AlphaPlus

NMC Nursing & Midwifery Council | Test of Competence

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

Gaining informed consent – Assessment station

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	Checks for allergies verbally and on wrist band (where appropriate).
6	Gains consent and explains reason for the assessment. Consent needs to be documented in the patient notes.
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 the examiner's 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) • 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 specific assessment tools.

10	Accurately completes document: signs, dates, and adds time on assessment charts (where required).
11	Conducts a holistic assessment relevant to the patient's scenario.
12	Disposes of equipment appropriately – verbalisation accepted.
13	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
14	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates'.

Red flags:

	Candidate does not gain informed consent.

Gaining informed consent – Implementation station

Assessment criteria	
1	Explains and discusses the procedure with the person, ensuring that they understand the procedure and give informed consent.
2	Before administering any prescribed drug, looks at the person's prescription chart and checks ALL of the following: Correct: • person (checks ID with person verbally and against 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 candidate should not proceed with administration and should consult the prescriber.
4	Cleans hands with alcohol rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
5	Closes the curtains/door (as appropriate) 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	If skin cleansing is considered necessary, swabs for 30 seconds with isopropyl alcohol and then allows to dry for 30 seconds.
8	Removes the needle used for drawing. Gently pinches the skin to select the correct needle size (this is commonly 25G needle).
9	Explains the following procedure to examiner (prompts may be required): • Gently pinch the skin into a fold. • Hold the needle between thumb and forefinger of dominant hand as if grasping a dart. • Insert the needle into the skin at an angle of 90° (necessary for administering insulin) and the grasped skin in released. (An angle of 45° is permitted if the candidate considers the person to have less subcutaneous tissue present) - prompt permitted. • Inject the drug slowly over 10 to 30 seconds. • Withdraw the needle rapidly. • Apply gentle pressure with sterile gauze. • Do not massage the area.
10	Ensures that all sharps and non-sharp waste is disposed of safely (including scooping method of re-sheathing and transportation of sharps) and in accordance with locally approved procedures.
11	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines.
12	Signs and dates medicines administration record.
13	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code:

	Professional standard of practice and behaviour for nurses, midwives, and nursing associates'.

Red flags:

	Candidate does not gain informed consent.
	Safety of administration of medication. Administration should include the following essential criteria: • right patient/right route/right drug/right time/right dose. • The drug chart should be signed, with the date and time noted. If any of the above is missed, it should result in an automatic fail.

Gaining informed consent – Evaluation station

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

Pain assessment

	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 assessment to be carried out and the rationale for and importance of this.
3	Gains consent from the patient. Identifies the patient by checking name/date of birth or ID.
4	Uses the universal pain assessment tool provided alongside PQRST mnemonic to assess pain.
5	Acknowledges that the patient is in discomfort, and offers to make them more comfortable by repositioning.
6	Asks patient whether they have had any analgesia so far. States will arrange for suitable analgesia.
7	Identifies the need to communicate with the multidisciplinary team/doctor.
8	Identifies the need for regular reassessment.
9	Indicates the need to document findings accurately and clearly in the patient notes/charts.
10	Reassures the patient.

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	Conducts a holistic assessment relevant to the patient's scenario.
4	Acknowledges the patient's concerns.
5	Uses a calm voice, speech is clear, body language is open, and personal space is appropriate.
6	Clearly and legibly handwrites notes.
7	Accurately completes admission document, including adding signature, date/s and time/s to the documentation.
8	Reassures the patient.
9	Indicates the need to store document securely – prompt permitted.
10	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standard of practice and behaviour for nurses, midwives, and nursing associates'.

Gaining informed consent

Assessment criteria	
1	The candidate needs to demonstrate an understanding of consent. For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision.
2	Assesses that the person has **capacity** – the person must be capable of giving consent, which means that they understand the information given to them and can use it to make an informed decision.
3	Explains and discusses the procedure with the person. This means that they are **informed** – the person must be given all the information about what the procedure involves, including the benefits and risks, whether there are reasonable alternative procedures, and what will happen if the procedure does not go ahead.
4	Ensures that the consent is **voluntary** – the decision to consent or not to consent to treatment must be made by the person and must not be influenced by pressure from medical staff, friends, or family.
5	Accepts/recognises one of the following types of consent required from the patient/person: Verbal – for example, a person saying that they are happy to have a blood test. Non-verbal – for example, holding out an arm for a blood cuff to be placed on it.
6	Ensures that the agreed type of informed consent is gained and is documented before any action is carried out.
7	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standard of practice and behaviour for nurses, midwives, and nursing associates'.

Physiological observations

	Assessment criteria
1	Introduces self, explains procedure to the person, 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	**Blood pressure:** • assesses whether the patient has any contraindications to using a particular arm, such as lymphoedema, trauma or surgery, intravenous infusion • provides a relaxed and comfortable environment • ensures that the cuff is the correct size for the arm • ensures that the patient's arm is free from clothing and is supported on a pillow, placed mid-sternal level, legs are uncrossed, feet are flat on the floor, artery marking centred over the brachial artery and superior to the elbow • places the lower edge of the cuff 2cm to 3cm above the brachial artery pulsation • asks the patient to stop talking during the procedure • inflates the cuff on Dinamap.
4	**Pulse:** • places the first and second finger along the appropriate artery • applies light pressure until pulse is felt • counts pulse for 60 seconds • assesses rhythm – verbalisation accepted • assesses strength – verbalisation accepted.
5	**Respirations and pulse oximetry:** • counts respiratory rate for 60 seconds • assesses rhythm – verbalisation accepted • assesses depth – verbalisation accepted • observes for respiratory noises (rattle, wheeze, stridor, coughing) • observes for unequal air entry • observes for visual signs of respiratory distress (use of accessory respiratory muscles, sweating, cyanosis, 'see-saw' breathing) • determines the site to be used to perform the pulse oximetry (warmth and capillary refill) • ensures that the area is clean and that all nail polish and artificial nails have been removed.
6	**Temperature:** • inspects the ear canal • checks the thermometer for damage • verifies the mode setting (ear) • places disposable probe covering on probe tip • aligns the probe tip with the ear canal and gently advances into the ear canal, ensuring a snug fit • presses and releases the scan button.
7	Accurately measure and documents the patient's vital signs, completes documentation – signs, dates, and adds time.
8	Calculates national early warning score accurately.

9	Disposes of equipment appropriately – verbalisation accepted.
10	Cleans hands with alcohol hand rub, or washes with soap and water and dries with paper towels, following WHO guidelines – verbalisation accepted.
11	Acts professionally throughout the procedure in accordance with NMC (2018) 'The Code: Professional standards of practice and behaviour for nurses, midwives, and nursing associates'.

Red flags:

	Candidate does not accurately measure the patient's vital signs. Candidate does not accurately complete documentation, including signature, date and time.
	Candidate does not accurately calculate the national early warning score.

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.

Red flags:

	Any red flag issue (leading DIRECTLY to patient harm) identified by the assessor.

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.

Red flags:

	Any red flag issue (leading DIRECTLY to patient harm) identified by the assessor.

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.

Red flags:

	Any red flag issue (leading DIRECTLY to patient harm) identified by the assessor.

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.

Red flags:

	Any red flag issue (leading DIRECTLY to patient harm) identified by the assessor.

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.

Red flags:

	Any red flag issue (leading DIRECTLY to patient harm) identified by the assessor.

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.

Red flags:

	Any red flag issue (leading DIRECTLY to patient harm) identified by the assessor.

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.

Red flags:

	Any red flag issue (leading DIRECTLY to patient harm) identified by the assessor.

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 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.

Red flags:

	Any red flag issue (leading DIRECTLY to patient harm) identified by the assessor.

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.

Red flags:

	Any red flag issue (leading DIRECTLY to patient harm) identified by the assessor.

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.

Red flags:

	Any red flag issue (leading DIRECTLY to patient harm) identified by the assessor.

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