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Child Health Growth Development and Nutrition Assessment

Practical 01 / Supervised clinical practice

Aim

Perform age-appropriate child assessment and plot reliable growth data.

Principle

Exact age, correct chart and a measurement trend help identify concerns. History and play help assess development.

Articles and Materials

- Infant scale, length board, stadiometer and tape
- Growth charts, developmental cards and caregiver interview form

Procedure

1. Confirm identity, date of birth, gestation where relevant and caregiver concerns. Ask about birth, feeding, illnesses, milestones and any loss of skills.
2. Check overall state, breathing, hydration and vital signs. Use age-appropriate methods and escalate significant illness before routine measurement.
3. Zero the scale and weigh with appropriate clothing. Use recumbent length for the young child and standing height when the chosen chart requires it.
4. Measure head circumference at the largest occipitofrontal plane where appropriate, repeating any unexpected value with corrected technique.
5. Plot data on the correct age- and sex-specific chart. Compare earlier points and review weight for length or BMI for age as applicable.
6. Observe gross motor, fine motor, language and social skills through suitable play or discussion. Note observed, caregiver-reported and untested items separately.
7. Review dietary intake, feeding ability and family context. Discuss nutrition or developmental concerns with the supervising team.
8. Document measurements with units, chart, time, trajectory, limits and the agreed follow-up.

Precautions

- Support infants safely during measurement.
- Promptly review developmental regression or signs of significant illness.

Observations and Record

Child Health Growth Development and Nutrition Assessment

Documentation

Item	What to record	Why it matters
Age and growth	Date, weight, length or height and chart	Supports valid plotting
Development	Domain, observation and caregiver report	Identifies needs
Plan	Risk, discussion and referral	Supports reassessment

Worked Example

The recorded weight trend falls while length follows its previous pattern. The student confirms the measurements and asks about recent illness and feeding.

Result and Evaluation

Produce an accurate growth and development record with an appropriate review plan.

Viva Questions and Answers

Why check the chart and exact age?

Expected values change with age and chart convention.

Why record what was untested?

It distinguishes lack of observation from absence of a skill.

Infant Bath Feeding and Play Based Care

Practical 02 / Skills laboratory

Aim

Perform safe model infant hygiene and feeding and select a suitable activity to support comfort and development.

Principle

Warmth, responsive feeding, position and caregiver involvement protect infant wellbeing.

Articles and Materials

- Infant doll, bath supplies and clean linen
- Approved cup, spoon or paladai trainer and age-appropriate toys

Procedure

1. Verify infant identity, age, temperature, feeding plan and stability. Ask the caregiver about preferred participation and explain the sequence.
2. Prepare a warm area, supplies and clean clothes. Check bath temperature with the approved method and keep the infant supported throughout.
3. Demonstrate sponge or baby bath care in order, keeping areas covered where practical. Dry folds, inspect skin and restore warmth promptly.
4. Check feeding readiness, prescribed route and volume. Identify if poor alertness, respiratory concerns or swallowing difficulty requires review before feeding.
5. Demonstrate approved cup, spoon or paladai method on the doll with head supported. Present small amounts to the lips under the faculty technique and observe feeding cues.
6. Pause the model feed for coughing, choking, fatigue or other concern. Record intake, tolerance and any clinical need for a different plan.
7. Select a safe toy or activity for age and illness and invite the caregiver to use it during care. Check infection prevention.
8. Document bath, skin and temperature, feeding, teaching and planned follow-up.

Precautions

- Support the infant and maintain warmth.
- Confirm readiness and prescribed feeding method.

Observations and Record

Infant Bath Feeding and Play Based Care

Documentation

Item	What to record	Why it matters
Hygiene	Temperature, skin and tolerance	Maintains warmth and comfort
Feeding	Route, volume and signs	Protects feeding safety
Support	Activity, caregiver and review	Promotes development

Worked Example

The case describes coughing and fatigue during cup feeds. The student stops the simulation and seeks assessment before continuing.

Result and Evaluation

Demonstrate safe infant hygiene and feeding and update care according to tolerance.

Viva Questions and Answers

Why assess breathing before feeding?

Respiratory distress affects safe feeding and may need immediate review.

Why involve the caregiver in play?

It supports comfort, familiar interaction and learning.

Paediatric Medication Fluid and Safety Checks

Practical 03 / Skills laboratory

Aim

Verify model weight-based medicine and fluid orders and monitor safe administration.

Principle

Children need accurate weight, units, equipment and independent checks to prevent dose and infusion errors.

Articles and Materials

- Child injection and oral trainers, pump and mock orders
- Weight, fluid and observation charts

Procedure

1. Confirm two identifiers, current weight in kilograms, allergies and indication. Verify the actual order and the student's supervised role.
2. Identify whether the order is per dose or per day and check authorised single-dose or daily limits. Calculate with units and obtain the required independent check.
3. Read strength or concentration and calculate the delivery volume and rate from the authorised order. Verify the exact fluid or preparation with faculty.
4. Compare oral, IV, IM, SC and intradermal model requirements for the assigned case. Use the appropriate measuring device, route and trainer.
5. Trace the line and demonstrate pump setup, verification and labelling on the trainer. Check the recorded settings, actual delivery and site at planned times.
6. Assess comfort, tolerance, skin and relevant observations. If a safety restraint is discussed, use only the authorised least restrictive model plan and monitoring.
7. Report dosing, identification or device discrepancies promptly and reassess the case's response and remaining risk.
8. Record dose, route, time, device checks, intake, effect and follow-up.

Precautions

- Use dummy products and authorised calculations.
- Escalate all unclear or mismatched orders.

Observations and Record

Paediatric Medication Fluid and Safety Checks

Documentation

Item	What to record	Why it matters
Order	Verified weight, units and independent check	Prevents calculation error
Delivery	Route, amount, device and monitoring	Checks execution
Response	Tolerance, safety and escalation	Supports ongoing care

Worked Example

A case order is written per day while the learner calculated each dose as that amount. The independent check catches the error before simulation.

Result and Evaluation

Demonstrate verified model medication and fluid administration and time-based reassessment.

Viva Questions and Answers

Why distinguish amount per day from amount per dose?

Frequency changes the amount that is given at one time.

Why record current measured weight?

Many paediatric calculations depend on it.

Paediatric Specimen Collection and Procedure Assistance

Practical 04 / Skills laboratory

Aim

Prepare the child and caregiver for model samples and selected clinician-led investigations.

Principle

Developmentally appropriate explanation, accurate labelling and safe support improve quality and reduce distress.

Articles and Materials

- Child trainer, mock blood, urine and stool containers
- Lumbar puncture and marrow demonstration records

Procedure

1. Verify the requested test, identity, site and timing and the planned method. Discuss the child's usual coping approach with the caregiver.
2. Provide an age-appropriate explanation and check consent and assent as applicable. Plan positioning, distraction, comfort and staffing with the clinician.
3. Gather the correct containers and labels. Demonstrate the approved urine, stool or blood workflow on prepared examples or the sampling trainer.
4. Match each specimen to two identifiers, collection site and time and check request and packaging. Flag unsuitable or uncertain samples promptly.
5. For the lumbar puncture or bone marrow case verify documentation, baseline observations and procedure-specific preparation and monitoring.
6. Assist the faculty demonstration with age-appropriate positioning and comfort. Record supplied observations and match each mock specimen to request.
7. Reassess pain, vital signs, skin or puncture site and activity or intake instructions. Communicate concerning findings and pending results.
8. Document collection, preparation, caregiver teaching and who will follow the case or results.

Precautions

- Use approved trainers and specimens.
- Adapt explanation to age and protect privacy.

Observations and Record

Paediatric Specimen Collection and Procedure Assistance

Documentation

Item	What to record	Why it matters
Preparation	Consent, test, method and coping support	Supports safe participation
Sample	Site, timing and identification	Protects traceability
Review	Recovery, symptoms and next action	Detects complications

Worked Example

The model sample is labelled but the intended collection time differs from the order. The learner confirms timing with the laboratory before release.

Result and Evaluation

Demonstrate safe preparation, specimen traceability and a documented follow-up plan.

Viva Questions and Answers

Why use both age-appropriate information and caregiver involvement?

They can improve understanding, comfort and cooperation.

Which sample details support traceability?

Approved identifiers, source, collection time and correct request.

IMNCI Danger Signs Diarrhoea and Feeding Counselling

Practical 05 / Clinical case or record exercise

Aim

Use the current IMNCI chart and counsel caregivers on the authorised plan for a child.

Principle

Danger signs and hydration, respiratory and nutrition findings guide classification, immediate care and review.

Articles and Materials

- Current facility IMNCI chart booklet and fictional cases
- ORS model supplies and caregiver counselling card

Procedure

1. Verify age and ask about the main concern, duration, intake, urine, symptoms and previous treatment. Check age-specific danger signs immediately.
2. Assess breathing, alertness and hydration using the chart criteria. Record relevant findings and escalate any urgent sign before routine counselling.
3. For the diarrhoea case compare stool and fluid history with reviewed hydration signs and identify the assigned classification and appropriate facility plan.

Continue with step 4 on the next page.

Procedure Continued

IMNCI Danger Signs Diarrhoea and Feeding Counselling

4. Demonstrate preparation of an ORS packet using its specified safe water volume. Show the caregiver the label, safe handling and how to offer according to the plan.
5. Review breastfeeding or complementary feeding, hygiene and age-appropriate foods using the supplied guide. Address practical barriers and signs of poor nutrition.
6. Discuss authorised referral, review time and danger signs that require earlier help. Ask for teach-back on fluid preparation or follow-up.
7. Record classification basis, approved care, family response and any prescribed treatment checked with the supervisor.
8. Reassess the simulated child and confirm that any referral was received and follow-up responsibility is clear.

Precautions

- Use the current national or facility chart.
- Prioritise urgent referral for danger signs.

Observations and Record

IMNCI Danger Signs Diarrhoea and Feeding Counselling

Documentation

Item	What to record	Why it matters
Signs	Age, danger signs and hydration	Guides classification
Care	Approved plan and teaching	Supports accurate care
Review	Return signs and referral	Protects follow-up

Worked Example

A child with diarrhoea is unusually sleepy and unable to drink in the case. The learner escalates immediately and keeps the reported intake and examination findings visible.

Result and Evaluation

Assign the supported chart category and provide practical and traceable caregiver counselling.

Viva Questions and Answers

Why check the exact ORS water volume?

The correct dilution gives the intended composition.

What is teach-back useful for?

It checks the caregiver can explain the plan and when to seek help.

Immunisation Session and Caregiver Follow Up

Practical 06 / Skills laboratory

Aim

Review a child's vaccine record and demonstrate authorised preparation, safety and counselling.

Principle

Age, valid prior doses, storage and identity checks reduce immunisation errors and help maintain continuity.

Articles and Materials

- Fictional child card and current national schedule
- Vaccine tray, cold-chain indicators and injection trainer

Procedure

1. Verify birth date, identifiers and written dose history. Compare exact dates with the current programme and applicable region-specific guidance.
2. Ask about severe previous reactions, current illness and relevant contraindications. Obtain qualified review where eligibility is uncertain.
3. Check the mock product, intended dose, route, site, expiry, lot and storage record. Verify any vial monitor and documented temperature concern.
4. Explain the purpose, consent and common expected reactions. Prepare the correct trainer device and materials using infection prevention.
5. Demonstrate model administration and correct sharps disposal under the approved route and site checklist. Record what was actually simulated.
6. Observe the scenario for the required period and identify symptoms needing urgent review or adverse-event reporting.
7. Update the child card with date, dose and next visit and teach the caregiver how to obtain help.
8. Reconcile the session record and discuss any missed visit, stock hold or follow-up issue with the supervising team.

Precautions

- Follow current programme and manufacturer requirements.
- Hold questionable stock for authorised review.

Observations and Record

Immunisation Session and Caregiver Follow Up

Documentation

Item	What to record	Why it matters
Eligibility	Age, dose history and risks	Selects correct session plan
Product	Lot, storage, route and checks	Protects administration
Follow-up	Observation, card and due date	Supports series completion

Worked Example

An older card documents a valid initial dose but a later visit was missed. The learner uses the current catch-up instructions and verifies the due date with faculty.

Result and Evaluation

Complete safe model immunisation workflow and a documented next visit.

Viva Questions and Answers

Why verify dated doses?

Eligibility and timing depend on age and valid intervals.

What should caregivers know after the visit?

Expected responses, warning signs and the next appointment.

Infant and Child Oxygen Support and Paediatric Life Support

Practical 07 / Skills laboratory

Aim

Recognise paediatric respiratory distress and demonstrate trainer oxygen, ventilation and CPR.

Principle

Early recognition, support for breathing and effective circulation are essential to paediatric life support.

Articles and Materials

- Infant and child manikins, oximeter, masks, cannula and oxygen hood trainer
- Bag-mask and AED trainers and current algorithm

Procedure

1. Assess response, breathing, airway sounds, chest movement, perfusion and colour. Call for help and assign AED and equipment roles.
2. Check a suitable saturation probe and clinical signs. For the breathing child select the authorised cannula, mask or hood and verify settings and response.
3. For the ventilation scenario position the airway, choose correct mask size and use a supported seal. Deliver model breaths to visible chest rise and reassess.
4. In the healthcare-provider simulation check breathing and pulse together for at most ten seconds. Start CPR when there is no definite pulse. With a pulse under 60/min and poor perfusion despite oxygenation and ventilation, start CPR according to the paediatric algorithm.

Continue with step 5 on the next page.

Procedure Continued

Infant and Child Oxygen Support and Paediatric Life Support

5. Compress at 100 to 120 per minute to at least one-third of the chest depth. For an infant use the two-thumb encircling method or the heel of one hand. For a child use one or two hands as suitable. Allow full recoil.
6. With no advanced airway demonstrate 30 to 2 for one rescuer and 15 to 2 for two trained rescuers, keeping pauses short.
7. Fit the AED promptly, using paediatric attenuation where available and appropriate. Follow the device’s pad diagram and keep pads from touching. Clear for analysis and shock and resume CPR promptly.
8. Record observations, settings, actions, times and response during handover. Note that resuscitation at birth follows the separate neonatal pathway.

Precautions

- Use authorised manikins and current paediatric algorithms.
- Monitor chest rise and patient response.

Observations and Record

Infant and Child Oxygen Support and Paediatric Life Support

Documentation

Item	What to record	Why it matters
Recognition	Breathing, perfusion and time	Guides urgency
Support	Device, ventilation and compression quality	Checks effectiveness
Handover	AED use, actions and response	Supports continuity

Worked Example

There is poor chest rise on the infant manikin. The team adjusts head position and uses a two-person seal, then confirms effective trainer ventilation.

Result and Evaluation

Recognise distress and demonstrate safe age-specific support, reassessment and communication.

Viva Questions and Answers

What is a visible sign of an effective trainer breath?

Gentle chest rise.

Which compression depth applies?

At least one-third of the anteroposterior chest diameter for infants and children.

Essential Newborn Assessment Warmth and Kangaroo Care

Practical 08 / Skills laboratory

Aim

Assess a stable newborn trainer and demonstrate thermal and feeding support.

Principle

Warmth, feeding support, respiratory assessment and early recognition of abnormalities protect newborn transition.

Articles and Materials

- Newborn doll, calibrated scale and thermal care setup
- Cord care, KMC model and newborn chart

Procedure

1. Verify birth time, gestation, maternal history and immediate transition record. Check breathing, tone, colour, temperature and feeding concerns.
2. Maintain warmth and verify identification and safe positioning. Demonstrate skin-to-skin and handling using the approved clinical scenario.
3. Weigh the trainer and record measurements, temperature and observations with time. Inspect cord, skin, breathing and other assigned newborn findings.
4. Review the authorised vitamin K and immunisation records and explain the team checks and follow-up to the caregiver.
5. Demonstrate kangaroo care positioning under the facility guide, with face and breathing observable, head supported and thermal checks.
6. Assess feeding readiness and support the caregiver with the approved feeding plan. Escalate poor feeding, breathing difficulty, abnormal temperature or other concerning signs.
7. Discuss cord and thermal care, safe follow-up and urgent symptoms and check caregiver teach-back.
8. Record findings, measures, duration, response and any referral or monitoring required.

Precautions

- Maintain safe positioning and warmth.
- Follow the newborn team’s feeding and monitoring plan.

Observations and Record

Essential Newborn Assessment Warmth and Kangaroo Care

Documentation

Item	What to record	Why it matters
Transition	Breathing, tone and temperature	Assesses stability
Measure	Weight, care and feeding observations	Supports care plan
Review	Risks, teaching and follow-up	Guides continuity

Worked Example

A stable low-birth-weight case card calls for kangaroo care. The student verifies airway visibility, warmth and the nursing monitoring plan.

Result and Evaluation

Demonstrate essential newborn nursing care and clear recognition of signs needing review.

Viva Questions and Answers

What must remain observable in kangaroo care?

Breathing and the infant's face and airway.

Why record temperature before and after care?

It helps assess whether the infant maintained warmth.

Newborn Resuscitation and Stabilisation

Practical 09 / Skills laboratory

Aim

Assess a newborn trainer at birth, demonstrate timely ventilation and document response and transfer.

Principle

A newborn with inadequate breathing needs effective ventilation and continued warmth. An improving heart rate supports an effective response.

Articles and Materials

- Newborn manikin, warmer, dry linen and timer
- Specified mask, ventilation device and current neonatal algorithm

Procedure

1. Check gestation, risk and roles before simulated birth. Test the warmer, appropriate mask size, ventilation equipment and heart-rate assessment method.
2. At birth assess breathing or crying and tone. Provide routine warmth and observation for the stable case and call the newborn team if support is needed.
3. Demonstrate warmth, position, drying and appropriate stimulation for the model. Clear the airway only when obstruction is suspected and follow the skilled team's instructions.
4. For apnoea, gasping or persistent heart rate below 100/min after initial care, show ventilation within 60 seconds of birth. Under the 2025 AHA neonatal trainer pathway, deliver 30 to 60 inflations per minute.
5. Look for chest movement and reassess heart rate. Correct mask seal and head position or obtain skilled airway assistance if ventilation remains ineffective.
6. Escalate for trained compression and advanced support if heart rate remains below 60/min after at least 30 seconds of ventilation that moves the chest.
7. After stabilisation monitor breathing, temperature, feeding readiness and changes and prepare the receiving neonatal team.
8. Record birth time, initial findings, start of ventilation, response and handover. Explain the next steps to the caregiver within the assigned role.

Precautions

- Use the approved neonatal algorithm and trainer.
- Keep temperature and ventilation under observation throughout.

Observations and Record

Newborn Resuscitation and Stabilisation

Documentation

Item	What to record	Why it matters
Initial assessment	Breathing, tone and time	Guides first actions
Support	Ventilation timing, chest rise and heart rate	Shows effectiveness
Follow-up	Thermal care, response and receiving team	Maintains continuity

Worked Example

The manikin remains apnoeic and its heart rate is 80/min after initial steps. The student calls for help and demonstrates timely mask ventilation and reassessment.

Result and Evaluation

Demonstrate effective and timely model ventilation, appropriate escalation and a clear nursing handover.

Viva Questions and Answers

What sign suggests ventilation is effective?

A rising heart rate supports an effective response.

When should the team escalate to the neonatal compression pathway?

A heart rate below 60/min after at least 30 seconds of ventilation that moves the chest requires trained escalation.

Psychiatric Nursing History and Mental Status Examination

Practical 01 / Supervised communication practice

Aim

Obtain a respectful mental health history and document a structured mental status examination.

Principle

History describes changes over time, while examination records the observed or elicited current state.

Articles and Materials

- Standardised patient brief and private setting
- Nursing history and mental status templates

Procedure

1. Introduce yourself, verify identity and role, explain confidentiality and ask permission. Arrange privacy, preferred language and communication support.
2. Invite description of the main concern, onset, symptom course and effect on sleep, activity and relationships. Establish the baseline.
3. Review health history, relevant medicines, substance exposure, previous episodes and supports. Identify who provides each detail.
4. Observe appearance, behaviour, speech, alertness and activity. Ask about mood, then record observed affect and reported experience separately.
5. Explore thought organisation and content, perception, cognition and insight as appropriate. Record the actual response and any test limitations.
6. Assess immediate physical or psychological safety and notify the supervising clinician for urgent concerns. Practise non-judgemental wording.
7. Summarise relevant findings and strengths and check the person’s account. Ask about a practical support they would accept and explain the next step within the nursing role.
8. Document the date, findings, uncertainty, care priorities and who will review them.

Precautions

- Use neutral language and consent for collateral information.
- Escalate urgent safety concerns promptly.

Observations and Record

Psychiatric Nursing History and Mental Status Examination

Documentation

Item	What to record	Why it matters
History	Timeline, function and source	Establishes change
Mental status	Observed and reported findings	Supports care decisions
Safety	Concern and team response	Clarifies urgency

Worked Example

The patient describes poor sleep and the student observes pressured speech. The note labels reported sleep and observed speech in separate fields.

Result and Evaluation

Obtain an accurate structured account and communicate immediate needs and follow-up.

Viva Questions and Answers

How does affect differ from mood?

Affect is observed emotional expression and mood is the person's reported emotional state.

Why record an untestable item?

It explains a limitation and avoids assuming a finding.

Mental Health Screening Psychometric and Neurological Observation

Practical 02 / Clinical case or record exercise

Aim

Demonstrate supportive screening preparation and record results and limitations of the assigned tools.

Principle

Screening observations depend on language, baseline ability, test conditions and trained interpretation.

Articles and Materials

- Instructor-approved screening and attention tasks
- Fictional neurological observation chart and score sheet

Procedure

1. Verify identity, age, clinical purpose and consent and confirm which clinician selected the tool. Check preferred language, hearing and vision.
2. Review recent illness, medicine changes, substance use and baseline functioning. Identify urgent medical or safety concerns before continuing.
3. Prepare a calm space and give the tool's standard instructions. Record whether an interpreter, sensory aid or other adaptation was used.
4. Observe alertness, orientation, attention and relevant neurological findings within scope. Compare across time when change or fluctuation is suspected.
5. Score the approved training tool according to its key, documenting incomplete items and limits. Refer formal interpretation to the qualified clinician.
6. Consider how language, education, fatigue or an acute change affects the result. Note what further assessment or collateral is needed.
7. Explain next steps in plain language and document concerns without unsupported labels or diagnoses.
8. Give a handover with the test, results, context, urgency and person responsible for reassessment.

Precautions

- Use only approved tools and trained interpretation.
- Prioritise acute illness or immediate safety.

Observations and Record

Mental Health Screening Psychometric and Neurological Observation

Documentation

Item	What to record	Why it matters
Context	Baseline, consent and adaptations	Supports fair interpretation
Observation	Tool, score and neurological findings	Records evidence
Review	Limit, next test and responsible team	Prevents overinterpretation

Worked Example

Recent confusion fluctuates and attention is poor in a simulated case. The student alerts the team for medical assessment and labels the screening score as limited.

Result and Evaluation

Produce an interpretable observation record and respond appropriately to new or concerning findings.

Viva Questions and Answers

What may affect psychometric performance?

Language, sensory impairment, fatigue and acute illness are examples.

What helps identify possible delirium?

An acute change with fluctuating attention and alertness merits urgent medical review.

Therapeutic Interaction and Process Recording

Practical 03 / Supervised communication practice

Aim

Use therapeutic communication and complete a confidential process record of a role-play.

Principle

Open questions, listening and reflection support rapport. Process recording helps review how the interaction affected understanding and care.

Articles and Materials

- Fictional interview brief, notebook and communication checklist
- Approved process-record template

Procedure

1. Verify the topic, role and consent and arrange a private setting. Ask what the person would like to discuss.
2. Use an open question and non-judgemental listening, allowing comfortable pauses. Observe relevant nonverbal signs without assuming meaning.
3. Reflect or clarify one statement and check whether the person agrees with the summary. Avoid leading questions and unsupported promises.
4. Ask about concerns, supports and preferred next steps and communicate urgent needs to the responsible clinician if identified.
5. Close with a brief summary and explain who will follow up. Confirm the person understands and agrees with the plan.
6. Write selected dialogue and responses in the process record with date, purpose and minimal fictional identifiers. Separate observed behaviour and interpretation.
7. Label the technique used in each exchange, note its effect and identify a respectful alternative for one missed opportunity.
8. Review with faculty, protect confidentiality and document any appropriate change to the nursing plan.

Precautions

- Use approved fictional material for teaching.
- Ask permission before including family or support persons.

Observations and Record

Therapeutic Interaction and Process Recording

Documentation

Item	What to record	Why it matters
Exchange	Relevant words and observed response	Preserves communication evidence
Technique	Method and effect	Supports reflection
Plan	Safety issue, follow-up and improvement	Connects discussion to care

Worked Example

The learner switches from multiple questions to one open question. The actor provides more detail and confirms the summary.

Result and Evaluation

Demonstrate useful communication and a process record with a specific improvement.

Viva Questions and Answers

What is reflection in therapeutic communication?

Restating the person's feeling or meaning to check understanding.

Why separate observation and inference?

It keeps the record clear and reviewable.

Family Psychoeducation and Mental Hygiene Promotion

Practical 04 / Supervised communication practice

Aim

Deliver an approved mental health education session and verify the family's understanding and follow-up.

Principle

Collaborative education addresses priorities, reduces stigma and supports early recognition and continuity of care.

Articles and Materials

- Fictional family brief and approved teaching materials
- Teach-back and referral checklist

Procedure

1. Check the person's permission for family involvement and confirm privacy, preferred language and goals. Ask what questions the family wants answered.
2. Assess baseline understanding, distress, routines, strengths and practical barriers. Clarify which information may be shared.
3. Set a simple objective, such as recognising an early warning sign or describing how to contact the service.
4. Share the approved information in brief sections, using neutral terms and examples. Discuss supportive routines, treatment follow-up and crisis contact as relevant.
5. Invite questions and practise an agreed daily support or follow-up action. Clarify which signs require immediate assessment.
6. Use teach-back with both patient and caregiver where appropriate. Revisit an unclear point in simpler language and check access to the agreed service.
7. Provide the approved contact and follow-up route and agree on the next check or referral.
8. Document topic, attendance, permission, understanding, outstanding needs and who will review them.

Precautions

- Respect the patient's choices and confidentiality.
- Refer complex or urgent questions to the qualified team.

Observations and Record

Family Psychoeducation and Mental Hygiene Promotion

Documentation

Item	What to record	Why it matters
Audience	Consent, needs and goals	Guides relevant education
Session	Approved content and response	Shows engagement
Follow-up	Teach-back, referral and timing	Supports continuity

Worked Example

A family can name the clinic but is unsure when to ask for early help. The learner rehearses the agreed contact scenario and rechecks understanding.

Result and Evaluation

Complete a patient-centred training session and document one achievable follow-up action.

Viva Questions and Answers

Why check consent before family discussion?

It protects privacy and respects the person's choice.

What makes a warning-sign plan usable?

Specific signs and a clear person or service to contact.

Child Guidance Clinic and Caregiver Education

Practical 05 / Supervised communication practice

Aim

Prepare a child-guidance visit and document behavioural, developmental and family observations for the specialist team.

Principle

Age, development and behaviour across settings help the team understand needs. Child and caregiver accounts add different information.

Articles and Materials

- Fictional child-guidance brief and permission checklist
- Play materials, observation form and caregiver teaching record

Procedure

1. Confirm identity, age, caregiver role, purpose and consent. Explain the student role and arrange developmentally appropriate assent or permission as required.
2. Ask the caregiver about the concern, when it began, function at home and school, developmental history and changes in sleep or daily routines.
3. Invite the child to describe concerns in an age-appropriate way. Observe interaction, play, attention and comfort without coaching responses.
4. Review previous reports or the assigned screening tool and document who provided each item. Identify whether the specialist needs further observations from another setting.
5. Prepare and observe the clinician’s assessment, recording specific actions and barriers such as fatigue, language or hearing difficulty.
6. Discuss one agreed caregiver support strategy or school follow-up using the specialist’s plan. Confirm ability to use it and request teach-back.
7. Escalate safeguarding, significant distress or safety concerns promptly through the authorised service.
8. Record observations, permission, teaching, referral and the person responsible for follow-up.

Precautions

- Protect privacy and avoid diagnostic labels from a single observation.
- Respect the child’s comfort and the agreed consent process.

Observations and Record

Child Guidance Clinic and Caregiver Education

Documentation

Item	What to record	Why it matters
History	Concern, onset and setting	Clarifies the pattern
Observation	Actual behaviour, task and limits	Supports specialist review
Plan	Teaching, referral and review owner	Supports family follow-through

Worked Example

Difficulty with attention is reported at school but the caregiver sees a different pattern at home. The student records both accounts and asks the team how to obtain additional information with permission.

Result and Evaluation

Prepare a clear child-guidance record and verify one feasible caregiver action.

Viva Questions and Answers

Why ask about more than one setting?

Behaviour and support needs can vary across settings.

How should screening observations be recorded?

Include the task, actual response, sources and limits.

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.

Lesson Planning Microteaching and Teaching Aids

Practical 01 / Supervised communication practice

Aim

Prepare and deliver a short nursing teaching session and improve it using feedback.

Principle

Observable outcomes, relevant demonstration and learner practice align teaching and evaluation.

Articles and Materials

- Lesson plan, selected device or visual aid
- Microteaching checklist and learner feedback sheet

Procedure

1. Define audience, prior knowledge, available time and the specific skill or concept. Choose an observable learning outcome.
2. Sequence introduction, demonstration, practice and evaluation. Allocate time and identify materials and safety requirements.
3. Prepare a simple accessible teaching aid and verify its content against the approved nursing method. Check legibility and accuracy.
4. Introduce the session and link it to a real nursing task. Demonstrate the skill at an appropriate pace with key checks.
5. Ask learners to repeat one part and prompt discussion. Give specific feedback and adjust language when understanding is uncertain.
6. Evaluate the outcome with a brief return demonstration or question. Compare performance with the planned criterion and record the exact action that was missed or completed.
7. Collect feedback, select one change and repeat or revise the affected part of the lesson.
8. Record the plan, outcome, teaching aids, feedback and modification.

Precautions

- Use approved skill content.
- Keep instructions and aids accessible.

Observations and Record

Lesson Planning Microteaching and Teaching Aids

Documentation

Item	What to record	Why it matters
Plan	Audience, objective and time	Guides teaching
Practice	Aid, method and learner response	Shows engagement
Evaluation	Evidence and revision	Improves next session

Worked Example

Learners can explain why to check cuff size but skip the actual measurement. The instructor revises the demonstration and asks them to practise it.

Result and Evaluation

Demonstrate alignment between learning outcome, method and evaluation.

Viva Questions and Answers

What is microteaching?

A brief focused teaching exercise followed by feedback and improvement.

What is an observable objective?

One that states an action or performance that can be assessed.

Nursing Assessment Blueprint MCQs and Observation Checklist

Practical 02 / Lab or data practical

Aim

Design a short skills assessment with an aligned checklist and clear scoring criteria.

Principle

Assessment is stronger when items and criteria sample the intended learning outcomes and can be scored consistently.

Articles and Materials

- Learning outcome list and blank blueprint
- Sample station, MCQ and observer checklists

Procedure

1. Identify the clinical skill or content area and the specific performance outcome. Decide which elements are core or safety-critical.
2. Draft a blueprint mapping content, expected level, items, marks and time. Check the balance against the objectives.
3. Write a clinical question stem with one clearly best answer and plausible alternatives. Check for ambiguity and unwanted clues.
4. For the practical station write a concise candidate instruction and list equipment and model conditions. Provide the same setup for each learner.
5. Create an observation checklist with specific behaviours and scoring anchors, including how critical errors are handled in the faculty exercise.
6. Pilot the station or questions with a peer, compare scoring and identify unclear wording or timing problems.
7. Revise the blueprint, items and checklist and include answer or scoring rationale for reviewer use.
8. Document reviewer feedback, final criteria and the method for providing learner feedback.

Precautions

- Protect learner information and use approved clinical content.
- Make criteria observable and scoreable.

Observations and Record

Nursing Assessment Blueprint MCQs and Observation Checklist

Documentation

Item	What to record	Why it matters
Blueprint	Outcomes, items and time	Supports coverage
Tool	Stem, task and checklist	Improves clarity
Review	Pilot, scoring and revision	Supports consistency

Worked Example

Two observers disagree on whether a result was recorded correctly. The group clarifies the exact documentation required and repeats the pilot.

Result and Evaluation

Produce a clear and usable nursing assessment with a tested scoring plan.

Viva Questions and Answers

Why use a blueprint?

It checks that assessment represents the intended objectives.

What helps different observers score consistently?

Clear criteria, shared instructions and a trial of the checklist.

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