FIRST P. B. B. Sc. NURSING REVISED SYLLABUS 2005

PROFORMA & GUIDELINES FOR INTERNAL

ASSESSMENT & EVALUATION.

SUBJECT :-

1. ***MATERNAL NURSING.***
2. ***CHILD HEALTH NURSING***
3. ***MEDICAL SURGICAL NURSING.***

INTERNAL ASSESSMENT PROFORMA & GUIDELINE

MATERNAL NURSING

1st year 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 Marks

(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)

Details as follows:

1. Mid-Term Exam: 050 Marks
2. Preliminary Exam: 050 Marks
3. Clinical Evaluation & Clinical Assignment: 500 Marks
   - i) Case study: Two (50marks each): 100 Marks
   - ii) Case presentation: One: 050 Marks
   - iii) Clinical evaluation (100 marks each): 300 Marks
     ANC/ LABOUR ROOM/ PNC
   - iv) Group Health teaching (One): 025 Marks
   - v) Nursing care Plan (Gyanae: One): 025 Marks

Total Marks: 600 Marks

(600 Marks from Practical to be converted into 50 Marks for Internal Assessment (Practical))

I P.B.B.Sc NURSING : MATERNAL NURSING EXPERIENCE
PROFORMA & GUIDELINE FOR CASE STUDY

1. Introduction

Purpose of the study
Objectives of the study
Duration of the study

2. History and assessment:

Patient biodata
a) Name.
b) Age.
c) Gravida.
d) Parity.
e) Educational qualification
f) Occupation
g) Income
h) Religion
i) Years of marriage
j) Marital status : Married/widow/single/divorcee
k) Family : Joint/Nuclear

3. Presenting complaints:

4. Menstrual history
a) Age of menarche
b) Duration of menstruation
c) Regularity of periods

5 Past medical history

3. Past surgical history

4. Family history

8 Personal history: Smoking/alcohol/tobacco chewing

9. Dietary history:

a) Diet Veg/Non-veg
b) Meal pattern
c) Food habits

10. Obstetric history

Gravida or parity	Nature of Delivery		Bad obstetric History if any	Outcome of pregnancy (a child)				Puerperium & Family planning History
	Full Term	Pre Term		Sex	Alive	SB	Any other	

11. Assessment

Assessment Findings	In patient	In Book	Interpretation

a) General Examination
b) Abdominal examination
c) Pelvic Examination

12. Investigations

Investigations	Results	Normal value	Remark

13. Problems/Needs identified

14. Theoretical background with correlative patient findings

a) Definition
b) Incidence and mortality rate
c) Etiology Etiological factors Present in patient & Analysis
d) Clinical manifestations Present in patient & Scientific rationale
e) Management : Medical
Obstétrical

15. Nursing Care - Objectives
Nurses Notes – Daily nurses notes

Nursing care Plan – Short Term & Long Term Plans

Date /Time	Need/ Problem	Nsg diagnosis	Objective	Plan of care	Rationale	Implementation	Evaluation

16. Prognosis

17. Discharge notes

18. Summary of the Case

19. Conclusion

20. Bibliography

EVALUATION CRITERIA FOR CASE STUDY

(Maximum Marks - 50)

SN	CRITERIA	MARKS ALLOTTED	MARKS OBTAINED	TOTAL
1.	Introduction	3.0		
2.	History & assessment	5.0		
3.	Comparative findings with patient	10.0		
4.	Theoretical knowledge & understanding of diagnosis	5.0		
5.	Nursing process	15.0		
6.	Follow-up care	5.0		
7.	Summary & conclusion	5.0		
8.	Bibliography	2.0		
	Total	**50.0**		

N B : Two Case Studies 50 marks each

Signature of Students **Signature of Supervisor**

I P.B. B.Sc NURSING : MATERNAL NURSING EXPERIENCE
PROFORMA & GUIDELINE FOR CASE PRESENTATION

1. Patient biodata

a) Name
b) Age
c) Gravida
d) Parity
e) Educational qualification
f) Occupation
g) Income
h) Religion
i) Years of marriage
j) Marital status : Married/widow/single/divorcee
k) Family : Joint/Nuclear

2. Obstetric history

Gravida or parity	Nature of Delivery		Bad obstetric History if any	Outcome of pregnancy child				Puerperium & Family planning History
	Full Term	Pre Term		Sex	Alive	SB	Any other	

5. Presenting complaints

6. Past medical history

7. Past surgical history

6. Assessment

a) General examination
b) Per abdominal examination
c) Pelvic examination

7. Investigations

8. Treatment

9. Diagnosis

a) Definition
b) Review of related anatomy & physiology

10. Clinical presentation

Signs & symptoms as per the book	Signs & symptoms present in the patient	Related path physiology

11. Management.

a) Aims.
b) Medical, obstetrical & nursing management.
c) Complications.

12. Health teaching on discharge.

13. Bibliography.

EVALUATION CRITERIA FOR CASE PRESENTATION

(Maximum Marks - 50)

SN	CRITERIA	MARKS ALLOTTED	MARKS OBTAINED	TOTAL
1	Content/ Subjective & Objective data	8		
2	Problems & needs identified & Nsg. care plan in mother & child	15		
3	Effectiveness of presentation	5		
4	Correlation with patient & book	10		
5	AV aids	5		
6	Physical arrangement	2		
7	Group participation	3		
8	Bibliography	2		
	Total	**50**		

N B : One case presentation 50 marks

Signature of Students **Signature of Supervisor**

CLINICAL EVALUATION: MATERNITY NURSING

Area :- Ante Natal Ward. (Maximum Marks – 100)

Name of the Student _____

Year: I Year PB B.Sc Nursing Duration of Experience: ___

SN	Criteria	1	2	3	4
	KNOWLEDGE, SKILL & APPLICATION				
1.	Demonstrates, sound scientific knowledge & understanding in her dealings with the patient & family				
2.	Demonstrates ability & skill in history taking of antenatal mothers				
3.	Demonstrates skill in antenatal assessment				
4.	Demonstrates skill in identifying the needs & problems of antenatal mothers				
5.	Demonstrates ability to analyze & plan care for antenatal mothers				
6.	Demonstrate ability to implement the planned care to antenatal mothers				
7.	Demonstrate ability in preparing patients for surgical intervention if necessary				
8.	Able to perform & assist in diagnostic & treatment modalities				
9.	Demonstrate skill in intrauterine fetal monitoring				
10.	Makes relevant observations & record & reports them promptly & effectively				
11	Identifies risk factors & manages emergency situations effectively & promptly				
12.	Works independently & makes prompt, relevant decisions in all situations				
13.	Able to carry out health talks & incidental health teachings effectively				
14.	Demonstrates sound knowledge of drug used safely during antenatal period.				
15.	Able to establish therapeutic relationship with the patient & family				
	Personality aspects				
16.	Professional grooming & turn-out in uniform				
17.	Patient, keen & attentive listener				
18.	Courteous, tactful & considerate in all her dealings with colleagues, seniors, patients & family				
19.	Expresses ideas/concepts concisely				
20.	Enthusiastic & interested, takes interest in clinical setting				
21.	Follows instructions & exhibits positive behavioral changes as and when required				
22.	Displays emotional maturity in all her dealings in the clinical setting				
23.	Demonstrates evidence of self learning by additional reading of current literature				
24.	Displays persuasive, assertive & compulsive leadership behavior, affecting changes in patient's behavior in clinical setting				
25.	Practices economy in relation to time effort & material in all aspects of care				

Positive & Negative Aspects.

Signature of Student Signature of Clinical supervisor

CLINICAL EVALUATION: MATERNITY NURSING

Area :- Labour Room. (Maximum Marks – 100)

Name of the Student _____

Year: I Year PB B.Sc Nursing Duration of Experience: _____

SN	Criteria	1	2	3	4
	KNOWLEDGE, SKILL & APPLICATION				
1.	Demonstrates, sound scientific knowledge & understanding in her dealings with the patient & family				
2.	Demonstrates ability & skills in history taking of maternity patients				
3.	Demonstrate ability to perform general, abdominal & per-vaginal examination				
4.	Demonstrate ability to analyze & interpret the data collected for nursing care planning				
5.	Demonstrate the ability to identify the needs of maternity patients & neonates				
6.	Demonstrates ability in planning nursing care & implement according to the needs of the patients.				
7.	Displays skill in trolley setting & assisting in instrumental deliveries & other procedures				
8.	Confident & skillful in conducting normal deliveries with episiotomy & immediate post natal care				
9.	Identifies risk factors & manages emergency situations effectively				
10.	Works independently & makes prompt, relevant decisions in all situations				
11.	Able to carry out health talks & incidental health teachings effectively				
12.	Demonstrates sound knowledge of drug used in obstetrics & gynaec practice				
13.	Able to establish therapeutic relationship with the patient & family				
14.	Able to perform & assist in diagnostic procedures & treatment modalities				
15.	Makes relevant observations & records & reports them promptly & effectively.				
	Personality aspects				
16.	Professional grooming & turn-out in uniform				
17.	Patient, keen & attentive listener				
18.	Courteous, tactful & considerate in all her dealings with colleagues, seniors, patients & family				
19.	Expresses ideas/concepts concisely				
20.	Enthusiastic & interested, takes interest in clinical setting				
21.	Follows instructions & exhibits positive behavioral changes as and when required				
22.	Displays emotional maturity in all her dealings in the clinical setting				
23.	Demonstrates evidence of self learning by additional reading of current literature				
24.	Displays persuasive, assertive & compulsive leadership behavior, affecting changes in patient's behavior in clinical setting				
25.	Practices economy in relation to time effort & material in all aspects of care				

Positive & Negative aspects.

Signature of Student Signature of Clinical supervisor

CLINICAL EVALUATION: MATERNITY NURSING

Area :- Post Natal Ward. (Maximum Marks – 100)

Name of the Student _____

Year: I Year PB B.Sc Nursing Duration of Experience:____

SN	Criteria	1	2	3	4
	KNOWLEDGE, SKILL & APPLICATION				
1.	Demonstrates, sound scientific knowledge & understanding dealings with the patient & family				
2.	Demonstrates ability & skill in history taking of postnatal mothers				
3.	Demonstrates skill in postnatal assessment				
4.	Demonstrates skill in identifying the needs & problems of post natal mothers & neonates				
5.	Demonstrates ability to analyze & plan care for postnatal mothers & neonates				
6.	Demonstrate ability to implement the planned care to post natal mothers & neonates				
7.	Demonstrate ability in care of post LSCS patients.				
8.	Able to perform & assist in diagnostic & treatment modalities				
9.	Demonstrate skill in immediate newborn assessment & care				
10.	Makes relevant observations & record & reports them promptly & effectively				
11	Identifies risk factors & manages emergency situations effectively & promptly				
12.	Works independently & makes prompt, relevant decisions in all situations				
13.	Able to carry out health talks & incidental health teachings effectively				
14.	Demonstrates sound knowledge of drug used in obstetrics & gynaec practice				
15.	Able to establish therapeutic relationship with the patient & family				
	Personality aspects				
16.	Professional grooming & turn-out in uniform				
17.	Patient, keen & attentive listener				
18.	Courteous, tactful & considerate in all her dealings with colleagues, seniors, patients & family				
19.	Expresses ideas/concepts concisely				
20.	Enthusiastic & interested, takes interest in clinical setting				
21.	Follows instructions & exhibits positive behavioral changes as and when required				
22.	Displays emotional maturity in all her dealings in the clinical setting				
23.	Demonstrates evidence of self learning by additional reading of current literature				
24.	Displays persuasive, assertive & compulsive leadership behavior, affecting changes in patient's behavior in clinical setting				
25.	Practices economy in relation to time effort & material in all aspects of care				

Positive & Negative aspects.

Signature of Student Signature of Clinical supervisor

I P.B. B-Sc NURSING: MATERNAL NURSING EXPERIENCES
PROFORMA 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

Health teaching plan

SN	Time	Specific objectives	Content	Teaching Learning Activities	AV Aids	Evaluation

References:

EVALUATION CRITERIA FOR HEALTH TEACHING

(Maximum Marks – 25)

SN	Criteria	Total Marks
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**

I P.B.B.Sc NURSING : MATERNAL NURSING EXPERIENCE

PROFORMA & GUIDELINE FOR NURSING CARE PLAN (GYNAEC)

I Patient Biodata

a) Name
b) Age
c) Gravida
d) Parity
e) Educational qualification
f) Occupation
g) Income
h) Religion
i) Years of marriage
j) Marital status : Married/widow/single/divorcee

II Spouse's particulars

a) Age
b) Educational qualification
c) Occupation
d) Income
e) Religion

III Presenting complaints: In chronological order

a) Menstrual history
b) Age of menarche
c) Duration of menstruation
d) Regularity of periods
e) Age of menopause

IV Contraceptive history

V Past history of pregnancy

VI Past medical history: Heart disease/hypertension/diabetes Mellitus/tuberculosis/malaria/kidney disease

VII History of allergy/blood transfusion

VIII Past surgical history

IX Family history

X Personal history: Smoking/alcohol/tobacco chewing

XI Dietary history:

a) Diet Veg/Non-veg
b) Meal pattern
c) Food habits

XII General examination

a) Appearance
b) Build
c) Anthropometric measurements (relevant)

XIII Psychosocial Status

XIV Investigations done

XV Management – Aim
Objectives of Nursing Care

XVI Medication

SN	DRUG	DOSE	FREQ	TIME	ACTION	SIDE EEFFECTS	DRUG INTERACTION	NURSES RESPONSIBILITY

XVII Nursing care Plan(Short Term & Long Term)

ASSESSMENT	NSG DIAGNOSIS	EXPECTED OUTCOME	PLAN OF CARE	RATIONALE	IMPLEMENTATION	EVALUATION

XVIII Health education on discharge

XIX Bibliography

EVALUATION CRITERIA FOR NURSING CARE PLAN

Maximum marks 25

SN	CRITERIA	MARKS ALLOTTED	MARKS OBTAINED	TOTAL
1.	History taking	3		
2.	Assessment of needs & problems	5		
3.	Nursing process	8		
4.	Implementation of care	5		
5.	Follow-up care	2		
6.	Bibliography	2		
	Total	**25**		

N B : One Nursing Care Plan : 25 Marks

Signature of Students **Signature of Supervisor**

INTERNAL ASSESSMENT PROFORMA & GUIDELINE

CHILD HEALTH NURSING

I 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 Marks

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

Internal assessment (Practicum): **50 Marks**

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

Practical Exam

1) Mid-Term exam 050 Marks
2) Prelim 050 Marks
3) Clinical Evaluation & Clinical Assignment:500 Marks
   i) Case study (two): 100 Marks
   (One Paediatric Medical &
   One paediatric surgical-50 marks each)
   ii) Case presentation (one) 050 Marks
   iii) Clinical evaluation of compressive
   nursing care- 300 Marks
   (One paediatric medical, One paediatric
   surgical & One NICU-100 Marks each)
   iv) Health teaching 025 Marks
   v) Assessment of growth and development:100 Marks
   (Preterm baby, Infant, Toddler, Preschloolar,
   and schoolar (Marks 20 each).

Total: **675 Marks**

(675 Marks from Practicum to be converted into 50 Marks)

I P B. B. Sc NURSING : CHILD HEALTH NURSING

PROFORMA & GUIDELINE FOR CASE STUDY

I] Patient's Biodata

Name, Age, Sex, Religion, Marital status, Occupation, Source of health care, Date of admission, Provisional Diagnosis, Date of surgery if any.

II] Presenting complaints

Describe the complaints with which the child has been admitted to the ward.

III] Child's Personal data:

- Obstetrical history of mother
- Prenatal & natal history
- Growth & Development (compare with normal)
- Immunization status
- Dietary pattern including weaning
- Nutritional status
- Play habits
- Toilet training habits
- Sleep pattern
- Schooling

IV] Socio-economic status of the family:

Monthly income, expenditure on health, food, education

V] History of Illness

i) History of present illness – onset, symptoms, duration, precipitating/ aggregating factors

ii) History of past illness – Illnesses, hospitalizations, surgeries, allergies.

iii) Family history – Family tree, family history of illness, risk factors, congenital problems, psychological problems.

VI] Diagnosis :- Provisional & confirm.

VII] Description of disease: Includes the followings**:**

1. Definition
2. Related anatomy and physiology
3. Etiology & risk factors
4. Path physiology
5. Clinical features

VIII] Physical Examination of Patient

Clinical features present in the book	present in the patient

IX] Investigations:-

Date	Investigation done	Result	Normal value	Inference

X] Management - Medical / Surgical

- Aims of management
- Objectives of Nursing Care Plan

XI] Medical Management

SN	Drug (Pharmacological name)	Dose	Frequency / Time	Action	Side effects & drug interaction	Nurse's responsibility

XII] Nursing management (Use Nursing Process) (Short Term & Long Term Plans).

Assessment	Nursing Diagnosis	Objective	Plan of care	Rationale	Implementation	Evaluation

XIII] Complications

Prognosis of the patient

XIV] Day to day progress report of the patient

XV] Discharge planning

XVI] References:

EVALUATION CRITERIA FOR CASE STUDY

(Maximum Marks: 50+50=100)

SN	Item	Marks
01.	Introduction.	03
02.	History and assessment.	05
03.	Comparative finding with patients.	10
04.	Theoretical knowledge and understanding of diagnosis.	05
05.	Nursing Process.	15
06.	Follow up care.	05
07.	Summary and conclusion.	05
08.	Bibliography.	02
	Total	50

Note :- One Medical and One Surgical Pediatrics Case study. 50 Marks each.

I P B B Sc NURSING: CHILD HEALTH NURSING
PROFORMA & GUIDELINE FOR CASE PRESENTATION

I] Patient Biodata

Name, Age, Sex, Religion, Marital status, Occupation, Source of health care, Date of admission, Provisional Diagnosis, Date of surgery if any.

II] Presenting complaints

Describe the complaints with which the child has been brought to the hospital

III] Child's Personal data:

- Obstetrical history of mother
- Prenatal & natal history
- Growth & Development, compare with normal (Refer Assessment Proforma).
- Immunization status
- Dietary pattern including weaning(Breast feeding relevant to age)
- Play habits
- Toilet training
- Sleep pattern
- Schooling

IV] Socio-economic status of the family: Monthly income, expenditure on health, food, education etc.

V] History of Illness

i) History of present illness – onset, symptoms, duration, precipitating/aggravating factors

ii) History of past illness – Illnesses, surgeries, allergies, medications

iii) Family history – Family tree, history of illness in the family members, risk factors, congenital problems, psychological problems.

VI] Diagnosis: (Provisional & confirmed).

Description of disease: Includes the followings

2. Definition.
3. Related anatomy and physiology
4. Etiology & risk factors
5. Path physiology
6. Clinical features.

VII] Physical Examination of Patient (Date & Time)

Physical examination: with date and time.

Clinical features present in the book	Present in the patient

VIII] Investigations

Date	Investigation done	Results	Normal value	Inference

IX] Management - (Medical /Surgical)

- Aims of management
- Objectives of Nursing Care Plan

X] Treatment:

SN	Drug (Pharmacological name)	Dose	Frequency / Time	Action	Side effects & drug interaction	Nurse's responsibility

- Surgical management
- Nursing management

XI] Nursing Care Plan: Short Term & Long Term plan.

Assessment	Nursing Diagnosis	Objective	Plan of care	Rationale	Implementation	Evaluation

XII] Discharge planning:

It should include health education and discharge planning given to the patient.

XIII] Prognosis of the patient:

XIV] Summary of the case:

XV] References:

EVALUATION CRITERIA FOR CASE PRESENTATION

(Maximum Marks – 50)

Criteria	Total Marks
1. Content Subjective & objective data.	**08**
2. Problems & need Identified & Nsg. Care Plan.	**15**
3. Effectiveness of presentation.	**05**
4. Co-relation with patient & book.	**10**
5. Use of A. V. Aids.	**05**
6. Physical arrangement.	**02**
7. Group participation.	**03**
8. Bibliography & references.	**02**
Total	**50**

CLINICAL EVALUATION: CHILD HEALTH NURSING

Area :- Paed. Medical / Paed. Surgical Nursing. Maximum Marks – 100

Name of the Student

Year: I Year P. B. B.Sc Nursing Duration of Experience

SN	Criteria	1	2	3	4
	KNOWLEDGE, SKILL & APPLICATION				
1.	Possess sound knowledge of principles of Paed Nsg				
2.	Has an understanding of the modern trends and current issues in paed nsg practice				
3.	Has knowledge of normal growth and development of children				
4.	Has adequate knowledge of paed nutrition and applies principles of normal therapeutic diet				
5.	Able to elicit health history of child and family accurately				
6.	Identifies need/problems of Children with ***Medical & Surgical*** problems				
7.	Able to plan, implement and evaluate care both preoperatively and post operatively				
8.	Able to calculate and administer medications to children accurately				
9.	Recognizes the role of play in children & facilitates play therapy for hospitalized children				
10.	Acts promptly in paediatric emergencies				
11.	Makes relevant observations, maintain records & reports promptly & effectively.				
12.	Skilful in carrying out physical examination, developmental screening and detecting deviations from normal				
13.	Able to carry out therapeutic regime related to children in accordance with principles of paediatric Nsg				
14.	Identifies opportunities for health education & rehabilitation and encourages parent participation in the care of the child				
15.	Demonstrates evidence of self learning by reading of current literature/seeking help from experts.				
	Personality aspects				
16.	Professional grooming & turn-out				
17.	Able to think logically, alert, attentive and well informed				
18.	Communicates effectively				
19.	Enthusiastic & takes interest in clinical setting				
20.	Trust worthy and reliable				
21.	Courteous, tactful & considerate in all her dealings with colleagues, seniors, patients & family				
22.	Displays emotional maturity and leader ship qualities.				
23.	Follows instructions & exhibits positive behavioral changes as and when required				
24.	Practices economy in relation to time, effort & material in all aspects of care				
25.	Complete assignments in time with self motivation and efforts.				

Note: Same format to be used for assessment of Paed. Medical & Paed. Surgical Nursing

Positive & Negative aspects.

Signature of Student Signature of Clinical supervisor

CLINICAL EVALUATION: CHILD HEALTH NURSING

Area :- NICU **(Maximum Marks – 100)**

Name of the Student

Year: I Year P.B B. Sc Nursing Duration of Experience:

S. No	Criteria	1	2	3	4
	KNOWLEDGE SKILL & APPLICATION.				
1.	Possess sound knowledge of principles of Paed Nsg and the modern trends and current issues in Paed Nsg practice				
2.	Is familiar with the NICU protocol for maintenance of asepsis and prevention of cross infection in NICU				
3.	Has knowledge and skill in assessment & care of New born				
4.	Possess knowledge and demonstrates skill in neonatal resuscitation				
5.	Has adequate knowledge, identifies needs and exhibit skill and efficiency in caring for the LBW infants				
6.	Makes relevant observations, maintains records & reports promptly & effectively				
7.	Has adequate knowledge regarding feeding and follows safe feeding practices				
8.	Able to calculate and administer medications to neonates accurately				
9.	Demonstrates ability to care for neonates in incubator and on ventilator.				
10.	Acts promptly in paediatric emergencies				
11.	Able to apply principles of paed nsg in the management of neonates under phototherapy.				
12.	Has knowledge of exchange transfusion				
13.	Able to identify early manifestations of common neonatal problems and manage accordingly				
14.	Identifies opportunities for health education and encourages parent participation in the care of the child				
15.	Demonstrates evidence of self learning by reading of current literature/seeking help from experts.				
	PERSONALITY ASPECTS.				
16.	Professional grooming & turn-out				
17.	Able to think logically, alert, attentive and well informed				
18.	Communicates effectively				
19.	Enthusiastic & takes interest in clinical setting				
20.	Trust worthy and reliable				
21.	Courteous, tactful & considerate in all her dealings with colleagues, seniors, patients & family				
22.	Displays emotional maturity and leadership qualities.				
23.	Follows instructions & exhibits positive behavioral changes as and when required				
24.	Practices economy in relation to time, effort & material in all aspects of care				
25.	Complete assignments in time with self motivation and effort				

Positive & Negative aspects.

Signature of Student Signature of Clinical supervisor

1st YEAR P. B. B. Sc. NURSING.
PROFORMA & GUIDELINE FOR HEATLH 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 group.
8. General objectives.
9. Specific objectives.
10. A. V. Aids. used.

Plan for Health Teaching.

SN	Time	Specific objectives	Content	Teaching learning activities	A. V. Aids	Evaluation.

References.

EVALUATION CRITERIA FOR HELATH TEACHING.

(Maximum Marks – 25)

SN	Criteria	Marks Allotted.	Marks Obtained	Total
01.	Lesson plan.	6		
02.	Presentation.	5		
03.	Communication skill	3		
04.	A. V. Aids.	4		
05.	Relevance to the topic.	3		
06.	Group participation.	2		
07.	Bibliography / References.	2		
	Total	25		

Signature of Student Signature of Clinical supervisor

I P B B Sc NURSING: CHILD HEALTH NURSING

PROFORMA & GUIDELINE FOR EXAMINATION AND ASSESSMENT OF NEW BORN (Preterm Baby)

I] Biodata of baby and mother

Name of the baby (if any) : Age:
Birth weight : Present weight:
Mother's name : Period of gestation:
Date of delivery :
Identification band applied :
Type of delivery : Normal/ Instrumental/ Operation
Place of delivery : Hospital/ Home
Any problems during birth : Yes/ No
If Yes explain :
Antenatal history :
Mother's age : Height: Weight:
Nutritional status of mother :
Socio-economic background :

II] Examination of the baby :

Characteristics	In the Baby	Comparison with the normal
1. Weight 2. Length 3. Head circumference 4. Chest circumference 5. Mid-arm circumference 6. Temperature 7. heart rate 8. Respiration		

III] General behavior and observations

Color :
Skin/ Lanugo :
Vernix caseosa :
Jaundice :
Cyanosis :
Rashes :
Mongolian spot :
Birth marks :
Head :

- Anterior fontanel :
- Posterior fontanel :
- Any cephalhematoma/ caput succedaneum
- Forceps marks (If any) :

Eyes : Face:

Cleft lip/ palate

Ear Cartilage :

Trunk:

- Breast nodule
- Umbilical cord
- Hands :

Feet/Sole creases :

Legs :

Genitalia :

Muscle tone :

Reflexes

- Clinging :
- Laughing/sneezing :
- Sucking :
- Rooting :
- Gagging :
- Grasp :
- Moro :
- Tonic neck reflex :

Cry: Good/ week

APGAR scoring at birth :

First feed given :

Type of feed given :

Total requirements of fluid & calories:

Amount of feed accepted :

Special observations made during feed:

Care of skin :

Care of eyes, nose, ear, mouth :

Care of umbilicus and genitalia :

Meconium passed/ not passed :

Urine passed/ not passed :

IV] Identification of Health Needs in Baby & Mother.

V] Health education to mother about Breast feeding :

Care of skin, eye, and umbilicus ect.

V]Bibliography

Evaluation Criteria :Examination & Assessment of Newborn

(Maximum Marks : 25)

S. No.	Item	Marks
1	Adherence to format	02
2	Skill in Physical examination & assessment	10
3	Relevance and accuracy of data recorded	05
4	Interpretation of Priority Needs Identification of baby & mother	06
5	Bibliography	02
	Total	25

(Note: To be counted out of 20 Marks)

I P B B Sc NURSING: CHILD HEALTH NURSING

PROFORMA & GUIDELINE FOR ASSESSMENT OF GROWTH & DEVELOPMENT

(Infant)

I] Identification Data

Name of the child :
Age :
Sex :
Date of admission :
Diagnosis :
Type of delivery : Normal/ Instrumental/LSCS
Place of delivery : Hospital/ Home
Any problem during birth : Yes/ No
If yes, give details :
Order of birth :

II] Growth & development of child & comparison with normal:

Anthropometry **In the Child** **Normal**

Weight
Height
Chest circumference
Head circumference
Mid arm circumference
Dentition

III] Milestones of development:

Developmental milestones	In Child	Comparison with the normal
1. Responsive smile 2. Responds to Sound 3. Head control 4. Grasps object 5. Rolls over 6. Sits alone 7. Crawls or creeps 8. Thumb-finger co-ordination (Prehension) 9. Stands with support 10. Stands alone 11. Walks with support 12. Walks alone 13. Climbs steps 14. Runs		

IV] Social, Emotional & Language Development:

Social & emotional development	In Child	Comparison with the normal
Responds to closeness when held Smiles in recognition Recognizes mother Coos and gurgles Seated before a mirror, regards image Discriminates strangers Wants more than one to play Says Mamma, Papa Responds to name, no or give it to me Increasingly demanding Offers cheek to be kissed Can speak single word Use pronouns like I, Me, You Asks for food, drinks, toilet, Plays with doll Gives full name Can help put things away Understands difference between boy & girl Washes hands Feeds himself/herself Repeats with number Understands under, behind, inside, outside Dresses and undresses		

V] Play habits

Child's favourite toy and play:

Does he play alone or with other children?

VI] Toilet training

Is the child trained for bowel movement & if yes, at what age:

Has the child attained bladder control & if yes, at what age:

Does the child use the toilet?

VII] Nutrition

- Breast feeding (as relevant to age)
- Weaning Has weaning started for the child: Yes/No If yes, at what age & specify the weaning diet. Any problems observed during weaning:

Meal pattern at home

Sample of a day's meal: Daily requirements of chief nutrients :

Breakfast: Lunch: Dinner: Snacks:

VIII] Immunization status & schedule of completion of immunization.

IX] Sleep Pattern

How many hours does the child sleep during day and night?

Any sleep problems observed & how it is handled:

X] Schooling

Does the child attend school?

If Yes, which grade and report of school performance:

XI] Parent child relationship

How much time do the parents spend with the child?

Observation of parent-child interaction:

XII] Explain parental reaction to illness and hospitalization

XIII] Child's reaction to the illness & hospital team

XIV] Identification of needs on priority

XV] Conclusion

XVI] Bibliography

Evaluation Criteria :Assessment of Growth & Development (New born baby)

(Maximum Marks : 25)

S. No.	Item	Marks
1.	Adherence to format	02
2.	Skill in Physical examination & assessment	10
3.	Relevance and accuracy of data recorded	05
4.	Interpretation Identification of Needs	05
5.	Bibliography	03
	Total	25

Note: 1. To be counted out of 20 Marks.

2. Same format to be used for assessment of Toddler, Preschooler child & Schooler child.

INTERNAL ASSESSMENT PROFORMA & GUIDELINE

MEDICAL SURGICAL NURSING

I P.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)

Practical Exams: 100Marks

Mid-Term Exam: 050 Marks
Prelim: 050 Marks

Clinical Evaluation & Clinical Assignment: 600 Marks

1. Case Study (Two) (50 Marks Each) 100 Marks
   (One Medical & One Surgical Nursing)
2. Case Presentation (Two) (50 Marks Each) 100 Marks
   (any specialty i.e., ENT/Ophthalmology/Skin/Burns.)
3. Nursing care plans (25 marks each) 100 Marks
   i.e., Neurology/Orthopedic/Cardiology/Onchology.
4. Clinical Evaluation Comprehensive Nursing Care-300 Marks
   (100 marks each) i.e., medical Nursing, Surgical Nursing, Critical Care Units

Total: 700 Marks

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

I P B B Sc NURSING : MEDICAL SURGICAL NURSING

PROFORMA & GUIDELINE FOR CASE STUDY

Area :- Medical / Surgical. **(Maximum Marks: 50+50=100)**

Name of the Student

Year: I Year P.B. B.Sc Nursing Duration of Experience:

01. Selection of patient.

02. Demographic data of the patient.

03. Medical history past and present illness.

04. Comparison of the patient's disease with book picture.
    a) Anatomy and physiology.
    b) Etiology.
    c) Patho physiology.
    d) Signs and symptoms.
    e) Diagnosis provisional & final
    f) Investigations
    g) Complications & prognosis.

05. Management:- Medical or Surgical
    a) Aims and objectives.
    b) Drugs and Medications.
    c) Diet.

06. Nursing Management (Nursing Process approach)
    a) Aims and objectives.
    b) Assessment and specific observations.
    c) Nursing diagnosis.
    d) Nursing care plan (Short term & long term with rationale.)
    e) Implementation of nursing care with priority.
    f) Health teaching.
    g) Day to day progress report & evaluation.
    h) Discharge planning.

07. Drug Study.

08. Research evidence.

09. Summary and conclusion.

10. Bibliography.

EVALUATION CRITERIA FOR CASE STUDY.

(Maximum Marks: 50+50=100)

Sr. No.	Criteria	Marks Allotted.	Marks Obtained	Total
01.	Assessment	5		
02.	Theoretical knowledge about disease (Medical/Surgical.	5		
03.	Comparative study of the patient's disease & book picture.	10		
04.	Management: Medical or Surgical.	5		
05.	Nursing Process.	15		
06.	Drug study.	3		
07.	Summary & conclusion including research evidence.	5		
08.	Bibliography.	2		
	Total	50		

Note :- One Medical & One Surgical Nursing Case study of 50 Marks each.

Signature of Student

Signature of Clinical supervisor

I P B B Sc NURSING: MEDICAL AND SURGICAL NURSING
PROFORMA & GUIDELINE FOR CASE PRESENTATION

I] Patient Biodata

Name, Age, Sex, Religion, Marital status, Occupation, Source of health care, Date of admission, Provisional Diagnosis, Date of surgery if any.

II] Presenting complaints

Describe the complaints with which the child has been brought to the hospital

III] Socio-economic status of the family: Monthly income, expenditure on health, food, education etc.

IV] History of Illness (Medical & Surgical)

i) History of present illness – onset, symptoms, duration, precipitating/aggravating factors

ii) History of past illness surgery, allergies, medications etc.

iii) Family history – Family tree, history of illness in the family members, risk factors, congenital problems, psychological problems etc.

V] Diagnosis: (Provisional & confirmed).

Description of disease: Includes the followings

1. Definition.
2. Related anatomy and physiology
2. Etiology & risk factors
3. Path physiology
5. Clinical features.

VI] Physical Examination of Patient (Date & Time)

Physical examination: with date and time.

Clinical features present in the book	Present in the patient

VII] Investigations

Date	Investigation done	Results	Normal value	Inferences

VIII] Management - (Medical /Surgical)

a) Aims of management
b) Objectives of Nursing Care Plan

IX] Treatment:

SN	Drug (Pharmacological name)	Dose	Frequency / Time	Action	Side effects & drug reaction	Nurse's responsibility

- Medical or Surgical Management.
- Nursing management

X] Nursing Care Plan: Short Term & Long Term plan.

Assessment	Nursing Diagnosis	Objective	Plan of care	Rationale	Implementation	Evaluation

XI] Discharge planning:

It should include health education and discharge planning given to the patient.

XII] Prognosis of the patient:

XIII] Summary of the case:

IVX] References:

EVALUATION CRITERIA FOR CASE PRESENTATION
(Maximum Marks: 50+50=100)

SN	Criteria	Marks Allotted.	Marks Obtained	Total
01.	Content Subjective & objective data.	08		
02.	Problems & need Identified & Nsg. Care Plan.	15		
03.	Effectiveness of presentation.	5		
04.	Co-relation with patient & book.	10		
05.	Use of A. V. Aids.	5		
06.	Physical arrangement.	2		
07.	Group participation.	3		
08.	Bibliography & references	2		
	Total	50		

(Note :- Two presentations of 50 marks each from any specialty i.e. ENT / Ophthalmology / Skin / Burns.)

CLINICAL EVALUATION: COMPREHENSIVE NURSING CARE

Area :- Medical / Surgical / Critical Care Nursing **(Maximum Marks – 100)**

Name of the Student

Year: I Year P.B. B.Sc Nursing Duration of Experience:

SN	Criteria	1	2	3	4	5
I.	UNDERSTANDING OF PATIENT AS PERSON. **A. Approach.** 1. Rapport with patient/ family members. 2. Collects significant information. **B. Understanding of patient's health problems.** 1. Knowledge about disease condition. 2. Knowledge about investigations. 3. Knowledge about treatment. 4. Knowledge about progress of the patient.					
II.	NURSING CARE PLAN. **A. Assessment of the condition of the patient.** 1. History taking – past & present health and illness. 2. Specific observation of the patient. 3. Nursing diagnosis. **B. Development of the short – term & long term Nursing care plans.** 1. Identification of all problems in the patient/ family. 2. Prioritization & implementation of the plans. 3. Evaluation of the care given & replanning.					
III.	TECHNICAL SKILL 1.Economical & safe adaptation to the situation & available facilities. 2.Implements the procedure with skill speed & completeness.					
IV.	RECORDING & REPORTING. 1.Prompt, precise, accurate & relevant. 2.Maintenance of clinical experience file.					
V.	HEALTH TEACHING. 1.Incidental/ planned teaching with principles of teaching & learning. 2.Uses visual aids appropriately.					
VI.	PERSONALITY 1. Professional appearance (uniform, dignity, tact fullness interpersonal relationship, punctuality etc. 2. Sincerely, honesty & Sense of responsibility.					
	Total Marks					

Note: Same Performa to be used for Medical, Surgical & Critical Care Nursing having 100 Marks each, Total 300 Marks

Positive & Negative aspects.

Signature of Student Signature of Clinical supervisor