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High Risk Antenatal Assessment Fetal Movements and Glucose Screening

Practical 01 / Skills laboratory

Aim

Identify antenatal warning findings, review fetal movement reports and prepare authorised follow-up testing.

Principle

Gestation, symptoms, documented trends and current observations guide urgent review and targeted assessment.

Articles and Materials

- Fictional high-risk antenatal record, movement chart and abdominal trainer
- BP device and timed glucose test cards

Procedure

1. Verify identity, gestation and current symptoms. Ask about bleeding, headache, visual change, pain, fetal movements, fluid loss and relevant risks.
2. Assess maternal vital observations with correct technique and review current and prior readings. Notify the responsible team promptly for severe findings or deterioration.
3. Review the prenatal card, fetal growth and the movement history with the case's chart. Document change from the person's usual pattern and follow the urgent review pathway where indicated.

Continue with step 4 on the next page.

Procedure Continued

High Risk Antenatal Assessment Fetal Movements and Glucose Screening

4. Prepare supervised fetal assessment or ultrasound using the authorised indications and instructions. Record findings, limits and who will interpret them.
5. For the glucose screening exercise verify the test type, any fasting instructions, timing and specimen labels. Match each value to the correct interval.
6. Review the combined maternal and fetal findings and identify appropriate referral, monitoring and education with the clinician.
7. Explain next steps, danger signs and access to urgent care, then confirm understanding and transport or support needs.
8. Document risks, findings, actions, result ownership and scheduled reassessment.

Precautions

- Do not delay urgent assessment for completion of routine charting.
- Use current local decision and testing pathways.

Observations and Record

High Risk Antenatal Assessment Fetal Movements and Glucose Screening

Documentation

Item	What to record	Why it matters
Risk review	Gestation, symptoms and observations	Guides urgency
Fetal and glucose data	Movement, timing and method	Supports evaluation
Referral	Priority and receiving team	Maintains safe continuity

Worked Example

The patient says fetal movement is markedly reduced compared with usual. The student activates the facility's urgent assessment pathway and records the exact time.

Result and Evaluation

Recognise high-risk findings and document appropriate maternity assessment and follow-up.

Viva Questions and Answers

Why ask about the individual's usual movement pattern?

A significant change may need clinical assessment.

Why label glucose samples by time?

Interpretation depends on the specific test and collection interval.

Obstetric Hypertension and Antenatal Medicine Monitoring

Practical 02 / Skills laboratory

Aim

Recognise a severe hypertension scenario and demonstrate nursing checks for authorised obstetric medicines.

Principle

Maternal and fetal observations, dose verification and monitoring detect deterioration or medicine-related complications.

Articles and Materials

- Maternal manikin, case observations and emergency pathway
- Mock magnesium sulfate and corticosteroid orders and pump trainer

Procedure

1. Confirm gestation, symptoms and earlier findings. Assess breathing, alertness and relevant observations and recognise severe headache, visual symptoms or convulsions.
2. Call the maternity team immediately for severe concern. Prepare the assigned safe position, monitoring and emergency equipment while help arrives.
3. Verify identity, allergy, order, medicine, indication, dose, route and rate. Obtain the required independent check before model preparation.

Continue with step 4 on the next page.

Procedure Continued

Obstetric Hypertension and Antenatal Medicine Monitoring

4. For the magnesium sulfate scenario document the prescribed baseline and serial monitoring, including respiration, reflexes, urine output and signs of toxicity.
5. Demonstrate pump or authorised route checks on the trainer and record start and observations. For an antenatal corticosteroid case verify schedule and clinical responsibility.
6. Escalate signs of deterioration, toxicity or adverse response urgently and follow the protocol for holding or urgent review as directed.
7. Reassess maternal and fetal status with the assigned team. Give a direct handover with symptoms, observations, timing, medicine and response.
8. Document all checks, action and next planned monitoring and reviewer.

Precautions

- Use mock orders and current facility pathways.
- Require qualified review for severe symptoms, deterioration or uncertain administration.

Observations and Record

Obstetric Hypertension and Antenatal Medicine Monitoring

Documentation

Item	What to record	Why it matters
Initial signs	Symptoms and timed observations	Identifies urgency
Medicine	Order, independent checks and monitoring	Reduces error
Response	Findings, action and handover	Detects complications

Worked Example

Respiratory observations worsen on the magnesium trainer case. The learner calls for urgent review and reports the verified setting, timing and current findings.

Result and Evaluation

Demonstrate emergency readiness and the correct nursing observation and escalation workflow.

Viva Questions and Answers

What nursing observations are important with magnesium sulfate?

Respiration, reflexes, urine output and other prescribed maternal observations.

Why check timing in the handover?

It links clinical changes to onset, medicines and response.

Complicated Labour Induction and Fetal Monitoring

Practical 03 / Skills laboratory

Aim

Prepare an induction or complicated-labour case and respond to maternal or fetal warning findings.

Principle

Continuous reassessment of the person, labour progress and fetal status supports timely escalation.

Articles and Materials

- Labour model, visual trace and observation cards
- Mock induction order and facility labour checklist

Procedure

1. Verify identity, gestation, indication, consent, relevant risk and current labour assessment. Clarify the student's role in the planned sequence.
2. Record baseline maternal observations, contractions and fetal assessment. Confirm qualified review of eligibility and contraindications before any intervention.
3. Compare the authorised medical induction order with the clinical plan using independent checks. Prepare the model monitoring equipment and record settings and times.
4. In the amniotomy trainer observe indication, presentation and engagement checks and note fetal assessment before and after. Record the fluid and timed findings.
5. Observe the supplied trace, contractions and maternal condition and identify worsening symptoms or abnormal findings. Activate senior review promptly.
6. Protect comfort, respectful communication and safe monitoring during transfer or review. Prepare newborn support if delivery may be expedited.
7. Document actions and response in the labour chart with exact times and communicate outstanding concerns.
8. Give handover with the intervention, condition, trace finding, team contacted and agreed reassessment.

Precautions

- Use the authorised case order and faculty trainers.
- Delay routine charting if urgent help is needed.

Observations and Record

Complicated Labour Induction and Fetal Monitoring

Documentation

Item	What to record	Why it matters
Baseline	Indication, consent and findings	Confirms readiness
Monitoring	Actions, times and maternal-fetal changes	Supports escalation
Continuity	Receiver and next assessment	Protects safe care

Worked Example

The fetal trace becomes concerning after a simulated labour intervention. The student escalates immediately and records the intervention and change times.

Result and Evaluation

Complete preparation and monitoring with timely escalation of a significant finding.

Viva Questions and Answers

Why record fetal assessment before and after intervention?

It helps identify new changes associated with the procedure.

Who confirms safe induction eligibility?

The responsible maternity clinician using facility criteria.

Assisted Birth Caesarean Preparation and Recovery

Practical 04 / Skills laboratory

Aim

Prepare a case for assisted birth or caesarean and support safe maternal-newborn transition and recovery.

Principle

Verified procedure, time-sensitive preparation, qualified roles and good handover reduce avoidable delays and complications.

Articles and Materials

- Obstetric emergency and theatre cases
- Birth or repair model, transfer form and newborn equipment checklist

Procedure

1. Confirm indication, urgency, identity, consent and maternal-fetal status. Review relevant orders and the role of the maternity and newborn teams.
2. Prepare the required monitoring, transport, theatre or delivery equipment. Use the safety checklist and communicate unresolved concerns.
3. For the assisted vaginal birth scenario identify model instrument or support requests and assist within the assigned role. Confirm newborn readiness and communication.

Continue with step 4 on the next page.

Procedure Continued

Assisted Birth Caesarean Preparation and Recovery

4. For caesarean check preparation, position, vital observations, allergies and authorised medicines. Match the theatre team's identity and procedure confirmation.
5. For episiotomy or repair observation verify indication, consent, patient comfort, asepsis and model instrument and sharps counts with faculty.
6. In recovery assess bleeding, tone, vital observations, wound, comfort and newborn condition. Identify concerns requiring urgent review.
7. Record times, procedure, specimen or counts as applicable and arrange monitoring, feeding support and reassessment.
8. Handover maternal and neonatal findings separately with actions, pending items and the receiving teams.

Precautions

- Work within faculty and authorised team roles.
- Preserve monitoring, dignity and communication during an urgent transfer.

Observations and Record

Assisted Birth Caesarean Preparation and Recovery

Documentation

Item	What to record	Why it matters
Preparation	Procedure, readiness and roles	Reduces delays
Birth or procedure	Timing, observations and checks	Establishes traceability
Recovery	Bleeding, comfort and newborn plan	Supports continuity

Worked Example

The team must transfer urgently for caesarean. The learner confirms identity and urgent clinical details and notifies the neonatal team with the agreed checklist.

Result and Evaluation

Demonstrate organised assistance and a complete maternal and newborn handover.

Viva Questions and Answers

Why prepare newborn support in advance?

An urgent or assisted birth may require immediate newborn assessment or support.

What is recorded after a model repair?

Procedure, assessed site, counts, observation and follow-up.

Postpartum Haemorrhage Response and Nursing Assistance

Practical 05 / Skills laboratory

Aim

Recognise excessive bleeding, quantify loss and assist the maternity emergency team on trainers.

Principle

Early recognition, emergency activation, cumulative blood loss and targeted cause assessment support timely treatment.

Articles and Materials

- Postpartum manikin, calibrated drape and vital chart
- Emergency checklist, access and haemorrhage device trainers

Procedure

1. Observe bleeding and clinical state and activate the haemorrhage team promptly. Assign monitoring, documentation, equipment and communication roles.
2. Measure cumulative loss and record times, pulse, pressure, perfusion, alertness and tone. In the WHO-based vaginal birth case activate the bundle at 500 mL or more of measured loss, or at 300 mL or more with an abnormal haemodynamic sign such as pulse over 100/min or systolic pressure below 100 mmHg. Escalate instability immediately.
3. Use Tone, Trauma, Tissue and Thrombin to organise findings. With the responsible team, rehearse the first-response bundle, which includes uterine massage, uterotonic treatment, tranexamic acid, IV fluids, examination and escalation.

Continue with step 4 on the next page.

Procedure Continued

Postpartum Haemorrhage Response and Nursing Assistance

4. Prepare authorised model access, specimens, fluids or blood checks and support clear read-back, including concentration and timing of any dummy order.
5. At faculty trainers review indications and timing for bimanual or aortic compression, balloon tamponade and retained placenta management. Demonstrate assigned assistance or device checks under direct instruction.
6. Reassess tone, bleeding, perfusion and vital findings after each action. State when transfer or further definitive care is needed.
7. Provide respectful communication to the patient or family within the approved role. Keep emergency actions and observations time-stamped.
8. Give a structured handover with total loss, response, pending treatment and the team assuming care.

Precautions

- Use trainers and current maternity protocols.
- Escalate worsening bleeding or instability without waiting for complete documentation.

Observations and Record

Postpartum Haemorrhage Response and Nursing Assistance

Documentation

Item	What to record	Why it matters
Recognition	Loss, tone, observations and times	Supports early response
Assistance	Team role, orders and model action	Keeps response coordinated
Reassessment	Trend, result and transfer	Guides definitive care

Worked Example

The calibrated drape shows a rapidly rising volume and the simulation has worsening perfusion. The student activates the protocol and reports both the measured loss and clinical change.

Result and Evaluation

Show prompt escalation, accurate quantification and safe supervised participation.

Viva Questions and Answers

What are the four Ts?

Tone, Trauma, Tissue and Thrombin.

Why reassess after each action?

Ongoing loss and perfusion determine whether further support is needed.

Postnatal Complications Maternal Sepsis Breast and Leg Assessment

Practical 06 / Clinical case or record exercise

Aim

Identify significant postnatal symptoms and prepare a priority-based nursing response and referral.

Principle

Maternal infection, bleeding, thromboembolic symptoms and breast or wound problems can present after delivery and require timely review.

Articles and Materials

- Fictional postnatal records and observation chart
- Maternal wound and breast models and escalation form

Procedure

1. Confirm delivery time, method, complications and discharge or current plan. Ask about fever, bleeding, pain, wound, feeding and wellbeing.
2. Assess vital observations and current stability, then identify serious symptoms such as severe breathlessness, faintness or impaired alertness.
3. With specific consent assess the model wound, perineal or breast findings as assigned, describing site, symptoms, discharge and recent change.
4. Ask about unilateral leg swelling or pain and relevant risks and report concern for a vascular complication. Avoid manipulation of a suspected affected limb.
5. Compare fever, wound or breast findings with the facility pathway and involve the clinician. Plan authorised comfort and feeding support pending review.
6. Reassess after care and prepare urgent escalation if the person deteriorates. Include timing, observations and relevant interventions.
7. Explain warning signs, approved follow-up and how to reach care. Check understanding and support needs.
8. Document findings, limitations, actions and the responsible team and next reassessment.

Precautions

- Obtain permission before sensitive examination.
- Report serious symptoms promptly and follow authorised care.

Observations and Record

Postnatal Complications Maternal Sepsis Breast and Leg Assessment

Documentation

Item	What to record	Why it matters
Maternal status	Symptoms, timeline and vital signs	Sets urgency
Focused review	Wound, breast or leg findings	Guides assessment
Action	Referral, comfort and follow-up	Protects continuity

Worked Example

A postnatal case has sudden chest symptoms and one swollen leg. The learner activates urgent review and communicates exact findings and onset.

Result and Evaluation

Recognise the need for urgent or planned review and record an appropriate nursing response.

Viva Questions and Answers

Why ask about chest symptoms with leg swelling?

The combination may signal a time-sensitive vascular concern.

What should be documented for possible infection?

Symptoms, location, timed observations and which clinician was notified.

Sick Newborn Recognition Treatment Support and Referral

Practical 07 / Skills laboratory

Aim

Identify a sick newborn and prepare safe treatment monitoring and transfer in a model case.

Principle

Newborns can deteriorate quickly. Warmth, breathing, hydration, feeding and reliable handover are essential.

Articles and Materials

- Newborn trainer and referral case
- Warmer and phototherapy demonstrations, monitoring and transfer checklist

Procedure

1. Confirm birth details, gestation, current weight, symptoms and previous care. Check breathing, alertness, colour, temperature, perfusion and feeding.
2. Identify urgent signs and summon the neonatal team. Maintain warmth and support breathing according to the supervised pathway.
3. Review jaundice timing and bilirubin and other relevant results. Use approved treatment criteria and confirm any prescription or referral decision.

Continue with step 4 on the next page.

Procedure Continued

Sick Newborn Recognition Treatment Support and Referral

4. Demonstrate warmer and phototherapy preparation on the trainer and verify position, protective equipment and ordered observations.
5. Recheck temperature, breathing, perfusion, intake and output and report failure to improve or new warning signs.
6. Check transport readiness, communication with the receiving service, escort, thermal support, monitoring and records. Confirm who will provide ongoing support and repeat vital measurements during transfer.
7. Explain the condition, support and transfer plan to caregivers as authorised. Confirm how the receiving team can contact them.
8. Record observations, treatment, response, time and transfer or follow-up ownership.

Precautions

- Use trained support and prescribed settings.
- Maintain warmth and monitor breathing in transfer.

Observations and Record

Sick Newborn Recognition Treatment Support and Referral

Documentation

Item	What to record	Why it matters
Baseline	Age, gestation and urgent signs	Guides priority
Support	Warmth, treatment and response	Detects change
Transfer	Destination, escort and handover	Maintains safe care

Worked Example

An infant under the model warmer develops poor feeding and abnormal temperature. The student calls for immediate neonatal assessment and prepares a timed handover.

Result and Evaluation

Demonstrate safe supportive care and a complete, urgent newborn referral when needed.

Viva Questions and Answers

Why record gestation and age?

They influence risk, interpretation and treatment plans.

What accompanies a newborn referral?

Findings, timings, treatment, response, monitoring needs and caregiver details through authorised channels.

Postabortion Care and Postpartum Contraceptive Skills

Practical 08 / Skills laboratory

Aim

Assess postabortion recovery and demonstrate safe counselling and authorised contraceptive model preparation.

Principle

Privacy, voluntary informed choice, observation and timely referral support reproductive healthcare.

Articles and Materials

- Fictional reproductive care records, counselling materials
- Pelvic trainer, contraception case and procedure checklists

Procedure

1. Verify identity, timing, symptoms, clinical plan and consent. Ask about pain, bleeding, fever and wellbeing in a private, supportive setting.
2. Assess stability and identify urgent bleeding, pain or concerning symptoms. Escalate and document the immediate response.
3. Review the clinical record and physician-led procedure or aftercare instructions. For evacuation or manual aspiration observation verify preparation and monitoring roles.
4. Explain the approved follow-up, warning signs and psychosocial support. Use plain language and confirm understanding.
5. Ask whether contraception is desired and review relevant options, medical eligibility and timing respectfully. Confirm voluntary decision.
6. For a model postpartum intrauterine device or other teaching procedure verify consent, correct equipment and asepsis, and demonstrate only the approved trainer sequence.
7. Record method or decision, procedure observations, concerns and the agreed review. Arrange confidential referrals as needed.
8. Confirm responsible follow-up and safe communication and provide written approved instructions.

Precautions

- Preserve privacy and informed choice.
- Refer urgent signs through the maternity or gynaecology pathway.

Observations and Record

Postabortion Care and Postpartum Contraceptive Skills

Documentation

Item	What to record	Why it matters
Assessment	Symptoms, stability and procedure record	Identifies care needs
Choice	Eligibility, information and consent	Supports autonomy
Follow-up	Warning signs, visit and responsible team	Protects continuity

Worked Example

The patient wants time to decide on contraception. The learner records the preference and provides a private follow-up option after recovery checks.

Result and Evaluation

Provide a dignified assessment, safe model assistance and a voluntary plan with follow-up.

Viva Questions and Answers

Why verify the person's preferred contact?

It helps protect confidentiality and follow-up.

What is documented for a contraceptive procedure?

Consent, indicated method, relevant checks, observations and the review plan.

Gynaecological Assessment Screening and Procedure Support

Practical 09 / Skills laboratory

Aim

Prepare a woman for clinician-led gynaecological assessment or screening and verify model specimen and recovery checks.

Principle

Appropriate indication, consent, specimen accuracy and result follow-up protect sensitive care.

Articles and Materials

- Fictional gynaecology record and pelvic trainer
- Pap and visual inspection models, lab form and recovery checklist

Procedure

1. Ask about symptoms, timing, bleeding, pregnancy possibility, relevant history and the person's concerns. Check stability and urgency.
2. Explain examination, privacy, consent choices and chaperone arrangements. Prepare the trained team and appropriate supplies.
3. Distinguish routine cervical screening from investigation of symptoms and verify the current facility pathway for cytology, HPV testing or visual methods.
4. On the trainer demonstrate the authorised collection support and correctly label the dummy specimen. Record site, medium and any limitation.
5. Prepare the case for colposcopy, biopsy or other gynaecological procedure and verify readiness, consent and the recovery and observation plan.
6. Check postoperative bleeding, pain, vital signs and site as ordered. Escalate deterioration and document changes promptly.
7. Discuss breast health awareness, infertility support or referral where applicable and reinforce follow-up and warning signs. Check which contact method preserves privacy.
8. Document assessment, procedure, specimen, observations, pending result owner and next contact.

Precautions

- Use a pelvic trainer and trained clinical staff for procedures.
- Keep sensitive details confidential.

Observations and Record

Gynaecological Assessment Screening and Procedure Support

Documentation

Item	What to record	Why it matters
Assessment	Symptoms, screening indication and consent	Directs care
Procedure	Preparation, specimen and timing	Maintains traceability
Follow-up	Observations, results and referral	Protects continuity

Worked Example

The case has concerning symptoms despite a previous routine screening result. The student arranges appropriate clinical review and records the reason.

Result and Evaluation

Demonstrate clear preparation, specimen checks and follow-up within the supervised nursing role.

Viva Questions and Answers

Why distinguish screening from assessment of symptoms?

Symptoms may require targeted clinical evaluation regardless of screening history.

Who should review the specimen result?

The named authorised clinical service with a documented plan for notification.

Safe Delivery App Learning and Maternity Simulation

Practical 10 / Skills laboratory

Aim

Complete a faculty-approved learning activity and demonstrate transfer to a maternity or newborn simulation.

Principle

Reviewing an approved module, practising on a trainer and recording feedback help consolidate skills.

Articles and Materials

- Faculty-approved Safe Delivery App learning access or training extracts
- Assigned simulator, competence checklist and learning log

Procedure

1. Confirm the assigned module, language, case, access requirements and faculty learning objective. Prepare a private learning setup.
2. Review the approved content and note time-sensitive steps and the corresponding local care pathway. Discuss differences with faculty before practice.
3. Write a brief step sequence and identify equipment, team roles, alerts and clinical checks for the assigned scenario.
4. Prepare the model station and verify supplies, monitoring and help activation. Allocate roles and perform the first scenario under supervision.
5. Record observations, actions, timings and simulated response. Identify the first missed or delayed action in the debrief.
6. Repeat the relevant sequence after feedback and measure whether it improved. Document what remains to practise.
7. Complete the authorised knowledge or skills activity and arrange required faculty review or programme sign-off, documenting the specific action the supervisor observed.
8. Record module, date, evidence, feedback and next learning goal without patient identifiers.

Precautions

- Use current faculty-approved guidance and a trainer.
- Keep module completion and clinical competency verification traceable.

Observations and Record

Safe Delivery App Learning and Maternity Simulation

Documentation

Item	What to record	Why it matters
Learning	Module and objective	Sets focus
Simulation	Steps, timing and response	Shows practical performance
Review	Feedback and signed evidence	Tracks competence

Worked Example

The learner completes the maternity emergency exercise and identifies delayed reassessment. A repeat run includes a named observer and timed review.

Result and Evaluation

Demonstrate application of the assigned learning and document the status of faculty verification.

Viva Questions and Answers

Why compare the module with local guidance?

The assigned actions and escalation must fit the practice setting.

What evidence belongs in the learning log?

The activity, date, observed performance, feedback and verification status.

Antepartum Bleeding and Preterm Labour Triage

Practical 11 / Skills laboratory

Aim

Identify urgent findings in late pregnancy bleeding or suspected preterm labour and prepare a timed maternity referral.

Principle

Maternal stability, suspected blood loss, gestation and fetal status guide assessment and safe transfer.

Articles and Materials

- Pregnancy case, observation chart and fetal assessment trainer
- Maternal emergency and transport checklists

Procedure

1. Confirm gestation and time of onset and ask about bleeding, pain, contractions, fluid loss and fetal movement. Call the maternity team promptly for concerning findings.
2. Check airway, breathing, circulation and alertness. Record pulse, blood pressure and perfusion and repeat observations while the case is being reviewed.
3. Record the amount and character of bleeding from the available measurements. Review known placental location and leave digital vaginal examination to the maternity team after placenta praevia has been excluded when relevant.

Continue with step 4 on the next page.

Procedure Continued

Antepartum Bleeding and Preterm Labour Triage

4. In a suspected preterm labour case document contraction pattern, possible membrane rupture, temperature and fetal assessment findings available from the scenario.
5. Prepare authorised monitoring, oxygen or access equipment and clinical records as requested. Verify identifiers, orders, samples and the appropriate receiving team.
6. Maintain respectful communication and support and rehearse safe urgent transfer, with suitable escort and a plan for monitoring in transit.
7. Give a time-specific handover including stability, gestation, bleeding or contractions, fetal findings and what was done or remains pending.
8. Document the time of escalation, receiver, repeat observations and transfer or ongoing assessment plan.

Precautions

- Prioritise urgent help for instability.
- Follow the maternity team’s instructions for examination and transport.

Observations and Record

Antepartum Bleeding and Preterm Labour Triage

Documentation

Item	What to record	Why it matters
Presentation	Gestation, bleeding and symptoms	Determines urgency
Assessment	Maternal trend and fetal status	Guides referral
Transfer	Actions, monitoring and receiver	Maintains continuity

Worked Example

The case has painless bleeding and a previously low-lying placenta. The student calls for urgent obstetric review, records maternal status and prepares transfer without a digital examination.

Result and Evaluation

Recognise urgent maternal and fetal concerns and deliver a traceable emergency referral.

Viva Questions and Answers

Why check placental location in antepartum bleeding?

It can affect whether a digital vaginal examination is safe.

What information matters in a preterm labour handover?

Gestation, timed contractions, membrane status, maternal observations and available fetal findings.

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