AHP PRACTITIONER INTERPROFESSIONAL SIMULATION HANDBOOK

NHS AHP Clinical Skills Steering Group

NHS GREATER GLASGOW & CLYDE [Company address]

Contents

Introduction

Newly qualified healthcare practitioners require structured support to ensure they are confident, competent, and fully prepared for clinical practice. Interprofessional Simulation-Based Education (Sim-IPE) focuses on improving collaborative practice, communication and team dynamics. Through immersive and experiential learning, Sim-IPE enables practitioners to strengthen their clinical knowledge, refine practical skills, and enhance teamwork in a safe and supportive environment.

This handbook offers an accessible resource to guide postgraduate simulation training for Allied Health Professionals (AHPs), Dietitians, Occupational Therapists, Physiotherapists, and Speech and Language Therapists working at Practitioner Level (Level 5). It aims to provide a consistent framework that supports early-career practitioners as they transition into their professional roles.

To accommodate the varied contexts in which AHPs work, the handbook content can be applied to both acute and community settings. This dual-setting approach offers flexibility, allowing training to meet the needs of different services and clinical environments.

Regardless of the setting, each simulation session is structured as a half-day programme, lasting approximately 3 to 3½ hours, ensuring it is both comprehensive and manageable within workplace rotas.

Course Objectives

The course aligns with level 5 of the NMAHP Development Framework covering several Key Knowledge, Skills and Behaviors (see appendix 1).

In addition, the scenarios focus on non-technical skills (NTS) such as situational awareness, patient safety and communication. NTS are “crucial to safe and effective team performance in health care” (O’Connor 2024).

The scenarios included promote:

- Teamwork,
- Leadership,
- Communication
- Decision Making

The shared scenarios focus on dementia however simulation scenarios are highly adaptable and applicable to a wide variety of clinical diagnoses however the NTS examples are relevant and transferrable across many aspects of Practitioner Level AHP care.

Set up for the session

A well-structured pre-brief is essential to the success of any simulation-based learning experience. It helps participants understand what to expect, reduces unnecessary anxiety, and creates the conditions for meaningful engagement. The pre-brief is most effective when delivered in two stages.

1. Pre-session Communication

At least one week before the session, participants should receive an introductory email outlining:

- The purpose of the simulation
- What they can expect during the session
- Any relevant background information or preparatory material

Providing this information in advance allows participants to orient themselves to the scenario and reduces cognitive load during the simulation itself (Reedy, 2015). Early communication also supports learners who benefit from additional time to process information or who may be unfamiliar with simulation-based education.

2. Introductory Welcome and On-site Pre-brief

The second component of the pre-brief occurs at the start of the session. The primary aim is to establish a psychologically safe learning environment. Facilitators should clearly communicate that:

- The simulation is designed solely for educational purposes
- It is not an assessment of competence, knowledge, or clinical skill
- Confidentiality “what happens in simulation stays in simulation”

Participants should be made aware and consented if recording processes are used. Some may have no prior experience with recorded simulations, so it is important to reassure them that:

- Recordings are stored securely
- They are used only for educational review
- They will not be shared publicly

Establishing trust and transparency from the outset encourages learners to fully engage, take risks, and reflect openly—key ingredients for effective simulation-based education.

Learning outcomes

Establishing Participant Expectations:

At the start of the session, participants should be encouraged to document their expectations and identify what they hope to achieve. These learner-generated goals can be revisited during the closing discussion. Ideally, both facilitator-defined outcomes and participant-identified outcomes should be met by the end of the session, supporting a sense of progress and personal achievement.

Orientation to the Simulation Environment:

Before the first scenario begins, participants should be given time to walk through the simulation area. This familiarisation period helps reduce anxiety, supports situational awareness, and allows learners to focus more effectively on the clinical and behavioural elements of the scenario once it begins.

Running Scenario blurb

Debriefing

1. Agenda Setting

Debriefing begins with a brief agenda-setting phase, lasting no more than five minutes. This serves as an extended period of decompression and allows participants to transition out of the scenario. Facilitators may use prompts such as “triumphs and challenges”, “what went well?”, or “what would you change if you were to do it again?”.

Capture participant comments verbatim on a whiteboard, divided into the relevant categories. Once all initial reflections are gathered, the group together with the facility selects up to three key items for deeper exploration.

2. Analysis

Lead by the faculty, participants should be encouraged to lead the discussion. The aim is to explore behaviours, decision-making processes, and clinical or teamwork principles in a supportive and reflective manner.

3. Take-Forward Messages

Debriefing concludes with the identification of clear, specific take-forward messages. Participants should be encouraged to articulate concrete learning points or actions they intend to apply in future practice.

4. Timing

The full debriefing process should take approximately 30–40 minutes following each scenario, allowing sufficient time for reflection, analysis, and consolidation of learning.

Examples of scenarios developed, implemented, and evaluated in both acute and community settings are provided below.

Scenario examples

Dementia & Falls Risk (Community)

Target group

Allied Health Professionals working at 'Practitioner' Level - Dietitian, OT, Physio and SLT. This has been designed for 8 participants (2 from each profession). This will allow for each participant to be a participant in a scenario and observe in another.

Learning objectives

By the end of the scenario and debrief participants will be able to:

- Discuss the process of gathering information from multiple sources
- Consider the role of the carer in information gathering
- Be able to demonstrate holistic assessment skills in relation to dementia, falls and other comorbidities
- Identify potential risks for elderly patient and carer (i.e. wellbeing & falls)
- Recognise and demonstrate the importance and application of non-technical skills (e.g. communication, leadership, delegation, situational awareness) in the clinical workplace
- Consider MDT involvement with this patient & develop collaborative multi-disciplinary decision-making skills
- Identify when, who and why to seek further support and advice to enable decision-making and deliver person-centred care

The scenarios are designed to have two de-briefs. The first de-brief will be after parts 1 a & b and the second de-brief will be after parts 2 a & b. There is a swift transition from part 1 a to part b (and part 2 a to part b).

Setting, Equipment, Personnel and Props

Part 1a

Home environment - this scenario is set in the man's home. Suggested equipment.

- Chairs for patient and partner
- Bed
- Bucket
- Loose trousers (for patient)
- Walking Aid (walking stick)
- Toilet/commode
- Rugs
- House phone

Personnel - 2 embedded professionals

- 1 as patient
- 1 as partner/spouse

Parts 1b

Community department staff room

- 6 chairs set in a circle (or round a table)

Personnel – 2 embedded professionals

- 1 as team lead
- 1 as HCSW

Candidates

- 1 participant from each profession (Physiotherapy, Occupational Therapy, Dietetics and Speech & Language Therapy)
- Participants can change after first de-brief

Handover of the clinical scenario

S - You have been referred a patient (Tam Jamieson) in the community by the patient's GP and an initial visit is being carried out.

B - The patient, a 79 year old man and his 71 year old wife are present during the visit. The patient was diagnosed with dementia 4 months ago. He believes he is 'managing fine' at home and doesn't want to make a fuss. His wife is worried about his balance and walking and says he's a bit wobbly on his feet.
He is a retired plumber.
PMH - type 2 diabetes and angina Osteoarthritis, hypertension, cataracts (recently worsening)
Meds – Aricept, Metformin, Nitro-glycerine, Atenolol

A - The referral states that he has reduced mobility, he has been struggling to transfer on and off the toilet and has had a reduced appetite which is affecting his oral intake and GP is concerned re significant weight loss.

R - (OT + Dietitian) Please assess this man and plan your intervention (if any) or onward referral.

R – (Physio and SLT) You are currently having a tea break at the community AHP department with colleagues but aware you will be reviewing Tam in the near future and awaiting discussion with OT and Dietitian on their visit

Additional Background (for faculty)

He has a stick at home but does not use it. He has stopped going to his usual social activities; men's shed with friends, church with his wife, local football team on a Saturday. He is experiencing difficulty finding words and keeping track during conversations. The patient states he has just had a cold but will be going back to them soon, when the weather is better.

He is quite a domineering man, and his wife is quiet during the visit but tries to make her point a few times. She appears tired and anxious.

Scenario Storyboard Part 1a (First visit) - 10mins

Timing	Clinical condition	Expected Clinical Course with actions, triggers and prompts		
1. Beginning OT & Dietitian visit Introduce self to patient, gain consent and initial conversation.	**Patient** 'No idea why you are here, I'm fine. Just HER making a fuss as usual' **Wife (faculty)** 'Just ignore him. We're glad you're here. We need a bit of help as he's not been himself recently' **Environment** Patient in bed Bucket beside bed TV controls / newspaper etc. all beside chair.	**Expected learner actions:** Gather patient's and carer's perception of reason for referral.	**Transition Trigger:** (Actions OR Time) After 2 minutes **Prompt:** **Patient response** All fine, no need for you. Patient needs toilet. tries to get wife to pass him the bucket, struggles with word finding. Wife states he needs to leave the room and use the toilet off the hall.	**Teaching Points:**

Timing	Clinical condition	Expected Clinical Course with actions, triggers and prompts		
2. Middle Patient goes to toilet. OT should offer to help and dietician stay with wife.	**Patient** Struggles to stand, needs support from wife, OT should intervene. Once up needs reminding that he was going to toilet. Shuffling gait. **Carer** Back pain when helping him. Shares quickly whilst he is out of room that she is struggling, he's up during night and has started doing funny things – putting things in wrong place etc. He can be angry.	**Expected learner actions:** Identify carer needs Identify signs of struggling in environment Identify patient reduced mobility	**Transition Trigger:** **Prompt:** **Patient response** Calls wife for help from toilet **Environment** Spot notes pinned to phone, tv remote etc as reminders for patient Few odd objects in wrong places in home	**Teaching Points:** Dementia Carers needs Identify need for physio Consider diet and weight loss. Consider referral to SALT

Timing	Clinical condition	Expected Clinical Course with actions, triggers and prompts		
	Not eating, refusing meals and he's lost a lot of weight, was usually about 76kg but now 68 kg. Tending only to eat soup, porridge. Has gone off meat in the last few months.			
3. End Patient returns from toilet. Refer for Physio and SLT assessment	**Patient:** Frustrated and a bit embarrassed	**Expected Learner actions** Acknowledge that they have observed that the patient is finding some things a bit hard	**Transition trigger** If NMAHP role acknowledges the struggles and information from wife then go on to have open conversation. Not leaving house and wife not happy to leave him so not going out	**Teaching points** Value of carer information Risks to wellbeing Mental health and wellbeing Need to liaise with daughter as follow up

Timing	Clinical condition	Expected Clinical Course with actions, triggers and prompts		
			either. Becoming isolated and stressed.	Goal planning

Conclusion

Stop this scenario after 15 minutes maximum. If the discussion reaches goal setting before then or if the conversation is closed without reaching this stage then stop the scenario. To stop scenario either

- patient or partner can say that they are tired and thank them for the visit or
- Phone call from faculty to patient's 'house' phone as a prompt to end scenario

Transition

This scenario will immediately transition to part 1b where the MDT discussion/handover will take place

Scenario Storyboard Part 1b (MDT discussion and handover); 15 minutes

Timing	Clinical condition	Expected Clinical Course with actions, triggers and prompts		
1. Beginning OT and Dietitian return from initial visit to MDT office Faculty members; team lead, HCSW Physio and SLT	**Patient** Summarise and feedback their key findings and reasons for referral to other MDT members. **Environment** Office environment, phones ringing, admin on laptop/computer. Consider confidentiality of discussion.	**Expected Learner actions** Team discussion and confidentiality. Use of language when handing over. Goal setting / delegation Identify risks	**Transition Trigger:** (Actions OR Time) After 2 minutes **Prompt:** To think about who else is in the room while discussing pt. Agree problems and actions, and MDT goals / goal setting. Identify who would be appropriate to go out next.	**Teaching Points:** Effective handover, person centred goals. Language and confidentiality in team environments. **Notice risk factors;** Environment, clutter, carpets etc. Support for wife/carer needs. Patient, BP, eyesight, dizziness, general observation of patient, clothing, footwear, weight loss.

Conclusion:

Stop this scenario after 15 minutes maximum. If the discussion reaches goal setting before then or if the conversation is closed without reaching this stage, then stop the scenario.

Discussion and Feedback:

Dementia services and input

- Carer needs and risks to carer if can't cope
- Awareness of MDT/AHP roles, knowledge and skills
- Communication skills (home environment and within MDT)
- Decision-making – Prioritising for patient family needs

Part 2 - Second visit

Environment, equipment and essential props

As per parts 1a and 1b
OT and dietitian participants will stay within the ‘community department staff room’. This is to support the realism of the handover for part 2b

Brief;

S - Physio and SLT visit –
B - Tam’s wife has left a message to say he has been experiencing frequent falls at home in the last week since being seen.
A - His wife is concerned and struggles to help him up from the floor and worries about him walking around.
R – (Physio and SLT) The focus of the visit is to follow up from the last visit and to understand the causes of his falls, addressing environmental and physical factors, and creating a comprehensive care plan to prevent future falls and ensuring carer able to support him.

R – (OT and Dietitian) You are currently having a tea break at the community AHP department with colleagues but aware you will be reviewing Tam again in the near future and awaiting discussion with physio and SLT on their visit.

Scenario Storyboard Part 2a (Second visit) - 15mins

Timing	Clinical condition	Expected Clinical Course with actions, triggers and prompts		
1. Beginning Physio and SLT Introduce self to patient, gain consent and initial conversation	**Patient** Patient has fallen several times since last visit. Wife is anxious about him moving around the house Wearing loose fitting slippers Glasses beside him and very dirty **Environment** Rugs on the floor Poor lighting Slippery floors No alert alarm Walking stick/walking aid on other side of the room	**Expected learner actions:** Gather patient/wife's perception of reason for referral.	**Transition Trigger:** (Actions OR Time) After 2 minutes **Prompt:** Wife says - I'm glad you're here I am so scared of him falling and I can't get him up when he does.	**Teaching Points:** Listening to their worries **Notice risk factors;** Environment, clutter, carpets etc. Patient, BP, eyesight, dizziness, general observation of patient, clothing, footwear, weight loss. Observe communication exchange and any word finding/comprehension difficulties Observe patient taking a drink of water

	Glass of water on table with plate with sandwich and two biscuits (one jaffa cake or soft cake bar wrapped and a digestive). Pot of custard and spoon also sitting * uneaten lunch			
2. Middle Patient reluctant to engage, can't remember first visit. Continues to have word finding difficulties. Patient encouraged to take a drink of water and eat	**Patient** Uses furniture to get around the house. Not using walking aid. Doesn't feel he needs anyone, wants everyone out the house. **Environment** House appears more cluttered than first visit.	**Expected learner actions:** Opportunity created to Assess Patient's balance, gait, while walking to bedroom. Assess patient's ability to perform relevant activities	**Transition Trigger:** **Prompt:** **Patient response** "I'm going to my bed" **Environment;** Hazards on route And patient makes sudden decision to	**Teaching Points:** Recommend assistive devices, such as grab bars, a walker, suggest home modifications to reduce fall risks. Teach him safe movement techniques. SLT Assessment/ observation of communication ability and swallowing > provide advice. Need for more in depth assessment

some of his lunch		of daily living (ADLs).	go to the toilet instead.	
Timing	**Clinical condition**	**Expected Clinical Course with actions, triggers and prompts**		
3. End He sits on bed and wife has to lift his legs up.	**Patient:** I used to be so much more independent, I don't need you Emotional and tearful.	**Expected Learner actions** **Acknowledge** Consider side effects from his medications and other reasons that affect his balance.	**Transition trigger.** Wife feels lonely and is nervous about going out and leaving him alone. Misses her book club and friends	**Teaching points** Consideration about getting in touch with their daughter Ask about wife's mood and any need for support Home alarm system/telecare

Conclusion

Stop this scenario after 15 minutes maximum. If the discussion reaches goal setting before then or if the conversation is closed without reaching this stage, then stop the scenario. To stop scenario either

- patient or partner can say that they are tired and thank them for the visit or
- Phone call from faculty to patient's 'house' phone as a prompt to end scenario

Transition

This scenario will immediately transition to part 2b where the MDT discussion/handover will take place

Scenario Storyboard Part 2b (MDT discussion and handover); 15 minutes

Timing	Clinical condition	Expected Clinical Course with actions, triggers and prompts		
1. Beginning Physio and SLT return from initial visit to MDT office Either observers or original participants from part 3. Faculty members; team lead, admin support. SW, and HCSW Physio and SLT	**Patient** Summarise and feedback their key findings and any additional concerns. MDT goals Reasons for referral to other MDT members. Priority visits / which professional and ongoing treatment plan. **Environment** Office environment, phones ringing, admin on laptop/computer.	**Expected Learner actions** Team discussion and confidentiality. Use of language when handing over. Goal setting / delegation Identify risks.	**Transition Trigger:** (Actions OR Time) After 2 minutes **Prompt:** To think about who else is in the room while discussing pt. Agree problems and actions, and MDT goals / goal setting. Identify who would be appropriate to go out next. Any onward referrals. (eg. home care, carer support, 3rd sector)	**Teaching Points:** Effective handover, person centred goals. Language and confidentiality in team environments. **Notice risk factors;** Recent falls. Environment, clutter, carpets etc. Support for wife/carer needs. Patient, BP, eyesight, dizziness, general observation of patient, clothing, footwear, weight loss.

	Consider confidentiality of discussion.			

Discussion and Feedback:

Decisions:

- Profession input (ie)
    - Diet and SLT swallowing recommendations
    - Changes to the environment
    - Alert alarm/telecare
    - Need for alternative walking aids
- Request for assistance - further medical intervention; consider eyesight, BP, impact of medications on balance and fatigue
- Family needs
    - Carer Assessment needs
    - Consider contacting daughter
- Learning from the MDT discussion can be adaptable but may include
    - Leadership – advocating for family,
    - Joint decision making

Situational awareness – shared mental model

Dementia Care in Acute Environment (Acute)

Target group

Allied Health Professionals working at 'Practitioner' Level - Dietitian, OT, Physio and SLT. This has been designed for 8 participants (2 from each profession). This will allow for each participant to be a participant in a scenario and observe in another.

Learning objectives:

By the end of the scenario and debrief participants will be able to:

- Be able to demonstrate holistic assessment skills in relation to dementia, falls and other comorbidities
- Understand the roles of different members of the inter-professional team
- Recognise and demonstrate the importance and application of non-technical skills (e.g. communication, leadership, delegation, situational awareness) in the clinical workplace
- Demonstrate joint decision-making with the inter-professional team, patient and carer
- Consider the role of the care partner when delivering person-centred care
- Demonstrate patient/carer advocacy

Part 1 - Acute Initial Review

Setting, Equipment, Personnel and Props

Setting
This scenario is set in a care of the elderly acute ward.

Equipment/Props

- Hospital bed
- Have 2 chairs and table in bed space.
- Place jug of water, full cup, uneaten yoghurt, post it notes (various reminders) and mobile phone/instructions on table. Newspaper on bed.
- Walking stick

Personnel
Faculty

- 2 embedded professionals (1 patient and 1 carer (daughter/son))
- 1x Physio, 1x OT, 1x SLT, 1x Dietitian for debrief (any 2 within debrief at any one time)

Candidates
1x Physio, 1x OT, 1x SLT, 1x Dietitian

Handover of the clinical scenario

S - You have been referred a patient (Thomas (Tam) Jamieson) for your professional assessment for discharge home who has been admitted with a UTI.

B – Tam was admitted over the weekend and has improved medically with antibiotics. Consultant reviewed today (Monday morning) and has placed him fit for discharge.
His medical background is

PC – UTI
HPC – Admitted 2 days ago following GP home visit with increased confusion, dysuria, tachycardia and hypotension. UTI confirmed from microbiology. Tachycardia and hypotension now resolving following commencement of antibiotics.
PMH – Alzheimer's (diagnosed 8 months previously), Myocardial Infarction 2016, Angina, Hypertension, Asthma,
DH – Atorvastatin, Amlodipine, Rivaroxaban, Metformin, Salbutamol inhaler, Clenil modulate inhaler.
SH – Widowed, lives in an upper cottage flat. Ex-smoker, no alcohol. Retired plumber. Has 48-year-old daughter who lives 5 miles away. No social services.

A - A referral has been sent to each AHP for assessment and discharge planning. The referral states that he has reduced mobility, he has been struggling to transfer on and off the toilet and has had a reduced appetite which is affecting his oral intake – MUST score of 2. He has had 2 episodes of choking – one at home and one in hospital.
R - Please assess this man and plan your intervention (if any) or onward referral.

- Physio and OT – review together and handover to Dietitian and SLT after your assessment
- Dietitian and SLT – review together after Physio and OT review

Additional Background (for Faculty)

The patient was diagnosed with Alzheimer's dementia 8 months ago. He believes he is 'managing fine' at home and doesn't know why he is in hospital and they are making too much fuss.

He has stopped going to his usual social activities – men's shed with friends, church with his wife, local football team on a Saturday. The patient states he has just had a chill but will be going back to them soon, when the weather is better.

He is quite a domineering man, and his daughter arrives during the assessment but tries to make her point a few times. She appears tired and anxious. The daughter reports that the neighbour has reported they have gone into assist her father after a couple of falls in the house. She has tried to get follow up via the GP but as she lives a distance away this has been difficult. She reports her father is reluctant to attend GP and insists he is fine and the neighbour is a 'good help'.

Scenario 1 – Storyboard

Timing	Clinical condition	Expected Clinical Course with actions, triggers and prompts		
1. Beginning PT/OT enter scenario to assess patient Introduce self to patient, gain consent and initial conversation.	**Patient** 'No idea why you are here, I'm fine. Just Everyone making a fuss as usual' **Environment** Full jug of water and undrunk cup of tea. Newspaper open at sports page. Hand made sign "press the buzzer for help". Mobile phone instruction sheet next to a mobile phone. Digital dementia clock.	**Expected learner actions:** Gather patient's and care partner's perception of reason for referral. Consider referral to other professional.	**Transition Trigger:** (Actions OR Time) After 2 minutes **Prompt:** **Patient response** All fine, no need for you. Patient takes a drink of water and coughs. Patient needs toilet. Tries to get up to the toilet but struggles with transfers and has word finding difficulty. Daughter arrives in the room to visit her father. Looks a bit harassed.	**Teaching Points:** • Gathering information • Listening to patient and carer

Timing	Clinical condition	Expected Clinical Course with actions, triggers and prompts		
2. Middle Patient goes to toilet	**Patient** Struggles to stand, needs support from daughter. Once up needs reminding that he was going to toilet. Shuffling gait. **Care partner** Back pain when helping him. Shares quickly whilst he is out of room that she is struggling with the increased visits and is leaving him meals. Noticed that meals are often uneaten and he is putting things in the wrong place. Worried about choking, choked on a biscuit when she was with him.. He can be angry with her at times. Not accepting support well and	**Expected learner actions:** Identify care partner needs Identify signs of struggling in environment Identify patient reduced mobility/transfers. Identify oral intake /social needs. Identify choking risk. Discussion about referring onto MDT	**Transition Trigger:** **Prompt:** **Patient response** Calls daughter for help from toilet. Asking where the toilet roll is. Needs help to stand up again. **Environment** Trousers not zipped up – disheveled.	**Teaching Points:** • Dementia needs • Carers needs • Seeking other team members

Timing	Clinical condition	Expected Clinical Course with actions, triggers and prompts		
	getting agitated with her.			

Timing	Clinical condition	Expected Clinical Course with actions, triggers and prompts		
3. Handover SLT+/- Dietitian enter to get handover from PT/OT	**N/A**	**Expected Learner actions** Effective handover between professions	**Transition Trigger** If handover being prolonged, n/staff (stooge) comes in and says daughter has some questions for dietian/SLT	**Teaching Points** • Communication/handover
4. Dietitian/SLT Review Patient and daughter return	**Patient:** Frustrated and a bit embarrassed – a wee bit brittle with daughter and AHP's.	**Expected Learner actions** Acknowledge that they have observed that the patient is finding some things a bit hard.	**Transition trigger** If NMAHP role acknowledges the struggles and information from daughter then go on to have open conversation.	**Teaching points** Risks to wellbeing Mental health and wellbeing Stress and distress

		Discussion around d/c planning, MDT input, need to discuss at ward round complexity around pending d/c. Discussing stress and distress / choking with nursing staff.	If continues to ask generic questions daughter starts reporting she is worried about him going home without any help. “I can’t do much more – I’m already having to take time off work” Patient reports he is fine to go home “don’t know what all the fuss is about” Daughter increased stress – tearful – “Can I have a private word”	

Conclusion:

Stop this scenario after 20 minutes maximum. If the discussion reaches goal setting before then or if the conversation is closed without reaching this stage then stop the scenario.

Discussion and Feedback:

- Team member roles, responsibilities, knowledge and skills
- Communication (patient, family, handover to colleagues)
- Care partner needs and risks to them
- Decision-making – Goal setting and treatment planning for patient and prioritisation
- Dementia care services

Part 2 - MDT meeting

Setting, Equipment, Personnel and Props

Setting - Room for MDT Meeting

- Enough chairs for participating faculty and participants

Personnel
Faculty

- 2 embedded professionals (1 locum consultant and 1 lead nurse)

Candidates

- 1x Physio, 1x OT, 1x SLT, 1x Dietitian

Handover of the clinical scenario

S - You are attending the bi-weekly MDT to discuss care planning for patients in the ward.
B – The MDT meeting is to discuss current inpatients in the ward and to help decide future plans for discharge and ongoing care.
A – Tam is the first person to be discussed in the ward round. The ward round will be led by the locum consultant for the ward and charge nurse.
R - Please contribute to the MDT meeting to discuss your clinical reasoning for future care.

Additional Background (for Faculty)

Locum consultant – Just been in unit for 1 week aware of pressures of bed space and keen to improve this. With discussion will become receptive to not rushing patient out.
Senior nurse – Awareness of patients in unit but also has a managerial role so not always in ward area. Getting information second hand from nurses. Knows ‘’Tam’s” history but hasn’t spent time with him.

Scenario – Conversation with patient and care partner– Storyboard

Timing	Clinical condition	Expected Clinical Course with actions, triggers and prompts		
1. Beginning Start of MDT	AHP participants in a room, (locum) consultant enters with nurse. Consultant and nurse having conversation about bed pressures so looking at who could be discharged from the ward. Conversation within earshot but not directed to the 3 participants. Introductions to the meeting to discuss the patients in the wards as part of twice weekly MDT (Monday and Thursdays)	**Expected learner actions:** Introduce themselves to the meeting.	**Transition Trigger:** (Actions OR Time) Prompt: Consultant goes round the room asking for everyone to introduce themselves.	**Teaching Points:** Bed Pressures MDT Roles

Timing	Clinical condition	Expected Clinical Course with actions, triggers and prompts		
2. Middle Discussion of Thomas	Nurse introduces first patient for discussion – Thomas (Tam). Initial feelings from nurse and consultant is that he is now medically stable, back to baseline and now keen for discharge home. Tam had mentioned that he was keen to get home at ward round.	**Expected learner actions:** All participants give feedback on their progress on Tam and what their goals/expectations are for Tam	**Transition Trigger:** Consultant initially asks nurse of progress then will indicate their thoughts **Prompt:** Consultant - Are we in agreement that we should be aiming for discharge.	**Teaching Points:** Speaking up, challenging opinions from other members of MDT Supporting each other Advocate for patient/carer

Timing	Clinical condition	Expected Clinical Course with actions, triggers and prompts		
3. End Identifying a plan	**Patient:** Consultant questions, can he live with daughter.	**Expected Learner actions** Communicate reasons for further assessment and what additional care/ services he needs. Can he live at home or residential??	**Transition trigger** If group aren't creating ideas for next steps, n/staff and/or consultant suggest potential next steps to facilitate discussion.	**Teaching points** Using objective measures Communication with MDT and collaborative patient-centred care Scope of practice/ senior support

Conclusion

Consultant moves onto next patient once there has been an agreement on future steps for Tam.

Discussion and Feedback:

- Exploring challenges of bedspaces/ dealing with conflict
- Leadership - Advocating for patient
- Communicating rehabilitation goals/use of objective measures
- Discussing and understanding the roles within the MDT/AHPs
- Joint decision making with MDT

Development of the AHP Practitioner Interprofessional Clinical Simulation Handbook

This handbook was developed by the NHSGGC AHP Clinical Skills Group.

For further information pleas3e contact Barry.Johnstone2@nhs.scot or Elspeth.Lee4@nhs.scot

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Appendix 1

Key Knowledge, Skills and Behaviours covered in Simulation Scenarios

Clinical

5C1 Use a range of skills and strategies to communicate with people about difficult matters or situations.

5C2 Acts and influences others in demonstrating non-judgemental, values-based care.

5C3 Promote and deliver safe, effective and person-centred care as part of the multi-disciplinary team.

5C7 Apply critical thinking and evaluation skills to make timely and informed clinical decisions related to all aspects of the care process.

5C9 Provide and share information effectively and concisely for a range of situations and contexts to ensure safety and continuity of care.

5C10 Practise in ways which recognise and respond to health inequalities, respect diversity, protect against discrimination and support others to do the same.

5C11 Apply a range of skills to promote health and well-being, improve health literacy and empower patients to share decision making.

5C12 Develop and apply clinical knowledge, skills and behaviours appropriate to specific area of practice.

Facilitating Learning

5F1 Demonstrate knowledge and applies the skills of facilitation, teaching, assessment and behaviours including supervising, teaching and maintaining the learning environment.

5F2 Evidence experiential learning through supervision, feedback, reflective practice techniques and evaluation.

5F3 Apply an inclusive and collaborative approach to the development of a positive learning environment.

5F4 Evidence reflection on own and others experiences of the workplace to develop a positive learning environment.

5F8 Motivate, stimulate and encourage others to facilitate the learning process.

5F9 Develop and apply knowledge of adult learning theory appropriate to specific role.

Leadership

5L1 Demonstrate leadership qualities and behaviours including skills in motivating, influencing and negotiation.

5L2 Communicate effectively verbally non-verbally and in writing to a range of people.

5L3 Seek, receive and provide feedback in an open, honest and constructive manner.

5L4 Identify and analyse problems and recommend solutions.

5L5 Respond proactively to own and others concerns and know how to escalate ongoing issues.

5L6 Demonstrate the ability to work well within a team and in collaboration with others.

5L8 Engage in own personal and professional development planning and review; and support others to develop personally and professionally.

5L10 Develop and apply leadership skills and behaviours appropriate to specific role.