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Community Internship Family Care and Referral Follow Through

Practical 01 / Supervised community practicum

Aim

Carry out a supervised family follow-up, coordinate referral and document whether agreed care was reached.

Principle

Continuity depends on a usable plan, confidential follow-up and an accountable receiving service.

Articles and Materials

- Field assignment, approved bag and coded family folder
- Referral, visit and competence log forms

Procedure

1. Review the assigned family, current plan, risk and previous visits, verifying approved consent and the supervising community nurse.
2. Check field safety, equipment and clean bag setup. Confirm the family's priorities, preferred contact and practical barriers.
3. Repeat relevant observations, comparing baseline and interval change. Identify an immediate concern or a missing action in the care plan.

Continue with step 4 on the next page.

Procedure Continued

Community Internship Family Care and Referral Follow Through

4. Complete the agreed household care, prevention or education activity and record the person's response and remaining need.
5. Prepare or review the referral with reason, urgency, findings and expected follow-up. Coordinate with the assigned health worker.
6. Verify attendance, outcome and remaining barriers without unnecessary sharing. Arrange a feasible next review with the family and service.
7. Revisit the nursing plan and compare actual progress with the agreed outcome. Document any change or unmet need.
8. Enter supervised activity dates, the student's actual role and evidence and arrange faculty review in the official internship log.

Precautions

- Follow field supervision and privacy requirements.
- Record the actual role and obtain verification through faculty.

Observations and Record

Community Internship Family Care and Referral Follow Through

Documentation

Item	What to record	Why it matters
Family priority	History, visit and observations	Establishes care context
Linkage	Referral, worker and result	Verifies follow-through
Competence	Role, feedback and verification	Records training honestly

Worked Example

A referred older adult missed review because transport failed. The intern coordinates a new appointment through the supervisor and confirms attendance.

Result and Evaluation

Complete a supervised family-care cycle with verified referrals and documented evidence.

Viva Questions and Answers

What does closed referral follow-up show?

The action, receiver and outcome have been confirmed or a barrier has been documented.

What belongs in the official log?

The actual observed, assisted or performed role, date, evidence and verification.

Community Internship Programme Review and Improvement

Practical 02 / Lab or data practical

Aim

Review a primary care activity and present a measurable service improvement to the field supervisor.

Principle

Reliable records, defined coverage and clear task ownership support effective community services.

Articles and Materials

- Fictional programme data and approved reporting template
- Calculation, mapping and team review forms

Procedure

1. Confirm which activity is being reviewed, its eligibility, reporting period and oversight. Request only authorised aggregate or coded information.
2. Check registers against source counts and identify missing or duplicated entries. Document the action taken to reconcile each discrepancy.
3. Calculate coverage or completion with a defined numerator, denominator and interval. Check the total independently and state limitations.
4. Map where missed visits or follow-up barriers occur without exposing household identities. Discuss practical explanations with the field team.
5. Select a feasible improvement such as a scheduled reminder or an accessible follow-up contact. Assign a responsible worker and review time.
6. Trial or simulate the agreed action and measure the same indicator again. Identify what changed and which barriers remain.
7. Prepare a brief presentation with evidence, decision, planned adjustment and additional support needed.
8. Document the activity, feedback and verified role in the internship log alongside the team's review plan.

Precautions

- Use authorised records and aggregate reporting.
- Verify results and limitations before presenting.

Observations and Record

Community Internship Programme Review and Improvement

Documentation

Item	What to record	Why it matters
Measure	Population, count and period	Makes review interpretable
Improvement	Action, owner and timing	Supports implementation
Evaluation	Repeated measure and evidence	Tracks result

Worked Example

The clinic identifies incomplete follow-up records. The intern reviews the denominator, helps reconcile the register and arranges a repeat check with the team.

Result and Evaluation

Produce a practical, measurable improvement and an accurate supervised activity record.

Viva Questions and Answers

Why repeat the same indicator?

Consistent definitions allow meaningful comparison.

Why use a named owner?

It helps ensure the action is carried out and reviewed.

Adult Health Internship Shift Care Plan and Handover

Practical 01 / Supervised clinical practice

Aim

Coordinate a supervised shift of adult nursing care and give an accurate end-of-shift handover.

Principle

Prioritisation, verified orders and repeated assessment support safe continuity over a complete shift.

Articles and Materials

- Fictional ward assignment or supervised clinical plan
- Care plan, observation chart, medication record and internship log

Procedure

1. Receive handover and identify immediate risks, required observations, orders, devices and pending results. Agree on tasks with the supervising nurse.
2. Assess the allocated patient and compare baseline observations, symptoms, function and comfort. Escalate new concerns before routine care.
3. Set shift priorities, measurable goals and an observation and care timeline. Verify medicines, diet, mobility and device restrictions.
4. Provide the assigned hygiene, mobility, medicine, wound or device care within scope. Review identity, orders, asepsis and checks for each task.
5. Assess response and compare with goals. Adjust nursing priorities with supervision when pain, vital signs, intake or function changes.
6. Prepare discharge or ongoing care instructions if relevant and verify who reviews results and unresolved issues.
7. Give a complete handover including trends, actions, response, concerns and explicit requests. Confirm acceptance and timing.
8. Complete accurate clinical and competency entries, obtaining supervisor review for duties actually performed, assisted or observed.

Precautions

- Practise only within authorised placement responsibilities.
- Escalate deterioration and medication or device discrepancies immediately.

Observations and Record

Adult Health Internship Shift Care Plan and Handover

Documentation

Item	What to record	Why it matters
Allocation	Risks, orders and priorities	Sets safe coverage
Care	Intervention, timing and response	Evaluates nursing plan
Handover	Outstanding issues and verification	Protects continuity

Worked Example

An adult receiving postoperative care develops a new low urine-output trend. The intern verifies the measurement, alerts the supervisor and documents the intervention and repeat.

Result and Evaluation

Complete an organised and traceable supervised shift and handover with a reviewed care plan.

Viva Questions and Answers

Why compare observations with earlier values?

It shows the timing and direction of change from baseline.

What goes in a useful end-of-shift request?

The action needed, how soon and who should do it.

Adult Health Internship Deterioration and Procedure Competency Review

Practical 02 / Skills laboratory

Aim

Demonstrate response to a deteriorating adult and submit traceable evidence of a selected supervised skill.

Principle

Early recognition, clearly assigned roles and objective feedback support safe care and competent practice.

Articles and Materials

- Adult case and observation trend with procedure model
- Handover sheet and faculty competence checklist

Procedure

1. Choose the approved case and confirm bedside or simulation roles, required skills and supervisor assessment criteria.
2. Review the procedure, baseline observations, identity, orders and risks. Verify equipment readiness and availability of help.
3. Start the authorised assessment or procedure with the correct safety and aseptic checks for the assigned skill.

Continue with step 4 on the next page.

Procedure Continued

Adult Health Internship Deterioration and Procedure Competency Review

4. Recognise a simulated change in airway, breathing, perfusion, bleeding or consciousness. Stop routine activity, summon help and provide an exact observation trend.
5. Demonstrate appropriate initial actions within scope and reassess. Record the timing, response and any additional monitoring after intervention.
6. Give a clear handover including current priorities and what has been completed or deferred. Identify the clinician or nurse responsible.
7. Review performance against the checklist, correct one observed problem and repeat the affected part if appropriate.
8. Document the actual role, evidence, feedback and supervisor's verification status in the official log.

Precautions

- Obtain supervisor approval for clinical duties.
- Use the applicable current emergency pathway.

Observations and Record

Adult Health Internship Deterioration and Procedure Competency Review

Documentation

Item	What to record	Why it matters
Baseline	Case, procedure and readiness	Guides safety
Response	Change, action, time and reassessment	Demonstrates clinical reasoning
Evidence	Role, feedback and verification	Documents development

Worked Example

During an adult procedure simulation the patient develops breathing difficulty. The intern stops, calls, reassesses and provides a clear direct report.

Result and Evaluation

Demonstrate a timely response and produce transparent competency evidence for faculty review.

Viva Questions and Answers

Why give exact times during escalation?

They show progression and the response to interventions.

How should supervised participation be recorded?

With the actual role and dated evidence for verification.

Child Health Internship Family Centred Ward Care

Practical 01 / Supervised clinical practice

Aim

Plan and review a supervised child nursing shift and support the caregiver's role.

Principle

Age-specific assessment, accurate weight, safe treatment and caregiver communication protect paediatric care.

Articles and Materials

- Fictional paediatric chart or supervised placement assignment
- Growth chart, dose and fluid worksheet and care log

Procedure

1. Confirm identity, age, current measured weight, indication and relevant precautions. Review caregiver concerns and baseline feeding, development and function.
2. Assess immediate symptoms, breathing, behaviour, hydration and age-appropriate observations. Escalate danger signs and compare with the baseline.
3. Set a measurable nursing goal for the shift and prioritise authorised feeding, medication, mobility or observation tasks.
4. Verify all weight-based orders and rates with independent checks when required. Demonstrate the assigned care with appropriate equipment and caregiver involvement.
5. Record intake, output, treatment, symptoms and response. Reassess pain, alertness and vital trends at the agreed times.
6. Explain the current plan and warning signs to the caregiver and use teach-back. Verify the next review or referral.
7. Give a structured paediatric handover with age, weight, concern, trends, actions and pending review.
8. Complete the shift and supervised competency records and obtain faculty review of actual participation.

Precautions

- Check weight and order with trained staff.
- Escalate new respiratory, hydration or alertness findings promptly.

Observations and Record

Child Health Internship Family Centred Ward Care

Documentation

Item	What to record	Why it matters
Baseline	Age, weight and caregiver concern	Supports safe assessment
Care	Verified order, response and teaching	Demonstrates nursing role
Review	Handover and competency evidence	Supports continuity

Worked Example

A caregiver notices reduced activity before the next scheduled observation. The intern reassesses promptly and communicates the change with measured findings.

Result and Evaluation

Complete a supervised, age-appropriate nursing care plan and verify caregiver follow-up.

Viva Questions and Answers

Why document caregiver observations?

They can reveal a change from normal behaviour or intake.

What does a paediatric medicine handover include?

Current weight, verified order, timing, monitoring and any unexplained discrepancy.

Child Health Internship Newborn or PICU Observation and Escalation

Practical 02 / Skills laboratory

Aim

Review a high-risk child or newborn case and document supervised intensive-care observation and escalation.

Principle

Precise age, device checks and time-based observations support early recognition and follow-up.

Articles and Materials

- High-risk infant or child case with equipment models
- PICU or neonatal chart and competence review card

Procedure

1. Confirm age, weight, baseline and clinical support, reviewing device labels, orders and trainee role with the supervisor.
2. Assess breathing, colour, perfusion, temperature and alertness and note the patient's usual behaviour or feeding. Identify the most urgent finding.
3. Review ordered respiratory, thermal or infusion support using the appropriate device and case-specific settings. Trace connections and document checks.
4. Demonstrate one approved model task, such as temperature probe review, airway device checks or prescribed pump verification.
5. Record a change in clinical observations or support and take the assigned model response. Summon help promptly and reassess after action.
6. Review feeding, output and comfort or family information in the case and identify the next safe action with the team.
7. Handover age, weight, symptoms, settings, actions, response and follow-up. Confirm the receiving clinician.
8. Record actual skills-lab or clinical involvement, faculty feedback and the next practice goal.

Precautions

- Use trained supervision and approved settings.
- Monitor the child's condition alongside equipment displays.

Observations and Record

Child Health Internship Newborn or PICU Observation and Escalation

Documentation

Item	What to record	Why it matters
Status	Clinical baseline, age and support	Identifies risk
Observation	Device setting, measurements and trend	Supports reassessment
Evidence	Response, reviewer and log	Documents competence

Worked Example

A high-risk newborn case develops apnoea with a falling trend. The intern activates neonatal help, follows the assigned simulated response and records time and recovery.

Result and Evaluation

Demonstrate focused intensive-care observation and escalation with traceable evidence.

Viva Questions and Answers

Why confirm age and weight before support checks?

Device selection, orders and clinical interpretation are age and size dependent.

What must be recorded after an urgent action?

Time, findings, action, response and the responsible team.

Mental Health Internship Supervised Shift and Therapeutic Care

Practical 01 / Supervised clinical practice

Aim

Provide supervised mental health nursing, reassess safety and communicate the shift plan.

Principle

Respectful engagement, ongoing assessment and documented response support recovery and continuity.

Articles and Materials

- Supervised assignment or fictional ward case
- Mental status, observation and care plan records

Procedure

1. Receive handover and identify care goals, risks, orders, current status and team responsibilities. Confirm authorised activities and supervision.
2. Establish rapport, obtain permission and review the person's concerns, function and baseline mental state. Check immediate medical and psychological safety.
3. Record relevant mental status findings and update priorities with the supervisor. Set a measurable goal for therapeutic contact, activity or self-care.
4. Carry out the assigned supportive conversation, activity or medicine checks while preserving privacy. Record actual response and any limitations.
5. Reassess changes in distress, safety, function or adverse effects and alert the team when urgent review is needed.
6. Review the plan with the person and discuss coping supports and agreed next steps. Include family only with permission.
7. Give handover with current findings, actions, response, risks and ownership of further assessment.
8. Document the actual role and observed evidence and obtain faculty feedback and verification as required.

Precautions

- Respect autonomy and confidentiality.
- Escalate immediate physical or safety concerns promptly.

Observations and Record

Mental Health Internship Supervised Shift and Therapeutic Care

Documentation

Item	What to record	Why it matters
Assessment	Concerns, mental state and safety	Guides care priorities
Nursing activity	Action, response and reassessment	Evaluates intervention
Competency	Handover and verified role	Shows supervised practice

Worked Example

A patient reports increased distress during a group task. The intern reduces demands, uses a calm conversation and calls the nurse for reassessment.

Result and Evaluation

Complete a supervised mental health care cycle and communicate an accurate updated plan.

Viva Questions and Answers

Why document the person's response?

It shows whether the nursing intervention helped and informs the next plan.

What is communicated at handover?

Current mental state, safety, care, response and the next accountable action.

Mental Health Internship Discharge Review and Community Linkage

Practical 02 / Supervised community practicum

Aim

Prepare an individual discharge or community review and verify safe follow-up and family education.

Principle

Recovery after discharge depends on practical access, agreed support, safe contact and a clearly owned clinical plan.

Articles and Materials

- Fictional discharge and follow-up chart
- Medication plan, referral and competence log

Procedure

1. Review the approved discharge or follow-up plan, patient preferences, existing support and next appointment. Confirm current clinical stability with the supervisor.
2. Verify medicines, monitoring, early concerns and the clinician responsible for changes. Identify barriers such as cost, access and language.
3. Review the person's goals and consent for involving family or community staff. Agree on the safe contact route.
4. Discuss signs of relapse or difficulty and how to obtain timely care. Use teach-back for the plan and whom the person would call.
5. Prepare the referral or home follow-up with the relevant findings and agreed actions. Confirm which team receives it.
6. Review attendance or adherence barriers and adjust support with the authorised team. Verify whether urgent safety or clinical concerns emerged.
7. Document agreements, review timing, response and responsibilities and protect confidential information.
8. Ask faculty to review the learning evidence and record what was performed, assisted or observed.

Precautions

- Confirm services and contact permissions.
- Refer any significant new safety concern promptly.

Observations and Record

Mental Health Internship Discharge Review and Community Linkage

Documentation

Item	What to record	Why it matters
Plan	Consent, goals and approved follow-up	Supports continuity
Linkage	Referral, receiver and barriers	Reduces missed care
Review	Response, next step and verification	Tracks care and learning

Worked Example

The patient is unsure how to attend follow-up while working. The intern discusses consented support and arranges an accessible clinical check.

Result and Evaluation

Complete a workable discharge or community plan with verified handover and a supervised learning record.

Viva Questions and Answers

What makes follow-up accessible?

A feasible date, address or channel and a known point of contact.

Why check teach-back?

It confirms the person can explain the plan and when to request help.

Midwifery Internship Continuity of Maternal and Newborn Care

Practical 01 / Supervised clinical practice

Aim

Organise supervised maternity care across antenatal, labour and postnatal contacts and document each role accurately.

Principle

Consistent maternal and newborn observations, respectful consent and timely handover protect continuity.

Articles and Materials

- Fictional or authorised maternity assignment and linked records
- Observation charts, discharge checklist and competence log

Procedure

1. Confirm maternal and newborn identification, gestation or birth details, woman's priorities and assigned student role at each stage.
2. Review history, current observations, relevant results and required consent and check whether any maternal or newborn sign requires urgent review.
3. Complete assigned supervised antenatal assessment or labour charting and document when findings were obtained. Verify team response to any warning finding.

Continue with step 4 on the next page.

Procedure Continued

Midwifery Internship Continuity of Maternal and Newborn Care

4. Assist the authorised birth or recovery workflow, recording maternal and fetal or newborn observations separately and verifying the care plan.
5. Monitor postnatal bleeding, comfort and feeding or newborn status as assigned. Reassess after care and involve the appropriate clinician or lactation support.
6. Explain follow-up, danger signs and contact plans to the family, respecting preferences and consent.
7. Handover maternal and newborn findings, treatment or support, unresolved issues and responsible clinicians separately.
8. Document only actual participation and arrange faculty verification of procedure evidence and review needs.

Precautions

- Follow respectful care, privacy and authorised supervision.
- Escalate changes in maternal or newborn condition promptly.

Observations and Record

Midwifery Internship Continuity of Maternal and Newborn Care

Documentation

Item	What to record	Why it matters
Continuity	Stage, observations and risk	Links stages of care
Support	Nursing role, care and response	Documents safe practice
Review	Handover, follow-up and verification	Supports ongoing care

Worked Example

A mother and newborn need different follow-up appointments. The intern confirms the two plans, checks understanding and records the responsible teams separately.

Result and Evaluation

Complete a linked supervised maternity care record and appropriate follow-up.

Viva Questions and Answers

Why record maternal and newborn findings separately?

They describe distinct patients and actions, even when coordinated.

What belongs in the clinical log?

Dated evidence, the actual role, supervisor feedback and verification.

Midwifery Internship Emergency Readiness and Competency Assessment

Practical 02 / Skills laboratory

Aim

Demonstrate assigned nursing tasks in a maternity emergency and submit verified training evidence.

Principle

Rapid recognition, role allocation, clear communication and reassessment protect mother and newborn in emergencies.

Articles and Materials

- Maternal and newborn models, emergency case and monitoring tools
- Local emergency pathway, handover and competency records

Procedure

1. Confirm the approved scenario, required competencies and student role. Verify the supervising team and emergency equipment readiness.
2. Review history and initial maternal and fetal or newborn observations, noting which findings require immediate escalation.
3. Activate the emergency team and assign actions in the simulation. Give the formal indication and time and begin the appropriate checklist.

Continue with step 4 on the next page.

Procedure Continued

Midwifery Internship Emergency Readiness and Competency Assessment

4. Demonstrate the assigned observed skills, such as measured bleeding, vital monitoring or neonatal ventilation checks under faculty instruction.
5. Reassess after each action, record findings and timing and communicate any unresolved concern or need for specialist transfer.
6. Prepare a clear maternal and newborn handover and verify the receiving roles and following observations in the exercise.
7. Debrief technical and communication performance, correct one missed action and repeat it on the trainer if the assessor requests.
8. Record the case, actual participation, evidence, feedback and whether formal competency verification is complete or pending.

Precautions

- Use trainers and the facility's current maternity guidance.
- Record observed performance and verification accurately.

Observations and Record

Midwifery Internship Emergency Readiness and Competency Assessment

Documentation

Item	What to record	Why it matters
Emergency	Case, signs and start time	Guides urgent response
Team performance	Role, actions and serial observations	Shows safe coordination
Competence	Feedback, repeat and verification	Documents supervised learning

Worked Example

Communication about the measured loss is delayed on the first run. On repetition a named recorder shares the total and vital trend promptly.

Result and Evaluation

Demonstrate a coordinated emergency response and produce accurate competency evidence.

Viva Questions and Answers

Why name specific roles during an emergency?

It clarifies accountability and enables simultaneous tasks.

Why record verification status?

It distinguishes completed supervised assessment from practice still requiring review.

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