The Log Book of Internship Program
for
Diploma in Nursing Science and MidwiferyCourse

Bangladesh Nursing & Midwifery Council

মূদ্রণ পূর্ববর্তী

The Log Book of Internship Program for
Diploma in Nursing Science & MidwiferyCourse

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Bangladesh Nursing & Midwifery Council

Diploma in Nursing Science and Midwifery Course

Internship Log Book

Particulars of Intern

Name of the Intern	
Year of Graduation with Moth	
Name of Nursing College/Institution	
Medical College Hospital/ GH/ SH	
Placement period	From . . . . . to . . . . .
Duration of Internship	
Signature of Intern & Date	
Signature of Observer Date&Detail with Seal	

Diploma in Nursing Science and Midwifery Course
Internship Log Book

Contents

INTRODUCTION

The Logbook of Internship Program for Diploma in Nursing Science &Midwifery course is designed to support the student nurses from transition to professional practice. During this program theInternwill work with an individual preceptor(s) to synthesize knowledge and skills gained from previous coursework over the past three years and apply them to various patient populations. Emphasis is placed on refining nursing process skills with particular attention given to prioritization of care. The practice provides an opportunity for theIntern to enact professional practice and demonstrate competencies (knowledge, skills, attitude, and ability) in providing evidence-based care. All instructions are enclosedwith this logbook includingalist of procedures. The competencies arearranged as per area of practice. The student will acquire clinicalcompetenciesby observingand demonstrating the procedures several times until passed.The internship program will be managed by the Nursing Internship Program Committee (NIPC). This logbook will be effective from the session of 2018-2019.

PURPOSE OF THE LOGBOOK

The purpose of this logbook is to provide detailed guideline for the Intern to acquire nursing competencies in order to assume professional roles and responsibilities.

Goal of Internship Program

To make the interns as a competent nurse-midwife to meet the growing healthcare needs of the peopleat home and abroad.

Objectives:

After completion of the internship program an intern will be able to:

1. Integrate theory into practice.
2. Communicate with the patients, their relatives, and the multidisciplinary team members.
3. Record nursing notes efficiently and accurately.
4. Analyze and interpret the laboratory findings and take necessary actions as required.
5. Use nursing process competently to assess, diagnose, plan, implement and evaluate the healthproblems of individuals, families and communities across the life span.
6. Apply health illness continuum model in order to promote, maintain and restore health.
7. Consider ethical and legal issues involving the part of nursing care.
8. Provide client-centeredevidence-based holistic nursing care to the patient.
9. Carry out practice that demonstrates positive attitudes, ethical behaviors and accountability in accordance with the BNMC rules and regulations with professional standards.
10. Recognize Interns' limitations in providing patient care and find the ways of addressing limitations.
11. Demonstrate competencies in discharging the professional roles and responsibilities.

Course Structure

Total duration	06 (six) months	= 182 days
Duration of practice	26 wks x 6 days	= 156 days
Weekly holidays	26 wks x 1 day	= 26 days (±)
Working hours for each of the individual day		=6 hours (Morning & Evening shift)/12 hrs (Night shift)
Hours per week		=48 hours

Total hours within the internship period: 48 hrs. x 26 wks/156 days/1248 hrs

Internship Clinical Rotation:

Internship rotations include the following clinical areas:

Rotation Schedule	
Department Name	**Duration of rotation (wks / hour)**
Medical Nursing	07 weeks /336 hrs
Surgical Nursing	08 weeks / 384 hrs
Pediatric Nursing	03 weeks / 144 hrs
Mid/Obs/Gynae	08 weeks /384 hrs
Total	**26 weeks /1248 hrs**

Selected Departments /Areas for Internship:

Sl. No.	Major Fields	Areas/department/ward/units
1	Medicine	Medicine, OPD, Emergency, ICU and CCU, Psychiatric and Nephrology
2	Surgery	Surgery, Surgery OPD, General OT, Post-operative, Burn unit, Orthopedic, Emergency,Eye and ENT
3	Pediatric	Pediatric OPD
4	Midwifery,Obs, and Gynae	Antenatal, Antenatal OPD, Labour, Postnatal, Newborn/SCABU, Caesarian OT, Eclampsia and Gynae

Master Plan of Internship Clinical Rotation for Diploma in Nursing Science and Midwifery Course
Duration: 06 (six) Months

	Medicine							Surgery					
Week	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**
Area	MOPD	EW	MW	MW	ICU/CCU	PW	NW	SOPD	SW	SW	GOT/POW	BU	OW
	Surgery		**Pediatric**			**Midwifery, Obstetric and Gynae**							
Week	**14**	**15**	16	17	18	19	20	21	22	23	24	25	26
Area	EyeW	ENTW	POPD	PMW	PSW	GYOPD	GYW	GYW	LW	COT	ECW	PNW	NBW

Acronym:
MOPD = Medicine Out Patient Department
EW = Emergency Ward
MW = Medical Ward
ICU/CCU = Intensive Care Unit/Coronary Care Unit
PW = Psychiatric Ward
NW = Nephrology Ward
SOPD = Surgical Out Patient Department
SW = Surgical Ward
GOT/POW= General Operation Theater/ Post-Operative Ward
BU = Burn Unit
OW = Orthopedic Ward
EyeW = Eye Ward
ENTW = Ear Nose & Throat Ward
POPD = Pediatric Out Patient Department
PMW = Pediatric Medical Ward
PSW = Pediatric Surgical Ward
GYOPD = Gynae Out Patient Department
LW = Labour Ward
COT = Caesarian Operation Theater
ECW = Eclampsia Ward
PNW = Post Natal Ward
NBW = New Born Ward

Schedule for Clinical practice

The interns will be placed in the evening shift after night duty

Name of department	Duration		
	Weeks	**Working days**	**Weekly Holidays**
Medicine:			
1) OPD	1 week	6 days	1 day
2) Emergency Ward	1 week	12 days	2 days
3) Medical Ward	2 weeks	6 days	1 day
4) ICU and CCU	1 week	6 days	1 day
5) Psychiatric Ward	1 week	6 days	1 day
6) Nephrology Ward	1 week	6 days	1 day
Total	**7 weeks**	**42 days**	**days**
Surgery:			
1) Surgical OPD	1 week	6 days	1 day
2)Surgical Ward	2 week	12 days	2 days
3) General OT& Post-operative Ward	1 week	6 days	1 day
4) Burn Unit	1 week	6 days	1 day
5) Orthopedic Ward	1 week	6 days	1 day
6) Eye Ward	1 week	6 days	1 day
7) ENT Ward	1 week	6 days	1 day
Total	**8 weeks**	**48 days**	**8 days**
Pediatric:			
1)Pediatric OPD	1 week	6 days	1 day
2) Pediatric Medical Ward	1 week	6 days	1 day
3) Pediatrics Surgical Ward	1 week	6 days	1 day
Total	**3 weeks**	**18 days**	**3 days**
Midwifery, Obs and Gynae:			
1) Gynae OPD	1 week	6 days	1 day
2) Gynae ward	2 weeks	12 days	2 days
3)Labour Ward	1week	6 days	1 day
4)Caesarian OT	1week	6 days	1 day
5)Eclampsia Ward	1week	6 days	1 day
6)Postnatal Ward	1week	6 days	1 day
7)Newborn/SCABU Ward	1week	6 days	1day
Total	**8 weeks**	**48 days**	**8 days**

N.B: If there is any discipline/area mentioned in the logbook is non-existed in any medical college hospital/district hospital; intern will be placed in the major discipline/area for that period.

Responsibilities for the Interns

1. Receiving newly admitted/transferred/post-operative patient(s) of the ward.
2. Performing health assessment.
3. Developing nursing care plan for ill/seriously ill patient(s).
4. Utilizing/considering laboratory findings in developing/preparing nursing care plan(s).
5. Establishing nurse-client and nurse-doctor relationship.
6. Maintenance of personal and environmental hygiene.
7. Maintenance of cleanliness and sterilization of equipment, linen and others.
8. Utilization of available resource materials to ensure cost effective care/services.
9. Providing holistic and client centered care to the patients in Medical, Surgical, Pediatric, Gynae and Obstetrical units by using nursing process.
10. Providing holistic and client centered care to the patients in child medical, surgical and neonate units by using nursing process.
11. Providing special nursing care (ICU/CCU/Neonate Units and others).
12. Providing pre and post-operative care.
13. Administering medication/drugs
14. Keeping nursing notes and other documentation.
15. Collecting and sending specimen to the laboratories.
16. Preparing patients for diagnostic tests and procedures.
17. Preparing preoperative patients for surgery.
18. Conducting health education session(s).
19. Assisting dying patients with peaceful death.
20. Attending the inward round.
21. Conducting pre and post conference(patient and ward briefing).

Generic competenciesfor the Interns

1. Receiving newly admitted/transferred/post-operative patients.
2. History taking.
3. Physical assessment.
4. Maintenance of cleanliness of the patients & their environment.
5. Providing nursing care to all categories of patients in accordance with nursing care plan.
6. Preparing the patients for diagnostic tests and procedures.
7. Specimen collection.
8. Interpretations of laboratory findings.
9. Assisting with common emergencies e.g. High fever, CPR, Shock, ARI, Hemorrhage etc.
10. Maintaining sterilization/disinfection (instruments, linen, rubber goods etc.) in wards/OT.
11. Administering safe drugs/medications.
12. Operating medical and non-medical devices such as ECG, ventilator, cardiac monitor, pulse oximeter, Glucometer, sucker machine and oxygen meter and cylinder, nebulizer and so on.
13. Maintaining different charts i.e. Temperature chart, intake and output chart, medication chart, diabetic chart etc.
14. Inserting IV cannula, urinary catheter, Ryle's tube/flatus tube etc.
15. Application of enema simplex/glycerin suppository.
16. Assisting in blood transfusion.
17. Discharge planning.
18. Documenting records.
19. Keeping proper death note(s) and medico-legal information.

Group Discussion/Case Conference Topics

Sl. No	Name of Topic	Name of Resource Person with Designation	Signature of Resource Personnel with date
1.	Communication		
2.	Nursing Process(Assessment, diagnosis, planning, implementation & Evaluation)		
3.	Basic Life Support (BLS)		
4.	Calculation of medication		
5.	Impact of psychological and social factors in disease condition		
6.	Pain management		
7.	Fall risk assessment		
8.	Nursing code of conducts and ethics		
9.	Nursing notes/record keeping/reporting		
10.	Quality improvement		
11.	Occupational hazards (COVID-19, HBsAg, HIV, Radiation, Needle stick injury etc.)		
12.	Patients' safety		
13.	Infection control		
14.	Over view on nursing management/ procedures		
15.	Patients' right		
16.	Discharge plan and health education		
17.	Rehabilitation		
18.	Palliative care /Critical care		
19.	Care of dying patient and medico-legal issues		

Techniques/methods for case study presentation:

- Lectures & presentation, and discussions;
- Power point presentation
- Pre and post conference

Teaching Aids:

- Flip chart and multimedia
- White board
- Audio-visual aids

Structure of the Nursing Internship Program Committee

1.	Chairman -	Director of Hospital/ Superintendent
2.	Secretary -	Nursing Superintendent/Deputy Nursing Superintendent/Nursing Supervisor
5.	Member	Nursing Supervisor
6.	Member -	Senior Staff Nurse (Ward in-charge) of the medicine ward
7.	Member -	Senior Staff Nurse (Ward in-charge) of the surgery ward
8.	Member -	Senior Staff Nurse (Ward in-charge) of the pediatric ward
9.	Member -	Senior Staff Nurse (Ward in-charge) of the ANC/Postnatal/Gynae ward/OPD

Responsibility of the NIPC

The committee should:

- Monitor, guide, and support whenever required as per scheduled
- Observe the Intern's competencies
- Guide the Intern's competencies according to parameters

Criteria of the NIPCMembers:

- Registered Nurse-Midwives with valid registration.
- B.Sc Nurse/B.Sc in Public Health Nurse, M.Sc Nurse/MPH is preferable
- Minimum 3 years of clinical experience
- Energetic and enthusiastic
- Committed to professional development

Note: IfB.Sc Nurse/B.Sc in Public Health Nurse, M.Sc or MPH Nurse is not available in any hospital then Registered Nurse with Diploma in Nursing and Midwifery degree will be included in the committee.

Instructionsfor the Nursing Internship ProgramCommittee

The Nursing Superintendent/ Deputy Nursing Superintendent will implement and maintain the internship program in the selected hospitals.S/he is responsible to organize an orientation program for the Interns with the consultation of nursing representatives from medicine, surgery, pediatric, and Midwifery/Obstetric/Gynae departments. In-charge of the concerned ward will be responsible for signing the logbooks after successful completion of assigned tasks within her/his jurisdiction. Here responsible in-charge should check the activities of Interns carefully with due attention. If any Intern remains absent for three months then Intern has to make up those absent days within three months or certified by registered medical doctor after completion of the scheduled internship or hospital authority will decide.

The NIPC is responsible to check the competencies identified for the Interns and sign in the appropriate column based on the observation. The committee is also accountable to grade the individual Interns according to the prescribed parameters and submitit to the Nursing Superintendent/Deputy Nursing Superintendent for issuing the completion certificate.

Nursing Superintendent/Deputy Nursing Superintendent should form a monitoring committee.The committee will beresponsible for-

1. Making the rotation plan and ensuring the placement.
2. Checking the attendance register of the interns on a regular basis.
3. Checkingthat activities are assigned to all interns by the ward in-charge based on the tasks as mentioned in the logbook.
4. Ensuringthat the Interns has accomplished all the tasks identified for them.
5. Providing necessary guidance and support towards the accomplishment of assigned task/competencies whenever required.
6. Ensuringthat the Interns has achieved all the generic competencies identified for them.
7. Signing against the tasks and competencies after keen observation/examination.
8. Checking that the ward in-charge has noted the reason/s in the remark column against the tasks which has not been accomplished by the Interns within the prescribed period.
9. Checkingthat the logbook is properly signed by the ward in-charge in time.

10. Collecting the grading forms and grading the Interns according to parameters.
11. Organizing small group discussion/case conference on the prescribed topic(s) for the Interns.
12. Submitting the completed grading forms to the concerned Nursing Superintendent/Deputy Nursing Superintendent and assisting her/him in issuing the completion certificate.

Activities related to Grading and Certification:

No.	Activities	Responsible person
1.	Allocation of interns to the different departments/ units	Member of the NIPC
2.	Supervise, guide and monitor the activities of Interns	
3.	Signing against the tasks and competencies identified for the Interns	
4.	Signing against the parameters i.e. attitude and behavior, punctuality, responsibility and dressing up with proper uniform using personal judgment	Member of the NIPC
	Signing the logbook	In-charge of the concerned ward
5.	Grading the Interns based on parameters	Member of the NIPC
6.	Certification	Hospital Director/Civil Surgeon and Nursing Superintendent/ DeputyNursing Superintendent of the concerned hospital

Guidelines for Nursing Internship Program Committee

The Committee:

- Will organize the small group discussion session/case conference on the selected topics either in the morning or evening in their respected unit at least once in a week.
- Should ensure the participation of the Interns in a small group discussion/case conference alongwith maintaining the register.
- May invite resource persons (Doctors/Nurses) to observe the discussion sessions/case conference.
- Should maintain the register where resource person will sign against the session s/he has observed.
- Ward In-charge of the major disciplines/departments will try to ensure the accomplishment of tasks mentioned in the generic skills within 1st two weeks of placement.
- Nursing Lecturer or Nursing Instructor of the Nursing College / Institute will be responsible for visiting their Interns once in a month during the Internship Program. They will not beresponsible for any marking.

Resource persons for the internship:

1. Nursing Superintendent/Deputy Nursing Superintendent of the concerned hospital.
2. Nursing Supervisor of the concerned hospital.
3. Ward In-charge of the concerned wards.
4. Members of NIPC.

Instructions for the Interns

The main responsibility of the Intern is to accomplish all the tasks mentioned in the logbook. This will help the Intern to work competently and confidently in the hospital in future. There are some instructions for the Interns which they should follow during their internship.

The instructions are as follows:

1. The Intern should wear appropriate hospital uniform during duty hours.
2. S/he should sign on the attendance registrar at the time of arrival and departure from duty.
3. S/he should maintain a notebook correctly after achieving the targets identified in the logbook every day.
4. S/he has to collect the logbook, fill it up properly, and get counter sign in the logbook from the concerned ward in-charge after completion of all assigned tasks.
5. S/he should get sign from the concerned members of the monitoring committee.
   - Intern needs to achieve concerned competencies as appropriate site during his/her internship.
   - Intern needs to perform their task following sample observational checklist as appropriate site during his/her internship.
6. S/he has to attend the group discussion session/case conference which will be arranged by the concerned personnel.
7. S/he can seek support and assistance from the monitoring committee in achieving his/her competencies whenever required.
8. S/he should conduct pre and post conference with nursing staff.

Guidelines for the Interns:

- The Interns should attend in the small group sessions and participate in discussion.
- The Interns should achieve competencies required for performing tasks listed on the generic skills by observing other nurses activities, assisting others in performing tasks and practicing these activities independently.
- They should get signature on the logbook from the concerned ward in-charge after completion of tasks.
- The Interns should individually select and present at least one case study in front of the committee at the end of their internship. They also have to submit one hand written hard copy of their presentation to the committee.

Code of Conduct, Rules and Regulations

The code of conduct, rules and regulations will be applicable to theIntern as per Govt. order for Internship program of the Ministry of Health and Family Welfare. In addition, the Government Service Rules are also applicable to the Interns.

1. If any Intern remains absent due to unavoidable circumstances for more than the allowed casual leave, an extra period of work is required to complete the task in the relevant unit.He/she will have to complete the absent period in the same placement unit after completion of the scheduled internship. For the period of absence pay of the Intern will be suspended. After performing duty for the absent period Intern's salary will be paid accordingly.
2. If an Intern remains unauthorized absent, he/she has to work for extra double time to make the absent period or his/her previous training in the respective discipline will be cancelled which ever decided by the concerned committee in consultation with In-charge of the major discipline and Nursing Superintendent of the hospital.
3. If any Intern remains absent for three months then s/he has to make up those absent days within three months or any period certified by the registered medical officer after completion of scheduled internship or hospital authority will decide.

Note for NIPC and Interns

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

Induction Course at Hospital

On the first day of joining at the hospitals, the Interns should undergo one day induction course underthe guidance of Nursing Superintendent/ hospital management committee.

Objectives:

At the end of induction course, the new Interns should acquire knowledge about the health care delivery system of that hospital and understand about:

1. Nursing ethics
2. Nurse-patient relationship
3. Code of conduct, rules and regulations related to nursing services/hospital
4. Leave and other instructions
5. Introduction to Bangladesh health services and linkage with other hospitals
6. Organogram of Medical College Hospital/District Hospital
7. Roles and responsibilities of different categories of Hospital staff
8. Role of nurses and doctor-nurse relationship
9. Hospital procedures
10. Safety and incidence issues

Grading Parameters and Mark Distribution

Concerned authority should consider the following parameters in grading the individual Intern. Parameter 1 and 2 carry 40 marks in each.Parameter 3, 4, 5, and 6 will be marked by the concerned authority.

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

No. of Parameters	Parameters	Marks
1	Completion of the number of assigned tasks (Log book)	40
2	Generic Skills/ Competencies	40
3	Attitude and behavior	05
4	Punctuality	05
5	Responsibility and accountability	05
6	Dressed up with proper uniform	05
Total		**100**

Grading System

Mark Obtained (%)	Grade Point Letter	Grade Point
80 – 100	A+	4.00
75 – 79	A	3.75
70 – 74	A-	3.50
65 – 69	B+	3.25
60 – 64	B	3.00
< 60	F	0.00

Instruction for Logbook and Competency Marking

1. The Log book will be marked by the assigned authority such as In-charge of the ward or the member of the committee.
2. Competencies should be acquired through observing, assisting and performing tasks. So every single task should be accomplished by the interns by observation, assisting others and performing independently.
3. In each section ward in-charge/ member of the committee have to give their signature after marking in the log book in the signature column.
4. At the end of the log book the member of the committee/ concerned authority have to count the Intern's total obtained marks and have to convert this mark into grading sheet (parameter 1).
5. Same as the logbook the member of the committee have to mark the Intern's competency/ generic skills and have to convert this mark into grading sheet (parameter 2).
6. Both the log book and generic skill total mark of 1000 & 100 respectively will be considered as equivalent with 40 (parameter 1 & 2) of the grading sheet. So Intern's obtained mark has to be calculated first and then put in to the grading sheet.
7. After converting the mark if there any fraction marking is raised, the concerned committee has to make that fraction marking into round figure. If the fraction marking is below 0.5 then no mark will be added. For example- if someone gets 1.4 then the mark will be just 1. Whenever the fraction mark is equal or more than 0.5, here mark will be added one. For example- if someone gets 1.5 or more than 1.5 then the mark will be 2.

Log Book

Group of Tasks	Allocated marks Marking based on observation, assist and perform	Obtained marks Marking based on observation, assist and perform	Remarks	Sign of In-charge
General Procedure (applicable in all discipline/ departments/units)				
Receiving of newly admitted pts.	05			
History taking and recording	05			
Performing health assessment	05			
Receiving of transferred in patients	05			
Checking and recording vital signs	05			
Maintenance of personal hygiene	05			
Maintenance of environmental hygiene	05			
Specimen collection	05			
Administering I/M injection	05			
Administering I/V injection	05			
Opening of I/V channel	05			
Maintaining I/V channel	05			
Administering oral medications	05			
Administering suppository in anal route	05			
Providing mouth care	05			
Providing back care	05			
Administering Oxygen inhalation	05			
Administering Inhaler/ Nebulizer	05			
Tube feeding	05			
Performing catheterization	05			
Caring of dying patient	05			
Caring of dead body	05			
Medical Nursing and Allied (07 weeks)				
Attend patient at MOPD	10			
Special Procedure				
Assist in lumber puncture	05			
Assist in sternum puncture	05			
Assist in fluid aspiration	05			
Nursing Management based on Nursing Process				
Management of Hypertension	05			
Heart failure	05			
Peptic ulcer	05			
Rheumatic fever	05			
Typhoid fever	05			
Dengue fever	05			
Nephrotic syndrome	05			
UTI	05			
Anemia	05			

Group of Tasks	Allocated marks	Obtained marks	Remarks	Sign of In-charge
	Marking based on observation, assist and perform	Marking based on observation, assist and perform		
Diabetes mellitus	05			
Hepatitis	05			
Meningitis	05			
Tuberculosis	05			
Pneumonia	05			
COPD	05			
Malaria	05			
Leprosy	05			
Chikungunya	05			
Psychiatric Nursing				
Management of Schizophrenia	05			
Anxiety disorder	05			
Depression	05			
Psychotic disorder	05			
Dementia	05			
Substance abuse	05			
Nursing Management (Emergency Unit)				
Management of Acute asthma	05			
Diabetic coma	05			
Poisoning	05			
Snake bite	05			
Shock	05			
Hemorrhage	05			
Hematemesismelena/epistaxis/ Hemoptysis	05			
Unconscious patient	05			
Fracture	05			
Epilepsy	05			
Intensive and Coronary care unit				
Performing ECG	05			
Using/operating Cardiac monitor	05			
Mechanical ventilator	05			
Defibrillator	05			
CPR	05			
Palliative care	05			
Management of IHD	05			
CVD	05			
MI	05			
Stroke	05			
Coma	05			
Nephrology Nursing				
Management of Chronic renal failure	05			
Acute renal failure	05			
Nephrotic syndrome	05			

Group of Tasks	Allocated marks Marking based on observation, assist and perform	Obtained marks Marking based on observation, assist and perform	Remarks	Sign of In-charge
Surgical Nursing and Allied (08 weeks)				
Attend patient at SOPD	10			
Care of surgical wound	05			
Aseptic dressings	05			
Colostomy care	05			
Preoperative care	05			
Postoperative care	05			
Stitching and removing of suture	05			
Nursing Management based on Nursing Process				
Management of Acute appendicitis	05			
Acute Cholicystitis/ cholelithiasis	05			
Acute abdomen	05			
Intestinal obstruction	05			
Hernia	05			
Pancreatitis	05			
Bleeding per rectum	05			
Carcinoma	05			
Operation Theater (OT) skill				
Cleaning and decontamination of OT	05			
Sterilization of Linen	05			
sharp instruments	05			
blunt instruments	05			
rubber goods	05			
Scrubbing , gowning, and gloving	05			
Preparation of operation trolley	05			
Maintenance of records	05			
Maintenance of stock ledger	05			
Post-operative (PO) patient Management				
Receiving post-operative patient by checking/examining (position, secretion, vital signs, bleeding, I/V cannulation, drainage)	05			
Provide immediate PO care	05			
Orthopedic & Traumatology Unit				
Special procedure for orthopedic nursing Application of roller bandage	05			
Application of triangular sling	05			
Application of cast	05			
Care of cast	05			
Removal of cast	05			
Assist in traction	05			
Nursing Management				
Management of	05			

Group of Tasks	Allocated marks	Obtained marks	Remarks	Sign of In-charge
	Marking based on observation, assist and perform	Marking based on observation, assist and perform		
Fracture				
Dislocation	05			
Amputation	05			
Osteoarthritis	05			
Osteomyelitis	05			
Congenital disorders	05			
Clients with traction	05			
Immobility	05			
Assist patient in performing active and passive range of motion	05			
Eye and ENT ward				
Attend patients in OPD	10			
Nursing management of Corneal ulcer	05			
Cataract	05			
Glaucoma	05			
Eye injury	05			
Acute otitis media	05			
Chronic otitis media	05			
Hearing impairment	05			
Acute rhinitis	05			
Chronic rhinitis	05			
Acute sinusitis	05			
Chronic sinusitis	05			
Acute tonsillitis	05			
Chronic tonsillitis	05			
Tonsillectomy	05			
Tracheostomy	05			
Dental carries	05			
Perio-dental disease	05			
Oral candidiasis	05			
Removal of foreign body from Ear / Nose	05			
Performing Ear toileting	05			
Application of Nasal pack in case of epistaxis	05			
Applying eye/bandage	05			
Nursing management of patients with burn				
Nursing management of First degree burn	05			
second degree burn	05			
Third degree burn	05			
Dressing of burn patient	05			
Pediatric Nursing (4 weeks)				
Attend patients in POPD	10			
Nursing management of ARI/pneumonia	05			
Measles	05			
Ventricular Septal Defect	05			

Group of Tasks	Allocated marks	Obtained marks	Remarks	Sign of In-charge
	Marking based on observation, assist and perform	Marking based on observation, assist and perform		
Febrile convulsion	05			
Epilepsy	05			
Congenital anomalies	05			
CHD/Chromosomal Abnormalities/spina bifida/Hydrocephalus/cleft palate/cleft lip	05			
Anemia	05			
Hemophilia	05			
Leukemia	05			
Thalassemia	05			
Diarrheal disease	05			
Juvenile DM	05			
Diabetic insipidus	05			
Carditis	05			
Tonsillitis	05			
Worm infestation	05			
Midwifery and Obstetrical Nursing (7 weeks)				
Attend antenatal patients in OPD	10			
History taking and documentation	05			
Antenatal assessment General examination	05			
Abdominal examination	05			
Per vaginal examination	05			
Counseling	05			
Birth plan	05			
Nursing management of APH (Acute post-partum hemorrhage)	05			
Rupture membrane	05			
Premature/low birth weight babies	05			
Monitoring of labor by using Partograph	05			
Conduction of normal delivery	05			
Active management of third stage labor Perform episiotomy	05			
Examination of placenta	05			
Immediate newborn care Newborn assessment/APGAR scoring	05			
Newborn resuscitation	05			
Nursing management of baby with Birth asphyxia	05			
Neonatal sepsis	05			
Neonatal jaundice	05			
Convulsion	05			
Congenital anomalies	05			
Birth Injury	05			
Management of PPH	05			

Group of Tasks	Allocated marks	Obtained marks	Remarks	Sign of In-charge
	Marking based on observation, assist and perform	Marking based on observation, assist and perform		
Post-partum infection	05			
Post-partum depression	05			
Mastitis	05			
Management of Eclampsia	05			
Preparation of patient for C/S	05			
Preparation of C/S trolley	05			
Management of Abortion	05			
Ectopic pregnancy	05			
Molar pregnancy	05			
Uterine prolapsed	05			
Cord prolapsed	05			
Shoulder dystocia	05			
VVF/RVF	05			
Total mark	**1000**			

Generic competencies

Checklists to be filled up by the member of the monitoring committee

Sl. No	Skills/Competencies	Allocated mark	Obtained mark	Comments
1.	Cleanliness of the patients & their environment	04		
2.	Maintenance of personal hygiene	04		
3.	Sterilization of instruments, linen, rubber goods (wards/OT)	04		
4.	Receiving of newly admitted patients; transferred in patients; post-operative patients	04		
5.	History taking (physical, psychological, social and spiritual aspects)	04		
6.	Specimen collection	04		
7.	Preparation for diagnostic tests and procedures	04		
8.	Interpretations of laboratory findings	04		
9.	Nursing care to all categories of patients followed by nursing process	04		
10.	Dealing with common emergencies e.g. High fever	04		
11.	Dealing with CPR	04		
12.	Dealing with Shock	04		
13.	Dealing with Hemorrhage etc.	04		
14.	Maintenance of intake and output chart; medication chart; diabetic chart etc.	04		
15.	Administering drugs/medication correctly and safely	04		
16.	Induction of catheter	04		
17.	Induction of ryles tube	04		
18.	Induction of flatus tube	04		
19.	Operating sucker machine/ Operating oxygen cylinder/ meter/ central supply	04		
20.	Operating Mechanical Ventilation; Operating cardiac monitor	04		
21.	Assisting with blood transfusion; management of complication of blood transfusion	04		
22.	Discharge planning,	04		
23.	Keeping proper death note	04		
24.	Documenting records	04		
25.	Enema simplex	04		
Total mark		**100**		

Signature of the concerned Member of the Internship Program Committee

Full Name :

Designation :

Date :

Grading Sheet

Annex-1

Name of the Intern :

Roll No :

Year of Internship :

No.	Parameters	Marks Allocated	Marks Obtained	Grade Obtained
1	Completion of the number of assigned tasks (Log book)	40		
2	Generic Skills/Competencies	40		
3	Attitude and behavior*	05		
4	Punctuality*	05		
5	Responsibility and accountability*	05		
6	Dressed up with proper uniform*	05		
Total		**100**		

Signature of the Member of the Monitoring Committee

Full Name :

Designation :

Date :

Note: * marked items (3, 4, 5, 6) should be marked by the concerned authority.

Sample of Certificate

Annex-2

Monogram of respected Hospital

Certificate of completion of 6th month internship Program

This is to certify that

.....

S/O/D/O .....

Successfully completed the six month Internship Program for Diploma in Nursing Science and Midwifery course held from..... to ..... 20.... at the .... Hospital, ... under the supervision of approved Committee.

During the internship she/he has cover the following area-

Name of Department	Duration of Program
Medical Nursing	07 weeks
Surgical Nursing	08 weeks
Pediatric Nursing	04 weeks
Mid/Obs/Gynae Nursing	07 weeks

During this internship he/she has achieved ……score out of ……100…….

S/he acted as a Registered Nurse of the concerned wards/ departments during the placement.

Nursing Superintendent/	Principal/Incharge	Hospital Director/Superintendent
Deputy Nursing Superintendent	.....	…….
……..……	Nursing	Hospital
Hospital	College/Institute	

Annex-3

Samples of Observational Checklist

Overall Observation (General)

Checklists to be filled up by the member of the monitoring committee/concerned Ward In-charge

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

Sl. No	Tasks	Yes	No	Comments
1	Receiving of newly admitted patients;			
2	Receiving of transferred in patients;			
3	Following up the patient's conditions,			
4	Making discharge plan,			
5	Keeping proper death note.			
6	Performing health assessment			
7	Maintenance of personal hygiene			
8	Maintenance of environmental hygiene			
9	Developing nursing care plan based on nursing process			
10	Establishing nurse-client relationship			
11	Establishing nurse-doctor relationship			
12	Providing holistic and client centered care to the patients in adult medical units by using nursing process			
13	Providing holistic and client centered care to the patients in adult surgical units by using nursing process			
14	Providing holistic and client centered care to the patients in gynecological department by using nursing process			
15	Providing holistic and client centered care to the patients in obstetrical units by using nursing process			
16	Providing holistic and client centered care to the patients in child medical units by using nursing process			
17	Providing holistic and client centered care to the patients in child surgical units by using nursing process			
18	Providing holistic and client centered care to the patients in neonate units by using nursing process			
19	Maintenance the cleanliness and sterilization of equipment,			
20	Maintenance the cleanliness and sterilization of linen,			
21	Maintenance the cleanliness and sterilization of rubber goods			
22	Utilization of available resource materials to ensure the cost effective care/services			
23	Providing bedside care for an individual patients emphasizing on basic nursing procedure			
24	Providing special nursing care			

Sl. No	Tasks	Yes	No	Comments
25	Providing bedside care for an individual patients emphasizing on basic nursing procedure			
26	Providing pre-operative care			
27	Assisting patients undergo for surgery			
28	Providing post-operative care			
29	Administering medication/drugs by following 6 rights to minimize any medication error			
30	Considering laboratory findings during the development/ preparation of nursing care plan			
31	Collecting specimen according to the physician orders			
32	Sending specimen to the concerned laboratories			
33	Preparing patients for different diagnostic tests and procedures			
34	Sending patients to the concerned diagnostic department			
35	Keeping nursing notes and other documentation properly			
36	Conducting health education sessions			
37	Assisting dying patients with peaceful death			
38	Caring for dead body			
39	Joining with ward/physician round			
40	Conducting pre and post conference with nursing staff.			

Signature of the concerned Member of the Monitoring Committee

Full Name :

Designation :

Date :

Check list for evaluator

Procedure Name : Taking health history (Adult, Child)

Name of Intern :

Roll no :

[Please observer the intern's activities and tick (√) in the appropriate boxes]

Tasks	Performed	Not performed
Greet patient/attendant/parents		
Explain what s/he is going to do and why		
Seek required cooperation/assistance		
Maintain privacy		
Keep the patient in comfortable position		
Use nonthreatening gesture during communication		
Ask one question at a time		
Avoid medical terminology		
Consider ethical issue during data collection		
Ensure the patient about confidentiality		
Obtain data related to history of health		
Obtain data related to nutritional, economic, family status		
Organize/record collected data accordingly		
Thanks patient/attendant/parents for her/his cooperation		
Document all the history		

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

Date ----------

Procedure Name : Measuring Vital signs

Name of Intern :

Roll no :

[Please observer the intern's activities and tick (√) in the appropriate box]

Tasks	Performed	Not performed
Collect necessary equipment		
Identify the patient		
Greet the patient and explain the procedure		
Ensure privacy		
Keep the patient in comfortable position		
Wash hands properly		
Recording Radial Pulse		
Place the fingertips of index, middle and ring finger on the patient's radial artery just above the wrist joint. The index towards the patient's thumb.		
When the patient's pulse is clearly felt observe first the regularity of rhythm and the force of the pulse before beginning to count the rate.		
Count the pulse for 1minute.		
Measuring Oral Temperature		
Ask the client whether s/he has taken hot or cold drink, if so wait for 10 minutes		
Hold the thermometer by stem, wash and dry it and shake down to below 96^{0F}		
Place the thermometer in client's mouth under the tongue and ask the client to keep the mouth close and not to bite and leave in for 2 minutes. For children use axilla for measuring temperature.		
Remove the thermometer and hold the thermometer at eye level and read the nearest tenth.		
Recording Respiration		
Place patient's arm over the chest. Do not tell the patient that you are going to count their respirations, as this will affect how they breathe.		
Observe the rise and fall of the chest. Each rise and fall=1 respiration.		
Count respiration for 1 minute.		

Tasks	Performed	Not performed
Measuring Manual Blood Pressure		
Select one hand for BP monitoring.		
Extended arm and rest level with heart, palm upward on bed or table.		
Locate brachial artery and wrap cuff tightly around upper arm, one inch above elbow.		
Palpate radial artery and inflate cuff 20-30 mmHg beyond point where pulse was last felt.		
Place the diaphragm of stethoscope directly over brachial artery and deflate cuff at even rate of 2-4 mm per second by turning valve counter clockwise.		
Note point on scale where first sound heard (systolic) and where sound disappears or changers (diastolic reading)		
Deflate the cuff completely from the arm		
Document all the vital signs in vital sign chart		

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

Date ----------

Procedure Name : Giving back massage/ Back Care

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

Tasks	Performed	Not performed
Collect necessary equipment		
Identify the patient to provide back care according to procedure		
Greet the patients and explain the procedure		
Ensure privacy		
Turn the patient on lateral position with the back towards		
Place the rubber sheet, covered with draw sheet, along length of the patient tucked in closely to back		
Wash hands properly		
Expose the patients back from the shoulder to buttock		
If the back of the patients is dirty wash the back first with warm water and soap water		
Using sponge cloth and warm water, gently massage the back, shoulder, hip and buttock in a circular motion		
Dry the back with towel		
Apply lotion on the palm and gently rub the back, shoulder hip and buttocks		
Apply power on the buttock to prevent moist skin		
Assist the patient to change cloth and keep him in a comfortable position		
Thank for his/her cooperation		
Maintain proper disposal and wash hands		
Document the procedure		

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

Date ----------

Procedure Name : Nebulization

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

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

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

Date ----------

Procedure Name : Administering Oral Medication

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

Tasks	Performed	Not performed
Wash hands		
Collect necessary medicine.		
Greet the patient and explain the procedure clearly.		
Obtain verbal consent to the procedure.		
Maintain privacy and make the patient comfortable position.		
Ensure medication order satisfactory, checking 6 rights of medication--		
• Check right patient		
• Check right drug		
• Check right time		
• Check right route		
• Check right dose		
• Check right documentation		
Check expiry date and color of prescribed drug.		
For liquid suspension drug check the appropriate amount of drug and mix with juice.		
Check above 5 rights once again.		
Accurately administer medication.		
Comfort the patient.		
Avoid undue delay in procedure		
Monitor and document client response to medication and report to the ward in-charge if necessary.		

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

Date ----------

Procedure Name : Administering Oxygen Therapy by face mask

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

Tasks	Performed	Not performed
Check physician's order.		
Collect all equipment.		
Explain the procedure to the patient or family members.		
Check whether the oxygen cylinder is full or not, whether there is any default.		
Select oxygen flow as per order, check correct level of water in humidifier.		
Wash hands.		
Positioning the patient i.e. propped up/comfortable.		
Ensure the airway is clear.		
Open the oxygen and regulate the flow of oxygen after attaching the mask.		
Ensure appropriate apparatus at the bed side such as calling bell, paper and pencil.		
Make the patient comfortable.		
No mosquito coil and "No Smoking Sign" are placed on patient's door/bedside.		
Observe the patient at regular interval.		

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

Date ----------

Procedure Name : Administering I/M Injection

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

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

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

Date ----------

Procedure Name : Wound dressing

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

Tasks	Performed	Not performed
Greet the patients and explain the procedure		
Collect and take trolley with sterilized equipment to the patient's bedside.		
Maintain privacy		
Keep the patient in comfortable position and instruct patient not to touch wound or dressing materials		
Wash hands		
Place rubber sheet and its cover under the affected side.		
Observe wound and check if there is drainage rubber or tube.		
Take specimen for culture or slide if ordered (do not cleanse wound with antiseptic before you obtain the specimen).		
Remove the outer layer of the dressing using the first sterile forceps and discard both the soiled dressing and the forceps.		
Take the second sterile forceps. Clean wound with gauge soaked in antiseptic solution, starting from inside to the outside.		
Start cleaning wound from the cleanest part of the wound to the most contaminated part using antiseptic solution.		
Apply medication if any and dress the wound with sterile gauge.		
Use gauge for drying the skin around the wound properly.		
Dress the wound and make sure that the wound is covered completely.		
Fix dressing in place with adhesive tape or bandage.		

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

Date ----------

Procedure Name : Tracheostomy Tube Suctioning

Name of Intern:

Roll No:

[Please observer the intern's activities and tick in the appropriate box]

Tasks	Performed	Not performed
Position the patient in semi-fowler's position. Frequency of suction will vary and must be individually assessed.		
Place a linen-saver pad, towel or clean sheet on the patient's chest.		
Put on a face shield, mask or goggles.		
Turn on the wall suction or portable suction machine. Check and adjust the pressure regulator according to policy/protocol (typically 100-120 mmHg for adults, 95-110 mmHg for children, and 50-95 mmHg for infants).		
Test the suction equipment by occluding the connection tubing.		
Open the suction catheter kit or the gathered equipment if a kit is now available.		
Consider dominant hand keep sterile with sterile gloves and the non-dominant hand non sterile.		
Pour sterile saline into the sterile container, using the non-dominant hand.		
Pick up the suction catheter with the dominant hand and attachés it to the connection tubing.		
Put the tip of the suction catheter into the sterile container of normal saline solution and suctions a small amount of normal saline solution through the catheter.		
Lubricate the suction catheter tip with normal saline.		
Using the dominant hand, gently but quickly insert the suction catheter into the Tracheostomy tube.		
Advance the suction catheter, with suction off, gently aiming downward and being careful not to force the catheter.		
Apply suction only while withdrawing the catheter.		
Do not apply suction for longer than 10 seconds at a time.		
Repeat suctioning as needed, allowing at least 30 seconds interval between suctioning.		
Hyper oxygenate patient between each pass.		
Replace the oxygen source, if the patient was removed from the source during suctioning.		
Discard the gloves and catheter in a water resistant receptacle.		
Using the non-dominant hand, clears the connective tubing of secretions by placing the tip into the container of sterile saline.		
Provide mouth care		
Document the procedure		

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

Date ----------

Procedure Name : Catheterization

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

Tasks	Performed	Not performed
Collect all required equipment bring to the patient bed side		
Greeting the patient and explain the procedure		
Maintain proper position- dorsal recumbent (pillows can be used to elevated the buttocks in female)		
Maintain privacy with screen		
Wash hands properly		
Wash the perennial area with warm water and soap.		
Rinse and dry the area.		
Create a sterile field.		
Drape the client with a sterile drape.		
Clean the area with antiseptic solution.		
Lubricate the insertion tip of the catheter (5-7 cm)		
Expose the urinary meatus adequately by retracting the tissue or the labia minora in an upward direction female.		
Retract the fore skin of uncircumcised male.		
Grasp the penis firmly behind the glands and hold straighten the downward curvature of vertical it go to the body-hold the catheter 5cm from the insertion tip.		
Insert the catheter into the urethral orifice.		
Insert the catheter until urine comes.		
Insert 5-10ml of distilled water into the balloon of the catheter.		
Collect the urine for specimen (adult 30ml) if necessary.		
Connect the catheter with the urine bag.		
Fix the catheter in the thigh area with adhesive tape.		
Hang the urine bag in the bed.		
Document the procedure.		

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

Date ----------

Procedure Name : Specimen Collection

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

Task	Performed	Not performed
Check physician order for specimen collection.		
When collecting specimen wear gloves to protect self from contact with body fluid.		
Get request for specimen collection and identify the types of specimen being collected and the patient from which the specimen to be collected.		
Give adequate explanation to the patient about the purpose, type of specimen being collected and the method used.		
Assemble and organize all the necessary materials for the specimen collection.		
Get the appropriate specimen container and level clearly and placed in the plastic bag or tracks.		
Check the patient's identification such as – name, age, card number, the ward and bed number (if in patient).		
Clear the types of specimen and method used (if needed).		
Write down the time and date of specimen collection.		
Collect the desire specimen maintains aseptic technique.		
Put the collected specimen into the container without contaminating outer part of the container and its cover.		
The entire specimen should be sent promptly to the laboratory with appropriate requisition form.		

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

Date ----------

Procedure Name : Enema Simplex

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

Task	Performed	Not performed
Inform the patient about the procedure.		
Collect all the necessary equipment.		
Put bedside screen for privacy.		
Attach rubber tube with enema can with nozzle and stop the cork or clamp		
Place the patient in lateral position with the Rt. leg flexed, for adequate exposure of the anus (facilitates the flow of solution by gravity into the sigmoid and descending colon, which are on the side).		
Maintain the temperature of enema solution (990-1030F).		
Fill the enema can which 1000 cc of solution for adults.		
Lubricate about 5cm of the rectal tube to facilities insertion through the sphincter and minimize trauma.		
Hung the can 45cm from bed or 30cm from patient on the stand.		
Place a piece of mackintosh under the bed.		
Make the tube air free by releasing the clamp and allowing the fluid to run down little to the bed pan and clamp open- prevents unnecessary distention.		
Lift the upper buttock to visualize the anus.		
Insert the tube in an adult smoothly and slowly.		
Raise the solution container and open the clamp to allow fluid to flow.		
Administer the fluid slowly if client complains of fullness or pain, stop the flow for 30minutes and restart the flow at a slower rate.		
Decrease intestinal spasm and premature ejection of the solution.		
Do not allow all the fluid to go as there is a possibility of air entering the rectum or when the client cannot hold anymore and wants to defecate, close the clamp and remove the rectal tube from the anus and offer the bed pan.		
Remove bed pan and clean the rectal tube.		
Do not flash the commode if the patient's defecate in toilet.		
Observe the color, smell, any blood in the toilet.		
Record the procedure.		

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

Date ----------

Procedure Name : Antenatal Assessment

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

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

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

Date ----------

Procedure Name: **Per Vaginal (P/V) Examination**

Name of Intern **:**

Roll no **:**

[Please observer the intern's activities and tick in the appropriate box]

Task	Performed	Not performed
Prepare all necessary equipment		
Greet mother & explain the procedure		
Wash hands thoroughly with soap & dry		
Put high level disinfected surgical gloves on both hands		
Observe the vulva for the presence of blood, mucus, amniotic fluid & other discharge.		
Cleanse the vulva with an antiseptic solution		
Gently insert two lubricated fingers of the examining hand into the vagina		
Direct the fingers along the anterior wall of the vagina and note vaginal temp, moisture & texture.		
Palpate around the fornices& sense the proximity of the presenting part of the fetus to the examining fingers.		
Note the length, consistency & dilatation of the cervix		
Note the membrane are intact or rupture, ensure the cord has not prolapsed		
Measure the level of the presenting part in cm. above or below the women's ischial spines (station)		
Identify the presentation & determine position by feeling the feature of the presenting part		
Immerse both hands in 0.5% chlorine solution		
Remove gloves by turning them inside out		
Record all findings from the vaginal examination.		

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

Date ----------

Procedure Name : Management of 2nd stage of labour

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

Task	Performed	Not performed
Prepare all necessary equipment		
Put on protective barrier & wash hands		
Greet mother & explain the procedure		
Maintain privacy		
Provide continual emotional support & reassurance		
Allow the mother about choice of birth position		
Clean the perineum		
Use one hand to support the perineum with pad		
Assess the perineum whether an episiotomy is necessary or not		
Gently feel around the newborn neck for the cord		
Allow restitution & external rotation		
Apply gently downward traction on the head to allow the anterior shoulders to slip beneath the symphysis pubis		
Guide the head & trunk in an upward curve to allow the posterior shoulder to escape over the perineum		
Grasp the newborn around the chest to aid the birth of the trunk & lift it toward the women's abdomen		
Note the time of birth		
Dry the newborn quickly & thoroughly with a clean, dry towel/cloth immediately after birth		
Wipe the newborn's eyes with a clean piece of cloth		
Place the newborn in skin- to- skin on the mother's abdomen & cover with a clean, dry towel/cloth		
Observe the newborn's breathing		
Wash hands thoroughly		
Record all findings on women's record		

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

Date ----------

Procedure Name : Management of 3rd stage of labour

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

Task	Performed	Not performed
Prepare all necessary equipment		
Wash hand thoroughly		
Provide continual emotional support & reassurance the woman		
Place a sterile receptacle against the woman's perineum		
Palpate the mother abdomen to exclude the second baby		
Give 10 unit oxytocin intramuscularly		
Clamp the cord close to the perineum with forceps		
Use one hand to grasp the forceps		
Wait for the uterus to contact		
Place the other hand on mother's abdomen, with the palm facing towards the mother's umbilicus & gently apply pressure in an upward direction (counter traction).		
Firmly apply traction to the cord, in a down ward direction, using the hand that is grasping the forceps.		
Apply steady tension by pulling the cord firmly & maintaining pressure.		
When the placenta is visible at the vaginal opening, cup it in both hands.		
Use a gentle upward & downward movement or twisting action to deliver the membranes		
Place the placenta in the receptacle provided e.g kidney tray		
Gentle massage the uterus & make sure that the uterus is well contracted.		
Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out		
Wash hands thoroughly with soap & water & dry with a clean, dry cloth or air dry		
Record all findings on record sheet		

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

Date ----------

Procedure Name : Clamping & cutting the cord

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

Task	Performed	Not performed
Prepare all necessary equipment		
Wash hands		
Greet mother & explain the procedure		
Put high level disinfected surgical gloves on both hands		
Palpate the cord & feel pulsation is stop or not		
Once the pulsation is stop tie the cord 2 fingers away from the umbilicus		
Tie the 2nd knot 1 finger away from the Ist knot		
Tie the 3rd knot 4 finger away from the 2nd knot		
Cut the cord 1 finger away from the 2nd knot		
Clean & maintain aseptic technique		
Observe any bleeding from the cord or not		
Advice the mother about care of cord		
Record all findings		

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

Date ----------

Procedure Name : Placenta Examination

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

Task	Performed	Not performed
Put clean gloves on both hands		
Hold the placenta in the palms of the hands, with maternal side facing upwards.		
Check all of the lobules are present and fit together.		
Hold the cord with one hand & allow placenta & membranes to hang down.		
Insert the other hand inside the membranes, with fingers spread out.		
Inspect the membranes for completeness.		
Note the position of insertion of the cord.		
Inspect the cut end of the cord for the presence of two arteries and one vein.		
Measuring placenta		
Place the placenta in a leakproof container for dispose after asking women about cultural practices.		
Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out.		
Wash hands thoroughly with soap & water & dry with a clean, dry cloth or air dry		
Record all findings on record sheet		

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

Date ----------

Procedure Name : Newborn Assessment

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

Task	Performed	Not performed
Prepare all necessary equipment		
Explain procedure to the mother		
Wash hands thoroughly		
Place new born on a clean, warm surface		
Remove the newborn's clothing		
Check the newborn's general appearance, cry, breathing, heart rate & temp (APGAR score).		
Weigh the newborn		
Measure the head circumference		
Examine head, checking for abnormality		
Examine the upper limbs, checking the skin, soft tissues and bones for abnormality		
Examine the chest for symmetrical movement		
Examine the umbilicus for bleeding and tightness of cord tie.		
Examine the genitalia for abnormalities		
Ensure the anus is patent		
Examine the lower limbs, checking the skin, soft tissues and bones for abnormality		
Examine the spine for abnormalities		
Wash hand thoroughly		
Inform mother of findings & ask the mother if she has additional question		
Record all relevant findings from the physical examination.		

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

Date ----------

Procedure Name : Postpartum examination

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

Tasks	Performed	Not performed
Prepare all necessary equipment		
Observe the women's general appearance		
Wash hands thoroughly		
explain each step of the physical examination		
Take the women vital signs		
Check the women's conjunctiva and palms for pallor		
Examine the breasts for engorgement and cracked/sore nipples.		
Examine the abdomen to check the uterus and detect tenderness.		
Examine legs for pain and tenderness.		
Examine perineum and genitalia for signs of trauma and infection.		
Observe color, odor and amount of lochia.		
Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning them inside out		
Wash hands thoroughly		
Record all relevant findings from the physical examination on the women's record.		

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

Date ----------

Procedure Name : Manual Removal of Placenta

Name of Intern :

Roll no :

[Please observer the intern's activities and tick in the appropriate box]

Task	Performed	Not performed
Prepare necessary equipment		
Provide continual emotional support & reassurance		
Ask the women to empty her bladder or insert a catheter		
Give medication to relieve pain		
Give prophylactic antibiotic		
Put on personal protective barriers		
Wash hands & forearms thoroughly & put on high-level disinfected elbow gloves		
Hold the umbilical cord with a clamp & pull the cord gently		
Place the fingers of one hand into the uterine cavity & locate the placenta		
Provide counter-traction abdominally		
Move the hand back & forth in a smooth lateral motion until the whole placenta is separated from the uterine wall.		
Withdraw the hand from the uterus, bringing the placenta with it while continuing to provide counter-traction abdominally		
Give oxytocin in IV fluid		
Massage the fundus of the uterus		
Examine the uterine surface of the placenta to ensure that it is complete		
Examine the women carefully & repair any tears to the cervix or vagina or repair episiotomy		
Remove gloves & discard them in a		
Wash hands thoroughly		
Monitor vaginal bleeding, & make sure that the uterus is firmly contracted		

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

Date ----------

Structure of the Nursing Internship Program Committee

1.	Chairman -	Director of Hospital/ Superintendent
2.	Secretary -	Nursing Superintendent/Deputy Nursing Superintendent/Nursing Supervisor
5.	Member	Nursing Supervisor
6.	Member -	Senior Staff Nurse (Ward in-charge) of the medicine ward
7.	Member -	Senior Staff Nurse (Ward in-charge) of the surgery ward
8.	Member -	Senior Staff Nurse (Ward in-charge) of the pediatric ward
9.	Member -	Senior Staff Nurse (Ward in-charge) of the ANC/Postnatal/Gynae ward/OPD

Responsibility of the Committee

Committee should -

- Observe the interns competencies
- Grading the Interns by using given parameters
- Monitoring, guiding and supporting when required
- Perform duty from 8am---4pm every day

Criteria of forming the Committee

- Register Nurse-Midwives
- M.Sc Nurse/MPH
- B.Sc Nurse/B.Sc in Public Health Nurse
- Minimum 03 years of service experience
- Energetic and enthusiastic
- Committed to professional development

List of Reviewer

1. **Dr. Ashrafi Ahmed** NDC
   Joint Secretary (Nursing Education), Medical Education and Family Welfare Division
   Ministry of Health and Family Welfare
2. **Mr. Rashidul Mannaf Kabir**
   Director (Education) (Deputy Secretary), Directorate General of Nursing & Midwifery
3. **Ms. Rashida Akhter**
   Registrar (Add. Charge)
   Bangladesh Nursing and Midwifery Council
4. **Ms. Ava Adhikari**
   Principal, Nursing Institute Mitford, Dhaka.
5. **Ms. Saleha Khatun**
   Vice Principal, Grameen Caledonian College of Nursing, Dhaka
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List of Contributors

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List of Stakeholders

Name of Officials (not in according to seniority):

1. Mr. Nitish Chandra Sarker, Vice-President, BNMC &Additional Secretary (Medical Education), Medical Education & Family Welfare Division, Ministry of Health & Family Welfare.
2. Md. Shah Alam, Additional Secretary (Admin), Medical Education & Family Welfare Division, Ministry of Health & Family Welfare.
3. Ms. Siddika Akter, Additional Secretary & Director General, Directorate General of Nursing & Midwifery.
4. Md. Ahsan Kabir, Joint Secretary (Medical Education), Medical Education & Family Welfare Division, Ministry of Health & Family Welfare.
5. Md. Saiful Islam, Joint Secretary (Nursing Education), Medical Education & Family Welfare Division, Ministry of Health & Family Welfare.
6. Ms. Shara Diba, Deputy Secretary (Nursing Education), Medical Education & Family Welfare Division, Ministry of Health & Family Welfare.
7. Mr. Anowarul Haque, Deputy Secretary (Nursing Services-1), Health Service Division, Ministry of Health & Family Welfare.
8. Professor Dr. Syada Shahin Subhan, Director, Center for Medical Education (CME).
9. Mr. Md. Shahin Reza, Nursing Officer, Directorate General of Nursing & Midwifery.
10. Ms. LT. CoL. Nilufa Yeasmin, Chief Principal Matron, Directorate General of Medical Services (DGMS-ARMY).
11. Dr. Md. AsharafulAlam, Deputy Director, Dhaka Medical College Hospital, Dhaka.
12. Dr. Sattajit Kumar Shaha, Assistant Director, Mugda Medical College Hospital, Dhaka.
13. Dr. Emily Huque, Incharge Emergency Department, Representative of Director, Kurmitola General Hospital, Dhaka.
14. Ms. Shikha Biswas, Nursing Superintendent, Dhaka Medical College Hospital, Dhaka.
15. Ms. Ferdousi Begum, Nursing Superintendent, Sir Salimullah Medical College & Mitford Hospital, Dhaka.
16. Mst. Nazneen Khanam, Nursing Superintendent, Mugda Medical College Hospital, Dhaka.
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42. Mr. Alok Kumar Das, Admin Officer, Bangladesh Nursing & Midwifery Council.