# SIMULATION CASE –CA\_1

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| **Learning outcomes:**By the end of this simulation the candidates will:* Understand how to assess and manage aggression in hospital settings

Simulation focus: Management of Delirium, De-escalation aggression; Communication |

**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:

* Clock available
* Setup should be Emergency Department cubicle.

[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 78 year old with confusion, agitation and aggression. Pateints daughter is concerned that *s/he* has gone “mad” as she speaking of their dead spouse and has tried to assault the daughter. |
| **B**ackground | As the history above |
| **A**ssessment | A | No concerns with Airway. Talking – swearing and shouting |
| B | No concerns with Respiratory system. RR 20. Chest clear SpO2 96% |
| C | Heart sounds I+II+0. HR 98. BP 144/85 ECG - Nil acute.  |
| D | AVPU – Voice. GCS 14/15 (confusion).  |
| E | Glucose 5.8. MSU positive for nitrites and leucocytes Temp 34.9 |
| **R**ecommendation | Please assess this agitated, aggressive elderly patient |

Further information if requested by the candidate

You have been asked to see *Mr/Mrs*. Smith (78 years old). *S/he* is a retired teacher who lives alone after being widowed 1 year ago. Daughter visits on a daily basis. Approximately two days ago the daughter noticed that *s/he* was acting oddly, had not washed that morning and had not eaten the meals the daughter had prepared. *Mr/Mrs.* Smith stated that *s/he* felt “under the weather” and needed to rest. Today when the daughter visited, *s/he* found her *father/mother* *Mr/Mrs.* Smith partially dressed and agitated in the living room. *Mr/Mrs.* Smith told her she could see her dead spouse and hear him talking. Also talked about events from the past as if they were in the present. The daughter noticed *s/he* smelled quite strongly of urine. When the daughter tried to talk to *Mr/Mrs.* Smith said “you’re the one having an affair” and attempted to hit her. *S/he* has never been aggressive before to the daughter’s knowledge.

An ambulance was called after *Mr/Mrs*. Smith refused to go in a car to hospital and was brought to the Emergency Department.

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

Collateral history – *Mr/Mrs*. Smith’s daughter is extremely concerned as she has never seen her *mother/father* like this. Her *mother/father* was a model teacher, sympathetic and quiet. *Mr/Mrs*. Smith is now agitated, trying to hit out and swearing at their daughter (daughter has never heard her swear before). The daughter is very concerned that *Mr/Mrs*. Smith is not making sense and especially is saying that *s/he* can see her deceased spouse. The daughter wonders if *s/he* has gone psychotic or has had a “breakdown”, especially as she feels *s/he* never quite got over the loss of her spouse.

|  | Physical health | **☑** | Mental health | **☑** |
| --- | --- | --- | --- | --- |
| PRIMARY | Physical assessment looking for organic cause | A | Shouting and swearing |  | Mental health primary assessment | **A**gitation/arousal | High level of arousal |  |
| B | Chest clear RR 22 SpO2 96% |  | **E**nvironment | Low |  |
| C | HS I+II+0. HR 98. BP 144/85 Flushed. WarmECG - Nil acute.  |  | **I**ntent | Moderate |  |
| D | AVPU-Voice GCS 13/15 E3V4M6 PERLA 3mm Moving all 4 limbs |  | **O**bjects | Low |  |
| E | Glucose 5.8. MSU positive for nitrites and leucocytes Temp 34.9 |  | Risk to self?Risk to others?Flight risk? | YesYesYes (in confused state) |  |
|  |
| Unified assessment:Immediate Treatment: Measures to minimise psychiatric or physical risk to patient or others | Urinalysis - positive for nitrites and leucocytes Commence antibiotics eg trimethoprim 200mg bdOrientation to surroundingsOne to one observationMedication for sedation / reduction of agitationCapacity assessment |  |
|  |
| SECONDARY | Focused physical history and secondary examination | **P**roblem | Confusion. Dysuria and urinary frequency |  | Focused conversational psychosocial history and mental state examination | Demographic and historical factors | 78 year old / Lives alone / Hypertension (treated) / Nil else |  |
| **H**istory of presenting problem | Daughter reports well normally up until 2 days previously. |  | Co-morbid mental illness | Episode of depression 10 years ago successfully treated with antidepressants.No psychosis, schizophrenia or Bipolar Affective Disorder in history |  |
| **R**elevant medical history | Hypertension |  | Overall risk profile | High level of arousal and moderate intent indicates 3-4 staff |  |
| **A**llergies | Nil |  |  |  |  |
| **S**ystems review | No GI symptoms. No cardiorespiratory symptoms. Nil ENT issues |  |  |  |  |
| **E**ssential family and social history | Lives alone. Retired teacher. No walking aids. Normally independent in ADLs |  |  |  |  |
| **D**rugs | Amlodipine 10mgBendroflumethiazide 2.5mg |  |  |  |  |
| Top to toe | Smells of urine. Unkempt. No signs of injury. |  |  |  |  |
| Emergency physical treatment | **TIME Bundle****Think, exclude and treat possible triggers**NEWS (? Sepsis)Medication review (identify new and changed medications)Pain reviewAssess for urinary retentionAssess for constipationCheck blood glucose.Exclude signs of head injury.**Investigate and treat underlying causes**Hydration – start fluid balance chartBloods (FBC, U+Es, Ca, LFTs, CRP, Mg, Glucose)Look for signs/symptoms of infection (skin, chest, urine, CNS)Perform appropriate cultures, imagingECG (?ACS)**Management Plan Completed**Initiate treatment of ALL underlying causes found above**Engage and explore**Is this usual behaviour?Ask how family would like to be involved?Explain diagnosis of deliriumDocument diagnosis of delirium |  | Emergency psychiatric management / consider MHA | Orientation to surroundingsOne to one observation (requires 3-4 staff on profile above)Medication for sedation / reduction of agitationCapacity assessment initially as organic cause is initial working diagnosis.If considerate that psychiatric disorder is primary cause, and organic cause treated or excluded consider Mental Health Act assessment. |  |
| INITIVE CARE AND DISPOSAL | Disposal | Impression – Delirium secondary to a UTIHandover to medical doctors |  |
| Reassess risk | 1.To self: low. No evidence found of low mood. Risk of accidental harm from falls and assaulting people ongoing due to delirium 2.To others: none identified Other:3.potential risk of refusal to engage with treatment and/or abscond4. Manage UTI  |  |
| Handover to:

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| Medical Registrar |

Including on-going care plan | **S**ituation | *Mr/Mrs* Smith is a retired teacher with acute behavioural disturbance. |  |
| **B**ackground | Normally well apart from hypertension and no recent psychiatric history – depression 10 years ago. 24-48 hour history of ‘not being right’ then short several hours history of agitation and aggression with reported urinary frequency and dysuria and mild suprabubic discomfort. |  |
| **A**ssessment | Delirium secondary to UTI. Cardiorespiratory and abdominal exam normal apart from low temperature and mild suprapubic tenderness. AVPU =V, GCS 13/15 E3V4M6. No signs of head injury. Urinalysis positive for nitrites, leucocytes and protein. BM and ECG normal.  |  |
| **R**ecommendation | Please continue the ongoing care of *Mr/Mrs* Smith’s UTI and manage their delirium |  |

 [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

* Consideration of both medical and physical causes
* Reduction of agitation through use of orientation (clocks, adequate lighting, use of same staff if possible), clear instruction and communication
* Treatment of underlying cause
* Ensuring that potential psychiatric causes are excluded or potentially treated (this may include a follow-up to ensure an underlying adjustment disorder (bereavement reaction) has not occurred)
* Use of sedating medication and doses for elderly patient
* Reassurance of relative (“my mother has gone mad”)
* Reducing risk to others from agitated patient

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

Candidate will be assessed on their:-

* Assessment of an elderly client with potential delirium including the differential diagnosis with both medical and psychiatric causes, appropriate treatments and follow up (immediate and longer term)

Interaction with the patient, ensuring the environment is adequate, repeatedly orientating the patient, using calming techniques in communication, being clear with instructions, communication with a distressed relative and clear plan for ongoing disposal of the patient.

* Candidate will display knowledge of causes of delirium and treatment, management of aggression including communication, environmental and medication techniques.

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 *Mr/Mrs*. Smith (78 years old) a retired teacher who lives alone after being widowed 1 year ago. Your daughter visits on a daily basis. Approximately two days ago your daughter noticed that you were acting oddly, had not washed that morning and had not eaten the meals your daughter had prepared. You felt “under the weather” and needed to rest. Today when your daughter visited, she found you partially dressed and agitated in the living room. You can see your dead spouse and hear them talking to you. You are very unsure of the date but think it might be 1989. You are very worried that your spouse is having an affair with the neighbor as they always seems to be talking over the garden fence. You are determined to do something about this, even if it comes to violence.

***Medication***

Antihypertensive medication

Now

You don’t recognize your daughter. You think she might be the neighbor having an affair, but you are not sure. You are not sure if your *husband/wife* is alive or dead, it’s very confusing, you are not sure if it is day or night. At times you can hear his voice talking to you and you are sure you saw *him/her* last night but then you keep getting told *s/he* has died. This is very distressing.

Your lower abdomen hurts and it is painful to go to the toilet to urinate.

ICE (Ideas, Concerns, Expectations)

 ***Thoughts and concerns***

You want to find out what has happened to your *husband/wife* and why you can’t go home.

You want to hit the person having an affair with your spouse.

Above all else you want the pain when urinating to stop and to try and become less confused.

Opening statement

“Let me talk to my *husband/wife*, how dare you keep me here”.

“I know you’re all part of it with *him/her*, they won’t get away with trying to have *him/her*, the Trollope”

Emotional behaviours/statements/questions

***If asked directly:***

If asked about your spouse’s state that you heard him talking to you this morning behind the curtain and are sure you saw them last night. You don’t see or hear them at the moment. However you were also told *s/he* has died and want to know did this happen today.

You don’t know the time, date, place or your daughter

You don’t think you have a physical illness, but you do need to rest.

If asked about leaving you want to go home, however if the interviewer is nice and calms the situation If asked about medication, after persuasion you will accept some

***Possible statements:***

Let me see my *husband/wife*

Margaret Thatcher is Prime Minister

Dos and Don’ts

Do – be agitated, confused and can even swear. Reduce this if the client orientates you and is calm and reassuring

Don’t be too aggressive

**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.

***Ability and skills:***

No specific skills required