AlphaPlus

NMC Nursing & Midwifery Council | Test of Competence

Test of Competence 2021:
Mock OSCE
Mental Health Nursing

Mock OSCE

Mental health nursing

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

Four of the six remaining stations will take the form of two sets of two linked stations, testing practical clinical skills. Each pairing of skills stations will last for approximately 16 minutes in total (including reading time), with no break between each paired skill.

There are also two new silent stations. In each OSCE, one station will specifically assess professional issues associated with professional accountability and related skills around communication (called the professional values and behaviours, or PV, station). One station will also specifically assess critical appraisal of research and evidence and associated decision-making (called the evidence-based practice station, or EBP).

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

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

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

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

The marking criteria and expected performance apply only to this mock OSCE. They provide a guide to the level of performance we expect in relation to nursing care, knowledge and attitude. Other scenarios will have different assessment criteria appropriate to the scenario.

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

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

	Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues	Supports others by providing accurate, honest and constructive verbal and written feedback.
	Keep clear and accurate records relevant to your practice	Provides clearly written feedback on all care given, and demonstrates accurate evidence-based verbal handover of care to others.
	Be accountable for your decisions to delegate tasks and duties to other people	Accountably delegates to competent others, ensuring patient safety at all times.
Preserve safety	Recognise and work within the limits of their competence	Accurately identifies, observes and assesses signs of normal or worsening physical and mental health in the person receiving care, requesting timely and appropriate assistance as required.
	Be open and candid about potential mistakes, preventing harm	Documents events formally and takes further action (escalates) if appropriate, so they can be dealt with quickly.
	Provide assistance in an emergency	Acts in an emergency within the limits of their knowledge and competence, seeking appropriate support as required.
	Act swiftly if there is a danger to others, maintaining safety	Delivers care according to national policies and procedures to prevent danger to others, and applies appropriate personal protective equipment (PPE) as indicated by the nursing procedure in accordance with the guidelines to prevent healthcare-associated infections.

	Raise concerns for those who are seen to be vulnerable or at risk of harm	Shares information if someone is at risk of harm, in line with the laws relating to the disclosure of information.
	Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations	Checks prescriptions, patient identification and administers medicines safely, highlighting appropriately any areas of concern.
	Demonstrate awareness of any potential harm associated to their practice	Takes all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public.
Promote professionalism and trust	Uphold the reputation of the profession at all times	Demonstrates and upholds the standards and values set out in the code.
	Fulfil the registration requirements	Demonstrates up-to-date knowledge, skills and competence to provide safe and effective care at all times.
	Provide leadership to make sure that people's wellbeing is protected and to improve their experiences of the health and care system	Identifies priorities, manages time and resources effectively, and deals with risk to make sure that the quality of care or service is maintained and improved, putting the needs of those receiving care or services first.

The mock APIE below is made up of four stations: assessment, planning, implementation and evaluation. Each station will last approximately 15 minutes and is scenario-based. The instructions and available resources are provided for each station, along with the specific timing.

Scenario
Terry Thomas was referred by their GP to the primary care mental health team in the community clinic earlier today, increasing panic attacks and not leaving their home. A mental health nursing assessment has been carried out, and Terry has agreed to work with the primary care mental health team to explore interventions to manage the panic disorder.

You will be asked to complete the following activities to provide high-quality, individualised nursing care for the patient, providing an assessment of needs that is based on the recovery model of care. 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 – **20 minutes** You will collect, organise and document information about the patient.	• Assessment overview and documentation (pages 10–12) • A patient health questionnaire 9 to complete (PHQ-9) (pages 13–14)
Planning – **14 minutes** You will complete the planning template, choosing two aspects of the patient's care needs and establishing how they will be met.	• A blank nursing care plan to be completed for two nursing care problems or needs (pages 15–18)
Implementation – 15 minutes You will administer and document medications while continuously assessing the individual's current health status.	• An overview and a medication administration record (MAR) (pages 19–22)
Evaluation – 8 minutes You will document the care that has been provided so that you can do a verbal handover to the nurse on the next shift (the examiner).	• Documents from the previous three stations • A blank situation, background, assessment and recommendation (SBAR) tool (pages 23–24)

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

Assessment criteria
Assesses the safety of the scene and privacy and dignity of the patient.
Cleans hands with alcohol hand rub, or washes with soap and water, and dries with paper towels following World Health Organisation (WHO) guidelines.
Introduces self to person.
Checks identity (ID) with person or carer (person's name is essential and either their date of birth or hospital number) verbally, against wristband (where appropriate) and documentation.
Gains consent and explains reason for the assessment.
Uses SOLER throughout the assessment: • Sitting at a comfortable angle and distance • Open posture, with arms and legs uncrossed • Leaning forward from time to time, looking genuinely interested and listening attentively • Effective eye contact without staring • Remaining relatively relaxed.
Uses appropriate questioning skills (open questions).
Builds trust and rapport by demonstrating compassion, taking time, active listening, and taking an interest.
Uses brief verbal and non-verbal affirmations.
Uses reflection/paraphrasing to demonstrate concern.
Conducts a holistic mental health assessment relevant to the patient's scenario, using the recovery model of care areas, including patient self-care and non-adherence to prescribed medications.
Identifies and discusses any current risk factors, if present.
Accurately completes any assessment tools included, and accurately calculates and records score, where appropriate.
Discusses the assessment findings with the person and closes the assessment appropriately.
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
Acts professionally throughout the procedure in accordance with NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’.

Planning criteria
Clearly and legibly handwrites answers.
Identifies two relevant nursing problems/needs.
Identifies aims for both problems.
Sets appropriate evaluation date for both problems.
Ensures nursing interventions are current/evidence based/best practice.
Uses professional terminology in care planning.
Does not use abbreviations or acronyms.
Ensures strike-through errors retain legibility.
Accurately prints, signs and dates.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Implementation criteria
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
Introduces self to person.
Seeks consent from person or carer prior to administering medication.
Checks allergies on chart and confirms with the person in their care, and also notes red ID wristband (where appropriate).
Before administering any prescribed drug, looks at the person's prescription chart and correctly checks ALL of the following: Correct: • person (check ID with person: verbally, against wristband (where appropriate) and documentation) • drug • dose • date and time of administration • route and method of administration • diluent (as appropriate) • any allergies.
Correctly checks ALL of the following: • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed

with administration and should consult the prescriber.
Considers contraindication where relevant and medical information prior to administration (prompt permitted). (This may not be relevant in all scenarios.)
Provides a correct explanation of what each drug being administered is for to the person in their care (prompt permitted).
Administers drugs due for administration correctly and safely.
Omits drugs not to be administered and provides verbal rationale. (Ask candidate reason for non-administration if not verbalised.)
Accurately documents drug administration and non-administration.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Evaluation criteria
Situation
Introduces self and the clinical setting.
States the patient's name, hospital number and/or date of birth, and location.
States the reason for the handover (where relevant).
Background
States date of admission/visit/reason for initial admission/referral to specialist team and diagnosis.
Notes previous medical history and relevant medication/social history.
Gives details of current events and details findings from assessment.
Assessment
States most recent observations, any results from assessments undertaken and what changes have occurred.
Identifies main nursing needs.
States nursing and medical interventions completed.
States areas of concerns.
Recommendation
States what is required of the person taking the handover and proposes a realistic plan of action.
Overall
Verbal communication is clear and appropriate.
Systematic and structured approach taken to handover.

Acts professionally throughout the procedure in accordance with NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’.

Assessment
Panic disorder

Candidate briefing

You are a mental health nurse, working in the primary care mental health team in the community clinic. Terry Thomas has been referred to you by the GP because of regular panic attacks.

Please conduct an **A to E assessment** and a holistic **mental health assessment** using the recovery model of care areas below and including patient self-care and adherence to prescribed medications.

A patient health questionnaire (PHQ-9) has already been completed by Terry. You will need to calculate the score and refer to the scoring outcome table for the result.

Please discuss the outcome of your assessment and the PHQ-9 with your patient.

Consider the current risks for the patient using the information from the GP referral and the information gathered in your assessment.

This document must be completed using a GREEN PEN.

You have **20 minutes** to complete this station, including all the required documentation.

Assume that it is TODAY and that it is **09:00 hours.**

Overview of recent history

Patient history

Name: Terry Thomas
DOB: 01/01/1984
Address: 1 Sweet Street, Westshire, WW6 5PQ
GP: Dr Andrew Gibson, The Plains Surgery, Westshire

Presenting complaint:

- Repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes (panic attacks).

History of presenting complaint:

- Terry has feelings of impending doom and also feelings of being out of control.
- Terry experiences shortness of breath, chest pain, and rapid, fluttering or pounding heart (heart palpitations).
- These attacks are leading to worrying about them happening again and avoiding situations in which they've occurred.
- Terry also fears what they might do when they are experiencing an episode.
- Terry has visited A&E on two occasions because of the fast heartrate. Electrocardiograms showed no abnormalities.
- Terry has recently completed a 6-week course of low-intensity cognitive behaviour therapy.
- Terry has reported that this has not helped with the current episodes of panic attacks.

Past medical history:

- Iron deficiency anaemia.
- Anxiety.
- Acne.
- Sick leave for 8 weeks.

Social history:

- Never married.
- No children.
- Lives alone, near mother and next of kin (Katy Thomas).
- No pets or dependants.
- Terry has been the headteacher of a secondary school for 5 years and used to enjoy this job, although has been on sick leave for 8 weeks.
- Lives alone in a two-storey house with bedroom and bathroom upstairs.
- Non-smoker.
- Does not drink alcohol.

Drug history:

- Oxytetracycline 500mg two times a day.
- Sertraline 100mg once a day.
- Ferrous sulfate 200mg two times a day**.**

Allergies: None known.

Assessment
Panic disorder

Candidate notes

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

Patient details: Name: Terry Thomas Hospital No: 0004321 Address: 1 Sweet Street, Westshire, WW6 5PQ Date of birth: 01/01/1984
Capacity/Consent
Relationships
Major life events
Living situation
Patient self-care
Non-adherence to medication
Current risks

The Patient Health Questionnaire (PHQ-9)

Patient name TERRY THOMAS

NHS number 0004321

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 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)

Planning care
Panic disorder

Candidate paperwork and briefing

Candidate's name: _____

This document must be completed using a BLACK PEN.

Scenario
Terry Thomas was referred by their GP to the primary care mental health team in the community clinic earlier today, for increasing panic attacks and not leaving their home. A mental health nursing assessment has been carried out, and Terry has agreed to work with the primary care mental health team to explore interventions to manage the panic disorder.

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

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

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

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

Assume that it is TODAY and that it is **10:00 hours**.

Planning care
Panic disorder

Patient details: Name: Terry Thomas Hospital number: 0004321 Address: 1 Sweet Street, Westshire, WW6 5PQ Date of birth: 01/01/1984
1) Nursing problem/need
Aim(s) of care:
Re-evaluation date:
Nursing and self-care interventions

Planning care
Panic disorder

2) Nursing problem/need
Aim(s) of care:
Re-evaluation date:
Nursing interventions
NAME (Print):
Nurse signature: **Date:**

Planning care
Panic disorder

This page is not a required element but is for use in case of error.
Nursing problem/need
Aim(s) of care:
Re-evaluation date:
Nursing interventions

Implementing care: Panic disorder

Candidate paperwork and briefing

Candidate name: _____

This document must be completed using a BLACK PEN.

Scenario
Terry Thomas was referred by their GP to the primary care mental health team in the community clinic earlier today for increasing panic attacks and not leaving their home. A mental health nursing assessment has been carried out and Terry has agreed to work with the primary care mental health team to explore interventions to manage increasing panic attacks and not leaving their home. Terry has been prescribed additional medication to help with their panic attacks, the GP asks you to administer the first dose while in the community clinic and adds this to the community prescription chart.

Please administer and **document** Terry's 10:00 medications in a safe and professional manner.

- Talk to the person.
- Please verbalise what you are doing and why to the examiner.
- Read out the chart and explain what you are checking/giving/not giving and why.
- Complete all the required drug administration checks.
- Complete the documentation and use the correct codes.
- The correct codes for non-administration are on the chart.
- Check and complete the last page of the chart.

You have **15 minutes** to complete this station, including all the required documentation.

Complete **all** sections of the document.

Assume that it is TODAY and that it is **10:00 hours**.

COMMUNITY MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Thomas **Forename(s):** Terry **Date of birth:** 01/01/1984 **Hospital/NHS number:** 0004321	**Address:** 1 Sweet Street, Westshire WW6 5PQ
GP Name: Dr Andrew Gibson	**Surgery Address: T**he Plains Surgery, Westshire

Number of prescription records	**Chart** 1 ☑ 2 ☐ 3 ☐ **of** 1 ☑ 2 ☐ 3 ☐

Details of prescribers: must be completed by ALL prescribers			
NAME	**GMC/NMP Number**	**Signature**	**Contact details**
Dr Andrew Gibson	3214213	*Dr Andrew Gibson*	The Plains Surgery, Westshire

Details of person administering medication: must be completed by ALL administering medication			
NAME	**Initials**	**Signature**	**Base**
Elizabeth Green	**EG**	*E Green*	Community Clinic, Westshire

ALERTS: Allergies/sensitivities/adverse reaction					
Medicine(s)/Substance			**Effect(s)**		
NONE KNOWN			N/A		
IF NO KNOWN ALLERGIES TICK BOX ☑					
Signature:	*Dr Andrew Gibson*	**Bleep Number:**	874	**Date:**	TODAY
Allergy status MUST be completed and SIGNED by a prescriber/pharmacist/nurse BEFORE any medicines are administered.					

Medication risk factors			
Pregnancy ☐	**Renal impairment ☐**	**Impaired oral access ☐**	**Diabetes ☐**
Other high-risk conditions ☐ –specify		**Patient self-medicating ☐**	

COMMUNITY MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Thomas **Forename(s):** Terry **Date of birth:** 01/01/1984 **Hospital/NHS number:** 0004321	**Address:** 1 Sweet Street, Westshire WW6 5PQ
GP Name: Dr Andrew Gibson	**Surgery Address: T**he Plains Surgery, Westshire

Information for prescribers:	**Medicine non-administration/self-administration:**	
Write in BLOCK CAPITALS using black or blue ink. Sign and date and include bleep number.	If a dose is omitted for any reason, the nurse should enter the relevant code on the administration record and sign and date the entry.	
Record detail(s) of any allergies.	1. Medicine unavailable – INFORM DOCTOR OR PHARMACIST	2.Patient not present at time of administration
Sign and date allergies box. Tick box if no allergies know.	3.Self-administration	4.Unable to administer – INFORM DOCTOR (alternative route required?)
Different doses of the same medication must be prescribed on different lines.	5.Stat dose given	6.Prescription incorrect/unclear
Cancel by putting a line across the prescription and sign and date.	7.Patient refused	8. Nil by mouth (on doctor's instruction only)
Indicate the start and finish date.	9. Low pulse and/or low blood pressure	10. Other – state in nursing notes including action taken

COMMUNITY PATIENT-SPECIFIC DIRECTION									
Check allergies/sensitivities and patient identity									
Date	**Drug**	**Dose**	**Route**	**Time**	**Frequency**	**End date**	**Prescriber name & date**	**Given by: Sign date & time**	**Pharmacy check**
TODAY	DIAZEPAM	2 mg	PO	10:00	Once only		Dr Gibson TODAY		*K. Davis*
TODAY	OXYTETRACYCLINE	500 mg	PO	10:00	BD	+4 days	Dr Gibson TODAY		*K. Davis*
TODAY	OXYTETRACYCLINE	500 mg	PO	22:00	BD	+4 days	Dr Gibson TODAY		*K. Davis*
TODAY	SERTRALINE	100 mg	PO	08:00	OD	+6 days	Dr Gibson TODAY	*E Green TODAY* 08.00	*K. Davis*
TODAY	FERROUS SULFATE	200 mg	PO	08:00	BD	+4 days	Dr Gibson TODAY	*E Green TODAY* 08.00	*K. Davis*

COMMUNITY MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Thomas **Forename(s):** Terry **Date of birth:** 01/01/1984 **Hospital/NHS number:** 0004321	**Address:** 1 Sweet Street, Westshire WW6 5PQ
GP Name: Dr Andrew Gibson	**Surgery Address: T**he Plains Surgery, Westshire

TODAY	FERROUS SULFATE	200 mg	PO	18:00	BD	+4 days	Dr Gibson TODAY		*K. Davis*

OMITTED DOSES OF MEDICINE CODED 10 (OTHER) AND DELAYED DOSES								
Check allergies/sensitivities and patient identity								
Date	**Drug**	**Dose**	**Route**	**Instructions**	**Time given**	**Reason for omission 10/delay >2 hours**	**Signature**	**Pharmacy check**

Evaluating care
Panic disorder

Candidate paperwork and briefing

Candidate name: _____

- **This document must be completed using a BLUE PEN.**
- **At this station, you should have access to your assessment notes (but not the assessment overview), and the planning and implementation documentation. If not, please alert the examiner.**

Scenario
Terry Thomas was referred by their GP to the primary care mental health team in the community clinic earlier today, for increasing panic attacks and not leaving their home. A mental health nursing assessment has been carried out, and Terry has agreed to work with the primary care mental health team to explore interventions to manage their increased anxiety and low mood. Terry has been prescribed additional medication to help with the increased anxiety.

Using the situation, background, assessment and recommendation (SBAR) tool, please make notes regarding your patient and use them to hand information over verbally to the community nurse who will take over Terry's care after discharge (the examiner).

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

You have **8 minutes** in total to make notes on the SBAR form (this is not assessed) and to complete the verbal handover to the examiner. You will be informed when there are **2 minutes** remaining.

Complete **all** sections of the document.

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

Evaluating care
Panic disorder

Candidate notes

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

Patient details: Name: Terry Thomas Hospital number: 0004321 Address: 1 Sweet Street, Westshire,WW6 5PQ Date of birth: 01/01/1984
Situation:
Background:
Assessment:
Recommendation:

Mock clinical skills

The mock clinical skills assessment below is made up of two paired stations. The instructions and available resources are provided for each station, along with the specific timing.

Station	You will be given the following resources
Female urinary catheter insertion – 8 minutes You will insert the urinary catheter according to current evidence-based practice.	• Overview documentation (page 28)
Stoma bag change – 8 minutes You will change a stoma bag according to current evidence-based practice.	• Overview documentation (page 29)

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

Marking criteria – Female urinary catheter insertion
Explains the procedure to the patient and gains consent.
Assembles equipment required and checks equipment is sterile. Takes the equipment to the person's bedside on trolley.
Ensures that the patient is in a supine position with knees bent, hips flexed and feet apart.
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
Dons a disposable plastic apron.
Using an aseptic non-touch technique, opens the sterile pack and places the rest of the sterile equipment onto the sterile field.
Dons sterile gloves. Places a sterile towel under the patient's buttocks.
Uses non-dominant hand to separate labia and uses gauze swabs soaked in sodium chloride 0.9% to clean the urethral orifice using downward strokes, being careful not to touch surrounding skin.
Applies anaesthetic lubrication to the meatus and gently inserts nozzle of anaesthetic syringe into urethra, and then instils gel into the urethra.
Places the catheter, in the sterile receiver, between the patient's legs and attaches the drainage bag.
Uses dominant hand to introduce the tip of the catheter into the urethral orifice in an upward and backward direction. Advances the catheter until urine is draining and up to the bifurcation point (junction of the catheter/balloon inflation tubing).
Cautiously inflates the catheter balloon with prefilled syringe containing water for injection, noting any pain or discomfort.
Gently withdraws the catheter slightly, until resistance is felt.
Assists in cleaning the patient and disposing of equipment.
Supports the catheter using a specially designed support (such as Simpla G-Strap), ensuring that the catheter lumen is not occluded by the fixation device. Ensures drainage bag is supported and secure, with the drainage port away from the floor.
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
States would document the reasons for catheterisation, time and date of catheterisation, catheter type, length and size, batch number and manufacturer.
States would measure and record urine output.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Marking criteria – Stoma bag change
Introduces self. Explains procedure to the person and gains consent.
Ensures that the patient is in a comfortable and suitable position where they are able to watch the procedure.
Checks all equipment required for the procedure, including expiry dates: new colostomy bag, a disposable bag, gauze, scissors and a receptacle are needed.
Cleans hands with alcohol rub or washes with soap and water and dries with paper towels according to the WHO guidelines.
Dons a disposable plastic apron and non-sterile gloves.
Places a small protective disposable pad below the stoma area to protect patient's clothes from accidental spillage.
Removes the stoma bag slowly using adhesive remover. Peels the adhesive off the skin while using the opposite hand to apply pressure on the surrounding skin.
Folds the removed stoma bag to prevent spillage before placing into a disposable bag.
Removes any visible faeces or mucus from the stoma with a piece of gauze soaked in warm tap water.
Examines the stoma site and peristomal skin for soreness, ulceration, signs of infection and other unusual signs such as unusual site colour (black or pale), foul odour or discharge.
Washes the skin around the stoma (peristomal area) with gauze soaked in warm tap water.
Gently dries the peristomal skin with dry gauze, ensuring that the area is thoroughly dry.
Measures the stoma site, cuts a hole in the adhesive flange of the new bag, aiming for 3mm larger than the site.
Applies the clean appliance, using the flat of hand to gently press to ensure it adheres in all areas.
Disposes of equipment including apron and gloves appropriately – verbalisation accepted.
Cleans hands with alcohol rub or washes with soap and water and dries with paper towels according to the WHO guidelines.
States would document the change of stoma bag in nursing notes and would report any abnormalities to the stoma nurse and/or surgical team.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Overview
Female urinary catheter insertion

Scenario
You are working on the surgical admissions unit. You are caring for Catherine Higgins, who has been diagnosed with obstruction of the bowel, and the doctor has requested the insertion of a urinary catheter for fluid monitoring. **Please insert the urinary catheter according to current evidence-based practice**. All identification checks have been completed and the patient has no known allergies. The trolley has been cleaned. The patient is lying in bed, with their lower clothing removed, is covered with a towel and has an absorbent pad underneath them.

All the equipment you need is provided.

You are not required to document anything during this skills station.

You have **8 minutes** to complete this station.

Overview
Stoma bag change

Scenario
You are working on a post-operative surgical ward. You are caring for Kendi Abara, who has undergone a right hemicolectomy and colostomy formation. They are 3 days post surgery, the one-piece stoma bag needs to be replaced, and Kendi is currently not well enough to do this themselves. **Please change the patient's stoma bag according to current evidence-based practice.** All identification checks have been completed, and the patient has no known allergies. The trolley has already been cleaned prior to the procedure.

Please change the patient's stoma bag and speak to your patient throughout the procedure.

All the equipment you need is provided.

You are not required to document anything during this skill station, but if necessary, verbalise to the examiner what would be documented or reported.

You have **8 minutes** to complete this station.

Assume that it is TODAY and that it is **12:00 hours**.

Mock silent stations

You will also be required to undertake two new silent stations. In each OSCE, one station will specifically assess professional issues associated with professional accountability and related skills around communication (called the professional values and behaviours station, or the PV station). One station will also specifically assess your critical appraisal of research and evidence and associated decision-making (called the evidence-based practice station, or EBP station).

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

Station	You will be given the following resources
Professional values and behaviours **Drug misuse – 8 minutes** You will read the scenario and summarise the actions that you would take, considering the professional, ethical and legal implications of this situation.	• Overview documentation (pages 32–33)
Evidence-based practice **Sleep in intensive care – 8 minutes** You will read the scenario and summary of the research, then write up how you would apply the findings to the scenario.	• Overview documentation (pages 34–35)

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

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

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

Mock silent stations

Professional values and behaviours: Drug misuse

Overview

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

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

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

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

You have 8 minutes to complete this station.

Professional values and behaviours: Drug misuse

Candidate documentation

Candidate name:_____

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Mock silent stations

Evidence-based practice: Sleep in intensive care

Overview

Read the scenario and the summary of the research below.

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

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

You have 8 minutes to complete this task.

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

Candidate documentation

Candidate name: _____

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

Give your responses here as bullet points:

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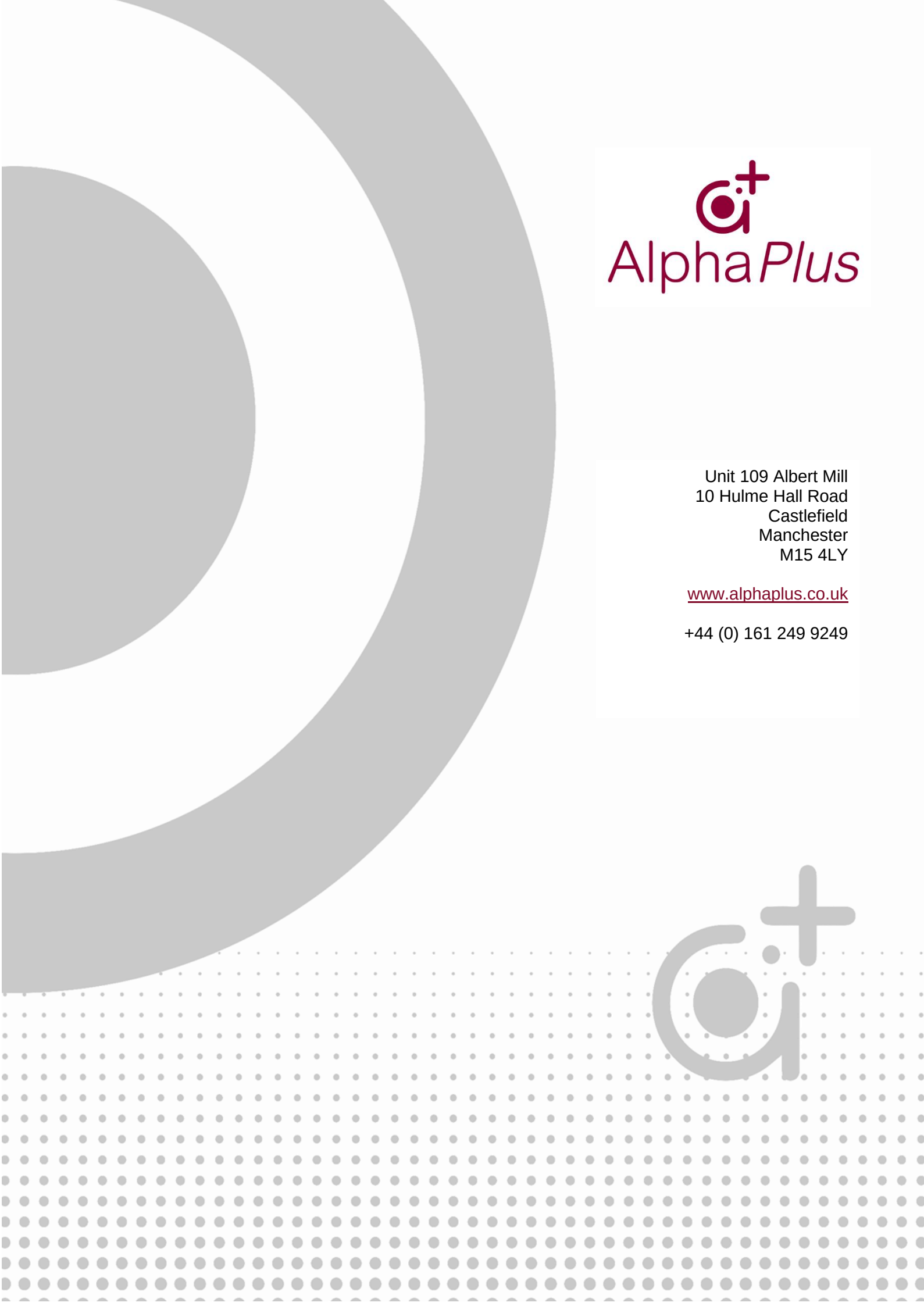

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