# SIMULATION CASE –AD\_2

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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: discuss outlay of scenario with co-instructor and actor and check equipment

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 38 years old m/f history of asthma and type 1 diabetes, bipolar affective disorder.  |
| **B**ackground | M/F, 38 years old, history of asthma and type 1 diabetes, bipolar affective disorder. Drowsy patient is refusing investigations Drowsy – very difficult to rouse and smells of alcohol.  |
| **A**ssessment | A | Patent |
| B | Resp rate 20, sats 98% on room air, chest – mild scattered wheeze  |
| C | BP 110/78, HR 102bpm, cap refill <2 secs, Heart sounds i+ii+0 |
| D | V on AVPU scale. Moving all 4 limbs spontaneously but not co-operating with motor section of GCS by obeying commands. Refusing to allow examination of pupils or a blood glucose check.  |
| E | Became irritable – could not complete |
| **R**ecommendation | Triage would like a joint ED/mental health assessment if possible |

Further information if requested by the candidate

You are in ED trolleys majors area. Your next patient is Denise/Denis Hunter, 38 years old, history of asthma and type 1 diabetes. Brought into ED by paramedics. Friends became worried about the patient on their work night out as s/he collapsed and wasn’t making any sense. S/he vomited a few minutes before the ambulance arrived. S/he presents as drowsy and irritable.

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

Denise/Denis is very drowsy and doesn’t wish to be disturbed.

Candidate should prioritise what is necessary – completion of ABCDE (glucose is essential, pupils and exposure if possible specifically looking for signs of head injury including basal skull fracture). Need to make sure Denise/Denis can be left safely for a period of observation to see if things improve. Collateral *his/her* to from friends. (any suggestion of MOI to suggest neck injury)

ABCDE

FIngerprick glucose is 3.4mmol/L

Pupils are equal and reactive to light

Exposure - no signs of trauma or self harm. Injection marks on abdomen consistent with insulin injections.

Next step [Alcohol level may not be checked; but if they are these are the results]:

Breathylyser 0.15 - v intoxicated. 2h observation period and re test.

Breathylyser 0.8 - can now be assessed by mental health team

Secondary assessment can take place.

Medical and psychiatric assessments take place – deliver relevant information as scenario proceeds.

Deliver ancillary information (test results) after completion of medical and psychiatric assessments.

Patient is recovering from uncomplicated alcohol intoxication and can be discharged home. Their Community mental health team should be alerted to her alcohol intake so they can support them with this.

|  | Physical health | **☑** | Mental health | **☑** |
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| PRIMARY | Physical assessment looking for organic cause | A | Patent .  |  | Mental health primary assessment | **A**gitation/arousal | Drowsy - requires physical health assessment as hx diabetes and presenting with collapse, vomiting, drowsiness in context of alcohol intoxication |  |
| B | R 18bpm, Sats 98% on room air, chest – scattered mild wheeze, 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 124/82. HS I+II+0. |  | **I**ntent | No risk of harm to others identified |  |
| D | Fluctuating alertness. GCS 12/15 (E3, V4, M5). No neck stiffness, moving all 4 limbs. Refuses pen torch for pupils but eventually allows. Glucose 3.4. |  | **O**bjects  | No risk identified |  |
| E | Temperature 37 C. No rashes, no scalp, limb or torso injuries. Injection marks on abdomen consistent with insulin injections |  | Risk to self?Risk to others?Flight risk? | * Risk to self : nothing in current presentation to suggest immediate risk of self harm.
* Risk to others: nothing in current presentation to suggest immediate risk of harm to others
* 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 other causes for presentation
* Absconsion risk: No current concerns as too drowsy. Contingency plan if she wakes and decides to leave before period of observation ends. [Some departments put a description including height on electronic system so that it is easier for police and security to identify them]
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| Unified assessment:Immediate Treatment: Measures to minimise psychiatric or physical risk to patient or others | * Assessment should occur within 15 minutes of arrival
* 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 [see CG176 head injury: assessment and early management] half hourly until GCS15
 | * Currently too drowsy to be assessed. Serial assessment to occur to determine when patient able to engage.
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| SECONDARY | Focused physical history and secondary examination | **P**roblem | Hx type 1 diabetes and asthma. Recent collapse, vomiting, drowsy ?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?** | Was a weekend drinker (Friday and Saturday) – 10 pints, plus spirits. Now drinking in evenings too – 2 pints. No craving, some tolerance and salience, repertoire not narrowed.  |  |
| **H**istory of presenting problem | As above |  | **Impact on work, relationships, finances, police involvement** | No |  |
| **R**elevant medical history | Type 1 diabetesAsthmaBipolar affective disorder |  | **Previous detoxification? Longest abstinence?** | No |  |
| **A**llergies | None known |  | **Willingness to receive help?** | Doesn’t feel it’s necessary |  |
| **S**ystems review | Unremarkable |  | **Barriers to engaging with interventions** | Doesn’t see a problem |  |
| **E**ssential family and social history | None known |  | Confusion screen | COMA CHAMP**C**onscious level – GCS 13. Any fluctuations?**O**rientation in time and place – Now oriented**M**emory (3 words or name and address – immediate and after short delay) – forgets after delay**A**ttention – can spell WORLD and do months of year backwardsSerial subtractions – cannot do**C**ognitive tests – not appropriate at this stage**H**allucinations - no **A**ffective state - (normal)**M**otor – no ataxia**P**aranoia and other psychotic symptoms – No other sx |  |
| **D**rugs | Salbutamol and beclomethasone inhalersInsulin – basal bolus regimen: Glargine and NovorapidAripiprazole 20mg OD |  | Co-morbid mental illness | Bipolar affective disorder. Has remained well for last 3 years on aripiprazole. Seen regularly by community mental health team (CMHT). Last relapse – manic relapse 3 years ago. Sectioned under mental health act.  |  |
| Top to toe | Unremarkable |  | Overall risk profile | As primary AEIO |  |
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| Emergency physical treatment | Monitor blood glucosePabrinexEncourage oral intake (for low blood glucose)CT headHalf hourly neuro obs until GCS 15Watch for withdrawal; consider Librium.  |  | Emergency psychiatric management / consider MHA | **Risks** to self and others – denies thoughts or plans to harm self or others **Capacity** – willing to stay and receive care |  |
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| DEFINITIVE CARE AND DISPOSAL | Disposal | Impression – uncomplicated alcohol intoxicationCROC – discharge home  |  |
| 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: none identified Other:3.potential risk of refusal to engage with treatment and/or abscond4. Monitoring glucose levels |  |
| Handover to:

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| Medical Registrar |

including on-going care plan | **S**ituation | 38 year old. History of asthma, type 1 diabetes, bipolar affective disorder. Brought in after collapse and confusion. Working diagnosis uncomplicated alcohol intoxication. Requires period of observation before discharge home.  |  |
| **B**ackground | Found collapsed in a bar. Vomited once. Appeared confused. Gradually improved over last few hours.  |  |
| **A**ssessment | GCS 12 on admission. Glucose 3.3. steadily improving. CT Brain – no intra or extra axial collection |  |
| **R**ecommendation | Can be discharged home when more alert and steady on her feet. Alert GP and CMHT to presentation. Offer community alcohol and drug services contact details. |  |

ANCILLARY INFORMATION:

Investigations [not all of these will be requested, but all results are here for completeness]:

Routine blood tests – normal

Lab glucose 3.3

Urine dip – protein+

Urine drug screen Cannabis +ve

CT head – normal.

[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

* Is a mental health assessment necessary for this patient – if so why? If not, why not?
* NICE criteria for CT head scan
* Is her alcohol use problematic?

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. Effective deployment of the team to manage irritability in a patient who is intoxicated

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 sleepy. Your speech is slurred, you just want to 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 everyone to go away.

Background

Your name is Denise/Denis. You are 38 years old.

You are an accountant. Tonight you were out at a local bar with work colleagues celebrating someone’s promotion. You all had a lot to drink – cant remember what. The next thing you know you are lying on the side of the road and an ambulance crew are talking to you. You felt sick, in fact you still feel really rough. You have thrown up a couple of times. You are now 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 when you have had some sleep.

Your medical history includes asthma, type 1 diabetes and bipolar affective disorder

You take inhalers for your asthma (a blue one and a brown one), injections for your diabetes (a long acting one then short acting ones at mealtimes) and meds for your bipolar (aripiprazole). You see a community mental health worker once a month.

***Medication***

*Asthma inhalers – a blue and a brown one*

Now

The candidates introduce themselves to you. You ignore them. You just want to carry on sleeping. They try to examine you – you brush them off but eventually let them if they persist. They may ask you to blow into a breathylyser – you agree. This is all done whilst you are lying down with your eyes closed. You are very sleepy and feel a bit muddled.

**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. Carry on chatting/murmuring in a slurred ramble on and off – 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.

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 it. 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

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

Eventually you wake up a bit and are able to chat with the people assessing you

**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 morgue . No idea where but it’s in England. 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 or spelling world backwards – you can do this.

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

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

Risks – you don’t want to harm yourself or other people

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 pro’s 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 for ever. They should get on with it.

**HISTORY**

Medical – you have been diabetic since you were a teenager. You take your insulin regularly (a long acting injection then short acting at mealtimes). You do have hypo’s sometimes and carry a little jar of jam or a hypostop in your pocket. You use your asthma inhalers regularly and haven’t had any problems for a couple of years.

You are well in terms of your bipolar. You were diagnosed as a young person. You have had a few admissions, usually when you are manic. The last one was 3 years ago.

Alcohol: you drink a lot at weekends – ten pints and shots on top. You like to have a good time. More recently you have started drinking a bit on weeknights. A couple of pints. You don’t crave alcohol. It does take a bit more these days to get drunk. You manage to work okay and like to play football two nights a week. You don’t think you need any help with it. You do like a bit of cannabis every now and again. Again, you don’t see it as a problem.

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.