

Documentation guidelines based on expectation of documentation helps accurate documentation among nurses in psychiatric settings

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ABSTRACT:

Careful documentation is an integral part of nursing care. It is written information about a client that describes the care or service provided by nurse to client according to their need. Through documentation, nurses communicate their observations, decisions, actions and outcomes of these actions for clients. In the present study an 'ideal documentation guidelines of nurses caring mentally ill client' was developed which can be used by the psychiatric nurses for thorough assessment as well as assessment of the documents. The ideal documentation guidelines consist of four important care areas namely are admission, discharge, selected procedure and specific incident. The study was conducted to compare the expectation of documentation by nurse administrators and actual performance by staff nurses in selected settings. Twenty five administrative nurses and 25 staff nurses were participated in the study. Result showed assessment of majority of actual performance documentation by the staff nurses showed almost proper behaviours and remaining was partially proper. No nurses documentations depict nurses behaviours proper (lowest level) or (highest level) i.e. proper. Same manner administrative nurse also expected a behaviour from the staff nurses that was almost proper behaviours in documentation. Study revealed actual performance with documentation and expectation of the administrators has a significant relationship. Training, CNE etc which might prove to improve administrative nurses expectations of behaviours in psychiatric settings but an ideal documentation format or guideline can help nurses to follow proper documentation behaviour which will be based on the ideal documentation guidelines.

KEYWORDS: Nursing documentation, Nursing assessment, Nursing recording, Nursing information

INTRODUCTION:

Accurate record keeping and careful documentation is an essential part of nursing practice. The Nursing and Midwifery Council (NMC 2002) state that 'good record keeping helps to protect the welfare of patients and clients' – which of course is a fundamental aim for nurses' everywhere¹. Documentation is any written information about a client that describes the care or service provided to that client. It is not merely a set of certain forms, framed and designed but a document of facts and figures; containing segments of observations by trained and experienced observers².

It is a perfect proof of the expertise and experience of the team work of all those contributing towards the patient's health. Without knowledge of care given in the past, and of circumstances which made that care necessary, continuity of care can't be achieved. The two main forms of communication in nursing are verbal handover reports and written nursing documents. It is seen that comprehensive nursing documentation improves patient care³.

A study was done to determine the underlying causes of persistent antipathy towards documentation in patient's chart. The results supported a common belief that resistance to charting is influenced by extrinsic or environmental factors, such as flexibility of charting systems and insufficient allocation of time. In addition, intrinsic factors of cognitive and psychosocial domain, such as lack of confidence about written expression, a tendency to succumb to group norms governing charting and difficulty in articulating the nature of nursing practice, surface as impediments to documentation⁴. Nurses are considered to be enhancers of healing and health. They use the humanistic ally oriented nursing practices to achieve their goal. In the care of mentally ill, the main work requires nurses to understand the dysfunctional internal processes. The nurses are responsible for performing the

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