# SIMULATION CASE OD\_SH\_8

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| **Learning outcomes:**By the end of this simulation the candidates will:* Be able to work through an integrated (medical and psychiatric) assessment of a patient who has taken an overdose / self harmed
* Use communication skills to elicit a clear history from a patient who has taken a significant deliberate overdose
* Make an accurate assessment of the ongoing risk to self and others including risk of future completed suicide
* Assess the patient’s capacity
* Understand the issues regarding Advanced Directives in the context of self-harm
* Determine a sensible and safe plan regards the medical and psychiatric management of a patient who has taken a significant deliberate overdose, which will be lethal unless treated

Simulation focus: A potential lethal overdose in the context of a possible Advanced Directive is a complicated legal area. The clinician must act within the law (which is not particularly clear), assess capacity and appreciate the role that mental health issues may play in relation to capacity.  |

**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 | Please assess this lady/gentleman who has taken an overdose of ethylene glycol |
| **B**ackground | The patient has phoned an ambulance and has asked to be brought to ED after drinking a large quantity of ethylene glycol. He/she is not sure how much but at least 2 bottles of antifreeze. |
| **A**ssessment | A | Own and patent  |
| B | Appears to be breathing normally. |
| C | Tachycardia, baseline 110/60  |
| D | GCS 13 currently no focal neurological signs |
| E | Looks tired and somewhat withdrawn. Speech is slightly slurred. But able to respond to questions and fully orientated. |

Further information if requested by the candidate

*Alex* is a 35 year old *male/female*, brought to A&E by ambulance, after calling the ambulance and asking to be taken to the ED to die. *He/she* has brought a note with her and says it is an advanced directive. The note is handwritten and states that it is her/his expressed wish not to have any treatment for the OD, specifically no dialysis, but that he/she wishes to be kept comfortable while he/she dies. It is undated, not witnessed and unsigned. This is her/his third presentation to the ED in the last year with serious ODs and he/she is currently under the care of mental health services. In the last year, he/she had been admitted to hospital under the MHA on two occasions. He/she has been given a diagnosis of borderline personality disorder. She is very vague about when she drank the ethylene glycol but it is at least several hours ago. She has felt sick but has not vomited. She has not taken ethylene glycol before.

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

The patient is becoming gradually more drowsy and feels nauseous but remains reasonably alert during the assessment. Repeat observation will be consistent with that of ethylene glycol poisoning. (This bit needs to be written by a ED specialist).

Patient accepts investigations and is asking for morphine for abdominal pain but continues to refuse specific treatment for the poisoning i.e. antidote. Blood gases show a rising acidosis. Initial tachycardia becomes a bradycardia. The patient refuses to see a psychiatrist.

|  | Physical health | **☑** | Mental health | **☑** |
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| PRIMARY | Physical assessment looking for organic cause | A | Currently no sign of airway compromise though it should be noted that ethylene glycol may cause drowsiness and coma which could cause significant occlusion of the airway |  | Mental health primary assessment | **A**gitation/arousal | Remember that *s/he* may have taken other tablets, now or in the recent past. |  |
| B | Saturations on air 98 %, RR 18, no signs of respiratory distress and chest sounds clear on auscultation  |  | **E**nvironment | Risk is low as patient is becoming drowsy and unwell. |  |
|  |  |  | **I**ntent | The story suggests significant intent at the time of overdose, followed by a stated wish to die and not to have treatment. However, he/she called an ambulance and asked to be taken to hospital. |  |
| C | P 60 irregular periodsBP 126/70 –ECG shows alteration of curvature of the S-T segment combined with a diphasic T wave  |  | **O**bjects | A check for objects the patient may have to harm him/herself should still be carried out, even though the patient is quite unwell. |  |
| D | A on AVPU or GCS 12, no focal neurological signs then slight increase in drowsiness as scenario progresses to V on AVPU  |  |  |  |  |
| E | The patients skin is a little clammy. *S/he* complains of mild nausea and abdominal pain, but the abdomen is soft on examination |  | Risk to self?Risk to others?Flight risk? | Until more facts are known *s/he* should be considered high risk to him/herself. |  |
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| Unified Assessment;Immediate Treatment: Measures to minimise psychiatric or physical risk to patient or others |

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| Medical Treatment as per toxbase advice but refuses treatment In all patients monitor pulse, blood pressure, temperature, level of consciousness and cardiac rhythm. Perform a 12-lead ECG in all patients who require assessment. Repeat 12-lead ECGs are recommended, especially in symptomatic patients or in those who have ingested sustained release preparations. Check cardiac rhythm, QRS duration and QT interval.Check urea, electrolytes, creatinine, glucose, LFTs, Calcium, Magnesium and CK.Correct hypotension by adequate fluid resuscitation with a crystalloid (normal saline)Check blood gases for metabolic acidosis.Recognise the risk of serotonin syndrome, seizures, hypotension, hyperthermia, agitation  |
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| SECONDARY | Focused physical history and secondary examination | **P**roblem | Overdose of ethylene glycol |  | Refuses psych assessment. But in this high risk scenario, mental health team will need to intervene. It is unclear whether patient has capacity to make the decision to refuse treatment and the patient may be suffering from a mental disorder that may warrant detention under the MHS. A focused conversational psychosocial history and mental state examination should be attempted | **SELF HARM** | **S**uicidal thoughts at the time of self-harm | Establish what *s/he* was trying to do. The context makes a genuine attempt to end his life more likely. *S/He* is under mental health services with a diagnosis of BDP and has taken previous serious ODs in the previous year. Has been detained twice under the MHA in last 12 months in similar circumstances. It is unclear what precipitated this event.  |  |
| **H**istory of presenting problem | Taken several hours ago now, has felt nauseated and tired. Has brought an ‘Advanced directive’.Query capacity. |  | **L**ethality of the episode | The medical risk of the overdose is very high and will most likely result in death unless treated.  |  |
| **R**elevant medical history | Nil of note |  | **I**ntent now | This should be interpreted with caution. Patient is saying he/she still wishes to die but has attended hospital and it is unclear if she has capacity. She is drowsy and under the influence of ethylene glycol. The paper she has brought with her is not an advanced directive. It is not dated or signed so is not legally binding.  |  |
| **A**llergies | NKDA |  | **P**rotective factors | Called for help. Nil else identified.  |  |
| **S**ystems review | Recent constipation, nil else |  | **A**dverse factors | Patient has a mental health condition- BPD. He/she is prone to unstable episodes of extreme emotion including anger and despair. In between these episodes she is noted to at times be cheerful and enjoy life.  |  |
| **E**ssential family and social history | Estranged from family. History of CSA |  | Demographic and historical factors | Psych notes reveal that she has been involved in similar scenarios in the past when she has taken tablets then refused treatment. She has always been persuaded to take treatment in the past and has had periods of well being following this. Staff have queried a dynamic involving a wish to be rescued.  |  |
| **D**rugs | May have taken alcohol. |  | Co-morbid mental illness | BPD |  |
| Top to toe | Multiple scars to forearms, stomach and legs. |  | Overall risk profile | This is a high risk situation. |  |
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| Emergency physical treatment | As toxbase advice, IV access, IV fluids, ECG 12 lead and ongoing monitoring Whether this treatment is administered needs to be discussed with the team, including Consultant Psychiatrist.ED staff should make an assessment of capacity but may wish for further examination/assessment from psych team. |  | Emergency psychiatric management / consider Capacity and MHA | The priority is to assess the patient’s capacity and mental state, and with that information decide on a management plan. The ED staff should have made an initial assessment of capacity but may need help in this case . He/she is able to understand what he/she has done and the consequences of not having treatment. He/she can retain this information. The question is whether he/she can weigh this information in the balance or whether his/her mental condition is inferring with tis. She is drowsy and also has BPD so is subject to extreme emotional arousal which may temporarily impair judgement. The so-called advanced directive is not known to mental health services and it is very unclear when it was written and it has no legal validity. There are also grounds to detain under the MHA and treatment for an OD can be given under the MHA. This is a very specific circumstance when physical treatment can be given in addition to mental health treatment.A Consultant Psychiatrist needs to be involved in the management of this patient and a discussion between the ED Consultant and Consultant Psych must take place (even if the Con Psych is not on site). |  |
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| INITIVE CARE AND DISPOSAL | Disposal | This is a very complicated scenario. The legal situation regarding this area may change or be clarified further.This scenario suggests the patient does not have current capacity to make such an important decision and treatment should go ahead in his/her best interests. There is no relative to call and an IMCA would take too long to contact. The patient should also be detained under the MHA (this process takes several hours) and will probably need to be admitted to the ITU. Treatment should start as soon as possible.If the ‘note’ was a formal Advanced Directive…..this situation has not been tested under the law and emergency legal advice would need to be taken. This case should rightly raise significant debate amongst the course participants. |  |
| Reassess risk |  |  |
| Handover to:

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| Medical and Psychiatry teams |

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

This case is based on a true case when the patient was allowed to die. However, the body of opinion since then has suggested that he/she did probably not have capacity at the time, and she should have been treated according to best interests, with additional use of the MHA.

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

Background

***Location***

***Background***

***Medication***

Now

ICE (Ideas, Concerns, Expectations)

 ***Thoughts and concerns***

Opening statement

Emotional behaviours/statements/questions

***If asked directly:***