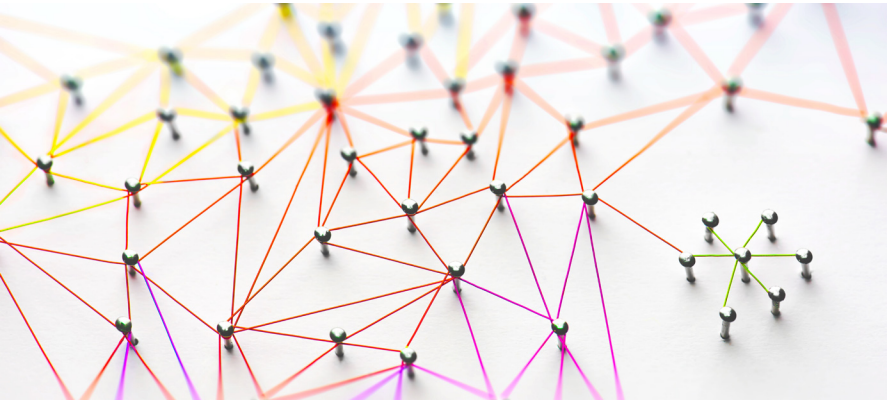
EPaCCS- A SystmOne User's Guide



Developed by the Kirklees EPaCCS Task and Finish Group, 2019

For use with refreshed template, July 2019.

EPaCCS- A User's Guide

What is EPaCCS?

EPaCCs stands for the Electronic Palliative Care Co-ordination System. It can be accessed on SystmOne using the clinical tree and is divided into several sections. Not all the sections have to be completed at once. EPaCCs was developed to ensure that the care of persons felt to be in final year of life was well co-ordinated. It allows professionals to go to one place and find lots of relevant information.

How EPaCCs may benefit the persons in your care will depend on what your role is.

- If you work for an out of hours service it may be appropriate to access the information if a person becomes less well to ensure they receive appropriate care and are not moved from their preferred care location.
- If you work in the community or in social care it may be helpful to have some information about the person's carers and know whether their preference is to stay in their own home.
- For those in primary care, using EPaCCS supports QOF guidance.

What difference does being on EPaCCS make?

National evidence suggests use of EPaCCS enables more patients to die at their preferred place and reduce unnecessary hospital admissions and ambulance journeys, inappropriate interventions, use of unscheduled care and repeated 'difficult conversations'.

EPaCCS also:

- Promotes multi-agency working
- Encourages good inter-professional communication
- Important information is documented in one place and accessible to many professionals

Tips and tricks

- If there is a green pencil icon, this means that some free-text information has been inputted. Left click on this to reveal.
- Not all persons with an EPaCCs record may be known to the palliative care team.
- EPaCCS is a quick point of call within S1 for entering information, and for finding and viewing it.
- It is NOT a tick box exercise; it is a person-focussed tool.

EPaCCS is all about the person and supporting them to make choices where they are able...

My choices are shared with all the professionals are involved within my care.

I have an Advance Care Plan in place and this is recorded, communicated and co-ordinated.

I understand my illness and prognosis.

I have the opportunity to consider and discuss my choices with those close to me.

I am referred for specialist assessment if my symptoms or problems are complex and difficult to manage.

I have the chance to agree what happens in the future if I choose to do so, and this is documented.

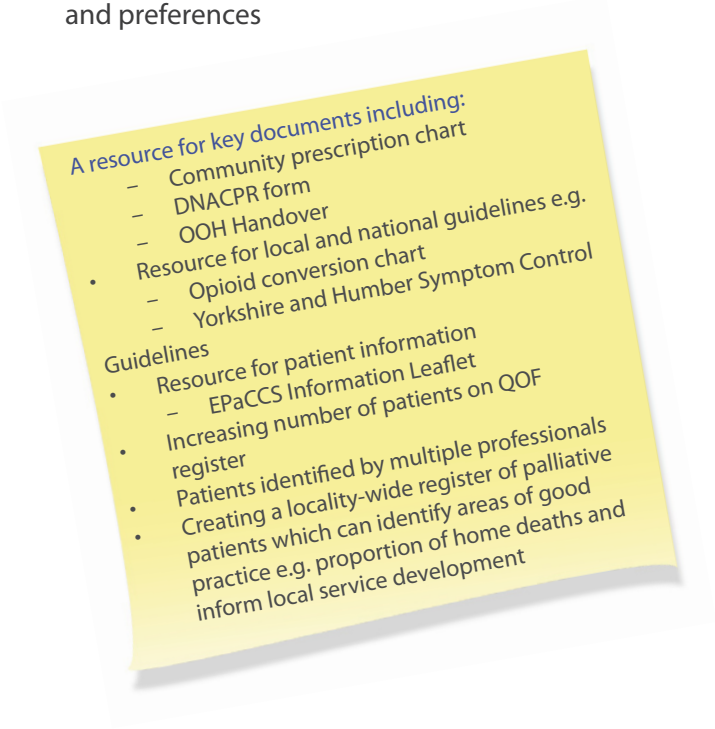
What are the benefits?

There are number of benefits associated with using EPaCCS:

- Improved efficiency (and effectiveness of GSF meetings)
- Patients are identified including GSF status
- Reports can be run prior to meetings and missing information is identified in 'summary view'
- Can review deaths, reflecting on positive and negative experience using as a learning experience

Whilst the template might look big and busy:

- It doesn't all have to be completed at once
- You can input as much or as little on to it at any time
- It is multidisciplinary: anyone can enter information on to it (with consent)
- All the little bits add up to create a bigger picture of the patient's illness and preferences



When should an EPaCCS record be created?

An EPaCCS record should be created as soon as a person has been identified as being within the last year of life.

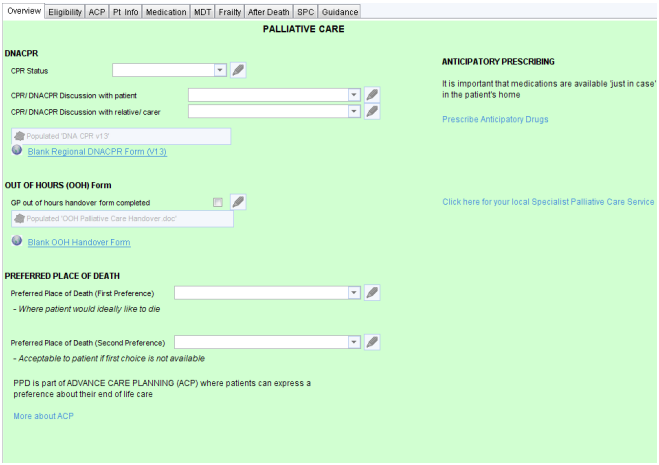
General indicators of poor or deteriorating health as detailed within the Supportive and Palliative Care Indicators Tool (SPICT™) include:

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility (e.g. the person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- The person has had significant weight loss over the last few months, or remains underweight.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Multiple unplanned hospital admissions should also be a prompt for EPaCCS.

Would you be surprised if this person dies within the next 12 months? If not, create an EPaCCS.

Overview



This page provides all the key information for a person. This is the priority page to complete. Some of the important concepts covered include:

DNA CPR:

- Any significant information about the discussion (e.g. a person's reaction or comments) or any other relevant information.
- all discussions around resuscitation should be documented.
- It is important to document which relative/carer it has been discussed with (free text) to avoid confusion and family distress.

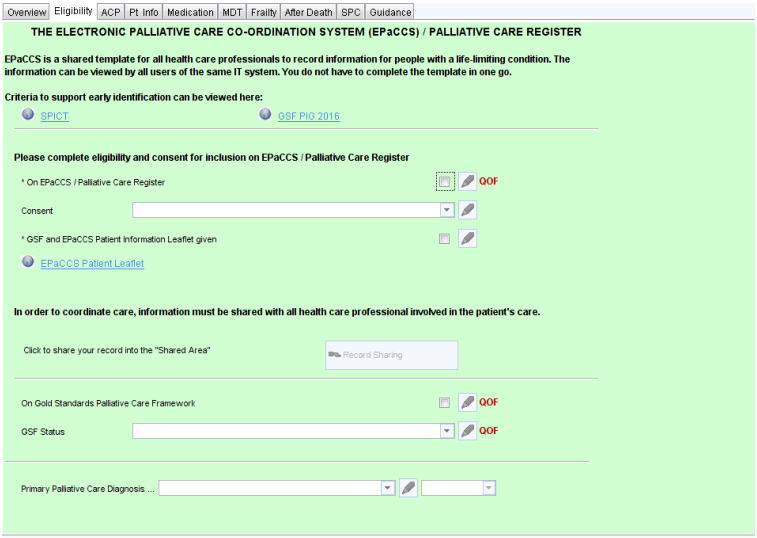
Preferred place of death:

- Preferred place of care v Preferred Place of death: again free text reasons for choice – they might be compelling and may influence decisions (e.g. a person may not want to die at home, there may be family dynamics to consider, or may be important to be at home because of faith and family tradition, etc.).

Anticipatory medication:

- Ensuring anticipatory medication is in place is a key part of proactive end of life care. For a person and their carer this should be framed as having medication available in the house just in case a DN or GP needs to give something in the event of a sudden problem – which then saves having to find OoH chemist and unnecessary delay.
- Medications will be listed in the box at the bottom of the screen, so it's possible to see whether anticipatory medications been prescribed without having to leave the EPaCCS template.

Eligibility



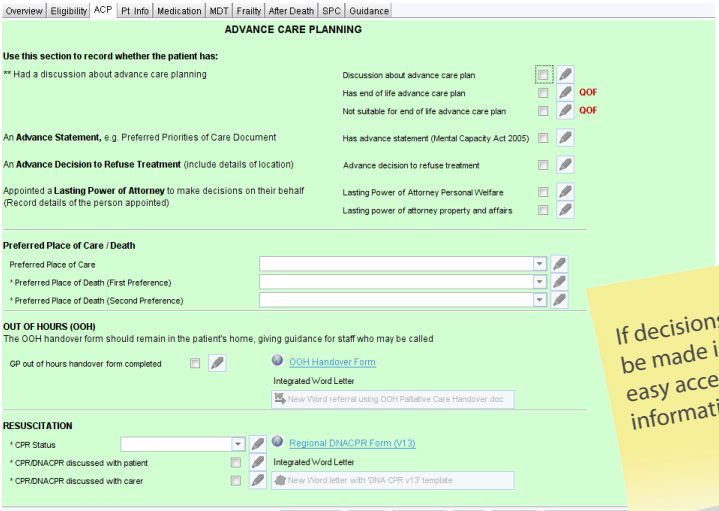
This tab is entitled 'Eligibility' and is where person consent will be documented. There is also some brief information about diagnosis and expected prognosis.

Consent:
Record sharing consent needs to be gained, if record sharing is not set to share out, please ensure you do so. This box must be completed because a person has a right to know that their illness is palliative (i.e. life limiting). Completion of consent indicates that a conversation has been with them about the palliative status of their illness. This also supports auditing the use of EPaCCS.

QOF codes for GSF status – to be entered by GPs only (or with their approval)

- Reviewing QOF codes for GSF status allows us to see whether people are being identified early enough in their illness before being put on EPaCCS.
- There are other codes which GPs may be using (red, amber, green) – might be worth switching to the template codes as they form part of the reporting and evaluation data – and are more helpful in terms of e.g. prognosis.

Advance Care Planning



If decisions need to be made in a hurry, easy access to this information is vital.

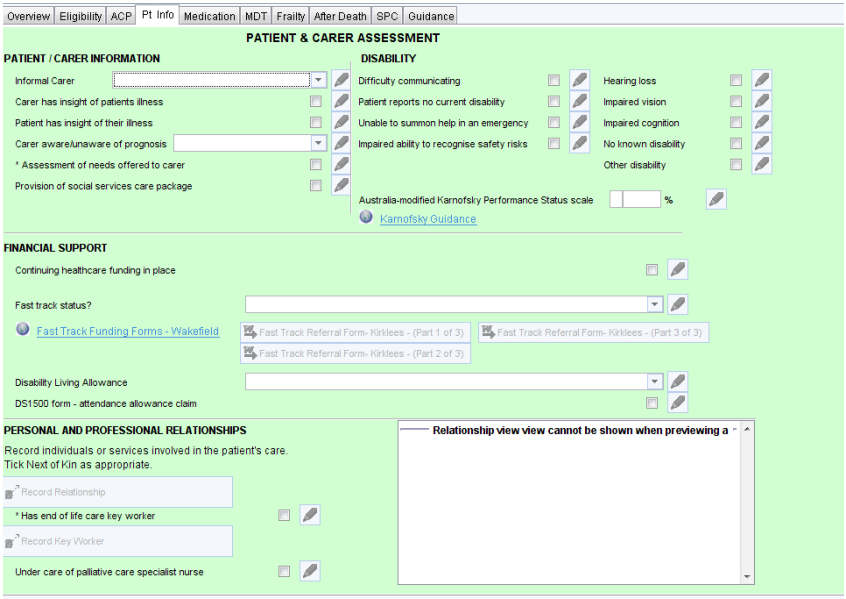
An essential part of palliative care is Advance Care Planning (ACP).
Advance Care Planning should be about enabling people to live well until they die. An Advance Care Plan is an expression of preferences- which may be verbal. This makes clear what a person's wishes are, recognising that they may deteriorate and not be able to communicate their wishes to others or have capacity to make decisions as their illness progresses.

Discussions need to be recorded given that these may be an evolving process - and so keeping an up to date record of where things are in terms of ACP allows the next health professional involved to move discussions on incrementally and for the person to feel that care is co-ordinated if previous discussions have been documented.

This tab can also be used to record if a person does not want to have these discussions.

Please use free text here to allow documents to be found quickly and easily. This includes:
Advance Statement (a written declaration of preferences) - use free text to say where the Advance Statement is kept or whether it is scanned onto S1 (including date)
ADRT- free text what the person has refused and where to find the documentation
LPA- free text who it is, how to contact them and where the documentation is kept.

Patient and Carer Information



Carer information:

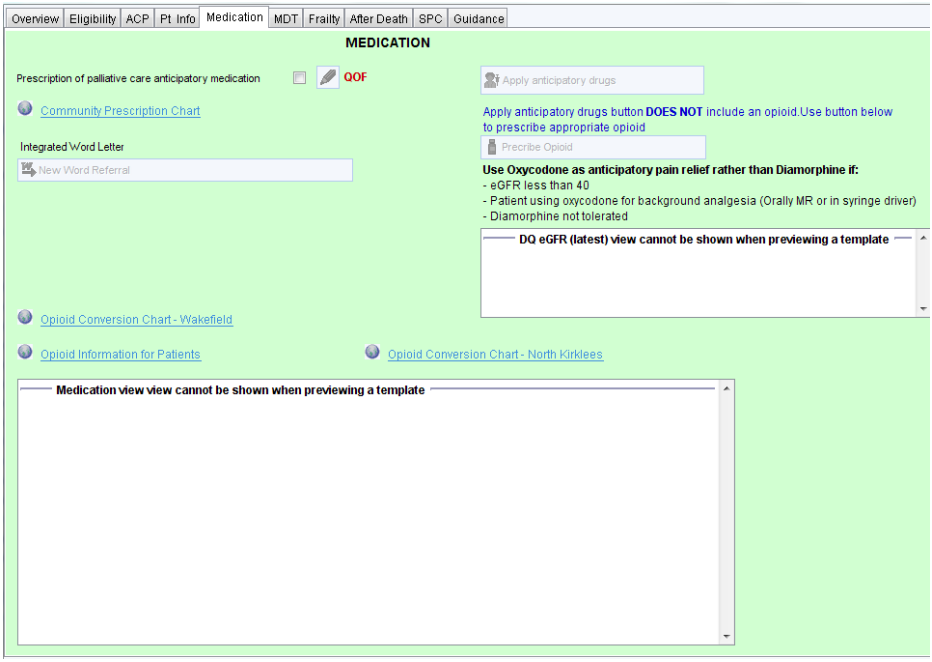
Recording who the unpaid carer is and their relationship to the person, as well as their insight of the illness, allows us to avoid any assumptions about what the person and their carer may understand. It also helps us to 'pitch' our conversations accordingly.

Financial support:

Capturing whether a referral to social services has been offered and whether a care package is in place may impact on your decisions (e.g. place of care) if as a health professional you know whether the person has support or not.

If the person is in the final short weeks of life then it may be appropriate to apply for fast track funding. You can look in the patient/carer tab to see if this has already been done.

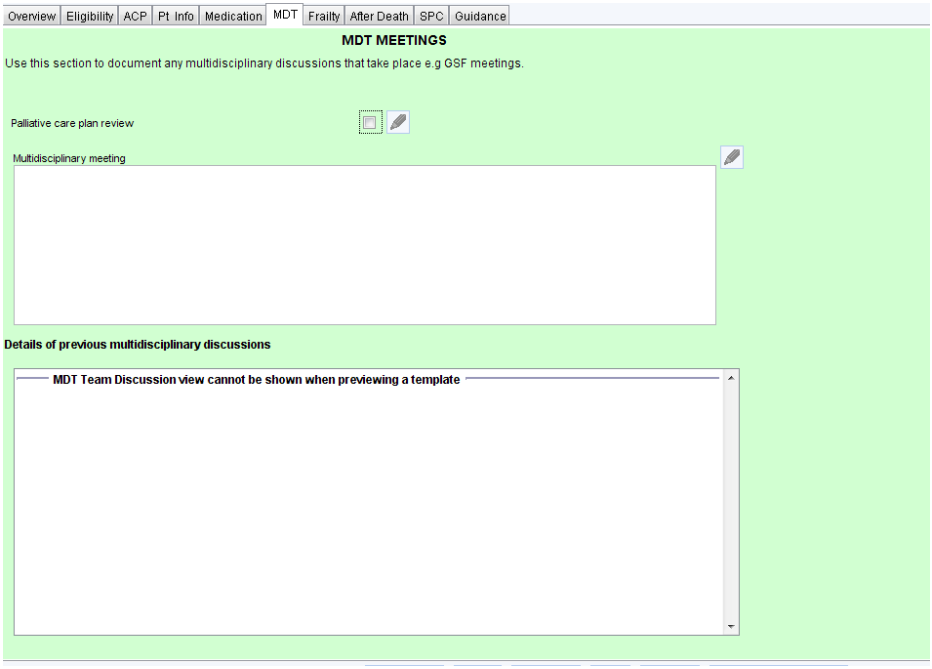
Medication



Medications are listed in the box at the bottom of the screen, so it's possible to see whether anticipatory medications been prescribed, or this tab can be used to prescribe, without having to leave the EPaCCS template.

Resources such as the opioid conversion chart and symptom management booklet are hyperlinked.

MDT



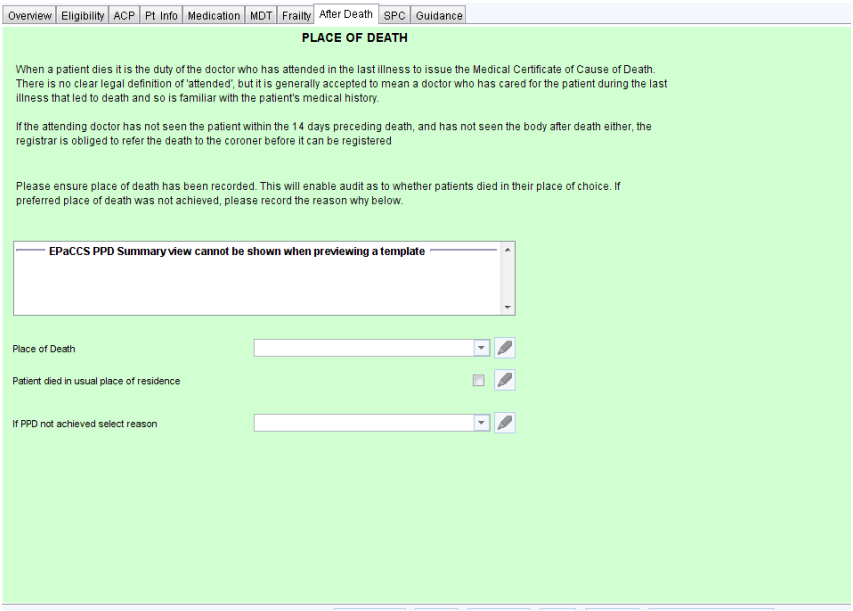
GP practices might like to use this is a template for GSF/palliative care review meetings.

Documentation from previous meetings will be visible below, so it is possible to see a chronological progression throughout the illness.

Frailty

If a person has been identified as being frail and coded accordingly, this can be showed within this tab.

After Death



Recording preferred place of death and actual place of death allows us to consider whether there are any deficits in service provision. Any improvements which can be made to achieve the preferred place of death ultimately improves patient care and the experience for carers.

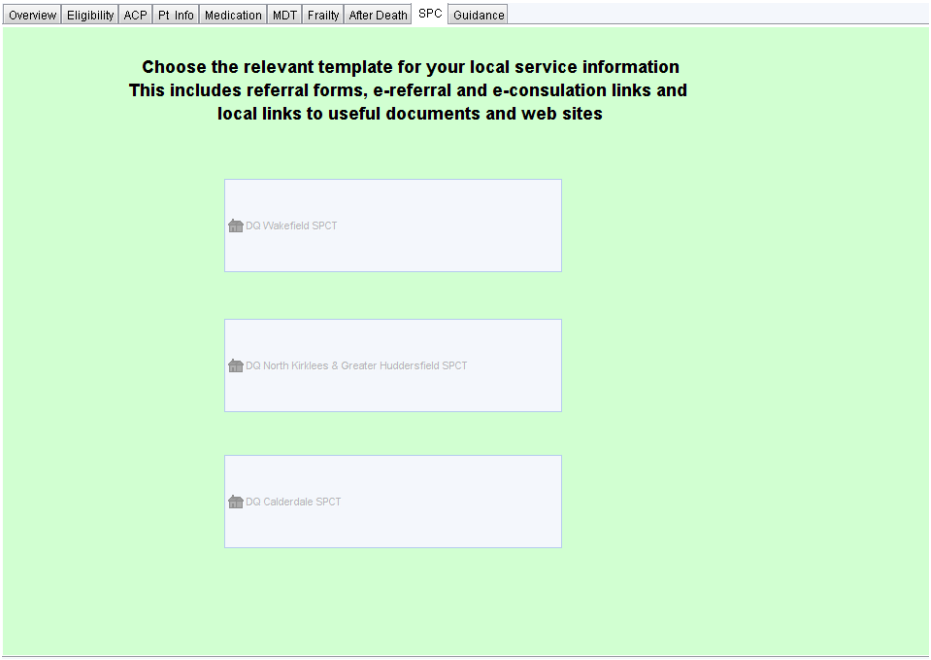
Free texting why the preferred place of death was not achieved helps us to identify why not, in line with QOF QI guidance.

This may well be an administrative task to complete this – whoever would normally record the practice deaths on S1 could potentially use this tab on the template.

This might raise questions and considerations:

- Is there a lack of support for patients dying at home (lack of education or lack of care package provision)?
- Are we not anticipating symptoms sufficiently well at home – can we improve?
- Did we not pick up on the fact that the carer was struggling to cope – could we have got carer support in earlier?

Specialist Palliative Care (SPC)



Where there is a complex specialist palliative care need, we would suggest timely referral to SPC services- in Kirklees this is Kirkwood Hospice.

A wide range of support is available including community SPC nursing input, self-management programmes, drop in services and bereavement support. Patients should have an active, progressive and potentially life threatening illness.

Patients should have unresolved, complex needs that cannot be met by their current caring team, or it is anticipated that the patient may develop these needs in the future. These may be psychological, social, spiritual or physical needs.

Remember, EPaCCS is about the person and their wishes:

- Imagine you'd never met the person – what would you want to know?
- Put as much relevant, concise information on as possible.
- The quality of the information is only as good as the quality of the information entered.
- It is important it is kept up to date.
- It's for everybody to contribute to.
- Even if you only add one piece of information, it adds something and helps the next professional who sees the patient to understand more
- It's a quick and easy reference point to find important information quickly.
- It is also full of useful resources, links and websites.

Who can I contact for further advice or support?

The Kirklees EPaCCS Task and Finish Group can be contacted for further information, advice and support through emailing:
Sadaf.adnan@kirkwoodhospice.co.uk

Regular EPaCCS training and education sessions for staff within Kirklees are also being considered by the Group.