Mock Scenario for Nursing Associate OSCE

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

The Code outlines the professional standards of practice and behaviour which sets out the expected performance and standards that are assessed through the test of competence.

The Code is structured around four themes – Prioritise people, Practise effectively, Preserve safety and Promote professionalism and trust. These statements are explained below as the expected performance and criteria. The criteria must be used to promote the standards of proficiency in respect of knowledge, skills and attributes. They have been designed to be applied across all fields of nursing practice – including Nursing Associates, irrespective of the clinical setting and should be applied to the care needs of all patients.

Please note - this is a mock OSCE example for education and training purposes only.

The marking information applies to all of the scenarios. They provide a guide to the level of performance we expect in relation to nursing care, knowledge and attitude.

Evidence for the expected performance criteria can be found in the reading list and related publications on the learning platform.

Theme from the Code	Expected Performance and Criteria
Promote professionalism	Behaves in a professional manner respecting others and adopting non-discriminatory behaviour. Demonstrates professionalism through practice. Upholds the patient's dignity and privacy.
Prioritise people	Introduces self to the patient at every contact.
	Actively listens to the patients and provides information and clarity.
	Treats each patient as an individual showing compassion and care during all interactions. Displays compassion, empathy and concern. Takes an interest in the patient.
	Respects and upholds people's human rights. Upholds respect by valuing the patient's opinions and being sensitive to feelings and/or appreciating any differences in culture.
	Checks that patient is comfortable, respecting the patient's dignity and privacy.
Infection prevention and control	Adopts infection control procedures to prevent healthcare-associated Infections at every patient contact.
	Applies appropriate Personal Protective Equipment (PPE) as indicated by the nursing procedure in accordance with the guidelines to prevent healthcare associated infections.
	Disposes of waste correctly and safely.
Care, compassion and communication	Seeks patient's permission/consent to carry out observations/procedures at every patient contact.
	Checks patient identity correctly both verbally, and/or with identification bracelet and the respective documentation at every patient contact.
	Uses a range of verbal and non-verbal communication methods. Displays good verbal communication skills by appropriate language use, some listening skills, paraphrasing, and appropriate use of tone, volume and inflection. Good non-verbal communication including elements relating to position (height and patient distance), eye contact and appropriate touch if necessary.
Practice effectively	Maintains the knowledge and skills needed for safe and effective practice in all areas of clinical practice.
Organisational aspects of care specific to specific skills	Ensures people's physical, social and psychological needs are assessed.
	Completes physiological observations accurately and safely for the required time using the correct technique and equipment.
	Ensures any information or advice given is evidence based including using any healthcare products or services.
Documentation	Documents all nursing procedures accurately and in full, including signature, date and time.
	Writes clearly so that it can be easily read by others.
	Records the date, month and year of all observations.
	Charts all observations accurately.
	Scores out all errors with a single line. Additions are dated, timed and signed.
	Writes the record in ink.
Preserve safety	Administers medicines within the limits of training, competence, the law, the NMC and other relevant policies, guidance and regulations.
Medicine management	

The Mock OSCE scenario part is made up of three stations: Ongoing Assessment, Implementing Care and Ongoing Care. The instructions and available resources are provided for each station, along with the specific timing.

Scenario
Alice Sharman has attended her General Practitioner (GP) appointment today with a history of feeling 'poorly' for the past 2 days. She is not eating and feels very tired. Alice also has a headache. She has pain and frequency of micturition

You will be asked to complete the following activities to provide high quality, individualised care for the patient.

Station	**You will be given the following resources**
Ongoing Assessment – 15 minutes You will collect, organise and document information about the patient.	• A Patient Record document from the GP • Assessment overview and documentation which you will be asked to complete • Observations chart
Implementing Care – 15 minutes You will administer medications in this station	• An overview and Medication Administration Record (MAR)
Ongoing Care – 15 minutes You will document the care that has been provided using an SBAR tool – (Situation, Background, Assessment and Recommendation) so that this is communicated with other healthcare professionals.	• An overview and Ongoing Care letter for the person you have been caring for

Marking
You will be marked against 4 domains in each station -

1. Interpersonal skills
2. Provide and monitor safe and effective care
3. Professional behaviour
4. Documentation

As well as these domains you will be given a global overall result of excellent, good, borderline, fail or unsafe practice

Example Documentation for Nursing Associate Scenario
Below is an example of an OSCE which is based in the community setting. Other scenarios will be based in a variety of care settings including Hospital based care. The OSCE covers all ages from children to care of the older person. As well as a scenario element there will also be clinical skills that you need to complete to achieve an overall pass in the OSCE. Documentation include below –

1. General Practitioners Person Information form
2. Ongoing Assessment
3. Implementing Care – medication documentation
4. Ongoing Care

Ashwood Medical Centre
Green Street
NN1 7AL

Patient Records

Patient Details	
Name	Alice Sharman
Address	1 Sweet St, Northampton, NN1 7AL
Date of Birth	10.10.1990
NHS number	87654321
Contact number	07123456789
General Practitioner (GP)	Dr. Albany

Family History	
Mother	Eleanor Sharman
Father	Ali Sharman
Siblings	Ali Sharman – brother Ellie Sharman – sister
Contact	07987654321 - mother

Past Medical History

Mild learning disabilities following meningitis at 4 days old due to maternal Group B Streptococcus infection.

Asthma as a child – not on any current treatment

Hayfever

For the past week, Alice has complained of headaches and has had regular blood pressure monitoring – her blood pressure has ranged from 160/100 to 170/110

Allergies

Peanuts – carries an EpiPen

Medications

Cetirizine hydrochloride 10mgs once a day for hayfever

EpiPen – for allergic reaction

Social

Alice lives in independent supported housing. She currently attends the local college and is studying Catering. Alice has a part time job in a charity shop one day a week. She has regular contact with her family who are supportive and involved in her health and social care needs. Alice has a carer who helps her maintain her independence in her flat.

Today

Alice attended a GP appointment today accompanied by her Carer. Housing Manager is aware of the GP appointment. Social Worker to be informed if needed. Alice will call parents later.
For the last 2 days she has felt 'poorly', not eating, feeling very tired and has a headache. She is also complaining of frequency and painful micturition.
Normal bowel movement – once a day.
Diet – feeling nauseous, tolerating fluids.
Last menstrual period – 1 week ago.
Not currently taking any medication

Referral for -

Review by Practice Nursing Associate –

Complete temperature, pulse, respirations and blood pressure.

Urinalysis

Discuss some activities of living as these need to be reviewed

Ongoing Assessment

Candidate name_____

Alice Sharman has attended her GP appointment today with a history of feeling 'poorly' for the past 2 days. She is not eating and feels very tired. Alice also has a headache. She has pain and frequency of micturition.

You have been asked to complete temperature, pulse, respirations and blood pressure. You also need to undertake a urinalysis.
The GP would also like a review of Alice's Activities of Living to be completed
You need to briefly discuss the following -

- **Maintaining a safe environment**
- **Breathing**
- **Nutrition and hydration**
- **Sleeping**

Assume it is today and it is 10:30a.m.

Alice Sharman has just arrived.

This documentation forms part of your exam and is marked by the Examiners

Activities of Living

Maintain a safe environment
Breathing
Nutrition and hydration
Sleeping

Nursing & Midwifery Council

Nursing Associate
Implementing Care

Safe administration of medicines

Candidate Name_____

The Examiner will retain all documentation at the end of the station.

Alice Sharman has attended her GP appointment today with a history of feeling 'poorly' for the past 2 days. She is not eating and feels very tired. Alice also has a headache. She has pain and frequency of micturition.
The GP requested you undertaken her temperature, pulse, respirations, blood pressure and a urinalysis. Alice has had a consistency high blood pressure for the last week and today her blood pressure was 160/100mmHg. You also sent a mid-stream specimen of urine for culture and sensitivity.

Following on from the previous station, you are now asked by the GP to complete a home visit to explain, administer and document Alice's medication, in a safe and professional manner.

Candidate Instructions

- Talk to Alice
- Please verbalise what you are doing and why to the examiner
- Read out the chart and explain what medications you are checking/giving/not giving and why
- Complete all the require drug administration checks
- Complete the documentation and use the correct codes for non-administration
- Ensure you compete all the pages of the chart
- You have 15 minutes to complete this station including the required documentation

It is now 12:00 and you are visiting Alice in her home. You have brought her medications with you.

Prescription Chart for :	ALICE SHARMAN	Female	NHS Number 87654321 Date of Birth 10.10.1990 1 Sweet Street Northampton NN2 7AL
Review Date and Time			
Does the patient have any documented Allergies?	*YES* NO	*Please check the chart before administering medications.*	

Known Allergies or Sensitivities		Type of Reaction	
Peanuts		Anaphylaxis	
Signature:	Dr. *A.Kumar – BLEEP 456*	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.*

		HEIGHT	5ft 6inches (1.67m)
GP	Dr. Albany	WEIGHT	10 stone (63.5kg) BMI= 22.7
ANY Special Dietary requirements?	YES NO	If YES please specify	

Prescription Chart for :	ALICE SHARMAN	Female	NHS Number 87654321 Date of Birth 10.10.1990 1 Sweet Street Northampton NN2 7AL
Review Date and Time			
Does the patient have any documented Allergies?	*YES* NO	*Please check the chart before administering medications.*	

ONCE ONLY AND STAT DOSES:								
DATE	TIME DUE	DRUG NAME	DOSE	ROUTE	Prescribers' signature	Prescribers' bleep	GIVEN BY:	TIME GIVEN:

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 SIGNATUREAND BLEEP	TIME GIVEN	GIVEN BY:
Today	PARACETAMOL	1gram	Oral		Dr. Albany (GP)		

Prescription Chart for :	ALICE SHARMAN	Female	NHS Number 87654321 Date of Birth 10.10.1990 1 Sweet Street Northampton NN2 7AL
Review Date and Time			
Does the patient have any documented Allergies?	*YES* NO	*Please check the chart before administering medications.*	

ONCE ONLY AND STAT DOSES:								
DATE	TIME DUE	DRUG NAME	DOSE	ROUTE	Prescribers' signature	Prescribers' bleep	GIVEN BY:	TIME GIVEN:

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 SIGNATUREAND BLEEP	TIME GIVEN	GIVEN BY:
Today	PARACETAMOL	1gram	Oral		Dr. Albany (GP)		

Ongoing Care

Candidates Name:_____

Note to Candidate:

- **This document must be complete using a BLUE PEN**
- **At this station, you should have access to your Ongoing Assessment and Implementing Care documentation**
    - **Please Note: there are 3 pages to this document**
- **Document to NMC standards**
- **The examiner will retain all documentation at the end of the station**

Alice Sharman attended her General Practitioner (GP) today complaining of feeling generally unwell, headache and frequency and pain on micturition. For the past week Alice has had her blood pressure monitored as it has been raised.
You completed a set of observations and a urinalysis. Along with updating a review of activities of living with Alice.

Following this appointment Alice had –

- A midstream specimen of urine sent for culture and sensitivity which showed a urinary tract infection - antibiotics were prescribed
- Antihypertensive medication has been prescribed and regular blood pressure monitoring planned

You need to complete the Ongoing Care document to update Alice's records. You will also be required to provide a verbal handover to the District Nurse to ensure they have a full an accurate account of Alice's recent history, monitoring and care needs

Ensure you complete **all** sections of the Ongoing Care document

Ongoing Care

Alice Sharman
NHS Number: 87654321
Date of Birth: 10.10.1990
1 Sweet Street, Northampton NN2 7AL

Complete each section <u>In Full</u>

Clearly identify the initial reason for GP appointment -

Confirmed Diagnosis -

Date of appointment

Situation

Background

Assessment

Recommendations

Document allergies and associated reactions
Identified areas of self-care
Identified potential areas for health promotion:
Other members of the multidisciplinary team who need to be aware of the ongoing care needs for this patient
PRINT NAME
Signature
Date