



Year 3 Formative OSCE 2018

Reading for Station 4

Candidate Instructions

You will remain in the corridor for the entire 10 minutes of this station (2 minutes reading and 8 minutes 'doing').

You may document anything on the blank paper provided, but please DO NOT mark the script provided.

Clinical Scenario

You are an intern on the rehabilitation ward at Gold Coast University Hospital. Your supervising registrar has been called away, and they have asked you to provide a clinical handover to the evening registrar about Janet Martins, a 77-year-old woman on the ward.

Task

In a total of ten (10) minutes you are to:

- Read through the provided patient clinical notes
- Make any notes you deem necessary on the blank paper provided in preparation for giving a **clinical handover** in Station 5

Please **leave the script** provided at the station for the next candidate's use.

This station is provided to give you additional time to collect your thoughts and plan a response. You **will not** be entering a room or providing a handover until the "do" time of **Station 5**. You will have up to an additional 6 minutes reading time at Station 5.

Patient Notes: Ms Janet Martins, 77**URN: 145 683**

Admission Date: 26/09/18 Current Date: 02/10/18

Emergency Department

26/09/18 – 1430

Presenting complaint:

- Brought in by Ambulance following fall at home, resulting in left-sided hip pain

HxPC:

- Walking to kitchen, slipped on wet floor and landed heavily on left hip at 9am. Unable to get up due to the pain.
- Found by neighbour 4 hours after fall.
- Immediate onset, constant, dull pain in left hip (7/10). Pain worsens to 9/10 on movement
- Denies paraesthesia in left leg. Denies hitting head
- Denies preceding chest pain, shortness of breath, light headedness, headache, dizziness, loss of consciousness or palpitations

PMHx:

- 1995 – Hypertension, Rx Ramipril
- 2005 – Atrial fibrillation, Rx warfarin, atenolol.
- 2011 – Osteoporosis, Rx Alendronate, vitamin D

Past Surgical History:

- 2000: Left total mastectomy for breast carcinoma
 - o Nil recurrences, last checked 2 years ago
 - o Nil issues with anaesthetic.
 - o Nil blood transfusion required.
 - o Recovered postoperatively without concern.

Allergies

- Sulphur antibiotics (anaphylactic reaction in childhood, has not taken since)

Medications History:

- Warfarin 6mg nocte
- Atenolol 25mg OD
- Ramipril 5mg OD
- Alendronate 70mg once weekly
- VitD 1000 IU OD

Social History:

- Lives at home alone. Husband deceased 3 years ago in motor vehicle accident
- Home assistance from Ozcare for grocery shopping and cleaning
- Independent for showering, dressing, cooking, cleaning
- No mobility aids
- Ex-smoker, 1 pack per day from age 17 to 55
- Alcohol: social drinker, 2-3 standard drinks per week (wine)

Family History:

- Father died from myocardial infarction at 60
- Mother died from lung cancer at 75 (was a smoker)

Examination:

- Vitals: Temp 37.1°C, HR 92, BP 128/76, RR 16, O₂Sat 97%
- Normal heart sounds, nil added sounds
- JVP not elevated
- Nil jaundice, pallor, central cyanosis or peripheral cyanosis
- Nil respiratory distress

- Normal chest expansion, percussion note, breath sounds
- Nil abdominal distension, tenderness, guarding, rigidity, rebound tenderness, organomegaly
- Left leg shortened and externally rotated. Bruising over left hip joint
- Right lower limb appears normal
- Nil obvious trauma to upper limbs, chest, abdomen or head
- Cranial Nerves II – XII intact. Brief cognitive assessment normal

ED Investigations:

- X-Ray: L) hip fractured neck of femur
- CT Head: no abnormalities detected
- CXR: no abnormalities detected
- ECG: Atrial fibrillation, HR 76

ED Management:

1. Admit to orthopaedics for open reduction, internal fixation of left NOF fracture
2. Send bloods for pre-operative assessment, along with blood type and cross match

Orthopaedics Pre-Operative Notes

26/09/18 – 1630

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- Preoperative diagnosis: left sided neck of femur fracture
 - Planned procedure: open reduction, internal fixation
 - Laboratory studies: Na⁺ 134 (135-145), Cl⁻ 100 (95-110), K⁺ 4.5 (3.5-5.2), Hb 110 (130-180), WBC 7.0 (4.5-13.5), INR 2.5
 - ECG: Atrial fibrillation, HR 84
 - Type and cross/screen performed for O + in blood bank
 - Patient made NBM and warfarin ceased in ED in anticipation of operation
 - Intravenous fluids ordered in ED (patient weight: 85 kg)
 - Prothrombinex administered at 15IU/kg for reversal of warfarin to allow surgery to proceed tonight
 - Operative consent obtained in writing, attached to patient's chart

Orthopaedics Operation Notes

26/09/18 – 1730

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- Preoperative diagnosis: left sided neck of femur fracture
 - Postoperative diagnosis: same as above
 - Procedure: open reduction, internal fixation
 - Surgeon: Turk (Consultant Orthopaedic Surgeon)
 - Assistants: Reed (Orthopaedic PHO)
 - Anaesthesia: General endotracheal anaesthesia
 - Estimated blood loss: minimal
 - Urine output: Foley catheter inserted pre-operatively, minimal output during procedure (exact value unquantified)
 - Intravenous fluids: 500 cc crystalloid
 - Findings: Garden's Type 3 femoral neck fracture, consistent with findings on ED X-Ray. Proceeded to relocation to resolve displacement and internal fixation across fracture line.
 - Complications: none
 - Disposition: To recovery room, extubated, in stable condition. Recommence warfarin with LMWH bridge.

PLEASE NOTE

Notes from 26/09/18 – 1730 to 02/10/18 – 0930 have been omitted from the records here. Patient remained in rehabilitation ward during this time with nil complications.

Orthopaedics AM Ward Round

02/10/18 – 0930

Situation

- 77-year-old female, Day 6 Post ORIF for Garden's 3 NOF fracture

Review

- Patient comments on pain & discomfort on urination for the past 12 hours
- Noticed urine is particularly malodorous
- Patient denies: Subjective fevers, flank or groin pain, nausea or vomiting
- Surgical site healing well with nil erythema, discharge or warmth on palpation
- INR 1.3. Not on clexane or mechanical prophylaxis.
- Otherwise well and ambulating around ward with assistance of Physiotherapist
- Vitals: Temp 37.3°C, HR 90, BP 130/80, RR 16, O₂Sat 96%
- On examination: deep, suprapubic tenderness. Nil flank pain.

Assessment

- Clinically suspicious for a urinary tract infection, likely cystitis due to lack of systemic findings

Plan

1. Remove catheter
2. Urine M/C/S and commence antibiotics when sensitivities have returned
3. Continue mobilisation encouraged by nursing staff and physiotherapy with thanks

Addendum: PM Ward Round - 1800

Urine MCS cultured *E. Coli* sensitive to trimethoprim, which has now been charted 80mg PO twice daily.

Orthopaedics PM Ward Round

02/10/18 – 1830

The following notes are written by you

Situation

- 77-year-old-female currently on rehabilitation ward with new onset shortness of breath

Background

- Has become progressively short of breath over previous 20 minutes while lying in bed
- Nurses note she is more anxious & distressed over the last couple of hours
- Describes sharp, stabbing 8/10 left sided anterior chest pain that begun at same time as shortness of breath. Worse on inspiration. Pain is worsening breathlessness. Nil radiation of pain.
- Tried to stand up before calling the nurses & felt particularly light-headed, so sat down again
- Denies cough, haemoptysis, substernal or radiating chest pain, leg pain, sweating

Examination

- Patient appears visibly uncomfortable and anxious lying in bed at 45°
- Skin appears pale and mottled
- Vitals: Temp 37.8°C, BP 110/70, HR 105, RR 28, O₂Sat 93%
- Nil palpable heaves or thrills.
- Heart sounds dual, with audibly accentuated second heart sound.
- Air entry equal bilaterally, some bibasal rales on auscultation.
- Left lower limb - calf soft and non-tender, no swelling

- Right lower limb - calf appears erythematous, slightly swollen, and tender to palpation. Patient had no evidence of TEDS at time of review.
- Surgical site healing well with nil erythema, discharge or warmth on palpation

Investigations

- STAT ECG: Atrial fibrillation with tachycardia and non-specific T wave changes in praecordial leads.
- Mobile CXR: AP. Some rotation and moderately underexposed. Small, right sided basal atelectasis. Otherwise no radiographic abnormalities detected.

You have not yet had a chance to include an assessment or recommendation in the patient notes