**Test of Competence 2021:**

**Mock OSCE**

**Adult Nursing**

**EU Aptitude Test**

# Elective surgery

In your objective structured clinical examination (OSCE), four of the stations are linked together around a scenario: this is called the APIE, with one station for each of Assessment, Planning, Implementation and Evaluation, delivered in that sequence and with no stations in between.

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

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.

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 APIE. 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.

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

The mock APIE below is made up of four stations: assessment, planning, implementation and evaluation (A.P.I.E). 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.

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| **Scenario** |
| Leslie Roberts has been admitted for a laparoscopic cholecystectomy, planned for later this morning. |

You will be asked to complete the following activities to provide high-quality, individualised nursing care for the patient, providing an assessment of 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.

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| **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 11–15)
* A blank national early warning score chart (NEWS) (pages 16–18)
 |
| **Planning** – **14 minutes**You will complete the planning template to establish how two aspects of the patient’s care needs will be met. | * A partially completed nursing care plan for two nursing care problems or needs (pages 19–22)
 |
| **Implementation – 15 minutes**You will administer medications while continuously assessing the individual’s current health status. | * An overview and a medication administration record (MAR) (pages 23–28)
 |
| **Evaluation – 8 minutes**You will document the care that has been provided so that you can do a verbal handover to the nurse on the next shift (the examiner). | * Documents from the previous three stations
* A blank situation, background, assessment and recommendation (SBAR) tool (pages 29–30)
 |

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

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| **Assessment criteria** |
| Introduces self to person. |
| Explains the assessment process and confidentiality.  |
| Documents findings accurately, clearly and legibly. |
| Ask patient how they normally mobilise and how they mobilise with current condition, performs a short assessment by asking patient to walk unaided. |
| Asks patient what diet is normally like, as well as with recent illness. Highlighting obesity/diet changes/lifestyle changes. |
| Assessment of pain, how it is normally treated, what pharmacological/non-pharmacological methods are taken. Normal methods of communication – hearing aids etc. |
| Explores smoking history and breathlessness, pillows at night, breathless at restor on what level of exertion? |
| Explores normal sleeping patterns, and aids used, length of sleep, disruptions? |
| Discusses bowel and urinary habits, stool type, how often and difficulties. Issues passing urine, how often. |
| Highlights need to check or notes airway is patent. |
| Records accurate saturations and respiration rate, additionally noting any signs of effort, cyanosis, or noise. |
| Records manual pulse, blood pressure, specific note to pallor. |
| Assessment of consciousness, ACVPU, blood glucose. |
| Exposes abdomen, checks for distention, bruising, discoloration, jaundice of the skin. Checks for signs of peripheral oedema. |
| Calculates national early warning score accurately. |
| Writes name, date and signs documentation. |
| Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines. |
| Acts professionally throughout procedure in accordance with NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’. |

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| **Planning criteria** |
| Clearly and legibly handwrites answers. |
| Identifies two appropriate goals from the following: * pain management
* early mobilisation
* deep-vein thrombosis prevention
* wound management.
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| Aim: To give patient regular analgesia, pain scoring with observations/physiotherapy.Occupational therapy assessment to be mobile when comfortable/to ensure anticoagulation is prescribed, deep-vein thrombosis prevention, i.e. flow boots/stockings considered or implemented/wound assessment, dressing change if needed. |
| Sets appropriate re-evaluation date (24 hours). |
| All care is evidence based – up-to-date practice. |
| Uses professional terminology in care planning. |
| Does not use abbreviations or acronyms. |
| Ensures strike-through errors retain legibility. |
| Accurately prints, signs and dates. |
| Acts professionally throughout procedure in accordance with the NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’. |

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| **Implementation criteria** |
| Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines |
| Introduces self to person. |
| Ensures that the correct medication is prescribed – acknowledges medications on chart. |
| 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 (check ID with person, verbally, against wristband (where appropriate)
* paperwork
* drug
* dose
* date and time of administration
* route and method of administration.
 |
| Correctly checks **ALL** of the following*:*• validity of prescription• signature of prescriber• prescription is legible.If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber. |
| Briefly acknowledges any possible contraindications and relevant medical information prior to administration. |
| 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.  |
| Accurately records drug administration and non-administration, including the details of the person administering the medication. |
| Acts professionally throughout procedure in accordance with the NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’. |

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| **Evaluation criteria** |
| **Situation** |
| Introduces self and the clinical setting.  |
| States the patient’s name, hospital number and/or date of birth/location and consultant or team leading care. |
| States the reason for the handover (where relevant). |
| **Background** |
| States date of admission/surgery time/complications and priorities. |
| Notes previous medical history and relevant medication/social history. |
| Gives details of current events and details the findings from assessment.  |
| **Assessment** |
| States most recent observations, any results from assessments undertaken and what changes have occurred.  |
| Identifies main needs as per care plan, i.e. pain/deep-vein thrombosis prevention or mobilisation.  |
| States medical interventions completed at last pain assessment/NEWS recording. |
| States areas of concerns. |
| **Recommendation** |
| States what is required of the person taking the handover and proposes a realistic plan of action for overnight care. |
| **Overall** |
| Verbal communication is clear and appropriate. |
| Systematic and structured approach taken to handover. |
| Acts professionally throughout procedure in accordance with the NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’. |

**Candidate briefing**

Leslie Roberts has been admitted for a laparoscopic cholecystectomy, planned later this morning. The patient has just arrived.

1. Complete a nursing assessment of the person, including a blood glucose reading.

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

3. As part of your assessment, please complete an **A to E assessment** (airway, breathing, circulation, disability, exposure), and 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).

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: NEWS chart.**

Assume it is **TODAY** and it is **17:30 hours.**

**Overview of recent history**

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| **Patient information** |
| **Name:** Leslie Roberts**Date** **of birth:** 01/01/1960**Address**: 1 Sweet Street, Westshire, WW6 5PQ**GP:** Dr Best, West Street, Westshire **Presenting complaint:** Inflamed gall bladder for laparoscopic cholecystectomy.* Severe pain in the centre of the abdomen, including pain that spreads to the right shoulder.
* Tender abdomen when touched.
* Nauseous.

**Past medical history:** * Partially deaf.
* History of painful gallstones and removal of several gall stones.
* Leslie is a smoker but has no current or previous respiratory conditions.

**Social history:** * Leslie has four children and lives with the family over the family-owned restaurant.
* Leslie is not very physically active and has suffered for many years with obesity.

**Drug history:** * Currently taking regular doses of analgesia – paracetamol 1g QDS.
* In the past was prescribed orlistat (Xenical) for the treatment of obesity. **Allergies:**
* Codeine phosphate (causes severe nausea and vomiting).
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**Candidate notes**

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| **Patient details:****Name:** Leslie Roberts**Date** **of birth:** 01/01/1960**Address:** 1 Sweet Street, Westshire, WW6 5PQ |
| **Safe environment** |
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| **Mobilising** |
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| **Nutrition and hydration** |
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| **Communication/pain** |
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| **Breathing** |
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| **Sleeping** |
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| **Elimination** |
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**This documentation is for your use and is not marked by the examiners.**

**Candidate notes**

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

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| **Patient details:****Name:** Leslie Roberts**Date of birth:** 01/01/1960**Address**: 1 Sweet Street, Westshire, WW6 5PQ |
| **Airway**  |
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| **Breathing** |
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| **Disability** |
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| **Exposure – full clinical history** |
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**Candidate notes**

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

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| **Sexu****al** |
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**Chart 2: NEWS thresholds and triggers**

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| **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.

Chart 3, overleaf, may also be accessed online via:

<https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2>



**Candidate paperwork and briefing**

**Candidate name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This document must be completed using a BLACK PEN.**

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| **Scenario**  |
| Leslie Roberts was admitted to the surgical ward today for a planned laparoscopic cholecystectomy. He was taken to the recovery suite following his operation.Leslie’s operation was uneventful, although it was noted that the gall bladder appeared inflamed and slightly infected. Leslie is now on the ward. |

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

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

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

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

Assume it is **TODAY** and it is **11:30 hours**.

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| **Patient details:****Name:** Leslie Roberts**Date of birth:** 01/01/1960 **Address**: 1 Sweet Street, Westshire, WW6 5PQ |
| 1. **Nursing problem/need**
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| **Aim(s) of care:** |
| **Re-evaluation date:** |
| **Nursing interventions**  |
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| **Nurse signature: Date:** |
| **2) Problem/need** |
| **Aim(s) of care:** |
| **Re-evaluation date:** |
| **Nursing interventions**  |
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| **This page is not a required element but is for use in case of error.** |
| **Problem/need** |
| **Aim(s) of care:** |
| **Re-evaluation date:** |
| **Nursing interventions**  |
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**Candidate paperwork and briefing**

**Candidate name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
This document must be completed using a BLACK PEN.**

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| **Scenario** |
| Leslie Roberts returned to the ward from theatre at 13.00 hours.Please administer and document Leslie’s 18:00 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 it is **TODAY** and it is **18:00 hours.**

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| **Known allergies or sensitivities** | **Type of reaction** |
| **CODEINE PHOSPHATE** | **SEVERE NAUSEA AND VOMITING** |
|  |  |
| **Signature:** | Dr Z Gupta Bleep 505 | **Date:** | Today |

|  |  |
| --- | --- |
| **Information for prescribers:** | **INFORMATION FOR 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.** |

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

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| ***Does the patient have any documented allergies?*** | ***YES***  | ***Please check the chart before administering medications.*** |

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| **WARD** | **CONSULTANT**  | **HEIGHT** | **5 feet 11 inches (1.8m)** |
| **Starlight Ward – Surgical short stay** | **Mr R SMITH** | **WEIGHT** | **18 stone (114 kg)** |
| **ANY Special Dietary requirements?** | ***Yes***  | **If YES please specify** | *LOW FAT* |
|  |  | **BMI** | **35.15** |

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| **ONCE ONLY AND STAT DOSES:** |
| **Date** | **Time due** | **Drug name** | **Dose** | **Route** | **Prescriber’s signature** | **Prescriber’s bleep**  | **Given by:** | **Checked by:** | **Time given** |
| Today | 11:00 | PARACETAMOL | 1g | IV | Dr Z Gupta | 505 | Kez Gupta RN | Ann GreenRN | 11:00 |
| Today | 18.00 | PROCHLORPERAZINE | 12.5 mgs | IM | Dr Z Gupta | 505 |  |  |  |
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**PRESCRIBED OXYGEN THERAPY:**

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| **Date and time** | **Prescribers' signature and bleep** | **Target oxygen saturation** | **Therapy instructions** | **Device** | **Flow** | **Time started and signature** | **Time discontinued****and signature** |
| 20/08/20  | Dr Z Gupta 505 | 94-98% | Titrate as needed | Nasal specs or simple face mask | Titrate as required 2-6L |  |  |
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**PRN (AS-REQUIRED MEDICATIONS):**

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| **Date** | **Drug** | **Dose** | **Route** | **Instructions** | **Prescriber signature and bleep** | **Time given** | **Given by:** |
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**ANTIMICROBIALS:**

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| **1. DRUG**  | **Co-amoxiclav**  | **Date and signature for administration of medications.****Code for non-administration** |
| **DATE** | **DOSE** | **FREQUENCY** | **ROUTE** | **DURATION** | **TIME** | **Today** | **Tomorrow** |
| Today | 1.2g | BD | IV | 1 days | 06.00 | ***1.*** *Jamie Frost RN* |  |
| **Start date** | **Today** |  |  |  |  |
| **Finish date** | **1 days** | 18.00 |  |  |
| **Prescriber’s signature and bleep** | Dr Z Gupta 505 |  |  |  |
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**Regular medications**

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| **1. DRUG**  | **Paracetamol** | **Date and signature for administration of medications.****Code for non-administration** |
| **DATE** | **DOSE** | **FREQUENCY** | **ROUTE** | **DURATION** | **TIME** | **Today** | **Tomorrow** |
| **Today** | **1g** | 4 hourly | PO | +/-3 Days |  |  |  |
| **Start date** | **20/8/20** |  |  |  |  |
| **Finish date** | **25/8/20** |  |  |  |
| **Prescriber’s signature and bleep** | Dr Z Gupta 505 |  |  |  |
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| **2. DRUG**  | **Tramadol** | **Date and signature for administration of medications.****Code for non-administration** |
| **DATE** | **DOSE** | **FREQUENCY** | **ROUTE** | **DURATION** | **TIME** | **Today** | **Tomorrow** |
| **Today** | **50mg** | 4-6 hourly | PO | +/-2 Days |  |  |  |
| **Start date** | **20/8/20** |  |  |  |  |
| **Finish date** | **25/8/20** |  |  |  |
| **Prescriber’s signature and bleep** | Dr Z Gupta 505 |  |  |  |
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| **3. DRUG**  | **OMPERAZOLE** | **Date and signature for administration of medications.****Code for non-administration** |
| **DATE** | **DOSE** | **FREQUENCY** | **ROUTE** | **DURATION** | **TIME** | **Today** | **Tomorrow** |
| **Today** | **20mg** | OD | PO | 5 days | 08:00 | ***7*** *Jamie Frost RN* |  |
| **Start date** | **Today** |  |  |  |  |
| **Finish date** | **+ 4 days** |  |  |  |
| **Prescriber’s signature and bleep** | Dr Z Gupta 505 |  |  |  |
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| **4. DRUG**  |  | **Date and signature for administration of medications.****Code for non-administration** |
| **DATE** | **DOSE** | **FREQUENCY** | **ROUTE** | **DURATION** | **TIME** | **Today** | **Tomorrow** |
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| **Start date** |  |  |  |  |  |
| **Finish date** |  |  |  |  |
| **Prescriber’s signature and bleep** |  |  |  |  |
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**INTRAVENOUS FLUID THERAPY:**

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| **Date** | **Fluid** | **Volume** | **Rate/time** | **Prescriber** | **Batch number:** | **Commenced @** | **Given by:** | **Checked by:** | **Finished @** |
| 20/08/20 | N/Saline 0.9% | 1000 mls | 8 hourly  | Dr Z Gupta 505 | 549639629 | 08.00 | *Jamie Frost RN**Jamie Frost* | Hilda BolongRN |  |
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**DRUGS NOT ADMINISTERED:**

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| **DATE** | **TIME** | **DRUG** | **REASON** | **NAME AND SIGNATURE** |
| Today | 0600 | Cefuroxime | 1 – not on ward  | *Jamie Frost RN**Jamie Frost* |
|  |  |  |  |  |
|  |  |  |  |  |
| Today | 08.00 | Omeprazole | 7 – nil by mouth | *Jamie Frost RN**Jamie Frost* |
|  |  |  |  |  |

**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, planning and implementation documentation. If not, please alert the examiner.**

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| **Scenario:** |
| Leslie Roberts has undergone the procedure and is in post-operative recovery. The patient is due to stay overnight on the ward. |

**Using the situation, background, assessment and recommendation (SBAR) tool, please make notes regarding your patient and use this to verbally hand information over to the nurse on the next shift (the examiner).**

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

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

Assume it is **TODAY** and it is **19:00 hours**.

**Candidate notes**

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

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| **Patient details****Name:** Leslie Roberts**Date of birth:** 01/01/1960**Address:** 1 Sweet Street, Westshire, WW6 5PQ |
| **Situation:**  |
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| **Background:** |
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| **Assessment:** |
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| **Rec****ommendation:** |
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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.

|  |  |
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| **Station** | **You will be given the following resources** |
| **Professional values and behaviours****Drug misuse** – **10 minutes** You will read the scenario and summarise the actions that you would take, considering the professional, ethical and legal implications of this situation. | * Overview documentation (pages 33–34)
 |
| **Evidence-based practice****Sleep in intensive care** – **10 minutes**You will read the scenario and summary of the research, then write up how you would apply the findings to the scenario. | * Overview documentation (pages 35–36)
 |

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.

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

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

**Overview**

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

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

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

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

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

**Candidate documentation**

**Candidate name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Overview**

**Read the scenario and the summary of the research below.**

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

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

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

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

The review concluded that sleep disorders in ICU were common and that there were multiple influencing factors causing sleep deprivation.  |

**Candidate documentation**

**Candidate name:**

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

**Give your responses here as bullet points:**

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