NURSING FOUNDATIONS

Placement: First year

Theory 265 hrs
Practical- 650hrs
(200 lab and 450 Clinical)

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.

COURSE OBJECTIVEE : 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.

Theory Hours : 265

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
I	**15**	• 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 Promotion and Prevention, Primary care , Diagnosis, Treatment, Rehabilitation and Continuing care • Health care teams • Types of health care agencies: • Hospitals: Types, Organization and Functions • Heath Promotion 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 • Objectiv e type
II	**20**	• 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	• Lecture discussion • Case discussion • Role plays	• Essay type • Short answers • Objective type

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
			○ Categories of nursing personnel ○ Nursing as a profession ○ History of Nursing in India • Values : Definition, Types, Values Clarification and values in professional Nursing : Caring and Advocacy • Ethics : ○ Definition and Ethical Principal ○ Code of ethics and professional conduct for nurses ○ Consumer rights ○ Patients Bill of rights		
III	**4**	• Explain the admission and discharge procedure • Performs admission and discharge procedure	Hospital admission and discharge • Admission to the hospital ○ Unit and its preparation admission bed ○ Admission procedure ○ Special considerations ○ Medico-legal issues ○ Roles and Responsibilities of the nurse • Discharge from the hospital ○ Types: Planned discharge, LAMA and abscond, Referrals and transfers ○ Discharge Planning ○ Discharge procedure ○ Special considerations ○ Medico-legal issues ○ Roles and Responsibilities of the nurse ○ Care of the unit after	• Lecture discussion • Demonstra-tion • Lab Practice • Supervise clinical practice	• Essay type • Short answers • Objective type • Assess skills with check list • Clinical practical examinati on.

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
			discharge		
IV	**12**	• 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 • Helping Relationships (NPR): Dimensions of ? Helping Relationships, Phases of a helping relationship • 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
V	**20**	• 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		

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
			• Nursing Process Overview: Application in Practice o Nursing process format : INC current format o Assessment - Collection of Date: 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		
VI	**4**	• Describe the purposes, types and techniques of recording and reporting	Documentation and Reporting • Documentation : Purpose of Recording and reporting • Communication within the Health Care Team, • Types of records; ward records, medical/nursing	•Lecture discussion •Demonstration •Practice Session •Supervised clinical practice	• Essay type • Short answers • Objective type

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
			records, • Common Record-keeping forms, Computerized documentation • Guidelines for Reporting: Factual basis, Accuracy, completeness , Organization, confidentiality • Methods of recording • Reporting: Change –of shift reports, Incident reports • Minimizing legal Liability through effective record keeping		
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	• Lecture discussion • Demonstration • Practice Session • Supervised clinical practice	• Essay type • Short answers • Objective type • Assess with check list Clinical practical examination

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
			○ Alterations in pulse: • Respiration: ○ Physiology and Regulation, Mechanics of breathing Characteristics of the respiration, factors affecting respiration ○ Assessment of respirations: technique, special considerations ○ Alterations in respiration • Blood pressure: ○ Physiology and Regulation, Characteristics of the blood pressure, Factors affecting blood pressure. ○ Assessment of blood pressure: sites, equipments and technique, special considerations ○ Alterations in blood pressure • Recording of vital signs		
VIII	**25**	• 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 ○ Health history ○ Physical examination: - Methods-Inspection, palpation ,Percussion, Ausculatation Olfaction - Preparation for examination : Patient and unit - General assessment - Assessment of each body system - Recording of health assessment	•Lecture discussion •Demonstration •Practice Session •Supervised Clinical practice	• Essay type •Short answers •Objective type
IX	**5**	• Identifies the various machinery	Machinery ,Equipment and linen • Types: Disposables and	•Lecture discussion •Demonstration	•Essay type •Short

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
		equipment and linen and their care	Re-usables-Linen, rubber goods, glass ware, metal , plastics, furniture, machinery • Introduction: o Indent o Maintenance o Inventory		answers •Objective type
X	55	•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 - Patient environment: Room Equipment and lines, making patient beds	•Lecture discussion •Demonstration •Practice sessions •Supervise •Clinical practice	• Essay type • Short answers • Objective type • Assess with check list and clinical practical examination

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
			▪ Types of beds and bed making 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/Oro-gastric, gastrostomy o 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,		

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
			procedures and special considerations ▪ Providing urinal/bed pan ▪ Condom drainage ▪ Perineal care 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 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		

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
			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 o 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 ▪ Inhalations : Dry and moist ▪ Chest Physiotherapy and postural drainage ▪ Pulse oximetry ▪ CPR-Basic life support o Fluid, Electrolyte, and Acid Base Balances - Review of Physiological Regulation of Fluid, electrolyte, and Acid		

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
			Base Balance - Factors Affecting Fluid Electrolyte, and Acid Base Balance - Nursing intervention in Fluid, Electrolyte and Acid - Base Imbalances : assessment, procedure and special considerations ▪ Measuring fluid intake and output ▪ Correcting Fluid Electrolyte imbalance : • Psychosocial Needs o Concepts of Cultural Diversity, Stress and adaptation, Self- Health, Coping with loss, death & grieving o Assessment of psychosocial needs o Nursing intervention for Psychosocial needs - Assist with coping and adaptation - creating therapeutic environment o Recreational and divers ional therapies		
XI	**20**	Describe principles and techniques for infection control and biomedical waste management in supervised Clinical setting	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,	• Lecture discussion • Demonstration • Practice session • Supervised Clinical practice	

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
			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		
XII	**25**	• Explain the principles, routes, effects of administration of medications • Calculate conversions of drugs and dosages within and between systems of measurements • Administer drugs by the following routs- oral, inhalation	Administration of Medications • General Principles/Consideration o Purposes of Medication o Principles: 5 rights, Special considerations, Prescription Safety in administering Medications and Medication errors o Drug forms o Routes of administration o Storage and maintenance of drugs and Nurses responsibility o Broad classification of drugs o Therapeutic Effect, Side Effects, Toxic effects Idiosyncratic Reactions, Drug Tolerance, Drug Interactions, o Factors Influencing drug Actions, o Systems of Drug Measurement: Metric system, Apothecary system, Household Measurements, Solutions. o Converting	• Lecture • discussion • Demonstration • Practice session • Supervised • Clinical practice	• Essay type • Short answers • Objective type • Assess with check list and clinical practical examination

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
			Measurements Units: conversion within one system, conversion between systems, Dosage Calculation. o Terminologies and abbreviations used in prescriptions of medication • Oral Drugs Administration: Oral , sublingual and Buccal : Equipment, procedure • Topical Administration : Purposes, site equipment procedure special considerations for o Application to Skin o 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 • Inhalation : Nasal, oral, endo tracheal / tracheal (steam oxygen and medications) purposes, types, equipment procedure, special considerations o Recording and reporting of medications administered		
XIII	**10**	• Prepare post operative unit • Apply Bandages Slings. • Apply heat and cold	o Recovery Unit o Post operative unit o Postoperative care surgical asepsis o Application of Bandages, Binders, Splints, Slings o Heat and cold Therapy	• Lecture • Discussion Demonstration	
XIV	**15**	• Explain care of patients	Meeting special needs of the patient	• Lecture • Discussion	

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
		having alterations in body functioning	• Care of patients having alteration in o Temperature (hyper and hypothermia) : Types, Assessment, Management o Sensorium (Unconsciousness) : assessment, Management o Urinary Elimination (retention and unconsciousness)Assessment , Management o Functioning of sensory organs: (visual & hearing impairment) o assessment of self- Care ability o communication Methods and special considerations o Mobility (physical challenged, cast) assessment of self-care ability: Communication Methods and special considerations o Mental state (mentally challenged) , assessment of Self-Care ability; o Communication Methods and special considerations o Respiration (distress);Types, Assessment, Management o Comfort-(pain)-Nature, Types, Factors influencing pain, coping ,Assessment; Management	Demonstration	
XV	**10**	• Explain care of terminally ill patient	Care of Terminally ill patient o Concepts of Loss, Grief grieving process o Signs of clinical death o Care of dying patient;	• Lecture Discussion • Demonstrations • Case discussion/Role	• Essay type • Short Answers

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
			special considerations -Advance directives: euthanasia will dying declaration ,organ donation etc o Medico-legal issues o Care of dead body: o Equipment, procedure and care of unit o Autopsy o Embalming	play • Practice session • Supervised • Clinical practice	• Objective type
XVI	**10**	• Explain the basic concepts of conceptual and theoretical models of nursing	Professional Nursing concepts and practices • Conceptual and theoretical models of nursing practice: Introduction to models- holistic model, health belief model , health promotion model etc • Introduction to Theories in Nursing ; Peplau's , Henderson's Orem's , Neumann's Roger's and Roy's • Linking theories with nursing process • Complimentary and alternate healing techniques.	• Lecture Discussion	• Essay type • Short Answers

NURSING FOUNDATIONS- PRACTICAL

Placement: First Year **Practical 650hours**
(200 lab and 450 clinical)

Course Description: This course is designed to help he 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.

Areas	(Hrs)	Objective	Skills	Assignments	Assessment Methods
Demonstration Lab General Medical and surgery ward	10	• Performs admission and discharge procedure	**Hospital admission and discharge (III)** • Admission • Prepare Unit for new patient • Performs admission procedure • New patient • Transfer in • Prepare patient records **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 **Perform assessment**: • History taking, Nursing diagnosis, problem list,	• Practice in Unit/ hospital	• Evaluate with check list • Assessment of clinical performance with rating scale • Completion of Practical record
	17			• Write nursing Process records of patient • Simulated -1 • Actual-1	• Assessment of nursing process records with checklist • Assessment of actual care given with rating

Areas	(Hrs)	Objective	Skills	Assignments	Assessment Methods
			Prioritization, goals & Expected Outcomes, selection of interventions • Write Nursing care plan • Gives care as per the plan		scale
	10 20 15	• Communicate effectively with patient, families and team members and • Maintain effective human relations • Prepare patient reports • Presents Reports • Monitor vital signs • Perform health assessment of each body system	**Communication** • Use verbal and non verbal communicatio n techniques **Prepare a plan for patient teaching session** **Write patient report** • Change pf shift reports Transfer reports, Incident reports etc. • Presents patient Report **Vital signs** • Measure, Records and interpret alterations in body temperature , pulse respiration and blood pressure **Health assessment** • Health history taking • Perform assessment: • General • Body systems • Use various methods of	• Role – plays in simulated situations on communicat ion • Write nurses notes and present the patient report of 2-3 assigned patient. • Lab practice • Measure vital signs of assigned patient	• Asses role plays with the checklist on communi-cation techniques • Assesmen t of communi-cation techniques by rating scale • Assessme nt of perform-mance with rating scale • Assessme nt of each skill with checklist • Completi on of activity record

Areas	(Hrs)	Objective	Skills	Assignments	Assessment Methods
			physical examination • Inspection, Palpation, Percussion, Auscultation, Olfaction • Identification of system wise deviations		

Areas	(Hrs)	Objective	Skills	Assignments	Assessment Methods
	10	• Provide basic nursing care to patients	**Prepare Patient's unit:** • Prepare beds: o Open , closed , Occupied, operation , amputation, o Cardiac, fracture, burn, Divided, & Fowlers bed • Pain assessment and provision for comfort	• Practice in lab & hospital • Simulated exercise on CPR manikin	• Assessment of each skillwith rating scale • Completion of activity record
	14		**Use comfort devices** **Hygienic care:** • Oral hygiene: • Baths and care of pressure points • Hair wash, Pediculosis Treatment		
	7		**Feeding** : • Oral, Enteral, Naso Orogastirc. • Naso-gastric insertion, suction, and irrigation		
	5		**Assisting patient in urinary elimination** • Provides urinal/ bed pan • Condom drainage • Perineal care • Catheterization • Care of urinary drainage		
	6		**Assisting bowel Elimination**: • Insertion of flatus tube • Enemas		

Areas	(Hrs)	Objective	Skills	Assignments	Assessment Methods
	8		• Insertion of Suppository • Bowel wash **Body Alignment and Mobility:** o Range of motion exercises o Positioning: Recumbent, Lateral (rt/lt) , Fowlers, Sims, Lithotomy, Prone, Trendelenburg , position		
Field visit Field visit	8 5 5 8 1 3		o Assist patient in Moving, lifting transferring, walking o Restraints **Oxygen administration Chest physiotherapy and postural drainage** **CPR- Basic life support** **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 clod applications:** local and general sitz bath Communicating and assisting with self care of visually & 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**		

Areas	(Hrs)	Objective	Skills	Assignments	Assessment Methods
	10 5 10	• Perform infection control procedures	**Infection control** • Perform following procedures: o Hand washing techniques o (Simple, hand antisepsis and surgical antisepsis (scrub) o Prepare isolation unit in lab/ ward o Practice technique of wearing and removing personal protective equipment (PPE) o Practice standard safety precautions (Universal precautions) **Decontamination of equipment and unit:** • Surgical asepsis; o Sterilization o Handling sterilized equipment o Calculate strengths of lotions, o Prepare lotions • Care of articles • **Application of Bandages, Binders, splints & slings.** • Bandaging of various body parts	• Observation study-2 • Department of infection control & CSSD • Visits CSSD write observation report 1 • Collection of samples for culture • Do clinical posting in infection control department and write report Practice in lab/ward	• Assess observation study with checklist • Evalutall procedures with checklist
	18	• Administer drugs	• **Administration of medications** • Administer Medications in different forms and routes • Oral, Sublingual and Buccal • Drug measurements and dose calculations • Preparation of lotions and solutions • Administers topical Applications • Insertion of drug into body cavity: Suppository &		

Areas	(Hrs)	Objective	Skills	Assignments	Assessment Methods
			medicated packing etc. • Inhalations: dry and moist		
	3	• Provide care to dying and dead • Counsel and support relatives	**Care of dying patient** • Caring and packing of dead body • Counseling and supporting grieving relatives Terminal care of the unit		

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Evaluation Scheme :

Subject Nursing Foundation	Assessment			
	Hours	**Internal**	**External**	**Total**
Theory	3	25	75	100
Practical & Viva Voce		100	100	200

Details as follows:

Internal Assessment (Theory): 25 Marks
Internal Assessment (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

Nursing Foundation Practical & Clinical Assignment	Clinical evaluation – 1 (Medical)	100 Marks
	Clinical evaluation – 1 (Surgical)	100 Marks
	Nursing care plan – 2	50 X 2 = 100 Marks
	Procedure evaluation	50 Marks

Internal Practical Examination & Viva voce	Midterm	50 Marks
	Pre - Final Examination	75 Marks
	Total Marks	**475 Marks**

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

External Assessment: **175 Marks**
(University Examination)
Theory: 075 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

GUIDELINES FOR CLINICAL / PRACTICAL EXPERIENCE

(FOUNDATIONS OF NURSING)

1] CONTENTS OF NURSING PROCEDUER BOOK

I st year	Date		Signature
	Class room	Ward	
FUNAMENTALS 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			

I st year	Date		Signature
	Class room	Ward	
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			
A. 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 year	Date		Signature
	Class room	Ward	
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 DEMOGRAHIC DATA

NAME :- AGE :- SEX

MARITAL STATUS : RELIGION

EDUCATION :

OCCUPATION INCOME :

ADDRESS :

II CHIEF COMPLANINTS / PRESENT MEDICAL HISTORY

III PAST MEDICAL HISTORY :-

IV PAST SURGICAL HISTORY :-

V MENSTRUCAL HISTORY (FEMALES) :-

VI FAMILY HISTORY :-

SN	Name of family Members	Age	Sex	Relation with patient	Occupation	Health status	Health habits

VII DIETARY HISTORY :-

VIII HEALTH HABITS :-

X SOCIO ECONOMIC HISTORY :-

XI 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_____

Diagnosis_____

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.

ADL	Subjective data(report)	Objective data(exhibits)	Nursing diagnosis
ACTIVITY	Usual Activities	Uses aids	
	Gait	Coordinated / uncoordinated	
	Limitations	Immobile / Partial ambulatory Ambulatory	
	Sleep	Insomnia / Sleep apnea / other	
	Body movement	Purposeful movement / tremor	
	Deformities	Handicap Grasp / muscle strength and grade Deep tendon reflex Cutaneous reflex	
COMMUNICATION	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)	
	Nose	Sense of smell	
	Pain	Facial grimacing / guarding	

ADL	Subjective data(report)	Objective data(exhibits)	Nursing diagnosis
N U T R I T I O N	Usual diet Eating (Likes & dislikes) Drinking Anorexia Nausea/vomiting Swallowing	Weight height / BMI Recent changes Vomitus I.V. infusion NGT Gag reflex : present / absent	
E L I M I N A T I O N	Usual bowel pattern Bleeding/constipation Diarrhea Uses laxatives Urine Frequency Difficulty Menstruation(Female)	Bowel sounds/abdominal girth Feces Urine-amount/ color Drainage On CBD/condom I&O chart Bleeding Dysmenorrhoea LMP	
R E S P I R A T I O N	Cough Sputum Smoking	Dry / productive Respiratory rate Dyspnoea Cyanosis Sputum (color, consistency, amount) On Auscultation Breath sounds (Rales / Rhonchi / wheezes / pleural friction rub) Chest expansion (Equal / unequal) Oxygen saturation (optional) ABG (optional) use of Anesthetics	
C I R C U L A T I O N	Chest pain, numbness Tingling Extremities	Heart rate Edema Bleeding Wound BP…….. HB…… Peripheral pulse… Color-temperature Nail beds Capillary refill Lesion Lymph nodes	

ADL	Subjective data(report)	Objective data(exhibits)	Nursing diagnosis
H Y G I E N E	Skin- wound Mouth/teeth Dirty/odor/Teeth Hair, scalp	Clean / unclean / body odour Drainage / odour Dentures / Swallowing Halitosis / dental caries / any other Lice / dandruff / lesions / other	
EGO integrity	Clam. Anxious Sighs deeply	Calm / tensed / Anxious / relaxed Excited / dull / restless Fearful / nervous	

Remarks : Interpretation of above data

- Proposed nursing care plan.
-Discharge plan :

Signature of Nurse.

Date :

3] <u>FORMATE FOR NURSING CARE PLAN</u>

Name of the Patient _____

Age _____ Reg. No. _____ Date & Time Of Admission

Sex Bed No. _____ Diagnosis :

Dr's Unit Ward no _____ Surgery & Date of surgery

Marks : 50

Assessment (12)		Nursing Diagnosis (3)	Goal (2)	Outcome Criteria (2)	Nursing Intervention (15)	Rationale (3)	Evaluation (3)
Subjective	Objective						

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

Max 100 marks

SN	PERFORMANCE CRITERIA	(5) Excellent	(4) very Good	(3) Good	(2) Satisfactory	(1) Poor	Remarks
	Nursing Process (75)						
I	**Assessment and Nursing Diagnosis (15)**						
1.1	Collects data accurately						
1.2	Identifies & Categorizes basic Needs of Patients						
1.3	Formulates Nursing Diagnosis						
II	**Planning (15)**						
2.1	Prioritizes patients needs						
2.2	Plans nursing action for each of need						
2.3	States rationale for nursing action						
III	**Implementation (20)**						
3.1	Implements nursing care Accurately and safely with in given time						
3.2	Applies scientific Principles						
3.3	Maintains safe and comfortable environment						
3.4	Gives health teaching as per plan to the patients / family						
IV	**Evaluation (10)**						
4.1	Evaluate patient's response to nursing care						
4.2	Reexamines & Modifies care plan						
V	**Documentation (15)**						
5.1	Records patient information accurately						
5.2	Report patient information accurately						
5.3	Maintains self up to date						

SN	PERFORMANCE CRITERIA	(5) Excellent	(4) very Good	(3) Good	(2) Satisfactory	(1) Poor	Remarks
	Professional Conduct – (25)						
VI	**Uniform and Punctuality**						
6.1	Always well groomed, neat & conscious about professional appearance						
6.2	Is always punctual in Clinical & completing assignments						
6.3	Readily accepts responsibility for own behavior & has initiative						
VII	**Communication skills**						
7.1	Establishes & Maintains effective working / communication relationship with patients and family						
7.2	Establishes good inter personal relationship with members of health team / supervisors / Teachers						
	Total Marks						

Comment / Remarks by Teacher / Supervisor:

_____ _____

_____ _____

_____ _____

_____ _____

Total marks 100

Total marks obtained

Signature of Teacher

Date :

Evaluation is seen and discus by the student

Signature of student

Date of Sign

FOUNDATIONS OF NURSING

GUIDELINES FOR UNIVERSITY PRACTICAL AND ORAL EXAMINATION

INTERNAL EXAMINER Maximum 50 marks

SN	NURSING PROCEDURE	Total marks	Marks allotted	Remarks
I	***Planning and Organizing***	**10**		
	1-Preparation – day	06		
	2-Environment	02		
	3-Preparation of patient	02		
II	***Execution of Procedure***	**14**		
	1-Applies scientific principles	06		
	2-Proficiency in skill	06		
	3-Ensures sequential order	02		
III	***Termination of procedure***	**06**		
	1-Makes patient comfortable	02		
	2-Reports & Records	02		
	3-After care of articles	02		
	TOTAL	**30**		
	VIVA			
	1-Knowledge related to Principles	06		
	2-Equipment & Articles	06		
	3-Medical & Surgical asepsis	04		
	4-Bandaging	04		
	TOTAL	**20**		

Date :- **Signature of the Internal Examiner**

(Refer to examination section)

FOUNDATIONS OF NURSING

GUIDELINES FOR UNIVERSITY PRACTICAL AND ORAL EXAMINATION

EXTERNAL EXAMINER Maximum 50 marks

	NURSING PROCESS	Total marks	Marks allotted	Remarks
1	Assessment	06		
2	Nursing Diagnosis	04		
3	Goal	02		
4	Outcome criteria	02		
5	Nursing intervention	06		
6	Rationale	04		
7	Evaluation	02		
8	Nurses notes	04		
	TOTAL	**30**		
	VIVA			
1	Knowledge of Drugs and Solutions	04		
2	Assessment data	06		
3	Dietary management	04		
4	Health education	06		
	TOTAL	**20**		

Date :- **Signature of the External Examiner**

Refer – examination section

MAHARASHTRA UNIVERSITY OF HEALTH SCIENCES

FOUNDATIONS OF NURSING
PRACTICAL / ORAL MARK LIST

NAME OF THE EXAMINATION : MONTH :- YEAR :-

FIRST YEAR B.SC. NURSING:- MARKS :-

SUBJECT :- NURSING FOUNDATION PAPER :-

CENTRE :-

Seat No.	Internal examiner		External examiner		Grand Total
	Procedure	Viva voce	Nursing process	Viva voce	
	30	20	30	20	100

Signature of the Internal Examiner
Signature of the External Examiner