Hospital Training II - Activity and Report Guide

Guide 01 | Hospital Training II

Aim

To organize the required hospital placement and prepare a clear report of the activities actually completed.

Principle

- The course requires hospital training for a minimum of 45 days. Its learning areas include first aid, injection routes, patient observation charts, prescriptions and dispensing, and simple diagnostic reports.
- A training or project report links the stated objective to documented activity, observations and conclusions.
- Report only work actually completed and protect confidential institutional and patient information.
- Hospital Training I may be undertaken at the end of Semester 4; Hospital Training II may be undertaken at the end of Semester 6.
- Activities involving patients remain under authorized clinical supervision. These notes are an observation and reporting guide.

Materials and Apparatus

- Hospital supervisor, approved rotation schedule, attendance register, anonymized teaching cases and a daily learning log.
- Supervisor-approved plan, institutional instructions, observation log and permitted supporting records.
- Report-writing software and a dated activity log.

Method

1. Confirm the hospital placement, supervisor and rotation plan through the institution.
2. Maintain daily attendance and identify the department and activity studied.
3. Observe first-aid teaching with trained staff; record the purpose of wound care and resuscitation demonstrations.
4. Identify injection-route names and their general differences through supervised teaching material.
5. Study anonymized observation charts, prescriptions, dispensing records and diagnostic reports with the supervisor.
6. Prepare the report from verified activities and have the supervisor review the learning log.

Learning Areas

First aid

Record the purpose of wound assessment, clean dressing practice, escalation and resuscitation teaching. Describe the supervised demonstration observed.

Injection routes

Compare intravenous, intramuscular, subcutaneous and intradermal routes by anatomical destination and general use. Record the teaching demonstration rather than patient identifiers.

Observation charts

Identify dated entries for vital signs, medication administration, intake/output and clinician instructions. Preserve units and describe trends only with supervisor guidance.

Prescription and dispensing

Record the checks demonstrated for identity, medicine name, strength, dosage form, directions, interactions or omissions, storage and labelling. Escalate uncertainty to the supervising pharmacist.

Diagnostic reports

Identify the test name, unit, laboratory interval and clinical context shown in anonymized teaching material. A laboratory interval alone does not establish a diagnosis.

Report Arrangement

Opening pages

Title, student details, placement dates, institution, supervisor acknowledgement and contents.

Hospital overview

Describe the hospital and departments actually visited. Explain the pharmacy service and its coordination with other departments.

Daily activities

Use a table of dates, department, observations and learning outcomes. Add only permitted anonymized case examples.

Closing pages

Present learning outcomes, limits of the exposure, conclusion and verified attendance or supervisor documents required by the institution.

Submission Check

Before submission

Check the minimum 45-day duration, consistent dates, removal of identifying information, readable tables and the institution's prescribed signatures and copies.

Observation Record

Complete this record using actual laboratory findings or the provided teaching data.

Observation / parameter	Record / finding
Date and department	_____
Activity observed	_____
Learning outcome	_____
Supervisor feedback	_____
Attendance days	_____

Calculations and Interpretation

- Total completed days = sum of verified attendance days.
- Record the actual duration and any absence; a scheduled day is not automatically a completed day.

Result

Present the completed activity log, learning outcomes and report prepared from actual work, with the required supervisor confirmation.

Finding: _____

Conclusion: _____

Precautions

- Use actual attendance and findings rather than invented completion records.
- Obtain permission for institutional material and remove identifying patient details.
- Verify the submission requirements in the supplied course instructions and the institution.

Viva Questions

1. What should a student record from a hospital rotation?

The department, actual activities observed, relevant learning, supervisor feedback and dated attendance.

2. What makes a report reproducible?

A clear objective, documented method, traceable observations and a conclusion supported by those observations.

3. Why distinguish observation from interpretation?

The reader needs to know which statements are directly recorded and which are reasoned explanations.

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