

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:

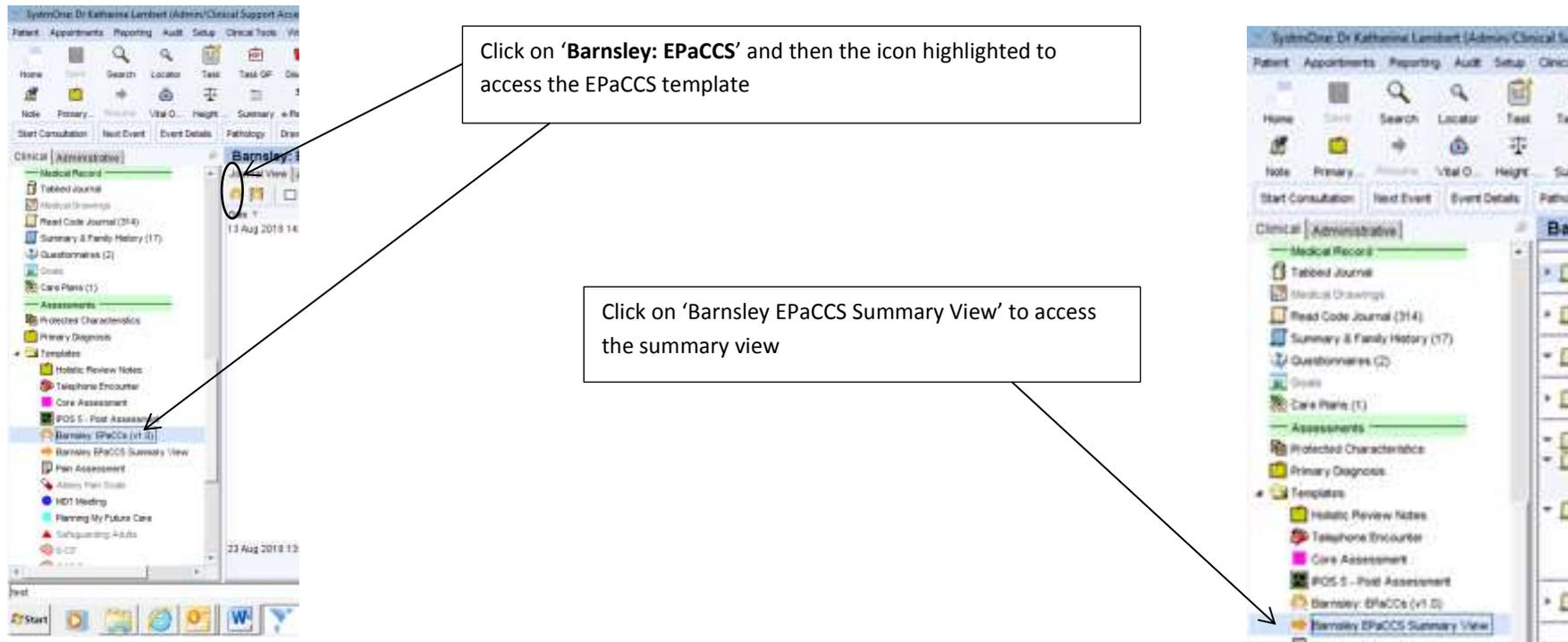
Janet Owen

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.



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 Aastra (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](#)

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.

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

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.

The screenshot shows a web application interface for recording patient relationships. The main heading is "Relationships" with a sub-heading "Record names and contact details for all carers and professionals involved in the patient's care". Below this is a table with the following data:

Name	Organisation	Address	Work Contact
Laure South	Barnsley Maudsley Service	Stowell Clinic Stowell Road Stowell Barnsley S70 5TF	01226 433520

To the right of the table is a "Record Relationship" button. Below the table are several checkboxes and buttons for recording care services and needs assessments. A box around the "Relationships" section and an arrow pointing to the "Record Relationship" button correspond to the text in the adjacent box.

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

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.

The screenshot shows a patient record form with several sections. The 'Function and disability' section includes checkboxes for 'Hearing loss', 'Difficulty communicating', 'Other disability', 'Impaired cognition', 'Impaired vision', and 'No known disability'. Each checkbox has a pencil icon next to it. Below this is a 'Karnofsky Performance Status' dropdown menu and an 'Australia modified Karnofsky Performance Status scale' field. The 'Social and financial support' section includes a note about social services, a 'Has social or private care package' checkbox, and a 'CHC / Fast Track status' dropdown. There are also links for 'My Best Life Social Prescribing form', 'CHC - Checklist', 'CHC - Fast Track', 'Blue badge referral', and 'Macdonald Welfare Rights Referral'. At the bottom, there is a 'Social and personal history' section with a large text area and a pencil icon.

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.

Click on the 'CHC – Checklist' and 'CHC – Fast Track' boxes to access the relevant forms. The patient demographics will 'pull through' from SystemOne 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.

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.

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'.

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.

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

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 screenshot shows a clinical software interface with the following sections:

- Treatment Escalation Plan:** A yellow header section with a text area for "Emergency health care plan" and a "preset" button.
- Resuscitation:** A section with a "CPR Status" dropdown, checkboxes for "Resuscitation discussed with patient" and "Resuscitation discussed with carer", and a "DNACPR form" button.

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

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

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

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)

Medication

It is recommended to prescribe 'anticipatory' medication for any patient expected to be in the last days of life even if they are not currently experiencing any particular symptoms. A minimum of 5 ampoules of medication plus water for injection should be prescribed. The dose and quantities will need adjustment if the patient is taking the medication regularly.

For advice contact the Macmillan Community Palliative Care Team on 01226 645200 or Hospice on 01226 244244.

[Last part of life prescribing guidelines](#) [Macmillan Last Days of Life Symptom Management](#)
[Last days of life prescribing - examples of PPTs](#) [Palliative care participating pharmacies](#)

Tick when anticipatory medications have been prescribed: Prescription of palliative care anticipatory medication

If using the below options to prescribe, you must amend the dose for each drug manually.

Pain

Morphine sulfate 10mg/ml injection Usual dose is morphine 2.5-5mg sc 2 hourly prn if not on regular opioid. To convert oral morphine to sc divide by 2. If not recommended in renal failure - seek specialist palliative care advice.

Oxycodone 10mg/ml injection Oxycodone is an alternative to morphine. To calculate the sc dose from the oral dose divide by 2.

Nausea and vomiting

Haloperidol 5mg/ml injection Haloperidol 0.5-1.5mg sc PRN up to 4 hourly is recommended first line. Cyclizine 50mg sc PRN is an alternative used in patients with Parkinson's Disease or who have experienced extrapyramidal side effects. Levomepromazine 0.25mg sc PRN up to 4.8 hourly is an alternative broad spectrum antiemetic.

Levomepromazine 25mg/ml injection

Cyclizine 10mg/ml injection

Anxiety, restlessness or panic

Haloperidol 5mg/ml injection Usual dose is haloperidol 2.5-5mg sc PRN up to hourly.

Respiratory tract secretions

Hyoscine butylbromide 20mg/ml injection Usual dose is hyoscine butylbromide 20mg sc PRN up to 2 hourly.

Other

Water for injection Ten ampoules of 10mls water for injection is recommended.

Tegaderm Film dressing Three GCSs x 7cm dressings are recommended.

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

The screenshot shows a web-based form titled 'Place of death' with the following sections:

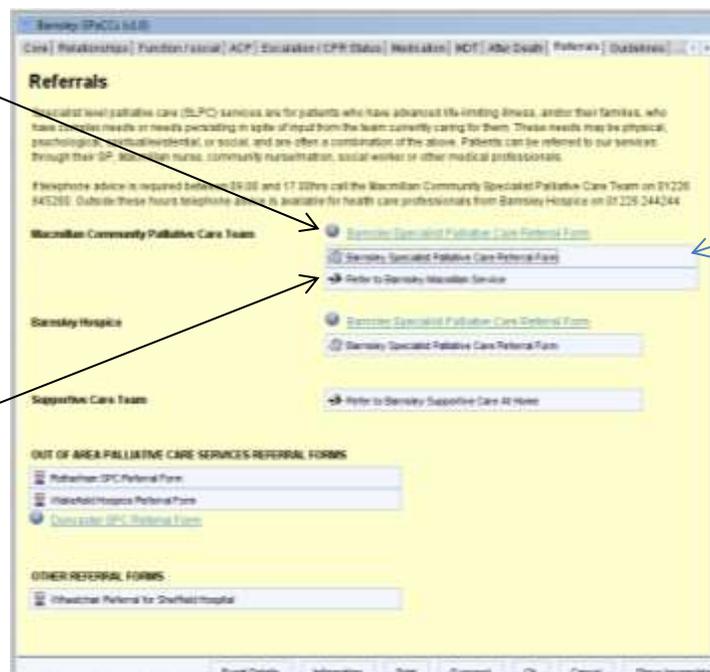
- Preferred place of death:** Includes a dropdown menu and a text area with the message: "Preferred Place of Death view has no data for patient".
- Actual place of death:** Includes a dropdown menu for 'Place of death' and a checkbox for 'Patient died in usual place of residence'.
- Reason preferred place of death not achieved:** A dropdown menu with a note: "If preferred place of death not achieved, please select main reason why preferred place was not achieved. It can be helpful to add 'free text' information to provide more detail for audit purposes".
- After Death Check List:** A checkbox that is currently checked.

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

The screenshot displays the 'EPaCCS Summary View' interface with the following sections:

- Primary palliative care diagnosis**
 - 12 Aug 2018 Cancer - Eye, Brain & Other CNS (Y1003)
Notes: Glioblastoma
- History of illness and treatment**
 - 12 Aug 2018 Clinical history and observations (X76sV)
Notes: May 2018: Presented with seizure. CT scan showed glioblastoma. Commenced keppra and reducing dose of dexamethasone. MDT decision for best supportive care only
- Prognosis**
 - 12 Aug 2018 GSF prognostic indicator stage C (yellow) - weeks prognosis (XaZbD)
- Emergency Care Plans**
 - 12 Aug 2018 EHCP (Emergency Health Care Plan) agreed (XaadB)
Notes: Has had seizures. On keppra. Has buccal midazolam in home which wife has used previously. Aim to commence syringe driver with midazolam 30mg over 24hrs when unable to manage oral medication in order to reduce risk of seizures
This patient is known to the Harrogate Palliative Care Team. If advice needed Monday-Friday 09.30-17.00 contact the team on 01423 553464. Outside these hours contact Saint Michael's Hospice (Harrogate) on 01423 872658.
- Treatment Escalation Plan**
 - 12 Aug 2018 Treatment Escalation Plan (XacZq)
Notes: Comfort symptomatic treatment only
- Advance Care Plans**
 - 12 Aug 2018 Has end of life advance care plan (XaRFF)
Notes: ACP decisions have been made without involving the patient as they lack mental capacity (in their best interests).
- Preferred place of death**
 - 12 Aug 2018 Preferred place of death: home (XaJ3g)
- Resuscitation**
 - 12 Aug 2018 Not for attempted CPR (cardiopulmonary resuscitation) (XaZ9c)
Notes: Patient lacks capacity to make decisions but wife is fully aware of decision. DNACPR form completed and at home