

Documentation in Psychiatric Nursing

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Documentation is anything written or electronically generated that describes the status of a client or the services given to that client (1). In nursing practice, it is used to monitor a client's progress and to communicate with other care providers; it also reflects the nursing care that is provided to a client (2).

Thus regardless of the area of practice or whether it is paper-based or electronic, documentation is inevitable in nursing as it is essential for safe, ethical and effective nursing practice.

Three common documentation methods are used namely - focus charting, SOAP/SOAPIER and narrative documentation. Flow sheets and checklists are also frequently used as an adjunct to document routine and ongoing assessments and observations.

Purposes of Documentation in Psychiatric Nursing Practice

It is a tool to enhance practice and patient care. Patient care documents are reliable, permanent records of client care which serve as basis for communication between health professionals. Documentation demonstrates professional accountability; it can be used for nursing audit and legal requirements. Further it provides a base for improving the quality of service and facilitates research and also provides a valuable source of evidence and rationale for funding and resource management.

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Nurses working in the psychiatric care settings have a vital role in collecting information about patients which will help in making accurate diagnosis and providing therapeutic care for the patients.

Principles in Psychiatric Nursing Documentation

In addition to ensuring that the documentation is factual, accurate, prompt, organized, and complete and guided by institutional policy, nurses assigned to psychiatric in-patient care can enrich the quality of their record by including specific aspects such as:

- A bio- psychosocial assessment of the patient to assist in developing the nursing care plan.
- Condition of the patient and the chief (target) symptoms for which he/ she is being treated.
- Observations on patients who need seclusion and restraints
- Side effects of medications are mentioned specifically as it alerts the health care professionals on the severity of the health problems caused by the drugs and the need for patient monitoring and reviewing the drugs prescribed for the patients.
- Record of the vital signs as per routines and policies of the psychiatric ward most importantly for those patients requiring frequent monitoring.
- Observations on behaviors of the patient during activity therapies and interaction with other patients, family members, and ward staff, appetite, medication, compliance with hospital policies, as this provides information on patients' progress and state of mind.
- Nursing interventions provided and the effectiveness.
- Record of interaction during the therapeutic nurse-patient relationship.
- The opinion and reasons for the level of care needed for the patients (whether they need further hospitalization).

Psychiatric –mental health care providers must remember that treatment of mentally ill patients are often less voluntary, and public often lack awareness of treatment and care of patients with mental disorders. On admission to the hospital, patients lose their freedom to walk in and out of the hospital, schedule their activities, and manage home, finances, business and sometimes even making important decisions.

Because of the curtailment of freedom, patient advocacy values the rights of mentally ill patients. Every patient has a right to a written record that enhances his/her care. These are legal documents. Therefore the nurses' records, progress notes should be objective, non-judgmental and descriptive. A medical record is the best source of legal protection in a malpractice suit.

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