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Poisoning Assessment and Exposure Documentation

Practical 05 / Clinical or documentation case

Aim

Recognise a time-sensitive poisoning scenario and produce an objective exposure and examination record.

Principle

Symptoms, vital signs, exposure history and concerning syndrome patterns guide urgent assessment. Similar clinical findings can have different causes.

Materials and Requirements

- Fictional exposure cards and photographs of labelled inert exhibits
- Simulated clinical chart
- Local emergency and poison-information pathway

Procedure

1. In the simulation check immediate threats to airway, breathing, circulation and alertness and call for supervised clinical help.
2. Establish scene safety and whether the scenario involves contamination. Call for assistance and state what protective equipment and support the treating team's protocol requires.
3. Record the reported product, route, time, estimated amount if known, symptoms and relevant co-exposures.

Continue with step 4 on the next page.

Procedure Continued

Poisoning Assessment and Exposure Documentation

4. Derive a timeline from the patient or witness, available label and transport record. Enter what is confirmed and what is estimated and avoid handling a real unknown product in the skills exercise.
5. Review vital trends, mental state and supplied examination or laboratory findings. Consider alternative explanations for apparent intoxication.
6. Record vital signs and consciousness by time, then compare trends and the supplied ECG or laboratory results. Review plausible medical, metabolic or trauma-related explanations with the supervisor.
7. Identify the urgent concern and rehearse a focused message to the treatment or poison-information service. Include suspected exposure, time, current findings and support already given.
8. Prepare the medico-legal note with uncertainty, care given by the team, disposition and any authorised specimen request.
9. Complete a dated simulated clinical and medico-legal record. Note the source of each history item, authorised specimens and responsible team for results, review and disposition.

Precautions

- Use inert exhibits and supplied case records.
- Keep treatment within the emergency team and local protocol. Do not induce vomiting or improvise an antidote.

Observations and Interpretation

Poisoning Assessment and Exposure Documentation

Observations and Record

Item	What to record	What it tells you
Exposure reported	Product, route, time and information source	Separates known and uncertain data
Clinical assessment	Vitals, mental state and focused observations	Prioritises urgent care
Medico-legal record	Date, findings and action	Preserves chronology and objectivity

Worked Example

A fictional drowsy patient is said to have consumed alcohol. Escalate altered consciousness and consider other medical causes such as hypoglycaemia or trauma based on supplied findings.

Result and Interpretation

Present a time-linked report and state the urgent clinical priority and any evidence still required.

Viva Questions and Answers

Can smell alone establish a diagnosis?

History, examination and appropriate tests are needed.

What has priority over evidence paperwork?

Immediate clinical assessment and patient care.

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