Administration OSCEs

In these OSCEs you are asked to perform a task that is more administrative or managerial. These are often difficult OSCEs as they ask you to perform tasks that you do not do on a daily basis. This means that you need to know your theory and have a structure or template in mind to tackle these.

The domains likely to be tested in these stations are:
• Medical Expertise
• Communication
• Prioritisation and Decision Making
• Professionalism
• Leadership and Management
• Teamwork and Collaboration

Examples of topics that are likely to be examined in these OSCEs are:
• Addressing flow of patients in the ED e.g. you have a full department and you are about to receive 2 cat 1 patients
• Formulating or enacting a disaster plan
• Formulating a guideline
• Formulating a quality improvement plan
• Addressing overcrowding and access block

The biggest mistake that candidates make in these types of OSCEs is to concentrate solely on what can be done in the ED. Those issues are often the ones that you can address the most as they are within your department but you also need to think about the wider hospital and community in your discussions.

Universal management principles:
-Notify - public health, NOK, workplace, managers, colleagues -Document
-Arrange follow-up
-QI cycle
-Review protocols
-Educate to prevent recurrence

Transmission-based Precautions
1. Universal (aka 'standard) precautions. Assume blood/fluids of any patient could be infectious. Glove for fluid, mucous membranes, broken skin. Gown if clinician's skin/clothes is predicted to contact fluid, mucous membranes, broken skin. Mask if splash/spray predicted.
2. Expanded precautions

a. Contact. Gown/gloves if any contact with pt or either environment. Norovirus, c. diff, rotavirus
b. Droplet. Mask within 1 metre patient. Influenza, pertussis, meningococcal.
c. Airborne infection isolation. Negative pressure, particulate respirator. Chicken pox, measles, pulm TB.

Major Incident Medical Management and Support (MIMMS) approach
-Command & control: Emergency ops room, hierarchy, delegation & roles, ID
-Safety: PPE, toxins, media/crowds/violence
-Comms: Vertical + horizontal, devices (radio, phone, PA), runners, with duplication/redundancy
-Assessment
-Triage: Red/yellow/green vs. ATS -Treatment: Consultant-led specialist teams -Transport

Disaster triage:
1. Black = dead. Analgesia until death
2. Red = immediate. Life-threatening injuries. Cannot survive without immediate treatment but have a chance of survival.
3. Yellow = delayed. Non-life threatening injuries, stable. Require observation and possible later re-triage.
4. Green = minor. Walking wounded, require medical care at some point.

Aus Triage Scale
-1 = 0 mins, 2 = 10 mins, 3 = 30 mins, 4 = 60 mins, 5 = 120 mins
-Allows standardised care, measuring, research
-Allows benchmarking, measurements of access and efficiency
-Validity, reliability, acceptability
-Aims for high sensitivity; trade-off with low specificity (high false-positive rate)

Managing a pending/current surge or disaster with a full department
-Identify major issues: Access block, staff, space, timing (handover/night)
-Situation control: Liaise with key stakeholders, command & control, gather information, establish priorities ranked by clinical demand
-Leadership + delegation: Maintain oversight (not getting immersed in details), delegate tasks, re-assign most senior staff to highest acuity cases, liaise with senior nurse, liaise with hospital admin/inpatient/other stakeholders (internal escalation), communicate
-Recruit resources: Redistribute/free up current resources, call-backs, retain day staff, recruit ward personnel
-Demand management: Reduce inflow - bypass/diversion, increase outflow - clear patients able to leave, consider HITH/GP F/U for patients awaiting admission, patients can await ix in WR, admit boarded patients asap - need to increase inpatient flow
-Communicate: Hospital-wide situation, involve ED director, administrators
-Staff support: Positivity, adequate breaks

Access Block
-Admitted pts can't leave ED due to lack of inpatient capacity

-Spends longer than 8 hrs in ED from time of arrival
-Principle factor for ED overcrowding
-Increased harm, mortality, wait time, LOS, ambulance turnaround time
-NOT an ED problem - symptomatic of a health system in crisis, cannot be solved by ED-only interventions
-Solutions should be multifactorial, evidence-based, sustainable.
a) More inpatient beds, clinical process redesign for increased efficiency, over-capacity protocols to redistribute load equally throughout hospital, time-based targets for inpatient units, extend hospital function outside business hours
b) Hospital avoidance (e.g. HITH), chronic disease outreach, advance care directives

How to announce/report an incident: METHANE
-Major incident standby/declared -Exact location
-Type of incident
-Hazards present
-Access for vehicles
-Number, severity, type of cases -Emergency services present/required

Did Not Wait
-Percentage pt's not waiting for care
-Associated with dept performance and adverse events
-Caused by time to being seen and subsequent delays
-When investigating consider timing, staffing, presentation profile, pt/dept factors, overcrowding, access block, acuity, actual/potential adverse outcomes, high risk case types
-Manage process: Document vital signs, escalate, manage WR, observation area, DNW advice, FU arrangements
-Manage staff, rostering
-Manage model of care
-Follow up cases, chart reviews
-Education, training
-Manage access block - early discharge, manage hospital bedstock

Write a guideline
-Rationale
-Background
-Target
-Recommendations
-Investigations + management issues -Special circumstances
-Quality Improvement -Governance issues -References, cited literature -Incident management -Disseminate guideline

Write a protocol
-Title
-Who must comply
-Applicable setting
-Indications

-Precautions + contraindications -Equipment
-Procedure - outline steps
-Tools & resources
-Document management: Author, review

Forensic issues, chain of evidence

Principles
Collection only by trained personnel, without compromise of emergent clinical care
Preservation of evidence, chain of evidence
Documentation
Hand over to police
Meticulous collection without destroying / contaminating evidence
Gloves
Collect clothing and all articles in bags
Do not cut through holes in clothing, cut around them
Documentation
-Write in pts words, do not embellish
-Draw pictures to help with recall
- Take photos – yourself +/- Police photographer preferably Storage before hand over: preservation and security
Hand over to designated member of police

ED departmental layout/redesign

Equipment purchase (EQUIP)
-Equipment need/options/research
-Quantify money. Funding available, upfront costs, maintenance, disposables, training, accreditations, credentialling
-Unify stakeholders
-Implement a trial and invite feedback
-Purchase

Short stay medicine

-Reduced LOS compared with medical admission, facilitates turnover
-Early senior involvement
-Safety net for juniors
-Asthma, renal colic, mod trauma, self harm, pyelonephritis, head injury, tox
-Requires compliance with pt selection rules, or causes social admissions, dumping, inc workload -Only for ED patients
-24 hours access to investigations on a priority basis
-Rules on time limits, protocols for what to do if pt there over 24 hrs -Access to discharge planning, SW, allied health

Managing an error/missed diagnosis/inappropriate discharge

-Label this critical incident
-Report to hospital lawyer/directors/managers. Log in relevant registries.
-Open disclosure as below.

-Supportive debrief with all staff involved
-Investigate - blame-free, supportive, educationally-focussed, jointly alongside all stakeholders. Root cause analysis.
-Clinical governance: risk management and quality improvement. Review ED processes & guidelines.
-Review the individual - are they impaired, do they need on-shift support, are they safe to be on night shifts.
-Education opportunity. M&M.

Managing a complaint - live OSCE with pt/family
-Stabilise clinical situation
-Investigate as above - take advice from peers, senior colleagues, experts, patient's GP
-Move to a different area - change the environment
-Take adequate time, listen, display empathy, really appear to be sorry, understand emotions -Explore the underlying reasons for complaint - previous experience, expectations, level of understanding, SES factors
-Acknowledge complaint, establish specific details, progress since last discharge, review clinical records

-"This is a recognised complication"
-Open disclosure as below.
-Don't be too factual
-Don't get too focused on what you 'need to say', be responsive to the relative's needs -Provide support/social work
-Plan follow-up after next phase of treatment -Document
-Quality improvement

Managing a complaint - Quality Assurance
-Case review, full investigation, interviews, review documentations, systems issues
-Identify preventable factors
-Review resource issues
-Communicate with NOK. Acknowledge bad outcome. Arrange timeframe for follow-up contact/meeting in private environment. Obtain their version of events. Express regret. Discuss known facts. Discuss concerns, answer questions. Offer ongoing care.
-Notify GP, inpatient team, hospital admin
-Notify RMO. Avoid punitive approach. Counsel re: indemnity.
-Document
-Staff support
-Educate staff re: red flags, clinical pathways and protocols, optimise senior involvement in care

Open disclosure: a discussion and exchange of info which may take place over several meetings.
-Apology/express regret. Say "sorry".
-Factual explanation
-Family to relate their experience

-Potential consequences of the adverse event - discuss -Manage event, prevent recurrence

Pt refusing care - Jehovah's witness, anti-vaccinators.
-Capacity (competence): Pt's ability to make informed medical decisions based on personal values and comprehension of likely consequences of the decision.
-Beneficence: Is there good reason to provide clinical care?
-Autonomy: Do they have enough knowledge, understanding, and freedom? -Concordance: If pt was competent, is it likely they'd consent?
De-escalation/ladder of convincing - patient/family: -Reassure
-Bargain
-Threat
-Medical symptoms management - analgesia, anxiolysis, sedative -Physical restraint
-Medical sedation/anaesthesia

How to balance up pros/cons of whether to restrain a borderline case of DAMA:
-Autonomy vs. duty of care
-Assess competence
-Empower patient by providing options
-Risk of self discharge vs. the negative effects of restraint (future attitudes/compliance lower) -Negotiate an acceptable middle ground/third options such as close outpatient F/U
-Provide discharge at own risk form
-Always gain pt trust/confidence, address concerns, empower patient, build report, remain calm, fix misunderstandings, reassure, enlist family, involve patient in planning
Involuntary detention/Mental Health Act

Managing a death in ED:
Clinical: resus, correct length of resus, resus termination, assess advance care directives
Communication principles
Support staff such as security, chaplaincy, social work
Family presence policy. Private location for next of kin/family to be with deceased, means and location to conduct rituals. Care of family, say goodbye, memory-making.
Organ donation
Media
Notifications - registries, incident report

Legal and forensic
-Autopsy
-Working with police and coroner/medical examiner
-Child protective services
-Child fatality review team
-Documentation - comprehensive & contemporaneous
-Preservation of evidence
Debriefing for team - hot & cold
Follow-up care for family

-Helping family to know everything was done
-Assisting family in explaining to siblings, family, friends
-Assisting family in locating community support to address grief and bereavement -Plan for post-autopsy meeting to answer questions
-Plan for scheduled follow-ups and marking of meaningful dates
Quality improvement opportunities
-Review system flaws/errors
-Mortality & morbidity meetings
-Case discussion with inpatient teams

Transfer/retrieval principles:
Airway and nasogastric tube
Breathing and end-tidal carbon dioxide Circulation and invasive monitoring
Disability/cervical collar and head injury care Exposed and examined
Family informed
Final considerations
-Ask for notes and x rays?
-Bed confirmed?
-Continuity of care assured?
-Drugs and spares?/documentation -Everything secure?

Handover
-Acute problem
-Before admission to intensive care unit -Current clinical condition
-Drugs/infusions and documentation -Examination and any problems during transport -Family

Problematic staff member - general template
-Establish purpose of meeting
-Privacy, respect, dignity, transparency, confidentiality
-Gather information
-Explore all 7 B's (Bank, Background, Boy/girl, Bonkers, Blues, Bereavement, Booze) -Mental health of doctor
-Immediate safety of doctor - where exactly are they going now, immediate support, not driving, best not to be alone
-Follow-up plan, GP, psychologist, drug/alcohol counselling, employee assistance

Problematic staff member - specifically misbehaving ED doctor
-Need to both notify and support.
-"Unacceptable" "Unprofessional" behaviour
-Can reassure confidentiality within the department, but can't assure absolute confidentiality if you are going to notify medical council

Problematic staff member - specifically impaired ED doctor (acting as their mentor)
-Establish nature of mentoring
-Encourage reflection

-Support
-Empathy, active listening, allow trainee to vent -Encourage trainee to 'reframe'
Problematic staff member - specifically impaired ED doctor (acting as their boss) -Empathy
-Begin to develop an appropriate support plan

Problematic staff member - specifically inadequate ED doctor
-Don't be confrontational
-Discuss workplace expectations
-Identify specific deficits
-Plan for remediation and follow-up
http://www.heti.nsw.gov.au/Global/Prevocational/trainee-in-difficulty-2nd.pdf

Problematic staff member - specifically misbehaving inpatient doctor
-Explore facts - perhaps their behaviour is more rational than it initially appears
-Be firm if necessary - calm tone but strong words
-"Unacceptable" "Unprofessional" behaviour
-Offer to escalate to their head of department or hospital administration or supervisor, understand their side and offer support and ensure they are looked after esp if long shifts, stress etc.

Discharge Against Medical Advice
-Determine if pt is competent
-Risk stratify
-Communicate management plan, rationale -Provide 2nd opinion if wanted
-Identify and address pt issues, needs and concerns -Collaborate to negotiate a patient-centred management plan -Document

Needlestick/other body fluid exposure to patient
-Specific details. Assess risk.
-Check HBV vaccination status. Check victim's HIV/HBV/HCV serum levels. -Check perpetrator's levels.
-Emergency OCP levonorgestrel 1.5mg OTC/IUD
-Ceftriaxone/azithromycin STD
-PEP
-Counsel PEP side effects. Safe sex/no blood donations.
-Reassure generally low risk of transmission.
-Document.
-F/U

Needlestick/other body fluid exposure to staff
-Specific details. Assess risk.
-First aid
-Local damage, tetanus, future bacterial infection risk
-Check HBV vaccination status.
-Check victim's HIV/HBV/HCV serum levels.

-HIV 0.3%, Hep C 3%, Hep B 30%
-Check perpetrator's HIV/hepatitis status.
-Emergency OCP levonorgestrel 1.5mg OTC/IUD
-Ceftriaxone/azithromycin STD
-2-agent PEP: Truvada (tenofovir/emtricitabine). Controversy over whether 3rd antiretroviral dolutegravir adds benefit - consider in higher-risk exposures. Most effective within 2 hrs but can start within 72 hrs, and continue 28 days.
-PEP reduces transmission risk by approx 75%
-Counsel PEP side effects.
-Barrier precautions for sex/no blood donations. Career implications if infected.
-Reassure generally low risk of transmission. HIV normal life expectancy. Hep C curable. -Check welfare - not feeling suicidal/depressed due to events
-Document.
-F/U Management plan

Organ donation - ACEM policy 2011
-Identify potential donors
-Should not influence decisions regarding resus or continuing management -FACEM empowered to determine brain death. Appropriate facility is ICU. -Maintenance of a potential donor should never compromise other patients' care.

NFR/end-of-life care
-Communicate clearly & early the pt's prognosis, that the patient is dying -Explore patient wishes or prior decision making
-Details of palliation/keeping comfortable
-Explain expected clinical course
-Allow for question
-Convince relative this is in pt's best interest
-If too rushed seem abrupt & not empathetic -Continue active support until definitive decision -Organ donation

Breaking bad news
-Rapport, reassure, trust, ethical therapeutic relationship -Information, explanations followed by "warning shot"
-Develop a common understanding of diagnosis, prognosis, plan -Effective verbal + non-verbal communication
-Good use of demeanour, language, words -Identify + explore issues
-Problem-solve

Clinical handover - ACEM policy 2015
-Standardised procedure individualised to department environment, activity, staffing -Responsibility of every staff member
-Staff need structured orientation and ongoing education in communication techniques that support safe handover
-Recognised models can be used as a basis for structured handover
-Should occur at start of each shift, as well as other times

-Protected time during rostered working hours
-Supervision by consultant staff. Allow and support questions and clarification. Generate ongoing management plan. Ensure staff taking over care are appropriate and understand the situation.
-Document
-Involve patients and carers

Distressed/injured medical student/staff member

-Remove from area
-Delegate another staff member to assess/treat (analgesia, psychological support) -Consider impact on staffing if unable to continue
-Arrange follow-up
-OH&S concerns. Incident report. Document.
-QI: Explore circumstances. Contributing factors. Mitigate these factors. Review protocols. Educate staff.
Reassure a parent

Violence in ED's - ACEM policy 2017

-Workplace violence: Incident in which a person is abused, threatened or assaulted in the course of their work.
-All people in vicinity of ED & wider hospital have right to safety
-Violence should be prevented, minimised, managed.
-Behavioural assessment room is a low-stimulus place to manage behaviourally disturbed, aggressive, violent pts
-ED design can prompt positive behaviours, guide expectations
-Code Black: Serious armed threat to personal safety
-Code Grey: Violent emergency
-Psychological violence: Intentional use of power, including threat of physical force, against another person or group resulting in harm to physical, mental, spiritual, moral or social development and includes verbal abuse, bullying, harassment and threats.
-Staff training
-Restraint as measure of last resort for shortest time possible. ED security.
-Standardised reporting
-Encourage reporting of violent incidents to police
-Psychosocial and legal support systems for staff during investigations/return to work

Informed consent: C-FIDDE.

Must be informed, specific and freely given by a patient with capacity/competence. May be implied, verbal or written.
-Competence (functional term)/capacity (legal term): Understand info, manipulate info in a rational manner, maintain & communicate a choice, appreciate situation & consequences - Free choice
-Inform - provide clear, relevant, adequate, accurate information. Treatment options, foreseeable A/E's, consequences of not proceeding.
-Discuss/decide. Opportunity to ask questions/reflect.

-Document
-Exceptions - emergencies, public health imperative

Consent issues in ED:
-Time pressure
-Emotional overlay in acute events
-Acutely delirious patient temporarily losing capacity
-Proxy/surrogate decision-makers, EPOA, NOK, family
-Information must be accurate. Often a senior inpatient consultant has more knowledge than an ED physician about the nuances of a particular scenario, so it is better for them to consent the patient.

Consent of a minor:

-Chronological age is a crude proxy for what is most important - intellectual and emotional maturity
-Competence is a dynamic state influenced by multiple factors: prior experience of illness, level of independence, ethnicity, temperament, environment, manner info is presented, socio-cultural context, family support
-Gillick competence identifies a group of under-16 year olds with: "Sufficient understanding and intelligence to enable them to understand fully what is proposed."
-The maturity cut-off required for a procedure correlates to its gravity and consequences to one's future self - appendectomy has less potential consequences than hysterectomy - Document steps taken to obtain consent
-2nd opinion +- director/lawyer involvement
-Jehovah's witness child: Doctor can prescribe life-saving treatment in the face of active opposition by the parents.

How to prevent blood transfusion reactions:
-Follow national and local protocols and guidelines
-Stop unnecessary transfusions by strict adherence to triggers (reduce denominator). Consider senior approval for transfusions.
-Follow blood compatibility checking protocols with lab
-Check blood product - name, DOB, expiry, counter-check
-Intensive initial monitoring and surveillance for early reactions. Special initial 1:1 nursing. No unnecessary overnight transfusions.
-Educate: ED doctors/nursing lecture, M&M review of adverse events