

# The RAMPPS Course Handbook

Developing people  
for health and healthcare



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Many people have been involved with the RAMPPS project over the course of its lifetime. We would like to give our acknowledgement and thanks to the following people and organisations.

.....

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...and our dedicated simulated patients

## Historical Acknowledgements

RAMPPS has been developed over a number of years, and we would like to thank all those who have worked directly on the project over this time.

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Dr Rowlands has been a significant supporter of the RAMPPS project since its inception. He continues to promote the spread of the work throughout the Yorkshire and Humber region area and through other avenues such as the Royal College of Psychiatrists.

### Dr. Mike Akroyd and Mr. Gary Jordan

Dr Akroyd, a Clinical Leadership Fellow, and Mr Jordan, a specialist nurse, worked together on RAMPPS during the early development of the course. They established RAMPPS in a number of areas and introduced pilots in various places across the Yorkshire and Humber region. The first edition of the workbook for RAMPPS came about from their work. They have both continued their work after formally ending their posts and their help has been integral in getting RAMPPS to where it is today.

Dr Akroyd has published his work with RAMPPS in the Health Informatics Journal.

*Interprofessional, simulation-based technology-enhanced learning to improve physical health care in psychiatry: The recognition and assessment of medical problems in psychiatric settings course.* Health Informatics J 2014 Nov 25. [VIEW HERE](#)

Mr Jordan has also published his work on simulation in mental health

*An inter-professional simulation course to address the physical health agenda in mental health.* Mental Health Practice. June 2015. Vol 18 No 9. [VIEW HERE](#)

### Dr. Zead Said and Ms. Tracy Latham

Dr Said took up the Clinical Leadership Fellow post six months after it was vacated by Dr. Akroyd. At this point Mr Jordan had ended his secondment and Ms. Latham stepped in. During their year the RAMPPS programme continued to develop and improve, with developments in results analysis, debrief and new stations. The second edition workbook was created and RAMPPS has been presented at a number of conferences and events.

## The Future

We expect further Fellows and Specialist Nurses to take on the mantle of developing RAMPPS in the future, and leave this space so they may document their work.

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September 2015

# Simulation and Psychiatry



# Simulation & Psychiatry

## The Physical Health Agenda

Physical health in mental health has received a significant amount of media exposure in the last couple of years, and with good reason. Patients suffering mental health problems have more physical health problems and a greater morbidity and mortality rate than the general population.

Many suffer premature deaths. “Diagnostic overshadowing” is still a recognised problem across medical specialties and other professions. This can adversely affect the quality of physical healthcare that people with mental health problems receive. People with a mental disorder smoke almost half of all tobacco consumed and account for nearly half of all smoking related deaths. A diagnosis of depression is associated with a doubled risk of ischaemic heart disease

and is associated with poorer survival rates in people with a diagnosis of cancer. People with chronic pain are four times more likely than the general population to suffer with depression or anxiety.

Although the major causes of death for people with mental health problems are the same as the general population – namely circulatory and respiratory disorders and cancer – the training of mental health professionals, (other than psychiatrists as part of their general medical training) does not reflect these facts. Professionals, including psychiatrists, often lack confidence in dealing with these issues, and services can sometimes see these issues as 'someone else's' responsibility.

## The Benefits of Simulated Patients

First, a definition of a “simulated patient” - it is a person without any real clinical signs or symptoms trained to portray a certain physical or symptom, or to play a particular role to facilitate teaching or assessment. Simulated patients have been used to expose health professionals to a wide range of diagnoses and teach communication skills. They are effective in highlighting delegate attitudes and are very useful at providing benefits to the teaching of communication skills.

Simulation allows space and time for reflective thinking, team-based learning and feedback from peers, teachers and simulated patients, all of which enhances the learning experience. Simulated patients have been shown to enhance the realism of the experience. One experiment involved having “unannounced” patients in a real clinic, and were undetected by the treating team.

The benefits for the team involved in the simulation are that errors can be made in safety,

different ways of approaching a scenario can be reviewed and the team can “rewind” a scenario and compare different techniques or styles of working. It allows the relatively uncommon scenario to be experienced by a team, so if it does happen outside of simulation, they have some base experience to help them deal with the situation. Professional simulated patients can also step in and out of role and provide unique and invaluable feedback to a team.

Whilst the evidence for the effectiveness of simulation in psychiatry is still being explored, other industries with a potential for significant adverse events, such as the aviation industry, have shown simulation training enhances learning satisfaction and improves safety. Our own work with RAMPPS so far has shown significant increases in the confidence of doctors, nurses and health care assistants in their own abilities.



# Recognising and Assessing Medical Problems in Psychiatric Settings

## What is RAMPPS?

RAMPPS stands for Recognising and Assessing Medical Problems in Psychiatric Settings. It is a simulation course aimed at getting a multi-disciplinary team to engage with patients on not only the psychological level, but also to address the physical health needs of the patient. By using realistic scenarios based around real life incidents, we hope to encourage teams to consider the ways that a mental health problem can complicate recognition of a physical problem. We also hope to increase the confidence of individuals and teams in communicating clearly around these issues.

RAMPPS consists of 10 scenarios which can be used flexibly in a range of situations and areas. They are all written for an adult male, though course organisers can change the gender, age, ethnicity and physical observations as required. Most scenarios allow flexibility in the use of manikins or simulated patients, and the flexibility provided allows local needs to be addressed. RAMPPS can be run as a multi-station set up with rotating groups, as a single station with one delegate group and an observing group per scenario, and as an in-situ simulation course in particular environments.

All the RAMPPS scenarios are generated with the multi-disciplinary team in mind, typically consisting of a doctor, a nurse and a health care assistant. In reality, many members of a team

will work to care for a patient who is unwell in a mental health setting. RAMPPS is explicitly a multi-disciplinary course with emphasis on team working, communication, mutual respect and collaborative integration of care.

Trained multi-disciplinary faculty provide debrief immediately after each scenario, and can intervene during the scenario if they feel it is warranted. Peer feedback is part of the process, with the aim of allowing the scenario delegates the space and interaction to reflect, analyse the way they work and feedback to the rest of the delegates.

RAMPPS also has an E-Learning package, aimed to give delegates attending the chance to review some of the key principles such as AVPU, the ABCDE approach, SBARD (Situation, Background, Assessment, Recommendation, Decision) and the basics of simulation teaching with an introduction to RAMPPS. By having delegates on the same level of knowledge prior to attending the course, more time and effort can be invested in reviewing how the team works in scenarios and less time is spent on didactic teaching and theoretical work.

For a recap and review of RAMPPS, please see the video by clicking the button below.

 WATCH HERE

# Simulation & Psychiatry

## How was RAMPPS created?

A team of Regional Clinical Skills Advisors (RCSAs) were established in June 2010 to create a Clinical Skills and Simulation Team. This team's purpose was to establish a strategy for the Yorkshire and Humber region across all specialities.

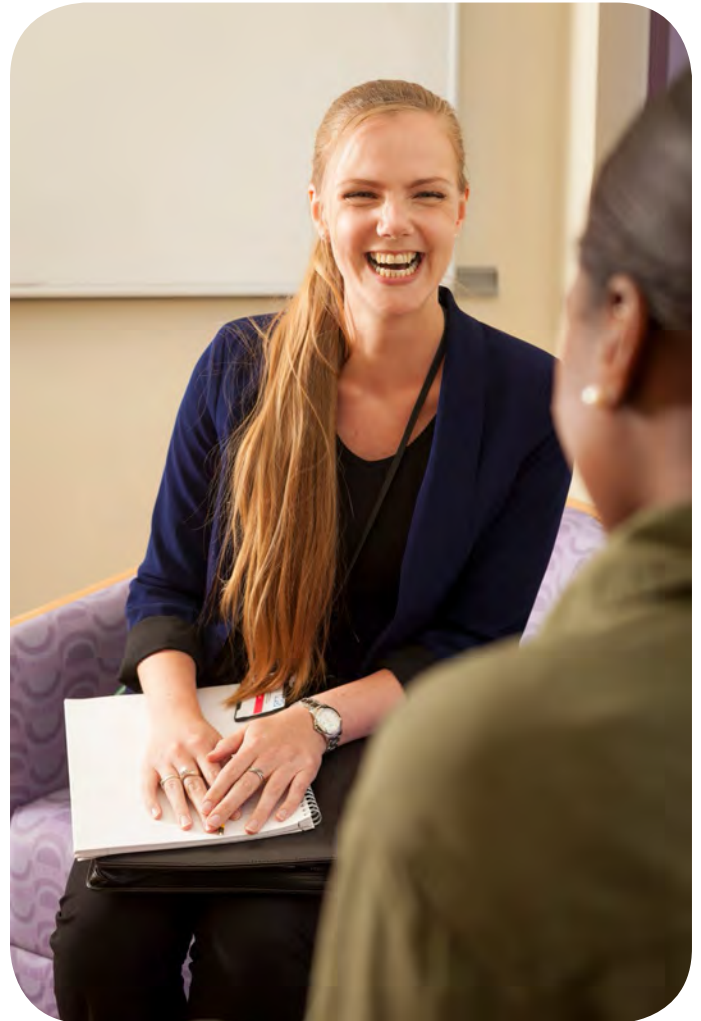
The team reviewed addressing the physical health agenda in mental health and learning disabilities by identifying and contacting NHS trusts and independent providers in the region. They found, at the time, that there was no co-ordinated plan towards addressing this agenda and effective initiatives were being implemented in isolation. The upshot was that there was good work being accomplished, but no sharing of ideas, collaboration or communication of plans.

In 2011, following the review, the clinical skills network, Trusts within the region and the School of Psychiatry worked together to establish a strategy to apply simulation training to mental health: from this RAMPPS was born.

This coincided with a significant investment in simulation facilities and training within the region, thus creating a unique opportunity to implement a new course. The emphasis of RAMPPS on multi-disciplinary training distinguished it from other courses being developed and followed the Department of Health's Framework for Technology Enhanced Learning.

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/215316/dh\\_131061.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215316/dh_131061.pdf)

A faculty for RAMPPS was created including doctors, nurses and RCSAs. RAMPPS scenarios were developed based around experience of real Serious Incidents (SIs). A pilot in Leeds in November 2012 tested out the scenarios and further refined them



and the overwhelmingly positive feedback from delegates confirmed the feasibility of extending the project. The Clinical Leadership Fellow worked with the RCSAs to build from the pilot the spread of RAMPPS courses and to promote this approach to improving patient care and patient safety.

Following this, the information was released to trusts around the area and a Clinical Leadership Fellow was tasked with further developing RAMPPS and implementing the work around the local, regional, and eventually, national area.

## Personal Insight

### Dr. Paul Rowlands

**Paul Rowlands is a Consultant Psychiatrist, and is Head of School for Psychiatry in the Yorkshire and Humber region. The initial development of RAMPPS had a lot of input from Dr. Rowlands, and the initial stations designed for RAMPPS originated from his work. He talks about his experience setting up RAMPPS here.**



The first ideas of simulation came out of a deanery wide training event that was held a number of years ago. There was discussion about how we could move from the model of training where you learn on the job and just learn by doing, whatever the procedure was. Surgical procedures in particular were moving to a model involving training beforehand in a simulated setting.

The Deanery was putting a lot of resources into building simulation centres across the area, of which the psychiatric specialty was blissfully unaware. For a long time, we have done simulation training in the form of mock interviews. I was encouraged to think about how psychiatry could do something with these simulation centres, how we could use the facilities and get some great educational ideas.

I had the good fortune to meet with colleagues, including Gary Jordan and Tracy Latham, Regional Clinical Skills Advisors who had been

given a brief to develop simulation training in mental health. I realised that I had a lot of clinical experiences and knowledge about the sort of things that would lend themselves to simulation training, and importantly, I had access to people who could be trained and could sell the idea to line managers of nurses in trusts.

*Continues on next page*

## Personal Insight - Dr. Paul Rowlands (continued)

There was a coming together and we talked about how you wrote scenarios and came up with a structure and format for them. We set up a date to form a faculty, when someone said *"These scenarios are great, but you need to have a good acronym!"*. I was having a walk when I thought *"What's this about?"* and came up with the acronym. It's stuck ever since.

With patients on psychiatric wards there are several things that can conspire against things being recognised: Nurses may have little formal training in physical health care, and doctors will have done their medical training but are now used to working in a setting where physical problems are not the main focus of care. If you work somewhere specialising in cardiac failure, you get very good at recognising the signs, symptoms and causes. The same patient in a psychiatric setting is placed somewhere where those same cues may not be picked up. The context is different and the team may end up recognising the problem late, sometimes to the point where it may be too late or the patient has become very acutely unwell.

I've been around mental health wards a long time. Over the years, you accumulate a memory bank of what has happened to your patients, your units, your organisations. Serious events don't happen every day, but you start to think *"Actually, these things were preventable if there was a better underlying awareness of the staff working in the units."*

For setting RAMPPS up, we set a date for the faculty day, and went to the simulation centre at St. James Hospital and Montagu to see the simulation facilities. RAMPPS is quite an intuitively appealing idea to those working in these settings. I then wrote the scenarios. You have to be prepared to see them picked apart.

You might have an idea in your head about making a scenario that doesn't work for all sorts of reasons. It's rooting back into real clinical scenarios that have occurred, which is the best way of trying to do these, and then relating this to the basic principles that people can follow in their everyday work, including having ways of communicating that are efficient and that convey key information. That's key: enabling all staff to develop a standard way of regularly approaching situations in a safe way – that is where the principles of ABCDE and SBARD become so useful.

*"The emphasis on Multi Disciplinary Training is crucial: It's a great course for learning more about who you work with"*

The emphasis on Multi Disciplinary Training is crucial: It's a great course for learning more about who you work with. On the RAMPPS course you get much greater insight into how somebody works as a doctor, nurse or health care assistant. The doctors, by the nature of how life works, are not the first on the scene. The nurses and health care assistants are, and they do the initial de-escalation. How they communicate to doctors and how doctors respond to that is interesting to see as an observer. You can see how different professional roles operate, which is great to take back to the workplaces.

I like to make little improvements as a means to big improvements. If we can understand physical health a little better, that can have big knock on effects.

## Benefits of RAMPPS - The Feedback

All the RAMPPS courses run to date have involved getting feedback from delegates before and after attending the course. The return rate has been excellent at over 95% usable feedback.

Using a combination of Likert Scales and free hand written feedback, we are able to make conclusions about the RAMPPS work to date, including areas for improvement and areas of strength. The benefit of the feedback used is that it can be analysed on a per course basis, per area basis and on a cumulative basis - thus allowing us to see the whole picture for RAMPPS, or to focus on one area running the RAMPPS course. By using this differing scale, advice and areas of excellence can be identified for the course as a whole or for individual centres.

All the questions asked on the feedback forms (see appendix 2) link in to specific curriculum and learning objectives for doctors, nurses and HCAs. By using before and after scales, we can assess how confident people are in these specific areas. To date using Chi-Square analysis, we have shown significant improvements in communication, collaboration, medical expertise, clinical skills, care and compassion. Free text feedback showed many delegates felt the scenarios reflected real-life experiences and suggest further dissemination of the RAMPPS course. Many commended the structure of the feedback and debrief session, and those who have partaken in the E-Learning feel it was a useful introduction to the main teaching points prior to attending.



*“ The benefit of the feedback used is that it can be analysed on a per course basis, per area basis and on a cumulative basis ”*

# Setting up the RAMPPS Course



# Setting up the RAMPPS Course

## Setting up Faculty

Any course being run, RAMPPS included, works best when there are a group of enthusiastic people who can take responsibility for the course and strive to make it a worthwhile effort both for those attending and those who are running and organising it.

Current RAMPPS courses have worked best when there are local or regional employees involved as part of a local RAMPPS group. There are four key roles; Medical Lead, Nursing Lead, Simulation Lead and Administrative Lead. Respectively, these roles involve:

**Medical Lead:** Medical recruitment, ensuring simulations are medically cogent when run, providing medical advice as required

**Nursing Lead:** Recruiting nurses and health care assistants and ensuring the appropriate nursing procedures are integrated into the local course

**Simulation Lead:** Ensuring the simulation equipment is set up and works as required, troubleshooting problems on the day and planning the layout and rooms

**Administrative Lead:** Administering the RAMPPS course, organising the paperwork needed and acting as a central point of contact.

Other roles that will need to be chosen are presenters for the introduction on the day, the lead for “meeting the manikin”, the debrief teacher and lead, the results analyser and the presenter for the closing debrief. All the roles can be further split or combined as a local team desires. Sheffield for example has a combined Simulation and Administrative Lead, Montagu combines a number of Medical Lead roles with



the Simulation Lead. These roles are not set in stone.

There is no reason the team can't be flexible to include a range of grades and staff, such as Approved Mental Health Professionals (AMHPs), RMNs, trainee doctors, health care assistants and so on. The key principles are that they are enthusiastic about teaching, have a drive to create a meaningful long term program, and are knowledgeable of their locality. We emphasise the locality as RAMPPS requires a number of factors to work, and being able to interact with any issues or dilemmas directly is far more effective than trying to negotiate or manage these through distance working.

Once the faculty is set up, it is useful to then start looking at what would be required to run your RAMPPS course locally.

# Setting up the RAMPPS Course

## Personal Insight

### Dr. Paul McCormick

**Paul McCormick is a Consultant Psychiatrist working in the Yorkshire and Humber region, specialising in Old Age Psychiatry. He was involved with the initial set up of RAMPPS in Sheffield, and talks here about his experience.**

"I initially attended the RAMPPS pilot in Leeds, saw what a good thing it was and how enjoyable people found it. When the Head of the Yorkshire School (Dr. Paul Rowlands) told me to "go and set one up in Sheffield", I did.

I started by sending loads of emails to the medical directors and service managers about how good it was, how important it is and how we should implement it in Sheffield. I didn't let it go, almost nagging people: "It's good for trainees"

I kept nagging, making sure it was there in everyone's thoughts and memory. I arranged a meeting with the senior management for inpatients. I created a presentation along with a trainee and nurse from the RAMPPS course, Dr. Stuart Laverack and Charlie Turner. We presented on how much we believed in RAMPPS and how we felt it was a good thing. With that positivity set, we felt there was enthusiasm from senior management and the training department.

Once everyone was on board, it was a matter of liaising with the Training Program Director and Deanery, make it a part of the training program,



and set a date. Once they had a date, it had to happen!

Charlie and Lorena made sure to get delegates from the nursing and health care assistant side, ensuring day release, to make the day multi-disciplinary as planned.

## Personal Insight - Dr. Paul McCormick (continued)

Then, we talked to people about having a meeting to set up a faculty, which we did at the Royal Hallamshire Hospital in makeshift facilities. We set aside the whole day for this as people didn't know what it was about. We gave examples, showing videos from the Leeds pilot. People turned up not knowing what to expect, and left with knowledge and enthusiasm once they understood.

We set up a facilitator development day, gave people a scenario each to run and ran through the collection of scenarios we had, therefore giving ownership to subgroups, each having a scenario they "owned".

We had a pre-RAMPPS development day to run through it again and iron out any difficulties. The RAMPPS day was booked, and they then had to do it. There was help getting actors through the Regional Clinical Skills Advisors, the day started, and off they went.

There was some apprehension to start with, but it was so well organised with good logistics and organisation that it all went well. We gave our introduction, afterwards, whilst the first scenario was "difficult", it all clicked into place. At the end of the day, we were given excellent feedback. We took this back to the Deanery and

said "we're doing this", next time doing it in our own facilities.

My advice to set up a RAMPPS course is to get the 'higher ups' involved, the medical director, chief executive, senior management, get an appointment to present your idea in a team meeting, be enthusiastic and get a trainee and nurse involved.

There's a lot of material available now which makes it easier, the RAMPPS video, workbook, feedback from many courses.

I think the RAMPPS course has been amazing, and I've thoroughly enjoyed working on it"

*" My advice to set up a RAMPPS course is to get the higher ups involved, the medical director, chief executive, senior management, get an appointment to present your idea in a team meeting, be enthusiastic and get a trainee and nurse involved"*

# Setting up the RAMPPS Course

## Requirements

### Costing

RAMPPS does require resources, and this comes in the guises of time, space and sometimes money. When it comes to considering what you want to do with RAMPPS and what resources you can get, you may find that one defines the other, and a team may have to be flexible both on what funding can be achieved from a locality and what can be done for a RAMPPS course.

### Space

The first requirement that is usually addressed is “Where can we run the RAMPPS course?”. The size of the facilities, as well as what is locally available, will have a significant impact on what type of RAMPPS course is run and how big it is. Planning in-situ ward based RAMPPS may only require a side room and a meeting room to debrief. A large multi-station RAMPPS course may require 4 simulation rooms, a briefing room and a control room.

Other considerations are accessibility, capacity for the numbers you wish to attend and local facilities such as food and drink. Not having lunch facilities for a whole day course can seriously affect the morale of the attendees.

### Facilitators

Each station or event planned requires, ideally, two facilitators to help run the station and to provide effective debrief and feedback to the delegates attending. Having facilitators of different backgrounds will increase the experiences and knowledge that they can draw upon during the debrief session. Stations can be run with one facilitator, though the depth and



breadth of the feedback shrinks. Each facilitator needs to be familiar with the station they are running, the processes of effective debriefing and with the basic principles of the RAMPPS course.

Having more facilitators than required provides insurance against sickness or unexpected absence, and can allow some rotation of the facilitators. This can achieve cross-pollination of styles and ideas, as well as allow some rest in a cyclical fashion.

Time and teaching has to be made available for the facilitators to learn this process and to become familiar with the equipment they are using and the requirements of the station.

### Delegates

Delegates are the people we run the RAMPPS course for, without them, there is no course. If the course being run doesn't have the multi-disciplinary team attending, without a doctor, or nurse, or health care assistant, the principles to impart and learning to achieve becomes immensely restricted. There are many ways to

# Setting up the RAMPPS Course

recruit delegates, be it from mass e-mails, fliers, posters, meetings or through management and supervisors. Any method to get the word out increases awareness and applicants for RAMPPS. Trainee doctors tend to find release to attend easier than nursing staff and health care assistants, so negotiation with the nursing leads may be required.

It is wise to plan numbers and station so that delegates should ideally have the opportunity to experience two simulations. The first to experience a simulation setting and get feedback, the second to see what the barriers are to implementing that feedback.

## Simulated Patients and Manikins

Simulated Patients are an integral part of the simulation process. They provide a real person for the delegate to deal with, can express far more than a manikin and provide a palpable aura of realism. What the simulated patients can't do is adjust their pulse, respiratory rate, oxygen saturations and stop breathing. This is part of where station design comes in, as stations can be implemented with actors, manikins or a combination of both, and it is up to the local RAMPPS organisers to decide how they'd like to do this. Costs for actors for simulated patients vary, although in our experience the cost average is £100 for one day. Contact simulated patient UK for further details: <http://www.simulatedpatients.co.uk/>

Manikins provide a useful tool to simulate significant or rapid changes in physical signs for the delegates. They vary widely in what they can do, and how they can be integrated into your RAMPPS course will depend heavily as to the specification of the locally available manikins. Some come with radio voice options, allowing

someone in the control room to monitor the station by video-link and respond appropriately to the scenario. Some may require the voice actor, which could well be a facilitator, to be present in the room.

Having something akin to a "simpad" allows the facilitator or station technician to see what is happening and adjust the physical observations as appropriate. This requires quick thinking, and can be challenging, especially when voice acting as well, though the feedback is that it is a lot of fun too!

## Time

This can be a significant challenge, as alluded to earlier when trying to organise day release. The challenge of time applies both to faculty, facilitator and delegate.

The faculty needs to be able to set aside time to plan, organise and run the RAMPPS course. Someone with 9 clinics a week, a teaching session, supervision sessions, on-call and a voluntary session will be unlikely to commit enough time to run a RAMPPS course. Realistic goals and targets must be set, and if more members of faculty need to be recruited to achieve your goals then go for it.



# Setting up the RAMPPS Course

The facilitators will also need time to attend the teaching sessions, RAMPPS course and debrief afterwards. Most can sort this out locally with their supervisors or employers, although sometimes help is required in emphasising what a positive impact the RAMPPS course can have.

Finally, the delegates all need the day free to be able to attend RAMPPS. There will always be inevitable drop outs, and we try to incorporate that in terms of planning the number of spaces on the course. Ensuring that you have a good relation with the senior managers and clinicians and have them on board helps with this greatly.

## Administration and Organisation

Ideally, there should be one point of contact for any course being set up in a region. It takes times to set up the actual day and organise everything to come together, without also having to keep track of answering e-mail queries and keeping lists of attendees and facilitators up to date. Additionally, the very nature of organising time for staff to attend RAMPPS, which is set up differently for doctors, nurses and HCAs, may mean that the lead for each group is different resulting in potentially five or six people all trying to do the same thing.

It is vital to nominate one person to take the lead on organising the administrative side, which would include organising attendees, delegates, keeping in touch with actors (once arranged) and the course leaders, and liaising with any others groups involved with your local RAMPPS course.

This person could also either prepare the simulated notes and drug charts for the scenarios on the day, or arrange someone to be in charge of providing these.

## Restricted Funding

Sometimes, funding isn't available, especially when starting a RAMPPS course. This is a reality of the current financial times and can bring up challenges when running a course. It does not mean a course cannot be run on a shoestring budget. Through the creative use of simple manikins, ingenuity in adapting the scenarios and good use of debrief a RAMPPS course can still be run on a very minimal budget.

# Setting up the RAMPPS Course

## Personal Insight

### Charlie Turner

**Charlie Turner is the lead nurse involved with the RAMPPS course at Sheffield Health and Social Care (SHSC). Below, he gives his story as to how he got involved.**



"I started out as an enrolled nurse for mental health and converted to a registered mental health nurse. I worked in different settings with different age groups in mental health, setting up services as a staff nurse, such as the day hospital. I was lucky in that my ward manager previously worked with and involved other nurses and OTs. I then moved into education to do professional training, and had a lot to do with "PREP", Post-Registration Education Practice.

After designing the first aid course, I achieved approval for SHSC to be a learning centre. I moved into risk related training and took the post of Clinical Risk Manager, ending up as the resuscitation lead of the trust. I applied for a Senior Nurse patient safety role and did some work in clinical risk training.

After some time, I got a substantive post in education and training and became Senior Nurse Clinical Training Lead, looking at other ways of training and developing simulation, initially with ILS, and then with the RAMPPS course.

People come with their anxieties, which reduce during the course of the RAMPPS day very much because of the number of scenarios we do. If they do just one scenario, the anxieties stay there, the same as if they do one role play, as a lot of emphasis can be on past actions or "playing

another role". What RAMPPS does is help people realise that over the day they're not role playing, they're just doing their job. It gives them the opportunity to practice in a safer environment.

Over the course of the day, I see a lot of development in people. You see their communication and confidence changing, they don't know what it is, but their whole approach changes.

It was initially aimed at Core Trainees and staff nurses, but we've had Foundation Doctors, Broad Based Trainees, Pharmacists, GPs and Health Care Assistants. We have presented our work to the AMHPs with a view to involving them. They've come with some ideas of their own.

I'd like to put on more RAMPPS courses and develop community scenarios with community teams, both in learning disability and mental health. When you think about it, there are so many people who can be involved in simulation."

# Setting up the RAMPPS Course

## Training the Facilitators

Facilitators are a key part of the RAMPPS course. Without facilitators the scenarios cannot be run, the learning points cannot be drawn out and critical incidents or errors can be missed. Having an enthusiastic and knowledgeable group of facilitators can really create a RAMPPS course that is an exceptional learning experience.

Part of getting to this involves teaching the facilitators. This is usually done as a day or half-day informal teaching session at some time prior to a RAMPPS course being run. It covers a range of topics, most of which are covered in the workbook. These topics can include the benefits and difficulties of simulation training, the reasons behind using scenarios based upon real events, the need to be familiar with the station they run and what to do if it goes wrong, debrief styles, the importance of debrief and the need to have a structure when you are debriefing. Facilitators have reported it being helpful to run a simple simulated station on the training day to have an idea of what to expect.

The intricacies of debrief itself are covered in much more detail in the next chapter.

## Keeping Up To Date

As the number of RAMPPS courses you run progresses, you may acquire a number of facilitators who are available to help. Something that has become evident over time is that some facilitators may slip into bad habits over time. This could include anything from using **killer phrases**, to not pointing out the key learning points, to being too friendly and avoiding difficult points to raise (such as delegates causing significant harm to a simulated patient).

It is important that before each RAMPPS course

that all facilitators, new and old, are encouraged to attend the training day. It is inevitable that RAMPPS courses will evolve over time, whichever locality is running it, and it is inevitable that debrief skills will become less effective over time when not used regularly. Having old and new facilitators attend not only allows better teaching to occur by utilising the wider range of skills available, but also helps to reduce variance in the facilitation provided during a RAMPPS course.

## The Steering Committee

RAMPPS couldn't have reached the achievements it's made without the Steering Committee. It allows faculty members and those involved with organising and running RAMPPS courses to meet every six months to discuss the future direction of RAMPPS, issues they have encountered, solutions to problems and to allow the central RAMPPS team to help and assist wherever they can.

Currently these are held in the Yorkshire and Humber region, although this can change as required.

## The Checklist

- Have you a faculty willing to work to create a local RAMPPS course?
- Have you designated leaders for doctors? Nurses? Simulation? Administration?
- Have you made senior managers aware of the RAMPPS course and the aims of faculty?
- Is there a suitable facility in which to run RAMPPS?
- Has the faculty decided which scenarios to run for the next RAMPPS course?
- Have you identified the materials required?
- Have you recruited the appropriate number of facilitators?
- Can you arrange teaching for those facilitators?
- Can you recruit the multi-disciplinary delegates for RAMPPS?
- Can they attend with time off as required?
- Has funding been applied for? (if required)
- Are appropriate simulated patients / manikins available?
- Has a day been chosen for the RAMPPS course to run?
- Have the facilitators been taught about the RAMPPS debrief?
- Are facilitators familiar with their stations?
- Have the E-learning links been distributed to delegates?
- Have lunch and refreshments been arranged? (as required)
- Has the introductory presenter been chosen?
- Have the feedback questionnaires been printed?

# Running the RAMPPS Course



## Starting the Day

### Introduction

An introduction on the day is useful not only to ground people a little and let them settle into the event. A good introduction explains who the people working for the local RAMPPS course are, show a manikin being used so people know what to expect, goes over essential details such as the fire escape/alarms and briefly reviews AVPU, ABCDE and SBARD. The initial feedback forms should be completed during the introduction before any delegates have started the simulation sessions. This is also the ideal time to organise and get people into groups so that the simulation stations can begin straight after the introduction.

Remember to give the feedback forms during the final debrief as well. This is essential to prove that the course you are running is having benefit, and is a key part of learning how to better run and improve not only your local course, but other courses as well.

There are three basic communication tools the RAMPPS course imparts to its delegates prior to and during the simulation day.

### RAMPPS E-learning

Prior to attending the RAMPPS course, all delegates should complete the RAMPPS e-learning module. We recommend delegates complete the e-learning up to two weeks before attending the RAMPPS course itself, allowing them time to complete the module whilst remaining fresh in memory. The e-learning module takes 10-15 minutes to complete.

The RAMPPS e-learning module is designed to be accessed via your organisation's learning management system (LMS), which will record

completion of the module on the learners record. NHS organisations using ESR for e-learning can find the module in the catalogue by searching for "000 YH RAMPPS"; questions about accessing the RAMPPS e-learning module via ESR should be directed to your local organisation's e-learning support. Other NHS, primary care and public sector healthcare organisations using a LMS other than ESR should ask your local e-learning lead/department to contact [elarningsupport@yas.nhs.uk](mailto:elarningsupport@yas.nhs.uk) for more information. RAMPPS can also be accessed via the national ESR platform 000RAMPPS and by health and social care staff via eLFH <http://www.e-lfh.org.uk/programmes/recognising-and-assessing-medical-problems-in-psychiatric-settings/>

The e-learning module itself reviews the basic principles of assessment and communication, and aims to bring all the delegates to the same level of knowledge about AVPU, ABCDE and SBARD, so less time is spent explaining these on the day, and more time can be spent implementing them.

### ABCDE

ABCDE is a systematic approach, based on airway, breathing and circulation, used to assess and treat the acutely ill patient. More complete details can be found in the summary sheets.

It is worth re-emphasising the key points here, such as re-assessing after a treatment or intervention, correcting life-threatening abnormalities before moving to the next stage using early monitoring of vital signs.

Depending on the set up and style of RAMPPS used, you could go through the Resuscitation Council guide to ABCDE if the delegates wish to review this.

# Running the RAMPPS Course

## AVPU

Alert, Voice, Pain, Unresponsive. This is a simplification of the Glasgow Coma Scale, the emphasis is that it is a rapid and almost immediate screening tool to use on the scene. An alert and fully awake patient (though not necessarily oriented) scores "A" and could be further assessed. Responding to voice, pain or being unresponsive should be considered an indication to get further help and for further assessment. It is not suitable for long term observations.

## SBARD

SBARD is a communication tool, and stands for Situation, Background, Assessment, Recommendation, Decision. The aim is to use it when someone wants to share key information and/or ask for advice about actions to be taken. In summary, it can be broken down into five questions:

- “ What is happening now? ”
- “ What are the relevant factors in this situation? ”
- “ What do you think is going on? ”
- “ What action do you propose? ”
- “ Can we summarise what we have agreed? ”

## Early Warning Scores

The Early Warning Scores in the summary sheets are those provided by the Royal College of Physicians, and includes the observation chart, the scoring system and outlines the appropriate clinical response to the possible scores.

The observation chart is designed to provide an overall summary of the physical health measurements of the patient. This was created as a replacement for the previous "TPR" charts.

The scoring system outlines the boundaries of scoring for the different physiological parameters one could encounter.

The clinical response sheet outlines the likely appropriate course of action for the different NEWS scores that may be found.

It is common for trusts to use their own modified system of the Early Warning Score. An example being in Sheffield Health and Social Care, they use a system called the Sheffield Early Warning Scores (SHEWS). Whatever system of Early Warning Score is used locally, should be made universally available to the delegates before the RAMPPS course runs.

The principles should be the same, whatever local modification there is. Early Warning Scores provide a structured and systematic way of providing guidance to the degree of a person's ill health. Someone scoring above a certain threshold should be reviewed by either a qualified nurse, a doctor, or have emergency services called.

The key is to ensure that the system is being implemented and used properly. RAMPPS provides an ideal opportunity to see any local issues an area may have with their Early Warning Scores, and provides individuals the chance to use and implement them in a safe environment.

## The Debrief

This forms an essential part of the RAMPPS course, and can be of huge benefit to delegates if run well. Likewise, a poorly planned debrief session can leave delegates feeling confused and upset. What makes debrief a challenge is that there is no “one size fits all” approach. There are guidelines, theoretical constructs and structures to follow, but it is up to the facilitator how to use and implement these ideas. We hope this section will provide guidance for facilitators, helping them decide how they would best like to run their debrief session. It is immensely rewarding when done well.

Whilst the cons of debriefing can include people not enjoying the scrutiny of analysis, the time required to complete a debrief and the personal investment needed, the benefits are significant. It allows adult learning through self-discovery and self-analysis, which can be much more insightful and relevant to an individual. It also allows learners to interpret what happened in an event, why it happened and what they can do to change. It allows a blended approach to integrating a group's theoretical knowledge into the practical experience of a scenario. Such integration supports retention of knowledge that is individualised and based in reality.

Learning objectives are important, and give a structure that the debrief session as a whole can be steered towards. Given the different ways RAMPPS can be run, there will be many variations upon which learning objectives you may wish to focus on. Small in-situ RAMPPS running one station at a time may focus on team communication and SBARD, or recognising the deteriorating patients and Early Warning Scores.

You may decide to focus on particular objectives, such as rapid tranquilisation, and the issues surrounding that, and so tailor a station to focus more on that aspect.

By focussing on time realistic and achievable learning objectives, the debrief has a focus for learning something new, whilst allowing group and individual reflection and unique learning. Trying to focus on too many objectives at once, or repeating the same learning over the course of the day will leave delegates feeling frustrated or bored.

It is important to strike the correct balance in debriefing between reviewing the learning objectives and allowing a group to explore their emotions and thoughts about the scenario and what they have seen. If too much emphasis is placed on learning objectives, the group may disengage or not listen, as they will be occupied by their own thoughts. Likewise, a group that is allowed to overly focus on emotional and reactionary content will not address the learning objectives and may leave without learning from the experience. A simulation scenario for most people will be anxiety provoking initially - they are stressful events! By allowing delegates a chance to “offload”, they can move to a more focused state of mind and be ready to engage.

# Running the RAMPPS Course

## Giving Structure to Debrief

Below is a descriptive structure for debrief based upon the Sheffield Children's NHS Foundation Trust debrief tools. It includes the more productive advocacy-inquiry approach which can avoid the 'dirty questions' and the lecture based approach. A summary sheet is included in Appendix 4a.

### 1. Feelings

Ask the delegates how they found it, what they feel. Let them "off load" the emotional results of the simulation- "I'm so buzzed", "that was terrible", "I should have done X, Y, Z". It is important to acknowledge the feelings of the delegates and ensure they have felt heard as to not do so will result in them coming back to, or internally focusing on, those unexpressed emotions.

If there are particularly overwhelming or strong feelings that threaten to derail debrief, acknowledge them and let the delegate know that they will be revisited. Make sure to note it down and do revisit them, they may well have resolved by the end of debrief or provide valuable insight.

### 2. Facts

What was happening: Medically? With the team as a whole? With each team member? Try and start with the "leader" in the scenario then encourage the team participating to join in, then the group.

This section aims to gather the "what" in the delegates own perspective, and allow facilitators to see how this matches between what they observed and the other team members. By

asking what was happening medically, and talking with the group, the facilitators can check that everyone, delegates and observers, has understood what had happened in the scenario.

### 3. Advocacy and Inquiry

This section aims to explore why the delegates did what they did, having covered results and actions in parts 1 and 2. It is important to remove the emotional inclination in questions, and to ensure the questions asked help the group focus on what happened and why it happened, as opposed to "what did I do wrong?" and "why me?". By using good judgement, a facilitator can share observations without assuming the role of the leader with a monopoly on knowledge.

The advocacy part involves identifying a specific behaviour or event and to make an objective statement about this. The inquiry involves the facilitator posing a brief question to the delegate in the spirit of genuine curiosity.

"I noticed that the sats started deteriorating and that oxygen was applied at ten minutes. I was wondering why that was?"

The goal is to move the onus of knowledge from facilitator only to the whole group and facilitator. It moves away from parental style judgement where the delegates are to be taught by the "correct" person. By keeping respect for yourself (I have to take on what I've seen and have observed...) and for the delegate (you are smart and well trained, you are trying to do the right thing, and you have your own view on the simulation...) and by approaching this as a genuine puzzle, clarity through honest inquiry and learning or change in thought processes

# Running the RAMPPS Course

can be achieved. It is allowable to have your own judgements, and statements can start with “it concerned me...” or “I was pleased that...” for example. It can be helpful to remove any emotional ambiguity to a statement that could be interpreted in different ways.

It is important to listen to the discussion and check back too.

“You noticed the sats dropping and thought that someone else noticed and would do something about it whilst you were focusing on the pulse and falling blood pressure.”

This crystallises the issue at hand, allows acknowledgement of the difficulty (“that’s hard”) and neatly allows movement of the discussion to the group, so that can come up with their own answers and solutions to the dilemma put forward.

“Has anyone else had a situation like that? Can we come up with any strategies to overcome this?”

Once the discussion is under way, the facilitator can also insert or revisit the learning objectives to facilitate discussion as a member of the discussion group.

“I wonder if SBARD would be a part of a way to overcome what happened?”

This time also allows encouragement of those who find it hard to participate, by asking individuals if they have had similar experiences, or what they think could be helpful. Bringing your own experience as a facilitator can help stimulate discussion if the group is finding it hard.

## 4. Questions

This section allows the group to explore any areas they haven’t visited but wished to do so with regards to the scenario, and allows a chance to revisit difficult areas, such as strong emotions contained from part 1.

## 5. Summary

At this point, it’s a summary of the key learning points, which may or may not be focused on the learning objectives decided before the start.

“During this session we learned about...”

Once the summary has started, this signifies the end of debrief. After the summary, debrief has finished. Do not revisit topics to discuss.



# Running the RAMPPS Course

## Pairing Facilitators

Debriefing sessions are ideally done by a pair of facilitators to allow more than one perspective of any discussions and to keep track and organise debrief. If the facilitators assign themselves number 1 and number 2, facilitator 1 can lead the discussion for feeling and facts whilst facilitator 2 takes notes. Facilitator 2 then has all the material needed to lead the advocacy and inquiry, whilst facilitator 1 can take notes to lead the summary section.

## Human Factors

Human factors refer to environmental, organisational and job factors, as well as human and individual characteristics which influence behaviour at work in a way which can affect health and safety. Despite the term "Human Factors", it is not a collection of particular factors to consider, but the name given to the discipline of seeking out the factors and influences that change our behaviour.

In a nutshell, if a group can determine the reasons they behaved in a certain way, the "why" of their actions, they will discover their own human factors. A good facilitator who can get to the understanding of the ways a group behaves will naturally discover the human factors. It isn't always easy to find out what the factors are. Some individuals are readily able to verbalise the cause of their behaviour, for some this may be the first time anyone has asked them to explain why they do the things they do. It is important to remember that to err is human,

and to vary your performance is human. In simulation, some of the factors may be as simple as "I'm nervous" or "I wouldn't normally do that" (see **Killer Phrases**). Acknowledge this and explore if you feel there's something there ("what happens when you get nervous? What ways can you think of to step out of feeling nervous and relax in a real situation?"). It's not always easy to get to why.

Sometimes a group of delegates will lead their own discussion and naturally discover their own factors, in which case they may need little discussion from the facilitator. Some may struggle, and the facilitator will need to put forward ideas for discussion, and some may be somewhere in-between, where a simple "nudge" from a facilitator can stimulate excellent discussions.

## Situational Awareness

Situational awareness is another concept to be aware of as a facilitator. This is essentially a combination of awareness, comprehension and projection. If a delegate's behaviour is led by a loss of situational awareness discovering where the breakdown is in the chain of understanding can bring valuable insights to both the group and to the individual involved.

Perception involves situation assessment and situational awareness. It is the gathering and retention of data. Factors such as memory failure, misperception of data, failure to observe the data and difficulties in collection of data (such as not being available) are examples that can interfere with this part of awareness. If someone misreads a patient's pulse as 60 instead of 160, the following process of comprehension and projection will be skewed.

Comprehension involves sense-making and understanding. It is the processing of the data gathered and retained in perception. Someone with a poor or incorrect mental model or with a memory failure in this process will affect the understanding of the situation and eventual projection.

Projection is using the data gathered and understanding the data to create analysis and prediction. This is where a delegate can formulate what will happen next with various action, whether the patient will deteriorate if something isn't done for example, or what the outcome of an intervention may be. At this point, the main factor that can create poor judgement is a lack of or poor mental model (for example, a thought process that goes pulse of 160, temp 39.4°C and resp of 36 is OK and I don't need to escalate).



There can be many factors that can interfere with a person's situational awareness. External factors include distractions, unfamiliarity, communication breakdown and influence from authority. Internal factors can include stress, fatigue, fixation, confirmation bias and being overloaded.

Someone who is losing, or has lost, situational awareness may be given away by clues, such as not responding or acknowledging others (often referred to as 'the zombie look'), ignoring information or repeating different information, fixation and having a bias in their perceptions. Factors that can improve this can be recognising fixation and "stepping out" of it, recognising one leader / co-ordinator for a scenario, good communication and being aware of your own limits.

Good debrief will help delegates recognise factors that affect their situational awareness and allow them to reflect and facilitate changes they may need to implement to improve this.

# Running the RAMPPS Course

## Killer phrases – Facilitators

### **“Does everyone understand?” / “Is there anyone who doesn’t understand?”**

Delegates, even when comfortable, still have concerns that asking a question they think they should know the answer to will annoy others or make them look foolish.

### **“You did great, I’ve nothing to add”**

This is a facilitator taking on a parental role. There will always be an opportunity for discussion, even a review of what went well, what tools people were using, how they felt during the simulation and so on.

### **“Let’s focus on the positives”**

A second meaning can be given to this statement. It can imply that the scenario ran so badly that the problems encountered are too big to deal with. It also prevents the group from addressing what happened and learning from areas they wish to review and explore.

## Killer phrases – Delegates

### **“Well, I wouldn’t do X in real life” “It’s not realistic”**

This can be a defence mechanism from a delegate who felt they performed below their expectation, or someone who wasn’t able to immerse in simulation. Acknowledging the limitations of simulation is important, then move the conversation to more fruitful discussion - “Blood pressure can be difficult to take on a manikin, so I can sympathise with that. I wonder if anyone has had difficulty taking blood pressure in real life? What was it like? How can we address that?”

### **“I had a situation like this before, five years ago in Africa. Let me tell you about it and what I did. It started when I went on the plane...” (The Storyteller)**

Delegates can fill in the debrief time with stories, and this can have two purposes. If someone is talking then they’re not being asked questions, it may be a form of disengaging and derailing the debrief. If you feel a story is relevant to what is being discussed, that is fine. If you feel that time is being misused, acknowledge that the person has a story to tell, then bring the discussion back into the here and now. “I recognise that you have an interesting story to tell and it might be important later, we can come back to that. I’d like to bring the discussion to what just happened here.”

## Someone who is shrinking into the background

A facilitator needs to recognise when someone isn't actively engaging with the debrief and try to bring them forward. Avoid isolating them by asking a question (especially a dirty question – this a question where you already know the answer and comes across as “testing” the individual) as this will encourage them to shrink even further. It can be as simple as asking them to move in closer or ask them about a past experience they have had.

## “It was terrible, I hated it and I didn’t do what I should have done”

This can be difficult as it may come across as confrontational. This situation can result in some great insight if you can try and find out what's behind the strong negative feeling. They may need time to vent, then the facilitator can try to find out what the thoughts were behind those feelings.

## Silence

This is difficult, especially if the whole group is disengaging. In something like the RAMPPS course this should be rare. The challenge here is to try and get the group talking about something. This may involve the facilitator having to bring forward their own experience, share their thoughts and ideas and create a dialogue to the point where someone from the group joins in.

## Facilitating the Facilitator

Much like the delegates, the facilitators will be well served by having a debrief session at the end of the RAMPPS day to offload any emotions and get feedback from colleagues about how the day went and any areas for discussion.

This session can be run almost identically to how the scenarios debriefs are run, and should ideally be led by someone who understands the facilitation process but hasn't been heavily involved in the facilitation of the day.

# Running the RAMPPS Course

## Personal Insight

### Tracy Latham

**Tracy Latham is a Regional Clinical Skills Advisor, and has been involved with the RAMPPS course from its early days. Here she talks about her experiences with RAMPPS and where it could go in the future.**

"My role is always developing, and I started in May 2012 just as RAMPPS was starting. My first meeting was a RAMPPS meeting. I've been involved in the development of RAMPPS, from the pilot day in Leeds and working to embed RAMPPS in Sheffield and beyond.

My role is to advise and support sustaining clinical skills and simulation training throughout the region, getting multiple professions to work together and train together and making sure things aren't repeated. As of August 2014, I have been a lead for RAMPPS and have been trying to get it rolled across the region.

I went to the original team meetings for RAMPPS, where we were setting up the first five scenarios. My bit was to try and get some simulated patients to enhance the experience. I met up with Charlie Turner and Paul McCormick to talk about how to do a faculty development day and get it embedded in Sheffield. I've helped at most of the RAMPPS days with debrief, general support and even being the bell ringer.

I'm now working with the Leadership Fellows, trying to take RAMPPS to the next step. My vision is have it so that it's sustainable, so that each of the hospitals around the region are running the course. At the end of the day, I want patients to

have the right care and the best care by the best trained professionals who work together. I want clinicians to be able to be more confident about how they deal with the physical health agenda and patients to have the most timely treatments and responses from professionals.

I think the RAMPPS course can help with that. It gives people an opportunity to train together, that's what I like about it. We use a model of training the trainers on the development days – we hope to train people to use RAMPPS, and those people can then train others. That's key to get it running across a region.



# Running the RAMPPS Course

*“I want to see a shift from healthcare workers sitting passively in lecture halls and classrooms towards multi professional experiential learning in a safe simulated environment.”*

I want to see a shift from healthcare workers sitting passively in lecture halls and classrooms towards multi professional experiential learning in a safe simulated environment. You don't forget these things and learn lots from other people.

I've been involved in E-Learning and have been working with Health Education Yorkshire and the Humber E-Learning group. By using e-learning and simulation we can get a better education and learning experience through multiple modes of learning. It gets everybody to a certain level with tools like SBARD and AVPU, so that when they arrive at RAMPPS they'll be on the same page and using the same models.

That will be a breakthrough already, as by getting all healthcare workers communicating the same way there would be fewer mistakes. It breaks down barriers and can be used by all the different healthcare groups to bring us together.

I hope to use the national Technology Enhanced Learning (TEL) hub to upload the RAMPPS resources so that anyone can access it. We are looking at e-learning, simulation and mobile learning. Mobile learning is one area where I think there are still opportunities. I've used RAMPPS as an example of learning about "Human Factors" in the national work-stream "Learning to be Safer", which is currently being rolled out across the thirteen LETBs.

RAMPPS is certainly a concept that could go national and my role is to help achieve that." "My role is always developing, and I started in May 2012 just as RAMPPS was starting. My first meeting was a RAMPPS meeting. I've been involved in the development of RAMPPS, from

the pilot day in Leeds and working to embed RAMPPS in Sheffield and beyond.

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I think the RAMPPS course can help with that. It gives people an opportunity to train together, that's what I like about it. We use a model of

*“It breaks down barriers and can be used by all the different healthcare groups to bring us together.”*

# Running the RAMPPS Course

## Setting up the Scenarios and Delegates

On the day itself, it should be known which facilitators are running which scenarios, who is the overall lead for the technical aspects, such as manikins and equipment, who is the lead to assist with any difficulties arising from or during debrief session, such as distressed delegates. Actors should be aware of what is required and groups should be planned to accommodate a balanced distribution of medics, nurses and health care assistants. Someone should be assigned to “reset” the station for the next group if required.

Ideally, a run through of the scenarios will have taken place before the RAMPPS day to review any problems with equipment, station design, facilitators and ensure that scripts have integrated well to your locality.

“Clinical notes”, “drug cards” and “observation charts” for the scenarios will need to be prepared in advance of the RAMPPS day. Appendix 1 contains scenario scripts for the patient notes. These can either be copied verbatim, or modified to suit your local needs, such as being written on trust paper or an admission package if you have one.

If you use electronic notes, “simulated e-notes” can be printed on paper by taking screenshots of the e-notes with a test patient; a computer can be put in the scenario room with access to simulated patient notes. It would allow for a truly immersive experience if a set-up is made where a computer is available with the scenario patient notes available.

## Running the Scenario

Each scenario is designed to start with the person who has the most contact with patients - the health care assistant. The opening script is designed for them to read and be aware of.

The nurse and doctor may, or may not be given the script, depending on how the local organiser wishes to run each scenario. It is not unrealistic for a nurse to be transferred to another ward for “emergency cover” and not be aware of their patients, or for the doctor to be “on-call” and never have met the patient before. This is something you may wish to introduce in later scenarios to test communication skills. In a similar vein, you may wish on some scenarios for the nurse and health care assistant to start the scenario together and review how they work together.

Once the scenario starts, the facilitators effectively have free reign over what happens. They may see the group making progress and let the whole scenario play out naturally, or they can intervene so people can rewind certain sections and change behaviours, remind delegates of the basic principles such as ABCDE, and they can help if there are any technical issues with the manikin.

Facilitators acting as Occupational Therapists can also be used in the scenarios. This provides a way for facilitators to have a more direct role and impact on the scenario and work with delegates and observe the interactions more intimately. It can provide useful insights as a facilitator, but also provide a much more organic

# Running the RAMPPS Course

way for facilitators to assist delegates who may be struggling. The OT who suggests “He keeps complaining of his headache?” breaks the immersion far less than someone outside the scenario area asking if they’ve considered a particular aspect of the scenario.

Actors are expected to know their script and how they should progress with the scenario. Ear-pieces can be used to provide information from a control room during the scenario, or a key-phrase can be used by the facilitator to direct a specific behaviour (for use in the respiratory depression station for example, to indicate the point of collapse).

The facilitators will also need to decide when the scenario should end. This is a judgement call, and there will be some variance in this.

Once the scenario has ended, it is up to the facilitator whether to sit the group down or remain in place for possible review of the section.

This will depend upon the style of RAMPPS being done. An in-situ RAMPPS event will require a planned time to run the scenario and a debrief session. A multi-station set-up aiming to last an entire work day will require a planned timetable, preferably distributed to delegates before attending. We would recommend an introductory session, 20 minutes per scenario, 35 minutes for debrief and 5 minutes lee-way time. A final debrief session should be arranged for delegates to share their views and learning of the day with each other, and to allow time for the delegates to complete the feedback forms. An example timetable is below.

## Structuring the Day

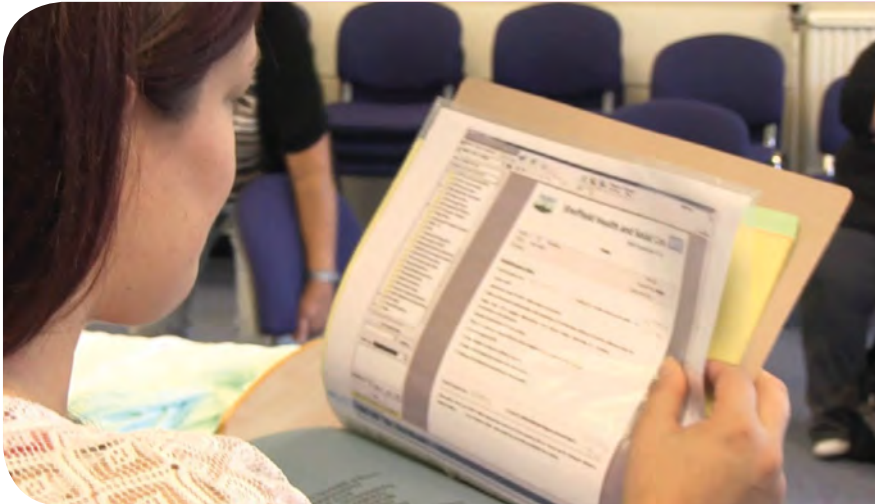
EVENT	TIME
Arrival and Registration	08:30 - 09:00
Introduction Session - Complete Pre-Course Questionnaire	09:05 - 10:00
Scenario 1	10:00 - 11:00
Scenario 2	11:00 - 12:00
Lunch / Refreshments	12:00 - 12:45
Scenario 3	12:45 - 13:45
Scenario 4	13:45 - 14:45
Scenario 5	14:45 - 15:45
Debrief and Feedback Complete Post-Course Questionnaire	15:45 - 16:15
Facilitator and Organiser Debrief	16:15 - 16:30

# Scenarios



# Scenarios

## Resources for Scenarios



**Appendix 1 contains example scripts and “clinical notes” for scenarios.**

**Appendix 5 contains scenario flowcharts, which can assist facilitators in responding to changes in the situation, such as treatment or non-treatment of a hypoglycaemic crisis.**

## General Notes

Please bear in mind that each scenario has a focal point. The debrief is not just a learning objectives tick box exercise. Each scenario is designed to test the basic skills of AVPU, ABCDE and SBARD, as well as test areas such as collaboration and clinical skills, and these should be borne in mind when debriefing each scenario.

Personnel involved assumes that a trainee psychiatrist, nurse and health care assistant are delegates for the station. Manikins and actors are interchangeable, though we have made a recommendation for each scenario. Extra personnel are recommended in some stations to allow some background explanation, or to enrich the experience of a scenario.

Some delegates may struggle with the scenarios. This is common and can often occur in the first scenario of the day. Prompting can come from the facilitator, or a simulated ward manager/facilitator if available. Towards the end, a simulated “ward manager” can attend mentioning that they’ve noticed the problem and want to know what the plan is.

# Scenario 1 - Brain Tumour

## Scenario 1: Brain Tumour

*Designer: Dr. Paul Rowlands*

It is a rare but recognised clinical scenario for serious organic brain disorders to present with psychiatric symptoms, sometimes leading to admission to psychiatric wards. The causative factor of their psychiatric symptoms may go unrecognised, leading to significant, negative outcomes.

### Focal Point

To appreciate that serious neurological disorders can present with predominantly psychiatric symptoms

### Personnel involved

Manikin, voiced by an actor

### Setting

Acute psychiatric ward

### Equipment required

- Pen torch, sphygmomanometer, SpO<sub>2</sub> monitor, thermometer, stethoscope
- A blank observation chart with the patient name but no readings
- A sick bowl. Imaginative organisers may put something in there.
- A “broken” ophthalmoscope and a working ophthalmoscope less obviously available.

### Scenario brief

“James Smith is a 48 year old man. He was admitted to hospital with severe depressive syndrome. He has not been eating, and his relatives report a change in his behaviour over the last six months. On the ward, he has been withdrawn and eating only with prompting. He has required assistance and encouragement from nursing staff to walk around the ward. James has been reported as having fallen today. He has been placed back in bed and you have been asked to check on him.”

# Scenario 1 - Brain Tumour

## Scenario Information

James is conscious, but a little drowsy. He complains mainly of a pain in his right arm, where he has fallen. If asked for other symptoms, he complains of headache and feeling very sick. He says little other than short statements such as “my arm hurts”, “my head hurts” or “I’m going to be sick”, and will not respond to other questions, either repeating these statements, groaning or being uncommunicative.

**A - Patent Airway**

**B - Respiratory rate around 12/min, but varies, SpO<sub>2</sub> 95% on air**

**C - Pulse 48 bpm, regular, raised blood pressure 160/95 mmHg**

**D - Apparent confusion but responding to voice**

**E - Temperature normal, BM 5.5, pupil abnormalities as detailed below**

There is no doctor on the ward at present, although the Core Trainee has been seen helping with an admission next door. The OT states that James has complained of headaches since admission and this seems to be getting worse. They apologise that they haven’t had a proper handover about James, but he hasn’t done well in any activities. There are medical notes available, with clerking of the patient carried out the previous night. There was no witnessed fall - the OT found James on the floor and helped him back into bed. He hasn’t fallen before.

When / If the doctor arrives, they ask for an ophthalmoscope. The first ophthalmoscope should be notably present on a desk or equipment trolley and immediately available. It should not work (remove the battery). There should be a proper ophthalmoscope kit/bag available with a working ophthalmoscope for the team to find should they persist beyond the first one. If the doctor looks to the facilitator for help, they should point out they can’t help with this.

Examination of the patient’s eyes should show unequal pupils with papilloedema, but no other neurological signs. If ophthalmoscopy is performed correctly, and a set up isn’t available for the doctor to do a simulated examination, they should be told their findings.

From this point, the delegates should recognise the severity of their findings and arrange a transfer to A&E or discuss the case with the Neurosurgical team. This can be done with simulated phone equipment, or with the facilitator standing in as the receiving doctor. The scenario can end either on recognition of the severity or on completion of the handover of information.

# Scenario 1 - Brain Tumour

## Scenario Case Notes

Please note that the dates of birth fit in for the scenario description as of February 2015.  
You will need to change the dates of birth to fit in with the dates you run your RAMPPS course.

### Scenario 1: Brain Tumour

**James Smith**, DOB 15/11/1965

(insert localised address)

Married, 1 daughter at home

Admitted (day before RAMPPS course), voluntary admission

Admission Clerking - Ward Doctor on-call

PC: James was informally admitted following a visit from Home Treatment Team, after relatives noted change in behaviour and low mood

HPC: James was largely uncooperative and irritable. He gave little history. Objectively, he appears low and withdrawn. Information from letters indicate family feel deterioration started six months ago and gradually, James has worsened since then. Unsure what triggered this change.

Persistent low mood, no diurnal variation, lethargy, anhedonia, poor appetite and sleep, lost about 10kg in 6 months, concentration very poor, behavioural change and irritability.

PMH: Unknown, not indicated in letter. GP to be contacted for past history and drug consolidation.

P H: As above

DH: As above

SH: Lives with wife and daughter at home. No child safety issues noted. Ex-smoker, smoked 20 a day for 20 years. Tee-total. No illicit substance use.

MSE: Appears withdrawn, objectively seems low. Doesn't want to engage with staff. Flat affect. Some psychomotor retardation. Irritable at times.

Impression: ?Severe depressive episode without psychotic symptoms

### Plan:

1. Admit to inpatient ward
2. Day team to complete physical examination and bloods (refused with me)
3. Contact GP in morning to confirm history and complete medicines reconciliation

# Scenario 1 - Brain Tumour

## Scenario Flowchart & Development Tool

**Learning Objectives:**

- 1. Recognises Patient is Unwell
- 2. Uses ABCDE Approach
- 3. Calls for Help When Appropriate
- 4. Uses SBARD in Handover

### Baseline

A: Patent

B: RR 10-15/min, irregular, SpO<sub>2</sub> 95% on air

C: p48, reg, BP 210/115, CRT <2s

D: Confused, BM 5.5, unequal pupils, papilloedema

E: Temp 37.9°C

No change to position

Raises head to 30°

Deteriorates

Slower Deterioration

A: Patent

B: RR 10-15/min, irregular, SpO<sub>2</sub> 95% on air

C: p48, reg, BP 240/125, CRT <2s

D: Confused, BM 5.5, unequal pupils, papilloedema

E: Temp 37.9°C

A: Patent

B: RR 10-15/min, irregular, SpO<sub>2</sub> 95% on air

C: p48, reg, BP 230/120, CRT <2s

D: Confused, BM 5.5, unequal pupils, papilloedema

E: Temp 37.9°C

## Scenario 2 - Chest Infection

### Scenario 1: Chest Infection

*Designer: Dr. Paul Rowlands*

Chest infections are common, with a clinical picture that can quickly change with rapid deterioration. Timely recognition and management of the problem can avoid more negative outcomes.

#### Focal Point

To recognise the interaction between underlying physical illness and the presenting mental state

#### Personnel involved

Actor

#### Setting

Acute psychiatric ward in the morning, before day team has arrived

#### Equipment required

- Pen torch, sphygmomanometer, SpO<sub>2</sub> monitor, thermometer, stethoscope, peak flow device
- An observation chart showing a slight increase in temperature yesterday, but not above 37°C and slightly faster resp rates. Today's observations should be blank. EWS should not exceed 1.
- A sick bowl, used tissues, asthma inhalers
- A drugs chart showing refusal of regularly-prescribed inhalers and increased use of PRN inhalers; two stat doses of 1mg oral lorazepam; allergy to penicillin
- Nicotine staining of fingers for actor/manikin if possible
- Wet/damp clothes to simulate sweating

#### Scenario brief

"Frank Evans is a 59 year old man with a history of severe depression with psychotic symptoms. He was admitted yesterday with symptoms of an acute manic episode. One of the ward OTs reported that he become a lot quieter this morning."

## Scenario 2 - Chest Infection

### Scenario Information

Frank is initially lying in bed and appears quite breathless. He has a cough. He reports that he is “fine, but a little hot” and “having a five minute break”. He goes on to explain he’s getting ready for his rehearsals for his Britain’s Got Talent audition and asks if Simon Cowell has arrived yet. His routine for the Queen needs to be seen as he’s been paid a million pounds to perform.

He is not irritable and allows his observations to be taken, with a little persuasion:

**A - Patent Airway**

**B - Respiratory rate around 24/min, regular, SpO<sub>2</sub> 86% on room air when lying down, sitting up improves this to 90%. Refuses to do a peak flow**

**C - Pulse 110bpm, regular, raised blood pressure 135/80 mmHg**

**D - Evidence of confusion, vocalising in a distorted manner**

**E - Temperature 37.9°C, BM 4.0. Evidence of reduced air entry with dullness to percussion and crepitations on auscultation on the right side of chest**

When the health care assistant and nurse have reviewed the patient and call for the on-call doctor, the doctor should be delayed for a couple of minutes with “a write up” in another ward. This allows some time for the nurse and HCA to manage Frank’s behaviour, which is starting to get a little more irritable.

When the doctor arrives, Frank becomes elated, believing them to be a celebrity (of their choice) to perform for. He is determined in this, and unless the nurse/HCA/doctor use appropriate de-escalation skills (not raising their own voices, reassuring Frank and not physically restraining him) he will persist in singing for the doctor. When he calms, he will allow repeat observations and a physical examination (“worst audition I’ve been to”). When asked about the coughing, Frank will point out how the green phlegm he’s been coughing up has been hampering his singing, and move to talk about his singing routine. If pressed about the sick bowl, Frank reports that he thought he was going to vomit earlier from coughing, but feels fine now.

The delegates should decide what action needs to be taken, agree and discuss an appropriate management plan - prescription of an appropriate antibiotic (note penicillin allergy), a chest X-ray (as he is over 50) and a plan to monitor his physical health and what to do if he deteriorates further. There may be an argument for transfer to a medical ward although this could be seen as inappropriate.

CRB-65 can be noted as a useful tool here. CRB-65, scores one point for each of the following:

- Confusion of recent onset

- Respiratory rate greater than 30

- Blood pressure systolic less than 90 mmHg or diastolic 60 mmHg or less

- 65 years or older

Scoring 3 or more requires urgent care, 2 same day assessment in secondary care with a potential short-stay as an inpatient, 1 consideration of further assessment and 0 treat at home.

Emphasise this is a tool and does not replace clinical judgement.

# Scenario 2 - Chest Infection

## Scenario Case Notes

### Scenario 2: Chest Infection

**Frank Evans**, DOB 25/10/1955

(insert localised address)

Widowed, no children, no other family we are aware of

Admitted (day before RAMPPS course), detained under Section 2 Mental Health Act

Admission Clerking - Ward Doctor on-call

PC: Appears elated, neighbours concerned, brought in under 136 and sectioned followed MHA assessment

HPC: Irritable. Limited information from patient. Crisis team have been seeing Frank for 10 days. Last admission 6 months ago, on ward for 4 months. Spending money on clothing, now in debt, talking about upcoming appearance on show and seeing the queen. Not slept for 24 hours+. Unsure when last ate.

PMH: Not known, GP to be contacted for information

PΨH: Previous admission for depression requiring 4 month inpatient stay and ECT.

DH: Not known

SH: Lives alone at home, good social contact with neighbours who check on him occasionally. Smokes heavily (wouldn't say how much), drinks daily, no illicit substance use.

MSE: Elated, overactive, dancing, a bit belligerent when trying to complete physical examination (unable to do). Reduced awareness of social cues, overfamiliar and verbally hostile x1. Didn't want to engage in interview process after a short amount of time. Fleeting descriptions of grandiosity and overtly displaying dance routines.

Impression: ?Acute manic episode

### Plan:

1. Admit to inpatient ward
2. Physical examination / Bloods to be completed
3. Needs collateral history / medicines reconciliation

## Scenario 2 - Chest Infection

### Scenario Flowchart & Development Tool

#### Learning Objectives:

1. Recognises Patient is Unwell
2. Uses ABCDE Approach
3. Calls for Help When Appropriate
4. Uses SBARD in Handover

### Baseline

A: Patent

B: RR 24/min, regular, SpO2 90% on air

C: p110, reg, BP 135/80, CRT <2s

D: Confused, BM 5.5,  
delusional, hallucinatory

E: Temp 39.2oC, Right lower lobe  
reduced air entry, crepitations,  
dull to percussion

Increase in SpO2 if oxygen given  
No other changes

# Scenario 3 - Hypoglycaemia

## Scenario 3: Hypoglycaemia

Designer: Dr. Paul Rowlands

Diabetes is a common co-morbidity for people suffering serious mental illness. Changes in dietary intake will impact the management of the condition. A patient with diabetes who becomes severely depressed and stops eating may be at risk of developing hypoglycaemia if adjustments to their treatment regime are not made and their condition is not monitored.

### Focal Point

To recognise the effect that dietary changes can have upon physical and mental health presentations

### Personnel involved

Manikin, voiced by an actor

### Setting

Acute psychiatric ward

### Equipment required

- Pen torch, sphygmomanometer, SpO2 monitor, thermometer, stethoscope, BM monitor available on request
- Notes are not available (the e-system has crashed / notes are missing as appropriate)
- Drug card with a complex medication regime including insulin
- Obs chart with the BM measurements missing
- No monitoring of input/output

### Scenario brief

"Robert West is a 61 year old man admitted 4 days ago with a history of depression. He has been managed at home by the crisis team and has talked of hanging himself. He is reported to have fainted in the day room by the ward OT but is now conscious again."

## Scenario 3 - Hypoglycaemia

### Scenario Information

Robert will present as confused and slightly irritable, but is able to answer questions with short answers. If asked he will admit to being off his food as of late. He will allow his observations to be taken.

**A - Patent Airway**

**B - Respiratory rate around 18/min, regular, SpO2 96% on air**

**C - Pulse 120 bpm, regular, raised blood pressure 175/110 mmHg**

**D - Evidence of disorientation and irritability, but not uncooperative**

**E - Temperature normal, BM 2.6, evidence of sweating**

There is a drug card showing a prescription of insulin which has been administered as written with no comments. There should also be no BM chart and a blank input/output chart. A doctor is available and will be there shortly.

Once all the delegates have the available information they should decide what action needs to be taken. An appropriate management plan would include changing his prescription, administering glucagon or suitable alternative, referral to a dietician and diabetes specialist nurse, informing the day team and confirming the appropriate observations.

The scenario can end once the appropriate management plan is discussed, or ended to discuss what management plan the delegates have in mind.

## Scenario 3 - Hypoglycaemia

### Scenario Case Notes

#### Scenario 3: Hypoglycaemia

For this scenario, the notes are deliberately missing. Either the electronic notes system is down and/or the physical notes are unavailable (example, someone took them for audit and they haven't returned them).

# Scenario 3 - Hypoglycaemia

## Scenario Flowchart & Development Tool

### Learning Objectives:

1. Recognises Patient is Unwell
2. Uses ABCDE Approach
3. Calls for Help When Appropriate
4. Uses SBARD in Handover

## Baseline

A: Patent

B: RR 18/min, regular, SpO<sub>2</sub> 96% on air

C: p120, reg, BP 175/110, CRT <2s

D: Confused, BM 2.6, disoriented, irritable, confused

E: Temp 38.4°C, subtle tremor, sweating

### Untreated

### Deteriorates

A: Patent

B: RR 22/min, regular, SpO<sub>2</sub> 96% on air

C: p140, reg, BP 175/110, CRT <2s

D: Confused, BM 2.1, disoriented, irritable

E: Temp 37.9°C, tremor, increased sweating

### Biscuit, toast or similar

### Slight Improvement

A: Patent

B: RR 18/min, regular, SpO<sub>2</sub> 96% on air

C: p125, reg, BP 175/110, CRT <2s

D: Confused, BM 2.6

E: Temp 37.9°C

### Glucagon or similar

### Improvement

A: Patent

B: RR 16/min, regular, SpO<sub>2</sub> 96% on air

C: p100, reg, BP 175/110, CRT <2s

D: Confused, BM 4.2, more lucid

E: Temp 37.9°C

## Scenario 4 - Substance Abuse & Respiratory Depression

# Scenario 4: Substance Abuse and Respiratory Depression

Designer: Dr. Paul Rowlands

A number of serious incidents have occurred in different Trusts within the Yorkshire and Humber area involving this situation. Tolerance to opiates is lost quickly. An opiate dependent individual who uses their habitual amount after a period of abstinence is at risk of potentially fatal respiratory depression.

### Focal Point

To recognise potentially high risk situations that can occur with in-patients who have a history of substance misuse

### Personnel involved

Actor alone, or actor with either a manikin or part task trainer split

### Setting

Acute psychiatric ward

### Equipment required

- Pen torch, sphygmomanometer, SpO2 monitor, thermometer, stethoscope, BM monitor
- Drug card and notes available
- Obs chart showing seven days of normal observations
- O2 cylinder and mask available
- Immersion item: can of beer and/or smell of alcohol on actor/manikin
- Pen or make up to make track marks on left arm (covered with a sleeve initially)

### Scenario brief

"Geoff Collins is a 38 year old man with a history of psychosis and previous heroin dependence. He has been receiving treatment on the ward for the last four weeks and is detained under Section 3 of the Mental Health Act. He has just been returned by the police having taken unauthorised leave over the weekend"

## Scenario 4 - Substance Abuse & Respiratory Depression

### Scenario Information

Geoff is initially quite agitated and verbally abusive. He's annoyed at being brought back to the ward and he will repeatedly state he's tired, wants to get out and to leave him alone. There is no physical aggression although clear signs of agitation are present. Geoff has taken significant amounts of alcohol and IV heroin whilst off the ward, but will not answer questions about this if asked and will continue to present as verbally aggressive.

Geoff will not allow his observations to be taken, and his respiratory rate is normal to start with (18 if using a manikin). He smells of alcohol. Continuing to ask if obs can be taken will result in frank verbal hostility.

The on-call doctor isn't available on the ward immediately, but will answer the phone and attend depending how urgent the candidate thinks the situation is.

Geoff will decide he wants to lie after a few minutes, remaining verbally hostile but becoming increasingly drowsy and less responsive. If observations are taken at this point, Geoff will mumble but not resist them.

They reveal:

**A - Patent Airway**

**B - Respiratory rate around 8/min, but varies, SpO2 94% on air**

**C - Pulse 120 bpm, regular, raised blood pressure 90/60 mmHg**

**D - Responds to voice but limited communication**

**E - Fresh track marks on this left arm, pinpoint pupils**

The delegate team will need to make an action plan based upon the information they have at this point. There is an O2 cylinder and Naloxone available if requested. Calling 999/crash team as appropriate to locality is also appropriate. If no action is taken, the patient will eventually go into respiratory arrest.

The scenario should end when an appropriate action plan is taken or the patient starts to arrest.

## Scenario 4 - Substance Abuse & Respiratory Depression

### Scenario Case Notes

#### Scenario 4: Substance Abuse and Respiratory Depression

Geoff Collins, DOB 14/12/1976

Admitted (four weeks before RAMPPS course), detained under Section 3 Mental Health Act

Admission Clerking - Ward Doctor on-call

PC: Admitted for psychotic episode, likely substance induced

HPC: Seen in A&E after being brought in under S136 by police yesterday. Sectioned by SpR and AMPH and admitted to ward after drug screen came back negative. History of poly-substance misuse, including cannabis, heroin and amphetamines. Very agitated, complains of hallucination of lizards that are going to take him away. Unable to take any reasonable history of note.

PMH: Nil

P H: As above, long history of substance misuse and engagement then disengagement with services.

DH: Nil known

SH: Lives alone at home, frequent contact and abuse from drug dealers, has been assaulted numerous times, flat currently uninhabitable, council are involved with this.

MSE: Responding to psychotic phenomenon, talking about lizards taking him away, clearly afraid, not hostile to myself or other members of staff. Scared. Rapid speech. Accepting of care on ward and knows staff are here to help.

Physical Examination NAD. Bloods from A&E, NAD.

Impression: ?Acute psychotic episode, ?substance induced

#### Plan:

1. Admit to inpatient ward
2. Lorazepam 1mg QDS PRN

## Scenario 4 - Substance Abuse & Respiratory Depression

### Notes for following day:

Mr. Collins discussed at MDT. History as per clerking.

Much more settled today, good use of lorazepam, wants help with substance misuse. Unable to return to flat, to work with OT and council to try and return flat to fit state of use.

Still believe lizards are spying on him whilst on the ward and are going to take him away if he leaves.

Plan, trial Olanzapine 2.5mg OD.

### Notes one week later:

MDT meeting, Mr. Collins reviewed.

Doing well, accepting medication, engaging with OT and taking medications as appropriate.

?withdrawal symptoms but not asking for help with these. Continuing psychotic symptoms which are interfering with function. OT has found it difficult to get Geoff to engage with activities unsupervised or with strangers.

Plan, trial Olanzapine 5mg OD.

### Notes another week later:

MDT meeting, Mr. Collins is engaging better with team and psychotic symptoms appear to be improving, but still present.

Flat remains uninhabitable and council are making plans to clean it up and make repairs. Squatters have been found in flat and caused considerable damage. To remain on ward whilst this is sorted.

### Notes 3 days before RAMPPS course:

MDT meeting. Continuing evidence of some psychotic symptoms, Geoff has started withdrawing from ward activities and is disengaging from staff and peers. Requesting period of leave. Noted history of absconson in previous admissions and suggested escorted leave with care coordinator given history and continued psychotic symptoms. Geoff has declined this and is clearly unhappy with this idea.

Plan: no change to medication, discuss escorted leave with care coordinator, encourage Geoff to engage with staff, leave status unchanged.

### Notes day before the RAMPPS course:

Geoff not found on morning checks. Not present on ward. Police informed.

## Scenario 4 - Substance Abuse & Respiratory Depression

### Scenario Flowchart & Development Tool

#### Learning Objectives:

1. Recognises Patient is Unwell
2. Uses Appropriate De-escalation Techniques
3. Uses ABCDE Approach
4. Calls for Help When Appropriate
5. Uses SBARD in Handover

## Baseline

### Respiratory Depression

#### Changes:

RR drops to 8/min, SpO<sub>2</sub> 94%  
Pulse 120, BP 90/60  
Responsive to pain only, moaning

A: Patent

B: RR 18/min, regular, SpO<sub>2</sub> 97% on air

C: p110, reg, BP 120/80, CRT <2s

D: Agitated, abusive, pacing, pinpoint pupils, refusing obs

E: Temp 37.6°C, alcohol smell, fresh track marks

Can switch to manikin

### Untreated

### Deteriorates

#### A: Patent

B: RR 4/min, regular, SpO<sub>2</sub> 88% on air

C: p130, reg, BP 80/50, CRT <2s

D: Unresponsive

E: Temp 37.9°C

### Oxygen

### Slight Improvement

#### A: Patent

B: RR 6/min, regular, SpO<sub>2</sub> 92% on air

C: p130, reg, BP 80/50, CRT <2s

D: Unresponsive

E: Temp 37.9°C

### Naloxone

### Improvement

#### A: Patent

B: RR 10/min, regular, SpO<sub>2</sub> 97% on air

C: p110, reg, BP 100/70, CRT <2s

D: Confused, responding to voice

E: Temp 37.9°C

# Scenario 5: Complications of Rapid Tranquilisation

Designer: Dr. Paul Rowlands

In situations where there are high levels of behavioural disturbance, use of restraint and rapid tranquilisation has the potential to progress rapidly to situations of serious medical emergency. The aim of this station is for clinicians to demonstrate their awareness of this and to manage the situation appropriately.

### Focal Point

To appreciate the importance of baseline investigations in pressure situations. The importance of de-escalation techniques and their use in physically unwell patients

### Personnel involved

Actor alone, or actor with either a manikin or part task trainer split

### Setting

Acute psychiatric ward

### Equipment required

- Pen torch, sphygmomanometer, SpO2 monitor, thermometer, stethoscope available with equipment, BM available on request
- Patient notes, recent admission clerking, recent ward entries
- Drug chart showing all medication given, indicating administration of Quetiapine above BNF limits (such as Quetiapine XL 800mg OD), excess use of Lorazepam (given 4mg over the last 24hours) and PRN Haloperidol use (at least 10mg given)
- Record of physical observation, normal
- 12-lead ECG done on admission showing a prolonged QT-interval (~500ms)

### Scenario brief

"Jason Edwards is a 35 year old man with a diagnosis of paranoid schizophrenia. He was admitted to the ward 3 days having become non-concordant with his medication and deteriorating. He is detained under Section 3 of the Mental Health Act. Handover finished ten minutes ago. Another patient has told you there's a lot of shouting coming from his room."

# Scenario 5 - Complications of Rapid Tranquilisation

## Scenario Information

Jason is agitated at the outset and verbally hostile to the first person on the scene. He will tell them to go away and repeatedly state that he shouldn't be here (in hospital). He believes the nursing staff have been stealing parts of his brain and that poison gas is being pumped into the room through the floor in an attempt to kill him. He makes a number of threats such as "Get out of my way or I'll put this chair through the window" and "I'll move you out of my way" and so on. He does not physically assault anyone.

If another colleague joins in Jason's behaviour should escalate with increased pacing, agitation and accusations. The aim is the behaviour should escalate to the point where the delegates discuss the need for a medical review and use of medication.

Jason's drug card should show judicious use of antipsychotics, such as Quetiapine 800mg ON with Lorazepam 1mg and Haloperidol 5mg PRN for "agitation", showing use of Haloperidol PRN about an hour ago by staff on the previous shift.

Direct observations are not possible, but objectively his respiratory rate should be increased and he is very clearly alert and agitated.

When the doctor arrives Jason should respond appropriately, believing them to be ganging up on him and getting ready to kill him. Jason's notes should indicate they have seen the prolonged QT interval but not say if anything has been done about this. The ECG can either be left blank or have a circled QT.

Delegates will hopefully discuss what the appropriate course of action is. Further antipsychotics should not be prescribed, this may be a suitable point for facilitator intervention if the team arrange for more antipsychotics to be given. Alternative ways the scenario can be run is to allow further administration of antipsychotic and then to simulate a cardiac arrest. We recommend that CPR is not moved to as this is not the aim of the course.

Jason will refuse oral medication. Should the delegates give Jason Lorazepam IM, he will calm down, but will then move towards sedative overdose. He should become poorly responsive, slur his speech, become unsteady and suffer a drop in blood pressure, moving to unresponsive.

**A - Patent Airway**

**B - Respiratory rate increased as per actor, manikin if used 30 resps per minute, but varies, SpO2 99% on air**

**C - Pulse 140 bpm, regular, blood pressure 100/70 mmHg**

**D - Distressed**

**E - Temperature normal, BM 5.0**

The delegates should make a plan of what to do next, which should include observations, repeat ECG and, given the severity of the prolonged QT, probable transfer to A&E and at least a discussion with the on call cardiologist. Delegates may need prompting as what they would do for further management. The scenario can be ended at this point. Should the facilitators not wish to stop the scenario when intervention with another administration of haloperidol is performed, then the scenario should proceed to include cardiac arrest. The scenario should be stopped at this point.

### Scenario Case Notes

#### Scenario 5: Complications of Rapid Tranquilisation

Jason Edwards, DOB 12/11/1979

(insert localised address)

Single, no children, parents live in Germany

Admitted (two day before RAMPPS course), detained under Section 3 Mental Health Act

Admission Clerking - Ward Doctor on-call

PC: Admitted from 136 suite after being found wandering the streets accosting passers by

HPC: Patient is acutely agitated and unable to take historical data. Believes staff are stealing his thoughts, pumping poison gas in the room and destroying his mind. Similar presentation in the past. Improves with treatment of Quetiapine. Has been non-concordant with medication.

PMH: No physical health problems known of, GP to be contacted.

P H: Numerous admissions in the past of relapse following medication issues. Has done well with Quetiapine. Last admission one year ago for 4 months, previous detention under S3 MHA.

DH: Quetiapine, dose not known, to be re-titrated.

SH: Lives alone at home, unable to get further information.

MSE: Very agitated, as per HPC.

Impression: Relapse of paranoid schizophrenia.

#### Plan:

1. Admit to inpatient ward
2. Physical examination / Bloods to be completed
3. Contact GP for full information
4. Day team to re-establish Quetiapine 600mg XL PO - patient just accepted this
5. Lorazepam 1mg PO/IM QDS
6. Refused ECG - to be taken

Continues on next page

## Scenario 5 - Complications of Rapid Tranquilisation

### Scenario Case Notes Continued

#### Note entry dated one day before course:

MDT review. Jason remains agitated, overactive and aggressive. Suspicious of named nurse and lacking insight. Reports compliance with Quetiapine marked deterioration noted, as discussed with Jason. Aware of benefits and risks of treatment and is willing to take medication.

**Plan:** Increase Quetiapine XL to 800mg PO ON, remain under Section 3 MHA, no leave for now, Ward Doctor to do ECG.

#### Night before the course:

On-call Ward Doctor

Asked to review Jason as becoming increasingly agitated. Very distressed, pacing, shouting, threatening violence but hasn't acted on any of these threats. Noted history of relapse of schizophrenia, stating poison gas coming through vents and that we are trying to damage his mind. Likely risk of harm to self and others, note quetiapine increase has not controlled psychotic symptoms.

Unable to contact seniors on-call for advice. Nursing staff asking for intervention. Advice given for rapid tranquilisation:

Haloperidol IM 5mg TDS PRN

Day team to consider PICU and senior review mane

# Scenario 5 - Complications of Rapid Tranquilisation

## Scenario Flowchart & Development Tool

### Learning Objectives:

1. Recognises Patient is Unwell
2. Uses Appropriate De-escalation Techniques
3. Uses ABCDE Approach
4. Calls for Help When Appropriate
5. Uses SBARD in Handover

## Baseline

### A: Patent

B: RR 24/min, regular, SpO<sub>2</sub> 98% on air

C: p140, reg, BP 110/60, CRT <2s

D: Agitated, abusive, pacing, acute psychosis, refusing obs

E: Temp 37.6°C

## Increasing Agitation

**Oral Benzo  
(faster effect  
for sake of  
simulation)**

**De-escalation  
Only**

**IM Haloperidol  
(faster effect  
for sake  
of time)**

**Sedated**

**Physically  
Stable**

**Catastrophic  
Event**

### A: Patent

B: RR 8/min, regular, SpO<sub>2</sub> 88% on air

C: p80, reg, BP 100/60, CRT <2s

D: Responsive to pain, moaning

E: Temp 37.9°C

### A: Patent

B: RR 6/min, regular, SpO<sub>2</sub> 92% on air

C: p130, reg, BP 80/50, CRT <2s

D: Unresponsive

E: Temp 37.9°C

### A: Patent

B: RR 4/min, regular, SpO<sub>2</sub> 84% on air

C: p70, irregular, BP 100/70, CRT <2s

D: Significant distress, then unresponsive

E: Temp 37.9°C

**Cardiac Arrest**

## Scenario 6 - Neuroleptic Malignant Syndrome

# Scenario 6: Neuroleptic Malignant Syndrome

*Designer: Dr. Paul McCormick*

Neuroleptic Malignant Syndrome is an idiopathic reaction that can happen in anyone taking antipsychotic medication. It is potentially fatal, and requires prompt recognition and appropriate transfer to manage potential associated circulatory, respiratory and renal disorders.

### Focal Point

To recognise the signs and symptoms of NMS and take appropriate action

### Personnel involved

Manikin, voiced by an actor

### Setting

Acute psychiatric ward

### Equipment required

- Pen torch, sphygmomanometer, SpO<sub>2</sub> monitor, thermometer, stethoscope available with equipment, BM monitor
- Medical notes from the last two weeks detailing a decision to commence depot, with reports of some difficulty with speech, mobility and activities of daily living over the last week, increasing agitation, new onset auditory hallucinations
- Drug chart with test dose of depot medication prescribed and given 2 weeks before course date, haloperidol PRN with 2 doses administered the day of the course
- Observation charts for the last seven days - fluctuating temperature, blood pressure and pulse
- 12-lead ECG on admission showing normal sinus rhythm
- Blood test from yesterday showing WCC - 16.0, Urea - 11 (prev 6), Creatinine - 135 (prev 70), Hb - 13.0, LFTs normal, TFTs normal, CK - 1323, MSU NAD, Sputum clear. Plan: day team to review on morning ward round.

### Scenario brief

"Steve Morris is a 61 year old man. He was admitted to hospital with an episode of mania six months ago. He has been complaining this morning of stiffness and you have been asked to see him."

## Scenario 6 - Neuroleptic Malignant Syndrome

### Scenario Information

The nurse and doctor should not be given this script. The healthcare assistant should see Steve and recognise that his stiffness, pain and crankiness aren't normal. Things have been getting worse over the past few days but Steve can't really explain how, just that he's stiff and in pain when moving.

When the nurse arrives, Steve complains of the same, but starts getting people mixed up, calling them by the wrong name or even by people not present. If there is an OT facilitator, they can mention that Steve used to be such a jovial and lucid, albeit disinhibited gentleman. He didn't have any problems with his speech or walking before, but recently he fell whilst walking and told the OT he's hearing people speak to him when he's alone. He even needed help dressing this morning. The OT is concerned he may not be able to move to get his depot, which is already overdue.

**A - Patent Airway**

**B - Respiratory rate around 14/min, SpO<sub>2</sub> 99% on air**

**C - Pulse 120 bpm, regular, blood pressure 150/95 mmHg**

**D - Alert but seems a little confused**

**E - Temperature 37.1°C, evidence of sweating, BM 5.5**

The OT facilitator can start pressing that Steve really is overdue for his depot and they don't want to get the blame for this.

The health care assistant and nurse should recognise that the picture is one where Steve needs a medical review prior to any further depot and call the doctor. They can attend in good time as they are just down the corridor chatting with the ward staff.

Ideally, once the history is clarified the doctors will review the notes, obs chart and perform a physical examination - hindered by Steve's stiffness. The drug chart and notes should point towards a depot being due today, first thing this morning. The OT facilitator can mention that she is anxious he's getting unwell because he hasn't had it yet.

*Continues on next page*

# Scenario 6 - Neuroleptic Malignant Syndrome

## Scenario Information Continued

If physical observations are repeated, the fluctuations associated with NMS should be revealed:

**A - Patent Airway**

**B - Respiratory rate around 14/min, SpO<sub>2</sub> 99% on air**

**C - Pulse 130 bpm, regular, blood pressure 180/105 mmHg**

**D - Alert but increasingly confused and irritable**

**E - Temperature 38.4°C, evidence of diaphoresis, tremor and rigidity, BM 5.0**

If an actor is being used, examination should show stooped posture, shuffling gait, restlessness and tremor, with generalised rigidity.

By this point the patient should be speaking less comprehensibly and start showing definite signs of confusion and agitation.

The delegates should recognise Neuroleptic Malignant Syndrome (with acute renal failure) and that the depot would be inappropriate to give. The ideal management plan is to stop further antipsychotic medication and contact a senior for advice, arrange an urgent transfer to A&E or discuss with the Acute Medical SpR on-call. The scenario should end when this is agreed, or if the delegates need prompting to move to the management plan.



## Scenario 6 - Neuroleptic Malignant Syndrome

### Scenario Case Notes

#### Scenario 6: Neuroleptic Malignant Syndrome

An error in medical records means that only 2 weeks of notes are available to view at present

Steven Morris, DOB 15/11/1953

(insert localised address)

Admitted (six months before RAMPPS course), voluntary admission

Widowed, 3 children all live away, 2 grandchildren.

#### 2 weeks before course:

MDT review. Remains elated, some overactivity and disinhibition. No perceptual abnormalities. No history of having trialled depot medication. Discussed this with Steven who is aware of the intended benefits and risks. Consenting to trial of Flupenthixol depot. Plan is to test dose of 20mg Flupenthixol IM today. 40mg IM to be given in 14 days. No change in leave status.

#### 7 days before course:

MDT. Steven has refused to attend MDT. Nursing staff report increasing irritability today, though not entirely out of keeping with past behaviour. Named nurse not available today to discuss change. Plan is full review by Ward Doctor before next MDT.

#### 3 days before course:

Dr. Williams - Current ward doctor off sick, covering ward in his absence. Asked to review Steven. Found pacing around room, presented as irritable and anxious, muttering to self ?auditory hallucinations. Asked me to leave shortly after. Advised by team that medication has been altered and looking to increase in the future. Plan for now, Haloperidol 5mg PO/IM up to TDS for agitation until dose increase of current meds. Senior review when available.

# Scenario 6 - Neuroleptic Malignant Syndrome

## Scenario Flowchart & Development Tool

### Learning Objectives:

1. Recognises Patient is Unwell
2. Uses ABCDE Approach
3. Calls for Help When Appropriate
4. Uses SBARD in Handover
5. Recognises Depot not Appropriate

## Baseline

A: Patent

B: RR 12/min, regular,  
SpO<sub>2</sub> 99% on air

C: p120, reg, BP 150/95, CRT <2s

D: Alert, confused, irritable,  
incomprehensible at times, BM5.5

E: Temp 39.2°C, tremor,  
rigidity, sweating

**Physiological Observations  
Unstable, +/- 25% fluctuation**

# Scenario 7: Wernicke's Encephalopathy

*Designer: Dr. Simon Taylor*

It is common for a "repeat mental health attender" with medical symptoms to be referred to the mental health team and admitted to a mental health ward. The key questions of "Why these symptoms?", "Why now?" and "Why in this patient?" continue to hold true.

### Focal Point

To recognise that treatable medical emergencies can present in chronic psychiatric condition and be the cause of associated behaviour. Also to note that Wernicke's Encephalopathy can present in situations other than alcohol abuse

### Personnel involved

Manikin or actor, though an actor would be preferable

### Setting

Acute psychiatric ward

### Equipment required

- Pen torch, sphygmomanometer, SpO<sub>2</sub> monitor, thermometer, stethoscope available with equipment, BM monitor
- Medical recommendation for detention under Section 2 of the Mental Health Act detailing deterioration in behaviour, 10 year history of mental health problems, diagnosis of OCD and Diogenes syndromes and past history of schizophrenia
- Transfer letter with limited information - Gordon has been accosting people in the town centre and has been self-neglecting. His home contains significant fire and fall hazards. The patient hasn't been clerked in yet
- A sick bowl. Imaginative organisers may put something in there
- A blank observations chart

### Scenario brief

"Gordon Freeman is a 61 year old single male who has arrived on the ward minutes ago to be admitted. He was detained at home by his community team and GP after police gained entry to his house using Section 135. He hasn't met any ward staff yet, and you've been asked to welcome him to the ward and perform any checks you see appropriate."

# Scenario 7 - Wernicke's Encephalopathy

## Scenario Information

Gordon should be found sat in a chair or lying in bed dozing. He is easily woken and will get up. He should be notably unsteady, as if intoxicated. His clothing should be stained with vomit. He asks the first attendee why he's here, who they are, how long he's been here, showing that he is clearly disoriented. He repeats the questions and finds it hard to answer questions in a timely and sensible fashion. He is concerned about the welfare of animals and will inappropriately discuss this. He also complains of feeling weak and tired, especially in his legs, and asks the staff member to come back and visit him next week. He frequently reports feeling cold, no matter how many covers he is given.

This should be alarming enough to ask the nurse to come and see Gordon. He should present in a similar fashion to the nurse. He will allow observation but doesn't understand why people are doing this to him.

**A - Patent Airway**

**B - Respiratory rate around 12/min, SpO<sub>2</sub> 98% on air**

**C - Pulse 80 bpm, regular, 100/65 mmHg**

**D - Confused and easily riled, BM 5.5**

**E - Temperature 35.5°C,**

He recalls seeing his GP but thinks this was days ago. He can't understand why so many people are here in his "house" but would rather they leave. He will quickly go back to answering his initial questions or rambling about animal welfare.

The doctor is readily available if called. On entering, Gordon should comment on why there are so many people now, including two doctors, and "why aren't people standing still?", "you all keep moving about". Ophthalmoscopy should show papilloedema and retinal haemorrhage.

The aim is for the delegates to recognise that Gordon is significantly unwell and suffering Wernicke's Encephalopathy. This is a medical emergency and the team should arrange urgent transfer to A&E or contact the Medical Registrar on-call to arrange transfer. The scenario can also end if the facilitator needs to prompt the delegates for a management plan.

## Scenario 7 - Wernicke's Encephalopathy

### Scenario Case Notes

#### Scenario 7: Wernicke's Encephalopathy

This scenario involves no ward notes as the patient has just arrived to the ward. Below are the transcripts for 2 Mental Health Act Assessments.

##### First recommendation by GP:

Known OCD and sufferer of schizophrenia for at least 10 years. Increasing concerns about home situation, not looking after self, living in squalor, approaching people on the street and expressing extremist views. Clearly unwell. Problems with medication compliance that have led to deterioration in the past - unclear whether this is the situation here. Needs assessment in hospital but patient is refusing this at present.

##### Second recommendation by Consultant:

Gordon is a 61 year old gentleman with a working diagnosis of OCD and Diogenes Syndrome, currently manifest in increases in hoarding behaviour. His living situation is now untenable. There have been reports of Gordon talking aggressively to strangers in town, expressing his long-held views on avoidance of animal product testing, hunting, animal rights and other similar ideas. He has a previous diagnosis of paranoid schizophrenia, but no evidence of delusional content to speech on assessment today.

Treatment in the community is not possible because of the risks posed to Gordon by his living situation, this makes 24-hour specialist inpatient admission necessary.

Hospital admission is necessary in the interests of Gordon's health to manage the risks of his self-neglect and in the interests of Gordon's safety given the risks of fire and falls, as well as potential risks from others.

Informal admission is not appropriate because Gordon is not agreeing to inpatient admission.

# Scenario 7 - Wernicke's Encephalopathy

## Scenario Flowchart & Development Tool

### Learning Objectives:

1. Recognises Patient is Unwell
2. Uses ABCDE Approach
3. Calls for Help When Appropriate
4. Uses SBARD in Handover
5. Recognises Significance of Presentation

## Baseline

### A: Patent

B: RR 12/min, regular, SpO<sub>2</sub> 98% on air

C: p80, reg, BP 100/65, CRT <2s

D: Confused and easily riled, BM5.5

E: Temp 35.5°C

Physiologically Stable

# Scenario 8: Venous Thrombosis with Possible PE

*Designer: Dr. Mike Akroyd*

Venous thrombosis has a well-documented association with immobility, and patients undergoing major surgery are routinely prescribed preventative anticoagulation. In psychiatric settings, other causes of immobility such as prolonged restraint or profound psychomotor retardation can confer similar risks, particularly in individuals who are already vulnerable to development of thrombosis.

### Focal Point

Recognise signs of venous thrombosis and pulmonary embolism. Explore the issues relating to the presence of a distressed relative in a situation where staff anxieties are also raised

### Personnel involved

Manikin as the patient  
Actor as the distressed relative

### Setting

Acute psychiatric ward

### Equipment required

- Pen torch, sphygmomanometer, SpO<sub>2</sub> monitor, thermometer, stethoscope available with equipment, peak flow device
- Mock notes outlining 4 days of care notes, drug card, physical obs chart and ECT pack partially completed.
- Reddening of right lower leg, with swelling/heat.

### Scenario script

"George Mason is a 58 year old male admitted four days ago. He has a diagnosis of recurrent depressive disorder and is currently experiencing a severe depressive episode. He was detained at home by his consultant psychiatrist and his GP following concern from his relatives that he had become increasingly withdrawn to the point where he would no longer get out of bed. His relative is visiting at the moment and does not appear happy."

## Scenario 8 - Venous Thrombosis with Possible PE

### Scenario Information

The scenario should start with the relative, "Tim" angrily demanding that someone see George who "isn't himself". George is found sat in his bed showing little awareness of his surroundings other than response to pain. This is normal for George, who is awaiting ECT. His drug card should show prescriptions for intramuscular benzodiazepines.

George's breathing is rapid and shallow, and although he does not answer, he is in discomfort from his breathing. Groaning sounds can be for the breathing if voice transmission is available on the manikin. Tim notes that George was "the same as he always is when he's unwell", but in the last 10 minutes he changed and "now he looks in pain. Do something".

The relative is clearly anxious about the situation, and becomes increasingly upset as more delegates enter the room, asking "What's going on?", "What are you doing to him?" "Is he going to die?" and so on. If a delegate calmly explains that the team need some space to work, and asks if Tim would go out with them and they can explain the situation, he agrees. If they neglect this, or simply ask Tim to leave he become more irate and angry, eventually becoming obstructive and attempts to arrange a direct transfer to A&E himself by whatever means he can think of.

George cannot answer any questions, but continues to express discomfort. He allows any observations to be taken.

#### **A - Patent**

**B - Respiratory rate 20/min, regular, SpO<sub>2</sub> 92% on room air**

**C - Pulse 118 bpm, regular, blood pressure 132/86 mmHg, CRT<2s**

**D - Responding to pain, dyspnoea, BM 5.5**

**E - Temperature 37.8°C, right lower leg warm with swelling and tenderness**

If George's legs are exposed, the lower right leg should be warm, tender and red when compared to the left leg. Pulses in the right leg are difficult to feel or absent. George had clinical signs and a DVT, which alongside the tachycardia and immobility should direct the delegates to probable pulmonary embolus requiring intervention. High flow oxygen increases SpO<sub>2</sub> by 1-2% only.

The scenario ends following appropriate transfer of information to A&E and/or the medical registrar on-call. If this point isn't reached, a "ward manager" can attend asking what the relative was distressed about and what the plan is.

### Scenario Case Notes

#### Scenario 8: Venous Thrombosis with Possible PE

George Mason, DOB 05/02/1957

(insert localised address)

Widowed, three children, Tim, William and Sarah.

Admitted (four day before RAMPPS course), detained under Section 3 Mental Health Act

Admission Clerking - SHO on-call

PC: Admitted from home after assessment by GP and Section 12 approved doctor. Severe depressive episode, admission for treatment.

HPC: Patient is severely depressed and non-communicative. Did not respond to questions or staff presence. Similar presentations in the past. Poor past response to medication, has had previous ECT treatment last completed two years ago to good effect.

PMH: No physical health problems known of, GP to be contacted.

P H: Numerous admissions in the past for treatment of depression. 3 courses of ECT over lifetime. Last admission two years ago.

DH: Mirtazapine 45mg OD Amitriptyline 200mg OD.

SH: Lives alone at home, children help him and visit frequently. Has been withdrawn recently and not left his bed for some time.

MSE: Unresponsive, as per HPC.

Impression: Relapse of depression.

Physical examination: Nil abnormal noted. Neurological exam normal. ECG normal.

#### Plan:

- 1. Admit to inpatient ward**
- 2. Bloods to be completed**
- 3. Contact GP for full information**
- 4. Day team to arrange further treatment and/or ECT as appropriate**

Continued on next page

## Scenario 8 - Venous Thrombosis with Possible PE

### Scenario Case Notes Continued

#### Day before course:

MDT review. George remains poorly responsive and is becoming increasingly unwell. ECT to be arranged as soon as possible. Family to be informed.

Plan: Arrange ECT, inform family.

#### Two days before the course:

Ward Doctor

Asked to discuss George's care with family. They are insistent that he have ECT and are concerned that his physical health is getting worse. Explained George will be seen by consultant tomorrow in ward round and appropriate plan of action to be made. ECT is a possibility but not something I can arrange at present.

Medications being given as previously prescribed.

#### First recommendation by GP:

Known depressive disorder for at many years, requiring inpatient treatment in the past. Increasing concerns about home situation, not looking after self, lethargic and deteriorating. Clearly unwell. Problems with medication compliance that have led to deterioration in the past - unclear whether this is the situation here. Needs assessment in hospital but patient is not responding to others. Recommend inpatient treatment as a life saving measure for severe depression.

#### Second recommendation by Consultant:

George is a 58 year old gentleman with a working diagnosis of recurrent depressive disorder, current episode severe. His living situation is such that he has some care from his family but the situation is worsening and he is unable to receive appropriate care in the community. He is poorly responsive to others, not self caring and his physical health is suffering as a consequence of this.

Treatment in the community is not possible because of the risks posed to George by the severity of his depression and utter lack of concern for his own health, this makes 24-hour specialist inpatient admission necessary.

Hospital admission is necessary in the interests of George's health to manage the risks of his self-neglect and in the interests of George's safety given his self neglect.

Informal admission is not appropriate because George is not agreeing to inpatient admission.

## Scenario 8 - Venous Thrombosis with Possible PE

### Scenario Flowchart & Development Tool

#### Learning Objectives:

1. Recognises Patient is Unwell
2. Uses ABCDE Approach
3. Calls for Help When Appropriate
4. Uses SBARD in Handover
5. Recognises Depot not Appropriate

### Baseline

#### A: Patent

B: RR 20/min, regular, SpO<sub>2</sub> 92% on air

C: p118 reg, BP 132/86, CRT <2s

D: Responding to pain, dyspnoea, looks distressed, BM 5.5

E: Temp 37.8°C, right lower leg warm swelling with tenderness

Increase in SpO<sub>2</sub> if oxygen given  
Deteriorates over time

## Scenario 9 - Ligature Strangulation

# Scenario 9: Ligature Strangulation

*Designer: Dr. Zead Said*

Ligature strangulation is a serious and potentially fatal event. Staff can find such events distressing, and some report feeling overwhelmed and under-prepared when it happens. This scenario aims to try and mitigate that and emphasise the important actions to take when this event occurs.

### Focal Point

To recognise the shock that can accompany this situation and recognise the important actions to take until emergency services arrive

### Personnel involved

Manikin

### Setting

Acute psychiatric ward

### Equipment required

- Pen torch, sphygmomanometer, SpO<sub>2</sub> monitor, thermometer, stethoscope available with equipment, peak flow device
- An observation chart showing normal observations.
- A drugs chart showing acceptance of medication
- Ligature around the neck of the manikin tied to an attachment point or similar, red marks around neck of manikin. Head and neck petechiae on manikin, cyanosis make up.

### Scenario brief

"Edward James is a 42 year old male with a history of bipolar disorder, current episode depression, and was hospitalised under section after being found and restrained at the top of a car park. You are managing your day-to-day work as normal and are checking in as he hasn't been out of his room today."

## Scenario 9 - Ligature Strangulation

### Scenario Information

Edward should be found in a position such that a ligature around his neck is asserting pressure on his neck and airways. Clothing may be used to mask the ligature point as you see fit.

Observations are for when the ligature is removed. Resps are 0 when the ligature is in place.

**A - Stridor++**

**B - Respiratory rate around 44/min, regular, SpO<sub>2</sub> 85% on room air**

**C - Pulse 142 bpm, regular, raised blood pressure 200/100 mmHg, CRT<2s**

**D - Not responsive, stridor, pale, BM 4.8**

**E - Temperature 35.8°C, BM 4.7. Head awkwardly angled, ligature around neck, red marks on neck**

All staff should be readily available for this scenario, the simulated situation is that the doctor and nurse are both in the nurses office writing up notes. They are the only staff available on the ward at that time due to an emergency situation on another ward. This should be recognised as a critical situation, with a member of staff leading the team of 3, and arranging for someone to contact emergency services and two people to start emergency assessment and care.

The manikin does not require voice acting and should be treated as non-responsive for the period of the scenario. The key care requirements are airways care and C-spine care. The focus of the dilemma is that the ligature is causing strangulation, and removal of the ligature should take priority.

Airway care should be prioritised. The single action of opening the airway and cutting the ligature is enough to prevent a fatality in this case and raises the oxygen saturations. Oxygen application alone, without removal of ligature, will not raise the oxygen saturations significantly and will be terminal. Ensure ligature cutters are available in the scenario. This scenario can also be used to raise issues of equipment layout. Try to make it similar to the set up on the inpatient wards in your Trust.

This scenario, although not requiring complicated interventions (endotracheal intubation is not going to be attempted in an acute psychiatric setting) is designed to see how delegates can respond in a high pressure situation, especially with regards to taking control of a situation, working cohesively and maintaining the principles of AVPU, ABCDE and SBARD.

Untreated, the patient in this scenario deteriorates into suffering bradycardia and then arrest (fatal outcome).

The scenario ends once the team appear to be settled in their position and frequent monitoring of the patient situation. Intervention will be required if too long has elapsed without appropriate care.

# Scenario 9 - Ligature Strangulation

## Scenario Case Notes

### Scenario 9: Ligature Strangulation

Edward James, DOB 27/10/1972

(insert localised address)

Parents deceased, no significant others.

Admitted (night before RAMPPS course), detained under Section 2 Mental Health Act

Admission Clerking - SHO on-call

PC: Admitted from community after being found at the top of a car park. Required restraint by police.

HPC: Patient is not happy to be here and would not talk openly with me or with other staff. Clearly distressed and repeatedly saying wants to kill self. Previously diagnosed with bipolar disorder.

PMH: No physical health problems known of, GP to be contacted.

P H: No previous admission to hospital. Diagnosed in the community with bipolar affective disorder seven years ago, has been managed in community.

DH: Refused to state current medication. Last note entry indicates was on lithium but has been managed by lithium clinic.

SH: Lives alone in council housing.

MSE: Agitated but not aggressive towards staff. Has tried to harm self using objects to cut self, but not successful at causing significant physical damage. Shouting and wailing, wants to end life.

Impression: Depressive episode secondary to bipolar disorder.

Physical examination: Unable to perform physical examination.

Continued on next page

### Scenario Case Notes Continued

#### Plan:

1. Admit to inpatient ward
2. Bloods and physical examination to be completed by day team
3. Contact GP for full information
4. Agree 1 to 1 observation for now.
5. 1mg Lorazepam oral accepted. PRN Haloperidol / Lorazepam written up.
6. Consultant review as soon as possible

#### Day of course:

Asked to stop 1 to 1 observation for Edward. He appears settled now and is saying that he wants to co-operate with staff and will take medication. Denies ideas of self harm.

Agreed with nursing staff to change obs to routine.

The section papers are not available for this scenario as they have been sent for copying.

# Scenario 9 - Ligature Strangulation

## Scenario Flowchart & Development Tool

### Learning Objectives:

1. Recognises Emergency Situation
2. Uses ABCDE Approach
3. Uses SBARD in Handover
4. Airway and C-Spine Management

## Baseline

A: Stridor++

B: RR 44/min, SpO<sub>2</sub> 85% on air

C: p142 reg, BP 200/100, CRT <2s

D: Not responsive, stridor, pale, BM 4.8

E: Temp 35.8°C, head awkwardly angled, ligature around neck, marks on neck, cyanosed, petechiae above neck

### Untreated

Oxygen sats continue to drop  
  
This will be terminal, leading to bradycardia and arrest

### C-Spine Care and Airway Opened

Small increase in oxygen sats  
  
This action will save the patient

### Oxygen

Increase in oxygen sats  
  
By itself, this will not save the patient

# Scenario 10: Clozapine Induced Bowel Obstruction

*Designer: Dr. Zead Said*

Clozapine is well known as a cause of agranulocytosis, but less well known is that there have been numerous cases of recorded bowel obstruction secondary to Clozapine use, with an estimated 27.5% fatality rate of affected people. Gastric Hypomotility will significantly affect 3 in every 1000 people on Clozapine, and non-recognition of the signs and symptoms can be fatal.

### Focal Point

To appreciate that constipation and bowel obstruction can be caused by anti-psychotics and should be taken seriously

### Personnel involved

Manikin, voiced by an actor

### Setting

Acute psychiatric ward

### Equipment required

- Pen torch, sphygmomanometer, SpO<sub>2</sub> monitor, thermometer, stethoscope available with equipment
- A blank observation chart with the patient name with previously normal readings
- A sick bowl. Imaginative organisers may put something in there along the lines of chocolate spread mixed with water

He has reported feeling "a bit off" the last few days and is asking if someone could see him as he feels worse today

### Scenario brief

"Michael Tarley is a 37 year old male, admitted some time ago with a relapse of paranoid schizophrenia following non-compliance with medication. He has been retitrated on Clozapine and is responding well to treatment."

## Scenario 10 - Clozapine Induced Bowel Obstruction

### Scenario Information

Michael is conscious and alert, but is distressed. He complains of some abdominal pain and discomfort and wants some relief for this. He's more concerned about the discomfort, and finds it difficult to explain exactly what the discomfort is. With some prompting he discloses that he vomited something "really nasty" earlier, but put it down to a bad take-away he ordered last night.

**A - Patent Airway**

**B - Respiratory rate around 18/min, regular, SpO<sub>2</sub> 99% on air**

**C - Pulse 125 bpm, regular, blood pressure 110/70 mmHg**

**D - Alert, BM 5.5**

**E - Temperature 38.2°C, hyperactive and high-pitched bowel sounds, faeculent vomit in bowl nearby**

A nurse and doctor are available on the ward if called for. If an OT is present, she can prompt candidates by steering them towards Michael's increasing complaints about constipation and difficulties passing motions. Michael himself will talk about this if asked. He will disclose as well that he has suffered bad diarrhoea this morning (actually overflow diarrhoea) and that he's been bloated for weeks.

There are medical notes available, with no mention of constipation or abdominal problems.

Examination of the patients will be abnormal for abdominal examination, reporting tenderness, high pitched and hyperactive bowel sounds, distention (Michael mentions this) and tympanic percussion.

Ideally, the delegates will recognise this is a case of likely bowel obstruction with early signs of septic shock, requiring immediate and urgent surgical intervention. As part of the scenario, appropriate handover to the surgical team should be made by simulated phone. The facilitator on the phone should be resistant to referral but not dangerously obstructive. The candidates should give an appropriate and relevant handover. If "constipation" is the only reason given for an urgent referral, the surgical on-call should reject the referral.

The scenario should end after this. If needed, a ward manager can attend the scenario and ask the delegates what is happening and what their plan is.

### Scenario Case Notes

#### Scenario 10: Clozapine Induced Bowel Obstruction

Michael Tarley, DOB 06/12/1977

(insert localised address)

Parents aware of admission, no siblings or children.

Admitted (two months before RAMPPS course), informal

Admission Clerking - SHO on-call

PC: Informal admission to ward following relapse of schizophrenia after non-compliance with Clozapine.

HPC: See previous notes.

PMH: No physical health problems.

P H: Numerous admissions in the past for treatment of schizophrenia. Previous response to Clozapine.

DH: Nil at present.

SH: Lives in social accommodation, no issues reported.

MSE: Aware why he is admitted. Suffering auditory hallucinations and low levels of paranoia. Has insight that he is relapsing and is keen to engage with treatment.

Impression: Relapse of schizophrenia.

Physical examination: Nil abnormal noted. Neurological exam normal. ECG normal.

# Scenario 10 - Clozapine Induced Bowel Obstruction

## Scenario Case Notes Continued

### Plan:

1. Admit to inpatient ward
2. Bloods to be completed by day team
3. Contact GP for full information
4. Day team to arrange Clozapine titration

### 7 weeks before course:

MDT review. Michael has started Clozapine titration and is engaging well with ward staff. Working with OT and bloods are within normal parameters. Plan is to titrate Clozapine to previous levels as discussed with Michael and discharge when appropriate.

### 6 weeks before course:

MDT review. Michael on leave. His accommodation has been taken away from him. New accommodation to be arranged. No issues with Clozapine titration.

### 5 weeks before course:

MDT review. Michael on day leave. No issues raised. Awaiting accommodation.

### 4 weeks before course:

MDT review. As previous, ongoing issues with accommodation. Funding has been withdrawn, we believe in error.

### 3 weeks before course:

MDT review. No issues with Clozapine titration. Significant issues with council, Michael is receiving support for this. Complaining of abdominal discomfort, Ward Doctor to review.

### 2 weeks before course:

MDT review. Clozapine titration complete, Michael's symptoms of schizophrenia appear to be well controlled. Ongoing housing problems. Michael has reported to nurses that he is suffering ongoing abdominal discomfort. Dietary changes suggested along with reduction of night time meals. Ward Doctor reviewed and found no abnormalities.

### 1 week before course:

MDT review. No issues raised, awaiting housing. Abdominal discomfort reported, suggest PRN Gaviscon.

## Scenario 10 - Clozapine Induced Bowel Obstruction

### Scenario Flowchart & Development Tool

#### Learning Objectives:

1. Recognises Patient is Unwell
2. Uses ABCDE Approach
3. Calls for Help When Appropriate
4. Uses SBARD in Handover
5. Manages Medical Handover Appropriately

### Baseline

A: Patent

B: RR 18/min, regular, SpO<sub>2</sub> 99% on air

C: p125 reg, BP 110/70, CRT <2s

D: Alert, distressed, BM 5.5

E: Temp 38.2°C, hyperactive and high-pitched bowel sounds, faeculent vomit if facility available, tender abdomen

No impact of physical observations possible

Non-surgical referral is a fatal outcome

After the  
RAMPPS Course

# After the RAMPPS Course



## The Questionnaires

After successfully running a RAMPPS course, the next step is to find out what has gone well, what has gone not so well and ways to improve your local RAMPPS course for the future.

One normally gets some feel of how things have gone, both from the perspectives of the delegates and the facilitators, during the final delegate debrief session and the post-course facilitator debrief.

The questionnaires, however, can give immense amounts of useful and valuable insight. There are two ways the questionnaires give this feedback, one is through the Likert Scale (1 - 5)

and the other is through the free text feedback. The Likert Scale feedback is linked to the NMC Essential Skills Clusters of mental health nurses and RCPsych core curriculum of psychiatric trainees. This will help show if there has been any improvement in how confident the delegates feel about their own performance in these areas. It is almost impossible to get event linked data about the performance of delegates after RAMPPS, as physical health emergencies are, thankfully, rare events. The free hand written feedback covers what delegates were expecting before attending, what they feel went well, what went not so well and what they feel can be changed to improve the RAMPPS course.

## Inputting and Using the Data

The Likert Scale feedback is converted into useful data through use of Chi-Square calculations using an excel spreadsheet. Not only does this provide a permanent record of your data, but it also reduces the chance of miscalculation.

You can download the spreadsheets by clicking the button below. There are instructions on using the sheet within the sheet itself as well.

A video explaining how the sheet works, how to input data and what you can do with the results can be viewed by clicking the button below:

 WATCH HERE

 DOWNLOAD

Once you complete the questionnaire input into spreadsheet, please e-mail the spreadsheet to [RAMPPSUK@gmail.com](mailto:RAMPPSUK@gmail.com) with a line saying which trust has run this RAMPPS course and on what date the course was run. This allows the RAMPPS team to collate a central bank of information that can help us further improve the course.

# After the RAMPPS Course

## Personal Insight

### Victoria Lattimer

**Dr. Victoria Lattimer is a Core Trainee working in the Sheffield area, and has been a delegate on the Sheffield RAMPPS course. Here she talks about her experience on the course and the benefits the course has provided.**

"I suppose as with all compulsory induction training, I went into the RAMPPS course with a bit of a feeling that it would be the same things we cover every 6 months. Also, I have previously completed a RAMPPS session at Mexborough during my CT2 year.

However, not only did I really enjoy the experience, I also took away several important learning points which I had to put into action suprisingly quickly.

The final station of the day was a patient with neuroleptic malignant syndrome and I was the junior doctor in the team. Afterwards, we spoke as a group about the scenario, and I mentioned that I'd never had to treat it before so it was a good exercise to practice rare and unusual presentations. Later that evening, I was on call, covering the wards in Sheffield. I had a job handed over to chase a patient's blood tests results who hadn't been well that day. On seeing a creatinine kinase result of over 1000, I immediately thought NMS and transferred the patient to A+E. Had I not had the experience given to me by the RAMPPS course earlier that day, maybe I wouldn't have seen the significance of that result, or maybe the course gave me the confidence to say, this is NMS, he needs to go to hospital as soon as possible.



Either way, I believe attending the RAMPPS course has had a positive impact on my practice as a junior doctor. RAMPPS is also a really good experience for junior doctors to learn about our colleagues. As doctors we often arrive on the scene of an incident much later than our nursing colleagues. It was great to see how they engage with and manage patients who are presenting with challenging behaviour, and to see how much is done before the doctor is even called. I often think it is easy to forget what other members of the MDT roles actually are, and RAMPPS certainly gave me the opportunity to see situations from other perspectives."

*" I believe attending the RAMPPS course has had a positive impact on my practice as a junior doctor "*

## Making Changes

As the RAMPPS course is best run when it is led by local leaders and aimed at the needs of the local workforce, changes may need to be localised as well. This can be anything from adjusting the physical observations in a scenario to better match local Early Warning Score systems, to changing the scripts or flow of a scenario, to creating and writing a new scenario based upon local events.

The Steering Committee, as mentioned on page 20, is there to help improve collaboration between groups of people who are running RAMPPS courses. These meetings are an ideal place to meet and exchange ideas, pick up ways to overcome difficulties and review how different areas are running the RAMPPS course. The RAMPPS teams are always open to new ideas, new ways of working and innovations to make in the areas of simulation and teaching.

## Creating Your Own Scenarios

Scenarios for RAMPPS can be created by an individual or a team, and can be based upon real life incidents that you or others have experienced, or by the use of case notes and publications to pull together the information needed to make a realistic and relevant scenario.

In Appendix 5, you will find the RAMPPS Scenario Development Framework, the tool used to develop to the current range of RAMPPS scenarios available today. It provides a way of laying out the groundwork for a scenario for development, including the requirements, learning aims and structure of the scenario itself.

Once a scenario is laid out, further details or analysis of the accuracy and realism of the scenario can then be further developed, either by reviewing the entry in the framework itself, or further developing the scenario into a flow.

Local or regional simulation centres may be willing to help in this area. As an example, the Mexborough Montagu Simulation Centre has a team of consultants who work within simulation, and can review and “dummy run” potential scenarios for local simulation work.

We would kindly ask that any new scenarios made for the RAMPPS course are presented to the Steering Committee for review, input and approval before you run them as official scenarios of the RAMPPS course. This can be done by e-mailing the committee before a meeting with the materials so it may be reviewed and, if appropriate, approved within one meeting. All the scenarios included in this book have been edited, improved and modified from their original drafting, resulting in a great improvement in quality and realism.

# RAMPPS Pre/Post-Course Questionnaires

Core Trainees, Nursing Staff and Health Care Assistants



## RAMPPS Pre-Course Questionnaire - Core Trainees

What stage of training are you currently at?

CT1

CT2

CT3

Other (please specify).....

What do you hope to get out of this course?

.....

.....

.....

In what way has the e-learning helped you in preparation for today?

.....

.....

To what extent do you agree or disagree with the statements below?	Disagree		Neutral		Agree
	5	4	③	2	1
<b>RCPsych Core Curriculum: Medical Expert (ILO 1, 3, 4)</b>					
I am confident in assessing for the presence of general medical illness	5	4	3	2	1
I am confident in interpreting the results of investigations	5	4	3	2	1
I am confident in applying knowledge of the implications of coexisting medical illnesses	5	4	3	2	1
I am confident in the supervision and management of challenging behaviour and medical complications in relation to condition presenting as psychiatric emergencies	5	4	3	2	1
<b>RCPsych Core Curriculum: Communicator (ILO 8)</b>					
I am confident in my ability to stay within the limits of my expertise	5	4	3	2	1
I am confident in my demonstration of respect, empathy, responsiveness and concern for patients and their problems	5	4	3	2	1
<b>RCPsych Core Curriculum: Collaborator (ILO9, 11)</b>					
I am confident in my ability to communicate and work effectively with team members	5	4	3	2	1
I am confident in my demonstration of respect for the skills, contributions and opinions of others	5	4	3	2	1
I am confident that I demonstrate a good understanding of clinical priorities	5	4	3	2	1
I am confident that I respond appropriately to requests when on call	5	4	3	2	1
<b>RCPsych Core Curriculum: Professional (ILO 17)</b>					
I am confident that my behaviour is in accordance with contemporary standards of professional practice	5	4	3	2	1

# Appendix 1

## RAMPPS Post-Course Questionnaire - Core Trainees

What stage of training are you currently at?

CT1

CT2

CT3

Other (please specify).....

To what extent do you agree or disagree with the statements below?	Disagree		Neutral		Agree
	5	4	3	2	1
<b>RCPsych Core Curriculum: Medical Expert (ILO 1, 3, 4)</b>					
I am confident in assessing for the presence of general medical illness	5	4	3	2	1
I am confident in interpreting the results of investigations	5	4	3	2	1
I am confident in applying knowledge of the implications of coexisting medical illnesses	5	4	3	2	1
I am confident in the supervision and management of challenging behaviour and medical complications in relation to condition presenting as psychiatric emergencies	5	4	3	2	1
<b>RCPsych Core Curriculum: Communicator (ILO 8)</b>					
I am confident in my ability to stay within the limits of my expertise	5	4	3	2	1
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I am confident that I demonstrate a good understanding of clinical priorities	5	4	3	2	1
I am confident that I respond appropriately to requests when on call	5	4	3	2	1
<b>RCPsych Core Curriculum: Professional (ILO 17)</b>					
I am confident that my behaviour is in accordance with contemporary standards of professional practice	5	4	3	2	1

What did you think worked well in the course?

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## RAMPPS Post-Course Questionnaire - Core Trainees

What do you think could, or should, be done differently in future courses?

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.....

To what extent do you agree or disagree with the statements below?	Disagree		Neutral		Agree
	5	4	③	2	1
<b>Pre-course</b>					
I knew about the RAMPPS course before I agreed to take part	5	4	3	2	1
I understood what the RAMPPS course involve before attending today	5	4	3	2	1
I was able to access all the information that I wanted before the RAMPPS course	5	4	3	2	1
<b>E-Learning</b>					
I found the e-learning easy to access	5	4	3	2	1
E-learning helped me understand RAMPPS	5	4	3	2	1
I found the e-learning useful	5	4	3	2	1
<b>The RAMPPS Course</b>					
The scenarios reflected situations that I have been in	5	4	3	2	1
I found the use of video intimidating	5	4	3	2	1
I performed better in the scenarios than I would in real life	5	4	3	2	1
I found it hard to give feedback to other colleagues	5	4	3	2	1
I received some useful feedback about my own performance	5	4	3	2	1
I think that other colleagues at my training level would benefit from this type of course	5	4	3	2	1
I think that everyone should have to take part in the RAMPPS course	5	4	3	2	1
I will now feel more able to assess and manage medical problems that arise in inpatient psychiatric setting	5	4	3	2	1

Did you achieve what you wanted? Any other comments about the RAMPPS course?

.....

.....

.....

.....

Many thanks for agreeing to take part and for your valuable feedback.  
The RAMPPS Development Team

# Appendix 1

## RAMPPS Pre-Course Questionnaire - Nursing Staff

What level do you currently work at?

Band 5

Band 6

Band 7

Other (please specify).....

What do you hope to get out of this course?

In what way has the e-learning helped you in preparation for today?

To what extent do you agree or disagree with the statements below?	Disagree		Neutral		Agree
	5	4	3	2	1
<b>NMC Essential Skills Clusters: Care, Compassion and Communication (ES 1, 5, 6)</b>					
I demonstrate clinical confidence through sound knowledge, skills and understanding relevant to my field	5	4	3	2	1
I am self aware and self confident, I know my own limitations and I am able to take appropriate action	5	4	3	2	1
I am confident in listening to, watching for, and responding to verbal and non-verbal cues	5	4	3	2	1
I am confident in communicating effectively and sensitively in different settings, using a range of methods and skills	5	4	3	2	1
<b>NMC Essential Skills Clusters: Organisational Aspects of Care (ES 14 - 19)</b>					
I am confident in actively consulting and exploring solutions and ideas with others to enhance care	5	4	3	2	1
I am confident in working within the requirement of the code (NMC 2008) in delegating care and when care is delegated to me	5	4	3	2	1
I am able to inspire confidence and provide clear direction to others	5	4	3	2	1
I am confident in managing my time effectively	5	4	3	2	1
I am confident in prioritising my own workload and managing competing and conflicting priorities	5	4	3	2	1
I am confident in assessing and implementing measures to manage, reduce or remove risk that could be detrimental to people, self and others	5	4	3	2	1
I am confident in applying appropriate strategies and techniques for conflict resolution, de-escalation and physical intervention in the management of potential violence and aggression	5	4	3	2	1
<b>NMC Essential Skills Clusters: Medicines Management (ES 35)</b>					
I work confidently as part of the team and, where relevant, as leader of the team to develop treatment options and choice with the person receiving care	5	4	3	2	1
I am confident in safely and effectively administering medicines via routes commonly used and maintaining accurate records	5	4	3	2	1

## RAMPPS Post-Course Questionnaire - Nursing Staff

What level do you currently work at?

Band 5

Band 6

Band 7

Other (please specify).....

To what extent do you agree or disagree with the statements below?	Disagree	Neutral			
	5	4	3	2	1
<b>NMC Essential Skills Clusters: Care, Compassion and Communication (ES 1, 5, 6)</b>					
I demonstrate clinical confidence through sound knowledge, skills and understanding relevant to my field	5	4	3	2	1
I am self aware and self confident, I know my own limitations and I am able to take appropriate action	5	4	3	2	1
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I am confident in prioritising my own workload and managing competing and conflicting priorities	5	4	3	2	1
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I am confident in applying appropriate strategies and techniques for conflict resolution, de-escalation and physical intervention in the management of potential violence and aggression	5	4	3	2	1
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I work confidently as part of the team and, where relevant, as leader of the team to develop treatment options and choice with the person receiving care	5	4	3	2	1
I am confident in safely and effectively administering medicines via routes commonly used and maintaining accurate records	5	4	3	2	1

What did you think worked well in the course?

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.....

# Appendix 1

## RAMPPS Post-Course Questionnaire - Nursing Staff

What do you think could, or should, be done differently in future courses?

.....

.....

.....

To what extent do you agree or disagree with the statements below?	Disagree		Neutral		Agree
	5	4	3	2	1
<b>Pre-course</b>					
I knew about the RAMPPS course before I agreed to take part	5	4	3	2	1
I understood what the RAMPPS course involve before attending today	5	4	3	2	1
I was able to access all the information that I wanted before the RAMPPS course	5	4	3	2	1
<b>E-Learning</b>					
I found the e-learning easy to access	5	4	3	2	1
E-learning helped me understand RAMPPS	5	4	3	2	1
I found the e-learning useful	5	4	3	2	1
<b>The RAMPPS Course</b>					
The scenarios reflected situations that I have been in	5	4	3	2	1
I found the use of video intimidating	5	4	3	2	1
I performed better in the scenarios than I would in real life	5	4	3	2	1
I found it hard to give feedback to other colleagues	5	4	3	2	1
I received some useful feedback about my own performance	5	4	3	2	1
I think that other colleagues at my training level would benefit from this type of course	5	4	3	2	1
I think that everyone should have to take part in the RAMPPS course	5	4	3	2	1
I will now feel more able to assess and manage medical problems that arise in inpatient psychiatric setting	5	4	3	2	1

Many thanks for agreeing to take part and for your valuable feedback.

*The RAMPPS Development Team*

## RAMPPS Pre-Course Questionnaire - Health Care Assistants

What level do you currently work at?

Band 1

Band 2

Band 3

Other (please specify).....

What do you hope to get out of this course?

.....

In what way has the e-learning helped you in preparation for today?

.....

To what extent do you agree or disagree with the statements below?	Disagree		Neutral		Agree
	5	4	③	2	1
RCNHCA First Steps Topic: Communication					
I am confident in communicating required information to others clearly, accurately and in a timely fashion	5	4	3	2	1
I am confident in taking appropriate action to address any misunderstandings	5	4	3	2	1
I am confident in presenting suggestions and offering ideas and information to benefit team members and improve team working	5	4	3	2	1
RCNHCA First Steps Topic: Health, Safety and Security					
I am confident in taking appropriate and immediate action to deal with health and environmental emergencies	5	4	3	2	1
I am confident in summoning assistance appropriate to emergencies	5	4	3	2	1
I am confident in working with individuals, key people and others to identify the type of situations, events and personal crises that might results in danger, harm and abuse	5	4	3	2	1
I am confident in identifying and taking action when changed in behaviour and situations may lead to aggression, danger, harm and abuse	5	4	3	2	1
RCNHCA First Steps Topic: Quality					
I am confident in collaborating effectively and proactively during actions that require close team working	5	4	3	2	1
I am confident in ensuring my behaviour towards others in the team supports effective functioning of the team	5	4	3	2	1
I am confident in ensuring that no action in any way makes other individual feel inferior	5	4	3	2	1
I am confident in providing ongoing support and assistance within my own competence until someone who is qualified to deal with the emergency is available	5	4	3	2	1
I am confident in recognising the boundaries of my own roles and responsibilities and seeking supervision when situations are beyond my own competence and authority	5	4	3	2	1
RCNHCA First Steps Topic: Clinical Skills					
I am confident in taking measurements at the prescribed time and in the prescribed sequence	5	4	3	2	1
I am confident in using appropriate equipment in such a way as to obtain an accurate measurement	5	4	3	2	1

# Appendix 1

## RAMPPS Post-Course Questionnaire - Health Care Assistants

What level do you currently work at?

Band 1

Band 2

Band 3

Other (please specify).....

To what extent do you agree or disagree with the statements below?	Disagree		Neutral		Agree
	5	4	3	2	1
<b>RCNHCA First Steps Topic: Communication</b>					
I am confident in communicating required information to others clearly, accurately and in a timely fashion	5	4	3	2	1
I am confident in taking appropriate action to address any misunderstandings	5	4	3	2	1
I am confident in presenting suggestions and offering ideas and information to benefit team members and improve team working	5	4	3	2	1
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I am confident in taking appropriate and immediate action to deal with health and environmental emergencies	5	4	3	2	1
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I am confident in recognising the boundaries of my own roles and responsibilities and seeking supervision when situations are beyond my own competence and authority	5	4	3	2	1
<b>RCNHCA First Steps Topic: Clinical Skills</b>					
I am confident in taking measurements at the prescribed time and in the prescribed sequence	5	4	3	2	1
I am confident in using appropriate equipment in such a way as to obtain an accurate measurement	5	4	3	2	1

What did you think worked well in the course?

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## RAMPPS Post-Course Questionnaire - Health Care Assistants

What do you think could, or should, be done differently in future courses?

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.....

To what extent do you agree or disagree with the statements below?	Disagree		Neutral		Agree	
	5	4	③	2	1	
<b>Pre-course</b>						
I knew about the RAMPPS course before I agreed to take part	5	4	3	2	1	
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<b>The RAMPPS Course</b>						
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I received some useful feedback about my own performance	5	4	3	2	1	
I think that other colleagues at my training level would benefit from this type of course	5	4	3	2	1	
I think that everyone should have to take part in the RAMPPS course	5	4	3	2	1	
I will now feel more able to assess and manage medical problems that arise in inpatient psychiatric setting	5	4	3	2	1	

Did you achieve what you wanted? Any other comments about the RAMPPS course?

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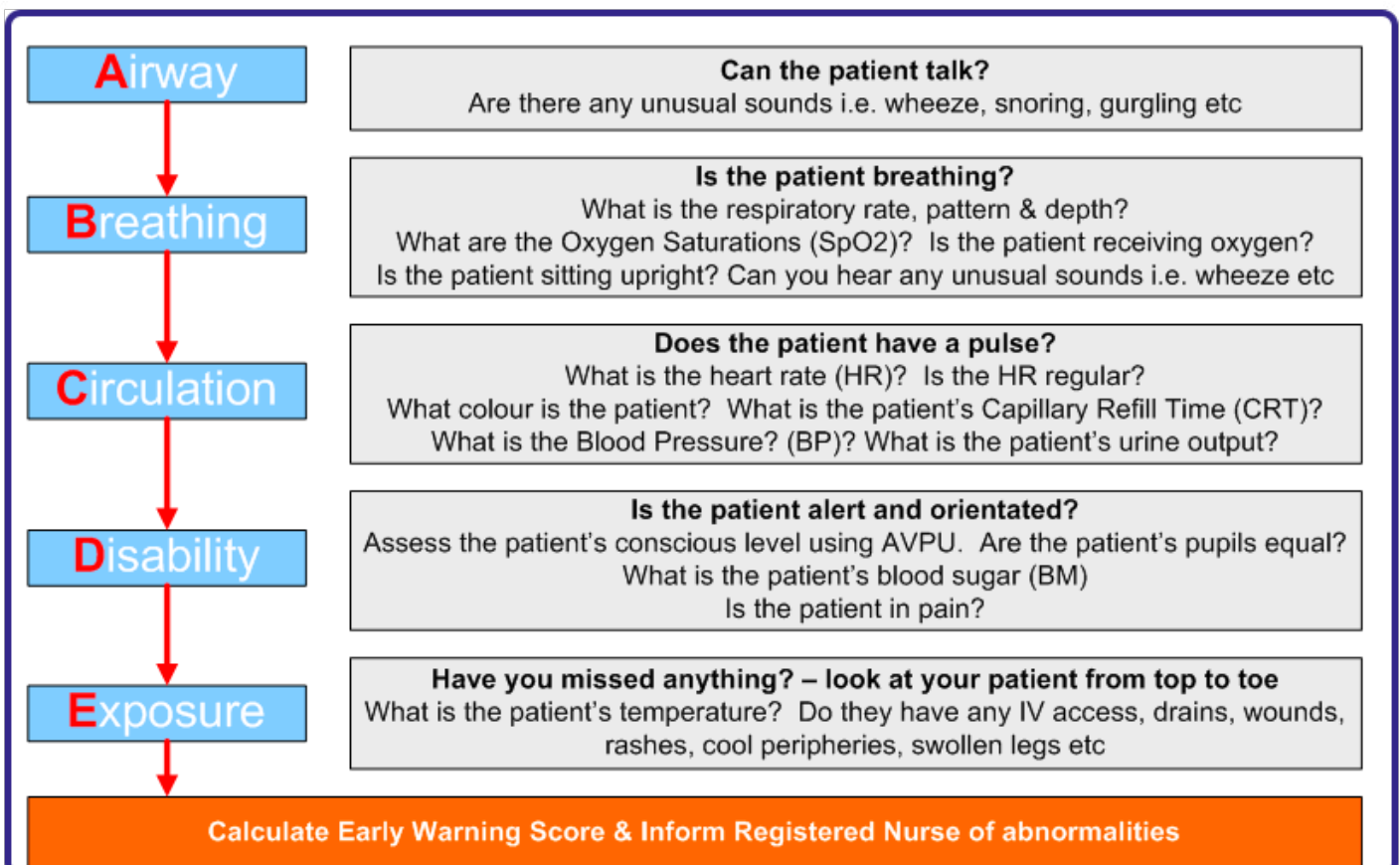
Many thanks for agreeing to take part and for your valuable feedback.  
The RAMPPS Development Team

# Assessment Tools



## Appendix 2

<b>A</b>	<b>Alert</b> the patient is fully responsive, they can tell you their name, the month and year correctly	<b>CALL FOR HELP</b>  <b>AIRWAY SUPPORT MAY BE NEEDED</b>
<b>V</b>	<b>Verbal</b> the patient responds to your voice, but may be drowsy, keep their eyes closed and may appear confused or agitated	
<b>P</b>	<b>Pain</b> when you apply pain to the shoulder muscle or eyebrow ridge of the patient, they try to move their hand/arm to the source of pain	
<b>U</b>	<b>Unresponsive</b> When the patient is unresponsive to any of the above they are unconscious	



## Observation chart for the National Early Warning Score (NEWS)

NEWS KEY 0 1 2 3		NAME:	D.O.B.	ADMISSION DATE:	
DATE TIME					DATE TIME
RESP. RATE	≥25		3		≥25
	21-24		2		21-24
	12-20				12-20
	9-11		1		9-11
	≤8		3		≤8
SpO <sub>2</sub>	≥96		1		≥96
	94-95		2		94-95
	92-93		3		92-93
	≤91		2		≤91
Inspired O <sub>2</sub> %	%				%
TEMP	≥39°		2		≥39°
	38°		1		38°
	37°				37°
	36°		1		36°
	≤35°		3		≤35°
NEW SCORE uses Systolic BP  BLOOD PRESSURE	230		3		230
	220				220
	210				210
	200				200
	190				190
	180				180
	170				170
	160				160
	150				150
	140				140
	130				130
	120				120
	110		1		110
	100		2		100
	90				90
	80		3		80
	70				70
	60				60
	50				50
	HEART RATE	>140		3	
130			2		130
120					120
110			1		110
100					100
90					90
80					80
70					70
60					60
50			1		50
40			3		40
30					30
Level of Consciousness		Alert V / P / U		3	
BLOOD SUGAR					Bl'd Sugar
TOTAL NEW SCORE					TOTAL SCORE
Additional Parameters	Pain Score				Pain Score
	Urine Output				Urine Output
Monitoring Frequency					Monitor Freq
Escalation Plan Y/N n/a					Escal Plan
Initials					Initials

National Early Warning Score: July 2012

Please see next page for explanatory text about this chart.

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Training for Innovation

# Appendix 2

## Using the NEWS observation chart

The NEWS chart should replace currently used TPR charts. This would provide a standardised system for recording routine clinical data for all patients in hospital. This consistent format, if used in all hospitals, would provide familiarity in recognition of patient data and facilitate training in the measurement and recording of such data in a systematic and standardised way by all NHS staff.

The NEWS chart contains dedicated sections to record the frequency of monitoring as defined by the score and the clinical response to a change in score, eg an escalation in acute care – this will facilitate tracking of the response to changes in the NEWS score. The NEWS chart also contains dedicated sections to record urine output and pain severity. These do not form part of the NEWS score.

Please note that when the measured physiological parameter exceeds the range on the chart, the actual value should be recorded on the chart.

Please also note that the NEWS is not designed to replace recognised generic scoring systems such as the GCS or disease-specific systems.

**Reproducing this chart:** this chart must be reproduced in colour and in actual size, and should not be modified or amended.

## The NEWS educational tool

The Royal College of Physicians' NEWS Development and Implementation Group (NEWSDIG) commissioned the NHS Training for Innovation team to work with members of NEWSDIG, including representation from the Royal College of Nursing and the National Outreach Forum, to develop a standardised generic NEWS chart that would be suitable for downloading for use by clinical teams across the NHS. Alongside, an online training package focused on the use of NEWS has been developed to facilitate implementation (<http://tfnews.ocbmedia.com>).

## National Early Warning Score (NEWS)\*

PHYSIOLOGICAL PARAMETERS	3	2	1	0	1	2	3
Respiration Rate	≤8		9 - 11	12 - 20		21 - 24	≥25
Oxygen Saturations	≤91	92 - 93	94 - 95	≥96			
Any Supplemental Oxygen		Yes		No			
Temperature	≤35.0		35.1 - 36.0	36.1 - 38.0	38.1 - 39.0	≥39.1	
Systolic BP	≤90	91 - 100	101 - 110	111 - 219			≥220
Heart Rate	≤40		41 - 50	51 - 90	91 - 110	111 - 130	≥131
Level of Consciousness				A			V, P, or U

\*The NEWS initiative flowed from the Royal College of Physicians' NEWS Development and Implementation Group (NEWSDIG) report, and was jointly developed and funded in collaboration with the Royal College of Physicians, Royal College of Nursing, National Outreach Forum and NHS Training for Innovation

Please see next page for explanatory text about this chart.



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### The NEWS scoring system

In some settings, patients will have an impaired level of consciousness as a consequence of sedation, eg following surgical procedures. Thus, the assessment of consciousness level and the necessity to escalate care should be considered in the time-limited context of the appropriateness of the consciousness level in relation to recent sedation.

For patients with known hypercapnoeic respiratory failure due to chronic obstructive pulmonary disease (COPD), recommended British Thoracic Society target saturations of 88–92% should be used. These patients will still 'score' if their oxygen saturations are below 92 unless the score is 'reset' by a competent clinical decision-maker and patient-specific target oxygen saturations are prescribed and documented on chart and in the clinical notes.

All supplemental oxygen when administered, must be prescribed.

**Reproducing this chart:** please note that this chart must be reproduced in colour, and should not be modified or amended.

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## Outline clinical response to NEWS triggers

NEWS SCORE	FREQUENCY OF MONITORING	CLINICAL RESPONSE
<b>0</b>	Minimum 12 hourly	<ul style="list-style-type: none"> <li>Continue routine NEWS monitoring with every set of observations</li> </ul>
<b>Total: 1-4</b>	Minimum 4-6 hourly	<ul style="list-style-type: none"> <li>Inform registered nurse who must assess the patient;</li> <li>Registered nurse to decide if increased frequency of monitoring and / or escalation of clinical care is required;</li> </ul>
<b>Total: 5 or more  or  3 in one parameter</b>	Increased frequency to a minimum of 1 hourly	<ul style="list-style-type: none"> <li>Registered nurse to urgently inform the medical team caring for the patient;</li> <li>Urgent assessment by a clinician with core competencies to assess acutely ill patients;</li> <li>Clinical care in an environment with monitoring facilities;</li> </ul>
<b>Total: 7 or more</b>	Continuous monitoring of vital signs	<ul style="list-style-type: none"> <li>Registered nurse to <b>immediately</b> inform the medical team caring for the patient – this should be at least at Specialist Registrar level;</li> <li>Emergency assessment by a clinical team with critical care competencies, which also includes a practitioner/s with advanced airway skills;</li> <li>Consider transfer of Clinical care to a level 2 or 3 care facility, i.e. higher dependency or ITU;</li> </ul>

Please see next page for explanatory text about this chart.



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## Outline clinical response to NEWS\* triggers

Where a patient is being continuously monitored invasively or non-invasively, a full set of vital signs data should be charted using the 'minimum interval' algorithm (eg for a patient with a previous NEWS of 5, data from a continuous device must be charted at least hourly).

At all levels of NEWS, but particularly at levels of 7 or above, clinical staff should consider the 'ceiling of care' including the suitability of CPR.

**Reproducing this chart:** please note that this chart must be reproduced in colour, and should not be modified or amended.

**S**

**Situation:**

I am (nurse X) on ward (X),  
I am calling about patient (X), I am calling because I am concerned that..... (e.g. patient's mood is very low and expressing suicidal ideation)

**B**

**Background:**

Patient (X) was admitted on (X date) following (X) but has until today been well.  
Patient has a diagnosis of (X condition) and their Mental Health Act status is (X) and he/she is receiving (medication/therapy)  
The patient has deteriorated in the last (X) AND/ OR following (X)

**A**

**Assessment:**

I think the problem is (X) and I have (e.g. Put the patient on higher level observation)  
OR I am not sure what is wrong but patient (X)'s mental state has deteriorated and I am worried they are at higher risk of X  
OR  
I do not know what is wrong but I am worried and concerned

**R**

**Recommendation:**

I need you to (eg. come and see the patient by X time) in order to (X)

**D**

**Decision:**

So we have agreed you will visit the ward in the next (X mins), and in the meantime we will (X) (eg. Place the patient on enhanced observation and engagement)

Ask receiver to repeat key information to ensure understanding

The SBAR tool originated from the US Navy and was adapted for use in healthcare by  
Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA

If you require further copies quote SC060

# RAMPPS Debrief Guide



### Feelings

Ask the delegates how that felt, give them a chance to offload any strong feelings, stresses or worries that they have.

### Facts

What do you think was happening? This is open to answer by anyone, though should be aimed at the medic / nurse, with a chance to explain to others what was happening. Come in early if they are struggling with this.

### Advocacy/Inquiry

Facts following by curious question. "I saw that the sats dropped and oxygen wasn't administered for 5 minutes. I was wondering why that was?"

Good Judgement – "I was concerned that..." "I was pleased that..."

Listen and Check Back – "OK, oxygen wasn't administered because the focus was on the blood pressure and everyone thought someone else was checking the sats."

Then Generalise to Group – "Can anyone think of strategies to overcome this?" "Has anyone else been in a similar situation?"

### Questions

Open questions to the group, revisit any points you put on hold

### Summary

General summary of key points, "During this session we have learned..."

Do not revisit area for discussion.

# RAMPPS Learning Objectives Debrief Tool



## Basic Debrief Sheet

Area	Focus	Notes
Early Warning Scores	Appropriate Use Accuracy	
ABCDE & AVPU	Use of Recognition of problems Appropriate response	
SBARD	Opportunities Use of Tool	
Scenario Focus:		
Human Factors / Situational Awareness		
General Notes		

### Debrief Structure

1. Feelings
2. Facts
3. Advocacy / Inquiry
4. Questions
5. Summary

### Learning Points from Debrief:

## Appendix 3b

### Example sheet for Neuroleptic Malignant Syndrome

Area	Focus	Notes
Early Warning Scores	Appropriate Use Accuracy	
ABCDE & AVPU	Use of Recognition of problems  Appropriate response	
SBARD	Opportunities  Use of Tool	
Scenario Focus: Identify Depot Inappropriate	Depot Inappropriate	
Human Factors / Situational Awareness	Urgent need of NMS	
General Notes		

#### Debrief Structure

1. Feelings
2. Facts
3. Advocacy / Inquiry
4. Questions
5. Summary

#### Learning Points from Debrief:

## Title

Area	Focus	Notes
Early Warning Scores	Appropriate Use Accuracy	
ABCDE & AVPU	Use of Recognition of problems Appropriate response	
SBARD	Opportunities Use of Tool	
Scenario Focus:		
Human Factors / Situational Awareness		
General Notes		

### Debrief Structure

1. Feelings
2. Facts
3. Advocacy / Inquiry
4. Questions
5. Summary

### Learning Points from Debrief:

# Scenario Flowcharts and Development Tool



## SCENARIO DEVELOPMENT FRAMEWORK

**SCENARIO** – Title/Description

### SETTING – ENVIRONMENT → TRANSFER

Setting may be single or multiple involving a transfer, for example, from Home to A+E

<b>Nursing home Residential</b>	→ ←	<b>Acute - Inpatient A+E</b>	→ ←	<b>Home/ Community/GP</b>	→ ←
<b>Learning Objectives/ Curriculum Outcomes</b> <i>After this particular scenario, the delegate will have....</i>		Learning Objectives/ Curriculum Outcomes At the conclusion of the scenario the delegate will		Learning Objectives/ Curriculum Outcomes By completing the specific activities, the delegate will...	

### PARTICIPANTS/PLAYERS/DELEGATES

*Relevant combination of Medics, General Nurses, Learning Disability Nurses,  
Paramedics, Physiotherapist, Radiographers, HCA etc*

<b>Low/Medium fidelity</b> e.g. Part task – Nursing Ann	+/- Independent or blended	<b>Real/Simulated patient</b> e.g. Actor/standardised/ real patient	+/- Independent or blended	<b>High Fidelity</b> e.g. METiMan – SimMan	+/- Independent or blended

**EQUIPMENT PICK LIST** – For example **Clinical equipment** – Patient monitor, **Reports**  
– Chest X-ray, **Therapy** – IV Fluids, **Documentation** – MEWS Chart

## Appendix 4

### **PATIENT PROFILE –**

*For example, 63yr old Male 84kg 176cm with Alzheimers Disease and rheumatoid arthritis*

### **SETTING THE SCENE – PREPARATION OF ENVIRONMENT AND PATIENT OR SIMULATOR –**

*For example - No monitoring. Fully clothed +/- name band (no allergy band) no oxygen on, no IV access, eyelids half shut.  
Found drowsy and lethargic by healthcare professional with raised temperature, breathlessness and generally unwell*

### **OUTLINE OF TRENDS – Combination of (1) (2) (3) or all**

- (1) Communication > Scripts/directions*
- (2) Physiological > Low, medium or high fidelity programming*
- (3) Psychomotor skills*

### **DEBRIEFING OVERVIEW To include -**

- Review of learning objectives against performance*
- Key indicators of achievement against objectives*
- Discussion around tagged events that occur during simulation*

If you would like to get in touch, our recommended  
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