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
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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
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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 :**