MINISTRY OF SCIENCE AND HIGHER EDUCATION OF THE RUSSIAN FEDERATION
MINISTRY OF SCIENCE, HIGHER EDUCATION AND INNOVATION OF THE KYRGYZ REPUBLIC
Kyrgyz-Russian Slavic University
named after the first President of the Russian Federation B.N. Yeltsin
Department of Therapy No. 1 (Pediatrics and Dentistry)

FUND OF ASSESSMENT TOOLS (FAT)

for the discipline

NURSING

Curriculum: 310501_24_2 ld in.plx
Specialty: 560001 — General Medicine (for international students)
Qualification: Doctor (Physician)
Form of study: Full-time | Semester: 1 (Year 1, Semester 1) | Weeks: 21
Total hours: 72 (classroom: 32 | independent work: 39.7)
Form of assessment: Credit (pass/fail)
FGOS: Order No. 1578/1 of 21.09.2021 (Specialty 31.05.01)

The Fund of Assessment Tools is designed to control students' knowledge in the field of study (specialty) PHYSICIAN (DOCTOR) in the discipline " PROFESSIONAL CYCLE
Nursing "

The Fund of Assessment Tools was reviewed and approved at the meeting of the department of
THERAPY-1 OF PEDIATRICS AND DENTAL SPECIALTIES

Protocol No. 1 dated 27.08.2024

Head of Department
Therapy-1 of Pediatrics and Dental specialties __ _ Suranova G.Zh.

Executors
Candidate of Medical Sciences, Associate Professor _ Suranova G.Zh.

1. PASSPORT OF THE FUND OF ASSESSMENT TOOLS

1.1. Competencies Assessed

The FAT ensures assessment of the following competencies formed through the discipline 'Nursing' (curriculum 310501_24_2 ld in.plx):

Code	Competency	Description	Assessment Tools
SLK-4	Ethics & law	Ability to conduct activities in accordance with moral and legal norms; social and ethical responsibility for decisions made.	Tests, oral quiz, credit
PC-1	Medical ethics	Ability to comply with rules of medical ethics, laws on confidential information, and maintain medical confidentiality.	Situational tasks, credit
PC-17	Therapeutic care	Ability to perform basic therapeutic measures for common diseases and conditions in adult and paediatric patients on outpatient and inpatient basis.	Practical skills, tasks, credit
PC-28	Staff management	Ability to ensure rational organisation of work of middle and junior medical personnel of healthcare institutions.	Tests, oral quiz, credit
PC-22	Rehabilitation	Ability to apply rehabilitation measures (medical, social, professional) for common pathological conditions and injuries.	Situational tasks, credit

1.2. Assessment Tools and Control Stages

Assessment Tool	Control Type	Semester	Competency	RPD Section
Test tasks (current control)	Current	1	SLK-4, PC-1, PC-17	Sections 1–2
Situational tasks	Current / Milestone	1	PC-1, PC-17, PC-22	Sections 1–2
Practical skills assessment	Current / Milestone	1	PC-17, PC-28	Sections 1–2
Oral questions / quiz	Current	1	SLK-4, PC-1, PC-28	Sections 1–2
Workbook tasks	Current	1	PC-17, PC-22	Sections 1–2
Report / Presentation (SRS)	Current	1	SLK-4, PC-1	Sections 1–2
Milestone test (CrTO, topic 2.11)	Milestone	1	All	Sections 1–2
Credit — final (pass/fail)	Intermediate	1	All	Sections 1–2

2. TEST TASKS

Used for current and milestone control. Correct answer shown in bold green (printed versions use a separate answer-key sheet). 1 point per correct answer. 20 questions per sitting; time: 20 minutes.

Section 1 — Organisation of Nursing, Documentation, Infection Control, Medicines

The nursing process in a therapeutic department consists of:

A) Two stages: assessment and implementation
B) Three stages: assessment, planning, and evaluation
C) Five stages: assessment, nursing diagnosis, planning, implementation, and evaluation
D) Four stages: diagnosis, planning, treatment, and discharge
E) It is not standardised — nurses follow physician orders only

Which document regulates infection control and prevention of nosocomial infections in healthcare facilities of the Kyrgyz Republic?

A) International Classification of Diseases (ICD-11)
B) Orders of the Ministry of Health of the Kyrgyz Republic on disinfection, sterilisation, and infection control
C) Patient's admission form
D) The nursing shift handover report
E) The facility's fire safety plan

Standard precautions in infection control must be applied to:

A) Only patients with confirmed infectious diseases
B) All patients regardless of diagnosis or known infection status
C) Only patients in isolation rooms
D) Only when the nurse has skin wounds or abrasions
E) Only during surgical procedures

The CORRECT sequence of medical device reprocessing (after single use) is:

A) Sterilisation → disinfection → pre-sterilisation cleaning
B) Pre-sterilisation cleaning → disinfection → sterilisation
C) Disinfection → sterilisation → pre-sterilisation cleaning
D) Rinse with water → sterilise directly
E) Disinfection only is sufficient for all instruments

Which statement about HIV transmission in a healthcare setting is CORRECT?

A) HIV is transmitted by airborne droplets — masks are sufficient protection
B) HIV is transmitted through contact with intact skin
C) HIV can be transmitted through needlestick injuries, mucosal contact with infected blood; standard precautions and post-exposure prophylaxis are required
D) HIV is transmitted only through sexual contact, posing no risk to healthcare workers

E) Single-use gloves provide complete protection without any other measures

A nurse discovers a needlestick injury after drawing blood from an HIV-positive patient. The FIRST action is:

A) Ignore if there is no bleeding
B) Squeeze out blood from the wound, wash thoroughly with soap and water, report to the head of department, document the incident, and start post-exposure prophylaxis (PEP) as per protocol
C) Apply a plaster and continue working
D) Wait to see whether symptoms develop
E) Only inform the patient

Which drug administration route ensures the FASTEST onset of action in an emergency?

A) Oral (per os)
B) Subcutaneous
C) Intramuscular
D) Intravenous
E) Rectal

Medical documentation in a therapeutic ward includes all of the following EXCEPT:

A) In-patient medical record (case history)
B) Nursing observation and vital signs chart
C) Medication administration record
D) Financial accounting ledger of the hospital
E) Fluid balance (diuresis) chart

The correct working concentration of 70% ethyl alcohol for skin antisepsis of injection sites is:

A) 30%
B) 50%
C) 70%
D) 96%
E) 100%

Medical confidentiality (PC-1) means that a healthcare worker must NOT disclose patient information WITHOUT the patient's consent, EXCEPT when:

A) A colleague asks out of curiosity
B) Required by law (e.g., reporting notifiable infectious diseases, court order, risk to third parties)
C) The patient's relatives ask politely
D) The information is already known in the community
E) The nurse considers it in the patient's best interest

Section 2 — Body Mechanics, Patient Feeding, Specimen Collection, Emergency Care

When moving a bedridden patient up in bed, the correct body mechanics for the nurse include:

A) Bend the back with straight legs

B) Stand close to the bed, feet shoulder-width apart, bend knees, keep back straight, use leg muscles to push/lift

C) Pull the patient by the arms

D) Always use one nurse regardless of patient weight

E) Lift with arms fully extended away from the body

A patient on diet No. 10 (cardiac diet) should have all of the following RESTRICTIONS EXCEPT:

A) Salt restriction to 3–5 g/day

B) Fluid restriction to 1–1.2 L/day

C) Avoidance of fatty, fried, and smoked foods

D) High-protein, unlimited-salt diet

E) Small frequent meals (4–5 per day)

The correct procedure for collecting a 24-hour urine specimen (Zimnitsky test) is:

A) Collect all urine including the first morning void at 06:00

B) Discard the 06:00 void; collect ALL subsequent urine in 8 separate portions every 3 hours until 06:00 the next morning

C) Collect only morning urine for 3 consecutive days

D) Collect a random midstream specimen

E) Collect the specimen immediately after catheterisation only

Before an oesophago-gastro-duodenoscopy (FGDS/EGDS), the nurse instructs the patient to:

A) Eat a light breakfast 2 hours before the procedure

B) Fast for at least 8 hours; refrain from smoking on the day; remove dentures before the procedure

C) Drink 2 litres of water one hour before

D) Take a cleansing enema the morning of the procedure

E) Take an antacid 30 minutes before

The CORRECT technique for bladder catheterisation in women involves:

A) Clean technique using non-sterile gloves and tap water

B) Strict aseptic technique: sterile gloves, sterile field, sterile catheter, antiseptic cleansing of the urethral meatus before insertion

C) No special preparation; any catheter may be used

D) Catheterisation only by a physician; nurses may not perform this procedure

E) Catheter insertion without lubrication to reduce infection risk

A patient develops sudden chest pain radiating to the left arm, diaphoresis, and nausea. The nurse's PRIORITY action is:

A) Offer the patient water and reassure them

B) Immediately inform the physician, place patient in semi-recumbent position, ensure IV access, administer O_2 if SpO_2 <94%, prepare for ECG

C) Measure temperature and wait for the next scheduled visit
D) Give paracetamol and observe for 2 hours
E) Ask the patient to walk to reduce anxiety

The signs of CLINICAL DEATH include:
A) Cyanosis, hypothermia, and pinpoint pupils
B) Loss of consciousness, absence of carotid pulse, and absence of breathing
C) Bradycardia (HR 40 bpm), shallow breathing
D) Unconsciousness with snoring breathing only
E) Fixed dilated pupils alone

The correct compression-to-ventilation ratio for single-rescuer adult CPR according to current international guidelines is:
A) 5:1
B) 15:2
C) 30:2
D) 30:1
E) 15:1

When collecting sputum for bacteriological examination, the patient should be instructed to:
A) Collect saliva (not sputum) for convenience
B) Rinse the mouth with water, then expectorate a deep cough sample into a sterile wide-mouth container in the morning before eating or taking medications
C) Collect the specimen after a meal for better yield
D) Refrigerate the specimen at −20 °C for 48 hours before delivery to the laboratory
E) A regular cup is acceptable if a sterile container is unavailable

A patient is found with facial asymmetry, right-sided arm weakness, and slurred speech that appeared 30 minutes ago. The nurse recognises this as a suspected stroke and should:
A) Give the patient aspirin immediately and observe
B) Activate the emergency stroke protocol immediately: call the physician, do not give food/water/oral medications, position head elevated 30°, monitor neurological status, prepare for urgent CT/thrombolysis evaluation
C) Place the patient supine with legs elevated
D) Administer oxygen only and wait for spontaneous recovery
E) Perform CPR since the patient is semiconscious

Anaphylaxis is characterised by the triad:
A) Fever, jaundice, and abdominal pain
B) Acute onset of urticaria/angioedema, bronchospasm/dyspnoea, and haemodynamic compromise (hypotension/shock) following allergen exposure
C) Bradycardia, hypertension, and confusion
D) Local oedema at injection site only
E) Haemoptysis, cough, and chest pain

Which disinfection level is required for endoscopes used for non-invasive procedures (e.g., FGDS)?

A) Low-level disinfection (surface wipe with alcohol)
B) High-level disinfection (e.g., glutaraldehyde 2% or ortho-phthalaldehyde 0.55%)
C) Sterilisation in an autoclave at 134 °C
D) Rinsing with hot water only
E) No special processing between patients

The Fowler's position (semi-sitting, 45–60°) is indicated for patients with:

A) Hypovolaemic shock (systolic BP <90 mmHg)
B) Acute left ventricular failure, dyspnoea, pulmonary oedema
C) Suspected spinal cord injury
D) Hypoglycaemic coma
E) Preparation for spinal anaesthesia

According to medical ethics (PC-1) and the principles of deontology, a nurse should:

A) Share patient information with family members without asking the patient
B) Maintain professional boundaries, respect patient autonomy, protect confidentiality, and demonstrate empathy and respect in all interactions
C) Avoid discussing diagnosis with the patient to prevent anxiety
D) Follow physician orders even if they appear harmful to the patient
E) Prioritise administrative convenience over patient welfare

When preparing a patient for a kidney X-ray (intravenous urography), the nurse should:

A) Give the patient a high-fibre meal the evening before
B) Assess for allergy to iodine-containing contrast agents, ensure NPO for 6–8 hours before, administer bowel preparation the evening before as prescribed, establish IV access
C) Instruct the patient to drink 2 litres of water immediately before the procedure
D) No special preparation is required for IV urography
E) Administer laxatives on the morning of the procedure only

3. SITUATIONAL TASKS

Situational tasks assess 'Be Able' and 'Own' competency levels (PC-17, PC-22, PC-1). Used at practical classes, milestone, and final credit. Graded per model answer: 20–30 points (see Section 8).

Task 1. Infection Control — Needlestick Injury

> A first-year medical student, during her first week on the therapeutic ward, accidentally sustains a needlestick injury while recapping a needle after drawing blood from a patient with confirmed hepatitis B. The student is not wearing gloves. She reports the incident to the supervising nurse.

Questions:

1. What immediate first-aid actions should the nurse supervise/perform?
2. What documentation must be completed and which persons must be notified?
3. What post-exposure measures may be indicated, and who makes this decision?
4. What rule was violated that contributed to the incident, and how should it be prevented in future?
5. What are the nurse's responsibilities under PC-28 (staff organisation) in this situation?

Model Answer:

1. Immediate first aid: do NOT squeeze or suck the wound; allow blood to flow freely for a few seconds; wash thoroughly with soap and running water for at least 2–3 minutes; treat with 70% alcohol or iodine; cover with a sterile plaster.
2. Documentation: complete an incident/occupational accident form; record in the emergency register; notify the head nurse, department head, and infection control officer on the same day.
3. Post-exposure prophylaxis (PEP): the physician assesses the risk; for hepatitis B — check student's vaccination status; if unvaccinated or antibody titre <10 IU/L — administer HBIg and/or accelerated HBV vaccine; blood samples from both student and source patient to be taken with consent. The physician prescribes; the nurse prepares and administers.
4. Rule violated: 'Never recap needles with two hands — use the one-handed scoop method or a needle-capping device'. Prevention: safety-engineered devices, routine training on sharps safety, and mandatory glove use during blood procedures.
5. Under PC-28, the nurse is responsible for organising safe working practices for junior staff and students: briefing them on standard precautions, ensuring availability of PPE, and reporting all incidents through the correct chain of command.

Task 2. Gastric Lavage — Oral Drug Overdose

> A 22-year-old student is brought to the emergency department 45 minutes after intentional ingestion of approximately 20 tablets of a sedative-hypnotic drug. She is drowsy but rousable, GCS 13/15, BP 105/65, HR 82, RR 16, SpO_2 97%. The physician orders gastric lavage.

Questions:

6. State the indications and contraindications for gastric lavage in this patient.
7. Describe patient positioning and equipment preparation.
8. Outline the step-by-step procedure.
9. What nursing observations are required during and after the procedure?
10. How should the nurse address the patient's psychological state before and after the procedure (PC-1, SLK-4)?

Model Answer:

6. Indication: oral drug overdose within 1–2 hours (some guidelines allow up to 4–6 h for slow-release preparations); patient is conscious with intact airway reflexes. Contraindications: corrosive (acid/alkali) ingestion, petroleum products, loss of airway protective reflexes (unless intubated), oesophageal varices, recent upper GI surgery.
7. Position: left lateral decubent or seated upright; protect airway. Equipment: gastric tube Ch36–40, lubricant (Vaseline/glycerine), 10–12 L warm water (36–37 °C), 500 ml syringe or funnel, emesis basin, IV access established, suction ready.
8. Step-by-step: measure tube length (earlobe–nose–xiphoid ~45–55 cm); mark with tape; lubricate tip; insert through mouth, asking patient to swallow; confirm placement (auscultate air insufflation over epigastrium); instil 300–500 ml water; lower tube/funnel below stomach level for siphon drainage; repeat cycle until effluent is clear (total ~10–12 L); remove tube smoothly; keep first portion for toxicology.
9. During: monitor GCS, RR, SpO_2 every 5 min; watch for vomiting and aspiration (suction ready); record input/output volumes. After: position in recovery position; NPO until fully alert; vital signs every 15 min for 1 h; document time, volumes, patient response, and complications.
10. Approach with calm, non-judgmental communication; explain each step clearly; maintain privacy and dignity; do not comment on the circumstances of the overdose to other staff or patients (medical confidentiality — PC-1); after the procedure, ensure psychiatry or crisis team referral as per protocol (SLK-4 — ethical responsibility).

Task 3. Emergency Care — Syncope/Collapse

> During a morning visit to an outpatient clinic, a 55-year-old patient suddenly becomes pale, sweaty, and loses consciousness. She collapses to the floor. She is breathing and has a weak, rapid pulse (HR 105, BP 80/50). Temperature 36.5 °C.

Questions:

11. What is the likely diagnosis and what should the nurse do in the first 30 seconds?
12. Describe positioning and initial nursing management.
13. List the vital signs and parameters to monitor and document.
14. When is CPR indicated, and what are the criteria?
15. Formulate a nursing diagnosis and priority problem.

Model Answer:

11. Likely diagnosis: vasovagal syncope or acute vascular insufficiency (collapse). First 30 seconds: call for help (emergency code/physician), lower patient safely to the floor, do not leave alone.
12. Position: supine with legs elevated 30–45° (to improve venous return); loosen tight clothing; ensure airway is open (head tilt-chin lift); administer O_2 4–6 L/min via nasal cannula; establish IV access; prepare 0.9% NaCl infusion as prescribed.

13. Monitor and document: BP (every 5 min), HR, RR, SpO_2, GCS, skin colour and temperature, urine output; time of collapse and recovery; all medications administered.
14. CPR is indicated if: no pulse detected at carotid artery within 10 seconds AND no breathing (or only agonal gasps). Start 30:2 CPR immediately, call resuscitation team.
15. Nursing diagnosis: 'Decreased cardiac output related to acute vascular insufficiency, evidenced by loss of consciousness, BP 80/50, HR 105, pallor'. Priority problem: Risk of cerebral hypoxia and cardiac arrest.

Task 4. Patient Preparation — Abdominal Ultrasound + Urine Specimen Collection

> A 48-year-old patient is admitted to the therapeutic ward with suspected gallstone disease and urinary tract infection. The physician orders: (1) abdominal ultrasound for the following morning; (2) general urinalysis; (3) Nechiporenko urinalysis; (4) urine culture.

Questions:

16. What instructions should the nurse give the patient for preparation for abdominal ultrasound?
17. Describe the correct procedure for collecting a midstream urine specimen for general analysis.
18. How does urine collection for Nechiporenko analysis differ from general urinalysis?
19. What precautions are required for urine culture (bacteriological examination)?
20. How should the nurse document and label all specimens, and what are the ethical considerations?

Model Answer:

16. Ultrasound preparation: follow a gas-reducing diet for 2–3 days (exclude legumes, cabbage, carbonated drinks, black bread, milk); NPO for 6–8 hours before the scan; do not smoke on the morning of the scan; for pelvic organs — full bladder (drink 1 L water 1 h before). Inform the patient that the procedure is painless.
17. General urinalysis — midstream clean-catch: patient performs thorough external genitalia hygiene with soap and water or antiseptic wipe; begins urination, discharges the first 10–15 ml (first stream) into toilet; collects the middle portion (30–50 ml) into a clean container; delivers to lab within 1–2 hours.
18. Nechiporenko: identical collection technique (midstream, clean-catch); only 5–10 ml of the mid-stream portion is needed (counts formed elements per 1 ml); must be delivered to lab within 1 hour; no preservatives.
19. Urine culture: must be collected in a STERILE container; strict hygiene of external genitalia; strictly mid-stream catch; deliver to lab within 30 minutes or refrigerate at 4 °C for no more than 2 hours; label with patient name, date, time, and type of examination.
20. Label each container clearly: patient full name, ward/bed number, date, time, type of specimen, and examination requested. Accompany with completed laboratory referral form. Maintain patient dignity and confidentiality throughout — do not discuss results with unauthorised persons (PC-1).

Task 5. Rehabilitation Nursing — Post-Myocardial Infarction Patient

> A 62-year-old patient, Mr. K., is on day 7 after acute myocardial infarction. He is prescribed strict bed rest. He is anxious, asks about prognosis, and expresses reluctance to start any activity. The nurse is assigned to provide care and begin mobilisation preparation.

Questions:

21. What principles of rehabilitation nursing (PC-22) apply to this patient at day 7 post-MI?
22. How should the nurse approach the patient's anxiety and reluctance (PC-1, SLK-4)?
23. Describe the positioning, skin care, and pressure ulcer prevention required for a patient on strict bed rest.
24. What basic monitoring should the nurse perform and document daily?
25. What elements of patient education should the nurse provide regarding activity progression?

Model Answer:

21. Rehabilitation principles at day 7: follow the physician-prescribed physical activity regime; mobilisation is gradual — passive → active range-of-motion exercises in bed → sitting at the edge of the bed (with physician clearance); the nurse ensures exercises do not provoke chest pain, dyspnoea, or ECG changes; coordinate with the physiotherapist; document tolerance.
22. Therapeutic communication: acknowledge the patient's fears without dismissal; provide clear, honest information within the nurse's scope (refer specific prognosis questions to the physician); maintain confidentiality; use a calm, reassuring tone; involve the patient in goal-setting for recovery. Ethical principle: respect for autonomy (SLK-4).
23. Strict bed rest care: reposition every 2 hours (supine ↔ right lateral ↔ left lateral, or as prescribed given infarct location); inspect sacrum, heels, elbows, and scapulae at each repositioning; use anti-decubitus mattress if available; apply barrier cream to pressure areas; ensure bed linen is smooth and dry; use a special back rest pillow for semi-recumbent position.
24. Daily monitoring: HR, BP (both arms, compare), RR, SpO_2, temperature; fluid balance (input/output); weight (to detect fluid retention); pain scale; oedema (ankles, sacrum); bowel function (straining is contraindicated — lactulose/stool softener if prescribed); ECG monitoring per protocol.
25. Patient education: explain the rationale for gradual activity increase; teach how to self-monitor pulse and recognise warning symptoms (chest pain, dyspnoea, palpitations); provide dietary advice (low-salt, low-fat, no large meals); smoking cessation counselling; importance of medication adherence; refer to cardiac rehabilitation programme information.

4. PRACTICAL SKILLS ASSESSMENT

Practical skills are assessed during practical classes and at the final credit. Skills are performed on simulators, phantoms, or demonstrated step-by-step. Graded by checklist (maximum 30 points each).

4.1. Required Skills List

- Blood pressure measurement (auscultatory method, Korotkoff technique)
- Pulse measurement (radial artery, 1 minute) and respiratory rate counting
- Body temperature measurement (axillary, oral); thermometer disinfection and storage
- Six-step hand hygiene technique (WHO protocol): routine handwashing and hygienic antisepsis
- Donning and doffing personal protective equipment (gloves, gown, mask, eye protection)
- Subcutaneous injection (on phantom): insulin/heparin administration technique
- Intramuscular injection (on phantom): upper outer gluteal quadrant technique
- Preparation and set-up of an IV infusion system; peripheral IV care
- Preparation of 1% chloramine-B solution from dry powder (disinfection preparation)
- Gastric lavage technique (on phantom): siphon method step-by-step
- Cleansing enema administration (on phantom)
- Rectal gas-outlet tube insertion and management (on phantom)
- Female urinary catheterisation (on phantom): strict aseptic technique
- Patient repositioning in bed: supine, lateral, Fowler's, Sim's positions
- Pressure ulcer prevention: skin inspection, repositioning schedule, barrier cream application
- Oxygen therapy: nasal cannula and simple face mask setup and adjustment
- Adult CPR on resuscitation manikin: 30:2, correct depth/rate, full recoil
- Recovery position for unconscious patient with spontaneous breathing
- Venipuncture for blood sampling (on phantom): general analysis, biochemistry, culture
- Patient preparation instructions: FGDS, abdominal ultrasound, ECG, urinalysis

4.2. Skill Checklist: Intramuscular Injection (Example)

Assessment Criterion	Max Pts	Score
Verifies physician order and drug (name, dose, route, patient)	4	
Washes/sanitises hands; prepares sterile tray	4	
Draws up correct dose aseptically; checks for air bubbles	6	
Identifies patient (name + date of birth or ID)	4	
Explains procedure; obtains verbal consent	4	
Positions patient appropriately; exposes injection site	4	

Identifies upper outer quadrant of the gluteal muscle correctly	8	
Disinfects skin with 70% alcohol (2 × wipe, allow to dry)	6	
Stretches skin taut; inserts needle at 90° to full length	8	
Aspirates (draws back plunger) to check no blood return	8	
Injects drug slowly (1 ml per 10 seconds)	6	
Withdraws needle smoothly; presses with dry cotton ball	6	
Disposes of needle in sharps container without recapping	8	
Documents administration (drug, dose, site, time, signature)	8	
Asks patient about post-injection comfort; advises on side effects	6	
TOTAL	100	

4.3. Practical Skills Grading Scale

Score %	Grade	Criterion	Credit
90–100	Excellent	All steps performed correctly, safely, in proper sequence, without prompting	Pass
75–89	Good	Minor omissions, no safety violations	Pass
60–74	Satisfactory	Errors corrected after prompting; no critical safety failure	Pass
<60	Unsatisfactory	Critical safety errors or incomplete procedure	Fail — repeat

5. MILESTONE CONTROL (CrTO — Topic 2.11)

The milestone control (CrTO) takes place at the end of the semester, covering both RPD sections. Format: 20 test questions + 1 situational task + 1 practical skill demonstration. Total time: 60 minutes.

5.1. Scope of Milestone Control

- Section 1 (topics 1.1–1.6 and self-study 1.7): organisation of nursing, documentation, infection control, disinfection/sterilisation, drug administration.
- Section 2 (topics 2.1–2.9 and self-study 2.10): body mechanics, patient feeding, catheterisation, GI manipulations, specimen collection, emergency care, CPR.
- Practical skills: any item from the list in Section 4 of this FAT.
- Theoretical questions: any items from the credit question list in Section 6 of this FAT.

5.2. Milestone Control Grading

Component	Max Points	Pass Threshold	Notes
Test questions (20 items)	40	24 (60%)	2 points per correct answer
Situational task	30	18 (60%)	Per model answer — levels III–IV
Practical skill	30	18 (60%)	Per checklist in Section 4
TOTAL	100	60	All three components must reach threshold

6. QUESTIONS FOR THE FINAL CREDIT

The credit (pass/fail) includes: (1) one theoretical question drawn by the student; (2) one situational task; (3) one practical skill demonstration. Students scoring >60 cumulative points may receive credit without an oral examination.

Section 1 — Organisation, Documentation, Infection Control, Medicines

1. The nursing process: five stages, their content, and documentation in a therapeutic ward.
2. Goals and objectives of nursing in therapy; structure of therapeutic departments and outpatient clinics.
3. Nursing deontology and professional ethics: key principles, communication with patients, colleagues, and physicians.
4. Medical documentation in therapeutic departments: types, rules for completion, legal significance.
5. Infection control in healthcare facilities: the chain of infection, standard precautions, levels of protection.
6. Disinfection: definition, levels (low, intermediate, high), methods, preparation of working solutions (chloramine-B, alcohol).
7. Sterilisation: definition, methods (autoclave, dry-heat oven, chemical), sterility indicators, packaging requirements.
8. HIV/AIDS: routes of transmission, precautions, post-exposure prophylaxis protocol for healthcare workers.
9. Viral hepatitis B and C: transmission in healthcare settings, prevention, vaccination, safe hospital environment.
10. Post-injection complications: types (infiltrate, abscess, embolism, haematoma, nerve injury), prevention, and management.
11. Drug administration routes: oral, sublingual, rectal, inhalation, transdermal, subcutaneous, intramuscular, intravenous — indications, technique, nursing responsibilities.
12. IV infusion systems: setup, care of IV sites, complications (phlebitis, infiltration), nurse's role.
13. Storage, accounting, and distribution of medicines in a therapeutic ward; rules for controlled substances.
14. Medical confidentiality (PC-1): legal basis, exceptions, practical application in nursing.
15. Organisation of junior and middle nursing staff (PC-28): functions of ward and procedure nurses, nursing management principles.

Section 2 — Biomechanics, Feeding, Diagnostics, Emergency Care

1. Biomechanics of patient movement: principles, methods for repositioning a bedridden patient, pressure ulcer prevention (Braden scale).
2. Therapeutic diets: Pevzner diet numbers 1, 2, 5, 7, 9, 10 — indications, principles; organisation of feeding in hospital.
3. Parenteral nutrition: indications, types (peripheral vs central), nurse's role, monitoring.
4. Urinary catheterisation: indications, types of catheters, female technique (strict aseptic), complications.
5. Bladder lavage through epicystostomy: indications, technique, nurse's monitoring.

6. Gastric lavage: indications, contraindications, equipment, siphon technique, complications.
7. Enemas: types (cleansing, siphon, therapeutic, nutritional), technique, complications.
8. Patient preparation for X-ray examinations: plain abdominal X-ray, IVU, cholecystography — preparation algorithm.
9. Patient preparation for endoscopic examinations: FGDS, colonoscopy — dietary preparation, fasting, patient instruction.
10. Patient preparation for ultrasound: abdominal organs, kidneys, pelvic organs — preparation algorithm.
11. Specimen collection: blood (venipuncture — biochemistry, general analysis, serology, culture), urine (general, Nechiporenko, Zimnitsky, culture), sputum, faeces (general, occult blood, parasitology).
12. Pleural puncture and abdominal paracentesis: nurse's role — equipment preparation, positioning, post-procedure care.
13. Pain syndrome: assessment tools (NRS, PQRST), differential approach (cardiac, abdominal, renal pain), nursing management.
14. Emergency nursing care in cardiovascular events: suspected MI (positioning, O_2, IV access, ECG, nitrates as prescribed), hypertensive crisis, acute pulmonary oedema.
15. Acute vascular insufficiency: syncope, collapse, anaphylactic and haemorrhagic shock — pathophysiology, recognition, emergency nursing actions.
16. Cardiopulmonary resuscitation: clinical vs biological death; BLS algorithm (30:2); AED use; post-resuscitation care; documentation.
17. Rehabilitation nursing (PC-22): stages of rehabilitation, nurse's role in physical activity progression after MI, stroke, and chronic disease.

Credit Grading (Pass/Fail) — Knowledge Levels

Level	Task Type	Points	Criterion	Outcome
I	Test questions	0–10	Correct answers to all test questions	Pass / Fail
II	Theoretical question	10–20	Correctly formulates basic definitions and concepts	Pass / Fail
III	Situational task	20–25	Correctly identifies the problem, provides recommendations	Pass / Fail
IV	Practical skill	25–30	Fully and correctly completes the practical task	Pass / Fail

Pass threshold: ≥60 cumulative points across all four levels. Failure to reach 60 points results in credit not granted; student must retake within the established schedule.

7. REPORT AND PRESENTATION TOPICS (SRS)

Topics are selected from the list below or agreed with the instructor. Requirements: up to 15 slides; oral report 10 minutes + discussion 5 minutes. Prepared in Microsoft PowerPoint.

7.1. Topic List

1. Philosophy and conceptual models of nursing: Henderson, Orem, Roy — comparative analysis.
2. Nursing deontology and medical ethics: principles, dilemmas, and practical application (PC-1, SLK-4).
3. Infection control in the context of multidrug-resistant organisms (MRSA, VRE): nursing protocols.
4. Prevention of healthcare-associated infections (HAIs): evidence-based nursing interventions.
5. Safe injection practices and prevention of post-injection complications.
6. Viral hepatitis B and C in healthcare settings: epidemiology, prevention, and vaccination.
7. HIV/AIDS care in a therapeutic ward: infection control, psychological support, stigma reduction.
8. Stages of processing and sterilisation of medical devices: current regulatory requirements in KR and RF.
9. Therapeutic nutrition (Pevzner diets): clinical indications and nurse's role in dietary counselling.
1. Pressure ulcer prevention: evidence-based protocols, risk assessment scales (Braden, Norton).
2. Cardiopulmonary resuscitation: history and development of BLS guidelines; common errors and their prevention.
3. Acute vascular insufficiency in clinical practice: syncope, shock, collapse — nursing recognition and emergency response.
4. Rehabilitation nursing after myocardial infarction: stages, nurse's role, patient education (PC-22).
5. Medical documentation and electronic health records: legal aspects, confidentiality (PC-1, SLK-4).
6. Organisation and management of nursing staff in therapeutic departments (PC-28): roles and responsibilities.

7.2. Presentation Evaluation Criteria

Criterion	Max Points	Score
Correspondence to topic and structural completeness	15	
Scientific accuracy, use of current evidence	20	
Logical organisation and clarity of presentation	20	
Quality of visual design (slides, figures, tables)	15	
Command of material; quality of answers to questions	20	
Adherence to time limits and formatting requirements	10	
TOTAL	100	

8. CUMULATIVE GRADING SYSTEM

The final credit result is formed cumulatively across the semester. Students must score ≥60 cumulative points to be admitted to the credit examination. The instructor may grant credit without oral examination if the student has ≥60 points from current and milestone control.

Form of Control	Weight %	Max Points	Pass Threshold
Current control (attendance, oral quiz, workbook tasks)	20	20	12
Milestone control (CrTO — test + task + skill)	30	30	18
Practical skills assessment (2 skills checked during semester)	20	20	12
Report / Presentation (SRS)	10	10	6
Final credit (theory + task + skill)	20	20	12
TOTAL	100	100	60

Assessment Levels and Grading at Intermediate Control

Level	Type	Points	Criterion	Result
I (Know)	Test questions	Up to 10	Correct answers to all questions	Pass / Fail
II (Know)	Theoretical question	10–20	Correct formulation of basic definitions	Pass / Fail
III (Be Able, Own)	Situational task	20–25	Correct identification of problem and recommendations	Pass / Fail
IV (Be Able, Own)	Practical task	25–30	Full and correct task completion	Pass / Fail

Note: a student who fails to reach the threshold in any single component must retake that component within the schedule of the department before the final credit.