Griffith UNIVERSITY
School of Medicine

GRIFFITH UNIVERSITY MEDICINE SOCIETY
GUMS

## Year 3 Formative OSCE 2018

# Reading for Station 5

## Candidate Instructions

**In this station, you may continue reading and documenting information in the 2 minutes reading time. After 2 minutes, you may enter the room.**

**Please do not write on the script provided, but you may write as many notes as you wish on the blank paper given. LEAVE THE SCRIPT OUTSIDE THE ROOM. ANOTHER SCRIPT IS PROVIDED INSIDE.**

### Clinical Scenario

You are an intern on the rehabilitation ward at Gold Coast University Hospital. You have been asked by your registrar, who was called away, 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 eight (8) minutes you are to:

- Spend a maximum of **4 minutes** familiarising yourself with the patient clinical notes.
- Make any notes you deem necessary on the blank paper provided
- Handover Ms Martins to the registrar (who will be played by the examiner), including your assessment with justification and recommendations.

If you have not begun the handover by 4 minutes, you will be prompted to begin.

# 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.

## The candidate has the following scenario and task

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**Clinical Scenario**

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- Please familiarise yourself with the patient clinical notes
- This clinical scenario has run across both Station 4 and Station 5
    - In Station 4, candidates were given 10 minutes to familiarise themselves (and take notes) with the patient clinical notes
    - Once candidates enter Station 5, they have up to a further **4 minutes** of reading and note-taking time before they must begin the handover.
    - Candidates are permitted to provide the handover before the 4 minutes has elapsed
    - If after the allowed **4 minutes** the candidate has not begun the handover, **please prompt them to do so**
- Student should be awarded marks for clarity if they present a handover focussing on the pertinent patient problems. Higher clarity marks should not be awarded if the student presents too much detail on the orthopaedic presentation.
- Possible differential diagnoses for the scenario include:
    - Pneumonia
    - Osteoporotic rib fracture
    - Anxiety disorder (diagnosis of exclusion)

Year 3 Formative OSCE 2018

# OSCE Score Sheet

## Station 5 – ISBAR Handover

Student Name/Number…….

**ID Check**
(please tick)

| No. | Assessment Item (details) | PLEASE MAKE ONE TICK IN EVERY ROW |
|---|---|---|
| 1 | **Introduction**<br>States name and role, confirms identity of recipient of handover, confirms individual is ready to receive handover | 0 1 2 3 |
| 2 | **Situation**<br>77 year old female, day 6 post-op ORIF # LNOF, sudden onset pleuritic chest pain and SOB, appears distressed, bibasal rales, tender swollen right lower limb, skin pale/mottled | 0 1 2 3 4 5 6<br>7 |
| 3 | **Situation continued**<br>Vital signs, notes decreased O2 sats compared with earlier review, temperature increased, patient warfarinised, low INR, no TEDS, ECG (AF), CXR (small right sided atelectasis) | 0 1 2 3 4 5 6<br>7 8 |
| 4 | **Background – Orthopaedic & Inpatient Complications**<br>Perioperative period uneventful with nil complications, suspected post-operative UTI/cystitis early today, identifies sulpha antibiotic allergy | 0 1 2 3 4 |
| 5 | **Background – General History**<br>States PE risk factors (bedridden/major surgery), states cardiovascular co-morbidities (hypertension, atrial fibrillation), pertinent social history about premorbid function, pertinent negatives in past medical history | 0 1 2 3 4 |
| 6 | **Assessment**<br>Concern for DVT with justification, concern for PE with justification<br>Other reasonable differential #1, justification<br>Other reasonable differential #2, justification | 0 1 2 3 4 5 6 |
| 7 | **Recommendation**<br>Urgent review, continuous monitoring, CT pulmonary angiography, provide nasal cannula oxygen | 0 1 2 3 4 |
| 8 | **Recommendation continued**<br>Check INR and adjust warfarin appropriately, provide analgesia if required, compression stockings, other reasonable | 0 1 2 3 4 |
| 9 | **CLARITY**<br>Organisation, appropriate confidence, appropriate amount of detail and information | 1 2 3 4 5 6 7<br>Confused, disorganised, unclear — Below expected — Above expected — Outstanding |
| 10 | **PROFESSIONALISM**<br>Engagement, respect | 1 2 3 4 5 6 7<br>Cold, uncaring, brusque — Below expected — Above expected — Outstanding |

# 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
  - Nil recurrences, last checked 2 years ago
  - Nil issues with anaesthetic.
  - Nil blood transfusion required.
  - 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$^{o}$C, HR 92, BP 128/76, RR 16, $O_2$Sat 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

- 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

- 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: Gardens 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 <u>26/09/18 – 1730</u> to <u>02/10/18 – 0930</u> 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, $O_2$Sat 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, $O_2$Sat 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**