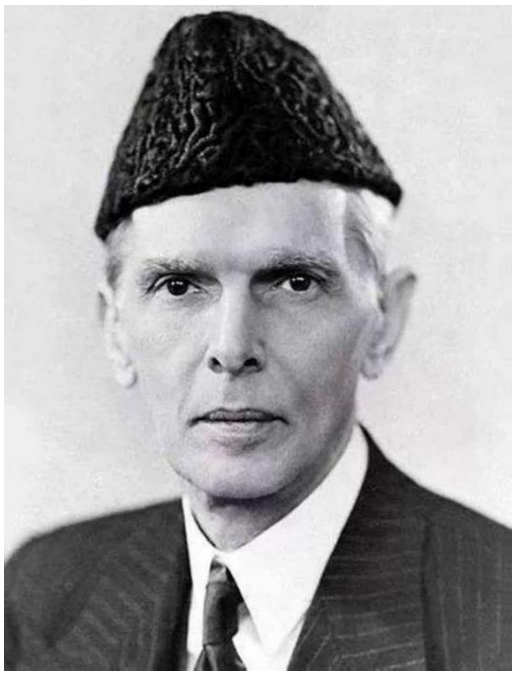
COMPETENCY-BASED
OUTCOME-BASED
ASSESSMENT
SKILLS
SAFETY
PATIENT-CENTERED
MULTICULTURAL
UHS

COMPASS

Curriculum for Nursing Clinical Skills.

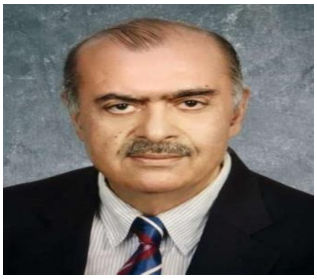
VERSION 1

University of Health Sciences Lahore



Without education it is complete darkness and with education it is light. Education is a matter of life and death to our nation. The world is moving so fast that if you do not educate yourselves, you will be not only completely left behind, but will be finished up.

Quaid e Azam Muhammad Ali Jinnah
Islamia College Lahore 1945



Vice Chancellor

The University of Health Sciences (UHS), Lahore, takes pride in presenting the newly developed and implemented curriculum for the Bachelor of Science in Nursing-Nursing Curriculum 2025: COMPASS-across its affiliated nursing colleges. This curriculum represents a transformative shift in undergraduate nursing education in Pakistan, aligning academic rigor with clinical relevance, cultural sensitivity, and global preparedness.

The current state of nursing education in Pakistan is marked by several critical gaps, including limited clinical exposure, outdated teaching methodologies, and a disconnect between theoretical instruction and practical application. The COMPASS curriculum directly addresses these issues through a comprehensive, competency-based clinical education model that integrates essential skills, simulation-based training, cultural awareness, and patient-centered care. This curriculum aims to produce well-rounded, skilled, and compassionate nursing professionals equipped to meet the demands of an evolving healthcare system both nationally and internationally.

Developed after extensive consultation with experts and stakeholders, COMPASS introduces a block-based instructional model. Students spend three days per week in the classroom and three days in clinical settings, promoting a seamless blend of knowledge acquisition and real-world application. The integration of over 200 essential clinical skills across eight semesters ensures a gradual and reinforced development of nursing competencies, assessed on a progressive scale from novice to expert.

A distinguishing feature of this curriculum is its focus on cultural competence, enabling nursing graduates to deliver respectful and contextually appropriate care to individuals from diverse cultural backgrounds. This dimension of the curriculum reflects UHS's commitment to holistic healthcare education that is inclusive, ethical, and globally informed.

Additionally, mandatory life-support workshops-ranging from emergency triage to neonatal and obstetric resuscitation—ensure that every nursing graduate is well-prepared for critical clinical situations. These enhancements underscore our commitment to patient safety and excellence in emergency care.

The Nursing Curriculum 2025: COMPASS is more than a pedagogical upgrade; it is a bold step toward redefining nursing education in Pakistan. I commend the Medical Education Department, curriculum development team, our faculty, and partner institutions for their dedication to this vision. I am confident that this initiative will elevate the standards of nursing education and significantly contribute to improving the quality of healthcare delivery in the country.

Prof. Ahsan Waheed Rathore
Vice Chancellor
University of Health Sciences Lahore

Pro-Vice Chancellor

University of Health Sciences envisions a standardized, structured, globally accredited quality education for all its students in all its affiliated institutes. Nursing being one of the integral facets of the healthcare education remains a vital dimension of our institutional ideology. Current transition to the semester system and the revamping of the Allied Health Sciences and Nursing curriculum reflects a visionary commitment to adaptability and excellence in healthcare education. Emphasizing the need for innovation and relevance in the constantly evolving field of allied health sciences and Nursing, the University remains dedicated to preparing students for the dynamic challenges of modern healthcare. The revamped curricula integrate the cutting-edge technologies, interdisciplinary approaches, and industry-relevant skills within the curriculum to ensure that graduates are well-equipped to contribute meaningfully to the healthcare sector. This initiative not only aligns with the university's mission to foster academic excellence but also serves as a testament to its forward-thinking approach to shaping the future healthcare workforce. The novel additions of Professionalism, Ethics, Research, Leadership, English and Arabic language skills (in collaboration with Arabic department of Punjab University) will hopefully inspire a sense of purpose and relevance among students and faculty, encouraging them to actively participate in the transformation of nursing and allied health sciences education based on a semester system.

Prof. Nadia Naseem
Pro-Vice Chancellor
University of Health Sciences Laho

University of Health Sciences
Lahore

Vision Statement

UHS is a leading University aiming to keep its graduates apt with the ever emerging global health challenges evolving educational methodologies and emerging technological advancements to maintain its distinguishable position as a Medical University.

Mission Statement

UHS shall continue to strive for producing a human resource par at excellence to cater for the health needs of the people of Punjab and Pakistan.

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LIST OF CONTRIBUTORS

BOARD OF GOVERNORS	
01	Honorable Justice (Retired) Shaikh Ahmad Farooq
02	Ms. Salima Hashmi
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08	Prof. Dr. Ahsan Waheed Rathore Vice Chancellor, University of Health Sciences Lahore
09	Registrar University of Health Sciences Lahore
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10	Prof. Maryam Malik
11	Prof. Soufia Farukh

12	Dr. Zahid Pervaiz
13	Mr. Muhammad Haider Amin
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02	Ms. Misbah Zafar (Director Academics, Saida Waheed FMH College of Nursing Lahore)
03	Dr. Naseem Rafiq (Principal, Shalamar Hospital College of Nursing, Lahore)
04	Ms. Farzana Iqbal (Principal, CON Allama Iqbal Medical College, Lahore)
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2	Dr. Lamia Yusuf Assistant professor Medical Education (Team Lead)
3	Mr. Mubashar Arshad (CME Coordinator)

BS-Nursing Curriculum

Semester Based

2025 VERSION 1

8 Semesters
72 Courses
185 Credit Hours

BASIC LAYOUT FOR BS NURSING 4 YEAR PROGRAM

INTRODUCTION TO THE PROGRAM

The Bachelor of Science in Nursing (BSN) program is a rigorous 4-year (8-semester) academic and clinical training course aimed at developing competent, compassionate, and culturally aware nursing professionals. Structured under the COMPASS framework, the program integrates the core natural and biomedical sciences, nursing theory, clinical competencies, cultural competence, and research. It employs a Block System model that ensures equal exposure to theory and clinical practice throughout the academic calendar.

Key Highlights:

- Three (3) days per week of interactive classroom learning (basic sciences, nursing theory, communication, ethics)
- Three (3) days per week of immersive clinical exposure across shifts in accredited hospitals
- Integration of around 200 essential clinical skills using simulation and real-world experience
- Emphasis on cultural competence and outcome-based, competency-based clinical skills curriculum through an 8-credit-hour longitudinal module
- Capstone project and mandatory skill-based workshops in emergency and life-saving care

1. AIMS OF THE PROGRAM

a. Equip students with evidence-based clinical and theoretical nursing findings.
b. Enhance leadership, clinical reasoning, and ethical decision-making.
c. Nurturing cultural sensitivity and global readiness in nursing.
d. Promote lifelong learning and personal-professional development

2. OBJECTIVES OF THE PROGRAM

a) Demonstrate proficiency in nursing fundamentals, health assessments, and pharmacology.
b) Deliver safe, compassionate, patient-centred care across the lifespan.
c) Effective collaboration with interdisciplinary healthcare teams.
d) Uphold ethical, legal, and cultural competence.
e) Lead quality improvement, research, and health advocacy initiatives
f) Exhibit cultural competency skills in dealing with ailing patients

3. PROGRAM LEARNING OUTCOMES

Upon successful completion, graduates will be able to
a) perform core nursing procedures aligned with safety and competency levels (1–5: Novice to Expert).
b) Apply the nursing process to both simulated and real clinical settings.

c) Demonstrating cultural competence in assessments and care planning.
d) Effective communication in diverse, multilingual, and multicultural contexts. Leadership, team coordination, and healthcare system navigation.
e) Engage in reflective practice and continuous professional development

4. Career Opportunities for Graduates

BSN graduates will be prepared to serve in local and international health systems in roles such as

. Clinical Nurse (Medical/Surgical, ICU, ER)
. Community Health Nurse
. Pediatric Nurse
. Mental Health Nurse
. Nurse Educator
. Emergency & Critical Care Nurse
. Nursing Leadership & Management

5. Program Details

. Total Credit Hours: 185
. Duration: 4 Years (8 Semesters)
. Courses: 72
. Clinical Hours: Increased up to 54 hours with mandatory workshops
. **Mandatory Workshops:**

- Emergency triage Assessment and Treatment
- Cardiac first response / Basic life support
- Immediate cardiac care/Advance life support cardiac
- Immediate trauma care
- Emergency neonatal care/Neonatal Resuscitation
- Emergency obstetrics & neonatal care
- All the students must complete these workshops up to the final exam

6. Clinical Portfolio Requirements (e.g., Log Books)

LOG book is designed with check lists.

7. Assessment (Formative and Summative)

The scheme of assessment shall be as under:

Sr. No.	Assessments	Weightage
1.	Mid-semester Examination	15%
2.	Class Performance (quiz/class test/presentations/ assignments)	5%
3.	Final Examination	80%

a. INTERNAL ASSESSMENT:
   i. The internal assessment shall be done by the institution/department.
   ii. The internal assessment for each semester in each subject shall be assessed through;

Sr. No.	Internal assessment method	Number per semester	Maximum marks	Total Marks
1	Quizzes/class tests	02	5 per Quiz/class test	10
2	Assignments	02	5 per assignment	10
3	Presentation	01	5 per presentation	5

iii. The Institution/Department shall ensure that cognitive and psychomotor domains are assessed through internal assessment.

b. MID- SEMESTER EXAMINATION:

i. The mid-semester examination shall be held in the 9th week of the semester.
ii. The schedule/date sheet of mid-semester examination shall be notified by the concerned head of the department, two weeks before the commencement of examination, in accordance with the notified academic calendar.
iii. The Question Paper of mid-semester examination shall be prepared by the relevant faculty member not below the rank of Assistant Professor and approved by the Head of Department.
iv. The mid-semester examination shall be conducted by the relevant academic department.
v. The candidate shall be required to attempt all the Questions given in mid-semester examination. There shall be no choice.
vi. Result of mid-term examination shall be a mandatory requirement for appearance in the final term examination. The candidates shall be required to pass the mid-term examination by scoring at least 50% marks.
vii. The result of mid-term examination shall be declared within 07 days after conclusion of the examination and it shall be submitted to the University same day in case of departments/institutions located in Lahore and within 24 hours in case of departments/institutions located outside the Lahore.
viii. The answer books of mid-semester examination shall be shown to the students and taken back immediately. The answer books shall only be shown to the students on the announced day failing which the student cannot claim to be shown the answer book.
ix. The Answer Books shall be kept as a record for two years in the concerned Department. The University reserves the right to seek submission of solved answer books/record of mid-term examination as and when required.

c. FINAL EXAMINATION

i. The schedule/date sheet of final examination shall be notified by the UHS Examination Department in accordance with the notified Academic

Calendar.

ii. The Examination Department of the University shall hold the final examination.

d. FORMAT OF MID-SEMESTER & FINAL EXAMINATION

i. Mid-Semester Examination shall comprise of only Theory Examination.

ii. Final Examination of Semester shall consist of Theory and Practical Examinations in subjects where Cognitive and Psychomotor domains are to be assessed whereas only Theory Examination will be given in subjects where Cognitive domain is to be assessed in isolation.

iii. The student shall be required to submit a Research Project in the Final Semester of the Program. The Research Project shall be allocated by the Head of Department. The Research Project can be allocated to a group of students. The group shall comprise a maximum of 5 students.

iv. The research project shall be evaluated by an External Examiner and each student shall appear before the External Examiner for taking the Viva Voce examination based on Research Project.

e. GRADING:

i. The subject wise grading system will be followed for the grading of the students.

ii. Minimum qualifying CGPA required for the completion of undergraduate degree shall be 2.

f. INDISCIPLINE / USE OF UNFAIR MEANS IN EXAMINATIONS:

i. Any candidate found guilty of using unfair means in the Examinations shall be dealt under the Regulations for Examinations pertaining to Use of Unfair Means.

g. ADMISSION OF STUDENT TO SEMESTER EXAMINATION:

A student shall be allowed to take the final examination of each semester provided;

i. His/her admission has been sent by the Head of Department/Institution on the prescribed form/medium within due date

ii. The Head of Department/Institution has certified that he/she has attained 80% attendance in the course to be examined. The attendance for each course is to be submitted specifically and separately.

iii. The Head of Department/Institution has submitted certified result of Mid-Term Examination.

iv. The Head of Department/Institution has submitted the Internal Assessment Score.

v. The evidence for payment of prescribed fee to take examination has been attached / furnished.

8. Table of Specifications (TOS)

TOS of each subject theory and practical are available in details with each subject according to subject credits.

9. Program Structure

GENERAL SUBJECT (11 Courses, 30 Credit Hours)	
Subject	**Credit Hours (Theory + Lab)**
Arts and Humanities	02+0
Natural Sciences	02+1
Social Sciences	02+0
Functional English	03+0
Expository Writing	03+0
Quantitative Reasoning (I and II)	06 (2x03)
Ideology and Constitution of Pakistan	02+0
Islamic Studies	02+0
Applications of Information and Communication Technologies (ICT)	02+1
Entrepreneurship	02+0
Civics and Community Engagement	02+0

INTERDISCIPLINARY SUBJECTS (11 Courses, 26 Credit Hours)	
Subject	**Credit Hours (Theory + Lab)**
General Pathology	03+0
Special pathology	03+0
Developmental Psychology	02+0
Teaching & Learning	03+0
Epidemiology	02+0
Applied Nutrition	01+0
Basic Anatomy	03+0
Basic Biochemistry	03+0
Basic Physiology	03+0
Microbiology	01+0
Diagnostic Procedures	02+0

MAJOR SUBJECTS
(32 Courses, 77 Credit Hours)

Subject	Credit Hours (Theory/Clinical + Lab)
Fundamental of Nursing-I	02+0
Fundamental of Nursing-I Lab	0+02
Fundamental of Nursing-II	02+0
Fundamental of Nursing-II Clinical	0+03
Adult Health Nursing-I	02+0
Adult Health Nursing-I Clinical	0+02
Health Assessment-I	01+01
Health Assessment Lab-	0+01
Pharmacology-I	02+0
Adult Health Nursing-II	04+0
Adult Health Nursing-II Clinical	0+04
Health Assessment-II	01+01
Health Assessment II-Lab	0+01
Pharmacology-II	02+0
Pediatric Health Nursing-I	02+0
Pediatric Health Nursing-I Clinical	0+02
Community Health Nursing I	02+0
Community Health Nursing I Clinical	0+01
Reproductive Health	02+0
Reproductive Health Clinical	0+03
Nursing Ethics	01+0
Pediatric Health Nursing-II	02+0
Pediatric Health Nursing-II Clinical	0+02
Mental Health Nursing	03+0
Mental Health Nursing Clinical	0+03
Nursing Theories & Models	02+0
Leadership/management in nursing	02+1
Leadership and Management Clinical	0+01
Nursing Research	03+0
Critical Nursing Care	04+0
Critical Nursing Care Clinical	0+04

Community Health Nursing-II	02+0
Community Health Nursing-II Clinical	0+03
Oncology and Palliative Care Nursing	02+0
Oncology and Palliative Care Nursing Clinical	0+02

COMPASS 8semester (54 hours)
Professional Ethics (PERLS) 08 courses, (1+0) x 8 = 08 Credit hours
English Proficiency Courses (EPC) 06 courses, (2+0) x 6 = 12 Credit hours
Arabic Language Course, 01 course, (2+1) x 1 = 03 Credit hours
Capstone Project 03 Credit Hours
INTERNSHIP/ FIELD EXPERIENCE 03 Credit Hours

SCHEME OF STUDIES

Semester	Course Code	Course Title	Theory	Lab	Clinical	Credit Hours
1st Semester		Arts and Humanities	02	0		02
		Natural Sciences	02	01		03
		Functional English	03	0		03
		Ideology and Constitution of Pakistan	02	0		02
		Quantitative Reasoning (I)	03	0		03
		Basic Anatomy	03	0		03
		Fundamental of Nursing-I	02	0		02
		Fundamental of Nursing-I Lab	0	02		02
		Clinical Training	0	0	**06**	**06**
		PERLS 01	01	0		01
		COMPASS 01	**01**	**0**		**01**
Total Credit Hours			**19**	**3**	**06**	**28**
2nd Semester		Social Sciences	02	0		02
		Expository Writing	03	0		03
		Quantitative Reasoning (II)	03	0		03
		Islamic Studies	02	0		02
		Basic Biochemistry	03	0		03
		Basic Physiology	03	0		03
		Fundamental of Nursing-II	02	0		02
		Fundamental of Nursing-II Clinical	0	0	03	03
		Clinical Training	**0**	**0**	**03**	**03**
		PERLS 02	01	0	0	01

		COMPASS 02	**0**	**0**	**01**	**01**
Total Credit Hours			19	0	07	26

3rd Semester		General Pathology/ Pathophysiology I	03	0	0	03
		ICT (Computer Sciences)	02	01	0	03
		Civics and Community Engagement	02	0	0	02
		Entrepreneurship	02	0	0	02
		Adult Health Nursing-I	02	0	0	02
		Adult Health Nursing-I Clinical	0	0	02	02
		Health Assessment-I	01	0	0	01
		Health Assessment-I Lab	0	01	0	01
		Pharmacology-I	02	0	0	02
		Microbiology	01	0	0	01
		English Proficiency Course-1 (EPC 1)	02	0	0	02
		Clinical Training	**0**	**0**	**04**	**04**
		PERLS 03	01	0	0	01
		COMPASS 3	**0.5**		**0.5**	**01**
Total Credit Hours			**18.5**	**02**	**6.5**	**27**
4th Semester		Special Pathology/ Pathophysiology II	03	0	0	03
		Adult Health Nursing-II	04	0	0	04
		Adult Health Nursing-II Clinical	0	0	04	04
		Health Assessment-II	01	0	0	01
		Health Assessment-II Lab	0	01	0	01
		Pharmacology-II	02	0	0	02

		Developmental Psychology	02	0	0	02
		English Proficiency Course-2 (EPC 2)	02	0	0	02
		Clinical Training	**0**	**0**	**02**	**02**
		PERLS 04	01	0	0	01
		COMPASS 04	**0**		**01**	**01**
Total Credit Hours			**15**	**01**	**07**	**23**

5th Semester		Pediatric Health Nursing-I	02	0	0	02
		Pediatric Health Nursing-I Clinical	0	0	02	02
		Community Health Nursing I	02	0	0	02
		Community Health Nursing I Clinical	0	0	01	01
		Reproductive Health	02	0	0	02
		Reproductive Health Clinical	0	0	03	03
		Teaching/Learning: Principles/Practices	03	0	0	03
		Nursing Ethics	01	0	0	01
		English Proficiency Course-3 (EPC 3)	02	0	0	02
		PERLS 05	01	0	0	01
		COMPASS 05	**0**		**01**	**01**
Total Credit Hours			**13**		**07**	**20**
6th Semester		Pediatric Health Nursing-II	02	0	0	02
		Pediatric Health Nursing-II Clinical	0	0	02	02
		Mental Health Nursing	03	0	0	03
		Mental Health Nursing Clinical	0	0	03	03
		Epidemiology	02	0	0	02
		Nursing theories & Models	02	0	0	02

		Leadership/Management in Nursing	02	0	01	03
		Applied Nutrition	01	0	0	01
		English Proficiency Course-4 (EPC 4)	02	0	0	02
		PERLS 06	01	0	0	01
		COMPASS 06	**0**		**01**	**01**
Total Credit Hours			**15**	**0**	**07**	**22**
7th Semester		Nursing Research	03	0	0	03
		Critical Nursing Care	04	0	0	04
		Critical Nursing Care Clinical	0	0	04	04
		Diagnostic Procedures	02	0	0	02
		English Proficiency Course-5 (EPC 5)	02	0	0	02
		PERLS 07	01	0	0	01
		Internship/Field Experience	0	0	03	03
		COMPASS 07	0.5	0	0.5	0.5
Total Credit Hours			**12.5**		**7.5**	**20**
8th Semester		Community Health Nursing-II	02	0	0	02
		Community Health Nursing-II Clinical	0	0	03	03
		Oncology and Palliative Care Nursing	02	0	0	02
		Oncology and Palliative Care Nursing Clinical	0	0	02	02
		English Proficiency Course-6 (EPC 6)	02	0	0	02
		PERLS 08	01	0	0	01
		Arabic Language Course	02	01	0	03
		Capstone Project	03	0	0	03
		COMPASS 08	**0**		**01**	**01**
Total Credit Hours			**12**	**01**	**06**	**19**

GENERAL COURSES

BEHAVIOURAL SCIENCES (ARTS & HUMANITIES)

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Accurately describe the influence and potential implications of culture and community context on health behaviors, beliefs and outcomes, as well as how physicians should appropriately integrate this knowledge into patient care.
2. Build a comprehensive, accurate, and relevant patient history using an approach that supports a therapeutic alliance between patient and physician and that displays self-awareness and reflective practice.
3. Effectively explain to a patient, using the principles of shared decision- making, the patient's medical condition and/or treatment options (for common conditions and risk factors) within the context of that patient's background, education and belief systems.
4. Provide patient-centered behavioral guidance, and explain the appropriate theoretical model that supports the approach.
5. Accurately describe how social determinants of health influence health outcomes and how physicians can incorporate this knowledge in the care of patients.
6. Accept and report personal errors, discuss the potential sources of errors, and develop an action plan to reduce the risk of future errors.

Course Content	MCQ	SEQ
Unit I: Introduction to Behavioral Sciences and its importance in health: **1.** Bio-Psycho-Social Model of Health Care and the Systems Approach **2.** Normality Vs Abnormality **3.** Professionalism and desirable Attitudes in Health Professionals	02	0
Unit II: Life Cycle: **1.** Behavioral aspects of development through lifecycle (Infancy, Childhood, Adolescence, Adulthood) **2.** Death and Dying and Bereavement	04	01
Unit III: Biological and Psychological basis of Behavior: **1.** Psychodynamic factors (Learning, Memory, Thinking, Perception, Motivation, Personality, Intelligence, Emotions and Stress)	07	02
Unit IV: Social and Anthropological basis of Behavior: **1.** Sociological aspects of health and illness (Social Class, Gender, Health belief model, Stigma, Sick role, Ethnicity, Groups, Illness and Sickness) **2.** Anthropological aspects of Health (Culture, sensitive assessment, Health disparity and Health inequality)	07	01
Unit V: Illness and healthcare professional relationship: **1.** Medical Communication (Medical interview, non-pharmacological interventions, Breaking bad news, Crisis intervention) **2.** Coping with the disability (Coping, Stress, Anxiety, Self-help groups, Pain management, Psychosocial aspects of disability)	10	02

3. Doctor patient relationships (Psychological reactions, Models of doctor pt. relationship, Treatment adherence, Psycho-trauma & Post Traumatic Stress Disorder) **4.** Psychosocial aspects of disease and illness (Various medical conditions, Disability including intellectual disability)		

Recommended Books/ Reading Materials

1. Psychology and sociology applied to medicine: An illustrated color text, 3rd ed. by Beth alder
2. Behavioral Science in Medicine, 2nd Ed. Barbara Fadem
3. Handbook of Behavioral sciences, 2nd Ed. MH Rana
4. Integrating Behavioral sciences in healthcare,2nd Ed. Asma Humayun and Michel Herber

NATURAL SCIENCES (BIOPHYSICS)

Credit Hours: 03 (02+01)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Acquire Knowledge of the fundamental concepts of physics in the context of biological systems.

Course Content	MCQ	SEQ
Unit I: Essentials of thermodynamics **1.** Basic principles of different forms of energy- Heat and Thermodynamics **2.** Concept of entropy **3.** Enthalpy and Gibb's free energy **4.** Boltzmann distribution	5	01
Unit II: Molecular Transport in living cells **1.** Diffusion, random motion, diffusion equation **2.** Osmosis, osmotic pressure in liquid and gas **3.** Diffusion across membrane **4.** Membrane potential.	3	0.5
Unit III: Methods of studying macromolecules **1.** Viscosity measurements **2.** Chromatographic methods; and free-boundary electrophoresis **3.** Sedimentation velocity, and sedimentation equilibrium.	3	01
Unit IV: Interactions of molecules in 3-D space-determining binding and dissociation constants **1.** Intermolecular interactions **2.** Interamolecular interactions	3	0.5
Unit V: Biomolecular Structure **1.** DNA **2.** RNA **3.** POLYPEPTIDES	5	0.5
Unit VI: Biophysical processes **1.** Biomechanics **2.** Bioenergetics **3.** Biomagnetism	3	01
Unit VII: Physics of ion channels.	5	0.5
Unit VIII: Order and disorder in biological systems	3	01

Practical	OSPE
1. Determination of the optical density (absorbance) of Bromophenol blue dye through spectrophotometer **2.** Determination of pressure at the bottom most position of a cylinder using the concept of thermodynamic principle **3.** Derivation of Beer-Lambert Law **4.** Separation of components of two different colored liquids using thin layer **5.** Chromatography	03

Recommended Books/ Reading Materials:

1. Nelson P, 2004. Biological Physics, Energy, Information and Life. 1st Edition; WH Freeman & Company.
2. Kirsten et al., 2010. Introduction to Biological Physics for the Health and Life Sciences. 2nd Edition; John Wiley & Sons.
3. Davidovits P, 2013. Physics for Biology & Medicine. 4th Edition; Academic Press.
4. Newman, 2010. Physics of the Life Sciences. Springer.
5. Duncan, 1975. Physics for Biologist. Blackwell Science.

MEDICAL SOCIOLOGY (SOCIAL SCIENCES)

Credit Hours: 02(02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Understand the historical progression and evolution of healthcare systems and practices.
2. Analyze the interconnectedness of body, mind, illness, and environmental factors shaping health outcomes.
3. Critically evaluate diverse theories, research methodologies, and ongoing debates in medical sociology.

Course Content:	MCQs	SEQs
Unit I: Evolution of Health and Healing **1.** Historical Development of medical practices and knowledge. **2.** Evolution of Healthcare Systems and Treatment Modalities. **Unit II: Body, Mind, Illness, and Environment** **1.** Impact of Environmental factors on health and Disease **2.** Interconnection between Physical and Mental Health	5	1
Unit III: Theories, Research, and Debates of Medical Sociology **1.** Overview of Medical Sociology Theories **2.** Research Methods in Medical Sociology **3.** Current Debates and Controversies in Medical Sociology **Unit IV: Social, Environmental, and Occupational Factors in Health and Illness** **1.** Influence of Socioeconomic Status on Health **2.** Impact of Environment and Living Conditions on Health **3.** Occupational hazards and Health Implications	5	1
Unit V: The meaning of Health and Illness from the Patient's Perspective **1.** Patient's Subjective Experience of health and Illness **2.** Cultural and Social Influences on Perception of Health and Illness **3.** Patient Empowerment and Decision-Making in Healthcare **Unit VI: Historical Transformation of health Professions and the Health Workforce** **1.** Evolution of Healthcare Professions and Roles **2.** Changes in Healthcare Delivery Systems. **3.** Impact of technological Advancements on Healthcare Professions.	5	1
Unit VII: Social and Cultural Factors Surrounding the Creation and labeling of Diseases **1.** Social Construction of Diseases and Illnesses **2.** Cultural Interpretations and Stigmatization of diseases. **3.** Medicalization and Pathologization of Behavior. **Unit VIII: Disparities in Health, Access to Healthcare, and the Healthcare received** **1.** Socioeconomic Disparities in Health Outcomes. **2.** Access Barriers to Healthcare services.	8	2

3. Quality Discrepancies in Healthcare Provision.		
Unit IX: Organizational and ethical issues in medicine including rising costs and medical technology; and health care reform. **1.** Rising Healthcare costs and Technology. **2.** Healthcare Reforms and Ethical Considerations. **3.** Patient Rights, Consent, and Ethical Dilemmas in Medicine.	7	1

Recommended books / Reading Materials

1. Medical Sociology by William Cockerham, 15th Edition. B/W Illustrations Published September 30, 2021, by Routledge.
2. A Sociology of Health by David Wainwright, 2008
3. The Sociology of Health and Illness Critical Perspectives,11th Edition by Peter Conrad, Valerie Leiter Published: June 2023
4. The Sociology of Health, Illness, and Health Care: A Critical Approach", 7th Edition by Rose Weitz, 2016.

FUNCTIONAL ENGLISH

Credit Hours: 03 (03+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Apply enhanced English communication skills through effective use of word choices, grammar, and sentence structure.
2. Comprehend a variety of literary / non-literary written and spoken texts in English.
3. Effectively express information, ideas, and opinions in written and spoken English.
4. Recognize inter-cultural variations in the use of English language and to effectively adapt their communication style and content based on diverse cultural and social contexts.

Course Content:	MCQs	SEQs
Unit I: Foundations of Functional English: **1.** Vocabulary building (contextual visage, synonyms, antonyms, and idiomatic expressions). **2.** Communicative grammar (subject-verb-agreement, verb tenses, fragments, run-ons, modifiers, articles, word classes, etc.). **3.** Word formation (affixation, compounding, clipping, back formation, etc.). **4.** Sentence structure (simple, compound, complex and compound-complex). **5.** Sound production and pronunciation.	15	03
Unit II: Comprehension and Analysis: **1.** Understanding purpose, audience, and context **2.** Contextual interpretation (tones, biases, stereotypes, assumptions, inferences, etc.) **3.** Reading strategies (skimming, scanning, SQ4R, critical reading, etc.) **4.** Active listening (overcoming listening barriers, focused listening, etc.)	15	03
Unit III: Effective Communication: **1.** Principles of communication (clarity, coherence, conciseness, courteousness, correctness, etc.) **2.** Structuring documents (introduction, body, conclusion, and formatting) **3.** Inclusivity in communication (gender-neutral language, stereotypes, cross-cultural communication, etc.) **4.** Public speaking (overcoming stage fright, voice modulation and body language) **5.** Presentation skills (organization content, visual aids and engaging the audience) **6.** Informal communication (small talk, networking, and conversational skills) **7.** Professional writing (business e-mails, memos, reports, formal letters, etc.)	15	03

Recommended Books / Reading Materials:

1. “High School English Grammar and Composition” by H. Martin & P.C. Wren.

2. Technical Communication: Principles and Practice (3rd Edition) by Meenakshi Raman and Sangeeta Sharma. Oxford University Press
3. The Art and Science of Business Communication (4th Edition) by P.D Chaturvedi and Mukesh Chaturvedi. Pearson.
4. College Writing Skills with Readings by John Langan (8th Edition) McGraw Hill.
5. Patterns for College Writing: A Rhetorical Reader and Guide (12th edition) by Laurie G. Kirszner and Stephen R. Mandell. Bedford/St. Martin's

Additional Reading:

1. "Understanding and Using English Grammar" by Betty Schrampfer Azar.
2. "English Grammar in Use" by Raymond Murphy.
3. Style: Lessons in Clarity and Grace by Joseph M. Williams and Joseph Bizup
4. "The Blue Book of Grammar and Punctuation" by Jane Straus.

EXPOSITORY WRITING

Credit Hours: 03 (03+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Understand the essentials of the writing process integrating pre-writing, drafting, editing and proof reading to produce well-structured essays.
2. Demonstrate mastery of diverse expository types to address different purposes and audiences.
3. Uphold ethical practices to maintain originality in expository writing.

Course Content:	MCQs	SEQs
Unit I: Introduction to Expository Writing: **1.** Understanding expository writing (definition, types, purpose, and applications). **2.** Characteristics of effective expository writing (clarity, coherence, and organization). **3.** Introduction to paragraph writing.	05	1
Unit II: The Writing Process: **1.** Pre-writing techniques (brainstorming, free-writing, mind-mapping, listing, questioning, and outlining etc.). **2.** Drafting (three stage process of drafting techniques). **3.** Revising and editing (ensuring correct grammar, clarity, coherence, conciseness etc.). **4.** Proof reading (fine-tuning of the draft). **5.** Peer review and feedback (providing and receiving critique).	05	1
Unit III: Essay Organization and Structure: **1.** Introduction and hook (engaging readers and introducing the topic) **2.** Thesis statement (crafting a clear and focused central idea) **3.** Body Paragraphs (topic sentences, supporting evidence and transitional devices) **4.** Conclusion (types of concluding paragraphs and leaving an impact) **5.** Ensuring cohesion and coherence (creating seamless connections between paragraphs)	05	1
Unit IV: Different Types of Expository Writing: **1.** Description **2.** Illustration **3.** Classification **4.** Cause and effect (exploring causal relationships and outcomes) **5.** Process analysis (explaining step-by-step procedures) **6.** Comparative analysis (analyzing similarities and differences)	**10**	**2**
Unit V: Writing for Specific Purposes and Audiences: **1.** Different types of purposes (to inform, to analyze, to persuade, to entertain etc.). **2.** Writing for academic audiences (formality, objectivity, and academic conventions). **3.** Writing for public audiences (engaging, informative and persuasive language). **4.** Different tones and styles for specific purposes and audiences.	**10**	**2**

Unit VI: Ethical Considerations: **1.** Ensuring original writing (finding credible sources, evaluating information etc.). **2.** Proper citation and referencing (American Psychological Association **(**APA), Modern Language Association (MLA), or other citation styles). **3.** Integrating quotes and evidence (quoting, paraphrasing, and summarizing). **4.** Avoiding plagiarism (ethical considerations and best practices).	**10**	**2**

Recommended Books / Reading Materials:

1. “The Norton Field Guide to Writing” by Richard Bullock, Maureen Daly Goggin, and Francine Weinberg
2. “American Psychological Association”. Manual of the American Psychological Association (7th edition).
3. “The Art and Science of Business Communication” (4th Edition) by P.D Chaturvedi and Mukesh Chaturvedi. Pearson.
4. “College Writing Skills with Readings” by John Langan (8th Edition) McGraw Hill.
5. “Patterns for College Writing: A Rhetorical Reader and Guide” (12th edition) by Laurie G. Kirszner and Stephen R. Mandell. Bedford/St. Martin’s

Additional Reading:

1. "The St. Martin's Guide to Writing" by Rise B. Axelrod and Charles R. Cooper.
2. "Style: Lessons in Clarity and Grace" by Joseph M. Williams and Joseph Bizup.
3. "Good Reasons with Contemporary Arguments" by Lester Faigley and Jack Selzer.
4. "Writing Today by Richard Johnson-Sheehan and Charles Paine

QUANTATIVE REASONING (I)

Credit Hours: 03 (03+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Fundamental numerical literacy to enable them work with numbers, understand their meaning, and present data accurately.
2. Understanding of fundamental mathematical and statistical concepts.
3. Basic ability to interpret data presented in various formats including but not limited to tables, graphs, charts and equations etc.

Course Content:	MCQs	SEQs
Unit I: Numerical Literacy: **1.** Number system and basic arithmetic operations. **2.** Units and their conversions, dimensions, area, perimeter, and volume. **3.** Rates, ratios, proportions, and percentages. **4.** Types and sources of data. **5.** Measurement scales. **6.** Tabular and graphical presentation of data. **7.** Quantitative reasoning exercises using number knowledge.	15	03
Unit II: Fundamental Mathematical Concepts: **1.** Basics of geometry (lines, angles, circles, polygons etc.). **2.** Sets and their operations. **3.** Relations, functions, and their graphs. **4.** Exponents, factoring and simplifying algebraic expressions. **5.** Algebraic and graphical solutions of linear and quadratic equations and inequalities. **6.** Quantitative reasoning exercises using fundamental mathematical concepts.	15	03
Unit III: Fundamental Statistical Concepts: **1.** Population and sample. **2.** Measures of central tendency, dispersion, and data interpretation. **3.** Rules of counting (multiplicative, permutation and combination). **4.** Basic probability theory. **5.** Introduction to random variables and their probability distributions. **6.** Quantitative reasoning exercises using fundamental statistical concepts.	15	03

Recommended Books / Reading Materials:

1. "Quantitative Reasoning: Tools for Today's informed Citizen" by Bernard L. Madison, Lynn and Arthur Steen, 2nd Edition, Pearson, 2012.
2. "Quantitative Reasoning for the information Age" by Bernard L. Madison and David M. Bressoud.
3. "Fundamentals of Mathematics" by Wade Ellis, 2008.
4. "Quantitative Reasoning: Thinking of Numbers" by Eric Zaslow, 1st Edition, Cambridge University Press, 2020.

5. “Thinking Clearly and Data: A Guide to Quantitative Reasoning an Analysis” by Ethan Bueno de Mesquita and Anthony Fowler, Princeton University Press, 2021.
6. “Using and Understanding Mathematics: A Quantitative Reasoning Approach” By Bennet, J. O., Briggs, W.L., & Badalamenti, A, 7th Edition, Pearson, 2018.
7. “Discrete Mathematics and its Applications” By Kenneth H. Rosen, 8th Edition, Mc Graw Hill, 2018.
8. “Statistics for Technology: A Course in Applied Statistics” by Chatfield, C, 3rd Edition, Routledge.
9. “Statistics: Unlocking the Power of Data” by Robin H. Lock, Patti Frazer Lock, Kari Lock Morgan, and Eric F. Lock, 3rd Edition, Wiley, 2020.

QUANTATIVE REASONING (II)

Credit Hours: 03 (03+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Understanding of logic and logical reasoning.
2. Understanding of basic quantitative modeling and analyses.
3. Logical reasoning skills and abilities to apply them to solve quantitative problems and evaluate arguments.
4. Ability to critically evaluate quantitative information to make evidence-based decisions through appropriate computational tools.

Course Content:	MCQs	SEQs
Unit I: Logic, Logical and Critical Reasoning: **1.** Introduction and the importance of logic. **2.** Inductive, deductive, and abductive approaches of reasoning. **3.** Proportions, arguments (valid; invalid), logical connectives, truth tables and propositional equivalences. **4.** Logical fallacies. **5.** Venn Diagrams. **6.** Predicates and quantifiers. Quantitative reasoning exercises using logical reasoning concepts and techniques.	**15**	**03**
Unit II: Mathematical Modelling and Analyses: **1.** Introduction to deterministic models. **2.** Use of linear functions for modeling in real-world situations. **3.** Modeling with the system of linear equations and their solutions. **4.** Elementary introduction to derivatives in mathematical modeling. **5.** Linear and exponential growth and decay models. **6.** Quantitative reasoning exercises using mathematical modeling.	**15**	**03**
Unit III: Statistical Modeling and Analyses: **1.** Introduction to probabilistic models. **2.** Bivariate analysis, scatter plots. **3.** Simple linear regression model and correlation analysis. **4.** Basics of estimation and confidence interval. **5.** Testing of hypothesis (z-test, t-test) **6.** Statistical inference in decision making. **7.** Quantitative reasoning exercises using statistical modeling.	**15**	**03**

Recommended Books / Reading Materials:

1. "Using and Understanding Mathematics: A Quantitative Reasoning Approach" By Bennet, J. O., Briggs, W.L., & Badalamenti, A, 7th Edition, Pearson, 2018.
2. "Discrete Mathematics and its Applications" By Kenneth H. Rosen, Rosen, 8th Edition, Mc Graw Hill, 2018.
3. "Discrete Mathematics with Applications" By Susanna S. Epp, 4th Edition, Cengage Learning, 2010.
4. "Applied Mathematics for Business, Economics and Social Sciences" by Frank S Budnick, 4th Edition, McGraw Hill.

5. “Elementary Statistics: A Step-by-Step Approach” by Allan Bluman, 10th Edition, McGraw Hill, 2017.
6. “Introductory Statistics” by Prem S. Mann, 7th Edition, Wiley, 2010.
7. “Applied Statistical Modeling” by Salvatore Babones, 1st Edition, SAGE Publications Ltd, 2013.
8. “Barons SAT” by Shavron Weiner Green, M.A and Ira K. Wolf, 26th Edition, Barrons Educational Series, 2012.

IDEOLOGY AND CONSTITUTION OF PAKISTAN

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Demonstrate enhanced knowledge of the basis of the ideology of Pakistan with special reference to the contributions of the founding fathers of Pakistan.
2. Demonstrate fundamental knowledge about the Constitution of Pakistan 1973 and its evolution with special reference to state structure.
3. Explain about the guiding principles on rights and responsibilities of Pakistani citizens as enshrined in the Constitution of Pakistan 1973.

Course Content:	MCQs	SEQs
Unit I: Introduction to the Ideology of Pakistan: **1.** Definition and significance of ideology. **2.** Historical context of the creation of Pakistan (with emphasis on socio-political. religious, and cultural dynamics of British India between 1857 till 1947). **3.** Contributions of founding fathers of Pakistan in the freedom movement including but not limited to Allama Muhammad Iqbal, Muhammad Ali Jinnah., etc. **4.** Contributions of women and students in the freedom movement for separate homeland for Muslims of British India.	05	01
Unit II: Two-Nation Theory: **1.** Evolution of the Two-Nation Theory (Urdu-Hindi controversy, Partition of Bengal, Simla Deputation 1906, Allama lqbal's Presidential Address1930, Congress Ministries1937 Lahore Resolution 1940). **2.** Role of communalism and religious differences.	05	01
Unit III: Introduction to the Constitution of Pakistan: **1.** Definition and importance of a constitution. **2.** Ideological factors that shaped the Constitution(s) of Pakista (Objectives Resolution 1949). **3.** Overview of constitutional developments in Pakistan.	05	01
Unit IV: Constitution and State Structure: **1.** Structure of Government (executive, legislature, and judiciary). **2.** Distribution of powers between federal and provincial governments. **3.** 18th Amendment and its impact on federalism.	05	01
Unit V: Fundamental Rights, Principles of Policy and Responsibilities: **1.** Overview of fundamental rights guaranteed to citizens by the Constitution of Pakistan 1973 (Articles 8-28). **2.** Overview of Principles of Policy (Articles 29-40). Responsibilities of the Pakistani citizens (Article 5).	05	01
Unit VI: Constitutional Amendments: **1.** Procedures for amending the Constitution.	05	01

2. Notable constitutional amendments and their implications.		

Recommended Books / READING MATERIALS

1. "The Struggle for Pakistan" by I.H. Qureshi.
2. "Pakistan the Formative Phase" by Khalid Bin Sayeed, 2nd Edition, Oxford University Press, 1991.
3. "Ideology of Pakistan" by Sharif-ul-Mujahid.
4. "Constitutional and Political Development of Pakistan" by Hamid Khan.

Supplementary Books

1. "The Making of Pakistan: A Study in Nationalism" by K.K. Aziz, Sang- E-Meel Publication, 2002.
2. "The. Constitution of Pakistan 1973". Original.
3. "The Struggle for Pakistan: A Muslim Homeland and Global Politics" by Ayesha Jalal, Belknap Press: An Imprint of Harvard University Press; Bilingual edition, 2017.
4. "The Idea of Pakistan" by Stephen P. Cohen, 2nd Edition, Brookings Institution Press, 2006.

ISLAMIC STUDIES

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Demonstrate enhanced knowledge of Islamic foundational beliefs, practices, historical development, spiritual values, and ethical principles.
2. Describe basic sources of Islamic law and their application in daily life.
3. Identify and discuss contemporary issues being faced by the Muslim world including social challenges, gender roles and interfaith interactions.

Course Content:	MCQs	SEQs
Unit I: Introduction to Islam: **1.** Definition of Islam and its core beliefs. **2.** The Holy Quran (introduction, revelation, and compilation). **3.** Hadith and Sunnah (compilation, classification, and significance). **4.** Key theological concepts and themes (Tawhid, Prophet hood, Akhirah etc.)	05	1
Unit II: Sirah of the Holy Prophet (Peace Be Upon Him) as Uswa-i-Hasana: **1.** Life and legacy of the Holy Prophet PBUH. **2.** Diverse roles of the Holy Prophet PBUH (as an individual, educator, peace maker, leader etc.)	05	1
Unit III: Islamic History and Civilization: **1.** World before Islam. **2.** The Rashidun Caliphate and expansion of Islamic rule. **3.** Contribution of Muslim scientists and philosophers in shaping world civilization.	05	1
Unit IV: Islamic Jurisprudence (Fiqh): **1.** Fundamental sources of Islamic jurisprudence. **2.** Pillars of Islam and their significance. **3.** Major schools of' Islamic Jurisprudence. **4.** Significance and principles of ijtihad.	05	1
Unit V: Family and Society in Islam: **1.** Status and rights of women in Islamic teachings. **2.** Marriage, family, and gender roles in Muslim society. **3.** Family structure and values in Muslims society.	05	1
Unit Vi: Islam and the Modern World: **1.** Relevance of Islam in the modern world (globalization, challenges, and prospects). **2.** Islamophobia, interfaith dialogue, and multiculturalism. **3.** Islamic viewpoint towards socio-cultural and technological changes.	05	1

References / Reading Materials:

1. "The Five Pillars of Islam: A Journey Through the Divine Acts of Worship" by Muhammad Mustafa Al-Azarni.
2. “The Five Pillars of Islam: A framework for Islamic Values and Character Building" by Musharraf Hussain.

3. “Towards Understanding Islam” by Abul A’ la Mawdudi.
4. “Islami Nazria e Hayat” by Khurshid Ahmad.
5. “An Introduction to Islamic Theology" by John Renard.
6. “Islamic Civilization Foundations Belief & Principles” by Abu1 A’ la Mawdudi.
7. “Women and Social Justice: An Islamic Paradigm” by Dr. Anis Ahmad.
8. “Islam: Its Meaning and Message” by Khurshid Ahmad.

APPLICATIONS OF INFORMATION AND COMMUNICATION TECHNOLOGIES (ICT)

Credit Hours: 03 (02+01)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Explain the fundamental concepts, components, and scope of Information and Communication Technologies (ICT).
2. Identify uses of various ICT platforms and tools for different purposes.
3. Apply ICT platforms and tools for different purposes to address basic needs in different domains of daily, academic, and professional life.
4. Understand the ethical and legal considerations in use of ICT platforms and tools.

Course Content:	MCQs	SEQs
Unit I: Introduction to Information and Communication Technologies: **1.** Components of Information and Communication Technologies (basics of hardware. software, ICT platforms, networks, local and cloud data storage etc.). **2.** Scope of Information and Communication Technologies (use of ICT in education. business, governance, healthcare, digital media and entertainment, etc.). **3.** Emerging technologies and future trends.	05	01
Unit II: Basic ICT Productivity Tools: **1.** Effective use of popular search engines (e.g., Google, Bing, etc.) to explore World Wide Web. **2.** Formal communication tools and etiquettes (Gmail, Microsoft Outlook, etc.). **3.** Microsoft Office Suites (Word, Excel, PowerPoint). **4.** Google Workspace (Google Docs, Sheets, Slides). **5.** Dropbox (Cloud storage and file sharing), Google Drive (Cloud storage with Google Docs integration) and Microsoft OneDrive (Cloud storage with Microsoft Office integration). **6.** Evernote (Note-taking and organization applications) and OneNote (Microsoft's digital notebook for capturing and organizing ideas). **7.** Video conferencing (Google Meet, Microsoft Teams, Zoom, etc.). **8.** Social media applications (LinkedIn, Facebook, Instagram, etc.).	10	02
Unit III: ICT in Education: **1.** Working with learning management systems (Moodle, Canvas, Google Classrooms, etc.). **2.** Sources of online education courses (Coursera, edX, Udemy, Khan Academy, etc.). **3.** Interactive multimedia and virtual classrooms. **Unit IV: ICT in Health and Well-being:** **1.** Health and fitness tracking devices and applications (Google Fit, Samsung Health, Apple Health, Xiaomi Mi Band, Run keeper, etc.). **2.** Telemedicine and on-line health consultations (OLADOC, Sehat Kahani, Marham, etc.).	05	01

Unit V: ICT in Personal Finance and Shopping: **1.** Online banking and financial management tools (jazz Cash, Easypaisa, Zong, Pay May, 1LINK and MNET, Keenu Wallet, etc.). **2.** E-commerce platforms (Daraz.pk, Telemart, Shophive, etc.) **Unit VI: Digital Citizenship and Online Etiquette:** **1.** Digital identity and online reputation. **2.** Netiquette and respectful online communication. **3.** Cyberbullying and online harassment.	05	01
Unit VII: Ethical Considerations in Use of ICT Platforms and Tools: **1.** Intellectual property and copyright issues. **2.** Ensuring originality in content creation by avoiding plagiarism and unauthorized use of information sources. **3.** Content accuracy and integrity (ensuring that the content shared through ICT platforms is free from misinformation, fake news, and manipulation).	05	01

Practical Requirements	OSPE/ Performances
As part of the overall learning requirements, the course will include: **1.** Guided tutorials and exercises to ensure that students are proficient in commonly used software applications such as word processing software (e.g., Microsoft Word), presentation software (e.g., Microsoft PowerPoint), spread sheet software (e.g., Microsoft Excel) among such other tools. Students may be assigned practical tasks that require them to create documents, presentations, and spread sheets etc. **2.** Assigning of tasks that involve creating, managing, and organizing files and folders on both local and cloud storage systems. Students will practice file naming conventions, creating directories, and using cloud storage solutions (e.g., Google Drive, OneDrive). **3.** The use of online learning management systems (LMS) where students can access course materials, submit assignments, participate in discussion forums, and take quizzes or tests. This will provide students with the practical experience with online platforms commonly used in education and the workplace.	03

Recommended Books / Reading Materials

1. Discovering Computers" by Vermaat, Shaffer, and Freund, 17th Edition, Cengage Learning, 2022.
2. "GO! with Microsoft Office" Series by Gaskin, Vargas, and McLellan, 2nd Edition, Pearson, 2012.
3. "Exploring Microsoft Office" Series by Grauer and Poatsy, 1st Edition, Pearson, 2016.
4. "Computing Essentials" by Morley and Parker, 16th Edition, Cengage Learning, 2016.
5. "Technology in Action" by Evans, Martin, and Poatsy, 14th Edition, Pearson, 2017.

ENTERPRENUERSHIP

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Knowledge of fundamental entrepreneurial 2 concepts, skills and process.
2. Understanding on different personal, social and financial aspects associated with entrepreneurial activities.
3. Basic understanding of regulatory requirements to set up an enterprise in Pakistan, with special emphasis on export businesses;
4. Ability to apply knowledge, skills and competencies acquired in the course to develop a feasible business plan.

Course Content:	MCQs	SEQs
Unit I: Introduction to Entrepreneurship: **1.** Definition and concept of entrepreneurship. **2.** Why to become an entrepreneur? **3.** Entrepreneurial process. **4.** Role of entrepreneurship in economic development.	05	01
Unit II: Entrepreneurial Skills: **1.** Characteristics and qualities of successful entrepreneurs (including stories of successes and failures). **2.** Areas of essential entrepreneurial skill and ability such as creative and critical thinking. innovation and risk-taking abilities etc.	05	01
Unit III: Opportunity Recognition and Idea Generation: **1.** Opportunity identification, evaluation and exploitation, **2.** Innovative idea generation techniques for entrepreneurial ventures. **Unit IV: Marketing and Sales** **1.** Target market identification and segmentation; **2.** Four P's of Marketing **3.** Developing a marketing strategy. **4.** Branding	05	01
Unit V: Financial Literacy **1.** Basic concepts of income, savings and investments **2.** Basic concepts of anets, liabilities and equity **3.** Basics of reverse and expenses **4.** Overview of cash-flows **5.** Overview of banking products including Islamic modes of financing **6.** Sources of funding for startups (angel financing, debt financing, equity financing etc.)	05	01
Unit VI: Team Building for Startups: **1.** Characteristics and features of effective teams **2.** Team building and effective leadership for startups	05	01
Unit VII: Regulatory Requirements to Establish Enterprises in Pakistan: **1.** Types of enterprises (e.g., sole proprietorship, partnerships private limited companies etc.). **2.** Intellectual property rights and protection	05	01

3. Regulatory requirements to register an enterprise in Pakistan, with special emphasis on sport firms **4.** Taxation and financial reporting obligation		

Recommended Books/Reading Materials

1. "Entrepreneurship: Successfully Launching New Ventures" by Bruce R. Barringer and R. Duane Ireland, 6th Edition, Pearson, 2018.
2. "Entrepreneurship: Theory, Process, and Practice" by Donald F. Kuratko, 12th Edition, Cengage Learning, 2023.
3. "New Venture Creation: Entrepreneurship for the 21st Century" by Jeffry A. Timmons, Stephen Spinelli Jr., and Rob Adams, 9th Edition, McGraw-Hill, 2011.
4. "Entrepreneurship: A Real-World Approach" by Rhonda Abrams, 2012.
5. "The Lean Startup: How Today's Entrepreneurs Use Continuous Innovation to Create Radically Successful Businesses" by Eric Ries, Crown Currency, 2011.
6. "Effectual Entrepreneurship" by Stuart Read, Saras Sarasvathy, Nick Dew, Robert Wiltbank, and Anne-Valérie Ohlsson, 1st Edition, Routledge, 2010.

CIVICS AND COMMUNITY ENGAGEMENT

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Demonstrate fundamental understanding of civics, government, citizenship and civil society.
2. Understand the concept of community and recognize the significance of community engagement for individuals and groups.
3. Recognize the importance of diversity and inclusivity for societal harmony and peaceful co-existence.

Course Content:	MCQs	SEQs
Unit I: Civics and Citizenship: **1.** Concepts of civics, citizenship, and civic engagement. **2.** Foundations of modern society and citizenship. **3.** Types of citizenship: active, participatory, digital, etc **Unit II: State, Government and Civil Society:** **1.** Structure and functions of government in Pakistan. **2.** The relationship between democracy and civil society. **3.** Right to vote and importance of political participation and representation.	05	01
Unit III: Rights and Responsibilities: **1.** Overview of fundamental rights and liberties of citizens under Constitution of Pakistan 1973. **2.** Civic responsibilities and duties. **3.** Ethical considerations in civic engagement (accountability, non-violence, peaceful dialogue, civility, etc.)	05	01
Unit IV: Community Engagement: **1.** Concept, nature and characteristics of community. **2.** Community development and social cohesion. **3.** Approaches to effective community engagement. **4.** Case studies of successful community driven initiatives.	05	01
Unit V: Advocacy and Activism: **1.** Public discourse and public opinion. **2.** Role of advocacy in addressing social issues. **3.** Social action movements.	05	01
Unit VI: Digital Citizenship and Technology: **1.** The use of digital platforms for civic engagement. **2.** Cyber ethics and responsible use of social media. **3.** Digital divides and disparities (access, usage, socioeconomic, geographic, etc.) and their impacts on citizenship.	05	01
Unit VII: Diversity, Inclusion and Social Justice: **1.** Understanding diversity in society (ethnic, cultural, economic, political etc.). **2.** Youth, women and minorities' engagement in social development. **3.** Addressing social inequalities and injustices in Pakistan.	05	01

4. Promoting inclusive citizenship and equal rights for societal harmony and peaceful co-existence.		

Recommended Books/ Reading Materials

1. "Civics Today: Citizenship, Economics, & You" by McGraw-Hill Education, McGraw-Hill Education, 6th Edition, 2009.

2. "Citizenship in Diverse Societies" by Will Kymlicka and Wayne Norman, 1st Edition, Oxford University Press, 2000.

3. "Engaging Youth in Civic Life" by James Youniss and Peter Levine, Vanderbilt University Press, 2009.

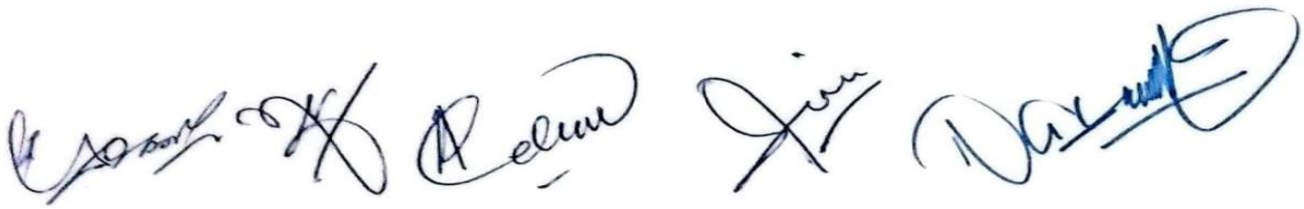
4. "Digital Citizenship in Action: Empowering Students to Engage in Online Communities" by Kristen Mattson, 2017.

5. "Globalization and Citizenship: In the Pursuit of a Cosmopolitan Education" by Graham Pike and David Selby.

6. "Community Engagement: Principles, Strategies, and Practices" by Becky J. Feldpausch and Susan M. Omilian.

7. "Creating Social Change: A Blueprint for a Better World" by Matthew Clarke and Marie-Monique Steckel

INTERDISCIPLINARY COURSES



GENERAL PATHOLOGY

CREDIT HOURS: 03 (03+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. To understand the basic terminologies in different pathological states
2. To elaborate the cell injuries, necrosis, their types and practical applications of pathology

Course Content	MCQs	SEQs
Unit I: Cellular response to stress and toxic insults **1.** Adaptation (Hyperplasia, Atypia, Hypertrophy, Metaplasia) **2.** Cell Injury (causes, morphological alterations and mechanisms of Reversible/Irreversible cell injury) **3.** Cell Death (Necrosis, Apoptosis) **4.** Intracellular Accumulations and Pathological calcification	5	1.5
Unit II: Inflammation and Repair **1.** Acute Inflammation **2.** Chronic inflammation **3.** Tissue repair	8	2
Unit III: Hemodynamic Disorders, Thromboembolic Disease, and Shock **1.** Hyperemia and Congestion **2.** Hemostasis, Hemorrhagic Disorders, and Thrombosis **3.** Embolism **4.** Infarction **5.** Shock	5	1
Unit IV: Diseases of the Immune System **1.** Normal immune response **2.** Hypersensitivity	5	1
Unit V: Neoplasia **1.** Nomenclature **2.** Characteristics of benign and malignant neoplasms **3.** Clinical aspects of neoplasia **4.** Diagnosis and treatment of Cancer in general, fate, survival and prognosis with tumors	8	2
Unit VI: Infectious Diseases **1.** General Principles of Microbial Pathogenesis	4	0.5
Unit VII: Environmental and Nutritional Diseases **1.** Injury by physical agents (mechanical trauma, thermal injury, electrical injury, radiation injury) **2.** Nutritional diseases	5	0.5
Unit VIII: Miscellaneous topics **1.** Anemia **2.** Fever **3.** Hypertension **4.** Diarrhea **5.** Peptic & duodenal ulcer	5	0.5

Recommended Books/ Reading Materials

1. Oxford Handbook of Clinical Pathology Oxford Medical Handbooks) 2nd Edition by James Carton.
2. Robbins & Cotran Pathologic Basis of Disease by Vinay Kumar, Abul K. Abbas, Jon C. Aster, 10th Edition.

SPECIAL PATHOLOGY/ PATHOPHYSIOLOGY II

Credit Hours: 03 (03+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Describe the factors in the environment, which contribute to produce changes in Physiological processes.
2. Discuss the relationship of normal body function with altered physiological mechanisms in disease process.
3. Integrate the knowledge of the basic principles of Pathophysiology in a hospital and community environment.

Course Content	MCQs	SEQs
Unit I: Genetic Disorders **1.** Differentiate between Genetic & Congenital disorders **2.** Terminologies related to genetic disorders: Trisomy **3.** Monosomy, Polysomy **4.** The Chromosomal defects with special emphasis on aneuploidy **5.** The pathophysiology and the clinical manifestation of the following genetic disorders. **6.** Down's syndrome **7.** Turner's syndrome **8.** Kleinfelter's syndrome	8	1
Unit II: Endocrine & Metabolic Disorders **1.** Disorders of Growth Hormone **2.** Disorders of endocrine pancreas: Diabetes Mellitus (DM) **3.** Disorders of Thyroid Gland & Parathyroid gland **4.** Disorders of Adrenal gland	10	2
Unit III: Disorders of Neurological system **1.** Pain, and special senses i.e. eye & ear. **2.** Cerebral Vascular Accidents & Stroke. **3.** The somatosensory pathway. **4.** The function of Nociceptors in response to pain information. **5.** The function of endogenous analgesic mechanism. **6.** The mechanism of pain relief with the use of heat, cold & TENS i.e. Transcutaneous electrical nerve stimulation. **7.** The major vessels in the cerebral circulation. **8.** Stroke, Risk factors and types of stroke **9.** Transient Ischemic Attacks (TIAS)	10	2
Unit IV: Disorder of Special Senses (Eye & ear) **1.** The Anatomy & Physiology of eye & ear **2.** some common visual & auditory dysfunction Cataract, Glaucoma, Tinnitus & hearing Loss	4	1
Unit V: Disorder of Cardiovascular system **1.** Coronary circulation **2.** Collateral arteries **3.** Heart action i.e. conduction system, myocardial contraction &relaxation. **4.** The atherosclerosis	8	2

5. The Frank Starling and Laplace's law. Preload, after load, & contractility. **6.** Ischemic heart diseases myocardial ischemia (angina & its types) myocardial infarction		
Unit VI: Alteration in Musculoskeletal support and movement **1.** Trauma & Injury **2.** Skeletal structures. **3.** The pathological processes of metabolic bone disease and inflammatory joint diseases	5	1
Total Marks	**45**	**09**

Recommended Books/ Reading Materials

1. Porth, C., & Matfin, G. (2019). Pathophysiology: Concepts of altered health states (10th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins
2. Robbins & Cotran)2020(. Pathologic Basis of Disease by Vinay Kumar, Abul K. Abbas, Jon C. Aster, 10th Edition.

DEVELOPMENTAL PSYCHOLOGY

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Describe basic concepts of Psychology.
2. Demonstrate application of the learnt concepts in practicing nursing.
3. Explain developmental Psychology and factors influencing human psychosocial development.
4. Discuss human development through the life span with reference to the psychological, social and cognitive perspective.

Course Content	MCQs	SEQs
Unit I: Introduction to Psychology **1.** Define Psychology. **2.** Identify different perspectives in Psychology. **3.** Identify various fields of Psychology **4.** Demonstrate its understanding	1	0
Unit II: Theories of Personality Development **1.** Define Developmental Psychology. **2.** Identify various stages of development. **3.** Describe theories of development (Freud, Erickson, Piaget) **4.** Describe interaction between heredity and environment.	4	1
Unit III: Infancy (0-2 years) **1.** Growth and motor development. **2.** Cognitive development (learning and memory) **3.** Piaget's sensorimotor stage. **4.** Freud's interpretation and parent – child relationships. **5.** Erickson's stage of Psycho Social Development trust and autonomy.	4	1
Unit IV: Pre-School Child (2-6 years) **1.** Cognitive Development. (Piaget's pre-operational thought stage) **2.** Language development. **3.** Personality Development **4.** Erikson's Stage of Psycho Social Development "initiative vs guilt stage" **5.** Influence and peers in personality development. **6.** Play **7.** Stage of psychosexual development.	4	1
Unit V: School Child (6-12 years) **1.** Cognitive development. **2.** Personality Development. **3.** Relationships with significant others and peers. **4.** Types of parenting **5.** Stage of Psychosexual development.	2	1
Unit VI: Adolescence (age 12-19) **1.** Impact of physical maturity. **2.** Impact of sexual maturity. **3.** Erickson's identity vs role confusion stage. **4.** Interpersonal relationships with parents and peer group. **5.** Problems of Adolescence.	3	1

6. Piaget's stage of cognitive development		
Unit VII: Adulthood (age 19-60) **1.** Early and middle adulthood. **2.** Interpersonal relationships (work and family). **3.** Erickson's intimacy vs isolation stage. **4.** Mid-life crises and life satisfaction.	2	0
Unit VIII: Old Age (60 and beyond) **1.** Physical changes in old age. **2.** Erickson's Generativity vs. self-absorption and integrity vs. self-despair stages. **3.** Quality of life and old age. **4.** Emotional and social changes in old age.	2	0
Unit IX: Learning **1.** Define Learning **2.** Define and describe classical conditioning **3.** Define and describe operant conditioning. **4.** Demonstrate an understanding of application of conditioning in daily life	1	1
Unit X: Intelligence **1.** Define Intelligence. **2.** Demonstrate an understanding of the concept of the measurement of intelligence **3.** Describe the characteristics of tests **4.** Identify various measurements scales.	2	0
Unit XI: Emotions **1.** Arousal and emotion. **2.** Expression and emotion. **3.** General reactions to being in an emotional state. **4.** Aggression as an emotional reaction. **5.** Cultural expression of emotions.	2	0
Unit XII: Memory **1.** Define memory **2.** Define and describe various types of Memories **3.** Demonstrate an understanding of the processes of forgetting from long term memory	1	0
Unit XIII: Motivation **1.** Describe theories of motivation. **2.** Describe theories of motivation. **3.** Application of motivation principles to personal and professional life. **4.** Demonstrate an understanding of application of motivation principles to achievement and failure	1	0
Unit XIV: Stress **1.** Types of stress **2.** Reaction to stress **3.** Stress in nursing	1	0
Total Marks	**30**	**6**

Recommended Books/ Reading Materials:

1. Morris, C. G., Maisto, A. A. (2019). Understanding psychology (12th ed.). New York, NY: Pearson Education, Inc.

TEACHING/LEARNING: PRINCIPLES AND PRACTICES

Credit Hours: 03 (03+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Analyze various adult learning theories and the characteristics of adult learners.
2. Describe the complexity of conditions that impact on learning.
3. Critically reflect on one's own learning.
4. Utilize appropriate health teaching strategies for diverse settings.
5. Plan patient and family education session by utilizing the steps of patient education.

Course content	MCQs	SEQs
UNIT I: Reflective Writing and Critical Thinking **1.** Develop an understanding of the reflective learning. **2.** Process of journal writing. **3.** Critical thinking.	5	1
Unit II: Stages in Learning, Physical Environment and Well Being **1.** Developmental stages and learning, experiential learning **2.** Impact of state of physical health on learning **3.** Emotional aspect including stress **4.** Physical environment conducive to learning in addition wellbeing and learning including behavioral, cognitive, humanistic and dialectical (interactive) learning theories.	5	1
Unit III: Learning Cycle, Models and Learning Styles **1.** Examination of the learning cycles **2.** Models of Kolb and Taylor and how they impact on learning **3.** Types of Learning/styles **4.** Problems-solving and the learning cycle.	6	1
Unit IV: Learning Theories and Characteristics of Adult Learners **1.** Characteristics of Adult Learner psychological, past experience, time perspectives, the self, and self-direction **2.** Factors that influence learning **3.** Cognitive and affective aspects and learning theories	7	1
Unit V: health education/health promotion **1.** Discuss the basic goals of health education, and factors influencing on health education. **2.** Utilize the health belief model and health promotion model and relate to cognitive and behaviorist theories. **3.** Discuss the steps in developing the health education programme. **4.** Utilize effectively a variety of teaching aids and creative application of teaching strategies **5.** Plan patient and family education session	7	2
Unit VI: Needs Assessment **1.** Develop a framework to assess the learning needs, health problems, of a target group. **2.** Analyze the problems according to the priority.	5	1
Unit VII: writing Objectives		

1. Differentiate between general and specific objectives. **2.** Taxonomy of objectives. **3.** Levels of objectives **4.** Use of verbs in writing objectives **5.** How to write SMART objectives.	5	1
UNIT VIII: Lesson Planning **1.** Develop a lesson plan on a selected topic which would include steps in preparing learning objectives **2.** Criteria for measuring outcome of objectives, developing appropriate content **3.** Selecting teaching methods, target dates of achievement of objectives and how the objective would be evaluated.	5	1
Total	45	9

Recommended Books/ Reading Materials

1. Bastable, S. (2019). *Nurse as Educator*. (5th ed.). Jones & Bartlett Learning

2. Basavanthappa, B. T. (2009). Nursing education. (2nd ed.). New Delhi: Jaypee Medical publication

EPIDEMIOLOGY

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Illustrate the general use of Epidemiology
2. Illustrate the use of a model of the natural history of a disease as a base for community intervention
3. Describe the common epidemiological methods
4. Describe the steps of an epidemiological investigation
5. Interpret the relevance of epidemiological research findings to community health nursing practice.
6. Discuss the impact of population growth on the socioeconomic and health status in Pakistan.

Course Content	MCQs	SEQs
Unit I: Introduction of Epidemiology **1.** Uses of epidemiology **2.** Scope of epidemiology	3	0
Unit II: Concept of Health & Disease **1.** Health **2.** Health Indicators **3.** Disease **4.** Concept of causation **5.** Illness **6.** Well-being **7.** Determinants of disease in individuals and community	3	1
Unit III: Epidemiological Models **1.** Natural history of disease **2.** Web of causation and Epidemiological Triad	3	1
Unit IV: Concepts of prevention **1.** Levels of prevention (Primordial prevention, Primary prevention**,** Secondary prevention and Tertiary prevention)	4	0.5
Unit-V: Basic Measurement **1.** Rate **2.** Mortality rate **3.** Morbidity rate **4.** Ratio **5.** Incidence & prevalence rate **6.** Maternal and infant mortality rate	4	0.5
Unit-VI: Epidemiological transition in disease pattern **1.** Heath &demographic transition and Population changes (population pyramid) **2.** Factors affecting population changes (dependency ratio, sex ratio) **3.** Changes in life expectancy and major cause of death	3	1
Unit-VII: Epidemiological Methods **1.** Description –person, place or time **2.** Analytic: Basic concept of cross sectional prospective & retrospective **3.** Intervention /Experimental study	3	1

Unit IX: Surveillance and notification **1.** Define the term surveillance **2.** Discuss the principles of surveillance and notification **3.** Describe different methods of surveillance **4.** Identify nurse's role in surveillance	2	0.5
Unit -9: Screening **1.** Definition **2.** Types of screening, **3.** Methods of screening, **4.** Sensitivity & specificity	2	0.5
Unit-10: Data management & presentation	3	0
Total	**30**	**6**

Recommended Books/ Reading Materials

1. Bonita, R., Beaglehole, R., Kjellström, T. (2006). *Basic Epidemiology.* (2nd ed.) WHO Library Cataloguing-in-Publication Data

APPLIED NUTRITION

Credit hours: 01 (01+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Describe the role of diet for prevention and management of diet related diseases.
2. Identify locally available and acceptable food sources to provide the nutritional needs for the health and growth at different ages.
3. Apply the knowledge of the nutrition in the management of the nutritional needs of patients with chronic and long-term diseases.

Course content	MCQs	SEQs
Unit I: Maternal Nutrition **1.** Nutritional need in pregnancy and Lactation. **2.** Pre-pregnancy diet. **3.** Pregnancy and adolescents **4.** Nutritional risk factor of pregnancy **5.** Concerns during pregnancy / weight gain/feeding twins/Diabetes Mellitus (DM) in pregnancy. **6.** Prevalence of Iron deficiency anemia in Pakistani women.	2	0.5
Unit II: Nutritional Considerations in infancy and preschool years **1.** Identify the best feeding options for infants in different circumstances in Pakistan. **2.** Identify the major nutritional risk factors and strategies to prevent or manage them in the first years of life and during the pre-school years. **3.** Weaning, Pre lacteal feeds, food introduce with quantity and type. **4.** Counsel mothers regarding nutritional care of the children.	2	0
Unit III: Weight management **1.** Explain the concept of appropriate body weight. **2.** Discuss the relationship of excess body weight to the development of chronic disease. **3.** Explain the concept of energy balance. **4.** Explain body mass index calculations. **5.** Explain the role of diet in weight management. **6.** Identify factors in the Pakistani diet that are particularly conducive to weight gain **7.** Explain the role of exercise in weight management **8.** Explain the role of behavior modification techniques in weight management. **9.** Council patient regarding weight management.	3	0.5
Unit IV: Enteral and Prenatal Nutrition. **1.** Identify the characteristics, nutritional composition and concentration of formula feedings. **2.** Complications associated with Enteral feeding.	2	0

Unit V: Nutritional considerations in the prevention and management of cardio vascular diseases **1.** Identify the risk factors for the development of hypertension. **2.** Identify the risk factors for the development of coronary artery disease. **3.** Discuss the role of a nurse in dietary management of hypertension and patient with hyperlipidemia. **4.** Counsel patients on the dietary prevention of coronary artery disease **5.** State dietary modification for low cholesterol diet – low saturated fat - low sodium diet	2	0.5
Unit VI: Nutritional considerations in the prevention and management of liver disease **1.** Describe the role of diet in the management of gall stone **2.** Describe the role of diet management of liver disease, especially hepatitis, cirrhosis, encephalopathy. **3.** Discuss current beliefs and practices related to diet in liver disease in the community. **4.** Identify the role of the nurse in dietary management of liver disease.	2	0.5
Unit VII: Nutritional considerations in the prevention and management of renal disease **1.** Identify nutritional risk factors for nephrolithiasis and renal failure. **2.** Discuss the role of a diet in etiology, prevention and management of nephrolithiasis and renal failure and during dialysis. **3.** Describe the nutritional management in nephritic syndrome. **4.** Review iron deficiency anemia and Iron sources (since it is common in renal patients.	1	0.5
Unit VIII: Nutritional considerations in the prevention and management of Type II Diabetes Mellitus. **1.** Describe the prevalence of Type II DM in Pakistan. **2.** Describe dietary factors associated with the diseases. **3.** Explain the role of weight gain in the Etiology of Type II DM. **4.** Identity the role of the nurse in prevention and management of Type II DM.	1	0.5
TOTAL	**15**	**3**

Recommended Books/ Reading Materials

1. Chuhan, D., (2021). *Nutrition for BSc. and post Basic Nursing Students*. (2nd ed.). Lotus Pulishers. India.

2. Dudek, S. G. (2022). Nutrition essentials for nursing practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins

BASIC ANATOMY

Credit Hours: 03 (03+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Have an understanding of the structural components of body
2. Comprehend the basic anatomical structure of human organs and systems
3. Identify the principal histological features of various tissues and blood composition.

Course Content:	MCQs	SEQs
Unit I: General Anatomy: Planes, axes, general body organization & structures, Bone & cartilage, Joint, Muscle	5	1
Unit II: Gross Anatomy of Digestive system: Oral Cavity, pharynx, esophagus, stomach small & large intestine	5	1
Unit III: Gross Anatomy of Urinary system: Kidney, ureter, bladder, urethra	3	1
Unit IV: Gross Anatomy of cardiovascular & lymphatic system: Heart, Pericardium, arterial & venous system, major arteries & veins, Lymph flow, Lymph Vessel & Lymph node	5	1
Unit V: Gross Anatomy of respiratory system: Nose, paranasal sinuses, larynx, trachea, bronchus, lungs and diaphragm	3	1
Unit VI: Gross Anatomy of reproductive system: Male: Testis, spermatic cord, penis, prostate, bulbourethral glands, Female: Ovaries, fallopian tubes, uterus, vagina, vulva, breast.	5	1
Unit VII: Gross Anatomy of endocrine system: Pituitary, thyroid, parathyroid, thymus, adrenal gland, Kidneys	4	1
Unit VIII: Gross Anatomy of Nervous system & sensory organs: Brain, spinal cord, cranial nerves, brachial plexus, sciatic nerve, Ear, Eye, Tongue, Taste buds, Nose.	5	1
Unit IX: **Histology of cells, tissues, epithelium & connective tissue**	5	1
Unit X: Histology of Bone, cartilage, muscles, Cardio Vascular System, lymphoid & blood	5	

Recommended Instructional / Reading Materials:

1. Snell, Richard S. (2018). Clinical anatomy by regions (10th). Baltimore, MD: Wolters Kluwer/Lippincott Williams & Wilkins
2. Laiq Hussain (2023) Medical Histology Text and Atlas (8th Ed)
3. Agur, M.R. and F.D. Arthur. (2020). Grant's Atlas of Anatomy; (15th). Lippincott Williams and Wilkins, New York, U.S.A.
4. Waugh, Anne, Grant, Allison. (2023). *Ross and Wilson anatomy and physiology in health and illness* (14th). Toronto: Churchill Livingstone/Elsevier.

BASIC BIOCHEMISTRY

Credit Hours: 03 (03+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Students will be able to apply chemical principals to biological phenomena.
2. They will develop knowledge of the structure and function of the major classes of biological molecules and their role in cellular structure, function and bioenergetics.
3. They will know the clinical outcomes of any change in the structure and functions of these biological molecules.

Course Content:	MCQs	SEQs
Unit I: Introduction **1.** Introduction of carbohydrates **2.** Introduction of lipids. **3.** Bioenergetics and oxidative phosphorylation.	05	01
Unit II: Carbohydrate metabolism **1.** Glycolysis, TCA (Tricarboxylic acid cycle) **2.** Gluconeogenesis, Glycogen metabolism, metabolism of monosaccharaide and disaccharides, Pentose phosphate shunt, **3.** Glycosaminoglycan and Glycoproteins **4.** Carbohydrate metabolism disorders	05	01
Unit III: Dietary lipid metabolism **1.** Fatty acid triacylglycerol metabolism **2.** Complex lipid metabolism **3.** Cholesterol and sterol metabolism. **4.** Lipid metabolism disorders	05	01
Unit IV: Proteins **1.** Amino acids, structure of proteins **2.** Globular proteins, hemoglobin, myoglobin, Hemoglobinopathies, xenobiotic.	05	01
Unit V: Protein Metabolism **1.** Disposal of nitrogen, amino acid degradation and synthesis, **2.** conversion of amino acids to specialized product and amino acid metabolism disorders	05	01
Unit VI: Vitamins, nutrition, obesity and diabetes mellitus	04	01
Unit VII: Enzymes **1.** Classifications, functions, **2.** Regulation and diagnostic significance, **3.** Michaelis Menten equation. **Unit VIII: Fibrous proteins** **4.** Collagen and elastin synthesis and their disorders, **5.** Hormones.	04	01
Unit IX: Cell **1.** Cell structure, **2.** Cell to cell signaling and cytoskeleton,	05	01

3. Receptors **4.** Water and PH balance, **5.** The feed/fast cycle, **6.** Metabolic effects of insulin and glucagon. **7.** Nucleotide metabolism		
Unit X: DNA and RNA **1.** DNA structure, replication and repair, **2.** RNA structure synthesis and processing, **3.** Protein synthesis, **4.** Regulation of gene expression, **5.** Biotechnology and human disease	07	01

Recommended Books / Reading Materials:

1. Ferrier, Denise R. (2021). Lippincott Illustrated Reviews: Biochemistry (8th) Philadelphia, PA: Wolters Kluwer Health. Chicago Style.
2. Rodwell, Victor W, Bender, David A, Botham, Kathleen M, Kennelly, Peter J, Weil, Anthony P. (2022). *Harper's Illustrated Biochemistry* (32nd). New Delhi: Mc Graw Hill

BASIC PHYSIOLOGY

Credit Hours: 03 (03+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Acquire knowledge of various aspects of human physiology

Course Content:	MCQs	SEQs
Unit I: Digestion and absorption of macromolecules (carbohydrate, lipid and protein)	5	1
Unit II: Hormones (introduction, classification, mechanism of action, biological functions of thyroid, parathyroid, pituitary, adrenal, gonadal and pancreatic hormones)	9	2
Unit III: Blood (composition, characteristics, functions, hemoglobin, synthesis, degradation, coagulation and clotting factors, blood pressure, blood groups, buffers)	9	2
Unit IV: Respiration (structure and functions of lungs, transport of oxygen and carbon dioxide)	6	1
Unit V: Specialized tissue: muscle	6	1
Unit VI: Specialized tissue: kidney structure and functions, acid base, electrolyte and water balance	5	1
Unit VII: Specialized tissue: liver (structure and functions)	5	1

Recommended books / Reading Materials:

1. Hall, J. E. (2020). *Guyton and Hall textbook of medical physiology* (14th). Elsevier.
2. Waugh, Anne, Grant, Allison. (2023). *Ross and Wilson anatomy and physiology in health and illness* (14th). Toronto: Churchill Livingstone/Elsevier.

MICROBIOLOGY

Credit Hours: 01 (01+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Explain the necessity of the knowledge of Microbiology needed when providing nursing care to the clients.
2. Use basic principles of Microbiology in nursing practice, in a hospital and community environment.

Course Content	MCQs	SEQs
Unit I: Introduction to Microbiology **1.** Define microbiology. **2.** Explain the importance of microbiology in nursing practice **3.** List the contribution of the following scientists in the field of microbiology. **a.** A.V. Leuwenhoek **b.** F. Redi **c.** L. Pasteur **d.** R. Koch **4.** Distinguish between eukaryotic and prokaryotic cell. **5.** List some basic properties of virus **6.** List basic nutritional requirements of microorganisms **7.** Classify bacteria on the bases of their nutritional requirement and **8.** Morphology	2	0
Unit II: Control of Microorganisms **1.** Explain importance of the control of microbial growth. **2.** Describe some physical and chemical methods to control microbial growth **3.** Define the terms i.e. sterilization, antiseptic, asepsis, aseptic, macrobiotic, microbiocidal, antibiotic etc. **4.** Differentiate between broad spectrum and narrow spectrum antibiotics.	3	1
Unit III: Defense Mechanisms of the body **1.** Explain the role of good health in protection against the microbial infection. **2.** Define resistance and susceptibility. **3.** Define nonspecific resistance. **4.** Describe the role of the skin and mucous membrane in nonspecific resistance. **5.** Explain the process of phagocytosis. **6.** Define the specific resistance, innate resistance and immunity. **7.** Explain four types of acquired immunity. **8.** Differentiate between humoral and cell mediated immunity. **9.** Define antigens, happen and antibodies. **10.** List the five classes of antibodies and their functions. **11.** Explain the role of memory, tolerance and specificity in immunity. **12.** Distinguish between primary and secondary immune response. **13.** Define Hypersensitivity. **14.** Differentiate between i.e. delayed and immediate Hypersensitivity.	3	1
Unit IV: Human and Microbial Interaction	4	1

1. Define normal flora of the body. **2.** Differentiate between resident and transient normal flora. **3.** List at least three beneficial roles of normal flora. **4.** Define nosocomial infections. **5.** List at least three measures to control nosocomial infections. **6.** Describe some pathogenic microbes and diseases i.e. tetanus, typhoid, **7.** Cholera, diphtheria, tuberculosis, pertussis, mumps, measles, polio, **8.** Influenza ascariasis, taeniasis and dermatomycosis.		
Unit V: Microbiology in Every Day Life **1.** Describe how microorganisms affect environment i.e. air, water and food. **2.** List some safety measures to control water and food borne diseases. **3.** Differentiate between food infection and food poisoning.	3	0
Total	**15**	**3**

Recommended Instructional / Reading Materials:

1. Warren E. Lavinson (2023) Medical Microbiology and Immunology (17th). Lange publishers

DIAGNOSTIC PROCEDURES

Credit hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Provide the client and/or significant others with an explanation of the diagnostic test, the purpose of the diagnostic tests and the procedure that will be followed for the specific diagnostic test, in addition to any specific preparation such as NPO after midnight, as indicated for the particular diagnostic test
2. Perform complete and accurate labeling of all specimens that are obtained by the nurse at the bedside that minimally includes the client's full name, the date and time of the specimen collection
3. Perform preservation and transportation of the specimen to the laboratory in a timely manner along with the proper laboratory requisition slip
4. Use properly the receptacle or container for the specific specimen that contains any necessary preservatives, chemical or anticoagulants
5. Dispose properly all supplies and equipment that was used for the diagnostic test

Course Content	MCQs	SEQs
Unit I: Laboratory Investigations - Acid Base Balance **1.** Review the physiology mechanism responsible to regulate acid base balance in the body. **2.** Interpret Arterial Blood Gases (ABGs) with different types of acid base imbalance with scenario. Discuss pre, intra, and post nursing care specific to ABGs **3.** Basic interpretation of test and its requirements in different diseases conditions **4.** Point of care testing of ABGs in Intensive Care Units (ICUs) and Emergency conditions. **5.** Nursing management of ABGs, safe sampling for ABGs, and care of arterial line.	3	1
Unit II: Laboratory Investigations - Fluid and Electrolytes and Renal Function **1.** Review the pathophysiology of fluid and electrolyte in the body. **2.** Discuss isotonic, osmotic and compositional imbalance. **3.** Basic interpretation of test and its requirements in different diseases conditions **4.** Point of care testing of Electrolytes in hospital settings **5.** Nursing management of patient with electrolytes imbalance, education, and safe sampling.	3	1
Unit III Laboratory Investigations - Coagulation function **1.** Identify the function and importance of the following investigation in relation to cardiac pulmonary disorder. **a.** Bleeding time **b.** Coagulation time **c.** Partial Thromboplastin time (PTT) **d.** Fibrinogen **e.** Platelet **f.** Prothrombin Time (PT)	4	1

g. Thrombin Time **2.** Relate the laboratory investigation with the scenario in the case base tutorials **3.** Discuss pre, intra and post nursing care specific to the coagulation investigation.		
Unit IV: Laboratory Investigations- Cardiopulmonary Function **1.** Identify the function and importance of the following investigation relation to cardiac pulmonary disorder **a.** Creatinine Phosphokinase (CPK) **b.** Plasma Cholesterol **c.** Triglycerides **d.** Lipoprotein **e.** Trop-I **2.** Relate the laboratory investigation and clinical manifestations with the scenario. **3.** Discuss the nursing care of the patients specific to the above-mentioned laboratory investigation. **4.** Discuss pre, intra, and post nursing care specific to the related blood test.	3	1
Unit V: Laboratory Investigations – Complete Blood Count **1.** Basic interpretation of test and its requirements in different diseases conditions **2.** Point of care testing of CBC in hospital setting **3.** Nursing management of patient with deranged CBC (infections, platelets count, anemic conditions)	2	0
Unit VI: Overview - Chest radiography **1.** Review the basic anatomy and physiology of the respiratory system and cardiac system. **2.** Explain the purpose of taking a chest X-ray **3.** Identify normal cardiothoracic anatomical structures demonstrable on a chest film. **4.** Identify different views to assess chest (AP/PA view) **5.** Basics of chest X-ray interpretations **6.** Preparing patient for X-Ray (in inpatient and critical care settings) **7.** Precautionary and safety measures for X-rays (safety of persons and surroundings, in OT, and open space areas-wards settings) **8.** Nursing consideration for different X-rays **9.** Analyze physical signs and symptoms of pulmonary and trauma with chest radiographic findings. **10.** Identify all intravascular catheters and pacemaker electrodes for position **11.** Analyze physical signs and symptoms of cardiovascular disease with chest radiographic findings **a. X- ray Interpretation for Chronic Obstructive Pulmonary Disease** • Chronic Bronchitis • Asthma • Emphysema **b. X-ray Interpretation for chest Infections** • Bronchiectasis • Pneumonia • Tuberculosis **c. X-ray interpretation for Pleural and Diaphragm Disorder**	5	1

• Pneumothorax • Pleural effusion • Pneumonia • Diaphragmatic Hernias **d. X-ray Interpretation for Pulmonary Trauma & Neoplasm** • Solitary Nodules • Pulmonary mass • Contusions and hematomas • Acute Respiratory Distress Syndrome • Airway Obstruction **e. X-ray interpretation for Cardiovascular Disorder** • Pulmonary edema • Pulmonary hypertension • Heart enlargement • Pericardial disease		
Unit VII: Electro Cardio Graph (ECG) Interpretation **1.** Review the ECG wave component and intervals of normal ECG. **2.** Relate each component of ECG complex with cardiac contraction. (Cardiac Cycle) **3.** Measure the atrial rate (AR) and ventricular rate (VR). **4.** Demonstrate ECG electrode placement for 12 lead ECG. **5.** Identify the purpose of different leads. **6.** Preparing patient for ECG (in inpatient and critical care settings) **7.** Precautionary and safety measures for ECG **8.** Nursing consideration for ECGs in ICU and emergency settings. **9.** Basic interpretation of ECG for emergency conditions **10.** Performing ECG for patient, lead placement of 12 Lead ECG and on defibrillator **11.** Normal features **12.** Sinus Arrhythmias **13.** Atrial Premature Contractions (APCs) **14.** Premature Ventricular Contractions (PVCs) **a. Atrial arrhythmia** • Atrial Flutter • Atrial Fibrillation • Supraventricular Tachycardia **b. Ventricular arrhythmia** • Ventricular Tachycardia • Ventricular Fibrillation • Junctional Arrhythmia **c. ECG Interpretation for Conduction Disorder** • First Degree Heart Block • Second Degree Heart Block Type I • Second Degree Heart Block Type II • Complete /Third Degree Heart Block • Pace maker **d. ECG Interpretation** • Hypertrophy	6	1

• Axis deviation **e. ECG Interpretation for Coronary Artery Diseases** • Ischemia • Injury • Myocardial Infarction		
Unit VIII: Ultrasound **1.** Basic requirement of Ultrasound in clinical settings **2.** Nursing care for patient and preparation of patient undergoing different types of Ultrasounds Basic interpretation of ultrasound reports including whole abdomen, KUB etc.	2	0
Unit IX: CT Scan and MRI **1.** Basic requirement of CT Scan and MRI in clinical settings **2.** Nursing care for patient and preparation of patient undergoing different types of CT Scans and MRI (Contrast, without contrast) Patient education for CT Scan and MRI	2	0
Total	30	6

Recommended Books/ Reading Materials:

1. Hinkle, J. L., Cheever, K. H. & Overbaugh, K. (2021). Brunner & Suddarth's textbook of medical-surgical nursing (15th ed.). Wolters Kluwer.
2. Burgener, F., A., Kormano, M., & Pudas, T. (2006). The chest X-ray: differential diagnosis in conventional radiology. Germany: Theme.
3. Coviello, J. S. (2020). ECG interpretation made incredibly easy (7th.ed.). Texas: Lippincott Williams & Wilkins.
4. Karthikeyan, D.C., (2017). Chest X-ray made easy. (2nd) Jaypee: New Delhi

MAJOR COURSES

FUNDAMENTAL OF NURSING-I

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Describe the historical development of Health care and nursing.
2. Describe early Nursing Leaders and their contributions to the profession of nursing.
3. Compare requirements and advantages of different Nursing Educational Programs.
4. Compare and contrast definitions of nursing by different Nursing Scholars.
5. Describe the roles of a professional nurse.
6. Describe the relationship among Human needs, Adoption Homeostasis, alterations in Health, Voluntary and Involuntary processes, and nursing intervention.
7. Explain the content and purposes of Code of Ethics, and Standards of Nursing practice.
8. Discuss the purposes and activities of the World Health Organization and the International Council of Nurses.

Course Outline	MCQ	SEQ
Unit I: History of Nursing **1.** Summary of ancient cultures **2.** Site of Health Care in Ancient Cultures **3.** Islam and Nursing **4.** The founder of Nursing **5.** Historical Perspective **6.** Nursing in Mogual period **7.** Nursing Defined by different scholar **8.** Definition of Nursing by WHO 17 **9.** Types of Nursing Educational Programs **10.** History of Nursing Education in Pakistan	2	0
Unit II: Role of nurse in health care **1.** Professional **2.** Characteristics of a Profession **3.** Role of the Professional nurse **4.** Description of Career roles **5.** Description of role as Communicator **6.** Description of role as a Teacher **7.** Description of role as Counselor	1	1
Unit III: Goals of nursing and related concepts **1.** Define basic human needs. **2.** Discuss basis of nursing practice. **3.** Define World Health Organization. **4.** Explain model of conceptual framework for generic BSN program. **5.** Explore nursing and nursing practice. **6.** Define goal of nursing process. **7.** Identify historical perspective of the nursing process	2	1
Unit IV: Communication	3	1

1. Define Communication, elements of the communication process, ways of communication. **2.** Identify the characteristics of the effective verbal communication. **3.** Describe factors that's facilitates and interfere with the effective communication **4.** Discuss techniques that facilitate and interfere with effective communication. **5.** Define ways to respond therapeutically **6.** Identify non therapeutically respond **7.** Discuss the legal aspects of documentations.		
Unit V: Nursing skills **1.** Define Vital Signs. **2.** Define terms related to Vital sign. **3.** Describe the physiological concept of temperature, respiration and blood pressure. **4.** Describe the principles and mechanisms for normal thermoregulation in the body. **5.** Identify ways that affect heat production and heat loss in the body. **6.** Define types of body temperature according to its characteristics. **7.** Identify the sign and symptoms of fever. **8.** Discuss the normal ranges for temperature, pulse, respiration and blood pressure. **9.** List the factors affecting temperature, pulse, respiration (TPR). **10.** Describe the characteristics of pulse and respiration. **11.** List factors responsible for maintaining normal blood pressure (B.P). **12.** Describe various methods and sites used to measure TPR & B.P. **13.** Recognize the signs of alert while taking TPR and B.P.	6	1
Unit VI: Skin management **1.** Define decubitus ulcer (bed sore) **2.** List the causes of decubitus ulcer **3.** Apply nursing interventions to prevent decubitus ulcer. **4.** Identity risk factors of bedsores	3	1
Unit VII: Concept of safety: risk management **1.** Define safety **2.** Describe the characteristics of safety **3.** Identify physical and microbial hazards in environment. **4.** Discuss various ways to minimize hazards. **5.** Discuss the assessment for environmental safety. **6.** Identify physical and microbial hazards in the hospital environment, which interfere with patients' safety. **7.** Explain general preventive measures for safe environment for health team members and patient. **8.** Using assessment, identify people at risk for safety dysfunction.	2	0
Unit-VIII: Concept of Teaching Learning **1.** Identify the learning needs of the patient at the clinical site **2.** Develop teaching learning plan **3.** Perform health teaching at the clinical site	2	0
Unit-IX: Oxygenation: Respiratory Function & Cardiovascular System	5	1

1. Identify factors that can interfere with effective oxygenation of body tissues. **2.** Describe common manifestations of altered respiratory and cardiovascular function. **3.** Discuss lifespan-related changes and problems in respiratory function and cardiovascular system. **4.** Describe nursing measures to ensure a patient airway. **5.** Apply Nursing Process and teaching plan for a client with altered respiratory function and cardiovascular function. **6.** Recognize the emergencies related to respiratory and cardiovascular system. **7.** Explain ways that caregivers can decrease the exposure of clients to infection. **8.** Differentiate between medical and surgical asepsis.		
Unit X: Activity and Exercise Pattern **1.** Define terms mobility, joint mobility, body alignments and body mechanics. **2.** Discuss the benefits of activity and exercise. **3.** Identify the principles of gravity that affects balance. **4.** Discuss factors affecting mobility. **5.** Discuss the effects of immobility on human body. **6.** Review A&P of muscular skeletal system and characteristics of normal movement. **7.** Describe the impact of immobility on Physiologic and Psychological functioning. **8.** Apply nursing process while planning for the client with altered muscular skeletal system.	2	0
Unit XI Process of Hospitalization **1.** Define the team admission, transfer and discharge. **2.** Discuss the procedure for admission, transfer and discharge. **3.** Identify nursing responsibility during admission, transfer and discharge **4.** Discuss nurse role in preparing patients and family for discharge. **5.** Discuss the normal reaction of patient being hospitalized	2	0
Total	30	6

Recommended Books / Reading Materials:

1. Berman, A., Snyder, S., & Frandsen, G. (2020). Kozier and Erb's fundamentals of nursing: Concepts, process, & practice (11th ed.). New York, NY: Pearson

2. Delaune, S. C., & Ladner, P. K. (2010). *Fundamentals of Nursing: Standards and Practice.* (4th ed.) Canada: Delmar.

FUNDAMENTAL OF NURSING-I LAB

Credit Hours:02 (0+02)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Assess, document and identify variations in Vital Signs
2. Discuss the observations for different Vital Signs pattern.
3. Develop problem list based on patients' assessments and rationalize each problem identified.
4. Observe the process of admission of a patient in hospital.
5. Orient a patient to hospital environment.
6. Assist in transfer of patients from one unit to another unit and department.
7. Assist in preparing patients and family for discharge.
8. Document the discharge of patients from the hospital.
9. Make nursing care plan according to patient's problems

Sr. No.	List of Skills Lab	OSPE/OSCE
1	Preparing of different beds	06
2	Bathing a patient in bed	
3	Measuring body temperature	
4	Assessment of pulse	
5	Assessment of Respiration	
6	Monitoring of Blood pressure	
7	Mouth care of unconscious patient	
8	Measurement of Height & Weight	
9	Admission of a patient in hospital	
10	Discharge of patient in hospital	

Recommended Instructional / Reading Materials:

1. Berman, A., Snyder, S., & Frandsen, G. (2020). Kozier and Erb's fundamentals of nursing: Concepts, process, & practice (11th ed.). New York, NY: Pearson
2. Delaune, S. C., & Ladner, P. K. (2010). *Fundamentals of Nursing: Standards and Practice.* (4th ed.) Canada: Delmar.

FUNDAMENTAL OF NURSING-II

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Identify the prescribed standards of nursing care set by the institution.
2. Begin to identify the importance of evaluation in his/her nursing practice.
3. Identify relevant sources, which contribute to personal and professional growth.
4. Begin to use the nursing process to deliver safe nursing care to individuals.
5. Begin to understand the knowledge derived from Humanities, Natural and Behavioral Sciences, when providing nursing care to clients.
6. Identify basic principle that protection against
7. Use critical thinking skills in selecting nursing intervention and outcomes for the planning of care setting.
8. Perform all basic nursing skills safely and accurately at clinical settings

Course Content:	MCQs	SEQs
Unit- I Nursing Process **Nursing Process:** **1.** Define nursing process. **2.** Describe the purposes of nursing process. **3.** Identify the components of the nursing process. **4.** Discuss the requirements for effective use of the nursing process **5.** Describe the functional health approach to the nursing process. **Nursing Assessment:** **1.** Describe the assessment phase of the nursing process. **2.** Discuss the purpose of assessment in nursing practice. **3.** Identify the skills required for nursing assessment. **4.** Differentiate the three major activities involved in nursing assessment. **5.** Describe the process of data collection. **6.** Perform a nursing assessment using a functional health approach. **Nursing Diagnosis:** **1.** Define diagnosis in relation to the nursing process. **2.** State the meaning of nursing diagnosis **3.** Describe the components of a nursing diagnosis **4.** Differentiate between a nursing diagnosis and medical diagnosis. **5.** Identify the clinical skills needed to make nursing diagnoses. **6.** Formulate nursing diagnoses according to NANDA list. **Outcome Identification and Planning**: **1.** Define outcome identification and planning **2.** Explain the purposes of outcome identification and planning. **3.** Describe the components of the nursing plan of care. **4.** Use a functional health approach to plan client care. **Implementation and evaluation:** **1.** Define implementation and evaluation	6	1

2. Discuss the purposes of implementation and evaluation **3.** Describe clinical skills needed to implement the nursing plan of care. **4.** Describe activities the nurse carries out during the evaluation phase of the nursing process. **5.** Use a functional approach to implement and evaluate client care. **Communication of the Nursing Process: Documenting and Reporting:** **1.** Describe the purposes of the client record **2.** List the principles of charting **3.** Discuss the guidelines of documentation. **4.** Discuss the importance of confidentiality in the documenting and reporting. **Critical Thinking:** **1.** Explain the importance of critical thinking in nursing. **2.** Discuss definitions of, characteristics of, and skills used in critical thinking. **3.** Identify the three major factors that affect thinking. **4.** Explore ways to enhance and develop critical thinking skills especially as applied to nursing. **5.** Set personal goals for developing critical thinking skills.		
UNIT II: Concept of Value Belief **1.** Define value/belief pattern **2.** Explain how behaviors related to values **3.** Identify sources of professional nursing values **4.** Apply cultural and developmental perspective when identifying values **5.** 5. Examine values conflict and resolution in nursing care situations	2	0
UNIT III: Self-Concept and Self Perception **1.** Define self-perception/ self-concept pattern **2.** Describe the functions of self and self-concept **3.** Discuss how self-concept develops throughout the life span **4.** Discuss factors that can affect self-concept **5.** Identify possible manifestation of altered self-concept **6.** Apply nursing process for a person with an altered self-concept	2	0
UNIT IV: Concept of Pain (Different Therapies) **1.** Define the process of pain (physiological changes) **2.** Describe the different theories of pain theory **3.** Differentiate between acute and chronic pain **4.** Discuss the non-pharmacologic interventions pain management. **5.** Identify pharmacologic interventions for pain management	2	1
UNIT V: Concept of Nutrition and Dietary **1.** Define nutrition/metabolic pattern. **2.** Review essential nutrients and examples of good dietary sources for each **3.** Review normal digestion, absorption, and metabolism of carbohydrates, fats, and proteins.	2	1

4. Discuss nutritional considerations across the life span **5.** List factors that can affect dietary pattern **6.** Describe manifestations of altered nutrition **7.** Explain nursing interventions to promote optimal nutrition and health **8.** Apply nursing process for client with altered nutritional status		
UNIT VI: Concept of Elimination **1.** Define elimination pattern **2.** Discuss common problems of elimination. **3.** Identify nursing interventions for common problems of fecal elimination. **4.** Discuss common problem of Urinary Elimination **5.** Identify nursing intervention for common urinary problems **6.** Describe factors that can alter urinary function **7.** Discuss nursing process for a patient with altered elimination pattern.	2	1
UNIT VII: Concept of Sleep **1.** Define rest and sleep pattern **2.** Define terms related to rest and sleep **3.** Compare the characteristics of sleep and rest **4.** Discuss the characteristics of two kinds of sleep **5.** Enumerate the functions of sleep. **6.** Discuss factors affecting sleep. **7.** Identify common sleep disorders. **8.** Identify conditions necessary to promote sleep. **9.** Discuss nursing process for a patient to promote sleep.	2	1
UNIT VIII: Human Reponses to Illness **1.** Define coping stress tolerance pattern **2.** Differentiate the concepts of stress as a stimulus, response, and transaction. **3.** Identify physiological and psychological manifestations of stress. **4.** Discuss Factors affecting coping pattern during hospitalization. **5.** Describe various types of coping pattern. **6.** Discuss the nursing process related to coping stress pattern.	2	0
UNIT IX: Concept of Sexuality **1.** Review the Anatomy and physiology of the male and female reproductive system **2.** Describe normal sexual pattern **3.** Relate sexuality to all stages of life cycle **4.** Identify factors that effects sexual functioning **5.** Describe common risks and alteration in sexuality. **6.** Understand the nursing process as it relates to sexual functioning	2	0
UNIT X: Concept of Loss & Grieving and Death and Dying **1.** Assess the physiologic signs of death. **2.** Identify beliefs and attitude about death in relation to age. **3.** Discuss the various ways of helping the dying patient meet his/her physiological, spiritual and emotional needs **4.** Discuss care of the body after death.	2	0

5. Discuss the legal implications of death. **6.** Describe how a nurse meets a dying patient's needs of comfort. **7.** Discuss important factors in caring for the body after death. **8.** List changes that occur in the body after death. **9.** Define terms related to loss and grieving. **10.** Discuss Kubler-Ross' theory to assess grieving behaviors. **11.** Identify common manifestations of grief **12.** Discuss the effects of multiple losses on the grief process **13.** Apply the nursing process to grieving clients.		
UNIT XI: Concept of Stress & Coping **1.** Define stress **2.** Enlist the Stages of General Adaptation Syndrome **3.** Discuss Common Stress Associated **4.** Discuss Sources of Stress **5.** Overview of Terminology **6.** Enlist Causes of Stress **7.** Differentiate Types of Stressors **8.** Enlist Signs & Symptoms of Stress **9.** Elaborate Promote Adaptive Coping **10.** Avoid Maladaptive Coping	2	1
UNIT XII: Oral Medication **1.** Introduction to Medication Administration **2.** Discuss Essential Components of a Medication Order **3.** Enlist Rights of medication administration **4.** Discuss Nurse's Responsibility for Medication Administration **5.** Differentiate Routes of Medication **6.** Enlist types of Oral Medications **7.** Documentation **8.** Enlist Types of Syringes	2	0
UNIT XIII: Parenteral Medication **1.** Introduction to Parenteral Medication **2.** Intradermal medication **3.** Subcutaneous medication **4.** Intramuscular medication **5.** Intravenous medication	2	0
Total	30	6

Recommended Books / Reading Materials:

1. Berman, A., Snyder, S., & Frandsen, G. (2020). Kozier and Erb's fundamentals of nursing: Concepts, process, & practice (11th ed.). New York, NY: Pearson
2. Delaune, S. C., & Ladner, P. K. (2010). *Fundamentals of Nursing: Standards and Practice.* (4th ed.) Canada: Delmar.

FUNDAMENTAL OF NURSING -II CLINICAL

Credit Hours: 03 (0+03)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1 Demonstrate fundamental nursing psychomotor skills in a safe manner.
2 Apply therapeutic communication skills in the clinical area.
3 Utilize organizational skills and time management concepts in setting priorities for clinical performance.
4 Demonstrate critical thinking and decision-making skills based on standards of theory, practice, and research.
5 Apply theoretical content to the nursing care of the client in a clinical setting.
6 Implement care plans that reflect an understanding of the legal and ethical responsibilities of the nurse.
7 Perform nursing interventions that reflect caring behaviors in response to bio-psychosocial, cultural, and spiritual care needs.
8 Utilize the nursing process in the care of patients.
9 Demonstrate responsibility for own behavior and growth as an adult learner and a professional.
10 Safely administer medication to patients as ordered by physician.

Sr.No.	List of Skills Lab	OSPE/OSCE
1	Application of hot water bag	09
2	Application of Cold Compresses	
3	Applying bandages including wound dressing	
4	Performing nebulization/steam therapy	
5	Apply suction therapy.	
6	Care of drainage bags (catheter)	
7	Sitz bath	
8	Administering Suppositories, Enema, Flatus Tube	
9	Specimen Collection	
10	Urine Testing through dipstick	
11	Administration of oral medication	
12	Administration of Intramuscular injection	
13	Administration of Intradermal injection	
14	Administration of intravenous injection	
15	Administration of subcutaneous medication	

Recommended Books / Reading Materials:

1. Berman, A., Snyder, S., & Frandsen, G. (2020). Kozier and Erb's fundamentals of nursing: Concepts, process, & practice (11th ed.). New York, NY: Pearson
2. Delaune, S. C., & Ladner, P. K. (2010). *Fundamentals of Nursing: Standards and Practice.* (4th ed.) Canada: Delmar.

ADULT HEALTH NURSING-I

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Discuss the disease process, medical and surgical management, including patient's education for client's experiencing following disorders:
    a. Hematology Disorders
    b. Immunological Disorders
    c. Fluid, Electrolyte and Acid Base Balance and Imbalance
    d. Gastrointestinal Disorders
    e. Genitourinary Disorders
2. Discuss the purposes, indications and the nursing care of clients undergoing medical, surgical and diagnostic procedures related to the above-mentioned disorders.
3. Utilize nursing process when caring for adult clients and their families related to above-mentioned disorders.
4. Integrate knowledge of pathophysiology, nutrition & pharmacology for clients experiencing the above-mentioned disorders.
5. Begin to recognize the need for integrating research-based information in the care of clients.
6. Demonstrate awareness of the importance of legal and ethical issues in nursing practice.

Course Content	MCQs	SEQs
Unit I: Gastrointestinal Tract **1. Disorders of mouth and esophagus:** **a.** Stomatitis **b.** Oral cancer/tumor **c.** Salivary gland disorders **d.** Gastro esophageal reflux disorder **e.** Diverticula **f.** Hiatal hernia **g.** Achalasia **h.** Esophageal cancer/tumor	**3**	**0**
2. Disorders of stomach **a.** Gastritis **b.** Ulcer disease **c.** Gastric carcinoma **3. Disorders of small and large intestine:** **a.** Irritable bowel syndrome **b.** Hernias **c.** Intestinal obstruction **d.** Hemorrhoids **e.** Colorectal cancer **f.** Appendicitis **g.** Peritonitis **h.** Ulcerative colitis **i.** Chron's disease **j.** Anorectal abscess	**3**	**1**

k. Anal fissure **l.** Anal fistula **4. Disorders of hepatobiliary system:** **a.** Pancreatitis **b.** Pancreatic pseudocyst/abscess **c.** Pancreatic carcinoma **d.** Hepatic abscess **e.** Cancer of liver **f.** Cirrhosis of liver **g.** Cholecystitis **h.** Cancer of gall bladder **i.** Cholelithiasis **j.** Cancer of gall bladder	**4**	**1**
Unit II: Fluid, Electrolyte, and Acid Base Balance & Imbalances: **1.** Fluid volume excess **2.** Fluid volume deficit **3.** Respiratory Acidosis **4.** Respiratory Alkalosis **5.** Metabolic Acidosis **6.** Metabolic Alkalosis	**4**	**1**
Unit III: Genitourinary Tract Disorders **1.** Urinary tract infections **2.** Renal abscess & tuberculosis Glomerulonephritis (immunologic disorder) Urethral strictures, hydroureter and hydronephrosis **3.** Urinary incontinence/ Retention & Urinary Calculi **4.** Acute & Chronic Renal failure **5.** Urinary Bladder and Renal cell carcinoma	**4**	**1**
Unit IV: Reproductive Disorders **1.** Female reproductive disorders **a.** Reproductive tract Infections **b.** Menstrual Disorders **c.** Dysfunctional uterine bleeding **d.** Menopause **e.** Endometriosis **f.** Pelvic inflammatory disease **g.** Uterine prolapse **h.** Cystocele **i.** Rectocele **j.** Fistulas **k.** Infertility **l.** Ectopic Pregnancy **m.** Abortion **n.** Hydatidiform mole **o.** Ovarian cyst **p.** Ovarian tumor and cancer **q.** Uterine tumor/ fibroids **r.** Breast cancer	**5**	**1**

2. Male Reproductive Disorders: **a.** Benign prostate hypertrophy **b.** Erectile dysfunction **c.** Prostate and testicular cancer **d.** Infertility		
Unit V: Hematology Disorders **1.** Sickle cell anemia. **2.** Immune hemolytic Anemia **3.** Iron deficiency anemia **4.** Vitamin B12 deficiency anemia **5.** Folic acid deficiency anemia **6.** Aplastic anemia. **7.** Leukemia **8.** Hodgkin disease & non-Hodgkin lymphoma **9.** Autoimmune and thrombotic Thrombocytopenic purpura **10.** Disseminated Intravascular Coagulation (DIC)	**4**	**0**
Unit VI: Immunological Disorders **1.** Human Immunodeficiency virus (HIV)/ Acquired immunodeficiency syndrome (AIDS) **2.** Hypersensitivity and autoimmunity disorders	**3**	**1**
Total	**30**	**6**

Recommended Books/ Reading Materials

1. Hinkle, J. L., Cheever, K. H. & Overbaugh, K. (2021). Brunner & Suddarth's textbook of medical-surgical nursing (15th ed.). Wolters Kluwer.
2. Medical-Surgical Nursing: Assessment and Management of Clinical Problems" by Sharon L. Lewis, Linda Bucher, Margaret M. Heitkemper, and Mariann M. Harding (Saunders, an imprint of Elsevier) 11th Edition 2019
3. "Medical-Surgical Nursing Made Incredibly Easy!" by Lippincott Williams & Wilkins 4th edition 2019

ADULT HEALTH NURSING-I CLINICAL

Credit Hours: 02 (0+02)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Successfully insert an Intravenous (IV) catheter using proper technique and aseptic practices
2. Administer a blood transfusion safely, including verification of compatibility and monitoring for adverse reactions.
3. Accurately calculate and administer IV medications while ensuring patient safety and monitoring for any adverse effects
4. Perform Nasogastric (NG) tube insertion and removal with proficiency, ensuring correct placement and patient comfort.
5. Manage NG tube feeding, including calculation of feeding rates, administration of feedings, and patient education on care and maintenance
6. Successfully catheterize male and female patients using sterile technique and minimizing the risk of complications.
7. Safely remove a urinary catheter, provide post-removal care instructions, and monitor for any complications
8. Provide comprehensive care for patients with ostomies, including assessment, appliance application, and patient education on ostomy management

Sr. No	List of Clinical Skills	OSCE/OSPE
1	IV Cannulation	06
2	Blood transfusion and related products	
3	IV Medications	
4	NG Tube insertion	
5	NG Tube removal	
6	NG tube feeding	
7	Male urinary catheterization	
8	Female Urinary Catheterization	
9	Removal of urinary catheter	
10	Ostomy Care	

Recommended Books / Reading Materials:

1. Hinkle, J. L., Cheever, K. H. & Overbaugh, K. (2021). Brunner & Suddarth's textbook of medical-surgical nursing (15th ed.). Wolters Kluwer.
2. Medical-Surgical Nursing: Assessment and Management of Clinical Problems" by Sharon L. Lewis, Linda Bucher, Margaret M. Heitkemper, and Mariann M. Harding (Saunders, an imprint of Elsevier) 11th Edition 2019
3. "Medical-Surgical Nursing Made Incredibly Easy!" by Lippincott Williams & Wilkins 4th edition 2019
4. Fundamentals of Nursing" by Barbara Kozier and Glenora Erb 10th edition, 2018

HEALTH ASSESSMENT-I

Credit Hours: 01 (01+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Systematically assess the health status of an individual by obtaining a complete health history using interviewing skills appropriately.
2. Utilize proper techniques of observation and physical examination in assessing various body systems.
3. Differentiate normal from abnormal findings.
4. Record findings in an appropriate manner.
5. Demonstrate an awareness of the need to incorporate health assessment as part of their general nursing practice skills.
6. Apply knowledge of growth & development, anatomy, physiology, & psychosocial skills in assessment & analysis of data collected.

Course Content	MCQs	SEQs
Unit I: Introduction to Health Assessment Concepts **1.** Discuss the need for health assessment in general nursing practice. **2.** Explain the concepts of health, assessment, data collection, and diagnosis. **3.** Identify types of health assessments **4.** Document health assessment data using a problem-oriented approach.	1	0
Unit II: Interviewing Skills and Health History **1.** Explain the purpose, process & principles of interviewing. **2.** Describe the content and format used to obtain a health history. **3.** Discuss the process of investigating positive findings during the health history. **4.** Practice obtaining and recording a client health history. **5.** Practice utilizing therapeutic skills with a learner's partner. **6.** Identify strengths and weaknesses via observation of a videotaped interaction and self/peer analysis. **7.** Interview patient in clinical and collect feedback from colleagues and faculty about use of therapeutic communication	2	1
Unit III: Introduction to Physical Examination (PE) and the General Survey **1.** Identify the general principles of conducting an examination. **2.** Identify the equipment needed to perform a physical examination. **3.** Describe the appropriate use & technique of inspection, palpation, percussion & auscultation. **4.** Discuss the procedure & sequence for performing a general assessment of a client. **5.** Discuss the guidelines for documenting physical examination. **6.** Document the PE findings of patients in PE documentation sheet on an ongoing basis.	3	1
Unit IV: Assessment of the Skin, Head & Neck **1.** Describe the component of health history that should be elicited during the assessment of skin, head & neck.	3	0

2. Describe specific assessments to be made during the physical examination of the above systems. **3.** Document findings. **4.** Describe age related changes in the above systems & differences in assessment findings		
Unit V: Assessment of Nose, Mouth & Pharynx **1.** Describe the component of health history that should be elicited during the assessment of nose, mouth and pharynx. **2.** Identify the structural landmarks of the nose, mouth and pharynx. **3.** Describe specific assessments to be made during the physical examination of the above systems. **4.** Document findings	2	0
Unit VI: Assessment of the Abdomen, Anus & Rectum **1.** Discuss the pertinent health history questions necessary to perform the assessment of Abdomen, Anus and Rectum. **2.** Describe the specific assessment to be made during the physical examination of the abdomen. **3.** Discuss components of a rectal examination. **4.** Document findings. **5.** List the changes in abdomen that are characteristics of aging process	2	1
Unit VII: Assessment of the Breast, Axilla & Genitalia **1.** Discuss the history questions pertaining to male and female breast and Genitalia assessment. **2.** Perform a breast examination including axillary nodes and interpret findings. **3.** Discuss components of a genital exam on a male or female. **4.** Review components of a comprehensive reproductive history. **5.** Document findings. **6.** List the changes in breast, male & female genitalia that are characteristics of aging process	2	0
Total	**15**	**3**

Recommended Books / Reading Materials:

1. Weber, J. R., & Kelley, J. H. (2021). *Health assessment in nursing* (7th ed.). Lippincott Williams and Wilkins.

2. Bickley, Lynn S. (2020). Bates' guide to physical examination and history taking. (13th ed) Philadelphia: Lippincott Williams & Wilkins,

HEALTH ASSESSMENT LAB-I

Credit Hours: 01 (0+01)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Develop the ability to conduct a comprehensive health history interview with patients, including gathering relevant information about their medical history, current complaints, social history, and psychosocial factors, while demonstrating empathy and cultural sensitivity.
2. Demonstrate proficiency in assessing the skin, head, and neck by accurately identifying normal variations, abnormalities, and lesions, and effectively documenting findings
3. Successfully perform a thorough examination of the nose, mouth, and pharynx, identifying abnormalities such as nasal congestion, oral lesions, or signs of pharyngeal inflammation, and providing appropriate patient education on oral hygiene practices.
4. Develop competency in conducting a systematic abdominal assessment, including inspection, auscultation, percussion, and palpation, and accurately identifying abdominal landmarks and abnormalities, as well as performing a digital rectal examination and assessing for signs of gastrointestinal disorders or rectal abnormalities.

Sr. No	List of Skills	OSCE/OSPE
1	Health History taking and interview skills	**03**
2	Assessment of Skin, Head/Neck	
3	Assessment of Nose, Mouth & Pharynx	
4	Assessment of Abdomen, Anus & Rectum	
5	Assessment of Breast, axilla & Genitalia	

Recommended Books / Reading Materials:

1. Weber, J. R., & Kelley, J. H. (2021). *Health assessment in nursing* (7th ed.). Lippincott Williams and Wilkins.
2. Bickley, Lynn S. (2020). Bates' guide to physical examination and history taking. (13th ed) Philadelphia: Lippincott Williams & Wilkins,

PHARMACOLOGY-I

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Discuss the effects of different drugs on human body for example on gastrointestinal system, genitourinary system and immunology system
2. Relate the knowledge of drug with in terms of indication of use which would include disorders of different systems
3. Explain the rationale for using a particular drug/s for a patient.
4. Select appropriate nursing interventions for drugs given in clinical situations.
5. Impart teaching to the patient/family regarding medications, based on their needs.
6. Utilize nursing process to evaluate the need for and the effectiveness of the drug/s given to the patients.
7. Integrate the knowledge of legal and ethical issues in administration of drug.
8. Incorporate relevant research findings with guidance in development of new drug/s as a foundation for nursing practice.
9. Incorporate cognitive, interpersonal and technical skill derived from the humanities, natural and behavioral sciences when administrating medication to clients, keeping in mind principles of different drugs.
10. Calculate drug dosage accurately when administering oral and parental medications.

Course Content	MCQs	SEQs
Unit I: Introduction to Pharmacology **1.** Discuss the terminologies related to pharmacology **2.** Discuss the history of pharmacology briefly **3.** Identify the purposes of medication **4.** Identify the source of medication **5.** Discuss the classification of drugs **6.** Describe the three types of drug supply system. **7.** Discuss the drugs standards and legislation. **8.** Identify resource to collect and utilize drug information. **9.** Learn to prepare drugs cards	6	1
Unit II: Drugs used to prevent and treat infection **1.** Define the most used drug category that is used to prevent and treat infections including antibiotics, antifungal, antiphrastic, antimalarial and antiviral drugs. **2.** Briefly discuss action and effects of selected drug category. **3.** List some of the most commonly used drugs for each drug category. **4.** Discuss the nursing measures/patient education which can be taken if patient is using to treat and prevent infections.	6	2
Unit III: Drugs Affecting the Gastrointestinal System **1.** Discuss common symptoms / disorders for which gastrointestinal drugs are used **2.** Describe uses and effects of gastrointestinal drugs **3.** Describe the classification and action of drugs on the body	6	1

4. Identify the expected and adverse reactions of gastrointestinal drugs **5.** Discuss the nursing responsibility related to gastrointestinal drugs **6.** Calculate the drugs dosage accurately.		
Unit IV: Drugs Affecting Hematology System **1.** Describe uses and effects of drugs affecting hematology system **2.** Describe the classification of drugs used in hematology disorders **3.** Discuss the action of hematology drugs on the body **4.** Identify the expected and adverse reactions of drugs affecting hematology system **5.** Discuss the nursing responsibility related to drugs affecting hematology system **6.** Calculate the drugs dosage accurately.	6	1
Unit V: Anti-Neoplastic-Drugs **1.** Describe uses and effects of anti-neoplastic drugs **2.** Describe the classification of anti-neoplastic drugs **3.** Discuss the action of anti-neoplastic drugs on the body **4.** Identify the expected and adverse reactions of anti-neoplastic drugs **5.** Discuss the nursing responsibility related to anti-neoplastic drugs **6.** Calculate the drugs dosage accurately.	6	1
Total	**30**	**6**

Recommended Instructional / Reading Materials:

1. Whallen. K., (2022). Lippincott Illustrated Reviews: Pharmacology (8th). Philadelphia: Lippincott

2. Katzung, Bertram G., (2018). *Basic & clinical pharmacology* (14th). New York: McGraw-Hill.

ADULT HEALTH NURSING-II

Credit Hours: 04 (04+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Demonstrate an ability to utilize nursing process in extending holistic care to adult patients with a variety of Cardiovascular, Respiratory,
2. Endocrine, Musculo-skeletal, Neurological and ENT (Ear, Nose and Throat) related disorders.
3. Describe the risk factors, etiology, signs & symptoms and integrate Pathophysiology of various disease processes using a nursing framework, (Functional Health pattern) to assess patient's needs and problems.
4. Discuss the need of using relevant research findings in designing appropriate nursing care for the patients.
5. Demonstrate an awareness of legal and ethical standards in caring for patients with various disorders in a variety of acute and intermediate care settings.

Course Content	MCQs	SEQs
Unit I: Orthopedic Nursing **1.** Soft Tissue Injury **2.** Fracture and Amputation **3.** Paget's disease, Rheumatoid Arthritis **4.** Osteomyelitis osteoarthritis, Osteoporosis **5.** Bone tumors, bone tuberculosis	8	1
Unit II: Endocrine Nursing **1.** Disorders of parathyroid glands **2.** Diabetic Mellitus. **3.** Hypoglycemia, Hyperglycemia and Diabetic Keto Acidosis (DKA) **4.** Thyroid gland Disorders **5.** Adrenal glands Disorders	12	2
Unit III: Neurological Nursing **1.** Intra cranial pressure and Head injury **2.** Spinal cord injury and cerebrovascular accidents (CVA) **3.** Infection/ inflammation of central nervous system (CNS) **4.** Meningitis /encephalitis /Brain abscess **5.** Epilepsy / Seizures. **6.** Myasthenia Gravis (MG) **7.** Guillain Barre Syndrome (GBS) **8.** Trigeminal Neuralgia **9.** Migraine / Headache **10.** Parkinson's disease, **11.** Alzheimer's disease **12.** Brain damage and special state of altered level of consciousness	12	3
Unit IV: Cardiovascular Disorders **1.** Atherosclerosis and aneurysm **2.** Varicose veins and venous thrombosis **3.** Hypertension **4.** Pericarditis, **5.** Myocarditis	10	2

6. Endocarditis **7.** Heart block and pacemaker **8.** Myocardial infarction (MI)		
Unit V: Pulmonary Nursing **1.** Sinusitis **2.** Pharyngitis **3.** Tonsillitis **4.** Influenza **5.** Lung Abscess **6.** Pneumonia and its types **7.** COPD (chronic obstructive pulmonary disease) **8.** Acute respiratory failure **9.** Chest trauma **10.** Acute Respiratory distress syndrome **11.** Lung cancer	10	2
Unit VI: Eye and ENT Nursing **1.** Mastoiditis **2.** Meniere's disease **3.** Tonsillitis, **4.** Laryngitis and its Nursing management **5.** Cataract, Retinal detachment	4	1
Unit VII: Burns **1.** Define the Burns &Classification of burn. **2.** Rehabilitation and constructive management of Burns	4	1
Total Marks	**60**	**12**

Recommended Books / Reading Materials:

1. Hinkle, J. L., Cheever, K. H. & Overbaugh, K. (2021). Brunner & Suddarth's textbook of medical-surgical nursing (15th ed.). Wolters Kluwer.
2. Medical-Surgical Nursing: Assessment and Management of Clinical Problems" by Sharon L. Lewis, Linda Bucher, Margaret M. Heitkemper, and Mariann M. Harding (Saunders, an imprint of Elsevier) 11th Edition 2019
3. "Medical-Surgical Nursing Made Incredibly Easy!" by Lippincott Williams & Wilkins 4th edition 2019

ADULT HEALTH NURSING-II CLINICAL

Credit Hours: 04 (0+04)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Demonstrate proficiency in providing comprehensive tracheostomy care, including suctioning, cleaning, and maintaining the airway, while minimizing the risk of infection and promoting patient comfort and safety.
2. Develop competency in performing tracheal suctioning safely and effectively, ensuring adequate airway clearance and patient comfort while minimizing the risk of complications such as trauma or hypoxia.
3. Successfully assist healthcare providers in performing lumbar punctures, including preparing the patient, positioning, and providing assistance during the procedure while ensuring patient safety and comfort.
4. Demonstrate proficiency in assisting with thoracentesis procedures, including patient positioning, equipment setup, and providing support to the patient while ensuring accurate sample collection and monitoring for complications.
5. Develop competency in assisting with paracentesis procedures, including patient preparation, positioning, and providing assistance during the procedure while ensuring patient comfort and safety.
6. Successfully assist healthcare providers in inserting chest tubes, including preparing the patient, providing sterile technique, and monitoring for complications while ensuring optimal drainage and lung re-expansion.
7. Demonstrate proficiency in assisting patients undergoing CT scans, including ensuring patient safety, proper positioning, and coordination with radiology staff to obtain high-quality images while minimizing radiation exposure.
8. Develop competency in assisting with cerebral angiography procedures, including patient preparation, positioning, and providing support during the procedure while ensuring accurate imaging and monitoring for complications.
9. Successfully assist healthcare providers in performing myelogram procedures, including patient preparation, positioning, and providing assistance during the procedure while ensuring patient safety and comfort.
10. Demonstrate proficiency in assisting with audiometric testing, including patient preparation, equipment setup, and providing support to the patient during the procedure while ensuring accurate assessment of hearing function.
11. Develop competency in assisting with thyroid scanning procedures, including patient preparation, positioning, and providing assistance during the procedure while ensuring accurate imaging and patient comfort.
12. Successfully assist patients undergoing X-ray procedures, including ensuring proper positioning, radiation safety measures, and collaboration with radiology staff to obtain diagnostic images of high quality while ensuring patient comfort and safety.
13. Demonstrate proficiency in applying and monitoring skin traction devices safely and effectively to assist in the management of orthopedic conditions, ensuring proper alignment and immobilization while minimizing the risk of complications such as pressure injuries or nerve damage.

14. Develop competency in applying plaster or cast immobilization devices for fractures or musculoskeletal injuries, ensuring proper technique, alignment, and patient comfort while minimizing the risk of complications such as skin irritation or compartment syndrome.
15. Successfully apply eye bandages or dressings following ocular procedures or injuries, ensuring proper technique, protection of the eye, and patient comfort while promoting healing and preventing infection.
16. Demonstrate proficiency in performing eye irrigation procedures to remove foreign bodies or irritants from the eye, ensuring proper technique, irrigation solution selection, and patient comfort while minimizing the risk of corneal abrasions or infection.
17. Develop competency in performing ear irrigation procedures to remove cerumen or debris from the ear canal, ensuring proper technique, irrigation solution temperature, and patient comfort while minimizing the risk of injury to the ear canal or tympanic membrane.
18. Demonstrate proficiency in performing blood sugar monitoring, including fingerstick blood glucose testing or continuous glucose monitoring, ensuring accurate technique, interpretation of results, and patient education on self-management of diabetes.
19. Develop competency in setting up and monitoring cardiac telemetry systems to continuously monitor cardiac rhythms, recognizing and responding to arrhythmias or abnormalities, and ensuring patient safety and appropriate intervention as needed.

Sr. No	Clinical Skills List	OSPE/OSCE
1.	Tracheostomy care	12
2	Suctioning (Tracheal)	
3	Assist in procedures of Lumber puncture	
4.	Assist in procedures of Thoracentesis	
5.	Assist in procedures of Paracentesis	
6.	Assist in procedures of Chest tube insertion	
7.	Assist in procedures of C.T. Scan	
8.	Assist in procedures of Cerebral Angiography	
9.	Assist in procedures of Lumber puncture	
10.	Assist in procedures of Myelogram	
11.	Assist in procedures of Audiometric testing	
12.	Assist in procedures of Thyroid scanning.	
13.	Assist in procedure of X rays	
14.	Skin Traction	
15.	Application of plaster, cast	
16.	Eye bandaging	
17.	Eye irrigation	
18.	Ear irrigation	
19.	Blood Sugar Monitoring	
20.	Cardiac monitoring /telemetry	

Recommended Books / Reading Materials:

1. Hinkle, J. L., Cheever, K. H. & Overbaugh, K. (2021). Brunner & Suddarth's textbook of medical-surgical nursing (15th ed.). Wolters Kluwer.
2. Medical-Surgical Nursing: Assessment and Management of Clinical Problems" by Sharon L. Lewis, Linda Bucher, Margaret M. Heitkemper, and Mariann M. Harding (Saunders, an imprint of Elsevier) 11th Edition 2019
3. "Medical-Surgical Nursing Made Incredibly Easy!" by Lippincott Williams & Wilkins 4th edition 2019
4. Fundamentals of Nursing" by Barbara Kozier and Glenora Erb 10th edition, 2018

HEALTH ASSESSMENT II

Credit Hours: 1 (01+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Systematically assess the health status of an individual by obtaining a complete health history using interviewing skills appropriately.
2. Utilize proper techniques of observation and physical examination in assessing various body systems.
3. Differentiate normal from abnormal findings.
4. Record findings in an appropriate manner.
5. Demonstrate an awareness of the need to incorporate health assessment as part of their general nursing practice skills.
6. Apply knowledge of growth & development, anatomy, physiology, & psychosocial skills in assessment & analysis of data collected.

Course Content	MCQs	SEQs
Unit I: Assessment of the Peripheral Vascular and Musculoskeletal Systems **1.** Discuss the patient health history question necessary to perform the assessment of Peripheral Vascular System (PVS) and Musculoskeletal System (MS) system. **2.** Discuss critical observations to assess PVS. **3.** Assess musculoskeletal functions including muscles strength, symmetry, size, contour, ROM and its characteristics. **4.** Document findings. **5.** List the changes in the given systems that are characteristics of aging process.	2	0
Unit II: Assessment of the Mental Status and Sensory Neuro System **1.** Perform mental status examination of a client. **2.** Assess cranial nerve, sensory, sense of proprioception and cerebellar functions and deep tendon reflexes **3.** Document findings. **4.** List the changes in the nervous system that are characteristics of the aging process	2	0
Unit III: Assessment of Cardio Vascular System **1.** Describe the components of health history that should be elicited during the assessment of cardiovascular system. **2.** Identify the landmarks of the chest. **3.** Describe the following: **a.** Pulse rate, **b.** Rhythm and pulsation characteristics **c.** Point of Maximum Impulse (PMI) **d.** Heart sounds **4.** Discuss systolic and diastolic murmurs **5.** Assess the cardiovascular system systematically. **6.** Document findings. **7.** List the changes in cardiovascular system that is characteristics of aging process.	2	1
Unit IV: Assessment of Thorax and Lungs	2	1

1. Describe the components of health history that should be elicited during assessment of respiratory system. **2.** Describe the following: **a.** Chest contour and symmetry **b.** Respiratory rate and pattern **c.** Tactile fremitus **d.** Chest expansion **e.** Density of lung fields **f.** Diaphragmatic excursion **3.** Auscultated lung sounds **4.** Assess the respiratory system including inspection, palpation, percussion and auscultation. **5.** Document findings. **6.** List the changes in respiratory system that are characteristics of aging process.		
Unit V: Assessment of the Eyes, & Ears **1.** Identify the component of health history necessary for the examination of eye & ear. **2.** Describe the following: **a.** Eye structure and position **b.** Upper and lower eyelids **c.** Gross visual perception **d.** Characteristics of the cornea, sclera, pupil, and lens fundi. **e.** Peripheral fields **f.** Color, shape, and location of auricle **g.** External ear canal and tympanic membrane **h.** Gross hearing **3.** Perform the examination of eye and ear of a healthy patient. **4.** Document findings. **5.** List the changes in eye and ear that are characteristics of aging process.	4	0
Unit VI: Assessment of an Elderly Client **1.** Describe the variations in history taking for an elderly client. **2.** Differentiate health assessment variations for elderly clients. **3.** Identify any differing examination techniques or skills for elderly client	1	0
Unit VII: Assessment of Pediatric Client **1.** Describe the component of a thorough pediatric history, including differences for developmental levels. **2.** Differentiate health assessment norms for infants, and children. **3.** Identify common examination techniques/skills for pediatric health assessment	2	1
Total Marks	**15**	**03**

Recommended Books / Reading Materials:

1. Weber, J. R., & Kelley, J. H. (2017). *Health assessment in nursing* (6th ed.). Lippincott Williams and Wilkins.

2. Bickley, Lynn S. (2020). Bates' guide to physical examination and history taking. (13th ed) Philadelphia: Lippincott Williams & Wilkins,

HEALTH ASSESSMENT II-Lab

Credit Hours: 01 (0+01)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Demonstrate proficiency in assessing the peripheral vascular system and musculoskeletal system by accurately identifying normal findings, abnormalities, and assessing for signs of circulatory or musculoskeletal dysfunction.
2. Develop competency in conducting a comprehensive cardiovascular assessment, including obtaining vital signs, auscultating heart sounds, assessing peripheral pulses, and identifying signs of cardiovascular disease or dysfunction.
3. Successfully perform a thorough mental status and sensory neuro assessment by evaluating cognitive function, mood, behavior, and sensory perception, while also recognizing signs of neurological deficits or alterations in mental status, and providing appropriate support and referrals as needed.
4. Demonstrate proficiency in assessing the eyes and ears by conducting visual acuity tests, examining ocular structures, assessing for signs of eye or ear infections, and identifying abnormalities in vision or hearing.
5. Develop the ability to conduct a comprehensive thorax and lungs assessment, including inspection, palpation, percussion, and auscultation of lung sounds, while accurately identifying normal breath sounds, abnormal findings, and signs of respiratory dysfunction.
6. Gain proficiency in performing a holistic assessment of elderly clients by considering age-related changes, assessing for common geriatric syndromes, identifying signs of functional decline or cognitive impairment, and addressing the unique healthcare needs and concerns of older adults.
7. Successfully conduct a comprehensive assessment of pediatric clients by considering developmental milestones, assessing growth parameters, evaluating physical and psychosocial development, and identifying signs of common pediatric conditions or concerns

Serial #	Clinical Skills List	OSPE/OSCE
1	Peripheral Vascular & Musculoskeletal system Assessment	03
2	Cardiovascular system Assessment	
3	Mental Status & Sensory Neuro Assessment	
4	Eyes & Ears Assessment	
5	Thorax & Lungs Assessment	
6	Assessment of elderly client	
7	Assessment of pediatric client	

Recommended Books / Reading Materials:

1. Weber, J. R., & Kelley, J. H. (2021). *Health assessment in nursing* (7th ed.). Lippincott Williams and Wilkins.
2. Bickley, Lynn S. (2020). Bates' guide to physical examination and history taking. (13th ed) Philadelphia: Lippincott Williams & Wilkins,

PHARMACOLOGY II

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Apply conceptual knowledge about the drugs used in Cardiovascular (CVS), Respiratory, Central Nervous system (CNS), Autonomic nervous system (ANS) & Ear, Eyes, Nose and Throat (EENT) and endocrine disorders and their mechanisms of action.
2. Calculate drug dosage calculations accurately when administering oral and parental medications.
3. Explain the rationale for using a particular drug/s for a patient.
4. Select appropriate nursing interventions for drugs given in clinical situations.
5. Impart teaching to the patient/family regarding medications, based on their needs.
6. Utilize nursing process to evaluate the need for and the effectiveness of the drug/s given to the patients.
7. Integrate the knowledge of legal and ethical issues in administration of drug. Incorporate relevant research findings with guidance in development of new drug/s as a foundation for nursing practice.
8. Incorporate cognitive, interpersonal and technical skill derived from the humanities, natural and behavioral sciences when administrating medication to clients, keeping in mind principles of different drugs.
9. Begin to understand alternative therapies in medicine.
10. Utilize an advanced level of English Language in classroom and clinical setting for Pharmacology.

Course Content	MCQs	SEQs
Unit I: Drugs used in Endocrine Disorders **1.** Drugs effecting endocrine system (thyroid, anti-thyroid, para thyroid) **2.** Drug effecting endocrine system (steroid and diabetic and anti-diabetic drugs)	4	1
Unit II: Drugs used for Nervous System Disorders **1.** Drugs affecting Nervous System **2.** Critical care drugs, **3.** Anesthetics, **4.** Antiepileptic **5.** Antiparkinsons **6.** Antimigraine & analgesic dosage calculation **7.** Drug Dosage calculations (adrenergic and CNS)	5	1
Unit III: Drugs used for Autonomic Nervous System Disorders and Drugs affecting Sympathetic Nervous System (Adrenergic & Antiadrenergic drugs) **1.** Drugs affecting sympathetic/autonomic nervous system (ANS) **2.** Adrenergic and antiadrenergic drugs **3.** Skeletal muscle relaxants and CNS stimulants	4	1
Unit IV: Drugs Affecting Parasympathetic Nervous System **1.** Drugs affecting parasympathetic system **2.** Cholinergic and anticholinergic	4	1
Unit V: Drugs Affecting the Cardio-Vascular System **1.** Drugs affecting Cardiovascular system	5	1

2. Critical care drugs & dosage calculation of drug		
Unit VI: Drugs Affecting the Respiratory System **1.** Drugs affecting Respiratory system **2.** Critical care & dosage calculation of drugs	4	1
Unit VII: Drugs used in Ophthalmic/ENT Disorders **1.** Drugs affecting Ophthalmic/ENT system **2.** Critical care & dosage calculation of drugs	4	0
Total Marks	**30**	**06**

Recommended Books/ Reading Materials

1. Whallen. K., (2022). Lippincott Illustrated Reviews: Pharmacology (8th). Philadelphia: Lippincott
2. Katzung, Bertram G., (2018). *Basic & clinical pharmacology* (14th). New York: McGraw-Hill.

PEDIATRIC HEALTH NURSING-I

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Develop awareness on common health issues of the children in Pakistan
2. Discuss principles of growth and development and its deviation in all aspects of nursing care.
3. Discuss the impact of hospitalization on the child and family.
4. Discuss the role of a family in the care of sick children in Pakistani Context.
5. Integrate pharmacological knowledge into care of sick children.
6. Integrate research-based information in the care of child and family.

Course Content	MCQs	SEQs
Unit I: Perspective of Pediatric nursing. 1. Evolution in Pediatric Nursing 2. Role of pediatric nurse 3. Pediatric Nursing in Pakistani culture 4. Convention on the rights of the child. 5. Commonly occurring ethical issues in pediatric setting of Pakistan	02	0
Unit II: Growth and development in children and Nursing Aspects for dealing with deviations: 1. Assessing Growth & Development in children of different age group 2. Growth & Development pattern in South Asian Countries, and influence of Pakistani culture on Growth and Development of child. 3. Factors influencing physical and emotional development of children 4. Assessing Milestones Nursing Care aspects for dealing with deviations in Growth & Development pattern	03	0.5
Unit III: Pharmacological Care aspects while dealing with Pediatric Patients 1. Drug dosage calculation for the Pediatric drugs 2. Common Pediatric drug dilutions 3. Common Pediatric concerns/complications during drug therapy 4. Caring for children receiving Chemotherapy, antimicrobial therapy and long-term Insulin therapy. 5. Managing pain in children by using pharmacological and non- pharmacological approaches	03	0.5

Unit IV: Communication/Therapeutic Play while caring for children with various disease process 1. Guidelines for communication with children and families. 2. Role of play in growth and development of children. 3. Functions of play for hospitalized children. 4. Therapeutic play versus play therapy. 5. Play as a tool for nursing management	02	0.5

6. Importance of therapeutic play from Pakistani Perspectives		
Unit V: Health promotion of the new born and family from Global and Pakistani Perspectives 1. Nursing care approaches for dealing with Small for Gestation Age and Low Birth Weight infants: A commonly occurring problem in Pakistan 2. Concept of Small for Gestation Age, Low for Gestation Age, Appropriate for Gestation Age and low birth weight infants 3. Assessment of new born 4. Gestational age assessment 5. Head to toe assessment 6. Developmental Care Approach for premature and newborns in Pakistani families 7. Nursing care of the full term and premature babies and their families	03	01
Unit VI: Nursing Care Aspects for High-Risk newborn: Common newborn related problems in Pakistan and its Management: 1. Birth injuries and other related injuries in newborns 2. Respiratory Distress Syndrome and surfactant therapy 3. Transient Tachypnea of Newborn 4. PPHN 5. Intra Ventricular Hemorrhage 6. Hyperbilirubinemia. 7. Child with G6PD 8. Birth Asphyxia and nursing management 9. Septicemia and care aspects 10. Hypoglycemia/ Infant of diabetic mothers 11. Hypocalcemia 12. Inborn error of metabolism 13. Nursing care, pharmacological and non- pharmacological measures for dealing with the above health issues of newborns	04	01

Unit VII: Care of child & family during hospitalization Impact of hospitalization on the child and family and related Nursing Care Approaches: 1. Stressor and reaction related to developmental stage. 2. Stressor and reactions of the family of the child who is hospitalized. 3. Nursing care of a child who is hospitalized. 4. Nursing care process of child and family with hospitalization 5. Medication administration to children (clinical). 6. Pharmacological and non-pharmacological pain management. 7. Preparation for hospitalization (clinical).	03	0
Unit VIII: Common Health problems in Pakistani children and their nursing management in Infants **1.** Nutrition disturbance **a.** Protein energy malnutrition **b.** Feeding difficulties	03	01
c. Failure to thrive **d.** Sudden infant death syndrome **e.** Teething problems (Early /later child hood) **2.** Nursing Care approaches for dealing with above health problems according to the age group. **3.** Dealing with common complications of Nutritional problems and communicable diseases found commonly in Pakistan **4.** Post-Polio Syndrome **5.** Chronic inflammatory demyelinated polyneuropathy		
Unit IX: Congenital defects of heart and Cardio-vascular dysfunction. **1.** Understanding Fetal circulation **2.** Congenital malformations of heart. **3.** Pharmacology related treatment modalities for the above (Indomethacin and prostaglandin therapy). **4.** Rheumatic heart disease. **5.** Nursing Care approaches while dealing with clients with above disorders	04	01
Unit X: Paediatric Oncology **1.** Leukemia in children and its prognosis in Pakistan from current treatment modalities **2.** Hodgkin disease and non-Hodgkin lymphoma **3.** Porta Cath care in Pediatric patients **4.** Nursing Care for pediatric patients receiving chemotherapy from different routes **5.** Palliative Care approaches in Pakistani Culture **6.** Nursing care approach for dealing with death and dying situations	03	0.5
Total	30	6

Recommended Books/ Reading Materials

1. Hockenberry, M., Wilson, D., Rodgers, C. (2022). Wong's Essentials of Pediatric Nursing (11th ed.). Elsevier
2. Sethi. N., (2017). Essential of pediatric nursing (4th ed).

PEDIATRIC HEALTH NURSING-I CLINICAL

Credit Hours: 02 (0+02)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Appreciate the history and developments in the field of pediatrics and pediatric nursing as a specialty
2. Apply the concepts of growth and development in providing care to the pediatric clients and their families.
3. Appreciate the child as a holistic individual
4. Perform physical, development, and nutritional assessment of pediatric clients
5. Apply nursing process in providing nursing care to neonates and children.
6. Integrate the concept of family centered pediatric nursing care with related areas such as genetic disorders, congenital malformations and long term illness.

S. No	Practical	OSPE/OSCE
1	General Examination of New Born	06
2	APGAR Score	
3	New Born and Infant Reflex Assessment	
4	Anthropometric Assessment (Birth weight, Head circumference, Chest circumference, Length of baby)	
5	Child head to toe assessment	
6	Tub bath to an infant	
7	Care of an infant in incubator	
8	Care of an infant / neonate receiving oxygen therapy	
9	Care of an infant under phototherapy	
10	Oral/SC/ Rectal Intravenous Medication administration in children	

Recommended Books/ Reading Materials

1. Hockenberry, M., Wilson, D., Rodgers, C. (2022). Wong's Essentials of Pediatric Nursing (11th ed.). Elsevier
2. Sethi. N., (2017). Essential of pediatric nursing (4th ed).

COMMUNITY HEALTH NURSING-I

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Discuss the role of a community health nurse and other health team members.
2. Describe the concept of Primary Health Care as a strategy for achieving the Alma Ata Declaration of "Health for All by the Year 2000 and beyond (2025)."
3. Identify services provided by the government health care system in Pakistan.
4. Discuss the effects of environment on health.
5. Learn the process of Health Education.
6. Use Nursing Process with guidance to provide nursing care to the clients in communities through Home visits and health education

Course Content	MCQs	SEQs
Unit I: Introduction to Community Health Nursing **1.** Define the terms: **a.** Community **b.** Community health, and **c.** Community health nursing **d.** Urban & rural communities **2.** Discuss the historical background of Community Health Nursing from Public Health Nursing. **3.** Describe the philosophy of Community Health Nursing. **4.** Discuss the concepts of health, wellness, illness and disease. **5.** Discuss the roles of the Community Health Nurse in community settings.	3	1
Unit II: Primary Health Care (PHC) **1.** Explain Alma Atta Deceleration "Health for All by the Year 2000" and beyond. **2.** Define Primary care and PHC **3.** Describe the five basic principle of PHC **4.** Explain the elements of PHC in relation to health **5.** Discuss application of PHC in Pakistan	5	1
Unit III: Pakistan Health Care System **1.** Define the terms, system, and health care system. **2.** Identify the health services available to community by Pakistan Government Health Care System. **3.** Explain the roles of health care team members within the health care system. **4.** Discuss the Devolution Plan of 2000	3	0.5
Unit-IV: International Health Organizations and Nursing Organizations **1.** International Council of Nursing **2.** World Health Organization **3.** Pakistan Nursing Association, Federation and Council	3	0.5
Unit V: Environment and community health **1. Environment** **a.** Definition of `environment' **b.** Component of environment and	10	2

c. Factors and its impact on community health **2. Water** **a.** Definition of safe and wholesome water **b.** Uses of water **c.** Daily requirements for one person. **d.** Sources of water and its pollution **e.** Water-borne diseases (viral, Bacterial, protozoal, worms etc.) **f.** Water purification at small and large scales. **3. Community Wastes Management** **a.** Definition of refuse / solid waste, and sewage **b.** Methods for solid waste and sewage disposal **c.** Types of latrines used in communities **d.** Fecal-borne diseases **e.** Control of fecal-borne diseases **f.** Types of rodents **g.** Disease transmission by rodent **h.** Control of rodents **4. Food Sanitation** **a.** Definition of healthy foods **b.** Methods of food preservation. **c.** Principles of safe food handling. **d.** Prevention at transmission of food-borne diseases **e.** Control of food-borne disease. **5. Air/ Ventilation & Housing** **a.** Define ventilation **b.** Discuss the importance of air & ventilation **c.** Discuss effects of poor ventilation on health **d.** Describe the types standard, and needs of housing, **e.** 5Discuss effects of poor housing on health		
Unit V: Health Education **1.** Define the term; Teaching, learning and health education **2.** Explain the purpose and goal of health education **3.** Discuss principles of teaching learning. **4.** Describe various strategies used to deliver health education. **5.** Develop a teaching Plan and conduct mock health session on a selected topic.	3	0.5
Unit VI: Introduction to Home Visiting **1.** Define homes visiting **2.** Discuss the principles, purposes and advantages of Home Visiting in community **3.** Describe the steps of Home Visiting	3	0.5
Total	**30**	**6**

Recommended Books/ Reading Materials

1. Alam, N. (2020). Excell Community Medicine, (13th ed.). Nishtar Publications
2. Basavanthappa, B. T. (2003). Nursing education New Delhi: Jaypee Medical publication
3. Ansari. I. M., (2016) Public health and community medicine. (8th ed) Karachi.

COMMUNITY HEALTH NURSING-I CLINICAL

Credit Hours: 01 (0+01)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Identify the role and responsibilities of staff working in each visited facility
2. Describe the processes of:
    - **a.** Sewerage treatment
    - **b.** Water purifications at large scale
    - **c.** Milk transportation & preservation
    - **d.** Meat slaughtering, handling and distribution
3. Identify environmental issues exist and their effects on health
4. Discuss the role of CHN in maintaining healthy environment
5. Begin to use nursing process during the home visits.
6. Utilize various methods of health education while providing health education to the clients.

Field Visits	OSPE / Practical Book
a. 1. Basic Health Unit (BHU), Rural Health Center (RHC), Primary Health Center **(PHC)**	03
b. 2. Walking Survey in a Community	
c. 3. Bulk Water Supply Plant	
d. 4. Sewage Treatment Plant	
e. 5. Milk Plant & Dairy Farm	

Recommended Books/ Reading Materials

1. Alam, N. (2020). Excell Community Medicine, (13th ed.). Nishtar Publications
2. Basavanthappa, B. T. (2022). Community health Nursing. (3rd. ed.). New Delhi: Jaypee Medical publication
3. Ansari. I. M., (2016) Public health and community medicine. (8th ed) Karachi.

REPRODUCTIVE HEALTH

Credit hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Discuss the role of a nurse and other health team members in providing reproductive health care.
2. Discuss attitudes and practices towards marriage, birth, family planning, communicable diseases and immunization
3. Integration of reproductive health and its relationship to poverty, access and quality of care. Issues related to maternal morbidity and mortality.
4. Discuss the maternal and child health care programs in Pakistan and integrate the relevant concepts into nursing practice.
5. Provide family centered care with focus on mother and child.
6. Begin to demonstrate the legal and ethical nursing practice while providing care to the family.
7. Identify the role of the individual and the family in the promotion and maintenance of health and prevention of disease.

Topic Detail	MCQs	SEQs
Unit I: Introduction to reproductive health **1.** Nurses' role in Reproductive health **2.** Reproductive health in relation to poverty, quality of care, and access. **3.** Gender equity, basic health service, and emotional psychological support	03	0
Unit II: Immunization **1.** Introduction to Expanded Program For Immunization (EPI) **2.** Review Types of immunity **3.** Define Tropical and communicable diseases **4.** Vaccine preventable diseases **5.** Types of vaccines **6.** Preparation and administration of vaccines **7.** Vaccine Schedule **8.** Contra indications and side effects of vaccines **9.** Preparation for an immunization session **10.** Storage of vaccine **11.** Role of a Nurse in maintaining of Cold Chain **12.** Motivation for immunization in the community **13.** Health education in an immunization program **14.** Post vaccination teaching and Health education in an immunization program	05	01
Unit III: FAMILY CENTERED CARE **1.** Definition, Structure and types of Family **2.** Functions of Family **3.** Family Health Nursing Process (Assessment, Nursing Diagnosis, Goals, Implementation and Evaluation) **4.** Family as a unit of care (Care of a family as client) **5.** Communication Patterns	02	01

6. Developmental Approach **7.** Values and Beliefs **8.** Family Roles, Power & coping Strategies **9.** Decision making process,		
Unit IV: Safe motherhood **1.** Pre conception and Conception care **2.** Antenatal care of mothers (History taking, Physical examination, Antenatal visits schedule, Maternal Immunization, baseline investigations, Diagnostic tests in pregnancy **3.** Assessment of pregnant women **4.** Physiological changes during pregnancy **5.** Minor disorders in Pregnancy and management (pregnancy induced anemia **6.** Prevention of infection **7.** High risk pregnancy **8.** High Risk mothers **9.** Pregnancy induced hypertension, Pre- eclampsia and eclampsia, Gestational Diabetes Mellitus (GDM), Placenta Previa, Placenta Accreta, Placenta Abruption, multiple gestations)	05	01
Unit V: Natal care **1.** Delivery process and nursing care (stages of Labor) **2.** Breast feeding **3.** Role of health care team in the community **4.** Role of Traditional birth attendant in the Community **5.** Establishing contacts with pregnant women **6.** Assessment of home for delivery **7.** Preparation for home delivery **8.** TBA delivery kit **9.** Care during Home Delivery	03	01
Unit VI: Postnatal Care **1.** Care of Post Natal mothers **2.** Post Natal complications **3.** Post Natal contraception **4.** Diet and exercise **5.** Health education on immediate and long-term needs of mother and infant **6.** High Risk mothers **7.** Post-partum Hemorrhage **8.** Post-partum Infections	05	01
Unit VII: Family Planning **1.** Introduction of family planning **2.** Constrains of family planning in Pakistan **3.** Consequences of population growth in Pakistan **4.** Methods of family planning **5.** Actions and side effects of different methods **6.** Action & side effects of different methods **7.** Role of Nurse in motivating and counseling the client for Family Planning in community setting	04	01
Unit VIII: Adolescent reproductive and sexual health		

1. Changes during puberty **2.** Common problem occurs during puberty **3.** Nursing care and counseling	03	0
Total	30	06

Recommended Books/ Reading Materials

1. Alam, N. (2020). Excell Community Medicine, (13th ed.). Nishtar Publications
2. Basavanthappa, B. T. (2022). Community health Nursing. (3rd. ed.). New Delhi: Jaypee Medical publication
3. Marshall, J.E. and Raynor, M.D. (2020) Myles Textbook for Midwives. 17th ed. London: Elsevier

REPRODUCTIVE HEALTH CLINICAL

Credit hours: 03 (0+03)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Perform prenatal, natal, and postnatal assessment. (male students will perform theses skill on simulation in skills lab)
2. Develop action plan of the prioritized problem.
3. Implement and evaluate plan of care.
4. Observe delivery process and provide care accordingly.
5. Apply teaching learning principle in conducting health education sessions at Women and Child health center.

S No	Practical's 1 Credit Hour	OSPE/ OSCE
1.	Antenatal assessment (Vital Signs, EDD, Fundal Height, FHR)	03
2.	Family Planning counseling	
3.	Family Planning Methods	
4.	Nutritional Counselling	
Case Book 2 Credit Hour = 6 OSPE/OSCE		
5.	Observation of 10 normal delivery cases	01
6.	Assist 05 normal delivery cases	01
7.	Conduct 05 Normal delivery cases under supervision	01
8.	Conduct 05 Independent normal delivery cases	01
9.	Independent post-natal care	01
10.	Independent newborn care	01

Recommended Books/ Reading Materials

1. Alam, N. (2020). Excell Community Medicine, (13th ed.). Nishtar Publications
2. Basavanthappa, B. T. (2022). Community health Nursing. (3rd. ed.). New Delhi: Jaypee Medical publication
3. Marshall, J.E. and Raynor, M.D. (2020) Myles Textbook for Midwives. 17th ed. London: Elsevier

NURSING ETHICS

Credit Hours: 01 (01+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Define ethical principles in health care.
2. Discuss ethical, moral and professional responsibilities of the nurse.
3. Discuss the nurse's individual liability with in the ethical scope of nursing practice.
4. Identify ethical concern at the clinical area and discuss alternatives for the identified ethical concerns.
5. Discuss the changing health environment for the role of nurse in delivery of ethical nursing care

Course Content	MCQs	SEQs
Unit I: Introduction to Nursing Ethics **1.** Define the terms: ethics, nursing ethics and bio-ethics, value, belief, morals, attitude, conflict, dilemma, ethical dilemma **2.** Discuss importance of ethics in nursing **3.** Review criteria of a profession **4.** Develop Characteristics of a Professional Nurse	1	0
Unit II: Value Set **1.** Define Value &value clarification **2.** List types of values **3.** Identify personal, societal, organizational professional and moral values **4.** Explain modes of value transmission **5.** Recognize value conflicts and its implication to nursing practice. **6.** List advantages of value clarification in nursing profession. **7.** Develop professional values **8.** Discuss implication of Nursing Care Ethics in Divers Society.	1	0.5
Unit III: Ethical Principles and Theories **1.** Discuss ethical principles in health care in the light of ethical theories. **2.** Discuss the ethical dilemmas face by nurses and client. **3.** Discuss the strategies to resolve ethical dilemma in daily nursing practice. **4.** List steps of ethical decision-making	2	0.5
Unit IV: Confidentiality and Informed consent **1.** Define confidentiality and informed consent **2.** Discuss the importance of confidentiality & consent **3.** List ethical and legal elements of informed consent **4.** Discuss the process informed consent. **5.** Discuss nurse's roles and responsibilities in consent process **6.** Implication of case consultation in nursing ethics.	2	0.5
Unit V: Bills of Rights **1.** Define rights & bills of right. **2.** List the types of rights.	2	0.5

3. Describe the role of nurse in relation to bills of right. **4.** Explain patient's bills of right in a tertiary care health facility.		
Unit VI: Code of Ethics **1.** Define code & code of ethics. **2.** List the function & elements of ethical code **3.** Explain code of ethics by ICN and Pakistan Nursing Council **4.** Compare code of ethics by ICN and Pakistan Nursing Council **5.** Discuss application of code of ethics in clinical settings. **6.** Define Nursing Pledge in relation to code of ethics	2	0.5
Unit VII: Professional Autonomy and Ethics **1.** Define profession, professional, autonomy, accountability and unity. **2.** Discuss the characteristics of professional nurse. **3.** Relate the code of ethics to professional status. **4.** Discuss the professional autonomy and ethics. **5.** Relate accountability to professional status. **6.** Discuss the concept of unity and its relationship to professional status in nursing. **7.** Relate Nursing ethics to standards of nursing practice.	2	0.5
Unit VIII: Ethical Dilemma in Professional Practice **1.** Define dilemma and professional obligation **2.** Identify common areas of negligence and nurses' liability in these areas. **3.** Discuss nurses' advocacy in various scenarios and clinical cases related to **a.** Life support equipment **b.** Selling body parts **c.** Risk management and occupational hazards. **d.** Documentation of nursing care. **e.** Employment issues **f.** Medical malpractice lawsuit	3	0
Total	**15**	**3**

Recommended Books/ Reading Materials:

1. Beauchamp T. L. and Childress, J. F (2019). Principles of Biomedical Ethics (8th ed), Oxford University Press, New York.

PEDIATRIC HEALTH NURSING-II

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Develop awareness on common health issues of the children.
2. Integrate system wise knowledge of diseases into care of sick children.
3. Integrate research-based information in the care of child and family.
4. Provide disease specific nursing care to children.

Course Content	MCQs	SEQs
Unit I: Gastro Intestinal (GI) dysfunctions in Children Commonly occurring GI dysfunctions reported in early days of life that needs urgent management: **1.** Ingestion problems and structural defects of GI (Cleft palate, cleft lip tongue tie and Tracheoesophageal fistula) **2.** Pyloric stenosis. **3.** Biliary Atresia **4.** Liver Abscess **5.** Intestinal obstruction **6.** Hernia **7.** Hirschprung's disease **8.** Intussusceptions **9.** volvulus **10.** Amibiasis **11.** NEC (Necrotizing Enterocolitis) Nursing care, pharmacological, medical and surgical modalities for dealing with the above disorders Commonly used medications in Pakistan for the above disorders	04	1
Unit II: Genito-urinary (GU) dysfunctions in Children Commonly occurring GU dysfunctions in pediatrics **1.** Upper and Lower Urinary tract infection **2.** Nephrotic syndrome **3.** Congenital Renal atrophy **4.** Bartter syndrome Nursing management and treatment modalities for the children with the above disorders	03	1
Unit III: Fluid and Electrolyte imbalance in Children with various dysfunction **1.** Nursing Care aspects for maintaining fluid and electrolyte balance in the children with following conditions **2.** Burns, **3.** GI Disorders **4.** GU Disorders	02	0.5

Unit IV: Respiratory dysfunction in Children: Commonly occurring Respiratory problems in Pediatrics: Upper and Lower Respiratory Tract Infections: **1.** Pharyngitis **2.** Tonsillitis **3.** Otitis media **4.** Bronchitis **5.** Pneumonia **6.** Asthma **7.** Croup Syndrome **8.** Cystic fibrosis **9.** Reactive Airway Diseases (RAD) **10.** Caring for pediatric client on Mechanical ventilator Nursing care aspects, pharmacological and other medical management for the pediatric patients with the above disorders.	03	0.5
Unit V: Musculo-skeletal dysfunctions in Children **1.** Kyphosis **2.** Lordosis **3.** Scoliosis **4.** Types of common Fractures in children **5.** Rheumatoid arthritis **6.** Congenital hip dislocation Nursing care, child with cast and traction, rehabilitative care and other medical and surgical management for the children with the above disorders.	03	0.5
Unit VI: Neuro-muscular dysfunctions in Children Commonly occurring neuron-muscular dysfunctions in Pediatric patients: **1.** Cerebral palsy **2.** Muscular dystrophy **3.** Gillian–Barre Syndrome **4.** Spina bifida **5.** Meningomyelocele **6.** Nursing care, rehabilitative care and other medical and surgical management for the children with the above disorders **7.** Overview of institutes i-e, NGO's and Government law organization working in Pakistan for the rehabilitation of children with the above dysfunctions	04	0.5
Unit VII: Cognitive/Sensory dysfunctions and Rehabilitation **1.** Hearing and visual impairment. **2.** Mental retardation **3.** Downs' syndrome Nursing care, rehabilitative care and other medical management for the children with the above disorders	02	0.5
Unit VIII: Cerebral dysfunction in children **1.** Meningitis, Hydrocephalus **2.** Encephalitis **3.** Seizures disorders (Febrile and Epilepsy) **4.** Head injury due to various causes in children with different age group	03	0.5

Nursing care aspects; pharmacological, medical and surgical modalities for the above disorders		
Unit IX: Hematological dysfunctions in Children **RBC disorders:** **1.** Anaemia **2.** Thalassemia, **3.** Sickle cell anaemia, **4.** Aplastic anaemia **Platelet disorder** **5.** Hemophilia **6.** Disseminated intravascular coagulation, **7.** Thrombocytopenia Care of pediatric patients receiving blood transfusion and blood products (Pharmacological and non-pharmacological management)	03	0.5
Unit 10-Endocrine dysfunctions in Pediatric Clients **1.** Insulin Dependent diabetes mellitus (IDDM) and Diabetic insipidus **2.** Cushing syndrome. **3.** Hyperthyroidism **4.** Hypothyroidism **5.** Hypopituitarism **6.** Hypopituitarism Nursing Care approaches for dealing with above health problems Pharmacological, medical and surgical management for the above**.**	3	0.5
Total	**30**	**6**

Recommended Books/ Reading Materials

1. Hockenberry, M., Wilson, D., Rodgers, C. (2022). Wong's Essentials of Pediatric Nursing (11th ed.). Elsevier
2. Sethi. N., (2017). Essential of pediatric nursing (4th ed). Lotus Publishers.

PEDIATRIC HEALTH NURSING-II CLINICAL

Credit Hours: 02 (0+02)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Recognize and manage emergencies in neonates.
2. Describe various recent technologies and treatment modalities in the management of high-risk neonates.
3. Prepare a design for layout and management of neonatal units
4. Apply the nursing process in the care of ill infants to pre adolescents in hospital and community
5. Incorporate evidence-based nursing practice and identify the areas of research in the field of pediatric / neonatal nursing
6. Recognize the role of pediatric nurse as a member of the pediatric and neonatal health team.
7. Apply nursing process in the management of pediatric population problems and health issues.

Sr. No	Practical	OSPE/OSCE
1	N/G or O/G tube insertion	06
2	N/G or O/G tube feeding and removal	
3	Oro/Naso-pharyngeal suctioning	
4	Tracheostomy suctioning	
5	Blood Specimen Collection in children	
6	Urine specimen collection in children	
7	Care of a child during Lumber Puncture	
8	Care of a child in Peritoneal dialysis	
9	Foleys Catheter insertion in children	
10	Positioning and Restraining Pediatric Clients	

Recommended Books/ Reading Materials

1. Hockenberry, M., Wilson, D., Rodgers, C. (2022). Wong's Essentials of Pediatric Nursing (11th ed.). Elsevier
2. Sethi. N., (2017). Essential of pediatric nursing (4th ed). Lotus Publishers.

MENTAL HEALTH NURSING

Credit Hours: 03 (03+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Demonstrate an awareness and acceptance of mental health and illness as legitimate health issues
2. Describe the nursing process as applied to mental health nursing
3. Utilize knowledge base to actively participate in therapeutic milieu for clients with mental health problems
4. Explore factors affecting mental health especially in the Pakistani culture
5. Demonstrate care of a client suffering from different mental health illnesses
6. Identify need and relevance of community mental health in Pakistan and the resources available to manage it

Course Content	MCQs	SEQs
Unit I: Mental Health & Mental Illness **1.** Analyze own perceptions, values, beliefs and feelings towards mental health and mental illness **2.** Analyze cultural perceptions to mental health, mental illness and mental health nursing. **3.** Discuss about the history of psychiatry and psychiatric nursing in Pakistan **4.** Demonstrate understanding about laws governing admissions and discharge of clients in mental health settings **5.** Analyze the common personal and civic rights retained by patients in mental health settings and ethical issues related to it	3	0
Unit II: Tools of Psychiatric Nursing **A: Therapeutic Communication and therapeutic relationship**: **1.** Discuss significance of communication skills in mental health settings **2.** Describe techniques that facilitate or impede therapeutic communication in mental health settings **3.** Demonstrate 'use of therapeutic self' while dealing with clients with mental health problems in selected settings. **B: Mental health assessment:** **1.** Discuss nature, purpose and process of mental health assessment **2.** Begin to analyze clinical findings that indicate mental health problems in selected clients. **C: Self Awareness**: **1.** Define self-awareness **2.** Establish relationship between self-awareness and development of therapeutic relationship in mental health setting.	3	1
Unit III: Factors Affecting Mental Health and Mental Illness **1.** Describe biological, sociocultural and interpersonal factors and their impact on mental health and mental illness **2.** Discuss stress and adaptation, and its relationship with mental health and mental illness	3	0
Unit IV: Bio-Psychosocial Interventions	4	0

1. Discuss effective ways of managing anger **2.** Discuss cognitive behavioral therapy		
Unit V: Psycho-Pharmacodynamic **1.** Discuss psychopharmacological interventions **2.** Describe the mechanism of action, clinical use, and side effects related to drugs used in mental health settings **3.** Identify role of the nurse in psychopharmacological treatments **4.** Analyze relevance and appropriateness of these therapies in the field of mental health	3	1
Unit VI: Personality Disorders **1.** Discuss the development of personality disorders. **2.** Discuss some common features exhibited by individuals with antisocial and borderline personality disorder. **3.** Explore causative factors of personality disorders **4.** Utilize nursing process based on an understanding of the psychodynamics' of clients exhibiting various maladaptive behaviors in selected situations.	4	1
Unit VII: Anxiety and dysfunctional anxiety responses **1.** Discuss the concept of anxiety **2.** Discuss physiological, perceptual, cognitive, and behavioural effects of anxiety **3.** Discuss various dysfunctional anxiety responses [Generalized anxiety disorder, Post traumatic stress disorder, Phobia, Obsessive Compulsive disorder, Conversion reaction] and their basis in etiology **4.** Demonstrate understanding of the principles of nursing and psychosocial care, while caring for clients with dysfunctional anxiety responses.	4	1
Unit VIII: Altered mood states: **1.** Describe the continuum of adaptive and maladaptive emotional response **2.** Discuss phenomenon of 'depression' **3.** Analyze the prevailing psychological, biological, and social theories that serves as basis for caring for clients with altered mood states. **4.** Analyze the human responses to mood alterations **5.** Discuss effective nursing and psychosocial interventions for clients with Altered mood states	3	1
Unit IX: Deliberate self-harm and suicidal behavior: **1.** Describe the continuum of adaptive and maladaptive self- protective responses **2.** Discuss prevalence of self-harm and suicidal behavior in Pakistani population. **3.** Explore predisposing factors, precipitating stressors, and appraisal of stressors related to self-protective responses **4.** Discuss effect to nursing interventions related to self-protective responses.	3	1
Unit X: Altered thoughts and perceptions: **1.** Describe 'schizophrenia' in light of altered thoughts and perceptions **2.** Distinguish key positive and negative symptoms found in clients with thought disorder	3	1

3. Analyze human response to schizophrenia with emphasis on perception, thought, activity, and consciousness, affect, and interpersonal relationship **4.** Analyze predisposing factors, precipitating stressors and appraisal of stressors related to schizophrenia **5.** Discuss principles of care for helping client suffering from altered thoughts and perceptions and their families.		
Unit XI: Substance abuse and dealing with aggressive clients: **1.** Define the terms related to substance abuse **2.** Discuss predisposing factors related to substance abuse **3.** Describe different categories of drugs of abuse and their specific effects **4.** Discuss principle of care for client who abuses the drug. **5.** Define violence, its possible causes and characteristics **6.** Describe theories contributing to the development of aggressive behavior **7.** Identify factors useful in predicting aggressive behavior among clients **8.** Discuss strategies to assess patients with aggressive behaviors **9.** Relate behaviors and values of nurses related to violence and substance abuse **10.** Discuss primary and secondary prevention of aggression in hospital setting.	2	1
Unit XII: Childhood Mental Disorders **1.** Oppositional Defiant Disorder (ODD) **2.** Conduct Disorder (CD) **3.** Attention-Deficit/Hyperactivity Disorder (ADHD) **4.** Tourette Syndrome **5.** Post-traumatic Stress Disorder (PTSD)	3	1
Unit XIII: Geriatric Mental Health problems **1.** Identify and describe the elements of a comprehensive psychiatric assessment of elderly clients with compromised cognition. **2.** Discuss Dementia and delirium in relation to mental health of elderly **3.** Analyze nursing care needs for elderly clients with mental health problems	3	0
Unit XIV: Community Mental Health Nursing **1.** Discuss various models of community mental health nursing and its relevance to Pakistan **2.** Analyze functions of mental health nurse in community setting of Pakistan Demonstrate understanding of faith healing practices as local resource for community mental health in Pakistan.	2	0
Unit XV: Rehabilitation and Recovery **1.** Define tertiary prevention and rehabilitation **2.** Discuss the behaviors and rehabilitative needs of people with serious mental health problems **3.** Discuss response of families and communities towards rehabilitative needs of clients.	2	0
Total	45	9

Recommended Books/ Reading Materials:

1. Sheila L. Videbeck (2022) *Psychiatric Mental Health Nursing* 9th Edition. LWW.

MENTAL HEALTH NURSING CLINICAL

Credit Hours: 03 (0+03)

Learning Outcomes/Objectives: At the end of the course, students will be able to:

1. Perform clinical interviews and complete biopsychosocial assessments with adults and older adults.
2. Make appropriate DSM-V diagnoses.
3. Develop treatment plans, recommendations and referrals that are appropriate and congruent with the individual's age, socioeconomic and cultural background.
4. Efficiently perform on-going assessments on patients' progress.
5. Demonstrate an advanced knowledge base of psychiatric assessment and diagnosis of mental health illnesses.
6. Relate critical thinking, clinical judgment, and diagnostic reasoning principles to solve hypothetical mental health illnesses.
7. Incorporate relevant research findings in management of selected mental health needs of adults and older adults.
8. Provide culturally competent care to meet the psychiatric/mental health needs of adults and older adults having different mental health issues

S No	Practical	OSPE/ OSCE
1	History Taking (Process Recording)	09
2	Mental Status Examination (Cognitive & Affective)	
3	Counselling Skills (Scenario Based)	
4	Aggression Management	
5	Withdrawal Symptoms management	
6	Suicidal Ideation Assessment	
7	Nursing care of a patient undergoing EEG	
8	Guided Imagery	
9	Group Therapy	
10	Cognitive Behavioral Therapy	
11	Managing patient with drug abuse	

Recommended Books/ Reading Materials:

1. Sheila L. Videbeck (2022) *Psychiatric Mental Health Nursing* 9th Edition. LWW.

NURSING THEORIES AND MODELS

Credit hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Analyze the historical evolution and philosophical tenets of theory and science development in nursing.
2. Synthesize terminology related to theory development.
3. Appraise ways of knowing in nursing.
4. Analyze the role of inductive and deductive thinking in theory development.
5. Evaluate the appropriateness and unique perspectives of nursing theories in the description, explanation, prediction and control of clinical phenomena.
6. Critique a nursing concept using the process of concept analysis.
7. Evaluate selected nursing theories for their potential utilization in nursing practice, education and research.

Course content	MCQs	SEQs
Unit I: An introduction to nursing theories: **1.** Define theory, Nursing Theory and Conceptual Model. **2.** Describe nature of theories. **3.** Discuss characteristics of a theories. **4.** Explain types of theories. **5.** Elaborate paradigm and metaparadigm of Nursing. **6.** Discuss importance of theories.	5	1
Unit II: Theory development **1.** Discuss components/structure of theory. **2.** Elaborate paradigm and metaparadigm of nursing theory. **3.** Levels of theory **4.** inductive and deductive thinking in theory development **5.** Steps of Development of nursing theories **6.** Analysis and evaluation of a theory	3	1
Unit III: Relationship between theory and the science and practice of nursing **1.** Nursing Theory and research **2.** Nursing Theory and science of knowing (patterns of knowing) **3.** Nursing Theory and practice	2	1
Unit IV: Need / problem-oriented theory **1.** Florence nightingale way **2.** Faye Glenn Abdellah **3.** Virginia Henderson **4.** Dorothea E. Orem **5.** Lydia E Hall **6.** Jean Watson	5	1
Unit V: Interaction oriented theory **1.** Hildegard E Paplau **2.** Ida Jean Orlando **3.** Ernestine Wiedenbach **4.** Imogene M King **5.** Paterson and Zderad	5	1
Unit VI: System oriented Theory	5	0.5

1. Dorothy E Peplau **2.** Callista Roy **3.** Betty Neuman **4.** Madeline M Leininger		
Unit VII: Energy Field Theories **1.** Martha E Rogers **2.** Rosemarie Rizzo Parse **3.** Margaret Newman	3	0.5
Unit VIII: conceptual models in Nursing **1.** Difference between theory and conceptual model **2.** Use of conceptual model as framework	2	0
TOTAL	**30**	**6**

Recommended Books/ Reading Materials

1. Basavanthappa, B. T. (2007). Nursing theories. (1st. ed.). New Delhi: Jaypee Medical publication

LEADERSHIP AND MANAGEMENT IN NURSING

Credit Hour: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Discuss the structures and functions of organizations.
2. Assess various management systems within, and related to, the health care system by utilizing various organizational theories.
3. Integrate various theories in relation to leadership, management, problem solving and decision making, motivation, managing change and, conflict management.
4. Describe implementation of an effective human resource management in nursing e.g. performance / annual appraisal, work load management, and other related issues.
5. Identify different mechanisms for managing resources and monitoring effective utilization of resources among health care professionals.
6. Demonstrate effective communication and interpersonal relationship
7. Discuss the application of the assertive behavior.
8. Describe the Quality Management System and its application to create an environment conducive to the provision of cost effective quality nursing care.
9. Describe the contribution of Information Technology to efficiency and effectiveness of nursing.

Course content	MCQs	SEQs
Unit I: Management /Organizational Theories, Structure and Culture **1.** Discuss various theories of management. **2.** Discuss different terminologies related to management **3.** Identify different types of health care organizations. **4.** Identify various types of organizational structures **5.** Differentiate between formal and informal structure within the organization. **6.** Define staff and line relationship **7.** Describe the importance of organizational structure **8.** Describe different levels of management. **9.** Describe redesigning and restructuring in the organization	2	1
Unit II: Management Functions and Their Application to Nursing Strategic Planning. **1.** Discuss various strategies managers use to coordinate material and human resources and for the accomplishment of organizational goals. **2.** Analyze the functions of a nurse manager in relation to: planning, controlling. Organizing. Directing and evaluating. **3.** Discuss the attributes of an effective manager. **4.** Discuss some selected management processes commonly used by nurses in their managerial role. **5.** Discuss how a nurse manager monitors the functioning of his/her area of administration. **6.** Understand the concepts of strategic planning.	2	1

Unit III: Leadership Theories and Styles **1.** Understand different Leadership theories. **2.** Discuss the styles of Leadership. **3.** Describe the different types of power used by a leader. **4.** Differentiate between the roles of manager & leader. **5.** Discuss ways to become an effective leader	2	1
Unit IV: Power and Politics Nursing **1.** Define politics, power, and policy. **2.** Discuss the different sources of power. **3.** Describe reasons why nurses should know the political strategies. **4.** Describe ways how power can be used constructively for professional purposes.	1	0
Unit V: Change Management **1.** Define change. **2.** Discuss categories and types of change. **3.** Understand different change theories. **4.** Integrate any of the change theories in given situation Lewin's theory and steps of change in a ward situation. **5.** Learn about the techniques for dealing with resistance. **6.** Learn about the skills that a change agent should possess.	2	0
Unit VI: Problem Solving and Decision Making **1.** Define the terms decision making and problem solving. **2.** Discuss the importance of critical thinking in decision making **3.** State the importance of decision making and problem solving **4.** Identify the types of decision making **5.** Describe the models used for decision making **6.** Describe the application of the models to a given situation **7.** Describe the problem-solving process and its application to clinical and administrative situations.	2	1
Unit VII: Communication in Management **1.** Review the basic principles of communication. **2.** Describe the importance of formal and informal channels of communication in organizations. **3.** Discuss concepts of organizational and interpersonal communication. **4.** Describe the different direction of communication **5.** Describe the mode of communication. **6.** Describe the factors influencing communication. **7.** Discuss the role of communication in leadership	2	1

Unit VIII: Negotiation and Collaboration: **1.** Discuss negotiation skills. **2.** Apply negotiation and collaborations skills while dealing with different population. **3.** Describe collective bargaining. **4.** Conflict Resolution & Management **5.** Define conflict. **6.** Discuss the positive and negative aspects of conflict. **7.** Explain causes of conflict. **8.** Explain different types of conflict. **9.** Describe different techniques of conflict resolution.	2	0
Unit IX: Resource Management Financial Management **1.** Describe the purpose of budgets. **2.** Differentiate and manage different types of budgets. **3.** Discuss the importance of budget for nurses. **4.** Apply specific terminology of budget. **5.** Discuss goals setting to establish budget. **6.** Discuss the elements of preparing, controlling and monitoring budget. **7.** Determine the efficiency of selected budget. **8.** Describe the applications of budgeting in their specific institution	2	0
Unit X: Human Resource Management **1.** Define Human Resource management, **2.** Discuss the different strategies for staff management. **3.** Describe the recruitment process. **4.** Discuss staffing and scheduling **5.** Discuss the importance of staff retention and staff development. **6.** Discuss the importance of delegation.	2	0
Unit XI: Work Load Management **1.** Define Work load management. **2.** Discuss different patient care processes, input, though put and output. **3.** Define efficiency, productivity and effectiveness. **4.** Discuss the different types of Nursing Care Models. **5.** Differentiate the advantages and disadvantages of each model. **6.** Discuss application of these models in patient care areas of the hospital.	2	0
Unit XII: Motivational Theories, Performance Appraisal and Managing Challenging Personnel **1.** Discuss different motivational theories. **2.** Define the term Performance Appraisal. **3.** Discuss the different evaluation philosophies. **4.** State the purpose of performance appraisal. **5.** Describe the process of performance appraisal. **6.** Describe the components, methods and types of evaluation. **7.** Discuss the potential problems and strategies to reduce them. **8.** Discuss counseling and the types. **9.** Describe the process of counseling and its importance to performance appraisal and managing with challenging / difficult personnel.	2	1

Unit XIII Quality Management System **1.** Discuss the historical elements fostering implementation of quality management system. **2.** Discuss the relationship between Total Quality Improvement (TQI), Total Quality Management (TQM), and Quality Management System (QMS). **3.** Describe the characteristics and process of quality management system. **4.** Define performance improvement standards. **5.** Identify the role of the nurse manager in the quality management process. **6.** Discuss Nursing role in risk management. **7.** Delineate the type of risk involve in health care setting. **8.** Discuss key behaviors for handling customers' complaints. **9.** Analyze the Plan Do Check & Action (PDCA) cycle	2	0
Unit XIV: Accreditation for Institutions **1.** Describe the historical back ground of the accreditation of institution. **2.** Define Accreditation. **3.** Discuss the importance of accreditation in growth of the institutions. **4.** Differentiate between ISO 9000 and JCIA. **5.** Discuss its implementation of these standards hospitals/organization.	3	0
Unit XV: Hospital Management System (HMS) **1.** Define Management Information System (MIS) **2.** Discuss different Information system used in hospital setting. **3.** Describe different obstacles with Nursing Information System (NIS). **4.** Describe the role of a nurse manager in application of this technology. **5.** Discuss ethical consideration in NIS. **6.** Discuss Nursing Informatics and its implication in nursing profession. **7.** Describe the contribution of Information technology to efficiency and effectiveness of nursing.	2	0
TOTAL	**30**	**6**

Recommended Books/ Reading Materials

1. Sullivan, E.J., (2018). *Effective Leadership and Management in Nursing*. (10th Ed.). New Jersey.

LEADERSHIP AND MANAGEMENT CLINICAL

Credit hour: 01 (0+01)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Identify basic nursing leadership principles related to caring for groups of patients, including delegation and prioritization.
2. Identify how to safety prioritize care for a variety of clients on the unit the day of the experience.
3. Observe how the preceptor handles conflict on the unit.
4. Discuss how to effectively delegate to other members of the health care team.
5. Assess the communication and collaboration between members of the health care team
6. Identify effective patterns of leadership.
7. Identify the various types of leadership styles encountered during the experience.
8. Perform leadership skills on the unit related to: patient-centered care; teamwork and collaboration; evidence-based practice; quality improvement; safety; informatics and how the situation may be resolved through effective leadership.

S.NO.	Practical	OSCE/OSPE
1.	Staffing and Scheduling	03
2.	Problem solving skills for effective decision making in management.	
3.	Conflict management strategies (scenario based)	
4.	Budgeting and resource allocation	
5.	Performance appraisal interviews	

Recommended Books/ Reading Materials

1. Sullivan, E.J., (2018). *Effective Leadership and Management in Nursing*. (10th Ed.). New Jersey.

NURSING RESEARCH

Credit hours: 03 (03+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Recognize the research process as a systematic approach to thought and the generation of nursing knowledge.
2. Understand the process of Evidence based health care.
3. Identify the role of nursing research in the development of a body of nursing knowledge that promotes nursing as a profession.
4. Explain the ethical consideration used in nursing research for the safety of human subject and the conduct of research.
5. Analyze/ critique research studies in nursing and other health sciences to evaluate the use of research process, methodologies, validity, reliability, application & research findings to the practice, and its significant to development of nursing.
6. Prepare a condensed research proposal (either quantitative or qualitative)

Course Content	MCQs	SEQs
Unit I: Introduction to Research **1.** Discuss the historical evolution of nursing research **2.** Define the Research Terminology **3.** Explain the method of acquiring knowledge **4.** Define problem solving **5.** Explain the steps of problem-solving methods **6.** Mention the steps in scientific method **7.** Discuss the limitations of scientific methods **8.** Define research and nursing research **9.** Discuss the types of research **10.** Enumerate the characteristics and purpose of research **11.** Explain the scope and area of nursing research **12.** Identify the problems in conducting nursing research **13.** Discuss the role of a nurse in the research process	3	0
Unit II: Ethics in research **1.** Introduce the terms related to ethics **2.** Explain the code of ethics **3.** Discuss the importance of ethics in research **4.** Mention the ethical principles for protecting human rights **5.** Identify the measures to protect the rights of study participants **6.** Discuss the ethical implications for nursing research	4	1
Unit III: Selecting and identifying the research problems and purposes **1.** Define the research process **2.** Identify the steps in the research process **3.** Define the research problems **4.** Recognize the sources research problems **5.** Interpret the steps of identifying a research problem **6.** Enumerate the components of a research problem	2	1

7. Discuss the research questions **8.** State the evaluation criteria for a research problem **9.** Define he variable and its types **10.** Define the operational definition **11.** Discuss the research objectives		
Unit IV: Formulating the hypothesis **1.** Define the term hypothesis **2.** Classify the types of hypotheses **3.** Describe the sources of hypothesis **4.** Identify the characteristics of hypothesis **5.** Implement the hypothesis testing **6.** Describe the assumptions **7.** Enumerate the delimitations and limitations	3	1
Unit V: Literature review **1.** Define the term literature review **2.** Discuss the characteristics of a quality review **3.** Enlist the factors affecting the literature review **4.** Explain the purposes of literature review **5.** Describe the importance of literature review **6.** Identify the types of Literature Review **7.** Recognize sources of Literature Review **8.** Explain the steps of Literature Review **9.** Translate the tips for writing Literature Review **10.** Discuss the critical appraisal of Review	2	1
Unit VI: Theories and conceptual models in Research **1.** Define the term Theory and its terminologies **2.** Classify the types of Theories **3.** Discuss the importance of Theory in Nursing **4.** Define the term model **5.** Differentiate between the conceptual framework and theoretical framework **6.** Describe the importance of Theory, Models and Framework in research **7.** State the use of Theory in Research **8.** Discuss the process of conceptual framework development	2	0
Unit VII: Research Methodology **1.** Sampling and its Design **2.** Define the term Sample and Population **3.** Describe the characteristics of a good Sampling Design **4.** State the criteria for Sample selection **5.** Enlist the factors influencing Sampling **6.** Discuss the Sampling design process **7.** Classify the types of Sampling techniques **8.** Differentiate the Sampling errors and non-sampling errors	5	1

9. Discuss the types of errors		
Unit VIII: Methods of Data Collection **1.** Discuss the types of Research data **2.** Describe the Data Collection Plan **3.** Discuss the Developing Data Collection Plan **4.** Identify the steps of Developing Data Plan **5.** State the methods and tools of Data Collection **a.** Interview ✓ Characteristics of Interview ✓ Benefits of Interview ✓ Other types of Interviews ✓ Steps of conducting an Interview **b.** Questionnaire **c.** Observation **d.** Bio physiological method **e.** Projective techniques **f.** Visual analogue scale (VAS) **g.** Ordinal scale **h.** Interval scale **i.** Ratio scale	5	1
Unit IX: Analysis of Data and Application of Biostatics in Nursing Research **1.** Analysis of Quantitative Data **2.** Steps of Quantitative Data Analysis **3.** Descriptive Statistics **4.** Application of Statistics **5.** Measure of central Tendency **6.** Certain terms in Probability **7.** Normal Distribution **8.** Chi- Square Test **9.** Analysis of Qualitative Data	5	0
Unit X: Quantitative Research Design **1.** Discuss the research Design **2.** Describe the characteristics of good Research Design **3.** Enumerate the factors affecting the selection of study design **4.** Discuss types of Quantitative Research designs **a.** Cross sectional Study Design **b.** Correlation Study Design **c.** Experimental research **d.** Quasi Experimental Research	7	1

Unit XI: Qualitative Research Designs **1.** Introduction to phenomenological study **2.** Case Study **3.** Grounded Theory/ Ethnography **4.** Historic Research / Qualitative Research Methodologies and Triangulations	4	1

Unit XII: Proposal Writing **1.** Definition of Research Proposal **2.** Discuss the types of Research Proposal **3.** Describe the importance of Research Proposal **4.** Enumerate the advantages of Research Proposal **5.** State the relationship of Research Proposal with Research **6.** Discuss the components of Research Proposal **a.** Title **b.** Introduction **c.** Statement of the problem **d.** Review of related literature **e.** Hypothesis **f.** Purpose or objective of study **g.** Work plan **h.** Method, Research, Design Sample **i.** References **7.** Identify the common error in Research Proposal **8.** Evaluate the Process of Research Proposal	3	1
Total	45	9

Recommended Books/ Reading Materials

1. Polit, D. F., & Beck, C. T. (2017). *Nursing research: Generating and Assessing Evidence for Nursing Practice (10th ed.).* Philadelphia: Lippincott Williams & Wilkins.

CRITICAL NURSING CARE

Credit hours: 04 (04+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Analyze critically, the assessment data of the patient incorporating physical, psychological, social, emotional and spiritual aspects of care.
2. Relate normal and altered physiological concepts to patient care in critical care and emergency setting.
3. Apply a variety of concepts and theories to the care of individuals and families, using the nursing process and Gordon's functional Health pattern as the framework.
4. Demonstrate an awareness of legal and ethical standards in caring for patients with various disorders in a variety of acute and intermediate care settings.
5. Discuss the concept & principles of Disaster Management

Course Content	MCQs	SEQs
Unit I: Conceptual foundations in critical care nursing **1.** Psychosocial implications in the care of critically ill patient and family **2.** Stress and coping **3.** Individual and family response to the critical care experience **4.** Death and Dying theories **5.** sleep and sensory balances in critically ill patient **6.** Infection control in critical care **7.** Nutrition in critical care **8.** Contemporary issues in critical care area **9.** Complementary therapies	20	4
Unit II: Tools of critical Care **1.** Methods of hemodynamic monitoring **2.** Intra-aortic balloon pump monitoring **3.** Code management **4.** Ventilator care	15	4
Unit III: Emergency Nursing **1.** Concepts of disaster, triage and trauma management in pre-hospital and hospital setting **2.** Nursing management of medical and surgical emergencies (pre-hospital and/or hospital settings) **3.** Trauma and Hemorrhage **4.** Life threatening emergencies **5.** Airway emergencies **6.** Cardiopulmonary emergencies **7.** Shock **8.** Poisoning and drug overdose **9.** Contemporary issues in emergency nursing	25	4
Total	**60**	**12**

Recommended Books/ Reading Materials

1. Urden, L. D., Stacy, K. M., & Lough, M. E. (2021). Critical care nursing: Diagnosis and management (9th ed.). Elsevier/Mosby.
2. Sole, M. L., Klein, D. G., & Moseley, M. J. (2024). Introduction to critical care nursing (9th ed.). Saunders.
3. Dolan. B., & Halt. Lynda., (2013) Accident & Emergency Theory into Practice (3rd). Elsevier

CRITICAL NURSING CARE CLINICAL

Credit hours: 04 (0+04)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Describe the organizational setup, policies, staffing norms, of the ICU.
2. Develop skills in handling monitors, ventilators, infusion pumps, IABP machines etc.
3. Able to prepare emergency trolley.
4. Perform defibrillation, CPR to the collapsed patients
5. Provide nursing care to the patients receiving fibrinolytic drugs, Antihypertensive drugs, pacemaker, angioplasty & angiograms.

Sr. No	Nursing Skills	OSPE/OSCE
1	Oxygen inhalation by BiPAP, CPAP	12
2	Tracheostomy dressing	
3	Administration of meter dose inhaler (MDI)	
4	Measurement of peak flow meter	
5	Chest Tube Care	
6	Suctioning of ETT	
7	ABGs Interpretation	
8	Bed sore care	
9	Glasgow coma scale (GCS) Assessment	
10	Intra-arterial pressure monitoring	
11	CVP measurement	
12	Assisting and prepare CVP	
13	ATT care	
14	Left arterial pressure monitoring	
15	Pulmonary arterial pressure monitoring	
16	Cardiac output monitoring	
17	Intra-aortic balloon pump monitoring (IABP)	
18	Ventilator care	
19	BLS	
20	Triage coding	

Recommended Books/ Reading Materials

1. Urden, L. D., Stacy, K. M., & Lough, M. E. (2021). Critical care nursing: Diagnosis and management (9th ed.). Elsevier/Mosby.
2. Sole, M. L., Klein, D. G., & Moseley, M. J. (2024). Introduction to critical care nursing (9th ed.). Saunders.
3. Dolan. B., & Halt. Lynda., (2013) Accident & Emergency Theory into Practice (3rd). Elsevier

COMMUNITY HEALTH NURSING-II

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Demonstrate the role of the community health nurse as a practitioner, researcher, educator and manager while participating in the health care of the community.
2. Participate in planning, implementing, and evaluating the Health / Developmental project with the community.
3. Utilize the concepts of Primary Health Care, Health Promotion, Epidemiology and planning cycle in health/ development project in community setting.

Course Content	MCQs	SEQs
Unit I: Review health transition and global health **1.** Demography **2.** Health statistics **3.** Burden of disease **4.** Natural history of disease transmission	05	01
Unit II: Tropical and Communicable Diseases and role of a nurse and Disorders spread by droplet infections **1.** Tuberculosis **2.** Diphtheria **3.** Pertussis **4.** Measles **5.** Mumps	05	01
Unit III: Disorders spread by ingestion of contaminated food and water borne diseases **1.** Diarrheal diseases **2.** Cholera **3.** Dysentery **4.** Food Poisoning **5.** Enteric Fever **6.** Poliomyelitis **7.** Worms Infestation (Round worms, Pin worms, Hook worms & Tape worms) **8.** Hepatitis	05	01
Unit IV: Disorders spread by insects and animal vector **1.** Rabies **2.** Malaria **3.** Dengue Fever **4.** Pediculosis **5.** Typhus Fever	05	01

Unit V: Diversity in Community Health Nurse role **1.** Health Promotion **2.** Early Childhood care and development **3.** Child health **4.** School health **5.** Environmental health **6.** Occupational health **7.** Disaster management	05	01
Unit VI: Community as partner **1.** Review. Introduction and Need Assessment **2.** Community as Partner: Assessment & System frame work **3.** Community as Partner: Management information systems (MIS) & Surveillance **4.** Community as Partner: Approaches **5.** Community as Partner: Community participation **6.** Community as Partner: Priority setting- Disability-Adjusted Life Year (DALY) and Quality-Adjusted Life Year (QALY) **7.** Community as Partner: Planning & Implementation **8.** Community as Partner: Monitoring & Evaluation **9.** Presentation of project"	05	01
Total	30	6

Recommended Books/ Reading Materials

1. Alam, N. (2020). Excell Community Medicine, (13th ed.). Nishtar Publications
2. Basavanthappa, B. T. (2022). Community health Nursing. (3rd. ed.). New Delhi: Jaypee Medical publication
3. Ansari. I. M., (2016) Public health and community medicine. (8th ed) Karachi Urdu Bazaar.
4. Anderson, E. T., & McFarlance, J. (2019). Community as partner: Theory and practice in nursing. (8th ed.). Philiadelphia: Lippincott

COMMUNITY HEALTH NURSING-II CLINICAL

Credit Hours: 02 (0+02)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Analyze and demonstrated the role of a CHN in the Community.
2. Apply the concepts of community participation and empowerment when addressing the specific health / developmental needs of the community.
3. Complete community assessment and diagnosis including the identification of high-risk groups, utilizing Gordon's Functional Health patterns and the principles of community participation.
4. Collect, interpret, and apply health statistics.
5. Develop and implement action plan relevant to the community's need.
6. Evaluate interventional strategies and modify the action plan accordingly.
7. Participate in field team activities at the PHC Centre etc.
8. Identify and utilized available resources and NGO's working with in the Community, city, and country.
9. Develop linkages between the PHC Centre and the community, NGO's, CBO's, etc. for the sustainability purpose.
10. Complete a community health/development project based on the needs identified by the community.

FIELD PROJECT

The field project is based on components of Evidenced Based Practice (EBP). Learners need to assess, diagnose, plan, implement & evaluate accordingly. It is important for learners to understand the guidelines given below in order to do the project efficiently.

Things to remember:

1. Community involvement.
2. Involve PHC team (if required and available)
3. Integrate steps of planning cycle, concepts of PHC and epidemiology.

Use the following steps:-

- Assess a community
- Use of previous records, research data observations, interviews etc.
- Create a list of major problems in the community.
- Prioritized these problems and choose one particular problem (a problem which can be resolved).

Identify various strategies to solve the problem

Based on literature review and choose one strategy (a strategy that is doable) Formulate a complete plan of action. Remember to plan for sustainability of the project from the beginning. When planning and implementing the project, learners must be aware that they are accountable to the community and responsible to the health stake holders. Learners should be prepared to answer the community or

the health stake holders if they are asked to justify what they are doing, for example, they can expect question like why do you think this is a problem? Why is this the problem you would want to resolve? Why is this best strategy to solve this problem? Is this the problem the community wants to solve? Who is involved? Is it sustainable?

Modifications

The modifications or changes made in the initial plan and why were they needed.

Implementations:

Resources used, how, where, when and who of the implementation phase.

Evaluation:

What was the outcome, whether the objectives were achieved and how were they measured.

Conclusion and discussion:

A general analytical conclusion including a discussion of problem faced, future recommendations, and research needs.

Note: Refer appendix A for evaluation tool to be used for presentation.

EVALUATION CRITERIA FOR FIELD PROJECT = 6 OSPEs/OSCEs

Sr. No	Description	OSPE/OSCE
1	**The Situation** Assessment of the community: Introduction, population pyramid, dynamics. Introduction to the problem: what is the problem, specific problem statement, magnitude of the problem, effect of the problem, and what steps did you and the community take to select this particular problem etc.	01
2	**Review of The Literature and Analysis of The Situation** A review of literature to support the problem and to outline its effects in the community. A concise review of literature discussing various possible strategies to solve the problem.	01
3	**Recommended Strategy** Justify the selected strategy for its appropriateness and relevance to the community. Sustainability of the project, application of principle of the PHC and community participation, how scientifically sound is the idea.	01
4	**Plan of Action** Objectives of the plan. Give a complete plan of action including who, where, how, when of the plan. How do you plan to evaluate the project	

5	**Implementation** With Modification Description of project implementation in the community along with measures taken to sustain the project. Clear & concise description of modifications needed along with rationale.	01
6	**Implementation** At Field Level Planning and implementation at field level will also be assessed. Involvement of PHC team & community from identification to evaluation of project and efforts made to sustain the project will also be assessed.	01
7	**Results** Provide a complete, analytical description, of the outcomes of your project including expected and unexpected results.	
8	**Conclusion** Brief summary of project including limitations and recommendations.	01
9	**Style of writing** APA style, references, organization, flow and transition and Succinctness.	

Recommended Books/ Reading Materials

1. Alam, N. (2020). Excell Community Medicine, (13th ed.). Nishtar Publications
2. Basavanthappa, B. T. (2022). Community health Nursing. (3rd. ed.). New Delhi: Jaypee Medical publication
3. Ansari. I. M., (2016) Public health and community medicine. (8th ed) Karachi Urdu Bazaar.
4. Anderson, E. T., & McFarlance, J. (2019). Community as partner: Theory and practice in nursing. (8th ed.). Philiadelphia: Lippincott

ONCOLOGY AND PALLIATIVE CARE NURSING

Credit Hours: 02 (02+0)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Deliver evidence-based information by enabling them to practice with accurate scientific knowledge, a solid nursing science foundation, excellent communication, and an understanding of the healthcare system for policy development as they work to prevent, identify, and treat patients with cancer.
2. Identify current treatments in interventional and pharmacological therapeutics with a focus on evidence-based holistic nursing care.
3. Place emphasis on the development of sound clinical judgment, critical thinking and collaborative care to achieve optimal outcomes for their patients.
4. Apply safeguards to support a safe practice environment for both patients and healthcare workers.

Course Content	MCQs	SEQs
Unit I: Cancer Biology **1.** Describe the concepts of normal and cancer cell growth, proliferation, differentiation, and regulatory mechanisms. **2.** Define the characteristics of benign and malignant cells and tumors. **3.** Recognize the genetic, immunological, and hormonal basis of cancer. **4.** Describe processes of invasion and metastases. **5.** List common classification systems for cancer. **6.** Compare and contrast common methods for diagnosing, staging, and grading cancer.	02	0
Unit II: Cancer Treatment Planning **1.** Describe how classification of tumors influence treatment planning. **2.** Describe the individual related factors that influence cancer treatment planning. **3.** Discuss influence and use of cancer clinical trials in cancer treatment planning. **4.** Identify the principles for facilitating decision making by people affected by cancer. **5.** Define evidence-based guidelines. **6.** Identify evidence-based guidelines for cancer treatment planning.	02	0
Unit III: Surgery in Cancer Treatment **1.** Describe the factors influencing the selection of surgery for cancer.	02	1

2. Identify the types of surgery in the prevention, diagnosis, staging, treatment, and palliation of cancer. **3.** Identify upcoming surgery alternatives for cancer management. **4.** Explore nurse's role in surgical cancer treatment. **5.** Identify the impact of cancer surgery on various aspects of the patient's overall health. **6.** Discuss the prevention, detection, and management of common health alterations experienced by people undergoing surgery for cancer. **7.** Explore the nurse's role during pre & post-surgery for cancer.		
Unit IV: Radiotherapy in Cancer Treatment **1.** Recognize the concepts of applied radiation physics and radiation biology. **2.** Describe the factors influencing the selection of radiotherapy for cancer. **3.** Discuss the role of radiotherapy in the treatment and palliation of cancer. **4.** List the methods for delivering radiotherapy. **5.** Describe the radiation safety principles to limit exposure to ionizing radiation for radiotherapy personnel, people affected by cancer, and the general public. **6.** Identify upcoming radiotherapy alternatives for cancer management. **7.** Identify the impact of radiotherapy on various aspects of the patients' overall health. **8.** Describe the prevention, detection, and management of common health alterations experienced by people undergoing radiotherapy for cancer.	02	1
Unit V: Antineoplastic Agents in Cancer Treatment **1.** Describe the classification of antineoplastic agents. **2.** Explain the role of antineoplastic agents in the treatment and palliation of cancer. **3.** Describe factors influencing the selection of antineoplastic agents for cancer. **4.** Compare the methods for administering antineoplastic agents. **5.** Describe the principles of safe handling of antineoplastic agents. **6.** Identify upcoming alternatives for antineoplastic therapies in the management of cancer. **7.** Describe the experience and impact of antineoplastic therapies on the patients' overall health. **8.** Discuss the prevention, detection, and management of common health alterations experienced by people receiving antineoplastic therapies for cancer.	02	0

Unit VI: Safe Handling of Hazardous Drugs **1.** Identify hazardous drugs related to cancer treatment. **2.** Describe the risk of exposure to hazardous drugs and its consequences. **3.** Describe use of personal protective equipment (PPE), spill cleanup and waste disposal of hazardous drugs in cancer treatment.	02	0
Unit VII: Nursing Management of Tissue Integrity and Nutrition in Cancer Patient **1.** Identify cancer treatment procedures that affect skin integrity of the patient. **2.** Describe how skin integrity is assessed and cared for in cancer patients. **3.** Explain the concept of maintenance of tissue integrity for cancer patient in nursing care management and planning. **4.** Identify information for patient education/counselling on self-care related to skin integrity. **5.** Recognize the importance of promoting nutrition for the cancer patient in nursing care management and planning. **6.** Identify the main cancer treatment-related nutrition issues. **7.** Describe how well nutrition is assessed and addressed in cancer patients. **8.** Identify different nutrition therapy strategies in cancer patients. **9.** Identify information for patient education/counselling on self-care related to nutrition.	02	1
Unit VIII: Nursing Management of Pain, Fatigue and Weakness in Cancer Patient **1.** Define the concept and characteristics of pain in cancer care. **2.** Describe the classifications and mechanisms of pain of cancer patients. **3.** Describe pain assessment techniques and tools used in cancer care. **4.** Describe pharmacological pain management in cancer patients. **5.** Identify interventions for the management of side effects from pain medication in cancer patients. **6.** Identify non-pharmacological pain management in cancer patients. **7.** Identify information for patient education/counseling on pain management at home. **8.** Define the fatigue and weakness normally experienced by cancer patients. **9.** Describe the methods to assess fatigue and weakness.	02	1

10. Use methods of non-pharmacological and pharmacological interventions to address the fatigue generally experienced by cancer patients. **11.** Identify information for patient education and counselling on fatigue management at home.		
Unit IX: Nursing Management of Anemia, Thrombocytopenia/Bleeding, Neutropenia and Mouth/Throat in Cancer Patient **1.** Identify the common side effects of chemotherapy and radiation cancer therapies. **2.** Identify causes, signs/symptoms, and diagnostic factors of anemia in cancer patients. **3.** Describe the management of anemia in cancer patients. **4.** Describe the nurse's role in the management of anemia in cancer patients. **5.** Define thrombocytopenia. **6.** Identify causes, signs/symptoms, and diagnostic factors of thrombocytopenia and bleeding in cancer patients. **7.** Describe the management of thrombocytopenia/bleeding in cancer patients. **8.** Describe the nurse's role in the management of thrombocytopenia/bleeding in cancer patients. **9.** Describe neutropenia and mouth/throat problems as side effects related to cancer and cancer treatment. **10.** Describe the management of these side effects. **11.** Describe the nurse's role in the management of these side effects.	02	1
Unit X: Nursing Management of Extravasation and Peripheral Neuropathy in Cancer Patient*:* **1.** Describe extravasation and peripheral neuropathy as side effects related to cancer and cancer treatment. **2.** Identify risk factors, signs, and symptoms of extravasation and peripheral neuropathy in cancer treatment. **3.** Describe the management of these side effects. **4.** Describe the nurse's role in the management of these side effects.	02	0
Unit XI: Self-esteem and Body Image Concerns in Cancer Patient **1.** Describe the definition of self-esteem and body image. **2.** Identify patient's concerns regarding body image and self-esteem as a consequence of cancer treatment. **3.** Discuss ways to improve body image and self-esteem in the nursing management of cancer patients.	02	

4. Identify information for patient education/counseling on self-esteem management and positive image at home.		
Unit XII: Effective Communication **1.** Describe the fundamentals of communicating clearly and concisely, both orally and in writing. **2.** Summarize the principles of facilitation skills to help in decision making. **3.** Describe the learning needs of the adult learner **4.** Describe the principles to effectively teach virtual coaching/learning situations to inspire and engage team members. **5.** Use skills to effective coaching in individual and group situations to inspire and engage team members. **6.** Breaking bad news, nursing skills and support for breaking bad news **7.** Communicating code status for DNR, palliative care of patients with cancer.	01	
Unit XIII: Patient Education and Supportive Care **1.** Define patient education. **2.** Discuss nurse's role in provision of patient education. **3.** Identify benefits of patient education in cancer patients. **4.** Describe evidence-based approaches and process of patient education. **5.** Define supportive care during and after cancer treatment. **6.** Describe the supportive care needs during and after cancer treatment. **7.** Identify the barriers to supportive care provision to cancer patients. **8.** Describe evidence-based screening and assessment approaches to identify supportive care needs. **9.** Explain the role of self-management as part of the supportive care process. **10.** Recognize self-care practices for nurses.	01	
Unit XIV: Palliative Care **1.** Define palliative care. **2.** Discuss the role and benefits of palliative care. **3.** Identify the barriers to palliative care. **4.** Outline the requirements for having an effective care team in palliative care. **5.** Discuss the topic of pain management in palliative care. **6.** Identify the common psychosocial issues during end-of-life care of patients and their families. **7.** Role of nurse in palliative care	02	1

8. Scope and current practices of palliative care nursing in Pakistan		
Unit XV: Death and Dying **1.** Describe the role of spirituality and cross-cultural beliefs and practices surrounding death. **2.** Identify the various aspects of providing support and comfort to terminally ill patients. **3.** Recognize common emergencies in oncology. **4.** Describe actions to address common oncology emergencies. **5.** Describe nurse's role in end-of-life planning and Advanced Directives **6.** Provide insights on Legacy and Life Review Projects. **7.** Describe the nurse's role in respect to funeral practices, rituals, and legalities.	02	0
Unit XVI: Grief and Bereavement **1.** Describe the stages and expressions of grief. **2.** Identify the grieving process around cancer diagnosis, trajectory, and prognosis. **3.** Describe the importance of self-reflection in grief and bereavement management **4.** Identify resources and support networks to face the diagnosis, trajectory, and prognosis of cancer. **5.** Summarize the understanding on self-reflection on one's own mortality, myths, beliefs, and attitudes facing the death.	02	0
Total	30	6

Recommended Books/ Reading Materials

1. Core Curriculum for Oncology Nursing, Jeannine M. Brant 6th Edition, Elsevier Health Sciences, 2019, ISBN 0323608620, 9780323608626
2. Placement Learning in Cancer & Palliative Care Nursing: A guide for students in practice. Bailliere Tindall; 1st edition (December 11, 2012)

ONCOLOGY AND PALLIATIVE CARE NURSING CLINICAL

CREDIT HOURS: 02 (0+02)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Describe the history and evolution of different models of palliative care
2. Identify life limiting illnesses and contrast their trajectories
3. Examine specific structural and functional changes in cells, tissues and organs function in cases of cancer and chronic illness
4. Examine life limiting oncological and neurological disease states and appraise their treatment
5. Summarize the principles of pain and symptom management including psychosocial care
6. Discuss ethical, spiritual and cultural aspects of palliative nursing, including an indigenous perspective
7. Demonstrate an understanding of the multidisciplinary team approach to palliative care
8. Develop essential communication skills for palliative care nursing and outline self-care strategies
9. Discuss and review grief and loss theories and experiences of people and families with a life limiting illness
10. Recognize bodily manifestations of dying and discuss care in the last days of life

Sr.No	Skills	OSPE/OSCE
1	Central venous line care and dressing	06
2	Administration of analgesia – continuous infusion, continuous epidural infusion, Patient controlled analgesia (PCA) pump, syringe driver and transdermal patches	
3	Caring of patient with chest and surgical drains	
4	Safe administration of oncological medications	
5	Spill and hazard (body fluids after chemo) management (protocol)	
6	Blood culture collection/sampling (venous sampling, Arterial sampling)	
7	Irrigation and instillation – bladder	
8	Body surface area calculation (BSA)	
9	Operating machines for TPN, infusion and syringe pump	
10	Assistance in biopsy.	

Recommended Books/ Reading Materials:

1. Core Curriculum for Oncology Nursing, Jeannine M. Brant 6th Edition, Elsevier Health Sciences, 2019, ISBN 0323608620, 9780323608626
2. Placement Learning in Cancer & Palliative Care Nursing: A guide for students in practice. Bailliere Tindall; 1st edition (December 11, 2012)

INTERNSHIP

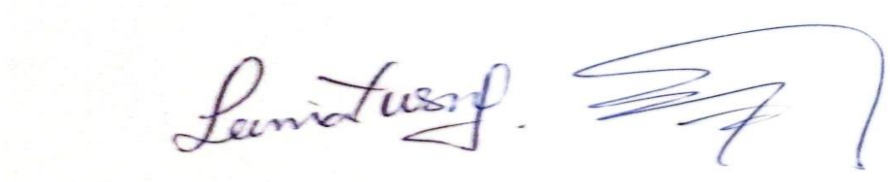
Credit hours: 03 (0+03)

Learning Outcomes/Objectives: By the end of this course, students will be able to:

1. Apply theoretical knowledge to the clinical setting by:
2. Encouraging them to function as a member of the multidisciplinary health care team.
3. Provide total nursing care to the patients in the hospital under close supervision of preceptor/senior Registered Nurse.
4. Enhancing communication and relationship skills.
5. Strengthening assessment and clinical skills

Sr. No	Nursing Subjects	Working Departments	Time Allocation	Remarks
1.	Medical Nursing	Medical ward	One week	
2.	Surgical nursing	Surgical ward	One week	
3.	Critical Care nursing	ICU/CCU	One week	
4.	Pediatric nursing	Pediatric Ward	One week	
5.	Nursing management	Any department	One week	Project
Total			05 weeks	

OTHER COMPULSORY COURSES



PERLs Module

Attributes	Competencies	Portfolio Entries Per Semester							
PROFESSIONALISM SKILLS		**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Communicator	1. Demonstrate non-verbal, verbal, written and electronic communication skills								
	2. Communicate effectively with patients and families								
Caring & Empathic	3. Demonstrate respect of diversity in gender, age, culture, race, religion, disabilities, and sexual orientation for patients, peers, colleagues, and other health professionals.								
	4. Demonstrate empathy in patient encounters								
Responsible & Accountable	5. Follow the dress code and rules and regulation of the institution and the profession								
	6. Demonstrate punctuality								
	7. Demonstrate availability and timely delivery of patient care as and when required								
	8. Take responsibility of one's actions and be accountable to patients and teachers								
Team Player	9. Work respectfully and effectively with their peers, seniors, and juniors								
	10. Participate in different team roles								
	11. Work with other health professionals to establish and maintain a climate of mutual respect, dignity								
Self-Aware	12. Identify personal strengths and areas of improvement								
	13. Identify limits in one's own level of knowledge and expertise								
	14. Show willingness to seek help through advice and support in patient care when required								
ETHICS SKILLS									
Ethical Practitioner	15. Obtain verbal and written informed consent								
	16. Comply with relevant laws and regulation including the minimum standards of health delivery and demonstrate patient safety in all aspects of healthcare delivery								
Ethical Researcher	17. Maintain research participants confidentiality								

	18. Demonstrate awareness of publication ethics								
Digital Citizen	19. Keep professional data and information safe								
	20. Design a professional digital footprint								
	21. Understand cyberbullying, harassing, sexting, or identity theft								
RESEARCH SKILLS									
Evidence based practitioner	22. Make informed decisions based on up-to- date scientific evidence								
	23. Locate credible scientific data								
Writer & Presenter	24. Develop a research proposal								
	25. Develop a research report/article								
	26. Present in college or on scientific forums								
LEADERSHIP SKILLS									
Resilient & Adaptable	27. Demonstrate flexibility in adjusting to changing environments								
	28. Demonstrate healthy coping mechanisms to respond to stress								
Systems thinker	29. Recognize own role as contributor towards management and leadership in health services								
	30. Identify new advancements in guidelines, standards, technologies, and services that can improve patient outcomes								
Self-directed learner	31. Seek active feedback from colleagues, and other health professionals								
	32. Incorporate reflection in routine practice to set and track learning goals								
	33. Seek membership in professional networks and societies								

COMPASS

Conceptualization and Development By

Team Lead

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Assistant Professor

Medical Education University of Health Sciences, Lahore

Prof. Samina Kasur,

HoD Institute of Nursing

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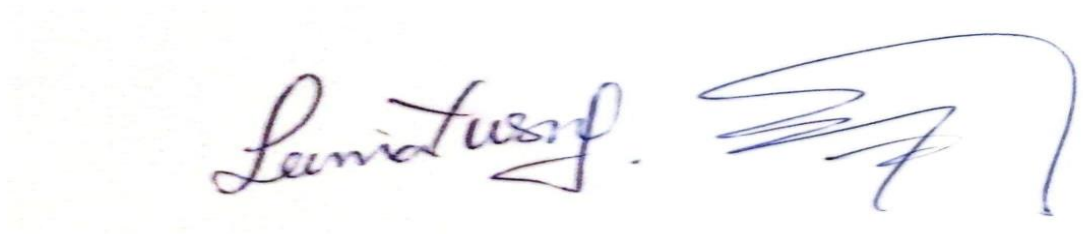
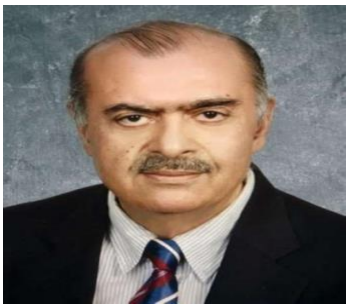
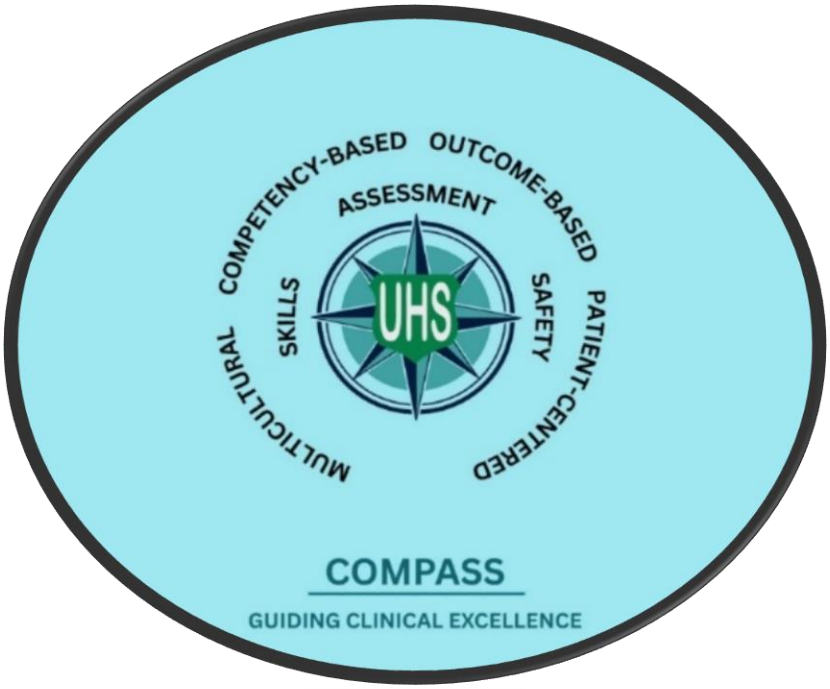


COMPASS
Curriculum for Nursing Clinical Skills



C	**COMPETENCY BASED**
O	**OUTCOME BASED**
M	**MULTICULTURAL**
P	**PATEINT CENTERED**
A	**ASSESSMENT**
S	**SKILLS AND**
S	**SAFETY**



Preamble

The COMPASS is an entire clinical skills module that addresses technical competency, cultural awareness, patient-centered evaluations, applied Skills, Simulation, and safety. It is an innovative, state-of-the-art clinical education model uniquely developed for undergraduate nursing students in Pakistan. This curriculum is a major departure from outdated, episodic pedagogy to a convergent, block-based model that integrates theory and practice with cultural competencies and global preparedness at its heart.

This curriculum meets the increasing demand for skilled, empathetic, and culturally competent nurses to excel in national and global healthcare settings. It targets key deficiencies in existing nursing education, such as limited clinical exposure, poor skill-based education, and limited integration of cultural competency into practice.

COMPASS curriculum is developed on best global practices and in accordance with the Pakistan Nursing Council (PNC), Higher Education Commission (HEC) of Pakistan, World Health Organization (WHO) guidelines for nursing education, and global standards like the ICN Competency Framework for Nursing Education. The University of Health Sciences Lahore, in terms of its vision and mission, is committed to introducing excellence in the training and education of nurses and learning under Vice Chancellor Prof. Dr. Ahsan Waheed Rathore and our visionary Pro Vice Chancellor Prof Nadia Naseem.

Introduction

Present nursing education in Pakistan is plagued with uneven clinical practice, inadequate faculty development, outdated curricula, and a lack of integration between theory and practice. As a result, this has led to a generation of academically qualified graduates who are frequently ill-prepared to manage the fast-paced and demanding clinical settings in the country and worldwide.

Rationale for Developing the COMPASS Curriculum

The rationale behind transforming nursing education through utilizing the COMPASS module is derived from the following reasons:

1**. Inadequate Clinical Exposure**: Curricula are devoid of well-designed and appropriate hospital-based teaching. It results in lack of confidence, poorly developed dexterities in hands, and compromised patient safety.

2. **Lack of Training in Cultural Competency:** Contemporary nurses are expected to deliver culture-safe care, particularly in the multicultural setting. Nevertheless, the important component remains absent in the nursing curriculum in Pakistan.

3. **Deficient Theory-Practice Integration**: Lack of classroom-to-practice integration results in shallow knowledge and low problem-solving capacity in the clinical setting.

4. **Local and Global Needs for Accreditation**: Compliance with WFME, WHO, PNC, and ICN requirements necessitates a curriculum that is skills-oriented and outcome-based as well as sensitive to social and cultural contexts.

5. **Ethical Decision Making and Soft Skills**: Today's nurse needs to be a good communicator, effective caregiver, and ethical decision maker, and culturally sensitive caregiver— skills not very well covered in current curricula.

6. **Workforce vacancies and Immigration trends**: Global shortage of nurses in nations such as Saudi Arabia, Qatar, the UK, and Canada has been opening up for international qualified Pakistani

nurses an added surge in demand. But today's nursing graduates would most probably lag behind the desired clinical and communication skills of these countries.
By incorporating structured learning blocks, shift-based clinical rotations, simulation, and reflective practice, the COMPASS curriculum provides a transformative model that satisfies the PNC and HEC regulatory standards and graduates who are globally competent, ethically based, clinically skilled, and culturally aware.

WHAT IS COMPASS

There are two components of the **COMPASS,**

I. Competency-Based, Outcome-Based Clinical Skills Module
II. Cultural competence

Skill-Based, Clinical Rotation

To facilitate solutions to the issues of greater importance in the current nursing curriculum, the COMPASS curriculum will provide a Block-Based model of instruction. Based on this model, students will be involved in:

- **Three study days a week in the lecture rooms**, learning the basic knowledge and basic and higher nursing curriculum under UHS, PNC & HEC instructions in 8 semesters. This curriculum shall be instructed spirally, which will increase in complexity by degree.
- **Three clinical days a week** in partner hospitals, working in three alternating shifts according to UHS, PNC& HEC guidelines and policies to receive maximum exposure to actual patient care, inter-professional interaction, case-based learning, cultural sensitivity, and ongoing skill development.
- **This new format balances** and immerses students into the actual application of classroom knowledge directly to the clinic, and ongoing development skills in real-world environments.

This enables graduates to become skilled, confident professionals who can serve the needs of Pakistan's evolving healthcare system and the expectations of the global nursing community.

Cultural competencies

Cultural competence refers to the ability of a person to understand and respect the attitudes, values, and beliefs of people with different cultural backgrounds. Cultural competence in nursing is the ability of nurses to provide nursing care to patients while demonstrating cultural awareness toward the patient and their loved ones.

Program Goals

1. Equip students with safe and effective clinical nursing skills.
2. Foster culturally competent, patient-centred care.
3. Promote clinical reasoning assessments of patient and skills mastery.
4. Prepare graduates for global practice environments.

Learning Outcomes

Students completing the COMPASS curriculum will be able to:

1. Demonstrate core nursing procedures aligned with safety protocols.
2. Apply outcome-based strategies in clinical care and decision-making.
3. Conduct and document patient assessments accurately.
4. Perform in simulations and real-world clinical environments with confidence.
5. Apply the nursing process in patient care.
6. Communicate empathetically and effectively across cultural contexts.
7. Perform cultural assessments and integrate cultural competence in care plans.
8. Reflect on personal and professional development in clinical settings.

Core Competency Domains

Cultural Competence Module Planner

This cultural competence module is designed to equip students with the theoretical understanding and practical skills necessary for culturally sensitive healthcare. It will span eight semesters and be 8 credit hours, with two credit hours of teaching and six credit hours of clinical training. The module includes interactive sessions, patient-centred activities and simulation-based activities.

Credit Hours
Theory 02
Clinical Hours 06

Semester	Theme	Theory C.H	Clinical C. H	Total Hours	MCQS	SEQS	OSCE/OSPE
1.	Introduction to Cultural Competence	1	0	1	3	1	
2.	Self-Awareness & Cultural Identity	0	1.0	1	---0	-	3
3.	Cultural Diversity in Health	0.5	0.5	01	2	0	2
4.	Cross-Cultural Communication	0	1.0	01	0	0	3
5.	Ethical & Legal Dimensions	0	1.0	01	0	0	3
6.	Global Case Studies	0	1.0	01	0	0	3
7.	Cultural Assessment Tools	0.5	0.5	01	2	0	2
8.	Integration & Reflection	-	1.0	01	0	0	3

COURSE CONTENTS

INTRODUCTION TO CULTURAL COMPETENCIES

- Definitions, WHO & global models
- Definitions of diversity
- Analyses of social constructs (ethnicity, race, culture, gender, etc.)
- Definitions of cultural competence (individual, system, or organizational)
- History of health care discrimination—Societal and professional
- Bias stereotypes, and cultural humility
  - Discussion of bias and stereotyping during the clinical encounter
  - Models of effective cross-cultural communication and clinical decision making
  - Ways to use an interpreter, Healing traditions and practices

Self-Awareness & Cultural Identity

- Self-awareness of values, cultures, beliefs, and biases
- Complete cultural health heritage history —Cultural beliefs and behaviours
- Elicit cross-cultural health history, which includes the patient's health beliefs

Cultural Diversity in Health

- Cross-cultural communication and clinical decision making
- Healing traditions and practices
- Traditional healing, beliefs about illness, pain, birth, death
- Facilitate cross-cultural collaboration in the community
- Identify level of cultural competence development with special populations
- Comfort level with cross-cultural clinical encounters

Cross-Cultural Communication

- Demonstrate respect during the clinical encounter
- Verbal/non-verbal communication, language barriers

Ethical & Legal Dimensions

- Informed consent,
- religious and gender considerations
- ethical dilemmas

Global Case Studies

- Cultural scenarios from different WHO regions

Cultural Assessment Tools

- LEARN, ETHNIC, models
- LEARN Model Listen, Explain, Acknowledge, Recommend, Negotiate.

- ETHNIC Model Explanation, Treatment, Healers, Negotiate, Intervention, Collaboration.
- Other Tools

Integration & Reflection

Simulation OSCEs, cultural care plans, global readiness

References

- Cuellar, N. G., Brennan, A. M. W., Vito, K., & de Leon Siantz, M. lou. (2008). Cultural Competence in the Undergraduate Nursing Curriculum. *Journal of Professional Nursing*, *24*(3), 143–149. https://doi.org/10.1016/J.PROFNURS.2008.01.004
- Yousaf Shah, S., Binti Mohd Said, F., Hussain, R., Bano, N., Ali, L., Khan, A., & Author, C. (2025). ADVANCING CULTURAL COMPETENCE IN NURSING: A QUANTITATIVE EVALUATION OF TRANSCULTURAL TRAINING PROGRAMS AMONG NURSING STUDENTS IN KARACHI PAKISTAN. *JPTCP*, *32*(01), 703–711. https://doi.org/10.53555/1n97h841
- Ličen, S., & Prosen, M. (2023). The development of cultural competences in nursing students and their significance in shaping the future work environment: a pilot study. *BMC Medical Education*, *23*(1). https://doi.org/10.1186/s12909-023-04800-5
- McFarland MR, Wehbe-Alamah HB. Leininger's Theory of Culture Care Diversity and Universality: An Overview With a Historical Retrospective and a View Toward the Future. J Transcult Nurs. 2019 Nov;30(6):540-557. doi: 10.1177/1043659619867134. Epub 2019 Aug 13. PMID: 31409201.

Competency-Based, Outcome-Based Clinical Skills Module

These skills are extracted from the BSN nursing curriculum, based on the Guidelines of UHS, PNC, & HEC. This module underpins the vision of the Vice-Chancellor University of Health Sciences. Competency-based, skill-based training ensures that students acquire modern nursing competencies. Essential clinical skills will be embedded in the COMPASS. All these skills will span over all 8 semesters, and students will learn these skills in skill labs and ward rotations.

SEMESTER-I COMPASS -1

Fundamental of Nursing-I (Lab) -2 CH

Clinical training - 6 CH

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S #	Skills	Level of competency	Minimum Frequency	OSCE/OSPE
1.	Preparing of un occupied beds	1-5	20	18
2.	Preparing of Occupied bed	1-5	20	
3.	Bathing a patient in bed	1-5	05	
4.	Measuring body temperature	1-5	50	
5.	Assessment of pulse	1-5	50	
6.	Assessment of Respiration	1-5	50	
7.	Monitoring of Blood pressure	1-5	50	
8.	Mouth care of unconscious patient	1-5	05	
9.	Measurement of Height & Weight	1-5	05	
10.	Admission of a patient in hospital	1-5	05	
11.	Discharge of patient in hospital	1-5	05	
12.	Perform aseptic hand wash protocols	1-5	10	
13.	Perform aseptic gowning	1-5	10	
14.	Perform aseptic glowing	1-5	10	
15.	Develop a care plan for patients with complex wounds	1-5	10	
16.	Apply Nursing care plan for a client with altered respiratory function and cardiovascular function	1-5	10	
17.	Application of PPE	1-5	05	
18.	Safe removal of PPE	1-5	05	

SEMESTER-II (COMPASS- II)

FUNDAMENTAL OF NURSING-II (CLINICAL) -3 CH
CLINICAL TRAINING- 3 CH
Self-Awareness & Cultural Identity 1-CH

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S #	Skills	Level of competency	Minimum Frequency	OSCE/OSPE
1	Application of hot water bag	1-5	05	16
2	Application of Cold Compresses	1-5	05	
3	Applying bandages including wound dressing	1-5	15	
4	Performing nebulization/steam therapy	1-5	05	
5	Apply suction therapy.	1-5	05	
6	Care of drainage bags (catheter)	1-5	10	
7	Sitz bath	1-5	05	
8	Administering Suppositories, Enema, Flatus Tube	1-5	05	
9	Specimen Collection	1-5	20	
10	Urine Testing through dipstick	1-5	10	
11	Administration of oral medication	1-2	10	
12	Administration of Intramuscular injection	1-2	05	
13	Administration of Intradermal injection	1-2	05	
14	Administration of intravenous injection	1-2	05	
15	Administration of subcutaneous medication	1-2	05	
16	Application of ECG leads	1-5	05	
17	Develop a care plan for patient with sleep disorder	1-5	01	
18	Develop health education plan for a malnourished client	1-5	01	
19	Elicit a detailed health heritage history including traditional practices	1-5	05	03
20	Eliciting cultural beliefs and behaviors, Connecting care plans with cultural context, Patient-centered communication across cultures	1-5	05	
21	The history of different religious groups and addressing in their beliefs while taking history	1-5	05	
22	**Complete** a cultural self-assessment to **analyze** their own cultural influences on health beliefs (such as beliefs about illness, pain, birth, or death in their family) reflection writing	1-5	1	
23	Connect care plan of nursing with patient cultural context	1-5	5	

SEMESTER-III (COMPASS-III)

ADULT HEALTH NURSING-I (Clinical Practicum)- 02 CH

CLINICAL TRAINING- 04 CH

Cultural Diversity in Health-0.5CH

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S #	Skills	Level of competency	Minimum Frequency	OSPE/OSCE
1.	IV Cannulation	1-2	40	16
2.	Blood transfusion and related products	1-2	10	
3.	IV Medications	1-2	40	
4.	NG Tube insertion	1-2	20	
5.	NG Tube removal	1-3	30	
6.	NG tube feeding	1-3	40	
7.	Male urinary catheterization	1-2	40	
8.	Female Urinary Catheterization	1-2	40	
9.	Removal of urinary catheter	1-3	30	
10.	Ostomy Care	1-2	40	
11.	Arterial Blood Sampling	1-2	30	
12.	Assessment of Edema	1-2	30	
13.	Bladder Irrigation	1-2	40	
14.	Pap Smear	1-2	40	
15.	Collection of Urine Specimen	1-2	40	
16.	Ring Pessary Insertion	1-2	40	
17.	Develop health education plan for post-menopausal woman	1-5	5	
18.	Develop health education plan for menstrual hygiene	1-5	5	
19.	Develop nursing care plan for patient with breast cancer	1-5	5	
20.	Develop nursing care plan for patient with anemia	1-5	5	
21.	Develop nursing care plan for male patients with prostate surgery	1-5	5	
22.	Engage the patient and family respectfully about treatment preferences.	1-5	5	
23.	Use culturally appropriate communication styles and confirm understanding	1-5	5	

24.	Document patient's cultural considerations and communicate with the care team.	1-5	5	02
25.	Report and reflect on the role of community collaboration in successful patient outcomes.	1-5	1	

SEMESTER-IV (COMPASS-IV)

ADULT HEALTH NURSING-II (CLINICAL)-4 CH

CLINICAL TRAINING- 02 CH

Cross-Cultural Communication -1CH

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S #	Skills	Level of competency	Minimum Frequency	OSPE/OSCE
1.	Tracheostomy care	1-5	5	18
2.	Suctioning (Tracheal)	1-5	5	
3.	Assist in procedures of Lumber puncture	1-5	5	
4.	Assist in procedures of Thoracentesis	1-5	5	
5.	Assist in procedures of Paracentesis	1-5	5	
6.	Assist in procedures of Chest tube insertion	1-5	5	
7.	Assist in procedures of C.T. Scan	1-5	10	
8.	Assist in procedures of Cerebral Angiography	1-5	5	
9.	Assist in procedures of Lumber puncture	1-5	5	
10.	Assist in procedures of Myelogram	1-5	5	
11.	Assist in procedures of Audiometric testing	1-5	5	
12.	Assist in procedures of Thyroid scanning.	1-5	5	
13.	Assist in procedure of X rays	1-5	10	
14.	Skin Traction	1-5	5	
15.	Application of plaster, cast	1-5	5	
16.	Eye bandaging	1-5	5	
17.	Eye irrigation	1-5	5	
18.	Ear irrigation	1-5	5	
19.	Blood Sugar Monitoring	1-5	5	
20.	Cardiac monitoring /telemetry	1-5	5	
21.	Demonstrate how to Utilize non-verbal communication (gestures, pictures) to explain procedures.	1-5	5	03
22.	Call for a hospital translator or a staff member fluent in other languages	1-5	5	
23.	Use the teach-back technique once the interpreter is available to ensure understanding	1-5	5	
24.	Demonstrate Respect for cultural norms	1-5	5	

	During interaction with patients			
25.	Demonstrate Gender-sensitive interaction during interaction with opposite gender	1-5	5	
26.	Shows building rapport across cultures	1-5	5	

SEMESTER V (COMPASS-V)

CLINICAL TRAINING
PEDIATRIC HEALTH NURSING- 2 CH
COMMUNITY HEALTH NURSING I- 1 CH
REPRODUCTIVE HEALTH- 3 CH
Ethical & Legal Dimensions-1CH

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S #	List of Clinical skills	Level of competency	Minimum Frequency	OSPE/OSCE
01	General Examination of New Born	1-5	10	18
02	APGAR Score	1-5	20	
03	New Born and Infant Reflex Assessment	1-5	20	
04	Anthropometric Assessment (Birth weight, Head	1-5	5	
05	circumference, Chest circumference, Length of baby)	1-5	5	
06	Child head to toe assessment	1-5	5	
07	Tub bath to an infant	1-5	5	
08	Care of an infant in incubator	1-5	5	
09	Care of an infant / neonate receiving oxygen therapy	1-5	5	
10	Care of an infant under phototherapy	1-5	10	
11	Oral/SC/Rectal/Intravenous Medication Administration			
12	Antenatal assessment (Vital Signs, EDD, Fundal Height, FHR) low risk pregnancy/ high risk pregnancy	1-5	20	
13	Offer Family Planning counseling of the client	1-4	10	
14	Prescribe Family Planning Methods to the client	1-4	10	
15	Perform Nutritional Counselling for the pregnant lady	1-5	10	
16	Perform nutritional counselling for the locational mothers	1-5	10	
17	Observation of normal delivery cases	1-2	10	
18	Assist with normal delivery cases	1-3	10	
19	Conduct Normal delivery cases under supervision	1-4	10	
20	Conduct Independent normal delivery cases	1-5	10	
21	Independent post-natal care	1-5	10	
22	Independent newborn care	1-5	10	

23	Ensure the patient's understanding of the procedure through a qualified interpreter. demonstrating a language barrier	1-5	5	06
24	Demonstrating consent taking. Verify that consent is informed, voluntary, and documented in her presence.	1-5	5	
25	Clarify legal rights regarding consent even when families wish to shield the patient.	1-5	5	
26	Demonstrate how to initiate discussion with healthcare team about ethical dilemma	1-5	5	
27	Involve family in a culturally respectful manner to explore patient preferences	1-5	5	
28	Follow ethical and institutional policies in handling truth-telling.	1-5	5	

SEMESTER VI (COMPASS VI)

CLINICAL TRAINING

Pediatric Health Nursing-II 2CH

Mental Health Nursing Clinical 3CH

Leadership/Management in Nursing 1CH

Global Case Study 1-CH

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S. No	List of Skills Lab	Level of competency	Minimum Frequency	OSPE/OSCE
1	Nasogastric (N/G) or Orogastric (O/G) Tube Insertion	1-5	5	18
2	Nasogastric (N/G) or Orogastric (O/G) Tube Feeding and Removal	1-5	5	
3	Oropharyngeal or Nasopharyngeal Suctioning	1-5	9	
4	Tracheostomy Suctioning	1-5	5	
5	Blood Specimen Collection in Children	1-5	5	
6	Urine Specimen Collection in Children	1-5	10	
7	Care of a Child During Lumbar Puncture	1-5	5	
8	Care of a Child Undergoing Peritoneal Dialysis	1-5	5	
9	Foley's Catheter Insertion in Children	1-5	5	
10	Positioning and Restraining Pediatric Clients	1-5	10	
11	Assessment of hydration status in patients with burn, GIT disorders	1-5	10	
12	Assessment of the proportion of body surface area in burn patient using rule of 9	1-5	05	
13	Perform respiratory assessment and differentiate between normal and abnormal findings in paeds	1-5	10	
14	Perform muculo skeletal assessment and differentiate between normal and abnormal findings in paeds	1-5	05	
15	Develop a plan of care and formulate expected outcome based on the indication for blood transfusion	1-5	05	
16	Develop nursing care plan for patient with mental health disorder	1-5	05	
17	Develop nursing care plan patient with drug abuse	1-5	05	
18	Develop health education plan for diabetic patient in peads	1-5	05	
19	Develop a plan of care for a child with nephrotic syndrome	1-5	05	
20	Use culturally sensitive counseling techniques	1-5	05	
21	Compare traditional beliefs about fertility control and	1-5	5	

	postpartum care			
22	Document and negotiate acceptable care plans respecting cultural beliefs.	1-5	5	3

SEMESTER VII (COMPASS-VII)

CLINICAL TRAINING

Critical nursing care clinical 04 CH

Internship/field experience 03 CH

Cultural Assessment Tools 0.5 CH

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S #	Skills	Level of competency	Minimum Frequency	OSPE/OSCE
1.	Oxygen inhalation by BiPAP, CPAP	1-5	5	
2.	Tracheostomy dressing	1-5	5	
3.	Administration of meter dose inhaler (MDI)	1-5	5	
4.	Measurement of peak flow meter	1-5	5	
5.	Chest Tube Care	1-5	5	
6.	Suctioning of ETT	1-5	10	
7.	Arterial blood gases Monitoring	1-5	5	
8.	Bed sore care	1-5	10	
9.	Glasgow coma scale (GCS) Assessment	1-5	10	
10.	Intra-arterial pressure monitoring	1-5	5	
11.	CVP measurement	1-5	5	
12.	Assisting and prepare CVP	1-5	5	
13.	ETT care	1-5	5	
14.	Left arterial pressure monitoring	1-5	5	
15.	Pulmonary arterial pressure monitoring	1-5	5	
16.	Cardiac output monitoring	1-5	5	
17.	Intra-aortic balloon pump monitoring (IABP)	1-5	5	
18.	Ventilator care	1-5	5	
19.	BLS	1-5	5	
20.	Triage coding	1-5	5	
21.	Interpretation of ABGs	1-5	5	
22.	Interpretation of ECG	1-5	5	
23.	Interpretation of XRAYs Of different body part	1-5	5	
24.	Interpretation of Basic CBC report	1-5	05	
25.	Develop nursing care plan for patient with cardio pulmonary disorders	1-5	02	
26.	Demonstrate how to Apply the LEARN model to understand the patient's beliefs and negotiate a care plan.	1-5	5	

18

02

27.	Respectfully explain the prescribed treatment and acknowledge her traditional beliefs.	1-5	5	
28.	Document the agreed care plan including safe traditional practices	1-5	5	
29.	Conduct an assessment using the ETHNIC model.	1-5	5	
30.	Identify and document traditional practices being used and collaborate with the patient to develop a safe birth plan.	1-5	5	

SEMESTER VIII (COMPASS-VIII)

CLINICAL TRAINING

Oncology and Palliative care nursing Clinical – CH 02

Community Health Nursing-II Clinical – CH 03

Integration & Reflection- 1 CH

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S #	Skills	Level of competency	Minimum Frequency	OSPE/OSCE
1.	Central venous line care and dressing	1-5	5	**15**
2.	Administration of analgesia – continuous infusion, continuous epidural infusion, Patient controlled analgesia (PCA) pump, syringe driver and transdermal patches.	1-5	5	
3.	Caring of patient with chest and surgical drains	1-5	5	
4.	Safe administration of oncological medications	1-5	5	
5.	Spill and hazard (body fluids after chemo) management (protocol)	1-5	5	
6.	Blood culture collection/sampling (Venous sampling, Arterial sampling)	1-5	5	
7.	Irrigation and instillation – bladder	1-5	5	
8.	Body surface area calculation (BSA)	1-5	5	
9.	Operating machines for TPN, infusion and syringe pump	1-5	5	
10.	Assistance in biopsy (Bone Marrow)	1-5	5	
11.	Develop a plan of care for a patient on chemotherapy	1-5	5	
12.	Develop a pre op care plan for a patient undergoing oncology surgery	1-5	5	
13.	Develop a post Op care plan for patient undergoing oncology surgery	1-5	5	
14.	Develop a health education plan for patients experiencing health alterations in patients undergoing oncology treatment	1-5	5	
15.	Interact with patients using cultural humility and curiosity	1-5	5	03
16.	Identify one cultural practice that was unfamiliar and research about it post-rotation.	1-5	5	
17.	Write a reflective report on how this experience will influence future nursing practice.	1-5	2	

IMPLEMENTATION PLAN

Faculty Training Rollout

- Block base system

- Simulation-based learning
- Teaching Clinical Training skills
- LOG BOOK workshop

Workshops for social competencies Skills

- WHO Cultural Competence Modules
- Leininger's theory of cultural care diversity and universality
- OSCE and Assessment Design
- Quality Assurance & Feedback

MONITORING

- Semester-wise, every college will be visited by the UHS monitoring team, and it will be a surprise visit.
- The colleges will be graded according to their implementation plan, class schedules, clinical rotation rosters as per UHS guidelines, logbooks, and feedback from students and faculty.

READING RESOURCES

1. Carpinito L. J. (1998). *Nursing Care Plans & Documentation: Nursing Diagnosis and Collaborative Problem* (3rd ed.) Philadelphia: Lippincott
2. Craven, R. F., & Hirnle, C. J. (2000). *Fundamentals of Nursing: Human Health and Function.* (3rd ed.). New York: Lippincott.
3. Delaune, S. C., & Ladner, P. K. (2002). *Fundamentals of Nursing: Standards and Practice.* (2nd ed.) Canada: Delmar.
4. Erb, G. K., B. (2000). *Fundamentals of Nursing: Concepts, Process and Practice* (5th ed.) Addison: Wesley.
5. Potter, P. A & Perry, A. G. (2003). *Basic Nursing: Essentials for Practice* (5th ed.) St. Louis: Mosby.
6. Carpinito L. J. (1998). Nursing Care Plans & Documentation: Nursing Diagnosis And Collaborative Problem (3rd ed.) Philadelphia: Lippincott
7. Craven, R. F., & Hirnle, C. J. (2000). Fundamentals of Nursing: Human Health and Function. (3rd ed.). New York: Lippincott.
8. Delaune, S. C., & Ladner, P. K. (2002). Fundamentals of Nursing: Standards and Practice. (2nd ed.) Canada: Delmar.
9. Erb, G. K., B. (2000). Fundamentals of Nursing: Concepts, Process and Practice (5th ed.) Addison: Wesley.
10. Potter, P. A & Perry, A. G. (2003). Basic Nursing: Essentials for Practice (5th ed.) St. Louis: Mosby.
11. Potter, P.A., Perry, A.G., Stockert, P.A., & Hall, A.M. (2021). *Fundamentals of Nursing* (10th ed.). Elsevier.
12. Smeltzer, S.C., Bare, B.G., Hinkle, J.L., & Cheever, K.H. (2010). *Brunner & Suddarth's Textbook of Medical-Surgical Nursing* (12th ed.). Lippincott Williams & Wilkins.

13. American Heart Association. (2020). Highlights of the 2020 American Heart Association's Guidelines for CPR and ECC.

ARABIC LANGUAGE COURSE FOR NURSES

Credit Hours: 03 (02+01)

Program Introduction

The Arabic Language Course for Nursing Staff has been designed according to the requirements of paramedical staff likely to perform their duties in medical field in the Middle East. The program will enable the students to acquire the ability of the four skills of language learning: reading, understanding, speaking and writing. This curriculum is comprised of comprehensive set of Arabic dialogue and text that prompt the student to interact with the Arab environment and the requirements of daily Arab life, as it enables the student to understand what s/he listens and express his/her feelings.

Mechanism of Work in Class:

Group discussions, exercises, applications, quiz and group activities in the classroom are adopted as teaching tools. During training sessions, dialogues and conversations among the students are recorded, and then presented to them, in order to identify their mistakes committed during these sessions.

Program's Alignment with University Mission

Based on university vision and mission, this program will strive for achieving the following aims and goals:

Program Aims:

1. This program aims at training the student to read and comprehend Arabic text directly.
2. Developing of real sense of Arabic phonology so that the students may know the correct pronunciation.
3. Grooming students' abilities for interpreting and equipping them with necessary proficiency to express their needs in various areas and places.
4. Enabling students to display substantial proficiency in oral and written Arabic.
5. Strengthening social, cultural, political, economic and religious relations between Pakistan and rest of the Arabic world.
6. Creating a soft image of Pakistani medical staff in service sectors of Middle East.

OBJECTIVES: by the end of this course, students will be able to gain:

1. Proficiency in four skills of language learning; understanding, reading, speaking and writing.
2. Special Proficiency in Spoken Arabic.
3. Ability to do a common translation from Arabic to Urdu and vice versa.
4. Proficiency in interpretation from Arabic to English and vice versa.

5. Ability to comprehend official documents written in Arabic.
6. Proficiency in understanding signboards and navigators written in Arabic.

Course Description توصيف المقرر

إن هذا المقرر الدراسي للغة العربية قد وُضع لموظفي التمريض الذين من المحتمل أن يؤدوا واجباتهم في المجال الطبي وفقًا لمتطلبات وظائفهم في الشرق الأوسط. سيمكن البرنامج الطلاب من المهارات الأربع من القراءة والاستماع والتحدث والكتابة. وهذا المقرر يركّز هذا الجانب من المحادثة مما يساعد الطلاب في الإظهار عما في ضميرهم وباطنهم .وقد روعي في هذا المنهج مجموعة وافية من الحوارات والنصوص العربية التي تدفع الطالب إلى التفاعل مع البيئة العربية ومقتضيات الحياة العربية اليومية حيث يمكن الطالب من الفهم ما يسمع والتعبير عما يريد ويحس به.

Course Objective أهداف المقرر:

- تنمية مهارات النطق والقراءة والاستعمال اللغوي مراعياً السهولة والابتعاد عن الاستعانة بأية لغة أخرى أثناء التدريس، وهذا ما يوصل الطالب إلى تذوق هذه اللغة واكتساب الدراس القدرة على الاتصال بأهل اللغة من خلال عرض هذه الحوارات مشافهة وكتابة وشعورًا وتعبيرًا.
- تمكين الدارس من الكفايات اللغوية والاتصالية والثقافية فضلًا عن اكتسابه القدرة على المهارات الأربع من فهم وقراءة وكلام وكتابة.
- تنمية المعنى الحقيقي للأصوات العربية حتى يتمكن الطالب من النطق الدقيق للكلمات.
- تنمية قدرات الطالب في الترجمة ، وإكسابه الكفاءة اللازمة للتعبير عن حاجته في مختلف المجالات والأماكن.
- تعزيز العلاقات الاجتماعية والثقافية والسياسية والاقتصادية والدينية بين باكستان وبقية العالم العربي.
- تنمية صورة ناعمة للطاقم الطبي الباكستاني في قطاعات الخدمات في الشرق الأوسط.

Course Contents محتويات المقرر:

Unit 01 1-الوحدة الأولى: التحية والتعارف

1.1 الحوارات الثلاثة حول التحية والتعارف
(إلقاء التحية- التعريف بنفسك وبالآخرين- التعريف بأفراد الأسرة وأعمالهم- السؤال عن الاسم والبلد والجنسية- الاستفهام ب: هل- من أين-ما، اسما الإشارة: هذا-هذه)

1.2 التدريبات :1- المفردات تتعلق بالتحية والتعارف
2- أسماء الإشارة: هذا- هذه- ذلك- تلك

الكلام: تبادل حوارات- تبادل أسئلة- أسئلة اتصالية

1.3 التدريبات: 1- الضمائر المتصلة: ياء المتكلم- نا المتكلمين- كاف المخاطَب(المذكر/المؤنث) هاء الغائب(المذكر/المؤنث) الكلام: تبادل حوارات- تبادل أسئلة- أسئلة اتصالية

2-الوحدة الثانية : الحياة اليومية

Unit02

2.1 الحوارات الثلاثة حول الحياة اليومية
(السؤال عن الوقت- وسيلة المواصلات- العطلة وأنشطتها)

2.2 التدريبات : 1-المفردات : تتعلق بالحياة اليومية

2- الاستفهام ب:كَمْ (في جملة اسمية) و ماذا+ فعل مضارع (متكلم ومخاطب).

2.3 التدريبات : الاستفهام ب: متى- أين+ فعل مضارع (متكلم ومخاطب)- النفي بلا.
الكلام: تبادل حوارات- تبادل أسئلة- تكوين جمل تدور حول النشاط اليومي.

3-الوحدة الثالثة: الطعام والشراب **Unit 03**

3.1- الحوارات الثلاثة حول الطعام والشراب

(السؤال عن الوجبات ومكوناتها والوزن- طلب الطعام والشراب- التعبير عن الجوع)

3.2- التدريبات : 1- المفردات،:تتعلق بأشياء الطعام والشراب

2- الاستفهام ب:هل/أ والاستجابة بالنفي لا+ فعل مضارع و بالإيجاب (نعم).

الكلام: تبادل حوارات- تبادل أسئلة- أسئلة اتصالية.

3.3- التدريبات : و الفعل المضارع المسند للمخاطب المؤنث(تطلبين- تشربين)

الكلام: تبادل حوارات- تبادل أسئلة- تكوين جمل تدور حول الطعام والشراب.

4- الوحدة الرابعة: الدراسة **Unit 04**

4.1- الحوارات الثلاثة حول الدراسة

(الاستفسار عن الدراسة والاختبارات والعطلة والتحدث عن المستقبل)

4.2- التدريبات : 1- المفردات تتعلق بالدراسة

4.3- 2- الفعل الماضي(التصريف إلى الفاعل الغائب الواحد و المخاطب الواحد-المذكر والمؤنث-والمتكلم).

الكلام: تبادل حوارات- تبادل أسئلة وإجابات.

4.4- التدريبات : كان- يكون +خبر كان أو (للتخيير) - قريب مِنْ ، وبعيد عَنْ في أيّ....؟ . الكلام: تبادل حوارات- تبادل أسئلة- تكوين جمل تدور حول الدراسة. 5-

الوحدة الخامسة: المهن والعمل **Unit 05**

5.1- الحوارات الثلاثة حول المهن والعمل

(التعريف بمهنتك، والسؤال عن مكان العمل وعدد ساعات العمل، والسؤال عن الوظائف في المستقبل، والوقت)

5.2- التدريبات : 1- المفردات تتعلق بالمهن والعمل والوظائف والأحرف.
2- والعدد والمعدود من واحد إلى عشر.
الكلام: تبادل حوارات- تبادل أسئلة وإجابات.

5.3- التدريبات : الاستفسار عن الساعة والوقت، وأيام الأسبوع.

الكلام: تبادل حوارات- تبادل أسئلة- تكوين جمل تدور حول المهن والعمل.

6- الوحدة السادسة: التسوّق **Unit 06**

6.1- الحوارات الثلاثة حول التسوّق

(الترحيب، الاستفسار، الطلب بأدب، الاستجابة للطلب بأدب، السؤال عن الأسعار)

6.2- التدريبات : 1- المفردات: تتعلق بالنقود وأشياء صغيرة وأواني وملابس وأطعمة
2- الاستفهام ب: أىّ, كَمْ, بِكَمْ، والمبتداء والخبر شبه جملة.

6.3- الكلام: التحدث عن التسوق من خلال تبادل الحوارات.

التدريبات : ا- العدد من أحد عشر إلى المأئة.

الكلام: تبادل حوارات- تبادل أسئلة- تكوين جمل تدور حول التسوق.

7- الوحدة السابعة: السفر بالحافلة **Unit 07**

7.1- الحوارات الثلاثة حول السفر بالحافلة
(الاستفسارعن تقديم الخدمة، تقديم المعلومات، فقدان الأشياء)

7.2- التدريبات : 1- المفردات: تتعلق بالسفر بالحافلة وذرائع المواصلات الأخرى

2- الممارسة في الحروف الجارة

7.3- التدريبات : ترتيب كلمات لتصير جملا, ملء الفراغات في الجمل, تصحيح الأخطاء في الجمل.

الكلام: تبادل أسئلة وإجابات وحوارات. 8- الوحدة

الثامنة: في السكن/ في الفندق

Unit 08

8.1 - الحوارات الثلاثة حول السكن و الفندق

(الاستفسار عن السكن، مكانه ونوعه ورقمه ، البحث عن الفندق- الطلب)

8.2 التدريبات : 1- المفردات: تتعلق بالسكن و الفندق

2- الاستفهام ب:الإعداد الترتيبية

8.3 التدريبات : تصحيح الأخطاء في الجمل، و ترتيب الكلمات لتصير جملًا, و ملء الفراغات

الكلام: تبادل حوارات- تبادل أسئلة عن السكن والبيت والأثاث وأسئلة اتصالية

9- الوحدة التاسعة: في المطار **Unit 09**

9.1 - الحوارات الثلاثة حول المطار والسفر الجوي

(الاستفسار عن الحجز وتأكيد الحجز، اجراءات الجوازات والإقامة، المفقودات)

9.2 التدريبات : 1- المفردات: تتعلق بالسفر الجوي أسماء الشهور الإنجليزية **2-**

الكلام: تبادل حوارات- تبادل أسئلة- أسئلة اتصالية.

9.3 التدريبات : تصحيح الأخطاء في الجمل, ترتيب الكلمات لتصير جملًا, ملء الفراغات

الكلام: تبادل حوارات وأسئلة حول السفر الجوّي.

10- الوحدة العاشرة: في الأماكن المختلفة **Unit 10**

10.1- الحوارات الثلاثة في المصرف و مكتب البريد و مكتب الشرطة

10.2-التدريبات : 1- المفردات: تتعلق بالمصرف والبريد والشرطة. العدد بعد مئة

10.3- التدريبات : تصحيح الأخطاء في الجمل, ترتيب الكلمات لتصبح جملا و ملء الفراغات.

الكلام: تبادل حوارات وأسئلة حول المصرف و البريد و الشرطة

11- الوحدة الحادية عشرة: الصحة **Unit 11**

11.1 - الحوارات الثلاثة حول الصحة

(الاستفسار عن الصحة، المرض وعلاماته و أسبابه، الحمية، البدانة والنحافة)

11.2 التدريبات : 1- المفردات: تتعلق بالصحة فعل ماضي **2-**

11.3 التدريبات : ترتيب الكلمات لتصبح جملا, تصحيح الأخطاء في الجمل, ملء الفراغات, إكمال الجمل.

الكلام: تبادل حوارات وأسئلة وإجابات حول الصحة والمرض 12- الوحدة الثانية عشرة : المستشفى **Unit 12**

12.1 - الحوارات الثلاثة حول المستشفى

(التعرف على أقسام المستشفى المختلفة وما يتعلق بها)

12.2 التدريبات : 1- المفردات: تتعلق بالمستشفى **2-** فعل مضارع

12.3 التدريبات : ترتيب الكلمات لتصبح جملًا وتصحيح الأخطاء وملء الفراغات

الكلام: تبادل حوارات وأسئلة واجابات حول المستشفى

13- الوحدة الثالثة عشرة: عند الطبيب (1) **Unit 13**

13.1 - الحوارات الثلاثة حول طبيب الأذن و الحنجرة والأنف

(الاستفسار عن الموعد، أسئلة وإجابات حول المرض وعلاماته)

13.2 التدريبات : 1- المفردات: تتعلق بالأمراض والفحص والأدوية
2- فعل أمر

الكلام: تبادل حوارات- تبادل أسئلة- أسئلة اتصالية.

13.3 التدريبات : ترتيب الكلمات لتصبح جملًا, وتصحيح الأخطاء وملءالفراغات
الكلام : تبادل
حوارات وأسئلة واجابات

14- الوحدة الرابعة عشرة: عند الطبيب (2)
Unit 14

14.1 - الحوارات الثلاثة حول طبيب الأسنان وطبيب العين و
الطبيب العام

(الاستفسار عن الموعد، أسئلة وإجابات حول المرض
وعلاماته والتقرير الطبي)

14.2 - التدريبات : 1- المفردات: تتعلق بالأمراض والفحص
وأدوات الفحص
2- مركب إضافي.

الكلام: تبادل حوارات- تبادل أسئلة- أسئلة
اتصالية.

14.3 التدريبات :ترتيب الكلمات لتصبح جملًا وتصحيح الأخطاء
وملءالفراغات وإجابات الأسئلة.
الكلام: تبادل حوارات وأسئلة وإجابات

15- الوحدة الخامسة عشرة: عند الطبيب (3) **Unit 15** - 15.1

الحوارات الثلاثة حول طبيب القلب وطبيب العظام والجراح

(الاستفسار عن الموعد، أسئلة وإجابات حول المرض
وعلاماته والتقرير الطبي)

15.2- التدريبات : 1- المفردات: تتعلق بالأمراض والفحص وأدوات
الفحص

2- مركب توصيفي

الكلام: تبادل حوارات وأسئلة وإجابات

15.3- التدريبات : تصحيح الأخطاء, ترتيب الكلمات لتصبح جملا,
ملءالفراغات والأسئلة
الكلام: تبادل حوارات وأسئلة وإجابات

16- الوحدة السادسة عشرة: الممرض/الممرضة **Unit 16**

16.1- الحوارات الثلاثة حول التمريض والممرضة

(الاستفسار عن مهنة التمريض وغايته والدراسة فيه وظائفه وواجباته)

16.2- التدريبات : 1- المفردات: تتعلق بالتمريض والممرضة

2- جملة فعلية و جملة اسمية

الكلام: تبادل حوارات- تبادل أسئلة- أسئلة اتصالية.

16.3- التدريبات : ترتيب الكلمات لتصبح جملا، تصحيح الأخطاء وملءالفراغات

الكلام: تبادل حوارات واسئلة وإجابات

17-الوحدة السابعة عشرة: الجهاز الهضمي **Unit 17**

17.1 - الفقرات الثلاث حول الجهاز الهضمي

(تحتوي الفقرات على الجهاز الهضمي و وظائف أعضائه مثل الأسنان واللسان والبلعوم والمرىء والمعدة)

17.2- التدريبات : 1- المفردات: تتعلق بالجهاز الهضمي

2- معرفة المفرد والمثنى والجمع

الكلام: تبادل حوارات- تبادل أسئلة- أسئلة اتصالية.

17.3-التدريبات : وصال بين المفرد والجمع ، ترتيب الكلمات لتصبح جملا، تصحيح الأخطاء، ملءالفراغات

الكلام: تبادل حوارات واسئلة وإجابات الوحدة

الثامنة عشرة: المملكة السعودية العربية **Unit 18**

18.1- الفقرات الثلاث حول المملكة السعودية العربية

(الفقرات تحتوي على الموقع الجغرافي للمملكة وأهم مدنها وطقسها وأهمية الحرمين الشريفين للمسلمين وزيارتهما)

18.2- التدريبات : 1- المفردات: تتعلق بالحج والعمرة والمدن السسعودية والصادرات والواردات ،و

2- أدوات ظرف المكان (فوق، تحت، أمام، وراء، حيث) الجهات الأربع

الكلام: تبادل حوارات(تستخدم فيها أدوات ظرف المكان)- تبادل أسئلة

18.3-التدريبات : أسئلة حول موقع الأماكن وإجابات، ترتيب الكلمات لتصبح جملا، تصحيح الأخطاء

الكلام: تبادل حوارات (تستخدم فيها الجهات الأربع) واسئلة وإجابات

قائمة المفردات: **Glossary**

التدريبات المتنوعة: **Miscellaneous Exercises**

الكتب المقترحة: **Suggested Books**

- صيني، د. محمود إسماعيل وناصف مصطفى ومختار: العربية للناشيين (كتاب الطالب1،2،3)، المملكة العربية السعودية، إدارة الكتب المدرسية.الطبعة الأولى 1403ه.
- الفوزان، الدكتورعبد الرحمن وآخرون:العربية بين يديك (كتاب الطالب1،2) ،الملكة العربية السعودية. الناشر،العربية للجميع.2014م
- المفيد في المحادثات العربية: لجنة التأليف، جامعة العلامة إقبال المفتوحة، إسلام آباد - عبد الرحيم، ف، الدكتور: دروس اللغة العربية لغير الناطقين بها(الجزء الأول والثاني)، المملكة العربية السعودية، الجامعة الإسلامية بالمدينة المنورة، 1418 ه.

Arabic Language Course for Nursing Staff (English Version)

Program Introduction:

The Arabic Language Course for Nursing Staff has been designed according to the requirements of paramedical staff likely to perform their duties in medical field in the Middle East. The program will enable the students to acquire the ability of the four skills of language learning: reading, understanding, speaking and writing. This curriculum is comprised upon a comprehensive set of Arabic dialogues and texts that prompt the student to interact with the Arab environment and the requirements of daily Arab life, as it enables the student to understand what he listens and express his wants and feelings.

Mechanism of Work in Class

Group discussions, exercises, applications, quiz and group activities in the classroom are adopted as teaching tools. During training sessions, dialogues and conversations among the students are recorded, and then presented to them, in order to identify their mistakes committed during these sessions.

Program's Alignment with University Mission

Based on UHS vision and mission, this program strives for achieving the following aims and goals:

Aims

Training the student to read and comprehend Arabic text directly.

Developing the real sense of Arabic phonology so that the students may know the correct pronunciation of different words.

Focusing students' abilities for interpreting, equipping them with necessary proficiency to express their needs in varied situations.

Making students display substantial proficiency in oral and written Arabic.

Strengthening social, cultural, political, economic and religious relations between Pakistan and the Arab world.

Creating a soft image of Pakistani medical staff in service sector of the Middle East.

OBJECTIVES: by the end of this course, students will be able to gain:

Proficiency in language learning: understanding, reading, speaking and writing.

Fluency in Spoken Arabic.

Ability to translate from Arabic to Urdu and vice versa.

Smooth interpretation from Arabic to English and vice versa.

Comprehension of official documents written in Arabic.

Understanding signboards and navigators written in Arabic.

Course Contents	MCQs	SEQs
Unit 01- Greetings and Introduction 1.1- Three dialogues on greetings and introduction 1.2-Vocabulary about greetings, introduction, grammar: demonstrative pronouns 1.3-Relative pronouns, exercises, conversation	1	0

Unit 02- Daily Life 2.1- Three dialogues on daily life activities 2.2-Vocabulary about daily life activities, Arabic question words, future tense 2.3-Question words, future tense, sentence construction, exercises	1	0

Unit 03 – Food and Drinks 3.1-Three dialogues on food and drinks 3.2-Vocabulary about food, drink, grammar: interrogative and negative sentences 3.3-Future tense, exercises, conversation	1	0
Unit 04 – The Study 4.1- Three dialogues on reading and study 4.2- Vocabulary about study, grammar: past tense in Arabic 4.3- Grammar: words which changes noun case, exercises, conversation	1	1
Unit 05 – Professions and Works 5.1-Three dialogues on professions and work 5.2- Vocabulary about professions and works, grammar: number 1 to 10 5.3- Asking about time, date and day, exercises, conversation	1	1
Unit 06 – The Shopping 6.1- Three dialogues on shopping 6.2- Vocabulary about currency, utensils, garments, food; question words 6.3- Grammar: number from 11 to 100, exercises, conversation	1	0
Unit 07- Travel by Bus 7.1- Three dialogues on travel by bus 7.2- Vocabulary about travelling, means of transportation, preposition words 7.3- Exercises on rearranging, fill in the blanks, correction, conversation	1	0
Unit 08 – Hostel/Hotel 8.1- Three dialogues on hostel/hotel 8.2- Vocabulary about hostel/ hotel, ordinal number in Arabic 8.3- Exercises on rearranging, fill in the blanks, correction, conversation	1	0
/ Plane Unit 09 – Journey by Train 9.1- Three dialogues on journey by train/plane; inquiry, reservation, buying ticket etc. 9.2- Vocabulary about air travel, names of English month, conversation 9.3 Exercises on rearranging, fill in the blanks, correction, conversation	1	0
Unit 10 – At Different Places 10.1- Three dialogues on bank, post office and police station 10.2- Vocabulary about bank, post office and police station, number 100 onwards 10.3- Exercises on rearranging, fill in the blanks, correction, conversation	1	0

Unit 11 – Healthcare 11.1- Three dialogue on health, illnesses, symptoms, causes, precautions 11.2- Vocabulary about health, grammar: past tense in Arabic 11.3- Exercises on rearranging, fill in the blanks, correction, conversation	1	1

Unit 12 – Hospital 12.1- Three dialogue on hospital, kinds of hospital 12.2- Vocabulary about hospital, grammar: future tense in Arabic 12.3- Exercises on rearranging, fill in the blanks, correction, conversation	3	1
Unit 13 – At Clinic 13.1- Three dialogue on otolaryngologist, appointment, illness and symptoms 13.2- Vocabulary about illness, diagnosis, medication, grammar: imperative mood 13.3- Exercises on rearranging, fill in the blanks, correction, conversation	3	0
Unit 14 – At Clinic 14.1- Three dialogues on dental, optician, general physician 14.2- Vocabulary about illnesses, diagnosis, diagnostic equipment 14.3- Exercises on rearranging, fill in the blanks, correction, conversation	3	0
Unit 15 – At Clinic 15.1- Three dialogues on cardiologist, orthopedist, surgeon 15.2- Vocabulary about illnesses, diagnosis, diagnostic equipment 15.3- Exercises on rearranging, fill in the blanks, correction, conversation	3	1
Unit 16 – The Nursing 16.1- Three dialogue on nursing, profession, duties, job opportunities 16.2- Vocabulary about nursing; grammar: verbal and nominal sentences 16.3- Exercises on rearranging, fill in the blanks, correction, conversation	3	1
Unit 17 – Digestive System 17.1- Three paragraphs on digestive system, function of different body parts 17.2- Vocabulary about digestive system, grammar: singular, dual, plural 17.3- Exercises on rearranging, fill in the blanks, correction, conversation	3	0
Unit 18 – Kingdom of Saudi Arabia 18.1- Three paragraphs on KSA, geography, important cities, weather 18.2- Vocabulary about Hajj, Umrah, imports and exports, grammar: time and place, directions 18.3- Exercises on rearranging, fill in the blanks, correction, conversation	1	0
Total	30	6

Practical: Listening/speaking

Course Contents	OSPEs/OSCEs
Greetings and Introduction/Daily Life/Food and Drinks	
The Study/Professions and Works/The Shopping	

Travel by Bus/about Hostel/Hotel/Journey by Train/ Plane	03
At Different Places/Police station/Bank/Hospital	
At Clinic/The Nursing	

Glossary
Miscellaneous exercises Suggested Books

1. Dr. Mahmoud Ismael Sini, Nasif Mustafa: ***Al-ARABIYYAH LI AL-NASHIEN*** (Reader 1, 2, 3) KSA, Department of Textbooks, 1403 AH.
2. Dr. Abd al-Rahman al-Fauzan Et al: ***ARABIYYA H BAIN YADAYEKA*** (Reader 1, 2) KSA, Arabic for All Project, 2014.
3. ***AL-MUFEED FI AL-MUHADISAAT AL-ARABIYYAH*** by A Committee of Authors, Allama Iqbal Open University, Islamabad.
4. Dr. Abd al-Raheem F: ***DUROOS AL-LUGHAH LI GHAIR AL-NATIQEEN BI HA*** (Reader 1, 2) KSA, Islamic University of Medina, 1418 AH.

CLINICAL LOG BOOK

Semester Based

2025 VERSION 1

CLINICAL LOG BOOK

SEMESTER-I

Fundamental of Nursing-I (Lab) 02 Cr. Hours

Clinical Training 06 Cr. Hours

Course Description:

This course introduces the student to nursing as a professional discipline. The concept of a professional nurse is addressed through a brief overview of nursing historical development, definitions of nursing, nursing education, the practice, roles of the nurse and nurse's accountability. The conceptual basis for nursing practice is presented as the relationship which exists among human needs, adoption and homeostasis, alterations in health, voluntary and involuntary processes, and nursing intervention. The position of nurses in the health care delivery system of the Country is explained through a description of its organization and administration, facilities, and personnel. International health and nursing organizations are discussed.

Clinical Rotation plan:

This semester will be of 16/22 weeks; the student nurse will observe and demonstrate skills in skill lab for half of the semester. In the next half, student nurse will go to clinical rotation (in batches to ensure 24/7 clinical placement at hospitals in all three shifts) and perform skills under the supervision of clinical instructor.

Clinical Objectives

1. Assess, document and identify variations in Vital Signs
2. Discuss the observations for different Vital Signs pattern.
3. Develop problem list based on patients' assessments and rationalize each problem identified.
4. Observe the process of admission of a patient in hospital.
5. Orient a patient to hospital environment.
6. Assist in transfer of patients from one unit to another unit and department.
7. Assist in preparing patients and family for discharge.
8. Document the discharge of patients from the hospital.
9. Make nursing care plan according to patient's problems

Evaluation Criteria:

Sr. No	Clinical Portfolio Content	%	Frequency
1.	Clinical Objectives	***10%***	Weekly
2.	History Taking Performa	***15%***	10
3.	Physical Examination Checklists	***15%***	10
4.	Nursing Care Plan	***10%***	10
5.	Nursing Skills Checklists	***20%***	10
6.	Reflection/ Critical Incident Analysis	***10%***	Weekly
7.	Case Study	***20%***	01

Clinical Objectives Form

Student Name: _____ Faculty: _____
Clinical placement: _____ Date: _____

Clinical Objectives	Strategies	Evaluation

History Taking Proforma

Student Name: _____Group #: _____Faculty: _____

1. Document the client presenting complaint, Functional Health Patterns and Review of Systems findings and draw family genogram

Checklist for taking a client health history

Sr. No	Interviewing Checklist	Satisfactory	Need to improve
1.	Introduced self, purpose, and agenda		
2.	Arranged for proper environment (position, distance, light)		
3.	Asks open ended question (to explore chief concern)		
4.	Explores information about chief concern (COLDERRAA) Character, Onset, Location, Duration, Exacerbation, Radiation, Relief, Antecedent, Associated factors		
5.	Proceed from general to specific, follows cues, probes positive finding, asks clear, logical qufestions, one at a time		
6.	Uses effective communication techniques (Facilitation, Clarification, Paraphrasing, Transitions, Summarization)		
7.	demonstrates appropriate verbal / nonverbal gesture (Eye contact, voice tone, active listening, hand gestures)		
8.	Avoids being non therapeutic (asking why questions, biased, leading, judgmental, false reassurance, changing topic)		
9.	Explores client past history of any illness		
10.	Explores client family history		
11.	Explores client functional abilities & life style patterns		
12.	Explores Review of System checklist efficiently		

Faculty comments:

Nursing Care Plan

Assessment	Nursing Diagnosis	Goal	Planning	Implementation	Rationale	Evaluation
Subjective Data						
Objective Data						

List of Skills

Levels of competency = 1-5 (Novice to Expert)

Sr. No	Skills	Level of competency	Minimum Frequency
1.	Sterilization, steps of Hand washing	1-5	20
2.	Preparing of different beds	1-5	20
3.	Bathing a patient in bed	1-5	05
4.	Measuring body temperature	1-5	50
5.	Assessment of pulse	1-5	50
6.	Assessment of Respiration	1-5	50
7.	Monitoring of Blood pressure	1-5	50
8.	Mouth care of unconscious patient	1-5	05
9.	Measurement of Height & Weight	1-5	05
10.	Admission of a patient in hospital	1-5	05
11.	Discharge of patient in hospital	1-5	05

Sr. No	Procedures	Clinical Experience					
		Skill Lab Instructor Signature	Date	Ward Sister Signature	Date	Clinical instructor Signature	Date
1.	**Sterilisation, steps of hand washing**						
2.	**Preparing of different beds**						
3.	**Bathing a patient in bed**						
4.	**Measuring body temperature**						
5.	**Assessment of pulse**						
6.	**Assessment of Respiration**						
7.	**Monitoring of Blood pressure**						
8.	**Mouth care of unconscious patient**						
9.	**Measurement of Height & Weight**						
10.	**Admission of a patient in hospital**						
11.	**Discharge of patient in hospital**						

Nursing Skills Checklists

Preparing of different beds

Preparation of Unoccupied / Occupied Bed

Equipment Required:

- Gloves, as per need
- Personal protective equipment, as indicated
- Flat sheet
- Fitted sheet, if available
- Draw sheet
- Mackintosh
- Blanket
- Pillowcase
- Plastic laundry bag or portable linen hamper, if available

Checklist

Sr. No	Tasks	Yes	No	Comments
1.	Introduce self if the client is in bed, Verify the client's identity. Explain the procedure and its importance to the client.			
2.	Perform hand hygiene and consider other infection control measures if indicated.			
3.	Put Screen or close the door.			
4.	Use overbed table or client's chair to place fresh linen; do not put it on another client's bed.			
5.	Assist the client to get out of bed using appropriate assistive devices.			
6.	Raise the bed to a comfortable working height. Drop the side rails.			
7.	Wear disposable gloves if there is Contamination.			
8.	Strip the bed. • Check if there is any item belonging to the client • Detach the call bell or any drainage tubes from the bed linen. • Systematically loosen all bedding by moving around bed. • Pillowcase if soiled, remove it and place it on the bedside chair • Fold linens, such as top sheet as it can be reused. • Wrap all dirty linen inside the bottom sheet and place it			

	directly in the linen hamper holding it away from your uniform. • Hold the mattress tightly and move up to the head of the bed. Clean mattress if soiled • Remove and discard gloves and perform hand hygiene			
9.	Place the bottom sheet with its center fold in the center of the bed. Open the sheet and fan-fold to the center			
10.	Place Mackintosh and drawsheet (optional) in the same manner and position it as it comes under midsection of the client.			
11.	Pull the bottom sheet over the corners at the head and foot of the mattress by making mitered corners. Tuck the draw sheet securely under the mattress			
12.	Move to the other side and repeat the procedure			
13.	Place the top sheet on the bed with its center fold in the center of the bed and with the hem align with the head of the mattress. Unfold the top sheet. Follow same procedure with top blanket or spread, keep the upper edge about 6 inches below the top of the sheet.			
14.	Tuck them under the foot of the bed on the near side by making Mitered corners.			

Preparing an Occupied Bed

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Introduce self to the client Verify the client's identity. Explain the procedure to the client.			
2.	Perform hand hygiene and consider other infection control measures if indicated.			
3.	Put Screen or close the door.			
4.	Use overbed table or client's chair to place fresh linen; do not put it on another client's bed.			

5.	Raise the bed to a comfortable working height. Drop the side rails.			
6.	Wear disposable gloves if there is Contamination.			
7.	**Remove the top bedding.** a. Detach the call bell or any drainage tubes from the bed linen. b. Systematically loosen all bedding by moving around bed. c. Remove blanket but Leave the top sheet over the client or replace it with bath blanket. Spread the bath blanket over the top sheet and ask the client to hold the top edge of the blanket. Then grasp the top edge of the sheet and draw it down to the foot of the bed reaching under the blanket and leave the blanket in place. Remove the sheet from the bed and place it in the soiled linen hamper directly.			
8.	**Change the bottom sheet and drawsheet**. • Raise the side rail. • Assist the client to turn on the side away from you toward the raised side rail. • Loosen the bottom linens on the free side of bed • Fanfold the dirty linen (i.e., drawsheet and the bottom sheet) toward the center of the bed and client as close to as possible. • Place the new bottom sheet on the bed, and vertically fanfold as close to the client as possible. • Miter the corner and tuck the sheet under the near half of the bed • Do same with the mackintosh and			

	Drawsheet. • Assist the client to roll backward towards you over clean and fanfolded linen • Move the pillows towards clean side and raise the side rail. • Move to the other side of the bed, lower the side rail and remove the used linen and place it in the dirty linen hamper. • Unfold the fanfolded bottom sheet and use both hands to pull the bottom sheet and tuck and make mitered corners. • Similarly unfold the drawsheet and pull the sheet in three divisions: (a) Face the side of the bed to pull the middle division, (b) face the far top corner to pull the bottom division, and (c) face the far bottom corner to pull the top division. Tuck the excess drawsheet under mattress.			
9.	Reposition the client in the center of the bed. Place the client in recommended or comfortable position.			
10.	Place the top sheet on the bed with its center fold in the center of the bed and with the hem align with the head of the mattress. Unfold the top sheet. Follow same procedure with top blanket or spread, ask client to hold top bedding and remove bath blanket			
11.	Move to the other side of the bed and secure the top bedding in the same manner			
12.	Raise the side rails and Attach the call light to the bed linen within the client's reach.			
13.	Reposition all things (bedside table and over bed			

	table)			
14.	Dispose of soiled linen according to agency policy. Remove any other PPE, if used. Perform hand hygiene.			

Nursing instructor's signature: _____ Date: _____

Bathing a Patient in Bed

Equipment Required:

- Washbasin and warm water
- Personal hygiene supplies (deodorant, lotion, and others)
- Skin-cleaning agent
- Emollient and skin barrier, as indicated
- Towels (2)
- Washcloths (2)
- Bath blanket
- Gown or pajamas
- Bedpan or urinal
- Laundry bag
- Nonsterile gloves; other PPE as indicated
-

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Review the chart for any limitations regarding the patient's physical activity.			
2.	Place the necessary equipment on the bed side stand or over bed table.			
3.	Perform hand hygiene and don gloves and/ or other personal protective equipment (PPE) as indicated.			
4.	Identify the patient, explain the procedure, and assess the patient's ability to assist with the bathing process along with their personal hygiene preferences.			

5.	Close the curtains around the bed and the door to the room, if possible. Adjust the room temperature as needed.			
6.	Remove sequential compression devices and anti-embolism stockings from the lower extremities according to agency protocol.			
7.	Offer patient bedpan or urinal.			
8.	Remove gloves and perform hand hygiene.			
9.	Adjust the bed to a comfortable working height, typically at the caregiver's elbow height.			
10.	Put on gloves. Lower the side rail closest to you and assist the patient to the side of the bed where you will be working. Position the patient on their back.			
11.	Loosen the top covers and remove all except the top sheet. Place a bath blanket over the patient and then remove the top sheet while the patient holds the bath blanket in place. Place the soiled linen in a laundry bag.			
12.	Remove the patient's gown while keeping the bath blanket in place. If the patient has an IV line and is not wearing a gown with snap sleeves, remove the gown from the arm without the IV line first.			
13.	Raise side rails. Fill basin with a sufficient amount of comfortably warm			

	water (110°F to 115°F). Add the skin cleanser, if appropriate, according to manufacturer's directions.			
14.	Put on gloves, if necessary. Fold the washcloth into a mitt shape on your hand, ensuring there are no loose ends.			
15.	Place a towel across the patient's chest on top of the bath blanket.			
16.	Without using any cleanser, wipe one eye from the inner corner near the nose to the outer corner. Rinse or turn the washcloth before cleaning the other eye.			
17.	Bathe patient's face, neck, and ears. Apply appropriate emollient.			
18.	Expose the patient's far arm and place a towel lengthwise underneath it. Using firm strokes, wash the hand, arm, and axilla, lifting the arm as needed to access the axillary region. Rinse, if necessary, then dry the area. Apply an appropriate emollient.			
19.	Place a folded towel on the bed next to the patient's hand and set the basin on top of it. Soak the patient's hand in the basin, then apply an appropriate emollient.			
20.	Repeat Actions 15 and 16 for the arm nearer you.			
21.	Spread a towel across the patient's chest and lower the bath blanket to the umbilical area. Wash, rinse if			

	necessary, and dry the chest, keeping it covered with the towel between washing and rinsing. Pay special attention to the folds of skin under the breasts.			
22.	Lower bath blanket to the perineal area. Place a towel over patient's chest.			
23.	Wash, rinse, if necessary, and dry abdomen. Carefully inspect and clean umbilical area and any abdominal folds or creases.			
24.	Return the bath blanket to its original position and expose the far leg. Place a towel under the far leg. Using firm strokes, wash, rinse if necessary, and dry the leg from the ankle to the knee, then from the knee to the groin. Apply an appropriate emollient.			
25.	Wash, rinse if necessary, and dry the foot, paying particular attention to the areas between the toes. Apply an appropriate emollient.			
26.	Repeat Actions 21 and 22 for the other leg and foot			
27.	Make sure patient is covered with bath blanket. Change water and washcloth at this point or earlier, if necessary.			
28.	Assist the patient into a prone or side-lying position. Put on gloves if you haven't already. Arrange the bath			

	blanket and towel to expose only the back and buttocks.			
29.	Wash, rinse if necessary, and dry the back and buttocks area, paying particular attention to cleansing between the gluteal folds. Observe the sacral area for any redness or skin breakdown.			
30.	If not contraindicated, give the patient a backrub. A back massage may also be given after perineal care. Apply an appropriate emollient and/or skin barrier product.			
31.	Raise the side rail. Refill basin with clean water. Discard washcloth and towel. Remove gloves and put on clean gloves.			
32.	Clean perineal area or set patient up so that he or she can complete perineal self-care. If the patient is unable, lower the side rail and complete perineal care, following guidelines in the accompanying Skill Variation. Apply skin barrier, as indicated. Raise side rail, remove gloves, and perform hand hygiene.			
33.	Help patient put on a clean gown and assist with the use of other personal toiletries, such as deodorant or cosmetics.			
34.	Protect pillow with towel and groom patient's hair.			
35.	When finished, make sure the			

	patient is comfortable, with the side rails up and the bed in the lowest position.			
36.	Replace bed sheets. Get rid of soiled bed sheets based on procedures of the agency. Take off gloves as well as any other PPE if employed. Wash your hands.			

Nursing instructor's signature: _____ Date: _____

Assessing Body Temperature

Equipment Required:

- Thermometer (selected based on site used)
- Thermometer sheath or cover
- Water-soluble lubricant for a rectal temperature
- Clean gloves for a rectal temperature
- Towel for axillary temperature
- Tissues/wipes
- Additional PPE, as indicated
- Pencil or pen, paper or flow sheet, computerized record

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Check medical order or nursing care plan for frequency of measurement and route. Bring necessary equipment to the bedside stand or over bed table.			
2.	Perform hand hygiene and put on Personal Protective Equipment (PPE), if indicated.			
3.	Identify the patient. Introduce yourself and explain the procedure to patient.			
4.	Close curtains around bed and close the door to the room, for the privacy of patient.			
5.	Ensure the electronic or digital thermometer is in working condition.			
6.	Select the appropriate site based on previous assessment data.			
7.	Place the thermometer. • Apply a protective sheath or probe cover if appropriate. Lubricate a rectal thermometer.			
8.	Wait the appropriate amount of time. Electronic thermometer will			

	indicate that the reading is complete through a light or tone.			
9.	When measurement is completed, remove gloves, if worn. Remove additional PPE, if used. Perform hand hygiene.			

Nursing instructor's signature: _____ Date: _____

Assessing Peripheral Pulse

Equipment Required

- Wrist watch with second hand or digital display
- Pen and vital sign flow sheet or electronic health record (EHR)

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Check medical order or nursing care plan for frequency of measurement and route. Bring necessary equipment to the bedside stand or overbed table.			
2.	Perform hand hygiene and put on Personal Protective Equipment (PPE), if indicated.			
3.	Identify the patient. Introduce yourself and explain the procedure to patient.			
4.	Close curtains around bed and close the door to the room, for the privacy of patient.			
5.	Select the appropriate peripheral site based on assessment data.			
6.	Move the patient's clothing to expose only the site chosen.			
7.	Place your first, second, and third fingers over the artery. Lightly compress the artery so pulsations can be felt and counted.			
8.	Using a watch with a second hand, count the number of pulsations felt for 30 seconds. Multiply this number by 2 to calculate the rate for 1 minute. If the rate, rhythm, or amplitude of the pulse is abnormal in any way, palpate and count			

	the pulse for 1 minute.			
9.	Note the rhythm and amplitude of the pulse.			
10.	Assist patient return to comfortable position.			
11.	When measurement is completed, remove gloves, if worn. Remove additional PPE, if used. Perform hand hygiene.			

Nursing instructor's signature: _____ Date: _____

Assessment of Respiration

Equipment Required:

- Stethoscope
- Watch with second hand or digital readout
- Pencil/Pen, Sheet
- Personal protective equipment (PPE)

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Prior to perform the procedure, introduce yourself and verify the client's identity using agency protocol			
2.	Draw curtain around bed or close door. Perform hand hygiene.			
3.	Note the rise and fall of the patient's chest			
4.	Observe the patient's respirations while your fingers are placed for pulse measurement.			
5.	Count the numbers of respiration for 30 seconds using watch and multiply it with 2 to calculate the respiratory rate per minute.			
6.	If you feel any abnormality in respiration, count the respirations for at least 1 full Minute			
7.	Note the depth and rhythms of Respirations			
8.	When measurement is completed, cover the patient and help him or her to a position of comfort.			
9.	Perform Hand hygiene.			

Nursing instructor's signature: _____ Date: _____

Monitoring Arterial Blood Pressure

Equipment Required:

- Stethoscope
- Sphygmomanometer
- Blood pressure cuff of appropriate size
- Pencil or pen, paper or flow sheet
- Alcohol swab
- Personal protective equipment (PPE)

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Prior to performing the procedure, introduce yourself and verify the client's identity using agency protocol.			
2.	Draw curtain around bed or close door. Perform hand hygiene and put on PPE.			
3.	Explain procedure to patient so the patient is able to assist you with the procedure.			
4.	For application of the cuff, choose the appropriate arm.			
5.	Make sure that the patient is comfortable either lying or sitting position with the forearm supported at the level of the heart and the palm of the hand upward. In sitting position, it is important to let the patient sit back on the chair fully depending on the back of the chair. In addition, make sure the patient keeps the legs uncrossed.			
6.	Remove the garments to expose the brachial artery and to place the cuff.			

7.	Locate the brachial artery by palpation. Place the bladder of the cuff over the brachial artery, positioning it midway on the arm so that the lower edge of the cuff is 2.5 to 5 cm (1 to 2 inches) above the inner elbow. Align the artery marking on the cuff with the patient's brachial artery, and ensure the tubing extends from the cuff edge closer to the patient's elbow.			
8.	Ensure that your equipment is calibrated. There is no zero error (zero of instrument is not at zero position).			
9.	For **estimating systolic pressure**, inflate the cuff with continuously palpating the brachial artery by pressing gently with the fingertips. Note the point on the gauge where the pulse disappears.			
10.	Deflate the cuff and wait for 1 minute.			
11.	Place the earpiece of stethoscope in your ears and bell of stethoscope on brachial artery firmly but with little pressure. Make sure it is not touching any cloth or cuff.			
12.	Inflate the cuff with the pressure almost 30 mm Hg more than the estimated systolic pressure and then allow the air to escape slowly (allowing the gauge to drop 2 to 3 mm per second)			
13.	Note the point on the gauge when the first faint but clear sound is heard that increases in intensity slowly.			
14.	Don’t re-inflate the cuff again to			

	recheck the systolic blood pressure.			
15.	Note the point at which the sound completely disappears.			
16.	Remove the remaining air quickly. Repeat any suspicious reading but after the pause of 1 minute.			
17.	After completing the procedure, remove the cuff and maintain the patient's comfortable position.			
18.	Remove the PPE and perform hand hygiene.			
19.	Disinfect the apparatus using alcohol.			

Nursing instructor's signature: _____ Date: _____

Oral Hygiene

Equipment Needed

- Toothbrush
- A glass filled with chilled water
- Dental floss (optional)
- Equipment for washing dentures
- Paste for teeth
- Single-use gloves
- Cup for dentures
- Mouth wash not necessary
- Basin of Emesis
- Towel
- Denture cleans

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	If helping with dental care, wash your hands thoroughly and put on gloves or other protective gear (PPE) as needed.			
2.	Determine who the patient is. Give the patient an explanation of the process.			
3.	Place equipment within the patient's reach on an overbed table.			
4.	Close the drapes or the mother's door. Adjust the bed to a suitable and comfortable height for the caregiver, usually elbow height.			
5.	If the patient is allowed, lower the side nail and twist them into a sitting position, or flip them onto their side. Lay a cloth over the patient's chest for acne. Make the bed comfy enough to work in.			
6.	Brush with moistened hands and coat bristles with toothpaste.			

Nursing instructor's signature: _____ Date: _____

Measurement of Height and Weight

Equipment Required:

- Stadiometer
- Tape Measure
- Height Rod
- Digital Scale
- Mechanical Scale
- Privacy Screen
- Pen or Ball Point

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Ensure the scale is calibrated and on a flat, stable surface.			
2.	Instruct the patient to remove shoes, heavy clothing, and accessories.			
3.	Explain the procedure to the patient.			
4.	Ask the patient to stand in the center of the scale with feet slightly apart and arms at their sides.			
5.	Wait for the scale to stabilize and record the weight.			
6.	Provide the patient with their weight information.			
	Height Measurement			
7.	Ensure the stadiometer and scale are calibrated and positioned correctly.			
8.	Explain the procedure to the patient.			
9.	Ask the patient to remove shoes, heavy clothing, and accessories.			
10.	Have the patient stand straight with back against the stadio-meter or wall, feet together, and arms at sides.			
11.	Ensure the patient's head is in the Frankfurt plane.			
12.	Lower the headpiece to touch the crown of the head and read the measurement at eye level.			
13.	Provide the patient with their height information.			

Admitting a Patient

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Complete patient medication reconciliation by checking home medication list for duplication, omission, or potential drug interactions with newly ordered medications. Update medication list based on health care provider's orders for treatment.			
2.	Inform patient about procedures or treatments scheduled for the next shift or day (e.g., visits by health care provider or dietitian). These vary based on nature of patient's condition.			
3.	Complete learning needs assessment for patient and family.			
4.	Give patient and family chance to ask questions about procedures or therapies. (If patient is unresponsive or unable to understand, review with family).			
5.	Collect valuables that patient chooses to keep at agency. Complete clothing and valuables listing sheet (see agency policy). Have patient or family member sign it. Place valuables in agency safe or send home with family.			
6.	Ensure that patient and family have time together alone if desired.			
7.	Be sure that call light is within easy reach and bed is in low position. (Check			

	agency policy regarding use of side rails.)			
8.	Perform hand hygiene.			

Nursing instructor's signature: _____ Date: _____

Discharging Patients
Checklist

Sr. #	Tasks	Yes	No	Comments
1	Preparation before day of discharge: a) Suggest ways to change physical arrangement of home to meet patient's needs b) Provide patient and family with information about community health care resources (e.g., medical equipment companies, Meals on Wheels, adult day care). Referrals are usually made while patient is in hospital. c) Conduct teaching sessions with patient and family as soon as possible during hospitalization (e.g., signs and symptoms of complications, information regarding medications, use of medical equipment, follow-up care, diet, exercise, restrictions imposed by illness or surgery). Refer patient to reliable and current resources on the Internet. d) Communicate patient's and family's response to teaching and proposed discharge plan to other health care team members.			
2	Procedure on day of discharge: a) Let patient and family ask questions or discuss issues related to home care. A final			

	opportunity to demonstrate learned skills is helpful. b) Check health care provider's discharge orders for prescriptions, change in treatments, or need for special medical equipment. (Make sure that orders are written as early as possible.) c) Determine whether patient or family has arranged for transportation. d) Provide privacy and assistance as patient dresses and packs all personal belongings. Check all closets and drawers for belongings. Obtain copy of valuables list signed by patient and have security or appropriate administrator deliver valuables to patient. e) Complete medication reconciliation per agency policy. Check discharge medication orders against the medication administration record and home medication list. Offer a final review of information needed to facilitate safe medication self-administration. f) Provide information on follow-up appointments to health care provider's office. Provide phone number of units.			

	g) Contact agency business office to determine whether patient needs to finalize arrangements for payment of bill. Arrange for patient or family to visit business office h) Acquire utility cart to move patient's belongings. Obtain wheelchair for patient. Transport patients leaving by ambulance or ambulance stretchers. i) Assist patient to wheelchair or stretcher using safe patient handling and transfer techniques. Escort patient to entrance of agency where source of transportation is waiting (see agency policy) (see illustrations). j) Return to division. Notify admitting or appropriate department of time of discharge. Notify housekeeping of need to clean patient's room.			

Nursing instructor's signature: _____ Date: _____

Skill: Perform Aseptic Handwash Protocols

Equipment Required:

- Clean running water (temperature-regulated)
- Antimicrobial soap (e.g., chlorhexidine, povidone-iodine) or alcohol-based hand rub
- Disposable paper towels
- Foot- or elbow-operated sink/faucet (preferred)
- Waste bin (preferably foot-operated)
- Nail brush (if indicated)

Checklist:

Sr. #	Tasks	Yes	No	Comments
1	Remove all jewelry (rings, watch) and inspect hands for cuts or abrasions			
2	Turn on water using elbow/foot controls or with a paper towel if manual faucet			
3	Wet hands and forearms thoroughly			
4	Apply antimicrobial soap without touching the dispenser nozzle			
5	Rub palms together, covering all surfaces			
6	Rub back of each hand with opposite palm			
7	Interlace fingers and clean between them			
8	Rub backs of fingers to opposing palms with fingers interlocked			
9	Rotational rubbing of each thumb clasped in opposite hand			
10	Rub fingertips in opposite palm in circular motion			
11	Rub each wrist with opposite hand (if surgical handwash, include forearms)			
12	Continue washing for recommended duration (40–60 sec for hygienic, 2–6 min surgical)			
13	Rinse thoroughly from fingertips down to wrists/elbows without splashing			
14	Allow water to drip off fingertips without shaking hands			
15	Dry thoroughly using disposable towel from fingertips to wrist			
16	Use the towel to turn off faucet if not foot/elbow operated			
17	Dispose of towel properly in designated waste bin			
18	Inspect hands to confirm they are visibly clean and dry			
19	Document the procedure as required (e.g., audit checklist or clinical notes)			

Skill: Perform Aseptic Gowning

Equipment Required:

- Sterile gown (disposable or reusable)
- Sterile gloves (pair)
- Surgical mask and cap (already worn)
- Sterile drape or gown pack
- Handwashing or hand antisepsis area
- Waste bin for packaging

Checklist:

Sr. #	Tasks	Yes	No	Comments
1	Verify procedure to be performed and location of sterile field.			
2	Perform surgical handwashing or hand antisepsis thoroughly.			
3	Enter sterile area without touching non-sterile surfaces.			
4	Open sterile gown pack carefully without contamination.			
5	Pick up gown by inside neck area only (touch only the inside).			
6	Let the gown unfold naturally without shaking.			
7	Insert both arms into sleeves without pushing hands through cuffs.			
8	Allow a sterile assistant to tie gown at back and secure neckline.			
9	Don sterile gloves using closed-glove technique (hands inside sleeves).			
10	Adjust gloves and gown without touching non-sterile areas.			
11	Maintain sterility by keeping hands above waist and in front.			
12	Dispose of packaging materials in appropriate receptacles.			
13	Confirm readiness for sterile procedure.			

Skill: Perform Aseptic Gloving

Equipment Required:

- Sterile gloves (correct size)
- Hand sanitizer or antiseptic handwash supplies
- **Clean, flat surface** for gloving procedure
- Waste bin (preferably foot-operated)

Checklist:

Sr. #	Tasks	Yes	No	Comments
1	Verify the procedure and gather necessary equipment			
2	Perform hand hygiene using antiseptic hand rub or wash			
3	Ensure hands are completely dry before gloving			
4	Inspect glove packaging for integrity and expiration date			
5	Open the outer glove package carefully without contaminating inner contents			
6	Open the sterile inner wrapper using the flaps, touching only the outer 1-inch margin			
7	With the non-dominant hand, pick up the dominant hand glove by the inside cuff			
8	Insert the dominant hand into the glove without touching the outside surface			
9	Slide gloved fingers under the cuff of the second glove without touching the skin			
10	Insert the non-dominant hand into the glove, ensuring a secure fit			
11	Adjust the gloves carefully by touching only the sterile surfaces of each glove			
12	Keep hands above waist level and in front of body to maintain sterility			
13	Avoid touching non-sterile surfaces while gloved			
14	Perform the sterile procedure or task as indicated			
15	Remove gloves by pinching the outer surface of one glove and peeling it off			

16	Hold the removed glove in the gloved hand, slide ungloved fingers under cuff of second			
17	Peel the second glove off inside out over the first glove and discard properly			
18	Perform hand hygiene after glove removal			
19	Document the procedure as required			

Skill: Application of Personal Protective Equipment (PPE)

Equipment Required:

1. Disposable gown (fluid-resistant or impermeable, as required)
2. Medical/surgical mask or N95 respirator (based on risk assessment)
3. Protective eyewear or face shield
4. Disposable gloves (non-sterile or sterile as indicated)
5. Hand sanitizer (alcohol-based) or antiseptic soap and water
6. Waste disposal container (biohazard or general, depending on use)

Checklist: Donning PPE (Putting On)

Sr. #	Tasks	Yes	No	Comments
1	Identify the need for PPE based on the procedure or exposure risk.			
2	Perform hand hygiene thoroughly using soap and water or alcohol-based rub.			
3	Ensure all PPE items are available and the area is clean.			
4	Put on **gown**: fully cover torso from neck to knees, arms to wrists, and wrap around the back.			
5	Fasten the gown at the neck and waist securely.			
6	Put on **mask or respirator**: - Secure ties or elastic bands at middle of head and neck. - Fit flexible band to nose bridge - Fit snugly to face and below chin			
7	If using an **N95 respirator**, perform a **seal check**.			
8	Put on **goggles or face shield**, ensuring full eye coverage.			
9	Put on **gloves**: extend to cover the wrist of the gown.			

10	Check overall fit of all PPE and ensure **no skin is exposed**.			
11	Instruct self not to touch face, mask, or gown during procedure.			
12	Ready to proceed to patient care or sterile procedure.			

Note:

- PPE order: **Gown → Mask → Goggles/Face Shield → Gloves**
- Use PPE as per **standard, contact, droplet, or airborne precautions**
- Donning should be done in a **clean area** before entering the contaminated or patient zone.

Skill: Safe Removal of PPE

Equipment Required:

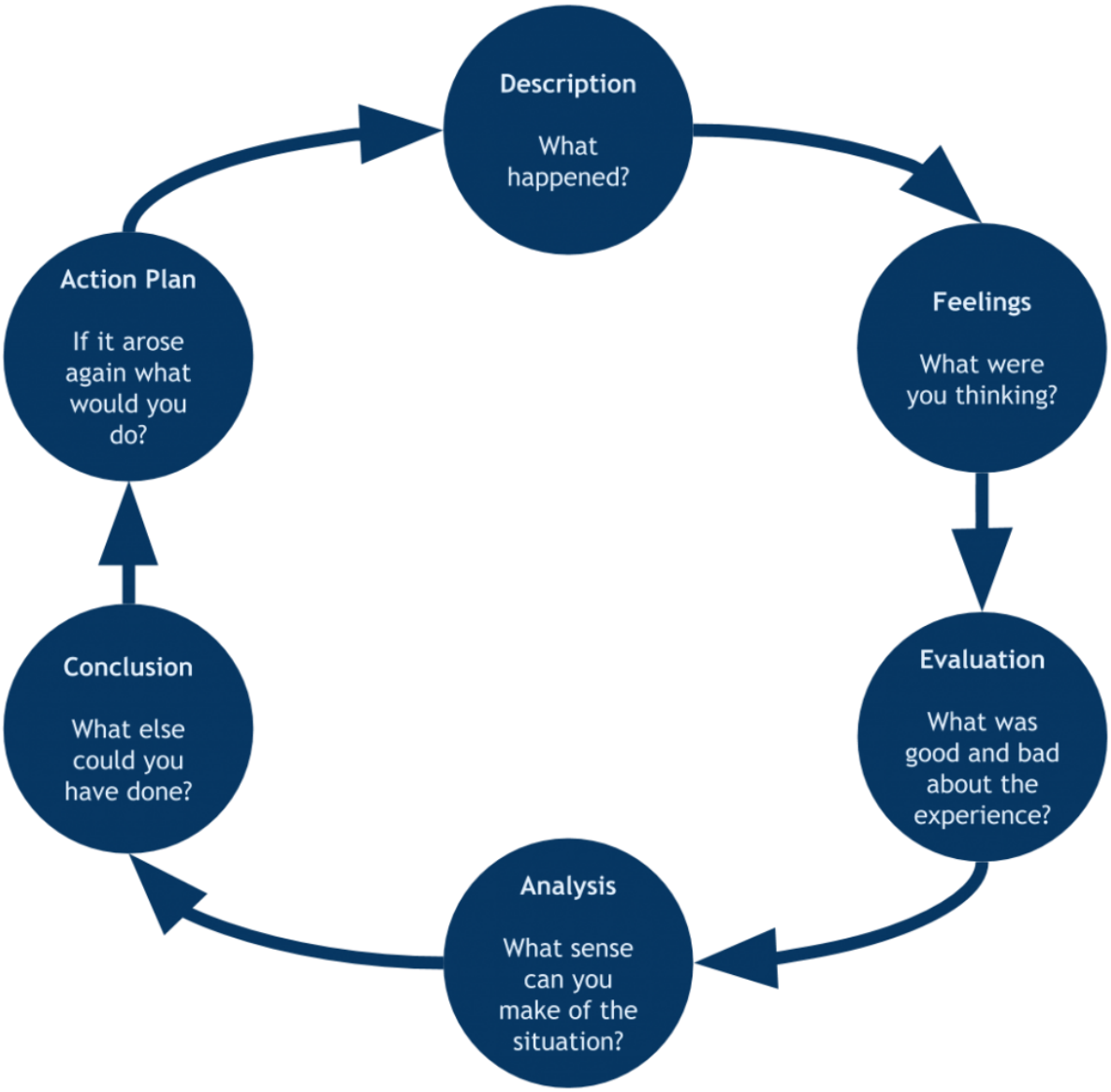
1. Waste bin (foot-operated, with lid and appropriate liner – e.g., biohazard)
2. Alcohol-based hand rub
3. Antimicrobial soap and running water (optional/preferred)
4. Clean gloves (for re-gloving if needed)
5. Disinfectant wipes (for reusable goggles/face shield)
6. Designated doffing area with clear signages

Checklist: Doffing PPE (Removing)

Sr. #	Tasks	Yes	No	Comments
1	Move to designated PPE removal (doffing) area			
2	Perform hand hygiene if hands are visibly soiled or gloves are damaged			
3	**Remove gloves**: Grasp outside of one glove, peel off, hold in gloved hand, slide ungloved finger under cuff			
4	Discard gloves into appropriate waste container			
5	Perform **hand hygiene** using Alcohol based hand rub or soap and water			
6	**Remove face shield/goggles**: Handle only by straps or arms, avoid touching front surface			
7	Place reusable items in disinfecting area or disposable ones in waste			

8	**Remove gown**: Untie at waist and neck, pull away from body, turn inside out while removing			
9	Discard gown safely in biohazard bin			
10	Perform hand hygiene again			
11	**Remove mask/respirator**: Remove by bottom strap, then top strap, without touching the front			
12	Discard mask into appropriate waste container			
13	Perform final hand hygiene thoroughly			
14	Inspect for contamination and ensure all PPE was removed correctly			
15	Document PPE removal in patient or staff safety record if applicable			

Reflection/ Critical Incident Analysis



Gibbs' Reflective Cycle 1998

CASE STUDY FORMAT

I. INTRODUCTION

Background/scenario of the case.

II. BIOGRAPHIC DATA

- Name
- Address
- Age
- Gender
- Race
- Marital Status
- Occupation
- Religious orientation
- Health care financing and usual source of medical care

III. CHIEF COMPLAINT OR REASON FOR VISIT

IV. NURSING HEALTH HISTORY

A. History of Present Illness

B. Past Medical History

a) Childhood diseases
b) Immunizations
c) Allergies
d) Accidents and injuries
e) Hospitalization
f) Medication

C. Family History of Illness (use Genogram)

D. Obstetric History (for OB cases only; with Assessment Guide)

E. Developmental History (for Pediatric cases only; with Assessment Guide)

V. FUNCTIONAL HEALTH PATTERN (with guide questionnaire)

1. Health Perception and Health Management Pattern
2. Nutrition and Metabolic Pattern
3. Elimination Pattern
4. Activity-Exercised Pattern (use Barthel index)
5. Sleep-rest Pattern
6. Cognitive-perceptual Pattern
7. Self-perception and self-control Pattern

8. Role-relationship Pattern
9. Sexuality-reproductive Pattern
10. Coping-stress tolerance Pattern
11. Value-belief Pattern

Interpretation:
Analysis: (with reference)

VI. REVIEW OF SYSTEM (all subjective complaints)

VII. PHYSICAL ASSESSMENT (all objective findings; indicate date performed; Head to Toe Assessment)

1. General Survey (Short Paragraph)
2. Vital Signs

BODY PART (Technique used)	NORMAL FINDINGS	ACTUAL FINDINGS	INTERPRETATION / ANALYSIS w/ Reference

VIII. ANATOMY & PHYSIOLOGY

IX. DIAGNOSTIC / LABORATORY STUDIES (Table)

NAME OF TEST / PROCEDURE	DATE DONE	INDICATION FOR THE TEST / PROCEDURE	NORMAL VALUE	ACTUAL RESULT / FINDINGS	SIGNIFICANCE OF THE RESULT / FINDINGS

X. SURGICAL PROCEDURE (Operative worksheet, if any)

XI. PATHOPHYSIOLOGY (Present in Schematic Diagram; Mind Mapping)

XII. DRUG STUDY / IV INFUSIONS, BLOOD TRANFUSIONS, TREAMENTS GIVEN

Drug Study

Drug Order (Generic, Name, Dosage, Route, Frequency)	Trade / Brand Name	Pharmacologic Action Of Drug	Indication And Contraindications	Adverse Effects Of The Drug	Desired Action On Your Client	Nursing Responsibilities / Precautions

Treatments Given

Treatment / Infusion	Classification	Indication	Contraindication	Nursing Responsibilities / Precautions

XIII. COURSE IN THE WARD (narrative form)

- Summary of day to day medical/nursing management from the date of admission up to the time case study was done
- Patient's Status:
    a. General condition of the client (ex. LOC, VS, and other Subjective & Objective, complaint during the day)
    b. 4 D's with inference / analysis:
        - Diet
        - Drugs/IVF
        - Lab/Diagnostics procedure
        - Disposition

XIV. PRIORITIZED LIST OF NURSING PROBLEMS (Table)

- Prioritized using ABC's and Maslow's Hierarchy of Needs

Date	Nursing Problems Identified	Cues	Justification

XV. NURSING CARE PLAN

Assessment	Nursing Diagnosis	Planning	Implementation	Rationale	Evaluation

XVI. PROPOSED / DISCHARGE PLAN (to be submitted by students whose patients are for discharge)

- M - Medications to take at home
- E - Exercises
- T - Treatment
- H - Health Teachings
- O - Out - patient follow-up
- D - Diet
- S - Spiritual / Sexual activity (optional)

References:

14. Carpinito L. J. (1998). *Nursing Care Plans & Documentation: Nursing Diagnosis and Collaborative Problem* (3rd ed.) Philadelphia: Lippincott
15. Craven, R. F., & Hirnle, C. J. (2000). *Fundamentals of Nursing: Human Health and Function.* (3rd ed.). New York: Lippincott.
16. Delaune, S. C., & Ladner, P. K. (2002). *Fundamentals of Nursing: Standards and Practice.* (2nd ed.) Canada: Delmar.
17. Erb, G. K., B. (2000). *Fundamentals of Nursing: Concepts, Process and Practice* (5th ed.) Addison: Wesley.
18. Potter, P. A & Perry, A. G. (2003). *Basic Nursing: Essentials for Practice* (5th ed.) St. Louis: Mosby.
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21. Delaune, S. C., & Ladner, P. K. (2002). Fundamentals of Nursing: Standards and Practice. (2nd ed.) Canada: Delmar.
22. Erb, G. K., B. (2000). Fundamentals of Nursing: Concepts, Process and Practice (5th ed.) Addison: Wesley.
23. Potter, P. A & Perry, A. G. (2003). Basic Nursing: Essentials for Practice (5th ed.) St. Louis: Mosby.

SEMESTER-II

Fundamental of Nursing-II (Clinical) 03 Cr. Hours

Clinical Training 03 Cr. Hours

Course Description:

This course introduces learners to different concepts of nursing practice with emphasis on identifying the patient needs, developing communication skills and use of the nursing process. Learners will gain knowledge related to theoretical concepts, values, and norms of the profession, while learning skills for providing basic nursing care to patients in hospital settings. Gordon's Functional Health Pattern (FHPs) will be used to assess patient needs.

Clinical rotation plan:

This semester will be of 16/22weeks, the student nurse will go to clinical rotation in batches to ensure 24/7 clinical placement at hospitals in all three shifts to observe, learn and perform clinical skills in clinical setting under the supervision of clinical instructor.

CLINICAL OBJECTIVES:

11 Demonstrate fundamental nursing psychomotor skills in a safe manner.

12 Apply therapeutic communication skills in the clinical area.

13 Utilize organizational skills and time management concepts in setting priorities for clinical performance.

14 Demonstrate critical thinking and decision-making skills based on standards of theory, practice, and research.

15 Apply theoretical content to the nursing care of the client in a clinical setting.

16 Implement care plans that reflect an understanding of the legal and ethical responsibilities of the nurse.

17 Perform nursing interventions that reflect caring behaviors in response to bio- psychosocial, cultural, and spiritual care needs.

18 Utilize the nursing process in the care of patients.

19 Demonstrate responsibility for own behavior and growth as an adult learner and a professional.

20 Safely administer medication to patients as ordered by physician.

EVALUATION CRITERIA

Sr. No	Clinical Portfolio Content	%	Frequency
1.	Clinical Objectives	*10%*	Weekly
2.	History Taking Performa	*15%*	20
3.	Physical Examination Checklists	*15%*	20
4.	Nursing Care Plan	*10%*	20
5.	Nursing Skills Checklists	*20%*	15
6.	Reflection/ Critical Incident Analysis	*10%*	Weekly
7.	Case Study	*20%*	01

CLINICAL OBJECTIVES FORM

Student Name: _____ Faculty: _____

Clinical placement: _____ Date: _____

Clinical Objectives	Strategies	Evaluation

HISTORY TAKING PROFORMA

Student Name: _____Group #: _____

Faculty: _____ date: _____

1. Document the client presenting complaint, follow Functional Health Patterns, Review of Systems findings and draw family genogram

CHECK LIST FOR TAKING A CLIENT HEALTH HISTORY

Interviewing Checklist	Satisfactory	Need to improve
Introduced self, purpose, and agenda		
Arranged for proper environment (position, distance, light)		

Asks open ended question (to explore chief concern)

Explores information about chief concern
(COLDERRAA)
Character, Onset, Location, Duration, Exacerbation, Radiation, Relief, Antecedent, Associated factors
Proceed from general to specific, follows cues, probes positive finding, asks clear, logical questions, one at a time
Uses effective communication techniques (Facilitation, Clarification, Paraphrasing, Transitions, Summarization)
demonstrates appropriate verbal / nonverbal gesture (Eye contact, voice tone, active listening, hand gestures)
Avoids being non therapeutic (asking why questions, biased, leading, judgmental, false reassurance, changing topic)
Explores client past history of any illness

Explores client family history

Explores client functional abilities & life style patterns

Explores Review of System checklist efficiently

Faculty comments:

NURSING CARE PLAN

Assessment	Nursing Diagnosis	Goal	Planning	Implementation	Rationale	Evaluation
Subjective Data						
Objective Data						

LIST OF SKILLS

Levels of competency = 1-5 (Novice to Expert)

S #	Skills	Level of competency	Minimum Frequency
1	Application of hot water bag	**1-5**	**05**
2	Application of Cold Compresses	**1-5**	**05**
3	Applying bandages, including wound dressing	**1-5**	**15**
4	Performing nebulization/steam therapy	**1-5**	**05**
5	Apply suction therapy.	**1-5**	**05**
6	Care of drainage bags (catheter)	**1-5**	**10**
7	Sitz bath	**1-5**	**05**
8	Administering Suppositories, Enema, and Flatus Tube	**1-5**	**05**
9	Specimen Collection	**1-5**	**20**
10	Urine Testing through dipstick	**1-5**	**10**
11	Administration of oral medication	**1-2**	**10**
12	Administration of Intramuscular Injection	**1-2**	**05**
13	Administration of Intradermal Injection	**1-2**	**05**
14	Administration of intravenous injection	**1-2**	**05**
15	Administration of subcutaneous medication	**1-2**	**05**

Sr. No	Procedures	Clinical Experience					
		Clinical instructor Signature	Date	Ward Sister Signature	Date	coordinator Signature	Date
1	Use of hot water bag						
2	Application of Cold Compresses						
3	Applying bandages including wound dressing						

4	Performing nebulization/ steam therapy						
5	Apply suction therapy.						
6	Care of drainage bags (catheter)						
7	Sitz bath						
8	Administering Suppositories, Enema, Flatus Tube						
9	Specimen Collection						
10	Urine Testing through dipstick						
11	Administration of oral medication						
12	Administration of Intramuscular injection						
13	Administration of Intradermal injection						
14	Administration of intravenous injection						
15	Administration of subcutaneous medication						

NURSING SKILLS CHECKLISTS

1. APPLICATION OF HOT WATER BAG

Equipment Required:

- Commercially prepared Hot water bag
- Small towel or washcloth
- PPE, as indicated
- Disposable waterproof pad
- Gauze wrap or tape
- Bath Thermometer
- Bath Towel

CHECK LIST

Steps	Yes	No	Remarks
1. Review the medical order or nursing plan of care for the application of heat therapy, including frequency, type of therapy, body area to be treated, and length of time for the Application			
2. Gather the necessary supplies and bring to the bedside			
3. Perform hand hygiene and put on PPE, if indicated.			
4. Introduce yourself to the client.			
5. Check Client's identity			
6. Explain procedure to the client			
7. Maintain privacy			
8. Assess the condition of the skin where the heat is to be applied			
9. Assist the patient to a comfortable position. Expose the area and cover patient with a bath blanket if needed. Put the waterproof pad under the wound area, if necessary.			
10. Measure the temperature of the water using a bath thermometer.			
11. Fill the bag about two-thirds full.			

12. Expel the remaining air and secure the top.			
13. Dry the bag and hold it upside down to test for leakage.			
14. Wrap the bag in a towel or cover and place it on the body site			
15. Remove after 30 minutes or in accordance with agency protocol.			
16. Check area of therapy for any abnormal signs			
17. Remove the plug and drain all the water once you've finished using the product.			
18. Allow the hot water bag to dry naturally by hanging it upside down.			

Nursing instructor's signature: _____ Date: _____

2. APPLICATION OF COLD COMPRESS

Equipment Required:

- Ice bag, gloves
- Commercially prepared cold packs
- Small towel or washcloth
- PPE, as indicated
- Disposable waterproof pad
- Gauze wrap or tape
- Bath Towel

Checklist

Steps	Yes	No	Remarks
1.Review the medical order or nursing plan of care for the application of cold therapy, including frequency, type of therapy, body area to be treated, and length of time for the application			
2. Gather the necessary supplies and bring to the bedside.			
3. Perform hand hygiene and put on PPE, if indicated.			

4. Introduce yourself to the client.			
5. Check Client's identity.			
6. Explain procedure to the client.			
7. Maintain privacy.			
8. Assess the condition of the skin where therapy is to be applied.			
9. Assist the patient to a comfortable position. Expose the area and cover patient with a bath blanket if needed. Put the waterproof pad under the wound area, if necessary.			
10. Fill the bag about two-thirds full with ice.			
11. Expel the remaining air and secure the top.			
12. Dry the bag and hold it upside down to test for leakage.			
13. Wrap the bag in a towel or cover and place it on the body site.			
14. Remove after 30 minutes.			
15. Check area of therapy for any abnormal signs.			
16. Reapply the equipment if there is no sign of injury.			
17. Continue the procedure according to orders or in accordance with agency protocol.			
18. Remove PPE, if used. Perform hand hygiene.			

Nursing instructor's signature: _____Date: _____

3. APPLYING BANDAGES INCLUDING WOUND DRESSING

BANDAGE MATERIAL

1. Gauze
2. Elasticized bandage

CHECKLIST

Step	Yes	No	Remarks
1- Review the medical record and nursing plan of care to determine the need for type of bandage.			
2-Perform hand hygiene. Put on PPE, as indicated.			
3-Identify the patient. Explain the procedure to the patient.			

4-Close curtains around bed and close the door to the room, if possible. Place the bed at an appropriate and comfortable working height, usually elbow height of the caregiver			
5-Assist the patient to a comfortable position, with the affected body part in a normal functioning position.			
6- Hold the bandage roll with the roll facing upward in one hand while holding the free end of the roll in the other hand. Make sure to hold the bandage roll so it is close to the affected body part.			
7- Place the bed in the lowest position, with the side rails up.			
8-Remove PPE, if used. Perform hand hygiene.			
9-Elevate the wrapped extremity for 15 to 30 minutes after application of the bandage.			
10-Assess the distal circulation after the bandage is in place. Lift the distal end of the bandage and assess the skin for color, temperature, and integrity.			
11-Assess for pain and perform a neurovascular assessment of the affected extremity after applying the bandage and at least every 4 hours, or as per facility policy.			
12-Perform hand hygiene.			

Nursing instructor's signature: _____ Date: _____

4. PERFORMING NEBULIZATION THERAPY

EQUIPMENT REQUIRED

- Medication
- Stethoscope
- Nebulizer tubing and chamber
- Pulse oximeter
- Air compressor or oxygen hookup
- Sterile saline (if not premeasured)
- Computer-generated Medication Administration Record (CMAR) or Medication Administration Record (MAR).
- PPE, as indicated.

CHECKLIST

Action	Yes	No	Remarks
1- Prior to perform the procedure, introduce yourself and verify the client's identity using agency protocol.			
2- Arrange all required equipment. • Check and clarify each medication order prescribed by physicians. • Check the patient's chart for allergies.			
3- Perform Hand hygiene.			
4- Set the Assembly of nebulizer per manufacturer directions.			
5- Prepare correct dosage of prescribed medicine and pour it into nebulizer cup. Prepare medications for one patient at a time.			
6- Carefully and securely attach the top to the nebulizer cup. The connect cupto mouthpiece or face mask.			
7- Give the mouthpiece to patient and instruct him/her about its gentle holding. c- In case of infant, child or fatigued adult, use facemask. d- Use special adapters for patients with tracheostomy.			
8- Turn on nebulizer machine and ensure that a sufficient mist begins to flow.			
9- Instruct patient to inhale slowly and deeply through the mouth. Hold the breath for a slight pause before exhaling.			
10- Continue this inhalation technique until all medication in the nebulizer cup has been aerosolized (usually about 15 minutes).			
11- When medication is completely nebulized, turn off machine. Rinse nebulizer cup per agency policy.			
12- Ensure that the patient receives the medications at the correct time.			
13- In case, steroids are nebulized, instruct patient to rinse mouth and gargle after nebulizer treatment.			
14- After nebulizer treatment is complete, have patient take several deep breaths and cough to expectorate mucus.			
15- Maintain the patient's comfort position.			
16- Perform hand hygiene.			

Nursing instructor's signature: _____ Date: _____

5. APPLYING SUCTION THERAPY

EQUIPMENT REQUIRED:

Oral and Nasopharyngeal/Nasotracheal Suctioning (Using Sterile Technique)

- Towel or moisture-resistant pad.
- Portable or wall suction machine with tubing, collection receptacle, and suction pressure gauge.
- Sterile disposable container for fluids.
- Sterile normal saline or water.
- Goggles or face shield, if appropriate.
- Moisture-resistant disposal bag.
- Sputum trap, if specimen is to be collected.

Oral and Oropharyngeal Suctioning (Using Clean Technique)

- Yankauer suction catheter or suction catheter kit.
- Clean gloves.

Nasopharyngeal or Nasotracheal Suctioning (Using Sterile Technique)

- Sterile gloves.
- Sterile suction catheter kit (#12 to #18 Fr for adults, #8 to #10 Fr for children, and #5 to #8 Fr for infants).
- Water-soluble lubricant.
- Y-connector.

CHECKLIST

Step	Yes	No	Remarks
1. Review the medical record and nursing plan of care to determine the need for suction.			
2. Perform hand hygiene. Put on PPE, as indicated.			
3. Identify the patient.			
4. Explain the procedure to patient. Inform the client that suctioning will relieve breathing difficulty and that the procedure is painless but may be uncomfortable and stimulate the cough, gag, or sneeze reflex.			
5. Close curtains around bed and close the door to the room, if possible. Place the bed at an appropriate and comfortable working height, usually elbow height of the caregiver.			

6. Prepare the client. • Position a conscious person who has a functional gag reflex in the semi- Fowler's position with the head turned to one side for oral suctioning or with the neck hyperextended for nasal suctioning. • Position an unconscious client in the lateral position, facing you.			
7. Prepare the equipment. • Turn the suction device on and set to appropriate negative pressure on the suction gauge. The amount of negative pressure should be high enough to clear secretions but not too high.			

FOR ORAL AND OROPHARYNGEAL SUCTION

Step	Yes	No	Remarks
1-Apply clean gloves.			
2-Moisten the tip of the Yankauer or suction catheter with sterile water or saline.			
3-Pull the tongue forward, if necessary, using gauze.			
4-Do not apply suction (that is, leave your finger off the port) during insertion.			
5-Advance the catheter about 10 to 15 cm (4 to 6 in.) along one side of the mouth into the oropharynx.			
6-It may be necessary during oropharyngeal suctioning to apply suction to secretions that collect in the mouth and beneath the tongue.			
7-Remove and discard gloves.			
8-Perform hand hygiene.			

FOR NASOPHARYNGEAL AND NASOTRACHEAL SUCTION

Step	Yes	No	Remarks
1. Open the lubricant. 2. Open the sterile suction package. a) Set up the cup or container, touching only the outside. b) Pour sterile water or saline into the container. c) Apply the sterile gloves, or apply an unsterile glove on the nondominant hand and then a sterile glove on the dominant hand. d) With your sterile gloved hand, pick up			

the catheter and attach it to the suction unit.			
3. Test the pressure of the suction and the patency of the catheter by applying your sterile gloved finger or thumb to the port or open branch of the Y- connector (the suction control) to create suction. If needed, apply or increase supplemental oxygen.			
4. Lubricate and introduce the catheter. • Lubricate the catheter tip with sterile water, saline, or water-soluble lubricant. • Remove oxygen with the non-dominant hand, if appropriate. • Without applying suction, insert the catheter into either naris and advance it along the floor of the nasal cavity. • Never force the catheter against an obstruction. If one nostril is obstructed, try the other.			
5. Perform suctioning. • Apply your finger to the suction control port to start suction, and gently rotate the catheter. • Apply suction for 5 to 10 seconds while slowly withdrawing the catheter, then remove your finger from the control and remove the catheter. • A suction attempt should last only 10 to 15 seconds. During this time, the catheter is inserted, the suction applied and discontinued, and the catheter removed.			

6. Rinse the catheter and repeat suctioning as above if necessary. • Rinse and flush the catheter and tubing with sterile water or saline. • Relubricate the catheter, and repeat suctioning until the air passage is clear. • Allow sufficient time between each suction for ventilation and oxygenation. Limit suctioning			
to 5 minutes in total. • Encourage the client to breathe deeply and to cough between suctions. • Use supplemental oxygen, if appropriate.			
7. Obtain a specimen if required. Use a sputum trap as follows: • Attach the suction catheter to the tubing of the sputum trap. • Attach the suction tubing to the sputum trap air vent. • Suction the client. The sputum trap will collect the mucus during suctioning. • Remove the catheter from the client. Disconnect the sputum trap tubing from the suction catheter. Remove the suction tubing from the trap air vent. • Connect the tubing of the sputum trap to the air vent. • Connect the suction catheter to the tubing. • Flush the catheter to remove secretions from the tubing.			
8. Dispose of equipment and ensure availability for the next suction. • Dispose of the catheter, gloves, water, and waste container. • Rinse the suction tubing as needed by inserting the end of the tubing into the used water container. • Wrap the catheter around your sterile gloved hand and hold the catheter as the glove is removed over it for disposal.			
9. Perform hand hygiene.			

10. Empty and rinse the suction collection container as needed or indicated by protocol. Change the suction tubing and container daily.			

Nursing instructor's signature: _____ Date: _____

6- URINARY CATHETER CARE

EQUIPMENT REQUIRED

- Clean gloves (needed for care and removal)
- Waterproof pad
- Bath blanket
- Soap
- Washcloth
- Towel
- Basin filled with warm water

CHECK LIST

Action	Yes	No	Remarks
1. Complete pre-procedural protocol.			
2. Preparation for catheter care: a) Observe urinary output and urine characteristics. b) Assess patient's knowledge of catheter care. c) Observe any discharge or redness around urethral meatus.			
3. Perform hand hygiene, and apply clean gloves.			
4. Position patient, and cover with bath blanket, exposing only perineal area. a) Female in dorsal recumbent position. b) Male in supine position.			
5. Catheter care: Place waterproof pad under patient. Provide routine perineal care with soap and water. Application of topical antimicrobial agents is not recommended. a) Assess urethral meatus and surrounding tissues for inflammation, swelling, and discharge, and ask patient if burning or discomfort is present. b) Using a clean washcloth, soap, and water, cleanse the catheter in a circular motion along its length for about 10 cm (4 inches). Start cleansing where the catheter enters the meatus and down toward the drainage tubing. Make sure to remove all traces of soap. c) Replace, as necessary, the adhesive tape (remove any adhesive residue from skin) or multipurpose tube holder that anchors catheter to patient's leg or abdomen. d) Avoid placing tension on the catheter.			

6.Check drainage tubing and bag fo the following: a) Tubing does not have dependent loops, and it is not positioned above level of bladder. b) Tubing is coiled and secured onto bed linen. c) Tube is without kinks, tube is not clamped, and patient is not lying on tubing. d) The collection bag is lower than the bladder level at all times. Hook the catheter on the bed frame, not on the side rail. e) Empty collection bag when one-half full.			

Nursing instructor's signature: _____ Date: _____

7. CARE OF DRAINAGE BAG

EQUIPMENT REQUIRED:

- Graduated container for measuring drainage
- Clean disposable gloves
- Additional PPE, as indicated
- Cleansing solution, usually sterile normal saline
- Sterile gauze pads
- Skin-protectant wipes
- Dressing materials for site dressing, if used

CHECKLIST

Action	Yes	No	Remarks
1. Review the medical orders for wound care or the nursing plan of care related to wound/drain care.			
2. Gather the necessary supplies and bring to the bedside stand or overbed table.			
3. Perform hand hygiene and put on PPE, if indicated.			
4. Identify the patient.			
5. Close curtains around bed and close door to room if possible. Explain what you are going to do and why you are going to do it to the patient.			

6. Assess the patient for possible need for non-pharmacologic pain-reducing interventions or analgesic medication before wound care dressing change.			
7. Place a waste receptacle at a convenient location for use during the procedure.			
8. Adjust bed to comfortable working height, usually elbow height of the caregiver (VISN 8, 2009).			
9. Assist the patient to a comfortable position that provides easy access to the drain and/or wound area.			
10. Put on clean gloves; put on mask or face shield if indicated.			
11. Place the graduated collection container under the outlet of the drain. Without contaminating the outlet valve, pull the cap off. The chamber will expand completely as it draws in air. Empty the chamber's contents completely into the container. Use the gauze pad to clean the outlet. Fully compress the chamber with one hand and replace the cap with your other hand.			
12. Check the patency of the equipment. Make sure, the tubing is free from twists and kinks.			
13. Secure the Jackson-Pratt drain to the patient's gown below the wound with a safety pin, making sure that there is no tension on the tubing.			
14. Carefully measure and record the character, color, and amount of the drainage. Discard the drainage according to facility policy. Remove gloves.			
15. Put on clean gloves. If the drain site has a dressing, re-dress the site. Include cleaning of the sutures with the gauze pad moistened with normal saline. Dry sutures with gauze before applying new dressing.			
16. If the drain site is open to air, observe the sutures that secure the drain to the skin. Look for signs of pulling, tearing, swelling, or infection of the surrounding skin.			
17. Remove and discard gloves. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.			

18. Remove additional PPE, if used. Perform hand hygiene.			
19. Check drain status at least every four hours. Check all wound dressings every shift. More frequent checks may be needed if the wound is more complex or dressings become saturated quickly			

Nursing instructor's signature: _____ Date: _____

8. SITZ BATH

EQUIPMENT REQUIRED:

- Clean gloves.
- Additional PPE, as indicated.
- Towel.
- Adjustable IV pole.
- Disposable sitz bath bowl with water bag.

CHECKLIST

Action	Yes	No	Remarks
1. Review the medical order for the application of a Sitz bath, including frequency, and length of time for the application.			
2. Gather the necessary supplies and bring to the bedside stand or overbed table.			
3. Perform hand hygiene and put on PPE, if indicated.			
4. Identify the patient.			
5. Close curtains around bed and close door to room if possible.			
6. Put on gloves. Assemble equipment; at the bedside if using a bedside commode or in bathroom.			
7. Raise lid of toilet or commode. Place bowl of sitz bath, with drainage ports to rear and infusion port in front, in the toilet (Figure 1). Fill bowl of sitz bath about halfway full with tepid to warm water (37–46C [98^{o}F–115^{o}F]).			
8. Clamp tubing on bag. Fill bag with same temperature water as mentioned above. Hang bag above patient's shoulder height on the IV pole.			
9. Assist patient to sit on toilet or commode and provide any extra draping if needed. Insert tubing into infusion port of sitz bath. Slowly unclamp tubing and allow sitz bath to fill.			
10. Clamp tubing once sitz bath is full. Instruct patient to open clamp when water in bowl becomes cool. Ensure that call bell is within reach. Instruct patient to call if she feels lightheaded or dizzy or has any problems. Instruct patient not to try standing without assistance.			
11. Remove gloves and perform hand hygiene.			
12. When patient is finished (in about 15–20 minutes, or prescribed time), put on clean gloves. Assist the patient to stand and gently pat perineal area dry. Remove gloves. Assist patient to bed or chair. Ensure that call bell is within reach.			

13. Remove gloves and any additional PPE, if used. Perform hand hygiene.			

Nursing instructor's signature: _____ Date: _____

9. RECTAL SUPPOSITORY INSERTION

EQUIPMENT REQUIRED:

- Rectal suppository
- Water-soluble lubricating jelly
- Clean gloves
- Tissue paper
- Drape
- Medication administration record (MAR) (electronic or printed)

CHECKLIST

Action	Yes	No	Remarks
1. Complete pre-procedural protocol.			
2. Check accuracy and completeness of each medication administration record (MAR) with health care provider's medication order. Check patient's name, drug name and dosage, route, and time for administration. Clarify incomplete or unclear orders with health care provider before administration.			
3. Review patient's medical history for history of rectal surgery or bleeding, cardiac problems, history of allergies, and medication history.			
4. Assess patient's ability to hold suppository and to position self to insert medication.			
5. Review patient's knowledge of purpose of drug therapy and interest in self-administering suppository.			
6. Prepare suppository for administration. Check label of medication against MAR 2 times. Check expiration date on container.			
7. Identify patient using two identifiers (e.g., name and birthday or name and account number) according to agency policy. Compare identifiers with information on patient.			
8. At patient's bedside, again compare MAR or computer printout with names of medications on medication labels and patient name. Ask patient if he or she has allergies.			
9. Perform hand hygiene, arrange supplies at bedside, and apply clean gloves. Close room curtain or door.			
10. Help patient assume a left side-lying Sims' position with upper leg flexed upward.			
11. If patient has mobility impairment, help into lateral position. Obtain assistance to turn patient, and use pillows under patient's upper arm and leg.			

12. Keep patient draped with only anal area exposed.			
13. Examine condition of anus externally. Option: Palpate rectal walls as needed (e.g., if impaction is suspected). Dispose of gloves by turning them inside out and placing them in proper receptacle if they become soiled.			

Nursing instructor's signature: _____ Date: _____

10. ADMINISTRATING ENEMA

EQUIPMENT REQUIRED:

- Enema solution (varies depending on reason for enema), often prepackaged
- Nonsterile gloves
- Additional PPE, as indicated
- Waterproof pad
- Bath blanket
- Washcloth, soap, and towel
- Bedpan or commode
- Toilet tissue
- Water-soluble lubricant

CHECKLIST

Action	Yes	No	Remarks
1. Verify the order for the enema. Bring necessary equipment to the bedside stand or overbed table. Warm the solution to body temperature in a bowl of warm water.			
2. Perform hand hygiene and put on PPE, if indicated.			
3. Identify the patient.			
4. Close curtains around bed and close the door to the room, if possible. Explain what you are going to do and why you are going to do it to the patient. Have a bedpan, commode, or nearby bathroom ready for use.			
5. Adjust bed to comfortable working height, usually elbow height of the caregiver (VISN 8 Patient Safety Center, 2009). Position the patient on the left side (Sims' position), as dictated by patient comfort and condition. Fold top linen back just enough to allow access to the patient's rectal area. Place a waterproof pad under the patient's hip.			
6. Put on nonsterile gloves.			

7. Remove cap of prepackaged enema solution. Apply a generous amount of lubricant to the tube.			
8. Lift buttock to expose anus. Slowly and gently insert rectal tube 3 to 4 inches (7 to 10 cm) for an adult. Direct it at an angle pointing toward the umbilicus. Ask patient to take several deep breaths.			
9. If resistance is met while inserting the tube, permit a small amount of solution to enter, withdraw tube slightly, and then continue to insert it. Do not force entry of tube.			
10. Slowly squeeze enema container, emptying entire contents.			
11. Remove container while keeping it compressed. Have paper towel ready to receive tube as it is withdrawn.			
12. Instruct patient to retain enema solution for at least 30 minutes or as indicated, per manufacturer's direction.			
13. Remove your gloves. Return the patient to a comfortable position. Make sure the linens under the patient are dry and ensure that the patient is covered.			
14. Raise side rail. Lower bed height and adjust head of bed to a comfortable position.			
15. Remove additional PPE, if used. Perform hand hygiene.			
16. If the patient has a strong urge to dispel the solution, place him or her in a sitting position on bedpan or assist to commode or bathroom. Stay with patient or have call bell readily accessible.			
17. Remind patient not to flush commode before you inspect results of enema, if used for bowel evacuation. Record character of stool, as appropriate, and patient's reaction to enema.			
18. Put on gloves and assist patient, if necessary, with cleaning of anal area. Offer washcloths, soap, and water for handwashing. Remove Gloves			
19. Leave patient clean and comfortable. Care for equipment properly.			

Nursing instructor's signature: _____ Date: _____

11. ADMINISTRATING FLATUS TUBE

EQUIPMENT REQUIRED:

- Sterile gloves
- Lubricant (water-soluble)
- Flatus tube
- Drainage bag
- Measurement tool (ruler)
- Hypoallergenic adhesive patch
- Basin with warm water (optional)
- Drape or towel (optional)

CHECKLIST

Action	Yes	No	Remarks
1. Explain procedure to the patient, Inform the patient about what will be done and why it is necessary.			
2. Perform hand hygiene, wash hands thoroughly with soap and water before donning gloves.			
3. Position the patient, place the patient in the left lateral (Sims') position with the upper leg flexed.			
4. Put on clean gloves.			
5. Apply a water-soluble lubricant to the tip of the flatus tube.			
6. Gently insert the tube past the internal sphincter (about 3-4 inches for adults).			
7. Keep the tube in place until gas stops escaping or as per the physician's instructions.			
8. Observe the patient for signs of discomfort or adverse reactions during the procedure.			
9. Gently withdraw the tube after the procedure is completed.			
10. Properly dispose of gloves and other used materials.			
11. Wash hands thoroughly after removing gloves.			
12. Offer the patient a clean pad and assist with hygiene as needed.			

Nursing instructor's signature: _____ Date: _____

12. COLLECTING BLOOD SPECIMENS

EQUIPMENT REQUIRED:

- Nonsterile gloves
- Additional PPE, as indicated
- Tourniquet
- Antimicrobial swab, such as chlorhexidine or alcohol
- Sterile needle, gauge appropriate to the vein and sampling needs, using the smallest possible
- Vacutainer needle adaptor
- Blood-collection tubes appropriate for ordered tests
- Appropriate label for specimen, based on facility policy and procedure
- Gauze pads (2x2)
- Adhesive bandage

CHECKLIST

Step	Yes	No	Remarks
1. Verify the patient's identity using two identifiers (e.g., name and date of birth).			
2. Perform hand hygiene and put on PPE, if indicated.			
3. Explain the procedure to the patient and ensure they understand the purpose.			
4. Gather all necessary equipment (e.g., gloves, tourniquet, alcohol swab and needle).			
5. Assist the patient to a comfortable position, either sitting or lying.			
6. Select an appropriate venipuncture site, avoiding contraindicated areas.			
7. Apply a tourniquet 3-4 inches above the selected site. Apply sufficient pressure to impede venous circulation but not arterial blood flow.			
8. Clean the selected site with an alcohol swab and allow it to dry.			
9. Insert the needle into the vein at a 15–30-degree angle with the bevel facing up.			
10. Remove the tourniquet as soon as blood flows adequately into the tube.			
11. Collect the required amount of blood into the appropriate collection tubes.			
12. Remove the needle and apply pressure to the site with a sterile gauze. Do not apply pressure to site until the needle has been fully removed.			
13. After bleeding stops, apply an adhesive bandage.			
14. Label the specimen tubes correctly at the bedside.			
15. Dispose of the needle and other used materials in appropriate sharps and waste containers.			
16. Remove gloves and perform hand hygiene.			

Nursing instructor's signature: _____ Date:

_____

13. COLLECTING A URINE SPECIMEN

EQUIPMENT REQUIRED:

- Moist cleansing towelettes or soap, water, and washcloth
- Nonsterile gloves
- Additional PPE, as indicated
- Sterile specimen container
- Biohazard bag.
- Appropriate label for specimen

CHECKLIST

Steps	Yes	No	Remarks
1. Identify the patient. Explain the procedure to the patient.			
2. Perform hand hygiene and put on PPE, if indicated.			
3. For self-collection, patient should perform hand hygiene.			
4. Apply screen around bed and close the door to the room, if possible.			
5. Instruct the female to clean the perineal region and males to clean the penis.			
6. Have patient void a small amount of urine into the toilet, bedpan, or commode. The patient should then stop urinating briefly, then void into collection container. Collect specimen (10 to 20 mL is sufficient), and then finish voiding. Do not touch the inside of the container or the lid.			
7. Place lid on container.			
8. Provide perineal care, if necessary.			
9. Remove gloves and perform hand hygiene.			
10. Remove other PPE, if used and perform hand hygiene.			

Nursing instructor's signature: _____ Date: _____

14. COLLECTION OF SPUTUM SPECIMEN

EQUIPMENT REQUIRED

- Sterile sputum specimen container
- Nonsterile gloves
- Goggles or safety glasses
- Additional PPE, as indicated
- Biohazard bag
- Appropriate label for specimen

CHECKLIST

Action	Yes	No	Remarks
1. Apply screen around bed and close the door to the room, if possible.			
2. Identify the patient. Explain the procedure to the patient.			
3. Perform hand hygiene and put on PPE especially disposable gloves and goggles.			
4. Before beginning procedure, Patient should have to clear nose and throat and rinse mouth with water.			
5. Instruct the patient to inhale deeply two or three times and cough with exhalation.			
6. When patient produces sputum, open the lid to the container and give it to patient to expectorate the specimen into container. Repeat the procedure, in case more sputum is produced.			
7. Close lid to container. Offer oral hygiene to the patient			
8. Remove PPE such as goggles and gloves. Perform hand hygiene.			
9. Transport the specimen to the laboratory immediately.			

Nursing instructor's signature: _____ Date: _____

15. COLLECTING A STOOL SPECIMEN FOR CULTURE

EQUIPMENT REQUIRED:

- Tongue blades.
- Clean specimen container (or container with preservatives for ova and parasites).
- Biohazard bag.
- Non-sterile gloves.
- PPE, if required.

Appropriate label for specimen

CHECKLIST

Action	Yes	No	Remarks
1. Apply screen around bed and close the door to the room, if possible.			
2. Identify the patient. Explain the procedure to the patient.			
3. Perform hand hygiene and put on necessary PPE such as gloves.			
4. After the patient has passed a stool, use the tongue blades to obtain a sample, free of blood or urine, and place it in the designated clean container.			
5. Collect as much of the stool as possible to send to the laboratory.			
6. Place lid on container. Dispose of used equipment.			
7. Place container in plastic, sealable biohazard bag.			
8. Remove PPE such as gloves. Perform hand hygiene.			
9. Transport the specimen to the laboratory immediately.			

Nursing instructor's signature: _____ Date: _____

16. URINE TESTING THROUGH DIPSTICK

EQUIPMENT REQUIRED:

- Gloves
- Clean specimen container
- Urine specimen
- Dipstick
- Watch
- PPE, if required.

CHECKLIST

Steps	Yes	No	Remarks
1. Introduce yourself and explain the procedure to the patient.			
2. Gather necessary supplies (dipstick, clean container, gloves, etc.)			
3. Instruct the patient to collect a midstream urine sample			
4. Use a clean, dry container for the urine sample			
5. Wash hands and wear gloves			
6. Dip the stick into the urine sample, ensuring all pads are covered			
7. Remove the dipstick and tap it on the side of the container to remove excess urine			
8. Compare each test pad to the color chart at the specified times			

Nursing instructor's signature: _____ Date: _____

17. ADMINISTERING ORAL MEDICATIONS

EQUIPMENT REQUIRED

- Medication in disposable cup or oral syringe
- Liquid (e.g., water, juice) with straw, if not contraindicated
- Medication cart or tray
- Computer-generated Medication Administration Record (CMAR) or Medication Administration
- Record (MAR)
- PPE, as indicated
- Paper Towel

CHECKLIST

Action	Yes	No	Remarks
1. Gather equipment. Check each medication order against the original in the medical record, according to facility policy. Clarify any inconsistencies. Check the patient's chart for allergies.			
2. Know the actions, special nursing considerations, safe dose ranges, purpose of administration, and adverse effects of the medications to be administered. Consider the appropriateness of the medication for this patient.			
3. Perform hand hygiene.			
4. Move the medication cart to the outside of the patient's room or prepare for administration in the medication area.			
5. Unlock the medication cart or drawer. Enter pass code into the computer and scan employee identification, if required.			
6. Prepare medications for one patient at a time.			
7. Read the CMAR/MAR and select the proper medication from the patient's medication drawer or unit stock.			
8. Compare the label with the CMAR/MAR. Check expiration dates and perform calculations, if necessary. Scan the bar code on the package, if required.			

9. Prepare the required medications: a) Unit dose packages: Place unit dose packaged medications in a disposable cup. Do not open the wrapper until at the bedside. Keep narcotics and medications that require special nursing assessments in a separate container. b) Multidose containers: When removing tablets or capsules from a multidose bottle, pour the necessary number into the bottle cap and then place the tablets or capsules in a medication cup. Break only scored tablets, if necessary, to obtain the proper dosage. Do not touch tablets or capsules with hands. c) Liquid medication in multidose bottle: When pouring liquid medications out of a multidose bottle, hold the bottle so the label is against the palm. Use the appropriate measuring device when pouring liquids, and read the amount of			

medication at the bottom of the meniscus at eye level. Wipe the lip of the bottle with a paper towel.			
10. When all medications for one patient have been prepared, recheck the labels with the CMAR/MAR before taking the medications to the patient. Replace any multidose containers in the patient's drawer or unit stock. Lock the medication cart before leaving it.			
11. Transport medications to the patient's bedside carefully, and keep the medications in sight at all times.			
12. Ensure that the patient receives the medications at the correct time.			
13. Perform hand hygiene and put on PPE, if indicated.			
14. Identify the patient. Usually, the patient should be identified using two methods. Compare the information with the CMAR/MAR. a) Check the name and identification number on the patient's identification band. b) Ask the patient to state his or her name and birth date, based on facility policy. c) If the patient cannot identify him- or herself, verify the patient's identification with a staff member who knows the patient, for the second source.			
15. Scan the patient's bar code on the identification band, if required			
16. Complete necessary assessments before administering medications. Check the patient's allergy bracelet or ask the patient about allergies. Explain the purpose and action of each medication to the patient.			
17. Assist the patient to an upright or lateral position.			
18. Administer medications: a) Offer water or other permitted fluids with pills, capsules, tablets, and some liquid medications. b) Ask whether the patient prefers to take the medications by hand or in a cup.			
19. Remain with the patient until each medication is swallowed. Never leave medication at the patient's bedside			

20. Assist the patient to a comfortable position. Remove PPE, if used. Perform hand hygiene.			
21. Document the administration of the medication immediately after administration.			
22. Evaluate the patient's response to medication within appropriate time frame.			

Nursing instructor's signature: _____ Date: _____

18. ADMINISTERING AN INTRAMUSCULAR INJECTION

EQUIPMENT REQUIRED

- Sterile syringe
- Needle length corresponds to site of injection and age and size of patient
- Alcohol swab
- Small gauze pad
- Vial or ampule of medication
- Clean gloves
- Medication administration record (MAR) or computer printout
- Puncture-proof container

CHECKLIST

STEP	Yes	No	Remarks
1. Prepare medications for one patient at a time using aseptic technique and avoiding distractions. Check label of medication carefully with MAR or computer printout 2 times when preparing medication.			
2. Take medication(s) to patient at correct time. Medications that require exact timing include stat, first-time or loading doses, and one-time doses.			
3. Close room curtain or door.			
4. Identify patient using two identifiers (i.e., name and birthday or name and account number) according to agency policy.			
5. At patient's bedside again compare MAR or computer printout with names of medications on medication labels and patient name. Ask patient if he or she has allergies.			
6. Discuss purpose of each medication, action, and possible adverse effects. Allow patient to ask any questions. Tell him or her that injection will cause a slight burning or sting.			
7. Perform hand hygiene and apply clean gloves. Keep sheet or gown draped over body parts not requiring exposure.			

8. Select appropriate site. Note integrity and size of muscle. Palpate for tenderness or hardness. Avoid these areas. If patient receives frequent injections, rotate sites. Use ventrogluteal if possible.			
9. Help patient to comfortable position. Position patient depending on chosen site (e.g., sit, lie flat, on side, or prone).			
10. Relocate site using anatomic landmarks.			
11. Clean site with antiseptic swab. Apply swab at center of site and rotate outward in circular direction for about 5 cm (2 inches).			
12. Remove needle cap or sheath by pulling it straight off.			

13. Hold syringe between thumb and forefinger of dominant hand; hold as dart, palm down.			
14. Administer injection. a) Position ulnar side of non-dominant hand just below site and pull skin laterally approximately 2.5 to 3.5 cm (1 to 11 2 inches). Hold position until medication is injected. With dominant hand inject needle quickly at 90-degree angle into muscle. b) Option: If patient's muscle mass is small, grasp body of muscle between thumb and forefingers. c) After needle pierces skin, still pulling on skin with nondominant hand, grasp lower end of syringe barrel with fingers of nondominant hand to stabilize it. Move dominant hand to end of plunger. Avoid moving syringe. d) Pull back on plunger 5 to 10 seconds. If no blood appears, inject medication slowly at rate of 10 sec/mL. e) Wait 10 seconds, smoothly and steadily withdraw needle, release skin, and apply gauze gently over site.			
15. Apply gentle pressure to site. Do not massage site. Apply bandage if needed.			
16. Help patient to comfortable position.			
17. Discard uncapped needle or needle enclosed in safety shield and attached syringe into puncture- and leak-proof receptacle.			
18. Remove gloves and perform hand hygiene.			
19. Stay with patient for several minutes and observe for any allergic reactions.			

Nursing instructor's signature: _____ Date: _____

19. ADMINISTERING AN INTRADERMAL INJECTION

EQUIPMENT REQUIRED

- Sterile 1-mL syringe calibrated into hundredths of a milliliter (i.e., tuberculin syringe) and a #25 to #27- gauge safety needle that is 1/4 to 5/8inch long
- Small gauze pad
- Alcohol swab
- Vial or ampule of medication
- Clean gloves
- Bandage (optional)
- Medication administration record (MAR) or computer printout
- Puncture-proof container
- Epinephrine on hand in case of allergic anaphylactic reaction.

CHECKLIST

Action	Yes	No	Remarks
1- Prepare medications for one patient at a time using aseptic technique and avoiding distractions. Check label of medication carefully with MAR or computer printout 2 times when preparing medication.			
2- Take medication(s) to patient at correct time (see agency policy). Medications that require exact timing include stat, first-time or loading doses, and one-time doses.			
3- Close room curtain or door.			
4- Identify patient using two identifiers (i.e., name and birthday or name and account number) according to agency policy.			
5- At patient's bedside again compare MAR or computer printout with names of medications on medication labels and patient name. Ask patient if he or she has allergies.			
6- Discuss purpose of each medication, action, and possible adverse effects. Allow patient to ask any questions. Tell him or her that injection will cause a slight burning or sting.			
7- Perform hand hygiene and apply clean gloves. Keep sheet or gown draped over body parts not requiring exposure.			

8- Select appropriate site. Note lesions or discolorations of skin. If possible, select site three to four finger widths below antecubital space and one hand width above wrist. If you cannot use forearm, inspect upper back. If necessary, use sites appropriate for subcutaneous injections.			
9- Help patient to comfortable position.			
10- Clean site with antiseptic swab. Apply swab at center of site and rotate outward in circular direction for about 5 cm (2 inches).			
11- Remove needle cap from needle by pulling it straight off.			
12- Hold syringe between thumb and forefinger of dominant hand with bevel of needle pointing up.			
13- Administer injection. a. With nondominant hand stretch skin over site with forefinger or thumb. b. With needle almost against patient's skin, insert it slowly at 5- to 15-degree angle until resistance is felt. Advance needle through epidermis to approximately 3 mm (1/8 inch) below skin surface. c. Inject medication slowly. Normally you feel resistance. If not, needle is too deep; remove and begin again. d. While injecting medication, note that small bleb (approximately 6 mm [¼ inch]) resembling mosquito bite appears on skin surface. e. After withdrawing needle, apply alcohol swab or gauze gently over site.			
14- Do not massage the area after removing needle. Tell patient not to rub or scratch the site. If necessary, gently blot the site with a dry gauze square. Do not apply pressure or rub the Site			
15- Help patient to comfortable position.			
16- Discard uncapped needle or needle enclosed in safety shield and attached syringe in puncture- and leak-proof receptacle.			
17- Remove gloves and perform hand hygiene.			
18- Stay with patient for several minutes and observe for any allergic reactions.			

Nursing instructor's signature: _____ Date: _____

20. ADMINISTERING INTRAVENOUS MEDICATIONS

EQUIPMENT REQUIRED

- Adhesive tape
- Antiseptic swab
- Clean gloves
- IV pole
- Tourniquet
- IV catheter (A #20- to #22-gauge catheter is indicated for most adults. Always have an extra catheter and ones of different sizes available.)
- Medication administration record (MAR) or computer printout
- Puncture-proof container

Piggyback or Mini-infusion Pump

- Medication prepared in 50- to 250-mL labeled infusion bag or syringe
- Prefilled syringe of normal saline flush solution (for saline lock only)
- Short microdrip, macrodrip, or mini-infusion IV tubing set with blunt-ended (needleless) cannula attachment
- Needleless device

Mini-infusion pump if indicated

- Volume-Control Administration Set
- Volutrol or Buretrol
- Infusion tubing with needleless system attachment
- Syringe (1 to 20 mL)
- Vial or ampule of ordered medication

CHECKLIST

STEP	Yes	No	Remarks
1- Prepare medications for one patient at a time using aseptic technique and avoiding distractions. Check label of medication carefully with MAR or computer printout 2 times when preparing medication.			
2- Take medication(s) to patient at correct time. Medications that require exact timing include stat, first-time or loading doses, and one-time doses.			
3- Close room curtain or door.			
4- Identify patient using two identifiers (i.e., name and birthday or name and account number) according to agency policy.			
5- At patient's bedside again compare MAR or computer printout with names of medications on medication labels and patient name. Ask patient if he or she has allergies.			

6- Discuss purpose of each medication, action, and possible adverse effects. Allow patient to ask any questions. Explain that you will give medication through existing IV line. Encourage patient to report symptoms of discomfort at site.			
7- Administer infusion.			

PIGGYBACK INFUSION			
Action	**Yes**	**No**	**Remarks**
8- Connect infusion tubing to medication bag. Fill tubing by opening regulator flow clamp. Once tubing is full, close clamp and cap end of tubing.			
9- Hang piggyback medication bag above level of primary fluid bag. (Use hook to lower main bag.)			
10- Connect tubing of piggyback infusion to appropriate connector on upper Y-port of primary infusion line: b) Needleless system: Wipe off needleless port of main IV line with alcohol swab, allow to dry, and insert cannula tip of piggyback infusion tubing.			
11- Regulate flow rate of medication solution by adjusting regulator clamp or IV pump infusion rate. Infusion times vary. Refer to medication reference or agency policy for safe flow rate.			
12- Once medication has infused: (c) Continuous infusion: Check flow rate of primary infusion. Primary infusion automatically begins after piggyback solution is empty. (d) Normal saline lock: Disconnect tubing, clean port with alcohol, and flush IV line with 2 to 3 mL of sterile 0.9% sodium chloride. Maintain sterility of IV tubing between intermittent infusions.			
13- Regulate continuous main infusion line to ordered rate.			
14- Leave IV piggyback and tubing in place for future drug administration (see agency policy) or discard in puncture- and leak-proof container.			
Volume-control administration set			

Action	Yes	No	Remarks
1- Fill Volutrol with desired amount of IV fluid (50 to 100 mL) by opening clamp between Volutrol and main IV bag (see illustration).			
2- Close clamp and check to be sure that clamp on air vent Volutrol chamber is open.			
3- Clean injection port on top of Volutrol with antiseptic swab.			
4- Remove needle cap or sheath and insert needleless syringe or syringe needle through port and inject medication (see illustration). Gently rotate Volutrol between hands.			
5- Regulate IV infusion rate to allow medication to infuse in time recommended by agency policy, pharmacist, or medication reference manual.			
6- Label Volutrol with name of medication; dosage, total volume, including diluent; and time of administration following ISMP (2011) safe medication label format.			
7- If patient is receiving continuous IV infusion, check infusion rate after Volutrol infusion is complete.			
8- Dispose of uncapped needle or needle enclosed in safety shield and syringe in puncture- and leakproof container. Discard supplies in appropriate container. Perform hand hygiene.			
Mini-infusion Administration			
Action	**Yes**	**No**	**Remarks**
1- Connect prefilled syringe to mini-infusion tubing; remove end cap of tubing.			
2- Carefully apply pressure to syringe plunger, allowing tubing to fill with medication.			
3- Place syringe into mini-infusion pump (follow product directions) and hang on IV pole. Be sure that syringe is secured			
4- Connect end of mini-infusion tubing to main IV line or saline lock: b) Existing IV line: Wipe off needleless port on main IV line with alcohol swab, allow to dry, and insert tip of mini-infusion tubing through center of port.			

5- Set pump to deliver medication within time recommended by agency policy, pharmacist, or medication reference manual. Press button on pump to begin infusion.			
6- Once medication has infused: c) Main IV infusion: Check flow rate. Infusion automatically begins to flow once pump stops. Regulate infusion to desired rate as needed. d) Normal saline lock: Disconnect tubing, clean port with alcohol, and flush IV line with 2 to 3 mL of sterile 0.9% sodium chloride. Maintain sterility of IV tubing between intermittent infusions.			
7- Dispose of supplies in puncture- and leak-proof container			
8- Remove gloves and perform hand hygiene.			
9- Stay with patient for several minutes and observe for any allergic reactions.			

Nursing instructor's signature: _____ Date: _____

21. ADMINISTERING SUBCUTANEOUS INJECTIONS

EQUIPMENT REQUIRED:

- Subcutaneous: syringe (1- to 3-mL) and needle (25- to 27-gauge, 3/8 - to 5/8-inch)
- Subcutaneous U-100 insulin: insulin syringe (1 mL) with preattached needle (28- to 31-gauge, 5/16- to 1/2 -inch)
- Small gauze pad (optional)
- Alcohol swab
- Medication vial or ampule
- Clean gloves
- Medication administration record (MAR) or computer printout
- Puncture-proof container

CHECKLIST

STEP	Yes	No	Remarks
1- Prepare medications for one patient at a time using aseptic technique and avoiding distractions. Check label of medication carefully with MAR or computer printout 2 times when preparing medication.			
2- Take medication(s) to patient at correct time. Medications that require exact timing include stat, first-time or loading doses, and one-time doses.			
3- Close room curtain or door.			
4- Identify patient using two identifiers (i.e., name and birthday or name and account number) according to agency policy.			
5- At patient's bedside again compare MAR or computer printout with names of medications on medication labels and patient name. Ask patient if he or she has allergies.			
6- Discuss purpose of each medication, action, and possible adverse effects. Allow patient to ask any questions. Tell him or her that injection will cause a slight burning or sting.			
7- Perform hand hygiene and apply clean gloves. Keep sheet or gown draped over body parts not requiring exposure.			
8- Select appropriate injection site. Inspect skin surface over sites for bruises, inflammation, or edema. Do not use an area that is bruised or has signs associated with infection.			

10- Help patient into comfortable position. Have him or her relax arm, leg, or abdomen, depending on site selection.			
9- Palpate sites and avoid those with masses or tenderness. Be sure that needle is correct size by grasping skinfold at site with thumb and forefinger. Measure fold from top to bottom. Make sure that needle is one-half length of fold.			
11- Clean site with antiseptic swab. Apply swab at center of site and rotate outward in circular direction for about 5 cm (2 inches).			
12- Remove needle cap or protective sheath by pulling it straight off.			
13- Hold syringe between thumb and forefinger of dominant hand.			
14- Administer injection: • For average-size patient, hold skin across injection site or pinch skin with nondominant hand. • Inject needle quickly and firmly at 45- to 90-degree angle. Release skin if pinched. • For obese patient pinch skin at site and inject needle at 90-degree angle below tissue fold. • After needle enters site, grasp lower end of syringe barrel with nondominant hand to stabilize it. Move dominant hand to end of plunger and slowly inject medication over several seconds. Avoid moving syringe. • Withdraw needle quickly while placing antiseptic swab or gauze gently over site.			
15- Apply gentle pressure to site. Do not massage site. (If heparin is given, hold alcohol swab or gauze to site for 30 to 60 seconds.)			
16- Help patient to comfortable position.			

17- Discard uncapped needle or needle enclosed in safety shield and attached syringe into puncture- and leak-proof receptacle.			
18- Remove gloves and perform hand hygiene.			
19- Stay with patient for several minutes and observe for any allergic reactions.			

Nursing instructor's signature: _____ Date: _____

Skill: Application of ECG Leads

Equipment Required:

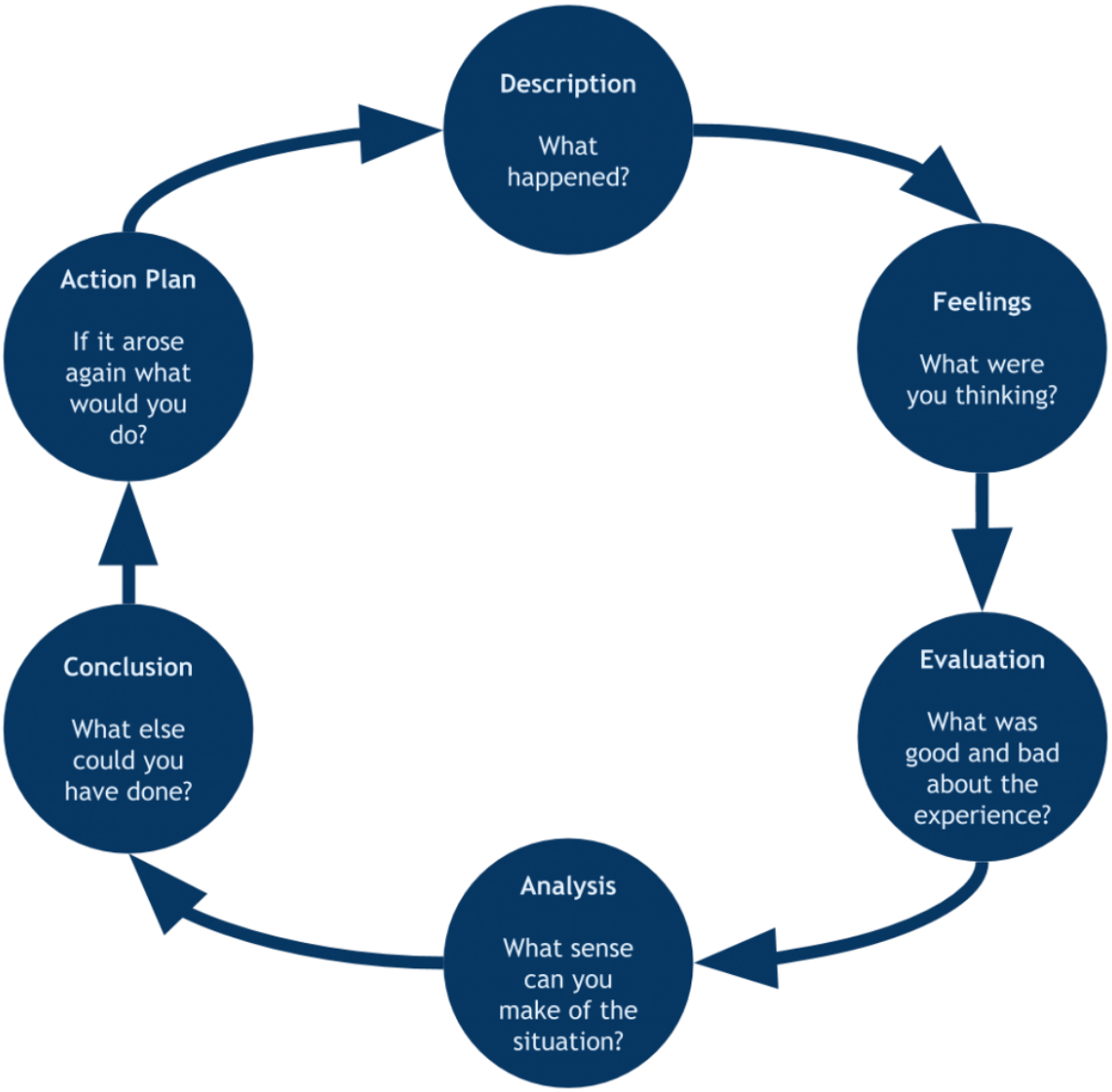
- ECG machine with leads
- Disposable ECG electrodes
- Alcohol swabs or soap and water
- Razor (if necessary to remove hair)
- Gloves (non-sterile)
- Privacy drape or gown
- Documentation sheet or electronic health record

Checklist:

Sr. #	Tasks	Yes	No	Comments
1.	Introduce self and verify the client's identity using two identifiers			
2.	Explain the procedure and its purpose to the client			
3.	Perform hand hygiene and apply gloves			
4.	Provide privacy using curtains or screens			
5.	Position the client supine or semi-recumbent with chest exposed			
6.	Inspect skin for cleanliness, hair, or moisture at electrode sites			
7.	Clean electrode sites with alcohol swabs or soap and water and allow to dry			
8.	Shave electrode areas if excessive hair is present (with consent)			
9.	Attach ECG electrodes to lead wires and apply to correct anatomical locations			
10.	**Chest (Precordial) Lead Placement:**			
11.	- V1: 4th intercostal space at right sternal border			
12.	- V2: 4th intercostal space at left sternal border			
13.	- V3: Midway between V2 and V4			
14.	- V4: 5th intercostal space, midclavicular line			
15.	- V5: Same horizontal level as V4, anterior axillary line			

16.	- V6: Same horizontal level as V4, midaxillary line			
17.	**Limb Lead Placement (RA, LA, RL, LL):** Outer upper arms and legs or inner wrists and ankles			
18.	Ensure all leads are firmly attached and the client is relaxed			
19.	Start ECG recording and monitor trace for artifact or error			
20.	Remove electrodes if not continuous monitoring is required and clean the skin			
21.	Dispose of used materials properly and remove gloves			
22.	Perform hand hygiene			
23.	Document the procedure, date, time, and any observations			

Reflection/ Critical Incident Analysis



Gibbs' Reflective Cycle 1998

CASE STUDY FORMAT

XVII. INTRODUCTION

Background/scenario of the case.

XVIII. BIOGRAPHIC DATA

Name

Address

Age

Gender

Race

Marital Status

Occupation

Religious orientation

Health care financing and usual source of medical care

XIX. CHIEF COMPLAINT OR REASON FOR VISIT

XX. NURSING HEALTH HISTORY

F. History of Present Illness

G. Past Medical History

g) Childhood diseases

h) Immunizations

i) Allergies

j) Accidents and injuries

k) Hospitalization

l) Medication

H. Family History of Illness (use Genogram)

I. Obstetric History (for OB cases only; with Assessment Guide)

J. Developmental History (for Pediatric cases only; with Assessment Guide)

XXI. FUNCTIONAL HEALTH PATTERN (with guide questionnaire)

12. Health Perception and Health Management Pattern

13. Nutrition and Metabolic Pattern

14. Elimination Pattern

15. Activity-Exercised Pattern (use Barthel index)

16. Sleep-rest Pattern

17. Cognitive-perceptual Pattern
18. Self-perception and self-control Pattern
19. Role-relationship Pattern
20. Sexuality-reproductive Pattern
21. Coping-stress tolerance Pattern
22. Value-belief Pattern

Interpretation:
Analysis: (with reference)

XXII. REVIEW OF SYSTEM (all subjective complaints)

XXIII. PHYSICAL ASSESSMENT (all objective findings; indicate date performed; Head to Toe Assessment)

3. General Survey (Short Paragraph)
4. Vital Signs

BODY PART (Technique used)	NORMAL FINDINGS	ACTUAL FINDINGS	INTERPRETATION / ANALYSIS w/ Reference

XXIV. ANATOMY & PHYSIOLOGY

XXV. DIAGNOSTIC / LABORATORY STUDIES (Table)

NAME OF TEST / PROCEDURE	DATE DONE	INDICATION FOR THE TEST / PROCEDURE	NORMAL VALUE	ACTUAL RESULT / FINDINGS	SIGNIFICANCE OF THE RESULT / FINDINGS

XXVI. SURGICAL PROCEDURE (Operative worksheet, if any)

XXVII. PATHOPHYSIOLOGY (Present in Schematic Diagram; Mind Mapping)

XXVIII. DRUG STUDY / IV INFUSIONS, BLOOD TRANFUSIONS, TREAMENTS GIVEN

Drug Study

Drug Order (Generic, Name, Dosage, Route, Frequency)	Trade / Brand Name	Pharmacologic Action Of Drug	Indication And Contraindications	Adverse Effects Of The Drug	Desired Action On Your Client	Nursing Responsibilities / Precautions

Treatments Given

Treatment / Infusion	Classification	Indication	Contraindication	Nursing Responsibilities / Precautions

XXIX. COURSE IN THE WARD (narrative form)

- Summary of day to day medical/nursing management from the date of admission up to the time case study was done
- Patient's Status:
    a. General condition of the client (ex. LOC, VS, and other Subjective & Objective, complaint during the day)
    b. 4 D's with inference / analysis:
        - Diet
        - Drugs/IVF
        - Lab/Diagnostics procedure
        - Disposition

XXX. PRIORITIZED LIST OF NURSING PROBLEMS (Table)

- Prioritized using ABC's and Maslow's Hierarchy of Needs

Date	Nursing Problems Identified	Cues	Justification

XXXI. NURSING CARE PLAN

Assessment	Nursing Diagnosis	Planning	Implementation	Rationale	Evaluation

XXXII. PROPOSED / DISCHARGE PLAN (to be submitted by students whose patients are for discharge)

- M - Medications to take at home
- E - Exercises
- T - Treatment
- H - Health Teachings
- O - Out - patient follow-up
- D - Diet
- S - Spiritual / Sexual activity (optional)

References:

24. Carpinito L. J. (1998). *Nursing Care Plans & Documentation: Nursing Diagnosis and Collaborative Problem* (3rd ed.) Philadelphia: Lippincott
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28. Potter, P. A & Perry, A. G. (2003). *Basic Nursing: Essentials for Practice* (5th ed.) St. Louis: Mosby.
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SEMESTER-III

Adult Health Nursing-I (Clinical Practicum) 02 Cr. Hours

Clinical Training 4 Cr. Hours

Course Description:

This course aimed to furnish learners with the knowledge and skills to care for an adult patient admitted to the hospital with a disease condition. It emphasizes on effective utilization of nursing process to provide care to the client and facilitate them in restoration of optimum health. Assessment Tool has been utilized for recognizing the responses towards disease process on individuals and their families and plan care accordingly. Specific nursing skills and procedures necessary to care for ill patients are included. Learners are exposed to the variety of clinical settings to integrate theory into practice under supervision.

Clinical Rotation plan:

This semester will be of 16/22 weeks, the student nurse will go to clinical rotation in batches to ensure 24/7 clinical placement at hospitals in all three shifts to observe, learn and perform skills under the supervision of clinical instructor.

CLINICAL OBJECTIVES

By the end of this course, students will be able to:

9. Successfully insert an Intravenous (IV) catheter using proper technique and aseptic practices
10. Administer a blood transfusion safely, including verification of compatibility and monitoring for adverse reactions.
11. Accurately calculate and administer IV medications while ensuring patient safety and monitoring for any adverse effects
12. Perform Nasogastric (NG) tube insertion and removal with proficiency, ensuring correct placement and patient comfort.
13. Manage NG tube feeding, including calculation of feeding rates, administration of feedings, and patient education on care and maintenance
14. Successfully catheterize male and female patients using sterile technique and minimizing the risk of complications.
15. Safely remove a urinary catheter, provide post-removal care instructions, and monitor for any complications
16. Provide comprehensive care for patients with ostomies, including assessment, appliance application, and patient education on ostomy management

Evaluation Criteria:

S No	Clinical Portfolio Content	%	Frequency
1.	Clinical Objectives	***10%***	Weekly
2.	History Taking Performa	***15%***	20
3.	Physical Examination Checklists	***15%***	20
4.	Nursing Care Plan	***10%***	20
5.	Nursing Skills Checklists	***20%***	10
6.	Reflection/ Critical Incident Analysis	***10%***	Weekly
7.	Case Study	***20%***	01

Clinical Objectives Form

Student Name: _____ Faculty: _____

Clinical placement:_____ Date: _____

Clinical Objectives	Strategies	Evaluation

History Taking Proforma

Student Name: _____Group #: _____Faculty: _____

1. Document the client presenting complaint, Functional Health Patterns and Review of Systems findings and draw family genogram

Checklist for taking a client health history

Interviewing Checklist	Satisfactory	Need to improve
Introduced self, purpose, and agenda		
Arranged for proper environment (position, distance, light)		
Asks open ended question (to explore chief concern)		
Explores information about chief concern (COLDERRAA) Character, Onset, Location, Duration, Exacerbation, Radiation, Relief, Antecedent, Associated factors		
Proceed from general to specific, follows cues, probes positive finding, asks clear, logical questions, one at a time		
Uses effective communication techniques (Facilitation, Clarification, Paraphrasing, Transitions, Summarization)		
demonstrates appropriate verbal / nonverbal gesture (Eye contact, voice tone, active listening, hand gestures)		
Avoids being non therapeutic (asking why questions, biased, leading, judgmental, false reassurance, changing topic)		
Explores client past history of any illness		
Explores client family history		
Explores client functional abilities & life style patterns		
Explores Review of System checklist efficiently		

Faculty comments:

Nursing Care Plan

Assessment	Nursing Diagnosis	Goal	Planning	Implementation	Rationale	Evaluation
Subjective Data						
Objective Data						

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S #	Skills	Level of competency	Minimum Frequency
1.	IV Cannulation	1-5	
2.	Blood transfusion and related products	1-5	
3.	IV Medications	1-5	
4.	NG Tube insertion	1-5	
5.	NG Tube removal	1-5	
6.	NG tube feeding	1-5	
7.	Male urinary catheterization	1-5	
8.	Female Urinary Catheterization	1-5	
9.	Removal of urinary catheter	1-5	
10.	Ostomy Care	1-5	
11.	Arterial Blood Sampling	1-5	
12.	Assessment of Edema	1-5	
13.	Bladder Irrigation	1-5	
14.	Pap Smear	1-5	
15.	Collection of Urine Specimen	1-5	
16.	Ring Pessary Insertion	1-5	

No	Procedures	Clinical Experience					
		Skill Lab Instructor Signature	Date	Ward Sister Signature	Date	Clinical instructor Signature	Date
1.	IV Cannulation						
2.	Blood transfusion						

	and related products						
3.	**IV Medications**						
4.	**NG Tube insertion**						
5.	**NG Tube removal**						
6.	**NG tube feeding**						
7.	**Male urinary catheterization**						
8.	**Female Urinary Catheterization**						
9.	**Removal of urinary catheter**						
10.	**Ostomy Care**						
11.	**Arterial Blood Sampling**						
12.	**Assessment of Edema**						
13.	**Bladder Irrigation**						
14.	**Pap Smear**						
15.	**Collection of Urine Specimen**						
16.	**Ring Pessary Insertion**						

Nursing Skills Checklists

Intravenous Cannulation

Equipment required:

- **IV cannula** (of appropriate size, based on patient need)
- **Tourniquet** (to help engorge the vein for easier access)
- **Antiseptic solution or alcohol swabs** (for cleaning the insertion site)
- **Sterile gloves** (to maintain asepsis)
- **Gauze pads or sterile dressings** (to cover the insertion site post-cannulation)
- **Adhesive tape or transparent dressing** (to secure the cannula in place)
- **Syringe and saline flush** (to confirm vein patency and ensure proper placement)
- **IV extension set or IV tubing** (for connection to IV fluids or medications)
- **Sharps disposal container** (for safe disposal of the needle after insertion)
- **IV fluid or medication** (depending on the purpose of cannulation)

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Gathered and prepared all necessary equipment (IV cannula, tourniquet, antiseptic solution, sterile gloves, gauze, etc.)			
2.	Performed hand hygiene and wore sterile gloves			
3.	Applied the tourniquet correctly			
4.	Selected an appropriate vein			
5.	Cleaned the insertion site with antiseptic			
6.	Inserted the IV cannula at the correct angle (15-30 degrees)			
7.	Observed blood return in the cannula chamber			
8.	Advanced the cannula and removed the needle correctly			
9.	Confirmed cannula placement by aspirating and flushing with saline			
10.	Secured the IV cannula with sterile dressing or adhesive tape			
11.	Removed the tourniquet			

12.	Disposed of sharps in a sharp's container			
13.	Monitored the insertion site for signs of complications (e.g., swelling, redness)			
14.	Documented the procedure and patient response			

Nursing instructor's signature: _____ Date: _____

Blood Transfusion and Related Products

Equipment Required:

- IV cannula (of appropriate size, based on patient need)
- Tourniquet (to help engorge the vein for easier access)
  - **Antiseptic solution or alcohol swabs** (for cleaning the insertion site)
  - **Sterile gloves** (to maintain asepsis)
  - **Gauze pads or sterile dressings** (to cover the insertion site post-cannulation)
  - **Adhesive tape or transparent dressing** (to secure the cannula in place)
  - **Syringe and saline flush** (to confirm vein patency and ensure proper placement)
  - **IV extension set or IV tubing** (for connection to IV fluids or medications)
  - **Sharps disposal container** (for safe disposal of the needle after insertion)
  - **IV fluid or medication** (depending on the purpose of cannulation)

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Obtained blood component from the blood bank within 30 minutes of release			
2.	Checked blood bag for contamination (clumping, gas bubbles, discoloration) and leaks			
3.	Verified patient, blood product, and type with another qualified person			
4.	Identified patient using two identifiers (name, date of birth, or account number)			
5.	Verified that the transfusion record and patient's ID match			
6.	Ensured that blood type on record matches with the blood bag			
7.	Checked patient's and donor's blood type and Rh type compatibility			
8.	Checked expiration date and time on the blood unit			
9.	Reviewed purpose of transfusion with the patient and instructed them to report any symptoms			
10.	Ensured that the urine drainage container was empty or patient had voided			
Administration				
11.	Performed hand hygiene and applied clean gloves			
12.	Opened Y-tubing blood administration set for a single unit or multiple units			
13.	Set all clamps to the "off" position			
14.	Spiked the 0.9% normal saline bag and primed the tubing			
15.	Maintained clamps as required to prime tubing and closed all clamps			

16.	Prepared the blood component, agitated the bag, and spiked it with the Y-tubing			
17.	Attached primed tubing to patient's vascular access device (VAD)			
18.	Initiated infusion at 2 mL/min during the first 15 minutes			
19.	Remained with the patient during the first 15 minutes of transfusion			
20.	Monitored the patient's vital signs at 5 minutes, 15 minutes, and every 30 minutes			
21.	Regulated transfusion rate according to orders if no reaction occurred			
22.	Cleared IV line with 0.9% normal saline after blood had infused			
23.	Disposed of all supplies according to agency policy			
24.	Removed gloves and performed hand hygiene			

Nursing instructor's signature: _____ Date: _____

Administering Intravenous Medications

Equipment Required:

- Adhesive tape
- Antiseptic swab
- Clean gloves
- IV pole
- Tourniquet
- Puncture-proof container
- IV catheter (A #20- to #22-gauge catheter is indicated for most adults. Always have an extra catheter and ones of different sizes available.)
- Medication administration record (MAR)

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Prepare medications for one patient at a time using aseptic technique and avoiding distractions. Check the label of medication carefully with MAR or computer printout 2 times when preparing medication.			
2.	Take medication(s) to the patient at the correct time. Medications that require			

	exact timing include stat, first-time or loading doses, and one-time doses.			
3.	Close room curtain or door.			
4.	Identify the patient using two identifiers (i.e., name and birthday or name and account number) according to agency policy.			
5.	At the patient's bedside, again compare the MAR or computer printout with the names of medications on the medication labels and the patient's name. Ask the patient if they have any allergies.			
6.	Discuss the purpose of each medication, its action, and possible adverse effects. Allow the patient to ask any questions. Explain that you will give the medication through an existing IV line. Encourage the patient to report any symptoms of discomfort at the site.			
7.	Administer the infusion.			

Piggyback Infusion

Sr. #	Tasks	Yes	No	Comments
1.	Connect infusion tubing to medication bag. Fill tubing by opening regulator flow clamp. Once tubing is full, close clamp and cap end of tubing.			
2.	Hang piggyback medication bag above level of primary fluid bag. (Use hook to lower main bag.)			
3.	Wipe off needleless port of main IV line with alcohol swab, allow to dry.			
4.	Insert cannula tip of piggyback infusion tubing into the appropriate connector on the upper Y-port of the primary infusion line.			
5.	Regulate flow rate of medication solution by adjusting regulator clamp or IV pump infusion rate.			
6.	Continuous infusion: Check flow rate of primary infusion after piggyback solution is empty.			
7.	Normal saline lock: Disconnect tubing, clean port with alcohol, and flush IV line with 2 to 3 mL of sterile 0.9% sodium chloride.			

8.	Regulate continuous main infusion line to ordered rate.			
9.	Leave IV piggyback and tubing in place for future drug administration or discard in puncture- and leak-proof container.			

Volume-Control Administration Set

Sr. #	Tasks	Yes	No	Comments
1.	Fill Volutrol with desired amount of IV fluid (50 to 100 mL) by opening clamp between Volutrol and main IV bag.			
2.	Close clamp and check that air vent on Volutrol chamber is open.			
3.	Clean injection port on top of Volutrol with antiseptic swab.			
4.	Remove needle cap or sheath, insert needleless syringe or syringe needle through port, and inject medication. Gently rotate Volutrol between hands.			
5.	Regulate IV infusion rate to allow medication to infuse in the recommended time.			
6.	Label Volutrol with medication name, dosage, total volume (including diluent), and time of administration.			
7.	If patient is receiving continuous IV infusion, check infusion rate after Volutrol infusion is complete.			
8.	Dispose of uncapped needle or needle enclosed in safety shield and syringe in a puncture- and leak-proof container. Discard supplies appropriately. Perform hand hygiene.			

Mini-Infusion Administration

Sr. #	Tasks	Yes	No	Comments
1.	Connect prefilled syringe to mini-infusion tubing; remove end cap of tubing.			
2.	Apply pressure to syringe plunger, allowing tubing to fill with medication.			
3.	Place syringe into mini-infusion pump and secure it properly on IV pole.			
4.	Existing IV line: Wipe off needleless port on main IV line with alcohol swab, allow to dry, and insert tip of mini-infusion tubing through the port.			

5.	Set pump to deliver medication within the recommended time and press button to start infusion.			
6.	Main IV infusion: Check flow rate after infusion and regulate as needed.			
7.	Normal saline lock: Disconnect tubing, clean port, and flush IV line with 2 to 3 mL of sterile 0.9% sodium chloride.			
8.	Dispose of supplies in a puncture- and leak-proof container.			
9.	Remove gloves and perform hand hygiene.			
10.	Stay with the patient and observe for any allergic reactions for several minutes.			

Nursing instructor's signature: _____ Date:

_____

Insertion of NG Tube

Equipment Required:

- Nasogastric tube of appropriate size (8–18 French)
- Stethoscope
- Water-soluble lubricant
- Normal saline solution or sterile water, for irrigation
- Tongue blade
- Irrigations set, including a Toomey (20–50 mL)
- Flashlight
- Non-allergenic tape (1" wide)
- Tissues
- Glass of water with straw
- Topical anesthetic (lidocaine spray or gel) (optional)
- Clamp
- Suction apparatus (if ordered)
- Bath towel or disposable pad
- Emesis basin
- Safety pin and rubber band
- Nonsterile disposable gloves
- Additional PPE, as indicated
- Tape measure, or other measuring device
- Skin barrier
- pH paper

Checklist

Sr. #	Tasks	Yes	No	Comments
10.	Checked the medical order for insertion of the NG tube			
11.	Identified the patient using two identifiers			
12.	Performed hand hygiene and applied PPE, if indicated			
13.	Introduced yourself and informed the patient about the procedure			
14.	Gathered necessary equipment and selected an appropriate NG tube			
15.	Closed the patient's bedside curtain or door for privacy			
16.	Raised the bed to a comfortable height and positioned the patient in a high Fowler's position			
17.	Covered the patient's chest and placed an emesis basin and tissues within reach			
18.	Measured and marked the distance for tube insertion			
19.	Applied gloves and lubricated the tip of the tube with a water-soluble lubricant			
20.	Inserted the tube into the selected nostril with the patient's head tilted slightly back			
21.	Advanced the tube as the patient swallowed, with their chin tucked to their chest			
22.	Stopped and removed the tube if the patient showed signs of distress			
23.	Aspirated a small amount of gastric content to confirm placement			
24.	Measured the pH of the aspirated fluid			
25.	Checked the color and consistency of the aspirated contents			
26.	Confirmed the tube's placement with an X-ray			
27.	Applied a skin barrier to the nose and secured the tube			
28.	Clamped the tube and attached it to suction if ordered			
29.	Secured the tube to the patient's gown			
30.	Assisted with or provided oral hygiene at 2- to 4-hour intervals			
31.	Removed equipment, positioned the patient comfortably, and adjusted the bed and side rails			
32.	Removed PPE, if used, and performed hand hygiene			

Nursing instructor's signature: _____ Date:_____

Removing NG tube

Equipment Required:

- Tissues
- 50-mL syringe (optional)
- Nonsterile gloves
- Additional PPE, as indicated
- Stethoscope
- Disposable plastic bag
- Bath towel or disposable pad
- Normal saline solution for irrigation (optional)
- Emesis basin

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Checked the medical order for removal of the NG tube			
2.	Identified the patient using two identifiers			
3.	Performed hand hygiene and applied PPE, if indicated			
4.	Introduced yourself and informed the patient about the procedure			
5.	Closed the patient's bedside curtain or door for privacy			
6.	Raised the bed to a comfortable height and positioned the patient in a high Fowler's position			
7.	Covered the chest with a bath towel or disposable pad and gave an emesis basin and tissues to the patient			
8.	Wore gloves, turned off suction, removed the tube from suction equipment, and unpinned the tube from the patient's gown			
9.	Attached a syringe to the NG tube and flushed it with water or saline, or cleared it with air			
10.	Clamped the tube and instructed the patient to take a deep breath and hold it, then removed the tube carefully while coiling it into a disposable pad			
11.	Disposed of the tube properly, removed gloves, and performed hand hygiene			
12.	Provided mouth care to the patient and assisted them to a comfortable position			

13.	Removed equipment, raised the side rail, and lowered the bed for patient safety			
14.	Put on gloves, measured the amount of nasogastric drainage, and recorded it on the output flow record			
15.	Removed additional PPE, if used, and performed hand hygiene			

Nursing instructor's signature: _____ Date: _____

Nasogastric (NG) Tube Feeding

Equipment Required:

- Prescribed tube feeding formula at room temperature
- Feeding bag or prefilled tube feeding set
- Stethoscope
- Nonsterile gloves
- Additional PPE, as indicated
- Alcohol preps
- Disposable pad or towel
- Asepto or Toomey syringe
- Enteral feeding pump (if ordered)
- Rubber band
- Clamp (Hoffman or butterfly)
- IV pole
- Water for irrigation and hydration as needed
- pH paper
- Tape measure, or other measuring device

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Verified physician's orders and patient's care plan			
2.	Identified the patient using two identifiers			
3.	Performed hand hygiene and put on PPE, if indicated			
4.	Introduced yourself and informed the patient about the procedure			
5.	Closed the patient's bedside curtain or door for privacy			
6.	Raised the bed to a comfortable working height and positioned the patient in a high Fowler's position			
7.	Assessed residual gastric contents by aspirating			

8.	Flushed the NG tube with 30 mL of water before starting the feeding			
9.	Prepared the feeding formula, checking the label for type, expiration date, and temperature			
10.	Administered the feeding via syringe or feeding pump at the prescribed rate			
11.	Flushed the tube with 30 mL of water after feeding			
12.	Kept the head of the bed elevated for at least 30-60 minutes post-feeding			
13.	Monitored the patient for signs of intolerance			
14.	Removed equipment, raised the side rail, and lowered the bed for patient safety			
15.	Removed additional PPE, if used, and performed hand hygiene			

Nursing instructor's signature: _____ Date: _____

Male Urinary Catheterization

Equipment Required:
Sterile catheter kit that contains:

- Sterile gloves
- Sterile drapes (one of which is fenestrated [having a window-like opening])
- Sterile catheter (Use the smallest appropriate-size catheter, usually a 14F to 16F catheter with a 5- to 10-mL balloon.
- Antiseptic cleansing solution and cotton balls or gauze squares; antiseptic swabs
- Lubricant
- Forceps
- Prefilled syringe with sterile water (sufficient to inflate indwelling catheter balloon)
- Sterile basin (usually base of kit serves as this)
- Sterile specimen container (if specimen is required)
- Flashlight or lamp
- Waterproof, disposable pad
- Sterile, disposable urine collection bag and drainage tubing (may be connected to catheter in catheter kit)
- Velcro leg strap or tape
- Disposable gloves
- Additional PPE, as indicated
- Washcloth and warm water to perform perineal hygiene before and after catheterization

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Reviewed chart for any limitations in physical activity and confirmed medical order for indwelling catheter insertion			
2.	Brought catheter kit and necessary equipment to the bedside			
3.	Performed hand hygiene and put on PPE, if indicated			
4.	Identified the patient using two identifiers			
5.	Closed the curtains/door, discussed the procedure with patient, assessed ability to assist, and checked for allergies			
6.	Provided good lighting and placed a trash receptacle within reach			
7.	Adjusted bed to a comfortable height and stood on the appropriate side (right for right-handed, left for left-handed)			
8.	Positioned patient with thighs slightly apart, draped the patient, and placed waterproof pad under them			
9.	Put on clean gloves and cleaned the genital area appropriately			
10.	Prepared the urine drainage setup if a separate collection system was used			
11.	Opened sterile catheterization tray using sterile technique			
12.	Put on sterile gloves and placed sterile drape and fenestrated drape on patient			
13.	Placed catheter set on sterile drape on patient's legs			
14.	Opened all supplies and prepared equipment (antiseptic solution, lubricant, specimen container if needed)			
15.	Placed drainage end of catheter in receptacle and positioned it on the sterile field			
16.	Lifted the penis with non-dominant hand, cleaned with cotton balls/swabs in a circular motion, and discarded swabs			
17.	Held penis with slight tension, inserted lubricant into urethra, and maintained sterility			
18.	Inserted catheter while patient bore down, advanced to bifurcation, and managed resistance appropriately			
19.	Held catheter at meatus, inflated balloon, and gently pulled catheter back into			

	place			
20.	Ensured proper balloon inflation by gently pulling on catheter to feel resistance			
21.	Attached catheter to drainage system if necessary			
22.	Removed equipment, disposed of it, and cleaned perineal area			
23.	Removed gloves and secured catheter tubing to patient's thigh or abdomen with slack for movement			
24.	Assisted patient to comfortable position, covered with bed linens, and lowered bed			
25.	Secured drainage bag below bladder level and ensured no kinks in tubing			
26.	Put on gloves and obtained urine specimen, if needed, labeling it correctly			
27.	Removed gloves and PPE, performed hand hygiene			

Nursing instructor's signature: _____ Date: _____

Female Urinary Catheterization

Equipment Required:
Sterile catheter kit that contains:

- Sterile gloves
- Sterile drapes (one of which is fenestrated [having a window-like opening])
- Sterile catheter (Use the smallest appropriate-size catheter, usually a 14F to 16F catheter with a 5- to 10-mL balloon.
- Antiseptic cleansing solution and cotton balls or gauze squares; antiseptic swabs
- Lubricant
- Forceps
- Prefilled syringe with sterile water (sufficient to inflate indwelling catheter balloon)
- Sterile basin (usually base of kit serves as this)
- Sterile specimen container (if specimen is required)
- Flashlight or lamp
- Waterproof, disposable pad
- Sterile, disposable urine collection bag and drainage tubing (may be connected to catheter in catheter kit)
- Velcro leg strap or tape
- Disposable gloves
- Additional PPE, as indicated

- Washcloth and warm water to perform perineal hygiene before and after catheterization

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Reviewed the patient's chart for any physical limitations and confirmed the medical order for indwelling catheter insertion			
2.	Brought the catheter kit and necessary equipment to the bedside			
3.	Performed hand hygiene and put on PPE, if indicated			
4.	Identified the patient using two identifiers			
5.	Closed the curtains/door, discussed the procedure with patient, assessed ability to assist, and checked for allergies (latex, iodine)			
6.	Provided good lighting and placed a trash receptacle within reach			
7.	Adjusted the bed to a comfortable working height and positioned yourself according to the patient's handedness			
8.	Positioned the patient in the dorsal recumbent or Sims' position, draped the patient, and placed waterproof pad under them			
9.	Put on clean gloves and cleaned the perineal area using proper technique (front to back) and performed hand hygiene again			
10.	Prepared the urine drainage system and secured it to the bed frame			
11.	Opened the sterile catheterization tray using sterile technique			
12.	Put on sterile gloves and unfolded the sterile drape, placing it under the patient with protected gloved hands			
13.	Positioned the fenestrated sterile drape over the perineal area			
14.	Placed sterile tray on drape between patient's thighs			
15.	Opened all supplies, prepared antiseptic solution and lubricated the catheter tip			
16.	Lubricated 1 to 2 inches of catheter tip			
17.	With non-dominant hand, spread labia to identify the meatus and maintained separation throughout the procedure			
18.	Cleaned one labial fold, then the other, and finally the meatus with antiseptic, using a new swab for each			

	stroke			
19.	Positioned the catheter drainage end in the receptacle or prepared it in the sterile field			
20.	Inserted the catheter 2-3 inches into the urethra until urine appeared, then advanced another 2-3 inches			
21.	Inflated the catheter balloon with the entire volume of sterile water provided			
22.	Gently pulled on the catheter to feel resistance after balloon inflation			
23.	Attached the catheter to the drainage system, if not pre-attached			
24.	Removed equipment and disposed of it properly; cleaned and dried the perineal area			
25.	Removed gloves and secured catheter tubing to the patient's thigh with Velcro strap, allowing for movement			
26.	Assisted the patient into a comfortable position, covered them with linens, and placed the bed in the lowest position			
27.	Secured drainage bag below bladder level and checked for kinks in tubing or interference with bed rails			
28.	Put on clean gloves, obtained a urine specimen if needed, labeled it, and sent it to the lab			
29.	Removed gloves and PPE, if used, and performed hand hygiene			

Nursing instructor's signature: _____ Date: _____

Removing an Indwelling Catheter

Equipment Required:

- Syringe sufficiently large to accommodate the volume of solution used to inflate the balloon (balloon size/inflation volume is printed on the balloon inflation valve on the catheter at the bifurcation)
- Waterproof, disposable pad
- Disposable gloves
- Additional PPE, as indicated
- Washcloth and warm water to perform perineal hygiene after catheter removal

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Confirmed the order for catheter removal in the medical record			
2.	Brought necessary equipment to the bedside			

3.	Performed hand hygiene and put on PPE, if indicated			
4.	Identified the patient using two identifiers			
5.	Closed curtains/door, provided privacy, explained the procedure to the patient, and evaluated ability to assist			
6.	Adjusted bed to comfortable working height and positioned yourself according to patient's handedness			
7.	Positioned the patient for catheter removal, draped appropriately, and placed waterproof pad under/over thighs			
8.	Removed the leg strap, tape, or device securing the catheter			
9.	Inserted syringe into balloon inflation port and allowed water to return by gravity or aspirated the sterile water			
10.	Asked patient to take slow deep breaths, slowly and gently removed the catheter, placed it on the waterproof pad, and wrapped it			
11.	Washed and dried the perineal area as needed			
12.	Removed gloves, assisted patient to a comfortable position, covered with linens, and lowered the bed			
13.	Put on clean gloves, removed equipment, disposed of it according to policy, and noted characteristics and amount of urine in drainage bag			
14.	Removed gloves and PPE, if used, and performed hand hygiene			

Nursing instructor's signature: _____ Date: _____

Ostomy Care

Equipment Required:

- Ostomy pouch and accessories: As per patient's type of ostomy.
- Clean, disposable gloves.
- Skin barrier paste or powder.
- Stoma cleanser and water.
- Absorbent pads or towels.
- Waste disposal bag.

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Confirmed the care plan and orders for the patient's ostomy care			

2.	Gathered all necessary supplies and brought them to the bedside			
3.	Performed hand hygiene and put on clean gloves			
4.	Identified the patient and explained the procedure			
5.	Positioned the patient comfortably for ostomy care			
6.	Carefully removed the old ostomy pouch and assessed the stoma and surrounding skin			
7.	Cleaned the skin around the stoma with stoma cleanser and water			
8.	Applied a skin barrier paste or powder if needed to protect the skin			
9.	Attached a new ostomy pouch, ensuring a secure fit around the stoma			
10.	Disposed of the used pouch and materials according to facility policy			
11.	Documented the procedure, including the condition of the stoma and skin, and the type of ostomy pouch used			

Nursing instructor's signature: _____ Date: _____

Arterial Blood Sampling

Equipment Required:

- **Heparinized arterial blood gas (ABG) syringe**
- **Antiseptic solution** (e.g., chlorhexidine or alcohol swabs)
- **Sterile gloves**
- **Sterile gauze pads or cotton balls**
- **Adhesive bandage or tape**
- **Sharps container**
- **Ice pack or transport container** (if sample analysis is delayed)
- **Local anesthetic** (optional, e.g., lidocaine with syringe and needle)
- **Tourniquet** (not usually used but may assist in locating brachial/femoral sites)
- **Towel or underpad** (to protect bedding/clothing)
- **Labeling materials** (patient label, pen/marker)
- **Biohazard bag** (for sample transport)
- **Watch or timer** (for post-procedure pressure time)

Checklist

Sr. #	Tasks	Yes	No	Comments
	Preparation Phase			

1	Gather and organize all required equipment.			
2	Perform hand hygiene.			
3	Introduces self and explains the procedure to patient clearly			
4	Confirm patient identity.			
5	Perform Allen’s test if using radial artery.			
6	Wear gloves and maintained aseptic technique.			
	Procedure Phase			
7	Select appropriate site and palpates the artery.			
8	Clean site with antiseptic using correct technique.			
9	Insert needle at correct angle (30–45°).			
10	Allow arterial pressure to fill the syringe (no aspiration).			
11	Remove needle promptly and applies firm pressure.			
12	Label sample correctly and places on ice (if needed).			
13	Disposes of sharps properly.			
	Post-Procedure Phase			
14	Monitor site for bleeding or complications.			
15	Ensure patient comfort and safety.			
16	Document procedure accurately.			
17	Maintain patient confidentiality and professionalism.			

Assessment of Edema

Equipment Required:

- Non-sterile gloves
- Measuring tape

- Pen and documentation sheet
- Skin marker (optional)
- Weighing scale
- Camera or mobile device (optional, if permitted)

Checklist

Sr. #	Tasks	Yes	No	Comments
1	Performs hand hygiene and wears gloves			
2	Introduces self and explains the procedure to patient			
3	Observes affected area for swelling, color changes			
4	Uses measuring tape correctly (if needed)			
5	Palpates area gently and presses firmly for 5 seconds			
6	Accurately identifies pitting or non-pitting edema			
7	Assigns correct pitting grade (1+ to 4+)			
8	Notes symmetry and compares with opposite limb			
9	Assesses for pain, redness, or warmth			
10	Properly documents findings (site, grade, type)			
11	Maintains patient comfort and privacy			

Bladder Irrigation

Equipment Required:

- Sterile irrigation solution (e.g., normal saline)
- Irrigation tubing and solution bag (for continuous irrigation)
- 3-way Foley catheter (for continuous irrigation)
- 60 mL catheter-tipped syringe (for intermittent/manual irrigation)
- Sterile gloves
- Antiseptic solution (for cleaning insertion site)
- Sterile drape and dressing
- Kidney tray
- Waste disposal bag
- IV pole (for hanging irrigation solution if continuous)
- Lubricant (if catheter insertion is needed)
- Clamp (for tubing, if needed)

Checklist

Sr. #	Tasks	Yes	No	Comments
1	Introduces self and explains the procedure to patient			
2	Performs hand hygiene and wears sterile gloves			
3	Gathers and checks all necessary equipment			
4	Positions patient appropriately and ensures privacy			
5	Checks catheter placement and balloon inflation status			
6	Connects irrigation solution to correct catheter port			
7	Regulates irrigation flow (continuous) or uses syringe correctly (manual)			
8	Observes return flow for color, clarity, and clots			
9	Maintains aseptic technique throughout			
10	Documents procedure, solution used, amount in/out, findings			

Pap Smear

Equipment Required:

- Vaginal speculum (appropriate size)
- Water-based lubricant
- Cervical brush/spatula (e.g., Ayre's spatula)
- Cytology specimen container (liquid-based or glass slide)
- Fixative spray or transport medium (for slide samples)
- Gloves (non-sterile for external exam, sterile for internal)
- Gown and drape for patient privacy
- Light source or exam lamp
- Cotton swabs or gauze (for cleaning cervix if needed)
- Waste disposal bag
- Label and lab request form

Checklist

Sr. #	Tasks	Yes	No	Comments
1	Introduces self and explains the procedure to patient			
2	Performs hand hygiene and wears appropriate gloves			
3	Gathers and organizes all necessary equipment			
4	Ensures privacy, provides gown, and positions patient properly			
5	Inserts speculum gently and correctly			
6	Uses brush/spatula to collect sample from cervix			
7	Transfers sample to slide or liquid container correctly			
8	Applies fixative if needed			
9	Labels sample and completes documentation accurately			
10	Provides aftercare instructions and ensures patient comfort			

Urine specimen collection

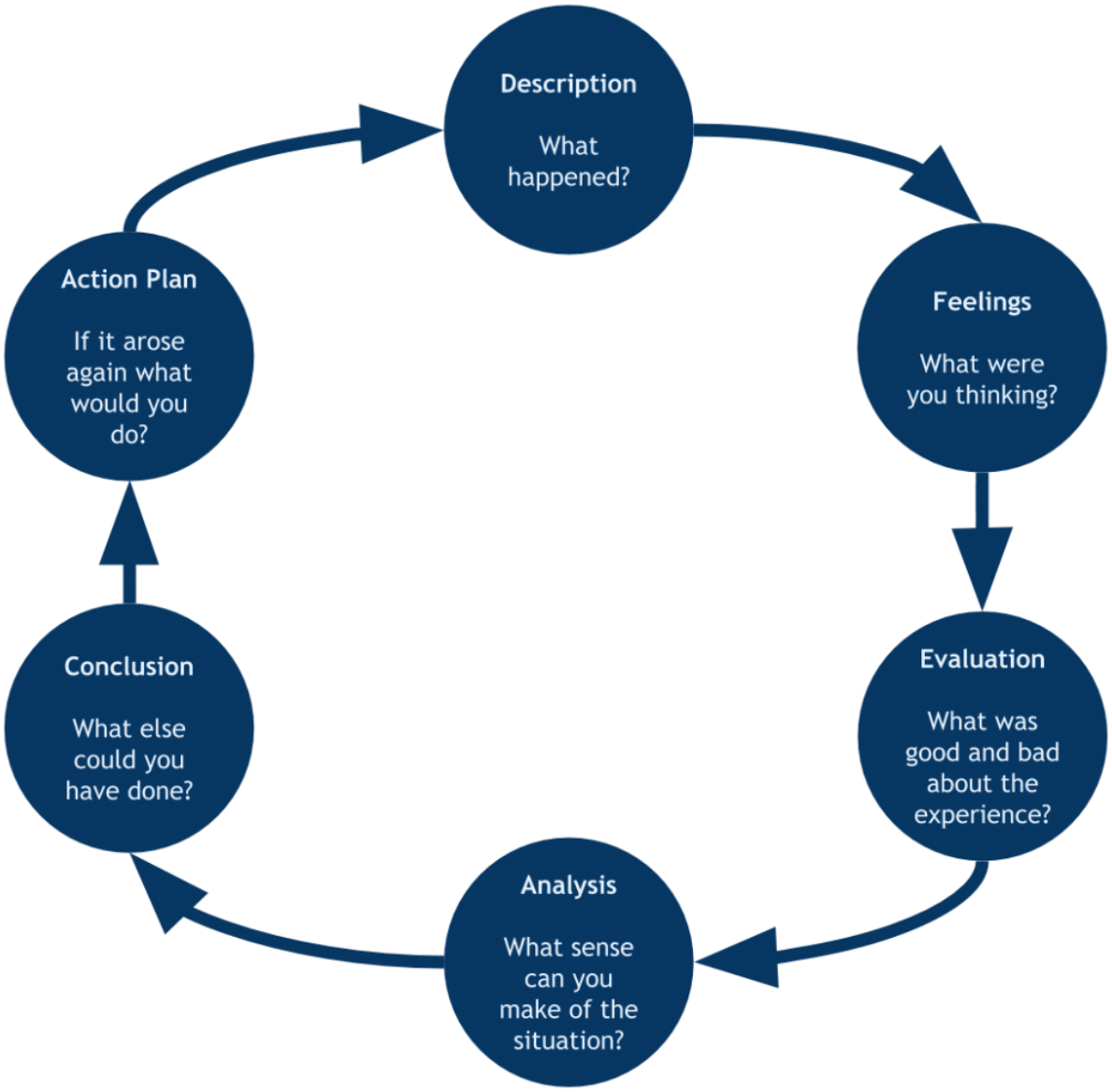
Equipment Required:

- Sterile urine specimen container (with lid)
- Clean gloves (non-sterile)
- Antiseptic wipes or swabs
- Urine hat or bedpan (for non-ambulatory patients)
- Label for specimen container
- Laboratory request form
- Biohazard transport bag
- Foley catheter and sterile kit (if from catheter)
- Clamp (if collecting from catheter tubing port)
- Hand hygiene supplies (soap/sanitizer)

Checklist

Sr. #	Tasks	Yes	No	Comments
1	Introduce yourself, explains the procedure to patient and obtains consent.			
2	Performs hand hygiene and wears gloves.			
3	Provides appropriate container and instructions.			
4	Uses aseptic technique (especially for midstream sample).			
5	Assists or guides patient for proper collection (if needed)			
6	Labels container correctly before sending to lab.			
7	Completes lab requisition and documents procedure.			
8	Ensures sample is transported promptly and correctly.			
9	Maintains patient privacy and comfort throughout.			

Reflection/ Critical Incident Analysis



Gibbs' Reflective Cycle 1998

CASE STUDY FORMAT

XXXIII. INTRODUCTION

A. Background of the study
B. Objective (general & specific showing Knowledge, Skills & Attitude)
C. Scope and Delimitation
D. Theoretical Framework

XXXIV. BIOGRAPHIC DATA

Name

Address
Age
Gender
Race
Marital Status
Occupation
Religious orientation
Health care financing and usual source of medical care

XXXV. CHIEF COMPLAINT OR REASON FOR VISIT

XXXVI. NURSING HISTORY (with guide questionnaire)

K. History of Present Illness
L. Past Medical History
   m) Childhood diseases
   n) Immunizations
   o) Allergies
   p) Accidents and injuries
   q) Hospitalization
   r) Medication
M. Family History of Illness (use Genogram)
N. Obstetric History (for OB cases only; with Assessment Guide)
O. Developmental History (for Pediatric cases only; with Assessment Guide)

Note: Assessment guide *used should be attached as annexes at the back of the case study report.*

XXXVII. FUNCTIONAL HEALTH PATTERN (with guide questionnaire)

23. Health Perception and Health Management Pattern
24. Nutrition and Metabolic Pattern
25. Elimination Pattern
26. Activity-Exercised Pattern (use Barthel index)
27. Sleep-rest Pattern
28. Cognitive-perceptual Pattern
29. Self-perception and self-control Pattern
30. Role-relationship Pattern
31. Sexuality-reproductive Pattern
32. Coping-stress tolerance Pattern
33. Value-belief Pattern

Interpretation:
Analysis: (with reference)

XXXVIII. REVIEW OF SYSTEM (all subjective complaints)

XXXIX. PHYSICAL ASSESSMENT (all objective findings; indicate date performed; Head to Toe Assessment; follow IPPA sequence)

5. General Survey (Short Paragraph)

6. Vital Signs

BODY PART (Technique used)	NORMAL FINDINGS	ACTUAL FINDINGS	INTERPRETATION / ANALYSIS w/ Reference

XL. ANATOMY & PHYSIOLOGY

XLI. DIAGNOSTIC / LABORATORY STUDIES (Table)

NAME OF TEST / PROCEDURE	DATE DONE	INDICATION FOR THE TEST / PROCEDURE	NORMAL VALUE	ACTUAL RESULT / FINDINGS	SIGNIFICANCE OF THE RESULT / FINDINGS

XLII. SURGICAL PROCEDURE (Operative worksheet, if any)

XLIII. PATHOPHYSIOLOGY (Present in Schematic Diagram; Mind Mapping)

XLIV. DRUG STUDY / IV INFUSIONS, BLOOD TRANFUSIONS, TREAMENTS GIVEN

Drug Study

DRUG ORDER (Generic, name, dosage, route, frequency)	TRADE / BRAND NAME	PHARMACOLOGIC ACTION OF DRUG	INDICATION AND CONTRAINDICATIONS	ADVERSE EFFECTS OF THE DRUG	DESIRED ACTION ON YOUR CLIENT	NURSING RESPONSIBILITIES / PRECAUTIONS

Treatments Given

TREATMENT / INFUSION	CLASSIFICATION	INDICATION	CONTRAINDICATION	NURSING RESPONSIBILITIES / PRECAUTIONS

XLV. COURSE IN THE WARD (narrative form)

- Summary of day to day medical/nursing management from the date of admission up to the time case study was done
- Patient's Status:
    a. General condition of the client (ex. LOC, VS, and other Subjective & Objective, complaint during the day)
    b. 4 D's with inference / analysis:

- Diet
- Drugs/IVF
- Lab/Diagnostics procedure
- Disposition

XLVI. PRIORITIZED LIST OF NURSING PROBLEMS (Table)

- Prioritized using ABC's and Maslow's Hierarchy of Needs

DATE	NURSING PROBLEMS IDENTIFIED	CUES	JUSTIFICATION

XLVII. NURSING CARE PLAN

CUES (Defining Characteristics of Nursing Diagnosis)	NURSING DIAGNOSIS (Problem & Etiology)	BACKGROUND KNOWLEDGE (Pathophysiology/psychosocial explanation or consequences of the nursing diagnosis)	GOALS AND OBJECTIVES (include long and short term objectives)	NURSING INTERVENTIONS AND RATIONALE	EVALUATION

XLVIII. PROPOSED / DISCHARGE PLAN (to be submitted by students whose patients are for discharge)

- M - Medications to take at home
- E - Exercises
- T - Treatment
- H - Health Teachings
- O - Out - patient follow-up
- D - Diet
- S - Spiritual / Sexual activity (optional)

References:

Berman, A., Snyder, S. J., Levett-Jones, T., Dwyer, T., Hales, M., Harvey, N.,... & Stanley, D. (2018). Kozier and Erb's Fundamentals of Nursing [4th Australian edition].

Lister, S., Hofland, J., Grafton, H., & Wilson, C. (Eds.). (2021). *The Royal Marsden manual of clinical nursing procedures*. John Wiley & Sons.

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Yoost, B. L., Crawford, L. R., & Castaldi, P. (2022). *Study Guide for Fundamentals of Nursing E-Book: Study Guide for Fundamentals of Nursing E-Book*. Elsevier Health Sciences.

SEMESTER-III

Health Assessment-I (Lab)-1 CH

Course Description:

This course aimed to provide nursing students with foundational knowledge and skills to systematically collect and analyze data related to the health status of individuals across the lifespan. Emphasis is placed on developing competency in history-taking, physical examination techniques, and the use of clinical reasoning to identify normal and abnormal findings. Students learn to perform comprehensive and focused assessments using a holistic approach that incorporates physical, psychosocial, cultural, and developmental factors.

Clinical Rotation plan:

This semester will be of 16/22 weeks, the student nurse will go to clinical rotation (in block days) to observe, learn and perform skills under the supervision of clinical instructor.

Objectives: By the end of this course, students will be able to:

5. Develop the ability to conduct a comprehensive health history interview with patients, including gathering relevant information about their medical history, current complaints, social history, and psychosocial factors, while demonstrating empathy and cultural sensitivity.
6. Demonstrate proficiency in assessing the skin, head, and neck by accurately identifying normal variations, abnormalities, and lesions, and effectively documenting findings
7. Successfully perform a thorough examination of the nose, mouth, and pharynx, identifying abnormalities such as nasal congestion, oral lesions, or signs of pharyngeal inflammation, and providing appropriate patient education on oral hygiene practices.
8. Develop competency in conducting a systematic abdominal assessment, including inspection, auscultation, percussion, and palpation, and accurately identifying abdominal landmarks and abnormalities, as well as performing a digital rectal examination and assessing for signs of gastrointestinal disorders or rectal abnormalities.

Clinical Objectives Form

Student Name: _____ Faculty: _____

Clinical placement:_____ Date: _____

Clinical Objectives	Strategies	Evaluation

History Taking Proforma

Student Name: _____Group #: _____Faculty: _____

1. Document the client presenting complaint, Functional Health Patterns and Review of Systems findings and draw family genogram

Checklist for taking a client health history

Interviewing Checklist	Satisfactory	Need to improve
Introduced self, purpose, and agenda		
Arranged for proper environment (position, distance, light)		
Asks open ended question (to explore chief concern)		
Explores information about chief concern (COLDERRAA) Character, Onset, Location, Duration, Exacerbation, Radiation, Relief, Antecedent, Associated factors		
Proceed from general to specific, follows cues, probes positive finding, asks clear, logical questions, one at a time		
Uses effective communication techniques (Facilitation, Clarification, Paraphrasing, Transitions, Summarization)		
demonstrates appropriate verbal / nonverbal gesture (Eye contact, voice tone, active listening, hand gestures)		
Avoids being non therapeutic (asking why questions, biased, leading, judgmental, false reassurance, changing topic)		
Explores client past history of any illness		
Explores client family history		
Explores client functional abilities & life style patterns		
Explores Review of System checklist efficiently		

Faculty comments:

Nursing Care Plan

Assessment	Nursing Diagnosis	Goal	Planning	Implementation	Rationale	Evaluation

Subjective Data

Objective Data

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S #	Skills	Level of competency	Minimum Frequency
1.	Health History taking and interview skills	1-5	
2.	Assessment of Skin, Head/Neck	1-5	
3.	Assessment of Nose, Mouth & Pharynx	1-5	
4.	Assessment of Abdomen, Anus & Rectum	1-5	
5.	Assessment of Breast, axilla & Genitalia	1-5	

No	Procedures	Clinical Experience					
		Skill Lab Instructor Signature	Date	Ward Sister Signature	Date	Clinical instructor Signature	Date

1.	**Health History taking and interview skills**						
2.	**Assessment of Skin, Head/Neck**						
3.	**Assessment of Nose, Mouth & Pharynx**						
4.	**Assessment of Abdomen, Anus & Rectum**						
5.	**Assessment of Breast, axilla & Genitalia**						

Checklists for Physical Examination

Assessment of Skin, Hair and Nails
Equipment Required:

- Millimeter ruler
- Clean gloves
- Magnifying glass

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	**Preparation Phase**			
2.	Prepare necessary equipment.			
3.	Review interview note.			
4.	Explain procedure.			
5.	Conduct general survey.			
6.	Position and drape patient correctly.			
7.	Expose body part to be examined and drape patient			

	appropriately.			
8.	Ensure adequate light.			
9.	Ensure patient privacy			
10.	Wash hands.			
11.	Follow Inspection and Palpation sequence appropriate for this system.			
12.	**Inspect Skin for:** **A.** Color **B.** Thickness **C.** Symmetry Bruises, scars, scratches, wounds, unusual marks **E.** Presence of skin lesions - Location and distribution on body - size - color - Elevation and depth - Content - Border Palpate Skin Lesion Put gloves on and palpate the lesion between the thumb and index finger for: size, mobility, consistency, and tenderness **F.** Edema			
13.	**Palpation (Skin)** Palpate skin for: a. Moisture b. Temperature c. Texture d. Turgor e. Mobility f. Edema			
14.	**Inspection and Palpation (Hair and Scalp)** a. Color b. Distribution c. Quantity d. Hygiene e. Texture f. Presence of Scalp Lesions			
15.	**Inspection (Nails)** Inspect the shape and contour of the nails. a. Surface			

	b. Posterior and Lateral nail folds c. Nail edges d. hygiene Inspect consistency. Inspect color. Measure nail base angle. Test Capillary Refill.			
16.	**Palpation (Nails)** Palpate Nail for: a. Texture b. Firmness c. Thickness d. Adherence to nailbed			

Nursing instructor's signature: _____ Date: _____

Assessment of Head, Face, Ear, Nose, Neck, And Throat

Equipment Required:

- Nasal speculum
- Flashlight/penlight

Checklist

Sr. #	Tasks	Yes	No	Comments
	Principles of Physical Examination 1. Introduce self 2. Explain examination 3. Give proper instructions 4. Wash or sanitize hands 5. Arrange for proper Environment 6. Position client properly Drapes client properly			
	Subjective Data			
	Demographic Data: • Age: • Gender: • Education status: • Occupation: • Marital status: Diagnosis:			
	Presenting illness: (reason for seeking healthcare			

	/ admission)			
	History of presenting illness: (**COLDERRAA** to investigate positive finding)			
	Past medical or surgical history: (Any illness, surgery, injury, or accident)			
	Social History: (Use of cigarette, alcohol, and illicit drugs)			
	Family history:			
	Lifestyle: alcohol, diet, exercise, stress, use of over-the-counter medications and sleep pattern)			
	Objective Data			
	General survey: Observe for • Gait • Posture • Body habitus/ structure • Deformity. Hygiene & body odors (well-groomed or unkempt)			
	• Signs of distress • Pain and Shortness of breath Assess Mental status and Level of Consciousness			
	Subjective Data			
	History taking: **<u>History</u>** **Present problem:** Changes in hearing or smell? Any complain of headache, ear or facial pain, ear or nasal discharge and itching or redness in nose or ear, nasal obstruction, breathing difficulty or nasal bleeding? **Past medical history**: any trauma, ear or nasal surgery, chronic disease like diabetes or hypertension **Family history:** Deafness, Nasal, or Diabetes, Hypertension or Hyperthyroidism or Hypothyroidism			
	Examination			

	Head and Face Examination			
	1. (Inspection & Palpation) ➢ Inspect the general size and contour of the skull. ➢ Note any deformities, depressions, lumps, or tenderness. ➢ Inspect the patient's facial expression and contours. Observe for asymmetry, involuntary movements, edema, and masses			
	2. Ear Examination			
	1. (Inspection & Palpation) ➢ Inspect ear shape, size, position, symmetry, lesions, nodules, discharge ➢ Inspect auditory meatus **3.** Palpate auricles, mastoid & tragus			
	2. A**ssess for Hearing Tests** ➢ Whisper Test (stand 1 feet away, close far ear) Weber Test and report			
	Rinnie Test and report			
	3. Otoscopic Examination ➢ Check colour, patency and condition of auditory canal ➢ Presence of cerumen and exudate in canal ➢ Perform Otoscopic examination of tympanic membrane accurately ➢ Describe membrane colour, shape, consistency, landmark and cone of light Performed hearing test (CN VII)			
	4. External Nose			
	Shape and size (disfigurement) Tenderness Nasal Patency **5.** Sense of Smell –CN 1			
	Internal Nose			
	Mucosa (color, swelling, polyp, exudate,			

	bleed) Septum (deviation, perforation, exudate) Turbinate (color, swelling)			
	Mouth			
	Inspection: Inspect Lips Inspect Teeth and gums Inspect Buccal mucosa (color, moisture, and integrity, any lesions, ulcers) Inspect dorsal and ventral of Tongue Inspect Opening of Salivary glands Inspect Hard & soft palate Inspect Pharynx & Tonsils (tongue blade kept at side of tongue, shine light at throat)			
	Palpation: Palpate Tongue (dorsum & ventral surface, sides) **Assess for:** Check for Tongue movement and taste (Hypoglossal CN XII) Check for rise of uvula and soft palate on phonation Check Gag reflex (Glossopharyngeal CN IX & Vagus CN X nerves)			
	Neck			
	Inspect thyroid gland (ask client to swallow, identifies landmark thyroid notch, cricoid cartilage & thyroid gland location)			
	Inspect thyroid gland (ask client to swallow, identifies landmark thyroid notch, cricoid cartilage & thyroid gland location)			
	Palpate thyroid gland (from posterior side)			

	Palpate carotid artery			
	Palpate trachea (central or deviated)			
	Palpate Lymph nodes of face & neck: Preauricular 1. Post auricular 2. Tonsillar 3. Sub mental 4. Sub maxillary 5. Superficial cervical 6. Deep cervical 7. Posterior cervical supraclavicular			
	Auscultate carotid artery			
	Perform range of motion of neck			

Nursing instructor's signature: _____ Date: _____

Assessment of Abdomen

Equipment Required:

- Examining light
- Tape measure (metal or unstretchable cloth)
- Skin-marking pen
- Stethoscope

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Ask the client to void prior to the exam.			
2.	Position the client supine with the knees slightly flexed.			
3.	Examine abdomen in this order: inspection, auscultation, percussion, palpation.			
4.	**Inspect the abdomen for:**			

	a. Size, symmetry, and contour.			
	b. Has client raised his head to check for bulges.			
	c. If distention is present, measures girth at umbilicus with tape measure.			
	d. Observe the condition of skin and skin color; lesions, scars, striae, superficial veins, and hair distribution.			
	e. Note abdominal movements.			
	f. Note position, contour, and color of the umbilicus.			
5.	Auscultate the abdomen for bowel sounds, using diaphragm of stethoscope.			
	a. Listens for 5 min. before concluding that bowel sounds are absent.			
	b. Uses stethoscope bell to listen for bruits.			
	c. Listens for bruits over aorta and renal, femoral, and iliac arteries.			
6.	a. Use indirect percussion to assess at multiple sites in all four quadrants. b. Estimate size of liver, spleen, and bladder.			
7.	Use fist or blunt percussion to percuss the costovertebral angle for tenderness.			
8.	**Palpates abdomen:**			
	a. Begins with light palpation then uses deep palpation to palpate organs and masses.			
	b. For light palpation, presses down 1–2 cm in a rotating motion. Identifies surface characteristics, tenderness, muscular resistance, and turgor.			
9.	**Palpate liver:**			
	a. Places right hand at the client's midclavicular line under and			

	parallel to the costal margin. b. Places left hand under the client's back at the lower ribs and pressing upward. c. Asks client to inhale and deeply exhale while pressing in and up with the right fingers.			
10.	**Palpate spleen by:** a. Stands at client's right side. b. Places left hand under costovertebral angle and pulls upward. c. Places right hand under the left costal margin. d. Asks client to exhale and presses hands inward to palpate spleen.			

Nursing instructor's signature: _____ Date: _____

Assessment of Anus & Rectum

Equipment Required:

- Gloves
- Lubricant
- An anoscope (or anal speculum)
- A light source
- Topical anesthetic gel

Checklist

Sr. #	Tasks	Yes	No	Comments
	Preparation o Arrange equipment o Clean gloves o Lubricant			
	Procedure			
1.	Introduce yourself and verify the client identity o Explain procedure to client in detail.			
2.	Perform hand hygiene			
3.	Wear gloves			
4.	Observe other appropriate infection control procedures.			
5.	Provide client privacy.			

6.	Drape the client appropriately to prevent the exposure of body parts			
7.	Inquire if the client has any history of the following: ○ Bright blood in stools, tarry black stools, diarrhea, constipation, abdominal pain, excessive gas, hemorrhoids, or rectal pain ○ Family history of colorectal cancer			
8.	**Position the client** In adults, a left lateral or Sims' position with the upper leg acutely flexed is required for the examination. For females: A dorsal recumbent position with hips externally rotated and knees flexed or a lithotomy position may be used. ○ For males: A standing position while the client bends Over the examining table may also be used.			
9.	**Assessment** Inspect the anus and surrounding tissue for color, integrity, and skin lesions.			
10.	Then, ask the client to bear down as though defecating.			
11.	Describe the location of all abnormal findings in terms of a clock, with the 12 o'clock position toward the pubic symphysis			
12.	Palpate the rectum for anal sphincter tonicity, nodules, masses, and tenderness.			
13.	On with drawing the finger from the rectum and anus observe it for feces. If ordered, perform a test for occult blood on the stool.			
14.	Document findings in the client record			

Nursing instructor's signature: _____ Date: _____

Assessment of Breast and Axilla

Equipment Required:

- Centimeter ruler

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Introduce self and verify the client's identity using agency protocol.			
2.	Explain to the client what you are going to do, why it is necessary, and how he or she can participate.			
3.	Inquire whether the client has ever had a clinical breast exam previously.			
4.	Discuss how the results will be used in planning further care or treatments.			
5.	Perform hand hygiene and observe other appropriate infection prevention procedures			
6.	Inspect the breasts for size, symmetry, and contour or shape while the client is in a sitting position			
7.	Inspect the skin of the breast for localized discolorations or hyperpigmentation, retraction or dimpling, localized hyper vascular areas, swelling or edema			
8.	Emphasize any retraction by having the client: • Raise the arms above the head. • Push the hands together, with elbows flexed. • Press the hands down on the hips			
9.	Inspect the areola area for size, shape, symmetry, color, surface characteristics, and any masses or lesions.			
10.	Inspect the nipples for size, shape, position, color, discharge, and lesions			
11.	Palpate the axillary, sub clavicular, and supraclavicular lymph nodes			
12.	Palpate the breast for masses, tenderness, and any discharge from the nipples. Palpation of the breast is generally performed while the client is supine			
13.	Palpate the areolae and the nipples for masses.			
14.	Assess any discharge for amount, color, consistency, and odor. Note also any tenderness on palpation			
15.	Document findings in the client record.			

Nursing instructor's signature: _____ Date: _____

Assessment of Genitalia

Equipment Required:

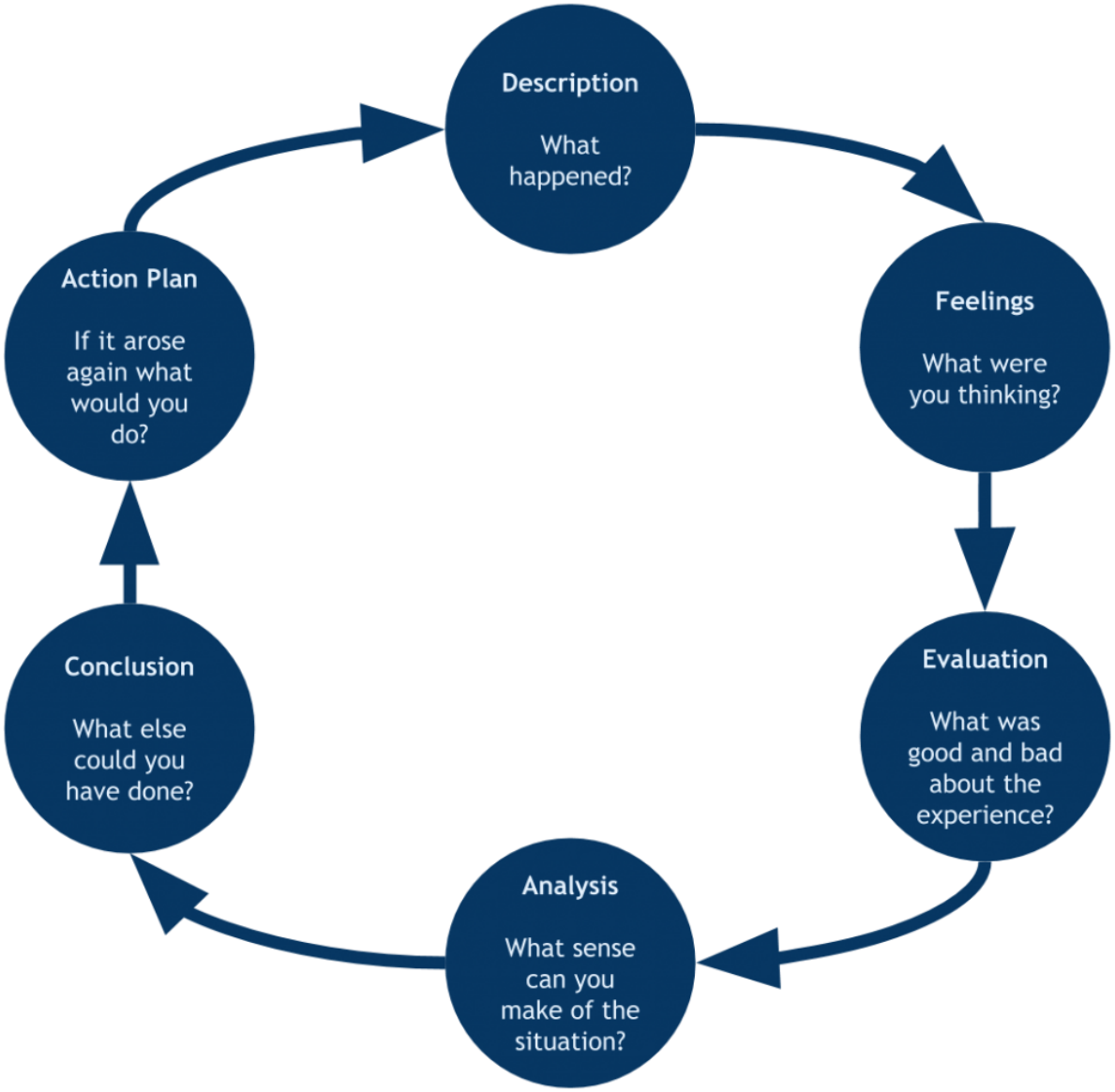
- Clean gloves
- Drape
- Supplemental lighting

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Introduce self and verify the client's identity using agency protocol.			
2.	Explain to the client what you are going to do, why it is necessary, and how he or she can participate.			
3.	Inquire about the following: • age of onset of menstruation • last menstrual period (LMP) • regularity of cycle • duration • urgency and frequency of urination at night • blood in urine • painful urination • incontinence • history of sexually transmitted infection			
4.	Discuss how the results will be used in planning further care or treatments.			
5.	Perform hand hygiene and observe other appropriate infection prevention procedures			
6.	Cover the pelvic area with a sheet or drape at all times when the client is not actually being examined. Position the client supine.			
7.	Inspect the distribution, amount, and characteristics of pubic hair.			
8.	Inspect the skin of the pubic area for parasites, inflammation, swelling, and lesions. To assess pubic skin adequately, separate the labia majora and labia minora.			
9.	Inspect the clitoris, urethral orifice, and vaginal orifice when separating the labia minora			
10.	Palpate the inguinal lymph nodes.			
11.	Remove and discard gloves. Perform hand hygiene.			
12.	Document findings in the client record			

Nursing instructor's signature: _____ Date: _____

Reflection/ Critical Incident Analysis



Gibbs' Reflective Cycle 1998

CASE STUDY FORMAT

XLIX. INTRODUCTION

E. Background of the study
F. Objective (general & specific showing Knowledge, Skills & Attitude)
G. Scope and Delimitation
H. Theoretical Framework

L. BIOGRAPHIC DATA

Name
Address
Age
Gender
Race
Marital Status
Occupation
Religious orientation
Health care financing and usual source of medical care

LI. CHIEF COMPLAINT OR REASON FOR VISIT

LII. NURSING HISTORY (with guide questionnaire)

P. History of Present Illness
Q. Past Medical History
   s) Childhood diseases
   t) Immunizations
   u) Allergies
   v) Accidents and injuries
   w) Hospitalization
   x) Medication
R. Family History of Illness (use Genogram)
S. Obstetric History (for OB cases only; with Assessment Guide)
T. Developmental History (for Pediatric cases only; with Assessment Guide)

Note: Assessment guide *used should be attached as annexes at the back of the case study report.*

LIII. FUNCTIONAL HEALTH PATTERN (with guide questionnaire)

34. Health Perception and Health Management Pattern
35. Nutrition and Metabolic Pattern
36. Elimination Pattern
37. Activity-Exercised Pattern (use Barthel index)
38. Sleep-rest Pattern
39. Cognitive-perceptual Pattern
40. Self-perception and self-control Pattern
41. Role-relationship Pattern
42. Sexuality-reproductive Pattern
43. Coping-stress tolerance Pattern
44. Value-belief Pattern

Interpretation:

Analysis: (with reference)

LIV. REVIEW OF SYSTEM (all subjective complaints)

LV. PHYSICAL ASSESSMENT (all objective findings; indicate date performed; Head to Toe Assessment; follow IPPA sequence)

7. General Survey (Short Paragraph)
8. Vital Signs

BODY PART (Technique used)	NORMAL FINDINGS	ACTUAL FINDINGS	INTERPRETATION / ANALYSIS w/ Reference

LVI. ANATOMY & PHYSIOLOGY

LVII. DIAGNOSTIC / LABORATORY STUDIES (Table)

NAME OF TEST / PROCEDURE	DATE DONE	INDICATION FOR THE TEST / PROCEDURE	NORMAL VALUE	ACTUAL RESULT / FINDINGS	SIGNIFICANCE OF THE RESULT / FINDINGS

LVIII. SURGICAL PROCEDURE (Operative worksheet, if any)

LIX. PATHOPHYSIOLOGY (Present in Schematic Diagram; Mind Mapping)

LX. DRUG STUDY / IV INFUSIONS, BLOOD TRANFUSIONS, TREAMENTS GIVEN

Drug Study

DRUG ORDER (Generic, name, dosage, route, frequency)	TRADE / BRAND NAME	PHARMACOLOGIC ACTION OF DRUG	INDICATION AND CONTRAINDICATIONS	ADVERSE EFFECTS OF THE DRUG	DESIRED ACTION ON YOUR CLIENT	NURSING RESPONSIBILITIES / PRECAUTIONS

Treatments Given

TREATMENT / INFUSION	CLASSIFICATION	INDICATION	CONTRAINDICATION	NURSING RESPONSIBILITIES / PRECAUTIONS

LXI. COURSE IN THE WARD (narrative form)

- Summary of day to day medical/nursing management from the date of admission up to the time case study was done
- Patient's Status:
    a. General condition of the client (ex. LOC, VS, and other Subjective & Objective, complaint during the day)
    b. 4 D's with inference / analysis:
        - Diet
        - Drugs/IVF
        - Lab/Diagnostics procedure
        - Disposition

LXII. PRIORITIZED LIST OF NURSING PROBLEMS (Table)

- Prioritized using ABC's and Maslow's Hierarchy of Needs

DATE	NURSING PROBLEMS IDENTIFIED	CUES	JUSTIFICATION

LXIII. NURSING CARE PLAN

CUES (Defining Characteristics of Nursing Diagnosis)	NURSING DIAGNOSIS (Problem & Etiology)	BACKGROUND KNOWLEDGE (Pathophysiology/psychosocial explanation or consequences of the nursing diagnosis)	GOALS AND OBJECTIVES (include long and short term objectives)	NURSING INTERVENTIONS AND RATIONALE	EVALUATION

LXIV. PROPOSED / DISCHARGE PLAN (to be submitted by students whose patients are for discharge)

- M - Medications to take at home
- E - Exercises
- T - Treatment
- H - Health Teachings
- O - Out - patient follow-up
- D - Diet
- S - Spiritual / Sexual activity (optional)
-

References:

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Bickley, Lynn S. (2003). Bates' guide to physical examination and history taking. Philadelphia Lippincott Williams & Wilkins,

SEMESTER-IV

Adult Health Nursing-II (Clinical)-4 Cr. Hours

Clinical Training- 02 Cr. Hours

Course Description:

This course aimed to furnish learners with the knowledge and skills to care for an adult patient admitted to the hospital with a disease condition. It emphasizes on effective utilization of nursing process to provide care to the client and facilitate them in restoration of optimum health. Assessment Tool has been utilized for recognizing the responses towards disease process on individuals and their families and plan care accordingly. Specific nursing skills and procedures necessary to care for ill patients are included. Learners are exposed to the variety of clinical settings to integrate theory into practice under supervision.

Clinical Rotation plan:

This semester will be of 16/22 weeks, the student nurse will go to clinical rotation in batches to ensure 24/7 clinical placement at hospitals in all three shifts to observe, learn and perform skills under the supervision of clinical instructor.

CLINICAL OBJECTIVES

By the end of this course, students will be able to:

20. Demonstrate proficiency in providing comprehensive tracheostomy care, including suctioning, cleaning, and maintaining the airway, while minimizing the risk of infection and promoting patient comfort and safety.
21. Develop competency in performing tracheal suctioning safely and effectively, ensuring adequate airway clearance and patient comfort while minimizing the risk of complications such as trauma or hypoxia.
22. Successfully assist healthcare providers in performing lumbar punctures, including preparing the patient, positioning, and providing assistance during the procedure while ensuring patient safety and comfort.
23. Demonstrate proficiency in assisting with thoracentesis procedures, including patient positioning, equipment setup, and providing support to the patient while ensuring accurate sample collection and monitoring for complications.
24. Develop competency in assisting with paracentesis procedures, including patient preparation, positioning, and providing assistance during the procedure while ensuring patient comfort and safety.
25. Successfully assist healthcare providers in inserting chest tubes, including preparing the patient, providing sterile technique, and monitoring for complications while ensuring optimal drainage and lung re-expansion.
26. Demonstrate proficiency in assisting patients undergoing CT scans, including ensuring patient safety, proper positioning, and coordination with radiology staff to obtain high-quality images while minimizing radiation exposure.

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27. Develop competency in assisting with cerebral angiography procedures, including patient preparation, positioning, and providing support during the procedure while ensuring accurate imaging and monitoring for complications.

28. Successfully assist healthcare providers in performing myelogram procedures, including patient preparation, positioning, and providing assistance during the procedure while ensuring patient safety and comfort.
29. Demonstrate proficiency in assisting with audiometric testing, including patient preparation, equipment setup, and providing support to the patient during the procedure while ensuring accurate assessment of hearing function.
30. Develop competency in assisting with thyroid scanning procedures, including patient preparation, positioning, and providing assistance during the procedure while ensuring accurate imaging and patient comfort.
31. Successfully assist patients undergoing X-ray procedures, including ensuring proper positioning, radiation safety measures, and collaboration with radiology staff to obtain diagnostic images of high quality while ensuring patient comfort and safety.
32. Demonstrate proficiency in applying and monitoring skin traction devices safely and effectively to assist in the management of orthopedic conditions, ensuring proper alignment and immobilization while minimizing the risk of complications such as pressure injuries or nerve damage.

33. Develop competency in applying plaster or cast immobilization devices for fractures or musculoskeletal injuries, ensuring proper technique, alignment, and patient comfort while minimizing the risk of complications such as skin irritation or compartment syndrome.
34. Successfully apply eye bandages or dressings following ocular procedures or injuries, ensuring proper technique, protection of the eye, and patient comfort while promoting healing and preventing infection.
35. Demonstrate proficiency in performing eye irrigation procedures to remove foreign bodies or irritants from the eye, ensuring proper technique, irrigation solution selection, and patient comfort while minimizing the risk of corneal abrasions or infection.
36. Develop competency in performing ear irrigation procedures to remove cerumen or debris from the ear canal, ensuring proper technique, irrigation solution temperature, and patient comfort while minimizing the risk of injury to the ear canal or tympanic membrane.
37. Demonstrate proficiency in performing blood sugar monitoring, including fingerstick blood glucose testing or continuous glucose monitoring, ensuring accurate technique, interpretation of results, and patient education on self-management of diabetes.
38. Develop competency in setting up and monitoring cardiac telemetry systems to continuously monitor cardiac rhythms, recognizing and responding to arrhythmias or abnormalities, and ensuring patient safety and appropriate intervention as needed.

Evaluation Criteria:

S No	Clinical Portfolio Content	%	Frequency
1.	Clinical Objectives	***10%***	Weekly
2.	History Taking Performa	***15%***	20
3.	Physical Examination Checklists	***15%***	20
4.	Nursing Care Plan	***10%***	20
5.	Nursing Skills Checklists	***20%***	10
6.	Reflection/ Critical Incident Analysis	***10%***	Weekly
7.	Case Study	***20%***	01

Clinical Objectives Form

Student Name: _____ Faculty:

_____

Clinical placement:_____ Date:

_____

Clinical Objectives	Strategies	Evaluation

History Taking Proforma

Student Name: _____Group #: _____Faculty:

_____

1. Document the client presenting complaint, Functional Health Patterns and Review of Systems findings and draw family genogram

Checklist for taking a client health history

Interviewing Checklist	Satisfactory	Need to improve
Introduced self, purpose, and agenda		
Arranged for proper environment (position, distance, light)		
Asks open ended question (to explore chief concern)		
Explores information about chief concern (COLDERRAA) Character, Onset, Location, Duration, Exacerbation, Radiation, Relief, Antecedent, Associated factors		
Proceed from general to specific, follows cues, probes positive finding, asks clear, logical questions, one at a time		
Uses effective communication techniques (Facilitation, Clarification, Paraphrasing, Transitions, Summarization)		
demonstrates appropriate verbal / nonverbal gesture (Eye contact, voice tone, active listening, hand gestures)		
Avoids being non therapeutic (asking why questions, biased,		

leading, judgmental, false reassurance, changing topic)

Explores client past history of any illness

Explores client family history

Explores client functional abilities & life style patterns

Explores Review of System checklist efficiently

Faculty comments:

Nursing Care Plan

Assessment	Nursing Diagnosis	Goal	Planning	Implementation	Rationale	Evaluation
Subjective Data						
Objective Data						

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S #	Skills	Level of competency	Minimum Frequency
1.	**Tracheostomy care**	**1-5**	
2.	**Suctioning (Tracheal)**	**1-5**	
3.	**Assist in procedures of Lumber puncture**	**1-5**	
4.	**Assist in procedures of Thoracentesis**	**1-5**	

5.	**Assist in procedures of Paracentesis**	**1-5**	
6.	**Assist in procedures of Chest tube insertion**	**1-5**	
7.	**Assist in procedures of C.T. Scan**	**1-5**	
8.	**Assist in procedures of Cerebral Angiography**	**1-5**	
9.	**Assist in procedures of Lumber puncture**	**1-5**	
10.	**Assist in procedures of Myelogram**	**1-5**	
11.	**Assist in procedures of Audiometric testing**	**1-5**	
12.	**Assist in procedures of Thyroid scanning.**	**1-5**	
13.	**Assist in procedure of X rays**	**1-5**	
14.	**Skin Traction**	**1-5**	
15.	**Application of plaster , cast**	**1-5**	
16.	**Eye bandaging**	**1-5**	
17.	**Eye irrigation**	**1-5**	
18.	**Ear irrigation**	**1-5**	
19.	**Blood Sugar Monitoring**	**1-5**	
20.	**Cardiac monitoring /telemetry**	**1-5**	

No	**Procedures**	**Clinical Experience**					
		Skill Lab Instructor Signature	**Date**	**Ward Sister Signature**	**Date**	**Clinical instructor Signature**	**Date**
1.	**Tracheostomy care**						
2.	**Suctioning (Tracheal)**						
3.	**Assist in procedures of Lumber puncture**						
4.	**Assist in procedures of Thoracentesis**						

5.	**Assist in procedures of Paracentesis**						
6.	**Assist in procedures of Chest tube insertion**						
7.	**Assist in procedures of C.T. Scan**						
8.	**Assist in procedures of Cerebral Angiography**						
9.	**Assist in procedures of Lumber puncture**						
10.	**Assist in procedures of Myelogram**						
11.	**Assist in procedures of Audiometric testing**						
12.	**Assist in procedures of Thyroid scanning.**						
13.	**Assist in procedure of X rays**						
14.	**Skin Traction**						
15.	**Application of plaster , cast**						
16.	**Eye bandaging**						
17.	**Eye irrigation**						
18.	**Ear irrigation**						

19.	**Blood Sugar Monitoring**						
20.	**Cardiac monitoring /telemetry**						

Nursing Skills Checklists

Tracheostomy care

Equipment Required :

- Disposable gloves
- Sterile gloves
- Goggles and mask or face shield
- Additional PPE, as indicate
- Sterile normal saline
- Sterile cup or basin
- Sterile cotton-tipped app
- Disposable inner tracheostomy cannula, appropriate size for patient
- Sterile suction catheter and glove set
- Commercially prepared tracheostomy or drain dressing
- Commercially prepared tracheostomy holder
- Plastic disposal bag
- Additional nurse

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Bring necessary equipment to the bedside stand or overbed table			
2.	Perform hand hygiene and put on PPE, if indicated			
3.	Identify the patient			
4.	Close curtains around the bed and close the door, if possible			
5.	Determine the need for tracheostomy care and assess patient's pain			
6.	Explain the procedure and reassure the patient			
7.	Adjust bed to elbow height, lower side rail, position patient, and set up work area			
8.	Wear face shield or goggles and mask, and suction the tracheostomy if needed			
9.	Open sterile packages and prepare saline and disposable bag			
10.	Put on disposable gloves			
11.	Remove the oxygen source, stabilize the outer cannula, and remove the inner cannula			
12.	Remove gloves, put on sterile gloves, and insert the new inner cannula			
13.	Clean the stoma using saline and sterile applicators, moving outward from the site			
14.	Pat the skin dry with sterile gauze			
15.	Apply a new tracheostomy dressing			
16.	Change the tracheostomy holder with assistance, ensuring proper fit			
17.	Remove gloves, assist the patient to a comfortable position, raise bed rails, and lower the bed			
18.	Remove face shield or goggles, mask, and additional PPE, and perform hand hygiene			
19.	Reassess the patient’s respiratory status (rate, effort, oxygen saturation, lung sounds)			

Nursing instructor’s signature: _____ **Date:** _____

Suctioning an Endotracheal Tube (Open System)

Equipment Required:

- Portable or wall suction unit with tubing
- A commercially prepared suction kit with an appropriate size catheter
- Sterile suction catheter with Y-port in the appropriate size
- Sterile, disposable container
- Sterile gloves
- Towel or waterproof pad
- Goggles and mask or face shield
- Additional PPE, as indicated
- Disposable, clean glove
- Resuscitation bag connected to 100% oxygen
- Assistant (optional)

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Gathered necessary equipment to the bedside stand or over-bed table			
2.	Performed hand hygiene and put on PPE.			
3.	Identified the patient			
4.	Closed curtains around bed and close the door, if possible.			
5.	Determined the need for suctioning. Assess for pain and verify suction order.			
6.	Explained the procedure to the patient and reassure them			
7.	Adjusted bed to elbow height and position patient (semi-Fowler's for conscious, lateral for unconscious)			
8.	Placed towel or waterproof pad across patient’s chest			
9.	Set suction to appropriate pressure (based on patient age and equipment)			
10.	Checked suction pressure by occluding tubing			
11.	Open sterile suction package and prepare sterile saline			
12.	Wear face shield or goggles, mask, and sterile gloves			
13.	Connected suction catheter to tubing, maintaining sterility			
14.	Moistened catheter with sterile saline and check suction			
15.	Hyperventilated patient using a manual resuscitation bag (3–6 breaths)			
16.	Opened adapter or removed resuscitation bag to expose tracheostomy			
17.	Inserted catheter gently into trachea without occluding the Y-port			
18.	Applied suction intermittently while rotating catheter during withdrawal			
19.	Hyperventilated the patient after suctioning with resuscitation bag (3–6 breaths)			
20.	Flushed catheter with saline, assess suction effectiveness, and repeat if needed			
21.	Wait 30 seconds to 1 minute between suction passes; do not exceed 3 passes per session			
22.	Removed gloves, coil catheter inside, and dispose of properly			
23.	Turned off suction and remove face shield or goggles, mask, and perform hand hygiene			

24.	Offered oral hygiene after suctioning			
25.	Reassessed respiratory status: rate, effort, oxygen saturation, lung sounds			
26.	Removed additional PPE and performed hand hygiene			

Nursing instructor's signature: _____ Date: _____

Suctioning an Endotracheal Tube (Closed System)

Equipment Required:

- Portable or wall suction unit with tubing
- Closed suction device of appropriate size for patient
- 3 mL or 5 mL normal saline solution in dosette or syringe
- Sterile gloves
- Additional PPE, as indicated

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Bring necessary equipment to the bedside stand or over-bed table.			
2.	Perform hand hygiene and put on PPE, if indicated.			
3.	Identify the patient.			
4.	Close curtains around bed and close the door, if possible.			
5.	Determine the need for suctioning. Verify suction order and assess for pain.			
6.	Explain the procedure to the patient, and reassure them.			
7.	Adjust bed to elbow height and position the patient accordingly (semi-Fowler's for conscious, lateral for unconscious).			
8.	Turn suction to the appropriate pressure based on patient age and equipment (wall unit or portable).			
9.	Open the package of the closed suction device using aseptic technique.			
10.	Put on sterile gloves.			
11.	Disconnect ventilator from the endotracheal tube using the non-dominant hand, keeping the inside of tubing sterile.			
12.	Connect the closed suctioning device to the endotracheal tube, keeping it sterile.			
13.	Attach the ventilator tubing to the suction port and connect the suction tubing.			
14.	Open the port and insert a saline dosette or syringe into the suction catheter.			
15.	Hyperventilate the patient using the ventilator’s sigh button. Turn the safety cap on the suction button to enable suctioning.			

16.	Hold suction catheter, insert it into the endotracheal tube, and advance to the predetermined length without occluding the Y-port.			
17.	Apply intermittent suction by pressing the suction button and rotating the catheter while withdrawing it. Limit suctioning to 10-15 seconds.			
18.	Clean the catheter by depressing the suction button while squeezing the saline dosette. Wait 30-60 seconds before additional suctioning if needed. Limit to 3 suction passes.			
19.	After completing suctioning, withdraw the catheter into the sheath and turn off suction.			
20.	Suction the oral cavity with a separate, disposable catheter and perform oral hygiene. Turn off suction and remove gloves.			
21.	Assist the patient to a comfortable position, raise bed rails, and lower the bed.			
22.	Reassess the patient's respiratory status: rate, effort, oxygen saturation, and lung sounds.			
23.	Remove additional PPE, if used, and perform hand hygiene.			

Nursing instructor's signature: _____ Date: _____

Assist in the Procedure of Lumbar Puncture

Equipment Required:

- Sterile lumbar puncture tray (includes needles, syringes, sterile drapes).
- Manometer for pressure measurement.
- Sterile spinal needle (20-22 gauge, 3.5-inch for adults).
- Local anesthetic (e.g., lidocaine 1%).
- Antiseptic solution (e.g., povidone-iodine or chlorhexidine).
- Sterile gauze and dressing.
- CSF collection tubes (3 or 4 sterile, labeled tubes).
- Adhesive bandage.

Checklist

Sr. #	Tasks	Yes	No	Comments

1.	Ensure the patient is lying in the lateral decubitus (fetal) position or seated, with the back arched outward.			
2.	Perform hand hygiene and don sterile gloves.			
3.	Clean the lumbar area with antiseptic solution in a circular motion from the puncture site outward. Allow to dry.			
4.	Administer local anesthetic at the puncture site.			
5.	Insert the spinal needle between L3-L4 or L4-L5 with bevel facing upward, advancing until entry into the subarachnoid space is felt.			
6.	Measure opening pressure using the manometer, if indicated.			
7.	Collect 3-4 tubes of cerebrospinal fluid (CSF), ensuring proper labeling.			
8.	Withdraw the needle carefully and apply sterile gauze and adhesive bandage to the puncture site.			
9.	Position the patient supine for 1-2 hours post-procedure to reduce the risk of post-lumbar puncture headache.			
10.	Dispose of all materials according to hospital policy and maintain a sterile field throughout.			

Nursing instructor's signature: _____ Date: _____

Assist in the Procedure of Thoracentesis

Equipment Required:

- Sterile thoracentesis tray (includes syringe, needles, scalpel, and collection tubing).
- Sterile thoracentesis needle (18 or 20 gauge).
- Antiseptic solution (e.g., povidone-iodine or chlorhexidine).
- Local anesthetic (e.g., lidocaine 1%).
- Sterile dressing and adhesive bandage.
- Collection container for pleural fluid (vacuum bottles or syringes).
- Ultrasound machine (for guidance in complex cases).
- Sterile gloves, drapes and gowns

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Position the patient in an upright, seated position, leaning slightly forward with arms supported.			
2.	Perform hand hygiene and apply sterile gloves and gown.			
3.	Clean the insertion site with antiseptic solution, starting at the puncture site and working outward in a circular motion.			
4.	Administer local anesthetic (lidocaine) at the insertion site.			
5.	Insert the thoracentesis needle above the rib, avoiding the intercostal nerve and vessels. Advance carefully until pleural fluid is aspirated.			
6.	Drain pleural fluid into the collection container, removing no more than 1,000 to 1,500 ml.			
7.	Withdraw the needle and apply a sterile dressing over the insertion site.			
8.	Position the patient in a semi-Fowler's position and monitor for respiratory distress or signs of pneumothorax.			

Nursing instructor's signature: _____ Date: _____

Assist in the Procedure of Abdominal Paracentesis

Equipment Required:

- Sterile paracentesis tray (includes syringes, needles, scalpel, and tubing for fluid drainage).
- Sterile gloves, gowns, and drapes.
- Local anesthetic (e.g., lidocaine 1%).
- Antiseptic solution (e.g., povidone-iodine or chlorhexidine).
- Paracentesis needle or catheter.
- Collection container for pleural fluid (vacuum bottles or syringes).
- Ultrasound machine (for guidance in complex cases).
- Sterile gloves, drapes and gowns

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Position the patient in a semi-Fowler's position or supine with the head elevated.			
2.	Perform hand hygiene and wear sterile gloves and gown.			
3.	Clean the puncture site (lower abdomen) with antiseptic, working outward from the center.			
4.	Administer local anesthesia (lidocaine) at the puncture site.			
5.	Insert the paracentesis needle into the peritoneal cavity and carefully aspirate fluid.			
6.	Attach tubing to the needle and collect fluid in a sterile container, draining no more than 5 liters.			
7.	Withdraw the needle and apply a sterile dressing to the puncture site.			
8.	Position the patient comfortably and monitor vital signs (especially blood pressure and heart rate).			

Nursing instructor's signature: _____ Date: _____

Assist in the Procedure of Chest Tube Insertion

Equipment Required:

- Sterile chest tube tray (includes tube, trocar, and sterile gloves).
- Chest tube (sizes vary depending on patient needs).
- Surgical drapes, sterile gauze, and sutures.
- Local anesthetic (e.g., lidocaine 1%).
- Chest drainage system (e.g., water-seal or suction system).
- Antiseptic solution (e.g., povidone-iodine).
- Ultrasound machine (for guidance in complex cases).
- Syringes and needles

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Position the patient in a supine or semi-Fowler's position based on pleural effusion or pneumothorax location.			
2.	Perform hand hygiene and wear sterile gloves and gown.			
3.	Clean the insertion site with antiseptic solution.			

4.	Administer local anesthesia (lidocaine) to numb the insertion site.			
5.	Assist the physician with chest tube insertion and secure it with sutures.			
6.	Connect the chest tube to the drainage system and verify correct function (e.g., check for bubbling in the water-seal chamber).			
7.	Apply a sterile dressing over the insertion site.			
8.	Monitor the patient for signs of complications (respiratory distress, tube dislodgement, etc.).			

Nursing instructor's signature: _____ Date: _____

Assist in the Procedure of CT Scan

Equipment Required:

- CT scanner (with imaging software).
- Contrast material (oral or intravenous, if needed).
- Patient positioning aids (e.g., pillows, straps).
- Vital signs monitoring equipment.
- Patient education material

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Position the patient appropriately for the CT scan.			
2.	Perform hand hygiene and apply gloves as needed.			
3.	Administer contrast material as prescribed, following protocols for intravenous or oral administration.			
4.	Monitor the patient for any adverse reactions during and after contrast administration.			
5.	Communicate with the radiologic technologist to ensure proper scan protocols and positioning.			

Nursing instructor's signature: _____ Date: _____

Assist in the Procedure of Cerebral Angiography

Equipment Required:

- Angiography machine (with fluoroscopy capabilities).
- Contrast material (usually iodine-based).
- Sterile drapes, gloves, and gown.
- Patient monitoring equipment (e.g., ECG, blood pressure cuff).
- Sedation or anesthesia (as required)

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Position the patient appropriately on the angiography table.			
2.	Perform hand hygiene and apply sterile gloves and gown.			
3.	Clean the groin area (common access site) with antiseptic solution.			
4.	Administer local anesthesia at the catheter insertion site.			
5.	Assist the physician with catheter insertion and contrast material injection.			
6.	Monitor the patient's vital signs and comfort level during the procedure.			
7.	Provide post-procedure care, including monitoring for bleeding at the catheter site and ensuring patient recovery.			

Nursing instructor's signature: _____ Date: _____

Assist in the Procedure of Myelogram

Equipment Required:

- Fluoroscopy or CT scanner.
- Contrast material (typically iodine-based).
- Sterile drapes, gloves, and gown.
- Patient monitoring equipment (e.g., ECG, blood pressure cuff).
- Sedation or anesthesia (as required)

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Position the patient in a prone or lateral decubitus position on the table.			
2.	Perform hand hygiene and apply sterile gloves and gown.			
3.	Clean the lumbar puncture site with antiseptic solution.			

4.	Administer local anesthesia at the lumbar puncture site.			
5.	Assist the physician with the lumbar puncture and injection of contrast material.			
6.	Monitor the patient's vital signs and comfort throughout the procedure.			
7.	Provide post-procedure care, including monitoring for headaches, nausea, and changes in neurological status.			

Nursing instructor's signature: _____ **Date:** _____

Assist in the Procedure of Audiometry

Equipment Required:

- Audiometer (for pure-tone, speech, or impedance audiometry).
- Headphones or insert earphones.
- Bone conduction vibrator (if required).
- Soundproof booth (for pure-tone audiometry).
- Patient response button or system.

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Seat the patient comfortably in a soundproof booth or quiet room.			
2.	Perform hand hygiene and ensure the equipment is clean and calibrated.			
3.	Place the headphones or insert earphones on the patient and ensure a proper fit.			
4.	Instruct the patient to press the button or raise their hand whenever they hear a sound.			
5.	Administer pure-tone audiometry, presenting sounds at various frequencies and intensities to each ear.			
6.	If required, perform speech audiometry to assess the patient's ability to understand speech at different sound levels.			
7.	Monitor the patient for fatigue or discomfort during the test and provide breaks if necessary.			

Nursing instructor's signature: _____ **Date:** _____

Assist in the Procedure of Thyroid Scanning

Equipment Required:

- Gamma camera or scintillation camera.
- Radioactive iodine (I-123 or I-131) or technetium-99m.
- Sterile syringe for administering the radioisotope.
- Patient monitoring equipment (e.g., blood pressure cuff, ECG).
- Lead shielding (to minimize radiation exposure).

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Position the patient comfortably on the imaging table.			
2.	Perform hand hygiene and wear gloves.			
3.	Administer the radioisotope orally or intravenously as prescribed.			
4.	Instruct the patient to remain still during imaging, which typically occurs 30 minutes to several hours after radioisotope administration.			
5.	Monitor the patient for any allergic reactions or discomfort following the administration of the radioisotope.			
6.	Assist with operating the gamma camera to capture images of the thyroid gland.			
7.	Advise the patient to maintain hydration to aid in the clearance of the radioisotope from the body.			

Nursing instructor's signature: _____ Date:

_____

Assist in the Procedure of X-Ray

Equipment Required:

- X-ray machine with detector or film.
- Lead shielding for patient and healthcare workers.
- Patient monitoring equipment (if required).
- Positioning aids (e.g., pillows or foam pads).

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Position the patient appropriately on the X-ray table or in a standing/sitting position as required by the area being imaged.			
2.	Perform hand hygiene and wear appropriate protective gear (e.g., lead			

	apron).			
3.	Ensure that all metallic objects have been removed from the patient's body.			
4.	Place lead shielding (e.g., lead apron) over non-targeted body areas to minimize radiation exposure.			
5.	Instruct the patient to remain still and hold their breath (if required) during the exposure.			
6.	Assist the radiographer with operating the X-ray machine, ensuring proper settings for exposure and imaging.			
7.	Monitor the patient for discomfort or anxiety and provide reassurance throughout the procedure.			

Nursing instructor's signature: _____ Date: _____

Assist in the Procedure of Skin Traction

Equipment Required:

- Bed with traction frame and trapeze
- Weights
- Velcro straps or other straps
- Rope and pulleys
- Boot with footplate
- Elastic anti-embolism stocking, as appropriate
- Nonsterile gloves and/or other PPE, as indicated
- Skin cleansing supplies

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Check the medical order and nursing care plan to determine the type of skin traction being used and care for the affected body part.			
2.	Identify the patient.			
3.	Perform hand hygiene and put on PPE, if indicated.			
4.	Introduce yourself and inform the patient about the procedure, explaining what will be done and why it is necessary.			
5.	Gather necessary equipment.			

6.	Close the patient’s bedside curtain or door.			
7.	Raise the bed to a comfortable working height.			
8.	Ensure the traction apparatus is firmly secured to the bed and evaluate the traction setup.			
9.	Check that the ropes glide smoothly through the pulleys and that all knots are securely tied and positioned away from the pulleys. Ensure pulleys are free of linens.			
10.	Position the patient lying on their back (supine) with the foot of the bed slightly elevated, ensuring the head is close to the head of the bed and properly aligned.			
11.	Clean the affected area and apply the elastic stocking to the affected limb as needed.			
12.	Place the traction boot on the patient's leg, ensuring the heel is properly positioned, and fasten it securely.			
13.	Attach the traction cord to the footplate of the boot, passing the rope over the pulley and attaching the weight (usually 5 to 10 pounds for an adult). Gently let go of the weight.			
14.	Check the patient’s alignment with the traction.			
15.	Check the boot for correct placement and alignment, ensuring the line of pull is parallel to the bed and not angled downward.			
16.	Place the bed in the lowest position that allows the weight to hang freely.			
17.	Remove additional PPE, if used, and perform hand hygiene.			

Nursing instructor’s signature: _____ Date: _____

Assist in the Application of Cast

Equipment Required:

- Stockinette
- Padding (cotton or synthetic)
- Plaster bandages or fiberglass tape
- Bucket of water
- Scissors or cast saw
- Bandage shears
- Cast spreader
- Casting stand or support
- Disposable, nonsterile gloves and aprons
- PPE, as indicated

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Check the medical order and nursing care plan to determine the need for the cast.			
2.	Identify the patient and verify the area to be casted.			
3.	Perform hand hygiene and put on PPE, if indicated.			
4.	Introduce yourself and inform the patient about the procedure, explaining what will be done and why it is necessary.			
5.	Gather necessary equipment.			
6.	Close the patient's bedside curtain or door.			
7.	Raise the bed to a comfortable working height.			
8.	Perform a pain assessment and check for muscle spasms. Administer prescribed medications with enough time for analgesics or muscle relaxants to take full effect.			
9.	Position the patient appropriately based on the type of cast and the location of the injury. Ensure the affected limb or body part is properly supported during the cast application.			
10.	Drape the patient with waterproof pads.			

11.	Cleanse and dry the affected body part.			
12.	Position the affected body part as instructed by the physician while applying stockinette, wadding, and padding. Ensure the stockinette extends beyond the edges of the cast. Smooth out wrinkles in the wadding.			
13.	Assist with finishing by folding the stockinette or padding down over the outer edge of the cast.			
14.	Support the cast while it hardens using the palms of your hands, ensuring it rests on a firm, smooth surface. Avoid placing it on hard or sharp edges, and do not apply pressure.			
15.	Raise the injured limb above heart level using pillows or folded blankets, ensuring even pressure distribution underneath the cast.			
16.	Position the bed at its lowest level with side rails raised for safety. Ensure the call bell and essential items are easily accessible.			
17.	Remove additional PPE, if used, and perform hand hygiene.			
18.	Obtain x-rays, as ordered.			
19.	Advise the patient to promptly report any pain, unusual odor, drainage, changes in sensation, tingling, or difficulty moving the fingers or toes of the affected limb.			
20.	Leave the cast uncovered and exposed to the air. Reposition the patient every 2 hours.			

Nursing instructor's signature: _____ **Date: _____**

Eye Bandaging

Equipment Needed for Eye Bandaging

- Clean gloves
- Sterile eye pad
- Hypoallergenic adhesive tape or roller bandage
- Saline or prescribed eye drops
- Gauze or cotton ball
- Scissors (if using a roller bandage)
- Documentation tool

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Identify the patient using two identifiers (e.g., name and birthday) according to agency policy.			
2.	Perform hand hygiene and apply clean gloves.			
3.	Position the patient comfortably, either sitting or lying down, with head supported.			
4.	Clean the area around the eye using sterile gauze or cotton balls moistened with saline or prescribed eye drops.			
5.	Place the sterile eye pad gently over the closed eyelid, ensuring complete coverage without pressure on the eyeball.			
6.	Secure the eye pad using hypoallergenic adhesive tape or a roller bandage.			
7.	If using adhesive tape, place it diagonally across the eye pad to keep it secure, but not too tight. If using a roller bandage, wrap it around the head, avoiding excessive tension.			
8.	Instruct the patient to avoid rubbing or applying pressure on the bandaged eye.			

Nursing instructor's signature: _____ Date:

_____

Eye Irrigation

Equipment Required:

- Prescribed irrigating solution: volume usually 30 to 180 mL at 32° to 38° C (90° to 100° F) (For chemical flushing, use normal saline or lactated Ringers fluid in large volume to provide continuous irrigation over 15 minutes.)
- Waterproof pad or towel
- 4 × 4–inch gauze pads
- Soft bulb syringe, eyedropper, or intravenous (IV) tubing
- Clean gloves
- Penlight
- Medication administration record (MAR)
- Sterile basin
- Curved emesis basin

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Identify patient using two identifiers (i.e., name and birthday or account number)			

	according to agency policy. Compare identifiers in MAR/medical record with patient's identification bracelet and/or ask patient to state name.			
2.	Perform hand hygiene. Apply clean gloves.			
3.	Remove any contact lens if possible. Remove gloves after contact lens is removed. Reapply new gloves.			
4.	Explain to patient that the eye can be closed periodically and that no object will touch it.			
5.	Place towel or waterproof pad under the patient's face and curved emesis basin just below patient's cheek on the side of the affected eye.			
6.	Using gauze moistened with prescribed solution (or normal saline), gently clean visible secretions or foreign material from eyelid margins and eyelashes, wiping from inner to outer canthus.			
7.	Explain next steps to the patient and encourage relaxation: a. With gloved finger, gently retract upper and lower eyelids to expose conjunctival sacs. b. To hold lids open, apply gentle pressure to lower bony orbit and bony prominence beneath the eyebrow. Do not apply pressure over the eye.			
8.	Hold irrigating syringe, dropper, or IV tubing approximately 2.5 cm (1 inch) from the inner canthus.			
9.	Ask patient to look toward their brow. Gently irrigate with a steady stream toward the lower conjunctival sac, moving from inner to outer canthus.			
10.	Reinforce the importance of the procedure and encourage the patient with a calm, confident, and soft voice.			
11.	Allow the patient to blink periodically.			
12.	Continue irrigation with prescribed solution volume or time, or until secretions are cleared. (An irrigation of 15 minutes or more is needed to flush chemicals.)			
13.	Dispose of soiled supplies, remove gloves, and perform hand hygiene.			

Nursing instructor's signature: _____ Date: _____

Ear Irrigation

Equipment Required:

- Clean gloves
- Irrigation syringe
- Basin for irrigating solution (Use sterile basin if sterile irrigating solution is used).
- Curved emesis basin
- Towel
- Cotton balls or 4 × 4–inch gauze
- Prescribed irrigating solution warmed to body temperature or mineral oil, over-the-counter softener
- Medication administration record (MAR)
- Otoscope (optional)

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Identify patient using two identifiers (i.e., name and birthday or name and account number) according to agency policy. Compare identifiers in MAR/medical record with information on the patient's identification bracelet and/or ask the patient to state their name.			
2.	Perform hand hygiene and arrange supplies at the bedside.			
3.	Close curtain or room door.			
4.	Help patient to a sitting or lying position with head turned toward affected ear. Place a towel under the patient's head and shoulder, and have patient, if able, hold an emesis basin under the affected ear.			
5.	Pour prescribed irrigating solution into a basin. Check the temperature of the solution by pouring a small drop on your inner forearm.			
6.	Apply clean gloves. Gently clean the auricle and outer ear canal with gauze or cotton balls. Do not force drainage or cerumen into the ear canal.			
7.	Fill irrigating syringe with solution (approximately 50 mL).			
8.	For adults and children over 3 years old, gently pull the pinna up and back. For children 3 years or younger, pull the pinna down and back. Place the tip of the irrigating device just inside the external meatus,			

	leaving space around the irrigating tip and canal.			
9.	Slowly instill the irrigating solution by holding the tip of the syringe 1 cm (1/2 inch) above the ear canal opening. Direct fluid toward the superior aspect of the ear canal. Allow it to drain into the basin during instillation.			
10.	Maintain a steady flow of irrigation until pieces of cerumen flow from the canal.			
11.	Periodically ask if the patient is experiencing pain, nausea, or vertigo.			
12.	Drain excessive fluid from the ear by having the patient tilt their head toward the affected side.			
13.	Dry the outer ear canal gently with a cotton ball. Leave the cotton ball in place for 5 to 10 minutes.			
14.	Help the patient to a sitting position.			
15.	Remove gloves, dispose of supplies, and perform hand hygiene.			

Nursing instructor's signature: _____ Date: _____

Blood Glucose Monitoring

Equipment Required:

- Clean gloves
- Glucometer (blood glucose meter) (e.g., Accucheck III, OneTouch)
- Test strips (specific to glucometer brand)
- Lancet device
- Alcohol swabs or antiseptic wipes
- Gauze or cotton ball
- Sharps container
- Documentation tool (MAR/EHR)

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Identify patient using two identifiers (e.g., name and birthday or account number). Compare identifiers with MAR/medical record or have the patient state their name.			
2.	Perform hand hygiene. Instruct patient to clean hands and forearm (if applicable) with soap and water, then rinse and dry.			
3.	Position patient comfortably in a chair or in semi-Fowler's position in bed.			
4.	Remove reagent strip from vial, tightly seal cap, and check the code on the test strip vial. Use only test strips recommended for the glucose meter.			
5.	Insert strip into meter following manufacturer directions. Ensure strip is not bent.			
6.	Remove unused reagent strip from the meter and place it on a clean, dry surface with the test pad facing up.			
7.	Ensure the code on the meter matches the code on the test strip vial. Confirm matching codes on the meter.			
8.	Perform hand hygiene and apply clean gloves. Prepare single-use lancet or multiple-use lancet device by inserting a new lancet. Twist off protective cover from the lancet and replace the cap of the device. Adjust puncture depth.			
9.	Wipe patient's finger or forearm with an antiseptic swab. Choose a vascular area for puncture (lateral side of the finger for adults).			
10.	Hold the puncture site in a dependent position and apply the lancet device to the skin. Press the release button and remove the device after puncture.			
11.	Gently squeeze or massage the finger to form a round drop of blood if the blood sample does not appear immediately.			
12.	Obtain test results from the meter.			
13.	Turn the meter off (or ensure it turns off automatically) and dispose of the test strip, lancet, and gloves in appropriate receptacles.			

Nursing instructor's signature: _____ Date: _____

Cardiac Monitoring/Telemetry

Equipment Required:

- Clean gloves

- Telemetry monitor or cardiac monitor
- ECG electrodes and leads
- Skin preparation supplies (e.g., alcohol wipes or adhesive remover)
- Documentation tool (MAR/EHR)

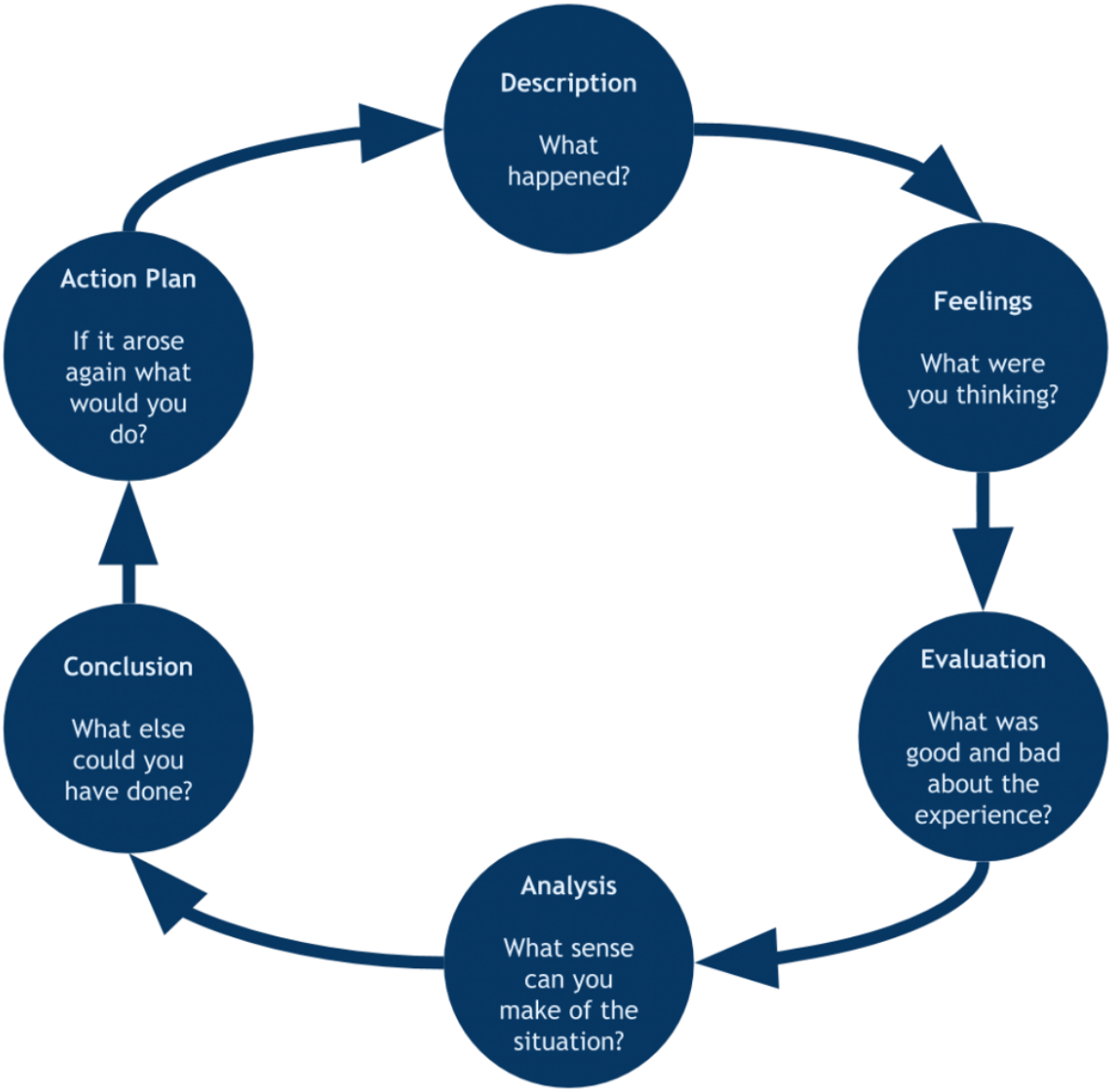
Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Identify patient using two identifiers (e.g., name and birthday) according to agency policy.			
2.	Perform hand hygiene and apply clean gloves.			
3.	Position the patient comfortably in a supine or semi-Fowler's position.			
4.	Prepare the skin by cleaning electrode placement areas with alcohol wipes or adhesive remover, and dry the skin thoroughly.			
5.	Apply electrodes at the correct anatomical locations according to telemetry requirements (e.g., right arm, left arm, right leg, left leg, and precordial positions).			
6.	Avoid placing electrodes over bony prominences or areas of excessive hair.			
7.	Connect the lead wires to the electrodes, ensuring each lead is attached to the correct electrode.			
8.	Confirm that the monitor displays the correct waveform and heart rate, adjusting lead placement if necessary.			
9.	Instruct the patient to report any symptoms, such as chest pain, dizziness, or palpitations.			

Nursing instructor's signature: _____ Date:

_____

Reflection/ Critical Incident Analysis



Gibbs' Reflective Cycle 1998

CASE STUDY FORMAT

LXV. INTRODUCTION

I. Background of the study
J. Objective (general & specific showing Knowledge, Skills & Attitude)
K. Scope and Delimitation
L. Theoretical Framework

LXVI. BIOGRAPHIC DATA

Name
Address
Age
Gender

Race
Marital Status
Occupation
Religious orientation
Health care financing and usual source of medical care

LXVII. CHIEF COMPLAINT OR REASON FOR VISIT

LXVIII. NURSING HISTORY (with guide questionnaire)

U. History of Present Illness
V. Past Medical History
   y) Childhood diseases
   z) Immunizations
   aa) Allergies
   bb) Accidents and injuries
   cc) Hospitalization
   dd) Medication
W. Family History of Illness (use Genogram)
X. Obstetric History (for OB cases only; with Assessment Guide)
Y. Developmental History (for Pediatric cases only; with Assessment Guide)

Note: Assessment guide *used should be attached as annexes at the back of the case study report.*

LXIX. FUNCTIONAL HEALTH PATTERN (with guide questionnaire)

45. Health Perception and Health Management Pattern
46. Nutrition and Metabolic Pattern
47. Elimination Pattern
48. Activity-Exercised Pattern (use Barthel index)
49. Sleep-rest Pattern
50. Cognitive-perceptual Pattern
51. Self-perception and self-control Pattern
52. Role-relationship Pattern
53. Sexuality-reproductive Pattern
54. Coping-stress tolerance Pattern
55. Value-belief Pattern

Interpretation:
Analysis: (with reference)

LXX. REVIEW OF SYSTEM (all subjective complaints)

LXXI. PHYSICAL ASSESSMENT (all objective findings; indicate date performed; Head to Toe Assessment; follow IPPA sequence)

9. General Survey (Short Paragraph)
10. Vital Signs

BODY PART (Technique used)	NORMAL FINDINGS	ACTUAL FINDINGS	INTERPRETATION / ANALYSIS w/ Reference

LXXII. ANATOMY & PHYSIOLOGY

LXXIII. DIAGNOSTIC / LABORATORY STUDIES (Table)

NAME OF TEST / PROCEDURE	DATE DONE	INDICATION FOR THE TEST / PROCEDURE	NORMAL VALUE	ACTUAL RESULT / FINDINGS	SIGNIFICANCE OF THE RESULT / FINDINGS

LXXIV. SURGICAL PROCEDURE (Operative worksheet, if any)

LXXV. PATHOPHYSIOLOGY (Present in Schematic Diagram; Mind Mapping)

LXXVI. DRUG STUDY / IV INFUSIONS, BLOOD TRANFUSIONS, TREAMENTS GIVEN

Drug Study

DRUG ORDER (Generic, name, dosage, route, frequency)	TRADE / BRAND NAME	PHARMACOLOGIC ACTION OF DRUG	INDICATION AND CONTRAINDICATIONS	ADVERSE EFFECTS OF THE DRUG	DESIRED ACTION ON YOUR CLIENT	NURSING RESPONSIBILITIES / PRECAUTIONS

Treatments Given

TREATMENT / INFUSION	CLASSIFICATION	INDICATION	CONTRAINDICATION	NURSING RESPONSIBILITIES / PRECAUTIONS

LXXVII. COURSE IN THE WARD (narrative form)

- Summary of day to day medical/nursing management from the date of admission up to the time case study was done
- Patient's Status:

a. General condition of the client (ex. LOC, VS, and other Subjective & Objective, complaint during the day)

b. 4 D's with inference / analysis:
   - Diet
   - Drugs/IVF
   - Lab/Diagnostics procedure
   - Disposition

LXXVIII. PRIORITIZED LIST OF NURSING PROBLEMS (Table)

- Prioritized using ABC's and Maslow's Hierarchy of Needs

DATE	NURSING PROBLEMS IDENTIFIED	CUES	JUSTIFICATION

LXXIX. NURSING CARE PLAN

CUES (Defining Characteristics of Nursing Diagnosis)	NURSING DIAGNOSIS (Problem & Etiology)	BACKGROUND KNOWLEDGE (Pathophysiology/psychosocial explanation or consequences of the nursing diagnosis)	GOALS AND OBJECTIVES (include long and short term objectives)	NURSING INTERVENTIONS AND RATIONALE	EVALUATION

LXXX. PROPOSED / DISCHARGE PLAN (to be submitted by students whose patients are for discharge)

- M - Medications to take at home
- E - Exercises
- T - Treatment
- H - Health Teachings
- O - Out - patient follow-up
- D - Diet
- S - Spiritual / Sexual activity (optional)

Reference

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Luokkamäki, S., Härkänen, M., Saano, S., & Vehviläinen-Julkunen, K. (2021). Registered Nurses'

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SEMESTER-IV

Health Assessment-II (Clinical)-1 CH

Course Description:

This course aimed to provide nursing students with foundational knowledge and skills to systematically collect and analyze data related to the health status of individuals across the lifespan. Emphasis is placed on developing competency in history-taking, physical examination techniques, and the use of clinical reasoning to identify normal and abnormal findings. Students learn to perform comprehensive and focused assessments using a holistic approach that incorporates physical, psychosocial, cultural, and developmental factors.

Clinical Rotation plan:

This semester will be of 16/22 weeks, the student nurse will go to clinical rotation (in block days) to observe, learn and perform skills under the supervision of clinical instructor

CLINICAL OBJECTIVES

By the end of this course, students will be able to:

1. Systematically assess the health status of an individual by obtaining a complete health history using interviewing skills appropriately.
2. Utilize proper techniques of observation and physical examination in assessing various body systems.
3. Differentiate normal from abnormal findings.
4. Record findings in an appropriate manner.
5. Demonstrate an awareness of the need to incorporate health assessment as part of their general nursing practice skills.
6. Apply knowledge of growth & development, anatomy, physiology, & psychosocial skills in assessment & analysis of data collected.

Clinical Objectives Form

Student Name: _____ Faculty: _____

Clinical placement:_____ Date: _____

Clinical Objectives	Strategies	Evaluation

History Taking Proforma

Student Name: _____Group #: _____Faculty: _____

1. Document the client presenting complaint, Functional Health Patterns and Review of Systems findings and draw family genogram

Checklist for taking a client health history

Interviewing Checklist	Satisfactory	Need to improve
Introduced self, purpose, and agenda		
Arranged for proper environment (position, distance, light)		
Asks open ended question (to explore chief concern)		
Explores information about chief concern (COLDERRAA) Character, Onset, Location, Duration, Exacerbation, Radiation, Relief, Antecedent, Associated factors		
Proceed from general to specific, follows cues, probes positive finding, asks clear, logical questions, one at a time		
Uses effective communication techniques (Facilitation, Clarification, Paraphrasing, Transitions, Summarization)		
demonstrates appropriate verbal / nonverbal gesture (Eye contact, voice tone, active listening, hand gestures)		
Avoids being non therapeutic (asking why questions, biased, leading, judgmental, false reassurance, changing topic)		
Explores client past history of any illness		
Explores client family history		
Explores client functional abilities & life style patterns		
Explores Review of System checklist efficiently		

Faculty comments:

Nursing Care Plan

Assessment	Nursing Diagnosis	Goal	Planning	Implementation	Rationale	Evaluation
Subjective Data						
Objective Data						

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S #	Skills	Level of competency	Minimum Frequency
1.	Peripheral Vascular & Musculoskeletal system Assessment	1-5	
2.	Cardiovascular system Assessment	1-5	
3.	Mental Status & Sensory Neuro Assessment	1-5	
4.	Eyes & Ears Assessment	1-5	
5.	Thorax & Lungs Assessment	1-5	
6.	Assessment of elderly client	1-5	
7.	Assessment of pediatric client	1-5	

No	Procedures	Clinical Experience					
		Skill Lab Lecturer Signature	Date	Ward/Clinics Signature	Date	Supervisor Signature	Date

1.	**Peripheral Vascular & Musculoskeletal system Assessment**						
2.	**Cardiovascular system Assessment**						
3.	**Mental Status & Sensory Neuro Assessment**						
4.	**Eyes & Ears Assessment**						
5.	**Thorax & Lungs Assessment**						
6.	**Assessment of elderly client**						
7.	**Assessment of pediatric client**						

Checklists for Physical Examination

Peripheral Vascular Assessment

Equipment Required

- None

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Prior to performing the procedure, introduce self and verify the client's identity using agency protocol. Explain to the client what you are going to do, why it is necessary, and how he or she can participate. Discuss how the results will be used in planning further care or treatments			
2.	Perform hand hygiene and observe other appropriate infection prevention procedures.			
3.	Provide for client privacy			
4.	Inquire if the client has any of the following: past history of heart disorders, varicosities, arterial disease, and hypertension; lifestyle habits such as exercise patterns, activity patterns and tolerance, smoking, and use of alcohol.			
5.	**PERIPHERAL PULSES** Palpate the peripheral pulses on both sides of the			

	client's body individually, simultaneously (except the carotid pulse), and systematically to determine the symmetry of pulse volume. If you have difficulty palpating some of the peripheral pulses, use a Doppler ultrasound probe			
6.	**PERIPHERAL VEINS** Inspect the peripheral veins in the arms and legs for the presence and/or appearance of superficial veins when limbs are dependent and when limbs are elevated			
7.	Assess the peripheral leg veins for signs of phlebitis. • Inspect the calves for redness and swelling over vein sites. • Palpate the calves for firmness or tension of the muscles, the presence of edema over the dorsum of the foot, and areas of localized warmth. • Push the calves from side to side to test for tenderness. • Firmly dorsiflex the client's foot while supporting the entire leg in extension (Homans' test), or have the person stand or walk			
8.	**PERIPHERAL PERFUSION** Inspect the skin of the hands and feet for color, temperature, edema, and skin changes.			
9.	Assess the adequacy of arterial flow if arterial insufficiency is suspected			
10.	**CAPILLARY REFILL TEST** • Press at least one nail on each hand and foot between your thumb and index finger sufficiently to cause blanching (about 5 seconds) • Release the pressure, and observe how quickly normal color returns (less than 2 seconds)			
11.	Inspect the fingernails for changes indicative of circulatory impairment.			
12.	Document findings in the client record using printed or electronic forms or checklists supplemented by narrative notes when appropriate			

Nursing instructor's signature: _____ Date: _____

Musculoskeletal System Assessment

Equipment Required:

- Goniometer
- Tape measure

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	**Principles of Physical Examination** 1. Introduce self 2. Explain examination 3. Give proper instructions 4. Wash or sanitize hands 5. Arrange for proper Environment 6. Position client properly 7. Drapes client properly			
2.	**Objective Data**			
3.	**General survey:** Observe for ● Gait ● Posture ● Body habitus/ structure ● Deformity. ● Hygiene & body odors (well-groomed or unkempt) ● Signs of distress ● Pain and Shortness of breath			
4.	Assess Mental status and Level of Consciousness			
5.	**Demographic Data:** ● Age: ● Gender: ● Education status: ● Occupation: ● Marital status: ● Diagnosis:			
6.	**Presenting illness:** (reason for seeking healthcare / admission)			
7.	**History of presenting illness:** (**COLDERRAA** to investigate positive finding)			
8.	**Past medical or surgical history:** (Any illness, surgery, injury, or accident)			
9.	**Social History**: (Use of cigarette, alcohol, and illicit drugs)			

10.	**Family history:**			
11.	**Lifestyle**: alcohol, diet, exercise, stress, use of over-the-counter medications and sleep pattern)			
12.	**Review musculoskeletal system complaints**. ● Positive historical and family history ● Any leg cramps, varicosities, edema, ulcers or skin pigmentation or color change ● How are your muscles and joints? Any problems with back, muscle cramps, joint pain, stiffness, swelling, fixation, limitation, fracture, dislocation. Any problems carrying out ADL			
13.	**Head Face and Neck** Inspect Facial symmetry & palpate TMJ joint			
14.	**Neck:** Inspect neck/ spine for cervical concavity Palpate cervical vertebrae / spine for tenderness or swelling			
15.	**Spine & Back:** Inspect & palpate for Thoracic convexity & Lumbar concavity Perform range of motion of spine (Flexion, extension, rotation & lateral bending)			
16.	**Upper extremities (UE)** Assess muscle mass, bone structure, contour, symmetry Inspect UE and symmetry of joints (Shoulders, Elbows, Fingers and wrist) Palpate UE joints for tenderness and any deformity Perform and assess ROM of Shoulders, Elbows, Fingers and wrist			
17.	**Shoulders:** flexion, extension, internal and external rotation, abduction and adduction. **Elbows:** Flexion & extension, supination and pronation. **Wrist:** flexion, extension, abduction & adduction. **Fingers (metacarpophalangeal. interphalangeal joints):** flexion, extension, adduction, abduction			
18.	**Lower extremities (LE)** Assess muscle strength, bone structure, symmetry Inspect LE, and symmetry of joints (hips, knee, ankle, feet) Palpate for tenderness and crepitus Perform and assess ROM of LE **Hips:** flexion, extension, Abduction, adduction, internal & external rotation) **Knees:** Flexion & extension. **Ankles & Foot (Metatarsophalangeal, interphalangeal joints):** inversion, eversion, planter flexion, dorsiflexion			
19.	**Special test:** Perform Ballottement test			

	Perform Bulge test			

Nursing instructor's signature: _____ Date:

_____

Cardiovascular System Assessment

Equipment Required:

- Stethoscope
- Centimeter ruler

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	**Inspection (in sitting position)** Patient appearance (Comfortable, well appearing, anxious, short of breath, etc).			
2.	**Note any cyanosis, clubbing, pallor, cachexia, and tachypnea (see your physical diagnosis text for definition).**			
3.	**Vital signs, carotid pulses, jugular venous findings: Check radial pulse for 15 seconds (Note pulse rate in beats per minute, also note if pulse is regular or irregular).**			
4.	Position patient in supine position, with head elevated at 30-45 degrees. Stand to the patient's right.			
5.	Inspect right carotid artery: Turn patient's head to left, look for bounding pulses.			
6.	Inspect right internal jugular vein while palpating right radial artery. Look for A waves and V waves (see text). State whether A wave is larger, smaller, or the same as the V wave.			
7.	Sequentially palpate each carotid pulse. Are the pulses equal? Assess volume and upstroke (bounding, diminished, or delayed).			
8.	Sequentially auscultate each carotid artery for bruits or transmitted murmurs.			
9.	State the jugular venous pressure in centimeters of water			
10.	Inspect precordium for abnormal pulsations			
11.	**Palpation** Palpate the apical impulse, and note its location (e.g. 5th intercostal space, midclavicular line). Note if the impulse is sharp or diffuse.			
12.	**Palpate the left parasternal borders for right ventricular heaves or thrills (a vibration representing a severe murmur**			
13.	Palpate the 2nd left intercostal space for pulmonary artery			
14.	Palpate the suprasternal notch for aortic pulsations.			

15.	**Auscultation (with head of bed up 30 – 45 degrees)** Listen to the following areas of the precordium with both the bell and diaphragm: 2nd right intercostal space 2nd left intercostal space Left lower sternal border **Apex**			
16.	**Listen for:** **S1 and S2 (Helpful hint: Palpate a carotid pulse while listening. S2 is after the carotid pulse).**			
17.	S3 and S4 (This can be tricky. S4 is before S1 and S2, and the three beats sound like 'Tennessee'. S3 is after S1 and S2, and the sound is more like "Kentucky".)			
18.	Other sounds to listen for during systole and diastole: murmurs, rubs, clicks, opening snaps (see your physical diagnosis text for detailed descriptions).			
19.	Ask patient to roll onto left side. Identify the apex by palpation (i.e., the point of maximal impulse or PMI). Using the bell, listen at the apex. This will bring out mitral valve abnormalities			
20.	Ask the patient to sit up and to inhale, exhale deeply, and then lean forward. Listen over the aortic and pulmonic areas for the diastolic murmur of aortic insufficiency and for pericardial rubs. (This maneuver is a particularly important one to master – and remember.)			
21.	**Peripheral Vascular Exam** ➢ Inspect lower extremities for size, symmetry, color, temperature and venous patterns (e.g. venous stasis). ➢ Palpate lower extremities for signs of edema. • Palpate lower extremity arterial pulses (i.e. dorsalis pedis and posterior tibial arteries).			

Nursing instructor's signature: _____ Date:

_____

Mental Status Assessment

Equipment Required:

- None

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Prior to performing the procedure, introduce self and verify the client's identity using agency protocol. Explain to the client what you are going to do, why it is necessary, and how he or she can participate. Discuss			

	how the results will be used in planning further care or treatments			
2.	Perform hand hygiene and observe other appropriate infection prevention procedures.			
3.	Provide for client privacy			
4.	Observe for signs of distress in posture or facial expression			
5.	Observe body build, height, and weight in relation to the client's age, lifestyle, and health			
6.	Observe client's posture and gait, standing, sitting, and walking.			
7.	Observe client's overall hygiene and grooming			
8.	Note body and breath odor			
9.	Note obvious signs of health or illness (e.g., in skin color or breathing).			
10.	Assess the client's attitude (frame of mind)			
11.	Note the client's affect/mood; assess the appropriateness of the client's responses			
12.	Listen for quantity of speech (amount and pace), quality (loudness, clarity, inflection)			
13.	Listen for relevance and organization of thoughts			
14.	Document findings in the client record using printed or electronic forms and checklists supplemented by narrative notes when appropriate			

Nursing instructor's signature: _____ Date: _____

Eye Assessment Checklist

Equipment Required:

1. Snellen Chart
2. Penlight or Torch
3. Ophthalmoscope
4. Cotton Wisp or Cotton Ball
5. Gloves

Checklist

S No	Task	Yes	No	Comments
1	**Assesses distance vision using a Snellen chart.**			
a	Chooses correct chart for age and literacy.			

b	Allows client to wear corrective lenses for test.			
c	Has patient stand 20 ft from chart and cover one eye at a time.			
d	Tests eyes singly and then together. Records findings correctly.			
2	**Tests near vision by measuring the ability to read newsprint at a distance of 14 inches (35 cm). Correctly identifies hyperopia or presbyopia if present.**			
3	**Tests color vision by using color plates or the color bars on the Snellen chart.**			
4	**Assesses peripheral vision by determining when an object comes into sight.**			
a	Seats client 2 to 3 feet from nurse			
b	Has client cover one eye and gaze straight ahead.			
c	Begins well outside normal peripheral vision and brings object to the center of the visual fields.			
d	Repeats in all 4 visual fields, clockwise.			
5	**Assesses EOMs by examining:**			
a	for parallel alignment.			
b	the corneal light reflex.			
c	the ability to move through the six cardinal gaze positions			
d	the cover/uncover test.			
6	**Inspects external structures:**			
a	Color and alignment of eyes.			
b	Eyelids: notes any lesions, edema, or lid lag.			
c	Symmetry and distribution of eyelashes.			
d	Lacrimal ducts and glands, checks for edema, and drainage.			
e	Notes color, moisture, and contour of conjunctiva.			
f	Inspects both palpebral and bulbar conjunctiva.			
g	Sclera: Notes color and presence of lesions.			
h	Inspects cornea and lens with penlight; notes color and lesions.			
i	Tests the corneal reflex with a cotton wisp.			
j	Notes color, size, shape, and symmetry of iris and pupils			
k	Checks pupil reaction for direct and consensual response.			
l	Assesses pupil accommodation by having the patient focus on an approaching object.			
m	Inspects anterior chamber with penlight, for color, size, shape, and symmetry.			

7	**Palpates the external eye structures for tenderness and discharge; palpates globes and lacrimal glands and ducts.**			
8	**Assesses the internal structures via ophthalmoscopy. Darkens the room.**			
a	Stands about 1 foot from the patient at a 15 degree lateral angle.			
b	Dials the lens wheel to zero with index finger.			
c	Holds ophthalmoscope to own brow.			
d	Has the patient look straight ahead while shining the light on one pupil to identify the red light reflex.			
e	Once the red light reflex is identified, moves in closer to within a few inches of the eye and observes the internal structures of the eye. Adjusts the lens wheel to focus as needed.			
f	Uses right eye to examine the patient's right eye, and left eye to examine the patient's left eye.			

Nursing instructor's signature: _____ Date: _____

Sensory Neuro Assessment

Equipment Required:

Equipment (Depending on Components of Examination)

- Percussion hammer
- Wisps of cotton to assess light-touch sensation
- Sterile safety pin for tactile discrimination

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Prior to performing the procedure, introduce self and verify the client's identity using agency protocol. Explain to the client what you are going to do, why it is necessary, and how he or she can participate. Discuss how the results will be used in planning further care or treatments			
2.	Perform hand hygiene and observe other appropriate infection prevention procedures.			
3.	Provide for client privacy			
4.	Tests orientation to person, place, and time.			
5.	Tests immediate memory (attention) with digit span (asking patient to repeat up to 7 digits), serial 7's, or asking patient to			

	spell WORLD forward and backward.			
6.	Tests recent long term memory by asking about recent current events, who is the president, how they got here, what they had for supper, etc.			
7.	Tests remote long term memory by asking for past presidents, birth date, names and birthdays of children or grandchildren, work history, etc.			
8.	Tests Content clarity.			
9.	Tests Proverbial test.			
10.	Tests Judgment.			
11.	Test constructional ability by saying 3 steps order or thought			
12.	Tests calculation by asking straightforward computation questions such as how many nickels in $1.35? what is 6x7?			
13.	**Cranial Nerves** Asks patient to identify smell of coffee or spice (not alcohol) (CN I).			
14.	Tests visual acuity of each eye separately, using near card and with patient's own corrective lenses (CN II).			
15.	Tests visual fields to confrontation in each eye (CN II).			
16.	Examines optic disc (CN II) by fundoscopic exam.			
17.	Examines pupils in darkened room, checks pupillary light responses, both direct and consensual with swinging flashlight test (CN II, III, autonomics).			
18.	Comments on eyelid position / ptosis (CN III).			
19.	Examines horizontal, vertical, and diagonal eye movements (CN III, IV, VI).			
20.	Tests light touch sensation on forehead, cheeks, and jaw (CN V sensory).			
21.	Tests muscles of mastication, jaw opening and closing (CN V motor).			
22.	Tests muscles of facial expression such as smile, eye closure, brow wrinkling (CN VII motor).			
23.	Tests hearing to finger rub or tuning fork (CN VIII).			
24.	Examines palatal movement (CN IX, X).			
25.	Comments on dysarthria (CN VII, IX, X, XII).			
26.	Tests strength of head rotation in each direction (CN XI).			
27.	Tests strength of shoulder elevation (CN XI).			

28.	Tests tongue movements both side to side and protrusion (CN XII)			
29.	**Sensory** Tests light touch on all 4 extremities, both proximally and distally.			
30.	Tests light touch to double simultaneous stimulation on right and left.			
31.	Tests sensation to pinprick (Pain/Temperature sensation) on all 4 extremities, both proximally and distally.			
32.	Tests joint position sense at thumbs and great toes.			
33.	Tests vibratory sense on distal bony prominence of hands and feet.			
34.	Tests graphesthesia on finger or palm by drawing a letter or number with retracted ballpoint pen or pencil.			
35.	Tests stereognosis by placing an object in patient's hand and asking to identify it without looking.			
36.	**Motor, Gait and Coordination** Tests muscle tone by passive manipulation. This can be done at shoulders, elbows, wrists, hips, knees, and ankles			
37.	Examines casual gait			
38.	Checks patient walking on heels, toes, and in tandem (heel to toe walking)			
39.	Tests finger tapping bilaterally.			
40.	Tests rapid alternating movements of each hand.			
41.	Tests finger-to-nose bilaterally.			
42.	Tests heel-to-shin bilaterally.			
43.	Romberg test.			
44.	Tests pronator drift.			
45.	Tests strength of shoulder abduction, elbow flexion, wrist extension, elbow extension, finger flexion and hand intrinsics (abduction of fifth finger).			
46.	Grades strength on 0-5 scale (5 being full strength).			
47.	Tests strength of hip flexion, knee extension, knee flexion, ankle dorsiflexion, ankle Plantarflexion.			
48.	Grades strength on 0-5 scale (5 being full strength).			
49.	Comments on muscle bulk and symmetry.			
50.	**Reflexes** Tendon reflexes at biceps, triceps, brachioradialis, patellar, and Achilles bilaterally.			

51.	Plantar Reflexes (Babinski).			

Nursing instructor's signature: _____ Date: _____

Thorax and Lungs Assessment

Equipment Required:

- Stethoscope

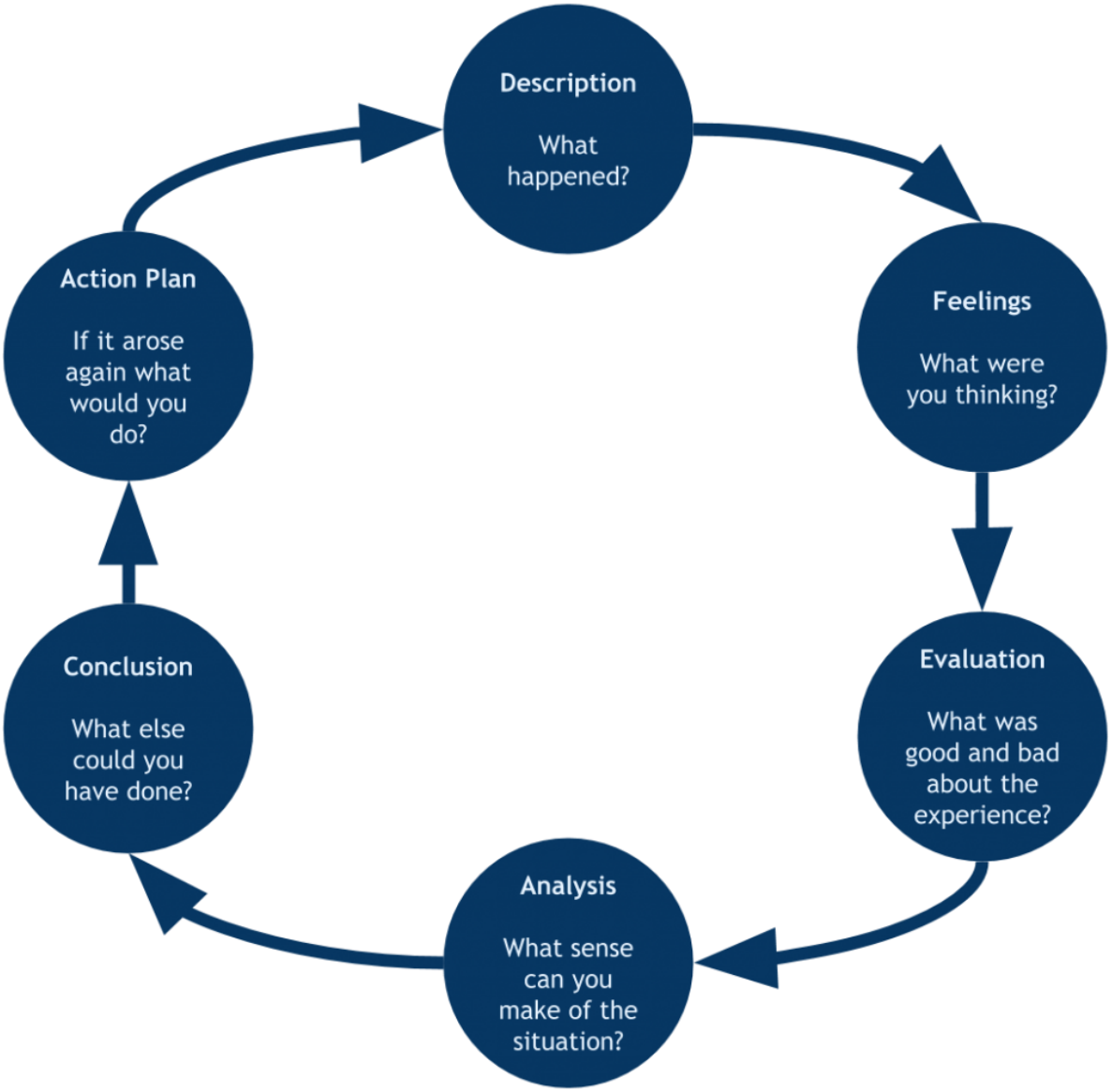
Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Prior to performing the procedure, introduce self and verify the client's identity using agency protocol. Explain to the client what you are going to do, why it is necessary, and how he or she can participate. Discuss how the results will be used in planning further care or treatments			
2.	Perform hand hygiene and observe other appropriate infection prevention procedures.			
3.	Provide for client privacy			
4.	**Palpation:** a. Assess extent and symmetry of lower thoracic expansion. With palms of hands, assess symmetry of fremitus throughout lung fields.			
5.	**Percussion:** a. Symmetrically percuss lung fields, comparing right and left chest walls. (See your syllabus and physical diagnosis text for percussion techniques.) Identify diaphragms on right and left sides, and assess bilateral diaphragmatic excursion.			
6.	**Auscultation:** a. Ask patient to breath quietly and deeply through an open mouth. b. Using diaphragm of stethoscope, symmetrically assess posterior lung fields by listening and comparing each side for at least one full breath (inspiration and expiration) at each location c. Use a forced expiration in both mid or lower lung fields to try and elicit wheezing, and to determine if there is a prolongation of the expiratory phase. (No breath sounds after four seconds is normal) d. Continue auscultation in both axillae to assess the right middle lobe and the lingual. Demonstrate egophony and whispered pectoriloquy			
7.	**Anterior Chest Inspection** **Inspect:**			

	For women: a. Taking care to maintain patient privacy b. inspect: the upper chest from above. (Ask the patient to lower her gown to just above her breasts.) c. The lower chest may be inspected by asking the patient to raise her gown, while keeping her breasts covered. For men: Ask the patient to lower his gown to waist level. a. Symmetry b. Shape - Pectus c. Tracheal deviation d. Strap muscle use e. Accessory muscle use f. Retractions Chest and abdomen should move symmetrically. (Paradoxical movement suggests diaphragmatic fatigue.)			
8.	**Palpation:** With palms of hands, assess symmetry of fremitus throughout lung fields			
9.	**Percussion** Symmetry percuss lungs fields ,comparing the right & lift chest wall Identify diaphragms on right & lift sides and assess bilateral diaphragmatic excursion.			
10	**Auscultation:** Listen to upper lobes (anteriorly), and compare each side for at least one full breath (inspiration and expiration) at each location.			

Nursing instructor's signature: _____ Date: _____

Reflection/ Critical Incident Analysis



Gibbs' Reflective Cycle 1998

CASE STUDY FORMAT

LXXXI. INTRODUCTION

M. Background of the study
N. Objective (general & specific showing Knowledge, Skills & Attitude)
O. Scope and Delimitation
P. Theoretical Framework

LXXXII. BIOGRAPHIC DATA

Name
Address
Age
Gender
Race
Marital Status
Occupation
Religious orientation
Health care financing and usual source of medical care

LXXXIII. CHIEF COMPLAINT OR REASON FOR VISIT

LXXXIV. NURSING HISTORY (with guide questionnaire)

Z. History of Present Illness
AA. Past Medical History
ee) Childhood diseases
ff) Immunizations
gg) Allergies
hh) Accidents and injuries
ii) Hospitalization
jj) Medication
BB. Family History of Illness (use Genogram)
CC. Obstetric History (for OB cases only; with Assessment Guide)
DD. Developmental History (for Pediatric cases only; with Assessment Guide)

Note: Assessment guide *used should be attached as annexes at the back of the case study report.*

LXXXV. FUNCTIONAL HEALTH PATTERN (with guide questionnaire)

56. Health Perception and Health Management Pattern
57. Nutrition and Metabolic Pattern
58. Elimination Pattern
59. Activity-Exercised Pattern (use Barthel index)
60. Sleep-rest Pattern
61. Cognitive-perceptual Pattern
62. Self-perception and self-control Pattern
63. Role-relationship Pattern

64. Sexuality-reproductive Pattern
65. Coping-stress tolerance Pattern
66. Value-belief Pattern

Interpretation:
Analysis: (with reference)

LXXXVI. REVIEW OF SYSTEM (all subjective complaints)

LXXXVII. PHYSICAL ASSESSMENT (all objective findings; indicate date performed; Head to Toe Assessment; follow IPPA sequence)
11. General Survey (Short Paragraph)
12. Vital Signs

BODY PART (Technique used)	NORMAL FINDINGS	ACTUAL FINDINGS	INTERPRETATION / ANALYSIS w/ Reference

LXXXVIII. ANATOMY & PHYSIOLOGY

LXXXIX. DIAGNOSTIC / LABORATORY STUDIES (Table)

NAME OF TEST / PROCEDURE	DATE DONE	INDICATION FOR THE TEST / PROCEDURE	NORMAL VALUE	ACTUAL RESULT / FINDINGS	SIGNIFICANCE OF THE RESULT / FINDINGS

XC. SURGICAL PROCEDURE (Operative worksheet, if any)

XCI. PATHOPHYSIOLOGY (Present in Schematic Diagram; Mind Mapping)

XCII. DRUG STUDY / IV INFUSIONS, BLOOD TRANFUSIONS, TREAMENTS GIVEN

Drug Study

DRUG ORDER (Generic, name, dosage, route,	TRADE / BRAND NAME	PHARMACOLOGIC ACTION OF DRUG	INDICATION AND CONTRAINDICATIONS	ADVERSE EFFECTS OF THE DRUG	DESIRED ACTION ON YOUR CLIENT	NURSING RESPONSIBILITIES / PRECAUTIONS

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ncy)

Treatments Given

TREATMENT / INFUSION	CLASSIFICATION	INDICATION	CONTRAINDICATION	NURSING RESPONSIBILITIES / PRECAUTIONS

XCIII. COURSE IN THE WARD (narrative form)

- Summary of day to day medical/nursing management from the date of admission up to the time case study was done
- Patient's Status:
    a. General condition of the client (ex. LOC, VS, and other Subjective & Objective, complaint during the day)
    b. 4 D's with inference / analysis:
        - Diet
        - Drugs/IVF
        - Lab/Diagnostics procedure
        - Disposition

XCIV. PRIORITIZED LIST OF NURSING PROBLEMS (Table)

- Prioritized using ABC's and Maslow's Hierarchy of Needs

DATE	NURSING PROBLEMS IDENTIFIED	CUES	JUSTIFICATION

XCV. NURSING CARE PLAN

CUES (Defining Characteristics of Nursing Diagnosis)	NURSING DIAGNOSIS (Problem & Etiology)	BACKGROUND KNOWLEDGE (Pathophysiology/psychosocial explanation or consequences of the nursing diagnosis)	GOALS AND OBJECTIVES (include long and short term objectives)	NURSING INTERVENTIONS AND RATIONALE	EVALUATION

XCVI. PROPOSED / DISCHARGE PLAN (to be submitted by students whose patients are for discharge)

- M - Medications to take at home
- E - Exercises
- T - Treatment
- H - Health Teachings
- O - Out - patient follow-up
- D - Diet
- S - Spiritual / Sexual activity (optional)

Reference

Berman, A., Snyder, S. J., Levett-Jones, T., Dwyer, T., Hales, M., Harvey, N.,... & Stanley, D.

(2018). Kozier and Erb's Fundamentals of Nursing [4th Australian edition].

Bickley, Lynn S. (2003). Bates' guide to physical examination and history taking. Philadelphia:

Lippincott Williams & Wilkins,

SEMESTER V

CLINICAL TRAINING

Pediatric Health Nursing- 2 Cr. Hours
Community Health Nursing I- 1 Cr. Hours
Reproductive Health- 3 Cr. Hours

Course Description:

This course aims to deepen students' understanding of pediatric nursing by appreciating the historical developments and advancements within the field of pediatrics as a specialty. It emphasizes the importance of applying growth and development concepts in the care of pediatric patients and their families. Students will learn to view the child as a holistic individual, considering both physical and psychosocial needs. The course includes practical skills in performing comprehensive physical, developmental, and nutritional assessments of pediatric clients. Students will also apply the nursing process in delivering effective care to neonates and children, ensuring personalized and evidence-based practices. Additionally, the course focuses on integrating family-centered care with critical issues such as genetic disorders, congenital malformations, and long-term illnesses, highlighting the nurse's role in supporting both the child and their family throughout the care process.

Clinical Rotation plan:

This semester will be of 16/22weeks, the student nurse will go to clinical rotation in batches to ensure 24/7 clinical placement at hospitals in all three shifts to observe, learn and perform clinical skills in clinical setting under the supervision of clinical instructor.

CLINICAL OBJECTIVES

1. Develop awareness on common health issues of the children in Pakistan
2. Discuss principles of growth and development and its deviation in all aspects of nursing care.
3. Discuss the impact of hospitalization on the child and family.
4. Discuss the role of a family in the care of sick children in Pakistani Context.
5. Integrate pharmacological knowledge into care of sick children.
6. Integrate research-based information in the care of child and family.

Evaluation Criteria:

Clinical Portfolio Content	%	Frequency
Clinical Objectives	***10%***	Weekly
History Taking Performa (Weekly)	***15%***	10
Physical Examination Checklists	***15%***	10
Nursing Care Plan (Weekly)	***10%***	10
Nursing Skills Checklists (Weekly)	***20%***	10
Reflection/ Critical Incident Analysis (Weekly)	***10%***	Weekly
Case Study (One Per Semester)	***20%***	01

Clinical Objectives Form

Student Name: _____ Faculty: _____

Clinical placement:_____ Date: _____

Clinical Objectives	Strategies	Evaluation

History Taking Proforma

Student Name: _____Group #: _____Faculty: _____

Presenting Complaint, FHP, and ROS (Review of Systems)

(Include both the child's and caregiver's perspectives)

- Presenting Complaint (as described by caregiver):

- History of Present Illness:

- Family Health Patterns (FHP):

- Review of Systems (General, Respiratory, GI, Neurological, etc.):

2. Birth and Developmental History

- **Developmental Milestones:**

- Gross Motor:_____
- Fine Motor:_____
- Language:_____
- Social:_____

- **Immunization Status:**
  - Up-to-date: ☐ Delayed: ☐ Not immunized: ☐

- **Nutrition and Feeding Patterns:**

- **Sleep and Elimination Patterns:**

Checklist for taking a client health history

Interviewing Skills Checklist	**Satisfactory**	**Need to improve**
Introduced self, role, and clarified the purpose of the interview		
Ensured a child-friendly, private, and safe environment		
Developed rapport with both child (if age-appropriate) and caregiver		
Used open-ended questions and encouraged storytelling from the caregiver		
Explored history of present illness using COLDERRAA		

Collected information step-by-step, clarified responses, followed logical order
Adapted communication for child's developmental level
Used appropriate non-verbal cues (smiles, tone, body language)
Avoided non-therapeutic techniques (e.g., leading, judgmental, false reassurance)
Explored past medical and surgical history of the child
Assessed developmental milestones and delays
Reviewed family history of illnesses and genetic conditions
Evaluated lifestyle factors (nutrition, play, hygiene, routines)
Completed age-appropriate ROS efficiently

Faculty comments:

_____

_____

_____

_____

Nursing Care Plan

Assessment	N. Diagnosis	Goal	Planning	Rationale	Implementation	Evaluation
Subjective Data						

Objective

Data

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S #	List of Clinical skills	Level of competency	Minimum Frequency
01	General Examination of New Born	1-5	10
02	APGAR Score	1-5	20
03	New Born and Infant Reflex Assessment	1-5	20
04	Anthropometric Assessment (Birth weight, Head	1-5	5
05	circumference, Chest circumference, Length of baby)	1-5	5
06	Child head to toe assessment	1-5	5
07	Tub bath to an infant	1-5	5
08	Care of an infant in incubator	1-5	5
09	Care of an infant / neonate receiving oxygen therapy	1-5	5
10	Care of an infant under phototherapy	1-5	10
11	Antenatal assessment(Vital Signs, EDD, Fundal Height, FHR) low risk pregnancy/ high risk pregnancy	1-5	20
12	Offer Family Planning counseling of the client	1-4	10
13	Prescribe Family Planning Methods to the client	1-4	10
14	Perform Nutritional Counselling for the pregnant lady	1-5	10
15	Perform nutritional counselling for the lacational mothers	1-5	10
16	Observation of normal delivery cases	1-2	10
17	Assist with normal delivery cases	1-3	10
18	Conduct Normal delivery cases under supervision	1-4	10

19	Conduct Independent normal delivery cases	1-5	10
20	Independent post-natal care	1-5	10
21	Independent newborn care	1-5	10
22	Ensure the patient's understanding of the procedure through a qualified interpreter. demonstrating a language barrier	1-5	5
23	Demonstrating consent taking. Verify that consent is informed, voluntary, and documented in her presence.	1-5	5
24	Clarify legal rights regarding consent even when families wish to shield the patient.	1-5	5
25	Demonstrate how to initiate discussion with healthcare team about ethical dilemma	1-5	5
26	Involve family in a culturally respectful manner to explore patient preferences	1-5	5
27	Follow ethical and institutional policies in handling truth-telling.	1-5	5

No	Procedures	Clinical Experience					
		Skill Lab Instructor Signature	Date	Ward Sister Signature	Date	Clinical instructor Signature	Date
1.	General Examination of New Born						
2.	APGAR Score						
3.	New Born and Infant Reflex Assessment						
4.	Anthropometric Assessment (Birth weight, Head						

5.	circumference, Chest circumference, Length of baby)						
6.	Child head to toe assessment						
7.	Tub bath to an infant						
8.	Care of an infant in incubator						
9.	Care of an infant / neonate receiving oxygen therapy						
10	Care of an infant under phototherapy						

Nursing Skills Checklists

General Examination of Newborn

Equipment Needed for General Examination of Newborn

- Gloves, as per need
- Personal protective equipment (PPE), as indicated
- Stethoscope
- Thermometer
- Sphygmomanometer (if necessary for BP measurement)
- Measuring tape for head circumference

• Scale for weight measurement
• Measuring board for length/height
• Cotton swabs or antiseptic wipes (if needed)
• Pen and paper for documentation

Checklist

Sr.	Tasks	Yes	No	Comments
1.	Introduce self to the caregiver and explain the procedure. Verify the newborn’s identity using appropriate identifiers (e.g., wristband, mother's details).	☐	☐	
2.	Perform hand hygiene and wear appropriate PPE (gloves, etc.) before starting the examination.	☐	☐	
3.	Assess the newborn’s general appearance: Observe for color (pink or cyanotic), activity (alert, lethargic), and posture (flexed or extended).	☐	☐	
4.	Inspect the head: Check for shape, symmetry, presence of molding or swelling, and fontanelle status (soft and flat).	☐	☐	
5.	Assess the eyes: Check for the red reflex, symmetry of pupils, and any signs of infection or abnormality.	☐	☐	
6.	Examine the ears: Inspect for symmetry, size, and shape. Ensure they are positioned at or slightly above the level of the eyes.	☐	☐	
7.	Inspect the mouth and throat: Check for cleft lip/palate, tongue tie, and observe feeding behaviors.	☐	☐	
8.	Check the skin: Observe for rashes, bruising, jaundice, and any congenital birthmarks or abnormalities.	☐	☐	

9.	Assess the respiratory system: Observe for chest movement, breathing rate, and effort. Auscultate for any abnormal lung sounds.	☐	☐	
10	Measure the newborn's vital signs: Temperature, heart rate, respiratory rate, and blood pressure (if necessary).	☐	☐	
11	Examine the abdomen: Check for distention, any visible abnormalities, and palpate for tenderness or masses.	☐	☐	
12	Assess the extremities: Check for symmetry, movement, and any deformities. Assess muscle tone and joint mobility.	☐	☐	
13	Inspect the umbilical cord: Ensure it is clean, dry, and exhibits normal characteristics (2 arteries, 1 vein).	☐	☐	
14	Evaluate reflexes: Test the newborn's reflexes (e.g., rooting, sucking, Moro, grasp).	☐	☐	
15	Record the newborn's weight, length, and head circumference, and compare with expected growth parameters.	☐	☐	
16	Document any abnormalities or findings requiring further investigation or immediate attention.	☐	☐	

Nursing instructor's signature: _____ Date: _____

APGAR score

Equipment Needed for Apgar score Assessment

- Timer or stopwatch
- Stethoscope
- Gloved hands for handling the newborn
- Pen and paper or electronic device for documentation

Checklist

Sr.	Tasks	Yes	No	Comments
1.	**Appearance (Skin Color)**			
2.	Check if the newborn's skin for appearance and rated appropriately	☐	☐	
3.	**Pulse (Heart Rate)**			
4.	Measure heart rate and rated appropriately	☐	☐	
5.	**Grimace (Reflex Response)**			
6.	Check Reflex response of newboen and rated accordingly	☐	☐	
7.	**Activity (Muscle Tone)**			
8.	Check the muscle tone of the newborn and rated it properly.	☐	☐	
9.	**Respiration (Breathing)**			
10.	Checked the respiratory status of newborn and rated it.	☐	☐	

Nursing instructor's signature: _____ Date: _____

Newborn and Infant Reflex Assessment

Equipment Needed for Reflex Assessment

- Gloved hands (if needed)
- Penlight (for visual stimulation)
- Soft cloth or cotton (for tactile stimulation)
- Stopwatch (optional)

• Pen and paper or electronic device for documentation

Checklist

Sr.	Reflex	Normal Response	Yes	No	Comments
1.	**Moro Reflex (Startle Reflex)**	Infant's arms and legs extend and then quickly retract in response to loud noise or sudden movement.	☐	☐	
2.	**Rooting Reflex**	Infant turns head and opens mouth when cheek is stroked.	☐	☐	
3.	**Sucking Reflex**	Infant sucks on nipple or finger when placed in the mouth.	☐	☐	
4.	**Grasp Reflex**	Infant tightly grasps the finger placed in the palm.	☐	☐	
5.	**Babinski Reflex**	Toes fan out when the sole of the foot is stroked.	☐	☐	
6.	**Stepping Reflex**	Infant makes stepping motions when held upright with feet touching a surface.	☐	☐	
7.	**Tonic Neck Reflex (Fencing Reflex)**	Infant extends the arm and leg on the side the head is turned and flexes the opposite arm and leg.	☐	☐	
8.	**Galant Reflex (Trunk Incurvation Reflex)**	Infant curves the trunk toward the side being stroked along the back.	☐	☐	
9.	**Plantar Reflex**	Toes curl when the sole of the foot is stimulated.	☐	☐	
10.	**Swimming Reflex**	Infant makes swimming movements when placed in water (temporary).	☐	☐	

Nursing instructor's signature: _____ Date: _____

Anthropometric Assessment

Equipment Needed for Anthropometric Assessment

• Baby scale (for weight measurement)
• Measuring tape (for head, chest circumference, and length)
• Calipers (optional, for more precise measurements)
• Pen and paper or electronic device for documentation
• Infant's clothing (minimal, for accurate measurements

Checklist

Sr.	Task	Yes	No	Comments
1.	**Birth Weight** • Weigh the baby immediately after birth with minimal clothing.	☐	☐	
	• Ensure proper scale calibration before weighing.	☐	☐	
2.	**Head Circumference** • Measure the circumference of the baby's head at the widest part (across the forehead and over the occipital prominence).	☐	☐	
3.	**Chest Circumference** Measure around the chest at the level of the nipples (inspiration should be at rest).	☐	☐	
4.	**Length of Baby**	☐	☐	

	Measure the baby from the crown of the head to the heel (use a firm, flat surface).			

Nursing instructor's signature: _____ Date: _____

Child Head-to-Toe Assessment

Equipment Needed for Head-to-Toe Assessment

- Stethoscope
- Thermometer
- Sphygmomanometer (for blood pressure)
- Penlight or flashlight
- Tongue depressor (if necessary)
- Gloves
- Cotton swabs or antiseptic wipes (if needed)
- Pen and paper or electronic device for documentation

Checklist

Sr.	Task	Yes	No	Comments
1.	**General Appearance**	☐	☐	
	• Observe the child's overall appearance, activity level, and behavior. • Note the child's alertness, mood, and comfort level.	☐	☐	
2.	**Head and Neck**			
	• Inspect the head for shape, symmetry, and any abnormal findings (e.g., lumps, swelling).	☐	☐	

	• Palpate the scalp for any tenderness or abnormal masses.	☐	☐	
	• Check for the presence of fontanelles (if applicable) and their status (sunken or bulging).	☐	☐	
	• Inspect the ears for symmetry, positioning, and any discharge.	☐	☐	
	• Assess the eyes for symmetry, red reflex, and any signs of irritation or discharge.	☐	☐	
	• Inspect the mouth and throat for clefts, sores, or inflammation. Check the tongue for normal color and mobility.	☐	☐	
3.	**Chest and Lungs**			
	• Inspect the chest for symmetry and any signs of respiratory distress.	☐	☐	
	• Observe the rate, rhythm, and effort of breathing.	☐	☐	
	• Auscultate lung sounds to assess for normal breath sounds (clear, no wheezes or crackles).	☐	☐	
4.	**Cardiovascular System**			
	• Check for any signs of cyanosis (blueness of lips, fingertips).	☐	☐	
	• Auscultate the heart for rate, rhythm, and any murmurs.	☐	☐	
	• Palpate pulses at the radial, femoral, and pedal sites for rate, rhythm, and strength.	☐	☐	
5.	**Abdomen**			

	• Inspect the abdomen for shape, distention, and any visible abnormalities (e.g., masses, scars).	☐	☐	
	• Palpate the abdomen for tenderness or masses.	☐	☐	
	• Listen for bowel sounds (presence of normal, active sounds).	☐	☐	
6.	**Genitourinary System**			
	• Inspect the genital area for any signs of irritation or abnormalities.	☐	☐	
	• Ensure normal urination patterns (frequency, color).	☐	☐	
7.	**Musculoskeletal System**			
	• Inspect the limbs for symmetry, length, and deformities.	☐	☐	
	• Palpate joints for any signs of swelling or tenderness.	☐	☐	
	• Assess for normal range of motion (flexion, extension).	☐	☐	
8.	**Skin**			
	• Inspect the skin for color, rashes, bruises, or any abnormal findings (e.g., birthmarks).	☐	☐	
	• Check for any signs of dehydration (e.g., dry skin, sunken eyes).	☐	☐	
9.	**Neurological System**			
	• Assess the child's alertness and response to stimuli.	☐	☐	
	• Check the child's cranial nerve functions (visual, auditory, and motor responses).	☐	☐	

	• Observe the child's coordination, balance, and muscle strength.	☐	☐	
10.	**Reflexes**			
	• Check for appropriate reflex responses (e.g., Moro, Babinski, rooting, sucking).	☐	☐	

Nursing instructor's signature: _____ Date: _____

Tub Bath to an Infant

Equipment Needed for Tub Bath to an Infant

• Infant tub or a small basin
• Mild baby soap or cleansing solution
• Soft washcloths or sponges
• Baby towel or soft towels for drying
• Diaper, clean clothes, and a clean blanket
• Baby lotion or oil (optional)
• Cotton balls (optional for cleaning eyes and ears)
• Thermometer (for checking water temperature)
• Warm water (ideal temperature: 37°C or 98.6°F)
• Gloves (optional, based on infection control protocols)

Checklist

Sr.	Task	Yes	No	Comments
1.	**Preparation of Bathing Area**			
	• Prepare the bathing area: Ensure the room is warm and draft-free.	☐	☐	
	• Fill the tub or basin with warm water at the ideal temperature (37°C or 98.6°F).	☐	☐	

	• Gather all necessary supplies (soap, towels, lotion, clean clothes).	☐	☐	
2.	**Preparing the Infant for the Bath**			
	• Wash hands thoroughly before handling the infant.	☐	☐	
	• Lay the infant on a soft, clean towel or blanket before undressing.	☐	☐	
	• Remove the infant's clothing and diaper, making sure to keep the baby warm.	☐	☐	
3.	**Giving the Bath**			
	• Gently place the baby into the tub or basin, supporting the head and neck.	☐	☐	
	• Use a soft washcloth to wash the baby's face and eyes, starting with the cleanest area first.	☐	☐	
	• Wash the rest of the body gently with mild baby soap, avoiding the face.	☐	☐	
	• Rinse the soap off with warm water using a clean washcloth or sponge.	☐	☐	
	• Gently wash the baby's hair with a mild shampoo, if needed.	☐	☐	
4.	**Post-Bath Care**			
	• Lift the baby out of the tub carefully, supporting the head, neck, and body.	☐	☐	
	• Wrap the baby immediately in a soft, clean towel and pat dry.	☐	☐	
	• Dry all areas thoroughly, including folds of skin, to prevent moisture buildup.	☐	☐	
	• Dress the baby in clean, comfortable clothes.	☐	☐	
	• Apply baby lotion or oil (optional) to keep the skin moisturized.	☐	☐	

5.	**Safety and Comfort**			
	• Ensure the baby is never left unattended in the bath.	☐	☐	
	• Check the water temperature regularly to avoid overheating or chilling.	☐	☐	
	• Keep the bathing area clutter-free and remove any objects that could cause harm.	☐	☐	

Nursing instructor's signature: _____ Date: _____

Care of an Infant in Incubator

Equipment Needed for Infant Care in an Incubator

• Incubator with temperature and humidity control
• Monitoring equipment (heart rate, respiratory rate, and oxygen saturation)
• Sterile gloves
• Infant thermometer
• Pulse oximeter
• Soft cloths or diapers for infant comfort
• Suction equipment (if needed)
• Feeding tube or bottle (if required)
• Oxygen supply (if required)
• Baby clothing and blankets
• Sterile syringes and feeding materials (for feeding via tube)
• Pen and paper or electronic device for documentation

Checklist

Sr.	Task	Yes	No	Comments
1.	**Preparation of the Incubator**			

	• Ensure the incubator is set at the appropriate temperature (usually between 32°C and 34°C for premature infants).	☐	☐	
	• Check the incubator humidity level (typically 50-60%).	☐	☐	
	• Ensure the incubator is clean and free from any contamination.	☐	☐	
	• Verify the infant's position in the incubator (infant should be lying in a neutral position with the head slightly elevated).	☐	☐	
2.	**Monitoring of Infant's Vital Signs**			
	• Check the infant's body temperature regularly to ensure it remains within the normal range.	☐	☐	
	• Continuously monitor heart rate, respiratory rate, and oxygen saturation using monitoring equipment.	☐	☐	
	• Assess for signs of respiratory distress (e.g., tachypnea, nasal flaring, or grunting).	☐	☐	
	• Regularly check the oxygen supply and adjust if the infant is on oxygen therapy.	☐	☐	
3.	**Feeding and Nutritional Support**			
	• Ensure the infant is receiving proper nutrition via breast milk, formula, or IV fluids as prescribed.	☐	☐	
	• If using a feeding tube, verify that it is placed correctly and that the feeding schedule is followed.	☐	☐	
	• Monitor the infant's weight and growth, documenting progress.	☐	☐	
4.	**Hygiene and Skin Care**			

	• Perform routine hygiene care, including gentle cleaning of the infant's face and body with warm, moist cloths.	☐	☐	
	• Check the skin for any signs of breakdown, especially in areas that are in contact with medical equipment (e.g., tube insertion sites).	☐	☐	
	• Ensure that the infant’s diaper is changed regularly to maintain cleanliness and prevent skin irritation.	☐	☐	
5.	**Positioning and Comfort**			
	• Ensure the infant is properly positioned to prevent positional deformities or pressure sores.	☐	☐	
	• Ensure that the infant is swaddled or wrapped in a soft blanket for comfort and warmth.	☐	☐	
	• Offer comfort by speaking to the infant softly or using gentle touch when appropriate.	☐	☐	
6.	**Incubator Environment and Safety**			
	• Ensure that the incubator temperature and humidity levels are regularly checked and adjusted.	☐	☐	
	• Verify that all electrical and monitoring equipment are functioning properly and are within the safe range.	☐	☐	
	• Keep the incubator clean and free of any sources of infection.	☐	☐	
	• Limit unnecessary handling of the infant to reduce the risk of infection and prevent overstimulation.	☐	☐	

7.	**Parental Involvement**			
	• Encourage the parents to be involved in the care of the infant when possible, such as touching or talking to the baby.	☐	☐	
	• Provide emotional support and information to the parents about the infant's condition and progress.	☐	☐	

Nursing instructor's signature: _____ Date: _____

Care of an Infant/Neonate Receiving Oxygen Therapy

Equipment Needed for Oxygen Therapy in Infants/Neonates

• Oxygen supply (cylinder or wall-mounted system)
• Oxygen delivery device (nasal cannula, oxygen mask, or CPAP)
• Pulse oximeter
• Humidifier (if required)
• Suction equipment (if needed for secretions)
• Stethoscope
• Thermometer
• Gloves
• Pen and paper or electronic device for documentation

Checklist

Sr.	Task	Yes	No	Comments
1.	**Preparation for Oxygen Therapy**			
	Verify the prescription and the need for oxygen therapy.	☐	☐	
	Ensure the oxygen supply is adequate and functioning properly.	☐	☐	

	Set the appropriate oxygen flow rate and check settings on oxygen delivery equipment (nasal cannula, mask, or CPAP).	☐	☐	
	Check the oxygen saturation target levels (usually 90-95%) as per the physician’s orders.	☐	☐	
2.	**Administration of Oxygen**			
	Place the oxygen delivery device correctly on the infant (nasal cannula, mask, or CPAP).	☐	☐	
	Ensure the device is comfortable for the infant and that there are no areas causing pressure or irritation.	☐	☐	
	Check the oxygen saturation levels regularly using a pulse oximeter and adjust oxygen flow accordingly.	☐	☐	
	Monitor the infant for signs of oxygen toxicity (e.g., visual disturbances, irritability).	☐	☐	
3.	**Monitoring the Infant's Condition**			
	Assess respiratory rate, effort, and pattern.	☐	☐	
	Continuously monitor oxygen saturation levels to ensure they are within the prescribed range.	☐	☐	
	Observe for any signs of respiratory distress (e.g., nasal flaring, grunting, chest retractions).	☐	☐	
	Ensure that the infant is comfortable and not in distress while receiving oxygen therapy.	☐	☐	
4.	**Safety and Comfort**			
	Ensure the oxygen supply line is secure and free from any kinks or blockages.	☐	☐	
	Regularly check the infant’s skin for signs of irritation from the oxygen delivery device.	☐	☐	
	Avoid excessive handling of the infant to reduce the risk of hypothermia or oxygen desaturation.	☐	☐	

	Keep the infant's environment warm and avoid sudden temperature changes, as neonates are sensitive to temperature fluctuations.	☐	☐	
5.	**Weaning and Discontinuation of Oxygen Therapy**			
	Follow the prescribed plan for weaning the oxygen therapy, gradually reducing oxygen flow based on the infant's condition.	☐	☐	
	Monitor the infant closely during the weaning process to ensure oxygen levels remain stable.	☐	☐	
	Once oxygen therapy is discontinued, continuously monitor the infant's respiratory status.	☐	☐	
6.	**Parental Involvement and Education**			
	Educate the parents or caregivers about the purpose and importance of oxygen therapy for their infant's health.	☐	☐	
	Instruct the parents on how to monitor their infant's oxygen therapy at home, if applicable.	☐	☐	
	Provide emotional support to the parents, addressing concerns and reassuring them about their baby's condition.	☐	☐	

Nursing instructor's signature: _____ Date: _____

Care of an Infant Under Phototherapy

Equipment Needed for Phototherapy Care

- Phototherapy light (fluorescent light or fiber-optic blanket)
- Eye patches or shields
- Thermometer
- Gloved hands (for handling the infant)
- Infant monitor (for vital signs)

• Soft cloths or diapers for comfort
• Infant clothes (lightweight clothing to allow maximum exposure)
• Pen and paper or electronic device for documentation
• Gloves (as needed for infection control)

Checklist

Sr.	Task	Yes	No	Comments
1.	**Preparation for Phototherapy**			
	Verify the prescription for phototherapy treatment.	☐	☐	
	Ensure that the phototherapy light is functioning correctly and the proper wavelength is set.	☐	☐	
	Check the room temperature to ensure the infant is not exposed to cold drafts or excessive warmth.	☐	☐	
	Prepare the necessary materials (eye patches, gloves, etc.) for phototherapy.	☐	☐	
2.	**Positioning and Exposure**			
	Place the infant in a safe, secure position under the phototherapy light or fiber-optic blanket.	☐	☐	
	Ensure that the infant's eyes are covered with eye patches or shields to prevent retinal damage from the light.	☐	☐	
	Keep the infant’s skin exposed to the light, ensuring that only the diaper area is covered to avoid unnecessary heat loss.	☐	☐	
	Ensure that the phototherapy light source is at an appropriate distance from the infant to avoid overheating or underexposure.	☐	☐	
3.	**Monitoring the Infant’s Condition**			
	Monitor the infant’s temperature regularly, as phototherapy can cause overheating.	☐	☐	
	Check the infant’s hydration status regularly to avoid dehydration.	☐	☐	

	Observe for signs of discomfort (e.g., fussiness, temperature instability, skin irritation).	☐	☐	
	Continuously monitor the infant’s vital signs (heart rate, respiratory rate, and oxygen saturation).	☐	☐	
4.	**Eye Protection and Skin Care**			
	Ensure that the eye patches or shields are properly positioned and do not cause irritation to the infant’s eyes.	☐	☐	
	Inspect the infant's skin regularly for signs of rashes or skin breakdown due to prolonged exposure to phototherapy light.	☐	☐	
	Apply moisturizer to the infant’s skin (if necessary) after phototherapy sessions, especially if the skin appears dry.	☐	☐	
5.	**Feeding and Hydration**			
	Ensure the infant is fed regularly and that adequate hydration is maintained.	☐	☐	
	Monitor the infant’s feeding behavior and document any difficulties in sucking or feeding.	☐	☐	
6.	**Parental Involvement and Education**			
	Inform the parents about the purpose and benefits of phototherapy for managing jaundice.	☐	☐	
	Teach the parents how to monitor the infant during phototherapy, such as checking temperature, hydration, and skin condition.	☐	☐	
	Encourage the parents to visit and interact with the infant as much as possible while ensuring safety during phototherapy.	☐	☐	
7.	**Ending Phototherapy and Follow-Up**			
	Gradually reduce the exposure time as directed by the healthcare provider, based on bilirubin levels.	☐	☐	

	Monitor the infant's bilirubin levels regularly through blood tests to track the effectiveness of the therapy.	☐	☐	
	Once phototherapy is completed, remove the eye patches and assess the infant's skin and overall condition.	☐	☐	

Nursing instructor's signature: _____ Date: _____

Skill: Antenatal Assessment (Vital Signs, EDD, Fundal Height, FHR) – Low-Risk and High-Risk Pregnancies

Equipment Required:

- Stethoscope or Doppler fetal monitor
- Measuring tape
- Blood pressure apparatus
- Thermometer
- Watch (with second hand)
- Weight scale
- Antenatal record/chart
- Urine dipstick (for protein, glucose)
- Gloves (non-sterile)
- Fetal growth chart
- Obstetric wheel or calculator for EDD
- PPE as per policy

Checklist:

Sr. #	Tasks	Yes	No	Comments
1	Introduce self and confirm patient identity using two identifiers.			
2	Explain the antenatal assessment procedure and obtain informed consent.			
3	Ensure privacy, comfort, and infection control precautions (hand hygiene, PPE).			
4	Record vital signs: temperature, pulse, respiratory rate, and blood pressure.			

5	Check for signs of high-risk pregnancy (e.g., hypertension, proteinuria, bleeding).			
6	Assess weight and calculate BMI (baseline or trend).			
7	Calculate Estimated Date of Delivery (EDD) using LMP or obstetric wheel.			
8	Instruct the woman to empty bladder before fundal height measurement.			
9	Measure fundal height in centimeters (symphysis pubis to uterine fundus).			
10	Compare fundal height with gestational age for fetal growth monitoring.			
11	Palpate abdomen for fetal lie, presentation, and position.			
12	Assess Fetal Heart Rate (FHR) using Doppler or fetoscope (normal: 110–160 bpm).			
13	Observe fetal movements (ask woman or assess directly if indicated).			
14	Check for edema, especially in hands, face, and legs.			
15	Perform urine dipstick test for protein and glucose.			
16	Document all findings in antenatal chart and report abnormalities.			
17	Educate patient on danger signs of pregnancy and when to seek care.			
18	Reinforce healthy pregnancy practices and follow-up schedule.			
19	Perform hand hygiene and ensure documentation is complete.			

Normal Parameters for Antenatal Visits (Low-Risk Pregnancy)	
Parameter	**Normal Range**
Blood Pressure	<140/90 mmHg
Fundal Height	In cm ≈ gestational age (±2 cm) after 20 weeks
Fetal Heart Rate	110–160 bpm
Fetal Movement	At least 10 movements in 2 hours (after 20 weeks)

Weight Gain	11–16 kg (for normal BMI women) over pregnancy
Urine Protein	Negative or trace
Urine Glucose	Negative or trace

Key for High-Risk vs. Low-Risk Pregnancy

Criteria	Low-Risk	High-Risk
Maternal Age	18–35 years	<18 or >35 years
Obstetric History	No complications in previous pregnancies	History of miscarriage, preterm labor, stillbirth
Blood Pressure	Normal	Hypertension / Preeclampsia
Diabetes	Absent	Present (gestational or pre-existing)
Bleeding or Anemia	None	Hemorrhage, hemoglobin <10 g/dL
Infections	None	HIV, syphilis, UTI, TORCH
Fetal Abnormalities	None	Detected via scan or history
Multiple Gestation	Singleton	Twins or more
Other Risk Factors	None	Placenta previa, polyhydramnios, oligohydramnios, IUGR

Skill: Offer Family Planning Counselling to the Client

Equipment Required:

- Private space for counseling
- WHO Medical Eligibility Criteria (MEC) chart (if available)
- Flip chart or counseling aids
- Sample contraceptive devices (models)
- Pen, counseling forms or notes
- PPE (if physical assessment is included)
- Client education leaflets/booklets

Checklist:

Sr. #	Tasks	Yes	No	Comments
1	Introduce self and ensure client identity using two identifiers.			
2	Ensure privacy, comfort, and confidentiality.			
3	Explain the purpose of family planning counseling.			

4	Obtain informed consent before proceeding with counseling.			
5	Use open-ended, non-judgmental questions to assess reproductive goals and concerns.			
6	Assess client's medical history, reproductive history, menstrual patterns, and breastfeeding status.			
7	Discuss fertility awareness and the return of fertility after childbirth or discontinuing methods.			
8	Explain available contraceptive methods (barrier, hormonal, IUD, natural, permanent).			
9	Describe effectiveness, side effects, benefits, and risks of each method.			
10	Use counseling tools (charts, models, leaflets) for visual aid.			
11	Guide the client to choose a method based on needs, preference, and medical eligibility.			
12	Encourage client questions and address myths or misinformation.			
13	Offer partner involvement if client agrees.			
14	Discuss correct usage, follow-up, and what to do in case of problems.			
15	Document the counseling session and client’s chosen method.			
16	Schedule follow-up or refer to provider for method initiation, if required.			
17	Provide educational material for home reference.			
18	Maintain hand hygiene and thank the client.			

Key for Family Planning Counselling	
Key Component	**Description**
1. Voluntarism	Counseling must be voluntary, without pressure or coercion. The client's right to choose freely must be respected.
2. Informed Choice	Clients must be given accurate, unbiased, and complete information on all available contraceptive methods.

3. Privacy and Confidentiality	Ensure privacy during counseling and maintain confidentiality of client discussions and choices.
4. Respect and Non-Judgmental Attitude	Treat the client with dignity and without bias based on age, marital status, religion, or number of children.
5. Individualization	Counseling should be client-centered, addressing their unique needs, preferences, lifestyle, and medical history.
6. Comprehensive Method Information	Describe types of contraception (barrier, hormonal, IUD, natural, permanent), how they work, benefits, side effects, contraindications, and effectiveness.
7. Medical Eligibility	Use tools like the WHO Medical Eligibility Criteria (MEC) to guide safe method choices for clients with specific medical conditions.
8. Shared Decision-Making	Encourage active participation by the client and, if appropriate, their partner, in choosing the best method.
9. Counseling on Use and Follow-up	Explain how to use the method, what to expect, and when to return for follow-up or to switch methods.
10. Addressing Myths and Misconceptions	Actively ask about and correct false beliefs or fears about contraception using evidence-based information.
11. Reassurance and Support	Reassure the client they can change or discontinue their method at any time and seek help if problems arise.
12. Referral When Needed	Refer to appropriate health providers if clinical examination, method insertion, or further evaluation is needed.

Skill: Perform Nutritional Counselling for the Pregnant Woman

Equipment Required:

- Weighing scale
- Height chart
- BMI calculator or chart
- Nutritional counseling flip charts or pamphlets
- Pregnancy nutrition booklet (WHO or local guide)
- Counseling desk and privacy screen
- PPE (as per protocol)
- Pen and antenatal record

Checklist:

Sr. #	Tasks	Yes	No	Comments
1	Introduce self, verify client identity using two identifiers.			
2	Explain purpose of nutritional counselling clearly.			
3	Ensure client privacy and a comfortable counseling environment.			

4	Perform hand hygiene and wear PPE if required.			
5	Obtain dietary history including food habits, preferences, allergies, cultural practices.			
6	Measure weight and height; calculate BMI.			
7	Assess for signs of nutritional deficiencies (e.g., pallor, underweight, edema).			
8	Educate on **daily caloric needs** during pregnancy (+300 kcal/day in 2nd & 3rd trimester).			
9	Explain importance of a **balanced diet**: carbohydrates, proteins, fats, vitamins, and minerals.			
10	Recommend daily **protein intake** of 75–100 grams.			
11	Emphasize **iron-rich foods** (green leafy vegetables, lentils, meats) and **iron supplements (30–60 mg/day)**.			
12	Recommend **folic acid 400–600 mcg daily** to prevent neural tube defects.			
13	Promote **calcium intake** (1000–1200 mg/day) through dairy or supplements.			
14	Encourage **vitamin D intake (600 IU/day)** and safe sun exposure.			
15	Recommend 8–10 **glasses of water daily** and safe food handling.			
16	Counsel on **foods to avoid** (e.g., raw fish, unpasteurized milk, high-mercury fish, alcohol, caffeine >200 mg/day).			
17	Tailor recommendations for underweight, overweight, anemic, or diabetic pregnant women.			
18	Provide a sample meal plan or refer to a nutritionist if needed.			
19	Document findings and advice given in the antenatal record.			
20	Schedule follow-up and encourage client to ask questions.			

Nutritional Recommendations (WHO)		
Nutrient	**Recommended Intake (Daily)**	**Sources**
Energy	+300 kcal in 2nd/3rd trimester	Whole grains, fruits, vegetables, legumes

Protein	75–100 g	Eggs, meat, pulses, milk
Iron	30–60 mg (with 400 mcg folic acid)	Liver, spinach, red meat, fortified cereals
Folic Acid	400–600 mcg	Dark green vegetables, beans, folic acid supplements
Calcium	1000–1200 mg	Milk, yogurt, cheese, fortified soy milk
Vitamin D	600 IU	Fortified dairy, fish, safe sun exposure
Iodine	250 mcg	Iodized salt, seafood
Water	2–2.5 liters	Water, juices, soups
Avoid	Alcohol, raw fish, high-mercury fish, caffeine >200 mg/day	

Skill: Prescribe Family Planning Methods to the Client

Equipment Required:

- WHO Medical Eligibility Criteria (MEC) chart
- Family planning guideline (WHO)
- Client's health record
- Blood pressure apparatus
- Scale for weight
- Urine dipstick (if needed)
- Contraceptive supplies or prescription pad
- Gloves (if performing clinical procedures)
- PPE (as per infection control policy)

Checklist:

Sr. #	Tasks	Yes	No	Comments
1	Verify client identity and confirm voluntary participation.			
2	Review medical, surgical, obstetric, and reproductive history.			
3	Assess for contraindications using WHO Medical Eligibility Criteria (MEC).			
4	Measure vital signs (focus on BP for hormonal methods).			
5	Confirm current pregnancy status or menstrual history.			
6	Counsel on available contraceptive options.			

7	Match the client's health condition to a safe contraceptive method.			
8	Prescribe or dispense the chosen method or refer to a provider for procedure (IUD, implant, etc.).			
9	Educate the client on correct use, side effects, warning signs, and follow-up.			
10	Document the method prescribed, instructions given, and client response.			
11	Schedule or recommend follow-up as per method protocol.			
12	Perform hand hygiene and thank the client.			

Prescribing Guidelines by Client Condition as per WHO (2022)

Client Condition	Recommended Method(s)	Notes/Warnings
Healthy woman (no contraindications)	Any method: pills, IUD, implant, injectable, condoms, natural methods	MEC Category 1
Postpartum (<6 weeks, breastfeeding)	Progestin-only pills (POP), IUD, implant, condoms, LAM	Avoid estrogen
Postpartum (>6 weeks, not breastfeeding)	Any method except combined pills before 6 weeks	Combined OK after 6 weeks
Hypertension (SBP ≥ 140 or DBP ≥ 90)	Progestin-only pills, copper IUD, implant, condoms	Avoid COCs
Migraine with aura	Copper IUD, condoms, POPs (with caution)	Avoid COCs
History of DVT/PE	IUD, POP, implant, condoms	Avoid estrogen
Diabetes (uncomplicated)	Any method except caution with estrogen if vascular disease present	COCs = Cat 2–3
Smoker >35 years old	IUD, POP, implant, barrier methods	Avoid estrogen
Teenagers/adolescents	Long-acting methods preferred: implant, IUD; also pills or condoms	Ensure education
HIV-positive woman	IUD, POP, condoms, injectable (if stable)	Drug interactions
History of ectopic pregnancy	Copper IUD (safe), COCs, POPs	Avoid IUD if current PID

8	Prescribe or dispense the chosen method or refer to a provider for procedure (IUD, implant, etc.).			
9	Educate the client on correct use, side effects, warning signs, and follow-up.			
10	Document the method prescribed, instructions given, and client response.			
11	Schedule or recommend follow-up as per method protocol.			
12	Perform hand hygiene and thank the client.			

HIV-positive woman	IUD, POP, condoms, injectable (if stable)	Drug interactions
History of ectopic pregnancy	Copper IUD (safe), COCs, POPs	Avoid IUD if current PID

Skill: Assist with Normal Delivery Cases

Equipment Required:

- Sterile delivery kit (scissors, clamps, gauze, etc.)
- Sterile gloves and PPE
- Antiseptic solution
- Episiotomy set (if required)
- Maternity pads, sterile drapes, underpads
- Cord clamp/tie and sterile blade/scissors
- Warm towels and newborn tray (for resuscitation if needed)
- Oxytocin (if AMTSL* is practiced)
- Emergency tray (in case of complications)
- Mother’s chart and partograph
- Suction bulb or device
- Baby ID tags and APGAR chart

* active management of third stage of labor

Checklist:

Sr. #	Tasks	Yes	No	Comments
1	Introduce self, verify the identity of the mother, and obtain verbal consent.			
2	Explain the procedure to the mother and her companion/support person.			
3	Perform hand hygiene and wear sterile gloves and full PPE.			

4	Ensure delivery tray is complete, sterile, and within reach.			
5	Maintain patient privacy and position the mother comfortably (lithotomy or side-lying).			
6	Assist in monitoring uterine contractions and fetal descent.			
7	Support the mother with breathing and pushing techniques during the second stage.			
8	Perform perineal support and apply gentle pressure to control the delivery of the head.			
9	Check for nuchal cord and assist in its reduction or clamping if necessary.			
10	Support delivery of anterior and posterior shoulders.			
11	Assist with complete delivery of the baby and ensure the airway is clear.			
12	Dry the baby, place on the mother's abdomen, and promote immediate skin-to-skin contact.			
13	Clamp and cut the umbilical cord using sterile technique (1–3 minutes after birth if stable).			
14	Administer Oxytocin 10 IU IM if practicing active management of the third stage (AMTSL).			
15	Assist with controlled cord traction and observe placental delivery.			
16	Examine the placenta and membranes for completeness.			
17	Monitor the mother for excessive bleeding and uterine firmness.			
18	Assist with perineal inspection and suturing if episiotomy or tear is present.			
19	Document time of birth, condition of mother and newborn, placenta status, and any interventions.			
20	Assist with breastfeeding initiation and provide postnatal education.			

Oral/SC/Rectal/Intravenous Medication Administration in Children

Equipment Needed for Medication Administration

• Correct medication (prescribed dose)
• Medication administration forms or charts
• Oral syringe or medicine cup (for oral medications)
• Injection needles and syringes (for SC and IV administration)
• IV cannula, saline flush, and IV tubing (for intravenous medication)
• Thermometer (if necessary)
• Gloves (as needed)
• Cotton ball or gauze (for injection sites)
• Alcohol swabs
• Pen and paper or electronic device for documentation

Checklist

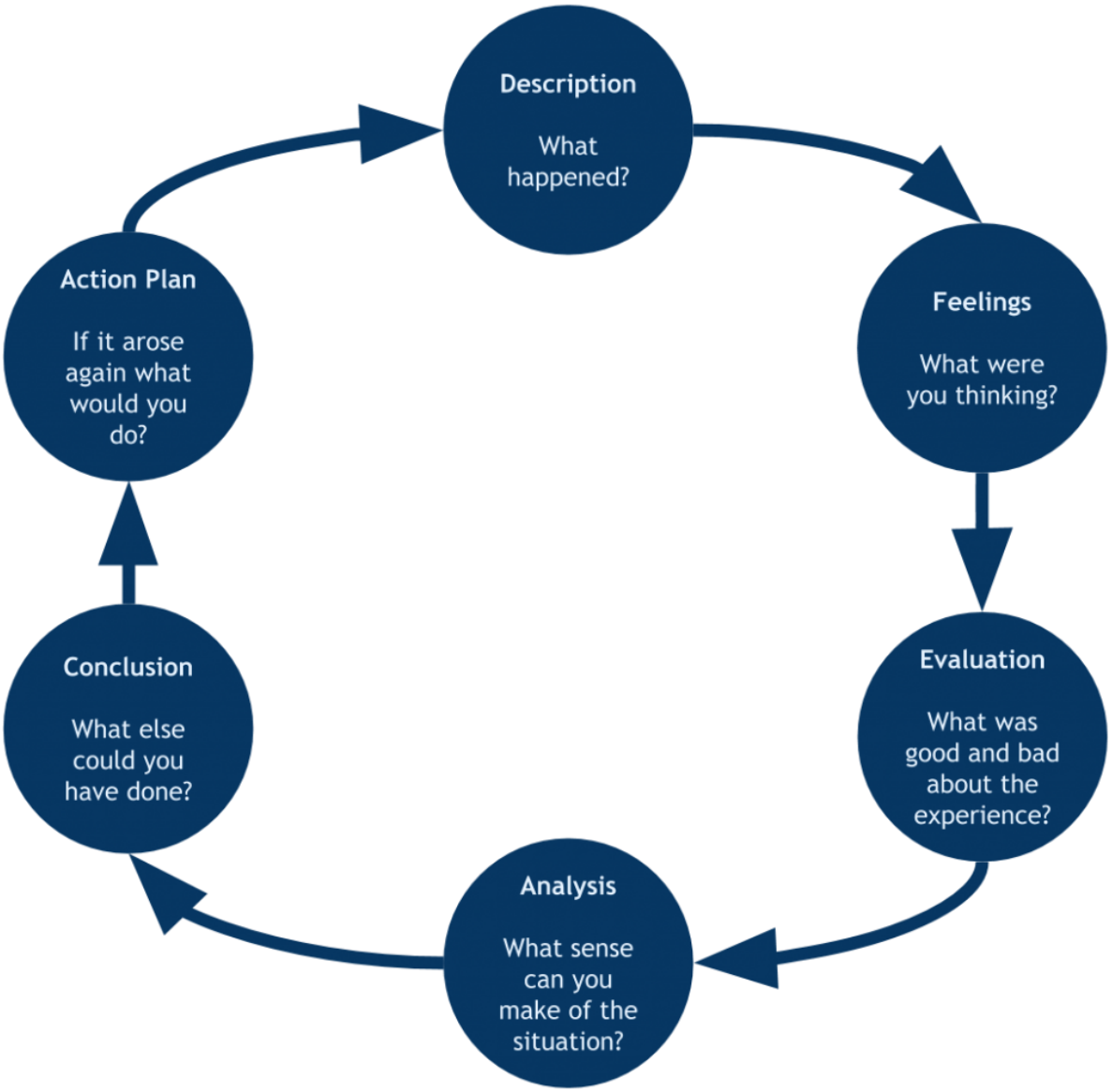
Sr	Task	Yes	No	Comments
1.	**Preparation for Medication Administration**			
	• Verify the correct medication and dosage as per the prescription.	☐	☐	
	• Double-check the child's identity with the caregiver, using appropriate identifiers.	☐	☐	
	• Ensure that all equipment for medication administration is ready (e.g., syringe, cup, alcohol swabs).	☐	☐	
	• Perform hand hygiene before preparing and administering the medication.	☐	☐	
2.	**Oral Medication Administration**			
	• Check the child's ability to swallow the medication (if applicable).	☐	☐	
	• Use an oral syringe or medicine cup to administer the correct dose.	☐	☐	

	• Ensure that the child takes the entire dose of the medication.	☐	☐	
	• Follow up with a small amount of water (if appropriate) to ensure the medication is swallowed.	☐	☐	
3.	**Subcutaneous (SC) Medication Administration**			
	• Select the appropriate site for SC injection (e.g., thigh, upper arm).	☐	☐	
	• Clean the injection site with alcohol swab and allow it to dry.	☐	☐	
	• Use a sterile syringe and needle to administer the medication.	☐	☐	
	• Inject the medication at a 45-degree angle, ensuring the needle is fully inserted.	☐	☐	
	• Apply pressure to the injection site with a cotton ball or gauze.	☐	☐	
	• Dispose of the needle and syringe properly in a sharps container.	☐	☐	
4.	**Rectal Medication Administration**			
	• Verify the correct rectal medication and dosage.	☐	☐	
	• Position the child comfortably (e.g., in a side-lying position for infants).	☐	☐	
	• Lubricate the medication (if needed) and insert it gently into the rectum.	☐	☐	
	• Hold the buttocks together for a few moments to prevent expulsion.	☐	☐	
	• Record the time of administration and monitor for proper absorption.	☐	☐	
5.	**Intravenous (IV) Medication Administration**			

	• Select an appropriate IV access site (e.g., hand, foot, scalp for infants).	☐	☐	
	• Clean the skin with alcohol swab and allow it to dry before inserting the IV catheter.	☐	☐	
	• Insert the IV cannula at the proper angle and confirm patency.	☐	☐	
	• Attach the IV tubing, and ensure that the medication flows at the prescribed rate.	☐	☐	
	• Flush the line with saline before and after administering the medication.	☐	☐	
	• Monitor the IV site for signs of infiltration, infection, or complications.	☐	☐	
6.	**Post-Administration Monitoring**			
	• Monitor the child for any adverse reactions to the medication (e.g., allergic reactions, side effects).	☐	☐	
	• Observe for signs of improvement or worsening of symptoms.	☐	☐	
	• Document the medication administration details, including time, dosage, and any observations.	☐	☐	

Nursing instructor's signature: _____ Date: _____

Reflection/ Critical Incident Analysis



Gibbs' Reflective Cycle 1998

CASE STUDY FORMAT

XCVII. INTRODUCTION

Q. Background of the study

R. Objective (general & specific showing Knowledge, Skills & Attitude)

S. Scope and Delimitation

T. Theoretical Framework

XCVIII. BIOGRAPHIC DATA

Name

Address

Age

Gender

Race

Marital Status

Occupation

Religious orientation

Health care financing and usual source of medical care

XCIX. CHIEF COMPLAINT OR REASON FOR VISIT

C. NURSING HISTORY (with guide questionnaire)

EE. History of Present Illness

FF. Past Medical History

kk) Childhood diseases

ll) Immunizations

mm) Allergies

nn) Accidents and injuries

oo) Hospitalization

pp) Medication

GG. Family History of Illness (use Genogram)

HH. Obstetric History (for OB cases only; with Assessment Guide)

II. Developmental History (for Pediatric cases only; with Assessment Guide)

Note: Assessment guide *used should be attached as annexes at the back of the case study report.*

CI. FUNCTIONAL HEALTH PATTERN (with guide questionnaire)

67. Health Perception and Health Management Pattern

68. Nutrition and Metabolic Pattern
69. Elimination Pattern
70. Activity-Exercised Pattern (use Barthel index)
71. Sleep-rest Pattern
72. Cognitive-perceptual Pattern
73. Self-perception and self-control Pattern
74. Role-relationship Pattern
75. Sexuality-reproductive Pattern
76. Coping-stress tolerance Pattern
77. Value-belief Pattern

Interpretation:
Analysis: (with reference)

CII. REVIEW OF SYSTEM (all subjective complaints)

CIII. PHYSICAL ASSESSMENT (all objective findings; indicate date performed; Head to Toe Assessment; follow IPPA sequence)

13. General Survey (Short Paragraph)
14. Vital Signs

BODY PART (Technique used)	NORMAL FINDINGS	ACTUAL FINDINGS	INTERPRETATION / ANALYSIS w/ Reference

CIV. ANATOMY & PHYSIOLOGY

CV. DIAGNOSTIC / LABORATORY STUDIES (Table)

NAME OF TEST / PROCEDURE	DATE DONE	INDICATION FOR THE TEST /	NORMAL VALUE	ACTUAL RESULT / FINDINGS	SIGNIFICANCE OF THE RESULT /

PROCEDURE	FINDINGS

CVI. SURGICAL PROCEDURE (Operative worksheet, if any)

CVII. PATHOPHYSIOLOGY (Present in Schematic Diagram; Mind Mapping)

CVIII. DRUG STUDY / IV INFUSIONS, BLOOD TRANFUSIONS, TREAMENTS GIVEN

Drug Study

DRUG ORDER (Generic, name, dosage, route, frequency)	TRADE / BRAND NAME	PHARMACOLOGIC ACTION OF DRUG	INDICATION AND CONTRAINDICATIONS	ADVERSE EFFECTS OF THE DRUG	DESIRED ACTION ON YOUR CLIENT	NURSING RESPONSIBILITIES / PRECAUTIONS

Treatments Given

TREATMENT / INFUSION	CLASSIFICATION	INDICATION	CONTRAINDICATION	NURSING RESPONSIBILITIES / PRECAUTIONS

CIX. COURSE IN THE WARD (narrative form)

- Summary of day to day medical/nursing management from the date of admission up to the time case study was done
- Patient's Status:
    a. General condition of the client (ex. LOC, VS, and other Subjective & Objective, complaint during the day)
    b. 4 D's with inference / analysis:
        - Diet
        - Drugs/IVF
        - Lab/Diagnostics procedure
        - Disposition

CX. PRIORITIZED LIST OF NURSING PROBLEMS (Table)

- Prioritized using ABC's and Maslow's Hierarchy of Needs

DATE	NURSING PROBLEMS IDENTIFIED	CUES	JUSTIFICATION

CXI. NURSING CARE PLAN

CUES (Defining Characteristics of Nursing Diagnosis)	NURSING DIAGNOSIS (Problem & Etiology)	BACKGROUND KNOWLEDGE (Pathophysiology/psychosocial explanation or consequences of the nursing diagnosis)	GOALS AND OBJECTIVES (include long and short term objectives)	NURSING INTERVENTIONS AND RATIONALE	EVALUATION

CXII. PROPOSED / DISCHARGE PLAN (to be submitted by students whose patients are for discharge)

- M - Medications to take at home
- E - Exercises
- T - Treatment
- H - Health Teachings
- O - Out - patient follow-up
- D - Diet
- S - Spiritual / Sexual activity (optional)

References:

1. Hockenberry, M., Wilson, D., Rodgers, C. (2022). Wong's Essentials of Pediatric Nursing (11th ed.). Elsevier
2. Sethi. N., (2017). Essential of pediatric nursing (4th ed).

Community Health Nursing-I Clinical -1 CH

Course Description:

This course provides practical experience in community health nursing, focusing on assessing and addressing health issues in community settings. Students will participate in field visits to Basic Health Units (BHUs), Rural Health Centers (RHCs), Primary Health Centers (PHCs), and other health facilities, observing health assessments, health education, and environmental health practices.

The course emphasizes the role of Community Health Nurses (CHNs) in promoting public health and preventing diseases. Students will develop health education plans, engage with the community, and apply the nursing process during home visits. By the end of the course, students will gain hands-on experience in community health nursing and be able to design and implement health interventions based on community needs.

Clinical Rotation plan:

This semester will be of 16/22 weeks, the student nurse will observe and demonstrate skills in skill lab for half of the semester. In the next half, student nurse will go to clinical rotation (in block days) and perform skills under the supervision of clinical instructor.

Clinical Objectives:

7. Identify the role and responsibilities of staff working in each visited facility
8. Describe the processes of:
    - **a.** Sewerage treatment
    - **b.** Water purifications at large scale
    - **c.** Milk transportation & preservation
    - **d.** Meat slaughtering, handling and distribution
9. Identify environmental issues exist and their effects on health
10. Discuss the role of CHN in maintaining healthy environment
11. Begin to use nursing process during the home visits.
12. Utilize various methods of health education while providing health education to the clients.

Evaluation Criteria:

List of Contents	%	Frequency
Learning Objectives	15%	Weekly
Community Health Assessment	15%	10
Health Education Planning and Documentation	15%	10
Field Visit Reports	20%	10
Reflection/Critical Incident Analysis	15%	Weekly
Case Study	20%	01

Clinical Objectives Form

Student Name: _____ Faculty: _____

Clinical placement:_____ Date: _____

Clinical Objectives	Strategies	Evaluation

Community Health Survey Performa

1. Title of Report

Health Survey Report for [Community Name]2. Date of Survey

Date: [DD/MM/YYYY]

3. Student Name(s)

Name(s): [Student Name(s)]

Group No.: [Group Number]

4. Community/Area Surveyed

Community Name/Location: [Community Name]

Area Description: [Brief description of the area: urban, suburban, rural, etc.]

5. Purpose of the Survey

The purpose of the Windshield Survey was to observe and assess the general health status, living conditions, and environmental factors that might affect the health of the community members. This includes identifying potential health risks and resources available in the area.

6. Community Overview

Provide a summary of the community's characteristics:

- **Type of Community**: [Urban, Suburban, Rural, etc.]
- **Population Density**: [High, Moderate, Low]
- **Demographics**: [Age distribution, diversity, income level]

7. Key Observations from the Survey

- **Housing and Living Conditions**
    - Description of the types of housing (e.g., well-maintained homes, dilapidated buildings, apartment complexes).
    - Evidence of overcrowding or homelessness.
    - Presence of any environmental hazards like exposed trash, pollution, or deteriorating infrastructure.
- **Environmental Health**
    - Condition of roads, sidewalks, and streets.
    - Availability of clean water and sanitation services.
    - Green spaces, parks, and recreational areas for public use.
    - Signs of environmental issues (e.g., waste management, air or water pollution).
- **Community Resources**

    - Availability and proximity of healthcare services (e.g., clinics, pharmacies, hospitals).
    - Presence of schools, community centers, and other public services.
    - Access to grocery stores, public transportation, and other essential services.
- **Safety and Security**
    - Visible signs of crime, vandalism, or social unrest.
    - Community policing presence or neighborhood watch programs.
    - Safety of public spaces (e.g., street lighting, well-maintained public areas).
- **Social and Economic Indicators**
    - Signs of economic disparity (e.g., well-kept areas vs. neglected or impoverished areas).
    - Presence of businesses, employment opportunities, or signs of economic activity.
    - Indicators of social problems such as poverty, substance abuse, or mental health concerns.
- **Health Indicators**
    - General health status of the community based on visible signs (e.g., obesity, smoking, physical activity levels).
    - Access to health education, vaccination services, or other public health programs.
    - Observable signs of common diseases or health conditions affecting the population.

8. Key Findings and Observations

- **Strengths:**
    - [List strengths, such as good access to healthcare, well-maintained infrastructure, active community participation.]
- **Weaknesses:**
    - [List weaknesses, such as lack of health services, poor sanitation, high crime rate.]

9. Reflection

- **Challenges:**

    - [Discuss any challenges observed in the community that could affect health outcomes.]
- **Suggestions for Improvement:**
    - [Provide recommendations for improving community health, such as better waste management, more healthcare facilities, or increased health education efforts.]

10. Conclusion

Summarize the major observations and how the survey contributes to understanding the community's health needs. Discuss how this information can inform future community health nursing interventions.

Community Health Survey Checklist

Sr.	Health Survey Checklist	Need to improve	Satisfactory
1.	**Preparation for Survey**		
2.	Has the community area to be surveyed been clearly identified?		
3.	Has the necessary equipment (pen, paper, recording devices) been prepared?		
4.	Has the safety and comfort of participants been ensured?		
5.	Has the purpose and objectives of the survey been reviewed with the students?		
6.	**Observations of Community Health and Living Conditions**		
7.	Are there signs of poor housing (e.g., dilapidated homes, overcrowding)?		
8.	Is homelessness or inadequate shelter visible in the community?		
9.	Are roads and streets well-maintained, or are there signs of disrepair?		
10.	Is the community exposed to any visible environmental hazards (e.g., pollution, open waste)?		
11.	Is waste disposal and garbage management adequate in the area?		
12.	**Environmental Health Conditions**		
13.	Are there green spaces, parks, or recreational areas available?		
14.	Is there access to clean drinking water in the community?		

15.	Is sewage treatment and waste management visible or operational?		
16.	Are there signs of environmental pollution such as air or water quality issues?		
17.	**Community Resources**		
18.	Are healthcare facilities (e.g., clinics, pharmacies) accessible and available?		
19.	Are there schools, community centers, or other public service resources available?		
20.	Are there sufficient food stores and essential services in the community?		
21.	Is there access to public transportation?		
22.	**Safety and Security**		
23.	Are there visible signs of crime, such as vandalism or abandoned vehicles?		
24.	Are safety measures such as street lighting or community policing visible in the community?		
25.	Does the general atmosphere in the community appear safe and secure?		
26.	**Social and Economic Indicators**		
27.	Is there evidence of economic disparity (e.g., wealthy vs. impoverished areas)?		
28.	Are there visible signs of poverty (e.g., neglected areas, poor housing)?		
29.	Are there employment or economic opportunities in the community?		
30.	**Health Indicators**		
31.	Are there visible health concerns affecting the community (e.g., respiratory issues, obesity)?		
32.	Are health education programs or screenings available in the community?		

33.	Is there access to preventive health services (e.g., vaccinations, maternal care)?		
34.	**Reflection on Survey Findings**		
35.	Are key strengths of the community identified (e.g., strong community involvement, well-maintained facilities)?		
36.	Are weaknesses or areas in need of improvement identified?		
37.	Are recommendations for improving community health and well-being proposed based on the survey findings?		
38.	**Conclusion and Next Steps**		
39.	Have the major findings from the survey been summarized?		
40.	Have suggestions for future health programs or interventions been made?		

Faculty comments:

_____

_____

_____

_____

Health Education Planning

Assessment	N. Diagnosis	Goal	Planning	Rationale	Implementation	Evaluation
Subjective Data						

Objective

Data

List of Field Visits

S #	List of Field Visits	Minimum Frequency
01	Basic Health Unit (BHU), Rural Health Center (RHC), Primary Health Center (PHC)	**5**
02	Walking Survey in a Community	**5**
03	Bulk Water Supply Plant	**5**
04	Sewage Treatment Plant	**5**
05	Milk Plant & Dairy Farm	**5**

Field Visit Checklist:

Basic Health Unit (BHU), Rural Health centre (RHC), Primary Health Centre (PHC)

Sr.	Task	Yes	No	Comments
1.	**Preparation for Field Visit**			
	Has the community or facility been identified?	☐	☐	
	Are necessary materials (pen, paper, recording tools) ready?	☐	☐	
	Have safety protocols been reviewed?	☐	☐	

2.	**Observations of Community Health and Living Conditions**			
	Are there signs of poor housing (e.g., dilapidated homes, overcrowding)?	☐	☐	
	Is homelessness or inadequate shelter visible?	☐	☐	
	Are roads and streets well-maintained or in disrepair?	☐	☐	
	Is there visible environmental pollution or waste?	☐	☐	
3.	**Environmental Health Conditions**			
	Is sanitation and waste management adequate?	☐	☐	
	Is clean drinking water accessible?	☐	☐	
	Is there a functioning sewage treatment system?	☐	☐	
	Are environmental hazards like pollution observed?	☐	☐	
4.	**Community Resources and Services**			
	Are healthcare services (clinics, pharmacies) accessible?	☐	☐	
	Are there schools, community centers, or public services?	☐	☐	
	Is there access to public transportation?	☐	☐	

References: (Ansari, 2016; Alam, 2020; Basavanthappa, 2022)

Nursing instructor's signature: _____ Date: _____

Walking Survey in a Community

Sr.	Task	Yes	No	Comments
1.	**Preparation for Survey**			
	• Has the community for the walking survey been clearly identified?	☐	☐	
	• Are the necessary materials (survey forms, pen, paper) ready for the survey?	☐	☐	
	• Have safety protocols and guidelines for walking surveys been reviewed?	☐	☐	
2.	**Community Observations**			
	• Are there signs of poor housing or overcrowded living conditions?	☐	☐	
	• Are there any visible environmental health risks (e.g., pollution, waste)?	☐	☐	
	• Is the neighborhood well-maintained, with clean streets and public areas?	☐	☐	
	• Are there signs of poverty or economic disparity in the community?	☐	☐	
3.	**Health Conditions and Resources**			
	• Are there any visible health concerns affecting the community (e.g., smoking, obesity)?	☐	☐	
	• Are there accessible health facilities such as clinics, pharmacies, or healthcare workers?	☐	☐	
	• Are there any community programs or resources aimed at improving health?	☐	☐	
4.	**Safety and Security**			
	• Is the community generally safe for residents, with adequate street lighting and public safety measures?	☐	☐	

	• Are there any visible signs of crime or unsafe areas in the community?	☐	☐	
5.	**Social and Environmental Factors**			
	• Are there visible environmental hazards that may affect health (e.g., waste, standing water)?	☐	☐	
	• Are social problems like drug use, alcohol consumption, or homelessness visible in the community?	☐	☐	
6.	**Community Engagement and Health Education**			
	• Are there visible efforts for community health education (e.g., health workshops, awareness campaigns)?	☐	☐	
	• Are community members actively involved in health-promoting activities?	☐	☐	
	• Are health education materials such as posters or pamphlets visible in the community?	☐	☐	
7.	**Environmental Health and Hygiene**			
	• Is there visible access to clean water and proper sanitation facilities?	☐	☐	
	• Are waste management practices apparent and functioning well in the community?	☐	☐	
	• Are there adequate recreational spaces, parks, or green areas?	☐	☐	
8.	**Reflection and Recommendations**			
	• Have the community strengths and assets been identified (e.g., active participation, health resources)?	☐	☐	
	• Have areas for improvement been identified, such as poor sanitation or lack of healthcare access?	☐	☐	

	• Have recommendations for improving community health been proposed (e.g., better sanitation, health education)?	☐	☐	

References: (Ansari, 2016; Alam, 2020; Basavanthappa, 2022)

Nursing instructor's signature: _____ Date: _____

Bulk Water Supply Plant

Sr.	Task	Yes	No	Comments
1.	**Preparation for Field Visit**			
	• Has the Bulk Water Supply Plant been identified as the visit location?	☐	☐	
	• Have all necessary materials (notebook, recording tools, etc.) been prepared?	☐	☐	
	• Have the students reviewed the learning objectives and goals for the visit?	☐	☐	
	• Have safety protocols been discussed and ensured for the visit?	☐	☐	
2.	**Observations of Water Supply Facility**			
	• Is the facility well-maintained and free from visible hazards?	☐	☐	
	• Are the water treatment processes clearly visible and well-explained?	☐	☐	
	• Is the infrastructure (pipes, tanks, pumps) in good condition?	☐	☐	
	• Are there any signs of inefficiency or leaks in the water supply system?	☐	☐	
3.	**Water Treatment Process**			
	• Are the methods used for water treatment (e.g., filtration, chlorination) clearly demonstrated?	☐	☐	
	• Is the water quality tested regularly, and are the results available?	☐	☐	
	• Is there a backup system for water supply in case of malfunction or emergency?	☐	☐	
	• Are the water supply processes environmentally sustainable?	☐	☐	
4.	**Environmental Health and Safety**			

	• Are there any environmental health risks associated with the water supply system?	☐	☐	
	• Are there safety measures in place to prevent contamination or pollution?	☐	☐	
	• Are there any visible signs of pollution, such as improper waste disposal or water contamination?	☐	☐	
5.	**Health Education and Public Awareness**			
	• Are community members educated about water conservation and safety?	☐	☐	
	• Are there health education materials (e.g., pamphlets, posters) visible in the facility?	☐	☐	
	• Is there a program in place to inform the public about the water treatment process and safety measures?	☐	☐	
6.	**Community Involvement and Resources**			
	• Is the community involved in any water-related decision-making or management?	☐	☐	
	• Are there resources available for the community to report water-related issues or concerns?	☐	☐	
7.	**Reflection and Recommendations**			
	Have you identified strengths in the water supply facility (e.g., efficient treatment processes, sustainability efforts)?	☐	☐	
	Have you identified weaknesses or areas for improvement in the water supply system?	☐	☐	
	Have you proposed any recommendations for improving water safety, conservation, or public education?	☐	☐	

References: (Ansari, 2016; Alam, 2020; Basavanthappa, 2022)

Nursing instructor's signature: _____ Date: _____

Sewage Treatment Plant

Sr.	Task	Yes	No	Comments
1.	**Preparation for Field Visit**			
	• Has the Sewage Treatment Plant been identified as the visit location?	☐	☐	
	• Have all necessary materials (notebook, recording tools, etc.) been prepared?	☐	☐	
	• Have the students reviewed the learning objectives and goals for the visit?	☐	☐	
	• Have safety protocols been discussed and ensured for the visit?	☐	☐	
2.	**Observations of Sewage Treatment Facility**			
	• Is the facility clean, well-maintained, and free of visible hazards?	☐	☐	
	• Are the sewage treatment processes clearly demonstrated and well-explained?	☐	☐	
	• Are the water and sewage pipes, tanks, and pumps in good condition?	☐	☐	
	• Are there signs of leakage or inefficiencies in the system?	☐	☐	
3.	**Sewage Treatment Process**			
	• Are the steps involved in sewage treatment (e.g., filtration, aeration, disinfection) clearly explained?	☐	☐	
	• Are water quality tests conducted regularly, and are the results available?	☐	☐	
	• Is there a backup or emergency system for sewage treatment in case of failure?	☐	☐	
	• Are the sewage treatment processes environmentally sustainable?	☐	☐	
4.	**Health and Safety**			
	• Are there visible health and safety protocols for workers and visitors?	☐	☐	

	• Are there signs of contamination risks or exposure to harmful chemicals?	☐	☐	
	• Is the facility taking adequate steps to prevent pollution of surrounding areas?	☐	☐	
5.	**Environmental Impact and Waste Management**			
	• Are there visible environmental management practices (e.g., waste disposal, air quality monitoring)?	☐	☐	
	• Are there systems in place to manage sludge or other by-products from the sewage treatment process?	☐	☐	
	• Are there visible signs of pollution or contamination in the surrounding environment?	☐	☐	
6.	**Community Engagement and Education**			
	• Are community members informed about the sewage treatment process and its benefits?	☐	☐	
	• Are there educational materials or programs available to the public regarding sewage treatment and waste management?	☐	☐	
	• Is the community educated on how to prevent pollution and improper waste disposal?	☐	☐	
7.	**Reflection and Recommendations**			
	• Have strengths of the sewage treatment facility been identified (e.g., efficient processes, sustainability efforts)?	☐	☐	
	• Have weaknesses or areas for improvement been identified in the sewage treatment system?	☐	☐	
	• Have recommendations been made for improving sewage treatment practices, waste	☐	☐	

	management, or community health education?			

References: (Ansari, 2016; Alam, 2020; Basavanthappa, 2022)

Nursing instructor's signature: _____ Date: _____

Milk Plant & Dairy Farm (Community Health Nursing)

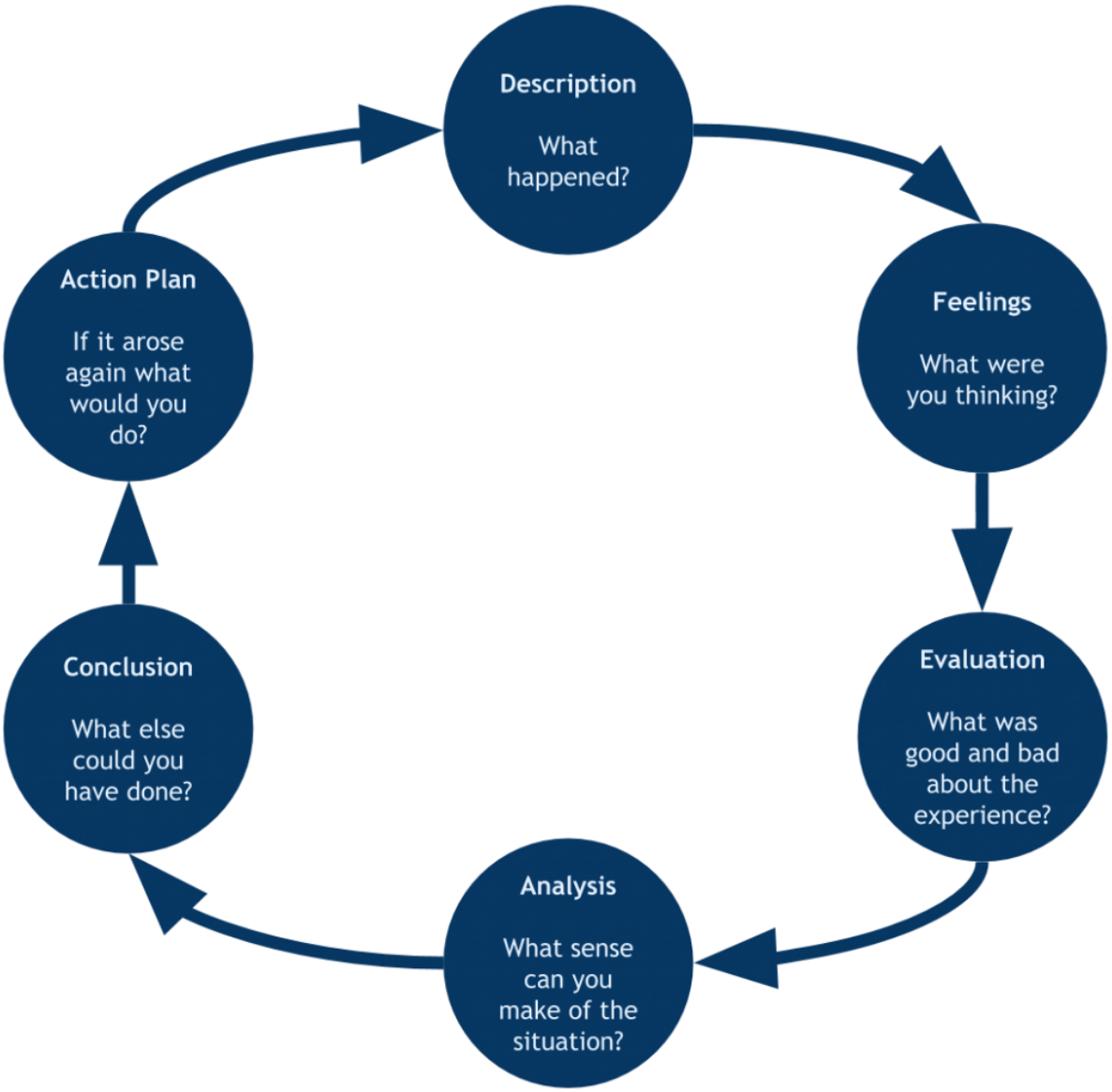
Sr.	Task	Yes	No	Comments
1.	**Preparation for Field Visit**			
	Has the Milk Plant or Dairy Farm been identified as the visit location?	☐	☐	
	Have all necessary materials (survey forms, notebooks, recording tools) been prepared?	☐	☐	
	Have students reviewed the learning objectives and goals for the visit?	☐	☐	
	Have safety protocols been discussed and ensured for the visit?	☐	☐	
2.	**Observations of Milk Plant/Dairy Farm**			
	Is the dairy farm/plant clean and well-maintained?	☐	☐	
	Are the cows well-cared for with appropriate living conditions?	☐	☐	
	Are the milking equipment and storage tanks in good condition?	☐	☐	
	Is the milking process hygienic and free of contamination risks?	☐	☐	
3.	**Milk Handling and Storage**			
	Is the milk cooled immediately after milking and stored properly?	☐	☐	
	Is the storage area for milk free from contamination and pests?	☐	☐	
	Are the milk processing and packaging methods compliant with health standards?	☐	☐	
4.	**Health and Safety Measures**			
	Are the workers following hygiene practices, including wearing gloves and sanitizing equipment?	☐	☐	
	Are there health and safety protocols for the workers handling milk?	☐	☐	

	Is there regular monitoring of the milk's quality for contaminants or bacteria?	☐	☐	
	Are there visible signs of any safety violations (e.g., unclean equipment, improper waste disposal)?	☐	☐	
5.	**Environmental Impact**			
	Is waste management handled appropriately (e.g., manure disposal, wastewater treatment)?	☐	☐	
	Are the environmental practices sustainable (e.g., energy use, water conservation)?	☐	☐	
	Are there any visible environmental hazards or signs of pollution around the facility?	☐	☐	
6.	**Community Health Education and Public Engagement**			
	Are community health education programs or materials (e.g., posters, leaflets) available on-site?	☐	☐	
	Are workers or the public educated about milk hygiene, safe handling, and consumption?	☐	☐	
	Is there any public outreach regarding the importance of milk safety and nutritional value?	☐	☐	
7.	**Reflections and Recommendations**			
	Have you identified any strengths in the milk plant/dairy farm (e.g., clean practices, quality control)?	☐	☐	
	Have you observed any weaknesses in the processes (e.g., improper sanitation, environmental risks)?	☐	☐	
	Have you proposed any recommendations for improving the practices, safety, or community engagement?	☐	☐	

References: (Ansari, 2016; Alam, 2020; Basavanthappa, 2022)

Nursing instructor's signature: _____ Date: _____

Reflection/ Critical Incident Analysis



Gibbs' Reflective Cycle 1998

CASE STUDY FORMAT

1. Title of the Case Study

Case Study on [Specific Health Issue or Community Health Topic] in [Community Name]
(Example: Case Study on Water Purification Practices in [Community Name])

2. Date of Case Study Submission

Date: [DD/MM/YYYY]

3. Student Name(s)

Name(s): [Student Name(s)]
Group No.: [Group Number]

4. Introduction to the Community or Health Issue

Provide a brief description of the community or health issue being discussed in the case study:

- **Location:** [Community Name and Region]
- **Population/Area:** [Details about the population served, demographics, size of the community]
- **Health Concern:** [Overview of the health issue or topic under investigation, such as water sanitation, nutrition, infectious diseases, etc.]

5. Health Issue Identification

Describe the health issue that is the focus of the case study:

- **Problem Identification:** [Describe the health problem, its prevalence in the community, and any contributing factors.]
- **Impact on Community Health:** [Discuss how the issue affects the overall health of the community and its population.]

6. Community Assessment

Provide an overview of the community's current health status and available resources:

- **Health Resources:** [Availability of clinics, hospitals, or other healthcare services.]
- **Community Resources:** [Access to sanitation, clean water, nutrition programs, health education services, etc.]
- **Environmental Factors:** [Discuss environmental factors that may contribute to or exacerbate the health issue, such as water contamination, pollution, or waste management.]

7. Role of Community Health Nurse (CHN)

Discuss the role of the **Community Health Nurse (CHN)** in addressing the identified health issue:

- **Interventions Provided:** [What interventions were or could be implemented by CHNs to address the health problem?]
- **Health Education:** [How can health education strategies be used to educate the community about the health issue?]
- **Collaboration with Other Stakeholders:** [How does the CHN collaborate with other health professionals, government agencies, or NGOs to address the issue?]

8. Data Collection and Methods Used

Describe the data collection methods used to gather information for the case study:

- **Survey/Questionnaire:** [If applicable, describe any surveys or questionnaires used to gather data from the community.]
- **Field Observations:** [Discuss any field observations made during community visits or health assessments.]
- **Interviews/Focus Groups:** [If applicable, describe interviews or focus groups conducted with community members or healthcare providers.]

9. Findings and Analysis

Present the key findings from the case study:

- **Health Indicators:** [Discuss the data collected regarding the health issue (e.g., rates of disease, access to healthcare, sanitation practices).]
- **Community Strengths:** [Identify strengths or resources in the community that can be leveraged to address the health issue.]
- **Challenges or Barriers:** [Describe any challenges faced by the community or health professionals in addressing the health issue (e.g., lack of resources, cultural barriers).]

10. Recommendations and Proposed Interventions

Based on the findings, provide recommendations for addressing the health issue:

- **Health Interventions:** [Discuss possible interventions, such as improved water treatment, health education programs, or improved sanitation infrastructure.]
- **Community-Based Solutions:** [Propose solutions that involve the community in the planning and implementation process.]
- **Role of CHN in Implementation:** [Explain how the CHN can be actively involved in the implementation of the proposed solutions.]

11. Conclusion

Summarize the key points discussed in the case study:

- **Key Takeaways:** [Highlight the most important findings and lessons learned from the case study.]
- **Importance of Community Health Nursing:** [Reinforce the role of CHNs in promoting health, preventing disease, and improving health outcomes in the community.]

References:

4. Alam, N. (2020). Excell Community Medicine, (13th ed.). Nishtar Publications
5. Basavanthappa, B. T. (2022). Community health Nursing. (3rd. ed.). New Delhi: Jaypee Medical publication
6. Ansari. I. M., (2016) Public health and community medicine. (8th ed) Karachi.

REPRODUCTIVE HEALTH CLINICAL – 3 CH

Course Description:

The Reproductive Health Clinical course provides hands-on experience in prenatal, natal, and postnatal care. Students will perform antenatal assessments, family planning counseling, and nutritional counseling. They will assist and conduct normal deliveries under supervision, as well as provide independent post-natal and newborn care.

The course focuses on developing action plans for reproductive health issues, implementing care plans, and applying teaching-learning principles in health education at Women and Child Health Centers. By the end, students will be equipped to provide comprehensive reproductive health care, educate women and families, and ensure safe maternity practices in clinical and community settings..

Clinical Rotation plan:

This semester will be of 16/22 weeks, the student nurse will observe and demonstrate skills in skill lab for half of the semester. In the next half, student nurse will go to clinical rotation (in block days) and perform skills under the supervision of clinical instructor.

Clinical Objectives

6. Perform prenatal, natal, and postnatal assessment. (male students will perform theses skill on simulation in skills lab)
7. Develop action plan of the prioritized problem.
8. Implement and evaluate plan of care.
9. Observe delivery process and provide care accordingly.
10. Apply teaching learning principle in conducting health education sessions at Women and Child health center.

Evaluation Criteria:

Sr.	Clinical Portfolio Content	%	Frequency
1.	**Clinical Objectives**	***10%***	**Weekly**
2.	History Taking Performa (Weekly)	***15%***	10
3.	Physical Examination Checklists	***15%***	10

4.	Nursing Care Plan (Weekly)	***10%***	10
5.	Nursing Skills Checklists (Weekly)	***20%***	10
6.	Reflection/ Critical Incident Analysis (Weekly)	***10%***	Weekly
7.	Case Study (One Per Semester)	***20%***	01

Clinical Objectives Form

Student Name: _____ Faculty: _____

Clinical placement:_____ Date: _____

Clinical Objectives	**Strategies**	**Evaluation**

History Taking Performa

1. Personal Information

- Name: _____
- Age: _____
- Marital Status: _____
- Occupation: _____
- Date of Birth: _____

2. Chief Complaints

- Main Complaint (as described by the patient):

  _____

  _____

- Duration of the complaint: _____

3. Obstetric History

- Gravida (Total number of pregnancies): _____
- Para (Number of live births): _____
- Abortions (Number of spontaneous/induced abortions): _____
- Previous pregnancies details:
    - Date of last delivery: _____
    - Type of delivery: Vaginal/ Caesarean/ Assisted/ Other: _____
    - Complications during delivery (if any):

      _____
    - Any previous issues with pregnancy (e.g., preeclampsia, gestational diabetes, etc.): _____

4. Menstrual History

- Age of Menarche: _____
- Menstrual Cycle (Regular/Irregular): Regular/Irregular
- Frequency of periods (days): _____
- Duration of menstruation (days): _____
- Flow (Heavy/Moderate/Light): _____
- Any abnormal bleeding (e.g., inter-menstrual, postcoital, etc.): _____

5. Contraceptive History

- Current contraception method (if any): _____
- Past contraceptive methods used (if any): _____
- Any issues with contraception (e.g., side effects, non-compliance, etc.):

  _____

6. Sexual History

- Sexual activity (active/inactive): _____
- Any history of sexually transmitted infections (STIs)? Yes/No
  If yes, specify: _____
- Number of sexual partners: _____
- History of any sexual dysfunction or discomfort (pain, vaginal dryness, etc.):

  _____

7. Medical History

- History of chronic conditions (e.g., hypertension, diabetes, thyroid disorders, etc.):

  _____
- Any surgeries or hospitalizations related to reproductive health:

- History of previous gynecological issues (e.g., fibroids, polycystic ovary syndrome, endometriosis, etc.):

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8. Family History

- Family history of reproductive or gynecological conditions:

- Family history of genetic disorders:

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9. Social History

- Lifestyle (smoking, alcohol consumption, drug use):

- Dietary habits (e.g., vegetarian, non-vegetarian, etc.):

- Exercise habits (e.g., sedentary, active):

- Stress levels (e.g., job-related, family issues):

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10. Current Pregnancy (If applicable)

- Estimated Due Date (EDD): _____
- Current trimester (1st/2nd/3rd): _____
- Any pregnancy-related complications (e.g., bleeding, swelling, headaches, vomiting, etc.):

- Current symptoms or concerns:

---

11. Physical Examination (To be filled by healthcare provider)

- General Appearance: _____
- Vital Signs:
  - Blood Pressure: _____
  - Pulse Rate: _____
  - Temperature: _____
  - Respiratory Rate: _____
- Abdominal Examination:

- Fundal Height: _____
- Fetal Heart Rate (FHR): _____
- Any tenderness or abnormal findings: _____

- Pelvic Examination (if applicable):
  - Cervical Dilatation (for labor cases): _____
  - Any other findings: _____

History Taking Checklist

Sr.	Task	Yes	No	Comments
1.	**Personal Information**			
	• Has the patient's name, age, sex, and marital status been recorded?	☐	☐	
	• Has the patient's occupation and phone number been noted?	☐	☐	
2.	**Chief Complaints**			
	• Has the main complaint been documented as described by the patient?	☐	☐	
	• Has the duration of the complaint been recorded?	☐	☐	
3.	**Obstetric History**			
	• Has the gravida and para status been documented?	☐	☐	
	• Have the details of previous pregnancies, deliveries, and complications been noted?	☐	☐	
4.	**Menstrual History**			
	• Has the age of menarche been recorded?	☐	☐	
	• Is the menstrual cycle information (frequency, duration, and flow) documented?	☐	☐	
	• Are any abnormal bleeding patterns recorded?	☐	☐	
5.	**Contraceptive History**			

	• Has current contraceptive use been documented?	☐	☐	
	• Have past contraceptive methods and issues been noted?	☐	☐	
6.	**Sexual History**			
	• Has the patient's sexual activity status been recorded?	☐	☐	
	• Are any sexually transmitted infections (STIs) documented?	☐	☐	
	• Is the number of sexual partners noted?	☐	☐	
7.	**Medical History**			
8.	• Has the patient’s chronic medical conditions been documented?	☐	☐	
	• Have any relevant surgeries or hospitalizations been recorded?	☐	☐	
	• Have gynecological issues been noted (e.g., fibroids, PCOS, endometriosis)?	☐	☐	
9.	**Family History**			
	• Has the family history of reproductive or gynecological conditions been noted?	☐	☐	
	• Are any genetic disorders in the family recorded?	☐	☐	
10.	**Social History**			
	• Has lifestyle information (smoking, alcohol, drugs) been documented?	☐	☐	
	• Have dietary habits and exercise routines been noted?	☐	☐	
	• Is the stress level documented?	☐	☐	
11.	**Current Pregnancy**			
	• Has the estimated due date (EDD) been recorded?	☐	☐	
	• Is the current trimester documented?	☐	☐	

	• Are pregnancy complications or concerns noted?	☐	☐	
12.	**Physical Examination**			
	• Are general appearance and vital signs documented (blood pressure, pulse, temperature, etc.)?	☐	☐	
	• Has an abdominal examination been performed (fundal height, fetal heart rate, tenderness)?	☐	☐	
	• Has a pelvic examination (if applicable) been done, with findings recorded?	☐	☐	
13.	**Plan of Care**			
	• Has the nursing diagnosis/assessment been clearly documented?	☐	☐	
	• Has an action plan with interventions and goals been developed?	☐	☐	
	• Has a follow-up and evaluation plan been created?	☐	☐	

Faculty comments:

Nursing Care Plan

Assessment	N. Diagnosis	Goal	Planning	Rationale	Implementation	Evaluation
Subjective Data						
Objective Data						

List of Clinical Skills

Levels of competency = 1-5 (Novice to Expert)

S #	Skills	Level of competency	Minimum Frequency
01	Antenatal assessment (Vital Signs, EDD, Fundal Height, FHR)	**1-5**	**20**
02	Family Planning counseling	**1-5**	**5**
03	Family Planning Methods	**1-5**	**5**
04	Nutritional Counselling	**1-5**	**5**
05	Observation of 10 normal delivery cases	**1-5**	**10**
06	Assist 05 normal delivery cases	**1-5**	**5**
07	Conduct 05 Normal delivery cases under supervision	**1-5**	**5**
08	Conduct 05 Independent normal delivery cases	**1-5**	**5**
09	Independent post-natal care	**1-5**	**5**

10	Independent newborn care	**1-5**	**5**

No	**Procedures**	**Clinical Experience**					
		Skill Lab Lecturer Signature	**Date**	**Ward/Clinics Signature**	**Date**	**Supervisor Signature**	**Date**
1.	Antenatal assessment(Vital Signs, EDD, Fundal Height, FHR)						
2.	Family Planning counseling						
3.	Family Planning Methods						
4.	Nutritional Counselling						
5.	Observation of 10 normal delivery cases						
6.	Assist 05 normal delivery cases						
7.	Conduct 05 Normal delivery cases under supervision						
8.	Conduct 05 Independent normal delivery cases						

9.	Independent post-natal care						
10	Independent newborn care						

Antenatal Assessment (Vital Signs, EDD, Fundal Height, FHR)

Equipment Needed for Antenatal Assessment:

- **Stethoscope** (for listening to FHR)
- **Measuring tape** (for measuring fundal height)
- **Sphygmomanometer** (for blood pressure)
- **Thermometer** (for measuring temperature)
- **Fetal Doppler** (for FHR detection)
- **Pen and paper** or electronic device for documentation

Checklist

Sr.	Task	Yes	No	Comments
1.	**Vital Signs**			
	• Has the Blood Pressure been measured and recorded?	☐	☐	
	• Is the Pulse Rate within normal limits (60-100 bpm)?	☐	☐	
	• Is the Temperature within normal limits (36.1°C - 37.2°C)?	☐	☐	
	• Is the Respiratory Rate within normal limits (12-20 breaths/min)?	☐	☐	
2.	**Estimated Due Date (EDD)**			
	• Has the Estimated Due Date (EDD) been calculated accurately?	☐	☐	

	• Has the method used to calculate the EDD been noted (e.g., Last Menstrual Period (LMP), Ultrasound)?	☐	☐	
3.	**Fundal Height**			
	• Has the fundal height been measured and recorded?	☐	☐	
	• Is the fundal height appropriate for the gestational age?	☐	☐	
	• Are there any discrepancies in fundal height (e.g., too small or large for gestational age)?	☐	☐	
4.	**Fetal Heart Rate (FHR)**			
	• Has the Fetal Heart Rate (FHR) been auscultated?	☐	☐	
	• Is the FHR within the normal range (110-160 bpm)?	☐	☐	
	• Is the FHR clearly heard and regular?	☐	☐	
5.	**General Observations and Findings**			
	• Are there any signs of discomfort, swelling, or other concerns?	☐	☐	
	• Is the patient aware of any abnormal symptoms (e.g., headache, vision changes, abdominal pain)?	☐	☐	
	• Has the patient been educated on warning signs during pregnancy (e.g., bleeding, severe headache, visual disturbances)?	☐	☐	

Nursing instructor's signature: _____ Date: _____

Reference: (Alam, 2020; Marshall and Raynor, 2020; Basavanthappa, 2022)

Family Planning Counseling

Equipment Needed for Family Planning Counseling:

- **Pen and paper** or electronic device for documentation
- **Educational materials** (e.g., pamphlets, posters, brochures)
- **Model contraceptive devices** (if applicable) for demonstration

Checklist

Sr.	Task	Yes	No	Comments
1.	**Initial Assessment**			
	• Has the patient's understanding of family planning been assessed?	☐	☐	
	• Has the patient expressed any concerns or preferences regarding family planning?	☐	☐	
	• Is the patient's medical history (e.g., chronic conditions, contraindications) considered in counseling?	☐	☐	
2.	**Discussion of Family Planning Methods**			
	• Are various family planning methods (e.g., hormonal, barrier, permanent) introduced?	☐	☐	
	• Is the effectiveness of each method explained clearly?	☐	☐	
	• Are the advantages and disadvantages of each method discussed?	☐	☐	
	• Are side effects of each method explained?	☐	☐	
	• Are contraindications for each method discussed?	☐	☐	
3.	**Patient Education**			

	• Is the patient educated about the proper use of the selected method?	☐	☐	
	• Has the patient been informed about the frequency of use (e.g., daily, monthly)?	☐	☐	
	• Is the patient aware of where to access emergency contraception (if applicable)?	☐	☐	
4.	**Follow-up and Support**			
	• Is the patient informed about the follow-up schedule (e.g., annual visit)?	☐	☐	
	• Is the patient provided with contact information for additional support or questions?	☐	☐	
	• Has the patient been advised to return for a check-up if there are concerns or complications?	☐	☐	
5.	**Confidentiality and Consent**			
	• Has the patient been informed about confidentiality regarding family planning counseling?	☐	☐	
	• Has the patient given informed consent for the selected family planning method?	☐	☐	

Nursing instructor's signature: _____ Date: _____

Reference: (Alam, 2020; Marshall and Raynor, 2020; Basavanthappa, 2022)

Family Planning Methods

Equipment Needed for Family Planning Methods Counseling:

- **Pen and paper** or electronic device for documentation
- **Contraceptive devices models** (e.g., IUD, condoms, implants)
- **Educational materials** (pamphlets, brochures, posters)

Checklist

Sr.	Task	Yes	No	Comments
1.	**Discussion of Available Family Planning Methods**			
	• Have all contraceptive methods (e.g., hormonal, barrier, permanent) been explained to the patient?	☐	☐	
	• Have the advantages and disadvantages of each method been discussed?	☐	☐	
	• Have the effectiveness rates of each method been explained?	☐	☐	
2.	**Method Selection**			
	• Has the patient been guided in selecting a method based on their preferences, lifestyle, and health status?	☐	☐	
	• Is the preferred method of family planning documented in the patient's records?	☐	☐	
	• Is the patient provided with information about how to access their chosen method?	☐	☐	
3.	**Method-Specific Information**			
	• **Oral Contraceptives**: Have the benefits, side effects, and proper use been explained?	☐	☐	

	• **Condoms**: Have the proper use and advantages (e.g., STI protection) been discussed?	☐	☐	
	• **Intrauterine Device (IUD)**: Has the patient been informed about insertion, possible side effects, and follow-up care?	☐	☐	
	• **Injectables**: Has the patient been informed about the schedule for injections and side effects?	☐	☐	
	• **Implants**: Has the patient been informed about the insertion process, effectiveness, and possible side effects?	☐	☐	
	• **Sterilization**: Has the patient been counseled on permanent sterilization options, including risks and irreversibility?	☐	☐	
	• **Emergency Contraception**: Has the patient been informed about how and when to use emergency contraception?	☐	☐	
	• **Natural Methods**: Have the withdrawal and fertility awareness methods been discussed?	☐	☐	
	• **Barrier Methods**: Has the use of diaphragms or cervical caps been explained?	☐	☐	
4.	**Follow-up and Support**			
	• Has the patient been informed about the follow-up appointments or check-ups for their selected method?	☐	☐	
	• Has the patient been provided with contact information for questions or concerns regarding the method?	☐	☐	
5.	**Confidentiality and Consent**			

	• Has the patient been informed that their method choice will be confidential?	☐	☐	
	• Has the patient provided informed consent for their selected method?	☐	☐	

Nursing instructor's signature: _____ Date: _____

Reference: (Alam, 2020; Marshall and Raynor, 2020; Basavanthappa, 2022)

Nutritional Counselling

Equipment Needed for Nutritional Counseling:

- **Pen and paper** or electronic device for documentation
- **Nutritional charts or materials** (e.g., food pyramid, sample meal plans)
- **Measuring tools** (e.g., body mass index chart, weight scale)

Checklist

Sr.	Task	Yes	No	Comments
1.	**Initial Assessment**			
	• Has the patient's current dietary habits been assessed?	☐	☐	
	• Has the patient's nutritional status (e.g., underweight, overweight) been evaluated?	☐	☐	
	• Have the patient's medical conditions (e.g., gestational diabetes, anemia) been considered in counseling?	☐	☐	
2.	**Education on Nutritional Requirements**			
	• Have the nutritional needs during pregnancy (or postpartum) been discussed?	☐	☐	
	• Has the importance of balanced meals (proteins, vitamins, minerals, carbohydrates) been emphasized?	☐	☐	
	• Has the patient been advised on the increase in caloric intake during pregnancy or breastfeeding?	☐	☐	
	• Have iron, calcium, and folic acid intake and their sources been explained?	☐	☐	
3.	**Healthy Eating Guidelines**			
	Have recommendations for healthy snacks and meal timing been provided?	☐	☐	

	Has the patient been educated on the importance of staying hydrated?	☐	☐	
	Have food safety practices (e.g., avoiding certain foods during pregnancy) been discussed?	☐	☐	
4.	**Special Considerations**			
	Has the patient with gestational diabetes been educated about controlling blood sugar with diet?	☐	☐	
	Have specific nutritional needs for lactating women been addressed (e.g., increased calorie and fluid intake)?	☐	☐	
	Have food preferences or dietary restrictions (e.g., vegetarianism, allergies) been taken into account?	☐	☐	
5.	**Follow-up and Support**			
	Has a follow-up plan for assessing dietary changes been provided?	☐	☐	
	Has the patient been informed about resources for continued support (e.g., dietitian, local programs)?	☐	☐	
6.	**Confidentiality and Consent**			
	Has the patient been informed that their nutritional plan will be kept confidential?	☐	☐	
	Has the patient given informed consent to the proposed nutritional counseling?	☐	☐	

Nursing instructor's signature: _____ Date: _____

Reference: (Alam, 2020; Marshall and Raynor, 2020; Basavanthappa, 2022)

Observation of Normal Delivery Cases

Checklist

Sr.	S. No.	Task	Yes	No	Comments
1.	**Labor Assessment**				
	• Has the maternal history been reviewed prior to labor?	☐	☐		
	• Was fetal heart rate (FHR) monitored continuously during labor?	☐	☐		
	• Was the progression of labor (cervical dilation, contractions) monitored?	☐	☐		
2.	**Maternal Care During Labor**				
	• Was the mother's pain appropriately managed?	☐	☐		
	• Was positioning of the mother correct and comfortable during labor?	☐	☐		
	• Was the supportive care (emotional, physical) given to the mother?	☐	☐		
3.	**Delivery Process**				
	• Was vaginal examination performed to assess fetal descent and presentation?	☐	☐		
	• Was the crowning and the delivery of the baby managed correctly?	☐	☐		
	• Was aseptic technique used throughout the delivery process?	☐	☐		
4.	**Immediate Post-Delivery Care**				

	• Was immediate skin-to-skin contact established between the mother and baby?	☐	☐		
	• Was the cord clamping performed properly (timing and technique)?	☐	☐		
	• Was breastfeeding initiated early, if applicable?	☐	☐		
5.	**Observation of Placenta Delivery**				
	• Was the delivery of the placenta managed properly?	☐	☐		
	• Was the uterine tone assessed after placenta delivery to prevent hemorrhage?	☐	☐		
6.	**Postpartum Maternal Care**				
	• Was the uterine fundus assessed for firmness and position after delivery?	☐	☐		
	• Was perineal care performed to prevent infection?	☐	☐		
	• Was the vital signs of the mother regularly monitored post-delivery?	☐	☐		
	Infant Care After Birth				
	• Was the baby's breathing assessed immediately after birth?	☐	☐		
	• Was the Apgar score performed at 1 and 5 minutes?	☐	☐		
	• Was the baby's temperature and other vital signs checked?	☐	☐		
	Was the newborn's weight and length measured?	☐	☐		
7.	**Documentation and Handover**				

	• Was the delivery documented in the patient's medical record accurately?	☐	☐		
	• Was the care plan updated post-delivery, including maternal and newborn care?	☐	☐		

Nursing instructor's signature: _____ Date: _____

Reference: (Alam, 2020; Marshall and Raynor, 2020; Basavanthappa, 2022)

Assisting in Normal Delivery Cases

Checklist

Sr.	S. No.	Task	Yes	No	Comments
1.	**Pre-Delivery Preparation**				
	• Did you prepare the delivery area (sterile setup, equipment, instruments)?	☐	☐		
	• Were maternal vitals (BP, pulse, temperature) taken before delivery?	☐	☐		
	• Did you assist in ensuring the patient's comfort and positioning during labor?	☐	☐		
2.	**Labor and Delivery Support**				
	• Did you assist in monitoring contractions and maternal progress?	☐	☐		
	• Did you assist in performing vaginal exams to monitor labor progression?	☐	☐		
	• Did you provide emotional and physical support to the patient during delivery?	☐	☐		
3.	**Delivery Process**				
	• Did you assist in delivery (catching the baby, supporting the perineum)?	☐	☐		
	• Were you involved in cord clamping after birth?	☐	☐		
	• Did you assist in suctioning the baby’s airways, if necessary?	☐	☐		
4.	**Post-Delivery Maternal Care**				
	• Did you assist in fundal massage to ensure the uterus contracts?	☐	☐		

	• Did you assist in monitoring bleeding and observing for signs of hemorrhage?	☐	☐		
	• Did you help with perineal care (e.g., checking for tears, stitches)?	☐	☐		
5.	**5. Post-Delivery Newborn Care**				
	• Did you assist in the initial newborn assessment (Apgar score, temperature)?	☐	☐		
	• Did you assist in drying and wrapping the newborn to maintain body temperature?	☐	☐		
	• Did you assist in initiating breastfeeding immediately after delivery?	☐	☐		
6.	**6. Documentation and Handover**				
	• Did you help with the documentation of the delivery details?	☐	☐		
	• Did you assist in the handover of the mother and baby to the postpartum care team?	☐	☐		

Nursing instructor's signature: _____ Date: _____

Reference: (Alam, 2020; Marshall and Raynor, 2020; Basavanthappa, 2022)

Conducting Normal Delivery Cases Under Supervision

Checklist

Sr.	S. No.	Task	Yes	No	Comments
1.	**Pre-Delivery Preparation**				
	• Have you reviewed the maternal history and medical records before labor?	☐	☐		
	• Have you ensured the sterile setup of the delivery area and necessary equipment?	☐	☐		
	• Have you checked that the patient is comfortable and in the correct position for delivery?	☐	☐		
2.	**Labor and Delivery Support**				
	• Have you monitored the progress of labor (contractions, cervical dilation)?	☐	☐		
	• Did you ensure maternal vitals (BP, pulse, temperature) are within normal range?	☐	☐		
	• Have you communicated with the patient to provide emotional support during labor?	☐	☐		
3.	**Delivery Process**				
	• Did you assist the mother during the second stage of labor (pushing)?	☐	☐		
	• Did you perform the delivery (catching the baby, ensuring safe passage)?	☐	☐		
	• Did you assist in cord clamping at the appropriate time after delivery?	☐	☐		

	• Did you suction the baby's airways if needed (for meconium, etc.)?	☐	☐		
4.	**Immediate Post-Delivery Maternal Care**				
	• Did you monitor for excessive bleeding and ensure the uterus is contracting properly?	☐	☐		
	• Did you perform fundal massage to aid uterine contraction?	☐	☐		
	• Did you check the perineum for tears and assist with suturing if necessary?	☐	☐		
5.	**Immediate Newborn Care**				
	• Did you assess the Apgar score at 1 and 5 minutes?	☐	☐		
	• Did you dry and wrap the newborn to prevent heat loss?	☐	☐		
	• Did you initiate skin-to-skin contact between the mother and baby?	☐	☐		
6.	**Post-Delivery Observations**				
	• Did you provide early breastfeeding support or guide the mother through it?	☐	☐		
	• Have you ensured the baby's vitals (temperature, heart rate, breathing) are normal?	☐	☐		
7.	**Documentation and Handover**				
	• Did you document the delivery details, including time, method, and complications (if any)?	☐	☐		
	• Did you handover care to the postpartum team, including the mother and newborn?	☐	☐		

Nursing instructor's signature: _____ Date: _____

Reference: (Alam, 2020; Marshall and Raynor, 2020; Basavanthappa, 2022)

Conducting Independent Normal Delivery Cases

Checklist

Sr.	S. No.	Task	Yes	No	Comments
1.	**Pre-Delivery Preparation**				
	• Have you reviewed the patient's medical history before labor?	☐	☐		
	• Have you ensured that the delivery area is sterile and well-prepared?	☐	☐		
	• Have you confirmed that the patient's comfort and positioning are optimal for delivery?	☐	☐		
2.	**Labor and Delivery Support**				
	• Have you monitored the progress of labor (cervical dilation, contractions)?	☐	☐		
	• Have you ensured the maternal vitals (BP, pulse, temperature) are stable?	☐	☐		
	• Did you provide emotional and physical support to the mother during labor?	☐	☐		
3.	**3. Delivery Process**				
	• Did you perform vaginal examinations to monitor labor progression?	☐	☐		
	• Did you assist in the delivery of the baby (catching, supporting perineum)?	☐	☐		
	• Did you ensure cord clamping was performed correctly at the appropriate time?	☐	☐		

	• Did you ensure asphyxia management (suctioning) was provided if necessary?	☐	☐		
4.	**Immediate Post-Delivery Maternal Care**				
	• Did you perform fundal massage to ensure uterine contraction and prevent hemorrhage?	☐	☐		
	• Did you assess and manage bleeding appropriately, ensuring it was within normal limits?	☐	☐		
	• Did you perform perineal care to check for any lacerations or tears, and assist in stitching if needed?	☐	☐		
5.	**Immediate Newborn Care**				
	• Did you perform an Apgar assessment (at 1 and 5 minutes)?	☐	☐		
	• Did you perform initial newborn resuscitation if needed (suction, stimulation)?	☐	☐		
	• Did you provide skin-to-skin contact between mother and baby?	☐	☐		
6.	**Post-Delivery Care and Documentation**				
	• Did you ensure breastfeeding initiation was performed or facilitated?	☐	☐		
	• Did you ensure newborn vitals (heart rate, temperature) were stable?	☐	☐		
	• Did you document the delivery process, maternal and newborn condition, and any complications?	☐	☐		
7.	**Handover to Postpartum Care Team**				

	• Did you handover the care of the mother and newborn to the postpartum team?	☐	☐		
	• Did you communicate key information about the delivery and postnatal care?	☐	☐		

Nursing instructor's signature: _____ Date: _____

Reference: (Alam, 2020; Marshall and Raynor, 2020; Basavanthappa, 2022)

Independent Post-Natal Care Checklist

Sr.	S. No.	Task	Yes	No	Comments
1.	**Maternal Post-Natal Care**				
	• Have you assessed the uterus to ensure it is firm and contracted?	☐	☐		
	• Have you monitored the vital signs (BP, pulse, temperature) post-delivery?	☐	☐		
	• Have you checked for any signs of postpartum hemorrhage (e.g., excessive bleeding)?	☐	☐		
	• Have you massaged the uterus to ensure it remains firm and reduce the risk of hemorrhage?	☐	☐		
	• Have you assessed and documented the perineum (e.g., healing after episiotomy or tears)?	☐	☐		
	• Have you performed vaginal examinations for any signs of infection or complications?	☐	☐		
	• Have you educated the mother about breastfeeding and its benefits?	☐	☐		
	• Have you discussed the importance of rest, nutrition, and hydration?	☐	☐		
	• Have you provided guidance on postpartum contraception and family planning methods?	☐	☐		
	• 2. Newborn Post-Natal Care				
	• Have you checked the newborn's vital signs (heart rate, temperature, breathing)?	☐	☐		

	• Have you performed physical assessments (e.g., weight, length, reflexes)?	☐	☐		
	• Have you checked for jaundice and documented any findings?	☐	☐		
	• Did you ensure the baby is kept warm after birth?	☐	☐		
	• Did you assist with newborn feeding (initiating breastfeeding or bottle-feeding)?	☐	☐		
	• Have you assessed infant bonding and assisted with skin-to-skin contact?	☐	☐		
	• Have you educated the mother on newborn care (e.g., diapering, bathing, handling)?	☐	☐		
	• 3. Emotional and Psychological Support				
	• Have you provided emotional support to the mother, addressing her physical and psychological needs?	☐	☐		
	• Have you discussed postpartum mood changes and provided resources if needed (e.g., postpartum depression)?	☐	☐		
	• Have you supported the family in the adjustment process post-delivery?	☐	☐		
2.	**Documentation and Handover**				
	• Have you documented all findings (maternal recovery, newborn status, breastfeeding, etc.)?	☐	☐		

	• Have you provided a proper handover to the next healthcare provider, ensuring continuity of care?	☐	☐		
	• Have you reviewed and updated the care plan based on maternal and newborn needs?	☐	☐		

Nursing instructor's signature: _____ Date: _____

Reference: (Alam, 2020; Marshall and Raynor, 2020; Basavanthappa, 2022)

Independent Newborn Care

Instructions for Faculty/Student:

- **Objective:** The goal is to independently provide newborn care after birth. This checklist will help ensure that all essential aspects of newborn care are provided and documented. Fill out this checklist after performing the independent care tasks to evaluate your actions and outcomes.

Checklist

Sr.	S. No.	Task	Yes	No	Comments
1.	**Initial Assessment**				
	• Did you assess the **newborn's breathing** and establish normal respirations (rate, effort)?	☐	☐		
	• Did you **assess the Apgar score** at 1 and 5 minutes?	☐	☐		
	• Did you assess the **newborn's heart rate** and temperature?	☐	☐		
2.	**Temperature Regulation**				
	• Did you **dry and warm** the newborn immediately after birth?	☐	☐		
	• Was the **newborn wrapped** in a warm blanket or placed on the mother’s chest for **skin-to-skin** contact?	☐	☐		
	• Did you **monitor the newborn's temperature** to ensure it is stable?	☐	☐		
3.	**Feeding Support**				
	• Did you initiate **breastfeeding** or assist the mother with **latching**?	☐	☐		

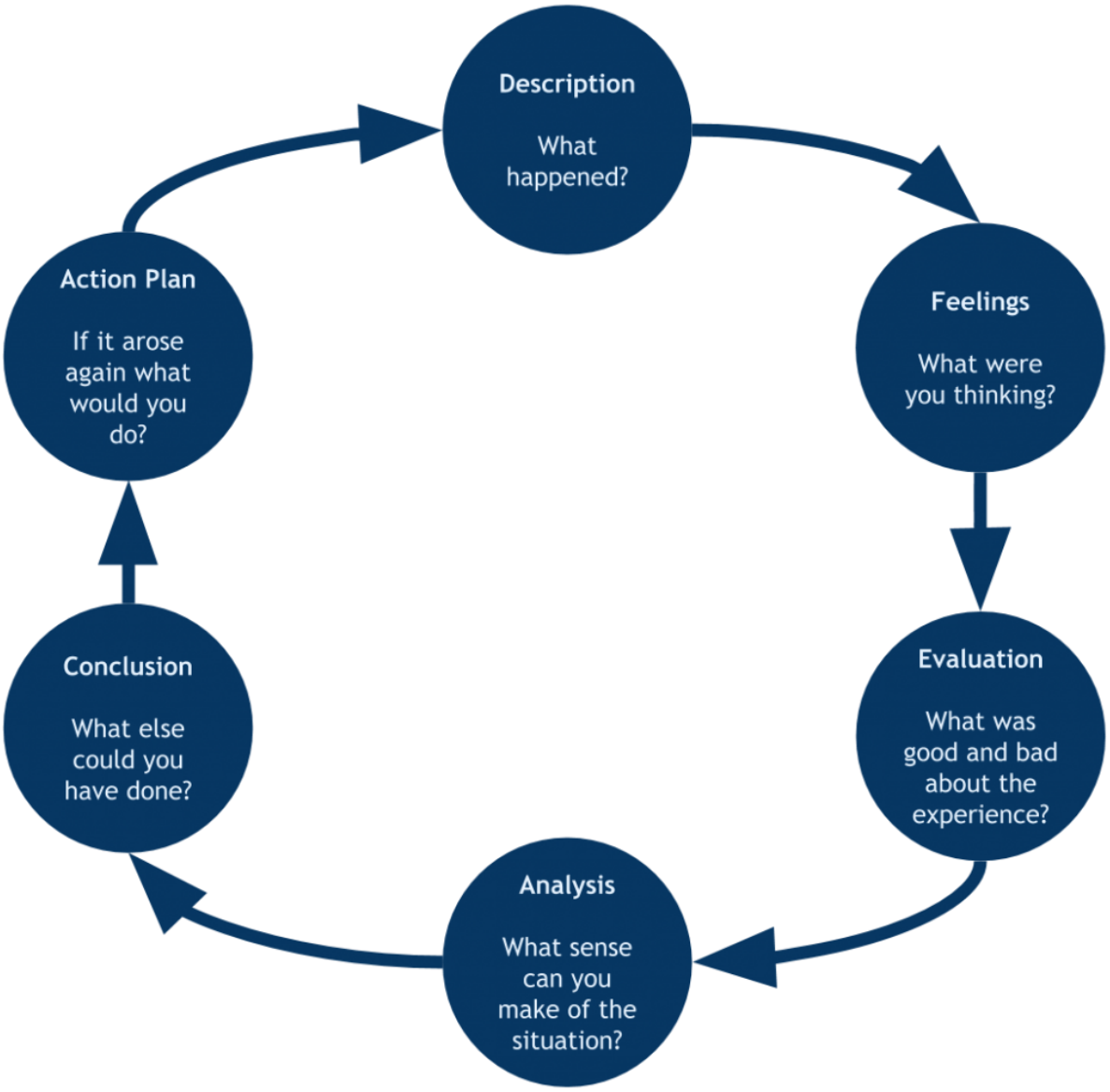
	• Did you observe for signs of **effective breastfeeding** (e.g., latch, swallowing)?	☐	☐		
	• If necessary, did you **support bottle-feeding** and ensure proper technique?	☐	☐		
4.	**Newborn Physical Examination**				
	• Did you perform a **head-to-toe physical exam** on the newborn?	☐	☐		
	• Did you check for **jaundice** or any abnormalities in the skin color?	☐	☐		
	• Did you assess the **newborn's reflexes** (e.g., rooting, sucking, Moro)?	☐	☐		
	• Did you check the **newborn's weight**, **length**, and **head circumference**?	☐	☐		
5.	**Cord Care**				
	• Did you check the **umbilical cord** for any signs of infection or abnormalities?	☐	☐		
	• Did you ensure proper **cord clamping** and **cleaning**?	☐	☐		
6.	**Newborn Hygiene**				
	• Did you **bathe the newborn** appropriately, using warm water and gentle soap?	☐	☐		
	• Did you **clean the baby's eyes** (if necessary) with sterile saline?	☐	☐		
	• Did you **diaper the baby** and ensure cleanliness?	☐	☐		
7.	**Infection Prevention and Safety**				

	• Did you **perform hand hygiene** before and after handling the newborn?	☐	☐		
	• Did you **ensure the newborn is protected from infection** (e.g., proper handwashing, sterile equipment)?	☐	☐		
8.	**Documentation**				
	• Did you **document the newborn's condition**, including vital signs, feeding, and physical examination results?	☐	☐		
	• Did you **record any complications** or concerns observed during care?	☐	☐		
9.	**Follow-Up and Handover**				
	• Did you **handover care** to the next healthcare provider (nurse, pediatrician) for continuous monitoring?	☐	☐		
	• Did you **provide the mother** with information on newborn care and signs of complications to watch for?	☐	☐		

Nursing instructor's signature: _____ Date: _____

Reference: (Alam, 2020; Marshall and Raynor, 2020; Basavanthappa, 2022)

Reflection/ Critical Incident Analysis



Gibbs' Reflective Cycle 1998

CASE STUDY FORMAT

CXIII. INTRODUCTION

U. Background of the study

V. Objective (general & specific showing Knowledge, Skills & Attitude)

W. Scope and Delimitation

X. Theoretical Framework

CXIV. BIOGRAPHIC DATA

Name

Address

Age

Gender

Race

Marital Status

Occupation

Religious orientation

Health care financing and usual source of medical care

CXV. CHIEF COMPLAINT OR REASON FOR VISIT

CXVI. NURSING HISTORY (with guide questionnaire)

JJ. History of Present Illness

KK. Past Medical History

qq) Childhood diseases

rr) Immunizations

ss) Allergies

tt) Accidents and injuries

uu) Hospitalization

vv) Medication

LL. Family History of Illness (use Genogram)

MM. Obstetric History (for OB cases only; with Assessment Guide)

NN. Developmental History (for Pediatric cases only; with Assessment Guide)

Note: Assessment guide *used should be attached as annexes at the back of the case study report.*

CXVII. FUNCTIONAL HEALTH PATTERN (with guide questionnaire)

78. Health Perception and Health Management Pattern

79. Nutrition and Metabolic Pattern

80. Elimination Pattern
81. Activity-Exercised Pattern (use Barthel index)
82. Sleep-rest Pattern
83. Cognitive-perceptual Pattern
84. Self-perception and self-control Pattern
85. Role-relationship Pattern
86. Sexuality-reproductive Pattern
87. Coping-stress tolerance Pattern
88. Value-belief Pattern

Interpretation:
Analysis: (with reference)

CXVIII. REVIEW OF SYSTEM (all subjective complaints)

CXIX. PHYSICAL ASSESSMENT (all objective findings; indicate date performed; Head to Toe Assessment; follow IPPA sequence)

15. General Survey (Short Paragraph)
16. Vital Signs

BODY PART (Technique used)	NORMAL FINDINGS	ACTUAL FINDINGS	INTERPRETATION / ANALYSIS w/ Reference

CXX. ANATOMY & PHYSIOLOGY

CXXI. DIAGNOSTIC / LABORATORY STUDIES (Table)

NAME OF TEST / PROCEDURE	DATE DONE	INDICATION FOR THE TEST / PROCEDURE	NORMAL VALUE	ACTUAL RESULT / FINDINGS	SIGNIFICANCE OF THE RESULT / FINDINGS

CXXII. SURGICAL PROCEDURE (Operative worksheet, if any)

CXXIII. PATHOPHYSIOLOGY (Present in Schematic Diagram; Mind Mapping)

CXXIV. DRUG STUDY / IV INFUSIONS, BLOOD TRANFUSIONS, TREAMENTS GIVEN

Drug Study

DRUG ORDER (Generic, name, dosage, route, frequency)	TRADE / BRAND NAME	PHARMACOLOGIC ACTION OF DRUG	INDICATION AND CONTRAINDICATIONS	ADVERSE EFFECTS OF THE DRUG	DESIRED ACTION ON YOUR CLIENT	NURSING RESPONSIBILITIES / PRECAUTIONS

Treatments Given

TREATMENT / INFUSION	CLASSIFICATION	INDICATION	CONTRAINDICATION	NURSING RESPONSIBILITIES / PRECAUTIONS

CXXV. COURSE IN THE WARD (narrative form)

- Summary of day to day medical/nursing management from the date of admission up to the time case study was done

- Patient's Status:
    a. General condition of the client (ex. LOC, VS, and other Subjective & Objective, complaint during the day)
    b. 4 D's with inference / analysis:
        - Diet
        - Drugs/IVF
        - Lab/Diagnostics procedure
        - Disposition

CXXVI. PRIORITIZED LIST OF NURSING PROBLEMS (Table)

- Prioritized using ABC's and Maslow's Hierarchy of Needs

DATE	NURSING PROBLEMS IDENTIFIED	CUES	JUSTIFICATION

CXXVII. NURSING CARE PLAN

CUES (Defining Characteristics of Nursing Diagnosis)	NURSING DIAGNOSIS (Problem & Etiology)	BACKGROUND KNOWLEDGE (Pathophysiology/psychosocial explanation or consequences of the nursing diagnosis)	GOALS AND OBJECTIVES (include long and short term objectives)	NURSING INTERVENTIONS AND RATIONALE	EVALUATION

CXXVIII. PROPOSED / DISCHARGE PLAN (to be submitted by students whose patients are for discharge)

- M - Medications to take at home
- E - Exercises
- T - Treatment
- H - Health Teachings
- O - Out - patient follow-up
- D - Diet
- S - Spiritual / Sexual activity (optional

Recommended Books/ Reading Materials

1. Alam, N. (2020). Excell Community Medicine, (13th ed.). Nishtar Publications
2. Basavanthappa, B. T. (2022). Community health Nursing. (3rd. ed.). New Delhi: Jaypee Medical publication
3. Marshall, J.E. and Raynor, M.D. (2020) Myles Textbook for Midwives. 17th ed. London: Elsevier

Semester VI

CLINICAL TRAINING

Pediatric Health Nursing-II	2 Cr. Hours
Mental Health Nursing Clinical	3 Cr. Hours
Leadership/Management in Nursing	1 Cr. Hours

Table of Content

Course Title: Pediatric Health Nursing-II Clinical

Credit Hours: 02 (0+02)

Course Description:

This clinical course is designed to provide hands-on experience and practical knowledge in pediatric and neonatal nursing. Students will gain the skills needed to recognize and manage neonatal emergencies, explore modern technologies and treatment approaches for high-risk neonates, and contribute to the planning and operation of neonatal care units. Through clinical practice, students will apply the nursing process in caring for sick infants through pre-adolescents in both hospital and community settings. The course emphasizes evidence-based nursing practices and introduces students to key research areas in pediatric and neonatal care. Additionally, students will understand the critical role of the pediatric nurse as part of a multidisciplinary healthcare team and effectively manage various health issues affecting the pediatric population.

Clinical Rotation plan:

This semester will be of 16/22weeks, the student nurse will go to clinical rotation in batches to ensure 24/7 clinical placement at hospitals in all three shifts to observe, learn and perform clinical skills in clinical setting under the supervision of clinical instructor.

CLINICAL OBJECTIVES

8. Recognize and manage emergencies in neonates.
9. Describe various recent technologies and treatment modalities in the management of high-risk neonates.
10. Prepare a design for layout and management of neonatal units
11. Apply the nursing process in the care of ill infants to pre adolescents in hospital and community
12. Incorporate evidence-based nursing practice and identify the areas of research in the field of pediatric / neonatal nursing
13. Recognize the role of pediatric nurse as a member of the pediatric and neonatal health team.
14. Apply nursing process in the management of pediatric population problems and health issues.

Evaluation Criteria:

Clinical Objectives (Weekly)	***10%***
History Taking Performa (Weekly)	***15%***
Physical Examination Checklists	***15%***
Nursing Care Plan (Weekly)	***10%***
Nursing Skills Checklists (Weekly)	***20%***
Reflection/ Critical Incident Analysis (Weekly)	***10%***
Case Study (One Per Semester)	***20%***

Clinical Objectives Form

Student Name: _____ Faculty: _____ Date: _____

Clinical placement_____ Bed #_____ Medical Diagnosis: _____

Clinical Objectives	Strategies	Evaluation

History Taking Performa

Student Name: _____Group #: _____ Faculty: _____

1. Presenting Complaint, FHP, and ROS (Review of Systems)

(Include both the child's and caregiver's perspectives)

- Presenting Complaint (as described by caregiver):

- History of Present Illness:

- Family Health Patterns (FHP):

- Review of Systems (General, Respiratory, GI, Neurological, etc.):

2. Birth and Developmental History

- **Developmental Milestones:**
    - Gross Motor:_____
    - Fine Motor:_____
    - Language:_____
    - Social:_____
- **Immunization Status:**

    Up-to-date: ☐ Delayed: ☐ Not immunized:

- **Nutrition and Feeding Patterns:**

- **Sleep and Elimination Patterns:**

Checklist for taking a client health history

Interviewing Skills Checklist	**Satisfactory *S***	**Need to improve *N***
Introduced self, role, and clarified the purpose of the interview		
Ensured a child-friendly, private, and safe environment		
Developed rapport with both child (if age-appropriate) and caregiver		
Used open-ended questions and encouraged storytelling from the caregiver		
Explored history of present illness using COLDERRAA		
Collected information step-by-step, clarified responses, followed logical order		
Adapted communication for child's developmental level		
Used appropriate non-verbal cues (smiles, tone, body language)		
Avoided non-therapeutic techniques (e.g., leading, judgmental, false reassurance)		
Explored past medical and surgical history of the child		
Assessed developmental milestones and delays		
Reviewed family history of illnesses and genetic conditions		
Evaluated lifestyle factors (nutrition, play, hygiene, routines)		
Completed age-appropriate ROS efficiently		

Faculty comments:

_____

_____

_____

Nursing Care Plan

Assessment	N. Diagnosis	Goal	Planning	Rationale	Implementation	Evaluation
Subjective Data						
Objective Data						

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S. No	List of Skills Lab	Level of competency	Minimum Frequency
1	**Nasogastric (N/G) or Orogastric (O/G) Tube Insertion**	1-5	5
2	**Nasogastric (N/G) or Orogastric (O/G) Tube Feeding and Removal**	1-5	5
3	**Oropharyngeal or Nasopharyngeal Suctioning**	1-5	9
4	**Tracheostomy Suctioning**	1-5	5
5	**Blood Specimen Collection in Children**	1-5	5
6	**Urine Specimen Collection in Children**	1-5	10
7	**Care of a Child During Lumbar Puncture**	1-5	5
8	**Care of a Child Undergoing Peritoneal Dialysis**	1-5	5
9	**Foley's Catheter Insertion in Children**	1-5	5
10	**Positioning and Restraining Pediatric Clients**	1-5	10
11	**Assessment of hydration status in patients with burn, GIT disorders**	1-5	10
12	**Assessment of the proportion of body surface area in burn patient using rule of 9**	1-5	05
13	**Perform respiratory assessment and differentiate between normal and abnormal findings in paeds**	1-5	10
14	**Perform muculo skeletal assessment and differentiate between normal and abnormal findings in paeds**	1-5	05
15	**Develop a plan of care and formulate expected out come based on the indication for blood transfusion**	1-5	05
16	**Develop nursing care plan for patient with mental health disorder**	1-5	05
17	**Develop nursing care plan patient with drug abuse**	1-5	05
18	Develop health education plan for diabetic patient in peads	1-5	05
19	Develop a plan of care for a child with nephrotic syndrome	1-5	05
20	Use culturally sensitive counseling techniques	1-5	05
21	Compare traditional beliefs about fertility control and	1-5	5

	postpartum care		
22	Document and negotiate acceptable care plans respecting cultural beliefs.	1-5	5

No	Procedures	Clinical Experience					
		Skill Lab Lecturer Signature	Date	Ward/Clinics Signature	Date	Supervisor Signature	Date
1	Nasogastric (N/G) or Orogastric (O/G) Tube Insertion						
2	Nasogastric (N/G) or Orogastric (O/G) Tube Feeding and Removal						
3	Oropharyngeal or Nasopharyngeal Suctioning						
4	Tracheostomy Suctioning						
5	Blood Specimen Collection in Children						
6	Care of a Child During Lumbar Puncture						
7	Urine Specimen Collection in Children						

8	**Care of a Child During Lumbar Puncture**						
9	**Care of a Child Undergoing Peritoneal Dialysis**						
10	**Positioning and Restraining Pediatric Clients**						

Nursing Skills Checklists

Procedure 01: Nasogastric (N/G) or Orogastric (O/G) Tube Insertion

Definition:

Nasogastric (N/G) or Orogastric (O/G) tube insertion is a clinical procedure in which a flexible tube is inserted through the nose (N/G) or mouth (O/G) into the stomach. It is performed for feeding, medication administration, gastric decompression, or sampling gastric contents in pediatric patients.

Equipment Needed for Preparation:

- Personal protective equipment (gloves, apron, mask)
- Appropriate size N/G or O/G feeding tube (based on child's age/weight)
- Water-soluble lubricant
- Sterile or clean water for flushing
- 10–20 mL syringe (catheter tip)
- Stethoscope
- Adhesive tape or tube fixation device
- pH paper (for aspirate verification)
- Suction apparatus (if needed)
- Towel or bib to protect clothing
- Measuring tape or ruler
- Pen for marking tube length
- Waste disposal bag
- Documentation sheet or patient chart

Indications for N/G or O/G Tube Insertion:

- Inability to swallow or feed orally
- Gastric decompression (e.g., in bowel obstruction, post-operative care)
- Administration of medications or fluids
- Nutritional support (enteral feeding)
- Aspiration of gastric contents for diagnostic testing
- Gastric lavage in poisoning or overdose

Checklist for Nasogastric (N/G) or Orogastric (O/G) Tube Insertion

S.NO	Tasks	Yes	No	Comments
01	Verified doctor's order and explained procedure to caregiver/child			
02	Performed hand hygiene and wore appropriate PPE			
03	Assembled all required equipment at bedside			
04	Positioned child properly (e.g., supine or semi-upright depending on age and condition)			
05	Measured and marked the tube (Nose → Ear → Xiphoid process for N/G; Mouth → Ear → Xiphoid for O/G)			
06	Lubricated tip of the tube with water-soluble lubricant			
07	Inserted tube gently through the nostril or mouth as per protocol, encouraging swallowing (if child is able)			
08	Verified placement (by aspirating stomach contents, checking pH, and/or auscultation with air bolus)			
09	Secured the tube with tape or fixation device			
10	Connected to prescribed feeding or suction system if needed			
11	Monitored the child for signs of distress or			

	improper placement			
12	Disposed of used materials properly and performed hand hygiene			
13	Documented the procedure, size of tube used, placement verification method, child's response			

Nursing instructor's signature: _____ Date: _____

(Hockenberry, Wilson and Rodgers, 2022)

Procedure 02: Nasogastric (N/G) or Orogastric (O/G) Tube Feeding and Removal

Definition:

Nasogastric (N/G) or Orogastric (O/G) tube feeding is the process of delivering nutrition, fluids, and medications directly into the stomach through a tube inserted via the nose (N/G) or mouth (O/G). Tube removal involves the safe withdrawal of the tube once it is no longer required for feeding or medical treatment.

Equipment Needed for Preparation:

- Personal protective equipment (gloves, apron)
- Prescribed feeding formula (warm to room temperature)
- Feeding syringe or enteral feeding set
- Sterile or clean water for flushing (30–50 mL)
- pH paper (to confirm placement before feeding)
- Stethoscope (optional if using auscultation method)
- Clean towel or bib
- Measuring cup and clean container for formula
- Waste disposal bag
- Documentation sheet/patient chart

For **Removal**:

- Gauze or tissue
- Clean gloves
- Kidney tray
- Clean towel or bib
- Waste disposal container

Indications for N/G or O/G Tube Feeding and Removal:

Feeding:

- Inability to take oral feeds due to illness, surgery, or developmental issues
- Nutritional support for preterm or low birth weight infants
- Medication administration when oral intake is not possible

Removal:

- Child is able to resume oral intake safely
- Tube is no longer needed for decompression or feeding
- Tube is dislodged or malfunctioning
- Physician's or healthcare provider’s order for removal

Checklist for N/G or O/G Tube Feeding

S.NO	Tasks	Yes	No	Comments
01	Verified doctor's order and explained the procedure to caregiver/child			
02	Performed hand hygiene and wore gloves			
03	Assembled and checked equipment			
04	Positioned child properly (e.g., semi-Fowler’s position)			
05	Verified tube placement (aspirate pH, check markings, or air auscultation if required)			
06	Flushed the tube with clean water before feeding			

07	Administered formula at the prescribed rate and volume (via syringe or gravity feed)			
08	Flushed the tube after feeding to maintain patency			
09	Burped the infant if necessary and kept child upright for 20–30 minutes post-feeding			
10	Cleaned and stored equipment properly			
11	Monitored child for feeding tolerance (vomiting, bloating, distress)			
12	Documented feeding details, child's response, and any issues			

Checklist for N/G or O/G Tube Removal

S.NO	Tasks	Yes	No	Comments
01	Verified order for tube removal and explained the procedure			
02	Performed hand hygiene and wore gloves			
03	Positioned child in upright or semi-upright position			
04	Flushed the tube with a small amount of water to clear contents (if applicable)			
05	Removed adhesive/tape gently to free the tube			
06	Asked the child to hold breath (if cooperative) and gently withdrew the tube in one smooth motion			
07	Wiped mouth/nose and ensured comfort			
08	Disposed of equipment safely and performed hand hygiene			
09	Observed child for any complications post-removal (e.g., coughing, vomiting, distress)			

10	Documented removal, child's response, and any observations			

Nursing instructor’s signature: _____ Date: _____

(Hockenberry, Wilson and Rodgers, 2022)

Procedure 03: Oropharyngeal or Nasopharyngeal Suctioning

Definition:

Oropharyngeal and nasopharyngeal suctioning is a procedure used to remove secretions from the upper airway passages—either through the mouth (oropharyngeal) or nose (nasopharyngeal)—using a suction catheter and device. It is commonly performed in pediatric patients who are unable to clear secretions effectively on their own.

Equipment Needed for Preparation:

- Personal protective equipment (gloves, mask, eye shield, gown)
- Sterile or clean suction catheter (appropriate size for age/weight of child)
- Suction machine with calibrated pressure (infants: 60–80 mmHg; children: 80–100 mmHg)
- Sterile normal saline (optional for moistening catheter)
- Water-soluble lubricant (for nasopharyngeal suctioning)
- Sterile gloves (for nasopharyngeal suctioning)
- Clean gloves (for oropharyngeal suctioning)
- Oxygen source and device (in case of desaturation)
- Pulse oximeter
- Tissues or gauze
- Waste disposal container
- Towel or bib to protect child’s clothing

- Documentation sheet

Indications for Oropharyngeal or Nasopharyngeal Suctioning:

- Noisy breathing due to mucus obstruction
- Inability to clear secretions independently
- Visible secretions in the mouth/nose
- Increased work of breathing or respiratory distress
- To obtain secretions for diagnostic testing
- Pre/post procedure (e.g., before feeding, physiotherapy) to maintain airway patency

Checklist for Oropharyngeal or Nasopharyngeal Suctioning

S.NO	Tasks	Yes	No	Comments
01	Verified doctor's order and explained the procedure to caregiver/child			
02	Performed hand hygiene and wore appropriate PPE			
03	Checked and prepared suction equipment, set appropriate pressure			
04	Positioned the child (e.g., supine with head to the side, or semi-upright)			
05	Applied clean gloves for oropharyngeal or sterile gloves for nasopharyngeal suctioning			
06	Lubricated catheter for nasopharyngeal suctioning (if required)			
07	Inserted catheter gently into mouth (oropharyngeal) or nostril (nasopharyngeal) without applying suction			
08	Applied intermittent suction while withdrawing catheter (rotation may be used)			
09	Limited suctioning to appropriate time (5–10 seconds) to prevent hypoxia			

10	Monitored child's respiratory rate, color, and oxygen saturation throughout			
11	Reassured and comforted the child post-procedure			
12	Disposed of used equipment safely and performed hand hygiene			
13	Documented the procedure, amount and character of secretions, child's tolerance and any complications			

Nursing instructor's signature: _____ Date: _____

(Hockenberry, Wilson and Rodgers, 2022)

Procedure 04: Tracheostomy Suctioning

Definition:

Tracheostomy suctioning is a sterile procedure used to remove accumulated secretions from the tracheostomy tube to maintain airway patency, improve oxygenation, and prevent infection or blockage. It is commonly performed in pediatric patients with a tracheostomy who are unable to clear secretions effectively on their own.

Equipment Needed for Preparation:

- Personal protective equipment (sterile gloves, mask, eye shield, gown)
- Sterile suction catheter (appropriate size for child's tracheostomy tube)
- Suction machine with regulated pressure (infants: 60–80 mmHg; children: 80–100 mmHg)
- Sterile normal saline (for flushing catheter or loosening thick secretions, if needed)
- Sterile water or saline bowl
- Pulse oximeter (to monitor oxygen saturation)
- Oxygen source with resuscitation bag (Ambu bag) if needed

- Sterile container or kidney tray
- Waste disposal bag
- Sterile drape or clean towel
- Documentation sheet or patient chart

Indications for Tracheostomy Suctioning:

- Audible or visible secretions in the tracheostomy tube
- Increased respiratory effort or desaturation
- Restlessness or irritability indicating distress
- Cyanosis or other signs of airway obstruction
- Before tracheostomy care or procedures (e.g., changing ties or tube)
- To maintain airway patency in non-ventilated or ventilated children

Checklist for Tracheostomy Suctioning

S.NO	Tasks	Yes	No	Comments
01	Verified doctor’s order and assessed need for suctioning			
02	Explained procedure to caregiver/child (age-appropriate)			
03	Performed hand hygiene and wore appropriate PPE			
04	Assembled all sterile and clean equipment			
05	Positioned the child appropriately (semi-Fowler’s or supine with head support)			
06	Checked suction pressure and ensured machine function			
07	Applied sterile gloves and maintained sterile field			
08	Connected catheter to suction tubing without contaminating tip			
09	Inserted catheter gently into tracheostomy tube without applying suction			
10	Applied intermittent suction while withdrawing catheter in a rotating motion (5–10 seconds max)			
11	Monitored oxygen saturation and child's response throughout			
12	Repeated suctioning if necessary, allowing adequate rest and oxygenation between attempts			
13	Flushed catheter with sterile saline if reusing during the session			
14	Provided supplemental oxygen if ordered or needed			
15	Disposed of used items properly and performed hand hygiene			
16	Documented procedure, amount and type of			

	secretions, child's tolerance, and oxygen saturation changes			

Nursing instructor’s signature: _____ Date: _____

(Hockenberry, Wilson and Rodgers, 2022)

Procedure 05: Blood Specimen Collection in Children

Definition:

Blood specimen collection in children is the process of obtaining a blood sample using various techniques such as venipuncture, heel prick, or finger prick. The procedure is done for diagnostic, therapeutic, or monitoring purposes, and requires special care to minimize pain, anxiety, and complications in pediatric patients.

Equipment Needed for Preparation:

- Personal protective equipment (gloves, mask if needed)
- Sterile syringes or vacutainer system (appropriate size)
- Blood collection tubes (labelled as per test requirement)
- Alcohol swab or antiseptic solution
- Tourniquet (preferably pediatric)
- Cotton ball or sterile gauze
- Adhesive bandage or tape
- Sharps disposal container
- Waste disposal bag
- Identification labels and requisition form
- Comfort items (pacifier, toys, distraction tools for children)
- Topical anesthetic (if prescribed or available)

Indications for Blood Specimen Collection:

- Diagnostic testing (CBC, electrolytes, blood culture, etc.)
- Monitoring of treatment (e.g., drug levels, glucose, renal function)
- Screening for infections, metabolic or genetic disorders
- Preoperative evaluation or routine health check-ups
- Blood typing and crossmatching

Checklist for Blood Specimen Collection in Children

S.NO	Tasks	Yes	No	Comments
01	Verified doctor's order and identified the child correctly			
02	Explained the procedure to caregiver and child (age-appropriate)			
03	Performed hand hygiene and wore gloves			
04	Assembled all necessary equipment			
05	Positioned and comforted the child appropriately, with restraint if needed			
06	Selected an appropriate site (heel, finger, or vein depending on age and test)			
07	Applied tourniquet (for venipuncture) and identified the vein			
08	Cleaned the site using antiseptic in circular motion and allowed it to dry			
09	Collected the required blood volume gently using correct technique			
10	Released the tourniquet before removing the needle (if applicable)			
11	Applied pressure with gauze and secured with tape or bandage			
12	Labeled specimens correctly in presence of caregiver or child			
13	Reassured and comforted the child post-procedure			
14	Disposed of sharps and waste properly and performed hand hygiene			
15	Documented the procedure, site used, amount of blood collected, child's response, and any complications			

Nursing instructor's signature: _____ Date: _____

(Hockenberry, Wilson and Rodgers, 2022)

Procedure 06: Urine Specimen Collection in Children

Definition:

Urine specimen collection in children is the process of obtaining a urine sample for diagnostic or monitoring purposes. The method of collection varies depending on the child's age and condition, and may include clean-catch midstream, catheterization, urine bag collection, or suprapubic aspiration.

Equipment Needed for Preparation:

- Personal protective equipment (gloves)
- Pediatric urine collection bag (for infants/toddlers)
- Sterile urine container (with tight lid)
- Antiseptic wipes or cotton swabs with cleansing solution
- Urine hat or bedpan (for toilet-trained children)
- Catheterization kit (if ordered)
- Diaper (if needed after collection)
- Identification label and laboratory requisition form
- Waste disposal bag
- Hand hygiene supplies
- Towel or waterproof underpad

Indications for Urine Specimen Collection:

- Diagnosis of urinary tract infections (UTI)
- Screening for metabolic or kidney disorders
- Monitoring fluid balance, glucose, ketones, or drug levels
- Pre-surgical or routine assessments
- Urine culture and sensitivity tests

Checklist for Urine Specimen Collection in Children

S.NO	Tasks	Yes	No	Comments

01	Verified doctor's order and identified the child correctly			
02	Explained the procedure to caregiver and child (age-appropriate)			
03	Performed hand hygiene and wore gloves			
04	Assembled all required equipment			
05	Chose appropriate collection method (clean-catch, bag, catheter)			
06	Cleaned genital area properly with antiseptic wipes			
07	For bag collection: Applied the pediatric urine collection bag securely			
08	For clean-catch: Instructed the child to void midstream into sterile container			
09	For catheterization: Performed sterile catheterization technique (if indicated)			
10	Ensured sufficient amount of urine collected (as per test requirement)			
11	Removed and sealed specimen container tightly			
12	Labeled specimen correctly and sent to lab immediately			
13	Reassured and cleaned the child after the procedure			
14	Disposed of waste properly and performed hand hygiene			
15	Documented the procedure, method of collection, time, volume, and child's response			

Nursing instructor's signature: _____ Date: _____

(Hockenberry, Wilson and Rodgers, 2022)

Procedure 07: Care of a Child During Lumbar Puncture

Definition:

Lumbar puncture (also known as a spinal tap) is an invasive procedure used to collect cerebrospinal fluid (CSF) from the subarachnoid space in the lower spine for

diagnostic or therapeutic purposes. Nursing care is crucial before, during, and after the procedure to ensure safety, comfort, and successful outcome.

Equipment Needed for Preparation:

- Lumbar puncture tray/kit (sterile)
- Antiseptic solution (e.g., chlorhexidine or povidone-iodine)
- Sterile gloves, gown, mask, and drapes
- Sterile dressing or bandage
- Local anesthetic (e.g., lidocaine) and syringe with needle
- Collection tubes (usually 3–4 labeled sterile containers)
- Adhesive labels and lab requisition forms
- Positioning aids (rolled towel, pillow)
- Pulse oximeter and vital sign monitor
- Comfort items (toy, pacifier, or caregiver presence)
- Emergency equipment (oxygen, suction)
- Documentation sheet

Indications for Lumbar Puncture in Children:

- Diagnosis of infections (e.g., meningitis, encephalitis)
- Detection of hemorrhage, malignancy, or multiple sclerosis
- Measurement of CSF pressure
- Administration of intrathecal medications
- Evaluation of neurological symptoms

Checklist for Care of a Child During Lumbar Puncture

S.NO	Tasks	Yes	No	Comments
01	Verified physician’s order and confirmed identity of child			
02	Explained procedure to caregiver and child in age-appropriate terms			
03	Performed hand hygiene and wore appropriate PPE			

04	Ensured informed consent was obtained from parent/guardian			
05	Assembled and prepared all necessary sterile and supportive equipment			
06	Assisted in positioning the child (side-lying with knees to chest or sitting, based on provider preference)			
07	Provided emotional support and distraction to reduce anxiety			
08	Maintained child's position and stillness during procedure (with help of assistant or caregiver)			
09	Monitored vital signs and observed for signs of distress			
10	Handed over sterile items as needed, ensuring sterile technique is maintained			
11	Assisted in labeling and securing CSF specimens properly			
12	Applied sterile dressing after completion of procedure			
13	Repositioned and comforted child, monitoring for post-procedure symptoms (e.g., headache, bradycardia, vomiting)			
14	Encouraged the child to lie flat (if ordered) to prevent post-LP headache			
15	Documented the procedure, time, number of attempts, specimen appearance, child's response, and any complications			

Nursing instructor's signature: _____ Date: _____

(Hockenberry, Wilson and Rodgers, 2022)

Procedure 08: Care of a Child in Peritoneal Dialysis (PD)

Definition:

Peritoneal dialysis is a renal replacement therapy that uses the child's peritoneum as a membrane across which fluids and dissolved substances are exchanged from the blood. This process helps manage kidney failure in children by removing waste,

excess fluids, and electrolytes when the kidneys are no longer functioning properly.

Equipment Needed for Preparation:

- Peritoneal dialysis solution (prescribed type, volume, and temperature)
- PD catheter (Tenckhoff catheter) and securement device
- Sterile gloves, mask, and apron (PPE)
- Dialysis tubing and connecting set (sterile)
- Alcohol/chlorhexidine swabs for catheter site cleansing
- IV pole or stand to hang dialysis bag
- Drainage bag and waste container
- Blood pressure monitor and vital signs equipment
- Weighing scale and fluid balance chart
- Emergency medications (as per protocol)
- Comfort items and distraction aids for the child

Indications for Peritoneal Dialysis in Children:

- Acute or chronic kidney failure
- Fluid overload unresponsive to medical treatment
- Severe electrolyte imbalances (e.g., hyperkalaemia)
- Metabolic acidosis
- Uremic symptoms (e.g., encephalopathy, pericarditis)
- As a bridge to kidney transplant

Checklist for Care of a Child in Peritoneal Dialysis (PD)

S.NO	Tasks	Yes	No	Comments
01	Verified the physician’s order for dialysis type, volume, and dwell time			
02	Identified the child and explained the procedure to the child and caregiver			
03	Performed hand hygiene and wore sterile gloves,			

	mask, and gown			
04	Assembled all required sterile equipment and supplies			
05	Ensured peritoneal dialysis fluid was warmed to body temperature			
06	Assessed and inspected the catheter site for signs of infection			
07	Measured and recorded pre-dialysis weight, abdominal girth, and vital signs			
08	Maintained aseptic technique while connecting and priming the dialysis tubing			
09	Infused dialysis solution as per protocol and ensured correct dwell time			
10	Monitored the child's response (vital signs, signs of discomfort, respiratory status)			
11	Drained fluid into drainage bag, observed for color, clarity, and amount			
12	Disconnected and clamped tubing aseptically, sealed catheter safely			
13	Recorded post-dialysis weight, fluid input/output, and any symptoms			
14	Provided emotional support and reassurance to the child throughout			
15	Educated caregivers on signs of complications (e.g., peritonitis) if home-based dialysis is planned			
16	Documented the entire procedure, findings, and child's tolerance			

Nursing instructor's signature: _____ Date: _____

(Hockenberry, Wilson and Rodgers, 2022)

(Sethi, 2017)

Procedure 09: Foley's Catheter Insertion in Children

Definition:

Foley's catheter insertion is a sterile procedure involving the insertion of a flexible tube (urinary catheter) into a child's bladder through the urethra to drain urine. It can be used for diagnostic, therapeutic, or monitoring purposes.

Equipment Needed for Preparation:

- Sterile Foley catheter (appropriate pediatric size)
- Sterile catheterization tray
- Sterile gloves, mask, and gown
- Antiseptic solution (e.g., povidone-iodine)
- Lubricant (sterile, water-soluble)
- Sterile drapes and gauze
- Catheter securing device (e.g., stat-lock)
- Urine drainage bag with tubing
- Syringe with sterile water (to inflate balloon)
- Adhesive tape or catheter strap
- Disposable underpad
- Waste disposal bag
- Hand hygiene supplies
- Documentation sheet

Indications for Foley's Catheter Insertion in Children:

- Accurate urine output monitoring in critically ill children
- Urinary retention or bladder obstruction
- Preoperative or postoperative urinary drainage
- Collection of sterile urine specimen
- Instillation of medications into the bladder
- Management of neurogenic bladder

Checklist for Foley's Catheter Insertion in Children

S.NO	Tasks	Yes	No	Comments
01	Verified physician’s order and identified the child			
02	Explained the procedure to the child and caregiver in age-appropriate language			
03	Performed hand hygiene and wore PPE			
04	Assembled all sterile supplies and ensured appropriate catheter size			
05	Positioned the child comfortably and maintained privacy			
06	Performed perineal hygiene using antiseptic solution			
07	Applied sterile gloves and maintained aseptic technique			
08	Lubricated catheter tip and gently inserted catheter into urethra			
09	Advanced catheter until urine flow was observed, then inserted further slightly			
10	Inflated balloon with prescribed amount of sterile water (if ordered)			
11	Connected catheter to drainage system and secured catheter to leg or abdomen			
12	Placed drainage bag below bladder level to prevent reflux			
13	Monitored child’s response and checked for discomfort or complications			
14	Disposed of waste properly and performed hand hygiene			
15	Documented date/time, catheter size, amount/type of drainage, child’s response, and any complications			

Nursing instructor’s signature: _____ Date: _____

(Hockenberry, Wilson and Rodgers, 2022)

Procedure 10: Positioning and Restraining Pediatric Clients

Definition:

Positioning and restraining pediatric clients involve safely placing and, if necessary, securing a child's body in a specific posture to ensure safety, comfort, cooperation, and successful completion of medical or nursing procedures. These techniques are used with sensitivity and respect for the child's emotional and physical well-being.

Equipment Needed for Preparation:

- Clean sheets, blankets, or towels for swaddling
- Pediatric restraint devices (e.g., papoose board, arm board)
- Pillows and positioning aids (rolled towels, wedges)
- Safety straps or Velcro fasteners (pediatric-sized)
- Comfort/distraction tools (toys, pacifier, caregiver presence)
- PPE as required for specific procedures
- Documentation tools (forms, charts)

Indications for Positioning and Restraining Pediatric Clients:

- To safely perform medical/nursing procedures (e.g., IV insertion, LP)
- To prevent self-harm or harm to healthcare staff during procedures
- To ensure accurate test results and treatment delivery
- To maintain a therapeutic position (e.g., postural drainage, oxygen therapy)
- To prevent disruption of medical devices (e.g., feeding tubes, catheters)

Checklist for Positioning and Restraining Pediatric Clients

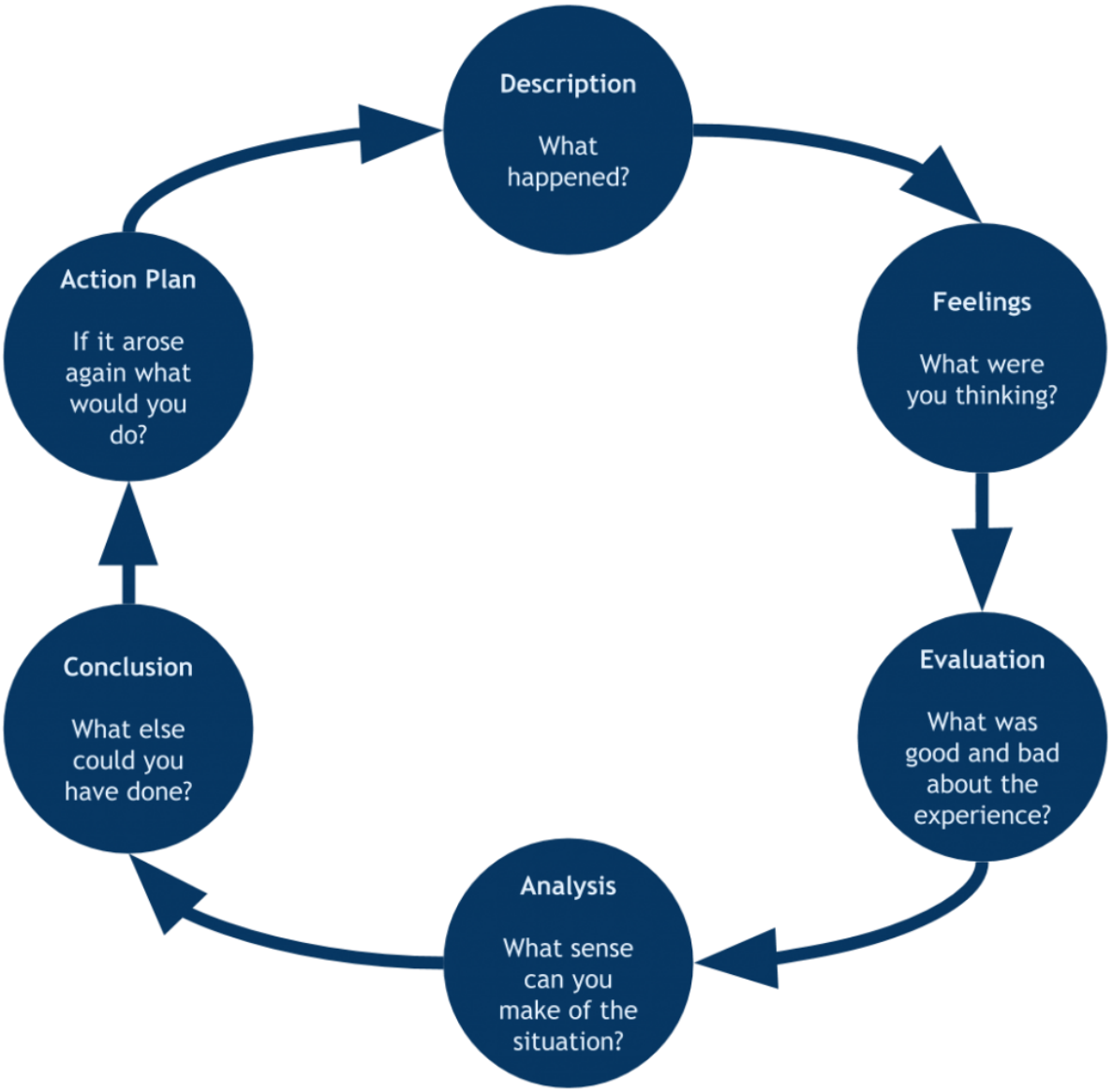
S.NO	Tasks	Yes	No	Comments
01	Verified procedure and assessed the need for positioning or restraint			
02	Identified the child and explained the procedure to caregiver and child in age-appropriate language			
03	Performed hand hygiene and wore appropriate PPE			
04	Chose the least restrictive method appropriate			

	for the child and procedure			
05	Ensured proper equipment was clean, intact, and safe to use			
06	Provided emotional support and comfort to reduce anxiety			
07	Positioned or restrained the child gently, ensuring limb alignment and circulation			
08	Ensured restraint was snug but not too tight—checked for skin integrity and distal pulse			
09	Reassessed child frequently for signs of distress, pain, or circulation issues			
10	Allowed caregiver to stay with the child when possible for reassurance			
11	Released restraints as soon as safe to do so or at regular intervals if prolonged			
12	Provided comfort measures and praised the child after the procedure			
13	Documented the type of positioning/restraint used, reason, duration, and child's response			

Nursing instructor's signature: _____ Date: _____

(Hockenberry, Wilson and Rodgers, 2022)

Reflection/ Critical Incident Analysis



Gibbs' Reflective Cycle 1998

CASE STUDY FORMAT

I. INTRODUCTION

A. Background of the Study

B. Objectives

- **General Objective:** To understand and manage pediatric health concerns using clinical reasoning and evidence-based care.
- **Specific Objectives:**
    - **Knowledge:** Understand the child's health condition and related pediatric concepts.
    - **Skills:** Apply nursing process and pediatric care skills appropriately.
    - **Attitude:** Demonstrate empathy, patience, and child-centered care.

    C. Scope and Delimitation

    D. Theoretical Framework (e.g., Erikson's stages of development, Orem's self-care theory)

II. BIOGRAPHIC DATA

- Name of the Child
- Age
- Gender
- Date of Birth
- Parent/Guardian Name(s)
- Address
- Religion
- Family Composition
- Usual Source of Medical Care
- Health Insurance/Financing Details

III. CHIEF COMPLAINT / REASON FOR VISIT

(As reported by caregiver or observed)

IV. PEDIATRIC NURSING HISTORY

A. History of Present Illness

B. Past Medical History

- Childhood Diseases
- Immunization Status (attach immunization chart if available)
- Allergies
- Accidents/Injuries
- Hospitalizations and Surgeries
- Medications (current and past)

C. Family History of Illness (attach Genogram)

D. Developmental History (include milestones with assessment guide annexed)

E. Birth History (if under 5 years): Prenatal, natal, postnatal events

V. FUNCTIONAL HEALTH PATTERNS (Modified Gordon's for Pediatrics)

1. Health Perception/Health Management (caregiver's view)
2. Nutritional-Metabolic Pattern (feeding practices, growth chart)
3. Elimination Pattern (toileting, bowel/bladder routines)
4. Activity-Play Pattern
5. Sleep-Rest Pattern
6. Cognitive-Perceptual Pattern (age-appropriate responses)
7. Self-Perception (observed behaviors/self-image in older children)
8. Role-Relationship Pattern (family bonding, peer interactions)
9. Sexuality (age-appropriate for adolescents)
10. Coping-Stress Tolerance (reaction to stress, separation)
11. Value-Belief Pattern (family/cultural influences)

VI. REVIEW OF SYSTEMS

(All subjective complaints by body system; reported by caregiver or child)

VII. PHYSICAL ASSESSMENT

- Date Performed:
- General Survey (Appearance, behavior, comfort)
- Vital Signs: TPR, BP, Weight, Height/Length, Head Circumference (for infants)

BODY PART (Technique used)	NORMAL FINDINGS	ACTUAL FINDINGS	INTERPRETATION / ANALYSIS w/ Reference

VIII. ANATOMY & PHYSIOLOGY

(Focused on affected system with diagrams)

IX. DIAGNOSTIC / LABORATORY TESTS

NAME OF TEST / PROCEDURE	DATE DONE	INDICATION FOR THE TEST / PROCEDURE	NORMAL VALUE	ACTUAL RESULT / FINDINGS	SIGNIFICANCE OF THE RESULT / FINDINGS

X. SURGICAL PROCEDURE

(If any – attach operative notes and recovery status)

XI. PATHOPHYSIOLOGY

(Schematic/Mind map form with child-specific manifestations)

XII. DRUG STUDY AND TREATMENTS

Drug Study Table

Drug order (generic, name, dosage, route, frequency)	Trade / Brand name	Pharmacologic action of drug	Indication and contraindications	Adverse effects of the drug	Desired action on your client	Nursing responsibilities / Precautions

Treatment Given

Treatment / Infusion	Classification	Indication	Contraindication	Nursing Responsibilities / Precautions

XIII. COURSE IN THE WARD (Narrative Format)

- Daily Summary
- General Condition of the Child
- 4 D's (Diet, Drugs, Diagnostics, Disposition) with Inference

XIV. PRIORITIZED LIST OF NURSING PROBLEMS

- Prioritized using ABC's and Maslow's Hierarchy of Needs

Date	Nursing Problems Identified	Cues	Justification

XV. NURSING CARE PLAN

Assessment	Nursing Diagnosis	Planning	Implementation	Rationale	Evaluation

XVI. PROPOSED / DISCHARGE PLAN (METHODS)

- **M** – Medications
- **E** – Exercises (if applicable)
- **T** – Treatments/Follow-up Procedures
- **H** – Health Teachings (to caregivers)
- **O** – Outpatient Follow-Up Schedule
- **D** – Diet Instructions
- **S** – Spiritual and Socio-emotional Support

References

- HOCKENBERRY, M.J., WILSON, D. and RODGERS, C., 2022. *Wong's essentials of pediatric nursing*. 11th ed. St. Louis, MO: Elsevier.
- SETHI, N., 2017. *Essential of pediatric nursing*. 4th ed. New Delhi: Jaypee Brothers Medical Publishers.

MENTAL HEALTH NURSING

Table of Content

Course Title: Mental Health Nursing Clinical

Credit Hours: 03 (0+03)

Course Description:

Course Definition:

This course is designed to help students gain the skills and knowledge needed to assess, diagnose, and manage the mental health needs of adults and older adults. By the end of the course, students will be able to conduct thorough clinical interviews, make accurate psychiatric diagnoses using the DSM-V, and create personalized treatment plans. They will learn to monitor patient progress, apply critical thinking and clinical judgment, use current research in their practice, and provide care that respects each individual's cultural and social background.

Clinical Rotation plan:

This semester, which spans 16/22 weeks, is divided into two equal parts. During the first half, student nurses will observe and practice clinical techniques in the skills laboratory. In the second half, they will undertake block-style clinical rotations and perform these procedures under the direct supervision of a clinical instructor.

CLINICAL OBJECTIVES

At the end of the course, students will be able to:

9. Perform clinical interviews and complete biopsychosocial assessments with adults and older adults.
10. Make appropriate DSM-V diagnoses.
11. Develop treatment plans, recommendations and referrals that are appropriate and congruent with the individual's age, socioeconomic and cultural background.
12. Efficiently perform on-going assessments on patients' progress.
13. Demonstrate an advanced knowledge base of psychiatric assessment and diagnosis of mental health illnesses.
14. Relate critical thinking, clinical judgment, and diagnostic reasoning principles to solve hypothetical mental health illnesses.
15. Incorporate relevant research findings in management of selected mental health needs of adults and older adults.
16. Provide culturally competent care to meet the psychiatric/mental health needs of adults and older adults having different mental

health issues

Evaluation Criteria:

Clinical Objectives	***10%***
History Taking Performa (Weekly)	***15%***
Physical Examination Checklists	***15%***
Nursing Care Plan (Weekly)	***10%***
Nursing Skills Checklists (Weekly)	***20%***
Reflection/ Critical Incident Analysis (Weekly)	***10%***
Case Study (One Per Semester)	***20%***

Clinical Objectives Form

Student Name: _____ Faculty: _____ Date: _____

Clinical placement_____ Bed #_____ Medical Diagnosis: _____

Clinical Objectives	**Strategies**	**Evaluation**

History Taking Proforma

Student Name: _____Group #: _____Faculty: _____

1. Presenting Problem / Chief Complaint

(Patient's own words or caregiver's statement; include duration, onset, and impact on functioning)

2. History of Present Illness (HPI)

- Course of illness (onset, progression, triggering factors)

_____

_____

_____

- Aggravating and relieving factors

_____

_____

_____

- Impact on personal, social, occupational life

_____

_____

_____

- Previous similar episodes and treatment

_____

_____

_____

3. past Psychiatric History

- Previous diagnoses

- Hospitalizations (where, when, why)

- Medications used and response

- Past therapy or counselling experiences

4. Medical History

- Chronic illnesses (e.g., hypertension, diabetes, epilepsy)

- Current medications

- Allergies

- History of head injury or neurological disorders

5. Substance Use History

- Alcohol, tobacco, drugs (type, frequency, amount)
- Duration of use
- Impact on mental and physical health

6. Family Psychiatric History

- Mental illnesses in family members
- Substance use disorders
- Suicide attempts or completions

7. Developmental and Social History

- Birth and early childhood

- School performance and behaviour

- Peer relationships

- Major life events (trauma, loss, abuse)

- Social support and family relationships

8. Personal and Occupational History

- Educational background

- Occupation and work history

- Financial situation

- Marital and relationship status

- Hobbies, interests

9. Mental Status Examination (MSE)

- General Appearance and Behaviour

- Speech (rate, volume, coherence)

- Mood and Affect

- Thought Process and Content

- Perception (hallucinations, illusions)

- Cognition (orientation, memory, attention)

- Insight and Judgment

- Suicidal or homicidal ideation

10. Risk Assessment

- Suicide risk

- Risk of harm to others

- History of violence or aggression

- Self-harm behaviour

_____

_____

_____

11. Cultural and Spiritual Considerations

- Beliefs about mental illness

_____

_____

_____

- Use of alternative/complementary therapy

_____

_____

_____

- Role of spirituality/religion in healing

_____

_____

_____

Checklist for taking a client health history

Interviewing Skills Checklist	**Satisfactory *S***	**Need to improve *N***
Introduced self and explained purpose clearly		
Ensured privacy and comfort		
Maintained a non-judgmental and empathetic approach		
Asked open-ended questions effectively		
Allowed client to speak freely and listened actively		
Explored all major domains (biopsychosocial,		

developmental)

Used culturally appropriate communication

Ensured emotional safety and support during difficult topics

Accurately documented responses and observations

Identified any immediate safety concerns (suicide/harm)

Faculty comments:

_____

_____

_____

_____

Nursing Care Plan

Assessment	N. Diagnosis	Goal	Planning	Rationale	Implementation	Evaluation
Subjective Data Objective Data						

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S No	Practical	Level of competency	Minimum Frequency
1	**History Taking (Process Recording)**	1-5	10
2	**Mental Status Examination (Cognitive & Affective)**	1-5	5
3	**Counselling Skills (Scenario Based)**	1-5	5
4	**Aggression Management**	1-5	5
5	**Withdrawal Symptoms management**	1-5	5
6	**Suicidal Ideation Assessment**	1-5	5
7	**Nursing care of a patient undergoing EEG**	1-5	10
8	**Guided Imagery**	1-5	5
9	**Group Therapy**	1-5	5
10	**Cognitive Behavioral Therapy**	1-5	5
11	**Managing patient with drug abuse**	1-5	10

No	Practical	Clinical Experience					
		Skill Lab Lecturer Signature	Date	Ward/Clinics Signature	Date	Supervisor Signature	Date
01	History Taking (Process Recording)						
02	Mental Status Examination (Cognitive & Affective)						
03	Counselling Skills (Scenario Based)						
04	Suicidal Ideation Assessment						
05	Nursing care of a patient undergoing EEG						
06	Guided Imagery						
07	Group Therapy						
08	Cognitive Behavioral Therapy						
09	Managing patient with drug abuse						

Nursing Skills Checklists

Practical 1: History Taking (Process Recording)

Definition:

History Taking in mental health nursing, also known as Process Recording, is a detailed written account of a nurse's interaction with a client during a therapeutic conversation. It includes verbal and non-verbal communication, thoughts, emotions, and responses from both the client and the nurse. This method helps in analyzing communication patterns, building rapport, and identifying psychological concerns for diagnosis and treatment planning.

Equipment Needed:

1. Pen and notebook or laptop for note-taking
2. Structured mental health history proforma (printed or digital)
3. Mental Status Examination (MSE) format
4. Risk assessment tools (e.g., suicide risk assessment scale)
5. DSM-5 Manual (for reference, if needed)
6. Private, quiet room for the interview
7. Consent form (for ethical and legal purposes)

Indications for History Taking (Process Recording):

1. Initial psychiatric assessment of a new patient.
2. Therapeutic communication training for nursing students.
3. Ongoing monitoring of a patient's mental and emotional state.
4. Documentation of interaction for supervision or academic evaluation.
5. Identifying themes and patterns in behavior and thought processes.
6. Evaluating effectiveness of nursing interventions and patient progress.
7. Developing and refining communication and therapeutic relationship skills.

Checklist for History Taking (Process Recording)

Sr. #	Tasks	Yes	No	Comments
01	Obtained informed consent from the client			
02	Ensured privacy and created a safe, non-threatening environment			
03	Introduced self and explained purpose of the interaction			
04	Used active listening techniques (nodding, eye contact, empathy)			
05	Asked open-ended questions to initiate conversation			
06	Maintained a non-judgmental and accepting attitude			
07	Documented both verbal and non-verbal cues accurately			
08	Identified the client's emotional tone and thought content			
09	Recognized any signs of distress, risk, or harm			
10	Summarized the session appropriately			
11	Reflected on nurse's own feelings and reactions during interaction			
12	Ensured ethical standards (confidentiality, respect) were maintained			

Nursing instructor's signature: _____ Date: _____

(Videbeck, 2022)

Practical 02: Mental Status Examination (Cognitive & Affective Domain)

Definition:

The Mental Status Examination (MSE) is a structured assessment of a patient's cognitive functions (like attention, memory, orientation) and affective state (like mood and emotional expression). It is used to evaluate the mental functioning of a patient and is an essential part of psychiatric assessment. The Cognitive domain assesses thinking abilities, while the Affective domain assesses emotional expression and mood.

Equipment Needed:

1. MSE format/template
2. Pen and notebook or digital device for documentation
3. Clock or watch (for orientation to time)
4. Reading material or objects (for language and abstraction tasks)
5. Quiet, private environment for interaction
6. Consent form (if required for academic or training purpose)

Indications for MSE:

1. Initial psychiatric evaluation of a patient
2. Monitoring of a patient with mental illness
3. Assessment of cognitive decline, such as in dementia
4. Identifying emotional instability, mood disorders, or psychosis
5. Risk assessment (e.g., suicidal or homicidal ideation)
6. Planning treatment and interventions
7. Evaluating progress or response to psychiatric treatment

Checklist for Mental Status Examination (Cognitive & Affective Domain)

Sr. #	Tasks	Yes	No	Comments
01	General Appearance and Behavior			
	• Grooming and hygiene			
	• Posture, eye contact, facial expressions			
	• Level of cooperation, rapport			
02	Speech			
	• Rate, volume, fluency, coherence			
03	Mood (subjective feeling)			
	• Ask patient: “How are you feeling today?”			
04	Affect (objective expression)			
	• Congruence with mood, range, appropriateness			
05	Thought Process			
	• Coherence, logic, goal-directedness			
06	Thought Content			
	• Delusions, obsessions, phobias			
	• Suicidal or homicidal ideation			
07	Perception			
	• Hallucinations or illusions			
08	Cognitive Functions			
	• Orientation (to time, place, person)			
	• Attention and concentration (digit span, serial 7s)			
	• Memory (immediate, recent, remote)			

	• Intelligence and abstraction (proverbs, similarities)			
09	Insight			
	• Awareness of illness and need for treatment			
10	Judgment			
	• Real-life scenarios (e.g., finding a lost wallet)			

Nursing instructor's signature: _____ Date: _____

(Videbeck, 2022)

Practical 03: Counselling Skills (Scenario-Based)

Definition:

Counselling skills refer to a set of communication and interpersonal techniques used by mental health professionals to help clients explore concerns, develop insight, and make decisions. In scenario-based counselling, learners engage in role-play or simulated real-life situations to practice therapeutic communication and build confidence in applying core counselling techniques in a safe and controlled environment.

Equipment Needed:

1. Scenario scripts or role-play prompts
2. Quiet and private counselling space
3. Notepad and pen for observation/reflection
4. Audio/video recording equipment (optional, for feedback)
5. Counselling skills checklist/rubric
6. Consent forms (if sessions are recorded or for academic use)

Indications for Scenario-Based Counselling Practice:

1. To train students in basic and advanced counselling techniques
2. To simulate real-world situations (e.g., grief, anxiety, abuse, crisis)
3. For assessment of student skills in therapeutic communication
4. To enhance self-awareness, empathy, and listening ability
5. To provide a safe environment to make and learn from mistakes
6. For interdisciplinary practice involving nursing, social work, or psychology

Checklist for Counselling Skills (Scenario-Based)

Sr. #	Tasks	Yes	No	Comments
01	**Introduction & Setting**			
	• Introduced self and established purpose of session			
	• Maintained privacy and confidentiality			
02	**Rapport Building**			
	• Used warm tone, open posture, friendly facial expressions			
	• Created a trusting environment			
03	**Active Listening**			
	• Used minimal encouragers (e.g., “I see,” “Go on”)			
	• Maintained eye contact, nodded appropriately			
04	**Empathy and Validation**			
	• Reflected feelings accurately			
	• Normalized or validated emotional responses			
05	**Questioning Techniques**			
	• Used open-ended and non-leading questions			
	• Avoided judgmental or confrontational language			
06	**Paraphrasing and Summarizing**			
	• Summarized key points at appropriate intervals			
	• Checked for understanding			

07	**Handling Emotions/Crisis**			
	• Responded appropriately to distress or emotional outbursts			
	• Offered grounding or calming strategies if needed			
08	**Goal Setting/Problem Solving**			
	• Helped the client identify goals or next steps			
	• Encouraged client participation in solution planning			
09	**Closure**			
	• Gave time for final reflections			
	• Ended session with support and a summary			
10	**Self-Reflection (by student)**			
	• Reflected on strengths and areas for improvement			

Nursing instructor's signature: _____ Date: _____

(Videbeck, 2022)

Practical 04: Aggression Management

Definition:

Aggression management refers to the structured approach used by healthcare professionals to identify, de-escalate, and manage aggressive or potentially violent behavior in patients. It involves verbal and non-verbal techniques, environmental control, and sometimes physical interventions, aiming to ensure safety while preserving patient dignity.

Equipment Needed:

1. Calm and safe environment (remove sharp objects, secure exits)
2. De-escalation tools (verbal scripts, visual cues)

3. Personal protective equipment (PPE) (gloves, face shield if needed)
4. Emergency call system or alarm
5. Documentation tools (incident report forms, observation sheets)
6. Restraint equipment (if absolutely necessary and as per protocol)
7. Support staff trained in non-violent crisis intervention

Indications for Aggression Management:

1. Patient displays threatening verbal or physical behavior
2. Sudden changes in mood or psychosis that may lead to violence
3. History of aggression or impulsivity
4. Patient under substance influence or withdrawal
5. To protect the patient, others, and staff from harm
6. Prevent escalation of minor aggression into violent outbursts
7. During involuntary admission or restraint application

Checklist for Aggression Management

Sr. #	Tasks	Yes	No	Comments
01	**Early Identification**			
	• Observes signs of escalating agitation (restlessness, pacing, clenched fists)			
	• Assesses verbal threats or aggressive tone			
02	**De-escalation Techniques**			
	• Maintains calm tone and body language			
	• Uses non-threatening stance and safe distance			
	• Avoids arguing or challenging the patient			
	• Sets clear, firm, and respectful limits			
	• Offers choices to promote patient control			
03	**Communication Skills**			
	• Uses therapeutic verbal interventions			
	• Engages with empathy, reassurance, and listening			

04	**Team Coordination**			
	• Alerts team and uses backup appropriately			
	• Follows institutional aggression protocol			
05	**Use of Physical Interventions (if needed)**			
	• Applies only as last resort and per policy			
	• Uses least restrictive measures			
	• Monitors patient safety throughout			
06	**Post-Incident Procedures**			
	• Documents the event and intervention clearly			
	• Provides emotional support to patient and staff			
	• Conducts debriefing and risk review			

Nursing instructor's signature: _____ Date: _____

(Videbeck, 2022)

Practical No 5: Withdrawal Symptoms Management

Definition:

Withdrawal Symptoms Management refers to the assessment and therapeutic care of individuals who are experiencing physiological and psychological symptoms after reducing or stopping the use of addictive substances (e.g., alcohol, opioids, benzodiazepines, nicotine). The goal is to relieve discomfort, prevent complications, and support recovery.

Equipment Needed:

1. Vital sign monitoring equipment (BP cuff, thermometer, pulse oximeter)
2. Emergency drugs (e.g., benzodiazepines for alcohol withdrawal, clonidine, naloxone)
3. Intravenous (IV) supplies for hydration and medication
4. Oxygen setup (if needed for respiratory support)
5. Calm, low-stimulation environment
6. Assessment tools (e.g., CIWA-Ar for alcohol, COWS for opioid withdrawal)

7. Documentation forms and care plans
8. Psychological support materials (education leaflets, calming techniques)

Indications for Withdrawal Management:

1. History of substance use with recent cessation or dose reduction
2. Signs of autonomic instability (sweating, tremors, palpitations)
3. Neuropsychiatric symptoms (irritability, agitation, hallucinations)
4. To prevent complications such as seizures or delirium tremens
5. To provide safe, supportive care during detoxification
6. For inpatient or supervised outpatient detox programs

Checklist for Withdrawal Symptoms Management

Sr. #	Tasks	Yes	No	Comments
	Initial Assessment			
1	• Assessed patient's history of substance use (type, amount, duration)			
2	• Performed mental status and risk assessment			
3	• Used appropriate withdrawal assessment tools (CIWA, COWS)			
	Symptom Monitoring			
4	• Regularly monitored vital signs			
5	• Documented changes in mental and physical status			
6	• Assessed for hallucinations, seizures, or autonomic symptoms			
	Pharmacological Management			

7	• Administered prescribed medications appropriately			
8	• Monitored effects and side effects of medications			
9	• Adjusted dosage as per protocol/tool scoring			
	Supportive Care			
10	• Maintained fluid and electrolyte balance			
11	• Provided nutritional support			
12	• Maintained a quiet, non-stimulating environment			
	Psychosocial Support			
13	• Offered reassurance and emotional support			
14	• Involved family or support person (if applicable)			
15	• Provided education on withdrawal and recovery process			
	Emergency Preparedness			
16	• Recognized and responded to complications (e.g., seizures, DTs)			
17	• Used emergency protocols when needed			
	Documentation & Reporting			
18	• Accurately documented assessments and interventions			
19	• Reported significant changes to healthcare team			

Nursing instructor's signature: _____ Date: _____

(Videbeck, 2022)

Practical 06: Suicidal Ideation Assessment

Definition:

Suicidal ideation assessment is the process of evaluating an individual's thoughts, intentions, and risk of suicide through therapeutic communication, standardized tools, and clinical observation. It helps in identifying the severity of the risk and developing an appropriate safety and care plan to prevent self-harm or suicide.

Equipment Needed:

1. Private and calm interview space
2. Suicide risk assessment tools (e.g., Columbia-Suicide Severity Rating Scale [C-SSRS], SAD PERSONS scale)
3. Vital signs monitor (for physical symptoms related to distress or overdose)
4. Observation chart (for 24-hour monitoring)
5. Emergency contact list and hotline numbers
6. Documentation materials
7. Crisis intervention protocols and referral forms
8. Supportive materials (e.g., calming kits, stress-relief objects)

Indications for Suicidal Ideation Assessment:

1. Expression of hopelessness, worthlessness, or desire to die
2. History of suicide attempts or self-harm
3. Diagnosis of depression, bipolar disorder, PTSD, schizophrenia, or substance use disorder
4. Recent major life stressors (loss, trauma, abuse, academic failure)
5. Behavioral warning signs (isolation, giving away belongings, withdrawal)
6. Family history of suicide or psychiatric illness
7. Requests for help, statements like "I can't go on" or "They'll be better off without me"

Checklist for Suicidal Ideation Assessment

Sr. #	Tasks	Yes	No	Comments
	Therapeutic Approach			
1	• Establishes rapport with a calm and non-judgmental tone			
2	• Ensures privacy and confidentiality			
3	• Uses open-ended and direct questions appropriately			
	Risk Identification			
4	• Asks about presence, frequency, and duration of suicidal thoughts			
5	• Inquires about specific plan, method, and access to means			
6	• Assesses for previous suicide attempts or self-harm			
7	• Identifies presence of protective factors (support system, reasons for living)			
	Use of Standardized Tools			
8	• Administers a suicide risk tool (e.g., C-SSRS, SAD PERSONS)			
9	• Interprets tool score to guide clinical judgment			
	Behavioral & Emotional Assessment			
10	• Observes for signs of agitation, withdrawal, emotional blunting			
11	• Assesses mood, affect, and cognitive patterns			
	Immediate Risk Response			
12	• Communicates findings to the mental health team immediately			

13	• Initiates suicide precautions if high risk (one-on-one observation, no-harm contract)			
14	• Ensures environment is free from means of self-harm			
	Post-Assessment Care			
15	• Documents findings thoroughly and accurately			
16	• Engages family/support network (with consent)			
17	• Refers to psychiatrist or emergency services if necessary			
18	• Provides emotional support and follow-up planning			

Nursing instructor's signature: _____ Date: _____

(Videbeck, 2022)

Practical 07: Nursing Care of a Patient Undergoing EEG (Electroencephalography)

Definition:

Electroencephalography (EEG) is a diagnostic procedure that records the electrical activity of the brain using electrodes placed on the scalp. It helps detect abnormalities such as seizures, brain disorders, or altered consciousness levels. Nursing care includes preparation, monitoring, and post-procedure support to ensure patient safety and comfort.

Equipment Needed:

1. EEG machine with electrodes and conductive gel/paste
2. Skin preparation materials (cotton swabs, alcohol wipes)
3. Clean linens and pillow for positioning
4. Suction apparatus (if patient has seizure risk)
5. Emergency cart (if needed)
6. Patient identification and consent forms
7. EEG procedure instruction sheet for patient/guardian
8. Documentation sheet or electronic medical record (EMR) access

Indications for EEG:

1. Diagnosis of epilepsy and seizure disorders
2. Evaluation of unexplained altered mental status
3. Assessment of sleep disorders
4. Investigation of brain tumors, stroke, or encephalopathies
5. Monitoring brain activity in coma or brain death confirmation
6. Pre- and post-neurosurgery evaluations

Checklist for Nursing Care of EEG Procedure

Sr. #	Tasks	Yes	No	Comments
	Pre-Procedure Care			
01	Verified doctor's order and obtained informed consent			
02	Explained procedure to patient/guardian in age-appropriate terms			
03	Ensured hair was clean, dry, and free of oils or hair products			
04	Withheld CNS-affecting medications as ordered (e.g., anticonvulsants, sedatives)			
05	Ensured patient had adequate rest prior to sleep EEG (if required)			
	During Procedure			
06	Positioned patient comfortably in a quiet, relaxed environment			
07	Provided reassurance and remained present for anxious or pediatric patients			
08	Monitored for any seizure activity or patient distress			
09	Assisted EEG technician as needed			
	Post-Procedure Care			
10	Removed paste/gel from scalp and cleaned patient's head			
11	Provided comfort and assisted with repositioning			
12	Observed and documented any post-procedure adverse effects			
13	Re-administered medications if withheld prior to EEG (as per order)			
14	Provided follow-up instructions and report to physician			

Nursing instructor's signature: _____ Date: _____

(Videbeck, 2022)

Practical 08: Guided Imagery

Definition:

Guided Imagery is a therapeutic technique that uses visualization and sensory imagination to promote relaxation, reduce stress, and enhance physical and emotional well-being. The nurse or therapist leads the patient through calming mental images, encouraging the mind-body connection to support healing and emotional regulation.

Equipment Needed:

1. Quiet, comfortable space (therapy room or private setting)
2. Comfortable chair or bed
3. Soft lighting or dimmer
4. Relaxing background music (optional)
5. Audio recordings or scripts for guided visualization
6. Blanket or pillow for patient comfort (optional)
7. Essential oils or aromatherapy (optional and only if not contraindicated)
8. Documentation materials for recording the patient's response

Indications for Guided Imagery:

1. Anxiety, stress, or emotional distress
2. Pain management (acute or chronic)
3. Sleep disturbances or insomnia
4. Nausea and treatment-related discomfort (e.g., chemotherapy)
5. Pre-procedure relaxation or surgical preparation
6. Support for coping with chronic illness or trauma
7. Enhancement of healing and immune function

8.

Checklist for Nursing Implementation of Guided Imagery

Sr. #	Tasks	Yes	No	Comments
	Preparation Phase			
01	Explained guided imagery and obtained consent			
02	Chose or created an appropriate imagery script based on the patient's preferences/needs			
03	Ensured the environment was quiet, comfortable, and free from distractions			
04	Positioned the patient comfortably and encouraged relaxed breathing			
	Implementation Phase			
05	Used a calm, soothing voice or played a pre-recorded script			
06	Guided the patient through sensory-rich visualization (e.g., beach, garden, forest)			
07	Monitored for signs of emotional discomfort or distress			
08	Paused or stopped if the patient appeared overwhelmed			
	Post-Session Phase			
09	Provided time for the patient to reorient gradually			
10	Encouraged sharing of the experience if the patient wished to discuss			
11	Documented the patient's response and any observed outcomes			
12	Provided resources for independent practice if appropriate			

Nursing instructor's signature: _____ Date: _____

(Videbeck, 2022)

Practical 09: Group Therapy

Definition:

Group Therapy is a form of psychotherapy where a trained facilitator (nurse, counselor, or therapist) leads a small group of individuals who share similar concerns or conditions. The group setting promotes self-expression, emotional support, skill-building, and problem-solving through shared experiences and guided interaction.

Equipment Needed:

1. Quiet and private room with enough seating for all participants (arranged in a circle)
2. Attendance sheet and consent forms
3. Whiteboard/flipchart and markers (for visual aids or group activities)
4. Clock or timer (to manage session time)
5. Session agenda or therapy plan (tailored to group needs)
6. Printed handouts or worksheets (if applicable)
7. Relaxing music or mindfulness tools (optional)
8. Emergency contact info and access to crisis intervention support (as needed)

Indications for Group Therapy:

1. Anxiety disorders or depression
2. Substance use disorders
3. Grief and loss support
4. Stress management and coping skill enhancement
5. Chronic illness adjustment or life transitions
6. Behavioural issues (especially in children or adolescents)
7. Social skill development for individuals with interpersonal difficulties

Checklist for Nursing Facilitation of Group Therapy

Sr. No	Tasks	Yes	No	Comments
	Pre-Session Preparation			
01	Reviewed group therapy goals and session plan			
02	Prepared physical environment (seating, materials, privacy)			
03	Ensured informed consent and confidentiality agreements were signed			
04	Assessed readiness of each participant (emotional state, willingness to participate)			
	During Session			
05	Welcomed group and reviewed purpose, rules, and confidentiality			
06	Facilitated introductions and group bonding (especially in early sessions)			
07	Guided discussion using open-ended questions and active listening			
08	Managed time and ensured all participants had opportunity to speak			
09	Addressed conflict or distress constructively and sensitively			
10	Monitored group dynamics and provided emotional support as needed			
	Post-Session Tasks			
11	Summarized key points and ensured closure of discussion			
12	Encouraged feedback and reflections from participants			
13	Documented session summary and individual participant progress (if applicable)			
14	Referred participants to further support if distress was observed			

Nursing instructor's signature: _____ Date: _____

(Videbeck, 2022)

Practical 10: Cognitive Behavioral Therapy (CBT)

Definition:

Cognitive Behavioral Therapy (CBT) is a structured, time-limited, and goal-oriented form of psychotherapy that helps individuals recognize and modify negative thought patterns, beliefs, and behaviors. It is based on the concept that thoughts, feelings, and behaviors are interconnected, and by changing negative thoughts and behaviors, emotional wellbeing can improve.

Equipment Needed:

1. Private, quiet therapy room
2. CBT worksheets and thought record templates
3. Pens/pencils or digital devices for journaling
4. CBT manuals or guides (if student-led or structured by protocol)
5. Whiteboard/flipchart for visual explanations
6. Patient file or progress tracking tools
7. Clock or timer to manage session length
8. Optional: Relaxation tools (deep breathing scripts, stress balls)

Indications for CBT:

1. Depression and mood disorders
2. Anxiety disorders (e.g., GAD, panic disorder, phobias)
3. Obsessive-compulsive disorder (OCD)
4. Post-traumatic stress disorder (PTSD)
5. Substance use disorders
6. Eating disorders
7. Anger management and self-esteem issues
8. Behavioral problems in children and adolescents

Checklist for Nursing Facilitation of CBT

Sr. #	Tasks	Yes	No	Comments
	Preparation Phase			
01	Assessed client's suitability for CBT (cognitive ability, readiness)			
02	Obtained informed consent and explained CBT process clearly			
03	Developed therapy plan based on the client's presenting problems			
04	Prepared environment and CBT tools (e.g., worksheets)			
	Session Implementation			
05	Established a collaborative, supportive relationship			
06	Identified and challenged irrational or distorted thoughts			
07	Guided client in identifying connections between thoughts, feelings, and behaviors			
08	Used CBT techniques (e.g., cognitive restructuring, behavioral experiments, exposure)			
09	Encouraged practice through homework assignments			
10	Used Socratic questioning to promote insight			
	Post-Session Tasks			
11	Reviewed client progress and adjusted goals as needed			
12	Provided feedback and encouragement			
13	Documented key issues, techniques used, and client response			
14	Planned next session with clear objectives			

Nursing instructor's signature: _____ Date:

_____

(Videbeck, 2022)

Practical 11: Managing a Patient with Drug Abuse

Definition:

Managing a Patient with Drug Abuse involves providing comprehensive care to individuals suffering from substance use disorders. This includes assessment, stabilization, detoxification, therapeutic interventions, and aftercare planning. The goal is to reduce or eliminate the use of harmful substances, prevent relapse, and improve overall health and wellbeing.

Equipment Needed:

1. Assessment tools (e.g., Addiction Severity Index, AUDIT, DAST)
2. Patient chart/medical record for tracking history and progress
3. Vitals monitoring equipment (e.g., blood pressure cuff, thermometer, pulse oximeter)
4. IV fluids and medications (for detoxification or withdrawal management)
5. Behavioral therapy materials (worksheets, self-help books, relaxation guides)
6. Supportive care resources (comfort items, stress-relief tools)
7. Confidentiality agreements and patient consent forms
8. Crisis intervention plans (for suicidal ideation or severe withdrawal symptoms)
9. Emergency medical kit (for complications related to withdrawal or overdose)

Indications for Managing Drug Abuse:

1. Acute or chronic substance use disorder (alcohol, opioids, cocaine, etc.)
2. Withdrawal symptoms (from alcohol, benzodiazepines, opioids)
3. Relapse prevention in individuals with a history of substance abuse
4. Co-occurring mental health conditions (e.g., depression, anxiety)

5. Medical complications related to drug use (e.g., liver disease, infections, overdose)
6. Detoxification and stabilization for inpatient or outpatient care
7. Need for therapeutic support to promote recovery and address triggers for abuse

Checklist for Nursing Management of a Patient with Drug Abuse

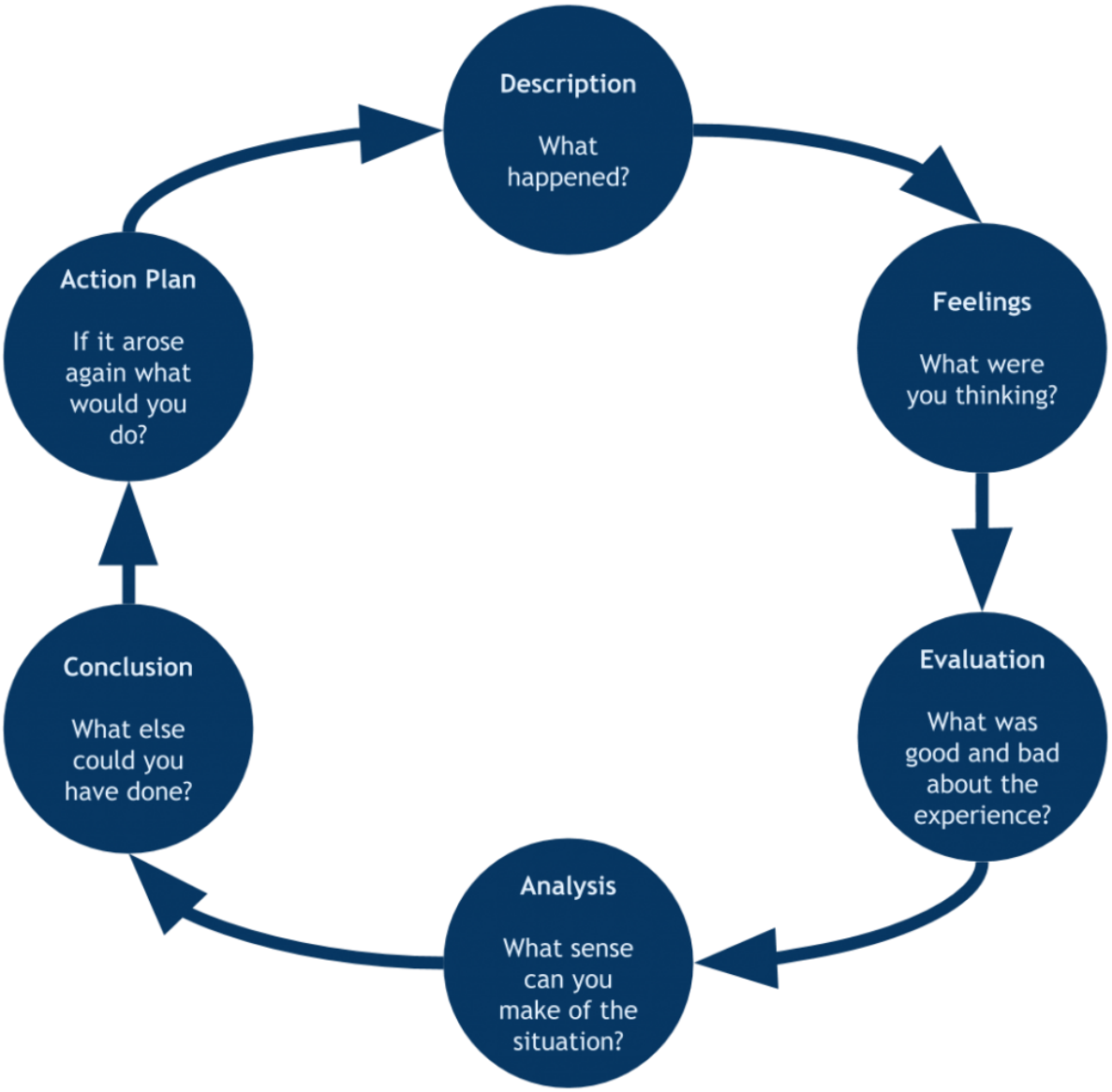
Sr. #	Tasks	Yes	No	Comments
	Initial Assessment and Stabilization			
01	Conducted thorough patient history (substance use, health status)			
02	Assessed for signs of intoxication or withdrawal			
03	Monitored vital signs (blood pressure, heart rate, respiratory rate)			
04	Administered medications for withdrawal symptoms or sedation (as ordered)			
05	Provided emotional support and reassurance			
	Treatment and Therapy Phase			
06	Developed an individualized care plan (detoxification, rehabilitation)			
07	Initiated behavioral therapy (e.g., Cognitive Behavioral Therapy, 12-Step programs)			
08	Encouraged participation in group therapy or support groups			
09	Provided education on substance use disorder and relapse prevention			
10	Ongoing Monitoring and Support			
11	Monitored for any adverse effects of withdrawal or medication			
12	Encouraged healthy coping strategies (stress management, exercise, etc.)			

13	Worked with interdisciplinary team (psychologist, addiction specialist, social worker)			
14	Reinforced goals of recovery and maintaining abstinence			
	Discharge Planning and Aftercare			
15	Provided resources for outpatient therapy and support (e.g., AA, NA)			
16	Set follow-up appointments with addiction specialists or counsellors			
17	Involved family or support system in recovery process (if applicable)			
18	Educated patient on the importance of ongoing care and relapse prevention			

Nursing instructor's signature: _____ Date: _____

(Videbeck, 2022)

Reflection/ Critical Incident Analysis



Gibbs' Reflective Cycle 1998

Psychiatric Mental Health Case Study Format

I. INTRODUCTION

A. Background of the Study

- Brief overview of psychiatric mental health issues
- Importance of early identification and nursing management

B. Objectives

General Objective:

- To apply nursing knowledge, skills, and attitudes in providing holistic care to a patient with psychiatric mental health concerns.

Specific Objectives:

- To assess and analyze the patient's mental, emotional, and physical condition using psychiatric nursing tools.
- To apply therapeutic communication and build rapport.
- To create and implement a care plan based on priority needs.
- To evaluate the effectiveness of nursing interventions provided.

C. Scope and Delimitation

- Focus on one psychiatric patient during the period of clinical exposure.
- Case study will be limited to the patient's present illness and associated psychiatric nursing care.

D. Theoretical Framework

- Choose relevant theories such as **Peplau's Interpersonal Theory**, **Orem's Self-Care Deficit Theory**, or **Cognitive Behavioral Theory** based on the patient's diagnosis.

II. BIOGRAPHIC DATA

- Name:
- Address:
- Age:
- Gender:
- Race:
- Marital Status:
- Occupation:
- Religious Orientation:
- Health Care Financing:
- Usual Source of Medical Care:

III. CHIEF COMPLAINT / REASON FOR VISIT

(As stated by the patient or noted upon admission)

IV. NURSING HISTORY

A. History of Present Illness

- Detailed history of psychiatric symptoms (onset, duration, triggers)

B. Past Medical History

- a) Childhood diseases
- b) Immunizations
- c) Allergies
- d) Accidents and injuries
- e) Hospitalizations (especially psychiatric)
- f) Medications (including psychotropic drugs)

C. Family History of Illness (Use Genogram if applicable)

D. Obstetric History *(for female clients if relevant)*

E. Developmental History *(only if patient is a child or adolescent)*

V. FUNCTIONAL HEALTH PATTERNS

(Include mental status data, psychosocial aspects)

1. Health Perception & Management
2. Nutrition & Metabolism
3. Elimination
4. Activity & Exercise *(Barthel Index, if applicable)*
5. Sleep & Rest
6. Cognitive & Perceptual *(include memory, attention, insight)*
7. Self-perception & Concept *(self-esteem, body image)*
8. Role & Relationships *(family, peers)*
9. Sexuality & Reproductive
10. Coping & Stress Tolerance *(include defense mechanisms, coping strategies)*
11. Value & Belief System

Interpretation:

- Summary of mental status exam & patient's coping abilities

Analysis:

- Connect findings to theoretical framework and DSM-5 diagnosis

VI. REVIEW OF SYSTEMS (Subjective Complaints)

- Include psychological and somatic symptoms

VII. PHYSICAL ASSESSMENT

(Date performed; note mental status, behavior, hygiene, appearance)

1. General Survey
2. Vital Signs

BODY PART (Technique)	NORMAL FINDINGS	ACTUAL FINDINGS	INTERPRETATION/ANALYSIS

VIII. ANATOMY & PHYSIOLOGY

- Focus on brain structures, neurotransmitters, and functions relevant to the diagnosis.

IX. DIAGNOSTIC / LABORATORY STUDIES

TEST/PROCEDURE	DATE	INDICATION	NORMAL VALUE	RESULT	SIGNIFICANCE

X. SURGICAL PROCEDURE

(Usually N/A unless relevant to neurological comorbidity)

XI. PATHOPHYSIOLOGY

- Present in schematic or mind map form
- Link brain chemistry, stressors, symptoms, and behaviors

XII. DRUG STUDY / TREATMENTS GIVEN

Drug Study Table

DRUG ORDER	TRADE NAME	ACTION	INDICATIONS	ADVERSE EFFECTS	DESIRED EFFECT	NURSING RESPONSIBILITIES

Treatments Given

Treatment	Classification	Indication	Contraindication	Nursing Responsibilities

XIII. COURSE IN THE WARD

- Daily summary from admission to present
- Interdisciplinary approach: psychotherapy, medications, nursing care

Patient Status:

- LOC, Vital signs, mood, behavior, compliance, safety

4 D's

- Diet
- Drugs/IVF
- Diagnostics
- Disposition (e.g., Home, Referred, Under Observation)

XIV. PRIORITIZED LIST OF NURSING PROBLEMS

Date	Nursing Problems Identified	Cues	Justification

XV. NURSING CARE PLAN

Assessment	Nursing Diagnosis	Planning	Implementation	Rationale	Evaluation

XVI. PROPOSED / DISCHARGE PLAN

(For patients ready for discharge)

M - Medications
E - Exercises (including relaxation techniques)
T - Treatment (e.g., therapy schedules)
H - Health Teachings (e.g., stress management, compliance)
O - Outpatient Follow-up (e.g., psychiatric consult, group therapy)
D - Diet
S - Spiritual/Sexual Health *(optional*

References

- **Videbeck, S.L., 2022.** *Psychiatric mental health nursing*. 9th ed. Philadelphia: Lippincott Williams & Wilki

LEADERSHIP AND MANAGEMENT

Table of Content

Course: Leadership and Management Clinical

Credit Hour: 01 (0+01)

Description: This course is designed to introduce nursing students to foundational principles of leadership in a clinical setting. Through observation, participation, and guided practice, students will explore effective leadership behaviors essential to managing patient care in a dynamic healthcare environment. Emphasis is placed on delegation, prioritization, conflict resolution, communication, and collaboration within the healthcare team. Students will examine various leadership styles, assess team dynamics, and practice core leadership skills aligned with patient-centered care, safety, informatics, evidence-based practice, quality improvement, and interprofessional teamwork**.**

Clinical Rotation plan:

This semester, which spans 16–22 weeks, is divided into two equal parts. During the first half, student nurses will observe and practice clinical techniques in the skills laboratory. In the second half, they will undertake block-style clinical rotations and perform these practicals under the direct supervision of a clinical instructor.

Learning Outcomes/Objectives

9. Identify basic nursing leadership principles related to caring for

groups of patients, including delegation and prioritization.

10. Identify how to safety prioritize care for a variety of clients on the unit the day of the experience.
11. Observe how the preceptor handles conflict on the unit.
12. Discuss how to effectively delegate to other members of the health care team.
13. Assess the communication and collaboration between members of the health care team
14. Identify effective patterns of leadership.
15. Identify the various types of leadership styles encountered during the experience.
16. Perform leadership skills on the unit related to: patient-centered care; teamwork and collaboration; evidence-based practice; quality improvement; safety; informatics and how the situation may be resolved through effective leadership

Leadership Observation Log

Student Name: _____ Faculty: _____

Date: _____ Clinical placement_____

Clinical Objectives	**Strategies (What the student plans to do to meet the objective)**	**Evaluation (Faculty/Preceptor feedback and student reflection)**
Observe conflict handling by the nurse leader/preceptor.	Shadow preceptor during interdisciplinary interactions and note approaches used to resolve conflicts.	
Identify leadership styles observed during clinical care.	Record behaviors of team leaders and categorize them	

	using leadership theory (e.g., transformational, democratic).	
Analyze how delegation is carried out on the unit.	Note specific tasks delegated, to whom, and how the preceptor ensures safe delegation.	
Examine prioritization of care decisions.	Observe how the nurse leader prioritizes care among multiple patients and urgent tasks.	

Communication and Collaboration Assessment Form

Student Name: _____ Faculty: _____

Month: _____ Clinical Placement: _____

Assessment Focus Areas

Criteria	Observation/Example from Clinical Experience	Self-Assessment (✓)	Faculty Feedback
Demonstrates effective verbal communication with patients and families		☐ Excellent ☐ Good ☐ Needs Improvement	
Engages in respectful and professional communication with healthcare team members		☐ Excellent ☐ Good ☐ Needs Improvement	

Participates in interdisciplinary team discussions (e.g., rounds, handovers)		☐ Excellent ☐ Good ☐ Needs Improvement	
Clarifies orders or care plans appropriately with team members		☐ Excellent ☐ Good ☐ Needs Improvement	
Demonstrates active listening and appropriate nonverbal communication		☐ Excellent ☐ Good ☐ Needs Improvement	
Collaborates effectively with nursing and allied health staff		☐ Excellent ☐ Good ☐ Needs Improvement	
Uses SBAR or other structured communication tools when needed		☐ Excellent ☐ Good ☐ Needs Improvement	
Reflects on strengths and areas for improvement in team communication		☐ Excellent ☐ Good ☐ Needs Improvement	

Faculty Comments:_____

Faculty Signature: _____ Date: _____

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S.No	Skills	Level of competency	Minimum Frequency
1.	Staffing and Scheduling	1-5	10
2.	Problem solving skills for effective decision making in management.	1-5	5
3.	Conflict management strategies (scenario based)	1-5	5
4.	Budgeting and resource allocation	1-5	5
5.	Performance appraisal interviews	1-5	5

No	Procedures	Clinical Experience					
		Skill Lab Lecturer Signature	Date	Ward/Clinics Signature	Date	Supervisor Signature	Date
01	Staffing and Scheduling						
02	Problem solving skills for effective decision making in management.						
03	Conflict management strategies (scenario based)						
04	Budgeting and resource allocation						
05	Performance appraisal interviews						
06	Staffing and Scheduling						

Nursing Leadership & Management Skills

S.No.	Topic/Skill	Mode of Evaluation	Evaluation Criteria/Checklist Components	Marks
1	Staffing and Scheduling	**Practical + OSCE**	• Analyzes patient census and acuity • Applies staffing principles • Prepares a duty roster • Considers skill mix and legal hours	5
2	Problem Solving for Decision Making	**Scenario-based OSCE**	• Identifies the problem • Analyzes options • Chooses appropriate solution • Justifies decision based on policy or evidence	5
3	Conflict Management Strategies	**Role-play OSCE**	• Identifies type/source of conflict • Applies suitable conflict resolution strategy (e.g., collaboration) • Demonstrates effective communication	5
4	Budgeting and Resource Allocation	**Practical/Case Study**	• Prepares a simple unit budget • Allocates resources effectively • Justifies allocations • Identifies cost-saving strategies	5

5	Performance Appraisal Interviews	**Role-play OSPE**	• Demonstrates preparation • Provides constructive feedback • Uses effective communication • Encourages staff reflection & goal-setting	5

Total: 25 Marks

Each station (OSCE/OSPE) can be timed (e.g., 5–7 minutes) and use a **structured checklist** to ensure objective evaluation. Faculty can act as assessors, with standardized rubrics for consistency.

Conflict Management Checklist (Total: 5 Marks)

Criteria	Excellent (1)	Good (0.5)	Needs Improvement (0)	Marks
Identifies Type and Cause of Conflict	Clearly identifies conflict type (e.g., interpersonal, task-based) and root cause	Identifies either type or cause	Misidentifies or does not identify conflict type	
Chooses Appropriate Conflict Strategy	Selects and applies a suitable strategy (e.g., collaboration, compromise)	Chooses a workable but less effective strategy	Chooses ineffective or no strategy	

Demonstrates Effective Communication	Listens actively, uses assertive yet respectful tone	Some communication barriers, mildly assertive	Poor communication or aggressive/passive approach	
Maintains Professionalism	Calm, respectful, promotes mutual understanding	Mostly professional with minor lapses	Unprofessional or emotional behavior	
Reflects on Conflict Outcome	Reflects on how the situation was managed and what could be improved	Basic reflection on outcome	No reflection or unclear analysis	
Total Marks				**/5**

Nursing instructor's signature: _____ Date: _____

(Sullivan, 2018)

Staffing and Scheduling (Total: 5 Marks)

Criteria	Excellent (1)	Good (0.5)	Needs Improvement (0)	Marks
Analyzes Patient Census and Acuity	Accurately assesses all patient needs and matches with staff levels	Partial assessment; some mismatch in acuity and staffing	Inaccurate or no consideration of patient acuity	
Applies Staffing Policies/Principles	Applies policies, nurse-patient ratio, and legal hour limits correctly	Applies most policies, but with minor errors	Does not apply or misinterprets policies	
Creates a Functional Duty Roster	Clear, balanced schedule with shift coverage and skill mix	Mostly functional with minor gaps	Incomplete or poorly structured schedule	
Considers Staff Preferences and Availability	Integrates shift preferences and	Acknowledges some preferences/availability	Ignores availability/preferences	

	known absences			
Plans for Contingencies/Back-up Staff	Includes float pool/on-call staff and breaks	Partial contingency planning	No plan for absenteeism or emergencies	
Total Marks				**/5**

Nursing instructor's signature: _____ Date: _____

(Sullivan, 2018)

Problem Solving for Decision Making (Total: 5 Marks)

Criteria	Excellent (1)	Good (0.5)	Needs Improvement (0)	Marks
Problem Identification	Clearly identifies the problem and its underlying causes	Identifies the problem but misses some factors	Fails to identify the problem or misinterprets it	
Option Generation	Generates multiple, realistic solutions	Generates a few solutions but lacks creativity	Generates only one solution or impractical options	
Decision-Making Process	Uses a structured, logical approach for decision making (e.g., evidence-based, pros and cons)	Uses a somewhat structured approach but with minor gaps	No clear decision-making process or unstructured approach	
Outcome Evaluation	Effectively evaluates the consequences of the decision	Evaluates some consequences but misses key points	Does not evaluate consequences or fails to consider outcomes	
Reflection	Reflects on the decision-making process and suggests areas for improvement	Reflects with minimal analysis	No reflection or unclear evaluation	
Total Marks				**/5**

Nursing instructor's signature: _____ Date: _____

(Sullivan, 2018)

Budgeting and Resource Allocation (Total: 5 Marks)

Nursing instructor's signature: _____ Date: _____

(Sullivan, 2018)

Performance Appraisal Interviews (Total: 5 Marks)

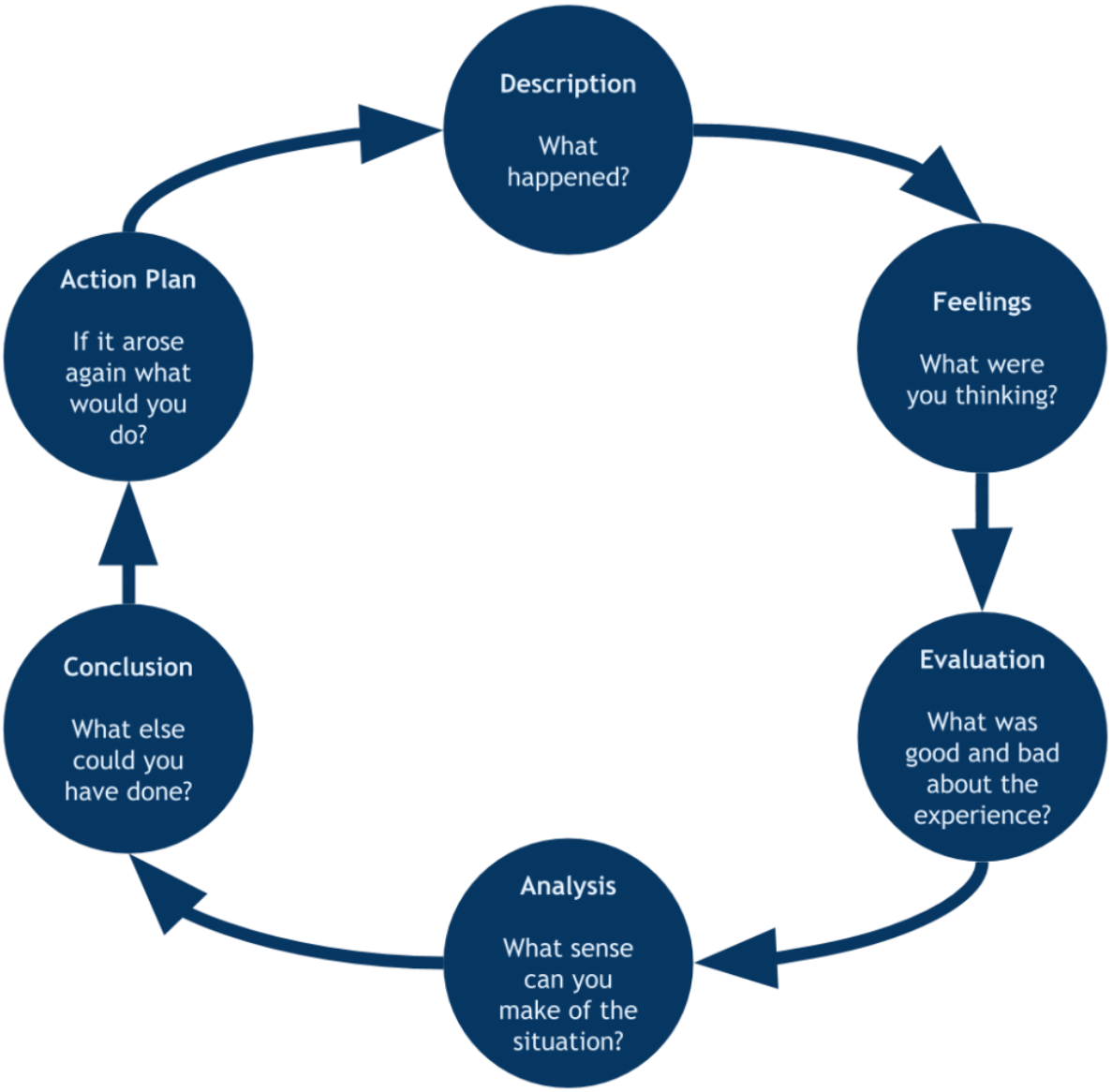
Criteria	Excellent (1)	Good (0.5)	Needs Improvement (0)	Marks
Preparation	Demonstrates thorough preparation, reviewing performance data and setting clear objectives	Prepares but misses some relevant data or objectives	Unprepared or lacks clarity in objectives	
Communication Skills	Communicates feedback clearly and respectfully, with an empathetic tone	Clear communication but lacks empathy or is somewhat formal	Poor communication, lacking clarity or empathy	
Feedback Delivery	Provides constructive, actionable feedback with clear examples	Provides feedback but lacks detail or clarity in examples	Vague feedback, no clear examples or actionable steps	

Goal Setting	Collaborates with the employee to set SMART (Specific, Measurable, Achievable, Relevant, Time-bound) goals	Sets some goals but lacks detail or clarity	Fails to set clear or achievable goals	
Closing the Interview	Ends with a positive, motivating note and ensures mutual understanding	Ends the interview, but lacks motivation or mutual understanding	Unclear or negative closing statement	
Total Marks				**/5**

Nursing instructor's signature: _____ Date: _____

(Sullivan, 2018)

Reflection/ Critical Incident Analysis



Gibbs' Reflective Cycle 1998

Position Paper: Application of Leadership Theories, Styles, and Team Management

Student Name: _____ Faculty: _____

Course Name: _____ Date: _____

Introduction (Approx. 200-300 words)

- **Purpose of the Paper:**
    - Introduce the purpose of the position paper, highlighting the importance of leadership in nursing practice.
    - Mention the leadership theories and styles that will be discussed and their relevance to team management in healthcare settings.
- **Brief Overview of Leadership in Healthcare:**
    - Provide a short introduction to leadership within nursing and healthcare teams. Explain how effective leadership contributes to the overall success of healthcare services, including patient outcomes, staff satisfaction, and teamwork.

Section 1: Overview of Leadership Theories (Approx. 300-500 words)

- **Define and Discuss Key Leadership Theories:**
    - **Transformational Leadership:** Explain how transformational leaders inspire and motivate their team members to exceed expectations and foster personal and professional growth.
    - **Transactional Leadership:** Discuss the focus on task completion and the use of rewards and penalties to motivate team members.
    - **Servant Leadership:** Describe how servant leaders prioritize the well-being of their team and foster a culture of empathy and collaboration.

- **Autocratic and Democratic Leadership Styles:** Compare and contrast these two styles and their application in healthcare settings.

- **Application to Nursing Leadership:**
  - Provide examples of how each of these leadership theories can be applied in a nursing context, particularly in team management and decision-making processes.

Section 2: Leadership Styles in Action (Approx. 200-300 words)

- **Explore Various Leadership Styles:**

  - Discuss leadership styles such as **authoritative**, **delegative**, **participative**, and **coaching**, linking each style to real-world healthcare scenarios where they are applied.
  - Reflect on your experiences or case studies where specific leadership styles have either positively or negatively impacted team dynamics and patient care.

- **Assess the Impact of Leadership Styles on Team Management:**

  - Analyze the effectiveness of different leadership styles in promoting collaboration, communication, and motivation within nursing teams. Discuss how a leader's style can influence team morale, problem-solving, and conflict resolution.

Section 3: Team Management in Nursing (Approx. 300-450 words)

- **Definition and Importance of Team Management:**

  - Define team management within the nursing context. Emphasize the importance of strong leadership in managing interdisciplinary teams to ensure quality patient care, collaboration, and effective communication.

- **Challenges in Team Management:**

    - Identify common challenges in managing healthcare teams, such as conflict resolution, delegation, communication breakdowns, and balancing team members' skills and workload.
    - Discuss strategies for overcoming these challenges through leadership.

- **Practical Application:**

    - Provide examples of how effective team management has been applied in your clinical experience or based on case studies. Discuss how leadership styles can shape team dynamics and resolve conflicts within healthcare teams.

Section 4: Personal Reflection and Application (Approx. 200-300 words)

- **Reflect on Your Leadership Development:**

    - Reflect on your personal experiences with leadership in your clinical placements. Which leadership theories and styles have you found most effective?
    - How have you applied leadership principles in your nursing practice to improve teamwork and patient care?

- **Future Leadership Goals:**

    - Outline your leadership goals for the future, including strategies for improving your leadership skills and applying them in team management.
    - Discuss how you plan to adapt your leadership style to meet the needs of different teams and situations.

Conclusion (Approx. 150-300 words)

- **Summary of Key Points:**

- Summarize the main findings of your position paper, emphasizing the importance of understanding and applying leadership theories, styles, and team management in nursing practice.
- Reiterate the significance of strong leadership in achieving effective healthcare outcomes and maintaining high team morale and collaboration.

- **Final Thought:**

  - Offer a concluding thought or insight on the future of nursing leadership and how it can continue to evolve to meet the challenges of healthcare today.

References

- Include a list of **academic sources**, **books**, **articles**, and **evidence-based research** you have referred to in your position paper, formatted according to UHS preferred citation style (Harvard, UHS Style).

Position Paper Template Example:

Section	Content
Introduction	Introduction to leadership in nursing, purpose of the paper, and the importance of leadership theories and styles in healthcare settings.
Overview of Leadership Theories	Definition and discussion of transformational, transactional, and servant leadership theories. Application to nursing leadership.
Leadership Styles in Action	Analysis of different leadership styles (authoritative, delegative, etc.), and their impact on team management in nursing.
Team Management in Nursing	Definition, challenges, and practical applications of effective team management in nursing, including conflict resolution and delegation.

Personal Reflection and Application	Reflection on personal experiences with leadership, future leadership goals, and plans for improvement.
Conclusion	Summary of key insights and concluding thoughts on leadership in nursing.
References	List of academic sources, articles, and books used in the paper.

References

- Sullivan, E.J., 2018. Effective leadership and management in nursing. 10th ed. New Jersey: Pearson Education

SEMESTER- VII

CLINICAL TRAINING

Critical nursing care clinical **04 Cr. Hours**

Internship/field experience **03 Cr. Hours**

Course Description: this course designed is to equip nurses with advanced knowledge, skills, and competencies to provide high-quality care to critically ill patients. Critical care nurses work in intensive care units (ICUs) and other settings where patients require close monitoring and life-sustaining interventions. Moreover, purpose of the course is to develop expertise in assessing and managing complex patient needs, understand advanced life support techniques and technologies, enhancing critical thinking and decision-making skills, improve communication and collaboration with interdisciplinary teams and provide holistic care to patients and families during critical illness.

Clinical Rotation plan:

This semester will be of 16/22 weeks, the student nurse will go to clinical rotation (in block days) to observe, learn and perform skills under the supervision of clinical instructor.

CLINICAL OBJECTIVES

1. Apply nursing process and critical thinking in delivering Holistic nursing care to clients in critical care and emergency setting.
2. Incorporate cognitive, interpersonal and technical skills from the humanities, natural and behavioral sciences while providing nursing care to clients.
3. Demonstrate awareness of legal and ethical standards when providing nursing care.
4. Demonstrate the knowledge of pharmacology used to treat all medical surgical disorders in critical care and emergency setting.
5. Demonstrate leadership abilities necessary to foster change in the delivery of care for the patients.
6. Provide culturally sensitive and realistic teaching to clients and families in collaboration with other health team members.
7. Collaborate with members of the health care team provide nursing care to critically ill patients.
8. Document all assessments, nursing care and discharge teaching provided to the clients in appropriate sheet

Evaluation Criteria:

S No	Clinical Portfolio Content	%	Frequency
1.	Clinical Objectives	***10%***	Weekly
2.	History Taking Performa	***15%***	25
3.	Physical Examination Checklists	***15%***	25
4.	Nursing Care Plan	***10%***	25
5.	Nursing Skills Checklists	***20%***	20
6.	Reflection/ Critical Incident Analysis	***10%***	Weekly
7.	Case Study	***20%***	03

Clinical Objectives Form

Student Name: _____ Faculty: _____

Clinical placement: _____ Date: _____

Clinical Objectives	Strategies	Evaluation

History Taking Proforma

Student Name: _____ Group #: _____

Faculty: _____

1. Document the client presenting complaint, Functional Health Patterns and Review of Systems findings and draw family genogram

Checklist for taking a client health history

Interviewing Checklist	Satisfactory	Need to improve
Introduced self, purpose, and agenda		
Arranged for proper environment (position, distance, light)		
Asks open ended question (to explore chief concern)		
Explores information about chief concern (COLDERRAA) Character, Onset, Location, Duration, Exacerbation, Radiation, Relief, Antecedent, Associated factors		
Proceed from general to specific, follows cues, probes positive finding, asks clear, logical questions, one at a time		
Uses effective communication techniques (Facilitation, Clarification, Paraphrasing, Transitions, Summarization)		
demonstrates appropriate verbal / nonverbal gesture (Eye contact, voice tone, active listening, hand gestures)		
Avoids being non therapeutic (asking why questions, biased, leading, judgmental, false reassurance, changing topic)		
Explores client past history of any illness		
Explores client family history		
Explores client functional abilities & life style patterns		
Explores Review of System checklist efficiently		

Faculty comments:

Nursing Care Plan

Assessment	Nursing Diagnosis	Goal	Planning	Implementation	Rationale	Evaluation
Subjective Data						
Objective Data						

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S #	Skills	Level of competency	Minimum Frequency
12.	Oxygen inhalation by BiPAP, CPAP	**1-5**	
13.	Tracheostomy dressing	**1-5**	
14.	Administration of meter dose inhaler (MDI)	**1-5**	
15.	Measurement of peak flow meter	**1-5**	
16.	Chest Tube Care	**1-5**	
17.	Suctioning of ETT	**1-5**	
18.	Arterial blood gases Monitoring	**1-5**	
19.	Bed sore care	**1-5**	
20.	Glasgow coma scale (GCS) Assessment	**1-5**	
21.	Intra-arterial pressure monitoring	**1-5**	
22.	CVP measurement	**1-5**	
23.	Assisting and prepare CVP	**1-5**	
24.	ATT care		
25.	Left arterial pressure monitoring	**1-5**	
26.	Pulmonary arterial pressure monitoring	**1-5**	
27.	Cardiac output monitoring	**1-5**	
28.	Intra-aortic balloon pump monitoring (IABP)		
29.	Ventilator care	**1-5**	
30.	BLS	**1-5**	
31.	Triage coding	**1-5**	

No	Procedures	Clinical Experience					
		Skill Lab Instructor Signature	Date	Ward Sister Signature	Date	Clinical instructor Signature	Date
12.	Oxygen inhalation by BiPAP, CPAP						
13.	Tracheostomy dressing						
14.	Administration of meter dose inhaler (MDI)						
15.	Measurement of peak flow meter						
16.	Chest Tube Care						
17.	Suctioning of ETT						
18.	ABGs Interpretation						
19.	Bed sore care						
20.	Glasgow coma scale (GCS) Assessment						
21.	Intra-arterial pressure monitoring						
22.	CVP measurement						
23.	Assisting and prepare CVP						
24.	ATT care						
25.	Left arterial pressure monitoring						
26.	Pulmonary arterial pressure monitoring						
27.	Cardiac output monitoring						
28.	Intra-aortic balloon pump monitoring (IABP)						
29.	Ventilator care						
30.	BLS						
31.	Triage coding						

Nursing Skills Checklists

Oxygen inhalation by BiPAP, CPAP

Equipment Required:
Nasal mask, full face mask, or nasal pillows of proper size (S, M, L)
Indelible marker
Airflow generator
Delivery tubing
If ordered: Oxygen source
Oxygen tubing
Pulse oximetry

Checklist

Sr. #	Tasks	Yes	No	Comments
15.	Check physician's orders or client's care plan.			
16.	Gather equipment and Perform hand hygiene			
17.	Explain purpose of procedure to client.			
18.	Have client wash face.			
19.	Connect CPAP/BiPAP device delivery tubing to pressure generator.			
20.	Plug pressure generator into grounded outlet.			
21.	Connect oxygen delivery tubing into device tubing adapter port (if ordered).			
22.	Turn on pressure generator.			
23.	Establish CPAP/BiPAP parameters: a. RAMP: time frame for pressure achievement, usually 5–15 minutes. b. CPAP or BiPAP setting. c. Respiratory rate if applicable. FIO2 if applicable.			
24.	Apply device over client's nose or face, avoiding tight fit, and mark straps for future proper fit.			
25.	Establish continuous pulse oximetry if ordered. a. ABGs may be obtained before and within the first hour of BiPAP initiation. Monitor vital signs, pulse oximetry, mental status, and work of breathing every 30 minutes X2, every hour X6, and every 2 hours X8.			

Nursing instructor's signature: _____ Date: _____

Tracheostomy dressing

Equipment Required:

- Disposable gloves
- Sterile gloves
- Goggles and mask or face shield
- Additional PPE, as indicate
- Sterile normal saline
- Sterile cup or basin
- Sterile cotton-tipped app
- Disposable inner tracheostomy cannula, appropriate size for patient
- Sterile suction catheter and glove set
- Commercially prepared tracheostomy or drain dressing
- Commercially prepared tracheostomy holder
- Plastic disposal bag
- Additional nurse

Checklist

Sr.	Tasks	Yes	No	Comments
20.	Bring necessary equipment to the bedside stand or overbed table			
21.	Perform hand hygiene and put on PPE, if indicated			
22.	Identify the patient			
23.	Close curtains around the bed and close the door, if possible			
24.	Determine the need for tracheostomy care and assess patient's pain			
25.	Explain the procedure and reassure the patient			
26.	Adjust bed to elbow height, lower side rail, position patient, and set up work area			
27.	Wear face shield or goggles and mask, and suction the tracheostomy if needed			
28.	Open sterile packages and prepare saline and disposable bag			
29.	Put on disposable gloves			
30.	Remove the oxygen source, stabilize the outer cannula, and remove the inner cannula			
31.	Remove gloves, put on sterile gloves, and insert the new inner cannula			
32.	Clean the stoma using saline and sterile applicators, moving outward from the site			
33.	Pat the skin dry with sterile gauze			
34.	Apply a new tracheostomy dressing			
35.	Change the tracheostomy holder with assistance, ensuring proper fit			
36.	Remove gloves, assist the patient to a comfortable position, raise bed rails, and lower the bed			
37.	Remove face shield or goggles, mask, and additional PPE, and perform hand hygiene			
38.	Reassess the patient’s respiratory status (rate, effort, oxygen saturation, lung sounds)			

Nursing instructor's signature: _____ Date: _____

Administration of meter dose inhaler (MDI)

Equipment Required:

- Patient's medication record and chart
- Metered dose inhaler
- Prescribed medication
- Normal saline solution (or another appropriate solution) for gargling
- Optional: emesis basin.

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Verify the order on the patient's medication record by checking it against the physician's order.			
2.	Wash your hands.			
3.	Check the label on the inhaler against the order on the medication record. Verify the expiration date.			
4.	Confirm the patient's identity.			
5.	Shake the inhaler bottle to mix the medication and aerosol propellant.			
6.	Remove the mouthpiece and cap.			
7.	Pull the spacer away from the section holding the medication canister until it clicks into place.			
8.	Insert the metal stem on the bottle into the small hole on the flattened portion of the mouthpiece. Then turn the bottle upside down.			
9.	Have the patient exhale; then place the mouthpiece in his mouth and close his lips around it.			
10.	As you firmly push the bottle down against the mouthpiece, ask the patient to inhale slowly and to continue inhaling until his lungs feel full.			
11.	Remove the mouthpiece from the patient's mouth, ask to hold breath for several seconds			
12.	Instruct him to exhale slowly through pursed lips.			
13.	Have the patient gargle with normal saline solution, if desired.			
14.	Rinse the mouthpiece thoroughly with warm water to prevent accumulation of residue.			

Nursing instructor's signature: _____ Date: _____

Measurement of peak flow meter

Equipment Required:

- Peak flow meter

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Identify the client and introduce yourself.			
2.	Describe the rationale for using a peak flow meter in asthma management.			
3.	Move the indicator to the bottom of the numbered scale.			
4.	Ask patient to Stand up.			
5.	Take a deep breath and fill the lungs completely.			
6.	Place mouthpiece in mouth and close lips around mouthpiece (do not put tongue inside opening).			
7.	Blow out hard and fast with a single blow.			
	Record the number achieved on the indicator.			
8.	Repeat steps 1–5 two more times and write the highest number in the asthma diary.			
9.	Explain how to determine the “personal best” peak flow reading.			
10.	Volume is measured in color-coded zones: • The green zone signifies 80% to 100% • Yellow, 60% to 80% • Red, less than 60%. If peak flow falls below the red zone, the patient should be referred to physician.			

Nursing instructor’s signature: _____ Date: _____

CHEST TUBE CARE

Equipment Required:

- Vital signs monitoring equipment
- Stethoscope
- Pulse oximeter and probe
- Sterile gloves disposable
- Chest tube drainage collection unit
- sterile water
- suction source
- suction connection tubing
- sterile drain dressings
- gauze pads
- two rubber tipped clamps

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Review the practitioners orders regarding chest tube care			
2.	Perform hand hygiene			
3.	Confirms the patient identity			
4.	Explain the procedure to the patient			
5.	Perform the comprehensive pain assessment			
6.	Maintain a sterile technique and wear a appropriate PPE			
7.	Repeatedly note the character consistency and amount of drainage			
8.	Mark the drainage level by writing the date and time			
9.	Observe the integrity of drainage tubing and chest tube every two to four hours			
10.	Periodically check that the air vent in the system is working properly			
11.	Coil the systems tubing and secure it to the edge of bed			
12.	Keep two rubber-tipped clamps at the bed sight			
13.	Instruct the patient to sit upright			
14.	Check the rate and quality of patients respirations			
15.	Tell the patient to immediately report if any breathing difficulty			
16.	Check the test tube dressing at least every 8 hours.			
17.	Replace the chest tube drainage system as per order			

Nursing instructor's signature: _____ Date: _____

Suctioning an Endotracheal Tube

Equipment Required:

- Portable or wall suction unit with tubing
- A commercially prepared suction kit with an appropriate size catheter
- Sterile suction catheter with Y-port in the appropriate size
- Sterile, disposable container
- Sterile gloves
- Towel or waterproof pad
- Goggles and mask or face shield
- Additional PPE, as indicated
- Disposable, clean glove
- Resuscitation bag connected to 100% oxygen
- Assistant (optional)

Checklist

	sks	s)	omments
1.	athered equipment to the bedside stand or over-bed table		
2.	erformed hand hygiene and put on PPE.		
3.	entified the patient and explain procedure to patient.		
4.	osed curtains around bed and close the door, if possible.		
5.	etermined the need for suctioning. Assess for pain and verify suction order.		
6.	xplained the procedure to the patient and reassure them		
7.	djusted bed to elbow height and position patient (semi-Fowler's for conscious, lateral for unconscious)		
8.	aced towel or waterproof pad across patient’s chest		
9.	et suction to appropriate pressure (based on patient age and equipment)		
10.	hecked suction pressure by occluding tubing		
11.	pen sterile suction package and prepare sterile saline		
12.	ear face shield or goggles, mask, and sterile gloves		
13.	onnected suction catheter to tubing, maintaining sterility		
14.	oistened catheter with sterile saline and check suction		
15.	yperventilated patient using a manual resuscitation bag (3–6 breaths)		
16.	pened adapter or removed resuscitation bag to expose tracheostomy		
17.	serted catheter gently into trachea without occluding the Y-port		
18.	plied suction intermittently while rotating catheter during withdrawal		
19.	yperventilated the patient after suctioning with resuscitation bag (3–6 breaths)		
20.	ushed catheter with saline, assess suction effectiveness, and repeat if needed		
21.	ait 30 seconds to 1 minute between suction passes; do not exceed 3 passes per session		
22.	emoved gloves, coil catheter inside, and dispose of properly		

23. rned off suction and remove face shield or goggles, mask, and perform hand hygiene
24. fered oral hygiene after suctioning
25. assessed respiratory status: rate, effort, oxygen saturation, lung sounds
26. moved additional PPE and performed hand hygiene

Nursing instructor's signature: _____ Date: _____

Arterial Blood Gases (ABGS)

Equipment Required:

- Sterile syringe and needle size 21G or smaller
- Heparin
- Ice in plastic bag
- Laboratory form
- Sterile gloves

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Explain procedure to the patient			
2.	Ensure that the laboratory form is complete and ice readily available before starting procedure.			
3.	Wash hands and put on gloves.			
4.	If the patient is on oxygen therapy, they must remain on constant for 20 minutes before taking the blood. If the test is done without oxygen , the oxygen must not given for 20 minutes before taking the blood			
5.	Arterial blood is normally taken from the radial artery. Alternatively, it can be taken from the dorsalis pedis, the brachial or the femoral artery.			
6.	The staff will put the heparinized syringe into the chosen artery at an angle of 45degree to the horizontal			
7.	After drawing the required amount of blood pressure must be applied to the for at least 2 minutes, 5-10 minutes in the case of the femoral or brachial artery.			
8.	The blood must be send to the laboratory in the bag of ice as soon as possible to obtain best results.			
9.	The patient should be made comfortable.			

Nursing instructor's signature: _____ Date: _____

Bed Sore Care

Equipment Required:

- Bath towel
- Soap
- Basin of warm water
- Mittens
- Gloves

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Identify the patient and introduce yourself			
2.	Explain the procedure to patient			
3.	Collect the equipment , draw the curtain screen off the area to ensure privacy			
4.	Adjust the bed to working height			
5.	Wash hands and turn patient to a lateral position if possible, exposing the patients back, wash back if necessary or preferred by the patient.			
6.	Observe any discolation or skin break down, particularly on sacrum, hips and heels.			
7.	Turn top attend to other hip.			
8.	Recover the patient and assist them to a comfortable position.			
9.	Explain to the patient the necessity for moving themselves if possible, on a regular basis to avoid any pressure sore.			
10.	Clean and place the equipment, wash hands and document in the patients note.			

Nursing instructor's signature: _____ Date: _____

Glasgow Coma Scale Assessment

Equipment Required:

- Patient's file
- Pen

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Identify patient and introduce yourself.			
2.	Observe patient's eye opening Best eye- opening response (Total score = 4) • Spontaneously (4) • In response to speech (3) • In response to pain (2) • No response (1)			
3.	Engage in communication with patients Best verbal response (Total score = 5) • Oriented (5) • Confused conversation (4) • Inappropriate words (3) • Garbled sounds (2) • No response (1)			
4.	Ask patient to move any limb. Best motor response (Total score = 6) • Obeys commands (6) • Localizes stimuli (5) • Withdrawal from stimulus (4) • Abnormal flexion (decorticate) (3) • Abnormal extension (decerebrate) (2) • No response (1)			
5.	Document patient's findings in patient's sheet.			

Nursing instructor's signature: _____ Date: _____

Intra-arterial pressure monitoring

Equipment Required:

- Gloves, gown and mask.
- Protective eye wear.
- Sterile gloves.
- Catheter 16 G to 20 G.
- Preassembled preparation kit.
- Sterile drapes.
- Sheet protector.
- Sterile towels.
- Prepared pressure transducer system.
- Local anesthetic agent (lignocaine 2%).
- Sutures.
- Syringe and needle (21G to 25G).
- IV pole.
- Tubing and medication labels.
- Site care set (containing sterile dressing, antimicrobial ointment and hypo allergic agent).
- Arm board and soft wrist restraints (formal site, ankle restraints).
- Shaving kit (optional)

For Blood Sample Collection

- Gloves, gown and mask.
- Sterile 4/4-inch gauze pads.
- Protective eye wear.
- Sheet protector.
- IV bag of 500 ml
- Syringe of 5 or 10 ml to discard sample.
- Syringe of appropriate size and number for ordered laboratory tests.
- Laboratory request forms and labels.
- Vacutainers.

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Identify the client and introduce yourself.			
2.	Prepare the client with providing adequate explanations.			
3.	Obtain informed consent.			
4.	Instruct the client to clench the hand tightly at the time of cannula insertion.			
5.	Wash hands thoroughly.			
6.	Maintain asepsis by wearing PPEs throughout preparation.			
7.	Position client for easy access to the catheter insertion site.			
8.	Place the sheet protector under the site.			
9.	Insert an arterial catheter by using preassembled preparation kit, the doctor prepares and anesthetizes the insertion site.			

10.	The catheter is then inserted in to the artery and attached to the fluid-filled pressure tubing.			
11.	The doctor may suture the catheter in place.			
12.	Apply antimicrobial ointment and cover the insertion site with dressing			
13.	Immobilize the insertion site by using an arm board and soft wrist restraint.			
14.	Activate monitor alarms as appropriate.			
	Observe the pressure wave form on the monitor and can enhance assessment of arterial pressure.			
15.	**Aftercare:** • Change the pressure tubing every 2 to 3 days. • Change the dressing at the catheter site at intervals specified by facility policy. • Regularly assess the site for signs of infection such as redness and swelling. • Notify the doctor immediately if you note any such sign. • Documentation.			

Nursing instructor's signature: _____ Date: _____

CVP (Central Venous Pressure) Measurement

Equipment Required:

- Sterile CVP manometer or transducer system
- Sterile gloves and gown
- Antiseptic solution (e.g., chlorhexidine)
- Transparent dressing
- IV fluid (normal saline)
- Pressure bag
- Zeroing stopcock
- IV pole
- Disposable measuring tape or ruler
- Central venous catheter (already in place)
- Waste container
- Hand hygiene supplies

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Identify the patient			
2.	Check physician's orders or client's care plan.			
3.	Gather equipment and perform hand hygiene.			
4.	Explain the procedure to the client.			
5.	Ensure the client is positioned flat or at 0–30° elevation.			
6.	Turn off IV infusions temporarily.			
7.	Connect the manometer or transducer to the central line via a stopcock.			
8.	Zero the manometer/transducer at the level of the phlebostatic axis (4th ICS, mid-axillary line).			
9.	Fill the manometer with sterile fluid to 20–25 cmH_2O using the IV fluid bag.			
10.	Open the stopcock to the patient and allow fluid to fall.			
11.	Measure CVP when the fluid column stabilizes. Normal range: 5–10 cmH_2O.			
12.	Record the CVP reading, time, and client's position.			
13.	Re-establish IV infusion as ordered.			
14.	Monitor for complications (e.g., infection, bleeding, air embolism).			

Nursing instructor's signature: _____ Date: _____

Assisting and Preparing for CVP Measurement

Equipment Required:

- CVP manometer set or transducer system
- Sterile gloves
- Antiseptic solution (e.g., chlorhexidine)
- IV fluid (normal saline)
- IV pole
- Pressure bag (if using transducer)
- Transparent dressing (if applicable)
- Measuring tape or ruler
- Stopcock and tubing set
- Waste container
- Hand hygiene supplies

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Identify the patient			
2.	Check physician's orders or client's care plan.			
3.	Gather necessary equipment and perform hand hygiene.			
4.	Explain procedure to client and ensure privacy.			
5.	Position client supine or with HOB 0–30° elevation.			
6.	Identify phlebostatic axis: 4th ICS at mid-axillary line.			
7.	Don sterile gloves and prepare sterile field (if applicable).			
8.	Connect CVP manometer or transducer to central line via stopcock.			
9.	Zero the manometer or transducer at phlebostatic axis.			
10.	Fill the manometer with saline to approx. 20–25 cmH_2O.			
11.	Turn stopcock to allow fluid column to fall and stabilize.			
12.	Observe and record the level of fluid where it stabilizes (CVP reading).			
13.	Reconnect IV fluids if previously disconnected.			
14.	Document the reading, client's position, time, and response.			
15.	Discard used supplies and perform hand hygiene.			

Nursing instructor's signature: _____ Date: _____

Left Arterial Pressure Monitoring

Equipment Required:

- Gloves, gown and mask.
- Protective eye wear.
- Sterile gloves.
- Catheter 16 G to 20 G.
- Preassembled preparation kit.
- Sterile drapes.
- Sheet protector.
- Sterile towels.
- Prepared pressure transducer system.
- Local anesthetic agent (lignocaine 2%).
- Sutures.
- Syringe and needle (21G to 25G).
- IV pole.
- Tubing and medication labels.
- Site care set (containing sterile dressing, antimicrobial ointment and hypo allergic agent).
- Arm board and soft wrist restraints (formal site, ankle restraints).
- Shaving kit (optional)

For Blood Sample Collection

- Gloves, gown and mask.
- Sterile 4/4-inch gauze pads.
- Protective eye wear.
- Sheet protector.
- IV bag of 500 ml
- Syringe of 5 or 10 ml to discard sample.
- Syringe of appropriate size and number for ordered laboratory tests.
- Laboratory request forms and labels.
- Vacutainers.

Checklist

Sr. #	Tasks	Yes	No	Comments
16.	Identify the client and introduce yourself.			
17.	Prepare the client with providing adequate explanations.			
18.	Obtain informed consent.			
19.	Instruct the client to clench the hand tightly at the time of cannula insertion.			
20.	Wash hands thoroughly.			
21.	Maintain asepsis by wearing PPEs throughout preparation.			
22.	Position client for easy access to the catheter insertion site.			
23.	Place the sheet protector under the site.			
24.	Insert an arterial catheter by using preassembled preparation kit, the doctor prepares and anesthetizes the insertion site.			
25.	The catheter is then inserted in to the artery and attached to the fluid-filled pressure tubing.			

26.	The doctor may suture the catheter in place.			
27.	Apply antimicrobial ointment and cover the insertion site with dressing			
28.	Immobilize the insertion site by using an arm board and soft wrist restraint.			
29.	Activate monitor alarms as appropriate.			
	Observe the pressure wave form on the monitor and can enhance assessment of arterial pressure.			
30.	**Aftercare:** • Change the pressure tubing every 2 to 3 days. • Change the dressing at the catheter site at intervals specified by facility policy. • Regularly assess the site for signs of infection such as redness and swelling. • Notify the doctor immediately if you note any such sign. • Documentation.			

Nursing instructor's signature: _____ Date: _____

Pulmonary artery pressure monitoring

Equipment Required:

- Balloon tipped, flow directed PA catheter.
- Prepare pressure transducer system.
- Alcohol sponges.
- Medication added label.
- Monitor and monitor cable.
- IV pole with transducer mount.
- Emergency resuscitation equipment.
- Electrocardiogram (ECG) monitor.
- Electrocardiogram electrodes.
- Arm board (for antecubital insertion).
- Lead aprons.
- Sutures.
- Sterile 4/4 inch gauze pads or other dry, occlusive dressing materials.
- Prepacked introducer kit.
- Dextrose 5 percent in water, shaving materials (for femoral insertion site).

If a prepacked introducer kit is unavailable, obtain the following:

- An introducer (one size larger than the catheter).
- Sterile tray containing instruments for procedure.
- Masks.
- Sterile gowns.
- Sterile gloves.
- Povidone-iodine ointment and solution.
- Solution.
- Sutures.
- Two 10 ml syringes.
- Local anesthetic agents (lignocaine 2%).
- One 5 ml syringe.
- 25 G needle.
- 1 and 3-inch tape.

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Identify client, introduce yourself and explain procedure to the patient.			
2.	Check the client's chart for heparin sensitivity.			
3.	Position the client at the proper height and angle, so the doctor will use a superior approach for percutaneous insertion.			
4.	Place the client flat or in a slight trendelenburg position, remove the client's pillow to help engorge the vessel and prevent air embolism.			
5.	Turn his head to the side opposite to the insertion site.			
6.	If the doctor uses an inferior approach to access a formal vein, position the client flat.			
7.	Maintain aseptic technique and use standard precautions throughout catheter preparation and insertion.			

8.	Wash hands, then clean the insertion site with a povidone-iodine solution and drape it.			
9.	Put on a mask, help the doctor put on a sterile mask, gloves and gown.			
10.	Open the outer packing of the catheter, revealing the inner sterile wrapping.			
11.	Using aseptic technique, the doctor opens the inner wrapping and picks up the catheter.			
12.	To remove air from the catheter and verify its patency, flush the catheter			
13.	Assist the doctor as he inserts the introducer to access the vessel.			
14.	After the introducer is placed and the catheter lumens are flushed, the doctor inserts the catheter through the introducer in the internal jugular or subclavian approach, and inserts the catheter into the end of the introducer sheath with the balloon deflated, directing the curl of the catheter toward the client's midline.			
15.	Using a gentile, smooth motion, the doctor advances the catheter through the heart chambers, moving rapidly to the PA because prolonged manipulation here may reduce catheter stiffness.			
16.	As the catheter floats into the PA, note that the upstroke from right ventricular systole is smoother and systolic pressure is nearly the same as right ventricular systolic pressure.			
17.	Record systolic, diastolic and mean pressure (typically ranging from 8 to 15 mm Hg)			
18.	To obtain a wedge tracing, the doctor lets the inflated balloon float downstream with venous blood flow to a smaller, more distal branch of the PA.			
19.	Conform the catheter position by obtaining chest X-ray.			
20.	Apply a sterile occlusive dressing to the insertion site.			
21.	Checking a Pulmonary Artery Wedge Pressure Reading			
22.	Pulmonary artery wedge pressure is recorded by inflating the balloon and letting it float in a distal artery.			
23.	To begin, verify that the transducer is properly leveled and zeroed.			
24.	Take the pressure reading at end expiration.			
25.	Note the amount of air needed to change the PA tracing to a wedge tracing (normally 1.25-1.5 cc).			
26.	He may perform a cut down or insert the catheter percutaneously, as with a modified Seldinger technique.			
27.	Document the findings in patients' file.			

Nursing instructor's signature: _____ Date:

Cardiac output monitoring

Equipment Required:

- Thermo-dilution PA catheter
- Cardiac monitor
- Closed injectant delivery system
- 10ml syringe
- 500ml bag of 5% dextrose water or saline
- Vital sign monitoring equipment's
- Crushed ice and water
- Sterile gloves

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	**Perform hand hygiene**			
2.	Identify the patient			
3.	Explain the procedure to the patient			
4.	Obtain patients vital signs			
5.	Make sure the patient is in a comfortable ,supine position			
6.	If the proximal cord is being used for an infusion, flush the port with normal saline.			
7.	If using ice injectant ,note the temperature of the injectant on monitor			
8.	Verify the presence of PA wave form and observe the patient's heart rate			
9.	Turn the stopcock, unclamp the injectant IV tubing and withdraw exactly 10 ml of solution into the syringe. reclamp the tubing			
10.	Turn the stop cock at the catheter injectant lumen			
11.	Press the start button on the cardiac output monitor			
12.	Inject the solution smoothly within 4 seconds at the end of expiration			
13.	Analyze the contour of thermo dilation curve on a strip chart recorder for a rapid upstroke			
14.	Repeat these steps up to 5 times waiting 1 minute between injection			
15.	Return the stopcock to its original position and make sure the injection delivery tubing system is clamped.			
16.	Restart medication infusion as necessary			
17.	Verify the presence of PA wave form on cardiac monitor			
18.	Make sure the clamp on the injectant bag is secured			

19.	Assess the patients respiratory and cardiovascular status			
20.	Position the patient for comfort.			
21.	Discard use supplies in an appropriate manner			
22.	Perform hand hygiene			
23.	Record the fluid volume injected for cardiac output measurements in patients IOP record			
24.	Document the procedure			

Nursing instructor's signature: _____ Date: _____

Care of patient with Ventilator

Equipment Required:

- Bed, locker with necessary articles
- Ventilator.
- Suction apparatus
- Continuous monitoring apparatus
- Resuscitation crash cart with defibrillator.
- Oxygen giving set and manual ventilation bag (AMBU bag).

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Give daily bed bath and change bed linen, if soiled.			
2.	Provide 2 hourly attentions to pressure sites by turning and repositioning of patient.			
3.	Four hourly oral hygiene, whenever needed.			
4.	Four hourly eye care. Instill artificial tears and cover with jaconet gauze/plastic foil, to prevent corneal abrasions.			
5.	Check and record vital signs every hour.			
6.	Measure blood, intravenous transfusion and fluid intake every hour.			
	Measure blood loss, urine, nasogastric, aspirate, etc. every hour.			
7.	Change drainage bags, chest drainage bottles and tubings as required.			
8.	Maintain intake/output chart every shift.			
9.	Eight hourly aseptic urinary catheter toilet and pm.			
10.	Assess bowel action every 3rd day.			
11.	Eight hourly wound dressings and pm.			
12.	Change the tape anchoring of ETT and Ryles tube pm.			
13.	Change intravenous administration sets and dressing of puncture sites every day.			
14.	Change intravenous administration sets and dressing of puncture sites every day.			
15.	Change suction bottle and connecting tubing every day.			
16.	Change ventilator circuit tubing, connections and adapters every day.			
17.	Record patient's condition and events that have occurred during each shift in nurse's progress sheet.			
18.	Give detailed hand over to nurse on following shift.			

Nursing instructor’s signature: _____ Date: _____

Basic life support

Equipment Required:

- Automated External Defibrillator (AED)
- Bag Valve Mask (BVM) or Ambu bag
- Oxygen supply and mask
- Airway adjuncts (e.g., oropharyngeal airway)
- First aid kit
- Gloves

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	Check patient's airway, breathing, and circulation (ABCs)			
2.	Assess level of consciousness			
3.	Identify potential causes of cardiac arrest (e.g., MI, trauma)			
4.	Call for help and activate emergency response system			
5.	start CPR (cardiopulmonary resuscitation): ✓ Chest compressions (30:2 ratio with ventilations) ✓ Ventilations (using bag valve mask or endotracheal tube)			
6.	Use automated external defibrillator (AED) if available			
7.	Administer oxygen as needed			
8.	Administer oxygen as needed			
9.	Monitor patient's cardiac rhythm			
10.	Follow ACLS (Advanced Cardiovascular Life Support) guidelines for medication administration			
11.	Prepare and administer medications as directed (e.g., epinephrine, amiodarone)			
12.	Document patient's condition, interventions, and response to treatment			
13.	Record timing of CPR, defibrillation, and medication administration.			

Nursing instructor’s signature: _____ Date: _____

Triage Assessment and coding

Equipment Required:

- Gloves
- Other basic personal protective equipment as appropriate for context (masks, gowns, eye protection)
- Watch or clock
- Thermometer
- Pulse oximeter
- Blood pressure cuff (sphygmomanometer and stethoscope if manual cuff)
- Glucometer
- Strips for glucometer
- Tongue depressor
- Weighing scale
- Means to identify patients' priority levels (for example, colour coded cards or stickers)
- MUAC (mid-upper arm circumference) tape
- ECG machine
- Oxygen source
- Oxygen masks (adult/paediatric)
- Basic dressing supplies (e.g., gauze, tape)
- Oral glucose
- Tourniquet
- Cervical spine immobilisation device (e.g., cervical collar)
- Defibrillator
- Emergency trolly.

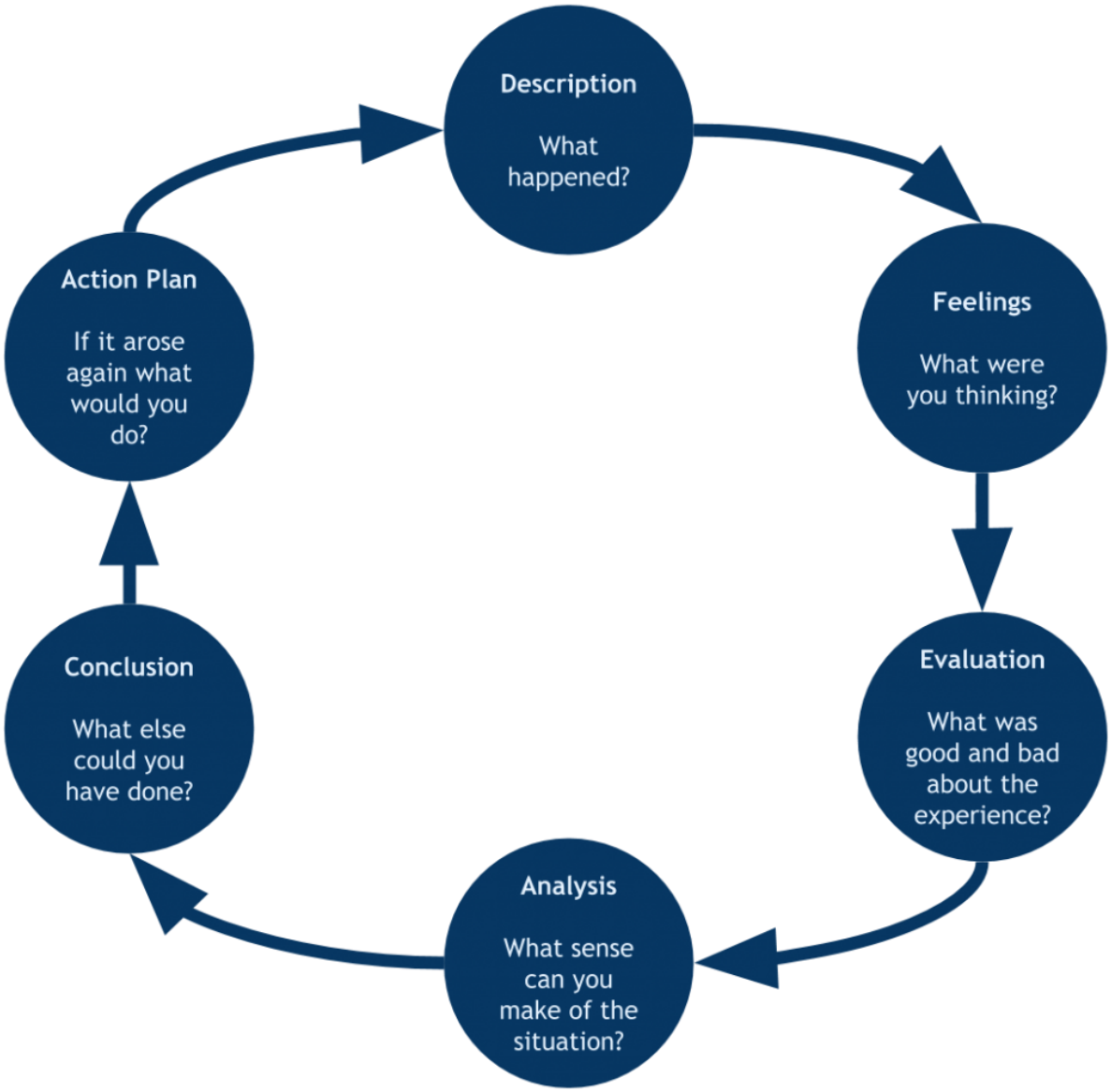
Checklist

Sr. #	Tasks	Yes	No	Comments
1.	identifies self and patient.			
2.	Assess patients and categories according to coding. • **Red tags** - (immediate) are used to label those who cannot survive without immediate treatment but who have a chance of survival. • **Yellow tags** - (observation) for those who require observation (and possible later re-triage). Their condition is stable for the moment and, they are not in immediate danger of death. These victims will still need hospital care and would be treated immediately under normal circumstances. • **Green tags** - (wait) are reserved for the "walking wounded" who will need medical care at some point, after more critical injuries have been treated. • **White tags** - (dismiss) are given to those with minor injuries for whom a doctor's care is not required. • **Black tags** - (expectant) are used for the deceased and for those whose injuries are so extensive that they will not be able to survive given the care that is available.			

3.	The Emergency department staff work collaboratively and follow the ABCD (airway, breathing, circulation, disability) method.			
4.	Establish a patent airway.			
5.	Provide adequate ventilation, employing resuscitation measures when necessary.			
6.	Trauma patients must have the cervical spine protected and chest injuries assessed first.			
7.	Evaluate and restore cardiac output by controlling hemorrhage, preventing and treating shock, and maintaining or restoring effective circulation.			
	Determine neurologic disability by assessing neurologic function using the Glasgow Coma Scale			
8.	After these priorities have been addressed, the ED team proceeds with the secondary survey			
9.	secondary survey.			
10.	A complete health history and head-to-toe assessment			
11.	Diagnostic and laboratory testing			
12.	Insertion or application of monitoring devices such as electrocardiogram (ECG) electrodes, arterial lines, or urinary catheters			
13.	Splinting of suspected fractures			
14.	Cleaning and dressing of wounds			
15.	Performance of other necessary interventions based on the individual patient's condition			
16.	Once the patient has been assessed, stabilized, and tested, appropriate medical and nursing diagnoses are formulated, initial important treatment is started, and plans for the proper disposition of the patient are made.			

Nursing instructor's signature: _____ Date: _____

Reflection/ Critical Incident Analysis



Gibbs' Reflective Cycle 1998

CASE STUDY FORMAT

CXXIX. INTRODUCTION

Background/scenario of the case.

CXXX. BIOGRAPHIC DATA

Name

Address

Age

Gender

Race

Marital Status

Occupation

Religious orientation

Health care financing and usual source of medical care

CXXXI. CHIEF COMPLAINT OR REASON FOR VISIT

CXXXII. NURSING HEALTH HISTORY

OO. History of Present Illness

PP. Past Medical History

ww) Childhood diseases

xx) Immunizations

yy) Allergies

zz) Accidents and injuries

aaa) Hospitalization

bbb) Medication

QQ. Family History of Illness (use Genogram)

RR. Obstetric History (for OB cases only; with Assessment Guide)

SS. Developmental History (for Pediatric cases only; with Assessment Guide)

CXXXIII. FUNCTIONAL HEALTH PATTERN (with guide questionnaire)

89. Health Perception and Health Management Pattern
90. Nutrition and Metabolic Pattern
91. Elimination Pattern
92. Activity-Exercised Pattern (use Barthel index)
93. Sleep-rest Pattern

94. Cognitive-perceptual Pattern
95. Self-perception and self-control Pattern
96. Role-relationship Pattern
97. Sexuality-reproductive Pattern
98. Coping-stress tolerance Pattern
99. Value-belief Pattern

Interpretation:
Analysis: (with reference)

CXXXIV. REVIEW OF SYSTEM (all subjective complaints)

CXXXV. PHYSICAL ASSESSMENT (all objective findings; indicate date performed; Head to Toe Assessment)

17. General Survey (Short Paragraph)
18. Vital Signs

BODY PART (Technique used)	NORMAL FINDINGS	ACTUAL FINDINGS	INTERPRETATION / ANALYSIS w/ Reference

CXXXVI. ANATOMY & PHYSIOLOGY

CXXXVII. DIAGNOSTIC / LABORATORY STUDIES (Table)

NAME OF TEST / PROCEDURE	DATE DONE	INDICATION FOR THE TEST / PROCEDURE	NORMAL VALUE	ACTUAL RESULT / FINDINGS	SIGNIFICANCE OF THE RESULT / FINDINGS

CXXXVIII. SURGICAL PROCEDURE (Operative worksheet, if any)

CXXXIX. PATHOPHYSIOLOGY (Present in Schematic Diagram; Mind Mapping)

CXL. DRUG STUDY / IV INFUSIONS, BLOOD TRANFUSIONS, TREAMENTS GIVEN

Drug Study

Drug Order (Generic, Name, Dosage, Route, Frequency)	Trade / Brand Name	Pharmacologic Action Of Drug	Indication And Contraindications	Adverse Effects Of The Drug	Desired Action On Your Client	Nursing Responsibilities / Precautions

Treatments Given

Treatment / Infusion	Classification	Indication	Contraindication	Nursing Responsibilities / Precautions

CXLI. COURSE IN THE WARD (narrative form)

- Summary of day to day medical/nursing management from the date of admission up to the time case study was done
- Patient's Status:
    a. General condition of the client (ex. LOC, VS, and other Subjective & Objective, complaint during the day)
    b. 4 D's with inference / analysis:
        - Diet
        - Drugs/IVF
        - Lab/Diagnostics procedure
        - Disposition

CXLII. PRIORITIZED LIST OF NURSING PROBLEMS (Table)

- Prioritized using ABC's and Maslow's Hierarchy of Needs

Date	Nursing Problems Identified	Cues	Justification

CXLIII. NURSING CARE PLAN

Assessment	Nursing Diagnosis	Planning	Implementation	Rationale	Evaluation

CXLIV. PROPOSED / DISCHARGE PLAN (to be submitted by students whose patients are for discharge)

- M - Medications to take at home
- E - Exercises
- T - Treatment
- H - Health Teachings
- O - Out - patient follow-up
- D - Diet
- S - Spiritual / Sexual activity (optional)

References:

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INTERNSHIP- 03 CH

Clinical Objectives: By the end of this course, students will be able to:

6. Apply theoretical knowledge to the clinical setting by:
7. Encouraging them to function as a member of the multidisciplinary health care team.
8. Provide total nursing care to the patients in the hospital under close supervision of preceptor/senior Registered Nurse.
9. Enhancing communication and relationship skills.
10. Strengthening assessment and clinical skills

S/NO	NURSING SUBJECTS	WORKING DEPARTMENTS	TIME ALLOCATION	REMARKS
1.	Medical Nursing	Medical ward	One week	
2.	Surgical nursing	Surgical ward	One week	
3.	Critical Care nursing	ICU/CCU	One week	
4.	Pediatric nursing	Pediatric Ward	One week	
5.	Nursing management	Any department	One week	Project
	Total		05 weeks	

Clinical Skills Checklist

Unit: Medical Nursing

Student Name**:** _____Started from: _____ to _____

For each skill/task demonstrated by the student, the preceptor/staff nurse trainer will sign in the appropriate column. The student is able to discuss the policy and demonstrate the following skill task:

S. #	Clinical Skill Task	Yes	No	Comments
1.	Basic nursing care			
2.	Admissions procedure			
3.	Taking and recording patient's: • Vital Signs • Abdominal Girth • Weight • Length • Head circumference • Laboratory tests			
4.	Performance of physical health assessment and nursing management: • Cardiovascular • Respiratory • Gastro-intestinal • Muscular-skeletal • Integumentary • Neurological • Metabolic • Hematology & Oncology • Endocrine • Genitor –urinary			
5.	Discharge procedures			
6.	Documentation and nurse note			
7.	Patient safety • Using bedrails appropriately • Using restraints when needed • Education of mother			
8.	IV Therapy: • Care of IV cannula & IV flush • Administering TPN/PPN			

9. Oxygen administration/respiratory therapy:
    - Simple face mask
    - Nasal cannula
    - Tracheostomy mask
    - Incentive Spirometry
    - Using Ambo bagging (pediatric & neonate)
    - Insertion of oral airway
    - Performing chest exercise
    - Nebulizer

10. Diagnostic preparation- follow protocol for various diagnostic procedure

Clinical Instructor: _____ Date: _____

Clinical Skills Checklist

Unit: Surgical Nursing

Student Name**:** _____Started from: _____ to _____

For each skill/task demonstrated by the student, the preceptor/staff nurse trainer will sign in the appropriate column. The student is able to discuss the policy and demonstrate the following skill task:

S. #	Clinical Skill Task	Yes	No	Comments
1.	Basic nursing care			
2.	Admissions procedure			
3.	Surgical nursing care: • Pre-operative care • Post-operative care • Positioning • Transporting of patients • Care of wound: • Caring of drains • Removal of sutures, staples • Care of Ostomies			
4.	Performance of physical health assessment & nursing management: • General surgery • Plastic surgery • Orthopedic • Renal • Neurological • Urinary surgery			
5.	Discharge procedure			
6.	Documentation and nurse's note			
7.	Patient safety: • Using bedrails appropriately • Apply required restraints			

Clinical Instructor: _____ Date: _____

Clinical Skills Checklist

Unit: Pediatric Nursing

Student Name**:** _____Started from: _____ to _____

For each skill/task demonstrated by the student, the preceptor/staff nurse trainer will sign in the appropriate column. The student is able to discuss the policy and demonstrate the following skill task:

S. #	Clinical Skill Task	Yes	No	Comments
1.	Basic nursing care			
2.	**Daily nursing care:** • Pediatric vital signs • Umbilical cord care • Taking and recording patient: • Abdominal girth • Chest circumference • Length and weight • Head circumference • Pediatric laboratory result • Assess of newborn reflexes			
3.	**Performance of physical health assessment & nursing management:** • Premature neonate and Low birth infant • Congenital anomalies (cardiac, respirator, gastric, neurological, urinary tract and Hydrocephalus) • Down syndrome • Communicable disease • Respiratory disease and nephritic syndrome • Seizures, unconscious, comatose • Diabetic • Care with sepsis • Post-natal disorder: ✓ Jaundice ✓ Infant of diabetic mother ✓ Respiratory surfactant disorder			
4.	**Patient safety:** • Using incubator & phototherapy • Using restraints – when required • Radiant wormer			
5.	IV therapy • Care of IV (cannula, cannula flushing and blood exchange) • Administering TPN/PPN			

6.	**Oxygen administration/ Respiratory therapy:** • Simple face mask • Nasal cannula • Tracheostomy mask • Incentive Spirometry • Using Ambo - bagging (pediatric & neonate) • Insertion of oral airway • Venture mask • Head box • Performing chest physiotherapy			
7.	Diagnostic preparation- follow protocol for various diagnostic procedure			
8.	**Caring of patient in NICU:** • Feeding • Infant formula • TPN / PPN • Fluid requirement • Gavage feeding • Medication • Vasopressor • Prostaglandin • Radiant wormer • Cardiac monitor /ventilator • Care of newborn in incubator			
9.	Collection of specimen (urine, blood, wound)			
10.	Admission, Discharge & Documentation			

Clinical Instructor: _____ Date: _____

Clinical Skills Checklist

Unit: Critical Care Nursing

Student Name**:** _____Started from: _____ to _____

For each skill/task demonstrated by the student, the preceptor/staff nurse trainer will sign in the appropriate column. The student is able to discuss the policy and demonstrate the following skill task:

S. #	Clinical Skill Task	Yes	No	Comments
1.	Basic nursing care			
2.	**Basic unit skill:** • Defibrillation /cardioversion • Administration of thrombolytic therapy • Temporary pacemaker transcutaneous /trans venous			
3.	**Air way management:** • Mechanical ventilator • Assist in initiating invasive & noninvasive mechanical ventilator • Providing care for patient with mechanical ventilator • Assist in weaning from MV • Air way tube • Assist in insertion of airway tube • (endotracheal , tracheostomy, nasopharyngeal) • Providing care of air way tube • Suctioning of air way passage			
4.	**Central lines:** • Collection of equipment for insertion of central line • Discuss the normal parameters for CVP measurement • Determines and records CVP using a water manometer and pressure monitor • Identifies chest landmarks for CVP measurement • The flushing of a central line • The administration of drugs and fluids • Aseptically change central IV lines • Aseptically change central IV lines dressing			

- Setting up a transducer system
- The safe removal of central lines
- Risks & complications of central line
- Intervention/troubleshoot complication of central lines

5. **Pulmonary artery catheters & arterial:**
    - Take appropriate action to prevent or resolve complications of PA catheters & arterial lines
    - Sitting up a single and multiple transducer system
    - Identify a PA and arterial trace on the cardiac monitor
    - Zeroing of PA & arterial lines
    - The purpose for performance of an Allen's test
    - Correct technique for drawing blood from PA catheter & arterial lines
    - Supervised performance of a PAWP
    - Identify normal reading and waveform
    - Care of wound drains/graft area
6. Chest physiotherapy/Spirometry
7. **Feeding management:**
    - Administration TPN
    - Administer tube feeding through tummy syringe
    - Feeding pump
8. **Under water seal:**
    - Assisting in insertion/removal of underwater seal drainage
    - Care of underwater seal drainage
9. **Nursing care of patient:**
    - Post CABG
    - Post valve reconstruction / replacement
    - Postoperative bleeding
    - Unconscious (general care to prevent of foot drop & contractures)
    - Post PTCA
    - Post cardiac catheterization
10. **Nursing care and Management of:**
    - Intracranial surgeries

- Fractures and osteoarthritis
- Biliary and pancreatic disorder
- MI/unstable angina
- Intestinal obstruction, colonic surgery and ostomies

11. Room/bed preparation pre/post-cardiac surgery
12. Administration of medications (vasopressors, antiarrhythmic, inotropes, anticoagulation)
13. **Use of electronic life support equipment**
    - Respiratory support
    - Renal support
    - Intravenous/ syringe pump
    - Cardiac monitoring
    - Non-invasive continuous cardiac output monitor
14. **Recognition and interpretation of:**
    - Dysrhythmias
    - Critical patient signs and symptoms
    - Laboratory findings
15. Psychosocial support of patient and family (specific to critical care situation)
16. Post mortem care

Clinical Instructor: _____ Date: _____

Unit: Nursing Management

Student Name**:** _____Started from: _____ to _____

For each skill/task demonstrated by the student, the preceptor/staff nurse trainer will sign in the appropriate column. The student is able to discuss the policy and demonstrate the following skill task:

S. #	Clinical Skill Task	Yes	No	Comments
1.	**Staffing and Scheduling** • Analyzes patient census and acuity • Applies staffing principles • Prepares a duty roster • Considers skill mix and legal hours			
2.	**Problem Solving and Decision Making** • Identifies the problem • Analyzes options • Chooses appropriate solution • Justifies decision based on policy or evidence			
3.	**Conflict Management Strategies** • Identifies type/source of conflict • Applies suitable conflict resolution strategy (e.g., collaboration) • Demonstrates effective communication			
4.	**Budgeting and Resource Allocation** • Prepares a simple unit budget • Allocates resources effectively • Justifies allocations • Identifies cost-saving strategies			
5.	**Performance Appraisal Interviews** • Demonstrates preparation • Provides constructive feedback • Uses effective communication • Encourages staff reflection & goal-setting			

Clinical Instructor: _____ Date: _____

SEMESTER VIII

CLINICAL TRAINING

Oncology and Palliative care nursing Clinical –02 Cr. Hours

Community Health Nursing-II Clinical – 03 Cr. Hours

Course Description:

This course is designed deliver evidence-based information to students by enabling them to practice with accurate scientific knowledge, a solid nursing science foundation, excellent communication, and an understanding of the healthcare system for policy development as they work to prevent, identify, and treat patients with cancer. Nurses will identify current treatments in interventional and pharmacological therapeutics with a focus on evidence-based holistic nursing care. Moreover, course will place emphasis on the development of sound clinical judgment, critical thinking and collaborative care to achieve optimal outcomes for their patients. It will enable them to apply safeguards to support a safe practice environment for both patients and healthcare workers.

Clinical Rotation plan:

This semester will be of 16/22 weeks, the student nurse will go to clinical rotation in batches to ensure 24/7 clinical placement at hospitals in all three shifts to observe, learn and perform skills under the supervision of clinical instructor.

Clinical Objectives:

1. Describe the history and evolution of different models of palliative care
2. Identify life limiting illnesses and contrast their trajectories
3. Examine specific structural and functional changes in cells, tissues and organs function in cases of cancer and chronic illness
4. Examine life limiting oncological and neurological disease states and appraise their treatment
5. Summarize the principles of pain and symptom management including psychosocial care
6. Discuss ethical, spiritual and cultural aspects of palliative nursing, including an indigenous perspective
7. Demonstrate an understanding of the multidisciplinary team approach to palliative care
8. Develop essential communication skills for palliative care nursing and outline self- care strategies
9. Discuss and review grief and loss theories and experiences of people and families with a life limiting illness
10. Recognize bodily manifestations of dying and discuss care in the last days of life.

Evaluation Criteria:

S No	Clinical Portfolio Content	%	Frequency
8.	Clinical Objectives	***10%***	Weekly
9.	History Taking Performa	***15%***	10
10.	Physical Examination Checklists	***15%***	10
11.	Nursing Care Plan	***10%***	10
12.	Nursing Skills Checklists	***20%***	10
13.	Reflection/ Critical Incident Analysis	***10%***	Weekly
14.	Case Study	***20%***	2

Clinical Objectives Form

Student Name: _____ Faculty: _____

Clinical placement: _____ Date: _____

Clinical Objectives	Strategies	Evaluation

History Taking Proforma

Student Name: _____Group #: _____Faculty: _____

1. Document the client presenting complaint, Functional Health Patterns and Review of Systems findings and draw family genogram

Checklist for taking a client health history

Interviewing Checklist	Satisfactory	Need to improve
Introduced self, purpose, and agenda		
Arranged for proper environment (position, distance, light)		
Asks open ended question (to explore chief concern)		
Explores information about chief concern (COLDERRAA) Character, Onset, Location, Duration, Exacerbation, Radiation, Relief, Antecedent, Associated factors		
Proceed from general to specific, follows cues, probes positive finding, asks clear, logical questions, one at a time		
Uses effective communication techniques (Facilitation, Clarification, Paraphrasing, Transitions, Summarization)		
demonstrates appropriate verbal / nonverbal gesture (Eye contact, voice tone, active listening, hand gestures)		
Avoids being non therapeutic (asking why questions, biased, leading, judgmental, false reassurance, changing topic)		
Explores client past history of any illness		
Explores client family history		
Explores client functional abilities & life style patterns		
Explores Review of System checklist efficiently		

Faculty comments:

Nursing Care Plan

Assessment	Nursing Diagnosis	Goal	Planning	Implementation	Rationale	Evaluation
Subjective Data Objective Data						

List of Skills

Levels of competency = 1-5 (Novice to Expert)

S #	Skills	Level of competency	Minimum Frequency
18.	Central venous line care and dressing	1-5	5
19.	Administration of analgesia – continuous infusion, continuous epidural infusion, Patient controlled analgesia (PCA) pump, syringe driver and transdermal patches.	1-5	5
20.	Caring of patient with chest and surgical drains	1-5	5
21.	Safe administration of oncological medications	1-5	5
22.	Spill and hazard (body fluids after chemo) management (protocol)	1-5	5
23.	Blood culture collection/sampling (Venous sampling, Arterial sampling)	1-5	5
24.	Irrigation and instillation – bladder	1-5	5
25.	Body surface area calculation (BSA)	1-5	5
26.	Operating machines for TPN, infusion and syringe pump	1-5	5
27.	Assistance in biopsy (Bone Marrow)	1-5	5
28.	Develop a plan of care for a patient on chemotherapy	1-5	5
29.	Develop a pre op care plan for a patient undergoing oncology surgery	1-5	5
30.	Develop a post Op care plan for patient under going oncology surgery	1-5	5
31.	Develop a health education plan for patients experiencing health alterations in patients undergoing oncology treatment	1-5	5
32.	Interact with patients using cultural humility and curiosity	1-5	5
33.	Identify one cultural practice that was unfamiliar and research about it post-rotation.	1-5	5
34.	Write a reflective report on how this experience will influence future nursing practice.	1-5	2

No	Procedures	Clinical Experience					
		Skill Lab Instructor Signature	**Date**	**Ward Sister Signature**	**Date**	**Clinical instructor Signature**	**Date**
32.	Central venous line care and dressing						
33.	Administration of analgesia – continuous infusion, continuous epidural infusion, Patient controlled analgesia (PCA) pump, syringe driver and transdermal patches.						
34.	Caring of patient with chest and surgical drains						
35.	Safe administration of oncological medications						
36.	Spill and hazard (body fluids after chemo) management (protocol)						
37.	Blood culture collection/sampling (venous sampling, Arterial sampling)						
38.	Irrigation and instillation – bladder						
39.	Body surface area calculation (BSA)						
40.	Operating machines for TPN, infusion and syringe pump						
41.	Assistance in biopsy.						

Nursing Skills Checklists

Central Venous Line Care and Dressing

Equipment:

- Antiseptic solution
- A sterile transparent semipermeable dressing or sterile 4" × 4" gauze pads
- Catheter securement device
- Sterile tape, or adhesive strips
- Gloves
- Mask
- Label
- Sterile disposable tape measure

Checklist

Sr#	Critical Behaviors	Yes	No	Comments
1.	Identify patient using appropriate identifiers.			
2.	Explain procedure to patient/significant other.			
3.	Perform hand hygiene.			
4.	Assemble equipment and supplies on clean work surface.			
5.	Position patient for comfort and ease of access to catheter.			
6.	Don masks and clean gloves.			
7.	Remove old stabilization dressing/securement device, carefully			
8.	Assess site for complications. Notify physician as needed.			
9.	Remove gloves. Perform hand hygiene.			
10.	Don sterile gloves.			
11.	Measure/note length of external catheter.			
12.	Vigorously cleanse around catheter insertion site with antimicrobial solution. Allow to air dry.			
13.	Apply transparent dressing/ securement device, covering catheter insertion site.			
14.	If using a gauze dressing, apply sterile gauze pad directly over insertion site and secure with sterile tape in an occlusive manner.			
15.	Secure needleless connector and extension set with tape.			
16.	Measure mid arm circumference 10 cm above ante-cubital fossa, and compare to previous measurement.			
17.	Dispose of used supplies per facility policy.			
18.	Remove mask and gloves. Perform hand hygiene.			
19.	Label dressing with: date, time and nurses initials.			

Nursing instructor's signature: _____ Date: _____

ADMINISTRATION OF ANALGESIA
Continuous infusion

Equipment required:

- Infusion pump
- IV pole
- Prescribed IV analgesia solution
- Sterile administration set
- Antiseptic pads
- Prefilled syringe with normal saline
- gloves

Checklist

S #	Procedure	Yes	No	Comments
	Medication Preparation: • **Verify the medication order** • **Prepare the medication according to instructions or a drug reference guide.** • **If mixing medication into a bag, ensure it's done aseptically.** • **Ensure IV tubing is primed and free of air bubbles.** • **Apply a label to the IV bag with the medication name, dose, infusion rate, start time, and initials of the preparer.**			
	Infusion Pump Preparation: • **Ensure the pump is working correctly and has sufficient battery power.** • **Select the appropriate infusion rate and volume based on the medication order.** • **Load the infusion tubing into the pump.**			
	IV Site Preparation: • **Check the IV site for redness, swelling, or any signs of infiltration.** • **Clean the IV hub with an alcohol swab and allow it to dry.** • **If using a saline lock, flush the IV line with saline to ensure patency.**			
	Starting the Infusion: • **Confirm the patient's name and date of birth.** • **Briefly explain the procedure to the patient.** • **Connect the IV tubing to the IV site and the infusion pump.** • **Begin the infusion according to the programmed rate.** • **Observe the IV site and the patient for any signs of complications during the first few minutes.**			

	Medication Documentation: • **Document the medication name, dose, infusion rate, and time of infusion on the MAR.**			

Nursing instructor's signature: _____ Date: _____

Continuous epidural infusion

Equipment required:

- **Epidural infusion pump with anti-free-flow protection epidural infusion tubing containing a 0.2 micron, surfactant-free, particulate-retentive filter**
- **Prescribed epidural solutions (preservative-free)**
- **Sterile transparent semipermeable dressing**
- **Sterile tape measures**
- **A sterile tape**
- **Epidural tray**
- **Epidural Infusion Labels**
- **Povidone-iodine solution**
- **Tape**
- **Sterile gloves**
- **Gloves**
- **Mask**
- **A monitoring equipment for blood pressure, pulse, and temperature**
- **Disinfectant pad**
- **Emergency equipment (oxygen, intubation equipment, handheld resuscitation bag with mask, 0.4 mg of IV naloxone)**
- **Optional: chlorhexidine-impregnated sponge dressing, capnography monitor.**

S. No	Procedure	Yes	No	Comments
1.	Ensures patient is positioned comfortably and safely in the middle of the bed			
2.	Adjusts height of bed appropriately			
3.	Carefully prepares a sterile work surface			
4.	Pours antiseptic solution (or has nurse pour it) without contaminating the epidural set			
5.	Washes hands and puts on gloves in a sterile fashion			
6.	Optimally positions him/herself for the procedure			
7.	Prepares the skin at the back widely and aseptically (skin prep _ 3)			
8.	Allows solution to dry			
9.	Neatly lays out and prepares all necessary equipment (needles, syringes, local anesthetic)			
10.	Asks patient to arch her back			
11.	Places drape over patient's back in a sterile fashion			
12.	Landmarks site of injection after palpating iliac crests			

13.	Warns patient of needle insertion			
14.	Infiltrates subcutaneous layers with local anesthetic			
15.	Places epidural needle with correct positioning of bevel			
16.	Inserts epidural needle through skin, subcutaneous tissue, and into ligament before attaching the syringe			
17.	Attaches air/saline filled syringe to the needle hub with needle well controlled			
18.	Braces hand/s holding the needle against patient's back in complete control of the needle			
19.	Identifies LOR and immediately releases pressure on the plunger			
20.	Notes depth of needle insertion before threading catheter			
21.	Warns patient about possible paresthesia during catheter threading			
22.	Detaches the syringe and threads the catheter to a depth of 4-5 cm			
23.	Pulls the needle out while maintaining correct catheter placement			
24.	Carefully aspirates from catheter			
25.	Injects test dose through flushed filter			
26.	Fixes the epidural catheter securely			
27.	Continue medicine following steps of continuous infusion			

Nursing instructor's signature: _____ Date: _____

SYRINGE PUMP

- Syringe pump
- IV pole
- Prescribed IV analgesia solution
- Sterile administration set
- Antiseptic pads
- Prefilled syringe with normal saline
- gloves

S.	Procedure	Yes	No	Comments
1.	Washing hands and/or using personal protective equipment (PPE) as per local procedures			
2.	Reviewing equipment			
3.	Ensure that all equipment is available and serviceable and check that: • The device is clean and visually intact • The device is appropriate for the intended use • The syringe and extension set are appropriate and compatible for the device and the medicine delivery • The battery has sufficient charge and is fitted correctly.			
4.	Completing a 'Medicines added' label			

5.	• Patient name • Date of birth • ID number • Medicine(s) name(s) • Dose of each medicine • Diluent name • Total volume in mL • Date and time prepared • Initials of the individuals checking and preparing the syringe.			
6.	Preparing the syringe for loading			
7.	• Draw up medicine using a 30 mL Luer lock syringe, as prescribed • Fill the 30 mL syringe with 20 mL combined volume of diluent and medicine. • Place 'Medicines added' label on syringe, ensuring it does not interfere with the barrel clamp or obscure the measurement gradient.			
8.	Turning on NIKI T34TM syringe pump			
9.	• Hold down ON/OFF key • Allow pre-loading actuator movement to complete before loading syringe.			

Nursing instructor's signature: _____ Date: _____

Transdermal patches

Equipment required:

- Gloves
- Transdermal patch
- Soap and water

Checklist

Sr#	Procedure	Yes	No	Comments
1.	Identify client, introduce yourself and explain procedure.			
2.	Follow the Rights of Medication Administration			
3.	Gloves should be worn to apply/remove transdermal patches.			
4.	Remove the old patch, if present.			
5.	Wash client's skin with soap and water (both new site and removal site).			
6.	Rotate application sites to avoid skin irritation.			
7.	Peel backing off the patch press on skin and apply pressure to assure skin adherence.			
8.	Include the site of application with documentation.			

Patient controlled analgesia (PCA) pump

S. No	Procedure	Yes	No	Comments
1.	**Pre-preparation** • **Verify Provider has PCA ordering privileges/ competency.** • **Verify that ordered basal rate dose for morphine sulfate is less than 10 mg/hr.** • **Obtain Provider order for PCA and ensure the following:** ✓ **Provider order is on an Adult or Pediatric PCA power plan/order set.** ✓ **Order is complete and signed by the physician.** ✓ **Order verified by pharmacy before administration** • **Verify order and PCA pump settings with second RN prior to administration.** • **Verify order at the bedside where the patient and pump are located** • **Program the pump using the Provider order** • **Verify correct pump settings prior to administration including: -** ✓ **Name of medication –** ✓ **Medication concentration –** ✓ **Dosage of medication**			
2.	**Initial Assessment:** • **Assess the following within 30 minutes prior to initiating PCA therapy:** ✓ **Level of consciousness** ✓ **IV site and patency** ✓ **Vital Signs (VS)** ✓ **Depth of respirations (depth of respirations is documented under "Respirations")** ✓ **Pain severity** ✓ **History of allergic reaction to opioid medications** ✓ **Oxygen saturation via pulse oximetry**			
3.	**On Going Assessment:** • **Assess the following between 15-30 minutes into infusion, after dose changes, then a minimum of every 2 hours (ICU), every 4 hours (Wards)** • **Assess for and document accuracy of pump settings, frequency of patient use of PCA, and clear pump every 4 hours.** • **Assess for Side effects:**			

	• **Evaluate patient's ongoing ability to use PCA effectively a minimum of every day.** • **Assess for effectiveness of pain relief within one hour after any pump setting change.**			
4.	**Administration:** • **Administer PCA per order.** • **Maintain primary IV at 10 mL/hour to keep vein open.** **Use pre-loaded syringes provided by Pharmacy Services.**			
5.	**Documentation:** • **Document on Pain Medication Infusion Record or Computerized medication administration record by both RNs**			

Nursing instructor's signature: _____ Date: _____

CARE OF DRAINAGE BAG

Equipment Required:

- Graduated container for measuring drainage
- Clean disposable gloves
- Additional PPE, as indicated
- Cleansing solution, usually sterile normal saline
- Sterile gauze pads
- Skin-protectant wipes
- Dressing materials for site dressing, if used

CHECKLIST

Sr#	Action	Yes	No	Remarks
1.	Review the medical orders or nursing plan for wound/drain care.			
2.	Gather the supplies and bring to the bedside stand or over-bed table.			
3.	Perform hand hygiene and put on PPE, if indicated.			
4.	Identify the patient.			
5.	Provide privacy. Explain procedure to the patient.			
6.	Assess the patient for analgesic medication before wound care dressing change.			
7.	Place a waste receptacle at a convenient location for use during the procedure.			
8.	Adjust bed to comfortable working height, usually elbow height of the caregiver.			
9.	Assist the patient to a comfortable position that provides easy access to the drain and/or wound area.			
10.	Put on clean gloves; put on mask or face shield if indicated.			
11.	Place the graduated collection container under the outlet of the drain. Without contaminating the outlet valve, pull the cap off.			
12.	Empty the chamber's contents completely into the container.			
13.	Use the gauze pad to clean the outlet. Fully compress the chamber with one hand and replace the cap with your other hand.			
14.	Check the patency of the equipment. Make sure the tubing is free from twists and kinks.			
15.	Secure the Jackson-Pratt drain to the patient's gown below the wound with a safety pin.			
16.	Carefully measure and record the character, color, and amount of the drainage. Discard the drainage according to facility policy. Remove gloves.			
17.	Put on clean gloves. If the drain site has a dressing, re-dress the site. Include cleaning of the sutures with the gauze pad moistened with normal saline. Dry sutures with gauze before applying new dressing.			

18.	Remove and discard gloves. Remove all remaining equipment; place the patient in a comfortable position, with side rails up and bed in the lowest position.			
19.	Remove additional PPE, if used. Perform hand hygiene.			
20.	Check drain status at least every four hours. Check all wound dressings every shift. More frequent checks may be needed if the wound is more complex or dressings become saturated quickly			
21.	If the drain site is open to air, observe the sutures that secure the drain to the skin. Look for signs of pulling, tearing, swelling, or infection of the surrounding skin.			

Nursing instructor's signature: _____ Date: _____

Safe administration of oncological medications

Equipment Required:

- Patient's medication record & chart.
- Prescribed drug or drugs.
- Injection trolley with spirit, cotton ball jar, clamp bottle/cheatle forceps bottle, sharp container, sterlium, adhesive and scissors.
- Disposable syringes as needed.
- Protective devices (gloves – 2, mask, apron, shoe cover and goggles).
- Vertical laminal airflow/biological safety cabinet.
- Diluents for mixing chemotherapy drugs and IV fluid for dilution.
- Drug label.

Checklist

Sr. #	Tasks	Yes	No	Comments
14.	**Pre-preparation Procedure**: • Check the height and weight of the patient and record it in the chart. • Calculate the body surface area. • Verify and document the absolute neutrophil count. • Review and document the laboratory reports of the patient. • Verify the duration between each cycle. • Chemotherapy orders must be written clearly (name of the drug, dosage, diluents, route, duration of administration and premedication) with the doctor's signature and date. • Protocol should be available and signed by the consultant. • Oral or unclear orders should not be followed.			
15.	**Preparation of Chemotherapy**: • The chemotherapy drug should be prepared by loading nurses who are trained specially in preparation and administration of chemotherapy. • The assigned nurse for the particular patient also should be present throughout the preparation of cytotoxic drugs along with the loading nurse to counter check the drug, dosage, route and dilution.			
16.	**Procedure:** • Assemble the needed equipment in the chemotherapy loading area. • Put on the UV light inside laminar hood 15mts before procedure. • Put on the airflow. • Clean the internal surface of the cabinet with 70% alcohol and a disposable towel. • Cover the work surface with a clean plastic absorbent pad to minimize contamination by droplets or spills. Change the pad at the end of the shift or whenever a spill occurs.			

	• Verify the drug, dosage and route of administration by checking the medication record against the doctor's order. • Keep the prepared labels beside the IV bottles and the specific chemotherapy drugs. • Wash hands with soap and water or sterilium. • Wear protective devices. • Open the glove paper and drop the spirit swab, syringes as needed on it. • Check the IV fluids for expiry date, contamination and any precipitation. • Remove the plastic cork of the IV fluid and wipe it with sprit swab. • Open the drug away from the face and body. Use a suitable pad or cotton for breaking the ampule. In case of vials, clean the top of the vial with spirit swab in a circular motion. Discard the cotton swab. • Introduce the diluents slowly in to the vial to prevent high pressure being generated inside the sealed vial. • Withdraw the chemotherapy drug using the syringe and expel the air without spillage of medications. When excess air is expelled from a filled syringe, it should be exhausted in to the vial and not straight into the atmosphere. • Mix the drug with IV fluid kept ready for infusion. • Keep sterile cotton on the loaded bottle and seal it with adhesive. • Label the drug correctly and get the counter sign from the assigned nurse. • Discard all the materials which have come into contact with the cytotoxic drugs (syringes, cotton, mask, apron, ampoules and vials) in a sealed black cover with adhesive. • Discard the needle in the sharp container. • Goggles, face shields, respiration are cleaned with mild detergents and are reused. • Wash hands.			
17.	**Administration** • Wash hand with soap and water or sterilium. • Wear protective devices. • Check the doctor's order. • Check the IV fluids for discoloration and any precipitation. • Transport the drug carefully to the patient's bedside. • Counter check the chemotherapy medicines in the bedside with assigned nurse.			

	• Pre-medicate the patient as per the doctor's order. • Connect the drug to the right patient using all rights of medication administration. • Monitor drops or ml per minute. • Assess the vital signs while chemotherapy is on flow. • Watch for any untoward reactions like nausea, vomiting, dyspnea, tachycardia, tachypnea, chest pain and allergic reaction. • Monitor for proper flow and complete the infusion on time.			
	Disposal • After infusion is complete, wrap the IV set in a purple cover and dispose. • Discard all the materials which have come into contact with the cytotoxic drugs (syringes, cotton, mask, apron, ampoules and vials) in a sealed black cover with adhesive. • Discard the needle in the sharp container. • Goggles, face shields, respiration are cleaned with mild detergents and are reused. • Wash hands.			
18.	**Documentation** • Document carefully and get the counter signature by the co-staff.			

Nursing instructor's signature: _____ Date: _____

Spill and hazard (body fluids after chemo) management (protocol)

Equipment Required:

Care of Spills Emergency procedures to cover spills or unintentional release of hazardous drugs should be included the hospital overall health and safety program. Incidental spills and breakages should be cleaned up immediately by a properly protected person trained in the appropriate procedures. The area should be identified with a warning sign to limit access to the area. Incident reports should be filled to document the spill and those exposed.

Checklist

Sr. #	Tasks	Yes	No	Comments
1.	**Personnel Contamination** • Contamination of protective equipment, clothing, a direct skin or eye contact should be treated by: • Immediately removing the gloves or gowns. • Immediately cleaning the affected skin with soap and water. • In case of eye exposure, washing the eye with water or isotonic eye wash for 15 minutes. • Obtaining medical attention. • Documenting the exposure in the employee's medical record			
2.	**Clean up of Small Spills** • Spill less than 5 ml is considered as small spill. • The 5ml volume of material should be used to categorize spills as large or small. • Liquids should be wiped with absorbent gauze pads; solids should be wiped with wet absorbent gauze. • The spill areas should be cleaned three times using a detergent solution followed by clean water. • Any broken glass fragments should be picked up using a small scoop and placed in a sharp container. • Glassware and scoops are treated as reusable items.			
3.	**Clean up of Large Spills** • When a large spill occurs, the area should be isolated and aerosol generation should be avoided. If powder is involved, damp clothes or towels should be used. • Protective devices including respirator should be used when there are small spills or any suspicion of airborne powder or aerosol will be generated. • Chemical inactivation should be avoided in this setting. • All contaminated surface should be thoroughly cleaned three times with detergent and water. • All contaminated absorbent sheets and other materials should be placed in the UD disposal bags.			

Nursing instructor's signature: _____ Date: _____

Blood culture collection/sampling (venous sampling, Arterial sampling)
BLOOD CULTURE

Equipment required:

- Mackintosh and towel.
- Surgical gloves.
- Surgical dressing packs to clean the skin over the vein.
- Surgical spirit and betadine solution.
- Disposable syringe 10 ml with needles.
- Culture bottles—3.
- Cotton swabs.
- Paper bag and K-basin.
- Tourniquet.

Checklist

S. No	Procedure	Yes	No	Comments
1.	**Verify the practitioner's order**			
2.	**Gather the appropriate equipment**			
3.	Choose the vein to be drawn by touching the skin before it has been disinfected.			
4.	**Cleanse the skin over the venipuncture site in a circle approximately 5 cm in diameter with 70 percent alcohol, rubbing vigorously.**			
5.	**Starting in the center of the circle, apply 2 percent iodine (or povidone-iodine).**			
6.	**Allow the iodine to remain on the skin for at least 1 minute.**			
7.	**Insert the needle into the vein and withdraw blood.**			
8.	**After the needle has been removed, the site should be cleansed with 70 percent alcohol again. Apply gentle pressure with cotton ball over the punctured site.**			
9.	**Transfer the blood in the syringe into the culture bottles.**			
10.	**Aftercare**			
11.	**Clean the culture bottle led with spirit swab.**			
12.	**Insert the needle and pour blood into culture bottle.**			
13.	**Mix the solution and blood gently by moving sideways.**			
14.	**Label the culture bottles and send immediately to the laboratories.**			
15.	**Replace the articles after cleaning.**			
16.	**Remove the gloves and wash hands thoroughly.**			
17.	**Record the procedure in the nurse's record sheet.**			

Nursing instructor's signature: _____ Date: _____

VENOUS SAMPLING

EQUIPMENT REQUIRED:

- Nonsterile gloves
- Additional PPE, as indicated
- Tourniquet
- Antimicrobial swab, such as chlorhexidine or alcohol
- Sterile needle, gauge appropriate to the vein and sampling needs, using the smallest possible
- Vacutainer needle adaptor
- Blood-collection tubes appropriate for ordered tests
- Appropriate label for specimen, based on facility policy and procedure
- Gauze pads (2x2)
- Adhesive bandage

CHECKLIST

Sr	Step	Yes	No	Remarks
1.	Verify the patient's identity using two identifiers (e.g., name and date of birth).			
2.	Perform hand hygiene and put on PPE, if indicated.			
3.	Explain the procedure to the patient.			
4.	Gather all equipment (e.g., gloves, tourniquet, alcohol swab and needle).			
5.	Assist the patient to a comfortable position, either sitting or lying.			
6.	Select an appropriate venipuncture site, avoiding contraindicated areas.			
7.	Apply a tourniquet 3-4 inches above the selected site. Apply sufficient pressure to impede venous circulation but not arterial blood flow.			
8.	Clean the selected site with an alcohol swab and allow it to dry.			
9.	Insert the needle into the vein at a 15-30 degree angle with the bevel facing up.			
10.	Remove the tourniquet as soon as blood flows adequately into the tube.			
11.	Collect the required amount of blood into the appropriate collection tubes.			
12.	Remove the needle and apply pressure to the site with a sterile gauze. Do not apply pressure to site until the needle has been fully removed.			
13.	After bleeding stops, apply an adhesive bandage.			
14.	Label the specimen tubes correctly at the bedside.			
15.	Dispose of the needle and other used materials in appropriate sharps and waste containers.			
16.	Remove gloves and perform hand hygiene.			

Nursing instructor's signature: _____ Date: _____

Arterial Blood Gases (ABGS)

Equipment Required:

- Sterile syringe and needle size 21G or smaller
- Heparin
- Ice in plastic bag
- Laboratory form
- Sterile gloves

Checklist

Sr. #	Tasks	Yes	No	Comments
10.	Explain procedure to the patient			
11.	Ensure that the laboratory form is complete and ice readily available before starting procedure.			
12.	Wash hands and put on gloves.			
13.	If the patient is on oxygen therapy, they must remain on constant for 20 minutes before taking the blood. If the test is done without oxygen , the oxygen must not give for 20 minutes before taking the blood			
14.	Arterial blood is normally taken from the radial artery. Alternatively, it can be taken from the dorsalis pedis, the brachial or the femoral artery.			
15.	The staff will put the heparinized syringe into the chosen artery at an angle of 45degree to the horizontal			
16.	After drawing the required amount of blood pressure must be applied to the for at least 2 minutes, 5-10 minutes in the case of the femoral or brachial artery.			
17.	The blood must be send to the laboratory in the bag of ice as soon as possible to obtain best results.			
18.	The patient should be made comfortable.			

Nursing instructor's signature: _____ Date: _____

Irrigation and instillation – bladder
Irrigation and instillation

Equipment:

- A sterile catheter of appropriate size
- Sterile gloves
- An antiseptic solution,
- Sterile lubricant
- A container for the solution to be instilled (for instillation)
- 60 ml catheter tip syringe
- Measuring container
- Normal saline
- Basin
- Drainage bag

Checklist

S. No	Procedure	Yes	No	Comments
1.	Wash hands.			
2.	Pour normal saline into measuring container.			
3.	Draw up 50-60mls of normal saline into syringe.			
4.	Catheterize per your normal routine and drain bladder contents in drainage bag. Leave catheter in place.			
5.	Attach syringe to end of catheter and gently push the normal saline into the bladder.			
6.	Gently pull back on the plunger of the syringe and draw the normal saline back out of the bladder, discard the normal saline into the basin.			
7.	If normal saline has a lot of mucous, repeat the irrigation process once or twice more using fresh normal saline to remove remaining mucous			
8.	If instructed to use the piston technique while irrigating, fill bladder with instructed amount of normal saline and then aspirate (pull out) 5-10ml of saline/urine contents, push back in and pull back out a few times quickly before drawing back the entire amount of bladder contents.			
9.	Pushing and pulling 5-10mls of normal saline quickly will stir up the mucous in the bladder, making it easier to aspirate (pull out).			
10.	Same procedure is used for instilation except medicine or instillation solution is not pulled out and kept in bladder			

Nursing instructor's signature: _____ Date: _____

Body Surface Area (BSA) calculation

Equipment:

- Weight Machine
- Height Scale
- Paper & Pen
- Calculator

Checklist

S. No	Procedure	Yes	No	Comments
1.	Gather Necessary Data: • **Height:** Measure height in centimeters (cm). • **Weight:** Measure weight in kilograms (kg).			
2.	Selected Formula: • BSA = {√ (height in cm x weight in kg) / 3600} • Calculation Step 1: Perform the initial multiplication (height x weight). • Calculation Step 2: Divide the result by 3600. • Calculation Step 3: Take the square root of the result.			
3.	Review and Verification: Double-check all measurements, calculations, and the final BSA value.			
4.	Accuracy: Ensures all necessary data is collected and calculations are performed correctly, minimizing errors.			
5.	Clarity: Provides a structured approach to the calculation process, making it easier to follow and review.			
6.	Consistency: Helps standardize the BSA calculation process, particularly when dealing with multiple patients or treatments.			

Nursing instructor's signature: _____ Date: _____

Operating machines for TPN, infusion and syringe pump

Equipment required:

- Infusion pump/syringe
- TPN bag
- IV pole
- Prescribed IV analgesia solution
- Sterile administration set
- Antiseptic pads
- Prefilled syringe with normal saline
- gloves

S. No	Procedure	Yes	No	Comments
1.	Verify that the patient has a central venous catheter with the tip terminating in the SVC.			
2.	Verify the order for TPN with the label on the TPN bag. Perform verification with two nurses if facility policy.			
3.	Remove the TPN from the refrigerator at least one hour per liter before administration.			
4.	Check MD order for appropriate lab orders.			
5.	Check MD order for 10% Dextrose order as backup in case TPN is not available.			
6.	Check MD order for appropriate flush order.			
7.	Perform hand hygiene and put on clean gloves.			
8.	Follow procedure for correctly adding ordered medications (vitamins, etc.) to the bag using Aseptic Non-Touch Technique (ANTT).			
9.	Explain procedure to patient.			
10.	Assemble appropriate administration set correctly. Label with date, time and initials.			
11.	Load and program pump correctly.			
12.	Disinfect needleless connector.			
13.	Attach flush syringe, aspirate for a blood return then flush the lumen to be used for TPN with 0.9% sodium chloride.			
14.	Disinfect needleless connector.			
15.	Attach administration tubing correctly to needleless connector on dedicated lumen of central venous catheter.			
16.	Open all clamps on administration tubing and catheter lumen being used for TPN. Begin infusion.			
17.	If using a multi-lumen catheter, clamp the lumens not being used.			
18.	Label TPN bag with date, time and initials.			
19.	Remove gloves and perform hand hygiene.			
20.	Document the procedure in patient’s chart and MAR according to policy.			

Operating machines for TPN, <u>SYRINGE PUMP</u>

S.	Procedure	Yes	No	Comments
10.	Washing hands and/or using personal protective equipment (PPE) as per local procedures			
11.	Reviewing equipment			
12.	Ensure that all equipment is available and serviceable and check that: • The device is clean and visually intact • The device is appropriate for the intended use • The syringe and extension set are appropriate and compatible for the device and the medicine delivery • The battery has sufficient charge and is fitted correctly.			
13.	Completing a 'Medicines added' label			
14.	• Patient name • Date of birth • ID number • Medicine(s) name(s) • Dose of each medicine • Diluent name • Total volume in mL • Date and time prepared • Initials of the individuals checking and preparing the syringe.			
15.	Preparing the syringe for loading			
16.	• Draw up medicine using a 30 mL Luer lock syringe, as prescribed • Fill the 30 mL syringe with 20 mL combined volume of diluent and medicine. • Place 'Medicines added' label on syringe, ensuring it does not interfere with the barrel clamp or obscure the measurement gradient.			
17.	Turning on NIKI T34TM syringe pump			
18.	• Hold down ON/OFF key • Allow pre-loading actuator movement to complete before loading syringe.			

Nursing instructor's signature: _____ Date: _____

Assistance in biopsy (Bone Marrow)

Equipment:

Bone Marrow tray including:

- **Sterile gauze or cotton balls**
- **Sterile forceps**
- **Sterile scalpel**
- **Sterile marker**
- **Antiseptic solution**
- **Two sterile fenestrated drapes**
- **Gauze pads (10cmx10cm)**
- **Two syringes (10ml)**
- **22G 1 or 2-inch needle**
- **Specimen bottle containing formaldehyde**
- **Bone Marrow needle**
- **Biopsy needle**
- **Glass slides and cover glass**
- **Sterile labels**
- **Adhesive tap**
- **Sterile gloves**
- **26 or 27 G needle**
- **Sterile pressure dressing**
- **PPEs**
- **70% isopropyl alcohol**
- **1% lidocaine with syringe and needle**
- **Laboratory biohazard transport bags**

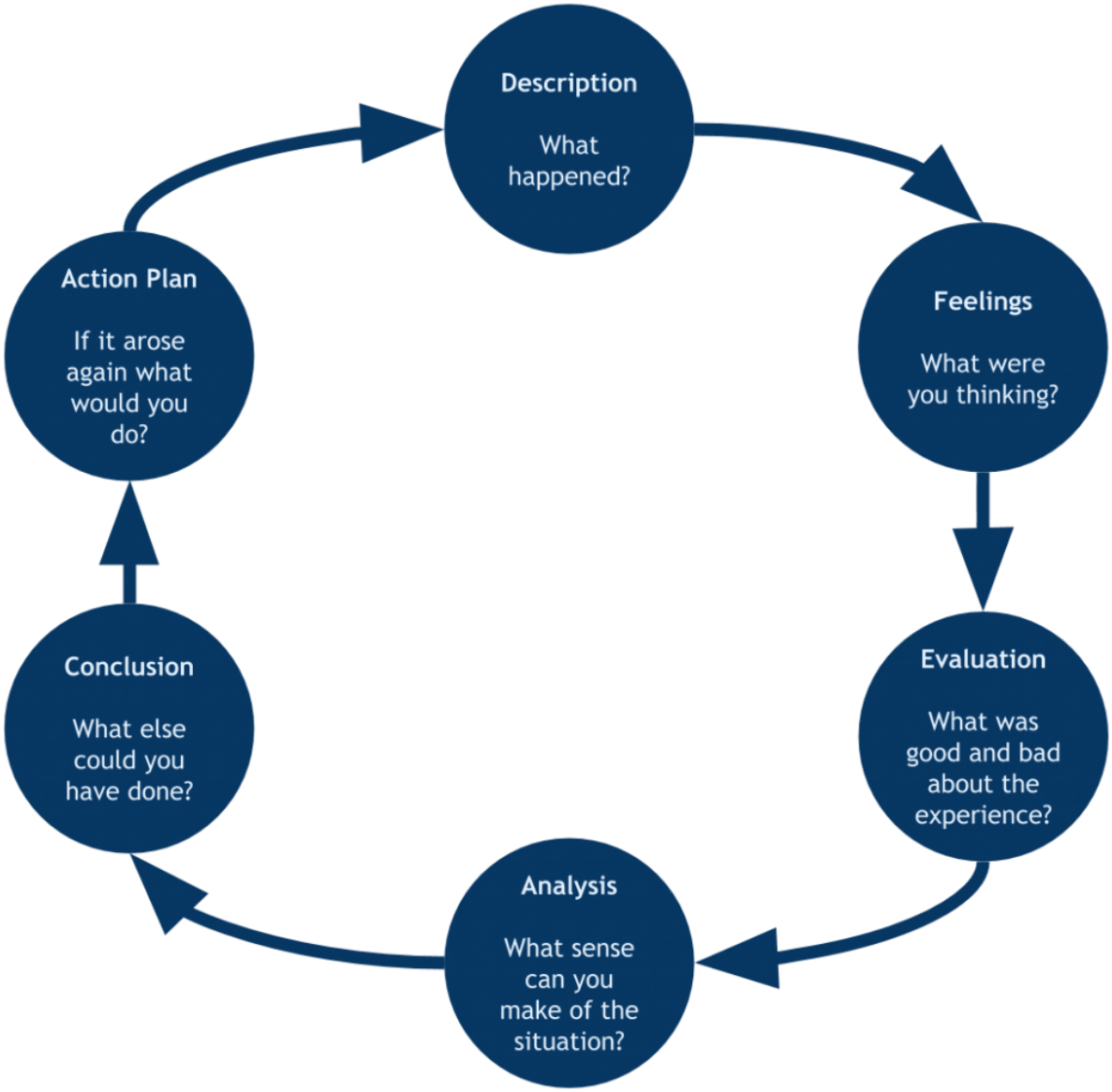
Checklist

S. No	Procedure	Yes	No	Comments
18.	**Verify the practitioner's order**			
19.	**Gather the appropriate equipment**			
20.	**Confirm the written informed consent from patient file**			
21.	**Check the patients history for hypersensitivity to the local aesthetic**			
22.	**Perform hand hygiene and put on PPEs**			
23.	**Inform the patient that procedure takes usually 20 minutes**			
24.	**Verify that the practitioner has marked the aspiration site.**			
25.	**The practitioner performed hand hygiene and put on PPEs**			
26.	**Administered a sedative as ordered, following safe medication administration practices**			
27.	**Prepare the sterile field, open the equipment tray and prepare the supplies**			
28.	**Position the patient according to the selected puncture site and instruct him to remain as still as possible**			
29.	**Using sterile forceps and sterile gauze, the practitioner cleans the puncture site with antiseptic solution and allows it to dry; then**			

	cover the area with sterile drapes			
30.	**To anesthetize the site, the practitioner infiltrates it with 1% lidocaine, using a 26 or 27G needle to inject a small amount intradermally and then a larger 22G needle to anesthetize the tissue down to the bone**			
31.	**When the needle tip reached the bone, the practitioner anesthetizes the periosteum by injecting a small amount of 1% lidocaine in a circular area about 2cm in diameter. He should withdraw the needle from the periosteum after each injection**			
32.	**After 1 minute for the lidocaine to take effect, the practitioner may use a scalpel to make a small stab incision in the patient's skin to accommodate the bone marrow needle**			
33.	**He inserts the bone marrow needle and lodges it firmly in the bone cortex. If the patient feels sharp pain instead of pressure when the needle first touches the bone, the practitioner probably inserted the needle outsize the anesthetized area. If this happen, the practitioner should withdraw the needle slightly and moved to the anesthetized area**			
34.	**The practitioner advances by applying an even, downward force with the heel of his hand or the palm, while twisting the needle back and forth slightly. A crackle sensation means that the needle has entered the bone marrow cavity**			
35.	**The practitioner removes the inner cannula attached the syringe to the needle, aspirate the required specimen (usually 3-5 ml) and withdraws the needle. Then he places the specimen on a glass slide and cover it with the cover glass**			
36.	**Label the specimen in the presence of the patient with proper name and date**			
37.	**After needle removal, apply pressure to the aspiration site with a gauze pad for 5 minutes to control bleeding. Then clean the area with alcohol to remove the antiseptic solution, dry the skin thoroughly with a gauze pad (10cm x10cm) and apply a sterile pressure dressing**			
38.	**Place the specimen in a laboratory biohazard transport bag and send it to the laboratory immediately**			
39.	**Disposed of used supplies properly**			
40.	**Remove and discard PPEs and perform hand hygiene**			
41.	**Document the procedure**			

Nursing instructor’s signature: _____ Date: _____

Reflection/ Critical Incident Analysis



Gibbs' Reflective Cycle 1998

CASE STUDY FORMAT

CXLV. INTRODUCTION

Background/scenario of the case.

CXLVI. BIOGRAPHIC DATA

Name

Address

Age

Gender

Race

Marital Status

Occupation

Religious orientation

Health care financing and usual source of medical care

CXLVII. CHIEF COMPLAINT OR REASON FOR VISIT

CXLVIII. NURSING HEALTH HISTORY

TT. History of Present Illness

UU. Past Medical History

ccc) Childhood diseases

ddd) Immunizations

eee) Allergies

fff) Accidents and injuries

ggg) Hospitalization

hhh) Medication

VV. Family History of Illness (use Genogram)

WW. Obstetric History (for OB cases only; with Assessment Guide)

XX. Developmental History (for Pediatric cases only; with Assessment Guide)

CXLIX. FUNCTIONAL HEALTH PATTERN (with guide questionnaire)

100. Health Perception and Health Management Pattern

101. Nutrition and Metabolic Pattern

102. Elimination Pattern

103. Activity-Exercised Pattern (use Barthel index)

104. Sleep-rest Pattern

105. Cognitive-perceptual Pattern
106. Self-perception and self-control Pattern
107. Role-relationship Pattern
108. Sexuality-reproductive Pattern
109. Coping-stress tolerance Pattern
110. Value-belief Pattern

Interpretation:

Analysis: (with reference)

CL. REVIEW OF SYSTEM (all subjective complaints)

CLI. PHYSICAL ASSESSMENT (all objective findings; indicate date performed; Head to Toe Assessment)

19. General Survey (Short Paragraph)
20. Vital Signs

BODY PART (Technique used)	NORMAL FINDINGS	ACTUAL FINDINGS	INTERPRETATION / ANALYSIS w/ Reference

CLII. ANATOMY & PHYSIOLOGY

CLIII. DIAGNOSTIC / LABORATORY STUDIES (Table)

NAME OF TEST / PROCEDURE	DATE DONE	INDICATION FOR THE TEST / PROCEDURE	NORMAL VALUE	ACTUAL RESULT / FINDINGS	SIGNIFICANCE OF THE RESULT / FINDINGS

CLIV. SURGICAL PROCEDURE (Operative worksheet, if any)

CLV. PATHOPHYSIOLOGY (Present in Schematic Diagram; Mind Mapping)

CLVI. DRUG STUDY / IV INFUSIONS, BLOOD TRANFUSIONS, TREAMENTS GIVEN

Drug Study

Drug Order (Generic, Name, Dosage, Route, Frequency)	Trade / Brand Name	Pharmacologic Action Of Drug	Indication And Contraindications	Adverse Effects Of The Drug	Desired Action On Your Client	Nursing Responsibilities / Precautions

Treatments Given

Treatment / Infusion	Classification	Indication	Contraindication	Nursing Responsibilities / Precautions

CLVII. COURSE IN THE WARD (narrative form)

- Summary of day to day medical/nursing management from the date of admission up to the time case study was done
- Patient's Status:
    a. General condition of the client (ex. LOC, VS, and other Subjective & Objective, complaint during the day)
    b. 4 D's with inference / analysis:
        - Diet
        - Drugs/IVF
        - Lab/Diagnostics procedure
        - Disposition

CLVIII. PRIORITIZED LIST OF NURSING PROBLEMS (Table)

- Prioritized using ABC's and Maslow's Hierarchy of Needs

Date	Nursing Problems Identified	Cues	Justification

CLIX. NURSING CARE PLAN

Assessment	Nursing Diagnosis	Planning	Implementation	Rationale	Evaluation

CLX. PROPOSED / DISCHARGE PLAN (to be submitted by students whose patients are for discharge)

- M - Medications to take at home
- E - Exercises
- T - Treatment
- H - Health Teachings
- O - Out - patient follow-up
- D - Diet
- S - Spiritual / Sexual activity (optional)

References:

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60. American Heart Association. (2020). Highlights of the 2020 American Heart Association's Guidelines for CPR and ECC.

61. Chellappan S, Sophia CJ, Jeyapal M. Protocol for Preparation and Administration of Chemotherapy. Ind J Holist Nurs 2018; 9(2): 12-15

Community Health Nursing-II Clinical – 03 CH

Course Description:

The course is designed to enable nurses Demonstrate the role of the community health nurse as a practitioner, researcher, educator and manager while participating in the health care of the community. Nurses will be able Participate in planning, implementing, and evaluating the Health / Developmental project with the community. Students nurses will be capable to utilize the concepts of Primary Health Care, Health Promotion, Epidemiology and planning cycle in health/ development project in community setting.

Clinical Rotation plan:

This semester will be of 16/22 weeks, the student nurse will go to clinical rotation (in block days) to observe, learn and perform skills under the supervision of clinical instructor.

Clinical Objectives:

- Analyze and demonstrated the role of a CHN in the Community.
- Apply the concepts of community participation and empowerment when addressing the specific health / developmental needs of the community.
- Complete community assessment and diagnosis including the identification of high risk groups, utilizing Gordon's Functional Health patterns and the principles of community participation.
- Collect, interpret, and apply health statistics.
- Develop and implement action plan relevant to the community's need.
- Evaluate interventional strategies and modify the action plan accordingly.
- Participate in field team activities at the PHC Centre etc.
- Identify and utilized available resources and NGO's working with in the Community, city, and country.
- Develop linkages between the PHC Centre and the community, NGO's, CBO's, etc. for the sustainability purpose.
- Complete a community health/development project based on the needs identified by the community.

Evaluation Criteria:

List of Contents	**%**	**Frequency**
Community clinical objectives form	05%	Weekly
Community health survey checklist	05%	1
Walking survey in community	05 %	1
Orientation report of community	05%	1
Primary health center report	05 %	1

Community survey assessment	10 %	1
House hold survey	10 %	2
Family folder	10 %	2
Nutritional assessment of under five children	10%	05
Preschool health assessment	10%	05
Health education plans with Health education criteria	10%	05
Community nursing care plans	10 %	05
Reflection/Critical Incident Analysis	05%	01

Community Clinical Objectives Form

Student Name: _____ Faculty: _____

Clinical placement: _____ Date: _____

Clinical Objectives	Strategies	Evaluation

Community Health Survey Checklist

Sr.	Health Survey Checklist	Need to improve	Satisfactory
41.	**Preparation for Survey**		
42.	Has the community area to be surveyed been clearly identified?		
43.	Has the necessary equipment (pen, paper, recording devices) been prepared?		
44.	Has the safety and comfort of participants been ensured?		
45.	Has the purpose and objectives of the survey been reviewed with the students?		
46.	**Observations of Community Health and Living Conditions**		
47.	Are there signs of poor housing (e.g., dilapidated homes, overcrowding)?		
48.	Is homelessness or inadequate shelter visible in the community?		
49.	Are roads and streets well-maintained, or are there signs of disrepair?		
50.	Is the community exposed to any visible environmental hazards (e.g., pollution, open waste)?		
51.	Is waste disposal and garbage management adequate in the area?		
52.	**Environmental Health Conditions**		
53.	Are there green spaces, parks, or recreational areas available?		
54.	Is there access to clean drinking water in the community?		
55.	Is sewage treatment and waste management visible or operational?		

56.	Are there signs of environmental pollution such as air or water quality issues?		
57.	**Community Resources**		
58.	Are healthcare facilities (e.g., clinics, pharmacies) accessible and available?		
59.	Are there schools, community centers, or other public service resources available?		
60.	Are there sufficient food stores and essential services in the community?		
61.	Is there access to public transportation?		
62.	**Safety and Security**		
63.	Are there visible signs of crime, such as vandalism or abandoned vehicles?		
64.	Are safety measures such as street lighting or community policing visible in the community?		
65.	Does the general atmosphere in the community appear safe and secure?		
66.	**Social and Economic Indicators**		
67.	Is there evidence of economic disparity (e.g., wealthy vs. impoverished areas)?		
68.	Are there visible signs of poverty (e.g., neglected areas, poor housing)?		
69.	Are there employment or economic opportunities in the community?		
70.	**Health Indicators**		
71.	Are there visible health concerns affecting the community (e.g., respiratory issues, obesity)?		
72.	Are health education programs or screenings available in the community?		
73.	Is there access to preventive health services (e.g., vaccinations, maternal care)?		
74.	**Reflection on Survey Findings**		

75.	Are key strengths of the community identified (e.g., strong community involvement, well-maintained facilities)?		
76.	Are weaknesses or areas in need of improvement identified?		
77.	Are recommendations for improving community health and well-being proposed based on the survey findings?		
78.	**Conclusion and Next Steps**		
79.	Have the major findings from the survey been summarized?		
80.	Have suggestions for future health programs or interventions been made?		

Faculty comments:

Walking Survey in a Community

Sr.	Task	Yes	No	Comments
9.	**Preparation for Survey**			
	• Has the community for the walking survey been clearly identified?	☐	☐	
	• Are the necessary materials (survey forms, pen, paper) ready for the survey?	☐	☐	
	• Have safety protocols and guidelines for walking surveys been reviewed?	☐	☐	
10.	**Community Observations**			
	• Are there signs of poor housing or overcrowded living conditions?	☐	☐	
	• Are there any visible environmental health risks (e.g., pollution, waste)?	☐	☐	
	• Is the neighborhood well-maintained, with clean streets and public areas?	☐	☐	
	• Are there signs of poverty or economic disparity in the community?	☐	☐	
11.	**Health Conditions and Resources**			
	• Are there any visible health concerns affecting the community (e.g., smoking, obesity)?	☐	☐	
	• Are there accessible health facilities such as clinics, pharmacies, or healthcare workers?	☐	☐	
	• Are there any community programs or resources aimed at improving health?	☐	☐	
12.	**Safety and Security**			
	• Is the community generally safe for residents, with adequate street lighting and public safety measures?	☐	☐	
	• Are there any visible signs of crime or unsafe areas in the community?	☐	☐	
13.	**Social and Environmental Factors**			
	• Are there visible environmental hazards that may affect health (e.g., waste, standing water)?	☐	☐	
	• Are social problems like drug use, alcohol consumption, or homelessness visible in the community?	☐	☐	
14.	**Community Engagement and Health Education**			
	• Are there visible efforts for community health education (e.g., health workshops, awareness campaigns)?	☐	☐	

	• Are community members actively involved in health-promoting activities?	☐	☐	
	• Are health education materials such as posters or pamphlets visible in the community?	☐	☐	
15.	**Environmental Health and Hygiene**			
	• Is there visible access to clean water and proper sanitation facilities?	☐	☐	
	• Are waste management practices apparent and functioning well in the community?	☐	☐	
	• Are there adequate recreational spaces, parks, or green areas?	☐	☐	
16.	**Reflection and Recommendations**			
	• Have the community strengths and assets been identified (e.g., active participation, health resources)?	☐	☐	
	• Have areas for improvement been identified, such as poor sanitation or lack of healthcare access?	☐	☐	
	• Have recommendations for improving community health been proposed (e.g., better sanitation, health education)?	☐	☐	

Nursing instructor's signature: _____ Date: _____

Orientation Report of Community

Time Schedule and Introduction of Orientation

Members of Group

Number of Groups

Getting Permission from Medical Officer

Distance from college to PHC, PHC to Village

Identification of PHC and Rout Map of PHC

_____
_____
_____
_____
_____
_____

Total number of House

_____
_____
_____
_____
_____
_____
_____

Total Population

_____
_____
_____
_____
_____
_____

Area

_____
_____
_____

Landmarks

_____
_____
_____

Specify the Religion Places

_____
_____
_____
_____
_____
_____

Area Map

_____

Signature of Clinical Instructor

Date:

Primary Health Center Report

Introduction

Name of Primary Health center (PHC)

Function of PHC

Staffing Pattern in PHC

Special Days in PHC

Drugs and Equipment Supplies in PHC

_____
_____

Floor Map

_____
Signature of Clinical Instructor
Date:

Note: During posting, students are observed that they have to write the observation as a PHC report.

Community Survey Assessment

Identification Data

1. Name of the area: Rural/Urban : _____
2. House Number : _____
3. Name of the Health Center :_____
4. Name of the Head of the Family : _____
5. Family Identification : _____

a. Total number of members in the family : _____

Type of family: Nuclear/
Non-nuclear (joint, extended) : _____

b. Religion : Hindu:_____ Muslim:_____ Christian:____
:Others: _____

c. Specify Sub caste : _____
d. Language Known :_____
e. Statement of expenditure in the Family:

Items	Amount Spent	Expenditure %	Items	Amount Spent	Expenditure %
Food			Food		
House rent			House rent		
Children Education			Children Education		
Smoking or liquor			Smoking or liquor		
Saving			Saving		

6. Housing Condition

a. Type of house: :_____

Kutcha: _____Pucca: _____Semipucca:_____

b. Living Room

Number: _____Adequate:_____Inadequate:_____

c. Occupancy: :_____

Tenant: _____Owner:_____Monthly Rent:_____

d. Ventilation: :_____

Adequate: _____Inadequate:_____ No Ventilation: _____

e. Source of lighting:

Electricity: _____ _____Kerosene:_____ Other (Specify)

f. Water supply:

Tube well: _____ Dug Well: _____ Lake:_____ Pond:_____

Municipality water: _____ others: _____

g. **Kitchen condition**:

Separate: _____ Corner of the House: _____ Veranda:_____

h. **Deposal of Waste**:

Open dumping: _____Incineration: _____ Manure pits:_____ Other:_____

i: Sullage water disposal:

Open drainage: _____ Closed drainage: _____ Soakage Pit: _____Kitchen garden: ____

ii. Refuse disposal:

Indiscriminate throwing: _____ Garbage:_____ Composting: _____

Burning: _____ Municipal Collection: _____ Dumping: _____

iii: Excreta disposal:

Open air defecation: _____ Separate Latrine: _____ Shared Latrine: _____

Public toilet:_____

7. Family profile:

S#	Name of the Family members	Relation with head	Age in year	sex	Education	Occupation	Income	Remarks on Health
1								
2								
3								
4								
5								
6								
7								

a. Total family income per month/year:

8. Transport and communication

a. Transport:

Own tempo/tractor

Use of BMTC/KSRTC/Private bus:

Any other

b. Communication:

Telephone

Television

Radio

Newspaper/Magazine

Post and telegraph

8. Dietary pattern:

Food	Foods used	Food preparation and storage		
		Traditional	Ideal	Unhygienic
Rice				
Ragi				
Jowar				
Wheat				
Vegetables				
Fish				
Meat				
Egg				
Milk and Milk product				
Pulses				
Tubers				
Any other (specify)				

Nutrition Status:

Name	Weight (kg)	Height (cm)	Body built				BMI(normal 19-25)		
			Thin	Moderate	Well	Obese	Below normal	Normal	Above Normal

a. Nutrition Deficiency

Anemia: _____ Goiter: _____ Night Blindness: _____ Scurvy: _____

Rickets: _____ Others: _____

11. Is there any Fever Cases? If yes, write Name, age, treatment with Remarks.
    a. With rigors
    b. With Cough
    c. With rash

S#	Name	Age	Discuss	Treatment	Remarks

12. Does any have any skin disease (e.g. itching, patch, rash)?

S#	Name	Age	Discuss	Treatment	Remarks

13. Does anyone have cough for more than 1 week?

S#	Name	Age	Discuss	Treatment	Remarks

14. Does anyone have any other illness?

S#	Name	Age	Discuss	Treatment	Remarks

15. Is there any Pregnant Women? If yes, write the following with Remarks.
    a. Specify gravida
    b. Has she been registered?
    c. Is she getting iron and folic acid treatment/drugs?
    d. Has she been vaccinated tetanus with toxoid?

S#	Name	Age	Discuss	Treatment	Remarks

16. Have there been any (within year) _____ vital statistics?
    a. Birth

S#	Name	Age	Discuss	Treatment	Remarks

b. Death

S#	Name	Age	Discuss	Treatment	Remarks

C. Marriages

S#	Name	Age	Discuss	Treatment	Remarks

17. Are there any children below 5 years who have not received immunization?
(Specify name, age, reason for not immunization in remarks)

a. BCG vaccination.
b. DPT vaccination
c. Poliomyelitis vaccination
d. Measles vaccination
e. Vitamin A solution

S#	Name	age	Sex	BCG	DPT 1	DPT 2	DPT 3	poliomyelitis	Measles	Vit. A

18. Presence of the following

a. Mosquitoes: _____ House fly: _____

b. Stary dogs: _____ Dogs: _____ Cats: _____

c. Accidental place environment

Sharp stone: _____Slippery floor: _____Stones: _____

Open drainage: _____ others: _____

_____

Signature of Clinical Instructor

Date:

House hold survey

Identification data

House number: _____

Name of the village: _____

Name of the street: _____

Name of the head of the family:

_____

Name of the informer: _____

Religion: _____

Cast: _____

Type of family: _____

Economic status: _____

Environmental sanitation: _____

Water supply: Adequate/ Inadequate

Mode of water supply: tank/Well/Hand pump

Water source: Protected/Unprotected

Refuse disposal: open dumpling/Burning/Manure pit

Waste water disposal: _____

Stagnation: Yes/No: _____

If yes, mention type: _____

Excreta disposal: _____

Latrine: yes/No: _____

If yes, type: _____

Particulars of the household member

Age	Sex	Marital status	Educational status	Occupational status	Income	Residential status	Health status	Remarks

SR#	Name of the family members	Relation with the head of the family
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Birth status

SR#	Name of the child /parent	Date of birth	Sex	Place of birth	Whether registered	Delivery conducted from	Health status of the child	Remarks
1.								
2.								
3.								
4.								
5.								

Death status

SL NO	Name of the deceased	Age	Sex	Date of death	Place of death	Whether registered	Cause of death	Remarks
1.								
2.								
3.								
4.								

Family welfare – maternal and child birth

S R #	Name of the eligible couple	Age at marriage/ whether registered	Number of prognancy/ pregnanc	Type of delivery	Infantalive / dead	Age of the infant	Sex of the infant	Birth weight of the infant	Term / abortion	Any congenital deformities	Remarks

_____

Signature of Clinical Instructor
Date:

Family Folder

Identification Data

Name of the area: Rural/Urban:
_____
House number:
_____
Name of the health center:
_____
Name of the head of the family:
_____
Family identification:
_____
Total number of members in the family:
_____
Type of family: Nuclear/Non-nuclear (joint, extended):
_____
Religion: Hindu: _____ Muslim: _____ Christian: _____
Others: _____
Specify subcaste:
_____
Languages known:
_____
Name of the informer:
_____
Age:
_____
___
Sex:
_____
____
Address:
_____

_____
__

Educational status:
_____
Occupational status:
_____
Income of the family: Rs.
_____/month

Family Composition

Sr/ No	Name of the family members	Age	Sex	Relationship with head of the family	Educational status	Occupational status	Health status
1							

Sr/ No	Name of the family members	Age	Sex	Relationship with head of the family	Educational status	Occupational status	Health status
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

Immunization

Immunization Chart

Sl No	Immunization schedule	Due date	Given date	Weight of infant/child	Advice
1	At birth: BCG, OPV				
2	45 day: DPT, OPV 1st				
3	75 day: DPT, OPV 2nd				
4	105 day: DPT, OPV 3rd				
5	9-10 month: measles				
6	18 month: DPT, OPV booster dose				
7	5 year: DPT, OPV				
8	10 year: TT				
9	Optional vaccines				
10					
11					

Past History of Illness

_____
_____
_____
_____
_____
_____
_____

Present complain

_____
_____
_____
_____
_____
_____
_____

List out the problems and needs

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Problem/ Needs Objective Implementation Rationale Evaluation

Nutritional Assessment of Under-five Children

Identification Data

Name of the village/area :_____
House number :_____
Name of the family head :_____
Age : _____
Sex :_____
Educational status : _____
Occupational status : _____
Address : _____
_____

Common cooking method Steaming Boiling Deep or shallow frying
Preparation of food Hygienic/Unhygienic
Commonly consuming food items
:_____

_____

Particulars of Parents

S.No	Name of the parents	Age	Sex	Education	Occupation	Remarks
1.						
2.						

Number of living children

Name of the children	Order of live birth	Date of birth	Age	Sex	Education

Anthropometric Measurements

Weight (kg):_____

Height or length (cm): _____

Head circumference (cm): _____

Chest circumference (cm):_____

Mid circumference (cm): _____

Degree of Malnutrition

_____
_____
_____

_____
_____
_____

Body Mass Index

_____
_____
_____
_____
_____
_____
_____
_____

Growth Chart

Twenty Four-hour Dietary Recall Survey

Name of the area

District

Religion

Total number of family members

Family income

Family Characteristics

S.No	Name	age	Occupation			Vegetarian	Non vegetarian
			Sedentary	Moderate	Hard		
1.							
2.							

3.
4.
5.
6.

Purchase of Raw Material and Their Expenditure Per Day

Items	How often Purchasing?			Monthly	Seasonally	Quantity	Expenditure per day
	Daily	Biweekly	Weekly				
Cereal							
Pulses							
Milk							
Fruits							
Vegetable							
Jaggrey							
Sugar							
Ghee							
Oil							
Egg							
Meat							
Fish							

Shopping facilities: Market Village shop/Sunday market/Any other forms
Preservation of raw food: Store room/Kitchen/No store/Living room
Preservation of cooked food: Refrigerator/Cupboard/Kitchen
Fuel used for cooking: Cooking gas/Electrical stove/Firewood/Kerosene stove

Do You Have

Vegetable garden: _____
Fruit tree: _____

Household Animals

Cow:_____
Buffalo:_____
Hen:_____
Goat: _____

Food Record:

Items per day	Items in Gram							Average daily intake	Category
	1	2	3	4	5	6	7		
Wheat									
Rice									
Jowar									
Bajra									
Others									
Toor daal									
Arhar									
Urad									
Moong									

Green Gram
Ground nuts
others
Milk
cured
Buttermilk
others
Oil
Ghee
Dalda
Leafy Vegetable
Roots/tubers
others
Tea
Coffee
others
Sugar
Jaggery
Meat
Fish
Egg
Banana
Orange
Papaya
Pineapple
Grapes
Apple
Guava
others

Inference

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Preschool Health Assessment

Identification Data
Name of the child
:_____
Sex
:_____
Date of birth
:_____
Mode of delivery
:_____
Place of birth
:_____
Condition of birth
:_____
Type of births
:_____
Birth weight
:_____
Name of the mother
:_____
Name of the father
:_____
Educational Status
Father :
_____
Mother
:_____
Occupational Status
Father
:_____
Mother
:_____
Family income
:_____
Address
:_____

_____

Growth and Development

S.No	Milestone	Actual development	Child's development
1.	Holds head erect	6th Month	
2.	Sits with support	6th Month	
3.	Crawling	9th Month	
4.	Turns over	9th Month	
5.	Stands with support	14th Month	
6.	Walk with support	16th Month	
7.	Walk without support	18th Month	
8.	Runs	19th Month	

9.	Brushes Tooth	24th Month
10	Washes self	24th Month
11	Dresses self	30th Month
12	Feeds self	36th Month
13	Talks sentence	40th Month

Physical Examination

General appearance

Nourishment :_____

Body build :_____

Health :_____

Activity :_____

Mental status :_____

Consciousness :_____

Look :_____

Vital signs

Temperature :_____

Pulse :_____

Respiration :_____

Blood pressure :_____

Anthropometric measurements

Height or length (cm) :_____

Weight (kg) :_____

Head circumference (cm):_____

Chest circumference (cm)_____

Midarm circumference (cm)_____

Body mass index (BMI):_____

Skin condition _____

Color : _____

Texture : _____

Temperature : _____

Lesion; _____

Sensation: _____

Head and face

Scalp : _____
Face : _____
Color of hair : _____

Eyes

Eyebrows : _____
Eyelashes : _____
Eyelids : _____
Eyeballs : _____
Conjunctiva : _____
Lens : _____
Vision: _____

Nose

External nose :

_____
Nostrils: _____
Nasal septum : _____

Ears

External ear: _____
Tympanic membrane:

_____
Hearing acuity :

_____

Mouth

Lips : _____
Odor: _____
Teeth: _____
Tongue : _____
Speech: _____

Chest

Inspection: _____
Palpation: _____
Percussion: _____
Auscultation: _____

Abdomen

Inspection: _____
Palpation: _____
Auscultation: _____
Percussion: _____

Genitalia

Back (Vertebral column):

_____
Impression : _____

Immunization

S.No	Age	Vaccine	Give on	Remarks

Inference

_____
_____
_____
_____
_____
____

Conclusion

_____
_____
_____
_____
_____
_____

_____
Signature of Clinical Instructor
Date:

Health Education

Identification Data

Name of the student: _____

Topic: _____

Method of teaching: _____

Audio-visual aids: _____

Duration: _____

Place: _____

Date: _____

Focus group: _____

Needs of Education

_____

_____

_____

_____

_____

_____

_____

_____

Objectives of Education

_____

_____

_____

_____

_____

_____

_____

Health Education format

Time	Goal/objectives	Activities Teacher	Client	Audio/video aids	Methods of teaching	Evaluation

_____

Clinical instructor signature
Date:

Evaluation Proforma for Health Education

Name of the student: _____

Date and time: _____

Topic: _____

Community area: _____

Name of the Clinical Instructor: _____

Sr #	Criteria	Excellent	Very good	Average	Poor	Very poor
		5	4	3	2	1
1	**Content:**					
	a. Relevant					
	b. Adequate					
	c. Organization					
	d. Depth of knowledge					
	e. Recent advancement					
2	**Presentation:**					
	a. Voice audible					
	b. Clarity					
	c. Modulation					
	d. Confidence					
	e. Posture language					
	f. Motivated					
	g. Group participation					
	h. Feedback					
3	**Audio-visual aids:**					
	a. Appropriate					
	b. Preparation					
	c. Visibility					
	d. Proper usage					
	e. Follow principles					
	f. Replace of material					
	g. Time management					

Total

Comments

_____

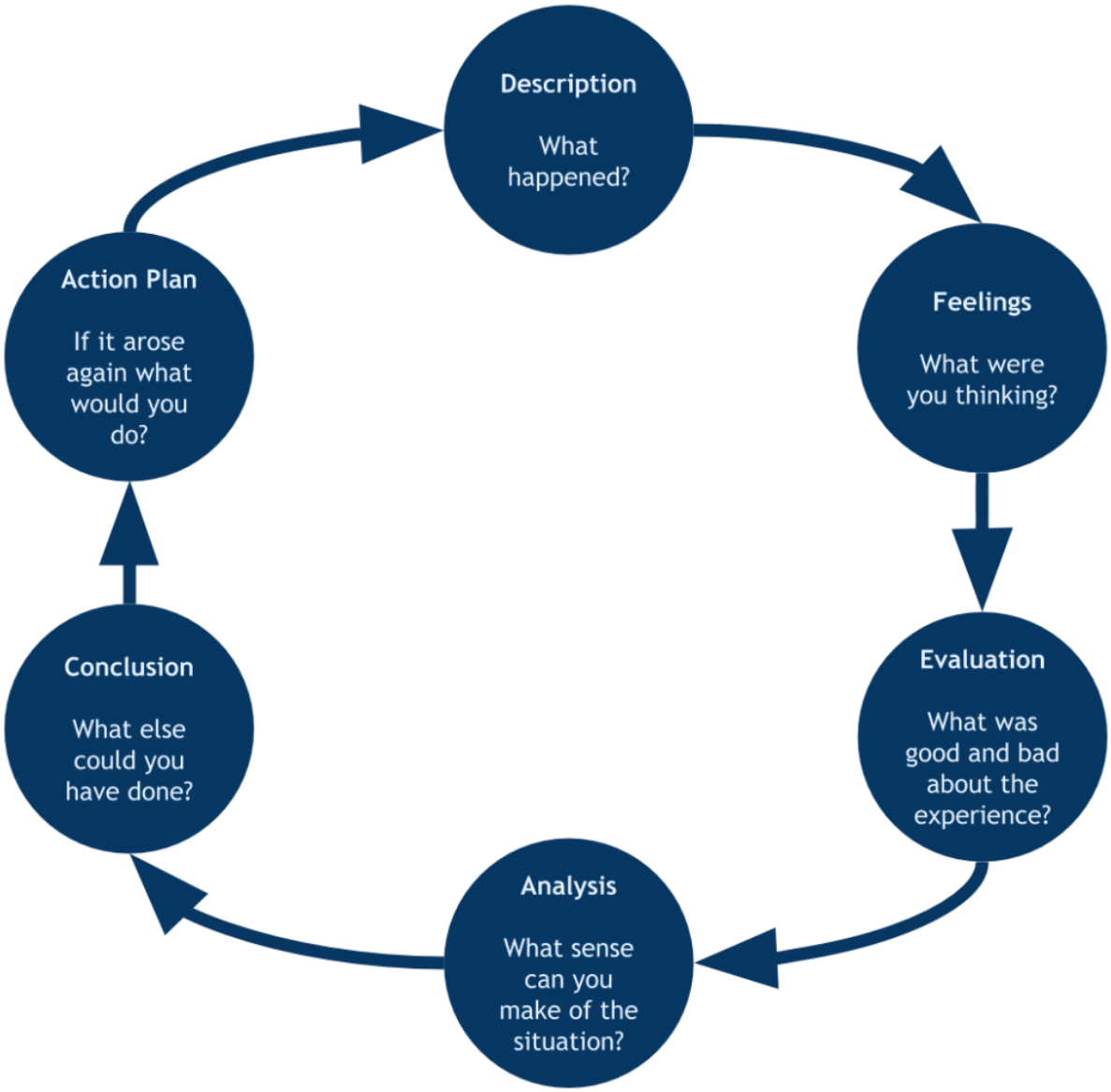
Signature of the Clinical Instructor

Date:

Nursing Care Plan

Assessment	Nursing Diagnosis	Goal	Planning	Implementation	Rationale	Evaluation
Subjective Data Objective Data						

Reflection/ Critical Incident Analysis



Gibbs' Reflective Cycle 1998

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