

COURSE OF INSTRUCTION THIRD YEAR BASIC B.SC. NURSING

SN	SUBJECT	THEORY HRS		PRACTICAL HRS	HRS
		Class	Lab		
1	Medical surgical Nursing (Adult including geriatrics) II	103	17	270	
2	Child health Nursing	80	10	270	
3	Mental health nursing	90	-	270	
4	Midwifery and Obstetrical nursing	90		180 * practical exp guidelines for 3 rd & 4 th year	
5	Library work / self study				50
6	Co-curricular activities				50
		363 hrs	27 hrs	990	100
	TOTAL HOURS	1480			

**SCHEME OF EXAMINATION
THIRD YEAR**

SN	SUBJECT	HOURS	INTERNAL ASSESSMENT	EXTERNAL EXAM	TOTAL
1	Medical surgical Nursing (Adult including geriatrics) II	3	25	75	100
2	Child health Nursing	3	25	75	100
3	Mental health nursing	3	25	75	100
	Practical Medical surgical Nursing (Adult including geriatrics) II		50	50	100
6	Child health Nursing		50	50	100
7	Mental health nursing		50	50	100

Scheme of Internal Assessment

Sr No	Subjects	Maximum marks for internal assessment	Assignments / tests	Weight age	Maximum marks of assessment / tests
1	Medical surgical Nursing (Adult including geriatrics) II Theory	25	Midterm Test – 1 Prefinal Exam – 1	50 75	25 marks
	Medical surgical Nursing (Adult including geriatrics) II Practical	50	Nursing care plan (ENT, Ophthalmology, Gynaec, Burns, Oncology) Case presentation / case study- neuro Health teaching Clinical Evaluation (Neurology and critical care unit) <u>Practical exam :-</u> Midterm Test – 1 Prefinal Exam - 1	125 50 25 200 50 75 <hr/> 525	50marks
2	Child health Nursing Theory	25	Midterm Test – 1 Prefinal Exam – 1	50 75	25 marks
	Child health Nursing Practical	50	Case presentation - (Paed Medical / Surgical 01) 2. Case study - (Paed. medical / surgical 01) 3. Nursing care plan 03 4. Clinical evaluation of comprehensive. (paed. Medical / surgical / P.I.C.U./ N.I.C.U.) 5. Health teaching - 01 6. Assessment of growth & development reports. (20 marks each) (Neonate, infant, toddler, preschooler, & School age) 7. Observation report of NICU surgery/ Medical <u>Practical exam:</u> Midterm exam Prefinal exam	50 50 75 300 25 100 25 50 50 <hr/> 725	50 marks

Sr No	Subjects	Maximum marks for internal assessment	Assignments / tests	Weight age	Maximum marks of assessment / tests
3	Mental health nursing Theory	25	Midterm Test – 1 Prefinal Exam – 1	50 75	25 marks
	Mental health nursing Practical	50	Nursing care plan (02 X 25) Case presentation Case study Health teaching History taking & mental status examination (02 X 50) Process recording Observation report of various therapies in psychiatry Clinical Evaluation (02 X 100) <u>Practical exam</u> Midterm test = 1 Prefinal exam = 1	50 50 50 25 100 25 200 50 50 <hr/> 600	50 marks
	Midwifery and obstetrical nursing Theory Final exam will take place in 4 the year		Mid term examination – (3 rd year) Pre final – (4 th year) Assignments: Seminar 01 (3 rd year) Drug study 01 (4 th year)	50 75 50 50	15 marks 10 marks
	Midwifery and obstetrical nursing Practical Final exam will take place in 4 the year		Case presentation 01 (4 th year) ANC/ PNC ward Care study 03 (4 th year) Antenatal ward- 01 Postnatal ward 01 Newborn 01 Health education 01 (3 rd year) Newborn assessment 01 (3 rd year) Case book (3 rd year, 4 th year & internship) Clinical evaluation 04 ANC ward 01 PNC ward 01 Nursery 01 (3 rd year, 4 th year) Labor room 01 Practical viva (3 rd year) Midterm examination (4 th yr) Prefinal examination (4 th year)	50 150 25 25 100 25 400 50 50 50 <hr/> 900	50marks

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	<ul style="list-style-type: none"> • Describe the etiology, patho-physiology, clinical manifestations, diagnostic measures and management of patients with disorders of Ear Nose and Throat 	<p>Nursing management of patient with disorders of Ear Nose and Throat</p> <ul style="list-style-type: none"> • 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: ○ External ear: deformities otalgia, foreign bodies, and tumours ○ Middle Ear-Impacted wax, Tympanic membrane perforation, otitis media, otosclerosis, mastoiditis, tumours 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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
			<ul style="list-style-type: none"> ○ 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. Physical assessment	<p>Nursing management of patient With disorders of eye</p> <ul style="list-style-type: none"> ● Review of anatomy and physiology of the eye- ● Nursing assessment – history and ● 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 	<ul style="list-style-type: none"> ● 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 	<ul style="list-style-type: none"> ● 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
			<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Describe the etiology, patho physiology clinical manifestations, diagnostic measures and nursing management of patients with neurological disorders 	<p>Nursing management of patient With neurological disorders</p> <ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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
			<ul style="list-style-type: none"> • Cranial / spinal neuropathies – Bell’s palsy, trigeminal neuralgia, Peripheral Neuropathies; Guillan-Barr’e syndrome Myasthenia gravis Multiple sclerosis, Degenerative diseases, Peripheral neuritis TIA <ul style="list-style-type: none"> □ 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	<ul style="list-style-type: none"> • 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 . 	<p>Nursing management of patient s With disorders of female reproductive system</p> <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Lecture discussion • Explain using Charts, graphs Models, films, slides • Demonstration /Practice session • Case discussions/ Seminar • Heath education • Supervised clinical practice • Drug book /presentation 	<ul style="list-style-type: none"> • 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
			<ul style="list-style-type: none"> • 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	<p>Nursing management of patients With Burns, reconstructive and Cosmetic surgery</p> <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Lecture discussion • Explain using Charts, graphs Models, films, slides • Demonstration • Practice session • Case discussion/ Seminar • Health education • Supervised clinical practice • Drug book / presentation 	<ul style="list-style-type: none"> • 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	<p>Nursing management of patients With oncological conditions</p> <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Lecture discussion • Explain using • Charts, graphs models, films, slides • Demonstration • Practice session • Case discussion/ Seminar • Health education • Supervised clinical practice • Drug book /presentation 	<ul style="list-style-type: none"> • Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problem
VII	10	<ul style="list-style-type: none"> • 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 	<p>Nursing management of patient in EMERGENCY & DISASTER situations</p> <ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • 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
			<p>organizations and International agencies</p> <ul style="list-style-type: none"> • 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; 	<ul style="list-style-type: none"> • Disaster management drills • Drug book /presentation 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> Explain the concept and problems of aging Describe nursing care of the elderly 	<p>Nursing care of the elderly</p> <ul style="list-style-type: none"> 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 Issues Provisions and Programmes of elderly; Privileges. Community programs and health services; Home and institutional care 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Essay type Short answers Objective type Assessment of skills with check list Assessment of patient management problem
IX	T 10 P 05	<ul style="list-style-type: none"> Describe organization of critical care units management role of nurse in management of patients critical care units 	<p>Nursing management of patient in critical care units</p> <ul style="list-style-type: none"> Nursing Assessment-History and Physical assessment Classification Principles of critical care nursing Organization; physical setup, Policies, staffing norms, Protocols, equipment and supplies 	<ul style="list-style-type: none"> Lecture discussion Explain using Charts, graphs Models, films, slides Demonstration Role plays counseling Practice session Case discussion/ 	<ul style="list-style-type: none"> Essay type Short answers Objective type Assessment of skills with check list Assessment of patient management

		<ul style="list-style-type: none"> • Special equipments; ventilators, cardiac monitors, defibrillators, • Resuscitation equipments • Infection Control protocols 	Seminar	problem
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Unit	Time (Hrs)	Learning Objectives	Content	Teaching Learning Activity	Assessment Method
			<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Health education • Supervised clinical practice • Drug book /presentation 	
X	8	<ul style="list-style-type: none"> • Describe the etiology, pathophysiology, clinical manifestations, assessment, diagnostic measures and management of patients with occupational and industrial health disorder 	<p>Nursing management of patients adults including elderly with occupational and industrial disorders</p> <ul style="list-style-type: none"> • 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 		

Student References –

1. Black J.M. Hawk, J.H. (2005) Medical Surgical Nursing Clinical Management for Positive Outcomes. (7thed) Elsevier.
2. Brunner S. B., Suddarth D.S. The Lippincott Manual of Nursing practice J.B.Lippincott. Philadelphia.

Suggested references

1. Lewis, Heitkemper & Dirksen (2000) Medical Surgical Nursing Assessment and Management of Clinical Problem (6thed) Mosby.
2. Black J.M. Hawk, J.H. (2005) Medical Surgical Nursing Clinical Management for Positive Outcomes. (7thed) Elsevier.
3. Brunner S. B., Suddarth D.S. The Lippincott Manual of Nursing practice J.B.Lippincott. Philadelphia.
4. Colmer R.M. (1995) Moroney's Surgery for Nurses (16thed) ELBS.
5. Shah N.S. (2003) A P I textbook of Medicine, The Association of Physicians of India Mumbai.
6. Satoskar R.S., Bhandarkar S.D. & Rege N.N. (2003) Pharmacology and Pharmacotherapeutics (19thed) Popular Prakashan, Mumbai.
7. Phipps W.J., Long C.B. & Wood N.F. (2001) Shaffer's Medical Surgical Nursing B.T.Publication Pvt. Ltd. New Delhi.
8. Haslett C., Chilvers E.R., Hunder J.A.A. & Boon, N.A. (1999) Davidson's Principles and Practice of Medicine (18thed) Churchill living stone. Edinburgh.
9. Walsh M. (2002) Watson's Clinical Nursing and Related Sciences (6thed) Bailliere Tindall Edinburgh.

PRACTICAL

Practical –270 hrs

Areas	Duration (inwks)	Objectives Posting	Skills to be developed	Assignments	Assessment Method
ENT	1	<ul style="list-style-type: none"> provide care to patients with ENT disorders counsel and educate patient and families 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Provide care to 2-3 assigned patients Nursing care plan-1 Observation reports of OPD Maintain drug book 	<ul style="list-style-type: none"> Assess each skill with checklist Assess performance with rating scale Evaluation of observation report of OPD Completion of activity record
Ophthalmology	1	<ul style="list-style-type: none"> Provide care to patients with Eye disorders Counsel and educate patient and families 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Provide care to 2-3 assigned patients Nursing care plan-1 Observation reports of OPD & Eye bank Maintain drug book 	<ul style="list-style-type: none"> Assess each skill with checklist Assess performance with rating scale Evaluation of observation report of OPD/Eye bank Completion of activity record
Neurology	2	<ul style="list-style-type: none"> provide care to patients with neurological disorders counsel and educate patient and families 	<ul style="list-style-type: none"> Perform Neurological Examination Use Glasgow coma scale Assist with diagnostic procedures Assist with therapeutic procedures Teach patient & families Participate in Rehabilitation program 	<ul style="list-style-type: none"> Provide care to assigned 2-3 patients with neurological disorders Case study/Case presentation-1 Maintains drug book Heath Teaching-1 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> • Provide care to patients with gynecological disorders • Counsel and educate patient and families 	<ul style="list-style-type: none"> • Assist with gynecological Examination • Assist with diagnostic procedures • Assist with therapeutic procedures • Teach patients families • Teaching self Breast Examination • Assist with PAP Smear collection. 	<ul style="list-style-type: none"> • Provide care to 2-3 assigned patients • Nursing care plan-1 • Maintain drug book 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Provide care to 1-2 assigned patients • Nursing care plan-1 • Observation report of Burns unit 	activity record
Oncology	1	<ul style="list-style-type: none"> • provide care to patients with cancer • counsel and educate patient and families 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Provide care to 2-3 assigned patients • Nursing care Plan –1 • Observation report of cancer unit 	<ul style="list-style-type: none"> • 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
			<ul style="list-style-type: none"> • Chemotherapy • Radiotherapy • Pain management • Stomalthrapy • Hormonal therapy • Immuno therapy • Gene therapy • Alternative therapy • Participate in palliative care • Counsel and teach patients families 		
Critical Care unit	2	<ul style="list-style-type: none"> • provide care to critically ill patients • counsel and families for grief and bereavement 	<ul style="list-style-type: none"> • 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/ trolley-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 	<ul style="list-style-type: none"> • Provide care to I assigned patient • Observation report of Critical care unit • Drugs book. 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> provide care to patients in emergency and disaster situation counsel patient and families for grief and bereavement 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Observation Report of Emergency Unit 	<ul style="list-style-type: none"> 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

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	<u>50</u>

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
I	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)	
<i>Planning and Organizing</i>	5 marks
• Preparation of tray	3
• Environment	1
• Preparation of patient	1
<i>Execution of Procedure</i>	7 marks
• Applies scientific principles	3
• Proficiency in skill	3
• Ensures sequential order	1
<i>Termination of procedure</i>	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

Unit	Learning Objectives	Content	Hrs : allocation.
II	<p>*Describe the normal growth & development of children at different ages</p> <p>*Identify the needs of children at different ages & provide parental guidance</p> <p>*Identify the nutritional needs of children at different ages & ways of meeting the needs.</p> <p>*Appreciate the role of play for normal & sick children.</p> <p>*Appreciate the preventive measures & strategies for children.</p>	<p>The healthy child</p> <ul style="list-style-type: none"> 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. 	<p>T 18 hrs.</p> <p>P 02 hrs</p> <p>1</p> <p>1</p> <p>6</p> <p>2</p> <p>1</p> <p>2</p> <p>2</p> <p>2</p> <p>1</p> <p>2</p>
III	<p>*Provide care to normal & high risk neonates.</p> <p>*Perform neonatal resuscitation.</p> <p>*Recognize & manage common neonatal problems.</p>	<p>Nursing care of a neonate.</p> <ul style="list-style-type: none"> 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. 	<p>T 12 hrs.</p> <p>P 03 hrs.</p> <p>4</p> <p>1</p> <p>4</p> <p>1</p> <p>1</p> <p>1</p> <p>2</p> <p>1</p>
IV	<p>*Explain the concept of IMNCI & other health strategies initiated by National population policy 2000.</p>	<p>Integrated management of neonatal & childhood illnesses (IMNCI).</p> <p>Health strategies: National population policy-</p> <ul style="list-style-type: none"> 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. 	<p>10 hrs.</p> <p>2</p> <p>2</p> <p>1</p> <p>3</p> <p>2</p>

Unit	Learning Objectives	Content	Hrs : allocation.
V	<p>*Provide nursing care in common childhood diseases.</p> <p>*Identify measures to prevent common childhood diseases including immunization.</p>	<p>Nursing management in common childhood diseases-</p> <ul style="list-style-type: none"> • 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, haemorrhage, burns & drowning. • Nursingcareof infant and children with HIV / AIDS 	<p>20 hrs.</p> <p>1</p> <p>2</p> <p>2</p> <p>3</p> <p>2</p> <p>3</p> <p>2</p> <p>1</p> <p>1</p> <p>1</p> <p>1</p> <p>1</p>
VI	<p>*Manage the child with behavioral & social problems</p>	<p>Management of behavioural & social Problems in children.</p> <ul style="list-style-type: none"> • 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. 	<p>10 hrs.</p> <p>4</p> <p>2</p> <p>2</p> <p>1</p> <p>1</p>

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. Parthasarathy et al. (2000) IAP Textbook of Paediatric Nsg. Jaypee bros., 2nd 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	<ul style="list-style-type: none"> • Provide nursing care to children with various medical disorders • Counsel and educate parents 	<ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> ➤ Malnutrition ➤ Oral rehydration therapy ➤ Feeding and weaning ➤ Immunization schedule ➤ Play therapy ➤ Specific disease conditions 	<ul style="list-style-type: none"> • Give care to three assigned pediatric patients • Nursing care plan- 1 • Case study /Presentation - 1 	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Recognize different pediatric conditions / malformations • Provide pre and post operative care to children with common pediatric surgical conditions/ malformation • Counsel and educate parents 	<ul style="list-style-type: none"> • Calculate,prepare and administer IV fluids • Do bowel wash • Care for ostomies: <ul style="list-style-type: none"> ➤ Colostomy irrigation ➤ Ureterostomy ➤ Gastrostomy ➤ Enterostomy • Urinary catheterisation and drainage • Feeding <ul style="list-style-type: none"> ➤ 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Perform assessment of children: Health, developmental and anthropometric • Perform immunization • Give health education/ nutritional education 	<ul style="list-style-type: none"> • Assessment of children <ul style="list-style-type: none"> ➤ Health assessment ➤ Developmental assessment ➤ Anthropometric assessment • Immunization • Health / Nutritional education 	Developmental study -1	<ul style="list-style-type: none"> • Assess clinical performance with rating scale • Completion of activity record.
Pediatric medicine and surgery ICU	1+1	<ul style="list-style-type: none"> • Provide Nursing care to critically ill children 	<ul style="list-style-type: none"> • 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.	<ul style="list-style-type: none"> • Assess clinical performance with rating scale • Completion of activity record • Evaluation of observation report.

EVALUATION

I. Internal assessment :

<u>Theory :</u>	Maximum marks 25	Marks
Midterm		50
Prefinal		75
<hr/>		
	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
	<hr/>
	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 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	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	<u>50</u>

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	<u>50</u>

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/t ime	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	<p>D) Planning and organization</p> <ul style="list-style-type: none"> 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 <p>II) Presentation:</p> <ul style="list-style-type: none"> a) Interesting b) Clear Audible c) Adequate explanation d) Effective use of A.V. Aids e) Group Involvement f) Time Limit <p>III) Personal qualities:</p> <ul style="list-style-type: none"> a) Self confidence b) Personal appearance c) Language d) Mannerism e) Self awareness of strong & weak points <p>IV) Feed back:</p> <ul style="list-style-type: none"> a) Recapitulation b) Effectiveness c) Group response <p>V) Submits assignment on time</p>						

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

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

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 :
 Jaundice :
 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
- Environment
- Preparation of patient

3

1

1

Execution of Procedure

7 marks

- Applies scientific principles
- Proficiency in skill
- Ensures sequential order

3

3

1

Termination of procedure

3marks

- Makes patient comfortable
- Reports & Records
- After care of articles

1

1

1

Viva (10 Marks)

10 marks

- Knowledge about common pediatric medical surgical conditions
- Preparation of various diagnostic procedures
- Instruments and articles
- Growth and Development

3

2

2

3

External Examiner

25 Marks

Nursing Process (15 Marks)

15 marks

- Assessment
- Nursing Diagnosis
- Goal
- Outcome criteria
- Nursing intervention
- Rationale
- Evaluation
- Nurses notes

3

2

1

1

3

2

1

2

Viva (10 Marks)

10 marks

- National Health Programs for child care including IMNSI
- Behavioral and social problem in children
- Drugs
- Nursing care of neonates

2

3

3

2

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	<ul style="list-style-type: none"> • 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 	<p>Introduction</p> <ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Lecture Discussion 	<ul style="list-style-type: none"> • Objective type • Short answer • Assessment of the field visit reports

2	5	<ul style="list-style-type: none"> • 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. 	<p>Principles and Concepts of Mental Health Nursing</p> <ul style="list-style-type: none"> • 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 : <ol style="list-style-type: none"> 1. Existential Model. 2. Psycho-analytical models. 3. Behavioral; models. 4. Interpersonal model. 	<ul style="list-style-type: none"> • Lecture discussion • Explain using Charts. • Review of personality development. 	<ul style="list-style-type: none"> • Essay type • Short answer. • Objective type
3	8	<ul style="list-style-type: none"> • Describe nature, purpose and process of assessment of mental health status 	<p>Assessment of mental health status.</p> <ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Lecture Discussion • Demonstration • Practice session • Clinical practice 	<ul style="list-style-type: none"> • Short answer • Objective type • Assessment of skills with check list.
4	6	<ul style="list-style-type: none"> • Identify therapeutic communication techniques • Describe therapeutic relationship. 	<p>Therapeutic communication and nurse-patient relationship</p> <ul style="list-style-type: none"> • Therapeutic communication: types, techniques, characteristics 	<ul style="list-style-type: none"> • Lecture discussion • Demonstration • Role play • Process 	<ul style="list-style-type: none"> • Short answer • Objective type

		<ul style="list-style-type: none"> Describe therapeutic impasse and its intervention. 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Explain treatment modalities and therapies used in mental disorders and role of the nurse. 	<p>Treatment modalities and therapies used in mental disorders.</p> <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Lecture discussion Demonstration Group work. Practice session Clinical practice. 	<ul style="list-style-type: none"> Essay type Short answers Objective type
6	5	<ul style="list-style-type: none"> Describe the etiology, psychopathology clinical manifestations, diagnostic criteria and management of patients with Schizophrenia, and other psychotic disorders Geriatric considerations Follow-up and home care and rehabilitation. 	<ul style="list-style-type: none"> Nursing management of patient with Schizophrenia, and other psychotic disorders Classification : ICD Etiology, psychopathology, types, clinical manifestations, diagnosis Nursing Assessment-History, Physical and mental assessment. Treatment modalities and nursing management of patients with Schizophrenia and other psychotic disorders Geriatric considerations 	<ul style="list-style-type: none"> Lecture discussion Case discussion Case presentation Clinical practice 	<ul style="list-style-type: none"> Essay type Short answers Assessment of patient management problems

			<ul style="list-style-type: none"> Follow – up and home care and rehabilitation 		
7	5	<ul style="list-style-type: none"> Describe the etiology, psychopathology clinical manifestations, diagnostic criteria and management of patients with mood disorders. 	<p>Nursing management of patient with mood disorders</p> <ul style="list-style-type: none"> Mood disorders : Bipolar affective disorder, Mania depression and dysthymia 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 	<ul style="list-style-type: none"> Lecture discussion Case discussion Case presentation Clinical practice 	<ul style="list-style-type: none"> Essay type Short answers Assessment of patient management problems
8	8	<ul style="list-style-type: none"> Describe the etiology, psychopathology, clinical manifestations, diagnostic criteria and management of patients with neurotic, stress related and somatization disorders. 	<p>Nursing management of patient with neurotic, stress related and somatization disorders</p> <ul style="list-style-type: none"> Anxiety disorder, Phobias, Dissociation and Conversion disorder, Obsessive compulsive disorder, somatoform disorders, Post traumatic stress disorder. Etiology, psychopathology, clinical manifestations, diagnosis Nursing Assessment-History, Physical and mental assessment Treatment modalities and nursing management of patients with neurotic, stress related and somatization disorders. Geriatric considerations Follow-up and home care and rehabilitation 	<ul style="list-style-type: none"> Lecture discussion Case discussion Case presentation Clinical practice 	<ul style="list-style-type: none"> Essay type Short answers Assessment of patient management problems

9	5	<ul style="list-style-type: none"> Describe the etiology, psychopathology, clinical manifestations, diagnostic criteria and management of patients with substance use disorders 	<p>Nursing management of patient with substance use disorders</p> <ul style="list-style-type: none"> 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. 	<ul style="list-style-type: none"> Lecture discussion Case discussion Case presentation Clinical practice 	<ul style="list-style-type: none"> Essay type Short answers Assessment of patient management problems
10	4	<ul style="list-style-type: none"> Describe the etiology, psychopathology, clinical manifestations, diagnostic criteria and management of patients with personality, Sexual and Eating disorders 	<p>Nursing management of patient with Personality, Sexual and Eating disorders</p> <ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Lecture discussion Case discussion Case presentation Clinical practice 	<ul style="list-style-type: none"> Essay type Short answers Assessment of patient management problems
11	6	<ul style="list-style-type: none"> Describe the etiology, psychopathology, clinical manifestations, diagnostic criteria and management of childhood and adolescent including mental deficiency 	<p>Nursing management of childhood and adolescent disorders including mental deficiency</p> <ul style="list-style-type: none"> Classification Etiology, psychopathology, characteristics, diagnosis Nursing Assessment- History, Physical, mental and IQ assessment Treatment modalities and 	<ul style="list-style-type: none"> Lecture discussion Case discussion Case presentation Clinical practice 	<ul style="list-style-type: none"> Essay type Short answers Assessment of patient management problems

			<p>nursing management of childhood disorders including mental deficiency</p> <ul style="list-style-type: none"> • Follow-up and home care and rehabilitation 		
12	5	<ul style="list-style-type: none"> • Describe the etiology psycho-pathology, clinical manifestations, diagnostic criteria and management of organic brain disorders 	<p>Nursing management of organic brain disorders</p> <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Lecture discussion • Case discussion • Care presentation • Clinical practice 	<ul style="list-style-type: none"> • Essay type • Short answers • Assessment of patient management problems
13	6	<ul style="list-style-type: none"> • Identify psychiatric emergencies and carry out crisis intervention 	<p>Psychiatric emergencies and crisis intervention</p> <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Lecture discussion • Demonstration • Practice session • Clinical practice 	<ul style="list-style-type: none"> • Short answers • Objective type
14	4	<ul style="list-style-type: none"> • Explain legal aspects applied in mental health settings and role of the nurse 	<p>Legal issues in Mental Health Nursing</p> <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Lecture discussion • Case discussion 	<ul style="list-style-type: none"> • Short answers • Objective type

			<ul style="list-style-type: none"> • Admission and discharge procedures • Role and responsibilities of nurse 		
15	4	<ul style="list-style-type: none"> • Describe the model of preventive psychiatry • Describe Community Mental health services and role of the nurse 	Community Mental Health Nursing <ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Lecture discussion • Clinical/field practice • Field visits to mental health service agencies 	<ul style="list-style-type: none"> • 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, , Elsevir, India Pvt.Ltd. New Delhi 2005
2. Michael Gelder, Richard Mayou, Philip Cowen, Shorter oxford text book of psychiatry, Oxford medical publication, 4 the ed. 2001.
3. M.S. Bhatia, A concised text Book of Psychiatric Nursing, CBS publishers and distributors, Delhi 2nd ed. 1999.
4. M.S. Bhatia, Essentials of Psychiatry, CBS publishers and distributors, Delhi
5. Mary C Townsend. "Psychiatric Mental Health Nursing". Concept of care, 4th edition. F.A.Davis Co. Philadelphia 2003.
6. Bimla Kapoor, Psychiatric nursing, Vol. I & II Kumar publishing house Delhi, 2001
7. Niraj Ahuja, A short textbook of pstchiatry, Jaypee brothers,new delhi, 2002.
8. The ICD10, Classification of mental and behavioural disorders, WHO, A.I.T.B.S. publishers, Delhi,2002
9. De Souza Alan, De Souza Dhanlaxmi, De Souza A, "National series – Child psychiatry" 1st ed, Mumbai, The National Book Depot, 2004

10. Patricia, Kennedy, Ballard, "Psychiatric Nursing Integration of Theory and Practice", USA, Mc Graw Hill 1999.
11. Kathernic M. Fort in ash, Psychiatric Nursing Care plans, Mossby Year book. Toronto
12. Sheila M. Sparks, Cynthia M. 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	Durati on (in week)	Objectives	Skills	Assignments	Assessment Methods
Psychiatric OPD	1	<ul style="list-style-type: none"> Assess patients with mental health problems Observe and assist in therapies Counsel and educate patient, and families 	<ul style="list-style-type: none"> History taking Perform mental status examination (MSE) Assist in Psychometric assessment Perform Neurological examination Observe and assist in therapies Teach patients and family members 	<ul style="list-style-type: none"> History taking and Mental status examination-2 Health education-1 Observation report of OPD 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Assessment of children with various mental health problems Counsel and educate children, families and significant others 	<ul style="list-style-type: none"> History taking Assist in psychometric assessment Observe and assist in various therapies Teach family and significant others 	<ul style="list-style-type: none"> Case work – 1 Observation report of different therapies -1 	<ul style="list-style-type: none"> Assess performance with rating scale Assess each skill with checklist Evaluation of the observation report
Inpatient ward	6	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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) 	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Conduct case work • Identify individuals with mental health problems • Assists in mental health camps and clinics • Counsel and Teach family members, patients and community 	<ul style="list-style-type: none"> • Case work – 1 • Observation report on field visits 	<ul style="list-style-type: none"> • Assess performance with rating scale • Evaluation of case work and observation report • Completion of activity record

Evaluation

Evaluation

Internal assessment

Theory

Midterm

50

Prefinal

75

Maximum marks 25

Total 125

Practical

Maximum marks 50

Nursing care plan

2 x 25

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
- Reability
- 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 (mania)	1. Attention seeking
Trustful (mania)	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
- Ill health or Somatic function
- Guilt
- Nihilism
- Poverty
- Love or erotomania
- Jealousy or infidelity

10. Judgement:-

According to the situation

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

11. Insight:-

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

Duration

12. Orientation:-

- Oriented to – time
- Place
- Person

13. Memory:-

- Fairs / Festival
- Surrounding environment
- PM of country
- CM of state

15. Attention:-

- Normal
- Moderate
- Poor attention
- Any other

16. Concentration:-

- Good
- Fair
- Poor
- Any other

17. Special points:-

- Bowel & bladder habits
- Appetite
- Sleep
- Libido
- Any other

Instructions for filling the MSE format:

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

EVALUATION CRITERIA FOR M.S.E.

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

EVALUATION FORMAT PROCESS RECORDING

1. Identification data of the patient.
2. Presenting Complaints
 - a. According to patient
 - b. According to relative
3. History of presenting complaints
4. Aims and objectives of interview
 - a. Patients point of view
 - b. Students point of view

5. 1st Interview

Date

Time

Duration

Specific objective

Sr.No.	Participants	Conversation	Inference	Technique used

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

Evaluation format of process recording

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

Total marks 10

Observation report of various therapies

ECT CARE STUDY

Select a patient who has to get electro convulsive therapy

Preparation of articles for ECT

Preparation of physical set up

- Waiting room
- ECT room
- Recovery room

Preparation of patient prior to ECT

Helping the patient to undergo ECT

Care of patient after ECT

Recording of care of patient after ECT

ECT Chart –

Name –

Diagnosis –

Age –

Sex –

Bed No. –

TPR/BP –

Time of ECT –

Patient received back at –

Time	Pulse	Respiration	Blood pressure	Level of Consciousness	Remarks

OBSERVATION REPORT – GROUP THERAPY

(Can be written in the form of report)

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

Evaluation criteria for group therapy

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

Total 25

CLINICAL POSTING EVALUATION

Name of the student : _____

Year : _____

Area of clinical experience : _____

Duration of posting in weeks : _____

Name of the supervisor : _____

Total Marks: - 100

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

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

Remarks of supervision in terms of professional strength and weakness

Sign of the student

Sign of the Supervisor

DRUG BOOK / STUDY

Generic Name	Dosage	Form/Strength Inj/Tab/Syrup	Action of Drug	Indication	Contraindicati on	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

NURSING RESEARCH AND STATISTICS

Total Hours : Theory – 45 Hour

Practical – 30 Hours per Week (Project work to be carried out during internship)

Course Description:

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

Total marks – 100

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

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

Unit	Time (Hrs)	Learning Objectives	Content	Training Learning Activities	Assessment Methods
I	4	<ul style="list-style-type: none"> • Describe the concept of research, terms, need and areas of research in nursing. • Explain the steps of research process. 	Research and research process <ul style="list-style-type: none"> • Introduction and need for nursing research. • Definition of Research & nursing research. • Steps of scientific method. • Characteristics of research. • Steps of research process -overview 	<ul style="list-style-type: none"> • Lecture Discussion. • Narrate steps of research process followed from examples of published studies. 	<ul style="list-style-type: none"> • Short answer • Objective type

Unit	Time (Hrs)	Learning Objectives	Content	Training Learning Activities	Assessment Methods
II	3	<ul style="list-style-type: none"> Identify and state the research problem and objectives 	Research Problem/Question <ul style="list-style-type: none"> Identification of problem area. & Problem statement. Stating objectives of the research problem. 	<ul style="list-style-type: none"> Lecture Discussion. Exercise on writing statement of problem and objectives <i>Each student selects a research problem</i> 	<ul style="list-style-type: none"> Short answer. Objective type
III	3	<ul style="list-style-type: none"> Review the related literature 	Review of Literature <ul style="list-style-type: none"> Steps in review of literature Identification of Publication Keeping a record Writing the review of literature Writing of Bibliography 	<ul style="list-style-type: none"> Lecture Discussion Exercise on reviewing one research report/article for a selected research problem. Prepare annotated bibliography (5) 	<ul style="list-style-type: none"> Short answer Objective type
IV	4	<ul style="list-style-type: none"> Describe the research approaches and designs 	Research approaches and designs <ul style="list-style-type: none"> Historical, survey and experimental Qualitative and Quantitative designs 	<ul style="list-style-type: none"> Lecture Discussion Explain types of research approaches used from examples of published and unpublished research studies with rationale. 	<ul style="list-style-type: none"> Short answer Objective type
V	8	<ul style="list-style-type: none"> Explain the sampling process Describe the methods of data collection Developing and standardizing an instrument 	Sampling and data collection <ul style="list-style-type: none"> Definition of Population, Sample, Sampling criteria, factors influencing sampling process, types of sampling techniques. Data collection Methods and instruments <ol style="list-style-type: none"> Questionnaire, interview, records & reports and other techniques Validity & Reliability of the instrument Pilot Study 	<ul style="list-style-type: none"> Lecture Discussion <i>Prepare the tool in respect to the selected research problem.</i> 	<ul style="list-style-type: none"> Short answer Objective type

Unit	Time (Hrs)	Learning Objectives	Content	Training Learning Activities	Assessment Methods
VI	15	<ul style="list-style-type: none"> Explain the use of statistics, scales of measurement and graphical presentation of data Describe the measures of central tendency and variability and methods of correlation 	Introduction to statistics <ul style="list-style-type: none"> Definition, use of statistics, scales of measurement Frequency distribution and graphical presentation of data Mean, Median, Mode, standard deviation Normal probability and tests of significance Coefficient of correlation Inferential statistics and types Statistical packages and its application 	<ul style="list-style-type: none"> Lecture, discussion Practice on graphical presentations Practice on computation of measures of central tendency, variability & correlation 	<ul style="list-style-type: none"> Short answer Objective type
VII	4	<ul style="list-style-type: none"> Analyze, interpret and summarize the research data 	Analysis of Data <ul style="list-style-type: none"> Compilation, Tabulation Classification, summarization, presentation, interpretation of data 	<ul style="list-style-type: none"> Lecture, discussion Preparation of sample tables 	<ul style="list-style-type: none"> Short answer Objective type
VIII	4	<ul style="list-style-type: none"> Communicate and utilize the research findings. 	Communication and utilization of Research <ul style="list-style-type: none"> Communication of research findings <ul style="list-style-type: none"> - Verbal report - Writing research report - Writing scientific article/ paper- Critical review of published research & Utilization of research findings 	<ul style="list-style-type: none"> Lecture, discussion Writing group research project & presentation 	<ul style="list-style-type: none"> Short answer Objective type Assessment of group research Project

Research Project work to be carried out during internship

References

1. Polit , D.F. & Beck CT, Nursing Research, Principles and Methods,7th ed, Lippincott Williams & Wilkins,Philadelphia, 2003.
2. Polit Dennis and Hunglar B P, Nursing research principles and methods, 6th edition Lippincott, Philadephia, 1999.
3. Laura A.Talbot, Principles and practice of nursing research, Mosby St. Louis 1995.
4. DorothyYB & Marie TH ,Fundamentals of research in Nursing, 3rd ed,Jones & Bartlett Publishers,Boston,2003.

5. Rao TB, Methods in Medical Research, 1st ed, Radha Rani Publishers, Guntur AP, 2002.
6. Smith, P ResearchMindedness for Practice> An interactive approach for nursing and health care, Churchill livingstone, New York, 1997
7. American Psychological Association publication manual. 2001.
8. Mahajan Methods in Bio statistics.
9. Trece E.W. & Treece JW: Elements of Research in Nursing, 3rd ed The CV Mosby CompanySt, Louis 1986_

Evaluation

Internal assessment: 100 Marks (College level qualifying exam to appear in 4th year University Exam.)

a) Theory: Maximum marks 50

Midterm	25
Prefinal	25

Total marks 50

b) Project: Maximum marks 50

Assignment: Group project	50
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Total marks 50

INTRODUCTION TO NURSING RESEARCH AND STATISTICS

PRACTICAL EXPERIENCE GUIDELINE AND EVALUATION FOR

4th BSc.Nursing

NURSING RESEARCH: "PROJECT"

Time Allotted Practical- 45 hrs.

Guideline for Research Project

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

II Objectives: Preparing nursing research proposal

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

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

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

2) Organizing for Review of Literature

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

- 3) Research Methodology: To determine logical structure & methodology for research project
 - a) Decide and state approach of study i.e. experimental or non-experimental.
 - b) To define/find out variables to observe effects on decided items & procedure (optional)
 - c) To prepare simple tool or questionnaire or observational check list to collect data.
 - d) To determined sample and sampling method.
 - i) mode of selection ii) Criterias iii) Size of sample
 - iv) Plan when, where and how data will be collected
 - e) To test validity of constructed tool (To check content in tool in relation to stated objectives) with experts / teachers opinion.
 - t) To check reliability by implementing tool before pilot study (10% of sample size)
 - g) To conduct pilot study by using constructed tool for 10% selected sample *size*.
- 4) Data Collection: To implement prepared tool
 - a) To implement constructed tool
 - b) Decide location
 - c) Time
 - d) Write additional information in separate exercise book to support inferences and interpretation.
- 5) Data analysis and processing presentation
 - a) Use appropriate method of statistical analysis i.e. frequency and percentage.
 - b) Use clear frequency tables, appropriate tables, graphs and figures.
 - c) Interpretation of data:
 - i) In relation to objectives
 - ii) Hypothesis (Optional)
 - iii) Variable of study or project (Optional)
 - iv) Writing concise report
- 6) Writing Research report
 - a) Aims:
 - i) To organize materials to write project report
 - ii) To make comprehensive full factual information
 - iii) To use appropriate language and style of writing
 - iv) To make authoritative documentation by checking footnotes, references & bibliography
 - v) To use computers.
 - b) Points to remember
 - a) Develop thinking to write research report.
 - b) Divide narration of nursing research report.
 - c) Use present tense and active voice
 - d) Minimize use of technical language
 - f) Use simple, straightforward, clear, concise language
 - g) Use visual aids in form of table, graphs, figures
 - h) Treat data confidentially
 - i) Review, rewrite if necessary

EVALUATION CRITERIA FOR PROJECT REPORT

Maximum Marks: 100

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

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

Remarks by the Supervisor / Guide

Date:

Signature

Signature of the students Date