AlphaPlus

NMC Nursing & Midwifery Council | Test of Competence

Test of Competence 2021: Marking Criteria Children's 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 Children’s 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	Assess the safety of the scene and privacy and dignity of the child/infant and parent.
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 infant/child and parent.
4	Checks identity (ID) with carer and/or child (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.
6	Gains consent and explains reason for the assessment.
7	Uses a calm voice, speech is clear, body language is open, and personal space is appropriate.
8	Conducts an A–E assessment (please refer to examiner guidance for specific scenarios) – verbalisation allowed:
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 paediatric early warning score accurately.
11	Accurately completes document: signs, and 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 family/child-centred care problems/needs.
3	Identifies aims for both problems.
4	Sets appropriate evaluation date for both problems.
5	Ensures that nursing and family/child-centred care 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 child and carer.
3	Seeks consent from child 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 child'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).
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 detailing findings from assessment.
Assessment	
3a	States most recent observations, any results from assessments undertaken, and what changes have occurred.
3b	Identifies main nursing family/child-centred care problems/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 confirms that consent has been given by the parent.
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 child 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 inhaler.
7	Shakes inhaler well for 2–5 seconds.
8	With a spacer device: • checks the appropriate size mask for the spacer mouthpiece • inserts metered dose inhaler (MDI) into end of spacer device • asks the child to exhale completely and then a) to grasp the spacer mouthpiece in the mouth, ensuring lips form a seal OR b) positions the mask over the child's nose and mouth to form a seal, while holding the inhaler.
9	Asks the child to tip head back slightly, inhale slowly and deeply through the mouth while depressing the canister fully.

10	Instructs the child to use ‘single breath technique’: • breathe in slowly for 2–3 seconds • hold breath for approximately 10 seconds • remove the MDI from mouth before exhaling slowly through pursed lips OR Instructs the child to use ‘tidal breathing’ or ‘multi breath technique’ if they cannot hold their breath for more than 5 seconds: • breathe in and out steadily five times.
11	Ensures the drug is administered as prescribed.
12	Instructs the child to wait 30–60 seconds between inhalations (if same medication) or 2–3 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.
15	Dates and signs the 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* • *then signs the chart.* *If any of this is missed, it should result in a fail.*

Basic life support (BLS) marking criteria

Assessment criteria	
1	Ensures personal safety (safe environment).
2	Checks the child or infant for a response, age appropriate.
3	Shouts for help when the child or infant does not respond (if not already done).
4	Turns the child or infant onto their back.
5	Opens the airway appropriate for the child's age: • infants should be in the neutral position • a child should be in the sniffing position using head tilt. Jaw-thrust should be used if risk of cervical spine injury.
6	Looks for any sign of obstruction and then opens airway.
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.
8	Establishes no signs of life – calls 999 or 2222. Ensures resuscitation team is called and resuscitation equipment requested. (If alone, leaves the person to get help and equipment).
9	Selects correct size of bag valve mask (to cover mouth and nose, and avoid pressure on eyes).
10	Gives five rescue breaths using bag valve mask to produce visible rise of the chest wall. Each breath should be given steadily over 1 second.
11	Ensures that a maximum of five attempts are made at rescue breaths. If any attempt is unsuccessful, the airway should be repositioned.
12	Assesses circulation by checking for signs of life – no more than 10 seconds. May assess a pulse: • child: carotid or femoral. • infant: brachial or femoral. Ensures that the circulation assessment takes no more than 10 seconds.
13	Commences cardiopulmonary resuscitation (CPR) with 15:2 ratio of chest compressions to ventilations.

14	Uses correct hand position for chest compression. In infants: The lone rescuer should compress the sternum with the tips of two fingers. If there are two or more rescuers, use the encircling technique: • place both thumbs flat, side-by-side, on the lower half of the sternum (as above), with the tips pointing towards the infant's head • spread the rest of both hands, with the fingers together, to encircle the lower part of the infant's rib cage with the tips of the fingers supporting the infant's back • press down on the lower sternum with two thumbs to depress it approximately one third of the depth of the infant's chest. In children aged over 1 year: • place the heel of one hand over the lower half of the sternum (as above) • lift the fingers to ensure that pressure is not applied over the child's ribs • position self vertically above the victim's chest and, with arm straight, compress the sternum to depress it by approximately one third of the depth of the chest. In larger children, or for small rescuers, this may be achieved most easily by using both hands with the fingers interlocked.
15	Performs chest compression at least one third of the depth of the chest in an infant, approximately 4cm. In a child, compresses the sternum by at least one third of the depth of the chest, approximately 5 cm.
16	Continues compressions at a rate of 100–120 compressions per minute (with or without verbal prompting).
17	Allows the chest to recoil completely after each compression (with or without verbal prompting).
18	Continues until help arrives or signs of life are shown, such as normal breathing, cough, movement or definite pulse of more than 60 beats per minute.
19	Ask candidate to clarify what they would do if no help arrives or is not available: • Commence basic life support for 1 minute. • In a child, continue for 1 minute then get help. • In an infant, to minimise interruptions in CPR, if possible, take infant with them while summoning help. • In a witnessed sudden collapse, where rescuer is alone and primary cardiac event is suspected, help should be sought immediately.
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 flag:

	If candidate does not demonstrate safe PBLS in the time of this station, this should result in a fail. This includes the following: • *inadequate airway opening* • *failing to call for help or assistance* • *consistent ineffective breaths or compressions* • *too slow or too fast* • *does not administer five rescue breaths.*

Blood glucose monitoring marking criteria

Assessment criteria	
1	Prior to taking equipment to the patient, checks that the strips are in date and have not been exposed to air.
2	Explains and discusses the procedure with the person, and gains consent.
3	Checks for allergies.
4	Cleans own hands with alcohol hand rub, or washes with soap and water and dries with paper towels. Dons non-sterile gloves.
5	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.
6	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.
7	Gives the patient a piece of gauze to stop the bleeding.
8	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 (prompt permitted).
9	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
10	Verbalises whether the result is within normal limits and indicates whether any action is required.
11	Documents the result accurately, clearly and legibly.

Red flag:

	Unable to identify normal limits OR acts appropriate to an abnormal limit.

Fine-bore nasogastric tube insertion marking criteria

Assessment criteria	
1	Introduces self to parent and child. Explains the procedure to be carried out and the rationale for it.
2	Positions the child lying at an angle of >30º. Ensure that the child is secure, warm and comfortably positioned – may be swaddled.
3	Measures the distance on the tube from the child's earlobe to the bridge of nose, plus the distance from earlobe to the bottom of the xiphisternum, taking note of the measurement marks on the tube.
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 dons a disposable plastic apron and non-sterile gloves.
6	Lubricates approximately 5–10cm of the tube with warm water.
7	Ensures that a receiver is placed beneath the end of the tube.
8	Inserts the proximal end of the tube into the nostril and slides backwards and inwards along the floor of the nose to the nasopharynx. Stops if any obstruction found, and tries again in slightly different direction or uses other nostril.
9	Asks the child to start swallowing if they are able to and can understand this instruction, as tube passes down nasopharynx into the oesophagus.
10	Advances the tube through the pharynx as child swallows until the measured indicator on tube reaches the entrance of the nostril.
11	Recognises any signs of distress such as coughing or breathlessness, in which case the tube would be removed immediately.
12	Uses adherent dressing tape to secure the tube to nostril and cheek.
13	Aspirates a small amount of the stomach contents using a syringe of no less than 20ml, confirming the tube is in position by using a 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.
14	Disposes of equipment including apron and gloves appropriately – verbalisation accepted.

15	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
16	Comforts and settles the child as necessary.
17	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).
18	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 a 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.

Peak expiratory flow rate (PEFR) marking criteria

Assessment criteria	
1	Explains the procedure to the child and parent 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 child to sit in an upright position.
5	Inserts a disposable mouthpiece into the peak flow meter.
6	Ensures that the needle on the gauge is pushed down to zero.
7	Asks the child to hold the peak flow meter horizontally, ensuring their fingers do not impede the gauge.
8	Asks the child to take a deep breath in through their mouth to full inspiration.
9	Asks the child to immediately place their lips tightly around the mouthpiece, obtaining a tight seal.
10	Asks the child 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 child to take a moment to rest and then repeat the procedure twice, noting the reading each time.
12	Accurately documents the highest of the three acceptable readings.
13	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
14	Disposes of equipment appropriately – 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’.

Global assessment criteria	
A	Examiner global rating: overall ability of the candidate to take peak expiratory flow rate reading.

Red flag:

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

Removal of urinary catheter (RUC) marking criteria

Assessment criteria	
1	Explains the procedure to the child and family and informs them of potential post-catheter symptoms (urgency, frequency and discomfort) often caused by irritation of the urethra.
2	Assembles the 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 the volume of water in the balloon (see patient documentation), uses syringe to deflate the balloon.
6	Asks the child to breathe in and then out and, as child exhales, gently but firmly with continuous traction removes the catheter.
7	Cleans and dries the area around the genitalia and makes the child comfortable.
8	Encourages the child, and asks the parent to encourage the child, 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.
11	Asks the child and parent to inform the nurse when the child needs to pass urine, so that the first urine output can be measured and recorded – 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 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 child and parents.
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, and dons a disposable plastic apron.
5	Assembles the equipment required and prepares medication using a 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	Use distraction techniques and assistance of parent/caregiver or play specialist.
8	Assesses the injection site for signs of inflammation, oedema, infection and skin lesions. Rotates injection sites if having regular injections.
9	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels. Dons non-sterile gloves.
10	Removes the needle used for drawing. Gently pinches the skin to select the correct needle size (commonly a 25G or 26G needle).
11	Cleans the injection site with a swab saturated with isopropyl alcohol 70% for 30 seconds, and allows to dry for 30 seconds.

12	Removes the needle sheath.
13	Gently pinches the skin into a fold.
14	Holds the needle between thumb and forefinger of dominant hand, as if grasping a dart.
15	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).
16	Injects the drug slowly over 10–30 seconds.
17	Withdraws the needle rapidly and applies gentle pressure with sterile gauze. Does not massage the area.
18	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.
19	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels.
20	Signs and dates the drug administration record (prompt permitted).
21	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 concern and feelings, acting with care and compassion, but explains the need to respect 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 of 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 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 raises 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 an 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, using 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 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 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 they are less likely to suffer with hypoglycaemia as they are not prescribed insulin. However, hypoglycaemia remains a serious concern and there is a need to be vigilant, to monitor 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 any of these symptoms is experienced.
1e	Advises the patient to inform friends and family that, if the patient appears confused or loses consciousness, it may be a hypoglycaemic episode and to seek emergency medical help by calling 999.
1f	Informs the patient that an episode of acute illness may cause irregularities in blood glucose, and so blood sugars need to be monitored more frequently and any changes reported.

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, 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 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 the patient that e-cigarettes are more likely to cause throat and mouth irritation compared with nicotine replacement.
1e	Advises the patient that nicotine replacement therapies are more likely to cause nausea.
1f	Emphasises to the patient that, without face-to-face support, there is low efficacy for both treatments, and recommends using a smoking cessation support service, signposting the local service.
1g	Positively acknowledges the patient's 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.

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