

ORIGINAL ARTICLE

Nursing documentation in inpatient psychiatry: The relevance of nurse–patient interactions in progress notes—A focus group study with mental health staff

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Aims and objectives: To gain insight into mental health staff's perception of writing progress notes in an acute and subacute psychiatric ward context.

Background: The nursing process structures nursing documentation. Progress notes are intended to be an evaluation of a patient's nursing diagnoses, interventions and outcomes. Within this template, a patient's status and the care provided are to be recorded. The therapeutic nurse–patient relationship is recognised as a key component of psychiatric care today. At the same time, the biomedical model remains strong. Research literature exploring nursing staff's experiences with writing progress notes in psychiatric contexts, and especially the space given to staff–patient relations, is sparse.

Design: Qualitative design.

Methods: Focus group interviews with mental health staff working in one acute and one subacute psychiatric ward were conducted. Systematic text condensation, a method for transverse thematic analysis, was used.

Results: Two main categories emerged from the analysis: the position of the professional as an expert and distant observer in the progress notes, and the weak position of professional–patient interactions in progress notes.

Conclusions: The participants did not perceive that the current recording model, which is based on the nursing process, supported a focus on patients' resources or reporting professional–patient interactions. This model appeared to put ward staff in an expert position in relation to patients, which made it challenging to involve patients in the recording process. Essential aspects of nursing care related to recovery and person-centred care were not prioritised for documentation.

Relevance to clinical practice: This study contributes to the critical examination of the documentation praxis, as well as to the critical examination of the documentation tool as to what is considered important to document.

KEYWORDS

documentation, mental health nursing, nurse–patient interactions, nurse–patient relations, nursing process, psychiatric nursing

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