Electronic Patient Records Must Talk to an Electronic Palliative Care Coordination System (EPaCCS) for Effective Advance Care Planning (ACP)

Declan Cawley,1,2 Jane Marshall1. 1Pilgrims Hospices, Canterbury, UK; 2University of Kent

Background Advance Care Planning (ACP) is integral in facilitating end of life care (EOLC) preferences for patients. Evidence suggests that patients would prefer to die at home but recognise “the practical and emotional difficulties of exercising this choice”. Whatever the cause of death, patients may experience symptoms so drugs should be prescribed pre-emptively and available in the patient’s home. Patient records need to have documentation supporting the preference(s) for death (PPOD), CPR status and pre-emptive drugs, is fundamental in facilitating the majority of individuals to die in their PPOD of home. However if data systems don’t cross talk to each other, in a ‘push/pull’ system of data transfer, the success of implementing a loco-regional EPaCCS is questionable.

Results 30 electronic patient records were randomly identified: the majority (73%) of patients had a cancer diagnosis (22/30), median age of 68 years. Interestingly 97% (29/30) of patients had reference to discussions about PPOD. 47% (14/30) had a documented preference for home, 23% (7/30) initially didn’t want to discuss with only one (1/30) person on initial meeting having a preference for hospice. 13% (4/30) had documented changes in their PPOD. Within our local EPaCCS, only 37% (11/30) of patients were registered on this system; 55% (6/11) had their PPOD documented with the remainder (5/11) having had a recorded PPOD in their electronic patient record.

Conclusions Documentation supporting the components of ACPs: PPOD, CPR status, pre-emptive drugs, is fundamental in facilitating the majority of individuals to die in their PPOD of home. However if data systems don’t cross talk to each other, in a ‘push/pull’ system of data transfer, the success of implementing a loco-regional EPaCCS is questionable.