Barnsley Electronic Palliative Care Coordination System (EPaCCS): Hints and Tips

EPaCCS is designed to improve the identification of patients in the last year of life, record the wishes and preferences of these patients (CPR status, preferred place of death etc.) and share the information recorded with as many health care professionals as possible who are caring for these patients. The codes in the template are based on the Information Standard for End of Life Care (SCCI 1580).

The template is designed to be used by professionals with access to EMIS who may be caring for this group of patients. If all professionals contribute and update the information recorded as necessary it will be a useful tool in GP Palliative Care / Gold Standards Framework meetings and the information can be used to support appropriate decision making e.g. out of hours. Access to the information recorded such as emergency care plans and treatment escalation plans may prevent potentially avoidable hospital admission.

The template includes links to relevant local and national resources to support end of life care such as clinical guidelines and forms.

This document provides hints and tips for completion of the template. Some codes are 'tick box' but there are other codes where the addition of extra 'free text' information ensures that EPaCCS becomes a more useful clinical tool.

If information has already been recorded and is accurate and up to date there is no need for duplication of recording.

For any further information about EPaCCS please contact:

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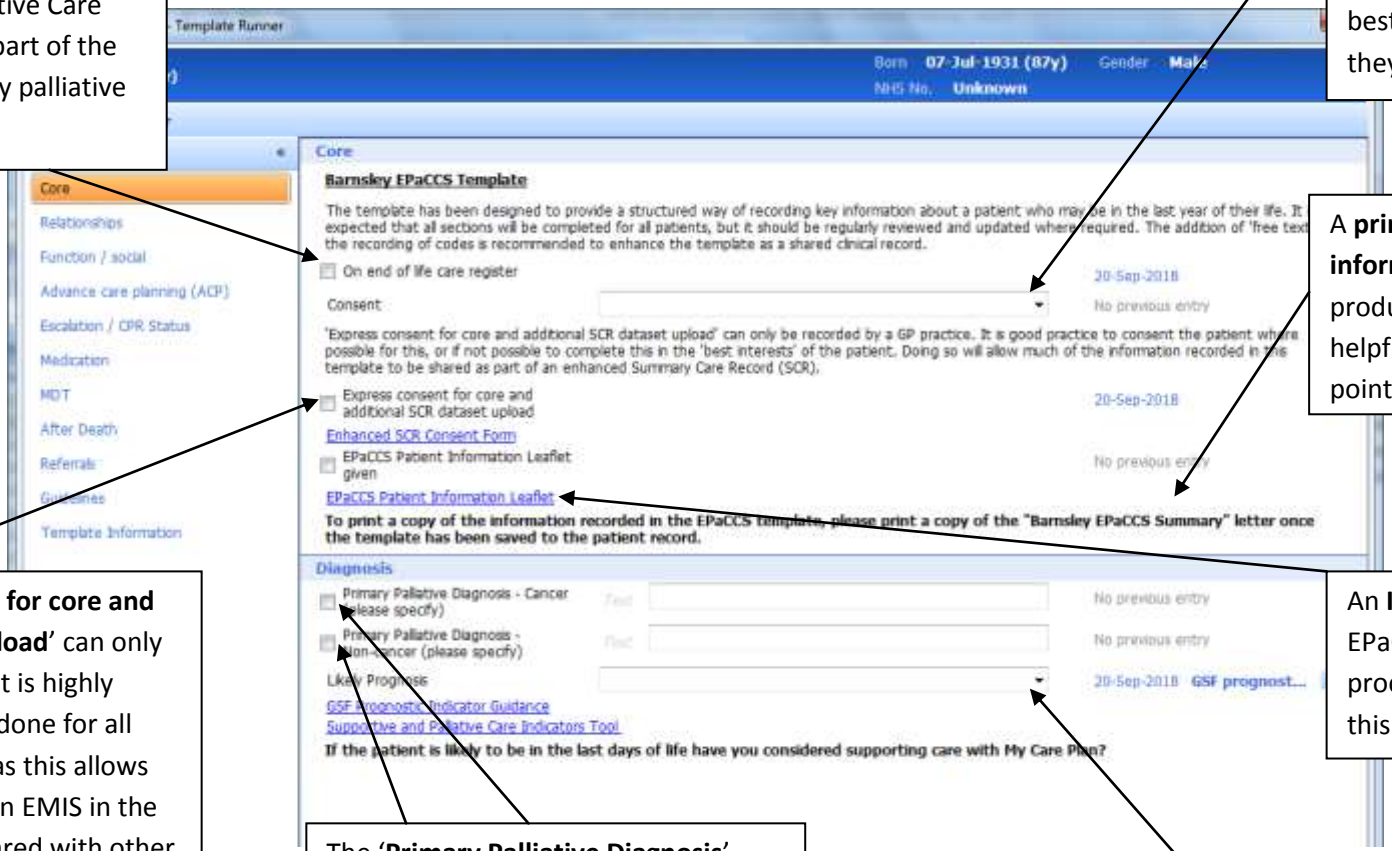
Selecting '**On end of life care registe**r' ensures the patient is included in the GP Palliative Care 'QOF' register so forms part of the discussion in the monthly palliative care MDT meetings.

'**Consent**' for sharing information recorded can be obtained from the patient or recorded in the best interests of the patient if they lack capacity.



A **printed summary of EPaCCS information** recorded can be produced from this link. This can be helpful as it can be produced at the point of care in emergency situations

Selecting '**Express consent for core and additional SCR dataset upload**' can only be done by a GP practice. It is highly recommended that this is done for all patients at the end of life as this allows the information recorded in EMIS in the EPaCCS template to be shared with other services using different IT systems such as SystmOne (OOH GPs) and Adastra (NHS 111, YAS) that access Summary Care Record. An additional consent form may be required by some GP Practices for this and it can be printed off from the link. Further information: SCR with AI

An **Information leaflet** about EPaCCS supports the consent process and can be printed from this link.

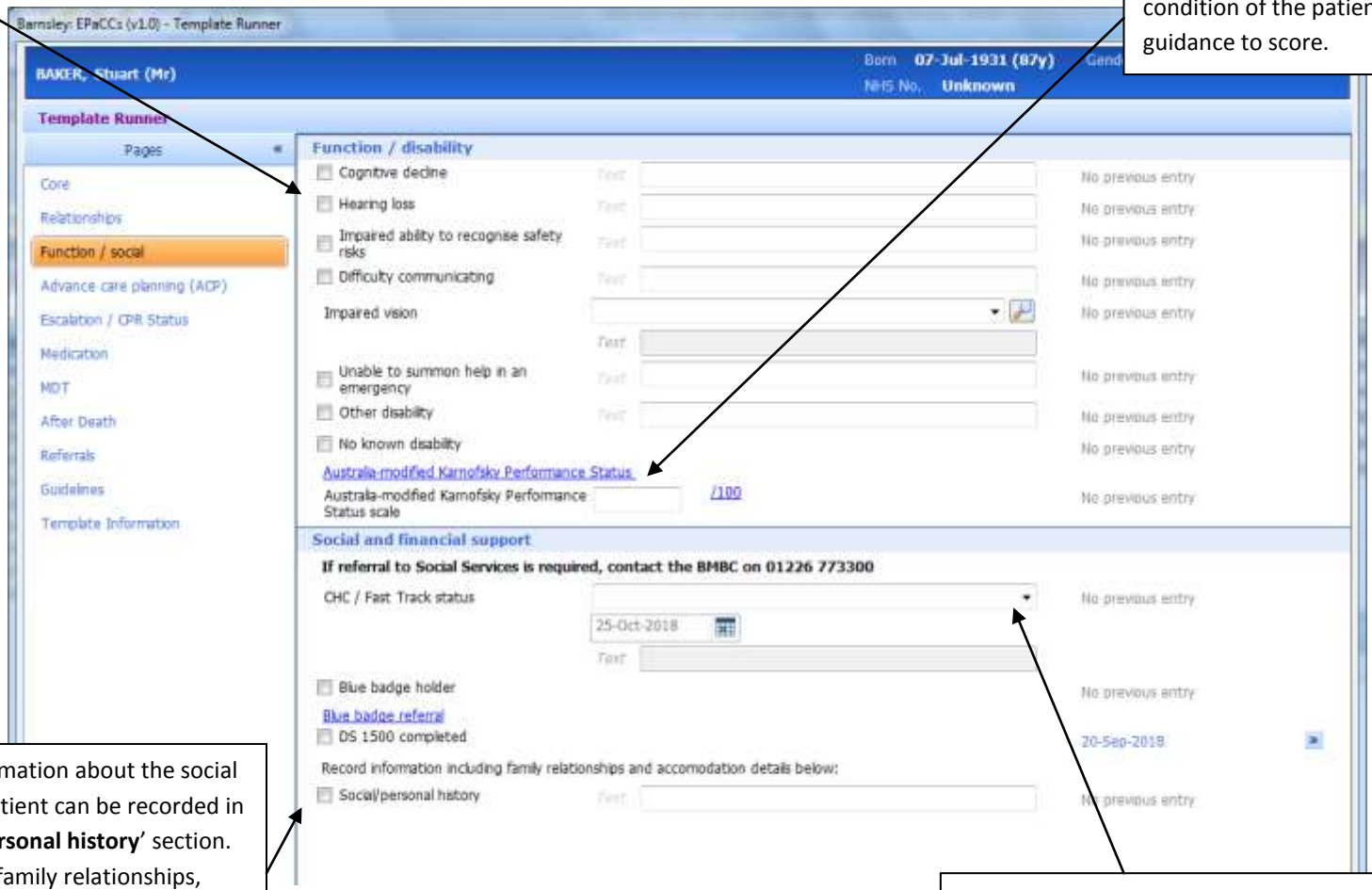
The '**Primary Palliative Diagnosis**' codes are divided into 'cancer' and 'non-cancer' codes. About three quarters of all deaths will be from non-malignant disease so it is expected that there are significant proportion of patients with non-cancer on the GP practice palliative care register.

The '**Likely prognosis**' code should be kept up to date as the condition of the patient changes. This information can be used to support the discussion at the GP palliative care meetings to focus on those patients with the most urgent need. A report can be produced for the meetings which includes this information.


Barnsley EPaCCs (v1.0) - Template Runner
BAKER, Stuart (Mr)
Born 07-Jul-1931 (87y)
Gender Male
NHS No. Unknown
Template Runner
Pages
Core
Relationships
Function / social
Advance care planning (ACP)
Escalation / CPR Status
Medication
MDT
After Death
Referrals
Guidelines
Template Information
Relationships
Record names and contact details for all carers and professionals involved in the patient's care
Key Services Involved
Has end of life care key worker
Has a carer
Does not have a carer
If a formal assessment of carers needs is needed, contact the BMBC on 01226 773300
Assessment of needs offered to carer
No previous entry

Details of the exact disability of the patient can be added as 'additional text'

The '**Karnofsky Performance Status**' is a standardised way of measuring the functional status of the patient. Regular recording can be used to demonstrate overall changes in the condition of the patient. Use the hyperlink as guidance to score.

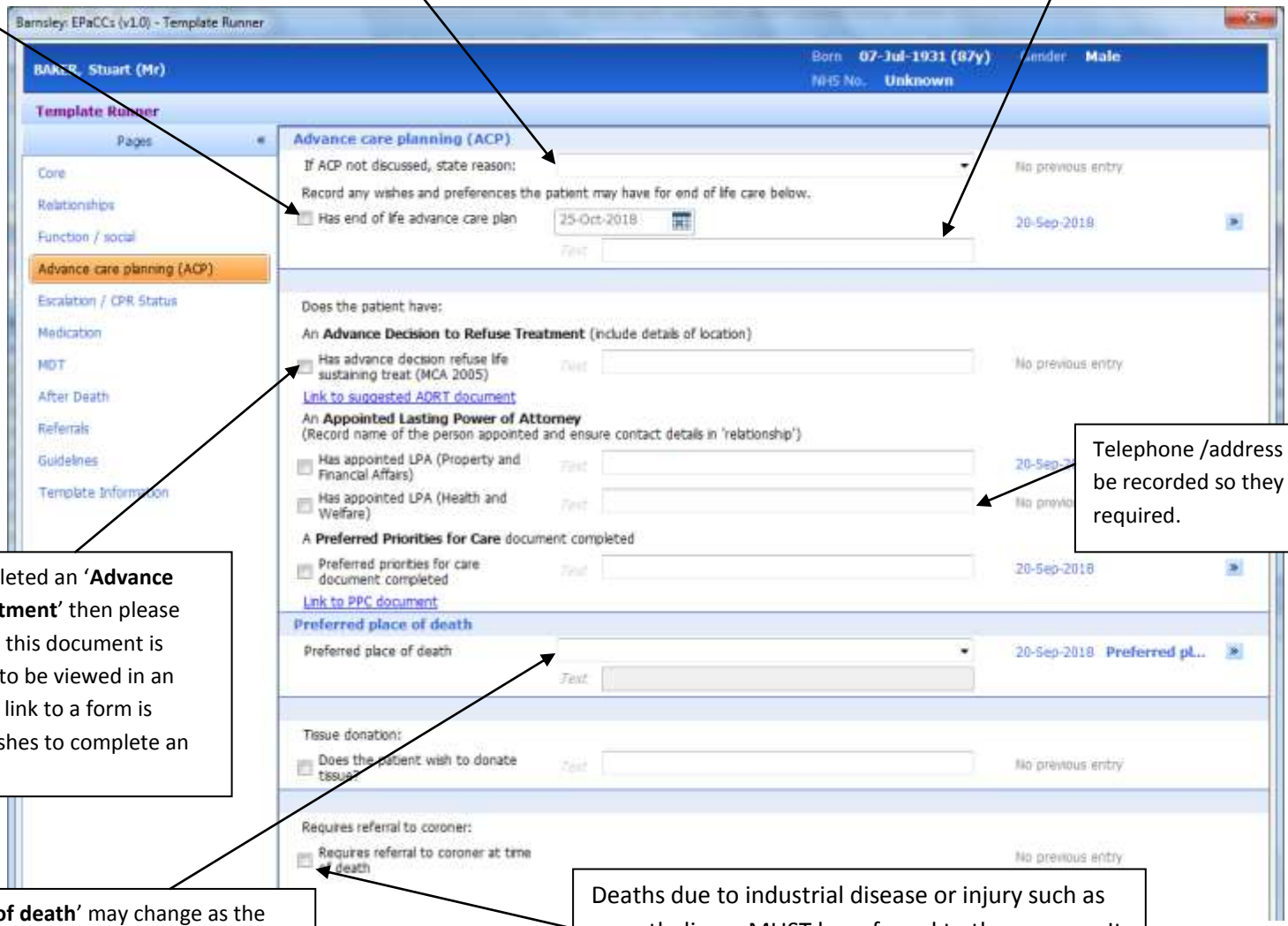


Any relevant information about the social situation of the patient can be recorded in the '**Social and personal history**' section. Examples include family relationships, housing situation, caring relationships.

Select '**CHC Fast Track funding granted**' if appropriate. This is usually allocated to patients in the last weeks of life with rapidly deteriorating condition in order to access appropriate care as required to meet changing needs.

Some patients may not wish to discuss **ACP** or discussion may be inappropriate at a particular time. It is important to include this information. As relationships develop then discussions may take place. Use the box to record details.

Any information the patient provides can form the basis of an '**advance care plan'**. Examples include: 'has made a will' or 'in event of incapacity the person to involve in decision making is….'.



Telephone /address details for the **LPA** should be recorded so they can be contacted as required.

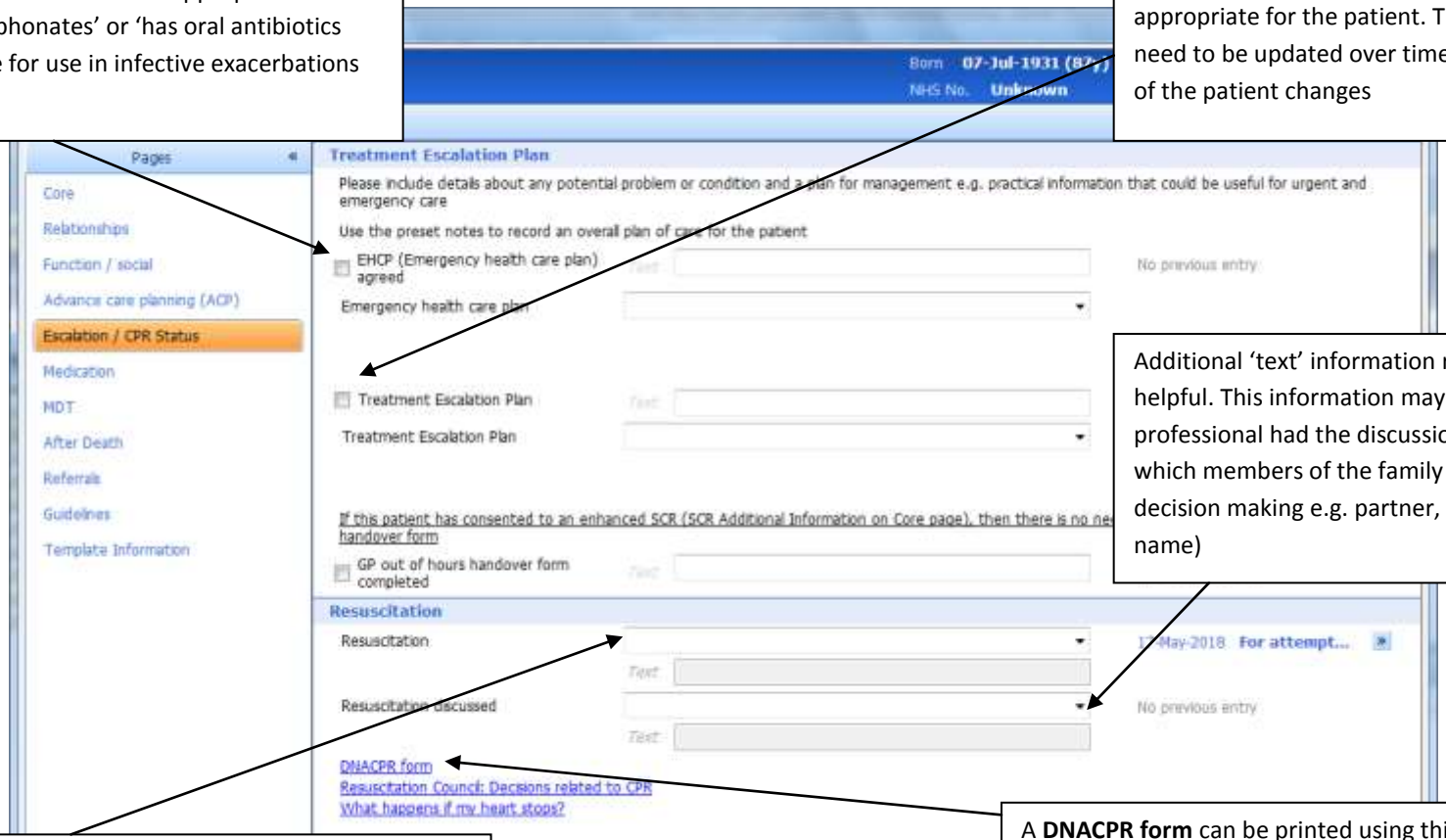
If the patient has completed an '**Advance decision to refuse treatment**' then please add details as to where this document is located as it may need to be viewed in an emergency situation. A link to a form is included if a patient wishes to complete an ADRT.

The '**Preferred place of death**' may change as the condition of the patient changes. Ensure this field is kept up to date with any new decisions. There are codes to record 'discussion not appropriate' or 'patient unable to express preference'.

Deaths due to industrial disease or injury such as mesothelioma MUST be referred to the coroner. It can be useful to note this prior to death and explain the process to the family to avoid unnecessary distress.

‘**Emergency health care plans**’ can be extremely useful to share and they can support decision making out of hours for professionals who may be called for advice. Include management plans for potential problems e.g. ‘at risk of hypercalcaemia. Would be appropriate to treat with iv bisphosphonates’ or ‘has oral antibiotics and steroids at home for use in infective exacerbations of COPD’.

The ‘**Treatment escalation plan**’ may include information such as ‘comfort/symptomatic treatment only’ or ‘full active treatment’. Other options can be added to this section as appropriate for the patient. This section may need to be updated over time as the condition of the patient changes

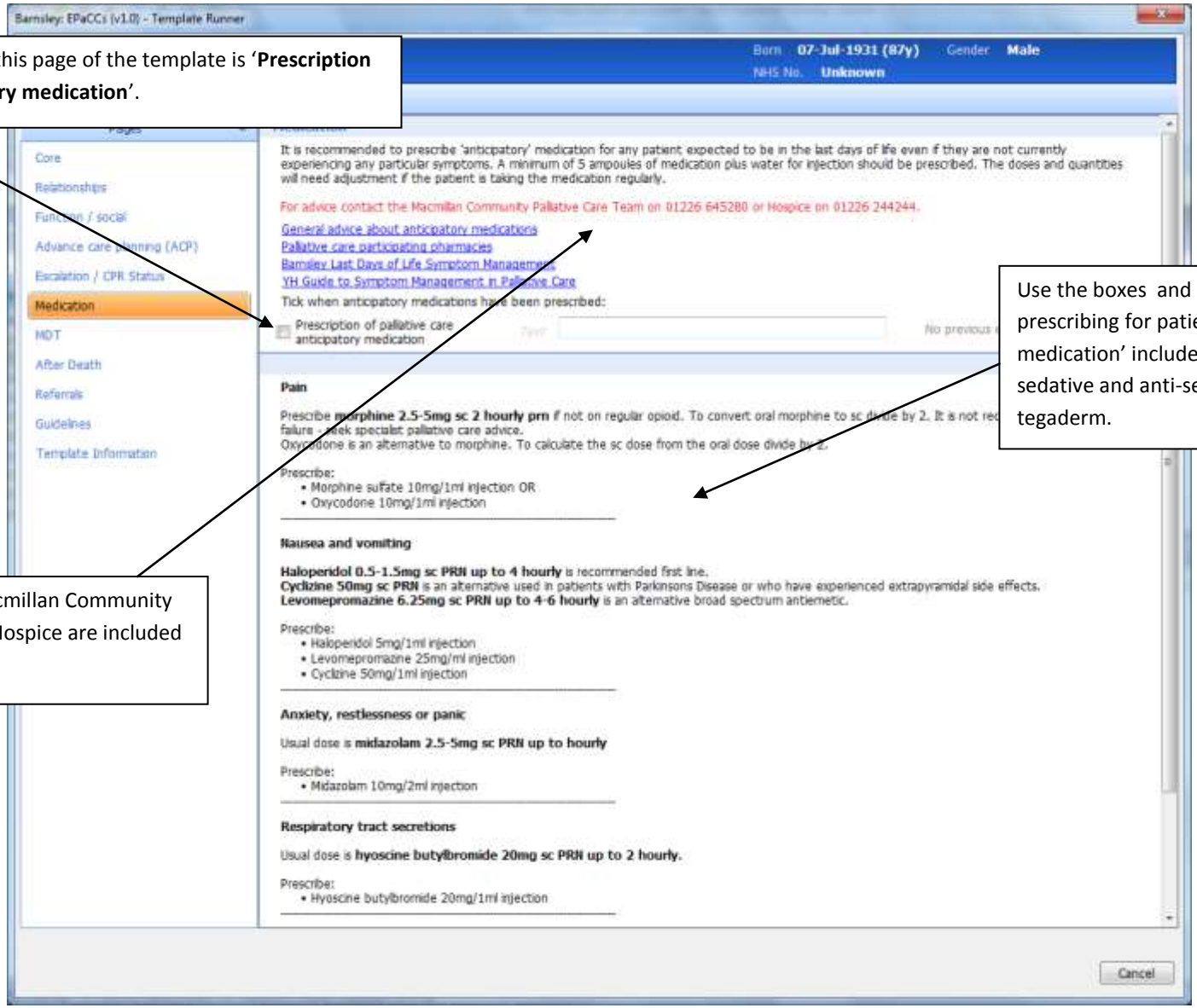


Additional ‘text’ information recorded can be helpful. This information may include which professional had the discussion with the patient and which members of the family were involved in the decision making e.g. partner, wife, daughter (and name)

Record the ‘**CPR status**’ for the patient. This section may need updating as the condition of the patient changes.

A **DNACPR form** can be printed using this button. Note a black and white form is acceptable but the original form must be with the patient and both sides of the form must be printed

The only code to record on this page of the template is '**Prescription of palliative care anticipatory medication**'.



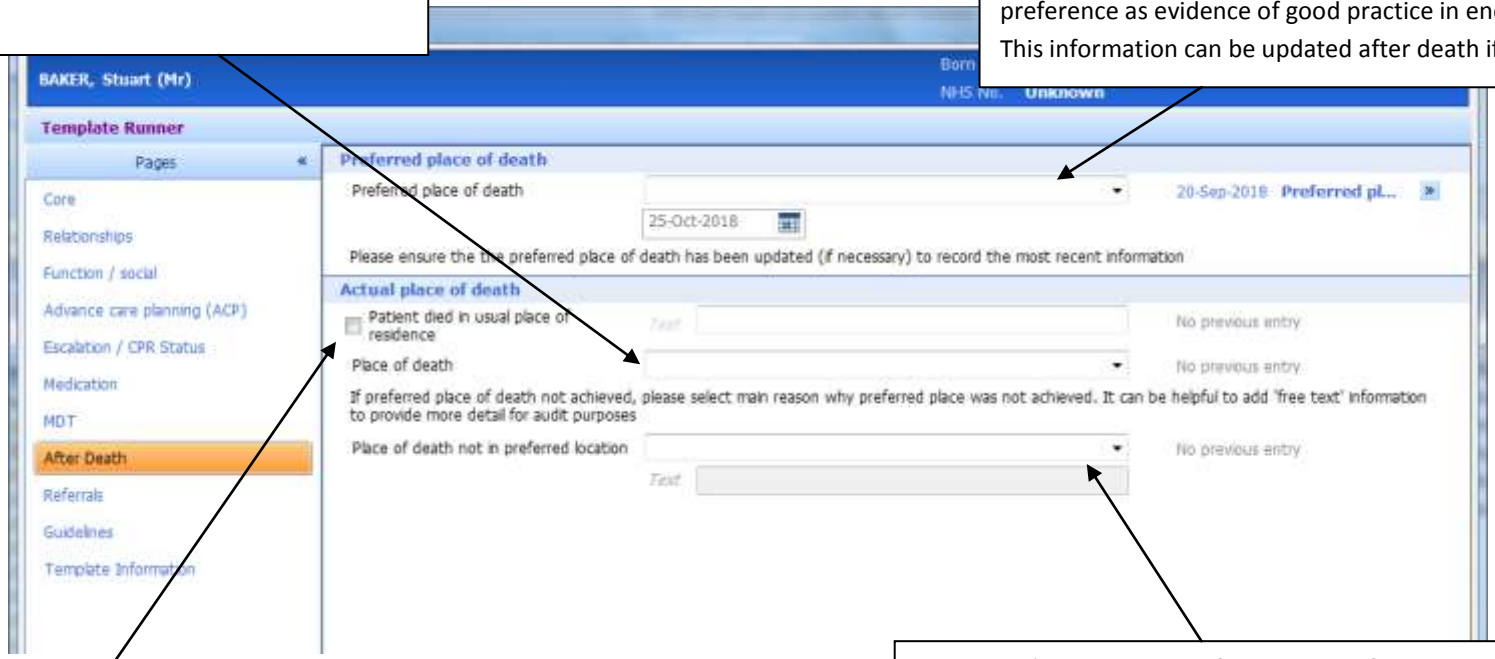
Use the boxes and clinical guidance to support prescribing for patients. Ensure the 'anticipatory medication' includes an opioid, anti-emetic, sedative and anti-secretory as well as water and tegaderm.

Contact details of the Macmillan Community Palliative Care Team and Hospice are included for further advice.

Some GP practices record the outcomes of any MDT meetings on the clinical record. This is not mandatory but is considered good practice.

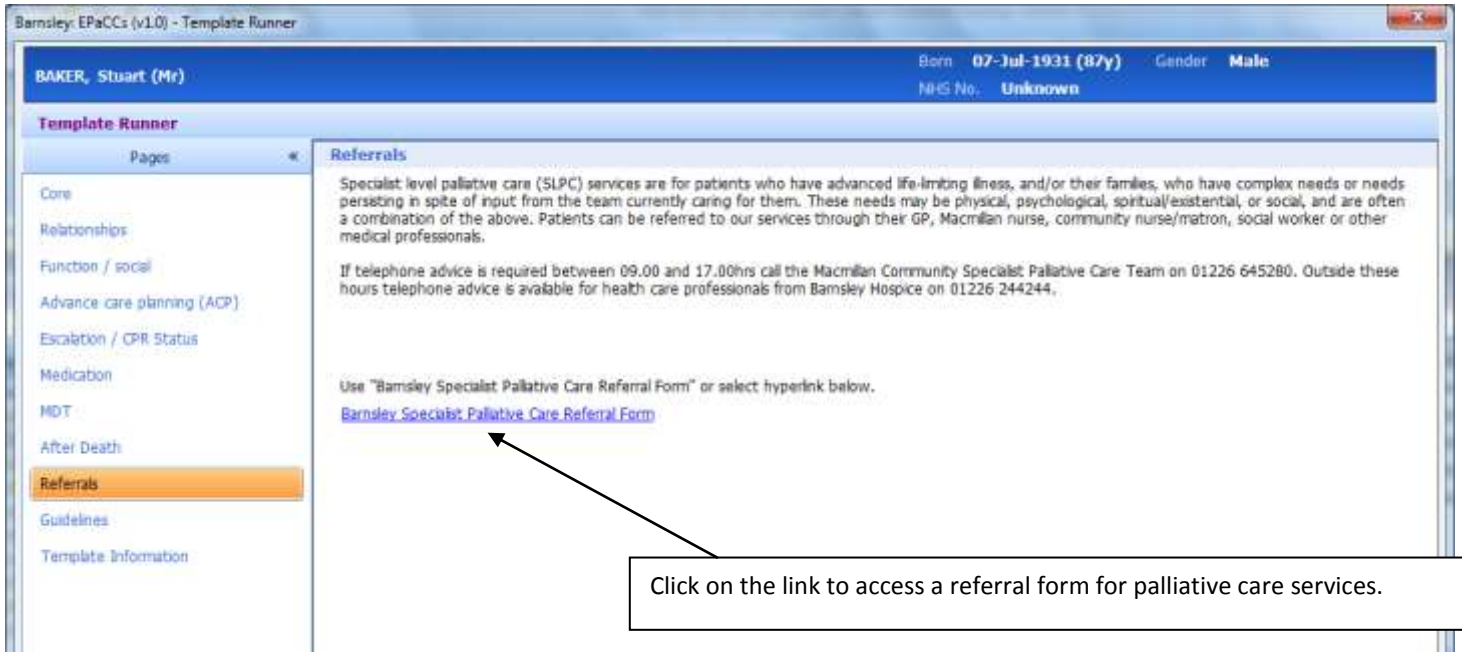
Recording '**Actual place of death**' is helpful as can be used by services to evidence good practice in supporting patients to achieve their preferences for end of life.

Ensure the most recently recorded '**Preferred place of death**' is correct at the time of death. Reports can demonstrate the proportion of patients who achieve this preference as evidence of good practice in end of life care. This information can be updated after death if necessary.



'**Death in usual place of residence**' should be recorded for deaths in the home or care home.

Recording '**Reason why preferred place of death not achieved**' can inform local strategy for end of life care to ensure that services are developed to support the wishes and preferences of patients. Additional ' text' information is often required as the reasons can be complex or multifactorial.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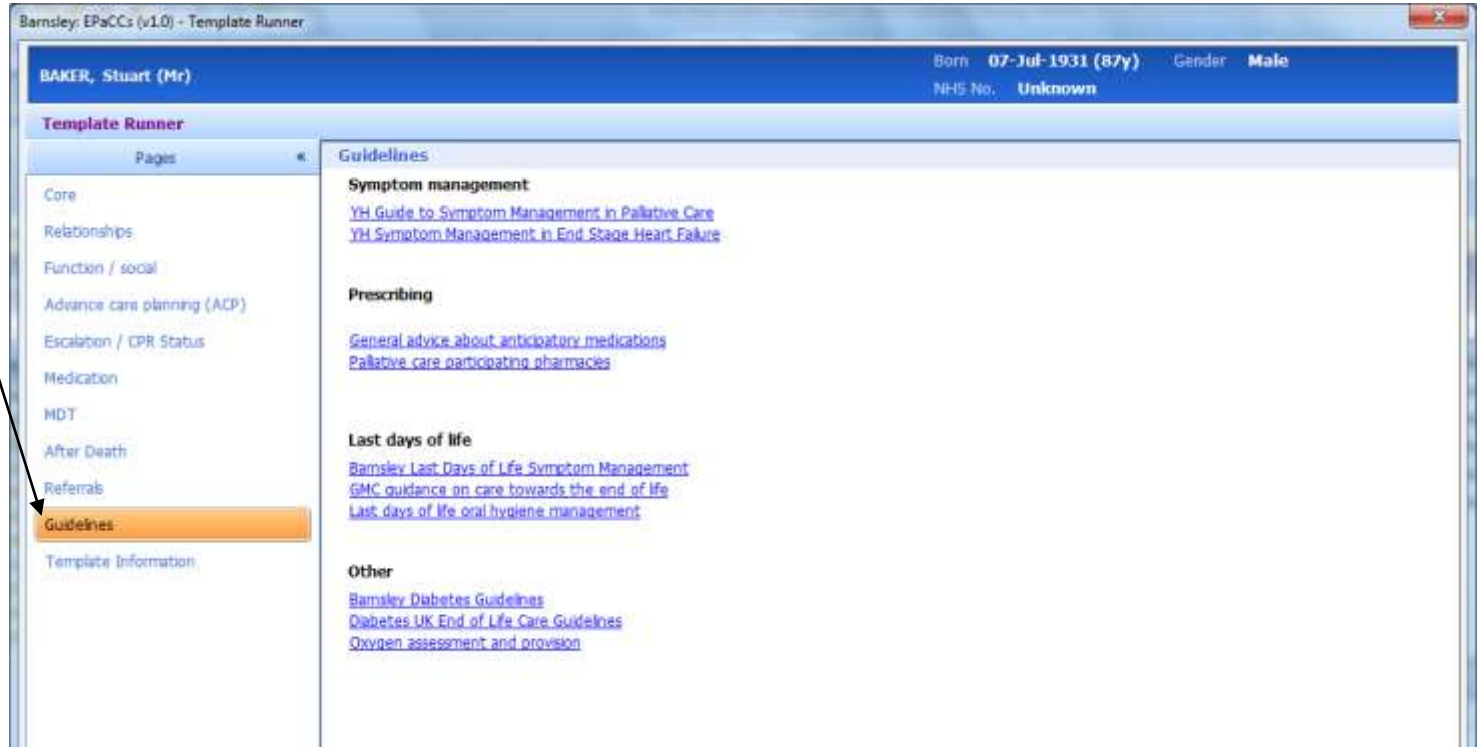
Referrals
Specialist level palliative care (SLPC) services are for patients who have advanced life-limiting illness, and/or their families, who have complex needs or needs persisting in spite of input from the team currently caring for them. These needs may be physical, psychological, spiritual/existential, or social, and are often a combination of the above. Patients can be referred to our services through their GP, Macmillan nurse, community nurse/matron, social worker or other medical professionals.
If telephone advice is required between 09.00 and 17.00hrs call the Macmillan Community Specialist Palliative Care Team on 01226 645280. Outside these hours telephone advice is available for health care professionals from Barnsley Hospice on 01226 244244.
Use "Barnsley Specialist Palliative Care Referral Form" or select hyperlink below.
Barnsley Specialist Palliative Care Referral Form
Click on the link to access a referral form for palliative care services.

This section will be kept updated with local and national clinical guidelines supporting patients at the end of life.



Note the email address for any problems related to the template.