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Psychiatric Nursing Documentation and Clinical Practice

Mental Health Nursing

Psychiatric case history, MSE recording, nursing care plans, therapeutic communication records, patient observation charts, clinical case presentations and psychiatric nursing reports.

For educational purposes only.

CHAPTER 27 / MENTAL HEALTH NURSING 27. Psychiatric Nursing Documentation and Clinical Practice

1. Purpose and principles

Records support continuity, treatment evaluation, communication, accountability, safety and lawful reporting. Documentation must be timely, accurate, objective, relevant, signed/attributed and confidential. Distinguish observed facts, patient quotes, collateral source and clinical interpretation. Use approved abbreviations, correct errors according to policy, never erase or backdate or copy unverified findings.

2. Psychiatric case history format

Identification; referral source/reason; chief complaints and duration; history of present illness (onset, course, symptoms, stressors, treatment, function); past psychiatric/medical history, medications, allergies, substance use; personal/developmental/family/social history; premorbid functioning as relevant; physical examination, MSE, risk, investigations and formulation; medical diagnosis as documented by clinician, nursing assessment and care plan. Avoid unnecessary intimate detail and stigmatizing labels.

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3. MSE and observation recording

Record	Example or essential fields
MSE	Date/time, appearance, behaviour, speech, subjective mood, observed affect, thought form/content, perception, cognition, insight/judgment, risk.
Observation chart	Required level, precise time, location, observed state/behaviour, intervention/response, staff identity and handover.
Nursing care plan	Assessment, individualized diagnosis/need, measurable goal, intervention, rationale, evaluation and revision.
Medication record	Drug, dose, route, time, verification, omitted/refused dose reason, therapeutic/adverse response.
Incident report	Objective event, time, immediate care, people notified, facts and follow-up; separate approved reporting system.
Discharge/transfer	Current condition, medication reconciliation, safety/relapse plan, referrals, appointments, education and consent.

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4. Therapeutic communication record (process recording)

Student learning record may contain interaction context, nurse's statement, patient response, observed nonverbal behaviour, technique/analysis and evaluation/alternative response. Use de-identified material and institutional consent requirements; do not create imagined patient quotes as real documentation. Example: nurse asks "What worries you about going home?" Patient says "I may not sleep." Technique: open question; follow-up assess sleep plan and warning signs.

5. Case presentation and clinical practice

Present concise history, priority findings, MSE, diagnosis/differential from team, risks, care plan, treatment, response, discharge/follow-up and learning points. Protect identifiers, don't post patient information/photos online. Use SBAR to report deterioration: current concern, relevant background, assessment, requested action. Document the escalation and response time. Review supervised skills and professional boundaries, report mistakes transparently.

6. Important Examination Questions

Long Answer Questions

1. 1. Describe psychiatric case history, MSE and nursing documentation with an example.

Short Answer Questions

1. 1. Explain process recording
2. 2. describe observation chart
3. 3. discuss handover and incident reporting.

Very Short Answer Questions (with answers)

1. 1. What is SBAR? - Situation, background, assessment, recommendation.
2. 2. Can unobserved checks be documented as completed? - No.

7. Quick Revision

- Documentation must be factual and timely.
- Maintain confidentiality and legal safeguards.
- Record risk, actions and actual outcomes.

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8. Conclusion

Documentation must be factual and timely. Maintain confidentiality and legal safeguards. Record risk, actions and actual outcomes.

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Practice questions

Choose one best answer. The answer key and explanations follow the questions.

1. Which documentation practice best supports an objective psychiatric record?

A. Present assumptions about motives as observed facts.

B. Copy previous findings without checking them.

C. Backdate entries to the time an assessment was planned.

D. Distinguish observed facts, patient quotes, collateral sources and interpretation.

2. What should a student do when using a therapeutic interaction for process recording?

A. Use de-identified material and follow institutional consent requirements.

B. Invent patient quotes and record them as real.

C. Post identifiable interactions online for feedback.

D. Include all intimate details regardless of relevance.

3. A prescribed dose is refused. Which information belongs in the medication record?

A. A completed administration entry despite refusal

B. The reason for the refused dose and relevant response

C. Only the drug name with no administration status

D. An assumed reason without asking or observing

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Answer key and explanations

1. D - Distinguish observed facts, patient quotes, collateral sources and interpretation.

Separating sources and interpretations makes the record accurate and reviewable.

2. A - Use de-identified material and follow institutional consent requirements.

Process recording is a learning tool that still requires confidentiality and consent safeguards.

3. B - The reason for the refused dose and relevant response

The medication record should include omitted or refused-dose reasons alongside dose and response information.

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