The electronic Palliative Care Summary (ePCS) – First Steps in using ePCS Guidance for Practices

1. Consider which patients to put on the Palliative Care Register.
The GSF Prognostic Indicator Guidance [PIG] http://www.ecs.scot.nhs.uk/wp-content/uploads/Gold-Standards-Prognostic-Indicators-Guidance1.pdf suggests three reasons to add a patient to the register – Clinical Need, Patient Choice and the Surprise Question. "would you be surprised if this patient were to die in the next 6-12 months?" This can be discussed at a team meeting, at a new diagnosis e.g. significant cancer or Heart Failure, or when someone comes home from hospital e.g. severe COPD

2. Explain the concept of ePCS to the patient and ask for their consent to create one.
The Patient Information Leaflet "the ePCS" leaflet http://www.ecs.scot.nhs.uk/wp-content/uploads/ePCS-Patient-Information-Leaflet1.pdf**.** If the patient agrees to have a Palliative Care Summary, their consent needs to be recorded on the ePCS. From there, it can be read by NHS24, OOHs, A&E departments and ambulance (from April 2011). Changes can only be made in the practice.

3. Three things must be done before an ePCS will be sent :

a) The consent box on ePCS must be ticked
If this is not done, data will not be transferred and ePCS information will not be available.
b) A review date must be set
This review date is for practice use – data will still be transmitted after this date but it allows practices to search for people who are due a review in the next week or month etc.
c) Save the changes

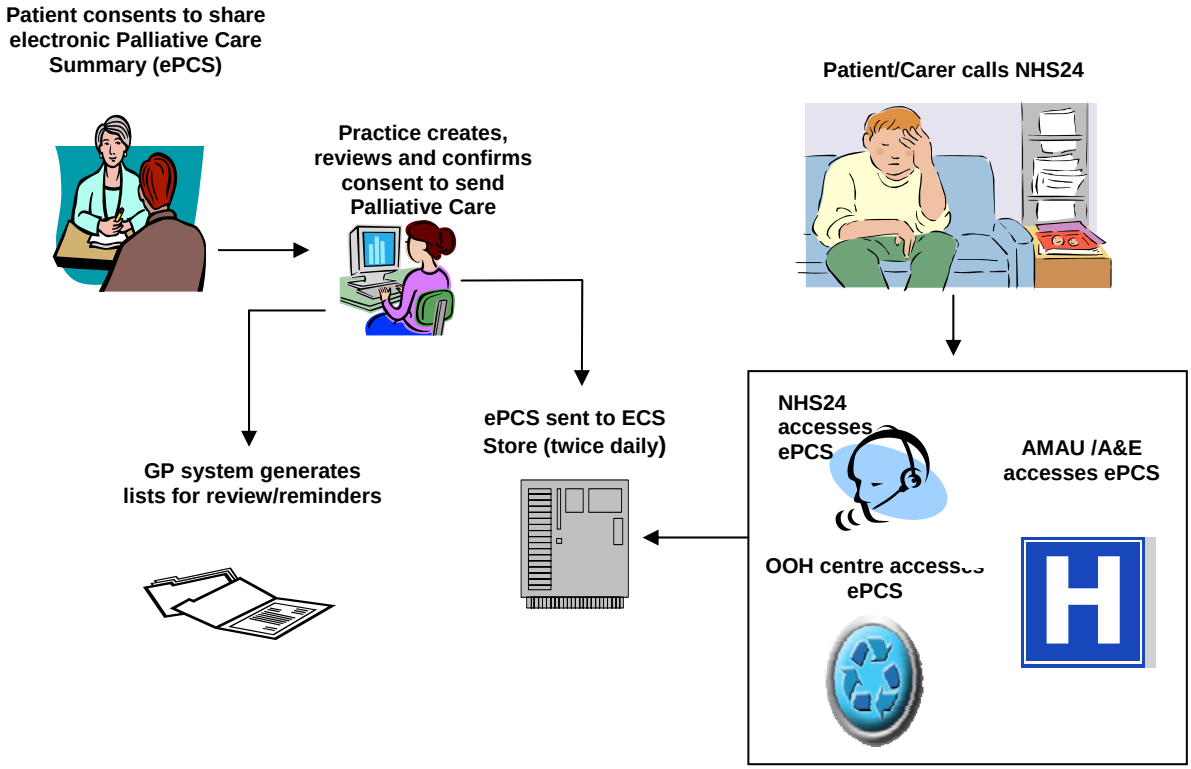
4. Decide with the patient which Medical details to add to ePCS.
ePCS allows a selection of priority Read Codes to be taken from the Medical History. Remember that the form will be viewed by colleagues working out of hours so include the **relevant details**.

5. Complete the rest of the ePCS as appropriate.
Add in details such as patient understanding of diagnosis with freetext (e.g. *"in denial"* or *"aware they have end stage condition")* as required. Such freetext information can be very useful out of hours.
N B FREE TEXT INFORMATION IS LIMITED TO 200 CHARACTERS WHEN IT IS DISPLAYED IN NHS24 AND OOHs.

6. It is NOT intended that every single question be completed at first.
Practices may use it as a dynamic, developing document. Questions such as Preferred Place of Care or DNACPR status are sensitive and may not be appropriate initially.

For more information, incl. ePCS Patient Information Leaflets & training materials see www.scotland.gov.uk/epcs or http://www.ecs.scot.nhs.uk/epcs.html

How does ePCS work?



ePCS – Full Information sent from GP systems	
Date – Updated when sent to ECS	Date – Patient review Date
Patient & Carer Details	**Patient's Own GP and Nurse**
Review date	Usual GP name
Patient Name and CHI	Nurse
Patient Address & Tel Number	Practice details
Carer Details/Next of Kin	
Access Information / potential issues	
Patient Medical Condition	**Current Care Arrangements**
Main diagnoses	Care arrangements
Other relevant issues	Syringe driver at home
Allergies/Drug reactions	Catheter continence products at home
Current drugs and doses	Moving and Handling equipment at home
Additional drugs available at home	
Patient's and Carer's Awareness of Condition	**Advice for Out Of Hours Care**
Patient's understanding of Diagnosis	Care Plan agreed
Patient's understanding of Prognosis	Preferred place of care
Carer's understanding of Diagnosis	Should GP be contacted out of hours?
Carer's understanding of Prognosis	GP Home telephone/mobile/pager
Resuscitation status agreed?	Will GP sign death certificate?
	Additional useful OOH information

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