Simulation Medicine for Orientation, Competencies, and Case Conferences

CDIM National Meeting
Friday, October 4, 2013

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Julia Mueller, MD

Disclosures

• Michael Maniaci, MD¹
  ▪ This faculty has no relationships with proprietary entities producing healthcare or simulation-related goods or services

• Christopher Austin, MD¹
  ▪ This faculty has no relationships with proprietary entities producing healthcare or simulation-related goods or services

• Julia Mueller, MD¹
  ▪ This faculty has no relationships with proprietary entities producing healthcare or simulation-related goods or services

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Objectives

• Develop skills and techniques to facilitate education and provide feedback related to student orientation skills including physician introductions, information gathering, and environmental recognition using the simulation environment

• Identify topics related to communication based interactions and determine simulation based interventions to address them. Communication based interactions include but are not limited to: effective staff handoffs, medical jargon and patient communication

• Recognize opportunities to implement simulation and other modalities to augment the learning of the students during clinical case presentations

How we gonna get there?

• Go over the basics of building a simulation

• Walk through the clinical competencies and see how simulation can be used in each to amplify learning

• Break up into workgroups, come up with some awesome simulation ideas

• Reassemble our group, discuss all workgroup ideas (we will scribe)

• Collect emails for work distribution
What am I walking away with?

• A universal simulation template
• A lot of good ideas
  ◦ Some from this talk
  ◦ Some from your work groups
• This presentation and 13 built simulations
  ◦ Practicing team introductions, teaching observational skills, introduction to codes, practicing handoffs, avoiding medical jargon, communicating with the non-English speaking patient, communicating with nurses using SBAR, delivering bad news, dealing with the deteriorating patient, dealing with pain medication seeking behavior, identifying acute stroke fast, hypovolemic shock, and acute respiratory failure

Some polling to see where we stand

• Who here already uses simulation?
• Who here has a simulation center?
• Who here has a built simulation curricula that is non-procedural in nature?
• What do you guys want to focus on?
Part One: How to Build a Basic Simulation

- Start with a goal
  - You can begin broad and then specify
  - If you have a particular learning point to focus on, then go for it

- Ask yourself if simulation will help you achieve that goal more convincingly?
  - Active learning vs Passive Learning

- What resources do I have available?
  - Rate limiting step

Plan your session

- Start at the end and work backwards
- Follow an outline every time
  - Easier for you
  - Easier for your team
Practice your plan

• The simulation team must have adequate time to study your simulation and prepare
• You must do a dress rehearsal
• The 3 “P’s” of simulation are critical:
  • Preparation
  • Partnership
  • Practice

Our approach

• Actual simulation runs about 1/3 of the time
• The debriefing and discussion period runs 2/3 of the time
• Make sure everybody leaves knowing the objective of the simulation
• Once the class of learners has left, debrief with the simulation team
  • What went right, what could have been done better
Part Two: Taking on the Competencies

• Medical Knowledge
  • Can easily replace a morning report or noon conference
  • Best to build these to medical learner level
    • Specific objectives for each level
    • Rare case findings and reenactment

• System Based Practice
  • Orientation skills
  • Team building (multidiscipline simulations)

Competency based simulations

• Communication and Interpersonal Skills
  • Team introductions
  • Avoiding medical jargon
  • Practicing handoffs
  • Cultural diversity
  • Delivering bad news
  • Non-English speaking patients and family members
Competency based simulations

• Patient care
  • Information gathering
  • Clinical skills
  • Information organization
  • Clinical reasoning $\rightarrow$ Integration
  • Clinical Judgement $\rightarrow$ Decision Plan

Competency based simulations

• Professionalism
  • Earlier year simulations focus on institutional goal
  • Showing bad examples works well
    • Try to limit humor

• Practice based learning
  • Filmed scenarios
  • What could you have done better?
**Detailed Case Data:**

<table>
<thead>
<tr>
<th>Name:</th>
<th>MC#:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Gender:</th>
<th>Age:</th>
<th>Weight:</th>
<th>Height:</th>
<th>BMI:</th>
</tr>
</thead>
</table>

**Other information:**

**Vital Signs:** enter time (min) or state for incremental change in hemodynamics as scenario progresses, consistent with flowchart

<table>
<thead>
<tr>
<th>Time or State</th>
<th>Temperature</th>
<th>Heart Rate</th>
<th>Blood Pressure</th>
<th>Respiratory Rate</th>
<th>Pulmonary Pressures</th>
<th>Oxygen Saturation</th>
<th>Cardiac Rhythm</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0:00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

**Chief Complaint:**

**Past Medical History:**

**Medications:**

**Allergies:**

**Data Summary:** (if normal, please indicate)

**Relevant Lab Data:**

**Relevant Imaging Data:**

**Relevant Physical Exam Findings:**

*For Example:*
- Pain steady, nothing obviously makes it better or worse
- Constant, dull pain
- If asked, it does radiate to back
- If asked, drinks on weekends but not daily
- Requests pain medications- pain currently 8/10
- ROS otherwise negative
- Physical exam
  - Tender to palpation in mid upper abdomen
Flowchart/Decision Tree, branch points (tie with objectives), scoring points within flowchart: This graphically shows the way the scenario will proceed, with pathways for anticipated actions of the trainees. It outlines the physiological states of the patient so also acts as a guide for programming of the mannequin. The flowchart can be created in Microsoft Visio or Microsoft Word.

Example:

- Alert & oriented x 3
- BP 112/55
- HR 92
- O2 Sat 100%

- Slurred speech
- Profound L-sided
- Weakness
- Vital signs unchanged from above

Correct Decisions

- Vital signs unchanged & scenario will end

Incorrect Decisions

- BP 86/42
- HR 110
- O2 Sat 85%

- Cardiac arrest
### Props and Equipment

Please indicate below the monitoring required as well as any other equipment/props that will be required.

#### Monitor Display and Props

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ECG</td>
<td>NIPB</td>
</tr>
<tr>
<td>SPO2</td>
<td>ART</td>
</tr>
<tr>
<td>CVP</td>
<td>PAP</td>
</tr>
<tr>
<td>Temp</td>
<td>Resp Rate</td>
</tr>
<tr>
<td>Cardiac Output</td>
<td>Wedge</td>
</tr>
<tr>
<td>ICP</td>
<td>Alarm Setting</td>
</tr>
</tbody>
</table>

#### Venous Access

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral IV</td>
<td>Site:</td>
</tr>
<tr>
<td>Arterial Line</td>
<td>Site:</td>
</tr>
<tr>
<td>Triple Lumen</td>
<td>Site:</td>
</tr>
<tr>
<td>Swan Ganz</td>
<td>Site:</td>
</tr>
<tr>
<td>PICC</td>
<td>Site:</td>
</tr>
<tr>
<td>Dialysis Catheter</td>
<td>Site:</td>
</tr>
<tr>
<td>Other</td>
<td>Site:</td>
</tr>
</tbody>
</table>

#### Oxygen Supplies Available (Available vs. At Bedside)

<table>
<thead>
<tr>
<th></th>
<th>Settings:</th>
<th></th>
<th>Settings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanical Vent</td>
<td></td>
<td>Anesthesia Bag/Mask</td>
<td></td>
</tr>
<tr>
<td>BIPAP</td>
<td></td>
<td>Flow Meter</td>
<td></td>
</tr>
<tr>
<td>Michigan Lung</td>
<td>Anesthesia Bag/Mask</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Inflating Bag/Mask</td>
<td>Flow Meter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Rebreather Mask</td>
<td>Simple Mask</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal Cannula</td>
<td>Nebulizer Set up</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Airway Management

<table>
<thead>
<tr>
<th></th>
<th>Size:</th>
<th>Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ETT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LMA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tracheotomy Tube</td>
<td>Size:</td>
<td>Type:</td>
</tr>
<tr>
<td>Bronchoscope</td>
<td>Type:</td>
<td></td>
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</table>

#### Carts/Bags

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Code Cart</td>
<td>Intubation Cart</td>
</tr>
<tr>
<td>Emergency Trauma Cart</td>
<td>Respiratory Code Bag</td>
</tr>
<tr>
<td>Special Requests</td>
<td></td>
</tr>
</tbody>
</table>

#### Intravenous
<table>
<thead>
<tr>
<th>IV Pump</th>
<th># needed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Drips or Fluids</td>
<td>Infusing</td>
</tr>
<tr>
<td></td>
<td>Available</td>
</tr>
</tbody>
</table>

1) Labeled: Bag Size: Dose: Rate: Site:
2) Labeled: Bag Size: Dose: Rate: Site:
3) Labeled: Bag Size: Dose: Rate: Site:
4) Labeled: Bag Size: Dose: Rate: Site:
5) Labeled: Bag Size: Dose: Rate: Site:

### Medications

<table>
<thead>
<tr>
<th>Syringe</th>
<th>Vial</th>
<th>Labeled:</th>
<th>Size:</th>
<th>Amount:</th>
<th>Description:</th>
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<tbody>
<tr>
<td>1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2)</td>
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<td>3)</td>
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<td>4)</td>
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<tr>
<td>5)</td>
<td></td>
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</tbody>
</table>

### Blood Products

<table>
<thead>
<tr>
<th>RBC</th>
<th># of Units:</th>
<th>Blood Type:</th>
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<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>FFP</th>
<th># of Units:</th>
<th>Blood Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Platelets</th>
<th># of Units:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>Description:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Chest Tube

<table>
<thead>
<tr>
<th>Chest Tube</th>
<th>Location:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Size:</td>
</tr>
<tr>
<td></td>
<td>Oasis volume:</td>
</tr>
</tbody>
</table>

### Urinary Catheter

<table>
<thead>
<tr>
<th>Urinary Catheter</th>
<th>Available</th>
<th>Indwelling</th>
<th>Amount:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Color:</td>
</tr>
</tbody>
</table>

### Moulage

| Moulage: Describe any moulage needs (i.e.: bruising, diaphoresis, skin ulcers, edema, etc.) |

### Miscellaneous

<table>
<thead>
<tr>
<th>Ultrasound</th>
<th>Other:</th>
</tr>
</thead>
</table>
**Simulator Needs**

**Simulator Features:** Please check all of the simulator features that are needed to achieve the scenario objectives

<table>
<thead>
<tr>
<th>Feature</th>
<th>Feature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blinking Eyes</td>
<td>Chest tube insertion</td>
</tr>
<tr>
<td>Pupil function</td>
<td>Bowel sounds</td>
</tr>
<tr>
<td>Airway intubation</td>
<td>Urinary Catheter</td>
</tr>
<tr>
<td>Cricotom/Trapeotomy</td>
<td>Intraosseous</td>
</tr>
<tr>
<td>Mannequin Voice</td>
<td>Tremor/Seizure</td>
</tr>
<tr>
<td>Heart sounds</td>
<td>Pulse</td>
</tr>
<tr>
<td>Normal</td>
<td>Carotid</td>
</tr>
<tr>
<td>Abnormal:</td>
<td>Brachial</td>
</tr>
<tr>
<td></td>
<td>Radial</td>
</tr>
<tr>
<td></td>
<td>Femoral</td>
</tr>
<tr>
<td></td>
<td>Popliteal</td>
</tr>
<tr>
<td></td>
<td>Pedal</td>
</tr>
<tr>
<td>Lung sounds</td>
<td>Other:</td>
</tr>
<tr>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>Abnormal:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

**Audio/Visual Needs:** Any special AV needs to run the scenario, any special camera views or special micro phoning?
## DEMOGRAPHIC INFORMATION

<table>
<thead>
<tr>
<th>Course Title:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Course Dates:</td>
<td></td>
</tr>
</tbody>
</table>
| Course Timeframe | 8-12  
1-5  
Full Day (8-5)  
2 hours Specify: _________ |
| New Course |  |
| Multidisciplinary |  |
| School/Department: |  |
| Program/Specialty: |  |
| Program/Course Director: |  |
| Education Coordinator: |  |
| Company/PAU: |  |

## COURSE INFORMATION

**Course Description/Title**

List Learning Goals and Objectives:

1.  
2.  

**Gap Analysis**

*Can a research project result from this training?*

Briefly describe education:

Method of Evaluation:

<table>
<thead>
<tr>
<th>Length of session:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Learner Level:</td>
<td></td>
</tr>
</tbody>
</table>
| Specialty instructor(s): | 1.  
2.  
3. |
| Participant type: |  |
| Number of participants: |  |
| Sim Faculty support needed: | Yes  
No |
| Respiratory Therapy support: | Yes  
No |
| Standardized Patient (SP) support needed: | Yes  
No |
| SP feedback: | Yes  
No |
<p>| Written Evaluation/No direct feedback to learner |  |
| Verbal direct feedback at the end of each scenario in scenario room |  |</p>
<table>
<thead>
<tr>
<th>Teaching methodology: (check all that apply)</th>
<th>Mannequin-based with a scenario(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Task trainer</td>
</tr>
<tr>
<td></td>
<td>Didactic</td>
</tr>
<tr>
<td></td>
<td>Standardized patient</td>
</tr>
<tr>
<td>Simulation Center 360 Evaluation Tool</td>
<td>Yes</td>
</tr>
<tr>
<td>Role evaluation:</td>
<td>Yes</td>
</tr>
<tr>
<td>Performance evaluation:</td>
<td>Yes</td>
</tr>
<tr>
<td>Contact Hour Certificates</td>
<td>Yes</td>
</tr>
<tr>
<td>Send map/orientation to sim information:</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**SIMULATION CENTER CHECKLIST**

- Additional course development meetings/communication:
  - Team Meeting (mandatory):
    - Date:
    - Attendees:
      - (Faculty, EC, RT, AV, SP Coord.)
  - Dry Run (optional):
    - Yes  No
    - Date:
    - Attendees:
  - Specialty equipment/supplies:
  - Debrief session(faculty and staff) (optional):
    - Yes  No
    - Date:
    - Attendees:

- Designated leader for day of session:
- Scenario Titles: 1.

**Additional Comments/Follow up:** (Total number of rooms, specific rooms, specific mannequin requests, etc.)

**AUDIOVISUAL NEEDS**

- [ ] Video Playback in Debriefing Session
- [ ] PowerPoint Support
- [ ] Archive Footage
- [ ] “Discrete” Communication (Headset usage)
- [ ] No Archiving of Video
- [ ] Other:

**ROOM/RESOURCE CHECKLIST**
<table>
<thead>
<tr>
<th>Room Type</th>
<th>Setup</th>
<th>Describe</th>
<th>Mannequin?</th>
<th>Select</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Room</td>
<td>OR</td>
<td>Describe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room</td>
<td>ER</td>
<td>Describe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Med/Surg Room</td>
<td>Med Surg</td>
<td>Describe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICU Room</td>
<td>ICU</td>
<td>Describe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic Room 1</td>
<td>Clinic Room</td>
<td>Describe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic Room 2</td>
<td>Clinic Room</td>
<td>Describe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Procedural Skills Room</td>
<td>Procedural Skills</td>
<td>Describe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debrief Room</td>
<td></td>
<td>Equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Center A</td>
<td>Lecture Style</td>
<td>Describe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Center B</td>
<td>Lecture Style</td>
<td>Describe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task Training Room</td>
<td>Describe</td>
<td>Equipment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ADDITIONAL ROOM SETUP NOTES**

Information for SIM team and/or observers:

Case root: This is a _ year old lady/gentleman who presents with

Vitals
Physical exam findings

Pertinent Labs
Pertinent Radiography or Procedures
Respiratory Failure

Goals:
- Review causes and differential hypoxic and hypercapnic respiratory failure
- Review importance of correct ABG interpretation
- Review initial treatment of respiratory failure

Scenario #1 – Hypoxic respiratory failure due to PE
63 yo F admitted to IMED service for cholecystitis, HD #3. POD #2 from laproscopic cholecystectomy. PGY-2 called by PGY-1 for patient with acute onset SOB starting ~5 min ago. PGY 1 has already ordered CXR, ABG, EKG.

VS: HR 110 (sinus tach), BP 95/76, RR 30, satting 75% on RA
PE: CVS – tachy, no murmurs, Lungs – clear, Ext – SCDs on bilaterally

Enter PGY-2 – PGY-1 explains situation . . . allow to simulate a few min while studies return . . .

Stop after CXR, ABG, labs come back and discuss . . .

CXR – clear (can we put it on screen?)
ABG: pH 7.52, CO2 30.9, HCO3 24.8, pa02: 40 (a:a gradient 72)
Labs: CBC normal, renal profile normal

Discussion points:
- Debrief from simulation
- differential diagnosis for hypoxia
- abg interpretation
- calculation and use of A:a gradient
- treatment of hypoxic respiratory failure

Scenario #2: Hypercapnic respiratory failure due to oversedation
38 yo M with history of ALS admitted for worsening SOB. Overnight very agitated and given 1mg IV ativan. PGY 2 called by PGY 1 for decreased mentation and low oxygen saturations on monitor. Has already ordered CXR, ABG, EKG.

VS: HR 95 (sinus tach), BP 95/76, RR 7, satting 88% on RA
PE: neuro: constricted pupils, incomprehensible response to questions, CVS: normal, Lungs: normal

Enter PGY2 – PGY 1 explains situation . . . allow to simulate a few minutes while studies return

ABG: pH 7.29, CO2 58.9, HCO3 25
CXR: clear

Discussion points
- debrief from simulation
- ABG interpretation
- Differential diagnosis of hypercapnic respiratory failure
- Treatment of hypercapnic respiratory failure
Interacting with Non-English speaking patients.

Objectives:
1. Practice interviewing a patient that does not speak English fluently
2. Discuss plan of care for heart failure with a non-English speaking patient.
3. Explain proper technique and etiquette of working with an interpreter.

Key Participants:
IMED Residents
Standardized Patient-Spanish Speaking
Interpreter from International Services
Sim Center team
ED/Hospital Room
Learning Center Room

Plan:
8am-805am: Introduce the scenario of the interpreter
805-815am: Scenario #1
815-825am: Debrief
825-830: Wrap-up

Scenario #1: Interviewing a patient

Resident Prompt: Ms. Rivera is a 37 year old woman who was admitted to the hospital for increasing dyspnea x3 days.

Patient’s Background (not given to residents): 37 year old woman who presented to the ER with three days of worsening dyspnea on exertion. ROS: +cough, 5lb weight gain, +chills, +nausea, slight dizziness, abdominal fullness, otherwise negative. This has never happened before. Patient delivered a healthy 8 lb baby boy six weeks ago (only reveal if asked)
Past Medical History: None
Past Surgical History:
Medications: Oral Contraceptive Medications
Allergies: sulfa drugs
Social History: denies tobacco use, rare alcohol use, no illicits. Married, works as a secretary at a law firm, recently returned to work
Family History: mother with high blood pressure father alive with heart failure

Scenario #2: Explaining Medical Problems to a patient with an Interpreter

Today you are seeing Ms. Rivera, a 38 year old woman on rounds who was admitted to the hospital for a postpartum cardiomyopathy. On admission, patient was only on oral contraceptive medications. In the hospital, you removed fluid with lasix and patient is now feeling markedly improved. Today your responsibility is to explain to the patient her disease process and plan for discharge. You will be discharging the patient with lasix and metoprolol,
among other medications. In addition, she will be following heart failure guidelines (weighing daily, following the diet, etc).

Resources:
http://intranet.mayo.edu/charlie/international-services/language-services/rochester/working-with-an-interpreter/
SIM CENTER CURRICULUM- Receiving SBAR from Nurses

Goals:
- Reinforce the importance of appropriately responding to SBAR Calls from Nursing
- Practice responding to overnight SBAR calls from RNs

Participants:
- Internal Medicine Residents
- Sim Center Staff
- Volunteer Nurses
- Internal Medicine Chief Residents

Location and Materials:
- SimCenter B
- Med/Surg Room
- Scenarios from "positive assertion modules"

Timeline:
800-805: Recap from Session 1: (SBAR format and PEARLS)
805-820: Residents given scenarios. Residents practice receiving SBARs from Nurses with nurse volunteers.
820-830: Debrief

Scenarios:
- Positive Assertion Training Scenarios from Dr. Maniaci

Key Discussion Points:
- It is important to respond to every page from RN and every SBAR
- The phrase “I need a little clarity” means that the staff member is concerned about the patient and does not understand the plan. It is not meant to be a threatening phrase. This phrase warrants further discussion about the patient so all members of the patient care team are on the same page.
- It is important to ask “are there any questions” to RN to ensure clarity on patient care plan.

References:
Dealing with Pain Seeking Behavior

Goals of Exercise
- Illustrate difficult nature of encounter with pain seeking patients
- Emphasize importance of good communication with difficult patients – PEARLS (Partnership, Empathy, Respect, Legitimization, Support)

Participants:
Facilitators: IMED Chiefs, Faculty
Learners: IMED Residents
Sim Center Standardized Patient (Conrad)
Sim Center Staff

Location and Materials
Hospital Room (non-ICU)
Conference room B

Timeline
- Introduce patient scenario (2 min)
- First Group (5 min)
- Debrief (15 min)

Scenario:
35 yo M with longstanding history of complicated Crohn’s disease, on home fentanyl patch with po dilaudid for breakthrough pain, followed by our pain service as outpatient. Admitted for increased abdominal pain, hospital day #3. Hospitalization has included extensive workup including CT scan, GI evaluation, surgical and urological evaluation, all without any source of pain. Crohn’s disease is stable and no intervention recommended. During the hospitalization the patient has required and requested increasing amounts of IV dilaudid, currently taking 2mg q2h and is requesting more for his pain.

You are rounding with your team in the morning, and you are going to go tell the patient that there is no acute cause of pain and that you are going to be transitioning to po pain regimen in preparation for discharge.

Standardized patient:
Sleeping in bed, comfortably when team enters
Wakes up when team awakens him.
Immediately appears in pain once wakes up, wincing, grabbing stomach.
Expresses severe pain to team.
If examined – severe pain when examining stomach, tenses stomach as if does not want to be touched, bring knees up to stomach as if to protect
As plan explained to patient he gets increasingly angry, argues that he knows something is wrong and that the only medication that treats his pain is IV dilaudid and he cannot be off of it or leave the hospital.

Discussion points
- Debrief, what went good, what went bad?
- Discuss how to handle patient
- PEARLS – (Partnership, Empathy, Apology, Respect, Legitimization, Support)
- Come up with “PEARLS” statements that may help facilitate communication
GIVING “BAD” NEWS: Utilizing Plain Language.

Goals of exercise:
-Demonstrate communication of bad news in an empathetic and effective manner
-Practice explaining disease processes using plain language

Participants:
Facilitators: IMED Chiefs, Faculty
Learners: IMED Residents
Sim Center Standardized Patient
Sim Center Staff

Location and Materials:
ED/ICU Room
Debrief Room

Timeline:
-Introduce Scenario (2 min)
-First Group –likely PGY2/3s… will deliver the bad news to the patient ineffectively (5 min)
-Debrief… (10 min)
-Second group: several interns to deliver bad news. (5 min)
-Debrief: (5-10 min)

Plain language scenario: 24 year old gentleman with increasing thirst, increased urination, and weight loss who presented to the emergency department for nausea and dizziness. He was found to have a blood sugar of 500 with blood salt abnormalities and acute kidney failure. He was treated for diabetic ketoacidosis (acid in the blood from high sugar in the blood) and diagnosed with diabetes mellitus. This is hospital day two, and the team is responsible for telling the patient that he has diabetes mellitus and kidney failure (which will improve by discharge). Patient as he has been treated for his high blood sugar, is feeling much better; his dizziness has resolved and he is tolerating food. However, once told, this diagnosis is extremely upsetting for the patient, as the patient has a distant cousin who has diabetes and has had several toes amputated. The patient has difficulty understanding that diabetes is a manageable disease as long as the patient maintains a diabetic diet, takes his medications, monitors his blood sugar and blood pressure, exercises, and gets regular follow ups with his doctors. The patient will need to give himself shots of insulin initially but may be able to come off of it or reduce the amount after a few months. He will have to take several other pills daily to prevent. If the patient does not take care of himself, the patient is at substantial risk for heart attack, kidney failure requiring dialysis, stroke, ulcers, and eye problems.

Scenario to be given to residents: 24 year old gentleman with polyuria, polydypsia, and polyphagia, and weight loss presenting with nausea and dizziness, found to be in DKA with new onset diabetes mellitus, with metabolic acidosis and acute renal failure. Gap was closed about 6-8 hours after admission. Patient tolerating diet. Is being transitioned to detemir and SSI. Renal
function is improving, but is not back to presumed baseline for patient. The purpose of this visit with the patient is to explain to the patient that he has diabetes mellitus and what that means, including what is required for this patient for the management of his condition as well as the consequences of diabetes if he does not take care of himself.

References on using plain language in medicine:

WSJ
http://online.wsj.com/article/SB10001424052748703620604575349110536435630.html?mod=WSJ_hps_MIDDLESSecondNews#articleTabs%3Dvideo

AMA Video:
http://www.youtube.com/watch?v=cGtTZ_vxjyA

CDC
http://www.cdc.gov/healthliteracy/training/page661.html

Reference: WSJ Article:
http://online.wsj.com/article/SB10001424052748703620604575349110536435630.html?mod=WSJ_hps_MIDDLESSecondNews#articleTabs%3Darticle

References on Diabetes Mellitus:
Patients:

Medical Residents
http://care.diabetesjournals.org/content/35/Supplement_1/S11.full.pdf+html
Recognize the Deteriorating Patient

Goals:
- Practice intervention on Deteriorating Patient.
- Remind the residents about the team structure for codes
- Discuss ways to assist during codes
- Review the ACLS Pulseless arrest algorithm

Plan:
- Introduce the teams
- Solicit volunteers: second year, several first years. Need a resident for nurse and for pharmacist.
- Run deteriorating patient scenario.

- Debrief
  - What went well?
  - What went wrong?
  - How does each team member participate and contribute to the situation?

- Review Pulseless Arrest algorithm
- Run code #2 with new volunteers.

- Debrief.

- Run Code #3
- Debrief

Scenarios for tomorrow for facilitators’ benefit:

1) 65 year old admitted for syncope. PMH significant for Htn and MSK pain, hx of ibuprofen for tx of pain. VS on admission: 37.4, 110, 98/65, RR18. Hgb 12. You called to bedside due patient complaint of nausea, dizziness. Patient will go into PEA…we will control from the control room

2) 91 year old admitted the hospitalist service for CAP. VS: 38.8, HR114, BP 110/78, RR25, Pox 88% 2L NC. (Patient DNR)

3) (Will not give this to residents…we are just going to “call the CODE”). 72 year old admitted for chest pain, goes into VTach (VS on admission: 36.6, P97, BP 145/88, RR20, Pox 100% 2L NC)