Advance care planning for cancer patients: a retrospective chart review in patients who died in a Dutch university hospital

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Background

Advance care planning helps to ensure appropriate palliative care that is in line with the wishes of the patient. A minority of patients dies in a university hospital. Insight into the documentation and practice of advance care planning for this highly complex patient population is important.

Aims

To assess how often advance care planning and end-of-life decisions are documented for patients who die from cancer in a university hospital in the Netherlands.

Methods

A retrospective chart review was conducted within the 8 Dutch university hospitals. For each hospital, data of the Dutch Cancer Registry were used to identify 150 oncological patients who died between October 2013 and February 2014. Those patients who died in the hospital due to cancer were selected. Outcome measures were derived from the patient file by trained data managers. Whether a patient was admitted to the hospital during a palliative care trajectory was retrospectively assessed by an oncologist (AR) and a specialized nurse (ML).

Results

Data of ninety-four patients were included. Of those patients, 47% were in a palliative trajectory upon admission to the hospital. In 66 patients (87%) the approaching death was discussed during the last week of life.

Frequency of documentation of advance care planning	
Life expectancy	18%
Preferred place of death	18%
Advance directives	
Do Not Resuscitate (DNR) order	80%
Do Not Treat (DNT) order	33%
Advance euthanasia directive	10%

For patients admitted to the hospital in a palliative care trajectory, DNR orders (93% vs. 69%, p=0.004) and DNT-orders (44% vs. 23%, p=0.035) were more often documented than for patients in a curative or diagnostic trajectory.

Conclusion

Although the majority of patients were not in a palliative care trajectory, advance care planning items were recorded in patients' files in most cases. Information on preferences regarding place of death was less often present in the patient file.