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Cumulative Record of Clinical Experience

of Basic BSc Nursing Students (As Per New Syllabus)

Name of the Candidate: _____

Name of the Institution: _____

_____

3rd Edition

BT Basavanthappa



Cumulative Record of Clinical Experience of Basic BSc Nursing Students

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

Registration no. : .....

Age and Date of Birth : .....

Name of the Father : .....

Name of the Mother : .....

Passport size photograph

Date of Joining the Course : .....

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

.....

.....

Name of the Hospitals/Nursing Homes (where the Clinical Practice Attended) : .....

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Date of completion of course : .....

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

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INSTRUCTIONS TO THE STUDENT

- Student must wear the uniform, shoes and socks prescribed by the Institution/College/School.
- Student must have prescribed pocket articles required during Clinical experience i.e. small scissors, color pens/ pencils or pocket notebook and ruler.
- Students are requested to groom their hair and cut their nails properly.
- Students are not expected to wear jewelries but they are expected to wear wrist watch with seconds.
- Students are not expected to use telephones, cellular/mobile phone, pocket radios and other electronic media during clinical hours or while on clinical posting - Hospital premises.
- Students are not expected to allow any of the visitors to clinical setting during clinical posting.
- Students are prohibited from entering, vacant rooms/unoccupied rooms at hospital or health center unless it is official or justifiable
- Students are expected to be in particular ward or unit of hospital allotted for them in clinical area for their learning experience.
- Students are expected to leave the clinical area by informing, supervisor or incharge staff nurse of hospital ward during emergencies.
- Students are expected to take care of individual client properly by applying nursing process and showing more concern about their clients.
- Students are expected to maintain sincerity in attending postings in clinical area.
- Students are expected to maintain honesty, punctuality, various humanitarian skills during their postings in clinical area.
- Students who show misbehavior like dishonesty, uncourtesy, forgery, immoral conduct, using dangerous drugs, alcohol, smoking and others not tolerated will be punished according to policy of the government or management of the institutions.
- Procedure record is a clinical evidence of each student, therefore, every student needs to handle this record carefully, keep it safe, and fulfill requirements mentioned in the record.
- Procedure record front page regarding student's information to be filled, fix passport size photograph, in respective place.
- Procedure once demonstrated with the theory in the laboratory, students are expected to do re-demonstration under supervision of nursing staff, signatures to be given in demonstration column with the date by the respective staff after conducting viva about the procedure done.
- Procedure done by the student in the clinical should get signature in the clinical column after performing three times, to ensure satisfaction by the staff after attending viva of the same procedure.
- Students who put forgery signature will be severely punished (or) will undergo strict disciplinary action.
- Students are not allowed to overwrite, (or) do any writing (or) scrabble anything in the procedure book.
- Students are expected to complete the procedure for each year, two weeks prior to university examination, get signature and submit to Principal, those who fail to complete procedure book will not be eligible for the university examination and practical.
- Students who lost this cumulative record are responsible for themselves, should get signatures completely in a new record at their own risk to their respective teachers by showing rough signatures obtained previously in the rough practical book.
- No student is permitted to do any procedure independently unless she/he obtained signature for that procedure under supervision of clinical instruction or Nursing staff of hospital.
- The student is expected to take responsibility for her/his own learning by:
  a. Requesting the clinical instructors to supervise the procedure she/he needs to have signature.
  b. Volunteering for experience she/he needs.
  c. Taking responsibility for obtaining signature from the clinical instructor who supervised the procedure, immediately following successful completion of procedure and attending viva regarding the same.
- Student should ensure that they get signature from internal and external examiners after successful completion of practival examination each year.
- Students who have back up in their academic activities, should get signature in the area from internal and external examiners, after completing their practical examination.

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FIRST YEAR
NURSING FOUNDATION-PRACTICAL

Placement: First year **Time: Practical 650 hours—(Lab 200 hours + Clinical 450 hours)**

Sl. No.	Nursing procedures/activities	Date of demonstration		
		Laboratory	Clinical setting	Signature of teacher/ supervisor
1.	**Hospital admission and discharge**			
	Admission of patient			
	a. Prepare unit for new patient			
	– Care of patients unit			
	b. Disinfection of unit			
	– Follow universal precautions			
	– Handwashing – medical, surgical			
	– Use of gloves, masks, gown			
	– Disposal of waste			
	c. Preparation of admission bed			
	d. Perform admission procedures			
	– Admission of new patient			
	– Transfer of patient (Transfer-in)			
	e. Discharge/transfer-out procedures			
	– Provide discharge counseling			
	– Perform discharge procedure			
	– Planned discharge			
	– Leave against Medical advice (LAMA)			
	– Abscond			
	– Referrals			
	– Transfer–out			
	– Dismantle, and disinfect unit (follow universal precautions)			
	– Disinfect equipment and linen after discharge			
	– Prepare records of discharge, transfer			
2.	**Perform assessment**			
	• History taking			
	• Nursing diagnosis			
	• List nursing problems/problem list			
	• Making prioritization			
	• Formulating goals			
	• Infer expected outcome			
	• Selection of nursing intervention			
	• Writing nursing care plan			
	• Providing care according to plan			

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Sl. No.	Nursing procedures/activities	Date of demonstration		
		Laboratory	Clinical setting	Signature of teacher/ supervisor
3.	**Communication**			
	• Proper use of verbal communication			
	• Timely use of non-verbal communication			
	• Role play in simulated situation			
	• Writing patient report			
	• Change of shift report			
	• Transfer report			
	• Incident report			
	• Presenting patient report			
	• Prepare plan for patient teaching (health talk) sessions			
4.	**Vital signs**			
	• Temperature measurement			
	– Oral			
	– Axillary			
	– Rectal			
	• Monitoring pulse			
	• Monitoring respiration			
	• Monitoring blood pressure			
	• TPR, BP recording and interpretation			
5.	**Health assessment**			
	• Taking health history			
	• Perform general assessment of body systems			
	– Use of various methods of physical examination			
	• Inspection			
	• Palpation			
	• Percussion			
	• Auscultation			
	• Olfaction			
	• Identify system wise deviations			
6.	**Prepare patients unit**			
	• Prepare beds (bed making)			
	• Open bed			
	• Closed bed			
	• Occupied bed			
	• Operation bed			
	• Amputation bed			
	• Cardiac bed			
	• Fracture bed			
	• Burns bed			

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Sl. No.	Nursing procedures/activities	Date of demonstration		
		Laboratory	Clinical setting	Signature of teacher/ supervisor
	• Divided bed			
	• Fowler bed			
7.	**Pain assessment and provision for comfort**			
	• Use of comfort devices			
	• Mattresses (air, water)			
	• Extra pillows			
	• Backrest			
	• Cardiac table			
	• Bed cradle			
	• Air cushion			
	• Footrest			
	• Cotton rings, hand rolls			
	• Pads			
	• Trochanter rolls			
	• Sandbags			
8.	**Hygienic care**			
	• Providing oral hygiene			
	• Assisting oral hygiene			
	• Giving bed bath			
	• Taking care of pressure points			
	• Perform hair wash/hair care			
	• Treating pediculosis			
	• Providing back care			
	• Taking care of nail, hands and feet			
9.	**Nutritional need/feeding**			
	• Planning therapeutic diet			
	• According disease conditions			
	• Feeding			
	– Oral feeding			
	– Enteral feeding			
	– Nasogastric feeding			
	• Nasogastric tube insertion			
	• Nasogastric tube suction			
	• Nasogastric tube irrigation			
10.	**Assisting urinary elimination**			
	• Providing urinal/bedpan			
	• Removal of urinal/bedpan			
	• Apply condom drainage			
	• Give perineal care			

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Sl. No.	Nursing procedures/activities	Date of demonstration		
		Laboratory	Clinical setting	Signature of teacher/ supervisor
	• Urinary catherization			
	• Catheter care			
	• Care of urinary drainage			
	• Perform bladder irrigation			
11.	**Assisting bowel elimination**			
	• Insertion of flatus tube			
	• Giving cleansing enema			
	• Insertion of suppository			
	• Giving bowl wash			
12.	**Body alignment and mobility (movements)**			
	• Use of body mechanics			
	– Changing position of helpless patient			
	– Lifting and handling bedridden patient			
	– Transferring from bed to wheelchair/stretcher or trolley and back			
	– Active exercises performance			
	– Perform passive exercises			
	– Range of motion exercises			
	– Deep breathing and coughing exercises			
	– Chest physiotherapy			
	– Helping patient with use of crutches and walker			
	– Use of restraints			
13.	**Positioning of patients**			
	• Dorsal recumbent position			
	• Left lateral position			
	• Right lateral position			
	• Supine position			
	• Prone position			
	• Semi-prone position			
	• C - position			
	• Sims' position			
	• Lithotomy position			
	• Trendelenburg position			
14.	**Oxygen administration**			
	• Through nasal cannula			
	• Through nasal catheter			
	• Through oxygen mask			
	• Through oxygen tent			
	• Through oxygen nasal prong/oxygen hood			

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Sl. No.	Nursing procedures/activities	Date of demonstration		
		Laboratory	Clinical setting	Signature of teacher/ supervisor
	• Preparation for O_2 administration			
15.	**Suctioning**			
	• Preparing for suctioning			
	• Oropharyngeal suctioning			
	• Nasopharyngeal suctioning			
16.	**Chest physiotherapy and postural drainage**			
	• Care of chest drainage			
	• Chest physiotherapy			
	• Postural drainage			
	• Chest percussion			
	• Vibration			
17.	**CPR/basic life support**			
	• Cardiopulmonary resuscitation (CPR)			
	• Simulated exercise on CPR manikin			
18.	**Intravenous therapy**			
	• Observation of intravenous therapy			
	• Assisting intravenous insertion/injection			
	• Assisting intravenous infusion			
	• Observation of blood and blood component therapy			
	• Assisting blood transfusion			
	• Maintenance of intake and output chart			
19.	**Collection and observation of specimens for investigation**			
	• Urine: Routine, culture, 24-hour urine collection			
	• Blood: Routine, culture, peripheral smear			
	• Stool: Routine and culture			
	• Vomitus			
	• Throat swab			
20.	**Perform laboratory tests**			
	• Urine: Sugar, albumin, acetone, reaction, specific gravity, bile salt, and bile pigment			
	• Blood: Sugar (with strip/glucometer)			
21.	**Application of hot and cold therapy**			
	• Hot water bottle bag			
	• Hot fomentation			
	• Infrared/ultravoilet lamp			
	• Steam inhalation			
	• Sitz bath			
	• Dry cold application/ice cap			
	• Cold compress			

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Sl. No.	Nursing procedures/activities	Date of demonstration		
		Laboratory	Clinical setting	Signature of teacher/ supervisor
	• Moist cold application			
	• Cold sponging			
	• Tepid sponging			
22.	**Communicating and assisting with impaired patient**			
	• Assisting self-care of visually impaired			
	• Communicating with visually impaired			
	• Assisting self-care of hearing impaired			
	• Communicating with hearing impaired			
	• Assisting self-care of mentally challenged			
	• Communicating with mentally challenged			
23.	**Alteration in sensorium patient care**			
	• Assessment of patient of alteration in sensorium			
	• Care of patient with alteration sensorium			
24.	**Recreation and diversion therapy**			
	Providing recreation and diversion therapy			
25.	**Infection control**			
	• Performing handwashing technique			
	• Simple handwashing			
	• Use of hand antiseptics			
	• Surgical handwashing (scrubbing)			
	• Preparing isolation unit			
	• Use of personal protective equipment (PPE)			
	• Wearing and removal of mask			
	• Wearing and removal of gowns			
	• Wearing and removal of gloves			
	• Follow universal precautions			
26.	**Decontamination of equipment and unit**			
	Follow surgical asepsis			
	Using method of sterilization			
	• Boiling			
	• Autoclaving			
	• Flaming			
	• Hot air oven			
	• Chemical methods			
	• Mechanical methods			
	• Handling sterilized equipment			
	• Handling sterilized linen			
	• Calculation and preparation of lotions			
	Care of articles			
	• Care of rubber goods			

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Sl. No.	Nursing procedures/activities	Date of demonstration		
		Laboratory	Clinical setting	Signature of teacher/ supervisor
	• Care of soiled linen			
	• Care of mattress and pillows			
	• Care of needle and syringes			
	• Care of sharp instruments			
	• Care of used articles			
	• Care of disposable articles			
	• Decontamination of hospital wastes			
	• Segregation and transportation of wastes			
27.	**Pre- and postoperative care**			
	• Skin preparation for surgical site for surgery			
	• Preparation of postoperative unit			
	• Pre- and postoperative teaching/counseling			
	• Pre- and postoperative monitoring			
	• Care of wound and dressing			
	• Clean and dressing of minor wounds			
	• Clean and dressing of surgical wounds			
	• Care of drainage			
	Application of binders, splints and slings			
	• Abdominal binder			
	• Breast binder			
	• T-binder			
	• Application of splints			
	• Application of slings			
	Bandaging of various body parts			
	• Simple spiral			
	• Reverse spiral			
	• Figure of eight			
	• Capline (head)			
	• Eye and ear bandage			
	• Finger bandage			
	• Elbow bandage			
	• Knee bandage			
	• Use of triangular bandage			
	• Use of binders			
28.	**Administration of medication**			
	a. Enteral route			
	– Oral medication			
	– Sublingual medication			
	– Buccal medication			

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Sl. No.	Nursing procedures/activities	Date of demonstration		
		Laboratory	Clinical setting	Signature of teacher/ supervisor
	b. Parenteral route			
	– Intradermal			
	– Subcutaneous			
	– Intramuscular			
	– Assisting intravenous medication administration			
	c. Drug measurement and dosage calculation			
	– Preparation of lotion and solutions			
	– Administration of topical applications			
29.	**Insertion of drug into body cavity**			
	• Insertion of suppository			
	• Insertion of medicated packing			
	• Instillation of eye drops			
	• Instillation of ear drops			
	• Instillation of nasal drops			
	• Instillation of drops to throat			
	a. Irrigations			
	– Irrigation of eye			
	– Irrigations of ear			
	– Irrigation of bladder			
	– Irrigation of vagina			
	– Irrigation of rectum			
	b. Inhalations			
	– Dry inhalations			
	– Steam inhalation			
	– Nebulization			
	– Identification of spurious drugs			
	c. Documentation of medication (date, time, dose, route, and signs after medication)			
30.	**Care of dying**			
	• Care of terminality in patient			
	• Care of the body after death			
	• Packing of the dead body			
	• Counseling of grieving relative			
	• Handing over the body to relative			
	• Handing over the patients valuable to relative			
	• Transforming the dead body to mortuary (when needed)			

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MAINTENANCE OF RECORDS OF ASSIGNMENT

I. Reports of Admission, Discharge, Transfer, etc.

Sl.No.	Name of the patient	Ward	Date of submission	Signature of supervisor
1.				
2.				
3.				

II. Health Assessment/Nursing Assessment

Sl.No.	Name of the patient	Ward	Date of submission	Signature of supervisor
1.				
2.				
3.				

III. Nursing Care Plans

Sl.No.	Name of the patient	Ward	Date of submission	Signature of supervisor
1.				
2.				
3.				

IV. Patient Teaching Session in the Ward

Sl.No.	Name of the patient	Ward	Date of submission	Signature of supervisor
1.				
2.				
3.				

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V. Record of Performed Procedures in Ward

Sl.No.	Name of the patient	Ward	Date of submission	Signature of supervisor
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Note:

1. Whatever the procedure that performed in the wards, student should write the steps, and patient response should be reported to supervisor.
2. Dairy of daily activities related to nursing should be maintained.

Signature of the Class Coordinator **Signature of the Principal**

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Cumulative Record of Clinical Experience

of Basic BSc Nursing Students (As Per New Syllabus)

Salient Features

- Designed according to revised Indian Nursing Council (INC) syllabus
- Helps to develop various skills in Nursing
- Covers all the prescribed areas of Nursing to practice in each Course
- Serves as guide in clinical areas for both students and instructors.

BT Basavanthappa MN PhD attained superannuation from government service, in Karnataka state as Principal of Government College of Nursing, Bengaluru, Karnataka, India in 2006. He has vast experience in the field of nursing, worked as staff nurse for 16 years at McGann District Hospital, Shivamogga, Karnataka. He did BSc Nursing (1978), Master of Nursing (1988) and PhD in Nursing (1994). He is the first person who earned and awarded PhD in Nursing in the state of Karnataka.

With over 44 years of service as a bedside nurse and as an academician, he has taught all the areas of nursing in undergraduate and postgraduate courses in nursing. He is recognised PhD guide by the Indian Nursing Council and Indian universities. He has published more than 30 titles on nursing. He held various positions in Nurses Association and Government Employees Associations. At present, he is the President of RGUHS Nursing Teachers' Association of Karnataka. He takes out as a matter of pride to shoulder any responsibility in the interest of Nursing Profession.

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