Children's Nursing

Marking Criteria

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Important Information

This *'Children's 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 Children's Nursing Mock OSCE and *'OSCE Top Tips Children's 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	Introduce self to child and carer
2	Explain to the child and family the purpose and format of the assessment process and gain consent
3	Determine the relationship of the adult present to the child
4	What is the family composition? Who lives at home with the child? Do they have siblings? If so what are their names and ages.
5	May establish who has parental responsibility for the child
6	Establish what the child likes to be called
7	Be welcoming in a warm, friendly fashion
8	Maintain good eye contact throughout
9	Use jargon-free, non-technical terms throughout
10	Encourage the child and family to ask questions and voice any concerns. Use a mixture of open and closed questions
11	May ask what the child and family's first language is? If it is not spoken English, do they need an interpreter or 'signer' to be present?
12	Demonstrate respect for the child's gender, cultural and religious beliefs throughout the assessment
13	Clarify understanding of issues raised by reflecting back the child's and parent's statements, such as 'What happens when your child eats peanuts?'
14	May check the height and weight recorded for the child with the child or parent
15	Find out what the child and family's reason for attending the hospital or clinic is
16	Ask the child and family to describe the symptoms of the illness or problem in their own words
17	Has the child been in hospital before? If so, when was this and what was wrong with them?
18	May check for allergies
19	What medicines is the child currently taking? (Note the dosage and frequency of all medicines)
20	Has the child been immunised? (If so, take details of which vaccinations they have received and when. Check this against the current recommended immunisation schedule. Make a note of any vaccinations they have not received and the reason why.)
21	Accurately complete the admission documentation.

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 child and parent
3	Check that the name and either date of birth or hospital number on the medication chart corresponds with the details on the child's name band and checks this verbally with the child or parent
4	May identify if the child has any previous experience of taking medication and if so, what the experience was like
5	Check the child does not have any known allergy or contra-indication to the prescribed medication (if the child does, do not give the medication and inform the responsible prescriber immediately)
6	Before administering any prescribed drug, look at the person's prescription chart and check the following is correct:
6a	Person
6b	Drug
6c	Calculation of dose
6d	Dose given
6d	Date and time of administration
6e	Route and method of administration
7	Ensures:
7a	Validity of prescription
7b	Signature of prescriber
7c	The prescription is legible
8	Confirm height and weight of the child with parent or MAR
9	Identify and administer drugs due for administration correctly and safely
10	Explain to the child using age and developmental appropriate language what medication is due and why
11	Negotiate roles for the administration of the medication with the child and parent/carer
12	Provide positive reinforcement as appropriate during and following administration of medication
13	Omit drugs not to be administered and provides verbal rationale (ask candidate reason for non-administration if not verbalised)
14	Accurately record drug administration and non-administration

Evaluation Marking Criteria: All scenarios

Assessment Criteria	
1	Clearly describe reason for initial admission and diagnosis
2	Record date of admission
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
7	Documents allergies
8	Ensure strike-through errors retain legibility
9	Print, sign and date

Paediatric Basic Life Support (infant and child) Marking Criteria

Assessment Criteria	
1	Ensure personal safety (safe environment)
2	Check the child/infant for a response
3	Shouts for help when child/infant 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) Infants should be in the neutral position a child should be in the sniffing position
6	Keeping the airway open, look, listen, and feel - for normal breathing (less than 10 seconds)
7	Give 5 rescue breaths using bag valve mask to produce visible rise of the chest wall - Breath should be given steadily over 1 second
8	Ensure a maximum of 5 attempts are made at rescue breaths. If any attempt is unsuccessful the airway should be repositioned
9	Select correct size mask (cover mouth and nose, avoid pressure on eyes)
10	Assess circulation by checking for signs of life for up to 10 secs
11	May check pulse carotid in child over 1 year of brachial in infant under 1 year or femoral pulse
12	Commence CPR with ratio of compressions to ventilations of 15:2
13	Uses correct hand position - for a child use one hand to compress the lower half of sternum 1 finger breath above the xiphisternum (with or without verbal prompting) (in larger children or smaller rescuers 2 hands may be used) In infant lone rescuer should use 2 fingers to compress the sternum when 2 or more rescuers the encircling technique may be used. Ensure pressure is applied by thumbs not fingers.
14	Compression depth of 4-5cm in child or approx 4cm in infants
15	Compression rate of 100-120 compressions per minute
16	Allow the chest to recoil completely after each compression
17	Ensure resuscitation team are called and resuscitation equipment requested (if alone, 1 min CPR first)
18	Continue until help arrives or signs of life are shown e.g. normal breathing, cough or definite pulse of more than 60/min
19	Ask candidate to clarify what they would do if no help arrives:- In a child continue for 1 minute then get help for an infant take with you to get help unless witnessed sudden collapse

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	Introduce self to child and parent
3	Check ID with parent/child: verbally, against wristband (where appropriate) and paperwork
4	Explain to the child and the family the purpose of the assessment process using jargon free, non technical terms and language appropriate for the child's age and development
5	In children over 2 years heart rate should be assessed by palpating the radial artery in infants under 2 years a stethoscope should be used to assess the apical beat.
6	In infants and young children place a hand just below the childs xiphoid process, use observation alone in an older child
7	Count the pulse for 1 full minute and the respiratory rate for 1 full minute
8	Ensure the BP measurement is taken in the childs right arm. Select the correct size cuff the internal bladder must encircle at least 80-100% of the circumference of the upper arm
9	Document and provide an accurate score using assessment tool
10	Measures and documents observations accurately

Removal of Urinary Catheter Marking Criteria

Assessment Criteria	
1	Prepare child and family
2	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels, and put on disposable gloves and apron
3	Use adhesive remover to remove adhesive strapping from abdomen/thigh while supporting weight of the catheter
4	Having checked volume of water in balloon (see patient documentation), use syringe to deflate balloon
5	Ask child to breathe in and then out
6	Remove catheter as child exhales by gentle pull in one steady motion
7	Dispose of equipment including apron and gloves in an orange plastic clinical waste bag
8	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
9	Observe child to ensure that they are able to pass urine. Inform child and family that the first micturition may be painful

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:
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 and don apron
5	Prepare medication using non touch technique
6	Change needle
7	Use distraction techniques and assistance of mum/play specialist
8	Assess the injection site for signs of inflammation, oedema, infection and skin lesions
9	Pinch the skin and select the correct needle size (this is commonly 25G needle)
10	Gently pinch the skin into a fold
11	Hold the needle between thumb and forefinger of dominant hand as if grasping a dart
12	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.
13	Wait 10 seconds before releasing grip on the pinch of skin and removing the needle
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