# SIMULATION CASE OD\_SH\_7

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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 attempted to hang themselves
* Use communication skills to elicit a clear history from a patient who has attempted to hang themselves
* 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 this patient

Simulation focus: Attempted hanging |

**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 young woman/man who has tried to hang themselves |
| **B**ackground | He/she has been brought to ED by friends after he/she tied to hang her/himself in a shared student flat. Went into his/her bedroom after an argument. Friends her a sudden noise to find him/her hanging from a roof beam.  |
| **A**ssessment  | A | Open and patent  |
| B | Appears to be breathing normally |
| C | Mild tachycardia, baseline 120/79 |
| D | GCS 15 currently no focal neurological signs |
| E | Looks tired and somewhat withdrawn, intermittently tearful, mild red mark around neck at site of ligature, but no other facial signs indicative of hypoxia |

Further information if requested by the candidate

*Jo/Josephine*  is a 20 year old *male/female*, brought to A&E by ambulance, after friends found him/her hanging in his/her bedroom. Could only have been hanging for a few seconds as friends heard a noise and rushed in to support him/her and then cut him/her down.

The flatmates tell the ambulance crew that Jo/Josephine has been drinking quite a lot, and has had a bottle of cheap wine today. They think s/he has been under a lot pressure recently. They also think that s/he has been taking amphetamines, cocaine and ketamine on a fairly regular basis, but probably not today.

There had been a row in the flat today, and one of the others had told him/her to ‘grow up’, shortly before finding hin/her in the bedroom

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

Physical signs remain stable. Patient however intimates that he /she wants to leave and does not want to wait to see a psychiatrist or member of the mental team.

Team need to discuss what they should do.

This will involve discussions of capacity……risk of SH, presence of mental illness, use of MHA etc.

Physical restraint?

|  | Physical health | **☑** | Mental health | **☑** |
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| PRIMARY | Physical assessment looking for organic cause | A | Currently no sign of airway compromise  |  | Mental health primary assessment | **A**gitation/arousal | Has had one bottle of wine so slightly disinbited and mildly intoxicated  |  |
| B | 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 also high. Consider it and risk assess it  |  |
|  |  |  | **I**ntent | The story suggests very impulsive but risky behavior . Intent is unclear |  |
| C | P120 regular BP 120/70 – ECG normal  |  | **O**bjects | Does s/he have any possessions with which s/ he could harm *him/herself*. A belt, a knife, a pen |  |
| D | GCS 15, no focal neurological signs  |  |  |  |  |
| E | There is a circular red mark around the neck. Not deep. No other signs patient was cynanosed. |  | Risk to self?Risk to others?Flight risk? | Until more facts are known *s/he* should be considered high risk to self. The fact that *s/he* is not wanting to stay to have a mental health assessment is of great concern. |  |
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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 – none required However, patient should be made safe until mental health team can respond and the high risk of absconsion should be noted.  |
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| SECONDARY | Focused physical history and secondary examination | **P**roblem | Attempted hanging |  | 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 suggests an impulsive reaction to an interpersonal dispute with a flat mate but the action was potentially very serious.  |  |
| **H**istory of presenting problem | Went into bedroom and hung self |  | **L**ethality of the episode | This is very serious, even if friends rushed in to cut the patient down. |  |
| **R**elevant medical history | Nil of note |  | **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 and however impulsive it seemed |  |
| **A**llergies | NKDA |  | **P**rotective factors | Possibly thought people would hear the attempt and save him/her. But few other protective factors. |  |
| **S**ystems review | Nil of note |  | **A**dverse factors | Alcohol +++, drugs ++, conflict with flatmates, estranged from family, university course not going well, no other social support, past history of SH and past history of mental health problems as a teenager, ambivalent about staying for assessment |  |
| **E**ssential family and social history | Estranged from family |  | Demographic and historical factors | If male ….PH of SH and PH of psych problems |  |
| **D**rugs | Has taken amphetamines and cocaine in the past but not with this event |  | Co-morbid mental illness | Low mood and distress sufficient to see counsellor (patient hasn’t given clear account) |  |
| Top to toe | Nil of note |  | Overall risk profile | This is a high risk situation, with demographic and social factors pointing to increased risk- the staff may feel that the patient is ‘attention seeking’ , but they should avoid this presumption as they do not know the patient well and the facts of the case should be acted upon ..rather than staff opinion |  |
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| Emergency physical treatment |  |  | Emergency psychiatric management / consider MHA | The priority is to assess the patient’s 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 the patient’s current lack of social support, the potential difficult atmosphere in the shared flat if the patient returns there. It may or 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 | referral to the psychiatric team for ongoing assessment and care planning |  |
| Reassess risk | The patient does not require on-going monitoring of their physical health. Disposal is to psych team who will need to decide whether or not admission is appropriate. A more complete assessment is required.  |  |
| 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 attempt at self harm may be viewed as impulsive. However, it was potentially very serious and the patient has very little social support and is therefore extremely vulnerable.
* The risk of further episodes in high, unless he’/she is offered further help. There is a possible depressive illness which needs to be assessed further.

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

You are Jo/Josephine, a 20 year old student at university, in your second year, studying English.

You have been finding the course harder and harder to cope with – you have been missing tutorials and not handing in assignments. You have already had a formal warning about attendance.

Things have been deteriorating slowly since you came to university. After a promising start, initial friendships didn’t continue, and you got into a group that would drink a lot. More recently, you have been taking drugs such as amphetamines and cocaine. The drugs are a mixed blessing – the ups are good, but the downs are bad. They make you irritable and generally bad tempered.

You’ve been having counselling with the university counsellors. When asked by the student to describe this more, say you would rather not talk about it, as it’s a difficult subject

Your flamates having been struggling with your erratic behaviour. There was a big row earlier (alright, you had had quite a bit to drink…) but one of them really hurt you by telling you to ‘grow up’. After this, you had just gone back to your room, and impulsively decided to hang yourself with your dressing gown cord, hanging off one of the top window latches. You don’t remember much after that, until ‘coming to’ in your room once the ambulance crew were there

Your backgound is a troubled one. You are the youngest of three, but when you were 7, your parents split up and your mother got a new boyfriend, who was violent towards her and you, and who was a drinker. Oftentimes, you would come home from school to find them having a row, and you would hide in your room. You started to self harm, making cuts on your arms and legs – somehow this made you feel better. You also took three overdoses during these teenage years. When you were 15, you saw a psychologist at school a few times, and you had not harmed yourself after the age of 16. You had a few friends at school, though had never been particularly popular

You had looked forward to starting university, over a year ago, because you thought this would be a ‘fresh start’ from the problems you had been having at home. You don’t have much contact with your mother (who is still with the same partner) as you find those contacts stressful and rather upsetting. More recently, your mother has said that she doenst really want to see you anymore

Until going to university, you hadn’t really drunk alcohol or taken drugs

***Medication***

None

Now

You are being looked after by a member of healthcare staff (this could be a paramedic, nurse, A&E doctor or mental health specialist. You have gone along with what has been offered to you up to this point

ICE (Ideas, Concerns, Expectations)

 ***Thoughts and concerns***

You still feel a little angry with everybody – your flatmates for having a go at you, your mother for disowning you, and your friends from last year from walking away from you. You don’t really know, or care, if you are alive or dead – you hadn’t planned the hanging, and hadn’t planned to die, though you don’t have that much to lose

Opening statement

Can I just go now, please. I don’t think I’ve damaged my neck, and I’ll be alright

Emotional behaviours/statements/questions

In the scenario…if the team member shows good interpersonal skills the role play person should be persuadable to stay. If they do not show good skills, the role play person should keep threatening to leave and say at some point….”well you will all be better off if I am dead”.