Course Title	IMT 3 Simulation	Scenario Title	Virtual outpatient clinic
Patient	Name: Janet/James Clarke Age: 68 Hospital number: K123456		

Learning Outcomes	Technical	Non-Technical
	▪ Appropriately manages virtual consultation. ▪ Demonstrates good communication with patient and documents well. ▪ Correctly interpreting results, screens and recognises need for 2WW referral. ▪ Demonstrates breaking bad news of possible concerning findings on CXR and explains the next steps. ▪ Managing interruptions and multi-tasking.	▪ Breaking bad news ▪ Virtual consultation skills ▪ Communication skills and patient centred-consultation. ▪ Managing workload ▪ Stress management

Scenario Overview

Summary: Setting of clinic outpatient environment on AMU – The patient appointment is virtual for follow-up after an admission with pneumonia to the acute medical unit. The patient was admitted with shortness of breath, productive cough, and palpitations 6 weeks ago. The patient had a repeat CXR 5 days ago which has shown some improved consolidation, but a persistent area of shadowing in the right lower lobe suspicious for malignancy.

The scenario will encourage candidates to build consultation skills and will require clear communication skills as well as breaking bad news (patient will require referral under 2 week wait). There are other elements making the scenario difficult, including other referrals while in consultation over the phone. The plant nurse will interrupt, stating that ED/GP are on an alternative line. Both referral patients are clinically stable and do not need immediate assessment but do require a medical review and advice. Candidates can delegate these referrals which would demonstrate leadership.

Detail on Progression:
This is a busy ambulatory clinic that is also having acute ED referrals. There will be some interruptions during the clinic and candidates can offer for an SHO to hold the bleep to limit interruptions. If a bleep is available, this can be used, or the nurse plant will come in and mention that ED/GP are on another line.

Options for interruptions (one during scenario if candidate doing well):
1) Patient with probable new onset atrial fibrillation for review in clinic.
2) GP referral with new onset breathlessness and chest pains? PE.

Referral 1 (ED):
You are calling for advice regarding a 60-year-old patient who you think has developed atrial fibrillation (ECG seen by F2 who thought it looked like AF). He attended A&E two days ago with vomiting and found to have food poisoning.

If asked: heart rate went up to 140 bpm (now around 100) and was irregular. BP 120/75, Saturations 97% on RA and RR 16. She has no chest pain, syncope or dizziness.

If asked:
PMH: previous appendicectomy, nil else
DH: no regular medications

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	SH: never smoker, 8 units EtOH per week. If the IMT3 says they cannot come now and may delegate this to a colleague and gives you some provisional advice, you are happy for the patient to be reviewed later today or tomorrow in ambulatory. **GP referral (can add in this as an extra interruption if necessary):** You are calling for advice regarding an 84-year old patient who has just had recent surgery for a left-sided fractured neck of femur. The surgery went smoothly and the patient was discharged two weeks ago. You have seen her today due to SOBOE at 50 yards, she is breathless with you but when she sits down her respiratory rate and saturations are normal. She reported some pleuritic chest pain last night. You are worried she may have a PE but you think she is stable enough to have a CTPA as an outpatient. The patient is reluctant to be admitted due to her recent hospital stay. She has no signs of DVT and no infective symptoms. Oxygen saturations are 96% on air, respiratory rate 20, heart rate 95 bpm, blood pressure 130/80 mmHg. If asked: PMH: osteoarthritis, hypertension DH: paracetamol, ramipril SH: smoker (10/day), no EtOH Both referral patients are clinically stable and do not need immediate assessment but do require a medical review and advice. Candidates can delegate these referrals which would demonstrator leadership.
Set Up	**Faculty Controlling/Observing:** Control room: x1 (for bleep interruptions, medical consultant if required via phone) Patient: x 1 (via telephone) **Faculty Embedded:** Outpatient nurse: For handover & managing interruptions. This scenario is designed for 1 candidate to undertake. <u>Entry:</u> Outpatient nurse present during scenario, handover given regarding the virtual patient and the busy clinic which is running. Nurse will hand the candidate the bleep & explain they need to cover the bleep during the clinic. <u>Room set up:</u> Outpatient virtual clinic with telephone & discharge letter. Bleep given to candidate during scenario by outpatient nurse. No manikin is required.
Prop List	Table & chair Telephone Bleep to be given to candidate (or interruptions can be done by plant nurse if bleep not available).

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	Patient discharge letter.				
Console		A	B	C	D
	RR				
	SpO_2				
	HR				
	BP				
	Rhythm				
	Temp				
	Eyes				
	Other				
	Other				
	Other				
Expected Actions	<u>Virtual clinic patient management:</u> Introduction and confirms patient identity Checks patients' ability to communicate on the phone Takes history and asks about patient symptoms. Recognises the limit of virtual consultations <u>Required explanation to patient:</u> Explain reasons for repeat CXR and concerns regarding ongoing residual changes for pneumonia. Explains the finding of anaemia and organises further tests/iron levels. Explained the need for a 2WW referral to respiratory clinic and a CT scan (can be organised via ambulatory) to review the CXR changes. Asked about red flag symptoms of cancer. Addresses smoking cessation. <u>Management of other pressures:</u> Referrals/interruptions: The candidate can defer these interruptions if appropriate, or can take patient details but explain they are with another patient in clinic. Once they have established that the patient is stable they can delegate this responsibility to an SHO and ask the nurse to contact them if necessary to minimise further interruptions, given the complexity in virtual clinic and the need to maintain rapport with the patient.				
End Point	The scenario will end once the IMT has completed their consultation with the patient virtually and has managed the interruptions presented.				

Participant briefing	You are the medical registrar covering ambulatory care clinic today. You have many patients waiting to be contacted virtually and you have been asked to hold the referral bleep by the consultant who is off sick. They are trying to find cover to help you. Your first virtual consultation patient attends for follow-up after a recent admission to AMU with shortness of breath, productive cough, and haemoptysis. You will be provided with the discharge summary for your information. Please explain the results of their repeat CXR and blood tests. You may also receive bleeps from the ward via the telephone; please answer these and give appropriate advice.
Patient Briefing	Pleasant on answering the phone and wasn't expected to be called so soon. You remark how helpful and amazing the medical team have been in caring for you

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	during your illness. You report that you were not aware of the reason for the CXR and you were surprised you needed one at all! You confirm your name and DOB. You are happy to continue with the virtual consultation and have no trouble with communication on the telephone. You ask the candidate if this is confidential as you are worried your daughter will stick her nose into your business by calling the team. Doctor may ask you if you are comfortable to speak freely during the consultation. When asked how you are feeling you report you have mostly recovered, but don't feel quite yourself now. You are very tired and fall asleep at the drop of a hat. When asked about chest symptoms you report you are still breathless when climbing stairs and must stop halfway up. But you have put this down to the pneumonia. You lost weight with the infection, and you haven't regained it (4kgs). You have been eating normally. You are a current smoker and smoke around 30/day and have done for some time (if asked). You deny: chest pain, temperatures, night sweats, haemoptysis, change in bowel habit or bony pains. No bleeding from anywhere and you eat a normal diet. No calf tenderness or swelling. **Once investigation results are explained:** Thank doctor for explaining the results and ask if your symptoms will get better. You are shocked that you need further tests and you are worried when they say you need to be investigated for cancer. You didn't have any idea about the anaemia, and you've never had that before. **Interruptions by nurse and bleeps:** There will be two interruptions during the scenario with referrals. If the doctor apologises about the interruptions, you accept their apology and say that you understand they have a busy job. If the doctor does not apologise about the interruptions, seems to start to rush the consultation or appears distracted, you become a bit disappointed and say you think you're wasting the doctor's time by talking on the phone.
Patient PMHx	PMH: Type 2 diabetes, hypertension, chronic kidney disease, previous breast cancer and osteoporosis. Drug hx: metformin 500mg BD, letrozole 2.5mg OD, ramipril 5mg OD and adcal D3 BD. Allergies: You have no drug allergies. SH: You live alone, and you are a widow. You have one daughter who lives nearby and has been supporting you with shopping post discharge from hospital. You are otherwise independent. Smoking: You smoke 30 per day since you were 25 years old. You are not keen to given up smoking as it would be too difficult, but you listen to the doctors when smoking cessation is suggested. You used nicotine patches in hospital and found them helpful.

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	ETOH: if asked, say you drink 2 or 3 glasses of wine per week. FH: If asked, your father had ischaemic heart disease. You have had your COVID vaccines, but not your pneumococcal or flu vaccine as you weren't sure you needed it.
Investigations & results	**Blood from day of discharge:** Hb 89 (microcytic) WCC 8 Plt 250 Na 130 K 4.2 Adj Ca 2.45 PO4 1.0 ALT 60 ALP 120 Bili 15 GGT 65 Creatinine 88 eGFR >90 CRP 2 **Sputum sample & blood cultures:** Negative for growth Discharge letter printed out for candidate information.
Plant Briefing	**Outpatient nurse:** You are an experienced outpatient nurse. You make sure you update the doctor about other patients arriving, so they are aware of the time. There will be some interruptions during the clinic and candidates can offer for an SHO to hold the bleep to limit interruptions. If a bleep is available, this can be used, or the nurse plant will come in and mention that ED/GP are on another line – Can they put them through please? They have been calling for some time and the patients are due to breach.

On Examination		A	B	C	D
	Colour	N/A			
	Skin				
	CRT				
	GCS				
	Pain Score				
	Abdomen				

Life Savers	If the candidate is struggling with the technical aspects of the scenario the plant can help with this. The plant can suggest the SHO can help with the patients discussed on the bleeps or suggest the candidate contacts the medical consultant to manage workload.
Telephone Assistance	**Medical consultant on call (via telephone):** You are happy to discuss the first clinic patient as well as the ward referrals. You recommend a 2WW referral and organisation of a CT scan. May suggest monitoring anaemia and sodium with repeat bloods.

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	If the candidate asks about the referral patients, you reassure them that it is appropriate to ask for initial investigations over the phone and go and review them after seeing the clinic patients.

Debriefing	• Discussion of the appropriate management of virtual outpatient clinic. • Clinical debrief regarding appropriate referral to the 2WW pathway and explanation of this to the patient. • Discussion of the human factors associated with virtual communication and breaking bad news over the telephone. • Discuss of the management of interruptions, delegation, leadership and triage of patients.
References	NICE guidelines: Lung cancer guidelines. Chest x-ray image courtesy of *World Journal of Surgical Oncology*
Curriculum mapping (CIPS for IMT stage 2 curriculum)	Generic CiP 1: Able to successfully function within NHS organisational and management systems. Generic CiP 3: Communicates effectively and can share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement. Clinical CiP 4: Managing patients in an outpatient clinic, ambulatory or community setting, including management of long-term conditions.
Written by: Date: Review date:	Dr Kathryn Price, King's college hospital Adapted from scenario written by Dr Jalpa Kotecha, King's college hospital Overseen by Dr Nadia Short, GSTT Written: 04/07/2022, Review: 04/07/24

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Discharge letter:

NHS Number: 4578915467 **Hospital Number**: K123456 **D.O.B:** 14/01/1954

Janet Clarke

68F

PC: Shortness of breath, productive cough and haemoptysis.

HPC: 2 week history of progressive shortness of breath associated with a green productive cough with speck of blood on occasion. They were found to have a high inflammatory markers on admission and a CXR which showed right lower lobe consolidation. The patient was treated with IV Amoxicillin for community acquired pneumonia.

PMH: HTN and osteoporosis

MEDS: Ramipril 5mg OD and adcal D3 BD. NKDA

SH: Lives alone. Daughter will support on discharge.

O/E:

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Obs – HR 65. BP 115/65. T37.1 Sats 98% RA. RR 15 on the day of discharge.

Urine dip NAD. Sputum and blood cultures negative.

Given – IV paracetamol & Amoxicillin (treated 5 day course).

Chest right lower zone crackles, HS normal
Abdomen – normal

Bloods from day of discharge:

Hb 89 (microcytic)
WCC 8
Plt 250
Na 130
K 4.2
Adj Ca 2.45
PO4 1.0
ALT 60
ALP 120
Bili 15
GGT 65
Creatinine 88
eGFR >90
CRP 2

IMP: CAP

PLAN:

Complete course of antibiotics

Review in Ambulatory with repeat CXR in 4-6 weeks.

Repeat CXR prior to clinic. Report: Persistent right lower zone opacification with improvement in previous consolidation.

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