# SIMULATION CASE OD\_SH\_4

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| **Learning outcomes:**  By the end of this simulation the candidates will:   * Be able to carry out a psychosocial assessment on an individual with a history of multiple self harm. * Be able to carry out a risk assessment in the context of multiple self harm * Develop a management plan which takes account of the patient’s needs and her frequent attendance at the ED.   Simulation focus: Parallel management of mental and physical issues related to self harm |

**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:

* Ensure bandage and dressing available

[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 47 year old *m/f* presented with a self inflicted wound to their left forearm. | |
| **B**ackground | *S/he* has a long history of self harm (mainly cutting) but has also taken life threatening overdoses in the past. *S/he* drinks alcohol regularly and has cut *his/her* left forearm tonight as *s/he* is feeling bad. | |
| **A**ssessment | A | Patent airway. Talking |
| B | Chest Clear RR15 SpO2 99% |
| C | HR 87 BP 130/80  HS 1+2+0 No murmurs  Warm well perfused |
| D | GCS 15. PERLA 4mm  Moving all 4 limbs |
| E | 6cm wound to left forearm, but able to move all digits and no active arterial spurting. Oozing.. BM 9.4 T37.2 |
| **R**ecommendation | Please assess this 47 year old persons injury and mental health. | |

Further information if requested by the candidate

Tamsin/Tommy, a 47 year old *m/f* has presented with a self-inflicted wound to their left forearm. *S/he* has had alcohol and is reportedly feeling very bad, but is currently willing to stay for assessment.

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

The wound will continue to ooze until a dressing is applied. The wound will need to be stitched after irrigation and confirmation that there is no neurovascular compromise from the injury.

*S/he* has a long history of self harm (mainly cutting) but has also taken life threatening overdoses in the past. The last near-fatal self harm episode was 2 years in the context of *his/her* partner dying by suicide. *His/Her* arms and legs are covered with old scarring. The circumstances of this episode are that *s/he* has been referred for dialectical behavior therapy at a local psychotherapy centre, but found out last week, that it will be six months before any of this treatment can be offered *him/her*. *S/he* lives alone and finds it difficult to cope by him/herself. *S/he* has a one bedroomed flat in a housing association block of flats about one mile from the hospital. *S/he* is a frequent attender at the ED because of self harm or alcohol misuse problems.

*S/he* describes drinking heavily alone in the hours leading up to the self harm and then using a razor blade to make a large incision, through old scar tissue, across her left arm above the wrist. The wound is deep and about 6 inches long. It is possible *s/he* has damaged a tendon, but *s/he* has not been examined properly. *S/he* is intoxicated but is able to sit upright and stay awake. *S/he* is fully orientated. *S/he* says *s/he* cut him/herself out of desperation and to stop feeling bad. *S/he* is over weight, has type 2 diabetes for which *s/he* takes oral hypoglycaemics in an erratic fashion. *His/her* diabetes is poorly controlled although *s/he* has no overt complications at present.

*S/he* will require a psychosocial assessment and ongoing care plan to de-escalate the frequent ED DSH episodes.

|  | Physical health | | | | | **☑** | Mental health | | | | | | **☑** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PRIMARY | Physical assessment looking for organic cause | | A | Patent airway. Talking | |  | AEIO primary assessment | **A**gitation/arousal | | | *S/he* has a moderate health need, which includes assessment and treatment of her self harm, and assessment of their diabetes. | |  |
| B | Chest Clear RR15 SpO2 99% | |  | **E**nvironment | | | *S/he* is waiting in the ED waiting area and will stay for treatment | |  |
| C | HR 87 BP 130/80  HS 1+2+0 No murmurs  Warm well perfused | |  | **I**ntent | | | No. There was no suicidal intent, although *s/he* was distressed at the time. | |  |
| D | GCS 15. PERLA 4mm  Moving all 4 limbs | |  | **O**bjects | | | We do not know if *s/he* has more razor blades on *him/her* or any other item that could be used to self harm. *S/he* has never previously harmed him/herself whilst in the ED. | |  |
| E | 6cm wound to left forearm, but able to move all digits and no active arterial spurting. Oozing.. BM 9.4 T37.2 | |  | Risk to self?  Risk to others?  Flight risk? | | | There is no major risk to self, whilst in the ED. There is no risk to others and the risk of flight is also low. | |  |
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| Unified Assessment  Immediate Treatment: Measures to minimise psychiatric or physical risk to patient or others | | No immediate psychiatric measures required.  Dressing to wound | | | | | | | | | |  |
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| SECONDARY | Focused physical history and secondary examination | **P**roblem | | | Left forearm wound self inflicted associated with ingestion of alcohol |  | Focused conversational psychosocial history and mental state examination | | **SELF HARM** | **S**uicidal thoughts at the time of self-harm | | No-wanted to stop pain and distress. |  |
| **H**istory of presenting problem | | | Cutting episode 1 hour ago |  | **L**ethality of the episode | | Low lethality |  |
| **R**elevant medical history | | | NIDDM (Type 2) |  | **I**ntent now | | No current suicidal intent |  |
| **A**llergies | | | Nil |  | **P**rotective factors | | No protective factors other than the offer of psychotherapy in six months and stable accommodation |  |
| **S**ystems review | | | Overweight.  Painful knees and ankles. Smells of alcohol |  | **A**dverse factors | | Ongoing alcohol misuse  Social isolation  No job and has never worked  Chronic physical illness  On-going emotional and psychological distress |  |
| **E**ssential family and social history | | | Previously in care  Missed lots of school  Incomplete vaccinations |  | Demographic and historical factors | | | Multiple prior self harm. Most is cutting but also several serious ODs. |  |
| **D**rugs | | | *Quetiapine 25 mg tds*  *Gliclazide 40mg bd* |  | Co-morbid mental illness | | | Likelihood of borderline personality disorder |  |
| Top to toe | | | Multiple old self harm cutting mark scars on abdomen, upper and lower limbs |  | Overall risk profile | | | Low risk of leaving the department and low risk of suicide in the immediate future, but high risk of suicide in the long term. On going psychosocial distress. High risk of further self harm. |  |
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| Emergency physical treatment | Ensure no active haemorrhage  Irrigate wounds  Explore wounds to identify if any neurovascular or tendon deficit – if none present wound needs to be closed – if deep will require sutures and local anaesthetic  Tetanus status | | | |  | Emergency psychiatric management / consider MHA | | This patient will agree to have investigations and treatment. *S/he* is distressed, but will wait for a psychosocial assessment from the liaison mental health team. *S/he* is too intoxicated at present for this. Although *s/he* is orientated, *s/he* is drowsy and keeps falling asleep in the waiting room. It is difficult to assess risk when people are in this state. *S/he* does not require detention under the MHA and does not fit threshold under the Act for detention. Liaison mental health should provide a preliminary assessment and contact whilst *s/he* is waiting for treatment to *his/her* arm. It is important *s/he* is treated with respect and kindness. | | | |  |
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| INITIVE CARE AND DISPOSAL | Disposal | | | | Following treatment for her laceration she will require psychosocial assessment. | | | | | | | |  |
| Reassess risk | | | | The mental health liaison team will carry out a full psychosocial assessment to assess on-going risk but also to start to plan on –going care for her to try to de-escalate the self harm and ED attendance. | | | | | | | |  |
| Handover to:   |  | | --- | | Mental health liason team |   including on-going care plan | | | | **S**ituation | Attendance for self harm | | | | | | |  |
| **B**ackground | Long history of prior self harm in the context of someone with chronic life problems and a diagnosis of borderline personality disorder. *His/her* episodes of self harm and attendance at the ED have been escalating in the last few weeks. | | | | | | |  |
| **A**ssessment | *S/he* is not suffering from a depressive disorder, but has ongoing alcohol misuse, psychosocial problems, poorly controlled diabetes type 2, social isolation and is at high risk of further self harm and further attendance at ED. | | | | | | |  |
| **R**ecommendation | This patient is clearly finding it difficult to cope at present and is a frequent attender at the ED. Following psychiatric assessment, *s/he* will probably not require in-patient treatment, but their attendances and the ED and SH episodes show an escalation in the last few weeks. *S/he* will require some additional input from mental health services or third sector services in the short term, before *s/he* can start psychotherapy. This may take the form of admission to a home treatment service or referral to a crisis third sector service or referral for brief psychotherapy if there is a self harm psychotherapy service. This patient is at very high risk of eventual suicide, so *his/her* presentations must be taken seriously. Following treatment in the ED, unless *s/he* needs surgery to her arm, the liaison mental health team should take over her care and arrange discharge. In some centres, *his/her* frequent attendance would trigger a case management meeting which should include mental health staff, ED staff and GP, to try to arrange more co-ordinated care for *him/her.* | | | | | | |  |

[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

* Staff, patient and public safety - consideration of patient being in possession of sharps and potential weapons
* The suicide risk in patients who self harm
* Protective factors
* Future positivity planning
* Development of individual patient risk management plans – red – yellow green traffic light scheme

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

Assessment, management planning and follow-up of patient with self harm.

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***

Tamsin/Tommy, a 47 year old patient who has presented with self laceration. You have a long history of self harm (mainly cutting) but have also taken life threatening overdoses in the past. The last near-fatal self harm episode was 2 years ago following the death of your partner by suicide. This followed a massive argument you had had with them. You had found out he had been seeing someone else and you asked them to leave. *S/he* hung himself in your flat whilst you were out at the shops. You found his body. A couple of weeks later you took a massive overdose of aspirin and were admitted to the Intensive Care Unit. After this you were admitted to a psychiatric bed under the mental health act for 2 weeks but you were then discharged. You didn’t think it helped. You take quetiapine on a regular basis which calms you down. You have been assessed for psychotherapy and you are waiting for treatment. It’s a day group you will be joining but you are fed up to learn it’s going to be at least six months. Your sleep is not too bad but you use alcohol to help you sleep. You are overweight but have pain in your back and legs and knees, so you can’t exercise.

You live alone and finds it difficult to cope by yourself. You have a one bedroomed flat in a housing association block of flats about one mile from the hospital. It’s ok but you don’t have any friends and people tend to ignore you. You end up in ED quite a bit either because you cut yourself or drink too much and have accidents. You have been cutting since you were 12 years old. You find it helps to relieve tension. You do not do it to kill yourself. If you want to kill yourself, you take tablets.

On this occasion, you became really low because it is the anniversary of your partners suicide. Things have been building for you over the last few weeks. You are also frightened that your benefits will be cut and you have an assessment next week, which you are dreading.

You are a bit tired but the alcohol is wearing off. You had drunk a large bottle of cider prior to cutting yourself. You are fully orientated. Your diabetes is poorly controlled although you have no overt complications at present. You are not under any formal psychiatric care at present, other than the psychotherapy unit, you are on a waiting list but you are not receiving any treatment. You drink 1-3 bottles of cider per day. You smoke 40 roll ups a day. You also use cannabis on an occasional basis. You have never been able to work due to a combination of mental health problems and a bad back. You do not wish to discuss your childhood. Just block any questions about this. You are not currently suicidal. You are willing to wait to be assessed. You are worried about going home tonight as you will be in your flat alone, where your partner killed them self. You have never been violent towards anyone else. You lose your temper a lot and you feel everyone has let you down. You think the staff in ED hate you. You can’t remember how many times you have been to the ED in the last few months.

You are not overtly anxious or depressed. You are a bit irritable and sleepy.

***Medication***

*Quetiapine 25 mg tds*

*Gliclazide 40mg bd*

Now

You are worried you may have damaged a tendon. You will wait for an assessment. It is better to be in ED than alone in your room.

ICE (Ideas, Concerns, Expectations)

***Thoughts and concerns***

You are preoccupied with the anniversary of your boyfriend’s death, and your assessment next week regarding your benefits.

Opening statement

Wait for them to ask you something. Just say you think you need more help.

Emotional behaviours/statements/questions

***If asked directly:***

Say you wanted to get some peace from the distress and cutting takes away the tension.

***Possible statements:***

I need some help and all I get is just being fobbed off all the time.

Additional notes/guidance

***Ability and skills:***

You have obvious pain in your ankles and knees and are overweight.