NURSING RESEARCH ANDSTATISTICS

Total Hours : Theory – 45 Hour
Practical – 30 Hours per Week

Course Description:

The course is designed to enable students to develop an understanding of basic concepts of research, research process and statistics and to enable them to conduct/participate in need based research studies in various settings. Further the students will be able to utilize the research findings to provide quality-nursing care.

Total marks – 100

Specific objectives: At the end of the course, the students will be able to:

1. Define the terms and concepts of nursing research.
2. Identify needs and scope of nursing research.
3. Define research problems.
4. Locate and list sources of literature review including operational definitions and conceptual framework.
5. Describe different approaches and research designs in nursing research.
6. Describe sample and sampling technique.
7. Develop tool for data collection.
8. Conduct pilot study to confirm reliability and validity of tool before data collection
9. To enumerate steps of data analysis and present data summary
10. Use descriptive and co- relational statistics in data analysis.
11. Conduct group project and write report.

Unit	Time (Hrs)	Learning Objectives	Content	Training Learning Activities	Assessment Methods
I	4	• Describe the concept of research, terms, need and areas of research in nursing. • Explain the steps of research process.	**Research and research process** • Introduction and need for nursing research. • Definition of Research & nursing research. • Steps of scientific method. • Characteristics of research. • Steps of research process -overview	• Lecture Discussion. • Narrate steps of research process followed from examples of published studies.	• Short answer • Objectiv e type

Unit	Time (Hrs)	Learning Objectives	Content	Training Learning Activities	Assessment Methods
II	3	• Identify and state the research problem and objectives	Research Problem/Question • Identification of problem area. & Problem statement. • Stating objectives of the research problem.	• Lecture Discussion. • Exercise on writing statement of problem and objectives • *Each student selects a research problem*	• Short answer. • Objective type
III	3	• Review the related literature	**Review of Literature** • Steps in review of literature • Identification of Publication • Keeping a record • Writing the review of literature • Writing of Bibliography	• Lecture Discussion • Exercise on reviewing one research report/ article for a selected research problem. • Prepare annotated bibliography(5)	• Short answer • Objective type
IV	4	• Describe the research approaches and designs	**Research approaches and designs** • Historical, survey and experimental • Qualitative and Quantitative designs	• Lecture Discussion • Explain types of research approaches used from examples of published and unpublished research studies with rationale.	• Short answer • Objective type
V	8	• Explain the sampling process • Describe the methods of data collection • Developing and standardizing an instrument	Sampling and data collection • Definition of Population, Sample, Sampling criteria, factors influencing sampling process, types of sampling techniques. • Data collection Methods and instruments 1) Questionnaire, interview, records& reports and other techniques 2) Validity & Reliability of the instrument 3) Pilot Study	• Lecture Discussion • *Prepare the tool in respect to the selected research problem.*	• Short answer • Objective type

Unit	Time (Hrs)	Learning Objectives	Content	Training Learning Activities	Assessment Methods
VI	15	• Explain the use of statistics, scales of measurement and graphical presentation of data • Describe the measures of central tendency and variability and methods of correlation	**Introduction to statistics** • Definition, use of statistics, scales of measurement • Frequency distribution and graphical presentation of data • Mean, Median, Mode, standard deviation • Normal probability and tests of significance • Coefficient of correlation • Inferential statistics and types • Statistical packages and its application	• Lecture, discussion • Practice on graphical presentations • Practice on computation of measures of central tendency, variability & correlation	• Short answer • Objective type
VII	4	• Analyze, interpret and summarize the research date	Analysis of Data • Compilation, Tabulation • Classification, summarization, presentation, interpretation of data	• Lecture, discussion • Preparation of sample tables	• Short answer • Objective type
VIII	4	• Communicate and utilize the research findings.	Communication and utilization of Research • Communication of research findings - Verbal report - Writing research report - Writing scientific article/ paper-Critical review of published research & Utilization of research findings	• Lecture, discussion • Writing group research project & presentation	• Short answer • Objective type • Assessment of group research Project

References

1. Polit , D.F. & Beck CT, Nursing Research, Principles and Methods,7th ed, Lippincott Williams & Wilkins,Philadelphia,2003.
2. Polit Dennis and Hunglar B P, Nursing research principles and methods, 6th edition Lippincott, Philadephia,1999.
3. Laura A.Talbot, Principles and practice of nursing research, Mosby St. Louis1995.
4. DorothyYB & Marie TH ,Fundamentals of research in Nursing, 3rd ed,Jones & Bartlett Publishers,Boston,2003.

5. Rao TB, Methods in Medical Research , 1st ed, Radha Rani Publishers, Guntur AP,2002.
6. Smith, P ResearchMindedness for Practice> An interactive approach for nursing and health care, Churchill livingstone, New York,1997
7. American Psychological Association publication manual.2001.
8. Mahajan Methods in Biostatistics.
9. Trece E.W. & Treece JW: Elements of Research in Nursing, 3rd ed The CV Mosby CompanySt, Louis1986

Evaluation

Scheme of internal Assessment of Theory: out of 25 marks			Weightage
S.N.	**Theory Assessment**	Marks	
1	Midterm	25	Average 15 marks
2	Prefinal	75	
	Group research project work	100	Average 10 marks
	Total	225	Average 25 marks

(Total marks obtained out of 125 to be converted in to 15 and out of 100 to be converted in to 10 and total out of 25 marks to be forwarded to the University towards internal assessment Theory)

Research Project:

Practical - 45 Hours (1 week)

Selecting and conducting small group research project (The number of students in a group should not exceed 10). Group project may be conducted in community setting during their clinical experience in community phase or during their clinical experience in the wards.

Group studies may include, studying existing health problems and practices, nursing procedures, health records and patient records etc.

INTRODUCTION TO NURSING RESEARCH AND STATISTICS

PRACTICAL EXPERIENCE GUIDELINE AND EVALUATION FOR

3rdBSc.Nursing

NURSING RESEARCH: "PROJECT"

Time Allotted Practical- 45 hrs.

Guideline for Research Project

I Aim: Student will identify the role of nurse in conducting research, writing research proposal based on scientific steps and will analyze the data using simple statistical methods. While conducting research project.

II Objectives: Preparing nursing research proposal

1) To get an opportunity to select topic or problem to formulate research proposal.
2) To follow the steps in research while writing research proposal and conducting project.
3) To differentiate and plan specific design in nursing research i.e. experimental and non-experimental including methodology.
4) To get an opportunity to frame/construct simple tool or questionnaire to collect data.
5) To follow the basic principles of data analysis including simple tables and statistical methods for proceedings and interpretation of data.
6) To be familiar to write research report to communicate the findings including bibliography, foot notes and future recommendations.
7) To present nursing research proposal as group activity.
8) Learns to use computers.

.III Guide line / check list to prepare / Nursing research proposal &project

1) Selection of research problem: Select your interest area of research, based on felt need, issues, social concern in nursing field.
   a) State the problem, brief concise, clear.
   b) State the purpose of selected study &topic
   c) State objective of study/proposal/project.
   d) State the hypothesis if necessary (optional).
   e) Prepare conceptual framework based on operational definition (optional).
   f) Write scope and delimitation of Research Proposal.

2) Organizing for Review of Literature
   a) It ad as in to needs to conduct Research project.
   b) To study related and relevant literature which helps to decide conceptual framework and research design to be selected for your study.
   c) To add specific books, bulletins, periodicals, reports, published and unpublished dissertations, encyclopedia, textbooks.
   d) Organize literature as per operational definition.
   e) To prepare summary table for review of literature.(Optional)

3) Research Methodology: To determine logical structure & methodology for research project

a) Decide and state approach of study i.e. experimental or non-experimental.

b) To define/find out variables to observe effects on decided items & procedure(optional)

c) To prepare simple tool or questionnaire or observational check list to collect data.

d) To determined sample and sampling method.

i) Mode of selection ii) Criterias iii) Size of sample

iv) Plan when, where and how data will be collected

e) To test validity of constructed tool (To check content in tool in relation to stated objectives) with experts / teachers opinion.

t) To check reliability by implementing tool before pilot study (10% of sample size)

g) To conduct pilot study by using constructed tool for 10% selected sample *size.*

4) Data Collection: To implement prepared tool

a) To implement constructed tool

b) Decide location

c) Time

d) Write additional information in separate exercise book to support inferences and interpretation.

5) Data analysis and processing presentation

a) Use appropriate method of statistical analysis i.e. frequency and percentage.

b) Use clear frequency tables, appropriate tables, graphs and figures.

c) Interpretation of data:

i) In relation to objectives

ii) Hypothesis(Optional)

iii) Variable of study or project(Optional)

iv) Writing concise report

6) Writing Research report

a) Aims:

i) To organize materials to write project report

ii) To make comprehensive full factual information

iii) To use appropriate language and style of writing

iv) To make authoritative documentation by checking footnotes, references &bibliography

v) To use computers.

b) Points to remember

a) Develop thinking to write research report.

b) Divide narration of nursing research report.

c) Use present tense and active voice

d) Minimize use of technical language

f) Use simple, straightforward, clear, concise language

g) Use visual aids in form of table, graphs, figures

h) Treat data confidentially

i) Review, rewrite if necessary

EVALUATION CRITERIA FOR PROJECT REPORT

Maximum Marks: 100

Sr. No.		Criteria	Rating					Remarks
			1	2	3	4	5	
I	Statement of the problem							
	1.	Significance of the problem selected						
	2.	Framing of title and objectives						
II	Literature Review							
	3.	Inclusion of related studies on the topic, and its relevance						
	4.	Operational definition						
III	Research Design							
	5.	Use of appropriate research design						
	6.	Usefulness of the research design to draw the inferences among stud variables /conclusion						
IV	Sampling design							
	7.	Identification and description of the target population						
	8.	Specification of the inclusion and exclusion criteria						
	9.	Adequate sample size justifying he study design to draw conclusions.						
V	Data Collection Procedure							
	10.	Preparation of appropriate tool						
	11.	Pilot study including validity and reliability of tool						
	12.	Use of appropriate procedure / method for data collection						
VI	Analysis of Data & Interpretation							
	13.	Clear and logical organization of the findings						
	14.	Clear presentation of the tables (Title, table & Column heading)						
	15.	Selection of appropriate statistical tests						

Sr. No.		Criteria	Rating					Remarks
			1	2	3	4	5	
Vll	Ethical Aspects							
	16.	Use of appropriate consent process						
	17.	Use appropriate steps to maintain ethical aspects and principles (physical harm etc.)						
VIII	Interpretation of the findings							
	18.	Consistent and appropriate discussion of the Results						
IX	Conclusion							
	19.	Summary and recommendations for to Nursing Practice / Education / Administration						
X	Presentation *I* Report writing							
	20.	Organization of the project work including Language and style of presentation						
		Maximum marks						100
		Marks obtained						
		Marks sent to University						/ 50

Remarks by the Supervisor / Guide

Date: **Signature**

Signature of the students Date

CHILD HEALTH NURSING.

Placement: Third Year. **Time: Theory-90 Hrs.**
(Class 80 + Lab 10hrs
Practical-270Hrs. + 75 Hrs*

Course Description: This course is designed for developing an understanding of the modern approach to child-care, identification, prevention and nursing management of common health problems of neonates and children.

Specific objectives: At the end of the course, the students will be able to:
1. Explain the modern concept of child care and the principles of child health nursing.
2. Describe the normal growth and development of children in various age groups.
3. Explain the physiological response of body to disease conditions in children.
4. Identify the health needs and problems of neonates and children, plan and implement appropriate nursing interventions.
5. Identify the various preventive, promotive and rehabilitative aspects of child care and apply them in providing nursing care to children in the hospital and in the community.

Unit	LearningObjectives	Content	Hrs : allocation.
I	*Explain the modern concept of child care & principles of child health nursing. *Describe national policy Progammes & legislations in relation to child health & welfare. *List major causes of death during infancy, early & late childhood. *Describe the major functions & role of the paediatric nurse in caring for a hospitalized child. *Demonstrate various Paediatric nursing procedures	**Introduction: Modern concept of childcare.** • Introduction to modern concept of child care & history, principles & scope of child health nursing. • Internationally accepted rights of the Child National policy & legislations in relation to child health &welfare. • National programmes related to child health & welfare. • Agencies related to welfare services to the children. • Changing trends in hospital care, preventive, promotive & curative aspects of child health. • Child morbidity & mortality rates. • Differences between an adult &child. • Hospital environment for a sick child. • Impact of hospitalization on the child &family. • Grief &bereavement. • The role of a child health nurse in caring for a hospitalized child. • Principles of pre & post-operative care of infants & children. • Child health nursing procedures.	**T 10 hrs.** **P 05 hrs** 1 1 1 1 1 1 1 1 1 1 1 5

Unit	Learning Objectives	Content	Hrs : allocation.
II	*Describe the normal growth &development of children at different ages *Identify the needs of children at different ages & provide parental guidance *Identify the nutritional needs of children at different ages & ways of meeting the needs. *Appreciate the role of play for normal &sick children. *Appreciate the preventive measures & strategies for children.	**The healthy child** • Principles of growth &development. • Factors affecting growth &development. • Growth & development from birth to adolescence • The needs of normal children through the stages of developmental & parental guidance • Nutritional needs of children & infants: Breast feeding, supplementary &artificial Feeding & weaning. • Baby friendly hospital concept. • Accidents: causes &prevention. • Value of play & selection of play material. • Preventive immunization, immunization programme & cold chain. • Preventive pediatrics • Care of under five& under five clinics/well baby clinic.	**T 18 hrs.** **P 02 hrs** 1 1 6 2 1 2 2 2 1 2
III	*Provide care to normal &high risk neonates. *Perform neonatal resuscitation. *Recognize &manage common neonatal problems.	**Nursing care of a neonate.** • Nursing care of a normal newborn /Essential newborn care. • Neonatal resuscitation. • Nursing management of a low birth weight baby &high risk babies. • Kangaroo mother care. • Organization of neonatal unit. • Identification & nursing management of common neonatal problems. • Nursing management of babies with common congenital malformations. • Control & prevention of infection in N.I.C.U.	**T 12hrs.** **P 03hrs.** 4 1 4 1 1 1 2 1
IV	*Explain the concept of IMNCI & other health strategies initiated by National population policy 2000.	**Integrated management of neonatal& childhood illnesses(IMNCI).** Health strategies: National population policy- • RCH camps & RCH outreach schemes. • Operationalization of district newborn care, home based neonatal care. • Border district cluster strategy. • Integrated management of infants& children with illnesses like diarrhea, A.R.I., malaria, measles & Malnutrition. • * Nurses' role: IMNCI.	**10 hrs.** 2 2 1 3 2

U nit	Learning Objectives	Content	Hrs : allocation.
V	*Provide nursing carein Common childhood diseases. *Identify measures to prevent common childhood diseases including immunization.	**Nursing management in common Childhood diseases-** • Nutritional deficiency disorders. • Respiratory disorders &infections. • Gastro-intestinal infections, infestations,& congenital disorders. • Cardio-vascular problems: congenital defects & rheumatic fever, rheumatic heart disease. • Genito-urinary disorders: acute glomerulo nephritis, nephritic syndrome, Wilm's tumour, infections, calculi, & congenital disorders. • Neurological infections &disorders: convulsions, meningitis, hydrocephalus, head injury. • Hematological disorders : anemias, thalassemia, ITP, leukemia, hemophilia. • Endocrine disorders: juvenile diabetes mellitus& other diseases. • Orthopaedic disorders : club feet, hip dislocation & fracture. • Disorders of skin, eye &ears. • Common communicable diseases in children, their identification, nursing care in hospital& home &prevention. • Child health emergencies :poisoning, haemmorrhage, burns &drowning. • Nursing care of infant and children with HIV/ AIDS	**20 hrs.** 1 2 2 3 2 3 2 1 1 1 1 1
VI	*Manage the child with behavioral & social problems	**Management of behavioural & social Problems in children.** • Management of common behavioral disorders. • Management of common psychiatric problems. • Management of challenged children: • Mentally, physically, &socially challenged. • Welfare services for challenged children in India. • Child guidance clinics.	**10 hrs.** 4 2 2 1 1

References-

1. GhaiO.p. et al. (2000) Ghai's Essentials of Paediatrics. 1st edn. Mehta offset works. NewDelhi.

2. Marlow Dorothy & Redding. (2001) Textbook of Paed. Nsg. 6th edn. Harbarcourt India ltd. NewDelhi

3. Parthsarathy et al. (2000) IAP Textbook of PaediatricNsg. Jaypee bros., 2 nd ed. NewDelhi.

4. Vishwanathan& Desai. (1999) Achar's Textbook of Paediatrics 3rd ed. Orient Longman. Chennai.

5. Wong Dona et al. Whaley & Wong's Nursing care of infants & children.6th edn. Mosby co., Philadelphia.

6. Dr. C.S. Waghale, Principles and Practice of Clinical Pediatrics, Vora publication1996

PRACTICAL

Time: 270 hrs (9 weeks)
75 Hrs* (2 weeks)

Areas	Duration (in weeks)	Objectives	Skills	Assignments	Assessment methods
Pediatric medicine ward	3	• Provide nursing care to children with various medical disorders • Counsel and educate parents	• Taking pediatric history • Physical examination and assessment of children • Administer of oral, IM/IV medicine and fluids. • Calculation fluid requirements • Prepare different strengths of IV fluids • Apply restraints • Administer O2inhalation by different methods • Give baby bath • Feed children by katori spoon etc • Collect specimens for common investigations • Assist with common diagnostic procedures • Teach mothers/parents ➢ Malnutrition ➢ Oral rehydration therapy ➢ Feeding and weaning ➢ Immunization schedule ➢ Play therapy ➢ Specific disease conditions	• Give care to three assigned pediatric patients • Nursing care plan- 1 • Case study /Presentation - 1	• Assess clinical performance with rating scale. • Assess each skill with checklist OSCE/OSPE • Evaluation of case study / presentation and health education session. • Completion of activity record

Pediatric surgery ward	3	• Recognize different pediatric conditions/ malformations • Provide pre and post operative care to children with common pediatric surgical conditions/ malformation • Counsel and educate parents	• Calculate, prepare and administer IV • fluids Do bowel wash • Care for ostomies: ➢ Colostomy irrigation ➢ Ureterostomy ➢ Gastrostomy ➢ Enterostomy • Urinary catheterisation and drainage • Feeding ➢ Nasogastric ➢ Gastrostomy ➢ Jejunostomy • Care of surgical wounds • Dressing • Suture removal	Give care to three assigned pediatric surgical patients Nursing care plan- 1 Case study / presentation - 1	• Assess clinical performance with rating scale. • Assess each skill with checklist OSCE/OSPE • Evaluation of case study / presentation and health education session. • Completion of activity record
Pediatric OPD/ Immunization room	1	• Perform assessment of children: Health, developmental and anthropometric • Perform immunization • Give health education/ nutritional education	• Assessment of children ➢ Health assessment ➢ Developmental assessment ➢ Anthropometric assessment • Immunization • Health / Nutritional education	Developmental study -1	Assess clinical performance with rating scale • Completion of activity record.
Pediatric medicine and surgery ICU	1+1	• Provide Nursing care to critically ill children	• Care of a baby in incubator /warmer • Care of child on ventilator. • Endotracheal suction • Chest physiotherapy • Administer fluids with infusion pump. • Total parenteral nutrition • Phototherapy • Monitoring of babies • Cardio pulmonary resuscitation	Nursing care plan 1 Observation report 1.	• Assess clinical performance with rating scale • Completion of activity record • Evaluation of observation report.

*** 75 Hrs 2 Weeks**

Area	Duration	Objective	Skills	Assignments	Assessment
Pediatric medicine ward / ICU	1 week	Provide comprehensive care to children with medical conditions	Integrated Practice	Bedside nursing rounds	Assess clinical performance with rating scale
Pediatric surgery ward / ICU	1 week	Provide comprehensive care to children with surgical conditions	Integrated Practice	Bedside nursing rounds	Assess clinical performance with rating scale

***shifted from Integrated practice**

EVALUATION

I. Internal assessment :

Maximum marks 25

Theory:	**Marks**
Midterm	50
Prefinal	75
Total marks	125

Practicum: **Maximum marks50**

1. Case presentation- (Paed Medical /Surgical 01)		50
2. Case study - (Paed. medical. / surgical. 01)		50
3. Nursing careplan03	3 x 25	75
4. Clinical evaluation of comprehensive. (paed. Medical / surgical / P.I.C.U./N.I.C.U.)	3 X 100 300	
5. Health teaching-01		25
6. Assessment of growth & development reports. (20markseach) (Neonate, infant, toddler, preschooler, & School age)	5 X 20	100
Observation report of NICU surgery/Medical	1 x 25	25

Practical exam :

1. Midtermexam	50
2. Pretermexam	50
	725

II External assessment : University exam:

Theory	**75**
Practical	**50**

FORMAT FOR CASE PRESENTATION

Patients Biodata: Name, address, age, sex, religion, occupation of parent, source of health care, date of admission, provisional diagnosis, date of surgery if any

Presenting complaints: Describe the complaints with which the patient has come to hospital

History of illness

History of present illness – onset, symptoms, duration, precipitating / alleviating factors

History of past illness – illnesses, surgeries, allergies, immunizations, medications

Family history – family tree, history of illness in family members, risk factors, congenital problems, psychological problems.

Childs personal data

Obstetric history of - prenatal & natal history of mother, growth an development (compare with normal), immunization status, dietary pattern including weaning, play habits, toilet training, sleep pattern, schooling.

Economic status of the family: Monthly income & expenditure on health, food and education material assets (own pacca house car, two wheeler, phone, TV etc…)

Psychological status: ethnic background, (geographical information, cultural information) support system available.

Physical examination with date and time

Investigations

Date	Investigations done	Normal value	Patient value	Inference

Treatment

Sr. No.	Drug (Pharmacological name)	Dose	Frequency / Time	Action	Side effects & drug interaction	Nursing responsibi--lity

Description of disease

Definition, related anatomy physiology, etiology, risk factors, clinical features, management and nursing care

Clinical features of the disease condition

Clinical features present in the book	Description of clinical features of patient	Pathophysiology

Nursing process:

Patients name Date Ward

Date	Assessment	Nursing Diagnosis	Objective	Plan of care	Implementation	Rationale	Evaluation

Discharge planning:
It should include health education and discharge planning given to patient

Evaluation of care
Overall evaluation, problem faced while providing care prognosis of the patient and conclusion

Evaluation format for case presentation

SN	Content	Marks
1	Assessment / Introduction	05
2	Knowledge and understanding of disease	10
3	Nursing care plan	15
4	Presentation skill	10
5	A.V. aids	05
6	Overall	
	Time	01
	Summary& conclusion	02
	Bibliography	02
	Total	50

Format for case study

Format is similar to case presentation but should be in detail
The nursing care given to the patient should be at least for 5 continuous days

Evaluation format for case study

SN	Content	Marks
1	Assessment / Introduction	05
2	Knowledge and understanding of disease	15
3	Nursing care plan	20
4	Discharge plan	05
5	Summary & evaluation	02
6	Bibliography	03
	Total	50

Nursing care plan

1. **Patients Biodata:** Name, address, age, sex, religion, occupation of parents, source of health care, date of admission, provisional diagnosis, date of surgery ifany
2. **Presenting complaints:** Describe the complaints with which the patient has come tohospital
3. **History of illness**

   History of present illness – onset, symptoms, duration, precipitating / alleviating factors
   History of past illness – illnesses, surgeries, allergies, immunizations, medications
   Family history – family tree, history of illness in family members, risk factors, congenital problems, psychological problems

4. Childs personal data

Obstetric history of - prenatal & natal history of mother, growth an development (compare with normal),immunization status, dietary pattern including weaning, play habits, toilet training, sleep pattern, schooling.

5 **Economic status:** Monthly income & expenditure on health, food and education, material assets (own pacca house car, two wheeler, phone, TV etc…)

6 **Psychological status:** ethnic background,(geographical information, cultural information) support system available.

7 **Personal habits:** consumption of alcohol, smoking, tobacco chewing, sleep, exercise, work elimination, nutrition.

8 **Physical examination with date andtime**

9 **Investigations**

Date	Investigations done	Normal value	Patient value	Inference

10. Treatment

SN	Drug (pharmacological name)	Dose	Frequency /time	Action	Side effects & drug interaction	Nursing responsibility

11. Nursing process:

Patients name Date Ward

Date	Assessment	Nursing Diagnosis	Objective	Plan of care	Implementa –tion	Rationale	Evaluation

Discharge planning:

It should include health education and discharge planning given to patient

12. Evalaution of care

Overall evaluation, problem faced while providing care prognosis of the patient and conclusion

Care plan evaluation

1. History taking	03
2. Assessment and nursing diagnosis	05
3. Planning of care	05
4. Implementation and evaluation	08
5. Follow up care	02
6. Bibliography	02
	25

EVALUATION FORMAT FOR HEALTH TALK

NAME OF THE STUDENT: ----------

AREA OFEXPERIENCE:_____

PERIOD OFEXPERIENCE: _____

SUPERVISOR: _____

Total 100 Marks

Scores: 5 = Excellent, 4 = Very good, 3 = Good, 2 = Satisfactory / fair, 1 = Poor

SN	Particular	1	2	3	4	5	Score
1	**I) Planning and organization** a) Formulation of attainable objectives b) Adequacy of content c) Organization of subject matter d) Current knowledge related to subject Matter e) Suitable A.V. Aids **II) Presentation:** a) Interesting b) Clear Audible c) Adequate explanation d) Effective use of A.V. Aids e) Group Involvement f) Time Limit **III) Personal qualities**: a) Self confidence b) Personal appearance c) Language d) Mannerism e) Self awareness of strong & weak points **IV) Feed back:** a) Recapitulation b) Effectiveness c) Group response **V) Submits assignment on time**						

* 100 marks will be converted into25

CLINICAL EVALUATION PROFORMA

Name of the student : _____

Year : _____

Area of clinical experience: _____ Duration of posting in weeks:

_____ Name of the supervisor

: _____

Total Marks: - 100

Scores:- 4 = Very good, 3 = Good, 2 = Satisfactory / fair, 1 = Poor

SN	EVALUATION CRITERIA	Grades			
		4	3	2	1
1	**Personal & Professional behavior**				
1	Wears clean & neat uniform and well groomed.				
2	Arrives and leaves punctually				
3	Demonstrates understanding of the need for quietness in speech & manner & protects the patient from undue notice.				
4	Is notably poised and effective even in situations of stress				
5	Influential & displaced persuasive assertive leadership behaviour				
II	**Attitude to Co-workers and patients**				
6	Works well as member of nursing team				
7	Gives assistance to other in clinical situations				
8	Understands the child as an individual				
9	Shows skills in gaining the confidence & co-operation of child and relatives, tactful and considerate.				
IV	**Application of knowledge**				
10	Possess sound knowledge of pediatric conditions.				
11	Has sound knowledge of scientific principles				
12	Has knowledge of normal growth and development of children				
13	Has knowledge of current treatment modalities inclusive of medicine, surgery, pharmacology and dietetics.				
14	Takes interest in new learning from current literature & seeks help from resourceful people.				

SR NO	EVALUATION CRITERIA	Grades			
		4	3	2	1
V	**Quality of clinical skill**				
15	Able to elicit health history of child and family accurately.				
16	Skillful in carrying out physical examination, developmental screening and detecting deviations from normal				
17	Identifies problems & sets priorities and grasps essentials while performing duties Able to plan and implement care both preoperatively and post operatively.				
18	Applies principles in carrying out procedures & carries out duties promptly.				
19	Has technical competence in performing nursing procedures. Able to calculate and administer medicines accurately				
20	Resourceful and practices economy of time material and energy.				
21	Recognizes the role of play in children and facilitates play therapy in hospitalized children				
22	Observes carefully, reports & records signs & symptoms & other relevant information				
23	Uses opportunities to give health education to patients & relatives				
24					
25					
	TOTAL				

Grade

Very good	=	70 % and above
Good	=	60 – 69 %
Satisfactory	=	50- 59 %
Poor	=	Below 50 %

Remarks for improvement:

Student's Remark:

Signature of the student Signature of the teacher

Assessment of growth & development reports

(Neonate, infant, toddler, preschooler, & School age)

PROFORMA FOR ASSESSMENT OF GROWTH & DEVELOPMENT

(Age group: birth to 5 yrs.)

I] Identification Data :

Name of the child	:	
Age	:	
Sex	:	
Date of admission	:	
Diagnosis	:	
Type of delivery	:	Normal/ Instrumental/LSCS
Place of delivery	:	Hospital/Home
Any problem during birth	:	Yes/No
If yes, give details	:	
Order of birth	:	

II] Growth & development of child & comparison with normal:

Anthropometry	**In the child**	**Normal**
Weight		
Height		
Chest circumference		
Head circumference		
Mid arm circumference		
Dentition		

III] Milestones of development:

Development milestones	In Child	Comparison with the normal
1.Responsive smile 2.Responds to Sound 3.Head control 4.Grasps object 5.Rolls over 6.Sits alone 7.Crawls or creeps 8.Thumb-finger co-ordination (Prehension) 9.Stands with support 10. Stands alone 11. Walks with support 12. Walks alone 13. Climbs steps 14. Runs		

IV] Social, Emotional & Language Development:

Social & emotional development	In Child	Comparison with the normal
Responds to closeness when held Smiles in recognition recognized mother coos and gurgles seated before a mirror, regards image Discriminates strangers wants more than one to play says Mamma, Papa responds to name, no or give it to me. Increasingly demanding offers cheek to be kissed can speak single word use pronouns like I, Me, You asks for food, drinks, toilet, plays with doll gives full name can help put thinks away understands differences between boy & girl washes hands feeds himself/ herself repeats with number understands under, behind, inside, outside Dresses and undresses		

V] Play habits

Child favorite toy and play:
Does he play alone or with other children?

VI] Toilet training

Is the child trained for bowel movement & if yes, at what age:
Has the child attained bladder control & if yes, at what age:
Does the child use the toilet?

VII] Nutrition

- Breast feeding (as relevant to age)
- Weaning has weaning started for the child: Yes/No If yes, at what age & specify theweaning diet. Any problems observed during weaning:

Meal pattern at home

Sample of a day's meal: Daily requirements of chief nutrients:
Breakfast: Lunch: Dinner Snacks:
VIII] Immunization status & schedule of completion of immunization.

IX] Sleep pattern

How many hours does the child sleep during day and night?
Any sleep problems observed & how it is handled:

X] Schooling

Does the child attend school?
If yes, which grade and report of school performance:

XI] Parent child relationship

How much time do the parents spend with the child?
Observation of parent-child interaction

XII] Explain parental reaction to illness and hospitalization

XIII] Child's reaction to the illness & hospital team

XIV] Identification of needs on priority

XV] Conclusion

XVI] Bibliography

Evaluation Criteria: Assessment of Growth & Development (birthto5year)

(Maximum Marks: 50)

S.No.	Item	Marks
1.	Adherence to format	02
2.	Skill in Physical examination & assessment	10
3.	Relevance and accuracy of data recorded	05
4.	Interpretation Identification of Needs	05
5.	Bibliography	03
	Total	25

Note: - Same format to be used for assessment of infant, Toddler & Preschooler child.

PROFORMA FOR EXAMINATION AND ASSESSMENT OF NEW BORN

I] Bio data of baby and mother :
Name of the baby (if any) : Age
Birth weight : Present weight:
Mother's name : Period of gestation:
Date of delivery :
Identification band applied
Type of delivery : Normal/ Instruments/Operation
Place of delivery : Hospital/Home
Any problems during birth : Yes/No
If yes explain :
Antenatal history :
Mother's age : Height: Weight:
Nutritional status of mother :
Socio-economic background :

II] Examination of the baby :

Characteristics	In the Baby	Comparison with the normal
1. Weight 2. Length 3. Head circumference 4. Chest circumference 5. Mid-arm circumference 6. Temperature 7. heart rate 8. Respiration		

III] General behavior and observations

Color :
Skin/ Lanugo :
Vernixcaseosa :
Jaundice :
Cyanosis :
Rashes :
Mongolian spot :
Birthmarks :
Head :

- Anterior fontanel:

- Posterior fontanel:
- Any cephal hematoma / caput succedaneum
- Forceps marks(if any) :

Face:

Eyes:
Cleft lip / palate
Ear Cartilage :
Trunk:

- Breast nodule
- Umbilical cord
- Hands :

Feet /Sole creases :
Legs
Genitalia :
Muscle tone :
Reflexes :

- Clinging
- Laughing/ sneezing :
- Sucking :
- Rooting :
- Gagging :
- Grasp :
- Moro :
- Tonic neck reflex :

Cry: Good / week
APGAR scoring at birth :
First feed given :
Type of feed given :
Total requirement of fluid &calories
:Amount of feed accepted :
Special observations made during feed:
Care of skin Care of eyes, nose, ear, mouth:
Care of umbilicus and genitalia :
Meconium passed /not passed: Urine passed /not passed :

IV] Identification of Health Needs in Baby & Mother.
V] Health education to mother about Breast feeding

Care of skin, eye and umbilicus etc.
V] Bibliography

Evaluation Criteria: Examination & Assessment of Newborn

(Maximum Marks: 50)

S.No.	Item	Marks
1	Adherence to format	02
2	Skill in Physical examination & assessment	10
3	Relevance and accuracy of data recorded	05
4	Interpretation of Priority Needs Identification of baby & mother	06
5	Bibliography	02
	Total	25

Maharashtra University of Health Sciences External Practical Evaluation Guidelines

III Basic B.Sc

Nursing Subject : Child Health Nursing

50Marks

Internal Examiner **25Marks**

Nursing Procedure (15 marks)

Planning and Organizing	**5marks**
• Preparation of tray	3
• Environment	1
• Preparation of patient	1
Execution of Procedure	**7marks**
• Applies scientific principles	3
• Proficiency in skill	3
• Ensures sequential order	1
Termination of procedure	**3marks**
• Makes patient comfortable	1
• Reports& Records	1
• After care of articles	1

Viva(10Marks)	**10marks**
• Knowledge about common pediatric medical surgical conditions	3
• Preparation of various diagnostic procedures	2
• Instruments and articles	2
• Growth and Development	3

External Examiner **25Marks**

Nursing Process(15Marks)	**15marks**
• Assessment	3
• Nursing Diagnosis	2
• Goal	1
• Outcome criteria	1
• Nursing intervention	3
• Rationale	2
• Evaluation	1
• Nurses notes	2

Viva(10Marks)	**10marks**
• National Health Programs for child care including IMNSI	2
• Behavioral and social problem in children	3
• Drugs	3
• Nursing care of neonates	2

CHILD HEALTH NURSING PRACTICAL
EXAMINATION PRACTICAL /
ORAL MARK LIST

NAME OF THE EXAMINATION: **CHILD**

HEALTH NURSING PRACTICALS MONTH: **YEAR:**

THIRD YEAR Basic B. ScNURSING: **MARKS :**

50 SUBJECT : CHILD HEALTHNURSING

CENTRE :

Roll No	Internal Examiner		External Examiner		Total	Total
	Procedure	Viva voce	Nursing process	Viva voce		
	15	10	15	10	50	25

Signature of the Internal Examiner **Signature of the External**

Examiner Date: **Date:**

MEDICAL SURGICAL NURSING

(Adult including Geriatrics) –II

Placement:Thirdyear

Time: Theory –120hours
(Classroom 103 + Lab17)
Practical- 270 hours + 60 hrs*

Course Description: The purpose of this course is to acquire knowledge and proficiency in caring for patients with medical and surgical disorders in varieties of health care settings and at home.

Specific objectives: At the end of the course the student will be able to:

1. Provide care for patients with disorders of ear nose andthroat.
2. Take care of patients with disorders ofeye.
3. Plan, implement and evaluate nursing management of patients with neurologicaldisorders.
4. Develop abilities to take care of female patients with reproductivedisorders.
5. Provide care of patients with burns, reconstructive and cosmeticsurgery.
6. Manage patients with oncologicalconditions
7. Develop skill in providing care during emergency and disastersituations
8. Plan, implement and evaluate care of elderly
9. Develop ability to manage patients in critical careunits.

Unit	Time (Hrs)	Learning Objectives	Content	Teaching Learning Activity	Assessment Method
I	T15 P02	•Describe the etiology, patho-physiology, clinical manifestations, diagnostic measures and management of patients with disorders of of Ear Nose and Throat	**Nursing management of patient with disorders of Ear Nose and Throat** • Review of anatomyand physiology • of the Ear Noseand Throat- • Nursing Assessment-Historyand • Physicalassessment • Etiology, pathphysiology, clinical • Manifestations,diagnosis, • Treatment modalitiesand medical & • Surgicalnursing management of Ear Nose and Throat disorders: ○ **External ear**: deformities otalgia, foreign bodies, and tumours ○ **Middle Ear**-Impacted wax, Tympanic membrane perforation, otitis media, otosclerosis, mastoiditis, tumours	• Lecture • Discussion • Explainusing Charts,graphs • Models,films, slides • Demonstration • Practicesession • Cans discussions/ seminar • Health education • Supervised clinical practice • Drugbook /presentation •Demonstrationof procedures	• Essaytype • Shortanswers • Objectivetype • Assessment of skills of patient and management of problems.

Unit	Time (Hrs)	Learning Objectives	Content	Teaching Learning Activity	Assessment Method
			○ **Inner ear**-meniere,s Disease, labyrinthitis, ototoxicity, tumours ○ **Upper airway infections**– Common cold, sinusitis, ethinitis, Rhinitis, Pharyngitis, Tonsillitis and Adenoiditis, Peritonsilarabscess, Laryngitis ○ Upper respiratory airway- Epistaxis, ○ Nasal obstruction, laryngeal obstruction, Cancer of thelarynx ○ Cancer of the oralcavity ○ Speech defects and speechtherapy • Deafness- Prevention, control and rehabilitation • Hearing aids, implantedhearing Devices •Specialtherapies •Drugs used in treatment of disorders of ear nose andthroat •Role of nurse Communicatingwith hearing impaired and mute. • Nursing procedures Oesophaostomy, Tracheostomy,		
II	T 15 P 02	Describe the etiology, path physiology, clinical manifestations diagnostic Physical assessment measures and management of patients with disorders of eye.	**Nursing management of patient With disorders of eye** □ Review of anatomy andphysiology of theeye- •Nursing assessment – historyand □ Etiology, pathophysiology, clinical manifestations, diagnosis, treatment nursing management of eyedisorders: □ Refractiveerrors □ **Eyelids**-inflammationand • Infection andbleeding • **Cornea**- inflammation andInfection • **Lens**-Cataracts • Glaucoma • Disorder of the uvealtract, • Ocular tumours • **Disorders of posteriorchamber and retina :**retinal and vitreous problems • Retinaldetachment • Ocular emergencies andtheir prevention	• Lecture • Discussion • Explainusing Charts, using Models, films. slides • Demonstration practicesession • Case discussions/ seminar • Health education • Supervised clinical practice • Drugbook /presentation • Visit to eye bank • Participation in eye-camps	• Essaytype • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problem

Unit	Time (Hrs)	Learning Objectives	Content	Teaching Learning Activity	Assessment Method
			• Drugs used in treatment of disorders ofeye • Blindness • National blindness control program • EyeBanking • Eye prostheses and rehabilitation • Role of anurse-Communication with visually impaired patient, Eye camps •Specialtherapies •Nursing procedures: eyeirrigation, assisting with removal of foreign body.		
III	T17 P02	• Describe the etiology, patho physiology clinical manifestations, diagnostic measures and nursing management of patients with neurological disorders	**Nursing management of patient With neurological disorders** • Review of anatomy and physiology of the neurological system • Nursing Assessment-History and physical and neurological assessment and Glasgow coma scale • Etiology, Pathphysiology, clinical manifestations, diagnosis,treatment modalities and medical & surgical nursing management of neurological disorders • Congenitalmalformations • Headache • HeadInjuries • Spinalinjuries • Paraplegia • Hemiplegia • Quadraplegia • Spinal cordcompression -Herniation of intervertebral disc • Tumors of the brain &spinal cord • Intra cranial andcerebral aneurysms • **Infections:**Meningitis, Encephalitis, brain abscess, neurocysticercosis • Movement disorders :Chorea Seizures / Epilepsy • Cerebro vascular accidents (CVA)	•Lecture discussion •Explainusing Charts, graphs • Models, films, slides •Demonstration • Practice session •Case discussions/ Seminar • Health education •Supervised clinical practice •Drugbook /presentation • Visit to rehabilitation drugs used in treatment of disorders of eye center	• Essay type • Short answers • Objective type • Assessment of skills with checklist • Assessment of patient management problem

Unit	Time (Hrs)	Learning Objectives	Content	Teaching Learning Activity	Assessment Method
			• **Cranial / spinal neuropathies** – Bell's palsy, trigeminal neuralgia, Peripheral Neuropathies; Guillan-Barr'e syndrome Myasthenia gravis Multiple sclerosis, Degenerative diseases, Peripheral neuritisTIA ❑ DeliriumDementia ❑ Alzheimer'sdisease ❑ Parkinson'sdisease • Management of unconscious patients and patients withstroke • Drugs used in treatment ofneurological disorders • Role of the nurse incommunication with patient having neurological deficit • Rehabilitation of patientswith neurologicaldeficit • Role of nurse in long stayfacility (institutions) and at home Special therapies Nursing procedures: GCS, assisting with diagnostic procedures and rehabilitation		
IV	T15 P02	• Describe the etiology, pathophysiology clinical manifestation, diagnostic measures and nursing management of patients with disorders of female reproductive system. • Describe concepts of reproductive health and family welfare programmes.	**Nursing management of patient s With disorders of female reproductive system** Review of anatomy andphysiology of the female reproductivesystem Nursing assessment-historyand physical assessment Breast self examination Etiology, pathophysiology, clinical manifestations, diagnosis, treatment modalities and medical & surgical nursing management of disorder of female reproductivesystem Congenital abnormalities of female reproductivesystem **Sexuality and ReproductiveHealth** Sexual HealthAssessment **Menstrual Disorders-** Dysmenorrhea,Amenorrhea, PremenstrualSyndrome Abnormal Uterine Bleeding; Menorrhagia,Metrorrhagia Pelvic inflammatorydisease- Ovarian and fallopiantube disorders; Infections Cysts, Tumours • **Uterine and cervicaldisorders;** Endometriosis, polyeps, Fibroids, Cervical and uterine tumours, • Uterine displacement ,Cystocele/ urethrocele/ rectocele	• Lecture discussion • Explainusing Charts, graphs Models, films, slides • Demonstration /Practice session • Case discussions/ Seminar • Heath education • Supervised clinicalpractice • Drugbook /presentation	• Essaytype • Short answers • Objective type • Assessment of skills withcheck list • Assessment of patient management problem

Unit	Time (Hrs)	Learning Objectives	Content	Teaching Learning Activity	Assessment Method
			• Vaginal disorders; Infections and Discharges,fistulas • Vulvur disorders; Infection, cysts, Tumours • Diseases of breast Deformities Infections Cysts and Tumours • Menopause andhormonal replacement therapy • Infertility • Contraception; Temporary and Permanent • Emergency contraceptionmethods • Abortion-natural, medicaland surgical abortion-MTPAct • Toxic shockSyndrome • Injuries and trauma; sexual violence • Drugs used in treatmentof gynaecological disorders Special therapies vaginal douche PAP smear • Nursing procedures assistingwith diagnostic and therapeutic procedures, self examination of breast.		
V	T08 P02	Describe the etiology, patho physiology, clinical manifestations, diagnostic measures and nursing management of patients with burns, reconstructive and cosmetic surgery	**Nursing management of patients With Burns, reconstructive and Cosmetic surgery** • Review of anatomy and physiology of the skin and connectivetissues • Nursing assessment-Historyand physical examination & assessment burns • Etiology, Classification, pathophysiology, clinical manifestations, diagnosis, treatment modalities and medical & surgical and nursing management of Burns with special emphasis of fluid replacement therapy. •Types ofsurgeries •Legal Issues,Rehabilitation •Specialtherapies •Psycho socialaspects	• Lecture discussion • Explainusing Charts, graphs Models, films, slides • Demonstration • Practicesession • Case discussion/ Seminar • Healtheducation • Supervised clinicalpractice •Drug book/ presentation	• Essaytype • Short answers • Objective type • Assessment of skills withcheck list • Assessment of patient management problem

Unit	Time (Hrs)	Learning Objectives	Content	Teaching Learning Activity	Assessment Method
VI	T13 P02	Describe the etiology, patho physiology, clinical manifestations, diagnostic manifestations, diagnostic measures and nursing management of patients withoncology	**Nursing management of patients With oncological conditions** • Structure & characteristics of normal & cancercells • Nursing Assessment-historyand physical assessment • Prevention, Screening for early detection, warning signs ofcancer • Common malignancies ofvarious body system; Brain Oral cavity, larynx lung liver stomach and colon, breast cervix, ovary, uterus, renal, bladder, prostate leukemias and lymphomas, Oncologicalemergencies. • Epidemiology, etiology, classifications, pathophysiology, staging, clinical manifestations, diagnosis treatment modalities and medical, surgical & nursing management of malignantdiseases • Treatment Modalities– Immunotherapy Chemotherapy, Gene therapy Stem cell & Bone Marrow transplants. • Surgicalinterventions • Psychosocial aspects ofcancer • Rehabilitation & Palliativecare • Management – nutritionalsupport Home care, Hospice care, Stoma care • Psycho socialaspects • Assisting with diagnosticand therapeutic procedures	• Lecture discussion • Explainusing • Charts, graphs models, films, slides • Demonstration • Practicesession • Case discussion/ Seminar • Healtheducation • Supervised clinicalpractice • Drugbook /presentation	• Essaytype • Short answers • Objective type • Assessment of skills withcheck list • Assessment of patient management problem
VII	10	• Describe organization of emergency and disaster care services • Describe the role of nurse in disaster management • Describe the role of nurse in management of Emergencies	**Nursing management of patient in EMERGENCY & DISASTER situations** • Concepts and principles of Disaster Nursing • Causes and types ofdisaster: Natural and man-made Earthquakes, floods, epidemics, Cyclones fire, Explosion, Accidents Violence, Terrorism; Bio-chemical war • Policies related to emergency/ disaster Management; International , national, state, institutional • Disaster preparedness: Team, guidelines, protocols, equipments, resources Coordination and involvement of community,various-government departments, non-government.	• Lecture discussion • Explainusing • Charts,graphs • Models, films, slides • Demonstration • Practicesession •Case discussion/Seminar • Healtheducation • Supervised clinicalpractice	

Unit	Time (Hrs)	Learning Objectives	Content	Teaching Learning Activity	Assessment Method
			organizations and International agencies • Role of nurse in disaster management • Legal aspects of disasternursing • Impact on Health and aftereffects; post Traumatic Stress Disorder • Rehabilitation;physical, psychosocial Social, Financial, Relocation Emergency Nursing Concept, priorities principle and • Scope of emergencynursing • Organization ofemergency services: physical setup, staffing, equipment and supplies, protocols, Concepts of triage and role of triage nurse • Coordination and involvementof different departments and facilities • Nursing Assessment-Historyand physical assessment • Etiology, pathophysiology,clinical manifestations, diagnosis, treatment modalities and medical & surgical nursing management of patient with medical and surgical Emergency • Principles ofemergency management • CommonEmergencies; • RespiratoryEmergencies • CardiacEmergencies • Shock and Haemorrhage • Pain • Poly-Trauma, road accidents,crush • Injuries,wound • Bites • Poisoning; Food, Gas, Drugs& chemical poisoning • Seizures • Thermal Emergencies; Heatstroke & Cold injuries • PediatricEmergencies • PsychiatricEmergencies • ObstetricalEmergences • Violence, Abuse, Sexualassault • Cardio pulmonaryResuscitation • CrisisIntervention • Role of the nurse;Communication And inter personal Relation • Medico-legalAspects;	• Disaster management drills • Drugbook /presentation	• Essaytype • Short answers • Objective type • Assessment of skills withcheck list • Assessment of patient management problem

Unit	Time (Hrs)	Learning Objectives	Content	Teaching Learning Activity	Assessment Method
VIII	10	• Explainthe concept and problems of aging • Describe nursing care of theelderly	**Nursing care of the elderly** • Nursing Assessment-History and physical assessment • Ageing; • Demography; Mythsand realities • Concepts and theoriesof ageing • Cognitive Aspects ofAgeing • Normal biologicalageing • Age related body systems changes • Psychosocial Aspects ofAging • Medications andelderly • Stress & coping in olderadults • Common Health problems& Nursing Management; • Cardiovascular,Respiratory, Musculoskeletal, • Endocrine, genito-urinary, gastrointestinal • Neurological, Skin andother Sensory organs • Psychosocial andSexual • Abuse ofelderly • Role of nurse for careof elderly: ambulation, nutritional, communicational, psychosocial and spiritual • Role of nurse for caregiversof elderly • Role of family and formaland non formal caregivers Use of aids and prosthesis (hearing aids, dentures, • Legal & Ethical lssues • Provisions and Programmes of elderly; Privileges. Community programs and health services; • Home and institutionalcare	• Lecture discussion • Explainusing Charts, graphs • Models, films, slides • Demonstration • Practicesession •Case discussion/Seminar • Healtheducation • Supervised clinicalpractice • Drugbook /presentation Visit to old age home	• Essaytype • Short answers • Objective type • Assessment ofskills with check list • Assessment of patient management problem
IX	T10 P 05	• Describe organization of critical careunits • management role ofnurse in management of patients critical care units	**Nursing management of patient in critical care units** • NursingAssessment-History and • Physicalassessment • Classification • Principles of critical care nursing • Organization; physicalsetup, Policies, staffing norms, • Protocols, equipment and supplies	• Lecture discussion • Explainusing Charts, graphs • Models, films, slides • Demonstration • Roleplays • counseling • Practicesession •Case discussion/	• Essaytype • Short answers • Objective type • Assessment ofskills with check list • Assessment of patient management

			• Special equipments; ventilators, cardiac monitors, defibrillators, • Resuscitation equipments • Infection Controlprotocols	Seminar	problem

Unit	Time (Hrs)	Learning Objectives	Content	Teaching Learning Activity	Assessment Method
			• Nursing managementof critically ill patient; • Monitoring of criticallyill patient • CPR-Advance Cardiaclife support • Treatments andprocedures. • Transitionalcare • Ethical and LegalAspects • Communication with patientand family • Intensive carerecords • CrisisIntervention • Death and Dying-copingwith • Drugs used in critical careunit • Nursing procedures;Monitoring of patients in, assisting in therapeutic and diagnostic procedures, CPR, ACLS	• Healtheducation • Supervised clinicalpractice • Drugbook /presentation	
X	8	• Describe the etiology, patho-physiology, clinical manifestations, assessment, diagnostic measures and management of patients with occupational and industrial healthdisorder	**Nursing management of patients adults including elderly with occupational and industrial disorders** • Nursing Assessment-Historyand physicalassessment • Etiology,pathophysiology, clinical manifestations, diagnosis, diagnosis, treatment modalities and medical & surgical nursing management of occupational and industrial health disorders • Role ofnurse Special therapies, alternative therapies Nursing procedures Drugs used in treatmentof Occupational and industrial disorders		

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8. 11 Haslett C., Chilvers E.R., Hunder J.A.A. &Boon, N.A. (1999)Davidson'sPrinciples and Practice of Medicine (18 thed) Churchill living stone.Edinburgh.

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PRACTICAL

Practical –270 hrs+ 60 hrs*

Areas	Duration (in wks)	Objectives Posting	Skills to be developed	Assignments	Assessment Method
ENT	1	• provide care to patients with ENT disorders counsel and educate patient and families	• performexamination of ear, nose and throat • Assistwith diagnostic procedures • Assistwith therapeutic procedures • Instillation ofdrops • Perform/assistwith irrigations. • Apply earbandage • Performtracheotomy care • Teach patientsand Families	• Provide care to 2-3 assigned patients • Nursing care plan-1 • Observation reports of OPD • Maintain drug book	• Assesseach sill with checklist • Assess performance with rating scale • Evaluation of observation report of OPD • Completion of activity record
Ophtha-mology	1	• Provide care to patients with Eye disorders • Counsel and educate patientand families	• Performexamination ofeye • Assist withdiagnostic procedures • Assist with therapeutic procedures Perform/assistwith • Irrigations. • Apply eyebandage • Apply eye drops/ ointments • Assist withforeign body removal. • Teach patientsand Families	•Provide care to 2-3 assigned patients • Nursing care plan-1 •Observation reports of OPD & Eye bank • Maintain drug book	• Assesseach skill with checklist • Assess performance with rating scale • Evaluation of observation report of OPD/Eye bank • Completion of activity record
Neurology	2	• provide care to patients with neurological disorders counsel and educate patient and families	• PerformNeurological • Examination • Use Glasgow coma scale • Assist withdiagnostic procedures • Assistwith therapeutic procedures • Teach patient & families • Participatein Rehabilitation program	•Provide care to assigned 2-3 patients with neurological disorders • Case study/Case presentation-1 •Maintains drug book •Heath •Teaching-1	• Assesseach skill with checklist • Assess performance with rating scale • Evaluation of case study & health • Completion of activity record

Areas	Duration (in wks)	Objectives Posting	Skills to be developed	Assignments	Assessment Method
Gynecology ward	1	• Provide care to patients with gynecological disorders • Counsel and educate patient and families	• Assist with gynecological • Examination • Assist with diagnostic procedures • Assistwith therapeutic procedures • Teachpatients families • Teaching self Breast • Examination • Assist withPAP • Smearcollection.	•Provide care to 2-3 assigned patients • Nursing care plan-1 • Maintain drug book	• Assesseach skill with checklist • Assess performance with rating scale •Evaluation of observation report of OPD/Eye bank • Completion of activityrecord
Burns Unit	1	Provide care	• Assessment of the burns patient Percentage ofburns • Degree ofburns. • Fluid &electrolyte replacement therapy • Assess • Calculate • Replace • Record intake/output • Care of Burnwounds • Bathing • Dressing • Perform active& passive exercises • Practiceasepsis surgical asepsis • Counsel &Teach patients and families • Participatein rehabilitation program	• Provide care to 1-2 assigned patients • Nursing care paln-1 • Observation reportof Burns unit	activity record
Oncology	1	• provide care to patients with cancer counsel and educate patient and families	• Screen forcommon cancers-TNM classification • Assist with diagnostic procedures • Biopsies • Papsmear • Bone-marrow aspiration • Breastexamination • Assistwith • Therapeutic • Participates • Participates invarious modalities of treatment	• Providecare to 2-3 assigned patients • Nursing care Plan –1 • Observation report of cancerunit	• Assesseach skill with checklist • Assess performance with rating scale • Evaluation of Care planand observation report Completion of activity record

Areas	Duration (in wks)	Objectives Posting	Skills to be Developed	Assignments	Assessment Method
			• Chemotherapy • Radiotherapy • Painmanagement • Stomal therapy • Hormonaltherapy • Immunotherapy • Genetherapy • Alternativetherapy • Participatein palliativecare • Counsel andteach patients families		
Critical Care unit	2	• provide care to critically ill patients • counseland families for grief and bereavement	• Monitoring of patients inICU • Maintain flowsheet • Care of patienton ventilators • PerformEndotracheal suction • Demonstrates use of ventilators, cardiac monitorsetc. • Collect specimens and interprets ABGanalysis • Assist witharterial puncture • Maintain CVPline • Pulseoximetry • CPR-ALS • Defibrillators • Pacemakers • Bag-m askventilation • Emergencytray/ trolly-Crash Cart • Administrationof drugs infusion pump • Epidural • Intrathecal • Intracardiac • Totalparenteral therapy • Chestphysiotherapy • Perform active& passive exercise • Counsel thepatient and family in dealing with grieving and bereavement	• Provide careto I assigned patient •Observation report of Critical care unit • Drugsbook.	□ Assesseach skill with checklist □ Assess performance with rating scale □ Evaluation of observation report □ Completion of activity record

Areas	Duration (in wks)	Objectives Posting	Skills to be developed	Assignments	Assessment Method
Causality / emergency	1	• provide care to patients in emergency and disaster situation • counsel patient and families for grief and bereavement	•Practice'triage". •Assist with assessment, examination, investigations & their interpretations, in emergency and disastersituations •Assist in documentations •Assist inlegal procedures in emergency unit • Participatein managing crowd • Counsel patientand Families in grief and bereavement	• Observation • Reportof Emergency Unit	Assess Performance with rating scale Evaluation of observation report Completion of activity record
*Neuro ICU,	1	• Develop skill in neurologic al assessment . • Give care to the patient with head injury and spinalinjur y. • Care with chest surgery and cranial surgery.	• Assess neurological status. • Implement care to head injury spinal injury patients. • Drug sheet. • Pre and postoperative care with neuro surgery patients.	• Assessment for all assigned patients. • Nursing care plaln-2 • Drug sheet	• Record book. • Observati on checklist.
***Shifted from Integrated Practices**					

Internal assessment

Evaluation

Theory Maximum marks25

Midterm	50
Prefinal	75
Total	125

Practical Maximum marks50

Nursingcareplan (ENT, Ophthalmology, Gynaec, Burns, Oncology)	5 x25	125
Case presentation / casestudy-neuro	1x 50	50
Healthteaching	1 x 25	25
Clinical Evaluation (Neurology and criticalcareunit)	2 x 100	200

Internal assessment

Practical

Midterm	50
Prefinal	75
Total	525

Practical examination

University examination

Theory	Marks75
Practical	Marks50

Nursing care plan

1. **Patients Biodata:** Name, address, age, sex, religion, marital status, occupation, sourceof health care, date of admission, provisional diagnosis, date of surgery ifany
2. **Presenting complaints:** Describe the complaints with which the patient has come tohospital
3. **History ofillness**

   History of present illness – onset, symptoms, duration, precipitating / alleviating factors
   History of past illness – illnesses, surgeries, allergies, immunizations, medications
   Family history – family tree, history of illness in family members, risk factors, congenital problems, psychologicalproblems.
4. **Economic status:** Monthly income & expenditure on health, marital assets (own pacca house car, two wheeler, phone, TV etc…)
5. **Psychological status:** ethnic background,(geographical information, cultural information) support systemavailable.
6. **Personal habits:** consumption of alcohol, smoking, tobacco chewing, sleep, exercise,and work elimination,nutrition.
7. **Physical examination with date andtime**
8. **Investigations**

Date	Investigations done	Normal value	Patient value	Inference

9. Treatment

Sr. No.	Drug (pharmacological name)	Dose	Frequency/ time	Action	Side effects & drug interaction	Nursing responsibility

10. Nursingprocess:

Patientsname Date Ward

Date	Assessment	Nursing Diagnosis	Objective	Plan of care	Implementa –tion	Rationale	Evaluation

Discharge planning:
It should include health education and discharge planning given to patient

11. Evaluation of care
Overall evaluation, problem faced while providing care prognosis of the patient and conclusion

Care plan evaluation

1.	Historytaking	03
2.	Assessment and nursing diagnosis	05
3.	Planning ofcare	05
4.	Implementation andevaluation	08
5.	Follow upcare	02
6.	Bibliography	02

FORMAT FOR CASE PRESENTATION

Patients Biodata: Name, address, age, sex, religion, marital status, occupation, source of health care, date of admission, provisional diagnosis, date of surgery if any

Presenting complaints: Describe the complaints with which the patient has come to hospital

History of illness

History of present illness – onset, symptoms, duration, precipitating / alleviating factors
History of past illness – illnesses, surgeries, allergies, immunizations, medications
Family history – family tree, history of illness in family members, risk factors, congenital problems, psychological problems.

Economic status: Monthly income & expenditure on health, marital assets (own pacca house car, two wheeler, phone, TV etc…)

Psychological status: ethnic background,(geographical information, cultural information) support system available.

Personal habits: consumption of alcohol, smoking, tobacco chewing, sleep, exercise, work elimination, nutrition.

Physical examination with date and time

Investigations

Date	Investigations done	Normal value	Patient value	Inference

Treatment

Sr. No.	Drug (pharmacological name)	Dose	Frequency / time	Action	Side effects & drug interaction	Nursing responsibility

Description of disease

Definition, related anatomy physiology, etiology, risk factors, clinical features, management and nursing care

Clinical features of the disease condition

Clinical features present in the book	Description of clinical features of patient	Pathophysiology

Nursing process:

Patientsname Date Ward

Date	Assessment	Nursing Diagnosis	Objective	Plan of care	Implementa –tion	Rationale	Evaluation

Discharge planning:
It should include health education and discharge planning given to patient

Evaluation of care
Overall evaluation, problem faced while providing care prognosis of the patient and conclusion

Evaluation format for case presentation

Sr.No.	Content	Marks
1	Assessment / Introduction	05
2	Knowledge and understanding of disease	10
3	Nursing care plan	15
4	Presentation skill	10
5	A.V. aids	05
6	Overall	
	Summary& conclusion	03
	Bibliography	02
	Total	50

Format for case study

Format is similar to case presentation but should be in detail
The nursing care given to the patient should be at least for 5 continuous days

Evaluation format for case study

Sr.No.	Content	Marks
1	Assessment / Introduction	05
2	Knowledge and understanding of disease	15
3	Nursing care plan	20
4	Discharge plan	05
5	Summary & evaluation	02
6	Bibliography	03
	Total	50

EVALUATION FORMAT FOR HEALTH TALK

NAME OFTHESTUDENT : _____

AREAOFEXPERIENCE : _____

PERIODOFEXPERIENCE : _____

SUPERVISOR : _____

Total 100 Marks

Scores: 5 = Excellent, 4 = Very good, 3 = Good, 2 = Satisfactory / fair, 1 = Poor

Sr. No.	Particular	1	2	3	4	5	Score
1	**I) Planning and organization** a) Formulation of attainableobjectives b) Adequacy ofcontent c) Organization of subjectmatter d) Current knowledge related to subjectMatter e) Suitable A.V. Aids **II) Presentation:** a) Interesting b) ClearAudible c) Adequateexplanation d) Effective use of A.V.Aids e) GroupInvolvement f) TimeLimit **III) Personal qualities**: a) Selfconfidence b) Personalappearance c) Language d) Mannerism e) Self awareness of strong & weakpoints **IV) Feed back:** a) Recapitulation b) Effectiveness c) Groupresponse **V) Submits assignment on time**						

* 100 marks will be converted into25

CLINICAL EVALUATION PROFORMA

NAME OFTHESTUDENT : _____

YEAR : _____

AREA OF CLINICAL EXPERIENCE : _____

DURATION OF POSTING INWEEKS: _____

NAME OFTHESUPERVISOR : _____

Total Marks :- 100

Scores:- 5 = Excellent, 4 = Very good, 3 = Good, 2 = Satisfactory / fair, 1 =Poor

SR NO	EVALUATION CRITERIA	Grades				
		5	4	3	2	1
1	**Personal & Professional behavior**					
1	Wears clean & neat uniform and well groomed.					
2	Arrives and leaves punctually					
3	Demonstrates understanding of the need for quietness in speech & manner & protects the patient from undue notice.					
4	Is notably poised and effective even in situations of stress					
5	Influential & displaced persuasive assertive leadership behaviour					
II	**Attitude to Co-workers and patients**					
6	Works well as member of nursing team					
7	Gives assistance to other in clinical situations					
8	Understands the patient as an individual					
9	Shows skills in gaining the confidence & co-operation of patients and relatives, tactful and considerate.					
IV	**Application of knowledge**					
10	Possess sound knowledge of medical surgical conditions.					
11	Has sound knowledge of scientific principles					
12	Able to correlate theory with practice					
13	Has knowledge of current treatment modalities inclusive of medicine, surgery, pharmacology and dietetics.					
14	Takes interest in new learning from current literature & seeks help from resourceful people.					

SR NO	EVALUATION CRITERIA	Grades				
		5	4	3	2	1
V	**Quality of clinical skill**					
15	Identifies problems & sets priorities and grasps essentials while performing duties					
16	Applies principles in carrying out procedures & carries out duties promptly.					
17	Has technical competence in performing nursing procedures.					
18	Resourceful and practices economy of time material and energy.					
19	Observes carefully, reports & records signs & symptoms & other relevant information					
20	Uses opportunities to give health education to patients & relatives					
	TOTAL					

Grade

Excellent= 80-100 %
Very good = 70 –79 %
Good = 60 – 69 %
Satisfactory = 50- 59 %
Poor = Below 50 %

Remarks for improvement:

Student's Remark:

Signature ofthestudent Signature of theteacher

Maharashtra University of Health Sciences External Practical Evaluation Guidelines
III Basic B.Sc Nursing
Subject:-Medical SurgicalNursingII 50Marks

InternalExaminer 25Marks

Nursing Procedure (15 marks)

PlanningandOrganizing **5marks**

- Preparationoftray 3
- Environment 1
- Preparationof patient 1

ExecutionofProcedure **7marks**

- Appliesscientific principles 3
- Proficiencyinskill 3
- Ensuressequentialorder 1

Terminationofprocedure **3marks**

- Makespatientcomfortable 1
- Reports& Records 1
- After careof articles 1

Viva(10Marks) **10marks**

- Knowledge about common medicalsurgicalconditions- (ENT, eye, neurological, Reproductive System) 4
- Nursing Care ofElderly persons 2
- Preparation of variousdiagnosticprocedures 2
- Instrumentsandarticles 2

ExternalExaminer 25Marks

Nursing Process(15Marks) **15marks**

- Assessment 3
- NursingDiagnosis 2
- Goal 1
- Outcomecriteria 1
- Nursingintervention 3
- Rationale 2
- Evaluation 1
- Nursesnotes 2

Viva(10Marks) **10marks**

- Knowledge about common medicalsurgicalconditions (Burns, Reconstructive and cosmetic surgery, Oncological conditions) 4
- Care of Patients in CriticalCareUnit 2
- OccupationalDisorders 2
- Drugs 2

MEDICAL SURGICAL NURSING-II PRACTICAL
EXAMINATION PRACTICAL / ORAL
MARK LIST

NAME OFTHEEXAMINATION: **MEDICAL**

SURGICAL -II PRACTICALS MONTH: **YEAR:**

SECOND YEAR Basic B. ScNURSING: **MARKS :**

50 SUBJECT : MEDICAL SURGICAL NURSING –

IPRACTICALS

CENTRE :

Roll No	Internal Examiner		External Examiner		Total	Total
	Procedure	Viva voce	Nursing process	Viva voce		
	15	10	15	10	50	25

Signature of theInternalExaminer **Signature of the External**

Examiner Date: **Date:**

MENTAL HEALTH NURSING

Placement: Third year

Time: Theory –120hours

Practical – 270 Hours+45* Hrs of Internship (Integrated Practice)

Course Description:
This course is designed for developing an understanding of the modern approach to mental health, identification, prevention, rehabilitation and nursing management of common mental health problems with special emphasis on therapeutic interventions for individuals, family and community.

Specific objectives: At the end of the course student will be able to:

1. Understand the historical development and current trends in mental health nursing.
2. Comprehend and apply principles of psychiatric nursing in clinical practice.
3. Understand the etiology, psychodynamics and management of psychiatric disorders.
4. Develop competency in assessment, therapeutic communication and assisting with various treatment modalities.
5. Understand and accept psychiatric patient as an individual and develop a deeper insight into her own attitudes and emotional reactions.
6. Develop skill in providing comprehensive care to various kinds of psychiatric patients.
7. Develop understanding regarding psychiatric emergencies and crisis interventions.
8. Understand the importance of community health nursing in psychiatry.

Unit	Time (Hrs)	Learning Objective	Content	Teaching Learning Activity	Assessment Method
1	5	• Describes the historical development & current trends in mental health nursing • Describe the epidemiology of mental health problems • Describe the National Mental Health Act, programmes and mental health policy. • Discusses the scope of mental health nursing • Describe the concept of normal & abnormal behaviour	**Introduction** • Perspectives of Mental Health and Mental Health Nursing : evolution of mental health services, treatments and nursing practices. • Prevalence and incidence of mental health problems and disorders. • Mental Health Act • National Mental health policy vis a vis National Health Policy. • National Mental Health programme. • Mental health team. • Nature and scope of mental health nursing. • Role and functions of mental health nurse in various settings and factors affecting the level of nursing practice • Concepts of normal and abnormal behaviour.	• Lecture Discussion	• Objective type • Short answer • Assessment of the field visit reports

2	5	• Defines the various terms used in mental health Nursing. • Explains the classification of mental disorders. • Explain psychodynamics of maladaptive behaviour. • Discuss the etiological factors, psychopathology of mental disorders. • Explain the Principles and standards of Mental Health Nursing. • Describe the conceptual models of mental health nursing.	**Principles and Concepts of Mental Health Nursing** • Definition : mental health nursing and terminology used • Classification of mental disorders: ICD. • Review of personality development, defense mechanisms. • Maladaptive behaviour of individuals and groups: stress, crises and disaster(s). • Etiology: bio-psycho-social factors. • Psychopathology of mental disorders: review of structure and function of brain, limbic system and abnormal neuro transmission. • Principles of Mental health Nursing. • Standards of Mental health Nursing practice. • Conceptual models and the role of nurse : 1. Existential Model. 2. Psycho-analytical models. 3. Behavioral; models. 4. Interpersonal model.	• Lecture discussion • Explain using Charts. • Review of personality developme nt.	• Essay type • Short answer. • Objective type
3	8	• Describe nature, purpose and process of assessment of mental health status	**Assessment of mental health status.** • History taking. • Mental status examination. • Mini mental status examination. • Neurological examination: Review. • Investigations: Related Blood chemistry, EEG, CT & MRI. • Psychological tests Role and responsibilities of nurse.	• Lecture Discussion • Demonstrat ion • Practice session • Clinical practice	• Short answer • Objective type • Assessment of skills with check list.
4	6	• Identify therapeutic communication techniques • Describe therapeutic relationship.	**Therapeutic communication and nurse-patient relationship** • Therapeutic communication: types, techniques, characteristics	• Lecture discussion • Demonstrat ion • Role play • Process	• Short answer • Objective type

		• Describe therapeutic impasse and its intervention.	• Types of relationship, • Ethics and responsibilities • Elements of nurse patient contract • Review of technique of IPR- Johari Window • Goals, phases, tasks, therapeutic techniques. • Therapeutic impasse and its intervention	recording	
5	14	• Explain treatment modalities and therapies used in mental disorders and role of the nurse.	**Treatment modalities and therapies used in mental disorders.** • Psycho Pharmacology • Psychological therapies : Therapeutic community, psycho therapy – Individual : psycho-analytical, cognitive & supportive, family, Group, Behavioral, Play Psycho-drama, Music, Dance, Recreational and Light therapy, Relaxation therapies : Yoga, Meditation, bio feedback. • Alternative systems of medicine. • Psychosocial rehabilitation process • Occupational therapy. • Physical Therapy: electro convulsive therapy. • Geriatric considerations Role of nurse in above therapies.	• Lecture discussion • Demonstration • Group work. • Practice session • Clinical practice.	• Essay type • Short answers • Objective type
6	5	• Describe the etiology, psycho-pathology clinical manifestations, diagnostic criteria and management of patients with Schizophrenia, and other psychotic disorders • Geriatric considerations • Follow-up and home care and rehabilitation.	• **Nursing management of patient with Schizophrenia, and other psychotic disorders** • Classification : ICD • Etiology, psycho-pathology, types, clinical manifestations, diagnosis • Nursing Assessment- History, Physical and mental assessment. • Treatment modalities and nursing management of patients with Schizophrenia and other psychotic disorders • Geriatric considerations	• Lecture discussion • Case discussion • Case presentation • Clinical practice	• Essay type • Short answers • Assessment of patient management problems

			• Follow – up and home care and rehabilitation		
7	5	• Describe the etiology, psycho-pathology clinical manifestations, diagnostic criteria and management of patients with mood disorders.	**Nursing management of patient with mood disorders** • Mood disorders : Bipolar affective disorder, Mania depression and dysthamia etc. • Etiology, psycho-pathology, clinical manifestations, diagnosis. • Nursing Assessment-History, Physical and mental assessment. • Treatment modalities and nursing management of patients with mood disorders • Geriatric considerations • Follow-up and home care and rehabilitation	• Lecture discussion • Case discussion • Case presentation • Clinical practice	• Essay type • Short answers • Assessment of patient management problems
8	8	• Describe the etiology, psycho-pathology, clinical manifestations, diagnostic criteria and management of patients with neurotic, stress related and somatization disorders.	**Nursing management of patient with neurotic, stress related and somatization disorders** • Anxiety disorder, Phobias, Dissociation and Conversion disorder, Obsessive compulsive disorder, somatoform disorders, Post traumatic stress disorder. • Etiology, psycho-pathology, clinical manifestations, diagnosis • Nursing Assessment-History, Physical and mental assessment • Treatment modalities and nursing management of patients with neurotic, stress related and somatization disorders. • Geriatric considerations • Follow-up and home care and rehabilitation	• Lecture discussion • Case discussion • Case presentation • Clinical practice	• Essay type • Short answers • Assessment of patient management problems

9	5	• Describe the etiology, psycho-pathology, clinical manifestations, diagnostic criteria and management of patients with substance use disorders	**Nursing management of patient with substance use disorders** • Commonly used psychotropic substance : Classification, forms, routes, action, intoxication and withdrawal • Etiology of dependence: tolerance, psychological and physical dependence, withdrawal syndrome, diagnosis, • Nursing Assessment-History, Physical, mental assessment and drug assay • Treatment (detoxification, antabuse and narcotic antagonist therapy and harm reduction) and nursing management of patients with substance use disorders. • Geriatric considerations • Follow-up and home care and rehabilitation.	• Lecture discussion • Case discussion • Case presentation • Clinical practice	• Essay type • Short answers • Assessment of patient management problems
10	4	• Describe the etiology, psycho-pathology, clinical manifestations, diagnostic criteria and management of patients with personality, Sexual and Eating disorders	**Nursing management of patient with Personality, Sexual and Eating disorders** • Classification of disorders • Etiology, psycho-pathology, characteristics, diagnosis, • Nursing Assessment – History, Physical and mental assessment. • Treatment modalities and nursing management of patients with Personality, Sexual and Eating disorders • Geriatric considerations • Follow-up and home care and rehabilitation	• Lecture discussion • Case discussion • Case presentation • Clinical practice	• Essay type • Short answers • Assessment of patient management problems
11	6	• Describe the etiology, psycho-pathology, clinical manifestations, diagnostic criteria and management of childhood and adolescent including mental deficiency	**Nursing management of childhood and adolescent disorders including mental deficiency** • Classification • Etiology, psycho-pathology, characteristics, diagnosis Nursing Assessment-History, Physical, mental and IQ assessment • Treatment modalities and	• Lecture discussion • Case discussion • Case presentation • Clinical practice	• Essay type • Short answers • Assessment of patient • Management problems

			nursing management of childhood disorders including mental deficiency • Follow-up and home care and rehabilitation		
12	5	• Describe the etiology psycho-pathology, clinical manifestations, diagnostic criteria and management of organic brain disorders	**Nursing management of organic brain disorders** • Classification: ICD? • Etiology, psycho-pathology, clinical features, diagnosis and Differential diagnosis (parkinsons and alzheimers) • Nursing Assessment-History, Physical, mental and neurological assessment • Treatment modalities and nursing management of organic brain disorders • Geriatric considerations • Follow-up and home care and rehabilitation	• Lecture discussion • Case discussion • Care presentation • Clinical practice	• Essay type • Short answers • Assessment of patient management problems
13	6	• Identify psychiatric emergencies and carry out crisis intervention	**Psychiatric emergencies and crisis intervention** • Types of psychiatric emergencies and their management • Stress adaptation Model: stress and stressor, coping, resources and mechanism • Grief : Theories of grieving process, principles, techniques of counseling • Types of crisis • Crisis Intervention: Principles, Techniques and Process • Geriatric considerations Role and responsibilities of nurse	• Lecture discussion • Demonstration • Practice session • Clinical practice	• Short answers • Objective type
14	4	• Explain legal aspects applied in mental health settings and role of the nurse	**Legal issues in Mental Health Nursing** • The Mental Health Act 1987: Act, Sections, Articles and their implications etc. • Indian lunacy Act. 1912 • Rights of mentally, ill clients • Forensic psychiatry • Acts related to narcotic and psychotropic substances and illegal drug trafficking	• Lecture discussion • Case discussion	• Short answers • Objective type

			• Admission and discharge procedures • Role and responsibilities of nurse		
15	4	• Describe the model of preventive psychiatry • Describe Community Mental health services and role of the nurse	**Community Mental Health Nursing** • Development of Community Mental Health Services: • National Mental Health Programme • Institutionalization Versus Deinstitutionalization • Model of Preventive psychiatry :Levels of Prevention • Mental Health Services available at the primary, secondary, tertiary levels including rehabilitation and Role of nurse • Mental Health Agencies: Government and voluntary, National and International • Mental health nursing issues for special populations: Children, Adolescence, Women, Elderly, Victims of violence and abuse, Handicapped, HIV/AIDS etc.	• Lecture discussion • Clinical/field practice • Field visits to mental health service agencies	• Short answers • Objective type • Assessment of the field visit reports

References (Bibliography:**)**

1. Gail Wiscars Stuart.Michele T. Laraia. "Principles and practice of psychiatric nursing", 8th edition, , Elseveir, India Pvt.Ltd. New Delhi 2005
2. Michael Gelder, Richard Mayou, Philip Cowen, Shorter oxford text book of psychiatry, Oxford medical publication, 4 the ed. 2001.
3. M.S. Bhatia, A concised text Book of Psychiatric Nursing, CBS publishers and distributors, Delhi 2nd ed. 1999.
4. M.S. Bhatia, Essentials of Psychiatry, CBS publishers and distributors, Delhi
5. Mary C Townsend. "Psychiatric Mental Health Nursing". Concept of care, 4th edition. F.A.Davis Co. Philadelphia 2003.
6. Bimla Kapoor, Psychiatric nursing, Vol. I & II Kumar publishing house Delhi, 2001
7. Niraj Ahuja, A short textbook of pstchiatry, Jaypee brothers,new delhi, 2002.
8. The ICD10, Classification of mental and behavioural disorders, WHO, A.I.T.B.S. publishers, Delhi,2002
9. De Souza Alan, De Souza Dhanlaxmi, De Souza A, "National series – Child psychiatry" 1st ed, Mumbai, The National Book Depot, 2004

10. Patricia, Kennedy, Ballard, "Psychiatric Nursing Integration of Theory and Practice", USA, Mc Graw Hill 1999.
11. Kathernic M. Fort in ash, Psychiatric Nursing Care plans, Mossby Year book. Toronto
12. Sheila M. Sparks, CynthiaM. Jalor, Nursing Diagnosis reference manual 5th edition, , Spring house, Corporation Pennsychiram's
13. R. Sreevani, A guide to mental health & psychiatric nursing, Jaypee brothers, Medical Publishers (ltd)_, New Delhi 1st edition.
14. R. Baby, Psychiatric Nursing N.R. Brothers, Indore, 1st edition 2001.
15. Varghese Mary, Essential of psychiatric & mental health nursing,
16. Foundations Journals of mental health nursing
17. American Journal of Psychiatry
18. Deborah Antai Otoing. "Psychiatric Nursing" Biological and behavioral concepts. Thomson. Singapore 2003
19. Mary Ann Boyd. "Psychiatric Nursing". Contemporary practice. Lippincott. Williams and Wilkins. Tokyo.

Internet Resources –

1. Internet Gateway : Psychology
http://www.lib.uiowa.edu/gw/psych/index.html

2. Psychoanalytic studies
http://www.shef.ac.uk~psysc/psastud/index.html

3. Psychaitric Times
http://www.mhsource.com.psychiatrictimes.html

4. Self-help Group sourcebook online
http://www.cmhe.com/selfhelp

5. National Rehabilitation Information center
http://www.nariic.com/naric

6. Centre for Mental Health Services
http://www.samhsaa.gov/cmhs.htm

7. Knowledge Exchange Network
http://www.mentalheaalth.org/

8. Communication skills
http://www.personal.u-net.com/osl/m263.htm

9. Lifeskills Resource center
http://www.rpeurifooy.com

10. Mental Health Net
http://www.cmhe.com

MENTAL HEALTH NURSING – PRACTICAL

Placement : Third Year

Time : Practical – 270 hours (9 weeks)

Areas	Duration (in week)	Objectives	Skills	Assignments	Assessment Methods
Psychiatric OPD	1	• Assess patients with mental health problems • Observe and assist in therapies • Counsel and educate patient, and families	• History taking • Perform mental status examination (MSE) • Assist in Psychometric assessment • Perform Neurological examination • Observe and assist in therapies • Teach patients and family members	• History taking and Mental status examination-2 • Health education-1 • Observation report of OPD	• Assess performance with rating scale • Assess each skill with checklist • Evaluation of health education • Assessment of observation report • Completion of activity record.
Child Guidance clinic	1	• Assessment of children with various mental health problems • Counsel and educate children, families and significant others	• History taking • Assist in psychometric assessment • Observe and assist in various therapies • Teach family and significant others	• Case work – 1 • Observation report of different therapies -1	• Assess performance with rating scale • Assess each skill with checklist • Evaluation of the observation report
Inpatient ward	6	• Assess patients with mental health problems • To provide nursing care for patients with various mental health problems • Assist in various therapies • Counsel and educate patients, families and significant	• History taking • Perform mental status examination (MSE) • Perform Neurological examination • Assist in psychometric assessment • Record therapeutic communication • Administer medications • Assist in Electro-convulsive Therapy (ECT)	• Give care to 2-3 patients with various mental disorders • Case study-1 • Care plan-2(based on nursing process) • Clinical presentation I • Process recording 1 • Maintain drug book	• Assess performance with rating scale • Assess each skill with checklist • Evaluation of the case study care plan, clinical presentatio, process recording • Completion of activity record.

		others	• Participate in all therapies • Prepare patients for Activities of Daily living (ADL) • Conduct admission and discharge counseling • Counsel and teach patients and families		
Community psychiatry	1	• To identify patients with various mental disorders • To motivate patients for early treatment and follow up • To assist in follow up clinic • Counsel and educate patient, family and community	• Conduct case work • Identify individuals with mental health problems • Assists in mental health camps and clinics • Counsel and Teach family members, patients and community	• Case work – 1 • Observation report on field visits	• Assess performance with rating scale • Evaluation of case work and observation report • Completion of activity record

* Practical- 1 weeks- (50 hours)

Area	Duration	Objective	Skills	Assignments	Assessment
Psychiatry ward	1 weeks	Provide comprehensive care to patients with mental health problems	Integrated Practice	• Journal presentation	Assess clinical performance with rating scale

***Shifted from Integrated Practice**

Evaluation

Evaluation

Internal assessment

Theory Maximum marks 25

Midterm	50
Prefinal	75
Total	125

Practical Maximum marks 50

Nursing care plan	2 x25	50
Case presentation	1x 50	50
Case study	1x 50	50
Health teaching	1 x 25	25
History taking & mental status examination & process recording	2 x 50	100
Observation report of various therapies in psychiatry	1x 25	25
Clinical Evaluation	2 x 100	200
Total marks		500

Practical examination

mid term	50
prefinal	50 (600)
Total mark	100

University examination

Theory	75
Practical	50

NURSING CARE PLAN

1. **Patients Biodata**: Name, sex, bed No., hosp Reg. No, marital status, religion, literacy, language, nationality, identification mark, address, date of admission, method of admission, date of discharge, duration of hospitalization, final diagnosis, informant.
   Presenting complaints: Describe the complaints with which the patient has come to hospital
2. **History of illness**: This includes the following data such as presenting complaints with duration, history of presenting complaints, past history of illness, personal history, legal history, family history, personality (Personality prior to illness)
3. **History of present illness** – onset, symptoms, duration, precipitating / alleviating factors nature of problem, associated problems (disturbance in sleep, appetite, wt), effect of present illness on ADL, patients understanding regarding present problem

   History of past illness – illnesses, surgeries, allergies, immunizations, medications, history of past hospitalization for psychiatric illness, any complication e.g. suicidal attempt, completeness of recovery.
   Personal history: Birth, early development, educational, occupational, menstrual, sexual, marital, religious, social activity, interests and hobbies.
   Legal history: any arrest imprisonment, divorce etc…
   Family history – family tree, type of family, parental history, occupation, history of illness in family members, risk factors, congenital problems, psychological problems, family dynamics, family events (initiating and exacerbating illness)
   Personality history: personality traits, habits, hobbies, interest, belief, attitudes, social relationship, coping resources, alcohol or drug use, any criminal record.

4 Mental status examination with conclusion

5. Investigations

Date	Investigations done	Normal value	Patient value	Inference

6. Treatment

SN	Drug (Pharmacological name)	Dose	Frequency/ Time	Action	Side effects & drug interaction	Nursing responsibility

Other modalities of treatment in detail

7. Nursing process:

Patients name Date Ward

Date	Assessment	Nursing Diagnosis	Objective	Plan of care	Implementa – tion	Rationale	Evaluation

Discharge planning:
It should include health education and discharge planning given to patient

8. Evaluation of care
Overall evaluation, problem faced while providing care prognosis of the patient and conclusion

Care plan evaluation

EVALUATION CRITERIA FOR NURSING CARE PLAN –

S.No.	Topic	Max Marks
1.	History	05
2.	M.S.E. & Diagnosis	05
3.	Management & Nursing. Process	10
4.	Discharge planning and evaluation	03
5.	Bibliography	02
	TOTAL	25

FORMAT FOR CASE PRESENTATION

1. **Patients Biodata**: Name, sex, bed No., hosp Reg. No, marital status, religion, literacy, language, nationality, identification mark, address, date of admission, method of admission, date of discharge, duration of hospitalization, final diagnosis, informant.
2. **Presenting complaints:** Describe the complaints with which the patient has come to hospital
3. **History of illness**: This includes the following data such as presenting complaints with duration, history of presenting complaints, past history of illness, personal history, legal history, family history, personality (Personality prior to illness)

a. History of present illness – onset, symptoms, duration, precipitating / alleviating factors nature of problem, associated problems (disturbance in sleep, appetite, wt), effect of present illness on ADL, patients understanding regarding present problem

b. History of past illness – illnesses, surgeries, allergies, immunizations, medications, history of past hospitalization for psychiatric illness, any complication e.g. suicidal attempt, completeness of recovery.

c. Personal history: Birth, early development, educational, occupational, menstrual, sexual, marital, religious, social activity, interests and hobbies.

d. Legal history: any arrest imprisonment, divorce etc…

e. Family history – family tree, type of family, parental history, occupation, history of illness in family members, risk factors, congenital problems, psychological problems, family dynamics, family events (initiating and exacerbating illness)

f. Personality history: personality traits, habits, hobbies, interest, belief, attitudes, social relationship, coping resources, alcohol or drug use, any criminal record.

4. **Mental status examination with conclusion**
5. **Description of disease**

Definition, etiology, risk factors, clinical features, management and nursing care
Clinical features of the disease condition

Clinical features present in the book	Description of clinical features of patient	Pathophysiology

6. **Investigations**

Date	Investigations done	Normal value	Patient value	Inference

7. Treatment

SN	Drug (Pharmacological name)	Dose	Frequency/ time	Action	Side effects & drug interaction	Nursing responsibility

Other modalities of treatment in detail

8.Nursing process:

Patients name Date Ward

Date	Assessment	Nursing Diagnosis	Objective	Plan of care	Implementa –tion	Rationale	Evaluation

Discharge planning:

It should include health education and discharge planning given to patient

9. Evaluation of care

Overall evaluation, problem faced while providing care prognosis of the patient and conclusion

EVALUATION CRITERIA FOR CASE PRESENTATION –

S.No.	Topic	Max Marks
1.	Orientation of History	10
2.	M.S.E.	10
3.	Summarization & Formulation of diagnosis	10
4.	Management & evaluation of care	10
5.	Style of presentation	05
6.	Bibliography	05
	TOTAL	50

Format for case study

Format is similar to case presentation but should be in detail
The nursing care given to the patient should be at least for 5 continuous days

Evaluation format for case study

Sr.No.	Content	Marks
1	History & MSE	10
2	Knowledge and understanding of disease	15
3	Nursing care plan	20
4	Discharge plan& evaluation	02
5	Bibliography	03
	Total	50

EVALUATION FORMAT FOR HEALTH TALK

NAME OF THE STUDENT : _____

AREA OF EXPERIENCE : _____

PERIOD OF EXPERIENCE : _____

SUPERVISOR : _____

Total 100 Marks

Scores: 5 = Excellent, 4 = Very good, 3 = Good, 2 = Satisfactory / fair, 1 = Poor

Sr. No.	Particular	1	2	3	4	5	Score
1	**I) Planning and organization** a) Formulation of attainable objectives b) Adequacy of content c) Organization of subject matter d) Current knowledge related to subject Matter e) Suitable A.V. Aids **II) Presentation:** a) Interesting b) Clear Audible c) Adequate explanation d) Effective use of A.V. Aids e) Group Involvement f) Time Limit **III) Personal qualities**: a) Self confidence b) Personal appearance c) Language d) Mannerism e) Self awareness of strong & weak points **IV) Feed back:** a) Recapitulation b) Effectiveness c) Group response **V) Submits assignment on time**						

* 100 marks will be converted into 25

FORMAT FOR PSYCHIATRIC CASE HISTORY MENTAL STATUS EXAMINATION & PROCESS RECORDING

PSYCHIATRIC CASE HISTORY

- Biodata of the Patient
- Informant
- Rehability
- Reason for referral
- Chief complaints with duration
- History of present illness
- History of past illness
- Family history of illness
    a. Family history

  (Draw family tree, write about each family members & relations with patient mention any history of mental illness, epilepsy renouncing the world.)
    b. Socio-economic data
- Personal History
    1. Prenatal and perinatal
    2. Early Childhood
    3. Middle Childhood
    4. Late childhood
    5. Adulthood

    b. Education History
    c. Occupational History
    d. Marital History
    e. Sexual History
    f. Religion
    g. Social activity, interests and hobbies.

- Pre-morbid personality
- Physical examination
- Diagnosis & identification of psychosocial stressors

EVALUATION CRITERIA FOR PSYCLATRIC CASE HISTORY-

S.No.	Topic	Max Marks
1.	Format	02
2.	Organisation of history of present illness	05
3.	Past History of illness	03
4.	Family history of illness	03
5.	Pre morbid personality	03
6.	Examination	02
7.	Diagnosis	02
	TOTAL	20

Mental Status Examination

1. General Appearance & behaviour & grooming:
   LOC- Conscious/ semiconscious/ unconscious
   Body Built- Thin
   Moderate
   Obese
   Hygiene- Good
   Fair
   Poor
   Dress- Proper/clean
   According to the season
   Poor-Untidy, Eccentric, Inappropriate.
   Hair- Good Combined in position.
   Fair
   Poor
   Disheveled
   Facial expression-
   Anxious
   Depressed
   Not interested
   Sad looking
   Calm
   Quiet
   Happy
   Healthy/Sickly
   Maintains eye contact
   Young / Old
   Any other
2. Attitude:-

Cooperative	Seductive
Friendly (mainia)	1. Attention seeking
Trustful (mainia)	2. Dramatic
Attentive	3. Emotional
Interested	Evasive
Negativistic	Defensive
Resistive	Guarded) Paranoia
Non-caring	
Any other	

3. Posture:-
   Good – Straight/proper
   Relaxed
   Rigid/Tense/Unsteady
   Bizarre Position
   Improper – Explain

4. Gait, Carriage & Psychomotor activities:-
   Walks straight / coordinated movements
   Uncoordinated movements
   Mannerism / Stereotypes / Echolatics
   Purposeless/hyperactivity/aimless/purposeless activity
   Hypo activity/Tremors/Dystonia
   Any other

5. Mood and affect:-

Mood- Pervasive & sustained emotions that columns the person's perception of the world

Range of mood: Adequate
Inadequate
Constricted
Blunt (sp)
Labile
(Frequent changes)

Affect: Emotional state of mind, person's present emotional response.

Congruent / In congruent

Relevance/Irrelevant

Appropriateness-according to situations

Inappropriate- Excited
Not responding
Sad
Withdrawn
Depressed
Any other

6. Stability & range of mood:

Extreme
Normal
Any other

7. Voice & speech / stream of talk:

Language- Written
Spoken
Intensity- Above normal
Normal
Below normal
Quantity-Above normal
Normal
Below normal
Quality- Appropriate
Inappropriate
Rate of production:- Appropriate / Inappropriate
Relevance- Relevant / Irrelevant
Reaction time-Immediate / Delayed
Vocabulary- Good / Fair /Poor

Rate, quality, amount and form:- under pressure, retarded, blocked, relevant, logical, coherent, concise, illogical, disorganized, flight of ideas, neologisms, word salad. Circumstantialities, Rhyming, punning, loud. Whispered. Screaming etc.

8. Perception:-

The way we perceive our environment with senses
Normal/Abnormal
A) Illusion:- misinterpretation of perception
B) Hallucination:- False perception in absence of stimuli.
1. Visual-not in psychiatric – Organic Brain Disorder.
2. Auditory
a. Single b. Conversation c. Command
3. Kinaesthetic hallucinations: Feeling movement when none occurs.
C) Depersonalization and derealization
d) Other abnormal perceptions

Déjà vu/Deja pense/Deja entendu/Deja raconte/Deja eprouve/
Deja fait/Jamais

9. Thought process / thinking

At formation level-

At content – continuity / lack of continuity

I. At progress level / stream

a. Disorders of Tempo

* Schizophrenia talking-Epilepsy
  - Loose association
  - Thought block
  - Flight of ideas

* Circumstantial talking – Epilepsy
* Tangential-taking without any conclusion
* Neologism – New words invented by patients.
* Incoherence

b. Disorders of continuity

* Perseveration:- Repetition of the same words over and over again.
* Blocking:- Thinking process stops altogether.
* Echolalia: - Repetition of the interviewer's word like a parrot.

II. Possession and control

* Obsessions: - Persistent occurrence of ideas, thoughts, images, impulses or phobias.
* Phobias: - Persistent, excessive, irrational fear about a real or an imaginary object, place or a situation.
* Thought alienation:- The patient thinks that others are participating in his thinking.
* Suicidal/homicidal thoughts.

III. Content:-

* Primary Delusion:- Fixed unshakable false beliefs, and they cannot be explained on the basis of reality.
* Delusional mood
* Delusional perception
* Sudden delusional ideas
* Secondary delusion

Content of Delusions:-

- Persecution.
- Self reference
- Innocence
- Grandiosity
- III health or Somatic function
- Guilt
- Nihilism
- Poverty
- Love or erotomania
- Jealousy or infidelity

10. Judgement:-

According to the situation

e.g.(If one inmate accidentally falls in a well and you do)

11. Insight:-

Awareness
Reason for hospitalization
Accepts / Not accepts / Accepts fees treatment not required
Types - Intellectual-awareness at mental level
- Emotional – aware and accepts

Duration

12. Orientation:-

Oriented to – time
Place
Person

13. Memory:-

Fairs / Festival
Surrounding environment
PM of country
CM of state

15. Attention:-

Normal
Moderate
Poor attention
Any other

16. Concentration:-

Good
Fair
Poor
Any other

17. Special points:-

Bowel & bladder habits
Appetite
Sleep
Libido
Any other

Instructions for filling the MSE format:

1. Tick wherever relevant
2. Write brief observations wherever relevant
3. Based on the observations make the final conclusion

EVALUATION CRITERIA FOR M.S.E.

S.NO	TOPIC	MAX MARKS
1.	Format	01
2.	Content (Administration of test and inference)	06
3.	Examination skill	02
4.	Bibliography	01
	TOTAL	10

EVALUATION FORMAT PROCESS RECORDING

1. Identification data of the patient.
2. Presenting Complaints
    a. According to patient
    b. According to relative
3. History of presenting complaints
4. Aims and objectives of interview
    a. Patients point of view
    b. Students point of view
5. 1st Interview
   Date
   Time
   Duration
   Specific objective

Sr.No.	Participants	Conversation	Inference	Technique used

6. Summary
   Summary of inferences
   Introspection
   Interview techniques used: Therapeutic/Non therapeutic
7. Over all presentation & understanding.
8. Termination.

Evaluation format of process recording

History taking	02
Interview technique	03
Inferences drawn from interview	03
Overall understanding	02
Total marks	10

Observation report of various therapies

ECT CARE STUDY

Select a patient who has to get electro convulsive therapy
Preparation of articles for ECT
Preparation of physical set up

- Waiting room
- ECT room
- Recovery room

Preparation of patient prior to ECT
Helping the patient to undergo ECT
Care of patient after ECT
Recording of care of patient after ECT

ECT Chart –

Name –
Diagnosis –
Age –
Sex –
Bed No. –
TPR/BP –
Time of ECT –
Patient received back at –

Time	Pulse	Respiration	Blood pressure	Level of Consciousness	Remarks

OBSERVATION REPORT – GROUP THERAPY

(Can be written in the form of report)

1. Name of the Hospital –
2. Ward No. –
3. No. of patients in the ward –
4. No. of male patients in the ward –
5. No. of female patients in the ward –
6. No. of patients for group therapy
7. Objectives of group therapy –
8. Size of the group –
9. Diagnosis of patients in the group –
10. Heterogenous group –
11. Homogenous group –
12. Procedure followed –
    a. Introduction
    b. Physical set up
    c. Maintenance of confidentiality & privacy
13. Content of group therapy –
14. Summary of group therapy –
15. Remarks –

Evaluation criteria for group therapy

Introduction to therapy	02
Purposes of therapy	03
Preparation for therapy	05
Care during therapy	05
Care after therapy	05
Recording	05
Total	25

CLINICAL POSTING EVALUATION

Name of the student : _____

Year : _____

Area of clinical experience : _____

Duration of posting in weeks : _____

Name of the supervisor : _____

Total Marks: - 100

Scores:- 5 = excellent , 4 = Very good, 3 = Good, 2 = Satisfactory / fair, 1 = Poor

SN	EVALUATION CRITERIA	Grades				
		5	4	3	2	1
I	**Understanding of patient as a person** A] Approach 1] Rapport with patient (family)relatives 2] Has she collected all information regarding the patient/family. B] Understanding patients health problems 1] Knowledge about the disease of patient 2] Knowledge about investigations done for disease. 3] Knowledge about treatment given to patient 4] Knowledge about progress of patients					
II	**Planning care.** 1] Correct observation of patient 2] Assessment of the condition of patient 3] Identification of the patients needs 4] Individualization of planning to meet specific health needs of the patient. 5] Identification of priorities					
III	**Teaching skill.** 1] Economical and safe adaptation to the situation available facilities 2] Implements the procedure with skill/speed, completeness. 3] Scientific knowledge about the procedure.					
IV	**Health talk** 1] Incidental/planned teaching (Implements teaching principles) 2] Uses visual aids appropriately					
V	**Personality** 1] Professional appearance (Uniform, dignity, helpfulness, interpersonal relationship, punctuality, etc.) 2] Sincerity, honesty, sense of responsibility					

Remarks of supervision in terms of professional strength and weakness

Sign of the student **Sign of the Supervisor**

DRUG BOOK / STUDY

Generic Name	Dosage	Form/Strength Inj/Tab/Syrup	Action of Drug	Indication	Contraindication	Side effects	Nursing Implications/ Responsibilities

Maharashtra University of Health Sciences External Practical Evaluation Guidelines
III Basic B.Sc Nursing
Subject:-Mental Health Nursing **50 Marks**

Internal Examiner **25 Marks**

Nursing Process (15 marks)	**15 marks**
• Assessment	3
• Nursing Diagnosis	2
• Goal	1
• Outcome criteria	1
• Nursing intervention	3
• Rationale	2
• Evaluation	1
• Nurses notes	2

Viva (10 Marks)	**10 Marks**
• Knowledge about common psychiatric conditions (psychotic, moods disorders)	5
• Therapies used in mental disorders	2
• Drugs used in psychiatric disorders	3

External Examiner **25 Marks**

Mental Status Examination (15 Marks)	**15 marks**
• General appearance, behavior.	2
• Mood and affect	2
• Thought Process and speech	4
• Perception	2
• Cognitive function (memory, orientation, attention, concentration, Intelligence, Abstraction)	3
• Insight and Judgment	2

Viva (10 Marks)	**10 Marks**
• Knowledge about common psychiatric conditions (neurotic, stress related disorders, substance abuse, personality, sexual and eating disorders)	3
• National Mental Health Programs	2
• Community-based Care	3
• Therapeutic Approach	2

MENTAL HEALTH NURSING PRACTICAL EXAMINATION
PRACTICAL / ORAL MARK LIST

NAME OF THE EXAMINATION : MENTAL HEALTH NURSING

PRACTICALS MONTH : **YEAR:**

THIRD YEAR Basic B. Sc NURSING : **MARKS :**

50 SUBJECT : MENTAL HEALTH NURSING

CENTRE :

Roll No	Internal Examiner		External Examiner		Total	Total
	Procedure	Viva voce	Nursing process	Viva voce		
	15	10	15	10	50	25

Signature of the Internal Examiner **Signature of the External**

Examiner Date : **Date :**