

- **DOCUMENTATION IN PSYCHIATRIC NURSING**

- **PROBLEM ORIENTED RECORDING**

- Established by **Lawrence Weed** in 1960s.
- The data are **arranged according to the problems** the client has rather than the source of the information.
- Member of the health team contribute to the **problem list, plan of care, and progress notes.**

- **FDAR**

- **FOCUS CHARTING**

- A method of charting that uses key words or foci to describe what is happening to the client.

- **3 COLUMNS OF RECORDING** are usually used:

- 1. DATA and time

- 2. Focus

- 3. Progress notes

- ❖ The Progress Notes are organized into: DAR

- ✓ DATA

- ✓ ACTION

- ✓ RESPONSE

- DATA

- category reflects the assessment phase of the nursing process and consists of observation of client status and behaviors, including data from flow sheet (e.g. Vital signs).

- The nurse records both subjective and objective data in this section.

- ACTION

- Category reflects planning and implementation and includes immediate and future nursing actions.

- It also include any changes to the plan of care.

- PROGRESS NOTES

- RESPONSE:

- Category reflects the evaluation phase of the nursing process and describes the client's response to any nursing and medical care.

- Sample Charting:

- NARRATIVE RECORDING

- Is a traditional part of the source-oriented record.

- **SOURCE-ORIENTED RECORD:** is a traditional client record.

- Each person or department makes notations in a separate section or sections of the client's chart.

- Ex.

- The Admission Department: Admission sheet.

- The physician: physician's order/Doctor's order sheet.

- The nurses: Nurse's notes

- **Narrative Recording**

- In this type of record, information about a particular problem is distributed throughout the record.

- It consists of written notes that include routine care, normal findings, and client problems.

- There is no right or wrong order to the information, although chronological order is frequently used.

-

- **PROCESS RECORDING**

- Is a verbatim (word -for- word) account of conversation.

- It can be taped or written and includes all verbal and nonverbal interactions of both the client and nurse.

- One method of writing a process recording is to make two columns on a page.

- First column: list what the nurse and client said along with the associated nonverbal behavior.

- Second column: contains an analysis about the nurse's responses.

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M Tight



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