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

PRACTICAL TRAINING

(Professional Skills and Experience — Ward Nurse Assistant)

Curriculum: 310501_20_56 ld in.plx
Specialty: 31.05.01 (RF) / 560001 (KR) — General Medicine (for international students)
Qualification: Medical Doctor
Form of study: Full-time | Semester: 3 (Year 2, Semester 1) | Weeks: 18
Total workload: 4 ZET / 144 hours (contact: 108 h | independent work: 36 h)
FGOS: Order No. 988, 12.08.2020 (Specialty 31.05.01)
Form of assessment: Credit with a grade (3rd semester)

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

PRACTICAL TRAINING

(Professional Skills and Experience — Ward Nurse Assistant)

"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 covers all competencies formed through the practical training 'Ward Nurse Assistant' (curriculum 310501_20_56 ld in.plx):

Code	Area	Description	Assessment Block
UK-4	Communication	Able to apply modern communication technologies (including in foreign languages) for academic and professional interaction.	A, B, C, D
UK-6	Self-development	Able to identify and implement priorities for own activities based on self-assessment and lifelong learning.	A, B, D
UK-8	Safety	Able to maintain safe living and professional conditions, including in emergency situations.	A, B, C
OPK-1	Ethics & law	Able to implement moral and legal norms, ethical and deontological principles in professional activities.	A, B, C, D
OPK-2	Prevention	Able to monitor and implement measures for prevention and healthy lifestyle promotion.	A, B, C
OPK-4	Medical devices	Able to use medical devices provided by medical care procedures; conduct patient examinations.	A, B, C
OPK-6	Patient care	Able to organise patient care, provide primary health care, and make decisions in emergencies at the pre-hospital stage.	A, B, C, D
OPK-8	Rehabilitation	Able to implement and monitor medical rehabilitation, including individual rehabilitation programmes for persons with disabilities.	B, C, D
OPK-9	Quality mgmt	Able to implement quality management principles in professional activities.	C, D
PC-14	Documentation	Capable of maintaining medical records (inpatient records, registers, logs, reports).	B, C, D

1.2. Assessment Blocks and Control Stages

Block	Content	Competencies	Type	Timing
A	Test questions on theory, ethics, law, patient safety, infection prevention	UK-4, UK-6, UK-8, OPK-1, OPK-2, OPK-4, OPK-6	Current / Boundary	Weeks 1–18
B	Situational tasks on patient care, emergency nursing, quality management	OPK-1, OPK-2, OPK-4, OPK-6, OPK-8, OPK-9, PC-14	Boundary	Weeks 4, 8, 12, 16
C	Practice-oriented tasks: manipulation simulations, documentation, rehabilitation planning	OPK-4, OPK-6, OPK-8, OPK-9, PC-14	Boundary / Credit	Weeks 4, 8, 12, 16
D	Boundary Controls 1–4: integrated assessment of all competencies	All	Boundary	Weeks 4, 8, 12, 16

2. DISCIPLINE TECHNOLOGY MAP (RATING SYSTEM)

Module	Topics	Control Type	Form	Min pts	Max pts	Week
Module 1 (topics 1.1–1.7)	Practical work in therapeutic dept.; organisation, documentation, patient admission	Current control	Frontal quiz + test (Block A) + practical skills + attendance	2	4	1–4
	Boundary Control No. 1	Boundary	Oral/written + situational task (Block B)	6	10	4
Module 2 (topics 1.6–2.3)	Therapeutic nutrition, medicines, sanitation, patient prep for surgery	Current control	Frontal quiz + test (Block A) + practical skills + attendance	2	4	5–8
	Boundary Control No. 2	Boundary	Oral/written + situational task (Block B–C)	6	10	8
Module 3 (topics 2.4–2.10)	Nursing care, emergency conditions, post-op care, GI care	Current control	Frontal quiz + test (Block A) + practical skills + attendance	2	4	9–12
	Boundary Control No. 3	Boundary	Oral/written + task + case history defence (Block C)	6	10	12
Module 4 (topics 3.1–3.8)	Diagnostics, specimen collection, transport, documentation, rehabilitation	Current control	Frontal quiz + test (Block A) + practical skills + attendance	2	4	13–16
	Boundary Control No. 4	Boundary	Oral/written + task + documentation defence (Block D)	6	10	16
SUBTOTAL	Current + boundary controls			**16**	**28**	
Credit (final)	All blocks A–D	Intermediate	All reporting docs + oral + practical	12	20	18
SEMESTER RATING				**60**	**100**	

3. ONGOING CONTROL

Ongoing control is conducted daily throughout the entire internship by the clinical supervisor (from the practice base) and the academic supervisor (from the department). The purpose is to identify student difficulties promptly, correct skill development, and assess professional behaviour.

3.1. Daily Internship Diary

The diary is the primary document reflecting the student's work during the internship. It must be filled in daily in the prescribed format.

Diary Requirements	Grading Criteria
• Date and placement name • Department/unit name • List of manipulations performed (with quantities) • Description of clinical case/observation • Supervisor's signature (daily) • Student's own conclusions and remarks	Pass — filled in daily, complete, neat; signed by supervisor every day. Partial pass — some days missing; individual sections incomplete. Fail — diary not kept or completed formally without signatures.

3.2. Attendance

Attendance is a mandatory prerequisite for admission to the final credit.

Attendance Level	% of Total Time	Consequences
Full attendance	100%	Eligible for credit without additional requirements
Permissible absences (valid reason)	≤20% (≤22 h)	Eligible for credit provided missed hours are made up
Absences without valid reason	>20% (>22 h)	Not eligible for credit; directed to repeat the internship

3.3. Active Participation in Manipulations under Supervisor's Control

Score	Level	Description
5	High	Student shows initiative; performs manipulations independently according to the correct algorithm; observes asepsis; communicates professionally with patients; asks relevant questions.
4	Sufficient	Student performs manipulations with minor prompting from supervisor; actively participates; makes isolated errors that they correct independently.
3	Satisfactory	Student performs manipulations under constant supervision; passive; requires repeated explanation of the algorithm.
2	Unsatisfactory	Student refuses to perform manipulations; violates asepsis and deontology rules; does not respond to supervisor's feedback.

4. BOUNDARY CONTROLS

Boundary Control No. 1 — Organisation, Documentation and Vital Signs

Scope: Topics 1.1–1.7 (Section 1 + therapeutic nutrition). Questions 1–50.
Format: 2–3 theoretical questions (oral) + 5 test items + 1 situational task. Time: 60 minutes.

Part A — Theoretical Questions (select 2–3)

The student prepares an oral answer to 2–3 questions from the following list (selected by the supervisor):

1. Structure of a healthcare institution: main units and their functions.
2. Goals and objectives of the Ward Nurse Assistant practical training.
3. Safety briefing in a medical institution: types and content.
4. Duties of a ward nurse assistant.
5. Organisation of the nursing station in a hospital ward.
6. Ward nurse's work schedule: shift and on-call arrangements.
7. Journal of incoming patients: purpose and rules for completion.
8. Journal of physician orders: types and rules for completion.
9. Rules for patient admission to hospital: action algorithm.
10. Medical record of an inpatient: structure and completion on admission.
11. List of physician prescriptions: structure and rules for completion.
12. Temperature chart: purpose, structure, and completion rules.
13. Thermometry: technique for measuring body temperature.
14. Pulse measurement: technique and pulse characteristics.
15. Blood pressure measurement: technique and normal values.
16. Therapeutic nutrition: basic principles of diet therapy.
17. Pevzner Diet No. 1 (peptic ulcer): indications and characteristics.
18. Pevzner Diet No. 9 (diabetes mellitus): indications and characteristics.
19. Pevzner Diet No. 10 (cardiovascular disease): indications and characteristics.
20. Rules for serving and delivering food to ward patients.

Part B — Test Questions (5 items, 1 point each)

Normal body temperature in adults is:
A) 35.5–36.0 °C
B) 36.0–37.0 °C
C) 37.0–38.0 °C
D) 38.0–38.5 °C

The document in which the ward nurse records BP, pulse, and temperature is:
A) Inpatient medical record
B) Temperature chart
C) Physician orders journal
D) Patient movement register

Normal adult resting pulse rate is:
A) 40–60 bpm
B) 60–80 bpm
C) 80–100 bpm
D) 100–120 bpm

Pevzner Diet No. 9 is prescribed for:
A) Peptic ulcer disease
B) Diabetes mellitus
C) Chronic renal failure
D) Cardiovascular disease

On patient admission, the ward nurse's FIRST priority is:
A) Measure blood pressure
B) Explain internal regulations and complete admission documentation
C) Dispense medications
D) Inspect for pediculosis

Part C — Situational Task

> Patient M., 54 years old, is admitted to the therapeutic ward with a diagnosis of Hypertension Stage II. The physician prescribes Diet No. 10, BP measurement 3 times daily, and temperature measurement twice daily. During the morning round, the nurse records BP 170/100 mmHg.

Questions:

1. What should the ward nurse do with this BP reading?
2. In which documents must the nurse record these vital signs?
3. What is Diet No. 10 and what are its key principles?

Model Answer:

1. BP 170/100 mmHg exceeds normal limits (120–140/80–90 mmHg). The nurse records the value in the temperature chart, documents it in the nursing observation log, and immediately informs the attending or on-call physician. The nurse does not administer additional antihypertensive medication without a physician order.
2. Values are recorded in: (1) the temperature chart (graphically for BP and temperature, numerically for pulse); (2) the nursing shift notes in the inpatient record; (3) the vital signs log at the nursing station.
3. Diet No. 10 — cardiovascular disease diet: salt restriction (≤3–5 g/day); fluid restriction (1.0–1.5 L/day); exclusion of fatty, fried, smoked foods, strong coffee and tea; emphasis on potassium-rich foods; 5–6 small meals per day.

Boundary Control No. 2 — Nursing Care, Medicines and Sanitation

Scope: Topics 1.6–2.3 (Section 2). Questions 51–100.

Format: 2–3 theoretical questions (oral) + 5 test items + 1 situational task. Time: 60 minutes.

Part A — Theoretical Questions (select 2–3)

51. Rules for the storage of medicines in hospital: general requirements.
52. Storage conditions for thermolabile medicines (vaccines, insulin) and controlled substances.
53. Disinfection: concept, levels (low/intermediate/high), and methods.
54. Pre-operative patient preparation: general rules and personal hygiene.
55. Sanitary-hygienic cleaning of hospital rooms: types and procedures.
56. Hand hygiene for medical personnel: 6-step WHO technique.
57. Surgical hand preparation: stages and rules.
58. Pressure ulcer prevention: repositioning schedule, skin care, Braden scale.
59. Care for patients in an unconscious state: airway, positioning, oral hygiene.
60. Cardiopulmonary resuscitation (CPR): algorithm and 30:2 ratio.
61. Emergency care for acute coronary syndrome / myocardial infarction.
62. Emergency care for collapse and anaphylactic shock.
63. Emergency care for arterial bleeding: tourniquet application.
64. Emergency care for syncope: positioning and initial actions.
65. Prevention of post-operative pulmonary complications: breathing exercises.

Part B — Test Questions (5 items)

Signs of clinical death include:
A) Slow breathing and bradycardia
B) Absence of carotid pulse and apnoea
C) Pallor and hypothermia
D) Loss of consciousness alone

For arterial bleeding, the correct first-aid measure is:
A) Apply a pressure bandage
B) Apply a tourniquet ABOVE the wound
C) Apply a tourniquet BELOW the wound
D) Apply ice

Pressure ulcer prevention requires repositioning a bedridden patient every:
A) 8 hours
B) 2 hours
C) 4 hours
D) Once daily

The correct adult CPR compression-to-ventilation ratio is:
A) 15:2
B) 30:2
C) 10:1
D) 5:1

For syncope, the correct nursing action is:
A) Sit the patient up and give water
B) Place supine, elevate legs 30°, ensure fresh air
C) Administer adrenaline immediately
D) Give ammonia and leave seated

Part C — Situational Task

> During morning rounds, the ward nurse finds a 68-year-old patient who has been immobile for 4 days. On examination of the sacral area, there is persistent non-blanchable skin erythema (5×5 cm area); skin integrity is intact but the area is painful to palpation.

Questions:

4. What complication is developing and what is its stage?
5. Describe the nurse's step-by-step management.
6. What preventive measures should have been applied from day 1 of immobility?

Model Answer:

4. Diagnosis: Stage I pressure ulcer — persistent non-blanchable erythema of intact skin. This is the earliest reversible stage.
5. Nurse's actions: (1) Inform the attending physician and document findings; (2) Gently clean the area with warm water and a pH-neutral soap; (3) Apply a transparent film dressing or barrier cream; (4) Immediately reposition the patient to completely relieve sacral pressure; (5) Request an anti-decubitus mattress; (6) Review and intensify the repositioning schedule.
6. Prevention from day 1: reposition every 2 hours (supine → right lateral 30° → supine → left lateral 30°); inspect all bony prominences at each repositioning; apply barrier cream to perianal and sacral areas; use anti-decubitus mattress if available; ensure adequate nutrition (protein ≥1.2 g/kg/day); keep skin clean and dry; use draw-sheet for repositioning (avoid friction/shear).

Boundary Control No. 3 — Diagnostic Preparation, Patient Transport and Professional Aspects

Scope: Topics 2.4–3.4 (Sections 3–4, part). Questions 101–134.

Format: 2–3 theoretical questions (oral) + 5 test items + 1 situational task. Time: 60 minutes.

Part A — Theoretical Questions (select 2–3)

1. 101. Preparation of a patient for colonoscopy: full algorithm including dietary restrictions and bowel cleansing.
2. 102. Preparation of a patient for intravenous urography (IVP): contrast allergy check and preparation steps.
3. 103. Preparation of a patient for abdominal ultrasound: dietary preparation and fasting protocol.
4. 104. Preparation of a patient for ECG: patient positioning and electrode placement.
5. 105. Urine collection for general urinalysis: midstream clean-catch technique.
6. 106. Urine collection (Zimnitsky test): 8-portion technique over 24 hours.
7. 107. Faecal specimen for occult blood: 3-day dietary exclusion protocol.
8. 108. Sputum collection for bacteriological examination: morning fasting technique.
9. 109. Blood collection from a peripheral vein: aseptic technique and correct tube selection.
10. 110. Transportation of a patient with suspected spinal injury: hard board, team technique.
11. 111. Transportation of a post-operative patient from the operating theatre: monitoring during transfer.
12. 112. Nursing care for patients after abdominal surgery: wound care, drain management.
13. 113. Nursing care for patients with a tracheostomy: suctioning, tube care.
14. 114. Nursing deontology: the principle of non-maleficence, patient autonomy, and confidentiality.
15. 115. Sanitary and epidemiological regime of the hospital: nosocomial infection prevention protocols.

Part B — Test Questions (5 items)

1. Preparation for abdominal ultrasound requires:

A) Normal breakfast on the day of scan

B) Gas-reducing diet for 3 days + fasting for 6–8 hours

C) Cleansing enema the morning of scan

D) No preparation is needed

2. The Nechiporenko urine test uses:

A) A 24-hour urine collection

B) The mid-stream portion of the first morning void (10–15 ml)

C) The last morning void

D) Any random portion

3. Transportation of a patient with suspected spinal cord injury must be:

A) Seated in a wheelchair
B) Supine on a hard board without spinal movement
C) Walking with support
D) In the recovery position

4. Faecal testing for occult blood (Gregersen test) requires:

A) A single stool sample without dietary preparation
B) Elimination of meat, fish, eggs, and dark-coloured vegetables 3 days before collection
C) Laxative administration the evening before
D) 12-hour fasting

5. Medical deontological principles include:

A) Prioritising personal interests
B) 'First, do no harm'; respect for patient rights; confidentiality
C) Disclosing diagnosis to relatives without patient consent
D) Withholding information from the patient

Part C — Situational Task (Case History Defence)

> Patient K., 45 years old, is scheduled for a colonoscopy tomorrow at 10:00. She asks the ward nurse about the preparation. The patient is taking iron supplements for iron-deficiency anaemia.

Questions:

7. Explain the complete preparation protocol for colonoscopy to the patient.
8. Does the iron supplement intake matter, and if so, why?
9. Which medical documentation must the nurse complete before the procedure?

Model Answer:

7. Colonoscopy preparation: (1) Low-residue diet for 2–3 days (exclude vegetables, fruit, black bread, legumes, seeds); (2) Clear liquid diet on the day before; no dinner the evening before; (3) Bowel cleansing: macrogol (polyethylene glycol) solution 3–4 L the evening before, or two cleansing enemas (evening + morning); (4) NPO from midnight; (5) Light breakfast only if split-dose preparation protocol is used (as prescribed); (6) Arrive with an escort.
8. Iron supplements must be discontinued 5–7 days before colonoscopy. Iron deposits on the colonic mucosa produce black/dark staining that can obscure mucosal lesions and mimic bleeding, making the examination unreliable. The ward nurse must inform the physician and document this in the prescription execution log.
9. Documentation: (1) Confirm written informed consent for the procedure (signed by patient and physician); (2) Record preparatory instructions given in the nursing notes; (3) Complete the laboratory/procedure referral form (Направление); (4) Record pre-procedure vital signs; (5) Note that iron supplements were discontinued and the date; (6) Prepare the patient transport record.

Boundary Control No. 4 — Documentation, Rehabilitation and Quality Management

Scope: Topics 3.5–3.8 (Section 4). Full question bank 1–150.

Format: 2–3 theoretical questions (oral) + 5 test items + 1 situational task. Time: 60 minutes.

Part A — Theoretical Questions (select 2–3)

135. Medical record of an inpatient (case history): structure, legal significance, and completion rules.
136. Types of nursing documentation at the ward nursing station.
137. Rules for the delivery and archiving of medical records.
138. Individual rehabilitation programme for a patient with physical disability: nurse's role.
139. Principles of quality management in nursing: Donabedian model (structure, process, outcome).
140. Nosocomial infection prevention: standard precautions, hand hygiene, medical waste disposal.
141. Personal hygiene of medical personnel: occupational health requirements.
142. Emergency care for acute coronary syndrome during patient transport.
143. Care for terminal patients: palliative care principles and dignity in dying.
144. Prevention of gastrointestinal paresis in post-operative patients: early mobility and nutrition.
145. Care for patients with venous catheters: daily site inspection and aseptic dressing change.
146. Care for patients with body cavity drains: monitoring, patency, and documentation.
147. Rights and duties of a ward nurse: legal framework.
148. Emergency accident register (журнал аварийных ситуаций): who must maintain it and why.
149. Deontological aspects of communication between the ward nurse and patient/family.

Part B — Test Questions (5 items)

1. Pevzner Diet No. 5 is prescribed for:

A) Peptic ulcer
B) Diseases of the liver and biliary tract
C) Diabetes mellitus
D) Chronic renal failure

2. Normal adult blood pressure values are:

A) 90/60 mmHg
B) 120/80 mmHg
C) 150/100 mmHg
D) 160/110 mmHg

3. The early sign of a developing pressure ulcer is:

A) Dark necrotic eschar
B) Persistent non-blanchable erythema of intact skin
C) Wet, weeping wound
D) Peripheral oedema

4. The emergency accident register must be maintained by:
A) Surgeons only
B) All medical personnel working with biological material
C) Laboratory technicians only
D) The head of department

5. Preparation for colonoscopy includes:
A) Cleansing enema the morning of the procedure only
B) Low-residue diet for 3 days + full bowel cleansing (macrogol or enemas)
C) 24-hour fasting
D) No preparation required

Part C — Situational Task (Documentation Defence)

> A student is escorting Patient A., 72 years old, diagnosed with unstable angina, to the ECG room. En route, the patient suddenly grabs his chest, complains of severe crushing substernal pain, breaks into a cold sweat, and becomes pale.

Questions:

10. What emergency condition do you suspect?
11. Describe the nurse's/student's complete action algorithm.
12. Can transportation continue? Justify your answer.
13. Which medical documentation must be completed after this event?

Model Answer:

10. Suspected diagnosis: Acute Coronary Syndrome (ACS) / Acute Myocardial Infarction.
11. Action algorithm: (1) STOP transportation immediately — do not continue moving the patient; (2) Position the patient semi-recumbent (45°) or supine if hypotensive; (3) Call the physician urgently (emergency button/phone); (4) Administer nitroglycerin 0.5 mg sublingual if BP ≥90 mmHg systolic and physician has pre-authorised (per standing order protocol); (5) Provide fresh air; loosen clothing; (6) Monitor pulse and BP every 2–3 minutes; (7) Remain with the patient at all times; (8) Prepare IV access if competent and instructed.
12. Transportation must NOT continue. ACS carries a risk of ventricular fibrillation and cardiac arrest at any moment. The patient must be returned to the ward or transferred to the resuscitation unit only on a trolley with a physician escort and cardiac monitoring.
13. Documentation required: (1) Emergency entry in the nursing notes (time, symptoms, actions taken); (2) Completion of the emergency accident/incident report form; (3) Entry in the vital signs log; (4) Medication administration record (if nitroglycerin given); (5) Transfer documentation if patient moved to ICU; (6) Physician notified — time and name recorded.

5. INTERNSHIP WORK SCHEDULE OPTIONS

Total contact hours for the internship: 108 hours (1 semester, 18 weeks). The student, together with the academic supervisor, selects the most suitable schedule from the options below. All options guarantee completion of the full contact hour volume.

Independent work (36 hours/semester) is completed outside the practice base: diary writing, essay preparation, and literature study.

Option 1 — Weekday Afternoons (3 hours per day)

Parameter	Value	Calculation	Total Hours	Note
Days of week	Mon–Fri	—	—	After classes end
Hours per day	3 h	—	—	e.g. 14:00–17:00
Number of working days	36 days	108 ÷ 3	108 h ✓	~4 days/week
Number of weeks	~9 weeks	36 ÷ 4	—	Approx.

Advantages	Disadvantages
Minimal daily workload. Easily combined with academic schedule. Recommended during peak study periods.	Longest overall duration (~9 weeks). Requires careful daily planning.

Option 2 — Weekday Afternoons (4 hours per day) — RECOMMENDED

Parameter	Value	Calculation	Total Hours	Note
Days of week	Mon–Fri	—	—	After classes end
Hours per day	4 h	—	—	e.g. 14:00–18:00
Number of working days	27 days	108 ÷ 4	108 h ✓	~3–4 days/week
Number of weeks	~7 weeks	27 ÷ 4	—	Approx.

Advantages	Disadvantages
Optimal balance of workload and learning. Recommended as the primary option for most students.	Requires consistently free afternoon time on multiple weekdays.

Option 3 — Saturdays (6 hours per day)

Parameter	Value	Calculation	Total Hours	Note
Day of week	Saturday	—	—	Weekend
Hours per session	6 h	—	—	e.g. 08:00–14:00
Number of Saturdays	18 Saturdays	108 ÷ 6	108 h ✓	1 per week
Duration	18 weeks	Full semester	—	All 18 weeks

Advantages	Disadvantages
Does not interfere with the weekday academic schedule. Full working block each session — deeper immersion in ward work.	Occupies Saturday for the entire semester. Requires prior agreement with the practice base.

Option 4 — Sundays (6 hours per day)

Parameter	Value	Calculation	Total Hours	Note
Day of week	Sunday	—	—	Weekend
Hours per session	6 h	—	—	e.g. 08:00–14:00
Number of Sundays	18 Sundays	108 ÷ 6	108 h ✓	1 per week
Duration	18 weeks	Full semester	—	All 18 weeks

Advantages	Disadvantages
Weekdays completely free. Opportunity to observe the on-call/duty shift on a weekend day.	On Sundays, some diagnostic services may operate at reduced capacity.

Option 5 — Night Shifts (12 hours per shift)

Parameter	Value	Calculation	Total Hours	Note
Shift time	20:00–08:00	—	—	Night shift
Hours per shift	12 h	—	—	Incl. handover
Number of shifts	9 shifts	108 ÷ 12	108 h ✓	~1/week
Duration	~9–12 weeks	—	—	By arrangement

Advantages	Disadvantages
Minimum number of attendances (9). Opportunity to observe emergency and acute conditions during night hours. Frees up daytime hours.	High physical workload. May adversely affect academic performance the following day. Requires dean's office approval.

IMPORTANT: Night shifts are only permitted with the student's written consent and the dean's office written authorisation. Students under 18 years of age are NOT permitted to undertake night shifts under any circumstances.

Summary Table — Schedule Options (108 contact hours)

No.	Type	Time	h/day	Days/sessions	Total hours	Duration
1	Weekdays (Mon–Fri)	14:00–17:00	3 h	36 days	108 h ✓	~9 weeks
2	Weekdays (Mon–Fri) ★	14:00–18:00	4 h	27 days	108 h ✓	~7 weeks
3	Saturdays	08:00–14:00	6 h	18 Saturdays	108 h ✓	18 weeks
4	Sundays	08:00–14:00	6 h	18 Sundays	108 h ✓	18 weeks
5	Night shifts	20:00–08:00	12 h	9 shifts	108 h ✓	~9–12 weeks

★ Recommended as the primary option. Combined schedules are permitted by agreement with the academic supervisor. The final schedule must be agreed and signed before the internship begins.

6. INDEPENDENT WORK (SRS) — 36 HOURS

Independent work is performed by the student outside the practice base: diary maintenance, essay/report writing, and literature review. Completed work is assessed at boundary controls.

6.1. Essay / Report Topics

Section 1 — Organisation and Documentation

- Organisation of work of the ward nurse in a therapeutic department.
- Regulatory documents and maintenance of the patient register.
- Monitoring the execution of physician prescriptions: theory and practice.
- Differentiated therapeutic nutrition: principles and application of Pevzner diets.

Section 2 — Patient Care and Complication Prevention

- Prevention of post-operative and pulmonary complications in patients.
- Preparation of patients for diagnostic and therapeutic procedures.
- Sanitary-hygienic processing of ward rooms and the operating unit.
- Pre-medical first aid: emergency algorithms for the ward nurse.

Section 3 — Diagnostics and Hospital Organisation

- Preparation of patients for radiological and laboratory diagnostic procedures.
- Patient transportation: types and safety rules.
- Features of the ward nurse's work in surgical departments.
- Medical documentation: maintenance, delivery, and archiving.

Section 4 — Rehabilitation and Quality Management

- Medical rehabilitation: goals, methods, and effectiveness monitoring.
- Quality management principles in medical personnel activities.
- Individual rehabilitation and habilitation programmes for persons with disabilities.
- Medical documentation: assessment of department performance indicators.

6.2. Essay / SRS Evaluation Criteria (100 points)

Criterion	Points	Details	Competency
Relevance and clarity of objectives	10	Clear aim; correspondence to discipline topic	UK-4
Depth of content and logical structure	30	Completeness; logical flow; use of current data	OPK-6
Scientific approach and critical analysis	20	≥5 sources; analytical approach; evidence-based	UK-6
Practical significance	15	Connection to clinical practice; case examples	OPK-6, OPK-8
Formatting and academic style	15	Correct structure: title page, TOC, conclusion, references	PC-14
Oral defence	10	7–10 min presentation; answers to questions	UK-4
TOTAL	100	—	—

7. FINAL CREDIT REQUIREMENTS

The credit with a grade is awarded after completion of the internship and includes verification of ALL reporting documentation plus an oral examination and practical skill demonstration.

7.1. Documentation Submitted for Credit

- Completed internship diary (all 18 weeks, daily entries, supervisor signatures).
- Manipulation log: list of all procedures performed with quantities.
- Practice report: 5–7 page structured summary of internship activities.
- Reference letter (характеристика) from the clinical base supervisor.
- At least one completed essay/SRS work from the list in Section 6.
- Grading records from all 4 boundary controls (RK1–RK4).

7.2. Credit Grading Scale

Rating %	Letter Grade	Traditional	Criterion	Credit
90–100	A — Excellent	5	All documentation complete; excellent theoretical and practical performance across all 4 modules; high professional behaviour	Pass
80–89	B — Good	4+	Documentation complete; good theoretical and practical performance; minor shortcomings	Pass
70–79	C — Good	4	Documentation mostly complete; satisfactory theoretical and practical performance; some errors corrected with prompting	Pass
60–69	D — Satisfactory	3	Documentation complete; minimum threshold met in all 4 boundary controls	Pass
50–59	E — Satisfactory	3−	Documentation incomplete or boundary control performance below standard; supplementary assessment required	Pass (conditional)
<50	FX / F — Fail	2	Critical deficiencies in documentation, attendance, or professional behaviour	Fail

7.3. Cumulative Grading System

Component	Weight %	Max Points	Min Threshold
Ongoing control (diary + attendance + participation) — 4 modules × 4 pts max each	16	16	9.6 (60%)
Boundary Control No. 1 (Module 1)	10	10	6 (60%)
Boundary Control No. 2 (Module 2)	10	10	6 (60%)
Boundary Control No. 3 (Module 3 — with case history defence)	10	10	6 (60%)
Boundary Control No. 4 (Module 4 — with documentation defence)	10	10	6 (60%)
Independent work / SRS (essay + diary)	4	4	2.4 (60%)
Final credit (oral + practical skill + documentation check)	20	20	12 (60%)
TOTAL	100	100	60

Note: a student who fails to reach the 60% threshold in any single boundary control must retake that control within 10 working days per the departmental schedule. Repeated failure results in non-admission to the final credit.