AlphaPlus

NMC Nursing & Midwifery Council | Test of Competence

Test of Competence 2021: Marking Criteria Adult Nursing

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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 Guidance on Taking Your OSCE.

As part of continuous improvement of the assessment and in response to changes in clinical best practice, the marking criteria for a specific OSCE station can be subject to change, so the information presented in this document should be treated as indicative. Candidates must be confident in performing the skills required by the NMC and should not attempt to memorise or rote learn the marking criteria as these are subject to periodic change.

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.

For each station, a red flag can be applied if a candidate makes an action which could cause harm to a patient.

APIE stations

Assessment marking criteria: all APIEs

Assessment criteria	
1	Assesses the safety of the scene and the 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 (WHO) guidelines.
3	Introduces self to person.
4	Checks identity (ID) with the person (the person's name is essential, and either their date of birth or hospital number) verbally, against wristband (where appropriate) and documentation.
5	Checks for allergies verbally and on wrist band (where appropriate).
6	Gains consent and explains reason for the assessment.
7	Uses a calm voice, speech is clear, body language is open, personal space is appropriate.
8a	**Airway:** Clear; no visual obstructions.
8b	**Breathing:** Respiratory rate; rhythm; depth; oxygen saturation level; respiratory noises (rattle wheeze, stridor, coughing); unequal air entry; visual signs of respiratory distress (use of accessory respiratory muscles, sweating, cyanosis, 'see-saw' breathing).
8c	**Circulation:** Heart rate; rhythm; strength; blood pressure; capillary refill; pallor and perfusion.
8d	**Disability**: conscious level using ACVPU (alert, confusion, voice, pain, unresponsive); presence of pain; urine output; blood glucose.
8e	**Exposure**: Takes and records temperature; asks for the presence of bleeds, rashes, injuries and/or bruises; obtains a medical history.
9	Accurately measures and documents the patient's vital signs and specific assessment tools.
10	Calculates and records relevant scores accurately
11	Accurately completes document: signs, adds date and time on assessment charts.
12	Conducts a holistic assessment relevant to the patient's scenario.
13	Disposes of equipment appropriately – verbalisation accepted.

14	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
15	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, also notes red ID wristband (where appropriate).
5	Before administering any prescribed drug, looks at the person's prescription chart and checks **ALL** of the following information is correct: • 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).
6	Correctly checks **ALL** of the following*:* • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
7	Briefly acknowledges any possible contraindications and relevant 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) and highlights any specific information regarding instruction for administration (e.g. on an empty stomach, take with food, take after food, specific timing etc. (This may not be relevant in all scenarios)).
9	Administers drugs due for administration correctly and safely.
10	Omits drugs not to be administered and provides a verbal rationale (ask candidate reason for non-administration if not verbalised).
11	Accurately documents drug administration and non-administration.
12	Accurately documents the details of person administering medication on page 2.
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'.

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 details the 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'.

Clinical skills stations

Administration of Inhaled Medication (AIM) marking criteria

	Assessment criteria
1	Introduces self, explains procedure and gains consent.
2	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
3	Requests/assists the person to sit in an upright position.
4	Before administering any prescribed drug, looks at the person's prescription chart and checks **ALL** of the following information is correct: • 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.
5	Correctly checks **ALL** of the following*:* • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
6	Removes the mouthpiece cover from the inhaler.
7	Shakes inhaler well for 2 to 5 seconds.
8	With a spacer device: inserts metered dose inhaler (MDI) into end of spacer device. Asks the person to exhale completely and then grasp spacer mouthpiece with teeth and lips while holding inhaler, ensuring that lips form a seal.
9	Asks the person to tip head back slightly, and to inhale slowly and deeply through the mouth while depressing the canister fully.
10	Instructs the person to use single-breath technique to breathe in slowly for 2 to 3 seconds and hold their breath for approximately 10 seconds, then remove the MDI from mouth before exhaling slowly through pursed lips **OR** If the person can't hold their breath for more than 5 seconds, instructs the person to use 'tidal breathing' or 'multi-breath technique', breathing in and out steadily five times.
11	Ensures that the drug is administered as prescribed.
12	Instructs the person to wait 30 to 60 seconds between inhalations (if same medication) or 2 to 3 minutes between inhalations (if different medication). Shakes the inhaler between doses.
13	Cleans any equipment used and discards all disposable equipment in appropriate containers.
14	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
15	Dates and signs drug administration record.
16	Reassures the person appropriately. Closes the interaction professionally and appropriately.

17	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Administration of Suppository marking criteria

Assessment criteria	
1	Introduces self, explains procedure and gains consent.
2	Ensures that a bedpan, commode or toilet is readily available.
3	Dons a disposable plastic apron and non-sterile gloves.
4	Verbalises that they would request/assist the person to lie on their left lateral side with knees flexed, feet level or slightly raised, buttocks near to the edge of the bed (the manikin should not be moved into position for health and safety reasons).
5	Places a disposable incontinence pad beneath the patient's hips and buttocks.
6	Before administering any prescribed drug, looks at the person's prescription chart and checks that ALL of the following information is correct: • 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.
7	Correctly checks ALL of the following: • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
8	Prior to inserting the suppository, verbalises that they are observing the anal area for evidence of skin soreness, excoriation, swelling, haemorrhoids, rectal prolapse or infestation.
9	Places some lubricating jelly on a gauze square and lubricates the suppository. Separates the patient's buttocks and inserts the suppository using the correct end (referring to the manufacturer's instructions), advancing it approximately 2cm to 4cm. Repeats this procedure if additional suppositories are to be inserted.
10	Cleans any excess lubricating jelly from the patient's perineal and perianal areas using gauze squares after insertion of suppository.
11	Verbalises that they would advise the patient to remain lying down and retain the suppository for about 20 minutes or until they are no longer able to do so. Informs the patient that there may be some discharge as the medication melts in the rectum.
12	Verbalises that they would assist the patient into a comfortable position and offers a bedpan, commode or toilet facilities, as appropriate.
13	Maintains patient dignity: arranges the bedcovers to keep the patient covered as much as possible during the procedure and replaces patient's bedclothes and covers once the suppository has been inserted.
14	Disposes of waste appropriately and cleans any equipment used.
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 medicines administration record.

17	Reassures the person appropriately. Closes the interaction professionally and appropriately.
18	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Aseptic non-touch technique (ANTT) marking criteria

Assessment criteria	
1	Cleans hands with alcohol hand rub and dons disposable gloves and apron.
2	Cleans trolley with detergent wipes (or equivalent) from farthest to nearest point.
3	Removes and disposes of gloves and apron. Cleans hands with alcohol hand rub.
4	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 sterilised items and have changed colour, where applicable).
5	Places all the equipment required for the procedure on the bottom shelf of the clean dressing trolley (or suitable equivalent). (Equipment: sterile dressing pack, NaCl 0.9% for cleaning, alcohol cleaning wipes, wound dressing, alcohol hand rub, and disposable apron.)
6	Takes the trolley to the person's bedside, disturbing the curtains as little as possible.
7	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
8	Dons a disposable plastic apron.
9	Opens the outer cover of the sterile pack and, once verified that the pack is the correct way up, slides the contents, without touching them, onto the top shelf of the trolley (or suitable equivalent).
10	Cleans hands with alcohol hand rub.
11	Opens the sterile field using only the corners of the paper.
12	Opens any other packs, tipping their contents gently onto the centre of the sterile field. Uses alcohol wipe to clean the saline solution for 30 seconds, and allows it to dry for 30 seconds.
13	Cleans hands with alcohol hand rub and dons sterile gloves.
14	Carries out and completes the relevant procedure using an **aseptic non-touch technique**: • drapes sterile field around/under the wound area • states which hand will be 'clean' and which will be 'dirty' • dips gauze in saline solution, moving from the clean to dirty hand • cleans wound from clean to dirty areas in a single stroke, taking care not to over clean the wound • applies new dressing • avoids contaminating sterile field or key parts at all times.
15	Replaces bedcovers.
16	Disposes of waste 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	Checks that the person is comfortable and is able to reach the call buzzer.
19	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Blood glucose monitoring marking criteria

Assessment criteria	
1	Assembles the equipment required and checks that the strips are in date and have not been exposed to air.
2	Explains the procedure to the patient and gains consent.
3	Cleans own hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
4	Dons a disposable plastic apron and non-sterile gloves.
5	Checks that the patient's hands are visibly clean.
6	Takes a single-use lancet and takes a blood sample from the side of the finger, ensuring that the site of the piercing is rotated. Avoids use of index finger and thumb.
7	Inserts the testing strip into the glucometer and applies blood to the strip. Ensures that the window on the test strip is entirely covered with blood.
8	Verbalises giving the patient a piece of gauze to stop the bleeding.
9	Ensures 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.
10	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
11	Verbalises whether the result is within normal limits, and indicates whether any action is required.
12	Documents the result accurately, clearly and legibly.
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'.

Bowel Assessment marking criteria

Assessment criteria	
1	Completes the Bristol stool chart accurately, and signs, dates and adds time where required.
2	Handwriting is clear and legible.
3	Ensures that strike-through errors retain legibility.
4	Recommends specific action to be taken depending on scenario:
4a	If using photo A or B: Correctly recognises Bristol stool type 1 or 2 appropriately and proposes plan of care to reduce/prevent constipation: • considers possible causes of constipation, such as medication, and explores potential alternatives • offers dietary advice (increasing fibre, fruit and vegetables) • proposes obtaining a prescription for laxatives • considers dehydration and encourages increased fluid intake • encourages physical movement where possible • encourages not to ignore the urge to defecate • promotes positive toilet habits: privacy, positioning, breathing exercises and spending time going to the toilet • recognises the need to continue to assess bowels. To achieve full marks, the candidate needs to identify a minimum of five aspects of care. For partial marks, the candidate needs to identify a minimum of three aspects of care.
4b	If using photo C or D: Correctly recognises Bristol stool type 6 or 7 appropriately and proposes plan of care to reduce/prevent diarrhoea: • considers possible causes of loose stool: food poisoning, overflow, medication such as antibiotics, healthcare-acquired infection such as norovirus or Clostridium difficile, or malabsorption • considers infection-control measures: patient isolation, sending sample for culture • offers dietary advice (reducing fruit and vegetables) • proposes obtaining a prescription of antimotility medication if suspected non-infectious cause • considers dehydration and encourages increased fluid intake • considers perianal skin integrity • promotes positive toilet habits: privacy, positioning, close proximity to toilet/commode and spending time going to the toilet • recognises the need to continue to assess bowels. To achieve full marks, the candidate needs to identify a minimum of five aspects of care. For partial marks, the candidate needs to identify a minimum of three aspects of care.
5	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Catheter specimen of urine (CSU) marking criteria

Assessment criteria	
1	Explains and discusses the procedure with the person.
2	Checks that any equipment required for the procedure is available and, where applicable, is sterile (i.e. that packaging is undamaged, intact and dry, is within the expiration date, that sterility indicators are present on any sterilised items and have changed colour, where applicable).
3	If no urine is visible in the catheter tubing: cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, dons a disposable plastic apron and non-sterile gloves prior to manipulating the catheter tubing.
4	Applies non-traumatic clamp a few centimetres distal to the sampling port. Removes gloves and disposes appropriately.
5	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
6	Dons non-sterile gloves.
7	Wipes sampling port with 2% chlorhexidine in 70% isopropyl alcohol and allows drying for 30 seconds.
8	If using needle and syringe***:*** inserts needle into port at an angle of 45°, using a non-touch technique, and aspirates the required amount of urine, then withdraws needle. If using needless system: inserts sterile syringe firmly into centre of sampling port (according to manufacturer's guidelines) using a non-touch technique, aspirates the required amount of urine, and removes syringe.
9	Transfers an adequate volume of the urine specimen (approximately 10ml) into a sterile container immediately.
10	Discards needle and syringe into sharps container (if relevant).
11	Wipes sampling port with 2% chlorhexidine in 70% isopropyl alcohol and allows drying for 30 seconds.
12	Unclamps catheter tubing (if relevant).
13	Disposes of equipment including apron and gloves appropriately – verbalisation accepted.

14	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
15	Verbalises the need to label the container correctly and place into microbiology bag ready to send to laboratory as soon as the sample is obtained.
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'.

Fine-bore nasogastric tube insertion marking criteria

Assessment criteria	
1	Introduces self.
2	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
3	Assembles the 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 forward or backwards.
6	Performs a NEX measurement by measuring the distance from the patient's nose to their earlobe plus the distance from the earlobe to the bottom of the xiphisternum, adding 5-10cm (if candidate does not add 5-10cm, this is not a fail), taking note of the measurement marks on the tube.
7	Checks that the nostrils are patent by asking the patient to sniff with one nostril closed. Repeats with other nostril.
8	Lubricates approx 15-20cm of the tube with warm water.
9	Ensures a reciever is to hand, in case the patient vomits. Ensure there is working oxygen and suction at the bedside.
10	Inserts the proximal end of the tube into the nostril, and slides backwards and inwards along the floor of the nose to the nasopharynx. Stops if encounters any obstruction and tries again in a slightly different direction or uses other nostril.
11	Asks the patient to start swallowing if they are able to, as tube passes down nasopharynx into the oesophagus.
12	Advances the tube through the pharynx as 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, when the tube should be removed immediately.
14	Uses adherent dressing tape to secure the tube to nostril and cheek.
15	Aspirates a small amount of the stomach contents using a 50ml or 60ml syringe, confirming that the tube is in position by using a pH indicator strip to confirm the presence of acid (the pH should be equal to or less than 5.5). Uses 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 that the patient is comfortable post procedure.
19	States the 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).
20	Acts professionally throughout the procedure in accordance with NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’.

Fluid balance (FB) marking criteria

Assessment criteria	
1	Handwriting is clear and legible.
2a	Accurately transposes the information onto the fluid balance chart.
2b	Calculates the fluid intake balance accurately.
3	Calculates the fluid output balance accurately.
4a	Calculates and documents the total fluid balance accurately.
4b	Denotes negative or positive balance accurately.
5	Ensures strike-through errors retain legibility.
6	Prints and signs name on the chart.

In-hospital resuscitation (IHR) marking criteria

	Assessment criteria
1	Ensures personal safety (safe environment).
2	Checks the person for a response – shakes shoulders and asks ‘Are you alright?’
3	Shouts for help when the person does not respond (if not already done).
4	Opens airway and looks for any sign of obstruction.
5	Opens the airway using head tilt and chin lift (jaw-thrust if risk of cervical spine injury).
6	Establishes absence of breathing normally – for up to 10 seconds: • looks for chest movement • listens at the mouth for breathing • feels for air on their cheek
7	Establishes no signs of life – calls 2222. Ensures resuscitation team is called and resuscitation equipment requested. (If alone, leaves the person to get help and equipment.)
8	Starts chest compressions: • lower half of sternum • heel of one hand on top of the other • no pressure on the rib, abdomen or lower sternum • arms straight.
9	Performs effective chest compressions on a firm surface: • compression depth 5–6cm • rate 100–120 compressions per minute • allows the chest to recoil completely after each compression; does not lean on the chest.
10	After 30 chest compressions, completes two rescue breaths: • head tilt • gives rescue breath while watching the chest rise over about 1 second (using a bag-valve mask) • pauses, watching for the chest to fall • gives a second rescue breath • the two rescue breaths should take no more than 5 seconds.
11	Recommences chest compressions and continues resuscitation with correct compression: rescue breaths ratio 30:2.
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’.

Intramuscular injection (IM) marking criteria

Assessment criteria	
1	Introduces self, explains procedure and gains consent.
2	Before administering any prescribed drug, looks at the person's prescription chart and correctly checks **ALL** of the following: Correct: • 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.
3	Correctly checks **ALL** of the following: • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
4	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
5	Assembles the equipment required and prepares medication using drawing up needle, before replacing with either 21g or 23g needle prior to administration.
6	Dons a disposable plastic apron. Closes the curtains/door and assists the person into the required position. Removes the appropriate garment to expose injection site.
7	Assesses the injection site for signs of inflammation, oedema, infection and skin lesions.
8	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines. Dons non-sterile gloves.
9	Cleans the injection site with a swab saturated with isopropyl alcohol 70% for 30 seconds and allows to dry for 30 seconds.
10	Stretches the skin around the injection site.
11	Inserts the needle at an angle of 90° into the skin until about 1cm of the needle is left showing.
12	Depresses the plunger at approximately 1ml every 10 seconds and injects the drug slowly. (ONLY if using dorsogluteal muscles: pulls back on the plunger to check for blood aspiration.)

13	Waits 10 seconds before withdrawing the needle.
14	Withdraws the needle rapidly. Applies gentle pressure to any bleeding point but does not massage the site.
15	Applies a small plaster over the puncture site.
16	Ensures that all sharps and non-sharp waste are disposed of safely (including scooping method of re-sheathing and transportation of sharps) and in accordance with locally approved procedures.
17	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
18	Dates and signs drug documentation.
19	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Intravenous (IV) flush and visual infusion phlebitis (VIP) assessment 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, that sterility indicators are present on any sterilised items and have changed colour, where applicable).
2	Assesses the cannula and verbalises signs of phlebitis: pain, erythema (colour), oedema, palpable venous cord, pyrexia (idenitifies two for a partial and five for a full pass).
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 checks ALL of the following information is correct: • 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: • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
10	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels. Dons non-sterile gloves.
11	Cleanses the end of the needle-free cap with sterile alcohol wipes saturated with 70% isopropyl alcohol/2% chlorhexidine gluconate for 30 seconds, leaving to dry over 30 seconds
12	Connects the pre-filled syringe to the needle-free cap using an aseptic non-touch technique (ANTT).
13	Flushes the cannula using a pulsating action.
14	Asks the patient whether any discomfort is experienced while flushing.
15	Disposes of waste appropriately – verbalisation accepted.
16	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.

17	Dates and signs drug administration record.
18	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Mid-stream specimen of urine (MSU) and urinalysis marking criteria

Assessment criteria	
1	Discusses the procedure with the person and gains consent.
2	Explains to the person how to perform MSU (women to part labia and clean meatus with soap and water from front to back, men to retract foreskin and clean around meatus. Urinate a small amount and then stop the flow of urine. Hold the specimen pot a few centimetres away from urethra and urinate until cup is approximately half full.)
3	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
4	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 sterilised items and have changed colour, where applicable).
5	Gives person a clean specimen pot. (Assessor then hands the sample to the candidate.)
6	Dons a disposable plastic apron and non-sterile gloves.
7	Dips reagent strip into the urine for no longer than 1 second.
8	Holds strip at an angle at the edge of the container.
9	Waits the required time before reading the strip against the colour chart – verbalisation accepted.
10	Disposes of equipment appropriately – verbalisation accepted.
11	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
12	Identifies the possible significance of the findings, provides appropriate health information to the person according to the results, and informs of the actions to be taken next.
13	Accurately documents the readings according to reagent strip.
14	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Nasopharyngeal Suctioning 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. Explains the procedure to be carried out and the rationale for this.
3	Arranges a signal with the patient so that they can communicate if they wish to halt/stop, e.g. raising hand.
4	States that they will monitor the patient's condition throughout the intervention, i.e. colour, breathing pattern, respiratory rate, heart rate, secretions, and evidence of trauma and distress, using pre-suction baseline observations as a guideline.
5	Assists the patient to sit in a semi-upright position in chair/bed, supporting head with pillows and ensuring no head tilt forwards or backwards.
6	Dons a disposable plastic apron, non-sterile gloves, mask and goggles.
7	Checks that the nostrils are patent by asking the patient to sniff with one nostril closed. Repeats with the other nostril.
8	Selects an appropriate type and size of catheter for the task and size of the patient (size 10 or 12 accepted).
9	Sets suction to 12–20 kPa/100–150 mmHg, and checks suction is working.
10	Assembles equipment using non-touch technique, and attaches tubing to the wall suction canister and suction catheter to the tubing.
11	Lubricates the tip of the catheter with sterile water and gently inserts the catheter into the nostril as the patient inhales until the patient coughs or resistance is felt.
12	States that if resistance is felt or distress caused, such as uncontrolled coughing, the catheter will be withdrawn 1cm before applying suction.
13	Applies suction by placing thumb over valve. Slowly withdraws, maintaining the vacuum, applying continuous or intermittent suctioning (10-second intervals). States that they would repeat the procedure 2 to 3 times as required/tolerated.
14	Flushes the suction tubing with sterile water.
15	Ensures that the patient's face is clean and that they are safe and comfortable post procedure.
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	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Nutritional assessment marking criteria

Assessment criteria	
1	Accurately calculates the BMI and the score in step 1 of the malnutrition universal screening tool (MUST).
2	Identifies the percentage of weight loss and accurately calculates the score in step 2 of MUST.
3	Interprets the clinical information provided and accurately calculates the score in step 3 of MUST.
4	Accurately calculates an overall risk score and identifies the correct risk category.
5	Documents date, time and signature where required.
6	Verbally reports the findings to the examiner.
7	Verbally recognises that the patient will need referring to a dietician or nutritional support team.
8	Verbally proposes a plan to improve nutritional intake.
9	Verbally proposes monitoring the patient's nutritional status.
10	Verbally considers possible underlying causes, provides food choices and offers assistance with feeding, if required.
11	Handwriting is clear and legible.
12	Ensures that strike-through errors retain legibility.
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'.

Oral Care Plan marking criteria

Assessment criteria	
1	Handwriting is clear and legible.
2	Ensures that strike-through errors retain legibility.
3	Recommends specific action to be taken depending on scenario:
3a	**Patient A:** • Twice-daily teeth cleaning with soft, compact-headed toothbrush or a suction toothbrush. • Twice-daily chlorhexidine mouthwash to reduce the risk of ventilator-associated pneumonia. • Apply oral moisturiser to the oral mucosa and lip balm to the lips every 2 to 4 hours. • Minimise traumatic ulceration caused by endotracheal tubes by using specifically designed fasteners and bite block, and alternating tubing from side to side. • Use suction to prevent aspiration, as required. • Identifies the need for regular reassessment every 8 hours. • Or/and the candidate identifies an aspect of care that is relevant and evidence-based in addition to the list above. **To achieve full marks, the candidate needs to identify a minimum of six aspects of care.** **For partial marks, the candidate needs to identify a minimum of three aspects of care.**
3b	**Patient B:** • Twice-daily teeth cleaning with soft, compact-headed toothbrush or electric toothbrush. • Encourage self-care, using a foam handle to assist with holding a toothbrush and pump-action toothpaste. • Regular oral mouth cleansing/swabbing/hydration (ice chips or sips of water) throughout the day. • Mouthwash if able to tolerate. • Keep lips clean and moist using moisturiser/lip balm. • Regular wiping of face to minimise moisture on skin and use of moisturising barrier cream on lower jaw to protect skin from drool. • Or/and the candidate identifies an aspect of care that is relevant and evidence-based in addition to the list above. **To achieve full marks, the candidate needs to identify a minimum of six aspects of care.** **For partial marks, the candidate needs to identify a minimum of three aspects of care.**
3c	**Patient C:** • Twice-daily teeth cleaning with soft toothbrush, if able to tolerate. • Twice-daily chlorhexidine mouthwash, if able to tolerate. • Regular oral cleansing/hydration (ice chips or sips of water) throughout the day. • Apply oral moisturiser to the oral mucosa and lip balm to the lips every 2 to 4 hours. • Use of artificial saliva. • Offers analgesia. • Identifies the need for 8-hourly reassessment.

	• Or/and the candidate identifies an aspect of care that is relevant and evidence-based in addition to the list above. **To achieve full marks, the candidate needs to identify a minimum of six aspects of care.** **For partial marks, the candidate needs to identify a minimum of three aspects of care.**
3d	**Patient D:** • Twice-daily teeth and denture cleaning with soft toothbrush, if able to tolerate. • Twice-daily chlorhexidine mouthwash, if able to tolerate. • Regular oral cleansing and hydration (using spray or dropper or ice chips or sips of water) throughout the day. • Remove dentures overnight and soak them in cleaning solution. • Keep lips clean and moist using moisturiser/lip balm (but not petroleum jelly/Vaseline as on oxygen). • Identifies the need for 8-hourly reassessment. • Or/and the candidate identifies an aspect of care that is relevant and evidence-based in addition to the list above. **To achieve full marks, the candidate needs to identify a minimum of six aspects of care.** **For partial marks, the candidate needs to identify a minimum of three aspects of care.**
4	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Oxygen therapy marking criteria

Assessment criteria	
1	Explains the procedure to the person and discusses it with them.
2	Before administering any prescribed drug, looks at the person's prescription chart and checks that ALL of the following are correct: • person (checks ID with person: verbally, against wristband (where appropriate) and documentation) • target saturations • device and flow rate • date and time of administration • Any allergies.
3	Correctly checks ALL of the following: • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
4	Cleans hands with alcohol hand rub, or washes with soap and water, and dries with paper towels, following WHO guidelines.
5	Identifies/selects the correct equipment and assembles and attaches tubing to the flow meter.
6	Turns the oxygen flow meter on, selecting the correct flow rate of oxygen for the method of delivery. Verbalisation accepted which must contain explanation of method of measurement.
7	Demonstrates covering the one-way valve with fingers and verbalise that they would do this until the reservoir bag is fully inflated.
8	Applies the oxygen mask by placing over the patient's nose and mouth, then pulls the elastic strap over the head and adjusts the nose brace and straps on both sides to secure the mask in a position that seals the face but is not too tight.
9	Ensures that the chosen delivery method is comfortable for the patient.
10	States that they will reassess the saturations to check whether they are within the normal target range for the patient (94–98%), escalating if this is not achieved.
11	States that they will inspect the patient's skin regularly around the face, ears and back of head, and provide regular mouth care.
12	Signs, dates and records the flow rate and device on the drug administration record.
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'.

Pain assessment marking criteria

Assessment criteria	
1	Introduces self and explains the assessment to be carried out and the rationale and importance of this.
2	Considers the following aspects of pain:
2a	P = provokes Where is the pain? (point to area) What causes the pain? What makes it better? What makes it worse?
2b	Q = quality What does the pain feel like? Is it dull, sharp, stabbing, burning, crushing, shooting, throbbing? Is the pain intense?
2c	R = radiating Where is it? Is it in one place? Does it move around? Did it start somewhere else?
2d	S = severity How bad is it? Uses the universal pain scale to ascertain severity.
2e	T = time When did the pain start? How long has it lasted? Is it constant? Does it come and go? Is it sudden or gradual?
3	Acknowledges that the patient is in discomfort, and offers to make them more comfortable by repositioning.
4	Asks patient whether they have had any analgesia, and states will arrange for suitable analgesia.
5	Identifies the need to communicate with multidisciplinary team/doctor.
6	Identifies the need for regular reassessment.
7	Indicates the need to document findings accurately and clearly in the patient notes/charts.
8	Discusses the assessment and reassures the patient.
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'.

Peak expiratory flow rate (PEFR) marking criteria

Assessment criteria	
1	Explains the procedure to the person and obtains their consent.
2	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines. Dons non-sterile gloves and apron.
3	Assembles equipment.
4	Asks and assists the person to sit in an upright position.
5	Inserts a disposable mouthpiece into the peak flow meter or uses a single-use/reusable peak flow meter.
6	Ensures that the needle on the gauge is pushed down to zero.
7	Asks the person to hold the peak flow meter horizontally, ensuring that their fingers do not impede the gauge.
8	Asks the person to take a deep breath in through their mouth to full inspiration.
9	Asks the person to place their lips tightly around the mouthpiece immediately, obtaining a tight seal.
10	Asks the person to blow out through the meter in a short sharp ‘huff’ as forcefully as they can.
11	Takes a note of the reading and returns the needle on the gauge to zero. Asks the person to take a moment to rest and then to repeat the procedure twice, noting the reading each time.
12	Accurately documents the highest of the three acceptable readings.
13	Disposes of equipment appropriately – verbalisation accepted.
14	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
15	Acts professionally throughout the procedure in accordance with NMC (2018) ‘The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates’.

Pressure area assessment marking criteria

Assessment criteria	
1	Completes the Braden tool accurately, and correctly calculates the subscores and overall score based on the patient scenario and pressure damage identified.
2	Identifies the most vulnerable areas of pressure risk (formal anatomical or plain English terminology accepted): • heels • sacrum • ischial tuberosities (buttocks) • elbows • temporal region of the skull • shoulders • femoral trochanters (hips) • back of head • toes • ears • spine. To achieve full marks, the candidate needs to identify a minimum of 8 areas. For partial marks, the candidate needs to identify a minimum of 5 areas.
3	Identifies signs that may indicate pressure ulcer development: • 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. To achieve full marks the candidate needs to identify a minimum of 7 areas. For partial marks, the candidate needs to identify a minimum of 4 areas.
4	Documents findings and answers accurately, clearly and legibly.

Removal of urinary catheter (RUC) marking criteria

Assessment criteria	
1	Explains the procedure to the person and informs 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	Assembles the equipment required.
3	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
4	Dons a disposable plastic apron and non-sterile gloves.
5	Having checked volume of water in balloon (see patient documentation), uses syringe to deflate balloon in full.
6	Asks person to breathe in and then out. As person exhales, gently but firmly with continuous traction removes catheter.
7	Cleans and dries area around the genitalia and makes the person comfortable.
8	Encourages person to exercise and to drink 2.5 litres of fluid per day.
9	Disposes of equipment including apron and gloves 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	Verbalises asking the patient to inform the nurse when urine has been passed.
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'.

Subcutaneous injection marking criteria

Assessment criteria	
1	Explains and discusses the procedure with the person.
2	Before administering any prescribed medicine, looks at the person's prescription chart and correctly checks ALL of the following: Correct: • person (checks ID with person: verbally, against wristband (where appropriate) and documentation) • medicine • dose • date and time of administration • route and method of administration • diluent (as appropriate). • Any allergies.
3	Correctly checks ALL of the following: • validity of prescription • signature of prescriber • prescription is legible. If any of these pieces of information is missing, unclear or illegible, the nurse should not proceed with administration and should consult the prescriber.
4	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines. Dons a disposable plastic apron.
5	Assembles equipment required and prepares medication using non-touch technique.
6	Closes the curtains/door and assists the person into the required position. Removes the appropriate garment to expose injection site.
7	Assesses the injection site for signs of inflammation, oedema, infection and skin lesions. Rotates injection sites if having regular injections.
8	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels. Dons non-sterile gloves.
9	States would assess the cleanliness of the injection site. States that if the site is clean there would be no need to clean, however if required would clean with a swab saturated with isopropyl alcohol 70% for 30 seconds and allows to dry for 30 seconds.
10	Removes the needle sheath.
11	Gently pinches the skin into a fold.
12	Holds the needle between thumb and forefinger of dominant hand as if grasping a dart.

13	Inserts the needle into the skin at an angle of 90° (necessary for administering insulin) and releases the grasped skin. (An angle of 45° is permitted if the candidate considers the person to have less subcutaneous tissue present or if administering medication other than insulin.)
14	Injects the medicine slowly over 10 to 30 seconds.
15	Withdraws the needle and applies gentle pressure with sterile gauze. Does not massage the area.
16	Ensures that all sharps and non-sharp waste are disposed of safely (including scooping method of re-sheathing and transportation of sharps) and in accordance with locally approved procedures.
17	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
18	Signs and dates medicines administration record.
19	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Wound assessment marking criteria

Assessment criteria	
1	Checks that the patient is comfortable and verbalises that a pain assessment will be undertaken prior to procedure.
2a	Examines for erythema as part of assessing and reporting the condition of the wound.
2b	Describes the area around the wound.
2c	Describes any exudate as part of assessing and reporting the condition of the wound.
2d	Describes the closure.
2e	Describes the condition of the floor.
2f	Asks about pain and tenderness.
3	Describes any further actions that should be taken such as swab and referral to the medical team.

Professional values stations

Bullying marking criteria

Assessment criteria	
1	Recognises that any form of bullying and harassment is unacceptable and violates a person's human and legal rights.
2	Identifies that employers have a duty of care to provide a safe and healthy working environment for their staff, and that this is not achieved if a staff member is subjected to bullying.
3	Recognises the need to follow the actions set out in the local bullying and harassment policy.
4	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. Bullying is not a behaviour that protects others or promotes trust.
5	Encourages and supports Pat to report the incidents of harassment to the senior manager. Reports their own observations to the senior manager at the earliest opportunity, verbally and in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
6	Recognises that they may be asked by the senior manager to record a witness statement, documenting what was seen and what steps were taken to deal with the matter, including to whom the incident was reported. The witness statement must be signed and dated.
7	Recognises that Pat may need psychological support from the employee counselling service, and encourages her to use this resource.
8	Handwriting is clear and legible.

Concealment of bed status marking criteria

Assessment criteria	
1	Recognises that taking rest breaks using a bed intended for patients might result in a failure to provide necessary patient care and could place patient safety at risk.
2	Considers that the action taken to mislead the hospital site manager was dishonest and does not promote the fundamental tenets of truth and honesty.
3	Requests that the nurse in charge correctly inform the hospital site manager that the bed is empty. If this request is met with refusal, states that they would inform the site manager.
4	Acknowledges their professional duty to report to management any dishonest behaviour by a colleague that could result in the care of patients being compromised, and which could result in a notification to the Nursing and Midwifery Council. Failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
5	Raises the concern with the manager at the earliest opportunity, verbally and in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
6	Recognises that they may be asked by the manager to record a witness statement, documenting what was seen and which steps were taken to deal with the matter, including to whom the incident was reported. The witness statement must be signed and dated.
7	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.
8	Handwriting is clear and legible.

Confidentiality marking criteria

Assessment criteria	
1	Outlines and provides reassurance to the patient of professional responsibility to respect 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 concerns 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 apologise, 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.

False representation marking criteria

Assessment criteria	
1	Recognises that false impersonation to provide a reference is an unlawful fraudulent action.
2	Acknowledges their professional duty to report the unlawful and dishonest behaviour of the nurse to the senior manager and the professional body, the Nursing and Midwifery Council. Failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
3	Recognises that the action of falsely providing a reference could indirectly create a risk to the safety of patients in the care home.
4	Makes a clear written record of the occurrence, including the date and with whom the concern was raised.
5	Recognises that this action will need to be shared with police and will likely result in the need for a formal police statement.
6	Suspends the nurse in question from work, pending investigation, removing them from any forthcoming shifts from the roster, and identifying cover.
7	Identifies that the act of impersonating a ward manager breaches the fundamental tenets of truth and honesty set out in 'The Code' and does not promote professionalism and public trust.
8	Handwriting is clear and legible.

Falsifying Observations marking criteria

Assessment criteria	
1	Recognises that their colleague has deliberately misrepresented the care given by falsifying vital observations.
2	Identifies the need for immediate action to assess all patients' vital signs to ensure patient safety.
3	Documents events, actions and consequences in the patients' records, and completes an incident report.
4	Acknowledges their professional duty to report their colleague's dishonest behaviour to their manager, which may result in a notification to the Nursing and Midwifery Council. Failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
5	Reports concerns to the manager at the earliest opportunity, verbally and in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
6	Recognises that the fundamental tenets of the nursing profession are truth and honesty, and that this behaviour does not promote the standards and values set out in 'The Code' of promoting professionalism and trust.
7	Handwriting is clear and legible.

Falsifying timesheets marking criteria

Assessment criteria	
1	Recognises that falsifying timesheets for personal financial gain is an unlawful fraudulent action.
2	Acknowledges their professional duty to report the nurse's unlawful and dishonest behaviours to their manager and the professional body, the Nursing and Midwifery Council. Failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
3	Verbally reports concerns to the manager and the temporary staffing manager at the earliest opportunity, verbally and in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
4	Makes a clear written incident report of the occurrence, including the date and with whom the concern was raised.
5	Recognises that they may be asked to make a formal witness statement for the NHS fraud team and the police.
6	Recognises that the fundamental tenets of the nursing profession are truth and honesty, and that this behaviour does not promote the standards and values set out in 'The Code' for promoting professionalism and trust.
7	Handwriting is clear and legible.

Hospital food marking criteria

Assessment criteria	
1	Recognises that taking or consuming NHS or hospital property is prohibited and constitutes theft.
2	Acknowledges their professional duty to report their colleague's dishonest behaviour to their senior manager, which may result in notification to the Nursing and Midwifery Council. Failure to report concerns may bring their own fitness to practise into question and may place their own registration at risk, reflecting the duty of candour.
3	Attempts to locate a replacement meal that the patient is happy with. If this is not possible, considers that it may compromise good nutritional care.
4	Raises concern with the senior manager at the earliest opportunity, verbally or in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
5	Recognises that they may be asked by a senior manager to record a witness statement, documenting what was seen and what steps were taken to deal with the matter, including to whom the incident was reported. The witness statement must be signed and dated.
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.

Impaired performance marking criteria

Assessment criteria	
1	Recognises that their colleague's social behaviour has created the potential for patient harm, as Dana is not able to practise safely and effectively.
2	Acknowledges the requirement to uphold the reputation of the profession and display behaviours that promote public trust.
3	Recognises the professional duty to report any concerns that may result in the care of patients being compromised, and that the failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
4	Raises the concern with a manager at the earliest opportunity, verbally and in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
5	Considers that their manager may ask them to record an incident report/witness statement, documenting what they have seen and which steps were taken to deal with the matter, including to whom the incident was reported. The witness statement must be signed and dated.
6	Takes into consideration their responsibility for the safety of their colleague, considering the effects of alcohol on their ability to work and drive home.
7	Considers that their colleague may need further support in dealing with an alcohol misuse problem.
8	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.
9	Handwriting is clear and legible.

Laboratory results marking criteria

Assessment criteria	
1	Outlines their colleague’s professional responsibility to respect a patient's right to privacy and confidentiality in all aspects of care and the requirement to act with honesty and integrity at all times (the duty of candour).
2	Reassures the colleague that the paramedics would share any concerns about her neighbour's welfare with other healthcare professionals.
3	Recognises that accessing patient data without need or consent is a breach of the General Data Protection Regulation (GDPR), which may incur a financial penalty and also poses a question as to their colleague’s professional suitability.
4	Acknowledges the colleague’s concern and feelings, and that they are acting with care and compassion. However, explains the need to respect the patient’s right to privacy and confidentiality.
5	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.
6	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 to raise 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 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: • establishing rapport • use of 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.

Racism marking criteria

Assessment criteria	
1	Recognises that Piper is not adhering to the fundamental tenets of 'The Code' of promoting the health, wellbeing, rights, privacy and the dignity of individuals.
2	Recognises that the action of posting racially abusive comments demonstrates personal attitudinal views that deviate from the values of the nursing profession.
3	Acknowledges their professional duty to report Piper's unlawful racist behaviour to their manager and professional body, the Nursing and Midwifery Council. Failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
4	Identifies that, although there are no clinical concerns about Piper, patients may be put at risk because of the racist attitudes she holds.
5	Reports the post to the social media platform and 'unfriends' the colleague to dissociate from them.
6	Recognises that the employer may share the event with the police and so they may be required to make a formal statement.
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 the 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 the 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 the concern with a manager at the first 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.

Witnessed abuse marking criteria

Assessment criteria	
1	Recognises that their colleague has used an unsafe and clinically inappropriate moving and handling technique to manoeuvre the patient up the bed.
2	Recognises that the patient may have suffered physical harm by being forcefully moved up the bed, undertakes a full assessment, and ensures that the patient is comfortable.
3	Identifies that the tone and delivery of their colleague's words were aggressive and inappropriate and caused the patient emotional distress. Communicates with compassion and empathy to reassure the patient.
4	Acknowledges their own professional duty to report the colleague's behaviours to their manager, which may result in notification to the Nursing and Midwifery Council. Failure to report concerns may bring their own fitness to practise into question and place their own registration at risk, reflecting the duty of candour.
5	Raises the concern with a manager at the earliest opportunity, verbally and in writing. Recognises the need to be clear, honest and objective about the reasons for concern.
6	Documents what was seen and the steps taken to deal with the matter, including to whom the incident was reported. Identifies that the witness statement must be signed and dated.
7	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.
8	Handwriting is clear and legible.

Evidence-based practice stations

Ankle sprain 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 Xi that both paracetamol and ibuprofen are equally effective analgesics.
1c	Explains to Xi that some clinicians prefer to prescribe ibuprofen but there is no clear evidence that it is superior.
1d	Advises that the current available research suggests that paracetamol is an effective analgesia for pain resulting from soft-tissue injuries.
1e	Explains to Xi that, although ibuprofen is safe, it can have more adverse effects and be contraindicated in patients who have bronchospasm, cardiac and renal failure.
1f	Recognises that Xi is asthmatic and advises that paracetamol would be more suitable.

Autism Spectrum Disorder marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Explains to Charlie that healthcare professionals' poor knowledge and lack of understanding of autism spectrum disorder (ASD) are likely to be a barrier to those people who have autism accessing mental health support and treatment.
1c	Considers that healthcare professionals may need additional training to communicate with people who have autism.
1d	Explains that people who feel disregarded by healthcare professionals are less likely to seek further help.
1e	Informs Charlie that adults who have autism, previously diagnosed with Asperger Syndrome before 2013, are affected by a misperception that they have a learning disability, but this is not true. However, they may still have difficulties with understanding and processing information.
1f	Considers that mental health support and treatment may help Leslie's overall wellbeing and improve his self-harming behaviour.

Bedside handover marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusion, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Informs Tanveer that research has shown that adult patients and nurses both prefer handover at the bedside rather than elsewhere.
1c	Informs Tanveer that most patients find bedside handovers beneficial as they feel involved in their own care and it supports two-way communication.
1d	Advises Tanveer that patients prefer to have a family member/carer/friend present and to have two nurses rather than the nursing team present. However, having a family member/carer/friend present was not considered important by nurses.
1e	Explains to Tanveer that, while patients expressed a weak preference for having sensitive information handed over quietly at the bedside, nurses expressed a relatively strong preference for handing sensitive information over verbally away from the bedside.
1f	Advises Tanveer that developing the process and design of bedside handover can improve the implementation of this important patient-centred safety initiative in hospitals.

Cervical screening marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Explains to Roshni that the main cause of cervical cancer is human papillomavirus (HPV).
1c	Informs Roshni that it can take between 10 and 20 years for cervical cancer to develop from an HPV infection. Therefore, a woman's current sexual behaviour does not necessarily reflect her current risk.
1d	Explains that the peak age for developing cervical cancer is 30 to 45, but it can occur in anyone who has a cervix, irrespective of age.
1e	Discusses any concerns and/or fears about screening with Roshni.
1f	Advises Roshni that she should attend for screening every 3 years until she turns 49, when she should attend every 5 years. Women will be invited to attend after 65 only if they have previously received an abnormal result.

Cranberry juice and urinary-tract infections (UTIs) marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Explains to Freda that there is some research that shows that cranberry juice may prevent a UTI occurring in healthy individuals, if drunk regularly.
1c	Considers that cranberry juice may be less likely to induce nausea than other sugary drinks, when taken regularly.
1d	Informs Freda that there is no evidence available that cranberry juice may prevent UTIs in individuals who have high-risk conditions or those with indwelling catheters as people in these groups were not included in the study.
1e	Explains to Freda that there is no evidence available to suggest that cranberry juice can be used to treat a UTI in place of antibiotics.
1f	Informs Freda that it is necessary to note that the research was funded by a leading cranberry juice manufacturer, indicating a potential conflict of interest.

Dementia and music marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Informs Bindu's daughter that research trials have been conducted where music therapy has been introduced and that they have had some benefits for individuals who have dementia. The patients involved in the study had all had at least five music therapy sessions.
1c	Explains to Bindu's daughter that there is a lack of evidence that music therapy can improve symptoms of agitation.
1d	Explains that the current research available suggests some evidence to show that music therapy can positively improve depression, and this may provide a rationale for implementing music therapy.
1e	Informs Bindu's daughter that music therapy may have a positive effect on the overall quality of life of individuals who have dementia. However, this evidence is less reliable than the evidence on depression.
1f	Informs Bindu's daughter that there is no clear evidence on how long the effects created by music therapy remain after the activity stops.

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 she is less likely to suffer with hypoglycaemia as she is not prescribed insulin. However, hypoglycaemia remains a serious concern and she should be vigilant to monitor her 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 she experiences any of these symptoms.
1e	Advises the patient to inform friends and family that, if she appears confused or loses consciousness, she may be having a hypoglycaemic episode and will need emergency medical help by calling 999.
1f	Informs the patient that an episode of acute illness may cause irregularities in blood glucose, so she will need to monitor her blood sugars more frequently and report any changes.

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.

Fever in children marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Explains to Selai that the fever is an important immune mechanism in fighting the underlying infection and that it is recommended to treat a fever only if it is causing the child distress.
1c	Considers that both paracetamol or ibuprofen can safely be used to treat the fever.
1d	Informs Selai that it is recommended that Ibuprofen is taken with food to reduce potential gastric side effects and they should encourage the child to eat something when taking ibruprofen. However explains that ibuprofen is safe to adminster with or without food in the short term (up to 7 days).
1e	Considers whether the child has asthma, as both ibuprofen and paracetamol can exacerbate respiratory symptoms.
1f	Explains that healthcare professionals may perceive that ibuprofen has more adverse effects than paracetamol but that there is not the evidence to support this.

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, he may still develop a pressure ulcer, 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.

Restraint marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Explains to Bharva that compassionate communication may prevent the need to restrain patients.
1c	Considers that physical restraint may be necessary to promote the safety of staff and patients as a last resort after other options have been exhausted.
1d	Informs Bharva that physical restraint may promote fear in patients and distress among staff.
1e	Considers that physical restraint may be perceived as a demonstration of power that staff display over patients.
1f	Explains that the use of physical restraint may create a loss of trust and a breakdown in patient and staff relationships.

Saline versus Tap water marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, making recommendations for practice.
1a	Writes clearly and legibly.
1b	Informs Fiona that trials comparing the occurrences of wound infections when cleaned with sterile saline or tap water have shown no difference between the two.
1c	Advises Fiona that there is a lack of available evidence on the effects of water or saline on wound healing.
1d	Makes Fiona aware that there are no differences in patient satisfaction in either group. However, there was a lack of robust evidence on the instances of pain experienced by patients, or on adverse events.
1e	Highlights to Fiona that there were no standard criteria for assessing wound infection across the trials, which limited the ability to pool the data across studies and limited the results.
1f	Explains to Fiona that tap water has been recommended as a cost-effective option for wound cleaning.

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 that e-cigarettes are more likely to cause throat and mouth irritation, compared with nicotine replacement.
1e	Advises that nicotine replacement therapies are more likely to cause nausea.
1f	Emphasises that, without face-to-face support, there is low efficacy for both treatments, and recommends that the patient use a smoking cessation support service, signposting them to the local service.
1g	Positively acknowledges the 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 *Staphylococcus aureus* (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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