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A to Z Guideline Manual in

NURSING

Performance Evaluation Tool

(for Practitioners and Students)



SN Nanjunde Gowda
Jyothi Nanjunde Gowda

Foreword
BN Muninarayanappa

JAYPEE

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CHAPTER

2

Nursing Assessment for Fundamentals of Nursing

History Taking and General Physical Examination

Name of the student ----------Course ----------

Date ---------- Clinical posting (Specialty) ----------

General Patient Information

Name	**IP No.**
Age	**Gender**
Marital status	**Nationality**
Language spoken	**Religion**
Occupation	**Home town/city**
Education	**Income**
Date of admission	**Treatment received on arrival to hospital**
Provisional diagnosis	**Significant lab value**

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History of Present Illness

Ask any or all of the following as appropriate and write summary below

What problem made you to come to hospital	
When this symptoms started	
Any precipitating factors/aggravating (what were you doing at that time)	
Was the onset sudden or gradual	
How often does the problem occur	
Where is the exact location of the problem	
Has the problem occurred before	
Did you try home or other remedies to cure the problem	
Significant area affected	
Reason for admission	
Direct admission	
Referred by others	

Any relevant information ----------

Relevant Family History

Type of family: Nuclear/Joint family
Members of the family: Parents/brothers/sisters

Any major illness in the family: Yes/No. If yes specify----------

Who is suffering ----------

What disease ----------

What is their condition now ----------

Past health history
Previous hospitalization
Surgery if any :
History of communicable disease :
Is the client taking any prescription or over the counter medications on a regular basis/ notice all the medications, how long :

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Family history of illness
Is there any family history of: Asthma/cancer/diabetes/epilepsy/hypertension/heart disease/ hepatitis/hemophilia/stroke/tuberculosis/mental disorders/aged grand parent and siblings alive? If so what is there current state of health if not state the cause of death and age of death.

Psychosocial and spiritual data
Social support system : Client occupational history. How does illness effect work/study and financial status of the client.

Emotional responses
How does the client appear—happy/sad/anxious/irritable
Body language congruent with what the client saying
Is the client dressed appropriately/clean/unkempt
How does the client feel?
What does the client normally do to cope with disease condition?

Cognitive responses
Does the client have on adequate knowledge of his/her illness and treatment?

Health behaviors
Use of alcohol/tobacco. Does the client comply with therapy/drug abuse.
Does the client comply with therapy?

Values and beliefs
What are the clients attitudes/beliefs about hospitalization?
Does he/she have any in appropriate perception of illness?

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General Physical Examination

Use questioning, observation and examination to gather data. Tick items that apply to the client and comment as needed.

Sensation

Eyes

- Poor vision
- Blurred vision
- Eye infection
- Blindness R/L
- Eye pain
- Itching
- Prosthesis
- Glasses/contact lens

Ears

- Ringing in ears
- Discharge
- Ear infection
- Loss of hearing R/L
- Ear pain
- Itching hearing aids

Tongue

Difficulty of taste
- Glossitis
- Stomatitis

Nose

- Frequent colds
- Nose bleeds
- Pain
- Discharge

Touch

Reduced sensation or tactile perception

Comments

Skin and Mucous Membranes

Skin

- Excessive dryness
- Bruising
- Jaundice itching
- Rash
- Broken skin/wound
- Pale/flushed
- Poor turgor
- Change in pigmentation

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Mouth and Throat

- Sore throat
- Coated tongue
- Dental caries
- Bad breath (halitosis)
- Bleeding gums
- Dentures upper/lower

Hair

- Itchy scalp
- Hygiene poor
- Dandruff
- Hair change
- Loss/excess

Nails

- Colors changes
- Biting
- Spliting
- Clubbing

Comments

Respiration

Rate ----------

Characteristics ----------

- Cough
- Dyspnea
- Wheezing
- Coughs blood (hemoptysis)
- Cyanosis
- Pain on breathing
- Restlessness
- Smoke (how many per day).

Comments

Circulation

Pulse rate ----------min Characteristics ----------

Blood pressure ----------mm Hg

- Fatigue
- Chest pain
- Nausea
- Vomiting
- Anemia
- Varicose veins
- Peripheral pulses
- Leg swelling/ulcers

Comments

Nutrition

Weight ---------- Height ----------Skin fold thickness -------

- Appetite change
- Weight change
- Nausea vomiting
- Dysphasia
- Heart burn
- Dentures upper/lower

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Normal eating pattern (likes and dislikes)

Comments

Abdomen

- Inspection: Rasheses
- Lesions
- Scar/ striae
- Distended
- Peristalsis
- Present/absent
- Tenderness/ mass

Elimination

Urinary

- Frequency
- Urgency
- Dribbling
- Urinary incontinence
- Painful urination
- Retention
- Dysuria
- Urinary appliance
- Nocturia
- Hematuria
- Anuria
- Distended bladder

Activity/Exercise

- Muscle pain
- Muscle weakness
- Cramps
- Joint pain/swelling
- Stiffness of movements
- Deformities
- Abnormal gait
- Fatigue
- Impaired coordination

Self care (describe limitation to eating, bathing, dressing, toileting, ambulating)

Comments

Comfort

Describes the following

Pain if yes how it is relived ----------

Sleep pattern and methods/treatment used for sleep ----------

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Neurological Responses

- Disorientation
- Unconscious
- Headache
- Tremors
- Paralysis
- Numbness
- Weakness
- Seizures (fits)
- Dizziness
- Loss of memory
- Difficult expressing self verbally

Comments

Immune Response

Temperature ----------

- Allergies
- Fever in last 45 hours
- Swollen glands

Chemotherapy----------

Sexuality

Female

Age of menarche ----------Last menstrual period (LMP) ----------Duration ------

Flow ----------Cycle ---------- (days)

- Dysmenorrhea
- Bleeding between periods
- Vaginal bleeding

Males

- Discharge
- Swelling/masses

Comments----------

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Clinical Evaluation

(Form A)

Name of the student----------

Students number ---------- Ward----------Unit --------

Group ----------

Nursing Process

1. Assessment and Diagnosis

Activities	Excellent 4	Very good 3	Good 2	Satisfactory 1	Not satisfactory 0	Not satisfactory	
Collects data about patients needs						Unable to collect data about patients needs	Marks
Identifies basic needs of patients						Unable to identify patients needs	
Categorizes the patients needs/ problems						Unabe to categorize the patients needs	
Formulates nursing diagnosis						Unable to categorize nursing diagnosis	

2. Planning

Activities	Excellent 4	Very good 3	Good 2	Satisfactory 1	Not satisfactory 0	Not satisfactory	
Prioritizes the patient needs						Unable to identify the priority needs	Marks
State the outcome criteria						Unable to state the outcome criteria	

Contd...

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Contd...

Activities	Excellent 4	Very good 3	Good 2	Satisfactory 1	Not satisfactory 0	Not satisfactory	
Plans nursing actions for each needs of the patient						Unabe to plan nursing actions for patient or unable to cope with routine work	
States rationale for nursing actions						Unable to state rationale for nursing actions	
Formulates the needed patient health instructions						Makes no attempt to find out the health learning needs of the patients and family	

3. Implementation

Activities	Excellent 4	Very good 3	Good 2	Satisfactory 1	Not satisfactory 0	Not satisfactory	
Implements nursing care competently, safely, and accurately within a given time						In competent to implement nursing care safely and accurately	Marks
Maintains comfortable environment for patient						Ignores body alignment. Does not pay attention to patients discomfort	

Contd...

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Contd...

Activities	Excellent 4	Very good 3	Good 2	Satisfactory 1	Not satis-factory 0	Not satis-factory	
Applies scientific principles						Ignores scientific principles when carrying out care	
Maintains safe environment						Unable to maintain healthy, safe and clean environment	
Records and reports patients information accurately						Fails to report or record accurate information	
Gives health instructions to patient and family						Unable to give even incidental teaching to patient and family	

4. Evaluation

Activities	Excellent 4	Very good 3	Good 2	Satisfactory 1	Not satis-factory 0	Not satis-factory	
Identifies outcome criteria used to evaluate the patients response to nursing care						Unable to identify outcome criteria or unable to monitor patients progress	Marks
Collects data related to identified criteria						Unable to collect data related to identified criteria	

Contd...

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Contd...

Activities	Excellent 4	Very good 3	Good 2	Satisfactory 1	Not satis-factory 0	Not satis-factory	
Re-examine the patient's care plan						Unable to re-examine the patients care plan	
Modifies the care plan						Unable to modify the care plan	

5. Professional Conduct

a. Uniform

Activities	Excellent 4	Very good 3	Good 2	Satisfactory 1	Not satisfactory 0	Not satis-factory	
Always well groomed and neat, conscious about professional appearance						Pays no attention to grooming and untidy	

b. Punctuality

Activities	Excellent 4	Very good 3	Good 2	Satisfactory 1	Not satis-factory 0	Not satisfactory	
Exceptionally punctual for clinical and has never been late, completes all given learning assignments on time						Consistently late for clinical. Makes no attempt to complete the learning assignments on time. Stops in mid task when clinical hours over	

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c. Sense of Responsibility

Activities	Excellent 4	Very good 3	Good 2	Satisfactory 1	Not satis-factory 0	Not satisfactory	
Readily accepts responsibility for own behaviors						Reluctant to take responsibility and avoids it. Breaks rules and regulations	
Respects rules and regulations						Reluctant to take responsibility and avoids it. Breaks rules and regulations	

d. Initiative for Self-learning

Activities	Excellent 4	Very good 3	Good 2	Satisfactory 1	Not satis-factory 0	Not satisfactory	
Eager to learn and seeks new learning experience						Fails to participate in new learning experiences	

e. Interpersonal Skills

Activities	Excellent 4	Very good 3	Good 2	Satisfactory 1	Not satis-factory 0	Not satisfactory	
Establishes and maintains outstanding working relationships						Fails to establish effective working relationship with patients and families	

Total marks: 100. ------- **Marks obtained** -------

Signature of Student ------- **Signature of Clinical Instructor** -------

- Excellent - 4
- Good - 2
- Not satisfactory - 1
- Very good - 3
- Satisfactory - 1

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NURSING

Performance Evaluation Tool

Basic nursing education depending on theory and clinical exposure, the quality of nursing education only gained through theory and clinical experience, nursing educators have the greater responsibilities to develop psychomotor and technical skills with the learner. If the theory and clinical experiences are systematically planned, organized and adhering to the criteria of evaluation, only then we can expect nursing care skills are imparted to the learner. The nursing educational institutes play a vital role in developing criteria for evaluating performance of learner and teacher.

- Concept of performance evaluation
- Appropriate standards of care and appropriate evaluation tools
- Evaluation process standards which describes the behavior of learner at the desired levels of performance
- All the activities concerned with delivering patient care
- Process standard which assist in measuring the degree of skills, technique or procedure was carried out by the learner with the levels of learner and client interaction, which includes:
  - Nursing techniques
  - Nursing procedures
  - Nursing activities (in terms of quality of care, appropriateness of care, adequacy of care)
- Appropriate assessment for collecting data, prioritizing the needs, and identify the expected outcome and plan of care.
- Standards of evaluation which measures the nursing actions or lack of actions involving patient care.

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