# SIMULATION CASE –CA\_2

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| **Learning outcomes:**By the end of this simulation the candidates will:* Recognise the structured approach and how it will be applied in simulations

**Simulation focus:** Severe depressive episode with nihilistic delusions |

**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 68yr old with weight loss and abdominal pain, already assessed by medical and surgical teams who have been unable to identify any medical or surgical cause despite numerous previous investigations. |
| **B**ackground | Reports that s/he has been having abdominal problems for several months and can’t be bothered to eat. Has seen her/his GP on several occasions and has already had blood tests including thyroid function, all normal as well as out-patient CT head, chest, abdomen and pelvis, again reported as normal. Has apparently not eaten for a couple of days and has had been eating less prior to this. S/he has normal fluid intake and is still passing urine. Appears slightly unkempt and church friend states that s/he “hasn’t been right for months and probably not since her/his spouse died 2 years ago”. |
| **A**ssessment | A | Open and secure |
| B | RR 16 SpO2 98% on air |
| C | P 90 BP 110/60 |
| D | Alert PERLA |
| E | T 36.5 No rashes apparent |
| **R**ecommendation | Has had full and comprehensive physical investigations that have failed to reveal any physical or organic cause, consider if there are any mental health issues. |

Further information if requested by the candidate

68yr old brought in from home by her church friend. S/he has been complaining of abdominal problems and has lost some weight over a period of several months. S/he appears slightly disheveled and states that s/he has not eaten for four days and has been struggling to drink adequate amounts of fluids.

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

The psychological underlying cause of this patient’s symptoms become apparent when a full history is taken. Careful history taking reveals no significant physical symptoms (in particular that the failure to eat is because of a fatalistic and nihilistic delusion that her/his “intestines are full and nothing can be done about it”. S/he actually has reasonable fluid intake and good urine output

Results can be given to the candidate as they have already completed a full physical assessment (see below)

U&E: Na 142, K 4.2, Urea 7, Creatinine 87 eGFR > 90. Glucose 3.5. Amylase 68. CRP <1

FBC: Hb 134, WBC 7.8, Platelets 234

Urine: Ketones ++

ECG: Nil acute

FoB: negative x 1

CXR and AXR today in ED – both normal

This patient has a dry mouth – but is not clinically dehydrated. S/he apparently hasn’t been eating properly for some time but electrolytes are essentially normal and eGFR is > 90. Of note within the last month s/he has also had a normal CT scan of her head chest abdomen and pelvis - this was arranged by her GP as an out-patient investigation following her repeated presentations with similar history being given.

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| Physical assessment looking for organic cause | A | Open and secure |  | Primary mental health assessment | **A**gitation/arousal | Dishevelled, slow movements, clothing a little loose. |  |
| B | RR 14 SpO2 98% 0n air |  | **E**nvironment | Currently being nursed in a cubicle in the majors area in ED. Movable objects within the room, good observation from the nursing station. |  |
| C | P 84 BP 155/85 |  | **I**ntent | Appears to want help with terminal illness |  |
| D | Alert PERLA |  | **O**bjects | None, admitted wearing night clothes no weapons. |  |
| E | T 36.7 |  | Risk to self?Risk to others?Flight risk? | Not statedDeniesDenies  |  |
|  |
| Immediate Treatment: Measures to minimise psychiatric or physical risk to patient or others | * Appears relatively low risk of harm to self or others and of absconding
* Physically weak/slow so potential risk of fall
* Needs full physical and psychiatric assessment
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| Focused physical history and secondary examination | **P**roblem | Nonspecific abdominal symptoms with weight loss. |  | Focused conversational psychosocial history and mental state examination | Demographic and historical factors | 68yr old widow(er), spouse died 2 yrs ago from lung cancer. Lives alone and no current financial worries. Son age 44 lives in Spain and relatively isolated other than church friends. |  |
| **H**istory of presenting problem | 6-12 month history of abdominal discomfort and complaints of difficulties digesting food, minimal poorly located pain.Some weight loss ?amount, minimal intake for several months and no intake for 2 days. Declining fluid intake. Recent constipation, no other change in bowel habit. |  | Co-morbid mental illness | Delusional beliefs that her/his intestines have died and are now poisoning her/him.Depressed in mood with poor sleep, appetite and anhedonia. Passive wish to be dead. |  |
| **R**elevant medical history | HypertensionHigh Cholesterol |  | Overall risk profile | Low risk of self harmLow risk of harm to others. Low risk of absconding.High risk of severe self neglect and very vulnerable. |  |
| **A**llergies | NKDA |  |  |  |  |
| **S**ystems review | Feels weakGI – see aboveGU – nilCVS- nilResp – nilNeuro - nil |  |  |  |  |
| **E**ssential family and social history | Father – alcoholic, IDHPt is a very infrequent drinker, no illicit drugs and non-smoker. |  |  |  |  |
| **D**rugs | Antihypertensive and cholesterol lowering meds ?namesHasn’t been taking for weeks/months. |  |  |  |  |
| Top to toe | Dishevelled wearing night clothes, slight weight loss. Not dehydrated. Abdominal examination unremarkable and in particular no organs or masses palpable and no tenderness. No injuries or other signs of physical illness. |  |  |  |  |
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| Emergency physical treatment | * Needs bloods to establish any renal failure, electrolyte imbalance or anaemia

VBG shows a Hb of 127 and no electrolyte disturbance. Glucose 5.6 mmol/l and lactate 0.6No changes on lab bloodsUrine = ketones ++ECG = nil acute * May need further investigation to exclude abdominal disease.
* Consider capacity.
 |  | Emergency psychiatric management / consider MHA | * Will need assessment by psychiatrist
* Will need admission due to poor food/fluid intake.
* If becomes more agitated/asking to leave then review risk assessment.
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| Disposal | Medical/psychiatric dependent on results of physical investigations |  |
| Reassess risk |  |  |
| Handover to:

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| Psychiatry |

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

* Treatment of physical health conditions as a complication of psychiatric illness
* Capacity

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

Assessing a severely depressed patient presenting with physical health concerns

Eliciting delusions relating to physical health concerns.

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 Cecilia/Cecil a 68yr old and you live alone. You were born in Ireland (Dublin) and grew up there, your parents are both deceased and you had an older sister who you lost contact with. You attended school and did ‘fairly well’ and went on to secretarial college. Age 23 you moved to Liverpool and then to Manchester where you met your spouse John/Joan (a salesperson). After you married you/your wife quickly became pregnant with your son, you were a stay at home Mum/Dad and a keen member of the local church. You didn’t have many friends outside this but had a happy home life and were married for over 30yrs. Your son Adam now 44 moved to Spain 15 years ago and you have contact 1-2x a month by phone, he is married and has two young children. You haven’t been over to see them for over a year. You were never very close to your sister and you lost contact with her many years ago. Spouse died 2 yrs ago after a short battle with lung cancer (4 months) following this you have had some support from the church but have been finding it difficult to attend events and have gradually withdrawn from your church friends, you have felt so physically unwell that for the first time that you can remember you have missed Sunday mass for the last few weeks.

Your Dad was a heavy drinker and died from a heart attack in his early 60’s, your Mum died some years later from ‘old age’. No other illnesses that run in the family. You have high blood pressure and cholesterol and have been taking medication for this.

You have never been much of a drinker at most having a glass at Christmas and on your birthday. No illicit drugs, non-smoker. You have no allergies.

Medication

Antihypertensives – you can’t remember the name

Something for cholesterol

You haven’t been taking these for several months as you couldn’t get to your GP to pick up the prescription and there didn’t seem much point.

Now

You were brought to ED by your friend from church who had visited you at home after not having seen you at church for the last few weeks. She was shocked that you had lost some weight and the fact that you were struggling to walk unaided. You have known for over 6 months that there has been something wrong with your stomach and your ability to digest food, you have had some pain but the main symptom is that your intestines haven’t been digesting food properly and over the last 3 months your ability to eat has been drastically reduced as when you eat you can feel the food sitting in your intestines and this is very uncomfortable. Over the last 2 days you have been struggling to eat at all and you have also been struggling to drink fluids. You haven’t sought any medical help as you know that no-one would be able to help you. You have minimal poorly located pain, some recent constipation. You’ve lost a lot of weight, clothes are now larger (but no idea how much or what you weigh). Your bowels are no longer regular and you feel constipated. No other physical problems. You are convinced that there is something sinister wrong with you and believe that you will die and you become very tearful when discussing this. You are initially vague about symptoms saying that when you eat it feels uncomfortable and you currently are not in any pain. When asked in more detail about your symptoms you will state that you think that part of your intestine had died and is now starting to poison you.

Currently you feel low in mood all the time ruminating about your physical health problems. You struggle to think clearly and to concentrate. You are slightly slow to respond to questions talking quietly and making little eye contact with people. You are tearful but able to continue to talk. You have felt low in mood for the last 2 years since the death of your spouse, s/he died from lung cancer and had been ill for only 4 months before his/her death. You had support from your friends from the local church following his/her death they cooked you meals and invited you out to social events, you attended these events on and off and initially found this helpful but gradually you found it difficult to enjoy them and you stopped attending and being invited. Your son and his family live in Spain and although you talk on the phone a few times a month you don’t want to upset him by telling him how unwell you are. You have continued to attend church every week until the last few weeks when you felt too physically unwell to attend. Your sleep has been poor for months and you stay in bed for hours on end unable to sleep, you haven’t enjoyed anything for months and haven’t the motivation to do anything. You wish that you could sleep and often wish that you could just go to sleep and not wake up as then this would all be over. You would never dream of harming yourself as this would be against your religion.

If anyone tries to reassure you that physical examination/bloods etc are normal you are not reassured in anyway. You believe that your mood is low due to your physical health problem and is understandable for someone with a terminal illness, you do not believe that a psychiatric illness could be causing your physical symptoms. You would consider admission to a medical ward although you don’t think they will be able to help and would prefer to be allowed to go home.

ICE (Ideas, Concerns, Expectations)

 ***Thoughts and concerns***

You believe that you are dying and that no-one could do anything to stop this

You are concerned how painful the death will be and may be amenable to palliative care.

You have no thoughts of harming yourself or anyone else.

Opening statement

Wait to be asked questions

Emotional behaviours/statements/questions

***If asked directly:***

Do you think that you will die – yes

Can anyone help you – no

Do you have any thoughts of harming yourself or others – no of course not

Could we contact your son/friend – no, I don’t want to worry them.

***Possible statements:***

See above

Dos and Don’ts

Slight delay in speech (but not too long) and minimal eye contact.

You sit in a slumped way.

**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.