

Nurses' Experiences of Documenting the Mental Health of Older Patients in Long-Term Care

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Abstract

Nursing documentation is repeatedly reported to be insufficient and unsatisfactory. Although nurses should apply a holistic approach, they tend to document physical needs more often than other caring dimensions. This study aimed to describe nurses' experiences documenting mental health in older patients receiving long-term care. Individual interviews were conducted with nine nurses and were analyzed by content analysis. One main theme, two categories and seven sub-categories emerged. The findings showed that the nurses perceived mental health as an ambiguous phenomenon that could be difficult to observe, interpret, and agree upon. Thus, the nurses were uncertain about what concepts and words corresponded to their observations. They also struggled with finding the right words to create accurate and complete documentation without breaking confidentiality or diminishing the dignity of the patient. The findings are relevant for nurses in different types of healthcare services and in the educational context to ensure comprehensive nursing documentation.

Keywords

nursing documentation, long-term care, electronic health records, mental health, home health nursing, nursing homes, aged, Norway

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Introduction

Documentation of care is an important part of any nursing practice and is necessary to ensure the continuity, quality and safety of patient care (Jefferies et al., 2010; Paans et al., 2011; Wang et al., 2011). In addition to being an important communication tool, it also promotes the visibility of nursing care and provides evidence that enables nursing managers to allocate resources and assess whether the care provided is safe and competent. In the event of a lawsuit, nurses' documentation in the Electronic Health Record (EHR) can also serve as legal evidence. For these reasons, nursing documentation has to be comprehensive and accurate and should reflect a holistic approach to the patient's needs (Jefferies et al., 2010).

Nursing education and practice are underpinned by values of individual and holistic care of patients (International Council of Nurses [ICN], 2012; McEvoy & Duffy 2008; Povlsen & Borup 2011). Holistic nursing is described by McEvoy and Duffy (2008) as an integration of the mind, body and soul of the individual patient, in a culture that supports a therapeutic relationship, resulting in wholeness, harmony and healing. As the holistic approach take into account

that something is more than a sum of the parts, a disturbance of one part affects all the other parts of the system. This implies that caring for the patient as a whole person is important rather than in fragmented parts. Although the holistic approach has been emphasized particularly in palliative care (Davies & Higginson 2004), it has been suggested that holistic care should form the basis of all care for older patients regardless if they are terminal or not (Hallberg, 2006). This implies that nurses' documentation in the EHR should include a holistic approach, that is, a documentation where physical, psychological, social and spiritual/existential needs are all emphasized.

Documentation of psychosocial care and mental health status is particularly important in older patients receiving long-term care because the rate of psychogeriatric problems is high among older people in the community (Olivera et al.,

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2011), and any change in condition can be a sign of an acute disease that necessitates specific approaches to clinical care (Marengoni et al., 2011). Municipal long-term care (i.e., nursing homes and home health nursing) is characterized by the involvement of many caregivers and collaboration between professionals at different care levels and from various professional disciplines (Gjevjon, 2014; OECD, 2013). Shifting treatment responsibilities from hospitals to the municipal health service implies that long-term care patients today are frailer and have more serious, complex and treatment-demanding conditions (Næss et al., 2017). In this complex healthcare environment, adequate documentation and information exchange is crucial for service cohesion and patient safety (Norwegian Ministry of Health & Care Services, 2009).

Nurses play a key role in providing patient information (Jefferies et al., 2010), but research shows that their practice poses major challenges, such as an absence or lack of information during care transitions (Hellesø et al., 2016; Olsen et al., 2013), problems with accuracy in diagnostic documentation (Paans et al., 2011), inaccuracies in the content and coherence of nursing care plans (Tuinman et al., 2017), and a predominant focus on recording physical health (Høgsnes et al., 2016; Paans & Wüller-Staub, 2015; Wang et al., 2011). To meet the challenges nurses face, much international efforts have been made to develop terminology for use in nurses' EHR documentation. Standardized terminologies are expected to improve the accuracy of nursing documentation (De Groot et al., 2019; Törnvall & Jansson, 2017), and the Norwegian Directorate of eHealth (2018) recommends the use of the International Classification for Nursing Practice (ICNP®) (ICN, n.d.). The implementation of ICNP in Norway has only just began, and standardized care plans used as a recording tool is piloted in the municipal healthcare setting (Østensen et al., 2020).

Over the last two decades, the quality of nursing documentation has repeatedly been reported as inadequate when compared to the guidelines and principles established for its content and structure (Akhu-Zaheya et al., 2018; Ehrenberg & Ehnfors, 2001; Gjevjon & Hellesø, 2010). Additionally, studies have shown that nurses fail to document psychosocial caring dimensions and patients' subjective experiences (Høgsnes et al., 2016; Kärkkäinen et al., 2005; Olsen et al., 2012, 2014; Paans & Müller-Staug, 2015). Some suggest that this has to do with electronic documentation systems; that it tend to classify and concentrate the documentation on nursing tasks rather than on the patient's health (Kärkkäinen & Eriksson, 2004), or if it is structured in a way so that the patient's needs related to physical aspects (e.g., nutrition, medicine, hygiene and activities) are given the most space (Hellesø & Sogstad, 2019).

In general, barriers to maintaining nursing documentation and information exchange have been studied extensively. Such barriers include time constraints, expendable resources and heavy workload, insufficient guidelines,

institutional policies (De Groot et al., 2019; Kärkkäinen et al., 2005; Laitinen et al., 2010; Olsen et al., 2013), and discontinuity of education (Blair & Smith, 2012) as underlying problems. Positive attitudes toward documentation have been reported by nurses both in hospitals (Petkovšek-Gregorin & Skela-Savič, 2015) and long-term care facilities (Bjerkan & Olsen, 2017), but they also report a negative view of documentation as a meaningless burden that hinders nurses from focusing on the patient (Bøgeskov & Grimshaw-Aagaard, 2018).

Based on our review of the literature, there seem to be systemic challenges to reporting on patients' mental health and well-being. For example, Østensen et al. (2019) found that nurses in long-term care often relied on their long-standing acquaintance with the patient and that much of the patient's information was not shared or was only communicated orally. Verbal information typically included ad hoc messages regarding practical issues. Olsen et al. (2014) also showed that descriptions of the patients' subjective health experiences were mostly conveyed verbally, and Kärkkäinen et al. (2005) found that patients and their views were seldom referred to in the documentation. In a focus group study by Grundberg et al. (2016), the district nurses stated that they lacked guidelines and established goals for promoting mental health, and that they typically focused on more practical home health care tasks rather than early identification and treatment of mental illness. This study calls for strengthening nurses' abilities to screen and assess patients' risk of developing mental health problems, such as depression.

Our literature review reveals that much research has investigated the content and structure of nursing documentation, and several studies also describe barriers related to insufficient nursing documentation. However, less is known about nurses' perceptions of their documentation practice, and knowledge about nurses' experiences of documenting mental health, in particular, is scant. To fill this gap, this study aimed to examine nurses' experiences of documenting mental health in older patients receiving long-term care. The aim was operationalized into two research questions: What perceptions do nurses have of what is meant by mental health in older adults? What challenges do they experience related to documenting mental health in long-term care?

Methods

Design

A qualitative descriptive design was used to investigate the nurses' experiences and perceptions (Sandelowski, 2010). This design recognizes and allows subjective aspects of a phenomenon to appear (Bradshaw et al., 2017) and is particularly useful when little is known about a topic (Doyle et al., 2019). We conducted semi-structured individual interviews to capture meanings from texts (Kvaale, 2007).

Setting and Sample

The participants in this study were nurses working in nursing homes and home health nursing in two municipalities in Mid-Norway. When recruiting the nurses, we assumed that everyone working in this context has daily experience with documenting care. We also assumed that most nurses in this context are generalist nurses without special education in mental health (Gautun & Syse, 2013). In order to provide the most realistic impression of the field, we sought “regular nurses” based on three inclusion criteria: (1) being a Registered Nurse, (2) being employed in nursing home or home health nursing, and (3) been working at least half a year at their work place. Nurse managers at the nursing home wards or home health nursing districts, forwarded an email invitation to all nurses who met the inclusion criteria, inviting them to participate. Employees may experience participation (in a research study) to be a strong expectations when recruitment is done by the help from their managers. To avoid that managers influenced selection and that employees experienced pressure, clear information on both inclusion criteria and voluntary participation were provided to the managers and also stated in the invitation letter to the nurses. In addition, the nurses who wanted to participate in the study volunteered by contacting the researcher by email or telephone – without involving the managers. Nine registered nurses (eight women and one man) with a mean age of 42.6 years (range 24–61 years) consented to participate. All were ethnic Norwegian. Their nursing experience varied from 1 to 40 years (mean = 16.6), and years of employment at their current workplace (including any employment as assistants or nurse assistants before nursing education) ranged from 4 to 34 years (mean = 16.7). Two of the informants had advanced education (in Geriatrics and in Intensive nursing). Five of the informants worked in nursing homes, two in home health nursing, and two worked both in nursing homes and home health nursing.

Data Collection

Eli Johanne H. Engen conducted individual interviews in 2015. A semi-structured guide was developed, based on the literature, and was used as a framework for the interviews. The initial section of the interview included questions about age, education and professional experience. The main section asked about the informants’ experiences related to documenting mental health, including their perception of defining mental health in older patients, preferences for the content of nursing documentation, challenges related to the documentation process, and expectations of their own and others’ documentation in the EHR. One interview was conducted with each of the participants and took place at the participants’ workplace. The interviews lasted between 45 and 60 min and were digitally audio-recorded and transcribed verbatim.

When we started the interviews, we had no guarantee that the participants would be sufficiently verbal. However, we found that all the participants were very communicative and they gave rich descriptions of their experiences. Malterud et al. (2015) describe the concept of information power, which is related to (a) the aim of the study, (b) sample specificity, (c) use of established theory, (d) quality of dialog, and (e) analysis strategy. Hence, the information power of our study was judged to be sufficient despite a relatively small sample. The aim of our study was narrow, the sample had significant experience with documenting health care, the theory used is well established, the quality of dialog was perceived as good, and the analysis strategy was not to do any comparisons.

The data collection was pragmatic in the sense that all informants who had agreed to be interviewed were interviewed. The interviews were transcribed continuously and first impressions of content were noted, but a thorough content analysis was only performed when all the interviews had been completed. After interviewing the nine participants who had agreed, we assessed that the data had sufficient saturation (repetitive information was recorded in all the interviews and they also contained nuanced and detailed data). The intention was not to produce generalizable knowledge, but to provide a perspective that could answer the purpose of this study.

Ethics. This research was approved by the healthcare administrations in the municipalities and by the Norwegian Centre for Research Data (No: 36635). Approval from an ethics committee was not needed, as the study was not affected by the Norwegian Health Research Act. All participants gave informed consent before the interviews. They were guaranteed confidentiality and were informed that participation was voluntary and that they could withdraw from the study at any time.

Analysis. The interview texts were analyzed using the qualitative content analysis process described by Graneheim and Lundman (2004). The analysis process was performed by Eli Johanne H. Engen, Siri Andreassen Devik and Rose Mari Olsen, and included both manifest and latent analysis. First, the texts were read through while listening to the tapes in order to validate the transcripts and to obtain an overall picture of the content. The text was then divided into meaning units, each comprised of sentences or phrases related to the aim of the study. The meaning units were condensed and labeled with codes based on the content. The codes were then compared and contrasted based on their similarities and differences, and codes that shared common content were broken down into categories and sub-categories. According to Graneheim and Lundman (2004), a category answers the question “what?” and mainly refers to the description of the text as it is expressed by the informant. Categories represent the *manifest* content in the text. The categories were then

Table 1. Example of Analysis.

Meaning unit	Condensed meaning unit	Code	Subcategory	Category	Theme
I guess we can be a little bit scared to write about mental health. You feel you don't have the right competence to do it, don't find the right concepts or use the correct phrases. Then you just let it be.	Afraid of documenting mental health because lack of competence to find the right words	Can't find the right words	Striving to make yourself understood	You have to choose your words wisely	Striving to document the right things in the right way

Table 2. Overview of the Main Theme, Categories, and Subcategories.

Main theme	Category	Subcategories
Striving to document the right things in the right way	Mental health as an ambiguous phenomenon You have to choose your words wisely	Mental health is less tangible Different views give different observations Mental health is more like "secret services" Afraid of breaking the confidentiality Afraid of showing the patient in a bad light Afraid of worsen the problem by documenting it Striving to make yourself understood

gathered into an overarching theme. According to Graneheim and Lundman (2004), themes exist at an interpretive level and answer the question "how?". Themes represent the *latent* content in the text, representing its underlying meaning. The data analysis software NVivo 11.0 © QSR International Pty Ltd. was used to assist in locating codes and grouping categories. An example of the analysis is given in Table 1.

To ensure the trustworthiness of the data and analysis, the authors used the criteria of credibility, transferability, dependability, and confirmability (Lincoln & Guba 1985). *Dependability* and *confirmability* were obtained by using the same interview guide for all interviews, audiotaping and transcribing all interviews verbatim, and by having three researchers working together to compare and discuss the coding, categories and themes for the study. Descriptions of informants, data collection, analysis, and quotes from the interviews are used to enable readers to judge the *transferability* of the findings to other contexts. *Credibility* was supported by conducting interviews with an adequate number of nurses in nursing homes and home health nursing, repeatedly listening to the audio recordings of the interviews, and through discussion of the interpretation of data among the researchers

Results

Nurses' experiences of documenting mental health in older patients in long-term care can be described by one main theme, presented in Table 2, together with the categories and subcategories underlying the theme. The theme, "striving to document the right things in the right way," reflected that the

nurses experienced documenting mental health to be challenging in several ways. The categories and their respective subcategories are presented below and are illustrated by quotations from the interview text.

Mental Health as an Ambiguous Phenomenon

This category relates to mental health as an ambiguous phenomenon that can be difficult to observe, interpret, and agree upon. The category includes three sub-categories.

Mental Health is Less Tangible

Most of the informants mentioned the difficulty of really grasping the state of patients' mental health because the signs were often vague and hard to define. One of them expressed, "I think it's (the documentation) difficult 'cause mental health isn't so specific and clear as for example a high blood pressure which is measurable. Hence it's challenging to know what to write, and which message you want to give" (I6). Patients with cognitive impairments, like dementia, were particularly difficult to observe because they often did not express themselves clearly. One of the informants pointed out that it could be easier to notice when a patient was in bad mental shape than in good mental shape because the signs appeared in their behavior: "It can be restlessness, the patient is moving around in the corridors. . . You see the body language change or hear doors slamming. That's clear signs that things aren't going so well" (I1). In some cases, however, the behavior could be misinterpreted, especially if the nurses lacked information about the patient's background. One informant gave the following example:

'What is the reason for the behaviour? Sometimes it's not possible to interpret the signs without having some knowledge about the patient. I have a classic example: a patient with dementia was restless and walked around knocking his hand in walls, tables and other furniture he passed by. No one understood why he did that. We taught it was just pacing behaviour in dementia. But after a while, we heard he had been an instrument maker, and his job was to find a piece of wood that could provide the right sound for a violin' (I3).

Different Views Give Different Observations

Some informants expressed that signs and symptoms related to mental health can be observed and interpreted differently depending on the nurse watching the patient. As one informant said, *"We may use different glasses and emphasize different things"* (I4). Unfortunately, this sometimes led to uncertainty and skepticism about what was documented in the EHR. One informant working in home care exemplified this with situations where she found the patient in a different condition than reported:

'Occasionally I come to a home and I realize things look much better, or worse, than described by my colleagues earlier that day. Then I wonder what was it the colleague who was there before me saw? Or, have I misunderstood something in that hand-over report?' (I6).

Working experience and professional development were mentioned as reasons for differences in the way nurses interpreted the patient. One of the informants reflected upon the impact that working experience has on the way she sees the patient situation:

'I think that, perhaps, when you have taken care of persons with dementia for several years, like I have, then you explain much of the symptoms as unwanted behaviour rather than mental issues. Newly qualified tend to over-interpret the signs, making the patient sicker than he is' (I9).

Mental Health is More Like "Secret Services"

This sub-category is about the tendency to silence mental health issues. Several of the informants expressed that mental health issues were far less discussed among the nursing team than physical problems. As one informant, who worked partly in a nursing home and partly in home health nursing, put it, *"Still it's a culture where we don't talk much about mental health. You could almost call it 'secret services'"* (I8). If nurses were not even talking about mental health, it is unlikely that they were documenting it.

The silence about mental health also became evident in the cooperation and communication across different nursing teams and services in the municipality. In this regard, one informant complained about psychiatric nurses' unwillingness to exchange necessary information during patient transfers:

'When patients are transferred from the psychiatric (nursing) services to us, the information we get in the nursing report is often sparse and insufficient. Then it is challenging to take care of the patient and to catch his unique needs (. . .) I cannot understand why the psychiatric nurse are so afraid of giving us the information that we need. It's taboo. It's very hush-hush' (I3).

You Have to Choose Your Words Wisely

This category, including four sub-categories, describes the nurses' attempts to describe patients' mental health in their documentation. Choosing the right words could be a balancing act between achieving accuracy and completeness in the documentation and maintaining the dignity of the patient.

Afraid of breaking confidentiality. Some informants were concerned that they could break confidentiality through the way they documented patients' mental health. It was not always easy to know the line between "permitted" and "forbidden" information, that is, to distinguish between what personal information that should, and should not, be recorded in the EHR according to the legislation. To ensure they complied with the law, nurses sometimes omitted information in the EHR. As one informant said,

'You need many words to describe mental health, and you may be afraid of documenting everything in the EHR. For example, you sense something in the atmosphere and the conversation between the patient and his relatives, and you worry that the relatives do not treat the patient good. To ensure you do not break the confidentiality, you rather explain this in verbal than document it in the EHR' (I6).

One of the informants described the unpleasant situation she sometimes finds herself in when a patient tells her about his inner thoughts that were necessary to know in the caring situation, but which seemed too private to describe in the documentation. Another informant said she feels that her many years of experience have given her confidence in doing documentation, and she feels more comfortable finding a balance between what is "permitted" and "forbidden" to document in the EHR. However, she realized that this can be a challenge for less experienced nurses, saying, *"I think that especially newly graduated nurses, those with less practice experience, are unsure on how to document comprehensive without revealing confidential information about the patient"* (I7).

Afraid of showing the patient in a bad light. Several of the informants talked about demanding situations with aggressive and violent patients. Although they felt obligated to report the behavior, they sometimes preferred not to document it in the EHR because they were afraid of being accused of applying patronizing labels to the patient. As one

informant put it, “How should you report that the patient pinches, hits and spits? Although you find him really nasty, you do not want to show the patient in a bad light, so you have to be careful” (I3). Special caution was taken with patients declared legally incompetent because then the relatives could be “very on guard” as one informant said, and request to see the EHR. Often the nurses were caught in a dilemma between preserving the patient’s dignity and creating accountable and comprehensive documentation. As one informant put it,

‘Obviously, you choose your words wisely, yes, you really do. And whatever you write, you must be able to defend what is documented. On the other hand, you cannot wrap it in. . . you cannot hide the message neither. For how can other personnel reading the record understand the seriousness? The facts must out’ (I5).

Afraid of worsening the problem by documenting it. Some of the informants had experienced that a mental problem or symptom, which was not a big issue in the first place, was given too much emphasis at the moment it was documented. One informant said, “You have to be careful and not mess up things. It’s a balancing act, ‘cause you should not make it a bigger problem than it is” (I4). One informant pointed out that mental health problems are often less predictable than physical problems, making it difficult to see the possible consequences this will have for the patient.

‘Sometimes it is difficult to know if you should document or not. Do we want to focus on the problem? Do we want to deal with it? Because if we deal with this problem, maybe we start working with something we don’t see the end of and which is not actually a problem for the patient. Obviously, it’s much more easy if the patient himself express a need for resolving the problem, then we can discuss it’ (I7).

Striving to make yourself understood. A common view among informants was that it is challenging to clearly describe a patient’s mental health status and issues in writing. To find the most appropriate words and phrases is a struggle that may lead to sparse documentation and a preference for oral reporting. Comments from two informants illustrate this:

‘I’m not quite sure, but I don’t think we can document everything. . . ‘Cause then we’ll be sitting there writing and writing. We just write the most necessary in EHR, and so we complement orally afterwards. You can explain much easier verbally than in writing, can deepen the understanding of the total situation. In written we may talk around the real issue rather than addressing it directly’ (I2).

‘I guess we can be a little bit scared to write about mental health. You feel you don’t have the right competence to do it, don’t find the right concepts or use the correct phrases. Then you just let it be’ (I8).

Discussion

This study aimed to describe nurses’ experiences of documenting mental health in older patients receiving long-term care. The overall theme of “striving to document the right things in the right way” reflected that the nurses experienced documenting mental health to be challenging in several ways. Mental health was perceived as an ambiguous phenomenon that could be difficult to observe, interpret, and agree upon; thus the nurses were uncertain about which concepts and words corresponded to their observations. Additionally, they struggled to find the right words to create accurate and complete documentation without breaking confidentiality or compromising the dignity of the patient. Sometimes the nurses chose not to document mental health issues in the health record at all—a finding that is in line with previous studies reporting insufficient nursing documentation on psychosocial dimensions of care (Høgsnes et al., 2016; Olsen et al., 2012, 2014; Paans & Müller-Staub 2015; Wang et al., 2011).

The findings of this study highlight nurses’ awareness of ethical responsibilities and legal liabilities when documenting care. Protection of confidential information is emphasized in the ICN Code of Ethics (ICN, 2012) and is a legal requirement according to the Health Care Act (Norwegian Ministry of Health & Care Services, 2001). Knowing what information was “permitted” or “forbidden” was not always obvious to the nurse informants, making the choice not to document an easier solution. This may be related to today’s increased demand for patient involvement and participation (WHO, 2016), where the patient or his relatives have the right to read what is recorded in the EHR. Nurses may be afraid that the patient or his relatives will find the documentation offensive. The findings of a study of hospitalized patients’ experiences of reading their EHR confirm this concern (Wibe et al., 2011). In this study, the authors found that for some patients reading the EHR made them feel that they were not being respected as a person, a feeling that could occur if the patient felt they were being dismissed or treated with prejudice by healthcare professionals. Descriptions of mental health issues, in particular, can be perceived as offensive by the patient because they are associated with taboos and shame around having non-physical health challenges. In a study of the oral and written language used in assessments and allocations of community healthcare services for persons with dementia, Hansen et al. (2017) found that professionals sometimes found it difficult to report that patients had a dementia disorder. They felt that the word “dementia” was too loaded and might be perceived as offensive or stigmatizing, and therefore they chose to avoid mentioning it. When informants in our study talked about mental health as “secret services”, it was a metaphor for a culture of silence around mental health issues. This also aligns with previous studies that revealed that nurses’ attitudes toward mental illness are, in several respects, comparable with public opinion. Both

somatic and psychiatric nurses have reported that they perceive mental health issues as stigmatizing, taboo, and difficult to communicate (Ben Natan et al., 2015; Björkman et al., 2008). Nurse informants in our study worked in somatic care but reported that psychiatric nurses in the municipality were also unwilling to exchange information regarding mental health issues.

Our findings suggest that nurses experience mental health as an ambiguous phenomenon that can be difficult to observe and document, whereas physical health status was seen as more visible and measurable. This difficulty observing patients' mental health can be seen as part of the "culture of silence" and taboos mentioned above. If the patients were not forthcoming about their mental health issues, then they were even more difficult to catch. In a study by Grundberg et al. (2016), most district nurses regarded the detection of mental health problems and promoting mental health as important tasks, but reported that patients preferred to discuss their physical conditions, rather than their mental health. As patients rarely expressed their issues concerning mental health, the nurses had to provide continuity and begin dialogs with these patients. In accordance with our study, the district nurses in the study by Grundberg et al. (2016) pointed to the importance of knowing the patient when detecting mental health problems. However, as a result of possessing in-depth knowledge about a patient, nurses may find documenting mental health redundant because they keep a lot of information "in their heads" (Østensen et al., 2019).

In our study nurses also mentioned that it was easier to describe mental health verbally than in writing because they could deepen the understanding of the total situation. Jefferies et al. (2010) found similarly results when comparing the content of nursing documentation and clinical handover. They suggest that nurses' verbal communication produces a more holistic view of the patient, because they incorporate information from a wider variety of sources which allows presenting more contextual information in the communication. The tendency to focus on physical care at the expense of other caring dimensions may reflect a lack of knowledge and skills in responding to other caring needs in one's nursing practice. Isola et al. (2018) found that nurses in geriatric care consider their capacity to meet the psychosocial needs of older people as less adept compared with their physical needs. However, the opposite has been reported about mental health nurses. In a study by Howard and Gamble (2011), mental health nurses in acute inpatient settings felt they lacked training in providing physical health care, and their documentation of physical health assessment and care was generally poor. In a community mental health service, Lawn et al. (2018) found that the systematic recording of physical health information was underreported and had gaps and inconsistencies.

Reported shortcomings in nursing documentation indicate that nurses in both contexts, mental health services and somatic health services, have problems with taking a

comprehensive, holistic approach to documenting care. This may be due to the old distinction between mental health and physical health, exemplified in the mind-body dualism of Descartes. In this manner of thinking, the human body is likened to a machine, where bodily functions are separated from the workings of the mind. Although nurses have been trained to take into account physical, psychological, social and spiritual dimensions (McEvoy & Duffy 2008), they have been socialized to think dualistically in terms of a mind-body split, where the patient's body is reduced to its parts (Hyde et al., 2005). So perhaps it should not be altogether surprising that mental health nurses prioritize the mind and psychosocial needs, while somatic nurses concentrate on the body and physiological dimensions. When observing that nurse informants in this study experienced a lack of communication between somatic and mental health services, one could suggest that nurses themselves contribute to maintaining this distinction. To ensure comprehensive and accurate documentation of patient care, they should instead collaborate and learn from each other's skills and knowledge. Similar tendencies were also found in a study by Brändström et al. (2015) where community nurses and psychiatric nurses in Sweden felt that a lack of knowledge about each other's work stood in the way of good collaboration and information exchange between them.

In general, this study has implications that are relevant to all healthcare services and educational institutions that are engaged in enhancing the quality of health professionals' documentation practices. The challenges revealed here may also form the basis for developing interventions to strengthen nurses' awareness of patients' mental health and encourage them to communicate and write down their observations and judgments concerning it. In such interventions, tools or guidelines should be available to ensure that essential observations specific to the mental health of older patients are collected and documented. Action research could be a useful way to evaluate these kinds of improvement efforts. In addition, a possible contextual influence, also across countries, on how nurses regard disclosure of mental health problems within their patients, is a suggestion for further research.

Strengths and Limitations

A strength of the current study is the informants' considerable experience, which contributed to rich qualitative data. It was also an advantage that all three authors were involved in the analysis process. One limitation was that nurse managers at the care units helped recruit participants for the study. To decrease the risk of selection bias and provide truly voluntary consent, the researchers informed the nurse managers well about the inclusion criteria, and the nurses who wanted to participate in the study gave their final agreement to participate directly to the researcher without involving the managers. According to the qualitative design, the findings cannot be generalized, but they can be transformed and

applied to similar situations in other contexts. As documentation of care is an important part of any nursing practice, and knowledge about nurses' experiences of documenting mental health of older people is scant, the findings of this study could be applied to several parts of nursing services giving elderly care, for example, nursing homes, sheltered housings and home health nursing.

The sample was diverse in terms of age (range 37 years), nursing experience (range 39 years) and duration of employment at current workplace (range 30 years), and it is reasonable to question if these differences have influenced the informants' experiences of nursing documenting. A previous Norwegian study, for instance, indicate that nurses with longer experience at the workplace have more positive attitudes toward documentation (Bjerkan & Olsen 2017). However, we cannot from our data see any relationship between age, nursing experience and experiences of documenting mental health. The sample included only one male nurse, but his experiences and perceptions did not differ from the experiences/perceptions of the women in the sample. Nevertheless, the sample is reflective of long-term care facilities, which are staffed mainly by women (Fagertun & Tingvold 2018).

Conclusion

This study provides insight into the challenges nurses experience when documenting the mental health of older patients in long-term care. The nurses in this study, perceived mental health as an ambiguous phenomenon that could be difficult to observe, interpret, and agree upon. Thus, the nurses were uncertain about what concepts and words corresponded to their observations. They also struggled with finding the right words to create accurate and complete documentation without breaking confidentiality or diminishing the dignity of the patient. These findings are relevant for nurses in different types of healthcare services and in educational contexts to ensure comprehensive nursing documentation. Efforts should be made to implement interventions to strengthen nurses' competencies in identifying and communicating their observations and judgments concerning patients' mental health.

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