# SIMULATION CASE – BS\_1

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| **Learning outcomes:**  By the end of this simulation the candidates will:   * Work through an integrated (medical and psychiatric) assessment of a patient behaving strangely * Practice communication skills with a patient who is suspicious and difficult to engage * Gain confidence in the assessment and management of risks in a patient presenting with psychosis   Simulation focus: Systematic simultaneous medical and psychiatric assessment of a patient behaving strangely. Consideration of potential organic causes and assessment of ongoing risks. |

**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 20yr old patient who has presented following a panic attack.  *S/he* is wandering around and appears to be looking into other cubicles and rooms. | |
| **B**ackground | *S/he* gives a history of becoming increasingly anxious over the past few weeks and has had several panic attacks. The panic attacks are lasting longer on each occasion.  *S/he* remains anxious and is convinced that something bad is about to happen to them but is not keen to divulge further details.  *S/he* is slightly irritable and suspicious of staff members and of other patients in the department. | |
| **A**ssessment | A | Maintaining own airway |
| B | RR-18, Oxygen saturations 99% on room air |
| C | HR 108bpm and normotensive |
| D | AVPU - A |
| E | Mild tremor, signs of recent weight loss as clothes are baggy, no signs of trauma, no signs indicative of self harm. Does not smell of alcohol. |
| **R**ecommendation | Requires further assessment to elicit her concerns and assess the cause for *him/her* presentation. | |

Further information if requested by the candidate

You have been asked to see Charlotte/Charlie who is a 20yr old dentistry student. *S/he* has presented following what appears to be a panic attack and now describes several weeks of increasing anxiety.  *S/he* continues to feel anxious and is concerned that something very bad is going to happen to them.

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

Charlotte/Charlie has had a full physical examination and bloods which included endocrine and inflammatory markers all of which are within normal limits – deliver relevant information as scenario proceeds.

Patients ECG is sinus tachycardia 108 bpm with nil acute findings. If CXR is requested this is also normal.

If female is not pregnant. *S/he* has a normal blood sugar and a normal temperature

|  | Physical health | | | | | **☑** | Mental health | | | | | **☑** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PRIMARY | Physical assessment looking for organic cause | | A | Maintaining own airway | |  | Mental health primary assessment | **A**gitation/arousal | | Tachycardic and mild tremor. Evidence of recent weight loss. May have thyrotoxicosis or sepsis.  Consider Drug or alcohol use (withdrawal) or accidental/deliberate overdose. | |  |
| B | RR-18, Oxygen saturations 99% on room air  Chest clear with good air entry throughout on examination | |  | **E**nvironment | | Currently in minors but has been wandering in the department. Movable objects which could be used as weapons and ligature points present. Easy for patient to abscond. | |  |
| C | HR 108bpm and normotensive  Peripheries warm and well perfused | |  | **I**ntent | | Difficult to assess due to difficulties in engagement. | |  |
| D | AVPU – A  (or GCS 15/15) Normal neurological examination  PEARL  if fundoscopy performed this is also normal | |  | **O**bjects | | Is clutching a small bag, states that *s/he* has no items to harm self or others. | |  |
| E | Mild tremor, recent weight loss (clothes baggy)  no signs of injury or trauma  no signs indicative of self harm  no rashes  no neck stiffness or photophobia  temperature  normal 37.4  No evidence of alcohol or drug use, no evidence of alcohol withdrawal | |  | Risk to self?  Risk to others?  Flight risk? | | Risk to self –Admits to occasional thoughts that life is not worth living due to severe anxiety but no plans to harm herself and hasn’t harmed themselves before coming to the department.  Risk to others – slightly irritable and behaving in an odd manner. Denies any thoughts of harm to others.  Flight Risk – Feels very anxious being in the department and wonders if *s/he* would be better off going home and seeing their GP. | |  |
|  | | | | | | | | | | | |
| Unified Assessment:  Immediate Treatment: Measures to minimise psychiatric or physical risk to patient or others | | ABCDE to consider organic causes primarily endocrine abnormalities or sepsis (consider drug or alcohol misuse and toxicology also)  Safety checks of the immediate environment and place in an area where the patient can be monitored and reduce disturbance of other patients/children  Plans for rapid tranquilisation and restraint if required.  Plans for potential flight risk either security or nursing staff to observe  Capacity assessment and assessment of mental state | | | | | | | | |  |
|  | | | | | | | | | | | | |
|  | Focused physical history and secondary examination | **P**roblem | | | Presumed panic attack |  | Focused conversational psychosocial history and mental state examination | | Demographic and historical factors | | White British, born and raised in rural Scottish community. Happy childhood. In first year of studying dentistry at university and living in University Halls, struggled initially with the move from home to University but gradually developed a small group of close friends. |  |
| **H**istory of presenting problem | | | 6wk history of anxiety, has lost 3kg over 5 weeks due to reduced appetite. 4 panic attacks in the last 2 weeks, none previously. Attacks preceded by increased anxiety, during attacks feels a sense of impending doom. During attacks struggles to breathe and her/his heart thuds in their chest, *s/he* gets pins and needles in her hands and feels nauseous. Attacks last up to 15 minutes and gradually resolve. During the attacks there is no loss of consciousness. |  | Co-morbid mental illness | | 2 months history that there is a conspiracy against *him/her*. Hears people commenting on *his/her* actions whilst s/he is in University Halls. *S/he* worries *s/he* is being followed. Believes that there are cameras in *his/her* room and has taken apart one of the plug sockets to attempt to locate these. Believes the people behind this may be *his/her* course organisers and believes they are marking her assignments down as part of this conspiracy. *S/he* is unclear about their intentions overall. *S/he* has become isolated from *his/her* friends and is finding it difficult to attend *his/her* University course. *S/he* wants help and protection/legal advice but doesn’t feel *s/he* needs to see psych and would not consider admission to hospital. |  |
| **R**elevant medical history | | | No significant past medical or psychiatric history |  | Overall risk profile | | High risk of harm to self and others – tampering with plug sockets. High risk of absconding |  |
| **A**llergies | | | NKDA |  |  | |  |  |
| **S**ystems review | | | Between panic attacks feels anxious and at times has a tremor. Nil else. |  |  | |  |  |
| **E**ssential family and social history | | | Father has hypertension. No other significant family history.  Has never used illicit substances, drinks socially occasionally to excess when out with friends. |  |  | |  |  |
| **D**rugs | | | No regular medication |  |  | |  |  |
| Top to toe | | | No signs of injuries, appears physically well and well presented. Specifically no signs of infection, injury or thyroid goitre |  |  | |  |  |
|  | | | | | | | | | | |  |
| Emergency physical treatment | Bloods to exclude organic cause  Blood Glucose (BM)  Temperature  ECG (for rapid tranquilisation)  Urinalysis and urinary pregnancy test if female  May consider CXR but not essential  May consider Venous or Arterial Blood Gas if concerned re acid base imbalance or new diabetes presentation but not essential | | | |  | Emergency psychiatric management / consider MHA | | * Requires assessment under the MHA * Ensure that she is under 1:1 observation * Plan for if *s/he* tries to leave * Consider use of Lorazepam orally * Rapid tranquilisation and restraint team organised. | | |  |
|  | | | | | | | | | | | | |
| INITIVE CARE AND DISPOSAL | Disposal | | | | Likely first episode psychosis, screen for organic cause is negative. In view of potential risk to self, others and absconding will need psychiatric admission but as refusing admission will need MHA. | | | | | | |  |
| Reassess risk | | | | High risk to self and others – interfering with plug sockets  High risk of absconding – lacks insight, suspicious, not wishing to be admitted. | | | | | | |  |
| Handover to:   |  | | --- | | Psychiatry |   including on-going care plan | | | | **S**ituation | 20yr old dentistry student presenting with anxiety and panic attacks. | | | | | |  |
| **B**ackground | 8 week history of increasing anxiety, weight loss and four panic attacks over the last two weeks. | | | | | |  |
| **A**ssessment | Physical assessment and investigations show NAD including no signs of sepsis or endocrine abnormalities, ECG NAD. No alcohol or illicit substance use. Persecutory delusional ideas including beliefs that university accommodation has been bugged leading to dismantling of plug sockets in room. Vulnerable due to her ‘odd’ behaviour. Lacks insight and is unwilling to see psychiatry or consider admission to hospital, has talked about leaving the department. Imp – first episode psychosis | | | | | |  |
| **R**ecommendation | High risk of harm to self and others, high risk of absconding, needs MHA | | | | | |  |

[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

* Engaging with and gaining the confidence of a suspicious patient
* Risks associated with psychosis that can be elicited by a careful history
* Use of the Mental Health Act
* The differential diagnoses of this presentation (if not a primary psychiatric illness)
* The essential considerations in the physical examination and clinical investigation of this patient to determine if there is an underlying organic cause.

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

* Building rapport with a suspicious and anxious/irritable patient
* Taking a history in an empathic and non-judgmental way
* Assessing risk including risks that are not immediately obvious – the patient dismantling plug sockets

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 Charlotte/Charlie Andrews a 20yr old dentistry student. You moved to Birmingham in September to start your first year at University, at first you struggled with this having moved from a small community in a remote area of Scotland. You are an only child and had a happy childhood. You enjoyed school, you were always top of the class in your small school and had a few close friends. Your Mum and Dad are farmers and you are the first in your family to go to University. You live in Halls of residence and you found the first few months of university difficult due to the massive culture shock but did manage to make a small group of friends and went out socially. You have found the course enjoyable but have been surprised that your marks have been lower than expected, at school you were always top of the class but now you are only scoring within the average range. You have no more financial worries than any other student and are not in a significant amount of debt. You are heterosexual and although you have had a few very short term relationships since coming to University you have never had any ‘serious’ relationships.

You were a healthy child and rarely saw your GP other than for your routine vaccinations, you have never had any operations. Your family are healthy, , no-one has any psychiatric illnesses.

You have never used illicit substances, don’t smoke and drink alcohol 1-2 times per week.

Approximately 8 weeks ago you became concerned that there was something more sinister going on in relation to your marks which are gradually dropping, you started to become increasingly anxious that you would eventually fail the course due to this and would disappoint your parents who are extremely proud of your achievements. Gradually you have become more convinced that the course organisers for some reason are conspiring to make you fail the course. Six weeks ago you began hearing a voice while you were in your flat which started commenting on what you were doing, the frequency of this voice (a single male voice, unknown to you, external in origin) has since increased. You have in the last 2-3 weeks become convinced that your room is bugged and that there have been cameras installed, you have searched the room with no success and yesterday became convinced that they may be hidden in either electrical appliances or plug sockets/ light switches – you have taken one of the plug sockets apart as well as you can to check but haven’t found anything so far. Over the last 2 weeks you have also worried that you are being followed and have become hypervigilant checking for familiar faces. Due to everything that’s been going on you have become increasingly anxious and have found it difficult to eat as your appetite has been reduced and difficult to sleep. On 3 occasions you have become so anxious about what has been going on and the worry about failing your course that you have had what you think is a panic attack.

***Medication***

*Not on any medication and no known allergies*

Now

You have come into the department following the fourth what you presume to be ‘anxiety attack’ in two weeks, these attacks are increasing in length and you thought that you should get checked out to make sure that there is no physical cause (you haven’t yet got around to registering with a local GP). You continue to feel anxious now that you are in the department (and are convinced that you have been followed on your way to A+E. While waiting to be seen you have been checking around the department and looking in cubicles to see if you can find the people (1 male and 1 female) who were following you –. You are willing to co-operate when seen by the doctors and happy for any physical examination. When asked to describe the panic attacks these occur after periods of increasing anxiety (if asked about what initially state “about university and whats been going on there” but are unwilling to give further details at first) during the attack you find it difficult to get your breath as if your chest is being restricted and your heart is racing, you feel sick but have never actual been sick – attacks last between 5-10 min but todays lasted 15minutes. You do not lose consciousness or become confused at anytime and you gradually calm down and the attack ends although you continue to feel anxious.

When first asked about the difficulties at university you are not keen to volunteer information “you’ll think it sounds ridiculous” “you won’t believe me” and you are mildly irritable especially if pushed. You have no weapons on you and no thoughts to harm yourself or others. Once a rapport is developed you are able to give details about your recent history and your beliefs although if challenged as to whether this is really happening then become slightly irritable and make a statement such as “see I knew you wouldn’t believe me” until you have been reassured enough to continue

* You do not have low mood or feel depressed, you are struggling to sleep and eat due to the anxiety but are able to enjoy somethings such as talking to your family.
* You don’t believe that you are controlled in anyway, that people can read your thoughts or interfere with them, you don’t get messages from the TV/Radio
* You have stopped seeing your friends as you have been too preoccupied with trying to find out what is going on.
* You do not believe that your beliefs could in anyway be part of a mental health issue, you don’t want to see a psychiatrist and do not wish to be admitted to a hospital.
* You would be willing to take Lorazepam if offered for the anxiety but are not willing to take anything for psychosis or antipsychotics.

ICE (Ideas, Concerns, Expectations)

***Thoughts and concerns***

* You have come to hospital to rule out a physical cause for your panic attacks
* You feel anxious and concerned about the conspiracy
* You are worried that people will not believe what you are experiencing
* You want help but are unsure who to contact/where to go ?police?legal

Opening statement

Wait to be asked why you have attended or similar

Emotional behaviours/statements/questions

***If asked directly:***

See above in scenario

***Possible statements:***

See above in scenario

Dos and Don’ts

Don’t volunteer the information that you have dismantled the plug socket unless asked, give them a cue that you suspect electrics etc but only volunteer that you have interfered with them if asked something along the lines of “have you looked in the sockets or investigated in anyway”

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.