HOSPITAL
CONTENTS OF THE RLE WRITTEN REQUIREMENTS

1st page: Area of exposure
Name of Student
Name of Clinical Instructor

2nd page: General and Specific Objectives

General Objectives:
Should contain the learning domains of the students (knowledge, skills and attitude).

Specific Objectives:
Always start with a behavioral verb.
Written in order of priority
Correlates to the concept of the entire exposure

Both should follow the SMART format

Sample:
General Objectives

After one-week exposure at (institution), being aided with the concept of Nursing Care of the client with high-risk labor and delivery of her family, I will be able to gain the exact knowledge, enhance my skills and develop positive attitude towards the care of the clients.

Specific Objectives

After one week exposure at (institution), I will be able to:

1. Be oriented to the physical set up, rules and policies and the staff.
2. Establish rapport with the client.
3. Communicate effectively with patient, families and other relevant persons by:
   - Listening and interpreting information
   - Demonstrating non-judgmental behavior.
   - Evaluating the interaction between members of the family
   - Discussing information at the appropriate intellectual level for all ages and condition.
4. Obtain pertinent information about the patient
5. Perform an appropriate physical examination (IPPAO).
6. Perform common procedures (V/S) using appropriate instruments and materials.
7. Elicit and interpret pertinent events from the patient, family and other sources.
8. Identify nursing problems and formulate nursing care plan.
9. Formulate management plans for short and long term care.
10. Apply appropriate interventions to the client
11. Evaluate the effectiveness of the nursing interventions.

Next succeeding pages:

HEALTH HISTORY FORMAT

Student Name:
Area of Assignment:
Date & Time of Interview:

I. Biographical and Demographic Data

Name:
Gender:
Birth Date:
Birth Place:
Age:
Address:
Contact Number:
Educational Level
Marital Status:
Occupation:
Nationality:
Religion:
Source of Data:
Contact Person in Case of Emergency:
Health Insurance:
Date & Time of Admission:
Attending Physician:
Diagnosis:

Chief Complaint: *(patient's exact words)*

II. Current Health (History of present illness)

Character: *(How does it feel, look, smell, sound, etc.?)*
Onset: *(When did it begin; is it better, worse or the same since it began?)*
Location: *(Where is it? Does is radiate?)*
Duration: *(How long it lasts? Does it recur?)*
Severity: *(How bad is it on a scale of 1 to 10?)*
Pattern: *(What makes it better? What makes it worse?)*
Associated factors: *(What other symptoms do you have with it? Will you be able to continue doing your work or other activities [leisure or exercise]?)*

Sample

A case of Mr. S.A, married, 34 years old, a resident of Sambag 1, admitted for the first time at SWU MEDICAL CENTER last January 18, 2023 because of LBM.

Three days prior to admission (January 15,2023), patient can still manage to do his work effectively without any pain felt. It was about 3 pm of the same day that patient experienced abdominal pain and loose bowel movement after having 1 cup of rice, "ginaling" and a bottle of Coca Cola for lunch.

The pain worsened and rated pain as 8 (10 is the highest and 1 is the lowest). The condition persisted & was associate with fever. Thus, the patient decided to seek consultation at SWU Medical Center and was advised for admission.

III. Past Health History

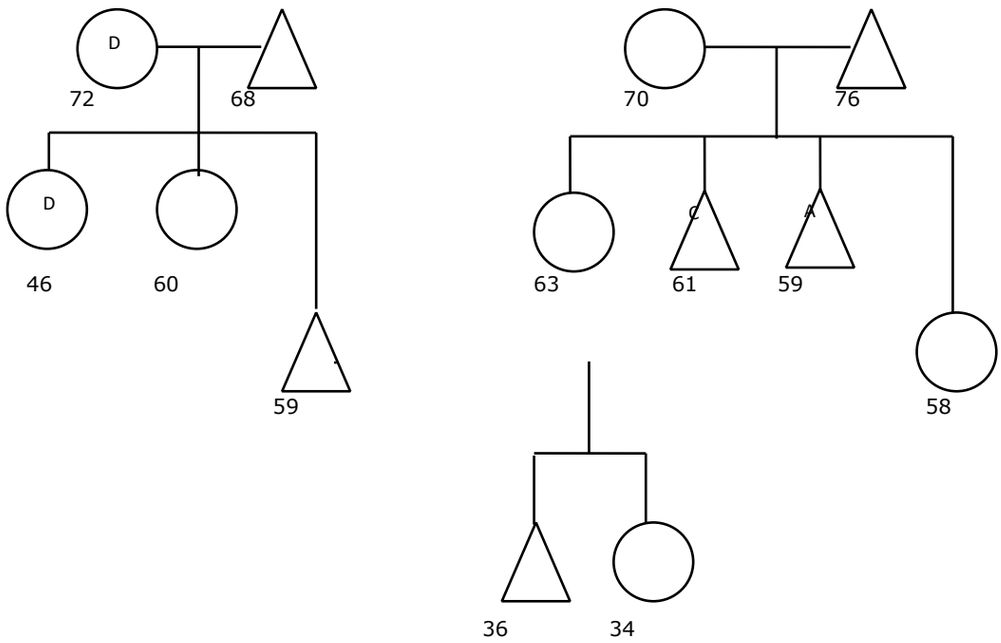
Previous Hospitalization: *(when? what reason? management?)*
Birth Problems:
Childhood Illnesses: *(acute & chronic)*
Immunizations: *(dates & reactions)*
Adult Illnesses: *(acute & chronic)*
Surgeries: *(minor & major)*
Accidents:
Pain:
Allergies: *(allergens [medication, food & environment] & reactions)*

Treatments: *(reasons)*
Medications: *(prescriptions, OTC, home remedies, herbal preparations, alternative therapies)*

IV. Family Health History (With Genogram)

Grandparents, Parents, Aunts/Uncles & Siblings:
(age? living or deceased? deceased date? cause of death?
(illness? asthma, cancer, cataracts, diabetes, glaucoma, heart disease, hemophilia, hypertension, sickle cell anemia, stroke, renal disease, tuberculosis, STD's)

Sample:



Legend:

Male		Patient	X
Female		Asthmatic	A
Deceased Male		Cancer	C
Deceased Female		Diabetic	D
		Hypertensive	H

Include a short narrative explanation of the genogram which includes:

- Ages, cause of death, and age of death of family members
- Ask specifically about: heart disease, hypertension, cerebrovascular accidents, epilepsy, migraines or headaches, mental illness, Alzhiemer's disease, Huntington's chorea, alcoholism, asthma, allergies, diabetes mellitus, thyroid problems, eating disease, arthritis, cancer, sickle cell anemia, hemophilia, HIV infections, developmental delay

V. Psychosocial history

- Lifestyle
- Personal styles
- Personal strengths

ADL: *(typical day? am to pm)*
Diet: *(24-hour food & fluid intake? amount? preparation?)*
Medication & Substances Use: *(caffeine, nicotine, alcohol, illicit drugs)*
Elimination: *(bowel, bladder, skin)*
Sleep & Rest: *(quality & quantity? nap?)*
Exercise:
Occupation:
Leisure: *(hobbies, social activities)*
Religious Observations: *(health beliefs, values)*
Environment: *(home, neighborhood, & work)*
Stressors & Coping Strategies:

Roles & Relationships: *(family & society)*
Self-Concept:
Self-Care Responsibilities: *(health promoting activities? safe sex, basic hygiene practices, regular check-ups, BSE/TSE; accident prevention & hazard prevention activities?)*

VI. Gordon's Functional Health Pattern (11 health patterns)
- Before and during admission
- Nursing diagnosis or problem

Sample:
I. Health Perception & Health Management

Client defined health as "himsug, walay sakit bisag gamay, ok ra ug normal ang lawas". He maintains a healthy body by eating 3x a day and taking a bath daily. He takes medicine as treatment in the presence of minor illness. He said, to again back strength, he just gets some rest. He is not taking any supplements because according to him, "wala nay budget".

Client has no knowledge in performing any physical examination like testicular examination and blood pressure taking but he knows how to get pulse rate and body temperature taking axillary thermometer & using also the dorsum of his palm & place it in the forehead & neck.

During admission patient can no longer maintain proper hygiene as evidenced by body odor, uncut & dirty nails. This is due to the abdominal pain of which patient rated as 7 out of 10, patient verbalized difficulty in meeting the basic health practices because of financial matters.

Remarks: Ineffective health maintenance r/t lack of material resources

VII. Review of Systems (IPPAO)
- What to include:

General Survey:
A. General Appearance
B. Vital Signs
C. Level of Consciousness
Follow by the systematic IPPAO of each system

Remember:
- ✓ Entries should be brief and not lengthily focusing only on data that are marked/distinguishably noted by the examiner.
- ✓ Always use medical terms.

Skin, Hair, and Nails: *(skin diseases, skin pigmentation, bruising, temperature, jaundice, ithching, excessive sweating or drying, rashes, change in color or size of moles, lesions or sores that heal slow, balding, dandruff, clubbing and splitting of nails)*

Head: *(headache, fainting, dizziness, fall or accident resulting in unconsciousness, swelling, stiffness of neck, difficulty swallowing, sore throat)*

Eyes: (*difficulty seeing, eye infection, redness, itching, excessive tearing, halos around lights, blurring, and loss of side vision, moving black spots/specks in visual fields, flashing lights, double vision, sensitivity to light, eye pain, and glasses/contact lenses)*

Ears: *(loss of hearing, ringing or buzzing, earaches, itching, drainage from ears, dizziness, exposure to loud noises, hearing aids)*

Nose: *(frequent colds, nosebleeds, allergies, pain, tenderness, postnasal drip, rhinorrhea, nasal obstruction, sneezing)*

Mouth, Throat, and Sinuses: *(sore & bleeding gums, lumps or white spots, mouth lesions, dentures, toothaches, cavities, sore throats, difficulty swallowing, hoarseness, and snoring)*

Neck: *(pain, swelling, stiffness, limited movement, swollen glands, enlarged lymph nodes)*

Breasts and Regional Lymphatics: *(lumps or discharge from nipples, scaling or cracks around nipples, dimpling or changes in breast size, swollen or tender lymph nodes in axilla, BSE pattern, mammogram)*

Thorax and Lungs: *(difficulty breathing, wheezing, pain, shortness of breath during routine activity, orthopnea, cough or sputum, hemoptysis, respiratory infections, X-ray)*

Heart and Neck Vessels: *(heart disease, last blood pressure, ECG tracing or findings, chest pain or pressure, palpitations, edema, heart murmur)*

Peripheral Vascular: *(swelling, or edema of legs and feet; pain; cramping; sores or ulcers on legs; color or texture changes on the legs or feet, varicose veins)*

Gastrointestinal: *(nausea, vomiting, loss of appetite, indigestion, heartburn, bowel habits, bright blood in stools, tarry-black stools, diarrhea, constipation, pain with defecation, abdominal pain, excessive gas, hernias, hemorrhoids, rectal pain, colostomy, ileostomy)*

Male Genitalia: *(excessive or painful urination, frequency or difficulty starting and maintaining urinary stream, leaking of urine, blood noted in urine, sexual problems, perineal lesions, penile drainage, pain or swelling in scrotum, difficulty achieving an erection and/or difficulty ejaculating, exposure to sexually transmitted infections)*

Female Genitalia: *(sexual problems; sexually transmitted disease; voiding problems [dribbling, incontinence]; reproductive data such as age at menarche, menstruation [length & regularity of cycle], pregnancies, and type of or problems with delivery, abortions, pelvic pain, birth control, menopause [date or year of last menstrual period], and use of hormone replacement therapy)*

Musculoskeletal: *(swelling, redness, pain and weakness of muscles; stiffness, swelling and soreness of joints; leg cramps; bone defects; ability to perform activities of daily living; muscle strength)*

Neurologic: *(general mood; emotional state changes; concussions; headache; difficulty walking; unconsciousness; seizures; tremors; paralysis; numbness; tingling or burning sensations in any body part; weakness on one side of body; speech problems; loss of memory; disorientation; forgetfulness; unclear thinking; loss of coordination; difficulty learning)*

Endocrine: *(history of goiter; heat or cold intolerance; diabetes; excessive thirst; excessive eating)*

Sample:

General Survey:

A case of Mr. S.A., 34 years old. male married and a Filipino admitted last March 08, 2006 because of LBM. Patient in medium built, with upright posture and steady gait with warm swinging on his side. Patient has poor hygiene as evidenced by body odor, uncombed hair and dirty fingernails. 5 ft. tall and weighs 56 kgs. Patient is conscious, coherent & cooperative with the following vital signs: T – 37.2, P 80, R – 20 bpm, BP 120/80 mmHg.

Skin:

- Fair complexion noted
- No lesion noted
- Dryness noted
- Poor skin turgor

Nails:

- Pinkish nails noted
- Nail plane is 160 and no signs of early clubbing
- Short & presence of dirt noted
- Smooth in texture
- Good capillary refill

VIII. Anatomy & Physiology (of the affected part)

This will show a drawing of the organ affected related to the diagnosis of the patient.

Followed by:

Parts of the organ and functions of each part
Definition of the disease
Clinical Manifestation/Signs & Symptoms

IX. A. Laboratory Results

Date	Type of Exam	Patient's Results	Normal Values	Significance/Interpretation
	HEMATOLOGY			
	URINALYSIS			

	STOOL EXAM			

B. Diagnostic Tests

Criteria	Patients result	Normal Findings	Significance

X. Drug Study

Drug Name	Classification	Mechanism of Action	Indication	Contraindication	Adverse reaction	Nursing responsibilities
○ Generic Name ○ Brand Name ○ Actual dosage, route, frequency						Before During After

XI. Problem List (at least 5)

XII. Nursing Care Plan

Defining Characteristics	Nursing Diagnosis	Scientific Analysis	Goal of Care	Intervention	Rationale
		Source: Title of the book, author, page no., edition, volume		Independent Dependent Collaborative Source: Title of the book, author, page no., edition, volume	

XIII. Readings: related to the diagnosis of the patient (updates)

Bibliography

Format: Author, Year published, Title (underlined), Edition, Publishing Company

FDAR - Sample

F = Fluid Volume Deficit related to excessive loss of fluids and electrolytes brought about by diarrhea

D = Received patient sitting on the chair with ongoing IVF #1 D5LR 1L at 40 gtts/min, infusing well at left arm, exhibits dry oral mucosa, with poor skin turgor, sunken eyes noted, passes out foul-smelling mucoid and blood tinged watery stools 5x approx. ½ cup per episode, Patient verbalized "Nagsige ra gyud ko ug kalibanga day" , with the following vital signs BP 130/90 TEMP 37.8 C PR 92 bpm & RR 24 bpm

A = Assessed the degree of dehydration, Increased oral fluid intake in volume per volume replacement, served food rich in potassium and sodium content, low in fat, low in fiber, restricted to eat chocolate

colored foods, monitored vital signs, monitored color, frequency, consistency, amount of stools, Given ORS as ordered, Monitored IVF and regulated to its desired rate.

R = BM 3x still watery about ½ cup per episode or
BM 2x with particles

Discharge Planning Guide

AMETHOD of discharge planning was developed and modified to provide a systematic method for ensuring client's needs during the termination phase of hospitalization.
The AMETHOD represent areas the nurse should consider before the client goes home.

F = Discharge instructions/ Health teachings
D =
A =

A ctivity - the client is assisted in attaining his or her highest level of mobility possible before discharge.

M edication - The client knows the name, action, purpose, dose, route of administration and side effects of each drug he or she is taking.

E nvironment - any actual or potential hazards in the home or remedies, Homemaking services and emotional and economic support systems are in place.

T reatment - the client the family will know the purpose and action of any treatment.

H ealth Teaching - the client and family is taught how to administer drugs and treatments when necessary. The client will also be able to describe how his or her disease affects his or her body, lifestyle and significant others. He will be able to identify and report signs and symptoms of potential health problems as well as drug and treatment side effects.

O utpatient Referral - Follow-up care it the clinics, hospitals, offices, etc. will be arranged. The client will know times, dates and location of appointments. He will also have available telephone number of referred physicians and agencies. A written discharge will be provided. It will be reviewed and explained to the client and family.

D iet - the client will describe his or her diet and its purpose. He will list recommended and restricted foods.

R = REVISIT/ RESCHEDULE