

Electronic Palliative Care Summary (ePCS) Guideline

A Guide to Data Entry

INPS



Table of Editions and Contents

Date	Version	Contents	Output
07/02/11	007	Complete rewrite (HDOO)	PDF
08/02/11	008	Review HMAG	PDF
09/02/11	009	Review ESTU	PDF
15/02/11	010	Review HMAG	PDF

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Electronic Palliative Care Summary (ePCS) Guideline – A Guide to Data Entry

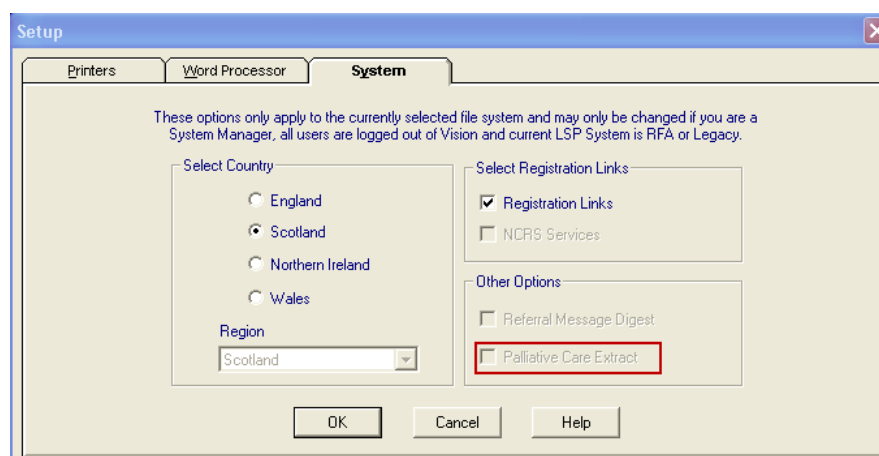
Overview

The Palliative Care Summary Project is based in general practice and aims to improve cancer and palliative care in the community, by sharing appropriate palliative Care information electronically with Out of Hours (OOH) partners. The purpose of this document is to summarise the entry of data in the Electronic Palliative Care Summary process. For more information please download the administrator guide from http://www.inps4.co.uk/my_vision/vua/scotland/index.html

Enabling ePCS

You must ensure that you have the Palliative Care Extract switched on. This is setup from the **Vision Front menu – Options – Setup – System**. Tick **Palliative Care Extract**.

Note – This action requires exclusive access to Vision, all other users must log out for this to be accessed.



Switching on Palliative Care Extract

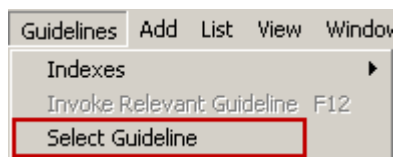
Using the ePCS Guideline

Accessing the ePCS Guideline

The ePCS Guideline can be accessed in several ways within Consultation Manager depending on how your practice has been set up:

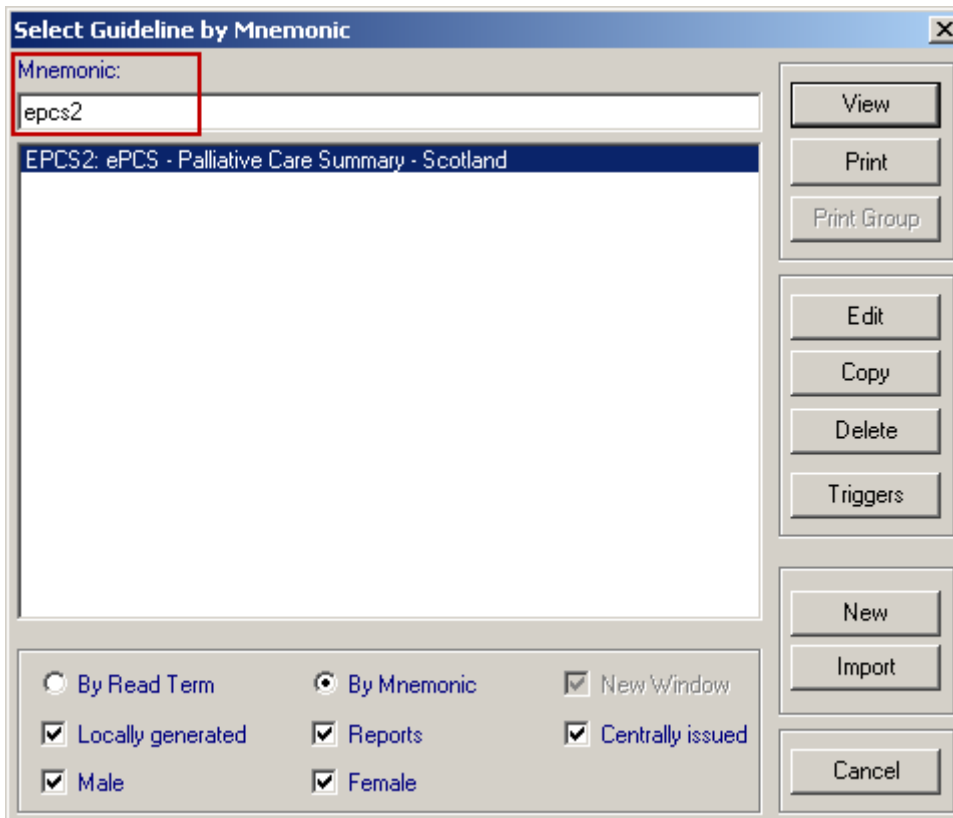
From the Main Guideline Menu

1. Click on **Guidelines** and then **Select Guideline**.



Guideline – Select Guideline

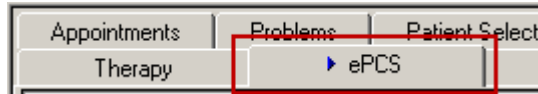
2. **Select Guideline by Mnemonic** is displayed, type epcs2 into **Mnemonic** and press enter.
3. The **EPCS2: ePCS – Palliative Care Summary – Scotland** Guideline is displayed in the main area of the **Select Guideline by Mnemonic** screen. Click on the Guideline and select **View**.



Select Guideline by Mnemonic with ePCS – Palliative Care Summary – Scotland selected


From a tab on Patient Record

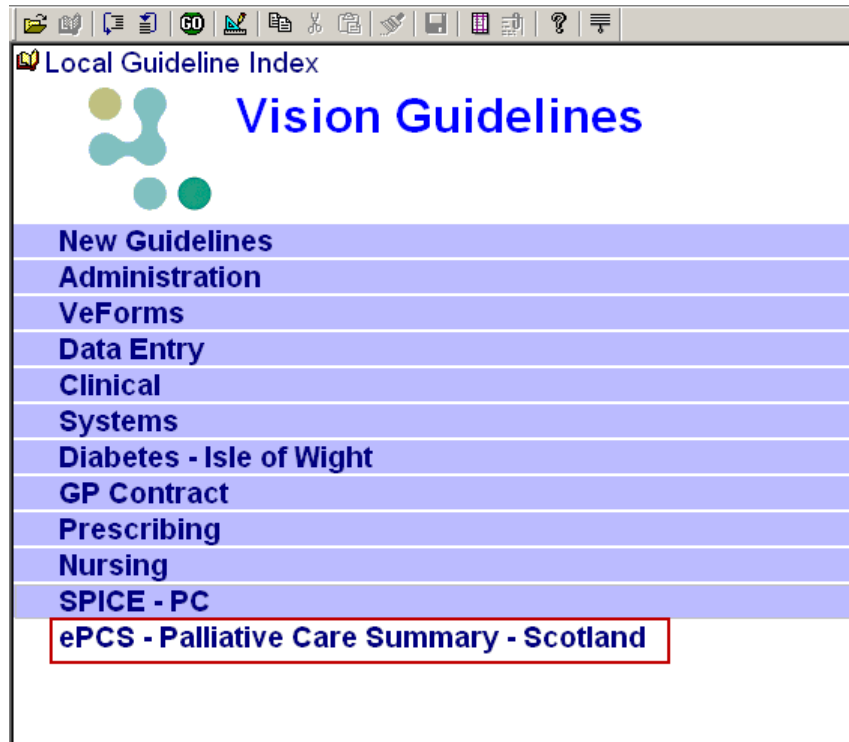
1. Click on the ePCS labelled tab to display the Guideline.



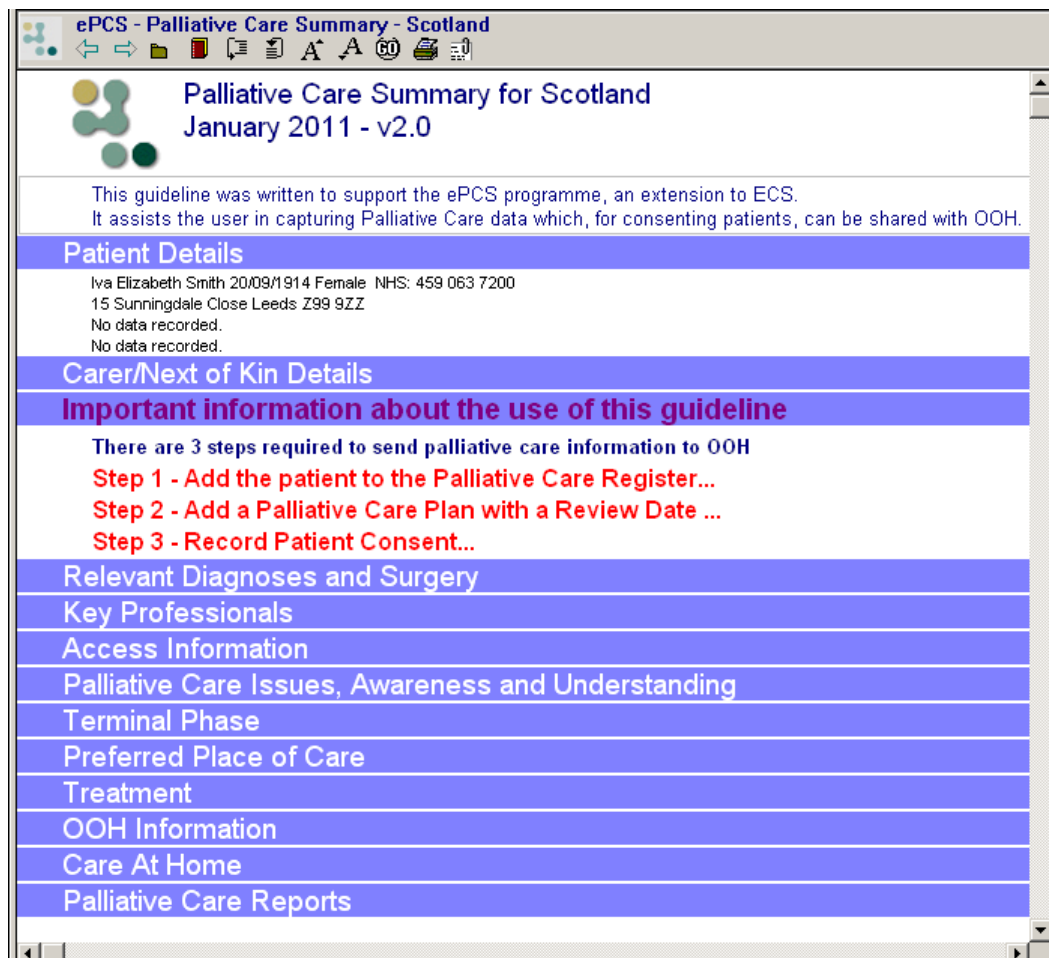
Example ePCS tab

From the Local Guidelines Index

1. Click  to display the Local Guideline Index.
2. Click on **ePCS – Palliative Care Summary - Scotland**.



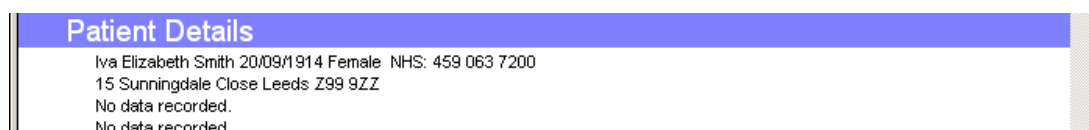
Example Local Guidelines Index including ePCS Palliative Care Summary – Scotland



Example ePCS Guideline

The ePCS – Palliative Care Summary – Scotland Guideline is broken down into sections. You can click any heading to expand or collapse it.

Patient Details



Patient Details section

This section is for reference only, it displays:

- Patients full name.
- Date of birth.
- Sex.
- CHI Number.
- Current Address.
- Communication numbers (if available).
- Other Identifiers (if available).

Carer/Next of Kin

Carer/Next of Kin Details

- Select the Patient Details/Contacts tab to check Carer/Next of Kin details are up-to-date
- If Carer and Next of Kin are different, both will be sent
- If they are the same, the information only one record will be sent to OOH

Carer/Next of Kin section

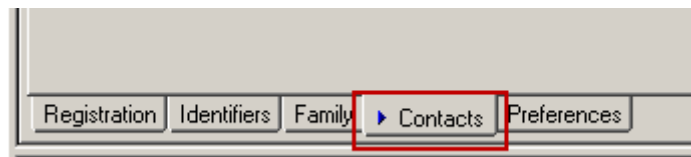
This section explains how to check or record carer/next of kin details:

1. From the Patient Record, select the Patient Details tab.



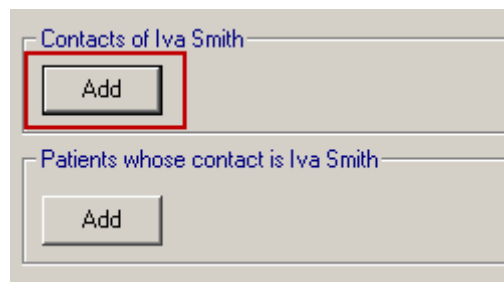
Patient Details tab

2. From Patient Details, select the Contact tab.



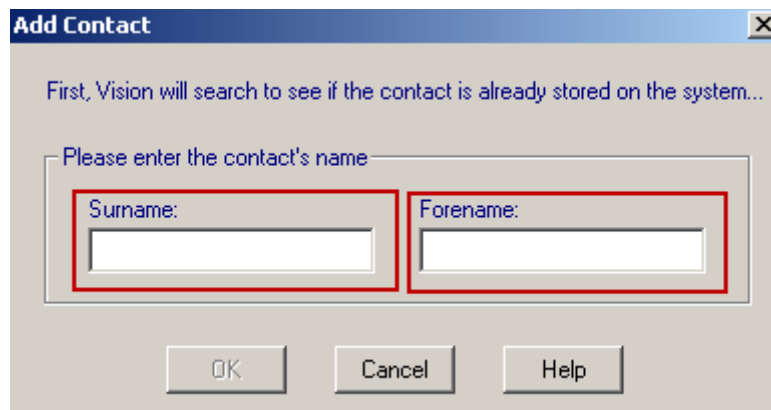
Contacts tab

3. Click **Add** under **Contacts of**



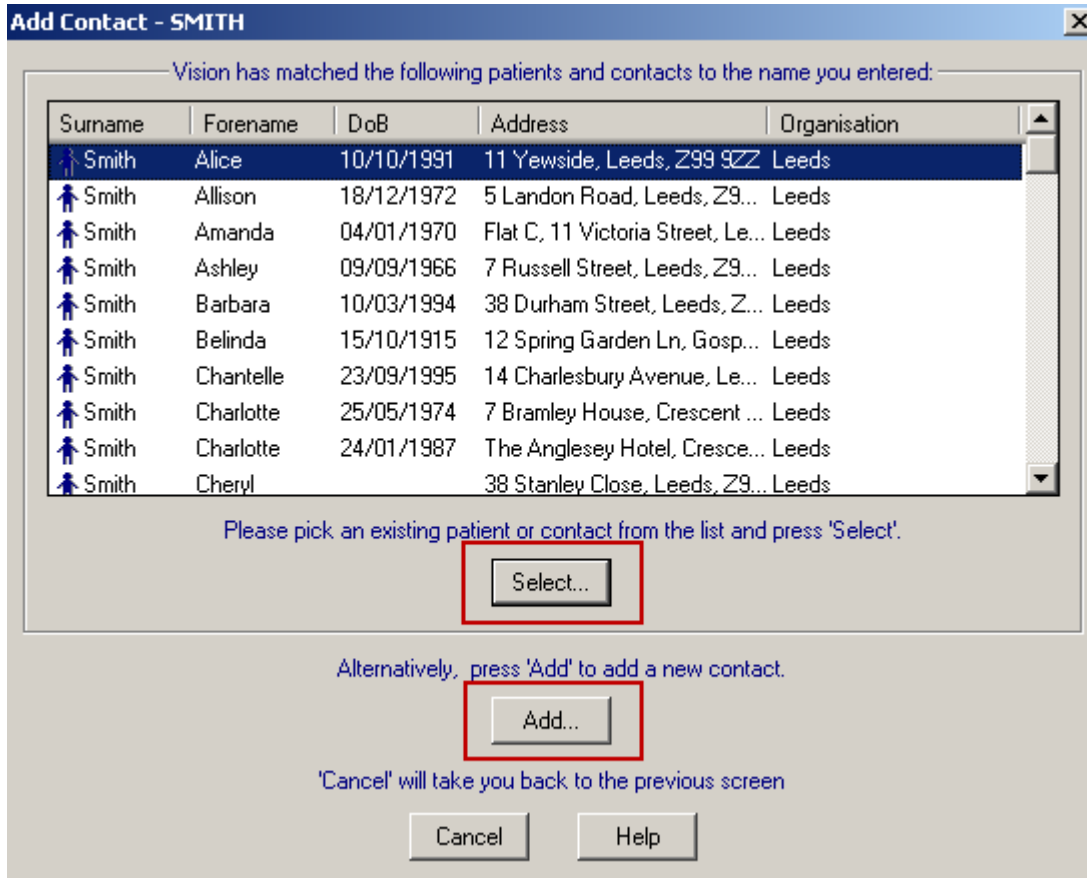
Example of Add Contact of...

4. Enter the Carer or Next of Kin surname and forename into the Add Contact screen and click **OK**.

A screenshot of a dialog box titled 'Add Contact'. It contains the text 'First, Vision will search to see if the contact is already stored on the system...'. Below this is a section titled 'Please enter the contact's name' with two input fields: 'Surname:' and 'Forename:'. Both input fields are highlighted with red boxes. At the bottom of the dialog are three buttons: 'OK', 'Cancel', and 'Help'.

Add Contact screen

5. Highlight and click **Select** on the details required. If the details required are not offered select **Add** and complete the **Person – Add screen**.



*Example Add Contact - ******

- The **Contact Relationship – Add** screen is displayed, enter the information required into **Relationship to Patient**, click into the Carer or Next of Kin check boxes as appropriate.



Example of completed Contact Relationship – Add screen

- Click **OK**.

Note - The Carer/Next of Kin information recorded is not displayed in the Guideline.

Important information about the use of this Guideline

Important information about the use of this guideline

There are 3 steps required to send palliative care information to OOH

Step 1 - Add the patient to the Palliative Care Register...

Step 2 - Add a Palliative Care Plan with a Review Date ...

Step 3 - Record Patient Consent...

Important information about the use of this Guideline section

This section facilitates the three essential steps required for an Out of Hours message to be sent. Click on the heading to access:

Step 1 - Add the patient to the palliative care register...

Step 1 - Add the patient to the Palliative Care Register...

- If no existing record, add at least one code from the list beneath to include the patient in the Palliative Care Register.

Palliative care register - existing records

No data recorded.

Record...

On gold standards palliative care framework
[V]Palliative care
Referral to palliative care service
Specialist palliative care
Specialist palliative care treatment - outpatient
Refer to terminal care consult
Palliative treatment
Refer for terminal care
Specialist palliative care treatment - daycare
DS 1500 Disability living allowance completed
Terminal illness - late stage
Referred to community specialist palliative care team
Terminal care

Step 1 - Add the patient to the palliative care register expanded

Palliative care register – existing records displays and is followed by a list of qualifying Read terms.

To add a qualifying record:

1. Double click on the Read term required.
2. A **History – Add** screen is displayed, add further detail if required.

The screenshot shows a 'History - Add' dialog box with the following fields and values:

- Event Date: 07 February 2011
- Clinician: Dr Fiona Venus
- Private:
- In Practice:
- Read Term for Characteristic: 8H7g.00 Referral to palliative care service
- Comment: Add free text here
- Type of Characteristic: Intervention
- Episode Type: Other
- Priority: 1
- End Date: (empty)

Buttons: Another, OK, Cancel, Help

Example of Referral to palliative care service History - Add

3. Click **OK** to save and close.

Step 2 – Add a Palliative Care Plan with a Review Date...

Step 2 - Add a Palliative Care Plan with a Review Date ...

Palliative care plan
No data recorded.

Add Palliative Care Plan

Step 2 – Add a Palliative Care Plan with a Review Date expanded

Palliative Care Plan displays the last Palliative Care Plan record for this patient if available.

To add a new Palliative Care Plan:

1. Click on **Add Palliative Care Plan**.

The screenshot shows the 'Palliative Care Plan - Add' dialog box. The fields are as follows:

- Date of Establishing Plan: 07 February 2011
- Clinician: Dr Fiona Venus
- Private:
- In Practice:
- Read Term: 8CS..00 Agreement of care plan
- Date of Agreement: [Empty]
- Last ECS Upload Date: [Empty]
- GP to Sign Death Cert.:
- Death Cert. Notes: [Text area]
- GSFS Review Date:** [Empty] (highlighted with a red box)
- Review Date Notes: [Text area]
- Notes: [Text area]

Buttons: OK, Cancel, Help, and a Refresh button.

Palliative Care Plan – Add with the GSFS Review Date highlighted

2. Complete the **Palliative Care Plan – Add** screen as required.

Note - A GSFS Review Date is essential for the OOH service.

3. Click **OK** to save and close.

Step 3 – Record Patient Consent...

Step 3 - Record Patient Consent...

- An OOH message will not be sent unless the patient has given consent.
- When it is appropriate, record consent to share palliative care data in Patient Registration
- To do this, click Consultation, select Patient Registration, then click the Consent tab

Step 3 – Record Patient Consent expanded

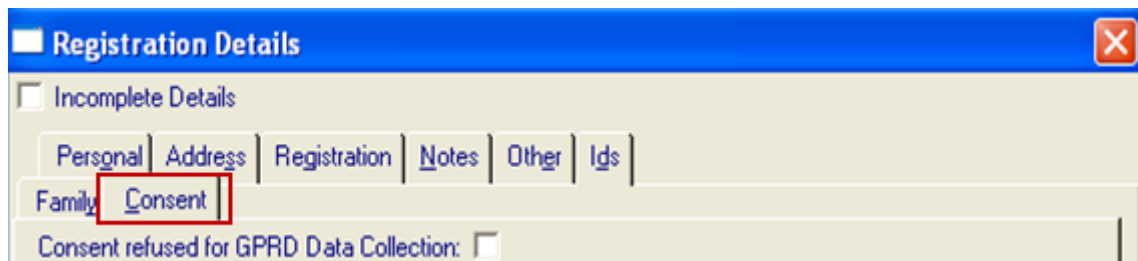
View or record Patient Consent as follows:

1. From Consultation Manager, select **Consultation – Patient Registration...**



Consultation – Patient Registration

2. The patients registration is displayed, select the **Consent** tab.



Patient Registration – Consent tab

3. Click into the **Consent given for palliative care data sharing** check box to record consent.

Registration Details

Incomplete Details

Personal | Address | Registration | Notes | Other | Ids

Family | Consent

Consent refused for GPRD Data Collection:

Consent refused for THIN Data Collection:

Consent refused to data sharing for emergency care:

Consent given for palliative care data sharing:


Consent refused for SCI-DC data sharing:

Acute Medication Service (AMS)
This patient is not eligible for this feature. Change...

Chronic Medication Service (CMS)
 This patient is not eligible for this feature. Change...
 This patient is not eligible for this feature.

OK Cancel Contacts Help

Registration Details – Consent – Consent given for palliative care data sharing

4. Click **OK** to save and close.
5. Click  to close the Registration module.

Relevant Diagnosis and Surgery

Relevant Diagnoses and Surgery

As well as the current data entered specifically for Palliative Care, you may wish to inform OOH of any relevant diagnoses and/or surgery already recorded

- Double click the heading below to view relevant items and select appropriate records for sharing with OOH...

Diagnoses and Surgery for OOH

Relevant Diagnosis and Surgery section

This section allows you to select relevant diagnosis and/or surgery records for sending to the OOH service by adding them to the *GSFS1 Problem.

To add additional data:

1. Double click on **Diagnosis and Surgery for OOH**.
2. The **Diagnosis and Surgery for OOH** screen is displayed.

Diagnoses and Surgery for OOH

- Vision uses a Problem with the name 'GSFS1 to send additional information about relevant diagnoses or surgery to OOH

- Check below to see if you have created the Problem which is required and whether it contains the relevant Medical History items for Diagnosis and/or Surgery.

Existing record of *GSFS1 Problem

If a Problem displays below, you can click to view content

No data recorded.

- If NO existing record of Palliative Care or ECS Out of Hours Summary Problem is shown above...

- Add one now by clicking the button below:

Add Palliative Care Problem Type *GSFS1 as the Short Name

Select the relevant diagnoses or operations for sending to OOH

From the list of Medical History or Surgery beneath...

1. Highlight a relevant item
2. Right click and select Problems...
3. Click to select *GSFS1 (click to deselect unwanted items which have been selected)

Medical History Priority 1 (Chapters A-U)

28/12/2006 Hypertensive disease Dr Michael Neptune
 28/12/2006 Diabetes mellitus Dr Michael Neptune
 19/03/2006 Asthma Dr Mel Earth

Surgical Procedures (Medical History Chapter 7)

13/06/2009 [SO]Skin of temple Dr Janet Outside Practice
 24/02/2007 Excision Dr Janet Outside Practice
 24/02/2007 [SO]Skin of scalp Dr Janet Outside Practice
 25/12/2005 Barium meal performed Dr Janet Outside Practice
 11/06/2004 Phacoemulsification of lens Dr Janet Outside Practice
 01/12/2003 Other extraction of cataract Dr Janet Outside Practice
 01/12/2000 Dacryocystorhinostomy NEC Dr Janet Outside Practice
 01/12/1982 Cholecystectomy Dr Janet Outside Practice

Note that Surgery records selected for the 'GSFS1 Problem will be sent to OOH however they DO NOT appear OOH Summary Report

Diagnosis and Surgery for OOH screen

Existing record of *GSFS1 Problem

3. If a relevant Problem has been recorded, it will be displayed. You can click the Problem heading to expand and view any data in it.
4. If no Problem is displayed and you wish to send additional diagnosis and surgery information to the OOH service, click **Add Palliative Care Problem**.
5. The Problem – Add screen is displayed, enter *GSFS1 into the **Short Name**.

Problem - Add

Start Date: 07 February 2011 Clinician: Dr Fiona Venus

Consultation date
 Event date
 Today's date

Read Code: 8BAP.00 Specialist palliative care

Short Name: *GSFS1 End Date:

Description: Specialist palliative care

OK Cancel Help

Problem Add – Specialist palliative care – Short Name highlighted

6. Click **OK** to save and close.

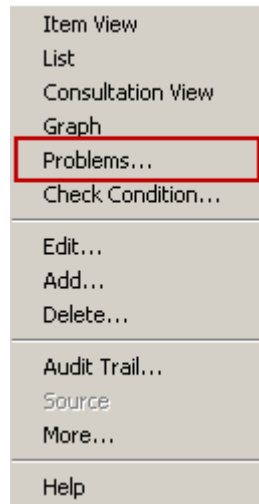
Note – Ensure the Short Name of your problem is *GSFS1.

Select the relevant diagnosis or operations for sending to OOH

This section displays all the Medical History Priority 1 (Chapters A-U) and Surgical Procedures (Medical History Chapter 7) recorded on the patient's record.

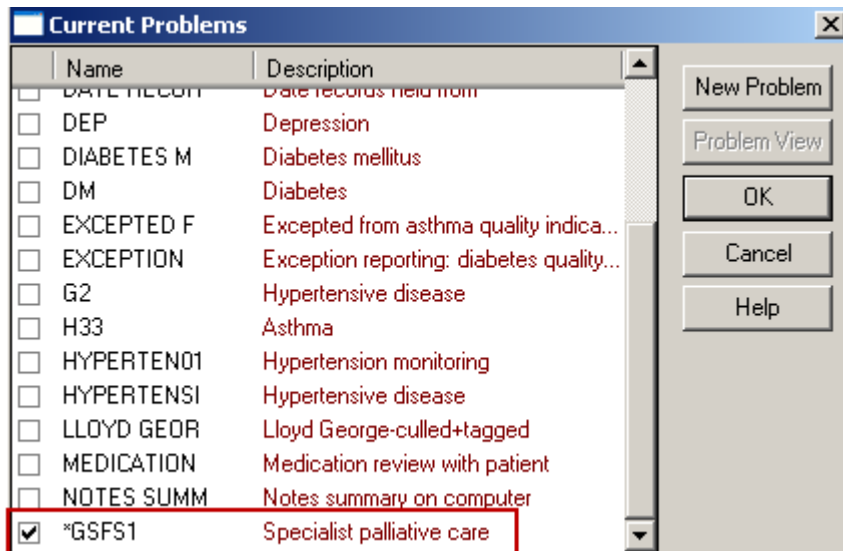
To add any of these to the OOH summary:

7. Right click on the data record you wish to include, select Problems.



Right click menu, Problems highlighted

8. The **Current Problems** screen is displayed, click on the *GSFS1 Problem.



*Current Problems, *GSFS1 Problem highlighted*

9. Repeat steps 6 and 7 until all the additional information required by the OOH service is added to the Problem.
10. Click **OK** to save and close.

Note – Records you have selected will be listed under the *GSFS1 Problem.

Key Professionals

Key Professionals

Under the care of:

Practice Nurse:

No data recorded.

District Nurse:

No data recorded.

Community Palliative Care Team:

No data recorded.

Macmillan Nurse:

No data recorded.

Multidisciplinary Team:

No data recorded.

Marie Curie:

No data recorded.

A screenshot of the 'Under the care of' section of a software interface. It displays six grey rectangular buttons with rounded corners, arranged in two rows. The top row contains three buttons: 'Practice Nurse', 'District Nurse', and 'Community Palliative Care Team'. The bottom row contains three buttons: 'Macmillan Nurse', 'Multidisciplinary Team', and 'Marie Curie'.

Refer care to:

A screenshot of the 'Refer care to' section of a software interface. It displays five grey rectangular buttons with rounded corners, arranged in two rows. The top row contains three buttons: 'Comm. Spec. Pall. Care Team', 'Social Services', and 'Voluntary Services'. The bottom row contains two buttons: 'Arrange Care by Relative' and 'Arrange Care Attender'.

Comm. Spec. Pall. Care Team:

No data recorded.

Social Services:

No data recorded.

Voluntary Services:

No data recorded.

Arrange Care by Relative:

No data recorded.

Arrange Care Attender:

No data recorded.

Key Professional section

Under the Care of:

The details of other professionals involved in the care of the patient (if known) are recorded here:

1. Click on the appropriate button to record.
2. Add free text if required.
3. Click **OK** to save and close.

Refer care to:

Referrals to other professionals for the care of the patient can be recorded here by:

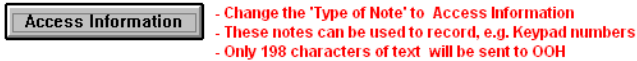
1. Click on the appropriate button to record.
2. Complete the Referral –Add screen as required.

3. Click **OK** to save and close.

The latest record of each type is displayed and will be sent to OOH along with any free text up to 198 characters.

Access Information

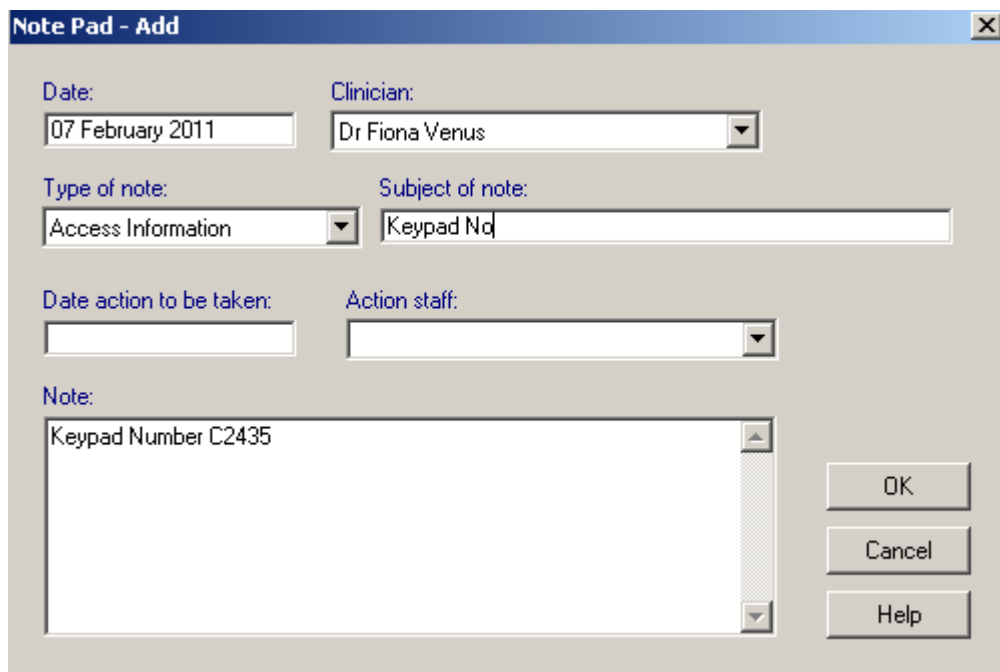
Access Information



Access Information section

This section can be used to record notes which might be useful in gaining access to the patient's home in an Out of Hours situation:

1. Click Access Information, the Note Pad – Add screen displays.



The screenshot shows a dialog box titled "Note Pad - Add". It contains the following fields and controls:

- Date:** A text box containing "07 February 2011".
- Clinician:** A dropdown menu showing "Dr Fiona Venus".
- Type of note:** A dropdown menu showing "Access Information".
- Subject of note:** A text box containing "Keypad No".
- Date action to be taken:** An empty text box.
- Action staff:** A dropdown menu.
- Note:** A large text area containing "Keypad Number C2435".
- Buttons:** "OK", "Cancel", and "Help" buttons are located on the right side of the dialog.

Example of completes Access Information Note Pad - Add

2. Press the 'A' key to set the **Type of note** to **Access Information**.
3. Enter the subject of the information into **Subject of note**.
4. Enter the information free text into **Note**.
5. Click **OK** to save and close.

Note – Only the first 198 characters are transferred with the OOH Summary.

Palliative Care Issues, Awareness and Understanding

Palliative Care Issues, Awareness and Understanding

No data recorded.

- In Palliative Care Issues you can record in freetext any issues relating to the patient's palliative care, whether it is social, medical or mental

Palliative Care Issues

- Change the 'Type of Note' to Palliative Care Issues
- Only 198 characters of text will be sent to OOH

Patient awareness and understanding of diagnosis:

No data recorded.

Family awareness and understanding of diagnosis

No data recorded.

Patient Aware of Diagnosis

Patient Unaware of Diagnosis

Family Aware of Diagnosis

Family Unaware of Diagnosis

Patient awareness and understanding of prognosis

No data recorded.

Relative awareness and understanding of prognosis

No data recorded.

Use free text to record details of patient's and carer's awareness and understanding of prognosis

Informing Patient of Prognosis

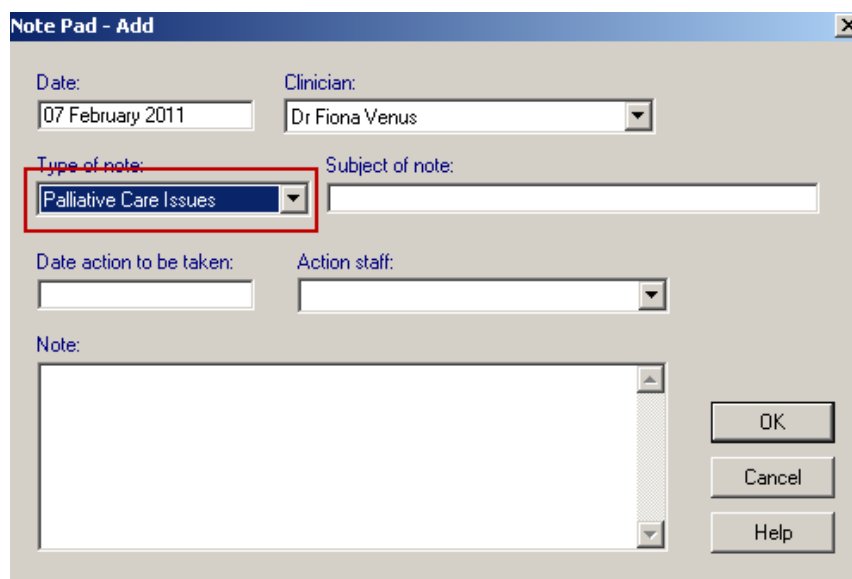
Informing Relative of Prognosis

Palliative Care Issues, Awareness and Understanding section

This section displays and allows you to record:

Palliative Care issues

1. Click on Palliative Care Issues, a Note Pad – Add screen displays.



Note Pad – Add, Type of note Palliative Care Issues

2. Press the 'P' key to set the **Type of note** to Palliative Care Issue.
3. Enter the subject of the information into **Subject of note**, this is also sent as a prefix to the **Note**.
4. Enter the information free text into **Note**.
5. Click **OK** to save and close.

Note – Only the first 198 characters are transferred with the OOH Summary.

Patient's Awareness and Understanding of Diagnosis

1. Click on the appropriate button, either **Patient Aware of Diagnosis** or **Patient Unaware of Diagnosis**.
2. A **History – Add** screen is displayed with the relevant Read code:
 - 1H0..00 Patient aware of diagnosis
 - 1H1..00 Patient not aware of diagnosisFree text should be added to expand on the patient's understanding of diagnosis.
3. Click **OK** to save and close.

Carer's Awareness and Understanding of Diagnosis

1. Click on the appropriate button, either **Family Aware of Diagnosis** or **Family Unaware of Diagnosis**.
2. A **History – Add** screen is displayed with the relevant Read code:
 - 1H2..00 Family aware of diagnosis
 - 1H1..00 Family not aware of diagnosisFree text can be added to expand on the carer's understanding of diagnosis.
3. Click **OK** to save and close.

Patient's and Carer's Awareness of Prognosis

1. Click on the appropriate button, either **Informing Patient of Prognosis** or **Informing Relative of Prognosis**.
2. A **History – Add** screen is displayed with the relevant Read code:
 - 67D1.00 Informing patient of prognosis
 - 67F1.00 Informing relative of prognosisFree text should be added to these entries to briefly describe what the patient or carer knows and/or understands about the prognosis.
3. Click **OK** to save and close.

Terminal Phase

Terminal Phase

No data recorded.

Palliative Care Plan

To update an existing Palliative Care Plan, right-click the record above and select **Edit** OR, to add a new record click the Palliative Care Plan button

Patient's wishes for resuscitation - DNACPR status

No data recorded.

Wishes to be Resuscitated

Does NOT wish to be resuscitated

- Only the most recent entry will be available to view by OOH
- If DNACPR status is unknown, please record using the button below, then in comments, type "Unknown" and any additional relevant information.

Resuscitation Status Unknown

Form DS1500

No data recorded.

Add DLA form completed

Terminal Phase section

This section displays and allows you to record:

Palliative Care Plan

To update an existing plan:

1. Right click on the plan displayed and select **Edit**.
2. Update as required.
3. Click **OK** to save and close.

To add a new plan

1. Click on **Palliative Care Plan**.
2. Complete the **Palliative Care Plan – Add** screen as required.

Note – Remember to add a GSFS Review Date.

3. Click **OK** to save and close.

Patient wishes for resuscitation – DNACPR status

1. Click on the appropriate button, either **Wishes to be Resuscitated**, **Does NOT wish to be resuscitated** or **Resuscitation Status Unknown**.
2. A **History – Add** screen is displayed with the relevant Read code:
 - 1R0..00 For resuscitation
 - 1R1..00 Not for resuscitation
 - 1R...00 Resuscitation status – Type UNKNOWN in comment.Free text can be added to these entries.
3. Click **OK** to save and close.

Form DS 1500 for Disability Living Allowance

1. Click on Add DLA form completed.

2. A History – Add screen is displayed with the relevant Read code
 - 9EB5.00 DS 1500 Disability living allowance completedFree text can be added to this entry.
3. Click **OK** to save and close.

Preferred Place of Care



This section displays and allows you to record the patient's preferred place of care:

1. Click on the appropriate button, either:
 - **Home**
 - **Nursing Home**
 - **Community Hospital**
 - **Hospital**
 - **Hospice**
2. A **Patient Preference – Add** screen is displayed with the relevant Read code:
 - 94Z1.00 Preferred place of death: home
 - 94Z5.00 Preferred place of death: nursing home
 - 94Z3.00 Preferred place of death: community hospital
 - 94Z4.00 Preferred place of death: hospital
 - 94Z2.00 Preferred place of death: hospiceFree text can be added to these entries.
3. Click **OK** to save and close.

Treatment

Treatment
No data recorded.
Add Cancer Care Review

Radiotherapy, chemotherapy and palliative treatment
No data recorded.
Add Chemotherapy **Add Radiotherapy** **Add Palliative Treatment**

Current repeat therapy
No data recorded.

Last 30 days acute prescriptions
No data recorded.

Allergies
28/02/2008 Drug Allergy Certain Moderate Allergy to PENICILLIN V elixir 125mg/5ml causing
28/02/2008 Drug Allergy Certain Moderate Allergy to ASPIRIN mr cap 162.5mg causing
No data recorded.

Treatment section

This section displays and allows you to record:

Cancer Care Review

1. Click on Cancer care review.
2. A **History – Add** screen is displayed with the relevant Read code:
 - 8BAV.00 Cancer care reviewFree text can be added to this entry.
3. Click **OK** to save and close.

Radiotherapy, chemotherapy and palliative treatment

1. Click on the appropriate button:
 - **Add Chemotherapy**
 - **Add Radiotherapy**
 - **Add Palliative Treatment**
2. A **History – Add** screen is displayed with the relevant Read code:
 - 8BAD000 Cancer chemotherapy
 - 7M37100 Radiotherapy NEC
 - 8BJ1.00 Palliative treatmentFree text can be added to these entries.
3. Click **OK** to save and close.

Current repeat therapy

This is a display of all active repeat medication which has been issued in the last 12 months.

Last 30 days acute prescriptions

This is a display of all acute therapy issued within the last 30 days.

Allergies

This is a display of all Drug and Non-drug allergies and intolerances.

OOH Information

OOH Information

No data recorded.

OOH Information

No data recorded.

Additional OOH Information

**Click this button to send any other useful information to OOH
Change the 'Type of Note' to OOH Information
Only 198 characters of text will be sent and and only the latest record can be seen by OOH**

OOH Information section

This section displays and allows you to record information about discussions you have had with the patient and/or their carer about their palliative care plan for sharing with the OOH staff:

OOH Information

To add OOH Information:

1. Click on **OOH Information**.
2. The **OOH Arrangements (Palliative Care) – Add** screen displays.

OOH Arrangements (Palliative Care) - Add

Date of Establishing Plan: 08 February 2011 Clinician: Dr Fiona Venus Private
 In Practice

Read Term: 9e00.00 GP out of hours service notified of cancer care plan

Date Discussed with Patient: 08 February 2011 Patient Discussed Notes: Patient happy to share information with out of hours service

Date Discussed with Carer: 08 February 2011 Carer Discussed Notes:

GP Should Be Contacted OOH GP OOH Contact Notes: Dr Venus wishes to be contacted

GP Contact Number: 07802 123456

Notes:

OK
Cancel
Help

Example of completed OOH Arrangements (Palliative Care) – Add screen

3. Complete each section as appropriate.

Note – Anything recorded in Notes on this screen is for practice use only, it is NOT included in the OOH message.

4. Click **OK** to save and close.

Additional OOH Information

This is the equivalent to the "Special Note". To add:

1. Click on **Additional OOH Information**, a **Note Pad – Add** screen is displayed.
2. Press the 'O' key to set the **Type of note** OOH Information.
3. Enter the subject of the information into **Subject of note**.
4. Enter the information free text into **Note**.
5. Click **OK** to save and close.

Note – Only 198 characters are transferred with the OOH Summary.

Care At Home

The screenshot shows a software interface with two main sections. The top section is titled "Care At Home" in a blue header bar. Below the header, it says "No data recorded." and there is a button labeled "Care at Home". The bottom section is titled "Syringe driver use" in a light blue header bar. Below this header, it says "No data recorded." and there are two buttons: "Syringe driver commenced" and "Syringe Driver discontinued".

Care At Home section

This section displays and allows you to record:

Care at Home

To add Care at Home:

1. Click on **Care at Home**.
2. The **Palliative Care at Home – Add** screen displays.

The screenshot shows a window titled "Palliative Care at Home - Add". It contains several input fields and checkboxes. "Date of Record:" is set to "08 February 2011". "Clinician:" is set to "Dr Fiona Venus". There are checkboxes for "Private" (unchecked) and "In Practice" (checked). "Read Term:" is set to "677K.00 Cancer home care pack given". There are three sections with checkboxes and text boxes: "Extra Drugs Available at Home" (checked) with "Drugs Notes:" containing "Just in case drugs prescription issued"; "Catheter Products at Home" (checked) with "Catheter Notes:" containing "Indwelling catheter in use"; and "Moving/Handling Equip. at Home" (checked) with "Equip. Notes:" containing "Kelly stand and bathing equipment". At the bottom, there is a "Notes:" text area. On the right side, there are buttons for "OK", "Cancel", and "Help", along with a refresh icon.

Example of completed Palliative Care at Home screen

3. Complete as appropriate.

Note – Anything recorded in Notes on this screen is for practice use only, it is NOT included in the OOH message.

4. Click **OK** to save and close.

Syringe driver commenced/Syringe Driver discontinued

1. Click on the appropriate button, either **Syringe driver commenced** or **Syringe Driver discontinued**.
2. A **History – Add** screen is displayed with the relevant Read code:
 - 8BD4.00 Syringe driver commenced
 - 8BC5.00 Syringe driver discontinuedFree text can be added to these entries.
3. Click **OK** to save and close.

Palliative Care Reports

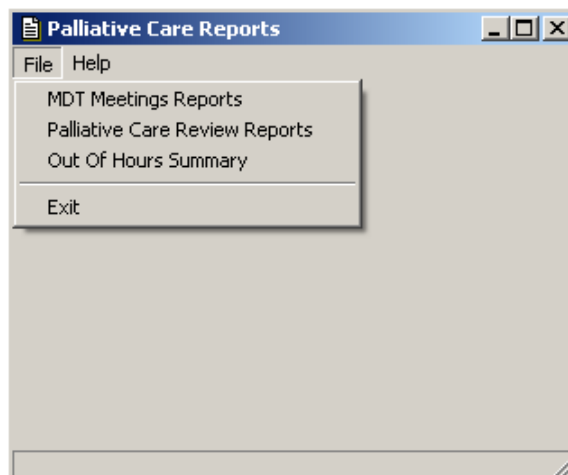
Palliative Care Reports

- Palliative Care Reports are available from the Vision Main Menu, Searches and Reports.
- The OOH Report shows the information sent to be sent to OOH.
- Note that any free text in excess of 198 characters will be truncated and not available to OOH.
- The Multidisciplinary Team Meeting report lists all patients on the Palliative Care register, even if they have not consented to share data with ePCS.

Palliative Care Reports section

This section advises on where to find the Palliative Care Reports within Vision:

1. From the Vision Main Menu, select **Reporting**.
2. Click on **Palliative Care Reports**.
3. Click on File and select the report you require.



Palliative Care Reports – File

Multidisciplinary Team (MDT) Meeting Report

This report lists all patients with qualifying Read codes even if they have not consented to their information being shared electronically.

1. From **Palliative Care Reports**, click on **File – MDT Meetings Reports**.
2. In **Select Palliative Care Type to be included in report** click in the boxes of the Read codes you wish to include or exclude.

Note - Clicking on **Select All** will include all qualifying Read codes, clicking on **Clear All** will clear all qualifying Read codes.

3. Select the registration type of patients by clicking either:
 - **Registered & unregistered within the last month.**
 - **Currently Registered.**
4. Click **Search**.

The screenshot shows a window titled "Palliative Care MDT Reports" with a close button (X) in the top right corner. Below the title bar are two tabs: "New" (selected) and "Existing". The main area is divided into several sections:

- MDT Meetings**: A section with the heading "Select Palliative Care Type to be included in report:" followed by a table with two columns: "Read Code" and "Desc".
- Patients**: A section with two radio buttons: "Registered & unregistered within the last month" (unselected) and "Currently registered" (selected).
- Scheduled Report Options**: A section with two buttons: "Save" and "Load".
- Buttons**: At the bottom of the dialog are buttons for "Select All", "Clear All", "Search", and "Close".

Read Code	Desc
<input checked="" type="checkbox"/> 8CM1.	On gold standards palliative care framework
<input checked="" type="checkbox"/> ZV57C	[V]Palliative care
<input checked="" type="checkbox"/> 8H7g.	Referral to palliative care service
<input checked="" type="checkbox"/> 8BAP.	Specialist palliative care
<input checked="" type="checkbox"/> 8BAT.	Specialist palliative care treatment - outpatient
<input checked="" type="checkbox"/> 8H6A.	Refer to terminal care consult
<input checked="" type="checkbox"/> 8HH7	Referred to community specialist palliative car

Palliative Care MDT Reports

5. The **Summary of Palliative Care Patients for Use at Multi-Disciplinary Meetings** report is displayed.
6. Select **File – Print** to print the report
7. Click to close the report.

SUMMARY OF PALLIATIVE CARE PATIENTS FOR USE AT MULTI-DISCIPLINARY TEAM MEETINGS

09/02/2011 14:37

USER DEFINED SEARCH CRITERIA:
 Patients currently Registered
 8CM1. On gold standards palliative care framework
 ZV57C [V]Palliative care
 8H7g. Referral to palliative care service
 8BAP. Specialist palliative care
 8BAT. Specialist palliative care treatment - outpatient
 8H6A. Refer to terminal care consult
 8HH7. Referred to community specialist palliative care team
 8BJ1. Palliative treatment
 8BA2. Terminal care
 8H7L. Refer for terminal care
 8BAS. Specialist palliative care treatment - daycare
 9EB5. DS 1500 Disability living allowance completed
 1Z01. Terminal illness - late stage

Registration Status	Patient Surname	Patient First Name	CHI Number	Diagnosis	Usual GP	Nurse	Carer details(name, relationship to patient)	On Palliative Care	Referred to Macmillan nurse	OOH form completed (date)	Preferred Place of Care
Y	A	Matthew			Dr Fiona Venus			8H6A.00 ZV57C00			
Y	Alan	Geoffrey			Dr Sarah Jupiter			ZV57C00 ZV57C00 8BAP.00 8BAP.00			
Y	Christopher	David			Dr Sarah Jupiter			8BJ1.00			
Y	Gouldspring	Lesley			Dr Sarah Jupiter			ZV57C00 8BAP.00 ZV57C00 8HH7.00			
Y	Kes	Anthony			Dr Jane Mars			8H7g.00			
Y	Lemin	Victoria			Dr Sarah Jupiter			8BJ1.00 ZV57C00 ZV57C00			
Y	Luke	Daniel			Dr Fiona Venus			ZV57C00 8HH7.00			
Y	Smith	Iva		Diabetes mellitus	Dr Fiona Venus			8BAP.00			
Y	Terrel	Edward			Dr Sarah Jupiter			8BJ1.00 ZV57C00			

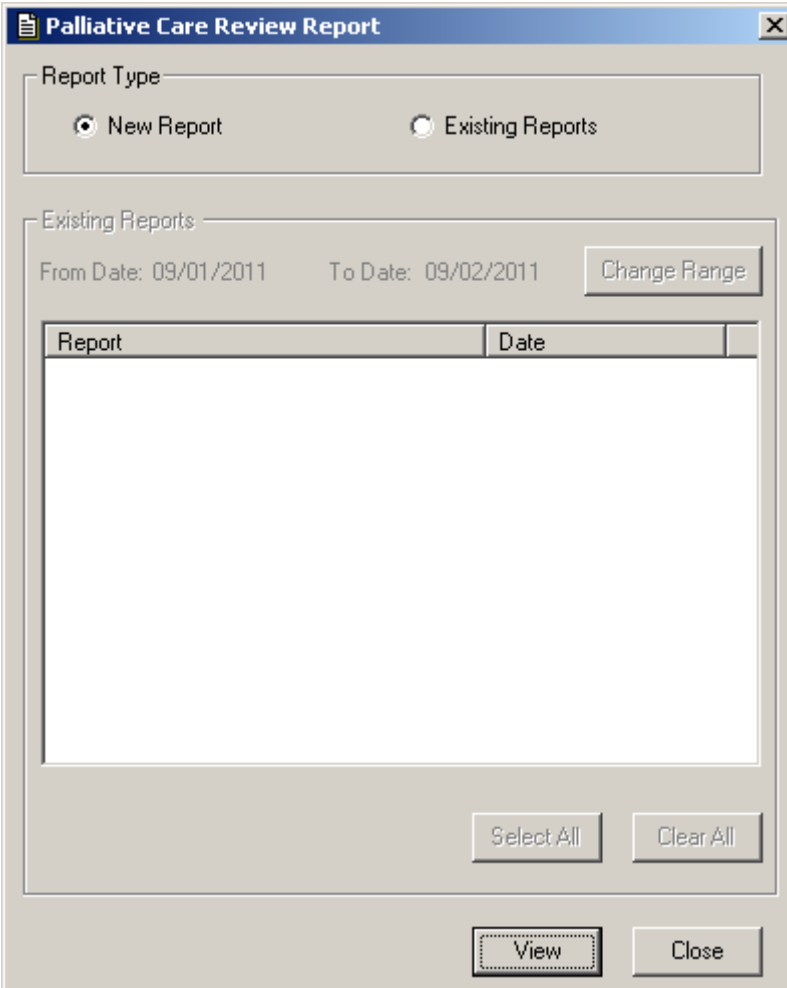
Summary of Palliative Care Patients for Use at Multi-Disciplinary Meetings report

Palliative Care Review Reports

This produces a report of all patients who are either due for review in the next week or whose review date has expired. The patient will be picked up even if they have not consented to their information being shared electronically.

Note - A patient will not be picked up if they have **no** review date.

1. From **Palliative Care Reports**, click on **File – Palliative Care Review Reports**.
2. Click on **View**.



The screenshot shows a dialog box titled "Palliative Care Review Report". It has a "Report Type" section with two radio buttons: "New Report" (selected) and "Existing Reports". Below this is an "Existing Reports" section with "From Date: 09/01/2011" and "To Date: 09/02/2011", and a "Change Range" button. A table with two columns, "Report" and "Date", is shown below the date fields. At the bottom of the dialog are buttons for "Select All", "Clear All", "View", and "Close".

Report	Date
--------	------

Palliative Care Review Report


3. The Report of **Palliative Care Patients with Upcoming/Overdue Reviews** report is displayed.
4. Select **File – Print** to print the report
5. Click on Close.

Out of Hours Summary

The OOH Summary report is a helpful summary which includes, for consenting patients, the date of last upload to ECS. It can be produced for either individual patients or patients matching the specified criteria.

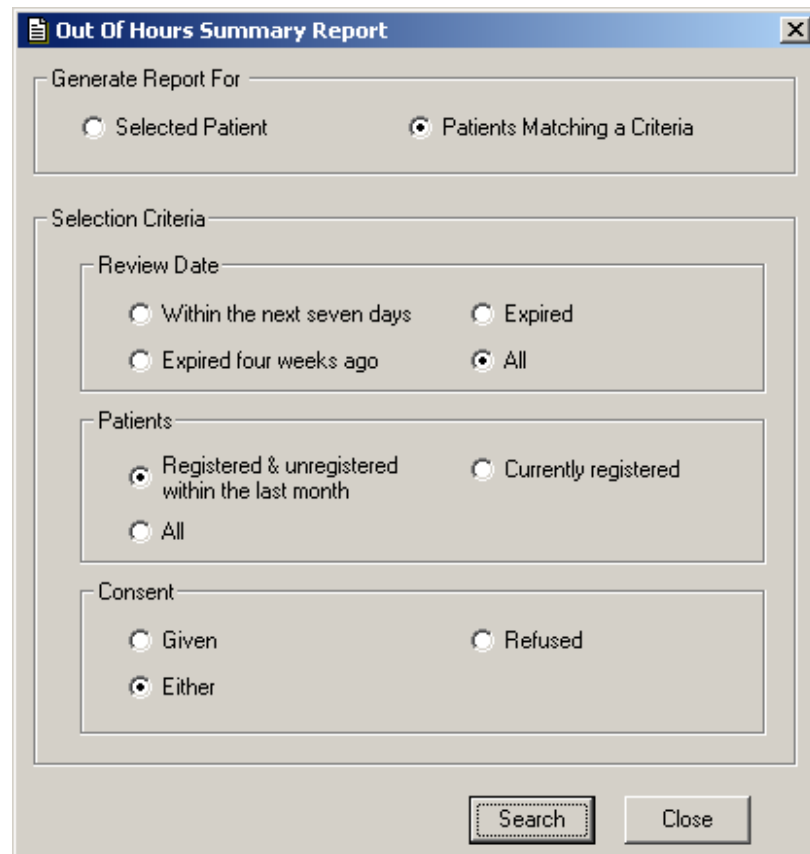
1. From **Palliative Care Reports**, click on **File – Out Of Hours Summary**.

For a Specific Patient

2. Leave the bullet in **Selected Patient** and click on **Search**.
3. Find the correct patient from the **Select Patient** screen.
4. The OOH Summary report is displayed
5. Select **File – Print** to print the report
6. Click  to close the report

For Patients Matching a Criteria

2. Click in to **Patients Matching a criteria**.
3. Select the criteria required from:
 - Review Date
 - Patients
 - Consent
4. Click on **Search**.



Out Of Hours Summary Report

Generate Report For

Selected Patient Patients Matching a Criteria

Selection Criteria

Review Date

Within the next seven days Expired
 Expired four weeks ago All

Patients

Registered & unregistered within the last month Currently registered
 All

Consent

Given Refused
 Either

Search Close

Out of Hours Summary Report screen

Section 1			
Patient and Carer Details		Patient's Own Gp and Nurse	
1a - Patient Surname	Aaron	1h - Usual GP name	Dr Fiona Venus
1b - Patient Forename	Stewart	1i - Nurse	
1c - CHI Number		1j - Practice Details	Practice Code: G12345 Inps Practice 1a Broughton Street Battersea London SW8 3QY
1d - Patient address	80 WILMOTT CLOSE LEEDS Z99 9ZZ		
1e - Patient Tel number			
1f - Carer Details	Debbie Brown 6 ST FAITHS CLOSE LEEDS Z99 9ZZ Relationship: Carer.		
1g - Access information including potential issues			
1k - Next of kin details	Samuel Aaron 10 CHARLESBURY AVENUE LEEDS Z99 9ZZ Relationship: Next of Kin / Son.		

Relevant diagnosis record(s) selected by adding to the *GSFS1 Problem

Section 2 Patient Medical Condition	
2a - Main Diagnoses	17/01/2008 Malignant lymphoma NOS
2b - Other Relevant Issues	01/02/2011 Use Palliative Care Issues to enter relevant notes up to the constraint of 198 characters
2c - Allergies / Adverse drug reactions	
2d - Current Drugs and Doses	01/02/2011 SIMVASTATIN tabs 20mg Supply: (28) tablet(s) take one at night 01/02/2011 RAMIPRIL caps 5mg Supply: (28) capsule(s) take one daily 01/02/2011 BENDROFLUMETHIAZIDE tabs 2.5mg [CP PHARM] Supply:

OOH Summary report sections 1 and 2

Note - This report shows full dosage information for medication items; this is truncated before sending, as per the ECS specification.


Section 3 Current Care Arrangements		
3a - Care arrangements	Agency Contact	
	On Palliative Care	03/02/2011 Specialist palliative care
3d - Syringe driver at home		01/02/2011 Yes
3e - Catheter continence products at home		03/02/2011 No
3f - Moving and handling equipment at home		03/02/2011 No

Section 4 Patient's and Carer's Awareness of Condition	
4a - Patient's Understanding of Diagnosis	Patient aware of diagnosis, Cancer nurses pedialist present
4b - Patient's Understanding of Prognosis	Informing patient of prognosis, Patient fully aware of prognosis, not yet ready to share this information with family members
4c - Carer's Understanding of Diagnosis	Family aware of diagnosis, Present at consultation with patient
4d - Carer's Understanding of Prognosis	

Section 5 Advice for Out Of Hours Care	
5a - Care Plan Agreed	Yes, plan agreed on 01/02/2011
5b - Preferred place of care	Preferred place of death: home
5c - Should GP be contacted out of hours?	Yes, Dr Waring wishes to be contacted
5d - GP - Home Tele/Mobile/Pager	09889 221223
5e - Resuscitation Status Agreed	Yes
5f - Actual Resuscitation Status	Not for resuscitation, DNAPCPR form in place
5g - Will GP sign death certificate in normal circumstances?	Yes
5h - Additional Useful OOH Information	01/02/2011 PATIENT CONDITION - Patient condition deteriorated over last 2 days. Wishes to remain at home as long as possible

This information, including the free text notes, is added through the ePCS Guideline

OOH Summary report sections 3 through to 5

5. Select **File – Print** to print the report
6. Click  to close the report