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Head to Toe Health Assessment and System Findings

Practical 01 / Supervised clinical practice

Aim

Perform a systematic nursing assessment and recognise changes that need escalation.

Principle

General and focused assessment link the health history with observed signs and functional needs.

Articles and Materials

- Standardised patient or manikin and privacy screen
- Stethoscope, penlight and assessment chart

Procedure

1. Verify identity, explain the assessment, obtain permission and check communication needs. Review presenting problem, relevant history, baseline function, medicines and allergies.
2. Check immediate airway, breathing, circulation and alertness before routine assessment. Record vital signs, pain and the need for prompt review.
3. Observe general appearance, speech, posture, movement, skin and hydration. Inspect head and neck, eyes and oral cavity within scope and record pertinent findings.
4. Assess breathing effort, chest symmetry and bilateral air entry using the approved comparison sites. Note whether oxygen support or difficulty hearing sounds affects the examination.
5. Check pulse, capillary refill, peripheral temperature and swelling. Document limb site and side and compare with the expected baseline.
6. Inspect the abdomen and follow the taught listening and gentle palpation sequence when appropriate. Ask about intake, elimination, discomfort and change.
7. Assess relevant strength, sensation, mobility and orientation safely. Use focused inspection, palpation, percussion or auscultation steps under supervision and record any limits.
8. Summarise significant findings by system with times. Report priority changes clearly and identify which system needs focused reassessment.

Precautions

- Protect privacy and explain each part before touch or exposure.
- Pause routine examination for deterioration.

Observations and Record

Head to Toe Health Assessment and System Findings

Documentation

Item	What to record	Why it matters
General	Appearance, observations and pain	Establishes acuity
Systems	Findings, site, side and limits	Supports comparison
Action	Concerns, handover and next check	Prioritises care

Worked Example

During assessment a patient has visibly increased work of breathing and a new low saturation reading. The student escalates immediately and records the exact oxygen context.

Result and Evaluation

Complete a clear system-based assessment with any urgent finding communicated.

Viva Questions and Answers

Why observe before touching?

Appearance and breathing can reveal immediate concerns.

Why document side?

It enables reliable comparison and follow-up.

Nursing Process and Individual Care Plan

Practical 02 / Clinical case or record exercise

Aim

Develop, implement and evaluate a nursing care plan from supplied clinical findings.

Principle

Assessment, problem identification, planning, implementation and evaluation link nursing actions to measurable goals.

Articles and Materials

- Fictional chart and care-plan template
- Observation trends and intervention checklist

Procedure

1. Review the shift record and collect relevant subjective and objective data. Confirm the concern and usual function with the simulated patient.
2. Group related findings and prioritise immediate safety, physiological needs, function and patient preferences. Mark information that needs confirmation.
3. Formulate a patient-specific nursing problem using the observed cues. Distinguish a current problem supported by signs from a risk supported by risk factors.
4. Set a measurable outcome with a time and method of evaluation. Confirm that it is achievable with the available support.
5. List interventions, indicating what the nurse may initiate and what requires an order or a team decision. Identify a short rationale for each.
6. Demonstrate the selected intervention on the model, confirming identity and safety checks. Document what was actually performed and patient tolerance.
7. Compare follow-up observations with the goal, describing whether it was met, partly met or unmet. Identify the reason for change or lack of improvement.
8. Update the plan and communicate any concern or outstanding follow-up during handover.

Precautions

- Use observed evidence and patient preferences.
- Escalate findings outside student scope or routine care.

Observations and Record

Nursing Process and Individual Care Plan

Documentation

Item	What to record	Why it matters
Assessment	Cues and priority problem	Connects plan to evidence
Plan	Goal, intervention and review time	Makes action measurable
Evaluation	Observed response and revision	Directs continuing care

Worked Example

A patient needs supervised transfers because of unsteadiness. The shift goal is to transfer once with the correct aid and no symptoms. The nurse records the result and adjusts assistance.

Result and Evaluation

Complete a defensible plan with time-based evaluation and a clear handover.

Viva Questions and Answers

How does a risk problem differ from a current problem?

Risk is based on vulnerability and a current problem has supporting signs or symptoms.

What makes an outcome measurable?

An observable indicator and a review time.

Bed Bath Oral Hair and Perineal Care

Practical 03 / Skills laboratory

Aim

Provide model hygiene care while protecting dignity, comfort and skin.

Principle

Clean-to-less-clean technique, appropriate equipment and systematic skin checks reduce contamination and skin damage.

Articles and Materials

- Manikin, wash supplies, towels and linen
- Oral kit, gloves and perineal model

Procedure

1. Assess dependence, preferences, pain, temperature tolerance and device restrictions. Explain the care and check permission, privacy and the level of help.
2. Gather supplies, set a safe bed height, check water temperature by the approved method and protect the bedding. Perform hand hygiene.
3. Wash and dry one body area at a time, keeping other areas covered. Change gloves or supplies when needed and inspect folds and pressure areas.
4. Demonstrate appropriate oral hygiene and denture care. Position for safety, check swallowing risk and use the approved dependent-care method on the model.
5. Assess scalp and hair before assisting with washing or combing. For possible pediculosis follow the facility assessment, isolation or treatment instructions and label personal items.
6. Explain perineal care separately and provide privacy. Use clean-to-less-clean strokes as taught, change wipes or cloth sections and protect any catheter from traction.
7. Dry skin thoroughly, replace linen and position comfortably. Secure devices, place the call bell and handle used linen and waste through the approved route.
8. Record assistance, skin and mouth findings, comfort and any reason follow-up or specialist review is needed.

Precautions

- Respect privacy and promote independence.
- Use targeted oral precautions for a person with impaired swallowing.

Observations and Record

Bed Bath Oral Hair and Perineal Care

Documentation

Item	What to record	Why it matters
Dependence	Tasks completed and level of help	Individualises care
Skin and oral findings	Site, appearance and symptoms	Detects needs
Evaluation	Comfort, devices and referral	Maintains safety

Worked Example

During model hygiene an area of redness is found on the heel. The student avoids friction, offloads it and reports the skin finding and documented risk.

Result and Evaluation

The person is clean, comfortable and safely positioned with skin and oral findings recorded.

Viva Questions and Answers

Why expose one area at a time?

It protects privacy and warmth.

In what order is hygiene usually performed?

From cleaner to more soiled sites, changing supplies as needed.

Pressure Injury Risk and Skin Protection

Practical 04 / Supervised clinical practice

Aim

Identify pressure injury risk and prepare a prevention and skin reassessment plan.

Principle

Pressure, shear, moisture and poor tolerance affect tissue integrity. Repositioning, offloading and review reduce preventable injury.

Articles and Materials

- Braden or Norton worksheet and skin cards
- Positioning aids and documentation form

Procedure

1. Review mobility, sensation, nutrition, moisture, friction and device use. Check the person's usual activity and time spent in bed or chair.
2. Score the approved risk tool using its descriptors and record each domain. Verify that the total is correctly interpreted for the selected tool.
3. With permission inspect common pressure sites and skin under relevant devices. Record colour, warmth, pain, firmness and whether redness blanches if assessed.
4. Describe any concerning area by exact site, size, appearance and surrounding skin. Use the facility classification only with the trained supervisor.
5. Plan offloading and safe repositioning aligned with skin condition, tolerance and activity. Protect heels or other exposed areas as indicated.
6. Address moisture and friction, check bedding and nutrition or hydration concerns and discuss referral with the supervising nurse.
7. Recheck skin and comfort after interventions and adjust plan when risk, mobility or condition changes.
8. Document the risk score, skin findings, prevention steps, education and next reassessment.

Precautions

- Avoid massaging a concerning pressure area.
- Follow the individual turning plan and device restrictions.

Observations and Record

Pressure Injury Risk and Skin Protection

Documentation

Item	What to record	Why it matters
Risk	Tool, score and contributing factors	Guides prevention
Skin	Site, appearance and sensation	Tracks local change
Plan	Offloading, timing and next check	Closes the prevention loop

Worked Example

A patient with limited mobility has new non-blanching redness at a heel. The student offloads it, documents findings and requests review.

Result and Evaluation

Establish an actionable prevention plan with explicit reassessment and communication.

Viva Questions and Answers

Why inspect under a device?

Device pressure can cause local injury.

What is shear?

Sliding-related force that distorts tissue beneath the skin.

Assisted Feeding and Nasogastric Feeding Safety

Practical 05 / Skills laboratory

Aim

Prepare a model feed and verify safe oral or tube administration steps and monitoring.

Principle

Correct patient, route, feed and confirmed tube position reduce risks of aspiration and wrong-route delivery.

Articles and Materials

- Feeding and nasogastric trainer with tubing and enteral connectors
- Dummy order, feed label and balance chart

Procedure

1. Verify identity, order, route, feed type, amount, timing and relevant fluid restriction. Review swallowing and positioning requirements and the team's feeding plan.
2. For supervised oral feeding sit the model appropriately, check texture and provide small manageable amounts as prescribed. Watch for cough, distress or difficulty swallowing.
3. For the nasogastric case check tube type, recorded external length and securement. Confirm initial placement with aspirate in the locally approved pH range or an appropriately interpreted radiograph, using the facility decision pathway.

Continue with step 4 on the next page.

Procedure Continued

Assisted Feeding and Nasogastric Feeding Safety

4. Keep the tube unused, including for flushes, feeds or medicines, until initial placement is confirmed. If the mark shifts or verification is missing, hold use and notify the responsible clinician for reassessment.
5. Check feed label and expiry, prepare the correct enteral giving equipment and connect only to the confirmed trainer feeding route. Verify method, rate and flush order.
6. Demonstrate administration with the prescribed position and settings. Observe the case for discomfort, distension, vomiting, coughing or a change in breathing and pause for concerns.
7. Record feed and fluid volumes, route, times, placement check and tolerance. Maintain prescribed position and equipment care afterwards.
8. Give a handover stating any missed feed, reasons and plan for review before resuming.

Precautions

- Verify tube position using the approved pathway before use.
- Use clearly identified enteral equipment and hold feeding for concerning symptoms.

Observations and Record

Assisted Feeding and Nasogastric Feeding Safety

Documentation

Item	What to record	Why it matters
Order and route	Feed, volume and access	Prevents mismatch
Position and verification	Placement result and time	Addresses aspiration and route risk
Tolerance	Delivery and observed response	Guides reassessment

Worked Example

The external mark has moved since the last record. The learner holds the model feed and requests repeat verification before preparing to use the tube.

Result and Evaluation

Deliver the authorised model feeding process and document reliable verification and tolerance.

Viva Questions and Answers

What makes tube position confirmation necessary?

Misplacement can deliver fluid into the respiratory tract.

What goes into the fluid chart?

Given feed and ordered flush volumes, recorded with time.

Intake Output and Intravenous Fluid Planning

Practical 06 / Clinical case or record exercise

Aim

Complete a fluid balance chart and calculate a verified simulated infusion setting.

Principle

Timing, consistent units and cumulative totals support evaluation of fluid status and safe delivery of an authorised order.

Articles and Materials

- Fictional intake and output chart, measuring containers and calculator
- IV pump trainer and mock order

Procedure

1. Review the fluid balance period, patient identity, indication, restrictions and relevant observations. List oral, enteral and IV sources.
2. Measure or record charted intake and each output using mL. Include losses from urine, vomiting, stool or drains where measured and identify estimates.
3. Total intake and output for each interval and calculate the net balance as intake minus output. Check entries for duplicate recording or missing periods.
4. Compare the balance with weight trend, perfusion, swelling, vital signs and relevant laboratory findings in the case.
5. Verify the authorised fluid, total volume, start time and duration. Divide volume by hours to calculate mL per hour, then compare with the written order.
6. For the gravity calculation exercise use the tubing’s stated drop factor and durations in minutes. Verify the result and independent check requirements before any model setup.
7. Observe the model infusion, site and patient response and recognise concerning swelling, leakage or change in perfusion. Report discrepancies to the assigned nurse.
8. Document verified totals, pump setting, checks, actions and the next review.

Precautions

- Keep prescribed calculations separate from independent treatment decisions.
- Confirm equipment and rate with the supervising nurse.

Observations and Record

Intake Output and Intravenous Fluid Planning

Documentation

Item	What to record	Why it matters
Inputs and losses	Source, volume and time	Ensures accurate totals
Rate	Verified order and calculation	Prevents delivery error
Review	Trend, site, symptoms and action	Detects complications

Worked Example

An authorised 500 mL trainer bag over four hours gives 125 mL per hour. A missed drain entry changes the recorded shift balance and is corrected with the source noted.

Result and Evaluation

Calculate and document the verified setting and relate the measured balance to clinical status.

Viva Questions and Answers

How is net fluid balance obtained?

Subtract measured output from intake for the same period.

Why note estimates?

They affect confidence in the calculated trend.

Bedpan Urinal Enema and Suppository Models

Practical 07 / Skills laboratory

Aim

Assist elimination and demonstrate case-specific rectal medication or enema checks on a trainer.

Principle

Privacy, positioning and the correct order or device protect comfort and prevent injury or recording error.

Articles and Materials

- Bedpan, urinal and dependent-care manikin
- Enema and suppository trainer, mock order and output sheet

Procedure

1. Review the reported elimination pattern, mobility, pain and toileting preference. Screen the fictional case for symptoms needing review before an ordered rectal procedure.
2. Verify identity and permission, prepare a private area and choose the appropriate bedpan or urinal. Protect bedding and perform hand hygiene.
3. Assist safe positioning and placement, provide toilet tissue and call bell, and ensure suitable supervision. Remove the device promptly after use.
4. Observe and measure output if prescribed, provide hygiene and restore comfort. Record stool or urine characteristics and any difficulty.
5. For enema, bowel wash or suppository simulation verify the exact authorised product, indication, route and contraindication checks with the instructor.
6. Use the assigned trainer position and faculty method. Demonstrate protection of the site, appropriate handling and stopping for resistance, pain or bleeding.
7. Monitor the simulated response, including when to assist toileting and which adverse findings require prompt review.
8. Document procedure, product if used, time, response, output and any reason it was deferred.

Precautions

- Keep intimate care consented and private.
- Follow case-specific restrictions and use a trainer for invasive practice.

Observations and Record

Bedpan Urinal Enema and Suppository Models

Documentation

Item	What to record	Why it matters
Need	Elimination history and assistance	Selects safe method
Delivery	Device or mock product, time and route	Confirms traceability
Result	Output, tolerance and escalation	Evaluates effect

Worked Example

The case reports new significant abdominal pain before an enema. The student confirms current observations and asks for clinical review before proceeding.

Result and Evaluation

Provide safe model elimination assistance and record relevant findings and response.

Viva Questions and Answers

Why document stool appearance as well as output?

Characteristics can guide further assessment.

What finding may stop a trainer rectal procedure?

Reported significant pain, resistance or bleeding.

Urinary Catheter and Drainage Care

Practical 08 / Skills laboratory

Aim

Maintain a model closed drainage system and identify issues that require clinical review.

Principle

A documented indication, unobstructed drainage and catheter review reduce avoidable infection and trauma.

Articles and Materials

- Catheterisation trainer and closed drainage set
- Securement device, measuring container and chart

Procedure

1. Confirm identity, indication, insertion record and need for continued catheterisation. Check comfort, allergies and available instructions and explain the care.
2. Inspect catheter and system connections, securement and tubing course. Check for kinks, tension, dependent loops and leakage without unnecessarily breaking the system.
3. Position the collection bag below the bladder and off the floor. Recheck after movement or bed adjustment and maintain hand hygiene.
4. Provide routine meatal and perineal hygiene according to policy, using clean equipment and protecting the site from traction.
5. Empty the bag into the dedicated clean container through the outlet, avoiding contact between outlet and container. Measure output, close the outlet and record time.
6. For the sample exercise identify the approved needleless port and demonstrate the authorised cleaning and aseptic sampling method on the trainer.
7. Recognise pain, no output despite concern, leakage, blood, fever or possible disconnection and communicate findings promptly. Verify plan for review or device removal.
8. Document urine, balance, integrity, hygiene, patient tolerance and the responsible team's follow-up.

Precautions

- Use authorised methods for sampling and device handling.
- Keep the bag below the bladder and above the floor.

Observations and Record

Urinary Catheter and Drainage Care

Documentation

Item	What to record	Why it matters
Indication	Reason, date and review time	Limits unnecessary use
System	Security, bag level and flow	Protects drainage
Findings	Volume, appearance and concerns	Supports timely action

Worked Example

Output falls after a model transfer and the tubing is bent at the bed rail. The student restores free flow, checks the case's current status and reports the change.

Result and Evaluation

Preserve a closed, freely draining model system and complete a documented need review.

Viva Questions and Answers

Why protect the closed system?

It limits contamination and reduces infection risk.

What should be reviewed each shift?

Ongoing need, device condition, drainage and patient tolerance.

Common Specimen Collection and Lab Handover

Practical 09 / Skills laboratory

Aim

Give clear specimen instructions and demonstrate correct labelling and handover on mock samples.

Principle

Source, timing, collection quality and correct identification affect the usefulness of the result.

Articles and Materials

- Simulated urine, stool and sputum containers
- Lab request cards, labels and packaging trainer

Procedure

1. Verify person, request, specimen site, timing and laboratory requirements. Check whether a test requires a sterile or special container.
2. Explain the aim and prepare a private setting and appropriate precautions. Ask the person to repeat the key collection directions.
3. For routine or culture urine use the lab's approved collection instructions. For timed urine explain start and end entries and the process for reporting a missed portion.
4. For the stool and sputum cases show container and label selection, explain cross-contamination prevention and use only simulated material. Check respiratory precautions for the scenario.
5. Match two identifiers and attach the label at collection with site, time and required details. Record relevant context such as antibiotics if requested.
6. Compare the labelled container with the request. Check closure, integrity and the approved transport packaging, including separate clean space for paperwork.
7. Hold a mismatched or unsuitable specimen, documenting the reason and informing the appropriate nurse or laboratory.
8. Record collection, verification, transport and recipient, and specify who will follow up the result.

Precautions

- Use prepared training samples.
- Follow facility collection, packaging and infection-control procedures.

Observations and Record

Common Specimen Collection and Lab Handover

Documentation

Item	What to record	Why it matters
Request	Test, site and container	Matches intended test
Label	Identifiers, time and collection detail	Protects traceability
Handover	Packaging, receiver or rejection	Supports safe reporting

Worked Example

A timed collection record shows a missed urine portion. The student confirms the issue and asks the laboratory how the collection should be handled.

Result and Evaluation

Prepare a traceable mock specimen and document any limitation or required recollection.

Viva Questions and Answers

Why distinguish timed from routine urine?

The timed test depends on collecting all output over the specified interval.

What if the label and request disagree?

Hold the specimen and resolve the discrepancy with the authorised team.

Urinalysis Using Reagent Strips

Practical 10 / Lab or data practical

Aim

Use a synthetic sample to record pH, specific gravity, protein and ketones and interpret test limitations.

Principle

Each strip pad has a controlled colour reaction and its own reading interval. Valid controls and sample quality support interpretation.

Articles and Materials

- Synthetic urine, positive and negative controls
- In-date strips, timing chart and timer

Procedure

1. Check specimen identity, collection time and storage. Note colour and clarity and mix the training material according to the kit.
2. Check the strip expiry, lot, storage and colour chart. Verify the control results before reading the unknown.
3. Dip or wet the designated pads according to the instructions and remove excess fluid as directed. Keep the strip level and start the timer.
4. Read and enter reaction or pH and specific gravity at their specified times under good light. Record the actual units or category.
5. Read protein or albumin pad and ketones using the correct scale. Record glucose, blood or other pads if included in the case.
6. Compare the result with symptoms, sampling method and earlier reports. Identify one interfering factor or reason additional confirmation is needed.
7. Repeat a result with an invalid control or reading time using the procedure approved by the instructor. Keep the first discrepancy in the record.
8. Document values, method, limitations and any urgent finding passed to the supervising clinician.

Precautions

- Read each pad at its own time.
- Keep training chemicals and supplies labelled.

Observations and Record

Urinalysis Using Reagent Strips

Documentation

Item	What to record	Why it matters
Controls	Valid results and expiry	Confirms reliable run
Pad results	Grade, units and timing	Supports interpretation
Follow-up	Confirmation or reason to repeat	Handles uncertainty

Worked Example

A blood pad is positive on the case strip while the supplied microscopy shows no red cells. The student records the discrepancy and requests correlation.

Result and Evaluation

Report validated screening findings with their timing and any need for confirmation.

Viva Questions and Answers

What can cause a misleading strip result?

Incorrect read time, storage or interfering sample conditions.

Why inspect the colour chart in good light?

Colour comparison determines the reported grade.

Oxygen Delivery and Supported Breathing

Practical 11 / Skills laboratory

Aim

Demonstrate safe oxygen device setup and basic respiratory nursing support.

Principle

Oxygen delivery requires an appropriate device, verified settings and reassessment of the clinical response.

Articles and Materials

- Oxygen trainer, cannula, simple and Venturi masks
- Oximeter and respiratory observations chart

Procedure

1. Assess breathing rate, effort, colour, alertness and oxygen saturation with signal quality. Identify distress and call for help before completing routine setup.
2. Verify the authorised oxygen target and device, check oxygen source, fire safety and connections and explain the equipment to the patient.
3. On the trainer fit a nasal cannula or the designated mask and document the setting. For Venturi use the prescribed adapter and marked flow requirement.
4. Check straps, skin contact, airway and comfort and protect tubing from obstruction. Reassess saturation, breathing and alertness after application.
5. Demonstrate the approved upright or supported position and coached slow breaths and effective coughing if tolerated and indicated.
6. In the oral suction model verify indication, equipment and monitoring and demonstrate the faculty technique. Pause on distress or desaturation and check response.
7. Review the supplied inhalation case through facility guidance, selecting approved devices and avoiding burn hazards from hot water.
8. Document device, setting, target, times, measured response, skin care and escalation when oxygenation or ventilation worsens.

Precautions

- Observe oxygen fire precautions.
- Treat worsening distress as urgent and use trained suction technique.

Observations and Record

Oxygen Delivery and Supported Breathing

Documentation

Item	What to record	Why it matters
Baseline	Respiratory rate, effort and saturation	Identifies urgency
Delivery	Device, setting and target	Supports safe use
Response	Clinical and measured trend	Guides review

Worked Example

After fitting a trainer mask the saturation displayed is unchanged and breathing effort worsens. The student checks fit and signal while activating senior assessment.

Result and Evaluation

Demonstrate correct setup and a documented response and escalation plan.

Viva Questions and Answers

What is the purpose of a Venturi device?

It delivers a specified inspired oxygen concentration when used as designed.

Why record room air or oxygen support?

It gives needed context for interpreting saturation.

Medicine Order Verification and Dosage Calculation

Practical 12 / Clinical case or record exercise

Aim

Prepare a simulated order check, dose and administration record with error prevention.

Principle

Identity, formulation, concentration, contraindications and independent checks are essential before administration.

Articles and Materials

- Mock prescription and medication administration record
- Training labels, calculator and dose worksheet

Procedure

1. Match patient identifiers and the order to the administration record. Check allergy and reaction history and clarify any incomplete or illegible entry.
2. Verify generic medicine, strength, formulation, route, scheduled time, indication and relevant observations. Read the package carefully to avoid look-alike products.
3. Identify ordered dose units and available concentration. Convert with dimensions shown and divide the ordered amount by concentration to obtain volume when required.
4. Check product restrictions, dose limits, rounding and whether an independent double-check is required. Read back any unclear order through the supervising nurse.
5. Compare the case order with recent doses, medicines and relevant clinical checks. Identify a reason to hold and escalate if the scenario is unsafe.
6. Explain the intended medicine and confirm concerns, permission and ability to take it. Document refusal or omission according to the facility policy.
7. Simulate the authorised route and observe response. Record actual time, dose, route, relevant assessments and the next monitoring need.
8. Reconcile an error or discrepancy promptly in the mock record and notify the appropriate team.

Precautions

- Use the fictional case's authorised dose.
- Keep leading zeros and clear units according to local policy.

Observations and Record

Medicine Order Verification and Dosage Calculation

Documentation

Item	What to record	Why it matters
Order	Identity, medicine, route and allergy	Prevents mismatch
Mathematics	Units, volume and verification	Prevents dose error
Record	Given or withheld, response and review	Enables safe follow-up

Worked Example

A training solution contains 50 mg per mL. A verified 100 mg mock order corresponds to 2 mL. Identity, label and rounding are rechecked before simulation.

Result and Evaluation

Produce a verified calculation and record with a clear response to any discrepancy.

Viva Questions and Answers

What is an independent check?

A second qualified person separately verifies the required items before comparison.

How do you calculate mL?

Divide the verified ordered mass by the strength in that mass per mL.

Oral Topical Inhaled and Instilled Medicines

Practical 13 / Skills laboratory

Aim

Demonstrate route-specific medication checks using trainers and explain the procedure to the patient.

Principle

Route, formulation, site and device instructions affect safe and accurate delivery.

Articles and Materials

- Dummy tablets, oral liquid, topical preparation and inhaler trainer
- Eye, ear and nasal models and order cards

Procedure

1. Verify two identifiers, allergies and authorised order. Match the preparation to route, time, label, expiry and any side or site requirement.
2. Check swallowing ability and positioning for oral medication. Measure liquids with an appropriate oral device and verify rules about altering tablets or capsules.
3. Prepare the indicated skin or mucosal site and clean hands. Check topical dose, area and contact precautions using the training product instructions.
4. Demonstrate the prescribed inhaler and spacer sequence where relevant. Observe the actor’s repeat technique and verify aftercare from the product card.
5. On eye, ear or nasal trainers confirm the correct side and position and use the instructed instillation or spray method. Keep the tip clear of the site.
6. For prescribed irrigation use the assigned model and faculty checks and confirm the specific solution and restrictions. Stop if the scenario indicates pain or injury.
7. Provide brief instructions, observe tolerance and communicate concerns about wrong route, site or patient response promptly.
8. Record dose, time, side or route, teaching and reassessment. Clean equipment and dispose of single-use items correctly.

Precautions

- Use the approved instructions for each product and model.
- Protect preparation and device tips from contamination.

Observations and Record

Oral Topical Inhaled and Instilled Medicines

Documentation

Item	What to record	Why it matters
Checks	Medicine, route, site and device	Supports accurate delivery
Technique	Position and key steps	Improves effectiveness
Evaluation	Tolerance and teaching	Supports repeat use

Worked Example

The dummy prescription says right eye and the tray label says left eye. The learner holds administration and clarifies the mismatch.

Result and Evaluation

Demonstrate the correct route and address any mismatch before simulated delivery.

Viva Questions and Answers

Why verify side before eye or ear medicine?

A wrong-side administration can harm the patient and leave the intended site untreated.

Why use an oral measuring device?

It measures the intended volume and reduces wrong-route risk.

Intramuscular Subcutaneous and Intradermal Injections

Practical 14 / Skills laboratory

Aim

Demonstrate safe preparation, route comparison and disposal with injection trainers.

Principle

Route determines appropriate site and delivery technique. Asepsis, consent and correct sharps handling reduce harm.

Articles and Materials

- IM, SC and ID trainers
- Dummy labels and syringes, skin preparation supplies and approved sharps container

Procedure

1. Confirm the mock order, identity, medicine, concentration, dose, route, allergies and timing. Resolve any discrepancy with the supervisor before preparing the trainer.
2. Explain the purpose and planned route. Check consent, site suitability and recent local reactions or restrictions in the case.
3. Set up a clean workspace, use hand hygiene and select the correct training syringe and needle for the route and model.
4. Verify the prepared dummy dose, labelled equipment and prescribed site. Demonstrate landmark selection and skin preparation using the instructor’s checklist.
5. For IM show the appropriate muscle landmark and model technique. For SC identify the authorised site and compare its depth and technique with IM.
6. For ID use the assigned trainer and demonstrate the faculty’s shallow approach and expected trainer feedback. Check route and dose independent of appearance.
7. Activate the safety feature as taught and discard sharps immediately at point of use. Check the model site and observe the simulated response.
8. Record site, route, medication and time and state the authorised observation or escalation plan.

Precautions

- Use dummy preparations and trainer pads.
- Dispose of sharps directly without recapping.

Observations and Record

Intramuscular Subcutaneous and Intradermal Injections

Documentation

Item	What to record	Why it matters
Preparation	Order, patient, allergy and dose	Prevents mismatch
Route	Model site and technique	Confirms correct delivery
Aftercare	Site, response and disposal	Supports monitoring

Worked Example

A dummy label states subcutaneous and the practice order states intramuscular. The learner stops and asks the supervisor to reconcile the order.

Result and Evaluation

Demonstrate route-specific skill, verifications and sharps safety on trainers.

Viva Questions and Answers

Why check the formulation as well as the medicine name?

Products with the same name may differ in strength or route.

What should an injection record include?

Medicine, dose, site, route, time and any response.

Altered Consciousness and Basic Nursing Care

Practical 15 / Skills laboratory

Aim

Identify changes in consciousness and plan immediate and ongoing nursing care.

Principle

Airway and breathing take priority. Serial, component-based neurological assessment and supportive care help detect deterioration.

Articles and Materials

- Manikin, airway and positioning aids
- Glasgow Coma Scale record, vital chart and care checklist

Procedure

1. Check responsiveness, airway, breathing and circulation and summon help if the person is deteriorating. Identify trauma or spinal precautions.
2. Measure vital signs and review the supplied glucose result where appropriate. Establish baseline consciousness and the time a change appeared.
3. Assess and record the best eye, verbal and motor responses separately using the Glasgow Coma Scale. Mark a blocked component as not testable, state the reason and avoid reporting a misleading total.
4. Check pupil observations, limb movement or asymmetry as assigned, documenting side and time. Escalate new findings immediately.
5. Demonstrate safe positioning, aspiration precautions and the assigned airway checks on the trainer. Verify orders before any oral intake.
6. Plan mouth, skin and eye care, turning, elimination monitoring and communication with the family under supervision.
7. Repeat observations at the prescribed interval and after any change. Compare components and trends and note limitations consistently.
8. Document immediate actions, current assessment and handover to the responsible team.

Precautions

- Prioritise airway and clinical review.
- Keep care and repositioning within the authorised plan.

Observations and Record

Altered Consciousness and Basic Nursing Care

Documentation

Item	What to record	Why it matters
Initial check	ABC and vital signs	Sets urgency
Neurology	Individual components and pupils	Tracks deterioration
Nursing care	Position, prevention and review	Supports ongoing safety

Worked Example

A model patient stops following commands. The student rechecks ABC and response components, calls the nurse and gives the exact time and changes.

Result and Evaluation

Detect and hand over meaningful change and establish a monitored supportive care plan.

Viva Questions and Answers

Why record GCS components separately?

A total can mask changes in individual responses or untestable components.

What is assessed first with new unconsciousness?

Immediate airway, breathing and circulation with prompt help.

Comfort Care at End of Life and Last Offices

Practical 16 / Skills laboratory

Aim

Provide comfort-focused nursing care and rehearse respectful after-death care.

Principle

Care preserves dignity, supports the family and follows the documented plan, cultural preferences and authorised process.

Articles and Materials

- End-of-life case and care plan
- Manikin, identification labels and last offices checklist

Procedure

1. Review goals of care, communication preferences, symptoms, authorised orders and who should be present. Introduce yourself and clarify the student role.
2. Assess pain, breathing discomfort, mouth dryness and distress using an appropriate method. Offer positioning, oral comfort and a calm environment as planned.
3. Reassess effects of comfort measures and report distress or family concerns to the responsible team. Document requests and approved decisions.
4. Following an expected death in the case, verify the required clinical confirmation and local procedure before beginning last offices. Identify referral or evidence-related restrictions.
5. Provide privacy and invite the family's cultural or spiritual preferences. Verify the handling of lines, devices and valuables with the authorised nurse.
6. On the model demonstrate dignified hygiene, positioning and identification, using the assigned checklist and standard precautions.
7. Complete the property, label and transfer checks, including who received custody and when. Respect restrictions on sharing information.
8. Document comfort interventions, family communication, authorised confirmation, after-death care and handover.

Precautions

- Follow the documented care plan and local authorisation.
- Protect confidentiality and belongings.

Observations and Record

Comfort Care at End of Life and Last Offices

Documentation

Item	What to record	Why it matters
Preferences	Goals, contact and cultural needs	Respects wishes
Comfort	Symptoms, measures and response	Evaluates care
Last office	Verification, labels, property and transfer	Preserves dignity and traceability

Worked Example

The case requires an authorised referral after death. The student pauses device removal and asks the supervising nurse for the permitted care and transfer plan.

Result and Evaluation

Demonstrate careful comfort care and a respectful, traceable after-death workflow.

Viva Questions and Answers

Why confirm the applicable procedure before removing a line?

Some records or devices may need preservation or review.

What is important in family communication?

Clear, compassionate explanation and respect for the family's needs.

Intravenous Medicines and Blood Components Observation

Practical 17 / Skills laboratory

Aim

Observe authorised IV or transfusion workflows and recognise complications requiring immediate nursing action.

Principle

The route, compatibility, correct identifiers and early response to adverse signs are essential to safety.

Articles and Materials

- IV arm trainer and mock IV order
- Dummy blood component, compatibility form and observation chart

Procedure

1. Review the prescribed route, indication, identity and allergies. Verify the IV access and component workflow and confirm the student's observation or assisted role.
2. Compare labels, concentration, timing and any required monitoring or compatibility with the authorised record. Notify the nurse of an unclear order or mismatch.
3. Trace the trainer line from the patient site to the intended container and check securement, condition and connections. Identify infiltration and other concerns in the case.

Continue with step 4 on the next page.

Procedure Continued

Intravenous Medicines and Blood Components Observation

4. Observe or demonstrate approved IV preparation on the trainer under supervision, checking the required aseptic technique and independently verified setting.
5. Observe the mock blood product check with two qualified team roles as required. Verify baseline observations, identity, consent, product details and compatibility.
6. Plot observations at the required times. If a reaction is suspected, stop the model transfusion, call for help, assess airway, breathing and circulation and preserve IV access without flushing the existing blood line.
7. Record symptoms, device or component identifiers, times, actions and who was notified. Keep sample and product handling within the authorised investigation.
8. Recheck the person or trainer and confirm the plan for further observation or treatment before leaving the station.

Precautions

- Use model lines and dummy products.
- Escalate unexpected symptoms or label discrepancies immediately.

Observations and Record

Intravenous Medicines and Blood Components Observation

Documentation

Item	What to record	Why it matters
Order	Route, identifiers and relevant checks	Confirms intended delivery
Baseline and checks	Access, observations and compatibility	Protects safety
Change	Symptoms, times and team response	Enables escalation

Worked Example

The teaching case develops chills and breathlessness during a simulated transfusion. The student stops it, calls for urgent assessment and records the onset time.

Result and Evaluation

Demonstrate accurate observations and an appropriate response to a suspected infusion or transfusion problem.

Viva Questions and Answers

Why obtain baseline observations?

They help identify a new change during administration.

What comes first in a suspected transfusion reaction?

Stop the transfusion and summon prompt assessment following the local procedure.

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