

## **A Study to Assess the Knowledge of Documentation while Taking Care of Mentally Ill Patients among Staff Nurses in the Psychiatric Ward of the Narayana Medical College Hospital at Nellore, Andhra Pradesh**

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### **Abstract**

The present study has determined the knowledge of documentation in caring for mentally ill patients among nursing staff in the psychiatric wards of Narayana Medical College Hospital at Nellore, Andhra Pradesh. The study has estimated demographic variables regarding 60 staff nurses, and it has been executed with the help of SPSS. Among 60 staff nurses, there are approximately 30% have done diploma, 38.3% have a B.Sc, 23.3% P.B.B.Sc, and 8.3% completed their M.Sc in nursing. From the study it has been found that proper documentation process offers clear proof of what takes place in mental health sessions. Without proper documentation, it is not feasible to assess therapeutic effectiveness as there is no comprehensible record of what took place in therapy session.

**Key-words:** Documentation, Record-Keeping, Quality Nursing Documentation, Nursing Care, Certified Nurse Educator (CNE), Accelerated Recovery Program (ARP)

### **Introduction**

Nursing documentation is the entire record of patient care that is designed and delivered to patients by other caregivers or qualified nurses. It is the fundamental clinical data resource to meet professional and legal needs while taking care any patients. "Quality nursing documentation" has a significant role while taking care a patient especially mentally ill one

through adequate better communication between others “care team members”. The initial role of mental health nurses is to give the proper care and treatment to patients who suffer from psychiatric disorders. They carefully diagnose, measure blood pressure and make correct plans for treating cognitive patients. This study focuses on assess the knowledge on documentation while taking care of mentally ill patients among staff nurses in psychiatric ward at Narayana Medical College Hospital at Nellore, Andhra Pradesh.

## **Literature Review**

### ***Role of Nurses in the Assessment of Patients with psychiatric disorders***

Staff nurses in the psychiatric ward give health promotions and perform the activities of self-care. The nurses aim to develop the efficacy of the Accelerated Recovery Program (ARP) for recovering their problem of CF and also evaluate intervention therapy, including cognitive behavior for patients [1]. Similarly, psychiatry nurses implement group therapy, including client education, support, and authoritative training for improving the mental health of psychiatric patients.

### ***Application of King’s goal attainment theory***

The usage of this theory helps in determining the relationship between nurses and patients and also assists in increasing the capability of patients to achieve their goals. The utilization of King’s goal attainment theory enables improving the effectiveness of nurses towards their responsibilities in taking care of patients [2]. Nurses usually implement the skills of interpersonal communication, problem-solving practice and also monitor and specify the behavioral conditions of cognitive health of psychiatric patients.

## **Methodology**

The present research has used a Cross-Sectional Descriptive Research Design for obtaining the actual data and appropriate vision. This research design is applied to assess the occurrence of diseases in addition to the samples that are clinical-based [3]. The study has utilized the quantitative research approach for achieving logical responses. The application of this research approach helps in providing facts and understanding with regard to the main issue, which is a mental disorder [4]. A pilot study was conducted among staff nurses in the Narayana Medical College Hospital at Nellore, Andhra Pradesh. The utilization of the non-probability sampling technique assists the whole study to define a subjective method with reference to the population [5]. There are 60 staff nurses have been selected from Narayana Medical College Hospital, Nellore, with the application of the non-probability sampling technique. A large number of data has been gathered from the Institution's Ethics Committee, and consent has been collected from the regulations of the Narayana Medical College Hospital in Nellore. Moreover, the data that has been estimated is tabulated, investigated, and diagnosed with the help of a Descriptive and Inferential Statistical Procedure.

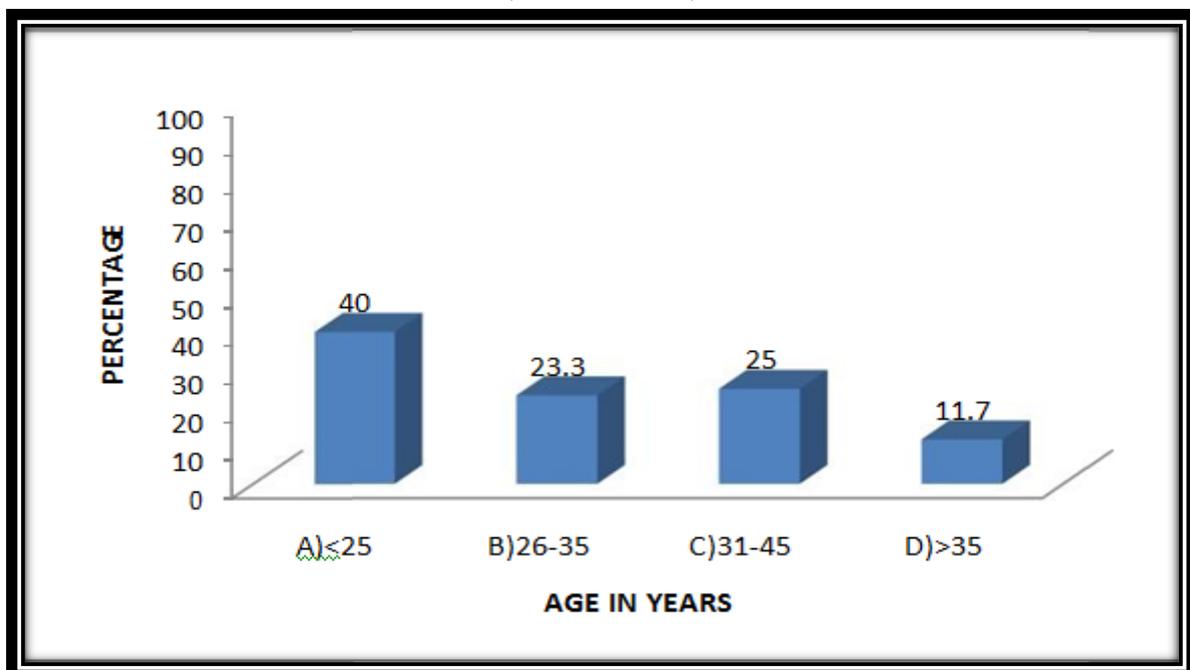
## **Data Analysis**

Data of staff nurses have been analysed in these mentioned tables;

SL.NO	AGE OF THE STAFF NURSES	FREQUENCY (f)	PERCENTAGE (%)
1.	A)<25	24	40.0
2.	B)26-35	14	23.3
3.	C)31-45	15	25.0
4.	D)>35	7	11.7
	<b>TOTAL</b>	<b>60</b>	<b>100</b>

**Table 1: Frequency and distribution of the percentage of staff nurses regarding their age**

(Source: SPSS)



**Figure 1: Distribution of percentage of staff nurses concerning age**

The table stated among 60 staff nurses, 24 (40%) fall under <25 years of age, 14 (23.3%) fall under 26 to 35 years of age, 15 (25%) % in 31 to 45 years, and 7 (11.7%) were in >35 years.

SL.NO	GENDER	FREQUENCY (f)	PERCENTAGE (%)
1.	A) Male	2	3.3
2.	B) Female	58	96.7
	<b>TOTAL</b>	<b>60</b>	<b>100</b>

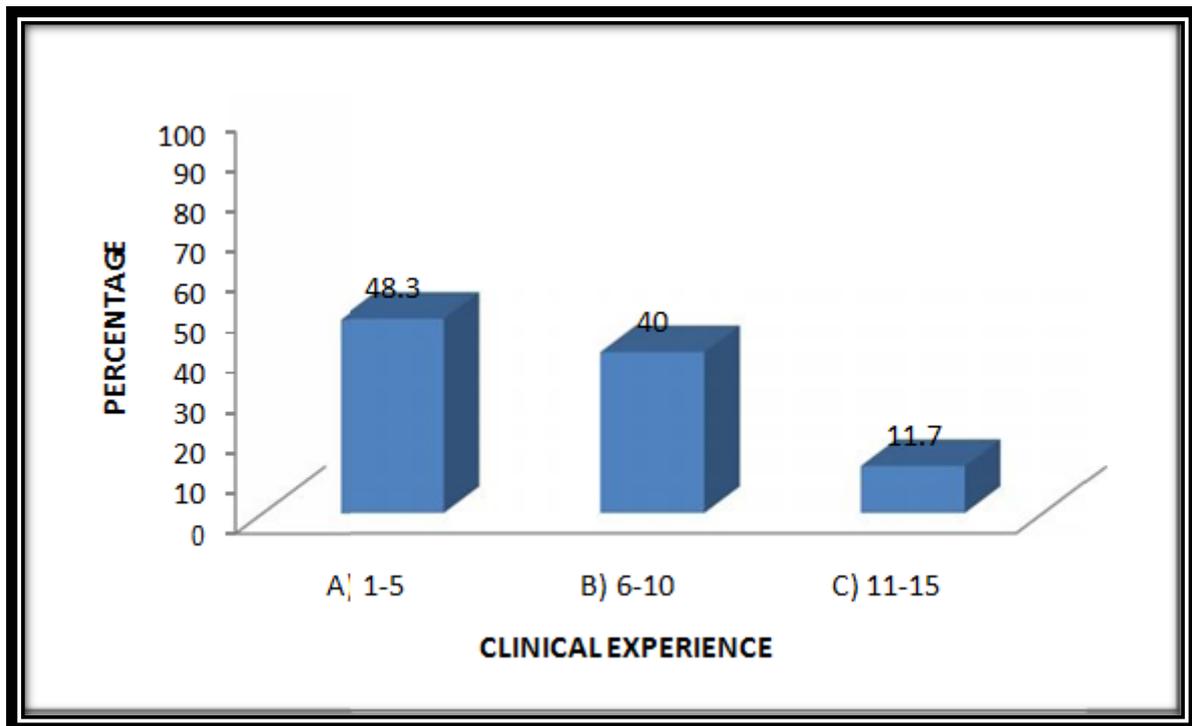
**Table 2: Frequency and distribution of the percentage of staff nurses regarding their gender**

(Source: SPSS)

The above table has defined that there are approximately 2 (3.3%) were male and 58 (96.7%) were female nursing staff. The majority of female nurses is more significant than male as women psychiatric nurses thoroughly maintain the healthcare guidelines and ensure the cleanliness of the wards.

SL.NO	CLINICAL EXPERIENCE	FREQUENCY (f)	PERCENTAGE (%)
1.	A) 1-5	29	48.3
2.	B) 6-10	24	40.0
3.	C) 11-15	7	11.7
	<b>TOTAL</b>	<b>60</b>	<b>100%</b>

**Table 3: Frequency and distribution of the percentage of staff nurses regarding their clinical experience**  
 (Source: SPSS)



**Figure 2: Distribution of percentage of staff nurses concerning clinical experience**

The above table states that around 29 (48.3%) have a clinical experience of 1 to 5 years, 24 (40.0%) have 6 to 10 years, and 7 (11.7%) have 11 to 15 years of experience among 60 staff nurses.

SL.NO	QUALIFICATION	FREQUENCY (f)	PERCENTAGE (%)
1.	A) Diploma in Nursing	18	30.0
2.	B) B.Sc Nursing	23	38.3
3.	C) P.B.B.Sc Nursing	14	23.3
4.	D) M.Sc Nursing	5	8.3
	<b>TOTAL</b>	<b>60</b>	<b>100%</b>

**Table 4: Frequency and distribution of the percentage of staff nurses regarding their qualification**

(Source: SPSS)

Among the 60 sample size, approximately 18 (30%) of staff nurses completed Diploma, 23 (38.3%) completed B.Sc, 14 (23.3%) completed P.B.B.Sc, and 5 (8.3%) completed M.Sc in nursing.

SL.NO	ATTENDED CNE PROGRAM	FREQUENCY (f)	PERCENTAGE (%)
1.	A) Yes	29	48.3
2.	B) No	31	51.7
	<b>TOTAL</b>	<b>60</b>	<b>100</b>

**Table 5: Frequency and distribution of the percentage of staff nurses regarding their Attended CNE programs**

(Source: SPSS)

The above table has demonstrated that among the 60 samples, there are approximately 29 (48.3%) stated yes, and 31 (51.7%) said no with regard to this program. This program upgrades the treatment quality, care, and self-satisfaction of patients and healthcare professionals.

SL.NO	LEVEL OF KNOWLEDGE	FREQUENCY (f)	PERCENTAGE (%)
1	A+	1	1.7
2	A	15	25.0
3	B+	38	63.3
4	B	6	10.0
	<b>TOTAL</b>	<b>60</b>	<b>100</b>

**Table 6: Frequency and distribution of percentage with regard to structured questions in the application of proper knowledge on documentation among staff nurses**

(Source: SPSS)

The above table has shown, the knowledge of documentation with 60 nursing staff, approximately 1 (1.7%) whose knowledge level was A+, 15 (25.0%) ranked A, 38 (63.3%) graded B+, and 6 (10.0%) were ranked B.

CRITERIA	MEAN	STANDARD DEVIATION
Staff nurses knowledge	18.78	2.8

**Table 7: Mean and standard deviation for the experiences of nursing staff with reference to addressing the knowledge of documentation**

(Source: SPSS)

It has been clearly stated that the mean score of staff nurses was 18.78, and S.D was 28 regarding the knowledge of documentation.

## Discussion and Findings

### Discussion

The study has shown various tables and graphs that properly illustrates the frequencies and distribution of percentage in different features among 60 staff nurses. Therefore, nurses can implement Cognitive Behavior Therapy (CBT) and interpersonal communication that helps psychiatric patients to diminish their mental disorders. It has discussed the frequency and percentage distribution of staff nurses based on their age, gender, clinical experience, and knowledge level. The study represented the clinical experiences of staff nurses for understanding their skills and knowledge of them. Approximately 29 (48.3%) have a clinical experience of 1 to 5 years, 24 (40.0%) have 6 to 10 years, and 7 (11.7%) have 11 to 15 years of experience among 60 staff nurses. From the above study it can be discussed that, documentation is an important part of “mental illness treatment” in present time of accountability. It is the crucial evidence narrating the effects and need of patient’s treatment. In simple words, at the time when a patient stated that certain treatment or therapy has been helpful to cure the illness, all though this is an opinion not a proper proof. Practical evidence narrates that treatment was significant and effectual to the patient care. It is mandatory to record the results of psychotherapy in measurable terms without dehumanizing or mechanizing the process. “Nursing documentation” generally comprises of nursing history or patient’s background data referred as progress notes or “nursing care plan” [6]. The nursing assessment documentation is the proper recording of the procedures how a judgement related to patient’s care was made. It makes the procedures of nursing evaluation visible through the presentation in the documented content.

## Findings

### *Demographic variables*

- There are approximately 24 (40%) belong to <25 years of age, 14 (23.3%) fell under 26 to 35 years of age, 15 (25%) % to 31 to 45 years, and 7 (11.7%) were in >35 years.
- It has been found in this study that approximately 2 (3.3%) were male, and 58 (96.7%) were female nursing staff.

Based on the knowledge documentation, there are approximately 1.7% achieved A+, 25% A graded, 63.3% were B graded, and 10% obtained a B grade. The study utilized a cross-sectional descriptive research design that represented 53.3% of staff nurses achieved satisfied practice, 40% good practice, and 6.7% showed poor practice in managing documentation.

From the above study it has been found that “the nursing care plan” is a recording of nursing procedures in the form clinical documentation. It is a systematic procedure of structuring and delivering proper care to clients according to their psychiatric history [7]. It was mainly created in the hospitals to guide all the nurses in giving care to patients, though the format was practical based other than the “nursing process depended”. “A Progress Note” is the documentation of nursing observations and actions in the process of nursing care, it assists them to monitor the entire course of patient care.

## Conclusion

It has been concluded that staff nurses are required to implement awareness and therapies in the matter of improving the mental disorders of patients in psychiatric wards. It can be concluded that poor quality of documentation were key factors in the dereliction to identify patients who were “clinically deteriorating”. Nurses are entirely responsible for controlling proper records of the care they are given and are accountable when the information is inaccurate also. Therefore, “a quality standard” is needed for proper recording of all the nursing documentation. Structured documentation can increase patient care by replacing the vague practice by nurses with accurate and cohesive data analysed by the overall “format of the care plan”. Hence, the introduction of care plans and proper documentation are observed as a medium by which all nurses can increase stands of “record saving practice”. A written documentation of the treatment, response, and care of the patients while taking care of them is the critical task of nurses.

## References

- [1] Rajeswari, H., Sreelekha, B.K., Nappinai, S., Subrahmanyam, U. and Rajeswari, V., 2020. Impact of accelerated recovery program on compassion fatigue among nurses in South India. *Iranian Journal of Nursing and Midwifery Research*, 25(3), p.249.
- [2] Fronczek, A.E., 2019. Nursing theory in virtual care. *Nursing science quarterly*, 32(1), pp.35-38.
- [3] Ncbi.nlm.nih.gov, (2023). *Methodology Series Module 3: Cross-sectional Studies*. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4885177/#:~:text=Cross%2Dsectional%20designs%20are%20used,baseline%20in%20a%20cohort%20study>.

- [4] Kartika, H., Norita, D., Triana, N.E., Roswandi, I., Rahim, A., Naro, A., Izzati, T., Munita, A.A., Junaedi, D., Suprihatiningsih, W. and Purwanto, A., 2020. Six sigma benefit for indonesian pharmaceutical industries performance: a quantitative methods approach. *Systematic Reviews in Pharmacy*, 11(9), pp.466-473.
- [5] Lamm, A.J. and Lamm, K.W., 2019. Using non-probability sampling methods in agricultural and extension education research. *Journal of International Agricultural and Extension Education*, 26(1), pp.52-59.
- [6] Sjöberg, M., Edberg, A.K., Rasmussen, B.H. and Beck, I., 2021. Documentation of older people's end-of-life care in the context of specialised palliative care: a retrospective review of patient records. *BMC palliative care*, 20(1), p.91.
- [7] Asmirajanti, M., Hamid, A.Y.S. and Hariyati, R.T.S., 2019. Nursing care activities based on documentation. *BMC nursing*, 18(1), pp.1-5.