NMC OSCE scenarios with answers

20 original NMC 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.

Midwifery: The head is born but the birth stops

Acute management · 8 minutes

The task

You are a midwife on a labour ward. Ruksana Chowdhury, aged 31, is having her third baby at 39 weeks. She is pushing and the head has just been born. A midwife colleague, Ffion, is with you, and Mrs Chowdhury's husband is at the head of the bed. An examiner will report what you find as you act. Manage the situation, communicate with the couple and your team, hand over to the obstetric registrar and record what happens. Say aloud what you are doing and why.

What a strong answer does

- **Safety:** Recognises shoulder dystocia from the retracted head, chin pressed in and failure of the shoulders to deliver, and stops pulling.
- **Safety:** Calls for help immediately (emergency call / 2222, obstetric and neonatal teams) and notes the time of the head.
- Asks the woman to stop pushing and explains clearly to her and her husband.
- Performs McRoberts manoeuvre with a colleague: legs flexed tightly back, lower the head of the bed.
- **Safety:** Asks for suprapubic pressure from the correct side, steady then rocking, and does not apply fundal pressure.
- Uses gentle axial traction only and avoids pulling or rotating the head excessively.
- Moves on promptly to internal manoeuvres: considers episiotomy and delivers the posterior arm or rotates.
- Hands over to the obstetric registrar with an SBAR including time of head and manoeuvres tried.
- Documents times, manoeuvres in order, who was present, the baby's condition and plans a debrief with the parents.

Model answer

A strong candidate recognises as soon as the head is born and then retracts against the perineum, with the chin pressed in and the shoulders not delivering with gentle traction, that this is shoulder dystocia. They stop pulling, ask Mrs Chowdhury to stop pushing, and say aloud that the head was born at 14:22. They press the emergency call and ask the colleague to ring 2222 for the obstetric emergency team and the neonatal team. They explain in a calm voice what is happening to Mrs Chowdhury and her husband and ask him to stay near her head. They ask the colleague and Mr Chowdhury to perform the McRoberts manoeuvre, flexing the legs tightly onto the abdomen and lowering the head of the bed, and they check that the baby's back is on the mother's left and ask for suprapubic pressure from that side, first steady and then rocking. They try gentle axial traction again, without pulling hard or applying fundal pressure. When the shoulders do not deliver, they move on to internal manoeuvres: they consider whether an episiotomy is needed for room and deliver the posterior arm, so that the shoulders rotate and the baby is born at 14:25. They hand the baby to the team for assessment, with help for the baby arriving, and keep telling the couple what is happening. They give the arriving obstetric registrar an SBAR handover, with the time of the head, the manoeuvres tried and their order. They check for maternal blood loss and perineal injury, and ensure paired cord gases are taken. They record the time of the head and body, the manoeuvres and their order, who attended, the condition of the baby and any injury, and discuss the event with the parents, and arrange a debrief and an incident report.

Wound assessment and aseptic dressing change

Aseptic technique · 12 minutes

The task

You are the nurse on a surgical ward. Pauline Hughes, aged 66, had abdominal surgery five days ago and her wound dressing is due to be changed. A wound care plan is in the patient folder. Assess the wound and change the dressing using aseptic non-touch technique, explaining each step to her. Say aloud and show what you do, including what you are looking for in the wound and why. Complete the wound record.

What a strong answer does

- Explains the procedure, checks identity and allergies including tape sensitivity, obtains consent and offers pain relief.
- Prepares a clean area, performs hand hygiene and gathers in-date equipment, protecting key parts throughout.
- **Safety:** Uses aseptic non-touch technique: hand hygiene at the right moments, appropriate gloves and not touching key parts or key sites.
- Assesses the wound systematically: size, edges, tissue, exudate, smell, swelling, heat, pain and surrounding skin, and compares with the previous record.
- Recognises signs of infection to look for and concludes that this wound is clean and healing, with mild expected pinkness.
- Cleans the wound only if needed, with sterile saline as the care plan states, and applies a sterile dressing with low-allergy tape.
- Disposes of waste correctly, removes gloves and apron and performs hand hygiene.
- Answers her worry, explains what to report, when the wound will be checked again and who to tell.
- Documents the assessment, dressing used, patient response and review plan, signed and timed.

Model answer

I introduce myself and explain that I will check her wound and change the dressing. I ask Mrs Hughes' name and date of birth, check her wristband, and ask about allergies. She tells me strong tape blisters her skin, so I plan low-allergy tape. I check the wound care plan, ask about pain and check she is comfortable, with privacy maintained. I clean a surface, clean my hands and gather an in-date dressing pack, saline, a non-adherent dressing and low-allergy tape. I apply an apron and non-sterile gloves and open the pack without touching key parts. I remove the old dressing, noting a small area of pale straw-coloured staining, and discard it. I assess the wound: a 10 cm midline incision with staples, edges together, mild pinkness up to 5 mm each side, scant clear fluid, no swelling, no pus and no smell. Her temperature is 36.8 and her pulse is 78. I compare with the previous record and conclude that it is clean and healing, and I explain the signs of infection I am looking for. I clean my hands, put on fresh gloves, clean gently with sterile saline using each swab once, and apply the sterile dressing without touching the part that touches the wound. I secure it with low-allergy tape. I dispose of everything in clinical waste, remove gloves and apron and clean my hands. I explain what to report, answer her worry about infection honestly and say when I will review the wound. I record the assessment and dressing, with my name and the time.

Paediatric life support for a collapsed child on a ward

Basic life support · 8 minutes

The task

You are a children's nurse on a paediatric ward. You find Ibrahim Rahman, aged 6, on the floor beside his bed. He was admitted yesterday after a viral illness. A colleague, Jade, a children's nurse, is nearby. No limitation of treatment is documented. Demonstrate paediatric basic life support, working with your colleague, until the cardiac arrest team arrives, then hand over. Say aloud what you are doing and why. An examiner will tell you what you find when you assess him.

What a strong answer does

- Checks for danger and checks response by speaking and gently stimulating the child.
- **Safety:** Shouts for help, and with a colleague present, asks her to call 2222 for the paediatric cardiac arrest team and to bring the trolley and defibrillator.
- Opens the airway and looks, listens and feels for normal breathing and other signs of life for no more than ten seconds.
- Gives five initial rescue breaths, with a bag and mask and oxygen when available, watching the chest rise.
- **Safety:** Goes straight to chest compressions after the rescue breaths, with correct hand position on the lower half of the sternum, depth at least one third of the chest, rate 100 to 120 per minute.
- Uses a ratio of 15 compressions to 2 breaths, minimises interruptions and swaps at about two minutes.
- Uses the defibrillator or monitor correctly when it arrives: paediatric pads or paediatric mode, minimal pauses and follows its instructions.
- Leads and communicates clearly, delegating tasks, using the colleague's name and keeping calm.
- Gives a clear SBAR handover to the arrest team leader and continues until relieved.
- Ensures parents are informed and documents the collapse, times and actions legibly, signed and timed.

Model answer

I check that the area is safe and approach Ibrahim. I speak to him and gently stimulate him, and there is no response. I shout for help and ask Jade to call 2222, state paediatric cardiac arrest and bring the resuscitation trolley and defibrillator. I note the time. I open his airway with a head tilt and chin lift and look, listen and feel for normal breathing and other signs of life for no more than ten seconds, finding

none. I give five rescue breaths, watching the chest rise, then go straight to chest compressions on the lower half of the breastbone, pressing at least one third of the chest depth at 100 to 120 compressions per minute, allowing full recoil. I continue with 15 compressions to 2 breaths, using a bag and mask with oxygen when available. When Jade returns we swap roles about every two minutes with minimal pauses. When the defibrillator arrives I attach paediatric pads or use paediatric mode, follow its prompts, and resume CPR immediately. I speak clearly to Jade, ask her to record times and to find his parents. When Dr Haddad arrives I give an SBAR handover: the situation, his viral illness and chest infection, my assessment of cardiac arrest with CPR in progress, and the recommendation for the team to take over. I continue until relieved, then document the times and actions, signed and timed.

Written care plan for heart failure with fluid overload

Care planning · 14 minutes

The task

You are the nurse looking after Fatima Begum, aged 72, on a cardiology ward. She was admitted two days ago with worsening breathlessness and swollen legs caused by chronic heart failure and fluid overload. Her information is in the patient folder. In the care plan sheet, write a plan for her two highest priority problems. For each problem state the aim with a date, the nursing interventions, the reason for each intervention, and when you will evaluate. Do not use abbreviations. End with your name, the date and the time.

What a strong answer does

- Chooses two clinically justified priority problems from the information given, with breathlessness and fluid overload first, and says why they are the priority.
- Writes a measurable aim for each problem with a date.
- For breathlessness and fluid overload, plans specific interventions: upright positioning, regular observations, diuretic as prescribed, accurate fluid balance and the prescribed fluid limit, same-scales daily weight and review of blood results.
- For the second problem, plans specific measures: repositioning, skin checks of the sacrum and heels, pressure relief, leg elevation and assisted mobilising with the call bell within reach.
- Gives a reason for each intervention based on evidence or the standards, such as national heart failure guidance, rather than routine.

- Includes explaining the fluid limit to Mrs Begum and her husband, offers choices within it and addresses her anxiety.
- States when and how each aim will be evaluated and what would trigger urgent escalation, such as worsening breathlessness, falling oxygen saturation or a raised early warning score.
- **Safety:** Keeps within the prescription: does not plan to change the diuretic dose or the fluid limit without the doctor, and refers any proposed change to the doctor.
- Writes in full words without abbreviations, and ends with name, date and time.

Model answer

I read the information and identify the two highest priority problems. The first is breathlessness and swollen legs from fluid overload caused by chronic heart failure: her oxygen saturation is 93 percent, she is breathless on exertion and has gained 5.6 kilograms above her dry weight. The second is the risk of skin damage and falls, because she has swollen legs, limited mobility and a red sacrum. For problem one my aim, by 8 November 2026, is that she reports less breathlessness at rest, her oxygen saturation is at least 94 percent on air and her weight is below 79.6 kilograms and moving towards 74 kilograms. I sit her upright with pillows, record her respiratory rate, oxygen saturation, pulse, blood pressure and early warning score at least four times a day, tell the doctor her oxygen saturation is below the usual target, give furosemide exactly as prescribed, keep an accurate fluid balance chart within the 1.5 litre limit, weigh her each morning on the same scales and check her blood results for kidney function and potassium. I explain the fluid limit to her and her husband and help her spread small drinks through the day, including her tea, because understanding improves cooperation and reduces anxiety. For problem two my aim is that her skin stays intact and she does not fall. I check the sacrum and heels every shift, help her change position, keep skin clean and dry, use pressure relief as her risk requires, raise her legs when seated, walk with her and keep the call bell in reach, and help her to the toilet promptly after the diuretic. For each action I give the reason. I evaluate at the end of each shift and on 8 November. If breathlessness, her early warning score or oxygen level worsens I tell the nurse in charge and doctor at once. I write in full words with no abbreviations and end with my name, the date and the time.

Subcutaneous injection to prevent blood clots

Clinical skills · 8 minutes

The task

You are the nurse on a medical ward. Callum Reid, aged 52, is being treated for cellulitis of the leg and is less mobile than usual. He has a prescription for a daily subcutaneous injection to reduce his risk of blood clots. The medicines chart and prefilled syringe are in the patient folder. Check the prescription, prepare and give the injection safely, and explain each step to him. Say aloud and show what you do. Complete the record.

What a strong answer does

- Performs hand hygiene, introduces self, checks full name and date of birth with the wristband, explains the purpose and obtains consent.
- **Safety:** Checks allergies, bleeding risks and the prescription: right drug, dose, route, time and signature, and recent blood results.
- Checks the prefilled syringe: label, dose, expiry, clear solution and intact packaging, and does not expel the air bubble.
- Chooses an appropriate site on the abdomen, at least 5 cm from the umbilicus, avoids the bruise and rotates sites.
- Uses correct technique: skin fold, needle at 90 degrees, slow injection, fold held until the needle is withdrawn, no rubbing.
- **Safety:** Activates the safety device, disposes of the syringe in the sharps bin without recapping and performs hand hygiene.
- Keeps him comfortable and addresses his anxiety and worry about bruising and bleeding.
- Gives after-care advice: what to expect, and to report bleeding, black stools or unusual bruising, and why the injection matters.
- Records the dose, time, site and own name immediately after giving, without abbreviations.

Model answer

I wash my hands, introduce myself and explain that this is the daily injection to prevent blood clots. I ask Mr Reid's full name and date of birth and check his wristband, and I ask about allergies, bleeding problems and blood-thinning medicines. He has none. I check the prescription: enoxaparin 40 mg subcutaneously once daily at 18:00, signed and legible, and his platelet count is normal. I check the prefilled syringe: the label shows his name, the dose is right, the expiry date is in 2027, the packaging is intact and the solution is clear. I leave the air bubble in, as the manufacturer advises. I inspect his abdomen. There is a small bruise on the left from yesterday, so I choose the right side, at least 5 cm from the umbilicus, away from scars. I help him lie comfortably and check that his skin is clean and dry. I pinch a fold of skin, insert the needle at 90 degrees, inject slowly, keep the fold until

I withdraw the needle and do not rub. I activate the safety device and put the syringe into the sharps bin without recapping, then wash my hands. I keep talking to him during the injection and ask how he is. I explain that minor bruising is common, that he should tell us about bleeding, black stools or large bruises, and why the injection helps to prevent clots. I sign the chart immediately with the time, dose and site, and note that the next site should be the left side once the bruise has settled.

Midwifery: Supporting a mother who chooses formula feeding

Counselling & explanation · 15 minutes

The task

You are a community midwife visiting on day 4. Kerry-Ann Bell, aged 24, has told the team she has chosen to formula feed her son Leo, who was born at term. Her partner is present. Support her choice, check how the family are making up and giving feeds, and give the advice they need. Record your discussion and advice on the form provided. Say aloud what you are asking and why, and explain safe feeding to the parents.

What a strong answer does

- Introduces self, confirms identities, and responds to the request not to be lectured by accepting her choice without judgement.
- Asks how feeds are prepared, stored and given, including powder amounts, water, equipment and bottle position, rather than assuming they know.
- Weighs Leo and calculates the change correctly (3.52 to 3.31 kg, 6 percent) and checks wellbeing and nappies.
- **Safety:** Explains safe preparation: fresh feed each time, water boiled and used within 30 minutes (70 degrees or more), level scoops, cooling and testing, and discarding leftovers.
- Explains why extra powder, added cereal and propping bottles are unsafe and corrects the relatives advice respectfully.
- Explains sterilising bottles and teats and cleaning equipment, and recommends first infant formula.
- Teaches responsive paced bottle feeding and cues, and gives comfort advice for her breasts.
- Checks understanding by asking them to repeat the steps, provides written steps and a safety net.

- Documents the discussion and advice, signed and timed.

Model answer

I introduce myself to Kerry-Ann and Josh, confirm names and Leo's date of birth, and accept her choice without judgement, saying I am there to help her feed Leo safely. I ask her how she made her decision and she relaxes. I ask them to talk me through making up a feed. They tell me they boil the kettle and let it cool, make four bottles in the morning and store them in a cupboard, heap the scoop and add a second scoop at night, and Josh's mother suggested baby rice. I also learn that they have no steriliser and prop the bottle when they are tired. I weigh Leo: 3.31 kg against a birth weight of 3.52 kg. That is a loss of 0.21 kg, about 6 percent. He is alert and has plenty of wet nappies. I explain how to prepare feeds safely. Use first infant formula, make each feed fresh, boil fresh water and use it within 30 minutes so it stays at least 70 degrees, add the powder using level scoops and exactly as the tin says, cool the bottle and test it on the wrist, and throw away leftovers after the feed. I explain why extra powder and cereal are unsafe, and that bottles must not be propped. I teach sterilising, paced responsive feeding, and comfort measures for her breasts. I ask them to repeat the steps, give written instructions and a safety net, thank Kerry-Ann for sharing, and record the discussion, signed and timed.

Fluid balance chart calculation after hip surgery

Documentation & charts · 10 minutes

The task

You are the nurse on an orthopaedic ward at 15:00. Betty Ng, aged 70, had surgery to repair a broken hip yesterday. She weighs 70 kg. Her fluid balance chart for 07:00 to 15:00 is in the patient folder. Total her intake and output, work out the balance and her urine output per hour, and interpret what you find. Speak to Mrs Ng about her drinks and passing urine. Record your findings and your plan, showing your working.

What a strong answer does

- Introduces self, performs hand hygiene, confirms name and date of birth and explains that the fluid chart and how Mrs Ng feels are being checked.
- Calculates total intake correctly (1130 mL) by adding every oral and intravenous entry.
- Calculates total output correctly (450 mL), including urine, vomit and drain.

- Calculates the balance correctly (+680 mL) and the urine output per hour (30 mL per hour, 0.43 mL per kg per hour).
- Asks about drinks and output not recorded and states that the chart is incomplete, recording the unmeasured tea and pad as a limitation.
- Interprets that low urine output with fast pulse, low blood pressure and dryness is concerning, and does not accept a positive balance as reassurance.
- **Safety:** Escalates to the nurse in charge and doctor now, requesting review of fluids and blood tests, and does not start or speed up intravenous fluids without a prescription.
- Plans monitoring: observations and early warning score hourly, accurate measuring of all output including the pad, and a clear fluid chart.
- Communicates with Mrs Ng: explains what is happening, addresses her worry about kidneys honestly and asks her to tell staff what she drinks.
- Documents the totals, working, limitations, escalation and plan with the time and own name, without abbreviations.

Model answer

I introduce myself, clean my hands and confirm Mrs Ng's name and date of birth. I explain that I am checking her fluid chart and how she feels. I add up the intake: intravenous 500, tea 150, water 200, coffee 180 and juice 100, which makes 1130 mL. I add up the output: urine 100, 80 and 60, vomit 150 and the drain 60, which makes 450 mL. The recorded balance is 1130 minus 450, a positive 680 mL. For the urine alone, 240 mL over 8 hours is 30 mL per hour. For a 70 kg patient, 30 divided by 70 is 0.43 mL per kg per hour, below 0.5, which is a warning sign. I ask Mrs Ng about drinks and passing urine. She tells me about a big mug of tea at about 13:30 and a leak into her pad at midday, neither of which is recorded, so the totals are approximate. She says her urine is dark, her mouth is dry and she feels light-headed. I check observations: pulse 104, blood pressure 102/60, dry mucous membranes and capillary refill 3 seconds. A positive balance does not mean she has enough fluid, because it ignores her urine output, her signs and any blood loss, so I also check her wound and drain. I tell the nurse in charge and ask for a medical review now, asking the doctor to consider her fluids, kidney blood tests and a blood count. I do not start or speed up intravenous fluid without a prescription. I repeat observations and the early warning score hourly, measure all drinks and output including the pad, and correct the chart. I explain to Mrs Ng and listen to her fear about her kidneys. I record all figures, my working and my plan, with my name and the time.

Mental health nursing: A voluntary patient wants to leave

Ethics, consent & capacity · 15 minutes

The task

You are a registered mental health nurse on an acute ward. Rosalind Achebe, aged 56, was admitted informally last week with severe depression. She is standing at the ward door with her coat on and says she is going home. A healthcare assistant is with you and the on-call psychiatrist can be reached by phone. Introduce yourself, talk with her, assess her risk and her reasons for leaving, and decide what to do. Say aloud what you would do if she tried to leave, and who you need to tell. Record your actions on the form provided.

What a strong answer does

- Approaches calmly, introduces self, keeps a safe distance and asks the healthcare assistant to stay close without crowding her.
- Listens to her reasons and explores her feelings without arguing or threatening.
- **Safety:** Asks directly about suicidal thoughts, plans, intent and means.
- **Safety:** Recognises the risk as high and immediate, and that she should not leave before a medical assessment.
- Tells the nurse in charge and telephones the on-call psychiatrist with a clear SBAR and an urgent timeframe.
- Explains and applies the legal framework: voluntary patients may leave, but a registered mental health nurse may decide to use the section 5(4) holding power when criteria are met and a doctor cannot attend immediately. It lasts up to six hours, or until a doctor or approved clinician arrives if sooner, and is recorded on Form H2. Does not use force beyond the law or policy.
- Keeps her safe meanwhile: one-to-one observation, quiet space, offers a drink and keeps talking.
- Involves her and her daughter, tells her honestly what will happen and why.
- Records the time, risk, actions, legal power used if any, and who was informed, signed and timed.

Model answer

I walk to the ward door calmly, introduce myself to Mrs Achebe and ask Dan to stay nearby but not crowd her. I speak slowly and keep a safe distance. I check her name and ask what is making her want to leave. She says she is a burden. I listen without arguing. I ask about suicidal thoughts directly, and ask about plans and means. She

tells me she has saved tablets at home and intends to take them. That is a high and immediate risk. I tell her that I am very worried about her safety and ask her to stay while a doctor sees her. I ask what would help her stay. She says she will stay if I keep talking to her and tell her what will happen. I explain that she has not been forced to stay and that I want her to be safe. I ask Dan to inform the nurse in charge and I telephone the on-call psychiatrist. SBAR: Situation, an informal patient who wants to leave the ward now. Background, severe depression, admitted a week ago. Assessment, she has intent and a plan to take stored tablets and a high risk. Recommendation, please attend urgently. I read back the plan. Her status is informal, so she may leave unless the law allows me to stop her. If she tries to leave before the doctor arrives and the risk is as I have described, I, as a registered mental health nurse, can decide to use the holding power under section 5(4). That is my own decision, and nobody can instruct me to use it. It lasts up to six hours, or until a doctor or approved clinician who can use section 5(2) arrives, whichever is sooner. I would record it on Form H2 with the time, send it to the hospital managers, tell her why, and use only the minimum force needed. If she were to leave and could not be found I would call 999. With her permission I phone her daughter. I keep her under one-to-one observation and record the time, risk, actions and people told.

Reading a single study on early mobilisation

Evidence-based practice · 10 minutes

The task

You are a registered nurse on a medical ward. The ward manager has asked you to read the study summary in the folder, which reports early mobilisation for older patients, and to say what it means for your practice. In the response sheet, explain what the study found and how far the results can be trusted. Then say what you would recommend for your ward and what you would want to find out next.

What a strong answer does

- States the main finding accurately: a 1.3-day shorter average stay in the walking group (6.1 compared with 7.4 days).
- Interprets the confidence interval correctly: it runs from 2.9 days shorter to 0.3 days longer, so it includes no difference and the result is uncertain.
- Identifies the weak allocation method: patients were allocated by order of arrival, not randomly.

- Identifies that assessors were not blinded and that more usual-care patients left the study early (23 % compared with 5 %).
- Notes the small sample, only two wards, and the funding by the equipment maker as possible sources of bias.
- **Safety:** Weighs the safety signal: 3 falls compared with 1 is too few to judge, but patient safety must be considered when mobilising older patients.
- Recommends a proportionate action: no change to practice from this study alone, continued supported and assessed mobilisation, and looking for stronger evidence.
- Describes follow-up: audit local length of stay and falls, and share the appraisal with the team, in line with the Code's requirement to use the best available evidence.

Model answer

The study compared walking within 24 hours with usual care in 148 older medical patients. The walking group stayed on average 6.1 days compared with 7.4 days, a difference of 1.3 days. However, the confidence interval runs from 2.9 days shorter to 0.3 days longer. Because the range includes no difference, the study does not show that early walking truly shortens hospital stay, even though the authors say it does. I would also question how the study was done. Patients were allocated in order of arrival, not randomly, so the groups may not have been alike. The people measuring the outcomes knew which group each patient was in. Far more patients left the usual care group early, 23 per cent compared with 5 per cent, which could change the results. The trial was small, took place on two wards and was paid for by the company that makes the walking aids, which could influence design or reporting. There were three falls in the walking group and one in the usual care group. The numbers are too small to draw a conclusion, but safety must be considered when supporting older patients to mobilise. My recommendation to the ward manager is not to change practice on this study alone. We should carry on assessing each patient and supporting safe mobilisation with falls precautions as part of usual care. I would look for larger randomised trials or systematic reviews, audit our own length of stay and falls, and share my appraisal with the team, in line with the Code's requirement to practise using the best available evidence.

Worsening abdominal pain after bowel surgery

Focused assessment · 20 minutes

The task

You are the nurse on a surgical ward. Kwame Mensah, aged 58, had a bowel operation two days ago and now has worsening abdominal pain. A healthcare assistant is available. Introduce yourself, confirm his identity and carry out a systematic assessment using an A to E approach, including a focused assessment of his abdomen. Record his observations and early warning score on the chart provided, then decide who you need to tell and how urgently. Say aloud what you are checking and why, and describe any examination you would do.

What a strong answer does

- Introduces self, performs hand hygiene, checks two identifiers against the wristband, explains what will happen and obtains consent.
- Positions him comfortably, offers privacy and asks the healthcare assistant to help with observations while staying with him.
- Works through A to E in order, speaking aloud what is checked: airway, breathing, circulation, disability including ACVPU and exposure.
- Measures and records a full set of observations accurately on the chart: respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and consciousness.
- Takes a focused history of the pain: site, onset, character, severity score, what makes it worse, nausea or vomiting, bowels and wind, analgesia taken, drinking and urine.
- Examines the abdomen with consent, covering inspection, the wound, listening for bowel sounds and gentle palpation for tenderness and guarding, and checks cannula, fluids and urine output.
- Calculates the NEWS2 score correctly (6) and interprets the picture as a possible serious post-operative complication with a risk of sepsis, not simple pain.
- **Safety:** Escalates without delay to the nurse in charge and the surgical team, giving a clear reason and a timeframe, and does not give more analgesia and wait before telling anyone.
- Takes immediate safe actions within the nurse's role: keeps him nil by mouth, arranges fluids and pain relief only as prescribed or directed, begins hourly observations and sepsis screening and keeps strict fluid balance.
- Listens to his fear of a leak, gives honest reassurance without promising an outcome, and explains what happens next in plain words.
- Documents findings, actions and who was told at what time, in clear words, with own name, without abbreviations and without recording care not yet given.

Model answer

I perform hand hygiene, introduce myself and check Mr Mensah's full name and date of birth against his wristband. I see that he is pale, sweating and guarding his abdomen, so I help him into a comfortable position, ask Jamal to stay with him and

explain what I am doing. I work through A to E aloud. His airway is clear. I count a respiratory rate of 22 and an oxygen saturation of 95% on air. His pulse is 112 and his blood pressure is 104/64, with cool hands and a capillary refill of 3 seconds. He is alert. His temperature is 37.9. I check his blood glucose and look at his skin. I take a focused history. The pain has become sharp and constant over the day and scores 8 out of 10. He has been sick once, has not passed wind, and has hardly passed urine. I then examine his abdomen with permission: it is distended and tender with guarding, the wound is clean, and I hear no bowel sounds. I check his cannula and note that his fluids stopped at 10:00. I calculate NEWS2: respiratory rate 2, saturation 1, pulse 2, systolic blood pressure 1, giving 6. With the abdominal findings I am concerned about a leak, obstruction or peritonitis and sepsis. I do not wait. I tell the nurse in charge and ask for an urgent surgical review now, giving my findings. Meanwhile I keep him nil by mouth, repeat observations hourly, ask the doctor about fluids and analgesia, keep a fluid balance chart and begin sepsis screening. I listen to his worry about a leak and answer honestly. I complete the chart with my name and the time.

Midwifery: Antenatal booking appointment at 9 weeks

History taking · 20 minutes

The task

You are a community midwife at a booking appointment in a children's centre clinic room. Adaeze Okafor, aged 29, is 9 weeks and 4 days pregnant with her first baby. She attends alone. Take a booking history, identify any factors that affect her care, measure what is needed, explain the screening and tests that are offered, and agree a plan with her. Record your findings, risk factors and plan on the form provided. Say aloud what you are asking and why.

What a strong answer does

- Introduces self, confirms identity and dates the pregnancy, and puts Adaeze at ease before starting the history.
- Takes a full booking history: obstetric, medical, medicines and supplements, family history, smoking, alcohol, vaping and drugs.
- Measures height and weight and calculates BMI correctly as 36.0 kg/m2, telling her the figure respectfully.
- Takes blood pressure and tests urine for protein as a baseline.

- **Safety:** Identifies the combined risk factors for pre-eclampsia (first pregnancy, BMI of 35 or over, mother affected) and offers low-dose aspirin from 12 weeks through the correct pathway.
- Asks about family origins and offers haemoglobinopathy screening, and explains the other bloods, infection screening and scans offered, making clear they are her choice.
- Gives health promotion advice: folic acid dose for BMI, vitamin D, food safety, and where support for healthy weight is available, without blame.
- Asks about mood and, privately, about safety at home.
- Explains pre-eclampsia warning signs and when to contact the maternity service, and agrees next steps and appointments.
- Records the history, risk factors, calculation and plan clearly, signed and timed.

Model answer

I introduce myself to Adaeze, confirm her name, date of birth and dates, and explain what the appointment involves. I take a full history. She is healthy, has never smoked, takes folic acid 400 micrograms, and her mother had pre-eclampsia. Her father has sickle cell trait. I weigh and measure her: 94.5 kg and 1.62 m, so BMI is 94.5 divided by 2.62, which is 36.0. I tell her kindly. Blood pressure is 118/74, urine protein negative, carbon monoxide reading normal. I recognise that a first pregnancy, a BMI of 35 or over and a mother with pre-eclampsia are more than one moderate risk factor, so I arrange a prescription for low-dose aspirin daily from 12 weeks until birth. I advise folic acid at the higher dose for a BMI of 30 or more until 12 weeks, on prescription, and vitamin D. I offer the haemoglobinopathy test as early as possible because of her family history. I explain that the screening bloods, infection screening and fetal anomaly scans are offered and are her choice, and I mention a glucose tolerance test at 24 to 28 weeks. I ask about mood and ask privately about safety at home. I discuss the local care pathway and obstetric review, explain pre-eclampsia warning signs and when to call, answer her worry about weight in a non-judgemental way, and agree a plan. I write everything down, signed and timed.

Handover about a painful swollen calf after hip surgery

Handover and escalation · 8 minutes

The task

You are the nurse on an orthopaedic ward. Terence Walsh, aged 69, had a right hip replacement three days ago and now has a painful, swollen left calf. You have

already assessed him and your findings are in the patient folder. Telephone the on-call ward doctor, Dr Rahman, and give a handover using SBAR. Complete the handover form. Then tell Mr Walsh briefly what will happen next. Be clear about what you need from the doctor and by when.

What a strong answer does

- Introduces self, role and ward, names the doctor, and gives the patient name, age and date of birth at the start of the call.
- Gives a clear Situation: states the problem, why the call is being made now and that it is urgent.
- Gives relevant Background: operation and day, thromboprophylaxis (dalteparin and stockings), risk factors, allergies and medicines.
- Gives a complete Assessment: full observations with the NEWS2 total, the calf findings including the size difference, and the absence of chest pain or breathlessness.
- Recognises that a low early warning score does not rule out a clot and does not use it to downplay urgency.
- **Safety:** Makes a specific Recommendation: says a clot is suspected and asks for medical review within a stated time, ideally also asking about a leg vein scan, treatment and rest or mobilising.
- Closes the loop: reads back the doctor plan, confirms the timeframe and what to do if he worsens, and records the name and time.
- States what the nurse will do meanwhile: hourly observations, leg rested and not massaged, and escalation for chest pain, breathlessness or collapse including the emergency call.
- Tells Mr Walsh in plain words what will happen, answers his fear about a clot honestly and tells him what symptoms to report.
- Completes the handover form with the time, the doctor and the plan, with own name and without abbreviations.

Model answer

I perform hand hygiene and check the records before phoning. When Dr Rahman answers I introduce myself, my role and the ward, and name the patient: Terence Walsh, 69, date of birth 21 January 1957. Situation: he has had a painful, swollen left calf since this morning, three days after a right hip replacement. I am worried about a deep vein thrombosis and I need an urgent review. Background: he is on day 3 after the operation, takes dalteparin daily, last given at 08:00 today, and wears anti-embolism stockings, although the left one was rolled down. He has no known allergies, takes blood pressure tablets and his mother had a leg clot. Assessment: his observations are stable: respiratory rate 18, saturation 97% on air, pulse 98, blood pressure 128/78, temperature 37.6, alert, NEWS2 total 1. A low score does not exclude a clot. The left calf is 3.5 centimetres bigger than the right with pitting

swelling and tenderness. He has no chest pain, breathlessness or cough, and the hip wound is clean. Recommendation: I ask Dr Rahman to review him within the hour, arrange a leg vein scan, decide whether to start treatment before the scan and advise whether he should rest or mobilise. I read back her plan, confirm the timeframe and what to do if he worsens, and record her name and the time. I mention that the rolled left stocking could restrict blood flow. I check his observations hourly, keep the leg supported and do not massage it. I explain to Mr Walsh that the doctor is coming and a scan is likely, answer his worry honestly and tell him to report chest pain or breathlessness at once. I add my name and the time to my entry.

Medicines for uncontrolled pain at home

Medication administration · 15 minutes

The task

You are a community nurse visiting Maureen Kearney, aged 81, at her home. She has advanced cancer and is cared for by her daughter, who is present. Her pain is not controlled. Her medicines record and prescribed medicines are in the patient folder. Check and give the medicine due now safely, assess her pain, explain what you are doing and plan what happens next. The on-call palliative care doctor can be reached by telephone. Complete the medicines record.

What a strong answer does

- Washes hands, introduces self to Mrs Kearney and her daughter, checks name and date of birth against the medicines record, explains the visit and obtains consent.
- Assesses pain properly: site, character, score out of ten and impact, and what has already been taken today.
- **Safety:** Checks allergy status and the prescription before giving: right patient, drug, dose, route, time, signature and clarity.
- **Safety:** Checks the time of the last breakthrough dose (09:45) and the dosing interval, and confirms that at least four hours have passed.
- Calculates the volume correctly (10 mg in 5 mL gives 5 mL) and measures it with the oral syringe.
- Checks respiratory rate and sedation before giving, and notes constipation and nausea.
- Gives the dose, stays until it is swallowed, and records the time, dose and signature straight afterwards.

- Reassesses pain, drowsiness and breathing 30 to 60 minutes after the dose and acts on the result.
- Escalates to the palliative care on-call doctor using SBAR because she needs repeated breakthrough doses, requesting review of the regular dose and constipation treatment.
- Addresses fears about addiction and sleepiness, explains safe use, storage and recording of morphine to Mrs Kearney and her daughter, and arranges follow-up.

Model answer

I wash my hands, introduce myself to Mrs Kearney and her daughter and ask her name and date of birth, matching them to the home medicines record. I explain why I have come and ask her permission. I assess her pain. It is deep hip and back pain, 8 out of 10, and her daughter reads the diary: long-acting morphine 30 mg at 08:00 and breakthrough doses at 05:30 and 09:45. I ask about allergies; codeine made her sick, which is an intolerance. I check her breathing rate (14) and that she is alert, and I ask about nausea, bowels and any new leg weakness. She has not opened her bowels for four days, so I offer today's laxative. I check the prescription: morphine sulfate oral solution 10 mg in 5 mL, 10 mg when required, at least four hours apart. The last dose was at 09:45, so more than four hours have passed. I calculate the volume: 10 mg divided by 10 mg per 5 mL is 5 mL. I check the bottle label and expiry date, measure 5 mL with the oral syringe, and give it, staying until she has swallowed. I sign the record straight away with the time. I explain that she is not likely to become addicted when it is used for pain, and the aim is comfort while staying alert. I recheck pain, drowsiness and breathing after 30 to 60 minutes. Because she needs more than two breakthrough doses in a day, I phone the palliative care on-call doctor and give an SBAR, asking for the regular dose to be reviewed and for help with constipation. I note and read back the plan, explain it to the family, show how to record doses, and agree the next visit.

Midwifery: Sleepy baby on a postnatal ward after caesarean

Medicines counselling · 20 minutes

The task

You are a midwife on a postnatal ward. Natasha Kowalski, aged 30, had a caesarean birth two days ago and is breastfeeding her baby, Oliver. You are asked to look at the baby, who the healthcare assistant says has seemed very sleepy. An obstetric

registrar can be reached by telephone. Assess and decide what to do next. Record your assessment and plan on the form provided. Say aloud what you are checking and why, and explain the plan to Natasha.

What a strong answer does

- Introduces self, confirms identity of mother and baby, and acknowledges her worry.
- Takes a medicines history including type, dose and timing of all painkillers, checks the drug chart, and queries paracetamol prescribed alongside co-codamol.
- Assesses the baby systematically: respiratory rate, heart rate, saturations, temperature, tone, alertness, weight and feeding, and checks blood glucose.
- Calculates the weight change correctly (3.35 to 3.18 kg, about 5 percent).
- **Safety:** Recognises that a sleepy, floppy, poorly feeding baby of a mother taking a codeine-containing painkiller needs urgent action, knows codeine should not be used while breastfeeding, stops further doses pending prescriber advice, and does not simply wake him to feed.
- Assesses the mother for sedation and checks her observations.
- Escalates the baby to the neonatal team and the mother to the registrar with SBAR, asking for a plan and alternative pain relief.
- Supports feeding and comfort, explains honestly without blame, and reports the suspected adverse reaction and completes an incident record.

Model answer

I introduce myself to Natasha, check her identity and Oliver's band, and ask what she has noticed. She says he falls asleep on the breast and is hard to wake. I take a medicines history and check the chart: co-codamol two tablets four times in the last day, with ibuprofen, and no paracetamol recorded. Co-codamol already contains paracetamol, so I query the separate paracetamol prescription. I assess Oliver: respiratory rate 34 and shallow, heart rate 128, saturations 96 percent, temperature 36.8. He is sleepy, pale, with reduced tone and a weak cry. His weight is 3.18 kg, down 0.17 kg from 3.35 kg, about 5 percent. His blood glucose is 3.1, which does not explain this picture. I check Natasha: blood pressure 108/64, pulse 84, respiratory rate 12, slightly drowsy. I recognise that a sleepy, floppy, poorly feeding baby whose mother is taking a codeine-containing painkiller may be affected by the medicine through breast milk, and infection must also be considered. Codeine should not be used while breastfeeding. I hold further co-codamol and stay with Oliver, watching his breathing. Because Natasha is drowsy too, skin to skin happens only with a member of staff at the bedside. I telephone Dr Nair with an SBAR: Natasha Kowalski, day 2 after caesarean, on co-codamol; Oliver is sleepy, floppy,

shallow respiratory rate 34, glucose 3.1; I've held the next dose, and need neonatal review now and alternative pain relief for Natasha. I ask for the neonatal team and read back the plan. I explain to Natasha without blame, support feeding or expressing as the neonatal team advises, make sure she has other pain relief, report the suspected adverse reaction through the Yellow Card scheme, complete an incident report, and record everything, signed and timed.

Assessment of a young woman with episodes of sudden fear

Mental health · 20 minutes

The task

You are a registered nurse in a community mental health team clinic. Anjali Menon, aged 26, was referred by her GP after several episodes of sudden, intense fear. She attends alone. Introduce yourself, build rapport, and carry out a focused mental health assessment, including risk. Record your assessment, risk summary and plan on the form provided. Say aloud what you are exploring and why, then agree the next steps with her in plain language.

What a strong answer does

- Introduces self, confirms her name and date of birth, explains the purpose and confidentiality including its limits, asks consent and sets a calm, unhurried tone.
- Explores the panic episodes in detail: first onset, triggers, physical symptoms, frequency, duration and what she thought was happening.
- Asks about avoidance, safety behaviours and the effect on work, travel, sleep and relationships.
- Checks for physical and lifestyle contributors: medical tests, medicines, caffeine, alcohol and drugs.
- Uses a structured anxiety scale such as GAD-7 and interprets the score correctly as moderate.
- **Safety:** Asks directly about self-harm and suicidal thoughts, and explores protective factors, even though she has not raised them.
- Explores her understanding, fears and what she hopes for, and responds with empathy without dismissing her worries.
- Explains panic in simple terms and offers a stepped-care plan: self-help, psychological therapy, lifestyle changes and review, rather than leading with medicines.
- Gives a safety net: who to contact if symptoms worsen, thoughts of self-harm appear or she is in crisis, including urgent routes out of hours.

- Agrees follow-up, shares information only with her consent and records the assessment, risk and plan clearly, signed and timed.

Model answer

I introduce myself, confirm her name and date of birth, explain confidentiality and its limits, and ask Miss Menon how she would like to be addressed. I invite her to describe the attacks in her own words, then ask about the first episode, triggers, body symptoms, frequency and length, and what she believed was happening. She describes a pounding heart, tingling and fear of dying, two or three times a week for three months. I ask about avoidance and learn she has stopped taking trains and has left work early. I check sleep, worry between attacks, medical tests, medicines, caffeine and alcohol, and complete the GAD-7 with her, scoring 13, moderate anxiety. I ask directly about self-harm and suicidal thoughts. She denies them and names her sister and flatmate as supports, which I record. I ask what she fears is wrong and reflect her feelings. I measure pulse and blood pressure, which are normal, and note her restlessness. I explain panic in plain words: adrenaline produces real symptoms that are frightening but not dangerous. I offer a stepped-care plan: reduce caffeine and alcohol, learn breathing and grounding skills, and start guided self-help or cognitive behavioural therapy, with medicines discussed later if needed. She prefers talking therapy first and I agree. I give a safety net with who to call, including her GP, NHS 111 and 999. I book a review in two weeks, confirm that I will share information only with her consent, and document the assessment, risk and plan clearly, signed and timed.

Pain assessment in an older man with dementia

Pain management · 15 minutes

The task

You are the nurse on an older people's ward. Ignatius Dolan, aged 84, has dementia and was admitted four days ago after a fall at home. He is calling out and pushing staff away when they move him. His daughter is at the bedside and a healthcare assistant is available. Introduce yourself and gain his agreement as best you can. Assess whether he is in pain using an appropriate method for someone who cannot reliably report pain, look for causes, decide what you will do about analgesia, and record your findings and plan on the form provided.

What a strong answer does

- Introduces self, uses a calm, slow approach, gains agreement as far as possible, and involves his daughter for his usual behaviour and pain signs.
- Uses an observational pain tool such as PAINAD or the Abbey pain scale at rest and on movement, scores it correctly and records the scores.
- Looks for causes of pain: left knee and leg, constipation, urinary retention and pressure areas.
- Reads the medicines chart, notices the missed 12:00 dose and that no other analgesic or laxative is prescribed.
- **Safety:** Gives or arranges prescribed analgesia safely: checks allergies, last dose, interval and total daily dose before giving paracetamol.
- Uses non-drug measures: comfortable positioning, calm environment, the presence of his daughter, gentle handling.
- **Safety:** Recognises the warm, swollen, tender knee and temperature as a possible infection or bleed, and tells the doctor today by SBAR.
- Asks for further analgesia and a laxative to be prescribed.
- Plans reassessment with the same tool after analgesia and during care.
- Responds to his daughter's worry about sedation and keeps her informed.

Model answer

I introduce myself calmly to Mr Dolan, at his eye level, and ask his daughter, Niamh, how he usually is and how he shows pain. She tells me he is normally cheerful, has been calling out for two days, and grips the rail and pulls up his left knee. Because he cannot reliably tell me about pain, I use an observational tool, PAINAD. At rest his score is 2. When the leg is moved it rises to 8: laboured breathing, repeated calling out, grimacing, pushing away, and he calms a little when I speak softly. I look for causes. His left knee is warm, swollen and tender with reduced bending. His abdomen is slightly distended and his bowels have not opened for four days. His bladder is not palpable and the skin on his sacrum and heels is intact. His temperature is 37.8. I read the chart: paracetamol 1 g four times daily, given at 06:00, the 12:00 dose refused, nothing else prescribed, no laxative, no allergies. I check the time and total, then give the missed paracetamol, because only 1 g has been given today. I support his leg on a pillow, ask Kirsty to help me turn him with a slide sheet, and keep his daughter at the bedside. I tell the doctor by SBAR about the pain score of 8 on movement, the warm swollen knee, temperature, missed doses and request review of his knee, stronger analgesia and a laxative. I tell his daughter we will use the lowest effective dose and monitor sleepiness. I plan to reassess his score in 30 to 60 minutes and during each move, record it, and escalate at once if he becomes drowsy or breathless.

Learning disability nursing: Finding where it hurts

Patient communication · 6 minutes

The task

You are a learning disability nurse visiting a supported living home. Stuart Penhaligon, aged 46, has a severe learning disability and uses a few words and signs. His support worker, Bethan, says he has been unsettled for two days. Assess whether he is in pain and where, using ways of communicating that suit him. Talk with Bethan, agree what to do next and complete the progress note.

What a strong answer does

- Introduces self to Stuart using his name, in simple words and a slow pace, and checks name and date of birth with Bethan.
- Asks Bethan how Stuart usually communicates and shows pain, and what has changed compared with his usual self.
- **Safety:** Uses accessible ways to ask Stuart where it hurts: pictures, signs, body chart or simple choices, and responds to his answers.
- Uses a recognised pain or distress tool for people with a learning disability, comparing with his usual baseline.
- **Safety:** Looks for a physical cause and does not label the change as challenging behaviour: examines face and mouth with permission, takes temperature and pulse.
- Takes a focused history from Bethan: onset, eating and drinking, sleep, dental history, medicines, allergies.
- Plans safe pain relief and urgent dental assessment with reasonable adjustments, with safety-net advice for fever, spreading swelling or difficulty breathing or swallowing.
- Explains to Stuart and Bethan what will happen next, involves Bethan, and listens to her concerns.
- Plans reassessment with the same tool and records the assessment clearly.

Model answer

A strong candidate greets Stuart by name, introduces themselves in short simple sentences, and confirms his name and date of birth with Bethan. They ask Bethan how he usually communicates and shows pain, and what has changed in the last two days. They learn he has stopped eating, sips only cold drinks, is dribbling and has had broken sleep. They do not accept that this is 'just behaviour'. They use accessible communication with Stuart himself: they slow down, use pictures and a

faces chart, ask him to show them where it hurts, and watch his signs. Stuart points to the right side of his jaw and chooses the sad face. They use a recognised distress tool and compare his current signs with his baseline in his hospital passport, finding guarding, grinding of teeth and loss of appetite. With Stuart's agreement, they check his temperature (37.6 degrees), pulse, and look at his face and, using a torch, his mouth, finding swelling over the right lower jaw and a broken tooth with a swollen gum. They take a focused history from Bethan, including dental history, medicines, epilepsy and allergies. They explain to Stuart in simple words, and to Bethan, that they think he has a toothache and that they will help. They check the medicines chart and arrange suitable pain relief with the prescriber, and arrange a same-day dental review with reasonable adjustments, such as Bethan going with him and practising with the torch first. They note that if Stuart cannot consent to dental treatment, a capacity assessment and a best-interests decision under the Mental Capacity Act will be needed. They safety-net: if his face swells further, he has a high temperature, or has trouble breathing or swallowing, call 999. They plan to recheck his pain in an hour using the same tool and record the findings, plan and who they told in his notes and passport, signed and timed.

Midwifery: Newborn physical examination at 30 hours

Examination · 20 minutes

The task

You are a midwife trained in the newborn and infant physical examination, working on a postnatal ward. Baby Yusuf Hussain is 30 hours old, born by elective caesarean section at 39 weeks. His mother, Amira Hussain, aged 28, and his father are at the cot side. Gain consent, examine Yusuf, and explain your findings. Record your examination, interpretation and plan on the form provided. Say aloud what you are examining, what you find and why.

What a strong answer does

- Introduces self, confirms the baby identity, and explains what the examination covers and does not cover, then gains consent.
- Asks about the pregnancy, birth and family history, including breech presentation and hip problems.
- Prepares safely: hand hygiene, warm room, baby undressed and settled, and checks identity band.

- Examines the eyes and red reflex, palate, heart and femoral pulses systematically and states findings.
- **Safety:** Examines the hips correctly and the testes, and recognises that breech presentation and family history mean a hip ultrasound is still needed despite normal clinical hips.
- Checks head, spine, skin, abdomen and limbs, and identifies the blue-grey sacral patch as a normal variant and records it.
- Explains findings clearly in plain words, answers the worry about the heart, and explains hearing and blood spot screening are separate.
- Gives a safety net, arranges the hip referral and repeat examination, and informs the GP.
- Records results in the red book and screening record, signed and timed.

Model answer

I introduce myself to Amira and Tariq, check Yusuf's identity band and explain what the newborn examination looks at: heart, hips, eyes and testes. I make clear that it cannot find every condition, and I ask for consent. I take a history. Yusuf was born by planned caesarean because he was breech, there were no pregnancy concerns, and Amira needed a harness for her hips as a baby. I wash my hands, keep the room warm and examine him undressed. He is alert and pink with good tone. The fontanelle is soft and flat. Both eyes are clear and each shows a red reflex. The palate is intact. The heart rate is 132, regular, with no murmur, femoral pulses equal, and respiratory rate 44. The abdomen is soft. Both testes are in the scrotum. His hips are symmetrical with a negative Barlow and Ortolani. The spine is normal and I see a blue-grey patch over the lower back, which I explain is a normal variant and note on the body map. Hands and feet are normal. I explain that clinical hips are normal, but breech presentation and a hip problem in a parent are risk factors, so I refer him for a hip scan at 4 to 6 weeks of age. I tell the parents about the examination at six to eight weeks, and explain that hearing screening and the heel prick are separate. I give a safety net for breathing, colour, tone and feeding, answer their questions kindly, and record everything in the red book and screening record, signed and timed.

A colleague who is not completing observations

Professional values · 10 minutes

The task

You are a registered nurse on a busy medical ward. During the evening shift you notice that a colleague, Sam, has not carried out the 2-hourly observations on two patients. One of them, Mr Evans, was recently found to have a raised early warning score. Sam looks tired and tells you the ward is too busy. Sam asks you not to say anything. In the response sheet, write what you would do, explain why, and say what you would do afterwards.

What a strong answer does

- **Safety:** Puts the safety of the patients first, and says Mr Evans, who had a raised score, needs checking now before anything else.
- States that missed observations may hide deterioration, and that observations must be done promptly and recorded accurately, only for what was actually measured.
- Escalates any concern about a deteriorating patient immediately, using SBAR, to the nurse in charge and doctor.
- **Safety:** Refuses to keep the secret and explains the duty to raise concerns when patients may be put at risk.
- Speaks to Sam in private, with kindness and without blame, to understand what is happening.
- Informs the nurse in charge about the missed observations and the pressure on staffing, and uses the local freedom to speak up route if the concern is not resolved.
- Links the response to the Code: prioritise people, practise effectively, preserve safety and promote professionalism and trust.
- Describes completing an incident report and factual, non-judgemental documentation, and supporting Sam's wellbeing afterwards.

Model answer

My first priority is the safety of the two patients. I would go straight to Mr Evans, who already had a raised early warning score, and take and record a full set of observations, scoring them with NEWS2. I would do the same for the second patient. I would record only what I have actually measured, at the true time. If any score is raised or a patient looks unwell, I would escalate at once to the nurse in charge and the doctor using SBAR, as I would for any deteriorating patient. Then I would speak to Sam privately and kindly. I would say what I saw, that I am worried about the patients and about Sam, and ask what has happened. Sam seems tired and under pressure, and I would listen and offer help. I cannot agree to say nothing. The Code asks me to put people first, to raise concerns when patients may be at risk, to keep honest and accurate records and to act in a way that promotes trust in nursing. Missed observations can hide deterioration, and silence could allow harm. I would report the missed observations and the staffing pressure to the nurse in

charge before the end of the shift, factually and without blame, so the team can make sure checks are covered. I would complete an incident report. I would not alter Sam's records. If the concern is not dealt with, or if it happens again, I would use the local freedom to speak up route, or contact the Freedom to Speak Up Guardian. I would also check on Sam later and encourage them to seek support from the manager or occupational health.

Pressure area assessment after a hip fracture

Risk assessment · 10 minutes

The task

You are the nurse on an orthopaedic ward. Gwen Pritchard, aged 84, was admitted three days ago with a hip fracture. Her surgery has been delayed for medical reasons. A healthcare assistant is available. Introduce yourself, explain what you will do and ask her consent. Carry out a pressure area assessment, using your usual risk assessment approach. Record your findings and plan on the form provided and say what care you would put in place.

What a strong answer does

- Introduces self, performs hand hygiene, checks identity and explains the assessment, obtaining consent and preserving dignity.
- Asks about pain, position, appetite, continence and general health, using what she says to guide the assessment.
- Uses a structured risk assessment approach, such as a validated scale combined with clinical judgement, and says why.
- Examines all pressure-bearing areas, including both heels and sacrum, and tests for blanching.
- **Safety:** Identifies the non-blanching redness on the right heel as a category 1 pressure ulcer and the sacral redness as blanching.
- Identifies the contributing risks: reduced movement, moisture, poor nutrition, equipment and gaps in turning.
- Plans offloading of the heel, a suitable surface, individual repositioning with pain relief given first, and continence care.
- Refers for nutrition support and escalates the new ulcer and the repositioning gaps to the nurse in charge, incident reporting and the tissue viability service according to local policy.
- Responds to her worries about pain and being a nuisance, and explains turning in words she understands.

- Documents skin findings, risk level, plan and review time clearly, signed and timed.

Model answer

I clean my hands, introduce myself and ask Mrs Pritchard for her name and date of birth, checking her wristband. I explain that I would like to check her skin and how she is lying so we can protect it, and I ask for her consent, ensuring curtains are drawn and she is covered. I ask whether anywhere is sore, how she has been moving, what she is eating and how she manages with the toilet. She tells me about her hot sore heel, that she lies on her back to avoid hip pain, her poor appetite and her accidents. I carry out a structured risk assessment using the ward tool, bringing in my own judgement. I check the chart and offer the pain relief that is due. Then I ask Megan to help me turn her gently towards her left side, with the fractured right leg supported. I check all pressure-bearing areas: the sacrum, hips, elbows and heels, pressing to see whether redness fades. The sacral redness blanches. On the right heel the redness does not fade and the skin is intact and warm, so this is a category 1 pressure ulcer. I note a standard mattress, a damp pad and gaps in the repositioning chart. My plan is to float the right heel off the bed, request a high-specification foam mattress, reposition her at least every 4 hours on a recorded individual plan with analgesia given first, keep her skin clean and dry and review her continence needs. I would refer her to the dietitian. I tell the nurse in charge about the new ulcer and the gaps in the chart, report it through the local process and ask for tissue viability advice according to local policy. I explain what I am doing, reassure her that she is not a nuisance, and record my findings, the plan and the next review time.