# SIMULATION CASE – AD\_1

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| **Learning outcomes:**  By the end of this simulation the candidates will:   * Work through a systematic, integrated (medical and psychiatric) assessment of the apparently drunk * Practice techniques of engaging with a confused, aggressive patient * Respond acutely to and contingency plan for acute behavioural disturbance using pharmacological and non-pharmacological methods   Simulation focus: Rapid, systematic assessment of medical and psychiatric aspects of presumed intoxication and development of an effective acute response to behavioural disturbance in this patient group |

**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:

* Oxygen mask, Pulse Oximeter, BP cuff, Stethoscope, pen torch
* Ancillary information – investigation results

[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 53 year old m/f with a history of epilepsy and depression refusing investigations. | |
| **B**ackground | Found unconscious and vomited twice in last hour. Involved in multiple fights outside a bar. Appears intoxicated and smells of alcohol. | |
| **A**ssessment | A | Patent. Moving head freely with no apparent difficulty / neck pain. |
| B | RR 18, SpO2 98% on room air, chest clear with good expansion bilaterally. |
| C | BP 160/88, HR 102bpm, cap refill <2 secs, Heart sounds i+ii+0 |
| D | Moving all 4 limbs. A to V on AVPU scale. Couldn’t co-operate with motor section of GCS. Couldn’t get near him with a pen torch or glucometer. |
| E | Refused examination – wants to leave. Smells strongly of alcohol. |
| **R**ecommendation | Triage would like a joint ED/mental health assessment if possible | |

Further information if requested by the candidate

You have been asked to see Stephen/Stephanie Gorman, 53 years old, history of epilepsy and depression. police are in attendance. S/he was found unconscious outside a local bar where a brawl involving 15-20 people had broken out. Witness accounts suggest s/he assaulted two people and police are considering pressing charges. Vomited x 2 since regaining consciousness. S/he presents as intoxicated with slurred speech, unsteady gait and smells strongly of alcohol. Currently refusing further assessment and wants to leave.

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

* As candidate attempts to introduce self and team, patient becomes verbally abusive and refuses point blank to engage. Wishes to leave hospital. Attempts to get up and leave. Will not be persuaded to stay.
* Restraint and rapid tranquilisation are necessary. If candidate does not suggest this, prompt. Then inform candidate patient was successfully restrained and given medication (restraint manouvres beyond scope of this course currently). Patient now allows assessment to proceed.
* Stephen/Stephanie initially presents as agitated and refuses all further input. *S/he* attempts to leave. Attempts to verbally de-escalate and persuade him to stay are unsuccessful. The team decide to restrain and administer rapid tranquilisation. Patient is then settled and engages with the rest of the assessment.
* Medical and psychiatric assessments take place – deliver relevant information as scenario proceeds.
* Deliver ancillary information (test results) after completion of medical and psychiatric assessments.
* Stephen has a head injury and requires admission for overnight observation. There are multiple risks that need to be thought through and plans need to be put in place

|  | Physical health | | | | | **☑** | Mental health | | | | | | **☑** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PRIMARY | Physical assessment looking for organic cause | | A | Patent. Moving head freely | |  | Mental health primary assessment | **A**gitation/arousal | | | Agitated; requires physical health assessment as possible head injury | |  |
| B | RR 20, Sats 98% on room air, chest clear, good, equal expansion | |  | **E**nvironment | | | Maximize safety; remove objects that could be used to harm others | |  |
| C | Warm peripheries, cap refill <2 secs. Sweaty. HR 102bpm, BP 158/92. HS I+II+0. | |  | **I**ntent | | | Risk of harm to others identified | |  |
| D | Fluctuating alertness. GCS 13/15 (E4, V4, M5). No neck stiffness, moving all 4 limbs. Refuses pen torch for pupils but eventually allows. Glucose 3.1. | |  | **O**bjects | | | No risks identified | |  |
| E | Temperature 37.3C. No rashes, no limb or torso injuries. Acutely tender - R posterior aspect of scalp. | |  | Risk to self?  Risk to others?  Flight risk? | | | * Risk to self :history of depression but nothing in current presentation to suggest immediate risk of self harm. * Risk to others: recently assaultative and may face police charges for violence towards others. Get collateral from police, including PNC. Remove unnecessary equipment that could be used to harm others during an assault. Prescription for rapid tranquilisation should be written up and plan for restraint (if necessary) agreed with team members. * Refusal of investigations and/or treatment: Focused assessment of capacity should take place. Agreement in advance that there is an imperative to investigate further to exclude serious injuries (head trauma, seizures). * Absconsion risk: confirm options for 1:1 observation if this risk escalates. Again, a capacity assessment should take place for reasons outlined above. | |  |
|  | | | | | | | | | | | | |
| Unified assessment:  Immediate Treatment: Measures to minimise psychiatric or physical risk to patient or others | | * Assessment should occur within 15 minutes of arrival * Confirm blood glucose OK * If decision for rapid iv tranqulisation need resus equipment immediately to hand including BVM and guedel airway * CT scan within 1 hour if signs or history of HI:-   -GCS <13 on initial assessment in the ED  -GCS<15 at 2h after injury on assessment in ED  -suspected open or depressed skull fracture  -signs of basal skull fracture  -post-traumatic seizure  -focal neurological deficit  -more than 1 episode of vomiting   * Ongoing neurological observations [CG 176 Head injury early management] half hourly until GCS15 * Check U+Es, FBC, LFTS * ECG | | | | | | * Safety checks in immediate environment, rapid tranquilisation to be written up and identification of team members who are capable and willing to engage in restraint * Capacity assessment and prioritization of essential investigations and interventions * Capacity assessment and confirmation of provision for 1:1 observations (nursing team, security). Confirmation of whether reasonable force can be used to prevent patient from leaving the hospital (if potentially life threatening condition then yes) | | | |  |
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| SECONDARY | Focused physical history and secondary examination | **P**roblem | | | Confused, unsteady on feet, witnessed assault - ?possible head injury. ?Intoxicated with alcohol |  | Focused conversational psychosocial history and mental state examination | | **ASSESSMENT OF ALCOHOL USE** | Amount, frequency and duration of current pattern?  Dependence criteria met? | |  |  |
| **H**istory of presenting problem | | | As above |  | Impact on work, relationships, finances, police involvement | |  |  |
| **R**elevant medical history | | | Epilepsy  Depression |  | Previous detoxification? Longest abstinence? | |  |  |
| **A**llergies | | | None known |  | Willingness to receive help? | |  |  |
| **S**ystems review | | | Nauseated otherwise unremarkable |  | Barriers to engaging with interventions | |  |  |
| **E**ssential family and social history | | | None known |  | Confusion screen | | | COMA CHAMP  **C**onscious level – GCS 13/AVPU. Any fluctuations?  **O**rientation in time and place - disoriented  **M**emory (3 words or name and address – immediate and after short delay) – forgets after delay  **A**ttention - MOYB, WORLD, Serial subtractions – cannot do  **C**ognitive tests – not appropriate at this stage  **H**allucinations - no  **A**ffective state - mood, energy, racing thoughts, new plans or projects (normal)  **M**otor – cerebellar ataxia  **P**aranoia and other psychotic symptoms – paranoid, a bit combative. No other sx |  |
| **D**rugs | | | Fluoxetine 20mg OD  Sodium Valproate 800mg BD |  | Co-morbid mental illness | | | Depression |  |
| Top to toe | | | Abdominal examination: unremarkable  Full neurological examination: cerebellar ataxia, unsteady gait but no other obvious neurological signs. Tender scalp |  | Overall risk profile | | | As primary AEIO |  |
|  | | | | | | | | | | | |  |
| Emergency physical treatment | * Assessment should occur within 15 minutes of arrival * Confirm blood glucose OK * If decision for rapid iv tranqulisation need resus equipment immediately to hand including BVM and guedel airway * CT scan within 1 hour if signs or history of HI:-   -GCS <13 on initial assessment in the ED  -GCS<15 at 2h after injury on assessment in ED  -suspected open or depressed skull fracture  -signs of basal skull fracture  -post-traumatic seizure  -focal neurological deficit  -more than 1 episode of vomiting   * Ongoing neuro observations [ref CG176 head injury early management] half hourly until GCS15 * Check U+Es, FBC, LFTS * ECG * Give pabrinex, consider dextrose if blood glucose low * Watch for alcohol withdrawal | | | |  | Emergency psychiatric management / consider MHA | | **Risks** to self and others – denies thoughts or plans to harm self or others but recently assaultative. Ongoing risk of harm to others.  **Capacity** – ambivalent about staying in hospital. Lacks capacity. | | | |  |
|  | | | | | | | | | | | | | |
| DEFINITIVE CARE AND DISPOSAL | Disposal | | | | Give ancillary information sheets for investigation results  Impression: traumatic brain injury and alcohol intoxication – requires further observation.  CROC - Admit with mental health liaison team input | | | | | | | |  |
| Reassess risk | | | | 1.To self: low. No evidence found of low mood or recent self harming behaviours. Risk of accidental harm ongoing as intoxicated.  2.To others: ongoing. Ensure pharmacological aspects of management plan in place on receiving ward to reduce risk. Emergency contingency planning – rapid tranquilisation written up along with details of who to contact in/out of hours should this prove ineffective (Psychiatry CT/SpR).  Other:  3.Ongoing risk of refusal to engage with treatment and/or abscond  4.\*\*RISK OF ALCOHOL WITHDRAWAL\*\* - implement CIWA-Ar and Librium regimen if necessary  5. Risk of seizures (Alcohol, brain injury)  6. Risk of evolving intracranial bleed- neuro observations necessary | | | | | | | |  |
| Handover to:   |  | | --- | |  |   including on-going care plan | | | | **S**ituation | 53 year old patient requiring admission. Working diagnosis of traumatic brain injury and alcohol intoxication. | | | | | | |  |
| **B**ackground | Epilepsy and depression. On Lamotrigine and citalopram. Found unconscious outside a bar after assaulting 2 people. Required rapid tranquilisation in ED as refusing input and attempting to abscond. Good response to 2mg Lorazepam IV | | | | | | |  |
| **A**ssessment | ABC stable. GCS 15/ AVPU – A to V, confused, ataxic. Blood glucose 3.1  Focal scalp tenderness. CT shows linear skull fracture and small R temporal pole haemorrhagic contusion (likely contracoup injury) | | | | | | |  |
| **R**ecommendation | Requires neuro observations and CIWA-Ar alcohol withdrawal scale  Currently lacks capacity to make informed decisions regarding investigation, and treatment. PRN Rapid tranquilisation prescribed. May require regular if persistently agitated. Contact details for psychiatry on call if advice required in/out of hours  May try to abscond when more alert – 1:1 observations recommended.  Police will want to interview at some point – not fit at present as still quite confused | | | | | | |  |

ANCILLARY INFORMATION:

Investigations: (Give to doctors to analyse. Nurses have the option to analyse or to ask instructor for results)

Hb 102

MCV 105

WCC 5.7

Neut 4.2

Lymph 1.6

Plt 396

Urea 8.1

Creatinine 103

Sodium 137

Potassium 4.8

Calcium 2.18

Bilirubin 14

ALT 118

ALP 189

GGT 143

Prothrombin time 13 secs

Glucose – 3.2

CRP - 12

ECG - sinus tachycardia

Urine dip – protein+

Urine drug screen Cannabis +ve, Cocaine +ve, benzodiazepine +ve

ECG - sinus tachycardia

CT head – There is a linear skull fracture of the posterior aspect of the right parietal bone. There is a haemorrhagic contusion within the right temporal pole consistent with an associated contre-coup injury. No other bony injury or parenchymal damage.

[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

* Making effective use of the team when engaging with an acutely agitated patient
* Prioritising salient aspects of the presentation – medical, psychiatric or both
* The Mental Capacity act
* Rapid tranqulisation risks and mitigation measures

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

1. Rapid response and effective deployment of the team to manage acute behavioural disturbance in a patient who is both intoxicated and medically unwell.

2. Carrying out a systematic assessment to confirm or exclude serious injury

3. Carrying out a systematic psychiatric assessment and comprehensive risk assessment

*Notes:*

You are very drunk and have a head injury, (you were hit over the back of the head with an iron bar but you don’t remember this – you have a vague recollection of someone squaring up to you and you are determined to find them and finish what you both started). Your speech is slurred, you drift in and out of sleep. You are a bit confused – can’t remember where you are or why you are here. You are rude and have no interest in what these people have to say. You know what’s best. You just want to go and kick that persons head in.

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***

Your name is Stephen/Stephanie Gorman. You are 53 years old. Since you lost your job six months ago your alcohol intake has increased such that you binge drink every day. When you drink you can become violent. Tonight you were out at a local bar and a fight broke out. You joined in and got some good punches in. It felt good. It was a laugh. The next thing you know you are lying on the side of the road and an ambulance crew are talking to you. You have a splitting headache and you feel sick, in fact you feel really rough. You have thrown up twice. You are on a bed somewhere A woman starts to check you over, saying she is worried about you. Is she a receptionist? You are just fine. You just want to go. It must have been that person who did this. You want to get them. Now.

***Medication***

*None*

Now

The candidates introduce themselves to you. You tell them you just want to go. You have no interest in what they say. You are rude to them, telling them to get out of your face or they will regret it. They try to tell you why they want you to stay but you aren’t interested. You keep trying to get up and leave but you are unsteady on your feet. They try to touch you but you swear at them and fight them off.

The candidate should suggest the team uses restraint techniques and rapid tranquilisation. If not the instructor will prompt them. If they offer you a tablet, swear at them and refuse, try to leave again. You need an injection to settle things down.

Restraint is not taught on this course. After it is suggested, the scenario will proceed to you feeling more settled and amenable so the examination can proceed

**THE EXAMINATION**

Airway – the candidate will assess this non invasively by encouraging you to talk

Breathing – the candidate should ask if its okay to examine you and talk you through what they are doing. They will want to put a probe on your finger and use a stethoscope. If they explain what these things are for, let them. If not, fight them off. Carry on chatting in a slurred ramble whilst they have the stethoscope on – this will encourage the candidate to think of creative ways to get you to be quiet for a few seconds so they can listen to your breathing. Ideally they should ask you to breathe in and out

Circulation – if B has proceeded, Circulation does not offer any surprises so you co-operate. Again they will need to be creative to stop you talking.

Disability – you might be asked to move your arms. You don’t understand what they mean. They may then touch your head or neck – you bring your hand up to touch them or accurately show them where they touched you. If they try to shine a light in your eyes tell them to get away and stop beaming that thing into you. If they politely persist let them do it.

Exposure – let them have a look at you if they explain why they want to (to check for rashes, bruises etc

If they touch your head, it is very tender on the back right hand side.

They want to do some tests to see if you are well – this is ok.

Psychiatry assessment

They might ask you to move your arms and hands again like in Disability = same response as before.

Orientation (where are you etc) – you think you might be in a cheap hotel . No idea where but it’s in England (start chanting like a football fan). You have no idea what day or date it is so you make it up

Memory test – you can repeat 3 words immediately but can’t remember them a few minutes later. Just make irrelevant guesses.

Months of the year backward – you do them forwards instead, and with a struggle – after a few months give up (its boring and you can’t remember why they are asking you to do it anyway) start talking about something irrelevant. Spell world backwards – you try but get it wrong (e.g. DORLDW). If they ask you to take 7 away from 100, make up numbers – you can’t do it then start chatting about something else after one or two attempts.

They might ask if you see or hear anything unusual. Just laugh and tell them it’s a stupid question. You aren’t mad. Of course you don’t see things or hear things.

They might ask about mood – you feel ok, energy levels normal, thoughts and thinking ok, plans – I’m gonna smash that persons face in when I see him. Veer off topic.

Questions about feeling safe / paranoid – laugh. Tell them you are fine.

Risks – you don’t want to harm yourself but that guy has got it coming. Mark my words.

You agree you will stay in hospital and have tests and treatment for now but you have to go a bit later. If they try and ask you to repeat what they are saying to you, swear at them and say you can’t remember. If they start asking you about pros and cons or risks and benefits of having tests and staying in hospital just shut them up. Everything will be fine. Do what you need to do etc but you won’t stick around forever. They should get on with it.

**Additional notes/guidance**

Most candidates will check their environment, but then forget to remove potential weapons, such as a lanyard, or an obvious physical object like a mug. After the initial de-escalation, and if still appropriate, reach for the lanyard, or the object, in a confused / aggressive / drunk manner. The purpose of this is to demonstrate that risks persist thoughout the time with the patient, and that mental states fluctuate. It is important for candidates to act on their environmental risk assessment, rather than just note objects by rote.