Mental Health Nursing

Marking Criteria

Contents

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Important Information

This *'Mental Health Nursing Marking Criteria'* document is intended to provide candidates with additional preparation information to help 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 *'OSCE Top Tips Mental Health Nursing'* document.

Examination Process

Each station is marked against unique criteria matched to the skill being assessed. Within each stations 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 NMC register.

Assessment Marking Criteria: All scenarios

	Assessment Criteria
1	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
2	May verbalise or make environment safe
3	Introduce self to person
4	Check ID with person (person's name is essential and either their date of birth or hospital number) : verbally, against wristband (where appropriate) and paperwork
5	Gain consent
6	Explain the reason for assessment
7	Use SOLER throughout the assessment;
7a	Sitting at a comfortable angle and distance
7b	Open posture. Arms and legs uncrossed
7c	Leaning forward from time to time, looking genuinely interested, listening attentively
7d	Effective eye contact without staring
7e	Remaining relatively relaxed
8	Use appropriate questioning skills
9	Builds trust and rapport
10	Uses brief verbal and non-verbal affirmations
11	Uses reflection/paraphrasing to demonstrate concern
12	Accurately documents assessment tool score (PHQ9, MOCA etc)
13	Discusses the outcome of the assessment tool including clinical response/recommendation
14	Close assessment appropriately and may check findings with person

Planning Marking Criteria: All scenarios

Assessment Criteria	
1	Handwriting is clear and legible for problems one and two
2	Identify two relevant nursing problems / needs
3	Identify aims for both problems
4	Set appropriate evaluation date for both problems
5	Ensure nursing interventions are current / relate to EBP / best practice
6	Self-care opportunities identified and relevant
7	Professional terminology used in care planning
8	Confusing abbreviations avoided
9	Ensure strike-through errors retain legibility
10	Print, sign and date

Implementation Marking Criteria: All scenarios

Assessment Criteria	
1	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
2	Introduce self to person
3	Seek consent prior to administering medication
4	Check ID with person; verbally, against wristband (where appropriate) and paperwork
5	May refer to previous assessment results
6	Must check allergies on chart and confirm with the person in their care, also note red ID wristband
7	Before administering any prescribed drug, look at the person's prescription chart and check the following are correct: • Person • Drug • Dose • Date and time of administration • Route and method for administration Ensures: • Validity of prescription • Signature of prescriber • Prescription is legible
8	Identify and administer drugs due for administration correctly and safely
9	Provide a correct explanation of what each drug being administered is for to the person in their care
10	Omit drugs not to be administered and provides verbal rationale
11	Accurately record drug administration and non-administration

Evaluation Marking Criteria: All scenarios

Assessment Criteria	
1	Clearly describe reason for initial admission and diagnosis/referral
2	Record date of admission/original assessment
3	Identify main nursing needs
4	Record approaches and interventions used
5	Outline current ability to self-care based on the person's care plan
6	List areas identified for health education/risks identified related to the persons mental health
7	Documents allergies
8	Ensure strike-through errors retain legibility
9	Print, sign and date

Aseptic Non-Touch Technique (ANTT) Marking Criteria

	Assessment Criteria
1	Check 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 sterilized items and have changed colour where applicable)
2	Explain and discuss the procedure with the person
3	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
4	Clean trolley with detergent wipes (or equivalent)
5	Place all the equipment required for the procedure on the bottom shelf of the clean dressing trolley (or suitable equivalent)
6	Put on a disposable plastic apron
7	Take the trolley to the person's bedside disturbing the curtains as little as possible
8	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
9	Open the outer cover of the sterile pack and, once you have verified that the pack is the correct way up, slide the contents, without touching them, onto the top shelf of the trolley (or suitable equivalent)
10	Open the sterile field using only the corners of the paper
11	Open any other packs, tipping their contents gently onto the centre of the sterile field
12	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
13	Carry out and complete the relevant procedure using ANTT
14	Dispose of waste appropriately - verbalisation accepted
15	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels

In-Hospital Resuscitation (without defibrillation) Marking Criteria

Assessment Criteria	
1	Ensure personal safety (safe environment)
2	Check the person for a response
3	Shouts for help when the person does not respond (if not already done)
4	Turn the person on to their back
5	Open the airway using head tilt and chin lift (jaw-thrust if risk of cervical spine injury)
6	Keeping the airway open, look, listen, and feel - to determine if the person is breathing normally (less than 10 seconds)
7	May check for carotid pulse at the same time
8	Ensure resuscitation team are called and resuscitation equipment requested (if alone leaves the person to get help and equipment)
9	Commence CPR with ratio of compressions to ventilations of 30:2
10	Uses correct hand position - middle of the lower half of sternum
11	Compression depth of 5-6cm
12	Compression rate of 100-120 compressions per minute
13	Allow the chest to recoil completely after each compression
14	Minimise any interruptions to chest compressions (hands-off time)
15	Use bag-valve mask (ambu-bag / self-inflating bag-mask) to produce a visible rise of the chest wall
16	Avoid rapid or forceful breaths

Intramuscular Injection (IM) Marking Criteria

	Assessment Criteria
1	Explain and discuss the procedure with the person
2	Before administering any prescribed drug, look at the person's prescription chart and check the following: Correct: • Person • Drug • Dose • Date and time administration • Route and method of administration • Diluent (as appropriate)
3	*Ensures:* • Validity of prescription • Signature of prescriber • Prescription is legible If any of these pieces of information are missing, are unclear or illegible then the nurse should not proceed with administration and should consult the prescriber
4	Prepare medication
5	Don apron and close the curtains / door and assist the person into the required position and wash hands
6	Remove the appropriate garment to expose injection site
7	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels and assess the injection site for signs of inflammation, oedema, infection and skin lesions
8	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels, and apply non-sterile gloves
9	Clean the injection site with a swab saturated with isopropyl alcohol 70% for 30 seconds and allow to dry for 30 seconds
10	Stretch the skin around the injection site
11	Insert the needle at an angle of 90° into the skin until about 1cm of the needle is left showing
12	Pull back on the plunger. If no blood is aspirated, depress the plunger at approximately 1ml every 10 seconds and inject the drug slowly
13	Wait 10 seconds before withdrawing the needle
14	Withdraw the needle rapidly. Apply gentle pressure to any bleeding point but do not massage the site
15	Apply a small plaster over the puncture site
16	Ensure 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
17	Date and sign drug administration record - verbalisation accepted

Physical Observations Marking Criteria

Assessment Criteria	
1	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
2	May verbalise or make environment safe
3	Introduce self to person
4	Check ID with person: verbally, against wristband (where appropriate) and paperwork
5	Gain consent
6	Sit / stand at an appropriate level and explain the reason for assessment
7	Establish reason for admission
8	Measures and documents observations accurately
9	Verbal communication is clear and appropriate
10	Close assessment appropriately and may check findings with person

Subcutaneous Injection Marking Criteria

Assessment Criteria	
1	Explain and discuss the procedure with the person
2	Before administering any prescribed drug, look at the person's prescription chart and check the following: Correct: • Person • Drug • Dose • Date and time of administration • Route and method of administration • Diluent (as appropriate)
3	*Ensures:* • Validity of prescription • Signature of prescriber • Prescription is legible If any of these pieces of information are missing, are unclear or illegible then the nurse should not proceed with administration and should consult the prescriber
4	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
5	Prepare medication
6	Don apron
7	Assess the injection site for signs of inflammation, oedema, infection and skin lesions
8	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels and apply non-sterile gloves
9	Pinch the skin and select the correct needle size (this is commonly 25G needle)
10	Where appropriate clean the injection site with a swab saturated with isopropyl alcohol 70%
11	Remove the needle sheath
12	Gently pinch the skin into a fold
13	Hold the needle between thumb and forefinger of dominant hand as if grasping a dart
14	Insert the needle into the skin at an angle of 45° and release the grasped skin (unless administering insulin when an angle of 90° should be used). Inject the drug slowly over 10-30 seconds
15	Withdraw the needle rapidly and apply gentle pressure with sterile gauze. Do not massage the area.
16	Ensure that all sharps and non-sharp waste are disposed of safely (including scooping method of re-sheathing is used) and in accordance with locally approved procedures - verbalisation accepted
17	Sign and date drug administration record - verbalisation accepted