# SIMULATION CASE - OD\_SH\_6

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| **Learning outcomes:**  By the end of this simulation the candidates will:   * Be able to carry out a psychosocial assessment on an individual with psychosis and self harm. * Be able to carry out a risk assessment in the context of a person with psychosis and self harm * Be able to keep a person with psychosis and self harm safe, within the ED and whilst awaiting transfer to the general hospital. * Be able to provide a clear management plan and handover that includes specific actions to keep the patient safe.   Simulation focus: Identification and management of mental health related psychosis while excluding alternative organic causes. |

**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. |

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:

* Dressing and bandages

[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 42 year old *m/f* who has presented after stabbing *him/herself* multiple times in the head with a small sharp screwdriver. | |
| **B**ackground | *S/he* lives with his/her mother. *S/he* has been more withdrawn, but has never done anything similar previously. | |
| **A**ssessment | A | Patent airway. Talking about the special defence force. |
| B | Chest Clear RR18 SpO2 99% |
| C | HR 103 BP 140/90  HS 1+2+0 No murmurs  Warm, sweaty, well perfused |
| D | GCS 15. PERLA 4mm  Moving all 4 limbs |
| E | Multiple (15) penetrating wounds to the scalp. Oozing.. BM 5.4 T38.7 |
| **R**ecommendation | Please assess this 42 year old patients injury and mental health. | |

Further information if requested by the candidate

A 42 year old *m/f* was brought to the ED by ambulance after stabbing himself multiple times in the head with a small sharp screwdriver. *S/he* lives with his mother who is in her 70s. *S/he* has had to wrestle the knife away from *him/her.* *S/he* is worried as s/he has been more withdrawn, but this behaviour is completely out of character. S/he is muttering about defence.

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

The patient is found to have a raised temperature of 38.7C and is tachycardic.

*S/he* allows bloods to be taken and cannula to be placed but refuses to have a CT Brain or Lumbar Puncture.

*S/he* has 15 separate stab wounds to his scalp. It is not clear how deep they are – when assessed they are not penetrating the skull and need to be irrigated and closed.

Patient admitted to a medical ward as he was thought to have a viral encephalopathy and commenced on antibiotics (eg ceftriaxone) and antivirals (acyclovir).

Patient becomes increasingly withdrawn and he has not said anything about why s/he tried to harm them self other than muttering about the special defence force. Appears paranoid.

Mother will provide most of the history as the patient is mono-syllabic.

“*S/he* is a 42 year old who was brought to the ED by ambulance after stabbing themselves multiple times in the head with a small sharp screwdriver. *S/he* lives with his mother who is in her 70s. *S/he* has not had contact with mental health services before. The mother says that *s/he* has always been shy and has never

mixed with people. In the last year *s/he* has become more reclusive and spends most of the time alone in the bedroom. *S/he* is awake during the night and she has heard *s/he* talking to themselves. *S/he* has not voiced any thoughts of self harm. There do not appear to be any triggers to this episode. *S/he* found

*him/her* in a pool of blood and grappled with *him/her* to take the screwdriver off them. *S/he* has brought in the screwdriver. It is small the type you use to unscrew tiny screws…” Will require one to one observation on the medical ward.

|  | Physical health | | | | | **☑** | Mental health | | | | | | **☑** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PRIMARY | Physical assessment looking for organic cause | | A | Patent – talking about defence | |  | Mental health primary assessment | **A**gitation/arousal | | | *S/he* is waiting assessment for the wounds to his head. | |  |
| B | Chest clear. SpO2 99%, RR15 | |  | **E**nvironment | | | *S/he* is currently waiting in one of the cubicles with mother. | |  |
| C | P102 BP125/80. Sweaty and clammy | |  | **I**ntent | | | We do not know what was *his/her* intent. This kind of injury is unusual. | |  |
| D | GCS 14/15 E4V4M6 PERLA 3mm | |  | **O**bjects | | | We do not know if *s/he* has any other weapons on them. | |  |
| E | T38.7 BM 7.6  15 scalp lacerations  No rash | |  | Risk to self?  Risk to others?  Flight risk? | | | We are unable to assess risk fully as *s/he* is not speaking –so it must be high  We do not know risk to others- but the bizarre nature of the self harm means we cannot rule out harm to others  We cannot exclude flight risk | |  |
|  | | | | | | | | | | | | |
| Unified assessment  Immediate Treatment: Measures to minimise psychiatric or physical risk to patient or others | | This patient requires one to one observation. The unusual nature of the self harm is suggestive of possible psychosis, whether organic or functional.  Wounds need to be irrigated, explored, closed.  Antibiotics and antivirals until meningo-encephalitis excluded.  Need to exclude low Blood glucose as cause of altered mental state | | | | | | | | | |  |
|  | | | | | | | | | | | | | |
| SECONDARY | Focused physical history and secondary examination | **P**roblem | | | Multiple penetrating wounds to scalp. Pyrexial ? cause |  | Focused conversational psychosocial history and mental state examination | | **SELF HARM** | **S**uicidal thoughts at the time of self-harm | | Unclear |  |
| **H**istory of presenting problem | | | Unwell for 2 days and more withdrawn – but has been more withdrawn in the last 6 months |  | **L**ethality of the episode | | Low lethality |  |
| **R**elevant medical history | | | Nil known |  | **I**ntent now | | Unclear |  |
| **A**llergies | | | Nil known |  | **P**rotective factors | | Lives with mother |  |
| **S**ystems review | | | Maculopapular rash  No joint issues  No cardiorespiratory symptoms. Nil ENT abnormalities. NO GI/GU symptoms |  | **A**dverse factors | | Not working  Has never worked  No friends  Family history of bipolar |  |
| **E**ssential family and social history | | | Father unknown. Mother well |  | Demographic and historical factors | | | No prior self harm |  |
| **D**rugs | | | Nil |  | Co-morbid mental illness | | | Possible psychosis |  |
| Top to toe | | | Maculopapular rash  Nil else |  | Overall risk profile | | | High risk of further self harm and flight as history is limited. |  |
|  | | | | | | | | | | | |  |
| Emergency physical treatment | Wounds need to be irrigated, explored, closed.  Antibiotics and antivirals until meningo-encephalitis excluded.  Need to exclude low Blood glucose as cause of altered mental state | | | |  | Emergency psychiatric management / consider MHA | | This patient requires one to one observation in the ED. | | | |  |
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| INITIVE CARE AND DISPOSAL | Disposal | | | | This patient requires further investigation on the OMU and will require one to one observation on the ward. | | | | | | | |  |
| Reassess risk | | | | *S/he* will require continued observation with regular review from liaison mental health at least every 24 hours, whilst investigations are being pursued. | | | | | | | |  |
| Handover to:   |  | | --- | | OMU |   including on-going care plan | | | | **S**ituation | Bizarre multiple self harm Possible auditory hallucinations. | | | | | | |  |
| **B**ackground | No prior psychiatric history. But pattern of increasing isolation over the last 12 months. Has raised temperature on assessment of unknown cause. | | | | | | |  |
| **A**ssessment | Difficult to assess as uncooperative. Appears suspicious. | | | | | | |  |
| **R**ecommendation | This may or may not be a functional or organic psychosis. Patient needs close observation on one to one basis to prevent further self harm. Ward should ensure this is put in place. Liaison mental health team to review on OMU and discuss observation and safety plan with OMU staff. | | | | | | |  |

[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

* Consideration of differential diagnosis of acute behavioural disturbance.
* Staff, patient and the public protection
* Management of pscyhosis

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

Assessment of self harm

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 live with your mother. You are 42 years old. You have stabbed yourself repeatedly in the head. You are frightened and suspicious. You are hearing people shouting at you all the time to be quiet. They are telling you that everyone around you are going to kill you. ‘Don’t listen to what they say’ ‘Don’t tell them anything’.

If someone asks you a question don’t answer. Don’t make eye contact. You can look a bit distracted at times.

. Don’t try to hurt anyone or actively run away. Just hold your head from time to time. You think a chip has been implanted in your brain and you were trying to get it out with the screwdriver. But don’t say this to anyone. At most, limit your communication to mumbling `get it out’ `get it out’ . This is much more about behaving oddly, rather than Making any meaningful communication.

***Medication***

*None*

Now

ICE (Ideas, Concerns, Expectations)

***Thoughts and concerns***

Don’t answer

Opening statement

Don’t say anything

Emotional behaviours/statements/questions

***If asked directly:***

Don’t reply. Look suspicious.