Griffith UNIVERSITY
School of Medicine

GUMS

Year 4 Formative OSCE 2018

Reading for Station 2

Candidate Instructions

Clinical Scenario

You are an intern in the anaesthetic clinic this afternoon. Your next patient is Mrs Elms, an 83-year-old woman due for a full knee replacement.

Task

In a total of eight (8) minutes:

- Take a detailed pre-operative anaesthetic history (7 minutes)
- In the last minute discuss with the registrar the investigations you would like to have ordered for Mrs Elms and why.

You will not be prompted. Please manage your time appropriately

[The examiner will assume the role of the registrar].

Simulated Patient Information

The candidate has the following scenario and task

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Instructions for simulated patient

- You are an 83-year-old woman (Mrs Elms).
- You live with your husband (Mark) and daughter (Claudia) and her family.
- You previously worked as a secretary in a law firm and retired at age 62.

Context for anaesthesia

- You have severe osteoarthritis of the right knee. This cause you severe pain on movement and it has severely limited your day to day activities and after evaluation by your GP and orthopaedic surgeon you have decided to go ahead with a total knee replacement. You have had osteoarthritis for 10 years and it has been slowly worsening over this time.

Surgical history

- Age 35 – caesarean section
- Age 42 – cholecystectomy
- You had no issues with the anaesthetics and woke up well with minimal nausea. You did not vomit in either case.
- There were no complications with either surgery.
- You had "a little pain" after both procedures however it resolved within a week.
- There is no family history of problems with anaesthetics/surgery, and you do not have malignant hyperthermia

Social history

- You have never smoked or used illicit drugs
- You have never been "a heavy drinker". You used to drink 1-2 glasses of wine at dinner per week, but have not had any alcohol for the past 17 years, when you started warfarin.
- You have severe difficulty walking due to your osteoarthritis, and use a walking frame to move around the house.
- You require some assistance with bathing/showering, toileting and dressing, from your husband. These tasks take longer than they used to, due to pain in your knee.
- Your daughter and her partner do the cooking in your house. You assist them sometimes, but prefer to sit down to avoid worsening the pain in your knee.

- You live in an extension of your daughter's house. There are no stairs in the house. You can walk for approximately 30 metres (with a walking frame) before you have to sit down because of pain in your right knee.
- Neither you or your husband drive anymore. Claudia drives you to doctor's appointments in her car. She will drive you to and from the hospital for the surgery.
- You do not have any trouble remembering to take your medication. You keep a checklist and use a pill box to keep track of your medication.

Family history
- Your father died of a heart attack at age 46. There is no other relevant family history
- There is no family history of problems with anaesthetics.

Past medical history
- You had a stroke from which you fully recovered 17 years ago (age 66). You were also diagnosed with atrial fibrillation (AF) at this time and placed onto warfarin. You take 3mg warfarin daily and have monthly INRs.
- Hypertension – for the past 36 years (age 47)
- "Heart attack" 10 years age (age 73)
- Doctors has told you that you have "heart failure" – 9 years ago (age 74)
- You have no other medical problems or conditions

Medication history – see list
- Warfarin (3mg daily) – started once diagnosed with atrial fibrillation
- You have monthly INRs. Your INR is 2.7 and your target is 2.5 to 3.5.
- Enalapril (5mg daily) – for hypertension
- Atenolol (50mg BD) – for controlling heart
- Aspirin (100mg daily)
- Simvastatin (20mg nocte)
- You have an allergy to penicillin. It caused rashes when you were 23.

Examiner Instructions

Please verify that you are examining the correct student by checking the name on the student's ID card against the name on the score sheet, as the student enters the room.

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You will not be prompted. Please manage your time appropriately

[The examiner will assume the role of the registrar].

Instructions
- You are playing the role of the examiner in this exam. You should address the student as a registrar, after you have checked ID. Please do not provide prompts on the station content.
- Stay out of the line of sight between the candidate and the patient during the history. Do not provide any positive or negative feedback to the candidate.
- Please record your observations on the scoresheet **as you go**, as discussed in the briefing.
- The student should discuss with you towards the end of the station (at 7 minutes) their assessment of the patient. Do not prompt the student.
- You have two minutes between candidates to finalise your scoring and 'reset' the station.

Props and Sundries
- Simulated patient
- Handwash
- Patient drug list

Author – Maddison Taylor & Kingsley Smith. Revised by Rhys Harris.

OSCE Score Sheet

Station 2: Pre-operative Anaesthetic Assessment

ID Check
(please tick)

Student Name/Number……………………………………………………………………..

Examiners Name: …………………………………… SP: ……………………………………

No.	Assessment Item (details)	PLEASE MAKE ONE TICK IN <u>EVERY</u> ROW
1	**Infection Control** appropriately washes hands before, appropriately washes hands after	0 1 2
2	**Anaesthetic History** previous surgeries and anaesthetics for each, response to each anaesthetic, complications, nausea/vomiting, pain post op, malignant hyperthermia/family history of anaesthetic problems	0 1 2 3 4 5 6
3	**Cardiac History** previous MI, previous stroke, hypertension, rhythm issues, murmurs, heart failure	0 1 2 3 4 5 6
4	**Respiratory History** smoking, COPD, asthma, OSA	0 1 2 3 4
5	**Other History** renal failure, diabetes, clotting disorders, hepatitis, reflux, teeth/dentures	0 1 2 3 4 5 6
6	**Medication History** warfarin, warfarin is for atrial fibrillation, enalapril, atenolol, aspirin, allergies	0 1 2 3 4 5 6
7	**Social History** alcohol use, living arrangements, supports (family/friend/carer), home layout/environment/stairs, travel to/from hospital	0 1 2 3 4 5
8	**Activities of Daily Living** motility/difficulty walking, bathing/shower, toileting, remembering medication, food preparation	0 1 2 3 4 5
9	**Assessment & Investigations (the student does not need to complete the following)** complete a physical examination, requires INR stabilisation and heparin bridging, ECHO to assess LVEF, ECG to assess rate/rhythm, FBC/CHEM 20	0 1 2 3 4 5

10	CLARITY	1	2	3	4	5	6	7
	(organisation, appropriate confidence)	Confused, disorganised, unclear		Below expected		Above expected		Outstanding

11	WARMTH	1	2	3	4	5	6	7
	(engagement, compassion, care for patient)	Cold, uncaring, brusque		Below expected		Above expected		Outstanding

Comments

Station 2 - Mrs Elms medications

- 100mg Aspirin daily
- 3mg warfarin, INR between 2.5-3.5
- 5mg enalapril daily
- 50mg atenolol BD
- Simvastatin 20mg nocte
- Penicillin allergy

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