MIDWIFERY AND OBSTETRICAL NURSING

Placement: Third Year (N)

Time: Theory-90 Hours
Practical-180 Hours
(+ 180 hours of 4th year)

Course Description:

This course is designed for students to appreciate the concepts and principles of Midwifery and obstetrical nursing. It helps them to acquire knowledge and skills in rendering nursing care to normal and high risk pregnant woman during antenatal, natal and post natal periods in hospitals and community settings. It also helps to develop skills in managing normal and high-risk neonates and participate in family welfare programme.

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

1. Describe the normal pregnancy, labor and peurperium and demonstrate the application of knowledge and skill in giving need –based care.
2. Demonstrate safe management of all stages of labour.
3. Identify the high risk factor during pregnancy, labor and peurperium as well as neonates and take appropriate interventions.
4. Motivate the mother for care of the baby and adapting family planning methods to maintain small family norms.
5. Prepare the mothers for self care during the pregnancy, labor and peurperium.

Unit	Time (Hrs)	Learning Objective	Content	Teaching Learning Activities	Assessment Method
1	5	• Recognize the trends and issues in midwifery and obstetrical Nursing	**Introduction to midwifery and obstetrical Nursing** • **Introduction to concepts of Midwifery and obstetrical nursing.** • Trends in Midwifery and obstetrical nursing. ❑ Historical perspectives and currents trends. ❑ Legal and ethical aspects ❑ Pre-conception care and preparing for parenthood ❑ Role of nurse in midwifery and obstetrical care. ❑ National policy and legislation in relation to maternal health & welfare ❑ Maternal, morbidity, mortality rates ❑ Perinatal, morbidity & mortality rates	* Lecture discussion *Explain using Charts and graphs	*Short answers *Objective type

Unit	Time (Hrs)	Learning Objective	Content	Teaching Learning Activities	Assessment Method
II	8 •	Describe the anatomy and physiology of female reproductive system	**Review of anatomy and physiology of female reproductive system and foetal development** • Female pelvis-general description of the bones joints, ligaments, planes of the pelvis diameters of the true pelvis important landmarks, variations in pelvis shape. • Female organs of reproduction-external genetalia, internal genital organs and their anatomical relations, musculature-blood- supply, nerves, lymphatics, pelvic cellular tissue, pelvic peritoneum. • Physiology of menstrual cycle • Human sexuality • Foetal development ❑ Conception ❑ Review of fertilization, implantation (embedding of the ovum), development of the embryo and placenta at term-function, abnormalities, the foetal sac, amniotic fluid, the umbilical chord, ❑ Foetal circulation, foetal skull, bones, sutures and measurements. • Review of Genetics	*Lecture discussion *Review with charts and models	*Short answers *Objective type

Unit	Time (Hrs)	Learning Objective	Content	Teaching Learning Activities	Assessment Method
III	8	• Describe the Diagnosis and management of women during antenatal period.	**Assessment and management of pregnancy (ante-natal)** • Normal pregnancy • Psychological changes during pregnancy. ❑ Reproductive system ❑ Cardio vascular system ❑ Respiratory system ❑ Urinary system ❑ Gastero intestinal system ❑ Metabolic changes ❑ Skeletal changes ❑ Skin changes ❑ Endocrine system ❑ Psychological changes ❑ Discomforts of pregnancy ❑ Diagnosis of pregnancy • Diagnosis of pregnancy • Signs • Differential diagnosis • Confirmatory tests • Ante-nantal care ❑ Objectives ❑ Assessment History and physical examination - Antenatal Examination - Signs of previous child-birth ❑ Relationship of foetus to uterus and pelvis: Lie, Attitude, Presentation, Position ❑ Per vaginal examination * Screening and assessment for high risk: * Risk approach • History and Physical Examination Modalities of diagnosis; Invasive & Non- Invasive & ultrasonic, cardiotomography, NST, CST	• Lecture discussion • Demonstration • Case discussion/presentation • Health talk • Practice session • Supervised Clinical practice	• Short answers • Objective type • Assessment of skills with check list *Assessment of patient management problems

Unit	Time (Hrs)	Learning Objective	Content	Teaching Learning Activities	Assessment Method
			• Antenatal preparation ❑ Antenatal counseling ❑ Antenatal exercises ❑ Diet ❑ Substance use Education for child-birth ❑ Husband and families ❑ Preparation for safe-confinement ❑ Preventio from radiation • Psycho-social and cultural aspects of pregnancy ❑ Adjustment to pregnancy ❑ Unwed mother ❑ Single parent ❑ Teenage pregnancy ❑ Sexual violence * Adoption		
IV	12	• Describe the physiology and stages of labour. • Describe the management of women during intranatal period	**Assessment and management of intra-natal period.** • Physiology of labour, mechanism of labour. • Management of labour ❑ First stage -Signs & symptoms of onset of labour -Preparation of: √ Labour room √ Woman -Assessment and observation of women in labour; partogram – maternal & foetal monitoring - Active management of labour, Induction of labour - Pain relief & comfort in Labor • Second stage ❑ Signs and symptoms; normal & abnormal ❑ Duration ❑ Conduct of delivery; Principles & techniques ❑ Episiotomy (only if required)	• Lecture discussion • Demonstration • Practice session • Supervised Clinical practice	• Essay type • Short answers • Objective type • Assessment of skills with check list *Assessment of patient management problems

Unit	Time (Hrs)	Learning Objective	Content	Teaching Learning Activities	Assessment Method
			❑ Receiving the new born - Neonatal resuscitation initial steps & subsequent resuscitation - Care of umbilical cord - Immediate assessment including screening for congenital anomalies - Identification - Bonding - Initiate feeding - Screening and transportation of the neonate • Third Stage ❑ Signs and symptoms; normal and abnormal ❑ Duration ❑ Method of placenta expulsion ❑ Management; Principles and techniques ❑ Examination of the placenta ❑ Examination of perineum ❑ Maintaining records & reports Fourth Stage		
V	**5**	• Describe the physiology of puerperium • Describe the management of women during post-natal period	**Assessment and management of women during post natal period** • Normal puerperium; Physiology Duration • Postnatal assessment and management ❑ Promoting physical & emotional well being ❑ Lactation management ❑ Immunization • Family dynamics after child-birth. • Family welfare services; methods, counseling • Follow – up • Records and reports	• Lecture discussion • Demonstration • Health talk • Practice session • Supervised Clinical practice	• Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problems

Unit	Time (Hrs)	Learning Objective	Content	Teaching Learning Activities	Assessment Method
VI	6	• Describe the assessment and management of normal neonate	**Assessment and management of normal neonates.** • Normal neonates; ❑ Physiological adaptation, ❑ Initial & Daily assessment ❑ Essential newborn care ; Thermal control, ❑ Breast feeding, prevention of infections • Immunization • Minor disorders of newborn and its management • Levels of neonatal care (level I,II& III) • At primary, secondary and tertiary levels • Maintenance of Reports & Records	• Lecture discussion • Demonstration • Practice session • Supervised Clinical practice	• Essay type • Short answers • Objective type • Assessment of skills with check list *Assessment of patient management problems
VII	10	• Describe the identification and management of women with high risk pregnancy	**High risk pregnancy- assessment & management** • Screening & assessment ❑ Ultrasonics, cardiotomography, NST, CST,non-invasive & invasive, ❑ Newer modalities of diagnosis • High – risk approach • Levels of care ; primary, secondary & tertiary levels • Disorders of pregnancy ❑ Hyper- emesis gravidarum, bleeding in early pregnancy, abortion, ectopic. ❑ Pregnancy, vesicular mole, ❑ Ante-partum haemorrage • Uterine abnormality and displacement. • Diseases complicating pregnancy ❑ Medical & surgical conditions ❑ Infections, RTI(STD), UTI,HIV, TORCH ❑ Gynecological diseases complicating pregnancy	• Lecture discussion • Demonstration • Practice session • Supervised Clinical practice	• Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problems

			❑ Pregnancy induced hypertension & diabetes, Toxemia of pregnancy, Hydramnios, ❑ Rh incompatibility ❑ Mental disorders • Adolscent pregnancy, Elderly primi and grand multipara • Multiple Pregnancy • Abnormalities of placenta & cord • Intra – uterine growth – retardation • Nursing management of mothers with high- risk pregnancy • Maintenance of Records & Report		
VIII	10	• Describe management of abnormal labour. • And Obstetrical emergencies	**Abnormal Labour- Assessment and management** • Disorders in labour ❑ CPD & contracted pelvis ❑ Malpositions and malpresentations ❑ Premature labour, disorders of uterine actions –precipitate labour prolonged labour ❑ Complications of third stage: injuries to birth canal *Obstetrical emergencies and their management; ❑ Presentation & prolapse of cord, Vasa praevia, amniotic fluid embolism ruoture of uterus, shoulder dystocia, obstretical shock • Obstetrical procedures & operations; ❑ Induction of labour, forceps, vacuum version, manual removal of placenta, caesarean section, destructive operations	• Lecture discussion • Demonstration • Practice session • Supervised Clinical practice	• Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problems

			* Nursing management of women undergoing Obstetrical operations and procedures		
IX	4	*Describe management of postnatal complications	**Abnormalities during postnatal periods** • Assessment and management of woman with postnatal complications ❑ Puerperial infections, breast engorgement & infections, UTI, thrombi-Embolic disorders, Post-partum haemorrage, Eclampsia and sub involution, ❑ Psychological complications: - Post partum Blues - Post partum Depression - Post partum Psychosis	• Lecture discussion • Demonstration • Practice session • Supervised Clinical practice	• Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problems

Unit	Time (Hrs)	Learning Objective	Content	Teaching Learning Activities	Assessment Method
X	8	* Identify the high risk neonates and their nursing management	**Assessment and Management High risk newborn.** • Admission of neonates in the neonatal intensive care units protocols • Nursing management of : - Low birth weight babies - Infections - Respiratory problems - Haemolytic disorders - Birth injuries - Malformations • Monitoring of high risk neonates • Feeding of high risk neonates • Organization & Management of neonatal intensive care units • Maintenance of reports and records	• Lecture discussion • Demonstration • Practice session • Supervised Clinical practice	• Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problems
XI	4	* Describe indication, dosage, action, side effects & nurses responsibilities in the administration of drugs used for mothers.	**Pharmaco- therapeutics in obstetrics** • Indication, dosage, action contra indication & side effects of drugs • Effect of drugs on pregnancy, labour & peurperium, • Nursing responsibilities in the administration of drug in Obstetrics – Oxytocins, antihypertensives, diuretics tocolytic agents, anti-convulsants; • Analgesics and anesthetics in obstetrics. • Effects of maternal medication on foetus & neonate	• Lecture discussion • Demonstration • Practice session • Supervised Clinical practice	• Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problems

Unit	Time (Hrs)	Learning Objective	Content	Teaching Learning Activities	Assessment Method
XII	10	• Appreciate the importance of family welfare programme • Describe the methods of contraception & role of nurse in family welfare programme	**Family welfare programme** • Population trends and problems in India • Concepts, aims, importance and history of family welfare programme • National Population: dynamics, policy & education • National family welfare programme; RCH, ICDS, MCH. Safe motherhood • Organization and administration ; at national state, district, block and village levels • Methods of contraception; spacing, temporary& permanent, Emergency contraception • Infertility & its management • Counseling for family welfare programme • Latest research in contraception • Maintenance of vital statistics • Role of national ,international and voluntary organizations • Role of a nurse in family welfare programme • Training / Supervision/ Collaboration with other functionaries in community like ANMs. LHVs, Anganwadi workers, TBAs(Traditional birth attendant-Dai)	• Lecture discussion • Demonstration • Practice session • Supervised • Practice • Group Project	• Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problems

REFRENCE

1. **DUTTA-**

-Text book of Obstetrics 4th Ed.,

-Text book of Gynecology 3rd ed.,

2. **C.S.DAWN-**

- Textbook of Gynecology Contraception and Demography 13th ed.,

3. **BOBAK JENSEN-**

- Essentials of Maternity Nursing 3rd ed.,

4. **LONGMAN**

- Clinical Obstetrics 9th ed.,

5. **CAMPBELL**

-Gynecology by ten teachers 17th ed.,

6. **MYLES**

- Text book of Midwifes 14th ed.,

Practical

Placement: Third Year **Time:Practical-180 Hours(Third year)**

Fourth Year **Practical 180 hrs (Fourth year)**

Areas	Duration (Weeks)	Objectives	Skills	Assessments	Assessment Methods
Antenatal Clinic/OPD	2	* Assessment of pregnant women	• Antenatal history taking • Physical • Examination • Recording of weight & B.P • Hb & Urine testing for sugar and albumin • Antenatal examination- abdomen & breast • Immunization • Assessment of risk status • Teaching antenatal mothers • Maintenance of Antenatal records	*Conduct Antenatal *Examinations 30 • Health talk-1 • Case book recordings	*Verification of findings of Antenatal examinations * Completion of casebook recordings
Post natal ward	4	• Provide nursing care to post natal mother & baby • Counsel & teach mother & family for parent hood	• Examination & assessment of mother & baby • Identification of deviations • Care of postnatal mother & baby • Perineal care • Lactation management • Breast feeding • Babybath • Immunization, • Teaching postnatal mother: ❑ Mother craft ❑ Post natal care & ❑ Exercises ❑ Immunization	• Give care to post natal mothers-20 • Health talks-1 • Case study- • Case presentation-1 • Case book recordings	• Assessment of clinical performanc e Assessment of each skill with checklists • Completion of case book recording • Evaluation of case study and presentatio n and health education sessions

Areas	Duration (week)	Objectives	Skills	Assessments	Assessment Methods
Newborn nursery	2	*Provide nursing care to Newborn at risk	• Newborn assessment • Admission of neonates • Feeding of at risk neonates ❑ Katori spoon, paladi, tube feeding, total parenteral nutrition • Thermal management of neonates-kangaroo mother care, care of baby in incubator • Monitoring and care of neonates • Administering medications • Intravenous therapy • Assisting with diagnostic procedure • Assisting with exchange transfusion • Care of baby on ventilator • Phototherapy • Infection control protocols in the nursery • Teaching & counseling of parents • Maintenance of neonatal records	• Case study-1 • Observation study-1	*Assessment of clinical performance • Assessment of each skill with checklists Evaluation of & Observation study
Family Planning clinic	Rotation from post natal ward 1 wk	• Counsel for & provide family welfare services	• Counselling technique • Insertion of IUD • Teaching on use of family planning methods • Arrange for & Assist with family planning operations • Maintenance of records and reports	• IUD insertion-5 • Observation Study-1 • Counselling-2 • Simulation exercise on recording and reporting-1	• Assessment of each skill with checklists • Evaluation of & Observation study

MIDWIFERY & OBSTETRIC PRACTICE

HOURS:

Hours prescribed	III year (Hours)	IV year (Hours)	Integr. Practice (Hours)
Theory	90	-	-
Practical	180	180	240

TOTAL HRS : THEORY 90 + PRACTICAL 600

EXAMINATIONS:

		THEORY			PRACTICAL	
	Marks	III year	IV year	Marks	III year	IV year
Viva	--	--	--	50	√	--
Midterm	50	√	-	50	--	√
Pre final	75	-	√	50	-	√
TOTAL	125			150		

ASSIGNMENTS:

THEORY				
NO	ASSIGNMENT	MARKS	III YEAR	IV YEAR
1	Seminar	50	√	-
2	Drug study	50	-	√
	TOTAL	100	-	-

NO	ASSIGNMENT / CLINICAL EVALUATION	NUMBER	MARKS	PLACEMENT
1	Health talk	1	25	III
2	Care study: ANC	1	50	IV
	PNC	1	50	IV
	New born	1	50	IV
3	Case presentation: ANC / PNC	1	50	IV
4	New born assessment	1	25	III
5	Case book	1	100	III, IV, I.P
6	Clinical evaluation:			
	ANC	1	100	III & IV
	PNC	1	100	
	Nursery	1	100	
	Labour ward	1	100	
	TOTAL	7	750	

Evaluation

Internal assessment

Theory: Maximum marks 25

Mid term examination –(3rd year) 50
Pre final – (4th year) 75

125
Out of 15

Assignments:

Seminar 01 (3rd year) 50
Drug study 01 (4th year) 50

100
Out of 10

Practical

Case presentation 01 (4th year) Marks 50
Antenatal ward / Postnatal ward

Care study 03 (4th year) Marks 150
Antenatal ward- 01 } (50 marks each)
Postnatal ward 01 }
Newborn 01

Health education 01 (3rd year) Marks 25
Newborn assessment 01 (3rd year) Marks 25
Case book (3rd year, 4th year & internship) Mark 100

Clinical evaluation 04 Marks 400
ANC ward 01
PNC ward 01 (100 marks each)
Nursery 01 (3rd year, 4th year)
Labor room 01

Practical examination
Viva Marks 50
Midterm examination Marks 50
Prefinal examination Marks 50

Total 900

Maximum marks = 100

External assessment

University examination
Theory Marks 75
Practical Marks 100

Note: Final examination will take place in 4th year

SEMINAR EVALUATION CRITERIA

NAME :- DATE :-
AUDIENCE :- TIME :-
TOPIC :- MARKS :-

Sr. No.	Factors/ Elements	1	2	3	4	5	Total	Remarks
I	Subject Matter 1) Introduction 2) Organization of Topic 3) Presentation of Topic 4) Relevant Examples 5) Relevant Statistical date 6) Group participation 7) Control of group 8) Conclusion							
II	A.V. AIDS 1) Appropriate to subject 2) Proper use of A.V.Aids 3) Self – Explanatory 4) Attractive 5) Planning & Preparation 6) Use of Modern Technology							
III	Personal Appearance 1) Voice and Clarity 2) Mannerism							
IV	References(Books, Journals & Resource Person)							
V	Physical facilities 1) Environment 2) Classroom Preparation							

Overall Observation

Signature of Teacher

Signature of the Candidate

Signature of Principal

Drug study

- Index of drug
- Introduction
- Classification of drugs
- Factors affecting action of drugs
- Name of the drug (Trade & Pharmaceutical name)
- Preparation, strength and dose
- Indications and contraindications
- Actions
- Adverse effects and drug interactions
- Nursing responsibility
- Conclusion
- References

Evaluation crit eria

Planning and organization ---------- 05
Content ----------10
Nursing responsibility ---------- 05
Conclusion & References ----------05
Total 25

ANC CASE STUDY / PRESENTATION FORMAT

Identification data

Patient: Name, Age in years, Dr's unit, reg.no

education, occupation, income, religion, marital

status, duration of marriage

Gravida, para, abortion, living, blood group

Husband: Name, Age, education, occupation, income

Present complaints

History of illness

Menstrual history: age of menarche, duration of menstrual cycle, duration of cycle in days, regularity, amount of flow, LMP, EDD, associated complaints

Contraceptive history:

Antenatal attendance:

Date, weight, pallor, edema, BP, Ut. Ht, presentation/position, FHS, Hb, Urine albumin/sugar, treatment

Obstetric history:

H/O Previous pregnancy / deliveries,

Period of pregnancy, type of labour/delivery, birth weight, PNC condition, remarks

Present pregnancy:

Date of booking, number of ANC visits, H/O minor ailments

Past medical, surgical history:

Family history:

Diet history:

Socioeconomic status

Personal habits

Psychosocial status

Physical assessment:

General examination: head to foot

Obstetric palpation, Auscultation

Conclusion

Investigation

Ultrasonograhy

Treatment

Description of disease

Therapeutic diet plan

Nursing care plan

Nurse's notes

Discharge planning

Antenatal advice

Evaluation of care

References

PNC CASE STUDY / PRESENTATION FORMAT

Identification data

Patient: Name, Age in years, Dr's unit, reg.no
education, occupation, income, religion, marital status, duration of marriage
Gravida, para, abortion, living, blood group
Husband: Name, Age, education, occupation, income

Present complaints
History of illness
Menstrual history: age of menarche, duration of menstrual cycle, duration of cycle in days, regularity, amount of flow, LMP, EDD, associated complaints
Contraceptive history:
Antenatal attendance:
Date, weight, pallor, edema, BP, Ut. Ht, presentation/position, FHS, Hb, Urine albumin/sugar, treatment
Obstetric history:
H/O Previous pregnancy / deliveries,
Period of pregnancy, type of labour/delivery, birth weight, PNC condition, Condition of new born, remarks
Present pregnancy:
Date of booking, number of ANC visits, H/O minor ailments
Past medical, surgical history:
Family history:
Diet history:
Socioeconomic status
Personal habits
Psychosocial status
Physical assessment:
Mother: General examination: head to foot
Baby: new born assessment
Conclusion
Investigation
Ultrasonograhy
Treatment
Description of disease
Therapeutic diet plan
Nursing care plan
Nurse's notes
Discharge planning
Antenatal advice
Evaluation of care
References

NEW BORN CASE STUDY FORMAT

Name, date of birth / discharge, reg.no, Dr's unit,
Mother's previous obstetric history, present pregnancy, labour history, baby's birth history
General examination: head to foot
Daily observation chart
Nursing care plan

EVALUATION CRITERIA CASE STUDY

Assessment / Introduction	**05**
Knowledge & understanding of disease / condition	**15**
Nursing care plan	**20**
Discharge plan	**05**
Summary & evaluation	**03**
Bibliography	**02**
TOTAL	**50**

EVALUATION CRITERIA CASE PRESENTATION

Assessment / Introduction	**05**
Knowledge & understanding of disease / condition	**10**
Presentation skill	**10**
Nursing care plan	**15**
A.V. aids	**05**
Summary & evaluation	**03**
Bibliography	**02**
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

NEW BORN ASSESSMENT

Refer "child health nursing "Subject, III Year page no20to 22

Case book

Note: 1. Case book contents

Antenatal examinations	**30**
Conducted normal deliveries	**20**
PV examinations	**05**
Episiotomy & suturing	**05**
Neonatal resuscitations	**05**
Assist with caesarian section	**02**
Witness / assist abnormal deliveries	**05**
Post natal cases nursed in hospital / health centre / home	**20**
Insertion of IUCD	**05**

2. All cases should be certified by teacher on completion of essential requirements.

CHILD HEALTH NURSING.

Placement: Third Year.

Time: Theory-90 Hrs.
(Class 80 + Lab 10 hrs)
Practical-270 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	Learning Objectives	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 child care.** • 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 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 12 hrs.** **P 03 hrs.** 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 care in 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. • Nursingcareof 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. Ghai O.p. et al. (2000) Ghai's Essentials of Paediatrics. 1st edn. Mehta offset works. New Delhi.

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

3. Parthsarathy et al. (2000) IAP Textbook of Paediatric Nsg. Jaypee bros., 2 nd ed. New Delhi.

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 publication 1996

PRACTICAL

Time: 270 hrs (9 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.

EVALUATION

I. Internal assessment :

Maximum marks 25

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

Practicum : Maximum marks 50

1. Case presentation - (Paed Medical / Surgical 01)		50
2. Case study - (Paed. medical. / surgical. 01)		50
3. Nursing care plan 03	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. (20 marks each) (Neonate, infant, toddler, preschooler, & School age)	5 X 20	100
Observation report of NICU surgery/ Medical	1 x 25	25

Practical exam :

1. Midterm exam	50
2. Preterm exam	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 if any
2. **Presenting complaints:** Describe the complaints with which the patient has come to hospital
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 and time**

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 OF EXPERIENCE: _____

PERIOD OF EXPERIENCE: _____

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 into 25

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				
	Identifies problems & sets priorities and grasps essentials while performing duties				
17	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 the weaning 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 (birth to 5 year)

(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] Biodata 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 :
Vernix caseosa :
Jaundiec :
Cyanosis :
Rashes :
Mongolian spot :
Birth marks :
Head :

- Anterior fontanel:

- Posterior fontanel:
- Any cephalhematoma / 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

50 Marks

Internal Examiner **25 Marks**

Nursing Procedure (15 marks)

Planning and Organizing	**5 marks**
• Preparation of tray	3
• Environment	1
• Preparation of patient	1
Execution of Procedure	**7 marks**
• 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 (10 Marks)	**10 marks**
• Knowledge about common pediatric medical surgical conditions	3
• Preparation of various diagnostic procedures	2
• Instruments and articles	2
• Growth and Development	3

External 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**
• 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. Sc NURSING : **MARKS : 50**

SUBJECT : CHILD 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 :**

MEDICAL SURGICAL NURSING

(Adult including Geriatrics) –II

Placement: Third year

Time: Theory –120 hours
(Classroom 103 + Lab 17)
Practical- 270 hours

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 and throat.
2. Take care of patients with disorders of eye.
3. Plan, implement and evaluate nursing management of patients with neurological disorders.
4. Develop abilities to take care of female patients with reproductive disorders.
5. Provide care of patients with burns, reconstructive and cosmetic surgery.
6. Manage patients with oncological conditions
7. Develop skill in providing care during emergency and disaster situations
8. Plan, implement and evaluate care of elderly
9. Develop ability to manage patients in critical care units.

Unit	Time (Hrs)	Learning Objectives	Content	Teaching Learning Activity	Assessment Method
I	T 15 P 02	•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 anatomy and physiology • of the Ear Nose and Throat- • Nursing Assessment- History and • Physical assessment • Etiology, path physiology, clinical • Manifestations, diagnosis, • Treatment modalities and medical & • Surgical nursing management of Ear Nose and Throat disorders: o **External ear**: deformities otalgia, foreign bodies, and tumours o **Middle Ear**-Impacted wax, Tympanic membrane perforation, otitis media, otosclerosis, mastoiditis, tumours	• Lecture • Discussion • Explain using Charts, graphs • Models, films, slides • Demonstration • Practice session • Cans discussions/ seminar • Health education • Supervised clinical practice • Drug book /presentation •Demonstration of procedures	• Essay type • Short answers • Objective type • 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, Peritonsilar abscess, Laryngitis ○ Upper respiratory airway- Epistaxis, ○ Nasal obstruction, laryngeal obstruction, Cancer of the larynx ○ Cancer of the oral cavity ○ Speech defects and speech therapy • Deafness- Prevention, control and rehabilitation • Hearing aids, implanted hearing Devices •Special therapies •Drugs used in treatment of disorders of ear nose and throat •Role of nurse Communicating with hearing impaired and mute. • Nursing procedures Oesophaostomy, Tracheostomy,		
II	T 15 P 02	Describe the etiology, path physiology, clinical manifestations diagnostic measures and management of patients with disorders of eye.	**Nursing management of patient With disorders of eye** • Review of anatomy and physiology of the eye- • Nursing assessment – history and Physical assessment • Etiology, pathophysiology, clinical manifestations, diagnosis, treatment nursing management of eye disorders: • Refractive errors • **Eyelids**-inflammation and • Infection and bleeding • **Cornea**- inflammation and Infection • **Lens**-Cataracts • Glaucoma • Disorder of the uveal tract, • Ocular tumours • **Disorders of posterior chamber and retina :** retinal and vitreous problems • Retinal detachment • Ocular emergencies and their prevention	• Lecture • Discussion • Explain using Charts, using Models, films. slides • Demonstration practice session • Case discussions/ seminar • Health education • Supervised clinical practice • Drug book / presentation • Visit to eye bank • Participation in eye-camps	• Essay type • 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 of eye • Blindness • National blindness control program • Eye Banking • Eye prostheses and rehabilitation • Role of a nurse-Communication with visually impaired patient, Eye camps •Special therapies •Nursing procedures: eye irrigation, assisting with removal of foreign body.		
III	T 17 P 02	• 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, Path physiology, clinical manifestations, diagnosis, treatment modalities and medical & surgical nursing management of neurological disorders • Congenital malformations • Headache • Head Injuries • Spinal injuries • Paraplegia • Hemiplegia • Quadraplegia • Spinal cord compression -Herniation of intervertebral disc • Tumors of the brain & spinal cord • Intra cranial and cerebral aneurysms • **Infections:** Meningitis, Encephalitis, brain abscess, neurocysticercosis • Movement disorders : Chorea Seizures / Epilepsy •Cerebro vascular accidents (CVA)	• Lecture discussion • Explain using Charts, graphs • Models, films, slides • Demonstration • Practice session • Case discussions/ Seminar • Health education • Supervised clinical practice • Drug book /presentation • Visit to rehabilitation drugs used in treatment of disorders of eye center	• Essay type • 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
			• **Cranial / spinal neuropathies** – Bell's palsy, trigeminal neuralgia, Peripheral Neuropathies; Guillan-Barr'e syndrome Myasthenia gravis Multiple sclerosis, Degenerative diseases, Peripheral neuritis TIA ❑ Delirium Dementia ❑ Alzheimer's disease ❑ Parkinson's disease • Management of unconscious patients and patients with stroke • Drugs used in treatment of neurological disorders • Role of the nurse in communication with patient having neurological deficit • Rehabilitation of patients with neurological deficit • Role of nurse in long stay facility (institutions) and at home Special therapies Nursing procedures: GCS, assisting with diagnostic procedures and rehabilitation		
IV	T 15 P 02	• 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 and physiology of the female reproductive system • Nursing assessment-history and physical assessment • Breast self examination • Etiology, pathophysiology, clinical manifestations, diagnosis, treatment modalities and medical & surgical nursing management of disorder of female reproductive system • Congenital abnormalities of female reproductive system • **Sexuality and Reproductive Health** • Sexual Health Assessment • **Menstrual Disorders-** Dysmenorrhea, Amenorrhea, Premenstrual Syndrome • Abnormal Uterine Bleeding; Menorrhagia, Metrorrhagia • Pelvic inflammatory disease- • Ovarian and fallopian tube disorders; Infections Cysts, Tumours • **Uterine and cervical disorders;** Endometriosis, polyeps, Fibroids, Cervical and uterine tumours, •Uterine displacement , Cystocele/ urethrocele/ rectocele	• Lecture discussion • Explain using Charts, graphs Models, films, slides • Demonstration /Practice session • Case discussions/ Seminar • Heath education • Supervised clinical practice • Drug book /presentation	• Essay type • 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
			• Vaginal disorders; Infections and Discharges, fistulas • Vulvur disorders; Infection, cysts, Tumours • Diseases of breast Deformities Infections Cysts and Tumours • Menopause and hormonal replacement therapy • Infertility • Contraception; Temporary and Permanent • Emergency contraception methods • Abortion-natural, medical and surgical abortion-MTP Act • Toxic shock Syndrome • Injuries and trauma; sexual violence • Drugs used in treatment of gynaecological disorders Special therapies vaginal douche PAP smear • Nursing procedures assisting with diagnostic and therapeutic procedures, self examination of breast.		
V	T 08 P 02	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 connective tissues • Nursing assessment-History and 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 of surgeries •Legal Issues, Rehabilitation •Special therapies •Psycho social aspects	• Lecture discussion • Explain using Charts, graphs Models, films, slides • Demonstration • Practice session • Case discussion/ Seminar • Health education • Supervised clinical practice •Drug book / presentation	• Essay type • 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
VI	T 13 P 02	Describe the etiology, patho physiology, clinical manifestations, diagnostic manifestations, diagnostic measures and nursing management of patients with oncology	**Nursing management of patients With oncological conditions** • Structure & characteristics of normal & cancer cells • Nursing Assessment-history and physical assessment • Prevention, Screening for early detection, warning signs of cancer • Common malignancies of various body system; Brain Oral cavity, larynx lung liver stomach and colon, breast cervix, ovary, uterus, renal, bladder, prostate leukemias and lymphomas, Oncological emergencies. • Epidemiology, etiology, classifications, pathophysiology, staging, clinical manifestations, diagnosis treatment modalities and medical, surgical & nursing management of malignant diseases • Treatment Modalities – Immunotherapy Chemotherapy, Gene therapy Stem cell & Bone Marrow transplants. • Surgical interventions • Psychosocial aspects of cancer • Rehabilitation & Palliative care • Management – nutritional support Home care, Hospice care, Stoma care • Psycho social aspects • Assisting with diagnostic and therapeutic procedures	• Lecture discussion • Explain using • Charts, graphs models, films, slides • Demonstration • Practice session • Case discussion/ Seminar • Health education • Supervised clinical practice • Drug book /presentation	• Essay type • Short answers • Objective type • Assessment of skills with check 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 of disaster: 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 • Explain using • Charts, graphs • Models, films, slides • Demonstration • Practice session • Case discussion/Seminar • Health education • Supervised clinical practice	

Unit	Time (Hrs)	Learning Objectives	Content	Teaching Learning Activity	Assessment Method
			organizations and International agencies • Role of nurse in disaster management • Legal aspects of disaster nursing • Impact on Health and after effects; post Traumatic Stress Disorder • Rehabilitation; physical, psychosocial Social, Financial, Relocation Emergency Nursing Concept, priorities principle and • Scope of emergency nursing • Organization of emergency services: physical setup, staffing, equipment and supplies, protocols, Concepts of triage and role of triage nurse • Coordination and involvement of different departments and facilities • Nursing Assessment-History and physical assessment • Etiology, pathophysiology, clinical manifestations, diagnosis, treatment modalities and medical & surgical nursing management of patient with medical and surgical Emergency • Principles of emergency management • Common Emergencies; • Respiratory Emergencies • Cardiac Emergencies • Shock and Haemorrhage • Pain • Poly-Trauma, road accidents, crush • Injuries, wound • Bites • Poisoning; Food, Gas, Drugs & chemical poisoning • Seizures • Thermal Emergencies; Heat stroke & Cold injuries • Pediatric Emergencies • Psychiatric Emergencies • Obstetrical Emergences • Violence, Abuse, Sexual assault • Cardio pulmonary Resuscitation • Crisis Intervention • Role of the nurse; Communication And inter personal Relation • Medico-legal Aspects;	• Disaster management drills • Drug book /presentation	• Essay type • 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
VIII	10	• Explain the concept and problems of aging • Describe nursing care of the elderly	**Nursing care of the elderly** • Nursing Assessment-History and physical assessment • Ageing; • Demography; Myths and realities • Concepts and theories of ageing • Cognitive Aspects of Ageing • Normal biological ageing • Age related body systems changes • Psychosocial Aspects of Aging • Medications and elderly • Stress & coping in older adults • Common Health problems & Nursing Management; • Cardiovascular, Respiratory, Musculoskeletal, • Endocrine, genito-urinary, gastrointestinal • Neurological, Skin and other Sensory organs • Psychosocial and Sexual • Abuse of elderly • Role of nurse for care of elderly: ambulation, nutritional, communicational, psychosocial and spiritual • Role of nurse for caregivers of elderly • Role of family and formal and 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 institutional care	• Lecture discussion • Explain using Charts, graphs • Models, films, slides • Demonstration • Practice session • Case discussion/Seminar • Health education • Supervised clinical practice • Drug book /presentation Visit to old age home	• Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problem
IX	T 10 P 05	• Describe organization of critical care units • management role of nurse in management of patients critical care units	**Nursing management of patient in critical care units** • Nursing Assessment-History and • Physical assessment • Classification • Principles of critical care nursing • Organization; physical setup, Policies, staffing norms, • Protocols, equipment and supplies	• Lecture discussion • Explain using Charts, graphs • Models, films, slides • Demonstration • Role plays • counseling • Practice session • Case discussion/	• Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management

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

Unit	Time (Hrs)	Learning Objectives	Content	Teaching Learning Activity	Assessment Method
			• Nursing management of critically ill patient; • Monitoring of critically ill patient • CPR-Advance Cardiac life support • Treatments and procedures. • Transitional care • Ethical and Legal Aspects • Communication with patient and family • Intensive care records • Crisis Intervention • Death and Dying-coping with • Drugs used in critical care unit • Nursing procedures; Monitoring of patients in, assisting in therapeutic and diagnostic procedures, CPR, ACLS	• Health education • Supervised clinical practice • Drug book /presentation	
X	8	• Describe the etiology, patho-physiology, clinical manifestations, assessment, diagnostic measures and management of patients with occupational and industrial health disorder	**Nursing management of patients adults including elderly with occupational and industrial disorders** • Nursing Assessment-History and physical assessment • Etiology, pathophysiology, clinical manifestations, diagnosis, diagnosis, treatment modalities and medical & surgical nursing management of occupational and industrial health disorders • Role of nurse Special therapies, alternative therapies Nursing procedures Drugs used in treatment of Occupational and industrial disorders		

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PRACTICAL

Practical –270 hrs

Areas	Duration (inwks)	Objectives Posting	Skills to be developed	Assignments	Assessment Method
ENT	1	• provide care to patients with ENT disorders counsel and educate patient and families	• perform examination of ear, nose and throat • Assist with diagnostic procedures • Assist with therapeutic procedures • Instillation of drops • Perform/assist with irrigations. • Apply ear bandage • Perform tracheotomy care • Teach patients and Families	• Provide care to 2-3 assigned patients • Nursing care plan-1 • Observation reports of OPD • Maintain drug book	• Assess each 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 patient and families	• Perform examination of eye • Assist with diagnostic procedures • Assist with therapeutic procedures Perform/assist with • Irrigations. • Apply eye bandage • Apply eye drops/ ointments • Assist with foreign body removal. • Teach patients and Families	• Provide care to 2-3 assigned patients • Nursing care plan-1 • Observation reports of OPD & Eye bank • Maintain drug book	• Assess each 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	• Perform Neurological • Examination • Use Glasgow coma scale • Assist with diagnostic procedures • Assist with therapeutic procedures • Teach patient & families • Participate in Rehabilitation program	• Provide care to assigned 2-3 patients with neurological disorders • Case study/Case presentation-1 • Maintains drug book • Heath • Teaching-1	• Assess each skill with checklist • Assess performance with rating scale • Evaluation of case study & health • Completion of activity record

Areas	Duration (inwks)	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 • Assist with therapeutic procedures • Teach patients families • Teaching self Breast • Examination • Assist with PAP • Smear collection.	• Provide care to 2-3 assigned patients • Nursing care plan-1 • Maintain drug book	• Assess each skill with checklist • Assess performance with rating scale • Evaluation of observation report of OPD/Eye bank • Completion of activity record
Burns Unit	1	Provide care	• Assessment of the burns patient Percentage of burns • Degree of burns. • Fluid & electrolyte replacement therapy • Assess • Calculate • Replace • Record intake/output • Care of Burn wounds • Bathing • Dressing • Perform active & passive exercises • Practice asepsis surgical asepsis • Counsel & Teach patients and families • Participate in rehabilitation program	• Provide care to 1-2 assigned patients • Nursing care paln-1 • Observation report of Burns unit	activity record
Oncology	1	• provide care to patients with cancer counsel and educate patient and families	• Screen for common cancers-TNM classification • Assist with diagnostic procedures • Biopsies • Pap smear • Bone-marrow aspiration • Breast examination • Assist with • Therapeutic • Participates • Participates in various modalities of treatment	• Provide care to 2-3 assigned patients • Nursing care Plan –1 • Observation report of cancer unit	• Assess each skill with checklist • Assess performance with rating scale • Evaluation of Care plan and observation report Completion of activity record

Areas	Duration (inwks)	Objectives Posting	Skills to be Developed	Assignments	Assessment Method
			• Chemotherapy • Radiotherapy • Pain management • Stomaltherapy • Hormonal therapy • Immuno therapy • Gene therapy • Alternative therapy • Participate in palliative care • Counsel and teach patients families		
Critical Care unit	2	• provide care to critically ill patients • counsel and families for grief and bereavement	• Monitoring of patients in ICU • Maintain flow sheet • Care of patient on ventilators • Perform Endotracheal suction • Demonstrates use of ventilators, cardiac monitors etc. • Collect specimens and interprets ABG analysis • Assist with arterial puncture • Maintain CVP line • Pulse oximetry • CPR-ALS • Defibrillators • Pace makers • Bag-m ask ventilation • Emergency tray/ trolly-Crash Cart • Administration of drugs infusion pump • Epidural • Intra thecal • Intracardiac • Total parenteral therapy • Chest physiotherapy • Perform active & passive exercise • Counsel the patient and family in dealing with grieving and bereavement	• Provide care to I assigned patient • Observation report of Critical care unit • Drugs book.	• Assess each skill with checklist • Assess performance with rating scale • Evaluation of observation report • Completion of activity record

Areas	Duration (inwks)	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 disaster situations • Assist in documentations • Assist in legal procedures in emergency unit • Participate in managing crowd • Counsel patient and Families in grief and bereavement	• Observation • Report of Emergency Unit	• Assess Performance with rating scale • Evaluation of observation report • Completion of activity record

Evaluation

Internal assessment

Theory Maximum marks 25

Midterm	50
Prefinal	75
Total	125

Practical Maximum marks 50

Nursing care plan (ENT, Ophthalmology, Gynaec, Burns, Oncology)	5 x25	125
Case presentation / case study- neuro	1x 50	50
Health teaching	1 x 25	25
Clinical Evaluation (Neurology and critical care unit)	2 x 100	200

Internal assessment

Practical

Midterm	50
Prefinal	75
Total	525

Practical examination

University examination

Theory	Marks 75
Practical	Marks 50

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**

   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. **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 system available.
6. **Personal habits:** consumption of alcohol, smoking, tobacco chewing, sleep, exercise, and work elimination, nutrition.
7. **Physical examination with date and time**
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. 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

11.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

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:

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

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 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

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:- 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 of the student

Signature of the teacher

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

Internal Examiner	**25 Marks**
Nursing Procedure (15 marks)	
Planning and Organizing	**5 marks**
• Preparation of tray	3
• Environment	1
• Preparation of patient	1
Execution of Procedure	**7 marks**
• 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 (10 Marks)	**10marks**
• Knowledge about common medical surgical conditions- (ENT, eye, neurological, Reproductive System)	4
• Nursing Care of Elderly persons	2
• Preparation of various diagnostic procedures	2
• Instruments and articles	2
External 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 medical surgical conditions (Burns, Reconstructive and cosmetic surgery, Oncological conditions)	4
• Care of Patients in Critical Care Unit	2
• Occupational Disorders	2
• Drugs	2

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

NAME OF THE EXAMINATION: MEDICAL SURGICAL -II PRACTICALS

MONTH : **YEAR :**

SECOND YEAR Basic B. Sc NURSING : **MARKS : 50**

SUBJECT : MEDICAL SURGICAL NURSING – I PRACTICALS

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 :**

MENTAL HEALTH NURSING

Time: Theory- 90 Hours
Practical – 270 Hours

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

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

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 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. Judgement:-

According to the situation

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

11. Insight:-

Awearness
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 :**