Council for Technical Education & Vocational Training

Sanothimi, Bhaktapur

FIRST YEAR

(INTERNAL ASSESSMENT)

PRACTICAL EVALUATION TOOL

FOR

FUNDAMENTAL OF NURSING

FIELD PRACTICUM

Proficiency Certificate of Nursing Program

CTEVT

2019

Council for Technical Education & Vocational Training

Sanothimi, Bhaktapur

Evaluation Scheme

Subject: Fundamental of Nursing Practicum **Total Mark: 150**

Total hours: 630

SN	Assignments	Marks	No. of assignment
1	Patient Assessment	20	5 Compulsory
2	Nursing Care Plan	20	10 Care Plans (2 Care Plans of each 5 patient)
3	Health Teaching	20 (10 + 10)	2 (1 in medical ward and 1 in surgical ward)
4	Procedure Log Book	10	1 (Should be also evaluated during final practical exam by external examiner)
5	Procedure evaluation Medical Ward	10	1
6	Procedure evaluation Surgical Ward.	10	1
7	Drug Card	10	10 drug card (1 drug in each card)
8	Clinical Performance Evaluation	50	1
	Total	**150**	

Council for Teaching Education & Vocational Training
Sanothimi, Bhaktapur

Course- PCL Nursing **Student's name-**
Subject- Fundamental of Nursing **Full Mark-** 20
Year- First **Pass Mark-** 10
Area of Practice- Medical/Surgical Ward **Student's mark-**
Date-

1. Patient's Assessment

Directions: Each student will practice history and physical examination of admitted patient during the clinical period of fundamental of nursing in medical/surgical ward. Individual student have to perform 5 patients assessment according to given format and one will be evaluated through criteria below.

Key for Marking:

Satisfactory	Good	Excellent
1	1.5	2

S.N.	Expected Behavior	1	1.5	2
1	Explain the procedure to the patient before doing the procedure.			
2	Prepare the necessary articles in an organized way.			
3	Demonstrate concern for the patient's safety and privacy to make the patient comfortable.			
4	Wash hands thoroughly before and after the procedure			
5	Maintain respect and dignity of the patient during the procedure.			
6	Follow the appropriate techniques (inspection, palpation, percussion and auscultation) during the assessment.			
7	Make patient comfortable after the procedure and provide related health information.			
8	Assure the patient for keeping the information confidential.			
9	Replace the articles in their proper place.			
10	Maintain record and report to supervisor/staff in time.			
	Total			

Strengths:

Areas to be improved:

…………………………… ……………………

Signature of supervisor **Date**

Annex – 1

History of present Illness format

S.N.	Problem	Onset Date/ Time	Frequency/ Duration	Severity	Aggravating Factors (If Any)	Alleviating Factors (If Any)	Remarks

Patient Assessment Format

A. History Taking

1. **Personal information of the client**
   Name:
   Date of Birth/age in completed years:
   Sex:
   Address:
   Religion:
   Occupation:
   Education:
   Economic Status:
   Marital Status:
   If married: No. of children:
   Ward/unit:
   Date of Admission:
   Inpatient No.:
   Diagnosis:
2. **Chief Complains in patient's own words**
   Onset
   Frequency
   Severity
   Duration
3. **History of present illness: (See Appendix-I)**
4. **Recent treatment history (If any specify)**
5. **History of Past Illness**
   A. Childhood Illness: (Diarrheal diseases, Measles, Mumps, Malnutrition, Malaria, Tuberculosis, Tetanus, Acute Respiratory Infections (ARI), Polio, others………………….

   B. Immunization according to National Immunization Schedule:
6. **History of any drug allergy :** (Yes/No) - If yes, specify

7. **Previous hospitalization : (** Yes/No)-If yes, reason for hospitalization

8. **History of any chronic illness**

   In the patient (Yes/No) - If yes, name the illness:

   In the Family: If yes, which family member / which illness

a. **Maternal Family**

- High Blood Pressure
- Diabetes
- Cancer
- Cardiovascular Disorder
- Respiratory Disorder
- Blood Disorder
- Muscular Skeletal Disorder
- Others

b. Paternal Family

- High Blood Pressure
- Diabetes
- Cancer
- Cardiovascular Disorder
- Respiratory Disorder
- Blood Disorder
- Muscular Skeletal Disorder
- Others

Family Tree (mention three generations)

9. **Personal History**

   - Habits: smoking /drinking /drugs:(Yes/No) specify
   - Frequency
   -Amount,
   - If quitted, mention time

10. **Menstrual and Obstetric history (In female patient)**

    a- Age of menarche

    b- Date of last menstruation

    - Blood Flow

- Regularity
- Associated problems

c- Number of live birth

- Place of delivery

d-Abortion history (if yes how many & causes)

e- Still birth

f- If Menopause (Specify the age).

11. Dietary Habits

- Vegetarian/Non vegetarian:
- Types of usual diets /number of meals taken in a day:
- Food likes/dislikes if any:
- Food allergies if any:

13. Elimination Habit

Urine

- colour
- Frequency
- Amount

Stool

- colour
- Consistency
- Frequency

14. Personal Care Habit:

- Oral care
- Nail care
- Bath
- Hand washing

15. Rest Habit/Sleep Habit in hours

- Day
- Night

16. Recreational Habit: (Watching TV, Listening music, Playing games, Visiting, etc.)

Others if any

17. Environment History

- Total number of family members
- Number of rooms in home
- Ventilation (adequate/ inadequate)
- Separate kitchen (Yes/No)
- Type of fuel used in cooking: (gas/kerosene/electric heater, etc)

- Source of drinking water: (pipe water, well, tube well, filter, rain, jar, bottle water etc.)
- Types of toilet used (borehole/ water- seal, latrine, etc.)
- types of drainage (Open /pipe drainage, safety tank)

18. Health Practices

-Traditional healer

- Ayurvedic medicine

-Allopathic medicine

- Homeopathic medicine

- Self medication

- Others

B. Physical Examination

A) General Inspection:

State of consciousness: alert/drowsy/non responsive: disoriented
Gait: balanced/limping: spastic/ haemeparalytic/ ataxic/ parkinsonism
Posture: erect/ stooped.
Nutritional status: well nourished/ under nourished/ obese
Facial expression: relaxed/tense/sad/grimacing
Hygiene state: maintain/not maintained
Speech: normal/ slurred/ hoarseness.

B) Measurement:

Height
Weight
Body Temperature
Pulse
Respiration
Blood Pressure
Abdominal girth

C) Inspect and Palpate Skin:

Color
Temperature
Texture
Excessive sweating
Dehydration
Hair distribution
Redness
Lesion
Patches
Edema
Injury

D) Examination of head, Face and Neck:

Inspect and Palpate head :

Color and texture of hair
Cleanliness
Pediculosis
Abrasions/injuries/other
mass/nodules
frontal sinuses

Inspect eyes :

Swelling of eyelids
Squint eyes
Eyebrows distribution

Eye lashes
Discharge
Color of sclera and conjunctiva
Corneal and lens opacity
Pupil size and reaction to light
Eye movement
Vision problem
- Visual acuity
- Peripheral

Blinking Reflex

Inspect and Palpation ears :

Appearance
Discharge, pain, bleeding and oedema
Wax/redness of external auditory canals
Hearing problem (Weber)
Foreign body
Lymph node (pre-auricular and post auricular)
Tenderness
Lateralization Bone Conduction (AC/BC)

Inspect and palpate nose:

Location, size of nostrils, Flaring, foreign body
Discharge
Blockage
Bleeding
Septal defect
Problem with smelling
Para-nasal and Maxillary sinus

Inspect mouth :

Color of lips/Color of mucous membranes
Sores/cracks on lips
Sores/cracks/swelling/bleeding/painful gums/tongue
Dental caries/missing teeth/dentures/bridge/color of teeth
Enlargement of tonsils
Oral Hygiene, gag reflex
Palpate for lymph Node (Submandibular, sub maxillaryl,

Inspect and palpate neck :

Mobility, Stiffness
Lymph nodes (Superficial cervical, Supraclavical and subclavical)
Thyroid gland,
Jugular vein,
Carotid Pulse
Back of Neck (Swelling, lump)

E) Examination of Chest:

Inspect :

Size:
shape (normal, barrel, pigeon, funnel, kyphoscoliosis)
Symmetry
Location of sternum
Equal movement of chest during breathing
Difficulty in breathing
Coughing Reflex

Palpate :

Tenderness
Lumps
Chest for expansion

Percussion

Anterior and posterior (Air/Fluid)

Auscultate :

Breathing sounds (anterior and posterior)

- Normal (Vesicular breathing sound, Bronchial breathing sound, Bronchial breathing sound, Bronchovesicular sound, Tracheal sound)
- Abnormal (Adventitious, Crackles, Wheezing, rhonchi)

Heart sound (4 areas)

Aortic
Pulmonic
Tricuspid
Mitral

F) Examination of Breast (in female client)

Inspect :

Symmetry, size, swelling

Condition of nipple:

Retraction, dimpling, cracks
Discharge from nipples

Palpate :

Abnormal masses, Lump, swelling, tenderness

G) Examination of Breast (in male client)

Inspect

Gyanecomastia

Palpate :

Abnormal masses, Lump, swelling, tenderness

H) Examination of Abdomen

Inspect :

Size
Shape
Scars
Enlarged veins
Swelling

Ausculate :

Bowel sounds

Percussion:

Air /Fluid

Palpate:

Tenderness
Masses
Enlarged Liver
Enlarged spleen
Kidney
Superficial abdominal reflexes

I) Examination of Limbs

Inspect and Palpate:

Joint mobility (ROM)
Tenderness
Redness
Oedema and Varicose vein
Bone deformity
Color of nail and Capillary refill
Extra digits
Axilla, groin for lymph nodes
Muscle strength
Co-ordination of movement
Brachial, radial, ulnar pulse in upper limbs
Femoral, popliteal, posterior tibial, dorsal pedis in lower limbs

Sensation test :

Sensation
Coldness and numbness of fingers

J) Examination of Female Genitalia
Inspect :

Colour of labia majora, minora, swelling ,sore, warts, vaginal prolapse
Vaginal discharge bleeding
Perineal hygiene

K) Examination of Male Genitalia
Inspect :

Position of meatus , scrotal size, redness, Swelling
Sore, lump, wart
Discharge
Perineal hygiene

L) Inspect rectum :
Haemoroids, warts ,birth mark, prolapse

M) Reflexes
Bicep
Tricep
Kneejerk
Achllis
Planter/Babinski

N) Examination of Back
Inspect :

Condition of skin
Shape of spine

(**Assessment of back chest can be done at this time**)

Specific findings:

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Signature of Teacher **Date**

Council for Technical Education & Vocational Training
Sanothimi, Bhaktapur

Course- PCL Nursing
Subject- Fundamentals of Nursing
Year- First
Area of Practice- Medical/Surgical Ward
Date-

Student's Name:
Full Mark: 20
Pass Mark: 10
Student's Mark:

2. Nursing Care Plan

Directions: Each student must submit 10 nursing care plan for 5 patients in medical and surgical ward according to given format (see appendix II). Each nursing care plan will be given score 4.
Key for Marking:

Satisfactory	Good	Excellent
1	1.5	2

S.N.	Expected Behavior	1	1.5	2
1	Identifies the patient's present and potential problem appropriately			
2	Prioritizes the severity of problem according to need			
3	Finds the patient's need according to nursing diagnosis to solve the problems			
4	Plans the nursing action in the basis of priority of the need			
5	States rational for each nursing action in relation to problem			
6	Implements and provides care according to the plan			
7	Involves in the family and self in the care process according to condition of patient			
8	Evaluates the progress of patients condition after giving care			
9	Reassures the care plan and implementation and re plan as need			
10	Records and reports properly			
	Total			

Strengths:

Areas to be improved:

……………………………
Signature of supervisor

…………………….
Date

Annex - 2

Council for Technical Education & Vocational Training
Sanothimi, Bhaktapur

Nursing Care Plan Format

S.N.	Problem Assessment	Nursing Diagnosis	Expected Outcome (Goal)	Plan of Nursing Action	Implementation of Action	Scientific Principle/ Rational	Evaluation
	Subjective data: Objective data:						

…………………………
Signature of Supervisor

Date :

……………………
Signature of student..

Date :

Council for Technical Education & Vocational Training
Sanothimi, Bhaktapur

Course-PCL Nursing
Subject- Fundamentals of Nursing
Year- First
Area of Practice- Medical/Surgical Ward
Date-

Student's Name:
Full Mark: 10
Pass Mark: 5
Student's Mark:

3. Health Teaching

Directions: Each student will give health teaching according to the need of the individual or group in medical or surgical ward
Key for Marking:

Satisfactory	Good	Excellent
1	1.5	2

S.N.	Expected criteria	1	1.5	2
1	Identifies the learning needs of patient/family.			
2	Assesses patient's level of knowledge in the topic.			
3	Organizes appropriate time and place for the teaching to the patient/ family.			
4	Prepares lesson plan with object content and learning activities.			
5	Uses appropriate audio-visual aids using available local resources and appropriate methods.			
6	Uses appropriate language according to level of understanding of patient / family.			
7	Encourages active patient/ group participation.			
8	Summarizes teaching by going over main points.			
9	Evaluates own teaching performance.			
10	Maintains discipline, attitude and dress appropriately in the clinical field areas.			
	Total			

(Total mark will be divided by 2)

Strengths:

Areas to be improved:

…………………………… ……………………….
Signature of supervisor **Date**

Council for Technical Evaluation & Vocational Training
Sanothimi, Bhaktapur

Course-PCL Nursing
Subject-Fundamentals of Nursing
Year-First
Area of Practice-Medical/Surgical Ward

Students Name-
Full Mark- 10
Pass Mark- 5
Students Mark-

Direction: Each student must get opportunity to observe and perform the following procedures in clinical area. Before beginning practice in the hospital, the students must perform all procedures in demonstration room under supervision of faculty. Each procedure contains 1 marks. The complete log book will also be verified and evaluated by external examiner during final practical examination, final score will be 10.

Name of external Examiner:

Signature :

Date :

4. Procedure Log Book

Note: Students and clinical supervisors are responsible to fill up the procedure Log Book provided by Nepal Nursing Council (NNC).

S. N	List of Procedures	Procedure Observation		Procedure performed Under supervision		Obtained Marks	Remarks
		Date and place	Sign of CT	Date and place	Sign of CT		
1	Occupied Bed Making						
2	Unoccupied Bed Making						
3	Post Operative Bed Making						
4	Cardiac Bed Making						
5	Orthopedic Bed Making						
6	Oral Care for Conscious patient						
7	Oral Care for Unconscious patient						
8	Back Care						
9	Hair Wash						
10	Pediculosis treatment						
11	Nail Care						
12	Sponge bath						
13	Vital sign						

14	History taking						
15	Physical examination						
16	Admission procedure						
17	Discharge Procedure						
18	Collection of Urine Specimen (routine)						
19	Urine Test for Albumin						
20	Urine Test for Sugar						
21	Collection of Stool specimen (routine)						
22	Collection of Blood specimen						
23	Collection of Sputum specimen						
24	Oral medication (tablet)						
25	Oral medication (capsule)						
26	Oral medication (liquid)						
27	IV bolus Injection						
28	Intramuscular						
29	Intradermal						
30	Subcutaneous injection						
31	I/V Canula Insertion						
32	I/V Drip						
33	O2 inhalation						
34	Steam Inhalation						
35	Nebulization						
36	Insertion of nasogastric tube						
37	Nasogastric tube feeding /aspiration						
38	Gastric Lavage						
39	Active and Passive Exercise						
40	Deep Breathing Exercise						
41	Hot application						
42	Cold application						
43	Foley"s Catherization						

44	Plain Catherization						
45	Enema						
46	Sitz Bath						
47	Simple Dressing						
48	Bandaging						
49	Intake and output charting/maintaining						
50	**Observation** • USG • Endoscopy • Computerized Tomography (CT scan) • Magnetic resonance imaging (MRI) • Colonoscopy • Bronchoscopy • Thoracocentesis • Paracentesis • Biopsy • Others						

(Total mark will be divided by 5)

……………………………… ……………………..

Signature of supervisor **Date**

Council for Technical Evaluation & Vocational Training
Sanothimi, Bhaktapur

Course-PCL Nursing
Subject-Fundamentals of Nursing
Year-First
Area of Practice-Medical/Surgical Ward

Student's Name-
Full Mark- 10
Pass Mark- 5
Student's Mark-

5. Procedure Evaluation

Directions: Each student will perform nursing procedures during the fundamental of nursing practicum in Medical/Surgical Ward. Any two procedures will be evaluated using the criteria stated below. Each procedure will be scored within 10 marks. One procedure in medical and one in surgical ward should be evaluated.

Key for Marking:

Satisfactory	**Good**	**Excellent**
1	1.5	2

Title of the procedure	Date	Time	Ward	Evaluated by

S. N.	Expected criteria	Student's Marks for Procedure		
		1	1.5	2
1	Explains the procedure to patient before doing the procedure.			
2	Sets up the necessary equipment in an organized way.			
3	Places the patient in the proper position for the procedure.			
4	Washes hands thoroughly before and after the procedure.			
5	Show concern for the patient's safety and privacy during the procedure.			
6	Follows the sequence using appropriate technique in performing the procedure.			
7	Keeps the patient comfortable after the procedure.			
8	Shares the outcome of the procedure with patient and family.			
9	Takes care of the equipment after the procedures by washing and putting them away in the proper place.			
10	Records and reports procedure appropriately.			
	Total			

(Total mark will be divided by 2)

Strength:

Areas to be improved:

……………………………
Signature of supervisor

……………………
Date

Council for Technical Evaluation & Vocational Training

Sanothimi, Bhaktapur

Course-PCL Nursing
Subject-Fundamentals of Nursing
Year-First
Area of Practice-Surgical Ward

Student's Name-
Full Mark- 10
Pass Mark- 5
Student's Mark-

6. Procedure Evaluation

Directions: Each student will perform nursing procedures during the fundamental of nursing practicum in Surgical Ward. Each procedure will be scored within 10 marks.

Key for Marking:

Satisfactory	**Good**	**Excellent**
1	1.5	2

Title of the procedure	**Date**	**Time**	**Ward**	**Evaluated by**

S.N.	**Expected criteria**	**Student's Marks for Procedure**		
		1	1.5	2
1	Explains the procedure to patient before doing the procedure.			
2	Sets up the necessary equipment in an organized way.			
3	Places the patient in the proper position for the procedure.			
4	Washes hands thoroughly before and after the procedure.			
5	Show concern for the patient's safety and privacy during the procedure.			
6	Follows the sequence using appropriate technique in performing the procedure.			
7	Keeps the patient comfortable after the procedure.			
8	Shares the outcome of the procedure with patient and family.			
9	Takes care of the equipment after the procedures by washing and putting them away in the proper place.			
10	Records and reports procedure appropriately.			
	Total			

(Total mark will be divided by 2)

Strength:

Areas to be improved:

……………......………
Signature of supervisor

…………………….............
Date

Council for Technical Evaluation & Vocational Training
Sanothimi, Bhaktapur

Course-PCL Nursing
Subject-Fundamentals of Nursing
Year-First
Area of Practice-Medical/Surgical Ward

Student's Name-
Full Mark- 10
Pass Mark- 5
Student's Mark-

7. Drug Card

Directions: Each student will submit drug book of at least ten drugs for evaluation according to the given format (appendix - III) and will be evaluated through the criteria below.

Key for Marking:

Satisfactory	Good	Excellent
1	1.5	2

S.N.	Evaluation Criteria	1	1.5	2
1	Name of drug			
2	Classification			
3	Route/s			
4	Dose			
5	Time			
6	Action			
7	Indication/s			
8	Contraindication/s			
9	Adverse reaction/s			
10	Nursing Implication/s			

(Total mark will be divided by 2)

Strength:

Areas to be improved:

………………………
Signature of supervisor

…………………….
Date

Annex – 3

Council for Technical Evaluation & Vocational Training

Sanothimi, Bhaktapur

Drug Card Format

Direction: Each student will submit ten drug cards for evaluation according to the given format.(one drug in each drug card)

SN	Name of drug		Classification	Route	Dose & Time	Mode of action	Indication of drugs	Contraindication of drug	Adverse reaction	Nursing implications	Remarks
	Trade Name	Generic Name									

…………………………

Signature of Supervisor

Date :

Council for Technical Evaluation & Vocational Training
Sanothimi, Bhaktapur

Course-PCL Nursing
Subject-Fundamentals of Nursing
Year-First
Area of Practice-Medical/Surgical Ward
Date -

Students Name-
Full Mark- 50
Pass Mark- 25
Students Mark-

8. Clinical Performance

Directions: Each student will spend 18 weeks in the hospital for acquiring skills in fundamentals of nursing. The expected behavior of the student in her clinical practice is given below. Each student will be evaluated during her clinical practice. Marks obtained from the evaluation will be counted in the assessment marks.

Key for Marking:

Satisfactory	Good	Excellent
1	1.5	2

S.N.	Expected Behavior	1	1.5	2
1	**Communication:** 1.1 Demonstrates respect to patient, family, teachers, seniors and team members. 1.2 Communicates effectively with the health team members and colleagues. 1.3 Demonstrates concern and care using verbal and non-verbal techniques while communicating with patients/family. 1.4 Encourages patient/family to express their feelings by answering their queries politely. 1.5 Supports traditional beliefs and practices that are beneficial to client's health.			
2	**Nursing Process:** 2.1 Assesses the patients' relevant history from the patients care taker. 2.2 Uses appropriate methods in examining the patient' care taker. 2.3 Examines the client in systematic way. 2.4 Relates data from history, and physical examination and investigation. 2.5 Uses assessment data in identifying the patients' health problems or needs and prioritizes the patients' problems using Maslow's Hierarchy of basic needs. 2.6 Formulates realistic goals (long term and short team) for the patient's care and prepares a plan of nursing actions that are within her scope of practice. 2.7 Applies knowledge from physical and social sciences in selecting nursing actions 2.8 Respects patient's preference in planning for his/her care. 2.9 Implements the plan of nursing actions to solve the patient's problems. 2.10 Evaluates and revise the care plan according to the changing need of patient.			

	2.11 Collaborates with other health team members in the provision of total patient care. 2.12 Demonstrates awareness of actions and side effects of drugs by observing the patient s after drug administration. 2.13 Records the care given in nursing note sheet. 2.14 Takeover /handover of the patient care to the staff on duty before leaving the unit. 2.15 Demonstrates concern about Proper disposal of waste product.			
3	**Professional Development:** 3.1 Arrives on duty punctually. 3.2 Demonstrates professional behavior by e.g. being neat and tidy, polite. 3.3 Shows interest in learning by asking questions and seeking for information on her own. 3.4 Shows sincerity by completing the nursing care assignment properly in time and accepts constructive feedback from teachers, seniors and colleagues. 3.5Adjusts to changes and copes in stressful situations.			
	Total			

Strength:

Areas to be improved:

…………………….. **………………**

Signature of Supervisor **Date**