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Therapeutic Communication and Nursing Handover

Practical 01 / Supervised communication practice

Aim

Obtain relevant information respectfully and give a concise, traceable handover.

Principle

Identity, privacy and focused questions improve accuracy. A structured handover gives the receiving nurse the current concern, urgency and next action.

Articles and Materials

- Standardised patient brief and bedside chart
- Nursing note and SBAR handover forms

Procedure

1. Review the assigned task and identify the nurse responsible for supervision. Select a private, quiet place and prepare a form with the current date and time.
2. Introduce yourself as a student, verify two identifiers and explain the purpose and estimated duration. Ask permission and check language, hearing and interpretation needs.
3. Start with an open question and allow the person to describe the concern. Clarify onset, effect on activities and what they would like help with.

Continue with step 4 on the next page.

Procedure Continued

Therapeutic Communication and Nursing Handover

4. Confirm relevant symptoms, observations, medication or allergy information and any change from baseline. Separate the person’s words from measured findings.
5. Summarise the key points in plain language and invite corrections. Explain the next nursing action and who will review the concern.
6. Give handover using situation, background, assessment and recommendation. State the exact observation, time and requested response, including the urgency.
7. Ask the receiving nurse to confirm the plan or read back a critical value. Escalate a concerning change if the first contact cannot respond promptly.
8. Record the time, objective findings, person notified and response on the approved form. Use fictional identifiers in practice material.

Precautions

- Protect privacy and maintain a neutral tone.
- Record observations and actions at the correct time.

Observations and Record

Therapeutic Communication and Nursing Handover

Documentation

Item	What to record	Why it matters
History	Main concern in the person's words and onset	Preserves the account
Assessment	Measured value, method and time	Supports comparison and triage
Handover	Recipient, request and confirmation	Establishes responsibility

Worked Example

A patient reports new dizziness on standing at 09:10. The student documents the symptom and measured observations and asks the supervising nurse to review before further mobilisation.

Result and Evaluation

The receiving nurse can state the current concern and what must happen before the next activity.

Viva Questions and Answers

What does SBAR stand for?

Situation, Background, Assessment and Recommendation.

Why ask for a read-back?

It confirms that the recipient understood the critical finding and requested action.

Temperature Pulse Respiration and Oxygen Saturation

Practical 02 / Skills laboratory

Aim

Make reproducible observations and chart the measurements with their method and context.

Principle

Position, activity, route, oxygen support and signal quality influence interpretation. A measured trend helps detect deterioration.

Articles and Materials

- Digital thermometer and route trainer
- Watch, stethoscope and pulse oximeter
- Vital-sign chart

Procedure

1. Verify the case identity, explain the observations and note recent activity, symptoms, oxygen therapy and reasons to alter the measurement technique.
2. Inspect equipment, choose the authorised temperature route, check the device instructions and use a clean probe cover. Check route restrictions in the case.
3. Demonstrate axillary or tympanic measurement on the model and show oral technique as assigned. Review documented rectal route restrictions through the instructor’s model exercise.

Continue with step 4 on the next page.

Procedure Continued

Temperature Pulse Respiration and Oxygen Saturation

4. Count a radial pulse with fingertip pads and record rate, rhythm and strength. Use a full minute for an irregular rhythm and practise apical counting at the instructed landmark.
5. Observe chest or abdominal excursion with the person at rest. Record respiratory rate, pattern and effort, counting for a full minute when irregular.
6. Apply the appropriate oximeter probe, check the signal and compare displayed pulse with the observed pulse. Note room air or exact oxygen support.
7. Repeat an inconsistent reading after checking method and equipment. Alert the supervising nurse promptly for concerning symptoms or a significant change.
8. Enter values with units, route, position, oxygen support and time. Clean shared equipment and document the action and response.

Precautions

- Use the device and route approved for the person.
- Escalate distress promptly while checking the equipment.

Observations and Record

Temperature Pulse Respiration and Oxygen Saturation

Documentation

Item	What to record	Why it matters
Temperature	Reading, route, device and time	Makes measurements comparable
Pulse and breathing	Rates, rhythm and effort	Helps detect change
Saturation	Percent, oxygen context and signal	Supports useful reassessment

Worked Example

The displayed saturation is unstable on a cold moving finger. The student checks the clinical condition, repositions the probe, verifies pulse agreement and records the repeat and oxygen context.

Result and Evaluation

Record a usable set of observations and report relevant deviations and limitations.

Viva Questions and Answers

Why note the temperature route?

Normal readings and sources of error differ by route.

When should an oximeter reading be rechecked?

When signal quality is poor or the result conflicts with the person’s condition.

Blood Pressure Measurement and Charting

Practical 03 / Skills laboratory

Aim

Measure resting blood pressure and recognise when a discrepancy requires a repeat or clinical review.

Principle

Correct cuff fit, supported posture and consistent technique reduce measurement error.

Articles and Materials

- Validated upper-arm device and size range of cuffs
- Manual sphygmomanometer and stethoscope trainer
- Observation chart

Procedure

1. Verify the person's identity, symptoms and arm restrictions in the case. Explain the measurement and choose a suitable arm with supervisor input.
2. Allow quiet seated rest when the situation permits, keeping the back supported, feet flat and legs uncrossed. Support the bare upper arm at heart level.
3. Select the cuff using the marked circumference range and wrap it evenly with the artery marker over the brachial region. Keep tubing and cuff from restricting movement.
4. For the automatic device ask the person to remain still and quiet, start the reading and record systolic and diastolic values with units.
5. For the manual trainer obtain a palpatory estimate as taught, then use the brachial site and controlled cuff deflation. Identify systolic onset and diastolic disappearance of sounds.
6. Repeat an unexpected value with correct positioning and cuff size, allowing the interval required by the protocol. Record both readings and the conditions.
7. Report symptomatic or markedly changed results with time, side, symptoms and position. Use the facility's pathway before routine rechecking if the person is acutely unwell.
8. Document the readings and actions and clean and return the equipment. Compare the result with earlier measurements taken under similar conditions.

Precautions

- Check for restrictions on cuff use on a limb.
- Avoid repeated inflations without the protocol's rest interval.

Observations and Record

Blood Pressure Measurement and Charting

Documentation

Item	What to record	Why it matters
Position	Arm, body position and cuff size	Explains important method differences
BP	Systolic and diastolic in mmHg	Supports an accurate trend
Response	Repeat and person informed	Captures follow-up

Worked Example

The initial reading was taken with an unsupported arm and a small cuff. After checking the patient and using an appropriate cuff and support, the student records the valid repeat with its conditions.

Result and Evaluation

Chart the measured pressure and respond according to symptoms, trend and local escalation criteria.

Viva Questions and Answers

Why choose a cuff from arm circumference?

A poor fit can bias the reading.

What does the first Korotkoff sound indicate?

Systolic pressure in the usual auscultatory method.

Hot and Cold Applications and Comfort

Practical 04 / Skills laboratory

Aim

Select and apply a supervised thermal comfort measure and protect skin during its use.

Principle

Temperature, contact time, skin condition and sensation determine whether a hot or cold application is tolerated safely.

Articles and Materials

- Wrapped warm and cool packs, compress and barrier cloth
- Manikin skin cards, timer and comfort chart

Procedure

1. Review the scenario indication, authorised method and baseline pain or comfort. Check the skin, circulation, sensation and ability to report heat or cold.
2. Select the prescribed compress, wrapped cold pack or warm pack based on the card. Identify any condition such as poor sensation that requires the nurse to reconsider its use.
3. Prepare the device as instructed and check its temperature by the approved method. Use a clean barrier and keep any moisture away from the bed where appropriate.
4. Expose only the site, support it comfortably and place the pack or compress with the model protected. Set the prescribed time and explain what the patient should report.
5. Check the skin, comfort, colour and sensation at the station’s observation points. Remove the application and alert the nurse for pain, skin change or reduced tolerance.
6. Compare the supplied tepid sponging scenario with other comfort measures. Check the indication and facility guidance and stop on discomfort or shivering.
7. Remove the device at the stated time, dry and inspect the site if indicated and reposition the person comfortably.
8. Document method, site, start and end times, skin checks, symptoms and response. Arrange further review if comfort remains poor.

Precautions

- Use faculty-approved materials and timing.
- Protect the skin and stop if the person is unable to tolerate it.

Observations and Record

Hot and Cold Applications and Comfort

Documentation

Item	What to record	Why it matters
Baseline	Skin, sensation, circulation and symptoms	Helps assess suitability
Application	Type, site, barrier and timing	Supports safe delivery
Evaluation	Recheck and comfort response	Detects intolerance

Worked Example

A model skin card reports numbness at the planned site. The student withholds the application and asks the supervisor to reassess the method.

Result and Evaluation

Comfort is reassessed with skin condition and any limit on application documented.

Viva Questions and Answers

Why check sensation first?

Impaired sensation can delay recognition of an injury.

What should be recorded after removal?

Skin condition, symptoms, duration and response.

Basic Health History and General Assessment

Practical 05 / Supervised clinical practice

Aim

Collect a short nursing history and document general appearance, baseline function and priority observations.

Principle

Reported concerns and objectively observed signs guide nursing priorities and the need for further assessment.

Articles and Materials

- Standardised patient and assessment form
- Observation equipment and privacy screen

Procedure

1. Identify the patient with two approved identifiers, introduce your role and explain the planned history and examination. Arrange privacy and check whether support is needed.
2. Ask the main concern and its onset, changes and impact on sleep, transfers, eating or daily activity. Check the person's immediate concerns first.
3. Review medicines, allergy reactions, relevant illness, prior procedures and baseline function. Ask about mobility, sensory aids and any current precautions.
4. Observe appearance, breathing, alertness, posture and engagement before optional measurements. Escalate a significant acute change promptly.
5. Record vital observations and the appropriate pain score. Inspect skin colour and visible changes within the agreed examination and note any swelling or mobility limitation.
6. Use the case's ordered assessment sequence and describe findings by exact site and method. Stop when discomfort, consent or scope limits the examination.
7. Link a priority finding to a nursing concern, such as dizziness affecting transfer safety. Confirm the appropriate next check with the supervising nurse.
8. Write a dated summary with reported symptoms, observed results, limitations, action and the planned reassessment.

Precautions

- Ask permission before contact or exposure.
- Record only findings obtained and state any examination limits.

Observations and Record

Basic Health History and General Assessment

Documentation

Item	What to record	Why it matters
Reported history	Concern, onset and baseline function	Establishes context
Examination	Findings, units and limitations	Supports clinical review
Nursing priority	Concern, action and recheck	Guides continuity

Worked Example

A person normally walks independently but now feels unsteady after getting up. The student records the change, checks observations and arranges a supported transfer plan.

Result and Evaluation

A focused assessment identifies a clear nursing priority and a documented next step.

Viva Questions and Answers

Why compare with baseline function?

A new change may alter care and urgency.

What is one objective finding?

A measured respiratory rate with its time and conditions.

Hand Hygiene and Personal Protective Equipment

Practical 06 / Skills laboratory

Aim

Select standard precautions and demonstrate safe hand hygiene and PPE use.

Principle

Correct timing, coverage and removal help prevent transfer of contamination between people, equipment and surroundings.

Articles and Materials

- Hand hygiene station and fluorescent trainer if available
- Gloves, gown, mask and eye protection
- Ward task cards and waste bins

Procedure

1. Read the assigned task and identify risk from contact, splashes or respiratory exposure. Locate the hand hygiene station and appropriate waste containers.
2. State the five hand-hygiene opportunities for the scenario, covering before patient contact, before an aseptic task, after body-fluid risk, after contact and after touching surroundings.
3. For clean-looking hands demonstrate the approved handrub, covering palms, backs, interdigital areas, thumbs and fingertips until dry. For visible soil use soap and water as taught.

Continue with step 4 on the next page.

Procedure Continued

Hand Hygiene and Personal Protective Equipment

4. Select PPE appropriate to the task and area. Inspect the items, perform hand hygiene and put them on in the facility's approved sequence.
5. Check fit and role with a partner. On the trainer avoid touching the clean supply area after contact with the simulated patient or contaminated items.
6. Remove PPE using the posted sequence and hand hygiene at the designated points. A partner observes contamination markers if the station uses them.
7. Segregate waste and place dummy sharps directly in the point-of-use container. Follow the exposure reporting workflow for a simulated breach or injury.
8. Record missed hygiene moments, contaminated areas and the corrective step, then repeat the affected sequence.

Precautions

- Gloves complement hand hygiene.
- Use approved training items and the facility's disposal rules.

Observations and Record

Hand Hygiene and Personal Protective Equipment

Documentation

Item	What to record	Why it matters
Task	Exposure category and precautions	Guides selection
Hygiene and PPE	Observed sequence and coverage	Shows technique
Breach	Site, action and person notified	Supports prevention and follow-up

Worked Example

During glove removal a learner touches the simulated contaminated surface. The observer flags the breach and the learner performs hand hygiene and repeats the step.

Result and Evaluation

Confirm appropriate precautions, observe a safe sequence and document any correction.

Viva Questions and Answers

Why clean hands after removing gloves?

Contamination can occur during removal or through damage.

When is eye protection indicated?

When activity risks splashes or sprays to the eyes.

Bed Making and Patient Unit Preparation

Practical 07 / Skills laboratory

Aim

Make an appropriate bed and leave a clean, comfortable unit ready for safe use.

Principle

Safe linen handling, a smooth sleeping surface and an organised unit protect skin, dignity and infection prevention.

Articles and Materials

- Adjustable bed, mattress, sheets and draw sheet
- Linen bags, bed cradle or back rest and transfer model

Procedure

1. Review the type of bed and assigned patient needs. Prepare clean linen, privacy screen and bags, clean hands and check bed brakes before handling supplies.
2. Make a closed or open bed by positioning and securing the bottom sheet, placing the protective and draw sheets as indicated and arranging the top linen for the intended use.
3. For an occupied bed, explain the procedure, obtain assistance and check lines, mobility limits and pain. Turn the manikin safely and keep it covered while working on one side.
4. Roll used linen inward and place clean linen on the exposed mattress side. With safe assistance move the manikin onto that side, remove the used linen and pull the clean linen smooth.
5. For a postoperative bed prepare transfer space and equipment, verifying required supports and safe access. Review where cardiac or fracture positioning needs an authorised setup.
6. Smooth wrinkles and set equipment or comfort devices without rubbing skin or obstructing lines. Keep linen off the floor and handle soiled linen with minimal agitation.
7. Lower and secure the bed, check call bell and personal items are accessible and confirm the prescribed position and assistance plan.
8. Record bed type, skin or comfort finding and equipment used. Dispose of linen correctly and clean shared surfaces.

Precautions

- Use assistance for occupied-bed handling when needed.
- Keep used linen separate from clean supply.

Observations and Record

Bed Making and Patient Unit Preparation

Documentation

Item	What to record	Why it matters
Bed type	Closed, open, occupied or postoperative	Matches intended use
Linen	Position, cleanliness and wrinkle check	Protects skin and infection control
Unit safety	Brakes, level, aids and call bell	Reduces falls

Worked Example

After an occupied bed change the student finds tubing compressed beneath a draw sheet. The team frees the tubing, checks function and rechecks the manikin's position.

Result and Evaluation

A clean bed and patient unit are ready with comfort, device safety and call access checked.

Viva Questions and Answers

Why roll soiled linen inward?

It helps contain contaminated surfaces.

What must be checked before lowering the bed?

Alignment, line freedom, safety devices and the person's reach.

Therapeutic Positions and Repositioning

Practical 08 / Skills laboratory

Aim

Position a patient model for an indication while supporting alignment, breathing and skin.

Principle

Position changes affect comfort, ventilation, pressure areas and device tension. Selection follows the indication, tolerance and clinical restrictions.

Articles and Materials

- Adjustable bed and manikin
- Pillows, wedges, bed cradle and model tubing
- Positioning and skin chart

Procedure

1. Review the ordered or planned position, mobility and spinal or postoperative restrictions and the purpose of the change. Ask about pain and obtain consent in the scenario.
2. Lock the bed, raise it for safe work, explain the team plan and secure any catheter, oxygen or drainage tubing. Use a slide aid and additional staff when indicated.
3. Demonstrate supine and low, semi or high Fowler positions, recording elevation and supporting pressure areas and alignment. Check breathing and comfort before advancing.
4. Set side-lying and Sims positions using pillows and avoiding pressure on dependent limbs. On the approved trainer demonstrate prone positioning using the assigned airway and team checks.
5. Identify dorsal recumbent, lithotomy and knee-chest positions only for the indicated model task with support and privacy. Demonstrate Trendelenburg only for an authorised indication.
6. Turn or logroll the dependent manikin as directed with staff working on one count. Maintain alignment and use the drawsheet or transfer aid.
7. Recheck comfort, skin at pressure points, symmetry, perfusion where relevant and tubing position. Set rails and call access according to the safety plan.
8. Document time, position, reason, person’s tolerance and the next change or review due.

Precautions

- Use a team and appropriate equipment for dependent moves.
- Follow restrictions and keep pressure areas visible for review.

Observations and Record

Therapeutic Positions and Repositioning

Documentation

Item	What to record	Why it matters
Position	Type, elevation and reason	Explains the choice
Support	Pillows, alignment and line checks	Prevents avoidable pressure or pull
Reassessment	Skin, breathing, pain and next review	Evaluates tolerance

Worked Example

During lateral positioning oxygen tubing is caught under the shoulder. The team relieves tension and reassesses breathing before completing the move.

Result and Evaluation

The intended position is achieved with supported alignment and a documented safety reassessment.

Viva Questions and Answers

Why check tubing before turning?

A move can obstruct or dislodge a device.

What determines repositioning frequency?

Skin risk, tolerance, mobility and the individual nursing plan.

Pain Assessment and Comfort Measures

Practical 09 / Supervised clinical practice

Aim

Assess pain consistently, provide an approved comfort measure and evaluate its effect.

Principle

An appropriate pain scale, symptom history and timed reassessment help the team judge comfort and detect deterioration.

Articles and Materials

- Symptom cards and age-appropriate pain scales
- Comfort aids and reassessment chart

Procedure

1. Explain the assessment, confirm identity and ask where and when pain began. Identify sudden severe pain or other symptoms needing prompt escalation.
2. Ask about quality, radiation, timing, triggers and relief, then assess effect on breathing, sleep, movement and daily care.
3. Choose a suitable observed or self-reported scale and explain how it works. Record baseline score, scale, position and time.
4. Review recent measures and the authorised comfort plan. Select a suitable position, support, quiet environment or other indicated non-drug measure.
5. Demonstrate the chosen measure with consent and check skin, alignment, breathing and device safety. Coordinate any ordered analgesia with the supervising nurse.
6. Reassess pain and function after the interval appropriate to the measure, using the same scale and conditions where feasible.
7. Check for unexpected symptoms or adverse effects and inform the nurse if pain persists, worsens or is accompanied by deterioration.
8. Record the patient’s goals, measure used, baseline and follow-up scores, timing and planned next action.

Precautions

- Use the patient’s account where possible.
- Follow the escalation plan for severe or changing symptoms.

Observations and Record

Pain Assessment and Comfort Measures

Documentation

Item	What to record	Why it matters
Pain	Site, description, score and scale	Establishes baseline
Measure	Action, time and safety checks	Links care to evaluation
Recheck	Score, function and further action	Tests effect

Worked Example

Repositioning reduces reported incisional discomfort from 6 to 4 on the same scale while coughing remains painful. The student records both findings and asks the nurse to review the plan.

Result and Evaluation

Use the recorded response and patient goals to decide the next supervised nursing action.

Viva Questions and Answers

Why use the same scale at recheck?

It makes the measurements more comparable.

Which detail helps judge benefit beyond the score?

A functional change such as improved ability to turn or cough.

Fall Risk Side Rails and Restraint Safety

Practical 10 / Skills laboratory

Aim

Assess fall risk, use the least restrictive safety measures and respond to a simulated fall.

Principle

Individual risk assessment and early assistance reduce falls. Physical restraint requires an authorised clinical decision and monitoring.

Articles and Materials

- Fall-risk tool and post-fall chart
- Bed, transfer trainer and restraint demonstration checklist

Procedure

1. Review baseline gait, recent falls, dizziness, cognition, toileting needs and medicines using the facility's assessment tool. Confirm restrictions and supervision.
2. Inspect bed height, brakes, clutter, footwear, lighting and call bell reach. Note what the patient can do safely without help.
3. Agree on assistance, accessible items and a toileting or mobility plan. Select the safest position of side rails from the team's documented plan.
4. In the restraint case state which less restrictive measures were tried. Verify indication, authorisation and facility requirements for monitoring and release.
5. Demonstrate the approved restraint check only on a trainer. Evaluate skin, breathing, circulation, positioning and access, and document reassessment and review times.
6. In a simulated fall call for help, check response and immediate threats and keep the person safe pending trained review. Avoid an unassessed lift.
7. Document the circumstances, observations, time, notifications and response using clinical and incident records as appropriate.
8. Reassess contributing factors and update the assistance plan with the supervising nurse.

Precautions

- Use least restrictive measures and the facility's authorisation process.
- Maintain privacy during supervision and assessment.

Observations and Record

Fall Risk Side Rails and Restraint Safety

Documentation

Item	What to record	Why it matters
Baseline	Risk factors and assistance level	Guides prevention
Intervention	Environment changes and safety plan	Shows action taken
After incident	Findings, notifications and review	Supports care and learning

Worked Example

A person attempts to reach the toilet alone despite dizziness. The student checks immediate safety and changes the supervised toileting plan after review.

Result and Evaluation

Deliver a patient-specific fall plan and demonstrate an appropriate response to a fall.

Viva Questions and Answers

Name two modifiable fall risks.

Unreachable call bell and an obstructed route.

What comes first after a fall?

Immediate safety, assessment and calling for help.

Admission Transfer and Discharge

Practical 11 / Clinical case or record exercise

Aim

Prepare safe transitions and document who is responsible for pending care.

Principle

A structured transition confirms identity, clinical status, devices, medicines, instructions and follow-up across settings.

Articles and Materials

- Fictional admission, transfer and discharge records
- Nursing chart and belongings checklist

Procedure

1. On admission confirm two identifiers, source and reason for admission. Record baseline observations, relevant history, allergies and immediate needs.
2. Orient the patient to the unit, call bell and assistance arrangements. Check belongings, valuables, mobility support and initial precautions with the team.
3. Review current orders and verify medicine information with the authorised nurse. Record new or unresolved issues separately in the nursing handover.
4. Before transfer confirm destination acceptance, patient status, equipment, escort, isolation and any oxygen or monitoring needs. Secure lines and collect the authorised records.
5. Give transfer handover with relevant findings, care completed, risks and pending results. Confirm which person accepted responsibility and record time.
6. Before discharge verify the clinician’s approved plan, medicine list, wound or device care, appointments and access needs.
7. Use teach-back on medicines, warning signs and whom to contact. Provide the approved written instructions and check help or transport arrangements.
8. Complete the date, time, destination, condition, handover and pending-action entries. Inform the relevant team of any unresolved need.

Precautions

- Reassess before a planned transfer if status changes.
- Use confidential channels for clinical records.

Observations and Record

Admission Transfer and Discharge

Documentation

Item	What to record	Why it matters
Admission	Identity, baseline and priority	Establishes care needs
Transfer	Destination, condition and receiver	Keeps care continuous
Discharge	Instructions, pending results and follow-up	Protects continuity after leaving

Worked Example

A lab result is pending at discharge. The summary identifies the clinician who will review it and the patient's preferred safe contact method.

Result and Evaluation

Complete a traceable transition with a named owner and timing for each outstanding issue.

Viva Questions and Answers

What must accompany a high-risk transfer?

The prescribed monitoring, escort, support and a structured handover.

Why document review ownership?

It reduces the chance of a pending action being missed.

Assisted Mobility Transfers and Range of Motion

Practical 12 / Skills laboratory

Aim

Help a patient model move or exercise within the documented mobility plan.

Principle

Suitable aids, alignment and a coordinated team protect against falls, staff injury and device dislodgement.

Articles and Materials

- Bed, chair, wheelchair and stretcher
- Slide or transfer aid, walking aid and limb model

Procedure

1. Confirm weight-bearing limits, baseline ability, pain, dizziness and the planned assistance level. Explain the move and obtain permission.
2. Prepare brakes, heights, route and footwear. Arrange staff and aids, check tubing length and keep the destination stable.
3. For a supported turn or logroll confirm alignment and plan one team count. Use the approved handling aid and spare limbs or lines from pressure.

Continue with step 4 on the next page.

Procedure Continued

Assisted Mobility Transfers and Range of Motion

4. For bed-to-chair or wheelchair practice demonstrate sitting at the bed edge, symptom check, supported stand and controlled pivot as permitted. Lock the wheelchair and move footrests as needed.
5. For stretcher transfer set compatible heights, lock equipment and use the approved lateral transfer method with adequate staff.
6. Practise assisted walking within the weight-bearing plan and stop for dizziness or unsafe gait. Demonstrate prescribed active or assisted range of motion slowly within comfort.
7. Recheck alignment, pain, breathing, observations where indicated and line position. Restore a safe bed or chair setup and call access.
8. Document assistance, aid, distance or exercise performed, tolerance and the next mobility plan.

Precautions

- Select equipment and assistance based on the person’s ability.
- Avoid forcing joint movement through pain or resistance.

Observations and Record

Assisted Mobility Transfers and Range of Motion

Documentation

Item	What to record	Why it matters
Baseline	Weight-bearing, symptoms and aid	Guides handling
Movement	Method and number of staff	Supports repeatable safe practice
Outcome	Tolerance and any change	Guides next attempt

Worked Example

At the bed edge the patient reports dizziness. The student keeps the patient supported, pauses the transfer and informs the supervising nurse.

Result and Evaluation

Complete the indicated move or record the reason for deferring it and reassess the plan.

Viva Questions and Answers

Why lock both transfer surfaces?

It prevents them separating during movement.

What does active range of motion mean?

The person moves the joint using their own muscle activity.

Individual Patient Teaching and Teach Back

Practical 13 / Supervised communication practice

Aim

Teach a practical health task and verify the learner can explain or demonstrate it.

Principle

An observable objective, plain language and teach-back reveal what the person can do and what needs reinforcement.

Articles and Materials

- Standardised patient scenario and approved handout
- Demonstration equipment and teaching record

Procedure

1. Confirm the agreed topic, preferred language and readiness for learning. Arrange a quiet place and appropriate support or interpreter.
2. Ask what the person already understands and what causes difficulty at home. Check relevant literacy, vision, hearing, access and caregiver needs.
3. Set one achievable outcome with the person, such as demonstrating the correct use of an approved device.
4. Explain the reason for the task in short pieces, using permitted materials and examples the person recognises.
5. Demonstrate the steps in order using the trainer, then let the person practise and ask questions. Correct one point at a time.
6. Ask the person to explain or show what they would do at home including whom to contact if a problem occurs.
7. Review any missed step in different words and repeat teach-back. Agree on a feasible action and follow-up.
8. Document what was taught, the person’s response, unresolved barriers and the next review point.

Precautions

- Ask permission before involving another person.
- Reinforce only the approved care instructions.

Observations and Record

Individual Patient Teaching and Teach Back

Documentation

Item	What to record	Why it matters
Needs	Language, baseline and barriers	Improves teaching fit
Objective	Observable skill and materials	Clarifies what to practise
Evaluation	Teach-back and follow-up	Shows understanding and continuity

Worked Example

A person can explain when to call for assistance but cannot operate the demonstrated device. The student revises the teaching and records the need for supported practice.

Result and Evaluation

Confirm one practical action and document how understanding was checked.

Viva Questions and Answers

What makes a teaching objective measurable?

It states what the learner should demonstrate or explain.

What is teach-back?

Asking the learner to show or explain the plan in their own words.

First Aid Assessment and Initial Response

Practical 14 / Skills laboratory

Aim

Recognise immediate threats and give appropriate basic assistance on training scenarios.

Principle

Scene safety, prompt help, primary assessment and reassessment take priority during first aid.

Articles and Materials

- First aid kit and adult model
- Case cards for bleeding, burn, fracture and reduced consciousness

Procedure

1. Check scene safety, use role-appropriate protection and call the emergency response with location and stated hazard. Assign a bystander to guide responders.
2. Check responsiveness and breathing promptly. If the casualty has absent normal breathing, follow the resuscitation station algorithm immediately.
3. Identify major visible bleeding and demonstrate direct pressure with the approved dressing on the model. Tell the team if loss continues or the person deteriorates.
4. For a small thermal burn demonstrate prompt cooling with cool running water for about 20 minutes when safe. Keep the rest of the person warm and avoid delaying urgent care. Remove loose constricting items and cover the area as taught.

Continue with step 5 on the next page.

Procedure Continued

First Aid Assessment and Initial Response

5. For limb injury support the part in the position found while arranging help. Check distal colour, warmth and sensation before and after the trainer support.
6. For an unconscious but breathing casualty use the appropriate taught position when safe and account for suspected spinal injury. Monitor for changes.
7. Recognise severe choking from an ineffective cough or inability to speak or breathe. For a responsive adult call for help and alternate five back blows with five abdominal thrusts on the trainer. Use chest thrusts in late pregnancy or if the abdomen cannot be encircled. Start CPR if unresponsive.
8. Reassess breathing, alertness and the response to measures while help is on the way. Keep the person warm as appropriate.
9. Report mechanism, times, observations, actions and changes directly to the receiving team.

Precautions

• Work within the first aid training pathway.

• Reassess after every intervention and use approved equipment.

Observations and Record

First Aid Assessment and Initial Response

Documentation

Item	What to record	Why it matters
Initial state	Hazards, response and breathing	Sets priority
Care	Basic measure and time	Tracks response
Handover	Changes and receiving team	Supports urgent care

Worked Example

A fall casualty is initially alert but becomes drowsy. The student reassesses airway and breathing and reports the change urgently.

Result and Evaluation

Demonstrate safe first aid priorities and a timely handover.

Viva Questions and Answers

What is the first step at the scene?

Check safety and call for appropriate help promptly.

What follows any first aid intervention?

Reassessment of the relevant signs and the person's response.

Bandages Slings and Binders

Practical 15 / Skills laboratory

Aim

Apply a suitable trainer bandage or support and verify circulation, comfort and stability.

Principle

A bandage protects or supports the area when tension and overlap are controlled. Circulation and function must be checked before and after application.

Articles and Materials

- Roller and triangular bandages, padding and binder
- Limb, head and torso trainers
- Distal circulation checklist

Procedure

1. Inspect the training injury, select a dressing and bandage of appropriate width and check the planned support and site restrictions.
2. Record baseline distal colour, warmth, sensation and movement where applicable. Explain the support and position the model comfortably.
3. Practise a circular anchor and an even spiral on the limb. Use the taught reverse spiral for a tapered region and overlap turns uniformly without wrinkles.

Continue with step 4 on the next page.

Procedure Continued

Bandages Slings and Binders

4. Demonstrate figure-of-eight over a joint and a spica at the assigned thumb or shoulder model. Check the bandage remains secure during the intended position.
5. On the trainer practise a recurrent wrap and the assigned capeline head, ear, eye or jaw bandage. Identify a condition where the site requires protection without pressure, such as a suspected open-globe injury.
6. Fit an arm sling or abdominal binder on the model for the approved indication. Check comfort and avoid restricting breathing or confining the neck.
7. Secure the end, examine skin and distal circulation, then adjust if new pain, coldness, numbness or difficulty with breathing occurs.
8. Record pattern, site, time, purpose and reassessment. State when the support needs further review.

Precautions

- Avoid pressure on a suspected penetrating injury or sensitive structure.
- Keep distal observations accessible when appropriate.

Observations and Record

Bandages Slings and Binders

Documentation

Item	What to record	Why it matters
Choice	Pattern, width and indication	Matches site and purpose
Application	Overlap, padding and securement	Shows technique
Recheck	Comfort, perfusion and sensation	Detects restriction

Worked Example

Following a figure-of-eight application the trainer card reports distal tingling. The student reassesses and adjusts it with the instructor.

Result and Evaluation

The selected support is secure, comfortable and accompanied by documented before-and-after checks.

Viva Questions and Answers

Why check circulation twice?

It detects changes after applying the support.

What is a spica useful for?

Supporting a region such as the thumb or shoulder with crossing turns.

Adult Basic Life Support in First Aid

Practical 16 / Skills laboratory

Aim

Demonstrate recognition of adult cardiac arrest, quality CPR and safe AED use.

Principle

Early emergency activation, effective compressions and timely defibrillator use support survival in cardiac arrest.

Articles and Materials

- Feedback manikin and AED trainer
- Barrier device and timing sheet

Procedure

1. Check scene safety, test responsiveness, shout for help and direct someone to activate emergency response and bring the AED.
2. Check for normal breathing. In the trained healthcare-provider scenario assess a central pulse at the same time for at most ten seconds. Treat gasping as abnormal.
3. Position the adult manikin on a firm surface. Start compressions promptly when indicated, placing hands over the lower half of the sternum and keeping shoulders over the hands.
4. Use 100 to 120 compressions per minute, at least 5 cm deep for an average adult and avoiding depths greater than 6 cm. Allow full recoil and use trainer feedback to correct technique.
5. For the trained-rescuer scenario use 30 compressions and two breaths before an advanced airway. Give each trainer breath over about one second to visible chest rise.
6. Turn on the AED, attach trainer pads to the exposed chest as pictured and clear for analysis and any instructed shock.
7. Resume compressions promptly after the shock or no-shock decision and rotate rescuers with short interruptions. Continue through the simulation algorithm.
8. Record call, first compression and AED times and review the longest pause and feedback with the instructor.

Precautions

- Practise compressions and shocks on approved trainers.
- Check visually that everyone is clear during analysis and shock.

Observations and Record

Adult Basic Life Support in First Aid

Documentation

Item	What to record	Why it matters
Recognition	Responsiveness, breathing and pulse check	Supports timely CPR
Compressions	Rate, depth, recoil and pauses	Measures quality
AED	Pad placement, clear call and resumption	Confirms safety

Worked Example

A deliberate pause while the trainer AED pads are unpacked interrupts CPR. The second learner prepares the pads during ongoing compressions on the repeat run.

Result and Evaluation

Show correct recognition, team activation and a continuous trainer response.

Viva Questions and Answers

What does an occasional gasp mean in an unresponsive pulseless adult?

It can be agonal breathing and warrants recognition of arrest.

What follows an AED shock?

Immediate resumption of CPR according to the prompts.

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