RCSI OSCE sample scenarios with answers

6 original RCSI 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.

Drowsy man with COPD on a medical ward

Acute management · 10 minutes

The task

You are the nurse on a medical ward. Mr Declan Walsh, aged 68, has chronic obstructive pulmonary disease and was admitted with a chest infection. He is having a nebuliser. His daughter asked you to look at him because he seems sleepy, and she has stepped out to make a phone call. A staff nurse is available. Introduce yourself, confirm his identity and assess him. Review the charts and equipment at the bedside. Take and record observations, decide what is wrong and what to do now, and contact the doctor by phone using ISBAR.

What a strong answer does

- Introduces self, performs hand hygiene, checks two identifiers and acts quickly because the patient is drowsy.
- Checks the oxygen prescription and notes the target range of 88 to 92 per cent.
- Notices that the nebuliser is oxygen driven and stops it, replacing it with an air-driven nebuliser, rather than leaving high-flow oxygen running.
- Assesses airway, breathing, circulation and disability, including level of consciousness, and notes the flapping tremor and bounding pulse.
- Records observations accurately, including the new drowsiness.
- **Safety:** Recognises probable carbon dioxide retention from excess oxygen and does not remove oxygen entirely; gives controlled oxygen to target.
- **Safety:** Escalates to the doctor urgently by ISBAR with observations, prescription target and actions taken.
- Reads back the plan, asks for an arterial blood gas and repeats observations frequently.
- Reassures Mr Walsh, explains what is happening in plain words, stays with him and arranges for his daughter to be updated.

- Plans for when he is more alert: an oxygen alert card, and advice to call 112 or 999 if very drowsy or severely breathless at home.
- Documents findings, actions and the escalation, signed and timed.

Model answer

I perform hand hygiene, introduce myself and check Mr Walsh's name and date of birth. He is drowsy and complains of a headache, so I move quickly. I ask the staff nurse to stay close and bring a nebuliser compressor and a controlled oxygen mask. I read his oxygen prescription: target saturation 88 to 92 per cent. I see that the nebuliser is being driven by oxygen at 6 litres and his saturation is 98 per cent. I assess airway, breathing, circulation and disability. His respiratory rate is 10, pulse 102 and bounding, blood pressure 146/88 and temperature 37.5. He responds only to voice and he has a flapping tremor. I check his glucose, which is normal. I recognise that excess oxygen may be causing carbon dioxide retention. I stop the oxygen-driven nebuliser and complete the treatment with an air-driven one, and I give controlled oxygen with a mask chosen to keep his saturation between 88 and 92 per cent. I do not remove oxygen altogether. I phone the registrar with ISBAR. I say that Declan Walsh, 68, with COPD, is newly drowsy with headache and flapping tremor after a nebuliser driven by oxygen, with saturation 98 per cent against a target of 88 to 92, and that I have changed to air and controlled oxygen. I ask for urgent review and a blood gas, read the plan back and agree observations every 15 minutes. I reassure him that this is treatable and that I will stay close, and I arrange for his daughter to be updated when she returns. I record observations, his INEWS total of 8, actions and times on the chart. When he is more alert I will talk to him about an oxygen alert card and about ringing 112 or 999 if he is very drowsy or breathless at home.

Catheter specimen of urine from a feverish man

Aseptic technique · 10 minutes

The task

You are the nurse on a medical ward. Mr Michael Ryan, aged 74, has a long-term urinary catheter and has become shivery and more confused since this morning. His urine looks cloudy. A healthcare assistant is available. Introduce yourself, confirm his identity and assess him. Take and record observations. Decide whether to collect a catheter specimen of urine and show and say how you would do so using

aseptic non-touch technique. Decide who you must tell and telephone the doctor using ISBAR if you think it is needed. Explain what you are doing to him and record the care.

What a strong answer does

- Introduces self, performs hand hygiene, checks two identifiers, explains the procedure in simple words and seeks his agreement.
- Assesses for infection and deterioration: temperature, pulse, respiratory rate, blood pressure and level of consciousness, and notes the new confusion.
- Takes a focused history of symptoms and of the catheter, including duration and last change.
- Recognises possible urinary sepsis in a catheterised patient with fever and new confusion, applies the sepsis screening tool and decides to collect a specimen and escalate.
- Takes the specimen from the sampling port, not the drainage bag, using aseptic non-touch technique: prepares a clean tray, performs hand hygiene, wears gloves, clamps below the port, cleans the port and allows it to dry, and draws urine with a sterile syringe into a sterile container, then releases the clamp.
- Labels the specimen at the bedside, completes the request form and sends it promptly, noting that no antibiotic has yet been given.
- **Safety:** Escalates by telephone straight away using ISBAR with observations, sepsis screen and urinary findings and agrees the plan.
- Reads back the plan: Sepsis 6 within one hour, observations at least every 30 minutes, review and catheter review.
- Explains care and reassures him, and asks the healthcare assistant to help with comfort and warmth.
- Documents findings, specimen collected and escalation, signed and timed.

Model answer

I perform hand hygiene, introduce myself and check Mr Ryan's name and date of birth, and explain in simple words that I need to check him and take a urine sample. I ask the healthcare assistant to bring a blanket and equipment. I take a focused history: shivering since breakfast, low abdominal ache, cloudy foul-smelling urine, the catheter in place for about five weeks and no allergies. I take observations: respiratory rate 20, saturation 96 per cent on air, pulse 102, blood pressure 126/74, temperature 38.4. He has new confusion. His INEWS total is 5. His glucose is 9.4. He has a suspected infection and an INEWS of 4 or more, so I apply the HSE sepsis screening tool. New altered mental status is a red flag, so this is probable sepsis and I do not delay. I phone the registrar now using ISBAR. I give the findings, the INEWS total and the red flag and ask for immediate review. I read back the plan: Sepsis 6

within one hour, observations at least every 30 minutes and a review of the catheter. I then collect a catheter specimen using aseptic non-touch technique. I clean a tray, clean my hands and collect a sterile syringe and container, gloves, a clamp and an alcohol wipe. I clamp the tubing below the sampling port, clean the port and let it dry. I do not take the sample from the drainage bag. I draw urine from the port with the syringe, put it into the sterile container, cap it and release the clamp. I dispose of the waste, remove my gloves and clean my hands. I label the specimen at the bedside with name, date of birth and time, and send it urgently. I record that no antibiotic has yet been given. I reassure Mr Ryan, keep him warm and explain the plan. I document the care, the specimen and the doctor's response, timed and signed.

Telling a daughter about a medicine error

Breaking bad news · 10 minutes

The task

You are the nurse on a medical ward. Mrs Teresa Kinsella, aged 67, was given her usual paracetamol twice within two hours this afternoon because the first dose was not recorded. The doctor has reviewed her, her observations are normal and a blood test is pending. Her daughter, Grace, has arrived and is upset about other care issues as well. The nurse in charge is aware. Speak with Grace. Introduce yourself, explain what has happened using an open disclosure approach and respond to her concerns. Record the disclosure.

What a strong answer does

- Introduces self, checks who Grace is and that Mrs Kinsella has agreed to information being shared, and finds a private place to talk.
- Acknowledges her distress and listens to her other concerns before explaining.
- **Safety:** Gives a clear, honest, factual account of the error in plain language: what happened, when and what was done, without hiding or minimising.
- Gives a sincere apology for the error and the poor experience, without blaming a colleague.
- Explains what has been done: doctor review, observations and blood test, and what could happen.
- Takes her report of a bad liver seriously, does not give false reassurance, and tells the doctor and nurse in charge today because it may change the plan.
- Does not speculate or guess; says what is not yet known and when she will be updated.

- Explains that an incident report has been made and a review will take place, and describes how the ward will prevent a recurrence.
- Offers support and follow-up: a named contact, a time for an update and how to give feedback through the complaints process.
- Documents the disclosure and the discussion factually, signed and timed.

Model answer

I introduce myself to Grace, check who she is and that her mother has agreed to me sharing information, and ask her to sit with me somewhere private. I have already told the nurse in charge and completed an incident report. I begin by listening. Grace tells me about her mother's wait for the toilet yesterday and her fear about her mother's liver. I do not interrupt or become defensive. I acknowledge her distress. I then explain what happened, clearly and honestly. I say that her mother received her usual paracetamol twice, about an hour and a half apart, because the first dose had not been recorded on the chart. I do not minimise it and I do not blame a colleague. I say that I am sorry that this happened. I explain what has been done: the doctor has reviewed her, her observations are normal and a blood test has been ordered to be careful, and no treatment is needed at present. Grace tells me about her mother's liver, which is not in the notes, so I say I will tell the doctor and nurse in charge now because it may change the plan. I say honestly what I do not yet know and when I will update her. I tell Grace that I have reported the error and that a review will look at how it happened and how to stop it happening again, and that I will share what the review finds. I apologise again for the other care concerns and offer her the nurse in charge's name and a time for the next update. I explain how to give feedback through the hospital complaints process, in line with the HSE open disclosure approach. I document the disclosure factually: who was present, what I said, her questions and the follow-up arranged, signed and timed.

Care after death and support for a widow

Clinical skills · 10 minutes

The task

You are the nurse on a medical ward. Mr Jim Fitzgerald, aged 74, died twenty minutes ago of heart failure. His wife, Mrs Nuala Fitzgerald, is at his bedside. A healthcare assistant is available. Speak with Mrs Fitzgerald first, then describe and carry out the after-death care you would provide, saying aloud each step and why,

including who you must inform. Ask about her wishes and any religious or cultural needs. Complete the record provided.

What a strong answer does

- Speaks to Mrs Fitzgerald first, offers condolences, privacy and time, and asks what she would like.
- **Safety:** Confirms that death has been verified by a doctor and identifies the patient with two identification bands before any care.
- Asks about religious and cultural wishes and arranges for the priest to be called.
- Performs hand hygiene and uses personal protective equipment as required by policy.
- Provides personal care with dignity: closes the eyes, lays him straight, cleans, checks that no coroner referral is planned before removing the cannula and catheter in line with policy, covers any wound, and offers Mrs Fitzgerald the chance to help.
- Notes the pacemaker and records it for the mortuary and funeral director in line with policy.
- Lists and returns belongings with Mrs Fitzgerald, leaves the wedding ring on with her agreement and records it.
- Informs the nurse in charge and the relevant staff, and arranges the mortuary in line with local policy after the family have had time.
- Offers practical and emotional support including family arriving, a drink, and information about bereavement support and what to do next, and responds kindly to her guilt.
- Documents the care clearly, signed and timed.

Model answer

I go to Mrs Fitzgerald first, introduce myself and tell her how sorry I am. I give her time and privacy and ask what she would like. She tells me she is Catholic and would like Father Brendan to come, would like to help wash her husband and wants his wedding ring to stay with him. I tell her that is possible and call the priest. Before I begin any care I perform hand hygiene, put on gloves and an apron and confirm that the doctor has verified the death and recorded it. I check two identification bands against the notes. I check the notes for devices and see a pacemaker, which I record for the mortuary documentation. I ask the healthcare assistant to help. We close the curtains and care for Mr Fitzgerald with dignity: we close his eyes, lay him straight with a pillow under the head and keep him covered. The notes record an expected death with no coroner referral, so we remove the cannula and catheter in line with local policy, cover the site, wash and dress him and offer Mrs Fitzgerald the chance to help. I list his belongings and give them to her, leaving the wedding ring in place with her agreement and recording this. I tell the nurse in charge and make sure the family are contacted in line with Mrs

Fitzgerald's wishes. I tell her the mortuary will be arranged only after her son and daughter have said goodbye. I listen to her feelings about not being at the bedside, tell her this is common and not her fault, and offer a drink and information on bereavement support. I document the care, the people informed and the belongings, signed and timed.

Sick day advice for a young woman with type 1 diabetes

Counselling & explanation · 10 minutes

The task

You are the nurse in a diabetes day unit. Ciara Murphy, aged 19, has type 1 diabetes and has come in feeling unwell with vomiting since last night. Introduce yourself, confirm her identity and carry out a focused assessment, including her glucose and ketone results. Give her clear sick day advice. Decide where she should be cared for and arrange this by telephoning the doctor using ISBAR. Check her understanding. The doctor is available by phone.

What a strong answer does

- Introduces self, performs hand hygiene, checks two identifiers and builds rapport.
- Takes a focused history of vomiting, abdominal pain, fluid intake and insulin taken.
- Identifies that she has omitted her long-acting insulin and explains why it must not be stopped when unwell.
- Measures and records glucose, ketones and a full set of observations and looks for dehydration.
- **Safety:** Interprets raised ketones with vomiting and dehydration as a risk of diabetic ketoacidosis needing same-day medical assessment, not home care.
- Escalates by telephone with ISBAR giving glucose, ketones, observations and missed insulin.
- Reads back the plan and arranges safe transfer, not sending her home alone or driving.
- Gives clear sick day advice: keep taking insulin, check glucose and ketones every 2 to 4 hours, sip sugar-free fluids and when to call 112 or 999.
- Uses teach-back and explores her worries without judgement.
- Documents findings, advice and transfer clearly, signed and timed.

Model answer

I perform hand hygiene, introduce myself and ask Ciara for her name and date of birth. She looks pale and unwell, so I sit her comfortably and explain what I will do. I ask about vomiting, pain, drinking and her insulin. She has been sick four times,

cannot keep water down and missed last night's long-acting insulin because she was not eating. I tell her that long-acting insulin must continue when she is unwell. I take her observations: pulse 108, blood pressure 106/64, respiratory rate 20, temperature 37.6 and oxygen saturation 98 per cent. Her glucose is 14.8 mmol/L and her ketones are 1.8 mmol/L. Her mouth is dry and her abdomen is mildly tender. I explain that ketones at this level with vomiting and dehydration mean she is at risk of diabetic ketoacidosis and needs same-day hospital care. I phone the diabetes registrar with ISBAR: Ciara Murphy, 19, type 1 diabetes, vomiting since last night with missed long-acting insulin, glucose 14.8, ketones 1.8, pulse 108 and dehydrated. I recommend urgent assessment. I read back the plan, that she goes to the emergency department now, with a member of staff going with her and not driving. I give her sick day advice: continue long-acting insulin, check glucose and ketones every 2 to 4 hours, sip sugar-free fluids and ring 112 or 999 if she is drowsy, confused or breathing deeply. I ask her to explain the advice back to me, acknowledge her worry about hospital and offer follow-up with the diabetes team. I document everything, timed and signed.

Arm bruising before going home with a nephew

Ethics, consent & capacity · 10 minutes

The task

You are the nurse on a medical ward. Mr Francis Hogan, aged 78, is waiting for discharge after a fall. While helping him dress, you notice bruising on both upper arms. His nephew has come to take him home today and Mr Hogan says he wants to go. Speak with Mr Hogan privately. Introduce yourself and confirm his identity. Explore the bruising and what he wants, check that he understands his decision and decide how to respond. The nurse in charge is available. Record your conversation and actions.

What a strong answer does

- Introduces self, checks two identifiers and creates privacy and a calm setting to talk without the nephew present.
- Asks open, non-leading questions about the bruising and safety and listens without judgement.
- Examines and records the bruises accurately with his consent, and does not confront the nephew.

- **Safety:** Does not promise to keep secrets and explains honestly that safeguarding concerns must be shared and why.
- Presumes capacity and assesses it for this specific decision, applying the functional test: understanding, retaining, using or weighing and communicating, supporting him to decide, in line with the Assisted Decision-Making (Capacity) Act, in force since April 2023.
- Respects his decision to go home when he has capacity while still acting on the concern and offering support and options.
- **Safety:** Tells the nurse in charge today so that the concern goes to the designated safeguarding officer or HSE Safeguarding and Protection Team in line with national policy, giving clear facts about the bruises and the money.
- Tells him he can contact the Gardaí at any time, that the team will talk to him first unless he is in immediate danger, and gives the emergency numbers 112 or 999.
- Documents facts in his own words, the capacity decision and actions, signed and timed.

Model answer

I introduce myself to Mr Hogan, check his name and date of birth and ask if we can talk in private, making sure his nephew is not present. I explain that I noticed bruises while helping him dress and ask open questions: how he got them and how things are at home. I listen without judgement. He tells me that his nephew grabs him when he does not do as asked, holds his bank card and pension book and that he is nervous when his nephew is in a bad mood. I ask if I may look at his arms, and record round bruises of different ages on both upper arms, consistent with finger marks. I do not confront the nephew. I tell him honestly that I cannot promise to keep this secret because when someone may be harmed I must tell people who can help, and that I will explain each step. I ask what he wants. He wants to go home and does not want the Gardaí. I presume capacity, in line with the Assisted Decision-Making (Capacity) Act, and assess it for this specific decision. I give him information, ask him to explain in his own words the risks of going home and of staying, and check that he understands, retains, weighs and can communicate his decision. He can. I respect that he may choose to go home, and a decision that others consider risky does not mean he lacks capacity. I am concerned about both physical and financial abuse. I report to the nurse in charge today so that the concern goes to the designated safeguarding officer or HSE Safeguarding and Protection Team in line with national policy. I tell him what will happen next, offer information on support at home and tell him to call 112 or 999 if in immediate danger. I document the facts in his own words, the capacity decision and the actions taken, signed and timed.