# SIMULATION CASE OD\_SH\_1

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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 an elderly 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
* Determine a sensible and safe plan regards the medical and psychiatric management of an elderly patient who has taken a significant deliberate overdose

Simulation focus: Overdose of any kind in an elderly patient should be taken seriously. There may be significant suicidal intent and ongoing risk to self especially in those socially isolated. Elderly patients may have numerous comorbidities and medications that may complicate the clinical picture. |

**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 an elderly lady/gentleman who has taken an overdose of medication |
| **B**ackground | Their spouse died 6 months ago following a long struggle with dementia throughout which time s/he was her main carer. |
| **A**ssessment | A | Own and patent  |
| B | Appears to be breathing normally, intermittently tearful |
| C | Mild tachycardia, baseline 126/84  |
| D | GCS 15 currently no focal neurological signs |
| E | Looks tired and somewhat withdrawn, no other physical abnormality noted initially  |

Further information if requested by the candidate

*Simon/Simone* is a 75 year old *male/female*, being assessed, after calling *his/her* daughter in tears, admitting that *s/he* had taken an overdose of 24 fluoxetine tablets and some zopiclone *s/he* had found in the medicine cabinet. *His/Her* partner died 6 months ago due to severe pneumonia. This was following *their* 5 year struggle with dementia, during which time *s/he* had cared for *her/him* until *s/he* died. About three months ago *s/he* had been to see his GP who had thought that *s/he* was depressed. *Simon/Simone* now lives on *his/her* own, though *s/he* has a daughter living on the same street.

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

The patient will be increasing tachycardic at the time of physical examination and repeat observations will show pulse now 120-130 bpm and regular, initially unclear whether this is due to the patient feels distressed or in fact due to the medication *his/her* has taken. ECG when performed will reveal sinus tachycardia and mild prolongation of the QT interval but no other abnormalities. Although this patient’s primary problem is their mental health, at present *s/he* is displaying some mild signs of toxicity and will require a brief period of medical observation and cardiac monitoring prior to transfer of care to the psychiatric team.

|  | 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 these medications 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, and that there may be co-morbid physical issues to consider  |  |
| B | Saturations on air 98 %, RR 18, no signs of respiratory distress and chest sounds clear on auscultation  |  | **E**nvironment | Assess for ligature points. There is a risk *s/he* may try to harm himself with objects in the room. The risk of absconsion is probably low, but consider it and risk assess it  |  |
|  |  |  | **I**ntent | The story suggests significant intent at the time of overdose, followed by fear or ambivalence  |  |
| C | P126 regular BP 126/78 – BUT this is low for this patient – *s/he* is usually hypertensive (170/90)and hence this is a relative hypotension for them, if *s/he* stands *s/he* will feel a little lightheaded. ECG shows mild QT prolongation  |  | **O**bjects | Does s/he have any possessions with which s/ he could harm *him/herself*. A belt, a knife, a pen |  |
| D | A on AVPU or GCS 15, 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 but the abdomen is soft and nontender on examination |  | Risk to self?Risk to others?Flight risk? | Until more facts are known *s/he* should be considered high risk to him. The fact that *s/he* called for help, or that he agrees to not try again, should not necessarily be reassuring |  |
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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 Consider activated charcoal by mouth if the patient presents within 1 hour of ingesting a toxic dose (too late in this case as was 4 hours ago)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)Recognise the risk of serotonin syndrome, seizures, hypotension, hyperthermia, agitation  |
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| SECONDARY | Focused physical history and secondary examination | **P**roblem | Mixed overdose of fluoxetine and zopiclone tablets |  | Focused conversational psychosocial history and mental state examination | **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 being treated for depression, and is depressed, so a detailed exploration of *her/his* mental state is warranted, with particular emphasis on biological symptoms of depression (such as sleep, early morning wakening and weight loss) as well as cognitive factors such as “life is pointless, the self is worthless and the future hopeless” |  |
| **H**istory of presenting problem | Taken approx. 4 hours ago now, has felt nauseated and tired |  | **L**ethality of the episode | The medical risk of the overdose was generally low, though his intention (and understanding of what *s/he* was doing) was that taking this overdose would kill them |  |
| **R**elevant medical history | Known hypertension, usually BP high – current BP actually low for patient |  | **I**ntent now | This should be interpreted with caution. There are multiple adverse demographic, social and psychiatric factors which make the risk of completed suicide very high, whatever *s/he* says |  |
| **A**llergies | NKDA |  | **P**rotective factors | Called for help. No previous psychiatric history. Supportive daughter who lived nearby |  |
| **S**ystems review | Recent constipation, nil else |  | **A**dverse factors | Age, recent bereavement , closeness to the bereaved. Living alone, concurrent depressive illness |  |
| **E**ssential family and social history | Death of spouse 6 months ago, lives alone Daughter nearby |  | Demographic and historical factors |  |  |
| **D**rugs | No elicit drug use. Numerus medications that *s/he* is unsure of, some for blood pressure  |  | Co-morbid mental illness | None, but consider that frailty and concurrent medication may increase the risk of completed suicide |  |
| Top to toe | Finger nails and toe nails dirty, a bit unkempt |  | Overall risk profile | This is a high risk situation, with demographic and social factors pointing to increased risk |  |
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| Emergency physical treatment | As toxbase advice, IV access, IV fluids, ECG 12 lead and ongoing monitoring This patient will likely require a short period of medical observation - 6 hours - until the signs and symptoms resolve. *S/he* would also have bloods taken for paracetamol levels though *s/he* denies taking this specific medication in overdose, *s/he* may not be being truthful. |  | Emergency psychiatric management / consider MHA | The priority is to assess the patients mental state, and with that information decide whether supervised discharge home is an option at all. The balance of risk assessment should be skewed towards significant concern about the risk of future self harm leading to completed suicide, and it may not be feasible to offer appropriate supervision in the community 24/7. An urgent decision on necessary levels of observation is required. An assessment under the MHA may be required, with particular consideration of any stated desire to leave. |  |
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| INITIVE CARE AND DISPOSAL | Disposal | A period of observation and cardiac monitoring under the medical admissions team followed by referral to the psychiatric team for ongoing assessment and care planning |  |
| Reassess risk |  |  |
| Handover to:

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| Medical and Psychiatry teams |

including on-going care plan | **S**ituation |  |  |
| **B**ackground |  |  |
| **A**ssessment | Using ABCSMITH |  |
| **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

* Elderly patients may have considerable intent despite relatively low risk medications being taken.
* It may be difficult as a young healthy nurse/doctor to relate to this gentleman and the loss of his life long partner and challenges of caring for a loved one with dementia

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 and manage risk in the context of multiple serious risk factors, where the actual overdose is not serious and where the patient may feel falsely reassuring

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 have been brought to ED by ambulance, after calling your daughter in distress saying that you have taken an overdose of 24 fluoxy-something tablets, and some of the sleeping tablets that you received after your spouse died, whose name starts with Z – you agree that the name zopiclone sounds familiar, if that is suggested to you.

You are a 75 year old retired teacher. About 6 months ago your spouse died – you had been married for over 40 years, but the past 5 years had been very difficult as *s/he* had developed dementia, and you had been their carer to the end. Although *s/he* death at first felt like relief, you have felt stuck and lost since – you have have been bursting into tears unexpectedly, you’ve lost interest in food and lost some weight, and you seem to be waking at 4AM and can’t get off to sleep again. You feel really bleak about a future without him/her, and sometimes wonder if you could have done more for her before *s/he* died. You don’t think you were a very good carer.

Your GP asked you about this about three months ago when you went for your blood pressure tablets, and your GP started you on some antidepressants. You’re not sure there is much point taking them – it’s normal to feel sad when your spouse dies, isn’t it?

The overdose you took was rather impulsive – you were taking your regular tablets that day, and dropped the glass, which shattered on the floor. This seemed to be a last straw, tipping you over the edge of feeling hopeless about things. You took the whole remaining packet of tablets, washed down with some sleeping tablets – actually, it was probably something that had been at the back of your mind for a few weeks.

***Medication***

Antidepressants for the past 3 months called fluoxy-something, as well as something for your blood pressure starting with a p. You’re sorry but you really can’t recall, as the pharmacist prepares your tablets in a box each month for you

Now

When asked if you will repeat the overdose, say that you won’t – you probably weren’t a very good carer, and now you can’t even take an overdose properly. Anyway, you say that your daughter won’t be leaving any tablets in the house anymore, so there shouldn’t be a problem

You don’t smoke and don’t drink alcohol because you are on medication. You’ve not had any previous problems with your mental health. Your only physical problem is high blood pressure, and you’ve not had any major ops in the past.

You now live alone in the marital home though your daughter lives just down the street and visits you on most days

If asked, you don’t hear voices, or hear strange things. You don’t feel there is any witchcraft, black magic or any other strange things, you feel in control of your body, and don’t have any other odd or unusual experiences

ICE (Ideas, Concerns, Expectations)

 ***Thoughts and concerns***

Your overall behaviour is to be depressed – you have low self esteem, you are pessimistic about the future and you now feel a burden to your family. However, you really don’t want to come into hospital, and will emphasise (in a rather depressed sort of way) that you hadn’t planned to kill yourself that morning, and that it had just all overwhelmed you all of a sudden but that you are OK now.

Opening statement

You’re not going to keep me in, are you?

Emotional behaviours/statements/questions

***If asked directly:***

Whether you want to try to hurt yourself again, say you won’t