

II	<ul style="list-style-type: none"> * Describe the normal growth & development of children at different ages. * Identify the needs of children at different ages & provide parental guidance. * Identify the nutritional needs of children at different ages & ways of meeting the needs. * Appreciate the role of play for normal & sick children. * Appreciate the preventive measures & strategies for children. 	The healthy child. <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. 	T 18 hrs. P 02 hrs 1 1 6 2 1 2 2 2 1 2
III	<ul style="list-style-type: none"> * Provide care to normal & high-risk neonates. * Perform neonatal resuscitation. * Recognize & manage common neonatal problems. 	Nursing care of a neonate. <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. 	T 12 hrs. P 03 hrs 4 1 4 1 1 1 2 1
IV	<ul style="list-style-type: none"> * Explain the concept of IMNCI & other health strategies initiated by National population policy 2000. 	Integrated management of neonatal & childhood illnesses (IMNCI). <ul style="list-style-type: none"> • Health strategies: National population policy- • RCH camps & RCH outreach schemes. • Operationalization of district newborn care, home based neonatal care. • Border district cluster strategy. • Integrated management of infants & children with illnesses like diarrhea, A.R.I., malaria, measles & Malnutrition. • * Nurses' role: IMNCI. 	10 hrs. 2 2 1 3 2

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. 1 • Respiratory disorders & infections. 2 • Gastro-intestinal infections, infestations, & congenital disorders. 2 • Cardio-vascular problems: congenital defects & rheumatic fever, rheumatic heart disease. 3 • Genito-urinary disorders: acute glomerulo nephritis, nephritic syndrome, Wilm’s tumour, infections, calculi, & congenital disorders. 2 • Neurological infections & disorders: convulsions, meningitis, hydrocephalus, head injury. 3 • Hematological disorders: anemia, thalassemia, ITP, leukemia, hemophilia. 2 • Endocrine disorders: juvenile diabetes mellitus & other diseases. 1 • Orthopedic disorders: club feet, hip dislocation & fracture. 1 • Disorders of skin eye & ears. 1 • Common communicable diseases in children, their identification, nursing care in hospital & home & prevention. 1 • Child health emergencies: poisoning, hemorrhage, burns & drowning. 1 • Nursing care of infant and children with HIV / AIDS 1 	<p>20 hrs.</p>
VI	<p>* Manage the child with behavioral & social problems.</p>	<p>Problems in children.</p> <ul style="list-style-type: none"> • Management of common behavioural disorders. 4 • Management of common psychiatric problems. 2 • Management of challenged children: 2 • Mentally, physically, & socially challenged. 2 • Welfare services for challenged children in India. 1 • Child guidance clinics. 1 	<p>10 hrs.</p>

Colour in blue indicates addition

References –

1. Ghai O.p. et al. (2000) Ghai’s Essentials of Paediatrics. 1st edn. Mehta offset works. New Delhi.
2. Marlow Dorothy & Redding. (2001) Textbook of Paed. Nsg. 6th edn. Harbarcourt India ltd. New Delhi.
3. Parthsarathy et al. (2000) IAP Textbook of Paediatric Nsg. Jaypee bros., 2 nd ed. New Delhi.
4. Vishwanathan & Desai. (1999) Achar’s Textbook of Paediatrics. 3rd ed. Orient Longman. Chennai.
5. Wong Dona et al. Whaley & Wong’s Nursing care of infants & children.6th edn. Mosby co., Philadelphia.
6. Dr. C.S. Waghale, Principles and Practice of Clinical Pediatrics, Vora publication 1996.

PRACTICAL

Time: 270 hrs (9 weeks)

Areas	Duration (in weeks)	Objective	Skills	Assignment	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 catheterization and drainage • Feeding <ul style="list-style-type: none"> ➤ Nasogastric ➤ Gastrostomy ➤ Jejunostomy • Care of surgical wounds • Dressing • Suture removal 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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:

Theory:	Maximum marks 25
Periodical	25
Midterm	50
<u>Pre-final</u>	<u>75</u>
Total Marks	150

Practicum: **Maximum marks 50**

1. 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. Periodical viva	25
2. Midterm exam	50
3. Preterm exam	50

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 and 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 pucca 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	Investigation done	Normal value	Patient value	Inference

Treatment

Sr. No.	Drug: (pharmacological name)	Dose	Frequency Time	Action	Side effect & 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:**Patient name:****Date:****Ward:**

Date	Assessment	Nursing diagnosis	Objective	Plan of care	Rationale	Implementation	Evaluation

Discharge planning:

It should include health education and discharge planning given to patient.

Evaluation of care

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

Evaluation format for case presentation

Sr. No.	Contents	Marks
1	Assessment / Introduction	05
2	Knowledge and understanding of disease	10
3	Nursing care plan	15
4	Presentation skill	10
5	A.V. aids	05
6	Overall	
	Time	01
	Summary & conclusion	02
	Bibliography	02
	Total	50

Format for case study

Format is similar to case presentation but should be in detail

The nursing care given to the patient should be at least for 5 continuous days

Evaluation format for case study

Sr. No.	Contents	Marks
1	Assessment / Introduction	05
2	Knowledge and understanding of disease	15
3	Nursing care plan	20
4	Discharge plan	05
5	Summary & conclusion	02
6	Bibliography	03
	Total	50

Nursing care plan

1. Patients Biodata:

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

2. Presenting complaints:

Describe the complaints with which the patient has come to hospital

3. History of illness

History of present illness – onset, symptoms, duration, precipitating / alleviating factors

History of past illness – illnesses, surgeries, allergies, immunizations, medications

Family history – family tree, history of illness in family members, risk factors, congenital problems, psychological problems.

4. Childs personal data

Obstetric history of - prenatal & natal history of mother, growth and development (compare with normal), immunization status, dietary pattern including weaning, play habits, toilet training, sleep pattern, schooling.

5. Economic status of the family:

Monthly income & expenditure on health, food and education, material assets (own pucca 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	Investigation done	Normal value	Patient value	Inference

10. Treatment

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

11. Nursing process:

Patient name:

Date:

Ward:

Date	Assessment	Nursing diagnosis	Objective	Plan of care	Rationale	Implementation	Evaluation

Discharge planning:

It should include health education and discharge planning given to patient

12. Evaluation of care

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

Care plan evaluation

Sr. No.	Contents	Marks
1	History 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
Total		50

EVALUATION FORMAT FOR HEALTH TALK

NAME OF THE STUDENT : _____

AREA OF EXPERIENCE : _____

PERIOD OF EXPERIENCE : _____

SUPERVISOR : _____

Total 100 Marks

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

Sr. No.	Particulars	1	2	3	4	5	Score
1	<p>I) Planning and organization</p> <p>a) Formulation of attainable objectives</p> <p>b) Adequacy of content</p> <p>c) Organization of subject matter</p> <p>d) Current knowledge related to subject Matter</p> <p>e) Suitable A.V.Aids</p> <p>II) Presentation:</p> <p>a) Interesting</p> <p>b) Clear Audible</p> <p>c) Adequate explanation</p> <p>d) Effective use of A.V. Aids</p> <p>e) Group Involvement</p> <p>f) Time Limit</p> <p>III) Personal qualities:</p> <p>a) Self confidence</p> <p>b) Personal appearance</p> <p>c) Language</p> <p>d) Mannerism</p> <p>e) Self awareness of strong & weak points</p> <p>IV) Feed back:</p> <p>a) Recapitulation</p> <p>b) Effectiveness</p> <p>c) Group response</p> <p>V) Submits assignment on time</p>						

* 100 marks will be converted into 25

CLINICAL EVALUATION PERFORMA

Name of The Student : _____
 Year : _____
 Area of Clinical Experience : _____
 Duration of posting in weeks : _____
 Name of the Supervisor : _____

Total 100 Marks

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

Sr. No.	EVALUATION CRITERIA	Grades			
		1	2	3	4
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 & cooperation of child and relatives, tactful and considerate.				
I	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.				
I	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)

PERFORMA FOR ASSESSMENT OF GROWTH & DEVELOPMENT

(Age group: birth to 5 yrs.)

I. Identification Data:

Name of the child :
Age :
Sex :
Date of admission :
Diagnosis :
Type of delivery : Normal/ Instrumental/ LSCS
Place of delivery : Hospital/ Home
Any problem during birth : Yes/ No
If yes, give details :
Order of birth :

II. Growth & development of child & comparison with normal:

Anthropometry	In the child	Normal
Weight		
Height		
Chest circumference		
Head circumference		
Mid arm circumference		
Dentition		

III. Milestones of development:

Development milestones	In Child	Comparison with the normal
1. Responsive smile		
2. Responds to Sound		
3. Head control		
4. Grasps object		
5. Rolls over		
6. Sits alone		
7. Crawls or creeps		
8. Thumb-finger Co-ordination (Prehension)		
9. Stands with support		
10. Stands alone		
11. Walks with support		
12. Walks alone		
13. Climbs steps		
14. Runs		

IV. Social, Emotional & Language Development:

Social & emotional development	In Child	Comparison with the normal
Responds to closeness when held Smiles in recognition recognized mother coos and gurgles seated before a mirror, regards image Discriminates strangers wants more than one to play says Mamma, Papa responds to name, no or give it to me.		
Increasingly demanding offers cheek to be kissed can speak single word use pronouns like I, Me, You asks for food, drinks, toilet, plays with doll gives full name can help put thinks away understands differences between boy & girl washes hands feeds himself/ herself repeats with number understands under, behind, inside, outside Dresses and undresses		

V. Play habits

Child favourite 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)

Sr. No.	Items	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.

PERFORMA 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.

VI. Bibliography

Evaluation Criteria: Examination & Assessment of Newborn

(Maximum Marks: 50)

Sr. No.	Items	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

COURSE OF INSTRUCTION THIRD YEAR B.Sc. NURSING

Sr. No.	Subject	Theory		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
	Total	363	27	990	100
Total Hours 1480					

**SCHEME OF EXAMINATION
THIRD YEAR**

Sr. No.	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
4	Practical: Medical surgical Nursing (Adult including geriatrics) II		50	50	100
5	Child health Nursing		50	50	100
6	Mental health nursing		50	50	100
	Grand Total				600

SCHEME OF INTERNAL ASSESSMENT

THEORY:

Sr. No.	Subject	Maximum marks for internal assessment	Assignments / tests	Weightage	Maximum marks of assessment / tests
1	Medical surgical Nursing (Adult including geriatrics) II Theory	25	Periodical Test – 1 Midterm Test – 1 Prefinal Exam – 1	25 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)	125 50 25 <u>200</u> 400	50 Marks
2	Child health Nursing Theory	25	Periodical Test – 1 Midterm Test – 1 Prefinal Exam – 1	25 50 75	25 Marks
	Child health Nursing Practical	50	1. Case presentation - (Paed. Medical / Surgical 01) 2. Case study - (Paed. Medical. / Surgical 01) 3. Nursing care plan 01 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 Practical exam: 1. Periodical viva 2. Midterm exam 3. Prefinal exam	50 50 75 300 25 100 25 25 50 <u>50</u> 750	50 Marks
3	Mental health nursing Theory	25	Periodical Test – 1 Midterm Test – 1 Prefinal Exam – 1	25 50 75	25 Marks

**MEDICAL SURGICAL NURSING
(Adult including Geriatrics) –II**

Placement: Third Year

**Time: Theory-120 Hrs.
(Class 103 + Lab 17 hrs)
Practical – 270 Hrs**

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)	Objective	Contents	Teaching Learning Activities	Assessment Methods
I	T=15 P=02	Describe the etiology, pathophysiology, 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, pathophysiology, clinical Manifestations, diagnosis, Treatment modalities and medical & Surgical nursing management of Ear Nose and Throat disorders: □ External ear: deformities otalgia, foreign bodies, and tumors □ Middle Ear-Impacted wax, Tympanic membrane perforation, 	<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.

			<p>otitis media, otosclerosis, mastoiditis, tumors</p> <ul style="list-style-type: none"> □ Inner ear- meniere,s Disease, labyrinthitis, ototoxicity, tumors □ Upper airway infections Common cold, sinusitis, ethinitis, Rhinitis, Pharyngitis, Tonsillitis and Adenoiditis, Peritonsilar abscess, Laryngitis <ul style="list-style-type: none"> • 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 Oesophagostomy, Tracheostomy, 		
II	T=15 P=02	Describe the etiology, path physiology, clinical manifestations diagnostic measures and management of patients with disorders of eye.	<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 Physical assessment • Etiology, pathophysiology, clinical manifestations, diagnosis, treatment nursing management of eye disorders: 	<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 	<ul style="list-style-type: none"> • Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problem

			<ul style="list-style-type: none"> ❑ Refractive errors ❑ Eyelids-infection, tumors and deformities ❑ Conjunctiva-inflammation 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 • 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. 	<ul style="list-style-type: none"> • Visit to eye bank • Participation in eye-camps 	
III	T=17 P=02	Describe the etiology, patho – physiology clinical manifestations, diagnostic measures and nursing management of patients with neurological disorders	Nursing management of patient With neurological disorders <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 	<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 	<ul style="list-style-type: none"> • Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problem

			<p>manifestations, diagnosis, treatment modalities and medical & surgical nursing management of neurological disorders</p> <ul style="list-style-type: none"> • Congenital malformations • Headache • Head Injuries • Spinal injuries • Paraplegia • Hemiplegia • Quadriplegia • 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) • Cranial / spinal neuropathies – Bell’s palsy, trigeminal neuralgia, Peripheral Neuropathies; Guillan-Barr’e syndrome Myasthenia gravis Multiple sclerosis, Degenerative diseases, Peripheral neuritis TIA ➤ Delirium Dementia ➤ Alzheimer’s disease ➤ Parkinson’s disease • Management of unconscious patients and patients with stroke • Drugs used in treatment of neurological disorders • Role of the nurse in communication with patient having neurological deficit 	<ul style="list-style-type: none"> • Visit to rehabilitation drugs used in treatment of disorders of eye center 	
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			<ul style="list-style-type: none"> • Rehabilitation of patients with neurological deficit • Role of nurse in long stay facility (institutions) and at home Special therapies <p>Nursing procedures: GCS, assisting with diagnostic procedures and rehabilitation</p>		
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 <p>Congenital abnormalities of female reproductive system</p> <ul style="list-style-type: none"> • 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 	<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 	<ul style="list-style-type: none"> • Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problem

			<p>disorders; Endometriosis, polyps, Fibroids, Cervical and uterine tumours,</p> <ul style="list-style-type: none"> • Uterine displacement, Cystocele/ urethrocele/ rectocele • 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; types Methods risk and effectiveness <ul style="list-style-type: none"> □ Spacing methods -Barrier methods - Intra uterine devices - Hormonal post conceptional methods etc. □ Terminal methods sterilization • Emergency contraception methods • Abortion-natural, medical and surgical abortion-MTP Act • Toxic shock Syndrome • Injuries and trauma; sexual violence • Drugs used in treatment of gynecological disorders Special therapies vaginal douche PAP smear • Nursing procedures assisting with diagnostic and therapeutic procedures, • self-examination of breast. • National family welfare programme 	
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V	T=08 P=02	Describe the etiology, patho physiology, clinical manifestations, diagnostic measures and nursing management of patients with burns, reconstructive and cosmetic surgery	Nursing management of patients With Burns, reconstructive and Cosmetic surgery <ul style="list-style-type: none"> • Review of anatomy and physiology of the skin and connective tissues various deformities • Nursing assessment- History and physical examination & assessment burns fluid and electrolytes loss • Etiology, Classification, pathophysiology, clinical manifestations, diagnosis, treatment modalities and medical & surgical and nursing management of Burns with special emphasis of fluid replacement therapy. Reconstructive surgery • Types of surgeries- reconstructive, cosmetic; for burns congenital deformities, injuries and cosmetic purposes • Role of nurse • Legal Issues, • Rehabilitation • Special therapies • Psycho social aspects • Nursing procedures, drugs used in treatment of burns, reconstructive and cosmetic surgeries. 	<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
VI	T=13 P=02	Describe the etiology, patho physiology, clinical manifestations, diagnostic manifestations, diagnostic measures and nursing management of patients with oncology	Nursing management of patients With oncological conditions <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 • Epidemiology, etiology, 	<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

			<p>classifications, pathophysiology, staging, clinical manifestations, diagnosis treatment modalities and medical, surgical & nursing management of malignant diseases</p> <ul style="list-style-type: none"> • Common malignancies of various body system; Brain Oral cavity, larynx lung liver stomach and colon, breast cervix, ovary, uterus, Sarcoma, renal, bladder, prostate leukemia and lymphomas, • Oncological emergencies. • Treatment Modalities – Immuno therapy Chemotherapy, Radiotherapy Gene therapy Stem cells & Bone Marrow transplants. other forms of treatment • Surgical interventions • Psychosocial aspects of cancer • Rehabilitation & Palliative care; symptom and pain Management – nutritional support • Home care, Hospice care, Stoma care • Psycho social aspects • Nursing procedures and Assisting with diagnostic and therapeutic procedures 		
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VII	T=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 Disaster Nursing</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, and non-government. Organizations and International agencies • Role of nurse in disaster management • Legal aspects of disaster nursing • Impact on Health and after effects; post Traumatic Stress Disorder • Rehabilitation; physical, psychosocial Social, Financial, Relocation <p>Emergency Nursing Concept, priorities principle and</p> <ul style="list-style-type: none"> • Scope of emergency nursing • Organization of emergency services: physical setup, staffing, equipment and supplies, protocols, Concepts of triage and role of triage nurse 	<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 • Disaster management drills • Drug book/ presentation 	<ul style="list-style-type: none"> • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problem
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			<ul style="list-style-type: none"> • 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 Hemorrhage • 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; 	
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VIII	T=10	<ul style="list-style-type: none"> • Explain the concept and problems of ageing • 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; 	<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
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			<ul style="list-style-type: none"> • Home and institutional care 		
IX	T=10 P=05	<ul style="list-style-type: none"> • Describe organization of critical care units • Describe the 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 • Special equipments; ventilators, cardiac monitors, defibrillators, • Resuscitation equipments • Infection Control protocols • 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"> • Lecture discussion • Explain using Charts, graphs • Models, films, slides • Demonstration • Role plays • Counseling • 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

X	T=4	Describe the etiology, pathophysiology, clinical manifestations, assessment, diagnostic measures and management of patients with occupational and industrial health disorder	Nursing management of patients adults including elderly with occupational and industrial disorders <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 	<ul style="list-style-type: none"> • Demonstration • Practice session • Case discussion/ Seminar • Health education • Supervised clinical practice • Disaster management drills • Drug book/ presentations 	<ul style="list-style-type: none"> • Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problem
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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 (6 thed) 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 (16 thed) ELBS.
5. 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 (19 thed) 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. 11 Haslett C., Chilvers E.R., Hunder J.A.A. &Boon, N.A. (1999) Davidson’s Principles and Practice of Medicine (18 thed) Churchill living stone. Edinburgh.
9. 13 Walsh M. (2002) Watson’s Clinical Nursing and Related Sciences (6thed) Bailliere Tindall

PRACTICAL**Time: 270 hrs**

Areas	Duration (in weeks)	Objective	Skills to be developed	Assignment	Assessment Methods
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 • Health 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
Gynecology ward	1	<ul style="list-style-type: none"> • Provide care to patients with gynecological disorders • Counsel and 	<ul style="list-style-type: none"> • Assist with gynecological Examination • Assist with diagnostic procedures 	<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

		educate patient and families	<ul style="list-style-type: none"> • Assist with therapeutic procedures • Teach patients families • Teaching self Breast Examination • Assist with PAP • Smear collection. 		<ul style="list-style-type: none"> • with rating scale • Evaluation of observation report of OPD/Eye bank • Completion of activity record
Burns Unit	1	<ul style="list-style-type: none"> • Provide care of the patient with burns • Counsel and educate patient and families 	<ul style="list-style-type: none"> • Assessment of the burns patient Percentage of burns • Degree of burns. • Fluid & electrolyte replacement therapy <ul style="list-style-type: none"> □ Assess □ Calculate □ Replace □ Record intake/output • Care of Burn wounds <ul style="list-style-type: none"> □ 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 	<ul style="list-style-type: none"> • Assess each skill with checklist • Assess performance with rating scale • Evaluation of observation • 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 <ul style="list-style-type: none"> □ Biopsies □ Pap smear □ Bone-marrow aspiration • Breast examination • Assist with Therapeutic • Participates in various modalities of treatment <ul style="list-style-type: none"> □ Chemotherapy □ Radiotherapy □ Pain management □ Stomaltherapy □ Hormonal therapy □ Immuno therapy □ Gene therapy □ Alternative therapy • Participate in palliative care 	<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

			<ul style="list-style-type: none"> • Participate in rehabilitation programme • Counsel and teach patients families <ul style="list-style-type: none"> □ Self breast examination □ Warning signs 		
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-mask ventilation • Emergency tray/ trolley- Crash Cart • Administration of drugs <ul style="list-style-type: none"> □ 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

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 of the family:

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	Investigation done	Normal value	Patient value	Inference

9. Treatment

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

10. Nursing process:

Patient name:

Date:

Ward:

Date	Assessment	Nursing diagnosis	Objective	Plan of care	Rationale	Implementation	Evaluation

11. Discharge planning:

It should include health education and discharge planning given to patient.

12. Evaluation of care

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

Care plan evaluation

Sr. No.	Contents	Marks
1	History 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
	Total	50

FORMAT FOR CASE PRESENTATION

Patients Biodata:

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

Presenting complaints:

Describe the complaints with which the patient has come to hospital

History of illness

History of present illness – onset, symptoms, duration, precipitating / alleviating factors

History of past illness – illnesses, surgeries, allergies, immunizations, medications

Family history – family tree, history of illness in family members, risk factors, congenital problems, psychological problems.

Economic status:

Monthly income & expenditure on health ,marital assets (own pacca house car, two wheeler, phone, TV etc...)

Psychological status:

Ethnic background,(geographical information, cultural information) support system available.

Personal habits:

Consumption of alcohol, smoking, tobacco chewing, sleep,exercise, work elimination, nutrition.

Physical examination with date and time

Investigations

Date	Investigation done	Normal value	Patient value	Inference

Treatment

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

Patient name:

Date:

Ward:

Date	Assessment	Nursing diagnosis	Objective	Plan of care	Rationale	Implementation	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

Care plan evaluation

Sr. No.	Contents	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	5
6	Overall	
	Summary & conclusion	03
	Bibliography	02
	Total	50

Format for case study

Format is similar to case presentation but should be in detail

The nursing care given to the patient should be at least for 5 continuous days

Evaluation format for case study

Sr. No.	Contents	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.	Particulars	1	2	3	4	5	Score
1	<p>I) Planning and organization</p> <p>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> <p>II) Presentation:</p> <p>a) Interesting b) Clear Audible c) Adequate explanation d) Effective use of A.V. Aids e) Group Involvement f) Time Limit</p> <p>III) Personal qualities:</p> <p>a) Self confidence b) Personal appearance c) Language d) Mannerism e) Self awareness of strong & weak points</p> <p>IV) Feed back:</p> <p>a) Recapitulation b) Effectiveness c) Group response</p> <p>V) Submits assignment on time</p>						

* 100 marks will be converted into 25

CLINICAL EVALUATION PERFORMA

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

Total 100 Marks

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

Sr. No.	EVALUATION CRITERIA	Grades				
		1	2	3	4	5
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 & cooperation of child and relatives, tactful and considerate.					
III	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.					
IV	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 % 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

MENTAL HEALTH NURSING

Placement: Third Year

**Time: Theory-90 Hrs.
Practical – 270 Hrs**

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

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

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

Unit	Time (Hrs)	Objective	Contents	Teaching Learning Activities	Assessment Methods
I	05	<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. 	Introduction <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 	<ul style="list-style-type: none"> • Lecture Discussion 	<ul style="list-style-type: none"> • Objective type • Short answer • Assessment of the field visit reports

			<p>mental health nurse in various settings and factors affecting the level of nursing practice</p> <ul style="list-style-type: none"> • Concepts of normal and abnormal behaviour. 		
II	05	<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

III	08	Describe nature, purpose and process of assessment of mental health status	Assessment of mental health status. <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 checklist.
IV	06	<ul style="list-style-type: none"> • Identify therapeutic communication techniques • Describe therapeutic relationship. • Describe therapeutic impasse and its intervention. 	Therapeutic communication and nurse-patient relationship <ul style="list-style-type: none"> • Therapeutic communication: types, techniques, characteristics • Types of relationship, • Ethics and responsibilities • Elements of nurse patient contract • Review of technique of IPR- Johari Window • Goals, phases, tasks, therapeutic techniques. • Therapeutic impasse and its intervention 	<ul style="list-style-type: none"> • Lecture discussion • Demonstration • Role play • Process recording 	<ul style="list-style-type: none"> • Short answer • Objective type
V	14	Explain treatment modalities and therapies used in mental disorders and role of the nurse.	Treatment modalities and therapies used in mental disorders. <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 : 	<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

			<p>Yoga, Meditation, bio feedback.</p> <ul style="list-style-type: none"> • Alternative systems of medicine. • Psychosocial rehabilitation process • Occupational therapy. • Physical Therapy: electro convulsive therapy. • Geriatric considerations <p>Role of nurse in above therapies.</p>		
VI	05	<ul style="list-style-type: none"> • Describe the etiology, sychopathology clinical manifestations, diagnostic criteria and management of patients with Schizophrenia, and other psychotic disorders • Geriatric considerations • Follow-up and home care and rehabilitation. 	<p>Nursing management of patient with Schizophrenia, and other psychotic disorders</p> <ul style="list-style-type: none"> • Classification: ICD • Etiology, psycho-pathology, types, clinical manifestations, diagnosis • Nursing Assessment- History, Physical and mental assessment. • Treatment modalities and nursing management of patients with Schizophrenia and other psychotic disorders • Geriatric considerations • Follow – up and home care and rehabilitation 	<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

VII	05	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
VIII	08	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

IX	05	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, and diagnosis. • Nursing Assessment- History, Physical, mental assessment and drug assay • Treatment (detoxification, antabuse and narcotic antagonist therapy and harm reduction) and nursing management of patients with substance use disorders. • Geriatric considerations • Follow-up and home care and rehabilitation. 	<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
X	04	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, psychopathology, characteristics, diagnosis. • Nursing Assessment – History, Physical and mental assessment. • Treatment modalities and nursing management of patients with Personality, Sexual and Eating disorders • Geriatric considerations • Follow-up and home care and rehabilitation 	<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

XI	06	Describe the etiology, psychopathology, clinical manifestations, diagnostic criteria and management of childhood and adolescent including mental deficiency	Nursing management of childhood and adolescent disorders including mental deficiency <ul style="list-style-type: none"> • Classification • Etiology, psychopathology, characteristics, diagnosis Nursing Assessment-History, Physical, mental and IQ assessment • Treatment modalities and nursing management of childhood disorders including mental deficiency • Follow-up and home care and rehabilitation 	<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
XII	05	Describe the etiology psychopathology, clinical manifestations, diagnostic criteria and management of organic brain disorders	Nursing management of organic brain disorders <ul style="list-style-type: none"> • Classification: ICD? • Etiology, psychopathology, clinical features, diagnosis and Differential diagnosis (Parkinson's and Alzheimer's) • Nursing Assessment-History, Physical, mental and neurological assessment • Treatment modalities and nursing management of organic brain disorders • Geriatric considerations • Follow-up and home care and rehabilitation 	<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

XIII	06	Identify psychiatric emergencies and carry out crisis intervention	Psychiatric emergencies and crisis intervention <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
XIV	04	Explain legal aspects applied in mental health settings and role of the nurse	Legal issues in Mental Health Nursing <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 • Admission and discharge procedures • Role and responsibilities of nurse 	<ul style="list-style-type: none"> • Lecture discussion • Case discussion 	<ul style="list-style-type: none"> • Short answers • Objective type

XV	04	<ul style="list-style-type: none"> • Describe the model of preventive psychiatry • Describe Community Mental health services and role of the nurse 	<p>Community Mental Health Nursing</p> <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
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3. M.S. Bhatia, A concised text Book of Psychiatric Nursing, CBS publishers and distributors, Delhi 2nd ed. 1999.
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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.

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12. Sheila M. Sparks, CynthiaM. Jalor, Nursing Diagnosis reference manual 5th edition, , Spring house, Corporation Pennsychiram’s
13. R. Sreevani, A guide to mental health & psychiatric nursing, Jaypee brothers, Medical Publishers p(ltd)_, New Delhi 1st edition.
14. R. Baby, Psychiatric Nursing N.R. Brothers, Indore, 1st edition 2001.
15. Varghese Mary, Essential of psychiatric & mental health nursing,
16. Foundations Journals of mental health nursing
17. American Journal of Psychiatry
18. Deborah Antai Otoing. “Psychiatric Nursing” Biological and behavioral concepts. Thomson. Singapore 2003
19. Mary Ann Boyd. “Psychiatric Nursing”. Contemporary practice. Lippincott. Williams and Wilkins. Tokyo.

Internet Resources –

1. Internet Gateway : Psychology
<http://www.lib.uiowa.edu/gw/psych/index.html>
2. Psychoanalytic studies
<http://www.shef.ac.uk~psyc/psastud/index.html>
3. Psychaitric Times
<http://www.mhsource.com.psychiatrictimes.html>
4. Self-help Group sourcebook online
<http://www.cmhe.com/selfhelp>
5. National Rehabilitation Information center
<http://www.nariic.com/naric>
6. Centre for Mental Health Services
<http://www.samhsaa.gov/cmhs.htm>
7. Knowledge Exchange Network
<http://www.mentalheaalth.org/>
8. Communication skills
<http://www.personal.u-net.com/osl/m263.htm>

9. Lifeskills Resource center
<http://www.rpeurifooy.com>
10. Mental Health Net
<http://www.cmhe.com>

MENTAL HEALTH NURSING – PRACTICAL

Placement: Third Year

Time: Practical – 270 hours (9 weeks)

Areas	Duration (in weeks)	Objective	Skills to be developed	Assignment	Assessment Methods
Psychiatric OPD	1	<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 others 	<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 Electroconvulsive Therapy (ECT) Participate in all therapies Prepare patients for Activities of Daily living (ADL) Conduct admission and discharge counseling Counsel and teach patients and families 	<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-1 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 presentation, process recording Completion of activity record

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
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EVALUATION

Internal Assessment:

Theory:	Maximum marks 25
Periodical	25
Midterm	50
<u>Pre-final</u>	<u>75</u>
Total Marks	150

Practical:	Maximum marks 50
Nursing care plan	2 x25 50
Case presentation	1x 50 50
Case study	1x 50 50
Health teaching	1 x 25 25
History taking & mental status examination & process recording	2 x 50 100
Observation report of various therapies in psychiatry	1x 25 25
Clinical Evaluation	2 x 100 200

Total marks 500

Practical Examination:

Periodic viva	25
mid term	50
<u>Prefinal</u>	<u>50</u> (625)
Total Marks	125

University Exam

Theory	75 Marks
Practical	50 Marks

Nursing care plan

1. Patients Biodata:

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

2. Presenting complaints:

Describe the complaints with which the patient has come to hospital

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

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

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

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

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

4. Mental status examination with conclusion

5. Investigations

Date	Investigation done	Normal value	Patient value	Inference

6. Treatment

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

Other modalities of treatment in detail

7. Nursing process:

Patient name:

Date:

Ward:

Date	Assessment	Nursing Diagnoses	Objective	Plan of care	Implementation	Rationale	Evaluation

Discharge planning:

It should include health education and discharge planning given to patient.

8. Evaluation of care

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

Care plan evaluation

Sr. No.	Contents	Marks
1	History	05
2	M.S.E. & Diagnosis	05
3	Management & Nursing. Process	10
4	Discharge planning and evaluation	03
5	Bibliography	02
	Total	25

FORMAT FOR CASE PRESENTATION

1. Patients Biodata:

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

2. Presenting complaints:

Describe the complaints with which the patient has come to hospital

3. History of illness:

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

- 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. Description of disease

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

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

6. Investigations

Date	Investigation done	Normal value	Patient value	Inference

7. Treatment

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

Other modalities of treatment in detail

8. Nursing process:

Patient name:

Date:

Ward:

Date	Assessment	Nursing Diagnoses	Objective	Plan of care	Implementation	Rationale	Evaluation

Discharge planning:

It should include health education and discharge planning given to patient.

9. Evaluation of care

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

Date	Assessment	Nursing diagnosis	Objective	Plan of care	Implementation	Rationale	Evaluation

EVALUATION CRITERIA FOR CASE PRESENTATION –

Sr. No.	Contents	Marks
1	Orientation of History	10
2	M.S.E.	10
3	Summarization & Formulation of diagnosis	10
4	Management & evaluation of care	10
5	Style of presentation	05
6	Bibliography	05
	Total	50

Format for case study

Format is similar to case presentation but should be in detail

The nursing care given to the patient should be at least for 5 continuous days

Evaluation format for case study

Sr. No.	Contents	Marks
1	History & MSE	10
2	Knowledge and understanding of disease	15
3	Nursing care plan	20
4	Discharge plan	02
5	Bibliography	03
	Total	50

EVALUATION FORMAT FOR HEALTH TALK

NAME OF THE STUDENT : _____
 AREA OF EXPERIENCE : _____
 PERIOD OF EXPERIENCE : _____
 SUPERVISOR : _____

Total 100 Marks

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

Sr. No.	Particulars	1	2	3	4	5	Score
1	<p>I) Planning and organization</p> <p>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> <p>II) Presentation:</p> <p>a) Interesting b) Clear Audible c) Adequate explanation d) Effective use of A.V. Aids e) Group Involvement f) Time Limit</p> <p>III) Personal qualities:</p> <p>a) Self confidence b) Personal appearance c) Language d) Mannerism e) Self awareness of strong & weak points</p> <p>IV) Feed back:</p> <p>a) Recapitulation b) Effectiveness c) Group response</p> <p>V) Submits assignment on time</p>						

* 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
- Reliability
- Reason for referral
- Chief complaints with duration
- History of present illness
- History of past illness
- Family history of illness
 - a. Family history
(Draw family tree, write about each family members & relations with patient mention any history of mental illness, epilepsy renouncing the world.)
 - b. Socio-economic data
- Personal History
 1. Prenatal and perinatal
 2. Early Childhood
 3. Middle Childhood
 4. Late childhood
 5. Adulthood
 - a. Education History
 - b. Occupational History
 - c. Marital History
 - d. Sexual History
 - e. Religion
 - f. Social activity, interests and hobbies.
- Pre-morbid personality
- Physical examination
- Diagnosis & identification of psychosocial stressors

EVALUATION CRITERIA FOR CASE PRESENTATION –

Sr. No.	Contents	Marks
1	Format	02
2	Organisation of history of present illness	05
3	Past History of illness	03
4	Family history of illness	03
5	Pre morbid personality	03

6	Examination	02
7	Diagnosis	02
	Total	20

Mental Status Examination

1. General Appearance & behaviour & grooming:

LOC- Conscious/ semiconscious/ unconscious

Body Built- Thin
 Moderate
 Obese

Hygiene- Good
 Fair.
 Poor

Dress- Proper/clean
 According to the season

Poor- Untidy, Eccentric, Inappropriate.

Hair- Good Combined in position.
 Fair
 Poor
 Disheveled

Facial expression-

 Anxious
 Depressed
 Not interested
 Sad looking
 Calm
 Quiet
 Happy
 Healthy/Sickly
 Maintains eye contact
 Young / Old
 Any other

2. Attitude:-

Cooperative	Seductive
Friendly (mania)	1. Attention seeking
Trustful (mania)	2. Dramatic
Attentive	3. Emotional
Interested	Evasive

Negativistic

Resistive

Non-caring

Any other

Defensive

Guarded Paranoia

3. Posture:-

Good – Straight/proper

Relaxed

Rigid/Tense/Unsteady

Bizarre Position

Improper – Explain

4. Gait, Carriage & Psychomotor activities:-

Walks straight / coordinated movements

Uncoordinated movements

Mannerism / Stereotypes / Echolalia

Purposeless/hyperactivity/aimless/purposeless activity

Hypo activity/Tremors/Dystonia

Any other

5. Mood and affect:-

Mood- Pervasive & sustained emotions that colour 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. Judgment:-

According to the situation

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

11. Insight:-

Awareness

Reason for hospitalization

Accepts / Not accepts / Accepts fees treatment not required

Types - Intellectual-awareness at mental level

- Emotional – aware and accepts

Duration

12. Orientation:-

Oriented to – time

Place

Person

13. Memory:-

Fairs / Festival

Surrounding environment

PM of country

CM of state

14. Attention:-

Normal

Moderate

Poor attention

Any other

15. Concentration:-

Good

Fair

Poor

Any other

16. Special points:-

Bowel & bladder habits

Appetite

Sleep

Libido

Any other

Instructions for filling the MSE format:

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

EVALUATION CRITERIA FOR M.S.E.

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

Mental Status Examination

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

Sr. No.	Participants	Conversation	Inference	Technique used

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

Evaluation format of process recording

SN	TOPIC	MAX MARKS
1.	History taking	02
2.	Interview technique	03
3.	Inferences drawn from interview	03
4.	Overall understanding	02
	TOTAL	10

Observation report of various therapies

ECT CARE STUDY

Select a patient who has to get electro convulsive therapy

Preparation of articles for ECT

Preparation of physical set up

- Waiting room
- ECT room
- Recovery room

Preparation of patient prior to ECT

Helping the patient to undergo ECT

Care of patient after ECT

Recording of care of patient after ECT

ECT Chart –

Name –

Diagnosis –

Age –

Sex –

Bed No. –

TPR/BP –

Time of ECT –

Patient received back at –

Time	Pulse	Respiration	Blood pressure	Level of Consciousness	Remarks

OBSERVATION REPORT – GROUP THERAPY

(Can be written in the form of report)

1. Name of the Hospital –
2. Ward No. –
3. No. of patients in the ward –
4. No. of male patients in the ward –
5. No. of female patients in the ward –
6. No. of patients for group therapy
7. Objectives of group therapy –

8. Size of the group –
9. Diagnosis of patients in the group –
10. Heterogenous group –
11. Homogenous group –
12. Procedure followed –
 - a. Introduction
 - b. Physical set up
 - c. Maintenance of confidentiality & privacy
13. Content of group therapy –
14. Summary of group therapy –
15. Remarks –

Evaluation format of process recording

SN	TOPIC	MAX MARKS
1.	Introduction to therapy	02
2.	Purposes of therapy	03
3.	Preparation for therapy	05
4.	Care during therapy	05
5.	Care after therapy	05
6.	Recording	05
	TOTAL	25

CLINICAL POSTING EVALUATION

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

Total 100 Marks

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

Sr. No.	EVALUATION CRITERIA	Grades				
		5	4	3	2	1
I	Understanding of patient as a person A] Approach 1] Rapport with patient (family)relatives 2] Has she collected all information regarding the patient/family. B] Understanding patients health problems 1] Knowledge about the disease of patient 2] Knowledge about investigations done for disease. 3] Knowledge about treatment given to patient 4] Knowledge about progress of patients					
II	Planning care. 1] Correct observation of patient 2] Assessment of the condition of patient 3] Identification of the patients needs 4] Individualization of planning to meet specific health needs of the patient. 5] Identification of priorities					
III	Teaching skill. 1] Economical and safe adaptation to the situation available facilities 2] Implements the procedure with skill/speed, completeness. 3] Scientific knowledge about the procedure.					
VI	Health talk 1] Incidental/planned teaching (Implements teaching principles) 2] Uses visual aids appropriately					
V	Personality 1] Professional appearance (Uniform, dignity, helpfulness, interpersonal relationship, punctuality, etc.) 2] Sincerity, honesty, sense of responsibility					

Remarks of supervision in terms of professional strength and weakness.

Signature of the student

Signature of the teacher

DRUG BOOK/STUDY

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

MIDWIFERY AND OBSTETRICAL NURSING

Placement: Third Year (N).

**Time: Theory-90 Hrs.
Practical – 180 Hrs
(+ 180 hours of 4th year)**

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

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

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

Unit	Time (Hrs)	Objective	Contents	Teaching Learning Activities	Assessment Methods
I	05	<ul style="list-style-type: none"> • Recognize the trends and issues in midwifery and obstetrical Nursing 	<p>Introduction to midwifery and obstetrical Nursing</p> <ul style="list-style-type: none"> • Introduction to concepts of Midwifery and obstetrical nursing. • Trends in Midwifery and obstetrical nursing. <ul style="list-style-type: none"> <input type="checkbox"/> Historical perspectives and currents trends. <input type="checkbox"/> Legal and ethical aspects <input type="checkbox"/> Pre-conception care and preparing for parenthood <input type="checkbox"/> Role of nurse in midwifery and obstetrical care. <input type="checkbox"/> National policy and legislation in relation to maternal health & welfare <input type="checkbox"/> Maternal, morbidity, 	<ul style="list-style-type: none"> • Lecture discussion • Explain using Charts and graphs 	<ul style="list-style-type: none"> • Short answers • Objective type

			<p>mortality rates</p> <ul style="list-style-type: none"> <input type="checkbox"/> Perinatal, morbidity & mortality rates 		
II	08	<ul style="list-style-type: none"> • Describe the anatomy and physiology of female reproductive system 	<p>Review of anatomy and physiology of female reproductive system and fetal development</p> <ul style="list-style-type: none"> • Female pelvis-general description of the bones joints, ligaments, planes of the pelvis diameters of the true pelvis important landmarks, variations in pelvis shape. • Female organs of reproduction-external genitalia, internal genital organs and their anatomical relations, musculature blood-supply, nerves, lymphatic, pelvic cellular tissue, pelvic peritoneum. • Physiology of menstrual cycle • Human sexuality • Foetal development <input type="checkbox"/> Conception <input type="checkbox"/> Review of fertilization, implantation (embedding of the ovum), development of the embryo and placenta at term-function, abnormalities, the foetal sac, amniotic fluid, the umbilical chord, <input type="checkbox"/> Foetal circulation, foetal skull, bones, sutures and measurements. • Review of Genetics 	<ul style="list-style-type: none"> • Lecture discussion • Review with charts and models 	<ul style="list-style-type: none"> • Short answers • Objective type
III	08	<ul style="list-style-type: none"> • Describe the Diagnosis and management of women during antenatal period. 	<p>Assessment and management of pregnancy (ante-natal)</p> <ul style="list-style-type: none"> • Normal pregnancy • Physiological changes during pregnancy. <input type="checkbox"/> Reproductive system <input type="checkbox"/> Cardio vascular system <input type="checkbox"/> Respiratory system 	<ul style="list-style-type: none"> • Lecture discussion • Demonstration • Case discussion/ presentation • Health talk • Practice session • Supervised Clinical practice 	<ul style="list-style-type: none"> • Short answers • Objective type • Assessment of skills with check list *Assessment of patient management problems

			<ul style="list-style-type: none"> <input type="checkbox"/> Urinary system <input type="checkbox"/> Gastro intestinal system <input type="checkbox"/> Metabolic changes <input type="checkbox"/> Skeletal changes <input type="checkbox"/> Skin changes <input type="checkbox"/> Endocrine system <input type="checkbox"/> Psychological changes <input type="checkbox"/> Discomforts of pregnancy • Diagnosis of pregnancy <ul style="list-style-type: none"> <input type="checkbox"/> Signs <input type="checkbox"/> Differential diagnosis <input type="checkbox"/> Confirmatory tests • Ante-natal care <ul style="list-style-type: none"> <input type="checkbox"/> Objectives <input type="checkbox"/> Assessment History and physical examination, Antenatal Examination, Signs of previous child-birth <input type="checkbox"/> Relationship of foetus to uterus and pelvis: Lie, Attitude, Presentation, Position <input type="checkbox"/> Per vaginal examination <ul style="list-style-type: none"> * Screening and assessment for high risk: * Risk approach • History and Physical Examination Modalities of diagnosis; Invasive & Non- Invasive & ultrasonic, cardio tomography, NST, CST • Antenatal preparation <ul style="list-style-type: none"> <input type="checkbox"/> Antenatal counseling <input type="checkbox"/> Antenatal exercises <input type="checkbox"/> Diet <input type="checkbox"/> Substance use Education for child-birth <input type="checkbox"/> Husband and families <input type="checkbox"/> Preparation for safe confinement <input type="checkbox"/> Prevention from radiation • Psycho-social and cultural aspects of pregnancy <ul style="list-style-type: none"> <input type="checkbox"/> Adjustment to pregnancy <input type="checkbox"/> Unwed mother <input type="checkbox"/> Single parent <input type="checkbox"/> Teenage pregnancy 		
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			<input type="checkbox"/> Sexual violence * Adoption		
IV	12	<ul style="list-style-type: none"> • Describe the physiology and stages of labour. • Describe the management of women during intranatal period 	Assessment and management of intra natal period. <ul style="list-style-type: none"> • Physiology of labour, mechanism of labour. • Management of labour <ul style="list-style-type: none"> <input type="checkbox"/> First stage -Signs & symptoms of onset of labour Duration Preparation of: <ul style="list-style-type: none"> √ Labour room √ Woman - Assessment and observation of women in labour; partogram maternal & foetal monitoring - Active management of labour, Induction of labour - Pain relief & comfort in Labor • Second stage <ul style="list-style-type: none"> <input type="checkbox"/> Signs and symptoms; normal & abnormal <input type="checkbox"/> Duration <input type="checkbox"/> Conduct of delivery; Principles & techniques <input type="checkbox"/> Episiotomy (only if required) <input type="checkbox"/> Receiving the new born <ul style="list-style-type: none"> - Neonatal resuscitation initial steps & subsequent resuscitation - Care of umbilical cord - Immediate assessment including screening for congenital anomalies - Identification - Bonding - Initiate feeding - Screening and transportation of the neonate • Third Stage <ul style="list-style-type: none"> <input type="checkbox"/> Signs and symptoms; normal and abnormal <input type="checkbox"/> Duration 	<ul style="list-style-type: none"> • Lecture discussion • Demonstration • Practice session • Supervised Clinical practice 	<ul style="list-style-type: none"> • Essay type • Short answers • Objective type • Assessment of skills with check list *Assessment of patient management problems

			<ul style="list-style-type: none"> <input type="checkbox"/> Method of placenta expulsion <input type="checkbox"/> Management; Principles and techniques <input type="checkbox"/> Examination of the placenta <input type="checkbox"/> Examination of perineum <input type="checkbox"/> Maintaining records & reports • Fourth Stage 		
V	05	<ul style="list-style-type: none"> • Describe the physiology of puerperium • Describe the management of women during post-natal period 	<p>Assessment and management of women during post natal period</p> <ul style="list-style-type: none"> • Normal puerperium; Physiology Duration • Postnatal assessment and management <input type="checkbox"/> Promoting physical & emotional well being <input type="checkbox"/> Lactation management <input type="checkbox"/> Immunization • Family dynamics after childbirth. • Family welfare services; methods, counseling • Follow – up • Records and reports 	<ul style="list-style-type: none"> • Lecture discussion • Demonstration • Health talk • Practice session • Supervised Clinical practice 	<ul style="list-style-type: none"> • Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problems

VI	06	<ul style="list-style-type: none"> • Describe the assessment and management of normal neonate 	<p>Assessment and management of normal neonates.</p> <ul style="list-style-type: none"> • Normal neonates; <input type="checkbox"/> Physiological adaptation, <input type="checkbox"/> Initial & Daily assessment <input type="checkbox"/> Essential newborn care; Thermal control, <input type="checkbox"/> Breast feeding, prevention of infections • Immunization • Minor disorders of newborn and its management • Levels of neonatal care (level I, II& III) • At primary, secondary and tertiary levels • Maintenance of Reports & Records 	<ul style="list-style-type: none"> • Lecture discussion • Demonstration • Practice session • Supervised Clinical practice 	<ul style="list-style-type: none"> • Essay type • Short answers • Objective type • Assessment of skills with check list *Assessment of patient management problems
VII	10	<ul style="list-style-type: none"> • Describe the identification and management of women with high risk pregnancy 	<p>High risk pregnancy assessment & management</p> <ul style="list-style-type: none"> • Screening & assessment <input type="checkbox"/> Ultrasonic, cardiotomography, NST, CST, non-invasive & invasive, <input type="checkbox"/> Newer modalities of diagnosis • High – risk approach • Levels of care; primary, secondary & tertiary levels • Disorders of pregnancy <input type="checkbox"/> Hyper- emesis gravidarum, bleeding in early pregnancy, abortion, ectopic Pregnancy, vesicular mole, <input type="checkbox"/> Ante-partum hemorrhage • Uterine abnormality and displacement. • Diseases complicating pregnancy <input type="checkbox"/> Medical & surgical conditions <input type="checkbox"/> Infections, RTI (STD), UTI, HIV, TORCH 	<ul style="list-style-type: none"> • Lecture discussion • Demonstration • Practice session • Supervised Clinical practice 	<ul style="list-style-type: none"> • Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problems

			<ul style="list-style-type: none"> <input type="checkbox"/> Gynecological diseases complicating pregnancy <input type="checkbox"/> Pregnancy induced hypertension & diabetes, Toxemia of pregnancy, Hydramnios, <input type="checkbox"/> Rh incompatibility <input type="checkbox"/> Mental disorders • Adolescent pregnancy, Elderly primi and grand multipara • Multiple Pregnancy • Abnormalities of placenta & cord • Intra – uterine growth – retardation • Nursing management of mothers with high- risk pregnancy • Maintenance of Records & Report 		
VIII	10	<ul style="list-style-type: none"> • Describe management of abnormal labour. And Obstetrical emergencies 	<p>Abnormal Labour- Assessment and management</p> <ul style="list-style-type: none"> • Disorders in labour <input type="checkbox"/> CPD & contracted pelvis <input type="checkbox"/> Malpositions and malpresentations <input type="checkbox"/> Premature labour, disorders of uterine actions –precipitate labour prolonged labour <input type="checkbox"/> Complications of third stage: injuries to birth canal * Obstetrical emergencies and their management; <input type="checkbox"/> Presentation & prolapse of cord, Vasa praevia, amniotic fluid embolism rupture of uterus, shoulder dystocia, obstretical shock • Obstetrical procedures & operations; <input type="checkbox"/> Induction of labour, forceps, vacuum version, manual removal of placenta, caesarean section, destructive operations 	<ul style="list-style-type: none"> • Lecture discussion • Demonstration • Practice session • Supervised Clinical practice 	<ul style="list-style-type: none"> • Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problems

			* Nursing management of women undergoing Obstetrical operations and procedures		
IX	04	*Describe management of postnatal complications	<p>Abnormalities during postnatal periods</p> <ul style="list-style-type: none"> • Assessment and management of woman with postnatal complications □ Puerperal infections, breast engorgement & infections, UTI, thrombi-Embolic disorders, Post-partum hemorrhage, Eclampsia and sub involution, □ Psychological complications: <ul style="list-style-type: none"> - Post partum Blues - Post partum Depression - Post partum Psychosis 	<ul style="list-style-type: none"> • Lecture discussion • Demonstration • Practice session • Supervised Clinical practice 	<ul style="list-style-type: none"> • Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problems

X	08	* Identify the high risk neonates and their nursing management	<p>Assessment and Management High risk newborn.</p> <ul style="list-style-type: none"> • Admission of neonates in the neonatal intensive care units protocols • Nursing management of: <ul style="list-style-type: none"> - Low birth weight babies - Infections - Respiratory problems - Hemolytic disorders - Birth injuries - Malformations • Monitoring of high risk neonates • Feeding of high risk neonates • Organization & Management of neonatal intensive care units • Infection control in neonatal care units • Maintenance of reports and records 	<ul style="list-style-type: none"> • Lecture discussion • Demonstration • Practice session • Supervised Clinical practice 	<ul style="list-style-type: none"> • Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problems
XI	04	* Describe indication, dosage, action, side effects & nurses responsibilities in the administration of drugs used for mothers.	<p>Pharmaco- therapeutics in obstetrics</p> <ul style="list-style-type: none"> • Indication, dosage, action contra indication & side effects of drugs • Effect of drugs on pregnancy, labour & puerperium, • Nursing responsibilities in the administration of drug in Obstetrics – Oxytocins, anti hypertensives, diuretics tocolytic agents, anticonvulsants; • Analgesics and anesthetics in obstetrics. • Effects of maternal medication on fetus & neonate 	<ul style="list-style-type: none"> • Lecture discussion • Demonstration • Practice session • Supervised Clinical practice 	<ul style="list-style-type: none"> • Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problems

XII	10	<ul style="list-style-type: none"> • Appreciate the importance of family welfare programme • Describe the methods of contraception & role of nurse in family welfare programme 	<p>Family welfare programme</p> <ul style="list-style-type: none"> • Population trends and problems in India • Concepts, aims, importance and history of family welfare programme • National Population: dynamics, policy & education • National family welfare programme; RCH, ICDS, MCH. Safe motherhood • Organization and administration; at national state, district, block and village levels • Methods of contraception; spacing, temporary & permanent, Emergency contraception • Infertility & its management • Counseling for family welfare programme • Latest research in contraception • Maintenance of vital statistics • Role of national, international and voluntary organizations • Role of a nurse in family welfare programme • Training / Supervision/ Collaboration with other functionaries in community like ANMs. LHVs, Anganwadi workers, TBAs(Traditional birth attendant-Dai) 	<ul style="list-style-type: none"> • Lecture discussion • Demonstration • Practice session • Supervised • Practice • Group Project 	<ul style="list-style-type: none"> • Essay type • Short answers • Objective type • Assessment of skills with check list • Assessment of patient management problems
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References:

1. DUTTA-
 - Text book of Obstetrics 4th Ed.,
 - Text book of Gynecology 3rd ed.,
2. C.S.DAWN-
 - Textbook of Gynecology Contraception and Demography 13th ed.,
3. BOBAK JENSEN-
 - Essentials of Maternity Nursing 3rd ed.,
4. LONGMAN
 - Clinical Obstetrics 9th ed.,
5. CAMPBELL
 - Gynecology by ten teachers 17th ed.,
6. MYLES
 - Text book of Midwives 14th ed.,

PRACTICAL

**Placement : Third Year
Fourth Year**

**Time : Practical 180 Hours
Practical 180 Hours**

Areas	Duration (in weeks)	Objective	Skills to be developed	Assignment	Assessment Methods
Antenatal Clinic/OPD	2	<ul style="list-style-type: none"> Assessment of pregnant women 	<ul style="list-style-type: none"> Antenatal history taking Physical Examination Recording of weight & B.P Hb & Urine testing for sugar and albumin Antenatal examination abdomen & breast Immunization Assessment of risk status Teaching antenatal mothers Maintenance of Antenatal records 	<ul style="list-style-type: none"> Conduct Antenatal Examinations 30 Health talk-1 Case book Recordings 	<ul style="list-style-type: none"> Verification of findings of Antenatal examinations Completion of casebook recordings
Labour room O.T.	4	<ul style="list-style-type: none"> Assess woman in labour Carry out per-vaginal examinations Conduct normal deliveries Perform episiotomy and suture Resuscitate newborns Assist with caesarean Sections, MTP & other surgical procedures 	<ul style="list-style-type: none"> Assessment of woman in labour Pervaginal examinations and interpretation Monitoring & caring of woman in labour Maintenance of partograph Conduct normal delivery Newborn assessment & immediate care Resuscitation of newborns Assessment of risk status of newborn Episiotomy & suturing Maintenance of labour and birth records Arrange for & assist with Caesarean section & care for woman & baby during Caesarean Arrange for and assist with MTP & other surgical procedures 	<ul style="list-style-type: none"> Conduct normal deliveries-20 Pervaginal examinations- 5 Perform and suture the episiotomies- 5 Resuscitate newborns-5 Assist with caesarean Sections-2 Witness abnormal deliveries-5 Assist with MTP & other surgical procedures-1 Case book recordings 	<ul style="list-style-type: none"> Assessment of clinical performance with rating scale Assessment of each skill with checklists Completion of case book recordings Evaluation of case study & presentation & health education sessions

Postnatal ward	4	<ul style="list-style-type: none"> • Provide nursing care to post natal mother & baby • Counsel & teach mother & family for parent hood 	<ul style="list-style-type: none"> • Examination & assessment of mother & baby • Identification of deviations • Care of postnatal mother & baby • Perineal care • Lactation management • Breast feeding • Baby bath • Immunization, • Teaching postnatal mother: <ul style="list-style-type: none"> <input type="checkbox"/> Mother craft <input type="checkbox"/> Post natal care & <input type="checkbox"/> Exercises <input type="checkbox"/> Immunization 	<ul style="list-style-type: none"> • Give care to post natal mothers-20 • Health talks- 1 • Case study- • Case presentation- 1 • Case book recordings 	<ul style="list-style-type: none"> • Assessment of clinical performance • Assessment of each skill with checklists • Completion of case book recording • Evaluation of case study and presentation and health education sessions
Newborn nursery	2	<ul style="list-style-type: none"> • Provide nursing care to Newborn at risk 	<ul style="list-style-type: none"> • Newborn assessment • Admission of neonates • Feeding of at risk neonates <ul style="list-style-type: none"> <input type="checkbox"/> Katori spoon, paladi, tube feeding, total parenteral nutrition • Thermal management of neonates-kangaroo mother care, care of baby in incubator • Monitoring and care of neonates • Administering medications • Intravenous therapy • Assisting with diagnostic procedure • Assisting with exchange transfusion • Care of baby on ventilator • Phototherapy • Infection control protocols in the nursery • Teaching & counseling of parents • Maintenance of neonatal records 	<ul style="list-style-type: none"> • Case study-1 • Observation study-1 	<ul style="list-style-type: none"> • Assessment of clinical performance • Assessment of each skill with checklists • Evaluation of & Observation study

Family Planning clinic	Rotation from post natal ward 1 wk	<ul style="list-style-type: none"> • Counsel for & provide family welfare services 	<ul style="list-style-type: none"> • Counseling technique • Insertion of IUD • Teaching on use of family planning methods • Arrange for & Assist with family planning operations • Maintenance of records and reports 	<ul style="list-style-type: none"> • IUD insertion-5 • Observation Study-1 • Counseling -2 • Simulation exercise on recording and reporting-1 	<ul style="list-style-type: none"> • Assessment of each skill with checklists • Evaluation of & Observation study
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MIDWIFERY & OBSTETRIC PRACTICE

HOURS:

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

TOTAL HRS : THEORY 90 + PRACTICAL 600

EXAMINATIONS:

	THEORY			PRACTICAL		
	Marks	III year	IV year	Marks	III year	IV year
Periodic	25	✓	✓	50	✓	✓
Midterm	50	✓	-	50	✓	-
Pre final	75	-	✓	50	-	✓
TOTAL		175		200		

ASSIGNMENTS:

THEORY				
No.	Assignment	Marks	III year	IV year
1	Group Project	50	-	✓
2	Seminar	50	✓	-
3	Drug Study	50	-	✓
	TOTAL	150	-	-

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

EVALUATION

Internal Assessment:

Theory:	Maximum marks 25
Periodical examination –02 (One in 3rd and one in 4th year) but average for 25 only	25
Mid term examination –(3rd year)	50
<u>Pre-final – (4th year)</u>	<u>75</u>
Total Marks	150
	Out of 15

Assignments:

Seminar 01 (3rd year)	50
Drug study 01 (4th year)	50
Total Marks	100
	Out of 10

Practical:

Case presentation 01 (4th year) Antenatal ward / Postnatal ward	Marks 50
Care study 03(4th year) Antenatal ward- 01 } (50 marks each) Postnatal ward 01 } Newborn 01	Marks 150
Health education 01 (3rd year)	Marks 25
Newborn assessment 01 (3rd year)	Marks 25
Case book (3rd year, 4th year & internship)	Marks 100
Clinical evaluation 04 ANC ward 01 } PNC ward 01 } (100 marks each) Nursery 01 } (3rd year, 4th year) Labor room 01 }	Marks 400
Practical examination Periodical viva	Marks 25
Midterm examination	Marks 50
Prefinal examination	Marks 100

Total marks 925
Maximum marks = 100

Practical Examination:

University Exam

Theory

Practical

Marks 75

Marks 100

Note: Final examination will take place in 4th year

SEMINAR EVALUATION CRITERIA

NAME : _____ DATE : _____
AUDIENCE : _____ TIME : _____
TOPIC : _____ MARKS : _____

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

Overall Observation

Signature of Teacher

Signature of the Candidate

Signature of Principal

Drug study

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

Evaluation criteria

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

ANC CASE STUDY / PRESENTATION FORMAT

Identification data

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

Husband: Name, Age, education, occupation, income

Present complaints:

History of illness:

Menstrual history:

Age of menarche, duration of menstrual cycle, duration of cycle in days, regularity, amount of flow, LMP, EDD, associated complaints

Contraceptive history:

Antenatal attendance:

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

Obstetric history:

H/O Previous pregnancy / deliveries, Period of pregnancy, type of labour/delivery, birth weight, PNC condition, remarks

Present pregnancy:

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

Past medical, surgical history:

Family history:

Diet history:

Socioeconomic status

Personal habits

Psychosocial status

Physical assessment:

General examination: head to foot

Obstetric palpation, Auscultation

Conclusion

Investigation

Ultrasonography

Treatment

Description of disease

Therapeutic diet plan

Nursing care plan

Nurse's notes

Discharge planning

Antenatal advice

Evaluation of care

References

ANC CASE STUDY / PRESENTATION FORMAT

Identification data

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

Husband: Name, Age, education, occupation, income

Present complaints:

History of illness:

Menstrual history:

Age of menarche, duration of menstrual cycle, duration of cycle in days, regularity, amount of flow, LMP, EDD, associated complaints

Contraceptive history:

Antenatal attendance:

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

Obstetric history:

H/O Previous pregnancy / deliveries, Period of pregnancy, type of labour/delivery, birth weight, PNC condition, Condition of new born, remarks

Present pregnancy:

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

Past medical, surgical history:

Family history:

Diet history:

Socioeconomic status

Personal habits

Psychosocial status

Physical assessment:

Mother: General examination: head to foot

Baby: new born assessment

Conclusion

Investigation

Ultrasonography

Treatment

Description of disease

Therapeutic diet plan

Nursing care plan
Nurse's notes
Discharge planning
Antenatal advice
Evaluation of care
References

NEW BORN CASE STUDY FORMAT

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

EVALUATION CRITERIA CASE STUDY

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

EVALUATION CRITERIA CASE PRESENTATION

Assessment / Introduction	05
Knowledge & understanding of disease / condition	10
Presentation skill	10
Nursing care plan	15
A.V. aids	05
Summary & evaluation	03
Bibliography	<u>02</u>
TOTAL	50

EVALUATION FORMAT FOR HEALTH TALK

NAME OF THE STUDENT : _____

AREA OF EXPERIENCE : _____

PERIOD OF EXPERIENCE : _____

SUPERVISOR : _____

Total 100 Marks

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

Sr. No.	Particulars	1	2	3	4	5	Score
1	<p>I) Planning and organization</p> <p>a) Formulation of attainable objectives</p> <p>b) Adequacy of content</p> <p>c) Organization of subject matter</p> <p>d) Current knowledge related to subject Matter</p> <p>e) Suitable A.V.Aids</p> <p>II) Presentation:</p> <p>a) Interesting</p> <p>b) Clear Audible</p> <p>c) Adequate explanation</p> <p>d) Effective use of A.V. Aids</p> <p>e) Group Involvement</p> <p>f) Time Limit</p> <p>III) Personal qualities:</p> <p>a) Self confidence</p> <p>b) Personal appearance</p> <p>c) Language</p> <p>d) Mannerism</p> <p>e) Self awareness of strong & weak points</p> <p>IV) Feed back:</p> <p>a) Recapitulation</p> <p>b) Effectiveness</p> <p>c) Group response</p> <p>V) Submits assignment on time</p>						

* 100 marks will be converted into 25

NEW BORN ASSESSMENT

Similar to child health nursing

Case book

Note: 1. Case book contents

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

2. All cases should be certified by teacher on completion