

**MAHARASHTRA UNIVERSITY OF HEALTH SCIENCES,
NASHIK**

**SECOND P.B. B.Sc. NURSING REVISED SYLLABUS 2005
PROFORMA & GUIDELINES FOR INTERNAL
ASSESSMENT & EVALUATION.**

Subject : -

- 1. Community Health Nursing**
- 2. Mental Health Nursing**
- 3. Introduction to Nursing Education**
- 4. Introduction to Nursing Service Administration**
- 5. Introduction to Nursing Research and Statistics**

INTERNAL ASSESSMENT PROFORMA & GUIDELINE
COMMUNITY HEALTH NURSING
II P.B. B.Sc. Nursing

EVALUATION: **Maximum Marks**

Internal Assessment:

Theory:	25 Marks
Practical:	50 Marks
Total:	75 Marks

Details as follows:

Internal Assessment (Theory): 25 Marks

(Out of 25 Marks to be send to the University)

Mid-Term: 50 Marks

Prelim: 75 Marks

Total: 125 Mark

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

Internal Assessment (Practical): 50 Marks

Practical Exam: 100 Marks

Mid-Term Exam: 050 Marks

Prelim Exam: 050 Marks

Clinical Evaluation & Clinical Assignment: 325 Marks

1. Clinical Evaluation (family oriented care Urban Area) 100 Marks

2. Community Health Survey & Community diagnosis 025 Marks

3. Family Health Care Study (Urban & Rural settings) 100 Marks
(50 marks each)

4. School Health Programme 025 Marks

5. Health Education 025 Marks

6. Rural Public Health (as per guideline): 050 Marks

Total: 425 Marks

(425 Marks from Practical to be converted into 50 Marks)

II YEAR P.B. B.SC. NURSING
SUBJECT :- COMMUNITY HEALTH NURSING
CLINICAL EXPERIENCE GUIDELINES

GUIDELINES FOR CLINICAL EXPERIENCE

I. Community Health Nursing objective of clinical experience

Urban Public Health field

160 Hours

Introduction :

The clinical practice is provided to the student to render comprehensive health care to the selected family, groups in the community, including health teaching. The student is provided an opportunity to learn a role of CHN in community Health Nursing field.

Objectives :

- 1) To be able to practice nursing process approach in family oriented nursing care.
- 2) To assess health needs of individual, family and community by means of observation and communication. (i.e. MCH, adolescents, geriatrics and other vulnerable group)
- 3) To give Health teaching on prevention of illness, promotion of health and care of minor ailments at home.
- 4) To carry out home nursing procedures / techniques
- 5) To develop ability / skill to communicate effectively and use Audio-Visual aids while imparting health information
- 6) To identify the factors affecting health and illness in relation to population, environment and nutrition.
- 7) To be aware about incidence and prevalence of communicable and non-communicable diseases in the community and practice preventive and control measures.
- 8) To be able to practice case finding approach and levels for prevention in common public health problems
- 9) To be able practice application of National control and Eradication Programme while rendering health services at urban and rural set up.
- 10) To develop ability in community diagnosis and conducting health surveys.

- 11) To apply knowledge of epidemiologist, Biostatistics and vital statistics while analyzing the survey data.
- 12) To develop ability to organize community health nursing programme. i.e. Various clinics, health education activities etc.
- 13) To be able to use appropriate referral system in community.
- 14) To develop ability to perform extended role in CHN at different level in public health administration.
- 15) To observe and maintain different records and reports in Urban and Rural set up.
- 16) To write family health care study based upon comprehensive community health and nursing process approach.
- 17) To develop ability to monitor and evaluate health services provided in given community.
- 18) To get an opportunity to work as investigator while conducting simple research activity in community health nursing practice field.

AREAS OF LEARNING EXPERIENCE

Urban Public Health (Clinical Experience)

- a) Working / Nursing care for families allotted.
- b) School health check up programme.
- c) Assessment of Venerable groups while posted in clinics, Home visiting, Industries.
- d) Community health education. In school, college, family, clinics or industries (Group and mass health teaching)
- e) Family health survey and community diagnosis of selected public health problem.
- f) Community oriented health care by visit to different health and other agencies.

II YEAR P.B. B.SC. NURSING
SUBJECT :- COMMUNITY HEALTH NURSING
CRITERIA FOR CLINICAL EXPERIENCE

1. **CLINICAL EVALUATION PROFORMA (Family Oriented Care Urban Area)**

(Maximum Marks: 100)

Name of Student : _____ Year _____
Area of Community Health Nursing _____
Evaluator : _____ Period Under Evaluation _____
From _____ to _____

Rating : 1 – In many respect fails to meet recruitment satisfactorily
 2 – Meets many requirements but deficient in important aspect
 3- Average, clearly meets basic requirements satisfactorily.
 4 – Clearly exceeds basic requirements, respecting superior
 5 – Outstanding in all respects.

SN	Areas with subheading		Rating				
			1	2	3	4	5
I	Knowledge and understanding about family						
	1.	Studies family health record and collects significant data					
	2.	Interprets significant data based on knowledge of community Health / Community Health Nursing.					
II	Home Visit						
	3.	Preplans are written based on the health needs of the family and identified goals					
	4.	Planning and organization of home visit					
	5.	Establishers report with the family and able to communicate effectively and tactfully with different individual / groups					
III	Health Assessment and Observation						
	6.	Identifies deviation from normal and set priorities in home care activities					
	7.	Plans and implements name care based on preset goals and health needs					
IV	Nursing Activities carried our :						
	8.	Application of scientific principles					
	9.	Technical skills with necessary modification and completeness of the procedure					
	10	Involvement and participating of the family members					
	11	Interpretation, reporting, recording of results					
	12	Takes, corrective follow standing orders selects and appropriate referral agencies.					

SN	Areas		Rating				
			1	2	3	4	5
V	Health information health teaching						
	13	Uses every opportunity for incidental / planned teaching for individual and group					
	14	Uses appropriate teaching learning principles					
VI	Post Visit						
	15	Reports significant information					
	16	Completes records, promptly, precisely and accurately.					
VII	Evaluation of Family Health Care						
	17	Able to evaluate the set goals, short and long term health care plans					
	18	Able to revise the family health needs and modify the care plans					
VIII	Professional qualities						
	19	Professional appearance					
	20	Interest, initiative, resourcefulness, responsible, leadership and attitude, response to constructive criticism and suggestions.					
Total Marks :			Percentage :			Grade :	

Remarks / comments by the Supervisor :

(In terms of strengths and weaknesses)

Instruction :

- 1) Application of theory to practice is considered through out the experiences.
- 2) Written explanation must over extreme grades.

Date of evaluation discussed

Signature of the student that

She/he has seen the evaluation

Signature of Supervisor

II. *Guideline for Family Health Survey / Community diagnosis / School Health Programme & Educational Visits.*

Introduction :

The clinical experience is designed to provide learning experience under the community health and community health nursing subject in different areas as such family health survey, community diagnosis and school health programme including educational Visits.

- I) *Family Health Survey:*** The students will acquire the knowledge in relation to -
- a) To conduct simple family health survey in the community.
 - b) To be able to use survey card as a tool to collect survey data.
 - c) To prepare various tables for the tabulation of collected data.
 - d) To be able to interpret and present the data with the help of graphs and charts and compare with the national norms.
 - e) To evaluate the continuity of family oriented health care based on survey.
 - f) To maintain records and reports allowed by survey.
- II) *Community Diagnosis:*** The students will acquire the knowledge in relation to -
- a) To select the significant public health problem to carry out community diagnosis.
 - b) To be able to follow the steps of community diagnosis.
 - c) To carryout assessment of selected group to identify deviation from normal in the community.
 - d) To be able to summarise and interpret the data followed by presentation.
 - e) To apply principles of epidemiology, levels of preventions will preparing future plans.
 - f) To complete report and records.
- III) *School health programme :*** The students will acquire the knowledge in relation to -
- a) To be able to plan, organize and implement school medical checkup of the school children.
 - b) To be able to identify deviation from normal while doing complete medical checkup of the school children.

- c) To complete the records on the school child assessment proforma and in the register.
- d) To be able to give health information to the school children and their parents.
- e) To use appropriate referral services.

IV) *Educational Visit to Community Health agencies:*

Objective : Student should able to

- i) Prepare a list of community health agencies in her field.
- ii) Explain how to organize educational visit.
- iii) To get acquainted with agency historical background, physical setup, broad policies & objectives and financial support.
- iv) To be able to - describe detailed organization structure of agency
 - List the broad areas of activity
 - identify role of organization dealing with health problem promoting primary care, education and training.

V) Public Health Administration (May not be for evaluation)

The students will acquire the knowledge in relation to

- a) To review the knowledge about public health administration at district level and selected Urban Public Health Centres.
- b) To acquire knowledge related to principles of management applied to public health and public health nursing practice field.
- c) To study system of procedures, work routines recordings and reporting being practiced in these practice field.
- d) To get an opportunity to act as a team leader.
- e) To identify needs for replanning and understand evaluation as an essential component of replanning in C.H. Nsg. services.
- f) Able to prepare an organizational chart of (i) District Health Office, (ii) Urban Public Health Center Bandra, (iii) Child Welfare Center, (iv) Rural Hospital, (v) Community Health Center, (vi) P.H.C.

2. EVALUATION CRITERIA FOR FAMILY HEALTH SURVEY / COMMUNITY DIAGNOSIS.

EVALUATION CRITERIA FOR FAMILY HEALTH SURVEY / COMMUNITY DIAGNOSIS

Name of the student

Period

(Maximum Marks : 25)

SN	Criteria	Marks Allotted	Marks Obtained	Total
1	Knowledge related to survey	03		
2	Data collection & entry on survey cards	02		
3	Table and tabulation of data	03		
4	Analysis and Interpretation of data	05		
5	Use of visual aids and graphs etc.	04		
6	Proposed future plans	03		
7	Recording in the registers	05		
	Total	25		

Signature of the Supervisor

Date :

3. EVALUATION CRITERIA FOR SCHOOL HEALTH PROGRAMME

Name of the student :

Area :

Period :

(Maximum Marks : 25)

SN	Criteria	Marks Allotted	Marks Obtained	Total
1	Organization for school / checkup programme	04		
2	Assessment to find out any deviation	05		
3	Knowledge and application of scientific practice (Head to foot examination of child).	04		
4	Communication skill with child, parent & teacher	02		
5	Action taken including Health Teaching & referrals	04		
6	Reporting to supervisor, parents and teacher	03		
7	Recording on assessment proforma	03		
	Total	25		

Remarks

Evaluation discussed

& Students Signature

Date :

Sing. Of Supervisor

Date :

III Guideline for Community Identification

This particular exercise helps the students in community identification and develop a community profile. Learns the systematic way of gathering data in the community aspects and liabilities in term of community health and illness.

Objectives : At the end of experience should able to -

- 1) Explain the importance of community identification
- 2) Systematically gather health related data about selected community.
- 3) Develop community profile
- 4) Identify health and health related resources in the community.
- 5) Examine relationship between data gathered to health and well being of the community.
- 6) Identify biological, physical and social factors that have bearing on the health of the community.
- 7) Use the information collected for community identification for necessary action.

Community Identification includes

1. Geographic Characteristics

Name of the locality or area

Boundaries

Important roads, street, buildings

Important landmarks

Seasons and months

Prepare a map of the area

Total area

2. Demographic Characteristics

a) Total population

Total Families

Average size of family

Population distribution according to Age & Sex

Education

Occupation

Income

Caste, religion, language

b) Vital health events

Birth rate

Death rate

Infant mortality rate

Morbidity rate

Specific morbidity

c) Special Health risk groups

(Infant, Toddlers, Antenatal Mothers, Lactating mothers,
Antenatal multi problem family)

3. Environmental Characteristics

a) Houses - Number

Type

Living space per head

Other facilities (Bath, Kitchen, Toilet, Electricity,

Water supply - Safe/unsafe)

b) Waste disposal and waste water disposal

- Collection and removal of soil waste
- Collection and removal of water waste
- Vector control measures
- Environmental sanitarium

c) Structural organization for environmental sanitatim services

d) Educational opportunities

Schools

Private institution

College

Vocational institutions

4. Social Environment

- Local administration - municipality / gram panchayat
- Community organization
- Youth welfare organization
- Mahila Mandals
- Trade Union Organizations
- Labour units
- Business organizations
- Statutory bodies
- Panchayat
- Counsellors
- Executive committees
- Leadership Pattern

5. Channels of communications : Official, Non-official

- Common meeting places used
- Chaupal, community centre, hall
- Important communicators
- Traditional like barber, teachers, retired people
- Mechanism of communications
- Fairs and festivals, religious meetings and official meetings
- Media of communications
- Radio, T.V. and Cinema

6. Resources

- a) Economic resources of community
- b) Institutional resources
- c) Human resources
- d) Natural resources

7. Health knowledge, Beliefs and practices

- About health and disease
- Outlook on cause of disease, spread and presentation of disease
- Existing health practices related to prevention, care of some specific illness

- Superstitions related food and health practices
- Promotional health practices, food, rest, relaxation, recreation, games etc
- Attitude towards health agencies - positive or negative, Health programmes and community organization.

8. Health problems as felt by the community

- Major health problem and needs
- Priority problems as felt by the people or community leaders

9. Factors that can help or binder community health actions

Success of these information

- Health and health allied resources
- Community people
- Community leaders - formal or informal
- Census records

IV. Guide Line for Rural Public Health Experience

Time allotted : 80 Hrs.

a) Introduction :

This experience is two weeks while staying in Rural area includes, actual exposure to Rural Health services including primary health care approach, which is adopted by Govt. of India to render health services. Experience will be provided through observational visits, working in selected health clinics at Primary Health Centers, sub-centers and Health Units and other agencies (NGOS).

At the end of experience student will develop realistic view of existing health care delivery system and role of various health team members at different levels in rural community health field. It will also help to understand role of nurse to promote health of people residing in rural area and problems which confront the nursing care.

b) Objectives of RPH Experience :

- 1) To acquire knowledge and scope of Rural Health Services in India.
- 2) To observe the Public Health activities carried out by the various health personnel based on the needs of that community.

- 3) To acquire knowledge of various Rural development (I.R.D.P.) schemes and implementation of national health programmes (central and state Govt.) and Role of C.H.N. in these programmes.
- 4) To acquire knowledge regarding - Health agencies and three tier system of rural self Government.
 - a) Organization, staffing and physical set up of
 - (i) Rural Hospital, (ii) P.H.C., (iii) S.C., (iv) Health Unit, (v) I.C.D.S./ Anganwadi, (vi) Grampanchayat (vii) Panchayat Samiti (viii) Zilla Parishad
 - b) To implement Multi-sectional approach in rural health services.
- 5) To work with / interview various health team members at P.H.C. and S.C. level, to find out their work responsibilities i.e. (M.P.H.W. (Fe) Male), Health Assistant (Fe)(Male) and Basic Health workers i.e. CHV, TBA etc.
- 6) To acquire knowledge about Public Health administration and to observe functions of P.H.N. and Health Supervisors in rural areas (a) To study work planning supervise for daily/wkly/mthly and yearly (b) Method of supervision adopted ANM/MPW (M/Fe)/A.W.W./Dai/CHV etc.
- 7) To be able to plan and organize health education programmes in rural area (Individual/Group)
- 8) To study available statistical data, method of recording and reporting at SC, PHC and H.U.P. as part of management information system.
- 9) To observe and participate in selected Public Health programme if possible i.e. (a) School health programme, (b) F.P. camps etc., (c) Any out break and emergency health crisis or disaster.
- 10) To select two beneficiaries to study family health care (vulnerable groups).
- 11) To be able to compare how the mode of living affects the health of families in rural and urban areas.
- 12) To be able to compare and note the strong and weak points of C.H. Nursing in rural area.

c) Rural Public Health Experience – Study Guide

I General Information and Administrative Aspects

- 1) Geographical distribution (Block, No. of PHCs, SCS etc.)
- 2) Physical set up
- 3) Organization set up and staffing for
 - a) Health Unit if visited
 - b) Rural Hospital
 - c) Primary Health Centre
 - d) Sub centre
 - e) Anganwadi / ICDS
 - f) Gram panchayat
 - g) Panchayat Samiti
 - h) Co-operative society
- 4) Prepare functional chart of above stated health and other agencies.
- 5) Compare your observations with national norms to provide primary health care, decided by Govt. of India (prepare a table only)
- 6) Write existing system of panchayatiraj in Block visited (prepare schematic diagram only)

II Health and Related Programme

- 1) List the existing health problems in visited village, PHC and SC.
- 2) List the existing national and state health programmes in visited rural area and list the role of health team members (Nursing staff) to implement common health programme.
- 3) List different rural development (IRD) schemes to uplift the economy of visited village (PHC and SC) while visiting gram panchayat.
- 4) To write role of nurse in multisectoral approach while giving care to rural community.

III Public Health Administration (Nursing)

- 1) Write scope and principles of public health administration.
- 2) Role and responsibilities of nurse administrator in rural community health i.e.(District PHN, Health Unit PH. N., Female and male Health supervisors at PHCs
- 3) Methods of supervision adopted by immediate supervisor at PHC and SC
- 4) To write work load planning and activities schedule of ANM (MPHW / female & male) based on allotted population of visited PHC and SC.

IV Health Education and Exhibition

To plan and implement individual and group health education and exhibition in ANC clinic maternity home, immunization in clinic at head quarters or in school and Anganwadi (Report Writing)

V Family Health Care study (Separate evaluation)

- 1) To collect data and health summary of one family of the rural area.
- 2) To write priority health problems and health needs followed by anticipatory family health care plans.

VI MIS (Management Information System) / Statistics

- 1) To collect demographic data and vital statistics of (last one year of visited PHC, SC)
- 2) To compare above data with estimated norms decided by Govt. of India.
- 3) To interpret the achievements against given targets to visited health centre and MPHW female & male.

VII Writing Observation Visit Report

- 1) To write brief report after every visit.
- 2) Visits are planned based on specific objectives, guidelines or check list.

VIII Evaluation and Conclusion

- 1) To write evaluation of RPH experience
 - a) Considering set objectives
 - b) Rural Programme planning and management
 - c) Each committee will unite report of their activities.
- 2) To write suggestions to improve set RPH Programme in future.

4) EVALUATION CRITERIA FOR RUAL PUBLIC HEALTH EXPERIENCE

(As per guideline)

(Maximum Marks : 50)

SN	Criteria	Marks Allotted	Marks Obtained	Total
1	General Information and administrative aspects	10		
2	Implementation of Health and Related Programs	10		
3	Public Health Nursing administration	10		
4	Health education and health exhibition	10		
5	MIS (Management Information System)	05		
6	Recording	05		
	Total	50		

Remarks

Evaluation discussed

& Students Signature

Date :

Sing. Of Supervisor

Date :

V. *Guide Line for family care study:*

- 1) Introduction & objectives
- 2) Assessment of data – subjective & objective
 - i) Data related to
 - Environment & Sanitation
 - Immunization status of <5 children
 - Family planning practices
 - Nutritional status
 - Chronic health problems in the family
 - ii) Assessment of family members and writing health summary specifically vulnerable groups and high risk individuals (including physical, mental and social health aspects.)
- 3) Health needs identification on priority basis considering family as unit of service
- 4) Planning for Family Oriented Care (FOC)
 - i) Objective of FOC
 - ii) Short term Home nursing care plan
 - iii) Long term Home nursing care plan
- 5) Implementation of FOC, with scientific rationale; adaptation in home situation.
- 6) Technique & skill in home nursing procedures with rationale
- 7) Planning & implementing health teaching
 - i) Individual or group
 - ii) Use of simple AV aids
- 8) Specific dietary plan & nutrition rehabilitation
- 9) Drug study and home care if necessary
- 10) Evaluation of home nursing care
 - i) Review short & long term plan
 - ii) Re-planning and future plans
- 11) Use of table and groups where ever necessary.

5. EVALUATION CRITERIA FOR FAMILY HEALTH CARE STUDY

(Urban & Rural Settings)

Name of the student :

Field placement :

Period :

(Maximum Marks: 50+50=100)

SN	Criteria	Marks Allotted	Marks Obtained	Total
1	Introduction & Objective	02		
2	Data Subjective	03		
3	Data objective	05		
4	Assessment of Family members (physical mental & social)	03		
5	Health needs identified	03		
6	Planning for family health nursing care (including short term & long term plan)	06		
7	Implementation of home nursing care plan with scientific rationale	06		
8	Health education planning & implementation	04		
9	Planning for diet	03		
10	Drugs study & home care	03		
11	Evaluation : - Out come of family health care - Self learning as a Nurse	02 02		
12	Future plan	03		
13	Conclusion & suggestion	02		
14	Use of table / graphs etc.	03		
	Total	50		

Note: One Urban & One Rural Setting Care Study having 50 Marks each.

Remarks

Evaluation discussed

Sing. Of Supervisor

6. **PROFORMA & GUIDELINE FOR HEALTH TEACHING**

Topic Selected :-

1. Name of the student teacher:
2. Name of the supervisor
3. Venue:
4. Date:
5. Time:
6. Group:
7. Previous knowledge of the group
8. AV aids used
9. General objectives
10. Specific objectives

Lesson plan for health talk

SN	Time	Specific objectives	Content	Teaching Learning Activities	A V Aids	Evaluation
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(Maximum Marks : 25)

SN	Criteria	Marks Allotted	Marks Obtained	Total
1	Lesson Plan.	08		
2	Presentation.	05		
3	Communication skill.	05		
4	Preparation & effective use of A V. Aids.	04		
5	Group participation.	03		
	Total	25		

Remarks

Evaluation discussed
& Students Signature

Date:

Sing. Of Supervisor

Date :

INTERNAL ASSESSMENT PROFORMA & GUIDELINE

MENTAL HEALTH NURSING

II P.B. B.Sc. Nursing

EVALUATION

Internal Assessment:

Theory:	25 Marks
Practical:	50 Marks
Total:	75 Marks

Details as follows:

Internal Assessment (Theory): 25 Marks

(Out of 25 Marks to be send to the University)

Mid-Term:	50 Marks
Prelim:	75 Marks
Total:	125 Mark

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

Internal Assessment (Practical): 50 Marks

(Out of 50 Marks to be send to the University)

Mid-Term Exam	050 Marks
Prelim Exam	050 Marks

Clinical Evaluation & Clinical Assignment: 625 Marks

1. History taking: Two (50 marks each)	100 Marks
2. MSE: Two (50 marks each)	100 Marks
3. Process Recording: Two (25 marks each)	050 Marks
4. Nursing Care Plan: Two (50 marks each)	100 Marks
5. Clinical performance evaluation (Male or female ward)	100 Marks
6. Case Study: One	050 Marks
7. Case Presentation: One	050 Marks
8. Drugs study	050 Marks
9. Health Education: One	025 Marks

Total: 725 Marks

(725 Marks from practical to be converted into 50 Marks)

II Year PB B.Sc. Nursing
SUBJECT :- PSYCHIATRIC & MENTAL HEALTH NURSING
CLINICAL EXPERIENCE GUIDELINES & EVALUATION FORMATS

I) PSYCHIATRIC NURSING HISTORY COLLECTION FORMAT

c) Demographic data:

- Name
- Age
- Sex
- Marital Status
- Religion
- Occupation
- Socio-economic status
- Address
- Informant
- Information (Relevant or not) adequate or not

II. Chief Complaints/presenting complaints (list with duration)

- In patient's own words and in informants own words.
E.g. : - Sleeplessness x 3 weeks
 - Loss of appetite & hearing voices x2 weeks
 - talking to self

III. Present psychiatric history /nature of the current episode

- Onset- Acute (within a few hours)
 - Sub acute (within a few days)
 - Gradual (within a few weeks)
- Duration – days, weeks or months
- Course – continuous/episodic
- Intensity / same / increasing or decreasing
- Precipitating factors – yes/no (if yes explain)
- History of current episode (explain in detail regarding the presenting complaints)
- Associated disturbances – includes present medical problems (E.g. Disturbance in sleep, appetite, IPR & social functioning, occupation etc).

IV. Past Psychiatric history:

- Number of episode with onset and course
- Complete or incomplete remission
- Duration of each episode
- Treatment details and its side effects if any
- Treatment outcomes
- Details if any precipitating factors if present

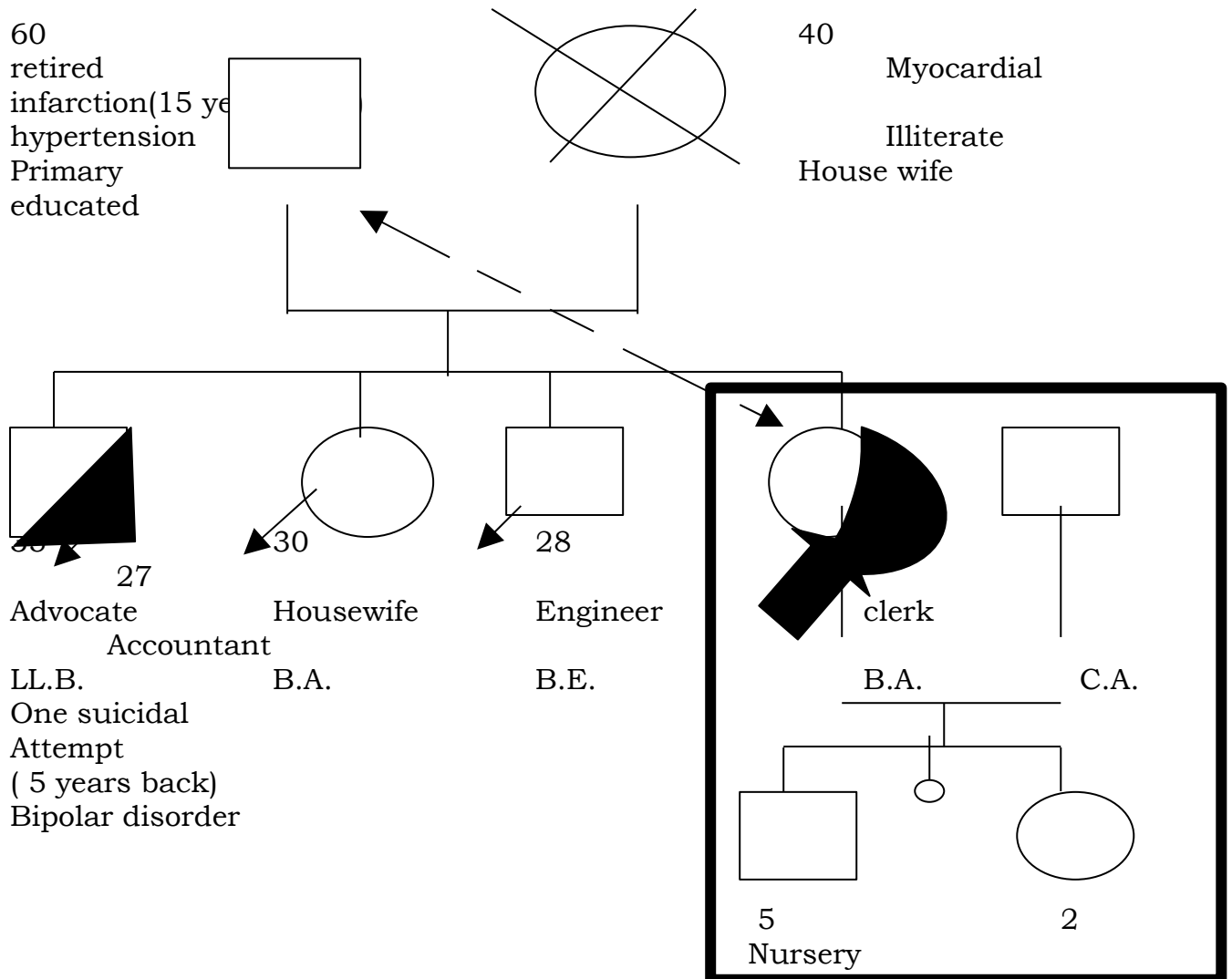
- V.**
- a) Past Medical History
 - b) Past Surgical History
 - c) Obstetrical History (Female)

Cont..

VI. Family History:

- Family genogram – 5 generations include only grandparents. But if there is a family history include the particular generation

A TYPICAL FAMILY TREE



(Taken from Neeraj Ahuja)

VII. Personal History:

- Pre-natal history
 - Maternal infections
 - Exposure to radiation etc.
 - Check ups
 - Any complications

- Natal history
 - Type of delivery
 - Any complications
 - Breath and cried at birth
- Neonatal infections
 - Mile stones: Normal or delayed

Behavior during childhood

- Excessive temper tantrums
- Feeding habit
- Neurotic symptoms
- Pica
- Habit disorders
- Excretory disorders etc.

Illness during childhood

- Look specifically for CNS infections
- Epilepsy
- Neurotic disorders
 - Malnutrition

Schooling

- Age of going to School
 - Performance in the School
 - Relationship with peers
 - Relationship with teachers
- (Specifically look for learning disability and attention deficit)
- Look for conduct disorders E.g. Truancy, stealing

- Occupational history
 - Age of joining job
 - Relationship with superiors, subordinates & colleagues
 - Any changes in the job – if any give details
 - Reasons for changing jobs
 - Frequent absenteeism

- Sexual history
 - Age of attaining puberty (female-menstrual cycles are regular)
 - Source and extent of knowledge about sex, any exposures
 - **Marital status** : with genogram.

VIII. Pre morbid personality : (Personality of a patient consists of those habitual attitudes and patterns of behavior which characterize an individual. Personality sometimes changes after the onset of an illness. Get a description of the personality before the onset of the illness. Aim to build up a picture of the individual, not a type. Enquire with respect to the following areas.)

1. **Attitude to others in social, family and sexual relationship:** Ability to trust other, make and sustain relationship, anxious or secure, leader or follower, participation, responsibility, capacity to make decision, dominant or submissive, friendly or emotionally cold, etc. Difficulty in role taking – gender, sexual, familial.
2. **Attitudes to self:** Egocentric, selfish, indulgent, dramatizing, critical, depreciatory, over concerned, self conscious, satisfaction or dissatisfaction with work. Attitudes towards health and bodily functions. Attitudes to past achievements and failure, and to the future.
3. **Moral and religious attitudes and standards:** Evidence of rigidity or compliance, permissiveness or over conscientiousness, conformity, or rebellion. Enquire specifically about religious beliefs. Excessive religiosity
4. **Mood:** Enquire about stability of mood, mood swings, whether anxious, irritable, worrying or tense. Whether lively or gloomy. Ability to express and control feelings of anger, anxiety, or depression.
5. **Leisure activities and hobbies:** Interest in reading, play, music, movies etc. Enquire about creative ability. Whether leisure time is spent alone or with friends. Is the circle of friends large or small?
6. **Fantasy life:** Enquire about content of day dreams and dreams. Amount of time spent in day dreaming.
7. **Reaction pattern to stress:** Ability to tolerate frustrations, losses, disappointments, and circumstances arousing anger, anxiety or depression. Evidence for the excessive use of particular defense mechanisms such as denial, rationalization, projection, etc.
8. **Habits:** Eating, sleeping and excretory functions.

IX. Summary& Clinical Diagnosis

EVALUATION CRITERIA FOR PSYCHIATRIC CASE HISTORY TAKING

(Maximum Marks: 50+50=100)

SN	Criteria	Marks Allotted	Marks Obtained	Total
1	Format	03		
2	Presenting Complaints	05		
3	Organization of history of present illness	10		
4	Past history of illness	05		
5	Family history of illness	04		
6	Personal history	05		
7	Pre-morbid personality	05		
8	Physical Examination	08		
9	Summary & Clinical Diagnosis	05		
	Total	50		

NB: Two Clients, 50 Mark Each

II) MENTAL STATUS EXAMINATION (MSE) FORMAT:

I. General appearance and behavior (GAAB):

- a) Facial expression (E.g. Anxiety, pleasure, confidence, blunted, pleasant)
- b) Posture (stooped, stiff, guarded, normal)
- c) Mannerisms (stereotype, negativism, tics, normal)
- d) Eye to eye contact (maintained or not)
- e) Rapport (built easily or not built or built with difficulty)
- f) Consciousness (conscious or drowsy or unconscious)
- g) Behavior (includes social behavior, E.g. Overfriendly, disinherited, preoccupied, aggressive, normal)
- h) Dressing and grooming – well dressed/ appropriate/ inappropriate (to season and situation)/ neat and tidy/ dirty.
- i) Physical features:- look older/ younger than his or her age/ under weight/ over weight/ physical deformity.

II. Psychomotor Activity:

(Increased/decreased/ Compulsive/echopraxia/ Stereotypy/ negativism/ automatic obedience)

III. Speech: One sample of speech (verbatim in 2 or 3 sentences)

- a) Coherence-coherent/ incoherent
- b) Relevance (answer the questions appropriately) – relevant / irrelevant.
- c) Volume (soft, loud or normal)
- d) Tone (high pitch, low pitch, or normal/ monotonous)
- e) Manner – Excessive formal / relaxed/ inappropriately familiar.
- f) Reaction time (time taken to answer the question) – increased, decreased or normal

IV. Thought:

- a) Form of thought/ formal thought disorder – not understandable / normal/ circumstantiality/ tangentiality/ neologism/ word salad/ preservation/ ambivalence).
- b) Stream of thought/ flow of thought- pressure of speech/ flight of ideas/ thought retardation/ mutism/ aphonia/ thought block/ Clang association.)
- c) Content of thought
 - i) Delusions- specify type and give example- Persecutory/ delusion of reference/ delusions of influence or passivity/ hypochondracal delusions/ delusions of grandeur/ nihilistic- Derealization/ depersonalization/ delusions of infidelity.
 - ii) Obsession
 - iii) Phobia
 - iv) preoccupation
 - v) Fantasy – Creative / day dreaming.

V. Mood (subjective) and Affect (objective):

- a) Appropriate/ inappropriate(Relevance to situation and thought congruent.
- b) Pleasurable affect- Euphoria / Elation / Exaltation/ Ecstasy
- c) Unpleasurable affect- Grief/ mourning / depression.
- d) Other affects- Anxiety / fear / panic/ free floating anxiety/ apathy/ aggression/ moods swing/ emotional liability

VI. Disorders Perception:

- a) Illusion
- b) Hallucinations- (specify type and give example) – auditory/ visual/ olfactory/ gustatory/ tactile
- c) Others- hypnologic/ hypnopombic/ lilliputian/ kinesthetic/ macropsia/ micropsia/

VII. Cognitive functions:

a) Attention and concentration:

- Method of testing (asking to list the months of the year forward and backward)
- Serial subtractions (100-7)

b) **Memory:**

- a) Immediate (Teach an address & after 5 mts. Asking for recall)
- b) Recent memory – 24 hrs. recall
- c) Remote : Asking for dates of birth or events which are occurred long back
 - i) Amnesia/ paramnesia/ retrograde amnesia/ anterograde amnesia
 - ii) Confabulation
 - iii) 'Déjà Vu'/ Jamaes Vu
 - iv) Hypermnesia

c) **Orientation :**

- a. Time approximately without looking at the watch, what time is it?
- b. Place – where he/she is now?
- c. Person – who has accompanied him or her

d) **Abstraction:** Give a proverb and ask the inner meaning (E.g. feathers of a bird flock together/ rolling stones gather no mass)

e) **Intelligence & General Information:** Test by carry over sums / similarities and differences/ and general information/ digit score test.

f) **Judgment:**

- Personal (future plans)
- Social (perception of the society)
- Test (present a situation and ask their response to the situation)

g) **Insight:**

- a) Complete denial of illness
- b) Slight awareness of being sick
- c) Awareness of being sick attribute it to external / physical factor.
- d) Awareness of being sick, but due to some thing unknown in himself.
- e) Intellectual insight
- f) True emotional insight

VIII General Observations:

- a) Sleep
 - i) Insomnia – temporary/ persistent
 - ii) Hypersomnia – temporary/ persistent
 - iii) Non-organic sleep- wake cycle disturbance
 - iv) EMA- Early Morning Awakening
- b) Episodic disturbances – Epilepsy/ hysterical/ impulsive behavior/ aggressive behavior/ destructive behavior

IX Summary & Clinical Diagnosis-

EVALUATION CRITERIA FOR MENTAL STATUS EXAMINATION

(Maximum Marks: 50+50=100)

SN	Criteria	Marks Allotted	Marks Obtained	Total
1	Format	02		
2	General appearance	04		
3	Motor disturbances	04		
4	Speech	04		
5	Thought disturbances	04		
6	Perceptual disturbances	05		
7	Affect and mood	04		
8	Memory	03		
9	Orientation	02		
10	Judgment	03		
11	Insight	02		
12	Attention and Concentration	03		
13	Intelligence and General information	03		
14	Abstract thinking	02		
15	General Observation	02		
16	Summary	05		
	Total	50		

N B : Two Patients, 50 marks each

III) EVALUATION OF PROCESS RECORDING

Process recording are written records of encounters with patients that are as verbatim as possible and include both verbal and nonverbal behaviours of the nurse and client.

1. FORMAT:

1. Base line data of the client.
2. List of Nursing problems identified through history, MSE and systematic observation.
3. List of objectives of interactions based on the problems identified and learning needs of.
 - a) Client
 - b) Student

(Note : The above data are obtained and recorded on initial contact. Later as each day's interaction are planned, the following format has to be followed).

2. DATE AND TIME DURATION :

3. SETTING : General ward/patient's unit

4. OBJECTIVES TO BE ATTAINED IN THAT PARTICULAR INTERACTION:

1.
2.

PARTICIPANT	CONVERSATION	INFERENCE	THERAPEUTIC COMMUNICATION TECHNIQUE USED
Nurse (N)	Good morning Mr. Ramu (smile, looks at patient)		
Patient (P)	Good morning sister (looks down, voice pitch and monotonous) Mr. Ramu, you appear	Patient appears sad and un-interested to converse	
	Making To be sadder than observation, showing interest Yesterday. Can we talk about it? (stands closer to patient) Let us sit down in the Room (leads the patient to the room)		

5. NATURE OF TERMINATION OF INTERACTION:

Evaluation by the student:

1. Your general impression about the interaction (this could include whether TNPR maintained, use of TCT, co-operation of client etc).
2. Whether objectives achieved, and to what extent. If not- why and how do you intend to achieve it.
3. Summary of your inferences

Evaluation by teacher:

1. Overall recording
2. Phases of nurse patient relationship
3. Use of Therapeutic Communication Techniques
4. Ability to achieve objectives

NOTE: Limit objective to one or two and make all efforts to attain the objectives. At the end of the process recording, mention if you were able to achieve the objective and to what extent. If not, how you intend to achieve it and what hindered you from achieving it. Maintain a therapeutic nurse-patient relationship (TNPR) in all you interactions and use as many therapeutic communications of the participants.

EVALUATION CRITERIA FOR PROCESS RECORDING EXAMINATION

(Maximum Marks: 25+25=50)

SN	Criteria	Marks Allotted	Marks Obtained	Total
1	Format	05		
2	Objectives	03		
3	Setting	02		
4	Therapeutic techniques used	10		
5	Evaluation by students	05		
	Total	25		

N B : Two Patients, 25 marks each

IV) FORMAT FOR NURSING CARE PLAN

1. Bio data of the patient.
2. History of the patient
3. Pre- morbid personality.
4. Physical examination.
5. Mental status examination.
6. Assessment Data – Objective data
– Subjective data
7. Nursing Diagnosis.
8. Short term goals, long terms goals.
9. Plan of action with rationale
10. Implementation including health teaching
11. Evaluation.
12. Bibliography.

EVALUATION CRITERIA FOR NURSING CARE PLAN

(Maximum Marks: 50+50=100)

SN	Criteria	Marks Allotted	Marks Obtained	Total
1	Format	03		
2	History	10		
3	MSE	15		
4	Nursing Diagnosis	05		
5	Planning & implementation of Nursing care with evaluation	15		
6	Bibliography	02		
	Total	50		

N B : Two Patients, 50 marks each

V) EVALUATION OF DRUG STUDY

EVALUATION CRITERIA FOR DRUG STUDY

(Maximum Marks : 50)

SN	Criteria	Marks Allotted	Marks Obtained	Total
1	Introduction	02		
2	Drug and its group	02		
3	Pharmacological name and trade name	02		
4	Dose	03		
5	Strength	02		
6	Route of administration	05		
7	Action / pharmacodynamics	05		
8	Indication	05		
9	Contraindication	05		
10	Side effects and toxic effects	05		
11	Nursing responsibility	10		
12	Home Management of drugs Therapy	04		
	Total	50		

VI) FORMAT FOR CASE PRESENTATION / CASE STUDY

1. History
2. Physical examination.
3. Mental status examination.
4. Description of the case.
 - a) Definition
 - b) Etiological Factors
 - c) Psycho Pathology / Psychodynamics
 - d) Clinical Manifestations
 - i) In general
 - ii) In the patient
5. Differential diagnosis.
6. Diagnosis & Prognosis
7. Management-AIM & OBJECTIVES(including Nursing care)
 - (a) Medical -
 - Pharmacotherapy & Somatic therapy
 - Psychosocial therapy
 - (b) Nursing Management – In general
 - (c) Nursing process approaches
 - (d) Rehabilitation / Long term care
8. Progress notes.
9. Bibliography.

VI a) Evaluation of Case Presentation

EVALUATION CRITERIA FOR CASE PRESENTATION

(Maximum Marks : 50)

SN	Criteria	Marks Allotted	Marks Obtained	Total
I	Case Presentation			
	1. History Taking	05		
	2. Mental Status Examination	05		
	3. Description of Disease Condition			
	a) Definition	02		
	b) Etiological Factors	02		
	c) Psycho Pathology/ Psychodynamics	03		
	4. Clinical Manifestations			
	a) In general / In books	03		
	b) In the patient	03		
	5. Differential Diagnosis	02		
	6. Prognosis	02		
	7. Management - AIM & OBJECTIVES			
	a) Pharamaco therapy & Somatic therapy	02		
b) Psychosocial approaches	02			
8. Nursing Management				
a) General approaches	02			
b) Nursing Process approach	06			
c) Rehabilitation / long term care	02			
II	Presentation (effectiveness)	04		
III	A.V. Aids	03		
IV	Bibliography	02		
	Total	50		

Remarks & signature of supervisor-

Date :

Signature of student

Date :

VI b) Evaluation of Case Study**EVALUATION CRITERIA FOR CASE STUDY**

(Maximum Marks : 50)

SN	Criteria	Marks Allotted	Marks Obtained	Total
1.	History Taking	05		
2.	Mental Status Examination	05		
3.	Description of Disease Condition –			
	a) Definition	02		
	b) Etiological factors	03		
	c) Psychopathology/	03		
4.	Clinical Manifestation –			
	In general / in book	04		
	In Patient -	03		
5.	Differential diagnosis	02		
6.	Prognosis	02		
7.	Management –			
	a) Pharmaco therapy and Somatic therapies	03		
	b) Psychosocial approaches	03		
8.	Nursing Management –			
	a) General approaches	03		
	b) Nursing Process	05		
	c) Rehabilitation/ long term care	03		
9.	Drugs Study	03		
10.	Bibliography	02		
	Total	50		

PSYCHIATRIC NURSING

VII) CLINICAL PERFORMANCE EVALUATION PROFORMA

Name of the student :

Batch :

Ward :.....

Period: From ----- to -----

Maximum Marks 100

	Excellent 5	V. Good 4	Good 3	Average 2	Poor 1
<p><u>I. KNOWLEDGE ABOUT THE PATIENT:</u></p> <ol style="list-style-type: none">1. Elicit the comprehensive history of the patient.2. Understands the disease aspect3. Examines the mental status of the patient4. Participates in the management of patient, in relation to drug and psycho-social intervention.5. Carries out Nursing process with emphasis on: Meeting physical needs of patient.6. Attends to psycho social needs7. Identifies and meets the family needs. <p><u>II. COMMUNICATION & INTERPERSONAL SKILLS</u></p> <ol style="list-style-type: none">1. Utilizes therapeutic communication techniques while interacting with patients & family members.2. Improve therapeutic communication skills by process recording.3. Maintains professional relationship with health team members. <p><u>III. APPLICATION OF THERAPEUTIC MILIEU CONCEPT</u></p> <ol style="list-style-type: none">1. Accepts the patient as he is Maintains consistency in behavior and attitude2. Structures time of the patient3. Provides a safe environment. <p><u>IV. RECORDING & REPORTING</u></p> <ol style="list-style-type: none">1. Records & Reports MSE daily (assigned patients)2. Applies the principles of recording and reporting (accuracy, apprehensiveness, accountability) <p><u>V. Health Teaching</u> Incidental and planned teaching.</p> <p><u>VI. Personality</u></p> <ol style="list-style-type: none">1. Professional appearance2. Sincerely Sense responsibility3. Punctuality					

Remarks & Signature of Supervisor & Date
Signature of student & Date

VII) PROFORMA FOR HEALTH TEACHING

(Total Marks 25)

Topic Selected :-

1. Name of the student teacher:
2. Name of the supervisor
3. Venue:
4. Date:
5. Time:
6. Group:
7. Previous knowledge of the group
8. AV aids used
9. General objectives
10. Specific objectives

Health teaching plan

SN	Time	Specific objectives	Content	Teaching Learning Activities	AV Aids	Evaluation

Note : Heath Education is included as part of Nursing care plan

INTERNAL ASSESSMENT PROFORMA & GUIDELINE
INTRODUCTION TO NURSING EDUCATION

II P.B. B.Sc. Nursing

CLINICAL EXPERIENCES/ PRACTICUM

Total Hours. : 75 hrs

Practice Teaching (Theory + Practical)	hours 20
- Prepare Teaching Aids	hours 10
- Attending peer group Teaching	hours 05
- Preparing rotation plan	hours 05
- Study various Nursing Programme	hours 10
- Plan inservice education Programme	hours 05
- Visiting Nursing Schools and Colleges	hours 20

EVALUATION:

Internal Assessment:

Theory:	15 Marks
Clinical Assignment:	10 Marks
Total:	25 Marks

Details as follows:

Internal Assessment (Theory): 15 Marks

(Out of 15 Marks to be send to the University)

Mid-Term:	50 Marks
Prelim:	75 Marks
Total:	125 Mark

(125 Marks from mid-term & prelim (Theory) to be converted into 15 Marks)

Clinical Assignment: 10 Marks

Practice Teaching (100 Marks Each)

 Theory – 2 cases: 200 Marks

 Clinical – 1 case: 100 Marks

Total: 300 Marks

(300 Marks from Clinical Assignment to be converted into 10 Marks)

II YEAR P.B. B.SC. NURSING
SUBJECT :- INTRODUCTION TO NURSING EDUCATION
PROFORMA & GUIDELINE FOR EVALUATION

I. EVALUATION FORM – PRACTICE TEACHING (CLASS ROOM)

(Two Cases of 100 Marks each. Total 200 Marks)

Name of the student teacher:

Area of the teaching :

Group to be taught :

Subject :

Topic to be taught :

Date of presentation :

Time :

Evaluator : 1.
2.

Rating –

*In any respect fails to meet requirements of quality	1
*Teaching, unsatisfactory performance	
*Meets many requirements, but deficient in certain respect	2
* Average, meets basic requirements-satisfactory performance	3
* Superior performance – exceeds clearly in basic requirements for quality teaching	4
* Excellent outstanding performance excellent in all basic requirements of a quality teacher and teaching.	5

GRADE & PERCENTAGE :

PASS	: 50-54 %
2 nd class	: 55-59%
1 st class	: 60-74%
Distinction	: 75% and above

Sr. No.	Item	Rating					Remarks
		1	2	3	4	5	
I.	<u>DEVELOPMENT OF LESSON</u>						
	1. Selection of topic, collection of subject matter, reliability, adequate, appropriate, research evidence						
	2. Statement of aims and objectives						
	3. Organization of subject matter (Sequence, continuity)						
	4. A.V. AIDS (Appropriate, self prepared, use of resources, planned well)						
	5. Technique of teaching method & technique appropriate, selected well)						
	6. Assignment and Bibliography appropriate, developed well						
II.	<u>PREPARATION FOR CLASS</u>						
	7. Class room arrangement (adequate/inadequate)						
	8. Arrangements of A.V.Aids well placed, visualized by students appropriately)						
III.	<u>PRESENTATION</u>						
	9. Introduction (Making objective clear, interesting, captive, related to topic)						
	10. Exhibits depth of knowledge and classification of ideas with illustrations and Examples.						
	11. Anticipated questions and answerers well						
	12. Correct technique of questioning (Clear, stimulating, well developed,)						
	13. Integration and correlation with other subjects done						
	14. A.V. aids used well						
	15. Maintained teaching learning atmosphere well, interesting, alive, command over language.						
	16. Motivated students for participation						
	17. Control over the group						
	18. Stimulation for further study (Summarization done, assignment given)						
	19. Budgeting of time						

Rating

II YEAR P.B. B.SC. NURSING
SUBJECT :- INTRODUCTION TO NURSING EDUCATION
PROFORMA & GUIDELINE FOR EVALUATION

II. EVALUATION FORM - CLINICAL PRACTICE TACHING (Total Marks: 100)

Name of student teacher :
Subject :
Topic :
Group to be taught :
Clinical Area : Ward / Field
Date of Presentation :
Time :
Evaluators : I.
II.

RATING * In any respect fails to meet requirements of quality -1
Teaching .Unsatisfactory performance.
*Meets many requirements but deficient in certain respect-2
*Average, meets basic requirements, satisfactory
performance -3
*Superior performance-exceeds clearly in basic require-
ments for quality teaching -4
*Excellent outstanding performance -5

INSTRUCTIONS: i) Teaching must be essentially a clinical teaching at bedside involving the patient
ii) Application of theory is considered throughout.
Written explanation must be covered while giving grades

GRADE: PASS : 50-54 %
2nd Class : 55-59 %
1st Class : 60-74 %
DISTINCTION : 75 % and above

Sr. No.	Item	Rating					Remarks
		1	2	3	4	5	
I.	DEVELOPMENT OF LESSON PLAN						
	1. Statement of Aim and objectives						
	2. Organization of subject matter						
	3. A.V. Aids (Appropriate self prepared, effective etc.)						
II.	KNOWLEDGE :						
	4. Familiar with patient his/her disease process.						
	5. Thorough with subject matter (depth, mastery, up to date, reliable etc.)						
	6. Research evidence						
III.	ORGANISATION :						
	7. Physical set up of Clinic.						
	8. Preparation of equipments						
	9. Preparation of patient and relatives.						
	10. Self preparation (for procedure & clinic)						
IV.	CONDUCTING CLINIC						
	11. Ability to introduce the clinic						
	12. Method adopted						
	13. Technical skills (Adoptation, modification)						
	14. Application of scientific principles						
	15. Use of visual aids						
	16. Patient involvement						
	17. Budgeting of time and summarization of clinic						
	18. Termination of clinic (Care of Pt. and articles, Recording Reporting etc.)						
V.	EFFECT OF TEACHING						
	19. students motivation and participation, questioning technique, clarification of doubts						
	20. Professional & personal appearance (posture, attitude, approach, gestures, voice, language manners, etc.						
N.B. – Each point carries 5 marks (XX x5 = 100 marks)							
There will be gradation of 5 marks between each point.							
Evaluators comments :							
Strengths :							
Weaknesses :							
Total score obtained:							
Percentage :							
Grade :							

Students signature that she/he has seen her/his evaluation
Date :

Evaluators Signature
Date :

INTERNAL ASSESSMENT PROFORMA & GUIDELINE
INTRODUCTION TO NURSING SERVICE
ADMINISTRATION CLINICAL

II P.B. B.Sc. Nursing

PRACTICUM

- Observe the functioning of Nursing administration at various levels i.e., Institutions, departments and units.
- Each student will practice ward management under supervision
- Student will prepare rotation plan of the staff duties, write reports, give verbal reports of the ward and assist in the maintaining the inventory of the nursing unit
- Develop an Assessment tool for performance appraisal
- Visit Private and Government Hospital and write observation reports
- Student will present one seminar during administration experience.

Note : visits for Nursing administration and Nursing Education may be planned together.

CLINICAL EXPERIENCES

Total Hours. : 180 hrs

- | | |
|--|-----------------|
| - Ward Management | hours 90 |
| - ICU Management | hours 30 |
| - OPD / Departments | hours 30 |
| - Visits to hospitals and other agencies
(ie. Govt, Pvt or corporation and any other) | hours 30 |

EVALUATION:

Internal Assessment:

Theory:	15 Marks
Clinical Assignment:	10 Marks
Total:	25 Marks

Details as follows:

Internal Assessment (Theory): 15 Marks

(Out of 15 Marks to be send to the University)

Mid-Term: 50 Marks

Prelim: 75 Marks

Total: 125 Mark

(125 Marks from mid-term & prelim (Theory) to be converted into 15 Marks)

Clinical Assignment: 10 Marks

(Marks from Clinical Assignment to be converted into 10 Marks)

1) ASSIGNMENT FORMAT FOR WRITING WARD MANAGEMENT Day & Night REPORT :-

- a) Introduction – Name of the ward, duration of the experience with date, objectives of the ward management experience.
- b) Organization chart of the ward – Draw the organization structure of the ward depicting staff position, communication channels and hierarchical lines.
- c) Draw the ward lay out, type of ward, Physical facilities and compare it with the standards of the ideal ward.
- d) Records and reports- Describe the various records and reports maintained in the ward, special reporting procedures. Study these documents critically and observe for completeness, accuracy and relevance and attach a brief report of your findings.
- e) Procedures and policies – Study the policies and procedures in the following areas and describe them briefly :-
 - Indenting procedure for drugs, supplies and equipments
 - Admission and discharge including emergency
 - SIL / DIL , Death
 - Visitors, out pass and absconding patient
 - Treatments, special procedures, referrals, operations and consent
 - Emergency care, reporting on conditions of critically ill patients, New admissions, special events in the wards
 - SOP'S for anaphylaxis, needle stick injuries, HIV infections, Hospital waste management and other medical procedures
 - Security of the ward, patient and his belongings
 - Fire drills
- f) Classify the various drugs, supplies and equipments in the ward. Study the procedure for indenting, accounting, maintenance and deletion of drugs, stores, supplies and equipment.
- g) Conclusion
- h) references

EVALUATION CRITERIA FOR WRITING WARD MANAGEMENT DAY & NIGHT REPORT

(Maximum Marks : 100)

SN	Criteria	Marks Allotted	Marks Obtained	Total
1	Introduction	15		
2	Organization of content	35		
3	Statistical data	10		
4	AV Aids	20		
5	Conclusion	10		
6	References	10		
	Total	100		

Remarks & signature of supervisor-

Date :

Signature of student

Date :

II) ASSIGNMENT FORMAT FOR WRITING PERFORMANCE APPRAISAL :-

Guidelines :-

- 1 Define the purpose of assessment
- 2 Decide as to which groups are to be assessed
- 3 Select and define the qualities to be assessed on a Five point Rating scale.
- 4 Include the following areas
 - Quality of performance
 - Quantity of work
 - Quality of work
 - Mental qualities
 - Ability to learn
 - Adaptability
 - Originality
 - Reasoning powers
 - Supervisory qualities
 - Leadership
 - Organizing ability
 - Cooperation
 - Personal qualities
 - Honesty
 - Self control
 - Initiative
 - Appearance
 - Attitude towards fellow workers
 - Attitude towards work
 - Capacity for further development
 - Intelligence
 - Acceptance of responsibility
 - To Lead a group

EVALUATION CRITERIA FOR WRITING PERFORMANCE APPRAISAL

(Maximum Marks : 50)

SN	Criteria	Marks Allotted	Marks Obtained	Total
1	Preparation of Tool	20		
2	Content	10		
3	Comprehension	10		
4	Conclusion	05		
5	References	05		
	Total	50		

Remarks & signature of supervisor-

Date :

Signature of student

Date :

III) ASSIGNMENT FORMAT FOR SEMINAR

Introduction to the topic___
Unit background
Concept, definition
History
Subject matter
Application in Nursing field
Summary
Conclusion
References

EVALUATION CRITERIA FOR SEMINAR PRESENTATION

Subject

Topic

Name of student

Group

Date

Time

Maximum Marks : 100

SN	Criteria	Rating					Remarks
		1	2	3	4	5	
1	Introduction						
2	Organization of Content						
3	Presentation of topic						
4	Relevant examples						
5	Relevant statistical data						
6	Group participation						
7	Control of group						
8	Conclusion						
	AV Aids						
9	Appropriate to subject						
10	Proper use of A/V Aids						
11	Self explanatory						
12	Attractive						
13	Planning and preparation						
14	Use of Modern technology						
	Physical facilities						
15	Environment						
16	Classroom preparation						
17	Over lay out						
	Personal Appearance						
18	Voice & clarity						
19	Mannerisms						
20	References						

Remarks & signature of supervisor-

Date :

Signature of student

Date :

IV) CLINICAL EVALUATION PERFORMS NURSING SERVICE ADMINISTRATION

Name of the student
Period :

Field placement
Name of the supervisor

DECECTION :- To facilitate the use of the clinical evaluation performs, typical activities behavior are described on a five point scale. The direction of all scale is from lowest (1) to highest (5). Mark your evaluation by placing a tick mark in the column, describing the student's standing in relation to other students in the general level experiences :-

1 Poor 2 Fair 3 Good 4 Very good 5 Excellent

Marks : 100

SN	SUPERVISOR TASKS	Rating					Remarks
		1	2	3	4	5	
1	Organizing ability						
2	Leadership						
3	Responsibility for equipments & supplies						
4	Maintenance of cleanliness of ward						
5	Assisting in Ward activity (Pharmacy, Dietary etc)						
6	Written & oral report						
7	Teaching						
8	Supervision of nonprofessional workers						
9	Problem solving ability						
	WORK PERFORMANCE						
1	Knowledge						
2	Skill (Accuracy & speed)						
3	Maintaining nursing & scientific principles						
	PERSONAL QUALITIES						
1	Communication skill						
2	Attitude towards work						
3	Self confidence						
4	Inter – personal relationship						
5	Emotional stability						
6	Punctuality						
7	Cooperation						
8	Reliability						

Remarks & signature of supervisor-

Date :

Signature of student

Date :

V) ASSIGNMENT FORMAT FOR WRITING REPORT ON DUTIES AND RESPONSIBILITIES OF NURSING PERSONNEL (NURSING SUPERINTENDENT, WARD IN CHARGES).

Introduction

Aim of the assignment

Objectives of the study

Qualification

Total years of service

Experience in Administration

Date of appointment in the Hospital for the assignment

Write the job description of each of the categories of the above employees in the hospital under Administrative, Supervisory, Clinical, Teaching, Records, Reports & Returns and other duties such as staff welfare, committee procedures

Conclusion

References

EVALUATION CRITERIA FOR WRITING REPORT ON DUTIES AND RESPONSIBILITIES OF NURSING PERSONNEL

(Maximum Marks : 50)

SN	Criteria	Marks Allotted	Marks Obtained	Total
1	Introduction	10		
2	Organization of content	20		
3	Comprehensive	10		
4	Conclusion	05		
5	References	05		
	Total	50		

Remarks & signature of supervisor-

Date :

Signature of student

Date :

VI) ASSIGNMENT FORMAT FOR WRITING VISIT REPORT TO HOSPITALS :-

Introduction to the hospital

Historical Background

Write the Philosophy of the Hospital

Write the Aim and Objectives of the visit

Draw the Organization chart of the hospital

Explain the staffing of the hospital

Explain the recruitment procedure for the Nursing employee (staff nurses).

Explain the various departments and Nursing department in detail

Explain the Admission and Discharge procedures for the patients including emergency admission & Discharge

Explain the procedure for payment of various services in the hospital

Explain the special equipments and services rendered by the hospital departments

Discuss the Disaster / Emergency plan of the hospital

Identify and describe the various research programmes under taken by the Nursing Department

Identify and describe In – Service education programmes going on the Nursing personnel Staff welfare activities

Staff guidance and counseling

Discuss the conflict and grievances management system in the hospital

Performance appraisal system followed in the hospital for nurses

Describe the hospital policies in relation the Employee promotions, transfers, Higher Education, special appointments, deputations, courses.

Public relations maintained by the hospital

List out VIP visits to the hospital in the recent / past two years

Does the hospital have a School / College of Nursing attached to it

If yes then –

Explain the organizational structure. Staffing of the School

Describe the Philosophy / Mission statement of the School

Explain the courses conducted at the School/ College of Nursing

Is the School / College recognized by the INC / MNC

Date of last visit of INC / MNC Inspectors

Does the School / College have a students hostel

EVALUATION CRITERIA FOR WRITING VISIT REPORT TO HOSPITALS

(Maximum Marks: 100)

SN	Criteria	Marks Allotted	Marks Obtained	Total
1	Introduction	15		
2	Organization of content	35		
3	Presentation of Report	10		
4	A.V. Aids	20		
5	Conclusion	10		
6	References	10		
	Total	100		

Remarks & signature of supervisor-

Date :

Signature of student

Date :

VII) ROTATION PLAN FOR STAFF DUTIES

Make a rotation plan based on the Principles of preparing rotation plan for one month duty of nursing staff for hospital you have visited for study for an Acute Medical Surgical ward of 55 patients. Work out the staff requirements for day and night duties.

Marks 25

II YEAR P. B. B. Sc. NURSING

INTRODUCTION TO NURSING RESEARCH AND STATISTICS

PRACTICAL EXPERIENCE GUIDELINE AND EVALUATION FOR

NURSING RESEARCH : "PROJECT"

**Time Allotted
Practical - 120 hrs.**

EVALUATION:

Internal Assessment: 100 Marks

(Out of 100 Marks to be send to the University)

Detials as follows:

*Theory - Mid-Term: 25 Marks

*Theory – Prelim: 25 Marks

*Practical – Research Project: 50 Mark

(*College level qualifying exam, minimum passing Marks 50%)

Guideline for Research Project

I Aim : Student will identify the role of nurse in conducting research, writing research proposal based on scientific steps and will analyze the data using simple statistical methods. While conducting research project.

II Objectives : Preparing nursing research proposal

- 1) To get an opportunity to select topic or problem to formulate research proposal.
- 2) To follow the steps in research while writing research proposal and conducting project.
- 3) To differentiate and plan specific design in nursing research i.e. experimental and non-experimental including methodology.
- 4) To get an opportunity to frame/construct simple tool or questionnaire to collect data.
- 5) To follow the basic principles of data analysis including simple tables and statistical methods for proceedings and interpretation of data.
- 6) To be familiar to write research report to communicate the findings including bibliography, foot notes and future recommendations.
- 7) To present nursing research proposal as group activity.
- 8) Learns to use computers.

III Guide line / check list to prepare / Nursing research proposal & project

- 1) Selection of research problem : Select your interest area of research, based on felt need, issues, social concern in nursing field.
 - a) State the problem, brief concise, clear.
 - b) State the purpose of selected study & topic

- c) State objective of study/proposal/project.
 - d) State the hypothesis if necessary (optional).
 - e) Prepare conceptual framework based on operational definition (optional).
 - f) Write scope and delimitation of Research Proposal.
- 2) Organizing for Review of Literature
- a) It adds in to needs to conduct Research project.
 - b) To study related and relevant literature which helps to decide conceptual framework and research design to be selected for your study.
 - c) To add specific books, bulletins, periodicals, reports, published and unpublished dissertations, encyclopedia, text books.
 - d) Organize literature as per operational definition.
 - e) To prepare summary table for review of literature. (Optional)
- 3) Research Methodology : To determine logical structure & methodology for research project
- a) Decide and state approach of study i.e. experimental or non experimental.
 - b) To define/findout variables to observe effects on decided items & procedure (optional)
 - c) To prepare simple tool or questionnaire or observational check list to collect data.
 - d) To determined sample and sampling method.
 - i) mode of selection
 - ii) Criterias
 - iii) Size of sample
 - iv) Plan when, where and how data will be collected
 - e) To test validity of constructed tool (To check content in tool in relation to stated objectives) with experts / teachers opinion.
 - f) To check reliability by implementing tool before pilot study (10% of sample size)
 - g) To conduct pilot study by using constructed tool for 10% selected sample size.

- 4) Data Collection : To implement prepared tool
 - a) To implement constructed tool
 - b) Decide location
 - c) Time
 - d) Write additional information in separate exercise book to support inferences and interpretation.

- 5) Data analysis and processing presentation
 - a) Use appropriate method of statistical analysis i.e. frequency and percentage.
 - b) Use clear frequency tables, appropriate tables, graphs and figures.
 - c) Interpretation of data :
 - i) In relation to objectives
 - ii) Hypothesis (Optional)
 - iii) Variable of study or project (Optional)
 - iv) Writing concise report

- 6) Writing Research report
 - a) Aims :
 - i) To organize materials to write project report
 - ii) To make comprehensive full factual information
 - iii) To use appropriate language and style of writing
 - iv) To make authoritative documentation by checking footnotes, references & bibliography
 - v) To use computers.
 - b) Points to remember
 - a) Develop thinking to write research report.
 - b) Divide narration of nursing research report.
 - c) Use present tense and active voice
 - d) Minimize use of technical language
 - f) Use simple, straightforward, clear, concise language
 - g) Use visual aids in form of table, graphs, figures
 - h) Treat data confidentially
 - i) Review, rewrite if necessary

EVALUATION CRITERIA FOR PROJECT REPORT

Maximum Marks: 100

SN		Criteria	Rating					Remarks
			1	2	3	4	5	
I	Statement of the problem							
	1.	Significance of the problem selected						
	2.	Framing of title and objectives						
II	Literature Review							
	3.	Inclusion of related studies on the topic, and its relevance						
	4.	Operational definition						
III	Research Design							
	5.	Use of appropriate research design						
	6.	Usefulness of the research design to draw the inferences among stud variables / conclusion						
IV	Sampling design							
	7.	Identification and description of the target population						
	8.	Specification of the inclusion and exclusion criteria						
	9.	Adequate sample size justifying he study design to draw conclusions.						
V	Data Collection Procedure							
	10.	Preparation of appropriate tool						
	11.	Pilot study including validity and reliability of tool						
	12.	Use of appropriate procedure / method for data collection						
VI	Analysis of Data & Interpretation							
	13.	Clear and logical organization of the findings						
	14.	Clear presentation of the tables (Title, table & Column heading)						
	15.	Selection of appropriate statistical tests						
VII	Ethical Aspects							

SN	Criteria	Rating					Remarks
		1	2	3	4	5	
I	Statement of the problem						
	16. Use of appropriate consent process						
	17. Use appropriate steps to maintain ethical aspects and principles (physical harm etc.)						
VIII	Interpretation of the findings						
	18. Consistent and appropriate discussion of the results						
IX	Conclusion						
	19. Summary and recommendations for to Nursing practice / Education / Administration						
X	Presentation / Report writing						
	20. Organization of the project work including language and style of presentation						
	Maximum marks						100
	Marks obtained						
	Marks sent to University						/50

Remarks by the Supervisor / Guide

Date & Signature

Signature of the students

Date