T Rajarathnam's

Quick Reference and Record of Clinical Experience

for BSc and GNM Students

Name of the Candidate: _____

Name of the Institution: _____

_____

Revised by
Sujatha Atri

4th Edition

JAYPEE

Contents

T Rajarathnam's

Quick Reference and Record of Clinical Experience for BSc and GNM Students

Student Identification

Name of the Student (in Block Letters) : .....

Register No. : .....

Age and Date of Birth : .....

Year : .....

Passport size photograph

Date of Joining the Course : .....

Name and Address of the Institution : .....

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Name of the Hospital/Nursing Home (Clinical Practice Attended) : .....

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Signature of Student	Signature of Class Coordinator	Signature of HOD	Signature of Principal
Date:	Date:	Date:	Date:

PERSONAL DATA

Name: .....

Blood Group: .....

Course: .....

Year: .....

Institute and Address: .....

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Permanent Address: .....

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Bank Account: .....

Any Other: .....

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Assignments/Projects given to Student

Sl. No.	Assignment	Patient Name and IPD No./Ward	Diagnosis/Topic	Signature of Faculty

Signature of HOD **Signature of Subject Coordinator** **Signature of Principal**

Department of _____

CALENDAR – 2024

JANUARY

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FEBRUARY

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SEPTEMBER

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DECEMBER

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CALENDAR – 2025

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CALENDAR – 2026

JANUARY

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CALENDAR – 2027

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THEORY CLASS TIME TABLE

Monday					**LUNCH BREAK**			
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								

THEORY CLASS TIME TABLE

Monday					**LUNCH BREAK**			
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								

CLINICAL ROTATION FIRST YEAR

Date	Duration	Area	Unit/Ward

CLINICAL ROTATION SECOND YEAR

Date	Duration	Area	Unit/Ward

CLINICAL ROTATION THIRD YEAR

Date	Duration	Area	Unit/Ward

CLINICAL ROTATION FOURTH YEAR

Date	Duration	Area	Unit/Ward

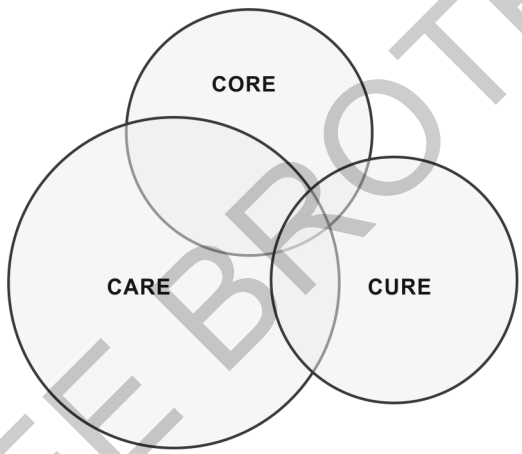
NURSING DEFINITIONS

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible.

Virginia Henderson

According to the American Nurses Association, "Nursing practice is a direct service, goal directed and adaptable to the needs of the individual, the family and community during health and illness".

Nursing is also defined as, "A dynamic, therapeutic and educative process in meeting the health needs of the individual, family and society".



LYDIA HALL'S MODEL OF NURSING PRACTICE

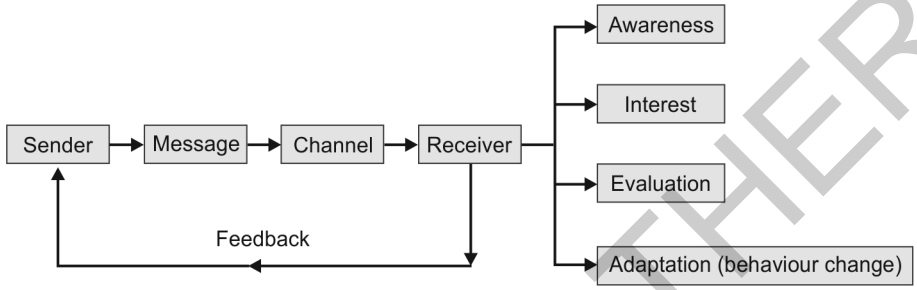
TECHNIQUES THAT FACILITATE COMMUNICATION

Technique	Description
Silence	Refraining from speech to give the client (and the nurse) time to sort out thoughts and feelings.
Self-disclosure	Sharing personal information at an opportune moment to convey understanding.
Suggestion	Posting alternatives for client consideration.
Confrontation	Acknowledging discrepancies in the client's verbal and non-verbal behaviours calling attention to evasions, distortions, smoke screens and game playing.
Concreteness	Clarifying the meaning of the client's communication; being clear, direct, and to the point.
Genuineness	Giving honest feedback when the client is ready; acting in a congruent manner with the client.
Immediacy	Acknowledging what is occurring between the nurse and the client as it happens.
Empathy	Experiencing another's feelings temporarily.
Respect	Conveying openness, a non-jugemental attitude, and a desire to hear what the client has to say.
Reflection	Paraphrasing what the client has said.
Broad opening	Using a general statement or question to encourage the client to set the direction for the session.
Restating	Repeating what the client has said to indicate that the nurse is listening and interested; may encourage the client to elaborate.
Focusing	Assisting the client to explore a specific topic.

COMMUNICATION PROCESS

Communication is the basis of human interaction in a complex process. It has the following main components.

- Sender (source)
- Receiver (audience)
- Message (content)
- Channels (medium)
- Feedback (effect)



Types of Communication

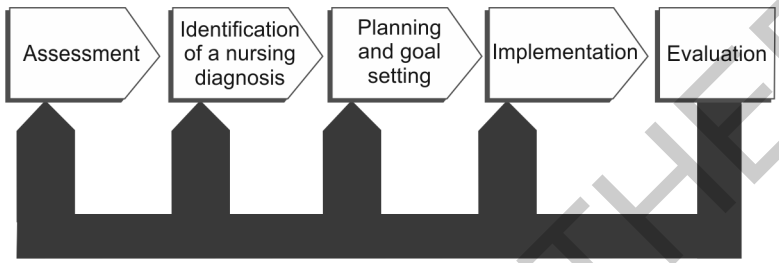
- One way communication
- Two way communication
- Verbal communication
- Nonverbal communication
- Formal and informed communication
- Visual communication
- Telecommunication and internet

THE NURSING PROCESS

INTRODUCTION

The nursing process—a scientific, systematic method of problem solving—forms the organising framework for effective nursing practice. Using the nursing process in an ongoing, dynamic and interactive manner with the client assures the client of a scientific approach to and continuous monitoring of, all the nursing care received (see Steps of the Nursing Process).

The following five steps make up the nursing process.



STEPS OF THE NURSING PROCESS

The nurse proceeds through the five steps of the nursing process, moving from assessment to evaluation. Depending on the evaluation findings, the nurse may update or change any of the previous steps.

Assessment

This initial phase of the nursing process involves collecting data and establishing a comprehensive data base. The nurse records subjective and objective data, including diagnostic test results.

Identification of a Nursing Diagnosis

The next step in the nursing process begins with data analysis which leads to identifying specific client needs and establishing nursing diagnosis according to a prescribed format and nomenclature.

Planning and Goal Setting

After analysing data and establishing nursing diagnosis, the nurse plans how to solve client problems according to their priority, identifying goals or client outcomes to measure the effectiveness of nursing actions. Goal setting ideally is mutual activity performed by the nurse and the client.

Implementation

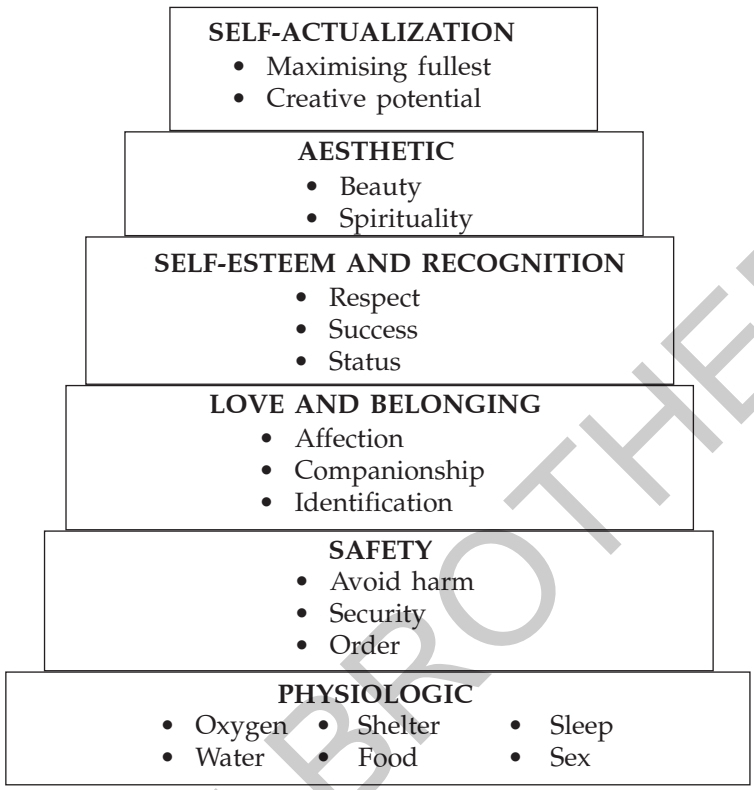
This fourth phase involves nursing actions based on the plans that have been established to achieve the desired client outcomes. Implementation includes everything a nurse does

to meet client's needs, such as health teaching, administering treatments and medications, providing support and comfort to the client and family, documenting all client care, and, as necessary, compensating for the client's inability to perform certain activities. Implementation implies that the nurse understands the rationale for all nursing actions.

Evaluation

The last phase of the nursing process, evaluation, focuses on the effectiveness of care the client receives, with a review of the extent to which the nursing process has met its goals. For goals achieved, no further action is necessary. For unmet goals, the nurse adjusts strategies at the appropriate phase to meet client needs.

MASLOW'S HIERARCHY OF NEEDS



NURSING PRINCIPLES

- *Principle of individuality:* It is to consider the needs and problems of a particular patient when a procedure is being done.
- *Principle of safety:* Prevention of mechanical, thermal, chemical and bacteriological injuries to the patient and workers and protection from all nuisance.
- *Principle of comfort:* To provide comfort and give satisfaction to the patient and the workers.
- *Principle of economy:* It implies the right use of time, energy and material.
- *Therapeutic effectiveness:* It is to achieve the purpose for which a procedure is done.
- *Good workmanship:* It is the art of doing.

STEPS INVOLVED IN NURSING PROCEDURE

- Preparation of the articles.
- Preparation of the patient.
- Performance of the procedure.
- Aftercare of the patient.
- Aftercare of the articles.
- Recording and reporting.

MEANING OF HEALTH EDUCATION

Health education is a process that informs, motivates and helps people to adapt and maintain healthy practices, lifestyle and advocates environmental changes.

- WHO in its constitution states that 'Health education is the extension to all people of the benefit of Medical, Psychological and related knowledge is essential to the fullest attainment of health'.
- Health education is the process by which individuals and groups of people learn to behave in a conducive manner to the promotion, maintenance or restoration of health.
- Any combination of learning opportunities and teaching activities designed to facilitate voluntary adaptations of behavior that are conducive to health.

NURSING DIAGNOSES

Approved by North American Nursing Diagnosis Association (NANDA)

Activity Intolerance
Activity Intolerance, High-risk for
Adjustment, Impaired
Airway Clearance, Ineffective
Anxiety
Aspiration, High-risk for
Body Image Disturbance
Body Temperature, High-risk for Altered
Breastfeeding, Effective
Breastfeeding, Ineffective
Breathing Pattern, Ineffective
Communication, Impaired Verbal
Constipation
Constipation, Colonic
Constipation, Perceived
Decisional Conflict (specify)
Decreased Cardiac Output
Defensive Coping
Denial, Ineffective
Diarrhoea
Disuse Syndrome, High-risk for
Diversional Activity Deficit
Dysreflexia
Family Coping, Compromised, Ineffective
Family Coping, Disabling, Ineffective
Family Coping: Potential for Growth
Family Processes, Altered
Fatigue
Fear
Fluid Volume Deficit, High-risk for
Fluid Volume Excess
Gas Exchange, Impaired
Grieving, Anticipatory
Grieving, Dysfunctional
Growth and Development, Altered
Health Maintenance, Altered
Health-Seeking Behaviours (Specify)
Home Maintenance Management, Impaired
Hopelessness
Hyperthermia
Hypothermia
Incontinence, Bowel
Incontinence, Functional
Incontinence, Reflex
Incontinence, Stress
Incontinence, Total
Incontinence, Urge
Individual Coping, Ineffective
Infection, High-risk for
Injury
Knowledge Deficit (Specify)
Noncompliance (Specify)
Nutrition: Less than Body Requirement, Altered
Nutrition: More than Body Requirements, Altered
Nutrition: Potential for More than Body
Requirements, Altered
Oral Mucous Membrane, Altered
Pain
Pain, Chronic
Parental Role Conflict
Parenting, Altered
Parenting, High-risk for Altered
Personal Identity Disturbance
Physical Mobility, Impaired
Poisoning, High-risk for
Post-trauma Response
Powerlessness
Protection, Altered
Rape-Trauma Syndrome: Compound Reaction
Rape-Trauma Syndrome: Silent
Reaction
Role Performance, Altered
Self-care Deficit, Bathing/Hygiene

Self-care Deficit, Feeding
Self-care Deficit, Dressing/Grooming
Self-care Deficit, Toileting
Self-esteem, Chronic Low
Self-esteem Disturbance
Sensory/Perceptual Alterations (Specify) (Visual, auditory, kinesthetic, gustatory, tactile, olfactory)
Sexual Dysfunction
Sexuality Patterns, Altered
Skin Integrity, Impaired
Skin Integrity, High-risk for Impaired
Sleep Pattern Disturbance
Social Interaction, Impaired
Social Isolation
Spiritual Distress (Distress of the Human Spirit)
Suffocation, High-risk for Swallowing, Impaired
Thermoregulation, Ineffective
Thought Processes, Altered
Tissue Integrity, Impaired
Tissue Perfusion, Altered (Specify Type) (Renal, Cerebral, Cardiopulmonary, Gastrointestinal, Peripheral)
Trauma, High-risk for
Unilateral Neglect
Urinary Elimination, Altered
Urinary Retention
Violence, High-risk for: Self-directed or directed at others

FORMAT FOR NURSING CARE PLAN

Institution and Address:.....

Clinical/Field Practice Area: .....

NURSING CARE PLAN

Name: ..... Age: ..... Sex: ..... IP No: .....

Medical Diagnosis: ..... Date of Admission: .....

Doctors Orders:

Assessment data base:
(*to be written under the following affected areas)*

1. Activity and rest	2. Hygiene	3. Food and Fluid	4. Elimination
5. Pain and Comfort	6. Safety	7. Circulation	8. Neurosensory
9. Respiration	10. Ego-integrity		

1. .....

   Subjective: .....

   .....

   Objective:.....

   .....

2. .....

   Subjective: .....

   .....

   Objective: .....

   .....

3. .....

   Subjective: .....

   .....

   Objective: .....

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4. Teaching/Learning: .....

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   Diagnostic Studies

Nursing Priorities:

1. ..... 2. .....
3. ..... 4. .....

1. Nursing Diagnosis:
   Related to:
   Evidenced by:
   Patient outcome:

Actions/Interventions	Rationale

2. Nursing Diagnosis:
   Related to:
   Evidenced by:
   Patient outcome:

Actions/Interventions	Rationale

3. Nursing Diagnosis:
   Related to:
   Evidenced by:
   Patient outcome:

Actions/Interventions	Rationale

Date: _____ Day: _____

Student	*Ward-in-charge*	*Coordinator/Tutor*

Date: _____ Day: _____

Student	*Ward-in-charge*	*Coordinator/Tutor*

Date: _____ Day: _____

Student	*Ward-in-charge*	*Coordinator/Tutor*

Date: _______________ Day: _______________

_____ Student

_____ Ward-in-charge

_____ Coordinator/Tutor

Date: _____ Day: _____

Student	*Ward-in-charge*	*Coordinator/Tutor*

Date: _____ Day: _____

Student	*Ward-in-charge*	*Coordinator/Tutor*

COMFORT DEVICES

1. *Back Rest*

   It provides support for the patient in the sitting position.

2. *Knee Rest*

   Knee rest may be substituted by a pillow, gives relaxation and thus relieves pain on abdominal muscles.

3. *Foot Rest*

   It helps to maintain the normal position of the feet and prevents foot drop.

4. *Bed Cradle*

   The bed cradles support and takes off the weight of the top bed clothing used specially in burns.

5. *Bed Blocks*

   It is used to raise the foot end or head end of the bed.

6. *Sand Bags*

   Sand bags are used to immobilize a part as in fractures and to relieve discomfort and also prevent foot drop.

7. *Air Cushion*

   It is used to take off the weight of the body to relieve pressure on certain parts of the body, e.g. buttocks.

8. *Rubber and Cotton Rings*

   These are also used to relieve pressure on certain parts of the body, e.g. head and foot.

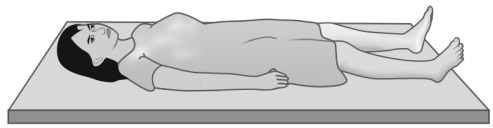
9. *Air and Water Mattress*

   These are used for very thin and very obese patients, and for bed ridden patients who are prone to pressure sores.

DIFFERENT TYPES OF POSITIONS

1. *Supine position (Dorsal Recumbent)*

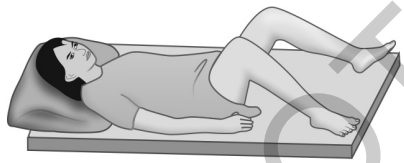
   In this position, the patient lies flat on his back with his leg together and hands on the sides.



Supine position (dorsal recumbent)

2. *Semirecumbent Position*

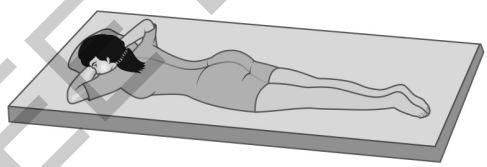
   The patient lies in the bed with two or more pillows which may be arranged in arm chair fashion to support the shoulders, arms and elbows.



Semirecumbent position

3. *Prone Position*

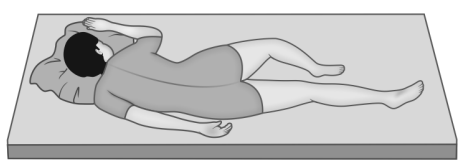
   The patient liest flat in the bed on his abdomen, face turned side ways, and arms rest in a comfortable position. Usually given to prevent aspiration.



Prone position

4. *Lateral Position (Side-lying Position)*

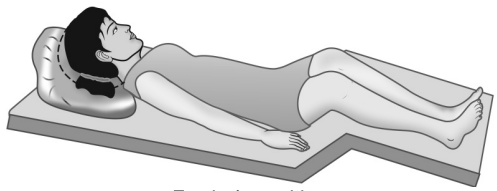
   The patient lies on his side with both knees slightly flexed towards the abdomen. This position is convenient for rectal examinations.



Lateral position (side-lying position)

5. *Fowler's Position*

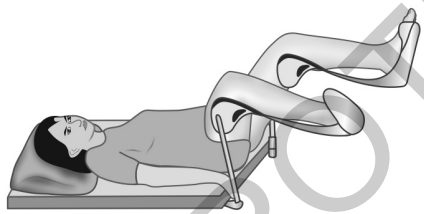
The patient is propped in a sitting position by means of back rest and pillows. This position relieves breathing difficulty.



Fowler's position

6. *Lithotomy Position*

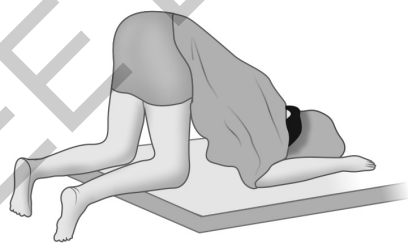
The patient lies on his back with one pillow under the head. The legs are well separated and the thighs are well flexed on the abdomen and the legs on the thighs. This position is used for gynaecological examination and procedures involving genitourinary systems.



Lithotomy position

7. *Knee-chest Position*

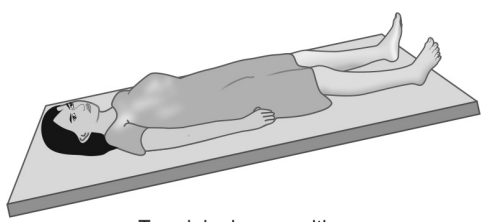
The patient rests on the knees and the chest. The head is turned to one side. This position is used for the examination of the rectum (sigmoidoscopy).



Knee-chest position

8. *Trendelenburg Position*

The patient lies on his back. The foot of the bed is elevated at 45'angle. This position is used for examination of the pelvic cavity and also during shock or decreased blood pressure.



Trendelenburg position

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