



2.5.4 The Institution provides opportunities to students for midcourse improvement of performance through specific interventions

- ❖ List of opportunities/ initiatives provided for the students for midcourse improvement of academic performance in the examinations
 - ❖ Corrective assignments
 - ❖ Revision classes
 - Tutorials and discussions
 - ❖ Small Group Discussions (SGDs)
 - ❖ Extra-classes (Special classes)
 - Morning session (7:30 to 8:30 a.m.)
 - Evening session (4 to 5 p.m.)
 - ❖ In-campus supervised learning hours (for hostel students)
 - Time: 6 p.m. to 8 p.m.
 - ❖ Frequent slip tests, re-tests and viva voce programs
 - ❖ OSPE (Objective Structured Practical Examination) and OSCE (Objective Structured Clinical Examination) -based assessments
 - ❖ Close attention through mentor-mentee program
 - ❖ Motivational speech by invited guest speakers
 - Importance of meditation and yoga to improve concentration
 - ❖ Encouragement to attend remedial online e-classes and focus on self-directed learning (SDL).

CORRECTIVE ASSIGNMENTS

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NARAYANA COLLEGE OF NURSING
CHINTHAREDDY PALEM: NELLORE
MEDICAL SURGICAL NURSING
II BSc NURSING

BSc/MSN/26

CHECKLIST FOR CARE OF INTERCOSTAL DRAINAGE

STUDENT NAME: SANDRA MOL P-S

WARD
DATE:

: GENERAL SURGERY
: 08/10/2024

SNO.	CRITERIA	5	4	3	2	1
21.	PRE PROCEDURE Check for 3 c's		/			
22.	Explain the procedure to the patient		/	/		
23.	Assemble the articles at bed side			/		
24.	Obtain informed consent from the patient		/			
25.	Perform hand hygiene			/		
26.	PROCEDURE: Assess the surgeon with insertion of chest tubes		/		/	
27.	Connect the chest tubes in water seal drainage					
28.	Assess the client for respiratory distress and chest pain		/	/	/	
29.	Observe the following Chest tube dressing Tubing for kinks, dependent loops		/			
30.	Chest drainage system should be upright and below the level of tube insertion			/		
31.	Observe for Water seal for fluctuations with the patients inspirations and exertions		/		/	
32.	Observe for Bubbling in water seal bottle or chamber			/		
33.	Record color and amount of drainage and follow up, care after the initial connection		/			
34.	Ensure drainage tube in water seal 2.5 cm below the water level			/		
35.	Establish original level of fluid by marking with pen or tape, filling to a present amount		/			
36.	Ensure the two tubing's ,clamps are always at the patient's bedside				/	
37.	Maintain high fowlers or medium fowler's position		/			
38.	Maintain all connections between the chest and drainage tubes intact and taped.				/	
39.	AFTER PROCEDURE: Perform hand washing every time handling the tubes		/		/	
40.	Recording and reporting	/				
TOTAL						22

SIGNATURE OF THE STUDENT *Sandra*

SIGNATURE OF THE EVALUATOR

REMARKS

— Good and add innovative techniques on intercostal drainage

N. Mary

Dr. B. Anj
Principal

ASSIGNMENT ON CARE OF INTERCOSTAL DRAINAGE

Submitted to,
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Submitted by,
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IInd year BSc (N)
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M. Mary

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INTRODUCTION

A chest drain is a tube inserted through the chest wall b/w the ribs and into the pleural cavity to allow drainage of air, blood fluids or puss out of the chest.

It allows draining of the pleural contents and re expansion of the lungs.

DEFINITION

Intercostal drainage is the drainage of fluid (air/ blood and puss discharges from the pleural space through intercostal space.

INDICATION

- Pneumothorax
- Hemothorax.
- empyema
- malignant pleural effusion
- Pleurodesis.

CONTRAINDICATION

- several pleural adhesions
- Incorrected.
- Diaphragmatic hernia.

POSITION

- sitting position
- lateral decubitus position
- localized pathology

EQUIPMENTS

- Sterile gloves
- gowns
- Antiseptic solution
- Sterile sponges
- Gauze swabs
- Syringes
- Local anesthetic
- Blade
- Curved clamp
- Guidance with dilators
- Chest tube
- Connecting tube
- Closed drainage system
- Dressing materials.

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CHEST TUBE TYPES

- Thoracostomy chest tube
- Thurn chest tube
- valve catheter
- Guidance type chest drain.

NURSING CARE

- Encourage deep breaths and cough
- adequate pain relief
- Encourage movement
- Assess water level tidaliens
- Avoid milking and clamping
- Ensure collection unit below the level of chest
- Suction can improve the speed of air and fluid removal

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CONCLUSION

A chest drain is a tube inserted through the chest wall below the ribs and into the pleural cavity to allow drainage of air, blood, fluid or pus out of the chest.

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page no: 770-775

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CHINTHAREDDY PALEM, NELLORE
MEDICAL SURGICAL NURSING
II B.Sc (N)

BSc/MSN/3

CHECKLIST FOR INTRAVENOUS DRUG ADMINISTRATION

STUDENT NAME: SANDRA MOL P.S
WARD : GENERAL MEDICINE

DATE : 02/08/2023

Sl.No	ITEMS	5	4	3	2	1
1.	BEFORE PROCEDURE: <i>First Check:</i> Checks medication order on Medication Administration Record against physician's order (patient name, identification number, medication, dose, route, time, and allergies) Check physician order.		✓			
2.	<i>Second Check:</i> When preparing medication, verifies correct medication, dose, time, route, and expiration date.		✓			
3.	<i>Third Check:</i> At the bedside, verifies correct patient (using two methods of identification, including armband), medication, expiration date, dose, route, time, and presence of drug allergies.	✓				
4.	Follow the Ten rights of drug administration		✓			
5.	Assess for any contraindications to client receiving medications (NPO, hypotension, heart rate, allergies, labs, etc.)			✓		
6.	DURING PROCEDURE Wash the hands		✓			
* 7.	Reassure the patient and explain the procedure to the patient			✓		
8.	Uncover arm completely			✓		
9.	Have the patient relax and support his arm below the vein to be used.		✓			
10.	Apply tourniquet and look for a suitable vein.			✓		
11.	Wait for the vein to swell.	✓				
12.	Disinfect skin with alcohol swab			✓		
13.	Stabilize the vein by pulling the skin taut in the longitudinal direction of the vein. Do this with the hand you are not going to use for inserting the needle.	✓				
14.	Insert the needle at an angle of around 35 degrees.			✓		
15.	Puncture the skin and move the needle slightly into the vein (3-5 mm)		✓			
16.	Hold the syringe and needle steady	✓				
17.	Aspirate. If blood appears hold the syringe steady, you are in the vein. If it does not come, try again		✓			
18.	Loosen tourniquet.			✓		
19.	Inject (very) slowly. Check for pain, swelling, hematoma; if in doubt whether you are still in the vein aspirate again!		✓			
* 20.	Withdraw needle swiftly. Press sterile cotton wool onto the opening. Secure with adhesive tape.	✓				

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21	Check the patient's reactions and give additional reassurance, if necessary	✓				
22	AFTER PROCEDURE Replace all the article		✓			
23	Dispose of waste safely	✓				
24	Wash the hands		✓			
25	Recording and Reporting			✓		

SIGNATURE OF THE STUDENT *Beth*

SIGNATURE OF THE EVALUATOR *N. Mary*

REMARKS: *Lack of contents*
— Include procedure & patient preparation, as per manual

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ASSIGNMENT ON INTRAVENOUS DRUG ADMINISTRATION

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Submitted to,
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N. Mary

Submitted by
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IInd year BSc (N)
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INTRODUCTION

Some medications must be given by an intravenous or injection or infusion. This means they're sent directly into your vein using a needle or tube. In fact the term "intravenous" means into the ven.

with IV administration, a thin plastic tube called an IV catheter is inserted into your vein. The catheter allows your healthcare professionals to give you multiple safe doses of medication without needing to poke you with a needle each time.

Dx. Bahuj
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DEFINITION

Intravenous Medication administration refers to the process of giving medication directly into a patient's vein. Methods of administering IV medication by rapid injection into the vein using a syringe, giving the medication intermittently over a specific amount of time using an IV secondary line.

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PURPOSE

- * The primary purpose of giving IV medications is to initiate a rapid systemic response to medication.
- * It is one of the fastest way of delivering medication.
- * The drug is immediately available to the body. It is easier to control the actual amount of drug delivered to the body by using the IV method.

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PRECAUTIONS

- Proper IV administration should follow the five rights of medication administration to avoid medication errors:
- The IV line must be intact before any IV medication can be administered.
- Some IV push medications must be diluted before injection.
- The drug delivery rate is an important factor when administering IV medication.
- The effects of medication appear rapidly after an IV injection.

PREPARATION

- The patient is placed in a comfortable position.
- The procedure should be explained and the patient is told the name of the drug to be administered.
- The patency of the IV line is checked to insure that the line is checked to intact and not to leaking.
- Check the physician's order correctly.
- The label of the medication should be checked and to be sure that it is not outdated.
- The health care professionals determine the amount of time over which the drug should be delivered according to the physician's order or the IV drug administration guidelines.

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COMPLICATIONS

- Infiltration of the IV line when a drug is injected IV bolus
- Tissue necrosis when drug are injected into infiltrated IV sites.
- thrombophlebitis of the vein
- Injection of air embolism
- serious adverse drug reactions such as hypotension, cardiac arrhythmias, and cardiac arrest
- Allergic reaction to the medication
- venous thrombosis
- pain at the IV site

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CONCLUSION

When administered according to the physician's orders, following drug administration guidelines, and using the correct techniques and W apparatus, W medications can have immediate positive therapeutic effects. The effects of the medication will vary depending upon the type of medication given.

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RETEST THEORY EXAMINATION

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ADVANCED MEDICAL SURGICAL NURSING

III YEAR BSC (N)

INTERNAL EXAM - I

RETEST QUESTION PAPER

DATE: 15/10/2024

TIME: 9-12 NOON

MARK: 75

I. ESSAY ON ANY TWO

(2X15=30)

1. a. DEFINE GLAUCOMA? 2M

B. WRITE ABOUT TYPES & CLINICAL MANIFESTATION OF GLAUCOMA 4M

C. WRITE IN DETAIL ABOUT MEDICAL & NURSING MANAGEMENT OF PATIENT WITH GLAUCOMA 9M

2. A. DEFINE BRAIN TUMOR 2M

B. WRITE THE CLASSIFICATION OF PATHPHYSIOLOGY OF BRAIN TUMOR 5M

C. WRITE IN DETAIL ABOUT MEDICAL & NURSING MANAGEMENT OF PATIENT WITH BRAIN TUMOR? 8M

3. A. DEFINE CHRONIC SUPPURATIVE OTITIS MEDIA 2M

B. WRITE ABOUT TYPES & CLINICAL MANIFESTATION OF CSOM 4M

C. WRITE IN DETAIL ABOUT MEDICAL & NURSING MANAGEMENT OF PATIENT WITH CSOM 9M

II. SHORT NOTES (ANY FIVE)

(5X5=25)

1. TONSILITIS

2. SPEECH THERAPY

3. REFRACTIVE ERRORS

4. RETINAL DETACHMENT

5. MENOPAUSE

6. HEADACHE

7. UTERINE FIBROIDS

III. VERY SHORT NOTES

(10X2=20)

1. DEFINE LUMBAR PUNCTURE

2. ENLIST SIGNS AND SYMPTOMS OF PHARYNGITIS

3. TYPES OF HEARING AIDS

4. ENLIST CONGENITAL DISORDERS OF FEMALE REPRODUCTIVE SYSTEM

5. ENLIST SYMPTOMS OF CONJUNCTIVITIS

7. ENLIST FOREIGN BODIES OF EAR

8. DEFINE GUILLIAN BARRE SYNDROME

9. ENLIST MENSTRUAL DISORDERS

10. DEFINE LARYNGITIS

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9-12 pm

50
75
good

Anjali K
IIIrd year B-batch
Roll No: 13
Narayana college
of nursing.

15/10/24
Wednesday

Pm

AMSN

RETEST

3.A)

CHRONIC SUPPURATIVE OTITIS MEDIA

Introduction

Otitis Media is the inflammation of the middle ear. characterized by the accumulation of fluid filled with middle-ear cavity. middle ear cavity with perforated or pus filled and Pain in the ear.

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Definition

Chronic suppurative Otitis Media (CSOM) is the chronic inflammation of the middle-ear cavity. It is the severe condition of acute otitis media. pus produced in the ear cavity. caused by ear pain and ear discharges.

or

Chronic suppurative otitis media is the long term condition in which the damage the ear drum and ear loss. fluid filled with middle ear cavity with pus formation and it may cause internal ear bleeding. is called CSOM.

B)

Types of CSOM

Acute suppurative Otitis Media

Otitis ^{Media} Effusion

Chronic Suppurative Otitis Media

Acute Suppurative Otitis Media

Acute suppurative Otitis Media is the inflammation of the middle ear. It is the accumulation of fluid filled with in the middle ear cavity. is called ASOM.

Otitis ^{Media} Effusion

Otitis ~~Media~~ Effusion is the non perforation of the ear canal. but it is also inflammation of the ear canal.

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Other types of CSOM

Primary CSOM

Secondary CSOM.

Primary CSOM

primary CSOM is defined as the first stage of chronic inflammation of the CSOM. It is called Primary CSOM

Secondary CSOM

Secondary CSOM is defined as the 2nd stage of chronic inflammation of the CSOM. It is called Secondary stage of CSOM.

Etiology

- Nasal Problems
- Infections
- Bacterial infection
- Change in altitude
- change in ~~am~~ climate
- Exposure to high volume
- Hereditary

Risk factors

- Hereditary
- Age
- Air Pollution
- Congenital
- family history
- Infections

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Clinical Manifestation of CSOM

- ⇒ Nausea & Vomiting.
- ⇒ Ear discharge
- ⇒ Irritability
- ⇒ Ear Pain
- ⇒ Pus formation
- ⇒ Headache
- ⇒ Hearing loss
- ⇒ Hearing impairment
- ⇒ Auditory
- ⇒ Communication problem due to hearing loss
- ⇒ Drizziness
- ⇒ Fluid thrill
- ⇒ Sleeping disturbances
- ⇒ Auditory problems.
- ⇒ Mastoiditis.

c)

Medical and Nursing Management of CSOM

Medical Management

Pharmacological Management

⇒ Antibiotics

- Amoxicillin
- Penicillin

⇒ Deconstrictant drops

- Ear drops

⇒ Analgesics

- paracetamol

Antibiotics are given to be effective against bacteria infection of the middle ear cavity.

Analgesics are given to reduce the ear pain.

Surgical Management

- ⇒ Tympanoplasty
- ⇒ Tympanotomy

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Nursing Management of pt with CSOM

Nursing Diagnostics

⇒ Acute pain related to the disease condition - as evidenced by Pain scale

⇒ sleeping disturbances ^{due} ~~are~~ ^{evident} to ear pain are evidenced by Redness of the eye and ear discharges.

⇒ Auditory problems due to hearing loss are evidenced by asking questions.

Nursing Intervention

⇒ Administered Medication ~~is~~ are analgesics to reduce the ear pain.

⇒ Administered ear drops

⇒ checking vital signs

⇒ Hearing test

⇒ Educate the patient with the seriousness of disease condition

⇒ Educate the family members due to disease condition

Planning	Rational Intervention
<p>Administer</p> <ul style="list-style-type: none">→ Provide Analgesics→ Provide psychological support→ Provide→ Administer Antibiotics	<ul style="list-style-type: none">→ To reduce Pain→ To provide improve comfort.→ To reduce the bacterial infection

Expected outcomes

According to the disease condition patient weaknesses may or may not be reduced.

1.9)

Glaucoma

Introduction

Glaucoma is the condition characterized by the eye problems. loss of visual power - damage the eye cells. It is the condition in which the intraocular pressure in the retinal layer of the eyes.

Definition

Glaucoma is the disease condition characterized by the increase the intra-ocular pressure in the retina damage the retinal layer and caused by loss of - visualization of the eyes.

Glaucoma is the condition occurring due to the increasing the intraocular pressure - due to the congenital and acquired - causes of the visual loss & is called - glaucoma.

B)

Types of Glaucoma

↳ Acquired Glaucoma

↳ Congenital Glaucoma

Acquired Glaucoma

Acquired glaucoma is the condition - characterized by the increasing the intra-ocular pressure. causes damage the retinal wall and loss of visualization.

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Types of Acquired glaucoma

Primary acquired glaucoma

Secondary acquired glaucoma
Traumatic glaucoma

Congenital Glaucoma

Congenital Glaucoma is the disease condition characterized by the hereditary and during-birth time will affected the condition that causing the retinal damage and visual-dysfunction. Is called congenital glaucoma.

It is the increasing the intra ocular pressure above 25 mmHg. Is called glaucoma. It is damage the Retinal layer. and visual dysfunction.

Etiology and Risk factors

- ⇒ Hereditary
- ⇒ Age
- ⇒ light exposure.
- ⇒ Retinal detachment
- ⇒ Radiation exposure
- ⇒ Increasing the IOP above 25 mmHg

Clinical Manifestation

- ⇒ Visual dysfunction
- ⇒ Blurred vision
- ⇒ Head ache
- ⇒ Numbness
- ⇒ pain
- ⇒ Edema
- ⇒ fluid thrill
- ⇒ Retinal detachment
- ⇒ Conjunctivitis.
- ⇒ Myopia
- ⇒ Redness of the eye.

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c]

Medical and Nursing Management

Diagnostic Evaluation

- ⇒ slip Lamb test
- ⇒ Eye power test
- ⇒ Measured IOP measured by Tonometry
- ⇒ Retinometry.

Medical Management

→ Use tonometry

→ Retinometry

⇒ Pharmacological Management

- * Antibiotics
- * Decongestant drops
 - Eye drops

* Analgesic's

* Surgical Management

⇒ Retinoplasty

2)

Nursing Management

Nursing Diagnosis

⇒ Acute pain related to disease condition as evidenced by pain scale

⇒ Blurred vision as related to facial expression as evidenced by reading test.

⇒ Sleeping disturbances related to the disease condition as evidenced by observation of Redness and swelling of the eyes.

Nursing Intervention

⇒ Administer the medication i.e., analgesics and antibiotics to reduce the pain and remove the bacterial infection.

⇒ Blurred vision as Tonometry as used to measure the intraocular pressure.

- ⇒ provide comfort devices due to sleeping disturbances
- ⇒ vital signs checked & recorded.

⇒

Complication

⇒ Retinal detachment

planning	Rational
Administer the medication	To decrease the pain and destroyed bacteria
Provide comfort device	To provide comfort
Provides psychological support	To improve the mental ability.

Expected outcome

According to the disease condition patient weakness may or may not be reduced.

II

1.)

Tonsilitis

Definition

Tonsilitis is the infection or inflammation of the ~~not~~ tonsil. caused by the entering to the any bacterial infections and throat infections. is called tonsilitis.

or

Tonsilitis is defined as the inflammation of the Tonsil from the throat. it may be caused by sore throat and - ~~no~~ changes in altitude and change in climate. Infection may be occurring to the respiratory ~~to~~ system also.

It characterized by the throat pain and difficulty to swallowing and redness and swelling the throat.

Types of tonsillitis

Acute Tonsillitis

Chronic Tonsillitis

Acute Tonsillitis

Acute Tonsillitis is defined as inflammation of the tonsils. It is ~~also~~ characterized by the short-term illness of during the fever or other sore throat. It causes the tonsillitis.

Chronic Tonsillitis

Chronic tonsillitis is defined as the ~~inflammation~~ chronic inflammation of the tonsils. Sore throat and difficulty to swallowing and difficulty to eating food and throat pain will occur. It is called chronic tonsillitis.

Etiology

- sore throat
- fever
- changes in climate
- Diabetes
- Fungal infection
- viral infection
- Bacterial infection.
- candidiasis.

Risk factors

- ⇒ Changes in climate
- ⇒ Sore throat
- ⇒ Fever
- ⇒ Drinking cool water
- ⇒ Life style
- ⇒ Bacterial infection

Clinical Manifestation

- ⇒ dysphagia
- ⇒ Difficulty to swallowing
- ⇒ Difficulty to speaking
- ⇒ Sore throat.

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⇒ Throat Pain

⇒ Mucous

⇒ Sputum production

⇒ Yellowish colour in sputum.

⇒ Cough

Pathophysiology

Due to Etiological factors



Infection or inflammation



Sore throat



Difficulty to swallowing



Severe cough



Tonsillitis.

Diagnostic Evaluation

⇒ Sputum Culture

⇒ Ultrasound

⇒ Physical Examination

Management

Management

Medical Management

- * Antibiotics
- * Analgesics
- * Comfort device hot water bag
- * Educate the patient drink hot water.

Nursing Management

Diagnoses

- ⇒ Acute Pain related to disease condition as evidenced by pain scale
- ⇒ Acute sleeping disturbances related to throat pain and cough as evidenced by redness of the eyes
- ⇒ Difficulty to swallowing related to throat pain as evidenced by facial expressions
- ⇒ Severe ^{Pain} cough as related to the disease condition as evidenced by cough

Intervention.

- provide Analgesic
- Administer the medications
- checking vital signs
- collection of sputum
- ⇒ ~~into Administer~~ provide comfort device
- Educate the Patient about drinking hot water.

Expected outcome

patient pain and weakness may or may not be reduced.

3)

Refractive Errors

Refractive errors means abnormally in the refraction of the eye. A light from the infinity need to focus on the retina and some times it focus in front or back of the retina. These are said to be abnormalities.

Types of Refractive errors

⇒ Ametropia.

⇒ Emmetropia

⇒ Myopia

⇒ Hypermetropia

⇒ Astigmatism.

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Ametropia

Ametropia means light from the infinity focus in the back of the retina.

Emmetropia

Emmetropia means light from the infinity focus in the front of the retina.

Myopia

Myopia is also called short sightness. The light from the infinity focus in the back of the retina and can't see clearly long distance images.

Hypermetropia

It is also called long sightness. The light from the infinity focus is found in front of the retina and can't see the object clearly short distance images.

4)

Retinal Detachment

Retinal Detachment is defined as the condition of the displacement of the retinal layer. It is called retinal detachment. It causes blurred vision and.

Etiology and Risk factors

↳ Glaucoma

↳ Hereditary

↳ Congenital

↳ Trauma.

↳ Age

↳ high light exposure

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Clinical Manifestation

- ⇒ Blurred vision
- ⇒ loss of vision
- ⇒ Blindness
- ⇒ Headache
- ⇒ itching
- ⇒ Irritability.

Diagnostic Evaluation

- ⇒ Eye test
- ⇒ split lamp test
- ⇒ Reading test
- ⇒ Refractometry
- ⇒ Tonometry
- ⇒ Retinometry

Management

⇒ Surgical

⇒ Retinoplasty

⇒ Nursing management

⇒ Provide Education about surgery

⇒ Administered Medication

⇒ Reading test

⇒ Administer ~~the~~ Eye drops.

complication

⇒ Glaucoma

⇒ cataract

5) Menopause

Introduction
Definition

Menopause is defined as the menstrual period stopped stage. The 40 to 65 years the age that menstrual cycle is stop and menstruated the age.

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Menopause is the ovulation cycle and reproduction is stopping and hormones is reduced.

Definition

Menopause is defined as the menstrual cycle is stopped and ovulation and menstruation is stop for hormonal change to damagny. age is 50 - 65 year. stop for ovulation and reproductive system. the

Menarche in 14 year or above year - the sexual and reproducing for baby the - preparing age. Menopause is -

Etiology

- Age
- Sex
- hormonal changes
- Early Menstruation (Menarche)
- hereditary condutors
- Obesity.

Clinical Manifestation

Manifestation

- Mental retardation
- Stress
- Hair loss
- Depression
- Aging
- Aggressiveness

Complications

- Excessive Obesity
- DM
- Hypertension
- Memory loss

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III
1)

Lumbar Puncture

Lumbar puncture is the diagnostic evaluation of the CNS. It is the procedure of collecting CSF from the spinal cord is called lumbar puncture.

6)

Meningitis.

Meningitis is defined as the inflammation of the meningeal layer. Damage the meningeal layer and swelling is occur. It is called meningitis.

10)

Laryngitis

Laryngitis is defined as the inflammation of larynx. due to the any laryngeal disease conditions. • during throat pain and difficulty to speaking and swallowing.

2)
10)

Signs and symptoms of Pharyngitis

⇒ Throat Pain

⇒ ~~Ab~~ Running Nose

⇒ Ear Pain

⇒ Swallowing difficulty

⇒ Difficulty to speaking.

⇒ Swelling in throat.

⇒ Headache

⇒ Nausea.

3)

4)

Congenital Disorders of female Reproductive system

→ Ovarian cancer

→ Uterine fibroids

⇒ Uterine cancer

⇒

2)

Types of Hearing Aids

↳ Pocket Mode

↳ Behind the ear

↳ In the ear

↳ In the canal

3)

Symptoms of conjunctivitis.

→ Blurred vision

→ Runny eyes

⇒ & loss of vision

→ Headache

→ difficulty to reading

→ Blinds

9)
9)

Menstrual Disorder

→ Amenorrhea

→ Over Bleeding

→ P.B

→ PCOD

7)

Foreign Bodies of ear

→ Dust

→ bacterial

→ Fungus

→

8)

Guillain Barre Syndrome

It is a neurotic disorder characterized by the paralysed the one side of the body part. It can't be passed, nerve impulses is called Guillain Barre Syndrome.

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PRACTICAL EXAMINATION

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PRACTICAL EXAM

DATE	MEDICATION	DOSE	ROUTE	TIME	NURSING CARE PLAN	TIME
25/10/24	INJ. AUGMENTIN	1gm	IV	BD	→ Establish inter personal relationship \bar{c} patient	7-7.10am
	INJ. DERYPHYLLIN	dmg	IV	OD	→ unit cleaning and bed making done	7.10-8am
	INJ. PANTOP	40mg	IV	OD	→ Administration of medications	8-8.30am
					→ Doctors rounds followed	8.30-9am
					→ Vitals checked & recorded	9-9.30am

2/2
2/5

DATE	TREATMENT	AMOUNT	
	—	—	→ History collection done 9.30-10am
			→ physical examination done 10-10.30am
			→ Nursing procedure on com- fore device 10.30-11am
			→ Health education given 11-12am
			→ Recording & Reporting 12-1pm

Religion	Age/sex	Bath	VITAL SIGNS				DIET
			T	P	RR	BP	
Hindu	58y / Female	Normal bath	98.6°F	72 1/2	20 1/2	130/90	Normal diet

PT. Name	BED. NO	DIAGNOSIS	DOCTAR NAME	IP No.
Lakshmi	001	Respiratory failure	Dr. Kalyani <i>Principa</i>	241016307

HISTORY COLLECTION

Name: Afifa Mariya Biju
Class: III D
Roll No: 02
Sree Narayana Nursing College

PATIENT PROFILE

Name of patient : Mrs. Lakshmi Narasama
Age/sex : 58y/F
Occupation : housewife
Education : 5th
Religion : Hindu
Ward : Pulmonology
IP No : 24106307
DOA : 16/10/2024
Diagnosis : **Respiratory Failure**

Dr. B. Anuj
Nursing
AD

CHIEF COMPLAINTS

Mrs. Lakshmi Narasama was admitted in Narayana medical college hospital with chief complaints of breathing difficulty, cough and body weakness since 2 days.

25/10/24.
INS. AUGMENTIN
1gm, IV
BD
Bedno: 001

25/10/24
INS. PANTOP
40mg, IV
OD
Bedno: 001

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MEDICAL HISTORY

PRESENT MEDICAL HISTORY

Mrs. Lakshmi Narasamma has a present medical history of breathing difficulty, cold and body weakness since 2 days. Dr. Kalyani Madam taken the case and advised some investigations such as CBP, X-Ray, sputum examinations and diagnosed as Respiratory failure and also prescribed some medications:

Rx.

INJ. AUGMENTIN

INJ. PANTOP

INJ. DERIPHILLIN

TAB. ABPHYLLIN

PAST MEDICAL HISTORY

Mrs. Lakshmi Narasamma has not having any past medical history.

§

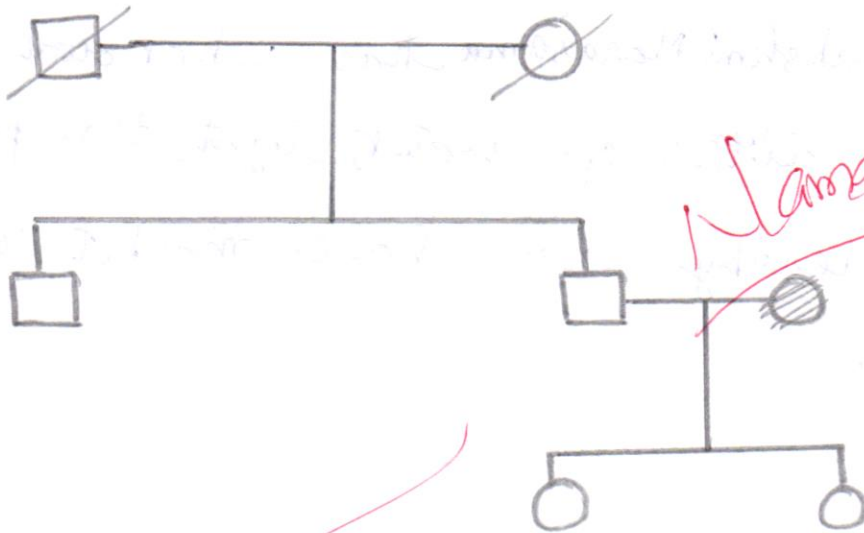
SURGICAL HISTORY

Mrs. Lakshmi Narasamma has not any significance of surgical history.

FAMILY HISTORY

- Key
- ☐ - male
 - - female
 - ◉ - female PC

FAMILY TREE



FAMILY MEDICAL HISTORY

Mrs. Lakshmi Narasama and her family members had no any significance of any congenital abnormalities like cleft lip or palate and not any communicable diseases like chickenpox, malaria

PERSONEL HISTORY

Mrs. Lakshmi Narasama had maintain a good personal of hygiene, she was taking a mixed diet and also had sleeping disturbances, she also having good bowel and bladder appetite

MENSTRUAL HISTORY

Mrs. Lakshmi Narasama had a normal menstrual history her menarche starts at the age of 15 years and

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menopause at the age of 48 years.

SOCIO-ECONOMIC HISTORY

Mrs. Lakshmi Narasama has her own house with all facilities of water, light, transport, drainage and nearby her house market, road and temple.

PHYSICAL EXAMINATION

GENERAL APPEARANCE

consciousness - conscious
orientation - oriented to ~~past~~ time
sign of distress - breathing difficulty
Body movement - ROM not possible

VITAL SIGNS

Temperature - 98.6°F
Pulse - 72 b/m
Respiration - 22 b/m
Blood pressure - 130/90 mmHg

MEASUREMENT

Height - 160 cm

Weight - 60 Kg

BMI - 23.11 cm²

SKIN AND NAILS

Colour and vascularity - Brown

moisture - moist

Nails - clean

Edema - No edema

HEAD AND SCALP

Skull - Normal

Scalp - clean

Hair - curly

face - symmetry

EYES

Eyebrows - curved

Sclera - white

Pupils - perta

Eye movement - Normal

EARS

Pinna - Normal

Position - Equal to outer canther

Ear canal - clean

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NOSE

- Septum - midline
- Nasal mucosa - pink
- Patency - patent

MOUTH AND PHARYNX

- Lip - pink
- Teeth - white
- Gum - pink
- tongue - Dry

NECK

- Appearance - symmetrical
- Thyroid - palpable
- trachea - midline
- movement - ROM

CHEST

- Thoracic configuration - symmetrical
- Respiratory pattern - Normal
- Lung sound - S₁S₂
- heart sound - S₁S₂

ABDOMEN

- INSPECTION - fluid around
- Palpation - palpable
- Perussion - No fluid thrill
- Auscultation - bowel sound pres

GENITALIA

Female genitalia : No foul smell, lesion present

ROM

No movement

EXTREMITIES

size : Edema present

muscle tone and strength : firm

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INVESTIGATIONS

Date	investigations	Pt. Value	Normal Value	Remark
25/10/24	Haemoglobin	12.8 mg/dl	12-13 gm/dl	Normal
	WBC	16,200 cells/cmm	4000-11000 cells	high
	sodium	143 meq/dl	130-145 meq/dl	Normal
	ESR	18 mm	0-10 mm/hg	high

MEDICATIONS

Date	Name of Drug	Dose	route	freq	side-effect	Nurse Respon
25/10/24	INJ. AUGMENTIN	1gm	IV	BD		Right patient
	INJ. DERYPHYLLIN	2mg	IV	OD		Right route
	INJ. PANTOP	40mg	N	BD		Right Dose
	TAB. ABPHYLLIN.		oral	BD		Right drug

NURSING DIAGNOSIS

- ⇒ pain over left and right chest related to breathing difficulty as evidenced by pain scale
- ⇒ increased BP as evidenced by checking vitals signs
- ⇒ Breathing difficulty related to disease condition as evidenced by respiratory rate
- ⇒ anxiety related to hospitalization as evidenced by asking more questions.

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NURSING CARE PLAN

Assesment	Δ's	Goal	Planning	Rational	Implementation	Evaluation
<p><u>Subjective Data</u></p> <p>Patient says that she having breathing difficulty.</p>	<p>Breathing difficulty related to disease condition as evidenced by monitoring RR</p>	<p>To reduce breathing difficulty</p>	<p>→ Asses patient condition</p>	<p>→ To know patient condition</p>	<p>→ Asses patient condition</p>	<p>By doing all these procedure Patient condition is improved</p>
<p><u>Objective Data</u></p> <p>Breathing difficulty as evidenced by monitoring RR</p>			<p>→ providing comfort device</p>	<p>→ To reduce Patient condition</p>	<p>→ provided comfort device</p>	
			<p>→ Administering medication</p>	<p>→ To relief from difficulty</p>	<p>→ Administered medication</p>	
			<p>→ provide nebulization</p>	<p>→ reduce diffi-culty</p>	<p>→ provided medication</p>	

DIET PLAN

Date	time	meal	menu	Amount	Kcal
25/10/24	6 am	Early morning	milk + biscuit	1 glass	100
	8 am	morning	idly	1 plate	150
	10 am	mid morning	Juice	1 glass	100
	12 pm	Lunch	Rice	1 plate	200
	4 pm	Evening	Snakes	1 glass	100
	8 pm	Dinner	puri	1 plate	200


HEALTH EDUCATION

- ⇒ Educate patient about disease condition
- ⇒ Educate to take nutritional food
- ⇒ Educate patient to check BP
- ⇒ Educate to do exercise

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RECORDING AND REPORTING

Date	Recording	Reporting	Sign
25/10/24	<p>→ Bed making done</p> <p>→ History collection</p> <p>→ Physical examination</p> <p>→ Monitor vitals</p> <p>Temp - 98.6°F PR - 72 b/m RR - 18 b/m BP - 140/90 mmHg</p> <p><u>PROBLEM</u></p> <p>breathing difficulty</p> <p><u>INTERVENTION</u></p> <p>→ vitals checked</p> <p>→ comfort device provide</p> <p><u>EVALUATION</u></p> <p>Patient pain reduced</p>	<p>I have done all these procedure and submitted to ward incharge madam</p> <p>Patel</p>	<p>Sign</p> <p></p>



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B.SC NURSING PROGRAMME
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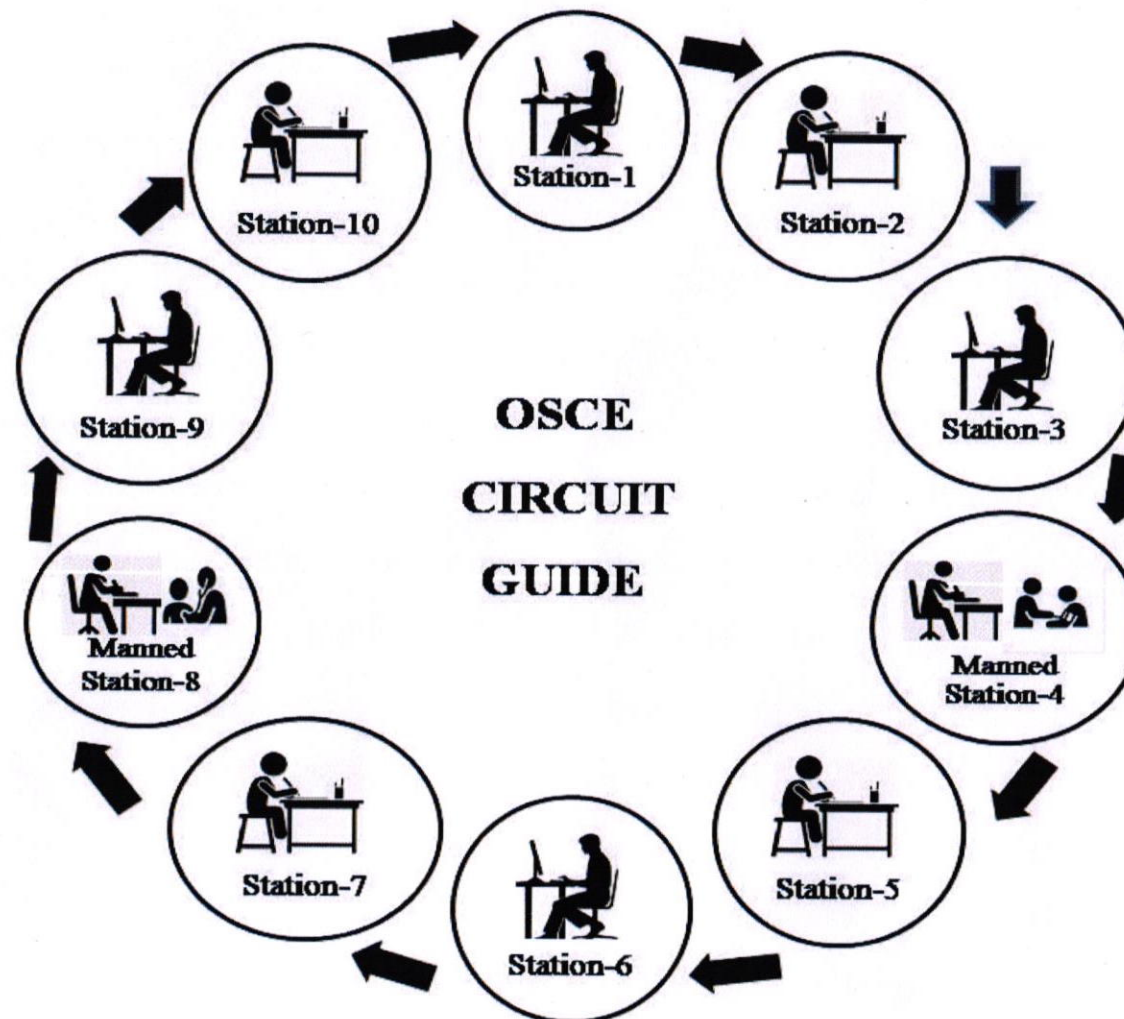
OSCE / OSPE
STATION BANK

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3. OSCE CIRCUIT GUIDE



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B.Sc NURSING DEGREE PROGRAMME – I YEAR
NURSING FOUNDATIONS
OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)
TEST MAP BASED ON BLUE PRINT

Station Num	Type of Station	Program Component	Item Title (Condition)	Competency Tested	Proposed Test Item	Domains of Clinical Experience														
						Communication		Examination		Procedure			Cognitive Skill							
						HT	OC	PE	VSI	TP	DP	IATF	DI	DM	PS					
						A	B	C	D	E	F	G	H	I	J					
1.	Manned	Oxygenation	CPR	TP	Mannequin					1										
2.	Manned	Care of wounds	Eye bandage	TP	Simulated patient					1										
3.	Unmanned	Comfort	Identification of positions & its pressure points	VSI	Printed images				1											
4.	Unmanned	Infection control	Bio Medical Waste Management	DM	Items														1	
5.	Unmanned	Vital signs	Identification of pulse site	VSI	Printed images				1											
6.	Unmanned	Health assessment	Equipment identification	VSI	Equipment				1											
7.	Unmanned	Administration of medication	Drug calculation	PS	Doctor's order															1
8.	Unmanned	Urinary elimination	Urine sample Identification	IATF	Test tubes									1						
9.	Unmanned	Vital signs	Abnormal breath sounds	IATF	Simulator/ laptop									1						
10.	Unmanned	Oxygen administration	Identification of venturi mask	DM	Venturi masks															1

Key words: HT: History Taking; OC: Other Communication; PE: Physical examination; VSI: Virtual Sign Identification; TP: Therapeutic Procedure; DI: Data Interpretation; IATF: Identification Of Abnormal Test Findings; DP : Diagnostic Procedure; DM: Decision Making; PS: Problem Solving

Subject Co-ordinator

HOD

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STATION NO: 1 –THERAPEUTIC PROCEDURE - CARDIO PULMONARY RESUSCITATION

Steps	Task	Max score	Registration number												
1.	Assesses for the safety of the patient	1													
2.	Positions the patient in supine on a flat surface	1													
3.	Assesses the patient's response by asking "are you okay?"	1													
4.	Assesses breathing by looking at the chest for movement	1													
5.	If the patient is not breathing, sends or calls for help.	1													
6.	Assesses circulation by palpating for the carotid pulse. If not felt, start compressions immediately	1													
7.	Chest compressions Identifies the center of the chest by placing the hands between the nipples.	1													
8.	Places the heel of the first hand over the lower half of the sternum and 2 nd over the 1 st .	1													
9.	Interlocks the fingers	1													
10.	Keeps the elbows straight and locked	1													
11.	Compresses the chest down 5 cms quickly and forcibly 30 times at a rate of 100 /minute	1													
12.	Observes for the return of chest movement after each compression.	1													
13.	Does not change position or lift hands in between the compressions.	1													
14.	Opens the airway and assess the airway. Use head tilt / chin lift method. Keeps one hand over the patient's forehead; apply firm pressure and tilt the head back.	1													
	Places the other hand under the bony prominence of the lower jaw and lift the jaw to bring it forward	1													
15.	Mouth to mouth breathing / Ambu Bag: Keeps the airway open, pinch the nose; take a deep breath;	1													
	Forms an airtight seal around the patient's mouth and ventilates with two full breaths or use Ambu bag. Delivers each breath for one full second (Compression : breaths = 30 :2)	1													
16.	Repeats the previous step until help arrives or until return of spontaneous breaths – whichever is earlier.	1													
17.	Sanitizes hands	1													
18.	Documents the care given	1													
	Total	20													

1=Fully competent; 0 = Incompetent

Name & Signature of the examiner

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B.Sc NURSING DEGREE PROGRAMME – I YEAR

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OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 1 –THERAPEUTIC PROCEDURE - CARDIO PULMONARY RESUSCITATION

ARTIFACT / EQUIPMENTS / PRELIMINARY REQUIREMENTS

For examiner	For examinee
<ul style="list-style-type: none">• Writing pad with instructions to the examiner & evaluation proforma• Tray for evaluated response sheet• Pen• Pencil• Scale• Sharpener• Eraser• Chair & Table• Gong	<ul style="list-style-type: none">• Writing pad with instructions to examinee• Cot with Mannequin• Bed side locker• A clean tray lined with paper containing<ul style="list-style-type: none">❖ Oral airway❖ Ambu bag❖ Mask❖ Hand sanitizer• Response sheet• Chair & Table• Pen

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STATION NO: 1 –THERAPEUTIC PROCEDURE - CARDIO PULMONARY RESUSCITATION

INSTRUCTION TO THE EXAMINEE

You have 5 minutes to perform CPR on the mannequin. Conduct a preliminary assessment and perform Basic Cardiac Life Support. Continue until you receive help or until the examiner states that “Vital parameters have improved and are stable”. Use the articles which are near the bedside. Document the care given.

Hand-over the response sheet to the examiner.

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OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 1 –THERAPEUTIC PROCEDURE - CARDIO PULMONARY RESUSCITATION

INSTRUCTION TO THE EXAMINER

Objectives

This station is designed to test the candidate's ability to

- assess the safety of the mannequin.
- position the mannequin.
- assess the circulation, airway and breathing of the mannequin
- perform CPR effectively
- document the care given

Observation: Observe if the participant is performing the following steps in the correct sequence when performing CPR. Inform the examinee that "Vital parameters have improved and are stable" or provide help when he/she completes 3-5 cycles of CPR

Score:

Score the task based on the following level of perfection

- **Score "1"** for each step conducted **correctly** (good skill)
- **Score "0"** if the task is **not done** or done **with mistakes**
- Calculate the total score

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STATION NO: 1 –THERAPEUTIC PROCEDURE - CARDIO PULMONARY RESUSCITATION

STUDENT RESPONSE SHEET

Registration Number: _____ Date: _____

Documentation:

Signature of the Examinee

Signature of the Examiner

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STATION NO: 2 –THERAPEUTIC PROCEDURE – EYE BANDAGE

Steps	Task	Max score	Registration number											
1.	Greets the patient	2												
2.	Introduces self	2												
3.	Explains the procedure and the reasons behind it.	2												
4.	Sanitizes hands	2												
5.	Eye Bandage Pads the affected eye.	2												
6.	Takes two circular turns around the head bandaging away from the injured eye	2												
7.	Carries the bandage, round the head until it reaches the eye on the affected side	2												
8.	Takes it obliquely to the back of the head, under the prominence on the back of the skull and from there;	2												
9.	Brings it upwards beneath the eye of the affected side.	2												
10.	Takes it further over the pad of the eye to a circular turn and continue over the head to the starting point	2												
11.	Repeats this turn 2 or3 times until the dressing is covered	2												
12.	Secures it just above the eye with a clip or a safety pin.	2												
13.	Removes and replace the eye bandage	2												
14.	Sanitizes hands	2												
15.	Documents the bandages done	2												
Total		30												

2 = Fully competent 1 = Partially competent 0 = Incompetent

Name & Signature of the examiner


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B.Sc NURSING DEGREE PROGRAMME – I YEAR

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OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 2 –THERAPEUTIC PROCEDURE – EYE BANDAGE

ARTIFACT / EQUIPMENTS / PRELIMINARY REQUIREMENTS

For examiner	For simulated patient	For examinee
<ul style="list-style-type: none">❖ Writing pad with instructions to the examiner & evaluation proforma❖ Tray for evaluated response sheet❖ Pen❖ Pencil❖ Scale❖ Sharpener❖ Eraser❖ Chair & Table❖ Gong	<ul style="list-style-type: none">• Cot with screen• Top sheet• Writing pad with case scenario• Instructions for simulated patient(to be informed prior to the OSCE)	<ul style="list-style-type: none">• Writing pad with instructions to examinee• Bed side locker• A clean tray lined with paper containing<ul style="list-style-type: none">❖ Bandage❖ Metal clip/safety pin❖ Bowl with gauze pad❖ K- Basin❖ Mask❖ Hand sanitizer• Response sheet• Chair & Table• Pen

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B.Sc NURSING DEGREE PROGRAMME – I YEAR

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OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 2 –THERAPEUTIC PROCEDURE – EYE BANDAGE

INSTRUCTION TO THE EXAMINER

Objectives

This station is designed to test the candidate's ability to

- greet the patient
- introduce self
- apply the eye bandage sequentially.
- document the procedure done

Observation: Observe if the participant is performing the following steps in the correct sequence when applying eye bandage for the patient.

Score:

Score the task based on the following level of perfection.

- Score "2" – Performs the step perfectly with a neat appearance
- Score "1" – Performs the step appropriately without a neat appearance
- Score "0" – Does not perform the step
- Calculate the total score

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B.Sc NURSING DEGREE PROGRAMME – I YEAR

NURSING FOUNDATIONS

OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 2 –THERAPEUTIC PROCEDURE – EYE BANDAGE

INFORMATION TO THE SIMULATED PATIENT

Your role: Patient, named Ms. Kumudha, aged 23 years.

Background information

Demographic data

- Name : Ms. Kumudha
- Age : 23 years
- Educational qualification : M.Sc - Physics
- Marital status : Un married
- Occupation : Executive
- Religion : Hindu
- Family income : Rs.40,000/ month

Present surgical history

You have undergone a surgery in the left eye.

Chief complaints

You have headache since morning. You also have pain in the eye. You do not have any other significant complaints.

Dy. B. C. Arany
Principal

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B.Sc NURSING DEGREE PROGRAMME – I YEAR

NURSING FOUNDATIONS

OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 4 – DECISION MAKING – BIO MEDICAL WASTE MANAGEMENT

INSTRUCTION TO THE EXAMINER

Objectives

This station is designed to test the candidate's ability to

- write the colour coding for the products displayed
- specify the methods of waste disposal for the same.

Observation: Observe if the participant is performing the following task.

Score:

Score the task based on the following.

- **Score "1"** for each point **written correctly**
- **Score "0"** if the task is **not written correctly**
- Calculate the total score

DY. Principal
Principal

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B.Sc NURSING DEGREE PROGRAMME – I YEAR

NURSING FOUNDATIONS

OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 4 – DECISION MAKING – BIO MEDICAL WASTE MANAGEMENT

Steps	Task	Max score	Registration number																	
1.	Writes the colour coding for product no 1	1																		
2.	Specifies the method of waste disposal for product no 1	1																		
3.	Writes the colour coding for product no 2	1																		
4.	Specifies the method of waste disposal for product no 2	1																		
5.	Writes the colour coding for product no 3	1																		
6.	Specifies the method of waste disposal for product no 3	1																		
7.	Writes the colour coding for product no 4	1																		
8.	Specifies the method of waste disposal for product no 4	1																		
9.	Writes the colour coding for product no 5	1																		
10.	Specifies the method of waste disposal for product no 5	1																		
11.	Writes the colour coding for product no 6	1																		
12.	Specifies the method of waste disposal for product no 6	1																		
13.	Writes the colour coding for product no 7	1																		
14.	Specifies the method of waste disposal for product no 7	1																		
15.	Writes the colour coding for product no 8	1																		
16.	Specifies the method of waste disposal for product no 8	1																		
17.	Writes the colour coding for product no 9	1																		
18.	Specifies the method of waste disposal for product no 9	1																		
19.	Writes the colour coding for product no 10	1																		
20.	Specifies the method of waste disposal for product no 10	1																		
Total		20																		

Name & Signature of the examiner

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B.Sc NURSING DEGREE PROGRAMME – I YEAR

NURSING FOUNDATIONS

OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 4 – DECISION MAKING – BIO MEDICAL WASTE MANAGEMENT

Steps	Task	Max score	Registration number																	
1.	Writes the colour coding for product no 1	1																		
2.	Specifies the method of waste disposal for product no 1	1																		
3.	Writes the colour coding for product no 2	1																		
4.	Specifies the method of waste disposal for product no 2	1																		
5.	Writes the colour coding for product no 3	1																		
6.	Specifies the method of waste disposal for product no 3	1																		
7.	Writes the colour coding for product no 4	1																		
8.	Specifies the method of waste disposal for product no 4	1																		
9.	Writes the colour coding for product no 5	1																		
10.	Specifies the method of waste disposal for product no 5	1																		
11.	Writes the colour coding for product no 6	1																		
12.	Specifies the method of waste disposal for product no 6	1																		
13.	Writes the colour coding for product no 7	1																		
14.	Specifies the method of waste disposal for product no 7	1																		
15.	Writes the colour coding for product no 8	1																		
16.	Specifies the method of waste disposal for product no 8	1																		
17.	Writes the colour coding for product no 9	1																		
18.	Specifies the method of waste disposal for product no 9	1																		
19.	Writes the colour coding for product no 10	1																		
20.	Specifies the method of waste disposal for product no 10	1																		
Total		20																		

Name & Signature of the examiner

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B.Sc NURSING DEGREE PROGRAMME – I YEAR

NURSING FOUNDATIONS

OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 4 – DECISION MAKING – BIO MEDICAL WASTE MANAGEMENT

ARTIFACT / EQUIPMENTS / PRELIMINARY REQUIREMENT

For examiner	For examinee
<ul style="list-style-type: none">• Writing pad with instructions to the examiner, evaluation proforma and answer key• Pen• Pencil• Scale• Sharpener• Eraser• Chair & Table• Gong	<ul style="list-style-type: none">• Writing pad with instructions to examinee• Response sheet• Drop box• Chair & Table• Pen• Products – needle, blood bag, underpad, gloves, syringe cover, ampule, dressing materials, tissue paper, ryles tube, disposable face mask

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STATION NO: 4 – DECISION MAKING – BIO MEDICAL WASTE MANAGEMENT

ANSWER KEY

S. No	Name of the waste product	Colour code (method of segregation)	Methods of disposal
1.	Used Needles	White translucent	Autoclaving or dry heat sterilization
2.	Blood bag	Red	Incineration
3.	Used Underpad	Yellow	Incineration
4.	Gloves	Red	Autoclaving
5.	Syringe cover	Black	Incineration
6.	Used ampule	White translucent	Autoclaving or disinfection
7.	Dressing material	Yellow	Incineration
8.	Tissue Paper	Black	Incineration
9.	Ryles tube	Red	Autoclaving or microwaving followed by shredding or mutilation
10.	Disposable face Mask	Black	Incineration

Dr. B. Anuj
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STATION NO: 4 – DECISION MAKING – BIO MEDICAL WASTE MANAGEMENT

INSTRUCTION TO THE EXAMINEE

You have 5 minutes to write the color coding for the displayed products as per the biomedical waste management system and specify the appropriate methods of waste disposal for each.

Drop the response sheet in the drop box kept on the table after documentation.

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STATION NO: 4 – DECISION MAKING – BIO MEDICAL WASTE MANAGEMENT

STUDENT RESPONSE SHEET

Registration Number: _____ Date: _____

S. No	Name of the product	Colour code (method of segregation)	Methods of disposal
1.	Used Needles		
2.	Blood bag		
3.	Used Underpad		
4.	Gloves		
5.	Syringe cover		
6.	Used ampule		
7.	Dressing material		
8.	Tissue Paper		
9.	Ryles tube		
10.	Disposable face Mask		

Signature of the Examinee

Signature of the Examiner

Dr. B. Anny
Principal

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B.Sc NURSING DEGREE PROGRAMME – I YEAR

NURSING FOUNDATIONS

OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 5 – VIRTUAL SIGN IDENTIFICATION- IDENTIFICATION OF PULSE SITE

INSTRUCTION TO THE EXAMINER

Objectives

This station is designed to test the candidate's ability to

- identify the sites for checking the pulse
- mark the sites correctly on the image given in the paper

Observation: Observe if the participant is identifying and marking the various sites for checking the pulse

Score

Score the task based on the following

- Score "1" for each point identified and written correctly
- Score "0" if the equipment is not identified correctly or if the purpose is not specified correctly.
- Calculate the total score.

Dr. B. Srinivas
Principal

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B.Sc NURSING DEGREE PROGRAMME – I YEAR

NURSING FOUNDATIONS

OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 5 – VIRTUAL SIGN IDENTIFICATION- IDENTIFICATION OF PULSE SITE

INSTRUCTION TO THE EXAMINER

Objectives

This station is designed to test the candidate's ability to

- identify the sites for checking the pulse
- mark the sites correctly on the image given in the paper

Observation: Observe if the participant is identifying and marking the various sites for checking the pulse

Score

Score the task based on the following

- Score "1" for each point identified and written correctly
- Score "0" if the equipment is not identified correctly or if the purpose is not specified correctly.
- Calculate the total score.

Dy. B. Anuj
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STATION NO: 5 – VIRTUAL SIGN IDENTIFICATION- IDENTIFICATION OF PULSE SITE

Steps	Task	Max score	Registration number												
1.	Labels the site 1 for checking pulse	1													
2.	Labels the site 2 for checking pulse	1													
3.	Labels the site 3 for checking pulse	1													
4.	Labels the site 4 for checking pulse	1													
5.	Labels the site 5 for checking pulse	1													
6.	Labels the site 6 for checking pulse	1													
7.	Labels the site 7 for checking pulse	1													
8.	Labels the site 8 for checking pulse	1													
9.	Labels the site 9 for checking pulse	1													
10	Specifies any two pulse sites that can be used during emergency for an adult	1													
Total		10													

Name & Signature of the examiner

D. Babu
Principal

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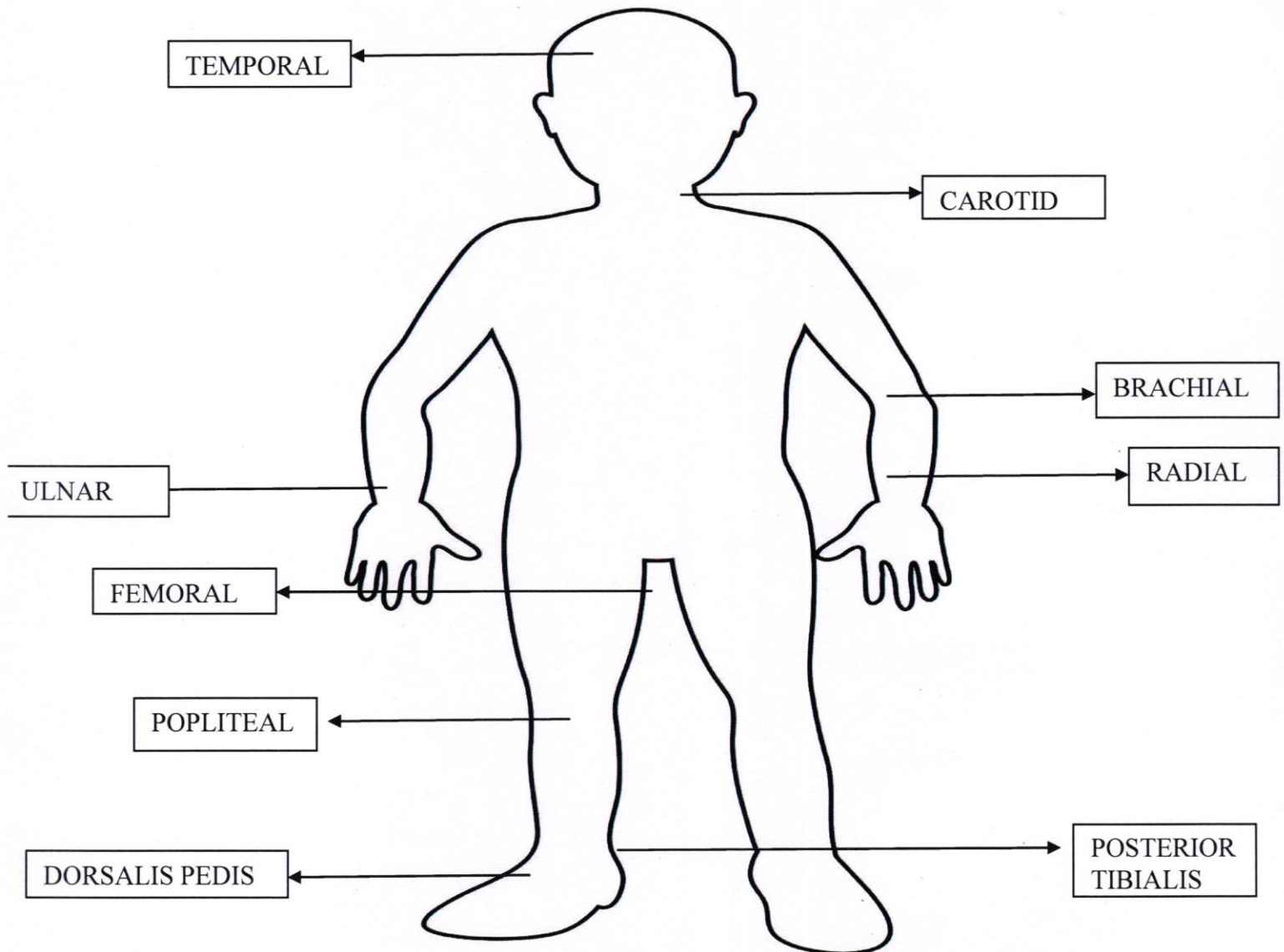
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STATION NO: 5 – VIRTUAL SIGN IDENTIFICATION- IDENTIFICATION OF PULSE SITE

ANSWER KEY



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STATION NO: 5 – VIRTUAL SIGN IDENTIFICATION- IDENTIFICATION OF PULSE SITE

ARTIFACT / EQUIPMENTS / PRELIMINARY REQUIREMENT

For examiner	For examinee
<ul style="list-style-type: none">• Writing pad with instructions to the examiner, evaluation proforma & answer key• Pen• Pencil• Scale• Sharpener• Eraser• Chair & Table• Gong	<ul style="list-style-type: none">• Writing pad with instructions to examinee• Printed image• Response sheet• Chair & Table• Pen• Drop box

Dr. B. Anuj
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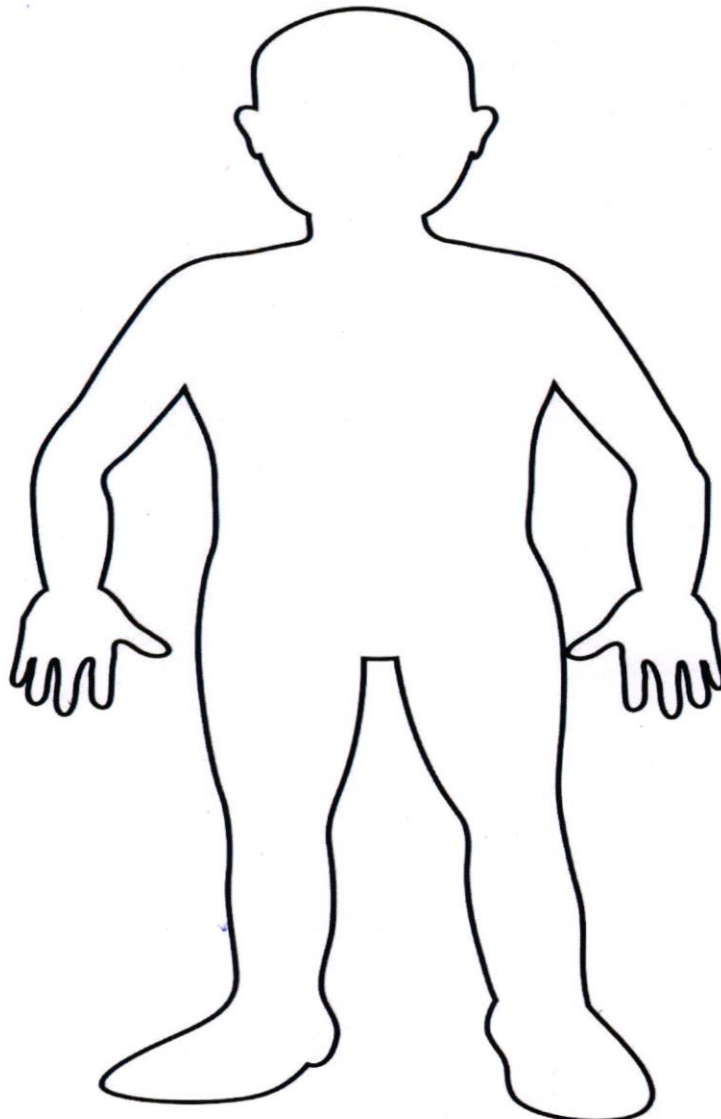


STATION NO: 5 – VIRTUAL SIGN IDENTIFICATION- IDENTIFICATION OF PULSE SITE

INSTRUCTION TO EXAMINEE

You have 5 minutes to complete this station. Mark the names of the 9 pulse sites for this image on the image given in the response sheet.

Drop the response sheet in the drop box kept on the table after documentation.



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B.Sc NURSING DEGREE PROGRAMME – I YEAR

NURSING FOUNDATIONS

OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 6 – VIRTUAL SIGN IDENTIFICATION – IDENTIFICATION OF EQUIPMENT

INSTRUCTION TO THE EXAMINER

Objectives

This station is designed to test the candidate's ability to

- identify the instruments displayed
- write any one purpose for each of the instrument

Observation: Observe if the participant is performing the following task.

Score

Score the task based on the following

- Score "1" for each point identified and written correctly
- Score "0" if the equipment is not identified correctly or if the purpose is not specified correctly.
- Calculate the total score.

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Principal

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STATION NO: 6 – VIRTUAL SIGN IDENTIFICATION – IDENTIFICATION OF EQUIPMENT

Steps	Task	Max score	Registration number								
1.	Identifies the 1 st instrument	1									
2.	Lists the purpose of instrument no 1	1									
3.	Identifies the instrument no 2	1									
4.	Lists the purpose of instrument no 2	1									
5.	Identifies the instrument no 3	1									
6.	Lists the purpose of instrument no 3	1									
7.	Identifies the instrument no 4	1									
8.	Lists the purpose of instrument no 4	1									
9.	Identifies the instrument no 5	1									
10.	Lists the purpose of instrument no 5	1									
Total		10									

Name & Signature of the examiner

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STATION NO: 6 – VIRTUAL SIGN IDENTIFICATION – IDENTIFICATION OF EQUIPMENT

ARTIFACT / EQUIPMENTS / PRELIMINARY REQUIREMENT

For examiner	For examinee
<ul style="list-style-type: none">• Writing pad with instructions to the examiner, evaluation proforma and answer key• Pen• Pencil• Scale• Eraser• Sharpener• Chair & Table• Gong	<ul style="list-style-type: none">• Writing pad with instructions to examinee• Response sheet• Drop box• Table & Chair• Pen• Equipments – Stethoscope, tuning fork, tongue depressor, proctoscope, pen torch

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STATION NO: 6 – VIRTUAL SIGN IDENTIFICATION – IDENTIFICATION OF EQUIPMENT

ANSWER KEY

S. No	Name of the equipment	Purpose
1.	Stethoscope	To listen to the sounds made by the heart, lungs or intestines
2.	Tuning fork	To assess patient's hearing ability
3.	Tongue depressor	For examining the oral cavity and to depress the tongue for procedures such as intubation, oral care, insertion of oral airway
4.	Proctoscope	To examine the rectum
5.	Pen torch	For clinical examination

Dy. B. Anuraj
Principal

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STATION NO: 6 – VIRTUAL SIGN IDENTIFICATION – IDENTIFICATION OF EQUIPMENT

INSTRUCTION TO THE EXAMINEE

You have 5 minutes to identify the name of the equipments that are displayed and write any 2 purposes for each of them in the response sheet provided.

Do not move the equipments.

Drop the response sheet in the drop box kept on the table after documentation.

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STATION NO: 6 – VIRTUAL SIGN IDENTIFICATION – IDENTIFICATION OF EQUIPMENT

STUDENT RESPONSE SHEET

Registration Number: _____ Date: _____

Documentation:

S. No	Name of the equipment	Purpose
1.		
2.		
3.		
4.		
5.		

Signature of the Examinee

Signature of the Examiner

Dr. B. Anuj
Principal

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B.Sc NURSING DEGREE PROGRAMME – I YEAR

NURSING FOUNDATIONS

OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 7 –PROBLEM SOLVING – DRUG CALCULATION

INSTRUCTION TO THE EXAMINER

Objectives

This station is designed to test the candidate's ability to

- calculate the amount that has to be loaded in the syringe
- specify the syringe that has to be taken for loading
- lists any two commonest veins that can be used for intravenous administration

Observation: Observe if the participant is performing the following task.

Score:

Score the task based on the following

- **Score "1"** for each point calculated/ specified / drawn **correctly**
- Score **"0"** for the steps **incorrectly** or **not performed** as recommended
- Calculate the score.

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STATION NO: 7 –PROBLEM SOLVING – DRUG CALCULATION

Steps	Task	Max score	Registration number											
1.	1a. Writes the formula for the order 1	1												
	1b. Calculates the amount of medication that has to be administered in mL	1												
	1c. Specifies the syringe for administration.	1												
2.	Lists any two veins that can be used for intravenous administration													
	a.	1												
	b.	1												
Total		5												

Name & Signature of the examiner

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STATION NO: 7 –PROBLEM SOLVING – DRUG CALCULATION

ARTIFACTS / EQUIPMENTS / PRELIMINARY REQUIREMENT

For examiner	For examinee
<ul style="list-style-type: none">• Writing pad with instructions to the examiner, evaluation proforma and answer key• Pen• Pencil• Scale• Eraser• Sharpener• Chair & Table• Gong	<ul style="list-style-type: none">• Writing pad with instructions to examinee & doctor's order• Response sheet• Drop box• Table & Chair• Pen

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STATION NO: 7 –PROBLEM SOLVING – DRUG CALCULATION

ANSWER KEY

1. Dr's order: Inj. Ceftriaxone – 3.0 gm od

Available dose = 2 vials of 2gm each

Each vial can be mixed with 5mL of distilled water.

So, 2g/5mL; 4g/10mL

Formula= $\frac{\text{what we want}}{\text{what we have}} \times \text{Available amount (mL)}$

$$3/4 * 10 = 30/4 = 7.5 \text{ mL}$$

2. Any two commonest veins for IV administration

- Cephalic
- Basilic
- Median cubital

Dy. Princy
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B.Sc NURSING DEGREE PROGRAMME – I YEAR

NURSING FOUNDATIONS

OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 7 –PROBLEM SOLVING – DRUG CALCULATION

INSTRUCTION TO THE EXAMINEE

The doctor's order for a drug administration is as follows. Calculate the following drug dosage.

1. Order: Injection Ceftriaxone 3.0 gm od IV. You have 2 vials in your hand. Each vial has 2gm. Five mL of distilled water can be used to dilute each vial.
 - Calculate the amount that has to be loaded in the syringe for order 1
 - Specify the syringe (mL)that has to be taken for loading
 - List any two commonest veins that can be used for intravenous administration

Drop the response sheet in the drop box kept on the table after documentation.

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STATION NO: 8 – IDENTIFICATION OF ABNORMAL TEST FINDINGS – INTERPRETATION OF URINE SAMPLE

Steps	Task	Max score	Registration number												
1.	Identifies the abnormality in urine sample 1	1													
2.	Identifies the abnormality in urine sample 2	1													
3.	Identifies the abnormality in urine sample 3	1													
4.	Identifies the abnormality in urine sample 4	1													
5.	Identifies the abnormality in urine sample 5	1													
6.	Lists in numerical value the amount of abnormality seen in sample 1	1													
7.	Lists in numerical value the amount of abnormality seen in sample 2	1													
8.	Lists in numerical value the amount of abnormality seen in sample 3	1													
9.	Lists in numerical value the amount of abnormality seen in sample 4	1													
10.	Lists in numerical value the amount of abnormality seen in sample 5	1													
Total		10													

Name & Signature of the examiner

Dr. Babu
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B.Sc NURSING DEGREE PROGRAMME – I YEAR

NURSING FOUNDATIONS

OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 8 – IDENTIFICATION OF ABNORMAL TEST FINDINGS – INTERPRETATION OF URINE SAMPLE

INSTRUCTION TO THE EXAMINER

Objectives

This station is designed to test the candidate's ability to

- identify the abnormality in the urine sample
- list the amount of variability in each sample.

Observation: Observe if the participant is performing the following task.

Score

Score the task based on the following

- Score "1" for each point identified and written correctly
- Score "0" if the equipment is not identified correctly or if the purpose is not specified correctly.
- Calculate the total score.

Dr. Rohini
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STATION NO: 8 – IDENTIFICATION OF ABNORMAL TEST FINDINGS – INTERPRETATION OF URINE SAMPLE

Steps	Task	Max score	Registration number											
1.	Identifies the abnormality in urine sample 1	1												
2.	Identifies the abnormality in urine sample 2	1												
3.	Identifies the abnormality in urine sample 3	1												
4.	Identifies the abnormality in urine sample 4	1												
5.	Identifies the abnormality in urine sample 5	1												
6.	Lists in numerical value the amount of abnormality seen in sample 1	1												
7.	Lists in numerical value the amount of abnormality seen in sample 2	1												
8.	Lists in numerical value the amount of abnormality seen in sample 3	1												
9.	Lists in numerical value the amount of abnormality seen in sample 4	1												
10.	Lists in numerical value the amount of abnormality seen in sample 5	1												
Total		10												

Name & Signature of the examiner


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STATION NO: 8 – IDENTIFICATION OF ABNORMAL TEST FINDINGS – INTERPRETATION OF URINE SAMPLE

ARTIFACTS / EQUIPMENTS / PRELIMINARY REQUIREMENTS

For examiner	For examinee
<ul style="list-style-type: none">• Writing pad with instructions to the examiner, evaluation proforma and answer key• Pen• Pencil• Scale• Eraser• Sharpener• Chair & Table• Gong	<ul style="list-style-type: none">• Writing pad with instructions to examinee• Response sheet• Drop box• Table & Chair• Pen• Test tubes with five urine samples – Positive for sugar with blue, green, yellow, orange and one with turbid urine

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STATION NO: 8 – IDENTIFICATION OF ABNORMAL TEST FINDINGS – INTERPRETATION OF URINE SAMPLE

ANSWER KEY

S.No	Colour	Interpretation	Amount
1.	Blue	No sugar	No sugar
2.	Green	+1	250 – 500 mg/100 mL
3.	Yellow	+2	500 – 1000 mg/100 mL
4.	Orange	+3	1000 – 1500 mg/100 mL
5.	White turbid/cloudy	Presence of albumin ++	100mg/dL

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STATION NO: 8 – IDENTIFICATION OF ABNORMAL TEST FINDINGS – INTERPRETATION OF URINE SAMPLE

INSTRUCTION TO THE EXAMINEE

The urine sample is kept in five test tubes. See the colour of the urine sample and identify the abnormality. After identification, list the amount of variability in each test tube with the correct unit. You have 5 minutes to complete this station.

Drop the response sheet in the drop box kept on the table after documentation.

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STATION NO: 8 – IDENTIFICATION OF ABNORMAL TEST FINDINGS – INTERPRETATION OF URINE SAMPLE

STUDENT RESPONSE SHEET

Registration Number: _____ Date: _____

Documentation:

S.No	Colour	Interpretation	Amount
1.			
2.			
3.			
4.			
5.			

Signature of the Examinee

Signature of the Examiner

Dr. R. Anji
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STATION NO: 8 – DATA INTERPRETATION– INTERPRETATION OF LAB VALUE

ANSWER KEY

S.No	Name of the investigation	Patient's value	Normal value	Remarks
1.	ESR	32 mm/hr	<20mm/hour	Suggestive of infection
2.	Haemoglobin (female)	10.5 gm/dL	12-14 mg/dL	Anemia
3.	S. Urea	23 mg/dL	8 -40 mg/dL	Normal
4.	S. Creatinine	1.2 mg/dL	0.8 – 1.4 mg/dL	Normal
5.	Sodium	138 mEq/L	135 – 145 mEq/L	Normal
6.	Potassium	4.2 mEq/L	3.5 – 5.1 mEq/L	Normal
7.	Total bilirubin	2.8 mg/dL	0.2 – 1.4 mg/dL	Suggestive of liver impairment
8.	Total cholesterol	268 mg/dL	<200 mg/dL	Suggestive of liver impairment
9.	Total protein	6.8 g/dL	6-8 gm/dL	Normal
10.	Serum albumin	2.8 g/dL	3.5 – 5 gm/dL	Hypoalbuminemia

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B.Sc NURSING DEGREE PROGRAMME – I YEAR

NURSING FOUNDATIONS

OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 9 –DATA INTERPRETATION – NAME & DEFINE THE VITAL PARAMETERS

INSTRUCTION TO THE EXAMINER

Objectives

This station is designed to test the candidate's ability to

- interpret the vital parameter based on the value
- define each of it.

Observation: Observe if the participant is identifying the vital parameter and is able to define it correctly.

Score

Score the task based on the following

- Score "1" for each point identified and written correctly
- Score "0" if it is not identified or defined correctly.
- Calculate the total score.

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STATION NO: 9 –DATA INTERPRETATION – NAME & DEFINE THE VITAL PARAMETERS

Step Num	Task	Max Score	Registration Number											
1.	Interprets the 1 st vital parameter	1												
2.	Defines the 1 st vital parameter	1												
3.	Interprets the 2 nd vital parameter	1												
4.	Defines the 2 nd vital parameter	1												
5.	Interprets the 3 rd vital parameter	1												
6.	Defines the 3 rd vital parameter	1												
7.	Interprets the 4 th vital parameter	1												
8.	Defines the 4 th vital parameter	1												
9.	Interprets the 5 th vital parameter	1												
10.	Defines the 5 th vital parameter	1												
Total		10												

Name & Signature of the examiner

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STATION NO: 9 –DATA INTERPRETATION – NAME & DEFINE THE VITAL PARAMETERS

ARTIFACT / EQUIPMENTS/ PRELIMINARY REQUIREMENTS

For examiner	For examinee
<ul style="list-style-type: none">• Writing pad with instructions to the examiner, evaluation proforma and answer key• Pen• Pencil• Scale• Eraser• Sharpener• Chair & Table• Gong	<ul style="list-style-type: none">• Writing pad with instructions to examinee• Printed values/images• Response sheet• Drop box• Table & Chair• Pen

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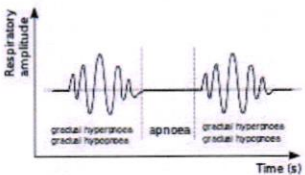
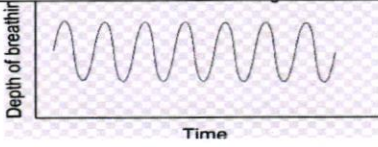
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STATION NO: 9 –DATA INTERPRETATION – NAME & DEFINE THE VITAL PARAMETERS

ANSWER KEY

S. No	Vital Parameters	Values	Interpretation	Definition
1	Temperature	101 ⁰ F	Hyperthermia	Increased body temperature
2	Pulse	50 beats/minute	Bradycardia	Pulse rate < than 60 beats/minute
3	BP	70/40 mm Hg	Hypotension	Decreased BP below the normal value – systolic - <90 mmHg
4	Respiration		Cheyne stoke respiration	Irregular rate & depth of respiration characterized by alternating period of apnea & hyperventilation
5	Respiration		Kussmaul's respiration	Abnormally deep regular respiration with increased rate

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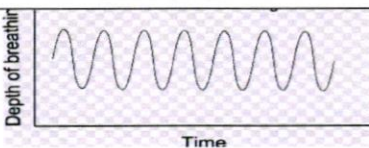


STATION NO: 9 –DATA INTERPRETATION – NAME & DEFINE THE VITAL PARAMETERS

INSTRUCTION TO THE EXAMINEE

You have 5 minutes to complete this station. Look at the vital parameters below. Interpret it and define each of the abnormality in the response sheet.

Drop the response sheet in the drop box kept on the table after documentation.

S. Num	Vital Parameters	Values	Interpretation	Definition
1	Temperature	101 ⁰ F		
2	Pulse	50 beats/minute		
3	BP	70/40 mm Hg		
4	Respiration			
5	Respiration			

Dr. B. Anji
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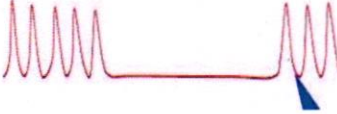
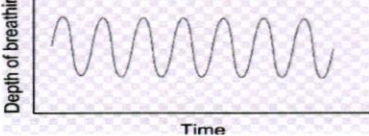


STATION NO: 9 –DATA INTERPRETATION – NAME & DEFINE THE VITAL PARAMETERS

STUDENT RESPONSE SHEET

Registration Number: _____ Date: _____

Documentation:

S. Num	Vital Parameters	Values	Interpretation	Definition
1	Temperature	101 ⁰ F		
2	Pulse	50 beats/minute		
3	BP	70/40 mm Hg		
4	Respiration			
5	Respiration			

Signature of the Examinee

Signature of the Examiner

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B.Sc NURSING DEGREE PROGRAMME – I YEAR

NURSING FOUNDATIONS

OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 9 – IDENTIFICATION OF ABNORMAL TEST FINDINGS – IDENTIFICATION OF BREATH SOUNDS

INSTRUCTION TO THE EXAMINER

Objectives

This station is designed to test the candidate's ability to

- identify the abnormal respiratory sound correctly.
- define the respiratory sound heard
- list the disease conditions in which these sounds can be heard.

Observation: Observe if the participant is performing the following task.

Score

Score the task based on the following

- Score "1" for each point identified and written correctly
- Score "0" if the equipment is not identified correctly or if the purpose is not specified correctly.
- Calculate the total score.

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STATION NO: 9 – IDENTIFICATION OF ABNORMAL TEST FINDINGS – IDENTIFICATION OF BREATH SOUNDS

Steps	Task	Max score	Registration number												
1.	Identifies the respiratory sound in the right lung appropriately	1													
2.	Defines the respiratory sound heard in the right lung	1													
3.	Lists down any three possible disease conditions for the respiratory sound heard in the right lung.														
	a.	1													
	b.	1													
	c.	1													
4.	Identifies the respiratory sound in the left lung appropriately	1													
5.	Defines the respiratory sound heard in the left lung	1													
6.	Lists down any three possible disease conditions for the respiratory sound heard in the left lung.														
	a.	1													
	b.	1													
	c.	1													
Total		10													

Name & Signature of the examiner


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STATION NO: 10 –DECISION MAKING – IDENTIFICATION OF VENTURI MASK

Steps	Task	Max score	Registration number																	
1.	Writes the F_{iO_2} for the 1 st venturi	1																		
2.	Mentions the litres of oxygen for the 1 st venturi	1																		
3.	Writes the F_{iO_2} for the 2 nd venturi	1																		
4.	Mentions the litres of oxygen for the 2 nd venturi	1																		
5.	Writes the F_{iO_2} for the 3 rd venturi	1																		
6.	Mentions the litres of oxygen for the 3 rd venturi	1																		
7.	Writes the F_{iO_2} for the 4 th venturi	1																		
8.	Mentions the litres of oxygen for the 4 th venturi	1																		
9.	Writes the F_{iO_2} for the 5 th venturi	1																		
10.	Mentions the litres of oxygen for the 5 th venturi	1																		
Total		10																		

Name & Signature of the examiner

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B.Sc NURSING DEGREE PROGRAMME – I YEAR

NURSING FOUNDATIONS

OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 10 –DECISION MAKING – IDENTIFICATION OF VENTURI MASK

INSTRUCTION TO THE EXAMINER

Objectives

This station is designed to test the candidate's ability to

- write the correct FiO_2 for all the five venturi
- mention the litres of oxygen that can be administered using each color.

Observation:

Observe if the participant is identifying and documenting the given task.

Score

Score the task based on the following

- **Score "1"** for each point identified / written **correctly** or mark
- **Score "0"** if the task is **not identified and written** as recommended
- Calculate the total score

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B.Sc NURSING DEGREE PROGRAMME – I YEAR

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OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 10 –DECISION MAKING – IDENTIFICATION OF VENTURI MASK

INSTRUCTIONS TO THE EXAMINEE

Identify the color of the venturi kept; write the color, the percentage of FiO_2 and the litres of oxygen that can be administered using each color of venturi.

You have 5 minutes to complete this station

Drop the response sheet in the drop box kept on the table after documentation.

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B.Sc NURSING DEGREE PROGRAMME – I YEAR

NURSING FOUNDATIONS

OBJECTIVE STRUCTURED PRACTICAL/CLINICAL EXAMINATION (OSPE/OSCE)

STATION NO: 10 –DECISION MAKING – IDENTIFICATION OF VENTURI MASK

STUDENT RESPONSE SHEET

Registration Number: _____ Date: _____

Documentation:

S. No	Colour	Fio ₂	Litres of oxygen/minute
1.			
2.			
3.			
4.			
5.			

Signature of the Examinee

Signature of the Examiner

Dr. B. S. S. S.
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