AlphaPlus

NMC Nursing & Midwifery Council | Test of Competence

Test of Competence 2021: Marking Criteria Adult Nursing

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Important information

This document is intended to provide candidates with additional information to help them to prepare for the test of competence (Part 2). This document should be read in conjunction with the candidate information booklet, recommended/core reading, the mock OSCE and the ‘Revised OSCE Top Tips Adult Nursing’ document.

OSCE assessment

Assessment process

Each station is marked against unique criteria matched to the skill being assessed. Within each station’s marking grid, there are essential criteria that a candidate must meet in order to pass. These reflect the minimum acceptable standards of a pre-registration nurse entering the register.

APIE stations

Assessment marking criteria: all APIEs

Assessment criteria	
1	Assesses the safety of the scene and the privacy and dignity of the patient.
2	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following World Health (WHO) guidelines.
3	Introduces self to person.
4	Checks identity (ID) with the person (the person's name is essential, and either their date of birth or hospital number) verbally, against wristband (where appropriate) and documentation.
5	Checks for allergies verbally and on wrist band (where appropriate).
6	Gains consent and explains reason for the assessment.
7	Uses a calm voice, speech is clear, body language is open, personal space is appropriate.
8a	**Airway:** Clear; no visual obstructions.
8b	**Breathing:** Respiratory rate; rhythm; depth; oxygen saturation level; respiratory noises (rattle wheeze, stridor, coughing); unequal air entry; visual signs of respiratory distress (use of accessory respiratory muscles, sweating, cyanosis, 'see-saw' breathing).
8c	**Circulation:** Heart rate; rhythm; strength; blood pressure; capillary refill; pallor and perfusion.
8d	**Disability**: conscious level using ACVPU (alert, confusion, voice, pain, unresponsive); presence of pain; urine output; blood glucose.
8e	**Exposure**: Takes and records temperature; asks for the presence of bleeds, rashes, injuries and/or bruises; obtains a medical history.
9	Accurately measures and documents the patient's vital signs and specific assessment tools.
10	Calculates National Early Warning Score (NEWS) or Glasgow coma scale accurately.
11	Accurately completes document: signs, adds date and time on assessment charts.
12	Conducts a holistic assessment relevant to the patient's scenario.
13	Disposes of equipment appropriately – verbalisation accepted.

14	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
15	Acts professionally throughout the procedure in accordance with NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’.

Planning marking criteria: all APIEs

Assessment criteria	
1	Clearly and legibly handwrites answers.
2	Identifies two relevant nursing problems/needs.
3	Identifies aims for both problems.
4	Sets appropriate evaluation date for both problems.
5	Ensures nursing interventions are current/evidence-based/best practice.
6	Uses professional terminology in care planning.
7	Does not use abbreviations or acronyms.
8	Ensures strike-through errors retain legibility.
9	Accurately prints, signs and dates.
10	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Implementation marking criteria: all APIEs

Assessment criteria	
1	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
2	Introduces self to the person.
3	Seeks consent from the person or carer prior to administering medication.
4	Checks allergies on chart and confirms with the person in their care; also notes red ID wristband (where appropriate).
5	Before administering any prescribed drug, looks at the person's prescription chart and correctly checks **ALL** of the following: Correct: • person (checks ID with person: verbally, against wristband (where appropriate) and documentation) • drug • dose • date and time of administration • route and method of administration • diluent (as appropriate).
6	Correctly checks **ALL** of the following*:* • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
7	Considers contraindication where relevant and medical information prior to administration (prompt permitted). (This may not be relevant in all scenarios.)
8	Provides a correct explanation of what each drug being administered is for to the person in their care (prompt permitted).
9	Administers drugs due for administration correctly and safely.
10	Omits drugs not to be administered and provides verbal rationale. (Ask the candidate the reason for non-administration if not verbalised.)
11	Accurately documents drug administration and non-administration, including the details of the person administering the medication.
12	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Evaluation marking criteria: all APIEs

Assessment criteria	
Situation	
1a	Introduces self and the clinical setting.
1b	States the patient's name, hospital number and/or date of birth, and location.
1c	States the reason for the handover (where relevant).
Background	
2a	States date of admission/visit/reason for initial admission/referral to specialist team and diagnosis.
2b	Notes previous medical history and relevant medication/social history.
2c	Gives details of current events and details the findings from assessment.
Assessment	
3a	States most recent observations, any results from assessments undertaken and what changes have occurred.
3b	Identifies main nursing needs.
3c	States nursing and medical interventions completed.
3d	States areas of concerns.
Recommendation	
4	States what is required of the person taking the handover and proposes a realistic plan of action.
Overall	
5	Verbal communication is clear and appropriate.
6	Systematic and structured approach taken to handover.
7	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Clinical skills stations

Administration of Inhaled Medication (AIM) marking criteria

	Assessment criteria
1	Introduces self, explains procedure and gains consent.
2	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
3	Requests/assists the person to sit in an upright position.
4	Before administering any prescribed drug, looks at the person's prescription chart and correctly checks **ALL** of the following: Correct: • person (check ID with person: verbally, against wristband (where appropriate) and documentation) • drug • dose • date and time of administration • route and method of administration • diluent (as appropriate). • Any allergies.
5	Correctly checks **ALL** of the following*:* • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
6	Removes the mouthpiece cover from the inhaler.
7	Shakes inhaler well for 2–5 seconds.
8	With a spacer device: Inserts metered dose inhaler (MDI) into end of spacer device. Asks the person to exhale completely and then to grasp the spacer mouthpiece with their teeth and lips while holding inhaler, ensuring lips form a seal.
9	Asks the person to tip head back slightly, and inhale slowly and deeply through the mouth while depressing the canister fully.
10	Instructs the person to use 'single-breath technique': breathe in slowly for 2–3 seconds and hold their breath for approximately 10 seconds, then remove the MDI from mouth before exhaling slowly through pursed lips **OR** Instructs the person to use 'tidal breathing' or 'multi-breath technique' if the person can't hold their breath for more than 5 seconds (breathing in and out steadily five times).

11	Ensures the drug is administered as prescribed.
12	Instructs the person to wait 30–60 seconds between inhalations (if same medication) or 2–3 minutes between inhalations (if different medication), and shakes the inhaler between doses.
13	Cleans any equipment used and discards all disposable equipment in appropriate containers.
14	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
15	Dates and signs drug administration record (prompt permitted) – verbalisation accepted.
16	Reassures the person appropriately. Closes the interaction professionally and appropriately.
17	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Red flag:

	Safety of administration of medication. This should include: *Checking prescription against patient,* *Right dose/right time/right patient/right route/right drug.* *The chart should then be signed.* *If any of this is missed, this should result in a fail.*

Aseptic non-touch technique (ANTT) and wound assessment marking criteria

Wound assessment marking criteria

	Assessment criteria
1	Checks that the patient is comfortable and verbalises that a pain assessment will be undertaken prior to procedure.
2	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels.
3	Dons a disposable plastic apron and non-sterile gloves.
4	Assesses and reports the condition of the wound: examines for erythema describes the area around the wound describes any exudate describes the defect in the closure describes the condition of the floor of the defect asks about pain and tenderness.
5	Disposes of waste appropriately – verbalisation accepted.
6	Describes any further actions that should be taken, such as swab and referral to the medical team.

Aseptic non-touch technique marking criteria

	Assessment criteria
1	Cleans hands with alcohol hand rub and dons disposable gloves and apron.
2	Cleans trolley with detergent wipes (or equivalent) from furthest to nearest point.
3	Removes and disposes of gloves and apron. Cleans hands with alcohol hand rub.
4	Checks that all the equipment required for the procedure is available and, where applicable, is sterile (i.e. that packaging is undamaged, intact and dry, and that sterility indicators are present on any sterilised items and have changed colour where applicable).
5	Places all the equipment required for the procedure on the bottom shelf of the clean dressing trolley (or suitable equivalent). (Equipment: sterile dressing pack, NaCl 0.9% for cleaning, alcohol cleaning wipes, wound dressing, alcohol hand rub, disposable apron.)
6	Takes the trolley to the person's bedside, disturbing the curtains as little as possible.
7	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
8	Dons a disposable plastic apron.
9	Opens the outer cover of the sterile pack and, having verified that the pack is the correct way up, slides the contents, without touching them, onto the top shelf of the trolley (or suitable equivalent).
10	Cleans hands with alcohol hand rub.
11	Opens the sterile field using only the corners of the paper.
12	Opens any other packs, tipping their contents gently onto the centre of the sterile field. Uses alcohol wipe to clean the saline solution for 30 seconds, allowing it to dry for 30 seconds.
13	Cleans hands with alcohol hand rub and dons sterile gloves.
14	Carries out and completes the relevant procedure using **ANTT:** Drapes sterile field around/under the wound area States which hand will be 'clean' and which will be 'dirty' Dips gauze in saline solution, moving from the clean to dirty hand Cleans wound from clean to dirty areas in a single stroke, taking care not to over-clean the wound

	Applies new dressing Avoids contaminating sterile field or key parts at all times.
15	Replaces bedcovers.
16	Disposes of waste appropriately – verbalisation accepted.
17	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
18	Checks the person is comfortable and is able to reach the call buzzer.
19	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Red flag:

	Candidates who obviously contaminate the sterile field OR are unable to recognise the sterile field. If contaminated, immediate rectification or verbalisation of error to the examiner is needed.

Blood glucose monitoring marking criteria

Assessment criteria	
1	Assembles the equipment required and checks that the strips are in date and have not been exposed to air.
2	Explains the procedure with the person. Gains consent.
3	Cleans own hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
4	Dons a disposable plastic apron and non-sterile gloves.
5	Checks that the patient's hands are visibly clean.
6	Takes a single-use lancet and takes blood sample from the side of finger, ensuring that the site of piercing is rotated. Avoids use of index finger and thumb.
7	Inserts the testing strip into the glucometer and applies blood to the strip. Ensures that the window on the test strip is entirely covered with blood.
8	Gives the patient a piece of gauze to stop the bleeding.
9	Ensures that all sharps and non-sharp waste are disposed of safely (including scooping method of re-sheathing, if used, and transportation of sharps) and in accordance with locally approved procedures.
10	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
11	Verbalises whether the result is within normal limits and indicates whether any action is required.
12	Documents the result accurately, clearly and legibly.
13	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Red flag:

	Candidate does not demonstrate knowledge of normal range of blood glucose or does not act appropriately/acknowledge abnormal reading.

Catheter specimen of urine (CSU) marking criteria

Assessment criteria	
1	Explains and discusses the procedure with the person.
2	Checks that any equipment required for the procedure is available and, where applicable, is sterile (i.e. that packaging is undamaged, intact and dry, is within the expiration date, that sterility indicators are present on any sterilised items and have changed colour, where applicable).
3	If no urine is visible in the catheter tubing: cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, dons a disposable plastic apron and non-sterile gloves prior to manipulating the catheter tubing.
4	Applies non-traumatic clamp a few centimetres distal to the sampling port. Removes gloves and disposes appropriately.
5	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
6	Dons non-sterile gloves.
7	Wipes sampling port with 2% chlorhexidine in 70% isopropyl alcohol and allows drying for 30 seconds.
8	If using needle and syringe***:*** inserts needle into port at an angle of 45°, using a non-touch technique, and aspirates the required amount of urine, then withdraws needle. If using needless system: inserts sterile syringe firmly into centre of sampling port (according to manufacturer's guidelines) using a non-touch technique, aspirates the required amount of urine, and removes syringe.
9	Transfers an adequate volume of the urine specimen (approximately 10ml) into a sterile container immediately.
10	Discards needle and syringe into sharps container (if relevant).
11	Wipes sampling port with 2% chlorhexidine in 70% isopropyl alcohol and allows drying for 30 seconds.
12	Unclamps catheter tubing (if relevant).
13	Disposes of equipment including apron and gloves appropriately – verbalisation accepted.
14	Cleans hands with alcohol hand rub, or washes with soap and water and dries with

	paper towels, following WHO guidelines – verbalisation accepted.
15	Verbalises the need to label the container correctly and place into microbiology bag ready to send to laboratory as soon as the sample is obtained.
16	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Red flag:

	Candidate takes the sample from the incorrect port, either leg bag emptying port OR water balloon port.

Fine-bore nasogastric tube insertion marking criteria

	Assessment criteria
1	Introduces self. Explains the procedure to be carried out and the rationale for it.
2	Arranges a signal with the patient so they can communicate if they wish to halt/stop, e.g. raising hand.
3	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
4	Assembles equipment required and dons a disposable plastic apron and non-sterile gloves.
5	Assists the patient to sit in a semi-upright position in chair/bed, supporting head with pillows to ensure no head-tilt forwards or backwards.
6	Measures the distance on the tube from the patient's earlobe to the bridge of the nose, plus the distance from earlobe to the bottom of the xiphisternum, taking note of the measurement marks on the tube.
7	Checks the nostrils are patent by asking the patient to sniff with one nostril closed. Repeat with the other nostril.
8	Lubricates approximately 15–20cm of the tube with warm water.
9	Ensures a receiver is placed beneath the end of the tube.
10	Inserts the proximal end of the tube into the clearer nostril and slides backwards and inwards along the floor of the nose to the nasopharynx. Stops if any obstruction and tries again in slightly different direction, or uses other nostril.
11	Asks the patient to start swallowing if they are able as tube passes down the nasopharynx into the oesophagus.
12	Advances the tube through the pharynx as patient swallows until the measured indicator on the tube reaches the entrance of the nostril.
13	Recognises any signs of distress, such as coughing or breathlessness, in which case the tube would be removed immediately.
14	Uses adherent dressing tape to secure the tube to nostril and cheek.
15	Aspirates a small amount of the stomach contents using a 50ml syringe, confirming the tube is in position by using pH indicator strip and confirms the presence of acid (the pH should be less than 5.5). Uses a spigot/integral cap to cap the tube.

16	Disposes of equipment, including apron and gloves, appropriately – verbalisation accepted.
17	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
18	Ensures patient is comfortable post procedure.
19	States additional checks that may be undertaken to check tube positioning before commencing feeding (i.e. further checking with pH indicator strip immediately prior to each feed/in very specific circumstances, radiologically).
20	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Red flags:

	Candidate does not recognise the significance of displaced tube, i.e. is not able to state what the pH should be to confirm correct tube positioning.
	Candidate does not recognise the significance of additional checks prior to commencing feeding.

Fluid balance (FB) marking criteria

Assessment criteria	
1	Handwriting is clear and legible.
2a	Accurately transposes the information onto the fluid balance chart.
2b	Calculates the fluid intake balance accurately.
3	Calculates the fluid output balance accurately.
4a	Calculates and documents the total fluid balance accurately.
4b	Denotes negative or positive balance accurately.
5	Ensures strike-through errors retain legibility.
6	Prints and signs name on the chart.

Red flag:

	Candidate miscalculates the total fluid balance, denoting incorrect negative or positive balance.

In-hospital resuscitation (IHR) marking criteria

Assessment criteria	
1	Ensures personal safety (safe environment).
2	Checks the person for a response: shakes shoulders, asks ‘Are you alright?’
3	Shouts for help when the person does not respond (if not done already).
4	Turns the person onto their back.
5	Opens airway and looks for any sign of obstruction.
6	Opens the airway using head tilt and chin lift (jaw-thrust if risk of cervical spine injury).
7	Establishes absence of breathing normally – for up to 10 seconds. • looks for chest movement • listens at the mouth for breathing • feels for air on their cheek • checks for carotid pulse (can be done at the same time as listening for breath).
8	Establishes no signs of life and calls 2222. Ensures resuscitation team are called and resuscitation equipment requested (if alone, leaves the person to get help and equipment).
9	Starts chest compressions: • lower half of sternum • heel of one hand on top of the other • no pressure on the rib, abdomen and lower sternum • arms straight.
10	Performs effective chest compressions: • Compression depth 5–6cm • Rate 100–120 compressions per minute.
11	After 30 chest compressions, completes 2 ventilations: • head tilt • gives ventilation while watching the chest rise over about 1 second (using a bag-valve mask) • pauses, watching for the chest to fall • gives a second ventilation • the two ventilations should take no more than 5 seconds.
12	Recommences chest compressions and continues resuscitation with correct compression: ventilation ratio 30:2.

13	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Red flag:

	An automatic fail should be applied if: • *the candidate does not call for help* • *the candidate is unable to demonstrate effective cardiopulmonary resuscitation (CPR).* *This should include inadequate airway support, or ineffective breaths or chest compressions.*

Intramuscular injection (IM) marking criteria

	Assessment criteria
1	Explains and discusses the procedure with the person.
2	Before administering any prescribed drug, looks at the person's prescription chart and correctly checks **ALL** of the following: Correct: • person (checks ID with person: verbally, against wristband (where appropriate) and documentation), • drug • dose • date and time of administration • route and method of administration • diluent (as appropriate). • Any allergies.
3	Correctly checks **ALL** of the following: • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
4	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
5	Assembles equipment required and prepares medication.
6	Dons a disposable plastic apron. Closes the curtains/door and assists the person into the required position. Removes the appropriate garment to expose injection site.
7	Assesses the injection site for signs of inflammation, oedema, infection and skin lesions.
8	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines. Dons non-sterile gloves.
9	Cleans the injection site with a swab saturated with isopropyl alcohol 70% for 30 seconds and allows to dry for 30 seconds.
10	Stretches the skin around the injection site.
11	Inserts the needle at an angle of 90° into the skin until about 1cm of the needle is left showing.

12	Depresses the plunger at approximately 1ml every 10 seconds and injects the drug slowly. (ONLY if using dorsogluteal muscles: pulls back on the plunger to check for blood aspiration.)
13	Waits 10 seconds before withdrawing the needle.
14	Withdraws the needle rapidly. Applies gentle pressure to any bleeding point but does not massage the site.
15	Applies a small plaster over the puncture site.
16	Ensures that all sharps and non-sharp waste are disposed of safely (including scooping method of re-sheathing and transportation of sharps) and in accordance with locally approved procedures.
17	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
18	Dates and signs drug documentation (prompt permitted).
19	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Red flag:

	Safety of administration of medication. *This should include checking the prescription against the patient, and checking right dose/right time/right patient/right route/right drug.* *The chart should be timed and signed.* *If any of the above is missed, this should result in a fail for this station.*

Intravenous (IV) flush and visual infusion phlebitis (VIP) assessment marking criteria

Assessment criteria	
1	Checks that all the equipment required for the procedure is available and, where applicable, is sterile (i.e. that packaging is undamaged, intact and dry; that sterility indicators are present on any sterilised items and have changed colour where applicable).
2	Assesses the cannula, identifies and verbalises signs of phlebitis: colour, pain, erythema, oedema, venous cord, pyrexia.
3	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
4	States that the tray or trolley has been cleaned with detergent wipes (or equivalent) and places all the equipment required for the procedure on the bottom shelf of the clean dressing trolley (or suitable equivalent).
5	Dons a disposable plastic apron.
6	Takes the equipment to the person's bedside in tray or trolley.
7	Gains consent and explains the procedure to the patient.
8	Before administering any prescribed drug, looks at the person's prescription chart and correctly checks ALL of the following: Correct: • person (checks ID with person: verbally, against wristband (where appropriate) and documentation), • drug • dose • date and time of administration • route and method of administration • diluent (as appropriate). • Any allergies.
9	Correctly checks ALL of the following**:** • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
10	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, and dons non-sterile gloves.

11	Cleanses the end of the IV port with sterile alcohol wipes saturated with 70% isopropyl alcohol for 30 seconds, leaving to dry for more than 30 seconds.
12	Connects the prefilled syringe to the port using aseptic non-touch technique and flushes cannula using a pulsating action.
13	Asks the patient whether any discomfort is experienced while flushing.
14	Disposes of waste appropriately – verbalisation accepted.
15	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
16	Dates and signs drug administration record (prompt permitted) – verbalisation accepted.
17	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Red flags:

	If the candidate fails to administer the medication correctly. *They must check the following:* • *Right patient/dose/time/route/drug.* *They must also sign, date and time the prescription.* *If any of the above is missed, this should result in a fail.*
	If candidate does not use aseptic non-touch technique for the procedure/contaminates the sterile areas, this should result in a fail.

Mid-stream specimen of urine (MSU) and urinalysis marking criteria

Assessment criteria	
1	Discusses the procedure with the person and gains consent.
2	Explains to the person how to perform MSU (women to part labia and clean meatus with soap and water from front to back, men to retract foreskin and clean around meatus.) Urinate a small amount and then stop flow of urine. Hold the specimen pot a few centimetres away from urethra and urinate until cup is approximately half full.
3	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
4	Checks that all the equipment required for the procedure is available and, where applicable, is sterile (i.e. that packaging is undamaged, intact and dry; that sterility indicators are present on any sterilised items and have changed colour where applicable).
5	Gives person clean specimen pot. (Assessor then hands sample to candidate.)
6	Dons a disposable plastic apron and non-sterile gloves.
7	Dips reagent strip into the urine for no longer than 1 second.
8	Holds strip at an angle at the edge of the container.
9	Waits the required time before reading the strip against the colour chart – verbalisation accepted.
10	Disposes of equipment appropriately – verbalisation accepted.
11	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
12	Identifies the possible significance of the findings, provides appropriate health information to the person according to results, and informs of actions to be taken next.
13	Accurately documents readings according to reagent strip.
14	Acts professionally throughout the procedure in accordance with NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’.

Red flag:

	Failure to demonstrate ability to read urinalysis strip or record the results accurately correctly should receive a fail.

Pain assessment marking criteria

Assessment criteria	
1	Introduces self and explains the assessment to be carried out and the rationale and importance of this.
2	Gains consent from the patient. Identifies the patient by checking name/date of birth or ID.
3	Considers the following aspects of pain:
3a	P = provokes Where is the pain? (point to area) What causes the pain? What makes it better? What makes it worse?
3b	Q = quality What does the pain feel like? Is it dull, sharp, stabbing, burning, crushing, shooting, throbbing? Is the pain intense?
3c	R = radiating Where is it? Is it in one place? Does it move around? Did it start somewhere else?
3d	S = severity How bad is it? Uses the universal pain scale to ascertain severity.
3e	T = time When did the pain start? How long has it lasted? Is it constant? Does it come and go? Is it sudden or gradual?
4	Acknowledges that the patient is in discomfort, and offers to make them more comfortable by repositioning.
5	Asks patient whether they have had any analgesia, and states will arrange for suitable analgesia.
6	Identifies the need to communicate with multidisciplinary team/doctor.
7	Identifies the need for regular reassessment.
8	Indicates the need to document findings accurately and clearly in the patient notes/charts.
9	Reassures the patient.
10	Acts professionally throughout the procedure in accordance with NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’.

Peak expiratory flow rate (PEFR) marking criteria

Assessment criteria	
1	Explains the procedure to the person and obtains their consent.
2	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
3	Assembles equipment.
4	Asks and assists the person to sit in an upright position.
5	Inserts a disposable mouthpiece into the peak flow meter.
6	Ensures needle on the gauge is pushed down to zero.
7	Asks the person to hold the peak flow meter horizontally, ensuring their fingers do not impede the gauge.
8	Asks the person to take a deep breath in through their mouth to full inspiration.
9	Asks the person to immediately place their lips tightly around the mouthpiece, obtaining a tight seal.
10	Asks the person to blow out through the meter in a short sharp ‘huff’ as forcefully as they can.
11	Takes a note of the reading and returns the needle on the gauge to zero. Asks the person to take a moment to rest and then to repeat the procedure twice, noting the reading each time.
12	Accurately documents the highest of the three acceptable readings.
13	Disposes of equipment appropriately – verbalisation accepted.
14	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
15	Acts professionally throughout the procedure in accordance with NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’.

Red flag:

	Candidate is unable to conduct the correct procedure for PEFR, for example advising incorrect positioning/technique to the patient, or not recording the correct reading.

Pressure area assessment marking criteria

	Assessment criteria
1	Identifies the most vulnerable areas of pressure risk. (Formal anatomical or plain English terminology accepted): • heels • sacrum • ischial tuberosities (buttocks) • elbows • temporal region of the skull • shoulders • femoral trochanters (hips) • back of head • toes • ears • spine. To achieve full marks, the candidate needs to identify a minimum of 8 areas, and for partial marks, a minimum of 5 areas.
2	Identifies signs that may indicate pressure ulcer development: • persistent erythema (flushing of the skin) • non blanching hyperaemia (discolouration of the skin that does not change when pressed) • blisters • discoloration • localised heat • localised oedema • localised indurations (abnormal hardening) • purplish/bluish localised areas • localised coolness if tissue death has occurred. To achieve full marks the candidate needs to identify a minimum of 7 areas, and for partial marks, a minimum of 4 areas.
3	Completes the Braden tool accurately, and correctly calculates the risk score based on the patient scenario and pressure damage identified.
4	Documents findings accurately, clearly and legibly.

Red flag:

	Failure to recognise damage OR miscalculates the score, resulting in no action. Either of these should result in a fail for this station.

Removal of urinary catheter (RUC) marking criteria

	Assessment criteria
1	Explains procedure to the person and informs them of potential post-catheter symptoms (urgency, frequency and discomfort) often caused by irritation of the urethra.
2	Assembles equipment required.
3	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
4	Dons a disposable plastic apron and non-sterile gloves.
5	Having checked volume of water in balloon (see patient documentation), uses syringe to deflate balloon.
6	Asks person to breathe in and then out; as person exhales, gently but firmly with continuous traction, removes catheter.
7	Cleans and dries area around the genitalia and makes the person comfortable.
8	Encourages person to exercise and to drink 2–5 litres of fluid per day.
9	Disposes of equipment including apron and gloves appropriately – verbalisation accepted.
10	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
11	Asks the patient to inform the nurse when they pass urine – verbalisation accepted.
12	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Red flag:

	If the candidate does not deflate the balloon prior to removal, this should result in a fail for this station.

Subcutaneous injection marking criteria

Assessment criteria	
1	Explains and discusses the procedure with the person.
2	Before administering any prescribed drug, looks at the person's prescription chart and correctly checks ALL of the following: Correct: • person (checks ID with person: verbally, against wristband (where appropriate) and documentation) • drug • dose • date and time of administration • route and method of administration • diluent (as appropriate). • Any allergies.
3	Correctly checks ALL of the following: • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
4	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines. Dons a disposable plastic apron.
5	Assembles equipment required and prepares medication using non-touch technique.
6	Closes the curtains/door and assists the person into the required position. Removes the appropriate garment to expose injection site.
7	Assesses the injection site for signs of inflammation, oedema, infection and skin lesions.
8	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels. Dons non-sterile gloves.
9	Removes the needle used for drawing. Gently pinches the skin to select the correct needle size (this is commonly 25G needle).
10	Cleans the injection site with a swab saturated with isopropyl alcohol 70% for 30 seconds, and allows to dry for 30 seconds.
11	Removes the needle sheath.
12	Gently pinches the skin into a fold.

13	Holds the needle between thumb and forefinger of dominant hand as if grasping a dart.
14	Inserts the needle into the skin at an angle of 90° (necessary for administering insulin) and releases the grasped skin. (An angle of 45° is permitted if the candidate considers the person to have less subcutaneous tissue present.)
15	Injects the drug slowly over 10–30 seconds.
16	Withdraws the needle rapidly and applies gentle pressure with sterile gauze. Does not massage the area.
17	Ensures that all sharps and non-sharp waste are disposed of safely (including scooping method of re-sheathing and transportation of sharps) and in accordance with locally approved procedures.
18	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
19	Signs and dates drug administration record (prompt permitted).
20	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Red flags:

	Safety of administration of medication. *Administration should include the following essential criteria:* *right patient/right route/right drug/right time/right dose.* *The drug chart should be signed, timed and dated.* *If any of the above is missed, it should result in an automatic fail.*
	Incorrect injection technique. Either failure to deliver at 45° angle or not pinching the skin.

Professional values stations

Confidentiality marking criteria

	Assessment criteria
1	Outlines and provides reassurance to the patient of professional responsibility to respect patient's right to privacy and confidentiality in all aspects of care, but outlines the need to act with honesty and integrity at all times (duty of candour).
2	Explores the patient's reasons for withholding diagnosis and prognosis from partner.
3	Offers support and time to facilitate discussion between patient and partner, respecting patient's decision, linked to duty of candour and confidentiality.
4	Documents the patient's wishes regarding the diagnosis and information sharing.
5	Acknowledges the partner's concerns and feelings, acting with care and compassion, but explains the need to respect the patient's right to privacy and confidentiality in all aspects of care.
6	Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety, and promote professionalism and trust.
7	Handwriting is clear and legible.

Drug error marking criteria

Assessment criteria	
1	Recognises the possible consequence of error and the importance of patient safety, and takes measures to reduce the effects of harm.
2	Checks the stability of the patient by taking observations, informs the nurse in charge and medical team of the event, and seeks advice.
3	Recognises the importance of disclosing the occurrence to the patient and apologise, reflecting duty of candour.
4	Documents events, actions and consequences in the patient's records, and completes an incident report.
5	Demonstrates the importance of reflection, explores the sequence of events and factors that may have influenced the occurrence, recognises the learning opportunity, and identifies the need to revisit drug administration procedure.
6	Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety, and promote professionalism and trust.
7	Handwriting is clear and legible.

Possible abuse marking criteria

Assessment criteria	
1	Acknowledges the need to escalate concern regarding safeguarding without patient consent, reflecting duty of candour.
2	Communicates with compassion and empathy in language appropriate to the patient.
3	Identifies the need to act without delay as there is a risk to patient safety, and to raise concern at the first reasonable opportunity.
4	Raises concern with manager or local authority safeguarding lead, in accordance with the safeguarding policy. Recognises the need to be clear, honest and objective about the reasons for concern.
5	Makes a clear written record of the concern (including a body map) and the steps taken to deal with the matter, including the date and with whom the concern was raised.
6	Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety and promote professionalism and trust.
7	Handwriting is clear and legible.

Professional confrontation marking criteria

Assessment criteria	
1	Recognises the importance of allowing the person to talk and vent frustration, showing interest in what the person says. Identifies the crux of the problem as quickly as possible. Empathises with the person and offers assistance.
2	Recognises the importance of: • establishing rapport • use of appropriate eye contact (not staring) • maintaining body language and open posture throughout. Identifies the need to remain calm using appropriate tone and pace of voice (not mirroring anger).
3	Offers an explanation of the circumstance and offers an apology as early as possible, where appropriate.
4	Documents the incident. Offers to refer to senior staff member and/or the complaints procedure as a sign of respect and of taking the circumstance seriously.
5	Takes account of own personal safety and ensures that a witness is present.
6	Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety, and promote professionalism and trust.
7	Handwriting is clear and legible.

Social media marking criteria

Assessment criteria	
1	Recognises that sharing confidential information and posting pictures of patients and people receiving care without their consent is inappropriate.
2	Recognises professional duty to report any concerns about the safety of people in their care or the public, and that failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
3	States that acknowledging someone else's post (sharing/reacting/commenting) can imply the endorsement or support of that point of view.
4	Raises concern with manager at the most reasonable opportunity, verbally or in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
5	Completes an incident report, recording the events, the steps taken to deal with the matter, including the date and with whom the concern was raised.
6	Acknowledges the need to keep to and uphold the standards and values set out in 'The Code': prioritise people, practise effectively, preserve safety, and promote professionalism and trust.
7	Handwriting is clear and legible.

Evidence-based practice stations

Diabetes marking criteria

Assessment criteria	
1	Summarises the main findings from the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Informs the patient that she is less likely to suffer with hypoglycaemia as she is not prescribed insulin. However, hypoglycaemia remains a serious concern and she should be vigilant to monitor her blood glucose levels and to recognise the signs and symptoms of hypoglycaemia.
1c	Advises the patient that hypoglycaemic episodes are often caused by diet-related factors, such as missing a meal or not eating enough carbohydrates. Emphasises the importance of eating regular meals, and discusses the daily recommended amount of carbohydrates.
1d	Advises the patient to observe for excessive sweating, feeling faint, light-headed, blurred vision, new confusion and/or nausea, and to call 999 if she experiences any of these symptoms.
1e	Advises the patient to inform friends and family that, if she appears confused or loses consciousness, she may be having a hypoglycaemic episode and will need emergency medical help by calling 999.
1f	Informs the patient that an episode of acute illness may cause irregularities in blood glucose, so she will need to monitor her blood sugars more frequently and report any changes.

Female myocardial infarction (MI) marking criteria

Assessment criteria	
1	Summarises the main findings from the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Recognises that the importance of early and correct recognition of MI symptoms is vital in order to seek medical care promptly for a better outcome.
1c	Informs the patient that, as a female, she may or may not experience chest pain.
1d	Informs the patient that she may experience nausea and back, shoulder, throat/neck, cheek/teeth and arm pain.
1e	Emphasises to the patient that she should report any symptoms whether she considers them to be ‘cardiac’ related or not.
1f	Encourages the patient to call 999 immediately if she experiences any of the above symptoms.

Pressure ulcer prevention marking criteria

Assessment criteria	
1	Summarises the main findings from the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Informs the patient that a specific foam preventative dressing applied to a person's sacrum has been shown to reduce pressure ulcer development by 10%. However, even with a dressing, he may still develop a pressure ulcer, although it may occur later.
1c	Explains that a very rare side effect of the foam dressing is a mild skin irritation.
1d	Advises the patient that, being male, he may be at more risk of developing a pressure sore.
1e	Explains to the patient that regular skin inspections, regularly changing position, staying well hydrated and maintaining a balanced diet will also help with the prevention of a pressure ulcer.
1f	Informs the patient that there is a foam dressing that may aid in the prevention of a pressure ulcer and that this will be discussed further with the tissue viability team.

Smoking cessation marking criteria

Assessment criteria	
1	Summarises the main findings from the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Informs the patient that replacement therapies have not been found to achieve the same level of satisfaction as smoking. However, e-cigarettes have higher rates of satisfaction compared with nicotine replacement.
1c	Discusses with the patient that studies show that stopping smoking is more likely when using e-cigarettes than nicotine replacement.
1d	Advises that e-cigarettes are more likely to cause throat and mouth irritation, compared with nicotine replacement.
1e	Advises that nicotine replacement therapies are more likely to cause nausea.
1f	Emphasises that, without face-to-face support, there is low efficacy for both treatments, and recommends that the patient use a smoking cessation support service, signposting them to the local service.
1g	Positively acknowledges the consideration of giving up smoking by offering support and encouragement.

Use of honey dressing for venous leg ulcers marking criteria

Assessment criteria	
1	Summarises the main findings from the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Informs the patient that there is currently no conclusive evidence indicating that medical-grade honey improves outcomes for patients with chronic venous leg ulcers.
1c	Informs the patient that one large study found no reduction in size of ulcer or healing time with honey compared with standard treatment.
1d	Advises that, in the same study, patients reported an increased rate of pain.
1e	Advises that another study suggests that honey may have anti-microbial properties and may help patients with chronic venous leg ulcers who have a methicillin-resistant *Staphylococcus aureus* (MRSA) infection. However, this was a very small study, and more research is required on the subject.
1f	Informs the patient that there is no evidence that medical-grade honey is cost-effective in the treatment of chronic venous leg ulcers.
1g	Recommends that, until further robust research is conducted and the efficacy of honey to treat chronic venous leg ulcers is established, the dressing of the wound should be based on current evidence-based trust protocol.

Unit 109 Albert Mill
10 Hulme Hall Road
Castlefield
Manchester
M15 4LY

www.alphaplus.co.uk

+44 (0) 161 249 9249