QuES for excellence	Simulation Scenario		
Title	Acute Left Ventricular Failure	Version	10.1
Target Audience	FY doctors & student nurses	Run time	10 -15 mins
Authors	N Feely, U Naidoo, P Wilder, M Loughrey	Last review	4/7/18
Faculty comments	Normal faculty requirements	Necessity	n/a

## **Brief Summary**

The main focus of this scenario is recognition of acute left ventricular failure with timely investigation and treatment. The FY doctor should be able to diagnose and manage this condition appropriately.

### **Educational Rationale**

Heart failure is one of the commonest medical emergencies on acute medical take. Heart failure should be a differential in all elderly patients presenting with breathlessness in addition to other causes. FY trainees should be able to work within, and lead, a team to safely assess and treat patients in a timely manner to ensure the best possible outcome.

# Learning Objectives: Nurse

- ABCDE assessment of a deteriorating patient
- Appropriate escalation and SBAR handover

# **Learning Objectives: Doctor**

- A-E assessment and management of a deteriorating patient
- Early recognition of left ventricular failure, appropriate investigations and use of local treatment protocols
- Appropriate call for help to escalate the management and concise transfer of information



No	CURRICULUM MAPPING	This scenario
1	Acts professionally	✓
2	Delivers patient-centred care and maintains trust	✓
3	Behaves in accordance with ethical and legal requirements	✓
4	Keeps practice up to date through learning and teaching	✓
5	Demonstrates engagement in career planning	
6	Communicates clearly in a variety of settings	✓
7	Works effectively as a team member	✓
8	Demonstrates leadership skills	✓
9	Recognises, assesses and initiates management of the acutely ill patient	✓
10	Recognises, assesses and manages patients with long term conditions	✓
11	Obtains history, performs clinical examination, formulates differential diagnosis and management plan	✓
12	Request relevant investigations and acts upon results	✓
13	Prescribes safely	✓
14	Performs procedures safely	✓
15	Is trained and manages cardiac and respiratory arrest	
16	Demonstrates understanding of the principles of health promotion and illness prevention	✓
17	Manages palliative and end of life care	
18	Recognises and works within limits of personal competence	✓
19	Makes patient safety a priority in clinical practice	✓
20	Contributes to quality improvement	

# Candidate Briefing: Nurse

Setting

**Emergency department** 

You are a nurse working in the Emergency Department. You are looking after Mary Emory, a 72 year old patient who has presented with acute shortness of breath and chest discomfort, on a background of IHD and COPD.

The admission notes, drug chart and observation chart are available.

Please take a set of observations and proceed.

# Candidate Briefing: Doctor

Setting

**Emergency department** 

You are an ED doctor working in A&E Majors.

Please wait until you are called by the nurses who are undertaking a patient assessment in resus, and then act as you would do in real life, including receiving SBAR handover from them.

Technical set-up					
Setting	Emergency department				
Simulator	High fidelity manikin				
Gender	Female	Age	72		

Initial monitor parameters						
RR	O2 sats	Pulse (HR)	ВР	ECG rhythm		
24	92% on air	125	110/50	Sinus tachycardia		
Cap Refill Time	Blood glucose	Temp.				
4 sec	5.9	36.9				

# Initial patient set-up Obstruction Airway adjunct No None

Droothing	Chest sounds	O2 supply
Breathing	Bibasal wheeze and crackles	air

Circulation	Heart sounds	Cannula	BP cuff	Peripheries / pulses
Circulation	Sinus tachycardia	In place	Attached	Cool

Disability	Eyelids	Pupils	AVPU/GCS
Disability	Open	Equal and reactive	A / 13

Evposuro	Posture	Moulage	Bowel sounds
Exposure	Sitting at 45 degrees	None	normal

# Specific equipment / prop requirements

- Oxygen and selection of masks inc non-rebreathe masks
- Monitoring equipment (ECG and sats probe)
- Syringes, flushes, iv fluids and giving sets
- Simulated drugs
- Blood bottles and request forms
- Observation chart, medical notes, drug chart
- BNF
- Mobile phone for guideline app

# **Facilitator Briefing**

### Telephone Advice

If the candidate is struggling with the diagnosis/management, give some clues:

- Ask for brief history of admission
- Ask for current state and examination findings
- Ask for cardiovascular status pulse volume, capillary refill time, whether hands warm/cold, any signs of sepsis?
- Ask about fluid balance for last 24 48 hours
- Ask for ECG findings\* if AF correctly diagnosed, recommend rate control with digoxin iv
- Ask for ABG result\*
- Ask for CXR result\* ask for the candidates opinion on findings
- \* if any investigations have not been performed, ask the candidate to call you back once they are available

#### **CONDUCT**

- You will be sitting in the control room for the duration
- Answer all calls as "switchboard" in the first instance to allow for realistic delay. Call back after 1
   2 minutes
- The Medical Registrar should sound busy and state they are tied up with another patient
- They should be helpful but press the candidate hard about what assessment has been performed e.g. nature of pain, findings of physical examination
- If the candidate is not armed with the information, tell them to get the required info and call you back

# How to run with candidates from only one discipline

An additional member of faculty can play the role of the nurse in this scenario if needed.

Sim Nurse briefing:

You are looking after Mary Emory, a 72 year old patient who has presented with acute shortness of breath and chest discomfort, on a background of IHD and COPD. You ask the FY doctor to assess him in the Emergency Department. An observation chart is available with the first set of obs recorded.

#### **CONDUCT**

Throughout the scenario you should act as a "competent robot" i.e. you should perform all tasks requested to the best of your ability, but should not initiate any treatment on your own. If you are not being effectively instructed by the candidate, you may be prompted via your ear piece by the lead facilitator as to what your next action should be.

If you strongly disagree with management then you are free to question them, stating your reasons. If asked to give drugs, you should request that they are prescribed on the drug chart. If they are unsure of the dosage please refer them to the BNF or Hospital Guidelines App or via Intranet.

Patient Briefing				
Setting	Emergency department			
Name	Mary Emory			
Age	72			
Gender	Female			

## What has happened to you?

- •Your chest has become uncomfortable for the past hour.
- •Your chest feels tight and it is really difficult to breathe.
- •You can only say 2 to 3 words at a time.
- •You took your GTN spray and your usual inhalers but they haven't helped.
- •If prompted by the faculty you will deteriorate and may arrest.

## How you should role-play

You are initially breathless but able to speak in short sentences. You have a tight sensation in your chest. You will quickly deteriorate and only be able to speak in single words. If correct treatment is not given you will deteriorate further and become drowsy.

## Your background

- · You are a retired shopkeeper.
- History of angina (for which you take a GTN spray)
- · Heart attack 8 years ago
- COPD (smoked since the age of 15)
- Exercise tolerance of about 100 yards (on a good day) limited by shortness of breath.

# Scenario flowchart

#### **INITIAL SETTINGS** Clear RR 24, sats 92% on air / 95% on 15L O2, bibasal wheeze and crackles HR 125, BP 110/50, CRT 4 sec, cool peripheries **EXPECTED ACTIONS** E3V4M6, PEARL 3mm, BM 5.9, distressed No rash, T 36.9, sweaty Recognise acutely unwell ABCDE assessment O2 facemask ECG + NIBP monitoring Consider DDx inc COPD, LVF, ACS **DETERIORATION** Review medical Clear, speaking in near full sentences notes and drug chart RR 35, sats 90% on 15L O2, bibasal wheeze and B: creps HR 140, BP 90/50, CRT 4 sec C: Eyes half open, obeys commands, PERL 3mm D: Unchanged **EXPECTED ACTIONS** No improvement if COPD, ACS treatment given Ix: ABG, bloods, **FURTHER DETERIORATION** ECG, CXR Consider (and treat) Clear, speaking in single words other diagnoses inc RR 35, sats 88% on 15L O2, widespread wheeze LVF as soon as ECG C: HR 140, BP 90/50, CRT 4 sec, chest pain

#### **RESULTS**

INITIAL ABG (on room air)

7.32 p02 8.0 pCO2 5.2 ΒE -4 Lact 1.9

CXR: pulmonary oedema

ECG: Anterolateral ST depression

ABG (after further deterioration) 7.30 pO2 7.3 pCO2 6.2 BE -6 Lact 2.3

**BLOODS**: Normal

#### **EXPECTED OUTCOME**

- Treat LVF Furosemide / GTN infusion / Morphine / CPAP
- Supportive management

Unchanged

Eyes half open, drowsy

D:

#### LOW DIFFICULTY

- ensures LVF drugs given, CPAP considered
- Patient stabilises

returned

Contact seniors

#### NORMAL DIFFICULTY

- Seniors not present initially
- Reassess, give LVF drugs
- Plan trial of CPAP

#### **HIGH DIFFICULTY**

- Deterioration even though treated appropriately: patient goes into cardiac arrest (VF)
- 3 cycles of CPR → ROSC with:
- B: RR 0, silent chest, sats 93%
- C: HR 140, BP 90/50, CRT 4s
- Unresponsive
- ITU team arrive and coordinates on-going care

Medical Registrar arrives early,

#### **RESOLUTION**

Appropriate treatment prescribed, investigations ordered, events discussed with patient, contemporaneous notes, decisions re: ongoing care

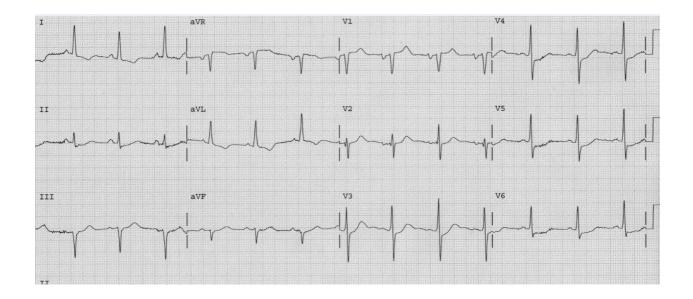
# References

- European Society of Cardiology guidelines for the diagnosis and treatment of acute and chronic heart failure 2012. European Heart Journal 33: 1787-1847 available at: <a href="https://www.escardio.org/Guidelines/Clinical-Practice-Guidelines/Acute-and-Chronic-Heart-Failure">https://www.escardio.org/Guidelines/Clinical-Practice-Guidelines/Acute-and-Chronic-Heart-Failure</a>
- NICE CG108. Chronic heart failure in adults: management. August 2010. Found at: https://www.nice.org.uk/Guidance/CG108
- NICE CG187. Acute heart failure: diagnosis and management. October 2014. Found at: https://www.nice.org.uk/guidance/cg187

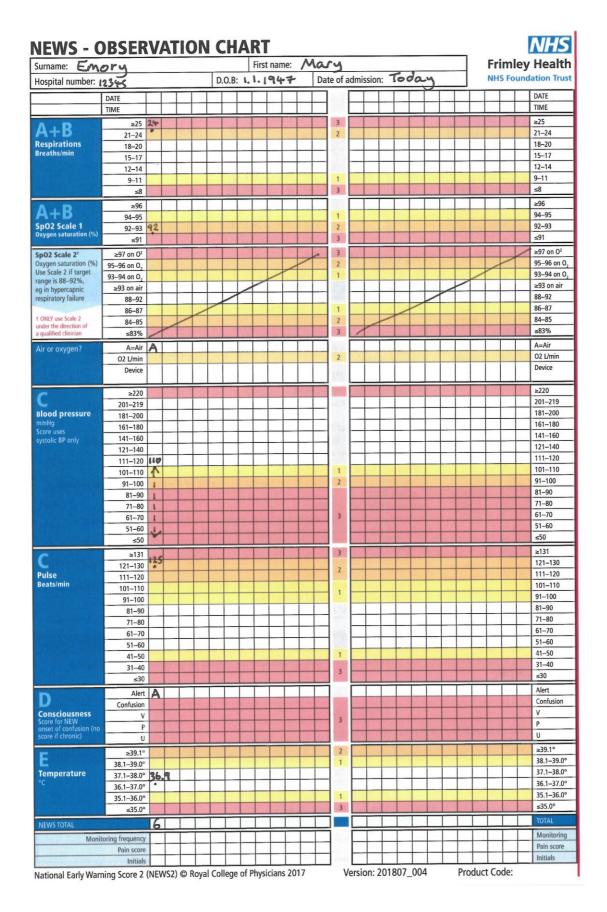
# Clinical props

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Blood Gas Values					-		
↓ pH	7.320		1	7.350	-7.450	1	
pCO <sub>2</sub>	5.80	kPa	1	4.70	- 6.00	1	
↓ pO₂	8.0	kPa	1	11.1	- 14.4	1	
Hctc	0.42	%					
Oximetry Values							
ctHb	11.9	g/L					
↓ FO₂Hb	92.0	%	[	94.0	- 98.0	1	
sO <sub>2</sub>	92.0	%					
FCOHb	0.6	%	1	0.5	- 1.5	1	
FHHb	4.0	%	1	0.0	- 5.0	1	
FMetHb	0.0	%	1	0.0	- 1.5	1	
Calculated Values							
cBase(Ecf) <sub>C</sub>	-4.0	mmol/L					
cHCO <sub>3</sub> -(P)c	18.0	mmol/L					
Electrolyte Values							
cNa+	143	mmol/L	[	136	- 146	1	
cK*	3.7	mmol/L	[	3.4	- 4.5	1	
cCl <sup>-</sup>	103	mmol/L	[	98	- 106	1	
cCa <sup>2+</sup>	1.17	mmol/L	1	2.2	- 2.45	1	
Anion Gap <sub>c</sub>		mmol/L					
Metabolite Values							
cGlu	4.5	mmol/L	]	3.9	- 5.8	1	
↑ cLac	1.9	mmol/L	[	0.5	- 1.6	1	
cCrea	88	µmol/L	1	44	- 97	1	
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170	sO,	91.0	%				
	FCOHb	0.7	%	1	0.5	- 1.5	1
	FHHb	4.1	%	1	0.0	- 5.0	1
	FMetHb	0.1	%	[	0.0	- 1.5	1
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Ele	ctrolyte Values						
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	cK*	4.2	mmol/L	1	3.4	- 4.5	1
	cCl-	106	mmol/L	1	98	- 106	1
	cCa <sup>2+</sup>	1.20	mmol/L	1	2.2	- 2.45	1
	Anion Gap <sub>c</sub>		mmol/L				
Met	abolite Values						
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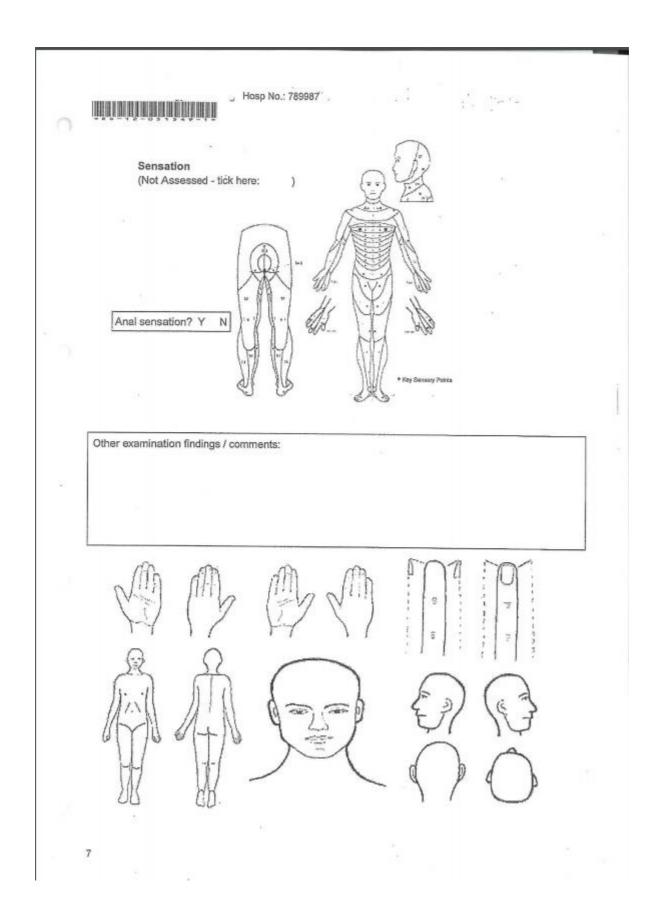
Hosp No.: 789987 Name Signature Initials Position Speciality Date Time Have you considered the use of a Chaperone when seeing this patient, Please refer to the Trust and Emergency Department Chaparone Policy. Chaperone Used? Y / N Name: Presenting Complaint: HISTORY: (Please continue on continuation sheets if necessary) Age >65 3 Coronary Artery Disease (CAD) Risk Factors: Family history, raised cholesterol, diabetes mellitus, hypertension, active smoker Chestpain 30 mins Feels byont non radiating No (ough active smoker Known CAD stenosis >50% Aspirin use in past 7 days Recent (<24 hours) severe angina Raised cardiac markers (CK) ST deviation >0.5mm TIMI Risk Score Age >60 BP >140/90 Clinical features: Unitat weak (2 pts) Speech only (1 pt) Duration: >60 mins (2 pt) 10-59 mins (1 pt) <10 mins (0 pt) Diabetic ABCD2 Score (max 7) 0 Pregnant? Y / N Women of Childbearing age? LMP: .....

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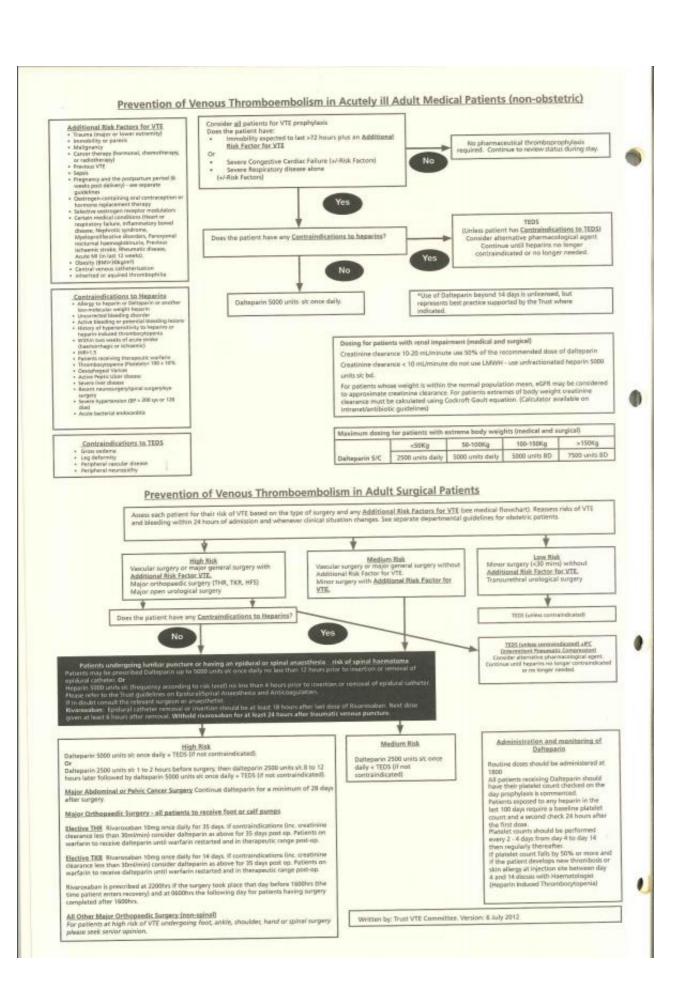


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V heparin infusion CA  Reminder: Pre Uni Communicatio Date	escriptions must l clear prescription on for doctors. M	Epidural be rewritten not s will be challen	amended	i	24 hours.	Medic	ines reconciliat	Sign and Bleep No.	sign and date
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## RISK ASSESSMENT RECORD SHEET FOR VENOUS THROMBOEMBOLISM (VTE)

- Please use in conjunction with Trust guidelines overleaf
   Please see separate Trust guidelines for obstetric patients

Thrombosis Risk	Patient Related	Procedure Related	Appenament	Assessment at 24 hours	Assessment	Assessmen
High	Previous VTE					-
	Immobility expected to test >72 hours	1				
	Malignancy					
	Acute or chronic lung disease	1				
	Acute or chronic inflammatory disease					
	Chronic heart failure Lower limb paralysis (excluding acute					
	stroke) Acute infectious disease, e.g.					
	pneumonia BMI >30kg/m2					
	Inharited or acquired thrombophilia					
	Pregnancy or less than 6 weeks post parture					
	300,000	Hip or Knee replacement				
		Hip fracture				
		Other major orthopaedic surgery				
		Surgical procedure lasting >30mins with additional VTE risk factor(s)				
Medium	Oestrogen containing onal contraception or HRT Selective destrogen receptor	The second of the second of				
	modulators					
	Age > 60					
	Dehydration					
	Varicose vains with philabitis					
		Minor surgical procedure with additional VTE risk factor(s)				
		Surgical procedure lasting >30mins with no additional VTE risk factors Plaster cast immobilisation of lower				
Low		limb				
LOW	None of above	None of above				
Bleeding Risk/ Contraindications	Patient Related	Procedure Related				
	Haemophilis or other known bleeding disorder					
	Thrombocytopenia (Platelets < 100 x 10 1/1.)		7			
	Within two weeks of acute stroke				_	
	(haemonhagic or ischaemic)  Severe hypertension (BP > 200 systolic or 120 diestolic)					
	Severe liver disease					
	Oesophageal Varices					
	Active Peptic Uter disease					
	Active bleeding or potential bleeding lesions					
	Major bleeding risk, existing anticoagulant therepy					
	Severe renal disease					
		Neurosurgery, spinul surgery or eye surgery				
		Other procedure with high bleeding risk				
		Lumber puncture/spinal/apidural in previous 4 hours or anticipated in next 12 hours				
čisk assessment per	rformed by	CA PROPERTY.				
Signature						
ony of Patient Infor	rmation Leaflet given to patient		Yes No			

NCE O	NLY DRUG	S AND PREMEDICATION.							
Date	Time	Drug	Dose	Route	Prescriber Sig. GMC no.	Batch number (vaccines only)	Time		Pharm.
							1		
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	1			-			+		
					-		+		
	-		-	+			+		
DRUGS	ADMINIS	TERED UNDER MIDWIFERY	EXEMPTION	AND PATI	ENT GROU	JP DIRECTI	ONS.		
Date	Time	Drug	Dose	Route	Batch n	umber (vaccional products	nes only)	Print name	Sig.
Date	Time	Drug							
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Date	Time	Drug (s)	Nurses s	ignature	Reason	NG for non ac	amirina	ration and action	HSC SHOOT
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REGULAR PRE	SCRIPTIONS					( TIMES	8 DA
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PRESCRIBERS SIGNATURE	***************************************		DATE	000000000000000000000000000000000000000		1800	
Home Oxygen Indicated: YE Referral to Respiratory Nurse	S/NO for MDCS Date:			Other:		2200	
Nurse to initial against time t meeting specified target. Flo	o confirm coygen is being administered as wrate is to be documented to the laft of	nd the		2L Sign	]	Device	
PHARMACOLOGICAL VTE			DOSE	ROUTE			
PRESCRIBERS	GMC No.		START	REVIEW	STOP		
SIGNATURE				Please tick appropris	ote status		-
INDICATION AND SPECIAL INSTRUCTIONS	270			□ NEW □ PRE A			+
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MECHANICAL VTE PROPHYLAXIS			DOSE	ROUTE			+
PRESCRIBERS SIGNATURE	GMC No.		START	REVIEW	STOP		
INDICATION AND SPECIAL INSTRUCTIONS				Please tick appropris			
PHARMACY				TO CONTINUE ON DISCHARGE	□ YES □ NO	1	
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PRESCRIBERS SIGNATURE	GMC No.		START	REVIEW	STOP	-	
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INDICATION AND SPECIAL INSTRUCTIONS				□ NEW □ PRE	AD CHANGE		
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ORUG (Approved Name)	14 100		DOSE	ROUT			-
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reme.				☐ NEW			-	Night		
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POD H POD W  WHEN RE  DOSE ( UNITS)  PRESCRIBERS SIGNATURE  INDICATION AND SPECIAL INSTRUCTION	ROUTE S/C	FREQUENC	Y Time	ruis)	ULE ON DOALS		YES			
POD H POD W  WHEN RE ORUG (Approved nam  DOSE ( UNITS)  PRESCRIBERS SIGNATURE INDICATION AND	ROUTE S/C	FREQUENC	Y Time	Tuta)	UE ON DOATH		YES			
POD H POD W  WHEN RE  DOSE ( UNITS)  PRESCRIBERS SIGNATURE  INDICATION AND SPECIAL INSTRUCTION	ROUTE S/C GMC No.	FREQUENC	Y Time TE DOSE IN U.S. Rout Give	n n	ULE ON DOALS		YES			
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BY⇔									-	-	-	-	_
PHARMACY POD H POD W													
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DRUG (Approve	d name)	- 17	DOSE			ROUTE							
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BY = PHARMACY POD H POD W DRUG (Approv PRESCRIBER'S SIGNATURE	ed name) GMC N		INDIC	CATION (M		ORY)	BATE OF TRIES						
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BY = PHARMACY POD H POD W DRUG (Approv PRESCRIBER'S SIGNATURE	ed name) GMC N	2ND REVIEW	INDIC	CATION (M		ORY)	DATE OF C TRACK						
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BY ⇒ PHARMACY POD H POD W  DRUG (Approv  PRESCRIBER'S SIGNATURE START  REVIEWED BY ⇒	ed name)  GMC N  48 HOUR REVIEW	2ND REVIEW	INDIC	CATION (M		ORY)	BATE-S ETRAIS						
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New	Previous Admission

C. Diff Status

New	Previous Admission

Specif Indicat	y Dosin; ion:	g Regin	ne 5mg/kg	3	3mg/kg		Other	
Date to be given	Time to be given	Dose (mg)	Prescribers signature GMC No.	Date of sig.	Start time of infusion	Given by: (sign)	Dute and Time blood level taken sign:	Gentamicin Levels mg/l
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#### General Guidance

- All antimicrobial prescriptions MUST follow the Trust's Antimicrobial Policies or MUST have been agreed by Microbiology. See full up to date policy on intranet.
- INDICATION, STOP AND REVIEW DATES MUST BE RECORDED ON THE CHART.
- CURB 65 score MUST be recorded for all community acquired pneumonia.
- Check previous relevant microbiology results before prescribing antibiotics and check new microbiology results daily. If a patient is not responding to treatment seek advice from a consultant microbiologist.
- Doses need to be adjusted to suit patient's age, size and renal function. To calculate creatinine clearance use calculator on intranet and see dose adjustments for antibiotics.
- All IV regimes MUST be reviewed at 48 hours and switched to oral if appropriate.

#### IV SWITCH GUIDELINES

If YES to all, consider change to ORAL	If YES to any, remain on IV
Patient able to swallow and tolerate oral fluids?	Oral route compromised?
Temperature settling and < 38°C for at least 48hrs?	Continuing serious sepsis?
Heart rate <100bpm for last 12hrs? (no unexplained tachycardia)	Febrile with neutropenia?
WCC between 4-12x10 <sup>9</sup> /L?	Specific indication / deep seated infection. (Meningitis, endocarditis, encephalitis, osteomylitis,
Oral formulation available?	neutropenia, cystic fibrosis, septicaemia, haematology/ immunocompromised pts, continuing sepsis, other
Others markers: BP stable Respiratory rate <20 breaths/min CRP returning to normal and less than 100 (adult)	severe infections as discussed with microbiology.) Seek microbiology advice if unsure.
Absence of mental confusion (when representing symptoms of infection)	No oral formulation available (seek microbiology advice on alternative)

d blood? (Indicate as appropriate) Yes / No?  MHS Number:  Date of Birth:  Caver infusion  Intuition  In	blood? (Indicate as appropriate) Yes ? (Indicate as appropriate) Yes / No? Route Drugs required to Duration / rate of (must be infusion prescribed on once only) section of chart)			i Mo	Start Given Did patient films / by/ experience stop time discload adverse readford by (YsarNo) •	Yes / No	Vacitho	Par J 001	Yes/No	Yes / No	Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No Yes / No Yes / No	Yes / No Yes / No Yes / No Yes / No Yes / No
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