| Course Title | IMT 3 Simulation | Scenario Title | MDT Safe Discharge Planning |
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| Learning Outcomes | Technical | Non-Technical |
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| | - Safe Discharge planning<br>- Appreciation of roles of different MDT members<br>- Knowledge of services to facilitate safe discharge including: Packages of care, Telecare, enabling home care/Physiotherapist at home, Community Matron, MOWs, Blister packs. Continence services etc.<br>- Confidentiality | - Mobilise all available resources<br>- Anticipate and plan<br>- Use good teamwork<br>- Exercise leadership and followership<br>- Set priorities dynamically<br>- Negotiate and communicate with family members regarding discharge planning<br>- Patient centred care |
| Scenario Overview | The scenario is regarding discharge planning for a patient identified as being medically fit for discharge, however the patient has a number of complex social and chronic medical problems which still need to be address with MDT, patient and family. It consists of a meeting with the nurse and OT looking after the patient in question. The patient is an 85 year old woman day 10 post admission with urosepsis. She is making good progress and is walking with a stick. She was initially delirious, but this has resolved and she is keen to go home. However, the patient's daughter has expressed some concerns to the nursing staff regarding the safety of discharge and their falls risk.<br><br>This scenario requires at least 3 faculty members: Nurse plant, Occupational Therapist, and phone advice. | |
| Set Up | - Scenario takes place in an MDT meeting room on the ward, ideally with a table and circle of chairs.<br>- The nurse looking after the patient will be in the room with one of the occupational therapists. Patient not present.<br>- This scenario does not require a simulation technician although a faculty member should be present to answer the phone.<br>- Notes (including entries from other MDT members will be on the table) with the drug chart | |
| Prop List | Brief patient notes available, with entries from MDT members<br>Obs chart (stable for past 72 hours)<br>Table | |

| Console | | A (last obs) | B | C | D |
|---|---|---|---|---|---|
| | RR | 16 | | | |
| | $SpO_2$ | 99% (RA) | | | |
| | HR | 80 | | | |
| | BP | 134/82 | | | |
| | Rhythm | Atrial fibrillation | | | |
| | Temp | 37.2C | | | |
| | Eyes | | | | |
| | Other | | | | |
| | Other | | | | |
| | Other | | | | |
| Expected Actions | Candidates will be expected to actively engage in discussion with the nurse in charge regarding suitability of discharge. This will involve collating the input of multiple reports from other members of the Multi-Disciplinary Meeting. | | | | |

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| | The best candidates will demonstrate knowledge of services to aid discharge process: Package of care from Social Services, Telecare, enabling home care/Physiotherapist at home, Community Matron, meals on wheels, blister packs, Continence services.<br><br>There is not necessarily a right answer. The patient can likely be discharged with community input, and this is probably the best outcome. If this does not suffice, suggestion of an MDT meeting with the patient and family may be appropriate.<br><br>It is also important to consider the patient's views and the families input during this meeting (if the patient has capacity an appreciation of the fact that these decisions cannot be made without the patient/family input should be demonstrated). |
| End Point | The scenario ends when a consensus has been made on whether the patient can go home, and a plan is in place. |

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| Participant briefing | You are the IMT 3 on the Acute Medical Unit. A patient has been identified for discharge by the discharge co-ordinator, as the notes stated they were medically fit; you have never met the patient. The daughter is unhappy with discharge and feels your patient is not well enough to go home. The daughter plays bridge with the chief executive of your hospital and is threatening to put in a complaint.<br><br>The nurse looking after the patient wished to talk to you regarding discharge planning and has asked for a meeting with you and the occupational therapist to discuss the concerns around discharge planning. Please lead discussions with the nurse in charge and occupational therapist to arrange an action plan moving forwards for the patient at hand. |
| Patient Briefing | N/A – Patient is not present in this scenario, but basic notes are available. |
| Patient PMHx | For more details, please see the notes. It may be helpful to give the candidate a copy of the medical notes prior to entering the room to ensure they are aware of the key medical issues prior to commencing the meeting.<br><br>HPC: The patient is day 10 of treatment in hospital after a fall and delirium, likely preceded by dysuria and frequency of urination (diagnosed with a urinary tract infection) and new atrial fibrillation. The patient has recovered from their delirium but has had some episodes of urinary incontinence post removal of her catheter. They have been fully treated for her UTI and atrial fibrillation. You would like to follow the patient up in the outpatient clinic to review their new incontinence and her cognitive decline. The patient's daughter reported their memory has worsened over the last 2 years; additionally, their cognition has deteriorated following delirium associated with the hospital admission but they are showing some improvement as they recover.<br><br>PMH: Mild cognitive impairment, OA, hypothyroidism, HTN, chronic kidney disease (stage 2).<br><br>Drug hx: Donepezil 10mg OD, ramipril 5mg OD, levothyroxine 75 mcgs OD, Apixaban 2.5mg BD.<br><br>Social hx: Usually mobilises independently with a stick outside the house, the daughter helps with shopping and some meals. She is independent with personal |

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| | care, but occasionally needs help getting out of the bath. Lives with her daughter who works full time as a legal associate.<br><br>Capacity assessment: The medical team have performed a capacity assessment for Janine due to her delirium during the admission there were concerns about her capacity for discharge planning decision making. She was deemed to have capacity to make these decisions regarding discharge. She expressed her wishes to go home as soon as possible and is happy to accept any help needed to facilitate this. However, she wishes her daughter to be involved in these decisions and wants her to be happy with the discharge too. |
| Investigations & results | Bloods: Hb 115, WCC 8.0, Pl 250, Ur 8.0, Creat 120, CRP 2, INR 2.1<br><br>CXR: Normal<br><br>ECG: Atrial fibrillation only |
| Plant Briefing | There are 2 roles for members of the simulation team. There is no console required for this scenario.<br><br>**Plant 1) - Nurse**<br>You are the nurse looking after the patient and have been nursing the patient for the past 2 days. You are competent in your role.<br><br>You have seen the patient mobilising on the ward with aid of a stick. You have not witnessed or been told about any incidents of falls while an inpatient.<br><br>The patient is incontinent now that the catheter has been removed. You have dipped the urine and it is negative for any infection. You suspect this is longstanding, and if asked, will convey that a community referral can be made to district nurses for follow-up of incontinence.<br><br>You have been approached by the daughter in quite an aggressive manner regarding discharge and she is not happy about it. She told you that the district nurses are “useless” and “unreliable” from previous experience when they were dressing her mother’s leg ulcers a few years ago. The daughter is angry that her mum is “not back to her normal self” and still appears confused at times on the ward when she visited a few days ago. The daughter expects her mother to be back to normal before discharge. She was quick to tell you that she plays bridge weekly with the chief executive and you feel under pressure as a result. You have also been contacted by the discharge co-ordinator who has identified this patient as a potential discharge and has told the site manager this information. You are under pressure to discharge this patient as soon as possible. The main issue is surrounding continence, resolving delirium and what would happen if her mum fell at home again, as she had been found on the ground previously. If the candidate explains their reasons that discharge can be performed safely and provides suggestions to help safe discharge you are happy to help this happen.<br><br>If the candidate is doing well / has completed tasks quickly– you can insist that this plan is explained to the daughter by the medical team once you have finished the meeting.<br><br>**Plant 2) – Occupational therapist** |

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You are a senior OT and are competent at your job. The patient has no previous package of care- this will need arranging, but you have already spoken to the social worker and they are confident this will be in place by this afternoon.

(If asked by candidate for your assessment) - The patient will need help with personal care. You have performed an access visit which shows the home environment is safe for discharge and will only need the provision of a commode/ some stair and toilet rails which are being delivered and fitted today. There is a key safe already in place. You have recommended a link alarm but the patient wishes to think about this, this is not mandatory for discharge and can be installed in the community if needed. You will be happy to talk about community follow-up which can be arranged with visits from Age UK if asked.

You feel the patient is safe for discharge and are keen to ensure this happens as per the patient's wishes. You have been told the patient's daughter has concerns but have not met her yet (daughter lives with her mother but her mother owns the house).

You are concerned about the patient's incontinence and want to check this will be followed up – you are aware that community services do exist for this.

**Plant 3 (telephone) – Daughter Maria** (only include this if candidate is doing really well and the scenario is coming to a close quickly):

Maria is the daughter of Janine, you live with her but are very busy working for a legal firm as an associate in family law. You play bridge with the chief executive and state you wish to make a complaint about the team "not caring" about her mother and wanted to "shove her out the door" especially given she had a fall on the ward last week. You have been very involved in your mother's care and you know everything which has happened so far in this admission including treatment for infection, atrial fibrillation and her declined cognition/mobility. You are concerned that her cognition has not be fully addressed as her memory has been worsening over the last 2 years and she now forgets names of family members. This was severe on admission where she was very unstable and seeing spiders on the ceiling. You think she has improved but she is still more confused that normal and you had to help her get dressed when you last visited her. You feel the hospital are trying to "get rid of a poor old lady too early" and you feel she needs some time to convalesce prior to discharge. You dislike the district nurses as they come a random time and are unreliable, from your previous experiences when they were dressing your mum's leg ulcers (now healed). You feel she would need more support than this on discharge and are worried how you will manage with the incontinence whilst you are at work. You feel she has lost her independence in hospital, and you want the team to help her gain continence prior to discharge. Once the doctor explained the plan and addresses your concerns you are amenable to discharge, but you cannot pick her up until tomorrow as you are at work.

| On Examination (patient not present | | A | B | C | D |
|---|---|---|---|---|---|
| | Colour | Normal | | | |
| | Skin | Normal | | | |
| | CRT | 2 seconds | | | |
| | GCS | 15 | | | |
| | Pain Score | No pain | | | |

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| during scenario) | Abdomen | Soft non-tender | | | |
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| Life Savers | If the candidate is struggling, the plant nurse can suggest that some outpatient services can be helpful in managing patients in the community, and can refer them to the entries in the notes. |
| Telephone Assistance | Will be dictated by who the candidate wishes to call.<br><br>**Discharge co-ordinator:** You are desperately short of beds and are keen to facilitate discharge. You suggest that community teams such as continence team, age UK, discharge support team and social worker could be called.<br><br>**Medical consultant:** You are currently post-taking patients and cannot particularly remember the patient. As you recall they are medically fit for discharge, have capacity and are keen to free up the bed if possible.<br><br>**Any other contact e.g. Physiotherapist/Social Services/Pharmacy:** You are currently busy and are not familiar with the patient in question. Your colleague who has reviewed the patient may have written in the notes and you can direct the candidate towards these. |

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| Debriefing | Patients should be discharged safely in a timely fashion. The focus of the debrief will be on safe discharge practices:<br><br>- In older patients, a comprehensive assessment of older people with complex needs can be useful for discharge. This involves input from a number of different MDT members (including but not limited to: OT, physio, social services, community-based teams)<br>- Assessment of capacity regarding discharge in older patients can be difficult to assess but should be documented clearly<br>- Patient permission should be sought to discuss with family members (confidentiality)<br>- MDT meetings with patients/family members can be a useful tool where differences in opinion occur<br>- Always consider early discharge planning<br><br>Knowledge of services to facilitate safe discharge including: Packages of care, Telecare, enabling home care/Physiotherapist at home, Community Matron, MOWs, Blister packs. Continence services etc. |
| References | NICE guidelines (2015) - Transition between inpatient hospital settings and community or care home settings for adults with social care needs |
| Curriculum mapping | **CiP Descriptors (Internal Medicine Curriculum Stage 1):**<br>- Providing continuity of care to medical inpatients<br>- Managing outpatients with long-term conditions<br>- Managing medical problems in patients in other specialties and special cases<br>- Managing an MDT including discharge planning |

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| Written by:<br>Date:<br>Review date: | Ewan Mackay (edited from Homerton Hospital GIM scenario, author unknown)<br>24/06/22<br>24/06/24<br>Reviewed by Kathryn Price (ST5 geriatric medicine) 04/07/2022 |

Patient notes

**Consultant WR (Dr Stevens) - yesterday**

Issues:

1) Urosepsis (dysuria, frequency and fever on admission)
   - Treated with antibiotics now completed.
2) Delirium on background of mild cognitive impairment
   - Resolving (AMTS 7/10)
3) Fall on ward
   - DATIX has been completed
4) AF – On Apixaban (started this admission, discussed with patient and family)

Patient sat up in bed, talking
Keen to get back home
Patient capacity assessed: has capacity to retain, weigh up, rationalise and communicate decisions regarding discharge planning. She wishes to go home as soon as possible and understands her needs on discharge. She is willing to accept any help she needs to facilitate discharge, but wishes her daughter to be happy with the plan also.

Plan

1) Discharge planning
2) Communicate with daughter regarding MDT plan.

**Junior Physiotherapy (James Matthews) entry - today**

Patient has been mobilising on the ward with a stick. She is able to independently transfer. She had one fall out of bed 3 days into her admission. This is being investigated by a DATIX but is thought to be due to poor safety awareness at night while she was trying to get out of bed to use the toilet.

When I assessed her a few days ago she was still at a high falls risk because of confusion and poor safety awareness, but she is improved, and her delirium has resolved and this is now less of a risk.

The patient is likely back at mobility baseline, so there is no requirement for inpatient rehab or reablement. The medical team today will be deciding if the patient will be discharged today, and I hope this is helpful for their assessment. I am sorry I cannot make the MDT meeting this morning.

**Social worker & discharge co-ordinator joint assessment (Sally Ludder & Bola Adeyoma):**

Noted medical team deem patient to have capacity for assessment.
Discussed at board round - OT and PT team recommended BD SH POC for discharge which can start at dinner call today if required (please call to confirm).
Patient has agreed to POC recommended but wishes the medical team to check with her daughter regarding this.