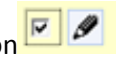
Barnsley Electronic Palliative Care Coordination System (EPaCCS): Hints and Tips

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 SystmOne (S1) 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 (by clicking on a 'pencil' icon ) 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:

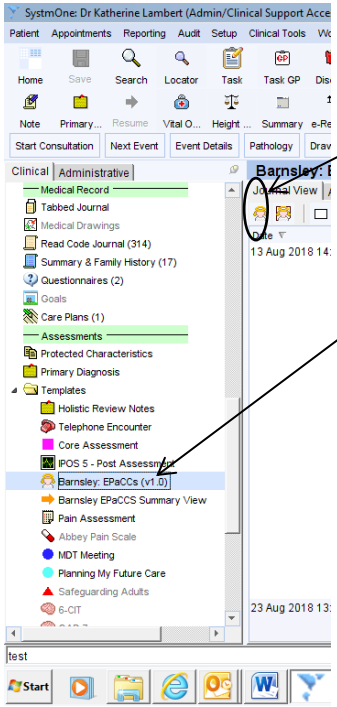
Janet Owen

End of life care clinical lead

janet.owen@swyt.nhs.uk

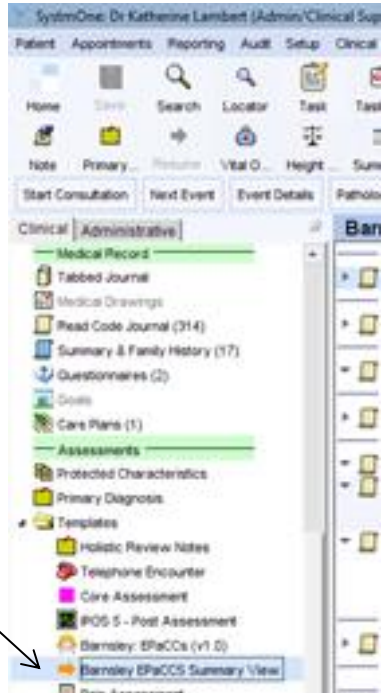
Accessing the EPaCCS template and EPaCCS Summary View

These will usually be accessible from the clinical tree of S1 units.



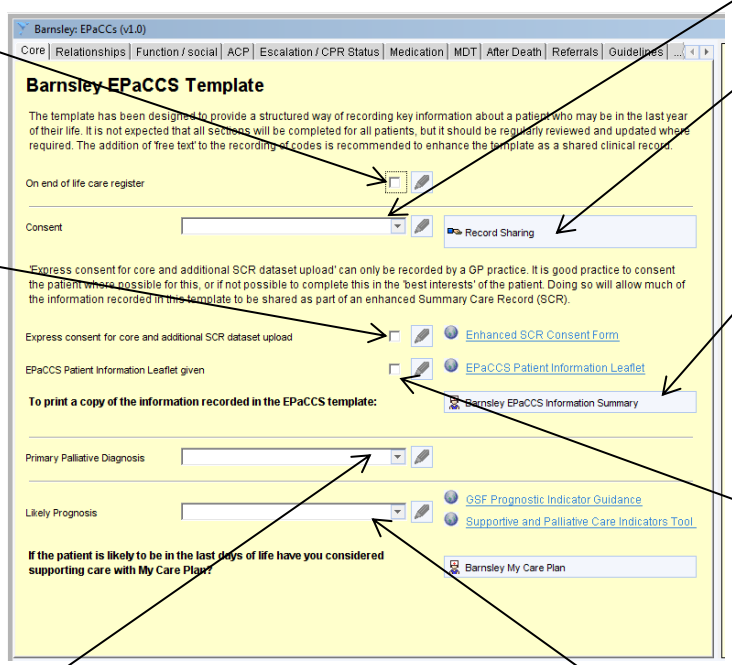
Click on '**Barnsley: EPaCCS**' and then the icon highlighted to access the EPaCCS template

Click on 'Barnsley EPaCCS Summary View' to access the summary view



Selecting '**On end of life care register**' 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.

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 SystmOne in the EPaCCS template to be shared with other services using different IT systems such as 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



'**Consent**' for sharing information recorded can be obtained from the patient or recorded in the best interests of the patient if they lack capacity. Ensure that the SystmOne record has been shared by checking the 'Record Sharing' box.

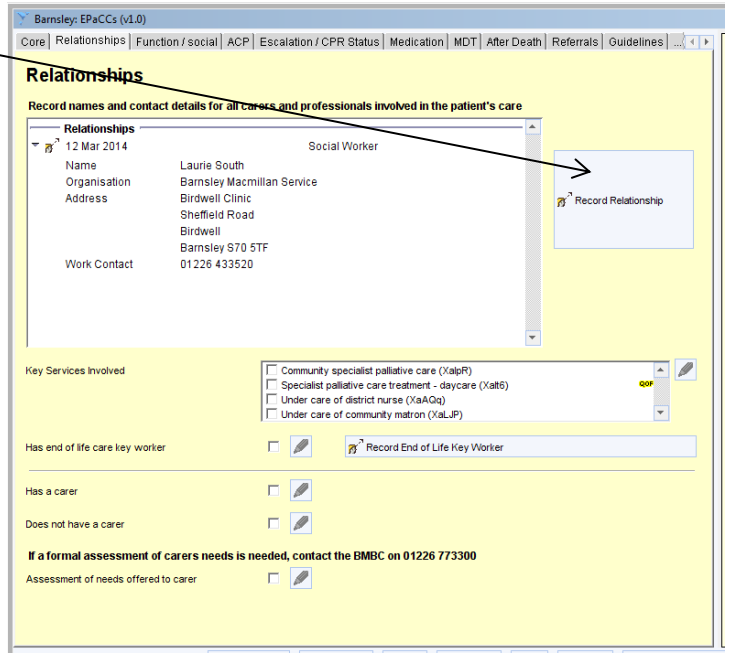
A **printed summary of EPaCCS information** recorded can be produced from this link. This can be helpful as it can be produced at the point of care in emergency situations for professionals who may not have immediate access to the electronic record e.g. care home staff, ambulance services.

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

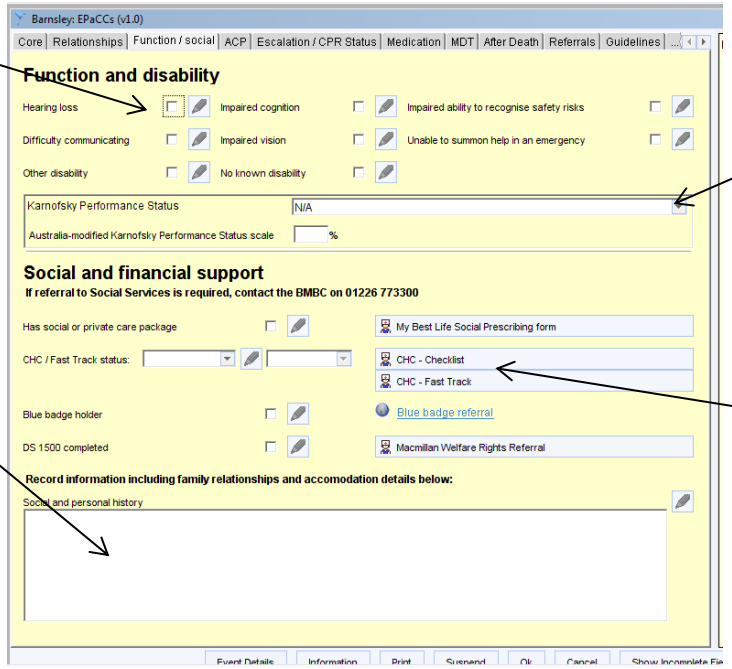
The '**Primary Palliative Diagnosis**' codes are minimum data set codes for palliative care services. Cancer codes are listed at the top with non cancer diagnoses at the bottom of the list. It is recommended that additional detail is recorded as 'free text' by highlighting the pencil icon. This should include specific details such as 'pancreatic cancer' or 'end stage COPD' to ensure that more useful clinical information is available.

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.

Record the names and contact details for any carer or professional involved in the patient care. If information has already been recorded and is up to date this does not need to be added to. Ideally an address and telephone number is required.



Details of the exact disability of the patient can be added as 'free text' by clicking on the pencil icon alongside the code.

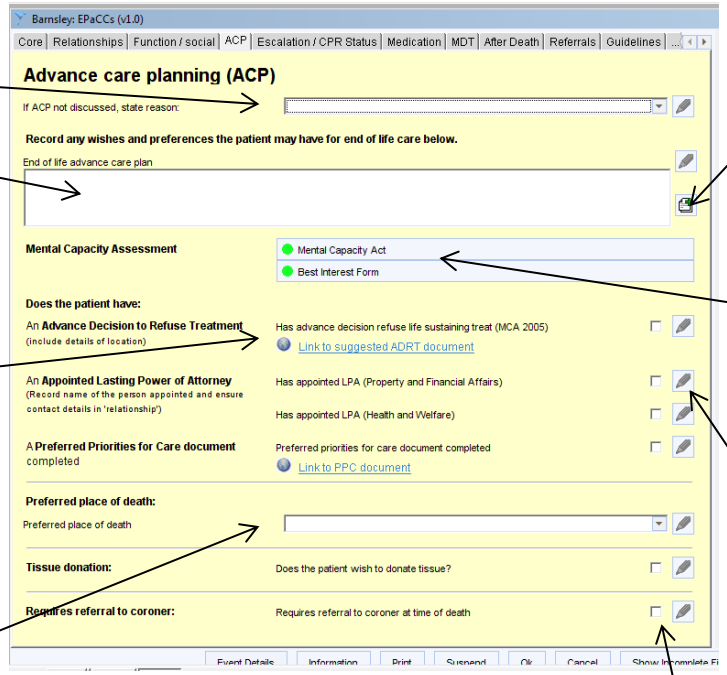


The '**Karnofsky Performance Status**' is a standardised way of measuring the functional status of the patient. Regular recording can be used to demonstrate overall changes in the condition of the patient. Use the drop down box as guidance to score.

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.

Click on the '**CHC – Checklist**' and '**CHC – Fast Track**' boxes to access the relevant forms. The patient demographics will 'pull through' from SystmOne to save time in completion and the forms can be saved in the 'Communications and letters' section of S1. They can then be printed off or emailed directly from S1 as necessary.

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.



Use the 'preset' box to save time. It gives hints of relevant information to include in the '**End of life advance care plan**' section such as 'has made a will' or 'in event of incapacity the person to involve in decision making is….'.

Use the linked questionnaires to record the outcome of any **mental capacity assessments** or 'best interest' decision making.

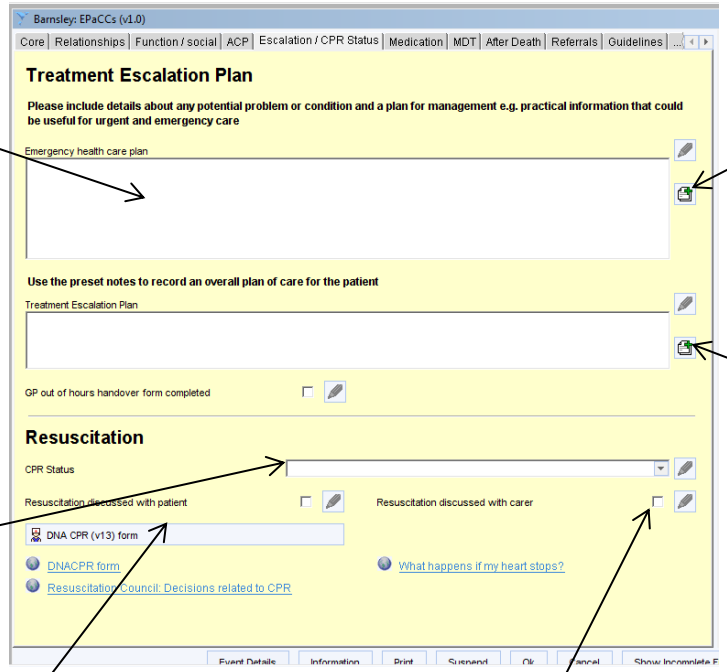
If the patient has completed an '**Advance decision to refuse treatment**' then please add details as to where this document is located as it may need to be viewed in an emergency situation e.g. copy scanned into S1. A link to a form is included if a patient wishes to complete an ADRT.

Contact details for the **LPA** should be recorded in the 'Relationships' section of the EPaCCS template.

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’.



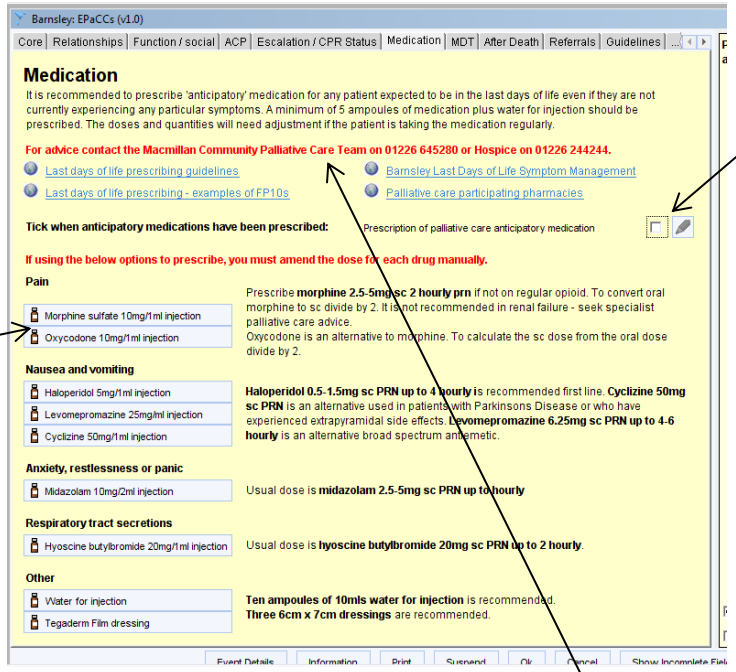
The ‘preset’ button includes contact details for the Community Macmillan, Community Matron and Respiratory services. If the patient is known to these services it can help to provide contacts for these services in and out of hours so that additional advice can be sought

The ‘presets’ in the ‘**Treatment escalation plan**’ give some suggestions including ‘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

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. It will include demographic details pulled from S1. 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

Additional ‘free text’ information recorded using the pencil icon 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)

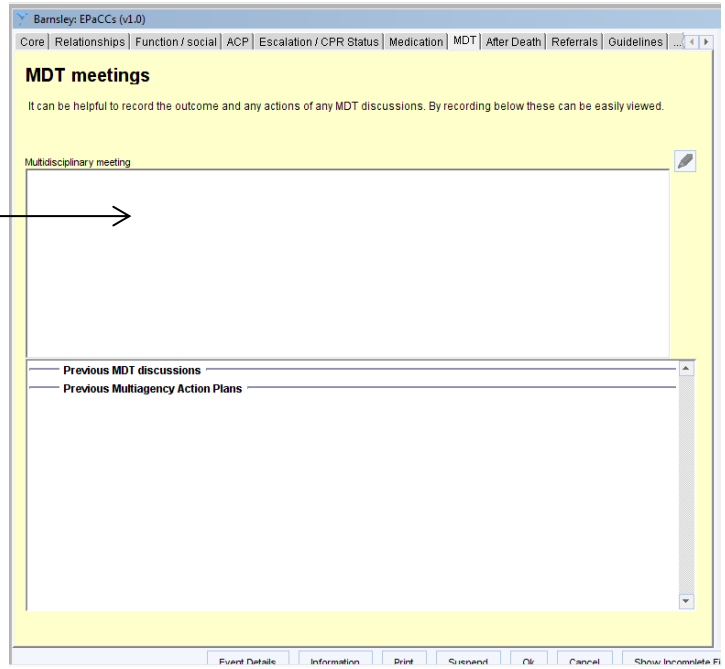


The only code to record on this page of the template is '**Prescription of palliative care anticipatory medication**'

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.

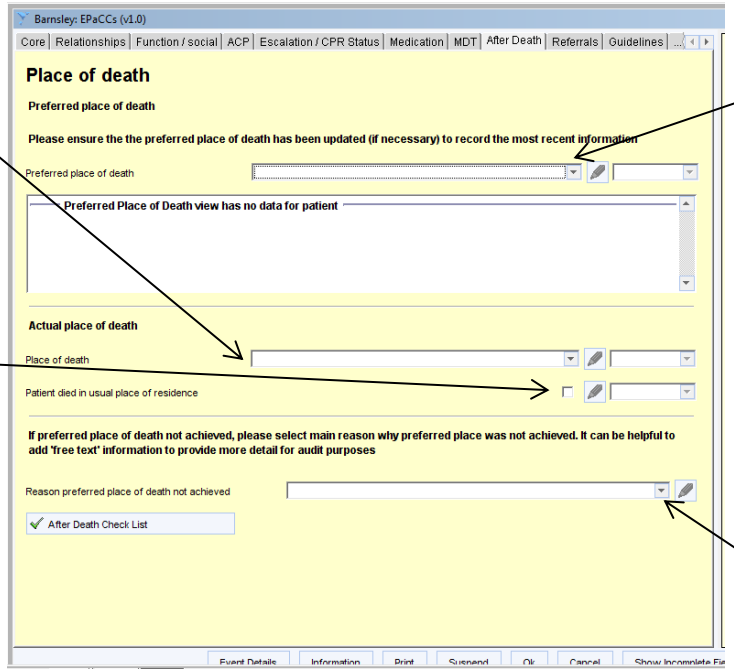
Contact details of the Macmillan Community Palliative Care Team and Hospice are included for further advice

Some teams and GP practices record the outcomes of any MDT meetings on S1. If this box is used then the 'view' below it highlights all previous discussion so that the information can be easily seen rather than having to search the full record



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

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

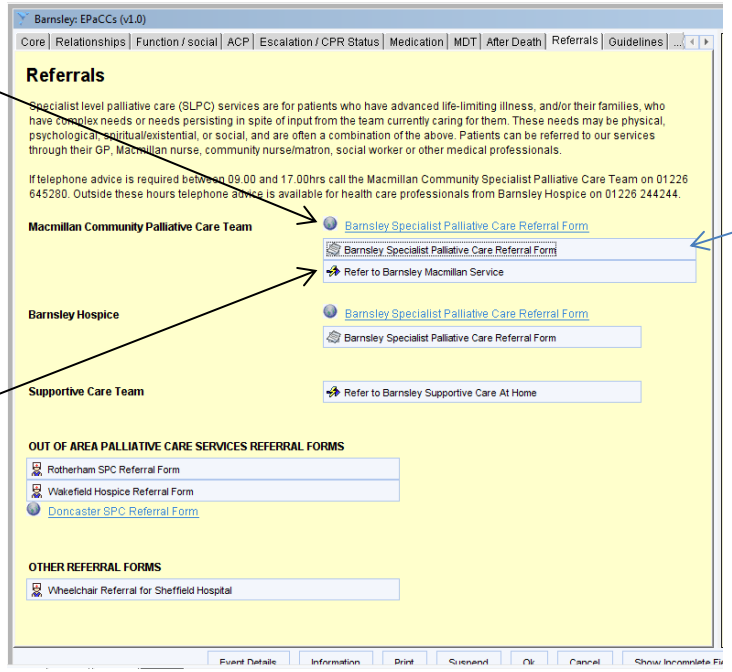


Ensure the most recently recorded '**Preferred place of death**' is correct at the time of death. The view shows what has been recorded. Reports can demonstrate the proportion of patients who achieve this preference as evidence of good practice in end of life care. This information can be updated after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

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 'free text' information is often required as the reasons can be complex or multifactorial.

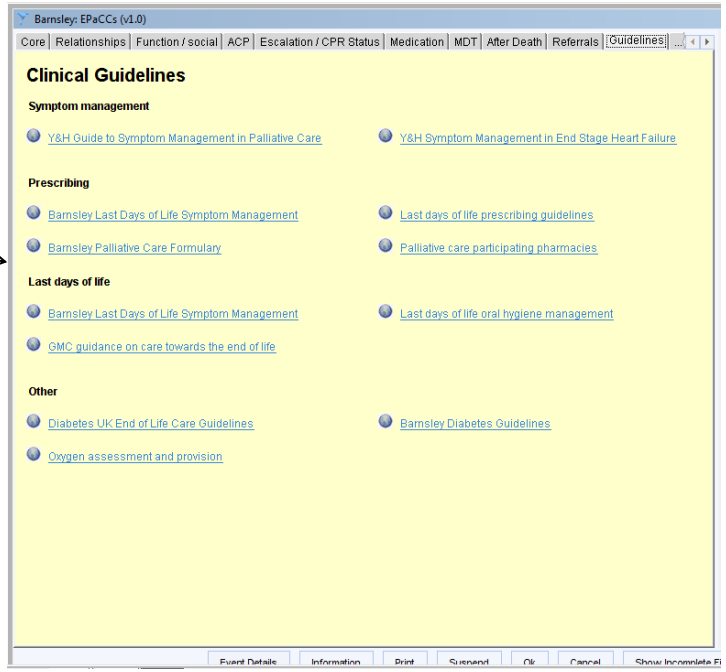
Click on the link to access a referral form for palliative care services.

Use this button to send an electronic referral. This is a quick and efficient way to refer. A task is sent back to the referrer when the referral is accepted.

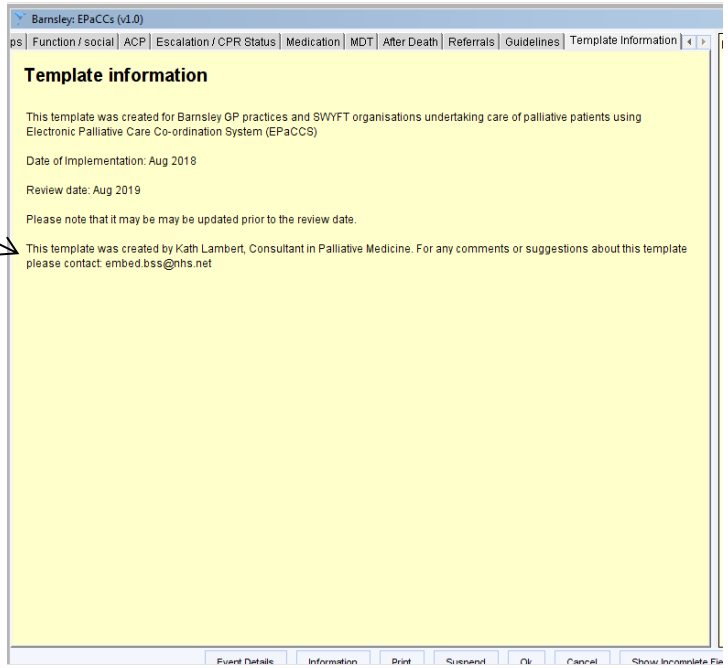


Using this button will create a referral form for palliative care services which includes demographic details from S1 to save time. The form can be saved in the 'Communications and letters' section and then printed off or emailed from S1 as required.

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.



EPaCCS Summary View

The' EPaCCS Summary View' shows the most recently recorded information in the EPaCCS template. It is recommended to use this to ensure that the information recorded is accurate or whether new information can be added or information amended e.g. likely prognosis. Information can only be added from the EPaCCS template which is usually adjacent to the 'EPaCCS Summary View' on the S1 clinical tree