Multidisciplinary Record Keeping in Palliative Care

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Introduction

• Palliative care focuses on ameliorating patient’s symptoms while providing supportive care to the patient and family.
• Uses a multidisciplinary team approach.
• Record keeping is a key component of managing an efficient system.
• So much information is generated during the care as the five domains espoused in this practice are focused on.

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Observation

- One of the main components of clinical governance is the “effective monitoring of clinical care with high quality systems for clinical record-keeping and the collection of relevant information” (Simpson, 2003).
- “Seamless care is difficult to achieve without seamless information” (Rigby et al 1998).
- Record methods: narrative, criterion referenced, quantitative recording, work samples

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Pillars of health recording

- Clinical audit
- Risk management
- Workforce issues
- Patients' experience
- Information
- Education and continuing professional development
- Research and effectiveness

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Method

• Retrospective study -- 16 clinical audit reports and interviews with palliative care team
• Inclusion-- under care for at least 1 year.
• Considered information recorded, flow, focus on domains and the follow up.
• Discussion with members of the team who had consulted the patient/family.
Method...

Clinical Audits

One on one interview

Observation

Group interview

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Results

- Much information lost from one visit to another.
- First, second and third visits had substantial information on the various domains but this disappeared as the number of consultations increased.
- In 80% of the cases, by the 6th visit only the domains the patient had issues in were considered and mostly, a continuing symptom.
• The focus on the family was totally lost by the fifth visit unless an issue was raised.
• Interviews -- team members could recall they always talked about all domains and engaged the families in these cases and could actually recall a conversation.
• Information was revealed that did not appear on the patients' records.
Results cont..

Patients concerns

Clinicians concerns

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Discussion

• Findings -- good record-keeping helps deliver high standards of care, improves continuity of care, communication and helps care planning

• Principle of shared records -- members of the multidisciplinary team use the same documentation within agreed protocols enhancing collaborative working.
Discussion

• Avoids duplication
• Maintain continuity of the patient's journey
• Appropriate information which is easier to find.
• Improve communication and hence clearer assessments. The single biggest problem in communication is the illusion that it has taken place. George Bernard Shaw (1856-1950)
• Saves time
Discussion

- Encourages various specialties to be more aware of each other's input
- Staff are more inclined to consult notes and reports
- It enables greater in-depth discussions
- Evaluation of treatment given to patient eases
Challenges

• Accountability
• Practice
• Record availability and integration
• Coordination and confidentiality
• Monitoring of quality and team development
• Harnessing Information Technology
• Patients Held Records

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Conclusion

- Good teamwork coupled with proper documentation benefits both patients and staff.
- Improved quality of service become a reality and its success can be owned by everyone involved.
- Use of IT can greatly foster sharing of information and reduce wastage as continuum of care proceeds.
- Enhance the visibility of P/C—can use the records for high quality research and for fund raising.
Conclusion....

• Records are important for legal, financial, taxation, monitoring activities
• Need to keep records simple and concise
• Do we need summary ?? For ease of interpretation

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References

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KEHPCA
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