Adult nursing

OSCE support materials provided on test centres' online learning platforms

September 2018

Contents

The test centres' platforms

If you're taking Part 2 of the test of competence (the OSCE), you'll be marked against the NMC's current pre-registration education standards. Read the test blueprints.

Once you book your OSCE with a test centre, you'll get access to the test centre's own online learning platform.

Oxford Brookes University

University of Northampton

Ulster University

On the learning platform, you'll find support material, you will also receive access to a digital resource library (Dawsonera and/or the Royal Marsden Manual). **This document outlines what is available as of 10 September 2018.**

The platform is also where you'll find important updates about the OSCE. Test centres advise you to regularly log in and check these.

As a candidate, it's important that you familiarise yourself with the online materials. A key document to have read and understood is the **candidate information booklet**.

We understand that most applicants receive training and OSCE preparation from their employers. Employers don't always receive access to test centres' platforms.

We encourage trainers to regularly check the test centre websites for updates, or directly contact test centres to stay informed.

Digital library – eBooks

Test centres encourage you to familiarise yourself with the following eBooks, which are available via the digital library

Dawsonera

Adam, S. K., Odell, M. and Welch, J. (2010) *Rapid assessment of the acutely ill patient*. Oxford: Wiley-Blackwell.

Best, C. and NetLibrary, Inc. (2008) *Nutrition: a handbook for nurses*. Chichester, West Sussex, U.K.: Wiley-Blackwell.

Booker, C. and Waugh, A. (2007) *Foundations of Nursing Practice: Fundamentals of Holistic Care.* Mosby Elsevier.

Boyd, C. (2013a) *Clinical skills for nurses*. Chichester: John Wiley.

Boyd, C. (2013b) *Medicine management skills for nurses*. Chichester: Wiley-Blackwell.
Brooker, C. and Waugh, A. (2007) *Foundations of nursing practice: fundamentals of holistic care*. Edinburgh: Mosby/Elsevier.

Carrier, J. (2016) *Managing long term conditions and chronic illness in primary care: a guide to good practice*. 2nd ed. London: Routledge.

Chapelhow, C. (2005) *Uncovering skills for practice*. Cheltenham: Nelson Thornes.

Crouch, S., Chapelhow, C. and Crouch, M. (2013) *Medicines management: a nursing perspective*. Abingdon: Routledge.

Dealey, C. (2012) *The care of wounds: a guide for nurses*. 4th ed. Oxford: Blackwell Science.

Dougherty, L., Lister, S. E. and Royal Marsden NHS Foundation Trust (2015) *The Royal Marsden manual of clinical nursing procedures*. 9th ed. Chichester: Wiley-Blackwell. (Access shared via Dawsonera at Oxford Brookes and Ulster University)

Gatford, J. D., Phillips, N. and NetLibrary, Inc. (2016) *Nursing calculations*. 6th ed. Edinburgh: Churchill Livingstone.

Goodman, B. and Clemow, R. (2010) *Nursing and collaborative practice: a guide to interprofessional and interpersonal working*. 2nd ed. Exeter: Learning Matters.

Hughes, R. (2010) *Rights, risk, and restraint-free care of older people: person-centred approaches in health and social care*. London: Jessica Kingsley.

Jasper, M. (2006) *Professional development, reflection and decision-making*. Oxford: Blackwell.

Jevon, P. and Ewens, B. (2012) *Monitoring the critically ill patient*. 3rd ed. Oxford: Wiley-Blackwell.

Jevon, P., Ewens, B. and Humphreys, M. (2008) *Nursing medical emergency patients*. Illustrated ed. Chichester: Wiley-Blackwell.

McArthur-Rouse, F. J. and Prosser, S. (2007) *Assessing and managing the acutely ill adult surgical patient*. Oxford: Blackwell

McCormack, B. and McCance, T. (2010) *Person-centred nursing: theory and practice*. Oxford: Wiley-Blackwell.

Merriman, C. and Westcott, L. (2010) *Succeed in OSCEs and practical exams: an essential guide for nurses*. Maidenhead: Open University Press.

Payne, S., Seymour, J. and Ingleton, C. (2008) *Palliative care nursing: principles and evidence for practice*. 2nd ed. Maidenhead: Open University Press.

Peate, I. (2010) *Nursing care and the activities of living*. 2nd ed. Chichester: Blackwell Publishing

Royal Marsden Manual

Dougherty, L., Lister, S. E. and Royal Marsden NHS Foundation Trust (2015) *The Royal Marsden manual of clinical nursing procedures*. 9th ed. Chichester: Wiley-Blackwell. (Access shared via the online Royal Marsden Manual at the University of Northampton)

OSCE support materials

We encourage you to familiarise yourself with these documents, which are available on the test centres' online learning platforms.

As new scenarios and skill stations are introduced, the test centres will make new documentation available. This list reflects what is available as of **10 September 2018**.

More documents are available for the APIE (assessment, planning, implementation, evaluation) stations. For clinical skill stations, we advise you to check the candidate handbook and Top Tips booklet to understand what type of clinical skills may come up in the exam. The Royal Marsden Manual and the United Kingdom Resuscitation Council Guidelines provides the basis of what is viewed as safe practice.

Examination briefing notes

These have been shared in advance to provide you with as much information as possible for the day.

- Candidate Briefing (Annexe 1)
- Invigilator Briefing (Annexe 2)

Individual station template examples

We'll give you **pre-filled patient information** ahead of the APIE stations. Here are two example documents for two different care environments:

- Blank adult inpatient admission form/discharge letter (Annexe 3)
- Blank community discharge care letter (Annexe 4)

Here are un-filled documents individual stations. Highlighted areas are filled in for you on the day.

- APIE: Assessment station (Annexe 5)
- APIE: Planning station (Annexe 6)
- APIE: Implementation station (Annexe 7)
- APIE: Evaluation station: Hospital setting (Annexe 8)
- APIE: Evaluation station: Community care setting (Annexe 9)
- Clinical skills: Community prescription chart (Annexe 10)

Charts and forms used in the OSCE

Test centres have shared the following charts and forms that are used in the OSCE.

On the day, some will be pre-filled. Some will be left blank for you to complete as part of the assessment. Some will be there for reference only.

It's important that you're familiar with all the charts and forms so you can demonstrate safe and patient-centred care.

Possible charts and forms that will have **pre-filled patient information** are:

- Blank patient health questionnaire example (Annexe 11)
    - This form is used in some of the scenarios for the assessment station.

Possible charts that you may **need to complete** as part of the assessment:

- Blank neurological observation chart (Annexe 12)
    - This chart is used in some of the scenarios for the assessment station.
- Blank NEWS2 chart (Annexe 13).
    - This chart is used in some of the scenarios for the assessment station
- Blank temperature, pulse, respiration (TPR) chart (Annexe 14)
    - This chart is used in some of the scenarios for the assessment station.

For reference only:

- Blank normal range peak expiry flow chart for adult males and females (Annexe 15)
    - This chart is used as guidance for applicants for some of the scenarios for the assessment station.

Further reading

The weblinks complement the OSCE documentation support materials and provide further guidance. Again, this list may get added to and updated as and when appropriate.

The below list of weblinks have been recommended by test centres on their learning platform to provide additional guidance:

Age UK
- Nursing the older person

British National Formulary
- main website/guidelines

Resuscitation Council (UK)
- Guidelines
- Videos

British Thoracic Society Guidelines
- Administration of oxygen

Department of Health and Social Care
- National dementia strategy

Essence of Care 2010
- Communication benchmarking

National electronic library of infection
- Infection control

National Outreach forum
- 'How to Guide' for reducing harm from deterioration

NHS Choices
- Depression self-assessment

NHS England
- Improving care for older people

NHS Improvement
- SBAR communication tool

NICE guidelines
- Venous thromboembolism
- Routine pre-operative tests for elective surgery
- Asthma

Nursing and Midwifery Council

- Standards for pre-registration nursing education
- Standards for medicine management
- Standard for competence of registered nurses/midwives
- Test blueprints (adult nursing)
- The Code
- Guidance
- Concerns about nurses and midwives

Nursing Times

- Effective communication skills

Royal College of Nursing

- Care of older people guidance
- Privacy and dignity
- Rehabilitation and the older person
- Sharps safety

Royal College of Physicians

- NEWS2 Information
- free e-learning unit for NEWS2

Stroke Training

- Main website

World Health Organisation

- Hand washing

YouTube

- Compassion in practice – it's in your hand video
- A new vision for nurses, midwives and care staff

Annexes

Annexe 1: Candidate briefing

Annexe 2: Invigilator briefing

Annexe 3: Adult inpatient admission/discharge form

Annexe 4: Community discharge care letter

Annexe 5: APIE assessment station

Annexe 6: APIE planning station

Annexe 7: APIE implementation station

Annexe 8: APIE evaluation station hospital setting

Annexe 9: APIE evaluation station community care setting

Annexe 10: Clinical skills community prescription chart

Annexe 11: Patient health questionnaire

Annexe 12: Neurological observation chart

Annexe 13: NEWS2 Chart

Annexe 14: Normal range peak expiry flow chart for adult males and females

Annexe 15: Temperature, pulse, respiratory rate observation chart

Candidate Briefing

- You must be dressed appropriately for your area of clinical practice and so demonstrate awareness of the importance of infection control in healthcare practice:
    - Only smooth stud earrings
    - No necklaces
    - Only smooth rings (e.g. wedding ring)
    - No watches, arm bands or bracelets
    - Hair must be well above the collar, with no decorative accessories
    - No nail varnish, gels or false nails
    - No low-cut tops
    - Suitable black shoes
- You must wear the photographic ID provided at all times while you are in the testing area. No other ID may be worn.
- Online learning platform: Have you accessed the resources and videos? If not, do you wish to continue? If **yes**, you must sign a disclaimer as you will not be able to appeal on these grounds.
- The OSCE assessment is assessed in English and you must speak English at all times in the test centre.
- When you have finished your OSCE assessment, talking or discussing your assessment with other candidates could be interpreted as cheating and could result in a fail.
- The use of phones is forbidden at all times in the test centre. Use of a phone for any reason, will be considered cheating. Put your phone on silent and place in your locker as soon as you have received your photographic ID.
- You must be physically fit and well enough to undertake the assessment, which may include physical activity.
- If you feel unwell or need any reasonable adjustments, advise an examiner or invigilator immediately.
- You must remain in the testing area unless instructed to leave by the invigilator or fire marshal.
- Your invigilator will answer general questions. All technical questions must be addressed to an examiner.
- Practice thermometers are available for you on the tables in reception. If you need help using them, please ask the receptionist.

Follow your codes and behave as though you are in professional practice at all times

- Please remember that the CTC is a training centre and you may be asked if an observer can sit in on an assessment. If you would prefer not to have an observer present, this will not affect the result of your assessment in any way.

- Each OSCE lasts approximately 15 minutes and all assessments are recorded for moderation purposes.

- The assessor will show you the equipment and layout of the station before the timer is started.

- The assessor will notify you when the assessment has begun and will prompt you with time remaining.

- Do not add anything after the timer has reached zero, it will not be included in the marking and will be classed as cheating.

- Do not attempt to re-enter a station once you have left. It is classed as cheating and unprofessional behaviour.

- Do not talk to other candidates between stations or during toilet breaks.

- The assessor will verbalise any relevant information before each OSCE starts.

- Use the equipment provided in each station. If you need additional equipment, or advice on how to use equipment, please verbalise this to the examiner.

- Some assessments require you to record information on nursing documentation - you must meet NMC guidelines at all times.

- Verbalise what you are doing and why (e.g. the area is safe, the patient's airway is clear).

- Talk directly to the patient (simulated patient/manikin) not the examiner. If a manikin is being used, talk to it as if it is a real person - the examiner will answer questions as the patient if appropriate.

- Examiners will not give you any feedback on your performance, however they may ask you questions and provide you with relevant information during your assessment.

- If you make a mistake, verbalise what you would do in practice.

- Verbalisation of any errors or omissions during your assessment will not overturn a critical fail element.

- In the event that any candidate demonstrates unsafe practice which may place the candidate, simulated patient or examiner at risk, then a U score (unsafe practice) must be awarded, and the station will be stopped.

If you have any technical questions, please ask an examiner.

For general questions, please ask an invigilator.

I confirm that I have read and understood this OSCE Candidate Briefing.

Date: _____ Signed: _____ Print Name: _____

Invigilator Briefing

1. Fire exits: All labs contain fire doors. Please stay with examiner when exiting.
2. Are you suitably dressed for clinical practice? Only smooth stud earrings (1 pair), no necklaces, only 1 smooth ring (e.g. wedding bands). No watches or arm bands, lower arms need to be bare. Hair must be up above the collar and off the face. Nails must be cut short, no nail varnish and no gel/false nails. Please wear suitable shoes.
3. Have you accessed Online learning platform resources and videos? – If you have not, do you wish to continue? If **yes**, you must sign a disclaimer, as you are not allowed to appeal on these grounds.
4. If you need anything today please ask the invigilator – water, toilet breaks and rests are all available.
5. If you feel unwell, please let any member of staff know.
6. Technical questions must be directed to the Examiners.
7. Do you have a pen, fob watch and pen torch? If not, please get one from the receptionist. If your pen runs out we have spare pens - just ask.

Today you will undertake Part 2 of the OSCE Test of Competence
Six Stations – four Nursing Processes and two Skills

1. A = Assessment of a real person with questions and answers. **Please write your name on the top of the assessment sheet so that we can ensure all your paperwork stays together.**
2. P = Planning care. Two written aspects of nursing care and self-care. You must use todays date on all your documentation. Complete all documentation. This is a written silent station which is also filmed. **Please write your name on the planning sheet paperwork.**
3. I = Implementation. Drug administration is with a manikin and you must use todays date on all your documentation. Complete all documentation.
4. E = Evaluation. A transfer letter about your patient – complete all documentation. This is a written silent station which is also filmed.
5. Today you will be asked to complete two skills using a manikin.

In the Examination Room

The examiners are there in an examiner capacity and the expectation is that you will be a **lone practitioner.**

At the start of each station the examiner will ask you the following questions:

- Please can you confirm that you do not know the examiner, invigilator or the actor (if applicable to the station) outside of this examination, and they were not involved in the preparation of this exam.
- Please can you confirm that you are fit and well to take this station.

Please can you respond to these questions with one of the following responses:
'Yes, I can confirm this is true.' or 'No, that is not true.'

Before you begin each station there will be a recap summary, the following questions will be asked:

- Do you understand what is expected of you?
- Are you fit and well to proceed?
- Do you have any questions?
- Are you ready to start?

Please can you respond to these questions with one of the following responses:
'Yes.' or 'No.'

Decontaminate hands as you would in the practice setting. Use your clinical judgement - we have hand gel available.

Manikins. Please talk to the manikin as if it is a real person. Examiners will answer any questions and engage in conversation as required. Please look at the manikin rather than the examiner.

Feel stuck or panicking? You can ask the examiner if you feel stuck. The examiners will reply: 'What would you do in practice?'

If you need help for example, to raise the bed or open anything, please ask the Examiner to do it for you. If you have any questions or need clarification, please ask the examiner.

If you make a mistake – Please tell the examiner straight away and tell them what you would do in practice. You can verbalise any errors or omissions in the timed station only. Verbalisation will not overturn an issue of unsafe practice.

Follow the NMC Code and behave as though you are in professional practice at all times.

All stations will have a camera in them, which **is set to continuously record**. On entering the station you will be asked to confirm your name to the camera and confirm that you do not know the examiner.

1. All stations have a digital clock which is set with the time for that station.
2. All documentation is given to you in the station and you will be given time to read it.
3. You will be shown the layout of the station and shown the equipment. I can confirm that this is a latex free environment and there will be no latex in any of the stations.
4. If equipment is different to what you normally use please tell the examiner, who will be happy to show you how to use it.
5. Examiners will not prompt you as to what to do next.
6. Examiners will prompt you with the time remaining.
7. When the timer reaches zero, that part of your exam is over. There will be no extra time unless a technical issue arose.
8. Do not add anything after the timer has reached zero, as it cannot be included and would be classed as cheating.
9. Do not attempt to re-enter a station once you have left. This would be classed as cheating and unprofessional behaviour.
10. You must not talk to other candidates in between stations or attempt to write on anything as this is cheating.

If you have any questions please ask your invigilator or examiners.

Filled out on day of examination

Adult Inpatient Admission/Discharge Form and

Trust Core Patient Activities of Daily Living (ADL)

Initial Assessment

Ward _____

ADDRESSOGRAPH

LABEL

Type of admission

Accident and Emergency ☐ Clinic ☐

General Practitioner (GP) ☐ Other ☐

Date of admission:_____ Time: _____

Estimated date of discharge: _____

Consultant: _____

Named nurse : _____

Reason for admission:

_____

_____

Diagnosis/operation:

_____

_____

_____

Previous medical history:

_____

_____

_____

_____

_____

_____

Single assessment document Yes ☐ No ☐

Preferred Name: _____

Age: _____ Status _____

Religion: _____ Ethnic origin _____

Does the patient agree to their name/information being written on white boards in wards? Yes ☐ No ☐

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

Have you been resident in the UK for 12 months?. If NO, complete NGV1398 Notification of overseas visitors. Yes ☐ No ☐

Next of kin

Name _____

Relationship: _____

Address: _____

_____ Postcode _____

Telephone numbers Home _____

Work: _____ Mobile: _____

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

Notified Yes ☐ No ☐ If NO, reason:

Significant others

Name: _____

Relationship: _____

Address: _____

_____ Postcode _____

Telephone numbers Home: _____

Work: _____ Mobile: _____

Notified Yes ☐ No ☐ If NO, reason:

Name and Contact number for night time:

_____

VALUABLES Yes ☐ No ☐ Hospital policy explained ☐

House keys ☐ Glasses ☐ Hearing aid ☐

Dentures ☐ Contact lens ☐

Property details:

General office ☐ Home ☐ Retained by patient ☐

NB. Refer to disclaimer on page 2.

Medication Brought in Yes ☐ No ☐

If YES, Retained on ward ☐ Sent home ☐

Patient Orientation Checklist – Nursing Staff to Complete

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

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

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

Signature _____ **PRINT name** _____

Designation _____ **Ward** _____ **Date** _____

DISCLAIMER

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

Signature of patient _____

Name (block capitals) _____

Date _____

On Admission

Allergies (include medicines, latex, food, other)	State reaction experienced:

1. Do you have a reaction to latex/rubber products — Yes ☐ Go to question 2; No ☐ (no allergy) Go to question 3

2. What kind of reaction do you have:

Localised eczema on skin in contact with rubber only — Yes ☐ (Type 4); No ☐ (no allergy)

and/or

	(Type 1)	(Type 4)
Hives	Yes ☐	No ☐
Wheezing	Yes ☐	No ☐
Difficulty breathing	Yes ☐	No ☐
Swelling of lips/tongue/throat	Yes ☐	No ☐
Collapse	Yes ☐	No ☐
Other (please describe):	Yes ☐	No ☐

3. Do you have a rash, itching, swelling or hives after contact with rubber products such as household gloves or balloons, — Yes ☐ No ☐

If YES, go back to question 2

Allergy identified, inform medical staff, anaesthetist as appropriate

No allergy ☐ Type 4 allergy ☐ Type 1 allergy ☐

Making every Contact Count – NGH Nursing Admission Questions

Smoking

1. Does the patient smoke? Yes ☐ No ☐

No – No further action
Yes – Offer a 'Time for a QUIT Chat' brief advice intervention and recommend a referral to the NHS Stop Smoking Service.

- Complete a Time for a QUIT Chat Referral form NGV1547 or via the referral form on the ICE System
- Combustibles - Sent home ☐ Locked away ☐

Date of referral _____ Signature _____

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

Alcohol Harm Reduction continued

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

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

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

Date of Referral _____ Signature _____

Social History

Do you live alone ☐ With others ☐ Who _____

Do you have dependents Yes ☐ No ☐

If yes, who is caring for them _____

Type of accommodation and how long at this address:

House ☐ Flat ☐ Floor e.g. 1,2,3,4,5,6 _____ Lift: Yes ☐ No ☐ Bungalow ☐

Mobile home ☐ Other _____ Warden controlled accommodation ☐

Contact number: _____

Nursing home ☐ Residential home ☐ Name and address _____

Access to home

What is the access to the property – specify how many steps, slope, etc_____

How many toilets are there in the property and where are they located? _____

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

Where is the bathroom located (indicate floor) _____

Where do you sleep? Upstairs ☐ Downstairs ☐

What equipment do you have at home? Grab rails ☐ Where are these situated_____

Zimmer frame ☐ Rota stand ☐ Stair lift ☐ Hoist ☐

Pressure relieving mattress ☐ Pressure relieving cushion ☐

Other (please specify) _____

Do you have dependent others or pets that will require support whilst you are in hospital?

Yes ☐ No ☐ Specify _____

PRINT name _____ Signature _____

Designation _____ Date _____

Pre admission services

Social worker name and contact number _____

Care package	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
How many times							

Care package includes: _____

	Yes	No
Community/specialist nurse		
Physiotherapist		
Occupational therapist		
Health Visitor		
Psychiatric nurse		
Warden		
Life line/Vitalink/Other		
Pet system		
Keysafe		

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Age concern							
Voluntary							
Meals on wheels (hot/frozen)							
Day Hospital							
Day Centre							

Interagency Community Team _____

Other (please specify) _____

Informal care arrangements

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

Please specify _____

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

Personal tasks Who does the following?

	Self	Others - identify		Self	Others - identify
Cooking			Cleaning		
Laundry			Ironing		
Hygiene needs			Medication		
Shopping			Finances		

Is a continuing health care assessment required? Yes ☐ No ☐

If yes, contact social work department.

Trust Core Patient Activities of Daily Living –

Initial Assessment

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

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

A Trust Fall Assessment Tool – within 12 hours

B Trust Patient Handling Assessment Tool – within 12 hours

C Trust Pressure Prevention Assessment Tool – within 8 hours

D Trust Nutritional Screening Assessment Tool – within 24 hours

E Trust Pain Assessment Tool – on admission

Signature _____ Time _____ Date _____

PRINT NAME/Stamp _____

To be completed in full by admitting nurse.

Activities of Daily Living Assessments

1a Maintaining a safe environment (prompts)

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

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

1b Is the VTE Risk Assessment complete Yes ☐ No ☐

If Yes – commence appropriate prescribed treatment

- refer to AES core care plan NGV1459

If No - escalate to medical staff

1c Dementia and carers of patients with dementia

Has the patient a diagnosis of dementia?

Yes ☐ • Utilise Butterfly magnet • Complete Butterfly patient profile • Give the patient/carer 'Information for Carers of patients with dementia' leaflet NGV1581 • Does the carer want to be involved in the patient's care whilst in hospital? Refer to Carer's policy • Does the carer require further support? If yes, contact Carer Assessment and Support Worker (CASW)	No ☐ • Does the patient have signs of delirium or cognitive impairment? If yes, Utilise 'Outline Butterfly' magnet

2. Communication (prompts)

Blind	Yes ☐ No ☐	Partially sighted	Yes ☐ No ☐
Glasses	Yes ☐ No ☐	Contact lens	Yes ☐ No ☐
Glasses/lens with patient	Yes ☐ No ☐		

Additional information :

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

If YES, commence Learning Disabilities Passport NGV1516

If YES, contact the Learning Disability Nurse, ext (Monday-Friday) 09.00-17.00 or on call duty nurse

Community hospitals ring _____

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

Is a Mental Capacity Assessment required? Yes ☐ No ☐

If YES, contact Safeguarding Lead, bleep (Monday-Friday) 09.00-17.00 or on call duty nurse for further advice and support.

Community hospitals ring _____

b) Hearing:

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

If NO, record action taken :
(Consider use of Piticom Booklet) _____

Additional information:

c) Speech and Language (prompts):

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

First language spoken if not English _____
(Consider use of Piticom booklet)

Additional information :
e.g. patient aphasic or suffers from dysphasia

3. Mobility (prompts) **Complete Trust Pressure Prevention Assessment Tool, page 17**
Complete Patient Handling Assessment, page 14

Independently mobilises Yes ☐ No ☐ Assistance/supervision required Yes ☐ No ☐

Identify aids used _____

Additional information:

4. Eating and Drinking (prompts) Complete Trust Nutritional Screening Assessment Tool, pg 25

Able to swallow Yes ☐ No ☐ Difficulty swallowing Yes ☐ No ☐

Wears dentures Yes ☐ No ☐ Dentures with patient Yes ☐ No ☐

Top set Yes ☐ No ☐ Bottom set Yes ☐ No ☐

Special diet required Yes ☐ No ☐

If YES, identify _____

Information required regarding - healthy eating Yes ☐ No ☐

- weight management Yes ☐ No ☐

If YES, refer to nutritional team

Referral date_____ Signature _____

Additional information

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

Independent Yes ☐ No ☐ Requires assistance Yes ☐ No ☐

Additional information:

6. Elimination (prompts)
a) Urine

Do you have to go to the bathroom during the night Yes ☐ No ☐

Do you suffer from frequency of passing urine Yes ☐ No ☐

Do you have any concerns regarding passing urine Yes ☐ No ☐

Do you have a long term catheter Yes ☐ No ☐

Additional information :

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

Date	Specific gravity	Urine PH	Leucocytes	Nitrate	Protein
Glucose	Ketones	Urobilinogen	Bilirubin	Blood erythrocytes	

b) Bowels (prompts)

Normal habit _____

Stoma present Yes ☐ No ☐

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

Blood in stools Yes ☐ No ☐

Diarrhoea Yes ☐ No ☐

Constipation Yes ☐ No ☐

Other _____

Additional information :

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

7. Breathing

Asthma Yes ☐ No ☐

Chronic obstructive airway disease Yes ☐ No ☐

Breathlessness Yes ☐ No ☐

Smoker Yes ☐ No ☐

Other long term breathing problems: _____

Identify inhalers (if used) _____

Additional information:

8. Sleeping (prompts)

Usual sleeping habits _____

Takes night sedation Yes ☐ No ☐ If YES, identify medication _____

Sleep interrupted Yes ☐ No ☐ If YES, by what, e.g. bathroom _____

If YES, what helps _____

Additional information:

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

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

Requires further discussion Yes ☐ No ☐ If YES, who _____

Additional information:

Date of referral _____ Signature _____

10. Death and dying

Visit required from religious/spiritual personnel Yes ☐ No ☐

If YES, what arrangements have been made _____

Additional information:

If appropriate:

- Has DNACPR status been considered Yes ☐ No ☐
- Has the patient been identified as requiring end of life care Yes ☐ No ☐

  If YES, have relatives/carers been informed/consulted Yes ☐ No ☐
- Has a chosen place of death or care been identified Yes ☐ No ☐

  If YES, where _____

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

Additional information:

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

Do you take regular analgesia Yes ☐ No ☐

Are they effective Yes ☐ No ☐

Are you in pain Yes ☐ No ☐

Is analgesia prescribed Yes ☐ No ☐

Additional information: (note alternative methods of pain relief

12. Working and playing

How do you spend your days Work _____ Hobbies/leisure _____

Do you undertake any physical activity? Yes ☐ No ☐

If YES, what are they _____

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

If YES, what _____

Action taken _____

Name of nurse assessing:_____ PRINT name _____ Date _____

Scenario

Discharge Care Letter

Scenario
Filled out on day of the examination

Assume it is **TODAY** and it is **xx:xx** hours.
This documentation is for your use and is **not marked** by the examiners.

Discharge Care Letter –filled out on day of the examination

Patient Details: Name: Hospital Number: NHS Number: Date of Birth: Address:	Next of Kin Details: Name, Relationship Contact Number
Patient GP: Name Address	
What was the main reason for admission?	
Date of admission:	
Primary Diagnosis	
Actual and/or potential nursing care needs/problems/activities of daily living identified during patient stay.	
Nursing/Medical Interventions	
Past Medical History	
Medications New Medications added this admission:	

Allergies
Social History
Discharge Summary
Name (print):
Nurse Signature:
Date: Yesterday
Date and time of transfer: Yesterday, xx:xx

Assessing Care

Complete a Nursing Assessment of your patient.

An observation chart is provided and must be completed within the station.

(Failure to complete the chart before leaving the station will result in a fail).

Scenario
Filled out on the day of the examination

Assume it is **TODAY** and it is **xx:xx hrs**. The patient has just arrived.

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

Nursing Assessment Candidate Notes – not marked

Patient Name, Hospital Number xxxxxx xxx
Patient Address xxx xxxx
Patient DOB xx/xx/xxxx

Maintaining a Safe Environment
Breathing
Communication/Pain
Controlling Temperature
Mobilising
Sleeping
Elimination

Additional Notes

Planning Care Scenario

Candidate's Name: _____

Note to Candidate:

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

Scenario:

Based on your nursing assessment of patient, please produce a nursing care plan for **2 relevant aspects of nursing care and self-care suitable for the next 24 hours.**

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

Assume it is **today** and it is **XX.XX**

Planning Care Scenario

Patient Details:	
1) Nursing problem / need	
Aim(s) of care:	
Re-evaluation date:	
Care provided by nurse(s)	**Patient self-care activities**

Planning Care Scenario

Nursing & Midwifery Council

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

Planning Care Scenario

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

Implementing Care

Candidate Name: _____

Note to Candidate:

Document to NMC standards.

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

Scenario
Filled out on day of examination

- Talk to your patient.
- 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 are on the chart and on the drug trolley.
- Check and complete the last page of the chart.
- You have 15 minutes to complete this station, including the required documentation.
- Please proceed to administer and document their xx:xx hours medications, safely in accordance with the NMC standards.

Complete **all** sections of the document.

Assume it is **TODAY** and it is xx:xx **hours**

Prescription Chart for:	**name**	sex	Name xxxxxxxx Hospital Number: xx/xx/xxxx Date of Birth: xx/xx/xxx Address xx

Admission Date and Time:	Filled out on day of examination

Known Allergies or Sensitivities	**Type of Reaction**
Filled out on day of examination	Filled out on day of examination

Signature:	Dr: *A.Kumar*	**Date:**	

Information for Prescribers:	**INFORMATION FOR NURSES ADMINISTERING MEDICATIONS:**	
USE BLOCK CAPITALS.	Record time, date and sign when medication is administered or omitted and use the following codes if a medication is not administered:	
SIGN AND DATE AND INCLUDE BLEEP NUMBER.		
SIGN AND DATE ALLERGIES BOX- IF NONE- WRITE "NONE KNOWN".	**1. PATIENT NOT ON WARD.**	**6. ILLEGIBLE/INCOMPLETE PRESCRIPTION, OR WRONGLY PRESCRIBED MEDICATION.**
RECORD DETAILS OF ALLERGY.	**2. OMITTED FOR A CLINICAL REASON**	**7. NIL BY MOUTH**
DIFFERENT DOSES OF THE SAME MEDICATION MUST BE PRESCRIBED ON SEPARATE LINES.	**3. MEDICINE IS NOT AVAILABLE.**	**8. NO IV ACCESS**
CANCEL BY PUTTING LINE ACROSS THE PRESCRIPTION AND SIGN AND DATE.	**4. PATIENT REFUSED MEDICATION.**	**9. OTHER REASON- PLEASE DOCUMENT**
INDICATE START AND FINISH DATE.	**5. NAUSEA OR VOMITING.**	

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

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

WARD	**CONSULTANT**	**HEIGHT**	Filled out on day of examination
Filled out on day of examination	Filled out on day of examination	**WEIGHT**	Filled out on day of examination
ANY Special Dietary requirements?	*YES* *NO* Filled out on day of examination	**If YES please Specify**	Filled out on day of examination

Prescription Chart for:	**name**	sex	Name xxxxxxxx Hospital Number: xx/xx/xxxx Date of Birth: xx/xx/xxx Address xx

Does the patient have any documented Allergies?	YES NO Filled out on day of examination	**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**
		Filled out on day of examination						

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**
	Filled out on day of examination						

PRN (AS REQUIRED MEDICATIONS):

DATE	**DRUG**	**DOSE**	**ROUTE**	**INSTRUCTIONS**	**PRESCRIBER SIGNATURE AND BLEEP**	**TIME GIVEN**	**GIVEN BY:**
	Filled out on day of examination						

Prescription Chart for:	**name**	sex	Name xxxxxxxx Hospital Number: xx/xx/xxxx Date of Birth: xx/xx/xxx Address xx

Does the patient have any documented Allergies?	YES NO Filled out on day of examination	***Please check the chart before administering medications.***

ANTIMICROBIALS:

1. DRUG	Filled out on day of examination					**Date and Signature of Nurse Administering Medications. Code for non administration**	
DATE	**DOSE**	**FREQUENCY**	**ROUTE**	**DURATION**	**TIME**	**Today**	**Tomorrow**
Start date							
Finish date							
Prescribers' Signature and bleep							

2. DRUG	Filled out on day of examination					**Date and Signature of Nurse Administering Medications. Code for non administration**	
DATE	**DOSE**	**FREQUENCY**	**ROUTE**	**DURATION**	**TIME**	**Today**	**Tomorrow**
Start date							
Finish date							
Prescribers'' Signature and bleep							

3. DRUG	Filled out on day of examination					**Date and Signature of Nurse Administering Medications. Code for non administration**	
DATE	**DOSE**	**FREQUENCY**	**ROUTE**	**DURATION**	**TIME**	**Today**	**Tomorrow**
Start date							
Finish date							
Prescribers'' Signature and bleep							

Prescription Chart for:	**name**	sex	Name xxxxxxxx Hospital Number: xx/xx/xxxx Date of Birth: xx/xx/xxx Address xx

Does the patient have any documented Allergies?	YES NO Filled out on day of examination	***Please check the chart before administering medications.***

REGULAR MEDICATIONS:

1. DRUG	Filled out on day of examination					**Date and Signature of Nurse Administering Medications. Code for non administration**	
DATE	**DOSE**	**FREQUENCY**	**ROUTE**	**DURATION**	**TIME**	**Today**	**Tomorrow**
Start date							
Finish date							
Prescribers'' Signature and bleep							
2. DRUG	Filled out on day of examination					**Date and Signature of Nurse Administering Medications. Code for non administration**	
DATE	**DOSE**	**FREQUENCY**	**ROUTE**	**DURATION**	**TIME**	**Today**	**Tomorrow**
Start date							
Finish date							
Prescribers'' Signature and bleep							
3. DRUG	Filled out on day of examination					**Date and Signature of Nurse Administering Medications. Code for non administration**	
DATE	**DOSE**	**FREQUENCY**	**ROUTE**	**DURATION**	**TIME**	**Today**	**Tomorrow**
Start date							
Finish date							
Prescribers'' Signature and bleep							

Prescription Chart for:	**name**	sex	Name xxxxxxxx Hospital Number: xx/xx/xxxx Date of Birth: xx/xx/xxx Address xx

Does the patient have any documented Allergies?	YES NO Filled out on day of examination	**Please check the chart before administering medications.**

INTRAVENOUS FLUID THERAPY:

DATE	FLUID	VOLUME	RATE/TIME	PRESCRIBER	BATCH NUMBER:	COMMENCED @	GIVEN BY:	CHECKED BY:	FINISHED @
				Filled out on day of examination					

DRUGS NOT ADMINISTERED:

DATE	TIME	DRUG	REASON	NAME AND SIGNATURE

The prescription chart will be completed for candidates on the day of the examination.

Evaluating Care Scenario

Candidate's Name: _____

Note to Candidate:

- **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 ask the examiner for it**
  - **Please Note: there are 3 pages to this document**
- **Document to NMC standards**
- **Your examiner will retain all documentation at the end of the station**

Scenario:

Complete a transfer of Care letter to ensure that the receiving nurses have a full and **accurate** picture of the patient's history and needs.

Complete **all** sections of the document.

Assume it is **today** and it is **XX:XX**.

Evaluating Care Scenario

Nursing & Midwifery Council

Transfer of Care Letter

Patient Details:
Clearly describe reason for initial admission and subsequent diagnosis
Date of admission:
Identify the main nursing needs addressed during the patients stay in MAU
Outline the nursing care provided to meet the identified needs

Evaluating Care Scenario

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

Evaluating Care Scenario

Nursing & Midwifery Council

Candidate's Name: _____

Note to Candidate:

- **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 ask the examiner for it**
  - **Please Note: there are 3 pages to this document**
- **Document to NMC standards**
- **Your examiner will retain all documentation at the end of the station**

Scenario:

Complete the Referral of Care letter to ensure that the receiving team have a full and accurate picture of the patient's history and needs.

Complete **all** sections of the document.

Assume it is **today** and it is **xx:xx**

Referral of Care Letter

Patient Details:
What is the main reason/purpose for the referral to xxxxxxxxxx?
Date of admission:
Identify the actual and/or potential nursing care needs / problems / activities of living which led to the referral to the Community Mental Health Team.
Outline the nursing care provided to meet the identified needs

Outline person's current ability to self-care based on the person's care plan.
Document person's allergies and associated reactions
List areas identified for patient education
Date and time of referral:
NAME (Print):
Nurse Signature: **Date:**

SKILL STATION

Candidate Name: _____

Please read this Insulin prescription chart carefully. You may refer to the brief during the assessment.

<table>
<tr><td colspan="4">Scenario

Filled out on day of the examination</td></tr>
<tr><td colspan="4">All the equipment you need is provided. Please administer the _____ safely using the prescription below.
It is TODAY and it is xx:xx hours.</td></tr>
<tr><td>PATIENT DETAILS</td><td>DRUG</td><td>DOSE</td><td>SIGNATURE</td></tr>
<tr><td>Name: xxxxxxxxxx
Address: xxxxxxxxxxxxx
Town/City: xxxxxxxxxxxxx
Post Code: xxx xxx
Date of Birth: xx/xx/xxx</td><td rowspan="2">MEDICATION
Dose

Batch Number:</td><td>TODAY at xx:xx hours</td><td rowspan="2">Signature:

Date:

Time:</td></tr>
<tr><td>ALLERGIES:
Signature (GP) Today xx:xx</td><td>Prescribers Signature:
Signature (GP) Today xx:xx</td></tr>
<tr><td colspan="4">Nurses Notes:</td></tr>
<tr><td colspan="2">Print Name:</td><td colspan="2">Signature and Date/ Time:</td></tr>
</table>

The Patient Health Questionnaire (PHQ-9)

Patient Name _____

NHS Number _____

Date _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Column Totals				
Add Totals Together				

V3.1| 19/04/2018

Kroenke K, Spitzer RL, Williams JB; The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001 Sep 16(9):606-13.

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation *Patient preferences should be considered*
5 - 9	Minimal symptoms	Support, educate to call if worse, return in one month
10 – 14	Minor depression Dysthymia Major depression, mild	Support, watchful waiting Antidepressant or psychotherapy Antidepressant or psychotherapy
15 – 19	Major depression, moderately severe	Antidepressant or psychotherapy
> 20	Major depression, severe	Antidepressant and psychotherapy (especially if not improved on monotherapy)

Kroenke K, Spitzer RL, Williams JB; The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001 Sep 16(9):606-13.

CANDIDATE NAME:	NEUROLOGICAL OBSERVATION CHART

PATIENT NAME:	HOSPITAL NO:	DATE:	TIME:

				TIME	TIME
COMA SCALE	Eye opening (E)	Spontaneous	4		Eyes closed by swelling = C
		To sound	3		
		To pressure	2		
		None	1		
		Not testable	NT		
	Verbal response (V)	Orientated	5		Endotracheal Tube or tracheostomy = T
		Confused	4		
		Words	3		
		Sounds	2		
		None	1		
		Not testable	NT		
	Best motor response (M)	Obeys commands	6		
		Localising	5		
		Normal flexion	4		
		Abnorma flexion	3		
		Extension	2		
		None	1		
		Not testable	NT		

Pupil scale (mm): 1, 2, 3, 4, 5, 6, 7, 8

Blood pressure and Pulse rate: 230, 220, 210, 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40, 30, 20

Respiration

Temperature °C: 40, 39, 38, 37, 36, 35, 34, 33, 32, 31, 30

PUPILS			
	Right	Size	
		Reaction	
	Left	Size	
		Reaction	

+ reacts
- no reaction
c eye closed

LIMB MOVEMENT			
	Arms	Normal power	Record right (R) and left (L) separately if there is a difference between the two sides
		Mild weakness	
		Severe weakness	
		Spastic flexion	
		Extension	
		No response	
	Legs	Normal power	
		Mild weakness	
		Severe weakness	
		Extension	
		No response	

Total GCS Score	
Oxygen Saturations	

NEWS key 0 1 2 3

FULL NAME

DATE OF BIRTH | **DATE OF ADMISSION**

	DATE / TIME		DATE / TIME
A+B Respirations Breaths/min	≥25	3	≥25
	21–24	2	21–24
	18–20		18–20
	15–17		15–17
	12–14		12–14
	9–11	1	9–11
	≤8	3	≤8
A+B SpO_2 Scale 1 Oxygen saturation (%)	≥96		≥96
	94–95	1	94–95
	92–93	2	92–93
	≤91	3	≤91
SpO_2 Scale 2† Oxygen saturation (%) Use Scale 2 if target range is 88–92%, eg in hypercapnic respiratory failure †ONLY use Scale 2 under the direction of a qualified clinician	≥97 on O_2	3	≥97 on O_2
	95–96 on O_2	2	95–96 on O_2
	93–94 on O_2	1	93–94 on O_2
	≥93 on air		≥93 on air
	88–92		88–92
	86–87	1	86–87
	84–85	2	84–85
	≤83%	3	≤83%
Air or oxygen?	A=Air		A=Air
	O_2 L/min	2	O_2 L/min
	Device		Device
C Blood pressure mmHg Score uses systolic BP only	≥220	3	≥220
	201–219		201–219
	181–200		181–200
	161–180		161–180
	141–160		141–160
	121–140		121–140
	111–120		111–120
	101–110	1	101–110
	91–100	2	91–100
	81–90	3	81–90
	71–80		71–80
	61–70		61–70
	51–60		51–60
	≤50		≤50
C Pulse Beats/min	≥131	3	≥131
	121–130	2	121–130
	111–120		111–120
	101–110	1	101–110
	91–100		91–100
	81–90		81–90
	71–80		71–80
	61–70		61–70
	51–60		51–60
	41–50	1	41–50
	31–40	3	31–40
	≤30		≤30
D Consciousness Score for NEW onset of confusion (no score if chronic)	Alert		Alert
	Confusion	3	Confusion
	V		V
	P		P
	U		U
E Temperature °C	≥39.1°	2	≥39.1°
	38.1–39.0°	1	38.1–39.0°
	37.1–38.0°		37.1–38.0°
	36.1–37.0°		36.1–37.0°
	35.1–36.0°	1	35.1–36.0°
	≤35.0°	3	≤35.0°
NEWS TOTAL			**TOTAL**
Monitoring frequency			Monitoring
Escalation of care Y/N			Escalation
Initials			Initials

NEW score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	• Continue routine NEWS monitoring
Total 1–4	Minimum 4–6 hourly	• Inform registered nurse, who must assess the patient • Registered nurse decides whether increased frequency of monitoring and/or escalation of care is required
3 in single parameter	Minimum 1 hourly	• Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary
Total 5 or more Urgent response threshold	Minimum 1 hourly	• Registered nurse to immediately inform the medical team caring for the patient • Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients • Provide clinical care in an environment with monitoring facilities
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level • Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills • Consider transfer of care to a level 2 or 3 clinical care facility, ie higher-dependency unit or ICU • Clinical care in an environment with monitoring facilities

OBSERVATION CHART	NHS NUMBER..... PATIENT SURNAME..... PATIENT FIRST NAME.....

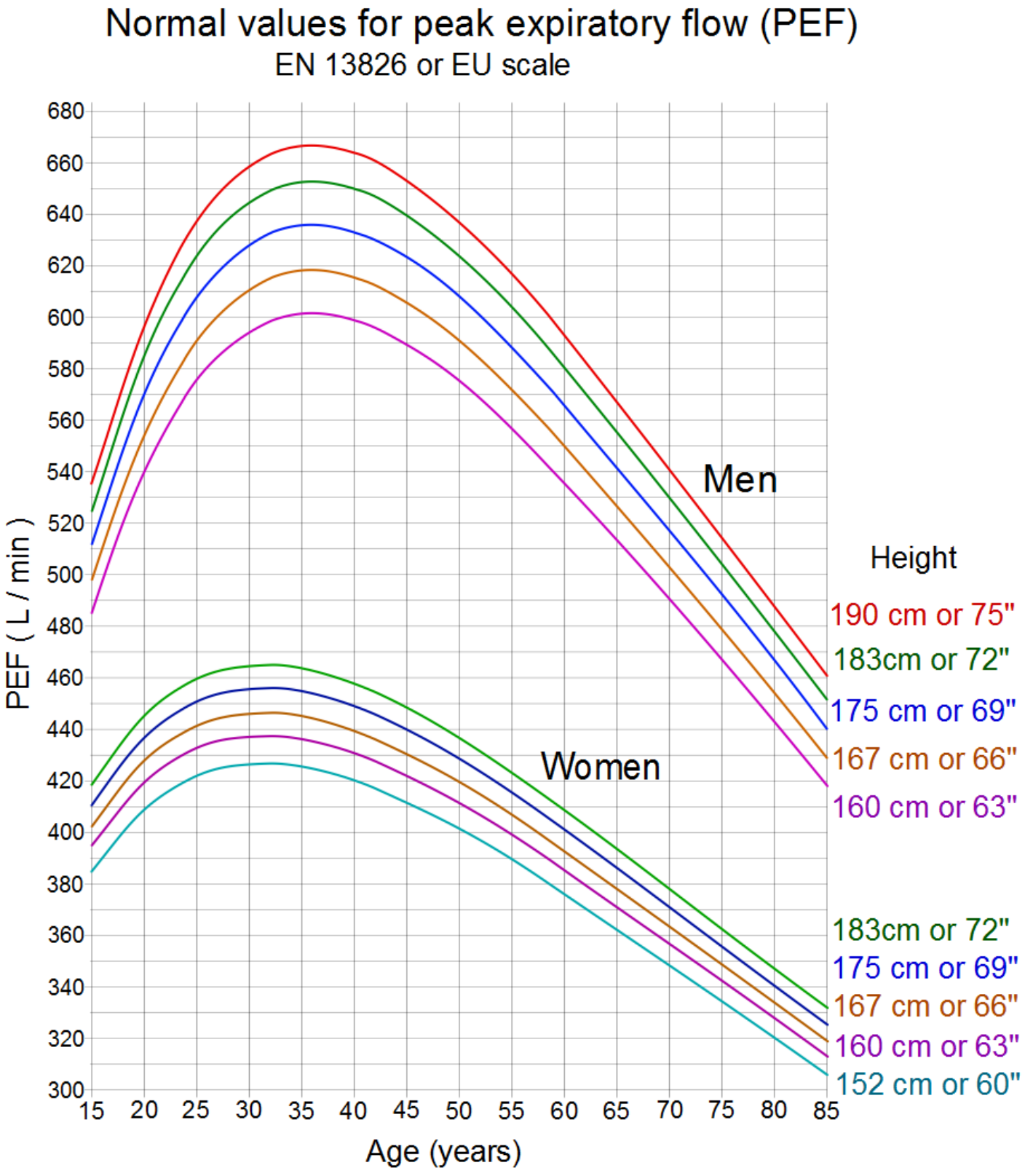
Candidate Name.....

PLEASE RECORD YOUR OBSERVATIONS FROM LEFT TO RIGHT

Year															
Date/Month															
Time															
BP ^ : : : : : : V	240 230 220 210 200 190 180 170 160 150 140 130 120 110 100 90 80 70 60 50 40														40ºC 39ºC 38ºC 37ºC 36ºC 35ºC 34ºC 33ºC
Pulse •															
Temp X															
Respiratory Rate															
Nurse's initials															

Peak Expiratory Flow Rate Chart

Patient name	
Date of birth	



Candidate name -