

Medical Documentation in the Care for a Minority Group Member

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Abstract

Introduction: Nursing documentation is part of the patient's medical documentation. It allows documenting the nursing care provided and at the same time gives much important information that healthcare professionals need to share among themselves.

Aim: The aim of the research survey was to develop a draft of nursing documentation for patients from minority groups based on established specificities that may affect the care provided to members of minority groups.

Method: Semi-structured interviews were conducted in order to determine the specifics of the selected minority groups. Questions for the semi-structured interview were compiled according to Larry D. Purnell's Model of Cultural Competence. The areas that appeared most "problematic" in providing nursing care to patients – members of minority groups in healthcare facilities in the Czech Republic were identified based on open coding. In addition, a draft of nursing documentation was created based upon the results of interviews and using the Model of Cultural Competences as one of the inputs.

Results: The following categories were included in the above-mentioned nursing documentation: communication, family, abuse, nutrition, spirituality, health care practices, care providers, pregnancy.

Conclusion: The draft nursing documentation is such a tool that can be used for a quick and clear mapping and recording of the specifics in the various areas under consideration. The final form of nursing documentation for clients from minority groups in population is currently being reviewed for user-friendliness.

Keywords: culturally competent healthcare, Model of Cultural Competence, nursing documentation

Introduction

Medical documentation is an inseparable and indispensable component of healthcare provided to every patient, not only with regards to the legal obligation to maintain it under Act No. 372/2011 Coll., on Health Services and Conditions for Provision of Health Services, as amended (Czech Republic), and Act No. 89/2012 Coll., Civil Code, as amended (Czech Republic), but mainly because of the fundamental information value it provides to physicians and other legitimate entities (Mach et al., 2013). All relevant and sensitive data found in the context of providing care to patients and protected by medical confidentiality are recorded in the medical documentation (Buriánek, 2005).

The duties of healthcare professionals related to the protection of clients' personal data are the content of most codes of conduct. These obligations are set out, for example, in the International Code of Ethics for Midwives and the Code of Ethics for Non-Medical Healthcare Workers (Czech Chamber of Midwives, 2014; Czech Republic, 2004).

Maintaining medical documentation while respecting all the above-mentioned rules is nowadays not only an ethical but also a legal obligation for all medical facilities (Stolínová & Mach, 2010). The obligation to maintain medical documentation is expressly stipulated by the provisions of Section 5 Para 2 Clause d) Act No. 160/1992 Coll., on Health Care in Non-State Health Facilities, as amended (Czech Republic). Medical documentation is maintained in textual, graphic or audiovisual form and the data contained in the documentation are kept in a paper or electronic form (Czech, 1966).

Nursing documentation

Nursing documentation is part of the patient's medical documentation. Simple and quality nursing documentation is an essential component of the nursing process (Staňková, 2005). Kudlová (2016) states that nursing documentation is a systematic recording of care planned and provided to the patient by a qualified nurse and other members of the nursing team. Quality record keeping in nursing documentation may affect the quality of care provided. These fundamental requirements are also unambiguously embedded in the Nursing Concept of the Czech Republic (Czech Republic, 2004).

In healthcare facilities in the Czech Republic, it is almost a daily routine that the patient is an individual from another country, another cultural environment. Non-medical healthcare professionals should be able to provide culturally competent care, taking into account patients' wishes, respecting their religion, traditions, culture, and values. That is why nursing documentation applied in the care for members of minorities in the Czech Republic should be comprehensive and sufficiently sensitive to the specifics arising from another cultural environment and values.

Aim

The aim of the research survey was to develop a draft of nursing documentation for patients from minority groups based on established specificities that may affect the care provided to members of minority groups.

Method

To develop a draft of nursing documentation for patients from minority groups, it was necessary to identify areas – specifics that should be part of the nursing documentation intended for minority group clients. Semi-structured interviews were used for determining such specifics. In this survey, respondents were members of minority groups, specifically confessions of Islam (respondents I1–I4), Ukrainians (U5–U10), Roma (R11–R15) and Vietnamese (V16–V18) over 18 years of age, hospitalized between July 2016 and July 2017 or having a recent experience with healthcare in the Czech Republic no older than one month.

Respondents were approached after obtaining prior approval from the medical facilities, where the research survey was conducted. The participants in the research were explained the purpose and aim of the survey and their informed consent to participation was obtained.

The questions of the semi-structured interview were composed based on the content of the various dimensions of the Model of Cultural Competence by Larry D. Purnell (Purnell & Paulanka, 2005). The interviews were recorded, a verbatim transcription of the various records was made then. The following phase of the data work was “pencil – paper” open coding (for individual codes see the Results).

The areas that appeared to be most “problematic” in providing nursing care to patients – members of minority groups in healthcare facilities in the Czech Republic were identified based on this approach. At the following stage, a draft nursing documentation was worked out and presented to four experts in the field of midwifery and nursing, who evaluated the nursing documentation in terms of usability and clarity. Based on their feedback, the nursing documentation was further altered. The final version will be examined for user-friendliness in practice using the focus group method with ward and charge nurses at selected departments.

Results

Resulting categories

As a result of open coding of interviews, new categories were introduced, further modified and merged, according to the meaning of statements, into further new categories and subcategories. The table (Tab. 1) is subdivided into categories contained in the documentation and non-contained therein based on their occurrence and importance attached by the respondents. For clarity, the respondents’ answers are distinguished by italics in the text.

Tab. 1 **Resulting categories**

Included in the documentation		Non-included in the documentation	
Category	Sub-category	Category	Sub-category
1 Communication	A Addressing	3 Work	A. Occupation
	B. Communication language		B. Risks
	C. Providing information	4 Biocultural ecology	A. Allergy
2 Family	A. Duties		B. Medicines
	B. Relatives		C. Genetics
	C. Relationships	7 Dying and death	A. Dying person
5 Abuse	A. Smoking		B. Funeral
	B. Alcohol		C. Death
6 Nutrition	A. Food composition		D. Posthumous life
	B. Beverages		
8 Spirituality	A. Religion		
9 Health care practices	A. Prevention		
	B. Pain		
	C. Donation		
10 Care providers	A. Doctor		
	B. Examination		
	C. Hospitalization		
11 Pregnancy	A. Conception		
	B. Pregnancy		
	C. Delivery		
	D. Newborn		

Communication

Communication among people is highly important, especially when it comes to communication between doctors, non-medical healthcare staff and the patient. Even a minor misunderstanding may cause health damage.

Addressing – No specifics were encountered in the way of addressing the interviewees; they wanted to be addressed as Mr. / Ms. followed by their surname. This subcategory was entered into the documentation for identification of clients.

Communication language – Language barrier is one of the most frequent challenges that arise in providing care to a patient whose mother tongue is not the language of the majority. Under Act No. 372/2011 Coll., on Health Services and Conditions of Their Provision (Czech Republic), each patient has the right to be provided with information on their health condition and care plan in a language they understand. An interpreter is either provided for by the healthcare facility or by the very patient. All respondents in our research group are able to communicate in Czech, in the language of their nationality and in their mother tongue; additionally, 9 respondents are also able to communicate in one or more world languages.

Providing information – Most respondents agreed that they wished that the information concerning their health condition and treatment plan be communicated to them directly. However, requirements for the diagnosis to be first told to the family and only then to the patient, were encountered too. Respondent U8 states: *“In Ukraine, this is first communicated to the family and only then to the patient. He is told by the family then.”* In reaction to the question who should be told the diagnosis and treatment plan, respondent V17 said: *“I should be told, but in other Vietnamese families the practice may be that the family is told first and they consider what the patient can or cannot bear, and only then pass on the information.”* This issue is very sensitive and extremely important, which is why it was included in the nursing documentation.

Family

The respondents reported that women are in charge of the household and childcare while men take care of the family finances. The nursing documentation contains the notion of the head of the family and the person deciding on the treatment. R13, for instance, stated: *“In our family, my husband is the head of the family, has the main word, and we all listen to him – myself, children, his sister, and sometimes even the parents. When they come to see me in the hospital, my husband speaks to the doctors and then he always tells me something”.*

Abuse

Smoking and alcohol – In this domain, the answers varied depending on the minority the respondents belong to. All respondents from the Roma national minority reported that they smoked. On the contrary, all respondents from the Vietnamese minority consistently reported that they did not smoke and only drank alcohol occasionally or not at all, and tried to keep a healthy lifestyle and to eat a lot of vegetables. Confessors of Islam do not drink alcohol at all and only one interviewee smokes. Respondents from the Ukrainian minority drink alcohol occasionally or not at all and no one smokes.

Nutrition

Food composition – Confessors of Islam avoid pork meat. So answered all Muslims in our research group. I1 reported, for instance: *“Me and my wife eat no pork because it is not allowed in our*

religion. But I respect the fact that others eat pork meat.” To the question of eating pork, respondent R2 said: *“If I had no choice, I would. Of course, when I have the choice, I don’t choose it – we don’t cook pork at home. But naturally, if I was to starve, I would eat it for sure.”* There were no specifics about food composition in the diet for the members of the Roma and the Ukrainian minorities. Respondents from the Vietnamese minority consistently stated that they preferred their traditional cuisine.

Beverages – Vietnamese women prefer to drink green tea or pure water. Confessors of Islam avoid alcoholic beverages and must not eat or drink from sunrise to sunset during the Ramadan period. Ill people are exempt from this rule; however, a large number of Muslims keep these habits in Ramadan even during illness as far as their health condition allows so. The Roma have no specific beverage requirements and neither do Ukrainian minority members.

The composition of the ingested food and fluids as well as the dietary requirements during hospitalization represent important information for the treatment regimen.

Spirituality

Religion – It plays a crucial role in human life and represents a very important aspect in an adaptation of an individual to a disease. All Islamic respondents adhere to the rules of Islam but do not consider themselves orthodox Muslims. For instance, in reaction to the question if he prayed, respondent I1, answered: *“We should pray five times each day, but sometimes I have a problem with that because I go to work and it’s not always possible. My wife prays five times a day.”* Respondents from the Ukrainian minority profess the Orthodox religion. They answered uniformly that they did not need anything in the healthcare facility. If their time and work conditions allow so, they go to church on Sundays, holidays or when they face difficulties and seek God’s advice. All the interviewed women from the Vietnamese community profess Buddhism. Two respondents from the Roma minority are Catholics and do not need anything to pray in the medical facility; the remaining respondents are non-denominational.

Healthcare practices

Prevention – Ukrainian respondents, confessors of Islam and the Roma do not attend regular preventive visits, except for one pregnant Roma woman. Vietnamese women, on the contrary, regularly attend preventive medical checks. For this reason, specific preventive programs were included in the draft nursing documentation, as the authors of the present paper consider this important for maintaining health.

Pain – Roma women show pain in loud expressions, men rather try to cope with pain by themselves using analgesics. Vietnamese women do not like to show pain and cope with it rather silently as they do not want to bother other people. They do not even use painkillers, using alternative methods such as heat, phytotherapy, massage and acupuncture to treat pain.

Donation – Respondents have no issue with blood donation if this is for their relatives. One Muslim respondent donated blood as a volunteer in Syria, where he comes from. To the question whether she would donate blood, respondent I4 replied: *“Yes, of course, if this could save someone, I surely would. I wouldn’t care if that person is a Muslim, a Christian or has no confession. If he is a good person, I would give him blood.”*

Care providers

The respondents endeavour to adhere to their treatment regimen and to respect the advice of the doctors and non-medical healthcare personnel. Confessors of Islam wish to be treated by a person of the same sex; this mainly applies to women. However, when only a treatment by a male person is possible, a male member of the family, such as husband or brother, should be present. Other respondents did not report any requirements concerning the healthcare personnel's gender.

Pregnancy

Conception – None of the respondents follow rituals or practices that would facilitate conception. Some female respondents tried to eat better before getting pregnant.

Pregnancy – Vietnamese women are afraid of gynaecological examinations during pregnancy, especially vaginal examination. The general principle among the Muslims is that it is necessary to accommodate the appetite desires of a pregnant woman in order to avoid undesirable changes in the foetus. If a pregnant woman feels like eating a certain meal and cannot obtain it, this food's form will appear on the child's body, either in the form of a different skin tissue or as a polymorphous growth. Respondents from the Ukrainian minority reported that pregnancy is a gift, a scarcity, and Roma women gave similar responses.

Birth – Vietnamese women favour vaginal delivery to Caesarean section. In the course of delivery, women suffer quietly and discreetly. Vietnamese women perceive showing symptoms of pain as a disgrace of a woman. Pain is understood as a natural part of delivery. Vietnamese women should not bathe after giving birth; they prefer a warm and very quick shower. They must not wash their hands in cold water, trying to avoid catching a cold. On the contrary, women from the Roma community stated that they tolerate pain very poorly and do not control or even want to control themselves during the delivery and experience the delivery very intensively and loudly.

Newborn – Caressing a newborn on the head shows disrespect among the Vietnamese. The Vietnamese believe that the head is sacred, which is why this area should be avoided completely. Vietnamese women begin with breastfeeding only on the third day after delivery as they consider the colostrum unclean (Tóthová et al., 2010, pp. 61–80). Our respondents appreciate the level of healthcare they receive. Respondent V17 stated: *“In my country, I was not provided such healthcare like in the Czech Republic.”* As for the Muslims, to the question whether any rituals are carried out after the child's birth, respondent I4 replied: *“When the baby is 40 days old, special perfumes are sprayed over its body. And most importantly, when a first child is born to a woman, everyone gives him money, buys gifts and clothes.”* Respondent I3, who already has two children, replied: *“I was extremely happy after the birth of both daughters. I didn't mind that they were daughters. After their birth, I whispered a special prayer in their ears.”*

The above-mentioned specifics identified during the interviews with the respondents of the four minorities that we encounter in the Czech Republic served as an input for the structure of the nursing documentation created. The draft documentation for minority members is conceived as a record chart, while the collected data on clients are entered by a healthcare professional by indicating the corresponding answer variant. The authors created two versions of this documentation – one for women and one for men. Documentation for women additionally contains information on pregnancy, delivery and minor differences regarding preventive examinations.

Discussion and Conclusion

In the present paper, the authors present the partial findings of a broad study focused on providing culturally competent care. With regards to the political situation and the increased migration of population across all continents, the problem area of multicultural care is an important topic. Nursing is primarily focused on maintaining health, promoting health, restoring health and developing self-sufficiency. It significantly participates in prevention, diagnosis, therapy and rehabilitation. The nurse helps both individuals and groups to be able to satisfy their basic physiological, psychosocial and spiritual needs (Czech Republic, 2004). For this reason, all healthcare professionals should be able to reflect on the specificities that multicultural care implies. This interaction is beneficial for both patients and nurses.

It is not easy and frequently even not realistic for all healthcare professionals to have comprehensive information on the characteristics of the minority groups living in the Czech Republic. Therefore, the authors focused on mapping out the specifics of minorities that a healthcare worker may encounter in the conditions of the Czech healthcare system most frequently. The different lifestyle areas can be diet, communication and health care. For Vietnamese, there is typically restraint, shyness, not complaining and not expressing pain. In verbal communication the word for “yes” rather than expressing a positive answer or agreement, may simply reflect an avoidance of confrontation or a desire to please the other person. Hugging and kissing are not seen outside the privacy of the home (Purnell, 2008). What about health, Vietnamese women have the highest rate of cervical cancer of any female population that has been surveyed in the United States, approximately six times the national average (Wright, 2000).

The main objective hereof was to develop a practical tool for non-medical healthcare professionals, which may help to easily and efficiently map the specifics that can influence the care for a particular client. The areas covered in the documentation result from a research survey with respondents – members of the monitored minority groups, and at the same time Purnell’s Model of Cultural Competence was used as a theoretical basis. The use of conceptual models is appropriate because they evaluate the human as a holistic entity and their application is not challenging as they work with specific nurse interventions (Maňhalová, 2017).

Where culturally-appropriate care is not delivered, studies demonstrate a negative trajectory of events ranging from simple miscommunication to life-threatening incidents (Meddings & Haith-Cooper, 2008; Reitmanova & Gustafson, 2008).

Salway, Higginbottom and Miller (2009) pertinently summarize the key dimensions and definitions of cultural competence below; these can be assessed and developed at the level of the individual, team, service, organization or wider healthcare system: Knowledge about diversity in beliefs, practices, values and world views both within and between groups and communities, thus recognition of similarities and differences across individuals and groups and of the dynamic and complex nature of social identities; Understanding of power differentials and the need to empower service users; Ability to empathize, show respect and engender trust in service users; Recognition of social, economic and political inequality and discrimination and how this shapes healthcare experiences and outcomes for minority groups; Effective communication with appropriate provision and effective use of resources for cross-lingual and cross-cultural communication.

The draft nursing documentation is such a tool that can be used for a quick and clear mapping and recording of the specifics in the various areas under consideration. The final form of nursing

documentation for clients from minority groups in population is currently being reviewed for user-friendliness. Only the feedback from clinical practice and the long-term application of a documentation so designed will show if it is a practical tool for identifying the specifics influencing the care for members of minority national and religious groups in the Czech Republic.

Ethical Aspects and Conflict of Interest

No risk of ethical conflict has been identified. The present work is part of a project approved by the Ethical Committee of the Faculty of Health Studies, University of Pardubice.

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