Council for Technical Education & Vocational Training

Sanothimi, Bhaktapur

Behavior Science and Mental Health Nursing (Clinical)

Evaluation Scheme

Subject: Behavior Science and Mental Health Nursing

Full Mark: 25

Pass Marks: 12.5

Location of Practice: Mental Hospital/Psychiatric Ward

During 2 weeks placement in Mental Hospital, students should submit following assignments.

SN	Activities	Marks	No. of Assignments
1.	Clinical Performance	5	
2.	Family Health Teaching	2.5	1
3.	Case study presentation	5	1
4.	Mental Status Examination	5	1
5.	Drug Book	2.5	1 (at least five drugs)
6.	Nursing Care Plan	5	
Total		**25**	

Council for Technical Education & Vocational Training

Sanothimi, Bhaktapur

Course: PCL Nursing
Year: Second
Subject: Mental Health
Area of practice: Mental Hospital

Student Name:
Full Mark: 5
Pass Mark: 2.5
Obtained Mark:

1. Clinical Performance

Direction: This evaluation form will be use to evaluate student's day to day performance in Mental Health practicum. Student's performance will be evaluated by following criteria.

Key for Marking:

Satisfactory	Good	Excellent
1	1.5	2

SN	Criteria	1	1.5	2
1	Demonstrates sensitivity to the needs and problems of patients and families			
2	Identifies verbal and non verbal response while communicating to patients and families			
3	Collects complete and relevant psychiatric history			
4	Performs Mental Status Examination			
5	Uses participatory approach to identify needs and planning for care			
6	Provides holistic care using traditional belief and practice			
7	Implement care plan in logical sequence according to priority need of patients			
8	Considers safety and comfort needs			
9	Maintains therapeutic relation to patients and families			
10	Involves patients in diversion therapy			
11	Provides counseling and psychological therapy to the patients and family members			
12	Interacts with health team members, patient, patient' family and colleagues			
13	Records all the pertinent information of patient's problems, his response to illness and care given clearly			
14	Demonstrates knowledge of various referral agencies for the rehabilitation of patient and family			
15	Provides health education to the patient and visitors during hospitalization and at the time of discharge			
16	Demonstrates accountability and responsibility for the outcome of all her nursing action			
17	Utilizes available resources and involve patients and family			
18	Punctuality			
19	Regularity			
20	Submits report in time			
Total				

(Total marks is divided by 8)

Strengths:

Areas to be improved:

………………………….. **…………………**

Signature of Supervisor **Date**

Council for Technical Educational & Vocational Training
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Area of practice: Mental Hospital
Obtained Mark:

Student Name:
Full Mark: 2.5
Pass Mark: 1.25

2. Health Teaching

Direction: Each student has to provide a health teaching to client and family in the respective clinical area.

Key for Marking:

Satisfactory	Good	Excellent
1	1.5	2

SN	Criteria	1	1.5	2
1	Identifies need of the client and select the topic.			
2	Assesses clients' level of knowledge in the topic			
3	Organizes appropriate time and place for the teaching to the client/family.			
4	Prepares lesson plan with objectives, content and teaching activities.			
5	Uses appropriate audio-visual aids using available local resources and appropriate methods.			
6	Uses appropriate language according to level of understanding of clients and family.			
7	Encourages active group participation			
8	Summarizes teaching by going over main points.			
9	Evaluates the presentation by self and accept the feedback.			
10	Maintains discipline, attitude and dress appropriately in the clinical field areas.			
Total				

(Total marks is divided by 8)

Strengths:

Areas to be improved:

…………………………. …………………

Signature of Supervisor **Date**

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Pass Mark: 2.5
Obtained Mark:

3. Case Study Presentation

Direction: During clinical practicum, each student will present one case study in clinical setting under supervision. The presentation will be evaluated according to the following criteria.

Key for Marking:

Satisfactory	Good	Excellent
1	1.5	2

SN	Expected Criteria	1	1.5	2
1	Plans, selects and informs the team for case presentation.			
2	Arranges an appropriate place and logistics.			
3	Organizes the presentation according to the given format.			
4	Communicates an overview of presentation to the audience.			
5	Presents in-depth information about case.			
6	Uses adequate related visual aids.			
7	Demonstrates in-depth knowledge and confidence about presentation.			
8	Interacts with audience and respond their queries.			
9	Summarizes the presentation within the time frame.			
10	Evaluates the presentation by self and accept the feed back.			
Total				

(**Total marks is divided by 4)**

Strengths:

Areas to be improved:

……………………… ……………

Signature of Supervisor **Date**

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Pass Mark: 2.5
Obtained Mark:

4. Format for Mental Status Examination

Identification Data of patient:

Name:
Age/Sex:
Marital Status:
Education:
Occupation:
Religion:
Residence:

- Present address:
- Permanent address:

Source of referral:

Informant:

- relation to patient:
- duration of stay with patient:

Inpatient Record:

Ward:
Diagnosis:
Bed no:
Attending Doctor:
Date of admission:
Number of ECT:
Type of psychotherapy:
I.P. number:

1. **GENERAL APPEARANCE AND BEHAVIOR**

- Body build and physical appearance(Approximate height, weight and appearance)
- Looks: comfortable/uncomfortable
- Grooming, Hygiene, self care
- Dressing(adequate/appropriate)
- Eye contact: Yes/no
- Attitude towards the examiner
    - Cooperation
    - Hostility
    - Attentiveness
    - show interest
    - appears disinterested

- Gait /posture (Normal/abnormal way of sitting, standing, walking, lying)
- Motor activity
  - Increase/decreased
  - Excitement/stupor
  - Abnormal voluntary movements
  - Restlessness/akathisia
  - Catatonic signs(mannerism, waxy flexibility, negativism)
- Rapport (Spontaneous difficult, not established)
- Hallucinatory Behavior (Smiling and talking to self)

2. Speech

- Volume and tone of speech: increased/decreased
- Reaction time: Normal, delayed,
- Rate: Normal, slow or rapid
- Tone: Normal, variation, spontaneous
- Relevance: Fully relevant, sometime off target, irrelevancy
- Coherence: Fully coherent, loosening of association, flight of ideas

3. Mood

- Subjective mood (patient is asked about present mood: How do you feel?)
- Objective mood (observed emotional change in the patient: happy, sad, anxious, worried)

4. Thought

- Stream and Form of thought
- Any loosening of association
- Flight of ideas
- Tangentiality
- Circumstantiality
- Illogical thinking
- Perseveration
- Verbigeration

ii. Content of thought (any preoccupation)

- Obsession
- Content of phobia
- Delusion
- Hopeless
- Helpless
- Worthless
- Suicidal ideation
- Thought insertion
- Thought broadcast

5. Perception

- Hallucination (auditory, visual, olfactory, gustatory, tactile)
- Illusion
- Depersonalization/derealization

6. Cognitive function

i. **Consciousness:** conscious, cloudy, comatose

ii**. Orientation**

- Time: time, day, date, month, year
- Place: Kind of place, area, city
- Person: Self, close associate, hospital staff

iii. **Attention** (normally aroused/ aroused with difficulty)

- Digit forward/backward

iv. **Concentration** (normally sustained/sustained with difficulty/distractible)

- 100-7, 40-3 ,20-1, name of month/week(backward)

v. **Memory**

- Immediate memory : Memory within 5-10 minutes, use digit span to assess the immediate memory
- Recent memory (memory within 24-72 hours): Ask what you ate for the dinner at night
- Remote memory (Memory of significant happening of life) : Ask for date and place of birth

vi. **Intelligence**

Ask for general information, keeping in minds the general education and social background, experience and interest e.g. Current Prime Minister Name, arithmetic ability

vii**. Abstract thinking**

- Interpretation of proverb
- Similarities/Dissimilarities between paired objects

7. Insight (present/absent)

Insight is the degree of awareness and understanding that the patient has regarding the illness

8. Judgment (good/intact, poor/impaired)

- Social judgment: Observe during hospital stay and during interview session
- Test judgment: Can be assessed in certain situation like by asking the patient what would you do in certain situation e.g. a house on fire
- Personal judgment:

Summary of the finding:

Strengths:

Areas to be improved:

……………………… **……………**

Signature of Supervisor **Date**

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Pass Mars: 1.25
Obtained Mark:

5. Drug Book

Direction: Each student should prepare drug book using following criteria and should include at least five drugs.

Key for Marking:

Satisfactory	Good	Excellent
1	1.5	2

SN	Criteria	1	1.5	2
1	States generic name and trade name			
2	Mentions indication and usage			
3	Mentions dose and route of administration			
4	States drug interaction			
5	Analyzes adverse reaction to the patient			
6	States contraindications			
7	States warnings sign			
8	Explains nursing management			
9	Prepares complete clear and in-depth drug book			
10	Submits report on time			
Total				

(Total marks is divided by 8)

Strengths:

Areas to be improved:

………………………….   …………………

Signature of Supervisor   **Date**

Council for Technical Educational & Vocational Training

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Student Name:
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Pass Mark: 2.5
Obtained Mark:

6. Nursing Care Plan

Direction: Each student has to submit five nursing care plan of patient according to given guidelines.

Key for Marking:

Satisfactory	Good	Excellent
1	1.5	2

SN	Criteria	1	1.5	2
1	Identifies the patient's present and potential problem appropriately			
2	Prioritizes problem as its severity and identify the significant cause			
3	Formulates the nursing diagnosis			
4	Plans the nursing action accordingly			
5	Gives rational for each nursing action in relation to the problem			
6	Provides the care according to the plan using available resources			
7	Involves the patient and the family in the care process accordingly			
8	Evaluates the progress of patient's condition after giving care			
9	Revises the care plan after assessing the process and implementation of care			
10	Records and reports completely on time.			
	Total			

(Total marks is divided by 4)

Strengths

Areas to be improved:

………………………….. **…………………**

Signature of Supervisor **Date**

Appendix

Council for Technical Education & Vocational Training

Sanothimi, Bhaktapur

Nursing Care Plan Format

Name of the Patient: Date of Admission:

Age/Sex: Diagnosis:

I.P. No.: Bed No:

Ward: Date:

S.N.	Problem Assessment	Nursing Diagnosis	Expected Outcome(Goal)	Plan of Nursing Action	Implementation of Action	Scientific Principle/ Rational	Evaluation
	Subjective data: Objective data:						

…………………………
Signature of Supervisor

Date :

……………………
Signature of student

Date :