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Psychiatric Admission Safety and Individual Nursing Care Plan

Practical 01 / Skills laboratory

Aim

Complete a psychiatric nursing admission and respond to immediate safety and distress in a simulation.

Principle

Assessment focuses on the person's needs and current safety. A structured plan supports observation, de-escalation and continuity.

Articles and Materials

- Fictional admission records and mental health observation chart
- Crisis communication and nursing care plan templates

Procedure

1. Confirm identity, admission context, role and consent. Establish a calm private setting and review acute medical concerns and the local safety procedure.
2. Ask about current distress, recent changes, self-care and available supports. Record pertinent observations and the person's account separately.
3. Ask directly and sensitively about current self-harm thoughts, intention and ability to remain safe. Report immediate danger or uncertainty without waiting for a score.
4. Use a calm tone, adequate space and simple choices to reduce distress. Activate trained assistance and protect safety under facility policy if concerns increase.
5. Identify nursing priorities and make a case-specific care plan with goals, observation needs, therapeutic interventions and the responsible team.
6. Check implementation and reassess symptoms, physical safety and the person's preferences. Update the plan when findings or ability to remain safe change.
7. Give handover with time, stated concerns, actions and an explicit receiver for urgent review and monitoring.
8. Document admission, consent, assessment, reassessment and any reporting or supportive action.

Precautions

- Seek trained and urgent support when safety is uncertain.
- Keep communication private and act within the authorised plan.

Observations and Record

Psychiatric Admission Safety and Individual Nursing Care Plan

Documentation

Item	What to record	Why it matters
Needs	Current concerns, strengths and baseline	Guides immediate priorities
Safety	Direct findings, response and support	Protects patient and others
Plan	Goals, observation and review	Supports continuity

Worked Example

The actor reports current intent to self-harm and uncertainty about remaining safe. The student activates urgent assessment and arranges appropriate staff presence.

Result and Evaluation

Produce a safe admission record and an individually reviewed nursing plan.

Viva Questions and Answers

Why ask directly about current safety?

It helps the person share concerns and guides immediate support.

What determines reassessment?

Symptoms, actual changes, agreed observations and the responsible team's plan.

Psychotropic Medicine Administration and Nursing Monitoring

Practical 02 / Skills laboratory

Aim

Verify a mock psychotropic medicine order and document clinical monitoring and adverse effects.

Principle

Medication, timing, baseline observations and potential effects inform safe delivery and follow-up.

Articles and Materials

- Mock medicine and monitoring records
- Dummy products, vital chart and adverse-reaction form

Procedure

1. Verify two identifiers, allergies, order, indication and consent. Check authorised route, interval and where relevant the last administration time.
2. Review baseline alertness, vital observations, fall risk, relevant movement or physical symptoms and case-specific monitoring.
3. Compare the label and administration record, then verify formulation, dose and any independent check. Clarify ambiguous or unsafe orders before proceeding.
4. Explain the medicine’s purpose and what to report using accessible language. Check concerns or refusal and inform the supervising team.
5. Demonstrate the authorised dummy administration and record actual time, dose and route. Use the assigned safety and disposal checks.
6. Monitor consciousness, behaviour, breathing, mobility and the specific effects assigned in the case. Escalate significant adverse findings promptly.
7. Document response, held or missed treatment, monitoring and education. Complete a fictional reaction report where appropriate.
8. Update the handover and confirm who will review the medicine or reassess the person.

Precautions

- Use only mock orders and trained supervision.
- Reassess safety when alertness or mobility changes.

Observations and Record

Psychotropic Medicine Administration and Nursing Monitoring

Documentation

Item	What to record	Why it matters
Verification	Order, route, consent and risks	Supports safe delivery
Monitoring	Baseline and timed findings	Detects adverse effects
Review	Education, action and owner	Maintains care

Worked Example

After a dummy administration the case reports marked dizziness on standing. The student protects the patient from falling and reports the change and timing.

Result and Evaluation

Demonstrate safe verification and a clear response to an adverse effect.

Viva Questions and Answers

Why record baseline findings?

They help identify changes after a medicine.

What should be done about a refused dose?

Document respectfully, assess the concern and inform the supervising nurse under policy.

Electroconvulsive Therapy Preparation and Recovery Nursing

Practical 03 / Skills laboratory

Aim

Prepare a simulated patient for clinician-led ECT and complete recovery and orientation checks.

Principle

Consent, anaesthetic readiness, monitoring and supportive explanation protect safety and dignity.

Articles and Materials

- Fictional ECT order and consent records
- Procedure and recovery checklists and orientation cards

Procedure

1. Verify patient, documented procedure, consent and authorised assessment. Identify the student's role and query incomplete preparation.
2. Review fasting, allergies, medicines, baseline observations and relevant anaesthetic findings. Report discrepancies before transfer.
3. Explain the nursing workflow and invite questions. Protect privacy and support the person's preferred communication and comfort needs.
4. Prepare correct records and equipment and assist the faculty demonstration within assigned roles. Record procedure time and provided observations.
5. In recovery assess airway, breathing, perfusion and alertness. Monitor comfort, orientation and adverse symptoms using the approved schedule.
6. Reorient the patient calmly and reassess memory or confusion as directed. Keep mobility and oral intake within recovery criteria and compare alertness with the documented pre-procedure baseline.
7. Escalate prolonged symptoms or instability promptly and document the exact change and response.
8. Give handover with procedure, current state, safety measures, education and next review ownership.

Precautions

- Use the authorised ECT and anaesthesia workflow.
- Protect consent, privacy and dignity throughout.

Observations and Record

Electroconvulsive Therapy Preparation and Recovery Nursing

Documentation

Item	What to record	Why it matters
Readiness	Consent, fasting and baseline	Supports safe preparation
Recovery	ABC, alertness and symptoms	Detects possible complications
Continuity	Orientation, actions and review	Supports dignity and safety

Worked Example

The patient remains more drowsy than expected. The learner reviews airway and breathing and informs the recovery team with the time and observations.

Result and Evaluation

Complete supervised preparation and recovery with accurate monitoring and clear communication.

Viva Questions and Answers

Why record baseline orientation?

It supports comparison during recovery.

What takes priority in recovery?

Airway, breathing, circulation, alertness and clinical stability.

Therapeutic Activities Group Work and Rehabilitation

Practical 04 / Supervised communication practice

Aim

Plan a supervised individual or group activity and evaluate participation, safety and a rehabilitation goal.

Principle

Purposeful activity matched to preferences and functional ability supports recovery and participation.

Articles and Materials

- Fictional group brief and approved activity materials
- Participation, safety and outcome sheets

Procedure

1. Review the therapeutic goal, supervisor and participant needs. Check suitability, access barriers and agreement to participate.
2. Select an activity appropriate to abilities and the care plan, such as a practice in communication or daily function. Set a measurable outcome.
3. Prepare the environment, staffing and equipment, including support for communication or mobility. Review boundaries and a safe pause or exit option.
4. Explain purpose and instructions in plain language and model the activity. Invite participation at a comfortable level.
5. Observe engagement, interaction, distress and assistance needs. Adapt the task and seek help when a participant becomes unwell or distressed.
6. Review the experience with participants, acknowledge preferences and agree on an achievable next action or continuation plan.
7. Compare performance with the intended outcome and discuss a modification with the supervising team.
8. Record attendance, activity, response, learning and follow-up while protecting identities.

Precautions

- Participation and disclosure are voluntary within the authorised programme.
- Follow staff safety and confidentiality procedures.

Observations and Record

Therapeutic Activities Group Work and Rehabilitation

Documentation

Item	What to record	Why it matters
Plan	Goal, suitability and support	Guides selection
Participation	Observations and adaptation	Supports individual care
Review	Outcome and next goal	Tracks progress

Worked Example

A participant prefers a quieter role and completes a smaller related task. The student records this as successful adapted participation.

Result and Evaluation

Facilitate a safe therapeutic activity and document response and next goal.

Viva Questions and Answers

Why adapt an activity?

It can match current function, preferences and support needs.

What indicates a useful evaluation?

Observed evidence of the planned outcome and a realistic next goal.

Mental Health Home Follow Up Substance Use and Discharge

Practical 05 / Supervised community practicum

Aim

Prepare a supported mental health discharge or home visit and coordinate appropriate referral or deaddiction follow-up.

Principle

Safe transitions require verified medicines, patient goals, family consent and a feasible contact plan.

Articles and Materials

- Fictional discharge and home visit cards
- Relapse, caregiver and referral worksheet

Procedure

1. Confirm the authorised plan, role, patient and contact preferences. Review the person's priorities, known risks and current ability to manage care.
2. Ask about symptoms, routines, access, social support and substance use or withdrawal concerns without judgement. Seek qualified review of new concerns.
3. Reconcile the authorised medicine and treatment plan and check barriers to following it. Verify which team owns changes or specialist advice.
4. Discuss one relapse or crisis sign and agree what the person would do. Include caregiver education only within agreed confidentiality.
5. For the deaddiction case observe the service's assessment and recovery or withdrawal support workflow. Document referrals and monitoring without providing an independent treatment plan.
6. Arrange the next visit, safe contact and handover to the approved service. Confirm practical access, language and transport needs.
7. Use teach-back about the plan, first point of contact and time for follow-up. Revisit misunderstandings before completing the record.
8. Document agreed actions, consent, outstanding issues and the named follow-up worker.

Precautions

- Follow the institutional field and safety plan.
- Seek qualified assessment for significant withdrawal risk or urgent concerns.

Observations and Record

Mental Health Home Follow Up Substance Use and Discharge

Documentation

Item	What to record	Why it matters
Transition	Goals, risks and authorised plan	Maintains continuity
Supports	Caregiver, access and referral	Addresses barriers
Review	Teach-back and next contact	Confirms follow-up

Worked Example

A person leaving care reports prior withdrawal symptoms and difficulty travelling for appointments. The learner requests clinical review and coordinates an accessible follow-up.

Result and Evaluation

Produce a practical, consented transition record and a clear escalation plan.

Viva Questions and Answers

Why verify preferred contact details?

It supports follow-up while protecting confidentiality.

Why ask about prior withdrawal?

It can indicate the need for supervised clinical assessment.

Community Mental Health Camp and Referral

Practical 06 / Supervised community practicum

Aim

Plan a supervised awareness or screening activity and link identified needs to confidential follow-up.

Principle

A successful outreach activity provides accessible education, timely triage and a clear referral owner.

Articles and Materials

- Fictional camp plan and role cards
- Approved education, screening and referral forms

Procedure

1. Confirm the event's purpose, venue, permission, partner roles and expected participants. Set one outcome for education or service linkage.
2. Prepare accessible registration, privacy, waiting areas, interpreter support and the authorised urgent-response route.
3. Brief the team on consent, scope and record access. Make clear how the public education activity and confidential case discussion are arranged.
4. Deliver the approved awareness message using supportive language. Check understanding and provide clear information about routine and urgent service access.
5. Conduct only the assigned supervised screening or interview. Record objective findings and respond to immediate safety concerns through the clinical pathway.
6. Complete a referral with the minimum needed detail and confirm the receiving service. Agree a safe means to contact the person.
7. Review attendance, completed referrals and barriers using aggregated or coded data. Assign responsibility for pending tasks.
8. Document event findings, actions and follow-up, safeguarding access to individual clinical records.

Precautions

- Use faculty-approved material and protect individual identities.
- Activate urgent support for immediate safety concerns.

Observations and Record

Community Mental Health Camp and Referral

Documentation

Item	What to record	Why it matters
Preparation	Purpose, permissions and team roles	Organises the activity
Delivery	Education, consent and triage	Supports safe participation
Follow-up	Referrals, barriers and next reviews	Prevents missed care

Worked Example

Someone discloses an immediate safety concern during a public event. The student arranges private support and activates the designated clinician.

Result and Evaluation

Run a structured exercise with safe escalation and accountable community follow-up.

Viva Questions and Answers

Why arrange a private space at a camp?

Confidential assessment and disclosure require privacy.

What makes a referral traceable?

A documented reason, destination, named responsibility and follow-up.

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