

Adult Nursing Marking Criteria

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Important Information

This '*Adult 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 the '*Revised OSCE Top Tips Adult Nursing*' document.

OSCE assessment

Assessment Process

Each station is marked against unique criteria matched to the skill being assessed. Within each 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 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	Sit / stand at an appropriate level and explain the reason for assessment
7	Establish reason for admission/visit
8	Document and provide a score using assessment tool - date, time and signature of nurse to be included
9	Measures and documents observations accurately
10	May identify risks associated with person's symptoms
11	May identify poor compliance with medication
12	Use Activities of Living model effectively with clear relevant questioning in a timely manner
13	Identify known allergies
14	Deal with health education sensitively
15	Verbal communication is clear and appropriate
16	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 (where appropriate)
7	<p>Before administering any prescribed drug, look at the person's prescription chart and check the following are correct:</p> <ul style="list-style-type: none"> • Person • Drug • Dose • Date and time of administration • Route and method for administration <p>Ensures:</p> <ul style="list-style-type: none"> • Validity of prescription / Community Patient Specific Direction • Signature of prescriber • Prescription / Community Patient Specific Direction is legible
8	If Digoxin is prescribed ensure the pulse rate is checked prior to administration
9	Identify and administer drugs due for administration correctly and safely
10	Provide a correct explanation of what each drug being administered is for to the person in their care
11	Omit drugs not to be administered and provides verbal rationale
12	Accurately record drug administration and non-administration

Evaluation Marking Criteria: All scenarios

Assessment Criteria	
1	Clearly describe reason for initial admission / referral to specialist team and diagnosis
2	Record date of admission / referral to specialist team
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 (if applicable) or the person's current spiritual and family care needs (if applicable)
6	List areas identified for health education (if applicable) or risks associated with the deterioration of the person's condition (if applicable)
7	Document allergies
8	Ensure strike-through errors retain legibility
9	Print, sign and date

Administration of Inhaled Medication (AIM) Marking Criteria

Assessment Criteria	
1	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
2	Explain and discuss the procedure with the person
3	Sit the person in an upright position
4	<p>Before administering any prescribed drug, look at the person's prescription chart and check the following:</p> <p>Correct:</p> <ul style="list-style-type: none"> • Person • Allergies • Drug • Dose • Date and time administration • Route and method of administration • Diluent (as appropriate)
5	<p><i>Ensures:</i></p> <ul style="list-style-type: none"> • Validity of prescription • Signature of prescriber • Prescription is legible <p>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</p>
6	Remove the mouthpiece cover from inhaler
7	Shake inhaler well for 2-5 seconds
8	With a device: Insert MDI into end of device. Ask the person to exhale and then grasp device mouthpiece with lips while holding device/inhaler
9	For each metered dose ask the person to depress canister to administer the drug and breathe
10	Instructs the person to breathe in and out normally or use single breath and hold technique whilst using the device
11	Remove the MDI from mouth before exhaling
12	Clean any equipment used and discard all disposable equipment in appropriate containers
13	Date and sign drug administration record
14	Reassures the person appropriately
15	Closes interaction professionally and appropriately

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
15	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels

Catheter Sample of Urine (CSU) Marking Criteria

Assessment Criteria	
1	Explain and discuss the procedure with the person
2	Check that any equipment required for the procedure is available and, where applicable, is sterile (i.e. that packaging is undamaged, intact and dry; that sterility indicators are present on any sterilised items and have changed colour where applicable)
3	If no urine visible in catheter tubing: wash / clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels, don apron and apply non-sterile gloves prior to manipulating the catheter tubing
4	Apply non-traumatic clamp a few centimetres distal to the sampling port
5	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels, don gloves
6	Wipe sampling port with 2% chlorhexidine in 70% isopropyl alcohol and allow drying for 30 seconds
7	<p><i>If using needle and syringe:</i> using a sterile syringe and needle, insert needle into port at an angle of 45°, using a non-touch technique, and aspirate the required amount of urine, then withdraw needle.</p> <p><i>If using needleless system:</i> insert sterile syringe firmly into centre of sampling port (according to manufacturer's guidelines), using a non-touch technique, aspirate the required amount of urine and remove syringe</p>
8	Transfer an adequate volume of the urine specimen (approx. 10ml) into a sterile container immediately
9	Discard needle and syringe into sharps container (if relevant)
10	Wipe the sampling port with an alcohol wipe and allow to dry
11	Unclamp catheter tubing (if relevant)
12	Dispose of waste, remove apron and gloves and clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels

Fine Bore Nasogastric Tube Marking Criteria

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

Fluid Balance (FB) Marking Criteria

Assessment Criteria	
1	Handwriting is clear and legible
2	Accurately transpose the information on the Fluid Balance chart
3	Complete the fluid intake balance accurately
4	Complete the fluid output balance accurately
5	Calculate and document the total fluid balance accurately
6	Denotes negative or positive balance accurately
7	Ensure strike-through errors retain legibility
8	Print and sign name on the chart

In-Hospital Resuscitation (IHR) 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	<p>Before administering any prescribed drug, look at the person's prescription chart and check the following:</p> <p>Correct:</p> <ul style="list-style-type: none"> • Person • Drug • Dose • Date and time administration • Route and method of administration • Diluent (as appropriate)
3	<p><i>Ensures:</i></p> <ul style="list-style-type: none"> • Validity of prescription • Signature of prescriber • Prescription is legible <p>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</p>
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

Midstream Specimen of Urine (MSU) and Urinalysis Marking Criteria

Assessment Criteria	
1	Discuss the procedure with the person
2	Explain to the person how to perform MSU (part labia and clean meatus with soap and water from front to back)
3	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
4	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)
5	Give the person a clean specimen pot
6	Don a disposable plastic apron and non-sterile gloves
7	Dip Reagent strip into the urine for no longer than 1 second
8	Hold strip at an angle at the edge of the container
9	Wait the required time (referring to either the Marsden Manual or product information sheet to determine the required time is acceptable) before reading the strip against the colour chart
10	Dispose of waste
11	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
12	Provide Health Education to Person according to results. Inform of actions to be taken next
13	Document readings according to reagent strip

Peak Expiratory Flow Rate (PEFR) Marking Criteria

Assessment Criteria	
1	Explain the procedure to the person and obtain their consent
2	Ask the person what their best peak flow measurements have been and what their current peak flow readings are
3	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
4	Assemble equipment
5	Push needle on the gauge down to zero
6	Ask the person to hold the peak flow meter horizontally, ensuring their fingers do not impede the gauge
7	Ask the person to take a deep breath in through their mouth to full inspiration
8	Ask the person to immediately place their lips tightly around the mouthpiece
9	Ask the person to blow out through the meter in a short sharp 'huff' as forcefully as they can
10	Take a note of the reading and return the needle on the gauge to zero. Ask the person to take a moment to rest and then repeat the procedure twice, noting the reading each time
11	Document the highest of the three acceptable readings
12	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels

Pressure Area Assessment Marking Criteria

Assessment Criteria	
1	<p>Identifies the most vulnerable areas of pressure risk (Formal anatomical or plain English terminology accepted):</p> <ul style="list-style-type: none"> • heels • sacrum • ischial tuberosities (buttocks) • elbows • temporal region of the skull • shoulders • femoral trochanters (hips) • back of head • toes • ears • spine. <p>To achieve full marks, the candidate needs to identify a minimum of 8 areas; for partial marks, a minimum of 5 areas.</p>
2	<p>Identifies signs that may indicate pressure ulcer development:</p> <ul style="list-style-type: none"> • 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. <p>To achieve full marks, the candidate needs to identify a minimum of 7 areas; for partial marks, a minimum of 4 areas.</p>
3	<p>Completes the Braden tool accurately and correctly calculates the risk score, based on the patient scenario and pressure damage identified.</p>
4	<p>Document's findings accurately, clearly and legibly.</p>

Removal of Urinary Catheter (RUC) Marking Criteria

Assessment Criteria	
1	Explain procedure to the person and inform them of potential post-catheter symptoms, such as urgency, frequency and discomfort, which are often caused by irritation of the urethra by the catheter
2	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels, and put on disposable gloves and don an apron
3	Wearing gloves, use saline soaked gauze to clean the meatus and catheter, always swabbing away from the urethral opening
4	Having checked volume of water in balloon (see patient documentation), use syringe to deflate balloon
5	Ask person to breathe in and then out; as person exhales, gently (but firmly with continuous traction) removes catheter
6	Clean area around the genitalia and make the person comfortable
7	Encourage person to exercise and to drink 2 - 2.5 litres of fluid per day
8	Dispose of equipment including apron and gloves in an orange plastic clinical waste bag
9	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels

Subcutaneous Injection Marking Criteria

Assessment Criteria	
1	Explain and discuss the procedure with the person
2	<p>Before administering any prescribed drug, look at the person's prescription chart and check the following:</p> <p>Correct:</p> <ul style="list-style-type: none"> • Person • Drug • Dose • Date and time of administration • Route and method of administration • Diluent (as appropriate)
3	<p><i>Ensures:</i></p> <ul style="list-style-type: none"> • Validity of prescription • Signature of prescriber • Prescription is legible <p>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</p>
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	Where appropriate clean the injection site with a swab saturated with isopropyl alcohol 70%
10	Remove the needle sheath
11	Gently pinch the skin into a fold
12	Hold the needle between thumb and forefinger of dominant hand as if grasping a dart
13	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
14	Withdraw the needle rapidly and apply gentle pressure with sterile gauze. Do not massage the area.
15	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
16	Sign and date drug administration record

Visual Infusion Phlebitis (VIP) Assessment and Intravenous Cannula Flush Marking Criteria

Assessment criteria	
1	Checks that all the equipment required for the procedure is available and, where applicable, is sterile (i.e. that packaging is undamaged, intact and dry, and that sterility indicators are present on any sterilized items and have changed colour, where applicable).
2	Assesses the photo of the cannula using the VIP scale, identifies and verbalises signs of phlebitis: pain, erythema (colour), swelling, palpable venous cord.
3	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
4	States that the tray or trolley has been cleaned with detergent wipes (or equivalent) and places all the equipment required for the procedure on the bottom shelf of the clean dressing trolley (or suitable equivalent).
5	Dons a disposable plastic apron.
6	Takes the equipment to the person's bedside in tray or trolley.
7	Gains consent and explains the procedure to the patient.
8	Before administering any prescribed drug, looks at the person's prescription chart and correctly checks ALL of the following: Correct: <ul style="list-style-type: none"> • person (checks ID with person: verbally, against wristband (where appropriate) and documentation), • drug • dose • date and time of administration • route and method of administration • diluent (as appropriate) • any allergies.
9	Correctly checks ALL of the following: <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>
10	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, and dons non-sterile gloves.
11	Cleanses the end of the IV port with sterile alcohol wipes saturated with 70% isopropyl alcohol for 30 seconds, leaving to dry for more than 30 seconds.
12	Connects the prefilled syringe to the port using a non-touch technique, and flushes the cannula using a pulsating action or stop/start procedure.
13	Asks the patient whether they are experiencing any discomfort while flushing.
14	Disposes of waste appropriately – verbalisation accepted.
15	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
16	Dates and signs drug administration record (prompt permitted) – verbalisation accepted.