Test of Competence 2021: Mock OSCE

Midwifery

V.4 updated January 2024

Mock OSCE

Midwifery

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

- four of the stations are linked together around a scenario: this is called the APIE, with one station for each of Assessment, Planning, Implementation and Evaluation, delivered in that sequence and with no stations in between. APIE stations will last between 8 and 20 minutes.
- Four stations will test practical clinical skills, at least one of which will be an acute emergency skill. Skills stations will last between 8 and 25 minutes.
- There are also two *silent* stations, lasting 10 minutes each. In each OSCE, one station will specifically assess professional issues associated with professional accountability and related skills around communication (called the professional values and behaviours, or PV, station). One station will also specifically assess critical appraisal of research and evidence and associated decision-making (called the evidence-based practice station, or EBP).

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

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

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

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

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

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

Theme from the code:	Expected performance	Criteria
Prioritise people	Treat people as individuals and uphold their dignity	Introduces self to the person at every contact and upholds the person's dignity and privacy.
	Listen to people and respond to their preferences and concerns	Actively listens to the person and provides clear information, behaving in a professional manner, respecting others and adopting non-discriminatory behaviour.
	Make sure that people's physical, social and psychological needs are responded to	Upholds respect by valuing the person's opinions and being sensitive to feelings and/or appreciating any differences in culture.
	Act in the best interest of people at all times	Treats each person as an individual, showing compassion and care during all interactions. Respects and upholds people's human rights.
	Respect people's right to privacy and confidentiality	Ensures that people are informed about their care and that information about them is shared appropriately, maintaining confidentiality.
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 person 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 midwifery procedure in accordance with the guidelines to prevent healthcare-associated infections.
	Raise concerns for those who are seen to be vulnerable or at risk of harm	Shares information if someone is at risk of harm, in line with the laws relating to the disclosure of information.
	Advise on, prescribe, supply, dispense or administer	Checks prescriptions, person's identification and administers

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

Assessment:
Vaginal bleed at term

The mock APIE below is made up of four stations: assessment, planning, implementation and evaluation. Each station will last between 8 and 20 minutes and is scenario-based. The instructions and available resources are provided for each station, along with the specific timing.

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

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

Station	You will be given the following resources
Assessment – 20 minutes You will collect, organise and document information about the individual.	• Assessment overview and documentation (pages 11–15) • A blank modified early obstetric warning score (MEOWS) chart to be completed (page 16-18)
Planning – 14 minutes You will complete the planning template to establish how two aspects of the individual's care needs will be met.	• A blank midwifery care plan for the next four hours (pages 21–22)
Implementation – 15 minutes You will administer medications while continuously assessing the individual's current health status.	• An overview and medication administration record (MAR) (pages 24–28)
Evaluation – 8 minutes You will provide a verbal handover to the midwife on the next shift (the examiner).	• Documents from the previous three stations • A document to make notes on to support your verbal handover (pages 30–31)

Assessment:
Vaginal bleed at term

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

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

Assessment:
Vaginal bleed at term

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

Assessment:
Vaginal bleed at term

Planning criteria
Logically and accurately provides details of the current situation (small post-coital bleed, fresh red blood loss on wiping with no active bleeding, intermittent abdominal pain).
Logically and accurately provides details of relevant medical and obstetric history, medication and any allergies (sexual intercourse at 7.30am this morning, intermittent abdominal pain since 8.30am, small fresh red blood loss noted on wiping and staining of underwear at 9.30am).
Logically and accurately provides details of the assessment (small post-coital bleed with abdominal pain, uterus soft and non-tender, no active bleeding. Differential diagnosis of early labour with blood-stained show, observations otherwise normal, fetal movements reassuring).
Logically and accurately provides details of the recommendation (medical review, Kleihauer, additional mid-stream sample of urine).
Referral for medical review is acknowledged and actioned appropriately, and within an appropriate timeframe in accordance with guidance on MEOWS chart.
Ensures recommendations are current/evidence-based/best practice.
Uses appropriate professional terminology in care planning.
Writes clearly and legibly
Accurately prints, signs and dates (when required)
Acts professionally throughout the procedure in accordance with NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’.

Assessment:
Vaginal bleed at term

Implementation criteria
Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
Seeks consent from woman prior to administering medication.
Checks allergies on chart and confirms with the person in their care, also notes red identity (ID) wristband (where appropriate).
Before administering any prescribed drug, looks at the woman's prescription chart and correctly verbalises all of the following checks: person (checks ID with person: verbally, against wristband (where appropriate) and documentation), drug dose, date and time of administration, route and method of administration, validity of prescription, signature of prescriber, and that the prescription is legible.
Considers contraindication where relevant and medical information prior to administration
Provides a correct explanation of what each drug being administered is for to the person. in their care.
Administers drugs due for administration (anti-D immunoglobulin, paracetamol) correctly and safely (checks expiration date)..
Omits drugs not to be administered and provides verbal rationale (ferrous sulphate – ask candidate reason for non-administration, if not verbalised).
Accurately records drug administration and non-administration.
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Assessment:
Vaginal bleed at term

Evaluation criteria
Situation
Introduces self and the clinical setting.
States the woman's name, hospital number and/or date of birth, and location.
States the reasons for discharge.
States the current situation with the woman and baby.
Background
Outlines date of admission/visit/reason for initial admission/referral to obstetric team and diagnosis.
Outlines previous medical history and relevant medication/social history/allergies.
Outlines current events and details findings from assessments/tests.
Assessment
Outlines most recent observations, any results from assessments undertaken and what changes have occurred.
States that medical review completed.
States any areas of concern.
Recommendation
States what is required of the person taking the handover and proposes a realistic plan of action.
States main ongoing care needs.
Overall
Uses SBAR tool to hand information over verbally
Verbal communication is clear and appropriate
Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Assessment:
Vaginal bleed at term

Candidate briefing

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

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

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

You are required to verbally identify to the examiner any observations which are a cause for concern.

This document provides an overview of the situation you are presented with to assess and the woman's history. Depending on Amy's circumstances and condition, you may wish to focus on some areas of assessment in more depth than others. Please ask the examiner for the information from the full antenatal assessment and any other clinical information you require.

An observation chart is provided and must be completed within the station. **This document must be completed using a GREEN PEN.**

You have **20 minutes** to complete this station, **including the completion of the following documentation: modified early obstetric warning score (MEOWS) chart.**

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

Assessment:
Vaginal bleed at term

Overview of recent history

Scenario
Name: Amy Hall **Date of birth**: 21/01/1995 **Hospital number**: 004321 **Address:** 17 Ladybrook Lane, Rotherham, Sheffield. **Postcode:** S11 3TF **GP:** Dr Shaw **Presenting history:** • Second pregnancy • 38 weeks pregnant. • Abdominal pain.Sexual intercourse at 7.30am this morning • Intermittent abdominal pain since 8.30am this morning • Small fresh red blood loss noted on wiping and staining of underwear at 9.30am this morning. • Cardiotocograph performed because of fresh vaginal bleed. CTG findings reassuring. • Urinalysis: 150mls volume +++ blood ++ leucocytes. **Past medical history:** • Postnatal depression following birth of last child. Managed with counselling and no medication required. • Unexplained infertility following birth of first child. Current pregnancy as result of a successful IVF cycle. **Previous obstetric history:** • 2015 – uneventful pregnancy. Spontaneous labour and delivery of live male infant at 40 weeks' gestation. Child fit and well at birth. **Current pregnancy:** • Consultant care because of IVF • 20-week anomaly USS identified low-lying placenta covering the internal os • Follow-up USS at 34 weeks identified the placental edge was now 2cm away from the internal os. Normal fetal growth. Transferred to midwifery care at 34 weeks' gestation. • Otherwise uneventful pregnancy to date – currently 38/40 • Blood group is A rhesus negative, has received prophylactic anti-D administration during pregnancy. **Social history:** • Married and lives with husband.

- Ex-smoker – previously smoked but gave up at booking.

Drug history:

- Ferrous sulphate – 200mg twice daily for iron-deficiency anemia.

Allergies:

- Codeine phosphate – severe nausea and vomiting.

Assessment:
Vaginal bleed at term

Candidate notes

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

Patient details:

Name: Amy Hall
Date of birth: 21/01/1995
Hospital number: 004321
Address: 17 Ladybrook Lane, Rotherham, Sheffield.

Assessment:
Vaginal bleed at term

Candidate notes

Additional space if needed:

Assessment:
Vaginal bleed at term

PROMPT - MODIFIED OBSTETRIC EARLY WARNING SCORE CHART

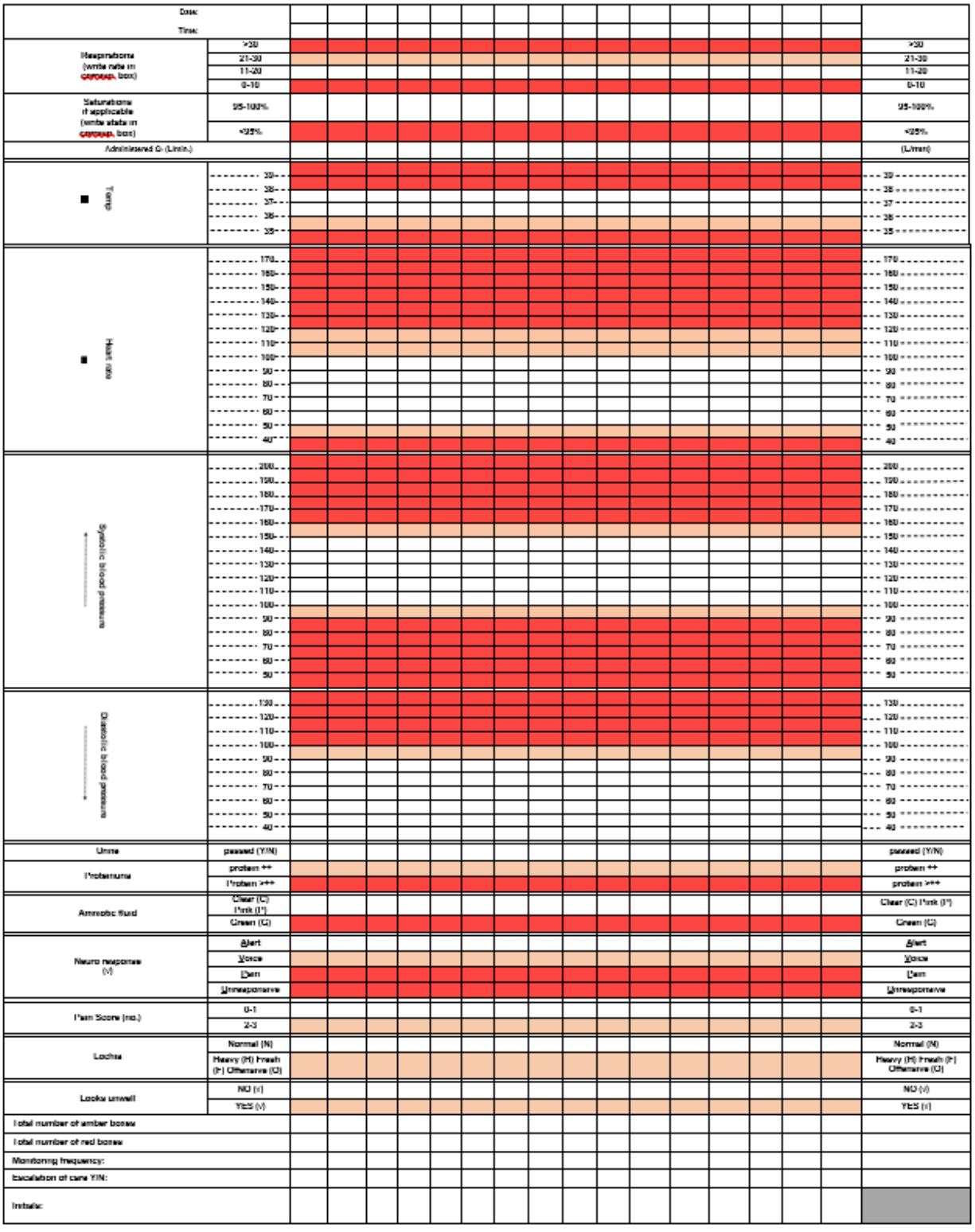
Use identification label or:-

Name: Amy Hall

DOB: 21/01/1995

Hospital No: 004321

Ward: AAU



Assessment:
Vaginal bleed at term

Guidance for using Modified Early Obstetric Warning Score Chart

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

Pain scores: Record pain levels as follows:

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

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

Key

Amber
Red

Identify the number of amber and/or red boxes

1 Amber Box

- Repeat observations
- Increasing frequency of observations to every 1 hour
- Seek advice from senior midwife/midwife in charge
- Consider obstetric review within 30 mins if not settled

2 Amber Boxes or 1 Red Box

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

2 Red Boxes

- Inform midwife in charge
- Immediate referral to obstetric registrar/ anaesthetist
- Increase frequency of observations to every 15 minutes
- Transfer to high level of care
- Consider transfer to High dependency unit (HDU)
- Consider review by obstetric consultant

Planning care
Vaginal bleed at term

Candidate paperwork and briefing

Candidate name: _____

This document must be completed using a BLACK PEN.

Scenario

You have conducted the following assessment of Amy Hall.
 	
Full clinical history:
• History of postnatal depression, unexplained infertility and IVF.
• Gravida 2 para 1 – previous uneventful pregnancy and spontaneous vaginal delivery at term.
• Current pregnancy – Originally consultant care, history of low-lying placenta at 20 weeks, normal placental position and fetal growth at 24 weeks, transferred to midwife-led care at 34 weeks.
• Currently 38 weeks, small post-coital bleed, fresh red blood loss on wiping with no active bleeding, intermittent abdominal pain.
  ○ Sexual intercourse at 7.30am this morning.
  ○ Intermittent abdominal pain since 8.30am this morning.
  ○ Small fresh red blood loss noted on wiping and staining of underwear at 9.30am this morning.
 	
Assessment of maternal wellbeing:
• Temperature: 36.6ºC
• Heart rate: 88 bpm
• Blood pressure: 120/60
• Oxygen saturations: 100%
• Urinalysis: 150mls volume +++ blood ++ leucocytes
• Alert, fit and well
• Pain level 2/3.
 	
Abdominal palpation:
• Abdomen soft and non-tender
• Mild uterine contractions noted 1:3-5 lasting 30 seconds
• Fundal height = 38cms, longitudinal lie, cephalic presentation 3/5th palpable.
 	
Assessment of fetal wellbeing:
• Normal fetal movements
• Fetal heart auscultated with Pinard – 146 bpm
• Cardiotocograph performed because of fresh vaginal bleed. CTG findings reassuring.
 	
Diagnosis:
• Small post-coital vaginal bleed and irregular uterine contractions.
 	
Differential diagnosis:
• Early labour with blood-stained show.

Planning care
Vaginal bleed at term

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

Include relevant information from your assessment.
This is a silent written station. Please ensure that you write legibly and clearly.
You do not need to write a report. You can use bullet points to summarise what you would do.

You have **14 minutes** to complete this station.

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

Planning care
Vaginal bleed at term

Midwifery Care Plan

Patient details: **Name:** Amy Hall **Address:**17 Ladybrook Lane, Rotherham, Sheffield, S11 3TF **Date of birth:** 21/01/1995 **Hospital number:** 004321

Planning care
Vaginal bleed at term

PRINT NAME:
MIDWIFE SIGNATURE:
DATE:

Implementing care
Safe administration of medications
Vaginal bleed at term

Candidate paperwork and briefing

Candidate name: _____

This document must be completed using a BLACK PEN.

Scenario
Amy Hall has now been reviewed by Dr Gupta, following her admission to the antenatal assessment unit with a post-coital vaginal bleed at 38 weeks' gestation. A speculum examination was performed by Dr Gupta where fresh red blood loss was seen on examination. The cervical os was reported to be short and approximately 1-2cms dilated. Intermittent abdominal pain continues. Dr Gupta has requested that Amy Hall be admitted to the antenatal ward for observation of her vaginal loss and abdominal pain overnight. Medications required for this admission are prescribed by Dr Gupta. Dr Gupta asks that all required medications due at 14:00 hours are to be administered prior to transfer to the antenatal ward.

Please administer and document all required 14:00 hours medications for Amy Hall in a safe and professional manner.

- During this station, you should communicate with Amy.
- 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.
- Explain to Amy what each drug being administered is for, and highlight any specific information regarding instructions for administration, including any possible contraindications, side effects and relevant medical information.
- Complete all the required drug administration checks.
- Complete the documentation and use the correct codes.
- The correct codes for non-administration are on the chart.
- Check and complete the last page of the chart.

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

Complete **all** sections of the document. Assume it is **TODAY** and it is **14:00 hours**.

Medicines prescription chart for:	Amy Hall	Female Height 1.7m Weight 70kg BMI 24	**Hospital number:** 004321 **Date of birth**: 21/01/1995 **Address**: 17 Ladybrook Lane, Rotherham, Sheffield, S11 3TF
Admission date and time	Today 10:30	Ward	MAU

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

All prescribers MUST complete the signature record							
NAME	**GMC/NMC Number**	**Signature**	**Bleep**	**NAME**	**GMC/NMC Number**	**Signature**	**Bleep**
Dr Z Gupta	9331801	*Dr Z Gupta*	505				

Details of person administrating medication: must be completed by ALL administering medication			
NAME	**Initials**	**Signature**	**Base**

ALERTS: Allergies/sensitivities/adverse reaction					
Medicine(s)/substance				**Effect(s)**	
Codeine phosphate				Severe nausea and vomiting	
IF NO KNOWN ALLERGIES, TICK BOX					
Signature:	*Dr Z Gupta*	**Bleep number:**	505	**Date:**	TODAY
Allergy status MUST be completed and SIGNED by a prescriber/pharmacist/nurse/midwife BEFORE any medicines are administered.					

Medicines prescription chart for:	Amy Hall	Female Height 1.7m Weight 70kg BMI 24	**Hospital number:** 004321 **Date of birth**: 21/01/1995 **Address**: 17 Ladybrook Lane, Rotherham, Sheffield, S11 3TF
Admission date and time	Today 10:30	Ward	MAU

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/midwife should enter the relevant code on the administration record and sign the entry.	
Record detail(s) of any allergies.	1. Medicine unavailable – INFORM DOCTOR OR PHARMACIST	2. Patient off ward
Sign and date allergies box. Tick box if no allergies known.	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 where relevant.	9. Low pulse and/or low blood pressure	10. Other – state reason

ONCE-ONLY MEDICINES, PREMEDICATION, ANTIBIOTIC PROPHYLAXIS AND PATIENT GROUP DIRECTIONS

Check allergies/sensitivities and patient identity

Date	Time due	Drug name	Dose	Route	Prescriber's signature	Prescriber's bleep	Given by:	Signature	Time	Pharmacy check
Today	14:00	Anti-D	500iu	IM	*Dr Z Gupta*	505				

ANTIMICROBIALS

Check allergies/sensitivities and patient identity

Review IV after 24-48 hours – Review oral after 5-7 days

1.Drug					Signature of nurse/midwife administering medications and code and signature if not administered.			
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Yesterday**	**Today**	**Pharmacy check**
Today								
Start date								
Finish date		Cultures sent?						

Medicines prescription chart for:	Amy Hall	Female Height 1.7m Weight 70kg BMI 24	**Hospital number:** 004321 **Date of birth**: 21/01/1995 **Address**: 17 Ladybrook Lane, Rotherham, Sheffield, S11 3TF
Admission date and time	Today 10:30	Ward	MAU

Prescriber signature and bleep		Print name	

ANTIMICROBIALS								
Check allergies/sensitivities and patient identity								
Review IV after 24-48 hours – Review oral after 5-7 days								
2.Drug					Signature of nurse/midwife administering medications and code and signature if not administered.			
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Yesterday**	**Today**	**Pharmacy check**
Today								
Start date								
Finish date		Cultures sent?						
Prescriber signature and bleep					Print name			

REGULAR MEDICINES									
Check allergies/sensitivities and patient identity									
1.Drug	FERROUS SULPHATE				Signature of nurse/midwife administering medications and code and signature if not administered.				
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Time**	**Yesterday**	**Today**	**Pharmacy check**	**Notes**
Today	200mg	Twice daily	Orally	2 WEEKS	08.00				New ☐
Start date		Instructions / indication							Amended ☐
Finish date					18:00				Unchanged ☐
Prescriber's signature and bleep		*Dr Z Gupta* 505			Print name				Supply at home ☐

Medicines prescription chart for:	Amy Hall	Female Height 1.7m Weight 70kg BMI 24	**Hospital number:** 004321 **Date of birth**: 21/01/1995 **Address**: 17 Ladybrook Lane, Rotherham, Sheffield, S11 3TF
Admission date and time	Today 10:30	Ward	MAU

	‘AS-REQUIRED’ MEDICINES								
	Check allergies/sensitivities and patient identity								
1.Drug	PARACETAMOL					Date/time and signature of nurse/midwife administering medications.			
Date	**Dose**	**Frequency**	**Route**	**Duration**	**Date**	**Time**	**Signature**	**Pharmacy check**	**Notes**
Today	1g	4-6-Hourly	PO	-					New ☑
Start date		Instructions / indication:	Pain (maximum 4g / 24 hours)						Amended ☐
Finish date									Unchanged ☐
									Supply at home ☐
Prescriber’s signature and bleep	*Dr Z Gupta* 505				Print name:	Dr Z Gupta			

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

Evaluating care
Vaginal bleed at term

Candidate paperwork and briefing

Candidate name: _____

- **This document must be completed using a BLUE PEN.**

At this station, you should have access to your assessment, planning and implementation documentation. If not, please alert the examiner.

Scenario
You are a midwife now working on the antenatal ward. Amy Hall has had an uneventful night on the antenatal ward. Amy has not experienced any further vaginal blood loss overnight and her abdominal pain has now settled. You have carried out an antenatal assessment of Amy this morning. A CTG was also carried out to assess fetal wellbeing, and both assessments are reassuring. Dr Gupta has also reviewed Amy this morning and has discharged Amy back to midwifery-led care in the community. You are required to provide a verbal handover to ensure that the community midwife has a full and accurate account of Amy's history and ongoing care needs.

This is a verbal station, but you will have the opportunity to make notes to support your answer.

Using the situation, background, assessment and recommendation (SBAR) tool, please make notes regarding Amy and use them to complete a verbal handover to the antenatal ward midwife on the next shift (the examiner). Please discuss any further care needs or actions the midwife may need to consider in the next 24 to 48 hours.

Your documentation from your assessment, planning and implementation stations is available for you to refer to, but you must not write on any of them.

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

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

Evaluating care
Vaginal bleed at term

Candidate notes – this documentation is for your use and is not marked

Patient details: **Name:** Amy Hall **Address:** 17 Ladybrook Lane, Rotherham, Sheffield, S11 3TF **Date of birth**: 21/01/1995 **Hospital number:** 004321
Situation:
Background:
Assessment:

Evaluating care
Vaginal bleed at term

Recommendations:

Mock clinical skill

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

Station	You will be given the following resources
Clinical skills	• Overview documentation (pages 33–37)

The marking criteria that follows highlights the important aspects to consider for this clinical skills station that you may encounter during your OSCE assessment.

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

Overview:
Systematic examination of the newborn

Scenario
You are working on a labour ward. You have been asked to assist with the care of Helen, who gave birth to her second baby 6 hours ago. Helen and her baby are fit and well postnatally, and Helen would like an early postnatal discharge home. You have been asked to perform the systematic examination of the newborn prior to Helen's discharge home. The midwife caring for Helen informs you of Helen's clinical history as follows. Helen opted to have full antenatal screening for fetal anomaly at 16 weeks, which were reported to be low risk. At 20 weeks, Helen opted to have a fetal anomaly scan, where the nuchal fold was reported to be 6mm with no further anomalies noted. Helen declined further follow-up. Helen was admitted in spontaneous labour and was in labour for 7 hours. Helen had an uncomplicated vaginal delivery of a live male infant. No resuscitation was required at birth. An examination of the infant at birth was performed and no abnormalities were detected.

You have **25 minutes** to complete this station including all the required documentation. You will be informed when there are **5 minutes** remaining.

- Please undertake a complete examination of the newborn.
- Please verbalise and demonstrate your actions throughout the examination, giving careful consideration to evidence-based practice and newborn guidance.
- Of the four key areas (eyes, heart, hips, testes), focus in more depth on the two key areas selected by the examiner. **For these key areas only, please provide a more in-depth assessment and verbalise potential referral pathways.**
- The systematic examination of the newborn offers an opportunity for parent education and health promotion. Please explain the purpose of the screening programme. You should include key information and advice as part of your examination.

Please record your findings and any relevant referrals in the document provided.

All the equipment you need is provided and has already been calibrated.

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

PART 2 – NEONATAL ASSESSMENT					
NEONATAL CONSIDERATIONS:					
Gestation at delivery:	38	Birth Weight:	2900g	Sex:	Male
ON NEONATAL EXAMINATION:					
Age at examination:	6 hours	Temp:	36.6	HC:	34cm

FINDINGS (please tick)		
	No Abnormality detected	**Abnormality detected/follow up required**
Symmetry:		
Tone:		
Movement:		
Skin:		

HEAD		
FINDINGS		**ADDITIONAL NOTES**
	No Abnormality detected	**Abnormality detected/follow up required**
Skull:		
Hair:		
Face:		
Eyes:		
Ears:		
Mouth:		
Nose:		
Tongue:		
Neck:		

PELVIC REGION AND LOWER EXTREMITIES		
FINDINGS		**ADDITIONAL NOTES**
	No Abnormality detected	**Abnormality detected/follow up required**
Genitalia and Anus:		
Testes:		
Spine and Back:		
Hips:		
Femoral Pulses:		
Legs and Feet:		

NEUROLOGICAL ASSESSMENT		
FINDINGS		**ADDITIONAL NOTES**
	No Abnormality detected	**Abnormality detected/follow up required**
Moro Reflex:		
Suck Reflex:		
Rooting Reflex:		
Grasp Reflex:		
Primitive Walking:		

UPPER EXTREMITIES AND THORACIC REGION		
FINDINGS		**ADDITIONAL NOTES**
	No Abnormality detected	**Abnormality detected/follow up required**
Arms and hands:		
Brachial Pulses:		
Chest:		
Heart Sounds:		

Mock clinical skill

Proforma Part 1 and 2

ABDOMINAL REGION		
FINDINGS		**ADDITIONAL NOTES**
	No Abnormality detected	**Abnormality detected/follow up required**
Abdomen:		
Cord:		

CONCLUSION AT TIME OF EXAMINATION	
Conclusions and recommendations following examination (physical, psychological and wider sociological factors)	
Parental participation/ health promotion points	
Midwife name:	
Midwife signature:	
Date:	

Mock silent stations

You will also be required to undertake two 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: **Dignity, respect and choice – 10 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 40–41)
Evidence-based practice: **Obstetric anal sphincter injury (OASI) – 10 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 42–43)

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

Professional values & behaviours marking criteria – Dignity, respect and choice
Considers Miriam's situation and is able to summarise the main points of concern in the scenario.
Is able to communicate fully and clearly with Miriam and her husband.
Demonstrates kindness and compassion when responding to Miriam.
Recognises Miriam's autonomy and right to choose how her babies are fed.
Works in partnership with the couple including care planning and follow-up support.
Acts as an advocate for Miriam and does not express own personal beliefs inappropriately.
Ensures that Miriam is supported to make an informed decision.
Recognises the need for reflection on the situation and the opportunity to improve practice.
Demonstrates an understanding of the need for accurate documentation of the situation.

Evidence-based practice marking criteria – Obstetric anal sphincter injury (OASI)
Summarises the main findings from the article summary and draws conclusion, making recommendations for practice.
Recognises and makes reference to the importance of woman-centred care and maternal choice, regardless of national recommendations or available evidence.
Recognises the fact that Hana has had a previous ventouse birth and may feel anxious about this.
Informs Hana that the results of the study showed a reduction in anal sphincter injury in both instrumental and spontaneous vaginal births.
Recognises the fact that there were variables across the participating hospitals that could have impacted on the results of the study.
Acknowledges the date of publication and is aware that newer evidence may have been published since 2010.

Professional values and behaviours: Dignity, respect and choice

Overview

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

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

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

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

You have 10 minutes to complete this station.

Professional values and behaviours: Dignity, respect and choice

Candidate documentation

Candidate name:_____

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Evidence-based practice:

Obstetric anal sphincter injury (OASI)

Overview

Read the scenario and the summary of the research below.

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

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

You have 10 minutes to complete this task.

Scenario
You are working in the community and have an appointment with Hana, who is 36 weeks pregnant with her second baby. She had a ventouse delivery last time and has been reading about how to prevent perineal trauma during birth. She wants to talk to you about whether the midwife or obstetrician can manually protect her perineum at the end of the second stage of labour to prevent trauma.
Article summary
An interventional cohort study published in 2010 was used as evidence to support the Royal College of Obstetricians and Gynaecologists' (RCOG) OASI care bundle, which is supported in UK practice by the Royal College of Midwives. The study involved the application of an intervention in 40,152 vaginal deliveries in Norway between 2003 and 2009. The intervention was manual support of the perineum at the end of the second stage of labour. The study found that the incidence of anal sphincter injury reduced from 4–5% to 1–2% during the study. The study also found that: • the incidence of perineal trauma reduced in both instrumental deliveries and spontaneous vaginal deliveries • reduction in fourth-degree tears was the most significant finding of the study • intervention had no harmful effects on the newborn. There were variables regarding episiotomy rates, mode of delivery and parity in different participating hospitals during the study.

Evidence-based practice:

Obstetric anal sphincter injury (OASI)

Candidate documentation

Candidate name: _____

What is the relevance of the findings from this research? What advice will you give to Hana?

Give your responses here as bullet points:

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