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Comprehensive Primary Care Assessment and Referral

Practical 01 / Supervised community practicum

Aim

Assess common primary care presentations and give a safe referral or follow-up under supervision.

Principle

Standard assessment, valid measurements and danger-sign recognition support timely care in community settings.

Articles and Materials

- Fictional primary care register, clinical pathways and examination equipment
- Referral and follow-up forms

Procedure

1. Confirm the site, assigned role, available services and current primary care pathway. Verify identity, consent and language support.
2. Ask about onset, symptoms, prior care, medicines and baseline function. Identify respiratory difficulty, instability, severe pain or other urgent signs.
3. Record approved observations and focused findings for the case, such as respiratory, gastrointestinal, urinary or eye symptoms. Use consistent technique and units.
4. Apply the authorised screening or triage criteria and identify which decision needs clinician assessment. Prepare supportive nursing care and education within scope.
5. Discuss warning signs, self-care within the approved plan, follow-up and how to access urgent help. Verify understanding.
6. Send a completed simulated referral with relevant findings, timing, current stability and request. Confirm who will receive and follow the person.
7. Track attendance, results or barriers with the authorised team and arrange review of an unresolved problem.
8. Record assessment, advice, referral, actions and follow-up status in the correct register.

Precautions

- Apply the current community pathway and supervision.
- Communicate urgent signs promptly.

Observations and Record

Comprehensive Primary Care Assessment and Referral

Documentation

Item	What to record	Why it matters
Presentation	Symptoms, findings and urgency	Guides disposition
Care	Authorised action and education	Supports safety
Referral	Receiving team and outcome	Tracks linkage

Worked Example

The clinic case has new respiratory distress. The student alerts the supervising clinician and prepares a direct referral with current observations.

Result and Evaluation

Document a safe first-contact assessment, approved intervention and clearly owned follow-up.

Viva Questions and Answers

Why confirm receipt of a referral?

It establishes responsibility and prevents loss to follow-up.

What supports a useful triage decision?

Relevant symptoms, measured observations and case-specific danger signs.

Pregnancy Newborn Tracking and Community Maternal Follow Up

Practical 02 / Supervised community practicum

Aim

Track pregnancy and postnatal care using a coded register and prepare a safe community transfer or follow-up.

Principle

Complete maternal and newborn records help identify missed care and support rapid referral for warning signs.

Articles and Materials

- Mock family folder, antenatal and postnatal cards
- Due-date list, referral and birth preparedness models

Procedure

1. Review the authorised area register and verify case identity, pregnancy dating and approved consent for follow-up. Check contact and access.
2. Record antenatal contacts, tests, risk indicators and delivery plan. Identify missing entries and check who will review them.
3. At the model visit ask about symptoms and check authorised observations and warning signs. Use the facility pathway for urgent maternal or fetal concern.

Continue with step 4 on the next page.

Procedure Continued

Pregnancy Newborn Tracking and Community Maternal Follow Up

4. Discuss birth preparedness, transport and whom to call and rehearse normal birth or emergency readiness through the approved simulation when assigned.
5. Link birth and postnatal entries with maternal and newborn status, feeding, warmth, vaccine or screening record and scheduled visits.
6. Teach danger signs and confirm a safe contact method and realistic next action. Include caregiver support with permission.
7. Refer through the authorised service and track outcome with the designated health worker while protecting privacy.
8. Update the case and facility records with date, responsible team and pending action.

Precautions

- Use coded or authorised data and confidential channels.
- Escalate pregnancy or newborn warning signs immediately.

Observations and Record

Pregnancy Newborn Tracking and Community Maternal Follow Up

Documentation

Item	What to record	Why it matters
Tracking	Gestation, visits and risk	Identifies missed care
Postnatal	Maternal and newborn findings	Supports early review
Continuity	Referral, worker and follow-up	Confirms linkage

Worked Example

The family reports a home visit could not occur because they moved temporarily. The student confirms an authorised contact and coordinates the next review.

Result and Evaluation

Maintain an accurate tracking record and connect the family to timely care.

Viva Questions and Answers

Why link maternal and newborn records?

It helps coordinate follow-up for both.

What belongs in a birth preparedness plan?

Intended facility, transport, contact and action for warning signs.

Adolescent Reproductive Health and Contraceptive Service

Practical 03 / Supervised communication practice

Aim

Counsel a fictional adolescent or adult on reproductive health and demonstrate authorised contraceptive service checks.

Principle

Privacy, informed choice, eligibility and clear follow-up support safe reproductive health services.

Articles and Materials

- Role-play cards, method aids and eligibility guide
- Interval intrauterine device trainer and service record

Procedure

1. Explain privacy, confidentiality limits and the purpose, confirm consent and ask what the person wants to discuss in their preferred language.
2. Assess relevant symptoms, pregnancy possibility, prior methods, sexual health concerns and need for safeguarding or timely care.
3. Compare available methods by use, reversibility, side effects and access. Discuss eligibility and infection prevention using the current guide.
4. Explain where qualified services provide safe abortion assessment or other reproductive care when relevant. Arrange confidential referral and communication under local policy.
5. Verify authorisation, indication and trainer checklist for interval device insertion or removal. Demonstrate model preparation and explain follow-up and warning signs.
6. Offer the authorised temporary method or referral within the case, record the person’s choice and allow time for questions or deferral.
7. Use teach-back on use, next appointment and whom to contact. Confirm private follow-up and document the agreed plan.
8. Communicate any concern urgently to the appropriate clinician and record responsibility.

Precautions

- Respect autonomy and confidentiality.
- Use authorised device trainers and clinical pathways.

Observations and Record

Adolescent Reproductive Health and Contraceptive Service

Documentation

Item	What to record	Why it matters
Counselling	Consent, preferences and eligibility	Supports informed decisions
Service	Method, model checks and referral	Supports safe access
Follow-up	Warning signs, date and provider	Maintains continuity

Worked Example

A person wants a reversible option but is uncertain about timing. The student explains choices and arranges a confidential eligibility review.

Result and Evaluation

Demonstrate non-directive counselling and accurate model and referral documentation.

Viva Questions and Answers

What is informed choice?

A voluntary decision after understanding relevant options, benefits, risks and follow-up.

Why verify eligibility?

Timing and clinical conditions can affect safe method selection.

Community NCD Older Adult and Mental Health Screening

Practical 04 / Supervised community practicum

Aim

Complete a supervised chronic disease and functional screening activity and document appropriate referrals.

Principle

Repeated valid measurements, screening limitations and practical linkage to services support early review.

Articles and Materials

- Fictional community clinic register and screening cards
- BP device, growth or nutrition tools and referral checklist

Procedure

1. Confirm target group, age and current screening criteria. Explain the session, obtain permission and ask about urgent symptoms first.
2. Record approved measures such as blood pressure or capillary glucose with technique, timing and units. Repeat or verify unexpected findings.
3. Review NCD history, medicines and lifestyle context and check the programme's referral criteria for the assigned case. Explain any screening limitations.

Continue with step 4 on the next page.

Procedure Continued

Community NCD Older Adult and Mental Health Screening

4. Assess an older adult's function, falls, sensory support and caregiving needs with an approved tool. Document baseline and meaningful change.
5. Use the approved mental health screen with privacy and verify clinical interpretation and safety needs with the supervising team.
6. Explain findings and agree a practical referral, prevention action or recheck. Confirm access and preferred contact.
7. Record the result and plan and coordinate with the authorised field worker or clinic. Track whether the referral was completed.
8. Document outcome, limitations and reassessment time without disclosing unnecessary personal details.

Precautions

- Follow programme and clinical criteria.
- Attend to new urgent physical or mental health concerns promptly.

Observations and Record

Community NCD Older Adult and Mental Health Screening

Documentation

Item	What to record	Why it matters
Measurements	Technique, values and context	Supports valid results
Risk	Functional and mental health concerns	Tailors care
Follow-up	Threshold, referral and completion	Protects linkage

Worked Example

A newly elevated BP screen is confirmed with correct technique and a repeat. The student records the values and books authorised follow-up.

Result and Evaluation

Complete a sound screening assessment and document a verified next step.

Viva Questions and Answers

Why repeat a questionable measurement?

It helps check technique and reliability.

What accounts for a positive screen?

It identifies need for appropriate assessment according to the programme.

Health Centre Programme Coordination and Waste Audit

Practical 05 / Supervised community practicum

Aim

Review a health centre activity, coordinate field follow-up and document a targeted waste or programme check.

Principle

Clear registers, accountable follow-up and correct waste handling improve safety and service delivery.

Articles and Materials

- Fictional health centre register and stock records
- Waste model and ASHA coordination worksheet

Procedure

1. Identify the assigned health centre activity, population and reporting interval. Confirm roles, authorised records and current programme procedures.
2. Review completed and missed services and reconcile registers using correct dates and case codes. Flag incomplete or inconsistent entries.
3. Prepare a follow-up list with reason, urgency, contact preference and responsible worker. Confirm assignments with the field team and record feedback.
4. Check point-of-use segregation and collection using the facility's waste chart and model containers. Record which materials are correctly separated.
5. Identify a service or waste problem that can be improved and propose one practical change and a named owner.
6. Communicate aggregate findings and urgent individual action through approved channels. Keep personal case information limited.
7. Set a review date and repeat the same measure or follow-up check. Note ongoing barriers and resources needed.
8. Complete the health centre activity record with result, actions and review.

Precautions

- Use the current facility waste process.
- Protect case identities and follow appropriate access rules.

Observations and Record

Health Centre Programme Coordination and Waste Audit

Documentation

Item	What to record	Why it matters
Programme	Period, eligible and completed services	Measures coverage
Safety	Waste findings and action	Supports infection prevention
Coordination	Worker, referral and review	Confirms follow-up

Worked Example

Several missed reviews are recorded but contact details are outdated. The student checks the approved register and assigns verified follow-up to the appropriate worker.

Result and Evaluation

Prepare a usable health centre report and a specific coordination or improvement action.

Viva Questions and Answers

Why reconcile registers?

It can reveal missed, duplicated or incomplete services.

What makes a useful improvement measure?

A clear definition that can be repeated after the change.

Community Disaster Drill Triage and Recovery Coordination

Practical 06 / Skills laboratory

Aim

Participate in a community emergency drill and assess triage, referral and recovery coordination.

Principle

Defined roles, safety checks, simple communication and reassessment support organised response in a surge.

Articles and Materials

- Fictional incident plan, triage tags and map
- Observation cards and drill evaluation sheet

Procedure

1. Review the exercise area, hazards, available services, authorised command structure and assigned student role.
2. Check scene safety and confirm team contact routes and locations for assessment, transport and family support.
3. Use the approved triage tool on model cases and assign categories according to observed findings. Record times and notify the appropriate team.

Continue with step 4 on the next page.

Procedure Continued

Community Disaster Drill Triage and Recovery Coordination

4. Reassess and update priority after a scenario change. Record immediate actions within scope and verify escort and destination.
5. Communicate patient or group status, resource needs and waiting priorities to the responsible coordinator. Use privacy and supportive communication.
6. Plan continuity for vulnerable persons, medicines and routine health services as assigned. Verify how families will receive approved information.
7. Debrief record quality, missed checks, coordination and one measurable improvement. Assign an owner and date for practice.
8. Complete the drill report with observations, transfers, unresolved needs and follow-up. Reconcile each simulated casualty with the transfer register.

Precautions

- Use the authorised disaster and triage plan.
- Reassess on changes and communicate urgent findings.

Observations and Record

Community Disaster Drill Triage and Recovery Coordination

Documentation

Item	What to record	Why it matters
Preparedness	Roles, hazards and contact routes	Supports organisation
Triage	Category, time and reassessment	Prioritises available care
Review	Transfers, gaps and improvement	Supports safe repeat drills

Worked Example

A model casualty deteriorates while waiting for transport. The student updates the category and tells the coordinator about the new priority.

Result and Evaluation

Demonstrate safe drill participation and provide a traceable debrief and improvement plan.

Viva Questions and Answers

Why reassess an assigned triage category?

It may need to change as the person's condition evolves.

What belongs in a drill debrief?

Observed performance, identified gaps, responsibilities and a retest plan.

Permanent Contraception Service Assistance

Practical 07 / Skills laboratory

Aim

Rehearse voluntary sterilisation counselling, preparation for authorised services and nursing follow-up.

Principle

Permanent contraception requires informed choice and reliable aftercare. Vasectomy needs temporary contraception until the treating service confirms effectiveness.

Articles and Materials

- Fictional vasectomy and tubectomy records
- Consent checklist, recovery chart and follow-up form

Procedure

1. Verify identity and which service the person wants to discuss. Establish privacy and explain why the decision is voluntary and may be deferred.
2. Describe the intended permanence, benefits, risks, possible failure and reversible alternatives. Record questions and refer clinical eligibility decisions to the authorised provider.
3. For the simulated procedure verify the person, method, documented consent, baseline observations, allergy and readiness. Confirm which nurse will receive the recovery handover.
4. Prepare the model service area, infection-prevention supplies and records. Assist the clinician's simulation only in the allocated role.
5. Assess comfort, vital observations and the site as ordered after the procedure. Escalate severe pain, bleeding, faintness or other concerning findings.
6. In the vasectomy case explain the need for continued contraception until clearance through the service's review and semen testing pathway.
7. Explain expected recovery, warning signs, contact details and the next review. Ask the person to repeat the agreed plan.
8. Document choice, consent, nursing findings, instructions and the responsible service for clearance or follow-up.

Precautions

- Protect privacy and freedom to defer a decision.
- Use authorised screening, recovery and clearance criteria.

Observations and Record

Permanent Contraception Service Assistance

Documentation

Item	What to record	Why it matters
Decision	Options discussed, choice and consent	Protects voluntary care
Service	Method, checks and observations	Supports safe assistance
Follow-up	Warnings, clearance and contact	Prevents missed care

Worked Example

A client asks if they can rely on vasectomy immediately. The student confirms the interim contraception plan and explains how the service will communicate clearance.

Result and Evaluation

Demonstrate voluntary counselling, safe preparation and a documented recovery and follow-up plan.

Viva Questions and Answers

When can a client rely on a vasectomy for contraception?

After the treating service confirms effectiveness under its follow-up protocol.

What should an aftercare record show?

Observations, instructions, warning signs and the service responsible for review.

Nursing Research Question Objectives and Protocol

Practical 01 / Clinical case or record exercise

Aim

Convert a nursing practice question into a feasible, ethical research proposal.

Principle

A focused question, defined variables and suitable design make a study answerable and reviewable.

Articles and Materials

- Fictional ward problem and protocol template
- Research design notes and ethics checklist

Procedure

1. Describe the nursing issue, setting and evidence gap. Identify the decision that a study could inform and define the population being considered.
2. Write a focused research question and measurable objectives. Define the outcome, key variables and any exposure, intervention or comparison.
3. State a hypothesis if suitable for the design. Clarify the expected relationship and how measurements would support interpretation.
4. Choose an appropriate design, setting, eligible population and proposed sampling method. Explain what the design can assess and its limits.
5. Outline data collection, timing, instrument and analysis. Specify how data quality, missing information and confounding would be considered.
6. Prepare consent, privacy and data handling steps and identify approvals required before any actual recruitment or collection.
7. Review feasibility, timeline, resources and responsibilities with the supervisor. Address one limitation or potential bias before finalising.
8. Present the draft protocol and record feedback, changes and approval status.

Precautions

- Use fictional data for drafting.
- Obtain the required approvals before real data collection.

Observations and Record

Nursing Research Question Objectives and Protocol

Documentation

Item	What to record	Why it matters
Research question	Population, variables and objective	Defines scope
Methods	Design, sampling and analysis plan	Makes the study reviewable
Ethics	Consent, handling and approvals	Protects participants

Worked Example

A proposal about fall prevention narrows its outcome to completion of a defined mobility safety check within one shift.

Result and Evaluation

Produce a feasible proposal with measurable outcomes and a clear approval pathway.

Viva Questions and Answers

What is an operational definition?

A precise statement of how a variable will be measured.

Why consider feasibility early?

It helps match the design, timing and workload to the setting.

Literature Search Annotated Bibliography and Evidence Appraisal

Practical 02 / Lab or data practical

Aim

Find and appraise relevant nursing evidence and produce a concise annotated bibliography.

Principle

A reproducible search, transparent selection and critical appraisal make conclusions easier to verify.

Articles and Materials

- Research question, approved catalogue or database access
- Search log, appraisal form and reference template

Procedure

1. Identify the core concepts and write inclusion criteria for population, context, outcomes, study types and period as appropriate.
2. Develop search terms and synonyms and use the planned databases or sources. Record date, source, key terms and any limits.
3. Screen titles and abstracts against the criteria and select full texts. Record reasons for excluding borderline or duplicate items.
4. Extract citation, purpose, design, participants, methods and findings into an evidence table. Check details from the primary paper.
5. Appraise bias, measurement, applicability and limitations with the assigned tool. Explain which evidence is most relevant to the question.
6. Write a short annotation for each selected item that describes the study, main finding and a useful limitation.
7. Summarise agreements, differences and remaining gaps and link the review to the proposed question.
8. Verify reference details and findability and retain the search and screening record for review.

Precautions

- Paraphrase accurately and credit sources in the project.
- Apply inclusion criteria consistently.

Observations and Record

Literature Search Annotated Bibliography and Evidence Appraisal

Documentation

Item	What to record	Why it matters
Search	Terms, sources, dates and limits	Supports reproducibility
Evidence	Design, findings and quality	Supports comparison
Synthesis	Agreement, gap and applicability	Guides research

Worked Example

Two studies use different definitions of a successful handover. The learner records the difference before comparing their conclusions.

Result and Evaluation

Produce a traceable search and annotated evidence summary with thoughtful appraisal.

Viva Questions and Answers

Why record exclusions?

It helps others understand selection and possible bias.

What belongs in an annotation?

The citation and a concise summary and appraisal linked to the question.

Sampling Tool Development and Pilot Data Collection

Practical 03 / Lab or data practical

Aim

Select a suitable sample, prepare a data tool and test it on a fictional pilot.

Principle

Defined variables, consistent instruments and documented pilot changes support reliable data and ethical collection.

Articles and Materials

- Fictional sampling frame and variable list
- Draft questionnaire or observation form and pilot guide

Procedure

1. Define target and accessible populations, inclusion and exclusion criteria and sampling unit. Verify what the supplied sampling frame represents.
2. Select the appropriate sample method for the question and note likely selection bias. Use the approved basis for size estimation.
3. Turn each objective into a measurable field. Define response categories, units, permitted values and missing-value codes.

Continue with step 4 on the next page.

Procedure Continued

Sampling Tool Development and Pilot Data Collection

4. Write or adapt the instrument and provide standard instructions. Check language, clarity, content and permission for a borrowed instrument.
5. Pilot the instrument on approved mock cases and record completion time, misunderstood items, missing data and observer disagreements.
6. Revise the fields and instructions and document what changed and why. Test a corrected portion and confirm past data handling.
7. Prepare a coded data-entry and quality plan, including checks, confidentiality and approval status before any live project.
8. Submit the tested instrument, data dictionary, sampling plan and pilot summary for supervisor approval.

Precautions

- Use approved data and supervision.
- Keep pilot changes and document versions traceable.

Observations and Record

Sampling Tool Development and Pilot Data Collection

Documentation

Item	What to record	Why it matters
Sampling	Population, method and eligibility	Determines scope
Tool	Variables, coding and instructions	Improves consistency
Pilot	Issues, revision and retest	Improves quality

Worked Example

Two observers mark the same patient-assistance level differently. The group adds examples and repeats the mock observation.

Result and Evaluation

Deliver a tested tool and traceable, ethical sampling plan.

Viva Questions and Answers

Why pilot a tool?

It reveals unclear questions, practical barriers and inconsistent measurement.

Why define a missing code?

It distinguishes an unavailable value from a genuine observation.

Data Tabulation Statistics and Nursing Project Presentation

Practical 04 / Lab or data practical

Aim

Organise a training dataset, calculate suitable summaries and present justified results.

Principle

Accurate coding, correct denominators and clear descriptions are essential to interpretation and reporting.

Articles and Materials

- Synthetic project dataset and codebook
- Calculator or spreadsheet, chart and report templates

Procedure

1. Create an analysis copy and verify identifiers, data definitions, units and missing codes. Check range, duplicates and inconsistent entries.
2. Document corrections and decisions about incomplete rows. Separate the original record from the analysed dataset and retain a reproducible log.
3. Identify categorical and numeric variables and select appropriate summaries. Review the distribution before choosing mean and spread or median and interquartile range.
4. Build tables with labelled groups, denominators and valid counts. Calculate relevant percentages or rates and independently check selected results.
5. Use an appropriate graph with units, sensible scales and readable labels. State whether missing values affected the plotted totals.
6. If the project calls for a comparison, select the analysis with the supervisor and verify the design and assumptions before interpretation.
7. Write results with time, units and uncertainty, then discuss limits and practical implications without making unsupported causal claims.
8. Prepare a brief project presentation and obtain review of tables, figures, results and confidentiality.

Precautions

- Use authorised or synthetic data.
- Distinguish descriptive findings from causal conclusions.

Observations and Record

Data Tabulation Statistics and Nursing Project Presentation

Documentation

Item	What to record	Why it matters
Quality	Codes, corrections and missingness	Supports reproducibility
Results	Summary, denominator and plot	Matches data type
Interpretation	Limitations and implications	Supports valid reporting

Worked Example

The project calculates 18 completed reviews among 24 eligible cases. The report gives 75% and states why two other records were not eligible.

Result and Evaluation

Present an accurate and reproducible analysis with clear limits and an accessible project summary.

Viva Questions and Answers

Why report the denominator with a percentage?

It identifies the base and magnitude of the result.

Which summary may suit skewed numeric data?

Median and interquartile range can describe the centre and spread.

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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