How to improve your NAC(OSCE) SCORE

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WHAT YOU ARE EXPECTING IN NAC OSCE EXAM?

A series of 12 stations where you are presented typical clinical scenarios. All candidates rotate through the same series of stations including 2 pilot stations that do not count towards the final score. Each station is **11 minutes** long with two minutes between stations. **No rest station.**
YOUR TASKS

• History Taking (8 mins) + post encounter questions (3 mins)

• Physical examination (8 mins) + post encounter questions (3 mins)

• History taking and physical examination (8 mins) + post encounter questions (3 mins)

• Counselling (11 mins) (no post encounter questions)
HOW TO PREPARE

• 3 months should be enough
• Dedicated Study group (ideally 3 people)
• Study materials: For example: Course notes, OSCE handbooks.
• Timed practice
• Practice, practice, and practice!!!
HISTORY STATION

• Most common station
• 8 mins with the SP (patient), you will have post encounter questions (3 mins)
• You have time, no rush
• Be calm, express confidence
• Remember, the first few mins are the most important as it is where the examiner’s impression and scoring will be made.
HISTORY STATION

Greet the patient
introduce yourself to the patient
ask How you like to be called

How can I help you?

Chief Complaint CC

- Onset
- Course
- Duration
- Is it the first time?

Pain Analysis: PQRST /COCA B/Event Analysis

- Alleviating factors
- Aggravating factor
- Associated Symptoms & DD

Red Flags

PMH
PSH
Medication & Allergy
Family H/o:
Social H/O

Thank the patient
HISTORY STATION

- Greet the patient
- Introduce your self to the patient
- Ask How you like to be called
- How can I help you
- CHIEF Complaint **CC**

Always **OCD, 1\textsuperscript{st} Time**

\textbf{O:Onset}
\textbf{C:Course}
\textbf{D:Duration}
\textbf{1\textsuperscript{st} Time?}
If CC is Pain=

Pain Analysis (PQRST), Alleviating factors

Aggravating factors

- **P:** Position
- **Q:** Quality
- **R:** Radiation
- **S:** Severity: on scale from 1-10, 10 would be the worst pain you have ever experienced, how do you put this pain?
- **T:** specific Time

- **Alleviating Factors:** any thing makes it better
- **Aggravating Factors:** Any thing makes it worse
If **CC** : Discharge, Diarrhea, vomiting, Sputum = **COCA B + severity**

- **C**: Color
- **O**: Order
- **C**: Consistency
- **A**: Amount
- **B**: Bleeding if **CC** is bleeding, then **B** = clots
- **Severity** in cases of bleeding.
HISTORY STATION

IF the **CC** an **event** such as a Fall, Seizure, Syncope

Use **Event Analysis**:

- Before
- During
- After
- Ask for **witnesses**: any one else who was there
- Ask for **Duration**
HISTORY STATION

• Don’t forget **RED FLAGS** (it tells you are a SAFE doctor)
• Fever, loss of weight, loss of appetite, lumps or pumps
• **PMH**: any long term medical problem
• **PSH**: any surgeries in the past
• **Med/Allergy**: are you on any med, allergic to any med
• **Family H/o**: any medical condition in the family
• **Social H/o**: do you smoke (since how long, how many per day, then - we can arrange another meeting to talk about smoking cessation programs if you are interested.
• Alcohol intake (How much, how often, what type)
• Who do you live with, what do you do for living, any financial difficulties?)
Toward the end of the station, put your FIFE (useful to Shaw that you are professional, also gives the SP a chance to help you)

You don’t have to use them all, at the same station)

- **FEAR:** what is your concern
- **IDEA** what do you think might be going on
- **FEELING:** How do you feel about
- **EXPECTATION:** Did I meet your expectation
- **Summarize:** if you have time at the end of the station or you go blank: just to summarize what you have kindly shared with me
- **Any thing else you would like to share with me !!!**
- Please don’t forget to **thank the patient**
- Don’t panic if you forget to ask some questions (it is a general assessment)
HISTORY STATION: SPECIAL CIRCUMSTANCES

If the SP (patient) a teenager add **HEADSSS** to social H/o

- **Home:**
- **Education:**
- **Activity:**
- **Diet:**
- **stress**
- **Sleep**
- **Sexual life, safe sex**
HISTORY STATION: SPECIAL CIRCUMSTANCES

FOLLOW UP STATION: the patient known... for example Diabetic, Asthmatic

You need to ask the **Disease & medication** package in the CC

- Since when you have been DX with ..
- Any hospitalization (especially in asthmatic patient)
- Are you on any medication.. If yes what medication
- Do you take your medication regularly
- Does it control your symptoms
- Are you on regular follow ups, when was your last follow up
- any change in your medication, change dose, adding or stopping medication.
- Any investigation, what was the result.
Ask about the: **child name**

Don’t forget the **red flags**: Fever, neck stiffness, Drowsiness, loss of consciousness, loss of appetite, no weight gain

Ask **BINDE**

- **B**: pregnancy & Birth
- **I**: Immunization
- **N**: Nutrition
- **D**: Development
- **E**: Environment

- Any other children at home with similar problem.
If the child is having: **Fever**

then you may ask **screening questions** to identify the source of infection most commonly it is **ear or chest infection** ; otherwise, move on as the pediatric history is quite long

- pulling ears, ear discharge
- Runny nose, sore throat, skin rash.
- Chest: cough, phlegm, noisy chest
- Abdominal pain (drawing legs up), Diarrhea, vomiting
- Crying during urination, smelly urine.
HISTORY STATION: SPECIAL CIRCUMSTANCES
OBSTETRICS & GYNAECOLOGY

Remember: **MOGS**
- **M:** Menstrual H/O
- **O:** Obstetric H/O
- **G:** Gynaecological H/O
- **S:** Sexual H/O

If the woman is **pregnant** you have to ask **ABCD**
- **A:** Activity of the baby (Baby movement)
- **B:** Bleeding and severity
- **C:** Contraction and pain
- **D:** Dribbling of the baby’s fluid
HISTORY STATION: SPECIAL CIRCUMSTANCES PSYCHIATRIC

Still you ask **OCD & 1st time** of what ever symptoms the patient is coming with & pay attention to the body language such as no eye contact, moving hands consistently.

- Remember to ask **4S**: Stress, Specific questions
- **Screening questions** *(MOAP)* & Suicide
  Ask about **Stress** if yes .. You are in the right direction!!!
- **Specific questions**: Depression: MI PASS ECG
  Mania: DIGFAST, Panic attack: STUDENT Fear CCC
Screening questions: may I ask you few questions to make sure there is no other problem, we can help with: MOAP

- **M**: Mood Do you feel down, or losing interest in things you used to enjoy before
- **O**: Organic Cause, especially in Fatigue cases.
- **A**: Anxiety DO you have excessive worry or sudden intense fear
- **P**: Psychosis Do you hear or see things that others cannot see nor see

Please don’t forget to ask about **Suicide** as it is **RED FLAG**: people in similar circumstances they might have thoughts about hurting themselves, have you experienced any

Ask **Homicidal** (any thought of hurting others) **(RED FLAG)**

**Family H/o**: Any H/o mental illness, H/o suicide in the family.
HISTORY STATION: SPECIAL CIRCUMSTANCES
PSYCHIATRIC

Almost always there is a Depression station is in the exam. Patient may come with different symptoms such as Headache, difficulty in sleeping .. Be aware of the patient’s body language.

Still you ask OCD of what ever symptoms is coming with & then ask about Stress if yes .. You are in the right direction.

Specific questions: for Depression: MI PASS ECG

- M: How is your mood recently
- I: Have you lost interest in doing thing you used to enjoy before
- P: Do you take longer time to finish tasks than before
- A: How is your appetite
- S: How is your sleep (is it is not already in CC)
- S: people In similar circumstances they might have thoughts about hurting themselves or others, have you experienced any
- E: do you feel lack of energy
- C: do you find it difficult to focus
- G: any feeling of guilt or shame

If 5 out of 9 & M or I is one of them = Dx depression
There will be at least **one** station of counselling. Counselling stations have **two parts**: History + advising the patient regarding his/her concern. Usually lasts **11 mins** and there won’t be any post Encounter questions.

**Tip for this station**: **ASK 3 main counselling Questions:**

- what raised your concern?
- How much do you know?
- How much do want to know?

**Take short focused history**, (shorter than the History stations), so you will have more time to counsel.
COUNSELLING STATION

- **Let the patient guide you to** what information he/she is looking for

- **Don’t overwhelm the patient with loads of information** without checking if this info is what he/she is looking for

- **Give the patient a chance to ask questions**

- Have the patient’s attention & check his/her understanding of what you are saying by asking: “are you following me?”, “am I clear so far?”, “Is there any thing I need to clarify at this stage?”.

- **End the station with brochures.**

- **Check if he/she is committed with the plan**

- **Ask about any other concerns**
PHYSICAL EXAMINATION STATION

- Introduce yourself to the patient.
- Ask the patient how he/she would like to be addressed.
- Take the patient’s permission and explain the nature of the examination.
- Wash hands.
- Drape the patient appropriately.
- Comment on general appearance.
- Ask for the vitals (pulse, BP, resp rate)
- Comment on vitals
- Comment on your findings during examination (you will lose marks if you won’t).
- Be **gentle** during the Examination
- **At End** : thank the patient & offer to close his/her gown.
PHYSICAL EXAMINATION STATION : CVS

FACE
Swelling
Pallor
Ophthalmoscopy

Mouth
Dehydration
Central cyanosis

Hands
Peripheral cyanosis
Capillary Refill
Pulse

Neck
Carotid (Auscultate) No Bruit
Carotid (palpate): “normal volume”

Check JVP
Kussmaul’s sign
Hepatojugular reflex
PHYSICAL EXAMINATION STATION: CVS

Chest:

**Inspection:** Shape, Deformity, pulsation, chest wall movements, use of accessory muscles

**Palpation:** PMI, Thrill, Tenderness

**Auscultate**

Mitral

Tricuspid

Pulmonary

Aortic

S1, S2, S3, S4, Murmurs

Listen to the **Base of Lungs** for Pulmonary edema

**ABDOMEN:** Auscultation for abdominal pulses: No Bruit.

**LEG:** Edema & pulses
PHYSICAL EXAMINATION STATION: RESP

Face:
No face swelling, No pallor, Red eye, or Eye discharge

Mouth/nose/throat:
No Dehydration, No central cyanosis, No runny nose No ear discharges ,No face tenderness

Hand:
Capillary refills normal, Symmetrical normal volume of pulse, Clubbing, Peripheral cyanosis,

Neck: Examine LN, Trachea

Chest:
Inspection: Shape, Deformity, pulsation, chest wall movements , use of accessory muscles

Palpate Tenderness Expansion TVF

Percussion

Auscultation: + adventitious sounds

Leg Edema
**PHYSICAL EXAMINATION STATION: GIT**

**Face:**
- Pallor
- Swelling
- Jaundice

**Mouth:**
- Dehydration
- Mouth ulcer
- Cyanosis
- Fetor hepaticus

**Hand:**
- Pulse
- Palmar erythema
- Clubbing
- Flapping tremor
- Capillary refill

**Chest:**
As part of abdominal examination, I need to complete chest examination to check for signs of gynecomastia and spider nevi
PHYSICAL EXAMINATION STATION: GIT

Inspection:
Normal contour abdomen, No visible (scars, pulsation, peristalsis)
No caput medusae, Umbilicus centrally placed and inverted,
Abdomen moving equally with respiration, Ask patient to cough
and check for Hernia

Auscultate:
Check for bowl movement and Comment on bowel sound

Palpation:
Ask patient to bend his/her knee to relax abdominal muscles,
Start away from pain

superficial palpation: No tenderness or rigidity on

Deep palpation: Comment “No palpable mass”
Palpate liver
Palpate spleen

Percussion:
4 quadrants:
Percuss liver: Say “normal liver span and no obliteration of liver
dullness”
Special test: **ONLY IF CC IS PAIN**

- McBurney’s tenderness
- Rebound tenderness
- Rovsing’s sign
- Psoas’ sign
- Obturator signs
- Murphy signs
- CVA tenderness
- Say “I need to conduct digital rectal, inguinal & genital examinations.”
Cranial Nerve Examination:

Olfactory nerve Cr1, Optic nerve Cr2: Visual acuity and color vision, Field of vision, Ophthalmoscopy.

Oculomotor Cr3, trochlear Cr4, and abducent nerves Cr6: pupils & Extra-ocular movement.

Trigeminal nerve Cr5: Motor & Sensory.

Facial Nerve Cr7: Inspection, Motor & Sensory.

Vestibulocochlear Nerve Cr8.


Accessory Nerve Cr11.

Hypoglossal nerve Cr12.

- **M: Motor**: inspection, Tone, power.
- **S: Sensory**: usually light touch.
- **R: Reflexes**
- **Gait**
PHYSICAL EXAMINATION STATION: MSK

- Inspection: **SEADS+GAIT**
  - S: Swelling
  - E: Erythema
  - A: Atrophy
  - D: Deformity
  - S: Skin changes/scar

- **Palpation** TTCER:
  - T: Temperature
  - T: Tenderness
  - C: Crepitus (moved the joint and felt it)
  - E: Effusion
  - R: Range of movement

- **MSRP**
  - M: Motor
  - S: Sensory
  - R: Reflex
  - P: Pulse

- **Special Tests**
HISTORY AND PHYSICAL EXAMINATION STATION

- There will be at least one station
- The time is tight at this station, mostly 8 mins for History & Physical Examination + 3 mins Post Encounter question.
- Communication skills won’t be assessed at this station
- Needs a lot of practice
- For History Taking, Use the same format as History station but ask less questions for each section (focused history) so you will have time for physical examination.
- Don’t forget the basics !!!
POST ENCOUNTER QUESTIONS

After 8 mins buzzer the examiner will ask you questions related to the station

For example:

• What is your **Diagnosis**
• What is your **DD**
• What is your **investigation**
• What is your **Management plan**: please don’t forget **CONSULTATION**, **Referral** & **FOLLOW UP**.
• Be prepared for Data interpretation: **X-RAY**, **ECG**, **Blood result**
THE DAY BEFORE THE EXAM

- Don’t study too much
- Visit the place where the exam will be held at & arrange your transportation

- **SLEEPY**

EEEPEEP!!!
THE DAY OF THE EXAM

• Have Healthy Breakfast
• Dress Formal, but not too formal!!!
• No Fragrance, no hand watches
• Arrive the Exam Centre on time
• Don’t Panic (it is going to be over soon)
You have **two** minutes

- Read the questions *carefully*
- Plan out what you will be doing
- Put One Label on your hand
- Stay calm
- Once you enter, give the Label to the examiner and focus on the patient

**Stick with the BASICS!!!!!!**
THE DAY OF THE EXAM

• Once you leave one station, forget about it & focus on the next one.
• When the Exam is over:

• **CONGRATULATIONS! YOU DID IT !!!!**
Always remember you are braver than you believe, stronger than you seem, and smarter than you think.