AlphaPlus

NMC Nursing & Midwifery Council | Test of Competence

Test of Competence 2021: Marking Criteria Midwifery

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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 Midwifery’ 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 midwife entering the register.

APIE stations

Assessment marking criteria: all APIEs

Assessment criteria	
1	Assesses the safety of the scene and the privacy and dignity of the woman.
2	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
3a	Introduces self to person.
3b	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.
3c	Checks for allergies verbally and on wrist band (where appropriate).
4	Reviews history.
5	Gains consent and explains reason for assessment.
6	Uses a calm voice, speech is clear, body language is open, and personal space is appropriate.
7	Conducts a structured assessment, which allows for the potential to identify a differential diagnosis.
8	Confirms situation – presenting symptoms, parity, gestation, presenting pain as appropriate.
9	Confirms background – medical history, obstetric history, allergies, medication.
10	Completes a full antenatal assessment – blood pressure, temperature, pulse, respiration, O2 saturation, per vaginam (PV) loss, urinalysis, abdominal palpation, auscultates fetal heart (Pinard/doppler).
10a	Accurately performs maternal observations.
10b	Accurately performs observations to assess fetal wellbeing.
10c	Accurately documents maternal observations on observation chart provided, and calculates assessment of wellbeing/clinical deterioration (in this case, using modified early obstetric warning score/chart).
10d	Identifies any observations which are a cause for concern to examiner.
10e	Accurately completes document: signs, dates and adds time on assessment charts.
11	Undertakes a holistic assessment relevant to the scenario.
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'.
13	Disposes of equipment appropriately – verbalisation accepted.

Red Flags:

	If the candidate fails to acknowledge the actor and/or communicate effectively.
	If the candidate is actively dismissive of the complaint, concerns/anxieties.
	If the candidate fails to acknowledge or record the main care needs.
	If the candidate openly displays judgemental behaviour about a person's personal characteristics (e.g., sexuality), belief/cultural/lifestyle preferences.
	If the candidate actively fails to utilise appropriate PPE causing risk to themselves and those in their care.
	Another Red Flag issue (leading DIRECTLY to patient harm) identified by assessor.

Planning marking criteria: all APIEs

Assessment criteria	
1	Assesses relevant history including medical and obstetric history, medication and allergies
2	Assesses current situation, identifying main issues including presenting symptoms, parity, gestation, pain.
3	Identifies plan of care for issues/needs, including for any differential diagnoses – urinary tract infection or labour. Makes recommendation – cardiotocography, mid-stream sample of urine, take blood for full blood count, C-reactive protein, urea and electrolytes, liver function tests, and obstetric review. Consider possibility of labour - VE/transfer to delivery suite. Consider analgesia.
4	Identifies complete antenatal assessment – blood pressure, temperature, pulse, respiration, per vaginam (PV) loss, urinalysis, abdominal palpation, auscultates fetal heart (Pinard/doppler).
5	Sets appropriate review time for identified issue/need.
6	Ensures midwifery interventions are current/evidence-based/best practice.
7	Uses professional terminology in care planning.
8	Does not use abbreviations or acronyms.
9	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:

	If the candidate fails to acknowledge or record the main care needs.
	If the candidate openly displays judgemental behaviour about a person's personal characteristics (e.g., sexuality), belief/cultural/lifestyle preferences.
	Another Red Flag issue (leading DIRECTLY to patient harm) identified by assessor.

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	Seeks consent from the woman prior to administering medication.
3	Checks allergies on chart and confirms with the woman in their care; also notes red ID wristband (where appropriate).
4	Before administering any prescribed drug, looks at the woman's prescription chart and checks that the following are correct: • person (checks ID with woman verbally, against wristband (where appropriate) and paperwork) • drug • dose • date and time of administration • route and method of administration • validity of prescription • signature of prescriber • prescription is legible.
5	Considers contraindications where relevant and medical information prior to administration (prompt permitted). (This may not be relevant in all scenarios.)
6	Provides a correct explanation of what each drug being administered is for to the person in their care (prompt permitted).
7	Administers drugs due for administration correctly and safely.
8	Omits drugs not to be administered and provides verbal rationale (if not verbalised, ask candidate reason for non-administration).
9	Accurately records drug administration and non-administration.
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'.

Red Flags:

	Yes - If the candidate fails to acknowledge the actor and/or communicate effectively.
	Yes - If the candidate ignores or fails to check allergy status and risks causing a reaction prior to the administration of medicine.
	Yes - If the candidate makes a drug error during the administration of medication.
	Yes - If the candidate fails to accurately sign and date the drug chart.
	Yes - If the candidate openly displays judgemental behaviour about a person's personal characteristics (e.g. sexuality), belief/cultural/lifestyle preferences.
	Yes - If the candidate actively fails to utilise appropriate PPE causing risk to themselves and those in their care.
	Another Red Flag issue (leading DIRECTLY to patient harm) identified by assessor.

Evaluation marking criteria: all APIEs

Assessment criteria	
Situation	
1a	Documents the reason for the handover (where relevant).
Background	
2a	Documents 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	Documents details of current events and details the findings from assessment.
Assessment	
3a	Identifies current care needs and ongoing plans and referrals.
3b	States recommendations and medical interventions completed.
3c	States areas of concerns and potential differential diagnosis.
Recommendation	
4	Documents what is required of the person taking the handover, and proposes a realistic plan of action.
Overall	
5	Systematic and structured approach taken to handover.
6	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:

	Yes - If the candidate fails to acknowledge or record the main care needs.
	Yes - If the candidate openly displays judgemental behaviour about a person's personal characteristics (e.g. sexuality), belief/cultural/lifestyle preferences.
	Another Red Flag issue (leading DIRECTLY to patient harm) identified by assessor.

Clinical skills stations

Linked skills stations marking criteria

Birth

	Assessment criteria
1	Cleans own hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO.
2	Encourages and supports the woman with contractions and informs her when the baby's head becomes visible.
3	Facilitates the birth of the baby using either 'hands on' (guarding the perineum and flexing the head) or 'hands poised' (hands off the perineum and head but in readiness). Places the baby on the woman's abdomen and support immediate contact between the two.
4	With consent, administers 10iu oxytocin by intramuscular injection into the maternal leg to facilitate separation of the placenta. This can be verbalised.
5	Cuts and clamps the umbilical cord. This should be deferred for between 1 and 5 minutes. This can be verbalised.
6	Recognises signs of placental separation (lengthening of umbilical cord, small gush of blood per vaginam) and then delivers the placenta using controlled cord traction (CCT). CCT should be performed with one hand applying gentle traction to the umbilical cord and the other hand guarding and stabilising the uterus immediately above the maternal symphysis pubis at the same time.
7	Checks placenta and umbilical cord (photograph available) and recognises the need to assess structure, completeness and presence of three umbilical vessels.
8	With consent, checks external genitalia, vagina and perineum for soft tissue damage. Checks blood loss PV and provides a sanitary pad – verbalisation accepted.
9	Performs maternal observations: pulse, blood pressure, temperature, uterine contraction and lochia – verbalisation accepted.

Red Flags:

	Any Red Flag issue (leading DIRECTLY to patient harm) identified by assessor.

Postnatal check

	Assessment criteria
1	Cleans own hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
2	Explains the procedure to the woman. Obtains consent.
3	Accurately assesses, interprets and records the health and wellbeing of the woman postnatally.
4	Considers and discusses the woman's mental health and wellbeing, including: appetite, energy levels, sleeping pattern, ability to cope with daily living, mood, anxiety and depression, family relationships.
5	Undertakes vital signs and physical assessment to exclude signs of infection, including: temperature, pulse, blood pressure, respirations, palpating involution of the uterus, considering lochia and perineal health and wellbeing.
6	Discusses individual mobility needs, risk factors from venous thromboembolic disorders, and includes any adaptations needed to carry/care for her newborn infant.
7	Accurately assesses all relevant aspects of infant feeding, for both the woman and the newborn infant, which must include: support and advice with feeding/position/attachment/responsive feeding/bottle-feeding advice; infant weight, growth/development/urine and stool output; observing feeding and considering breast tenderness/engorgement and pain management.
8	Effectively implements, reviews, and adapts an individualised, evidence-informed care plan for the woman and her newborn infant across the continuum, involving her partner and family as appropriate.

Red Flags:

	Any Red Flag issue (leading DIRECTLY to patient harm) identified by assessor.

Systematic examination of the newborn

(NB: Select 1 of 4: eyes, heart, testes, hips.)

	Assessment criteria
1	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
2	Conducts ongoing assessments of the health and wellbeing of the newborn infant, involving the mother and partner as appropriate, and providing a full explanation, which must include: parental confidence in handling and caring for the newborn infant, including response to crying and comfort measures.
3	Holistic assessment of the full systematic physical examination of the newborn infant in line with local and national evidence-based protocols, and ensuring that screening and diagnostic tests are carried out appropriately and as required, in line with local and national evidence-based protocols.
4	Identifies risk factors, screens maternal records, and carries out record-keeping of newborn child health record.
5	Explains the systematic examination of the screening programme's 4 areas, and gains informed consent.
6	Ensures the correct environment (warm, light, flat, firm surface, alongside mother), reviews the case history and identifies any risk factors.
7	Has a logical process for the examination.
8	Acts professionally throughout both procedures in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Red Flags:

	Any Red Flag issue (leading DIRECTLY to patient harm) identified by assessor.

Postnatal Sepsis marking criteria

Assessment criteria	
1	Introduces self to the woman, stating name and role/considers a safe environment in relation to the baby.
2	Washes hands or cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
3	Puts on apron and gloves.
4	Gains consent and explains procedures to the woman. Verbal communication is clear and appropriate.
5	Checks equipment prior to use.
6	Conducts holistic maternal observations skilfully.
7	Documentation: Prints name, signs and dates.
8	Documentation: Records results and maternal observations.
9	Handwriting is clear and legible throughout.
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'.
11	Identifies that immediate action is required, contacts 999 and pre-alerts as 'red flag sepsis' for immediate transfer, considers IV cannulation and commencement of IV fluids, informs family of requirement for transfer, advises on the care of the baby.

Red Flags:

	Any Red Flag issue (leading DIRECTLY to patient harm) identified by assessor.

Postpartum haemorrhage marking criteria

	Assessment criteria
1	Recognises the emergency and calls for help, recognising the need to use the emergency buzzer. Declares the emergency clearly, stating 'Postpartum haemorrhage', and recognises the need to request assistance from the appropriate members of the multidisciplinary team. Ensures that the baby is in a place of safety, such as the cot. Verbally considers the cause of the haemorrhage: tone, tissue, trauma or thrombin.
2	Supports the woman to lie back and commences high-flow oxygen using a non-rebreather mask – verbalisation accepted.
3	Rubs up a uterine contraction – this must be demonstrated. Ensures that the uterus is well contracted and clots are expelled – verbalisation accepted.
4	Verbalises the need to site 2 large-bore canulae, one in each arm, and take blood for urgent samples. This should include a full blood count, clotting studies, renal and liver function and cross-match of 4-6 units of blood. Verbalises the need to commence fluid resuscitation using a crystalloid infusion e.g. Hartmann's solution or 0.9% sodium chloride.
5	Verbalises the need to catheterise the urinary bladder using an indwelling Foley catheter with a urometer.
6	Carries out an assessment of the woman. This should include pulse, respiratory rate, blood pressure and oxygen saturations. Signs of shock should be considered. These include tachycardia >100 bpm, respiratory rate >30 bpm, systolic blood pressure <100 mmHg and capillary refill greater than 2 seconds. Maternal condition and blood loss should be reassessed continually during management of the emergency. This assessment should be verbalised.
7	Verbally considers appropriate medication to stop the bleeding. This should include a second dose of syntometrine **or** syntocinon **or** ergometrine, an oxytocin infusion, misoprostol and carboprost. Tranexamic acid should be considered if bleeding continues. Consideration of blood transfusion.
8	Performs bimanual compression of the uterus. One hand is inserted into the vagina, a fist is formed and used to apply pressure to the anterior uterine wall. The other hand applies pressure externally on the uterine fundus, trapping the placental site between the two and stemming the blood loss. This should be demonstrated using the manikin or verbalised very clearly.
9	Verbally considers other options if bleeding not settled – examination under anaesthetic and manual removal of retained products, repair of undiagnosed vaginal or cervical tears, uterine balloon tamponade, B-Lynch suture technique or hysterectomy.
10	Verbalises the need for the midwife to ensure that the woman understands what has happened and has the chance to bond with her baby. Verbalises the importance of maternal observations to establish condition and the importance of completing all

	relevant documentation, including an estimated or weighed blood loss and modified early obstetric warning score (MEOWS) chart.
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'.
12	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.

Red Flags:

1	Recognises the emergency and calls for help, recognising the need to use the emergency buzzer. Declares the emergency clearly, stating 'Postpartum haemorrhage', and recognises the need to request assistance from the appropriate members of the multidisciplinary team. Ensures that the baby is in a place of safety, such as the cot. Verbally considers the cause of the haemorrhage: tone, tissue, trauma or thrombin.
	Any Red Flag issue (leading DIRECTLY to patient harm) identified by assessor.

Shoulder dystocia marking criteria

Assessment criteria	
1	Recognises the emergency and calls for help, recognising the need to use the emergency buzzer. Declares the emergency clearly, stating 'Shoulder dystocia' and recognises the need to request assistance from the appropriate members of the multidisciplinary team – verbalisation accepted.
2	Asks the woman to stop pushing, reclines the back of the bed/couch and removes any pillows from behind the mother's head.
3	Carries out McRobert's manoeuvre – hyperflexes the mother's legs towards her abdomen. Once this position has been achieved, applies routine axial traction to try to deliver the fetal head. Supporting the woman to roll over into the all-fours position instead will likely have the same effect and is the decision of the midwife.
4	Applies suprapubic pressure from the side of the fetal back. This should be applied just above the maternal symphysis pubis in a downward and lateral direction. This should be conducted for no more than 30 seconds.
5	Evaluates for episiotomy – verbalisation accepted.
6	Attempts to deliver the posterior arm. Vaginal access should be gained posteriorly with fingers scrunched together while straight. Once the posterior arm is located and the wrist reached, the arm can be delivered in a straight line. Once the arm is delivered, routine axial traction should be applied to deliver the baby.
7	Attempts internal rotational manoeuvres. This is most successful when pressure is applied to either the anterior aspect or the posterior aspect of the posterior shoulder. If one of these is unsuccessful, the other should be attempted.
8	Supports the woman to roll over onto an all-fours position or verbalises the possible benefit of this change in position.
9	Demonstrates an awareness of additional manoeuvres of last resort – cephalic replacement and symphysiotomy – verbalisation accepted.
10	Verbalises the need for the midwife to ensure that the woman understands what has happened and has the chance to bond with her baby. Verbalises the importance of maternal observations to establish condition and the importance of completing all relevant documentation.
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'.
12	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.

Red Flags:

1	Recognises the emergency and calls for help, recognising the need to use the emergency buzzer. Declares the emergency clearly, stating 'Shoulder dystocia' and recognises the need to request assistance from the appropriate members of the multidisciplinary team – verbalisation accepted.
	Any Red Flag issue (leading DIRECTLY to patient harm) identified by assessor.

Unexpected Breech Birth marking criteria

Assessment criteria	
1	Recognises additional care needs for mother and newborn with unexpected breech presentation in the birth unit.
2	Recognises the emergency and the need to call for help and use the emergency buzzer. Declares the emergency clearly, stating 'breech birth', and recognises the need to request assistance from the appropriate members of the multidisciplinary team – verbalisation accepted.
3	Verbalises the need to prepare the environment and to clean hands.
4	Verbalises the need to communicate clearly to the woman, to include her in decision-making (for example, position for birth) and to gain consent.
5	Understands midwives' role in first-line assessment and the management of complications and additional care needs, to include clinical monitoring, preparing the environment, requesting organisation of transfer to be on standby, and maintaining professional standards.
6	Articulates the process of facilitating a physiological breech birth safely following evidence-based practices: hands off the breech, assistance, without traction, if necessary.
7	Articulates additional care that may be required: evaluates the need for episiotomy.
8	Demonstrates the ability to remove arms or, if nuchal, perform the Løvset manoeuvre, articulating the need for appropriate and timely intervention if progress is not made after the delivery of the umbilicus (poor tone, colour, delay of more than 5 minutes from delivery of the buttocks to the head, or more than 3 minutes from the umbilicus to the head). Avoids/minimises tactile stimulation to avoid reflex extension of the arms or head, avoids fetal trauma, grasps the fetus around the pelvic girdle (not soft tissues) and avoids hyperextension of the neck, keeps the back uppermost. Once the scapulae are visible, hook arms down by inserting finger in the elbow and flexing the arms across the chest, or, if nuchal, the Løvset manoeuvre is advised.
9	Performs the Mauriceau-Smellie-Veit manoeuvre to deliver aftercoming head (as per RCOG 2017).
10	Understands the need to promote a close and loving relationship at the point of birth and facilitates skin-to-skin contact between mother/father and the newborn.
11	Clearly communicates plan of care following birth to the examiner.

Red Flags:

	Any Red Flag issue (leading DIRECTLY to patient harm) identified by assessor.

Professional values station

Bereavement Care marking criteria

Assessment criteria	
1	Recognise the importance of building a respectful and trusting relationship with Helen, acting in Helen's best interests at all times (relationship building).
2	Provide clear, balanced information regarding the induction of labour process and be given adequate time in order to make an informed choice about her care (communication, partnership).
3	Provide individualised care and review Helen regularly as part of a holistic assessment of wellbeing and care requirements (holistic assessment).
4	Recognise the importance of providing respectful, empathetic, dignified care and promoting continuity of care and carer (continuity of care(r)).
5	Recognise the importance of advocating for Helen's care choices and work in partnership with Helen and the multi-disciplinary team, as required, to support Helen's choices (advocacy, partnership).
6	Recognise individual circumstances relating to stillbirth, including the arrangement of pastoral or spiritual care and supporting the family to spend time with their baby and build memories.

Red Flags:

	Any Red Flag issue (leading DIRECTLY to patient harm) identified by assessor.

Safeguarding marking criteria

Assessment criteria	
1	Recognises the importance of building a respectful and trusting relationship, acting in the mother and child's best interests at all times (relationship building).
2	Provides clear, balanced information about the outcomes of the postnatal check and follows up in a timely manner (communication, partnership).
3	Provides individualised care and reviews mother and child regularly as part of a holistic assessment of wellbeing and care requirements (holistic assessment).
4	Recognises the importance of providing respectful care and promoting continuity of care and carer (continuity of care(r)).
5	Recognises the importance of advocating for the mother and the child and works in partnership with the mother and the multi-disciplinary team, as required, to support mother and child (advocacy, partnership).
6	Recognises individual circumstances relating to the transition to parenthood, positive family attachment and bonding (bonding).

Red Flags:

	Any Red Flag issue (leading DIRECTLY to patient harm) identified by assessor.

Evidence-based practice station

Place of birth marking criteria

Assessment criteria	
1	Summarises the main findings from the article summary and draws conclusion, making recommendations for practice.
1a	Recognises the importance of building a respectful and trusting relationship, acting in the woman's best interests at all times.
1b	Provides clear, balanced information regarding all birth place options in order to facilitate an informed choice of place of birth and reviews this choice regularly as part of a holistic assessment of wellbeing and care requirements.
1c	Recognises individual circumstances relating to the transition to parenthood, positive family attachment and bonding.
1d	Recognises the importance of advocating choice of birth place and work in partnership with the woman and the multi-disciplinary team, as required, to support the woman's choice.
1e	Recognises that the woman should receive individualised care that promotes and optimises normal physiological processes.

Red Flags:

	Any Red Flag issue (leading DIRECTLY to patient harm) identified by assessor.

Induction of Labour at Term marking criteria

Assessment criteria	
1	Recognise the importance of building a respectful and trusting relationship with Tracy, acting in Tracy's best interests at all times (relationship building)
2	Tracy should receive clear, balanced information regarding the process of, as well as the risks and benefits of induction of labour versus expectant management, and be given adequate time, in order to make an informed choice (communication, evidence based care).
3	Irrespective of care plan choice, Tracy should be reviewed regularly as part of a holistic assessment of wellbeing and care requirements (continuity of carer, holistic assessment).
4	Recognise individual circumstances relating to the transition to parenthood, positive family attachment and bonding (bonding).
5	Recognise the importance of advocating for Tracy's choice and work in partnership with Tracy and the multi-disciplinary team, as required, to support Tracy's choice (advocacy, partnership).
6	Tracy should receive individualised care that promotes and optimises normal physiological processes (promoting physiological processes).

Red Flags:

	Any Red Flag issue (leading DIRECTLY to patient harm) identified by assessor.

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