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PLAB 2 & MLA CPSA KEYS

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18
Sample Pages

180
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PLAB 2 & MLA CPSA Keys

Free Preview eBook

High-Yield Free OSCE Station Samples

This preview includes selected A4 sample pages from the **PLAB 2 & MLA CPSA Keys** series, showing the style, colour-coding, clinical safety logic, candidate wording, red flags, management steps, safety-netting, and scoring approach used in the full product.

The complete resource includes **6 in-depth volumes with 180 high-yield OSCE stations**, built around important, frequently tested, recently seen, and commonly repeated PLAB 2 and MLA CPSA station patterns.

Each full station (Key) is organised into:

Part 1 — Recognition + Data Gathering

Part 2 — Best Next Step + Communication

Part 3 — Management + Safety-Net + Scoring

This free preview helps candidates assess the quality and value of the full access product before purchasing a plan.

To unlock the complete resource, purchase access at:

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PLAB 2 & MLA CPSA

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Anaphylaxis

IM Adrenaline, Airway Risk and Observation

PART 1 OF 3
RECOGNITION + DATA GATHERING

High-Yield OSCE Station Guide

1 ROLE-PLAYER & STATION SETTING

- Patient or nurse after food, drug, or sting exposure with wheeze, swelling, collapse, or rash.
- Candidate must recognise airway, breathing, or circulation compromise and stop a long history.
- High-scoring mindset: call for help, treat first, explain clearly, and do not let antihistamines distract from adrenaline.

2 OPENING / FIRST 20 SECONDS

"I can see this may be serious; I am checking breathing and circulation now."

- Ask onset, trigger, breathing difficulty, voice change, swelling, dizziness, previous reactions, asthma, beta-blocker use, and medicines already given.
- Start ABCDE assessment and request observations: SpO_2, pulse, blood pressure, and consciousness level.

3 CORE CONCERN

- Rapid airway swelling, bronchospasm, or shock.
- Best recognition clue: sudden illness after exposure plus respiratory or circulatory features.
- Do not reassure because urticaria alone may be mild, but airway symptoms or hypotension make this an emergency.

4 FOCUSED QUESTIONS TO ASK FIRST

1. What were you exposed to, and when did symptoms start?
2. Any throat tightness, hoarse voice, wheeze, chest tightness, faintness, or collapse?
3. Any previous anaphylaxis, asthma, mast-cell disease, pregnancy, or beta-blocker use?
4. Have you used an adrenaline auto-injector or taken antihistamine?

5 DIFFERENTIAL / DIAGNOSIS LOGIC

- **Anaphylaxis:** sudden exposure plus airway, breathing, or circulation symptoms → treat immediately.
- **Acute asthma:** wheeze without rash or swelling, but anaphylaxis is still possible after exposure.
- **Vasovagal episode:** pallor or bradycardia after a trigger, without wheeze or airway swelling.
- **Panic attack:** tingling and hyperventilation without hypotension, stridor, or angio-oedema.

6 RED FLAGS = ACT NOW

- Stridor, tongue swelling, hoarse voice, or drooling.
- Hypotension, collapse, confusion, or cyanosis.
- Persistent wheeze or a silent chest is not a minor allergic rash.

Do not delay IM adrenaline for antihistamines, steroids, consent forms, or a full history.

EXAM PEARL

Exposure plus breathing or circulation symptoms = treat as anaphylaxis first.

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Anaphylaxis

IM Adrenaline, Airway Risk and Observation

PART 2 OF 3
BEST NEXT STEP + COMMUNICATION

High-Yield OSCE Station Guide

7 BEST NEXT STEP

- **Call for urgent help** and give intramuscular **adrenaline into the anterolateral thigh now.**
- Follow the local **resuscitation dose chart** and repeat if life-threatening features persist.
- Lay flat with **legs raised** if tolerated; sit up only if breathing is worse lying flat.
- Remove the trigger if possible, give **high-flow oxygen** if hypoxic, establish **IV access,** and prepare **fluids for shock.**

8 IMMEDIATE WORK-UP / ASSESSMENT

- **Continuous observations:** airway, respiratory rate, SpO_2, pulse, blood pressure, capillary refill, consciousness, and response to adrenaline.
- Ask a colleague to bring the **emergency trolley, adrenaline, oxygen, suction, nebuliser equipment, and IV fluids.**
- After stabilisation, consider **serum tryptase** timing and **document suspected trigger, medicines,** and **response.**

9 MUST VERBALISE

- **"Anaphylaxis"**, not "allergy only".
- IM adrenaline is the **life-saving first-line treatment.**
- Antihistamines and steroids are **not immediate life-saving therapy.**
- Observation is needed because **symptoms can recur.**

10 SAFE CANDIDATE PHRASES

- "I am concerned this is a serious allergic reaction affecting breathing or circulation."
- "I am going to call for urgent help and give adrenaline into the outer thigh now."
- "We will keep monitoring you because symptoms can return even after improvement."

11 ROLE-PLAYER CHALLENGES & HIGH-SCORING REPLIES

"Can I just take an antihistamine?" →	"Because your breathing or circulation may be involved, adrenaline is needed first; antihistamine can wait."
"I feel better; can I go home?" →	"Not yet. You need observation and a prevention plan because reactions can recur."
"I am scared of adrenaline." →	"That is understandable; in anaphylaxis it is the safest urgent medicine to protect your airway and circulation."

EXAM PEARL

Say adrenaline, outer thigh, urgent help, observation, and prevention education.

Anaphylaxis

IM Adrenaline, Airway Risk and Observation

PART 3 OF 3
MANAGEMENT + SAFETY-NET + SCORING

High-Yield OSCE Station Guide

12 MANAGEMENT & OBSERVATION / FOLLOW-UP PLAN

- Continue **ABCDE reassessment** and document time of adrenaline and clinical response.
- Arrange **ED or acute observation, senior review,** and **allergen-avoidance advice** after stabilisation.
- Provide **auto-injector education, a written emergency plan,** and **allergy clinic referral** when appropriate.

13 EXACT RETURN ADVICE / SAFETY-NET

- Return immediately or call **999** for breathing difficulty, throat swelling, faintness, wheeze, widespread rash, or collapse.
- Use an adrenaline auto-injector at the **first sign of airway, breathing, or circulation symptoms** and **do not self-drive.**
- Keep **two auto-injectors** available if prescribed and **check expiry dates.**

14 DOCUMENTATION

- **Trigger** or exposure and timing.
- Airway, breathing, circulation **findings** and **observations.**
- Adrenaline **route, site, time, dose** per protocol, **response,** and repeat doses.
- **Escalation, observation plan,** discharge **education,** and **allergy referral.**

15 AVOID / FAIL TRAPS

- Calling it **"urticaria"** despite hypotension or wheeze.
- Giving **antihistamine before adrenaline** in life-threatening features.
- Letting the patient **stand or walk** during shock.
- Discharging **without observation, auto-injector advice, or safety-net.**

16 SCORE MAXIMISER & CLOSING LINE

- Name the **emergency** early,
- **Treat before** a long allergy history.
- Use **calm, clear patient-facing** explanation.
- Close with **prevention, observation,** and exact **999** advice.

> *"You did the right thing seeking help; we will keep you monitored and make sure you leave with a clear emergency plan."*

FINAL SUMMARY / EXAM PEARL

Anaphylaxis is won by early recognition, IM adrenaline, airway vigilance, observation, and a clear rescue plan.

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Acute Chest Pain

Suspected Acute Coronary Syndrome and First Actions

PART 1 OF 3
RECOGNITION + DATA GATHERING

High-Yield OSCE Station Guide

1 ROLE-PLAYER & STATION SETTING

- Adult with central crushing chest pain, radiation, sweating, nausea, breathlessness, or risk factors.
- Candidate must prioritise acute coronary syndrome while considering other life-threatening causes.
- High-scoring mindest: ECG and transfer are urgent; treatment should not delay ambulance or ED care.

2 OPENING / FIRST 20 SECONDS

- Introduce yourself, confirm patient and setting, and start ABCDE if acutely unwell.
- Ask for observations early: respiratory rate, SpO_2, pulse, blood pressure, temperature, pain score, glucose where relevant, and consciousness level.
- State your immediate concern clearly and involve urgent help when red flags are present.

3 CORE CONCERN

- Danger: myocardial infarction, arrhythmia, cardiogenic shock, or cardiac arrest.
- Do not reassure because pain has improved; recent pain with abnormal ECG still needs urgent assessment.
- Onset time matters because reperfusion decisions are time-sensitive.

4 FOCUSED QUESTIONS TO ASK FIRST

1. When did the pain start and what were you doing?
2. Is it crushing or heavy, radiating to the arm, jaw, or back, with sweating, nausea, or breathlessness?
3. Any collapse, palpitations, tearing back pain, pleuritic pain, haemoptysis, or leg swelling?
4. Any aspirin allergy, bleeding risk, anticoagulant use, or erectile dysfunction medicines?

5 DIFFERENTIAL / DIAGNOSIS LOGIC

- **ACS or MI:** central pressure plus radiation and sweating or nausea.
- **Aortic dissection:** tearing pain to the back, pulse or blood pressure difference, neurological signs.
- **Pulmonary embolism:** pleuritic pain, breathlessness, tachycardia, DVT risk.
- **Pneumothorax:** sudden unilateral pleuritic pain and reduced breath sounds.

6 RED FLAGS = ACT NOW

- Hypotension, syncope, severe breathlessness, new murmur, arrhythmia.
- ST elevation, dynamic ECG changes, or ongoing severe pain.
- Tearing pain to the back or neurological deficit.
- Chest pain with shock, cyanosis, or pulmonary oedema.

Do not delay ECG, aspirin if safe, monitoring, and urgent ED / ambulance transfer for suspected ACS.

EXAM PEARL Suspected ACS needs ECG, aspirin if safe, monitoring, and urgent transfer.

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Acute Chest Pain

Suspected Acute Coronary Syndrome and First Actions

PART 2 OF 3
BEST NEXT STEP + COMMUNICATION

High-Yield OSCE Station Guide

7 BEST NEXT STEP

- **Call 999** or arrange urgent ED transfer, do **ABCDE**, obtain a **12-lead ECG**, give **aspirin** if not contraindicated, and **treat pain or nausea** per local protocol.
- Use oxygen only if hypoxic or clinically indicated.
- **Escalate** immediately if STEMI, shock, arrhythmia, or pulmonary oedema.

8 IMMEDIATE WORK-UP / ASSESSMENT

- **12-lead ECG** within minutes and repeat if pain persists.
- **Troponin** in hospital; FBC, U&E, glucose, and CXR if the differential requires it.
- Assess **vitals, heart and lung examination, pulses or blood pressure in both arms** if dissection is a concern, and signs of heart failure.
- Clarify **anticoagulants, antiplatelets, PDE5 inhibitors,** and **allergies.**

9 MUST VERBALISE

- **"Possible heart attack"** or **"possible ACS".**
- **Urgent ambulance** or **ED, ECG, aspirin** if safe, and monitoring.
- **Do not self-drive.**
- Screen for **dissection and PE red flags** before giving simplistic advice.

10 SAFE CANDIDATE PHRASES

- *"Your symptoms could be from the heart, so this needs urgent hospital assessment."*
- *"I will arrange an ambulance; please do not drive yourself."*
- *"We will do an ECG now, but a normal first ECG does not always rule this out."*

11 ROLE-PLAYER CHALLENGES & HIGH-SCORING REPLIES

"Can I go by taxi?" →	"No. With possible ACS, ambulance monitoring is safest in case your rhythm changes."
"The pain has gone now." →	"That is good, but recent cardiac-type pain still needs urgent ECG and blood tests."
"I dislike aspirin." →	"I need to check allergy or bleeding risk, but aspirin can reduce clot progression in suspected ACS."

EXAM PEARL

Do not delay hospital care while trying to prove the diagnosis in primary care.

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Acute Chest Pain

Suspected Acute Coronary Syndrome and First Actions

PART 3 OF 3
MANAGEMENT + SAFETY-NET + SCORING

High-Yield OSCE Station Guide

12 MANAGEMENT & OBSERVATION / FOLLOW-UP PLAN

- Monitor vitals and rhythm if available; keep the patient resting, nil by mouth if likely procedure, and hand over onset time, ECG, risk factors, and treatments.
- Hospital pathway: serial troponins, reperfusion or PCI decisions, antiplatelet or anticoagulation plan, and cardiology review.
- After stabilisation: address smoking, blood pressure, lipids, diabetes, cardiac rehabilitation, and safety-netting.

13 EXACT RETURN ADVICE / SAFETY-NET

- **Call 999** for central chest pressure, pain with sweating, nausea, breathlessness, fainting, palpitations, or symptoms lasting more than minutes.
- Do not drive or walk around during symptoms.
- If discharged after assessment, return for recurrent chest pain, breathlessness, collapse, or blackouts.

14 DOCUMENTATION

- Pain onset, character, radiation, associated symptoms, and risk factors.
- ECG time and result plus repeat plan.
- Aspirin given or contraindicated and transfer plan.
- Differential red flags and handover.

15 AVOID / FAIL TRAPS

- Calling it reflux without ECG in cardiac-type pain.
- Letting the patient self-drive.
- Missing dissection or PE red flags.
- Relying on one normal ECG.

16 SCORE MAXIMISER & CLOSING LINE

1. Ask onset time.
2. ECG and ambulance early.
3. Give aspirin if safe.
4. Hand over dynamically.

> *I know this is worrying, but the safest plan is urgent assessment now so we do not miss a treatable heart problem.*

FINAL SUMMARY / EXAM PEARL

Chest pain stations reward urgent action, differential red flags, transfer safety, and clear explanation.

Ectopic Pregnancy

Shoulder Tip Pain, Collapse Risk and Emergency Action

PART 1 OF 3
RECOGNITION + DATA GATHERING

1 ROLE-PLAYER & STATION SETTING

- Emergency GP, EPU, or ED triage station: pregnant patient with abdominal pain, bleeding, shoulder-tip pain, or fainting.
- High-scoring mindset: keep the consultation safe, focused, patient-centred, and rule out immediate danger before routine counselling.

2 OPENING / FIRST 20 SECONDS

"Hello, I am one of the doctors. I will check your immediate safety first, then we can discuss this clearly and confidentially."

- Confirm identity, consent, privacy, and chaperone if intimate examination may be needed.
- Ask what worries the patient most today.

3 CORE CONCERN

- The danger is treating a rupturing ectopic as routine early pregnancy bleeding or advising self-transport when unstable.

4 FOCUSED QUESTIONS TO ASK FIRST

1. Gestation, LMP, pregnancy test, scan status, and whether an intrauterine pregnancy has been confirmed.
2. Pain site, suddenness, severity, unilateral pain, shoulder-tip pain, and rectal pressure.
3. Bleeding amount, clots, dizziness, fainting, collapse, pallor, or shortness of breath.
4. Risk factors: previous ectopic, tubal surgery, PID, IUD, IVF or fertility treatment, smoking.
5. Vital symptoms: tachycardia, low blood pressure, weakness, severe vomiting, inability to stand.
6. Who is with the patient, current location, and whether ambulance transfer is needed.

5 DIFFERENTIAL / DIAGNOSIS LOGIC

- **Ruptured ectopic:** pregnancy plus severe pain, shoulder-tip pain, syncope or collapse, or shock → emergency 999 or ED.
- **Unruptured ectopic:** pain or bleeding with unknown location but stable → urgent same-day EPU or gynaecology assessment.
- **Miscarriage or other pain:** may still need ectopic to be excluded before reassurance.

6 RED FLAGS = ACT NOW

- Shoulder-tip pain, syncope, collapse, severe abdominal pain, or peritonism.
- Tachycardia, hypotension, pallor, dizziness, or heavy bleeding.
- Positive pregnancy test with no confirmed intrauterine pregnancy.
- Previous ectopic or tubal surgery with pain or bleeding.
- Patient planning to self-drive while symptomatic.

Do not delay ED / 999 if unstable.

7 EXAM PEARL

Ectopic pregnancy stations are emergency-action stations: shoulder-tip pain, syncope, and collapse mean do not delay.

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Ectopic Pregnancy

Shoulder Tip Pain, Collapse Risk and Emergency Action

PART 2 OF 3
BEST NEXT STEP + COMMUNICATION

High-Yield OSCE Station Guide

7 BEST NEXT STEP

- If unstable or red flags are present, call ambulance or ED and urgent gynaecology now.
- If stable but ectopic is possible, arrange **same-day EPU assessment** to confirm pregnancy location.

8 IMMEDIATE WORK-UP / ASSESSMENT

- ABCDE and vital signs if face to face, with urgent senior help.
- Pregnancy test, group and save, FBC, and quantitative hCG through the acute pathway.
- Ultrasound by EPU or gynaecology.
- Avoid vaginal examination delays in an unstable patient; prioritise resuscitation and transfer.
- Analgesia, IV access and fluids, and no oral intake if surgery may be needed.

9 MUST VERBALISE

- Ectopic pregnancy can be life-threatening and may rupture.
- Shoulder-tip pain and fainting are emergency warning signs.
- Do not self-drive if red flags are present.
- The priority is **confirming pregnancy location and stabilising the patient.**

10 SAFE CANDIDATE PHRASES

- *"I am concerned this could be an ectopic pregnancy, where the pregnancy is outside the womb."*
- *"Because you have shoulder-tip pain or fainting, this needs emergency assessment now; please do not drive yourself."*
- *"We need to confirm the pregnancy location urgently and involve the gynaecology team."*

11 ROLE-PLAYER CHALLENGES & HIGH-SCORING REPLIES

"Can I wait until tomorrow?"
→ No. With these symptoms, waiting could be dangerous because an ectopic pregnancy can bleed internally.

"I can drive myself."
→ I do not want you to drive. If you faint or deteriorate, that would be unsafe; we need ambulance transport or someone else with emergency care."

"Is my baby okay?"
→ I know that is your biggest worry. Right now, your safety is the priority, and the scan and blood tests will clarify what is happening."

EXAM PEARL

The safest ectopic answer prioritises stability, transport, and pregnancy location.

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Ectopic Pregnancy

Shoulder Tip Pain, Collapse Risk and Emergency Action

PART 3 OF 3
MANAGEMENT + SAFETY-NET + SCORING

High-Yield OSCE Station Guide

12 MANAGEMENT & OBSERVATION / FOLLOW-UP PLAN

- Emergency transfer for shoulder-tip pain, syncope, collapse, severe pain, peritonism, or shock.
- Same-day EPU if stable but ectopic cannot be excluded.
- Give clear instructions not to eat or drink if surgery may be needed according to local advice.
- Provide emotional support and ensure the patient is accompanied and safe.

13 EXACT RETURN ADVICE / SAFETY-NET

- **Call 999 immediately** for fainting, collapse, severe or worsening abdominal pain, **shoulder-tip pain**, or heavy bleeding.
- Do not self-drive if symptomatic or advised urgent transfer.
- Attend same-day EPU or ED even if pain temporarily improves.

14 DOCUMENTATION

- Pregnancy status or location, gestation, symptoms, ectopic risk factors, and red flags.
- Stability and vitals if available, emergency advice or referral, and transport instructions.
- Information given, patient understanding, support person, and safety-net.

15 AVOID / FAIL TRAPS

- ✗ Sending a possible ruptured ectopic to a routine outpatient appointment.
- ✗ Advising self-driving with collapse risk.
- ✗ Reassuring because bleeding is light.
- ✗ Ignoring shoulder-tip pain.

16 SCORE MAXIMISER & CLOSING LINE

- Say "life-threatening internal bleeding" carefully but clearly.
- Name emergency transport.
- Prioritise ABCDE over a long history if unstable.

Closing line: *"This could be dangerous, so the safest plan is urgent emergency assessment now rather than waiting."*

FINAL SUMMARY / EXAM PEARL

★ **A high-scoring candidate does not let an unstable patient self-drive.**

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Acute Asthma Attack

Severity, Immediate Treatment and Escalation

PART 1 OF 3
RECOGNITION + DATA GATHERING

High-Yield OSCE Station Guide

1 ROLE-PLAYER & STATION SETTING

- Adult with acute wheeze, breathlessness, cough, chest tightness, reliever overuse or poor response.
- **Candidate must think severity first** and assess for potential deterioration early.

2 OPENING / FIRST 20 SECONDS

- **Introduce yourself,** confirm patient details, and explain you will assess and treat.
- Assess **ABCDE** quickly and efficiently.
- Ask if the patient can **speak in full sentences.**
- Request and act on observations: **respiratory rate, SpO_2, pulse, temperature,** and **PEF** if possible.

3 CORE CONCERN

- The danger is **severe bronchospasm** progressing to **respiratory failure.**
- A **silent chest, exhaustion, cyanosis,** or **low oxygen** are more dangerous than loud wheeze.

4 FOCUSED QUESTIONS TO ASK FIRST

1. Can the patient **speak in full sentences?**
2. How many **salbutamol doses** were used today and did they help?
3. Any previous **ICU** admission or **ventilation?**
4. Any previous **steroid** use?
5. Any **chest pain, fever,** or **allergy exposure?**
6. Are you **pregnant?**
7. Any poor **inhaler supply** or running out?

5 DIFFERENTIAL / DIAGNOSIS LOGIC

- **Acute asthma exacerbation:** most likely if typical history and variable airflow limitation.
- **Pneumonia / chest infection:** fever, productive cough, focal signs.
- **Pneumothorax:** sudden pleuritic pain, unilateral reduced breath sounds.
- **Pulmonary embolism:** risk factors, pleuritic pain, tachycardia, hypoxia.
- **Anaphylaxis (if trigger and swelling):** urticaria, angio-oedema, hypotension, wheeze.

6 RED FLAGS = ACT NOW

- Silent chest, exhaustion, confusion, or cyanosis.
- Bradycardia or hypotension.
- Low SpO_2 (e.g., < 92%) or very low PEF (e.g., < 50% of personal best / predicted).
- Previous near-fatal asthma.
- Poor response to initial therapy or worsening despite treatment.

EXAM PEARL ★ **In acute asthma, severity is clinical and reassessment is part of treatment.**

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Acute Asthma Attack

Severity, Immediate Treatment and Escalation

PART 2 OF 3
BEST NEXT STEP + COMMUNICATION

High-Yield OSCE Station Guide

7 BEST NEXT STEP

- Give **oxygen** if hypoxic.
- Start high-dose inhaled or nebulised **salbutamol** early.
- Give early **corticosteroids** (oral or IV).
- Add **ipratropium** if severe or life-threatening.
- Consider **IV magnesium** or **specialist escalation** if poor response.
- Do not wait for **blood tests** before treating a severe attack.

8 IMMEDIATE WORK-UP / ASSESSMENT

- Observations: **RR, pulse, SpO_2, BP,** temperature, work of breathing, **PEF,** and **mental state.**
- Check **inhaler technique,** recent steroid exposure, **infection signs,** allergy exposure, and **pregnancy status.**
- ABG or VBG, CXR, ECG, or blood tests only when **severe, atypical, not improving, or alternative diagnosis is suspected.**

9 MUST VERBALISE

- Say the **severity category** and **life-threatening features** if present.
- Verbalise **oxygen, salbutamol, streoids,** reassessment, and **escalation.**
- State that **deterioration can be rapid** even if the patient initially talks.
- Document **PEF** before and after treatment if it can be done safely.

10 SAFE CANDIDATE PHRASES

- "Your breathing signs suggest a severe asthma attack, so I need to treat you now."
- "We will give breathing treatment, steroids, and monitor you closely while I get senior support."
- "A quiet chest can be a dangerous sign, so I am not reassured by less wheeze."

11 ROLE-PLAYER CHALLENGES & HIGH-SCORING REPLIES

"I just need my inhaler and I'll go."	"A severe asthma attack can get worse quickly. You need treatment, monitoring, and we'll involve senior support to keep you safe."
"Steroids worry me."	"Steroids help reduce inflammation and prevent further attacks. A short course is safe and important right now."
"I feel slightly better."	"That's good, but your symptoms can return suddenly. We need to complete treatment, monitor you, and check your breathing."

EXAM PEARL

Life-threatening asthma needs treatment, monitoring, and senior help without delay.

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Acute Asthma Attack

Severity, Immediate Treatment and Escalation

PART 3 OF 3
MANAGEMENT + SAFETY-NET + SCORING

High-Yield OSCE Station Guide

12 MANAGEMENT & OBSERVATION / FOLLOW-UP PLAN

- Reassess after each bronchodilator cycle; review symptoms, SpO_2, respiratory effort, pulse, and PEF.
- Admit or escalate if life-threatening features, poor response, social risk, pregnancy, or previous near-fatal asthma.
- Before discharge address inhaler technique, spacer, preventer review, written asthma action plan, steroid course, and follow-up.

13 EXACT RETURN ADVICE / SAFETY-NET

- Call 999 or seek ED urgently for inability to speak, blue lips, exhaustion, drowsiness, silent chest, or reliever not helping.
- Use reliever as per action plan while awaiting help and do not drive if severe.
- Arrange same-day review if repeated reliever doses or relapse after treatment.

14 DOCUMENTATION

- Severity including speech, RR, SpO_2, pulse, and PEF.
- Treatment given, timings, and response.
- Escalation decisions and senior input.
- Discharge criteria, inhaler technique, written action plan, and follow-up.

15 AVOID / FAIL TRAPS

- Missing silent chest or exhaustion.
- Sending home without objective reassessment.
- Forgetting steroids or written action plan.
- Focusing on trigger counselling before urgent treatment.

16 SCORE MAXIMISER & CLOSING LINE

- State severity out loud.
- Treat and reassess in cycles.
- Escalate early if incomplete response.
- Close with inhaler technique and exact return advice.

> *"Once your breathing is safe, I will also help prevent another attack with a clear action plan."*

FINAL SUMMARY / EXAM PEARL

Asthma stations are scored by severity recognition, immediate bronchodilator and steroid treatment, reassessment, and safe discharge planning.

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Sepsis and Deteriorating Adult

Recognise Fast, Treat Early and Escalate

PART 1 OF 3
RECOGNITION + DATA GATHERING

High-Yield OSCE Station Guide

1 ROLE-PLAYER & STATION SETTING

- Patient in primary care, ED, or ward setting with fever or infection symptoms plus tachypnoea, hypotension, confusion, low urine output, or rapid deterioration.

2 OPENING / FIRST 20 SECONDS

- Introduce yourself and confirm the patient's name and date of birth.
- Use ABCDE approach to assess and request full observations early.
- Ask for senior help early if the patient looks acutely unwell.

3 CORE CONCERN

- Sepsis is infection with organ dysfunction and can rapidly progress to shock or death.
- Do not be falsely reassured by a young patient who still looks alert.

4 FOCUSED QUESTIONS TO ASK FIRST

1. Infection symptoms and onset.
2. Confusion, rigors, breathlessness, reduced urine, rash, severe pain, or collapse.
3. Immunosuppression, chemotherapy, diabetes, pregnancy, splenectomy, or recent surgery.
4. Antibiotics already taken or recent hospital admission.

5 DIFFERENTIAL / DIAGNOSIS LOGIC

- Sepsis (infection with organ dysfunction).
- Septic shock (sepsis with profound circulatory, cellular, and metabolic abnormalities).
- Severe localised infection with systemic response.
- Meningococcal sepsis.
- Other causes of shock or patient deterioration.

6 RED FLAGS = ACT NOW

- High NEWS2, low systolic BP, raised lactate, or new confusion.
- Respiratory distress, low SpO_2, mottled skin, or oliguria.
- Non-blanching rash or severe limb / abdominal pain.
- Frailty, pregnancy, immunosuppression, or recent surgery.

EXAM PEARL

Infection plus organ dysfunction signs means treat early and escalate.

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Sepsis and Deteriorating Adult

Recognise Fast, Treat Early and Escalate

PART 2 OF 3
BEST NEXT STEP + COMMUNICATION

High-Yield OSCE Station Guide

7 BEST NEXT STEP

- **Call senior or acute help**, start the **sepsis pathway**, give **oxygen** if needed, obtain **cultures**, give **IV antibiotics** promptly, give **IV fluids** if hypotensive, and monitor **urine output.**
- **Do not delay antibiotics** for imaging if the patient is high risk.
- Escalate to **critical care** if shock, rising lactate, airway risk, or poor response.

8 IMMEDIATE WORK-UP / ASSESSMENT

- **NEWS2** trend, **ABCDE**, **blood gas with lactate**, **FBC**, **U&E**, **LFT**, **CRP**, **clotting**, **cultures**, **urine** dip or culture, **CXR** or source imaging.
- Insert **cannulae**, consider **catheter** for urine output, and **reassess** after fluids or antibiotics.
- **Look for the source:** chest, urine, abdomen, skin, line, meningitis, or surgical site.

9 MUST VERBALISE

- Say **"possible sepsis"** early.
- Verbalise **antibiotics, cultures, fluids, lactate, urine output,** and **escalation.**
- Explain that early treatment **protects organs.**
- State **reassessment intervals** and **escalation triggers.**

10 SAFE CANDIDATE PHRASES

- "Your observations suggest your body may be reacting seriously to an infection."
- "We need to start urgent treatment while we look for the source."
- "I am getting senior help because sepsis can worsen quickly."

11 ROLE-PLAYER CHALLENGES & HIGH-SCORING REPLIES

"Can we wait for blood results?"	"We will take key tests, but if sepsis is likely, treatment must start now."
"I only came for a fever."	"The concern is not fever alone; it is fever with low blood pressure, fast breathing, or confusion."
"Can I go home?"	"With these warning signs, home is not safe until you are assessed and stabilised."

EXAM PEARL

The safest answer is not a test alone; it is sepsis pathway plus senior review.

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Sepsis and Deteriorating Adult

Recognise Fast, Treat Early and Escalate

PART 3 OF 3
MANAGEMENT + SAFETY-NET + SCORING

High-Yield OSCE Station Guide

12 MANAGEMENT & OBSERVATION / FOLLOW-UP PLAN

- Continue **IV antibiotics** per local guidance after cultures where possible.
- Give **fluids** with reassessment.
- Give **oxygen** if hypoxic.
- Seek **source control**, and arrange **catheter or urine monitoring** when indicated.
- Admit to acute medical or ED area.
- Escalate to **ICU or HDU** if **shock**, **rising lactate**, or **respiratory failure**.
- Review **medicines, allergies, renal function**, and **antimicrobial plan**.

13 EXACT RETURN ADVICE / SAFETY-NET

- **Call 999** or return urgently for confusion, blue lips, severe breathlessness, fainting, a non-blanching rash, no urine, or rapidly worsening illness.
- **Do not self-drive** if dizzy, collapsed, or severely breathless.
- If discharged after low-risk assessment, give **exact time-bound review** and clear **fever, urine, and breathing advice**.

14 DOCUMENTATION

- **NEWS2** and full observations.
- Suspected **source** and **differential**.
- **Cultures, lactate, fluids, antibiotics,** and **timings**.
- **Escalation discussion**, response, and **monitoring plan**.

15 AVOID / FAIL TRAPS

- Reassuring because **temperature is normal**.
- Forgetting **lactate or urine output**.
- Delaying **treatment for imaging**.
- Failing to **reassess** after fluids or antibiotics.

16 SCORE MAXIMISER & CLOSING LINE

- Say **sepsis** early.
- Use **ABCDE** plus **NEWS2**.
- **Treat and reassess** rather than only investigate.
- Use exact **escalation triggers**.

> *"We will treat this as urgent because acting early gives the best chance of preventing organ complications."*

FINAL SUMMARY / EXAM PEARL

Sepsis stations are won by recognition, time-critical treatment, source search, monitoring, and escalation.

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Contraception Counselling

Choosing the Safest Method for the Patient

PART 1 OF 3
RECOGNITION + DATA GATHERING

High-Yield OSCE Station Guide

1 ROLE-PLAYER & STATION SETTING

- GP or sexual health consultation: the patient wants contraception and may have **personal priorities, medical risks, relationship concerns,** or **anxiety** about **side effects.**

2 OPENING / FIRST 20 SECONDS

- Greet the patient, introduce yourself, and build rapport.
- Confirm **confidentiality, consent, privacy,** and **chaperone** if intimate examination may be needed.
- Ask the patient what **worries** them most today.

3 CORE CONCERN

- The danger is choosing a method before excluding **pregnancy risk, migraine with aura, thrombosis risk, interacting medicines, postpartum or breastfeeding status, STI risk,** or **coercion.**
- Emphasise a **shared decision-making** approach to choose the safest and most suitable method for the patient.

4 FOCUSED QUESTIONS TO ASK FIRST

1. **What matters most:** avoiding pregnancy, bleeding control, acne, privacy, or no hormones?
2. Any **unprotected sex, missed period, pregnancy** symptoms, or need for **emergency contraception**?
3. **Medical risks:** migraine with aura, VTE, high BP, smoking over age 35, diabetes complications, breast cancer, or liver disease?
4. **Medicines:** enzyme inducers, antiepileptics, rifampicin-like antibiotics, St John's wort, anticoagulants, or isotretinoin?
5. Any **abnormal bleeding, pelvic pain, discharge,** breast symptoms, headaches, **STI risk,** condom use, or **pressure from a partner**?

5 DIFFERENTIAL / DIAGNOSIS LOGIC

- **Combined hormonal contraception** suits some patients but avoid with migraine aura, high VTE risk, uncontrolled BP, or heavy smoking.
- **LARC options:** implant, IUD, IUS, or injection are effective, long-acting, and reversible.
- **Condoms** provide STI protection and give patients more control over their sexual health.

6 RED FLAGS = ACT NOW

- Possible pregnancy or recent unprotected sex.
- Migraine with aura, previous VTE, stroke, severe hypertension, or current breast cancer.
- Unexplained vaginal bleeding, pelvic pain, breast lump, or coercion.
- Sexual assault or safeguarding concerns.
- Enzyme-inducing medicines (e.g. rifampicin, some anticonvulsants, St John's wort).

EXAM PEARL

Contraception counselling scores highest when it is **personalised, safe,** and explicit about **pregnancy risk, STI protection,** and **contraindications.**

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Contraception Counselling

Choosing the Safest Method for the Patient

PART 2 OF 3
BEST NEXT STEP + COMMUNICATION

High-Yield OSCE Station Guide

7 BEST NEXT STEP

- Screen **eligibility, pregnancy risk, medicines, BP,** and **patient priorities.**
- Offer a shared choice with **LARC** and **condoms** clearly discussed.
- Arrange **same-day emergency contraception** if indicated.

8 IMMEDIATE WORK-UP / ASSESSMENT

- **Pregnancy test** if late period, symptoms, or uncertain risk.
- Measure **blood pressure** before combined hormonal contraception and check BMI, smoking status, and migraine history.
- Offer **STI screening** when there are new or multiple partners, age **under 25,** symptoms, or **condomless sex.**
- Document a clear **risk assessment** and **agreed follow-up plan.**

MUST VERBALISE

- **Confidentiality and consent** are respected unless safety or safeguarding risk overrides this.
- No contraceptive method except condoms protects against **STIs.**
- **Bleeding pattern changes** are common with many progestogen methods.
- A method can be changed if unacceptable; the patient is **not trapped with the first choice.**

10 SAFE CANDIDATE PHRASES

- "I will not push one option; my job is to make sure it is safe for you and fits your life."
- "Because you mentioned migraine with aura, I would avoid the combined pill and look at safer alternatives."
- "Condoms are still important if there is any STI risk, even when another method prevents pregnancy."

11 ROLE-PLAYER CHALLENGES & HIGH-SCORING REPLIES

"I just want the pill quickly." →	"I can help today, but first I need to check it's safe and discuss options so we choose something that suits you and is safe."
"Will this make me infertile?" →	"No. Routine contraception doesn't cause permanent infertility. Fertility usually returns after stopping, although timing varies."
"My partner does not like condoms." →	"Your safety and choices are important. Let's find a method that works for you, and condoms still protect against STIs."

EXAM PEARL

The best method is not the newest method; it is the safest acceptable method for this patient today.

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Contraception Counselling

Choosing the Safest Method for the Patient

PART 3 OF 3
MANAGEMENT + SAFETY-NET + SCORING

High-Yield OSCE Station Guide

12 MANAGEMENT & OBSERVATION / FOLLOW-UP PLAN

- Agree the chosen method and explain **start timing, backup contraception, common side effects,** and when protection begins.
- Offer condoms and STI testing where risk exists; advise **dual protection** for pregnancy and STI prevention.
- Plan **BP review** for combined methods and fitting appointments for **IUD, IUS, or implant.**
- Provide **written information** and arrange **follow-up.**

13 EXACT RETURN ADVICE / SAFETY-NET

- Seek urgent help if **severe lower abdominal pain, collapse, heavy bleeding,** or **suspected pregnancy with pain** occurs.
- Return promptly for new **neurological symptoms, severe chest pain, leg swelling,** or **severe headache** after hormonal contraception.
- Attend sexual health services urgently after **sexual assault, coercion,** or possible **STI exposure** needing time-sensitive care.

14 DOCUMENTATION

- Record **patient priorities,** pregnancy risk, LMP, unprotected sex, and **emergency contraception** discussion.
- Document **eligibility risks: BP, migraine aura, VTE risk, smoking, medicines, breastfeeding or postpartum status,** and relevant **comorbidities.**
- Note **options discussed, final shared choice, backup advice, condom or STI advice, follow-up,** and **safety-net.**

15 AVOID / FAIL TRAPS

- Prescribing combined contraception despite **migraine with aura** or **high thrombosis risk.**
- Forgetting to assess recent **unprotected sex** and the need for **emergency contraception.**
- Ignoring **coercion, confidentiality,** or **safeguarding** in a sexual health consultation.
- Saying contraception protects from STIs **without mentioning condoms.**

16 SCORE MAXIMISER & CLOSING LINE

- Ask **what the patient wants** before explaining options.
- Use **concise eligibility screening** instead of a long lecture.
- Check understanding with **teach-back.**
- Close with a short, safe summary line.

> *"We've agreed the safest option for you, I'll give you written information, and we'll arrange follow-up."*

FINAL SUMMARY / EXAM PEARL

A high-scoring candidate combines shared choice, medical eligibility, dual protection, and a clear follow-up plan.

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