



NMC Nursing &
Midwifery
Council

**Test of
Competence**

Test of Competence 2021: Mock OSCE Midwifery

Mock OSCE

Midwifery

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

- four of the stations are linked together around a scenario: this is called the APIE, with one station for each of Assessment, Planning, Implementation and Evaluation, delivered in that sequence and with no stations in between. Stations will last between 16 and 20 minutes.
- Two stations will take the form of a linked pair, testing practical clinical skills. Each pairing of skills stations will last for approximately 30 minutes in total (including reading time), with no break between each paired skill.
- Two stations will be separate skills stations, one of which will be an acute emergency skill. These skills will last 8 minutes each.
- There are also two *silent* stations, lasting 10 minutes each. 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).

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

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

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

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 midwifery 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: Prioritise people

Expected performance	Criteria
Treat people as individuals and uphold their dignity	Introduces self to the person at every contact and upholds the person's dignity and privacy.
Listen to people and respond to their preferences and concerns	Actively listens to the person 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 person'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 person 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.

Theme from the code: Practise effectively

Expected performance	Criteria
Always practise in line with the best available evidence	Provides skills, knowledge and attitude that is supported by an evidence base at all times.
Communicate clearly	Communicates clearly and effectively to people in their care, colleagues and the public.
Work co-operatively	Maintains effective and safe communication with people in their care, colleagues and the public.

Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues	Supports others by providing accurate, honest and constructive verbal and written feedback.
Keep clear and accurate records relevant to your practice	Provides clearly written feedback on all care given, and demonstrates accurate evidence-based verbal handover of care to others.
Be accountable for your decisions to delegate tasks and duties to other people	Accountably delegates to competent others, ensuring person safety at all times.

Theme from the code: Preserve safety

Expected performance	Criteria
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 midwifery 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	Checks prescriptions, person's

or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations	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.

Theme from the code: Promote professionalism and trust

Expected performance	Criteria
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.

Assessment

Vaginal bleed at term

The mock APIE below is made up of four stations: assessment, planning, implementation and evaluation. Each station will last between 16 and 20 minutes and is scenario-based. The instructions and available resources are provided for each station, along with the specific timing.

Scenario
<p>You are working on the antenatal assessment unit and you have been asked to assess a woman who has just presented unannounced with a vaginal bleed at term. The midwife in charge informs you that the woman is 38 weeks pregnant with her second pregnancy. The woman is reporting a small amount of fresh red blood loss vaginally as well as abdominal pain, and 'looks in pain' on admission.</p>

You will be asked to complete the following activities to provide high-quality, individualised midwifery care. All four of the stages in the process will be continuous and will link with each other.

Station	You will be given the following resources
<p>Assessment – 20 minutes You will collect, organise and document information about the individual.</p>	<ul style="list-style-type: none"> • Assessment overview and documentation (pages 10–14) • A blank modified early obstetric warning score (MEOWS) chart to be completed (page 15-16)
<p>Planning – 16 minutes You will complete the planning template to establish how two aspects of the individual's care needs will be met.</p>	<ul style="list-style-type: none"> • A partially completed midwifery care plan for the next four hours (pages 17–19)
<p>Implementation – 15 minutes You will administer medications while continuously assessing the individual's current health status.</p>	<ul style="list-style-type: none"> • An overview and medication administration record (MAR) (pages 20–25)
<p>Evaluation – 16 minutes You will document the care that has been provided so that you can do a verbal handover to the midwife on the next shift (the examiner).</p>	<ul style="list-style-type: none"> • Documents from the previous three stations • A blank transfer of care letter, including a communication tool (pages 26–29)

Assessment

Vaginal bleed at term

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

Assessment criteria
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
Introduces self and explains the assessment procedure to the woman.
Obtains consent.
Checks environment is safe and maintains privacy.
Accurately assesses, interprets and records the full medical and obstetric history of the woman (postnatal depression/unexplained infertility/in-vitro fertilisation (IVF)/gravida 2 para 1 (G2P1)/previous normal delivery at term).
Accurately assesses, interprets and records the health and wellbeing of the woman antenatally (midwifery-led care/second pregnancy/38 weeks pregnant/low-lying placenta (LLP) at 20 weeks/34-week ultrasound scan (USS) placental position and fetal growth no abnormality detected (NAD)/small fresh red vaginal bleed/abdominal pain/rhesus negative).
Demonstrates the ability to measure and record vital signs for the woman, using technological aids where appropriate, and implements appropriate responses and decisions.
Recognises normal vaginal loss and any deviations from normal, referring to an obstetrician as appropriate.
Undertakes abdominal examination and palpation of the woman (assessing any discomfort/the state of the uterus including uterine contractions/fundal height of the uterus/lie and presentation of the fetus).
Accurately assesses fetal wellbeing (fetal movements/undertake auscultation of the fetal heart, using Pinard stethoscope and technical devices as appropriate, accurately interpreting and recording all findings).
Accurately diagnoses small vaginal bleed provoked by sexual intercourse with a differential diagnosis of early labour and bloody show.
Accurately identifies investigations required (Kleihauer).
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Planning criteria
Utilises the communication tool to successfully verbalise a plan of care to the examiner.
Logically and accurately provides details of the situation (small post-coital bleed, fresh red blood loss on wiping with no active bleeding, intermittent abdominal pain).
Logically and accurately provides details of the background (sexual intercourse at 7.30am this morning, intermittent abdominal pain since 8.30am, small fresh red blood loss noted on wiping and staining of underwear at 9.30am).
Logically and accurately provides details of the assessment (small post-coital bleed with abdominal pain, uterus soft and non-tender, no active bleeding. Differential diagnosis of early labour with blood-stained show, observations otherwise normal, fetal movements reassuring).
Logically and accurately provides details of the recommendation (medical review, Kleihauer, additional mid-stream sample of urine).
Referral for medical review is acknowledged and actioned appropriately.
Ensures recommendations are current/evidence-based/best practice.
Uses professional terminology in care planning.
Ensures that the woman is involved in the care planning process, with consent gained for medical review and additional tests.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Implementation criteria
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
Seeks consent from woman prior to administering medication.
Checks allergies on chart and confirm with the person in their care, also notes red identity (ID) wristband (where appropriate).
Before administering any prescribed drug, looks at the woman's prescription chart and checks the following are correct: person (checks ID with person: verbally, against wristband (where appropriate) and paperwork), drug dose, date and time of administration, route and method of administration, validity of prescription, signature of prescriber, and that the prescription is legible.
Considers contraindication where relevant and medical information prior to administration (prompt permitted).
Provides a correct explanation of what each drug being administered is for to the person. in their care (prompt permitted).

Assessment

Vaginal bleed at term

Administers drugs due for administration correctly and safely (anti-D immunoglobulin, paracetamol).
Omits drugs not to be administered and provides verbal rationale (ferrous sulphate – ask candidate reason for non-administration, if not verbalised).
Accurately records 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'.

Evaluation criteria
Situation
Introduces self and the clinical setting.
Documents the woman's name, hospital number and/or date of birth, and location.
Documents the reasons for discharge.
Documents the current situation with the woman and baby.
Background
Documents date of admission/visit/reason for initial admission/referral to obstetric team and diagnosis.
Notes previous medical history and relevant medication/social history.
Documents current events and details findings from assessments/tests.
Assessment
Documents most recent observations, any results from assessments undertaken and what changes have occurred.
Documents that medical review completed.
Documents any areas of concerns.
Recommendation
Documents what is required of the person taking the handover and proposes a realistic plan of action.
Notes main ongoing care needs.
Proposes a realistic plan of care, including future appointment plan.
Overall
Systematic and structured approach taken to completing the transfer of care letter.
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

Vaginal bleed at term

Candidate briefing

You are working on the antenatal assessment unit and you have been asked to assess a woman, Amy Hall, who has just presented unannounced with a vaginal bleed at term.

The midwife in charge informs you that the woman is 38 weeks pregnant with her second pregnancy. The woman is reporting a small amount of fresh red blood loss vaginally as well as abdominal pain, and 'looks in pain' on admission.

You are required to **take a full history, complete a full antenatal assessment and perform any additional clinical checks, such as assessing maternal vital signs and fetal wellbeing**, according to the findings from her history. Please note that urinalysis and a Cardiotocograph (CTG) have already been performed, with results below.

This document provides an overview of the situation you are presented with to assess and the woman's history.

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

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: modified early obstetric warning score (MEOWS) chart.**

Assume it is **TODAY** and it is **10:30 hours.**

Overview of recent history

Scenario
<p>Name: Amy Hall Date of birth: 21/01/1995 Address: 17 Ladybrook Lane, Rotherham, Sheffield. Postcode: S11 3TF GP: Dr Shaw</p> <p>Presenting complaint:</p> <ul style="list-style-type: none">• Second pregnancy• 38 weeks pregnant.• Small fresh red vaginal bleed• Abdominal pain. <p>History of presenting complaint:</p> <ul style="list-style-type: none">• Sexual intercourse at 7.30am this morning• Intermittent abdominal pain since 8.30am this morning• Small fresh red blood loss noted on wiping and staining of underwear at 9.30am this morning.• Cardiotocograph performed because of fresh vaginal bleed. CTG findings reassuring.• Urinalysis: 150mls volume +++ blood ++ leucocytes. <p>Previous obstetric history:</p> <ul style="list-style-type: none">• 2015 – uneventful pregnancy. Spontaneous labour and delivery of live male infant at 40 weeks’ gestation. Child fit and well at birth. <p>Past medical history:</p> <ul style="list-style-type: none">• Postnatal depression following birth of last child. Managed with counselling and no medication required.• Unexplained infertility following birth of first child. Current pregnancy as result of a successful IVF cycle. <p>Current pregnancy:</p> <ul style="list-style-type: none">• Consultant care because of IVF• 20-week anomaly USS identified low-lying placenta covering the internal os• Follow-up USS at 34 weeks identified the placental edge was now 2cm away from the internal os. Normal fetal growth. Transferred to midwifery care at 34 weeks’ gestation.• Otherwise uneventful pregnancy to date – currently 38/40• Blood group is A rhesus negative, has received prophylactic anti-D administration

Assessment

Vaginal bleed at term

during pregnancy.

Social history:

- Married and lives with husband.

Drug history:

- Ferrous sulphate – 200mg twice daily for iron-deficiency anaemia.
- Ex-smoker – previously smoked but gave up at booking.

Allergies:

- Codeine phosphate – severe nausea and vomiting.

Assessment

Vaginal bleed at term

Candidate notes

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

Antenatal assessment
History
Vital signs
Fetal wellbeing
Additional investigations

Assessment

Vaginal bleed at term

PROMPT - MODIFIED OBSTETRIC EARLY WARNING SCORE CHART

DATE	TIME	FREQUENCY (IN HRS)	SIGNED	PRINT	STATUS

Use identification label or :-

Name: _____

DOB: _____

Hospital No: _____

Ward: _____

Date :															
Time :															
Respirations (write rate in corresp. box)	>30													>30	
	21-30													21-30	
	11-20													11-20	
	0-10													0-10	
Saturations if applicable (write stats in corresp. box)	95-100%													95-100%	
	<95%													<95%	
Administered O ₂ (L/min.)														(L/min)	
Temp	39													39	
	38													38	
	37													37	
	36													36	
	35													35	
Heart rate	170													170	
	160													160	
	150													150	
	140													140	
	130													130	
	120													120	
	110													110	
	100													100	
	90													90	
	80													80	
	70													70	
	60													60	
	50													50	
40													40		
Systolic blood pressure	200													200	
	190													190	
	180													180	
	170													170	
	160													160	
	150													150	
	140													140	
	130													130	
	120													120	
	110													110	
	100													100	
	90													90	
	80													80	
70													70		
60													60		
50													50		

Assessment

Vaginal bleed at term

Diastolic blood pressure	-----130----													-----130----	
	-----120----													-----120----	
	-----110----													-----110----	
	-----100----													-----100----	
	-----90----													-----90----	
	-----80----														-----80----
	-----70----														-----70----
	-----60----														-----60----
	-----50----														-----50----
	-----40----														-----40----
	Urine	passed (Y/N)													passed (Y/N)
Proteinuria	protein ++													protein ++	
	Protein >++													protein >++	
Amniotic fluid	Clear (C) Pink (P)													Clear (C) Pink (P)	
	Green (G)													Green (G)	
Neuro response (v)	<u>A</u> lert													<u>A</u> lert	
	<u>V</u> oice													<u>V</u> oice	
	<u>P</u> ain													<u>P</u> ain	
	<u>U</u> nresponsive													<u>U</u> nresponsive	
Pain Score (no.)	0-1													0-1	
	2-3													2-3	
Lochia	Normal (N)													Normal (N)	
	Heavy (H) Fresh (F) Offensive (O)													Heavy (H) Fresh (F) Offensive (O)	
Looks unwell	NO (v)													NO (v)	
	YES (v)													YES (v)	
Total number of amber boxes															
Total number of red boxes															
Name:															
Signature:															

Guidance for using Modified Obstetric Early Warning Score Chart

A – Alert	Alert and orientated
V – Voice	Drowsy but answers to name or some kind of response when addressed
P – Pain	Rousable with difficulty but makes a response when shaken or mild pain is inflicted (eg. rubbing sternum, pinching ears)
U – Unresponsive	No response to voice, shaking or pain

Pain scores: Record pain levels as follows:

- 0 – No pain
- 1 – Mild pain
- 2 – Moderate pain 3 – Severe pain

Scoring and responding: Document all the scores for all parameters at bottom of the chart. Follow the escalation algorithm.

Assessment

Vaginal bleed at term

Identify the number of amber
and/or red boxes

Key	
Amber	
Red	



1 Amber Box

- Repeat observations
- Increasing frequency of observations to every 30 minutes
- Seek advice from senior midwife/midwife in charge
- Consider obstetric review within 30 minutes if not settled

2 Amber Boxes or 1 Red Box

- Inform midwife in charge
- Immediate referral to obstetric registrar
- Increase frequency of observations to every 15 minutes
- Woman should be reviewed within 30 minutes
- Consider obstetric anaesthetist review
- Consider review by obstetric consultant

2 Red Boxes

- Inform midwife in charge
- Immediate referral to obstetric registrar/ anaesthetist
- Transfer to high level of care
- Consider transfer to HDU
- Consider review by obstetric consultant

Planning care

Vaginal bleed at term

Candidate paperwork and briefing

Candidate name: _____

This document must be completed using a BLACK PEN.

Scenario
<p>You have conducted the following assessment of Amy Hall.</p> <p>Full clinical history:</p> <ul style="list-style-type: none"> • History of postnatal depression, unexplained infertility and IVF. • Gravida 2 para 1 – previous uneventful pregnancy and spontaneous vaginal delivery at term. • Current pregnancy – Originally consultant care, history of low-lying placenta at 20 weeks, normal placental position and fetal growth at 24 weeks, transferred to midwife-led care at 34 weeks. • Currently 38 weeks, small post-coital bleed, fresh red blood loss on wiping with no active bleeding, intermittent abdominal pain. <ul style="list-style-type: none"> ○ Sexual intercourse at 7.30am this morning. ○ Intermittent abdominal pain since 8.30am this morning. ○ Small fresh red blood loss noted on wiping and staining of underwear at 9.30am this morning. <p>Assessment of maternal wellbeing:</p> <ul style="list-style-type: none"> • Temperature: 36.6°C • Heart rate: 88 bpm • Blood pressure: 120/60 • Oxygen saturations: 100% • Urinalysis: 150mls volume +++ blood ++ leucocytes • Alert, fit and well • Pain level 4/10. <p>Abdominal palpation:</p> <ul style="list-style-type: none"> • Abdomen soft and non-tender • Mild uterine contractions noted 1:3-5 lasting 30 seconds • Fundal height = 38cms, longitudinal lie, cephalic presentation 3/5th palpable. <p>Assessment of fetal wellbeing:</p> <ul style="list-style-type: none"> • Normal fetal movements • Fetal heart auscultated with Pinard – 146 bpm • Cardiotocograph performed because of fresh vaginal bleed. CTG findings reassuring. <p>Diagnosis:</p> <ul style="list-style-type: none"> • Small post-coital vaginal bleed and irregular uterine contractions.

Planning care

Vaginal bleed at term

Differential diagnosis:

- Early labour with blood-stained show.

Based on your assessment of Amy Hall, please produce a midwifery care plan for the next 4 hours.

You **may wish** to use the situation, background, assessment and recommendation (SBAR) tool provided. Please then use your notes to **explain verbally your plan of care to the midwife in charge of the antenatal assessment unit (the examiner)**. Your written work will not be marked but you may take it with you to the next station for reference.

You have **16 minutes** to complete this station. You have **10 minutes** to make notes on the form provided (this is not assessed), and up to **6 minutes** to verbalise your plan of care to the examiner.

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

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

Planning care

Vaginal bleed at term

Candidate notes

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

Patient details:
Name: Amy Hall
Address: 17 Ladybrook Lane, Rotherham, Sheffield, S11 3TF
Date of birth: 21/01/1995
Situation:
Background:
Assessment:
Differential diagnosis:
Recommendation:

Implementing care

Safe administration of medications

Vaginal bleed at term

Candidate paperwork and briefing

Candidate name: _____

This document must be completed using a BLACK PEN.

Scenario

Amy Hall has now been reviewed by Dr Gupta, following her admission to the antenatal assessment unit with a post-coital vaginal bleed at 38 weeks' gestation.

A speculum examination was performed by Dr Gupta where fresh red blood loss was seen on examination. The cervical os was reported to be short and approximately 1-2cms dilated. Intermittent abdominal pain continues.

Dr Gupta has requested that Amy Hall be admitted to the antenatal ward for observation of her vaginal loss and abdominal pain overnight. Medications required for this admission are prescribed by Dr Gupta. Dr Gupta asks that all required medications due at 14:00 hours are to be administered prior to transfer to the antenatal ward.

Please administer and document all required 14:00 hours medications for Amy Hall 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 **14:00 hours**.

Prescription chart for:	Amy Hall	Female	Hospital number: Date of birth: 21/01/1995
Admission date and time	Today 10:30		

Known allergies or sensitivities		Type of reaction	
Codeine phosphate		Severe nausea and vomiting	
Signature:	<i>Dr Z Gupta</i> Bleep 505	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.
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WARD	CONSULTANT	HEIGHT	1.7m (5 foot 6 inches)
MAU	Mr R SMITH	WEIGHT	70kg (11 stone)
ANY special dietary requirements?	<u>NO</u>	If YES please specify	
		BMI	24

Prescription chart for:	Amy Hall	Female	Hospital number: Date of birth: 21/01/1995
Admission date and time	Today 10:30		

ONCE-ONLY AND STAT DOSES:									
Date	Time due	Drug name	Dose	Route	Prescribers' signature	Prescribers' bleep	Given by:	Checked by:	Time given:
Today	14:00	Anti-D	500iu	IM	<i>Dr Z Gupta</i>	505			

PRESCRIBED OXYGEN THERAPY:

Date and time	Prescribers' signature and bleep	Target oxygen saturation	Therapy instructions	Device	Flow	Time started and signature	Time discontinued and signature

PRN (AS-REQUIRED MEDICATIONS):

Date	Drug	Dose	Route	Instructions	Prescriber signature and bleep	Time given	Given by:
Today	PARACETAMOL	1g	PO	4-6 hourly	<i>Dr Z Gupta</i> 505		

Prescription chart for:	Amy Hall	Female	Hospital number: Date of birth: 21/01/1995
Admission date and time	Today 10:30		

ANTIMICROBIALS:

1. DRUG						Date and signature of nurse administering medications. Code for non-administration	
DATE	DOSE	FREQUENCY	ROUTE	DURATION	TIME	Today	Tomorrow
Today							
Start date							
Finish date							
Prescriber's signature and bleep							

2. DRUG						Date and signature of nurse administering medications. Code for non-administration	
DATE	DOSE	FREQUENCY	ROUTE	DURATION	TIME	Today	Tomorrow
Today							
Start date							
Finish date							
Prescriber's signature and 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's signature and bleep							



Prescription chart for:	Amy Hall	Female	Hospital number: Date of birth: 21/01/1995
Admission date and time	Today 10:30		

REGULAR MEDICATIONS:

1. DRUG	FERROUS SULPHATE					Date and signature of nurse administering medications. Code for non-administration	
DATE	DOSE	FREQUENCY	ROUTE	DURATION	TIME	Today	Tomorrow
Today	200mg	Twice daily	Orally	2 WEEKS	08.00		
Start date	Today						
Finish date					18.00		
Prescriber's signature and bleep	<i>Dr Z Gupta</i> 505						

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's signature and 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's signature and bleep							

Prescription chart for:	Amy Hall	Female	Hospital number: Date of birth: 21/01/1995
Admission date and time	Today 10:30		

4. DRUG						Date and signature of nurse administering medications. Code for non-administration	
DATE	DOSE	FREQUENCY	ROUTE	DURATION	TIME	Today	Tomorrow
Today							
Start date							
Finish date							
Prescriber's signature and bleep							

INTRAVENOUS FLUID THERAPY:

Date	Fluid	Volume	Rate/time	Prescriber	Batch number:	Commenced @	Given by:	Checked by:	Finished @

DRUGS NOT ADMINISTERED:

DATE	TIME	DRUG	REASON	NAME AND SIGNATURE

Evaluating care

Vaginal bleed at term

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.

Scenario

You are now working on the antenatal ward.

Amy Hall has had an uneventful night on the antenatal ward. Amy has not experienced any further vaginal blood loss overnight and her abdominal pain has now settled. You have carried out an antenatal assessment of Amy this morning. A CTG was also done to assess fetal wellbeing, and both assessments are reassuring.

Dr Gupta has also reviewed Amy this morning and has discharged Amy back to midwifery-led care in the community.

You are required to complete a transfer of care letter to ensure that the community midwife has a full and accurate account of Amy Hall's history and ongoing care needs.

Please complete a transfer of care letter to ensure that the community midwife has a full and accurate account of Amy Hall's history and ongoing care needs.

You have **16 minutes** to complete **all** sections of the documentation.

Assume it is **1 DAY LATER** and it is **10:00 hours**.

Evaluating care

Vaginal bleed at term

Transfer of care letter

Patient details: Name: Amy Hall Address: 17 Ladybrook Lane, Rotherham, Sheffield, S11 3TF Date of birth: 21/01/1995
Date of admission:
Clearly describe the reason for handover, including the initial admission and subsequent diagnosis:
Situation – Identify who you are, where you work and explain what the current situation is with the woman and the fetus.
Background – Give the woman’s reason for admission, explain her pregnancy history, noting any significant medical or obstetric history as well as any tests or assessments that have taken place.
Assessment – Explain what you think any underlying causes might be for the woman’s admission, linking them to your clinical findings.

Evaluating care

Vaginal bleed at term

PRINT NAME:
Midwife's signature:
Date/Time:

Mock clinical skill

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

Station	You will be given the following resources
<p>Clinical skill – 30 minutes will be allotted for two linked skills and you will use your professional judgement to allocate time for this one station. You will carry out the required actions to undertake a systematic examination of a newborn infant.</p>	<ul style="list-style-type: none"> • Overview documentation (pages 31–35)

In the table below, we have outlined the expected standard 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.

Marking criteria – Systematic examination of the newborn
Cleans own hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
Conducts ongoing assessments of the health and wellbeing of the newborn infant, involving the mother and partner as appropriate, and providing a full explanation, which must include: parental confidence in handling and caring for the newborn infant, including response to crying and comfort measures.
Holistic assessment of the full systematic physical examination of the newborn infant in line with local and national evidence-based protocols, and ensuring that screening and diagnostic tests are carried out appropriately and as required, in line with local and national evidence-based protocols.
Identifies risk factors, screens maternal records, and carries out record-keeping of newborn child health record.
Explains the systematic examination of the screening programme's 4 areas, and gains informed consent.
Ensures the correct environment (warm, light, flat, firm surface, alongside mother), reviews the case history and identifies any risk factors.
Has a logical process for the examination.
Acts professionally throughout procedures in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Overview

Systematic examination of the newborn

Scenario

You are working on a labour ward.

You have been asked to assist with the care of Helen, who gave birth to her second baby 6 hours ago. Helen and her baby are fit and well postnatally, and Helen would like an early postnatal discharge home.

You have been asked to perform the systematic examination of the newborn prior to Helen's discharge home.

The midwife caring for Helen informs you of Helen's clinical history as follows. Helen opted to have full antenatal screening for fetal anomaly at 16 weeks, which were reported to be low risk. At 20 weeks, Helen opted to have a fetal anomaly scan, where the nuchal fold was reported to be 6mm with no further anomalies noted. Helen declined further follow-up.

Helen was admitted in spontaneous labour and was in labour for 7 hours. Helen had an uncomplicated vaginal delivery of a live male infant. No resuscitation was required at birth. An examination of the infant at birth was performed and no abnormalities were detected.

Please undertake a systematic examination of the newborn, focusing on the newborn guidance examination of the (*examiner will select **only one** key area in the live assessment*): eyes, heart, hips or testes.

Please verbalise and demonstrate your actions as you examine the newborn, giving careful consideration to evidence-based practice and newborn guidance.

The newborn infant physical examination offers an opportunity for parent education and health promotion. Please include key information and advice as part of your examination and document your findings, with any relevant referral and ongoing plan of care, on the documentation proforma.

Please note that you will have **30 minutes in total** to perform a pair of linked skills stations. It will be up to you to plan your time but this station is the longer one of the pair. The examiner will give you a warning 5 minutes before the end.

Mock clinical skill

Proforma Part 1 and 2

Newborn Health Assessment					
PART 1 - MATERNAL, FAMILIAL AND FETAL HISTORY					
MATERNAL AND FETAL CONSIDERATIONS					
Maternal age:	30	Paternal age:	30	Maternal blood group:	O positive
Maternal medical history:	Nil of note		Family history:	Nil of note	
FASP points of note:	Routine fetal screening - nil of note				
Obstetric History:	G 2 P 2		Notes:		
Current pregnancy considerations:	MLC				
	CLC				
Medication during pregnancy:	Nil				
LABOUR AND DELIVERY CONSIDERATIONS					
ROM (Hrs):			Liquor:	CLEAR	MECONIUM
Labour onset:	SPONTANEOUS		INDUCTION	AUGMENTATION	
1 st Stage:	6 hours 40 mins	2 nd Stage:	20 mins	Apgar:	8/1 9/5
Medication during labour:	Paracetamol, Entonox				
Mode of delivery:	Spontaneous vaginal birth				
Cord clamp interval:	> 3 mins	Cord gases:	Not taken	Normal	Abnormal
Specific areas of note regarding delivery:					

Mock clinical skill

Proforma Part 1 and 2

PART 2 – NEONATAL ASSESSMENT

NEONATAL CONSIDERATIONS:

Gestation at delivery:	38	Birth Weight:	2900g	Sex:	Male
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ON NEONATAL EXAMINATION:

Age at examination:	6 hours	Temp:	36.6	HC:	34cm
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FINDINGS		ADDITIONAL NOTES
Appraisal:		
Symmetry:		
Tone:		
Movement:		
Posture:		
Skin:		

HEAD

FINDINGS		ADDITIONAL NOTES
Skull:		
Hair:		
Face:		
Eyes:		
Ears:		
Mouth:		
Nose:		
Tongue:		
Neck:		

Mock clinical skill

Proforma Part 1 and 2

PELVIC REGION AND LOWER EXTREMITIES		
FINDINGS		ADDITIONAL NOTES
Genitalia and Anus:		
Spine and Back:		
Hips:		
Femoral Pulses:		
Legs and Feet:		
NEUROLOGICAL ASSESSMENT		
FINDINGS		ADDITIONAL NOTES
Moro Reflex:		
Suck Reflex:		
Rooting Reflex:		
Babinski Reflex:		
Gallant Reflex:		
Grasp Reflex:		
Head Lag:		
Primitive Walking:		
UPPER EXTREMITIES AND THORACIC REGION		
FINDINGS		ADDITIONAL NOTES
Arms and hands:		
Brachial Pulses:		
Chest:		
Heart Sounds:		
Lung Sounds:		

Mock clinical skill

Proforma Part 1 and 2

ABDOMINAL REGION			
FINDINGS			ADDITIONAL NOTES
Abdomen:			
Liver:			
Spleen:			
Kidneys:			
Cord:			
FEEDING AND ELIMINATION			
FINDINGS			
Method:	BF	Assessment of Feeding:	Has had first feed
Excretion:	PU	Stools:	Meconium not yet passed
CONCLUSION AT TIME OF EXAMINATION			
Conclusions and recommendations following examination (physical, psychological and wider sociological factors)			
Parental participation/ health promotion points			
At time of examination no apparent need for referral:	Referral required		
	Referral to:		
	Referral date:		
	Referral completed by:		

Mock silent stations

You will also be required to undertake two new 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
<p>Professional values and behaviours: Dignity, respect and choice – 10 minutes</p> <p>You will read the scenario and summarise the actions that you would take, considering the professional, ethical and legal implications of this situation.</p>	<ul style="list-style-type: none"> • Overview documentation (pages 38–39)
<p>Evidence-based practice: Obstetric anal sphincter injury (OASI) – 10 minutes</p> <p>You will read the scenario and summary of the research, then write up how you would apply the findings to the scenario.</p>	<ul style="list-style-type: none"> • Overview documentation (pages 40–41)

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

Professional values & behaviours marking criteria – Dignity, respect and choice

Considers Miriam’s situation and is able to summarise the main points of concern in the scenario.

Is able to communicate fully and clearly with Miriam and her husband.

Demonstrates kindness and compassion when responding to Miriam.

Recognises Miriam’s autonomy and right to choose how her babies are fed.

Works in partnership with the couple including care planning and follow-up support.

Acts as an advocate for Miriam and does not express own personal beliefs inappropriately.

Ensures that Miriam is supported to make an informed decision.

Recognises the need for reflection on the situation and the opportunity to improve practice.

Demonstrates an understanding of the need for accurate documentation of the situation.

Evidence-based practice marking criteria – Obstetric anal sphincter injury (OASI)

Summarises the main findings from the article summary and draws conclusion, making recommendations for practice.

Recognises and makes reference to the importance of woman-centred care and maternal choice, regardless of national recommendations or available evidence.

Recognises the fact that Hana has had a previous ventouse birth and may feel anxious about this.

Informs Hana that the results of the study showed a reduction in anal sphincter injury in both instrumental and spontaneous vaginal births.

Recognises the fact that there were variables across the participating hospitals that could have impacted on the results of the study.

Acknowledges the date of publication and is aware that newer evidence may have been published since 2010.

Professional values and behaviours: Dignity, respect and choice

Overview

Scenario
<p>You are working on a busy postnatal ward.</p> <p>One of the women you are caring for is Miriam, who birthed twin boys at 33 weeks gestation 2 days ago. The babies are doing well in the neonatal intensive care unit.</p> <p>Miriam calls her bell and, when you arrive, she is very distressed and angry. She tells you that she feels pressured into expressing breastmilk for her babies and she wants to stop. Miriam's husband is with her and he is upset as he is concerned that the babies need expressed breastmilk due to their early gestational age.</p>

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.

Evidence-based practice:

Obstetric anal sphincter injury (OASI)

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.

Scenario
<p>You are working in the community and have an appointment with Hana, who is 36 weeks pregnant with her second baby. She had a ventouse delivery last time and has been reading about how to prevent perineal trauma during birth. She wants to talk to you about whether the midwife or obstetrician can manually protect her perineum at the end of the second stage of labour to prevent trauma.</p>
Article summary
<p>An interventional cohort study published in 2010 was used as evidence to support the Royal College of Obstetricians and Gynaecologists' (RCOG) OASI care bundle, which is supported in UK practice by the Royal College of Midwives. The study involved the application of an intervention in 40,152 vaginal deliveries in Norway between 2003 and 2009. The intervention was manual support of the perineum at the end of the second stage of labour.</p> <p>The study found that the incidence of anal sphincter injury reduced from 4–5% to 1–2% during the study.</p> <p>The study also found that:</p> <ul style="list-style-type: none"> • the incidence of perineal trauma reduced in both instrumental deliveries and spontaneous vaginal deliveries • reduction in fourth-degree tears was the most significant finding of the study • intervention had no harmful effects on the newborn. <p>There were variables regarding episiotomy rates, mode of delivery and parity in different participating hospitals during the study.</p>



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