

Clinicians' and Nurses' Documentation Practices in Palliative and Hospice Care: A Mixed Methods Study Providing Evidence for Quality Improvement at Mobile Hospice Mbarara, Uganda

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Abstract : Aims: Health workers are likely to document patients' care inaccurately, especially when using new and revised case tools, and this could negatively impact patient care. This study set out to; (1) assess nurses' and clinicians' documentation practices when using a new patients' continuation case sheet (PCCS) and (2) explore nurses' and clinicians' experiences regarding documentation of patients' information in the new PCCS. The purpose of introducing the PCCS was to improve continuity of care for patients attending clinics at which they were unlikely to see the same clinician or nurse consistently. Methods: This was a mixed methods study. The cross-sectional inquiry retrospectively reviewed 100 case notes of active patients on hospice and palliative care program. Data was collected using a structured questionnaire with constructs formulated from the new PCCS under study. The qualitative element was face-to-face audio-recorded, open-ended interviews with a purposive sample of one palliative care clinician, and four palliative care nurse specialists. Thematic analysis was used. Results: Missing patients' biogeographic information was prevalent at 5-10%. Spiritual and psychosocial issues were not documented in 42.6%, and vital signs in 49.2%. Poorest documentation practices were observed in past medical history part of the PCCS at 40-63%. Four themes emerged from interviews with clinicians and nurses-; (1) what remains unclear and challenges, (2) comparing the past with the present, (3) experiential thoughts, and (4) transition and adapting to change. Conclusions: The PCCS seems to be a comprehensive and simple tool to be used to document patients' information at subsequent visits. The comprehensiveness and utility of the PCCS does appear to be limited by the failure to train staff in its use prior to introducing. The authors find the PCCS comprehensive and suitable to capture patients' information and recommend it can be adopted and used in other palliative and hospice care settings, if suitable introductory training accompanies its introduction. Otherwise, the reliability and validity of patients' information collected by this PCCS can be significantly reduced if some sections therein are unclear to the clinicians/nurses. The study identified clinicians- and nurses-related pitfalls in documentation of patients' care. Clinicians and nurses need to prioritize accurate and complete documentation of patient care in the PCCS for quality care provision. This study should be extended to other sites using similar tools to ensure representative and generalizable findings.

Keywords : documentation, information case sheet, palliative care, quality improvement

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