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Practical Record Book of

MEDICAL SURGICAL NURSING

for GNM



Alisha Talwar
Sandeep Kaur

Name of the Candidate: _____

Name of the Institution: _____

_____

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Section 7

Dermatology and Burns

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Burn Assessment

Demographic/Identification Data

Name: _____ Age: _____ Sex _____

MRD/Patient ID No.: _____

Address: _____

Religion: _____ Education _____ Occupation _____

Marital status: _____ Spoken Language: _____ Bed No:/Ward Sex _____

Date of admission _____ Medical Diagnosis _____

Information source: _____

Burn assessment				
History of Present Illness	Cause of burn	☐ Thermal ☐ Chemical ☐ Electrical ☐ Radiation		
General assessment	General condition	☐ Stable	☐ Critical	
	Level of consciousness	☐ Conscious	☐ Drowsy	☐ Unconsciousness

Vital chart

Date	*Time*	*Temperature (°C/°F)*	*Pulse (bpm)*	*Respiration (breaths/min)*	*Blood pressure (mm Hg)*	*SpO_2 (%)*

Primary assessment (ABCD Approach) Respiratory system	**Airway** Patent Y/N-	**Circulation** Capillary refill ☐ Normal ☐ Delayed	
	Chest movement ☐ Normal ☐ Restricted		

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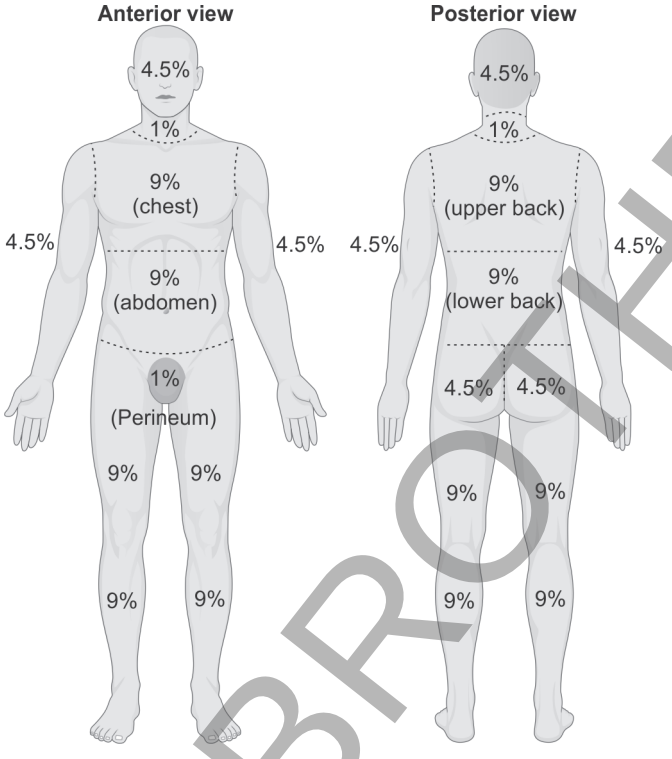
Secondary Assessment

Burn Wound Assessment



Thickness	*Degree*	*Depth involved*	*Characteristics*
Superficial	First degree	Epidermis	Painful, erythema, no blisters (e.g., sunburn)
Superficial partial thickness	Second degree (superficial)	Epidermis + papillary dermis	Extremely painful, blister formation, moist, red/pink, blanches on pressure
Deep partial thickness	Second degree (deep)	Extends into reticular dermis	Less painful, pale or waxy appearance, may be moist or dry, poor blanching
Full thickness	Third degree	Entire dermis (epidermis + dermis)	Painless (nerve destruction), white/brown, leathery (eschar), dry and inelastic
Full thickness with deeper involvement	Fourth degree	Extends to fascia, muscle, bone	Charred, black, insensate, may show eschar or gangrene

Extent of Burn (Rule of Nine)

Head and Neck: _____ %		Anterior trunk: _____ %	
Upper limb (each): _____ %		Posterior trunk: _____ %	
Lower limb (each): _____ %		Perineum: _____ %	
Total Body Surface Area (TBSA): _____ %			
Characteristics of wound			
Color	Red	Pale	Charred
Blisters	Present	Absent	
Edema	Yes	No	
Exudate	Yes	No	

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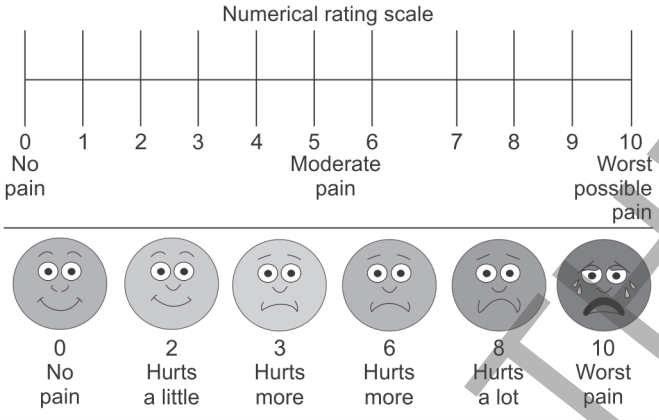
Odor	Yes	No
Pain assessment	Pain score (0 to 10).	Nature of pain



Investigations	HB	WBC	Electrolytes
	ABG	Urine output ml/hr	
Fluid assessment	Skin turgor ☐ Normal ☐ Poor	Signs of dehydration ☐ Yes ☐ No	

Nursing Care Plan

Nursing assessment	*Nursing diagnosis*	*Planning*	*Interventions*	*Evaluation*
Subjective data and Objective data				
Subjective data and Objective data				
Subjective data and Objective data				

Nursing Responsibilities

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Remarks

Signature

Student Nurse

Preceptors signature

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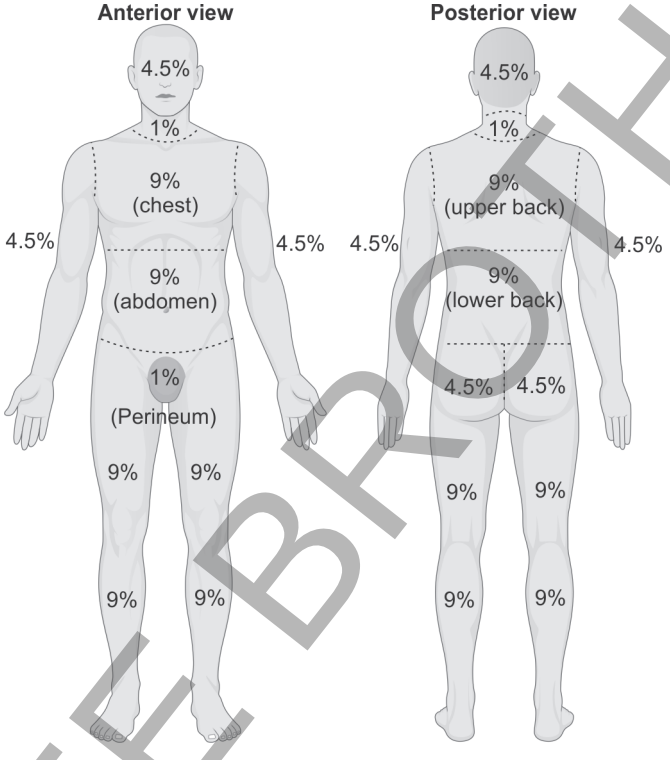
Calculation of Percentage/Degree of Burns

Palm Method (for Small Burns)

Patient's palm (including fingers) ≈ 1% of BSA

Rule of nine (Adults)



Thickness	*Degree*	*Depth involved*	*Characteristics*
Superficial	First degree	Epidermis	Painful, erythema, no blisters (e.g., sunburn)
Superficial partial thickness	Second degree (superficial)	Epidermis + papillary dermis	Extremely painful, blister formation, moist, red/pink, blanches on pressure
Deep partial thickness	Second degree (deep)	Extends into reticular dermis	Less painful, pale or waxy appearance, may be moist or dry, poor blanching
Full thickness	Third degree	Entire dermis (epidermis + dermis)	Painless (nerve destruction), white/brown, leathery (eschar), dry and inelastic
Full thickness with deeper involvement	Fourth degree	Extends to fascia, muscle, bone	Charred, black, insensate, may show eschar or gangrene

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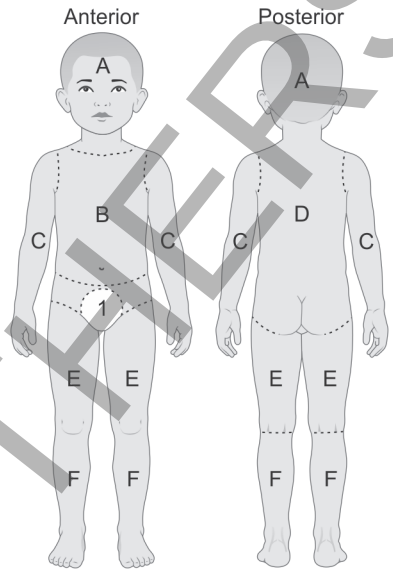
In Children (Lund and Browder Method)

Age (years)	Percentage of total body surface area (% TBSA)						
	A Head	B Anterior trunk	D Posterior trunk	C Each arm	E Each thigh	F Each leg	1 Perineum
0	19	13	13	4	5.5	5	1
1	17	13	13	4	6.5	5.5	1
5	13	13	13	4	8	6	1
10	11	13	13	4.5	8.5	6.5	1
15	9	13	13	4.5	9	7	1



BSA Calculation (General Body Surface Area)

BSA = $\sqrt{\text{Height(cm)} \times \text{Weight(kg)} / 3600}$

Where:

- **Height** = patient's height in centimetres (cm)
- **Weight** = patient's weight in kilograms (kg)
- **BSA** = body surface area in square meters (m^2)

Body Surface Area (BSA) Calculation

Parameter	*Value*
Height (cm)	
Weight (kg)	
Calculated BSA	

Fluid resuscitation formula for burn patients

The parkland formula for the total fluid requirement in 24 hours is as follows:

Fluid requirement (mL)= 4 × Weight (kg) × %TBSA burned

Fluid administration schedule

Time	*Fluid*
First 8 hours (from burn time)	50% of total
Next 16 hours	Remaining 50%

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Calculation Table

Parameter	*Value*
Weight (kg)	
% TBSA Burn	
Total Fluid (mL)	
First 8 hours (mL)	
Next 16 hours (mL)	
Type of Fluid	

Children receive maintenance fluid in addition, at an hourly rate of:

- First 10 kg body weight: 4 mL/kg/hr
- Second 10 kg body weight: 2 mL/kg/hr
- Above 20 kg body weight: 1 mL/kg/hr

Formula

Weight range	*Fluid rate*
0–10 kg	4 mL/kg/hr
10–20 kg	40 mL + 2 mL/kg/hr for each kg above 10
>20 kg	60 mL + 1 mL/kg/hr for each kg above 20

Record

Parameter	*Value*
Weight (kg)	
Maintenance fluid (mL/hr)	
Calculation	

Remarks

_____

_____

_____

Signature

Student Nurse Preceptors signature

Date:

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Provide Care to Assigned Patients (Care Note)-I

Demographic/Identification Data

Name: _____ Age: _____ Sex _____

MRD/Patient ID No.: _____

Address: _____

Religion: _____ Education _____ Occupation _____

Marital status: _____ Spoken Language: _____ Bed No:/Ward _____

Date of admission _____ Medical Diagnosis _____

Information source: _____

Assessment

Burn assessment				
History of Present Illness	Cause of burn	☐ Thermal ☐ Chemical ☐ Electrical ☐ Radiation		
General assessment	General condition	☐ Stable	☐ Critical	
	Level of consciousness	☐ Conscious	☐ Drowsy	☐ Unconsciousness
Vital chart				

General condition	Consciousness	☐ Conscious	☐ Drowsy	☐ Unconscious
	Orientation	☐ Oriented	☐ Disoriented	

Vital signs

Date	*Time*	*Temperature (°C/°F)*	*Pulse (bpm)*	*Respiration (breaths/min)*	*Blood pressure (mm Hg)*	*SpO_2 (%)*

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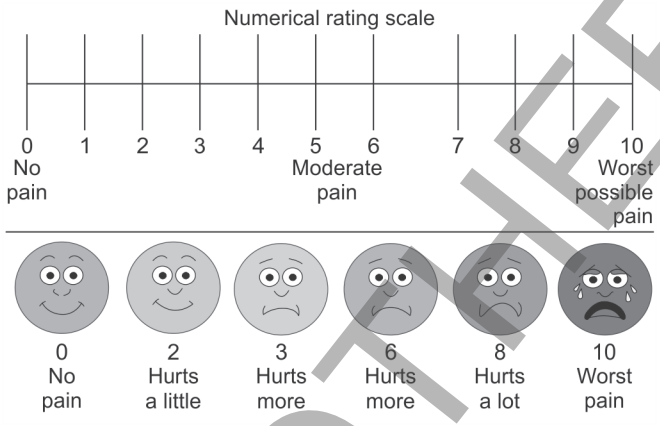
Pain assessment		Pain score (0-10) – Location – Nature: ☐ Burning ☐ Throbbing ☐ Sharp  				
Burn assessment		Cause of burn	☐ Thermal	☐ Chemical	☐ Electrical	☐ Radiation
	Depth	☐ Superficial		☐ Partial thickness		☐ Full thickness
	Presence of blisters – ☐ Yes ☐ No			Signs of infection - ☐ Yes ☐ No		
	Wound appearance	☐ Red	☐ Pink	☐ White		☐ Charred
Fluid status		Intake _____	Output _____	Urine output(ml/hr) _____	Signs of dehydration ☐ Yes ☐ No	
Nutritional status		Appetite	☐ Good ☐ Poor	Mode of feeding	☐ Oral	☐ NG tube ☐ IV

CARE NOTE

Instructions: Notes to be recorded using

- **DARP format**: D = Data; A = Action; R = Response; P = Plan OR
- **SOAP format:** S = Subjective data; O = Objective data; A = Assessment; P = Plan OR
- **SOPIER format**: S = Subjective data; O = Objective data; A = Assessment; P = Plan; I = Intervention; E = Evaluation; R = Response

NURSES NOTE

Date/Time	*Focus problem*	*Notes*

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Date/Time	*Focus problem*	*Notes*

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Nursing Care Plan

Nursing assessment	*Nursing diagnosis*	*Planning*	*Interventions*	*Evaluation*
Subjective data and Objective data				
Subjective data and Objective data				
Subjective data and Objective data				

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Nursing assessment	*Nursing diagnosis*	*Planning*	*Interventions*	*Evaluation*
Subjective data and Objective data				
Subjective data and Objective data				
Subjective data and Objective data				

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Nursing Responsibilities

Remarks

Signature

Student Nurse

Date:

Preceptors signature

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Provide Care to Assigned Patients (Care Note)-II

Demographic/Identification Data

Name: _____ Age: _____ Sex _____

MRD/Patient ID No.: _____

Address: _____

Religion: _____ Education _____ Occupation _____

Marital status: _____ Spoken Language: _____ Bed No:/Ward _____

Date of admission _____ Medical Diagnosis _____

Information source: _____.

Assessment

General condition	Consciousness	☐ Conscious	☐ Drowsy	☐ Unconscious
	Orientation	☐ Oriented	☐ Disoriented	

Vital signs						
Date	***Time***	***Temperature (°C/°F)***	***Pulse (bpm)***	***Respiration (breaths/min)***	***Blood pressure (mm Hg)***	***SpO_2 (%)***

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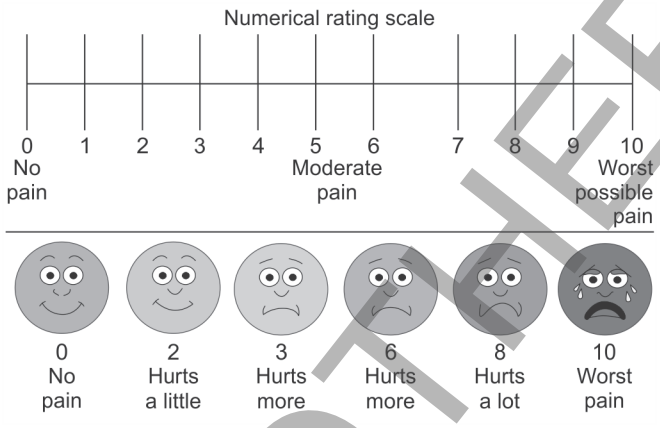
Pain assessment		Pain score (0–10) – Location – Nature: ☐ Burning ☐ Throbbing ☐ Sharp  				
Burn assessment		Cause of burn	☐ Thermal	☐ Chemical	☐ Electrical	☐ Radiation
	Depth	☐ Superficial		☐ Partial thickness		☐ Full thickness
	Presence of blisters – ☐ Yes ☐ No			Signs of infection - ☐ Yes ☐ No		
	Wound appearance	☐ Red	☐ Pink	☐ White		☐ Charred
Fluid status		Intake _____	Output _____	Urine output(ml/hr) _____	Signs of dehydration ☐ Yes ☐ No	
Nutritional status		Appetite	☐ Good ☐ Poor	Mode of feeding	☐ Oral	☐ NG tube ☐ IV

CARE NOTE

Instructions: Notes to be recorded using

- **DARP format**: D = Data; A = Action; R = Response; P = Plan OR
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NURSES NOTE

Date/Time	*Focus problem*	*Notes*

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Date/Time	*Focus problem*	*Notes*

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Nursing Care Plan

Nursing assessment	*Nursing diagnosis*	*Planning*	*Interventions*	*Evaluation*
Subjective data and Objective data				
Subjective data and Objective data				
Subjective data and Objective data				

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Nursing assessment	*Nursing diagnosis*	*Planning*	*Interventions*	*Evaluation*
Subjective data and Objective data				
Subjective data and Objective data				
Subjective data and Objective data				

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Nursing Responsibilities

Remarks

Signature

Student Nurse

Date:

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Alisha Talwar MSN BSN completed her BSc Nursing from the College of Nursing, Dr Ram Manohar Lohia (RML) Hospital, New Delhi, India in 2015 and earned her MSc Nursing from the Institute of Liver and Biliary Sciences (ILBS), New Delhi, in 2019. Driven by a passion for nursing academics and student learning, she has contributed as a reviewer for several nursing textbooks, including *Applied Sociology for Nurses, LC Gupta's Practical Nursing Procedures, Research Methodology for Nurses*, etc. She is dedicated to enhancing the quality and accessibility of educational resources for nursing students.

Sandeep Kaur BSN is a dedicated nursing professional and educator with over 7 years of combined clinical and academic experience. She completed her Bachelor of Science in Nursing (BSc Nursing) from the prestigious Sant Baba Bhag Singh Institute of Nursing, Khiala, Jalandhar, Punjab, India in 2016. A strong foundation in both clinical practice and academic instruction drives her to deliver comprehensive, accessible, and impactful educational content.

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