# SIMULATION CASE – CA\_3

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| **Learning outcomes:**  By the end of this simulation the candidates will:   * Work through a systematic, integrated (medical and psychiatric) assessment of an acutely confused patient * Practice techniques of engaging with a confused, aggressive patient * Respond acutely to and contingency plan for acute behavioural disturbance using pharmacological and non pharmacological methods   Simulation focus: Rapid, systematic assessment of medical and psychiatric aspects of confusion and development of an effective acute response to behavioural disturbance in this patient group |

**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: discuss outlay of scenario with co-instructor and actor and check equipment

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:

* Oxygen mask, Pulse Oximeter, BP cuff, Stethoscope, pen torch, +/- CAM scoring sheet or AMT
* Ancillary information – investigation results and collateral history sheet

[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 60 year old who has been confused & aggressive in a local shopping centre. | |
| **B**ackground | Approximately 60 years old. Brought in by paramedics with confusion and aggressive behavior. Medical and psychiatric history unknown. | |
| **A**ssessment | A | Patent – talking in jumbled sentences |
| B | RR 28, refused sats probe and threw oxygen mask on floor. No obvious cyanosis; possibly some accessory muscle use. Productive cough – green/yellow sputum on the floor. |
| C | Unable to assess – too combative. No complaints of chest pain. |
| D | Moving all 4 limbs. A to V on AVPU scale. Couldn’t co-operate with motor section of GCS. Couldn’t get near him with a pen torch or glucometer. |
| E | No obvious jaundice, bruising, bleeding, rashes, or needle marks |
| **R**ecommendation | Triage would like a joint ED/mental health assessment if possible | |

Further information if requested by the candidate

You are in ED trolleys. Your next patient is Alex approximately 60 years old, brought into the ED by paramedics after a passer by spotted *him/her* in a local shopping centre and raised concerns. *S/he* presents as confused and at times aggressive – paramedics have struggled to carry out a primary ABCDE assessment. *His/her* bus pass suggests the patient lives in Liverpool. There is a phone number written on the back of it. *S/he* appears unkempt and poorly nourished. *S/he* does not smell of alcohol. There is no other background information.

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

Patient eventually responds to reassurance and consents to a primary ABCDE assessment.

Towards the end of ABCDE, he becomes acutely aggressive and requires rapid tranquilisation. *S/he* is calmer after this and engages with the rest of the assessment.

Deliver ancillary information (test results) after completion of medical and psychiatric assessments. Invite team member to deliver collateral history.

Abida is septic (likely source – chest) and requires medical admission.

Immediate management includes oxygen, IV fluids and antibiotics

Rapid tranquilisation should be prescribed, alongside options for regular medication

|  | Physical health | | | | | | | **☑** | Mental health | | | | | | | **☑** |
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| PRIMARY | Physical assessment looking for organic cause | | A | Patent | | | |  | Mental health assessment | **A**gitation/arousal | | | |  | |  |
| B | RR 28bpm, Sats 88% on room air, chest – scattered wheeze, crepitations right base, reduced expansion bilaterally | | | |  | **E**nvironment | | | | Extraneous equipment should be moved from cubicle. Maximize safety of patient and others. | |  |
| C | Warm peripheries, cap refill <2 secs. Sweaty. HR 122bpm, BP 92/50. HS I+II+0. | | | |  | **I**ntent | | | | Combative towards others. Denies self harm. | |  |
| D | Fluctuating alertness. GCS 13/15 (E4, V4, M5). No neck stiffness, moving all 4 limbs. Pupils equal and reactive. Glucose 6.2. | | | |  | **O**bjects | | | | No risks identified | |  |
| E | Temperature 38C. No obvious bruising or bleeding. No ligature or burn marks, bites, scratches or cuts, corrosion of mucous membranes  Becomes acutely aggressive – verbal de-escalation and rapid tranquilisation required. Will accept oral. Begins to settle after 15-20 minutes. | | | |  | Risk to self?  Risk to others?  Flight risk? | | | | * Risk to self : unclear if presentation is associated with a self harm attempt – no immediate evidence of this. Careful primary assessment looking for ligature or burn marks, bites, scratches or cuts, corrosion of mucous membranes. * Risk to others: currently combative and confused. Remove unnecessary equipment that could be used to harm others during an assault. Prescription for rapid tranquilisation should be written up and plan for restraint (if necessary) agreed with team members. Given fast respiratory rate and accessory muscle use, take care with drugs that cause respiratory depression * Refusal of investigations and/or treatment: Focused assessment of capacity should take place if this becomes a salient issue * Absconsion risk: confirm options for 1:1 observation if this risk escalates. Again, a capacity assessment should take place. | |  |
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| Unified assessment:  Immediate Treatment: Measures to minimise psychiatric or physical risk to patient or others | | Sepsis 6 - Oxygen, iv fluids, antibiotics, VBG, blood cultures, fluid balance are needed  Check blood glucose OK.  Ensure no signs of head injury | | | | | | | | | Rapid tranquilisation for acute agitation – Olanzapine 2.5-10mg / Haloperidol 2.5-5mg / Risperidone 0.5-1mg depending on body habitus. Care with benzodiazepines – use short acting if deemed necessary (Lorazepam 1mg) | | | |  |
|  | | | | | | | | | | | | | | | | |
| SECONDARY | Focused physical history and secondary examination | **P**roblem | | | Acutely confused with symptoms and signs of LRTI | | |  | Focused psychosocial history and mental state examination | | **Delirium assessment** | | COMA CHAMP  **C**onscious level – GCS 13/AVPU. Any fluctuations?  **O**rientation in time and place  **M**emory (3 words or name and address – immediate and after short delay)  **A**ttention - MOYB, WORLD, Serial subtractions – forgets after delay  **C**ognitive tests – not appropriate at this stage  **H**allucinations - visual. Not distressed. Insightless.  **A**ffective state - mood, energy, racing thoughts, new plans or projects  **M**otor – restless, over familiar. No tremor, myoclonus. Ataxia hard to assess.  **P**aranoia and other psychotic symptoms – paranoid, no other sx | | |  |
| **H**istory of presenting problem (collateral) | | | Productive cough, fever and breathlessness for 2 weeks | | |  |  |
| **R**elevant medical history | | | None known | | |  |  |
| **A**llergies | | | None known | | |  |  |
| **S**ystems review | | | As above. Otherwise unremarkable | | |  |  |
| **E**ssential family and social history (collateral) | | | Lives alone. Spouse died 8 months ago. | | |  | Demographic and historical factors | | | | Bereaved, isolating and self neglecting |  |
| **D**rugs | | | None known | | |  | Co-morbid mental illness | | | | None known but grief and possibility of depressive symptoms should be explored |  |
| Top to toe | | | Resp exam as above.  Malnourished. Otherwise remainder of exam unremarkable | | |  | Overall risk profile | | | | As primary AEIO |  |
|  | | | | | | | | | | | | | | |  |
| Emergency physical treatment | Sepsis 6 - Oxygen, iv fluids, antibiotics, VBG, blood cultures, fluid balance are needed  Check blood glucose  Repeat observations including urine output  ABG if possible – get a venous gas if not  FBC, U+E’s, Calcium, LFT’s, Prothrombin time, Glucose, blood cultures, CRP, TFT’s and B12. CXR, ECG, Urinalysis.  Remainder of examination: unremarkable  Consider CT head | | | | | |  | Emergency psychiatric management / consider MHA | | Risks to self and others – denies thoughts or plans to harm self or others  Capacity – willing to stay in hospital and receive investigations and treatment | | | | |  |
|  | | | | | | | | | | | | | | | | |
| INITIVE CARE AND DISPOSAL | Disposal | | | | | Give ancillary information sheets for investigation results and collateral history  Impression: Delirium associated with a working diagnosis of chest sepsis.  CROC - Admit under medics with mental health liaison team input | | | | | | | | | |  |
| Reassess risk | | | | | To self: low. No evidence found of current or historical self harming behaviours.  To others: ongoing due to confusion. Ensure pharmacological and non pharmacological aspects of management plan in place on receiving ward to reduce risk. Emergency contingency planning – rapid tranquilisation written up along with details of who to contact in/out of hours should this prove ineffective (Psychiatry CT/SpR). | | | | | | | | | |  |
| Handover to:   |  | | --- | |  |   including on-going care plan | | | | | **S**ituation | 62 year old m/f requiring transfer to medical bed. Working diagnosis of community acquired pneumonia with associated delirium. | | | | | | | | |  |
| **B**ackground | No confirmed medical or psychiatric history. No regular medications. Found earlier today in a shopping centre, confused and aggressive. Required rapid tranquilisation (oral) in ED. Good response to – (what does the candidate suggest – olanzapine, haloperidol, risperidone, benzodiazepine) | | | | | | | | |  |
| **A**ssessment | Hypotensive (92/50) and tachycardic (122bpm), right sided crepitations on chest exam. Raised WCC and CRP. CXR – right sided consolidation. Awaiting blood and urine cultures. Good response to fluids. IV antibiotics commenced. | | | | | | | | |  |
| **R**ecommendation | Delirium - Regular orienting (day, month, place, why in hospital, names of key staff etc). Daily delirium screen such as CAM/4AT. PRN Rapid tranquilisation prescribed. May require regular if persistently agitated. Contact details for psychiatry on call if advice required in/out of hours  When delirium subsides, patient should be screened for depressive illness and impact of major bereavement several months ago | | | | | | | | |  |

ANCILLARY INFORMATION:

Investigations: (Give to doctors to analyse. Nurses have the option to analyse or to ask instructor for results)

Hb 135

WCC 17.2

Neut 9.4

Lymph 1.5

Plt 450

Urea 13.8

Creatinine 122

Sodium 137

Potassium 5.2

Calcium 2.17

Bilirubin 14

ALT 57

ALP 220

Prothrombin time 13 secs

Glucose – 6.2

blood cultures - pending

CRP - 110

TSH 2.2

T4 102

B12 - 458

CXR – consolidation right lower and mid zone

ECG - sinus tachycardia

Urine dip – protein+ nitrites+ ketones+

(M, C +S) - pending

Urine drug screen - negative

Collateral history over telephone (daughter Jane):

Abida is a 64 year old who lives in Liverpool*. S/he* has become reclusive and self neglecting since their spouse died 8 months ago and has refused regular attempts to help and support *him/her.* Jane last saw *him/her* 2 weeks ago and noticed *s/he* was unusually snappy and getting muddled up all the time. She thought *s/he* must be tired or drunk. *S/he* wasn’t in when she called in yesterday morning; *s/he* thought *s/he* had gone to the shop but became worried as *s/he* hadn’t returned that evening. She reported *him/her* missing this morning.

[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

* Making effective use of the team when engaging with an acutely agitated patient
* Prioritising salient aspects of the presentation – medical, psychiatric or both
* The Mental Capacity act
* Importance of collateral history

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

* Building rapport with and gaining trust from an acutely confused patient.
* Carrying out a systematic assessment of physical health and working through psychiatric diagnoses
* Responding quickly and appropriately in the event of acute behavioural disturbance (preventing risk of harm to the patient and others)

Notes: you are unwell and acutely confused but you don’t know it. Everything is muddled, it’s hard to focus on anything or remember specifics. You get bored and overloaded with information really easily, interrupt frequently with irrelevant topics and find it hard to answer questions appropriately, instead asking questions in return about other things. Every now and again you close your eyes for a little kip – you seem to drift in and out of feeling tired and wide awake. You aren’t sure if you can trust these doctors and nurses but as long as they are nice and explain what they are doing you will go with it for now.

*Background*

Your name is Abida. You are about 62, 63 (you can’t quite remember). A while ago (can’t be specific), some blokes in green outfits took you and brought you here. They tried to suffocate you with a mask and inject you with something but you fought them off. Your tired. Its hard to not nod off. Just let anyone try to do what those blokes did. They’ll get it. Your spouse died 8 months ago but right now you are expecting them to come and get you.

Example of confused speech – delivered as a rambling monologue. Why am I here? I should be at work. I support West Bromwich you know. When is my *wife/husband* coming? There’s them allotments you know. Chris evans is on Radio 2 tomorrow morning – I wonder if she did that homework. What school do you go to?

***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.

Now

Someone is asking me what I’m doing here. Where am I etc. How the heck should I know? I tell them about the blokes in green and what happened. Why am I here? I should be at work. I’m a welder. I support West Bromwich. When is Kath coming? You see one of those little mushrooms again floating and try to grab it. They ask you what you are doing. Its bloody obvious – I’m trying to get those mushrooms. They seem a bit thick so you point to the mushrooms so they know what you are going on about.

The candidate asks if they can examine you. If they explain and reassure you they are trying to help and it won’t hurt you let them. If they just go for it you, ask them what the hell are they playing at, tell them to get their bloody hands off you and if they come near you again you will smash their face in.

They should explain what they are doing as they go along. If not, ask – whats that for, whats this for, what are you doing now? Carry on chatting throughout the assessment about irrelevant topics, one after the other. Work, hobbies, family, news, Kath, the goblin bloke at the end of the bed, the mushrooms. Point to different members of the team and ask repetitively if they are trying to nick your wallet, Occasionally look around the room - you can see people in the corner and at the foot of the bed staring at you that no one else seems to be able to see.

**THE EXAMINATION**

Airway – the candidate will assess this non invasively by encouraging you to talk

Breathing – the candidate should ask if its okay to examine you and talk you through what they are doing. They will want to put a probe on your finger and use a stethoscope. If they explain what these things are for, let them. If not, fight them off. Carry on chatting whilst they have the stethoscope on – this will encourage the candidate to think of creative ways to get you to be quiet for a few seconds so they can listen to your breathing. Ideally they should ask you to breathe in and out

Circulation – you co-operate. Again they will need to be creative to stop you talking.

Disability – you might be asked to move your arms. You don’t understand what they mean. They may then touch your head or neck – you bring your hand up to touch them or accurately show them where they touched you. If they try to shine a light in your eyes tell them to get away and stop beaming that thing into you

Exposure – let them have a look at you if they explain why they want to (to check for rashes, bruises etc). In the middle of this, you think they are going to hurt you. You grab hold of the candidate (gently) and shout at them, imploring them to leave you alone, to get the F\*\* off you. You get off the couch and square up to the candidate, she/he’s heading for a punch. The team should band together, talk to you gently and calm you down. They reassure you they are trying to help , they are not going to hurt you. They will offer you something - a tablet to feel calmer. You decide to take it. You feel calmer. A bit more sleepy but still able to talk.

They want to do some tests to see if you are well – this is ok.

**Psychiatry assessment**

They might ask you to move your arms and hands again like in Disability = same response as before.

Orientation (where are you etc) – you think you might be in a café, or maybe a prison. No idea where but its in England. You have no idea what day or date it is so you make it up. It’s definitely 1997 though.

Memory test – you can repeat 3 words immediately but can’t remember them a few minutes later. Just make irrelevant guesses.

Months of the year backward – you do them forwards instead, and with a struggle – after a few months give up (its boring and you can’t remember why they are asking you to do it anyway) start talking about something irrelevant. Spell world backwards – you try but get it wrong (e.g. DORLDW). If they ask you to take 7 away from 100, make up numbers – you can’t do it then start chatting about something else after one or two attempts.

They might ask if you see or hear anything unusual. The mushrooms in the air are a bit weird (tangent – I don’t like mushrooms. Jane puts them in lasagna but I can always tell, even if they are cut up small. We have an allotment you know, the cabbages last year were massive). If brought back onto topic - theres a small man, more like a munchkin at the foot of the bed. He doesn’t talk. He isn’t frightening. These have been

there for a few days on and off, like the cat.

They might ask about mood – you feel ok, energy levels normal, thoughts and thinking ok, plans – I’ve got to get the bathroom decorated. Veer off topic.

Questions about feeling safe / paranoid – laugh. Tell them you know something is going on but you don’t know what.

Risks – you don’t want to harm yourself or anyone else, but if anyone tries anything they’ll be sorry.

You agree you will stay in hospital and have tests and treatment

**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.