Multidisciplinary patient records in a palliative care setting

THE GOVERNMENT'S white paper The New NHS: Modern, Dependable (Department of Health, 1997) and the consultation document A First Class Service (DoH, 1998) focused on modernising the NHS and improving the quality of care for patients. The concept of clinical governance was developed and defined as a 'framework through which the NHS organisations are accountable for continuously improving the quality of the services and safe-guarding high standards of care by creating an environment in which excellence in clinical care will flourish' (DoH, 1998).

Clinical governance focuses the NHS on maintaining the delivery of quality care to patients. 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’ (DoH, 1998). In 2000 the NHS Executive South East regional office proposed a concept of seven pillars of clinical governance:

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

A minimum requirement was that ‘the organisation regularly reviews the quality of documentation in patients’ health records’. The UKCC’s and the newly formed NMC’s belief in accurate record-keeping is well documented. UKCC guidelines clearly state that good record-keeping not only helps to deliver high standards of care but also improves continuity of care, enhances communication and helps with care planning (UKCC, 1998). The NMC supports the principle of shared records, when members of the multidisciplinary team use the same documentation within agreed protocols, as it enhances collaborative working.

The team at Thames Gateway

Thames Gateway NHS Trust is unique in having a palliative care directorate as part of its structure. The directorate provides a seamless, specialist palliative care service to the local population of Medway and Swale in Kent. Its multidisciplinary team embraces an inpatient unit, day hospice, nurses, doctors, a team of social workers, an occupational therapist, a physiotherapist, a domiciliary team and the hospital palliative care team.

Multidisciplinary teamwork is well developed and patient’s referrals, admissions and clinical decisions are made jointly. Communication and commitment to collaborative team working is well established. According to Gorman (1987) there are five core benefits of teamwork:

- Better quality decisions;
- Clear roles and responsibilities;
- Greater commitment to care plans;
- One team – one care;
- Mutual support and encouragement.

Gorman argues that good multidisciplinary working offers better treatment for patients and a better quality of working life for practitioners.

Multidisciplinary documentation

The role of the senior nurse manager in the palliative care directorate is to lead development, and in partnership with its clinical director and other members of the multidisciplinary team, continuously to improve the quality of service. Discussions at the directorate’s clinical forum and the clinical governance group identified the need to critically evaluate and audit the keeping of patient records. The development of multidisciplinary records became one of the objectives in the palliative care directorate’s business plan for 2000–2001.

An initial audit of nursing records revealed the existence of the following problems:

- A lot of duplication;
- A lack of relevant information;
- The recording of irrelevant data;
- Inaccurately filled pages.

In addition it became apparent that each department held separate documentation.

As a result of the audit, a working party was formed with representatives from each area who had an interest in and enthusiasm for effecting change. The representatives came from the following areas: inpatient unit, day hospice, hospital palliative care team, domiciliary team, doctors, social workers and therapists.

The aims and objectives for this project were to:

- Have one set of patient’s notes;
- Improve communication;
- Improve the clarity of information;
- Avoid duplication;
- Ensure multidisciplinary working.

Trial versions of the documentation were collated, examined, modified and consulted on with all staff. All comments were taken into account. Once the final version was agreed, multidisciplinary training began for all staff. This training was delivered by the senior nurse manager and the clinical director in a number of sessions and was followed by a six-month pilot. Three months into the pilot the results of an informal evaluation sug-
ggested some modifications were necessary, and these were then incorporated. A formal audit of the documentation was carried out at the end of the six-month pilot.

**Documentation audit**

The audit was carried out in two parts. One part involved randomly selecting 15 records and judging them against set criteria regarding the efficacy of note-writing and the participation of all professionals. The second part of the audit involved a questionnaire, which was sent to all staff seeking their opinions on the documentation.

**Results**

All professionals participated in using multidisciplinary records. The need to reinforce details such as date, signature, more space for patients’ next of kin and relatives (if they give more than one) was highlighted. The need to evaluate more clearly the care and treatment given to patients was emphasised. Other minor amendments were also made. All the information contained in the documentation was considered to be relevant and easy to understand.

The staff had a positive opinion about using the new documentation. Of the 43 questionnaires distributed, 30 were returned (70 per cent).

An analysis of the responses showed that the new multidisciplinary patient documentation had several benefits: 63 per cent of the respondents said that it saved duplication; 70 per cent said it helped to maintain continuity of the patient’s journey; and 77 per cent found that it provided more appropriate information. Most of the respondents (97 per cent) felt that it helped to improve communication.

On the subject of efficiency, 57 per cent said that it saved time, whereas the remainder (43 per cent) felt that it led to more time being spent on the documentation by one team in the first instance (see Table 1).

Many comments from respondents referred to the beneficial aspects of the new documentation. In relation to duplication, one respondent said that the ‘new documentation is easier to use and offers opportunities for all members of the multidisciplinary team to make entries to identify their care.’ This respondent also felt that the new documentation generally reduced the duplication of the work involved in hospital palliative care team assessments and domiciliary team assessments and that work was also reduced for staff at the day hospice. These staff had previously carried out their own assessments and drawn up their own care plans.

**Other comments:**

Respondents also made the following comments about the new documentation:

- The relevant information is easier to find;
- It improves communication and results in clearer assessments, including psychosocial assessments;
- The care plan is in place and you can see where other people have contact. It feels more like a team;
- There is more appropriate information and all information is together in one folder;
- All the information is in order of events happening;
- There is less repetition;
- It encourages various specialties to be more aware of each other’s input;
- Staff are more inclined to consult doctors’ notes and reports;
- No referrals forms (from inpatient unit and hospital palliative care team) are needed;
- Staff can clearly see all areas and appropriate and up-to-date information is provided;
- It enables greater in-depth discussions;
- The new documentation saves time;
- Patients benefit from not having to repeat the same details of their history or other aspects of information to various professionals.

The results of this audit were presented to all staff. Comments were noted during the presentation and as a result another meeting of the working group was convened. Further minor alterations were made. The patient’s detail sheet has now been incorporated into the computer system and patients’ details can be ‘mail-merged’ into this. An instruction manual has been written that provides reminders and a step-by-step guide for the correct use of the records. This acts as a useful reminder and can be used by new members of the team.

**Conclusion**

Implementing the new multidisciplinary patient documentation has gone smoothly. Everyone has been willing to participate and has shown the commitment needed for the project to succeed. This approach can be seen as a testament to good multidisciplinary working as all staff are involved in decision-making.

This project shows that if good teamwork is in place and the new documentation benefits both patients and staff, then a vision of improving the quality of service can become a reality and its success can be owned by everyone involved.