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Home Visit Bag Technique and Family Nursing Record

Practical 01 / Supervised community practicum

Aim

Conduct a supervised home visit and document family priorities and follow-up.

Principle

Respectful preparation, clean handling of supplies and shared decisions support community nursing care.

Articles and Materials

- Approved home visit bag, barrier and hand hygiene supplies
- Fictional family folder and referral record

Procedure

1. Confirm assigned household, visit purpose, supervisor and safe visit plan. Prepare the approved bag, forms, equipment and any referral contacts.
2. Introduce yourself and the service, obtain consent and choose a private, suitable place. Ask what the household wants to address first.
3. Place the bag on a clean barrier and take only needed items. Keep clean and used equipment separate and perform hand hygiene at required points.
4. Record household composition, reported health concerns, available care, water, sanitation and practical barriers. Distinguish observations and reports.
5. Complete the agreed basic assessment or care under supervision. Explain results and discuss one feasible household action or referral.
6. Clean and repack equipment through the approved sequence. Remove used items through the designated waste or reprocessing route.
7. Agree on a follow-up date and safe contact method. Verify that the household knows when and where to seek earlier care.
8. Update the coded family record and document referrals, response, responsible team and next action.

Precautions

- Protect privacy and use the institution’s community safety plan.
- Keep clean and used bag items separate.

Observations and Record

Home Visit Bag Technique and Family Nursing Record

Documentation

Item	What to record	Why it matters
Visit	Consent, date and priority	Supports respectful care
Care	Assessments and bag technique	Protects hygiene and accuracy
Continuity	Agreed action, contact and time	Supports follow-up

Worked Example

A caregiver reports transport barriers to clinic visits. The student documents the barrier and coordinates an approved follow-up with the field nurse.

Result and Evaluation

Complete a hygienic and traceable visit that addresses an agreed family priority.

Viva Questions and Answers

Why use a clean barrier under the bag?

It reduces contact with potentially contaminated surfaces.

What belongs in a useful follow-up record?

A named person or service, action and planned date.

Community Survey Nutritional Assessment and Referral

Practical 02 / Supervised community practicum

Aim

Conduct a structured community needs assessment and use growth, nutrition and basic screening results to prioritise care.

Principle

Defined populations, objective measures and consent support valid identification of needs and referral.

Articles and Materials

- Survey form, map and coded register
- Scales, growth charts and simulated basic test reports

Procedure

1. Define the area, population, case objectives and authorised sampling method with the supervisor. Use a consistent form and record missing households.
2. Explain the exercise and obtain consent. Ask about essential access, household status and priority concerns with neutral questions.
3. Observe relevant resources and environmental conditions and record them separately from reported information. Protect identities.
4. Measure or review age-appropriate growth, nutrition and other basic screening findings using the correct units and references.
5. For a simulated haemoglobin, urine or glucose result verify source, method, units, timing and the authorised interpretation and referral criteria.
6. Summarise findings using counts and denominators and identify which needs require individual care and which suggest a service priority.
7. Discuss feasible referrals and community feedback with the supervising nurse. Document the responsible service, contact method and expected date for review.
8. Complete the coded report with methods, findings, limits and review date.

Precautions

- Use authorised tools and protect identifiable data.
- Escalate serious findings through the programme’s pathway.

Observations and Record

Community Survey Nutritional Assessment and Referral

Documentation

Item	What to record	Why it matters
Coverage	Population, eligible cases and missing records	Identifies what was assessed
Findings	Measurements, results and reported needs	Guides priority
Action	Referral, owner and review	Supports care and evaluation

Worked Example

Several schoolchildren have apparent weight concerns, but some ages are unverified. The student checks dates, re-plots growth and refers using the approved criteria.

Result and Evaluation

Produce a useful, ethical needs summary and traceable referrals.

Viva Questions and Answers

Why document non-response?

It affects how representative the findings may be.

Why record test timing?

Timing can change interpretation or follow-up.

Health Education Behaviour Change and School Health

Practical 03 / Supervised community practicum

Aim

Conduct a feasible group teaching or school health activity and evaluate its immediate effect.

Principle

Audience needs, clear messages and measurable practice support behaviour change and useful school health follow-up.

Articles and Materials

- Fictional school or community scenario and teaching aids
- Approved screening, referral and evaluation sheets

Procedure

1. Agree the setting, purpose, supervisor and permission process with the school or community partner. Identify the intended audience and age.
2. Ask about current practice, barriers and preferred language. Select one programme priority such as hand hygiene, diet, safety or health service use.
3. Set an observable learning outcome and prepare an accessible demonstration or visual aid. Check clinical content with the supervising nurse.
4. Deliver the brief session in plain language and encourage participants to practise the action. Keep the setting respectful and inclusive.
5. For a school check verify permission and demonstrate the assigned screening steps using approved tools. Record and route concerns confidentially.
6. Use return demonstration or short questions to check progress. Correct a common error and note any participant who needs further support.
7. Provide contact and referral information and agree on next review. Discuss feasible changes with school or community staff as authorised.
8. Document audience, activity, findings, feedback, actions and follow-up.

Precautions

- Use approved materials and school consent procedures.
- Keep individual screening findings confidential.

Observations and Record

Health Education Behaviour Change and School Health

Documentation

Item	What to record	Why it matters
Needs	Audience, barrier and objective	Focuses education
Delivery	Teaching or screening method	Documents practice
Outcome	Response, referral and review	Checks benefit

Worked Example

Children can describe hand hygiene but miss fingertips during demonstration. The student repeats that movement and reassesses it.

Result and Evaluation

Complete and evaluate a relevant activity with practical next steps.

Viva Questions and Answers

What makes education age-appropriate?

Language, examples and activities that fit the learners.

Why assess after demonstrating?

It shows whether the audience can perform the action.

Epidemiology Calculation and Simulated Outbreak Investigation

Practical 04 / Lab or data practical

Aim

Build a coded line list, calculate outbreak measures and prepare a concise public health report.

Principle

A reproducible case definition, consistent onset data and correct denominators support interpretation.

Articles and Materials

- Fictional outbreak dataset and calculator
- Line-list, epidemic curve and briefing forms

Procedure

1. Identify the signal, setting and time period. Write the provisional case definition by person, place, time and relevant findings.
2. Build a de-identified line list with onset, location code and relevant exposure. Distinguish onset and reporting times and mark missing values.
3. Verify entries, remove confirmed duplicates through a traceable process and note records outside the definition.
4. Count cases by onset interval to draw an epidemic curve. Use suitable time bins and verify the plotted total.
5. Calculate attack proportion as cases divided by people at risk within a defined group and record both denominators for comparisons.
6. Compare time, place and person patterns and consider alternative explanations, missing data and the limitations of the case classification.
7. Propose appropriate notification, referral, education or control actions through the designated public health team.
8. Document the definition, results, urgent actions and the measure and timing for follow-up.

Precautions

- Keep records coded and use simulated data.
- Follow the authorised reporting pathway for clinical events.

Observations and Record

Epidemiology Calculation and Simulated Outbreak Investigation

Documentation

Item	What to record	Why it matters
Definition	Eligibility, period and case count	Supports consistent inclusion
Curve and measures	Onsets, denominators and proportions	Describes pattern
Response	Handover and verification plan	Supports public health action

Worked Example

A report date was entered in place of symptom onset. The student corrects the line list, updates the curve and explains the change.

Result and Evaluation

Present a reproducible fictional analysis and a clear public health brief.

Viva Questions and Answers

Why plot the date of symptom onset?

Accurate onset dates help describe the time course.

How is attack proportion calculated?

New cases divided by people at risk in the defined group during the stated period.

Environmental Health Water Sanitation and Waste Survey

Practical 05 / Supervised community practicum

Aim

Identify environmental health risks and document a feasible control and referral plan.

Principle

Mapping a source through use and storage helps locate contamination opportunities and practical improvements.

Articles and Materials

- Fictional map, observation form and water reports
- Household or school sanitation checklist and referral form

Procedure

1. Define boundaries and approved visit plan with the supervisor. Obtain consent and explain the purpose and types of observations.
2. Trace water source, distribution, collection, storage and household use. Mark interruptions, potential contamination routes and relevant storage practices.
3. Assess sanitation, waste handling, drainage and vector-related concerns using the checklist. Separate observed findings from reported practices.

Continue with step 4 on the next page.

Procedure Continued

Environmental Health Water Sanitation and Waste Survey

4. Review prepared water or environmental test records and verify site, collection date, method, units and the applicable target.
5. Compare source and household findings and identify what may need repeat or authorised sampling. Document safety risks that require prompt reporting.
6. Discuss a feasible prevention action with the household or partner and identify the responsible service for broader problems.
7. Prepare a concise referral with location code, observed risk, supporting data and urgency. Agree on additional checks.
8. Record actions, timeline and who will verify improvements. Agree how the household or partner will be told the follow-up result.

Precautions

- Protect personal details and avoid unsupported causal claims.
- Use authorised routes for sampling and referrals.

Observations and Record

Environmental Health Water Sanitation and Waste Survey

Documentation

Item	What to record	Why it matters
Location	Source, storage and observed exposure	Identifies point of concern
Evidence	Test result and sampling context	Supports interpretation
Action	Feasible control and review	Tracks improvement

Worked Example

Household storage water differs from the source report and the container lacks a cover. The student documents this relationship and requests supervised follow-up.

Result and Evaluation

Complete an evidence-linked environmental assessment with a practical action plan.

Viva Questions and Answers

Why note the exact sampling point?

Conditions can differ across source, distribution and household use.

What is a useful follow-up measure?

A repeated measure or observation tied to the original risk.

Primary Care Screening and National Programme Records

Practical 06 / Supervised community practicum

Aim

Use supervised screening and prepare an accurate programme and referral record.

Principle

Screening identifies possible need for assessment. Defined eligibility, valid observations and follow-up prevent missed care.

Articles and Materials

- Fictional community clinic register, screening tools and programme cards
- Referral and follow-up forms

Procedure

1. Confirm the service, target group and current programme criteria. Check assigned roles, equipment and record fields before the session.
2. Verify consent and identification and ask about current symptoms, relevant history and barriers. Account for urgent signs before routine screening.
3. Take the approved measurements with standard methods, documenting units and conditions. Repeat uncertain readings or request verification.
4. Compare the findings with the programme's referral and recheck criteria. Identify the results that require confirmation by the responsible clinician.
5. Explain the result and plan in plain language and provide approved information on follow-up, healthy practices and when to seek help.
6. Complete the relevant case or programme register and referral form, checking identifiers and protecting confidentiality.
7. Track whether the visit or referral was completed and coordinate with the designated health worker.
8. Record the outcome, pending issues and date for the next review of the case or programme.

Precautions

- Follow the current programme and supervisor's scope.
- Use safe channels to share results.

Observations and Record

Primary Care Screening and National Programme Records

Documentation

Item	What to record	Why it matters
Eligibility	Target group, consent and criteria	Supports correct intake
Screening	Method, results and limits	Sets follow-up
Linkage	Referral, worker and outcome	Closes the care loop

Worked Example

A repeated screening result meets the facility's referral threshold. The student documents readings and coordinates follow-up with the responsible primary care team.

Result and Evaluation

Demonstrate correct community screening and document referral completion and pending review.

Viva Questions and Answers

What does a positive screening result mean?

The person needs the appropriate further assessment under the programme.

Why track referral outcomes?

It helps services confirm that the person reached care.

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