Test of Competence: 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 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 midwife entering the register.

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

APIE stations

Assessment marking criteria: Postnatal APIE

Assessment criteria	
1	Introduces self to the woman, stating name and role.
2	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.
3	Cleans hands with alcohol hand rub or washes with soap and water and dries with a paper towels, following WHO guidelines. Applies appropriate PPE.
4	Reviews history. Confirms situation - presenting symptoms.
5	Confirms background - medical history, antenatal and intrapartum care to date, medication
6	Gains consent and explains reason for postnatal check.
7	Completes a full postnatal assessment and verbalises maternal observations (temperature, pulse, blood pressure, respirations).
8	Enquires about perineum and breast comfort.
9	Considers and discusses the woman's mental health and wellbeing.
10	Accurately documents all maternal observations on MEOWS chart provided (temperature, pulse, blood pressure, respirations, passing urine, alert, pain score, lochia, looks well), assessing wellbeing/clinical deterioration using chart
11	Accurately completes MEOWS chart: signs, dates and adds time and monitoring frequency on assessment charts.
12	Identifies any maternal observations that are a cause for concern to the examiner.
13	Addresses health education sensitively to include healthy eating and fluid intake, resting when tired, breastfeeding advice, postnatal exercise including pelvic floor exercises, and care of the perineum.
14	Recognises that a plan of care is required because of the abnormal findings of the maternal assessment.
15	Verbal communication is clear and appropriate.
16	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviors for nurses, midwives and nursing associates'.

Planning marking criteria: Postnatal APIE

Assessment criteria	
1a	Identifies current situation, identifying main issues including presenting symptoms.
1b	Utilises relevant history including medical and obstetric history, medication and allergies.
1c	Logically and accurately documents the details of the postnatal assessment.
1d	Identifies plan of care for issues and needs. Logically and accurately documents the details of the recommendation.
1e	Sets appropriate review time for identified issue/need.
2	Ensures that midwifery recommendations are current/evidence-based/based on best practice.
3	Uses appropriate professional terminology in care planning.
4	Recognises the need to involve the woman in the care-planning process.
5	Writes clearly and legibly.
6	Accurately prints, signs and dates (when required).
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'.

Implementation marking criteria: Postnatal APIE

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 woman prior to administering medication.
3	Checks allergies on chart and confirms with the person in their care. Also notes red ID wristband (where appropriate).
4	Before administering any prescribed drug, looks at the person's prescription chart and correctly verbalises ALL of the following checks: • person (checks ID with person verbally, against wristband (where appropriate) and paperwork) • drug • dose • date and time of administration • route and method of administration.
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 midwife should not proceed with administration and should consult the prescriber.
6	Briefly acknowledges any potential side effects and contraindications, where relevant, and medical information prior to administration.
7	Provides a correct explanation of what the medication being administered is for to the person in their care.
8	Administers drugs due for administration correctly and safely (checks expiration date).
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'.

Evaluation marking criteria: Postnatal APIE

Assessment criteria	
1a	States the woman's name, hospital number and/or date of birth, and discharge address.
1b	States the reason for the handover.
2a	States the woman's name, hospital number and/or date of birth, and discharge address.
2b	States the reason for the handover.
2c	Outlines recent events and details findings from assessment.
3a	Outlines care and medical interventions completed.
3b	States areas of concern for maternal wellbeing.
4	Uses SBAR tool to hand information over verbally to the examiner
5	States what is required of the person taking the handover and proposes a realistic plan of action.
6	Verbal communication is clear and appropriate.
7	Acts throughout in accordance with the values and requirements of NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Assessment marking criteria: Labour and Birth APIE

	Assessment criteria
1	Introduces self to the woman, stating name and role.
2	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.
3	Cleans hands with alcohol hand rub or washes with soap and water and dries with paper towels, following WHO guidelines and puts on disposable gloves and apron.
4	Reviews history. Confirms situation – presenting symptoms, parity, gestation, presenting pain as appropriate.
5	Confirms background – medical history (to include allergies), obstetric history, medication.
6	Gains consent and explains reason for assessment.
7	Demonstrates appropriate infection-control practices before and after assessment.
8	Undertakes an abdominal examination and palpation.
9	Accurately performs maternal clinical observations and assesses labour progress
10	Accurately assesses fetal wellbeing.
11	Accurately records all maternal and fetal observations on the partogram.
12	Considers the findings of full intrapartum assessment and discusses findings with the woman.
13	Verbal communication is clear and appropriate
14	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviors for nurses, midwives and nursing associates'.

Planning marking criteria: Labour and Birth APIE

	Assessment criteria
1	Logically and accurately documents the details of the intrapartum assessment.
2	Assesses relevant history including medical and obstetric history, medication and allergies
3	Identifies main concern
4a	Provides recommendations according to NICE Intrapartum Care Guidelines
4b	Considers options to promote normal physiological processes and comfort for the woman.
4c	Continues with appropriate frequency of maternal and fetal observations according to NICE Intrapartum Care Guidelines.
4d	Recognises the need to include the woman in the care -planning process
5	Recommends an appropriate timeframe for medical review
6	Uses appropriate professional terminology in care planning.
7	Writes clearly and legibly.
8	Accurately prints, signs and dates (when required).
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'.

Implementation marking criteria: Labour and Birth APIE

Assessment criteria	
1a	Cleans hands with alcohol hand rub, or washes with soap and water and dries with a paper towels, following WHO guidelines and puts on disposable gloves and apron.
1b	Seeks consent from the woman prior to administering medication.
2	Checks allergies documented on the medicines chart and confirms with the person in their care. Also notes red ID wristband (where appropriate).
3	Before administering any prescribed drug, looks at the woman's prescription chart and correctly verbalises ALL of the following checks: · person (checks ID with person: verbally, against wristband (where appropriate) and paperwork) · drug · dose · date and time of administration · route and method of administration.
4	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 midwife should not proceed with administration and should consult the prescriber.
5	Briefly acknowledges any potential side effects and contraindications, where relevant, and the medical information prior to administration.
6	Provides a correct explanation of what the medication being administered is for to the person in their care.
7a	Demonstrates the safe preparation of the prescribed drug due for administration.
7b	Demonstrates the safe administration of the prescribed drug, including checking expiry date.
7c	Demonstrates the safe handling and/or disposal of sharps.
8	Accurately records drug administration and non-administration on the medicines chart.
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'.

Evaluation marking criteria: Labour and Birth APIE

Assessment criteria	
1a	States the woman's name, hospital number and/or date of birth.
1b	States the reason for the handover.
2a	States the date of admission/visit/reason for initial admission/referral to specialist team and diagnosis.
2b	Notes previous medical history, obstetric history and relevant medication/social history.
2c	Outlines recent events and details the findings provided from the most recent assessment.
3a	Outlines care and medical interventions completed.
3b	States areas of concerns for maternal wellbeing.
4	Uses SBAR tool to hand information over verbally to the examiner.
5	States what is required of the person taking the handover, and proposes a realistic plan of action.
6	Verbal communication is clear and appropriate.
7	Acts throughout in accordance with the values and requirements of NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Assessment marking criteria: Antenatal APIE

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. and puts on disposable gloves and apron.
3	Introduces self to the woman, stating name and role
4	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.
5	Checks for allergies verbally and on wristband (where appropriate).
6a	Reviews history. Confirms situation – presenting symptoms, parity, gestation, presenting pain as appropriate.
6b	Confirms background – medical history, obstetric history, medication.
7	Gains consent and explains reason for assessment.
8	Completes a full antenatal assessment
8a	Verbalises maternal observations – blood pressure, temperature, pulse, respiration, oxygen saturation, per vaginam (PV) loss.
8b	Accurately performs observations to assess fetal wellbeing – abdominal palpation, auscultates fetal heart (Pinard), fetal movements and considers cardiotocograph (verbalisation only), measures symphysis fundal height.
8c	Puts on disposable gloves and apron.
8d	Accurately performs urinalysis (as per manufacturer's instructions).
8e	Differentiates between fetal and maternal heart rate.
8f	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
9	Accurately documents all maternal observations on MEOWS chart provided, assessing wellbeing/clinical deterioration using chart.
10	Identifies any observations that are a cause for concern to the examiner.

11	Accurately completes MEOWS chart: signs, dates and adds time and monitoring frequency on assessment charts.
12	Verbal communication is clear and appropriate. Uses a calm voice, speech is clear, body language is open, and personal space is appropriate.
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'.
14	Disposes of equipment appropriately – verbalisation accepted.

Planning marking criteria: Antenatal APIE

	Assessment criteria
1	Assesses current situation, identifying main issues including presenting symptoms, parity, gestation and pain.
2	Assesses relevant history including medical and obstetric history, medication and allergies.
3	Uses relevant, antenatal assessment findings in their plan.
4	Identifies diagnosis based on antenatal assessment findings.
5	Identifies plan of care for issues and needs.
6	Sets appropriate review time for identified issue/need (in line with MEOWS chart).
7	Ensures that midwifery interventions are current/evidence-based/ based on best practice (in line with current National Institute for Health and Care Excellence guidelines).
8	Uses appropriate professional terminology in care planning.
9	Writes clearly and legibly.
10	Accurately prints, signs and dates (when required).
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'.

Implementation marking criteria: Antenatal APIE

	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 woman prior to administering medication.
3	Checks allergies on chart and confirms with the person in their care, and also notes red ID wristband (where appropriate).
4	Before administering any prescribed drug, looks at the person's prescription chart and correctly verbalises ALL of the following checks: • person (checks ID with person verbally, against wristband (where appropriate) and documentation) • drug • dose • date and time of administration • route and method of administration.
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 midwife should not proceed with administration and should consult the prescriber.
6	Briefly acknowledges any potential side effects and contraindications, where relevant, and medical information prior to administration.
7	Provides a correct explanation of what the medication being administered is for to the person in their care.
8	Administers drugs due for administration correctly and safely (checks expiration date).
9	Considers pain relief requirements.
10	Accurately records drug administration and non-administration.
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’.

Evaluation marking criteria: Antenatal APIE

Assessment criteria	
1a	States the woman's name, hospital number and/or date of birth.
1b	States the reason for the handover.
2a	States the date of admission/visit/reason for initial admission/referral to specialist team and diagnosis.
2b	Notes relevant previous medical history, obstetric history and relevant allergies/medication/social history.
2c	Outlines findings provided from the most recent assessment.
3a	Outlines current events findings from most recent assessment.
3b	Outline all care and medical interventions completed.
4	Uses SBAR tool to hand information over verbally to the examiner.
5	States what is required of the person taking the handover, and proposes a realistic plan of action.
6	Verbal communication is clear and appropriate.
7	Acts throughout in accordance with the values and requirements of NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Clinical skills stations

Birth marking criteria

	Assessment criteria
1	Encourages and supports the woman with contractions and informs her when the baby's head becomes visible.
2	Performs appropriate evidence-based care with regard to ensuring fetal wellbeing during the second stage of labour – the candidate should demonstrate auscultation at least once during the second stage of labour.
3a	Guides the woman appropriately to encourage controlled delivery of head during crowning.
3b	Safely facilitates the birth of the baby's head using either 'hands on' (guarding the perineum and flexing the head) or 'hands poised' (hands off the perineum and head but in readiness).
3c	Demonstrates the safe facilitation of the baby's body consistent with the mechanisms of labour, namely allowing for restitution, internal rotation and lateral flexion.
3d	Notes the wellbeing of the baby at birth.
3e	Places the baby on the woman's abdomen and supports immediate contact between the mother and baby.
4	Verbalises the need to administer 10iu/ml oxytocin by intramuscular injection to facilitate separation of the placenta.
5	Simulates the clamping and cutting of the umbilical cord. Candidate verbalises that this should be deferred for between 1 and 5 minutes.
6a	Recognises signs of placental separation (lengthening of umbilical cord, small gush of blood per vaginam, firming of the uterine fundus).
6b	Demonstrates the safe delivery of the placenta using controlled cord traction (CCT) following signs of placental separation.
7	Verbalises checking the placenta, membranes and umbilical cord, 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.
9	Calculates total estimated blood loss per vaginam.
10	Verbalises ensuring the comfort of the woman, ensuring that the woman is clean, providing a clean maternity pad and clean sheets and covering over to maintain dignity.
11	Verbalises performing maternal observations: pulse, blood pressure, temperature, uterine contraction and lochia – verbalisation accepted.
12	Verbalises the importance of completing relevant documentation, namely the partogram and maternal case notes.
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'.

Birth scenario 1 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. Considers removing the end of the bed or supporting the woman to move to the end of the bed.
3	Carries out the McRoberts manoeuvre and attempts to deliver the baby.
4	Applies suprapubic pressure from the side of the fetal back.
5	Evaluates for episiotomy – verbalisation accepted.
6	Attempts to deliver the posterior arm.
7	Attempts internal rotational manoeuvres.
8	Supports the woman to roll over onto all fours or verbalises the possible benefit of this change in position.
9	Verbally considers additional manoeuvres of last resort – cleidotomy, cephalic replacement and symphysiotomy.
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.
11a	Verbalises the importance of maternal observations to establish condition.
11b	Verbalises the importance of newborn observations to establish condition.
12	Verbalises the importance of completing all relevant documentation, including the anterior shoulder at the time of the dystocia.
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’.

Intra-muscular injection marking criteria

	Assessment criteria
1	Explains procedure and gains consent.
2	Before administering the prescribed drug, looks at the person's drug prescription chart and correctly checks and verbalises **ALL** of the following: Correct: • person (checks ID with person: verbally, against wristband and documentation) • drug • dose • date and time of administration • route of administration. • Any allergies.
3	Correctly checks and verbalises **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 midwife 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.
5a	Assembles the equipment required in a safe manner.
5b	Draws up betamethasone accurately using a filter needle.
5c	Replaces the filter needle with a 21g needle in preparation for administration.
6	Puts on a disposable plastic apron and gloves. Removes the appropriate garment to expose injection site.
7	Verbalises assessing the injection site for signs of inflammation, oedema, and infection.
8	Verbalises checking the cleanliness of the injection site. States that there would be no need to clean if the site is clean, but, if required, would clean with a swab saturated with 70% isopropyl alcohol.
9	Stretches the skin around the injection site.
10	Inserts the needle at an angle of 90° into the skin until about 1cm of the needle is left showing.
11	Depresses the plunger at approximately 1ml every 10 seconds, and injects the drug slowly.
12	Waits 10 seconds before withdrawing the needle.

13	Withdraws the needle rapidly. Applies gentle pressure to any bleeding point but does not massage the site.
14	Applies a small plaster over the puncture site.
15	Ensures that all sharps and non-sharp waste is disposed of safely.
16	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
17	Records date and time of administration and signs drug prescription chart.
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'.

Systematic Examination of the newborn (SEN) marking criteria

	Assessment criteria
1	Cleans own hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
2a	Explains the purpose of the systematic examination and the screening programme.
2b	Gains informed consent.
3a	Ensures the correct environment (warm, light, flat, firm surface, infant alongside mother).
3b	Reviews the case history and identifies any risk factors.
4	Involves the mother in assessing the health and wellbeing of the newborn, providing an ongoing explanation of the process and findings.
5a	Undertakes holistic assessment of the systematic examination of the newborn. This should include feeding, passing urine, and opening bowels.
5b	Selected key area 1 (heart or hips): complete assessment carried out including the essential aspects for the specific area.
5c	Selected key area 2 (eyes or testes): complete assessment carried out including the essential aspects for the specific area.
6	Accurately documents the examination of the newborn, and dates and signs the newborn health assessment document.
7	Has a logical process for the examination.
8	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Removal of Urinary catheter 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	Puts on a disposable plastic apron and non-sterile gloves.
5	Confirms volume of water in balloon is 10 ml, and uses the syringe to deflate the balloon in full.
6	Asks person to breathe in and then out and, as the person exhales, gently but firmly with continuous traction removes catheter – verbalisation accepted.
7	Cleans and dries area around the genitalia and makes Scarlett comfortable.
8	Encourages the person to mobilise and to drink 2.5 litres of fluid per day.
9	Disposes of equipment appropriately, including apron and gloves.
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 that the person should inform the midwife when she has passed urine.
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'.

IV flush and VIP 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 sterilized items and have changed colour, where applicable).
2	Assesses the cannula and verbalises signs of phlebitis: pain, erythema (colour), oedema, palpable venous cord, pyrexia (identifies 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 woman.
8	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.
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 woman 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'.

Postnatal care marking criteria

Assessment criteria	
1	Accurately calculates the MEOWS score, completes the chart in full and signs.
2	Accurately completes the inpatient maternal sepsis screening tool in full.
3	Uses the MEOWs chart results to make an accurate assessment of the woman's condition.
4	Uses the inpatient maternal sepsis screening tool to make an accurate assessment of the woman's condition.
5	Identifies appropriate escalation, informed by both the MEOWS chart and the inpatient maternal sepsis screening tool.
6	Uses SBAR tool to outline the appropriate next steps for care.
7	Identifies appropriate staff/grade to escalate concerns to and indicates diagnosis
8	Verbal communication is clear and appropriate.
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'.

Postnatal check marking criteria

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	Considers and discusses the woman's mental health and wellbeing. This should include appetite, energy levels, sleeping pattern, ability to cope with daily living, mood, anxiety and depression and family relationships.
3	Considers and discusses the woman's physical health and wellbeing. This should include signs of infection, pain, bladder and bowel function, lochia and perineal healing.
4	Considers and discusses signs and symptoms of venous thromboembolic disorders and identifies any risk factors.
5	Discusses the relevant aspects of infant feeding. This should include support and advice with feeding/ position/ attachment/ responsive feeding and a consideration of breast tenderness/engorgement and pain management.
6	Accurately records the health and wellbeing of the woman postnatally and signs document.
7a	Effectively implements an evidence-informed care plan for the woman.
7b	Considers family support within the plan of care.
8	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Birth scenario 2 marking criteria

Assessment criteria	
1a	Recognises the emergency and calls for help, recognising the need to use the emergency buzzer.
1b	Ensures that the baby is in a place of safety, such as the cot.
1c	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.
3	Rubs up a uterine contraction – this must be demonstrated. Ensures that the uterus is well contracted and that clots are expelled – verbalisation accepted.
4a	Checks the placenta - verbalisation accepted.
4b	Verbally identifies the need to check for trauma.
4c	Verbally identifies the need to site 2 large-bore cannulae, one in each arm.
4d	Verbally identifies the need to take blood for urgent samples and states which bloods are required.
4e	Verbalises the need to commence fluid resuscitation using a crystalloid infusion, e.g. Hartmann's solution or 0.9% sodium chloride.
5	Verbally identifies the need to catheterise the urinary bladder using an indwelling Foley catheter.
6	Identifies appropriate physiological observations to take and potential indicators of shock.
7	Verbally considers appropriate medication to stop the bleeding.
8	Performs bimanual compression of the uterus, clearly verbalising the appropriate steps.
9	Verbally considers other options that might be taken by the medical team if bleeding not settled.
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.
11	Verbalises the importance of maternal observations to establish condition and estimated or weighed blood loss.

12	Verbalises the importance of completing all relevant documentation including modified early obstetric warning score (MEOWS) chart.
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’.

Complex birth marking criteria

Assessment criteria	
1	Declares the emergency clearly, stating ‘Breech birth’, and recognises the need to request assistance using the emergency buzzer. States that the calling of a 999 ambulance is indicated – verbalisation accepted.
2	Gains consent to provide care and verbalises the need to communicate the emergency situation clearly to the woman.
3	Recognises the importance of involving the woman in care planning and decision-making, in particular position for birth, and making evidence based recommendations to the woman
4	Recognises the midwife’s role in first-line management of emergency breech, ensuring maternal and fetal wellbeing and that the nearby obstetric unit is aware of the emergency.
5a	Demonstrates the principles of facilitating a physiological breech birth safely, following evidence-based practices (hands off the breech unless assistance is required), supporting the woman to push with contractions to facilitate birth.
5b	Articulates the importance of the fetal back being uppermost (anterior in line with the symphysis pubis when woman is in a semi-recumbent position). Articulates if the back starts to rotate posteriorly, gently grasps the fetus around the pelvic girdle (not soft tissues) and rotates without traction to ensure that the back remains anterior.
6	Articulates the need for timely identification of delay (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) and delivery of extended legs and nuchal or extended arm(s) if progress is not made after the delivery of the umbilicus and there is evidence of poor fetal condition.
7	Evaluates the need for an episiotomy.
8	Demonstrates the ability to remove extended legs (in a semi-recumbent position)
9	Demonstrates the ability to remove nuchal arms, by performing the Løvset manoeuvre (in a semi-recumbent position)
10	Articulates the need to perform the Mauriceau-Smellie-Veit manoeuvre to deliver aftercoming head, when indicated due to delay or if there is evidence of poor fetal condition.
11	Demonstrates the ability to perform the Mauriceau-Smellie-Veit manoeuvre to deliver aftercoming head (in a semi-recumbent position)

12	Verbalises that poor fetal condition at birth is anticipated and a requirement for neonatal life support.
13	Articulates the need to facilitate skin-to-skin contact between mother and the newborn if the newborn's condition allows.
14	Articulates the requirement for contemporaneous documentation of the labour and birth.
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'.

Professional values stations

Safeguarding women and children marking criteria

	Assessment criteria
1	Acknowledges the need to escalate the safeguarding concern without women consent, reflecting the duty of candour.
2	Communicates with compassion and empathy in language appropriate to the mother, providing clear, balanced information about the outcomes of the postnatal check.
3	Identifies the need to act without delay, given the risk to woman safety, and to raise the 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. Recognises the importance of advocating for the woman and the baby.
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.

Bereavement care marking criteria

	Assessment criteria
1	Recognises the importance of building a respectful and trusting relationship with the person, acting in the person's best interests at all times (relationship building).
2	Provides clear, balanced information regarding the induction of labour process and gives the person adequate time to make an informed choice about her care (communication, partnership).
3	Provides individualised care and reviews the person regularly as part of an holistic assessment of her wellbeing and care requirements (holistic assessment).
4	Recognises the importance of providing respectful, empathetic, dignified care and promoting continuity of care and carer (continuity of care(r)).
5	Recognises the importance of advocating for the person's care choices and works in partnership with the person and the multidisciplinary team, as required, to support the person's choices (advocacy, partnership).
6	Recognises 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.

Evidence-based practice stations

Induction of labour at term marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, 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 the risks and benefits of induction of labour versus expectant management to facilitate an informed choice.
1c	Recognises individual circumstances relating to the transition to parenthood, positive family attachment and bonding.
1d	Recognises the importance of advocating for the woman's choice and works in partnership with the woman (and the multidisciplinary 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.

Place of birth marking criteria

Assessment criteria	
1	Summarises the main findings of the article summary and draws conclusions, 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 birthplace 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 birthplace, and works in partnership with the woman and the multidisciplinary 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.