

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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1. Understanding the eBook Psychiatric Nursing Documentation Examples
 - The Rise of Digital Reading Psychiatric Nursing Documentation Examples
 - Advantages of eBooks Over Traditional Books
2. Identifying Psychiatric Nursing Documentation Examples
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Psychiatric Nursing Documentation Examples
 - User-Friendly Interface
4. Exploring eBook Recommendations from Psychiatric Nursing Documentation Examples
 - Personalized Recommendations
 - Psychiatric Nursing Documentation Examples User Reviews and Ratings
 - Psychiatric Nursing Documentation Examples and Bestseller Lists
5. Accessing Psychiatric Nursing Documentation Examples Free and Paid eBooks
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 - Psychiatric Nursing Documentation Examples Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Psychiatric Nursing Documentation Examples
 - Highlighting and Note-Taking Psychiatric Nursing Documentation Examples
 - Interactive Elements Psychiatric Nursing Documentation Examples
- 8. Staying Engaged with Psychiatric Nursing Documentation Examples
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Psychiatric Nursing Documentation Examples
- 9. Balancing eBooks and Physical Books Psychiatric Nursing Documentation Examples
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Psychiatric Nursing Documentation Examples
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Psychiatric Nursing Documentation Examples
 - Setting Reading Goals Psychiatric Nursing Documentation Examples
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Psychiatric Nursing Documentation Examples
 - Fact-Checking eBook Content of Psychiatric Nursing Documentation Examples
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development
 - Exploring Educational eBooks

14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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