Learning Disability Nursing

Marking Criteria

Version R1.2

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Learning Disability Nursing Marking Criteria

Important Information

This *'Learning Disability Nursing Marking Criteria'* document is intended to provide candidates with additional preparation information to help prepare for the test of competence (part 2). This document should be read in conjunction with the Candidate Information Booklet, recommended/core reading, the Mock OSCE and *'OSCE Top Tips Learning Disability 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 NMC register.

Assessment Marking Criteria: All scenarios

Assessment Criteria	
1	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
2	May verbalise or make environment safe
3	Introduce self to person
4	Check ID with person (person’s name is essential and verification with photograph)
5	Gain consent, ensures;
5a	The person is deemed to have sufficient capacity to make the decision e.g. questions asked around time, place and person
5b	Their decision must be voluntary with no evidence of coercion
5c	The person must have sufficient knowledge about the care or intervention being offered
5d	Ongoing review of decisions at all stages
6	Explain the procedure using effective communication principles;
6a	Address the person by their preferred name
6b	Speak slowly and do not shout
6c	Use very straightforward language and do not use medical jargon
6d	Is creative in using different methods of communication (Makaton, Signing, Picture cards, Talking mats etc where applicable)
6e	Provide extra time to facilitate understanding
6f	Confirm understanding with the person before moving on e.g. ask the person to repeat in their own words what has been said
6g	Be aware that the person may have additional hearing of visual impairments
6h	Pay attention to eye contact, body language, facial expression and contact via touch
7	Builds trust and rapport
8	Uses assessment tools correctly;
8a	Accurately documents assessment tool score (Wong-Baker FACES, Glasgow Depression Scale)
8b	Communicates recommendations of assessment tool (DisDAT, Glasgow Depression Scale) effectively
9	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 using the four C's;
3a	Client
3b	Competence
3c	Conditions
3d	Criteria
4	Set appropriate re-evaluation date for both problems
5	Ensure nursing interventions are current / relate to EBP / best practice
6	Self-care opportunities identified (if applicable)
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	Gains consent, ensures;
3a	The person is deemed to have sufficient capacity to make the decision e.g. questions asked around time, place and person
3b	Their decision must be voluntary with no evidence of coercion
3c	The person must have sufficient knowledge about the care or intervention being offered
3d	Ongoing review of decisions at all stages
4	Check ID with person; (persons name is essential and verification with photograph)
5	May refer to previous assessment results
6	Must check allergies on chart and confirm with the person in their care
7	Before administering any prescribed drug, look at the person's prescription chart and check the following: Correct: Person, Drug, Dose, Date and time of administration and Route and method of administration and Diluent (as appropriate)
8	Ensures: Validity of prescription, Signature of prescriber and the 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
9	Provide an ongoing evaluation of what each drug being administered is for to the person in their care
10	Ensure medication is swallowed avoiding an invasive approach e.g. do not ask the person to open their mouth, use questioning techniques
11	Omit drugs not to be administered and provide verbal rationale
12	Accurately record drug administration and non-administration

Evaluation Marking Criteria: All scenarios

Assessment Criteria	
1	Clearly describe the main reason for referral
2	Identify main nursing needs
3	Outline the main nursing care provided to meet the identified needs
4	Outline current ability to self-care based on the person’s care plan
5	Documents allergies and associated reactions
6	List areas identified for health education
7	Ensure strike-through errors retain legibility
8	Record date and time of transfer
9	Print, sign and date

Aseptic Non-Touch Technique (ANTT) Marking Criteria

Assessment Criteria	
1	Check that all the equipment required for the procedure is available and, where applicable, is sterile (i.e. that packaging is undamaged, intact and dry; that sterility indicators are present on any sterilized items and have changed colour where applicable)
2	Explain and discuss the procedure using effective communication principles;
2a	Address the person by their preferred name
2d	Speak slowly and do not shout
2c	Use very straightforward language and do not use medical jargon
2d	Is creative in using different methods of communication (Makaton, Signing, Picture cards, Talking mats etc where applicable)
2e	Provide extra time to facilitate understanding
2f	Confirm understanding with the person before moving on e.g. ask the person to repeat in their own words what has been said
2g	Be aware that the person may have additional hearing of visual impairments
2h	Pay attention to eye contact, body language, facial expression and contact via touch
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	Ensure ongoing review of decisions at all stages
15	Dispose of waste appropriately - verbalisation accepted
16	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels

Catheter Sample of Urine Marking Criteria

Assessment Criteria	
1	Explain and discuss the procedure using effective communication principles;
1a	Address the person by their preferred name
1b	Speak slowly and do not shout
1c	Use very straightforward language and do not use medical jargon
1d	Is creative in using different methods of communication (Makaton, Signing, Picture cards, Talking mats etc where applicable)
1e	Provide extra time to facilitate understanding
1f	Confirm understanding with the person before moving on e.g. ask the person to repeat in their own words what has been said
1g	Be aware that the person may have additional hearing of visual impairments
1h	Pay attention to eye contact, body language, facial expression and contact via touch
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	*If using needle and syringe*: 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. I*f using needleless system:* 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
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	Ensure ongoing review of decisions at all stages
13	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 - verbalisation accepted

In-Hospital Resuscitation (without defibrillation) Marking Criteria

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

Intramuscular Injection (IM) Marking Criteria

Assessment Criteria	
1	Explain and discuss the procedure using effective communication principles;
1a	Address the person by their preferred name
1b	Speak slowly and do not shout
1c	Use very straightforward language and do not use medical jargon
1d	Is creative in using different methods of communication (Makaton, Signing, Picture cards, Talking mats etc where applicable)
1e	Provide extra time to facilitate understanding
1f	Confirm understanding with the person before moving on e.g. ask the person to repeat in their own words what has been said
1g	Be aware that the person may have additional hearing of visual impairments
1h	Pay attention to eye contact, body language, facial expression and contact via touch
2	Before administering any prescribed drug, look at the person's prescription chart and check the following: Correct: Person, Drug, Dose, Date and time of administration and Route and method of administration and Diluent (as appropriate)
3	Ensures: Validity of prescription, Signature of prescriber and the prescription is legible If any of these pieces of information are missing, are unclear or illegible then the nurse should not proceed with administration and should consult the prescriber
4	Prepare medication
5	Don apron and close the curtains / door and assist the person into the required position and wash hands
6	Remove the appropriate garment to expose injection site
7	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels and assess the injection site for signs of inflammation, oedema, infection and skin lesions
8	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels, and apply non-sterile gloves
9	Clean the injection site with a swab saturated with isopropyl alcohol 70% for 30 seconds and allow to dry for 30 seconds
10	Stretch the skin around the injection site
11	Insert the needle at an angle of 90° into the skin until about 1cm of the needle is left showing
12	Pull back on the plunger. If no blood is aspirated, depress the plunger at approximately 1ml every 10 seconds and inject the drug slowly
13	Wait 10 seconds before withdrawing the needle
14	Withdraw the needle rapidly. Apply gentle pressure to any bleeding point but do not massage the site
15	Apply a small plaster over the puncture site
16	Ensure ongoing review of decisions at all stages
17	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
18	Date and sign drug administration record - verbalisation accepted

Peak Expiratory Flow Rate Marking Criteria

Assessment Criteria	
1	Explain and discuss the procedure using effective communication principles;
1a	Address the person by their preferred name
1b	Speak slowly and do not shout
1c	Use very straightforward language and do not use medical jargon
1d	Is creative in using different methods of communication (Makaton, Signing, Picture cards, Talking mats etc where applicable)
1e	Provide extra time to facilitate understanding
1f	Confirm understanding with the person before moving on e.g. ask the person to repeat in their own words what has been said
1g	Be aware that the person may have additional hearing of visual impairments
1h	Pay attention to eye contact, body language, facial expression and contact via touch
2	Gain consent, ensures;
2a	The person is deemed to have sufficient capacity to make the decision e.g. questions asked around time, place and person
2b	Their decision must be voluntary with no evidence of coercion
2c	The person must have sufficient knowledge about the care or intervention being offered
3	Ask the person what their best peak flow measurements have been and what their current peak flow readings are (if appropriate)
4	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
5	Assemble equipment
6	Push needle on the gauge down to zero
7	Ask the person to hold the peak flow meter horizontally, ensuring their fingers do not impede the gauge
8	Ask the person to take a deep breath in through their mouth to full inspiration
9	Ask the person to immediately place their lips tightly around the mouthpiece
10	Ask the person to blow out through the meter in a short sharp 'huff' as forcefully as they can
11	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
12	Document the highest of the three acceptable readings
13	Ensure ongoing review of decisions at all stages
14	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels

Removal of Catheter Marking Criteria

Assessment Criteria	
1	Explain and discuss the procedure using effective communication principles;
1a	Address the person by their preferred name
1b	Speak slowly and do not shout
1c	Use very straightforward language and do not use medical jargon
1d	Is creative in using different methods of communication (Makaton, Signing, Picture cards, Talking mats etc where applicable)
1e	Provide extra time to facilitate understanding
1f	Confirm understanding with the person before moving on e.g. ask the person to repeat in their own words what has been said
1g	Be aware that the person may have additional hearing of visual impairments
1h	Pay attention to eye contact, body language, facial expression and contact via touch
2	Inform the person of potential post-catheter symptoms, such as urgency, frequency and discomfort, which are often caused by irritation of the urethra by the catheter using the above communication principles
3	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
4	Wearing gloves, use saline soaked gauze to clean the meatus and catheter, always swabbing away from the urethral opening
5	Having checked volume of water in balloon (see patient documentation), use syringe to deflate balloon
6	Ask person to breathe in and then out; as person exhales, gently (but firmly with continuous traction) removes catheter
7	Clean area around the genitalia and make the person comfortable
8	Encourage person to exercise and to drink 2- 2.5 litres of fluid per day
9	Ensure ongoing review of decisions at all stages
10	Dispose of equipment including apron and gloves in an orange plastic clinical waste bag - verbalisation accepted
11	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
1a	Address the person by their preferred name
1b	Speak slowly and do not shout
1c	Use very straightforward language and do not use medical jargon
1d	Is creative in using different methods of communication (Makaton, Signing, Picture cards, Talking mats etc where applicable)
1e	Provide extra time to facilitate understanding
1f	Confirm understanding with the person before moving on e.g. ask the person to repeat in their own words what has been said
1g	Be aware that the person may have additional hearing of visual impairments
1h	Pay attention to eye contact, body language, facial expression and contact via touch
2	Before administering any prescribed drug, look at the person's prescription chart and check the following: Correct: Person, Drug, Dose, Date and time of administration and Route and method of administration and Diluent (as appropriate)
3	Ensures: Validity of prescription, Signature of prescriber and the prescription is legible If any of these pieces of information are missing, are unclear or illegible then the nurse should not proceed with administration and should consult the prescriber
4	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels
5	Prepare medication
6	Don apron
7	Assess the injection site for signs of inflammation, oedema, infection and skin lesions
8	Clean hands with alcohol hand rub, or wash with soap and water, and dry with paper towels and apply non-sterile gloves
9	Pinch the skin and select the correct needle size (this is commonly 25G needle)
10	Where appropriate clean the injection site with a swab saturated with isopropyl alcohol 70%
11	Remove the needle sheath
12	Gently pinch the skin into a fold
13	Hold the needle between thumb and forefinger of dominant hand as if grasping a dart
14	Insert the needle into the skin at an angle of 45° and release the grasped skin (unless administering insulin when an angle of 90° should be used). Inject the drug slowly over 10-30 seconds
15	Withdraw the needle rapidly and apply gentle pressure with sterile gauze. Do not massage the area.
16	Ensure ongoing review of decisions at all stages
17	Ensure that all sharps and non-sharp waste are disposed of safely (including scooping method of re-sheathing is used) and in accordance with locally approved procedures - verbalisation accepted
18	Sign and date drug administration record - verbalisation accepted