**CLINICAL SPECIALITY -I**

# MENTAL HEALTH (PSYCHIATRIC) NURSING

Placement :1st year

Hours of Instruction
Theory 150 hours
Practical 650 hours
Total: 800 hours

**Course Description**

The course is designed to assist students in developing expertise and in depth understanding in the field of Psychiatric nursing. It will help students to appreciate the clients as a holistic individual and develop skill to function psychiatric nurse specialist. It will further enable the student to function as educator, manager, and researcher in the field of psychiatric nursing

**Objectives**

At the end of the course the students will be able to:

1. Appreciate the trends and issues in the field of psychiatric and psychiatric nursing.
2. Explain the dynamics of personality development and human behaviour.
3. Describe the concepts of psychobiology in mental disorders and its implications for psychiatric nursing
4. Demonstrate therapeutic communications skills in all interactions
5. Demonstrate the role of psychiatric nurse practitioner in various therapeutic modalities
6. Establish and maintain therapeutic relationship with individual and groups
7. Uses assertive technique in personal and professional actions
8. Promotes self-esteem of clients , others and self
9. Apply the nursing process approach in caring for patients with mental disorders
10. Describe the psychopharmacological agents ,their effects and nurses role
11. Recognize the role of psychiatric nurse practitioner and as a member of the psychiatric and mental health team
12. Describe various types of alternative system of medicines used in psychiatric settings
13. Incorporate evidence based nursing practice and identify the areas of research in the field of psychiatric nursing

| Units | Hours | Contents |
|---|---|---|
| I | 15 | **Mental health and mental illness**<br>Historical perspectives<br>Trends ,issues and magnitude<br>Contemporary practices<br>Mental health laws/acts<br>National mental health program –National mental health authority ,state mental health authority<br>Human rights of mentally ill<br>Mental Health/ Mental Illness Continuum<br>Classification of mental illnesses –ICD ,DSM<br>Multi-Disciplinary team and role of nurse<br><br>Role of psychiatric nurse –extended and expanded |
| II | 10 | **Concepts of psychobiology**<br>The nervous system :<br>An anatomical review<br>The brain and limbic system<br>Nerve tissue<br>Autonomic nervous system<br>Neurotransmitters<br>Neuro endocrinology<br>Pituitary, Thyroid Gland<br>Circadian Rhythms<br>Gentics<br>Neuro psychiatric disorders<br>Psychoimmunology<br>Normal Immune response<br>Implications for psychiatric illness<br>Implications for Nursing |
| III | 10 | **Theories of personality development and relevance to nursing practice**<br>Psychoanalytic Theory-Freud's<br>Interpersonal Theory-Sullivan's<br>Theory of Psychosocial Development-Erikson's<br>Theory of object relations<br>Cognitive Development Theory<br>Theory of Moral Development<br>A Nursing Model-Hildegard E. Peplau |
| IV | 5 | **Stress and its management**<br>An introduction to the concepts of stress<br>Psychological Adaptation to stress<br>Stress as a Biological Response<br>Stress as an environmental event<br>Stress as transaction between the individual and environment<br>Stress management |

| Units | Hours | Contents |
|---|---|---|
| V | 10 | **Therapeutic communication and interpersonal relationship**<br>Review communication process ,factors affecting communication<br>Communication with individuals and in groups<br>Techniques of therapeutic communication-touch therapy<br>Barrier of communication with specific reference to psychopathology<br>Therapeutic attitudes<br>Dynamics of a therapeutic Nurse-client relationship;<br>Therapeutic use of self Gaining self-awareness<br>Therapeutic nurse-patient relationship in phases; Conditions essential to development of a therapeutic relationship<br>Therapeutic impasse and its management |
| VI | 10 | **Assertive training**<br>Assertive Communication<br>Basic Human rights<br>Response Patterns<br>(Nonassertive Behavior<br>Assertive Behavior<br>Aggressive Behavior<br>Passive-Aggressive Behavior)<br>Behavioral Components of Assertive Behavior<br>Techniques that promote Assertive Behavior<br>Thought-Stopping Techniques Method<br><br>Role of The Nurse |
| VII | 10 | **Promoting Self-Esteem**<br>Components of Self-Concept<br>The Development of Self-Esteem<br>The Manifestations of Low-Self-Esteem<br>Boundaries<br><br>Role of The Nurse |
| VIII | 10 | **The nursing process in psychiatric/mental health nursing**<br>Mental health assessment-History taking ,mental status examination<br>Physical and neurological examination<br>Psychometric assessment<br>Investigations, Diagnosis and Differential diagonosis<br>Interpretation of investigations<br>Nurse's Role<br>Nursing case management<br>Critical pathways of care<br><br>Documentation<br>Problem-oriented recording<br>Focus charting<br>The PIE method |

| Units | Hours | Contents |
|---|---|---|
| **IX** | **35** | **Psycho social therapies**<br>Individual therapy<br>Behavioral Therapy –Relaxation therapy, cognitive therapy, positive-negative reinforcemen, bio-feedback, guided imaginary<br>group Therapy<br>Family Therapy/ Marital therapy<br>Milieu therapy<br>The Therapeutic Community<br>Occupational therapy<br>Recreational therapy<br>Play therapy<br>Music therapy |
| X | **10** | **Psychopharmacology**<br>Historical Perspectives<br>Role of a Nurse in Psychopharmacological Therapy<br>Antianxiety Agents<br>Antidepressant Agents<br>Mood stabilizers<br>Antipsychotics<br>Sedative-Hypnotics<br>Central Nervous System Stimulants<br>Future developments |
| XI | **5** | **Electroconvulsive Therapy**<br>Historical Perspectives<br>Indications<br>Contraindications<br>Mechanisms of Actions<br>Side Effects<br>Risks Associated with Electroconvulsive Therapy<br>The Role of the Nurse in Electroconvulsive Therapy |
| **XII** | **20** | **Alternative systems of medicine in mental health**<br>Types of Therapies<br>Herbal Medicine<br>Unani<br>Siddha<br>Homeopathic<br>Acupressure and Acupuncture<br>Diet and Nutrition<br>Chiropractic Medicine<br>Therapeutic Touch and Massage<br>Yoga<br>Pet Therapy |

## PRACTICAL

Total = 650 Hours
1 Week = 30 Hours

| SN | Area of positioning | No. of Week | Total Hours | Assignment HT | MSE | PRS RE | Psych Ass | Per Ass | FT |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Acute Psychiatric Ward | 4 | 120 hrs | 1 | 1 | 1 | - | - | - |
| 2 | Chronic Psychiatric Ward | 4 | 120 hrs | 2 | 2 | 1 | - | - | - |
| 3 | Psychiatric Emergency Unit | 2 | 60 hrs | 1 | 1 | - | - | - | - |
| 4 | O.P.D. | 2 | 60 hrs | - | - | - | 1 | 1 | - |
| 5 | Family Psychiatric Unit | 2 | 60 hrs | - | - | - | - | - | 1 |
| 6 | Community Mental Health Unit | 4 | 120 hrs | Survey report -1 | | | | | |
| 7 | Rehabilitation/Occupational Therapy Unit/Half way home/Day care centre | 4 | 110 hrs | Study of a Case with rehabilitation point of view. | | | | | |
| | Total | 22 Weeks | 650 hrs | | | | | | |

Abbreviation : HT – History Taking, MSE- Mental Health Assessment,
PRS RE - Process Recording, Psych Ass -Psychometric assessment,
Pers Ass – Personality assessment, FT – Family Therapy

**Student Activities**

- History taking
- Mental health assessment
- Psychometric assessment
- Personality assessment
- Process recording
- Therapies- Group Therapy
- Family Therapy
- Psychotherapy
- Milieu Therapy
- The Therapeutic Community
- Occupational Therapy
- Recreational Therapy
- Play Therapy
- Music Therapy
- Pet therapy
- Counselling, ECT , EEG, Case Studies, Case presentation,
- Project work
- Socio and psycho drama
- Field visits – Deaddiction centre
  School for Mentally Challenged children
  Occupational therapy units, Half way home/Day care centre
  Ayurveda/ Unani/ Sidha/ Homeopathic – Colleges
  Acupressure& Acupuncture, Yoga

*CLINICAL ASSIGNMENTS*
*MENTAL HEALTH NURSING*

**EVALUATION**

I Internal Assessment (theory) Periodical Exams - 2 **Maximum Marks : 25**
(Practical) **Maximum Marks : 50**

**Practicum:**

| | |
|---|---|
| 1. History taking : | 50 marks each |
| 2. MSE: | 50 marks each |
| 3. Process Recording: | 25 marks each |
| 4. Clinical performance evaluation Marks: | 100 |
| 5. Case Study: Marks: | 50 |
| 6. Case Presentation: | Marks: 50 |
| 7. Drugs study | Marks : 50 |
| 9. Health Education: | Marks: 25 |

**Practical Exam :**

| | |
|---|---|
| 1. Midterm Exam | Marks 50 |
| 2. Prelims Exam | Marks 100 |

**External Assessment** - University Exam :Theory Marks Marks 75
Practical Marks Marks 100

**MENTAL HEALTH & PSYCHIATRIC NURSING**
**CLINICAL EXPERIENCE GUIDELINES & EVALUATION FORMATS**

## *I) PSYCHIATRIC NURSING HISTORY COLLECTION FORMAT*

c) **Demographic data:**

- Name
- Age
- Sex
- Marital Status
- Religion
- Occupation
- Socio-economic status
- Address
- Informant
- Information (Relevant or not) adequate or not

**II. Chief Complaints/presenting complaints (list with duration)**

- In patient's own words and in informants own words.

E.g. : - Sleeplessness x 3 weeks
- Loss of appetite & hearing voices x2 weeks
- talking to self

**III. Present psychiatric history /nature of the current episode**

- Onset - Acute (within a few hours)
- Sub acute (within a few days)
- Gradual (within a few weeks)
- Duration – days, weeks or months
- Course – continuous/episodic
- Intensity / same / increasing or decreasing
- Precipitating factors – yes/no (if yes explain)
- History of current episode (explain in detail regarding the presenting complaints)
- Associated disturbances – includes present medical problems (E.g. Disturbance in sleep, appetite, IPR & social functioning, occupation etc).

**IV. Past Psychiatric history:**

- Number of episode with onset and course
- Complete or incomplete remission
- Duration of each episode
- Treatment details and its side effects if any
- Treatment outcomes
- Details if any precipitating factors if present

**V.** a) Past Medical History

b) Past Surgical History

c) Obstetrical History (Female)

Cont..

**VI. Family History:**

- Family genogram – 5 generations include only grandparents. But if there is a family history include the particular generation

**VII. Personal History:**

- Pre-natal history - Maternal infections
- Exposure to radiation etc.
- Check ups
- Any complications
- Natal history - Type of delivery
- Any complications
- Breath and cried at birth
- Neonatal infections
- Mile stones: Normal or delayed

Behavior during childhood

- Excessive temper tantrums
- Feeding habit
- Neurotic symptoms
- Pica
- Habit disorders
- Excretory disorders etc.

Illness during childhood

- Look specifically for CNS infections
- Epilepsy
- Neurotic disorders
- Malnutrition

Schooling

- Age of going to School
- Performance in the School
- Relationship with peers
- Relationship with teachers

(Specifically look for learning disability and attention deficit)

- Look for conduct disorders E.g. Truancy, stealing

- Occupational history

- Age of joining job
- Relationship with superiors, subordinates & colleagues
- Any changes in the job – if any give details
- Reasons for changing jobs
- Frequent absenteeism

- Sexual history
- Age of attaining puberty (female-menstrual cycles are regular)
- Source and extent of knowledge about sex, any exposures
**- Marital status** : with genogram.

**VIII. Pre morbid personality :** (Personality of a patient consists of thosehabitual attitudes and patterns of behavior which characterize an individual. Personality sometimes changes after the onset of an illness. Get a description ofthe personality before the onset of the illness. Aim to build up a picture of the individual, not a type. Enquire with respect to the following areas.)

**1. Attitude to others in social, family and sexual relationship:** Ability to trust other, make and sustain relationship, anxious or secure, leader or follower, participation, responsibility, capacity to make decision, dominant or submissive, friendly or emotionally cold, etc. Difficulty in role taking – gender, sexual, familial.

**2. Attitudes to self:** Egocentric, selfish, indulgent, dramatizing, critical, depreciatory, over concerned, self conscious, satisfaction or dissatisfaction with work. Attitudes towards health and bodily functions. Attitudes to past achievements and failure, and to the future.

**3. Moral and religious attitudes and standards:** Evidence of rigidity or compliance, permissiveness or over conscientiousness, conformity, or rebellion. Enquire specifically about religious beliefs. Excessive religiosity

**4. Mood:** Enquire about stability of mood, mood swings, whether anxious, irritable, worrying or tense. Whether lively or gloomy. Ability to express and control feelings of anger, anxiety, or depression.

**5. Leisure activities and hobbies:** Interest in reading, play, music, movies etc. Enquire about creative ability. Whether leisure time is spent alone or with friends. Is the circle of friends large or small?

**6. Fantasy life:** Enquire about content of day dreams and dreams. Amount of time spent in day dreaming.

**7. Reaction pattern to stress:** Ability to tolerate frustrations, losses, disappointments, and circumstances arousing anger, anxiety or depression. Evidence for the excessive use of particular defense mechanisms such as denial, rationalization, projection, etc.

**8. Habits:** Eating, sleeping and excretory functions.

## IX. Summary& Clinical Diagnosis

### EVALUATION CRITERIA FOR PSYCHIATRIC CASE HISTORY TAKING

(Maximum Marks : 50)

| SN | Criteria | MarksAllotted | MarksObtained |
|---|---|---|---|
| 1 | Format | 03 | |
| 2 | Presenting Complaints | 05 | |
| 3 | Organization of history of present illness | 10 | |
| 4 | Past history of illness | 05 | |
| 5 | Family history of illness | 04 | |
| 6 | Personal history | 05 | |
| 7 | Pre-morbid personality | 05 | |
| 8 | Physical Examination | 08 | |
| 9 | Summary & Clinical Diagnosis | 05 | |
| | | **Total 50** | |

*II) MENTAL STATUS EXAMINATION (MSE) FORMAT:*

**I. General appearance and behavior (GAAB):**

a) Facial expression (E.g. Anxiety, pleasure, confidence, blunted, pleasant)
b) Posture (stooped, stiff, guarded, normal)
c) Mannerisms (stereotype, negativism, tics, normal)
d) Eye to eye contact (maintained or not)
e) Rapport (built easily or not built or built with difficulty)
f) Consciousness (conscious or drowsy or unconscious)
g) Behavior (includes social behavior, E.g. Overfriendly, disinherited, preoccupied, aggressive, normal)
h) Dressing and grooming – well dressed/ appropriate/ inappropriate (to season and situation)/ neat and tidy/ dirty.
i) Physical features:- look older/ younger than his or her age/ under weight/ over weight/ physical deformity.

**II. PsychomotorActivity:**

(Increased/decreased/ Compulsive/echopraxia/ Stereotypy/ negativism/ automatic obedience)

**III. Speech:** One sample of speech (verbatim in 2 or 3 sentences)

a) Coherence-coherent/ incoherent
b) Relevance (answer the questions appropriately) – relevant / irrelevant.
c) Volume (soft, loud or normal)
d) Tone (high pitch, low pitch, or normal/ monotonous)
e) Manner – Excessive formal / relaxed/ inappropriately familiar.
f) Reaction time (time taken to answer the question) – increased, decreased or normal

**IV. Thought:**

a) Form of thought/ formal thought disorder – not understandable / normal/ circumstantiality/ tangentiality/ neologism/ word salad/ preservation/ ambivalence).
b) Stream of thought/ flow of thought- pressure of speech/ flight of ideas/ thought retardation/ mutism/ aphonia/ thought block/ Clang association.)
c) Content of thought
i) Delusions- specify type and give example- Persecutory/ delusion of reference/ delusions of influence or passivity/ hypochondracal delusions/ delusions of grandeur/ nihilistic- Derealization/ depersonalization/ delusions of infidelity.
ii) Obsession
iii) Phobia
iv) preoccupation
v) Fantasy – Creative / day dreaming.

**V. Mood (subjective) and Affect (objective):**

a) Appropriate/ inappropriate(Relevance to situation and thought congruent.
b) Pleasurable affect- Euphoria / Elation / Exaltation/ Ecstasy
c) Unpleasurable affect- Grief/ mourning / depression.
d) Other affects- Anxiety / fear / panic/ free floating anxiety/ apathy/ aggression/ moods swing/ emotional liability

**VI. Disorders Perception:**

a) Illusion
b) Hallucinations- (specify type and give example) – auditory/ visual/ olfactory/ gustatory/ tactile
c) Others- hypnologic/ hypnopombic/ lilliputian/ kinesthetic/ macropsia/ micropsia/

**VII. Cognitive functions:**

**a) Attention and concentration :**

- Method of testing (asking to list the months of the year forward and backward)
- Serial subtractions (100-7)

**b) Memory**:

a) Immediate (Teach an address & after 5 mts. Asking for recall)
b) Recent memory – 24 hrs. recall
c) Remote : Asking for dates of birth or events which are occurred long back
i) Amnesia/ paramnesia/ retrograde amnesia/ anterograde amnesia
ii) Confabulation
iii) 'Déjà Vu'/ Jamaes Vu
iv) Hypermnesia

**c) Orientation :**

a. Time approximately without looking at the watch, what time is it?
b. Place – where he/she is now?
c. Person – who has accompanied him or her

**d) Abstraction:** Give a proverb and ask the inner meaning (E.g. feathers of a bird flock together/ rolling stones gather no mass)

**e) I ntelligence & General Information:** Test by carry over sums / similarities and differences/ and general information/ digit score test.

**f) Judgment:** - Personal (future plans)
- Social (perception of the society)
- Test (present a situation and ask their response to the situation)

**g) Insight:**

a) Complete denial of illness
b) Slight awareness of being sick
c) Awareness of being sick attribute it to external / physical factor.
d) Awareness of being sick, but due to some thing unknown in himself.
e) Intellectual insight
f) True emotional insight

**VIII General Observations:**

a) Sleep i)Insomnia – temporary/ persistent
ii) Hypersomnia – temporary/ persistent
iii) Non-organic sleep- wake cycle disturbance
iv) EMA- Early Morning Awakening
b) Episodic disturbances – Epilepsy/ hysterical/ impulsive behavior/ aggressive behavior/ destructive behavior

**IX Summary & Clinical DiagnosisEVALUATION**

**CRITERIA FOR MENTAL STATUS EXAMINATION**

(Maximum Marks : 50)

| SN | Criteria | MarksAllotted | MarksObtained |
|---|---|---|---|
| **1** | **Format** | **02** | |
| 2 | General appearance | 04 | |
| 3 | Motor disturbances | 04 | |
| 4 | Speech | 04 | |
| 5 | Thought disturbances | 04 | |
| 6 | Perceptual disturbances | 05 | |
| 7 | Affect and mood | 04 | |
| 8 | Memory | 03 | |
| 9 | Orientation | 02 | |
| 10 | Judgment | 03 | |
| 11 | Insight | 02 | |
| 12 | Attention and Concentration | 03 | |
| 13 | Intelligence and General information | 03 | |
| 14 | Abstract thinking | 02 | |
| 15 | General Observation | 02 | |
| 16 | Summary | 05 | |
| | | **Total 50** | |

## *III) EVALUATION OF PROCESS RECORDING*

Process recording are written records of encounters with patients that are as verbatim as possible and include both verbal and nonverbal behaviours of the nurse and client.

**1. FORMAT:**

1. Base line data of the client.
2. List of Nursing problems identified through history, MSE and systematic observation.
3. List of objectives of interactions based on the problems identified and learning needs of.

a) Client b) Student

**(Note :** The above data are obtained and recorded on initial contact. Later as each day's interaction are planned, the following format has to be followed).

**2. DATE AND TIME DURATION :**

**3. SETTING :** General ward/patient's unit

**4. OBJECTIVES TO BE ATTAINED IN THAT PARTICULAR INTERACTION:**

1. ……
2. ……

**PARTICIPANT CONVERSATION INFERENCE THERAPEUTIC COMMUNICATION TECHNIQUE USED**

Nurse (N) Good morning Mr. Ramu (smile, looks at patient)

Patient (P) Good morning sister Patient appears (looks down, voice pitch sad and monotonous) un-interested to converse

Mr. Ramu, you appear Making To be sadder than observation, showing interest Yesterday. Can we talk about it? (stands closer to patient)

Let us sit down in the
Room (leads the patientto the room)

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**5. NATURE OF TERMINATION OF INTERACTION:**

Evaluation by the student:

1. Your general impression about the interaction (this could include whether TNPR maintained, use of TCT, co-operation of client etc).
2. Whether objectives achieved, and to what extent. If not- why and how do you intend to achieve it.
3. Summary of your inferences

Evaluation by teacher:

1. Overall recording
2. Phases of nurse patient relationship
3. Use of Therapeutic Communication Techniques
4. Ability to achieve objectives

**NOTE:** Limit objective to one or two and make all efforts to attain the objectives. At the end of the process recording, mention if you were able to achieve the objective and to what extent. If not, how you intend to achieve it and what hindered you from achieving it. Maintain a therapeutic nurse-patient relationship (TNPR) in all you interactions and use as many therapeutic communications of the participants.

**EVALUATION CRITERIA FOR P ROCESS RECORDING E XAMINATION**

(Maximum Marks : 25)

| SN | Criteria | Marks Allotted | Marks Obtained |
|---|---|---|---|
| 1 | Format | 05 | |
| 2 | Objectives | 03 | |
| 3 | Setting | 02 | |
| 4 | Therapeutic techniques used | 10 | |
| 5 | Evaluation by students | 05 | |
| | | **Total 25** | |

***IV) FORMAT FOR NURSING CARE PLAN***

1. Bio data of the patient.
2. History of the patient
3. Pre- morbid personality.
4. Physical examination.
5. Mental status examination.
6. Assessment Data – Objective data – Subjective data
7. Nursing Diagnosis.
8. Short term goals, long terms goals.
9. Plan of action with rationale
10. Implementation including health teaching
11. Evaluation.
12. Bibliography.

***VI) FORMAT FOR CASE PRESENTATION / CASE STUDY***

1. History
2. Physical examination.
3. Mental status examination.
4. Description of the case.
    a) Definition
    b) Etiological Factors

c) Psycho Pathology / Psychodynamics
d) Clinical Manifestations
i) In general
ii) In the patient

5. Differential diagnosis.
6. Diagnosis & Prognosis
7. Management-AIM & OBJECTIVES(including Nursing care)
(a)Medical -
- Pharmaco therapy & Somatic therapy
- Psychosocial therapy

(b)Nursing Management – In general
(c) Nursing process approaches
(d)Rehabilitation / Long term care

8. Progress notes.
9. Bibliography.

***VI a) Evaluation of Case Presentation***

**EVALUATION CRITERIA FO R CASE PRESENTATION**

(Maximum Marks : 50)

| SN | Criteria | Marks Allotted | Marks Obtained |
|---|---|---|---|
| Total | | | |
| **I** | **Case Presentation** | | |
| 1. | ***History Taking*** | 02 | |
| 2. | ***Mental Status Examination*** | 02+2 | |
| 3. | ***Description of Disease Condition*** | | |
| a) | Definition | 03 | |
| b) | Etiological Factors | 03 | |
| c) | Psycho Pathology/ Psychodynamics | 02 | |
| 4. | ***Clinical Manifestations*** | | |
| a) | In general / In books | 02 | |
| b) | In the patient | 02 | |
| 5. | ***Differential Diagnosis*** | | |
| 6. | ***Prognosis*** | | |
| 7. | ***Management*** - AIM & OBJECTIVES | | |
| a) | Pharamaco therapy & Somatictherapy | 02 | |
| b) | Psychosocial approaches | 02 | |
| 8. | ***Nursing Management*** | | |
| a) | General approaches | 06+2 | |
| b) | Nursing Process approach | 05 | |
| c) | Rehabilitation / long term care | 05 | |
| **II** | **Presentation (effectiveness)** | 04 | |
| **III** | **A.V. Aids** | 03 | |
| **IV** | **Bibliography** | 03 | **Total 50** |

Remarks & signature of supervisor- Date : Signature of student
Date :

***VI b) Evaluation of Case Study***

**EVALUATION CRITERIA FOR CASE STUDY**

(Maximum Marks : 50)

| Sr.No. | Criteria | MarksAllotted | MarksObtained |
|---|---|---|---|
| ***1.*** | ***History Taking*** | 02 | |
| ***2.*** | ***Mental Status Examination*** | ***04*** | |
| ***3.*** | ***Description of Disease Condition*** – | 06 | |

a) Definition
b) Etiological factors
c) Psychopathology/

***4.Clinical Manifestation*** – 04
In general / in book
In Patient -
***5.Differential diagnosis*** ***04***
***6.Prognosis*** ***04***
***7.Management*** – 08
a) Pharmaco therapy and Somatic therapies
b) Psychosocial approaches
***8.Nursing Management*** – 08+2
a) General approaches
b) Nursing Process
c) Rehabilitation/ long term care
***Drugs Study*** ***04***
***Bibliography*** ***04*** **Total 50**

***PSYCHIATRIC NURSING***
***VII) CLINICAL PERFORMANCE EVALUATION PROFORMA***

Name of the student :
Batch : Ward :.....
Period: From ---------- to ---------- Maximum Marks 100

**Excellent 5 V. Good 4 Good 3Average 2 Poor1**

**I. KNOWLEDGE ABOUT THE PATIENT:**

1. Elicit the comprehensive history of the patient.
2. Understands the disease aspect
3. Examines the mental status of the patient
4. Participates in the management of patient, in relation to drug and psychosocial intervention.
5. Carries out Nursing process with emphasis on: Meeting physical needs of patient.
6. Attends to psycho social needs
7. Identifies and meets the family needs.

**II. COMMUNICATION & INTERPERSONAL SKILLS**

1. Utilizes therapeutic communication techniques while interacting with patients & family members.
2. Improve therapeutic communication skills by process recording.
3. Maintains professional relationship with health team members.

**III. APPLICATION OF THERAPEUTIC MILIEU CONCEPT**

1. Accepts the patient as he is Maintains consistency in behavior and attitude
2. Structures time of the patient
3. Provides a safe environment.

**IV. RECORDING & REPORTING**

1. Records & Reports MSE daily (assigned patients)
2. Applies the principles of recording and

reporting (accuracy, apprehensiveness, accountability)

**V. Health Teaching** Incidental and planned teaching.

**VI. Personality**

1. Professional appearance
2. Sincerely Sense responsibility
3. Punctuality

Remarks & Signature of Supervisor & Date

Signature of student & Date