**TEACHER RESOURCES**

## SUBJECT OUTLINE AND LEARNING GUIDE

### FUNDAMENTALS OF NURSING

**Subject Number: NUR 111**

**Autumn Semester**

# FUNDAMENTALS OF NURSING

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# INTRODUCTION

This is the teacher’s version of the learning guide developed for students in the subject Fundamentals of Nursing. This teacher’s version has some ideas for teachers so they can guide their students in their learning. Ideas and suggestions for teachers are included in red throughout this document.

*IT IS IMPORTANT* THAT TEACHERS WORK THROUGH THIS GUIDE THEMSELEVES BEFORE PRESENTING IT TO STUDENTS. IN THAT WAY THEY CAN BE SURE THAT THEY ARE FAMILIAR WITH THE CONTENT AND PROCESSES AND ARE HAPPY WITH THE STRUCTURE AND THE TEACHING/LEARNING ACTIVITIES.

Student activity & information is in black and teacher information in red

**ACTIVITY**

The Student Learning Guide (SLG) is designed specifically for student use during their studies in this subject.

**Please review the introduction to the SLG and check all the information is correct before finalising the document and giving it to the students**

You need to include staff contact details. Details of the textbooks, attendance requirements and all other information.

Students are **expected to complete the pre-reading in the SLG prior to attending the scheduled lecture/tutorial/practical sessions** for the week. This pre-reading will prepare students and give them a clear understanding of what is presented. The tutorial and practice activities are related to the lecture content. Instructions are given in this guide at the start of each session and students should complete the work to fully prepare for each week.

**The aim** of this subject is to introduce students to the essential elements of safe nursing care as practised in Papua New Guinea. Students will learn what we mean by a person-centred approach to nursing and through this they will develop an understanding of effective interpersonal and professional modes of communication, counselling skills, therapeutic relationships and the importance of being culturally aware. In this subject there is also focus on the development of core clinical nursing skills to help students develop beginning skills in relation to infection control, risk assessment and risk management, physical assessment, assisting with personal and hygiene needs, safe patient movement and promoting patient’s well-being.

The design and organisation of the subject means that there is a mixture of teacher-led classroom activities as well as guided self-directed learning activities that students will be expected to complete each week.

# TEACHING STAFF AND CONTACTS

**Subject Coordinator is teaching staff to fill in the details in the student’s guide**

Name:

Room:

Tel:

Email:

**Subject Lectures are**

Name:

Room:

Tel:

Email:

**Additional Resources to Assist your Learning**

List student support services here

**Library**

Give details about times, access etc

# REQUIRED TEXTBOOKS

There are many Open Access text books and journals available to you. Please access and download the texts below as many of the learning activities are related to content in these books.

**Essential Textbooks**

Ernstmeyer K., Christman D. Nursing Fundamentals, (2023). Open Resources for Nursing (Open RN). Chppewa Valley Technical College, Wisconsin, USA. Available: [https://med.libretexts.org/Bookshelves/Nursing/Nursing\_Fundamentals\_(OpenRN)](https://med.libretexts.org/Bookshelves/Nursing/Nursing_Fundamentals_%28OpenRN%29)

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Ernstmeyer K., Christman D. Nursing Skills, (2023). Open Resources for Nursing (Open RN). Chppewa Valley Technical College, Wisconsin, USA. Available: [https://med.libretexts.org/Bookshelves/Nursing/Nursing\_Skills\_(OpenRN)](https://med.libretexts.org/Bookshelves/Nursing/Nursing_Skills_%28OpenRN%29)

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## Useful websites:

<https://doaj.org/>Provides a list of open access journals

<https://academicjournals.org/open_access> Open access to academic journals

<https://www.ncbi.nlm.nih.gov/pmc/tools/openftlist/> Pubmed Central provides access to thousands of open access journal articles

# ATTENDANCE

It is expected that students will attend **all** sessions. In the event of a missed session for good reason, it is the student’s responsibility to make appropriate arrangements with their lecturer to make up the missed session. This will be in the student’s own time. Work must be completed and accepted by the lecturer **prior to** the end of semester. **Please check that this statement is correct.**

**NB:- POOR ATTENDANCE WILL RESULT IN FAILURE OF THE SUBJECT**

# SUBJECT DESCRIPTION

This subject will introduce students to the history of nursing and the influence of major nurse theorists in shaping the nursing profession. The development of nursing in PNG will be highlighted. The growth of nursing professionalism supported by standards for practice, codes of ethics and regulation will be discussed. Students will explore the essential elements of safe nursing practice including the Nursing Process, while developing basic clinical nursing skills and acquiring critical thinking skills in relation to infection control, risk assessment, physical assessment, assisting with personal hygiene care, patient safety, and promoting patients’ well-being. Using a person-centred care approach, students will develop an understanding of effective interpersonal and professional modes of communication, therapeutic relationships and the concept of cultural safety. The roles of other team members within the context of professional nursing practice in PNG will be considered.

#  SUBJECT OBJECTIVES

1. Describe the history of nursing and the growth in nursing professionalism in PNG and Global context
2. Explain nursing theory and at a basic level and apply this understanding to the development of the Nursing Process
3. Describe what is meant by person-centred care and its relevance to the PNG context
4. Apply beginning knowledge of scientific concepts to care practices
5. Demonstrate an application of effective, culturally safe and therapeutic communication (verbal, nonverbal and written) with patients and other healthcare professionals
6. Demonstrate the skills needed to deliver safe and effective nursing care within the constraints of level of knowledge, available resources and the boundaries of selected legal and ethical considerations
7. Apply knowledge of infection control standards to nursing care
8. Demonstrates mastery of basic life support
9. Review the evidence for nursing interventions and show beginning skills in the application of clinical judgement

# SUBJECT CONTENT

### Topic 1

**HISTORICAL DEVELOPMENT OF NURSING:** The history of nursing in PNG. International nursing beginnings. The influence of Florence Nightingale, Martha Rodgers, Patricia Benner and other nursing theorists.

### Topic 2

**NURSING PROFESSIONALISM:** Requirements of a profession highlighting basic ethical and legal responsibilities. Introduction to the code of ethics and professional regulation highlighting, patient’s rights, providing information and consent, confidentiality, invasion of privacy and negligence. PNG Nursing Council mandated roles and responsibilities.

**Topic 3**

**THE NURSING PROCESS:** The elements of the nursing process: assessment, planning, implementation and evaluation. The relationship between the nursing process and assessing alterations in health status. The process of assessment. Collecting unitive and objective data.

**Topic 4**

**CLINICAL REASONING AND THE APPLICATION OF CLINICAL JUDGEMENT:** Clinical reasoning: frameworks for making clinical decisions, applying clinical reasoning skills to case studies. Developing a framework for thinking like a nurse.Applying the Nursing Process.

**Topic 5**

**COMMUNICATION AND DOCUMENTATION:** Definition of communication, factors that influence effective communication, barriers to communication, definition and characteristics of the therapeutic relationship. Basic principles of nursing reports and documentation. Legal and ethical responsibilities.

**Topic 6**

**RISK AND SAFETY:**  Current issues in patient safety, evidence for need, applying the evidence: Hand hygiene**. I**nfection control (standard precautions). Hospital and environmental safety. Safe patient moving, body mechanics and safe moving techniques. Self-care and reflective practice. Exploring and applying patient safety competencies.

**Topic 7**

**CLINICAL SKILL DEVELOPMENT:** The following clinical skills will be taught and practiced in this unit:

|  |  |  |  |
| --- | --- | --- | --- |
| *Personal Care*: Assisted ambulation Hygiene: bed making Hygiene: shower/bath Hygiene: bed bath  | *Clinical Communication and Documentation*Recording vital signsRecording fluid input and output Using and maintaining patient records  | *Clinical Assessment and Monitoring:* Vital signs: TPR BP Sp02Physical assessment: weight height, BMI,  | *Clinical Interventions and Management*: First Aid (Mastery at a novice level)  |
| *Hygiene*: oral care Skin integrity: assessment  | Negotiating care with patient/family | Using a stethoscope Beginning nursing assessment |  |
| *Privacy and Dignity*: Respectful care Confidentiality  | *Promoting Self -management:* Health education and health promotion Applying evidence  | *Risk and Safety:* Hand hygiene Basic Infection control Beginning manual handling  |   |

# SUBJECT ASSESSMENT

There are three items of assessment in this subject. **Teaching staff,** please review and check this before finalising the student learning guide to make sure you’re happy with the assessments and the marking criteria

Assessment ITEM 1. NURSING CARE PLAN & APPLYING THE NURSING PROCESS

Value: 30%

Due Date:

Word limit: 1500-2000 words.

Assessment ITEM 2. SKILL EVALUATION

Value: 30%.

Due Date:

Assessment Item 3. OBJECTIVE STRUCTURE CLINICAL ASSESSMENT (OSCA)

 PRACTICAL EXAMINATION

Value: 40%

Scheduled: During the Examination Period.

Assessment Information:

Assessment item 1 will provide you with an opportunity to apply person-centred care and the Nursing Process to a case study. You will be given a case study and, using a provided template, asked to write a nursing report about the case. Assessment 2 will give you an opportunity to demonstrate your skills in basic first aid and basic life support. These assessments will enable you to demonstrate your knowledge and understanding of the key concepts presented in this subject. Assessment item 3 provides you with an opportunity to bring everything you have learned in this subject together. During the practical exam you will work through a number of clinically focused scenarios and apply the knowledge and skills you have learnt this semester. Your overall performance will be assessed using criteria based on clinical competency behaviours. The exam process, expectations and marking criteria will be discussed in class.

ALL PIECES OF ASSESSMENT MUST BE UNDERTAKEN TO BE ELIGIBLE FOR A PASS IN THIS SUBJECT

PART A

**THE CASE STUDY IS PRESENTED IN THE SUBJECT OUTLINE AND A SUGGESTED TEMPLATE PROVIDED. STAFF WILL NEED TO DECIDE IF THIS IS USEFUL AND ALSO DECIDE WHICH MARKING CRITERIA THEY WILL USE. THIS WILL NEED TO BE GIVEN TO STUDENTS AT THE BEGINNING OF THE SEMESTER.**

The assessment criteria below give you a guide about what is expected in this assessment. It illustrates the expected standards and what you need to think about when completing your assessment task. You will be given a more detailed marking guide and a thorough explanation of what is expected during class.

ASSESSMENT ITEM 1: APPLYING THE NURSING PROCESS

marking Criteria. DRAFT EXAMPLE BELOW, MARK WILL NEED TO BE ALLOCATED

|  |  |
| --- | --- |
| **Criteria** | **Description** |
| Comprehensive Data Collection | * Gathered both subjective and objective data from the case study.
* Demonstrated an understanding of the importance of thorough data collection in nursing practice.
* Included relevant patient information, such as chief complaint, medical history, vital signs, and observations.
 |
| Accurate Subjective and Objective Data Differentiation  | * Gathered both subjective and objective data from the case study.
* Demonstrated an understanding of the importance of thorough data collection in nursing practice.
* Included relevant patient information, such as chief complaint, medical history, vital signs, and observations.
 |
| Data Relevance  | * Evaluated the collected data for its relevance to the patient's health status.
* Discarded irrelevant information that doesn't contribute to the nursing assessment.
* Demonstrated critical thinking in selecting data essential for nursing diagnosis formulation.
 |
| Nursing Diagnosis Formulation | * Used the collected data to create appropriate nursing diagnoses.
* Demonstrated an understanding of how nursing diagnoses relate to patient assessment and care planning.
 |
| Clinical Reasoning and Justification | * Provided rationale for each nursing diagnosis based on the identified data.
* Demonstrated the ability to connect specific data points to the chosen nursing diagnoses.
 |
| Evidence-Based Practice | * Incorporated current evidence-based information in the nursing diagnoses and rationale.
 |
| Clear and Organized Documentation  | * Organized the nursing documentation in a clear and structured manner.
* Used appropriate headings or sections for each aspect of the nursing process (assessment, diagnosis, rationale).
 |
| Professionalism and Communication | * Maintained a professional tone and language in the documentation.
* Correct grammar, spelling, and formatting, reflecting attention to detail.
 |
| Overall Quality and Presentation  | * Presented a well-organized and thoughtfully prepared nursing documentation. Demonstrated a high level of engagement and effort in completing the assignment Showed creativity and innovation in the presentation while maintaining professionalism.
 |

Assessment ITEM 2. Clinical SKILLS ASSESSMENT: BASIC FIRST AID AND BASIC LIFE SUPPORT THESE PROVIDE A GUIDE TO THE ASSESSMENT TASK, PLEASE ADAPT OR USE AS NEEDED

Value: 30% of total mark.

Due Date:

**Assessment: First Aid Skills**

**Skill 1: Assessing the Scene** *Marking Criteria:*

1. **Scene Safety (3 points):**
	* Candidate identifies potential hazards and ensures their safety and that of others.
2. **Number of Victims (2 points):**
	* Candidate correctly explains the need to identify the number of victims and their condition.
	* Correctly triages care needs if more than one victim

**Skill 2: Calling for Help** *Marking Criteria:*

1. **Knows how and who to call for help (5 points):**
	* Candidate correctly explains where they can go for assistance,
	* As appropriate explains the contact number or radio call signal
	* Correctly explains the information they would provide.

**Skill 3: Identifying and Managing a Snake Bite** *Marking Criteria:*

1. **Recognition of snake bite (2 points):**
	* Candidate correctly identifies that the victim has been bitten by a snake.
2. **Description of snake(3 points):**
	* Candidate provides a brief description of possible snakes and whether or not they are poisonous
3. **Calms the victim & immobilises the limb (2 points):**
	* Candidate effectively reassures and calms the victim to reduce panic
	* Candidate advises the victim to stay as still as possible and is able to explain the rationale for doing this
4. **Correctly immobilises limb (3 points):**
	* Candidate correctly immobilizes the bitten limb using a splint, bandage, or other available materials
	* Candidate advises the victim to keep the bitten area at or below heart level and explains why to the victim.

**Skill 4: Choking Management** *Marking Criteria:*

1. **Identifying Choking (5 points):**
	* Candidate correctly identifies signs of choking in a victim.
2. **Correct Action (8 points):**
	* Candidate positions themselves & the patient correctly
	* Performs back blows correctly, dislodging the obstruction.

**Skill 5: Skill: Recovery Position** *Marking Criteria:*

* **Safe Positioning** (**5 points**): Assess if the candidate positions the casualty correctly to ensure an open airway and prevent choking.
* **Monitoring Vital Signs** (**5 points**): Evaluate if the candidate checks for breathing and responsiveness while maintaining the recovery position.
* **Comfort and Safety** (**2 points**): Check if the candidate ensures the casualty is comfortable and safe in the recovery position.

**Skill 6: Wound Management** *Marking Criteria:*

1. **Assessment (5 points):**
	* Candidate assesses the wound's severity, checking for bleeding, foreign objects, and contamination.
2. **Bleeding Control (5 points):**
	* Candidate applies direct pressure, elevates the wound if necessary, and uses appropriate dressings to control bleeding.

**Skill 7: Burns and Scalds** *Marking Criteria:*

1. **Assessment (5 points):**
	* Candidate assesses the burn's depth and size. Able to explain assessment accurately
2. **Cooling (5 points):**
	* Candidate correctly provides first aid by cooling the burn under running cool water.

**Skill 8: Fracture Management** *Marking Criteria:*

1. **Assessment (5 points):**
	* Candidate assesses the fracture, checking for deformity, swelling, and pain.
2. **Immobilization (10 points):**
	* Candidate correctly immobilizes the injured limb using appropriate materials (e.g., splints).

**Skill 9: Shock Management** *Marking Criteria:*

1. **Recognizing Shock (5 points):**
	* Candidate identifies signs of shock in a victim.
2. **Comfort and Support (10 points):**
	* Candidate provides comfort and support to the victim, such as elevating their legs and keeping them warm.

**Skill 10: Bleeding Control** *Marking Criteria:*

1. **Identification of Bleeding Source** (**2 points**): Assess if the candidate correctly identifies and applies pressure to the source of bleeding.
2. **Application of Pressure** (**5 points**): Evaluate the candidate's ability to apply firm and consistent pressure to control bleeding.
3. **Use of Dressing and/or Bandage** (**6 points**): Check if the candidate uses appropriate materials to dress and bandage the wound.
4. **Elevation of Limb (if applicable)** (**2 points**): Evaluate if the candidate correctly elevates the bleeding limb.

**Overall Performance** *Marking Criteria:*

1. **Overall Performance:**
	* Candidate demonstrates confidence, maintains composure, and effectively manages the situation.

**Total Points:** 100

Candidates can be assessed based on their performance in each skill, and the total points earned can determine their overall proficiency in first aid. It is essential to provide constructive feedback to help individuals improve their skills and knowledge in first aid.

**PART B BASIC LIFE SUPPORT**

**Demonstration of unassisted CPR to fellow student or lecturer (to sign) with evaluation. PASS/FAIL.**

|  |  |  |
| --- | --- | --- |
| Criteria | Achieved | Not Achieved |
| Assesses danger in situation for patient and self. |  |  |
| Assesses responsiveness of patient - shakes patient’s shoulder and calls. - indicates need to send for help |  |  |
| Assesses airway and breathing - looks for chest movement - listens for breath sounds - feels for air on cheek |  |  |
| Establishes airway - clears airway using fingers - tilts head back and lifts chin gently to open airway - reassesses airway and breathing |  |  |
| Delivers 2 effective expired air breaths, mouth to mask, assessing for chest inflation. |  |  |
| Assesses circulation - looks for movement - checks carotid pulse - observes facial skin colour |  |  |
| Delivers effective cardiac massage - places hands in centre of lower half of sternum - places heels of hand one on other, fingers interlocked - positions self vertically above hands - compresses chest 5 cms - delivers 80-100 compressions per minute |  |  |
| Ratio of compressions to breaths 15:2Delivered consistently for 2-3 minutes |  |  |

Evaluation of your performance:

Action you will take to improve your performance for criteria not achieved:

I have witnessed this student performing CPR and rated their performance as above

ASSESSOR: SIGNATURE: DATE:

ASSESSMENT 3: OBJECTIVE STRUCTURED CLINICAL ASSESSMENT (OSCA)-PRACTICAL ASSESSMENT

Overall assessment of your performance in this assessment is based on attainment of the clinical competencies identified by the PNG Nursing Council (PNGNC) competency standards as essential to the practice of the registered nurse. The PNGNC are designed to assess the competencies of Registered Nurses. However, because student are in the first semester of their program we have simplified the competency expectations. Structure the practical exam (OSCA) so that students rotate between 2 or 3 stations which examine different skills. Provide students with case studies so they can think about what they will do and how. After they perform the skills they will need to answer some questions to demonstrate their understanding and ability to link theory and practice. They should also be able to write up nursing notes.

DURING THE OSCA students should have the opportunity to integrate the knowledge & skills learned during the semester. You should develop some case studies that allow them to demonstrate both knowledge and skills and to reflect on their learning.

The competencies used to assess your performance are based on assessing your:

1. interpersonal ability
2. technical ability
3. professional growth
4. knowledge
5. clinical judgement
6. safe practice

A definition of each competency is provided below. Specific behaviours that describe each competency follow. In your examination as well as being graded on specific skills you will be graded against these competency standards in each task/skill you perform.

**NB, THESE COMPETENCIES ARE A GUIDE ONLY/ADAPT AS NEEDED**

**DESCRIPTION OF CLINICAL COMPETENCIES**

1. **Interpersonal Ability.**

Refers to the ability to appreciate the centrality of interpersonal processes in nursing, demonstrated by effective and therapeutic communication, compassion, trust and respect for the dignity and integrity of all people, and tolerance and understanding of values and beliefs in a pluralistic society.

1. **Technical Ability.**

Refers to the ability to demonstrate technical competence at a beginning level in the application of safe, effective and efficient use of technology and resources in nursing practice.

1. **Professional Behaviour.**

Refers to the ability to participate collaboratively in a multidisciplinary team and organisational structure, fulfil responsibilities, obligations and commitments of a professional person, and evaluate and enhance continuing personal and professional development of self and colleagues.

1. **Knowledge.**

Refers to the ability to apply a body of scientific knowledge including knowledge of structure and function of the human body, an understanding of human behaviour, and a knowledge of dysfunction related to physical, behavioural and social factors, and to contribute to nursing knowledge through reflection and research based practice.

1. **Clinical Judgement.**

Refers to the ability to reason appropriately using induction, deduction, categorisation, and ethical persuasion in both scientific and evaluative processes.

1. **Safe Practice.**

Refers to the ability to identify and rectify situations in the environment which are unsafe for the patient, self and colleagues and to appreciate the necessity for knowledge, clinical judgement, technical ability, interpersonal skills, and professional development in order to practice safely.

**OBJECTIVE STRUCTURED CLINICAL ASSESSMENT**

**CRITERIA FOR OVERALL ASSESSMENT OF STUDENT PERFORMANCE.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **INTERPERSONAL ABILITY**
 | **Examiner** |  | **Student** |  |
|  | **YES** | **NO** | **YES** | **NO** |
| * Introduces self
* Calls patient by preferred name.
* Seeks patient’s permission for care.
* Explains basic nursing care to patient.
* Maintains patient’s privacy and confidentiality.
* Recognises patient’s verbal and non-verbal cues.
* Uses open ended questions to encourage patient expression.
* Reflects on the influences of personal biases, feelings and opinions on interaction with patient.
* Recognises situations that require use of therapeutic communication.
* Demonstrates sensitive listening skills.

Comments: Student & Examiner. |  |  |  |  |
| 1. **TECHNICAL ABILITY**
 | **Examiner** |  | **Student** |  |
|  | **YES** | **NO** | **YES** | **NO** |
| * Selects and uses appropriate equipment.
* Investigates unfamiliar equipment and environment.
* Utilises observational skills accurately.
* Demonstrates dexterity.
* Organises time.

Comments: Student & Examiner. |  |  |  |  |
| 1. **PROFESSIONAL BEHAVIOUR**
 | **Examiner** |  | **Student** |  |
|  | **YES** | **NO** | **YES** | **NO** |
| * Is responsible for professional appearance.
* Is responsible for punctual attendance.
* Informs Teacher of unavoidable absence
* Recognises legal and ethical issues.
* Recognises and responds to patient’s value system and desires.
* Demonstrates responsibility for assigned care of patient.
* Interacts cooperatively with team members.
* Participates in appraising own practice.
* Accepts constructive criticism.

Comments: Student & Examiner. |  |  |  |  |
| 1. **KNOWLEDGE**
 | **Examiner** |  | **Student** |  |
|  | **YES** | **NO** | **YES** | **NO** |
| * Uses appropriate professional terminology.
* Demonstrates ability to integrate theory with practice.
* Applies appropriate principles in practice.
* Reflects on experiences to enhance practice.
* Seeks assistance in extending knowledge base.
* Completes assessment activities

Comments: Student & Examiner. |  |  |  |  |
| 1. **CLINICAL JUDGEMENT**
 | **Examiner** |  | **Student** |  |
|  | **YES** | **NO** | **YES** | **NO** |
| * Assesses patient’s activities of daily living.
* Identifies patient’s needs based on assessment data.
* Provides care appropriate to assessment.
* Evaluates care provided.
* Seeks confirmation of action when unsure.
* Demonstrates tact and understanding when speaking with patients.
* Checks to ensure understanding before reacting.
* Displays reasoning when confronted with new situations.

Comments: Student & Examiner. |  |  |  |  |
| 1. **SAFE PRACTICE**
 | **Examiner** |  | **Student** |  |
|  | **YES** | **NO** | **YES** | **NO** |
| * Identifies role in emergency procedures/situations.
* Recognises safety/risk factors in environment.
* Identifies situations beyond current level of experience and seeks appropriate assistance.
* Utilises safe body mechanics.
* Prevents cross infection.
* Recognises learning needs.
* Prepares self for informed clinical practice.

Comments: Student & Examiner. |  |  |  |  |

|  |  |
| --- | --- |
| ***Student’s Signature:*** | ***Date:*** |
| ***Examiner’s Signature:*** | ***Date:*** |
|  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **SCALE** | **PERFORMANCE STANDARD** | **QUALITY OF PERFORMANCE** | **SUPPORT REQUIRED** |
| **E****(Excellent)** | Level of performance is excellentStudent always achievesappropriate and accurate actions safely | Exceptional standard of care demonstrated. Proficient; coordinated; confident Outstanding time managementAble to provide excellent and detailed responses to all questions related to the activity. Exceptional level of clinical judgement and clinical skills demonstrated | No prompts required to achieve intended purpose |
| **M****(Minimal Supervision)** | Level of nursing practice is high Student always achieves appropriate and accurate actions safely | Coordinated most of the time, Confident in most aspectsPerforms well within a reasonable timeframe. Achieves intended purpose. Deliver safe & effective care. Able to answer to questions accurately and is smooth in performance | Minimal prompts required to achieve intended purpose |
| **C****(Competent)** | Level of nursing practice is fair, but adequateStudent mostly achieves appropriate and accurate actions safely | Able to demonstrate an ability to carry out nursing care. Minimal assistance needed. Fails to initiate more than a minimal level of clinical judgement. Knowledge level satisfactoryExpends excess energy Clinical judgement satisfactory Demonstrates safe practice | May need verbal and occasional physical directive cues in addition to supportive ones. Student able to respond satisfactorily. |
| **B****(Borderline)** | Level of nursing practice is weak Nursing practice may be unsafe when aloneStudent able to achieve appropriate and accurate actions when guided  | Lacks coordination, Lacks confidence, Performs with prolonged time frame Does not always achieve intended purpose; Inconsistently correlates theory to practice or superficial understanding demonstrated.  | Frequently requires verbal and physical prompts to achieve intended purpose |
| **F****(Fail)** | Level of nursing practice is poor Nursing practice is unsafe Nurse does not achieve appropriate and accurate actions unless constantly supported | Uncoordinated, Very low level of confidence. Not able to clearly explain what they are doing and why. Very slow and unsure.Fails to achieve intended purpose. Does not initiate actions. Does not or is unable to apply theory to practice | Requires continuous verbal and physical prompts to achieve intended purposeIs unsafe |

Overall grade: \_\_\_\_\_\_\_\_\_\_\_\_\_

###### Submission of Written Assignments

**Referencing style**

###### PLAGARISM POLICY

# SUBJECT TIMELINE

This subject time line is provided so that you may plan ahead in your studies. You will see how the time line highlights various dates or activities that are scheduled for the subject. This subject is offered over the period Weeks 9 to 15. There is room on the grid for you to add in dates or other activities that you want to remember.

**FUNDAMENTALS OF NURSING**

**Insert details of assignments, including due dates here, so everything is clear & transparent at the start of the semester.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Monday** | **Tuesday** | **Wednesday****Tutorial session** | **Thursday** | **Friday** |
| **Week 1** |  |  |  |  |  |
| **2** |  |  |  |  |  |
| **3** |  |  |  |  |  |
| **4** |  |  |  |  |  |
| **5** |  |  |  |  |  |
| **6** |  |  |  |  |  |
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| **12** |  |  |  | **DUE**  |  |
| **13** |  |  | ***Nursing Care Plan & Reflection*** |  |  |
|  |  |  |  | ***Skills Assessment*** |  |
| **14** |  |  |  |  |  |
| **15** |  |  |  |  |  |
| **16** |  | **Study week** |  |  |  |
| **17** |  |  **Examination Week: Date to be decided** |  |  |  |

# STUDENT LEARNING ACTIVITIES SECTION

# WEEK 1 INTRODUCTION TO NURSING LEARNING ACTIVITIES

|  |  |
| --- | --- |
| **Pre-requisite****knowledge** | Welcome to this subject. This is first subject in the nursing stream. You will not be expected to have done any work before attending this week, but we would like you to spend a bit of time thinking about what you know about nurses and nursing. What do you think that nurses do? Think about and be ready to discuss why you would like to become a registered nurse and your goals for the program and the future. |
| Pre-lecture**reading** | There is no pre-reading today. But you need to make sure you have download a copy of the textbook.Ernstmeyer K., Christman D. Nursing Fundamentals, (2023). Opena Resources for Nursing (Open RN). Chppewa Valley Technical College, Wisconsin, USA. Available: [https://med.libretexts.org/Bookshelves/Nursing/Nursing\_Fundamentals\_(OpenRN)](https://med.libretexts.org/Bookshelves/Nursing/Nursing_Fundamentals_%28OpenRN%29) |
| **Lecture Focus**  | **History of Nursing in PNG and internationally. The National Health System and the role of nurses.** |
| **Key points from lectures** | * History of Nursing in PNG
* International nursing beginning
* Influence of Nightingale & other nursing theorists.
* Concepts of health and nursing
* PNG Health System
 |
| **Post lecture questions** | 1. Review your lecture notes and read section 1.2 of your text book. What is your definition of nursing? Write your answer in the space below.

All the answers to these questions are in the student text book and should have been covered in the lectures1. What nursing theorists have you found? Which do you think aligns with your definition of nursing?
 |
| **Tutorial session preparation** | Review Chapter 1 of your text book. This is focused mainly on the USA. You will need to list the topics that are listed about nursing in the US and see which of the topics are relevant for you in PNG. These will be discussed next week. |
| **Tutorial session activities including****laboratory practice** | **TUTORIAL ACTIVITIES**1. Clarify subject requirements.
2. Divide into small groups. Ask students to read the subject guide and review the structure of the subject and the topics.
3. Review the assessment and discuss them with your group. Makes sure that students are clear about the requirements & deadlines.
4. In student groups ensure they participate in the activities about nursing in PNG an the role of nursing theorists.
 |
| **Independent activity** | TUTORS make sure students have access to the National Health Plan Take notes to ensure that you are clear about the Key Result Areas identified by the Plan and think about how nurses contribute to achieving national goals. **TUTORS** prepare discussion points about the KRA and the NHP for discussion in the next class. |

#  WEEK 2 NURSING PROFESSIONALISM LEARNING ACTIVITIES

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| **Pre-requisite activity** | Look up and download: PNG Nursing Council Nursing Competency Standards and the PNG Nursing Council Code of Ethics for Nurses in PNG |
| **Pre-lecture reading** | Read and review the standards identified above. These will be discussed in more detail in the tutorial session. |
| **Lecture focus** | Nursing professionalism |
| **Key points from lectures** | * Requirements of a profession
* Basic ethical and legal responsibilities in nursing
* Introduction to code of ethics competency standards, professional conducts & professional regulation, highlighting, patient’s rights, providing information and consent, confidentiality invasion of privacy and negligence
 |
| **Post lecture learning activities** | **Teachers make sure you know the answers to these questions. Make sure you have downloaded the PNG Nursing Council Code of Ethics and National Competency Standards for use in class.**1. What is the purpose of the PNG Nursing Council? How does it protect the public?

Available <https://www.health.gov.pg/subindex.php?health_ministry=7>Competency standards, available [https://www.health.gov.pg/nursing\_pdf/PNGNC&NC\_2014.pdf](https://www.health.gov.pg/nursing_pdf/PNGNC%26NC_2014.pdf)1. Review the Code of Professional Conduct for Nurses. Explain what the main purpose of this is. In your owns words, summarise the key points from the Code.

Available <https://www.health.gov.pg/nursing_pdf/PNGNCCE_2015.pdf>Available: <https://www.health.gov.pg/nursing_pdf/PNGNCCPC_2015.pdf>Nursing Code of Conduct and Code of Ethics access details above. Download for use in class. |
|  | 1. List the key points you have learned from reading the Code of Ethics. The write a brief reflection about what they mean for you as a professional nurse of the future.

These questions are for the students, but you might want to think about some key points so you can discuss them with the students in class. |
| **Tutorial session preparation.** | 1. Find a charter or statement on the web that lists patients’ rights or what they can expect from health services. For example the Australian Charter of Healthcare Rights available <https://www.safetyandquality.gov.au/our-work/partnering-consumers/australian-charter-healthcare-rights>

Review the document and then reflect on how this can apply to patients in the PNG. Briefly list your thoughts here. You will discuss this more in your tutorial.Tutors also need to read these documents and think about how they apply to PNG. Answer the questions below and prepare for the classRead Section 3.3 of your textbook: Patient’s Bill of Rights |
| **Tutorial session activities including laboratory practice** | * + Working in groups review your findings from reading the NHP. What did others notice? Analyse why this plan is important for nurses and patients?
	+ Share your review of Patient Bill of Rights/Charters. What key points did you notice? How relevant is it for the PNG health system? Be prepared to justify your answers with sound argument and critical analysis.

**Teachers, make sure you have read this information** and thought about how you would answer this. You need to be able to guide your students through these exercises. |
| **Self-directed activity** | * Look up and provide definitions for the following in your own words:

Consent:Confidentiality:Privacy:Negligence:Regulation in nursing:Professional behaviour: Teacher, make sure you complete these activities so you can check for students’ understandings in class. Some definitions below1. Consent: Consent in nursing refers to the voluntary and informed agreement by a patient to receive a specific medical intervention, treatment, or procedure. It is a fundamental ethical and legal principle that ensures patients have the right to make decisions about their healthcare after being provided with relevant information about the potential risks, benefits, and alternatives.
2. Confidentiality: Confidentiality in nursing is the ethical duty to safeguard and protect the privacy of patients' personal and health information. Healthcare providers are bound by law and professional ethics to keep patient information confidential and only share it with authorized individuals involved in the patient's care.
3. Privacy: Privacy in nursing pertains to the patient's right to have their personal space and information protected from unauthorized access or disclosure. This extends to both physical privacy (maintaining dignity during care) and informational privacy (keeping medical records and personal details confidential).
4. Negligence: Negligence in nursing refers to a failure to provide the standard of care expected from a reasonably prudent healthcare professional. It involves actions or omissions that result in harm or injury to a patient due to a breach in the duty of care. Nurses are expected to act competently and responsibly to avoid negligence.
5. Regulation in nursing: Regulation in nursing encompasses the laws, rules, and standards that govern the practice of nursing. These regulations are established by governmental bodies, professional organizations, and licensing boards to ensure that nurses meet specific education, ethical, and practice requirements to protect the public's safety and well-being.
6. Professional Behaviour: Professional behaviour in nursing involves adhering to the established ethical and moral standards of the nursing profession. This includes demonstrating respect for patients, colleagues, and the healthcare team, maintaining honesty and integrity, practicing with competence, and upholding the highest standards of care and accountability. It also involves professional conduct both in clinical practice and in interactions within the healthcare setting.
 |

# WEEK 3 NURSING PROCESS LEARNING ACTIVITIES

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| **Pre-requisite knowledge** | A preliminary understanding about what is meant by the Nursing Process |
| **Pre lecture reading** | Read Sections 4.1 and 4.2 of your text book and familiarise yourself with the terminology.Bring any questions to the next class. |
| **Lecture focus** | **The Nursing Process and its Application to Nursing Practice** |
| **Key points from lectures** | * Defining the Nursing Process
* Steps in using the Nursing Process to provide patient care
* Critical thinking and clinical judgement in nursing practice
 |
| **Post lecture questions** | Describe, in your own words what is meant by the Nursing Process. **STUDENTS NEED TO EXPLAIN THIS IN THEIR OWN WORDS, THIS WILL HELP YOU MAKE SURE THEY ARE CLEAR AND UNDERSTAND THE TERMINOLOGY.****Answer below**The nursing process is a systematic, problem-solving approach that nurses use to deliver patient-centred care. It consists of a series of steps designed to assess, diagnose, plan, implement, and evaluate patient care. The nursing process is a critical framework for nurses to provide individualised and holistic care to patients. The process typically consists of five key stages:1. Assessment:
	* In this initial step, the nurse gathers relevant data about the patient's health status. This information can be collected through interviews, physical examinations, reviewing medical records, and collaborating with other healthcare professionals. It's important to obtain a comprehensive understanding of the patient's physical, psychological, social, and environmental factors that may influence their health.
2. Diagnosis:
	* In this step, the nurse analyzes the collected data to identify the patient's health problems, needs, and risks. Nursing diagnoses are typically identified through clinical judgment and can be categorized as actual or potential problems. These diagnoses help nurses create care plans tailored to the patient's specific needs.
3. Planning:
	* Once nursing diagnoses are established, the nurse develops a care plan that outlines goals, outcomes, and interventions. The care plan is individualized to address the patient's unique needs and can include short-term and long-term goals. It may also involve collaboration with other healthcare team members to ensure comprehensive care.
4. Implementation:
	* This step involves putting the care plan into action. Nurses carry out the planned interventions, which may include tasks such as administering medications, providing patient education, offering emotional support, and coordinating with other healthcare professionals. It's essential to document the care provided and evaluate the patient's response to the interventions.
5. Evaluation:
	* In the final stage, the nurse assesses the patient's response to the interventions. If the goals and outcomes are met, the care plan may be revised accordingly. If the goals are not achieved, the nurse must reassess and modify the plan to improve the patient's health. Evaluation is an ongoing process that helps ensure the effectiveness of care and the best possible patient outcomes.

**Summary:** The nursing process is a dynamic and continuous cycle that adapts to the changing needs and conditions of the patient. It is a systematic approach that helps nurses provide high-quality, patient-centred care while maintaining a focus on individualized and holistic healthcare. |
|  | Students need to explain in their own words why the Nursing Process is useful in planning and carrying out nursing care. Teachers can use the explanation below to assist students.The nursing process is a systematic framework that nurses use to plan and deliver patient-centred care. It consists of a series of steps designed to assess, diagnose, plan, implement, and evaluate nursing care. Here's why the nursing process is useful in planning and delivering nursing care:1. Holistic Assessment: The nursing process begins with a thorough assessment of the patient's physical, emotional, psychological, social, and environmental factors. This comprehensive assessment helps nurses gather information about the patient's unique needs and concerns, allowing for individualized care planning.
2. Problem Identification: Through the assessment process, nurses can identify both actual and potential health problems or issues. This enables them to prioritise care and focus on the most critical areas of concern.
3. Care Planning: After identifying the patient's health needs and priorities, nurses develop a care plan. This plan outlines specific goals, interventions, and expected outcomes tailored to the individual patient. It is a roadmap that guides the care provided, ensuring that it aligns with the patient's needs and preferences.
4. Patient-Centred Care: The nursing process emphasises the importance of involving the patient in their care. Nurses collaborate with patients to set goals and make decisions about their treatment. This patient-centred approach respects the patient's autonomy and ensures that their values and beliefs are considered.
5. Evidence-Based Practice: The nursing process encourages the use of evidence-based practice, which involves incorporating the latest research and clinical guidelines into care plans. This helps ensure that care is based on the best available evidence, leading to improved patient outcomes.
6. Communication: The nursing process promotes effective communication within the healthcare team. Nurses collaborate with other healthcare professionals, such as doctors, therapists, and pharmacists, to coordinate care and share important patient information.
7. Continuity of Care: The nursing process facilitates continuity of care by providing a structured framework for documentation. It ensures that information about the patient's condition, care plan, and progress is well-documented and easily accessible to all team members, even across shifts or different care settings.
8. Evaluation and Adaptation: The nursing process does not end with care planning and implementation. Nurses continually assess the patient's progress, evaluate the effectiveness of interventions, and make adjustments to the care plan as needed. This ongoing assessment and adaptation are essential for improving care quality.
9. Quality Improvement: The nursing process contributes to quality improvement efforts by allowing healthcare organizations to track and analyse the effectiveness of nursing care. It helps identify areas where care can be enhanced and standards can be improved.
10. Legal and Ethical Accountability: The nursing process helps ensure that care is provided in a legally and ethically responsible manner. It supports documentation, accountability, and adherence to ethical principles, which are essential in nursing practice.

In summary, the nursing process is a systematic and patient-centered approach that guides nurses in delivering high-quality care. By focusing on assessment, planning, implementation, and evaluation, it helps ensure that nursing care is tailored to the patient's needs, evidence-based, and continuously improved. This systematic framework ultimately enhances patient outcomes and the overall quality of healthcare delivery. |
| **Tutorial session preparation** | Read the chapter on the Nursing Process in your text book, Ch 4 |
| Tutorial session activities including laboratory practice | Be prepared to work through a number of case scenarios in class and to practice applying the Nursing Process. **OTHER CASE STUDIES ARE AT THE BACK OF THIS GUIDE.****Case Study:** Mr. Johnson is a 45-year-old man who presented at the health clinic with a second-degree burn on his right forearm. He sustained the burn while cooking on an open fire. **Use this example to model how the Nursing Process could be applied and also what other information would be needed.****Nursing Process:****1. Assessment:*** Gather information from the patient, if conscious, or from family members if the patient is unable to provide information.
* Assess the burn for its depth, extent, and any signs of infection.
* Note any associated symptoms such as pain, swelling, or blistering.
* Evaluate the patient's vital signs and general health status.

**2. Diagnosis:*** Identify the nursing diagnosis, such as "Impaired Skin Integrity" related to thermal injury.
* Consider potential complications in a low-resource setting, such as infection and delayed wound healing.

**3. Planning:*** Set goals and priorities:
	+ Prevent infection and promote wound healing.
	+ Relieve pain and discomfort.
* Develop a care plan:
	+ Provide wound care to prevent infection.
	+ Administer pain management, if available.
	+ Educate the patient and family on proper wound care and signs of infection.
	+ Plan for a follow-up visit to monitor progress.

**4. Implementation:*** Clean the burn wound with sterile water or saline solution if available.
* Apply a sterile dressing, if available, to prevent infection and promote wound healing.
* Administer pain relievers if available.
* Teach the patient and family how to café for the wound emphasise the importance of hand hygiene.
* Advise the patient on avoiding further injury and infection, especially in their daily activities.
* Document the care provided and the patient's response to interventions.

**5. Evaluation:*** Reassess the patient regularly to monitor wound healing and signs of infection.
* Evaluate the patient's pain level and adjust pain management interventions as needed.
* Assess the patient's understanding and compliance with wound care instructions.
* Adjust the care plan as necessary based on the patient's response and the available resources.

Initially you need to focus on identifying key cues ie what are the signs and symptoms each patient is describing? |
| **Self-directed activity** | Read Chapter 4 of the text book and complete the review questions |
| **Learning activities** | Work in pairs or small groups and complete the Nursing Care Plan using the template provided and bring it to your next class. |

#  WEEK 4 NURSING PROCESS LEARNING ACTIVITIES

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| --- | --- |
| **Pre-requisite knowledge** | It is assumed you have completed the learning activities for last week |
| **Pre lecture reading** | Finish reading Ch 4. Note any questions to bring to class. |
| **Lecture focus** |  Relationships between nursing process and alterations in health status |
| **Key nursing points from lectures** | * Principles of care and the differences between medical and nursing diagnosis
* Using nursing diagnoses to help plan nursing care
* Principles of nursing assessment
* Criteria to evaluate nursing care given
 |
| **Post lecture activity** | Review the video Nursing Care Plan Tutorial: How to complete a care plan in nursing school . YouTube. All rights reserved. Video used with permission. [https//youtu.be/07Z4ywfmLg8](https://youtu.be/07Z4ywfmLg8)[↵](https://med.libretexts.org/Bookshelves/Nursing/Nursing_Fundamentals_%28OpenRN%29/04%3A_Nursing_Process/4.09%3A_Summary_of_the_Nursing_Process#return-footnote-123-1) |
| **Tutorial session preparation.** | As you watch the video note any questions you have, bring those to class with you |
| Tutorial session activities including laboratory practice | In groups or pairs discuss the questions you have. Try and answer them for each other. If there is any misunderstanding then ask your tutor to explain.In this tutorial you will have the opportunity to practice developing nursing care plans using provided case examples.As this is your first practice for developing a nursing care plan, at the moment you will concentrate on identifying patient signs and symptoms and then clustering them to develop nursing diagnoses.**Teachers you will need to develop some case studies for students to use and practice with. The textbook has some questions, case studies and examples that will need to be adapted for the PNG context****SOME EXAMPLE CASE STUDIES ARE INCLUDED AT THE END OF THIS GUIDE.** |
| **Assessment review and clarification** | This week you will discuss the Case Study Assignment. In groups you will be given the opportunity to work through an example to ensure you are clear about what is expected and the extent of the assessment.**Teachers, make sure you go through the assignment with the students in class. Get them into groups to review the expectations and then ask each group to explain to the larger group exactly what they think is being asked of them.** |
| **Self-directed learning** | Independently, or in pairs find and review at least two other written sources that explain more about the Nursing Process and how it can be used in Nursing.List the articles you have found and read below: make sure you have referenced them correctly.Under each citation provide a paragraph that summarises the key points from each article.**Students will be covering some of this information in their Communications subject, but teachers will still need to check that students have completed this activity and that they have cited the references correctly and summarised the key points of the articles.****You might find it easier to provide the students with the articles you would like them to review**Below are two open access simple explanations<https://www.nursingprocess.org/Nursing-Process-Steps.html><https://www.ncbi.nlm.nih.gov/books/NBK499937/> |

# WEEK 5 COMUNICATION & DOCUMENTATION LEARNING CTIVITIES

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| **Pre-requisite knowledge** | This week we will focus on communication and the different types of communication in nursing.Please take some time and list any rules you know about to do with communication eg who gets to talk first when there are women and children together with men? How far apart should you stand when talking to a stranger, compared to a family member.List as many rules as you can below.It is important that you check that students complete the pre-learning activities in your classes. You could use these activities to form part of discussion in the tutorial classes. |
| **Pre lecture reading** | Review section 2.2 and think about the types of communication discussed. Why is this important information for nurses. |
| **This week’s lecture focus** | Definition of communication Factors that influence effective communication, especially in nursing practice,Barriers in effective communication, Definition and characteristics of the therapeutic relationship.   |
| **Key points from lecture** | * Reflecting on what we mean by professional communication
* Communication styles and methods that demonstrate caring, respect, active listening, authenticity, and trust
* Communication with interprofessional team members and others to facilitate safe care delivery
* Therapeutic communication for nurses
 |
| **Post lecture questions** | Review section 2.2 of your text book and your lecture notes and answer the following questions.1. What aspects of communication are important to think about for nurses? Possible responses below. Remember students will need to use their own words to show they understand.

Effective communication is essential for nurses in their daily practice. It plays a crucial role in patient care, teamwork, and building strong relationships. Here are some key aspects of communication that are important for nurses:1. **Therapeutic Communicati**on: Nurses must establish a trusting and empathetic relationship with their patients. This includes active listening, providing emotional support, and showing empathy. It helps patients feel heard and understood, which can improve their overall well-being.
2. **Clear and Concise Language**: Nurses need to use clear and simple language when communicating with patients, families, and colleagues. This is especially important when conveying medical information to ensure that everyone understands the instructions and information provided.
3. **Non-Verbal Communication**: Body language, facial expressions, and gestures can convey a lot of information. Nurses should be aware of their non-verbal cues and be sensitive to those of their patients, as misinterpretation can lead to misunderstandings.
4. **Cultural Competence**: Nurses often work with patients from diverse cultural backgrounds. Understanding and respecting cultural differences in communication styles, values, and beliefs is essential to provide effective care.
5. **Health Literacy**: Assessing the health literacy level of patients is vital to tailor communication appropriately. Nurses should adapt their communication to ensure patients with limited health literacy can understand and follow instructions.
6. **Interprofessional Communication**: Nurses collaborate with various healthcare professionals, including doctors, therapists, and social workers. Effective interprofessional communication is critical for the coordination of care, patient safety, and the overall success of healthcare teams.
7. **Documentation:** Accurate and timely documentation is a crucial aspect of a nurse's role. Proper documentation ensures that patient information is accessible, up-to-date, and helps in continuity of care.
8. **Informed Consent**: Nurses often play a role in obtaining informed consent from patients before medical procedures. This involves explaining the procedure, potential risks, benefits, and alternatives, allowing the patient to make an informed decision.
9. **Confidentiality:** Nurses must adhere to strict confidentiality rules to protect patients' privacy. They should be mindful of what information can be shared and with whom, following legal and ethical guidelines.
10. **Patient and Family Education**: Nurses are responsible for educating patients and their families about health conditions, medications, and post-discharge care. Effective teaching skills are essential to ensure that patients can manage their health effectively.
11. **De-Escalation and Conflict Resolution**: Nurses may encounter situations where patients or family members become agitated or conflicts arise. The ability to de-escalate such situations and resolve conflicts peacefully is vital for maintaining a safe and therapeutic environment.
12. **Technology**: As healthcare technology advances, nurses should be proficient in using electronic health records (EHRs) and other communication tools to access and document patient information.

Effective communication enhances patient outcomes, improves patient satisfaction, and fosters a positive working environment for healthcare teams. It is a foundational skill that all nurses should continually develop and prioritize in their practice.1. What do you see the challenges might be for effective communication in health care settings? Ideas for answers below.

Effective communication in healthcare settings is essential for providing high-quality patient care and ensuring patient safety. However, there are several challenges that can affect communication in healthcare settings:1. **Language Barriers:** Healthcare facilities often serve diverse populations, and language barriers can impede effective communication between healthcare providers and patients. This can lead to misunderstandings, misdiagnoses, and inappropriate treatment.
2. **Cultural Differences:** Cultural differences can influence communication styles, beliefs, and expectations. Healthcare providers need to be culturally sensitive to ensure effective communication with patients from various cultural backgrounds.
3. **Health Literacy:** Not all patients have the same level of health literacy. Some may struggle to understand medical terminology, instructions, or informed consent forms. This can lead to poor compliance with treatment plans and medication regimens.
4. **Limited Time:** Healthcare professionals often have limited time with each patient due to high patient loads. This time constraint can affect the quality of communication and lead to rushed conversations.
5. **Technological Challenges:** The increasing use of electronic health records and other technology in healthcare can introduce communication challenges. Issues with electronic systems, data entry errors, and the overreliance on technology can disrupt effective communication.
6. **Hierarchy and Power Dynamics:** Hierarchical structures within healthcare organizations can create communication challenges. Lower-level staff may be hesitant to communicate issues to superiors, which can impede the flow of important information.
7. **Patient Anxiety and Stress:** Patients in healthcare settings are often anxious or stressed, which can hinder their ability to process information and communicate effectively with healthcare providers.
8. **Non-Verbal Communication:** Non-verbal cues, such as body language and facial expressions, play a significant role in communication. Misinterpretation of these cues can lead to misunderstandings.
9. **Interdisciplinary Communication:** Effective healthcare often requires collaboration among multiple healthcare professionals. Poor communication between different disciplines can result in fragmented care and increased risks for patients.
10. **Informed Consent:** Ensuring that patients fully understand the risks, benefits, and alternatives of a medical procedure is critical. Obtaining informed consent can be challenging, particularly when patients are in distress or when complex procedures are involved.
11. **Privacy Concerns:** Maintaining patient confidentiality is vital, but it can sometimes hinder the sharing of important information among healthcare providers.
12. **Emergency Situations:** In high-stress emergency situations, communication can break down due to the urgency of care and the chaotic environment. Clear communication protocols and training are essential to overcome this challenge.
13. **Ethical Dilemmas:** Ethical issues can complicate communication. For example, healthcare providers may need to communicate difficult news or discuss end-of-life decisions with patients and their families.
14. **Legal and Documentation Requirements:** Healthcare professionals are often burdened with extensive documentation requirements, which can detract from the time available for direct patient communication.

Addressing these challenges requires ongoing training and education for healthcare providers, improved systems and protocols, and a patient-centered approach to care that values effective communication as a crucial component of quality healthcare delivery.1. What do we mean by ‘therapeutic’ communication and a therapeutic relationship? Please explain in your own words.

The answers below may helpIn nursing, "therapeutic communication" and a "therapeutic relationship" refer to essential aspects of patient care that are focused on promoting the patient's well-being, fostering trust, and facilitating effective communication. These concepts are particularly important in the healthcare setting to ensure quality patient care and outcomes.1. **Therapeutic Communication**:

Therapeutic communication is a skill set used by healthcare professionals, including nurses, to interact with patients in a way that promotes their physical and emotional well-being. It involves several key principles:* **Empathy**: Understanding and validating the patient's feelings and emotions, demonstrating that you care about their concerns.
* **Active Listening**: Paying full attention to the patient, asking open-ended questions, and providing feedback to show that you understand their needs and concerns.
* **Nonverbal Communication**: Utilizing body language, facial expressions, and gestures to convey empathy and understanding.
* **Respect**: Treating the patient with dignity, respecting their cultural and personal values, and maintaining their privacy.
* **Openness**: Creating an environment where the patient feels comfortable discussing their concerns and asking questions.
* **Clarification**: Ensuring that the patient understands medical information and instructions by simplifying complex concepts, using layman's terms, and asking them to repeat back what they've learned.
* **Support**: Offering emotional support and reassurance to alleviate anxiety and stress.

Therapeutic communication enhances the nurse-patient relationship and helps patients feel heard, understood, and involved in their care, ultimately contributing to better outcomes.1. **Therapeutic Relationship**:

A therapeutic relationship in nursing is a professional, patient-centered, and goal-oriented connection established between a nurse and a patient. This relationship is built on trust, respect, empathy, and effective communication. It is not a personal or social relationship but one that aims to support the patient's physical, emotional, and psychological well-being. Key elements of a therapeutic relationship include:* **Trust**: Building trust through honesty, consistency, and confidentiality. Patients need to trust their healthcare providers to make informed decisions about their care.
* **Respect**: Treating the patient with dignity, respecting their autonomy, and acknowledging their individual values and beliefs.
* **Empathy**: Understanding and validating the patient's emotions and concerns, showing genuine care and concern.
* **Boundaries**: Maintaining professional boundaries to ensure the relationship remains therapeutic and patient-focused, rather than personal or social.
* **Communication**: Using effective communication skills to convey information, listen to the patient's needs, and collaborate on their care plan.
* **Collaboration**: Working together with the patient to set goals, make decisions, and manage their health effectively.

A therapeutic relationship is crucial for promoting patient well-being, enhancing compliance with medical recommendations, and ultimately achieving better health outcomes. It is a foundational element of patient-centred care and is often associated with improved patient satisfaction and trust in the healthcare system. |
| **Tutorial session preparation** | Read Section 2.3 of your text book. Note down the key points and any questions you have and bring them to class. |
| **Tutorial session activities** | In your groups draw a concept map that illustrates the key important aspects in nursing communication. Once you have completed this then show on your map what the barriers are to effective communication.Finally, in your groups, discuss how these barriers can be overcome/reduced.Following these activities you will be given case scenarios and have the opportunity to practice applying the communication skills you have identified as crucial for nurses. |
| **Self-directed learning** | Re-read and review sections 2.1, 2.2 and 2.3 from your text. Make sure you understand the concepts discussed. Bring questions to your next class.Please review the discussion about personal space. Do you agree or disagree with the description? Why? Why not? How applicable is this model in PNG? Is it helpful for nurses, if so how? Write your ideas below. |

# WEEK 6 COMMUNICATION & NURSING DOCUMENTATION LEARNING ACTIVITIES

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| **Pre-requisite knowledge** | Familiarity with the concepts and ideas related to effective communication for nursing practice. This week will focus on communicating effectively with other members of the healthcare team. |
| **Pre lecture reading** | Read Sections 2.4 and 2.5 of your text book. Note any questions and bring those to class with you. |
| **This week’s lecture focus** | Principles of nursing reports and nursing documentation |
| **Key points from lecture** | * Basic principles of nursing report and documentation
* Legal and ethical responsibilities
* Communicating with other members of the health team
* Requirement and format for nursing reports and nursing handover.
 |
| **Post lecture questions** | List the four most important things that you need to think about when documenting and reporting patient care. Why are these important?Remember students are also doing a Communications subject. Try and link with the teachers in that subject and see what their focus is and how you can reinforce the learning for students by using information gained in each of these units. |
| **Tutorial session preparation** | Identify new information and develop at least two questions to bring to your tutorial about nursing documentation. You will ask these questions to the other students in your group who will be expected to answer them.Make sure you follow this up and ask the students to ask their questions and get the other students involved to ask and answer questions. Each student will need to be ready to answer questions from their other group members |
| **Tutorial session activities** | Students will work in groups to ask and answer questions related to nursing documentation and communication.Using case scenarios you will have the opportunity to practice giving verbal nursing reports, writing nursing documentation and to practice communicating clinical concerns to other members of the health care team.During this class you will have an opportunity to gain assistance in completing your case study assignment. Your tutor will check you are clear about the requirements including correct referencing.**Teachers, please make sure you provide students with guidance about their case study assignment. Review what they are doing and correct errors and misunderstandings.** |
| **Self-directed learning** | Complete the learning activities found at the end of chapter 2.Write a brief reflection which focuses on what you have learned about effective nursing communication and how this is different to communicating with friends or family. |

# WEEK 7 RISK & SAFETY LEARNING ACTIVITIES

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| **Pre-requisite knowledge** | Every nurse is responsible for providing safe, high quality care to their patients by following the standards identified by the PNG Nursing Council and the laws which govern health care practice. Nurses also have a responsibility to use and apply research evidence to practice (evidence-based practice). *Before* attending the lecture this week take the time to explore on the web if you can, what we mean by ‘quality’ in health care.  |
| **Pre lecture reading** | Read Sections 5.1, 5.2, 5.3, 5.4 of your text book |
| **This week’s lecture focus** | Patient safety, using evidence to inform nursing practiceQuality frameworks and National Patient Safety Goal and StandardsExamples of patient safety and quality issues in health care |
| **Key points from lecture** | * Current issues in patient’s safety,
* Evidence for need, applying the evidence, applying the standards
* Infection control (standard precautions),
* Hand hygiene,
* Hospital and environment safety.
 |
| **Post lecture questions** | What do we mean by patient safety? Why is it important?**Possible answers: Remember students need to use their own words**Patient safety refers to the prevention of harm to patients during the provision of healthcare services. It encompasses a wide range of practices and measures designed to ensure that patients receive high-quality care without unnecessary risks or adverse events. Patient safety is a fundamental aspect of healthcare and involves:1. **Preventing Medical Errors:** Medical errors can include misdiagnoses, medication errors, surgical mistakes, and more. Ensuring patient safety means reducing the likelihood of such errors through protocols and best practices.
2. **Infection Control:** Measures to prevent the spread of infections within healthcare facilities. This includes hand hygiene, sterilization of equipment, and isolation procedures when necessary.
3. **Medication Safety:** Ensuring that patients receive the correct medications at the right dosages and times. This involves processes such as medication reconciliation, barcoding, and clear labeling.
4. **Effective Communication:** Effective communication among healthcare professionals, between healthcare providers and patients, and within healthcare teams is essential for patient safety. Miscommunication can lead to mistakes and misunderstandings.
5. **Fall Prevention:** Measures to prevent patient falls, especially among vulnerable populations like the elderly.
6. **Proper Documentation:** Accurate and complete medical records help ensure that patients receive the right care and that healthcare providers have the necessary information.
7. **Patient Education:** Ensuring that patients are informed about their conditions, treatment options, and how to take care of themselves after discharge.
8. **Continuous Quality Improvement:** Regularly reviewing processes and outcomes to identify areas where improvements can be made.
9. **Safety Culture:** Fostering a culture within healthcare organizations that values safety, encourages reporting of errors, and supports learning from mistakes rather than blaming individuals.
10. **Regulatory and Accreditation Standards:** Compliance with regulations and standards set by healthcare regulatory bodies and accreditation organizations is a crucial component of patient safety.
11. **Technology and Tools:** Implementing technology solutions such as electronic health records, decision support systems, and alarm systems to enhance patient safety.

Patient safety is paramount in healthcare to protect patients from harm, improve the quality of care, and enhance public trust in the healthcare system. Efforts to improve patient safety are ongoing, with organizations and professionals continually working to identify and address potential risks and issues.How should nurses use evidence in practice? What counts as evidence and why?**Possible answers below**Nurses should use evidence in their practice through a process known as evidence-based practice (EBP). EBP involves integrating the best available evidence from research with clinical expertise and patient preferences to make informed healthcare decisions. Here's how nurses should use evidence in their practice and why it's important:1. Identify the clinical question: Start by formulating a specific clinical question related to the patient's care. This question should be answerable and relevant to the patient's condition or the nursing care provided.
2. Search for evidence: Nurses should conduct a systematic search for relevant evidence. This may involve reviewing research articles, clinical guidelines, textbooks, and other credible sources.
3. Appraise the evidence: It's essential to critically evaluate the quality of the evidence. Consider factors like the research methods, sample size, and the applicability of the findings to the patient in question.
4. Integrate evidence with clinical expertise: Nurses should combine their clinical expertise and judgment with the evidence they've gathered. This means considering the patient's unique circumstances and values when making care decisions.
5. Implement evidence-based interventions: Based on the evidence and clinical expertise, nurses should implement the most appropriate and effective interventions or treatments.
6. Monitor and evaluate outcomes: After implementing evidence-based interventions, nurses should closely monitor the patient's progress and evaluate the outcomes. If necessary, adjustments should be made based on ongoing assessment.

Why nurses should use evidence in practice:1. Improved patient outcomes: Evidence-based practice is associated with better patient outcomes because it promotes the use of the most effective and safe interventions.
2. Quality care: EBP ensures that nursing care is of the highest quality by relying on the best available evidence and clinical expertise.
3. Patient safety: Using evidence-based guidelines and interventions can reduce the risk of errors and adverse events, enhancing patient safety.
4. Accountability: EBP helps nurses make informed decisions and provides a rationale for their actions, making them more accountable for their practice.
5. Cost-effectiveness: Evidence-based interventions often result in cost-effective care, as they focus resources on treatments that are proven to be effective.
6. Professional development: Engaging in EBP helps nurses stay updated on the latest research and developments in their field, fostering professional growth.
7. Ethical practice: Using evidence-based interventions ensures that patient care is based on the best available information, aligning with ethical principles of beneficence and non-maleficence.
8. Consistency in care: EBP promotes consistency in nursing care, reducing variations in practice and improving the standardization of care delivery.

In summary, nurses should use evidence in their practice to provide the best possible care to their patients. Evidence-based practice helps improve patient outcomes, enhances the quality of care, and ensures that nursing interventions are based on the most reliable and up-to-date information available. |
| **Tutorial session preparation** | **Find at least one resource** that explains about nursing and infection control and/or hand hygiene. Be ready to explain why good hand hygiene is crucial for all health workers and also for others in your family and community. |
| **Tutorial session activities** | **In this session tutors will need to demonstrate and guide students** about the standards of hand hygiene that are expected of nurses. You will explore the differences between domestic handwashing and the different types of hand hygiene that are expected in health facilities.**Teachers will need to know how to correctly perform hand hygiene & demonstrate to students who will** then work in pairs to review another student and have your own technique reviewed. You will be provided with an assessment tool and guidance about giving and receiving feedback. |
| **Self-directed learning** | Students will need to practice correctly carrying out hand hygiene on at least 3 occasions. You will need to be assessed by another student while performing this task, you will also need to assess one of the students performing hand hygiene and give constructive feedback to each other. |

# WEEK 8 RISK & SAFETY LEARNING ACTIVITIES

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| **Pre-requisite knowledge** | Find out and write down what your understanding is of the term ‘evidence-based practice’. What does it mean for nurses and how should evidence be used in clinical care? |
| **Pre lecture reading** | Read Section 9.6 in your textbook: |
| **This week’s lecture focus** | Infection control (standard precautions)Hospital and environment safetyPersonal Protection & the nurse’s role in infection prevention and control |
| **Key points from lecture** | * Revision of the main pathogens that cause infectious diseases and discuss emerging infectious diseases
* The chain of infection, how infections are spread and means of preventing transmission
* Common healthcare-associated infections (HAIs), prevention and hospital policies and practices to help.
* Essential concepts for the nursing management of patients with infectious diseases and healthcare associated infection
* Self-care and reflective practices.
 |
| **Post lecture questions** | In your own words write a definition for each of these terms: Teacher’s information belowInfection/infectious diseasePathogenChain of infectionCausative agentReservoirSusceptible hostPortal of entryMechanisms of transmissionPortal of exitThese terms are fundamental concepts in the study of infectious diseases:1. **Infectious Disease:** An infectious disease is a medical condition caused by the invasion and multiplication of pathogenic microorganisms, such as bacteria, viruses, fungi, or parasites, within a host organism.
2. **Pathogen:** Pathogens are microorganisms or agents (e.g., bacteria, viruses, fungi, parasites) that can cause disease when they enter a host organism and multiply within it.
3. **Chain of Infection:** The chain of infection is a model used to understand how infectious diseases spread. It consists of a series of interconnected links that need to be present for an infection to occur. The typical links in the chain of infection include:
	* **Causative Agent**: The microorganism (pathogen) responsible for the infection.
	* **Reservoir**: The source where the pathogen lives and multiplies, such as humans, animals, or the environment.
	* **Portal of Exit**: The way the pathogen leaves the reservoir host (e.g., through bodily fluids, respiratory droplets).
	* **Mode of Transmission**: How the pathogen is transmitted from the reservoir to the host (e.g., direct contact, airborne, vector-borne).
	* **Portal of Entry**: The route through which the pathogen enters a susceptible host.
	* **Susceptible Host**: An individual or organism that can be infected by the pathogen and develop the disease.
4. **Causative Agent:** This is the specific microorganism responsible for causing the infectious disease, such as a particular strain of bacteria or a virus.
5. **Reservoir:** A reservoir is a source or habitat in which a pathogen naturally lives and reproduces. Reservoirs can be human, animal, or environmental in nature. For example, humans can be reservoirs for diseases like tuberculosis, animals can be reservoirs for rabies, and contaminated water can be a reservoir for waterborne diseases.
6. **Susceptible Host:** A susceptible host is an individual or organism that can become infected by a pathogen. The host may be susceptible due to factors such as a weakened immune system, lack of prior immunity, or other predisposing conditions.
7. **Portal of Entry:** This is the route through which a pathogen enters a susceptible host's body. Common portals of entry can include the mouth, nose, eyes, and open wounds.
8. **Mechanisms of Transmission:** These are the various ways in which pathogens can be transmitted from a reservoir to a susceptible host. Common mechanisms of transmission include:
	* **Direct Contact:** Transmission occurs through physical contact between infected and susceptible individuals.
	* **Indirect Contact:** Transmission occurs via contaminated objects or surfaces.
	* **Airborne Transmission:** Pathogens are spread through respiratory droplets in the air.
	* **Vector-Borne Transmission:** Pathogens are transmitted by vectors such as mosquitoes or ticks.
	* **Faecal-Oral Transmission:** Pathogens are ingested through contaminated food or water.
	* **Bloodborne Transmission:** Pathogens are spread through contact with infected blood or blood products.
9. **Portal of Exit:** This is the route through which a pathogen leaves the reservoir host's body and enters the environment or another host. Common portals of exit include respiratory secretions, bodily fluids, and faeces.

Understanding the chain of infection and these associated concepts is crucial for preventing and controlling infectious diseases. Public health measures often focus on disrupting one or more links in this chain to prevent disease transmission. |
| **Tutorial session preparation** | You will also get an introduction to Standard Precautions and Infection Control. Ensure you understand what these terms mean.**Student activity highlighted below. Teachers need to make sure they understand and can draw a diagram that illustrates the chain of transmission****Work with one other student and draw a concept map/diagram that illustrates the chain of infection including the modes of transmission and portals of entry**. Bring that with you to your tutorial session |
| **Tutorial session activities** | Review chain of infection. Working in groups use your diagrams/concept maps and show how and where the chain of infection can be stopped. Personal protection. Staying safe as a nurse. **This session will give you the skills and knowledge needed to safely don and doff gloves, masks and eye protection and other personal protective devices as available**. You will also learn about the different forms of handwashing that nurses use in practice. You will discuss the purposes of each and then have an opportunity to practice using a correct handwashing technique.Teachers need to prepare the class and themselves so that the students can understand why they might need PPE, what it is and how to safely don and doff PPE.You will be given the opportunity to assess your partner and yourself using the handwashing skills checklist. This skill will be reassessed in the OSCA at the end of the semester. Following last week’s session students need to self and peer assess each other performing hand hygiene. |
| **Self-directed learning****Hand Hygiene** | **Handwashing.** You will need to ensure you are competent in safely performing hand hygiene. With your partner, practice correct hand hygiene techniques and then, using the checklist below, assess both yourself and your partner to make sure you are able to safely and correctly perform the required technique.

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| --- |
| **Criteria: C – Competent, NYC – Not Yet Competent** (Educator must comment why grade was NYC) |

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| **Criteria for skills performance** | **Self Practice** | **Observed Practice (P) with a partner, then assessed (A)** |
| **P** | **P** | **Assess** |
| Identifies need |  |  |  |  |
| Gathers equipment: * warm running water
* soap
* paper towels.
 |  |  |  |  |
| Prepares and assesses hands  |  |  |  |  |
| Turns on and adjusts water flow  |  |  |  |  |
| Wets hands, applies soap  |  |  |  |  |
| Cleans under the fingernails when required  |  |  |  |  |
| Thoroughly washes hands  |  |  |  |  |
| Rinses hands  |  |  |  |  |
| Turns off the water if elbow taps used. If ordinary taps, turns off after drying hands  |  |  |  |  |
| Dries hands  |  |  |  |  |
| Uses alcohol-based hand rub as an alternative to soap and water, when appropriate  |  |  |  |  |
| Demonstrates ability to link theory to practice  |  |  |  |  |

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| PNG Nursing Competency Standards – 1-4 |
| **Satisfactory: YES / NO** | **Date:** | **Signature:** |

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# WEEK 9 BASIC FIRST AID LEARNING ACTIVITIES

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| **Pre-requisite knowledge** | You need make sure that you are clear about what first aid is, what are the limitations of practice in first aid? Who can undertake first aid? Review your text book and make sure you understand these ideas. |
| **Pre lecture reading** | Read pages 9-11 in your First Aid text book to familiarise yourself with the purposes and principles of first aid. |
| **This week’s lecture focus** | Basic principles of first aid |
| **Key points from lecture** | * Principles of first aid
* Legal considerations
* Duty of Care
* Negligence
* Consent
* Scene assessment
* Assessing the victims, triaging according to need if there is more than one victim
* Introduction to basic life support and primary assessment.
* Emergencies causing lack of O2 – procedure for EAR, CPR and principles of BLS
 |
| **Post lecture questions** | List below the five principles of first aid. Please explain in your own words, what they mean.The five main principles of first aid are:1. Preserve Life: The primary goal of first aid is to assess and ensure the safety and survival of the injured or ill person. Immediate actions should be taken to prevent further harm and maintain the person's vital functions.
2. Prevent Further Injury: Once the immediate threat to life is addressed, the focus shifts to preventing further harm. This includes stabilizing the person's condition and taking steps to avoid aggravating their injuries or medical condition.
3. Promote Recovery: First aid aims to promote the recovery and well-being of the person. This may involve providing basic medical care or comfort measures to alleviate pain and suffering.
4. Protect the Unconscious: In cases where the person is unconscious, it is essential to protect their airway, maintain breathing, and ensure circulation. This may involve techniques like CPR (Cardiopulmonary Resuscitation).
5. Seek Professional Help: First aid is not a substitute for professional medical care. Once the immediate first aid measures have been taken, it is crucial to seek medical assistance or call emergency services to ensure that the person receives the necessary medical treatment and evaluation.

Below briefly summarise the legal and ethical considerations associated with providing first aid.Legal Considerations:1. Duty to Act: In many jurisdictions, there is a legal duty to provide reasonable assistance if you witness someone in need of first aid. Failing to do so may result in legal consequences.
2. Standard of Care: Rescuers must provide care that is consistent with established standards and guidelines, such as those issued by organizations like the American Heart Association or Red Cross. Failure to follow these standards could result in legal liability.
3. Consent: Before providing first aid, it's crucial to obtain the injured person's informed consent if they are conscious and capable of providing it. For unconscious or incapacitated individuals, implied consent may apply in emergencies.
4. Good Samaritan Laws: Many jurisdictions have Good Samaritan laws that protect individuals who provide reasonable assistance in good faith from legal liability, as long as they act within their level of training and do not exceed their capabilities.
5. Documentation: Maintaining accurate records of the care provided and the circumstances is important, as this can be valuable in legal proceedings or medical follow-up.

Ethical Considerations:1. Prioritisation: Ethical considerations include determining who to help first in a multiple-casualty situation. The principle of triage may be applied to ensure the most critically injured receive care first.
2. Respect for Autonomy: Rescuers should respect the injured person's autonomy by providing care in a manner that is respectful and considerate of their preferences and cultural beliefs, when possible.
3. Confidentiality: Protecting the injured person's privacy and medical information is an ethical duty. Rescuers should avoid sharing personal information about the individual without their consent.
4. Continuous Learning: Ethical first aid providers should commit to ongoing training and education to ensure they are up-to-date with the latest techniques and guidelines.
5. Non-Discrimination: Rescuers should provide care without discrimination based on race, gender, religion, sexual orientation, or any other characteristic. Every person deserves equal treatment.
6. Informed Decision-Making: When possible, explain the nature of the care being provided and seek the person's consent if they are conscious and capable of understanding. Informed decision-making respects the individual's right to be involved in their own medical care.

In summary, providing first aid involves both legal and ethical obligations. Rescuers should act within the boundaries of the law, adhere to established standards of care, and respect the injured person's autonomy and privacy. Being aware of these considerations is essential to ensure the best possible care for those in need while minimising legal and ethical risks. |
| **Tutorial session preparation** | Work with a learning partner and draw a labelled diagram that illustrates the structure and function of the heart and respiratory systems.Teachers need to make sure that they have a fully labelled and prepared diagram for the class so this can be reviewed before starting the first aid sessions. |
| **Tutorial session activities** | This session will focus on scene assessment, triage, chain of survival and beginning understanding of basic life support.Management of:* Choking
* Chest Pain
* Sudden Cardiac Arrest (SCA)
* Heart Attack
* Angina

All of this information is available in the First Aid Text book. Teachers will need to familiarise themselves with the content and associated skills to effectively teach the students.**Answers** to all of the first aid question are found at the end of the learning guide (before the case studies in this document). Students can self-assess. These questions can be used in the OSCA for further reinforcement of this knowledge. |
| **Self-directed learning** | Please answer the following questions to check for your understanding. Answers are provided at the end of the learning guide.Q1: What is the first step in scene assessment during first aid? Q2: What should you do after ensuring scene safety in first aid? Q3: How do you check a casualty's responsiveness? Q4: What should you do if a casualty is unresponsive? Q5: What is the purpose of a primary survey in first aid? Q6: In the primary survey, what does "ABC" stand for? Q7: How can you check a casualty's airway in the primary survey? Q8: What should you do if a casualty is not breathing in the primary survey? Q9: In the primary survey, how do you assess circulation? Q10: What is the purpose of a secondary survey in first aid? Q11: What steps should you follow during a secondary survey? Q12: When should you reassess a casualty's condition in first aid? Top of Form |

# WEEK 10 BASIC FIRST AID LEARNING ACTIVITIES

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| **Pre-requisite knowledge** | Anatomy & physiology of the skinAnatomy & physiology of the circulatory systemAnatomy of the abdomen |
| **Pre lecture reading** | Review pages 61-69 of your First Aid text book, write down any questions and bring them to class |
| **This week’s lecture focus** | Burns: types, causes and management  Haemorrhage and shock, causes, signs and symptoms & management  Abdominal injuries, blunt & penetrating trauma |
| **Key points from lecture** | * Types of burns: including thermal, inhalation, chemical and electrical burns.
* Haemorrhage including:
* Nose Bleed
* Minor and Life-Threatening Bleeds
* Constrictive Bandage (Arterial Tourniquet)
* Embedded Objects
* Internal Bleeding
* Abdominal Injuries
* Blunt or Penetrating Trauma
* Evisceration (exposed internal organs)
* Shock
 |
| **Post lecture questions** | What are the common types of burns seen in your community?What are the signs and symptoms of haemorrhage? What would lead you to think that someone was beginning to go into shock? What signs and symptoms might you see? |
| **Tutorial session preparation** | In this session you will be introduced to taking patient’s vital signs which you will practice taking on other students.You need to make sure you understand what vital signs assess and why this is important? What are the normal parameters for adults and children? |
| **Tutorial session activities** | You will be given a tutorial about taking vital signs and then using a series of case studies you will perform assessments on your fellow students. |
| **Self-directed learning** | Review what you have learned so far. You need to practice performing assessments on each other so you can easily find pulses, assess respiration and if possible blood pressure and temperature.Q1: What is a burn? Q2: What are the three main types of burns? Q3: What should you do immediately for a burn?.Q4: How do you differentiate between first-degree, second-degree, and third-degree burnsQ5: Should you pop blisters from a burn? Q6: How should you protect a burn wound after cooling it?Q7: When should you seek medical attention for a burn?Q8: What should you do if clothing is stuck to a burn? **Haemorrhage**Q: What is haemorrhage? Q: What are the common signs of external haemorrhage? Q: What is the first step in managing severe bleeding? Q: How can you apply direct pressure to a bleeding wound? Q: When should you elevate a bleeding limb? Q: What is a tourniquet, and when should it be used for bleeding control? Q: How long can a tourniquet remain in place? Q: What is shock, and why is it a concern in haemorrhage cases? Q: How can you help prevent shock in a haemorrhage victim? Q: What information should you provide to emergency responders when calling for help in a haemorrhage situation? Q: What should you do if the bleeding doesn't stop despite initial first aid efforts?  |

# WEEK 11 BASIC FIRST AID LEARNING ACTIVITIES

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| **Pre-requisite knowledge** |  |
| **Pre lecture reading** |  |
| **This week’s lecture focus** | Basic First Aid. Assessment and management of emergency conditions. |
| **Key points from lecture** | * Fractures and soft tissue injuries and management of symptoms
* Spinal injuries
* Crush injuries
* Head injuries, dealing with altered levels of consciousness
* Bandages, slings
* Poison: types, snake bites, signs and symptoms, management
* Handling and transporting causalities in emergencies
* Fire safety measures
 |
| **Post lecture questions** | What is important to assess for if a person presents with a head injury? What would you look for and why?What is the correct emergency treatment for a snake bite?  |
| **Tutorial session preparation** | Review your lecture notes and textbook. In this tutorial session you will be practicing applying slings, managing snake bites and fractures and other serious injuries. |
| **Tutorial session activities** | In this session you will work with other students to practice assessing and managing some of the emergency conditions outlined in this week’s lecture. You will have the opportunity to practice immobilising limbs, assessing and positioning a person with a serious head injury, and learn how to correctly apply a sling. |
| **Self-directed learning** | To help you revise what you have learned in class please complete these questions**Head Injury**1. Question: What is the first step in assessing a head injury?
2. Question: Why is it important to assess the level of consciousness in a head injury patient?
3. Question: How should you manage a head injury patient who is unconscious but breathing?
4. Question: When should you suspect a skull fracture in a head injury patient?
5. Question: What is the purpose of immobilizing the neck in a head injury patient?
6. Question: How should you control bleeding from a scalp wound?
7. Question: What is the recommended treatment for a suspected concussion?
8. Question: What signs should you look for to assess if a head injury patient is experiencing increased intracranial pressure (ICP)?
9. Question: What should you advise a head injury patient regarding activities following their injury?

**Fractures and Sprains****1**. Question: What is the first step in providing first aid for a suspected fracture or sprain? 1. Question: How can you distinguish between a fracture and a sprain during a first aid assessment?
2. Question**:** What should you do if you suspect a bone is broken (fractured) in a first aid scenario?
3. Question**:** In the case of a suspected sprain, what immediate first aid steps can be taken?
4. Question: What should you never do when providing first aid for fractures or sprains?
5. Question: When should you encourage the injured person to seek professional medical attention for a fracture or sprain?
6. Question: How can you minimize the risk of further injury when assisting someone with a suspected fracture or sprain?
7. Question: What should you do if the injured person cannot move the injured limb due to pain or other reasons?
8. Question: Why is it essential to monitor the injured person's condition after providing first aid for a fracture or sprain?
 |

# WEEK 12 BASIC FIRST AID LEARNING ACTIVITIES

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| **Pre-requisite knowledge** | You need to be familiar with the human body. The names of each part, how things fit together and what the consequences are when things start to go wrong. |
| **Pre lecture reading** | Review your first aid text book. Focus on the topics that will be discussed this week. Write down anything you are not clear about, anything you don’t understand and bring it to your tutorial session this week. |
| **This week’s lecture focus** | Basic First Aid, other emergencies and conditions. Assessment and management |
| **Key points from lecture** | * Eye injuries
* Ear injuries
* Stroke
* Seizures & Febrile Convulsions .
* Epileptic Seizures
* Asthma
* Allergic Reactions & Anaphylaxis
* Diabetes, hypoglycaemia, hyperglycaemia
 |
| **Post lecture questions** | Define what a stroke is and explain its causes and risk factors, including signs and symptoms. What does the acronym FAST stand for?What are the different types of seizure?What is the difference between a seizure and a febrile convulsion? |
| **Tutorial session preparation** | * + Read the sections in the First Aid Manual about ear and eye injury
	+ Read the section on seizures, febrile convulsions, asthma and anaphylaxis
 |
| **Tutorial session activities** | Today you will practice assessing and managing cases related to the emergencies discussed in the lecture and through your reading.You will also practice putting your fellow students into a recovery position and understand how you can protect patient’s airways when caring for them.Using a provided case study you will outline the treatment for a person presenting to your clinical with diabetes who is experiencing an imbalance in their insulin and glucose levels. |
| **Self-directed learning** | Complete the case studies provided and discuss them with your fellow students |

# WEEK 13 CLINICAL SKILL DEVELOPMENT LEARNING ACTIVITIES

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| --- | --- |
| **Pre-requisite knowledge** | Medical terminologyNursing Process, nursing documentation |
| **Pre lecture reading** | Read Chapters 1 and 2 in the nursing skills text |
| **This week’s lecture focus** | Personal careClinical assessment and monitoring Clinical communication and documentation  |
| **Key points from lecture** | Personal care* + Assisted ambulation
	+ Hygiene – bed making, shower/bath, oral care

Skin integrity assessment, Pressure area careClinical assessment and monitoring * + Vital signs: TPR, BP, SPO2
	+ Physical assessment: weight, height, BMI, BSL

Clinical communication and documentation  * + Recording vital signs
	+ Recording fluid input and output
	+ Using and maintaining patient records

Negotiating care with patient/family |
| **Post lecture questions** | What are the three most important things you found out during the lecture about providing personal care? Why are these important? |
| **Tutorial session preparation** | Review Chapters 1 & 2 of the nursing skills text bookRead Chapter 3List the key vital signs that need to be recorded when conducting a nursing assessment |
| **Tutorial session activities** | Today’s session is focusing on patient assessment, planning and delivering personal care or basic nursing care. Mari Songavari has been admitted hospital because she is too sick to stay in the community health centre. Her provisional diagnosis is pneumonia and she is unable to get out of her bed. You have been asked by your supervisor to take and record Mari’s vital signs and then to provide hygiene care for Mari.**In pairs please work together to list the vital signs** you will need to take and record for Mari. And then practice taking these observations on each other. How easy/hard was this to do?*Mari’s vital signs are as follows*:Blood pressure 160/90 mmHgHeart rate (pulse) 100 bpmRespiratory rate 28 bpmTemp 38.4CExplain in your own words what you think these signs show. Discuss your thinking with your group.After consultation with your supervisor have decided that Mari needs to be bathed in bed. (Which of the four C’s have you used and what steps of the nursing process have been applied so far in your care of Mair?) She has no *lain* with her so you will need to provide her hygiene care. This means providing care that is related to the patient’s body, appearance, hygiene, and movement.**Tasks Related to Personal Care Include:*** Bathing
* Teeth and [mouth](https://milnepublishing.geneseo.edu/home-health-aide/back-matter/glossary#Mouth) care
* Dressing/grooming
* Toileting
* Eating
* Ambulation
* [Transferring](https://milnepublishing.geneseo.edu/home-health-aide/back-matter/glossary#Transfer) patients
* Care of the patient’s environment
* Assisting with self-administration of medication

People may require personal care for a number of reasons. Remember, assistance with personal care may be temporary while a person is recovering from an injury or illness or may be permanent and required for the remaind*er* of their lives.Jot the steps of the nursing process down.Discuss with your classmates why a framework is important for planning your /provided nursing care and how it relates to the quality of care your patient receives. This short discussion is important because you will come back to it at the end of your activities today to evaluate the quality of the care you have planned. **Case Study continued:** Mari Songavari has been admitted hospital because she is too sick to stay in the community health centre. Her provisional diagnosis is pneumonia and she is unable to get out of her bed. You have been asked to provide hygiene care for Mari and after consultation with your supervisor have decided that Mari needs to be bathed in bed. She has no *lain* with her so you will need to provide her hygiene care.  *Bed Bathing:* Please list the equipment you need to prepare before you start this procedure:If you have a manikin in your nursing laboratory, use it to practice the procedure of bed bathing a patient. If there is no manikin you will need to be guided by your teacher as to what you need should do. Remember that practising bed bathing a patient is important this week and it related to the case you are studying today. At the completion of your practice think about how you relate to a person while you are carrying out your nursing care and what thigs may be difficult for you to do. Write down your thoughts and compare these with those of your classmates. As you provide Meri’s hygiene care what observations will you make and why are these observations important? Now imagine that you are working in remote area and your facility is poorly equipped, but you still need to provide hygiene care for a patient. What things can you think of that you could use to provide hygiene care? *Skin integrity*: Your observations will include matters related to skin integrity. What do we mean by skin integrity and why is it so important? Relate your answers to the health status and care of Mari. Again, refer to your textbook if you need to in order to answer this question. You may find that your answers here will be better if you also read about pressure area care. *Oral Care:* As part of her hygiene care Meri needs oral care. Please record the equipment you will assemble and use and then practice this nursing activity on your manikin. You need feedback from Mai about the effectiveness of the oral care she has received. What simple questions could you ask to obtain this feedback? A complication of your care has arisen, Mari doesn’t have a toothbrush with her so what could you do instead to achieve a clean mouth? |
| **Self-directed learning** | Write a complete nursing report about Mari. Discuss this with a classmate and bring it to your next class for review and discussion. |

# WEEK 14 CLINICAL SKILL DEVELOPMENT LEARNING ACTIVITIES

|  |  |
| --- | --- |
| **Pre-requisite knowledge** | Assessing and planning nursing careReview Ch 1 of your skills text book, make sure you know and understand the key concepts described in Section 1.4 |
| **Pre lecture reading** | Re-read Section 1.4Make sure you are clear about the concepts introduced in this chapter. Ensure that the students are directed to focus on the most important ones for your context. |
| **This week’s lecture focus** | **Title: Planning, Delivering, and Evaluating Nursing Care**Slide 1: Introduction* Title: Planning, Delivering, and Evaluating Nursing Care
* Objective: To understand the essential steps involved in providing effective nursing care.
* Importance: Proper care planning, delivery, and evaluation are crucial for patient outcomes and nursing practice.

Slide 2: The Nursing Process* The foundation of nursing care.
* Consists of five steps: Assessment, Diagnosis, Planning, Implementation, and Evaluation (ADPIE).
* Provides a systematic framework for delivering patient-centered care.

Slide 3: Assessment (A)* Data collection: Gathering information about the patient's health status.
* Types of assessment: Initial, ongoing, and comprehensive.
* Involves a holistic view of the patient, including physical, psychological, social, and spiritual aspects.

Slide 4: Diagnosis (D)* Identifying the patient's health problems, needs, and risks.
* Nurses use standardized language (NANDA-I) to label diagnoses.
* Helps to guide the care planning process.

Slide 5: Planning (P)* Developing a care plan based on the assessment and diagnosis.
* Goals: Specific, measurable, achievable, relevant, and time-bound (SMART).
* Collaborative planning: Involves the patient, family, and interdisciplinary team.

Slide 6: Implementation (I)* Putting the care plan into action.
* Involves nursing interventions, treatments, and education.
* Requires effective communication and coordination with the healthcare team.

Slide 7: Evaluation (E)* Ongoing assessment of the patient's progress toward achieving goals.
* Informs changes in the care plan as needed.
* Essential for quality improvement in nursing care.

Slide 8: Nursing Care Delivery Models* Different models: Team nursing, primary nursing, patient-centered care, and more.
* Each model has its advantages and disadvantages.
* Selecting the appropriate model depends on the patient population and healthcare setting.

Slide 9: Teamwork and Communication* Vital for delivering coordinated care.
* Importance of effective handoffs and documentation.
* Interprofessional collaboration: Working with other healthcare professionals for holistic patient care.

Slide 10: Cultural Competence* Understanding and respecting diverse cultural beliefs and values.
* Helps in delivering culturally sensitive care.
* Avoiding stereotypes and biases.

Slide 11: Technology in Nursing Care* Electronic Health Records (EHRs) and nursing informatics.
* Benefits and challenges.
* Ensuring data privacy and security.

Slide 12: Patient and Family Education* Informing and involving patients and their families in care.
* Promoting health literacy.
* Providing clear, understandable information.

Slide 13: Ethical Considerations* Maintaining patient confidentiality and privacy.
* Informed consent and autonomy.
* Ethical dilemmas and decision-making.

Slide 14: Quality Improvement* Continuous quality assessment and improvement.
* Monitoring patient outcomes.
* Evidence-based practice in nursing care.

Slide 15: Conclusion* The nursing process is the foundation of nursing care.
* Effective planning, delivery, and evaluation are essential for quality care.
* Nurses play a vital role in improving patient outcomes and healthcare delivery.

Slide 16: Questions and Discussion* Open the floor for questions and discussion.

Note to the Presenter: Encourage active participation and discussion among the nursing students, share relevant case studies, and real-life experiences to enhance the learning experience. Emphasize the importance of critical thinking, empathy, and adaptability in nursing care. |
| **Key points from lecture** | * Review of the Nursing Process
* The different stages and rationale for each
* Other considerations
 |
| **Post lecture questions** | Below are the questions that the students have to complete in their workbook with possible answers. Students need to answer the questions in their own words.1. What is the nursing process, and why is it essential for patient care? Answer: The nursing process is a systematic problem-solving approach used by nurses to provide individualised patient care. It consists of five steps: assessment, diagnosis, planning, implementation, and evaluation. It ensures comprehensive and effective care delivery.
2. Explain the first step of the nursing process: assessment. Answer: Assessment involves collecting data about the patient's health status, including physical, psychological, social, and environmental factors. It is the foundation of the nursing process and helps identify the patient's needs.
3. What is the purpose of a nursing diagnosis? Answer: A nursing diagnosis is a clinical judgment about the patient's response to actual or potential health problems. It guides the planning and implementation of nursing care tailored to the patient's specific needs.
4. Describe the planning phase of the nursing process. Answer: Planning involves setting goals and creating a care plan that outlines interventions to address the patient's identified nursing diagnoses. The plan should be patient-centred, measurable, and achievable.
5. What is the role of implementation in the nursing process? Answer: Implementation is the phase where the nurse carries out the interventions outlined in the care plan. This includes administering treatments, providing education, and assisting with activities of daily living.
6. Why is evaluation crucial in the nursing process? Answer: Evaluation assesses the effectiveness of the nursing interventions in achieving the desired patient outcomes. It helps nurses determine whether the care plan should be continued, modified, or terminated.
7. Can you explain the difference between a medical diagnosis and a nursing diagnosis? Answer: A medical diagnosis identifies a disease or medical condition, while a nursing diagnosis focuses on the patient's response to the condition and their healthcare needs. Nursing diagnoses guide nursing care, while medical diagnoses guide medical treatment.
8. How can the nursing process be adapted for different patient populations or settings? Answer: The nursing process is adaptable and can be tailored to the unique needs of various patient populations (paediatric, geriatric, etc.) and healthcare settings (acute care, community health, etc.) by adjusting assessment tools, care plans, and interventions.
9. Give an example of a short-term and a long-term goal in a nursing care plan. Answer: A short-term goal may be "The patient will be able to explain what their medication is and why they need to take it." A long-term goal could be "The patient will regain full mobility within six weeks following a hip replacement surgery."
10. How does documentation relate to the nursing process, and why is it important? Answer: Documentation is essential in the nursing process as it records the patient's health status, care provided, and outcomes. It ensures communication among healthcare team members and legal accountability for nursing care.
11. What ethical considerations should a nurse keep in mind during the nursing process? Answer: Ethical considerations include maintaining patient confidentiality, obtaining informed consent, respecting cultural and religious beliefs, and providing care with compassion and dignity.
12. How can critical thinking skills be applied in each phase of the nursing process? Answer: Critical thinking involves problem-solving and decision-making. In the nursing process, it helps nurses analyse data, make accurate diagnoses, develop effective care plans, implement interventions, and evaluate outcomes.
13. Explain the concept of holistic care within the nursing process. Answer: Holistic care means considering the patient as a whole, including their physical, psychological, social, and spiritual needs. Nurses aim to address all aspects of the patient's well-being in their care.
14. What are some common challenges nurses may face in the implementation phase of the nursing process? Answer: Challenges may include time constraints, patient non-compliance, unexpected complications, and the need to adapt interventions based on changing patient needs.
15. How does evidence-based practice (EBP) relate to the nursing process, and why is it important? Answer: EBP involves using the best available evidence to inform nursing practice. It ensures that nursing care is based on research and clinical expertise, enhancing the quality of care provided to patients.
 |
| **Tutorial session preparation** | Prepare the case scenarios so that students can work on them in groups to assess and plan care.Make sure the cases are structured so that the students need to also practice and perform skills such as assessment of vital signs and skin integrity. |
| **Tutorial session activities** | Using the case studies provided, break students into groups and ask them to work through the scenarios to assess and plan care. Allow them to work together to develop a nursing care plan and then present it to class.Set up a series of skill stations so students can practice taking and recording vital signs. Practice taking a patient history and practice documenting what they have found. |
| **Self-directed learning** | Students need to review and revise all the skills and competencies they have learnt during the semester. |

# WEEK 15 PULLING IT ALL TOGETHER LEARNING ACTIVITIES

|  |  |
| --- | --- |
| **Pre-requisite knowledge** | Each school is responsible for planning the last week of the semester. Teachers will know where they need students to focus and what they key revision and learning points are |
| **Pre lecture reading** | Remind students to review and revise their notes and learning guide |
| **This week’s lecture focus** | This should pull the key learning points from the semester together. |
| **Key points from lecture** | Make sure students are clear about how they need to prepare for the exam |
| **Post lecture questions** | It would probably help the students if you could give them a summary of the key points to study. Use the summaries at the end of each chapter in their text book, the key points are summarised and relevant questions arev asked. |
| **Tutorial session preparation** | You need to prepare the class so that students know what to expect in the practical exam (OSCA) |
| **Tutorial session activities** | Allow the students to guide you. Ask what they would like help with and provide the support they need to succeed |
| **Self-directed learning** |  |

# RESOURCE SECTION

# ANSWERS TO FIRST AID QUESTIONS

**Basic First Aid**

Q1: What is the first step in scene assessment during first aid? **A1**: The first step in scene assessment is ensuring safety for yourself and others.

Q2: What should you do after ensuring scene safety in first aid? **A2**: After ensuring scene safety, assess the casualty's responsiveness.

Q3: How do you check a casualty's responsiveness? **A3**: Gently tap the casualty and ask loudly, "Are you okay?"

Q4: What should you do if a casualty is unresponsive? **A4**: If the casualty is unresponsive, call for help and begin CPR (Cardiopulmonary Resuscitation).

Q5: What is the purpose of a primary survey in first aid? **A5**: The primary survey assesses and addresses life-threatening conditions in a systematic manner.

Q6: In the primary survey, what does "ABC" stand for? **A6**: "ABC" stands for Airway, Breathing, and Circulation.

Q7: How can you check a casualty's airway in the primary survey? **A7**: Tilt the casualty's head back and lift the chin to open the airway.

Q8: What should you do if a casualty is not breathing in the primary survey? **A8:** Start rescue breathing or CPR, depending on the situation.

Q9: In the primary survey, how do you assess circulation? **A9**: Check for signs of a pulse and severe bleeding.

Q10: What is the purpose of a secondary survey in first aid? **A10**: The secondary survey assesses and addresses non-life-threatening injuries and medical conditions.

Q11: What steps should you follow during a secondary survey? **A11**: Check for any other injuries, obtain a medical history (if possible), and provide appropriate care for identified conditions.

Q12: When should you reassess a casualty's condition in first aid? **A12**: Reassess the casualty's condition regularly to ensure their condition is not deteriorating.

**BURNS**

Q1: What is a burn? **A1**: A burn is an injury to the skin or underlying tissues caused by heat, chemicals, electricity, or radiation.

Q2: What are the three main types of burns? **A2**: The three main types of burns are first-degree burns, second-degree burns, and third-degree burns.

Q3: What should you do immediately for a burn? **A3:** For any burn, the immediate action is to cool the burn under running cool (not cold) water for about 10-20 minutes.

Q4: How do you differentiate between first-degree, second-degree, and third-degree burns? **A4**:

* First-degree burns: Superficial burns with redness and minor pain.
* Second-degree burns: Burns with blisters, redness, and moderate to severe pain.
* Third-degree burns: Full-thickness burns with white or charred skin, often painless due to nerve damage.

Q5: Should you pop blisters from a burn? **A5**: No, it's generally not recommended to pop blisters from a burn as it can increase the risk of infection. Keep the blister intact to protect the underlying skin.

Q6: How should you protect a burn wound after cooling it? **A6**: Cover the burn with a clean, non-stick bandage or a sterile dressing to prevent infection.

Q7: When should you seek medical attention for a burn? **A7**: Seek medical attention for burns if they are large, deep, on the face, hands, feet, genitals, or over major joints, or if there are signs of infection, like increased redness, swelling, or pus.

Q8: What should you do if clothing is stuck to a burn? **A8**: Do not try to remove stuck clothing. Instead, cut or carefully remove clothing from around the burn and leave any adhered fabric in place.

**HAEMORRHAGE**

Q: What is haemorrhage? **A**: Haemorrhage is the medical term for bleeding, often referring to excessive or uncontrolled bleeding.

Q: What are the common signs of external haemorrhage? **A**: Common signs of external haemorrhage include bleeding, swelling, and a visible wound.

Q: What is the first step in managing severe bleeding? **A**: The first step in managing severe bleeding is to apply direct pressure to the wound.

Q: How can you apply direct pressure to a bleeding wound? **A:** Use a clean cloth, bandage, or your hand to apply firm, continuous pressure directly over the bleeding site.

Q: When should you elevate a bleeding limb? **A:** Elevate a bleeding limb if it does not interfere with injury stabilization and if it helps control bleeding.

Q: What is a tourniquet, and when should it be used for bleeding control? **A:** A tourniquet is a device used to stop severe bleeding when direct pressure and other methods are ineffective or impractical. It should be a last resort and applied only when life-threatening bleeding cannot be controlled otherwise.

Q: How long can a tourniquet remain in place? A: **A** tourniquet should not remain in place for longer than 2 hours. Regularly reassess the need for the tourniquet and release it if bleeding is controlled.

Q: What is shock, and why is it a concern in haemorrhage cases? **A:** Shock is a life-threatening condition where the body's vital organs do not receive enough blood and oxygen. It's a concern in haemorrhage cases because severe bleeding can lead to shock.

Q: How can you help prevent shock in a haemorrhage victim? **A:** To prevent shock, keep the person lying down, elevate their legs if possible, and cover them with a blanket to maintain body heat.

Q: What information should you provide to emergency responders when calling for help in a haemorrhage situation? **A**: When calling for help, provide your location, the nature and severity of the bleeding, and any first aid measures already taken.

Q: What should you do if the bleeding doesn't stop despite initial first aid efforts? **A:** If bleeding continues despite initial first aid efforts, continue applying pressure and seek immediate medical assistance.

**Head Injury**

1. Question: What is the first step in assessing a head injury? **Answer**: The first step is to ensure scene safety and protect yourself from potential hazards.
2. Question: Why is it important to assess the level of consciousness in a head injury patient? **Answer**: Assessing consciousness helps determine the severity of the injury. A decreasing level of consciousness may indicate a more serious head injury.
3. Question: How should you manage a head injury patient who is unconscious but breathing? **Answer**: Place the patient in the recovery position to maintain an open airway while waiting for medical assistance.
4. Question: When should you suspect a skull fracture in a head injury patient? **Answer:** Suspect a skull fracture if there is bleeding from the ears, nose, or clear fluid (cerebrospinal fluid) leaking from the nose or ears.
5. Question: What is the purpose of immobilizing the neck in a head injury patient? **Answer:** Immobilizing the neck is essential to prevent any potential spinal cord injury if trauma to the head has occurred.
6. Question: How should you control bleeding from a scalp wound? **Answer**: Apply direct pressure to the wound using a sterile dressing or a clean cloth to control bleeding.
7. Question: What is the recommended treatment for a suspected concussion? **Answer:** Rest and close monitoring for any worsening symptoms are recommended for a suspected concussion. Seek medical evaluation.
8. Question: What signs should you look for to assess if a head injury patient is experiencing increased intracranial pressure (ICP)? **Answer**: Signs of increased ICP include severe headache, nausea and vomiting, altered mental status, and unequal pupil size.
9. Question: What should you advise a head injury patient regarding activities following their injury? **Answer:** Instruct the patient to avoid strenuous physical or mental activities, alcohol, and medications that can increase the risk of bleeding, and encourage them to follow up with a healthcare professional for further evaluation.

**Fractures and Sprains**

**1**. Question: What is the first step in providing first aid for a suspected fracture or sprain? **Answer:** The first step is to ensure the safety of the injured person and yourself. Check for any hazards in the area and approach the person cautiously.

**2.** Question: How can you distinguish between a fracture and a sprain during a first aid assessment? **Answer:** A fracture typically involves a broken bone, which may cause deformity, swelling, and severe pain. A sprain involves damage to ligaments and is characterized by swelling, bruising, and pain without bone deformity.

**3**. Question**:** What should you do if you suspect a bone is broken (fractured) in a first aid scenario? **Answer:** Immobilize the injured area by using a splint or improvised materials (e.g., a rolled-up newspaper or cardboard) to prevent movement, and call for professional medical help.

**4.** Question**:** In the case of a suspected sprain, what immediate first aid steps can be taken? **Answer:** Apply the R.I.C.E. method: Rest, Ice (apply ice wrapped in a cloth for 15-20 minutes), Compression (use an elastic bandage), and Elevation (elevate the injured limb above heart level) to reduce swelling and pain.

**5.** Question: What should you never do when providing first aid for fractures or sprains? **Answer:** Never try to realign a fractured bone or push it back into place. Also, avoid applying direct ice to the skin without a cloth or towel as it can cause frostbite.

**6.** Question: When should you encourage the injured person to seek professional medical attention for a fracture or sprain? **Answer:** Professional medical attention should be sought if there is significant deformity, an open wound with bone exposure, severe pain, or if the injury doesn't improve with initial first aid measures.

**7.** Question: How can you minimize the risk of further injury when assisting someone with a suspected fracture or sprain? **Answer:** Minimize movement of the injured area, support it with a splint or bandage, and be gentle when helping the person to prevent additional harm.

**8.** Question: What should you do if the injured person cannot move the injured limb due to pain or other reasons? **Answer:** Keep the limb in the position it was found and do not force movement. Immobilize it as best as possible and seek immediate medical help.

**9.** Question: Why is it essential to monitor the injured person's condition after providing first aid for a fracture or sprain? **Answer:** Monitoring allows you to assess for signs of complications such as infection, nerve damage, or impaired circulation. It also helps ensure that the injury is healing properly.

# EXAMPLE CASE STUDIES FOR TUTORIAL GROUPS AND OSCA

1. **Case Study: Child with Malnutrition**
2. **Case Study: Traumatic Injury in a rural setting**
3. **Case Study: Child with Gastroenteritis**
4. **Case Study: Snake Bite**
5. **Case Study: Febrile Convulsions**
6. **Case Study: 45-Year-Old Man with Myocardial Infarction**
7. **Case Study: 60-Year-Old Man with Pneumonia**
8. **Case Study: Oral Cancer**

**Teaching staff will need to add details to make case study relevant to their setting.**

**Case Study: Child with Malnutrition**

*Patient Information*:

* Name:
* Age:
* Gender:
* Date:
* Parent’s Name:
* Address:

*Chief Complaint*: The child is brought to the clinic with a chief complaint of severe malnutrition, as reported by the parent. The child's condition has deteriorated significantly over time, with notable symptoms including extreme weakness, emaciation, and signs of poor development.

*Present Illness*:

1. Duration of Malnutrition:
	* The parent reports that the child has been suffering from malnutrition for approximately [duration, e.g., 6 months].
2. Feeding History:
	* The child's diet primarily consists of [describe the usual diet, e.g., rice, water, occasional vegetables].
	* The parent states that they have been unable to afford or access adequate food and supplements for the child.
3. Weight Loss:
	* The child's weight has significantly decreased over time.
	* The parent is unable to provide the exact weight loss figures but reports that the child's clothes no longer fit.
4. Symptoms:
	* The child exhibits symptoms of severe malnutrition, including lethargy, irritability, sunken eyes, and protruding ribs.
5. Medical History:
	* No significant previous medical history is reported.
	* No known allergies.
6. Family History:
	* No known family history of chronic illnesses or genetic disorders.
7. Socioeconomic Status:
	* The family resides in a low-resource setting where access to healthcare, clean water, and proper nutrition is limited.
	* The family's income is well below the poverty line.

*Physical Examination*:

1. General Appearance:
	* The child appears lethargic and underweight.
	* Marked wasting and stunted growth.
2. Vital Signs:
	* Temperature: [record the temperature]
	* Heart Rate: [state the heart rate]
	* Respiratory Rate: [state the respiratory rate]
	* Blood Pressure: [state the blood pressure]
3. Anthropometric Measurements:
	* Weight: [state the weight]
	* Height/Length: [state the height/length]
	* Head Circumference: [state the head circumference]
4. Skin:
	* Dry, flaky, and may show signs of hyperpigmentation.
5. Eyes:
	* Sunken eyes, possibly with corneal changes.
6. Mouth:
	* Dry and pale mucous membranes.

*Laboratory Investigation*s:

* + Identify which are relevant and possible eg
1. Stool Examination:
	* To assess for parasitic infections, which are common in such settings.

*Diagnosis:* Severe acute malnutrition (SAM) with complications such as anaemia and electrolyte imbalances.

*Treatment and Management*:

According to PNG Guidelines and Standards

1. Stabilisation:
	* Initial management includes addressing dehydration and electrolyte imbalances, often with oral or intravenous rehydration.
2. Nutritional Rehabilitation:
	* Feeding schedules will be established and closely monitored.
3. Infection Control:
	* Management of any concurrent infections and prophylactic antibiotics may be given to prevent further complications.
4. Education and Counselling:
	* Parent will be educated about the importance of proper nutrition and hygiene.
5. Close Follow-Up:
	* Frequent monitoring of the child's progress will be essential.
6. Multidisciplinary Care:

*Prevention*: Long-term efforts should focus on improving living conditions, food security, and access to healthcare to prevent future cases of malnutrition.

**Case Study: Traumatic Injury in a rural setting**

Patient Information

* Name: John Walpiri
* Age: 32
* Gender: Male
* Occupation: Construction worker
* Location: Rural village
* Date of Incident:

*Presenting Complaint*: John Walpiri was brought to the local health centre after a motorbike accident. He was involved in a collision with another motorbike, resulting in a traumatic injury. The primary concerns are a fractured femur and a fractured right forearm.

*History:* John Walpiri was riding his motorbike on a gravel road when he collided with another bike. He was thrown off his bike and landed on his right side, causing significant trauma to his lower limb and forearm. Bystanders rushed to the scene and transported him to your clinic.

*Clinical Assessment*: Upon arrival at the health centre, John was conscious but in severe pain. The following clinical assessments were conducted:

1. Airway, Breathing, and Circulation (ABC) assessment: John's airway was clear, he was breathing spontaneously, and his pulse was regular.
2. Neurological examination: John was fully alert and oriented.
3. Primary Survey:
	* The patient's right leg showed signs of deformity and tenderness.
	* The right forearm was swollen and deformed.
4. Vital Signs:
	* Blood Pressure: 130/80 mmHg
	* Heart Rate: 90 bpm
	* Respiratory Rate: 18 breaths/min
	* Oxygen saturation: 98% on room air

*Diagnosis:* Based on clinical examination and initial X-rays, John Walpiri was diagnosed with the following injuries:

1. Fractured right femur.
2. Fractured right forearm.

*Treatment Plan*: The following treatment plan was initiated:

1. Stabilisation:
	* Immobilisation of the fractured right femur with a splint or traction.
	* Stabilisation of the fractured right forearm with a splint.
2. Pain Management:
	* If available, explain what is likely to be available
3. Wound Care:
	* The abrasions and open wounds on his right forearm were cleaned and dressed.
4. IV Fluids:
	* Decide if relevance
	* Transportation: If appropriate

**Case Study: Child with Gastroenteritis**

*Patient Background*: Name: Sarah Age: 5 years Gender: Female Location: A rural village Family: Sarah lives with her parents and two younger siblings. Her family has limited access to healthcare facilities and are very poor.

*Presenting Complaint*: Sarah was brought to a local community clinic with a chief complaint of persistent diarrhea, vomiting, and abdominal pain. Her symptoms began three days ago and have been progressively worsening.

*Medical History*: Sarah has no significant medical history, but she has experienced minor episodes of diarrhea in the past, which were usually self-limiting.

Social and Environmental Factors:

1. Sarah's family relies on farming for their livelihood.
2. They lack reliable access to clean drinking water and sanitation facilities, leading to poor hygiene practices.
3. The nearest health centre takes several hours to reach.

*Clinical Assessment*: Upon examination, the following clinical findings were noted:

1. Dehydration: Sarah appeared lethargic and had signs of moderate dehydration, including sunken eyes, dry mucous membranes, and decreased urine output.
2. Vital Signs: Her vital signs revealed a fast heart rate and low blood pressure.
3. Abdominal Pain: Sarah exhibited tenderness and discomfort in the lower abdomen upon palpation.
4. Diarrhea: She had watery diarrhea multiple times a day, leading to concerns of fluid and electrolyte loss.
5. Vomiting: She had vomited several times in the past 24 hours.

*Treatment*

1. Symptomatic Relief: Sarah was given antiemetic medication to control vomiting and antidiarrheal medication to alleviate diarrhea.
2. Nutrition: Her parents were advised to continue breastfeeding and provide small, easily digestible meals to maintain her nutritional status.
3. Hygiene Education: The family received education on improving hygiene practices, including handwashing and water purification methods.
4. Follow-Up: Sarah's parents were advised to return to the clinic if they were worried.

Outcome: Sarah's parents diligently followed the treatment plan and hygiene recommendations. Over the course of a week, her symptoms gradually improved, and she showed signs of rehydration. Within a few days, she was hydrated and had no abdominal discomfort or diarrhea. The family continued to focus on maintaining proper hygiene and safe water practices to prevent future episodes of gastroenteritis.

**Case Study: Snake Bite**

Patient Information:

* Name: Joseph
* Age: 22 years
* Gender: Male
* Location: Village
* Occupation: Council worker

*Presenting Complaint*: John was brought to the local clinic by family members with a complaint of a snake bite. He reported that he was working in his garden when he accidentally stepped on a snake, which bit him on the lower leg. The snake was not identified.

*Clinical Presentation:* On examination, Joseph appeared anxious and in pain. The following clinical findings were noted:

1. Local Effects:
	* Fang marks on the lower leg.
	* Swelling and redness around the bite site.
	* Mild bleeding from the bite wounds.
	* Pain at the site of the bite, radiating up the leg.
2. Systemic Effects:
	* Increased heart rate and blood pressure.
	* Nausea and vomiting.
	* Mild sweating.
	* No signs of respiratory distress.

*Initial Management*: Given the limited resources in the rural clinic, the following initial management steps were taken:

1. Immobilisation: Joeph’s bitten leg was immobilised to minimise the spread of venom.
2. Restriction of Movement: He was advised to minimise movement to slow down the circulation of venom.
3. Tourniquet: A tourniquet was applied above the bite site to restrict blood flow.
4. Wound Care: The bite wounds were cleaned with soap and water to prevent infection.
5. Pain Management: John was given pain relief medication.
6. Transport: Is it possible to transport Joseph.

*Recommendations:* adjust as needed. The points below make good discussion points for class discussions

1. Immediate Referral: It is essential to refer the patient to a higher-level healthcare facility with snakebite expertise and access to antivenom.
2. Education and Prevention: Educate the local community about snakebite prevention, appropriate footwear, and early presentation to healthcare facilities.
3. Stock Antivenom: Advocate for stocking essential medical supplies, including antivenom, at rural clinics to improve preparedness for snakebite cases.
4. First Aid Training: Train healthcare providers and community members in basic first aid for snakebites, including appropriate wound care and immobilization techniques.
5. Improve Transportation: Work to improve the transportation infrastructure to reduce delays in reaching higher-level healthcare facilities.

**Case Study: Febrile Convulsions**

**Patient Information:**

**Name:** Mary **Age:** 2 years **Gender:** Female **Location:** A rural village **Family Background:** Sarah comes from a low-income family with limited access to healthcare.

**Presenting Complaint:**

Mary was brought to the local clinic by her mother with a history of a fever and a seizure episode.

**History:**

Mary's mother reported that she had been experiencing a fever for the past two days, with her feeling very hot with dry flushed skin. Her mother also observed that Sarah was unusually irritable and lethargic during this time.

**Clinical Examination:**

Upon examination at the local clinic, the following findings were noted:

* Mary had a high fever (39.2°C) at the time of examination.
* She was responsive after the convulsion, but lethargic and drowsy.
* No signs of meningeal irritation were noted.
* No significant focal neurological deficits were observed.

**Diagnosis:**

Based on her clinical presentation, Mary was diagnosed with febrile convulsions, which are seizures that occur in children due to high fever. These seizures are typically benign and do not cause any long-term neurological damage.

**Treatment and Management:**

The clinic faces a number of challenges in managing Mary's condition:

1. **Limited Diagnostic Resources:** Diagnosis is based on clinical presentation and the history provided by the mother.
2. **Anti-Pyretic Medication:** The primary focus of treatment is to reduce Mary's fever and prevent further seizures. Ideally she should be paracetamol to lower her temperature. If there is no paracetamol, then tepid baths should be given.
3. **Reassurance and Education:** Mary's mother was educated about febrile convulsions, their benign nature, and how to manage them at home. She was reassured that these seizures typically resolve as the child grows older.
4. **Follow-up Care:** Due to limited resources, the clinic had to rely on the mother's ability to monitor Marys fever and seek care if necessary. The importance of seeking help if the fever persisted or if seizures recurred was emphasised.
5. **Community Health Worker Involvement:** Given the remote location, local health workers played a crucial role in monitoring Mary's progress and providing support to the family.

**Outcome:**

Mary's fever subsided, and she did not experience another seizure during her follow-up period. Her mother was empowered with the knowledge and resources to manage her fever at home and knew when to seek medical help if necessary.

**Discussion:**

This case study highlights the challenges of managing febrile convulsions in a low-resource setting. Community involvement and education are crucial in ensuring that caregivers can manage febrile convulsions effectively, given the limited access to healthcare services.

**Case Study: 45-Year-Old Man with Myocardial Infarction**

*Patient Information*:

* Name: John, Age: 45 years, Gender: Male
* Occupation: Labourer
* Location: A rural area in a low-resource environment

*Presenting Complaint*: John presented to a local clinic in a rural area with severe chest pain that had been ongoing for the past 3 hours. He described the pain as crushing, radiating to his left arm, and associated with shortness of breath and diaphoresis. His friend brought him to the clinic after he became concerned about John's condition.

*Background Information*: John is a 45-year-old labourer who works long hours in physically demanding conditions. He has a history of smoking a pack of cigarettes per day for the past 20 years. He has not had any regular medical check-ups, and this is his first encounter with healthcare services in several years due to the lack of nearby medical facilities in his rural area. He has no known history of chronic diseases, and his family has a history of heart disease.

*Clinical Assessment*: Upon arrival at the clinic, the medical team assessed John's condition:

1. Vital Signs:
	* Blood Pressure: 160/95 mm Hg
	* Heart Rate: 100 beats per minute
	* Respiratory Rate: 22 breaths per minute
	* Temperature: 37°C (98.6°F)
	* Oxygen Saturation: 95% on room air
2. Physical Examination:
	* John appeared anxious and in significant distress.
	* There were signs of diaphoresis (sweating) on his forehead.
	* On auscultation, crackles were heard in his lung bases.
	* His chest was mildly tender on palpation, and there were no murmurs or abnormal heart sounds.
3. ECG (Electrocardiogram):
	* ECG showed ST-segment elevation in leads II, III, and aVF, consistent with an inferior wall myocardial infarction (MI).

*Diagnosis*: John was diagnosed with an inferior wall myocardial infarction based on his clinical presentation and ECG findings.

*Management and Plan*: The following steps were taken:

1. **Immediate Oxygen Therapy**: John was provided with supplemental oxygen to maintain oxygen saturation above 90%.
2. **Sublingual Aspirin**: He was given aspirin (chewed) to reduce platelet aggregation.
3. **Pain Management**: Intravenous morphine was administered for pain relief.
4. **Nitroglycerine**: Sublingual nitroglycerine was provided to relieve chest pain.
5. **Continuous Monitoring**: John was placed on a cardiac monitor for continuous observation of his ECG and vital signs.
6. **Transport Planning**: Plans were made to transport John to a better-equipped hospital for further evaluation and potential angiography or coronary artery bypass surgery if necessary.

**Case Study: 60-Year-Old Man with Pneumonia**

*Patient Information*:

* Name: Mr. John Smith
* Age: 60 years
* Gender: Male
* Occupation: Retired construction worker
* Residence: Rural village in a low-resource environment
* Medical History: Chronic smoking for 20 years

*Presenting Complaint*: Mr. John Smith presented to the local health clinic with complaints of fever, cough, and difficulty breathing for the past five days. He reported a persistent productive cough with yellowish sputum and a high-grade fever.

*History of Present Illness*: Mr. Smith's symptoms started insidiously with a mild sore throat, which progressed to a persistent cough. He also developed a high fever, fatigue, and difficulty breathing over the course of several days. His family members reported that he had lost his appetite and had become increasingly lethargic. There was no known recent exposure to tuberculosis, and no history of recent travel.

*Medical History*:

1. Smoking: Mr. Smith has a 20-year history of cigarette smoking, averaging a pack a day. He has not attempted to quit smoking in the past.
2. Chronic Obstructive Pulmonary Disease (COPD): He has had a chronic cough and occasional shortness of breath for several years, but he has never sought medical attention for it.
3. Hypertension: Diagnosed 5 years ago and intermittently taking medication when available.
4. No known allergies.
5. No history of pneumonia or other serious respiratory illnesses in the past.

*Social History*:

1. Living Conditions: Mr. Smith resides in a rural village with limited access to healthcare facilities and infrastructure. He lives in a small, poorly-ventilated house with his wife.
2. Occupation: He worked as a construction labourer for most of his life but is now retired.
3. Smoking: Despite being aware of the health risks associated with smoking, Mr. Smith has been unable to quit due to a lack of support and resources.

*Physical Examination*: On physical examination, Mr. Smith appeared acutely ill. Key findings included:

* Elevated body temperature (39.5°C).
* Increased respiratory rate (26 breaths per minute) with signs of respiratory distress.
* Reduced breath sounds and coarse crackles on lung auscultation.
* Increased heart rate (110 beats per minute) with blood pressure slightly elevated.
* Generalized weakness and pallor.
* No evidence of clubbing, cyanosis, or lymphadenopathy.
* The rest of the physical examination was unremarkable.

*Diagnosis:* Based on the clinical presentation, medical history, and examination findings, Mr. Smith was diagnosed with community-acquired pneumonia, likely secondary to his chronic smoking and underlying COPD.

*Management*: In the low-resource environment of Mr. Smith's village, managing pneumonia poses unique challenges. The following steps were taken:

1. Supportive Care: Mr. Smith was provided with a bed, clean water, and nutrition to improve his general condition.
2. Antibiotics: Due to limited diagnostic capabilities, empiric antibiotic therapy with a broad-spectrum antibiotic (such as amoxicillin) was initiated.
3. Oxygen Therapy: Oxygen was administered via a simple mask to relieve his respiratory distress.
4. Smoking Cessation Counselling:The healthcare provider offered counselling to encourage Mr. Smith to quit smoking.
5. Blood Pressure Management: His blood pressure medication was adjusted.
6. Monitoring: Regular monitoring of vital signs and oxygen saturation was initiated.
7. Education: Mr. Smith and his family were educated about the importance of completing the antibiotic course, maintaining hygiene, and seeking prompt medical care if symptoms worsened.

*Follow-up*: Mr. Smith was advised to return to the clinic for follow-up and further evaluation after completing his antibiotic course. Long-term strategies for managing his COPD and quitting smoking were discussed, though the challenges in this low-resource setting remained substantial.

**Case Study: Oral Cancer**

*Introduction:* Papua New Guinea (PNG) is a country where the consumption of betel nut is deeply rooted in the culture. However, this practice has significant health implications, with an increasing number of individuals developing oral cancer due to long-term betel nut chewing. This case study focuses on a man named John, who faced the consequences of chewing betel nut over a long time.

*Patient Profile*: Name: John Jones Age: 52 years Gender: Male Location: Rural village Occupation: Farmer

*Background:* John had been chewing betel nut for over three decades, having started during his adolescence. He often combined betel nut with slaked lime and mustard leaves, which is a common practice in his community. Over the years, he noticed changes in the appearance of his mouth, including discoloured patches, persistent ulcers, and pain while swallowing. He did not seek medical attention initially, as traditional remedies were often preferred over modern healthcare services in his community. However, as his condition worsened, he decided to seek help from the local health centre.

*Diagnosis and Staging*: Upon examination at the local health centre, John was diagnosed with oral cancer. The cancer had progressed significantly, affecting his lower lip and oral cavity. Due to limited resources and infrastructure, it was challenging to perform in-depth diagnostic tests like CT scans or MRI. However, clinical assessment, including biopsy, confirmed the diagnosis of squamous cell carcinoma.

*Treatment Challenges*: John's case posed significant challenges in a low-resource setting like rural PNG:

1. Limited Medical Infrastructure: The health centre lacked the resources for comprehensive cancer treatment, such as radiation therapy or advanced surgical interventions.
2. Accessibility: Access to specialized cancer care facilities was hindered by the remote location of John's village, which required traveling long distances.
3. Lack of Awareness: Many people in his community, including John, had limited knowledge about the health risks associated with betel nut chewing and the importance of early medical intervention.

*Treatment Plan*: Despite the limitations, the healthcare team developed a treatment plan for John:

1. Surgery: John underwent surgery to remove the cancerous tissues from his lower lip and oral cavity, which aimed to prevent further spread.
2. Palliative Care: Given the advanced stage of his cancer, the focus of his treatment shifted towards palliative care. Pain management and nutritional support were provided to improve his quality of life.
3. Education and Awareness: Health professionals engaged in community outreach programs to raise awareness about the health risks of betel nut chewing and the importance of early diagnosis and treatment.

*Outcome*: John's case highlighted the challenges of managing oral cancer in low-resource settings like rural PNG. Despite the limitations, the healthcare team's efforts improved John's quality of life, reduced his pain, and offered emotional support to him and his family. His case also helped create awareness in the community about the dangers of betel nut chewing, potentially preventing future cases of oral cancer.

*Conclusion:* Oral cancer cases, like John's, remain a significant health concern in settings where betel nut chewing is prevalent. Addressing this issue requires a multi-pronged approach, including increased awareness, improved access to healthcare, and better infrastructure for diagnosis and treatment. John's case serves as a reminder of the urgent need for such initiatives to combat oral cancer in communities like his in Papua New Guinea.