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Head Injury Assessment and Glasgow Coma Scale

Practical 01 / Skills laboratory simulation

Aim

Assess an adult head-injury scenario and record the eye, verbal and motor components of the Glasgow Coma Scale.

Principle

Serial assessments show how responsiveness changes over time. The individual components clarify which response changed and make the handover more informative.

Materials and Requirements

- Adult manikin or simulated patient, head-injury case cards and clock
- GCS scoring card and neurological observation chart

Procedure

1. Call for help, check airway, breathing and circulation and use spinal precautions as indicated. Attend to immediate threats before scoring responsiveness.
2. In the trauma scenario identify time and mechanism of injury, oxygenation, perfusion and any prior change in alertness. Ask the team for bedside glucose and treatment information as appropriate after addressing immediate threats.
3. Check for factors that may alter the findings, including sedation, an airway tube, swollen eyelids, language barriers and baseline neurological impairment.
4. Note which component each factor affects. If swelling prevents eye opening or an airway tube prevents speech assessment, mark that component NT and record the reason. Assess the components that remain testable.

Continue with step 5 on the next page.

Procedure Continued

Head Injury Assessment and Glasgow Coma Scale

5. Observe for spontaneous responses and apply the structured sequence for eye opening, speech and movement. Use a simulated pressure stimulus when indicated.
6. Look for eye opening at rest. If the eyes remain closed, use your voice and then a pressure cue supplied on the simulator if needed. Check speech with short orientation questions and note language or hearing limitations.
7. Ask the manikin operator or simulated patient for a simple movement on each side. Use the supplied signs to distinguish localising from flexion or extension. Score the best motor response and document any difference between sides.
8. Enter the best response for each component and the time. Compare with earlier observations and notify the responsible clinician promptly of new deterioration.
9. Record the individual scores with pupil size and reactivity and current vital signs. Give a total out of 15 only when all components can be scored. Describe change over time and obtain the next observation time from the supervising team.

Precautions

- Use case cues or a manikin to simulate pressure. Keep trained supervision for a clinical assessment.
- Use NT if a component is untestable. Record why and omit the total.

Observations and Interpretation

Head Injury Assessment and Glasgow Coma Scale

Observations and Record

Item	What to record	What it tells you
Eye opening	4 spontaneous, 3 to voice, 2 to pressure, 1 absent	Record which stimulus was needed
Verbal response	5 oriented, 4 confused, 3 words only, 2 sounds only, 1 absent	Note barriers and ability to test
Motor response	6 follows commands, 5 localises, 4 normal flexion, 3 abnormal flexion, 2 extends, 1 absent	Record best response and asymmetry

Worked Example

At 14:05 an adult opens their eyes to voice, speaks coherently but is disoriented and follows a request. Record E3, V4, M6 (13/15) with the time.

Result and Interpretation

Report all three components, test limitations, pupil findings and any change over time. Escalate deterioration immediately through the trauma team.

Viva Questions and Answers

What do E, V and M stand for?

Eye opening, verbal response and motor response.

How do you score speech if an endotracheal tube blocks assessment?

Record the verbal component as NT, state the reason and report the other components.

Surgical Swelling Ulcer and Lymph Node Examination

Practical 02 / Supervised clinical examination

Aim

Describe a swelling or ulcer systematically and examine its regional lymphatic drainage.

Principle

Site, tissue plane, consistency, mobility, skin changes and regional nodes help guide a surgical differential. Clear measurements make findings comparable over time.

Materials and Requirements

- Supervised patient, task model or photographs
- Light, disposable ruler and examination record

Procedure

1. Take a history of onset, progression, pain, trauma and systemic symptoms. Obtain consent and expose only the area needed.
2. Clarify onset, changes in size, discharge, pain and impact on function. Confirm side and site, examine with appropriate lighting and draping and check consent.
3. Inspect site, size, shape, border and overlying skin. For an ulcer describe the edge, base, surrounding skin and exudate.
4. Describe the site relative to a reproducible landmark, then measure length and width. For ulcers distinguish edge and visible base from surrounding skin and report drainage amount and appearance.

Continue with step 5 on the next page.

Procedure Continued

Surgical Swelling Ulcer and Lymph Node Examination

5. Palpate gently as appropriate for tenderness, temperature, consistency, mobility and relation to deeper planes. Compare sides when applicable.
6. Compare temperature and tenderness with adjacent tissue. If safe, assess whether the swelling moves relative to the skin and deeper tissues and record its texture and border.
7. Examine regional nodes and distal perfusion where relevant. Measure and document anatomical position and dimensions.
8. Assess relevant draining nodal groups by site, size, mobility and tenderness. When relevant check skin temperature and distal pulse and compare the two sides.
9. Summarise findings and propose targeted imaging, tissue or microbiology evaluation when indicated.
10. Present a consistent description with location, size, surface, palpation and associated findings. Explain the working differential and what further assessment would change management.

Precautions

- Do not compress a pulsatile mass or probe wounds during routine examination.
- Escalate rapid enlargement, systemic signs or impaired perfusion.

Observations and Interpretation

Surgical Swelling Ulcer and Lymph Node Examination

Observations and Record

Item	What to record	What it tells you
Lesion description	Exact site, dimensions and surface features	Standardises the findings
Palpation	Consistency, mobility, tenderness and tissue plane	Supports a local differential
Drainage and perfusion	Regional nodes and relevant vascular signs	Flags wider involvement

Worked Example

A painless 2 × 2 cm mobile subcutaneous lump has normal overlying skin and no palpable regional nodes. It has enlarged slowly over two years.

Result and Interpretation

The examination suggests a superficial lesion. Consider benign causes and arrange appropriate review of persistent growth or uncertain features.

Viva Questions and Answers

Why document two dimensions of an ulcer?

They establish a baseline for subsequent comparison.

Which node features should be recorded?

Site, size, tenderness, consistency, mobility and whether nodes are discrete or matted.

Hernia Examination and Urgent Features

Practical 03 / Supervised clinical examination

Aim

Examine a groin or abdominal wall swelling and recognise findings that require urgent surgical assessment.

Principle

Examination with posture and cough, relevant landmarks and symptoms supports classification. Pain, irreducibility, vomiting or systemic illness can indicate a complication.

Materials and Requirements

- Groin examination model or supervised patient with consent
- Ruler and anatomical landmark diagram

Procedure

1. Ask about duration, discomfort, posture-related change, previous surgery, vomiting and bowel symptoms. Offer a chaperone and maintain privacy.
2. Ask about onset and change with standing, lifting or coughing, previous hernia or operation and any recent inability to reduce the swelling. Identify pain, vomiting and obstruction symptoms.
3. Inspect standing and supine when safe. Identify swelling in relation to the pubic tubercle, inguinal ligament, scars and midline.
4. With appropriate draping compare both groins and relevant scars from standing and supine positions if safe. Describe the swelling in relation to the inguinal ligament and pubic tubercle.

Continue with step 5 on the next page.

Procedure Continued

Hernia Examination and Urgent Features

5. Observe cough impulse if appropriate. Assess tenderness, skin change and reducibility only when clinically safe under supervision.
6. If the patient is comfortable and the supervisor approves, observe for a cough-related change and assess tenderness and overlying skin. Defer manipulation in a painful, fixed or suspicious swelling.
7. Examine the opposite side and abdomen, recording distension and other relevant findings.
8. Assess distension, tenderness and other signs relevant to bowel involvement. Record whether the other side and relevant abdominal wall sites were examined.
9. Describe the suspected site and whether the presentation is elective or urgent.
10. Summarise side, landmark relationships, dynamic findings and red flags. If a complication is suspected, give the team the current clinical status and request urgent assessment.

Precautions

- Protect privacy and examine the model when consent or chaperone arrangements are unavailable.
- Avoid forcible manipulation.

Observations and Interpretation

Hernia Examination and Urgent Features

Observations and Record

Item	What to record	What it tells you
Site	Landmarks, side and relation to scars	Helps classify the defect
Dynamic findings	Postural change, cough impulse and reducibility if safe	Supports a hernia
Urgent features	Pain, irreducibility, vomiting and skin signs	Identifies possible obstruction or ischaemia

Worked Example

A previously reducible groin swelling is now painful and fixed. There is vomiting and abdominal distension.

Result and Interpretation

Suspect a complicated hernia and arrange urgent surgical assessment. Avoid repeated attempts to reduce a painful swelling.

Viva Questions and Answers

Which landmarks distinguish inguinal from femoral sites?

Relationship to the inguinal ligament and pubic tubercle.

What is a cough impulse?

Expansion felt or seen at the swelling with increased intra-abdominal pressure.

Acute Abdomen and Surgical Case Presentation

Practical 04 / Supervised clinical examination

Aim

Obtain a focused history, examine the abdomen and communicate signs needing surgical review.

Principle

Timing, site, radiation, systemic signs and prior operations guide the differential. Observation trends and peritoneal findings influence the urgency of assessment.

Materials and Requirements

- Fictional case record or supervised patient
- Vital-sign chart, examination couch and investigation request sheet

Procedure

1. Assess immediate stability and symptoms. Ask about onset, migration and severity, bowel and urinary symptoms, medicines, operations and pregnancy possibility when relevant.
2. Check vital observations, perfusion and alertness early. Establish when pain began, its course and associated vomiting, bleeding, urinary or bowel features, and alert the team promptly for instability.
3. Inspect for distension, scars and visible changes. Examine gently, beginning away from pain. Note focal tenderness, guarding and other clinically appropriate signs.
4. With permission inspect contour, respiratory movement, scars and distension. Begin gentle assessment away from the most painful site and observe the patient’s reaction to light palpation.

Continue with step 5 on the next page.

Procedure Continued

Acute Abdomen and Surgical Case Presentation

5. Consider hernial sites and extra-abdominal causes when indicated. Record the general examination and peripheral perfusion.
6. Record location and distribution of tenderness, whether guarding is voluntary or involuntary when safely assessed and the limits of the exam. Consider relevant thoracic, urinary or hernial clues.
7. Discuss the investigations that would change management. Include the reason for each test and its urgency.
8. Choose case-appropriate investigations and write the reason and urgency for each. Confirm pregnancy-related considerations and what requires prompt surgical review before completing routine steps.
9. Give a timed handover covering stability, onset, examination, differential and what help is required.
10. Give a timed report including earlier and current observations, pain evolution, leading concern and actions so far. Confirm which results are pending and who is reviewing the patient.

Precautions

- Stop repeated palpation if it causes distress or does not add information.
- An unstable patient requires escalation before routine history completion.

Observations and Interpretation

Acute Abdomen and Surgical Case Presentation

Observations and Record

Item	What to record	What it tells you
History	Pain course, associated symptoms and prior surgery	Guides the differential
Examination	Vital signs, tenderness and guarding	Assesses severity and possible peritoneal irritation
Work-up	Test, purpose and escalation	Prioritises next action

Worked Example

A young adult reports pain moving to the right lower quadrant, with fever and localised guarding. The pregnancy status is unknown.

Result and Interpretation

Request prompt surgical assessment and consider relevant pregnancy and other investigations under supervision. Document the clinical reasoning and changes in observations.

Viva Questions and Answers

Why ask about prior abdominal operations?

They raise the possibility of adhesions and inform examination of scars and hernial sites.

What does involuntary guarding suggest?

It may indicate peritoneal irritation and warrants clinical assessment.

Breast Lump Examination on a Task Model

Practical 05 / Skills laboratory simulation

Aim

Demonstrate a respectful and systematic breast and regional node examination on a task model.

Principle

Location, size, mobility, skin and nipple findings and regional nodes inform the clinical component of breast assessment.

Materials and Requirements

- Breast model, clock-face diagram and clinical record
- Fictional imaging and tissue result cards

Procedure

1. Explain the examination, obtain simulated consent and offer a chaperone. Ask about lump duration, pain, discharge and family history.
2. Explain the examination sequence and simulated exposure. Ask about change with time, nipple symptoms, prior imaging or procedures and relevant family history and maintain privacy.
3. Inspect for symmetry, skin changes and nipple contour in appropriate positions. Describe what is observed.
4. On the model compare contour, skin, nipple position and asymmetry in the prescribed positions. Note dimpling or tethering in a specific region where visible.
5. Use a consistent palpation pattern over the appropriate anatomical boundaries and tail. Record the lump by side, clock position and distance from the nipple.

Continue with step 6 on the next page.

Procedure Continued

Breast Lump Examination on a Task Model

6. Use finger pads and a consistent pattern to cover the designated breast boundaries, including the axillary tail. Mark each finding on the correct side using clock position and distance.
7. Characterise size, shape, consistency, tenderness and relation to surrounding tissue. Assess regional nodes using the model or supplied findings.
8. Record dimensions, shape, consistency, mobility and relation to skin and deeper planes. Review the appropriate regional node areas on the model and document barriers to a complete view.
9. Explain how clinical assessment, age-appropriate imaging and tissue diagnosis when indicated form the next assessment.
10. Present the findings and urgency without assuming a tissue diagnosis. Explain how imaging and possible sampling fit into the supervised assessment and document the result follow-up plan.

Precautions

- Practice intimate examination with models and obtain explicit consent during clinical postings.
- Use neutral wording while a diagnosis is being established.

Observations and Interpretation

Breast Lump Examination on a Task Model

Observations and Record

Item	What to record	What it tells you
Site and measurement	Clock position, distance, size and side	Allows reliable re-examination
Associated findings	Skin, nipple and node changes	Guides differential and urgency
Plan	Investigation and communication	Identifies who will review results

Worked Example

A firm, irregular model lump is at 2 o'clock, 4 cm from the nipple, with reduced mobility. The supplied card reports skin tethering.

Result and Interpretation

The findings require prompt breast assessment. Explain the investigation plan and arrange clinician review of all results.

Viva Questions and Answers

What is triple assessment?

Clinical assessment, appropriate imaging and tissue assessment when indicated.

Why specify distance from the nipple?

It improves localisation for repeat assessment and imaging correlation.

Thyroid Swelling and Cervical Lymph Nodes

Practical 06 / Supervised clinical examination

Aim

Examine a neck swelling and discuss findings that warrant targeted investigation or expedited referral.

Principle

Site, movement with swallowing, consistency and nodal distribution help distinguish thyroid lesions from other neck swellings.

Materials and Requirements

- Supervised volunteer or neck model
- Neck diagram and fictional ultrasound report

Procedure

1. Ask about duration, growth, voice change, swallowing, breathing, thyroid symptoms and prior irradiation.
2. Record timing of growth, systemic thyroid symptoms, prior neck treatment and voice, breathing or swallowing complaints. Obtain permission and seat the patient comfortably.
3. Inspect location and asymmetry from the front. Observe movement with swallowing when it is safe.
4. Inspect from front and side and locate the swelling relative to the midline, cricoid and sternocleidomastoid. Record movement with a safe swallow when appropriate.
5. Palpate gently for size, nodularity, tenderness and movement. Document the relationship to trachea and nearby structures as assessable.

Continue with step 6 on the next page.

Procedure Continued

Thyroid Swelling and Cervical Lymph Nodes

6. Identify the isthmus and both lobes with gentle palpation. Note size, nodules, texture and tenderness and whether the lower edge or tracheal position could be assessed.
7. Examine cervical nodes systematically. Discuss alternative sites such as salivary glands when clinically indicated.
8. Examine the relevant cervical node chains bilaterally and describe any node's level, consistency and mobility. Review signs pointing to a non-thyroid origin where appropriate.
9. Correlate findings with the directed ultrasound report and indicate when specialist assessment or image-guided sampling may be appropriate.
10. Summarise the clinical site, relevant symptoms, nodal findings and ultrasound characteristics. Flag airway compromise, persistent hoarseness or concerning nodal findings for senior assessment.

Precautions

• Avoid repeated provocative manoeuvres if breathing is compromised.

• Use gentle palpation and refer promptly for new airway symptoms.

Observations and Interpretation

Thyroid Swelling and Cervical Lymph Nodes

Observations and Record

Item	What to record	What it tells you
Swelling	Midline or lateral position, motion and consistency	Supports tissue of origin
Local concerns	Voice, swallowing, airway and nodes	Influences urgency
Imaging report	Size, features and location	Guides clinician-selected follow-up

Worked Example

A firm thyroid region nodule moves with swallowing. The patient reports new persistent hoarseness and a palpable cervical node is present.

Result and Interpretation

Document the concerning associated findings and request timely specialist review. Clinical appearance, imaging and tissue evaluation inform diagnosis.

Viva Questions and Answers

Why ask about hoarseness?

Voice change can indicate laryngeal or recurrent laryngeal nerve involvement and needs assessment.

Does swallowing movement establish a thyroid diagnosis?

It supports a relationship to the thyroid or laryngeal region, which requires correlation.

Peripheral Vascular Examination and Ankle Brachial Index

Practical 07 / Supervised clinical examination

Aim

Examine limb perfusion and interpret a measured ankle–brachial index.

Principle

Pulse, temperature, skin and symptoms guide assessment of arterial or venous disease. Ankle systolic pressure relative to arm pressure provides a non-invasive arterial measure.

Materials and Requirements

- Supervised volunteer or simulation case, Doppler trainer and correctly sized cuffs
- Limb vascular map and pressure worksheet

Procedure

1. Ask about exertional pain, rest pain, wounds, swelling and vascular risks. Inspect symmetry, colour, skin and ulcers.
2. Clarify onset, walking distance at symptom onset, rest symptoms, wounds and vascular history. Inspect both limbs and map changes by side and site.
3. Compare warmth and palpate the major pulses bilaterally. Record pulses by anatomical site and examine relevant sensory and motor functions.
4. Compare femoral or accessible distal pulses as appropriate, recording landmarks and relative strength. Note temperature, colour and sensation or movement changes and escalate a threatened limb promptly.

Continue with step 5 on the next page.

Procedure Continued

Peripheral Vascular Examination and Ankle Brachial Index

5. On the teaching setup measure both brachial pressures at rest and dorsalis pedis and posterior tibial systolic pressures for each ankle.
6. After resting supine for the training measurement, use correctly sized cuffs and the Doppler setup as taught. Label both brachial and both ankle artery readings for each side.
7. Divide the higher ankle pressure for each leg by the higher brachial pressure. Record the raw measurements and note non-compressibility or other limitations.
8. Choose the higher arm pressure for the denominator and the higher of the two valid ankle pressures for that leg. Compute each side separately and record technical limitations.
9. Summarise evidence of impaired perfusion and report acute changes urgently.
10. Relate the ratios to symptoms and pulses and identify non-compressible or discordant readings for review. Give an urgent handover for a new perfusion or sensory deficit.

Precautions

- A sudden cold painful limb, loss of pulse or new sensorimotor change requires immediate assessment.
- Record factors that may make vessels non-compressible.

Observations and Interpretation

Peripheral Vascular Examination and Ankle Brachial Index

Observations and Record

Item	What to record	What it tells you
Symptoms	Exertional and rest symptoms, onset and wound history	Suggests acuity and functional impact
Pulses and skin	Sites, sides, temperature and ulcer findings	Localises possible impairment
Index	Ankle and arm pressures with calculated ratio	Quantifies the pressure difference

Worked Example

The higher arm pressure is 140 mmHg. The larger right ankle pressure is 98 mmHg. The right ankle–brachial index is 0.70 in a case with exertional calf pain.

Result and Interpretation

This is an abnormal low result in the teaching case and supports peripheral arterial disease. Correlate with the full clinical findings.

Viva Questions and Answers

Why use both arms?

The higher valid brachial pressure is the standard denominator.

What is a limitation in some patients with diabetes?

Arterial calcification can make ankle pressures falsely high.

Surgical Asepsis Instruments and Suturing

Practical 08 / Skills laboratory simulation

Aim

Set up an aseptic field, identify common surgical instruments and close a model wound.

Principle

Protecting key parts and the sterile field reduces contamination. Appropriate tissue handling and approximation reduce avoidable damage.

Materials and Requirements

- Suture pad, needle holder, forceps, scissors and training sutures
- Sterile practice pack, gloves and sharps container

Procedure

1. Check identity of the procedure and pack indicators, integrity and expiry. Perform hand hygiene and establish a clean, organised practice area.
2. Review the model wound, planned closure and sterile supplies. Check packaging condition and expiry and arrange the sharps bin and instrument count before opening the field.
3. Open the pack without passing over the sterile field. Demonstrate glove use and protect key parts. Replace contaminated supplies.
4. Open the sterile pack by its edges and separate clean working surfaces from unused or used equipment. Demonstrate how clean gloves handle key parts and declare a simulated aseptic break immediately.

Continue with step 5 on the next page.

Procedure Continued

Surgical Asepsis Instruments and Suturing

5. Identify the purpose of the needle holder, tissue forceps and scissors. Load the needle with the holder and control the sharp throughout.
6. Identify the needle's curve, the holder and the tissue-contact instruments on the tray. Check grip and line of movement with faculty and keep the sharp under control.
7. On the pad, place a simple interrupted stitch with balanced bites and gentle approximation. Demonstrate a faculty-taught secure knot and cut the ends as directed.
8. Take comparable bites on either side of the practice incision using the model's marked landmarks. Bring edges together without puckering and tie the approved knot with controlled tension.
9. Inspect approximation, count and dispose of sharps and record the skill attempt.
10. Compare the completed stitches for spacing, approximation and tension. Recount instruments and sharps, dispose as trained and record one issue to correct on the next pad attempt.

Precautions

- Use a practice pad and approved sharps handling.
- Address each break in asepsis at once.

Observations and Interpretation

Surgical Asepsis Instruments and Suturing

Observations and Record

Item	What to record	What it tells you
Field	Pack check, preparation and any break in asepsis	Confirms safe setup
Stitch	Even bites, edge approximation and tension	Assesses closure quality
Finish	Counts, disposal and teaching record	Reduces sharps harm

Worked Example

Two trainer stitches approximate the simulated skin, but one visibly indents the pad. The student repeats it with lower tension.

Result and Interpretation

Balanced approximation and a stable knot demonstrate control. Document contamination or sharps risks that arose in the practice attempt.

Viva Questions and Answers

What is a key part?

A component whose contamination could introduce organisms into a vulnerable site.

Why avoid excessive tension?

It can compromise tissue and impair healing.

Trauma Primary Survey and Burn Assessment

Practical 09 / Skills laboratory simulation

Aim

Carry out an initial trauma assessment and describe burn size, site, depth and urgent concerns.

Principle

The primary survey identifies immediate threats before a detailed assessment. Burn extent and inhalation risk affect urgency.

Materials and Requirements

- Trauma and burn manikin, vital-sign cards and body charts
- Age-appropriate burn surface chart and emergency handover sheet

Procedure

1. Confirm scene and team safety, activate help and identify catastrophic external bleeding. Assess airway with indicated spinal protection.
2. Call for help, state the injury mechanism and allocate the relevant team roles. Apply the facility's immediate major bleeding and airway approach on the trainer with spinal precautions if indicated.
3. Evaluate breathing, circulation, disability and exposure, treating immediate threats within the supervised scenario. Keep the patient warm.
4. Assess symmetry and effort of breathing, then perfusion, mental state and exposure with warmth. Tell the team what you found, what action occurred and whether the response is adequate at each stage.

Continue with step 5 on the next page.

Procedure Continued

Trauma Primary Survey and Burn Assessment

5. Recognise rapidly worsening respiratory distress and shock after chest trauma. Declare possible time-critical chest injury and call for the appropriate team action.
6. Compare the current signs with the earlier observations and identify an immediately dangerous chest injury pattern in the simulation. Activate the appropriate response without delaying for a detailed survey.
7. For burns document mechanism, time, site, depth and extent using the appropriate age-based chart. Identify smoke exposure, facial injury and circumferential burns.
8. Mark burn locations and depth clues on the age-appropriate diagram and calculate the documented area. Record time, associated injury, restricted circulation or inhalation concern.
9. Reassess observations after each action and give a structured handover.
10. Repeat the primary survey after the simulated intervention, then pass mechanism, suspected injuries, vital signs, response and next priority to the receiving team.

Precautions

- Practise emergency procedures only on trainers.
- Estimate burned area with the correct chart and avoid counting simple erythema as partial-thickness injury.

Observations and Interpretation

Trauma Primary Survey and Burn Assessment

Observations and Record

Item	What to record	What it tells you
Primary survey	Immediate threats and response	Determines priorities
Burn record	Extent, distribution, suspected depth and mechanism	Guides referral assessment
Handover	Times, changes, interventions and remaining concerns	Supports safe transfer

Worked Example

A burn after an enclosed-space fire includes facial burns and a new hoarse voice. The student calls for urgent airway assessment before completing the body chart.

Result and Interpretation

Possible inhalation injury takes priority. Reassess airway and breathing and complete burn mapping when the clinical situation permits.

Viva Questions and Answers

Why reassess the primary survey?

Findings can change rapidly and interventions must be checked for effect.

Why use an age-adjusted burn chart?

The relative surface areas of the head and limbs change with age.

Perioperative Checks Consent and Postoperative Review

Practical 10 / Clinical or documentation case

Aim

Complete a perioperative safety review, practise consent discussion and recognise postoperative deterioration.

Principle

Shared identity, procedure and site checks prevent avoidable error. Documentation and trends support timely recognition of postoperative complications.

Materials and Requirements

- Mock theatre list, consent and safety checklist
- Fictional operation note, drain record and postoperative chart

Procedure

1. Verify patient, procedure, site, allergies, patient agreement and important risks. Review fasting, medicines, chronic conditions and nutritional risk.
2. Review patient identity, side, operation, fasting, relevant medicines, airway history and allergies with the team. Check consent, equipment readiness and which issues must be resolved before proceeding.
3. Explain the procedure’s purpose, benefits, material risks, alternatives and recovery. Confirm questions and use the simulated consent process.
4. Discuss the proposed operation and anticipated recovery in plain language, then review meaningful risks and alternatives. Invite questions and use teach-back before documenting the simulated choice.

Continue with step 5 on the next page.

Procedure Continued

Perioperative Checks Consent and Postoperative Review

5. Use the checklist to rehearse sign-in before anaesthesia, time-out before incision and sign-out before leaving the operating room.
6. Confirm checks aloud with the team at each stage, including site and procedure before incision and counts, specimen labels and recovery concerns before transfer.
7. Review postoperative observations, pain, wound, urine and drain trends. Identify deterioration or missing orders that require action.
8. Compare postoperative values with baseline and recent trends. Check alertness, breathing, perfusion, pain, urine and drain output and escalate a significant change with the exact time and values.
9. Hand over the procedure, concerns, actions and timing for follow-up.
10. Handover operation, anaesthetic and surgical issues, early findings, pending tasks and urgency. Confirm who will repeat the observations and review the next result.

Precautions

- Use clinical consent procedures with the responsible clinician during postings.
- Treat deterioration as a priority even when the checklist is incomplete.

Observations and Interpretation

Perioperative Checks Consent and Postoperative Review

Observations and Record

Item	What to record	What it tells you
Preoperative checks	Identity, site, allergy, agreement and issues	Prevents avoidable mismatch
Team checklist	Checks at each operative stage	Builds a shared plan
Recovery trend	Vitals, outputs, pain and actions	Detects complications

Worked Example

After a simulated operation, heart rate rises and urine output falls. Drain output increases and becomes bloodier.

Result and Interpretation

Escalate the change and assess possible bleeding or other causes of hypoperfusion promptly. Include baseline and current observations and timings.

Viva Questions and Answers

What is checked at time-out?

The team verifies patient, site and procedure and reviews critical concerns before incision.

Why record the actual drain trend?

Change over time may be more informative than a single value.

Surgical Tubes Stoma Care and Prostate Model

Practical 11 / Skills laboratory simulation

Aim

Identify common surgical devices, interpret a stoma record and demonstrate a consented prostate examination on a model.

Principle

Device type and output must be linked to indication and documented findings. Simulated intimate examination allows structured consent and technique practice.

Materials and Requirements

- Stoma trainer, drainage and feeding tubes, collection bags and output cards
- Rectal examination trainer and fictional urology record

Procedure

1. Match each device to its purpose. Trace the connections visually and identify label, security and leak concerns.
2. Review the purpose, location and indication of each demonstrated device. Trace it from patient connection to destination and check label, securement, condition and any missing authorisation.
3. On the stoma model assess colour, protrusion, output and skin integrity. Explain appropriate pouch fit and document changes.
4. Inspect model stoma appearance and surrounding skin under good light. Measure or review output by time and note when pain, discolouration or output change requires early review.

Continue with step 5 on the next page.

Procedure Continued

Surgical Tubes Stoma Care and Prostate Model

5. For the prostate station explain the examination, consent and chaperone process. Demonstrate positioning and model technique under guidance.
6. Explain privacy, position, permission and chaperone before moving to the prostate trainer. Describe the expected sequence and demonstrate only the approved techniques on the model.
7. Describe model tone and prostate size, surface, symmetry, consistency, tenderness and palpable abnormalities. State indications for further evaluation.
8. Enter tone and prostate findings on the worksheet and distinguish the site of a hard or tender area from the overall gland description. State any aspect that could not be assessed.
9. Report abnormal output, unexpected device findings or a concerning examination using a focused handover.
10. Report device, stoma and examination findings as separate records. Document which concern requires prompt team assessment and which finding needs scheduled follow-up.

Precautions

- Use models for intimate and invasive practice.
- Do not reposition or use a clinical tube without confirmation and authorisation.

Observations and Interpretation

Surgical Tubes Stoma Care and Prostate Model

Observations and Record

Item	What to record	What it tells you
Device	Type, indication, connections and output	Supports safe review
Stoma and skin	Colour, output, surrounding skin and fit	Identifies care or urgent concerns
Prostate model	Size, symmetry, surface and tenderness	Structures the examination report

Worked Example

The stoma card records a previously pink stoma now appearing dusky with abdominal pain. The urinary examination model has a palpable firm asymmetry.

Result and Interpretation

Escalate the change in stoma colour and pain urgently. In the separate prostate case, arrange clinician review of the abnormal findings.

Viva Questions and Answers

Why document stoma output over time?

Large or changing losses affect hydration and may reflect a complication.

What must precede an intimate examination?

An explanation, consent, privacy and a chaperone offer according to policy.

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