MONASH University

MONASH EMERGENCY MonashHealth

MONASH PRACTICE EXAM December 2016

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Question 24
or

“Holy C&*p, Batman – I don’t know what they’re talking about”

Part 1

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But before that……

The Monash Health exam

The exam

- All examiners are volunteers and do this in their own time
- Costs of the exam cover printing, postage etc
- Questions are written by individuals, not a committee
- Questions are marked by an individual, not multiple examiners
- No Standard setting
- “Pass marks” are a guide to you
  - Total mark is important
  - Don’t forget the SCQ

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A big thanks

- Pourya
- Tom
- Draegar

You department statistics show that 50% of patients who are eventually found to have a Primary Psychiatric disorder are being seen initially by an Emergency Department Doctor. One solution suggested is a direct Mental Health referral from triage for patients that appear to have a Mental Health problem to allow more appropriate initial review.

a) List 4 Criteria for a patient to be transferred directly to psychiatric services

b) You institute a psychiatric triage reference card. List two points that distinguish category one psychiatric patients from lower triage categories

You department statistics show that 50% of patients who are eventually found to have a Primary Psychiatric disorder are being seen initially by an Emergency Department Doctor. One solution suggested is a direct Mental Health referral from triage for patients that appear to have a Mental Health problem to allow more appropriate initial review.

c) The ED Psychiatric team ask that patients deemed at risk of suicide by medical staff have a brief risk assessment. List 6 suicide risk factors that should be assessed

d) In order to identify patients with delirium in the initial nursing assessment, you plan to introduce the Confusion Assessment Method. State the 4 clinical features in the CAM to rapidly identify delirium

Q 24

- 6 minute question
- 16 Marks
- Initial “pass” mark set at 10/16
- Lowered to 8 on review

Results

- Mean 8.2
  - 7 candidates wrote nothing
    - No writing = no marks
  - Maximum score 12
- Pass rate
  - 10/16 7/38 = 18%
  - 8/16 18/38 = 47%
- Majority of candidates that passed were clustered on the borderline

A) List 4 Criteria for a patient to be transferred directly to psychiatric services

- Many struggled at this question
- Based on my initial draft answer everyone would have scored zero
  - No one stated “Primary suspected diagnosis purely psychiatric” or similar
- These patients would be diverting the ED
  - Think which patients do you actually want to see in the ED

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What do you do in your ED?

The patients I want to see are….

- Those patients that I don't think have a psych diagnosis, or new diagnosis/1st presentation

Or

- Those patients that are aggressive or have risk of violence

Or

- Those patients that are unstable

Or

- Those patients that are intoxicated or under the influence of drugs

Model answer

- Primary psych diagnosis suspected
- No intoxication or ingestions
- Not aggressive or risk of violence
- Those not requiring sedation or restraints
- Known psychiatric history
- No unstable/concurrent medical issues or trauma
- Normal vital signs

Common errors

- Multiple points around the same topic
  - Eg no trauma + no medical issues + normal vitals
- Method of Referral
- No attempt

B) List two points that distinguish category one psychiatric patients from lower triage categories

- Universally done poorly
- Think what makes a patient a Cat 1…….
  - These are patients that you need to see

IMMEDIATELY

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ATS (Health Dept)
Dunn (6th ed, page 1047)

Triage code – Treatment acuity	Description	Typical presentation	General management principles*
1 – Immediate	**Definite danger to life (self or others)** **Australasian Triage Scale[1] states:** – Severe behavioural disorder with immediate threat of dangerous violence	**Observed** – Violent behaviour – Possession of weapon – Self-destruction in ED – Extreme agitation or restlessness – Bizarre/disoriented behaviour **Reported** – Verbal commands to do harm to self or others, that the person is unable to resist (command hallucinations) – Recent violent behaviour	**Supervision** Continuous visual surveillance 1:1 ratio (see definition below) **Action** – Alert ED medical staff immediately – Alert mental health triage or equivalent – Provide safe environment for patient and others – Ensure adequate personnel to provide restraint/detention based on industry standards **Consider** – Calling security +/- police if staff or patient safety compromised. May require several staff to contain patient – 1:1 observation – Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management.
2 – Emergency Within 10 minutes	**Probable risk of danger to self or others** *AND/OR* **Client is physically restrained in emergency department** *AND/OR* **Severe behavioural disturbance** **Australasian Triage Scale[1] states:** Violent or aggressive (if): – Immediate threat to self or others – Requires or has required restraint – Severe agitation or aggression	**Observed** – Extreme agitation/restlessness – Physically/verbally aggressive – Confused/unable to cooperate – Hallucinations/delusions/paranoia – Requires restraint/containment – High risk of absconding and not waiting for treatment **Reported** – Attempt at self-harm/threat of self-harm – Threat of harm to others – Unable to wait safely	**Supervision** Continuous visual supervision (see definition below) **Action** – Alert ED medical staff immediately – Alert mental health triage – Provide safe environment for patient and others – Use defusing techniques (oral medication, time in quieter area) – Ensure adequate personnel to provide restraint/detention – Prompt assessment for patient recommended under Section 9 or apprehended under Section 10 of Mental Health Act 2000. **Consider** – If defusing techniques ineffective, re-triage to category 1 (see above) – Security in attendance until patient sedated if necessary – Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management

Common errors

- Aggression
- Agitation
- Psychosis
- Restraints
- Acutely suicidal

C) Risk factors for suicide

- S Sex – Male more likely than female
- A Age - >45 or <19
- D Depression – present in 70% of suicides
- P Previous attempt
- E Ethanol and drug abuse
- R Rationality (loss of)
- S Spouse (absence)
- O Organised plan
- N No support
- S Sickness (organic illness)

C) continued

- IPMO
  - Intention, Plan, Motivation, Opportunity
- Risk:Rescue ratio
- Other risk factors
  - Indigenous or in custody
  - Availability of effective means
  - Sexual abuse
  - Stressful event precipitant

C

- Mostly done well
- Common errors were lack of quantification of risk factors

D) Confusion Assessment Method

- Done very poorly
- Presumed majority haven't seen this

What do I do when the question asks me something I don't know?

- Option 1 – Write nothing
  - This scores you …….. Nothing!
- Option 2 – Base your answer around what you do know
  - Base it on your personal experience
  - This might score you something
  - Remember it's the total score that counts

So this is a question around delirium, right?

- So what makes a delirium?
- How many of you have seen a patient with delirium?
- Think:
  - The little old lady that is suddenly confused due to a UTI
  - The elderly patient who ‘sun downs’
  - Young man who is off his face after ingesting Angels trumpet

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Confusion Assessment Method (CAM) Diagnostic Algorithm	**Date of assessment**	
	Time of assessment	
		Yes or No
1. Acute onset and fluctuating course? (Acute change in mental status from baseline, fluctuating behaviour through the day)		
2. Inattention? (Difficulty focusing attention, easily distracted, difficulty keeping track of what is being said)		
3. Disorganised thinking? (disorganized or incoherent thinking, rambling or irrelevant conversation, unclear or illogical flow of ideas)		
4. Altered level of consciousness? (This feature is shown by any answer other than "alert", including: hyper-alert, lethargic, stupor, or coma)		
The diagnosis of Delirium by CAM requires the presence of features 1 and 2 *AND EITHER* 3 or 4		
Delirium detected?		**YES NO (Circle)**

Reference: Inouye SK, Van Dyck CH, Alessi CA, Balkin S, Siegal AP, Horwitz RI (1990) Clarifying confusion: the Confusion Assessment Method. *Annals of Internal Medicine* 113: 941-8

Common errors

- Vital signs
  - Abnormal vital signs don't equal delirium
  - Abnormal vitals makes delirium more likely

Remember

- Stay calm
- Be strict with time management
- Read all the question
- Answer with reference to your experience
- Use the results today to form a base for discussion with your DEMT to assess whether you are on track

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Good luck