# Clinical Practice Guideline for Diploma in Patient Care Technology (DPCT)

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Bangladesh Nursing and Midwifery Council

Clinical Practice Guideline for Diploma in Patient Care Technology (DPCT)



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## INTRODUCTION

This guideline is designed to fill-up the gaps for Diploma in Patient Care Technology (DPCT) to improve their level of skills in the areas of various fields for patients' care including Fundamentals of Nursing, Medical & Surgical Nursing, Pediatric Nursing, Midwifery, Psychiatric Nursing, and Orthopedic Nursing. The trainees will acquire the essential knowledge and skills through various practice-based learning activities such as assignments/case studies, discussions/presentations and clinical practice in different hospital settings.

**Program Description:**

This training program is designed to give a clinical practice knowledge and experience of the trainee who has completed their basic 4 (four) years degree on Diploma in Patients care Technology (DPCT) as part of the knowledge gap with Diploma in Nursing Science and Technology.

**Course Title:** Top-up Program for Diploma in Patient Care Technology (DPCT)

**Duration of the Course:** Six (06) Months

**Course Objectives:**

Upon completion of this clinical practice training program, the trainees will be able:

1) To demonstrate good understanding in effective communication with patients, their relatives and other healthcare team members.
2) To acquire knowledge and skills in fundamentals of nursing for effective patient management.
3) To demonstrate skills in providing quality patient care in the field of medical, surgical, pediatric, orthopedic and other prescribed fields.
4) To demonstrate basic knowledge and skills in midwifery for handling antenatal, intra-natal and postnatal care of pregnant women and newborn.
5) To consider ethical and legal issues involved with the part of patient care.
6) To interpret the laboratory findings and take necessary actions required.
7) To manage own work on day-to-day basis.
8) To maintain patient safety and quality care.
9) To manage emergency in patient care.
10) To carry out practice that demonstrates positive attitudes, ethical behaviors and accountability in accordance with the BNMC rules and regulations.

**Course Requirements:**

1. Practical attendance 100%
2. Assignment, case study and case presentation
3. Hands on practice
4. Group discussion and attending in morning session.

**Course Structure:**

| Sl. No | Activities | Duration |
|---|---|---|
| 1. | Total duration 06 months | 180 days |
| 2. | Clinical practice (6 days per week) | 156 days |
| 3. | Weekly holidays | 26 Days |
| 4. | Hours per week (8 hrs./day for 6 days) | 48 hours |
| 5. | Rotation | Morning, Evening and Night |
| 6. | Total hours | 1248 hrs. |

**Note:** Trainees should perform shifting duty (Morning, Evening & Night) according to rotation plan.

**Clinical Placement Rotation Plan:**

| Sl. No. | Subjects | Departments/Wards | Months |
|---|---|---|---|
| 1 | Fundamentals of Nursing | Medical Ward, Surgical Ward, General Operation Theatre, Post-Operative Ward, Eye and ENT | 10 weeks |
| 2 | Medical & Surgical Nursing | | |
| 3 | Pediatric Nursing | Pediatric Ward and Neonatal Ward | 04 weeks |
| 4 | Midwifery | Outpatient Department, Labor Ward, Post Natal Ward, Antenatal Ward, and Gynae Ward | 04 weeks |
| 5 | Psychiatric Nursing | Mental/Psychiatric Department/Hospital | 02 weeks |
| 6 | Orthopedic Nursing | Outpatient Department, Emergency Ward, Operation Theater, and Orthopedic Ward | 04 weeks |
| 7 | Examination | All Areas of Practices | 02 weeks |
| **Total Months (06)** | | | **26 Weeks** |

**N.B:** If there is any discipline/area mentioned in the above table, is not available in any medical college hospital/district hospital, trainees will be placed in the major discipline/area for that period.

**Responsibilities During Clinical Placement:**

1. Receiving of newly admitted/transferred/post-operative patients of the ward
2. Developing patient care plan based on patient's need, type of illness and severity
3. Maintaining personal and environmental hygiene
4. Performing health assessment
5. Maintaining cleanliness and sterilization of equipment, linen and others
6. Considering laboratory findings in providing patient care
7. Establishing therapeutic relationship (co-workers, doctors, nurses, patients, attendants etc.)
8. Providing optimum patients care in the prescribed fields
9. Conducting health education during hospitalization of patients and during discharge
10. Preparing Patients for diagnostic tests and procedures
11. Collection of specimens and sending it to laboratory
12. Providing pre and post-operative care
13. Administering medication/drugs followed by 6 rights to avoid medication errors
14. Keeping record and report essential for patients
15. Attending in ward/physician round
16. Utilizing available equipment or materials to ensure better patient care
17. Caring of dying and death patients
18. Carry out other activities as instructed by senior nurses.

**Generic Skills:**

These are the fundamentals skills which must be performed by the trainee during their clinic al placement in the hospitals:

1. Receiving newly admitted/transferred/post-operative patients with positive attitude
2. History taking (physical, psychological, social and spiritual aspects).
3. Physical assessment.
4. Cleanliness of the patients & their environment;
5. Maintenance of personal hygiene/assisting patients in maintaining personal hygiene;
6. Providing nursing care to all categories of patients followed by nursing care plan;
7. Specimen collection;
8. Preparing diagnostic tests and procedures
9. Interpreting laboratory findings;
10. Assisting with common emergencies e.g. High fever, CPR, Shock, ARI, Hemorrhage etc;
11. Maintaining sterilization/disinfection (instruments, linen, rubber goods etc.) in wards/OT;
12. Administering safe drugs/medications;
13. Maintaining different charts i.e., Temperature chart, intake and output chart, medication chart, diabetic chart etc.
14. Inserting IV cannula, urinary catheter, Ryle's tube/flatus tube etc.
15. Application of enema simplex/suppositories;
16. Operating sucker machine and oxygenation, nebulizer;
17. Assisting in Mechanical Ventilation;
18. Assisting in blood transfusion;
19. Discharge planning;
20. Keeping proper death note; and
21. Documenting records.

**Group Discussion/Case Conference:**

| Sl. No | Name of Topic | Name and Designation of Resource Person | Signature |
|---|---|---|---|
| 1. | Therapeutic communication | | |
| 2. | History taking | | |
| 3. | Calculation of medication | | |
| 4. | Impact of chronic diseases on socio-psychological aspect | | |
| 5. | Pain management | | |
| 6. | Fall risk assessment | | |
| 7. | Nursing code of conducts and ethics | | |
| 8. | Nursing notes/record keeping/ reporting | | |
| 9. | Quality improvement | | |
| 10. | Occupational hazards (COVID19, HBsAg, HIV, Radiation, needle stick injury) | | |
| 11. | Infection prevention and control | | |
| 12. | Over view on nursing management/ procedures | | |
| 13. | Patients' right | | |
| 14. | Patients' safety | | |
| 15. | Discharge plan and health education | | |
| 16. | Rehabilitation | | |
| 17. | Care of dying patient | | |

**Methods of Teaching:**

- Lectures
- Power point presentation
- Pre and post conference
- Open discussions
-

**Teaching Aids:**

- Flip chart and multimedia
- White board
- Paper/pencil

**Monitoring, Supervision and Evaluation Committee:**

| | | |
|---|---|---|
| 1. | Chairman: | Director of Hospital/Medical Superintendent |
| 2. | Member: | Principal/ Instructor In charge |
| 3. | Member: | Lecturer/ Nursing Instructor (Nearest College/ Institute) |
| 4. | Member: | Concern Ward in-charge |
| 5. | Member: | Nursing Supervisor |
| 6. | Member Secretary: | Nursing Superintendent/ Deputy Nursing Superintendent |

**Responsibilities of the Committee (TOR):**

Committee should perform the following responsibilities:

- Monitor, guide and support whenever required
- Observe the trainee skills/competencies
- Grade the trainee skills/competencies by using appropriate parameters.
- Final evaluation (written test.)

**Clinical Teacher (CT)/Preceptor:**

Two Nurse Teachers from the nearest Nursing/Midwifery College/Institute.

**Responsibilities of CT/ Preceptor:**

1. Maintenance of a register for the trainees.
2. Preparing rotation plan and ensuring the placement.
3. Checking attendance register of the trainees on regular basis.
4. Checking that all trainees are assigned the activities by the ward in-charge based on the tasks as mentioned in the objectives.
5. Organizing small group discussion/case conference on the prescribed topic(s) for the trainees.
6. Ensuring that trainees have accomplished all the tasks assigned for them.
7. Providing necessary guidance and support towards the accomplishment of assigned task/competencies when required.
8. Ensuring that trainees have achieved all the generic skills/competencies assigned for them.
9. Signing against the tasks and competencies after checking and observation/examination.
10. Signing against the parameters i.e. attitude and behavior, punctuality, responsibility and dressed up with proper uniform using personal judgment.

11. Checking that the ward in-charge noted the reason/s in the remark column against the task/s which has not been accomplished. If a trainee fails to accomplish assigned tasks within the given time h/she will make it up.
12. Checking that checklist is properly signed by the ward in-charge in time.
13. Submitting the completed grading forms to the monitoring, supervision and evaluation committee.

**Activities Related to Grading and Certification:**

| Sl No. | Activities | Responsible Person(s) |
|---|---|---|
| | | |
| 1. | Allocation of trainees to the different departments/ units according to rotation plan. | CT/ Preceptor/ ward in charge/ Nursing Supervisor. |
| 2. | Supervise, guide and monitor the activities of trainees. | |
| 3. | Signing against the tasks; and skills/ competencies identified for the trainees. | |
| 4. | Signing against the parameters i.e. attitude and behavior, punctuality, responsibility and dressed up with proper uniform using personal judgment | |
| 5. | Signing the checklists. | In-charge of the concerned ward |
| 6. | Grading the trainees based on parameters | Member of the Monitoring Committee |
| 7. | Certification | Hospital Director/Medical Superintendent and Nursing superintendent/ Dy. Ng. Superintendent of concerned hospital |

**Guidelines for Concerned Personnel/CT/ Preceptor of Placement Department:**

1. Will organize the small discussion session/case conference on the selected topics either in the morning or evening in their responsible unit at least once in a week.
2. Should ensure the participation of the trainees in a small group discussion/case conference with maintaining the register.
3. Should maintain the register where resource person will sign against the session s/he observed.
4. Ward In-charge of the major disciplines/departments will try to ensure the accomplishment of tasks mentioned in the generic skills within placement periods.
5. The clinical Teacher/ Preceptor/ ward in charge will be responsible for visiting the trainees during the clinical placement.

**Instructions for Trainees:**

1. Trainees should wear appropriate hospital uniform on duty time.
2. Trainees should sign on the attendance registrar at the time of arrival and departure from duty.
3. Trainees should maintain a notebook correctly after achieving the required skills/ competencies identified in the objectives and checklist.
4. Trainees should get sign from the concerned members of the monitoring committee such as- ward in charge / CT/ Preceptor (Appropriate site concerning generic skills or competencies trainees need to achieve during his/her clinical placement).
5. Trainees has to attend the group discussion session/case conference arranged by the concerned personnel.
6. Trainees can seek support and assistance from the CT or preceptor or ward in charge in achieving generic skills or competencies when required.
7. Trainees should conduct pre and post conference with nursing staffs.

**Code of Conduct, Rules and Regulations:**

1. The code of conduct, rules, and regulations will be applicable to trainee as per Govt. order from the Ministry of Health and Family Welfare, Bangladesh Nursing & Midwifery Council, Directorate General of Nursing & Midwifery and respective hospitals.
2. If any trainees remain absent due to unavoidable circumstances for more than the allowed casual leave; an extra period of work is required to complete the task in the relevant unit, he/she will have to complete the absent period in the same placement unit after the completion of scheduled of training period.
3. If a trainee remains unauthorized absent, he/she has to work extra double time to make the absent period or his/her previous training in the respective discipline will be cancelled which ever decided by concerned committee in consultation with In-charge of concerned major discipline/ CT/ Preceptor and Nursing Superintendent of hospital.
4. Duty of absent period should be completed within one month of completion of scheduled of training; failing of his/her training in concern major discipline will be cancelled.

**Special Note:**

- For easy identification of the trainees, one passport size photograph should be attached on the checklist and another one on the grading sheet.
- Hospital Director/Medical Superintendent and Nursing Superintendent /Dy. Nursing Superintendent will issue the completion certificate based on the grading numbers and comments.
- Hospital Director/ Medical Superintendent and Nursing Superintendent/Dy. Nursing Superintendent will not issue any completion certificate against trainees if there is any unsatisfactory grading.
- Logbook/checklist must be submitted to the Nursing Superintendent/ Dy. Nursing Superintendent for issuing the completion certificate.

**Grading Parameters and Marks Distribution:**

**The parameter number 1 (one) is compulsory to be achieved by all individual.**

| No. | Parameters | Marks |
|---|---|---|
| 1 | Completion of the number of assigned tasks from the list of the procedures. | 30 |
| 2 | Generic skills | 30 |
| 3 | Attitude and behavior. | 10 |
| 4 | Punctuality | 10 |
| 5 | Responsibility and accountability | 10 |
| 6 | Dressed up with proper uniform | 10 |
| **Total** | | **=100** |

**Grading:**

| Excellent | Very good | Good | Satisfactory | Unsatisfactory |
|---|---|---|---|---|
| | | | | |
| 91-100 | 81-90 | 71-80 | 61-70 | < 60 |

**List of the Procedures with Allocated Marks:**

| SN. | Name of the Tasks | Total Marks | Obtained Marks | Remarks | Signature |
|---|---|---|---|---|---|
| | **General Procedure** | | | | |
| 1. | Receiving of newly admitted pts. | 05 | | | |
| 2. | Making bed for the patients | 05 | | | |
| 3. | Taking and recording history | 05 | | | |
| 4. | Receiving of transferred in patients | 05 | | | |
| 5. | Checking and recording vital signs | 05 | | | |
| 6. | Sterile Technique & Infection Control | 05 | | | |
| 7. | Maintaining personal hygiene | 05 | | | |
| 8. | Maintaining environmental hygiene | 05 | | | |
| 9. | Collecting specimens | 05 | | | |
| 10. | Administering I/M injection | 05 | | | |
| 11. | Administering I/V injection | 05 | | | |
| 12. | Opening of I/V channel | 05 | | | |
| 13. | Maintaining I/V channel | 05 | | | |
| 14. | Administering oral medications | 05 | | | |
| 15. | Administering suppository in anal route | 05 | | | |
| 16. | Providing mouth care | 05 | | | |
| 17. | Providing back care | 05 | | | |
| 18. | Administering Oxygen inhalation | 05 | | | |
| 19. | Administering Inhaler/ Nebulizer | 05 | | | |
| 20. | Giving NG Tube feeding | 05 | | | |
| 21. | Performing catheterization | 05 | | | |
| 22. | Caring of dying patient | 05 | | | |
| 23. | Caring of dead body | 05 | | | |
| | **Medical & Surgical Nursing** | | | | |
| 24. | Assist in lumber puncture | 05 | | | |
| 25. | Assist in Sternum puncture | 05 | | | |
| 26. | Assist in Fluid Aspiration | 05 | | | |
| 27. | Care of surgical wound | 05 | | | |
| 28. | Aseptic dressings | 05 | | | |
| 29. | Colostomy care | 05 | | | |
| 30. | Preoperative care | 05 | | | |
| 31. | Postoperative care | 05 | | | |
| 32. | Stitching and removing of suture | 05 | | | |
| 33. | Management of acute appendicitis | 05 | | | |
| 34. | Management of acute abdomen | 05 | | | |
| 35. | Management of intestinal obstruction | 05 | | | |
| 36. | Management of hernia | 05 | | | |
| 37. | Maintaining Intake-Output fluid and chart | 05 | | | |
| 38. | Maintaining Temperature chart | 05 | | | |
| | **Operation Theater (OT) skill** | | | | |
| 39. | Cleaning and decontamination of OT | 05 | | | |
| 40. | Sterilization of Linen | 05 | | | |
| 41. | Sharp Instruments | 05 | | | |

| SN. | Name of the Tasks | Total Marks | Obtained Marks | Remarks | Signature |
|---|---|---|---|---|---|
| 42. | Blunt Instruments | 05 | | | |
| 43. | Rubber Goods | 05 | | | |
| 44. | Scrubbing, Gowning, And Gloving | 05 | | | |
| 45. | Preparation of operation trolley | 05 | | | |
| 46. | Receiving post-operative pts by checking/examining | 05 | | | |
| 47. | Provide immediate PO care | 05 | | | |
| | **Orthopedic & Traumatology Unit** | | | | |
| 48. | Special procedure for orthopedic nursing Application of roller bandage | 05 | | | |
| 49. | Application of triangular sling | 05 | | | |
| 50. | Application of cast | 05 | | | |
| 51. | Care of cast | 05 | | | |
| 52. | Removal of cast | 05 | | | |
| 53. | Assist in traction | 05 | | | |
| 54. | Managing fracture & dislocation | 05 | | | |
| 55. | Managing amputation | 05 | | | |
| 56. | Clients with traction | 05 | | | |
| 57. | Managing immobility | 05 | | | |
| 58. | Assist patient in performing active and passive range of motion | 05 | | | |
| | **Management of burn** | | | | |
| 59. | Care of burn patient | 05 | | | |
| 60. | Dressing of burn patient | 05 | | | |
| | **Pediatric Nursing** | | | | |
| 61. | Nursing management of ARI/pneumonia | 05 | | | |
| 62. | Measles | 05 | | | |
| 63. | Febrile convulsion | 05 | | | |
| 64. | Epilepsy | 05 | | | |
| 65. | Managing congenital anomalies | 05 | | | |
| 66. | Anemia. | 05 | | | |
| 67. | Diarrheal disease. | 05 | | | |
| 68. | Worm infestation | 05 | | | |
| | **Midwifery and Obstetrical Nursing** | | | | |
| 69. | Attend antenatal patients in OPD | 05 | | | |
| 70. | History taking and documentation | 05 | | | |
| 71. | Antenatal assessment General examination | 05 | | | |
| 72. | Abdominal examination | 05 | | | |
| 73. | Per vaginal examination | 05 | | | |
| 74. | Counseling | 05 | | | |
| 75. | Birth plan | 05 | | | |
| 76. | Nursing management of APH (Acute post-partum hemorrhage) | 05 | | | |
| 77. | Rupture membrane | 05 | | | |
| 78. | Premature/low birth weight babies | 05 | | | |

| SN. | Name of the Tasks | Total Marks | Obtained Marks | Remarks | Signature |
|---|---|---|---|---|---|
| 79. | Monitoring of labor by using Partograph | 05 | | | |
| 80. | Conduction of normal delivery | 05 | | | |
| 81. | Active management of third stage labor | 05 | | | |
| 82. | Perform episiotomy | 05 | | | |
| 83. | Examination of placenta | 05 | | | |
| 84. | Immediate newborn care | 05 | | | |
| 85. | Newborn assessment | 05 | | | |
| 86. | APGAR scoring | 05 | | | |
| 87. | Management of PPH | 05 | | | |
| 88. | Post-partum infection | 05 | | | |
| 89. | Postpartum depression | 05 | | | |
| 90. | Mastitis | 05 | | | |
| 91. | Management of Eclampsia | 05 | | | |
| 92. | Preparation of patient for C/S | 05 | | | |
| 93. | Preparation of C/S trolley | 05 | | | |
| 94. | Management of Abortion | 05 | | | |
| 95. | Ectopic pregnancy | 05 | | | |
| 96. | Molar pregnancy | 05 | | | |
| 97. | Uterine prolapsed | 05 | | | |
| 98. | Cord prolapsed | 05 | | | |
| 99. | VVF/RVF | 05 | | | |
| 100. | Care of Eye patients | 05 | | | |
| | **Total mark** | **500** | | | |

## CLINICAL SKILLS AND COMPETENCY BASED PROCEDURE

**Procedure Name : General Procedure**

**Name of Trainee :**

**Roll no :**

**Checklists to be Filled by the Clinical Teacher (CT) / Preceptor or Ward In-Charge**

**[Please put the tick mark (√) and write the comment(s) in the column below]**

| Sl. No | Tasks | Executed | Not executed | Comments |
|---|---|---|---|---|
| 1. | Receiving of newly admitted patients; | | | |
| 2. | Receiving of transferred in patients; | | | |
| 3. | Following up the patient's conditions, | | | |
| 4. | Making discharge plan, | | | |
| 5. | Keeping proper death note. | | | |
| 6. | Performing health assessment | | | |
| 7. | Maintenance of personal hygiene | | | |
| 8. | Maintenance of environmental hygiene | | | |
| 9. | Developing nursing care plan following nursing process | | | |
| 10. | Establishing relationship client | | | |
| 11. | Establishing relationship with nurses | | | |
| 12. | Establishing relationship with doctors | | | |
| 13. | Providing client centered care to the patients | | | |
| 14. | Maintenance the cleanliness and sterilization of equipment. | | | |
| 15. | Maintenance the cleanliness and sterilization of linen, | | | |
| 16. | Maintenance the cleanliness and sterilization of rubber goods | | | |
| 17. | Utilization of available resource materials to ensure the cost-effective care/services | | | |
| 18. | Providing bedside care for an individual patient emphasizing on basic nursing procedure | | | |

| Sl. No | Tasks | Executed | Not executed | Comments |
|---|---|---|---|---|
| 19. | Providing special nursing care | | | |
| 20. | Providing bedside care for an individual patient emphasizing on basic nursing procedure | | | |
| 21. | Providing pre-operative care | | | |
| 22. | Assisting patients undergo for surgery | | | |
| 23. | Providing post-operative care | | | |
| 24. | Administering medication/drugs by following 6 rights to minimize any medication error | | | |
| 25. | Considering laboratory findings during the development/ preparation of nursing care plan | | | |
| 26. | Collecting specimen according to the physician orders | | | |
| 27. | Sending specimen to the concerned laboratories | | | |
| 28. | Preparing patients for different diagnostic tests and procedures | | | |
| 29. | Sending patients to the concerned diagnostic department | | | |
| 30. | Keeping nursing notes and other documentation properly | | | |
| 31. | Conducting health education sessions | | | |
| 32. | Assisting dying patients with peaceful death | | | |
| 33. | Caring for dead body | | | |
| 34. | Joining with ward/physician round | | | |
| 35. | Attended in pre and post conference | | | |

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date :

**Procedure Name** : **Taking health history (Adult, Child)**

**Name of Trainee** :

**Roll no** :

**Purpose of health history**

The purpose of obtaining a health history is to gather subjective data from the patient and/or the patient's family so that the health care team and the patient can collaboratively create a plan that will promote health, address acute health problems, and minimize chronic health conditions.

**Equipment**

- The nurse should be familiar with the otoscope, penlight, stethoscope (bell and diaphragm), thermometer, bladder scanner, speculum, eye charts, cardiac and blood pressure monitors, fetal Doppler and extremity Doppler, and sphygmomanometer
- Stretcher or bed for proper positioning during a physical exam
- Hand hygiene products, personal protective equipment if required
- Alcohol swabs, sanitizer, or soapy water to clean equipment after use, such as with stethoscopes, to decrease the likelihood of cross-contamination of pathogens from inanimate objects (follow any manufacturer guidelines or institutional policies)
- Computer or paper chart to document findings
- Calculation devices for BMI, conversion from pounds to kilograms, kilograms to pounds, Celsius to Fare height.

**[Please observe the performed activities and tick (√) in the appropriate boxes]**

| Tasks | Executed | Not Executed |
|---|---|---|
| 1. Greet patient/attendant/parents | | |
| 2. Explain what s/he is going to do and why | | |
| 3. Seek required cooperation/assistance | | |
| 4. Maintain privacy | | |
| 5. Keep the patient in comfortable position | | |
| 6. Use nonthreatening gesture during communication | | |
| 7. Ask one question at a time | | |
| 8. Avoid medical terminology | | |
| 9. Consider ethical issue during data collection | | |
| 10. Ensure the patient about confidentiality | | |
| 11. Obtain data related to history of health | | |

| Tasks | Executed | Not Executed |
|---|---|---|
| 12. Obtain data related to nutritional, economic, family status | | |
| 13. Organize/record collected data accordingly | | |
| 14. Thanks patient/attendant/parents for her/his cooperation | | |
| 15. Document all the history | | |

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date :

**Procedure Name : Clinical Sills for Manual Handling of Patient**

**Name of Trainee :**

**Roll no :**

**Introduction:** Manual handling refers to any activity in the workplace that requires the use of manual force, such as lifting, pulling, pushing or holding objects. Manual patient handling (MPH) is a major occupational risk in healthcare settings. Therefore, it is an important part for the nurses in the daily activities of all hospital setting, particularly in handling the patients who are critically ill.

**Objectives:**

- To minimize the risk of injuries at home and hospital.
- To demonstrate the principles and practice of manual handling of patient.

**Procedural Competencies:**

The practice of manual handling of patients includes:

1) Risk Assessment
2) Critical Thinking and Planning
3) Carrying, Pushing and pulling
4) Lifting from low levels and Lowering from a height
5) Apply team lifting principles
6) Patient Handling moves: Sitting up, turning, standing, walking and sitting
7) Dealing with a falling and fallen patient: Use of hoist, Use of enablers such as banana boards & turntables
8) Apply Handling Technique:
    - Remove any object that could obstruct the route.
    - When performing a long lift, rest the load midway. Place it on a bench or table then change your grip.
    - Keep the load close to your waist. It should be kept close to your body for as long as you can when lifting.
    - Ensure that the heaviest part of the load is placed right next to your body.
    - Keep your back straight and bend your knees
    - Maintain a stable position and ensure that your feet are apart with one leg slightly moved forward to maintain balance.
9) Prepare and maintain record

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date :

**Procedure Name** : **Handling of Mental Health/Psychiatric Nursing**

**Name of Trainee** :

**Roll no** :

**Introduction:** Mental health nursing, also known as psychiatric nursing, is a specialized field of nursing practice that involves the care of individuals with a mental health disorder to help them recover and improve their quality of life.

**Objectives:**

- Assess patients with mental health problems/disorders
- Observe and assist in various treatment modalities or therapies
- Counsel and educate patients and families
- Provide nursing care to patients with mental health problems/disorders
- Motivate patients in the community for early treatment and follow up
- Observe the assessment and care of patients with substance abuse.

**Procedural Skills/Competencies:**

1) Identifying individuals with mental health problems,
2) History taking and perform mental status examination,
3) Observe and assisting in psychometric assessment,
4) Observe and assisting in neurological examination,
5) Observing and assisting in therapies,
6) Mental hygiene practice education,
7) Recording therapeutic communication,
8) Administration of medications,
9) Preparing patients for Activities of Daily living (ADL),
10) Counseling patients and families,
11) Conducting admission and discharge counselling.

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date :

**Procedure Name** : **Culturally Safe and Sensitive Nursing Care**

**Name of Trainee** :

**Roll no** :

**Introduction**: The word "culture" refers to integrated patterns of human behaviors, including norms, traditions, and values that affect the thinking and behavior of members of particular groups. Cultural competence describes the ability to effectively interact with people belonging to different cultures. The importance of cultural competence in nursing focuses on health equity through patient-centered care, which requires seeing each patient as a unique person. Culturally Safe and Sensitive Nursing Care consist of some key components to provide care for the patient at home, hospital and the community.

**Objectives:**

- Understand the importance of culturally safe and sensitive care for the patient.
- Identify the barriers of cultural differences, especially between nurses and their patients.
- Demonstrate the awareness of one's own beliefs, biases, values and cultural practices.
- Provide culturally safe and sensitive care for the patient at hospital and community.

**Procedural competencies:**

1) Building awareness and attitude
2) Applying knowledge and kills
3) Avoiding assumptions
4) Learning about other cultures
5) Building trust and rapport
6) Overcoming language barriers
7) Educating patients and their family members about healthcare practices
8) Practicing active listening
9) Using language and terms patients understand
10) Respecting patients' cultural and religious beliefs that conflict with treatment plans
11) Analyzing the ethnic composition demographics of patients currently served
12) Identifying patients in underserved populations and communities

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date :

**Procedure Name : Measuring Vital Signs**

**Name of Trainee :**

**Roll no :**

**Introduction**: Vital signs are a group of the four to six most crucial medical signs that indicate the status of the body's vital functions. These measurements are taken to help assess the general physical health of a person, give clues to possible diseases, and show progress toward recovery. There are six classic vital signs (blood pressure, pulse, temperature, respiration, height, and weight are reviewed on an historical basis and on their current use in patient care.

**Necessary Equipment**:

**Vital sign (Pulse, respiration, blood pressure):**

1) BP machines (blood pressure machine)
2) Stethoscope
3) Patients chart for recording
4) Thermometer with jar
5) Black and color pen for charting.
6) Dry sterile cotton swab
7) Wrist watch

**[Please observe the trainee's activities and tick (√) in the appropriate box]**

| Tasks | Executed | Not Executed | Comments |
|---|---|---|---|
| | | | |
| Collect necessary equipment. | | | |
| Identified the patient | | | |
| Greet the patient and explain the procedure | | | |
| Ensure privacy | | | |
| Keep the patient in comfortable position | | | |
| Wash hands properly | | | |
| **Recording Radial Pulse** | | | |
| Place the fingertips of index, middle and ring finger on the patient's radial artery just above the wrist joint. The index towards the patient's thumb. | | | |

| | | | |
|---|---|---|---|
| When the patient's pulse is clearly felt observe first the regularity of rhythm and the force of the pulse before beginning to count the rate. | | | |
| Count the pulse for 1minute. | | | |
| **Measuring Oral Temperature** | | | |
| Ask the client whether s/he has taken hot or cold drink, if so, wait for 10 minutes | | | |
| Hold the thermometer by stem, wash and dry it and shake down to below $96^0$F | | | |
| Place the thermometer in client's mouth under the tongue and ask the client to keep the mouth close and not to bite and leave in for 2 minutes. For children use axilla for measuring temperature. | | | |
| Remove the thermometer and hold the thermometer at eye level and read the nearest tenth. | | | |
| **Recording Respiration** | | | |
| Place patient's arm over the chest. Do not tell the patient you are going to count their respirations, as this will affect how they breathe. | | | |
| Observe the rise and fall of the chest. Each rise and fall=1 respiration. | | | |
| Count respiration for 1 minute. | | | |
| **Measuring Manual Blood Pressure** | | | |
| Select one hand for BP monitoring. | | | |
| Extended arm and rest level with heart, palm upward on bed or table. | | | |
| Locate brachial artery and wrap cuff tightly around upper arm, one inch above elbow. | | | |
| Palpate radial artery and inflate cuff 20-30 mmHg beyond point where pulse was last felt. | | | |

| | | | |
|---|---|---|---|
| Place the diaphragm of stethoscope directly over brachial artery and deflate cuff at even rate of 2-4 mm per second by turning valve counter clockwise. | | | |
| Note point on scale where first sound heard (systolic) and where sound disappears or changers (diastolic reading) | | | |
| Deflate the cuff completely from the arm | | | |
| Document all the vital signs in vital sign chart | | | |

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date

**Procedure Name** : **Giving Back massage/ Back Care**

**Name of Trainee** :

**Roll no** :

**Purposes of Back care:**

- To give comfort to the patients
- To stimulate blood circulation
- To prevent pressure sore
- To assess the skin condition
- To relax and relief tension in tissue and muscle.
- To refresh patient and relief fatigue.

**Necessary Equipment:**

1. Basin of warm water
2. Sponge cloths-2
3. Soap with soap case
4. Towel
5. Back rub lotion and powder
6. Mackintosh and towel
7. Kidney tray
8. Bed side screen.

**[Please observe the trainee's activities and tick in the appropriate box]**

| **Tasks** | **Executed** | **Not Executed** |
|---|---|---|
| Collect necessary equipment | | |
| Identified the patient to provide back care according to procedure | | |
| Greet the patients and explain the procedure | | |
| Ensure privacy | | |
| Turn the patient lateral position with the back towards | | |
| Place the rubber sheet, covered with draw sheet, along length of the patient tucked in closely to back | | |
| Wash hands properly | | |
| Expose the patients back from the shoulder to buttock | | |

| Tasks | Executed | Not Executed |
|---|---|---|
| If the back of the patients is dirty wash the back first with warm water and soap water | | |
| Using sponge cloth and warm water, gently massage the back, shoulder, hip and buttock in a circular motion | | |
| Dry the back with towel | | |
| Apply lotion on the palm and gently rub the back, shoulder hip and buttocks | | |
| Apply power on the buttock to prevent moist skin | | |
| Assist the patient to change cloth and keep him in a comfortable position | | |
| Thank for his/her cooperation | | |
| Maintain proper disposal and wash hands | | |
| Document the procedure | | |

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date

**Procedure Name** : **Nebulization**
**Name of Trainee** :
**Roll No** :

**Purpose:**

- To administer medication directly in to respiratory tract for sputum expectoration
- To reduce difficulty in bringing out thick tenacious respiratory secretion.
- To increase vital Capacity
- To relieve dyspnea

**Necessary Equipment:**

1. Air compressor
2. Connective tube
3. Nebulizer
4. Medication and Saline solution
5. Sterile water
6. Cotton balls
7. Face Musk's
8. Sputum cup with disinfectant
9. Disposable syringe
10. Kidney tray

**[Please observe the trainee's activities and tick in the appropriate box]**

| Tasks | Executed | Not Executed |
|---|---|---|
| Collect all required equipment bring to the patient bed side | | |
| Greeting the patient and explain the procedure | | |
| Maintain proper position | | |
| Wash hands properly | | |
| Check the medication and take right solution | | |
| Connect the nebulization mask to nebulizer | | |
| Connect the nebulizer switch | | |
| Check vapor production and explain the technique of taking vapor | | |
| Nebulize patient until finished the solution | | |
| Replace equipment after procedure | | |
| Evaluate and document the progress of therapy | | |

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date

**Procedure Name** : **Mouth Care**

**Name of Trainee** :

**Roll no** :

**Purposes:**

- To keep the mouth fresh and clean
- To keep the teeth in good condition
- To prevent and treat mouth infection and dental carries
- To improve appetite
- To maintain integrity of lips, tongue and mucus membrane of the mouth.
- To prevent infection of the poritid

**Necessary Equipment:**

A Tray Containing:

1. Artery forceps-1
2. Clean gloves
3. Face towel-1
4. Mackintosh and towel
5. Gauze pieces
6. Tongue depressor:1
7. A jug with clean water.
8. Kidney tray-2.
9. Gully pot-1
10. Paste or powder.
11. Oral brush.

**[Please observe the trainee's activities and tick in the appropriate box]**

| **Tasks** | **Executed** | **Not Executed** |
|---|---|---|
| Explain the procedures | | |
| Collect all instruments required | | |
| Close the door or put the screen | | |
| Perform hand hygiene and wear disposable gloves if possible | | |
| If you use solutions such as sodium bicarbonate, prepare solutions required. | | |
| Assist the client a comfortable upright position or sitting position | | |

| Tasks | Executed | Not Executed |
|---|---|---|
| Inspect whole the oral cavity, such as teeth, gums, mucosa and tongue, with the aid of gauze-padded tongue depressor and torch. | | |
| Take notes if you find any abnormalities, e.g., bleeding, swollen, ulcers, sores, etc. | | |
| Place face towel over the client chest or on the Thigh with mackintosh. | | |
| Put kidney tray in hand or assist the client holding a kidney tray. | | |
| Client places a soft toothbrush at a 45 °angle to the teeth. | | |
| Client brushes in direction of the tips of the bristles under the gum line with tooth paste. | | |
| Rotate the bristles using vibrating or jiggling motion until all outer and inner surfaces of the teeth and gums are clean. | | |
| Client brushes biting surfaces of the teeth. | | |
| Client clean tongue from inner to outer and avoid posterior direction. | | |
| Ask the client to rinse with fresh water and void contents into the kidney tray. | | |
| Advise him/her not to swallow water. If needed, suction equipment is used to remove any excess | | |
| Ask the client to wipe mouth and around it. | | |
| Confirm the condition of client's teeth, gums and tongue. | | |
| Rinse and dry tooth brush thoroughly. | | |
| Replace all instruments | | |
| Discard dirt properly and safety. | | |
| Remove gloves and wash your hands. | | |
| Document the care and sign on the records. | | |

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date

**Procedure Name** : **Administering Oral Medication**

**Name of Trainee** :

**Roll no** :

**Purpose**

- To prevent the disease
- To cure the disease
- To promote the health
- To give palliative treatment
- To give as a symptomatic treatment

**Necessary Equipment:**

A trolley containing-

1. A bowel of clean water
2. Ounce glass, medicine glass, dropper or teaspoon to measure the medicine
3. Drinking water in a feeding cup
4. Mortar and pestle to crush and powder the table if necessary
5. Duster/towel to wipe the outside the bottle after pouring the medicine ordered
6. Kidney tray and paper bag to discard the waste
7. Medicine cards to write the medication order from patients order sheet

**[Please observe the trainee's activities and tick in the appropriate box]**

| **Tasks** | **Executed** | **Not Executed** |
|---|---|---|
| | | |
| Wash hands | | |
| Collect necessary medicine. | | |
| Greet the patient and explain the procedure clearly. | | |
| Obtain verbal consent to the procedure. | | |
| Maintain privacy and make the patient comfortable position. | | |
| Ensure medication order satisfactory, checking 6 rights of medication-- | | |
| • Check right patient | | |
| • Check right drug | | |
| • Check right time | | |
| • Check right route | | |

| | | |
|---|---|---|
| • Check right dose<br>• Check right documentation | | |
| Check expiry date and color of prescribed drug. | | |
| For liquid suspension drug check the appropriate amount of drug and mix with juice. | | |
| Check above 5 rights once again. | | |
| Accurately administer medication. | | |
| Comfort the patient. | | |
| Avoid undue delay in procedure | | |
| Monitor and document client response to medication and report to the ward in-charge if necessary. | | |

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date

**Procedure Name** : **Administering Oxygen Therapy by Face Mask**

**Name of Trainee** :

**Roll no** :

**Purposes:**

- To relieve dyspnea
- To reduce or prevent hypoxemia and hypoxia
- To alleviate associated with struggle to breathe.

**Necessary Equipment:**

1. Client's chart and Kardex
2. Oxygen connecting tube (1)
3. Flowmeter (1)
4. Humidifier filled with sterile water (1)
5. Oxygen source: Wall Outlets or Oxygen cylinder
6. Tray with nasal cannula of appropriate size or oxygen mask (1)
7. Kidney tray (1)
8. Adhesive tape
9. Scissors (1)
10. Oxygen stand (1)
11. Gauze pieces, Cotton swabs if needed
12. "No smoking" sign board
13. Globes if available (1)

**[Please observe the trainee's activities and tick in the appropriate box]**

| **Tasks** | **Executed** | **Not Executed** |
|---|---|---|
| Check physician order. | | |
| Collect all equipment. | | |
| Explain the procedure to the patient or family members. | | |
| Check whether the oxygen cylinder is full or not, whether there is any default. | | |
| Select oxygen flow as per order, check correct level of water in humidifier. | | |
| Wash hands. | | |

| Tasks | Executed | Not Executed |
|---|---|---|
| Positioning the patient i.e. propped up/comfortable. | | |
| Ensure the airway is clear. | | |
| Open the oxygen and regulate the flow of oxygen after attaching the mask. | | |
| Ensure appropriate apparatus at the bed side such as calling bell, paper and pencil. | | |
| Make the patient comfortable. | | |
| No mosquito coil and "No Smoking Sign" are placed on patient's door/bedside. | | |
| Observe the patient at regular interval. | | |

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date

**Procedure Name** : **Administering I/M Injection**

**Name of Trainee** :

**Roll no** :

**Introduction:** Intra-muscular injection is the injection of medicine into muscle tissue. To produce quick action a patient as the medicine given by injection is rapidly absorbed. Intramuscular injections are often given in the deltoid, vastus laterals, ventrogluteal and dorsolateral muscles.

**Purposes:**

- To relieve symptoms of illness
- To promote and prevent from disease
- To treat the disease accordingly

**Necessary Equipment:**

A tray containing;

1. Client's chart and medicine card
2. Prescribed medication
3. Sterile syringe (3-5mL) (1)
4. Sterile needle in appropriate size: commonly used 21 to 23Gwith 1.5" (3.8cm) needle (1)
5. Spirit swabs
6. Kidney tray (1)
7. Disposable container (1)
8. Ampoule cutter if available (1)
9. Steel Tray (1)
10. Disposable gloves if available (1)
11. Pen

**[Please observe the trainee's activities and tick in the appropriate box]**

| **Tasks** | **Executed** | **Not Executed** |
|---|---|---|
| Check physician order. | | |
| Confirm correct patient. | | |
| Check that all necessary equipment is available. | | |
| Explain the procedure to the patient. | | |
| Obtain inform consent for the injection. | | |
| Keep the patient in suitable position. | | |
| Wash hands and put on gloves. | | |

| Tasks | Executed | Not Executed |
|---|---|---|
| Check the name, expiry date of the prescribed injection. | | |
| Prepare injection maintain five rights. Aspirate into syringe, ensure no air in syringe. | | |
| Uncover are to be injected (deltoid muscle, upper lateral thigh, and lateral upper quadrant major gluteal muscle). | | |
| Clean insertion point, must use at least 3 wipes with swab. | | |
| Ask patient to relax the target muscle. | | |
| Insert needle swiftly at an angle of 90 degree. | | |
| Aspirate briefly, if blood appears withdraws the needle and start again. | | |
| If no blood return, inject slowly. | | |
| Withdraw needle swiftly. | | |
| Press sterile cotton wool over the opening with pressure. Fix with adhesive tape. | | |
| Check the patient reaction and give additional reassurance, if necessary. | | |
| Document procedure in patient's medication chart including contents and location of injection and any complication. | | |
| Keep the patient in comfortable position. | | |
| Clean up, dispose of waste safely. | | |
| Maintain sterility appropriately throughout the procedure. | | |
| Wash hands. | | |

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date

**Procedure Name** : **Wound Dressing**

**Name of Trainee** :

**Roll no** :

## Purposes:

- To promote wound granulation and healing
- To prevent micro-organisms from entering wound
- To decrease purulent wound drainage
- To absorb fluid and provide dry environment
- To immobilize and support wound
- To assist in removal of necrotic tissue
- To apply medication to wound
- To provide comfort

**Necessary Equipment:**

1. Sterile gloves (1)
2. 2.Gauze dressing set containing scissors and forceps (1)
3. Cleaning disposable gloves if available (1)
4. 4 Cleaning basin(optional) (1) as required
5. Plastic bag for soiled dressings or bucket (1)
6. 6.Waterproof pad or mackintosh (1)
7. Tape (1)
8. Surgical pads as required
9. 9.Additional dressing supplies as ordered, e.g. antiseptic ointments, extra dressings
10. 10.Acetone or adhesive remover (optional)
11. Sterile normal saline (Optional)

**[Please observe the trainee's activities and tick in the appropriate box]**

| Tasks | Executed | Not Executed |
|---|---|---|
| Greet the patients and explain the procedure | | |
| Collect and take trolley with sterilized equipment to the patient's bedside. | | |
| Maintain privacy | | |
| Keep the patient in comfortable position and instruct patient not to touch wound or dressing materials | | |

| Tasks | Executed | Not Executed |
|---|---|---|
| Wash hands | | |
| Place rubber sheet and its cover under the affected side. | | |
| Observe wound and check if there is drainage rubber or tube. | | |
| Take specimen for culture or slide if ordered (do not cleanse wound with antiseptic before you obtain the specimen). | | |
| Remove the outer layer of the dressing using the first sterile forceps and discard both the soiled dressing and the forceps. | | |
| Take the second sterile forceps. Clean wound with gauge soaked in antiseptic solution, starting from inside to the outside. | | |
| Start cleaning wound from the cleanest part of the wound to the most contaminated part using antiseptic solution. | | |
| Apply medication if any and dress the wound with sterile gauge. | | |
| Use gauge for drying the skin around the wound properly. | | |
| Dress the wound and make sure that the wound is covered completely. | | |
| Fix dressing in place with adhesive tape or bandage. | | |

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date

**Procedure Name** : **Tracheostomy Tube Suctioning**

**Name of Trainee** :

**Roll No** :

**Introduction**: Tracheotomy, or tracheostomy, is a surgical procedure which consists of making an incision on the anterior aspect of the neck and opening a direct airway through an incision in the trachea.

**Purposes of Tracheostomy**:

A tracheostomy is usually done for one of three reasons:

1. to bypass an obstructed upper airway;
2. to clean and remove secretions from the airway;
3. to more easily, and usually more safely, deliver oxygen to the lungs.

**Necessary Equipment:**

1. Sterile suctioning kit containing:
2. Appropriate-sized suction catheter (14 Fr)
3. Pair of gloves
4. Container of saline to flush and lubricate
5. Suction catheter
6. Drape Pulse oximeter (10-15 liters)
7. Gauze and hydrogen peroxide;
8. Syringe, forceps, scissors, lubricant;
9. Gown, and mask.

**[Please observe the trainee's activity and tick in the appropriate box]**

| **Tasks** | **Executed** | **Not Executed** |
|---|---|---|
| Position the patient in semi-fowler's position. Frequency of suction will vary and must be individually assessed. | | |
| Place a linen-saver pad, towel or clean sheet on the patient's chest. | | |
| Put on a face shield, mask or goggles. | | |
| Turn on the wall suction or portable suction machine. Check and adjust the pressure regulator according to policy/protocol (typically 100-120 mmHg for adults, 95-110 mmHg for children, and 50-95 mmHg for infants). | | |
| Test the suction equipment by occluding the connection tubing. | | |

| Tasks | Executed | Not Executed |
|---|---|---|
| Open the suction catheter kit or the gathered equipment if a kit is now available. | | |
| Consider dominant hand keep sterile with sterile gloves and the non-dominant hand non sterile. | | |
| Pour sterile saline into the sterile container, using the non-dominant hand. | | |
| Pick up the suction catheter with the dominant hand and attachés it to the connection tubing. | | |
| Put the tip of the suction catheter into the sterile container of normal saline solution and suctions a small amount of normal saline solution through the catheter. | | |
| Lubricate the suction catheter tip with normal saline. | | |
| Using the dominant hand, gently but quickly insert the suction catheter into the Tracheostomy tube. | | |
| Advance the suction catheter, with suction off, gently aiming downward and being careful not to force the catheter. | | |
| Apply suction only while withdrawing the catheter. | | |
| Do not apply suction for longer than 10 seconds at a time. | | |
| Repeat suctioning as needed, allowing at least 30 seconds interval between suctioning. | | |
| Hyper oxygenate patient between each pass. | | |
| Replace the oxygen source, if the patient was removed from the source during suctioning. | | |
| Discard the gloves and catheter in a water-resistant receptacle. | | |
| Using the non-dominant hand, clears the connective tubing of secretions by placing the tip into the container of sterile saline. | | |
| Provide mouth care | | |
| Document the procedure | | |

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date

**Procedure Name** : **Catheterization**

**Name of Trainee** :

**Roll no** :

**Purpose of catheterization:**

- To relieve retention of urine
- Keeping incontinent clients dry
- To accurately measure the urine output
- To drain the bladder before, during or after surgery
- For investigation
- Obtaining sterile urine specimen
- Installing medication within the bladder
- To allow irrigation of bladder

**Necessary Equipment**

A. Clean tray containing

1. Flash light
2. A bowel with warm water and small towel
3. Antiseptic solution
4. Adhesive tape and scissors
5. Specimen jar (if necessary)
6. Sterile saline (if Necessary)
7. Tope to secure catheter to leg (e. g; micropore)

**[Please observe the trainee's activities and tick in the appropriate box]**

| **Tasks** | **Executed** | **Not Executed** |
|---|---|---|
| Collect all required equipment bring to the patient bed side | | |
| Greeting the patient and explain the procedure | | |
| Maintain proper position- dorsal recumbent (pillows can be used to elevated the buttocks in female) | | |
| Maintain privacy with screen | | |
| Wash hands properly | | |
| Wash the perennial area with warm water and soap. | | |
| Rinse and dry the area. | | |

| Tasks | Executed | Not Executed |
|---|---|---|
| Create a sterile field. | | |
| Drape the client with a sterile drape. | | |
| Clean the area with antiseptic solution. | | |
| Lubricate the insertion tip of the catheter (5-7 cm) | | |
| Expose the urinary meatus adequately by retracting the tissue or the labia minora in an upward direction female. | | |
| Retract the fore skin of uncircumcised male. | | |
| Grasp the penis firmly behind the glands and hold straighten the downward curvature of vertical it goes to the body-hold the catheter 5cm from the insertion tip. | | |
| Insert the catheter into the urethral orifice. | | |
| Insert the catheter until urine comes. | | |
| Insert 5-10ml of distilled water into the balloon of the catheter. | | |
| Collect the urine for specimen (adult 30ml) if necessary. | | |
| Connect the catheter with the urine bag. | | |
| Fix the catheter in the thigh area with adhesive tape. | | |
| Hang the urine bag in the bed. | | |
| Document the procedure. | | |

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date

**Procedure Name : Specimen Collection**

**Name of Trainee :**

**Roll no :**

**Purposes: '**

- To examine the condition of client and assess the present treatment
- To diagnose disease

**Necessary Equipment:**

1. Laboratory form
2. Sterilized syringe
3. Sterilized needles
4. Tourniquet (1)
5. Blood collection tubes or specimen vials as ordered
6. Spirit swabs
7. Dry gauze
8. DisposableGloves if available (1)
9. Adhesive tape or bandages
10. Sharps Disposal Container (1)
11. Steel Tray (1)
12. Ball point pen (1)

**[Please observe the trainee's activities and tick in the appropriate box]**

| Task | Executed | Not Executed |
|---|---|---|
| Check physician order for specimen collection. | | |
| When collecting specimen wear gloves to protect self from contact with body fluid. | | |
| Get request for specimen collection and identify the types of specimens being collected and the patient from which the specimen to be collected. | | |

| Task | Executed | Not Executed |
|---|---|---|
| Give adequate explanation to the patient about the purpose, type of specimen being collected and the method used. | | |
| Assemble and organize all the necessary materials for the specimen collection. | | |
| Get the appropriate specimen container and level clearly and placed in the plastic bag or tracks. | | |
| Check the patient's identification such as – name, age, card number, the ward and bed number (if in patient). | | |
| Clear the types of specimens and method used (if needed). | | |
| Write down the time and date of specimen collection. | | |
| Collect the desire specimen maintain aseptic technique. | | |
| Put the collected specimen into the container without contaminating outer part of the container and its cover. | | |
| The entire specimen should be sent promptly to the laboratory with appropriate requisition form. | | |

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date

**Procedure Name : Enema Simplex**

**Name of Trainee :**

**Roll no :**

**Purposes:** An enema involves inserting liquid or gas into the rectum, which is the lower part of the large intestine. The aim is to empty the bowels, allow for an examination, or administer medication. An enema can be effective in treating certain medical conditions, but regular enema use can cause serious health problems.

**Necessary Equipment:**

The equipment required to perform an enema is as follows:

1. Gloves and disposable apron;
2. Incontinence pads;
3. Lubricating solution;
4. Jug with water, warmed to the desired temperature;
5. Water thermometer;
6. Bedpan/commode;
7. Prepared solution.
8. Bedside screen

**[Please observe the trainee's activities and tick in the appropriate box]**

| Task | Executed | Not Executed |
|---|---|---|
| Inform the patient about the procedure. | | |
| Collect all the necessary equipment. | | |
| Put bedside screen for privacy. | | |
| Attach rubber tube with enema can with nozzle and stop the cork or clamp | | |
| Place the patient in lateral position with the Rt leg flexed, for adequate exposure of the anus (facilitates the flow of solution by gravity into the sigmoid and descending colon, which are on the side). | | |
| Maintain the temperature of enema solution (990-1030F). | | |
| Fill the enema can which 1000 cc of solution for adults. | | |
| Lubricate about 5cm of the rectal tube to facilities insertion through the sphincter and minimize trauma. | | |

| Task | Executed | Not Executed |
|---|---|---|
| Hung the can 45cm from bed or 30cm from patient on the stand. | | |
| Place a piece of mackintosh under the bed. | | |
| Make the tube air free by releasing the clamp and allowing the fluid to run down little to the bed pan and clamp open- prevents unnecessary distention. | | |
| Lift the upper buttock to visualize the anus. | | |
| Insert the tube in an adult smoothly and slowly. | | |
| Raise the solution container and open the clamp to allow fluid to flow. | | |
| Administer the fluid slowly if client complains of fullness or pain, stop the flow for 30minutes and restart the flow at a slower rate. | | |
| Decrease intestinal spasm and premature ejection of the solution. | | |
| Do not allow all the fluid to go as there is a possibility of air entering the rectum or when the client cannot hold anymore and wants to defecate, close the clamp and remove the rectal tube from the anus and offer the bed pan. | | |
| Remove bed pan and clean the rectal tube. | | |
| Do not flash the commode if the patients defecate in toilet. | | |
| Observe the color, smell, any blood in the toilet. | | |
| Record the procedure. | | |

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date

**Procedure Name** : **Antenatal Assessment**

**Name of Trainee** :

**Roll no** :

**Purposes:**

- To promote and maintain the physical, mental, and social health of mother and baby by providing education on nutrition, personal hygiene, and birthing process;
- To detect and manage complications during pregnancy, whether medical, surgical, or obstetrical;
- To develop birth preparedness and complication readiness has as goal to reduce maternal and neonatal mortality.

**[Please observe the trainee's activities and tick in the appropriate box]**

| Task | Executed | Not Executed |
|---|---|---|
| Communicate with the woman appropriately. | | |
| Take the pregnancy history and well-being. | | |
| Observe general appearances, oedema and anemia. | | |
| Accurately calculated gestation. | | |
| Accurately take blood pressure. | | |
| Measure height, weight | | |
| Correctly test the urine using universal precautions (albumin and sugar) | | |
| Perform the procedure of palpation systematically Fundal/Lateral/Pelvic | | |
| Inspection size/shape/scars | | |
| Identify fundal height, lie, position, presentation, descent of presenting part, amount of amniotic fluid. | | |
| Auscultation- | | |
| Listens to the fetal heart sound.<br>Count the beats for one minute is accurate | | |
| Discuss clinical finding with woman. | | |
| Interpret blood and urine results correctly identifying any deviation from the normal. | | |

| Task | Executed | Not Executed |
|---|---|---|
| Inform the woman about finding and give appropriate advice accordingly including nutrition. | | |
| Document all information. | | |

**Signature of evaluator/ward in-charge:**

Full Name :

Designation :

Date