

Test of Competence 2021: Marking Criteria

Nursing Associates

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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 – reasonable adjustments (skill)

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 and explains the admission process to be carried out. Uses a calm voice, speech is clear, body language is open, and personal space is appropriate.
3	Demonstrates sufficient reasonable adjustments as needed to carry out the admission process of this patient.
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	Accurately documents any patient disabilities and reasonable adjustments required.
8	Accurately documents the patient's activities of daily living and any reasonable adjustments required.
9	Legible handwriting, adds signature, date/s and time/s to the documentation.
10	Acknowledges the patient's concerns and reassures the patient.
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'.

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.

Intramuscular injection (IM)

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 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) • 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 nursing associate 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.
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'.

Swab marking criteria

Assessment criteria	
1	Introduces self, explains procedure and gains consent.
2	Dons a disposable plastic apron and non-sterile gloves.
3	Verbalises that they would request/assist the patient into a suitable and comfortable position for swabbing (the manikin should not be moved for health and safety reasons) and asks to clear any discharge, if applicable.
4	Checks all equipment for expiry date and undamaged.
5	Pours saline into gallipot.
6	Removes swab, holding handle from outer packaging.
7	Conducts swabbing following correct procedure.
8	Maintains patient dignity, provides patient with tissues if required, and ensures patient is comfortable.
9	Disposes of waste appropriately.
10	Cleans hands with alcohol hand rub, or washes with soap and water, and dries with paper towels following WHO guidelines – verbalisation accepted.
11	Completes, dates and signs the microbiology request form correctly.
12	Reassures the person appropriately. Closes the interaction professionally and appropriately.
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 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.

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.