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Audit on completeness of patient assessment forms at the palliative care clinic of National Cancer Institute, Maharagama

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Introduction & Aim: Medical documentation in palliative care is important for information dissemination within the multidisciplinary team and for medico-legal purposes. This study aimed to assess the completeness of the patient assessment form (PAF) within two timeframes at the Palliative Care Clinic, Maharagama and compare them for differences in completeness.

Method: This study was a retrospective internal desk research. All PAFs stored in the clinic were reviewed for two-time frames, which were the first four months since starting the clinic (September-December 2015) and the last four months prior to data collection (October 2016-January 2017). Data analysis was done with SPSS 23 using descriptive statistics.

Results: There were 56 and 42 PAFs for the two timeframes, respectively. In both time frames, only clinic number showed 100% documentation. In the first timeframe, age (94.6%) was the best documented and psychosocial section was the most poorly documented (48.2%). Reason for referral (55.4%), presenting conditions (60.7%) and problems (73.2%) were inadequately documented. For the second-time frame, primary diagnosis was the best recorded (97.6%) while site of metastases was the worst (59.5%). Documentation of presenting conditions (73.8%) and treatment plan (69%) were insufficient. There was no improvement in overall documentation of PAF with time (p=0.061). However, significant improvements were noted in the documentation of religion (p=0.007) and caregiver information (p=0.002). No difference in documentation between medical and nursing officers was seen for either timeframe (p=0.243, p=0.082).

Conclusion: Documentation in the PAF is incomplete. Training health personnel in this regard would improve documentation and care provision.

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