Test of Competence: Marking Criteria

Nursing associates

V 1.1

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Important information

This document is intended to provide candidates with additional information to help them to prepare for the test of competence (Part 2). This document should be read in conjunction with the candidate information booklet, recommended/core reading, the mock OSCE and the 'Revised OSCE Top Tips Nursing Associate' document.

OSCE assessment

Assessment process

Each station is marked against unique criteria matched to the skill being assessed. Within each station's marking grid, there are essential criteria that a candidate must meet in order to pass. These reflect the minimum acceptable standards of a pre-registration nursing associate entering the register.

AIE stations

Hospital Admission – Assessment

ID	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 WHO guidelines.
3	Introduces self to person.
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).
6	Gains consent and explains reason for the assessment.
7	Uses a calm voice, speech is clear, body language is open, and personal space is appropriate.
8	Conducts an A to E assessment **(please refer to examiner guidance for specific scenarios)** – verbalisation accepted.
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 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 completes documentation accurately.

10	Calculates national early warning score accurately.
11	Accurately completes document: signs, dates and adds time (when appropriate) 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'.

Hospital Admission – Implementation

ID	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, and also notes red ID wristband (where appropriate).
5	Before administering any prescribed drug, looks at the person's prescription chart, checks and verbalises that ALL of the following are 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, and highlights any specific information regarding instruction for administration (e.g. on an empty stomach, take with food, take after food, specific timing etc. (prompt permitted). (This may not be relevant in all scenarios)'.
9	Administers drugs due for administration safely and correctly: • Administers correct dose • Checks expiry date • Handles medication correctly
10	Omits drugs not to be administered and provides verbal rationale (ask candidate reason for non-administration if not verbalised).
11	Accurately documents drug administration and non-administration.
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'.

Hospital Admission – Evaluation

	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 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 concern.
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)

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 correctly checks and verbalises that ALL of the following are 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 nursing associate should not proceed with administration and should consult the prescriber.
6	Removes the cover from the inhaler or spacer device.
7	Shakes inhaler well for 2 to 5 seconds.
8	With a spacer device: inserts the metered-dose inhaler (MDI) into the end of the spacer device. Asks the person to exhale completely and then to grasp the spacer mouthpiece with their teeth and lips while holding the inhaler, ensuring that their lips form a seal.
9	Asks the person to tip their head back slightly, 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	Administers drugs due for administration safely and correctly:

	• Administers correct dose • Checks expiry date • Handles medication correctly.
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, shaking 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'.

Pain assessment

	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 the patient is in discomfort, and offers to make them more comfortable by repositioning.
4	Asks the patient whether they have had any analgesia so far. States they will arrange for suitable analgesia.
5	Identifies the need to communicate with multidisciplinary team (MDT)/doctor.
6	Identifies the need for regular reassessment.
7	Indicates the need to document findings accurately and clearly in the patient notes/charts (when required).
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'.

Hospital admission

	Assessment criteria
1	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
2	Explains the admission process to be carried out.
3	Uses a calm voice, speech is clear, body language is open, and personal space is appropriate.
4	Checks patient ID and documents allergies and reactions on form.
5	Accurately completes patient demographic and medical history.
6	Documents pain score and reason for admission.
7	Documents the patient's activities of daily living at time of admission/assistance required, as well as other key issues.
8	Legible handwriting, adds signature, date/s and time/s to the documentation.
9	Acknowledges the patient's concerns and reassures the patient.
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'.

Fluid Balance

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.

Pressure Area Assessment

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.

Professional issues and behaviours stations

Confidentiality

Assessment criteria	
1	Listens to people and responds to their preferences and concerns, maintaining the professional responsibility to respect a patient's right to privacy and confidentiality in all aspects of care, but outlining 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 the patient's decision, linked to the 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

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 apologising, reflecting the 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.

Possible abuse

Assessment criteria	
1	Acknowledges the need to escalate the safeguarding concern without patient consent, reflecting the duty of candour.
2	Communicates with compassion and empathy in language appropriate to the patient.
3	Identifies the need to act without delay given the risk to patient 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.
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

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); and • 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 a 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.

Social media

	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 concern with a manager at the most 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.

Evidence-based practice stations

Diabetes

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, both 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 or 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)

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 early and correct recognition of MI symptoms is vital in order to seek medical care promptly and secure 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.

Honey dressing

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 medicalgrade honey improves outcomes for patients who have chronic venous leg ulcers.
1c	Informs the patient that one large study found no reduction in size of ulcer or healing time with honey as compared with standard treatment.
1d	Advises that, in the same study, patients reported an increased level 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.

Pressure ulcer prevention

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, a pressure ulcer may still develop, 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.

Smoking cessation

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 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.