



Hidden outpatient oncology Clinical Nursing Minimum Data Set: Findings from an Italian multi-method study



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A B S T R A C T

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Purpose: The main aim of this study was to present the hidden Clinical Nursing Minimum Data Set adopted by Italian nurses in outpatient oncology settings.

Methods: A multi-method study design articulated in three phases was conducted from November 2009 to December 2010. A cross-sectional study design involving outpatient oncology centres located in the 20 Italian regions was undertaken in order to collect structured nursing records used by nurses in the documentation of daily nursing care. An evaluation of the items contained in each nursing record was performed in order to individuate homogeneities. A content analysis of the items was therefore undertaken in order to categorise them in assessment, problems, intervention, and outcomes.

Results: A total of 1080 different items from the structured nursing records were counted, comprising on average 29 items (range 8–175; ± 40.4) for each record. A total of 330 (30.6%) out of 1080 were categorised as assessment items, 146 (13.5%) as problems, 583 (54.0%) as interventions and 21 (1.9%) as outcomes items.

Conclusion: Italian nurses have developed a micro-system Clinical Nursing Minimum Data Set capturing and documenting several types of clinical data, following their implicit representation of what it is important to document: much consideration is given to nursing surveillance/monitoring and to at-risk problems, indicating the importance of the nursing role in the prevention and early recognition of a patient's clinical deterioration. However, there is a need to develop a macro-system national NMDS which will be useful for evaluating nursing outcomes and making decisions on workforce resources.

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Introduction

Many initiatives have been developed at the international level to identify a set of items to ensure systematic nursing data collection and documentation: this set of minimum information, called Nursing Minimum Data Set (NMDS), is based on uniform definitions of data divided into assessment, problems, intervention and outcome categories adopted on a regular basis by the majority of nurses (Werley and Lang, 1988, p. 8).

The first NMDS was established in the USA (Werley et al., 1991), followed by Canada (CNMSD, Anderson and Hannah, 1993), Australia (Ryan et al., 1999), and more recently by Thailand (Volrathongchai et al., 2003). Among European countries, the Belgian National NMDS, originated in 1998, is widely validated and

used as a reference (Goosen et al., 1998; Sermeus and Goossen, 2002); across Europe the Telenurse minimum data set has been developed (Anonymous, 1996), and examples are also available in France (Sermeus and Goossen, 2002), in the Netherlands (Goossen et al., 2000), Switzerland, Finland, Sweden (Mac Neela et al., 2006) and in Germany (Eberl and Bartholomeyczik, 2010).

Available NMDSs are meant for hospital settings (e.g. in Belgium), community or nursing home settings (e.g. USA (Saliba and Buchanan, 2012)) or across hospital and community settings as in the case of the Transition of Care Minimum Data Set accompanying patients from nursing homes to emergency departments (Kelly et al., 2012). Some NMDSs are general while others are dedicated to a specific group of patients, such as those suffering from dementia (Park et al., 2004), mental health disorders (Morris et al., 2010) or pressure sores (Bates-Jensen et al., 2003). Until now less attention has been given to outpatient clinical settings where as in the case of oncology patients, nursing care is prominently offered. To our knowledge, limited NMDS research experience has

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been developed in the field of oncology nursing care (Goossen et al., 2001; Van den Heede et al., 2009); moreover, an extensive review of the literature regarding the nursing sensitive outcomes in chemotherapy ambulatory care is available (Griffiths et al., 2012) and this might be a basis for the development of an NMDS dedicated to oncologic outpatient settings.

The lack of evidence available on NMDS in the specific field of oncologic patients might threaten the identification the amount of nursing resources to dedicate to patients (Sermeus et al., 2011) and also makes it difficult to compare nursing effectiveness among different settings, centres, and countries (Goossen et al., 2001).

NMDSs development methodologies

The historical development of the NMDS in the USA has recently been analysed by Hobbs (2011). The process of identifying items to be included in the NMDS was contentious: individual nurses argued on behalf of particular items due to a strong belief in the way nursing practice should be structured. Historically little attention was paid to existing practice conditions that would ultimately determine whether an NMDS would be used. More recently in the development of NMDS, a consensus method to determine items for inclusion was adopted, using multiple strategies such as interviews, focus groups, Delphi procedures, review of the literature and document analysis (Goossen et al., 2001; Butler et al., 2006). After identifying the set of items, an evaluation of their usefulness and their inter-rater reliability is performed (Goossen et al., 2001; Van den Heede et al., 2009; Morris et al., 2010). This formal process of progressive agreement takes much time and involves a number of participants (from 34 to 300) who aim to achieve, at the national level, a broad acceptance of NMDS by different groups of nurses (clinical nurses, managers, nursing directors) (Goossen et al., 2001).

According to Piper et al. (2011), while the available methods adopted to define an NMDS are based mainly on a top-down process, there is also a bottom-up process. This includes a nursing record review as a 'core component' of the process, given that this expresses insights into many implicit representations of the clinical constructs embedded in the practice that may not exist in the literature. According to their perspective, behind the macro-system NMDS, an implicit and hidden NMDSs exists in everyday clinical practice. The purpose of this article is therefore to reveal the hidden NMDS adopted in Italian outpatient oncology nursing care and to describe its characteristics.

Material and methods

The context

This research project was undertaken in Italy, which is defined – with regard to the specific aims of the study – by the following characteristics:

- a) *The epidemiological relevance of the cancer problem.* It is estimated that 2.8% of the Italian population (about 1.8 million people) have had a diagnosis of cancer in their lifetime, and it is expected that the number of people with a prior diagnosis of cancer in the country exceeds 1,900,000 individuals, of which 56% are women (Documento tecnico di indirizzo per ridurre il carico di malattia del cancro, 2011).
- b) *The organisation framework trends in Italian oncologic services.* The aim of the National Health Service (NHS) is to organise care in oncology departments (OD) as a regional network of hospitals and outpatient centres delivering prevention, treatment, care and rehabilitation. The Regional Oncology Network has

already been founded in some regions and is being implemented in others (Documento tecnico di indirizzo per ridurre il carico di malattia del cancro, 2011). Over the last year, there were 1,180,761 persons discharged with oncological problems: 69% of these were from hospitals and 31% were from outpatient settings (Relazione sullo stato sanitario del Paese, 2011).

- c) *The state of the art of the Italian NMDS in the nursing record.* At the moment of the study, there is a great variability in the Italian nursing record and in the information contained (Palese et al., 2012) given that there is no Italian NMDS: nurses document the care delivered in records, mainly developed through a local process of consensus involving the staff and/or the chief nurses. For each nursing record they decide which items need to be included on the basis of their experience, nursing vision and goals, and on the basis of personal belief about what is important in patient care (Palese et al., 2006). In recent years, in an attempt to reduce the time spent recording information (Bulfone et al., 2012; Coiz et al., 2012; Palese, 2012), nursing records have become more structured. Depending upon where the decision is taken (e.g., at the ward or hospital level), the data to be recorded might be homogeneous to a single ward, department, hospital, outpatient clinic or in a cluster of hospitals/districts and/or outpatients clinics; it might also be dedicated to a single population (e.g. surgical patients) or a full-range of patients; not lastly, might be structured or unstructured (Palese et al., in press).

Study design, data collection process and analysis

A multi-method study design, articulated in three phases, was conducted from November 2009 to December 2010:

- 1) First phase: a cross-sectional study involving outpatient oncology centres located in all 20 Italian regions was undertaken in order to collect structured nursing records used by nurses in the documentation of daily care. A preliminary assessment of the centres, available at the national level, was undertaken in cooperation with the Italian Association of Oncology Nurses (AIO).

Of the 186 centres, 37 were approached among those located in the provinces or in a hospital dedicated to oncology care. Considering the differences in population size among regions (from 128,000 [Aosta] to 9,917,970 [Lombardy]), from 2 to 5 centres for those regions with ≥ 5 million citizens (Venetia, Sicily, Latium, Campania, and Lombardy) were included.

The chief nurses of each centre included were therefore contacted first through a preliminary letter describing the aims of the study and then via telephone and/or email in order to answer their questions. During this personal contact made by one researcher (EC), a copy of the standard nursing record (not filled in for a specific patient) used each day (in paper or digital format) was requested and collected. A total of 37 structured nursing records, 1.8/region (range 1–5) were collected ($n = 32$ on paper, $n = 5$ on digital support): among these, 31 (83.8%) were specifically dedicated to outpatients while 6 (16.2%) were dedicated to both in- and outpatients. For the latter, data concerning patients in-hospital stay was not included as per the aims of the study. The items (NMDS elements (Volrathongchai et al., 2003), or variables (Goossen et al., 2001)) contained in each nursing record collected were then counted.

- 2) Second phase: in order to identify homogeneities, an evaluation of the items contained in each nursing record was performed by two researchers (AP, EC). Items described exactly in

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