Insert photo here

End of Life: Inpatient

Instructor Information

Patient Name: Stanley Goodman

Simulation Developer(s): Melissa Brickner, Bridgett Everett, Debra A. Mosley, Beverly Snyder-Desalles, and Judy Young

Scenario Purpose:

- Communicate effectively when caring for the patient experiencing end of life

Learner(s):

- **Registered Nurses (RN), Licensed Practical Nurses (LPN), Unlicensed Assistive Personnel (UAP)**
- **Others as desired, depending on facility protocols**
- **Recommend 2 learners in the room during the scenario (3 additional learners can observe)**

Time Requirements:

- **Setup:** 5 minutes
- **Scenario:** 25 minutes
- **Debrief:** 25 minutes
- **Reset/Breakdown:** 5 minutes

Confederate(s):

- **Wife/family member(s)**

Scenario Prologue:

- **Inpatient:** Eighty-nine (89) year-old male is an inpatient admitted 24 hours ago for altered mental status (AMS) who is unresponsive due to a fall resulting in a subarachnoid bleed. The wife/family member is at the bedside.
- Provide the learners with a disclaimer due to the sensitivity of the content covered in this scenario
- **The simulation begins when the learners enter the room**

Patient information:

- **General:** Unresponsive
- **Weight/Height:** 59.1kg (130lbs) 179.3cm (69in)
- **Vital Signs:** BP 54/36, Temp 96, HR 40, RR 8, O2 Sat 88%
- **Pain:** Unresponsive to painful stimuli
- **Neurological:** Pupils dilated and unresponsive
- **Respiratory:** Bradypneic
- **Cardiac:** Bradicardic
- **Gastrointestinal:** Hypoactive bowel sounds
- **Genitourinary:** Urinary output 30 mL/8 hours
- **Musculoskeletal:** Extremities flaccid
- **Skin:** Cool and mottled
- **Past Medical History:** Dementia, fibromyalgia, rheumatic fever, falls, and 30 year one pack per day cigarette smoker
- **Past Surgical History:** Mitral valve replacement 20 years ago

Medications:

- Pregabalin 100 mg three times daily
- Donepezil 5 mg one time daily at bedtime

Allergies:

- Hydromorphone and oak tree pollen

Green Text Confederate

Red Text Physiology Change

Learning Objectives

Patient Name: Stanley Goodman
Simulation Developer(s): Melissa Brickner, Bridgett Everett, Debra A. Mosley, Beverly Snyder-Desalles, and Judy Young
Scenario Purpose:

- Assist nursing staff when caring for the patient experiencing end of life

Pre-Session Activities:

- Complete facility specific end of life training
- Review policies and protocols on end of life and palliative care

Scenario Specific Learning Objectives (Knowledge, Skills, and Attitudes = K/S/A):
**The learner(s) will demonstrate ICARE principles throughout the scenario.
Learning Objective 1: Perform the appropriate interventions when providing care for the patient and experiencing end of life

a. ***K***- *Recognize signs and symptoms of end of life*
   A- *Demonstrate empathy*
b. ***S***- *Implement appropriate measures to alleviate symptoms associated with end of life*

Learning Objective 2: Facilitate the required actions to initiate a facility specific Hospice and palliative care consult

a. ***K***- *Discuss facility specific interdisciplinary resources and processes for palliative care (i.e. Advanced Directives, palliative care, pharmacy, mental health, chaplain, and social work) available for the patient experiencing end of life and family*
   S- *Verify facility specific do not resuscitate (DNR) orders*
b. ***S***- *Initiate a facility specific palliative care consultation*

Learning Objective 3: Communicate effectively when managing care for the patient experiencing end of life

a. ***K***- *Discuss signs and symptoms of end of life*
b. ***S***- *Explain the purpose and goals of palliative care*
c. ***S***- *Provide reassurance*
d. **S**- *Complete required facility specific documentation*

Debriefing Overview:

- Ask the learner(s) how they feel after the scenario
- Have the learner(s) provide a summary of the scenario from a healthcare provider/clinical reasoning point of view
- Discuss the scenario and ask the learners what the main issues were from their perspective
- Ask what was managed well and why.
- Ask what they would want to change and why.
- For areas requiring direct feedback, provide relevant knowledge by stating "I noticed you *[behavior]…"* Suggest the behavior they might want to portray next time and provide a rationale. "Can you share with us?"
- Indicate closing of the debriefing but provide learners with an opportunity to voice one or two take-aways that will help them in future practice
- Lastly, ask for any outstanding issues before closing the debrief

Critical Actions/Debriefing Points:

1. Verify the presence of do not resuscitate (DNR) orders
2. Recognize adventitious breath sounds (Death Rattle) and mottling as end of life symptoms
3. Discuss management of end of life symptoms
4. Explain the purpose and goals of palliative care
5. Demonstrate empathy

6. Provide reassurance
7. Explain resources available for Hospice and palliative care
8. Initiate a Hospice and palliative care consultation
9. Complete facility specific documentation

Simulation Set-Up

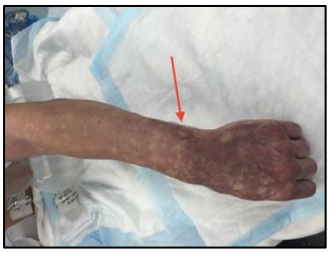
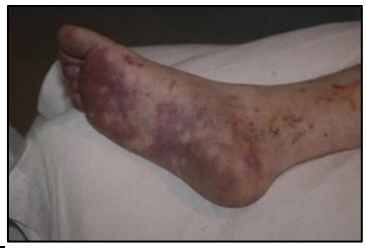
(ALS Mannequin)

Patient Name: Stanley Goodman
Simulation Developer(s): Melissa Brickner, Bridgett Everett, Debra A. Mosley, Beverly Snyder-Desalles, and Judy Young
Room Set-up:

- Inpatient: Set up like a hospital patient room

Patient Preparation:

- Hospital gown
- Patient identification band
- Vital signs: SpO2 88%; BP 54/36; Temp 96; HR 40; RR 8 ****The patient is not on the monitor***
- Apply a nasal cannula and connect to oxygen source at 2 liters/min or compressed air delivery system
- Saline lock in the right antecubital space
- Lips and earlobes are blue/cyanotic
- Moulage mottling on extremities with reddish-blue/purple blotches

Have the following equipment/supplies available:

- Telephone
- Gloves
- Hand sanitizer
- Stethoscope
- Tissues
- Oxygen source or compressed air delivery system
- Oxygen Nasal cannula
- Suction
- Saline lock
- Hospital bed/stretcher

Note: 5.8 Simpad software update is required to load scenarios (http://cdn.laerdal.com/downloads/f4343/simpad-upgrade.vs2
Scenarios may be used with Laerdal or LLEAP software

Scenario Supplements (On a clipboard in the patient's room)**:

- Confederate scripts
- Confederate and learner name tags
- Patient identification band
- Palliative care consult orders (facility specific) **(Laminate)**
- Do Not Resuscitate (DNR) orders (facility specific) **(Laminate)**
- Progress Notes
- Palliative care assessment tool (facility specific)
- ZZ test patient/Demo patient in CPRS (if desired) **(Laminate)**

Flowchart

Initial State:
- Mental Status: Unresponsive
- Sp02: 88%
- BP: 54/36
- Temp: 96
- HR: 40
- RR: 8
- Lungs: Bilateral gurgling rhonchi
- Eyes: Closed
- Pain level: Unresponsive to pain
- Skin: Cool and mottled

89 year old male inpatient admitted with altered mental status who is unresponsive due to a subarachnoid bleed related to a fall. The spouse/family member is at the bedside.

- ***The wife/family member asks "Why is he breathing that way? What's wrong with his skin?"***
- ***Recognizes gurgling breath sounds (Death Rattle) and mottling as end of life symptoms***
- ***Verifies facility specific do not resuscitate (DNR) orders***
- ***Explains end of life symptoms and management to the wife/family member***
- ***Implements appropriate interventions to alleviate end of life symptoms***

- ***The wife/family member asks "What does it mean that he has been admitted under palliative care?"***
- ***Explains the purpose and goals of palliative care***

- ***The wife/family member becomes tearful and states "Thank you. It is painful enough knowing I am going to lose him. I just don't know how to handle this and what to do. What kind of help can we receive?"***
- ***Provides reassurance***
- ***Discusses palliative care resources and services available (i.e. Hospice, healthcare provider, social worker, pharmacy, mental health, chaplain)***
- ***Initiates a palliative care consultation per facility protocol***
- ***Completes facility specific documentation***

Did not discuss/verify…
…end of life symptoms
…facility specific end of life orders
…palliative care resources and plan of care available
…plan of care
The wife/family member will become increasingly anxious/emotional and state "I don't understand what's going on! What's going to happen? Why isn't anybody doing anything?"

Critical Actions/Debriefing Points:
- Verify the presence of do not resuscitate (DNR) orders
- Recognize adventitious breath sounds (Death Rattle) and mottling as end of life symptoms
- Discuss management of end of life symptoms
- Explain the purpose and goals of palliative care
- Demonstrate empathy
- Provide reassurance
- Explain resources available for Hospice and palliative care
- Initiate a Hospice and palliative care consultation
- Complete facility specific documentation

Confederate

Change in physiology

Red border incorrect action

Supplements

Confederate Scripts

Confederate Name Tags

Patient Identification Band

Orders

Progress Notes

DNR Example

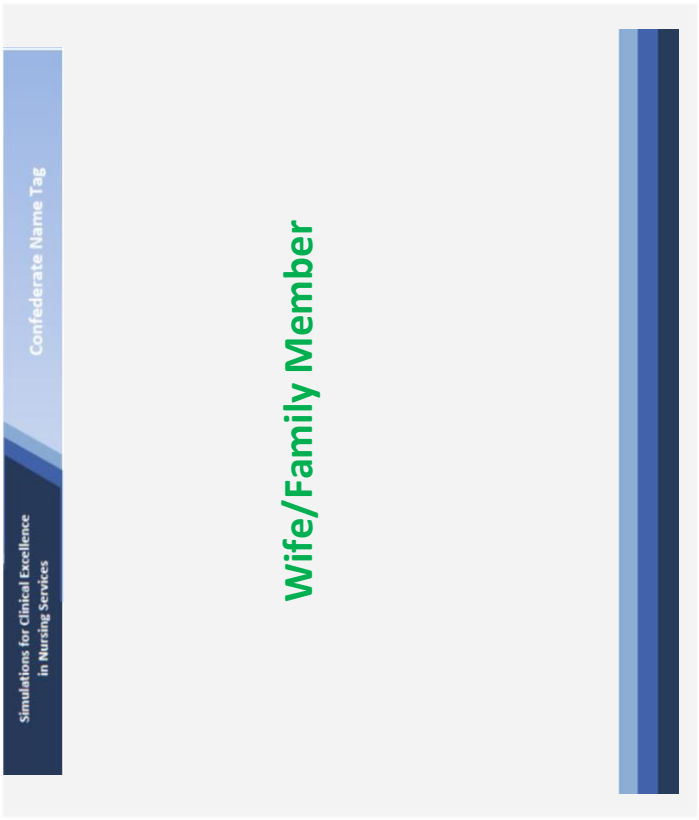
Confederate Scripts

Wife/Family Member

89 year-old male inpatient admitted with altered mental status who is unresponsive due to a subarachnoid bleed related to a fall. The wife/family member is at the bedside.

- **The wife/family member will ask "Why is he breathing that way? What's wrong with his skin?"**
- **The wife/family member will ask "What does it mean that my husband has been admitted under palliative care?"**
- **The wife/family member will become tearful and state "Thank you. It is painful enough knowing I am going to lose him. I just don't know how to handle this and what to do. What kind of help can we receive?"**
- **If the learner(s) do <u>not</u> discuss/verify…end of life symptoms; facility specific end of life orders; palliative care resources and plan of care available…**
    - **…the wife/family member will become increasingly anxious/emotional and state "I don't understand what's going on! What's going to happen? Why isn't anybody doing anything?"**

Confederate Name Tags



Patient Identification Band

Orders

Patient Information

Goodman, Stanley
Dr. M. Santana
Age: 89
Social Security #: 000-00-0000
Allergies: **Hydromorphone and oak tree pollen**
Weight: 59.1kg (130lbs)
Height: 179.3cm (69in)

Admit to	Medical Surgical unit
Diagnosis	Subdural hematoma
Condition	Poor
Diet	NPO
Activity	Bedrest
IV Therapy	Saline Lock
Medications (prn)	
Code Status	Do not resuscitate
Respiratory Therapy Orders	Oxygen 2 liters nasal cannula or compressed air per palliative care protocol
Miscellaneous Orders	Palliative care consultation

DO NOT WRITE IN THIS SPACE

Progress Notes

Patient Information

Goodman, Stanley
Dr. M. Santana
Age: 89
Social Security #: 000-00-0000
Allergies: **Hydromorphone and oak tree pollen**
Weight: 59.1kg (130lbs)
Height: 179.3cm (69in)

Date: Today	Discussed the patient's status with his spouse/family member as well as his poor
Time: 30 minutes ago	prognosis. The spouse/family member agrees to Do Not Resuscitate code status.
	Palliative care options and goals discussed with the spouse/family member.

DO NOT WRITE IN THIS SPACE

DNR Example

DNR COMFORT CARE

DNR IDENTIFICATION FORM

☒ **DNRCC**
(If this box is checked the DNR Comfort Care Protocol is activated immediately.)

☐ **DNRCC—Arrest**
(If this box is checked, the DNR Comfort Care Protocol is implemented in the event of a cardiac arrest or a respiratory arrest.)

Patient Name: Stanley Goodman

Address: 5513 Veterans Lane

City Your city State Your state Zip 12345

Birthdate XX-XX-XXXX Gender ☒ M ☐ F

Signature Stanley Goodman (optional)

Certification of DNR Comfort Care Status (to be completed by the physician)*

(Check only one box)

☒ **Do-Not-Resuscitate Order**—My signature below constitutes and confirms a formal order to emergency medical services and other health care personnel that the person identified above is to be treated under the State of Your state DNR Protocol. I affirm that this order is not contrary to reasonable medical standards or, to the best of my knowledge, contrary to the wishes of the person or of another person who is lawfully authorized to make informed medical decisions on the person's behalf. I also affirm that I have documented the grounds for this order in the person's medical record.

☐ **Living Will (Declaration) and Qualifying Condition**—The person identified above has a valid Living will (declaration) and has been certified by two physicians in accordance with ____ law as being terminal or in a permanent unconscious state, or both.

Printed name of physician*: Dr. M. Santana

Signature Dr. M. Santana Date Today

Address: 1111 East Lane Phone xxx-xxx-xxxx

City/State Your city, your state Zip 12345

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DNR Example

DNR
COMFORT CARE

DO NOT RESUSCITATE COMFORT CARE PROTOCOL

After the State of Your state DNR Protocol has been activated for a specific DNR Comfort Care patient, the Protocol specifies that emergency medical services and other health care workers are to do the following:

WILL:

- Suction the airway
- Administer oxygen
- Position for comfort
- Splint or immobilize
- Control bleeding
- Provide pain medication
- Provide emotional support
- Contact other appropriate health care providers such as hospice, home health, attending physician/CNS/CNP

WILL NOT:

- Administer chest compressions
- Insert artificial air way
- Administer resuscitative drugs
- Defibrillate or cardiovert
- Provide respiratory assistance {other than that listed above)
- Initiate resuscitative IV
- Initiate cardiac monitoring

If you have responded to an emergency situation by initiating any of the **WILL NOT** actions prior to confirming that the DNR Comfort Care Protocol should be activated, discontinue them when you activate the Protocol. You may continue respiratory assistance, IV medications, etc., that have been part of the patient's ongoing course of treatment for an underlying disease.

References

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