Mock Scenario
Postnatal depression

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, 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 criteria included within this document provides 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 nonverbal 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 patient's full name and hospital number 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	Supplies, dispenses or administers medicines within the limits of training, competence, the law, the NMC and other relevant policies, guidance and regulations.
Medicine management	

The Mock OSCE is made up of four stations: assessment, planning, implementation and evaluation. Each station will last approximately fifteen minutes and is scenario based. The instructions and available resources are provided for each station, along with the specific timing.

Scenario

Sam Smyth has been referred to the primary care mental health team by her health visitor following a routine home visit as she appeared to be presenting with Post Natal Depression type symptomology. Sam has arrived at the health centre for a mental health assessment.

You will be asked to complete the following activities to provide high quality, individualised nursing care for the patient, providing an assessment of her needs using a model of nursing that is based on the activities of living. All four of the stages in the nursing process will be continuous and will link with each other.

Station	**You will be given the following resources**
Assessment – **15 minutes** You will collect, organise and document information about the patient.	• A Health Visitor Telephone Referral (pages 9-10) • Assessment overview and documentation (pages 11-12)
Planning – **15 minutes** You will complete the planning template to establish how the care needs of the patient will be met, how these are prioritised and what evidence-based nursing care you'll provide.	• A partially completed nursing care plan for two nursing care and self-care needs (pages 13-16) • A blank Patient Health Questionnaire 9 (PHQ 9) (page 25-26)
Implementation – 15 minutes You will administer medications while continuously assessing the individual's current health status.	• An overview and Medication Administration Record (MAR) (pages 17-21)
Evaluation – 15 minutes You will document the care that has been provided so that this is communicated with other healthcare professionals, provide a record of clinical actions completed, disseminate information and demonstrate the order of events relating to individual care.	• An overview and transfer of care letter for admission to a Mother and Baby unit. (pages 22-24)

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

Assessment Criteria
Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
May verbalise or make environment safe
Introduce self to person
Check ID with person (person's name is essential and either their date of birth or hospital number) : verbally, against wristband (where appropriate) and paperwork
Gain consent
Explain the reason for assessment
Use **SOLER** throughout the assessment;
Sitting at a comfortable angle and distance
Open posture. Arms and legs uncrossed
Leaning forward from time to time, looking genuinely interested, listening attentively
Effective eye contact without staring
Remaining relatively relaxed
Use appropriate questioning skills
Builds trust and rapport
Uses brief verbal and non-verbal affirmations
Uses reflection/paraphrasing to demonstrate concern
Accurately documents assessment tool score (PHQ9, MOCA)
Discusses the outcome of the assessment tool including clinical response/recommendation.
Close assessment appropriately and may check findings with person

Planning Criteria
Handwriting is clear and legible for problems one and two
Identify two relevant nursing problems/needs
Identify aims for both problems
Set appropriate evaluation date for both problems
Ensure nursing interventions are current / relate to Evidence Best Practice
Self-care opportunities identified and relevant
Professional terminology used in care planning
Confusing abbreviations avoided
Ensure strike-through errors retain legibility
Print, sign and date

Implementation Criteria
Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
Introduce self to person
Seek consent prior to administering medication.
Check ID with person; verbally, against wristband (where appropriate) and paperwork.
May refer to previous assessment results
Must check allergies on chart and confirm with the person in their care, also note red wristband
Before administering any prescribed drug, look at the person's prescription chart and check the following: Correct: Person, Drug, Dose, Date and time of administration and Route and method of administration
Ensures: Validity of prescription, Signature of prescriber and the prescription is legible
Identify and administer drugs due for administration correctly and safely.
Provide a correct explanation of what each drug being administered is for to the person in their care
Omit drugs not to be administered and provides verbal rationale

Evaluation Criteria
Clearly describe reason for initial admission and diagnosis/referral
Record date of admission/original assessment
Identify main nursing needs
Record approaches and interventions used
Outline current ability to self-care based on the person's care plan
List areas identified for health education/risks identified related to the persons mental health
Documents allergies
Ensure strike-through errors retain legibility
Print, sign and date

Appendices

Post Natal Depression

Health Visitor Telephone Referral

Post Natal Depression

Patient Details: **Name:** Sam Smyth **NHS number:** 00046329 **Date of Birth:** 01/01/1987 1 Sweet Street, Westshire, WW6 5PQ	**Next of Kin Details:** Matthew Smyth (husband) 1 Sweet Street, Westshire, WW6 5PQ 07774242421
Patient GP: Dr Henry The Riverview GP Surgery, Westshire, WW6 1TG	
What was the main reason for referral? Sam is expressing low self-esteem, loss of energy, tearfulness and feeling unable to cope with life.	
Primary Diagnosis Postnatal depression	
Allergies None Known	
Medication Fluoxetine 40mg once daily Ferrous Sulfate 200 mg two times a day	
Past Medical History Postnatal depression and Post-traumatic stress disorder (PTSD) which began one year ago. Treated with an antidepressant and attended 10 weeks of Cognitive behavioural therapy (CBT).	
Referral Summary Sam lives at home with husband Matthew and two Children; Sally who is 1 year old and Tom who is 4 weeks old. Sam had a normal first pregnancy however the labour was traumatic and subsequently developed postnatal depression and post traumatic stress disorder. Sam was treated using antidepressants and CBT. Sam is currently still taking this antidepressant. Despite a normal pregnancy and delivery, Sam has been experiencing low self-esteem, loss of energy, tearfulness and feeling unable to cope with life since Tom was born 4 weeks ago. She is also concerned that she is not bonding with her son and not capable of fulfilling her role as a mother.	

Health Visitor Telephone Referral

Post Natal Depression

Please could you complete a nursing assessment of her mental state. I look forward to hearing from you in the near future.
Name (print): Rachel Canning
Health Visitor Signature: *Rachel Canning*
Date and time of referral: TODAY, 09:30

Assessment Overview

Post Natal Depression

Candidate's Name: _____

Scenario
You are a mental health nurse working in the primary care mental health team in a health centre. Sam Smyth has been referred to you by her health visitor after a routine home visit. Sam has given birth to her second child 4 weeks ago and is expressing low self-esteem, loss of energy, tearfulness and feeling unable to cope with life. You have been asked to undertake a mental health nursing assessment including **calculating a Patient Health Questionnaire 9 (PHQ 9) score**. The PHQ 9 has already been completed by Sam and the score must be calculated within this station. **Please discuss the clinical response and outcome of the PHQ 9 with Sam**. You may focus on the following **TWO** activities of living to help you plan the nursing care in the planning station. • **Mental health issues** • **Risks**

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

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

Assessment Candidate Documentation

Postnatal depression

Nursing Assessment Candidate Notes
Name: Sam Smyth
Hospital Number: 00046329
Address: 1 Sweet Street, Westshire. WW6 5PQ
Date of birth: 01/01/1987

Mental health issues
Risks
Nutrition / hydration
Capacity / consent
Expressing sexuality
Personal cleansing / dressing
Sleeping
Medication / substance / compliance issues

Planning Overview

Postnatal depression

Candidate's Name: _____

Note to Candidate:

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

Scenario
Sam Smyth was referred to the mental health team health centre earlier today by their health visitor with severe symptoms of Postnatal depression. A mental health nursing assessment has been carried out and Sam has agreed to work with the mental health team to develop strategies to manage her symptoms of Postnatal depression.

Based on your nursing assessment of Sam please produce an evidence based person centred nursing care plan for **2 relevant aspects of nursing care and self-care suitable for the initial phase of primary care treatment.**

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

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

Planning Candidate Documentation

Postnatal depression

Patient Details: Name: Sam Smyth Hospital Number: 00046329 Address: 1 Sweet Street, Westshire. WW6 5PQ Date of birth: 01/01/1987
1) Nursing problem / need
Aim(s) of care:
Re-evaluation date:

Care provided by nurse(s)	Patient self-care activities

Planning Candidate Documentation

Postnatal depression

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 Candidate Documentation

Postnatal depression

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**

Implementation Overview

Postnatal depression

Candidate's Name: _____

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

Scenario
Sam Smyth was referred to the primary care mental health care team in the health centre today by her health visitor for severe symptoms of Postnatal depression. A mental health nursing assessment has been carried out and Sam has agreed to work with the mental health team to develop strategies to manage her symptoms of Postnatal depression. Sam has been admitted to an Acute Mental Health Assessment unit in a community mental health hospital. Sam has been prescribed additional medication to help with her symptoms.

Please administer and **document** Sam's 14:00 medications in a safe and professional manner.

- Talk to the person
- Please verbalise what you are doing and why
- 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

Complete **all** sections of the documentation.

Assume it is **TODAY** and it is **14:00**.

Prescription Chart for:	Sam Smyth	Female	**HOSPITAL NUMBER:** **DATE OF BIRTH:** **ADDRESS:**	00046329 01/01/1987 1 Sweet Street, Westshire. WW6 5PQ
Date and Time:	TODAY 14:00		**WARD:**	Acute Mental Health Assessment unit

KNOWN ALLERGIES OR SENSITIVITIES		**TYPE OF REACTION**	
NONE KNOWN			
Signature:	*Dr Louise. Jones. 1234*	**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 CHART 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	5 FOOT 4 INCHES (1.62m)	BMI	21.8
WEIGHT	9 STONE (57.1kg)		
ANY Special Dietary requirements?	~~YES~~ **NO**	**If YES please specify**	NONE

Prescription Chart for:	Sam Smyth	Female	**HOSPITAL NUMBER:** **DATE OF BIRTH:** **ADDRESS:**	00046329 01/01/1987 1 Sweet Street, Westshire. WW6 5PQ
Date and Time:	TODAY 14:00		**WARD:**	Acute Mental Health Assessment unit

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 & bleep	Given by	Checked by	Time given
TODAY	14:00	DIAZEPAM	2 mg	PO	Dr L Jones, 1234			

PRN (AS REQUIRED MEDICATIONS):

Date	Drug	Dose	Route	Instructions	Prescriber signature & bleep	Given by	Time given

ANTIMICROBIALS:

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

Prescription Chart for:	Sam Smyth	Female	**HOSPITAL NUMBER:** **DATE OF BIRTH:** **ADDRESS:**	00046329 01/01/1987 1 Sweet Street, Westshire. WW6 5PQ
Date and Time:	TODAY 14:00		**WARD:**	Acute Mental Health Assessment unit

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

REGULAR MEDICATIONS:

1. DRUG	**FLUOXETINE**					**Date and signature of nurse administering medications. Code for non-administration.**	
DATE	**DOSE**	**FREQUENCY**	**ROUTE**	**DURATION**	**TIME**	**TODAY**	
TODAY	40mg	ONCE DAILY	PO	5 DAYS	08:00	1. J McNEILL	
Start date	Today						
Finish date	+ 4 DAYS						
Prescriber signature & bleep	*Dr L Jones, 1234*						

2. DRUG	**FERROUS SULFATE**					**Date and signature of nurse administering medications. Code for non-administration.**	
DATE	**DOSE**	**FREQUENCY**	**ROUTE**	**DURATION**	**TIME**	**TODAY**	**TOMORROW**
TODAY	200 mg	TWO TIMES A DAY	PO	5 DAYS			
Start date	TODAY						
Finish date	+4 DAYS				14:00		
Prescriber signature & bleep	*Dr L Jones, 1234*				22:00		

3. DRUG	**ZOPICLONE**					**Date and signature of nurse administering medications. Code for non-administration.**	
DATE	**DOSE**	**FREQUENCY**	**ROUTE**	**DURATION**	**TIME**		
TODAY	3.75 mg	ONCE DAILY	PO	5 DAYS			
Start date	TODAY						
Finish date	+4 DAYS						
Prescriber signature & bleep	*Dr L Jones, 1234*				22:00		

Prescription Chart for:	Sam Smyth	Female	**HOSPITAL NUMBER:** **DATE OF BIRTH:** **ADDRESS:**	00046329 01/01/1987 1 Sweet Street, Westshire. WW6 5PQ
Date and Time:	TODAY 14:00		**WARD:**	Acute Mental Health Assessment unit

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

DRUGS NOT ADMINISTERED:				
DATE	**TIME**	**DRUG**	**REASON**	**NAME AND SIGNATURE**
TODAY	**08:00**	FLUOXETINE	PATIENT NOT ON WARD	J MCNEILL *Julie McNeill RN*

Evaluation Overview

Postnatal depression

Candidate's Name: _____

Note to Candidate:

- This document must be completed in 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
Sam Smyth was admitted to the Acute Mental Health Assessment unit following a mental health assessment at her health centre earlier today. Sam was prescribed additional medication to help with her symptoms of severe Post Natal Depression. Sam is now being transferred to the Mother and Baby unit in the community health hospital for further assessment and monitoring before discharge back to the community.

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

Complete **all** sections of the documentation.

Assume it is **TODAY** and it is **20:00**.

Evaluation Candidate Documentation

Postnatal depression

Transfer of Care Letter

Patient Details: Name: Sam Smyth, Hospital Number: 00046329 Address: 1 Sweet Street, Westshire. WW6 5PQ Date of birth: 01/01/1987
What is the main reason for the referral?
Date of original assessment:
Identify the main patient needs addressed during Sam's assessment.
Outline the nursing approaches and interventions provided to meet the identified needs.

Evaluation Candidate Documentation

Postnatal depression

Outline Sam's current ability to self-care based on the person's care plan.
Document Sam's allergies and associated reactions.
List risks identified related to Sam's mental health.
NAME (Print):
Nurse Signature: **Date:**

The Patient Health Questionnaire (PHQ-9)

Patient Name SAM SMYTH

NHS Number 00046329

Date TODAY

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				

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)