Sample scenario

OSCE SAMPLE 1: PSYCHOSOCIAL ASSESSMENT

Purpose of the station

The purpose of this station is to demonstrate your clinical skills and decision making using both objective and subjective methods to complete a psychosocial nursing assessment of a given client who is referred to the Acute Mental Health Unit.

Scenario/situation

The client moved to Ireland from abroad two years ago with her family. She is in the first year of studying Pharmacy. Her husband works as a busy junior doctor in a local General Hospital. She has found all aspects of the transition to Ireland very challenging. She feels very isolated. She is responsible for the running of the house; dropping and collecting their two children to and from child care every. She feels increasingly that she is "not part of a couple".

For the last year she has felt increasingly irritable and reports getting upset quite frequently. This started after she had a recent miscarriage. She reports difficulty getting to sleep and sometimes wakes in tears feeling shaken at 4am. She gets upset, is very tense with sharpened senses, increasingly restless and fidgets for extended periods throughout the day. She often finds herself sweating and has lost weight over the last six months. She also reports having a constant dry mouth, nausea and frequently has to go to the toilet. Saanvi feels a little better in the evening when she sees her children. She can no longer be bothered with house chores. Although hopeless at times, her religious beliefs and children prevent her from killing herself, though she feels very low at times. She has never taken illicit drugs and says she drinks only moderately.

You are required to:

1. Consider the General Practitioner (GP) referral letter requesting immediate psychiatric assessment
2. Conduct a psychosocial interview and mental status assessment of the client including:
   - Demonstrate how to conduct a psychosocial interview
   - Demonstrate rapport with the patient and obtain informed consent from the patient to share the assessment data with the multidisciplinary team (MDT)
3. Complete an initial screening assessment to identify the patients identifying data, chief complaint, current and past psychiatric history, past medical history, family history, developmental and social history, substance use/abuse/addictions.
4. Assess the patient's current mental status using both objective and subjective examination methods
5. Document your complete nursing assessment findings within the provided Integrated Care Plan assessment notes

OSCE SAMPLE 2: INEWS AND OBSERVATIONS (VITAL SIGNS)

Purpose of the station

The purpose of this station is to assess how you take, record and analyse vital signs. Underpinning the station is your competencies and patient safety.

Case 1:

- Record each observation/vital sign on the NEWS chart
- Record the score for each observation/vital sign on the NEWS chart
- Record a total score on the NEWS chart
- Connect as appropriate (trace line) the two sets of observations/vital signs on the NEWS chart
- Fill in: Date; Time; HCW; Student/HCA Initials
- Record escalation response protocol for the 2nd set of observations/vital signs recorded on worksheet

Case 2:

- Record the Neurological Observations/GCS on the NEWS chart
- Based on the findings, note correct action to be taken and why

Case 3:

- Take radial pulse manually for one minute and record on the NEWS chart
- Take respirations manually for one minute and record on the NEWS chart
- Take temperature and record on the NEWS chart
- Take blood pressure above brachial and record on the NEWS chart
- Assess oxygen status and record on the NEWS chart
- Assess AVPU and record on the NEWS chart
- Score each vital sign on the NEWS chart and give a total score
- Using the total score, explain the Escalation Protocol Flow Chart
- Record name and date and time on NEWS chart
- Sign the NEWS chart
- Decontaminate the blood pressure apparatus and thermometer and pulse oximeter
- Establish and maintain a caring therapeutic interpersonal relationship
- Communicate in an accurate, clear and effective manner
- Demonstrate a level of competence essential for safe practice