WILEY Clinical Nursing

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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Kirllaug K. Muklebust, Institute of Health and Social Sciences, Molde University College, Molde, Norway, Email: kjellaug myklebunt@himolde.noAims 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.

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

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O'Brien, Winifred Z. Kennedy, Karen A. Ballard, 2012-02-15 A comprehensive easy to read introductory text for nursing students The book is organized into three sections Introduction to Psychiatric Mental Health Nursing Mental Health

Disorders and Nursing Management of Special Populations This unique text is the most comprehensive psychiatric mental health resource available The OTA's Guide to Documentation Marie Morreale, 2024-06-01 The bestselling newly updated occupational therapy assistant OTA textbook The OTA s Guide to Documentation Writing SOAP Notes Fifth Edition explains the critical skill of documentation while offering multiple opportunities for OTA students to practice documentation through learning activities worksheets and bonus videos The Fifth Edition contains step by step instruction on occupational therapy documentation and the legal ethical and professional documentation standards required for clinical practice and reimbursement of services Students and professors alike can expect the same easy to read format from previous editions to aid OTAs in learning the purpose and standards of documentation throughout all stages of the occupational therapy process and different areas of clinical practice Essentials of documentation reimbursement and best practice are reflected in the many examples presented throughout the text Worksheets and learning activities provide the reader with multiple opportunities to practice observation skills and clinical reasoning learn documentation methods create occupation based goals and develop a repertoire of professional language Templates are provided to assist beginning OTA students in formatting occupation based SOAP notes and the task of documentation is broken down into smaller units to make learning easier Other formats and methods of recording client care are also explained such as the use of electronic health records and narrative notes This text also presents an overview of the initial evaluation process delineating the roles of the OT and OTA and guidelines for implementing appropriate interventions New in the Fifth Edition Incorporation of the Occupational Therapy Practice Framework Domain and Process Fourth Edition and other updated American Occupational Therapy Association documents Updated information to meet Medicare Part B and other third party payer requirements Revised clinical terminology on par with current trends Added examples from emerging practice areas Expanded tables along with new worksheets and learning activities Included with the text are online supplemental materials for faculty use in the classroom this includes access to supplemental website worksheets learning activities and scenario based videos to practice the documentation process

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