



NMC Nursing &
Midwifery
Council

**Test of
Competence**

Test of Competence 2021: Marking Criteria Mental Health Nursing

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Important information

This document is intended to provide candidates with additional information to help to prepare for the test of competence (Part 2). This document should be read in conjunction with the candidate information booklet, resource list, the mock OSCE and the 'Revised OSCE Top Tips Mental Health 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 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 Organisation (WHO) guidelines.
3	Introduces self to person.
4	Checks identity (ID) with person or carer (person's name is essential and either their date of birth or hospital number) verbally, against wristband (where appropriate) and documentation.
5	Gains consent and explains reason for the assessment.
6	Uses SOLER throughout the assessment: <ul style="list-style-type: none"> • <u>S</u>itting at a comfortable angle and distance • <u>O</u>pen posture. arms and legs uncrossed • <u>L</u>eaning forward from time to time, looking genuinely interested, listening attentively • <u>E</u>ffective eye contact, without staring • <u>R</u>emaining relatively relaxed.
7	Uses appropriate questioning skills (open questions).
8	Builds trust and rapport by demonstrating compassion, taking time, active listening, and taking an interest.
9	Uses brief verbal and non-verbal affirmations.
10	Uses reflection/paraphrasing to demonstrate concern.
11	Conducts a holistic mental health assessment relevant to the patient's scenario using the recovery model of care areas, including patient self-care and non-adherence to prescribed medications.
12	Identifies and discusses any current risk factors, if present.
13	Accurately completes any assessment tools included and accurately calculates and records score, where appropriate.
14	Discusses the assessment findings with the person and closes the assessment appropriately.

15	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
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'.

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 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	<p>Before administering any prescribed drug, looks at the person's prescription chart and correctly checks ALL of the following:</p> <p>Correct:</p> <ul style="list-style-type: none"> • 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	<p>Correctly checks ALL of the following:</p> <ul style="list-style-type: none"> • validity of prescription • signature of prescriber • prescription is legible. <p>If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.</p>
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'.
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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 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'.

Skills stations

De-escalation marking criteria

Assessment criteria	
Identify the importance of the following in the written summary:	
1	Gains consent before entering the room.
2	Considers whether the physical environment is safe for self and person.
3	Introduces self to person.
4	Body language is non-threatening and relaxed.
5	Voice is calm, and tone and volume are low.
6	Speech is clear and kind.
7	Places self at person's eye level or below. Establishes eye contact while avoiding staring.
8	Allows the person time to share their concerns. Shows empathy.
9	Uses open-ended questions.
10	Uses active listening and acknowledges the person's concerns using reflective language and validation.
11	Offers answers to specific questions where able.
12	Repeats content of conversation as needed.
13	Uses distraction technique, using information of the person's interests.
14	Recaps areas discussed prior to ending the intervention.
15	Appropriately ends the intervention.
16	Writes clearly and legibly.

Red flag:

	<i>If the candidate does not assess the area, compromising their own or the patient's physical safety, they should fail this station.</i>
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Physiological observations marking criteria

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	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.
4	Gains consent and explains reason for the assessment.
5	Uses a calm voice, speech is clear, body language is open, and personal space appropriate.
6	Accurately measures and documents the patient's vital signs and specific assessment tools.
7	Calculates National Early Warning Score (NEWS) accurately.
8	Accurately completes documentation: signs, and adds date and time on assessment chart.
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'.

Red flags:

	<i>If the candidate does not document physiological observation readings accurately, this should result in an automatic fail.</i>
	<i>Miscalculation of NEWS score should result in an automatic fail.</i>

Reminiscence marking criteria

Assessment criteria	
1	Introduces self.
2	Checks patients ID by asking name and date of birth.
3	Explains and discusses the intervention with the person.
4	Establishes rapport and uses appropriate eye contact and body language.
5	Chooses more than one of the items available to base discussion around and stimulate senses: <ul style="list-style-type: none"> • toy animals • vanilla essence • marbles • photographs.
5a	Sight: photographs, animals, marbles.
5b	Sound: animal noises, marbles.
5c	Smell: vanilla essence.
5d	Touch: animals, marbles, photographs.
6	Uses active listening and reflective skills to show engagement with the person.
7	Prompts the person sensitively, when appropriate.
8	Allows time for the person to respond to stimulus.
9	Demonstrates the ability to show empathy when emotional responses emerge.
10	Redirects discussion if traumatic or painful memories emerge.
11	Recaps areas discussed prior to ending the session.
12	Appropriately ends the session, thanking the person for sharing.
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'.

Talking therapies marking criteria

Assessment criteria	
1	Introduces self.
2	Checks patient's ID by asking for name and date of birth.
3	Gains consent to continue the visit.
4	Body language is open and relaxed, personal space adequate, voice is calm, and speech is clear.
5	Discusses the reason for referral and the patient health questionnaire (PHQ9) assessment.
6	Listens to and acknowledges the person's feelings using reflective language and validation. Shows empathy, acknowledging person's feelings, compassion, and kindness.
7	<p>Explains the benefits of talking therapy, for example:</p> <ul style="list-style-type: none"> • having time to talk, cry, shout or just think • having someone to listen to how they feel can help • it can be easier talking to a stranger than to relatives or friends • assist to find own answers to problems • an opportunity to look at problems in a different way with someone who will respect you and your opinion in a non-judgmental manner. <p>Overall aim: to help the person to feel better. Talking therapies won't make problems go away, but therapy may make it easier to cope with problems and feel happier.</p>
8	<p>Identifies and clearly explains the most relevant therapeutic interventions with the person. For example:</p> <ul style="list-style-type: none"> • counselling • cognitive behavioural therapy (CBT) • psychotherapy • interpersonal therapy • mindfulness-based therapies.
9	Recommends a specific therapy, giving rationale for choice.
10	Recaps areas discussed prior to ending the visit.
11	Asks the person whether they have any questions, and correctly answers specific questions and provides information as required.
12	Appropriately concludes the visit.

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'.
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Professional values stations

Confidentiality marking criteria

Assessment criteria	
1	Outlines and provides reassurance to the patient of professional responsibility to respect the 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 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 apologises, 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 raising 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: <ul style="list-style-type: none"> • establishing rapport • using 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 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 <i>Staphylococcus aureus</i> (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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