Mock Scenario
Endoscopy

We have developed this scenario to provide an outline of the performance we expect and the criteria that the test of competence will assess.

The Code outlines the professional standards of practice and behaviour which sets 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 attributes. They have been designed to be applied across all fields of nursing practice, irrespective of the clinical setting and 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 only applies to this mock scenario. 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 and Criteria
Promote professionalism	Behaves in a professional manner respecting others and adopting non-discriminatory behaviour. Demonstrates professionalism through practice. Upholds the patient's dignity and privacy.
Prioritise people	Introduces self to the patient at every contact.
	Actively listens to the patients and provides information and clarity.
	Treats each patient as an individual showing compassion and care during all interactions. Displays compassion, empathy and concern. Takes an interest in the patient.
	Respects and upholds people's human rights. Upholds respect by valuing the patient's opinions and being sensitive to feelings and/or appreciating any differences in culture.
	Checks that patient is comfortable, respecting the patient's dignity and privacy.
Infection prevention and control	Adopts infection control procedures to prevent healthcare-associated Infections at every patient contact.
	Applies appropriate Personal Protective Equipment (PPE) as indicated by the nursing procedure in accordance with the guidelines to prevent healthcare associated infections.
	Disposes of waste correctly and safely.
Care, compassion and communication	Seeks patient's permission/consent to carry out observations/procedures at every patient contact.
	Checks patient identity correctly both verbally, and/or with identification bracelet and the respective documentation at every patient contact.
	Uses a range of verbal and nonverbal communication methods. Displays good verbal communication skills by appropriate language use, some listening skills, paraphrasing, and appropriate use of tone, volume and inflection. Good non-verbal communication including elements relating to position (height and patient distance), eye contact and appropriate touch if necessary.

Practice effectively	Maintains the knowledge and skills needed for safe and effective practice in all areas of clinical practice.
Organisational aspects of care specific to specific skills	Ensures people's physical, social and psychological needs are assessed.
	Completes physiological observations accurately and safely for the required time using the correct technique and equipment.
	Ensures any information or advice given is evidence based including using any healthcare products or services.
Documentation	Documents all nursing procedures accurately and in full, including signature, date and time.
	Writes patient's full name and hospital number clearly so that it can be easily read by others.
	Records the date, month and year of all observations.
	Charts all observations accurately.
	Scores out all errors with a single line. Additions are dated, timed and signed.
	Writes the record in ink.
Preserve safety	Supplies, dispenses or administers medicines within the limits of training, competence, the law, the NMC and other relevant policies, guidance and regulations.
Medicine management	

The Mock OSCE is made up of four stations: assessment, planning, implementation and evaluation. Each station will last approximately fifteen minutes and is scenario based. The instructions and available resources are provided for each station, along with the specific timing.

Scenario

Mia Khatar has been admitted to the Endoscopy Unit for investigations into Oesophageal Reflux and Dyspepsia. Today, she will have a planned Endoscopic Investigation.

You will be asked to complete the following activities to provide high quality, individualised nursing care for the patient, providing an assessment of her 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 – **15 minutes** You will collect, organise and document information about the patient.	• A partially completed inpatient admission document (pages 1-11) • Assessment overview and documentation (pages 12-13)
Planning – **15 minutes** You will complete the planning template to establish how the care needs of the patient will be met, how these are prioritised and what evidence-based nursing care you'll provide.	• A partially completed nursing care plan for two nursing care and self-care needs (pages 14-17) • A blank National Early Warning score chart 2 (NEWS2) (page 25)
Implementation – 15 minutes You will administer medications while continuously assessing the individual's current health status.	• An overview and Medication Administration Record (MAR) (pages 18-22)
Evaluation – 15 minutes You will document the care that has been provided so that this is communicated with other healthcare professionals, provide a record of clinical actions completed, disseminate information and demonstrate the order of events relating to individual care.	• An overview and transfer of care letter for admission to a discharge lounge (pages 23-25) • A blank National Early Warning score chart 2 (NEWS2) (page 26-27)

On the following page, we have outlined the expected standard of clinical performance and criteria. This marking matrix is there to guide you on the level of knowledge, skills and attitude we expect you to demonstrate at each station.

Assessment Criteria
Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels.
May verbalise or make environment safe.
Introduce self to person.
Check ID with person; verbally, against wristband (where appropriate) and paperwork.
Gain consent.
Sit / stand at an appropriate level and explain the reason for assessment.
Establish reason for admission.
Document and provide a score using assessment tool.
Measures and documents observations accurately.
May identify risks associated with person's symptoms.
Use Activities of Living model effectively with clear relevant questioning in a timely manner.
Identify known allergies.
Deal with health education sensitively.
Verbal communication is clear and appropriate.
Close assessment appropriately and may check findings with person.

Planning Criteria
Handwriting is clear and legible for problems one and two.
Identify two relevant nursing problems/needs.
Identify aims for both problems and add appropriate evaluation frequency.
Ensure nursing interventions are current/relate to evidence based practice/best practice.
Self- care opportunities identified and relevant.

Professional terminology used in care planning.
Confusing abbreviations avoided.
Ensure strike-through errors retain legibility.
Print, sign and date.

Implementation Criteria
Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels.
Introduce self to person.
Seek consent prior to administering medication.
Check ID with person; verbally, against wristband (where appropriate) and paperwork.
May refer to previous assessment results.
Must check allergies on chart and confirm with the person in their care, also note red wristband where appropriate.
Before administering any prescribed drug, look at the person's prescription chart and check the following: Correct: Person Drug Dose Date and time of administration Route and method of administration
Ensures: Validity of prescription Signature of prescriber The prescription is legible
Identify and administer drugs due for administration correctly and safely.
Check the integrity of the medication to be administered; dose and expiry date.
Provide a correct explanation of what each drug being administered is for to the person in their care.
Omit drugs not to be administered and provides verbal rationale.

Accurately record drug administration and non-administration.

Evaluation Criteria
Clearly describe reason for initial admission and diagnosis.
Record date of admission.
Identify main nursing needs.
Record approaches and interventions used.
Outline current ability to self-care based on the person’s care plan.
Identify areas for health education.
Documents allergies.
Ensure strike-through errors retain legibility.
Print, sign and date.

Appendices
Endoscopy

Test of Competence NHS Trust

Adult Inpatient Admission/Discharge Form and Trust Core Patient Activities of Living Initial Assessment

Hospital Number 0145692498

MIA KHATAR
FEMALE
25/02/1975
41 ALMOND CLOSE,
TATTERELL, LL12 TBU

Ward: DRAYTON UNIT

Type of admission

Accident and Emergency ☐ Clinic ☐

General Practitioner (GP) ☐ Other ☒

Date of admission: TODAY Time: 08:00

Estimated date of discharge:

Consultant: MR ADAIR

Named nurse: JOCELYN TOBIAS

Reason for admission:

ELECTIVE ADMISSION - INVESTIGATIONS

Diagnosis/operation:

OESOPHAGEAL REFLUX / INVESTIGATIONS

Previous medical history:

NO PREVIOUS MEDICAL HISTORY

Single assessment document Yes ☐ No ☐

Preferred name: MIA

Age: 43 Status: MARRIED

Religion: Ethnic origin:

Does the patient agree to their name/information being written on whiteboards in wards Yes ☐ No ☒

Is the above address your permanent residence? Yes ☒ No ☐

Have you been a resident in the UK for 12 months? Yes ☒ No ☐
If NO, complete NGV 1398 Notification of overseas visitors.

Next of kin

Name: MR MARCUS KHATAR

Relationship: HUSBAND

Address: 41 ALMOND CLOSE, TATTERELL

Post Code: LL12 TBU

Telephone Numbers Home: 01457278648

Work: N/A Mobile: N/A

Does the patient agree to next of kin being notified of admission and condition? Yes ☒ No ☐

Notified: Yes ☒ No ☐

If NO, reason:

Name and Contact number for night time:

MARCUS KHATAR - 01457278648

VALUABLES Yes ☐ No ☒

Hospital Policy explained ☐

House keys ☐ Glasses ☐ Hearing Aid ☐

Dentures ☐ Contact lenses ☐

Property details:

General office ☐ Home ☐ Retained by patient ☐

N.B. Refer to disclaimer on page 2.

Medication Brought in Yes ☒ No ☐

If YES Retained on ward ☒ Sent home ☐

Patient Orientation Checklist – Nursing Staff to Complete

All items in this checklist must be discussed with the patient on admission and on internal transfer.

	Please tick when discussed
Patient Orientation Checklist discussed with patient	☒
Introductions made – Introduce yourself by full name to the patient	☒
Name of ward – Advise the patient of the name of the ward that they have been admitted to and what sort of ward it is	☒
Ward facilities – Either show the patient around the ward or advise where the toilet/bathroom facilities/day rooms/visitors lounge etc are located on the ward	☒
Call bell devices – Explain to the patient how the call bell device works and when to use it	☒
Drinks/snacks – Advise the patient how to get snacks/drinks in between meals should they want them	☒
Personal belongings – Advise the patient where to store personal belongings and for security reasons, not to store anything of value here. Anything of value is to be stored as per Trust Policy (member of staff to advise)	☒
Visitor information – Advise the patient of visiting times, car parking for visitors and temporary permit provisions if appropriate	☒
Patient information leaflet given	☒
Patient's comments (if any):	
Patient Safety information leaflet – NGV1467 given	☐

Sign and PRINT your name below to confirm that you have discussed this checklist with the patient

Signature:	*Jocelyn Tobias*		**PRINT name:**	JOCELYN TOBIAS	
Designation:	RN	**Ward:**	DRAYTON UNIT	**Date:**	TODAY

DISCLAIMER

I hereby indemnify the Test of Competence NHS Trust against any loss or damage to property/monies that I do not wish to be held in safe custody on my behalf by the hospital.

Signature of patient: *Mia Khatar*

Name (block capitals): MIA KHATAR

Date: TODAY

On Admission

Allergies (include medicines, latex, food, other): NO KNOWN ALLERGIES	State reaction experienced: NONE	
1. Do you have a reaction to latex/rubber products?	Yes ☐ No ☒	Go to question 2 (no allergy) Go to question 3
2. What kind of reaction do you have?		
Localised eczema on skin in contact with rubber **only**	Yes ☐	(Type 4)
and/or:	No ☐	(no allergy)
Hives	Yes ☐	No ☐
Wheezing	Yes ☐	No ☐
Difficulty breathing	Yes ☐	No ☐
Swelling of lips/tongue/throat	Yes ☐	No ☐
Collapse	Yes ☐	No ☐
Other (please describe)		
3. Do you have a rash, itching, swelling or hives after contact with rubber products such as household gloves or balloons? **If YES, go back to question 2.**	Yes ☐	No ☒

Allergy identified, inform medical staff, anaesthetist as appropriate

No allergy ☒ Type 4 allergy ☐ Type 1 allergy ☐

Making Every Contact Count – Nursing Admission Questions

1. **Smoking**

Does the patient smoke? Yes ☒ No ☐

No – No further action

Yes – Offer a 'TIME for a QUIT Chat' brief advice intervention and recommend a referral to the NHS Stop Smoking Service.
Complete a TIME for a QUIT Chat Referral form NGV1547 or via the referral form on the ICE System

Combustibles Sent home ☒ Locked away ☐

Date of referral: **Signature:**

2. **Alcohol Harm Reduction**	Scoring system					Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	☐ never	☐ monthly or less	☐ 2-4 times per month	☒ 2-3 times per week	☐ 4+ times per week	3
How many unites of alcohol do you drink on a typical day when you are drinking?	☐ 1-2	☐ 3-4	☐ 5-6	☐ 7-9	☒ 10	4
How often have you had 6 or more units if female or 8 or more if male, on a single occasion in the last year?	☐ never	☐ less than monthly	☐ monthly	☒ weekly	☐ daily or almost daily	3
					TOTAL	10

A score of **0-7** indicates *lower risk drinking*

A score of **8-15** indicates *increasing risk drinking* – Give the patient a copy of Patient Information Healthy Lifestyles Leaflet NGV1577

A score of **16-20+** refer to the Alcohol Liaison Nurse

Date of Referral:		**Signature:**	

Social history

Do you live alone ☐ With others ☒ Who HUSBAND

Do you have any dependents Yes ☐ No ☒

If yes, who is caring for them

Type of accommodation and how long at this address

House ☒ Flat ☐ Floor Eg. 1 2 3 Lift Yes ☐ No ☐ Bungalow ☐

Mobile home ☐ Other Warden controlled accommodation ☐

Contact number:

Nursing home ☐ Residential home ☐ Name and address:

Access to home

What is the access to the property – specify how many steps, slope etc: FLAT ACCESS

How many toilets are there in the property and where are they located: 1 UPSTAIRS, 1 DOWNSTAIRS

Type of heating: Central heating ☒ Electric ☐ Gas ☐ Wood/coal ☐

Where is the bathroom located (indicate floor):

Where do you sleep: Upstairs ☒ Downstairs ☐

What equipment do you have at home: Grab rails ☐ Where are these situated:

Zimmer frame ☐ Rota stand ☐ Stair lift ☐ Hoist ☐

Pressure relieving mattress ☐ Pressure relieving cushion ☐

Other (please specifiy):

Do you have dependent others or pets that will require support whilst you are in hospital Yes ☐ No ☒

Specify:

PRINT name:	JOCELYN TOBIAS	**Signature:**	*Jocelyn Tobias*

Designation:	RN	**Date:**	TODAY	**Time:**	08:00

Pre-admission services NOT APPLICABLE

Social worker name and contact number:

Care package: Monday Tuesday Wednesday Thursday Friday Saturday Sunday

How many times:

Care package includes:

- ☐ Community nurse/specialist nurse
- ☐ Physiotherapist
- ☐ Occupational Therapy
- ☐ Health visitor
- ☐ Psychiatric nurse
- ☐ Warden
- ☐ Life Line/Vitalink/Other
- ☐ Pet system
- ☐ Key safe

Age Concern	☐Monday	☐Tuesday	☐Wednesday	☐Thursday	☐Friday	☐Saturday	☐Sunday
Voluntary	☐Monday	☐Tuesday	☐Wednesday	☐Thursday	☐Friday	☐Saturday	☐Sunday
Meals on wheels	☐Monday	☐Tuesday	☐Wednesday	☐Thursday	☐Friday	☐Saturday	☐Sunday
Day Hospital	☐Monday	☐Tuesday	☐Wednesday	☐Thursday	☐Friday	☐Saturday	☐Sunday
Day Centre	☐Monday	☐Tuesday	☐Wednesday	☐Thursday	☐Friday	☐Saturday	☐Sunday

Interagency Community Team

Other please specify:

Informal care arrangements

Are there any friends/neighbours/family providing help Yes ☐ No ☐

Please specify:

Are they happy to continue this Patient Yes ☐ No ☐ Carer Yes ☐ No ☐

Personal tasks Who does the following:

	Self	Others	Identify		Self	Others	Identify
Cooking	☐	☐		Cleaning	☐	☐	
Laundry	☐	☐		Ironing	☐	☐	
Hygiene needs	☐	☐		Medication	☐	☐	
Shopping	☐	☐		Finances	☐	☐	

Is a continuing healthcare assessment required Yes ☐ No ☐

If yes, contact social work department

Trust Core Patient Activities of Living – Initial Assessment

Test of Competence NHS Trust applies The Roper, Logan and Tierney model of nursing which is a model of care based upon activities of living. These activities are mainly used on admission as a basis to assess and compare how life has changed due to illness or injury resulting in admission to hospital and to plan appropriate nursing care following assessment.

All inpatients require these assessment tools to be completed on admission to the hospital as indicated following Activities of Living Assessment.

A. Trust Fall Assessment tool – within 12 hours
B. Trust Patient Handling Assessment Tool – within 12 hours
C. Trust Pressure Prevention Assessment Tool – within 6 hours
D. Trust Nutritional Screening Assessment Tool – within 24 hours
E. Trust Pain Assessment Tool – on admission

Signature:	Jocelyn Tobias	**Time:**	08:00	**Date:**	TODAY
PRINT name/stamp:	JOCELYN TOBIAS				

To be completed in full by admitting nurse

Activities of Living Assessments

1a. **Maintaining a safe environment (prompts)**

a. Orientation to place	Yes ☒	No ☐	d. History of confusion	Yes ☐	No ☒
b. Orientation to time	Yes ☒	No ☐	e. Have you fallen recently	Yes ☐	No ☒
c. Orientation to ward and bed area given	Yes ☒	No ☐	f. Appears rational	Yes ☒	No ☐

Additional information: If YES to d, e or f, complete Trust Falls Care Plan page 11

1b. **Is the VTE Risk Assessment complete** Yes ☒ No ☐

If Yes
- Commence appropriate prescribed treatment
- Refer to AES core care plan NGV1459

If No
- Escalate to medical staff

1c. **Dementia and carers of patients with dementia**

Has the patient a diagnosis of dementia?

Yes: ☐

- Utilise Butterfly magnet
- Complete Butterfly patient profile
- Give the patient carer 'Information for Carers of patients with dementia' leaflet NGV1581
- Does the carer want to be involved in the patient's care whilst in hospital? Refer to Carer's policy
- Does the carer require further support? If yes, contact Carer Assessment and Support Worker (CASW)

No: ☒

- Does the patient have signs of delirium or cognitive impairment?

If yes, Utilise 'Online Butterfly' magnet

2a. **Communication (prompts)**

Blind	Yes ☐	No ☒	Partially sighted	Yes ☐	No ☒
Glasses	Yes ☐	No ☒	Contact lenses	Yes ☒	No ☐
Glasses/lenses with patient	Yes ☐	No ☒			

Additional Information:

N.B. Are there any learning disability concerns Yes ☐ No ☒

If YES, commence Learning Disabilities Passport NGV1516

If YES, contact the Learning Disability Nurse, ext 554321 (Monday – Friday) 09:00 – 17:00 or on call duty nurse

Community hospitals ring: 01234 567 899

N.B. Are there any safeguarding/mental capacity concerns Yes ☐ No ☒

Is a Mental Capacity Assessment required Yes ☐ No ☒

If YES, contact Safeguarding Lead, bleep 54321 (Monday – Friday) 09:00 – 17:00 or on call duty nurse

Community hospitals ring: 01234 567 899

2b. **Hearing**

Deaf	Yes ☐	No ☒	Partially deaf	Yes ☐	No ☒
Lip reader	Yes ☐	No ☒	Sign language	Yes ☐	No ☒
Hearing aid with patient	Yes ☐	No ☒	Does hearing work	Yes ☐	No ☐

If NO, record action taken:

(Consider use of Piticom Booklet)

Additional information:

2c. **Speech and language (prompts)**

Understands English	Yes ☒	No ☐	Speaks English	Yes ☒	No ☐
Translator required	Yes ☐	No ☒			

First language spoken if not English:

(Consider use of Piticom Booklet)

Additional information:

e.g. patient aphasic or suffers from dysphasia

3. **Mobility (prompts) Complete Trust Pressure Prevention Assessment Tool page 17**

Complete Patient Handling Assessment page 14

Independently mobilise Yes ☒ No ☐ Assistance/supervision required Yes ☐ No ☒

Identify aids used:

Additional information:

4. **Eating and Drinking (prompts) Complete Trust Nutritional Screening Assessment Tool page 25**

Able to swallow	Yes ☒	No ☐	Difficulty swallowing	Yes ☒	No ☐
Wears dentures	Yes ☐	No ☒	Dentures	Yes ☐	No ☒
Top set	Yes ☐	No ☒	Bottom set	Yes ☐	No ☒
Special diet required	Yes ☒	No ☐			

If YES, identify: HALAL

Information required regarding - healthy eating Yes ☐ No ☒

- weight management Yes ☐ No ☒

If yes, refer to nutritional team

Referral date: **Signature:**

Additional information:

5. **Personal hygiene and dressing (prompts) Complete Trust Oral Care Assessment Tool NGV1465**

Independent Yes ☒ No ☐ Requires assistance Yes ☐ No ☒

Additional information:

6. **Elimination (prompts)**

a. Urine

Do you have to go to the bathroom during the night	Yes ☐	No ☒
Do you suffer from frequency of passing urine	Yes ☐	No ☒
Do you have any concerns regarding passing urine	Yes ☐	No ☒
Do you have a long term catheter	Yes ☐	No ☒

Additional information:

All patients must have a full urinalysis taken and documented below / or attach urometer print out. Any abnormalities detected must be reported to medical staff immediately.

Date	Specific Gravity	Urine pH	Leucocytes	Nitrate	Protein
	Glucose	**Ketones**	**Urobilinogen**	**Bilirubin**	**Blood Erythrocytes**

b. **Bowels (prompts)**

Normal habit:

Stoma present — Yes ☐ No ☒

Have you noticed any change in your bowel habits i.e.

- Blood in stools — Yes ☐ No ☒
- Diarrhoea — Yes ☐ No ☒
- Constipation — Yes ☐ No ☒
- Other

If YES to any of the above, commence Diarrhoea Trust Care Plan NGV1106

Additional information:

7. **Breathing**

Asthma — Yes ☐ No ☒

Breathlessness — Yes ☐ No ☒

Chronic obstructive airway disease — Yes ☐ No ☒

Smoker — Yes ☒ No ☐

Other long term breathing problems:

Identify inhalers (if used):

Additional information:

8. **Sleeping (prompts)**

Usual sleeping habits:

Takes night sedation — Yes ☐ No ☒ — If YES, identify medication

Sleep interrupted — Yes ☒ No ☐ — If YES, by what e.g. requires the bathroom

If YES, what helps: ANTACID MEDICATION, SLEEPING UPRIGHT (2-3 PILLOWS), AVOIDING CERTAIN FOODS

Additional information:

9. **Expressing sexuality (prompts). Be aware of privacy and dignity requirements, cultural and religious beliefs.**

Altered body image e.g. prosthesis, hair loss, stoma — Yes ☐ No ☒

Requires further discussion — Yes ☐ No ☒ If YES, who with:

Additional information:

Date of Referral: **Signature:**

10. **Death and dying**

Visit required from religious/spiritual personnel — Yes ☐ No ☒

If YES, what arrangements have been made:

Additional information:

If appropriate:

- **Has DNACPR status been considered** — Yes ☐ No ☒
- Has the patient been identified as requiring end of life care — Yes ☐ No ☒
- If YES, have relatives/carers been informed/consulted — Yes ☐ No ☐
- Has a chosen place of death or care been identified — Yes ☐ No ☐

IF YES, where:

Does the patient hold any beliefs that require burial within 24 hours of death — Yes ☐ No ☐

Additional information:

11. **Pain – Complete Pain Assessment page 27 or if appropriate, then Trust Pain Assessment Tool and Core Care Plan for Patients with Learning Disabilities (Adult) and Patients who have Dementia or Cognitive Impairment NGV1545**

Do you take regular analgesia — Yes ☒ No ☐

Are they effective — Yes ☐ No ☒

Are you in pain — Yes ☒ No ☐

Is analgesia prescribed — Yes ☐ No ☒

Additional information (note alternative methods of pain relief)

12. **Working and playing**

How do you spend your days (work) DENTAL RECEPTIONIST (hobbies/leisure)

Do you undertake any physical activity? Yes ☐ No ☐

If YES, what are they:

Is there anything about your stay in hospital that is of concern Yes ☐ No ☐

If YES, what are they:

Actions taken:

Name of nurse assessing:	JOCELYN TOBIAS	**PRINT name:**	JOCELYN TOBIAS	**Date:**	TODAY

Candidate's Name: _____

Note to Candidate:

- Complete a Nursing Assessment of the person.
- An observation chart is provided and must be completed within the station.

Scenario
Ms Mia Khatar has been admitted for investigations for **Oesophageal Reflux** and **Dyspepsia**. Mia has a planned endoscopy today. Please proceed with your nursing assessment including taking and recording vital signs; blood pressure, temperature, pulse rate, respiratory rate, saturation levels and calculating a **National Early Warning Score 2 (NEWS2)**. Focus on the following **TWO** Activities of Living to help you plan the nursing care in the next station: • **Anxiety pending procedure** • **Maintaining a safe environment**

Assume it is TODAY and it is 08:00. Ms Mia Khatar has just arrived.

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

Assessment Candidate Documentation
Endoscopy

Nursing Assessment Candidate Notes
Mia Khatar, 0145692498
41 Almond Close, Tatterell, LL12 TBU
25/02/1975

Anxiety pending procedure
Maintaining a Safe Environment
Nutrition and Hydration
Breathing
Communication/Pain
Mobilising
Sleeping
Elimination

Candidate's Name: _____

Note to Candidate:

- Document to NMC standards
- Your examiner will retain all documentation at the end of the station

Scenario
Ms Mia Khatar has been admitted for investigations for **Oesophageal Reflux** and **Dyspepsia**. Mia has a planned endoscopy today. Based on your nursing assessment of Mia Khatar, please produce a nursing care plan for **2 relevant aspects of nursing care and self-care suitable for the next 24 hours.**

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

Assume it is TODAY and it is 09:30.

Patient Details: Mia Khatar, Hospital Number 0145692498 41 Almond Close, Tatterell, LL12 TBU DOB 25/02/1975
1) Nursing problem / need
Aim(s) of care:
Re-evaluation date:

Care provided by nurse(s)	**Patient self-care activities**

2) Nursing problem / need	
Aim(s) of care:	
Re-evaluation date:	
Care provided by nurse(s)	**Patient self-care activities**
NAME (Print):	
Nurse Signature:	**Date:**

This page is not a required element but for use in case of error.	
Nursing problem / need	
Aim(s) of care:	
Re-evaluation date:	
Care provided by nurse(s)	**Patient self-care activities**

Candidate's Name: _____

Note to Candidate:

- Talk to the person
- Please verbalise what you are doing and why
- 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 are on the chart and on the drug trolley
- Check and complete the last page of the chart
- You have 15 minutes to complete this station, including the required documentation
- Please proceed to administer and document their 16:00 medications in a safe and professional manner

Scenario
Ms Mia Khatar has now returned from the Endoscopy Suite and is in the recovery area. Please administer and document Mia's 16:00 medications in a safe and professional manner.

Complete **all** sections of the documentation.

Assume it is TODAY and it is 16:00

Prescription Chart for:	MIA KHATAR FEMALE	**HOSPITAL NUMBER:** **DATE OF BIRTH:** **ADDRESS:**	0145692498 25/02/1975 41 ALMOND CLOSE TATTERELL, LL12 TBU
ADMISSION DATE & TIME:	TODAY 07:00	**WARD:**	ENDOSCOPY UNIT

KNOWN ALLERGIES OR SENSITIVITIES		**TYPE OF REACTION**	
NONE KNOWN			
Signature:	Dr A.Kitridge	**Date:**	TODAY

INFORMATION FOR PRESCRIBERS:	**INFORMATION FOR NURSES ADMINISTERING MEDICATIONS:**	
USE BLOCK CAPITALS.	RECORD TIME, DATE AND SIGN WHEN MEDICATION IS ADMINISTERED OR OMITTED AND USE THE FOLLOWING CODES IF A MEDICATION IS NOT ADMINISTERED.	
SIGN AND DATE AND INCLUDE BLEEP NUMBER.		
SIGN AND DATE ALLERGIES BOX- IF NONE- WRITE "NONE KNOWN".	**1. PATIENT NOT ON WARD.**	**6. ILLEGIBLE/INCOMPLETE PRESCRIPTION OR WRONGLY PRESCRIBED MEDICATION.**
RECORD DETAILS OF ALLERGY.	**2. OMITTED FOR A CLINICAL REASON**	**7.NIL BY MOUTH**
DIFFERENT DOSES OF THE SAME MEDICATION MUST BE PRESCRIBED ON SEPARATE LINES.	**3. MEDICINE IS NOT AVAILABLE.**	**8. NO IV ACCESS**
CANCEL BY PUTTING LINE ACROSS THE PRESCRIPTION AND SIGN AND DATE.	**4. PATIENT REFUSED MEDICATION.**	**9. OTHER REASON- PLEASE DOCUMENT**
INDICATE START AND FINISH DATE.	**5. NAUSEA OR VOMITING.**	

**** IF MEDICATIONS ARE NOT ADMINISTERED PLEASE DOCUMENT ON THE LAST PAGE OF THE DRUG CHART.***

Does the patient have any documented Allergies?	~~YES~~ **NO**	**Please check the chart before administering medications.**

WARD	**CONSULTANT**	**HEIGHT**	170 cm
MEDICAL	DR DANIELS	**WEIGHT**	65 kg
ANY Special Dietary requirements?	~~YES~~ **NO**	**If YES please specify**	

ONCE ONLY AND STAT DOSES:

Date	Time due	Drug name	Dose	Route	Prescribers signature & bleep	Given by	Checked by	Time given
TODAY	10:00	MIDAZOLAM	2 mg	IV	Dr P Smith, 3459	Karen Tang RN	Siju Thomas RN	10:00

Prescription Chart for:	MIA KHATAR FEMALE	HOSPITAL NUMBER: DATE OF BIRTH: ADDRESS:	0145692498 25/02/1975 41 ALMOND CLOSE TATTERELL, LL12 TBU
ADMISSION DATE & TIME:	TODAY 07:00	WARD:	ENDOSCOPY UNIT

PRESCRIBED OXYGEN THERAPY:								
Date	Time	Prescribers signature & bleep	Target oxygen saturation	Therapy instructions	Device	Flow	Time started & signature	Time discontinued & signature

PRN (AS REQUIRED MEDICATIONS):							
Date	Drug	Dose	Route	Instructions	Prescriber signature & bleep	Given by	Time given
TODAY	PARACETAMOL	1 g	PO	6 HOURLY PAIN	Dr P Smith, 3459		

ANTIMICROBIALS:							
1. DRUG						Date and signature of nurse administering medications. Code for non-administration.	
DATE	DOSE	FREQUENCY	ROUTE	DURATION	TIME	TODAY	TOMORROW
Start date							
Finish date							
Prescriber signature & bleep							

2. DRUG						Date and signature of nurse administering medications. Code for non-administration.	
DATE	DOSE	FREQUENCY	ROUTE	DURATION	TIME	TODAY	TOMORROW
Start date							
Finish date							
Prescriber signature & bleep							

3. DRUG						Date and signature of nurse administering medications. Code for non-administration.	
DATE	DOSE	FREQUENCY	ROUTE	DURATION	TIME	TODAY	TOMORROW
Start date							
Finish date							
Prescriber signature & bleep							

Prescription Chart for:	MIA KHATAR FEMALE	HOSPITAL NUMBER: DATE OF BIRTH: ADDRESS:	0145692498 25/02/1975 41 ALMOND CLOSE TATTERELL, LL12 TBU
ADMISSION DATE & TIME:	TODAY 07:00	WARD:	ENDOSCOPY UNIT

REGULAR MEDICATIONS:

1. DRUG	OMEPRAZOLE					Date and signature of nurse administering medications. Code for non-administration.	
DATE	DOSE	FREQUENCY	ROUTE	DURATION	TIME	TODAY	TOMORROW
TODAY	20 mg	ONCE DAILY	PO	1 DAY			
Start date	Today				16:00		
Finish date	Tomorrow						
Prescriber signature & bleep		Dr P Smith, 3459					

2. DRUG						Date and signature of nurse administering medications. Code for non-administration.	
DATE	DOSE	FREQUENCY	ROUTE	DURATION	TIME	TODAY	TOMORROW
Start date							
Finish date							
Prescriber signature & bleep							

3. DRUG						Date and signature of nurse administering medications. Code for non-administration.	
DATE	DOSE	FREQUENCY	ROUTE	DURATION	TIME	TODAY	TOMORROW
Start date							
Finish date							
Prescriber signature & bleep							

INTRAVENOUS FLUID THERAPY:

Date	Fluid	Volume	Rate/time	Prescriber signature & bleep	Batch number	Commenced @	Given by	Checked by	Finished @
TODAY	0.9% NORMAL SALINE	500 ml	250 ml / hour	Dr P Smith, 3459	099987	11.10	K Tang RN	S Cook RN	13:10

Prescription Chart for:	MIA KHATAR FEMALE	**HOSPITAL NUMBER:** **DATE OF BIRTH:** **ADDRESS:**	0145692498 25/02/1975 41 ALMOND CLOSE TATTERELL, LL12 TBU
ADMISSION DATE & TIME:	TODAY 07:00	**WARD:**	ENDOSCOPY UNIT

DRUGS NOT ADMINISTERED:				
DATE	**TIME**	**DRUG**	**REASON**	**NAME AND SIGNATURE**

Candidate's Name: _____

Note to Candidate:

- This document must be completed in **BLUE** pen
- At this station you should have access to your Assessment, Planning and Implementation documentation. If not, please ask the examiner for it
- Please note; there is a total of 3 pages to this document
- Document to NMC standards
- The examiner will retain all documentation at the end of the station

Scenario
Ms Mia Khatar has undergone their procedure and her post procedure recovery was uneventful. Mia has been diagnosed with a small peptic ulcer and is being transferred to the pre-discharge lounge prior to being discharged home later this evening. Complete a transfer of care letter to ensure that the receiving nurses have a full and accurate picture of Mia Khatar's history and needs.

Complete **all** sections of the documentation.

Assume it is TODAY and it is 17:30

Transfer of Care Letter

Patient Details: Mia Khatar, Hospital Number:0145692498 41 Almond Close, Tatterell, LL12 TBU DOB 25/02/1975
Clearly describe reason for initial admission and subsequent diagnosis.
Date of admission:
Identify the main nursing needs addressed during Ms Khatar's stay in Endoscopy Unit.
Outline the nursing care provided to meet the identified needs.

Outline Ms Khatar's current ability to self-care based on her care plan.
Document Ms Khatar's allergies and associated reactions
List areas identified for health education
Date and time of transfer:
NAME (Print):
Nurse Signature: **Date:**

NEWS key 0 1 2 3	FULL NAME		DATE OF BIRTH		DATE OF ADMISSION	
	DATE / TIME					DATE / 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	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

Chart 4: Clinical response to the NEWS trigger thresholds

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