NURSING FOUNDATIONS

Placement: First Year

Course Description - This course is designed to help the students to develop an understanding of the philosophy, objectives, theories and process of nursing in various supervised clinical settings. It is aimed at helping the students to acquire the knowledge, understanding and skills in techniques of nursing and practice them in supervised clinical setting.

Specific objectives – At the end of the course students will be able to develop:

1. Knowledge on concept of health, health-illness continuum and health care delivery system.
2. Knowledge on scope of nursing practice.
3. Knowledge on concept, theories and models of nursing practice.
4. Desirable attitude to ethics and professional conduct.
5. Skill in communicating effectively with patients and families and team members to maintain effective human relations.
6. Skill in health assessment and monitoring of patients.
7. Skill in carrying out basic nursing care procedures.
8. Skill in caring for patients with alterations in body functions.
9. Skill in applying steps of nursing process in the care of clients in the hospital and community.
10. Skill in applying scientific principles while performing nursing care.
11. Skill in documentation.
12. Skill in meeting basic psychosocial needs of the clients.
13. Knowledge on principles and techniques of infection control.
14. Confidence and competence in caring of terminally ill patients.
<table>
<thead>
<tr>
<th>Unit</th>
<th>Hrs</th>
<th>Learning Objective</th>
<th>Contents</th>
<th>Teaching / Learning / Activities</th>
<th>Assessment Methods</th>
</tr>
</thead>
</table>
| I    | 10  | Describe the concept of health, illness and health care agencies | **Introduction**  
- Concept of Health  
- Health illness continuum  
- Factors influencing health  
- Causes and risk factors for Developing illness.  
- Body defenses: Immunity and immunization  
- Illness and illness Behavior  
- Impact of illness on patient and family  
- Health care services:  
- Health Evaluation and Prevention, Primary care, Diagnosis, Treatment, Rehabilitation and Continuing care  
- Health care teams  
- Types of health care agencies:  
- Hospitals: Types, Organization and Functions  
- Heath Evaluation and levels of disease Prevention  
- Primary health care and its delivery:  
- Role of Nurse | **Lecture discussion**  
- Visit to health care agencies | **Essay type**  
- Short answers  
- Objective type |
| II   | 16  | Explain concept and scope of nursing  
Describe values, code of ethics and professional conduct for nurses in India | **Nursing as a profession**  
- Definition and Characteristics of a profession  
- Nursing:  
  - o Definition, Concepts, Philosophy, objectives  
  - o Characteristics, nature and scope of nursing practice  
  - o Functions of nurse  
  - o Qualities of a nurse  
  - o Categories of nursing personnel  
  - o Nursing as a profession  
  - o History of Nursing in India  
- Values: Definition, Types, Values Clarification and values in professional Nursing: Caring and Advocacy  
- Ethics:  
  - o Definition and Ethical Principal  
  - o Code of ethics and professional conduct for nurses | **Lecture discussion**  
- Case discussion  
- Role plays | **Essay type**  
- Short answers  
- Objective type |
| III  | 4   | - Explain the admission and discharge procedure  
- Performs admission and discharge procedure | **Hospital admission and discharge**  
- Admission to the hospital  
  o Unit and its preparation admission bed  
  o Admission procedure  
  o Special considerations  
  o Medico-legal issues  
  o Roles and Responsibilities of the nurse  
- Discharge from the hospital  
  o Types: Planned discharge, LAMA and abscond, Referrals and transfers  
  o Discharge Planning  
  o Discharge planning  
  o Special considerations  
  o Medico-legal issues  
  o Roles and Responsibilities of the nurse  
  o Care of the unit after discharge | - Lecture discussion  
- Demonstration  
- Lab Practice  
- Supervise clinical practice |
| IV   | 10  | - Communicate effectively with patient, families and team members and maintain effective human relations (professional image)  
- Appreciate the importance of patient teaching in nursing | **Communication and Nurse patient relationship**  
- Communication: Levels, Elements, Types, Modes, Process, Factors influencing Communication  
  o Methods of effective Communication  
  - Attending skills  
  - Rapport building skills  
  o Empathy skills  
  o Barriers to effective communication  
- Communication effectively with patient, families and team members and maintain effective human relations with special reference to communication with vulnerable group (children, women physically and mentally challenged and elderly)  
- Patient Teaching : Importance, Purposes, Process, role of nurse and Integrating teaching in Nursing process | - Lecture discussion  
- Role play and video film on the nurses interacting with the patient  
- Practice session on patient teaching  
- Supervised Clinical practice |
|       |     | **Essay type**  
- Short answers  
- Objective type  
- Assess skills with check list  
- Clinical practical examination. |
| V | 15 | Explain the concept, uses, format and steps of nursing process  
Documents nursing process as per the format | **The Nursing Process**  
- Critical Thinking and Nursing Judgment  
o Critical Thinking: Thinking and Learning.  
o Competencies, Attitudes for critical Thinking, Levels of critical thinking in Nursing  
- Nursing Process Overview: Application in Practice  
o Nursing process format: INC  
o Assessment  
- Collection of Data: Types, Sources, Methods  
- Formulating Nursing judgment: Data interpretation  
o Nursing diagnosis  
- Identification of client problems  
- Nursing diagnosis statement  
- Difference between medical and nursing diagnosis  
o Planning  
- Establishing Priorities  
- Establishing Goals and Expected Outcomes,  
- Selection of interventions: Protocols and standing Orders  
- Writing the Nursing Care Plan  
o Implementation  
- Implementing the plan of care  
o Evaluation  
- Outcome of care  
- Review and Modify  
o Documentation and Reporting | **Documentation and Reporting**  
- Documentation: Purpose of Recording and reporting  
- Communication within the Health Care Team,  
- Types of records; ward records, medical/ nursing records,  
- Common Recordkeeping forms,  
- Computerized documentation  
- Guidelines for Reporting: Factual basis, Accuracy, completeness, Organization, confidentiality  
- Methods of recording  
- Reporting: Change of shift reports, Transfer reports, Incident reports  
- Minimizing legal Liability through effective record keeping | **Lecture discussion**  
- Demonstration  
- Practice Session  
- Supervised clinical practice | **Essay type**  
- Short answers  
- Objective type |
| VII | 15 | • Describe principles and techniques of monitoring and maintaining vital signs  
• Monitor and maintain vital signs | **Vital signs** | • Guidelines for taking vital signs:  
• Body temperature:  
• Physiology, Regulation  
Factors affecting body temperature,  
• Assessment of body temperature: sites, equipments and techniques, special considerations  
• Temperature alterations: Hyperthermia, Heatstroke, Hypothermia  
• Hot and cold applications  
• Pulse:  
  o Physiology and regulation, Characteristics of the pulse, Factors affecting pulse  
  o Assessment of pulse : Sites, location, equipments and technique, special considerations  
  o Alterations in pulse:  
• Respiration:  
  o Physiology and Regulation, Mechanics of breathing Characteristics of the respiration, factors affecting respiration  
  o Assessment of respirations: technique, special considerations  
  o Alterations in respiration  
• Blood pressure:  
  o Physiology and Regulation, Characteristics of the blood pressure, Factors affecting blood pressure.  
  o Assessment of blood pressure: sites, equipments and technique, special considerations  
  o Alterations in blood pressure  
• Recording of vital signs | • Lecture discussion  
• Demonstration  
• Practice Session  
• Supervised clinical practice | • Essay type  
• Short answers  
• Objective type  
• Assess with check list  
• Clinical practical examination |
| VIII | 30 | • Describe purpose and process of health assessment  
• Describe the health assessment of each body system  
• Perform health assessment of each body system | **Health assessment** | • Purposes  
• Process of Health assessment  
  o Health history  
  o Physical examination:  
    - Methods-Inspection, palpation, Percussion, Auscultation,Olfaction  
    - Preparation for examination : Patient and unit  
    - General assessment  
    - Assessment of each body system  
    - Recording of health assessment | • Lecture discussion  
• Lecture discussion  
• Demonstration  
• Practice Simulators  
• Supervised Clinical practice | • Essay type  
• Essay type  
• Short answers  
• Objective type |
| IX  | 5  | • Identifies the various machinery equipment and linen and their care | Machinery, Equipment and linen  
• Types: Disposables and Reusables-Linen, rubber goods, glass ware, rubber, machinery  
• Introduction:  
  o Indent  
  o Maintenance  
  o Inventory  
|     |     | • Lecture discussion  
|     |     | • Demonstration  
|     |     | • Essay type  
|     |     | • Short answers  
|     |     | • Objective type  
| X   | 60 | • Describe the basic, physiological and psychosocial needs of patient  
• Describe the principles and techniques for meeting basic, Psychosocial and Psychosocial needs of patient  
• Perform nursing assessment, plan, implement and evaluate the care for meeting basic, physiological and psychosocial needs of patient  
|     |     | Meeting needs of patient  
• Basic needs (Activities of daily living)  
  - Maslow’s hierarchy of Needs  
  o Providing safe and clean Environment:  
    - Physical environment: Temperature, Humidity, Noise, Ventilation, light, Odor, pests control  
    - Reduction of Physical hazards: fire, accidents  
    - Safety devices: Restraints, side rails, airways, trapez etc.  
    - Role of nurse in providing safe and clean environment  
  o Hygiene:  
    - Factors Influencing Hygienic Practice  
    - Hygienic care: Care of the Skin- Bath and pressure points, feet and nail, Oral cavity, Hair care, Eyes, Ears and Nose  
    - Assessment, Principles Types, Equipments, Procedure, Special Considerations  
  o Comfort:  
    - Factors Influencing Comfort  
    - Comfort devices  
  • Physiological needs:  
    o Sleep and Rest:  
      - Physiology of sleep  
      - Factors affecting sleep  
      - Promoting Rest and sleep  
      - Sleep Disorders  
    o Nutrition:  
      - Importance  
      - Factors affecting nutritional needs  
      - Assessment of nutritional needs: Variables  
      - Meeting Nutritional needs: Principals, equipment procedure and special considerations  
      Oral Enteral: Naso/ Orogastric,  
|     |     | • Practice sessions  
|     |     | • Supervise  
|     |     | • Clinical practice  
|     |     | • Essay type  
|     |     | • Short answers  
|     |     | • Objective type  
|     |     | • Assess with check list and clinical practical examination |
gastrostomy

- Parenteral
- Urinary Elimination
  - Review of Physiology of Urine Elimination, Composition and characteristics of urine
  - Factors Influencing Urination
  - Alteration in Urinary Elimination
  - Types and Collection of urine specimen: Observation, urine testing
  - Facilitation urine elimination: assessment, types, equipments, procedures and special considerations
    - Providing uriinal/bed pan
    - Condom drainage
    - Perineal drainage
    - catheterization
    - care of urinary drainage
    - care of urinary diversion
- Bowel Elimination
  - Review of Physiology of Bowel elimination, composition and characteristics of faces
  - Factors affecting Bowel elimination
  - Alteration in Bowel elimination
  - Type and Collection of specimen of faces: Observation
  - Facilitation bowel elimination: assessment, equipments procedures and special considerations
    - Passing of Flatus tube
    - Enemas
    - Suppository
    - Sitz bath
    - Bowel wash
- care of ostomies
- Mobility and Immobility
  - Principles of Body Mechanics
  - Maintenance of normal body Alignment and mobility
  - Factors affecting body Alignment and mobility
  - Hazards associated with immobility
  - Alteration in body Alignment and Mobility
  - Nursing interventions for impaired Body Alignment and Mobility: Assessment, types, devices used method and special considerations. Rehabilitation aspects
  - Range of motion exercises
  - Maintaining body alignment: Positions
  - Moving
Lifting
Transferring
Walking
Restraints
• Oxygenation
  - Review of Cardiovascular and respiratory Physiology
  - Factors Affecting Oxygenation
  - Alteration in oxygenation
  - Nursing Intervention in oxygenation: assessment, types, equipment used, procedure and special considerations
  - Maintenance of patent airway
• Oxygen administration
  - Suction
  - Inhalations: Dry and moist
  - Chest Physiotherapy and postural drainage
  - Pulse oximetry
  - CPR-Basic life support
• Fluid, Electrolyte, and Acid Base Balances
  - Review of Physiological Regulation of Fluid, electrolyte, and Acid Base Balance
  - Factors Affecting Fluid Electrolyte, and Acid Base Balance
  - Alteration in fluid-electrolyte and acid-base balance
  - Nursing intervention in Fluid, Electrolyte and Acid Base Imbalances: assessment, types, equipment, procedure and special considerations
  - Measuring fluid intake and output
  - Correcting Fluid Electrolyte imbalance:
• Psychosocial Needs
  - Concepts of Cultural Diversity, Stress and adaptation, Self-concept, sexuality, spiritual health, Coping with loss, death & grieving
  - Assessment of psychosocial needs
  - Nursing intervention for Psychosocial needs
  - Assist with coping and adaptation
  - Creating therapeutic environment
  - Recreational and diversional therapies
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<tr>
<th>XI</th>
<th>20</th>
<th>Describe principles and techniques for infection control and biomedical waste management in supervised Clinical setting</th>
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</table>
|    |    | **Infection control in Clinical setting**  
|    |    | • Infection control  
|    |    | o Nature of infection  
|    |    | o Chain of infection transmission  
|    |    | o Defenses against infection: natural and acquired  
|    |    | o Hospital acquired infection (Nosocomial infection)  
|    |    | • Concept of asepsis: medical asepsis and surgical asepsis  
|    |    | • Isolation precautions (Barrier nursing)  
|    |    | o Hand washing: simple, hand antisepsis and surgical antisepsis (scrub)  
|    |    | o Isolation: source and protective  
|    |    | o Personal protecting equipments: types, uses and technique of wearing and removing  
|    |    | o Decontamination of equipment and unit  
|    |    | o Transportation of infected patients  
|    |    | o Standard safety precautions (Universal precautions)  
|    |    | o Transmission based precautions  
|    |    | • Biomedical waste management  
|    |    | o Importance  
|    |    | o Types of hospital waste  
|    |    | o Hazards associated with hospital waste  
|    |    | o Decontamination of hospital waste  
|    |    | o Segregation and transportation and disposal  
|    |    | • Lecture discussion  
|    |    | • Demonstration  
|    |    | • Practice session  
<p>|    |    | • Supervised Clinical practice  |</p>
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<tr>
<th>XII</th>
<th>40</th>
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<tbody>
<tr>
<td>Explain the principles, routes, effects of administration of medications</td>
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<td>Calculate conversions of drugs and dosages within and between systems of measurements</td>
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<td>Administer drugs by the following routes: oral, intradermal, subcutaneous, intramuscular</td>
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**Administration of Medications**

- **General Principles/Consideration**
  - Purposes of Medication
  - Principles: 5 rights, Special considerations, Prescription Safety in administering Medications and Medication errors
  - Drug forms
  - Routes of administration
  - Storage and maintenance of drugs and Nurses responsibility
  - Broad classification of drugs
  - Therapeutic Effect, Side Effects, Toxic effects
  - Idiosyncratic Reactions, allergic reaction, Drug Tolerance, Drug Interactions
  - Factors Influencing drug Actions,
  - Converting Measurements Units: conversion within one system, conversion between systems, Dosage Calculation.
  - Terminologies and abbreviations used in prescriptions of medication

- **Oral Drugs Administration:**
  - Oral, sublingual and Buccal: Equipment, procedure

- **Parenteral:**
  - General principles
  - Decontamination and disposal of syringes and needles
  - Types of parenteral therapies
  - Types of syringes, needles, canula and infusion sets
  - Protection from needle stick injuries: Giving medication with safety syringes
  - Roots of parenteral therapies
  - Intradermal: Purpose, site, equipments, procedure, special consideration
  - Intramuscular: Purpose, site, equipments, procedure, special consideration

- **Lecture**
- **Discussion**
- **Demonstration**
- **Practice session**
- **Supervised**
- **Clinical practice**
- **Essay type**
- **Short answers**
- **Objective type**
- **Assess with check list and clinical practical examination**
- Intravenous: Purpose, site, equipments, procedure, special consideration
- Advance techniques
  - Epidural intrathecal
  - Intraosseous
  - Intraperitonial
  - Intrapleural
  - Intraarterial

  Role of nurse
  - Topical Administration: Purposes, site equipment procedure special considerations for
    - Application to Skin
    - Application to mucous membrane
- Direct application of liquids – Gargle and swabbing the throat
- Insertion of Drug into body cavity: Suppository / medicated packing in rectum / vagina
- Instillation: Ear, Eye, Nasal, Bladder and Rectal
- Irrigation: Ear, Eye, Nasal, Bladder and Rectal Vaginal
- Spraying: Nose and Throat
- Inhalation: Nasal, oral, endotracheal / tracheal (steam oxygen and medications)

- Record of medications administered

**Meeting Needs of Preoperative Patient**
- Definition, and concepts of peri operative nursing
- Pre operative phase
  - Preparation of patient for surgery
- Intra operative phase
- Operation theater setup and environment

**Role of nurse**
- Post operative Phase
  - Recovery unit
- Post operative unit
- Post operative care
- Wounds: Types
  - Classification, Wound healing Process, Factor affecting wound complication of wound healing
- Surgical asepsis
- Care of the wound: Application of Bandages, Binders, Splints, Slings
  - Heat and cold Therapy

**Course Outline**

<table>
<thead>
<tr>
<th>XIII</th>
<th>10</th>
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<tbody>
<tr>
<td>• Describe the pre and post operative care of patient</td>
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<tr>
<td>• Explain the process of wound healing</td>
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<tr>
<td>• Explain the principles and techniques of wound care</td>
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<tr>
<td>• Perform care of wounds</td>
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<tr>
<td>• Apply bandages, Binders, Splints and slings.</td>
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<tr>
<td>• Lecture</td>
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<td>• Discussion</td>
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<td>• Demonstration</td>
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<td>XIV</td>
<td>15</td>
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<th>XV</th>
<th>5</th>
<th>• Explain care of terminally ill patient</th>
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<td><strong>Care of Terminally ill patient</strong></td>
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<td>• Concepts of Loss, Grief grieving process</td>
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<td>• Signs of clinical death</td>
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<td>• Care of dying patient;</td>
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<td>• special considerations</td>
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<td>• -Advance directives:</td>
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<td>• euthanasia will dying declaration, organ donation etc</td>
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<td>• Medico-legal issues</td>
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<td>• Care of dead body:</td>
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<td>• Equipment, procedure and care of unit</td>
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<td>• Autopsy</td>
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<td>o Embalming</td>
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<p>|     |    | <strong>Lecture</strong>                                                      |
|     |    | • Discussion                                                      |
|     |    | • Demonstrations                                                 |
|     |    | • Case discussion/ Role Play                                     |
|     |    | • Practice session                                               |
|     |    | • Supervised Clinical practice                                   |
|     |    | • Essay type                                                      |
|     |    | • Short answers                                                   |
|     |    | • Objective type                                                  |</p>
<table>
<thead>
<tr>
<th>XVI</th>
<th>6</th>
<th>Explain the basic concepts of conceptual and theoretical models of nursing</th>
<th>Professional Nursing concepts and practices</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>• Conceptual and theoretical models of nursing practice:</td>
<td>• Lecture Discussion</td>
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<td>• Introduction to models-</td>
<td>• Essay type</td>
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<td>• holistic model, health belief model, health promotion model etc</td>
<td>• Short Answers</td>
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<td>• Introduction to Theories in Nursing; Peplau’s, Henderson’s Orem’s,</td>
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<td>Neumann’s Roger’s and Roy’s</td>
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<td>• Linking theories with nursing process</td>
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<td>• Complimentary and alternate healing techniques.</td>
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Placement: First Year

Course Description - This course is designed to help the students to develop an understanding of the philosophy, objectives, theories and process of nursing in various clinical settings. It is aimed at helping the students to acquire knowledge, understanding and skills in techniques of nursing and practice them in clinical settings.

<table>
<thead>
<tr>
<th>Areas</th>
<th>Objective</th>
<th>Skills</th>
<th>Assignment</th>
<th>Assessment Methods</th>
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</thead>
<tbody>
<tr>
<td>Demonstration Lab General Medical and Surgery ward</td>
<td>Performs admission and discharge procedure</td>
<td>Hospital admission and discharge (III) • Admission • Prepare Unit for new patient • Performs admission procedure • New patient • Transfer in • Prepare patient records</td>
<td>Practice in Unit/hospital</td>
<td>Evaluate with checklist • Assessment of clinical performance with rating scale • Completion of Practical record</td>
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<td>Discharge/ Transfer out • Gives discharge counseling • Perform discharge procedure (Planned discharge, LAMA and abscond, Referrals and transfers) • Prepare records of discharge/ transfer • Dismantle, and disinfect unit and equipment after discharge / transfer</td>
<td>Write nursing Process records of patient • Simulated -1 • Actual-1</td>
<td>Assessment of nursing process records with checklist • Assessment of actual care given with rating scale</td>
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<td>Perform assessment: • History taking, Nursing diagnosis, problem list, Prioritization, goals &amp; Expected Outcomes, selection of interventions • Write Nursing care plan • Gives care as per the plan</td>
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<td>Communication • Use verbal and non verbal communication techniques</td>
<td>Role – plays in simulated situations on communication</td>
<td>Assess role plays with the checklist on communication techniques • Assessment of communication techniques by rating scale • Assessment of performance with rating scale</td>
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<td>Prepare a plan for patient teaching session</td>
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<td>Write patient report • Change of shift reports Transfer reports, Incident reports etc • Presents patient Report</td>
<td>Write nurses notes and present the patient report of 2-3 assigned patient.</td>
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<td>Vital signs • Measure, Records and interpret alterations in body temperature, pulse respiration and blood pressure</td>
<td>Lab practice • Measure vital signs of assigned patient</td>
<td>Assessment of each skill with checklist • Completion of activity record</td>
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<td>Health assessment</td>
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<tr>
<td>• Health history taking</td>
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<td>• Perform assessment:</td>
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<td>• General</td>
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<td>• Body systems</td>
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<td>• Use various methods of physical examination</td>
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<td>• Inspection, Palpation, Percussion, Auscultation, Olfaction</td>
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<td></td>
</tr>
<tr>
<td>• Identification of system wise deviations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prepare Patient’s unit:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prepare beds:</td>
</tr>
<tr>
<td>o Open , closed, Occupied, operation, amputation,</td>
</tr>
<tr>
<td>o Cardiac, fracture, burn, Divided, &amp; Fowlers bed</td>
</tr>
<tr>
<td>• Pain assessment and provision for comfort</td>
</tr>
<tr>
<td>Use comfort devices</td>
</tr>
<tr>
<td>Hygienic care:</td>
</tr>
<tr>
<td>• Oral hygiene:</td>
</tr>
<tr>
<td>• Baths and care of pressure points</td>
</tr>
<tr>
<td>• Hairwash, Pediculosis Treatment</td>
</tr>
<tr>
<td>Feeding :</td>
</tr>
<tr>
<td>• Oral, Enteral, Naso Orogastirc.</td>
</tr>
<tr>
<td>• Naso-gastric insertion, suction, and irrigation</td>
</tr>
<tr>
<td>Assisting patient in urinary elimination</td>
</tr>
<tr>
<td>• Provides urinal/ bed pan</td>
</tr>
<tr>
<td>• Condom drainage</td>
</tr>
<tr>
<td>• Perineal care</td>
</tr>
<tr>
<td>• Catheterization</td>
</tr>
<tr>
<td>• Care of urinary drainage</td>
</tr>
<tr>
<td>Assisting bowel Elimination:</td>
</tr>
<tr>
<td>• Insertion of flatus tube</td>
</tr>
<tr>
<td>• Enemas</td>
</tr>
<tr>
<td>• Insertion of Suppository</td>
</tr>
<tr>
<td>• Bowel wash</td>
</tr>
<tr>
<td>Body Alignment and Mobility:</td>
</tr>
<tr>
<td>o Range of motion exercises</td>
</tr>
<tr>
<td>o Positioning: Recumbent, Lateral (rt/lt) , Fowlers, Sims, Lithotomy, Prone, Trendelenburg, position</td>
</tr>
</tbody>
</table>

- Provide basic nursing care to patients
- Practice in lab & hospital
- Simulated exercise on CPR manikin
- Assessment of each skill with rating scale
- Completion of activity record
<table>
<thead>
<tr>
<th>Field visit</th>
<th>Field visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Assist patient in Moving, lifting transferring, walking o Restraints Oxygen administration Oropharyngeal, nasopharyngeal Chest physiotherapy and postural drainage Care of chest drainage CPR- Basic life support Intravenous therapy Blood and blood-component therapy Collect/ assist for collection of specimens for investigations Urine, sputum, faces, vomitus blood and other body fluids Perform lab tests: • Urine: Sugar, albumin, acetone • Blood: sugar (with strip/gluco meter) Hot and cold applications: Local and general sitz bath Communicating and assisting with self care of visually &amp; hearing impaired patients Communicating and assisting with self care of mentally challenged/ disturbed patients Recreational and diversional therapies Caring of patient with alteration in sensorium</td>
<td>•</td>
</tr>
<tr>
<td>Perform infection control procedures</td>
<td>Infection control</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>• Perform following procedures:</td>
<td>• Hand washing techniques</td>
</tr>
<tr>
<td>o Hand washing techniques</td>
<td>o (Simple, hand antisepsis and surgical antisepsis (scrub))</td>
</tr>
<tr>
<td>o Prepare isolation unit in lab/ ward</td>
<td>o Practice technique of wearing and removing personal protective equipment (PPE)</td>
</tr>
<tr>
<td>o Practice standard safety precautions (Universal precautions)</td>
<td></td>
</tr>
</tbody>
</table>

**Decontamination of equipment and unit:**
- Surgical asepsis;
  - Sterilization
  - Handling sterilized equipment
  - Calculate strengths of lotions,
  - Prepare lotions
- Care of articles
- **Application of Bandages, Binders, splints & slings.**
  - Bandaging of various body parts

<table>
<thead>
<tr>
<th>Administer drugs</th>
<th>Administration of medications</th>
<th>Administration of Medications in different forms and routes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Administer drugs</td>
<td>• Oral, Sublingual and Buccal</td>
<td>• Parenteral: Intradermal, Subcutaneous, Intramuscular</td>
</tr>
<tr>
<td>• Drug measurements and dose calculations</td>
<td>• Preparation of lotions and solutions</td>
<td>• Administers topical Applications</td>
</tr>
<tr>
<td>• Insertion of drug into body cavity: Suppository &amp; medicated packing etc.</td>
<td>• Inhalations: dry and moist</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provide care to dying and dead</th>
<th>Care of dying patient</th>
<th>Terminal care of the unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Counsel and support relatives</td>
<td>• Caring and packing of dead body</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Counseling and supporting grieving relatives</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Terminal care of the unit</td>
<td></td>
</tr>
</tbody>
</table>
BIBLIOGRAPHY
5. Brunner & Sudharth Lippincot manual of nursing practice JB Lippincot company
8. Bolander, fundamentals of nursing, Saunders 1994

Evaluation Scheme

<table>
<thead>
<tr>
<th>Subject</th>
<th>Hours</th>
<th>Internal</th>
<th>External</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Foundation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theory</td>
<td>3</td>
<td>25</td>
<td>75</td>
<td>100</td>
</tr>
<tr>
<td>Practical &amp; Viva Voce</td>
<td></td>
<td>100</td>
<td>100</td>
<td>200</td>
</tr>
</tbody>
</table>

Details as follows:
- **Internal Assessment**: Theory: 25 Marks
- **Practicum**: 100 Marks

(Out of 125 Marks to be send to the University)

Details as follows:
- **Internal Assessment**: Theory: 25 Marks
  - Mid-Term: 50 Marks
  - Prelim: 75 Marks
  - **Total**: 125 Marks

(125 Marks from mid-term & prelim (Theory) to be converted into 25 Marks)

**Internal Assessment (Practicum): 100 Marks**

<table>
<thead>
<tr>
<th>Nursing Foundation Practical &amp; Clinical Assignment Internal Practical Examination &amp; Viva voce</th>
<th>Clinical evaluation – 1 (Medical)</th>
<th>100 Marks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinical evaluation – 1 (Surgical)</td>
<td>100 Marks</td>
</tr>
<tr>
<td></td>
<td>Nursing care plan – 2</td>
<td>50 x 2 = 100 Marks</td>
</tr>
<tr>
<td></td>
<td>Procedure evaluation</td>
<td>50 Marks</td>
</tr>
<tr>
<td></td>
<td>Midterm</td>
<td>50 Marks</td>
</tr>
<tr>
<td></td>
<td>Pre - Final Examination</td>
<td>75 Marks</td>
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<tr>
<td></td>
<td><strong>Total Marks</strong></td>
<td>475 Marks</td>
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</tbody>
</table>

(475 Marks from practicum to be converted into 100 Marks)

**External Assessment:** 175 Marks

(University Examination)
- **Theory**: 75 Marks
- **Practical & Viva Voce**: 100 Marks
- **Total**: 175 Marks
EVALUATION CRITERIA:

PRACTICAL EXAMINATION UNIVERSITY

Total marks 100

INTERNAL EXAMINER : 50
- Procedure evaluation : 30
- Viva voce : 20

EXTERNAL EXAMINER : 50
- Nursing Process : 30
- Viva voce : 20
### Contents of Nursing Procedure Book

<table>
<thead>
<tr>
<th>1st year</th>
<th>Date</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Fundamentals of Nursing

**A. Comfort Measures:**

1. **Bed making**
   - a. Open bed
   - b. Occupied bed
   - c. Post-operative bed

2. **Nursing Positions:**
   - a. Lateral
   - b. Fowler’s
   - c. Sims, Recumbent

3. **Changing the position of a helpless patient**

4. **Use of comfort devices**
   - a. Use of cardiac table
   - b. Use of bed cradle

**B. Hygienic Needs:**

1. **Hand Washing**

2. **Bed bath**

3. **Care of nails and feet**

4. **Care of Pressure points**

5. **Oral Hygiene**
   - a. Helpless patient
   - b. Unconscious patient

6. **Care of hair**
   - a. Pediculosis treatment
   - b. Bed shampoo

**C. Nutritional Needs:**

1. **Preparation and serving of Diet**
   - a. Fluid
   - b. Soft solid

2. **Maintenance of intake and output record**

3. **Feeding a helpless patient**

4. **Feeding by different methods**
   - a. Nasogastric feeding
D. Elimination Needs:
1. Cleansing Enema
2. Bowel wash
3. Suppositories
4. Use of flatus tube
5. Bowel Irrigations

E. Specific Observational Skills:
1. Measuring & Recording of Vital Signs
   a. Temperature: I Oral
      II Rectal
      III Axillary
   b. Pulse
   c. Respiration
   d. Blood Pressure

2. Physical examination
   Setting up & assisting for
   a. General examination
   b. Rectal examination

F. Diagnostic Procedures:
1. Collection of specimens
   a. Farces
   b. Sputum
   c. Urine I Routine
      II 24 Hours
      III Culture

2. Urine Testing
   a. Albumin
   b. Specific gravity
   c. Reaction
   d. Sugar
   e. Ketone

G. Hot & Cold application & Therapeutic Measures
1. Hot water bag
2. Ice cap
3. Cold sponge
4. Cold compress
5. Simple fomentation
### H. Medication and Therapeutic Measures:
1. Oral medication
2. Steam Inhalation
3. Oxygen inhalation

### I. General procedures:
1. Admission of a patient
2. Discharge of a patient
3. Transfer of a patient
4. Lifting and transporting patients
   a. By stretcher
   b. By Wheelchair
5. Active & Passive exercise
6. Deep Breathing exercise

### J. Nursing Process:
1. Simple history taking
2. General physical examination
3. Planning of care
4. Writing Nursing care plans

### K. Bandages:
1. Circular turn
2. Spiral turn
3. Spiral reverse
4. Figure of eight
5. Spica
   a. Shoulder, Hip, Ankle, Thumb, Finger, Caplin, Stump
   b. Bandaging of eye, Ear, Jaw, Arm sling, Cuff and collar
   c. Triangular Bandage

### L. Binders
1. Abdominal Binder
2. Breast Binder

### M. Death care

---

**Signature of Supervisor** ______________________________

**Date:** ________________

**Signature of Principal** ______________________________

**Date:** ________________
2] FORMAT FOR HISTORY TAKING (CLINICAL EXPERIENCE)

I. DEMOGRAPHIC DATA

NAME :-       AGE :-       SEX

MARITAL STATUS :       RELIGION

EDUCATION :

OCCUPATION:       INCOME :

ADDRESS :

II. CHIEF COMPLAINTS / PRESENT MEDICAL HISTORY

III. PAST MEDICAL HISTORY :-

IV. PAST SURGICAL HISTORY :-

V. MENSTRUAL HISTORY (FEMALES) :-

VI. FAMILY HISTORY :-

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Name of Family Members</th>
<th>Age</th>
<th>Sex</th>
<th>Relation with patient</th>
<th>Occupation</th>
<th>Health status</th>
<th>Health habits</th>
</tr>
</thead>
</table>

VII. DIETARY HISTORY :-

VIII. HEALTH HABITS :-

IX. SOCIO ECONOMIC HISTORY :-

X. PHYSICAL ASSESSMENT :-

- Head to foot assessment
- Interpretation of data.
- Nursing diagnosis.
- Proposed nursing care plan.
## 3] ADULT ASSESSMENT FORMAT

**General information:**

Name: ___________________________________________________________________________________

Age: ________ Sex: ____________

Occupation______________ IP No.__________

Admission date____________ Time___________

Designation __________________________________________________________________________

History of other illness/operation/ Allergy __________________________________________________

General appearance: Body built (thin / Well / obese )

Posture : ___________________ grooming : __________________________

Habits : smoking/ alcohol/drug abuse/other

Behavior : Normal / Relaxed /Anxious/Distressed/Depressed/Withdrawn.

Level of Consciousness : Conscious/Confused/Semiconscious/Unconscious

### Assessment of Daily Activities.

<table>
<thead>
<tr>
<th>ADL</th>
<th>Subjective data (report)</th>
<th>Objective data (exhibits)</th>
<th>Nursing diagnosis</th>
</tr>
</thead>
</table>
| A M C O T B I I V L I I T T Y Y | Usual Activities  
Gait | Uses aids  
Coordinated / uncoordinated | | |
| Limitations | Immobile / Partial ambulatory  
Ambulatory | | |
| Sleep | Insomnia / Sleep apnea / other | | |
| Body movement | Purposeful movement / tremor  
Handicap  
Grasp / muscle strength and grade  
Deep tendon reflex  
Cutaneous reflex | | |
| Deformities | | | |
| Eyes- vision loss | Color, vision acuity | | |
| Wears glasses / Aid | Visual fields / normal / limited | | |
| Conjunctiva Corneal reflex | Pale / yellow / Red / other  
Pupil reaction : present /absent  
Infection : present /absent | | |
| Ears - Hearing loss | Hearing Acuity | | |
| Speech – Problems | Communication  
Verbal / nonverbal relevant / irrelevant | | |
| Skin | Temperature, color / texture /  
turgor / Any other  
Response to touch  
(painful stimuli, hot / cold) | | |
<p>| Nose | Sense of smell | | |
| Pain | Facial grimacing / guarding | | |</p>
<table>
<thead>
<tr>
<th>N U T R I T I O N</th>
<th>Usual diet Eating (Likes &amp; dislikes) Drinking Anorexia Nausea/vomiting Swallowing</th>
<th>Weight height / BMI Recent changes Voimitus I.V. infusion NGT Gag reflex: present / absent</th>
</tr>
</thead>
<tbody>
<tr>
<td>E L I M I N A T I O N</td>
<td>Usual bowel pattern Bleeding/constipation Diarrhea Uses laxatives Urine Frequency Difficulty Menstruation(Female)</td>
<td>Bowel sounds/abdominal girth Feces Urine-amount/ color Drainage On CBD/condom I&amp;O chart Bleeding Dysmenorrhoea LMP</td>
</tr>
<tr>
<td>C I R C U L A T I O N</td>
<td>Chest pain, numbness Tingling Extremities</td>
<td>Heart rate Edema Bleeding Wound BP……….. HB……….. Peripheral pulse… Color-temperature Nail beds Capillary refill Lesion Lymph nodes</td>
</tr>
<tr>
<td>H Y G I E N E</td>
<td>Skin-wound Mouth/teeth Dirty/odor/Teeth Hair, scalp</td>
<td>Clean / unclean / body odour Drainage / odour Dentures / Swallowing Halitosis / dental caries / any other Lice / dandruff / lesions / other</td>
</tr>
<tr>
<td>E G O integrity</td>
<td>Clam. Anxious Sighs deeply</td>
<td>Calm / tensed / Anxious / relaxed Excited / dull / restless Fearful / nervous</td>
</tr>
</tbody>
</table>
Remarks: Interpretation of above data
- Proposed nursing care plan.
- Discharge plan:

Signature of Nurse:
Date:
3] FORMAT FOR NURSING CARE PLAN

Name of the Patient: _____________________________________________________________ Age _______ Sex ________
Reg. No. _______________________________ Bed No. _______________________________ Date & Time of Admission ________________
Dr's Unit ______________________________ Ward No. ____________________________ Surgery & Date of surgery ________________

<table>
<thead>
<tr>
<th>Assessment (12)</th>
<th>Nursing Diagnosis (03)</th>
<th>Goal (02)</th>
<th>Outcome Criteria (02)</th>
<th>Nursing Intervention (15)</th>
<th>Rationale (03)</th>
<th>Evaluation (03)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjective</td>
<td>Objective</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Nurses notes / Progress report of the patient – (10)

Signature of Nurse.
Date:
### GUIDELINE FOR CLINICAL ASSESSMENT OF STUDENT (FOUNDATIONS OF NURSING)

**CLINICAL ASSESSMENT FORM**

Students Name:_________________________ Hospital:_________________________

Group/Year:__________________________ Unit/Ward:__________________________

Students Number:______________________ From _______________ to ________________

Maximum 100 Marks

<table>
<thead>
<tr>
<th>S.N.</th>
<th>PERFORMANCE CRITERIA</th>
<th>(5) Excellent</th>
<th>(4) Very Good</th>
<th>(3) Good</th>
<th>(2) Satisfactory</th>
<th>(1) Poor</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Assessment and Nursing Diagnosis (15)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>Collects data accurately</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1.2</td>
<td>Identifies &amp; Categorizes basic Needs of Patients</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td>Formulates Nursing Diagnosis</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>II</td>
<td>Planning (15)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>Prioritizes patients needs</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>2.2</td>
<td>Plans nursing action for each of need</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>States rationale for nursing action</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>III</td>
<td>Implementation (20)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3.1</td>
<td>Implements nursing care Accurately and safely within given time</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>3.2</td>
<td>Applies scientific Principles</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>3.3</td>
<td>Maintains safe and comfortable environment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4</td>
<td>Gives health teaching as per plan to the patients / family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>Evaluation (10)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4.1</td>
<td>Evaluate patient’s response to nursing care</td>
<td></td>
<td></td>
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<tr>
<td>4.2</td>
<td>Reexamines &amp; Modifies care plan</td>
<td></td>
<td></td>
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<tr>
<td>V</td>
<td>Documentation (15)</td>
<td></td>
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<tr>
<td>5.1</td>
<td>Records patient information accurately</td>
<td></td>
<td></td>
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<tr>
<td>5.2</td>
<td>Report patient information accurately</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td>Maintains self up to date</td>
<td></td>
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<tr>
<td></td>
<td>Professional Conduct – (25)</td>
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</tr>
<tr>
<td>VI</td>
<td>Uniform and Punctuality</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>6.1</td>
<td>Always well groomed, neat &amp; conscious about professional appearance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.2</td>
<td>Is always punctual in Clinical &amp; completing assignments</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6.3</td>
<td>Readily accepts responsibility for own behavior &amp; has initiative</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### VII Communication skills

<table>
<thead>
<tr>
<th>7.1</th>
<th>Establishes &amp; Maintains effective working / communication relationship with patients and family</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.2</td>
<td>Establishes good interpersonal relationship with members of health team / supervisors / Teachers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Marks</th>
</tr>
</thead>
</table>

**Comment / Remarks by Teacher / Supervisor:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Total marks 100  Total marks obtained

Signature of Teacher

Date:

Evaluation is seen and discuss by the student

Signature of student

Date of Sign
# Guidelines for University Practical and Oral Examination

**Internal Examiner**

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Nursing Procedure</th>
<th>Total Marks</th>
<th>Marks Allotted</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Planning and Organizing</td>
<td>10</td>
<td>10</td>
<td></td>
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Date: -

Signature of the Internal Examiner

(Refer to examination section)
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**VIVA**

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Date :-

Signature of the External Examiner

(Refer to examination section)
(FOUNDATIONS OF NURSING)

PRACTICAL / ORAL MARK LIST

NAME OF THE EXAMINATION : MONTH :-
FIRST YEAR B.SC. NURSING: MARKS :-
SUBJECT :- NURSING FOUNDATION PAPER :-
CENTRE :-

Seat
No.
Internal examiner External examiner Grand
Total

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Signature of the Internal Examiner
Signature of the External Examiner