BHTL-018

CERTIFICATE IN HOME HEALTH ASSISTANCE (CHHA)

BLOCK 3

LOG BOOK

School of Health Sciences
Indira Gandhi National Open University
Maidan Garhi, New Delhi - 110068

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CONTENTS

1. IDENTIFICATION DETAILS OF THE STUDENT

Photo

Name of the student

Enrollment Number

Address

Email

Mobile

Signature of Student

Name & Signature of the Academic counselor

2. GENERAL INSTRUCTIONS TO STUDENTS

This log-book is a compulsory component of the Skills for Home Health Assistance (BHTL-018). You are required to maintain all the learning activities that you perform as a part of this course. You will have to maintain log book during self-practice at your work place, supervised practice at Work Centre/ Programme Study Centre. The self practice (Log Book) activities and competency assessment activities will carry 50% weightage i.e., 25 marks for log book and 25 marks for competency assessment. The counselor at the Programme Study Centre shall evaluate log book.

This log-book contains different activities. We have provided a record performa and some blank space for brief recording of activities performed.You are required to fill up the case record proforma at Program Study Centre (PSC)/Skill Development Centre (SDC) / Community Health Centre (CHC) as mentioned. You will fill up the log of activities in the space provided against the respective activities separately. Your supervisor will give remarks & sign.

3. OBJECTIVES

The objectives of the log-book are to:

- enable the counsellors to have a first hand information about the activities performed by you;
- assess the field/academic experience gained by you;
- help you in planning your activities in advance so that you could complete them within the time frame; and
- document your input towards the practical component at Program Study Centre (PSC)/Skill Development Centre (SDC) / Community Health Centre (CHC).

4. HOW TO USE THE LOG BOOK

You may refer to the practical skills mentioned in the programme guide that are expected to be learnt by you during your posting at Program Study Centre (PSC)/Skill Development Centre (SDC) / Community Health Centre (CHC). While performing each skill, you have to record them in this log- book.

Please ensure that whenever you carry out the activities, these should be countersigned by the respective counsellor under whom the activities had been carried out.

5. DETAILS OF THE POSTING UNDERGONE

You should make a list of all your postings with dates as mentioned in the table below. This will help you to keep a tab on your posting and accordingly getting a completion certificate signed at the end of the posting to enable you to appear in the term-end practical examination.

S. No.	Place of Practical Postings	From	To	Signature by Supervisor/mentor	Remarks of the mentor/supervisor
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

6. RECORD OF THE ACTIVITIES CARRIED OUT BY STUDENT

6.1.1 History Taking

The sample format is given below:

Format for history taking

I. Identification Data:

Name

Age/Sex

Marital Status

No. of family members

Education

Occupation

Address

Income

Religion

Alcoholic/Smoking

Vegetarian/Non Vegetarian

II. Chief complaints of the patient

Problems with ambulation	Yes/No
Fatigue	Yes/No
Usual sleep patterns	Regular/Irregular
Any help required to promote sleep	Yes/No, If yes (specify)
Presence of pain or discomfort while sleep	Yes/No

Foods generally avoided

Likes, dislikes

Vitamin or mineral supplements taken

Problems with eating, tastes or smell

Denture

Recent changes in food-fluid intakes

Initial weight Changes in weight (recent, long-term). Elimination:

Problems with urination

Bowel problems-

Constipation	Yes/No
Diarrhoea	Yes/No
Incontinence	Yes/No

Perception and coping:

Present concerns related to health or life events	Yes/No
Expected changes in life-style because of present health problem	Yes/No
Recent changes in feelings about self or body image	Yes/No

If yes, specify .....

Spiritual practices or beliefs found helpful at present	Yes/No

If yes, specify .....

Availability of significant others as supportive persons	Yes/No

If yes, specify

III. History of present illness

IV. Past history of illness

Major illnesses if any — heart disease/blood sugar.

Injuries if any such as fracture, paralysis, surgery/amputation.

Medicine taken in the past Side effects/Allergies:

Any infectious disease

V. Family History of any disease :

VI. Social History:

Interaction with family, friends and relations/neighbours.	Yes/No
Visiting the temple for prayers	Yes/No
Any other social get together	Yes/No

Any other social interests

Religion, whether practicing or not, culture, beliefs and taboos.

Recreational activities such as reading, writing, listening music.

Signature of history taker

6.1.2 Record History of 10 Persons as per the above Format

Case-1

I. Identification Data:

Name

Age/Sex

Marital Status

Education

Occupation

Indoor Id number/Address

II. Chief complaints of the patient

III. History of present illness

IV. Past history of illness

V. Family History of any disease :

VI. Social History:

Signature of history taker

Case-2

I. Identification Data:

Name

Age/Sex

Marital Status

Education

Occupation

Indoor Id number/Address

II. Chief complaints of the patient

III. History of present illness

IV. Past history of illness

V. Family History of any disease :

VI. Social History:

Signature of history taker

Case-3

I. Identification Data:

Name

Age/Sex

Marital Status

Education

Occupation

Indoor Id number/Address

II. Chief complaints of the patient

III. History of present illness

IV. Past history of illness

V. Family History of any disease :

VI. Social History:

Signature of history taker

Case-4

I. Identification Data:

Name

Age/Sex

Marital Status

Education

Occupation

Indoor Id number/Address

II. Chief complaints of the patient

III. History of present illness

IV. Past history of illness

V. Family History of any disease :

VI. Social History:

Signature of history taker

Case-5

I. Identification Data:

Name

Age/Sex

Marital Status

Education

Occupation

Indoor Id number/Address

II. Chief complaints of the patient

III. History of present illness

IV. Past history of illness

V. Family History of any disease :

VI. Social History:

Signature of history taker

Case-6

I. Identification Data:

Name

Age/Sex

Marital Status

Education

Occupation

Indoor Id number/Address

II. Chief complaints of the patient

III. History of present illness

IV. Past history of illness

V. Family History of any disease :

VI. Social History:

Signature of history taker

Case-7

I. Identification Data:

Name

Age/Sex

Marital Status

Education

Occupation

Indoor Id number/Address

II. Chief complaints of the patient

III. History of present illness

IV. Past history of illness

V. Family History of any disease :

VI. Social History:

Signature of history taker

Case-8

I. Identification Data:

Name

Age/Sex

Marital Status

Education

Occupation

Indoor Id number/Address

II. Chief complaints of the patient

III. History of present illness

IV. Past history of illness

V. Family History of any disease :

VI. Social History:

Signature of history taker

Case-9

I. Identification Data:

Name

Age/Sex

Marital Status

Education

Occupation

Indoor Id number/Address

II. Chief complaints of the patient

III. History of present illness

IV. Past history of illness

V. Family History of any disease :

VI. Social History:

Signature of history taker

Case-10

I. Identification Data:

Name

Age/Sex

Marital Status

Education

Occupation

Indoor Id number/Address

II. Chief complaints of the patient

III. History of present illness

IV. Past history of illness

V. Family History of any disease :

VI. Social History:

Signature of history taker

6.1.3 Counselling a Person in Need

Conduct at laeast 3 session for one case.

Case-1

I. Identification Data:

Name

Age/Sex

Marital Status

Education

Occupation

Indoor Id number/Address

II. Chief complaints of the patient

III. History of present illness

IV. Past history of illness

V. Family History of any disease :

VI. Social History:

Signature of history taker

Case-2

I. Identification Data:

Name

Age/Sex

Marital Status

Education

Occupation

Indoor Id number/Address

II. Chief complaints of the patient

III. History of present illness

IV. Past history of illness

V. Family History of any disease :

VI. Social History:

Signature of history taker

Case-3

I. Identification Data:

Name

Age/Sex

Marital Status

Education

Occupation

Indoor Id number/Address

II. Chief complaints of the patient

III. History of present illness

IV. Past history of illness

V. Family History of any disease :

VI. Social History:

Signature of history taker

Case-4

I. Identification Data:

Name

Age/Sex

Marital Status

Education

Occupation

Indoor Id number/Address

II. Chief complaints of the patient

III. History of present illness

IV. Past history of illness

V. Family History of any disease :

VI. Social History:

Signature of history taker

Case-5

I. Identification Data:

Name

Age/Sex

Marital Status

Education

Occupation

Indoor Id number/Address

II. Chief complaints of the patient

III. History of present illness

IV. Past history of illness

V. Family History of any disease :

VI. Social History:

Signature of history taker

SUMMARY OF 5 CASES

Name, age, sex of patient/person	Key findings	Remarks	Signature of mentor

6.2 RECORDING PULSE RATE RESPIRATORY RATE BLOOD PRESSURE AND TEMPERATURE CHECKING

6.2.1 Recording of Pulse Rate

Collect all the equipments, which include watch or clock with second's hand and recording sheet and pen. Explain the person what you are going to do i.e . checking the pulse. Have a watch which has second's hand in front of you. Wash your hands. Select the site of the pulse (normally radial pulse is taken). Make the person to sit or lie down. You can help him to rest the arm alongside the body with palm facing downwards or fore arm can rest at 90 degree angle across the chest. If the patient is sitting, forearm can be put across the thigh with palm of hand facing downward. Gently place the tips of 1st three fingers of your right hand above the wrist of the person on the side of his thumbs by putting your thumb on other side of wrist until you feel the pulse. If you cannot feel the pulse at the first attempt move your fingers slightly until you can feel it.***Never use your thumb to feel a pulse because there is a pulse in your thumb that you may mistake for the patient's pulse.*** Count the number of pulsations (beats for one minute) using a watch with a second's hand. Note the strength and regularity of the beats (i.e. interval between the two pulsations/beats) as you are counting the pulse. Record the pulse in the record sheet.

6.2.2 Recording of Respiratory Rate

Collect all the articles i.e. watch or clock with second's hand, record sheet and pen. Make the patient comfortable. Keep the person/patient in a comfortable position preferably in sitting or lying down position. You can observe (count respiration) after you have counted the pulse so that you will be able to record it accurately. In such situation you can place the arm of the patient across the chest.

Observe/Watch the rise and fall of the chest. Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest). Record the rate of respiration in a record sheet.

6.2.3 Recording of Blood Pressure

(Explain the procedure to the patient. Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed. To begin blood pressure measurement, use a properly sized blood pressure cuff. The length of the cuff's bladder should be at least equal to 80% of the circumference of the upper arm.Wrap the cuff around the upper arm with the cuff's lower edge one inch above the antecubital fossa. Lightly press the stethoscope's bell over the brachial artery just below the cuff's edge. Some health care workers have difficulty using the bell in the antecubital fossa, so we suggest using the bell or the diaphragm to measure the blood pressure. Rapidly inflate the cuff to 180mmHg. Release air from the cuff at a moderate rate (3mm/sec). Listen with the stethoscope and simultaneously observe the sphygmomanometer. The first knocking sound (Korotkoff) is the subject's systolic pressure. When the knocking sound disappears, that is the diastolic pressure (such as 120/80). Record the pressure in both arms and note the difference; also record the subject's position (supine), which arm was used, and the cuff size (small, standard or large adult cuff.

6.2.4 Recording of Oral Temperature

Inform the patient about the procedure. Wash hands. After washing hands rinse the thermometer in cold water. Shake thermometer with a quick flip of the wrist till the mercury goes down to 95.5° . Insert the thermometer under the tongue and instruct the patient to close mouth for 3 minutes. Hold the thermometer at the stem with your thumb and finger tips. Read the thermometer by rotating and Bring the thermometer to eye level . Rotate the thermometer until you can see the numbers and long and short lines. Turn the thermometer back

and forth slowly until you can see silver (white) or (red) mercury line. Shake down the thermometer after use. Clean the thermometer with soapy swabs from stem to bulb and rinse with water preferably running water under the tap. Put in a disinfectant solution or when thermometer is not in use, you can put it in a closed case after cleaning and drying. Make the patient comfortable. Record temperature.)

6.2.5 Recording of Axillary Temperature

Collect all the articles. Explain the procedure to the person. Wash your hands. Rinse and dry the thermometer. Shake down the thermometer. Dry and wipe the axilla with a towel or tissue. Place bulb end of the thermometer in the center of the axilla. Help the patient to place the arm over the chest and hold the thermometer in place. In case the patient is not able to do it himself, you should hold the thermometer and the arm in place. Leave the thermometer for 3-4 minutes. Remove the thermometer. Wipe the thermometer from stem to bulb. Read the thermometer at eye level. Shake down the thermometer.Make the patient/person comfortable. Rinse and wash the thermometer and place it in disinfectant lotion. Wash your hands. Record the reading in record sheet. Report any abnormal temperature.

6.2.6 Record for Cases

Case-1

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Site for recording the pulse rate

Pulse rate per minute

Interpretation & actions to be taken

Remarks of the mentor

ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute

Interpretation & actions to be taken

Remarks of the mentor

iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine

Systolic pressure

Diastolic pressure

Interpretation & actions to be taken

Remarks of the mentor

iv. Recording temperature

Type of thermometer used Digital/mercury

Site for recording temperature Oral/Axillary/Anal specify

Temperature recorded in Centigrade

Interpretation & actions to be taken

Remarks of the mentor

Case-2

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Site for recording the pulse rate

Pulse rate per minute

Interpretation & actions to be taken

Remarks of the mentor

ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute

Interpretation & actions to be taken

Remarks of the mentor

iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine

Systolic pressure

Diastolic pressure

Interpretation & actions to be taken

Remarks of the mentor

iv. Recording temperature

Type of thermometer used Digital/mercury

Site for recording temperature Oral/Axillary/Anal specify

Temperature recorded in Centigrade

Interpretation & actions to be taken

Remarks of the mentor

Case-3

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Site for recording the pulse rate

Pulse rate per minute

Interpretation & actions to be taken

Remarks of the mentor

ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute

Interpretation & actions to be taken

Remarks of the mentor

iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine

Systolic pressure

Diastolic pressure

Interpretation & actions to be taken

Remarks of the mentor

iv. Recording temperature

Type of thermometer used Digital/mercury

Site for recording temperature Oral/Axillary/Anal specify

Temperature recorded in Centigrade

Interpretation & actions to be taken

Remarks of the mentor

Case-4

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Site for recording the pulse rate

Pulse rate per minute

Interpretation & actions to be taken

Remarks of the mentor

ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute

Interpretation & actions to be taken

Remarks of the mentor

iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine

Systolic pressure

Diastolic pressure

Interpretation & actions to be taken

Remarks of the mentor

iv. Recording temperature

Type of thermometer used Digital/mercury

Site for recording temperature Oral/Axillary/Anal specify

Temperature recorded in Centigrade

Interpretation & actions to be taken

Remarks of the mentor

Case-5

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Site for recording the pulse rate

Pulse rate per minute

Interpretation & actions to be taken

Remarks of the mentor

ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute

Interpretation & actions to be taken

Remarks of the mentor

iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine

Systolic pressure

Diastolic pressure

Interpretation & actions to be taken

Remarks of the mentor

iv. Recording temperature

Type of thermometer used Digital/mercury

Site for recording temperature Oral/Axillary/Anal specify

Temperature recorded in Centigrade

Interpretation & actions to be taken

Remarks of the mentor

Case-6

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Site for recording the pulse rate

Pulse rate per minute

Interpretation & actions to be taken

Remarks of the mentor

ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute

Interpretation & actions to be taken

Remarks of the mentor

iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine

Systolic pressure

Diastolic pressure

Interpretation & actions to be taken

Remarks of the mentor

iv. Recording temperature

Type of thermometer used Digital/mercury

Site for recording temperature Oral/Axillary/Anal specify

Temperature recorded in Centigrade

Interpretation & actions to be taken

Remarks of the mentor

Case-7

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Site for recording the pulse rate

Pulse rate per minute

Interpretation & actions to be taken

Remarks of the mentor

ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute

Interpretation & actions to be taken

Remarks of the mentor

iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine

Systolic pressure

Diastolic pressure

Interpretation & actions to be taken

Remarks of the mentor

iv. Recording temperature

Type of thermometer used Digital/mercury

Site for recording temperature Oral/Axillary/Anal specify

Temperature recorded in Centigrade

Interpretation & actions to be taken

Remarks of the mentor

Case-8

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Site for recording the pulse rate

Pulse rate per minute

Interpretation & actions to be taken

Remarks of the mentor

ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute

Interpretation & actions to be taken

Remarks of the mentor

iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine

Systolic pressure

Diastolic pressure

Interpretation & actions to be taken

Remarks of the mentor

iv. Recording temperature

Type of thermometer used Digital/mercury

Site for recording temperature Oral/Axillary/Anal specify

Temperature recorded in Centigrade

Interpretation & actions to be taken

Remarks of the mentor

Case-9

i. Pulse rate

Identi1fication Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Site for recording the pulse rate

Pulse rate per minute

Interpretation & actions to be taken

Remarks of the mentor

ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute

Interpretation & actions to be taken

Remarks of the mentor

iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine

Systolic pressure

Diastolic pressure

Interpretation & actions to be taken

Remarks of the mentor

iv. Recording temperature

Type of thermometer used Digital/mercury

Site for recording temperature Oral/Axillary/Anal specify

Temperature recorded in Centigrade

Interpretation & actions to be taken

Remarks of the mentor

Case-10

i. Pulse rate

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Site for recording the pulse rate

Pulse rate per minute

Interpretation & actions to be taken

Remarks of the mentor

ii. Recording of respiratory rate

Count the number of respirations (rise and fall) for one minute using a watch with second's hand (one respiration is equal to one rise and one fall of chest)

Respiratory rate per minute

Interpretation & actions to be taken

Remarks of the mentor

iii. Recording of blood pressure

Make her/him sit by a table to rest her/his arm. When the patient is lying down, tell the patient to put the arm on the bed

Position of the subject Sitting/Supine

Systolic pressure

Diastolic pressure

Interpretation & actions to be taken

Remarks of the mentor

iv. Recording temperature

Type of thermometer used Digital/mercury

Site for recording temperature Oral/Axillary/Anal specify

Temperature recorded in Centigrade

Interpretation & actions to be taken

Remarks of the mentor

SUMMARY OF THE 10 CASES

Name, age, sex of patient/person	Pulse rate	Respiratory rate	Blood pressure	Temperature	Remarks

6.3 ANTHROPOMETRIC MEASUREMENTS

6.3.1 Recording of Weight

The weighing scale should be placed on a hard-floor surface (not on a floor which is carpeted or otherwise covered with soft material). If there is no such floor available, a hard wooden platform should be placed under the scale. Calibration should occur at the beginning and end of each examination. Heavy outer garments (jacket, coat, etc. and shoes can be removed before checking the weight. The patient should stands in the centre of the platform, weight distributed evenly to both feet. Standing off-centre may affect measurement. Record the weight.

6.3.2 Recording of Height

Person is asked to remove their shoes, heavy outer garments, and hair ornaments. The person is asked to stand with his/her back to the height rule. The back of the head, back, buttocks, calves and heels should be touching the upright, feet together. The person is asked to look straight. Height is recorded to the resolution of the height rule (i.e. nearest millimetre/half a centimetre). If The person is taller than the measurer, the measurer should stand on a platform so that he/she can properly read the height rule.

6.3.3 Record of Cases

Case-1

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Recording of weight

Weight in Kgs

Recording of height
Height in cms & in meters

Calculate BMI(Body Mass index= Weight in Kgs/Square of Height in meters)

Interpretation & actions to be taken

Remarks of the mentor

Case-2

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Recording of weight

Weight in Kgs

Recording of height
Height in cms & in meters

Calculate BMI(Body Mass index= Weight in Kgs/Square of Height in meters)

Interpretation & actions to be taken

Remarks of the mentor

Case-3

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Recording of weight

Weight in Kgs

Recording of height
Height in cms & in meters

Calculate BMI(Body Mass index= Weight in Kgs/Square of Height in meters)

Interpretation & actions to be taken

Remarks of the mentor

Case-4

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Recording of weight

Weight in Kgs

Recording of height
Height in cms & in meters

Calculate BMI(Body Mass index= Weight in Kgs/Square of Height in meters)

Interpretation & actions to be taken

Remarks of the mentor

Case 5

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Recording of weight

Weight in Kgs

Recording of height
Height in cms & in meters

Calculate BMI(Body Mass index= Weight in Kgs/Square of Height in meters)

Interpretation & actions to be taken

Remarks of the mentor

Case-6

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Recording of weight

Weight in Kgs

Recording of height
Height in cms & in meters

Calculate BMI(Body Mass index= Weight in Kgs/Square of Height in meters)

Interpretation & actions to be taken

Remarks of the mentor

Case-7

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Recording of weight

Weight in Kgs

Recording of height
Height in cms & in meters

Calculate BMI(Body Mass index= Weight in Kgs/Square of Height in meters)

Interpretation & actions to be taken

Remarks of the mentor

Case-8

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Recording of weight

Weight in Kgs

Recording of height
Height in cms & in meters

Calculate BMI(Body Mass index= Weight in Kgs/Square of Height in meters)

Interpretation & actions to be taken

Remarks of the mentor

Case-9

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Recording of weight

Weight in Kgs

Recording of height
Height in cms & in meters

Calculate BMI(Body Mass index= Weight in Kgs/Square of Height in meters)

Interpretation & actions to be taken

Remarks of the mentor

Case-10

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Recording of weight

Weight in Kgs

Recording of height
Height in cms & in meters

Calculate BMI(Body Mass index= Weight in Kgs/Square of Height in meters)

Interpretation & actions to be taken

Remarks of the mentor

SUMMARY OF THE 10 CASES

Name, age, sex of patient/ person	Weight in KG	Height/Length in cms & in meters	BMIWeight in KGs/Height in Meters square	Remarks

6.4 SPECIMEN COLLECTION

6.4.1 Collecting Urine Sample

Wash hands and wear gloves. Use specimen container with lead having wide mouth. Give a bed pan to the bed ridden patient. Assist or allow the client to wash the private parts and collect the specimen. Ask the patient to pass some amount of urine and then collect sample in the middle. Once the patient stops passing urine, remove the bedpan, and make the patient comfortable. Replace the cap on the specimen container and remove the gloves.

Label it with name, age, sex, nature of examination. Transport the specimen to the laboratory with in 15 minutes or immediately refrigerate. Record Date and Time of collection of specimen.

6.4.2 Collecting Stool Sample

Explain the procedure. Ask the client to pass stool. Instruct the client to defecate into clean dry bed pan. Wear gloves. With a clean wooden spatula lift up a portion of the stool from the center of the mass and place it into the labeled container. Remove the gloves.

Wrap spatula in waste paper and discard properly. Send the specimen to the laboratory immediately. Make the client comfortable. Replace equipments after cleaning. Wash hands with soap and water.

6.4.3 Collecting Sputum Sample

Instruct the client to cough up the early morning sputum/specimen in the container after rinsing the mouth with plain water only to obtained overnight accumulated secretions. Help/encourage the patient to cough deeply to get lumps or thick sputum. Ask the patient to take deep long breath 2-3 times and then cough out deeply from the chest, collect the sputum in the mouth and then gently put it into it. Remove the lid and place sputum in it.- you can show to the patient how to open and close the container. Take care that the patient does not spoil the external surface or outer part of container. Send the labeled container to the laboratory as early as possible. Make the patient comfortable. Wash hand thoroughly.

6.4.4 Record of Specimen Collected

Case-1

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Collecting urine sample

Purpose of urine sample (routine examination, Microscopic examination, Urine culture)

Collection of urine specimen from Bed pan/from patient/catheter/24 hours collection

Date & time of sample collection

Remarks of the mentor

Collecting stool sample

Purpose of stool sample

Collection of stool specimen from Bed pan/from patient

Date & time of sample collection

Remarks of the mentor

Collecting sputum sample

Purpose of sputum sample (Microscopic examination for AFB/ Culture)

Collection of sputum specimen -fresh/24 hours collection

Date & time of sample collection

Remarks of the mentor

Case-2

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Collecting urine sample

Purpose of urine sample (routine examination, Microscopic examination, Urine culture)

Collection of urine specimen from Bed pan/from patient/catheter/24 hours collection

Date & time of sample collection

Remarks of the mentor

Collecting stool sample

Purpose of stool sample

Collection of stool specimen from Bed pan/from patient

Date & time of sample collection

Remarks of the mentor

Collecting sputum sample

Purpose of sputum sample (Microscopic examination for AFB/ Culture)

Collection of sputum specimen -fresh/24 hours collection

Date & time of sample collection

Remarks of the mentor

Case-3

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Collecting urine sample

Purpose of urine sample (routine examination, Microscopic examination, Urine culture)

Collection of urine specimen from Bed pan/from patient/catheter/24 hours collection

Date & time of sample collection

Remarks of the mentor

Collecting stool sample

Purpose of stool sample

Collection of stool specimen from Bed pan/from patient

Date & time of sample collection

Remarks of the mentor

Collecting sputum sample

Purpose of sputum sample (Microscopic examination for AFB/ Culture)

Collection of sputum specimen -fresh/24 hours collection

Date & time of sample collection

Remarks of the mentor

Case-4

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Collecting urine sample

Purpose of urine sample (routine examination, Microscopic examination, Urine culture)

Collection of urine specimen from Bed pan/from patient/catheter/24 hours collection

Date & time of sample collection

Remarks of the mentor

Collecting stool sample

Purpose of stool sample

Collection of stool specimen from Bed pan/from patient

Date & time of sample collection

Remarks of the mentor

Collecting sputum sample

Purpose of sputum sample (Microscopic examination for AFB/ Culture)

Collection of sputum specimen -fresh/24 hours collection

Date & time of sample collection

Remarks of the mentor

Case-5

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Collecting urine sample

Purpose of urine sample (routine examination, Microscopic examination, Urine culture)

Collection of urine specimen from Bed pan/from patient/catheter/24 hours collection

Date & time of sample collection

Remarks of the mentor

Collecting stool sample

Purpose of stool sample

Collection of stool specimen from Bed pan/from patient

Date & time of sample collection

Remarks of the mentor

Collecting sputum sample

Purpose of sputum sample (Microscopic examination for AFB/ Culture)

Collection of sputum specimen -fresh/24 hours collection

Date & time of sample collection

Remarks of the mentor

Summary of 5 such cases

Name, age & sex of person							
Name of specimen/Person	I	II	III	IV	V	Remarks	Signature of mentor
Urine Routine							
Urine culture							
Stool							
Sputum							
Sputum culture							

6.5 BLOOD GLUCOSE MONITORING WITH GLUCOMETER

6.5.1 Blood Glucose Monitoring

Turn the meter on. Always wait for the flashing blood drop symbol to be displayed before allowing the test strip to draw up blood. When the beeps turned on the meter also beeps at this point. The meter is ready to perform a blood glucose test. Now allow the test strip to draw up blood. You have approximately 70 seconds to perform this action. Prick the side of a fingertip. Gently massage the finger towards the fingertip to encourage a drop of blood to form. Hold the meter with the test strip pointing downwards. Touch the drop of blood as soon as it has formed, against the tip of the test strip where the black notch is located. The test strip draws up blood. Move the finger away from the test strip as soon as the hourglass symbol is displayed and the meter. The test strip has then drawn up enough blood, and the test starts. Hourglass symbol indicates that the meter is busy measuring. The test is complete after approx 5 seconds. The result is displayed and the meter beeps. The meter automatically saves the result in its memory.

6.5.2. Record of Cases

Case-1

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of the patient fasting/ random/ 2 hours after food

Blood sugar value

Date & time of sample collection

Remarks of the mentor

Case-2

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of the patient fasting/ random/ 2 hours after food

Blood sugar value

Date & time of sample collection

Remarks of the mentor

Case-3

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of the patient fasting/ random/ 2 hours after food

Blood sugar value

Date & time of sample collection

Remarks of the mentor

Case-4

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of the patient fasting/ random/ 2 hours after food

Blood sugar value

Date & time of sample collection

Remarks of the mentor

Case-5

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of the patient fasting/ random/ 2 hours after food

Blood sugar value

Date & time of sample collection

Remarks of the mentor

Summary of 5 such cases

Name, age, sex of patient/person	Blood glucose value using glucometer	Remarks	Signature of mentor

6.6 PERSONAL HYGIENE & GROOMING SKILLS

6.6.1 Performing Bed Bath

Draw curtains, close doors and windows to maintain privacy and to prevent crossing of air. Keep a gap of 2 hours between meals and bath. Temperature of the water should be according to patient's comfort. Only a small portion of the body should be exposed and bathed at a time. Explain the procedure to the patient. Bring the patient to the edge of the bed near you. Draw curtains, close doors and windows. Remove extra pillows and blankets. Put a bed sheet or bath sheet over the patient to cover him. Remove top bed sheet and clothes of the patient from under the bed sheet. After you have prepared the patient as just described, wash your hands and wear a pair of gloves (necessary if the patient is suffering from infections). Mix hot and cold water in a bath basin or a small tub or bucket. Check the temperature of the water for tolerance by placing elbow or back of the hand in the water. The patient can also be made to do this, if his condition permits. Place the bath towel over the chest under the chin. Fold sponge cloth (small towel) around fingers of your hands. Immerse this in water and squeeze thoroughly. Wash patient's eyes with plain warm water. Soak eyelids with damp sponge cloth for 2-3 minutes to remove dry crusts on eye and then dry eyes thoroughly but gently. Ask patient if he/she wants to use soap on face. Using wet sponge cloth, clean and dry well forehead, cheeks, nose, neck and ears. Men may wish to shave at this point. Place the bath towel lengthwise under the farthest arm. Wrap sponge cloth in your hand, wet it, apply soap on it and clean the arm with it, followed by wet sponge cloth to remove the soap off skin. Cleaning should be done from the hand to axilla, using long strokes. You can place the basin on bed and immerse the patients' hand in water for 3-5 minutes. Clean between fingers and nails. Dry the arm, axilla with bath towel and repeat the same on other arm.

Cover the patient's chest and abdomen with bath towel and fold the bed sheet to umbilicus in abdomen.Clean chest thoroughly with soapy and wet sponge cloth lifting the edge of the bath towel away from the chest. Clean skin folds under breasts in female patients. Dry well. Keep the chest covered between washing and rinsing. With towel remaining on the chest and abdomen, fold back the bath sheet down to the pubic region and clean the abdomen under the bath towel with soapy and wet sponge cloth. Dry well. Remove the bath towel and cover the patient with the bath sheet again. You can change the water in the basin at this point of time.

Turn the patient to abdomen or side lying position. Place the towel lengthwise along the patients' back. Expose back and clean with soapy and wet sponge cloth using long and firm strokes. Clean the buttocks and anus also. Dry the back and massage the back with spirit or oil and powder in long circular movements.

You can dress the patient in upper garments and cover with bath sheet. Expose the farthest legs, spread bath towel under the leg. Bend the knee and clean with soap and water using long and film strokes from ankle to knee and from knee to thighs. Dry well. Foot can be soaked in water for 3-5 minutes by placing the basin on the bed and then cleaned and dried paying attention between the toes and nails.

Expose genitalia (private part) and clean the perineum the same way. The patient can do it himself if he is able to do so. Put on the lower garments, comb hair, cut nails.Remove bath sheet and cover with blanket or top sheet. Remove, clean, and replace articles. Leave patient comfortable. Wash your hands.

6.6.2 Performing Mouth Care In Conscious Person

Explain the procedure to the patient. Make the patient sit in bed by giving pillow support to the back. Place a rubber sheet with towel across the chest of the patient.

Wash your hands and help the patient to rinse his mouth with water. Use a bowl to collect waste water. Wet the toothbrush, apply toothpaste and give it to the patient. Tell the patient to brush all sides of teeth, i.e. outer side, inner side, front teeth, sides of teeth, chewing surface. Brushing should be done from gum to enamel of teeth.

When brushing is done, wash the brush and keep it. Help the patient to rinse his mouth. Mouth wash solutions (as described earlier) or plain water can be used.

Ask the patient to massage the gums with fingers. Help the patient to wash his face and teeth and wipe with a towel. With a cotton bud, apply glycerin or oil or cream on lips. Make the patient comfortable. Remove, clean and replace articles and wash your hands.

6.6.3 Performing Mouth Care in Unconscious Person

Place the patient on his back with his head turned to your side or turn him to his side with his face facing you. Place a rubber sheet with towel under his head. Place the bowl to receive waste water close to the cheek of the patient. Wash your hands

Wrap a gauze piece around artery forceps. Ensure that the tips of the forceps are completely covered with the gauze. Wet the gauze and dip it in a cleaning agent and clean all the surfaces of the teeth. You can use as many gauze as required to clean the teeth. Take a spoon and depress the tongue with it and clean the inner and chewing surfaces of the teeth using the cleaning agent. Wet the gauze with mouthwash solution and plain water and clean the tongue and mouth thoroughly. **Do not pour water into patient's mouth.** Apply glycerin or cream or oil on lips with cotton bud. Leave the patient comfortable. Remove, clean and replace articles. Wash your hands.

6.6.4 Performing Eye Care

Explain the procedure to the patient. Keep the patient on his back with a pillow under his back. Cover the pillow with rubber sheet and towel and keep the empty bowl on it.

Wash hands always before and after the procedure. Pick up one cotton ball with a boiled spoon. Squeeze off the water from the ball by pressing it against the inner side of the bowl. Take the cotton ball between your thumb and forefinger without touching the spoon. Taking care that area of the cotton ball touched by the fingers do not come in contact with eyes, clean the eye from inside to outside angle of the eye. Throw the ball in dustbin/paper bag. Use one cotton ball for cleaning once.

Continue cleaning using more cotton balls till eye is clean. If dry crusts are on the eye, keep a wet cotton ball on the closed eye until the crust becomes soft. Repeat the same for the other eye.Wipe the face with a face towel. Remove articles from bedside.Make the patient comfortable. Wash your hands with soap and water and dry them.

6.6.5 Performing Hair Wash

Explain the procedure to the patient. Collect all articles near the bed of the patient. Close doors, windows, draw curtains to provide privacy and to prevent crossing of air. Remove the blanket or top sheet of the patient and cover him with bed sheet or bath sheet. Remove pillows under the head, back etc. Place the patient on his back and bring his head and shoulders to the edge of the bed, placing him diagonal on the bed. Place the pillow under the shoulders so that head is slightly tilted back. Cover the pillow with rubber sheet. Take a newspaper, roll it into a horse shoe shape and place the rubber sheet flat on it. Roll the edge of the rubber sheet over the roll of the newspaper to form a rim. This device is placed under the head of the patient and the open flat end of the rubber sheet is received into the bucket so that flow of water poured over the hair can be directed into the bucket to receive dirty water. Plug ears with cotton balls and cover the eyes with a folded face towel. Wash hands and loosen and comb the hair.Mix hot and cold water in bucket or basin. Wet the hair by pouring water over the hair and scalp. Apply shampoo and make lather. Clean the hair and massage the scalp with fmgertips. Clean properly from front hairline to the back of the head. Rinse thoroughly with water to remove shampoo. Squeeze off water from the hair. Wrap the head in a bath towel. Dry face, neck etc. Dry hair and scalp. Remove the rubber sheet, cotton plugs from the ears. Make the patient comfortable. Put on blankets or top sheet etc. after removing the bath sheet. Wash and replace articles and wash hands.

6.6.6 Performing Nail & Foot Care

Wash your hands and arrange the articles at bedside. If possible, make the patient sit on a chair or bed. Spread the rubber sheet with towel on the bed or patient's lap.

Keep the basin with warm water in it. The temperature of water should be checked by touching it with the back of the hand. The patient can also be made to do so. Dip the fingers of the hand of the patient in the water for 10-20 minutes.

Now take a big bowl or tub of warm water. Check it's temperature the same way.

Keep this big bowl or tub on floor lined with newspaper and ask the patient to dip his feet in it for 10-20 minutes. After 10-20 minutes, remove both the bowls and dry the fingers and the feet thoroughly. Cut the finger and toe nails and shape them with a file. Apply vaseline or cream to the hands and feet.Make the patient comfortable. Remove, clean and replace articles and wash your hands.

6.6.7 Record of Cases

Case-1

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving bed bath

List difficulties faced & their solutions while performing mouth care

List difficulties faced & their solutions while doing denture care

List difficulties faced & their solutions while giving eye care

List difficulties faced & their solutions giving hair wash & combing

List difficulties faced & their solutions while providing nail & foot care

List difficulties faced & their solutions while Assisting a Patient in Clothing

Date & time

Remarks of the mentor

Case-2

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving bed bath

List difficulties faced & their solutions while performing mouth care

List difficulties faced & their solutions while doing denture care

List difficulties faced & their solutions while giving eye care

List difficulties faced & their solutions giving hair wash & combing

List difficulties faced & their solutions while providing nail & foot care

List difficulties faced & their solutions while Assisting a Patient in Clothing

Date & time

Remarks of the mentor

Case-3

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving bed bath

List difficulties faced & their solutions while performing mouth care

List difficulties faced & their solutions while doing denture care

List difficulties faced & their solutions while giving eye care

List difficulties faced & their solutions giving hair wash & combing

List difficulties faced & their solutions while providing nail & foot care

List difficulties faced & their solutions while Assisting a Patient in Clothing

Date & time

Remarks of the mentor

Case-4

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving bed bath

List difficulties faced & their solutions while performing mouth care

List difficulties faced & their solutions while doing denture care

List difficulties faced & their solutions while giving eye care

List difficulties faced & their solutions giving hair wash & combing

List difficulties faced & their solutions while providing nail & foot care

List difficulties faced & their solutions while Assisting a Patient in Clothing

Date & time

Remarks of the mentor

Case-5

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving bed bath

List difficulties faced & their solutions while performing mouth care

List difficulties faced & their solutions while doing denture care

List difficulties faced & their solutions while giving eye care

List difficulties faced & their solutions giving hair wash & combing

List difficulties faced & their solutions while providing nail & foot care

List difficulties faced & their solutions while Assisting a Patient in Clothing

Date & time

Remarks of the mentor

Summary of 5 Cases for Each Activity

Name, age & sex of person							
Name of activity/Person	I	II	III	IV	V	Remarks	Signature of mentor
Bed Bath							
Mouth Care & brushing							
Care of Dentures							
Hair Wash & combing							
Eye Care							
Foot and Nail Care							
Assisting a Patient in Clothing							

6.7 NUTRITIONAL, ELIMINATION & MEDICATION NEEDS

6.7.1 Feeding Bed Ridden Person/Patient

Explain procedure to the patient. Check the physician orders for any specific precaution regarding diet. Position the patient in fowler's position and spread the mackintosh over patient's chest. Tell you patient that you are helping him/ her in feeding or if patient is able to eat him self then make sure that he eats well. Feed the patient slowly and in small amounts, encourage to chew and swallow. Give water in between if he/she wants. Help the patient to rinse his/her mouth, wash hands and dry them with towel.

RECORD OF CASES

Case-1

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

Type of feed Solid/Liquid

Name & amount of the of the food items given

List difficulties faced & their solutions while feeding the bedridden patient

Date & time

Remarks of the mentor

Case-2

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

Type of feed Solid/Liquid

Name & amount of the of the food items given

List difficulties faced & their solutions while feeding the bedridden patient

Date & time

Remarks of the mentor

Case-3

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

Type of feed Solid/Liquid

Name & amount of the of the food items given

List difficulties faced & their solutions while feeding the bedridden patient

Date & time

Remarks of the mentor

Case-4

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

Type of feed Solid/Liquid

Name & amount of the of the food items given

List difficulties faced & their solutions while feeding the bedridden patient

Date & time

Remarks of the mentor

Case-5

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

Type of feed Solid/Liquid

Name & amount of the of the food items given

List difficulties faced & their solutions while feeding the bedridden patient

Date & time

Remarks of the mentor

6.7.2 Feeding through Ryle's Tube

Explain the procedure to the patient. Bring the collected articles to bedside. Put the patient in fowler's position or sitting position. Spread mackintosh and towel over the patient's chest / we could use a water proof apron. Clean the nostrils with wet swab sticks. Wash hands with soap and water and put or gloves. Remove the piston by pinching tube near the point of attachment of syringe so that air does not enter into the tube. Pour the feed into the barrel of syringe, let it flow freely; refill the syringes before it gets empty. Give 200m1 feed at a time. After the feed, give 10-20 ml water to flush out the tube to keep it clean. Clamp the tube and make the patient comfortable. Keep the head of bed elevated for 30-60 minutes after the feed.

Record of Cases

Case-1

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

Name & amount of the of the food items given

List difficulties faced & their solutions while feeding through Ryles tube

Date & time

Remarks of the mentor

Case-2

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

Name & amount of the of the food items given

List difficulties faced & their solutions while feeding through Ryles tube

Date & time

Remarks of the ment

Case-3

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

Name & amount of the of the food items given

List difficulties faced & their solutions while feeding through Ryles tube

Date & time

Remarks of the ment

Case-4

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

Name & amount of the of the food items given

List difficulties faced & their solutions while feeding through Ryles tube

Date & time

Remarks of the ment

Case-5

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

Name & amount of the of the food items given

List difficulties faced & their solutions while feeding through Ryles tube

Date & time

Remarks of the ment

6.7.3 Gastrostomy Feeding

Explain the procedure to the patient. Place mackintosh and towel under the patient's back. Wash hands. Unscrew the clamp from the gastrostomy tube, attach the syringe and aspirate the gastric contents and empty it in a kidney tray. Remove the syringe, attach the glass adapter, tubing and fix the funnel to the tube. Pour feed into the funnel slowly; don't allow air into the tubing during the feed. Pour some water into the funnel to flush the tube. Clean the opening and apply Zinc oxide outside with sterile dressing and apply abdominal binder if indicated.

Record of Cases

Case-1

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

Name & amount of the of the food items given

List difficulties faced & their solutions while feeding through gastrostomy

Date & time

Remarks of the mentor

Case-2

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

Name & amount of the of the food items given

List difficulties faced & their solutions while feeding through gastrostomy

Date & time

Remarks of the mentor

Case-3

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

Name & amount of the of the food items given

List difficulties faced & their solutions while feeding through gastrostomy

Date & time

Remarks of the mentor

Case-4

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

Name & amount of the of the food items given

List difficulties faced & their solutions while feeding through gastrostomy

Date & time

Remarks of the mentor

Case-5

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

Name & amount of the of the food items given

List difficulties faced & their solutions while feeding through gastrostomy

Date & time

Remarks of the mentor

6.7.4 Urinary Catheter Care

Arrange the articles at the bedside. Explain the procedure to the patient. Position the patient with the knees flexed. Clean the perineal area by using clean cotton, soap and water. Make sure to clean each side and dry well again. Make sure that soap is fully removed. Reassess urethral meatus for any discharge. Change the gloves and clean the perineal area by using sterile cotton swabs dipped in antiseptic solution. From center to periphery in straight strokes from front to back, using one cotton ball for each stroke. Use each swab only once. Repeat the same using cotton swabs soaked in sterile (boiled and cooled) water. Apply antiseptic ointment at urethral meatus and 2.5 cm of catheter. Fix catheter tubing to the inner thigh with a strip of plaster properly to allow free movement in the bed.

Record of Cases

Case-1

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while doing urinary catheter care

Date & time

Remarks of the mentor

Case-2

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while doing urinary catheter care

Date & time

Remarks of the mentor

Case-3

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while doing urinary catheter care

Date & time

Remarks of the mentor

Case-4

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while doing urinary catheter care

Date & time

Remarks of the mentor

Case-5

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while doing urinary catheter care

Date & time

Remarks of the mentor

6.7.5 Applying Suppository

Check the general condition of the patient. Keep the required articles near bedside. Provide privacy by closing the door at the room (or) by pulling the curtain. Place a mackintosh with a towel under the patient's buttocks to protect the bed. Wash your hands thoroughly before and after the procedure. Assist patient in assuming left side lying position with upper leg flexed. Wear gloves.

Remove suppository from its package and lubricate the rounded end with jelly. Lubricate your gloved index finger also with jelly. Ask patient to take slow deep breath through mouth and to relax anal sphincter. Separate the buttocks with the left hand and insert the suppository into the anus. Once it has gone inside the anus, push it further (at least 10 cm in adults & 5 cm in children) with the lubricant gloved index finger. Withdraw finger and wipe patient's anal area with tissue paper (or) clean cloth. Discard gloves turning them inside out.Ask patient to remain flat or on the side for 5 minutes. Make sure that the suppository is in place. Instruct the patient to retain the suppository as long as it is possible and comfortable(at least for 20-30 minutes).Help the patient to go to the toilet if s/he wants to pass stool or ask about relieve in pain.

Record of Cases

Case-1

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while applying suppository

Date & time

Remarks of the mentor

Case-2

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while applying suppository

Date & time

Remarks of the mentor

Case-3

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while applying suppository

Date & time

Remarks of the mentor

Case-4

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while applying suppository

Date & time

Remarks of the mentor

Case-5

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while applying suppository

Date & time

Remarks of the mentor

6.7.6 Giving Enema

Assess the status of patient (last bowel movement, normal bowel pattern, abdominal pain and piles etc. Explain the procedure to the patient to get his cooperation. Provide privacy by closing the door (or) pull the curtain.

Keep all articles near the bedside. Wash hands and wear gloves to prevent (or) reduce infection. Place the mackintosh under the patients hip. Position the patient in left side - lying with right knee flexed . Cover the patient with a bath sheet (or) bed sheet exposing only anal area. Keep the bed pan in an easily accessible position.

Remove plastic cap from the tip of an enema pocket. Lubricate the tip with jelly if needed. The tip is already lubricated. Gently separate the buttocks and locate anus as done while inserting rectal thermometer also. Ask patient to relax by breathing through mouth. Insert tip of an enema pocket gently in to the rectum. Approximately 7.5 to 10 cm to be inserted if the patient is adult, in case of child 5 to 7.5 cm to be inserted. Squeeze the pocket until all the solution has entered in to the rectum and colon. Explain that the feeling of distension is normal. Instruct the patient to retain solution until an urge to defecate occurs. It occurs usually in 5 to 10 minutes. Place toilet tissue (or) cloth piece around the tube at anus and withdraw the tube. Discard the disposable items in proper container. Assist patient to go to the toilet (or) help to position on bed pan.

Record of Cases

Case-1

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving enema

Date & time

Remarks of the mentor

Case-2

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving enema

Date & time

Remarks of the mentor

Case-3

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving enema

Date & time

Remarks of the mentor

Case-4

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving enema

Date & time

Remarks of the mentor

Case-5

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving enema

Date & time

Remarks of the mentor

6.7.7 Giving Liquid Medicines

Wash your hands before preparing. Shake well the bottle of medicine. Check the medicine if the colour is changed or the solids are settled at bottom (except suspensions) or it has turned cloudy, (Do not give the medicine). Check the expiry date of the medicine. Hold the bottle with the label in the palms of your hand to avoid damaging the label if liquid spills on the label of the bottle. Hold the medicine glass or measuring glass at eye level so that you can measure accurately as you pour the medicine. Spread towel/cloth on person to prevent spilling of liquid medicine.Give liquid medicine completely in patient's mouth. Provide sips of water to rinse the mouth. Wipe the bottle before replacing the cap.Do not mix liquid medicine unless specifically mentioned. Give comfortable position after giving medicine.

Record of Cases

Case-1

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving liquid medicines.

Date & time

Remarks of the mentor

Case-2

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving liquid medicines.

Date & time

Remarks of the mentor

Case-3

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving liquid medicines.

Date & time

Remarks of the mentor

Case-4

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving liquid medicines.

Date & time

Remarks of the mentor

Case-5

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving liquid medicines.

Date & time

Remarks of the mentor

6.7.8 Giving Tablets

Wash your hands. Make sure the name of medicine and dose of medicine.Read the label carefully before taking out the medicine from the cupboard/ shelf. Take out the tablet or capsule from the bottle into the lid of the container (do not touch with hands). Take out the tablet or capsule from the bottle into the lid of the container or medicine cup. Make sure the patient is fully conscious or not sleepy to swallow the medicine. Provide water for drinking to swallow the medicine. Give a comfortable position after giving the medicine. Note the time of medicine when it was given. Observe for any change like nausea and vomiting. Record the name, dose and route of medicine in patient's record/diary.

Record Of Cases

Case-1

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving tablets.

Date & time

Remarks of the mentor

Case-2

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving tablets.

Date & time

Remarks of the mentor

Case-3

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving tablets.

Date & time

Remarks of the mentor

Case-4

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving tablets.

Date & time

Remarks of the mentor

Case-5

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving tablets.

Date & time

Remarks of the mentor

6.7.9 Giving Insulin Injection

Check doctor's written order/prescription order for name, dose and route of injection. Explain the procedure to the patient. Wash hand before preparation of injection.Use disposable sterile insulin syringe (this syringe which is marked in units) and needle (26 no.). Withdraw the required dose of injection into syringe

Select the site carefully. The injection site should be free of any injury, infection, abscess. Give proper position to the patient. Hold the syringe correctly between thumb and fingers at 45° angle to skin. For average build patient spread skin tightly or grasp the skin surrounding the infection site. Insert the needle quickly at correct site and push the medicine slowly. Take out needle completely after injecting the medicine, the amount of medicine should not be more than 2m1. Do not massage the area after injection.Assist patient to assure comfortable position. Discard the needle and syringe in appropriate container. Record name, dose, route and time of insulin injection. Look for any side effects like redness, pain, swelling, discharge at site of injection and report to doctor immediately.

Record of Cases

Case-1

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving injection of insulin

Date & time

Remarks of the mentor

Case-2

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving injection of insulin

Date & time

Remarks of the mentor

Case-3

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving injection of insulin

Date & time

Remarks of the mentor

Case-4

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving injection of insulin

Date & time

Remarks of the mentor

Case-5

Identification Data:

Name

Age/Sex

Indoor Id number/Address

Key findings of the case/ person

Status of patient: Ambulatory/ Bed ridden

List difficulties faced & their solutions while giving injection of insulin

Date & time

Remarks of the mentor

6.8 HOUSEKEEPING SKILLS

6.8.1 Record Atleast 5 Cases For Each Activity

Name of activity	Number of activities done	Remarks	Signature of mentor
Assistance in maintaining room of patient			
Care and maintenance of Rubber items			
Care and Maintenance of Linen			
Care and maintenance of furniture			
Hygienic hand washing			
Safe handling of needles and syringes			
Safe handling of spills			

6.9 CARE OF BED RIDDEN INDIVIDUAL

6.9.1 Record Atleast 5 Cases for Each Activity

Name, age & sex of person							
Name of activity/ Person	I	II	III	IV	V	Remarks	Signature of mentor
Giving hot water bottle							
Hot packs							
Moist Application							
Cold packs							
Cool Sponge bath							
Steam Inhalation							
Nebulization							
Dressing & cleaning of wound							

6.10 CARING FOR DIFFERENTLY ABLED PERSONS

6.10.1 Record Atleast 5 Cases for Each Activity

Name of activity	Number of activities done	Remarks	Signature of mentor
Supine/Dorsal Position			
Semi Supine/Semi Dorsal Position			
Fowler's (semi-sitting) position			
Cardiac (sitting) position			
Side lying (lateral) position			
Prone (lying on abdomen) position			
Shifting patient from bed to chair			
Shifting patient from chair to bed			

6.10.2 Basic Life Support (BLS)

Record at least 5 cases for practicing basic life support.

	Patient Name	Procedure carried out
1		
2		
3		
4		
5		

7. Details of the Demonstrations Attended by Student

S. No.	Date	Place (PSC/SDC/ CHC)	Signature of Student	Activity Demonstrated	Signature of Counselor

S. No.	Date	Place (PSC/SDC/ CHC)	Signature of Student	Activity Demonstrated	Signature of Counselor

S. No.	Date	Place (PSC/SDC/ CHC)	Signature of Student	Activity Demonstrated	Signature of Counselor

8. Details of Theteleconference Sessions Attended By Student

S. No.	Date	Place	Title of the sesstion	Signature of Student	Signature of Counselor

NOTES