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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 Nursing Associate' document.

As part of continuous improvement of the assessment and in response to changes in clinical best practice, the marking criteria for a specific OSCE station can be subject to change, so that the information presented in this document should be treated as indicative. Candidates must be confident in performing the skills required by the NMC and should not attempt to memorise or rote learn the marking criteria as these are subject to periodic change.

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 nursing associate entering the register.

For each station, a red flag can be applied if a candidate makes an action which would cause harm to a patient.

AIE stations

All AIEs – Assessment station

Assessment criteria	
1	Assesses the safety of the scene and 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 WHO guidelines.
3	Introduces self to person.
4	Checks ID with person (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. Consent needs to be documented in the patient notes.
7	Uses a calm voice, speech is clear, body language is open, and personal space is appropriate.
8	Conducts an A to E assessment **(please refer to the examiner's guidance for specific scenarios)** – verbalisation accepted:
8a	**Airway:** • clear • no visual obstructions.
8b	**Breathing:** • respiratory rate • rhythm • depth • oxygen saturation level • respiratory noises (rattle, wheeze, stridor, coughing) • 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 • 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 completes documentation accurately.
10	Calculates national early warning score accurately.
11	Accurately completes document: signs, dates and adds time (when appropriate) 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'.

All AIEs – Implementation station

	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 person.
3	Seeks consent from person or carer prior to administering medication.
4	Checks allergies on chart and confirms with the person in their care, and also notes red ID wristband (where appropriate).
5	Before administering any prescribed drug (including oxygen), looks at the person's prescription chart and correctly verbalises ALL of the following checks: • person (checks ID with person verbally and against documentation) • drug • dose • date and time of administration • route and method of administration • diluent (as appropriate) • any allergies.
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 candidate 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 candidate reason for non-administration if not verbalised).
11	Accurately documents drug administration and non-administration.
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'.

All AIEs – Evaluation station

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 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 concern,
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

	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 (including oxygen), looks at the person's prescription chart and correctly verbalises **ALL** of the following checks: • 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.
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 to 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 grasp spacer mouthpiece with teeth and lips while holding inhaler, ensuring that lips form a seal.
9	Asks the person to tip head back slightly, and to inhale slowly and deeply through the mouth while depressing the canister fully.
10	Instructs the person to use single-breath technique to breathe in slowly for 2 to 3 seconds and hold their breath for approximately 10 seconds, then remove the MDI from mouth before exhaling slowly through pursed lips **OR** If the person can't hold their breath for more than 5 seconds, instructs the person to use 'tidal breathing' or 'multi-breath technique', breathing in and out steadily five times.
11	Ensures that the drug is administered as prescribed.
12	Instructs the person to wait 30 to 60 seconds between inhalations (if same medication) or 2 to 3 minutes between inhalations (if different medication). 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.
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'.

Blood glucose monitoring

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 a blood sample from the side of the finger, ensuring that the site of the 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	Verbalises giving 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’.

Catheter specimen of urine (CSU)

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, checks the expiratory 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 the needle. If using needleless 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 the syringe.
9	Transfers an adequate volume of the urine specimen (approximately 10 ml) into a sterile container immediately.
10	Discards the 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 check that the container label is correct and to 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'.

Fluid balance

	Assessment criteria
1	Handwriting is clear and legible.
2a	Accurately transposes the information onto the fluid balance chart.
2	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 (when required).

Gaining informed consent

Assessment criteria	
1	The candidate needs to demonstrate an understanding of consent. For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision.
2	Assesses that the person has **capacity** – the person must be capable of giving consent, which means that they understand the information given to them and can use it to make an informed decision.
3	Explains and discusses the procedure with the person. This means that they are **informed** – the person must be given all the information about what the procedure involves, including the benefits and risks, whether there are reasonable alternative procedures, and what will happen if the procedure does not go ahead.
4	Ensures that the consent is **voluntary** – the decision to consent or not to consent to treatment must be made by the person and must not be influenced by pressure from medical staff, friends, or family.
5	Accepts/recognises one of the following types of consent required from the patient/person: Verbal – for example, a person saying that they are happy to have a blood test. Non-verbal – for example, holding out an arm for a blood cuff to be placed on it.
6	Ensures that the agreed type of informed consent is gained and is documented before any action is carried out.
7	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standard of practice and behaviour for nurses, midwives, and nursing associates'.

Hospital admission

	Assessment criteria
1	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
2	Explains the admission process to be carried out.
3	Conducts a holistic assessment relevant to the patient's scenario.
4	Acknowledges the patient's concerns.
5	Uses a calm voice, speech is clear, body language is open, and personal space is appropriate.
6	Clearly and legibly handwrites notes.
7	Accurately completes admission document, including adding signature, date/s and time/s to the documentation.
8	Reassures the patient.
9	Indicates the need to store document securely – prompt permitted.
10	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standard of practice and behaviour for nurses, midwives, and nursing associates'.

Oxygen therapy

	Assessment criteria
1	Explains the procedure to the person and discusses it with them.
2	Before administering any prescribed drug (including oxygen), looks at the person's prescription chart and correctly verbalises **ALL** of the following checks: • 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	Identifies/selects the correct equipment (reservoir mask) and assembles and attaches tubing to the flow meter.
6	Turns the oxygen flow meter on, selecting the correct flow rate of oxygen for the method of delivery (15 litres/minute). Verbalisation accepted which must contain explanation of method of measurement.
7	Demonstrates covering the one-way valve with fingers and verbalise that they would do this until the reservoir bag is fully inflated.
8	Applies the oxygen mask by placing over the patient's nose and mouth, then pulls the elastic strap over the head and adjusts the nose brace and straps on both sides to secure the mask in a position that seals the face but is not too tight.
9	Ensures that the chosen delivery method is comfortable for the patient.
10	States that they will reassess the saturations to check whether they are within the normal target range for the patient (94–98%), escalating if this is not achieved.
11	States that they will inspect the patient's skin regularly around the face, ears and back of head, and provide regular mouth care.
12	Signs, dates and records the flow rate and device on the drug administration record.
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'.

Pain assessment

Assessment criteria	
1	Introduces self and explains the assessment to be carried out and the rationale and importance of this.
2	Uses the universal pain assessment tool provided, alongside the PQRST mnemonic, to assess pain.
2a	P = provokes – Where is the pain? (Point to area.) What causes the pain? What makes it better? What makes it worse?
2b	Q = quality – What does the pain feel like? Is it dull, sharp, stabbing, burning, crushing/shooting/throbbing? Is the pain intense?
2c	R = radiating – Where is it? Is it in one place? Does it move around? Did it start somewhere else?
2d	S = severity – How bad is it? Uses the universal pain scale to ascertain severity.
2e	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?
3	Acknowledges that the patient is in discomfort, and offers to make them more comfortable by repositioning.
4	Asks patient whether they have had any analgesia so far. States will arrange for suitable analgesia.
5	Identifies the need to communicate with the multidisciplinary team/doctor.
6	Identifies the need for regular reassessment.
7	Indicates the need to document findings accurately and clearly in the patient notes/charts.
8	Reassures the patient.
9	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)

	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. Dons non-sterile gloves and apron.
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 or uses a single-use/reusable peak flow meter.
6	Ensures that the needle on the gauge is pushed down to zero.
7	Asks the person to hold the peak flow meter horizontally, ensuring that 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 place their lips tightly around the mouthpiece immediately, 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 the 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'.

Physiological observations

Assessment criteria	
1	Introduces self, explains procedure to the person, 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	**Blood pressure:** • assesses whether the patient has any contraindications to using a particular arm, such as lymphoedema, trauma or surgery, intravenous infusion • provides a relaxed and comfortable environment • ensures that the cuff is the correct size for the arm • ensures that the patient's arm is free from clothing and is supported on a pillow, placed mid-sternal level, legs are uncrossed, feet are flat on the floor, artery marking centred over the brachial artery and superior to the elbow • places the lower edge of the cuff 2cm to 3cm above the brachial artery pulsation • asks the patient to stop talking during the procedure • inflates the cuff on Dinamap.
4	**Pulse:** • places the first and second finger along the appropriate artery • applies light pressure until pulse is felt • counts pulse for 60 seconds • assesses rhythm – verbalisation accepted • assesses strength – verbalisation accepted.
5	**Respirations and pulse oximetry:** • counts respiratory rate for 60 seconds • assesses rhythm – verbalisation accepted • assesses depth – verbalisation accepted • observes for respiratory noises (rattle, wheeze, stridor, coughing) • observes for unequal air entry • observes for visual signs of respiratory distress (use of accessory respiratory muscles, sweating, cyanosis, 'see-saw' breathing) • determines the site to be used to perform the pulse oximetry (warmth and capillary refill) • ensures that the area is clean and that all nail polish and artificial nails have been removed.
6	**Temperature:** • inspects the ear canal • checks the thermometer for damage • verifies the mode setting (ear) • places disposable probe covering on probe tip • aligns the probe tip with the ear canal and gently advances into the ear canal, ensuring a snug fit • presses and releases the scan button.
7	Accurately measure and documents the patient's vital signs, completes documentation – signs, dates, and adds time.

8	Calculates national early warning score accurately.
9	Disposes of equipment 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	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives, and nursing associates'.

Pressure area assessment

	Assessment criteria
1	Completes the Braden tool accurately, and correctly calculates the subscores and overall score based on the patient scenario and pressure damage identified.
2	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. For partial marks, the candidate needs to identify a minimum of 5 areas.
3	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. • Or/and the candidate identifies an aspect of care that is relevant and evidence-based in addition to the list above. To achieve full marks, the candidate needs to identify a minimum of 7 areas. For partial marks, the candidate needs to identify a minimum of 4 areas.
4	Documents findings and answers accurately, clearly and legibly.

Subcutaneous injection

Assessment criteria	
1	Explains and discusses the procedure with the person.
2	Before administering any prescribed drug (including oxygen), looks at the person's prescription chart and correctly verbalises ALL of the following checks: • 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. Rotates injection sites if having regular injections.
8	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels. Dons non-sterile gloves.
9	States would assess the cleanliness of the injection site. States that if the site is clean there would be no need to clean, however if required would clean with a swab saturated with isopropyl alcohol 70% for 30 seconds and allows to dry for 30 seconds.
10	Removes the needle sheath.
11	Gently pinches the skin into a fold.
12	Holds the needle between thumb and forefinger of dominant hand as if grasping a dart.
13	Inserts the needle into the skin at an angle of 90° (necessary for administering insulin) with the skin remaining pinched (An angle of 45° is permitted if the candidate considers the person to have less subcutaneous tissue present or if administering medication other than insulin.)
14	Injects the medicine slowly over 10 to 30 seconds.
15	Withdraws the needle rapidly, releases the pinched skin, and applies gentle pressure with sterile gauze. Does not massage the area.
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	Signs and dates medicines administration record.

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'.

Professional issues and behaviours stations

Confidentiality

Assessment criteria	
1	Listens to people and responds to their preferences and concerns, maintaining the professional responsibility to respect a patient's right to privacy and confidentiality in all aspects of care, but outlining 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 the patient's decision, linked to the 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

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 apologising, reflecting the 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

Assessment criteria	
1	Acknowledges the need to escalate the safeguarding concern without patient consent, reflecting the duty of candour.
2	Communicates with compassion and empathy in language appropriate to the patient.
3	Identifies the need to act without delay given the risk to patient safety, and to raise the 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

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); and • 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 a 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

Assessment criteria	
1	Recognises that sharing confidential information and posting pictures of patients and people receiving care without their consent is inappropriate.
2	Recognises the 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 a 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

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, both 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 or 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)

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 early and correct recognition of MI symptoms is vital in order to seek medical care promptly and secure 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.

Honey dressing

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 who have chronic venous leg ulcers.
1c	Informs the patient that one large study found no reduction in size of ulcer or healing time with honey as compared with standard treatment.
1d	Advises that, in the same study, patients reported an increased level 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.

Pressure ulcer prevention

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, a pressure ulcer may still develop, 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

Assessment criteria	
1	Summarises the main findings of 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.

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