Community Health Nursing Department **Faculty of Nursing**

Community Health Nursing Log Book For Fourth Year Students

2023-2024

CONTENTS

Observation checklist

Of: Clean and arrangement of Nursing Bag

Procedure Steps	1	2	3
1. Remove all equipment from the bag(Inventory of the bag), check and refilled the bottles.			
2. Wash and sterilize the equipment. .			
3. Clean the bag from inside & outside.			
4. Place the bag on a clean surface (not the floor).			
5. Hand washing and wear gloves			
6. Arrangement of equipment: from (frequently used above less frequently used**.**			
7. Hand washing.			
8. Oral thermometer in the far right side.			
9. Rectal thermometer in the far left side.			
10. **Bottles:** of baby oil or vaseline at **right side.**			
11. **Bottles:** of alcohol- Betadine -Acetic acid & Benedict at **left side.**			
12. Metal container (with all its contents) at the bottom of the bag.			
13. Sphygmomanometer, stethoscope.			
14. Baby diaper, baby scale & 4-6 safety pins.			
15. Muslin bag.			
16. Apron.			
17. Paper bags.			
18. Soap at (dish) – 2 hand towel - 2 fanfold.			
19. Note book, pencil, health education materials at external pocket of the bag.			
20. Remove gloves			
Dr. Signature: **Student's Sig.** **Date :**			

Observation checklist

Of: Ante natal care at home first Visit (8-12 weeks)

Procedure Steps	1	2	3
Preplanning phase:			
1. Review of the family's chart.			
2. Prepare nursing care plan.			
3. Contact the family to set up appropriate time for home visit.			
4. Prepare necessary supplies & equipment.			
5. Ensure the equipment are functioning properly.			
6. Prepare nursing bag.			
Initiation Phase:			
7. Knock on the door & gain entrance into the residence.			
8. Introduce self, other colleague and the agency.			
9. Clearly states the expected purpose of the visit.			
10. Allow a few moments of socialization before beginning the visit.			
11. Ask the family if there is a pressing concern that they would like to deal with first, and if so, follows their needs.			
12. If this is the first visit, discuss expectations and management of future visits.			
Implementation Phase:			
13. Place the bag on a clean surface (not on the floor).			
14. Wash hands before removing equipment from the bag.			
15. Wear apron.			
16- Assessment the following: 1- History.			
2- Client's environment. 3- Psychosocial needs.			
4- Medication.			
5- Nutrition.			
17- Carry out the prepared procedures: 1-Take vital signs.			

2-General examination (as chest, neck observation of skin and hair and vital signs).			
3- Weight the mother.			
18- Health education for mother by using appropriate methods & materials in the instruction process. which includes: • Nutrition.			
• Cloths.			
• Hygiene (personal and environmental).			
• Rest and sleep.			
• Fresh air.			
• Work.			
• Marital relation.			
• Smoking.			
• Medication.			
• Danger signs.			
19- Wash hands between family members.			
20- Clean, dispose contaminated materials. The client & caregivers should be taught proper management of contaminated wastes & rational behind such management.			
21- Replace the equipment.			
Termination phase:			
22- Briefly summarizes the plan of care both procedures and health education that implemented with the family.			
23- Set up a time & the purpose for the next home visit.			
Post home visit and preplanning phase:			
25. Record home visit in complete, concise, & accurate manner.			
24. Communicate finding to other health care provider (report any abnormalities).			
Dr. Signature: **Student's Sig.** **Date:**			

Observation checklist

Of: Ante natal care at home Second Visit (24 -26 weeks)

Procedure Steps	1	2	3
Preplanning phase:			
1. Review of the family's chart.			
2. Prepare nursing care plan.			
3. Contact the family to set up appropriate time for home visit.			
4. Prepare necessary supplies & equipment.			
5. Ensure the equipment are functioning properly.			
6. Prepare nursing bag.			
Initiation Phase:			
7. Knock on the door & gain entrance into the residence.			
8. Clearly states the expected purpose of the visit.			
9. Allow a few moments of socialization before beginning the visit.			
10. Ask the family if there is a pressing concern that they would like to deal with first, and if so, follows their needs.			
Implementation Phase:			
11. Place the bag on a clean surface (not on the floor).			
12. Wash hands before removing equipment from the bag.			
13. Wear apron.			
14**.** Carry out the prepared procedures: 1- Take vital signs.			
2- General examination as examine the legs for edema.			
3- Local examination as (abdominal and breast examination).			
4- Weight the mother.			
5- Test urine for albumin.			
15. Health education for mother by using appropriate methods & materials in the instruction process. which includes:			

• Danger signs (as edema of lower limb or face, persistent headache, blurring of vision and severe abdominal pain).			
• Immunization (tetanus immunization schedule).			
• Exercises as (mild house work and walking).			
• Nutrition.			
• Personnel hygiene.			
• Clothes.			
16- Wash hands between family members.			
17- Clean, dispose contaminated materials. The client & caregivers should be taught proper management of contaminated wastes & rational behind such management.			
18- Replace the equipment.			
Termination phase:			
19- Briefly summarizes the plan of care both procedures and health education that implemented with the family			
20- Set up a time & the purpose for the next home visit			
Post home visit and preplanning phase:			
21-Record home visit in complete, concise, & accurate manner.			
22- Communicate finding to other health care provider (report any abnormalities)			
Dr. Signature: **Student's Sig.** **Date:**			

Observation checklist

Of: Ante natal care at home Third Visit (32 weeks)

Procedure Steps	1	2	3
Preplanning phase:			
1. Review of the family's chart.			
2. Prepare nursing care plan.			
3. Contact the family to set up appropriate time for home visit.			
4. Prepare necessary supplies & equipment.			
5. Ensure the equipment are function properly.			
6. Prepare nursing bag.			
Initiation Phase:			
7. Knock on the door & gain entrance into the residence			
8. Clearly states the expected purpose of the visit.			
9. Allow a few moments of socialization before beginning the visit.			
10. Ask the family if there is a pressing concern that they would like to deal with first, and if so, follows their needs.			
Implementation Phase:			
11. Place the bag on a clean surface (not on the floor).			
12. Wash hands before removing equipment from the bag.			
13. Wear apron.			
14**.** Carry out the prepared procedures : 1- Take vital signs.			
2- General examination as examine the legs for edema.			
3- Local examination as (abdominal and breast examination).			
4- Weight the mother.			
5- Test urine for albumin.			
15. Health education for mother by using appropriate methods & materials in the instruction process. which includes: • Danger signs (as edema in lower limb or face, persistent headache, blurring of vision and sever abdominal pain).			

• Signs of labor (contracted uterus with regular interval and frequency, presence of show and pain in lower back and extended to abdomen).			
• Place of delivery.			
• Exercises (mild house work and walking).			
• Nutrition.			
16- Wash hands between family members.			
17- Clean, dispose contaminated materials. The client & caregivers should be taught proper management of contaminated wastes & rational behind such management.			
18- Replace the equipment.			
Termination phase:			
19- Briefly summarizes the plan of care both procedures and health education that implemented with the family			
20- Set up a time & the purpose for the next home visit			
Post home visit and preplanning phase:			
21-Record home visit in complete, concise, & accurate manner.			
22. Communicate finding to other health care provider (or report any abnormalities).			
Dr. Signature: **Student's Sig.** **Date:**			

Observation checklist

Of: Ante natal care at home Fourth Visit (36-38 weeks)

Procedure Steps	1	2	3
Preplanning phase:			
1. Review of the family's chart.			
2. Prepare nursing care plan.			
3. Contact the family to set up appropriate time for home visit.			
4. Prepare necessary supplies & equipment.			
5. Ensure the equipment are function properly.			
6. Prepare nursing bag.			
Initiation Phase:			
7. Knock on the door & gain entrance into the residence.			
8. Clearly states the expected purpose of the visit.			
9. Allow a few moments of socialization before beginning the visit.			
10. Ask the family if there is a pressing concern that they would like to deal with first, and if so, follows their needs.			
Implementation Phase:			
11.Place the bag on a clean surface (not on the floor).			
12.Wash hands before removing equipment from the bag.			
13.Wear apron.			
14.Carry out the prepared procedures. 1- Take vital signs.			
2- General examination as examine the legs for edema.			
3- Local examination as (abdominal and breast examination).			
4- Weight the mother.			
5- Test urine for albumin.			
6- Observe danger signs.			
15- Health education for mother by using appropriate methods & materials in the instruction process. which includes: • Signs of labor (contracted uterus with regular interval and frequency, presence of show and pain in lower back and extended to abdomen).			

• Place of delivery.			
• Relaxation and breathing exercises for preparation of labor.			
• Family planning.			
• Breast care technique for preparation of breast feeding.			
• Nutrition.			
• Care of the baby as clothes, bathing, eye and cord care.			
16- Wash hands between family members.			
17- Clean, dispose contaminated materials. The client & caregivers should be taught proper management of contaminated wastes & rational behind such management.			
18- Replace the equipment.			
Termination phase:			
19- Briefly summarizes the plan of care both procedures and health education that implemented with the family			
20- Set up a time & the purpose for the next home visit			
Post home visit and preplanning phase:			
21- Record home visit in complete, concise, & accurate manner			
22- Communicate finding to other health care provider (report any abnormalities).			
Dr. Signature: **Student's Sig.** **Date:**			

Observation Checklist

Of: Post-partum care first visit

Procedure Steps	1	2	3
1. Hand washing.			
2. Prepare necessary equipment and supply.			
3. Ensure the equipment are functioning properly.			
4. Contact mother according to the time schedule.			
5. Prepare Nursing care plan.			
6. Prepare Nursing Bag			
7- Procedure: First visit (1st postpartum day).			
For the mother:			
8. wash hands			
9. wear apron and gloves			
10. Check vital signs.			
11. Estimate the Fundal level (immediately after labor uterus above umbilicus level (1/U) and then decrease 1finger/day.)			
12. Ask about Lochia (rubra, red color), bleeding, urine and bowel movement.			
13. Episiotomy care (if performed).			
14. Check the condition of the lower extremities for deep venous thrombosis.			
15. Assess the condition of the breast (engorgement, observe nipple for crackles, inverted, or flat)			
11.Remove gloves			
For baby:			
12.Wash hands and wear gloves			
18. Assessment of baby condition (APGAR score) A : Appearance P: Pulse			

G: Grimes (reflexes) A: Activity (muscle tone). R: Respiration			
19.Take anthropometric measurement (Weight, length, head and chest circumference).			
20. Assess the eye condition (as jaundice, pupils react to light, blink reflex).			
21. Make cord dressing.			
Post Procedure Activities:			
22. Remove gloves and wash hands.			
23.Educate the mother for: 1. Early ambulation 2. Nutrition. 3. Breast-feeding. 4. Rest & sleep. 5. Postpartum exercise. 6. Personal hygiene 7. New born care (as skin, eye, ear, and diaper care).			
24. Clean and dispose contaminated materials.			
25. Replace Equipment.			
26. Terminate the Visit			
27. Make appointment for the next visit.			
28. Record all data about the mother and the newborn.			
29. Report & communicate findings to MCH.			
Dr. Signature: **Student's Sig.** **Date:**			

Observation Checklist

Of: Post-partum care second visit

Procedure Steps	1	2	3
1. Hand washing.			
2. Prepare necessary equipment and supply.			
3. Ensure the equipment are functioning properly.			
4. Contact mother according to the time schedule.			
5. Prepare Nursing Bag.			
6. Prepare Nursing care plan.			
7-Procedure second visit (3^{th} postpartum day).			
8. wash hands			
9. wear apron and gloves			
10. Assess the mother's general condition (as appearance, color and ambulation).			
11. Check vital signs.			
12. Estimate the Fundal level (U/1).			
13. Check Lochia (rubra), and perineal condition.			
14. Check flow of milk and breast condition for engorgement.			
15.Remove gloves			
For baby			
16.Wash hands and wear gloves			
17. Check vital signs.			
18. Make baby bath.			

19. Make cord care.			
20. Assess color of skin for jaundice.			
Post procedure activities			
21. Remove gloves and wash hands.			
22. Educate the mother for: • Personal hygiene. • Rest & sleep. • Postpartum exercise. • Breast-feeding. • Nutrition.			
23. Clean and dispose contaminated materials.			
24. Replace Equipment.			
25. Terminate the Visit			
26. Make appointment for the next visit.			
27. Record all data about the mother and the newborn.			
28. Report & communicate findings to MCH.			
Dr. Signature: **Student's Sig.** **Date:**			

Observational Checklist

Of: Post-partum care third visit

Procedure Steps	1	2	3
1. Hand washing.			
2. Prepare necessary equipment and supply.			
3. Ensure the equipment are functioning properly.			
4. Contact mother according to the time schedule.			
5. Prepare Nursing Bag.			
6. Prepare Nursing care plan.			
7-Procedure Third visit (5^{th} postpartum day).			
For mother			
8. wash hands			
9. wear apron and gloves			
10. Assess mother's general condition (as appearance, color and ambulation).			
11. Check the vital sign.			
12. Check the level of the fundus (U/3).			
13. Check the Lochia (serosa, pale color).			
14. Check the breast condition for engorgement.			
15. Ensure the mother is assuming normal activities.			
16. Remove gloves			
For baby:			
17.Wash hands and wear gloves			
18. Check vital signs.			
19. Make cord care.			

Post procedure activities			
20.Remove gloves and wash hands			
21. Educate the mother for: 1- Personal hygiene. 2- Rest & sleep. 3- Postpartum exercise. 4- Breast-feeding. 5- Nutrition.			
22. Clean and dispose contaminated materials.			
23. Replace Equipment.			
24. Terminate the Visit			
25. Make appointment for the next visit.			
26. Record all data about the mother and the newborn.			
27. Report & communicate findings to MCH.			
Dr. Signature: **Student's Sig.** **Date:**			

Observational Checklist

Of: Post-partum care fourth visit

Procedure Steps	1	2	3
1. Hand washing.			
2. Prepare necessary equipment and supply.			
3. Ensure the equipment are functioning properly.			
4. Contact mother according to the time schedule.			
5. Prepare Nursing Bag.			
6. Prepare Nursing care plan.			
7- Procedure Fourth visit (7^{th} postpartum day).			
For mother			
8. wash hands			
9. wear apron and gloves			
10. Assess mother's general condition (as appearance, color of skin and ambulation).			
11. Check the vital sign.			
12. Check the level of the fundus (U/5).			
13. Check the Lochia serosa.			
14. Check the breast condition.			
15. Remove gloves			
For baby:			
16.Wash hands and wear gloves			
17. Check vital signs.			
18. Weight the baby.			

19. Check the cord drop.			
20. Newborn care (as eye, ear, and diaper care).			
Post procedure activities			
21. Remove gloves and Wash hands			
22. Educate the mother for: 1- Personal hygiene. 2- Rest & sleep. 3- Postpartum exercise. 4- Breast-feeding. 5- Nutrition.			
23. Clean and dispose contaminated materials.			
24. Replace Equipment.			
25. Terminate the Visit			
26. Make appointment for the next visit.			
27. Record all data about the mother and the newborn.			
Dr. Signature: **Student's Sig.** **Date:**			

Observational Checklist

Of: Mantoux skin test

Steps	1	2	3
1. Wash your hand.			
2. Gather your equipment.			
3. Prepare the vial contains tuberculin.			
4. Explain the procedure to the client.			
5. Wearing gloves			
6. Place forearm palm side up on a firm, well-lit surface			
7. Select an area free of barriers (e.g., scars, sores) to placing and reading			
8. Clean the area with an alcohol swab			
9. Check expiration date on vial and ensure vial contains tuberculin (5 TU per 0.1 ml)			
10. Use a single-dose tuberculin syringe with a ¼- to ½-inch, 27-gauge needle with a short bevel			
11. Fill the syringe with 0.1 ml of tuberculin			
12. Insert slowly, bevel up, at a 5- to 15-degree angle Needle bevel can be seen just below skin surface			
13. After injection, a tense, pale wheal should appear over the needle			
14. Wheal should be 6 to 10 mm in diameter. If not, repeat test at a site at least 2 inches away from original site			

15. Do not recap the needle. Discard it in the sharp boxes.			
16. Assist the client to return to a comfort position.			
17. Remove the glove & wash hands.			
18. Record all the information required for documentation (e.g., date and time of test administration, injection site location, lot number of tuberculin)			
19. Visually inspect site under good light			
20. Use fingertips to find margins of induration			
21. Use fingertip as a guide for marking widest edges of induration across forearm			
22. Place “0” ruler line inside left dot edge			
23. Read ruler line inside right dot edge (use lower measurement if between two gradations on mm scale)			
24. Record measurement of induration in mm			
Dr. Signature: **Student's Sig.** **Date :**			

Observation Checklist

Of: First Aid at School for Nose Bleeding (EPISTAXIS)

Procedure steps	1	2	3
1- Prepare necessary equipment and supplies.			
2-Ensure the equipment is functioning properly.			
3- Place the child in appropriate position			
4- Maintain body mechanic			
5- Have an assistant.			
Immediate First Aid for nose bleeding			
6- Wash hand			
7- Sit the student erect with the head tilted forward slightly.			
8-Apply aseptic techniques			
9- Apply simple pressure to the sides of the nose by grasping it with thumb and forefinger (pinch the soft part of the nose).			
10- Place cold packs on the nose.			
11- Release the pressure after 10 minutes. If the bleeding has not stopped, continue pressure for a further 10 minutes, or as necessary			
12- Clean the nose by wet cotton after bleeding stopped.			
13- When the bleeding stops, tell the student to avoid exertion.			

14- Seek medical aid. If after 30 minutes the bleeding persists or recurs			
Post Procedure Activities:			
15- Provide reassurance for the child			
16- Measure Vital Signs.			
17- Record the results in complete, concise and accurate manner in the child file.			
18- Reporting of any abnormality.			
19- Wash hands after removing equipment.			
Dr. Signature **Student's sig.** **Date**			

Observation Checklist

Of: First Aid at School for Burn

Procedure steps	1	2	3
1- Prepare necessary equipment and supplies.			
2-Ensure the equipment is functioning properly.			
3- Place the child in appropriate position			
4- Maintain body mechanic			
5- Have an assistant.			
Immediate First Aid for Burn			
6- Wash hand.			
7- Apply aseptic techniques			
8- Remove hot or burned cloth.			
9- Reassure the child.			
10- If burn is 1st degree - Put cold or tape water only. - Cover the burns loosely with clean clothes. - Protect the area from the sun			
11- If burn is 2nd degree - Use saline or tap water with antiseptic solution.			

- Remove jewelry or clothing that could become too tight if the area swells. - Don't break blisters. - Cover loosely with sterile, nonstick bandage - Separate burned toes and fingers with dry, sterile dressings. 12- If burn is 3rd degree - Do not soak the burn with water. - Do not remove clothing that is stuck to the area. - Cover the area with a sterile bandage or a clean loose cloth.			
13- Check vital signs.			
14- Assess the child for chilling, fatigue consciousness.			
15- Seek medical aid.			
Post Burn procedures:			
16- Provide reassurance for the child			
17- Measure Vital Signs.			
18- Record the results in complete, concise and accurate manner in the child file.			
19- Reporting of any abnormality.			
20- Wash hands after removing equipment.			
Dr. Signature **Student's sig.** **Date**			

Observation Checklist

Of: First Aid at School for Simple Fracture

Procedure steps	1	2	3
1- Prepare necessary equipment and supplies.			
2-Ensure the equipment is functioning properly.			
3- Place the child in appropriate position			
4- Maintain body mechanic			
5- Have an assistant.			
6- Explain the procedure to the child, instructor.			
Immediate First Aid for fracture			
7- Hand washing.			
8- Apply aseptic techniques			
9- Keep the child comfortable.			
10- Gentle handling of the fractured part.			
11- Place splint under the fracture part			
12- Apply adequate supports before and after the fracture part			
13- Keep the child warm.			
14- **Do not**:- • Attempt to set the bone in anatomical position. • Massage the affected area. • Move without support to broken bone. • Move joints above / below the fracture. • Give oral liquids / food.			
15- Assess the child for chilling, fatigue and consciousness.			

Post fracture procedures:			
16- Provide reassurance for the child			
17- Measure Vital Signs.			
18- Record the results in complete, concise and accurate manner in the child file.			
19- Reporting of any abnormality.			
20- Wash hands after removing equipment.			
Dr. Signature **Student's sig.** **Date**			

Observation Checklist

Of: Distance Vision Test (Snellen chart)

Procedure steps	1	2	3
1. Prepare necessary equipment			
2. Explain the procedure to the client.			
3. Wash and dry the occluder. If no plain occluder is available, ask the patient to wash his/her hands.			
4. Perform the vision test in a room that is well-lighted			
5. Use the Snellen chart containing various sized			
6. Position the client (6 meter) in front of the chart			
7. Direct him/her to cover the left eye start reading from the top of the chart to the smallest line of print possible. Then, repeat with the right eye.			
8. If the client wears glasses, first test with glasses, then without glasses			
9. Record the result in complete, concise, and accurate manner			
10. Report of finding to other health care provider (clinical instructor)			
Dr. Signature **Student's signature** **Date**			

Observation Checklist

Of: First Aid for Heat stroke

Steps	1	2	3
1. Prepare necessary equipment and supplies.			
2. Ensure the equipment is functioning properly			
3. Place the child in appropriate position			
4. Maintain body mechanic			
5. Have an assistant.			
6. Explain the procedure to the patient, instructor			
Immediate First Aid for Heat stroke			
7. Assess the patient's cardiopulmonary status, and evaluate for signs and symptoms of heat stroke.			
8. Measure vital signs			
9. Open the patient's airway as necessary; keep the patient's feet elevated.			
10. Cool the patient's body as quickly as possible in the following manner: a. Remove the clothing; spray the entire body with water while air is passed across the body with fans or by other means. b. If necessary, immerse the patient in cold water or pack him or her in ice; place ice packs in the axillae and groin areas and fan the patient; wet down the body with sheets or towels (keep the clothes wet with cool water)			
11. Continue the cooling procedure until the patient's temperature drops to 102° F. Stop at this point to prevent seizures and hypothermia.			
12. Do not give the person anything per mouth.			
13. Activate Emergency medical services (EMS) if the patient experiences unstable cardiopulmonary status or decreased level of consciousness. Stay with the patient until EMS assumes responsibility.			
14. Notify the physician for further orders.			
Post procedures			
15. Provide patient comfort measures.			
16. Clean and replace the equipment.			
17. Discard disposable items according to Standard Precautions.			
18. Refer the patient to hospital.			
19. Report and Document			
Dr. Signature **Student's sig.** **Date**			

Observation Checklist

Of: First Aid for Snake Bite

Steps	1	2	3
1. Prepare necessary equipment and supplies.			
2. Ensure the equipment is functioning properly			
3. Place the patient in appropriate position			
4. Maintain body mechanic			
5. Have an assistant.			
6. Explain the procedure to the patient			
Immediate First Aid for Snake Bite			
7. Assess the patient's cardiopulmonary status, and evaluate for signs and symptoms of snakebite.			
8. Measure vital signs.			
9. Be prepared to initiate CPR if necessary.			
10. Assess history and physical examination for snakebite. If possible, identify the snake species.			
11. Minimize the absorption of venom and the effects of shock in the following manner: a-Place the patient in a supine position; calm the patient and avoid manipulation of the bitten area b-Immobilize the injury site if possible into a horizontal position, avoiding elevation or dependency			
12. **Do not do the following:**			
• Give stimulants or alcohol			
• Apply ice on the bite (ice will reduce blood flow and enhance necrotoxicity, thus increasing tissue damage)			
• Apply a tourniquet			
• Perform an incision and suction (this has limited use and may cause injury)			
13. Cover the wound with a loose dressing.			
14. Activate EMS for snakebite. Stay with the patient until EMS assumes responsibility.			
Post procedures			
15. Notify the physician for further orders.			
16. Clean and replace equipment.			
17. Discard disposable items according to Standard Precautions.			
18. Hand washing			
Dr. Signature **Student's sig.** **Date**			