# DEMO 2 – BEHAVIOUR

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| **Key Teaching Objectives**To demonstrate a confusion and aggression simulation and emphasise the following:* The use of the combined ABCD/AEIO Unified assessment
* The management of how to assess and manage aggression in Emergency Department settings
* Teamwork
* Supportive critiquing
* Non-technical skills feedback
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ENVIRONMENT FOR DEMONSTRATION

Equipment required

See generic equipment list

Environment

The room should be large enough to accommodate the instructors and equipment and ensure that the candidates have a good view. The instructors should not obstruct the view.

Personnel required

* Instructor 1 to lead demonstration and overall feedback
* Instructor 2 to lead simulation and feedback on simulation
* Instructor 3 - Team leader/candidate
* Instructor 4 - Team member/candidate
* Actor/patient

SET FOR DEMONSTRATION

1. **Instructor 1** introduces the format (including roles) and objectives of the demonstration.
2. **Instructor 2** describes the simulation to the instructor who is the team leader.

SIMULATION DEMONSTRATION

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| **Learning outcomes:**By the end of this simulation the candidates will:* Understand how to assess and manage aggression in Emergency Department settings

**Simulation focus:** Management of Substance Misuse, De-escalation aggression; Communication |

**Introduction [Environment and Set]**

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:

* Nil equipment
* Setup should be Emergency Department seclusion suite.
1. **[Set] /**[Dialogue] Simulation

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

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| **S**ituation | It is Saturday evening in the Emergency Department. You have been asked to assess a 23 year old patient presenting with acute agitation, aggression and paranoia. S/he has been brought by the police into the seclusion suite of the emergency department. In the seclusion suite the patient is muttering to him/herself and looking in a hypervigilant way at the door and any movement. |
| **B**ackground | As the history above |
| **A**ssessment | A | No concerns with Airway |
| B | No concerns with Respiratory system. RR 18. Chest clear. SpO2 97% |
| C | Heart sounds I+II+0. HR 105. ECG Nil acute.  |
| D | AVPU – Voice. GCS 14/15 (confusion) |
| E | Glucose 5.2. Urine Drug Screen – negative for benzos, opioids, cannabinoids |
| **R**ecommendation | Please assess and manage this patient |

**Further information if requested by the candidate**

You have been asked to see *Mr/Mrs*. Jean Smith (23 years old). *Mr/Mrs* Jean Smith has been brought into the ED by the police with their friend who states that *Mr/Mrs* Smith is acting “crazy” and is scaring everyone. *Mr/Mrs* Smith’s friend states they were out drinking (approximately 5 pints of lager) and Jean suddenly “flipped” screaming that the government was after them and they had installed a homing device in *his/her* head so they could be transported to Russia. When Jeans friends tried to speak to *him/her* they attempted to punch them and then ran off down the street. S/he was then apprehended by the police who were out on patrol. Upon further questioning Jeans friend admits that Jean may have bought some drugs and it may have been ‘Spice’.

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

Collateral history – Jean’s friend is extremely worried, he says this is completely unlike *him/her*, Jean is studying for an electronical engineering degree at the university and is usually conscientious and hard working. S/he is doing well on his course. Jeans friend states he has never heard Jean speak of mental illness, although s/he does not know for sure. Jean has a long term partner but they have been taken home by friends as they were so distressed. S/He knows that Jean has tried ‘weed’ “a few times in the past” but all that happened was they got the giggles and felt very hungry. He has never seen anything like this.

Jeans friend wants to know if Jean will be “sectioned” and if s/he will be thrown off the course or lose their mind.

|  | Physical health | **☑** | Mental health | **☑** |
| --- | --- | --- | --- | --- |
| PRIMARY | Physical assessment looking for organic cause | A | Talking aggressively at a rapid rate. |  | Mental health primary assessment | **A**gitaiton/arousal  | High level of agitation |  |
| B | Chest clear RR 18 SpO2 97% |  | **E**nvironment | Low |  |
| C | HR135 BP 138/88 |  | **I**ntent | High |  |
| D | AVPU=A GCS= 14/15 E4V4M6 Pupils dilated. Attempting to point aggressively at people walking past the door |  | **O**bjects  | Low |  |
| E | BM 5.1 Temp 37.4Abdo –soft. No signs of Head Injury |  | Risk to self?Risk to others?Flight risk? | YesYesYes (in confused state) |  |
|  |
| Unified assessment: Immediate Treatment: Measures to minimise psychiatric or physical risk to patient or others | Medical assessment and attempt to establish substances ingested and any other underlying causeExclude alcohol withdrawal or deliriumOrientation to surroundings, ensure nothing in environment that could be used as weaponOne to one observationMedication for sedation / reduction of agitationMental Health Act Assessment |  |
|  |
| SECONDARY | Focused physical history and secondary examination | **P**roblem | Acute behavioural disturbance |  | Focused conversational psychosocial history and mental state examination | Demographic and historical factors | Lives in student flat, previous cannabis use |  |
| **H**istory of presenting problem | Well prior to night out |  | Co-morbid mental illness | No known mental illnesses No psychosis, schizophrenia or Bipolar Affective Disorder in history |  |
| **R**elevant medical history | Hayfever |  | Overall risk profile | High level of arousal and high intent indicates >4 staff |  |
| **A**llergies | Penicillin |  |  |  |  |
| **S**ystems review | Palpitations. Feels sweaty and nauseous  |  |  |  |  |
| **E**ssential family and social history | No FHx of note.Father retired chemist. Mother librarian. |  |  |  |  |
| **D**rugs | Antihistamines for hayfever |  |  |  |  |
| Top to toe | Sweaty, tachycardic, no signs of injury apart from a painful knuckle on his right hand where s/he punched a door  |  |  |  |  |
|  |  |
| Emergency physical treatment | Check BMExclude head injuryCheck U+Es, LFTs, Coag, VBG, GlXRay right hand to confirm no fractured metacarpal (Boxer’s fracture)ECG – sinus tachycardia only.Medication for sedation / reduction of agitationRegular neuro observations – half hourly initially |  | Emergency psychiatric management / consider MHA | One to one observation (requires >4 staff )Medication for sedation / reduction of agitationExclusion of other causes of agitation and treatment of ingested substance as necessary.Mental Health Act to be considered |  |
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| INITIVE CARE AND DISPOSAL | Disposal | If cleared from a medical perspective – handover likely to be detention under Mental Health Act for assessment |  |
| Reassess risk |  |  |
| Handover to:

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| Mental Health Team |

including on-going care plan | **S**ituation | *Mr/Mrs* Smith is a 23 year old who has consumed alcohol and unknown drugs possibly spice |  |
| **B**ackground | Normally well with only antihistamines for hay fever. While out with friends has ‘flipped’ and become agitated and paranoid. *S/he* has definitely consumed alcohol and also possibly ‘spice’. *S/he* has no mental health history and has occaisionally taken cannabis. |  |
| **A**ssessment | Apart from his tachycardia, sweating and being flushed there is nil of note on physical exam, but *s/he* is agitated, paranoid and hyperactive. Temperature and blood sugar are normal and U+Es, LFTs, FBC, Coag and VBG are unremarkable with a sinus tachycardia on his ECG. *S/he* refuses to be admitted to hospital and appears a risk to themselves.  |  |
| **R**ecommendation | Consider sectioning under mental health act |  |

1. Instructor 2 terminates demonstration and …

[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
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| 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
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* Feedback on Environment, where required

Potential issues that may be raised for this specific simulation

* Consideration of both medical and physical causes
* Reduction of agitation if possible through use of clear instruction and communication. However in this case there should be strong consideration for use of sedation or rapid tranquilization.
* Treatment of, or exclusion of, alternative underlying causes
* Attempting to ascertain type of ingested substance from patient, collateral sources
* Reassurance of friend (“John has gone crazy” “he’ll be thrown out of university”). This is important as the friend may be reluctant to give exact details of what was taken if he also fears expulsion. Emphasised that health of John is priority.
* Reducing risk to others from agitated patient

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

CLOSURE OF DEMONSTRATION

1. Instructor 1 then invites the course participants to ask questions, answer these and then summarise key points.

ACTOR BRIEFING

What the candidate is being assessed on

Ability to make an assessment of a young patient who is suspected of illicit substance intoxication

This will include consideration of both medical and psychiatric causes, their appropriate treatments and follow-up (both in immediate future and longer term).

Client will be assessed on their interaction with the patient, ensuring the environment is safe, using clear instructions. Client will also be assessed on their ability to keep themselves safe, being aware of dangers and escape routes

Client will display knowledge of differential diagnoses of acute agitation and treatment

Client will display knowledge of management of aggression including communication, environmental and medication techniques.

Client will have a clear plan for disposal of patient.

Background

***Location***

Emergency Department

***Background***

You are Mr/Mrs. Jean Smith (23 years old). You were having a very good night with your friends until they betrayed you to the Russian government and allowed that government to place a homing chip in your head. It’s giving you very bad headaches and you know that you will need to remove it as soon as possible, possibly by pulling it out of your ear. You are willing to speak to hospital staff, especially as they might be able to help you surgically remove the chip. To that end you would like to see a surgeon and are not pleased to see other doctors especially psychiatry. You were very angry with your friends earlier due to their part in the Russian takeover and wanted to punch them, but you don’t want to do this anymore and actually feel regretful as it’s not their fault, they are being controlled by chips too.

You remember drinking alcohol and taking some drugs (you are not sure what) but don’t think it is anything to do with this.

This has never happened to you before, but then the Russians have never taken over the UK before. You have never seen a psychiatrist in your life.

***Medication***

Antihistamines for hay fever

Now

As above

ICE (Ideas, Concerns, Expectations)

 ***Thoughts and concerns***

You want to find out how to get the chip out of your head, if they won’t help you, you will do it yourself.

With every passing minute the Russians will have taken more control, so there is no time to waste.

You are worried about your girlfriend as you tried to hit her earlier and now want to apologise.

You are worried the pain in your head won’t stop

Opening statement

“I know what’s happening, it’s all very clear, they’ve managed to get me and now they will get you”

Emotional behaviours/statements/questions

***If asked directly:***

If asked about drug use admit you took something tonight and it might have been Spice. You have never taken it before. You have smoked cannabis before, 5 times at most. Cannabis has never made you feel like this.

You binge drink most weekends but have never been hospitalised secondary to alcohol or experienced withdrawals. You don’t think you drink that much more than your friends.

You are worried about your university degree, but only in the context all the courses will be in Russian

You will ask for assistance with removal of the chip by the surgeons but will remain guarded about trying to remove it yourself unless asked twice by the interviewer.

If the interviewer is not empathetic or is abrupt you will become angry and agitated and you will accuse them of being a Russian spy.

***Possible statements:***

I don’t need a psychiatrist, I need a surgeon

I can feel the transmissions going from my head to Russia

Dos and Don’ts

Do – be paranoid and suspicious. Everybody else is in on this, but you now know that

Don’t – no physical violence but can be intimidating if the interview is going badly

Additional notes/guidance

Expect client to raise admission to hospital. Refuse.

***Ability and skills:***

Interview and Communication skills required.