Scenario – End-of-Life Care Transition from ICU to Ward

Initial Candidate (e.g. roles)	Equipment in Room	Simulator Control
➢ ICU Consultant or SpR ➢ ICU SHO ➢ ICU Nurse (Band 5 or 6) ➢ Ward Nurse (receiving ward) ➢ Family Member (simulated participant) ➢ Palliative Care Team Member (optional)	➢ COW and paper work – Patient notes, observation chart & drug chart ➢ Medication chart with current medications including IV anticipatory medications ➢ Cerner access (or simulation of it) for CCA documentation ➢ Patient monitoring equipment (showing stable but poor prognosis) ➢ Syringe drivers/pumps ➢ Infusions - sedative medications being weaned ➢ Oxygen delivery device (nasal cannula) ➢ Comfort care supplies (mouth care items, positioning aids) ➢ Handover documentation forms	**Mannequin setup:** • Hospital ID band • IV access (peripheral and central) • Urinary catheter • Monitoring leads • Oxygen delivery device • Set for stable but poor clinical condition
Candidate Briefing: 78-year-old woman, Mrs. Emily Thompson, 65kg. Previously independent with some mobility issues. Admitted to ICU 16 days ago with severe pneumonia leading to respiratory failure requiring intubation and ventilation. Has been extubated for the past 48 hours but showing minimal neurological improvement (GCS 7/10). Her renal function has been deteriorating over the past 3 days. The night team has documented "consider palliative approach" but no firm decisions have been made regarding ceiling of care. The ward round is about to begin, and the team needs to review Mrs. Thompson's case and determine the appropriate care plan moving forward. The patient's daughter (simulated participant) has arrived and is asking about her mother's prognosis and the plan going forward.		**Initial Parameters** A – Own airway, oxygen via nasal cannula 2L/min B – RR 18, SpO2 92% on 2L O2 C – HR 92 sinus rhythm, BP 110/65 (MAP 80mmHg) D – GCS 7/15 (E3 V1 M3), pupils equal and reactive, groaning E – Temp 37.2°C Patient positioned with head elevated 30 degrees

Scenario Progression:
• Team needs to assess patient and review overall trajectory
• Recognition that patient is approaching end of life with limited potential for recovery
• Discussion regarding appropriate ceiling of care and DNACPR status
• Once team determines end-of-life approach is appropriate, plant (ICU consultant or senior nurse) can guide discussion toward considering ward transfer
• Team then needs to initiate proper transition planning:
  ○ CCA documentation
  ○ Discussion with family
  ○ Conversation with ward team
  ○ Medication changes (IV to SC)
  ○ Spiritual/religious needs assessment
• Communication with palliative care team if identified by the team
		Deteriorating Parameters
		
		• Renal function worsens if the case is prolonged without decisions
		• Patient shows signs of distress if pain management not addressed
		• Family member becomes increasingly anxious if not properly informed

Commented [BA1]: Does it need to be clear that all reversible causes for deteriorating renal function and low GCS have been excluded? E.g. CT head nil acute and renal opinion sought.

Commented [BA2]: Should there be any signs of uncontrolled symptoms e.g. patient groaning as though in pain?

Commented [BA4]: Is this feasible during the scenario? Or should it be that the patient's renal function is already significantly impaired?

Commented [BA5]: Increased groaning, could she also become more tachycardic and tachypnoeic? This could then improve once analgesia given.

Commented [BA3]: I agree that a recognition that this may be needed is helpful but I would not expect a candidate to do the actual conversions without seeking specialist palliative care input.

	Investigation available
Key Expected Actions **Technical Skills** • Complete comprehensive assessment of patient status and prognosis • Make appropriate decision regarding ceiling of care • Complete CCA documentation • Prescribe appropriate anticipatory SC medications • Develop symptom management plan • Communicate DNACPR status • Create transition plan • Arrange SPC team referral • Provide family support resources • Ensure comfort measures **Non-Technical Skills** • Clear communication with team about prognosis and rationale for decisions • Empathetic approach to family concerns • Effective decision-making regarding appropriate level of care • Recognition of transition needs for end-of-life care • Collaborative approach with multidisciplinary team • Anticipation of potential issues	**Information** **Trust End-of-Life Care Guidelines:** • Care Agreement for the Last Hours and Days of Life (Cerner Document) • Symptom Management Guidelines for Dying Patients (Adults) • Guidelines for the Care and Management of a Patient with a Syringe Pump for Adult Palliative Care Patients **Faculty of Intensive Care Medicine (FICM) Guidance** **Tools Available:** • **CCA documentation template** • **ICU to ward handover form** • **Symptom assessment scales** • **PILHDL transition checklist** • **End-of-life care pathway documentation**
Debriefing Topics	
Technical Skills • Decision-making process for end-of-life care • CCA documentation completeness • Medication management for end-of-life care • Appropriateness of symptom control plan • Understanding of Trust guidelines for EOLC transitions	
Non-Technical Skills • Quality of communication with family • Handling of difficult conversations about prognosis • Team collaboration in decision-making • Approach to transition planning • Balancing clinical needs with family support	
Faculty roles	
ICU Nurse	

Commented [BA6]: Again, I wouldn't expect the candidate to be prescribing a syringe pump without having spoken to specialist palliative care

Commented [BA8]: This should be done with specialist palliative care support

Commented [BA9]: Another skill should be recognition of dying

Commented [BA10]: What is the seniority of the candidates? I suppose it would need to be either a senior decision maker or recognition that the candidate needs to escalate to a senior decision maker.

Commented [BA7]: What would the EOL pathway documentation be? This is generally not a term we would use in the Trust.

Briefing: Experienced ICU nurse who has been caring for the patient for several shifts and has built rapport with the family. Concerned about patient comfort during transfer.	Key tasks: • Provide clinical information about deteriorating status • Express concerns about ongoing aggressive treatment • Can guide toward transition planning if team is struggling • Provide clinical handover information • Express concerns about family anxiety • Highlight medication conversion needs • Question about spiritual support arrangements
Ward Nurse	
Briefing: Nurse from general medical ward receiving the patient. Has limited experience with patients transferred from ICU for end-of-life care.	• Ask questions about patient care requirements • Express some anxiety about managing end-of-life care • Request clear documentation and instructions • Ask about family expectations and support needs
Family Member	
Briefing: Patient's daughter who has been present throughout ICU stay. Supportive of transition plan but anxious about changes in care level and environment.	• Ask questions about mother's condition and chances of recovery • Express initial uncertainty about withdrawing active treatment • Once the decision is made, shift to questions about comfort and dignity • If ward transfer is proposed, ask about reasons and implications • Inquire about what to expect as patient approaches end of life
Medical Member (ICU Consultant / SpR/ SHO/FY)	
Briefing: Senior ICU consultant who has been involved in the patient's care and MDT discussions. Supportive of the transition plan but concerned about ensuring proper documentation and handover.	• Provide clinical context and decision-making rationale • Introduce the concept of ward transfer for EOLC if team doesn't • Guide team on appropriate CCA documentation requirements • Prompt discussion about medication conversion from IV to SC routes • Ask probing questions about anticipatory prescribing • Challenge team if important aspects of transition planning are missed • Encourage SPC referral if not considered by the team • Facilitate debriefing on technical and communication aspects • Guide discussion on Trust guidelines and ICS recommendations for EOLC transitions
Palliative Care Team Member (optional)	
Briefing: Available for consultation but not automatically present unless called.	Key tasks: • Provide specialist advice on symptom management • Support communication with family • Assist with CCA documentation if requested • Offer follow-up plan