Nursing Associate OSCE Top Tips

Contents

Introduction

This document is intended to provide additional preparation information to help Nursing Associate candidates prepare for the Test of Competence (Part 2). It should be read in conjunction with the OSCE Support Information, Candidate Information Booklet, Mock OSCE and with consideration to the reading advised. Remember scenario and skills stations will scan from children to care of the older person and could be in a variety or care settings. Each of the following will be included in the assessment process –

- Adult
- Children
- Learning Disabilities
- Mental Health

All stations – General examination tips

- Try not to be scripted – the assessors may ask you questions during the examination. This is to try to assess your knowledge or to ask for clarity.
- An OSCE is a demonstration of practice. However, it is helpful to verbalise what you are doing for aspects of practice that cannot be observed easily, e.g. checking expiry dates. You do not need to verbalise things that are easily observed, e.g. steps of hand hygiene.
- Listen and pay attention carefully when the examiner is introducing the station to you or you may miss some vital information.
- Read the instructions carefully as these will confirm what is required to be completed at the station.
- You have the opportunity to familiarise yourself with equipment in the reception area; please ask a member of the team if you need any help with equipment.
- It is preferable to eat before you attend your OSCE.
- Remember it is important to check the person's identity correctly where appropriate. You need to do this correctly by checking the person's details verbally and/or with the relevant identification band and against the corresponding documentation.
- Remember to complete the appropriate documentation in **all** required stations. Another member of the health care team must be able to continue care following your documentation.
- All clinical skills are assessed using the Royal Marsden procedures, except for In-Hospital Resuscitation which follows the UK Resuscitation Council guidelines
- The length of all assessment station times varies depending on the task you are required to undertake. Mostly the stations last 15 minutes but some are up to 20 minutes for example Aseptic Non-Touch Technique (17 minutes) and In-Hospital Resuscitation (10 minutes).
- You must wear appropriate attire for professional practice when attending for your OSCE.
- Please ensure you obtain consent, unless the station instructions/examiner informs you that this has already occurred.

- Always remember to maintain a person's dignity during any OSCE stations.
- When documenting, ensure accuracy and legibility. Also ensure you strike-through errors to retain eligibility.
- Try to stay calm as this will allow you to demonstrate your abilities to the examiner.

Scenario Stations

Ongoing Assessment

You will be given 5 minutes reading time before you go into this station. Use this time to familiarise yourself with the scenario and the person you will be caring for throughout the scenario. You will be faced with an actor in this station so ensure to communicate with them. The actor is well prepared and will provide you with information if you ask.

- Focus on the task you are being asked to do in this station. Make sure you complete the task as this is what you are being examined on
- Remember to complete hand hygiene before touching the 'patient'
- Take time to familiarise yourself and make sure you know how to complete, plot, calculate and chart the National Early Warning Score 2 (NEWS2), neurological observations including the Glasgow Coma Scale (GCS), Patient Health Questionnaire 9 (PHQ9), and vital signs on their relevant charts. Don't forget to follow the appropriate recommendations where applicable.
- Listen to what the person in your care is telling you and respond appropriately. It is important to demonstrate care and compassion.
- Do not turn off the vital signs monitor (e.g. Dinamap) until you have recorded your observations.
- When measuring heart rate and respiratory rate, make sure to take these for one full minute manually (e.g. radial pulse for heart rate).
- Ensure you document the observations correctly on the relevant chart you will be provided with
- Make sure you check ID in this station – remember this is your first contact with this patient.
- Gain consent for all interventions
- Listen to what the 'patient' says in this statin – there may be things you need to be aware.
- Make a note of the answers to the Activities of Living – these will be part of your exam
- Make sure you write your name on each document you complete

Implementing Care

In this station you will be administering medication. There is a mannequin in this station. The Assessor will speak as the patient so please remember to communicate throughout.

- Practice reading medication administration records (MAR) aloud and saying what you are thinking about for each section (for example, is this medication due today? Does the person have an allergy?)
- Try to develop a strategy to ensure you identify drugs that the patient is allergic to. If the patient has an allergy, remember what the allergy is and check if the patient is prescribed a medication containing that allergen. If so, you can code that medication prior to administering your medications.
- Use a systemic approach to checking the medication chart
- Check the time the patient last had analgesia. How long ago was it? What does that mean for this patient at this time? If it is too soon for them to have their analgesia what else would you do in practice?
- Provide a correct explanation of what each drug being administered is for.
- Ensure you know how to use the British National Formulary – a copy will be available in this station for you to use if you do not know what the drug prescribed is for.
- Ensure you check the 'patients' ID at the relevant points before you administer medication
- Before administering any prescribed drug, look at the person's prescription chart and check the following are correct:
    - Person
    - Drug
    - Dose
    - Date and time of administration
    - Route and method of administration
    - Diluent (as appropriate)
    - Validity of prescription
    - Signature of prescriber
    - Prescription is legible

  If any of these pieces of information are missing, are unclear or illegible then the nurse associate should not proceed with administration and should consult the prescriber.
- Do not sign the medication administration record until the examiner tells you the person has swallowed their medication.
- Practice completing the documentation appropriately and get feedback from your peers and trainers.
- Remember, you **will** have medications to administer in this station and so you need to make sure you can do this within the time given.
  If there are any medications you do not administer – you must note the code and the reason on the appropriate place on the medication chart – the codes are documented on the chart and can also be found on the Medication Trolley.

Ongoing Care

In this station you are required to complete an ongoing care document to give a full account of the 'patient's' history and ongoing care needs. On the front of the document will be a summary of the care, investigations and interventions that have occurred during the time indicated on the document. You are required to complete this document using the SBAR tool (Situation, Background, Assessment and Recommendations) to help you. You are then required to give a verbal handover to the Registered Nurse responsible for the ongoing care for this 'patient'.

- Ensure you read the front of the document properly – the investigations and interventions that are indicated may impact on the ongoing care for the 'patient'
- Consider the time – the scenario will go through a period of time and this station is the final station in this process
- Complete all sections of the document
- Make sure you deal with errors correctly and clearly
- Ensure you note a date of admission or appointment time from the Ongoing Assessment station
- Make sure your handwriting is legible
- Ensure you date and sign the document
- Be clear in your handover to the RN – you will have the document to hand so be sure to use it to help you.

Skills Stations

Aseptic Non-Touch Technique (ANTT)

- If you make a mistake or contaminate the sterile field verbalise what you did wrong and how you would address this in practice.
- Think before you touch anything – do you need to decontaminate your hands before proceeding? You need to understand the principles of ANTT so that if you make a mistake you can pick up from where you left off.
- Please remember that you are undertaking this skill as a **lone practitioner.**
- Check the integrity/sterility of all the equipment used in the procedure.
- Be aware of time during this station – you have 17 minutes to demonstrate using an ANTT approach to change the person's dressing and dispose of clinical waste.
- Ensure you perform hand hygiene at appropriate points during the procedure.
- Make sure you use Personal Protective Equipment (PPE).
- Practice your techniques – for example – glove technique and cleaning and drying the wound appropriately.

In-Hospital Resuscitation

You will not be expected to use the defibrillation in this station. The UK Resuscitation Council Guidelines is the recommended reading for this station.

- Practice your compressions rate, position and depth.
- Remember you cannot resuscitate a person if you are on your own. You need help so shout for a colleague if you find a person collapsed. Summon the emergency team if a cardiac arrest is confirmed.
- Ensure you practice performing the head-tilt chin-lift manoeuvre.
- Respond to examiner feedback regarding rate and depth.
- You will have up to **two minutes** to demonstrate competence. Your examiner may ask you to perform up to **six cycles** of compressions. This is to give you every opportunity to demonstrate your competence.
- The examiner will prompt you if you are not at the correct depth or rate – listen to this prompt and ensure you adapt your technique accordingly

Catheter Specimen of Urine (CSU)

- Ensure you demonstrate hand hygiene and use gloves to maintain infection control
- Wear appropriate Personal Protective Equipment prior to manipulating the catheter and throughout the procedure
- Don't forget to remove the clamp (if used)
- Use the sample port to take the specimen from
- Ensure you maintain infection control measures when transferring the sample into the specimen pot.
- Complete the documentation correctly

Removal of Urinary Catheter

- Ensure you demonstrate hand hygiene at appropriate points during this station
- Wear appropriate Personal Protective Equipment prior to manipulating the catheter and throughout the procedure.
- Make sure you remove the water from the balloon prior to removing the catheter.
- Make sure you dispose of the catheter promptly once you have removed the catheter in the appropriate clinical waste bin

Intra-muscular Injection (IMI)

- Practice this skill and understand the difference in technique between subcutaneous and intramuscular injections.
- Read the prescription carefully.
- Check the integrity/sterility of all the equipment used in the procedure.
- Ensure you record the administration correctly (sign, date).
- Use the most appropriate needle to draw up the medication.
- Demonstrate effective hand hygiene technique and use appropriate Personal Protective Equipment (PPE)
- Take a sharps bin with you to the patient, if you forget, put the sharps in the tray provided to transport to the patient.

Subcutaneous Injection

- Practice this skill and understand the difference in technique between subcutaneous and intramuscular injections.
- Read the prescription carefully.
- Take a sharps bin with you to the patient, if you forget, put the sharps in the tray provided to transport to the patient.
- Remember to administer insulin at a 45-degree angle.
- Ensure to check the person's identification appropriately.
- Make sure you demonstrate appropriate knowledge of the difference between intramuscular and subcutaneous injection.
- Candidates administered an incorrect dose of medication.
- Candidates did not demonstrate safe use of sharps.

Peak Expiratory Flow Rate (PEFR) and Nebuliser Administration

- Practice giving clear and concise instructions so that a person can understand what is being asked of them.
- Ensure you document correctly and accurately your three PEFR readings, including the **highest** of the three acceptable readings onto the nursing documentation – the documentation indicates what needs to be recorded.
- Ensure you read the prescription and administer the correct dose for the nebuliser.
- Documentation is essential in this station **–** complete this accurately
- You will only be expected to start the nebuliser in this station – you will not be expected to see the nebuliser completed.