Level of confidence amongst IMT

SIGNIFICANT UNDERCONFIDENCE	I feel confident in providing a discharge plan for a patient with palliative care needs
	I feel confident in managing palliative care issues specific to common medical conditions including motor neurone disease, Parkinson's disease etc
	I feel confident in demonstrating safe and effective use of a syringe driver to a patient who is dying
SOME UNDER CONFIDENCE	I feel confident in managing palliative care issues specific to common medical conditions including
SOME OF BOTH	I feel confident in the ethical issues and decision making around the end of life
	I feel confident in my knowledge on withdrawing treatment at the end of life
	I feel confident in my knowledge of the legal issues around end of life care (eg DNACPR / advanced directives, decision to refuse treatment)
	I feel confident dealing with distressed families (due to EOL care issues)
	I feel confident in providing a discharge plan for a patient with palliative care needs
	I feel confident in demonstrating safe and effective use of a syringe driver to a patient who is dying
SIGNIFICANT CONFIDENCE	I feel confident refereeing an acutely dying patient to the specialist palliative care team I feel confident introducing the anticipatory prescribing discussion for a patient in the dying phase of their illness with the team I feel confident assessing and managing a dying patient with symptoms including pain, constipation, vomiting, diarrhoea, swallowing difficulties etc I feel confident communicating end of life care issues such as ceiling of treatment / request for admission

Session Content Suggestions – with additional detail which are particular concern

ECHO 1 RECOGNISING DYING		ECHO 2 DISEASE OR SYMPTOM SPECIFIC DYING		ECHO 3 PALLIATIVE PHARMACOLOGY		ECHO4 COMMUNICATING DYING		ECHO 5 DYING ETHICS	
I feel confident in my knowledge on withdrawing treatment at the end of life	Decision making Identifying a dying patient **Withdrawing treatment (stopping futile interventions)** Complex decisions framework	I feel confident in managing palliative care issues specific to common medical conditions including motor neurone disease, Parkinson's disease etc	++ re MND/ Neurological symptoms When to switch from active management of the dying symptoms to palliative withdrawal Ie Important turning points	I feel confident in demonstrating safe and effective use of a syringe driver to a patient who is dying	How to prepare for fast track discharge – what's the best way to ensure that they have the right drugs	I feel confident communicating end of life care issues such as ceiling of treatment, requests for admission	How to implement a DNACPR (language to use) Communicating prognosis important turning points Talking to consultants / engaging the team – getting them to recognise dying	I feel confident in the ethical issues and decision making around the end of life	
I feel confident identifying a patient under my care admitted acutely, in the dying phase of their illness	Recognising my role (as an IMT 1) Managing prolonged / extended dying When to ask for help	I feel confident communicating end of life care issues such as ceiling of treatment, requests for admission	How to discuss a DNACPR Communicating prognosis	I feel confident on prescribing pain control in the dying patient, including opiate conversion	Stopping medications (esp DM) Managing hypoglycaemia and glucose monitoring	I feel confident dealing with distressed families (due to end of life care issues)	How to manage stressful encounters Supporting grieving families **How to break bad news empathetically** How to manage families in denial/overdemanding/different expectations	ETHICS OF managing palliative care issues specific to common medical conditions including motor neurone disease, Parkinson's disease etc (over escalation)	Demanding Vs Refusal of treatment and the law – How to communicate
I feel confident referring an acutely admitted dying patient to the specialist palliative care team	**Prognosticating dying form heart failure and renal failure**	I feel confident assessing and managing a dying patient with symptoms including pain, constipation, vomiting, diarrhoea, swallowing difficulties etc	Difficult symptoms to control ? Any "out of the box" solutions Difficulty swallowing	I feel confident introducing the anticipatory prescribing discussion for a patient in the dying phase of their illness with the team	Renal failure adjustments **Pain crisis management**	I feel confident in providing a discharge plan for a patient with palliative care needs	What needs to be in a palliative discharge plan Discussing advanced directives **When to verify, what to say when someone has just died**	OTHER	ReSPECT forms Common mistakes and how to avoid Re-establishing curative care ! – **reversing decisions**
		I feel confident managing a patient with limited reversibility to their medical condition (eg advanced malignancy, cardiac failure, COPD etc)	Does management change depending on the non reversible illness		Non pharmacological management advice for symptoms	I feel confident referring an acutely admitted dying patient to the specialist palliative care team	When to refer Fast tracked patients (who and how) What the hospice offer and who to refer		

Case Suggestions (not exhaustive)

ECHO 1 RECOGNISING DYING	ECHO 2 DISEASE OR SYMPTOM SPECIFIC DYING	ECHO 3 PALLIATIVE PHARMACOLOGY	ECHO4 COMMUNICATING DYING	ECHO 5 DYING ETHICS
• Patients who you recognised dying but others didn't or vice versa • Acute dying – patients that came in and died quickly • Young patients that died • When to stop CPR • When to refer / or not to ICU	• MND (we need one case of the 2 to be MND) • Parkinson's • Patients with complex needs • HIV • Heart failure • Elderly – when escalation is isn't appropriate • Dying in ICU / withdrawal in ICU	• When syringe drivers have / haven't been implemented • Use of morphine and midazolam when dying (will it hasten death) • Converting drugs to syringe driver • Which medicines to start / stop / continue when dying • Palliative chemotherapy – the implications when admitted to hospital	• Difficult conversations • Difficult angry families • Realisation that having these conversations was easier than you thought • Implementing DNR on someone who has refused – how to approach • Discussing withdrawal • Discussing ceilings of treatment • Dealing with conflict (in the teams / between the teams (ie haematologist says they have a curative cancer but they are intubated on ICU with neutropenic sepsis which has a 95% mortality)	• Patient wishes vs reasonable treatment • Withdrawal • Withholding • Demanding treatment