MENTAL HEALTH NURSING

Placement: Third Year **Time: Theory-90 Hrs.**
Practical – 270 Hrs

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

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

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

Unit	Time (Hrs)	Objective	Contents	Teaching Learning Activities	Assessment Methods
I	05	• Describes the historical development & current trends in mental health nursing • Describe the epidemiology of mental health problems • Describe the National Mental Health Act, programmes and mental health policy. • Discusses the scope of mental health nursing • Describe the concept of normal & abnormal behaviour.	**Introduction** • Perspectives of Mental Health and Mental Health Nursing: evolution of mental health services, treatments and nursing practices. • Prevalence and incidence of mental health problems and disorders. • Mental Health Act • National Mental health policy vis-a-vis National Health Policy. • National Mental Health programme. • Mental health team. • Nature and scope of mental health nursing. • Role and functions of	• Lecture Discussion	• Objective type • Short answer • Assessment of the field visit reports

			• mental health nurse in various settings and factors affecting the level of nursing practice • Concepts of normal and abnormal behaviour.		
II	05	• 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 development.	• Essay type • Short answer. • Objective type

III	08	Describe nature, purpose and process of assessment of mental health status	**Assessment of mental health status.** • History taking. • Mental status examination. • Mini mental status examination. • Neurological examination: Review. • Investigations: Related Blood chemistry, EEG, CT & MRI. • Psychological tests Role and responsibilities of nurse.	• Lecture Discussion • Demonstration • Practice session • Clinical practice	• Short answer • Objective type • Assessment of skills with checklist.
IV	06	• Identify therapeutic communication techniques • Describe therapeutic relationship. • Describe therapeutic impasse and its intervention.	**Therapeutic communication and nurse-patient relationship** • Therapeutic communication: types, techniques, characteristics • Types of relationship, • Ethics and responsibilities • Elements of nurse patient contract • Review of technique of IPR- Johari Window • Goals, phases, tasks, therapeutic techniques. • Therapeutic impasse and its intervention	• Lecture discussion • Demonstration • Role play • Process recording	• Short answer • Objective type
V	14	Explain treatment modalities and therapies used in mental disorders and role of the nurse.	**Treatment modalities and therapies used in mental disorders.** • Psycho Pharmacology • Psychological therapies: Therapeutic community, psycho therapy – Individual: psycho-analytical, cognitive & supportive, family, Group, Behavioral, Play Psycho-drama, Music, Dance, Recreational and Light therapy, Relaxation therapies :	• Lecture discussion • Demonstration • Group work. • Practice session • Clinical practice.	• Essay type • Short answers • Objective type

			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.		
VI	05	• Describe the etiology, sychopathology 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 • Follow – up and home care and rehabilitation	• Lecture discussion • Case discussion • Case presentation • Clinical practice	• Essay type • Short answers • Assessment of patient management problems

VII	05	Describe the etiology, psychopathology clinical manifestations, diagnostic criteria and management of patients with mood disorders.	**Nursing management of patient with mood disorders** • Mood disorders: Bipolar affective disorder, Mania depression and dysthamia etc. • Etiology, psychopathology, clinical manifestations, diagnosis. • Nursing Assessment- History, Physical and mental assessment. • Treatment modalities and nursing management of patients with mood disorders • Geriatric considerations • Follow-up and home care and rehabilitation	• Lecture discussion • Case discussion • Case presentation • Clinical practice	• Essay type • Short answers • Assessment of patient management problems
VIII	08	Describe the etiology, psychopathology, clinical manifestations, diagnostic criteria and management of patients with neurotic, stress related and somatization disorders.	**Nursing management of patient with neurotic, stress related and somatization disorders** • Anxiety disorder, Phobias, Dissociation and Conversion disorder, Obsessive-compulsive disorder, somatoform disorders, Post traumatic stress disorder. • Etiology, 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

IX	05	Describe the etiology, psychopathology, 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, and 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
X	04	Describe the etiology, psychopathology, 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, psychopathology, 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

XI	06	Describe the etiology, psychopathology, 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 nursing management of childhood disorders including mental deficiency • Follow-up and home care and rehabilitation	• Lecture discussion • Case discussion • Case presentation • Clinical practice	• Essay type • Short answers • Assessment of patient management problems
XII	05	Describe the etiology psychopathology, clinical manifestations, diagnostic criteria and management of organic brain disorders	**Nursing management of organic brain disorders** • Classification: ICD? • Etiology, psycho-pathology, clinical features, diagnosis and Differential diagnosis (Parkinson's and Alzheimer's) • Nursing Assessment-History, Physical, mental and neurological assessment • Treatment modalities and nursing management of organic brain disorders • Geriatric considerations • Follow-up and home care and rehabilitation	• Lecture discussion • Case discussion • Case presentation • Clinical practice	• Essay type • Short answers • Assessment of patient management problems

XIII	06	Identify psychiatric emergencies and carry out crisis intervention	**Psychiatric emergencies and crisis intervention** • Types of psychiatric emergencies and their management • Stress adaptation Model: stress and stressor, coping, resources and mechanism • Grief: Theories of grieving process, principles, techniques of counseling • Types of crisis • Crisis Intervention: Principles, Techniques and Process • Geriatric considerations • Role and responsibilities of nurse	• Lecture discussion • Demonstration • Practice session • Clinical Practice	• Short answers • Objective type
XIV	04	Explain legal aspects applied in mental health settings and role of the nurse	**Legal issues in Mental Health Nursing** • The Mental Health Act 1987: Act, Sections, Articles and their implications etc. • Indian lunacy Act. 1912 • Rights of mentally, ill clients • Forensic psychiatry • Acts related to narcotic and psychotropic substances and illegal drug trafficking • Admission and discharge procedures • Role and responsibilities of nurse	• Lecture discussion • Case discussion	• Short answers • Objective type

XV	04	• Describe the model of preventive psychiatry • Describe Community Mental health services and role of the nurse	**Community Mental Health Nursing** • Development of Community Mental Health Services: • National Mental Health Programme • Institutionalization Versus Deinstitutionalization • Model of Preventive psychiatry: Levels of Prevention • Mental Health Services available at the primary, secondary, tertiary levels including rehabilitation and Role of nurse • Mental Health Agencies: Government and voluntary, National and International • Mental health nursing issues for special populations: Children, Adolescence, Women, Elderly, Victims of violence and abuse, Handicapped, HIV/AIDS etc.	• Lecture discussion • Clinical/field practice • Field visits to mental health service agencies	• Short answers • Objective type • Assessment of the field visit reports

References (Bibliography:)

1. Gail Wiscars Stuart.Michele T. Laraia. “Principles and practice of psychiatric nursing”, 8th edition, Elseveir, India Pvt.Ltd. New Delhi.2005.

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3. M.S. Bhatia, A concised text Book of Psychiatric Nursing, CBS publishers and distributors, Delhi 2nd ed. 1999.

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

5. Mary C Townsend. “Psychiatric Mental Health Nursing”. Concept of care, 4th edition. F.A.Davis Co. Philadelphia 2003.

6. Bimla Kapoor, Psychiatric nursing , Vol. I & II Kumar publishing house Delhi, 2001

7. Niraj Ahuja, A short textbook of pstchiatry , ‚Jaypee brothers,new delhi, 2002.

8. The ICD10, Classification of mental and behavioural disorders, WHO, A.I.T.B.S. publishers, Delhi,2002
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10. Patricia, Kennedy, Ballard, “Psychiatric Nursing Integration of Theory and Practice”, USA, Mc Graw Hill 1999.
11. Kathernic M. Fort in ash, Psychiatric Nursing Care plans, , Mossby Year book. Toronto
12. Sheila M. Sparks, CynthiaM. Jalor, Nursing Diagnosis reference manual 5th edition, , Spring house, Corporation Pennsychiram’s
13. R. Sreevani, A guide to mental health & psychiatric nursing, Jaypee brothers, Medical Publishers p(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 weeks)	Objective	Skills to be developed	Assignment	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 others	• History taking • Perform mental status examination (MSE) • Perform Neurological examination • Assist in psychometric assessment • Record therapeutic communication • Administer medications • Assist in Electroconvulsive Therapy (ECT) • Participate in all therapies • Prepare patients for Activities of Daily living (ADL) • Conduct admission and discharge counseling • Counsel and teach patients and families	• Give care to 2-3 patients with various mental disorders • Case study- 1 • Care plan- 2(based on nursing process) • Clinical presentation-1 • Process recording 1 • Maintain drug book	• Assess performance with rating scale • Assess each skill with checklist • Evaluation of the case study care plan, clinical presentation, process recording • Completion of activity record

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

Internal Assessment:

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

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:

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

University Exam

Theory	75 Marks
Practical	50 Marks

Nursing care plan

1. **Patients Biodata:**

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

2. **Presenting complaints:**

   Describe the complaints with which the patient has come to hospital

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

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

   - Personal history: Birth, early development, educational, occupational, menstrual, sexual, marital, religious, social activity, interests and hobbies. Legal history: any arrest imprisonment, divorce etc…

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

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

4. **Mental status examination with conclusion**
5. **Investigations**

Date	Investigation done	Normal value	Patient value	Inference

6. **Treatment**

Sr. No.	Drug: (pharmacological name)	Dose	Frequency Time	Action	Side effect & Drug interaction	Nursing responsibility

Other modalities of treatment in detail

7. **Nursing process:**

   Patient 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.

8. Evaluation of care

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

Care plan evaluation

Sr. No.	Contents	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, address, age, sex, religion, marital status, occupation, source of health care, date of admission, provisional diagnosis, date of surgery if any

2. Presenting complaints:

Describe the complaints with which the patient has come to hospital

3. History of illness:

This includes the following data such as presenting complaints with duration, history of presenting complaints, past history of illness, personal history, legal history, family history, personality (Personality prior to illness)

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

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

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, related anatomy physiology, etiology, risk factors, clinical features, management and nursing care Clinical features of the disease condition

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

6. Investigations

Date	Investigation done	Normal value	Patient value	Inference

7. Treatment

Sr. No.	Drug: (pharmacological name)	Dose	Frequency Time	Action	Side effect & Drug interaction	Nursing responsibility

Other modalities of treatment in detail

8. Nursing process:

Patient 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.

9. Evaluation of care

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

Date	Assessment	Nursing diagnosis	Objective	Plan of care	Implementation	Rationale	Evaluation

EVALUATION CRITERIA FOR CASE PRESENTATION –

Sr. No.	Contents	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.	Contents	Marks
1	History & MSE	10
2	Knowledge and understanding of disease	15
3	Nursing care plan	20
4	Discharge plan	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.	Particulars	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
  a. Education History
  b. Occupational History
  c. Marital History
  d. Sexual History
  e. Religion
  f. Social activity, interests and hobbies.
- Pre-morbid personality
- Physical examination
- Diagnosis & identification of psychosocial stressors

EVALUATION CRITERIA FOR CASE PRESENTATION –

Sr. No.	Contents	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

Friendly (mainia)

Trustful (mainia)

Attentive

Interested

Seductive

1. Attention seeking
2. Dramatic
3. Emotional

Evasive

Negativistic

Resistive

Non-caring

Any other

Defensive

Guarded Paranoia

3. Posture:-

    Good – Straight/proper
    Relaxed
    Rigid/Tense/Unsteady
    Bizarre Position
    Improper – Explain

4. Gait, Carraige & 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. <u>Disorders of Tempo</u>

∗ 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. <u>Disorders of continuity</u>

∗ Perseveration:- Repetition of the same words over and over again.

∗ Blocking:- Thinking process stops altogether.

∗ Echolalia: - Repetition of the interviewer's word like a parrot.

II. Possession and control

∗ Obsessions: - Persistent occurrence of ideas, thoughts, images, impulses or phobias.

∗ Phobias: - Persistent, excessive, irrational fear about a real or an imaginary object, place or a situation.

∗ Thought alienation:- The patient thinks that others are participating in his thinking.

∗ Suicidal/homicidal thoughts.

III. Content:-

∗ Primary Delusion:- Fixed unshakable false beliefs, and they cannot be explained on the basis of reality.

∗ Delusional mood

∗ Delusional perception

∗ Sudden delusional ideas

∗ Secondary delusion

Content of Delusions:-

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

10. Judgment:-

According to the situation

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

11. Insight:-

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

14. Attention:-

Normal

Moderate

Poor attention

Any other

15. Concentration:-

Good

Fair

Poor

Any other

16. Special points:-

Bowel & bladder habits

Appetite

Sleep

Libido

Any other

Instructions for filling the MSE format:

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

EVALUATION CRITERIA FOR M.S.E.

SN	TOPIC	MAX MARKS
1.	Format	01
2.	Content (Administration of test and inference)	06
3.	Examination skill	02
4.	Bibliography	01
	TOTAL	10

Mental Status Examination

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

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

SN	TOPIC	MAX MARKS
1.	History taking	02
2.	Interview technique	03
3.	Inferences drawn from interview	03
4.	Overall understanding	02
	TOTAL	**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 format of process recording

SN	TOPIC	MAX MARKS
1.	Introduction to therapy	02
2.	Purposes of therapy	03
3.	Preparation for therapy	05
4.	Care during therapy	05
5.	Care after therapy	05
6.	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 100 Marks

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

Sr. No.	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.					
VI	**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.

Signature of the student　　　　　　　　　　Signature of the teacher

DRUG BOOK/STUDY

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