

Please have a calculator,
paper and a pen handy before
commencing the mock
station.

Post-Operative Patient on the Ward 3– Notes for Candidate

Post-Operative Patient Station: 10 minutes

Patient: Mary Watkins (82F)

DOB: 16/11/1940

E15589702

You are the FY1 on the Trauma and Orthopaedic ward.

Mary Watkins is an 82-year-old who underwent a right hemiarthroplasty for a neck of femur fracture.

Her pain is being managed with regular analgesia, and she is now very drowsy and confused. She is nil by mouth.

This is a medical records-based station, there is no simulator present.

The **examiner** will give you information relating to **clinical symptoms and signs if requested**.

The station will last 10 minutes.

You are expected to:

0-5 minutes:

- Review the available documentation
- Explain to the examiner your approach to the patient and describe your plan for improving confusion

5-10 minutes:

- Calculate the patient's fluid balance over the last 24 hours and determine requirements for the next 24 hours. You can use a pen, paper and calculator.
- Assume insensible losses of 600ml per day
- Describe a suitable fluid regime for the next 24 hours. You will be provided with this list:

Three bags of each of the following are available for use:

- Hartmann's 1L
- 0.9% NaCl 500 mL
- 0.9% NaCl 500 mL with 20 mmol KCl
- 0.9% NaCl 1L
- 0.9% NaCl 1L with either 20mmol OR 40 mmol KCl
- Dextrose saline 500 mL
- Dextrose saline 500 mL with 20 mmol KCl
- Dextrose Saline 1L
- Dextrose Saline 1L with either 20 mmol KCl OR 40 mmol KCl
- 5% Dextrose 500 mL
- 5% Dextrose 500 mL with 20 mmol KCl
- 5% Dextrose 1L
- 5% Dextrose 1L with either 20 mmol KCl OR 40mmol KCl

Post-Operative Patient on the Ward 3: Station documents

Clerking notes

HPC:

82F emergency admission for right neck of femur fracture resulting from fall. Precipitated by balance issues related to recent stroke 1 month ago. Patient BIBA, unable to weight bear, pain ++ on mobilising. Note patient also has dysphagia as result of stroke.

Normally NG fed, awaiting PEG tube. Bowels last opened yesterday. Patient otherwise alert, orientated to time, place, person.

Pelvic x-ray: Displaced sub-capital right neck of femur fracture Garden score IV.

Fascia iliaca block administered and listed for right hemiarthroplasty. Anaesthetic assessment passed. No prior surgeries.

O/E:

Chest : clear, HS I+II+0 regular rhythm

Abdomen: Soft, non-tender

Calves: SNT, no peripheral oedema

R leg shortened, externally rotate. No visible skin breaks or tenting. Pain on performing leg roll. Pulses palpable PT, DP. Warm peripheries. No signs DVT, cellulitis, no oedema.

L leg ROM intact, neuro-vasculature intact. No signs DVT or cellulitis, no oedema.

PMH:

CKD3

Hypertension

CVA 1 month ago

DHx:

Ramipril

Aspirin

Clopidogrel

Allergies: nkda

SHx:

Non-smoker, non-drinker

Patient height, weight:

Height: 153cm

Weight: 67kg

Operation notes

Patient: Mary Watkins

Date: 1/2/2024 (Day 1 as inpatient)

Procedure: Right hemiarthroplasty

Surgeon: Miss Frances Assistant: Dr. Shah

Anaesthesia: General, Propofol

The surgery proceeded uneventfully. NG tube removed prior to anaesthetic induction.

Standard posterior approach to the right hip joint utilised. Intraoperative examination revealed a displaced sub capital femoral neck fracture.

Femoral head excised, acetabulum prepared and sized.

Modular femoral stem and bipolar hemiarthroplasty head selected to measurements. Fixed with medicated cement.

Stability and range of motion assessed intraoperatively.

Closure: Soft tissues approximated and closed in layers. The surgical incision was closed in layers with absorbable sutures. Sterile dressing applied with local anaesthetic injection.

Miss Frances

Electronically signed

Post-operation notes

Patient arrived at post-op recovery 30 minutes after wound closure. The patient tolerated the procedure and anaesthetic well. PCA in situ.

Healthy skin and intact sutures. NG tube reinserted at time of transfer to ward. No active intervention required.

Post-op care and follow-up information handed over to ward staff. For early mobilisation and weight bearing as tolerated.

Dr Claire Holmes CT1

Signed

Day 2 as inpatient (02/02/2024) Post-op review. Ortho-geriatrics.

Patient confused, not orientated to time, place, person.

Overnight Mary has been hyperactive and noted to be fiddling with bedside buttons. Pulled out NG tube overnight.

Now lying in bed, drowsy ++ and minimally rousable. Alerted by nurses as scoring high on NEWS chart 7 – respiratory rate and saturations down trending. Commenced on 2L oxygen via nasal cannula now.

Operation site assessed – healthy skin and no signs of infection.

Pain controlled with PCA, IV paracetamol.

Unable to take history as patient drowsy. Bowels opened since surgery.

O/E:

Chest – clear

Abdo – SNT, BS +ve

Calves – SNT, no signs DVT or cellulitis

Name: **MARY WATKINS** S Number: _____ Ward: _____ Date: _____

NEWS 2 Key	DATE TIME	D1 6am	D1 10am	D1 2pm	D1 6pm	D2 10am	D2 2pm	D2 6pm	D2 10pm	DATE TIME											
A+B Respirations Breaths/min	≥25									3											≥25
	21-24									2											21-24
	18-20																				18-20
	15-17																				15-17
	12-14																				12-14
9-11									1											9-11	
≤8									3											≤8	
A+B SpO₂ Scale 1 Oxygen saturation (%)	≥96																				≥96
	94-95									1											94-95
	92-93									2											92-93
	≤91									3											≤91
SpO₂ Scale 2† Oxygen saturation (%) Use Scale 2 if target range is 95-92%, sig in hypercapnic respiratory failure †ONLY use Scale 2 under the direction of a qualified clinician	≥97 on O ₂									3											≥97 on O ₂
	95-96 on O ₂									2											95-96 on O ₂
	93-94 on O ₂									1											93-94 on O ₂
	≥93 on air																				≥93 on air
	88-92																				88-92
	86-87									1											86-87
84-85									2											84-85	
≤83%									3											≤83%	
Air or oxygen?	A=Air																				A=Air
	O ₂ L/min									2											O ₂ L/min
Device																					Device
C Blood pressure mmHg Score uses systolic BP only	≥220									3											≥220
	201-219																				201-219
	181-200																				181-200
	161-180																				161-180
	141-160																				141-160
	121-140																				121-140
	111-120																				111-120
	101-110									1											101-110
	91-100									2											91-100
	81-90																				81-90
71-80																				71-80	
61-70									3											61-70	
51-60																				51-60	
≤50																				≤50	
C Pulse Beats/min	≥131									3											≥131
	121-130									2											121-130
	111-120																				111-120
	101-110									1											101-110
	91-100																				91-100
	81-90																				81-90
71-80																				71-80	
61-70																				61-70	
51-60									1											51-60	
41-50																				41-50	
31-40									3											31-40	
≤30																				≤30	
D Consciousness Score for NEWS (instead of GCS) - alert U/A score if chronic	Alert																				Alert
	Confusion																				Confusion
	V									3											V
	P																				P
U																				U	
E Temperature °C	≥39.1*									2											≥39.1*
	38.1-39.0*									1											38.1-39.0*
	37.1-38.0*																				37.1-38.0*
	36.1-37.0*																				36.1-37.0*
	35.1-36.0*									1											35.1-36.0*
≤35.0*									3											≤35.0*	
NEWS TOTAL		1	1	0	0	3	3	4	5	7											TOTAL
Additional Parameters	Pain Score																				Pain Score
	Nausea																				Nausea
	Vomiting																				Vomiting
Monitoring frequency																					Monitoring frequency
Escalation of care Y/N																					Escalation of care Y/N
Initials																					Initials

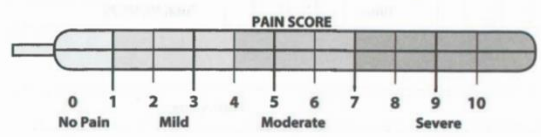
Name: **MARY WATKINS** S Number: _____ Ward: _____ Date: _____

Ward Round Review Senior Decision Maker only: (Tick) Previous INPUT: Previous 24 hours BALANCE: Previous OUTPUT: Patients Weight:

Time	INPUT							OUTPUT					BALANCE
	Oral Intake (mls)	Fluids IV or SC/ Blood	Bolus Drugs	Drug Infusions	PCA/ Epidural	NG/TPN/ PEG/Jej (mls)	Running Total In	Urine	Drains	Drains	Vomit/ NGT	Bowels/ Stoma	
1400	01.00	NBM	83.3		5			10					
1500	02.00		83.3		5			25				100	
1600	03.00		83.3		5			15					
1700	04.00		83.3		5			10					
1800	05.00		83.3		5			15					
1900	06.00		83.3		5			10					
2000	07.00		83.3		5			10					
2100	08.00		83.3		5			15					
2200	09.00		83.3		5			15					
2300	10.00		83.3		5			10					
2400	11.00		83.3		5			15					
0100	12.00		83.3		5			20					
0200	13.00				5			10					
0300	14.00				5			15					
0400	15.00				5			10					
0500	16.00				5			10					
0600	17.00				5			0					
0700	18.00				5			10				100	
0800	19.00				5			15					
0900	20.00				5			20					
1000	21.00				5			10					
1100	22.00				5			10					
1200	23.00				5			20					
1300	24.00				5			10					
Totals	↓		1000		120			310				200	

Total INTAKE= **1120** mls OUTPUT= **510** mls

Urinalysis pH: Protein: Blood: Leucocytes: Glucose: Ketones: Nitrates: Date:



Investigations

ECG:

Normal sinus rhythm

Bloods (pre-operative):

FBC: Hb 100(115), WCC 9.7(9.5), neuts 7.1(7.4), plts 380(345)

U&Es: Na⁺ 138(139), K⁺ 3.8(3.9), Ur 13.3(11.1), Cr 130(115), eGFR 34, CrCl: 35 ml/min

LFTs: NAD

Bone profile: Adj. Ca 2+ 2.0

Mg²⁺: 0.78

TFTs - NAD

CRP: 78(130)

CK pre-op: 1,005

Post-op pelvic x-ray:



Haemoglobin (Hb):

- ♂ 130 – 180 g/L
- ♀ 115 – 165 g/L

White cell count (WCC):

- Total: 3.6 – 11.0 x 10⁹/L
- Neutrophils: 1.8 – 7.5 x 10⁹/L

Platelet count: 140 – 400 x10⁹/L

Na⁺: 133–146 mmol/L

K⁺: 3.5–5.3 mmol/L

Ca²⁺(adjusted): 2.2–2.6 mmol/L

Mg²⁺: 0.7–1.0 mmol/L

Chloride: 98–106 mmol/L

Phosphate: 0.74 – 1.4 mmol/L

Urea: 2.5 – 7.8 mmol/L

Creatinine:

- ♂ 59–104 µmol/L
- ♀ 45–84 µmol/L

Alkaline phosphatase (ALP): 30–130 U/L

Alanine aminotransferase (ALT):

- ♂ <41 U/L
- ♀ <33 U/L

Aspartate aminotransferase (AST): 1 – 45 U/L

Bilirubin: <21 µmol/L

GGT:

- ♂ <60 U/L
- ♀ <40 U/L

Albumin: 35–50 g/L

Medication chart

DRUG ALLERGIES (MUST BE COMPLETED)

No known allergies Sign Date

Medicine	Reaction	Sign	Date

S No. _____ Patient's name **MARY WATKINS**

Date of birth **16/11/1940**

ADULT INPATIENT MEDICATION ADMINISTRATION RECORD

University Hospitals of Leicester NHS

Chart **1** of **1** Consultant **FRANCES** Ward **B44** Site **NHS**

PATIENT DETAILS Date recorded _____ BSA(m²) _____ Wt (kg) **67** Ht **153 cm**

Other (please specify) **MRD** Haemodialysis

DETAILS OF SUPPLEMENTARY CHARTS IN USE

Anticoagulant Chemotherapy

Diabetes Syringe driver

Supplementary infusion chart Gentamicin/Tobramycin

Other (please specify) Haemodialysis

PRESCRIPTION FOR ONCE-ONLY MEDICATION / PRE-ANAESTHETIC / ANTIMICROBIAL PROPHYLAXIS

Date	Time to be given	Medicine (approved name)	Dose	Route	Prescriber's signature and name	Blip No.	Date given	Time given
1	0102 1300	TAPROCN	1g	IV	Frances	111		
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								

MEDICINES MANAGEMENT CHECKLIST

Check	Initial	Date
Pre-admission	<input type="checkbox"/>	
Drug history check	<input type="checkbox"/>	
Source:		
Source: Rewritten drug chart checked	<input type="checkbox"/>	
Allergy check	<input type="checkbox"/>	
Patient's own medicines	<input type="checkbox"/>	
Self-administration	<input type="checkbox"/>	
Compliance aid	<input type="checkbox"/>	
Patient discharge	<input type="checkbox"/>	
TTO completed	<input type="checkbox"/>	

MEDICINE PRIOR TO ADMISSION NOT PRESCRIBED

Medicine	Dosage	Freq.	Reason

DISCHARGE INFORMATION

INITIAL VENOUS THROMBOEMBOLISM AND BLEEDING RISK ASSESSMENT/REASSESSMENT

REASSESSMENT WITHIN 24 HOURS (USING THE NATIONAL RISK ASSESSMENT TOOL)
This section MUST be completed by the Prescriber on admission for ALL adult patients
(for treatment options see UHL VTE guidelines)

ON ADMISSION	VTE risk assessed	Bleeding risk assessed	Signature	Print Name	Date
	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Shah	SHAH	01/02

WITHIN 24 HOURS	VTE risk reassessed	Bleeding risk reassessed	Signature	Print Name	Date
	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Shah	SHAH	02/02

FURTHER ASSESSMENT	VTE risk reassessed	Bleeding risk reassessed	Signature	Print Name	Date
	<input type="checkbox"/>	<input type="checkbox"/>			

FURTHER ASSESSMENT	VTE risk reassessed	Bleeding risk reassessed	Signature	Print Name	Date
	<input type="checkbox"/>	<input type="checkbox"/>			

VTE and bleeding risk should be reassessed and documented in the medical notes whenever the clinical situation changes

OXYGEN THERAPY

14 **SRUG OXYGEN OXYGEN SHOULD NOT BE WITHHELD WHILST AWAITING A PRESCRIPTION, IF IT IS REQUIRED**

CIRCLE TARGET OXYGEN SATURATION

88-92% 94-98% Other _____

PRN / Continuous (refer to O₂ guideline)

Tick here if saturation not indicated

Signature: _____ Date: _____ Print name: _____

15 **SRUG OXYGEN OXYGEN SHOULD NOT BE WITHHELD WHILST AWAITING A PRESCRIPTION, IF IT IS REQUIRED**

CIRCLE TARGET OXYGEN SATURATION

88-92% 94-98% Other _____

PRN / Continuous (refer to O₂ guideline)

Tick here if saturation not indicated

Signature: _____ Date: _____ Print name: _____

REGULAR MEDICINES

MORNING (AROUND 0800); MIDDAY (BETWEEN 1200 & 1400); TEATIME (AROUND 1800); BEDTIME (AROUND 2200)

ENTER DOSE AGAINST TIME REQUIRED

DATE	YEAR

MRS A DECOLONISATION PROPHYLAXIS REGIMEN

Antibacterial Wash Apply directly onto skin with a wash (200-250ml) instead of soap

Use to wash hair TWICE A WEEK

No high to use only Apply to tooth deposits TWICE times a day

Prescriber's signature: _____ Dr D Jenkins

1 **MEDICINE (approved name)** INDICATION SPECIAL INSTRUCTIONS PHARMACIST

Date: 01/02 Route: SC Sign: Shah Prescriber's signature & name: Shah Dr. SHAH Blip No: 165 Supply: POO

Dose: 5000 sachets

Teatime 5000 sachets

Anti Embolism Stockings

2 **MEDICINE (approved name)** INDICATION SPECIAL INSTRUCTIONS PHARMACIST

Date: _____ Route: _____ Sign: _____ Prescriber's signature & name: _____ Blip No: _____ Supply: POO

Time: _____ Dose: _____

Morning _____ Midday _____ Teatime _____ Bedtime _____

3 **MEDICINE (approved name)** INDICATION SPECIAL INSTRUCTIONS PHARMACIST

Date: _____ Route: _____ Sign: _____ Prescriber's signature & name: _____ Blip No: _____ Supply: POO

Time: _____ Dose: _____

Morning _____ Midday _____ Teatime _____ Bedtime _____

REGULAR MEDICINES

MORNING (AROUND 0800); MIDDAY (BETWEEN 1200 & 1400); TEATIME (AROUND 1800); BEDTIME (AROUND 2200)

ENTER DOSE AGAINST TIME REQUIRED

DATE	YEAR

40 **MEDICINE (approved name)** INDICATION SPECIAL INSTRUCTIONS PHARMACIST

Date: 01/02 Route: NG- Sign: Shah Prescriber's signature & name: Shah SHAH Blip No: 145 Supply: POO

Enter dose against time: 75mg

Morning 0800 75mg Day 1 Day 2

Midday _____ Teatime _____ Bedtime _____

41 **MEDICINE (approved name)** INDICATION SPECIAL INSTRUCTIONS PHARMACIST

Date: 01/02 Route: NG- Sign: Shah Prescriber's signature & name: Shah SHAH Blip No: 145 Supply: POO

Enter dose against time: 5mg

Morning 0800 5mg Day 1 Day 2

Midday _____ Teatime _____ Bedtime _____

42 **MEDICINE (approved name)** INDICATION SPECIAL INSTRUCTIONS PHARMACIST

Date: 01/02 Route: NG- Sign: Shah Prescriber's signature & name: Shah SHAH Blip No: 145 Supply: POO

Enter dose against time: 75mg

Morning 0800 75mg Day 1 Day 2

Midday _____ Teatime _____ Bedtime _____

43 **MEDICINE (approved name)** INDICATION SPECIAL INSTRUCTIONS PHARMACIST

Date: 01/02 Route: NG- Sign: Shah Prescriber's signature & name: Shah SHAH Blip No: 145 Supply: POO

Enter dose against time: 1 sachet

Morning 0800 1 sachet Day 1 Day 2

Midday 1800 1 sachet

Teatime _____ Bedtime _____

1 Discontinued 2 No access (NG PEG/IV) 3 Not by mouth 4 Not required 5 Drug not on ward 6 Cancellation - other treatment in progress
7 No access (NG PEG/IV) **8** Unable to take **9** Patient not on ward **10** Inappropriate/unfounded prescription **11** Awaiting medical advice **12** Self-administration

AS REQUIRED MEDICINES					
44	MEDICINE	SODIUM CHLORIDE 0.9%	DATE:	TIME:	
	DATE	DOSE	ROUTE	DOSE	
	INDICATION	Flash Cannula	MAX FREQUENCY	ROUTE	
	SIGN	SLEEP No.	PHARM. SUPPLY	GIVEN	
45	MEDICINE	SODIUM CHLORIDE 0.9%	DATE:	TIME:	
	DATE	DOSE	ROUTE	DOSE	
	INDICATION	Flash Cannula	MAX FREQUENCY	ROUTE	
	SIGN	SLEEP No.	PHARM. SUPPLY	GIVEN	
46	MEDICINE	PARACETAMOL	DATE:	TIME:	
	DATE	DOSE	ROUTE	DOSE	
	INDICATION	Pain / fever	MAX FREQUENCY	ROUTE	
	SIGN	SLEEP No.	PHARM. SUPPLY	GIVEN	
47	MEDICINE	ONDANSETRON	DATE:	TIME:	
	DATE	DOSE	ROUTE	DOSE	
	INDICATION	nausea + vomiting	MAX FREQUENCY	ROUTE	
	SIGN	SLEEP No.	PHARM. SUPPLY	GIVEN	
48	MEDICINE		DATE:	TIME:	
	DATE	DOSE	ROUTE	DOSE	
	INDICATION		MAX FREQUENCY	ROUTE	
	SIGN	SLEEP No.	PHARM. SUPPLY	GIVEN	
49	MEDICINE		DATE:	TIME:	
	DATE	DOSE	ROUTE	DOSE	
	INDICATION		MAX FREQUENCY	ROUTE	
	SIGN	SLEEP No.	PHARM. SUPPLY	GIVEN	
50	MEDICINE		DATE:	TIME:	
	DATE	DOSE	ROUTE	DOSE	
	INDICATION		MAX FREQUENCY	ROUTE	
	SIGN	SLEEP No.	PHARM. SUPPLY	GIVEN	

CODE FOR DRUG OMISSIONS (When drug is not administered, record the appropriate number in the box, circle and sign. Decision to be informed at discretion of nurse.)

PARENTERAL INFUSIONS											
Date	Infusion Fluid		Additions to Infusion					Signatures			
	Type/Strength	Vol.	Medicine	Dose	Route	Time to run or ml/hr	Prescriber	Fluid Batch No.	Start Time	Given by	Checked by
21/02	0.9% SODIUM CHLORIDE	1000ml			IV	12hr	Frances				

Intentionally left blank. Mark scheme ahead, do not scroll further until the end of station.

Post-Operative Patient on the Ward 3 – Examiner marksheet

MARKING RUBRIC	STATION SPECIFIC NOTES	✓
<p>Gathering of information</p> <ul style="list-style-type: none"> • Reviews available documentation (anaesthetic chart, post-operative instructions, drug prescription/IPAD charts, observation chart including fluid balance) • Reviews the blood result and interprets in the context of the patient 	<p>Gathering of information</p> <ul style="list-style-type: none"> - Respiratory depression and confusion related to delirium post-operatively, as well as inappropriate morphine PCA use. Patient has renal impairment. The PCA should be prescribed as per renal dosing. Alternatively use oxycodone to comply with renal impairment. - Always follow WHO ladder - Monitor for decline in renal function affecting medication levels and/or effects within the body 	
<p>Review of analgesia</p> <ul style="list-style-type: none"> • Reviews analgesia and anaesthetic charts • Indicates how they would assess the patient to determine cause of N&V • Identifies that the likely cause is <u>paralytic ileus</u> • Addresses the need to manage this • Explains the options available (e.g. IV or IM antiemetics, analgesic drug choice change, refers to ladder) 	<p>Review of analgesia</p> <p>Assess patient in A-E manner, focus on haemodynamic and hydration status.</p> <p>Reviews analgesia prescriptions and notes:</p> <ul style="list-style-type: none"> - Patient has PCA in situ - Notes NO morphine basal infusion - Notes bolus doses of 1mg/hour under patient control - Noted renal dosing boluses NOT utilised <p>- Patient also has paracetamol prescribed on normal drug chart. Prescribed as NG/IV due to patient being NBM.</p> <p>The patient is acutely unwell with delirium and respiratory depression. The PCA should be stopped.</p> <p>Naloxone administration should be considered if patient hedging towards unconsciousness.</p> <p>Alternative, regular analgesia should be used as per WHO ladder.</p> <p>Close monitoring of renal function should be undertaken.</p>	
<p>Calculations for fluid management over the last 24 hours</p>	<p>Fluid IP: 1120ml</p> <p>Fluid OP: 510ml</p> <ul style="list-style-type: none"> - Consider insensible losses of 600ml - Total OP = 1110ml 	

<ul style="list-style-type: none"> • Reviews the observation chart and confirms that the patient is hypovolaemic • Indicates that they would assess the patient to determine hydration status (thirst, CRT, oedema) • Calculates individual fluid inputs (oral and IV) • Calculates individual fluid outputs (NGT, drain, urine and INSENSIBLE LOSSES [i.e. 800ml]) • Calculates total fluid input, output and overall balance over the past 24 hours 	<p>24-hour balance = +ve 10ml</p>	
<p>Calculation of fluid prescription for the next 24 hours</p> <ul style="list-style-type: none"> • Correctly calculates the maintenance volume requirements by body weight (30ml/kg) • Correctly calculates the normal maintenance K+, Na+, glucose requirements by weight • Takes account of ongoing abnormal losses • Takes account of blood results • Suggests suitable IV fluid regime for the next 24 hours 	<p>Body weight = 67 kg</p> <p><u>Total daily requirements:</u> Water = 2010ml - Fluid excess of 10 = 2000ml total requirement. Na+ = 67mmol K+ = 67mmol Glucose = 50-100g</p> <p>Note electrolytes normal range, so we can replace ideally 60-80mmol each.</p> <p><u>Example regime I to meet above requirements:</u> 2L x 4% dextrose / 0.18% sodium chloride (dextrose saline) + 2* 40 mmol K+ each bag</p> <p>Total content: 62 mmol Na+(2*31), 80mmol K+, 142 mmol Cl- (62mmol plus Potassium chloride =2*40mmol), 80g glucose (2*40)</p> <p><u>Alternative Example regime II:</u> 1L 5% dextrose + 40 mmol K+ 500ml 5% dextrose + 20 mmol K+ 500ml 0.9% sodium chloride + 20 mmol K+</p> <p>Total content: 77mmol Na+ (500ml of 0.9%NaCl), 80mmol K+, 157mmol Cl-, 75g glucose (1.5 litre dex).</p> <p>Note: Hartmann's 500ml unavailable in the OSCE.</p>	

Clinical reasoning

- Clear communication
- Explains fully the reasons for prescribing the IV fluids
- Explains the need to increase the analgesia

The electrolyte composition of these crystalloid solutions is summarised in the table below.
You must know this information – it will not be provided in the Finals OSCE examination.

	[Na ⁺] (mmol/L)	[K ⁺] (mmol/L)	[Cl ⁻] (mmol/L)	Glucose (g/L)
0.9% sodium chloride	154		154	
4% dextrose / 0.18% sodium chloride (dextrose saline)	31		31	40
5% dextrose				50
Hartmann's solution	131	5	111	

Global Impression:

- Excellent
- Good
- Pass
- Borderline
- Fail