

Electronic key information summaries facilitate timely sharing of patient preferences relevant to palliative care



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Introduction

Electronic Key Information Summaries (KIS) are shared electronic patient records widely used throughout Scotland (Tapsfield *et al.* 2016). These allow selected parts of the GP patient record to be routinely shared with healthcare professionals across settings. The KIS may contain vital information to support out of hours palliative care decision-making, such as patient preferences for place of care, CPR status and anticipatory medicines.

Aim

To identify when different information pertinent to out-of-hours palliative care decision-making was serially recorded within the KIS for patients who died of cancer, organ failure or frailty and/or dementia.

Method

A retrospective review of the primary care notes of deceased patients across nine general practices in Lothian was conducted in 2014. Sudden and unexpected deaths were excluded. Data were collected on the type and timing of information recorded in the KIS.

Results

- Notes of 605 deceased patients were analysed.
- 60% of patients had a KIS record at the time of death. The proportion was highest for people dying with cancer, and lowest for those dying with organ failure. (Figure 1)
- KIS records for patients with organ failure, frailty or dementia were commenced approx. 5 months before death.
- KIS records for patients with cancer were generally commenced closer to death, reflecting the more rapid decline associated with many cancers in the last months of life.
- KIS records were often commenced before specific information relevant to palliative care was added.

Figure 1: Percentage of patients with a KIS at the time of death by illness trajectory.

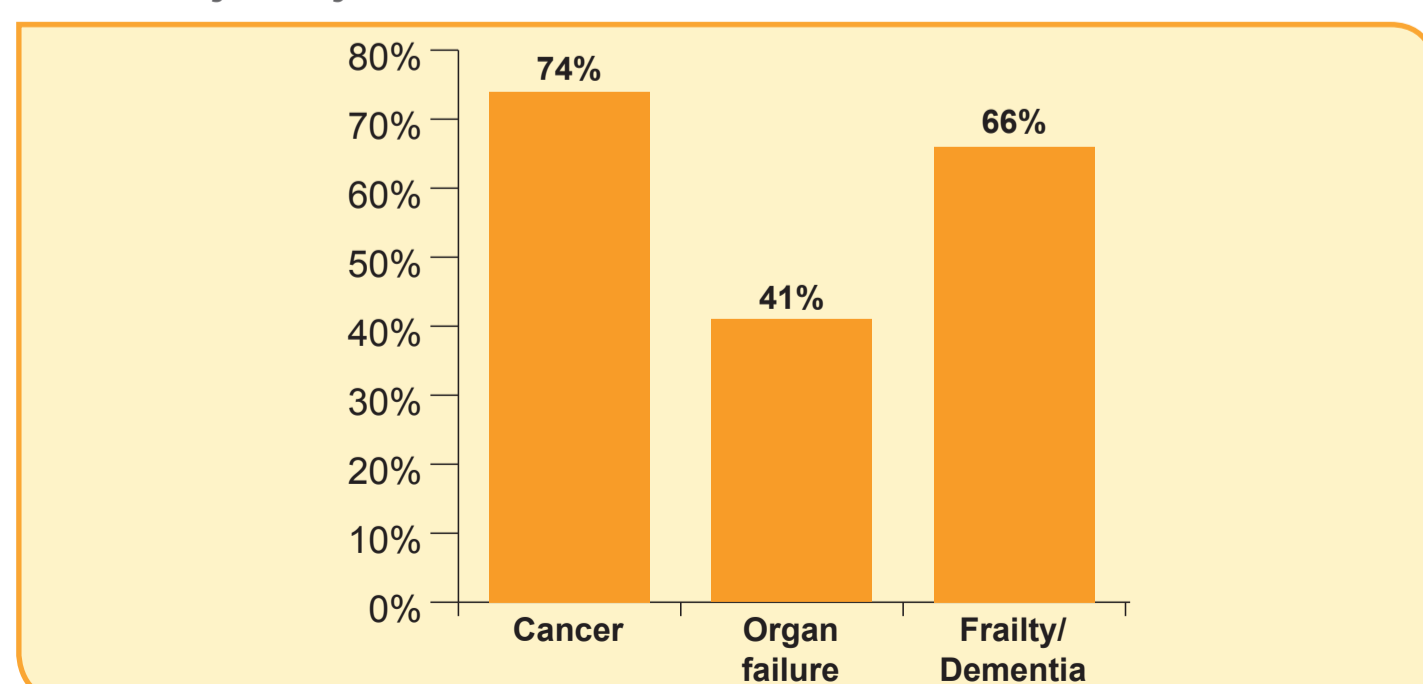


Figure 2: Timing of KIS updating for patients with cancer (weeks).

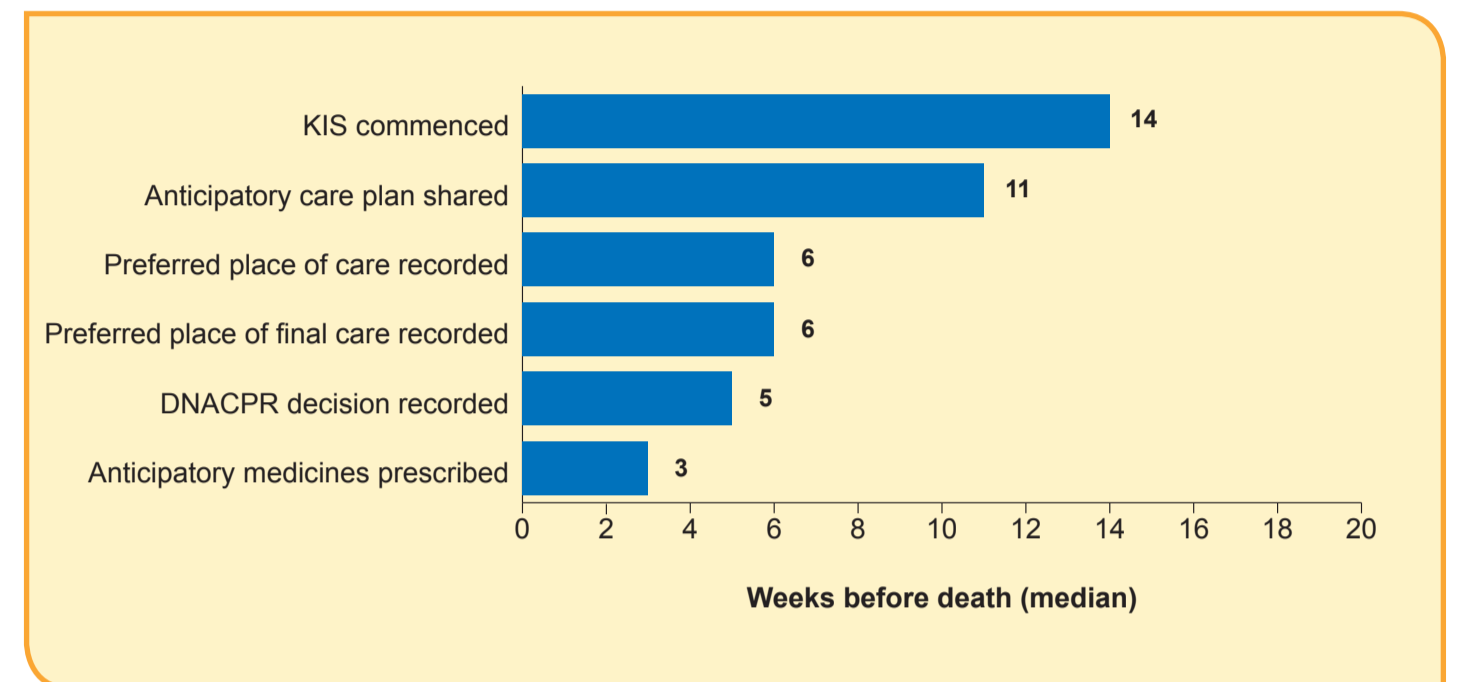


Figure 3: Timing of KIS updating for patients with organ failure (weeks).

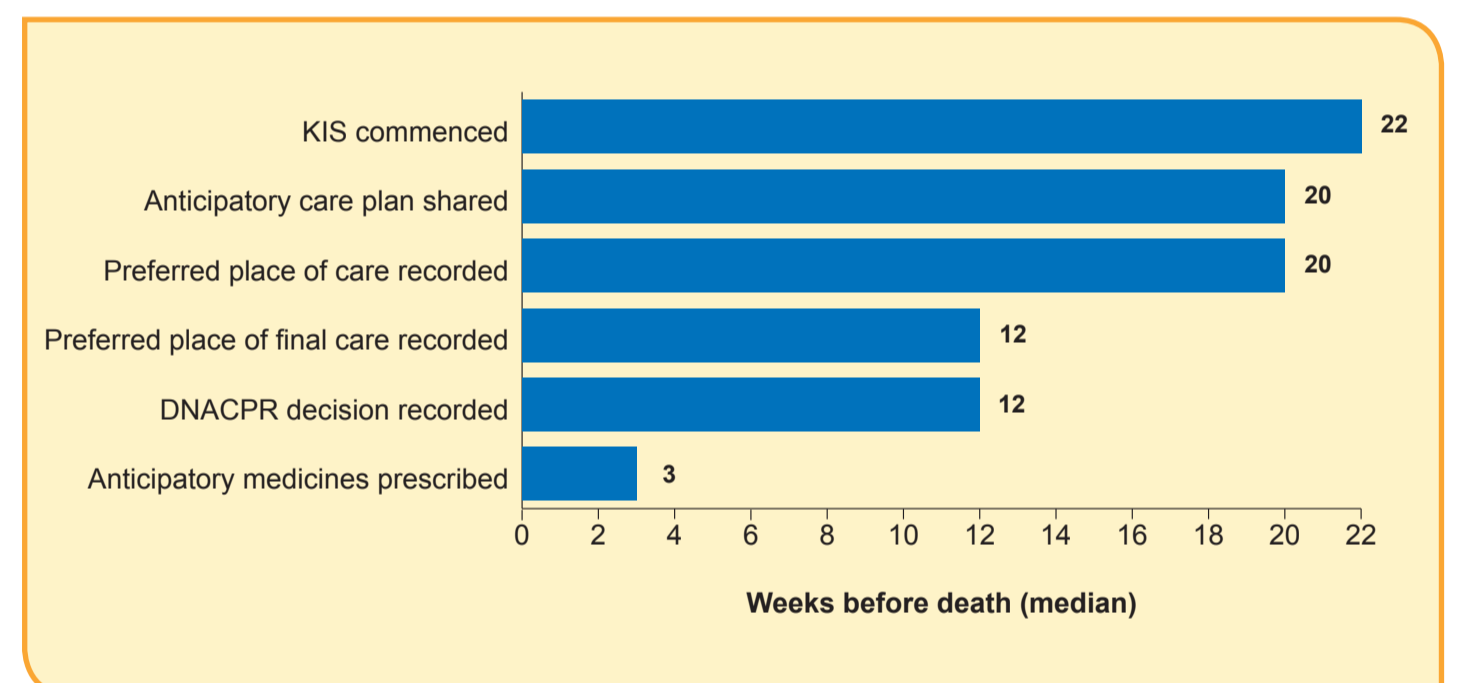
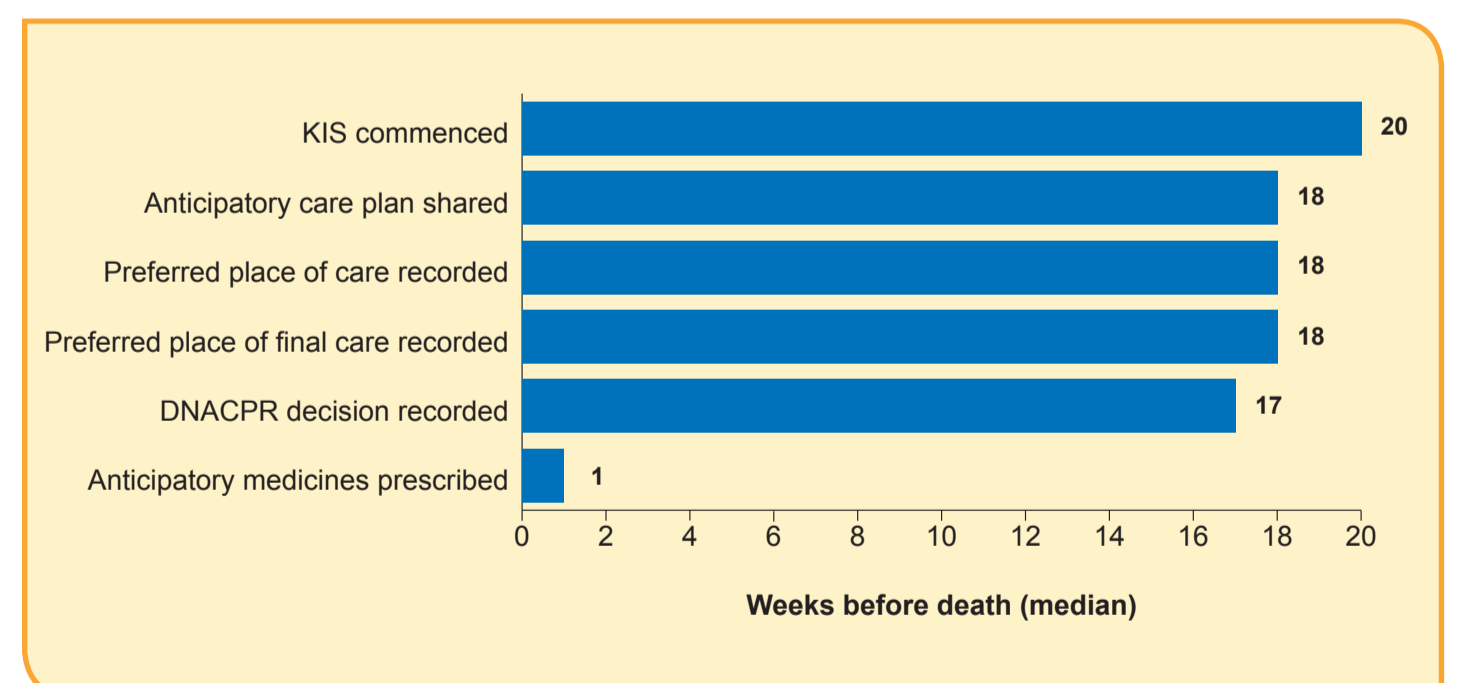


Figure 4: Timing of KIS updating for patients with frailty and/or dementia (weeks).



Conclusion

- Electronic key information summaries are often completed in a gradual manner with GPs adding to or updating the KIS as a patient's health status changes.
- The introduction of key information summaries in Scotland facilitates the timely documentation and sharing of patient information and the recording of patient preferences to promote early palliative care for all patients who might benefit.

