# SIMULATION CASE –OD\_SH\_2

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| **Learning outcomes:**  By the end of this simulation the candidates will:   * Be able to assess both the medical/surgical and psychiatric elements of the presentation of an adult patient with significant self harm incisions, blood loss and ongoing active hallucinations * Consider the risk of repeated similar presentations and the ongoing risk to self and to family members * Make a rapid and accurate assessment of mental capacity / incapacity ad be aware of the relevant legislation in this case used in the UK * Be able to make a sensible assessment of the seriousness of a self harm wound and the potential for blood loss by completing a thorough history and examination and recommend/perform wound closure when needed * Consider the need to sedation/tranquilisation of such patients in order to fully assess and treat wounds and balance this against the risk of hypotension if blood loss is significant * Be aware of the use of Major Haemorrhage Protocols in the Emergency department and when to use this mechanism   Simulation focus: This young adult patient has a known history of psychosis and is actively hallucinating. She has used a violent method to harm herself and has potentially suffered significant blood loss and intra-abdominal injury. This case is challenging from both a physical and mental health perspective. |

**Introduction [Environment and Set]**

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| Running simulations with teams and ‘own’ job roles and `PAUSE’  In order to make simulations relevant to candidates’ day to day work, ensure that they play the role as they would their own – to achieve this you may need to adjust the role of the clinician; the ‘place’ of the assessment and the scope of any intervention.  To reinforce the fact that they are teaching simulations, candidates can take a ‘time-out’ by saying ‘PAUSE’ if they want to work through an issue with the faculty or their team (of fellow candidates). During this ‘PAUSE’ phase faculty are able to assess if the candidate is approaching the assessment logically according to the structured approach.  **Collateral information:**  During the course of the simulation, it may be necessary for one instructor to play the role of a family member, friend or other healthcare professional to provide collateral information that is important for the case.  This role should be established at the outset and the instructor should remain in role until the debrief begins. |

Prior to the start of the simulation: one instructor to:

1. **[Environment] Brief candidate group to *check the Environment*:**

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| Room | Candidates to set up the room appropriately |  |
| Equipment | Candidates to check required equipment present and accessible |  |

**Equipment list:**

In addition to generic equipment list: None

[Set]/[Dialogue] Simulation

Initial handover *{to tell candidate on your arrival as the initial SBAR to Team Leader}*

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| **S**ituation | This is a 22yr old *M/F* who has been brought in by ambulance having sustained several incisions to the anterior abdomen due to a kitchen knife | |
| **B**ackground | This patient is known to have Schizophrenia and *his/her* parents explain that these wounds are due to self harm | |
| **A**ssessment | A | Airway clear, patient speaking to you |
| B | No obvious injury to the chest |
| C | A bit clammy, bleeding from anterior abdominal wall, dressing in situ by paramedic, has not leaked through dressing. IV access X 1 to ACF by paramedics en route. |
| D | GCS 15 – orientated though actively hallucinating |
| E | 5 linear partial thickness incisions to anterior abdominal wall, evidence of old scarring underlying also. Initially unclear as to exact depth of wounds. |
| **R**ecommendation | Assess patient ABCDE and mental health and make a plan | |

Further information if requested by the candidate

*Peter/ Petra* is a 22 year old, who was diagnosed with schizophrenia about 3 years ago. *S/He* has already had a couple of admissions for acute episodes of psychosis, the first of which had been precipitated by an episode of self harm where *s/he* believed that [normal] bowel sounds s/he was hearing was caused by spirits trying to leave *his/her* body. Over the past 3 weeks his CPN has been increasingly concerned that *s/he* is becoming unwell again, but hasn’t been able to arrange an appointment with the consultant yet. His/her parents found *him/her* in the kitchen making lacerations to *his/her* abdomen with a vegetable knife.

Clinical course *{to be given as the simulation progresses}*

This patient has obvious DSH incisions to the anterior abdominal wall. These are long and linear and in keeping with use of a kitchen knife as witnessed by parents. Parents are clearly distressed as this is the 3rd time in 3 years that this same pattern of injury has occurred.

The patient themself is distressed and trying to explain to you that he needs to release the demons inside. *S/He* is clammy and mildly tachycardic but has a normal BP. *S/He* requires a full A to E assessment and for you to sensitively expose his body in order to ensure there are no other wounds hidden by clothing or in high risk areas (neck / axilla / groins) S/He is initially not keen for the wounds to be exposed and appears to be frightened that ‘something’ will come out if you remove the dressing place by the paramedics. Eventually you can persuade the patient to allow this and although there are numerous wounds they do appear to only breach the abdominal soft tissues and subcutaneous fat. The wounds are oozing venous blood which slows easily with pressure alone. They will require closure, you can do this in the A+E, some can be glued and steri-stripped, one deeper wound is gaping a little and will need sutured. The patient is too distressed to allow this initially. You will need to consider whether it is best to sedate this patient to allow wound closure, or to use calming persuasive techniques to allow glue and dressing application only.

Thereafter this patient will require full psychiatric history and the history taken from their family will also be valuable.

|  | Physical health | | | | | **☑** | Mental health | | | | | | **☑** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PRIMARY | Physical assessment looking for organic cause | | A | Airway patent and patient talking clearly  No sign of airway compromise  No sign of tablet residue to lips or powder to nose  Does not smell of alcohol | |  | Mental health primary assessment | **A**gitation/arousal | | | *S/He* has already visibly self harmed, and may have other injuries that are not visible. *S/He* may have taken an overdose already, or swallowed other objects | |  |
| B | Although wounds do reach anterior chest wall at lower marging they are superficial only and no sign of chest injury RR 20 (anxious)  O2 Sats 99% (air) | |  | **E**nvironment | | | There is a risk *s/he* may try to harm himself with objects in the room. *S/He* is at risk of absconding | |  |
| C | Looks clammy initially not clear if this is due to anxiety or blood loss. Pulse 105 regular, BP 130/86 CRT <2 | |  | **I**ntent | | | At this stage *his/her* future plans are unknown, and *s/he* has self-harmed in the immediate past, which is therefore the predictor of the future. It must be assumed the intent to self-harm remains. | |  |
| D | No sign of head injury, patient is alert and fully orientated though actively hallucinating and might initially appeared confused due to this. | |  | **O**bjects | | | Does *s/he* have any possessions with which they could harm *him/herself*. A belt, a knife, a pen | |  |
| E | Wounds to abdominal wall as above. On further exposure there is evidence of old DSH scars to wrists and inner thighs. No other abnormality noted. Apyrexial. | |  | Risk to self?  Risk to others?  Flight risk? | | | Until more facts are known *s/he* has to be considered high risk to *him/herself*, and a flight risk. There is no evidence of being a risk to others at present | |  |
|  | | | | | | | | | | | | |
| Unified Assessment:  Immediate Treatment: Measures to minimise psychiatric or physical risk to patient or others | | Participant may attempt to apply oxygen but this will distress the patient and he will refuse. Patient will require venipuncture for routine bloods, has IV access by paramedic crew. Will try to remove this and requires bandaging protect. May consider IV fluids but BP ok and patient will refuse. Blood Sugar and Temperature to be checked – both will be normal.  ECG will show sinus tachycardia 105 bpm nil else. Patient can be ‘talked down’ but requires constant reassurance. Team may consider mild sedation to allow for wound management. | | | | | | | | | |  |
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| SECONDARY | Focused physical history and secondary examination | **P**roblem | | | Patient reports trying to remove demons from inside (stomach) has used a kitchen knife to incise anterior abdominal wall multiple times |  | Focused conversational psychosocial history and mental state examination | | **SELF HARM** | **S**uicidal thoughts at the time of self-harm | | The intent underpinning self harm needs to be established. Can you establish why *s/he* was cutting himself – to let something out, to remove something or to kill *him/herself*. What happened last time with regards to self harm. *S/He* has a major mental disorder, and may have been responding to hallucinations and delusions, but completed suicide in psychosis is common |  |
| **H**istory of presenting problem | | | Deterioration in mental health over several weeks, family explain this is similar to 2 x previous presentations. |  | **L**ethality of the episode | | Provided *s/he* does not harm himself further, the lethality of the presenting episode is low |  |
| **R**elevant medical history | | | Mild asthma as a child nil else |  | **I**ntent now | | This will depend on *his/her* beliefs at the time of the presenting complaint, and whether *s/he* believes that *s/he* needs to, or wishes to, die. Some patients with psychosis may be suffering from command hallucinations which hugely increases the risk of further attempts and completed suicide |  |
| **A**llergies | | | NKDA |  | **P**rotective factors | | *S/He* responded to medication at the last admission, and was discharged without further thoughts of self harm |  |
| **S**ystems review | | | Normal bowel and bladder function  No other abnormality |  | **A**dverse factors | | *S/He* had not reported their wishes to hurt themselves to *his/her* parents, and was found “by accident”. This is their third episode in three years |  |
| **E**ssential family and social history | | | Lives with parents.  Smoker  Occas alcohol use |  | Demographic and historical factors | | | Young male (if M), with psychosis, previous episodes in short time. *S/He* is a student living with *his/her* parents |  |
| **D**rugs | | | Says none initially then admits to cannabis when asked specifically  Parents unaware |  | Co-morbid mental illness | | | None, but consider potential co-morbid substance misuse |  |
| Top to toe | | | Wounds as described and old scarring  Nil other abnormality |  | Overall risk profile | | | Risk of current episode low to moderate, but as it in the context of a severe mental illness, the longer term risk of completed suicide is high |  |
|  | | | | | | | | | | | |  |
| Emergency physical treatment | Direct pressure to wounds  IV access and bloods taken  Consider for IV fluids (not essential, patient will refuse) | | | |  | Emergency psychiatric management / consider MHA | | The most important task is to establish the motives behind the self harm – in particular if *s/he* wanted to die, or to excise something. Depending on the level of distress, some tranquilisation might be appropriate, though probably oral rather than IM. An urgent decision on necessary levels of observation is required. An assessment under the MHA may be required, with particular consideration of any stated desire to leave, and whether detention under the MHA had been needed on the previous occasion | | | |  |
|  | | | | | | | | | | | | | |
| INITIVE CARE AND DISPOSAL | Disposal | | | | Once wounds closed and dressed appropriately and blood results return as normal this patient may have continued care with the psychiatric team accordingly | | | | | | | |  |
| Reassess risk | | | |  | | | | | | | |  |
| Handover to:   |  | | --- | |  |   including on-going care plan | | | | **S**ituation |  | | | | | | |  |
| **B**ackground |  | | | | | | |  |
| **A**ssessment |  | | | | | | |  |
| **R**ecommendation |  | | | | | | |  |

[Closure] Debrief (15 min)

Using the learning conversation, carry out the debrief of both the technical and non-technical elements of the simulation.

The debrief will be for the team as a whole and should focus on some or all of the following:

* Technical skills guided by the KTPs
* Non-technical skills, including qualities of team membership and leadership:

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| --- | --- |
| Team members | * Clear communication * Respect * Flexibility * Assertiveness * Ability to listen |
| Team leaders | All of the above, plus   * Full overview of all aspects associated with child, parents and team * Prioritises according to KTPs * Summarises and re-evaluates |

* Feedback on Environment, where required

Potential issues that may be raised for this specific simulation

* Difficulty in completing a thorough ABCDE assessment when a patient is distressed and reluctant to allow full external examination.
* Difficulty in assessing blood loss and relation between tachycardia and blood loss and/or patient anxiety.
* Decision making around wound examination, potential depth of wound and whether further exploration is required.
* Superficial wound closure – at times discussing options with patient may be best depending upon capacity.
* Best ways in which to calm patient and deescalate situation whilst simultaneously assessing risk to self and others.
* Decision making around best environment for ongoing care of a patient who has a physical injury but also a significant ongoing mental health presentation.
* History taking from family members who are already distressed.

At the end of the debrief, give the opportunity for candidates to ask questions, answer these and then summarise the key points

Assessment

The simulation is continuously assessed and you should score the lead candidate on the candidate progress log. If there are any candidates where you have serious concern, you should raise this with the course director immediately after the station.

ACTOR BRIEFING

What the candidate is being assessed on

Ability to manage the interaction with a psychotic patient who has self harmed, and in particular to establish motive and future risk by taking an appropriate history

Background

***Location***

Locations vary in accordance with the different specialties of the candidate being assessed.

This will be agreed with the candidate each time the simulation is run.

***Background***

You are a 22 year old university student, studying French, now in your third year. You live at home with your parents. You’ve been finding university increasingly hard because of other factors (in the next paragraph) that have been troubling you. Because of this, you have slowly been losing contact with your friends and spending more time on your own, thinking about these issues. To make matters worse you were admitted to a psychiatric hospital twice in the past couple of years. You were sectioned but can’t recall which section. You don’t drink much alcohol as you don’t like it, but you have been smoking several grams of cannabis each day as you feel it makes you feel “more chilled”.

You don’t have any medical problems and you’ve never been in trouble with the police. You have a student loan of £20,000 which worries you a little, especially if you keep being admitted to hospital and so might not finish your course

***Medication***

You are on medication called Olanzapine, but you don’t take it every day as sometimes you forget and in any case you aren’t sure why you need it. In fact, you can’t quite remember when you last took it, but it was probably only a few days ago, or so

Now

For the past two week, you have been increasingly concerned about noises coming from your abdomen. They are like rumbling sounds. They are worse before meal times and sometimes when you lie down. You think you’ve heard some screams as well, though you aren’t sure where they are coming from. In the news, everything seems to be about wars and unrest, and you think that the noises, rumblings and screams you are hearing are spirits of those killed in the war hiding in your body and now trying to get out. You have no idea how they got there, but you think they took refuge in you because they sensed that in the past few years you have worried a lot about the state of the world and the future of mankind. You don’t have any other voices or experiences (you might be asked a range of questions, to which you can say no).

This is very similar to how you felt before your previous admission, but you had thought matters had been sorted out by the time you had been discharged

The spirits are still there, but you would be willing to come into hospital if that will result in the spirits being removed and allowed to go and rest in peace. You agree not to try and remove them yourself for the time being.

ICE (Ideas, Concerns, Expectations)

***Thoughts and concerns***

You want reassurance that the hospital staff will be able to help remove the spirits, and in particular you don’t want the spirits to suffer any more as they suffered enough before coming into your body for refuge

Opening statement

It’s just not right you know – you need to help me get them out

Emotional behaviours/statements/questions

You are generally calm, and worried for the spirits. You don’t want to die, but you don’t want them to suffer