IENCAP OSCE scenarios with answers

6 original IENCAP OSCE practice scenarios, each with the task, what a strong answer does and a model answer. They are free to read and to download.

Every scenario is original, with invented patients. It is not from any exam, and it is not official material. Check clinical details against current national guidance.

Chest pressure in a community health clinic

Acute management · 13 minutes

The task

You are the nurse at a community health centre in Ontario. Vikram Singh, aged 61, has walked in saying he feels unwell. A clinic assistant is at the front desk. Introduce yourself, confirm his identity and assess his symptoms. Take his vital signs, decide how urgent the situation is and act on it. Explain to him what you are doing. Record your assessment and the actions you take on the chart provided.

What a strong answer does

- Introduces self, confirms identity, sits the client at rest in a safe position and stays with him.
- Asks about the chest pain using a structured approach: when it began, quality, spread, severity, what makes it better or worse, and associated symptoms.
- Asks about risk factors, medications, allergies and bleeding risk.
- Takes and records a full set of vital signs and notes pale, clammy skin.
- **Safety:** Recognizes a possible heart attack and does not delay: asks the assistant to call 911 for an ambulance at once.
- Offers chewable aspirin only after checking allergy and bleeding risk and only within the clinic medical directive; does not give food or drink otherwise.
- Keeps him at rest, loosens clothing, repeats observations and watches for deterioration, and prepares the emergency kit.
- Reassures him honestly, lets him know what is happening and addresses his worry about his family.
- Gives a clear SBAR handover to the paramedics with onset time, symptoms, observations, history and medication given.
- Documents the assessment, 911 call time, aspirin given and the timeline.

Model answer

I introduce myself, sit Mr Singh down and ask him to stay at rest while I stay with him. I confirm his full name and date of birth. He describes a heavy pressure in the middle of his chest that began forty minutes ago and spreads to his left arm and jaw, with sweating and nausea. I ask about risk factors and learn he has high blood pressure, smokes and has a father who died of a heart attack at fifty-eight. I ask about allergies and blood thinners. I take his observations: pulse 96, blood pressure 152 over 94, respiratory rate 20, oxygen saturation 96% on room air, temperature 36.8, alert. His skin is pale and clammy. I recognize this as a possible heart attack and there is no ECG available here. I do not wait for more tests. I ask the clinic assistant to call 911 immediately and to say that it is chest pain at our clinic. While we wait I stay with him and keep him at rest. Having checked he has no allergy and no bleeding risk, I give chewable aspirin under the clinic's medical directive. I repeat his observations, keep him calm and tell him honestly what is happening and that his family will be told. I listen to his fear about his father. When the paramedics arrive I give an SBAR handover: situation, background and risk factors, the observations, what I have given and the time, and my request that he be taken to hospital now. I document everything with times.

A conversation about smoking with a client who has COPD

Counselling & explanation · 13 minutes

The task

You are the nurse at a primary care clinic in Ontario. Raymond Lachance, aged 58, has COPD and was seen for a chest infection last month. His breathing test today shows no change. He smokes. Introduce yourself and talk with him about his smoking. Explore his views without lecturing, offer help that fits what he wants and agree a plan if he is ready. Check his understanding and record the conversation in the note provided.

What a strong answer does

- **Safety:** Introduces self, asks permission to talk about smoking and avoids lecturing or a one-way warning.
- Asks open questions about smoking history, dependence, previous quit attempts and what worked or did not.

- Explores his reasons, importance and confidence using scaling questions, and reflects them.
- Gives clear, personalized advice linked to COPD, his breathing and his grandson, in a respectful way.
- Explores barriers: stress, driving, wife who smokes, and cost.
- **Safety:** Offers evidence-based help matched to his readiness: combination nicotine replacement, prescription options through the physician, the Smokers' Helpline, and a cut-down-to-quit option.
- Addresses his past experience with the patch (dreams) and offers solutions without dismissing it.
- Agrees a plan, quit date or small step, and follow-up, and uses teach-back or summary to check.
- Documents the assessment, advice, plan and follow-up.

Model answer

I introduce myself to Mr Lachance and ask permission to talk about his smoking, acknowledging that he has probably heard it all before. I ask open questions: he smokes a pack a day, his first cigarette comes within five minutes of waking, he smokes in the cab, and he has tried to quit twice using the patch, which gave him vivid dreams, and he relapsed when his brother died. I check his saturation, 93 per cent on air, and chest, and review the spirometry which shows no change from last year. I use scaling questions: wanting to quit is a 6, confidence a 2. I reflect his reasons back: his two-year-old grandson, his breathlessness, and also that cigarettes calm him on the road. I give clear personalized advice linking smoking with his COPD and I do not lecture. I explore barriers such as stress, driving and his wife who smokes. I offer help that fits his readiness. He is not ready to stop next week, so I propose a cut-down-to-quit approach, a smoke-free cab, combination nicotine replacement with a patch plus gum or lozenge after discussion with the physician, advice to take the patch off at night if dreams return, and the Smokers' Helpline, 1-877-513-5333, which is free. I tell him that a relapse does not mean failure. I summarize the plan and ask him to repeat it back, then arrange a phone call in a week and a review in four weeks. I record the assessment, advice, plan and follow-up, and give him written information.

A client who wants to leave and refuse treatment

Ethics, consent & capacity · 13 minutes

The task

You are the nurse on a medical unit in Ontario. George Papadakis, aged 77, was admitted last night with a serious skin infection of the lower leg and is due to continue intravenous antibiotics. He has told a colleague he wants to go home now and does not want the IV. A colleague is nearby. Introduce yourself and talk with him. Explore his decision, including whether he understands the information. Decide what you need to do and who to tell. Record the conversation and your actions in the note provided.

What a strong answer does

- Introduces self, confirms identity, sits with him, and starts without judgment or argument.
- Presumes capacity and treats him as the decision maker, without assuming he is confused because of his age.
- Explores the reason for wanting to leave and finds the concern for his wife.
- Checks understanding of his illness, treatment, and the risks and benefits of staying or leaving.
- Checks that he appreciates what could happen to him, can explain his reasons, and that the decision is voluntary and consistent.
- Assesses orientation and attention and the leg and observations, and recognizes the infection is still spreading.
- **Safety:** Does not restrain, threaten or coerce him, and does not remove the right to decide; informs him that a physician will talk with him and may assess capacity formally.
- Offers ways to address the real problem: social work, care for his wife, phone home, and treatment options.
- Informs the physician and charge nurse promptly, with SBAR, and asks for a review before he leaves.
- Documents his words, the capacity discussion, the options offered and the people informed.

Model answer

I introduce myself, confirm Mr Papadakis's name and date of birth and sit down with him. I do not argue. I tell him it is his decision and that I want to understand. I ask why he wants to go home and he tells me that his wife Eleni has dementia and is with a neighbour who she barely knows. I acknowledge how heavy that must be. I check what he understands. He describes cellulitis and tells me the antibiotics go into the vein. I ask what could happen if he leaves and he tells me the infection could reach his blood and he could die. He says this is his own decision and nobody is pressuring him. His answers are consistent and he appreciates what could happen to him. He is oriented and attentive. I treat him as having capacity, because capacity is presumed and is specific to the decision, and I know the physician proposing the treatment is responsible for assessing it. I take his observations and

examine his leg. The temperature is 37.8 and the redness has spread past the line, so I understand the infection is active. I do not restrain, threaten or pressure him. I explain what I will do and offer practical help: a call to his neighbour, social work to arrange care for Eleni, and options such as returning each day for treatment. I ask the physician and charge nurse to see him now and give an SBAR summary. I document his words, the discussion, the options offered and everyone informed.

Shaking and sweating on the second day in hospital

Focused assessment · 13 minutes

The task

You are the nurse on a medical unit in Ontario. Terrence Mackie, aged 54, was admitted two days ago with leg cellulitis. This afternoon he is restless, shaking and sweating. His admission note records 'occasional alcohol'. A resident physician can be reached by phone. Introduce yourself, assess him for possible causes, including a physical examination and observations. Decide what to do, speak to the physician using SBAR and explain your plan to the client. Record your assessment and plan in the note provided.

What a strong answer does

- Introduces self, responds promptly, and uses a calm, non-judgemental approach in a quiet room.
- Takes a full set of observations and checks glucose.
- **Safety:** Asks directly and without judgement about alcohol use, quantity, and time of last drink.
- **Safety:** Asks about previous withdrawal, seizures, hallucinations and other substances.
- **Safety:** Recognizes probable alcohol withdrawal and its seizure risk, and does not attribute symptoms to anxiety or infection alone.
- Starts safety measures: seizure precautions, close observation, low stimulation and falls precautions.
- Calls the physician promptly using SBAR and requests withdrawal orders, thiamine and monitoring, then reads back the orders.
- Explains the plan honestly, answers his worries about trouble and his job, and respects confidentiality.
- Documents the true history, assessment, escalation and orders, and corrects the admission note.

Model answer

I introduce myself to Mr Mackie, move him to a quiet room near the desk and speak calmly. I take his observations: heart rate 112, blood pressure 158/96, temperature 37.6, respiratory rate 22, saturation 96 per cent and glucose 4.6. I see marked tremor and sweating. I ask directly and without judgement about his alcohol use and explain that I need an honest picture to keep him safe. He tells me he drinks about a 26-ounce bottle of rye a day, last drink two days ago, and had a withdrawal seizure two years ago. He saw shadows this morning. I recognize probable alcohol withdrawal, with a high seizure risk. His cellulitis is improving and does not explain these signs. I start seizure precautions, falls precautions, a low-stimulation room and close observation, and I ask a colleague to stay near. I phone the resident physician and give an SBAR: the situation, background of cellulitis and alcohol use previously recorded as occasional, my assessment of withdrawal with a past seizure, and my request for urgent orders. I read back the orders for the withdrawal protocol, an hourly scale, thiamine, a benzodiazepine as per the protocol, IV access and bloods. I explain the plan to Mr Mackie honestly, tell him he is not in trouble and that what he says stays within the care team. I correct the admission history, document everything and inform the nurse in charge, with rapid response available if he seizes or deteriorates.

Phone call about a worsening post-operative client

Handover and escalation · 13 minutes

The task

You are the nurse on a surgical unit in Ontario at night. Andre Boucher, aged 66, had a bowel resection yesterday. Another nurse, Keisha, has asked you to see him because he looks unwell, and she is with you. Introduce yourself, confirm his identity and assess him quickly. Then telephone the on-call surgical resident. Give a structured handover, say what you want done and by when, and confirm the plan. Record your SBAR on the form provided.

What a strong answer does

- Introduces self, confirms identity and quickly recognizes that he is acutely unwell, staying with him.
- Takes a full set of observations promptly and examines his abdomen and perfusion, and checks urine output.

- **Safety:** Recognizes sepsis or bleeding risk and urgent deterioration and does not wait for the end of a routine round.
- Asks the colleague for help and starts safe measures: positions him safely because he is drowsy and vomiting, checks the IV is patent, has oxygen ready to use if ordered or per protocol, and keeps him nil by mouth.
- Gathers the chart, observation record and allergy information before phoning.
- Gives a structured SBAR: identifies self, patient and location, states the problem and urgency in the first sentence.
- Gives relevant background and assessment with numbers and trends and states what she thinks the problem is.
- States a clear recommendation and a timeframe, asking the doctor to come and what orders she expects.
- **Safety:** Reads back the orders, including the fluid, the oxygen range and the call-back conditions, and clarifies anything unclear.
- Carries out the orders, reassesses, reassures the client and records the SBAR, orders, times and outcome.

Model answer

I introduce myself to Mr Boucher, confirm his name and date of birth and check his wristband. I see he is drowsy and he says he is cold. I stay with him, position him safely in case he vomits, and ask my colleague to bring the observation equipment, suction and the emergency equipment. I take his observations: pulse 118, blood pressure 88/52, respiratory rate 24, saturation 93% on room air and temperature 38.4. His abdomen is distended, tender and guarded, his hands are cool and his urine output is only 40 mL over four hours. I recognize this as serious deterioration after bowel surgery and I do not wait. Before I phone, I gather his chart, earlier observations and allergy status. Four hours ago his blood pressure was 116/70 and he was alert. I call the on-call surgical resident and give a structured SBAR. Situation: I am the nurse on the surgical unit, calling about Andre Boucher, 66, day 1 after a bowel resection, who has become hypotensive and tachycardic and I am worried. Background: he has no known allergies, his pain and swelling have worsened since supper, he has vomited twice and has had low urine output. Assessment: the numbers, the abdominal findings and my concern that he may be septic or bleeding. Recommendation: I ask the doctor to come and see him within 15 minutes and ask whether she wants fluids, bloods, cultures and antibiotics started. I write the orders as she gives them and read every one back, including the call-back conditions. I start the orders, give the antibiotic once the cultures are drawn, call her with his pressure after the bolus, stay with him, reassure him and

recheck observations every 15 minutes. I record the SBAR, orders, times and his response.

Giving an afternoon antibiotic on a medical unit

Medication administration · 13 minutes

The task

You are the nurse on a medical unit in Ontario. Tomasz Nowak, aged 70, is being treated for a chest infection. You are about to give his 14:00 medication. The charge nurse is nearby. Introduce yourself, confirm his identity and prepare to give the antibiotic on the chart provided. Say aloud each check you make. Decide what to do about anything you find, who you will tell and how you will record it.

What a strong answer does

- Performs hand hygiene, introduces self and confirms identity with two identifiers against the wristband and record.
- Reads the order with the allergy section, checking the drug, dose, route, time and indication for each medication before giving.
- Asks the client about allergies directly and elicits penicillin anaphylaxis.
- **Safety:** Notices the mismatch between the red wristband, the client and the record, and recognizes that the ordered drug is a penicillin-class antibiotic.
- **Safety:** Does not give the medication and keeps the client safe.
- Contacts the prescriber and pharmacist with a clear SBAR message and asks for an alternative.
- Tells the charge nurse and completes a safety event report; explains that the allergy section must be corrected after verification.
- Tells the client honestly what happened, thanks him for speaking up and reassures him about the plan.
- Checks the client for any signs of reaction or change, as nothing has been given.
- Documents the discrepancy, actions, communication and times without blaming.

Model answer

I wash my hands, introduce myself and ask Mr Nowak for his full name and date of birth, checking them against his wristband. I notice the red allergy band reads penicillin. I read the order for amoxicillin and clavulanic acid and check the drug, dose, route and time. Then I look at the allergy section and see it says no known allergies. I do not assume the record is right. I ask Mr Nowak about allergies and he

tells me that he has had anaphylaxis to penicillin, with a rash, lip swelling and trouble breathing, and that he told staff at admission. I recognize that this antibiotic belongs to the penicillin group, so the order is unsafe for him. I do not give the medication. I explain to him that I am going to hold the tablet and speak to his doctor and pharmacist. I check his observations and ask whether he has taken any of this antibiotic. He has not. I stay calm and make sure he is safe. I call the prescriber and the pharmacist and give an SBAR message: this client has a documented penicillin anaphylaxis, there is an order for a penicillin-class antibiotic, I have held it, and I need a different drug. I tell the charge nurse, correct the allergy record once it has been verified, and file a safety event report as policy requires, without blaming anyone. I tell Mr Nowak what happened, thank him for speaking up and document everything with times.