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
П	20	 Explain concept and scope of nursing Describe values, code of ethics and professional conduct for nurses 	Nursing as a profession Definition and Characteristics of a profession Nursing: Definition, Concepts, philosophy, objectives Characteristics, nature and scope of nursing practice Functions of 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 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 Demonstration 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 Methods of effective Communication Attending skills Rapport building skills Empathy skills 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 Critical Thinking: Thinking and Learning. 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		
			 Nursing process 		
			format : INC current		
			format		
			o Assessment		
			- Collection of Date:		
			Types, Sources,		
			Methods		
			- Formulating Nursing		
			judgment : Data		
			interpretation		
			Nursing diagnosisIdentification 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		
			Documentation and		
			Reporting		
		Describe the	Documentation and	•Lecture	
VI	4	purposes,	Reporting	discussion	• Essay type
	•	types and	• Documentation :	•Demonstration	• Short
		techniques of	Purpose of Recording	Practice Session	answers
		recording and	and reporting	•Supervised	• Objective
		reporting	Communication within	clinical practice	type
		r	the Health Care Team,	omnoar practice	', p
			 Types of records; ward 		
			records, medical/nursing		

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
VII	15	 Describe principles and techniques of monitoring and maintaining vital signs Monitor and maintain vital signs 	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 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: Physiology and regulation, Characteristics of the pulse, Factors affecting pulse 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
VIII	25	 Describe purpose and process of health assessment Describe the health assessment of each body system Perform health assessment of each body system 	 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 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: Indent Maintenance 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 Providing safe and clean Environment: Physicalenvironment: Physicalenvironment: Physicalenvironment: 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 Hygiene: - Factors Influencing Hygienic Practice Hygienic care:	•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	110111010	
			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		
			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		
			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	1101111105	
			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 tubeEnemas		
			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 Name in a		
			- Nursing		

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

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 - Concepts of Cultural Diversity, Stress and adaptation, Self- 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 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 Nature of infection Chain of infection transmission Defenses against infection: natural and acquired Hospital acquired infection (Nosocomial infection) Concept of asepsis: medical asepsis and surgical asepsis Isolation precautions (Barrier nursing) 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) Isolation: source and protective Personal protecting equipments: types, uses and technique of wearing and removing Decontamination of equipment and unit Transportation of infected patients Standard safety precautions(Universal precautions) 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 routsoral, inhalation 	Administration of Medications • General	 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. Terminologies and abbreviations used in prescriptions of medication Terminologies and abbreviations used in prescriptions of medication Toral Drugs Administration: Oral, sublingual and Buccal: Equipment, procedure 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 Inhalation: Nasal, oral, endo tracheal / tracheal (steam oxygen and medications) purposes, types, equipment procedure, special considerations Recording and reporting of medications administered		
XIII	10	 Prepare post operative unit Apply Bandages Slings. Apply heat and cold 	 Recovery Unit Post operative unit Postoperative care surgical asepsis Application of Bandages, Binders, Splints, Slings Heat and cold Therapy 	LectureDiscussionDemonstration	
XIV	15	• Explain care of patients	Meeting special needs of the patient	LectureDiscussion	

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
		having alterations in body functioning	 Care of patients having alteration in Temperature (hyper and hypothermia): Types, Assessment, Management Sensorium (Unconsciousness): assessment, Management Urinary Elimination (retention and unconsciousness)Assessment, Management Functioning of sensory organs: (visual & hearing impairment) assessment of self- Care ability communication Methods and special considerations Mobility (physical challenged, cast) assessment of self-care ability: Communication Methods and special considerations Mental state (mentally challenged),	Demonstration	
XV	10	Explain care of terminally ill patient	Care of Terminally ill patient Concepts of Loss, Griefgrieving processSigns of clinical deathCare of dying patient;	 Lecture Discussion Demonstrations Case discussion/Role 	Essay typeShort Answers

Unit	Hrs	Learning Objective	Content	Teaching Learning Activities	Assessment Methods
XVI	10	Explain the basic concepts of conceptual and theoretical models of nursing	special considerations -Advance directives: euthanasia will dying declaration, organ donation etc Medico-legal issues Care of dead body: Equipment, procedure and care of unit Autopsy Embalming 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,	Activities play Practice session Supervised Clinical practice Lecture Discussion	Objective type Essay type Short Answers
			Neumann's Roger's and Roy's • Linking theories with nursing process • Complimentary and alternate healing techniques.		

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
Demonstratio n Lab General Medical and surgery ward	17	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 Write nursing Process records of patient Simulated -1 Actual-1 	 Evaluate with check list Assessme nt of clinical performance with rating scale Completi on of Practical record Assessment of nursing process records with checklist Assessmen t 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	 Communicate effectively with patient, families and team members and Maintain effective human relations 	Communication • Use verbal and non verbal communicatio n techniques Prepare a plan for patient teaching session	Role – plays in simulated situations on communicat ion	 Asses role plays with the checklist on communication techniques Assesmen t of
	20	 Prepare patient reports Presents Reports 	Write patient report Change pf shift reports Transfer reports, Incident reports etc. Presents patient	• Write nurses notes and present the patient report of 2-3 assigned patient.	communication techniques by rating scale Assessme nt of perform-
	20	Monitor vital signs	Report Vital signs • Measure, Records and interpret alterations in body temperature, pulse	 Lab practice Measure vital signs of assigned patient 	mance with rating scale • Assessme nt of each skill with checklist
	15	Perform health assessment of each body system	respiration and blood pressure Health assessment Health history taking Perform assessment: General Body systems Use various methods of		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: Open, closed, Occupied, operation, amputation, Cardiac, fracture, burn, Divided, & Fowlers bed Pain assessment and provision for comfort 	 Practice in lab & hospital Simulated exercise on CPR manikin 	 Assessme nt of each skillwith rating scale Completio n 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		
	5		Assisting patient in urinary elimination • Provides urinal/ bed pan • Condom drainage • Perineal care • Catheterization • Care of urinary		
	6		drainage 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: Range of motion exercises Positioning: Recumbent, Lateral (rt/lt), Fowlers, Sims, Lithotomy, Prone, Trendelenburg, position Assist patient in 		
			Moving, lifting transferring, walking Restraints		
	8		Oxygen administration Chest physiotherapy and postural drainage		
	5		CPR- Basic life support		
	5		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) 		
	8		Hot and clod applications: local and general sitz bath		
Field visit			Communicating and assisting with self care of visually & hearing impaired patients		
Field visit			Communicating and assisting with self care of mentally challenged / disturbed patients		
	1		Recreational and diversional therapies		
	3		Caring of patient with alteration in sensorium		

Areas	(Hrs)	Objective	Skills	Assignments	Assessment Methods
	10	Perform infection control procedures	Infection control Perform following procedures: Hand washing techniques (Simple, hand antisepsis and surgical antisepsis (scrub) Prepare isolation unit in lab/ ward Practice technique of wearing and removing personal protective equipment (PPE) Practice standard safety precautions (Universal precautions) Decontamination of equipment and unit: Surgical asepsis; Sterilization Handling sterilized equipment Calculate strengths	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
	10		of lotions,		
	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	Assessment				
Nursing Foundation	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

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

	Total Marks	475 Marks	
Examination & Viva voce	Pre - Final Examination	75 Marks	
Internal Practical	Midterm	50 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 : 50Procedure evaluation : 30Viva 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

	T /	Da		
	I st year	Class room	Ward	Signature
FU	NAMENTALS 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			
	<u>_</u>	-		•

_	Dat	Date		
I st year	Class room	Ward	Signature	
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				

•	Dat	Date		
I year	Class room	Ward	Signature	
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				
T NY · D				
J. Nursing Process:				
1. Simple history taking				
2. General physical examination				
3. Planning of care				
4. Writing Nursing care plans				
V Dandagası				
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				
r n' l				
L. Binders				
1. Abdominal Binder				
2. Breast Binder				
M. Death care				
wi. Death Care	+		1	
Signature of Supervisor	D	ate		
Signature of Principal	L	oate		

2] FORMAT FOR HISTORY TAKING (CLINICAL EXPERIENCE)

I	DEMOGRAHIC D	OATA							
	NAME :-				AGE :-	SEX			
	MARITAL STAT	MARITAL STATUS:				RELIGION			
	EDUCATION:								
	OCCUPATION				INCOME :				
	ADDRESS:								
II	CHIEF COMPLAI	NINTS / I	PRESENT M	EDICAL HI	STORY				
III	PAST MEDICAL	HISTOR	Y :-						
IV	PAST SURGICAL	HISTOR	2Y :-						
V	MENSTRUCAL H	IISTORY	(FEMALES) :-					
VI	FAMILY HISTOR	Y:-							
SN	Name of family Members	Age	Sex	Relation with patient	Occupatio n	Health status	Health habits		
		1	1	1		l	l		
VII	DIETARY HISTO	RY :-							

XI PHYSICAL ASSESSMENT :- Head to foot assessment

SOCIO ECONOMIC HISTORY:-

- Interpretation of data.
- Nursing diagnosis.
- Proposed nursing care plan.

3] ADULT ASSESSMENT FORMAT General information:

HEALTH HABITS:-

VIII

X

Name		
Age Sex		
occupation	IP No	
Admission date	Time	
Diagnosis		
History of other illnes	s/operation/ Allergy	
General appearance:	Body built (thin / Well / obese)	
	Posture :	grooming:
Habits: smoking/alc	ohol/drug abuse/other	
Behavior: Normal / R	Relaxed /Anxious/Distressed/Depre	essed/Withdrawn.
Level of Consciousne	ss : Conscious/Confused/Semicon	scious/Unconscious

Assessment of Daily Activities.

ADL	Subjective data(report)	Objective data(exhibits)	Nursing diagnosis
A M	Usual Activities	Uses aids	
C O T B	Gait	Coordinated / uncoordinated	
I I V L	Limitations	Immobile / Partial ambulatory Ambulatory	
I T T	Sleep	Insomnia / Sleep apnea / other	
YY	Body movement	Purposeful movement / tremor	
	Deformities	Handicap Grasp / muscle strength and grade Deep tendon reflex Cutaneous reflex	
C O M M S U E N N I S C E A S T I O N	Eyes- vision loss Wears glasses / Aid Conjunctiva Corneal reflex Ears - Hearing loss Speech – Problems	Color, vision acuity Visual fields / normal / limited Pale / yellow / Red / other Pupil reaction : present /absent Infection : present /absent Hearing Acuity Communication Verbal / nonverbal relevant / irrelevant Temperature, color / texture /	
IN	Nose Pain	turgor / Any other Response to touch (painful stimuli, hot / cold) Sense of smell Facial grimacing / guarding	

ADL	Subjective data(report)	Objective data(exhibits)	Nursing diagnosis
N	Usual diet	Weight height / BMI	
U	Eating		
T	(Likes & dislikes)	Recent changes	
R	Drinking		
I	Anorexia	Vomitus	
T	Nausea/vomiting	I.V. infusion	
I		NGT	
0			
N	Swallowing	Gag reflex : present / absent	
Е	Usual bowel pattern	Bowel sounds/abdominal girth	
L	Bleeding/constipation	Feces	
I	Diarrhea		
M	Uses laxatives	Urine-amount/ color	
I	Urine	Drainage	
N	Frequency	On CBD/condom	
A	Difficulty	I&O chart	
T			
I	Menstruation(Female)	Bleeding	
0		Dysmenorrhoea	
N		LMP	
	Cough	Dry / productive	
		Respiratory rate	
R		Dyspnoea	
E	Sputum	Cyanosis	
S		Sputum (color, consistency,	
P		amount)	
I		On Auscultation	
R		Breath sounds	
A		(Rales / Rhonchi / wheezes /	
T		pleural friction rub)	
		Chest expansion	
O		(Equal / unequal)	
N		Oxygen saturation (optional)	
	G 1:	ABG (optional)	
	Smoking	use of Anesthetics	
C	Chest pain, numbness	Heart rate	
I	Tingling	Edema	
R		Bleeding	
C		Wound	
U L	Extremities	BP HB	
	Extremities		
A		Peripheral pulse	
T		Color-temperature Nail beds	
O			
N		Capillary refill Lesion	
1N		Lymph nodes	
L		Lymph nodes	1

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

Remarks: Interpretation of above data
- Proposed nursing care plan.
-Discharge plan:

Signat	ure	of	N	ur	se.

Date:

3] FORMATE FOR NURSING CARE PLAN

Name of the Patier	nt ———							
Age Reg. No				_ Date & Time				
Sex			Bed No.			Of Admission Diagnosis :		
Dr's Unit			Ward no				surgery	
							Marks : 50	
Asses (1	sment 2)	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) Excellen t	(4) very Good	(3) Good	(2) Satisfactor y	(1) Poor	Remarks
	Nursing Process (75)						
Ι	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) Excellen t	(4) very Good	(3) Good	(2) Satisfactor	(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						
Comn	nent / Remarks by Teacher / Su	pervisor:					

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 allotte d	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)

<u>FOUNDATIONS OF NURSING</u> GUIDELINES FOR UNIVERSITY PRACTICAL AND ORAL EXAMINATION

EXTERNAL EXAMINER

Maximum 50 marks

	NURSING PROCESS	Total	Marks	Remarks
		marks	allotted	
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	Grand Total	
	Procedure	Viva voce	Nursing process	Viva voce	
	30	20	30	20	100
	30	20	30		100

Signature of the Internal Examiner Signature of the External Examiner

BENGEN