				
	MEDICAL consultant (telephone):				
	You have not met the patient or been referred them. However, she does warrant further discussion and you listen to the handover. If they present a reasonable handover, ask the participant what they think is going on? It sounds like she is in the last hours to days of life. You feel it would be reasonable to focus on symptom control and set clear a clear treatment escalation plan and DNACPR decision – **prompt the participant as to what they think these decisions should be. Prompt them to speak to the family if not done so.**				

Debriefing	• Scenario should prompt a discussion about the challenges with recognising dying and managing uncertainty. • It should cover communication aspects (between team members and directly with patient's family member).

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	• It should discuss how to manage pain, including the safe use of a syringe driver and PRN medications

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References	• Each hospital should have their own local palliative care/management of the dying patient guidelines which includes support on anticipatory prescribing and how to access the palliative care team for advice 24 hours a day • Palliative care adult network guidelines https://book.pallcare.info/
Curriculum mapping	This scenario has been mapped to the IMT curriculum, capabilities in practice (CIP) 8 covers palliative care competencies. IMT3 doctor candidates should**;** Palliative care diagnoses: frailty and multi-morbid Identifies limited reversibility, recognises dying Address treatment escalation plan and DNACPR Communication in challenging circumstances (family) Symptom control of abdominal pain – non-pharmacological (repositioning) and pharmacological i.e. recognition that current prescriptions (incorrect route and not proportional to background MR morphine) Recognise on a background opioid and unable to swallow – safe initiation of syringe driver, SC PRNs with proportionate doses Initiate an individualised care plan for the dying patient (5 priorities of care of the dying patient) Escalate (specialist or from seniors) as appropriate using SBAR
Written by: Date: Review date:	Scenarios should be overseen by a faculty member with appropriate clinical, educational or simulation experience, reviewed & re-evaluated regularly. Written by: Theresa Tran (Theresa.tran@nhs.net), palliative medicine trainee Date: 29/06/2022 Reviewed and supported by: **PalliSim network members** pallisim Anna Bradley (palliative medicine registrar) Armita Jamali (palliative medicine consultant) Christina Chu (palliative medicine registrar) Ruth Caulkin (palliative medicine consultant) Louise Robinson (palliative medicine consultant) Stephanie Hicks (palliative medicine consultant) Please adapt the scenario to meet local needs.

PATIENT NOTES

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YESTERDAY

A&E clerking SHO Jones

89F nursing home resident
PC: new onset severe abdominal pain
Nursing home staff say newly grabbing abdomen today and grimacing in pain

Past medical history: Frailty, mild cognitive impairment, hypertension, atrial fibrillation, ischaemic heart disease, severe diverticular disease, Type 2 diabetes

Drug history:

- Amlodipine 10 mg OD
- Warfarin – recently stopped due to repeated falls
- Bisoprolol 5 mg BD
- Pregabalin 75 mg BD
- Morphine modified release tablets 10 mg BD
- Furosemide 20 mg OM
- Simvastatin 40 mg ON
- Aspirin 75 mg OM
- Metformin 500 mg BD
- Gliclazide 80 mg OM
- Lansoprazole 30 mg OM
- Paracetamol 500 mg QDS PRN
- Lactulose 10 mls BD
- Macrogol 1 sachet BD **Allergies:** none

Social history: Nursing home resident
Global deterioration over months and now bedbound, hoist transfer, double incontinence Fully dependent for all care
Has only 1 family member who lives nearby and tries to visit as often as possible

O/E: Chest clear, mildly tachycardic, groaning in severe pain
Abdomen diffusely tender with guarding centrally and rebound tenderness

Bloods in A&E :
Hb 90, WCC 14, Plts 90
Na 132, K 5.1, Creatinine 40, eGFR >90
INR 1.2
Bilirubin 12, ALP 50, ALT 45
CRP 112

Plan:

- **AXR**: pneumoperitoneum
- **CT abdomen pelvis**: bowel perforation. Severe diverticular disease. Constipation
- **Discussed with Surgical SpR Salvatore**: reviewed patient and scan, p-POSSUM very high, not a surgical candidate. For conservative management: give pain control and fluids. Refer to medics

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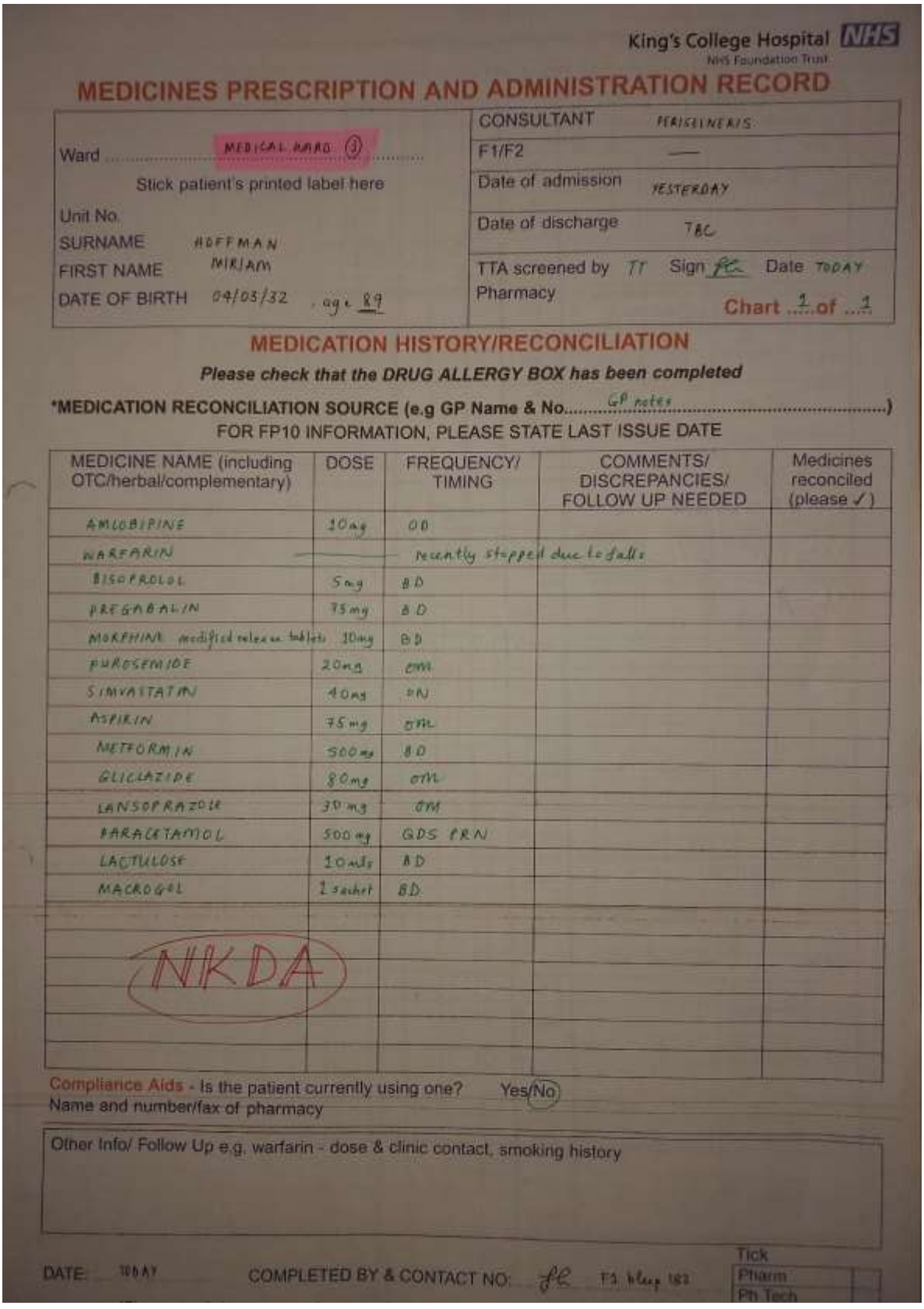

King's College Hospital NHS
NHS Foundation Trust

MEDICINES PRESCRIPTION AND ADMINISTRATION RECORD

Ward ..... MEDICAL WARD (3) .....
Stick patient's printed label here
Unit No.
SURNAME HOFFMAN
FIRST NAME MIRIAM
DATE OF BIRTH 04/03/32 age 89

CONSULTANT PERIGLINERIS
F1/F2 —
Date of admission YESTERDAY
Date of discharge TBC
TTA screened by TT Sign [illegible] Date TODAY
Pharmacy
Chart 1 of 1

MEDICATION HISTORY/RECONCILIATION

Please check that the DRUG ALLERGY BOX has been completed

***MEDICATION RECONCILIATION SOURCE (e.g GP Name & No.....GP notes.....)**

FOR FP10 INFORMATION, PLEASE STATE LAST ISSUE DATE

MEDICINE NAME (including OTC/herbal/complementary)	DOSE	FREQUENCY/ TIMING	COMMENTS/ DISCREPANCIES/ FOLLOW UP NEEDED	Medicines reconciled (please ✓)
AMLODIPINE	10mg	OD		
WARFARIN	—	recently stopped due to falls		
BISOPROLOL	5mg	BD		
PREGABALIN	75mg	BD		
MORPHINE modified release tablets	10mg	BD		
FUROSEMIDE	20mg	OM		
SIMVASTATIN	40mg	ON		
ASPIRIN	75mg	OM		
METFORMIN	500mg	BD		
GLICLAZIDE	80mg	OM		
LANSOPRAZOLE	30mg	OM		
PARACETAMOL	500mg	QDS PRN		
LACTULOSE	10mls	BD		
MACROGOL	1 sachet	BD		

NKDA

Compliance Aids - Is the patient currently using one? Yes/No
Name and number/fax of pharmacy

Other Info/ Follow Up e.g. warfarin - dose & clinic contact, smoking history

DATE: TODAY COMPLETED BY & CONTACT NO: [illegible] F1 bleep 182

Tick
Pharm
Ph Tech

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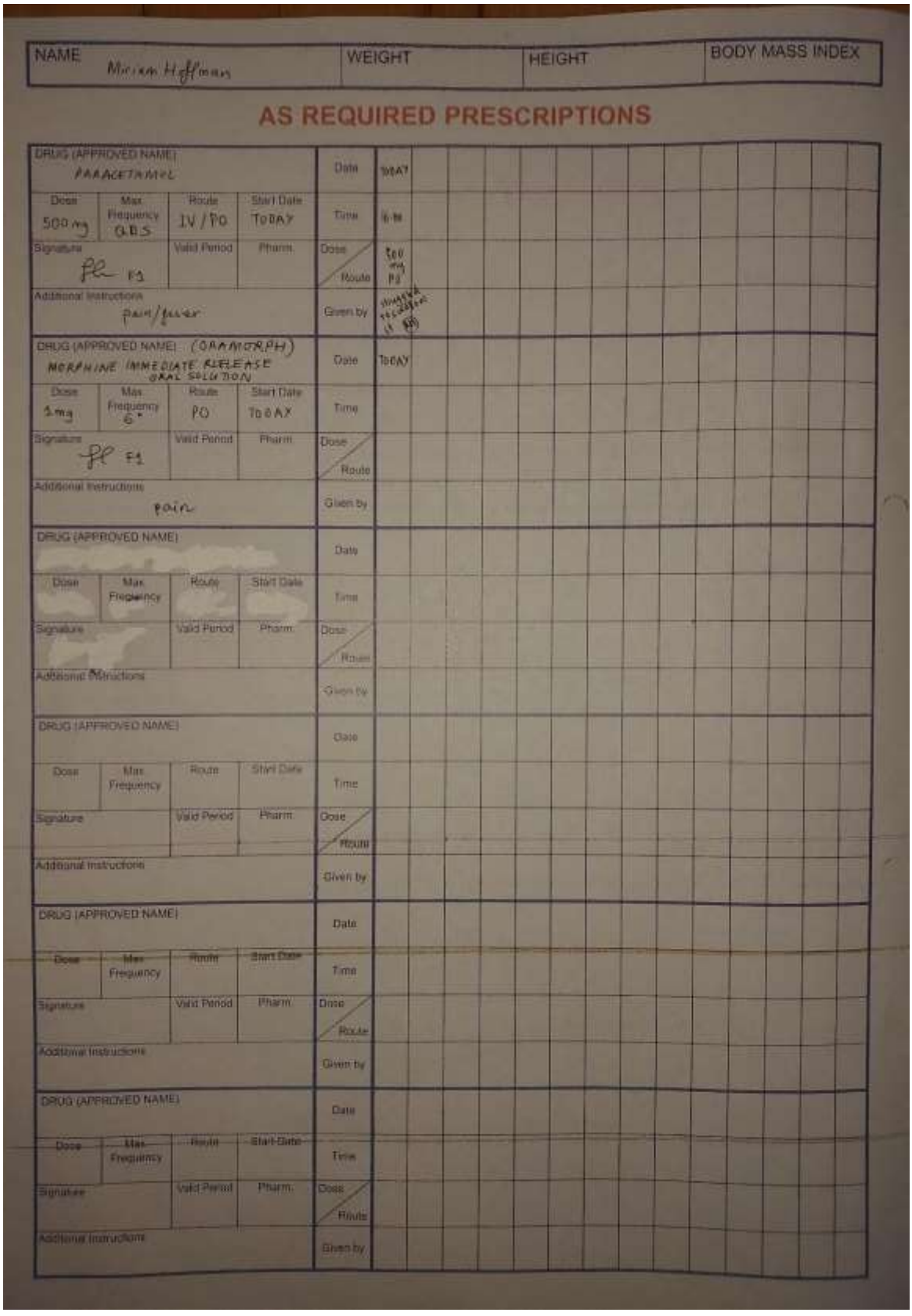

NAME: Miriam Hoffman | WEIGHT | HEIGHT | BODY MASS INDEX

AS REQUIRED PRESCRIPTIONS

DRUG (APPROVED NAME): PARACETAMOL
Dose: 500 mg | Max Frequency: QDS | Route: IV / PO | Start Date: TODAY
Signature: PP F3 | Valid Period | Pharm | Date: TODAY | Time | Dose / Route: 500 mg PO | Given by
Additional Instructions: pain/fever

DRUG (APPROVED NAME): (ORAMORPH) MORPHINE IMMEDIATE RELEASE ORAL SOLUTION
Dose: 5 mg | Max Frequency: 6* | Route: PO | Start Date: TODAY
Signature: PP F3 | Valid Period | Pharm | Date: TODAY | Time | Dose / Route | Given by
Additional Instructions: pain

DRUG (APPROVED NAME) | Dose | Max Frequency | Route | Start Date | Signature | Valid Period | Pharm | Additional Instructions | Date | Time | Dose / Route | Given by

DRUG (APPROVED NAME) | Dose | Max Frequency | Route | Start Date | Signature | Valid Period | Pharm | Additional Instructions | Date | Time | Dose / Route | Given by

DRUG (APPROVED NAME) | Dose | Max Frequency | Route | Start Date | Signature | Valid Period | Pharm | Additional Instructions | Date | Time | Dose / Route | Given by

DRUG (APPROVED NAME) | Dose | Max Frequency | Route | Start Date | Signature | Valid Period | Pharm | Additional Instructions | Date | Time | Dose / Route | Given by

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