

OSCE 1 – Candidate Information

SCENARIO

You are the consultant in a tertiary ED. A registrar asks for your assistance with this patient that she has just seen. The patient is an independent 68 year old man who lives at home. He has presented to the ED with chest pain and feeling unwell.

He is clammy and shut down. BP 70/-, PR 180 and sats 99% on 15L. He is in the resus room with full monitoring.

You are required to:

- Listen to the registrar about the patient
- Assist the registrar in deciding on the appropriate management plan
- Assist the registrar with executing the management plan

No additional people or equipment are involved in this station.

This is a single station OSCE (i.e. 3 minutes preparation followed by 7 minutes activity)

Domains assessed:

Medical Expertise

Communication

Scholarship and Teaching

Вопросы и ответы

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OSCE 1

Background information for Actor

CHARACTER

You are use your own name, a junior ED registrar

SCENE

You have just seen an independent 68 year old man who lives at home. He had an unconscious collapse at the bank while waiting in line to pay bills and has been brought in by ambulance which was called by concerned bystanders. His observations en route have been normal. He has IV access and has oxygen running at 6L/min. He tells you that he is really keen to go home.

He has told you that he had no preceding symptoms prior to the unconscious collapse, particularly chest pain, SOB or headache, and now feels quite well. His PMH includes only hypertension and type II diabetes and he is taking a sulfonyurea and candesartan.

His observations in the ED are normal and he has been telling the nurse that he wants to go home.

You recognise that he is shocked and placed in the resus room

You are unsure about how to treat the AF with shock so asking for guidance with treatment options.

You have never cardioverted anyone before so need help with the whole procedure.

OSCE 1 – Marking Sheet

Candidate Number:

A. Component Assessment

Please tick the box for each row which best describes the performance of the candidate you observed

COMPONENT ASSESSMENT

Select the **ONE** option that best represents the **minimum senior clinician involvement** required for the domain to be performed at the level of a new FACEM

☐ Candidate performs; senior clinician directly observes	☐ Candidate performs; senior clinician checks prior, during, upon completion	☐ Candidate performs; senior clinician checks prior and upon completion	☐ Candidate performs; senior clinician checks upon completion	☐ Candidate performs; senior clinician available to check in-person	☐ Candidate performs; senior clinician available to advise via telephone	☐ Candidate performs; ~~Senior~~ clinician not required	☐ Candidate performs above the level of a new consultant; ~~Senior~~ clinician not required	☐ Candidate performs at the level of a senior consultant; ~~Senior~~ clinician not required
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Medical expertise

Communication

Scholarship & Teaching

Domain	Criteria for High Rating
Medical Expertise	• Able to correctly interpret the ECG as rapid AF with ST depression • recognise that the patient is shocked and needs cardioversion • Asks appropriate questions about the assessment of the patient • Knows how to synchronised cardioversion
Communication	• Builds rapport with the registrar • Asks clear and focused questions about the student's assessment of the patient • Teaches the registrar about the ECG and cardioversion • Uses appropriate non-verbal communication, body language • Uses appropriate use of language and words
Scholarship and Teaching	• Teaches the registrar about AF and ischaemia on ECG • Teaches the registrar about tachyarrhythmia and shock management • Teaches the registrar about synchronised cardioversion • Answers questions from the registrar • Asks the registrar to paraphrase or repeat what was taught to ensure the intern has retained and learnt the information

OSCE 1 – Marking Sheet

Candidate Number:

OSCE STATION DIFFICULTY

Select the ONE BEST option
that describes the overall
difficulty of this OSCE station

Low difficulty

☐

Moderate difficulty

☐

High difficulty

☐

FINAL OSCE MARK

Clear Fail

☐

Borderline Fail

☐

Pass

☐

Clear Pass

☐

B. Examiner Notes on Candidate Performance

Positives

Areas for Improvement

OSCE 2 – Candidate Information

SCENARIO

You are the ED consultant and mentor to a mid-level advanced trainee who has had a challenging case on their last clinical shift two days ago.

The trainee has met you on the corridor and asked to speak to you in your office. You are an administration day.

The trainee was the night registrar looking after a trauma patient who was hypotensive and the trainee performed an eFAST and found 'fluid in the abdomen'.

A code crimson was activated and the patient went to the OT without a CT. There was no intraperitoneal fluid found and subsequent CT was also negative for abdominal injury. No ultrasound images were saved.

The trainee is concerned about what will happen after this.

You are already aware of the case and know that an in hospital investigation is already underway.

A: You are required to:

Listen to the trainee

Provide feedback on the case and decision making process

Provide support as to how the trainee should deal with this situation

No additional people or equipment are involved in this station.

This is a single station OSCE (i.e. 3 minutes preparation followed by 7 minutes activity)

Domains assessed:

Medical Expertise

Communication

Scholarship and Teaching

Prioritisation and Decision Making

OSCE 2

Background information for Actor

CHARACTER : ED registrar (mid- level advanced trainee)

SCENE

You have been called into your mentor's office to discuss a case from your previous clinical shift 2 days ago.

You were the night registrar, looking after a trauma patient who was hypotensive, and you did a e-FAST and saw "fluid in the abdomen".

The patient went directly to OT prior to CT, however there was no free fluid or intraabdominal injury.

You have seen many ultrasound scans done in the past, and have attended a 2 hr teaching session on doing FAST scans. However you have never attended a formal course, and have never been accredited to do ultrasound scans.

You have recently stepped up to being in-charge on nights, and you feel you should be able to be competent at doing FAST ultrasound scans. You are a confident registrar, and this has caused some self doubt.

You are concerned what will happen now that the patient went to OT and didn't actually require an operation.

You are also concerned that your colleagues will not respect your clinical skills now that this is common knowledge.

OSCE 2 – Marking Sheet

Candidate Number:

A. Component Assessment

Please tick the box for each row which best describes the performance of the candidate you observed

COMPONENT ASSESSMENT

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OSCE STATION DIFFICULTY

Select the **ONE BEST** option that describes the overall difficulty of this OSCE station

Low difficulty

☐

Moderate difficulty

☐

High difficulty

☐

OSCE 2 – Marking Sheet

Candidate Number:

FINAL OSCE MARK

Clear Fail

☐

Borderline Fail

☐

Pass

☐

Clear Pass

☐

B. Examiner Notes on Candidate Performance

Positives

Areas for Improvement

domain	Criteria for High Rating
Medical expertise	• Demonstrates knowledge and experience of trauma guidelines and a systematic approach. - Understands why false positive scans may occur - Understands the need for a credentialing system for ultrasound scans done in the ED
Communication	Non-judgemental. Supportive. Empathetic. Clear. Enquires as to the trainee's perspective on the situation. Acknowledges need for review and feedback to staff involved and to look QA measures to improve on for future. Explains the investigation process to the trainee in a clear manner. Ensures the trainee has a follow up plan to discuss the case further and assesses trainees risk of adverse mental health effects from the incident
Scholarship and teaching	Awareness of the pro's and con's of point of care ultrasound and potential false positives in the eFAST. Awareness of ultrasound training levels and QA with regard to saving images.
Prioritisation and decision making	Looks at the clinical situation and awareness of indications for referral to OT vs angio vs CT. Awareness of team approach and consultation with relevant senior in-patient team members



OSCE

FE/CPD:	St George trial exam 26/5/16	Author(s):	Kirsty Short
Subject and topic reference:	Informed consent: Paediatric ketamine use	LOA	Type LOA here
		Mark:	Type mark allocation here

Text Reference Type references to text here

Question stem:

You are the in-charge doctor in a tertiary ED. Your registrar has reviewed a 4 year old boy with an isolated 5cm laceration to his right forearm after falling off of a swing in the local park. There is no fracture or foreign body on X-ray.

The child is distressed and has been non-compliant with attempted nitrous administration. His mother is also very upset. You have already assessed the wound as a linear, clean full-thickness laceration of approximately 5cm. You have made the decision to perform wound closure with ketamine for procedural sedation and you are about to transfer the child and his mother to the resus bay. The child has EMLA on but no cannula.

The registrar has just completed an anaesthetic rotation and there will be an experienced emergency nurse available in the resus bay in about 10 minutes time. You would like the registrar to prepare for the procedure in the resus bay. *There is also an SRMO allocated to resus who is seeing a cat 2 chest pain in the acute area.*

Your task is to:

- 1) Engage with the mother and obtain informed consent for the procedure
- 2) Discuss with the junior registrar a detailed plan for the procedure, including role delegation
- 3) Explain the discharge plan to the mother

You will be assessed on the following domains:

- Medical Expertise
- Communication
- Leadership and management
- Teamwork and collaboration

Instructions

Mother (actor): You are upset as your child has been in ED for 3 hours and his wound is not yet closed. You thought this could all be sorted with 'happy gas' but that hasn't worked. You want to know what is happening next.

Prompts

During the consent process:

Are you giving a general anaesthetic?
What will happen to my child during the procedure?
What are the side effects? Are they common?
Are there any occasions when ketamine can't be given?

Discharge planning:

Can't I just let him sleep it off at home? His dad can help me carry him to the car.
When do the stitches need to come out?
Does he need antibiotics?
Won't he be sore afterwards?

ED Registrar (played by second examiner): You are an Advanced Trainee (PGY4) in emergency having just passed your primary exam. Your last rotation was anaesthetics, however you have never performed ketamine sedation on a child. You need some instructions to get set up for the procedure.

If asked, you have briefly reviewed the SRMOs chest pain patient, and they are pain free with a normal ECG.

Prompts

Pre-procedure:

How long should he be fasted for?
What dose should we start with? Shall we make some calculations?
Does he need a cannula?
Can we give it IM/IV? Does that change the dose? *How would you like me to draw up the ketamine?*
What monitoring would you like?
Do we need to get the airway trolley out? *Do you want any other drugs available?*
Who will give the drugs/do airway? What do you want me to do?

SET UP:

Patient treatment cubicle
Actors: mother, registrar
+/- Child substitute - ?doll or paed's mannikin

Examiner:

Observe interaction between candidate and mother/junior doctor and will not interact with the candidate

Scoring sheet:

Interaction with mother:

Appropriate introduction

Shows empathy to distressed mother and is reassuring

Confirms fasting status

Explains:

- Indications for ketamine in this case
- **Possible side effects** of ketamine, including dissociative state
- **Explores contraindications** of ketamine
- The procedure of wound management whilst under sedation
- Signature for consent form requested

Interaction with registrar:

Confirms level of training

Delegates roles

Procedure preparation checklist (**evidence of a structured approach**)

- Consent (done)
- Personnel – role delegation: airway doctor, procedure doctor, drug administration (this could also be the nurse), documentation.
- **Medications** – ketamine doses IV 1-1.5mg/kg given slowly (0.5mg/kg doses as repeats), IM 4mg/kg (2-4mg/kg repeat dose if needed after 10 mins). Consider onset of sedation.
- **Monitoring** – minimum BP/HR/RR/O2 sats
- End points – level of sedation
- Positioning
- Procedure – asepsis/PPE/procedure trolley preparation
- Preoxygenation
- **Prepares for unexpected airway issue:** paed airway trolley requested (SOAP-ME – Suction, Oxygen, Adjuncts, re-Positioning/additional Pharmaceuticals, considers additional Monitoring and ETCO2)

Post procedural discussion with mother:

Safety for discharge: Child needs to stay until they are awake/can walk unaided/not vomiting

This can be up to 2 hours

Warn that they might be a bit confused/clumsy post procedure and the need to be watchful caring for them over next 24 hr

Wound care/suture advice, including watching for signs of infection

No antibiotics indicated currently

Analgesia

Tetanus if unvaccinated

Situational awareness:

Candidate must show awareness of the SRMO's chest pain patient and ensure attention by alternative doctor of appropriate seniority.

CONFIDENTIAL Examiner Rating: Station *Number: Title*

CANDIDATE DETAILS	EXAMINER
Candidate ID:	Name:
EXAM DETAILS	
Date of OSCE:	

COMPONENT ASSESSMENT

	WORST				MID				BEST
Medical Expertise	☐	☐	☐	☐	☐	☐	☐	☐	☐
Communication	☐	☐	☐	☐	☐	☐	☐	☐	☐
Team Work & Collaboration	☐	☐	☐	☐	☐	☐	☐	☐	☐
Professionalism	☐	☐	☐	☐	☐	☐	☐	☐	☐

Detailed Assessment Criteria

Please use the following criteria to inform your overall ranking

Medical Expertise	- Knowledge re ketamine: dose, side fx, contra-indications - Safe preparation for procedural sedation - Discharge instructions post procedural sedation - Discharge instructions for wound
Communication	- Uses appropriate non-medical language for mother - Clear and concise
Team Work & Collaboration	- Delegates tasks appropriately - Structured approach to preparation for procedure
Professionalism	- Shows empathy for mother - Instructs registrar appropriate to level of training

EXAMINER NOTES

Candidate performance notes: Please provide candidate feedback including any areas of strength in their

performance and suggestions for how they could improve.

OSCE ‘incident reporting’ notes: Please provide details if an issue occurs which may influence this candidate’s exam outcome e.g. protocol breach, candidate illness etc.

Select the ONE BEST option that reflects your judgment of how well the trainee performed in this OSCE station:

Clearly performing below FACEM level

Performs just under FACEM level

Borderline FACEM performance

Performs at FACEM level

Excellent performance

GLOBAL RATING:

This scale is used in the standard setting process for the OSCE. We would like you to make a judgment that is independent of their scores on the adequacy of their performance. This element MUST be completed for the standard of the examination to be set.

OSCE 4 – Candidate Information

SCENARIO

You are the consultant in a tertiary ED. The triage nurse has approached you to speak to a 32 year old lady who is very distressed about her obstetric ultrasound. There is no FHR, no movement and the CRL is consistent with 5 weeks of age but by dates she is 8/40 gestation. She was assessed in the ED the night before and was given the impression that everything was fine.

You are required to:

- Obtain a focus history
- Address her concerns
- Explain further management plan to the patient

No additional people or equipment are involved in this station.

This is a single station OSCE (i.e. 3 minutes preparation followed by 7 minutes activity)

Domains assessed:

Medical Expertise

Health Advocacy

Communication

OSCE 4

BACKGROUND INFORMATION FOR ACTOR

CHARACTER

You are use your own name, a very distressed 32 year old lady who has just discovered that her pregnancy is not viable.

SCENE

You are 8 weeks pregnant by dates. You had presented to the ED last night with some PV bleeding. You had been seen by a Resident who had done some blood tests and performed a vaginal examination. He had reassured you that everything appeared alright and that the Registrar would have a look with the ultrasound. The registrar did the US at the bedside and commented that he saw the baby and that everything looked OK. You were told that you needed a formal ultrasound and was given a form to take to the Radiology Department in the morning.

This morning you had the ultrasound and the sonographer told you that the baby was not moving and had no heartbeat. The size of the baby is 5 weeks instead of the expected size of an 8 week gestation calculated from your last menstrual period. She indicated that these findings would suggest a likely miscarriage. You are very upset as you did expect this to be the case in view of the comments made by the ED doctor last night. You are questioning why this was not picked up last night. You also feel that the vaginal exam could have contributed to the baby's demise. You feel that the ED is in some way to blame for what has occurred. You want an explanation about the "poor" care you received in ED. You want to know what will happen next.

This is your second miscarriage and had taken you 2 years to fall pregnant again. You are concerned that you might need further investigation or review for the reasons why you have had another miscarriage. You also want to know what further management to prevent further miscarriage.

OSCE 4– Marking Sheet

Candidate Number:

A. Component Assessment

Please tick the box for each row which best describes the performance of the candidate you observed

COMPONENT ASSESSMENT

Select the **ONE** option that best represents the **minimum** senior clinician involvement required for the domain to be performed at the level of a new FACEM

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Medical Expertise

Health Advocacy

Communication

Domain	Criteria for High Rating
Medical Expertise	- competency in obtaining focus obstetric history - recognise likely miscarriage and serial B- HCG would be useful to confirm - recognise that the assessment in ED may have been incorrect but the outcome may still have occurred - Exhibits understanding of risk of fetal demise despite normal exam - Provide information regarding likely cause of miscarriage
Health Advocacy	- Appropriately addresses patient's concerns - Makes appropriate referral for follow up with O&G - Undertake to investigate the care by ED staff - Recruits support staff eg social worker appropriately - Provide options for the patient to take the complaints further
Communication	- Builds rapport and showing empathy with the patient - Clearly explains management plan for patient - Uses appropriate use of language and words - Uses appropriate non-verbal communication, body language

OSCE 4 – Marking Sheet

Candidate Number:

OSCE STATION DIFFICULTY

Select the ONE BEST option
that describes the overall
difficulty of this OSCE station

Low difficulty

☐

Moderate difficulty

☐

High difficulty

☐

FINAL OSCE MARK

Clear Fail

☐

Borderline Fail

☐

Pass

☐

Clear Pass

☐

B. Examiner Notes on Candidate Performance

Positives

Areas for Improvement

OSCE 5– Candidate Information

SCENARIO

You are the consultant in a tertiary centre. Your ED SRMO has just seen a patient who has presented with SOB and has done a chest xray (enclosed). He has spoken with the respiratory physician who asks him to do a therapeutic and diagnostic pleural tap. The patient is stable but it is unclear what the diagnosis may be.

(a) Explain to your SRMO how the procedure can be safely performed

(b) Outline the approach to make the correct diagnosis and the the tests required for the pleural fluid.

Domains assessed:

Medical Expertise

Scholarship and teaching

Communication

OSCE 5

Background information for Actors

CHARACTER

You are use your own name, a ED SRMO

SCENE

You have just seen an independent 68 year old man who lives at home. He presented with shortness of breath on exertion. His GP has sent him to the emergency department for further investigation and treatment after organising a chest xray. The CXR showed a moderately large pleural effusion (? left or right). The patient's vital signs are stable. You have seen the patient and discussed the case with the Respiratory Physician who has requested a thoracentesis to be done in ED with samples sent for tests.

You have never done a thoracentesis before.

You are not sure what the possible causes of this condition are.

You approach the ED consultant to take you through the procedure and what tests may be needed to establish the diagnosis.

You can ask questions to prompt:

- What are the contraindications/complications to look out for in doing the procedure
- How these tests will help diagnose the patient
- How the appearance of the fluid may guide the tests you order.

OSCE 5– Marking Sheet

Candidate Number:

A. Component Assessment

Please tick the box for each row which best describes the performance of the candidate you observed

COMPONENT ASSESSMENT

Select the **ONE** option that best represents the **minimum** senior clinician involvement required for the domain to be performed at the level of a new FACEM

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Medical Expertise

Scholarship and teaching

Communication

OSCE STATION DIFFICULTY

Select the ONE BEST option that describes the overall difficulty of this OSCE station

Low difficulty

☐

Moderate difficulty

☐

High difficulty

☐

FINAL OSCE MARK

Clear Fail

☐

Borderline Fail

☐

Pass

☐

Clear Pass

☐

B. Examiner Notes on Candidate Performance

Positives

Areas for Improvement

OSCE 5 – Marking Sheet

Candidate Number:

Domain	Criteria for High Rating
Medical Expertise	Correctly interprets the chest xray as showing a moderate unilateral right sided pleural effusion
	Orders the appropriate tests: protein, LDH, pH, glucose, wcc, cytology, gram stain and culture, serum LDH and protein for comparison (Bold for the essentials)
	Procedure for performing a thoracocentesis:
	1. Check contraindications (severe clotting abnormalities, cellulitis, herpes zoster at insertion site),
	Informed consent,
	2. Preparation: Equipment/ Personnel/ Location /Aseptic technique/LA/ Analgesia
	3. Procedure:insertion site/ positioning of patient amount of fluid drained (risk of post-expansion pulm oedema if >1000mls taken).
	4. Post op: Wound care/ Repeat CXR/ Monitoring of vitals for complications
	Understands the common causes of pleural effusion:
	1. Transudates : CCF, cirrhosis, hypoalbuminaemia,
	2. Exudates: pneumonia (bacterial, fungal, TB), malignancy, pulmonary infarction (from PE).
	3. Classic exudates that can be transudates: malignancy, PE (80% exudates, 20% transudates).
	Demonstrates some understanding of the biochemical difference between exudates and transudate: Light's criteria:
	1. Exudate if pleural fluid protein : serum protein >0.5 ; pleural fluid LDH:serum LDH > 0.6 ; pleural fluid LDH > 2/3 upper limit of normal serum LDH.
	2. Glucose : <3.3 associated with empyema, rheumatoid disease, SLE, 3. pH : <7.2 indicates infection and indication for drainage if parapneumonic.
	Gram stain and culture : infection, TB, fungal
	If bloody effusion : Hct : <1% not signif, 1-20% malignancy, PE, <u>>20</u> trauma , >50% haemothorax
	If cloudy effusion : triglyceride levels - ?chylothorax
Scholarship and Teaching	Covers the essential aspects on how to safely perform a thoracocentesis and outline different causes of pleural effusions
	Interacts with the registrar in positive manner
	Clearly articulates information to the registrar and checks understanding
Communication	Appropriate level of language for professional interaction

OSCE 6– Candidate Information

SCENARIO

You are the consultant in a rural ED

You have just arrived at work for your day shift

The ED SRMO comes to you in a distressed state

He/She has just finished inserting a pigtail catheter for a spontaneous pneumothorax under local anaesthetic and IV sedation. To their horror, they realised that they had inserted the catheter into the wrong side of the chest.

You are required to investigate what has happened, what needs to be done to remedy the situation and counsel the SRMO.

This is a single station OSCE (ie 3 minutes preparation followed by 7 minutes activity)

Domains assessed:

Leadership and Management

Health Advocacy

Professionalism

OSCE 6

Background information for Actor

CHARACTER

You are use your own name, an ED SRMO

Background information for actor

You are an ED SRMO having almost finished your night shift.

You have just finished inserting a pigtail catheter into a 25y lady for a spontaneous pneumothorax (50%)

The procedure was done under IV sedation and local anaesthetic. You realised that you had inserted the catheter into the wrong side after the procedure was completed. You have not yet spoken to the patient.

You were the senior doctor on overnight. You did not use a time-out sheet. You were horrified that you have made such a terrible mistake.

As you inform the ED consultant, you were anxious, upset and unsure as what to do next. Your tone and facial expression will reflect that.

Start with:

“Something bad has happened..... I’ve just placed a pig tail catheter for a spontaneous pneumothorax into the wrong side of the chest “

“I don’t know what I should do now?”

Await response from Consultant.

Response should cover:

1. What is the current condition of patient?

Patient current has stable observations but is asleep. The pig tail is connected to underwater- seal container and is bubbling well.

2. How did this happen?

I was very tired and in a rush as I was trying to get it done before the shift change over. I guess I must have confused with the side. I did not go through the time out sheet properly. It is all my fault!!

3. Treatment of initial condition

What do I do with the pigtail I have just inserted?

What about the pneumothorax on the other side?

4. Open disclosure

Who should talk to the patient?

What should I say to the patient?

5. Reporting and Investigation of incident

Will I be in trouble? What should I do now?

SRMO to provide medical documentation and assisted to fill in the incident form if required.

Consultant will take care of the reporting to the administration and investigation

Time out check list education

6. Management of SRMO-current state of mind

I am a bad doctor?

What about my other patients?

I have got 2 more night shifts coming up, not sure whether I can cope with that.

OSCE 6 – Marking Sheet

Candidate Number:

A. Component Assessment

Please tick the box for each row which best describes the performance of the candidate you observed

COMPONENT ASSESSMENT

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Leadership and management

Health Advocacy

Professionalism

Domain	Criteria for High Rating
Leadership and Management	Recognise that the SRMO has made a serious error Explore the circumstances of how the incident has happened Discuss the immediate action required: • Current condition of patient • Determine urgency for further intervention • Plan for pigtail catheter just inserted • Treatment plan for initial pneumothorax and possible
Health Advocacy	Open disclosure How and When and Who to Inform patient when not sedated Apologise to patient, explain potential harm and further treatment Inform relatives Inform CPIU or equivalent Inform ED and hospital executive
Professionalism	Management of SRMO's distress Determine current state of mind and safety Safe handover of other patients being cared for Explain plan for investigation to SRMO Determine system vs individual issues Time out check list policy and education Further investigation to prevent similar incidence from happening

OSCE 6 – Marking Sheet

Candidate Number:

OSCE STATION DIFFICULTY

Select the ONE BEST option
that describes the overall
difficulty of this OSCE

Low difficulty

☐

Moderate difficulty

☐

High difficulty

☐

FINAL OSCE MARK

Clear Fail

☐

Borderline Fail

☐

Pass

☐

Clear Pass

☐

B. Examiner Notes on Candidate Performance

Positives

Areas for Improvement

OSCE 8– Candidate Information

SCENARIO

You are the consultant in a tertiary centre. Your junior registrar has just seen an 80 year old lady who has presented with confusion and reduced level of consciousness (GCS 13). Other vital signs are normal.

The lab has just called notifying him that her sodium level is 114 mmol/L. Your registrar would like to know:

(a) How to differentiate the different causes of hyponatraemia and

(b) The indication of hypertonic saline and how to administer it

You may use pen & paper to better explain to your registrar if you wish.

Domains assessed:

Medical Expertise

Scholarship and teaching

Communication

OSCE 8

Background information for Actors

CHARACTER

You are use your own name, a junior ED registrar

SCENE

You have just seen an 80 year old lady from a Nursing Home who presented with acute confusion and reduced level of consciousness (GCS 13). Other vital signs are normal.

The lab has just called notifying you that her sodium level is 114 mmol/L.

Hyponatraemia has always confused you, and you are after a simple and structured approach to apply on your patient to determine the cause of hyponatraemia.

You are also unsure about the indication of hypertonic saline and how much to give as you have heard about the serious side effect of such treatment.

You may require to provide the following prompts:

- The patient is stable and being monitored in the acute treatment area
- What specific examination findings should I be looking for?
- What specific tests would be useful?
- When should I use hypertonic saline? How much to give? What is the end point?
- What are the potential complications in using hypertonic saline? How can these be avoided?

OSCE 8 – Marking Sheet

Candidate Number:

A. Component Assessment

Please tick the box for each row which best describes the performance of the candidate you observed

COMPONENT ASSESSMENT

Select the **ONE** option that best represents the **minimum senior clinician involvement** required for the **domain** to be performed at the level of a new FACEM

☐ Candidate performs; senior clinician directly observes	☐ Candidate performs; senior clinician checks prior, during, upon completion	☐ Candidate performs; senior clinician checks prior and upon completion	☐ Candidate performs; senior clinician checks upon completion	☐ Candidate performs; senior clinician available to check in-person	☐ Candidate performs; senior clinician available to advise via telephone	☐ Candidate performs; ~~Senior~~ clinician not required	☐ Candidate performs above the level of a new consultant; ~~Senior~~ clinician not required	☐ Candidate performs at the level of a senior consultant; ~~Senior~~ clinician not required
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Medical expertise

Scholarship and teaching

Communication

OSCE STATION DIFFICULTY

Select the **ONE BEST** option that describes the overall difficulty of this OSCE station

Low difficulty

☐

Moderate difficulty

☐

High difficulty

☐

FINAL OSCE MARK

Clear Fail

☐

Borderline Fail

☐

Pass

☐

Clear Pass

☐

B. Examiner Notes on Candidate Performance

Positives

Areas for Improvement

OSCE 8 – Marking Sheet

Candidate Number:

Domain	Criteria for High Rating
Medical Expertise	Recognised severe hyponatremia (Na <120mmol/L) Exclude factitious causes: - Hyperlipidaemia/hyperproteinaemia-(Normotonic) - Hyperglycaemia (Hypertonic) Calculate serum osmolarity (2 x Na + glucose + urea) to determine whether patient is isosmolar, hypoosmolar, or hyperosmolar Assess by volume: Hypovolaemic: sodium loss exceeds free water loss Renal losses (urine Na>20 mmol/L): Diuretics; Addison's; osmotic diuresis Extrarenal losses (urine Na< 20mmol/L): V &D; blood loss; third space loss Euvolaemic: free water gain, minimal sodium loss SIADH (Urine Na > 20 mmol/L; Urine osmolality > 100mmol/kg) Drugs/malignancy/Post op; Hypothyroid Hyervolaemic: free water gain exceeds sodium gain Cardiac Failure (urine Na< 20 mmol/L) Hepatic Failure (urine Na< 20 mmol/L) Renal Failure (urine Na> 20 mmol/L) Laboratory tests: Serum urine and urine osmolarity Urinary sodium level. Indications for hypertonic saline: Severe (Na <120mmol/L) with - Seizures/ Coma / altered mental status/ focal neurological deficit Dosing of HS (ACLS guidelines): 3%HS 1.5mls/kg (100mLs for 70kg) stat Repeat a further 1.5mLs/kg (100mLs) if symptoms persist and check Na 100mls HS will give approximately 2mmol/L elevation of serum Na Serum Na should not rise by > 10-12 mmol/L over 24hrs to avoid Central Pontine Demyelolysis. For a 24 hour period, this will equate to an infusion of 0.5ml/kg/hr of 3% HS
Scholarship and teaching	- Structured approach in discussing volume status and investigation - Interacts with the registrar in positive manner - Clearly articulates information to the registrar and checks understanding
Communication	Appropriate level of language for professional interaction

OSCE 10 : INSTRUCTIONS TO CANDIDATE

This is a double station involving simulation.

You are the emergency consultant on duty in a tertiary centre. You have just received a “batcall” about a 54 yr old male who will be arriving shortly to your department (the ambulance staff are pushing the patient into your resuscitation room at the commencement of the scenario). The patient has been found unresponsive by his family, who called the ambulance. The family made no attempt at CPR.

When the ambulance staff arrived, they found the patient pulseless with a broad complex tachycardia. They have intubated the patient, and have commence ALS . They have achieved a return of spontaneous cardiac output, however the patient has had several episodes of VF and VT and has received a total of 6 defibrillations on the way to the emergency department. The patient has had a GCS of 3 throughout the incident.

The patient currently has a pulse has just been transferred to your resuscitation bed.

The ambulance staff have a list of his medications for you.

You have an ED registrar and and 2 experienced resuscitation nurses with you.

You are required to

- (1) Obtain a handover and relevant information from the staff
- (2) Provide resuscitation as required
- (3) Consult any relevant teams/staff as required

You are being assessed on the following domains:

MEDICAL EXPERTISE

TEAMWORK AND COLLABORATION

HEALTH ADVOCACY

OSCE 10 : BACKGROUND INFORMATION FOR ACTORS

Required :

2 x resuscitation nurses:

1 x ambulance staff (same actor as for consult doctor)

1 x ED registrar

1 x consult doctor (via phone)

SCENE: Phase 1 (start to around 7 minutes)

Pt is initially on ambulance trolley, pt is intubated and being ventilated via a bag-valve-mask.

He is currently in a paced rhythm.

The patient has a ROSC and palpable pulse. He is being monitored and has defibrillator pads attached.

ambulance staff give a handover :

- pt found unresponsive by family members after they heard a fall.
- approximately 10 minutes from fall until ambulance arrival, no CPR during this time.
- Pt found in pulseless VT, intubated and ALS algorithm followed, including total adrenaline 4mg IV and 4 x 200J DC shocks.
- ETT position confirmed by colour change capnography
- Pt has remained GCS 3 throughout
- PHx "cardiac disease" , medication list available to give to consultant.

As the patient is about to be transferred from the ambulance bay he develops a broad complex tachycardia and loss of output.

Ambulance staff : " doctor – the rhythm has changed and I don't think I can feel a pulse"

If candidate prepares for defibrillation, ambulance staff "should we give him 3 stacked shocks ?"

ALS protocol should be commenced, including IV amiodarone.

There is a ROSC after the 3rd cycle, he will be in a broad complex paced rhythm HR 60-80, BP 80/40.

Phase 2 : Once ROSC achieved.

If amiodarone not given, then patient will have recurrent episodes of VT / VF , requiring ongoing CPR.

If amiodarone still not given,

Registrar “can we give him any medication to stop him going back into VT ?”

If still not given, the recurrent VT 1 further cycle ALS, then nurse “should give him some amiodarone ?”

Once amiodarone given and rhythm is stabilised :

Registrar : “ should we get any other tests” ? “who should we consult”

Expected :

As patient is on rivaroxaban , candidate should order CT head, as pt will likely require antiplatelet agents and GCS remains at 3.

Consult cardiology : - cardiology registrar feels as there has been 10 minute downtime and GCS remains at 3 that patient should not go to cardiac catheter lab at present, as prognosis is poor. They want aspirin and heparin to be commenced.

Candidate expected to advocate on behalf of patient in regards to this.

Cardiology will reluctantly agree to review pt in ED and perform echo in ED to decide ongoing management.

Consult ICU : ICU happy to accept patient, but want a plan for further management of patient.

Once consults complete (if time)

ED Nurse:

His BP is still low and I have put a catheter in and there is no urine output. What should we do ?

I-Simulate brief :

Phase 1 (start to around 7 minutes)

On arrival : pulse 80, paced rhythm. GCS 3, intubated. Has pulse according to ambulance staff.

As about to be transferred :

Loss of output and has pulseless VT.

Candidates should defibrillate and commence CPR.

If capnography attached then should have CO2 trace with CO2 of around 15

Pt will remain in VT throughout 2 full cycles.

Then after 3rd cycle should be ROSC.

Pt should receive amiodarone, if not then will have brief period of ROSC, but then develop recurrent pulseless VT.

Then prompt by registrar : “ can we give him any medication to stop him going back into VT ?”

If still not given then recurrent VT

Nurse : “can we give him some amiodarone” ?

Phase 2 :

ROSC achieved

Pt to remain in paced rhythm, wide complex

Hypotensive 80/50, pulse 80 bpm, CO2 improves to 30, sats 98% on 100% oxygen

If adrenaline infusion commenced at appropriate doses, then BP improves to 100/65

PATIENT MEDICATIONS :

Dilatrend 50mg daily

Frusemide 80 mg daily

Micardis plus 80/12.5 mg daily

Monodur 120 mg daily

Nexium 40mg daily

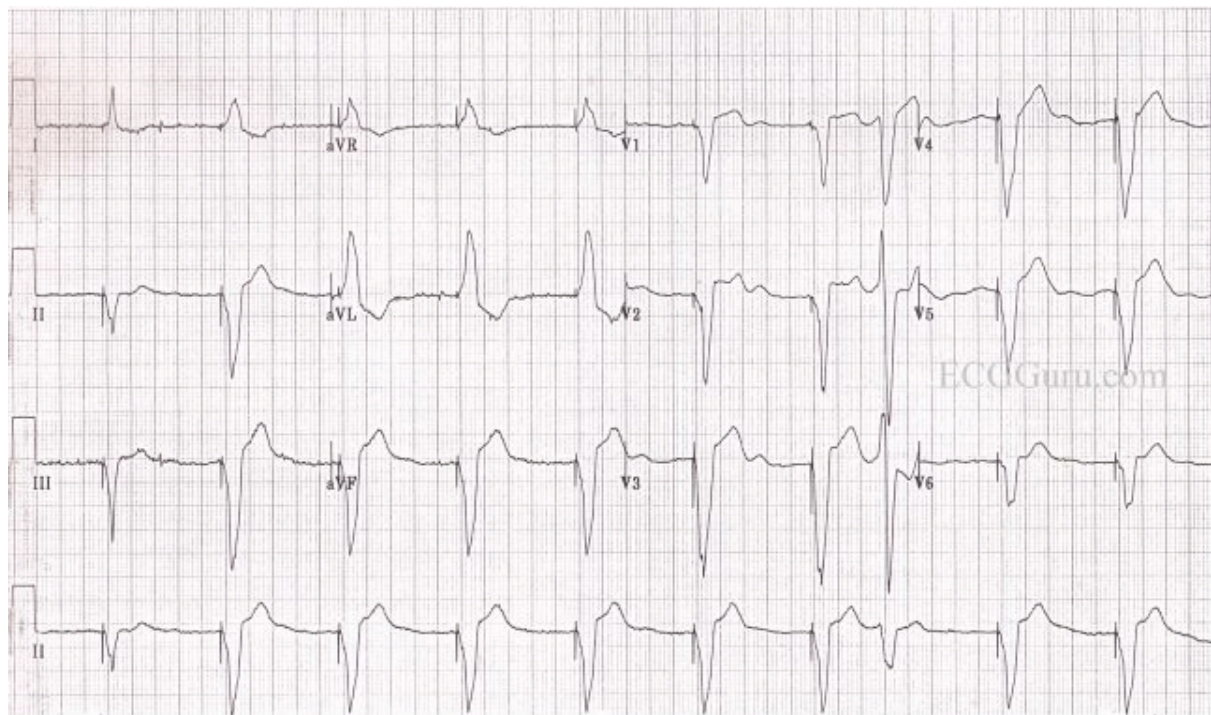
Physiotens 400mcg daily

Vitamin A 1 tablet daily

Xarelto 20mg daily

Zocor 40 mg daily

ECG once ROSC achieved : (if requested)



OSCE 10 – Marking Sheet

Candidate Number:

A. Component Assessment

Please tick the box for each row which best describes the performance of the candidate you observed

COMPONENT ASSESSMENT

Select the **ONE** option that best represents the **minimum senior clinician involvement** required for the domain to be performed at the level of a new FACEM

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Medical expertise

Teamwork & collaboration

Health Advocacy

OSCE STATION

DIFFICULTY

Select the ONE BEST option that describes the overall	Low difficulty ☐	Moderate difficulty ☐	High difficulty ☐
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FINAL OSCE MARK

Clear Fail ☐	Borderline Fail ☐	Pass ☐	Clear Pass ☐
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B. Examiner Notes on Candidate Performance

Positives

Candidate Number:

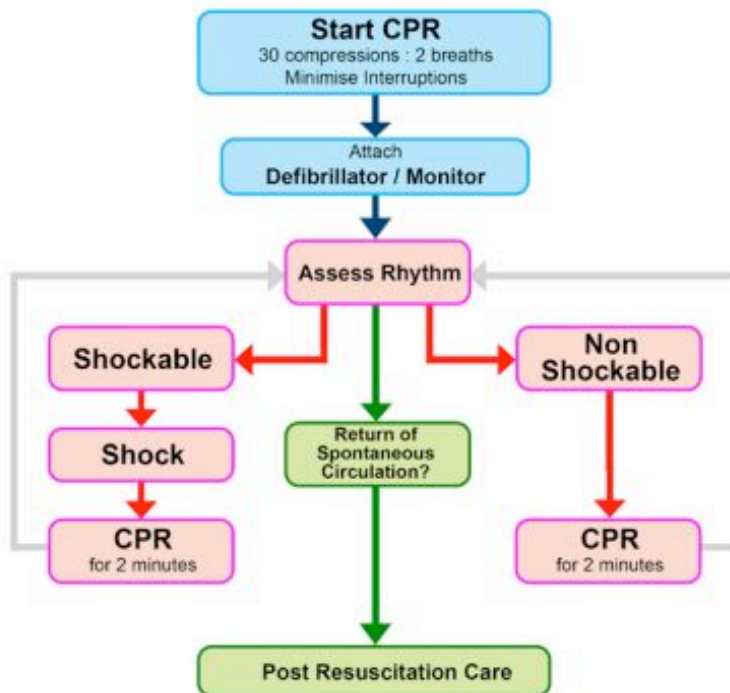
OSCE 10 – Marking Sheet

Areas for Improvement

Domain	Criteria for High Rating
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Medical expertise	- Correct application of ALS algorithm, including shocking patient prior to transfer to resuscitation bed. Also should not give stacked shocks. - Amiodarone should be given early, as recurrent VT. - Defibrillator should be charged and ready prior to CPR being ceased for rhythm check. - ETT position should be checked with capnography. - Expected high level knowledge for ALS algorithm - Should arrange CT brain prior to starting aspirin/ heparin (as patient has fallen and is on rivaroxaban). - Good post resuscitation care.
Teamwork and collaboration	- Should manage ED team appropriately, delegate roles and tasks - Closed loop communication - Clear instructions - Seeks suggestions from team
Health Advocacy	- Should advocate for cardiologist to consider taking patient for urgent cardiac catheterization - Should advocate for ICU to accept patient for admission - Should develop plan for management if patient develops recurrent VF/ VT whilst in ED, and parameters for urgent angiogram (e.g. discuss with cardiologist re indications for taking to angiogram). - Good post resuscitation care – commence on adrenaline infusion, maintain normoglycaemia, monitor urine output.

Advanced Life Support for Adults



During CPR

Airway adjuncts (LMA / ETT)
Oxygen
Waveform capnography
IV / IO access
Plan actions before interrupting compressions
(e.g. charge manual defibrillator)

Drugs

Shockable

- * Adrenaline 1 mg after 2nd shock
(then every 2nd loop)
- * Amiodarone 300mg after 3 shocks

Non Shockable

- * Adrenaline 1 mg immediately
(then every 2nd loop)

Consider and Correct

Hypoxia
Hypovolaemia
Hyper / hypokalaemia / metabolic disorders
Hypothermia / hyperthermia
Tension pneumothorax
Tamponade
Toxins
Thrombosis (pulmonary / coronary)

Post Resuscitation Care

Re-evaluate ABCDE
12 lead ECG
Treat precipitating causes
Aim for: SpO₂ 94-98%, normocapnia and normoglycaemia
Targeted temperature management



NEW ZEALAND
Resuscitation Council
WHAKAHAUHUA AITĀKARA

Double Station

Station Instructions: Anaphylaxis

Setting:

Midnight on Tuesday

45yo M presents with difficulty breathing after took he a drink from a beer can 30 minutes earlier at a family BBQ. He immediately reported he had swallowed something that stung him in the mouth, and his tongue began to swell.

He is accompanied by a relative (e.g. wife/brother).

He is in anaphylactic shock, with rash and wheeze. IV access is not possible.

After IO insertion, his circulation begins to improve with 2 adrenaline boluses and 1-2L IV fluid boluses. IV adrenaline infusion required to stabilise patient.

His breathing improves with nebulised adrenaline

He should be admitted to ICU under General Medicine with immunology consult.

Curriculum Domains:

- *Medical Expertise*
- *Scholarship & Teaching*
- *Communication*
- *Professionalism*

Set up:

- Personnel:
 - Examiner (and control manikin)
 - Relative (Wife or brother)
 - Triage Nurse
 - Competent JMO
- Equipment
 - Airway/Breathing:
 - O2 source, NRB, nebs, BVM, airway trolley (stocked) and difficult airway setup
 - Circulation:
 - Cannulas, needles, syringes
 - Ezi-IO: dummy limb, needles, connection port
 - Medications:
 - Adrenaline: vials (1:1000, 1:10000)
 - IVF: saline bags and tubing
 - Hydrocortisone
 - ? Promethazine (Phenergan): IV and oral

Double Station

Instructions to Candidate:

You are working in the emergency department, it is late Tuesday night. You have been called urgently to the resus bay to a middle-aged male patient who has swallowed a bee and appears unwell with rash and difficulty breathing.

You are required to:

- Assess and manage the clinical situation

You will be assessed on

- Medical Expertise
- Prioritisation and Decision Making
- Teamwork and Collaboration
- Communication
- Professionalism

Double Station

Instructions to Role Players:

Midnight on Tuesday

45yo M presents with difficulty breathing after took he a drink from a beer can 30 minutes earlier at a family BBQ. He immediately reported he had swallowed something that stung him in the mouth, and his tongue began to swell.

Accompanied by a relative (e.g. wife/brother).

He is in anaphylactic shock, with rash and wheeze. IV access is not possible.

After IO insertion, his circulation begins to improve with 2 adrenaline boluses and 1-2L IV fluid boluses. IV adrenaline infusion required to stabilise patient.

His breathing improves with nebulised adrenaline

He should be admitted to ICU under General Medicine with immunology consult.

Junior Registrar

You are a competent junior registrar in the department. You have just arrived in the resus bay. You will assist the emergency consultant to manage the patient. You can competently perform tasks such as IV access, however this fails on each occasion in this scenario. You can perform IO access. You are not confident to intubate an unwell patient, but can set up the equipment if requested.

- Provide result of CXR at suitable interval after they are requested.
- Gas not available (IO); formal bloods not back during scenario

Resus Nurse

You are a competent resus nurse. You have received a handover from the triage nurse and commenced assessment of the patient, including a full set of vital signs. You will assist the candidate to manage the patient within your usual scope of practice.

You are able to tell the candidate the outcome of their physical exam and of their actions.

- failed all cannula attempts
- provide intra-osseous equipment if asked
- no improvement after adrenaline IM x 2, patient still wheezing, hypotensive
- wheeze improves after adrenaline neb
- BP improves after adrenaline infusion commenced
- Provide results of ECG at suitable interval after they are requested.

Patient's relative

Wife or brother of Mr Jenkins. You provide the initial story – he was stung by a bee about half an hour ago at a family BBQ. He is not drunk and you don't think he ate anything he's allergic to. You can answer most questions about his past history.

Past Medical History: Usually well. No htn, chol, DM-2, IHD.

Medications: nil

Allergies: bee sting – throat swelling

Weight: 80kg

Job & hobbies: Builder. Swimming.

Family medical history: Father had MI. Mother has rheumatoid arthritis

Lifestyle: Married, 2 kids. Healthy, active. Non smoker. EtOH 5 nights a week, 3-4 light beers.

You are appropriately anxious, but calm and helpful.

Double Station

Instructions to Examiner:

You are required to observe the candidate and control the mannikin.

Signal to the junior registrar/resus nurse with 2 minutes to go, if required to move candidate through all assessment criteria

Assessment Criteria:

- Medical Expertise
 - Early recognition of anaphylaxis
 - Follow anaphylaxis guidelines
 - early administration of IM adrenaline
 - correct adrenaline strength and dose (0.3mg IM = 0.3mL of 1:1000)
 - Establish parenteral access - IO if no IVC within 60-90 seconds
 - Recognition of inadequate response
 - Commence adrenaline infusion
 - nebulised adrenaline for wheeze & stridor
 - Prepare to intubate - anticipation of potentially difficult airway
- Prioritisation and Decision Making
 - Escalate to IO insertion
 - Recognition of inadequate response to Rx
 - Calling for assistance from anaesthetics and/or ENT.
- Teamwork and Collaboration
 - Allocating roles on the go
 - Closed loop communication
 - Staying in role as leader
- Communication
 - Verbal clarity, conciseness, specificity
 - Appropriate medical language
- Professionalism
 - Shows respect for patient, carer, nurse and junior colleague
 - Professional appearance, demeanour & conduct

Double Station

Mannequin preparation

Make up: rash all over, swelling to tongue

Wounds, dressings: nil

Monitoring in situ: BP, HR, sats

Patient on: trolley

3rd Party Hosting has been temporarily disabled.



to unlock your account visit:
photobucket.com/p500

Props needed:

Airway/Breathing:

- O2 source, NRBM, nebs, BVM
- airway trolley (stocked) and difficult airway setup

Circulation:

Cannulas, needles, syringes

Ezi-IO: dummy limb, needles, connection port

Medications:

Adrenaline: vials (1:1000, 1:10000)

IVF: saline bags and tubing

Hydrocortisone

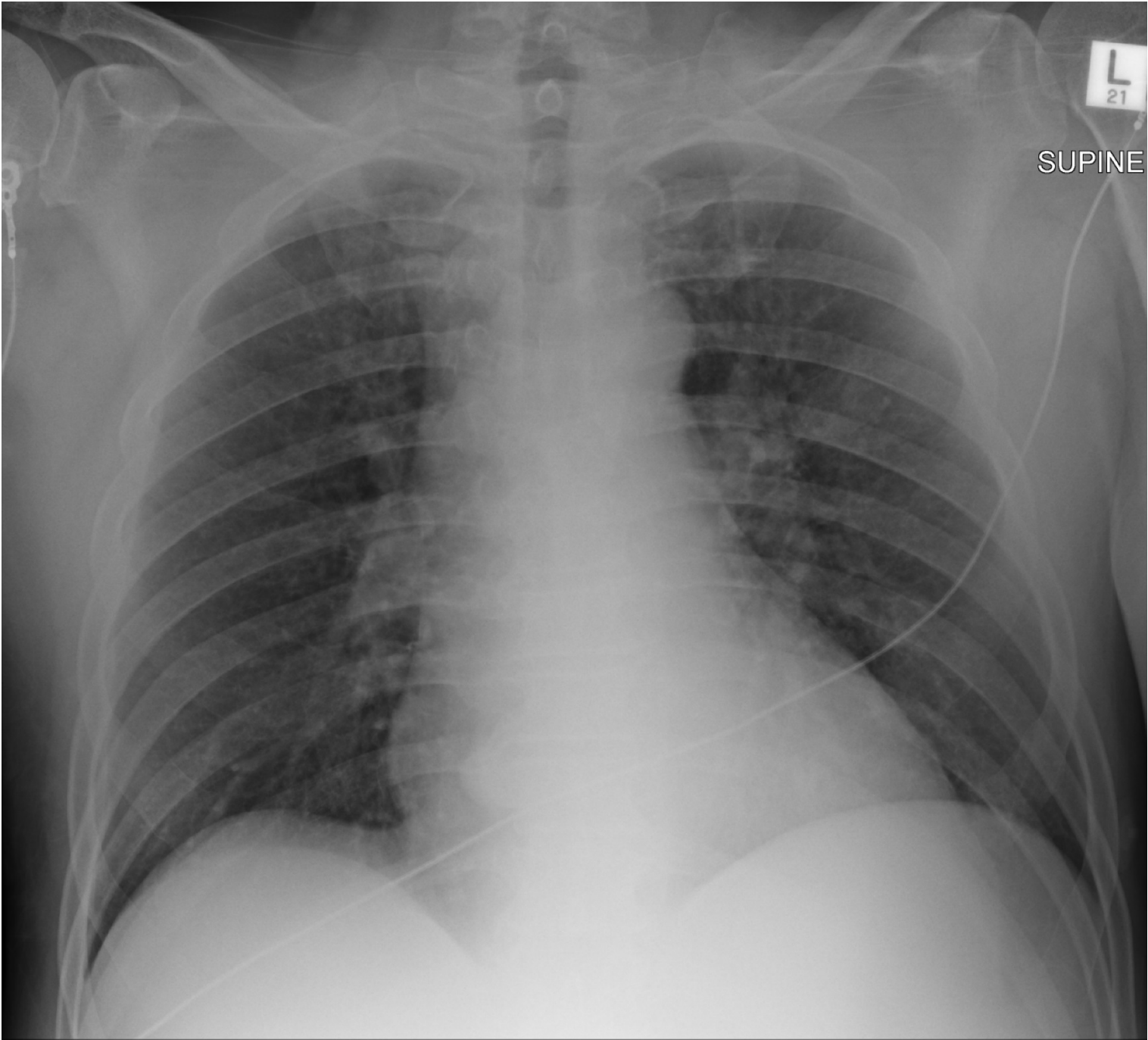
Promethazine (Phenergan): IV and oral

Scenario Set up

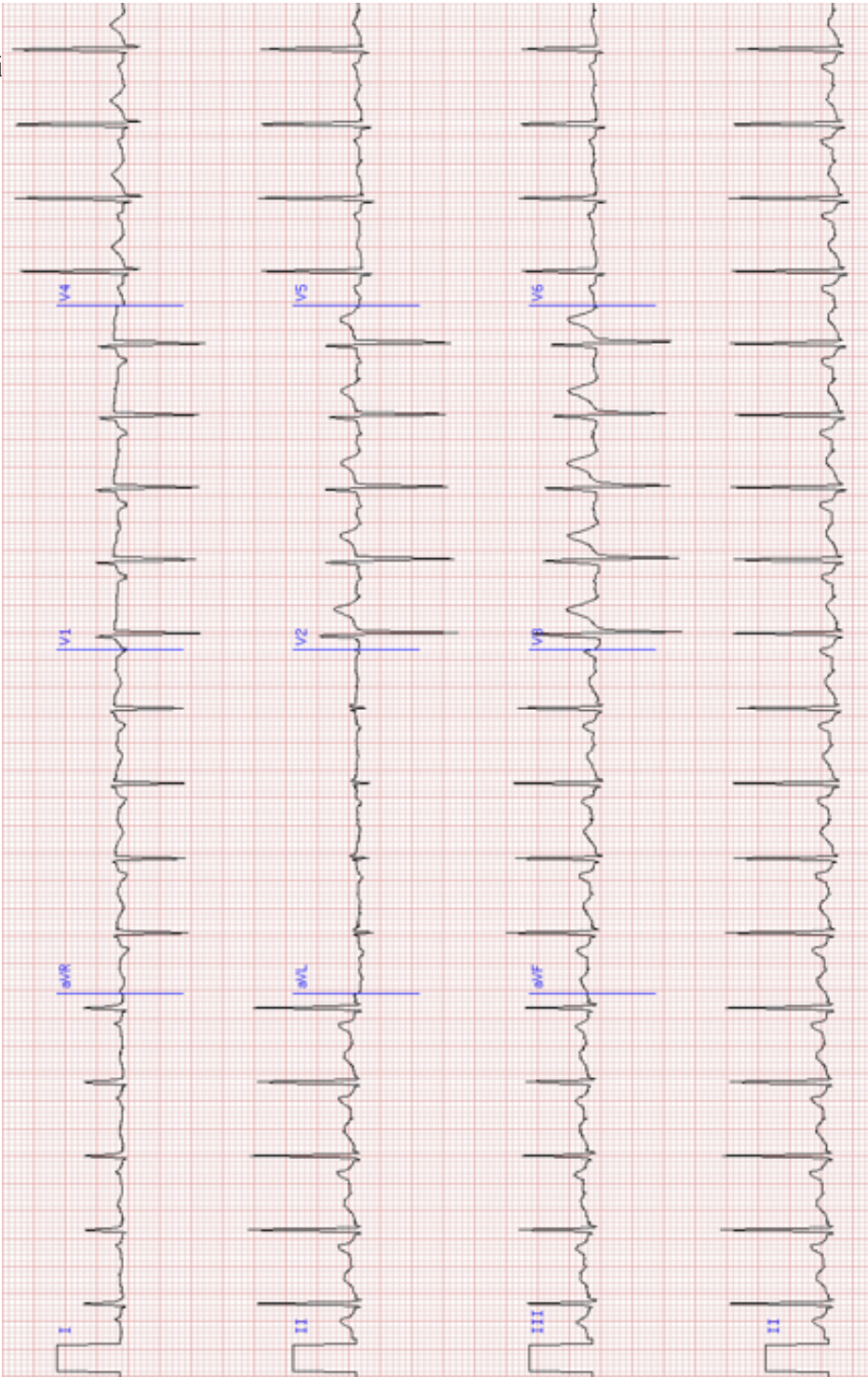
Mannequin Physiological parameters – unable to speak due to breathlessness				
Initial	HR: 130	Rhythm: sinus	BP: 80/60	
	SpO2: 91% ra	RR: 24	Temp:37.0	BSL: 7.8
	Other: wheeze & stridor			
Circulation vital signs improve after IM adrenaline x2 and intraosseus IVF 1-2L:				
	HR: 125	Rhythm: sinus	BP: 85/65	
Airway/breathing improve slightly after nebulised adrenaline:				
	SpO2: 96% 15L	RR: 24	Temp:37.2	BSL: 8.2
<i>Circulation improves further with adrenaline infusion</i>				
	HR: 110	Rhythm: sinus	BP: 100/70	

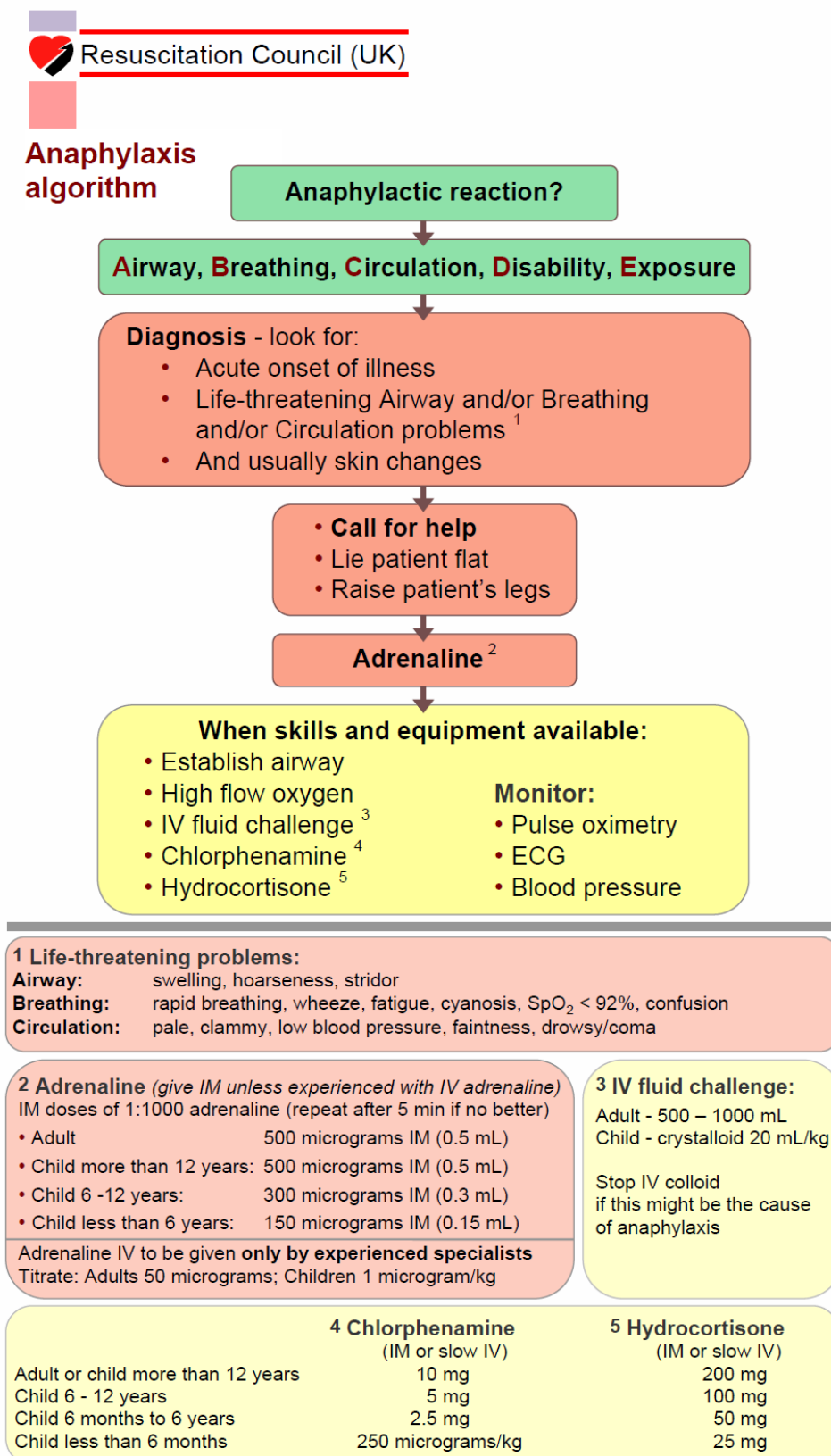
Results required

Lab results:	Gas not available - IO	EUC & FBC not available in timely fashion		
ECGs:	NSR, HR 130			
X-ray/other imaging:	CXR			
Other results:				



Double Stati





6.1.1.Preparation

■ 6mg of Adrenaline in 94mLs of 5% Dextrose (preferred) or 0.9% Normal saline(N/S) (withdraw 6mLs from a 100mL bag of 5% dextrose/0.9%N/S)

Via infusion pump as a continuous infusion

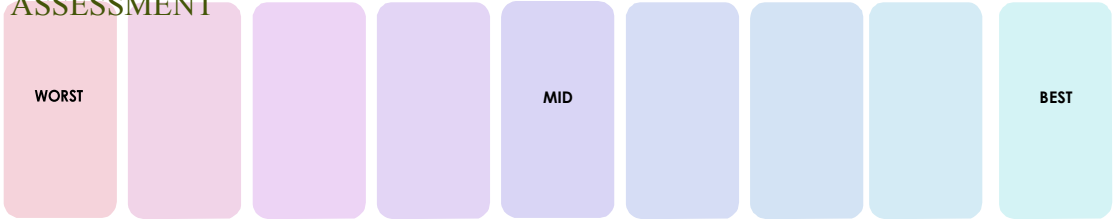
■ Commence at 1-5 mLs/hr (60micrograms/mL) and titrate as per prescribed therapeutic endpoints

CONFIDENTIAL Examiner Rating: Double Station: Adult Resuscitation Scenario

Double Station

CANDIDATE DETAILS	EXAMINER
Candidate ID:	Name:
EXAM DETAILS	
Date of OSCE:	

COMPONENT ASSESSMENT



Medical Expertise	☐	☐	☐	☐	☐	☐	☐	☐	☐
Communication	☐	☐	☐	☐	☐	☐	☐	☐	☐
Teamwork & Collaboration	☐	☐	☐	☐	☐	☐	☐	☐	☐
Prioritisation & Decision Making	☐	☐	☐	☐	☐	☐	☐	☐	☐
Professionalism	☐	☐	☐	☐	☐	☐	☐	☐	☐

Detailed Assessment Criteria

Please use the following criteria to inform your overall ranking

Medical Expertise	○ Early recognition of anaphylaxis ○ Follow anaphylaxis guidelines ○ Establish parenteral access - IO if no IVC within 60-90 seconds ○ Recognition of inadequate response & escalate ○ Prepare to intubate - anticipation of potentially difficult airway
Communication	○ Verbal clarity, conciseness, specificity ○ Appropriate language
Teamwork & Collaboration	○ Allocating roles on the go ○ Closed loop communication
Prioritisation & Decision Making	○ Escalate to IO insertion ○ Recognition of inadequate response to Rx ○ Calling for assistance from anaesthetics and/or ENT.
Professionalism	○ Shows respect for staff and patient ○ Professional appearance, demeanour & conduct

Double Station

EXAMINER NOTES

Candidate performance notes: Please provide candidate feedback including any areas of strength in their performance and suggestions for how they could improve.

OSCE 'incident reporting' notes: Please provide details if an issue occurs which may influence this candidate's exam outcome e.g. protocol breach, candidate illness etc.

GLOBAL RATING:

This scale is used in the standard setting process for the OSCE. We would like you to make a judgment that is independent of their scores on the adequacy of their performance. This element **MUST** be completed for the standard of the examination to be set.

Select the ONE BEST option that reflects your judgment of how well the trainee performed in this OSCE station:

Clearly performing
below FACEM level

Performs just
under FACEM level

Borderline FACEM
performance

Performs at FACEM
level

Excellent
performance



OSCE			
FE/CPD:	St George trial exam 26/5/16	Author(s):	Adam Sroor
Subject and topic reference:	Informed consent: Retrieval of a Trauma patient at a rural Hospital to a Trauma Centre	LOA	Type LOA here
		Mark:	Type mark allocation here
Text Reference	Type references to text here		
Question stem:	You are the in-charge doctor in a Rural ED. Your registrar has reviewed a 24 year old with no prior medical history Patient appears intoxicated with alleged assault with large scalp haematoma and chest contusions. Patient already assessed by your registrar and had a full trauma CT series. Patient GCS on presentation was 14. An hour later patient GCS has dropped to 12, and still no lateralising signs, pupils equal, reactive to light HR 110, Bp 130/70, RR 20, Spo2 95% on RA The registrar has already been in contact with trauma service at the nearby tertiary hospital and they have accepted the transfer. Retrieval service has been tasked to transfer the patient with a doctor and a nurse on board (Helicopter transfer) with ETA in 2 hours, transport time around 2 hours. Your task is to: Discuss with the registrar a detailed plan with regards to : • 1) Stabilising the patient • 2) optimising the patient and preparation for transport • 3) anticipated complications during transport You will be assessed on the following domains: • Medical Expertise • Communication • Leadership and management • Teamwork and collaboration		

Instructions

Registrar (actor):

Prompts by registrar

Airway management: Should we do RSI or keep monitoring his GCS?(Anticipated deterioration/safety in transport i.e. controlling A&B to prevent 2ry brain injury)

Should the patient have a thoracotomy tube placement or a conservative approach is appropriate?

What neuroprotective intervention could we install to prevent secondary brain injury? i.e Treatment targets

ED Registrar (played by second examiner): You are an Advanced Trainee (PGY4) in emergency have passed your primary exam. You had an anaesthetics rotation, and comfortable with your airway skills, and in performing thoracostomy tube placement.

You need some instructions with regards to prioritisation (Intubation versus chest tube placement 1st)

Prompts

Pre-RSI:

What RSI agents should I use?

What is the target End-tidal CO2 I should be aiming for?

Should I place an Arterial-line?

If patient developed lateralising signs or unequal pupils while waiting for transport? What agent should I use(mannitol vs hypertonic saline) and what temporising measures I can do to lower ICP ?

SET UP:

Patient treatment cubicle

Actors: registrar, presence of CT brain images, CT Chest

Examiner:

Observe interaction between candidate and registrar (Actor) and will not interact with the candidate

Scoring sheet:

Interaction with ED registrar (Actor):

Appropriate introduction

Shows CT brain images/ CT chest (for spot diagnosis , images showing:

CT Brain image with traumatic SAH/ skull fracture

CT Chest rib fractures with pneumothorax.

Interaction with registrar:

Confirms level of training/airways skills/Surgical skills in placing a thoracostomy tube.

-evidence of a structured approach to stabilise the patient and optimise for transport

-Neuroprotective measures post intubation:

(30 degree head up, improve venous drainage (No neck ties, limit PEEP), End tidal P_{CO2} target, avoid any hypotension, ...

Situational awareness:

Candidate must show awareness in:

-anticipated decline in GCS and need for RSI to control A&B for safe transport

-treating the pneumothorax in respect to PPV & gas expansion in transport

CONFIDENTIAL Examiner Rating: Station *Number: Title*

CANDIDATE DETAILS	EXAMINER
Candidate ID:	Name:
EXAM DETAILS	
Date of OSCE:	

COMPONENT ASSESSMENT

	WORST				MID				BEST
Medical Expertise	☐	☐	☐	☐	☐	☐	☐	☐	☐
Communication	☐	☐	☐	☐	☐	☐	☐	☐	☐
Team Work & Collaboration	☐	☐	☐	☐	☐	☐	☐	☐	☐
Professionalism	☐	☐	☐	☐	☐	☐	☐	☐	☐

Detailed Assessment Criteria

Please use the following criteria to inform your overall ranking

Medical Expertise	- Knowledge of TBI management/prevent 2ry brain injury - Knowledge of traumatic pneumothrorax manament in view of positive pressure ventation, and understanding of Aeromedical Concerns (gas expansion at altitude in untreated pneumothorax) - Safe preparation for Transport/Retrieval
Communication	- Clear communication with the ED Registrar, opportunity to teach - Clear and concise
Team Work & Collaboration	Structured approach to patient preparation
Professionalism	Instructs registrar appropriate to level of training

EXAMINER NOTES

Candidate performance notes: Please provide candidate feedback including any areas of strength in their performance and suggestions for how they could improve.

OSCE ‘incident reporting’ notes: Please provide details if an issue occurs which may influence this candidate’s exam outcome e.g. protocol breach, candidate illness etc.

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Clearly performing below FACEM level	Performs just under FACEM level	Borderline FACEM performance	Performs at FACEM level	Excellent performance



Traumatic SAH with skull fracture



Traumatic pneumothorax ,mild haemothorax, and rib fractures