Test of Competence: Marking Criteria

Mental Health Nursing

RN3 Mental Health Nursing Marking Criteria ToC V2.2 (Updated May 2025)

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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 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 Organisation (WHO) guidelines.
3	Introduces self to person.
4	Checks identity (ID) with person or carer (person's name is essential and either their date of birth or hospital number) verbally, against wristband (where appropriate) and documentation.
5	Gains consent and explains reason for the assessment.
6	Uses appropriate non-verbal body language (space, open posture, leaning forward, effective eye contact).
7	Uses appropriate questioning skills (open questions).
8	Builds trust and rapport by demonstrating compassion, taking time, active listening, and taking an interest.
9	Uses brief verbal and non-verbal affirmations.
10	Uses reflection/paraphrasing to demonstrate concern.
11	Conducts a holistic mental health assessment relevant to the patient's scenario using the recovery model of care areas, including patient self-care and non-adherence to prescribed medications.
12	Identifies and discusses any current risk factors.
13	Accurately completes any assessment tools included and accurately calculates and records score, where appropriate.
14	Discusses the assessment findings and the plan of action with the person and closes the assessment appropriately.

15	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
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'.

Planning marking criteria: all APIEs

Planning 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

	Implementation 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 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 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 • 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 safely and correctly: • Administers correct dose • Checks expiry date • Handles medication correctly.
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

Evaluation 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 detailing findings from assessment.
Assessment	
3a	States most recent observations (if applicable), 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'.

Skills stations

Intramuscular Injection 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	Closes the curtains/door and assists the person into the required position. Removes the appropriate garment to expose injection site.
6	Assesses the injection site for signs of inflammation, oedema, infection and skin lesions, rotating injection site if regular injections are needed.
7	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines.
8	States would check 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.
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. (ONLY if using dorsogluteal muscles: pulls back on the plunger to check for blood aspiration.)
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	Verbalises offering a plaster to the person.

15	Ensures that all sharps and non-sharp waste are disposed of safely and in accordance with locally approved procedures.
16	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels following WHO guidelines – verbalisation accepted.
17	Administers drugs due for administration safely and correctly: • Administers correct dose • Checks expiry date • Handles medication correctly.
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'.

De-escalation marking criteria

	Assessment criteria
1	Gains consent before entering the room.
2	Considers whether the physical environment is safe for self and person.
3	Introduces self to person.
4	Body language is non-threatening and relaxed.
5	Speech is clear and kind. Voice is calm, and tone and volume are low.
6	Places self at person's eye level or below. Establishes eye contact while avoiding staring.
7	Allows the person time to share their concerns. Shows empathy.
8	Uses open-ended questions.
9	Uses active listening and acknowledges the person's concerns using reflective language and validation.
10	Offers answers to specific questions where able.
11	Repeats content of conversation as needed.
12	Uses distraction technique, using information of the person's interests.
13	Recaps areas discussed prior to ending the intervention.
14	Appropriately ends the intervention.
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'.

Nutritional assessment marking criteria

	Assessment criteria
1	Accurately calculates the body mass index (BMI) and the records the BMI score in step 1 of the malnutrition universal screening tool (MUST).
2	Identifies the percentage of weight loss and accurately calculates and records the score in step 2 of MUST.
3	Interprets the clinical information provided and accurately calculates and records the score in step 3 of MUST.
4	Accurately calculates and documents an overall risk score and identifies the correct risk category.
5	Documents the 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 and provides food choices.
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'.

Physiological observations marking criteria

	Assessment criteria
1	Assesses the safety of the scene and 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	Gains consent and explains reason for the assessment.
6	Uses a calm voice, speech is clear, body language is open, and personal space appropriate.
7	Accurately measures and documents the patient's vital signs on assessment chart.
8	Calculates National Early Warning Score (NEWS) accurately, documents and states monitoring frequency and escalation.
9	Accurately completes documentation: signs, dates and adds time (when appropriate) on assessment chart.
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	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Reminiscence therapy

Marking criteria	
1	Introduces self to patient and checks patient ID by asking their name and/or date of birth.
2	Explains and discusses the intervention with the person.
3	Establishes rapport and uses appropriate eye contact and body language.
4	Chooses more than one of the items available to base discussion around and stimulate senses: • toy animals • vanilla essence • marbles • photographs.
4a	Sight: photographs, animals, marbles.
4b	Sound: animal noises, marbles.
4c	Smell: vanilla essence.
4d	Touch: animals, marbles, photographs.
5	Uses active listening and reflective skills to show engagement with the person.
6	Prompts the person sensitively, when appropriate.
7	Allows time for the person to respond to stimulus.
8	Demonstrates the ability to show empathy when emotional responses emerge.
9	Redirects discussion if traumatic or painful memories emerge.
10	Recaps areas discussed prior to ending the session.
11	Appropriately ends the session, thanking the person for sharing.
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'.

Talking therapies marking criteria

Assessment criteria	
1	Introduces self.
2	Checks patient's ID by asking for name and date of birth.
3	Gains consent to continue the visit.
4	Body language is open and relaxed, personal space adequate, voice is calm, and speech is clear.
5	Discusses the reason for referral and the patient health questionnaire (PHQ9) assessment.
6	Listens to and acknowledges the person's feelings using reflective language and validation. Shows empathy, acknowledging person's feelings, compassion, and kindness.
7	Explains the benefits of talking therapy, for example: • having time to talk, cry, shout or just think • having someone to listen to how they feel can help • it can be easier talking to a stranger than to relatives or friends • assisting to find own answers to problems • an opportunity to look at problems in a different way with someone who will respect you and your opinion in a non-judgmental manner. Overall aim: to help the person to feel better. Talking therapies won't make problems go away, but therapy may make it easier to cope with problems and feel happier.
8	Identifies and clearly explains the most relevant therapeutic interventions with the person. For example: • counselling • cognitive behavioural therapy (CBT) • psychotherapy • interpersonal therapy • mindfulness-based therapies.
9	Recommends a specific therapy, giving rationale for choice.
10	Recaps areas discussed prior to ending the visit.
11	Asks the person whether they have any questions, and correctly answers specific questions and provides information as required.
12	Appropriately concludes the visit.
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'.

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.

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 apologises, 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.

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 raising 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.

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.

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.

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

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 ibuprofen. However explains that ibuprofen is safe to administer 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, 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.

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 the patient that e-cigarettes are more likely to cause throat and mouth irritation compared with nicotine replacement.
1e	Advises the patient that nicotine replacement therapies are more likely to cause nausea.
1f	Emphasises to the patient that, without face-to-face support, there is low efficacy for both treatments, and recommends using a smoking cessation support service, signposting the local service.
1g	Positively acknowledges the patient's consideration of giving up smoking by offering support and encouragement.

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 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.