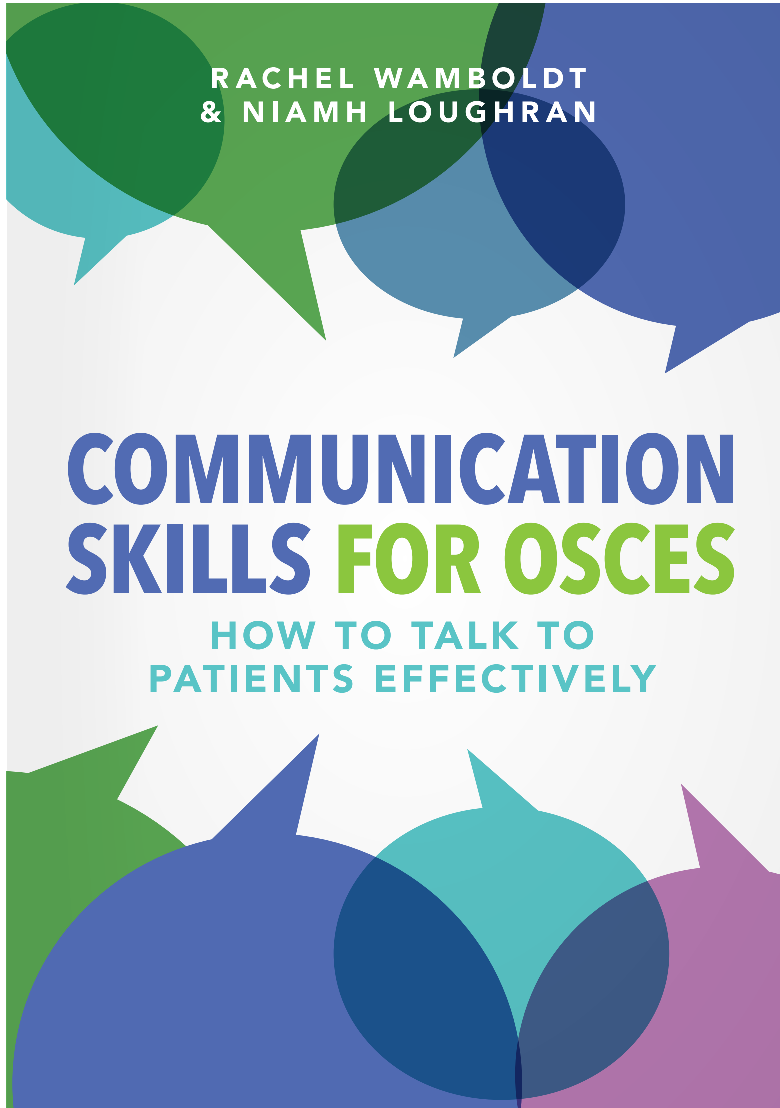
Sample mark schemes for



Role Play: Keys to Success

- Please be advised that the mark schemes are generic and are likely dissimilar to those that you will encounter during your OSCEs. They are to be used as a general assessment guide only.
- Practise as much as you can on the wards and with your peers. Actively seek feedback for your performance and give constructive feedback to others.
- Be aware that the structuring of your consultation is often as important as the content. Try to follow the Calgary–Cambridge Model as much as possible.

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Information gathering

Requirement	Max mark	Score
Initiating session • Greets/introduces/patient name/consent/context of consultation	1	
Identifying reason for consultation • Asks open question and allow for the Golden Minute	1	
Presenting complaint • History of presenting complaint	5	
Systems review	3	
Ideas, concerns and expectations	2	
Past medical history (as appropriate) • Major or chronic illnesses • Psychiatric history • Previous surgeries • Childhood illnesses • Obstetric and gynaecological history • Health promotion history	2	
Drug history and allergies	1	
Family history including shared environment (e.g. second-hand smoking)	1	
Social history (as appropriate) • Occupation, marital status, living condition and social support • Education and functional status (ADLs and IADLs) • Substance misuse (smoking, alcohol and illicit drug use) • Diet and exercise • Travel history • Spirituality	3	
Closing the consultation • Ensures that the patient is aware of the plan • Outlines relevant follow-up and opportunity for further questions • Thanks the patient	2	
Structuring consultation • Signposts, summarizes, screens • Recognizes, acknowledges and validates emotions and concerns	2	

Requirement	Max mark	Score
Process • Asks the right questions • Overall organization of the **consultation** • Recognizes and responds to cues • Appropriate non-verbal behaviour	2	
Total	25	

Information giving

Requirement	Max mark	Score
Initiating session • Greets/introduces/patient name/consent/context of consultation	1	
Identifying reason for consultation • Asks open question to establish the reason for the consultation • Takes a focused history	3	
Building rapport • Shows interest and respect. Acts supportively • Establishes the patient's ideas, concerns and expectations	2	
Preparing for info giving • Establishes the patient's starting point • Establishes how much information the patient wants to receive • Asks the patient if they have any specific questions • Establishes an agenda for the consultation with the assistance of the patient	3	
Giving the information • Gives the information in a clear and organized fashion (chunks and checks periodically) • Checks patient understanding • Avoids jargon and uses appropriate language • Gives relevant and an appropriate amount of information • Uses visual aids relevant to the scenario • Applies the information to the patient's ICE	8	
Closing the consultation • Ensures that the patient is aware of the plan • Outlines relevant follow-up and opportunity for further questions • Thanks the patient	2	
Structuring consultation • Signposts, summarizes, screens • Recognizes, acknowledges and validates feelings and concerns	4	
Process • Overall organization of the consultation • Appropriate non-verbal behaviour	2	
Total	25	

Shared decision making process

Requirement	Max mark	Score
Initiating session • Greets/introduces/patient name/consent/context of consultation	1	
Identifying reason for consultation • Asks open question to establish the reason for the consultation • Takes a focused history	2	
Building rapport • Shows interest and respect. Acts supportively • Establishes the patient's ideas, concerns and expectations	2	
Preparing for shared decision making • Establishes the patient's starting point • Outlines that there are various options for management and invites the patient's involvement • Establishes how much information the patient wants to receive • Asks the patient if they have any specific questions before continuing • Establishes an agenda for the consultation with the assistance of the patient (signposts the options) • Asks about initial preference	4	
Giving the options • Gives the information in a clear and organized fashion (chunks and checks periodically) • Checks patient understanding • Avoids jargon and uses appropriate language • Gives relevant and an appropriate amount of information • Uses visual aids relevant to the scenario • Applies the information to the patient's ICE	2	
Assisting with decision making process • Explores the advantages and disadvantages of each option discussed • Patient consulted and encouraged to reflect on options provided • Shares medical perspective (own insight) • Negotiates and agrees on a plan	4	

Requirement	Max mark	Score
Closing the consultation • Outlines relevant follow-up and opportunity for further questions • Thanks the patient	2	
Structuring consultation • Signposts, summarizes, screens • Recognizes, acknowledges and validates feelings and concerns	3	
Process • Overall organization of the consultation • Appropriate non-verbal behaviour	4	
Total	25	

Psychiatric assessment & mental state examination

Requirement	Max mark	Score
Initiating session • Greets/introduces/patient name/consent/context of consultation	1	
Identifying the reason for consultation • Starts with an open question • Allows for the Golden Minute	1	
History of presenting complaint • Establishes the duration of symptoms and the presence of any triggers • Depression • Biological symptoms: low energy, poor sleep, increased or decreased appetite • Cognitive: poor memory/concentration, low mood • Beck's triad: negative thoughts about self, the world and the future • OCD • Obsessions: form (thoughts, impulses), content, recurrence, intrusiveness, provocation and association with anxiety • Compulsion: type, frequency, duration and anxiety relief • Mania • Core symptoms: increase in mood, energy and enjoyment • Biological symptoms: decreased need for sleep, increased sexuality • Cognitive symptoms: racing thoughts, over-confidence • Delusions and hallucination • Eating disorders • Deliberate weight loss (methods, quantify, goals) • Episodes of binging • Distorted body image • Endocrine abnormalities (oligo-, amenorrhoea) • Complications (dizziness, palpitations)	10	
Assessment of insight • Insight • Willingness to accept help • Outlook on the future	3	

Requirement	Max mark	Score
Assessment of risk • Explores risk of self-harm and suicide • Assesses if there is a past history of self-harm of suicidal ideation/ previous attempts • Risk of isolation/neglect • Establishes degree of social support	5	
Past medical and psychiatric history • Including personal and forensic history as appropriate	3	
Medication history and allergies	2	
Family history	1	
Social history • Living conditions, marital status, social services involvement • Occupation and level of education, if appropriate • Substance misuse (using a CAGE score for alcohol) • Social support and coping strategies	3	
Closing the consultation • Discusses the plan of care and invites further questions • Thanks the patient	1	
Structuring Consultation • Signposts, summarizes, screens • Recognizes, acknowledges and validates emotions and concerns	2	
Process • Overall organization of the consultation • Asks the right questions • Recognizes and responds to cues • Appropriate non-verbal behaviour	3	

Requirement	Max mark	Score
Interpretation: mental state examination • Appearance: sex, race, build, clothing, hygiene and eye contact • Psychomotor behaviour: gait, movements and psychomotor agitation • Mood and affect: subjective and objective mood, anxiety, affect (appropriateness and range) and ability to build rapport (open, suspicious, guarded, shy, withdrawn) • Speech: rate, flow, intensity, clarity • Thoughts: clarity, relevance, flow, content • Perceptions • Cognition: level of consciousness and orientation • Insight • Risk	15	
Total	50	

Assessing suicide risk

Requirement	Max mark	Score
Initiating session • Greets/introduces/patient name/consent/context of consultation	3	
Identifying the reason for consultation • E.g. 'I understand that you tried to take your own life last night. Can you tell me a little bit about what happened?' • Allows for the Golden Minute	2	
The event • Explores the method and establishes timing of events • Purpose (were they trying to kill themselves?) • Expectation of lethality • How were they discovered and brought to hospital?	5	
History prior to the event • Duration of suicidal ideation • Triggers/stressors/life events • Planning and precautions • Previous history of mental illness, suicidality and attempts, self-harm • Screens for symptoms of depression • Medication history • Family history of mental illness or suicide attempts • Social history: living conditions, marital status, substance misuse, domestic abuse, occupation, education, etc. (explores what is relevant)	15	
Exploring current feelings • Explores how they are currently feeling about the self-harm or suicide attempt. Are they happy or upset that they are still living? • Ongoing stressors	4	
Exploring thoughts about the future • Explores thoughts about the future, including plans of self-harm • Explores support and protective factors	4	
Closing the consultation • Discusses the plan of care and invites further questions • Thanks the patient	2	

Requirement	Max mark	Score
Structuring consultation • Signposts, summarizes, screens (2) • Adequately covers ideas, concerns and expectations (2) • Recognizes, acknowledges and validates emotions and concerns (1)	5	
Process • Asks the right questions • Recognizes and responds to cues • Appropriate non-verbal behaviour	5	
Interpretation • What score did the patient receive? • How can this be interpreted? • What further investigations might you do?	5	
Total	50	

Obstetrical and Gynaecology History

Requirement	Max mark	Score
Initiating session • Greets/introduces/patient name/consent/context of consultation	2	
Identifying the reason for consultation • Starts by asking an open question and then allows for the Golden Minute • Asks specifically about discharge, lumps/bumps, dyspareunia and lower abdominal pain	5	
Systems review	1	
Ideas, concerns and expectations	2	
Menstrual history • Establishes age of menarche • Determines last known menstrual period, typical pattern and regularity (length of cycle and days of bleeding) • Troublesome physical and emotional symptoms including amount of bleeding (i.e. flooding) • IMB, PCB, PMB	6	
Obstetrical history • Determines if the patient is currently pregnant (if so, asks about use of prenatal vitamins, results of screening tests and how they conceived – natural vs. assisted) • For all previous pregnancies: • Number of live children and the number of miscarriages/terminations/stillbirths (including maternal age at each event) • Establishes if these were with her current partner • For each pregnancy, asks about complications, malformations, modes of delivery (including use of vacuum or forceps) and the current health of the child	8	
Gynaecological history • Cervical cytology (last test and previous results) • Breast screening (whether they have had a mammogram and results)	2	

Requirement	Max mark	Score
Sexual history • Explores contraception method, including use of a barrier • Establishes if there is any history of STIs • Details of sexual contacts over the last 3 months including: • Sex of the partner and the relationship with the individual – Type of sex – Use of barrier contraception – Was this person high risk for infection? • Asks about high risk behaviours including IV drug use, paying for sexual intercourse, having sex with someone who is HIV positive, tattoos in foreign countries and travel • Asks about hepatitis B and HPV vaccinations • Safety (determines Gillick competence if appropriate and asks about domestic abuse)	8	
Past medical, surgical and psychological history • Including episodes of postpartum blues, depression and psychosis • For obstetrical patients, specifically ask about epilepsy, diabetes, thyroid disease and a history of DVTs	2	
Medication history and allergies • For obstetrical patients, asks about folic acid, vitamin D and iron	2	
Family history • Obstetrics-specific: gestational diabetes, pre-eclampsia, pregnancy loss, inherited genetic conditions • Gynaecology-specific: breast or ovarian cancer	2	
Social history • Living conditions and support; for pregnant women, ask about involvement of social services • Relationship status • Occupation • Substance misuse (smoking, alcohol and drugs) • Coping strategies and mood	3	
Closing the consultation • Discusses the plan of care and invites further questions • Thanks the patient	1	
Structuring consultation • Signposts, summarizes, screens • Adequately covers ideas, concerns and expectations • Recognizes, acknowledges and validates emotions and concerns	3	

Requirement	Max mark	Score
Process • Asks the right questions • Overall organization of the consultation • Recognizes and responds to cues • Appropriate non-verbal behaviour	3	
Total	50	

Abbreviated mental test score/cognitive assessment

Be aware of the details on the front of the station. You may not need to assess all of the details mentioned below. Practise doing elements of this assessment as a collateral history.

Requirement	Max mark	Score
Initiating session • Greets/introduces/patient name/consent/context of consultation	2	
Identifying reason For consultation • Ask open question • Golden Minute	2	
Presenting complaint • Quick history of presenting complaint • Explores current symptoms (as relevant): • Amnesia – getting lost, forgetting appointments, etc. • Agnosia – difficulty recognizing familiar people • Aphasia – difficulty answering questions (finding words) • Apraxia – difficulty getting dressed • Hallucinations/delusion • Symptoms of depression • Behavioural changes – agitation, aggression, disinhibition, wandering and sleep disturbance • Explores risk (kitchen safety, driving, wandering, neglect)	5	
Ideas, concerns and expectations	2	
Past medical history and psychiatric history	2	
Drug history and allergies	2	
Family history	1	
Social history • Assesses ability to perform ADLs (ABCDETT): ambulating, bathing, continence, dressing, eating, transferring, toileting • Assesses ability to perform IADLs (SHAFTT): Shopping, housework, accounting, food preparation, transportation, telephone, taking medication • Who do they live with? Carers? • Alcohol and smoking history	10	
Systems review	3	

Requirement	Max mark	Score
Mini mental state examination 1) 'How old are you?' 2) 'What time is it?' 3) 'I would like you to remember an address and I will ask you to repeat it later – 42 West Street' 4) 'What year is it?' 5) 'What type of place is this?' 6) 'Do you know who this is? Do you know what my job is?' 7) 'What is your date of birth?' 8) 'What year did the Second World War end?' 9) 'Who is our current monarch?' 10) 'Can you count backwards from 20 to 1?' 11) 'Can you remember that address that I told you earlier?'	10	
Closing the consultation • Ensures that patient is aware of plan going forward • Outlines relevant follow-up and opportunity for further questions • Thanks the patient	2	
Structuring consultation • Signposts, summarizes, screens • Recognizes, acknowledges and validates emotions and concerns	3	
Process • Asks the right questions • Recognizes and responds to cues • Appropriate non-verbal behaviour	3	
Interpretation • What score did the patient receive? • How can this be interpreted? • What further investigations might you do?	3	
Total	50	

Paediatric consultation

Requirement	Max mark	Score
Initiating session • Greets and introduces in an age-appropriate manner • Determines the name and age of the child • Establishes who else is present in the consultation • Consent and confidentiality	1	
Identifying reason for consultation • Asks open question and allows for the Golden Minute (either to the child or parent, as appropriate)	1	
Presenting complaint • History of presenting complaint	5	
Systems review • General: fever, behaviour/activity, apathy, rashes • Neuro: seizures, headaches, abnormal movements • ENT: snoring, sore throat, ear pain • Cardioresp: cough, noisy breathing, dyspnoea, cyanosis, syncope • GI: abdominal pain, vomiting, bowel movements (frequency and consistency), feeding • GU: number of wet nappies, dysuria, smell	5	
Paediatric-specific elements • Pregnancy: any problems, maternal health, screening results • Birth: gestation, weight, mode, complications • Neonatal problems: breathing, jaundice, fever, fits • Feeding: breast/bottle, what type of formula, how much/how often, weaning and solid consumption • Growth and development (including gross, fine, hearing/language, social)	10	
Ideas, concerns and expectations • Allows opportunity for both parties to express their ideas, concerns and expectations	2	
Past medical history (as appropriate) • Major or chronic illnesses • Previous surgeries or hospital admissions • Health promotion history (vaccinations)	2	
Drug history and allergies	1	
Family history including shared environment	1	

Requirement	Max mark	Score
Social history • Living conditions (who is at home) and social service involvement • Second-hand smoke exposure, pets in the home • Attendance and performance at school • For adolescent consultation, use the HEADSSS protocol: – Home life and relationship with parents – Education and employment – Activities (including sports and social relationships) – Disability and Affect (mood) – Suicide and self-harm – Sex – Sleep	15	
Closing the consultation • Ensures that both parties are aware of the plan • Praises the child for their involvement in the consultation • Outlines relevant follow-up and opportunity for further questions • Safety nets appropriately • Thanks the patient	2	
Structuring consultation • Signposts, summarizes, screens • Encourages the expression of feelings (recognizes, acknowledges and validates emotions and concerns)	2	
Management of the triadic consultation • Establishes both parents' and child's perspective, where appropriate • Addresses both parents' and child's agenda • Handles any conflict appropriately • Builds rapport with both the parent and the child	3	
Total	50	

Drug history

Requirement	Max mark	Score
Initiating session • Greets, introduces self and explains purpose of consultation • Check patient ID (full name and DOB) • Gains consent and ensures confidentiality	1	
Ideas, concerns and expectations for the consultation	2	
Past medical history	2	
Allergies including reaction	2	
Medication review • For each medication: – Checks drug ownership (including label) – Determines indication – Duration of use – Assesses dosage and frequency – Enquires about compliance – Adverse effects or other issues	7	
Other medicinal drugs • Over-the-counter medication use • Supplements and herbal remedies • Screens for commonly forgotten medications (eye drops, inhalers, creams, contraception)	3	
Social history • Assesses for the use of cigarettes, alcohol and illicit drugs • Do they take any medications that are not prescribed to them?	2	
Closing the onsultation • Discusses the plan and invites further questions. • Thanks the patient	1	
Structuring consultation: • Signposts, summarizes, screens • Recognizes, acknowledges and validates emotions and concerns	2	
Process • Asks the right questions • Overall organization of the consultation • Recognizes and responds to cues • Appropriate non-verbal behaviour	3	
Total	25	

Breaking bad news

Requirement	Max Mark	Score
Initiating session • Greets/introduces/patient name/consent/confidentiality/ context of consultation • Establishes rapport (asks if the patient has brought anyone with them)	2	
Assessing the patient's starting point and what they already know • Assesses the patient's ideas, concerns and expectations • Summarizes what has happened thus far	3	
Delivering the bad news • Gives a 'warning shot' • Gives the news in a sensitive but straightforward manner • Allows adequate time for the patient to process the information • Picks up and responds to non-verbal cues • Shows empathy	5	
Exploring the patient's initial emotions • Identifies emotions • Asks the patient how they are feeling on hearing the news • Recognizes, acknowledges and validates concerns	3	
Giving information • Asks the patient if they have any immediate questions • Creates a shared agenda • Addresses ideas, concerns and expectations • Provides a clear explanation of options and offers medical opinion	5	
Assisting with the decision • Has the patient reflect on the information provided • Negotiates and agrees on a plan (shared decision)	2	
Closing the consultation • Summarizes the plan of care and invites further questions • Provides pamphlets to take away and information regarding support • Makes appropriate arrangements for follow-up • Thanks the patient	3	

Requirement	Max Mark	Score
Structuring the consultation • 'Chunks and checks' using the patient's response to guide the consultation • Uses clear language; shows empathy and provides support • Signposts, summarizes and screens • Recognizes, acknowledges and validates emotions and concerns	2	
Total	25	

Explaining risk

Requirement	Max Mark	Score
Initiating session • Greets/introduces/patient name/consent/context of consultation • Establishes the reason for the consultation	3	
Building the relationship • Assesses the patient's starting point including both the knowledge of the condition being discussed and research methods • Establishes ideas, concerns and expectations • Takes a focused history (as appropriate)	2	
Providing information • Establishes how much detail the patient wants to know • Sets an agenda • Conducts an organized consultation (chunking and checking, signposting, summarising and screening) • Gives a clear explanation of the information and avoids jargon • Uses visual aids (if appropriate)	5	
Explaining risk • Avoids descriptive terms (such as low risk) • Uses frequencies (e.g. 1 out of 100) rather than percentages • Overall knowledge of research being discussed • Individualizes the message	5	
Assisting with decision making • Encourages the patient to reflect on the information • Shares own insight and medical perspective	3	
Closing the consultation • Negotiates and agrees on a plan (shared decision making) • Invites further questions • Thanks the patient	2	
Structuring consultation • Signposts, summarizes, screens (2) • Adequately covers ideas, concerns and expectations (3) • Recognizes, acknowledges and validates emotions and concerns	3	
Process • Recognizes and responds to cues • Appropriate non-verbal behaviour	2	
Total	25	

Consenting for a procedure

Requirement	Max mark	Score
Initiating session • Greets/introduces/patient name/consent/context of consultation	2	
Identifying the reason for consultation • Establishes the reason for the consultation	2	
Information gathering • Background of reason for needing the procedure • Past medical and surgical history • Drug history and allergies • Family history, including surgical complications • Social history	10	
Ideas, concerns and expectations regarding the procedure	3	
Preparing for information giving • Establishes patient's starting knowledge of the procedure • Establishes how much information the patient wants to receive • Asks the patient if they have any specific questions • Establishes an agenda for the consultation with the assistance of the patient	4	
Giving information – content • Clarifies name and basic nature of procedure, explaining any basic anatomy or physiology that may need clarifying • Use of visual aids • Explains the details of the procedure including the events that will occur before, during and after the procedure • Explains the risk of the procedure • Explains the benefits of the procedure • Discusses the consequences of not having the procedure • States the alternatives • Safety nets (the recovery timeline and signs of complications)	15	

Requirement	Max mark	Score
Giving information – structure • Gives the information in a clear and organized fashion (chunks and checks periodically) • Checks patient understanding • Avoid jargon and uses appropriate language • Gives relevant and an appropriate amount of information • Uses visual aids relevant to the scenario • Applies the information to the patient's ICE	6	
Closing the consultation • Discusses the plan of care and invites further questions • Thanks the patient	2	
Structuring consultation • Signposts, summarizes, screens • Adequately covers ideas, concerns and expectations • Recognizes, acknowledges and validates emotions and concerns	3	
Process • Overall organization of the consultation • Recognizes and responds to cues • Appropriate non-verbal behaviour	3	
Total	50	

SBAR (Situation, background, assessment, recommendations)

Requirement	Max mark	Score
Situation • Introduces self, role and the team/ward on which they are working (3) • Confirms that they are speaking to the correct person and asks them to spell their name if necessary (1) • States the patient's name, hospital number and location (3) • States the reason for the call (1)	8	
Background • States why the patient was admitted to or arrived at hospital and how long ago (2) • Notes previous medical history and any other relevant findings on history (relevant medications, family history and social history) (4) • Describes the course in hospital or events prior to admission (2) • Gives details of the current event (2)	10	
Assessment • States what they think the problem is and why they are concerned (2) • States the most recent observations and what changes there have been from baseline (2) • Describes the examination findings (5) • States what investigations and interventions have been done thus far (5)	14	
Recommendations • States what they would like done (2) • Asks if any further investigations or management needs to be done at this time (2) • Repeats back the plan (1) • Asks if they can document the conversation in the notes (1) • Thanks the recipient of the call and reminds them of their own name and bleep number (2)	8	
Total	40	