OSCE checklist for vital signs

An OSCE checklist for vital signs covers checking identity and consent, then measuring respiration rate, oxygen saturation, blood pressure, pulse, level of consciousness and temperature, recording each value on the early warning chart and escalating anything abnormal.

OSCE checklist for vital signs: steps to practise

1. Clean your hands, introduce yourself, confirm the patient's name and date of birth against the wristband, explain what you will do and gain consent.
2. Give privacy, ask the patient to rest for a few minutes, and check that they have not just eaten, drunk, smoked or exercised.
3. Check that your thermometer, sphygmomanometer and pulse oximeter are clean and working, and choose the right cuff size.
4. Count the respiration rate for a full minute without telling the patient, and note depth, effort and any noise.
5. Check oxygen saturation on a warm finger, remove nail varnish if it blocks the reading, and note whether the patient is on air or oxygen and the device used.
6. Measure blood pressure with the right cuff, the arm supported at heart level and the patient seated or lying comfortably. Use a manual reading if the pulse is irregular or the automatic reading looks wrong.
7. Feel the radial pulse with two fingers. Count for 30 seconds and double it if regular, or a full minute if irregular, and note rate, rhythm and strength.
8. Assess the level of consciousness with ACVPU (alert, new confusion, voice, pain, unresponsive). Treat new confusion as a warning sign.
9. Measure the temperature with the device and route your ward uses, and note the route.
10. Look at the whole patient: colour, sweating, breathing effort and how they say they feel.
11. Record every value on the chart straight away, work out the NEWS2 score if your chart uses it, and compare with the previous set.
12. Escalate following NEWS2 and your local escalation policy: tell the nurse in charge at once about any raised score, any single parameter in the red zone, or a patient who looks unwell even if the

score is low. Call for urgent help if the patient is deteriorating.

13. Clean the equipment, clean your hands and leave the patient comfortable with the call bell in reach.

What candidates commonly forget

- Counting respirations for only a few seconds
- Forgetting consciousness level and new confusion
- Not noting oxygen use, the cuff size or the patient's position
- Writing values on a hand or scrap paper instead of the chart
- Not comparing with the previous set or not escalating a rising score
- Relying on the score when the patient looks unwell

Local policy comes first

This is our own practice checklist. Your college, hospital or country may do some steps differently. Where local policy and this list disagree, follow local policy. The normal ranges you quote should come from the chart your own school uses.

Practise the hands-on steps with a classmate or in a skills lab, because an AI patient cannot watch your technique. You can practise the talking part with an AI patient, and try one station free with no sign-up. Next, try Postoperative observations and urgent escalation. Back to the nursing foundation OSCE page: nursing foundation OSCE, or see the full OSCE checklist list.

Common questions

What is the OSCE checklist for vital signs?

Confirm identity and consent, rest the patient, measure respiration rate, oxygen saturation, blood pressure, pulse, consciousness level and temperature, record each value, score it if your chart uses NEWS2, and escalate anything abnormal.

In what order should I take vital signs in an OSCE?

Many UK wards follow the NEWS2 chart order: respiration rate, oxygen saturation, blood pressure, pulse, consciousness, then temperature. Follow the order your school or ward teaches. Accuracy and escalation matter more than the order.

Do I need to know normal ranges?

Yes. Use the bands on the chart your school uses, such as the NEWS2 chart. Say the value, whether it scores, and who you would tell.

What if the score is low but the patient looks unwell?

Escalate anyway. Clinical concern is a reason to call for help on its own.

Sources

- NMC: standards of proficiency for registered nurses
- Royal College of Physicians: National Early Warning Score (NEWS2)

Checked 2026-11-13. Fees and rules change, so confirm them with the regulator before you book.