Ward Round Notes 1 + 2 + 3 – Notes for Candidate

Please watch the ward round recordings and document appropriately.

We have made audio recordings for logistical ease, any information you would normally pick up from observation, we will convey to you in our conversation.

10 minutes for 2x ward rounds (No Examiner or Simulator)
WR 1 – PRACTICE
WR 2+3 back to back = 1 station (2 x 5 minutes)

You will be assessed on your ability to:
- **Assimilate the information from the 10 minute video, observation charts and drug charts (you will be warned when 2 mins remaining).**
- **Clear representation of ward round (multiple medical patients) with appropriate and legible notes.**

An invigilator will let you know when 8 minutes has elapsed.

WARD ROUND 1:
https://app.medall.org/contents/c-osce-express-session-1-ward-round-notes-examinations

WARD ROUND 2:
https://drive.google.com/file/d/1ebPS_hCRESU0Uzekuad50QUE4_A96yQL/view?usp=sharing

WARD ROUND 3:
https://drive.google.com/file/d/1jA-vt_5Af5mv0LBsq2cT9c2dK1YSPIrC/view?usp=sharing

BLANK CLERKING PAPER PROVIDED BELOW:

ADULTS

ADULTS

ADULTS

WARD ROUND NOTES 1: EXEMPLAR CLERKING

ADULTS

University Hospitals of St. Somewhere		Patient name: Amy Barrow
Hospital: SRI	Ward: AMU	Hospital ID: E372189
Consultant: Harris		DoB: 12/08/1963

01/11/23 9:45am WR: Harris (cons), Your name (FY1)

Presenting Complaint: Abdominal pain and vomiting

NEWS = 3
(Resp rate 18, 96% on room air, BP 98/56 mmHg, HR 110 bpm regular, Temp 36.1C)

Capillary blood glucose 12.6
Glasgow-Blatchford score = 7

Admission bloods:
Hb 106, WCC 9.1, neuts 6.2, CRP 53, Plts 450, INR 1.5
Sodium 135, Potassium 4.6, Urea 8.1, Creatinine 115
LFTs NAD
VBG lactate: 1.8

ECG: sinus tachycardia

HPC
Admitted yesterday with 2/52 history of worsening abdo pain and 1/52 vomiting. Small volume blood-streaked vomit evolved into dark coffee-ground haematemesis yesterday prompting admission.
No malaena or syncope, ongoing lightheadedness. No previous UGI bleeds.
Resuscitated with IVF (0.9% NaCl), and ibuprofen withheld.

PMH - Knee OA, diabetes, depression, acid reflux
DHx - metformin, ibuprofen, sitagliptin, sertraline
SHx - ex-smoker stopped 6 months ago, non-drinker

Issues: ongoing abdo pain, lightheadedness, no malaena, no further haematemesis.

ADULTS

University Hospitals of St. Somewhere		Patient name: Amy Barrow
Hospital: SRI	Ward: AMU	Hospital ID: E372189
Consultant: Harris		DoB: 12/08/1963

-> WR continued

O/E
Chest: clear, HS I+II+0
Abdo: epigastric tenderness, soft no guarding
Calves: SNT

Impression:
Upper GI bleed secondary to peptic ulcer disease

Plan:
- NBM
- Chase OGD
- Continue IVF
- Chase bloods including G&S - ?transfuse
- Hold ibuprofen and sertraline
- Continue IV paracetamol
- Cannula x 2
- IV omeprazole post OGD

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01/11/2023
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WARD ROUND NOTES 2: EXEMPLAR CLERKING

ADULTS

University Hospitals of St. Somewhere		Patient name: Alex Bingley
Hospital: SRI	Ward: Urology	Hospital ID: E372125
Consultant: Richards		DoB: 17/04/1949

10/04/2024 9:57am WR: Richards (cons), Your Name (FY1)

Presenting Complaint: Frank haematuria

NEWS = 1
(Resp rate 17, 97% on room air, BP 145/97 mmHg, HR 103 bpm irregular, Temp 36.4C)

Admission bloods:
Hb 120, WCC 7.5, neuts 5.8, CRP 21, Plts 310
Sodium 139, Potassium 4.8, Urea 5.3, Creatinine 125
LFTs NAD
VBG lactate: 0.8

ECG: rate controlled AF 98bpm

GP Ix:
Urine dip Hb +++
Urine cultures no growth

HPC
2ww GP referral for frank haematuria. 5 episodes over 1/12 duration. Last episode 10 days ago. GP investigations as above ruled out urinary infections. Urinary hesitancy, urgency but no dysuria, discharge or abdominal pain. No trauma or STIs.

History of fatigue and weight loss.

PMH- AF, htn
DHx- apixaban, ramipril, amlodipine
SHx- Lives with wife, heavy smoker, occasional drinking

WR Continued ->

ADULTS

University Hospitals of St. Somewhere		Patient name: Alex Bingley
Hospital: SRI	Ward: Urology	Hospital ID: E372125
Consultant: Richards		DoB: 17/04/1949

→ WR Continued

Issues: Haematuria, weight loss, fatigue

O/E:
Chest - clear, HS I+II+0 AF
Abdo - SNT BSP
Calves - SNT

Impression: Haematuria likely secondary to TCC

Plan:
- CT KUB
- Flexible cystoscopy
- Repeat bloods including Hb, clotting
- Hold apixaban - review post scope
- TEDs for VTE prophylaxis
- Possible MDT post cystoscopy

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WARD ROUND NOTES 3: EXEMPLAR CLERKING

ADULTS

University Hospitals of St. Somewhere		Patient name: Mark Chattington
Hospital: SRI	Ward: AMU	Hospital ID: E364981
Consultant: Cooper		DoB: 07/03/1976

10/04/2024 9:37am WR: Cooper (cons), Your Name (FY1)

Presenting Complaint: Cough and abdominal pain

NEWS = 3
(Resp rate 18, 97% on 1L NC, BP 136/93 mmHg, HR 79 bpm regular, Temp 38.3C)

Admission bloods:
Hb 135, WCC 12.5, neuts 11.8, CRP 104, Plts 286
Sodium 139, Potassium 3.8, Urea 3.6, Creatinine 118
LFTs NAD
VBG:
pH: 7.38 | CBG: 10.6
pCO2: 4.3 | ketones: 2.1
Bicarb: 22 | osmolality: 292 (285-295)
lactate: 2.4

ECG: sinus rhythm 81 bpm

HPC
Admitted with productive cough, fever and loss of appetite. Day 4 of amoxicillin prescribed by GP for chest infection. Began as productive cough with green sputum now gradually resolving. No haemoptysis.

Ongoing complaints of fatigue and anorexia for the last week. Has a background of T2DM with ketosis. Stopped taking metformin recently. Only been able to tolerate a few slices of toast/day. Attempting to keep up fluid intake.
Denies chest pain or chest tightness. Some SOBOE.
No abdominal pain, nausea or vomiting. Developed diarrhoea whilst taking metformin on empty stomach. No urinary symptoms, passing urine as normal.

PMH- T2DM, migraines
DHx- metformin, dapagliflozin
SHx- Lives with wife and children, non-smoker, occasional drinker

WR Continued ->

ADULTS

University Hospitals of St. Somewhere		Patient name: Mark Chattington
Hospital: SRI	Ward: AMU	Hospital ID: E364981
Consultant: Cooper		DoB: 07/03/1976

→ WR Continued

Issues: CAP, SOBOE, loss of appetite

O/E:
Chest - generalised wheeze, left basal crackles, HS I+II+0
Abdo - SNT BSP
Calves - SNT

Impression: CAP, chest sepsis, starvation ketosis

Plan:
- Sepsis 6: blood cultures, MSU, urine IP/OP
- Step up abx to IV co-amoxiclav, PO doxycycline
- CXR
- sputum cultures if able to provide
- salbutamol, saline nebs
- wean oxygen, aim sats >94%
- IV dex-saline. 2x 1 litre over 6 hours
- regular CBG, ketone monitoring
- hold metformin, dapagliflozin
- encourage oral intake
- repeat bloods including VBG in evening
- consider VRII if ketotic, raised lactate

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