MENTAL HEALTH NURSING

Placement: Third Year

Time: Theory-90 Hrs.
Practical – 270 Hrs

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.

<table>
<thead>
<tr>
<th>Unit</th>
<th>Time (Hrs)</th>
<th>Objective</th>
<th>Contents</th>
<th>Teaching Learning Activities</th>
<th>Assessment Methods</th>
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</table>
| I    | 05         | - 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 | Lecture Discussion | Objective type  
- Short answer  
- Assessment of the field visit reports |
mental health nurse in various settings and factors affecting the level of nursing practice
- Concepts of normal and abnormal behaviour.

<table>
<thead>
<tr>
<th>II</th>
<th>05</th>
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<tbody>
<tr>
<td>- Defines the various terms used in mental health Nursing.</td>
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<tr>
<td>- Explains the classification of mental disorders.</td>
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<td>- Explain psychodynamics of maladaptive behaviour.</td>
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<td>- Discuss the etiological factors, psychopathology of mental disorders.</td>
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<td>- Explain the Principles and standards of Mental Health Nursing.</td>
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<tr>
<td>- Describe the conceptual models of mental health nursing.</td>
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</table>

**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 development.

- Essay type
- Short answer.
- Objective type
| III | 08 | 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**  
**Demonstration**  
**Practice session**  
**Clinical practice** | **Short answer**  
**Objective type**  
**Assessment of skills with checklist.** |
| IV | 06 | • Identify therapeutic communication techniques  
• Describe therapeutic relationship.  
• Describe therapeutic impasse and its intervention.  
**Therapeutic communication and nurse-patient relationship**  
• Therapeutic communication: types, techniques, characteristics  
• 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 | **Lecture discussion**  
**Demonstration**  
**Role play**  
**Process recording** | **Short answer**  
**Objective type** |
| V | 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 :  
• Lecture discussion  
**Demonstration**  
**Group work.**  
**Practice session**  
**Clinical practice.** | **Essay type**  
**Short answers**  
**Objective type** |
| VI  | 05 | • Describe the etiology, psychopathology, 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, psychopathology, 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  
• Follow – up and home care and rehabilitation. | • Lecture discussion  
• Case discussion  
• Case presentation  
• Clinical practice | • Essay type  
• Short answers  
• Assessment of patient management problems |
<p>| VII | 05 | Describe the etiology, psychopathology 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 dysthmia etc. |
| • Etiology, psychopathology, 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 |
| VIII | 08 | Describe the etiology, psychopathology 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, psychopathology, 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 |</p>
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<tr>
<th>IX</th>
<th>05</th>
<th>Describe the etiology, psychopathology, clinical manifestations, diagnostic criteria and management of patients with substance use disorders</th>
<th><strong>Nursing management of patient with substance use disorders</strong>&lt;br&gt;• Commonly used&lt;br&gt;• Psychotropic substance: Classification, forms, routes, action, intoxication and withdrawal&lt;br&gt;• Etiology of dependence: tolerance, psychological and physical dependence, withdrawal syndrome, and diagnosis.&lt;br&gt;• Nursing Assessment- History, Physical, mental assessment and drug assay&lt;br&gt;• Treatment (detoxification, antabuse and narcotic antagonist therapy and harm reduction) and nursing management of patients with substance use disorders.&lt;br&gt;• Geriatric considerations&lt;br&gt;• Follow-up and home care and rehabilitation.</th>
<th>• Lecture discussion&lt;br&gt;• Case discussion&lt;br&gt;• Case presentation&lt;br&gt;• Clinical practice</th>
<th>• Essay type&lt;br&gt;• Short answers&lt;br&gt;• Assessment of patient management problems</th>
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<td>X</td>
<td>04</td>
<td>Describe the etiology, psychopathology, clinical manifestations, diagnostic criteria and management of patients with personality, Sexual and Eating disorders</td>
<td><strong>Nursing management of patient with Personality, Sexual and Eating disorders</strong>&lt;br&gt;• Classification of disorders&lt;br&gt;• Etiology, psychopathology, characteristics, diagnosis.&lt;br&gt;• Nursing Assessment – History, Physical and mental assessment.&lt;br&gt;• Treatment modalities and nursing management of patients with Personality, Sexual and Eating disorders&lt;br&gt;• Geriatric considerations&lt;br&gt;• Follow-up and home care and rehabilitation.</td>
<td>• Lecture discussion&lt;br&gt;• Case discussion&lt;br&gt;• Case presentation&lt;br&gt;• Clinical practice</td>
<td>• Essay type&lt;br&gt;• Short answers&lt;br&gt;• Assessment of patient management problems</td>
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<td>XI</td>
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<td>Describe the etiology, psychopathology, clinical manifestations, diagnostic criteria and management of childhood and adolescent including mental deficiency</td>
<td>Nursing management of childhood and adolescent disorders including mental deficiency</td>
<td>Lecture discussion</td>
<td>Essay type</td>
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|     |     | • Classification  
• Etiology, psychopathology, characteristics, diagnosis Nursing Assessment-History, Physical, mental and IQ assessment  
• Treatment modalities and nursing management of childhood disorders including mental deficiency  
• Follow-up and home care and rehabilitation |                                                                                       |                      | Short answers |
|     |     |                                                                                                                                  |                                                                                       |                      | Assessment of patient management problems |
| XII | 05 | Describe the etiology psychopathology, clinical manifestations, diagnostic criteria and management of organic brain disorders | Nursing management of organic brain disorders | Lecture discussion | Essay type |
|     |     | • Classification: ICD?  
• Etiology, psychopathology, clinical features, diagnosis and Differential diagnosis (Parkinson’s and Alzheimer’s)  
• 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 |                                                                                       |                      | Short answers |
|     |     |                                                                                                                                  |                                                                                       |                      | Assessment of patient management problems |
| XIII | 06 | 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 |
| XIV | 04 | 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  
- Admission and discharge procedures  
- Role and responsibilities of nurse | - Lecture discussion  
- Case discussion | - Short answers  
- Objective type |
| XV | 04 | • 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:)**


4. M.S. Bhatia, Essentials of Psychiatry, CBS publishers and distributors, Delhi


8. The ICD10, Classification of mental and behavioural disorders, WHO, A.I.T.B.S. publishers, Delhi, 2002


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


15. Varghese Mary, Essential of psychiatric & mental health nursing,

16. Foundations Journals of mental health nursing

17. American Journal of Psychiatry


**Internet Resources –**

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

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

3. Psychaitric Times

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.mentalhealhealth.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
| Areas                   | Duration (in weeks) | Objective                                                                                               | Skills to be developed                                                                                                                                                                                                 | Assignment                                                                                       | Assessment Methods                                                                                     |
|-------------------------|---------------------|---------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Psychiatric OPD         | 1                   | • Assess patients with mental health problems                                                            | • History taking                                                                                              | • History taking and Mental status examination- 2                                                                                                       | • Assess performance with rating scale                                                                 |
|                         |                     | • Observe and assist in therapies                                                                         | • Perform mental status examination (MSE)                                                                       | • Health education-1                                                                                                                                          | • Assess each skill with checklist                                                                            |
|                         |                     | • Counsel and educate patient, and families                                                                | • Assist in Psychometric assessment                                                                                | • Observation report of OPD                                                                                                                                      | • Evaluation of health education                                                                               |
|                         |                     |                                                                                                          | • Perform Neurological examination                                                                               |                                                                                                                                         | • Assessment of observation report                                                                             |
|                         |                     |                                                                                                          | • Observe and assist in therapies                                                                                |                                                                                                                                         | • Completion of activity record                                                                               |
|                         |                     |                                                                                                          | • Teach patients and family members                                                                             |                                                                                                                                         |                                                                                                                  |
| Child Guidance clinic   | 1                   | • Assessment of children with various mental health problems                                              | • History taking                                                                                              | • Case work – 1                                                                                                                                                | • Assess performance with rating scale                                                                 |
|                         |                     | • Counsel and educate children, families and significant others                                          | • Assist in psychometric assessment                                                                              | • Observation report of different therapies -1                                                                 丨                                                                                                           |
|                         |                     |                                                                                                          | • Observe and assist in various therapies                                                                       |                                                                                                                                         | • Assess each skill with checklist                                                                            |
|                         |                     |                                                                                                          | • Teach family and significant others                                                                          |                                                                                                                                         | • Evaluation of the observation report                                                                         |
| Inpatient ward          | 6                   | • Assess patients with mental health problems                                                              | • History taking                                                                                              | • Give care to 2-3 patients with various mental disorders                                                                                           | • Assess performance with rating scale                                                                 |
|                         |                     | • To provide nursing care for patients with various mental health problems                                 | • Perform mental status examination (MSE)                                                                       | • Case study- 1                                                                                                                                                | • Assess each skill with checklist                                                                            |
|                         |                     | • Assist in various therapies                                                                             | • Perform Neurological examination                                                                               | • Care plan- 2(based on nursing process)                                                                                                                   | • Evaluation of the case study care plan, clinical presentation, process recording |
|                         |                     | • Counsel and educate patients, families and significant others                                          | • Assist in Psychometric assessment                                                                                | • Clinical presentation-1                                                                                                                                      | •                                                                                                                 |
|                         |                     |                                                                                                          | • Record therapeutic communication                                                                              | • Process recording 1                                                                                                                                         | • Completion of activity record                                                                               |
|                         |                     |                                                                                                          | • Administer medications                                                                                        | • Maintain drug book                                                                                                                                        |                                                                                                                  |
|                         |                     |                                                                                                          | • Assist in Electroconvulsive Therapy (ECT)                                                                           |                                                                                                                                         |                                                                                                                  |
|                         |                     |                                                                                                          | • Participate in all therapies                                                                                    |                                                                                                                                         |                                                                                                                  |
|                         |                     |                                                                                                          | • Prepare patients for Activities of Daily living (ADL)                                                          |                                                                                                                                         |                                                                                                                  |
|                         |                     |                                                                                                          | • Conduct admission and discharge counseling                                                                       |                                                                                                                                         |                                                                                                                  |
|                         |                     |                                                                                                          | • Counsel and teach patients and families                                                                          |                                                                                                                                         |                                                                                                                  |
|                         |                     |                                                                                                          | • Conduct admission and discharge counseling                                                                       |                                                                                                                                         |                                                                                                                  |
Community psychiatry

1. To identify patients with various mental disorders
2. To motivate patients for early treatment and follow up
3. To assist in follow up clinic
4. 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

EVALUATION

Internal Assessment:

Theory: Maximum marks 25
Periodical 25
Midterm 50
Pre-final 75
Total Marks 150

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

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Total marks 500

Practical Examination:

Periodic viva 25
mid term 50
Prefinal 50 (625)
Total Marks 125

University Exam

Theory 75 Marks
Practical 50 Marks
Nursing care plan

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

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

3. History of 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

<table>
<thead>
<tr>
<th>Date</th>
<th>Investigation done</th>
<th>Normal value</th>
<th>Patient value</th>
<th>Inference</th>
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6. Treatment

<table>
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<tr>
<th>Sr. No.</th>
<th>Drug: (pharmacological name)</th>
<th>Dose</th>
<th>Frequency Time</th>
<th>Action</th>
<th>Side effect &amp; Drug interaction</th>
<th>Nursing responsibility</th>
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Other modalities of treatment in detail

7. Nursing process:

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<tr>
<th>Date</th>
<th>Assessment</th>
<th>Nursing Diagnosis</th>
<th>Objective</th>
<th>Plan of care</th>
<th>Implementation</th>
<th>Rationale</th>
<th>Evaluation</th>
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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**

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Contents</th>
<th>Marks</th>
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<tbody>
<tr>
<td>1</td>
<td>History</td>
<td>05</td>
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<td>2</td>
<td>M.S.E. &amp; Diagnosis</td>
<td>05</td>
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<td>3</td>
<td>Management &amp; Nursing. Process</td>
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<tr>
<td>4</td>
<td>Discharge planning and evaluation</td>
<td>03</td>
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<td>Bibliography</td>
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**FORMAT FOR CASE PRESENTATION**

1. **Patients Biodata:**

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

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.

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   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, 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 |

#### 6. Investigations

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#### 7. Treatment

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**Other modalities of treatment in detail**

#### 8. Nursing process:

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**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

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**EVALUATION CRITERIA FOR CASE PRESENTATION –**

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Contents</th>
<th>Marks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Orientation of History</td>
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<tr>
<td>2</td>
<td>M.S.E.</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>Summarization &amp; Formulation of diagnosis</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>Management &amp; evaluation of care</td>
<td>10</td>
</tr>
<tr>
<td>5</td>
<td>Style of presentation</td>
<td>05</td>
</tr>
<tr>
<td>6</td>
<td>Bibliography</td>
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<tr>
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<td><strong>Total</strong></td>
<td><strong>50</strong></td>
</tr>
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</table>
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

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Contents</th>
<th>Marks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>History &amp; MSE</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>Knowledge and understanding of disease</td>
<td>15</td>
</tr>
<tr>
<td>3</td>
<td>Nursing care plan</td>
<td>20</td>
</tr>
<tr>
<td>4</td>
<td>Discharge plan</td>
<td>02</td>
</tr>
<tr>
<td>5</td>
<td>Bibliography</td>
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<td></td>
<td><strong>Total</strong></td>
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</tbody>
</table>
# 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

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Particulars</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Score</th>
</tr>
</thead>
</table>
| 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) Feedback:  
   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
- Rehabilitation
- 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
     a. Education History
     b. Occupational History
     c. Marital History
     d. Sexual History
     e. Religion
     f. Social activity, interests and hobbies.
- Pre-morbid personality
- Physical examination
- Diagnosis & identification of psychosocial stressors

EVALUATION CRITERIA FOR CASE PRESENTATION –

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Contents</th>
<th>Marks</th>
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<tbody>
<tr>
<td>1</td>
<td>Format</td>
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</tr>
<tr>
<td>2</td>
<td>Organisation of history of present illness</td>
<td>05</td>
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<tr>
<td>3</td>
<td>Past History of illness</td>
<td>03</td>
</tr>
<tr>
<td>4</td>
<td>Family history of illness</td>
<td>03</td>
</tr>
<tr>
<td>5</td>
<td>Pre morbid personality</td>
<td>03</td>
</tr>
</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Negativistic</th>
<th>Defensive</th>
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</thead>
<tbody>
<tr>
<td>Resistive</td>
<td>Guarded Paranoia</td>
</tr>
<tr>
<td>Non-caring</td>
<td></td>
</tr>
<tr>
<td>Any other</td>
<td></td>
</tr>
</tbody>
</table>
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:

<table>
<thead>
<tr>
<th>Category</th>
<th>Written</th>
<th>Spoken</th>
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<tbody>
<tr>
<td>Language</td>
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<tr>
<td>Intensity</td>
<td>Above normal</td>
<td>Normal</td>
</tr>
<tr>
<td>Quantity</td>
<td>Above normal</td>
<td>Normal</td>
</tr>
<tr>
<td>Quality</td>
<td>Appropriate</td>
<td>Inappropriate</td>
</tr>
<tr>
<td>Rate of production</td>
<td>Appropriate / Inappropriate</td>
<td></td>
</tr>
<tr>
<td>Relevance</td>
<td>Relevant / Irrelevant</td>
<td></td>
</tr>
<tr>
<td>Reaction time</td>
<td>Immediate / Delayed</td>
<td></td>
</tr>
<tr>
<td>Vocabulary</td>
<td>Good / Fair / Poor</td>
<td></td>
</tr>
</tbody>
</table>

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.
   2. Auditory

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 with out 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. Judgment: -
   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

14. Attention: -
   Normal
   Moderate
   Poor attention
   Any other

15. Concentration: -
   Good
   Fair
   Poor
   Any other

16. 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.

<table>
<thead>
<tr>
<th>SN</th>
<th>TOPIC</th>
<th>MAX MARKS</th>
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<tbody>
<tr>
<td>1.</td>
<td>Format</td>
<td>01</td>
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<td>2.</td>
<td>Content (Administration of test and inference)</td>
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<td>3.</td>
<td>Examination skill</td>
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<tr>
<td></td>
<td>TOTAL</td>
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</tbody>
</table>
Mental Status Examination

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

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Participants</th>
<th>Conversation</th>
<th>Inference</th>
<th>Technique used</th>
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<tbody>
<tr>
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</tbody>
</table>

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

Evaluation format of process recording

<table>
<thead>
<tr>
<th>SN</th>
<th>TOPIC</th>
<th>MAX MARKS</th>
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<td>3.</td>
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<td>4.</td>
<td>Overall understanding</td>
<td>02</td>
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<tr>
<td></td>
<td>TOTAL</td>
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</tbody>
</table>
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 –

<table>
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<tr>
<th>Time</th>
<th>Pulse</th>
<th>Respiration</th>
<th>Blood pressure</th>
<th>Level of Consciousness</th>
<th>Remarks</th>
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<tr>
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</tbody>
</table>

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 format of process recording

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<td>2.</td>
<td>Purposes of therapy</td>
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<td>Preparation for therapy</td>
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<td>4.</td>
<td>Care during therapy</td>
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<td>Care after therapy</td>
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CLINICAL POSTING EVALUATION

Name of the Student : ___________________________________________________________
Year : ______________
Area of Clinical Experience : ___________________________________________________________
Duration of posting in weeks : ___________________________________________________________
Name of the Supervisor : ___________________________________________________________

Total 100 Marks

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

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

Signature of the student                                  Signature of the teacher
<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Dosage</th>
<th>Form/Strength</th>
<th>Action of Drug</th>
<th>Indication</th>
<th>Contraindication</th>
<th>Side effects</th>
<th>Nursing Implications/Responsibilities</th>
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