Test of Competence: Mock OSCE

Adult Nursing

V 1.9

Mock OSCE

Adult nursing

In your objective structured clinical examination (OSCE), you will be assessed on 10 stations in total:

- Four of the stations are linked together around a scenario: this is called the APIE, with one station for each of Assessment, Planning, Implementation and Evaluation, delivered in that sequence and with no stations in between.
- Four stations will take the form of two sets of two linked stations, testing practical clinical skills. Each pairing of skills stations will last up to 20 minutes in total (including reading time), with no break between each paired skill.
- There are also two *silent* stations. In each OSCE, one station will specifically assess professional issues associated with professional accountability and related skills around communication (called the professional values and behaviours, or PV, station). One station will also specifically assess critical appraisal of research and evidence and associated decision-making (called the evidence-based practice station, or EBP). These stations will each be 10 minutes long.

We have developed this mock OSCE to provide an outline of the performance we expect and the criteria that the test of competence will assess. This mock OSCE contains an APIE, one pair of linked clinical skills, one PV and one EBP station.

The Nursing and Midwifery Council's code (2018) outlines professional standards of practice and behaviours, setting out the expected performance and standards that are assessed through the test of competence.

The code is structured around four themes: prioritise people, practise effectively, preserve safety and promote professionalism and trust. These statements are explained below as the expected performance and criteria. The criteria must be used to promote the standards of proficiency in respect of knowledge, skills and attitudes. They have been designed to be applied across all fields of nursing practice, irrespective of the clinical setting, and they should be applied to the care needs of all patients.

Please note: this is a mock OSCE example for education and training purposes only.

The marking criteria and expected performance apply only to this mock OSCE. They provide a guide to the level of performance we expect in relation to nursing care, knowledge and attitude. Other scenarios will have different assessment criteria appropriate to the scenario.

Evidence for the expected performance criteria can be found in the reading list and related publications on the learning platform.

Theme from the code	Expected performance	Criteria
Prioritise people	Treat people as individuals and uphold their dignity	Introduces self to the patient at every contact and upholds the patient's dignity and privacy.
	Listen to people and respond to their preferences and concerns	Actively listens to patients and provides clear information, behaving in a professional manner, respecting others and adopting non-discriminatory behaviour.
	Make sure that people's physical, social and psychological needs are responded to	Upholds respect by valuing the patient's opinions and being sensitive to feelings and/or appreciating any differences in culture.
	Act in the best interest of people at all times	Treats each patient as an individual, showing compassion and care during all interactions. Respects and upholds people's human rights.
	Respect people's right to privacy and confidentiality	Ensures that people are informed about their care and that information about them is shared appropriately, maintaining confidentiality.
Practise effectively	Always practise in line with the best available evidence	Provides skills, knowledge and attitude that is supported by an evidence base at all times.
	Communicate clearly	Communicates clearly and effectively to people in their care, colleagues and the public.

	Work co-operatively	Maintains effective and safe communication with people in their care, colleagues and the public.

	Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues	Supports others by providing accurate, honest and constructive verbal and written feedback.
	Keep clear and accurate records relevant to your practice	Provides clearly written feedback on all care given, and demonstrates accurate evidence-based verbal handover of care to others.
	Be accountable for your decisions to delegate tasks and duties to other people	Accountably delegates to competent others, ensuring patient safety at all times.
P r e s	Recognise and work within the limits of their competence	Accurately identifies, observes and assesses signs of normal or worsening physical and mental health in the person receiving care, requesting timely and appropriate assistance as required.
	Be open and candid about potential mistakes, preventing harm	Documents events formally and takes further action (escalates) if appropriate, so they can be dealt with quickly.
	Provide assistance in an emergency	Acts in an emergency within the limits of their knowledge and competence, seeking appropriate support as required.

	Act swiftly if there is a danger to others, maintaining safety	Delivers care according to national policies and procedures to prevent danger to others, and applies appropriate personal protective equipment (PPE) as indicated by the nursing procedure in accordance with the guidelines to prevent healthcare-associated infections.

	Raise concerns for those who are seen to be vulnerable or at risk of harm	Shares information if someone is at risk of harm, in line with the laws relating to the disclosure of information.
	Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations	Checks prescriptions, patient identification and administers medicines safely, highlighting appropriately any areas of concern.
	Demonstrate awareness of any potential harm associated to their practice	Takes all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public.
Promote professionalism and trust	Uphold the reputation of the profession at all times	Demonstrates and upholds the standards and values set out in the code.
	Fulfil the registration requirements	Demonstrates up-to-date knowledge, skills and competence to provide safe and effective care at all times.

	Provide leadership to make sure that people's wellbeing is protected and to improve their experiences of the health and care system	Identifies priorities, manages time and resources effectively, and deals with risk to make sure that the quality of care or service is maintained and improved, putting the needs of those receiving care or services first.

Mock APIE: Post-operative care

The mock APIE below is made up of four stations: assessment, planning, implementation and evaluation. Each station will last up to 20 minutes and is scenario-based. The instructions and available resources are provided for each station, along with the specific timing.

Scenario
Ash Potter was referred to the surgical assessment unit after presenting 10 days post operatively with an inflamed abdominal wound and pain following an uncomplicated laparoscopic hemicolectomy to remove a small primary colorectal cancer.

You will be asked to complete the following activities to provide high-quality, individualised nursing care for the patient, providing an assessment of his needs, using a model of nursing that is based on the activities of living. All four of the stages in the nursing process will be continuous and will link with each other.

Station	**You will be given the following resources**
Assessment – **20 minutes** You will collect, organise and document information about the patient.	• Assessment overview and documentation (pages 10–13) • A blank national early warning score chart (NEWS) to be completed (pages 14–16).
Planning – **14 minutes** You will complete the planning template, choosing two aspects of the patient's care needs and establishing how they will be met.	• A partially completed nursing care plan for two nursing care problems or needs to be completed (pages 17–20).
Implementation – 15 minutes You will administer medications while continuously assessing the individual's current health status.	• An overview and medication administration record (MAR) to be completed (pages 21–28).
Evaluation – 8 minutes You will document the care that has been provided so that you can do a verbal handover to the nurse on the next shift (the examiner).	• Documents from the previous three stations • A blank situation, background, assessment and recommendation (SBAR) tool to be completed (pages 29–30).

Mock APIE: Post-operative care

On the following pages, we have outlined the expected standard of clinical performance and criteria. These marking matrices are there to guide you on the level of knowledge, skills and attitude we expect you to demonstrate at each station.

Assessment criteria
Assesses the safety of the scene and privacy and dignity of the patient.
Cleans hands with alcohol hand rub, or washes with soap and water, and dries with paper towels following WHO guidelines.
Introduces self to person, including name and job title, e.g. staff nurse.
Checks ID with person (person's name is essential and either their date of birth or hospital number) verbally, against wristband (where appropriate) and paperwork.
Gains consent and explains reason for the assessment.
Checks for allergies verbally and on wrist band (where appropriate).
Uses a calm voice, speech is clear, body language is open, and personal space is appropriate.
Measures accurately the patient's vital signs.
Documents vital signs accurately.
Calculates and accurately records NEWS score.
Conducts an A to E (airway, breathing, circulation, disability, exposure) assessment.
Identifies that wound pain is affecting mobility.
Identifies that the patient is feeling low.
Identifies reduced fluid and food intake.
Identifies that redness and pain around wound site are signs of infection.
Identifies that patient is drinking more alcohol than recommended.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Planning criteria
Clearly and legibly handwrites answers for problems 1 and 2.
Identifies two relevant nursing problems/needs.
Identifies aims for both problems.
Sets appropriate evaluation date for both problems.
Ensures nursing interventions are current/evidence-based/best practice.
Uses professional terminology in care planning.
Does not use abbreviations or acronyms.
Ensures strike-through errors retain legibility.
Accurately prints, signs and dates (when required).
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Implementation criteria
Cleans hands with alcohol hand rub, or washes with soap and water, and dries with paper towels following WHO guidelines.
Introduces self to person.
Seeks consent from person or carer prior to administering medication.
Checks allergies on chart and confirms with the person in their care, and also notes red ID wristband (where appropriate).
Before administering any prescribed drug, looks at the person's prescription chart and correctly checks all of the following: Correct: • person (check ID with person verbally, against wristband (where appropriate) and documentation); • drug • dose • date and time of administration • route and method of administration. • diluent (as appropriate).
Correctly checks ALL of the following: • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
Briefly acknowledges any possible contraindications and medical information prior to administration (prompt permitted) – verbalisation accepted.
Administers drugs due for administration correctly and safely: • Administers correct dose • Checks expiry date • Handles medication correctly.
Provides a correct explanation of what each drug being administered is for to the person in their care (prompt permitted).
Omits drugs not to be administered and provides verbal rationale (if not verbalised, ask candidate the reason for non-administration).
Accurately records drug administration and non-administration, including the details of the person administering the medication.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Evaluation criteria
Situation
Introduces self and the clinical setting.
States the patient's name, hospital number and/or date of birth, and location.
States the reason for the handover (where relevant).
Background
States date of admission/visit and reason for initial admission/referral to specialist team and diagnosis.
Notes previous medical history and relevant medication/social history.
Gives details of current events and details findings from assessment.
Assessment
States most recent observations, any results from assessments undertaken,and what changes have occurred.
Identifies main nursing needs.
Outlines which nursing and medical interventions have been undertaken.
Highlights areas of concerns.
Recommendation
States what is required of the person taking the handover and proposes a realistic plan of action.
Overall
Verbal communication is clear and appropriate.
Systematic and structured approach taken to handover.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Assessment
Post-operative care
Assessment Station

Candidate briefing

You are a registered adult nurse working on the surgical assessment unit.

Please conduct a holistic assessment of the patient's physical, psychosocial, spiritual and sexual care needs.

As part of your assessment, please:

- Complete and verbalise an **A to E assessment** (airway, breathing, circulation, disability, exposure).
- Take manual observations and record **the patient's vital signs** (blood pressure, temperature, pulse rate, oxygen saturations, and respiratory rate) and **verbalise the results to the patient**. Having recorded the patient's vital signs, please **calculate a national early warning score** (NEWS).

Depending on the patient's circumstances and condition, you may wish to focus on some areas of assessment in more depth than others.

In the **next** station, you will be required to use the information gathered from your assessment to write a plan of care for two aspects of care.

Please note that there is no need to remove the patient's clothing to assess exposure. Please ask the examiner for any additional clinical information you require.

All equipment has been checked, calibrated and is clean.

An observation chart is provided and must be completed in full within the station.

This document must be completed using a BLUE PEN.

You have **20 minutes** to complete this station, **including the completion of the following documentation: NEWS chart.**

Assessment
Post-operative care

Assume it is **TODAY** and it is **10:00 hours.**

Assessment
Post-operative care

Overview of recent history

Patient information

Assessment
Post-operative care

Name: Ash Potter
Date of birth: 01/01/1950
Address: 1 Sweet Street, Westshire WW6 5PQ
GP: Dr Biswaz, The Plains Surgery, Westshire

Presenting complaint:

- Recalled following bowel screening and undergone a rigid sigmoidoscopy.
- Diagnosed with a small primary colorectal cancer.
- Undergone a laparoscopic hemicolectomy, which was uncomplicated and no stoma necessary.
- Now attending the surgical assessment unit 10 days after surgery, with a 5cm wound at the surgical (extraction) site. The wound is inflamed with some exudate.
- Ash expresses feeling hot and more tired than usual.
- Reduced dietary and fluid intake since surgery and has not opened bowels for 4 days.
- Feeling emotionally 'low' and expressing abdominal pain.
- Walked unaided before surgery, but finding it more difficult to mobilise due to abdominal pain.

Past medical history:

- Broken arm aged 8.
- Hypertension since 2005.
- Glaucoma since 2017.

Social history:

- Normally lives and cares for partner, who suffers with slight cognitive impairment. Partner currently staying with daughter Jenny since Ash admitted to hospital. Ash refused to stay with Jenny as didn't want to leave own home.
- Lives in two-storey house.
- Non-smoker.
- Drinks at least two pints of lager every day, sometimes more.
- Daughter or son-in-law visits every other day, bringing meals.

Drug history:

- Ramipril – 5 milligrams, once a day.
- Timoptol – 0.5% eye drops, one drop, both eyes, twice daily.
- Paracetamol – 1 gram as required.

Allergies: None known.

Assessment
Post-operative care

Candidate notes

This documentation is for your use and is not marked by the examiners.

Patient details: Name: Ash Potter Hospital number: 0004321 Address: Sweet Street Hostel, Westshire, WW6 5PQ Date of birth: 01/01/1950
Airway
Breathing
Circulation
Disability
Exposure – full clinical history

Assessment
Post-operative care

Candidate notes

This documentation is for your use and is not marked by the examiners.

Assessment
Post-operative care

Candidate notes

This documentation is for your use and is not marked by the examiners.

Physical
Psychosocial
Spiritual
Sexual

Assessment
Post-operative care

Candidate notes

This documentation is for your use and is not marked by the examiners.

Chart 1: The NEWS scoring system

Physiological parameter	Score 3	2	1	0	1	2	3
Respiration rate (per minute)	≤8		9–11	12–20		21–24	≥25
SpO_2 Scale 1 (%)	≤91	92–93	94–95	≥96			
SpO_2 Scale 2 (%)	≤83	84–85	86–87	88–92 ≥93 on air	93–94 on oxygen	95–96 on oxygen	≥97 on oxygen
Air or oxygen?		Oxygen		Air			
Systolic blood pressure (mmHg)	≤90	91–100	101–110	111–219			≥220
Pulse (per minute)	≤40		41–50	51–90	91–110	111–130	≥131
Consciousness				Alert			CVPU
Temperature (°C)	≤35.0		35.1–36.0	36.1–38.0	38.1–39.0	≥39.1	

Chart 2 Clinical Response and triggers

NEW score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	• Continue routine NEWS monitoring
Total 1–4	Minimum 4–6 hourly	• Inform registered nurse, who must assess the patient • Registered nurse decides whether increased frequency of monitoring and/or escalation of care is required
3 in single parameter	Minimum 1 hourly	• Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary
Total 5 or more Urgent response threshold	Minimum 1 hourly	• Registered nurse to immediately inform the medical team caring for the patient • Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients • Provide clinical care in an environment with monitoring facilities
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level • Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills • Consider transfer of care to a level 2 or 3 clinical care facility, ie higher-dependency unit or ICU • Clinical care in an environment with monitoring facilities

NEWS key	FULL NAME Ash Potter	
0 1 2 3	DATE OF BIRTH 01/01/1950	DATE OF ADMISSION Today

	DATE																								DATE
	TIME																								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 **SpO_2 Scale 1** Oxygen saturation (%)	≥96																								≥96
	94–95												1												94–95
	92–93												2												92–93
	≤91												3												≤91
SpO_2 Scale 2† Oxygen saturation (%) Use Scale 2 if target range is 88–92%, eg 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												3												81–90
	71–80																								71–80
	61–70																								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																								51–60
	41–50												1												41–50
	31–40												3												31–40
	≤30																								≤30
D **Consciousness** Score for NEW onset of confusion (no score if chronic)	Alert																								Alert
	Confusion												3												Confusion
	V																								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																									**TOTAL**
Monitoring frequency																									Monitoring
Escalation of care Y/N																									Escalation
Initials																									Initials

Planning
Post-operative care
Planning Station

Candidate paperwork and briefing

Candidate name: _____

This document must be completed using a BLACK PEN.

Scenario
Ash Potter was referred to the surgical assessment unit after presenting 10 days post operatively with an inflamed abdominal wound and pain following an uncomplicated laparoscopic hemicolectomy to remove a small primary colorectal cancer.

Based on your nursing assessment, please produce a nursing care plan for <u>two relevant aspects</u> of nursing care suitable for the next 24 hours.

This is a silent written station. Please ensure that you write legibly and clearly.

You have **14 minutes** to complete this station, including all the required documentation.

Complete **all** sections of the care plan.

Assume it is **TODAY** and it is **11:00 hours**.

Planning
Post-operative care

Patient details: Name: Ash Potter Hospital number: 0004321 Address: 1 Sweet Street, Westshire, WW6 5PQ Date of birth: 01/01/1950
1) Nursing problem/need
Aim(s) of care:
Re-evaluation timeframe:
Nursing interventions
NAME (Print):

Planning
Post-operative care

Nurse signature:	Date:

2) Nursing problem/need
Aim(s) of care:
Re-evaluation timeframe:
Nursing interventions

Planning
Post-operative care

NAME (Print):	
Nurse Signature:	**Date:**

Planning
Post-operative care

This page is not a required element but is for use in case of error.	
Nursing problem/need	
Aim(s) of care:	
Re-evaluation timeframe:	
Nursing interventions	
NAME (Print):	
Nurse signature:	**Date:**

Implementing
Safe administration of medications
Implementation Station

Candidate paperwork and briefing

Candidate name: _____

This document must be completed using a BLACK PEN.

Scenario
Ash Potter was admitted to the surgical assessment unit after presenting with an infected abdominal wound, mild pain and constipation, following an uncomplicated laparoscopic hemicolectomy to remove a small primary colorectal cancer. Please administer and complete the documentation of their **12:00 hours** medications in a safe and professional manner.

- Talk to the person.
- Please verbalise what you are doing and why to the examiner.
- Read out the chart and explain what you are checking/giving/not giving and why.
- Provide an explanation to the person of what each drug being administered is for, and highlight any specific information regarding instructions for administration, including any possible contraindications and relevant medical information.
- Complete all the required drug administration checks.
- Complete the documentation and use the correct codes.
- The correct codes for non-administration are on the chart.
- Check and complete the last page of the chart.
-

You have **15 minutes** to complete this station, including all the required documentation.

Complete **all** sections of the document.

Assume it is **TODAY** and it is **12:00 hours**.

HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Potter **Forename(s):** Ash **Date of birth:** 01/01/1950 **Address**: Sweet Street Hostel, Westshire, WW6 5PQ **Hospital/~~NHS~~ number:** 0004321	**Height (m):** 1.57 **Weight (kg):** 74 **Body Mass Index (BMI) (m^2):** 25.6
Ward: Surgical Assessment Unit	**Consultant:** Dr A Richards
Date of admission: Today	**Time of admission:** 10:00

Number of prescription records	**Chart 1 ☑ 2 ☐ 3 ☐ of 1 ☑ 2 ☐ 3 ☐**

All prescribers MUST complete the signature record							
NAME	**GMC/NMC Number**	**Signature**	**Bleep**	**NAME**	**GMC/NMC Number**	**Signature**	**Bleep**
Dr P Wright	3214213	*Dr P Wright*	642				

Details of person administering medication: must be completed by ALL administering medication			
NAME	**Initials**	**Signature**	**Base**
SN Laura Beal	LB	*L Beal*	Surgical Assessment Unit

ALERTS: Allergies/sensitivities/adverse reaction					
Medicine(s)				**Effect(s)**	
IF NO KNOWN ALLERGIES TICK BOX			☑		
Signature:	*Dr P Wright*	**Bleep Number:**	*642*	**Date:**	TODAY
Allergy status MUST be completed and SIGNED by a prescriber/pharmacist/nurse BEFORE any medicines are administered.					

MEDICATION RISK FACTORS			
Pregnancy ☐	**Renal Impairment ☐**	**Impaired oral access ☐**	**Diabetes ☐**
Other high-risk conditions ☐–specify			
Patient self-medicating ☐			

HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Potter **Forename(s):** Ash **Date of birth:** 01/01/1950 **Address**: Sweet Street Hostel, Westshire, WW6 5PQ **Hospital/~~NHS~~ number:** 0004321	**Height (m):** 1.57 **Weight (kg):** 74 **Body Mass Index (BMI) (m^2):** 25.6
Ward: Surgical Assessment Unit	**Consultant:** Dr A Richards
Date of admission: Today	**Time of admission:** 10:00

Information for prescribers:	**Medicine non-administration/self-administration:**	
Write in BLOCK CAPITALS using black or blue ink. Sign and date and include bleep number.	If a dose is omitted for any reason, the nurse should enter the relevant code on the administration record and sign the entry.	
Record detail(s) of any allergies.	1.Medicine unavailable – INFORM DOCTOR OR PHARMACIST	2.Patient off ward
Sign and date allergies box. Tick box if no allergies know.	3.Self-administration	4.Unable to administer – INFORM DOCTOR (alternative route required?)
Different doses of the same medication must be prescribed on different lines.	5.Stat dose given	6.Prescription incorrect/unclear
Cancel by putting a line across the prescription and sign and date.	7.Patient refused	8.Nil by mouth (on doctor's instruction only)
Indicate the start and finish date.	9.Low pulse and/or low blood pressure	10.Other – state reason

ONCE-ONLY MEDICINES, PREMEDICATION, ANTIBIOTIC PROPHYLAXIS AND PATIENT GROUP DIRECTIONS

Check allergies/sensitivities and patient identity

Date	Drug	Dose	Route	Instructions	Time required	Prescriber's signature, print name & bleep number	Time given	Signature given	Pharmacy check

HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Potter **Forename(s):** Ash**Address**: Sweet Street Hostel, Westshire, WW6 5PQ **Date of birth:** 01/01/1950 **Address**: Sweet Street Hostel, Westshire, WW6 5PQ **Hospital/~~NHS~~ number:** 0004321	**Height (m):** 1.57 **Weight (kg):** 74 **Body Mass Index (BMI) (m^2):** 25.6
Ward: Surgical Assessment Unit	**Consultant:** Dr A Richards
Date of admission: Today	**Time of admission:** 10:00

PRESCRIBED OXYGEN

For most chronic conditions, oxygen should be prescribed to achieve a target saturation of 94-98% (or 88-92% for those at risk of hypercapnic respiratory failure i.e. CO_2 retainers).

Is the patient a known CO_2 retainer? Yes ☐ No ☑

Continuous oxygen therapy ☐ 'When required' oxygen therapy ☐ Target O_2 saturation 88-92% ☐ Target O_2 saturation 94-98% ☐ Other saturation range: _____ Saturation not indicated e.g. end-of-life care (state reason) _____ ☐	If oxygen is in progress, check and record flow rate (FR) during clinical observations.

Starting device and flow rate:		Administrator's name:	Print name:	Date	Time	FR/D
	Start date: Today					
Prescriber's signature:	Stop date:					
Print name:	Pharmacy check:					

Codes for starting device and modes of delivery			
Air not requiring oxygen or weaning or PRN oxygen	A	Humidified oxygen at 28% (add% for other flow rate)	H28
Nasal cannula	N	Reservoir mask	RM
Simple mask	M	Tracheostomy mask	TM
Venturi 24	V24	Venturi 35	V35
Venturi 28	V28	Venturi 40	V40
Venturi 60	V60	Patient on CPAP system	CP
Patient on NIV system	NIV	Other device (specify)	

HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Potter **Forename(s):** Ash **Date of birth:** 01/01/1950 **Address**: Sweet Street Hostel, Westshire, WW6 5PQ **Hospital/~~NHS~~ number:** 0004321	**Height (m):** 1.57 **Weight (kg):** 74 **Body Mass Index (BMI) (m^2):** 25.6
Ward: Surgical Assessment Unit	**Consultant:** Dr A Richards
Date of admission: Today	**Time of admission:** 10:00

ANTIMICROBIALS

Check allergies/sensitivities and patient identity

Review IV after 24-48 hours – Review oral after 5-7 days

1.Drug	FLUCLOXACILLIN				Signature of nurse administering medications, or code and signature if not administered.			
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**
Today	500mg	QD	PO	7 DAYS	06:00	X		*Siju Thomas*
Start date	TODAY	Indication/ Organism	Wound Infection		12.00			*Siju Thomas*
Finish date	+ 6 DAYS	Cultures sent?	Yes ✓ ~~No~~		18:00			*Siju Thomas*
					00.00			*Siju Thomas*
Prescriber's signature and bleep		*Dr P Wright 642*			Print name	Dr P Wright		

Check allergies/sensitivities and patient identity

2.Drug					Signature of nurse administering medications, or code and signature if not administered.			
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**
Today								
Start date		Indication/ Organism						
Finish date		Cultures sent?	Yes No					
Prescriber's signature and bleep					Print name			

Check allergies/sensitivities and patient identity

3.Drug					Signature of nurse administering medications, or code and signature if not administered.			
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**
Today								
Start date		Indication/ Organism						
Finish date		Cultures sent?	Yes No					
Prescriber's signature and bleep					Print name			

HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD

Surname: Potter **Forename(s):** Ash **Date of birth:** 01/01/1950 **Address**: Sweet Street Hostel, Westshire, WW6 5PQ **Hospital/~~NHS~~ number:** 0004321	**Height (m):** 1.57 **Weight (kg):** 74 **Body Mass Index (BMI) (m^2):** 25.6
Ward: Surgical Assessment Unit	**Consultant:** Dr A Richards
Date of admission: Today	**Time of admission:** 10:00

REGULAR MEDICINES

Check allergies/sensitivities and patient identity

1.Drug	RAMIPRIL				Signature of nurse administering medications, or code and signature if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**	**Notes**
Today	5mg	OD	PO	7 DAYS	08.00	X		*Siju Thomas*	New ☐
Start date	TODAY	Instructions/Indication	Secondary prevention and heart failure						Amended ☐
Finish date	+ 6 DAYS								Unchanged ☑
Prescriber's signature and bleep		*Dr P Wright 642*			Print name	Dr P Wright			Supply at home ☐

Check allergies/sensitivities and patient identity

2.Drug	DOCUSATE SODIUM				Signature of nurse administering medications, or code and signature if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**	**Notes**
Today	100mg	TD	PO	7 DAYS	06:00	X		*Siju Thomas*	New ☐
Start date	TODAY	Instructions/Indication	Constipation		12.00			*Siju Thomas*	Amended ☐
Finish date	+6 days				18:00			*Siju Thomas*	Unchanged ☑
Prescriber's signature and bleep		*Dr P Wright 642*			Print name	Dr P Wright			Supply at home ☐

Check allergies/sensitivities and patient identity

3.Drug	TIMOLOL MALEATE 0.5% Eye drops				Signature of nurse administering medications, or code and signature if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**	**Notes**
Today	1 drop in each eye	BD	Eye	7 DAYS	06.00	X		*Siju Thomas*	New ☐
Start date	TODAY	Instructions/Indication	Raised intra-ocular pressure						Amended ☐
Finish date	+6 days				18.00			*Siju Thomas*	Unchanged ☑

Prescriber's signature and bleep	*Dr P Wright 642*	Print name	Dr P Wright	Supply at home ☐

HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Potter **Forename(s):** Ash **Date of birth:** 01/01/1950 **Hospital/~~NHS~~ number:** 0004321	**Height (m):** 1.57 **Weight (kg):** 74 **Body Mass Index (BMI) (m^2):** 25.6
Ward: Surgical Assessment Unit	**Consultant:** Dr A Richards
Date of admission: Today	**Time of admission:** 10:00

'AS REQUIRED' MEDICINES									
Check allergies/sensitivities and patient identity									
1.Drug	PARACETAMOL				Signature of nurse administering medications, or code and signature if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**	**Notes**
Today	1g	4-6 HOURLY	PO					*Siju Thomas*	New ☑
Start date	TODAY	Instructions/Indication	Pain						Amended ☐
Finish date									Unchanged ☐
Prescriber's signature and bleep		*Dr P Wright 642*			Print name	Dr P Wright			Supply at home ☐

Check allergies/sensitivities and patient identity									
2.Drug					Signature of nurse administering medications, or code and signature if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**	**Notes**
Today									New ☐
Start date		Instructions/Indication							Amended ☐
Finish date									Unchanged ☐
Prescriber's signature and bleep					Print name				Supply at home ☐

Check allergies/sensitivities and patient identity									
3.Drug					Signature of nurse administering medications, or code and signature if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**	**Notes**
Today									New ☐
Start date		Instructions/Indication							Amended ☐
Finish date									Unchanged ☐

HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD					
Surname: Potter **Forename(s):** Ash	Prescriber's signature and bleep		**Height (m):** 1.57 **Weight (kg):** 74	Print name	Supply at home ☐
Date of birth: 01/01/1950 **Hospital/~~NHS~~ number:** 0004321			**Body Mass Index (BMI) (m^2):** 25.6		
Ward: Surgical Assessment Unit			**Consultant:** Dr A Richards		
Date of admission: Today			**Time of admission:** 10:00		

HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Potter **Forename(s):** Ash **Date of birth:** 01/01/1950 **Hospital/~~NHS~~ number:** 0004321	**Height (m):** 1.57 **Weight (kg):** 74 **Body Mass Index (BMI) (m^2):** 25.6
Ward: Surgical Assessment Unit	**Consultant:** Dr A Richards
Date of admission: Today	**Time of admission:** 10:00

INFUSIONS

Check allergies/sensitivities and patient identity

Bolus IV injections should be prescribed on the standard section of the drug chart. If no additive is to be used, enter 'nil' in the 'drug added' column.

Date	INFUSION FLUID			DRUG ADDED		Duration or rate	Prescriber's signature	Pharmacy check	Given by	Checked by	Start time	Stop time	Vol. given (ml)
	Name/Strength	Volume (ml)	Route (IV/SC)	Name	Dose								

Date	Time	Drug	Dose	Route	Instructions	Reason for omission or delay >2 hours	Signature	Pharmacy check

Evaluating
Post-operative care
Evaluation Station

Candidate paperwork and briefing

Candidate name: _____

- **This document must be completed using a GREEN PEN.**
- **At this station, you should have access to your assessment, planning and implementation documentation. If not, please alert the examiner.**

Scenario
Ash Potter was admitted to the surgical assessment unit after presenting with an infected abdominal wound, mild pain and constipation following a laparoscopic hemicolectomy. Ash has received analgesia, antibiotics and laxatives. However, he continues to feel hot, tired and unwell. Ash's most recent observations were: • Temperature: 38.4ºC • Pulse: 92bpm • Respirations: 20bpm • Oxygen saturations: 96% on air • Blood pressure: 108/59 mmHg • Level of consciousness: AlertNEWS score = 3

This is a verbally assessed station. You will have the opportunity to make notes to support your answer.

Using the situation, background, assessment and recommendation (SBAR) tool, please verbally handover your patient information to the nurse on the night shift (the examiner). You may make notes on the SBAR form, but they will not be assessed by the examiner.

You have **8 minutes** in total to make notes on the SBAR form (this is not assessed) and to complete the **verbal handover** to the examiner.

Assume it is **TODAY** and it is **14:00 hours**.

Evaluating
Post-operative care

Candidate notes

This documentation is for your use and is not marked by the examiners.

Patient details: Name: Ash Potter Hospital number0004321 Address: Sweet Street Hostel, Westshire, WW6 5PQ Date of birth: 01/01/1950
Situation:
Background:
Assessment:
Recommendation:

Mock clinical skills

The mock clinical skills assessment below is made up of two paired stations. The instructions and available resources are provided for each station, along with the specific timing.

Station	You will be given the following resources
Female urinary catheter insertion – 8 minutes You will insert the urinary catheter according to current evidence-based practice.	• Overview documentation (page 34)
Stoma bag change – 8 minutes You will change a stoma bag according to current evidence-based practice.	• Overview documentation (page 35)

On the following pages, we have outlined the expected standard of clinical performance and criteria. These marking matrices are there to guide you on the level of knowledge, skills and attitude we expect you to demonstrate at each station.

Marking criteria – Female urinary catheter insertion
Explains the procedure to the patient and gains consent.
Assembles equipment required and checks equipment is sterile. Takes the equipment to the person's bedside on trolley.
Ensures that the patient is in a supine position with knees bent, hips flexed and feet apart.
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
Dons a disposable plastic apron.
Using an aseptic non-touch technique, opens the sterile pack and places the rest of the sterile equipment onto the sterile field.
Dons sterile gloves. Places a sterile towel under the patient's buttocks.
Uses non-dominant hand to separate labia and uses gauze swabs soaked in sodium chloride 0.9% to clean the urethral orifice using downward strokes, being careful not to touch surrounding skin.
Applies anaesthetic lubrication to the meatus and gently inserts nozzle of anaesthetic syringe into urethra, and then instils gel into the urethra.
Places the catheter, in the sterile receiver, between the patient's legs and attaches the drainage bag.
Uses dominant hand to introduce the tip of the catheter into the urethral orifice in an upward and backward direction. Advances the catheter until urine is draining and up to the bifurcation point (junction of the catheter/balloon inflation tubing).
Cautiously inflates the catheter balloon with prefilled syringe containing water for injection, noting any pain or discomfort.
Gently withdraws the catheter slightly, until resistance is felt.
Assists in cleaning the patient and disposing of equipment.
Supports the catheter using a specially designed support (such as Simpla G-Strap), ensuring that the catheter lumen is not occluded by the fixation device. Ensures drainage bag is supported and secure, with the drainage port away from the floor.
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
States would document the reasons for catheterisation, time and date of catheterisation, catheter type, length and size, batch number and manufacturer.
States would measure and record urine output.

Mock clinical skills

Acts professionally throughout procedure in accordance with NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’.

Marking criteria – Stoma bag change
Introduces self. Explains procedure to the person and gains consent.
Ensures that the patient is in a comfortable and suitable position where they are able to watch the procedure.
Checks all equipment required for the procedure, including expiry dates: new colostomy bag, a disposable bag, gauze, scissors and a receptacle are needed.
Cleans hands with alcohol rub or washes with soap and water and dries with paper towels according to the WHO guidelines.
Dons a disposable plastic apron and non-sterile gloves.
Places a small protective disposable pad below the stoma area to protect patient's clothes from accidental spillage.
Removes the stoma bag slowly using adhesive remover. Peels the adhesive off the skin while using the opposite hand to apply pressure on the surrounding skin.
Folds the removed stoma bag to prevent spillage before placing into a disposable bag.
Removes any visible faeces or mucus from the stoma with a piece of gauze soaked in warm tap water.
Examines the stoma site and peristomal skin for soreness, ulceration, signs of infection and other unusual signs such as unusual site colour (black or pale), foul odour or discharge.
Washes the skin around the stoma (peristomal area) with gauze soaked in warm tap water.
Gently dries the peristomal skin with dry gauze, ensuring that the area is thoroughly dry.
Measures the stoma site, cuts a hole in the adhesive flange of the new bag, aiming for 3mm larger than the site.
Applies the clean appliance, using the flat of hand to gently press to ensure it adheres in all areas.
Disposes of equipment including apron and gloves appropriately – verbalisation accepted.
Cleans hands with alcohol rub or washes with soap and water and dries with paper towels according to the WHO guidelines.
States would document the change of stoma bag in nursing notes and would report any abnormalities to the stoma nurse and/or surgical team.

Mock clinical skills

Acts professionally throughout procedure in accordance with NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’.

Overview
Female urinary catheter insertion

Scenario
You are working on the surgical admissions unit. You are caring for Catherine Higgins, who has been diagnosed with obstruction of the bowel, and the doctor has requested the insertion of a urinary catheter for fluid monitoring. **Please insert the urinary catheter according to current evidence-based practice**. All identification checks have been completed and the patient has no known allergies. The trolley has been cleaned. The patient is lying in bed, with their lower clothing removed, is covered with a towel and has an absorbent pad underneath them.

All the equipment you need is provided.

You are not required to document anything during this skills station.

You have **8 minutes** to complete this station.

Overview
Stoma bag change

Scenario
You are working on a post-operative surgical ward. You are caring for Kendi Abara, who has undergone a right hemicolectomy and colostomy formation. They are 3 days post surgery, the one-piece stoma bag needs to be replaced, and Kendi is currently not well enough to do this themselves. All identification checks have been completed, and the patient has no known allergies. The trolley has already been cleaned prior to the procedure.

Please change the patient's stoma bag and speak to your patient throughout the procedure.

All the equipment you need is provided.

You are not required to document anything during this skill station, but if necessary, verbalise to the examiner what would be documented or reported.

You have **8 minutes** to complete this station.

Assume it is **TODAY** and it is **12:00 hours**.

Mock silent stations

You will also be required to undertake two silent stations. In each OSCE, one station will specifically assess professional issues associated with professional accountability and related skills around communication (called the professional values and behaviours station, or the PV station). One station will also specifically assess your critical appraisal of research and evidence and associated decision-making (called the evidence-based practice station, or EBP station).

The instructions and available resources are provided for each station, along with the specific timing.

Station	You will be given the following resources
Professional values and behaviours **Drug misuse – 10 minutes** You will read the scenario and summarise the actions that you would take, considering the professional, ethical and legal implications of this situation.	• Overview documentation (pages 38–39)
Evidence-based practice **Sleep in intensive care – 10 minutes** You will read the scenario and summary of the research, then write up how you would apply the findings to the scenario.	• Overview documentation (pages 40–41)

On the following pages, we have outlined the expected standards of clinical performance and criteria. These marking matrices are there to guide you on the level of knowledge, skills and attitude we expect you to demonstrate at each station.

Professional values & behaviours marking criteria – Drug misuse
Recognises that taking NHS/hospital property for personal use or gain, including medication, is prohibited.
Recognises professional duty to report any concerns that may result in compromising the safety of patients in their care or the public, and that failure to report concerns may bring their own fitness to practise into question and place own registration at risk.
Raises concern with manager at the earliest opportunity, verbally or in writing. Recognises the need to be clear, honest and objective about the reasons for concern, reflecting duty of candour.
Recognises that the manager may wish an incident report to be completed, recording the events, steps taken to deal with the matter including the date, and with whom the concern was raised.
Takes into consideration own responsibility for the safety of the colleague, and considers the effects of codeine on their ability to work and drive home.
Considers that the colleague may need a medical review for their headache or may need support in dealing with a substance misuse problem.
Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety and promote professionalism and trust.
Handwriting is clear and legible.

Evidence-based practice marking criteria – Sleep in intensive care
Summarises the main findings from the article summary and draws conclusions, making recommendations for practice.
Writes clearly and legibly.
Informs Mrs Green that it is very common for patients to experience sleep deprivation in ICU.
Explains that the disturbances in sleep may continue for several months after discharge.
Explains that the nature of a patient's illness, previous sleep experience and severity of illness may influence sleep pattern.
Informs Mrs Green that noise, light, pain, anxiety, nursing interventions, diagnostic tests, medications and non-invasive ventilation may have impacted her sleep.
Discusses with Mrs Green any feelings of pain or anxiety that may have impacted her sleep. Invites Mrs Green back in 2 or 3 months' time for follow-up support.

Mock silent stations

Professional values and behaviours: Drug misuse

Overview

Scenario
You are just about to commence the lunchtime drug round. You enter the clinical room and one of your nursing colleagues is in the room already. You witness the nurse take a 30 milligram codeine phosphate tablet from the drug cupboard. She puts it in her mouth and swallows it in front of you. You ask if she is okay, and she tells you that she needs the tablet for a headache. As far as you are aware, this is an isolated incident.

Using your knowledge of NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates', consider the professional, ethical and legal implications of this situation.

Please summarise the actions you would take in a number of bullet points.

This is a silent written station. Please write clearly and legibly.

You have 10 minutes to complete this station.

Mock silent stations

Professional values and behaviours: Drug misuse

Candidate documentation

Candidate name:_____

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Mock silent stations

Evidence-based practice: Sleep in intensive care

Overview

Read the scenario and the summary of the research below.

Please identify the main points from the summary and apply the findings to the scenario below.

This is a silent written station. Please write clearly and legibly.

You have 10 minutes to complete this station.

Scenario
You have been working on an intensive care unit (ICU) for the past 6 months. Most of your patients are given medication to induce a coma while they receive care and treatment. As patients improve and are weaned off the sedation, you notice that it is common for patients to report that they have not slept for the whole time they have been on the unit. The patient you are looking after today, Mrs Green, reports this same lack of sleep. She asks if is this common and, if so, why it might be.
Article summary
A systematic review in a well-regarded peer-reviewed journal investigated the sleep disturbances in patients in intensive care units. The review found that: • Study A, a large-scale study, showed that 60% of patients discharged from ICU reported sleep disorders and deprivations. • Study B, a smaller study, found similar results, with 51% of patients experiencing dreams and nightmares, and 14% reporting nightmares negatively impacting their quality of life 6 months after discharge from ICU. The study recommended that patients return for a follow-up support appointment 2 to 3 months after leaving ICU. • Study C, a quantitative study, concluded that the inability to obtain physiological sleep depends on the patient's illness, previous sleep experience and the varying severity of their illness. • Patients in Study C reported a number of sleep-disturbing factors impacting their sleep, including: noise, light, pain, anxiety, nursing interventions, diagnostic tests, medications and non-invasive ventilation. The review concluded that sleep disorders in ICU were common and that there were multiple influencing factors causing sleep deprivation.

Candidate documentation

Candidate name: _____

What is the relevance of the findings of this research for Mrs Green, and what advice would you give her?

Give your responses here as bullet points:

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