NZ nursing OSCE scenarios with answers

6 original NZ nursing 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.

Sudden droop of the face at a medical centre

Acute management · 8 minutes

The task

You are the practice nurse in a medical centre in New Zealand. Colin Ashworth, aged 72, has come for his influenza vaccination with his wife Pam. While you are preparing the injection, Pam says something is wrong with his face. A GP is in the next room. Introduce yourself, assess Mr Ashworth quickly and decide what to do. Take the actions you think are needed, speak to the GP and hand over to the ambulance crew. Record your assessment and immediate plan in the note provided.

What a strong answer does

- **Safety:** Responds immediately, introduces self and recognises the signs of stroke by checking face, arm and speech.
- **Safety:** Establishes the time he was last known well and when symptoms began.
- **Safety:** Calls 111 straight away without delay and asks for an ambulance for a suspected stroke.
- **Safety:** Does not give the vaccine, food, drink, aspirin or other medicines.
- Measures blood glucose and other observations, including blood pressure and heart rate.
- Takes the history needed: medicines, especially anticoagulants, atrial fibrillation, allergies and head injury.
- Informs the GP clearly and reads back the plan.
- Keeps him safe and comfortable, stays with him and reassures both with honest, warm words.
- Hands over to the ambulance crew in a structured way with times and medicines, and documents.

Model answer

I put down the vaccine, introduce myself and check Mr Ashworth quickly. When I ask him to smile, the right side of his face droops. When he lifts both arms, the right

drifts down, and his speech is slurred. I ask Pam when he was last known to be completely well: 9.50, with the first symptom about 9.55. I ask the GP to come and I call 111 at once, saying it is a suspected stroke, last known well 9.50. I do not give the vaccine and I keep him nil by mouth, with no aspirin or other tablets. I sit him comfortably with his airway safe and take observations: glucose 6.4 mmol/L, blood pressure 178/96, pulse 96 and irregular, saturation 96 per cent on air, respiratory rate 18 and temperature 36.8. He is alert. I ask Pam about his history and she tells me about hypertension, atrial fibrillation and apixaban taken this morning, and no allergies, no head injury and no diabetes. When Dr Sharma arrives I give a short handover with the times and medicines and read back his plan. I record observations every five minutes and keep reassuring Mr and Mrs Ashworth, telling Pam she was right to speak up and that I will ask the crew about her travelling with him. When the crew arrive I hand over in a structured way: suspected stroke, last known well 09:50, the findings of face droop and right arm drift with slurred speech, the observations, medicines including apixaban, and the history. I write my assessment, the plan and the times in the note.

Wound dressing change after hernia surgery

Aseptic technique · 8 minutes

The task

You are the nurse on a surgical ward. Barry Ogilvie, aged 66, had an open incisional hernia repair three days ago. The surgical team has ordered a dressing change today. A health care assistant is available. Prepare for and carry out the dressing change using an aseptic non-touch technique. Say aloud what you are doing and why. Introduce yourself, check identity and allergies, assess the wound, choose a suitable dressing and explain the care to Mr Ogilvie as you go. Say how you will document the dressing change.

What a strong answer does

- **Safety:** Checks identity with name, date of birth and wristband, checks the adhesive allergy before choosing a dressing, explains the procedure and gets consent.
- Reads the dressing order, assembles a clean tray and checks packaging and expiry dates.
- **Safety:** Performs hand hygiene at the right moments: before touching the patient or equipment, before the aseptic part, and after.

- Keeps an aseptic field and non-touch technique, and puts on new gloves for the aseptic part, without touching key parts.
- Removes the old dressing safely, assesses the wound, surrounding skin and signs of infection and describes findings.
- Cleanses with saline from clean to less clean and applies a suitable non-adhesive dressing with hypoallergenic tape, noting the adhesive allergy.
- Disposes of waste safely, cleans the work area and removes gloves properly, then performs hand hygiene.
- Gives wound care teaching, including showering and lifting, and signs of infection to report.
- Documents the wound appearance, dressing used, pain and teaching accurately.

Model answer

I introduce myself and check Mr Ogilvie's name, date of birth and NHI against his wristband. I check his allergy: adhesive plaster. I explain that I will change the dressing, say what to expect and get his consent, and I check pain and offer analgesia if needed. I review the order: saline, non-adhesive dressing and hypoallergenic tape. I clean my hands, and prepare a clean trolley, checking packaging and expiry dates. I clean my hands again, put on clean gloves and remove the old dressing, dropping it into the waste bag without touching other surfaces. I assess the wound as I go: a 9 cm incision with edges together, 5 mm of mild redness, a little dried blood at one end, no pus, no odour and no swelling. His temperature is normal. I remove my gloves, clean my hands and put on new gloves for the aseptic part, keeping key parts such as the dressing pad and the saline nozzle free from contact. I cleanse the wound once from top to bottom with saline using sterile single-use gauze, pat the skin dry and apply the non-adhesive dressing secured with hypoallergenic tape. I dispose of waste in the right bins, clean the trolley, remove gloves and clean my hands. I teach him about showering, avoiding heavy lifting and what signs to report: increasing redness, heat, pain, discharge or fever. I document the findings, dressing, pain, teaching and technique, signed and timed.

Collapse of a resident in a rest home lounge

Basic life support · 8 minutes

The task

You are the registered nurse on duty in a rest home. A care assistant calls you to the lounge where Desmond Clarke, aged 81, has been found on the floor beside his chair. A defibrillator and a pocket mask are on the wall nearby and a phone is available. Respond as you would in practice. Say aloud and demonstrate each action. When emergency services arrive, the examiner will play the paramedic and you must hand over. Resuscitation status is in his folder at the nurse's station, not with you. Complete the note provided afterwards.

What a strong answer does

- Checks for danger and for a response by voice and touch.
- **Safety:** Calls for help immediately: asks for 111 to be called and for the defibrillator to be brought, and gives clear instructions.
- Opens the airway and checks for normal breathing for no more than 10 seconds, recognising gasping as not normal.
- **Safety:** Starts chest compressions at once at the correct rate and depth, in the centre of the chest, with minimal interruption.
- Gives breaths at the correct ratio of 30 compressions to 2 breaths, or continues compressions if unable.
- Uses the AED as soon as it arrives: applies pads, follows the prompts, ensures nobody touches him during analysis and shock.
- Delegates clearly, rotates the compressor about every two minutes and keeps the team informed.
- Checks resuscitation status and verifies his identity without delaying care.
- Gives a structured ISBAR handover to the paramedic: identity, event, history, interventions and times, current status and what is needed.

Model answer

I check that the area is safe and approach Mr Clarke. I speak to him and squeeze his shoulders, but there is no response. I send Leilani to call 111 and to bring the defibrillator, giving clear instructions and the key information to pass on. I open his airway and look for normal breathing for no more than 10 seconds. He is only gasping occasionally, which I recognise is not normal breathing. I begin chest compressions straight away with the heel of my hand in the centre of his chest, pushing at least 5 cm deep, about a third of the chest, at a rate of 100 to 120 a minute, allowing full recoil. I give 30 compressions followed by two breaths with a pocket mask, then continue the cycle. When the defibrillator arrives, I attach the pads without long interruption, ask everyone to stand clear and follow its prompts. The AED advises a shock and I deliver it after checking nobody is touching him, then

I restart compressions immediately. I ask Leilani to take over compressions after about two minutes so I can keep the quality high, and I ask her to check his folder for his resuscitation status and identity, which confirm full resuscitation. When the paramedic arrives, I give an ISBAR handover: who he is, what happened and when, his history and medicines, what I did and when, his current state and what I need. I stay to help, then document the times and actions, and inform his family and the nurse manager.

Planning care after a fall with a granddaughter present

Care planning · 8 minutes

The task

You are the nurse on a medical ward for older people. Ngaire Hutchinson, aged 84, was admitted two days ago after a fall at home. Her granddaughter Jade is with her. Introduce yourself, confirm her identity and plan her nursing care with her and Jade, including safety, skin, nutrition, mobility, medicines and what matters to her for going home. Ask what she wants and who she would like involved in decisions. Record her goals and the care plan on the form provided. A health care assistant is nearby.

What a strong answer does

- Greets Mrs Hutchinson first, introduces self, checks name, date of birth and NHI against the wristband and speaks so she can hear.
- Asks Mrs Hutchinson directly what matters to her and what her goals are, before turning to Jade, and welcomes whānau involvement at her direction.
- Assesses falls risk by asking about previous falls, night toileting, medicines and dizziness, and measures lying and standing blood pressure.
- Assesses skin, nutrition and fluids, and identifies the non-blanching sacral redness and weight loss.
- Writes a plan with specific interventions for falls prevention, pressure care, nutrition and hydration, including assisted toileting at night.
- **Safety:** Escalates the postural blood pressure drop and new tablet to the doctor for medicine review, and involves the physiotherapist, dietitian and occupational therapist as needed.
- Includes Jade respectfully, asks Mrs Hutchinson's permission before sharing information, and explains in plain words.
- Checks understanding, invites questions and sets the goal for discharge and follow-up with her.

- Documents goals, risks and care plan clearly, with time and signature.

Model answer

I clean my hands, greet Mrs Hutchinson first, introduce myself and check her name, date of birth and NHI against her wristband, speaking clearly towards her good ear. I then greet Jade, tell her nothing needs her signature because her grandmother makes her own decisions, and ask Mrs Hutchinson how she would like to be involved in planning, and who else she wants informed. I ask her what matters most to her. She wants to go home to her garden and her cat and does not want to go into care. I ask about falls, night toileting, appetite, drinking, skin and medicines. She has fallen twice and got up at night to the toilet, she has a new blood pressure tablet, she is not eating or drinking much and her bottom is sore. I check lying and standing blood pressure and find a postural drop from 138/76 to 112/64 with light-headedness. I inspect her skin and find a 3 cm non-blanching red area over her sacrum. I note weight loss and a low fluid intake. With her and Jade I plan care. For falls: a low bed, call bell in reach, non-slip footwear and assisted toileting at night. For skin: offloading, repositioning, skin checks and a pressure-relieving mattress. For nutrition: her preferred foods and drinks, a fluid chart and a dietitian referral. I ask the doctor to review the blood pressure tablet and refer to physiotherapy and occupational therapy. I check that she agrees with the plan and ask permission before updating her son. I document her goals, risks and plan, signed and timed.

Delegating personal care after a stroke

Clinical skills · 8 minutes

The task

You are the nurse on a stroke ward looking after several patients. Rewi Parata, aged 77, had a stroke four days ago and has left-sided weakness. He needs a wash and help to a chair. Mereana, a health care assistant, is available. Decide what you will ask her to do and what you will keep yourself. Give clear instructions, check that she is able and confident, say what to report back to you, and confirm the plan with Mr Parata. Use the ward folder provided for his needs.

What a strong answer does

- Greets Mr Parata, checks identity and explains the plan, including who will help, and asks about his preferences, including who he would like to help.

- **Safety:** Chooses appropriate tasks to delegate (washing, dressing, mobilising with one person) and keeps assessment, medicines and interpreting observations.
- Gives specific instructions: weak-side technique, supporting the left shoulder, walking belt, one-person assist, upright position, falls precautions and his wishes for personal care.
- Checks that Mereana is trained and confident for what is being asked, and invites her questions.
- **Safety:** Declines Mereana's offer to give the tablets, moves the tablets off the locker, and keeps responsibility for acting on any blood pressure she takes.
- States what to report back immediately: pain, dizziness, coughing or choking, skin redness or breakdown, and anything that worries her.
- Confirms the plan with Mr Parata, respects privacy and dignity, and asks for his consent before care starts.
- Plans to check back with Mereana and review the care afterwards, and remains accountable for the delegated care.
- Records the delegation, what was delegated, what was retained and what to report.

Model answer

I greet Mr Parata, clean my hands and confirm his name, date of birth and NHI against his wristband. I explain that I will arrange a wash and help to the chair and ask how he likes his personal care done and who he would like to help him. He prefers a man but will accept respectful help, and he wants separate cloths for his head and body and his pillow kept off the chair. I note this and ask the nurse in charge if a male carer is available. I check his folder: high falls risk, one-person assist with a walking belt, a painful left shoulder, soft diet and thickened fluids. I decide what I can delegate. Washing, dressing and walking to the chair with one person are within Mereana's role, while assessment, interpreting observations and medicines stay with me. I give Mereana clear instructions: dress the weak arm first, support his left shoulder, use the belt, stand on his weak side, keep him upright, keep the call bell in reach and follow his wishes about the cloths and pillow. I ask whether she has done this before, whether she is confident and whether she has questions. She says she is experienced but not signed off for the hoist. When she offers to give his tablets, I decline politely, explain that medicines stay with me and take them off the locker. She can take his blood pressure if she is trained, and I will act on the result. I tell her what to report back at once: coughing or choking, dizziness, pain, redness or broken skin, or anything she is worried about. I confirm the plan with Mr Parata and gain his consent, and I check back with both after the wash. I document what was delegated and retained, and I remain accountable.

A medicine given twice to the same patient

Ethics, consent & capacity · 8 minutes

The task

You are the nurse on a medical ward. It is 10:00. The night nurse has just phoned to say she gave Maryam Karimi, aged 59, her morning blood pressure tablet at 06:00 but forgot to sign the chart. You gave the same tablet at 08:00 because the chart showed nothing. Mrs Karimi has told a health care assistant she feels light-headed. The nurse in charge is available and a doctor can be reached by phone. Assess Mrs Karimi, decide what must happen straight away, and speak with her honestly about what has happened. Explain what you will do next and how the event will be recorded.

What a strong answer does

- Checks identity with name, date of birth and NHI against the wristband and explains that blood pressure will be checked.
- Keeps her safe first: asks her to lie or sit back down, applies falls precautions and checks lying and standing observations.
- Confirms the two doses of perindopril from the chart and the night nurse report, and links the dizziness and fall in standing blood pressure to them.
- **Safety:** Informs the nurse in charge and the doctor immediately by ISBAR and asks for review and advice about monitoring and kidney function.
- **Safety:** Discloses the error honestly, promptly and in plain language to Mrs Karimi, stating what happened, without blaming colleagues or minimising it.
- Apologises sincerely and explains what is being done now and what will be done to reduce the chance of it happening again.
- Respects her rights: offers to contact her daughter with consent, invites questions at any time and tells her she can raise concerns.
- Completes an incident report, and documents the facts, patient response and actions accurately without speculation.

Model answer

I check Mrs Karimi's name, date of birth and NHI against her wristband and ask her to remain lying down because she feels light-headed. I explain I will check her observations. Lying blood pressure is 112/68 and, when I check standing with support, it falls to 92/56. Her pulse is 82, respiratory rate 16, saturation 98 % and she

is alert. Urine output is 40 mL/h. I put the call bell in reach and apply falls precautions. I review her chart with the night nurse report and confirm that perindopril 4 mg was given at 06:00, unsigned, and again at 08:00 by me. I recognise that this double dose is a likely cause of her dizziness and drop in standing blood pressure. I call the nurse in charge, then the doctor, by ISBAR, stating the error clearly with the observations, and ask for review and advice on monitoring, including kidney function and fluids. I read back the plan and do not wait until the end of the shift. I then speak honestly with Mrs Karimi. I tell her what happened in plain words, that I gave the second dose, and I apologise. I explain what is happening now: the doctor will review her, I will repeat her observations frequently and she should stay in bed until reviewed. I say that the event will be reported and reviewed so it does not happen again. I ask if she wants her daughter told, offer to answer any questions and tell her how she can raise concerns. I complete an incident report and document the facts, my actions and her response, signed and timed.