Test of Competence 2021: Mock OSCE

Learning Disabilities Nursing

V 1.6

Mock OSCE

Learning disabilities 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 up to 20 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	Shares information if

	who are seen to be vulnerable or at risk of harm	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 up to 20 minutes and is scenario-based. The instructions and available resources are provided for each station, along with the specific timing.

Scenario
Frankie Kapalis has a mild learning disability and Williams syndrome. However, Frankie can communicate verbally and is capable of independent self-care. They have lived in a supported living facility for the past 10 years. Two months ago, another resident at the complex, who Frankie was very friendly with, passed away suddenly. Since the loss of their friend, Frankie has become less talkative and increasingly reluctant to go to work or attend social group outings. Frankie has a loss of appetite and is no longer eating full meals. Frankie is becoming more resistant to eating meals,even with support from friends.

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 10–14) • A Glasgow depression scale completed by the patient (pages 15–19) • A copy of the Hospital Communication Book, for reference (pages 20–43)
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 completed nursing care plan for two nursing care problems or needs (pages 44–47)
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 48–51)
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 52–53)

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
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, 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, taking interest.
Uses brief verbal and non-verbal affirmations.
Uses reflection/paraphrasing to demonstrate concern.
Conducts a holistic assessment relevant to the patient's scenario.
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 (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'.

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, 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 (checks 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 DoB, 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 detailing 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
Grief and bereavement

Candidate briefing

You are a registered nurse for people who have learning disability working in a purpose-built residential facility supporting Frankie Kapalis. Frankie is a resident with a learning disability. Frankie may be experiencing issues of bereavement following the loss of their friend.

Please conduct a holistic assessment of the patient's physical, psychosocial, spiritual and sexual care needs.

Please proceed with your nursing assessment by calculating a pre-completed **Glasgow depression scale** score. The score must be **calculated** within this station. Please discuss the clinical response and outcome of the Glasgow depression scale with Frankie.

Complete your assessment using the headings in the table below.

You may focus on the following **TWO** care needs to help you to develop a care and support plan in the planning station.

- **Deteriorating mental and physical health**
- **Social needs**

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 **10:00 hours.**

Assessment
Grief and bereavement

Overview of recent history

Patient information
Name: Frankie Kapalis **Date of birth:** 01/01/1973 **Address:** Meadowlane Housing, 1 Sweet Street, Westshire, WW6 5PQ **GP**: Dr A. Beattie 1 Sugar Terrace, Westshire, WW6 5NP **Current location and time** Meadowlane Housing residential supported living, 10:00 hours. **Presenting complaint:** Two months ago, a resident in the complex passed away suddenly, and Frankie was very friendly with them. Since the loss of their friend, Frankie has become less talkative and increasingly reluctant to go to work or attend social group outings. Frankie has a loss of appetite and is no longer eating full meals. Frankie is becoming more resistant to eating meals, even with support from friends. **History of presenting complaint:** Frankie has lived in the supported living facility for the past 10 years. Frankie can communicate verbally and is capable of independent self-care. However, he has a mild learning disability and Williams syndrome. In the past, Frankie has had periods of depression and anxiety, which are common in people with Williams syndrome. Frankie has previously been treated with medication to manage depression and has had cognitive behavioural therapy. However, Frankie has not required any hospital admissions. Frankie requires a lot of support and supervision during these episodes. **Past medical history:** • Mild learning disability • Williams syndrome • Depression and anxiety • Insomnia • Hypertension **Social history:** • Single • Resident in the supported living home for the past 10 years, living and cooking with two flat mates. • Next of Kin is Frankie's mother, Elena Kapalis. Frankie's father is Christian Kapalis and there are two sisters; Chloe and Amelia. • Ethnic group: Greek • Next door neighbour is Sam who has a cocker spaniel dog called Buster. • Frankie attends a local college studying catering and has a part time job in a café. • Frankie likes to talk a lot and does not like it when someone interrupts. Frankie likes people to speak slowly. Sometimes, Frankie uses Makaton signs or cards when unable

to get the right words for the food they would like to eat.
- Does not smoke. Enjoys drinking cider from time to time.

Current medications:
- Lactulose 15 ml twice a day (as required)
- Zopiclone 3.75 mg once daily
- Ramipril 10 mg once daily

Allergies:
- Penicillin (reaction anaphylaxis).

Assessment
Grief and bereavement

Candidate notes

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

Patient details: Name: Frankie Kapalis Address: Meadowlane Housing, 1 Sweet Street, Westshire, WW6 5PQ Date of birth: 01/01/1973
Deteriorating mental and physical health
Social needs
Health promotion
Sleeping

Assessment
Grief and bereavement

Nutrition and hydration
Elimination

GLASGOW DEPRESSION SCALE

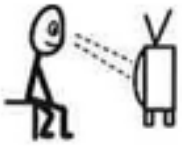
Client name: Frankie Kapalis Date: TODAY

Instructions to candidate:

This depression scale has been completed with Frankie. You are required to calculate the overall score and discuss the outcome with Frankie.

In the past week…		**Prompts**	**No**	**Sometimes**	**Always**
1.	 Have you felt sad?	*Have you felt upset?* *Have you felt miserable?* *Have you felt depressed?*	0	1	**2**
2.	 Have you been in a bad mood?	*Have you lost your temper?* *Have you felt as if you want to shout at people?*	0	1	**2**

In the past week…		Prompts	No	Sometimes	Always
3.	 Have you enjoyed doing things?	*Have you had fun?* *Have you enjoyed yourself?*	**2**	1	0
4.	 Have you enjoyed talking and being with people?	*Have you liked having people around you?* *Have you enjoyed other people's company?*	**2**	1	0
5.	 Have you had a bath/shower and changed your clothes?	*Have you taken care of the way you look?* *Have you looked after your appearance?*	2	**1**	0
6.	 Have you felt tired during the day?	*Have you gone to sleep during the day?* *Have you found it hard to stay awake during the day?*	0	1	**2**
7.	 Have you cried?		0	1	**2**

In the past week…		Prompts	No	Sometimes	Always
8.	 Have you felt people don't like you?	*Have you felt others don't like you?*	**0**	1	2
9.	 Have you been able to concentrate, such as watch TV?	*Have you been able to concentrate on things (like TV shows?)*	**2**	1	0
10.	 Have you found it hard to choose things?	*Have you found it hard to decide what to wear, or to do?* *Have you found it hard to choose between two things?*	0	1	**2**
11.	 Have you found it hard to sit still?	*Have you fidgeted when you are sitting down?* *Have you been moving around a lot, like you can't help it?*	0	**1**	2
12.	 Have you eaten less? Have you eaten more?	*Do people say you should eat more or less? (positive response to eating too much or too little is scored)*	0	1	**2**

In the past week…		Prompts	No	Sometimes	Always
13.	 Have you found it hard to get a good night's sleep?	*Have you found it hard to fall asleep at night?* *Have you woken up in the middle of the night and found it hard to get back to sleep?* *Have you woken up too early in the morning?*	0	1	**2**
14.	 Have you wished you were dead?	*Have you wished you could die?* *Have you felt you do not want to go on living?*	0	**1**	2
15.	 Have you felt like everything is your fault?	*Have you felt as if people blame you for things?* *Have you felt that things happen because of you?*	0	**1**	2
16.	 Have you felt that people are looking at you?	*Have you worried about what other people think of you?*	0	**1**	2
17.	 Have you been upset if you say you have done something wrong?	*Do you feel sad if someone disagrees with you or argues with you?* *Do you feel like crying if someone disagrees with you or argues with you?*	0	**1**	2

In the past week…		Prompts	No	Sometimes	Always
18.	 Have you felt worried?	*Have you felt nervous?* *Have you felt tense/wound up/on edge?*	0	1	**2**
19.	 Have you thought that bad things will happen to you?	*Have you felt that nothing nice ever happens to you anymore?*	0	1	**2**
20.	 Have you felt happy when something good happens?	*If nothing good has happened in the past week, ask: if someone gave you a nice present, would that make you happy?*	**2**	1	0
		Total of each column			
		Overall score			
		Signature			
		Date			

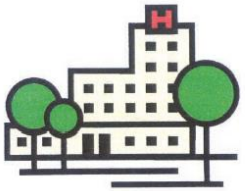
SCORING INSTRUCTIONS:

If you calculate a score of 13 or greater, please note that;

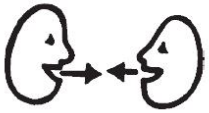
- A referral will be made for Frankie to have a consultation with the interdisciplinary team.

Cuthill, FM, Espie, CA, Cooper, S (2003), 'Development and Psychometric of the Glasgow Depression Scale for people with a Learning Disability', *The British Journal of Psychiatry* 182:347-353. Adapted by MK, GB, GW, DHCFT 2008.

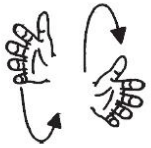
The Hospital Communication Book



Helping to make sure people who have difficulties understanding and /or communicating get an equal service in hospital



Talking clearly



Using Signing

Hearing loss

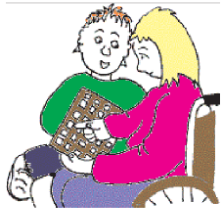
Visual Impairment

Using Pictures and Symbols

Developed on behalf of The Learning Disability Partnership Board in Surrey

Introduction and Contents

This communication book has been developed on behalf of The Learning Disability Partnership Board in Surrey.
The Partnership Board funded the Access To Acute Hospitals Project which aimed to help make sure that people with a learning disability had the right support when they used acute hospital services. The biggest barrier to people receiving the right support was found to be communication. This book aims to help hospital staff in 2 ways, and contains 2 sections.



- **Section 1** - To give acute hospital staff basic information about the communication needs people may have
- **Section 2** - To be a practical communication tool people can use to help communicate together.

Section 1 - Information Pages

These pages aim to explain some of the key communication issues for people with learning disabilities. Also to give you advice and practical tips on how to communicate clearly with people with learning disabilities, and other people who may have difficulties communicating.

Section 2 - The Picture, Symbol, Photo Toolkit

These are practical pages of pictures you can use to offer people choices, explain to people what is going to happen, and help them to communicate to you. Please read page 8 before using the pictures with people as this gives important advice on how to use them. Bear in mind not everyone will be able to recognise the meaning of all the pictures. They can help to back up what you are saying, and clue people in.

We are keen that you use this book in any way you feel can improve a person's experience whilst in hospital. You may find it useful to photocopy some of the pages to use separately. For example, the 'Nil by Mouth' page can be copied to be displayed above a person's bed.
To respect the copyright of Rebus, PCS, Makaton, Change Picturebank and Photosymbols graphics please do not reproduce these pages for any other purposes.

Many thanks to the Building Links Group from Bentley Day service for helping to choose the symbols used.

Communicating Clearly with Speech

We usually talk too fast

It takes more time for many people to process the words they hear.

This is true for many people with a learning disability.

And also true for all people when they are feeling anxious.

People don't understand all the words we use

Use everyday words wherever you can. Use short simple sentences. Have only one idea in a sentence.

You may have a much larger vocabulary than the person you are communicating with.

Use very Literal Language

When people are talking to us, we understand much of their meaning by their tone and body language.

Also, we often talk using abstract phrases rather than accurate words. Look at these phrases.

I'll give you a bell later

The doctor's doing her rounds

He can't see the wood for the trees

Some people will be less skilled at interpreting abstract language. They take a more literal meaning from words and can get confused.

Using gestures helps

Gestures and facial expressions give visual clues about the meaning of what you are saying, as well as slowing down the pace of your speech

Some people with a learning disability may only pick up key words in a sentence. This means they may only take in one, two, or three words of your sentence. **For example:**

Unfortunately, due to complications it's not possible for you to go **home** yet, we may know more **tomorrow**

home tomorrow

It's important to make sure the person has understood the main idea of your message

DON'T SHOUT - IT'S RUDE, AND DOESN'T HELP COMPREHENSION!

Supporting People with Visual Impairments

"In the UK 17,000 people with sight problems use a white cane. Another 5000 use guide dogs. There are many more who need help with their everyday living".

There are around 23,000 people in the UK who have a severe loss of both sight and hearing.

About 200,000 have less serious dual sensory loss.

Be aware how you explain things. We often talk in a very visual way. For example, when asked where the toilet is "the green door on the right" is not a helpful answer! If you are physically shown you can work the route out for yourself.

To make handwriting more legible, choose a dark felt-tip pen and write neatly using thicker strokes.
Be aware that some people have good vision in a limited area so would be ok with smaller print.

Avoid clutter! Try to minimise the risk of someone tripping over things.

It's important to take the time to tell people where the important things are like toilets, call buttons, and drinks.

People may need a bit of time before they are confident. It can help people to have a bed near a landmark in the room, say a bed at the end rather than in the middle.

Good lighting is important. A clip-on reading lamp may be useful for a person to have.

A magnifying glass may be useful to have around the ward for people who have a visual impairment to use to read.

Be aware that people have a variety of sight difficulties and a magnifier may not meet their needs.

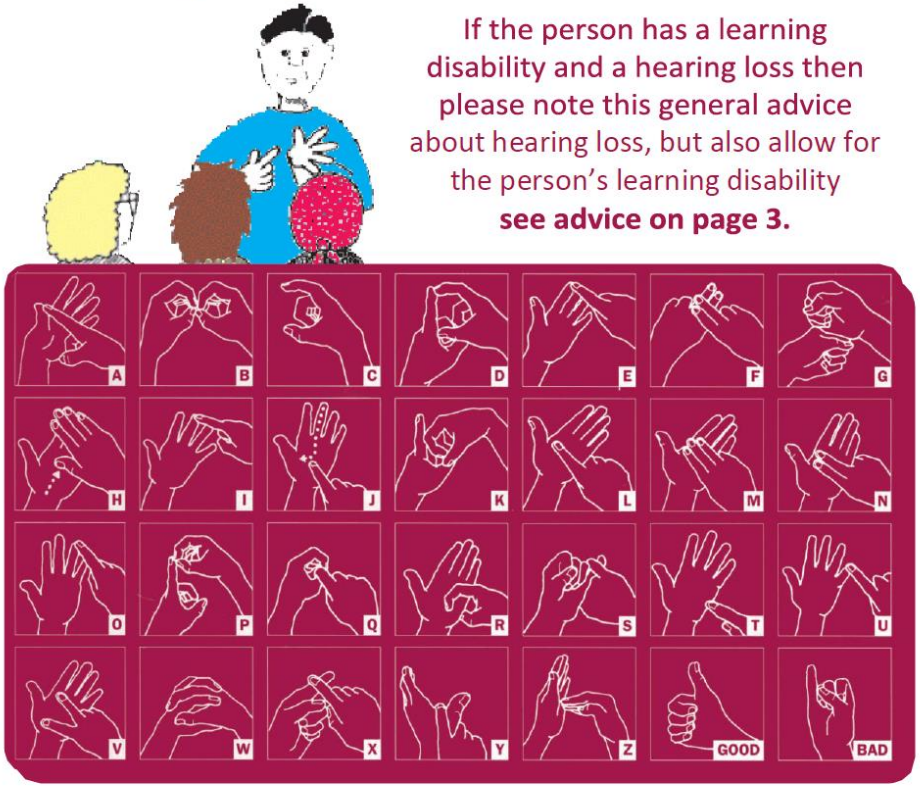
Encourage people to bring in their own magnifier.

Menus and food are a very common difficulty for people with sight problems in hospital
People will often have difficulty reading and ticking the menus as they are usually printed in very small writing. Read the menu out for someone or enlarge in on the photocopier if someone reads large print. **Meals may be left on a tray, on a table, which is out of reach near the end of the bed.** Someone who has a visual impairment may not see the meal and miss their food. It's important that staff take the time to describe to the person what is happening & where things are.

Supporting People with a Hearing Loss

Firstly, establish how the deaf person communicates.
If they are asking you a question using their voice, it is safe to assume that they will be expecting to lip-read your reply.

- **Face the person directly**, if you look away the deaf person cannot see your lips.
- **Speak clearly at a normal pace.** Do not shout
- **Make sure you have good light on your face** so the person can see your features and read your lips easily.
- **Use whole sentences rather than one-word replies** - lip-reading is 70% guess work and many words look the same. Using sentences gives contextual clues.
- **Be patient**, if you are asked to repeat something try changing the sentence slightly, it may make it easier to understand.
- **Do not give up**, if you cannot make yourself understood then try writing it down or drawing what you mean.
- **If the person is a sign language user, they will probably still expect to have to try to lip-read your reply**. Very few hearing people sign, and deaf people are used to trying to communicate with hearing people.
- **Use gestures to help explain what you are saying**. Use gestures, point, mime to help explain what you are saying. E.g. Show a cup and ask what they want to drink. Mime driving a car to ask if you can give them a lift. Point to objects to give clues, or point to give directions. Show size and shape with your hands
- **Use facial expressions to help convey meaning**.
- **Fingerspelling -** Deaf people usually fingerspell names, places, and unusual words.



If the person has a learning disability and a hearing loss then please note this general advice about hearing loss, but also allow for the person's learning disability
see advice on page 3.

Using Signing to Support Speech

The main benefit of using signing with speech is that it makes communication visual.

People can see what you are saying as well as hearing it.

People then have more ways of understanding the message.

British Sign Language (BSL)

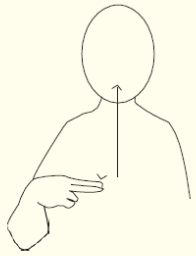
Is a full visual language used by many deaf people to communicate. Not everyone who signs uses the full BSL.

Some people use signs to support the words they are speaking. Many people who aquired a hearing loss later in life use signing in this way.

A deaf person may need the support of an interpretor. Contact your local Deaf Services Team

On the following page we have included diagrams of a few signs you may find useful on a hospital ward. These are signs for things not easily represented by a picture or symbol. It's best to use the symbols where you can.

Some signs have an arrow which shows you the direction to move your hand. The double headed arrow here means up and down.



A more specific action is explained in writing.

To explain that you are going for a drive you might say 'we are going in the car' as it keeps the language simple.

The limitation of signing is that, as with speech, when you stop signing the message is gone and relies on the person's memory.

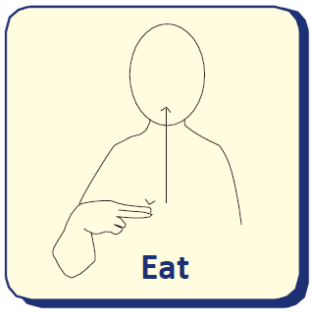
Makaton Signing

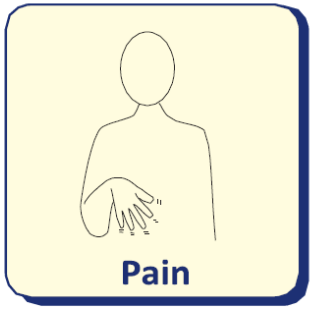
Makaton is a language programme integrating speech, manual signs, and graphic symbols. Many people with a learning disability use Makaton. Key words are signed.

We are **going** to the **shop** in the **car**.

You only sign the bold words. Contact Makaton for advice on training. Their website is www.makaton.org

Some Useful Makaton Signs





Please Note : These signs are for illustration. People learn Makaton signing in groups supported by Makaton representatives. Please go to www.makaton.org.for more information.

Using Photos, Pictures, and Symbols

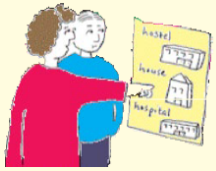
Photos, Pictures and symbols can help people to:

Understand Information
Many people with a learning disability do not read, and some people find it hard to understand when you explain things.

Pictures can help get your message across.

Tell you what they need
Some people with a learning disability do not communicate verbally. Some people 's speech can be hard to understand. **Pictures can help them get their message across**

Make choices
Many people find it hard to make choices in their head. Having pictures to look at helps.



One benefit of using pictures is that they are permanent. Once you stop speaking or signing you rely on the person's memory.

The symbols we have included on the next few pages may help you to communicate more clearly with a wide range of people.

car

Many people who have a learning disability will be familiar with some symbols

Symbols are simple line drawings that represent a word

headache

Note of Caution

A picture, photo, or symbol is only a 2-dimensional representation of an object or idea. Not all people with a learning disability will take a meaning from a picture, photo, or symbol.

Some people have a very profound disability and do not use pictures and symbols at all. Using an object, like a cup or a gown, can help to explain what you're saying.

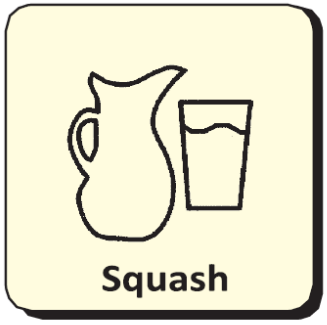
Many symbols look like what they represent - others are more abstract. If you can't easily tell what a symbol represents other people will struggle too, and will need help. Remember that many people won't be able to read the word underneath.

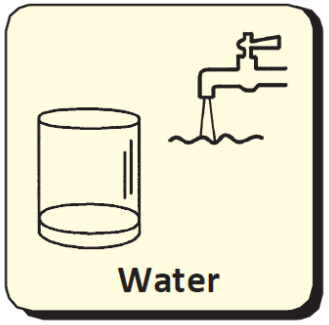
Some people will understand the symbol for car easily but may struggle with headache which is more abstract.

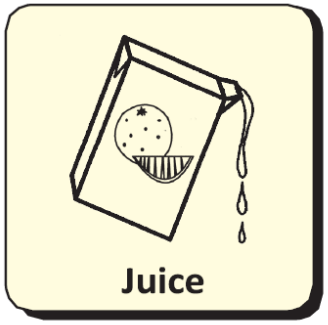
Symbols and Signing

Not everyone who uses signing will be familiar with symbols and not everyone who understands symbols will understand signing. Some people will use a mixture of both.

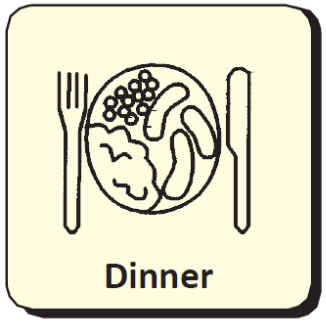
Symbols of Drinks

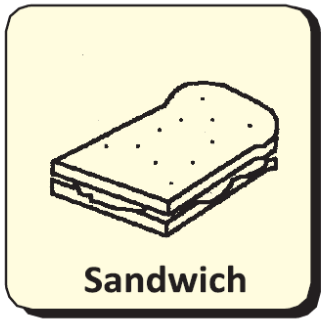


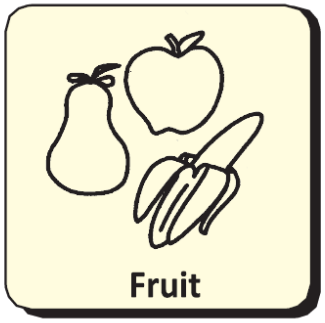




Symbols of Foods


Dinner


Sandwich

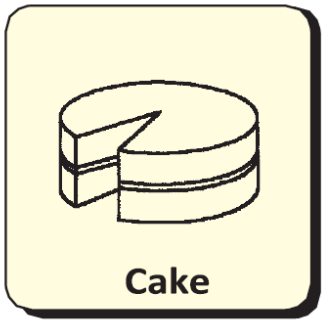

Fruit

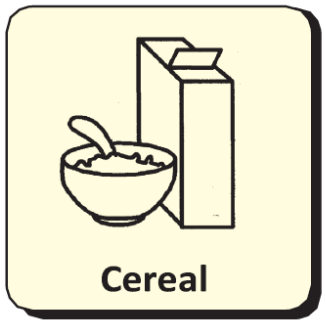

Sweets

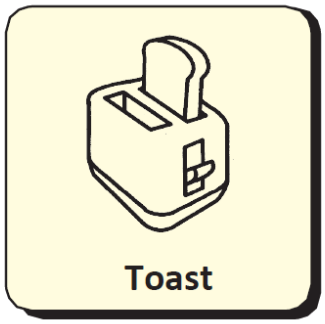

Pudding

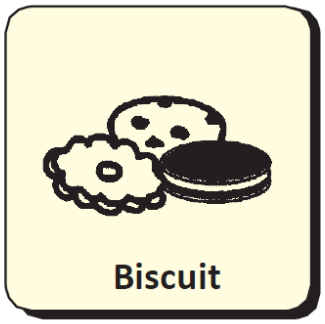

Yoghurt

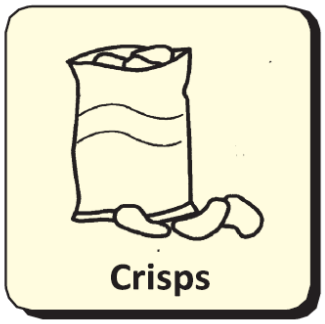

Chocolate


Cake

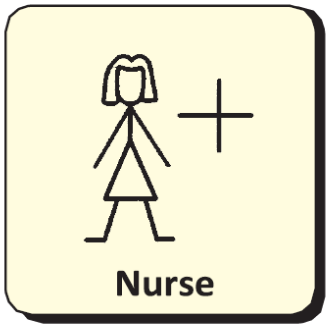

Cereal

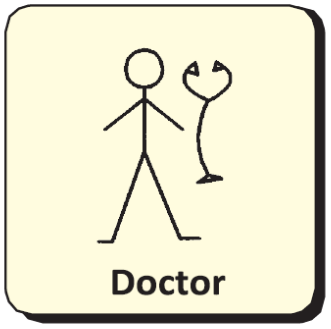

Toast

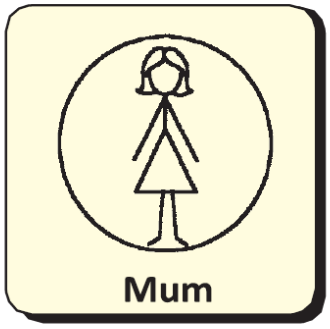

Biscuit

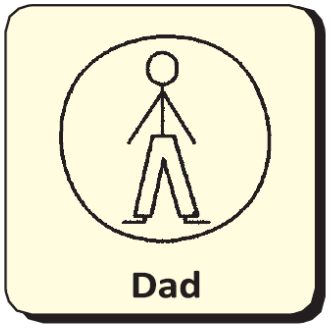

Crisps

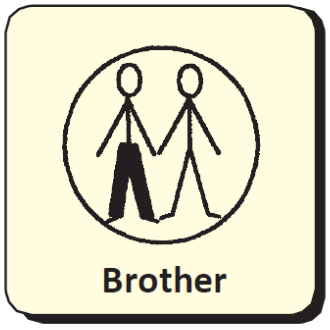
Symbols of People

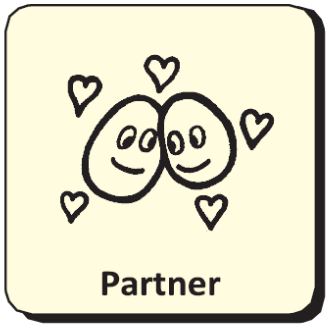


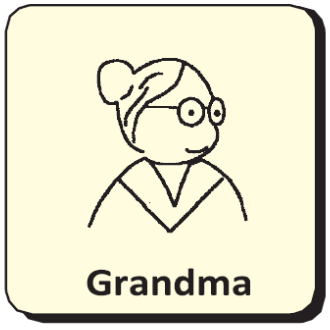


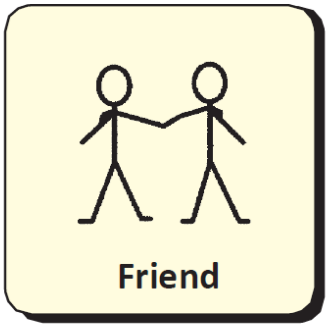




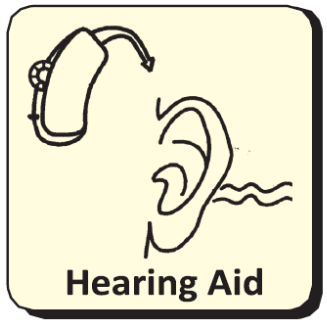


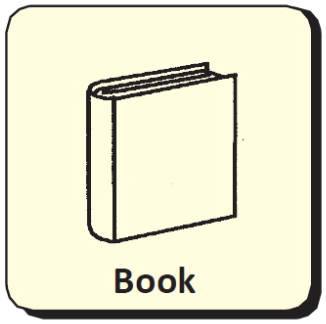




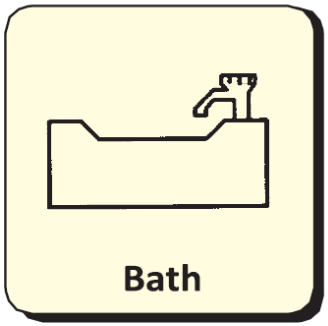


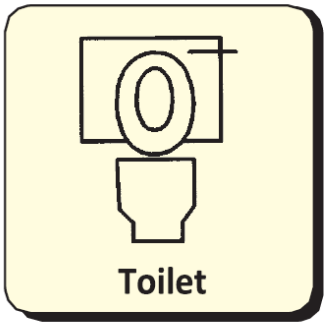
Symbols of Personal Things



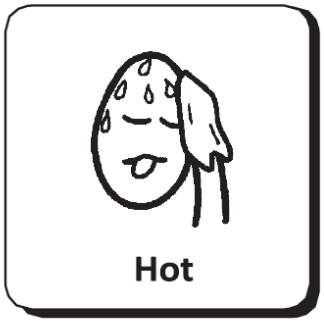


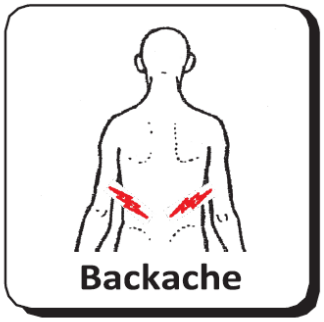
Personal Care Symbols

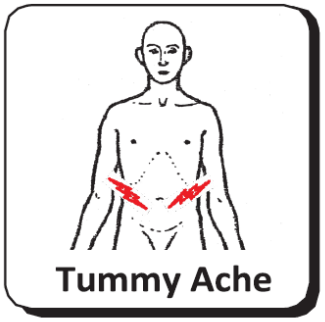


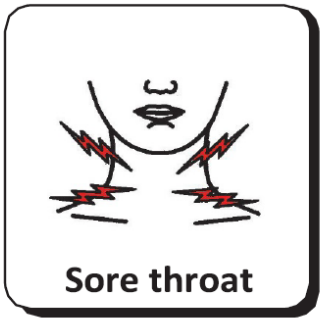


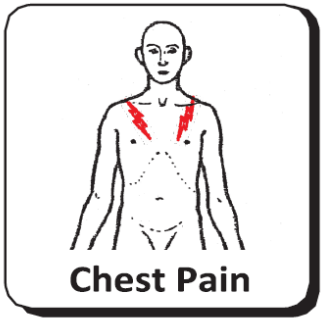
Symbols of Symptoms

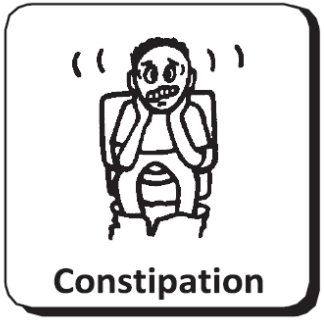


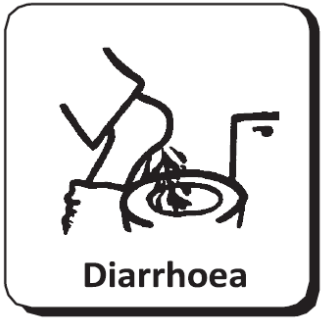




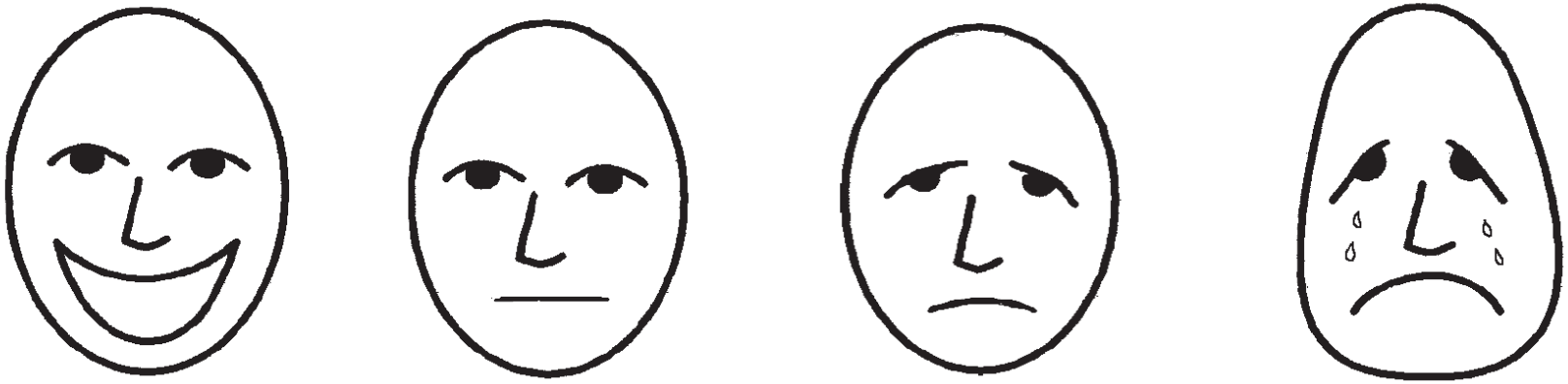




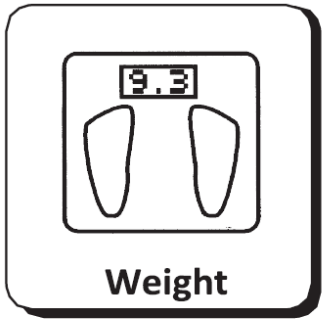


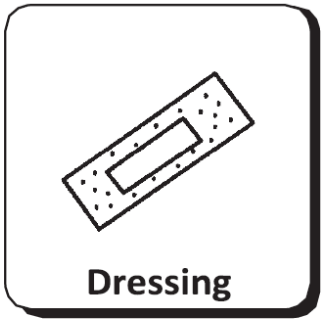


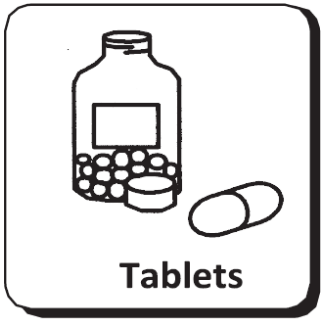
Degree of Pain

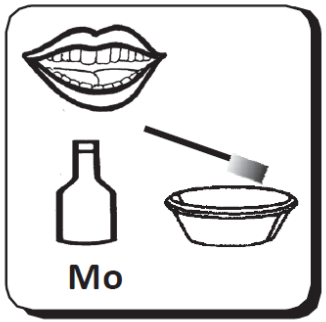


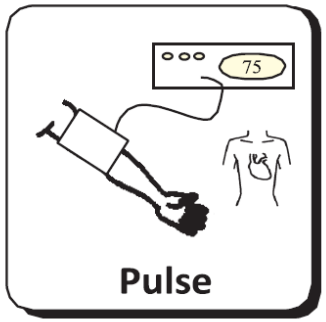
Symbols of Procedures



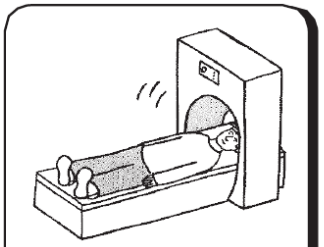


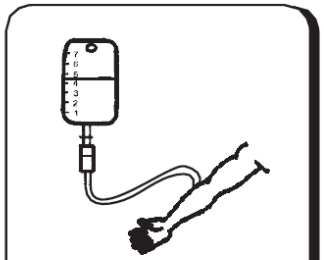


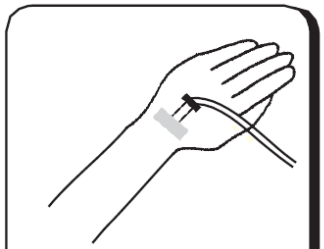


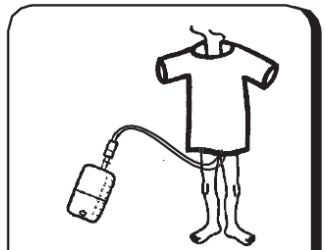


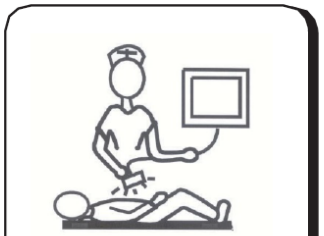
Symbols of Procedures

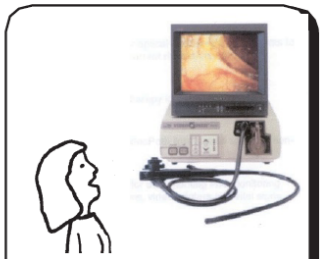

Scan

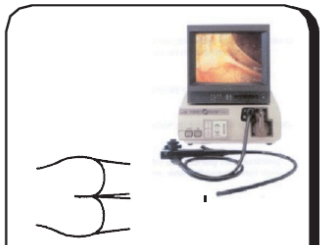

Drip


Canula

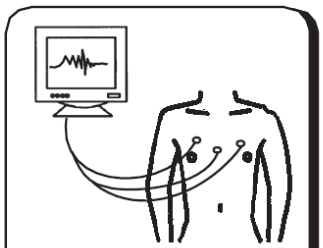

Catheter


ultrasound scan

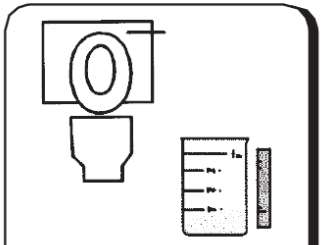

Endoscopy

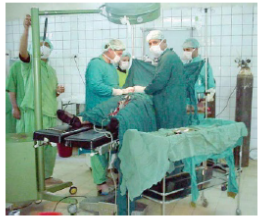

Sigmoidoscopy


EEG

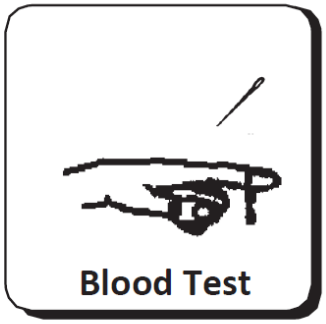

Heart Monitor / ECG

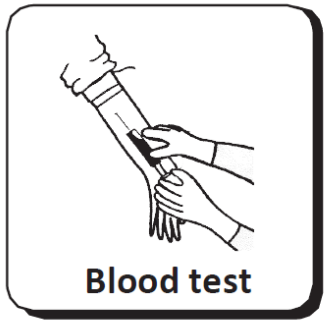

Naso-gastric tube

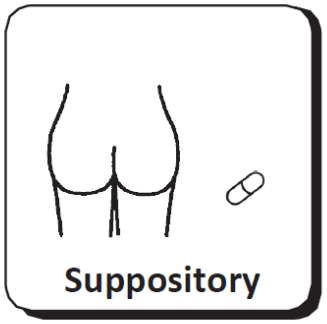

Urine Test

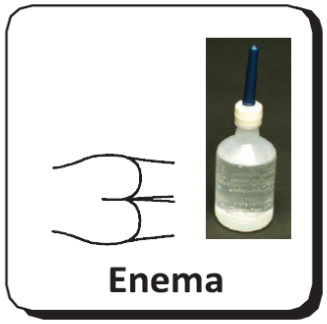

Operation

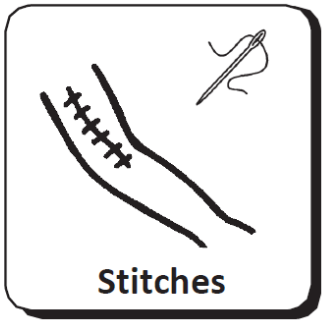
Symbols of Procedures

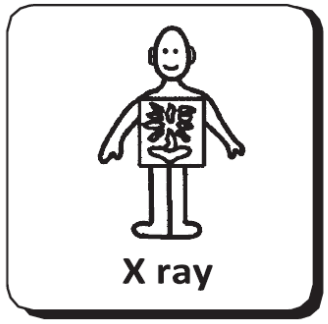


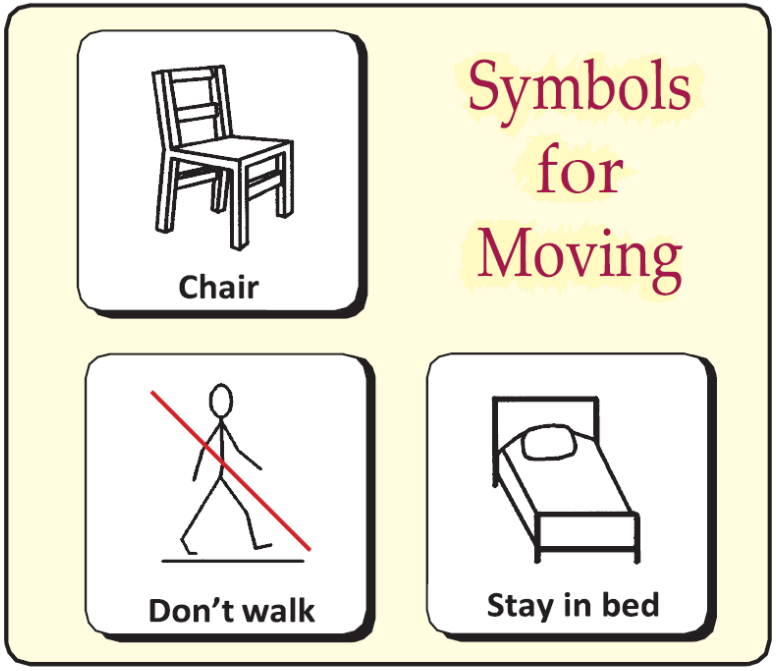


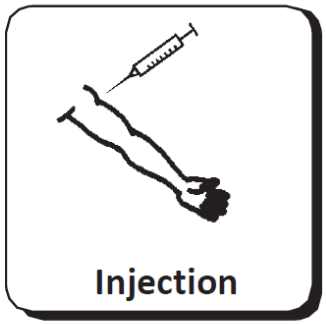


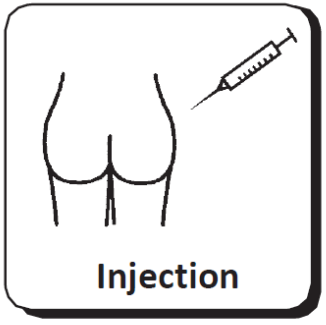




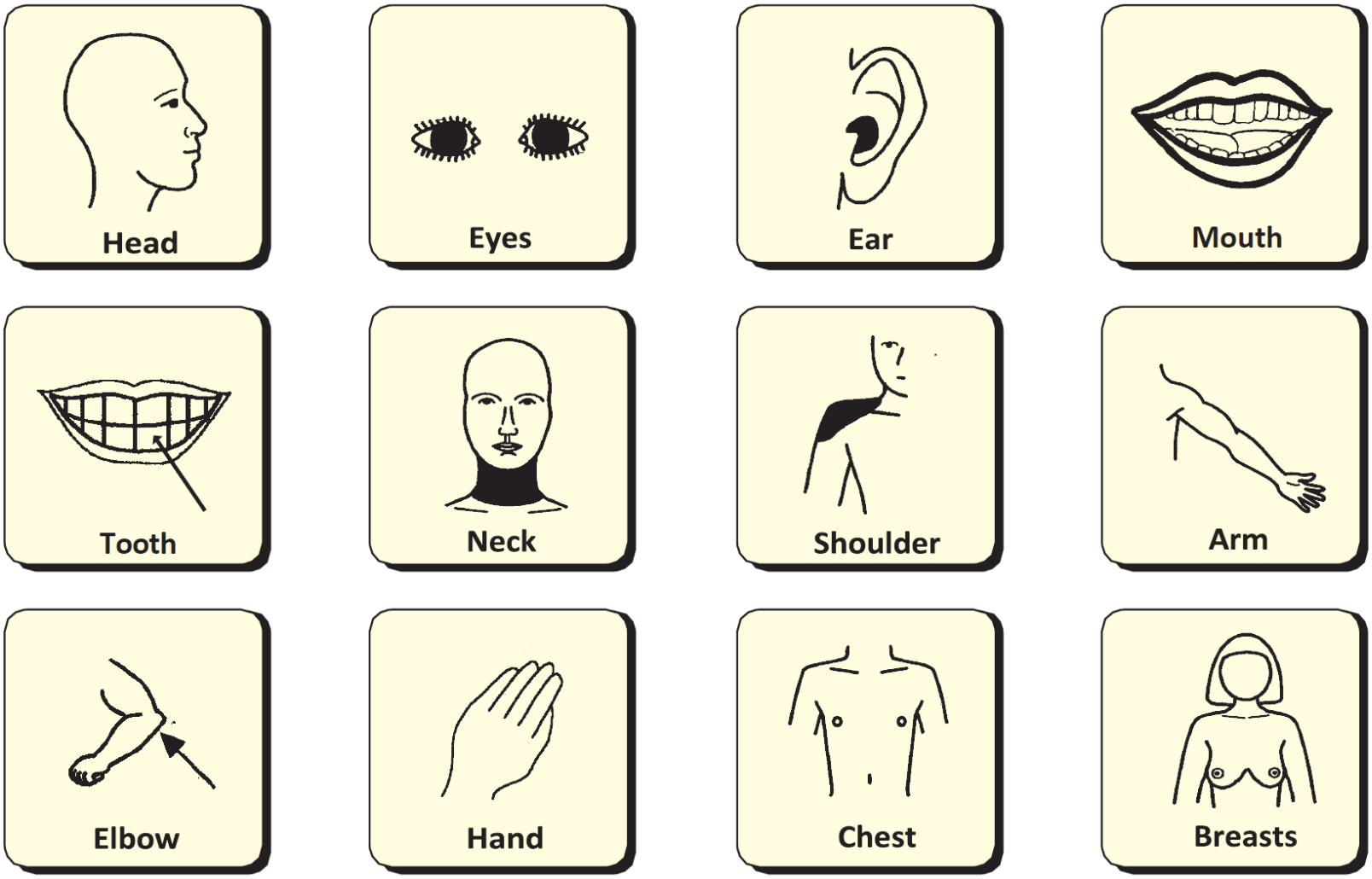




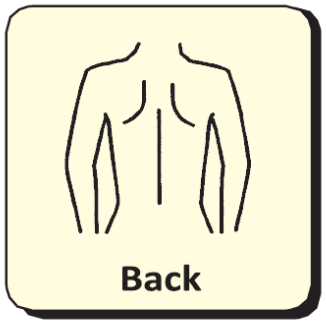


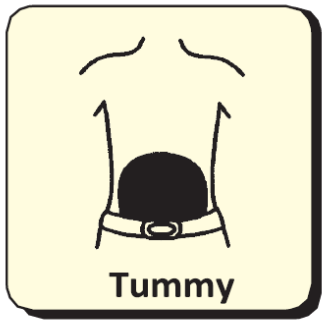


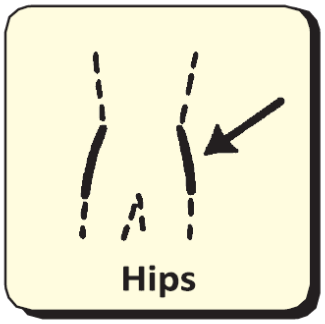
Body Parts

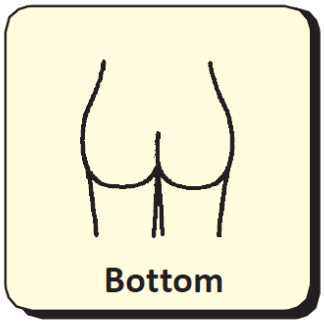

Head
Eyes
Ear
Mouth
Tooth
Neck
Shoulder
Arm
Elbow
Hand
Chest
Breasts

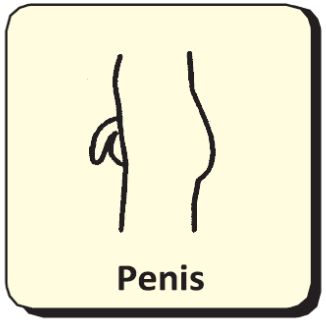
Body Parts

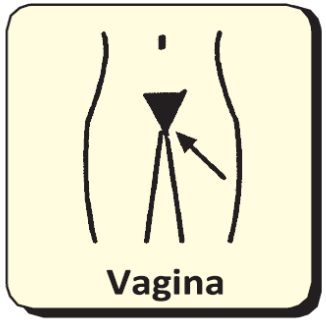

Back

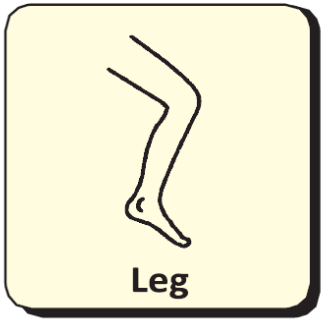

Tummy

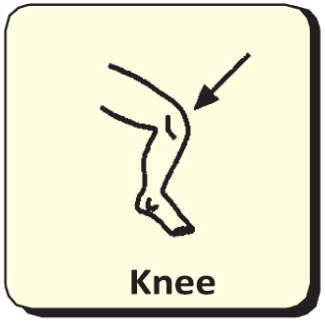

Hips

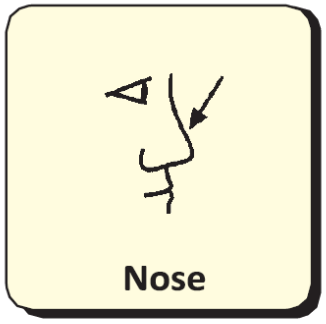

Bottom

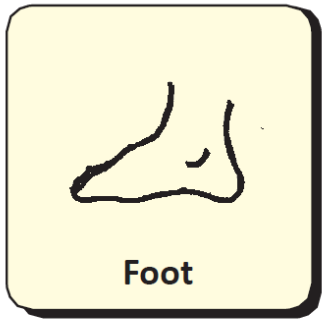

Penis

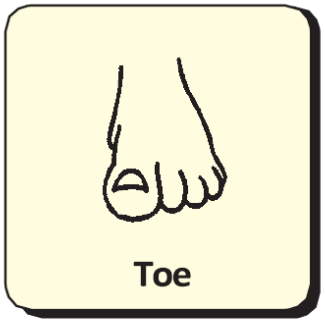

Vagina

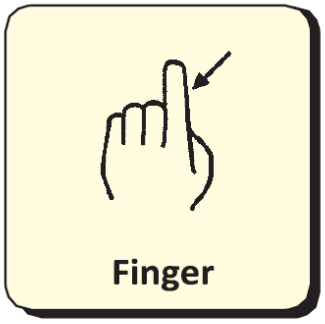

Leg


Knee

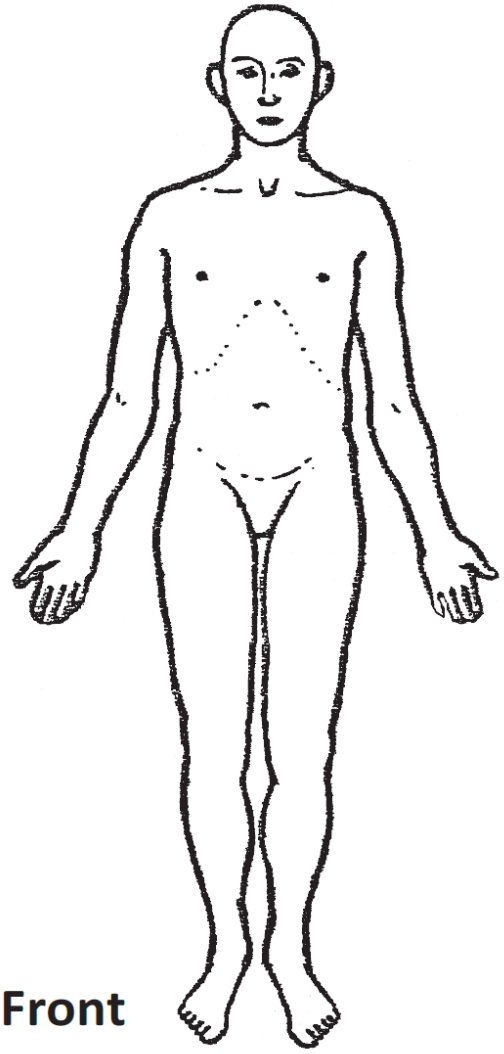

Nose


Foot

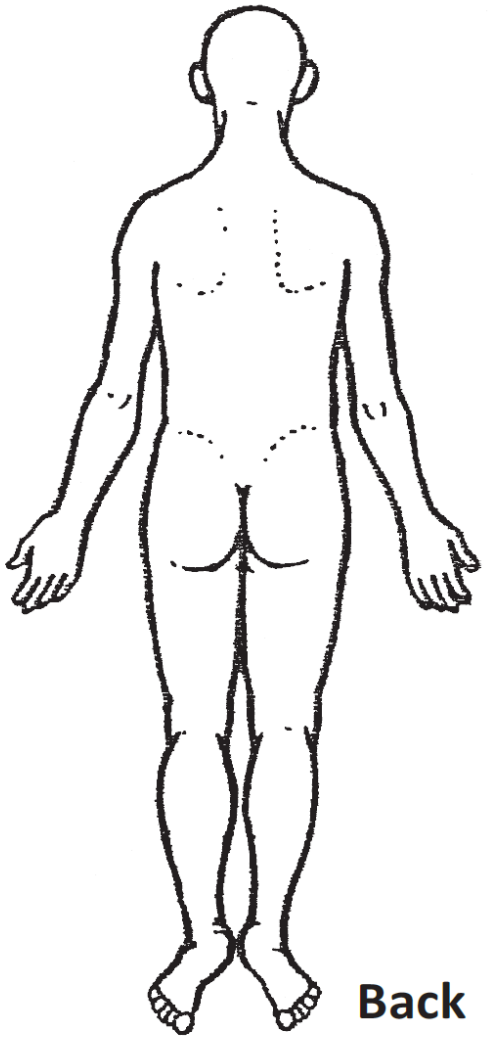

Toe


Finger

Full Body



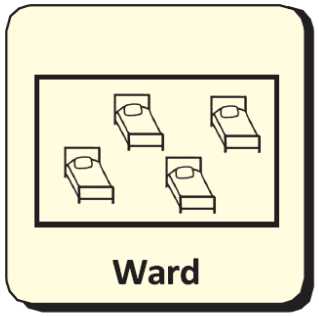
Front

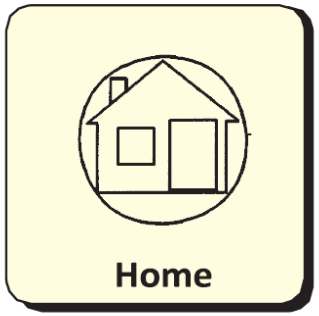


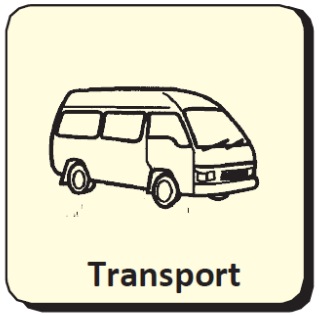
Back

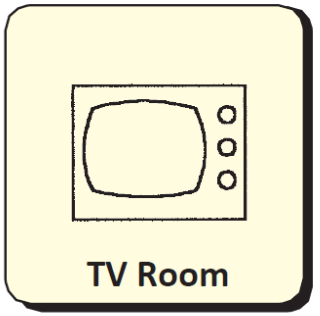
Nil By Mouth

Symbols of Places

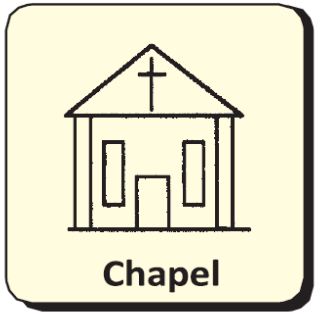

Ward

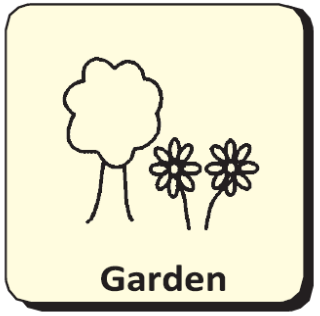

Home


Transport


TV Room


Cafe


Chapel


Garden


Day Centre


Shop

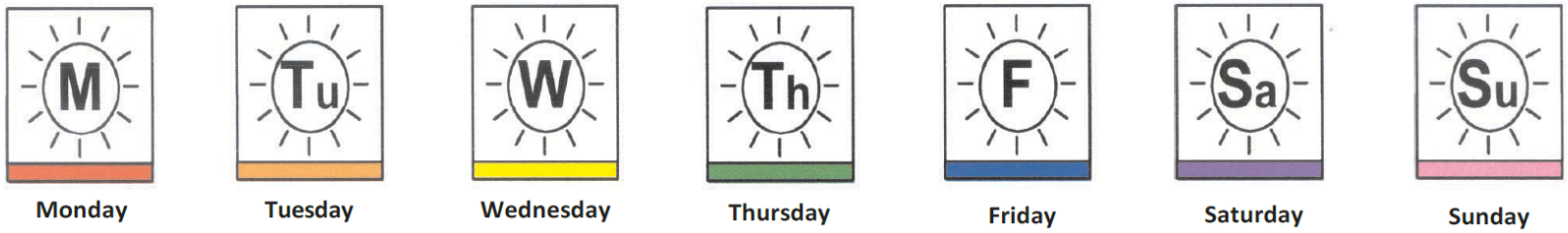

Newspapers and Magazines

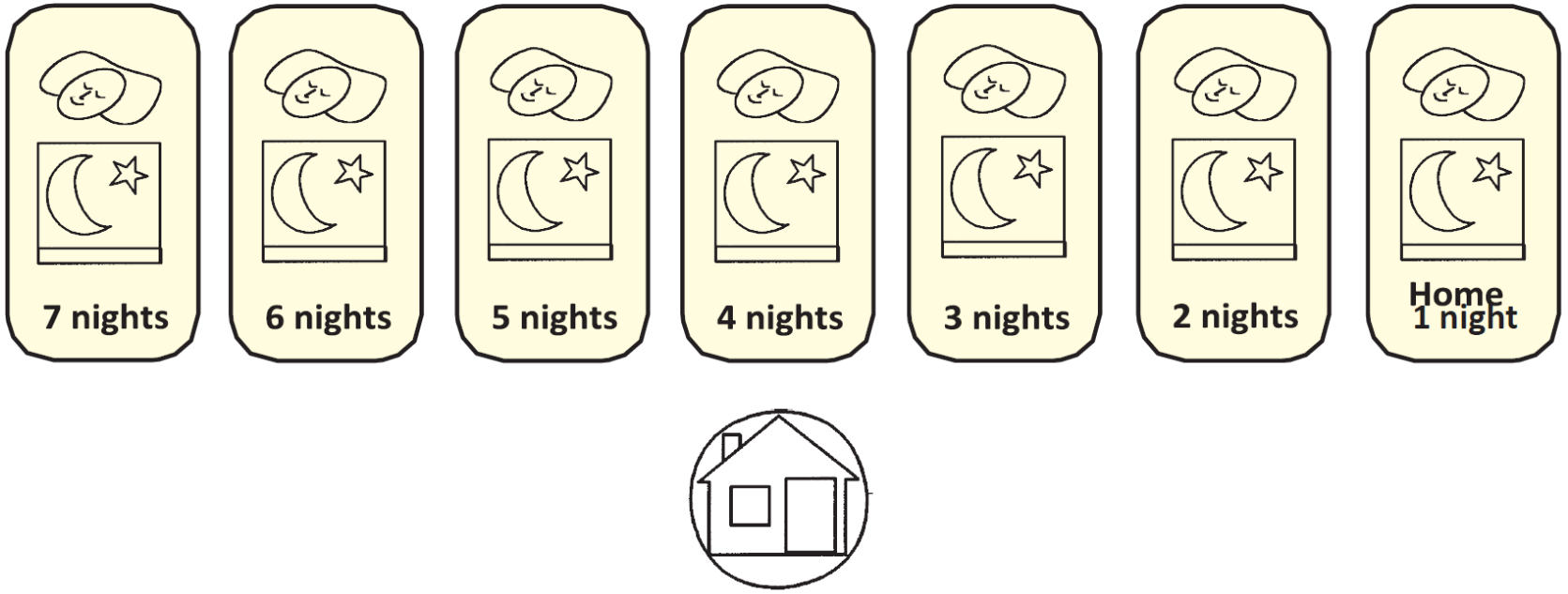

Flowers


Snacks


Drink

When do I go home?





Planning care
Grief and bereavement

Candidate paperwork and briefing

Candidate's name: _____

This document must be completed using a BLACK PEN.

Scenario
Frankie has a mild learning disability and Williams syndrome. In the past, Frankie has had periods of depression and anxiety. Frankie can communicate easily and is capable of independent self-care. On occasions when Frankie finds communication difficult, they will use Makaton signs or cards to help the other person understand their needs. Frankie's support worker has reported to you that, over the past 2 months, Frankie has become less talkative and reluctant to go to work or to attend social group outings. Following completion of your assessment on Frankie using the Glasgow depression scale, it has been determined that Frankie is experiencing issues with grief and bereavement.

Based on your nursing assessment of Frankie, please produce an evidence-based person-centred care and support plan for <u>two relevant aspects</u> of nursing care needs, suitable for the next 48 hours.

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 **11:00.**

Planning care
Grief and bereavement

Patient details: **Name:** Frankie Kapalis **Address:** Meadowlane Housing, 1 Sweet Street, Westshire, WW6 5PQ **Date of birth:** 01/01/1973
1) Problem/need
Aim(s) of care:
Re-evaluation timeframe:
Nursing interventions
NAME (Print):
Nurse signature: **Date:**

Planning care
Grief and bereavement

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

Planning care
Grief and bereavement

This page is not a required element but is for use in case of error.
Problem/need
Aim(s) of care:
Re-evaluation timeframe:
Nursing interventions
NAME (Print):
Nurse signature: **Date:**

Implementing care
Grief and bereavement

Candidate paperwork and briefing

Candidate name _____

This document must be completed using a BLACK PEN.

Scenario
For the past 2 months, Frankie has become gradually less talkative and more reluctant to go to work or to attend social group outings. Following completion of your assessment on Frankie using the Glasgow depression scale, it has been determined that Frankie is experiencing issues with grief and bereavement. As a result of this assessment, Frankie was referred for a consultation with the interdisciplinary team and, following the consultation, the general practitioner (GP) prescribed additional medications. **Please administer and document Frankie's 12:00 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 **12:00 hours.**

COMMUNITY MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Kapalis **Forename(s):** Frankie **Date of birth:** 01/01/1973 **Hospital/NHS number:** 0004321	**Address:** Meadowlane Housing Sweet Street, Westshire WW6 5PQ
GP Name: Dr A Beattie	**Surgery address:** 1 Sugar Terrace, Westshire, WW6 5NP

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 Beattie	3214213	*Dr Beattie*	1 Sugar Terrace, Westshire

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

ALERTS: Allergies/sensitivities/adverse reaction					
Medicine(s)/Substance			**Effect(s)**		
PENICILLIN			ANAPHYLAXIS		
IF NO KNOWN ALLERGIES TICK BOX ☐					
Signature:	*Dr Beattie*	**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: Kapalis **Forename(s):** Frankie **Date of birth:** 01/01/1973 **Hospital/NHS number:** 0004321	**Address:** Meadowlane Housing Sweet Street, Westshire WW6 5PQ
GP Name: Dr A Beattie	**Surgery address:** 1 Sugar Terrace, Westshire, WW6 5NP

Information for prescribers:	**Medicine non-administration/self-administration:**	
Write in BLOCK CAPITALS using black or blue ink.	If a dose is omitted for any reason, the nurse should enter the relevant code on the administration record and sign the entry.	
Sign and date and include bleep number.		
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 reason

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	LACTULOSE	15 ml	PO	12:00	BD		Dr Beattie TODAY		*K. Davis*
TODAY	LACTULOSE	15 ml	PO	22:00	BD		Dr Beattie TODAY		*K. Davis*
TODAY	RAMIPRIL	10 mg	PO	12:00	OD	+4 days	Dr Beattie TODAY		*K. Davis*
TODAY	FLUOXITINE	20 mg	PO	12:00	OD	+4 days	Dr Beattie TODAY		*K. Davis*
TODAY	ZOPICLONE	3.75 mg	PO	22:00	OD	+4 days	Dr Bothwell TODAY		*K. Davis*

COMMUNITY MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD	
Surname: Kapalis **Forename(s):** Frankie **Date of birth:** 01/01/1973 **Hospital/NHS number:** 0004321	**Address:** Meadowlane Housing Sweet Street, Westshire WW6 5PQ
GP Name: Dr A Beattie	**Surgery address:** 1 Sugar Terrace, Westshire, WW6 5NP

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

Evaluating care
Grief and bereavement

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
Frankie was referred for an assessment to you as a registered nurse for people who have learning disabilities working in a purpose-built residential facility. Following assessment, the GP prescribed additional medications for depression. Despite taking the prescribed medication, Frankie has not shown any sign of improvement and continues to deteriorate. Frankie is now being referred back to the GP.

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 GP (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.

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

Evaluating care
Grief and bereavement

Candidate notes

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

Patient details: Name: Frankie Kapalis NHS number: 0004321 Address: Meadowlane Housing, 1 Sweet Street, Westshire, WW6 5PQ Date of birth: 01/01/1973
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 57)
Stoma bag change – 8 minutes You will change a stoma bag according to current evidence-based practice.	• Overview documentation (page 58)

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.
Cleans hands with alcohol rub or washes with soap and water and dries with paper towels according to 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 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 – 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 61–62)
Evidence-based practice **Sleep in intensive care – 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 63–64)

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 10 minutes to complete this station.

Mock silent stations

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 10 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.

Evidence-based practice: Sleep in intensive care

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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Unit 109 Albert Mill
10 Hulme Hall Road
Castlefield
Manchester
M15 4LY

www.alphaplus.co.uk

+44 (0) 161 249 9249