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_21_5 ld in.plx

Specialty: 31.05.01 / 560001 — General Medicine (for foreign students)

Qualification: Specialist (Physician)

Form of study: Full-time | Semester: 2 (Year 1, Semester 2)

Form of assessment: Credit with a grade

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

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':

Code	Competency	Description	Assessment Tools
OPK-11	Medical devices	Readiness to use medical devices provided for by procedures of medical care delivery.	Tests, practical skills check, credit
OPK-10	Patient care	Readiness to organise patient care and provide primary pre-medical health care.	Situational tasks, patient care skills, credit
OK-7	First aid	Readiness to use first aid techniques and protective methods in emergency situations.	Practical skills, situational tasks, credit

1.2. Structure of Assessment Tools and Control Stages

Assessment Tool	Control Type	Semester	Competency	RPD Section
Test tasks (current control)	Current	2	OPK-10, OPK-11, OK-7	Sections 1–2
Situational tasks	Current / Milestone	2	OPK-10, OPK-11, OK-7	Sections 1–2
Practical skills assessment	Current / Milestone	2	OPK-10, OPK-11, OK-7	Sections 1–2
Oral questions / quiz	Current	2	OPK-10, OPK-11	Sections 1–2
Workbook tasks	Current	2	OPK-10, OPK-11	Sections 1–2
Milestone control (CrTO)	Milestone	2	OPK-10, OPK-11, OK-7	Sections 1–2
Report / Presentation	Current	2	OPK-10	Sections 1–2
Credit with a grade (final)	Intermediate	2	OPK-10, OPK-11, OK-7	Sections 1–2

2. TEST TASKS

Test tasks are used for current and milestone control. The correct answer is marked in bold green (in printed versions a separate answer key sheet is provided). Each correct answer = 1 point.

Section 1. Organisation of Nursing and Basic Care

1. The PRIMARY purpose of the nursing process is to:

A) Perform medical orders without question
B) Systematically identify and address patient needs through a cyclic five-step approach
C) Replace the physician in clinical decision-making
D) Reduce the workload of nursing staff
E) Document patient complaints only

2. Which disinfectant concentration of chloramine-B solution is routinely used for wet cleaning of hospital premises?

A) 0.1%
B) 0.5%
C) 1%
D) 3%
E) 10%

3. The CORRECT sequence of hand hygiene steps according to EN 1500 standard includes:

A) Palm to palm → back of hands → interlaced fingers → rotational rubbing of thumbs → fingertips
B) Rinse with water → apply soap → rinse → dry
C) Apply antiseptic to dry hands → rub fingertips only → air dry
D) Wash with soap for 5 seconds → rinse → apply antiseptic
E) Gloves replace hand hygiene in all cases

4. A patient has been found to have pediculosis on admission. The nurse's FIRST action should be:

A) Immediately inform the head physician and isolate the patient
B) Proceed with regular sanitisation without special measures
C) Treat the patient with a pediculicidal agent, document in the admission log, notify the epidemiologist
D) Refuse admission until the patient is treated at home
E) Shave the patient's head without consent

5. To prevent pressure ulcers, a bedridden patient should be repositioned at least every:

A) 30 minutes
B) 1 hour

C) 2 hours
D) 4 hours
E) 8 hours

The Fowler's position (head elevated 45–60°) is PRIMARILY used for patients with:
A) Hypovolaemic shock
B) Spinal cord injury
C) Dyspnoea and cardiac decompensation
D) Hypotension
E) Unconsciousness (coma)

7. Which thermometer reading is considered FEVER according to standard classification?
A) 36.0–36.9 °C
B) 37.0–37.4 °C
C) 37.5–38.0 °C (subfebrile)
D) 38.1–39.0 °C (febrile)
E) Both C and D are correct

8. A patient vomits. The CORRECT nursing action is:
A) Leave the patient alone and call the physician
B) Turn the patient's head to the side, support the head, provide a basin, monitor airway
C) Give water to drink to dilute stomach contents
D) Apply abdominal pressure to stop vomiting
E) Place the patient in a supine position immediately

9. Storage temperature for most thermolabile medicines (e.g., vaccines, insulin) is:
A) −20 °C
B) 2–8 °C
C) 15–25 °C
D) 30–37 °C
E) Room temperature without restrictions

10. Which diet number (Pevzner) is prescribed for patients with peptic ulcer disease in the acute phase?
A) Diet No. 1
B) Diet No. 5
C) Diet No. 7
D) Diet No. 9
E) Diet No. 15

Section 2. Clinical Skills and Emergency Care

11. A nurse is about to perform a gastric lavage. The CORRECT volume of water per wash cycle is:

A) 100–200 ml
B) 300–500 ml
C) 500–1000 ml
D) 1–2 litres per instillation
E) Until clear water appears with no volume limit

12. The CORRECT technique for inserting a rectal gas-outlet tube is:
A) Dry insertion without lubrication, 30 cm depth
B) Lubricate with Vaseline, insert 20–30 cm, leave for no more than 1 hour
C) Lubricate, insert 5 cm, leave overnight
D) Insert 40 cm, attach to drainage bag
E) Use only in unconscious patients

13. Before an FGDS (oesophago-gastro-duodenoscopy), the patient must be:
A) Given a light breakfast 2 hours before
B) NPO for at least 8 hours, not smoking on the day of examination
C) Given a cleansing enema the evening before
D) Hydrated with 1 L of water 1 hour before
E) Pre-medicated with antibiotics

14. When collecting a 24-hour urine sample (diuresis), the correct instruction is:
A) Collect ALL urine including the first morning void
B) Discard the first morning void, collect ALL subsequent urine for 24 h, including next morning void
C) Collect only the first morning void
D) Collect a random sample at midday
E) Refrigerate the specimen at −20 °C

15. A patient develops anaphylactic shock after an injection. The FIRST nursing action is:
A) Administer antihistamines IV
B) Call a senior nurse
C) Stop the allergen, call the physician, place patient supine with elevated legs, prepare adrenaline (epinephrine) 0.1%
D) Apply ice to the injection site only
E) Measure blood pressure and wait for instructions

16. Classic signs of clinical death include:
A) Cyanosis, cold skin, pinpoint pupils
B) Absence of consciousness, pulse (carotid), and breathing
C) Slow breathing and bradycardia
D) Dilated pupils only
E) Unconsciousness and snoring respiration

17. The correct compression-to-ventilation ratio for adult CPR (single rescuer) per current guidelines is:
A) 5:1
B) 15:2

C) 30:2
D) 30:1
E) 15:1

18. When applying a tourniquet to control arterial bleeding of the lower extremity, it should be removed or repositioned every:
A) 15 minutes
B) 30 minutes
C) 1 hour
D) 2 hours
E) Only when definitive care is available

19. The correct method of collecting sputum for bacteriological examination is:
A) Collect saliva in a regular cup
B) Expectorate after mouth rinse into a sterile wide-mouth container in the morning before meals
C) Collect at any time after eating
D) Nasopharyngeal suction is always required
E) A plain container without a lid is acceptable

20. Standard precautions in infection control apply to:
A) Only patients with confirmed infections
B) Patients with HIV/AIDS only
C) All patients regardless of diagnosis or infection status
D) Only surgical patients
E) Only when the nurse has skin cuts

21. Which injection route is used for insulin administration?
A) Intravenous
B) Intramuscular
C) Subcutaneous
D) Intradermal
E) Intraosseous

22. The correct anatomical landmark for an intramuscular injection in the gluteal region is:
A) Centre of the buttock
B) Upper outer quadrant of the buttock
C) Lower inner quadrant
D) Any area with sufficient muscle mass
E) The sciatic nerve area for faster absorption

23. A patient presents with chest pain, diaphoresis, and nausea. ECG shows ST elevation. The nurse should FIRST:
A) Give the patient water and observe
B) Call the physician immediately, ensure IV access, administer O_2, prepare for ECG monitoring
C) Measure blood pressure and wait for the next scheduled round

D) Reassure the patient that it is probably indigestion
E) Give paracetamol for pain

24. Urinary catheterisation should be performed using:
A) Clean technique with tap water
B) Strict sterile aseptic technique
C) Clean gloves and non-sterile catheter
D) No special technique if catheter is packaged
E) The technique depends on gender only

25. When preparing a patient for abdominal ultrasound, the nurse should instruct the patient to:
A) Eat a normal meal 1 hour before the scan
B) Fast for 4–6 hours and avoid gas-producing foods 2–3 days before; come with a full bladder
C) Perform a cleansing enema immediately before
D) Drink 2 litres of water 30 minutes before
E) Shave the abdominal region

3. SITUATIONAL TASKS

Situational tasks assess the 'Be Able' and 'Own' levels (OPK-10, OPK-11, OK-7). Used at practical classes, milestone and intermediate control.

Task 1. Fever Management

> Patient A., 68 years old, is admitted to the therapeutic ward with a diagnosis of community-acquired pneumonia. Temperature 39.4 °C. The patient is pale, confused, complaining of severe chills and headache. Respiratory rate 26/min, HR 102 bpm, BP 100/60 mmHg.

Questions:

1. Identify the stage of fever and describe the characteristic signs.
2. List the nursing interventions appropriate for this stage.
3. When would a temperature drop by crisis occur, and what emergency measures should the nurse prepare?
4. Formulate the nursing diagnosis and priority nursing problem.
5. Explain the principles of monitoring vital signs in this patient.

Model Answer:

1. Stage: fever at the peak (fastigium). Signs: high temperature 39.4 °C, chills, pallor (peripheral vasoconstriction), tachycardia, tachypnoea, altered mental status.
2. Nursing actions: keep patient warm (warm blankets), provide oral/IV fluids (if prescribed), antipyretics as ordered, frequent vital sign monitoring (every 30–60 min), oral hygiene, bed rest, O_2 supplementation if SpO_2 <94%.
3. Crisis drop: sudden rapid fall in temperature with profuse sweating and collapse risk. Prepare: dry warm linen for change, warm blankets, monitor BP, IV access, corticosteroids/vasopressors on standby as prescribed.
4. Priority nursing diagnosis: 'Hyperthermia related to infectious process, evidenced by temperature 39.4 °C, tachycardia, and altered sensorium'.
5. Monitor temperature every 30–60 min; HR, RR, BP every 1–2 h; SpO_2 continuously; document all readings.

Task 2. Gastric Lavage

> A 25-year-old patient is brought to the emergency department 1 hour after intentional ingestion of an unknown quantity of sleeping tablets. He is conscious, Glasgow Coma Scale 13/15, BP 110/70, HR 78, RR 14. The physician orders gastric lavage.

Questions:

6. List the indications and absolute contraindications for gastric lavage.
7. Describe the nurse's preparation of the patient and equipment.
8. Explain the step-by-step procedure for gastric lavage.
9. What complications may occur, and how should they be prevented?
10. How should the lavage fluid be handled after the procedure?

Model Answer:

1. Indications: oral poisoning within 1–2 h (up to 6 h for some substances), drug overdose. Contraindications: ingestion of strong acids/alkalis (corrosive poisoning), petroleum products, loss of airway protective reflexes (without intubation), oesophageal varices.
2. Preparation: explain procedure, place patient in left lateral or seated position, protect clothing, prepare 10–12 L warm water (36–37 °C), 1 m thick gastric tube (Ch36–40), lubricant, 500 ml syringe, basins, gloves, apron, suction equipment.
3. Procedure: measure tube length (earlobe–nose–xiphoid), lubricate tip, insert through mouth (ask patient to swallow), confirm placement by auscultation of air bolus, instil 300–500 ml warm water via funnel or syringe, lower funnel below stomach level (siphon) to drain, repeat until clear fluid returns (usually 10–12 L total).
4. Complications: aspiration (prevention: correct positioning, suction ready), mucosal trauma (gentle insertion), hypothermia (use warm water), water intoxication (do not exceed 500 ml per cycle). Monitor consciousness level throughout.
5. Collect first portion of lavage separately and send to toxicology lab. Dispose of remaining fluid per infectious waste protocol.

Task 3. Cardiopulmonary Resuscitation

> During a morning round, a nurse finds a 70-year-old patient unresponsive in bed. The patient does not respond to voice or sternal rub. No visible breathing movements. No carotid pulse detected within 10 seconds.

Questions:

1. What is the diagnosis and what immediate action should the nurse take?
2. Describe the correct technique for chest compressions in adults.
3. Describe the technique for mouth-to-mask ventilation.
4. When is the resuscitation team allowed to stop CPR?
5. What documentation must the nurse complete after a resuscitation event?

Model Answer:

6. Diagnosis: clinical death. Immediate actions: call for help / activate emergency code (shout or press alarm), begin CPR immediately, note time.
7. Chest compressions: place patient on firm surface (resuscitation board if available); heel of dominant hand on lower half of sternum, second hand on top; arms straight, elbows locked; compression depth 5–6 cm; rate 100–120/min; allow full chest recoil; minimise interruptions (<10 s).
8. Mouth-to-mask ventilation: apply mask tightly, tilt head–lift chin (or jaw thrust if trauma suspected); give 1 breath over 1 second (visible chest rise); ratio 30:2. If bag-valve-mask available, use it.
9. CPR may be stopped when: ROSC (return of spontaneous circulation) is achieved; physician declares biological death (rigor mortis, fixed dilated pupils, dependent lividity); rescuer exhaustion; advance directive (DNR order).
10. Document: time collapse discovered, time CPR started, interventions performed and times, medications given (by physician), outcome, time of ROSC or death declaration. Complete incident report and nursing notes.

Task 4. Prevention of Post-Injection Complications

> A nurse has administered an intramuscular injection of diclofenac sodium 75 mg into the right gluteal region. 3 days later, the patient reports pain, swelling, and redness at the injection site. Temperature 37.8 °C. The site is indurated and warm to touch.

Questions:

6. What complication has developed and what are its likely causes?
7. Describe the local nursing management of this complication.
8. List the rules for intramuscular injection that should have prevented this complication.
9. What documentation is required?
10. When should the nurse escalate to the physician?

Model Answer:

11. Complication: post-injection abscess (infiltrate → abscess formation). Likely causes: violation of aseptic technique, repeated injections at the same site, incorrect injection angle/depth, undissolved drug precipitate (diclofenac is irritant).
12. Local management: warm dry compress (dry heat) 3 × daily to promote resolution if still infiltrate stage; inform physician immediately; if fluctuation (abscess) present — surgical drainage required; monitor for systemic signs of infection.
13. Preventive rules: strict asepsis (sterile gloves, alcohol skin wipe, wait for drying); correct site (upper outer quadrant); rotate injection sites; correct needle length (40 mm for gluteal IM); Z-track technique for irritant drugs; ensure full needle insertion; avoid injecting into same site consecutively.
14. Document: injection site and time, drug/dose, patient complaint, local findings, temperature, actions taken, physician notification time and response.
15. Escalate if: temperature >38.5 °C, fluctuation (pus), cellulitis spreading, systemic sepsis signs (rigors, hypotension), no improvement after 48–72 h of conservative management.

Task 5. Emergency Care — Anaphylactic Shock

> 2 minutes after an IV penicillin infusion is started, the patient becomes restless, reports throat tightening and difficulty breathing. On examination: diffuse urticaria, BP 70/40 mmHg, HR 130 bpm, SpO_2 88%, stridor audible.

Questions:

11. Identify the diagnosis.
12. Describe the nurse's immediate actions (before the physician arrives).
13. What is the drug of choice and route of administration?
14. What is the nurse's role in prevention of this complication?
15. List at least four other drugs used in anaphylaxis management.

Model Answer:

16. Diagnosis: anaphylactic shock (systemic anaphylaxis, grade IV according to Ring–Messmer).
17. Immediate nursing actions: STOP the infusion immediately; call the physician / emergency code; position patient supine, legs elevated 30–45° (unless respiratory distress dominates — then semi-recumbent); maintain IV access; O_2 at high flow (10–15 L/min via non-rebreather mask); prepare adrenaline 0.1% solution for injection; monitor BP, HR, SpO_2 continuously.

18. Drug of choice: epinephrine (adrenaline) 0.1% — 0.5 mg (0.5 ml of 0.1%) intramuscular into the lateral thigh. IM preferred over IV except in cardiac arrest; can repeat every 5–15 min.
19. Prevention: thorough allergy history before any drug administration; skin test before first penicillin dose (when indicated by protocol); keep emergency tray (adrenaline, antihistamines, corticosteroids) available in any room where injections are given; monitor patient for at least 30 min after first injection.
20. Other drugs: corticosteroids (dexamethasone IV, methylprednisolone); antihistamines (chloropyramine/suprastin IV); bronchodilators (salbutamol nebulised); IV crystalloids for volume replacement (0.9% NaCl or Ringer's).

4. PRACTICAL SKILLS ASSESSMENT

Practical skills are assessed during practical classes and at the credit examination. Each skill is performed on a simulator/phantom or demonstrated step-by-step. Grading is by checklist.

4.1. List of Practical Skills

- Measurement of blood pressure (auscultatory method)
- Measurement of pulse (radial artery, 1 min), respiratory rate
- Measurement of body temperature (axillary, oral, rectal) and charting
- Hand hygiene: routine (soap and water) and hygienic antisepsis (6-step WHO technique)
- Donning and doffing personal protective equipment (gown, gloves, mask)
- Subcutaneous injection (insulin pen/syringe — on phantom)
- Intramuscular injection technique — upper outer gluteal quadrant (on phantom)
- Peripheral IV cannula insertion and IV infusion set-up (on phantom)
- Preparation of 1% chloramine-B disinfectant solution from stock
- Gastric lavage technique (on phantom) — step-by-step procedure
- Enema administration: cleansing enema (on phantom)
- Insertion of rectal gas-outlet tube (on phantom)
- Urinary catheterisation: female (on phantom)
- Dressing technique: aseptic wound dressing change
- Oxygen therapy: mask and nasal cannula technique
- Adult CPR: 30:2 ratio, correct hand placement, compression depth/rate (on resuscitation manikin)
- Positioning of unconscious patient (recovery position)
- Preparation of patient for ECG and electrode placement
- Specimen collection: morning urine (general analysis, Zimnitsky test)
- Patient transport techniques: wheelchair and stretcher

4.2. Checklist: Adult Cardiopulmonary Resuscitation (example checklist)

Assessment Criterion	Max Points	Score
Checks safety of scene and puts on gloves	2	
Checks responsiveness (voice + sternal rub)	4	
Calls for help / activates emergency code, notes time	4	
Checks breathing (look-listen-feel ≤10 s)	4	
Checks carotid pulse (≤10 s)	4	
Correct hand placement (lower half of sternum)	8	
Compression depth 5–6 cm	10	
Compression rate 100–120/min	10	
Full chest recoil between compressions	8	

Correct head tilt–chin lift before ventilation	6	
Correct ventilation (1 breath/s, visible chest rise)	8	
30:2 ratio maintained correctly	8	
Minimal interruptions (<10 s)	8	
Continues until physician arrives or ROSC	8	
Verbal report: time, actions, outcome	8	
TOTAL	100	

4.3. Grading Scale for Practical Skills

Score (%)	Grade	Criterion	Credit
90–100	Excellent (A)	All steps performed correctly, safely, in correct sequence	Pass
75–89	Good (B)	Minor omissions, no safety violations	Pass
60–74	Satisfactory (C)	Significant errors corrected after prompting	Pass
<60	Unsatisfactory	Critical safety errors or incomplete procedure	Fail

5. MILESTONE CONTROL (CrTO)

The milestone control (CrTO, topic 2.16 of the curriculum) takes place at the end of the semester and covers both sections. Format: 20 test questions + 1 situational task + 1 practical skill demonstration. Time: 60 minutes.

5.1. Scope of Milestone Control

- Section 1: Organisation of Nursing and Basic Care (topics 1.1–1.9 and self-study 1.10–1.16)
- Section 2: Clinical Skills and Emergency (topics 2.1–2.9 and self-study 2.10–2.15)
- Practical skills: as per the list in Section 4 of this FAT
- Theoretical questions: from Section 6 of this FAT (questions 1–30)

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 criteria
Practical skill	30	18 (60%)	Per checklist
TOTAL	100	60	All three components must reach threshold

6. QUESTIONS FOR THE CREDIT WITH A GRADE

The credit includes: (1) one theoretical question; (2) one situational task; (3) one practical skill. The final grade is based on the cumulative point system.

Section 1 — Organisation of Nursing and Basic Care

1. The nursing process: definition, five stages, documentation.
2. The philosophy and theory of nursing: main conceptual models (Henderson, Orem).
3. Nursing deontology and ethics: principles, types of communication with patients and colleagues.
4. Types of medical documentation in therapeutic departments; rules for completing nursing records.
5. Infection control in healthcare facilities: chain of infection, standard and transmission-based precautions.
6. Disinfection: definition, levels, methods, common disinfectants (chloramine-B, alcohol, peroxide), preparation of working solutions.
7. Sterilisation: definition, methods (autoclaving, dry heat, chemical), indicators of sterility, packaging rules.
8. HIV/AIDS and viral hepatitis in the hospital: routes of transmission, post-exposure prophylaxis, safe working practices.
9. Post-injection complications: types (infiltrate, abscess, air embolism, haematoma, nerve injury), prevention and management.
10. Rules for storage, preparation, and administration of medicines: oral, subcutaneous, intramuscular, intravenous routes.
11. Basic patient care: positioning in bed (Fowler's, Trendelenburg, lateral, prone), pressure ulcer prevention (Braden scale, repositioning).
12. Patient transport: methods (walking, wheelchair, stretcher), indications, safety rules.
13. Therapeutic nutrition: Pevzner diets (Nos. 1, 2, 5, 7, 9, 10, 15), indications; enteral and parenteral nutrition basics.
14. Fever: definition, stages, types by height, nursing management at each stage; crisis vs. lysis temperature drop.
15. Sanitary-hygienic regime of healthcare facilities: cleaning schedules, disinfection of surfaces, handling of linen and waste.

Section 2 — Clinical Skills and Emergency Care

1. Nursing manipulations in digestive diseases: gastric lavage — indications, contraindications, equipment, technique, complications.
2. Enemas: types (cleansing, therapeutic, nutritional, siphon), indications, technique, complications.
3. Gas-outlet tube: indications, insertion technique, maximum time of use.
4. Care of urinary drainage: urinary catheterisation (indications, types of catheters, aseptic technique), bladder lavage.
5. Preparation of patients for instrumental examinations: FGDS, colonoscopy, ECG, plain X-ray, contrast urography.
6. Preparation of patients for ultrasound examination of abdominal and pelvic organs.
7. Specimen collection: blood (venipuncture, sterile technique, serology, biochemistry, culture), urine (general analysis, Nechiporenko, Zimnitsky), sputum, faeces.

8. Pleural puncture and abdominal paracentesis: nurse's role, equipment preparation, patient positioning, post-procedure care.
9. Oxygen therapy: indications, methods (nasal cannula, mask, tent), flowrates, humidification, safety rules.
10. Assessment of pain: numeric rating scale, PQRST method, differential approach; nursing documentation of pain.
11. Emergency nursing care in cardiovascular events: suspected myocardial infarction (MONA protocol), hypertensive crisis, acute left ventricular failure.
12. Acute vascular insufficiency: syncope, collapse, anaphylactic and haemorrhagic shock — pathophysiology, nursing recognition, emergency actions.
13. Cardiopulmonary resuscitation: clinical vs. biological death; BLS algorithm (30:2); AED use; post-resuscitation care.
14. First aid: external bleeding (direct pressure, tourniquet), fractures (immobilisation), burns (cooling), poisoning (gastric lavage, antidotes), anaphylaxis (epinephrine protocol).
15. Care of patients with endocrine disorders: diabetic emergencies (hypoglycaemia — recognition, sugar protocol; hyperglycaemic crisis — symptoms, physician notification).

Credit Grading Scale (KRSU Grading System)

Points %	Letter Grade	Traditional	Criterion	Credit
90–100	A — Excellent	5	Full, accurate, structured answer; error-free practical skill	Pass
80–89	B — Good	4+	Minor inaccuracies, no critical errors	Pass
70–79	C — Good	4	Incomplete answer, minor practical errors corrected	Pass
60–69	D — Satisfactory	3	Significant gaps but understanding demonstrated	Pass
50–59	E — Satisfactory	3−	Substantial gaps; prompted corrections needed	Pass
<50	FX/F — Fail	2	Critical errors; competency not demonstrated	Fail

7. REPORT AND PRESENTATION TOPICS

Students choose a topic from the list or agree on an alternative with the instructor. Requirements: max 15–20 slides, 10-minute presentation + 5-minute discussion.

7.1. Topic List

1. New factors of the hospital environment and their impact on patient and staff safety.
2. Pressure ulcer prevention: evidence-based nursing protocols (Braden scale, repositioning schedules).
3. Standard precautions and transmission-based precautions: current WHO guidelines.
4. Safe injection practices and prevention of post-injection complications.
5. Cardiopulmonary resuscitation: history, development of BLS guidelines, common errors.
6. Anaphylaxis: recognition, epinephrine administration, nursing management algorithm.
7. Infection control in the context of multidrug-resistant organisms (MRSA, VRE).
8. Enteral and parenteral nutrition: nursing aspects, complications, care of feeding tubes.
9. Pain assessment tools in nursing practice: NRS, VAS, Wong-Baker FACES scale.
10. Nursing documentation: electronic health records, legal aspects, confidentiality.
11. Therapeutic diets: Pevzner classification — current relevance and modifications.
12. Ethical dilemmas in nursing practice: patient autonomy, informed consent, confidentiality.
13. Caring for patients with HIV/AIDS: infection control, psychological support, stigma reduction.
14. Basic life support in paediatric patients: differences from adult BLS.
15. Role of the nurse in prevention of healthcare-associated infections (HAIs).

7.2. Presentation Evaluation Criteria

Criterion	Max Points	Score
Relevance and correspondence to the topic	15	
Scientific accuracy and evidence-based content	20	
Logical structure and clarity of presentation	20	
Quality of visual aids (slides, tables, figures)	15	
Command of the material; quality of answers to questions	20	
Compliance with time limits	10	
TOTAL	100	

8. CUMULATIVE GRADING SYSTEM

The final grade is formed on a cumulative basis throughout the semester. Students must score at least 60 cumulative points to be admitted to the credit examination. Students scoring >60 points from current and milestone control may receive a credit without oral examination at the instructor's discretion.

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

Note: a student who fails any single component below its threshold must retake that component before the final credit.