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Using instrumentation in psychiatric nursing to assess documentation of the nursing process for emergent non-psychiatric patient events

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ABSTRACT

Ongoing education of experienced psychiatric nurses is imperative given the historically complex health presentations of psychiatric patients. Psychiatric patients tend to have medical co-morbidities and often do not have the financial resources for preventative health care. The hospitalization for acute psychiatric stabilization, is an opportunity for psychiatric nurses to teach and advocate for patients' physiological and psychological health. Documentation of patients' changes in condition and overall clinical presentation, is necessary to ensure patients' health care needs are met.

Introduction

As health care evolves, nursing practice has become evidenced-based and outcome focused. When patients have changes in their condition status or there is a sentinel event, documentation must be clear and logically explain the assessments and interventions made by nursing staff and the health care team. In absence of documentation that extrapolates from the objective and subjective results of the nurse-patient interactions and the direct care provided by the nurse, continuity of patient care is disrupted.

Purpose of the educational intervention

An educational intervention of a nursing in-service on documentation of the nursing process, was developed to elicit feedback from registered nurses working within the specialty of psychiatric nursing, as to how they document changes in patients' conditions. Of particular interest was documentation that involved patient transfers to medical or surgical units whereby detailed nursing assessments and care provided was instrumental to the continuance of care of the patient. This educational intervention of in-service training with nurses, was developed to reinforce the foundational practice and implementation of the nursing process as a framework, in the documentation of clinical events. Institutional Review Board attainment was not indicated, as this was a quality improvement initiative.

The in-service was implemented as a means to determine if nurses were using the nursing process when they documented. The nursing process was used by the hospital system on all clinical units, and was within the nursing policy and procedure manual, however a means of ensuring compliance other than random chart audits, did not exist. Nineteen (n = 19) registered nurses from three adult inpatient psychiatric units participated within the in-service. A 10-item Likert-type questionnaire entitled, the Nursing Process Documentation Questionnaire (NPDQ) was developed by the author to capture data that provided evidence that the psychiatric nurses understood and were using the nursing process in their documentation. The NPDQ has not been implemented into practice change at this time.

Background

The author, discussed with the Director of Nursing for Psychiatry and the Psychiatric Service-line Nurse Educator, the importance of ensuring that nurses were using the nursing process to document, after observing two incidences whereby patients were transferred to inpatient medical and surgical units secondary to complications related to pre-existing medical problems (i.e. poorly controlled diabetes) and nursing documentation had gaps in the timeline of interventions implemented by the nurses. The author, an Off-Shift Nurse Leader within the Department of Psychiatry, discussed with some of the nursing staff, the importance of documenting the care that they provided to patients using the nursing process. Application of the nursing process to practice was explained as a framework by which to guide documentation, so that details of patient care were thoroughly described to clinical units receiving psychiatric patients for medical and surgical stabilization of conditions.

Literature review

Nursing policy documentation requirements at Yale-New Haven

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Hospital (YNHH) included the use of the nursing process to aid nurses in ensuring that their documentation was comprehensive and clearly supported clinical findings and presentation of patients receiving care. The nursing process consists of assessment, diagnosis, planning, implementation, and evaluation (Garcia & Nobrega, 2009; Taylor, Lillis, Lynn, & LeMone, 2015). Nurses are traditionally introduced to the nursing process during their nursing education. Within the discipline of nursing, documentation is foundationally built on the principals of the nursing process and is applied in practice by nurses when assessing and reevaluating patients to whom they provide care.

According to de Almeida Lopes Monteiro da Cruz et al. (2016), "The nursing care model guided by nursing process (NP) values the planning of actions, the interventions, the evaluations, and specific goals established for each patient" (p. 184). At YNHH, the nursing theorist representative of the core concept of caritas for the nurses that work within the health system, is Jean Watson. Jean Watson's Theory of Human Caring (Watson, 2008) is the theory. The Iowa model of evidenced-based practice (EBP) to promote quality care (Fitzpatrick & McCarthy, 2014; Titler et al., 2001; Titler, 2008), is the model adapted by YNHH to promote EBP in all aspects of care provided to patients by nurses. The Iowa model, fosters clinical environments that embrace nursing research, evidenced-based practice and care delivery to patients that emphasizes quality care and patient safety.

Lima and Ortiz (2015) noted that, "The accurate documentation of clinical data and information of patients is essential for care continuity, to develop clinical knowledge, found judgements, ensure safety, and manage nursing care" (p. 597). Nursing documentation is crucial for the communication and evaluation of patient care executed by registered nurses. Documentation is also necessary for the reimbursement of services provided to patients receiving care within health care systems (Lima & Ortiz, 2015). The attitudes and perceptions toward documentation vary amongst nurses, and are usually focused on the availability of time within a shift to complete documentation thoroughly (Petkovšek-Gregorin & Skela-Savič, 2015).

Blair and Smith (2012) noted that documentation quality is both an international and national issue in nursing practice, and that barriers to accurate, safe, and timely documentation must be identified and addressed for changes in documentation to occur. Petkovšek-Gregorin and Skela-Savič (2015) conducted a quantitative non-experimental research design with 592 nurses from June 1, 2012 to March 31, 2013 that were provided a survey (with close-ended questions) that evaluated nurses' attitudes and perceptions about documentation. The Cronbach's coefficient alpha was 0.898. Petkovšek-Gregorin and Skela-Savič (2015) compared nurses with a college degree compared with nurses with secondary education ($p = 0.0001$), and found no significant correlation ($p = 0.98$). A negative correlation was however, found between positive attitudes toward documentation and time used for documentation ($p = 0.04$).

Methodology

In September of 2016, in-service sessions were scheduled in collaboration with Department of Psychiatry Service-line Educator, Georg'ann Bona, MSN, RN. An instrument entitled, the Nursing Process Documentation Questionnaire (NPDQ) was developed by the author. Expert validation of the instrument was completed by Richard Feinn, PhD. The NPDQ is a 10-item Likert-type questionnaire (Appendix A) that is used to assess the application of the nursing process in nursing documentation. Nineteen nurse participants, were requested to read each question and place a number alongside each item indicating the extent to which the participant agreed or disagreed with statements pertinent to the process of documentation. Examples of statements from the NPDQ questionnaire include: (1). *I use my personal nursing judgement when I document about my patients' condition(s).* (2). *An assessment of my patient should always be included in my documentation.* (3). *I do not always think in terms of interventions when I am caring for a patient.* (4). *I often don't have time during my shift to document my notes*. The NPDQ pre and posttests were completed by the psychiatric nurses during the one-day in-service training.

Upon completion of an NPDQ pretest, the nurses were provided a 7-min didactic lecture refresher regarding the use of the nursing process when documenting patients' condition changes during medical (or surgical) events. A case study involving a patient in respiratory distress following exposure to an allergen, with no prior history of respiratory illness nor condition, was reviewed. Facilitation of a discussion applying critical and clinical thinking that involved nursing staff using the nursing process, was initiated by the author. The case study presentation and discussion was 8 to 15 min in length. All of the 19 nurses demonstrated understanding of the nursing process and its application to the clinical documentation during emergent events (n = 19, 100%) necessitating transfer of patients to higher acuity inpatient settings from the acute inpatient psychiatric units.

Case study. Applying the nursing process, this example of an asthmatic patient requiring nursing care, was reviewed with the psychiatric nurses during the in-service training. **Medical/respiratory case example**: A nurse assessed a patient with a history of adult onset asthma. The patient had suddenly become short of breath in the dayroom. The psychiatric nurse auscultated the patient's lung sounds and noted bilateral wheezing, then obtained a complete set of vital signs; temperature, 98.7 F (oral), pulse 88, respirations 25, blood pressure 126/82, and oxygen saturation 91% on room air. The nurse, determined the cause (potential trigger) of the asthmatic event and immediately administered a rescue inhaler and/or nebulizer treatments. The nursing process was initiated with the psychiatric nurse's immediate respiratory **assessment** of the patient. Given that the patient had the diagnosis of adult onset asthma, an asthma attack was the likely **diagnostic** rationale. **Planning** of the care of a patient experiencing an asthma attack occurs when a patient specific individualized plan of care has been developed within the patient's medical record for both inpatient and at-home care. **Implementation** of treatment recommendations specific to this patient may have included the rescue inhaler (bronchodilator) and if there is no response to inhaler use, a nebulizer. An emergent medical code would be called in the event the patient requires intravenous access for administration of a steroid such as Solu-Medrol (Methylprednisolone), if indicated. Lastly, the patient is **evaluated** for achievement of respiratory/medical stabilization and discharged to an inpatient medical (or pulmonary) unit.

Results

Posttests of the NPDQ were administered to the nurses (n = 18, 94.73%, one of the nurse's posttest was not completed). The p-values were all greater than 0.05 between pre and posttest, indicating that there was no significant change. Responses ranged from agree to somewhat agree (Figs. 1, 2, & 3). Pretest and posttests were completed the same day; the pretest before the in-service and posttests after education on the nursing process was provided. Of interest were the narratives written by nurses that completed the posttest; nurses shared that limited time to document while providing patient care, impeded their ability to document in a timely manner status post the emergent treatment and transfer of acutely-ill patients. These narratives both in writing and verbalized during the in-service training, were reflective of the necessity and importance of health care organizations educating nurses on the implications of not documenting in a timely manner.

Examples of narratives written by the nurses included: (1) "When my patients with psychiatric problems get sick medically, I get so shaken up. I did not see a lot of medical complications to this degree when I first came to Psychiatry 30 years ago. Patients are sicker now, so I see it more often. Good to be prepared." (2) With all of this flowsheet charting in the computer, I have literally forgotten how to write a good note. This in-service helped me a lot." (3) "I sent a patient to the emergency department the other night. I am now thinking, I did not