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:

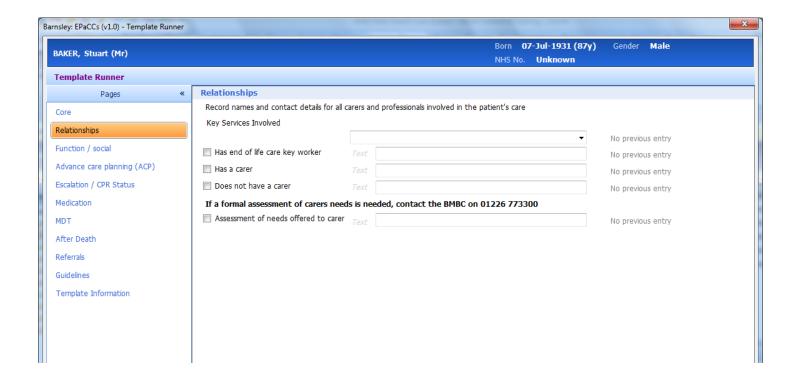
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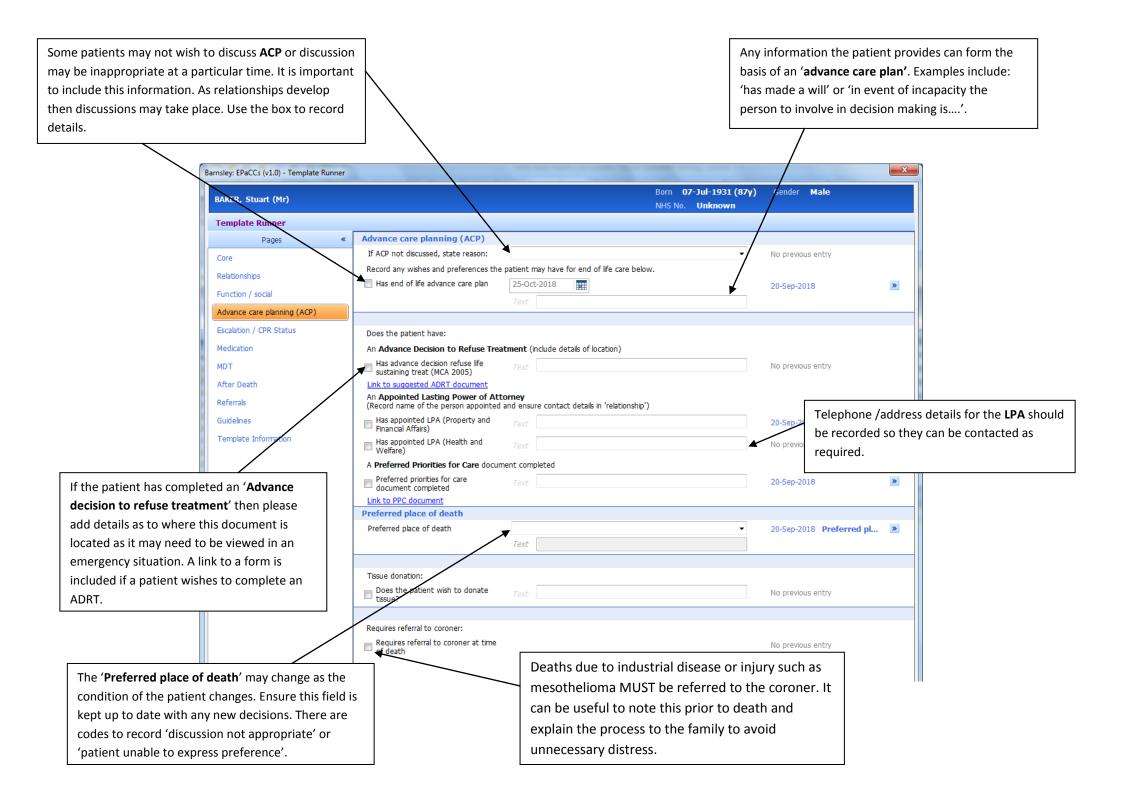
'Consent' for sharing information Selecting 'On end of life care recorded can be obtained from register' ensures the patient is the patient or recorded in the included in the GP Palliative Care best interests of the patient if Template Runner 'QOF' register so forms part of the they lack capacity. Born **07-Jul-1931 (87y)** discussion in the monthly palliative NHS No. Unknown care MDT meetings. Barnsley EPaCCS Template The template has been designed to provide a structured way of recording key information about a patient who may be in the last year of their life. It A printed summary of EPaCCS Relationships expected that all sections will be completed for all patients, but it should be regularly reviewed and updated where required. The addition of 'free text the recording of codes is recommended to enhance the template as a shared clinical record. Function / social information recorded can be 20-Sep-2018 Advance care planning (ACP) produced from this link. This can be No previous entre Escalation / CPR Status 'Express consent for core and additional SCR dataset upload' can only be recorded by a GP practice. It is good practice to consent the patient w possible for this, or if not possible to complete this in the 'best interests' of the patient. Doing so will allow much of the information recorded in helpful as it can be produced at the Medication template to be shared as part of an enhanced Summary Care Record (SCR). point of care in emergency situations Express consent for core and 20-Sep-2018 additional SCR dataset upload After Death Enhanced SCR Consent Form EPaCCS Patient Information Leaflet Referrals No previous EPaCCS Patient Information Leaflet To print a copy of the information recorded in the EPaCCS template, please print a copy of the "Barnsley EPaCCS Summary" letter once Template Information the template has been saved to the patient record. Primary Palliative Diagnosis - Cancer Selecting 'Express consent for core and An Information leaflet about No previous entry please specify) ary Palliative Diagnosis -EPaCCS supports the consent additional SCR dataset upload' can only No previous entry ncer (please specify) be done by a GP practice. It is highly process and can be printed from 20-Sep-2018 GSF prognost.. recommended that this is done for all this link. If the patient is likely to be in the last days of life have you considered supporting care with My Care Plan? patients at the end of life as this allows the information recorded in EMIS in the EPaCCS template to be shared with other The 'Primary Palliative Diagnosis' services using different IT systems such codes are divided into 'cancer' and The 'Likely prognosis' code should be kept as SystmOne (OOH GPs) and Adastra 'non-cancer' codes. About three up to date as the condition of the patient (NHS 111, YAS) that access Summary Care quarters of all deaths will be from changes. This information can be used to Record. An additional consent form may non-malignant disease so it is support the discussion at the GP palliative be required by some GP Practices for this expected that there are significant care meetings to focus on those patients and it can be printed off from the link. proportion of patients with nonwith the most urgent need. A report can be Further information: SCR with AI cancer on the GP practice palliative produced for the meetings which includes care register.

this information.



Details of the exact disability of the patient can be The 'Karnofsky Performance Status' is a added as 'additional text' 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 Barnsley: EPaCCs (v1.0) - Template Runner guidance to score. Born **07-Jul-1931 (87y)** BAKER, Stuart (Mr) NHS No. Unknown Template Runne Pages Function / disability Cognitive decline No previous entry Core Hearing loss No previous entry Relationships Impaired ability to recognise safety risks No previous entry Function / social Difficulty communicating No previous entry Advance care planning (ACP) Impaired vision No previous entry Escalation / CPR Status Text Medication Unable to summon help in an emergency No previous entry Other disability No previous entry After Death No known disability No previous entry Referrals Australia-modified Karnofsky Performance Status Guidelines /100 Australia-modified Karnofsky Performance No previous entry Template Information Social and financial support If referral to Social Services is required, contact the BMBC on 01226 773300 CHC / Fast Track status No previous entry 25-Oct-2018 Blue badge holder No previous entry Blue badge referral DS 1500 completed 20-Sep-2018 >> Any relevant information about the social Record information including family relationships and accomodation details below: Social/personal history previous entry situation of the patient can be recorded in the 'Social and personal history' section. Examples include family relationships, Select 'CHC Fast Track funding granted' if housing situation, caring relationships. 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.

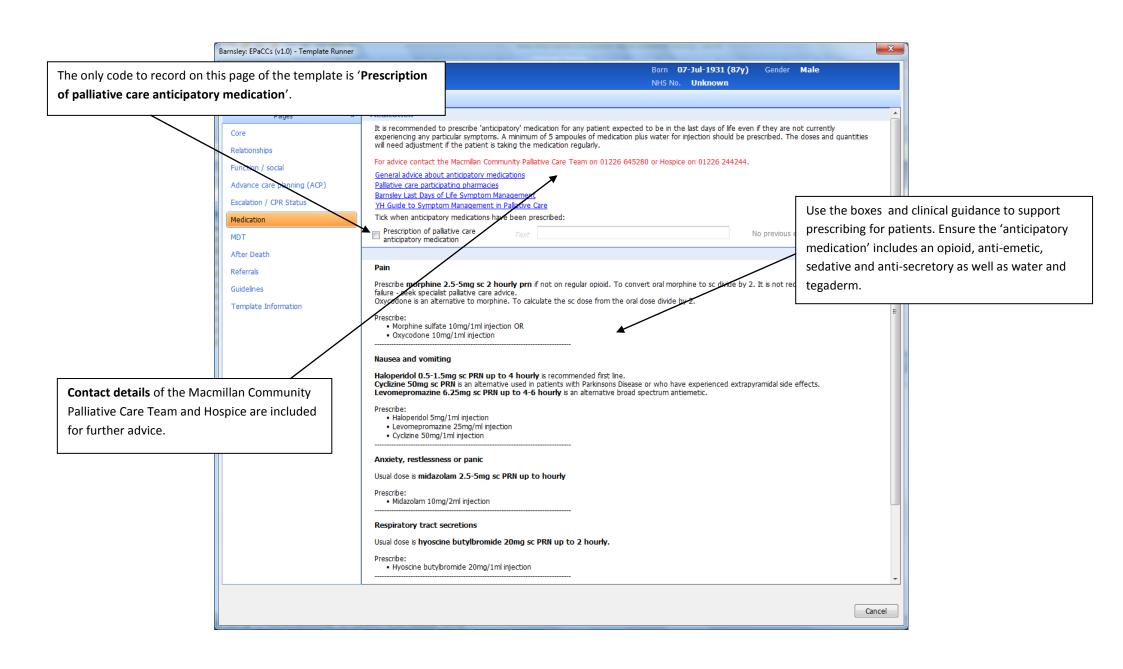


'Emergency health care plans' can be extremely useful to share and they can support decision making out of hours for professionals who may be called for advice. Include management plans for potential problems e.g. 'at risk of hypercalcaemia. Would be appropriate to treat with iv bisphosphonates' or 'has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

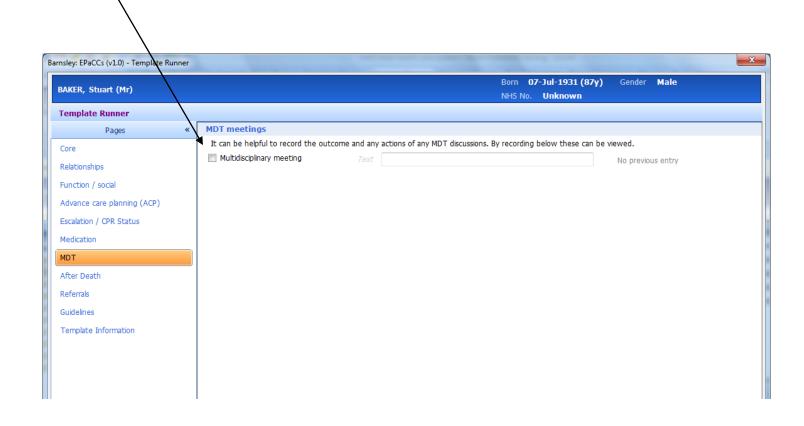
The 'Treatment escalation plan' may include information such as 'comfort/symptomatic treatment only' or 'full active treatment'. Other options can be added to this section as appropriate for the patient. This section may need to be updated over time as the condition of the patient changes

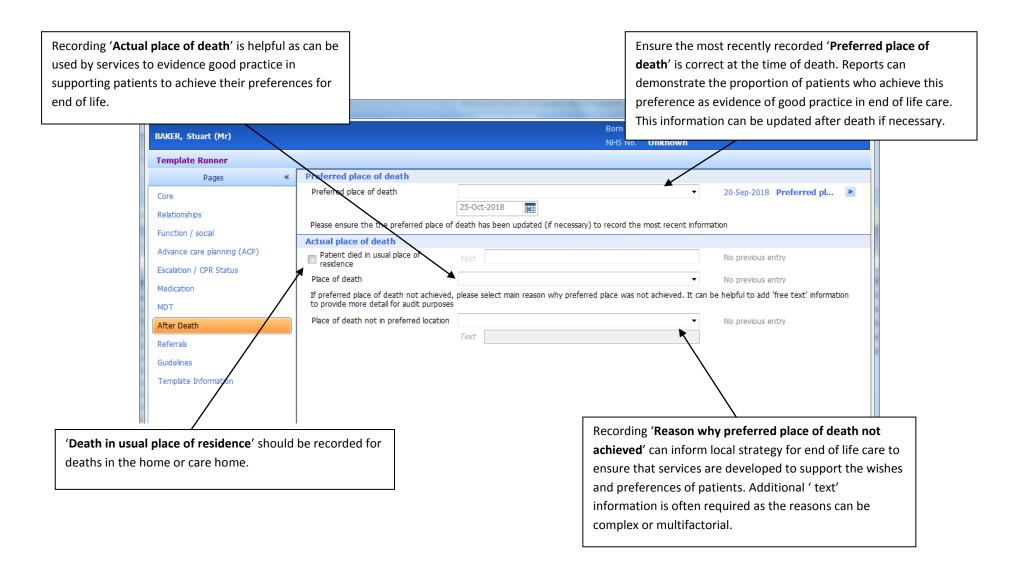
Treatment Escalation Plan Please include details about any potential problem or condition and a plan for management e.g. practical information that could be useful for urgent and Core Use the preset notes to record an overall plan of care for the patient Relationships EHCP (Emergency health care plan) Function / social No previous entry agreed Advance care planning (ACP) Emergency health care p Escalation / CPR Status Additional 'text' information recorded can be Medication helpful. This information may include which Treatment Escalation Plan professional had the discussion with the patient and Treatment Escalation Plan After Death which members of the family were involved in the Referrals decision making e.g. partner, wife, daughter (and Guidelines If this patient has consented to an enhanced SCR (SCR Additional Information on Core page), then there is no ne name) Template Information GP out of hours handover form completed Resuscitation Resuscitation May-2018 For attempt... » Text Resuscitati No previous entry DNACPR form Resuscitation Council: Decisions related to CPI What happens if my heart stops? A **DNACPR form** can be printed using this button. Record the 'CPR status' for the patient. This section may Note a black and white form is acceptable but the need updating as the condition of the patient changes. original form must be with the patient and both sides of the form must be printed

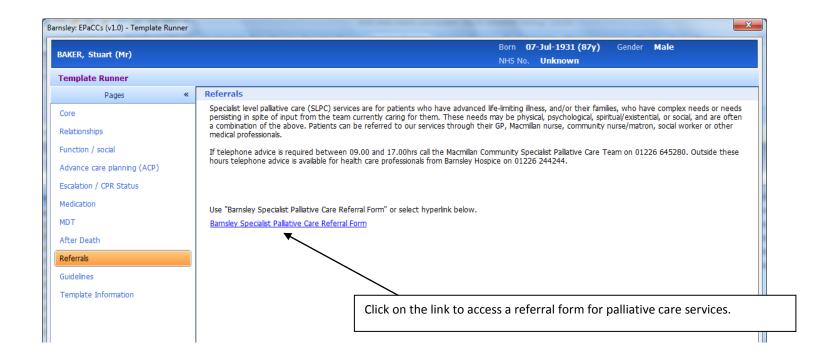
Born **07-Jul-1931 (87)** NHS No. **Unknown**



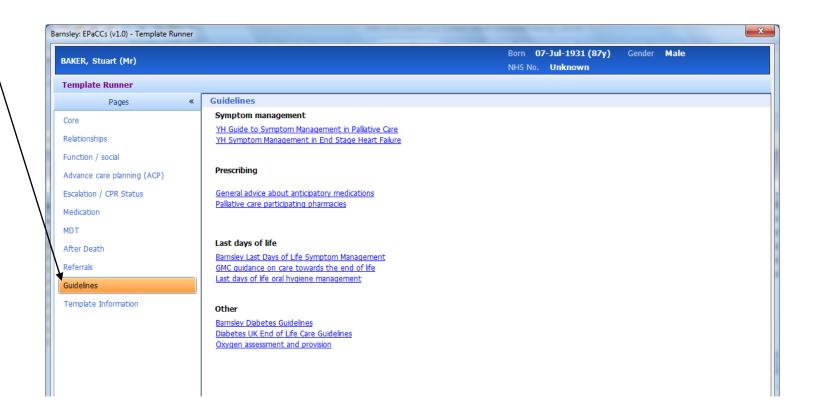
Some GP practices record the outcomes of any MDT meetings on the clinical record. This is not mandatory but is considered good practice.







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.

