# SIMULATION CASE –BS\_3

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| **Learning outcomes:**  By the end of this simulation the candidates will:   * Complete a physical and psychiatric assessment in the perinatal period * Be able to fully assess and manage risk to both mother and infant in the perinatal period   Simulation focus: Systemic assessment of medical and psychiatric aspects of behavior in the post-natal period including potential risks to both mother and baby |

**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 30yr old female who is 6 weeks post-partum and has presented with concerns over intermittent periods of confusion. | |
| **B**ackground | Husband has reported poor sleep and periods of confusion when she finds it difficult to complete routine daily tasks, he is concerned about her behaviour. She has over recent days expressed concerns that the baby appears different and that there is something wrong with her eyes - baby has been sent with father to the paediatric area with her father. | |
| **A**ssessment | A | normal |
| B | Normal, RR 14, Sats 100% air |
| C | Normal, P 72 reg, BP 115/82 |
| D | Normal, GCS 15, no evidence of confusion |
| E | Normal – no fever, no rash, no PV symptoms/discharge or abdominal pain |
| **R**ecommendation | Requires further history and examination - physical and psychiatric | |

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

The baby has now been seen in paediatrics and there are no medical concerns, Rachel’s husband will wait there with the baby until Rachel has been fully assessed. Rachel’s husband has told staff that he has been increasingly concerned about his wife over the last week and that he suggested taking the baby to A+E as a way of ensuring that she was assessed rather than the baby. He reports that Rachel has been unable to sleep even during periods when the baby is asleep or when he has taken the baby overnight to allow her to rest. Over the last few days she has seemed distant and suspicious of him and that there are occasions where Rachel appears confused for up to an hour and appears unable to undertake simple tasks that would normally be routine.

Further information if requested by the candidate

Rachel is a 39yr old lady who is 6 weeks post-partum. She initially attended ED accompanied by her husband (Dan) and their 6 week old daughter (Emilia) expressing concerns that something was wrong with her daughter’s eyes. When triaged her husband stated that his concerns were about his wife not his daughter who was fine. He expressed concerns that his wife was not her usual self and at times she appeared confused and she had been struggling to sleep at all over the last 48hrs. In view of Rachel becoming irritated with her husband and disagreeing it was agreed that Dan would take Emilia to the Paediatric section of the A+E and Rachel would stay in the main department.

|  | Physical health | | | | | **☑** | Mental health | | | | | **☑** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PRIMARY | Physical assessment looking for organic cause | | A | Patent airway, no concerns | |  | Mental health primary assessment | **A**gitation/arousal | | Appears tired, no agitation or aggression displayed. | |  |
| B | Bilaterally equal good air entry  No signs of respiratory distress  Sats 100% air,  RR 16 | |  | **E**nvironment | | Currently being assessed in a side room, limited view from the rest of the department, ligature points and unsecured objects. Easy exit points and access to paediatric A+E | |  |
| C | Pulse 72 reg,  BP 115/82, CRT <2, warm and well perfused  CVS – HS normal | |  | **I**ntent | | Wants to get her daughter assessed. Husband is concerned about her change in mental state, she doesn’t really think that there is anything wrong she is just concerned about the daughter. | |  |
| D | Alert and orientated  No focal neurological signs | |  | **O**bjects | | Came with her 6 week old daughter - currently with husband but accessible and in the department. | |  |
| E | No injury  No rash/photophobia or neck stiffness  Nil to suggest drug or alcohol misuse  Important to consider OBGYN causes – infection, retained placenta, patient has no PV discharge or abdominal pain | |  | Risk to self?  Risk to others?  Flight risk? | | Potentially a risk to self and baby in view of history from husband. Behaviour confused at times so risk of wandering. | |  |
|  | | | | | | | | | | | |
| Unified assessment:  Immediate Treatment: Measures to minimise psychiatric or physical risk to patient or others | | * Consider moving to a dedicated psychiatric assessment room * Consider member of staff to sit with her while she waits if she will not tolerate this then a member of staff to observe from a distance * Stop her from leaving and also from accessing the baby until fully assessed * In view of fluctuations in behavior plan for restraint and rapid traquilisation if required. | | | | | | | | |  |
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| SECONDARY | Focused physical history and secondary examination | **P**roblem | | | Periods of confusion, insomnia, unusual beliefs about her baby changing in appearance. |  | Focused conversational psychosocial history and mental state examination | | Demographic and historical factors | | White British, married with 6 week old baby. On maternity leave from job as supermarket manager. Born locally and grew up with Mum and elder sister. Dad left when she was 3 and no contact since. No significant past trauma. |  |
| **H**istory of presenting problem | | | 6 weeks postpartum. NVD with no complications, baby was jaundiced and admitted to NICU briefly for phototherapy but no concerns following this. Following birth she struggled to breastfeed suffering two episodes of mastitis before deciding to stop completely 2 weeks ago.  Following the birth she has been extremely anxious about SIDS and the babys health. She has found it increasingly difficult to sleep over the last 48hrs. She denies any episodes of confusion putting any difficulties down to being overtired. |  | Co-morbid mental illness | | Denies feeling depressed but appears low in mood. Currently expressing delusional beliefs that the baby has deformed eyes and believes this is her fault. Not sleeping or eating and episodes of confusion has thought about smothering the baby with a pillow only thing stopping her appears to be not having decided on a foolproof suicide plan for herself. |  |
| **R**elevant medical history | | | Treated with CBT for depression 3 yrs ago  5yr history of infertility.  Private Fertility Treatment resulting in recent pregnancy |  | Overall risk profile | | High risk of harm to self and the baby.  Appear willing to come into hospital and accept treatment. |  |
| **A**llergies | | | Penicillin (rash) |  |  | |  |  |
| **S**ystems review | | | CVS – nil  Resp – nil  GI-nil  Neuro – nil  GU – nil |  |  | |  |  |
| **E**ssential family and social history | | | Maternal Grandmother – postnatal depression  No information on Fathers side of the family. |  |  | |  |  |
| **D**rugs | | | Nil |  |  | |  |  |
| Top to toe | | | No signs of trauma or infection. Orientated to PTP |  |  | |  |  |
|  | | | | | | | | | | |  |
| Emergency physical treatment | Would need bloods and ECG in case of the need for rapid tranq.  Worth checking TFT | | | |  | Emergency psychiatric management / consider MHA | | * Requires inpatient admission to Mother and Baby unit or acute psychiatric unit. Will need assessment under the Mental Health Act due to capacity reasons and also the high likelihood that she may change her mind. * Continued 1:1 observations whilst this is arranged and keep separate from the baby * Plan for rapid tranquilisation or restraint if necessary. Consider oral Lorazepam while waiting. | | |  |
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| INITIVE CARE AND DISPOSAL | Disposal | | | | Admission to psychiatric unit | | | | | | |  |
| Reassess risk | | | | High risk to both Mum and Baby of harm | | | | | | |  |
| Handover to:   |  | | --- | | Psychiatry |   including on-going care plan | | | | **S**ituation | 39yr old lady with puerperal psychosis | | | | | |  |
| **B**ackground | Attended A+E with husband and concerns about the baby’s health. Husband expressed concern about a change in behaviour and periods of confusion. | | | | | |  |
| **A**ssessment | On assessment no physical concerns, delusions that the baby has a deformity of her eyes and believes that she may have caused this, no other psychotic symptoms. Has thoughts of putting the baby out of its misery by smothering her and also thoughts but no plans of killing herself. Likely diagnosis of puerperal psychosis with high risk to mother and baby. | | | | | |  |
| **R**ecommendation | Needs admission to Mother and Baby Unit or Acute unit and likely to require MHA assessment | | | | | |  |

[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

* Puerperal psychosis
* Risk assessing children when parents have a mental illness
* Importance of history from close family members
* Difficult to know what signs and symptoms may be ‘normal for a new mum’ e.g. due to sleep deprivation, hormonal changes, breastfeeding, ‘baby blues’ and when this develops into a more significant mental health problem.
* The real risk of maternal death, suicide, infantacide

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

Ability to assess an anxious new Mum empathically and understand her concerns

Ability to assess risk to both Mum and baby (and partner)

Ability to consider alternative physical causes of the current presentation

Ability to elicit a clear/concise pregnancy and birth history and demonstrate knowledge of normal physiology for both mother and baby in the first weeks postpartum

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 Rachel a 39yr old first time Mum and have a 6 week old daughter Emilia with your husband Dan. Before having Emilia you struggled for 5 years to conceive with no success. You were very aware of your advancing age and took out a loan to pay fore IVF but could only afford one round – luckily you became pregnant first time around! You were understandably very anxious throughout the pregnancy although everything went to plan and you gave birth.. The delivery was tiring but without any complications and you managed to breast feed initially. Unfortunately the baby was very jaundiced and so the day after her birth she was taken to the neonatal unit for phototherapy. Although everyone reassured you that this was a common occurrence and that everything would be fine you found this very stressful and you began to struggle with the breastfeeding. After four days you were discharged home which you had been really looking forward to as you felt that the reason you were finding difficulty bonding with the baby was the alien hospital environment.

When you got home you wished you could go back! You found it very frightening being responsible for your daughter continually worried that you would do something wrong or harm her in some way. You were very concerned that she would over heat which would put her at risk of sudden infant death so you continually checked her temperature throughout the night even when she was asleep. You were very worried that she would pick up an illness and so became obsessional about cleaning the house and worried whenever guests came to visit that they might have germs and pass them onto her. There just didn’t seem to be anytime to bond or relax with the baby and this was complicated by two bouts of mastitis and you eventually stopped breastfeeding two weeks ago which you feel very guilty about and are worried that in the future this will affect her immune system and make her more prone to developing asthma.

You do not have any history of major physical health problems.

None of your family has any particular health problems but you do know that your grandma had a ‘bit of a breakdown’ when your Mum was born.

During the time you were struggling with the infertility problems you did suffer from a period of depression and did have a course of cognitive behavioural therapy about 3 yrs ago which you found helpful.

You were born and brought up locally and have a younger sister, You had a generally happy upbringing although money was tight, you enjoyed the social aspects of school but were not very academic. After leaving school you have had various jobs in the retail industry and have worked your way up to be a supermarket manager. You met your husband Dan 10yrs ago, your relationship is generally good and he is supportive towards you.

When you were in your twenties you did smoke cannabis 2-3 times per week. You haven’t drunk any alcohol for over two years.

***Medication***

None, you have been told that you are allergic to penicillin as you came out in a rash after taking it as a child.

Now

You are rather baffled as to how you have ended up in A+E, you came to A+E with your husband and the baby (Emilia) due to the problem with its eyes, however, when you arrived he told that staff that he was worried that you had not been yourself, seemed confused and he was concerned about your health. It was agreed that he would take the baby to paediatrics and you are relieved that someone is finally going to have a proper look at the baby. You have been asked to stay in the main department and be assessed, you assume for an infection or something. You feel this is probably unnecessary but you do feel tired and so are happy to stay and be assessed even though you don’t think that they will find anything. You feel relieved that even if your husband doesn’t believe you the paediatric staff will immediately see the problem and to be honest it’s nice to be away from the baby for a bit as you really struggle to cope when she is crying.

From a physical health point of view aside from the mastitis which has now resolved you have recovered quite well from the delivery. You have no physical aches or pains.

You don’t feel that you are particularly depressed but you do feel tired and restless. You feel that you have not been a particularly good Mum and feel that you should be doing more and be more able to cope with the crying – you are not the earth mother figure that you hoped to be. You feel guilty about these failures and especially guilty about stopping breastfeeding. Over the last two days you have found it almost impossible to sleep or eat and you are convinced that there is something wrong with the baby’s eyes as they are clearly malformed, you have mentioned this to your husband and the health visitor and both have them have said that they are completely normal and so you are convinced that they are lying to you. You believe that they know that there is something terribly wrong with the baby but they don’t want to tell you as they don’t want to upset you. You think that these malformations must have been caused by something that you did during the pregnancy and you wonder if it would be better if the baby was put out of its misery. You have thought whilst the baby was crying that maybe you should just put a pillow over its face, you know this is wrong and feel quite guilty about it. If you were to do this then it would be best to also end your own life however you would want to use an effective method and are unsure what you would do. You do not hear voices or see things, no thoughts that people are controlling you or interfering with your thoughts, no problems watching TV or listening to the radio.

ICE (Ideas, Concerns, Expectations)

***Thoughts and concerns***

Main concern is for the baby and the malformation that the baby has.

You are hopeful that if the baby has something badly wrong that something will be able to be done to make the baby comfortable and ensure that she doesn’t suffer.

You think it is unlikely that you have any physical health problems but are willing to go along with the assessment.

Opening statement

I don’t really understand why I’m here, it was the baby that I was worried about.

Emotional behaviours/statements/questions

***If asked directly:***

If told directly that the baby is fine and there is nothing wrong with it then become agitated and threaten to leave “you’re all in it together” but you can be easily talked round with an empathic approach

If its suggested to you that you may be feeling the way that you are due to a mental health/psychiatric etc problem and would you agree to see the mental health team or to admission to the mother and baby unit then whilst you think this is unlikely you would be willing to consider this.

**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.