# SIMULATION CASE –BS\_2

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| **Learning outcomes:**By the end of this simulation the candidates will:Be able to assess risk and formulate a management plan in a patient with an incomplete accountDemonstrate knowledge and understanding of the potential medical differential diagnoses in this case (e.g. Injury, diabetic hypo or hyperglycaemia, infection, encephalitis, cerebrovascular disease, seizure, SAH, SOL, poisoning, assault/sexual assault) as well as the potential psychiatric/dissociative/depersonalization disorders Demonstrate communication skills and holistic approach in seeking all other potentially useful sources of information – family, friends, GP, police, social work, employers - whilst recognizing issues surrounding patient confidentiality. Simulation focus: taking a history from someone who can only give an incomplete account there are a wide range of differential diagnoses in this case and it is important to consider all organic physical causes rather than assuming mental health origin. |

**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 48 yr old m/f presented and asking for help because they left for work in London and found them self in Manchester 7 hours later, without recollection of the interval.  |
| **B**ackground | Not agitated but a little vague, anxious and perplexed. No evidence noted of confusion. |
| **A**ssessment | A | Airway patent, speaking normally, no concerns |
| B | Chest clear, good air entry bilaterally, Sats 99 % on air and RR 14  |
| C | Pulse 70 regular, BP 110/75 |
| D | Normal AVPU: GCS15. |
| E |  No obvious abnormalities  |
| **R**ecommendation | Needs assessment and consideration of potential medical and psychiatric causes |

Further information if requested by the candidate

Cubicle in in A & E minors: patient presented themselves at A & E reception and asked for help because s/he left for work in London and found themselves in Manchester 7 hours later, without recollection of the interval. S/he had lost his mobile phone and coat but still had a laptop and bag.

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

If the student asks to speak to the spouse on the phone: will say that *s/he* seemed fine this morning. **IF ASKED IF NOTICED ANYTHING** *S/he* has had some concerns over the last three months that *s/he* has had some odd episodes lasting a few minutes when s*/he* seemed not to hear people but carried on washing dishes or digging in the garden in a mechanical fashion. Also, a couple of episodes lasting a few minutes when *s/he* seemed confused about what was going on and their conversation made little sense but *s/he* had assumed that this was down to them being rather stressed and not sleeping well.

|  | Physical health | **☑** | Mental health | **☑** |
| --- | --- | --- | --- | --- |
| PRIMARY | Physical assessment looking for organic cause | A | Patent no concerns |  | Mental health primary assessment | **A**gitation/arousal | Nil abnormal |  |
| B | Good air entry bilaterally, no added sounds  |  | **E**nvironment | Loose objects, ligature points available, within sight of the nursing station. |  |
| C | Normal pulse and blood pressure warm and well perfused |  | **I**ntent | Suit, wallet, laptop bag, watch; no phone or weapons. |  |
| D | Alert but vague during history taking No focal neurological signs on examinationFundoscopy if performed normalNo photophobia or meningism  |  | **O**bjects | Innocent, unsure as to what has happened |  |
| E | blood sugar 5.5 and temperature 36.7 also normalno rashesno signs of injury no signs of drug or alcohol useno signs of assault or sexual assault  |  | Risk to self?Risk to others?Flight risk? | Not apparentNot apparentNot clear |  |
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| Unified Assessment:Immediate Treatment: Measures to minimise psychiatric or physical risk to patient or others | To be observed to prevent his leaving unobserved: to be stopped if he tries to leave.  Full set of observations including temperature and blood glucose (If there is a potential for unknown sexual assault in this patient the participant might consider BBV immunization or PEP) |  |
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| SECONDARY | Focused physical history and secondary examination | **P**roblem | Unable to recall a prolonged period. |  | Focused conversational psychosocial history and mental state examination | Demographic and historical factors | 48yr old solicitor british origin, Lives with spouse and two daughters. No significant past trauma. |  |
| **H**istory of presenting problem | Left for work in London at 8am, recalls nothing before finding himself at 3pm in Manchester. Some belongings unaccounted for during the day. |  | Co-morbid mental illness | None |  |
| **R**elevant medical history | Chronic back painMild anxiety ‘years’ ago |  | Overall risk profile | Episode of wandering not due to psychiatric illness. |  |
| **A**llergies | None |  |  |  |  |
| **S**ystems review | Normal |  |  |  |  |
| **E**ssential family and social history | Father and Uncle – diabetes.Non-drinker, no illicit drug use. |  |  |  |  |
| **D**rugs | Tramadol 100mg BD |  |  |  |  |
| Top to toe | NAD, no signs of trauma or injury |  |  |  |  |
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| Emergency physical treatment | Nothing emergency in the way of treatment but will require further investigations.Do not allow to leave without assessing capacity to do so. Consider detaining under Mental Capacity Act if confused and trying to leave. |  | Emergency psychiatric management / consider MHA | Do not allow to leave without assessing capacity to do so. Consider detaining under Mental Capacity Act or Mental Health Act if confused and trying to leave.  |  |
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| INITIVE CARE AND DISPOSAL | Disposal | Appears to new onset of seizures, needs neurology/medical opinion |  |
| Reassess risk |  |  |
| Handover to:

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| Medical/neurology |

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
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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

* Checking with the wife or GP or neurologist for collateral history – he can only recall the wife’s number – she gives useful information.
* Refer to neurology for urgent assessment and possible acute treatment, not the psychiatrists.
* Ensuring the safety of the patient – that he doesn’t wander again unobserved (needs observation until the neurologists attend). If he tries to leave he should be stopped and assessed, as he could be having another fugue or automatism and lack capacity regarding assessment and treatment. If so or if in doubt restraint is justified, although very unlikely to be necessary.

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

Finding out what’s gone on, getting details from the spouse, making appropriate referrals, reassuring the patient as far as they can.

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 Jo and you are a 48 year old partner in a large City of London firm of solicitors. You live with your spouse (who works part time as an accountant) and two daughters, 16 and 18, in West London. You were born in London

You had an uneventful childhood growing up with your parents and two siblings. You achieved well at school although were subject to some mild bullying and went onto study law at university. You met your spouse at University and have a happy relationship, there are no financial difficulties and your two daughters have both done well at school and the eldest is about to attend university.

You don’t drink and have never taken illicit substances. You are a non smoker.

***Medication***

*Tramadol 100mg BD*

Now

You left to walk to the station on your way to work at 8am this morning (you usually walk to the station, take the train and walk again to the office) and then recall nothing else until you found yourself on unfamiliar streets, uncertain how you got there, at 3pm. You had lost your coat and mobile phone but still had your bag and laptop. Feeling there must be something wrong with you, you looked for a public telephone but saw a black cab, hailed it and asked to be taken to the nearest A&E. You feel a little fuzzy but otherwise fine. You can remember everything else about yourself and your day until 8am. You have no history of head injury, headaches, paralysis or twitches, or numbness or any visual, auditory, taste or smell-related symptoms.

Nothing like this has ever happened to you before and are very concerned about the cause. Aside from having chronic back pain you have no other medical problems and are not allergic to anything. There is a history of diabetes in the family (father and uncle) but no psychiatric problems. You have experienced some anxiety many years ago but this was mild and self-limiting, you never sought any treatment for this.

You don’t feel depressed, work has been a little stressful with some difficult cases recently and this has disrupted your sleep slightly but otherwise you have no worries at home or at work. You have not been feeling anxious in anyway. You have not been hearing voices, seeing anything strange, no odd tastes or smells. You have not had any strange experiences, do not think that anyone has been following or spying on you. You do not have any strange powers. You do not feel as if you are being controlled and no-one is interfering with your thoughts.

ICE (Ideas, Concerns, Expectations)

 ***Thoughts and concerns***

You would like to ring your spouse to let her know what’s going on. You would like to know what the hell has just happened and why.

Opening statement

I’ve lost part of my day. I can’t remember anything from about 8am to about 3 in the afternoon.

Emotional behaviours/statements/questions

***If asked directly:***

I’d like to know what’s happened to me. “Am I going mad?”

***Possible statements:***

[If told you’ll see a psychiatrist] OK, but why do I need to see a psychiatrist? Am I going mad?

Dos and Don’ts

Don’t be more than mildly irritable and perplexed. Do try to present yourself as being coherent and reasonable, even if you feel slightly emotional.

**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.