AlphaPlus

NMC Nursing & Midwifery Council | Test of Competence

Test of competence 2021: Mock OSCE Nursing associates

Mock OSCE

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

- Three of the stations are linked together around a scenario about the 'provision and monitoring of care', with one station for each of Assessment, Implementation and Evaluation (AIE), delivered in that sequence and with no stations in between.
- Five stations will take the form of either standalone or linked stations, testing practical clinical skills. Each standalone station will last up to 8 minutes, with each pairing of skills stations lasting up to 16 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 AIE, one pair of linked clinical skills, one PV and one EBP station.

The Nursing and Midwifery Council's 'The 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. It is critical that you familiarise yourself with this document.

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, which are available 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 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.

Preserve safety	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 that 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 AIE
Post-operative return to the ward

The mock AIE below is made up of three stations: assessment, 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, which is strictly kept.

Scenario
Following an abdominal hysterectomy, Anne has returned from theatre to the surgical ward under your care.

You will be asked to complete the following activities to provide high-quality, individualised care for the patient, as would be expected of a registered nursing associate, providing an assessment of needs, using a model of nursing that is based on the activities of living. All three 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 10–12) • National early warning score (NEWS2) (page 13–14) • Universal pain assessment tool (page 15) • A fluid-balance chart (page 16)
Implementation – 15 minutes You will administer medications while continuously assessing the individual's current health status.	• An overview and medicines administration record (MAR) to be completed (pages 17–23).
Evaluation – 8 minutes You will document the care that has been provided so that you can do a verbal handover to your colleague (the examiner).	• Documents from the previous three stations • An overview and a blank situation, background, assessment and recommendation (SBAR) tool to be completed (pages 24–25)

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.

Mock AIE
Post-operative return to the ward

Marking criteria for Post-operative return to the ward – Assessment station
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.
Checks ID with person (person's name is essential and either their date of birth or hospital number) verbally, against wristband (where appropriate) and documentation.
Checks for allergies verbally and on wristband (where appropriate).
Gains consent and explains reason for the assessment.
Uses a calm voice, speech is clear, body language is open, and personal space is appropriate.
Conducts an A to E assessment **(please refer to the examiner guidance for specific scenarios)** – verbalisation accepted:
Airway: • clear • no visual obstructions.
Breathing: • respiratory rate • rhythm • depth • oxygen saturation level • respiratory noises (rattle, wheeze, stridor, coughing) • unequal air entry • visual signs of respiratory distress (use of accessory respiratory muscles, sweating, cyanosis, 'see-saw' breathing).
Circulation: • heart rate • rhythm • strength • blood pressure • capillary refill • pallor and perfusion.
Disability: • conscious level using ACVPU • presence of pain • urine output • blood glucose.
Exposure: • takes and records temperature • asks for the presence of bleeds, rashes, injuries and/or bruises • obtains a medical history.
Accurately measures and documents the patient's vital signs.

Accurately uses specific assessment tools: pain chart, fluid balance.
Calculates national early warning score accurately.
Repeats vital signs observations.
Accurately completes document: signs, dates and adds time to assessment charts.
Disposes of equipment appropriately – verbalisation accepted.
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives, and nursing associates'.

Mock AIE
Post-operative return to the ward

Marking criteria for Post-operative return to the ward – Implementation station
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, 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 (checks 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.
Considers contraindication where relevant and medical information prior to administration (prompt permitted). (This may not be relevant in all scenarios.)
Provides a correct explanation of what each drug being administered is for to the person in their care – prompt permitted.
Administers drugs due for administration correctly and safely.
Omits drugs not to be administered and provides verbal rationale (ask candidate reason for non-administration if not verbalised).
Accurately documents drug administration and non-administration.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives, and nursing associates'.

Mock AIE
Post-operative return to the ward

Marking criteria for Post-operative return to the ward – Evaluation station
Introduces self and the clinical setting.
States the patient's name, hospital number and/or date of birth, and location.
State the reason for the handover (where relevant).
States date of admission/visit/reasons for initial admission/referral to specialist team and diagnosis.
Notes previous medical history and relevant medication/social history.
Gives details of current events, detailing findings from assessment.
States most recent observations, any results from assessments undertaken, and what changes have occurred.
Identifies main nursing needs.
States nursing and medical interventions completed.
States areas of concerns.
States what is required of the person taking the handover.
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 return to the ward

Candidate briefing

You are a registered nursing associate working on a surgical ward at Brunel Hospital. A patient has been returned to the ward post-operatively.

Please conduct an assessment of the patient. As part of this, please complete an **A to E assessment** (airway, breathing, circulation, disability, exposure), **record the patient's vital signs** (blood pressure, temperature, pulse rate, oxygen saturations, respiratory rate), and **maintain a fluid-balance chart and a national early warning score (NEWS).**

Repeat the physiological observations as per the post-operative notes, **undertake a pain assessment and respond** to this appropriately, and **respond to the drop in oxygen saturation levels** as per the post-operative notes and the prescription chart.

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

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 within the station.

This document must be completed using a GREEN PEN.

You have **20 minutes** to complete this station, **including the completion of the following documentation: physiological measurements x 2, fluid-balance chart, national early warning score, and pain assessment.**

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

Assessment
Post-operative return to the ward

Overview of recent history

Patient information

Name: Anne Thomas
Date of birth: 01/01/1956
Address: 1 Sweet Street, Westshire, WW6 5PQ (own home)
GP: Dr Biswaz, The Plains Surgery, Westshire.
Consultant: Mr Beckett

Presenting complaint

- Post-operative – abdominal hysterectomy
- Nausea
- Patient-controlled analgesia (PCA) (will run out during shift)
- Urinary catheter
- Intravenous infusion
- Oxygen saturation levels – 90% on air.

Past medical history

- Uterine fibroids – diagnosed 2020.

Social history

- Has lived in a detached house for more than 30 years (own home)
- Lives with husband and two dogs
- Generally fit and active, a keen walker, attends a local gym, and enjoys swimming three times a week
- Smoking – never
- Alcohol – wine most days with evening meal.

Drug history

- Takes paracetamol for uterine pain – 1 gram four times a day (QDS) as required (PRN).

Allergies

- Shellfish (anaphylaxis).

Assessment
Post-operative return to the ward

Candidate notes

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

Name: Anne Thomas NHS number: 000654321 Date of birth: 01/01/1956 Address: 1 Sweet Street, Westshire, WW6 5PQ
Airway
Breathing
Circulation
Disability
Exposure – full clinical history

Assessment
Post-operative return to the ward

Chart 1: National early warning score (NEWS)

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	

National early warning score (NEWS2) ©Royal College of Physicians 2017

NEWS thresholds and triggers

NEW score	Clinical risk	Response
Aggregate score 0–4	**Low**	**Ward-based response**
Red score Score of 3 in any individual parameter	**Low–medium**	**Urgent ward-based response***
Aggregate score 5–6	**Medium**	**Key threshold for urgent response***
Aggregate score 7 or more	**High**	**Urgent or emergency response****

* Response by a clinician or team with competence in the assessment and treatment of acutely ill patients and in recognising when the escalation of care to a critical care team is appropriate.

**The response team must also include staff with critical care skills, including airway management.

NEWS key	FULL NAME: Anne Thomas	
0 1 2 3	DATE OF BIRTH: 01/01/1956	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											3			Alert
		Confusion														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

National Early Warning Score 2 (NEWS2) © Royal College of Physicians 2017

Assessment
Post-operative return to the ward

Chart 2: Universal pain assessment tool

Universal pain assessment tool

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0–10 scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.

	0	1	2	3	4	5	6	7	8	9	10
Verbal descriptor scale	No pain		Mild pain		Moderate pain		Moderate pain		Severe pain		Worst pain possible
Wong-Baker facial grimace scale	Alert smiling		No humor serious flat		Furrowed brow pursed lips breath holding		Wrinkled nose raised upper lips rapid breathing		Slow blink open mouth		Eyes closed moaning crying
Activity tolerance scale	No pain		Can be ignored		Interferes with tasks		Interferes with concentration		Interferes with basic needs		Bedrest required

Assessment
Post-operative return to the ward

Chart 3: Fluid-balance chart

NAME:	Anne Thomas
DATE:	TODAY

HOSPITAL NUMBER:	000654321

TIME	INPUT							OUTPUT					
	ORAL	ENTERAL	PARENTERAL			HOUR TOTAL	TOTAL INPUT	URINE	GASTRIC LOSSES	BOWELS	DRAINS	HOUR TOTAL	TOTAL OUTPUT
0800	0	0	1000	0	0	1000	1000	200	0	0	0	200	200
0900	0	0	500	0	0	500	1500	50	0	0	0	0	250
1000													
1100													
1200													
1300													
1400													
1500													
1600													
1700													
1800													
1900													
2000													
2100													
2200													
2300													
0000													
0100													
0200													
0300													
0400													
0500													
0600													
0700													

PRINT NAME OF NURSE COMPLETING THE FLUID BALANCE CHART:

TOTAL BALANCE:

SIGNATURE OF NURSE COMPLETING THE FLUID BALANCE CHART:

(NEGATIVE/POSITIVE):

Implementation
Post-operative return to the ward

Candidate paperwork and briefing

Candidate name: _____

This document must be completed using a BLACK PEN.

Scenario
Following an abdominal hysterectomy, Anne has returned from theatre to the surgical ward under your care. On handover, you are advised that Anne has: • nausea • a patient-controlled analgesia (PCA) pump (which will run out during the shift) • a urinary catheter • an intravenous infusion (IVI) • oxygen saturation levels at 90% on air. Please proceed to administer and complete the documentation for the 14:00 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.
- 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 that it is **TODAY** and that it is **13:50 hours**

HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Thomas **Forename(s):** Anne **Date of birth:** 01/01/1956 **Hospital/~~NHS~~ number:** 000654321	**Height (m):** 160 cm **Weight (kg):** 55 kg **Body mass index (BMI):** 21.4
Ward: Surgical ward	**Consultant:** Mr Beckett
Date of admission: Today	**Time of admission:** 08:30

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 LINDA WALKER	258852	*Dr L Walker*	654				

Details of person administering medication: must be completed by ALL administering medication			
NAME	**Initials**	**Signature**	**Base**

ALERTS: Allergies/sensitivities/adverse reaction					
Medicine(s)/Substances				**Effect(s)**	
SHELLFISH				ANAPHYLAXIS	
IF NO KNOWN ALLERGIES TICK BOX					
Signature:	*Dr L Walker*	**Bleep number:**	654	**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: Thomas **Forename(s):** Anne **Date of birth:** 01/01/1956 **Hospital/~~NHS~~ number:** 654321	**Height (m):** 160 cm **Weight (kg):** 55 kg **Body mass index (BMI):** 21.4
Ward: Surgical ward	**Consultant:** Mr Beckett
Date of admission: Today	**Time of admission:** 08:30

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 and date 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 in nursing notes including action taken

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

Check allergies/sensitivities and patient identity

Date	Time	Drug	Dose	Route	Instructions	Prescriber's signature, print name & bleep number	Time given	Signature given	Pharmacy check
Today	08:00	Patient-controlled analgesia (PCA) Morphine sulphate 50 mg in 50 ml sodium chloride 0.9%	1mg	IV	PCA set up in recovery (separate PCA chart – *not available to candidates*).	*DR L WALKER* Dr L Walker 654	10:19	*P. Corfield*	*Anne Jones*

HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Thomas **Forename(s):** Anne **Date of birth:** 01/01/1956 **Hospital/~~NHS~~ number:** 000654321	**Height (m):** 160 cm **Weight (kg):** 55 kg **Body mass index (BMI):** 21.4
Ward: Surgical ward	**Consultant:** Mr Beckett
Date of admission: Today	**Time of admission:** 08:30

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) _____ ☐		Check and record O_2 saturation levels as directed by Surgical team		
Starting device and flow rate: N (nasal cannulae)	Start date: Today	Date Today	Time 10.00	FR/D 4L/min/N
Prescriber's signature: *Dr L Walker*	Stop date: Today			
Print name: Dr Linda Walker	Pharmacy check: A Jones			

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 cannulae	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: Thomas **Forename(s):** Anne **Date of birth:** 01/01/1956 **Hospital/~~NHS~~ number:** 000654321	**Height (m):** 160 cm **Weight (kg):** 55 kg **Body mass index (BMI):** 21.4
Ward: Surgical ward	**Consultant:** Mr Beckett
Date of admission: Today	**Time of admission:** 08:30

ANTIMICROBIALS								
Check allergies/sensitivities and patient identity								
Review IV after 24-48 hours – Review oral after 5-7 days								
1.Drug					Date and signature of nurse administering medications and code 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								
2.Drug					Date and signature of nurse administering medications and code 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					Date and signature of nurse administering medications and code 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: Thomas **Forename(s):** Anne **Date of birth:** 01/01/1956 **Hospital/~~NHS~~ number:** 000654321	**Height (m):** 160 cm **Weight (kg):** 55 kg **Body mass index (BMI):** 21.4
Ward: Surgical ward	**Consultant:** Mr Beckett
Date of admission: Today	**Time of admission:** 08:30

REGULAR MEDICINES

Check allergies/sensitivities and patient identity

1.Drug	Enoxaparin				Date and signature of nurse administering medications and code if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**	**Notes**
Today	40mg	OD	S/C	Throughout hospital admission	18:00			*Anne Jones*	New ☑
Start date	Today	Instructions /indication	VTE risk factors						Amended ☐
Finish date									Unchanged ☐
Prescriber's signature and bleep		*DR L WALKER*			Print name	Dr L WALKER			Supply at home ☐

Check allergies/sensitivities and patient identity

2.Drug	Paracetamol				Date and signature of nurse administering medications and code if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**	**Notes**
Today	1g	QDS	Oral	Throughout hospital admission	08:00 14:00 18:00 22:00			*Anne Jones Anne Jones*	New ☐
Start date	Today	Instructions / indication	Post-operative pain control						Amended ☐
Finish date									Unchanged ☐
Prescriber's signature and bleep		*DR L WALKER*			Print name	Dr L WALKER			Supply at home ☐

Check allergies/sensitivities and patient identity

3.Drug					Date and signature of nurse administering medications and code 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 ☐

HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Thomas **Forename(s):** Anne **Date of birth:** 01/01/1956 **Hospital/~~NHS~~ number:** 000654321	**Height (m):** 160 cm **Weight (kg):** 55 kg **Body mass index (BMI):** 21.4
Ward: Surgical ward	**Consultant:** Mr Beckett
Date of admission: Today	**Time of admission:** 08:30

AS-REQUIRED MEDICINES									
Check allergies/sensitivities and patient identity									
1.Drug	METOCLOPRAMIDE HYDROCHLORIDE				Date and signature of nurse administering medications and code if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Today**	**Tomorrow**	**Pharmacy check**	**Notes**
Today	10 mg	TDS	PO					*Anne Jones*	New ☑
Start date	Today	Instructions/ indication	Post-operative nausea						Amended ☐
Finish date									Unchanged ☐
Prescriber's signature and bleep		*DR L WALKER*			Print name	Dr L WALKER			Supply at home ☐

Check allergies/sensitivities and patient identity									
2.Drug					Date and signature of nurse administering medications and code 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 ☐

OMITTED DOSES OF MEDICINE CODED 10 (OTHER) AND DELAYED DOSES								
Check allergies/sensitivities and patient identity								
Date	**Time**	**Drug**	**Dose**	**Route**	**Instructions**	**Reason for omission 10/delay >2hrs**	**Signature given**	**Pharmacy check**

Evaluating care
Post-operative return to the ward

Candidate paperwork and briefing

Candidate name: _____

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

Scenario
You are a registered nursing associate working on a surgical ward at Brunel Hospital. You have been caring for Anne Thomas following her abdominal hysterectomy. The surgical team has returned to review the patient, and you need to give an update on the current position and any required interventions. The most recent observations were: • Temperature: 36.9°C • Pulse: 72 beats per minute • Respirations: 16 breaths per minute • Oxygen saturations: 98% on oxygen • Blood pressure: 142/72 mmHg. The patient is comfortable in all aspects of care.

Using the situation, background, assessment and recommendation (SBAR) tool, please make notes regarding your patient and use them to hand information over verbally to your colleague (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. You will be informed when there are **2 minutes** remaining.

Assume that it is **TODAY** and that it is **13:30 hours**.

Evaluating care
Post-operative return to the ward

Candidate notes

These are for your use and are not marked by the examiners.

Patient details: Name: Anne Thomas NHS number: 000654321 Address: 1 Sweet Street, Westshire, WW6 5PQ Date of birth: 01/01/1956
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
Blood glucose monitoring – **8 minutes** You will perform a capillary blood glucose test on a patient who has lower-limb cellulitis.	• Overview and documentation (pages 30–31)
Physiological observations – **8 minutes** You will take and record vital signs and calculate a national early warning score for a patient admitted for a breast biopsy.	• Overview and documentation (page 32–34)

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 – Blood glucose monitoring station
Assembles the equipment required and checks that the strips are in date and have not been exposed to air.
Explains the procedure to the person. Gains consent.
Cleans own hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
Dons a disposable plastic apron and non-sterile gloves.
Checks that the patient's hands are visibly clean.
Takes a single-use lancet and takes a blood sample from the side of the finger, ensuring that the site of the piercing is rotated. Avoids use of index finger and thumb.
Gives the patient a piece of gauze to stop the bleeding.
Ensures that all sharps and non-sharp waste are disposed of safely (including scooping method of re-sheathing, if used, and transportation of sharps) and in accordance with locally approved procedures.
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
Verbalises whether the result is within normal limits and indicates whether any action is required.
Documents the result accurately, clearly and legibly.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Marking criteria – Physiological observations station
Introduces self, explains procedure to the person, and gains consent.
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
Blood pressure: • assesses whether the patient has any contraindications to using a particular arm, such as lymphoedema, trauma or surgery, intravenous infusion • provides a relaxed and comfortable environment • ensures that the cuff is the correct size for the arm • ensures that the patient's arm is free from clothing and is supported on a pillow, placed mid-sternal level, legs are uncrossed, feet are flat on the floor, artery marking centred over the brachial artery and superior to the elbow • places the lower edge of the cuff 2cm to 3cm above the brachial artery pulsation • asks the patient to stop talking during the procedure • inflates cuff on the Dinamap.
Pulse: • places the first and second finger along the appropriate artery • applies light pressure until pulse is felt • counts pulse for 60 seconds • assesses rhythm – verbalisation accepted • assesses strength – verbalisation accepted.
Respirations and pulse oximetry: • counts respiratory rate for 60 seconds • assesses rhythm – verbalisation accepted • assesses depth – verbalisation accepted • observes for respiratory noises (rattle, wheeze, stridor, coughing) • observes for unequal air entry • observes for visual signs of respiratory distress (use of accessory respiratory muscles, sweating, cyanosis, 'see-saw' breathing) • determines the site to be used to perform the pulse oximetry (warmth and capillary refill) • ensures that the area is clean and that all nail polish and artificial nails have been removed.
Temperature: • inspects the ear canal • checks the thermometer for damage • verifies mode setting (ear) • places disposable probe covering on probe tip • aligns the probe tip with the ear canal and gently advances into the ear canal, ensuring a snug fit

• presses and releases the scan button.
Accurately measures and documents the patient's vital signs, completes documentation – signs, dates and adds time.
Calculates national early warning score accurately.
Disposes of equipment appropriately – verbalisation accepted.
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Mock clinical skills
Blood glucose monitoring

Overview

Scenario
You are a registered nursing associate working on a medical ward. Ally King was admitted 4 days ago with lower-limb cellulitis to the left leg. Ally has a history of uncontrolled type 2 diabetes with episodes of hyperglycaemia, although it is now stable. Ally requires pre-meal blood glucose monitoring. Ally usually manages the diabetes and performs their own blood glucose monitoring at home, but they are currently unable to do this. All identification checks have been completed. Your patient has just washed their hands.

Please perform a capillary blood glucose test on your patient, adhering to infection-prevention procedures throughout.

Please verbalise your choice of testing site and speak to your patient throughout. Please document the result on the page provided and explain the result and any further action to the patient.

All the equipment you need is provided and has already been calibrated.

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

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

Mock clinical skills
Blood glucose monitoring

Candidate name: _____

Patient details:	**Pre-meal**			**Post meal**		
	Date & time	Blood glucose level mmol/L	Name & signature	Date & time	Blood glucose level mmol/L	Name & signature
Ally King 1 Sweet Street Westshire WW6 5PQ Date of birth: 01/01/1969 Hospital number: 000654321 Allergies: None GP: Dr Biswaz						

Mock clinical skills
Physiological observations

Overview

Scenario
You are working in the breast clinic. Sunita Lee has been admitted for a breast biopsy. As part of the admission process, you will need to take and record the patient's vital signs and calculate a national early warning score. All identification checks have been completed.

Please take and record the patient's vital signs (blood pressure, temperature, pulse rate, oxygen saturations, respiratory rate) and calculate a national early warning score (NEWS).

Please speak to your patient throughout. Please document your results on the NEWS observation form, calculate the score and complete the form in full.

All the equipment you need is provided and has already been cleaned and calibrated.

An observation chart has been provided.

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

Assume that it is **TODAY** and that it is **07:45 hours.**

Mock clinical skills
Physiological observations

Chart 1: National early warning score (NEWS)

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	

National early warning score (NEWS2) ©Royal College of Physicians 2017

NEWS thresholds and triggers

NEW score	Clinical risk	Response
Aggregate score 0–4	**Low**	**Ward-based response**
Red score **Score of 3 in any individual parameter**	**Low–medium**	**Urgent ward-based response***
Aggregate score 5–6	**Medium**	**Key threshold for urgent response***
Aggregate score 7 or more	**High**	**Urgent or emergency response****

* Response by a clinician or team with competence in the assessment and treatment of acutely ill patients and in recognising when the escalation of care to a critical care team is appropriate.

**The response team must also include staff with critical care skills, including airway management.

NEWS key

0 | 1 | 2 | 3

FULL NAME:

DATE OF BIRTH: | **DATE OF ADMISSION**

Parameter	Range	Score	Range (right side)
	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 (%)	≥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
Use Scale 2 if target range is 88–92%, eg in hypercapnic respiratory failure	88–92		88–92
	86–87	1	86–87
†ONLY use Scale 2 under the direction of a qualified clinician	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	3	71–80
	61–70	3	61–70
	51–60	3	51–60
	≤50	3	≤50
C Pulse Beats/min	≥131	3	≥131
	121–130	2	121–130
	111–120	2	111–120
	101–110	1	101–110
	91–100	1	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	3	≤30
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert		Alert
	Confusion	3	Confusion
	V	3	V
	P	3	P
	U	3	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

National Early Warning Score 2 (NEWS2) © Royal College of Physicians 2017

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 and documentation (pages 37–38)
Evidence-based practice **Cranberry juice and UTIs – 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 and documentation (pages 39–40)

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.

Mock silent stations

Marking criteria for Professional values and behaviours – Drug misuse station
Recognises that taking NHS/hospital property for personal use or gain, including medication, is prohibited.
Recognises the 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 their 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 their 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.

Marking criteria for Evidence-based practice – Cranberry juice and UTIs station
Summarises the main findings of the article summary and draws conclusion, making recommendations for practice.
Writes clearly and legibly.
Explains to Freda that there is some research that shows that cranberry juice may prevent a urinary-tract infection (UTI) occurring if drunk regularly in healthy individuals.
Considers that cranberry juice may be less likely to induce nausea than other sugary drinks when taken regularly.
Informs Freda that there is no available evidence that cranberry juice may prevent UTIs in individuals who have high-risk conditions or those who have indwelling catheters as people in these groups were not included in the study.
Explains to Freda that there is no available evidence to suggest that cranberry juice can be used to treat a UTI in place of antibiotics.
Informs Freda that it is necessary to note that the research was funded by a leading cranberry juice manufacturer, indicating a potential conflict of interest.

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 30mg tablet of codeine phosphate from the drug cupboard. She puts it in her mouth and swallows it in front of you. You ask whether 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 that 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
Cranberry juice and UTIs

Overview

Scenario
You are working on a urology ward, looking after Freda Garcia, who has developed a urinary tract infection (UTI) following surgery 2 days ago. She has a temperature of 37.8°C and a heart rate of 92 beats per minute. She has been reviewed by the medical team, and a course of oral antibiotics has been prescribed and commenced. During your comfort round, Freda asks whether you would recommend drinking cranberry juice to help with the UTI. Please prepare a response.
Article summary
A randomised, double-blind, placebo-controlled, multi-centre clinical trial in a well-regarded, peer-reviewed journal compared the preventative effects of cranberry juice and antibiotics on UTIs. • A total of 373 healthy women were recruited into the trial who had previously been diagnosed with two or more UTIs within the past year. • Participants were randomly assigned. The participant group (n = 185) was asked to consume one serving (240 ml) of cranberry juice daily, and the placebo group (n = 188) was asked to consume the same volume of a flavoured sugary drink daily over a period of 24 weeks. Any participant with a current UTI or actively taking antibiotics was excluded from the study. • UTI episodes were reported by 39 participants in the cranberry group and 67 in the placebo group. • Women who developed a UTI during the study were still given an antibiotic. • At 2 months, nausea was the only significant adverse effect commonly reported in the placebo group compared with those in the participant group (5.9% of participants in the placebo group versus 1.6% of participants in the cranberry group). • Overall, the results estimated that cranberry juice would prevent one symptomatic UTI per three women per year. • The study excluded those who needed to take a preventative antibiotic, had an indwelling catheter and/or had other high-risk conditions, such as diabetes, cancer, polycystic disease, interstitial cystitis, previous urologic surgery, stones, anatomical abnormalities, spinal cord injury, were immunocompromised, had severe renal impairment, multiple sclerosis or were pregnant. • This large-scale study was funded by a leading cranberry juice manufacturer.

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

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

You have **10 minutes** to complete this station.

Mock silent stations
Evidence-based practice
Cranberry juice and UTIs

Candidate documentation

Candidate name: _____

What is the relevance of the findings of this article for Freda, and what advice would you give?

Give your responses here as bullet points: