EMIS Web EPaCCS template guide

February 2015



Cheshire and Merseyside Strategic Clinical Networks



Greater Manchester, Lancashire and South Cumbria Strategic Clinical Networks

The importance of EPaCCS in supporting End of Life Care by Dr Peter Nightingale (RCGP)

Introduction

Caring for a patient right through to the end of life can be one of the most satisfying aspects of general practice, but it is also one of the most challenging.

Most people prefer to be cared for at the end of their lives at home, with dignity and their symptoms controlled, but many fail to achieve this. The current situation of multiple admissions in the last year of life, many of which are unplanned and potentially avoidable, is unsatisfactory for patients and does not make the best use of resources.

Many of us have been working hard to find the 1% of patients within our practice likely to be in the last year of life, and take a more proactive approach to their care, but this is not always easy.

In order to effectively identify and support patients we need to use both national and locally developed tools to proactively manage care.

Having recognised a patient might be within the last year(s) of life, it is beneficial both to the patient and their families to proactively manage care. This is likely to support patients to be cared for in the place of their choice and to reduce the likelihood of unnecessary investigations, interventions and hospital admissions. The use of an EPaCCS system should help collect key information about the patient and their care, help shape multidisciplinary team meetings and encourage information sharing across the wider system.

Previously known as locality registers, electronic palliative care coordination systems (EPaCCS) enable the recording and sharing of people's care preferences and key details about their care with those delivering care. The systems support co-ordination of care and the delivery of the right care in the right place, by the right person, at the right time.

There is strong evidence that EPaCCS supports patient choice, shared decision making, individual care planning and integration of care across sectors. Many areas have already implemented or are in the process of implementing EPaCCS across localities. Available data suggests that their use helps people to die in their preferred place of death, decreases the percentage of hospital deaths and increases the percentage of deaths at home and in hospices. Other key benefits include improvements in communication and information sharing between healthcare professionals and support for making appropriate decisions about patients' care.

The Electronic Palliative Care Co-ordination System (EPaCCS) template EMIS Web version

This template is for all EMIS Web users to enter information for patients considered to be in their last year of life. It is not an EPaCCS on its own, but is standardised to match all other templates across the North West to ensure easy communication between systems once this becomes possible – for this reason, please use only the terms listed (with their underlying Read codes) to enter End of Life Care information.

The template is named the 'End of Life & Palliative Care Co-ordination' template and can be found in Templates & Protocols > EMIS Library > Extended Healthcare (it replaces all previous palliative or end of life care templates, such as the Macmillan palliative care template). It has been updated to incorporate all the changes made by the Information Standard Board for Health and Social Care, reference ISB 1580 Amd16/2013. For further information about ISB 1580 and the changes that have been made to this template go to <u>http://www.isb.nhs.uk/documents/isb-1580/amd-16-2013/index_html</u>

The template is divided into the following eight pages to correspond to the elements of End of Life Care:

- 1. Summary of EoLC Status / Plans
- 2. EoL Diagnosis and Function
- 3. Demographic and Social
- 4. Carers

- 5. Patient Preferences
- 6. Care and Support in the Last Days of Life
- 7. Death Details
- 8. Template Information

This template is intended to facilitate greater continuity of care across all health providers (including NWAS). It includes important patient information that may be required in order to provide optimum care to patients.

The template has been designed to include the Qualifying diagnostic Read codes from the GMS Contract QOF Palliative Care indicator set 2014/15 (Palliative care ruleset_v28.0), highlighted below with a yellow border. It also uses the Read code for 'GSF Prognostic Indicator Stage A (blue) - year plus prognosis' to help GPs identify vulnerable patients and meet the DES requirement for case management registers, protecting patients from unplanned admissions.

Who is responsible for completing this template?

• The GP or a designated person within the practice.

How frequently does the information need to be updated?

- Following any End of Life Care discussions or on completion of any type of Advance Care Plan, or after any significant change occurs.
- Following receipt of any End of Life Care information from other health providers.

Please refer to the Revised North West End of Life Care Model 2015 for further details on when to update EPaCCS information (see Other Useful Resources).

NB - Following the death of a patient, it is important that you complete the Death Details page, to ensure your locality's EPaCCS is suitably updated.

Patient consent

It is important, as part of an End of Life Care conversation with a patient, to explain that they need to give their consent for their wishes and care preferences to be shared with the other organisations potentially involved in their end of life care (such as the ambulance service, out of hours GPs, hospices, hospitals etc) as without consent this will not happen. In the case of a patient lacking capacity this consent will need to be provided by someone acting in their best interests (see below for definitions).

9Nu6.	Consent given for sharing end of life care coordination record		
9Nu7.	Withdrawal of consent for sharing end of life care coordination record		
9Nu8.	Best interests decision taken (Mental Capacity Act 2005) for sharing end of life care coordination record		
9Nu9.	Consent given by legitimate patient representative for sharing end of life care coordination record		
9Nu90	Consent given by appointed person with lasting power of attorney for personal welfare (MCA 2005) for sharing end of life care coordination record		

Once consent has been given, subsequent conversations should not need to revisit the consent issue, even if information is being recorded on another system, as the consent given is for the sharing of an "end of life care coordination record" across all of the systems involved in the EPaCCS.

Consent for sharing via the MIG

If information entered on your EMIS Web system is being shared with other organisations through the use of the Medical Inteoperability Gateway (MIG) provided by Healthcare Gateway Ltd, then an additional two codes come into play:

93C0.	Consent given for upload to local shared electronic record
93C1.	Refused consent for upload to local shared electronic record

The 93C1. code **blocks all data** from leaving the GP practice for the patient, regardless of any of the other End of Life Care consent codes above being entered. Therefore, it is crucial that this is properly explained to the patient, so that there is no confusion about what is or isn't being shared. If a patient had previously not wanted to share any information, but then wants to have their wishes and care preferences shared with the other organisations potentially involved in their end of life care, it will be necessary to either remove the 93C1. code or add code 93C0. to counter it.

NB - It is therefore crucial that in the case of a patient lacking capacity where a 93C1. code had previously been applied, that if a best interest decision is taken, or consent is given by a legitimate patient representative or lasting power of attorney, the 93C1. code is also removed (or 93C0. applied), to allow the information to be shared.

These eight pages group together aspects of the patient's End of Life Care.

Add patient to EPaCCS

This is the date that the patient has been identified as potentially being in their last year of life. DO NOT re-enter this date. If entering retrospectively for someone previously identified, but not added to the EPaCCS, please ensure vou enter the date they were identified and not today's date.

Personal care plan completed

A personal care plan (sometimes known as a 'support plan') documents the care and treatment actions necessary to meet a person's needs, preferences and goals of care. These must have been agreed with the person receiving care or by those acting in the person's best interests as part of a comprehensive holistic assessment.

This is different from advance care planning which is about preferences and wishes for future care.

DS 1500 Disability living allowance

Please note - this field will be updated to refer to the Personal Independence Payment (PIP).

If the patient has a terminal illness or progressive disease and are not expected to live for longer than six months, they may be able to apply for benefit under special benefit rules called the Special Rules.

The advantages of making a claim under the Special Rules are:

- It is easier
- Claims are dealt with faster
- You automatically get the highest rate of benefit
- Benefit can be paid straight away ٠

Summary of EoLC Status / Plans

femplate Runner				
•				
Template Runner				
Pages	Add patient to EPACCS (Electron			
Summary of EoLC Status / Plans		for them to be recognised as	peing on the Palliative Care register in QOF	, please select the option below.
EoL Diagnosis and Function	This only needs recording once.			
Demographic and Social	Date person placed on end of life		•	No previous entry
Carers	register		13-May-2013	
Patient Preferences	End of Life Tool Used			
Care Pathway for Dying	GSF Supportive Care Stage		•	No previous entry
Death Details		ext		
Template Information	GSF Prognostic Indicator Stage		•	No previous entry
remplace information		Text		
	Care pathway for dying			No previous entry
		Text		
	Care Plan			
	Everyone in their last year of life should	I have a personal care plan or n	anagement plan. Please enter care plan o	letails in the free text box below.
	Personal care plan completed	Text		No previous entry
	Palliative care plan review	Text		No previous entry
	DIARY: Palliative care plan review	Pollow Up	13-May-2013	No previous entry
	Assessment of needs	Text		No previous entry
	Multidisciplinary review			No previous entry
	Notif to primary care OOHS of palliative care plan in place	Text		No previous entry
	DS 1500 Disability living allowance			No previous entry
	Electronic Record Sharing			
	Use this template only to record the pa	atient's preferences for the sha	ring of electronic records outside of EMIS.	
	For Summary Care Record or record sha template.	aring with other services using	EMIS across organisation boundaries, please	e use the Sharing screens outside of this
	Electronic Record Sharing Consent		•	No previous entry
		Text		
	Lack mental capacity make decision Mental Capacity Act 2005	Text		No previous entry

Lack mental capacity make decision (MCA 2005) If the patient lacks capacity, the consent will need to be obtained through a best interest decision, a legitimate patient representative, or appointed person with lasting power of attorney.

GSF Supportive Care / Prognostic Indicator Stage

Please indicate the stage of the patient's illness, by using either coding to suit the needs of the care setting, in line with local GSF practice.

NB - using the code for GSF Prognostic Indicator Stage A (blue) - year plus prognosis helps GPs meet the DES requirement for case management registers, and can help protect patients from unplanned admissions.

Care pathway for dying

Please note – this field will be updated when codes are available for the Individual Plan of Care and Support for the Dying Patient in the Last Days and Hours of Life.

Palliative care plan review

This is where you can log the recent GSF/Palliative care/MDT meeting, or individual review, and add a DIARY entry for the next review (e.g. at the next GSF/Pall. care/MDT meeting). These meetings must take place at least once every three months, but the frequency of review will vary depending upon the stage and complexity of the person's illness and their circumstances. This date may therefore need adjustment (e.g. if there is a change or deterioration in a person's condition or in their personal circumstances).

Read codes from QOF	9Ng7.	On end of life care register
Palliative Care	8CM1.%	On gold standards palliative care framework
indicator set 2014/15	9EB5.	DS 1500 Disability living allowance (terminal care) completed

EoL Diagnosis and Function

	Primary End of Life Diagnosis		
	Please free text the end of life diagnoses	below.	
	Diagnosis	22-0c	t-2014 🔢
		Text	End of life diagnosis:
	Disabilities affecting care		
	Hearing impairment	Text	
Disabilities affecting care	Visual impairment	Text	
These fields flag any additional	Difficulty communicating	Text	
disabilities that would potentially impact on the patient's care needs.	Cognitive impairment	Text	
impact on the patient's care necus.	Mobility (select as many as apply)		
	Ability to perform personal care activity		
		Text	
	Unable to summon help in an emergency	Text	
	Impaired ability to recognise safety risks	Text	
	Cardiac devices fitted		
		Text	
	🔲 No known disability	Text	
	Patient reports no current disability	Text	
	Physical disability	Text	
	Other Disabilities	Text	
Madified Version false Desfermences Carls (TDDC, COM DD)			

Modified Karnofsky Performance Scale (IP35, COM 32)

The Karnofsky performance scale is a measure of the patient's overall performance or ability to perform activities of daily living. It is a single score between 10-100 assigned by a clinician work and self care.

Scoring scales:

100%=Normal, no complaints or evidence of disease 90%=Able to carry on normal activity, minor signs or activity 80%=Normal activity with some effort, some signs of symptoms 70%=Care for self, unable to carry normal activity or do active work 60%=Occasional assistance but is able to care for most needs 50%=Requires considerable assistance and frequent medical care 40%=In bed more than 50% of the time 30%=Almost completely bedfast 20%=Totally bedfast and requiring nursing care and/or family 10%=Comatose or barely arousable
0%=Dead

Modified Karnofsky Performance Scale

/100

Primary End of Life Diagnosis

This refers to the main life-limiting illness. The following list can be used as a guide:

- cancer/malignant disease (breast)
- cancer/malignant disease (CNS tumour)
- cancer/malignant disease (colo-rectal)
- cancer/malignant disease (gynae/cervix)
- cancer/malignant disease (gynae/ovary)
- cancer/malignant disease (gynae/uterus)
- cancer/malignant disease (haematological)
- cancer/malignant disease (head/neck ca)
- cancer/malignant disease (lung ca/mesothelioma)
- cancer/malignant disease (other)
- cancer/malignant disease (unknown primary)
- cancer/malignant disease (upper GI/liver)
 - cancer/malignant disease (upper GI/oesophagus)
- cancer/malignant disease (upper GI/pancreas)
- cancer/malignant disease (upper Gl/stomach)
- cancer/malignant disease (urological/bladder)
- cancer/malignant disease (urological/kidney)
- cancer/malignant disease (urological/prostate)
- cancer unknown

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- chronic renal failure
- chronic respiratory disease
- dementia / Alzheimer's
- frail / elderly
- heart failure
- motor neurone disease
- neurology
- other heart and circulatory conditions
- all other conditions please specify

Demographic and Social

Language		
Main spoken language	- 🎤	05-Oct-2010 Main spoken I »
If the language cannot be found in the r	nain spoken language list, search the Additional and Supplemental lists.	
Additional main spoken language	-	05-Oct-2010 Main spoken I 🔌
Supplemental main language spoken	▼	No previous entry
Interpreter not needed		No previous entry
Need for interpreter	▼	No previous entry
Religion		
Are there any religious or spiritual needs i	mpacting on care?	
If so, please record the patient's religion	then describe the impact on care	
Religion	▼	No previous entry
	Text	
Social		
Usual place of residence	•	No previous entry
	Text	
Other social issues - select as many as apply		No previous entry
0pp,j	Text	

Carers

	Informal Carers			
	Please enter contact details for any ca	arers		
Main Informal carer	🔫 🥅 Main Informal carer	Text	No previous entry	Patient's next of kin
This would be the main carer	Carer - home telephone number	Text	No previous entry	This person may differ from the main
(a family member or friend) who	Carer - work telephone number	Text	NO previous entry	informal carer.
has agreed to take on this role.	Carer - mobile telephone number	Text	No previous entry	
	🔲 Patient's next of kin 🚽	Text	No previous entry	
	End of Life Care Key Worker det	tails		
	Please provide details of the patient's	End of Life Care Key Worker in the free text box below.		
Has end of life care pathway key worker	Has end of life care pathway key worker	Text	No previous entry	
This is the key professional	Has end of life care pathway key general practitioner	Text	No previous entry	
who co-ordinates the End of Life	Other formal carers or services	involved		
Care of the patient.	Please provide details of each health a contact telephone numbers	and social care agency involved. Use the free text boxes to provide the	names of health care professionals and their	
	Select as many as apply			
	Community Services involved		No previous entry	
	Hospital specialists involved		No previous entry	
	Other services involved		No previous entry	
	Full care by hospice	Text	No previous entry	
	Shared care - hospice / GP	Text	No previous entry	
	Shared care - specialist / GP	Text	No previous entry	

Read codes from QOF	9NNd.	Under care of palliative care specialist nurse
Palliative Care	9NNf0	Under care of palliative care physician
indicator set 2014/15	9NgD.	Under care of palliative care service

Has advance statement (Mental Capacity Act 2005)

This is a general statement of a patient's wishes and views. It allows a patient to state their preferences and indicate what treatment or care they would like to receive should they, in the future, be unable to decide or communicate their wishes for themselves. It can include nonmedical things such as food preferences or whether they would prefer a bath to a shower. It could reflect their religious or other beliefs and any aspects of life that they particularly value. It can help those involved in their care to know more about what is important to them. It must be considered by the people providing their treatment, when they determine what is in their best interests, but they are not legally bound to follow the patient's wishes.

PPC

Refers to a version of an advance care plan that is available to download. It is likely to contain the patient's advance statement of wishes and preferences including their preferred place of care at the end of life or maybe where they would prefer to die. Further information can be downloaded at http://www.nhsiq.nhs.uk/resourcesearch/publications/eolc-ppc.aspx

PPD

Some patients will choose to discuss their preferred place of death or this may have been previously written down within an advance care plan.

Patient preferences

Introduction

If there are any preferences or wishes recorded (e.g. PPC, ADRT, DNACPR, LPA, PPD), please record the location of any physical documentation in the relevant text boxes below.

Advance Care Planning Please provide name and telephone numbers of other persons identified in an advance statemen to be consulted on decisions about care i that they lose mental capacity Has advance statement (Mental No previous entry Capacity Act 2005) Has end of life advance care plan No previous entry Best interest decision made on No previous entry behalf of patient (MCA 2005) PPC (Preferred Priorities for Care) Preferred priorities for care No previous entry document completed Discussion about Preferred Place of Care No previous entry Preferred Place of Care No previous entry PPD (Preferred Place of Dying) biscussion about preferred lace of No previous entry death Preferred place of dving (1st choice) No previous entry Text 1st choice Preferred place of dying (2nd choice) No previous entry Text 2nd choice Preferred place of death: 1st choice is usual place of residence 1st choice No previous entry Preferred place of death: 2nd choice 2nd choice No previous entry is usual place of residence DNACPR (Do not Attempt Cardiopulmonary Resuscitation) Decision Discussion about resuscitation No previous entry Please indicate date of DNACPR decision and location of DNACPR documentation

DNACPR Decision 13-May-2013 DIARY: Resuscitation status Review Follow Up 13-May-2013 ADRT (Advance Decision to Refuse Treatment) iscussion about ADRT Please indicate location of ADR documentation Person has made an Advance Decision to -Refuse Treatment LPA (Lasting Power of Attorney) Please provide name and telephone number of person appointed as LPA Authority of LPA • Type of LPA DNACPR

Please refer to the Unified DNACPR policy.

Has end of life advance care plan

Has the same meaning as an advance statement but it more likely to refer to a patient's preferred place of care at the end of life or maybe where they would prefer to die.

Best interest decision made on behalf of patient

If a person lacks mental capacity to make a particular decision then whoever is making that decision or taking any action on that person's behalf must do this in the person's best interests. They should take into account any evidence they have of the patient's past wishes, their beliefs and values, and they should consult the patient's friends, family and carers where appropriate. The law gives a checklist of key factors which decision makers must consider - further information can be found at http://www.bestinterests.org.uk/best interests/

ADRT

If a patient makes an advance decision to refuse life-sustaining treatment, it must meet certain requirements set out in the Mental Capacity Act. Lifesustaining treatment is defined in the Act as treatment that, in the view of the person providing health care to the person concerned, is necessary to sustain their life. This could include artificial nutrition and hydration to someone who cannot eat or drink by mouth. The legal requirements for a valid advance decision to refuse life-sustaining treatment are as follows:

- The decision must be in writing. The patient can ask someone else to write it down.
- The patient must sign the document. They can instruct someone to sign it on their behalf in their presence if they can't sign it themselves.
- Their signature (or the signature of the person signing on your behalf) must be witnessed. The witness must also sign the document in the patient's presence.
- They must include a written statement that the advance decision is to apply to the specific treatment even if their life is at risk

Further information can be downloaded at <u>http://www.adrt.nhs.uk/</u>

Care and Support in the Last Days of Life

(tab is currently called **Care Pathway for Dying** – will change on next template update)

	Anticipatory Medicines / Just in C	ase Box Issued		
	Please indicate the location of the antici	patory medicines box		
	Issue of palliative care anticipatory medication box	Text		No previous entry
	Syringe driver commenced			No previous entry
	Syringe driver discontinued			No previous entry
	Oxygen			
	Home oxygen supply - cylinder			No previous entry
	Home oxygen supply - concentrator			No previous entry
	🔲 Home oxygen supply - liquid oxygen			No previous entry
	Other relevant Issues or preferen	ces about Provision of Care		
	Wishes to be donor	Text		No previous entry
	Consent to donate organs given	Text		No previous entry
	Discharged from hospital		13-May-2013	No previous entry
		Text		
	Awareness of Prognosis			
	Informing patient of prognosis			No previous entry
	Is the main informal carer aware of prognosis?		•	No previous entry
	progross:	Text		
	Medical Certificate of Causes of De	eath		
	Notification to primary care OOHS of anticipated death	Text		No previous entry
		ernative GPs able to issue a Medical Certificate	of Causes of Death in the ev	ent of your absence.
	1st alternative GP able to issue Medical Certificate of Causes of Death		۵. ۳	
	2nd alternative GP able to issue Medical Certificate of Causes of Death		~	
	/			
Notification to primary care OC For all Greater Manchester GPs whether a Statement of Intent t of Death has been completed.	•	ause		

Read code from QOF Palliative Care indicator set 2014/15

Death Details

D	etails about Death			
	Please ensure that all death details are co	mpleted as soon after a patient's death as poss	ible.	
	Date of death	Γ	13-May-2013	No previous entry
	Place of death			 No previous entry
			13-May-2013	
	Cause of death			No previous entry
		Text		
Date of death / Place of death				
These two sections MUST be complete	d as soon as possible			
after a patient's death.				

Template Information

emplate Runner				
Pages «	Template Information			
ummary of EoLC Status / Plans	This template has been developed to mee	t ISB 1580 "End of Life Care Co-ordination: Core Content".		
oL Diagnosis and Function	ISB 1580, produced by the Information Standards Board for Health and Social Care, aims to improve the co-ordination and quality of care provided for people at the end of life.			
emographic and Social	The standard supports communication about end of life care plans between providers such as:			
arers	 Primary and community care teams Secondary care teams 			
atient Preferences	 Social care providers 			
are Pathway for Dying	 Ambulance services Out of hours services 	Other useful resources		
eath Details	Further information about ISB 1580	The Revised North West End of Life Care Model 2015		
emplate Information		http://www.gmlscscn.nhs.uk/index.php		
		Find Your 1% Campaign - <u>www.dyingmatters.org/gp</u>		
		End of life Care - http://www.nhsiq.nhs.uk/improvement-programmes/long-ter		
		<u>conditions-and-integrated-care/end-of-life-care.aspx</u>		
		National Council for Palliative Care - <u>www.ncpc.org.uk</u>		
		The Gold Standards Framework - http://www.goldstandardsframework.org.uk		
		Guidance on QOF - <u>http://www.nhsemployers.org</u>		
		Guidance on confidentiality and consent - <u>http://www.gmc-uk.org/guidance</u>		
		Electronic Palliative Care Coordination Systems (EPaCCS) -		
		http://www.nhsiq.nhs.uk/improvement-programmes/long-term-conditions-and		
		integrated-care/end-of-life-care/coordination-of-care.aspx		
		EPaCCS in England: Survey of clinical commissioning groups (2013) -		
		http://www.endoflifecare-		
		intelligence.org.uk/resources/publications/epaccs in england		
		Locality Registers and EPACCS - <u>http://www.networks.nhs.uk/nhs-</u>		

Cancel

End of Life Care summary view

It is possible within EMIS Web to select a summary view for a number of areas, including one specifically set up for End of Life Care information entered as part of an EPaCCS (see screenshot below). This will bring together in one view all of the information from the EPaCCS dataset collected over time, to support and enhance the work done in GSF / palliative care / MDT meetings.

Record Sharing There are no other organisations contributing to the Shared Record.			Demographics and Social (Shows Latest Entries Only) (8) - No Shared Data Available		
			Term	Value	Date Adde
Data entered by this organisat			Language		
Implied record sharing consent operational for this patient		Main language	Main spoken language Cantonese	27-Jun-2014	
Summary Care Record		Additional language	Main spoken language Oromo	27-Jun-2014	
No consent preference set - Impl	ied consent for medication, allergies, and adverse reactions only		Supplemental language	Main spoken language Filipino	27-Jun-2014
			Interpreter needed	Need for interpreter	27-Jun-201
			Interpreter not needed	Interpreter not needed	27-Jun-201
			Religion		
Problems (13) - No Shared Data Available			Carers (Shows Latest Entries Only) (12) - No Shared Data Available		
Active Problems		Onset Date	Term	Value	Date Adde
Notes summary on computer		06-Aug-2007	Informal Carers		
Significant Past Problems			Has informal carer	Does not have an informal carer	27-Jun-201
Gastroenteritis • Viral infection NOS			Main informal carer	Details of informal carer	27-Jun-203
			Carer - home telephone	Carer - home telephone number	27-Jun-20
			Carer - work telephone	Carer - work telephone number	27-Jun-201
			Carer - mobile telephone	Carer - mobile telephone number	27-Jun-201
			Next of kin	Patient's next of kin	27-Jun-201
End of Life Summary (Sho	ws Latest Entries Only) (11) - No Shared Data Available		Patient Preferences (Show)	ws Latest Entries Only) (15) - No Shared Data Available	
Term	Value	Date Added	▲ Term	Value	Date Add
atient added to EPACCS			Advance Care Planning		
On end of life register	On end of life care register	27-Jun-2014	Advance statement	Has advance statement (Mental Capacity Act 2005)	27-Jun-20:
nd of Life Tool Used			Advanced care plan	Has end of life advance care plan	27-Jun-20
GSF Supportive Care Stage	GSF supportive care stage 2 - increasing decline	27-Jun-2014	Best interest decision	Best interest decision made on behalf of patient (MCA 2005)	27-Jun-201
GSF Prognostic indicator stage	GSF prognostic indicator stage D (red) - days prognosis	27-Jun-2014	Preferred Priorities for Care	2	
Care pathway for dying	On integrated care pathway	27-Jun-2014	Preferred priorities of care do	Preferred priorities for care document completed	27-Jun-201
are Plan			 Discussion about Preferred Pl 	Preferred place of care - patient declined to participate	27-Jun-20
End of Life Diagnosis and Function (Shows Latest Entries Only) (9) - No Shared Data Available		Care & Support in Last Days of Life/Death Details (Shows Latest Entries Only) (11) - No Shared Data Available			
Term	Value	Date Added	▲ Term	Value	Date Add
rimary End of Life Diagnosi	5		Anticipatory Medicines		
End of life diagnosis	Diagnosis	27-Jun-2014	Anticipatory medication	Prescription of palliative care anticipatory medication	27-Jun-20
isabilities Affecting Care			Syringe driver	Syringe driver discontinued	27-Jun-20
Hearing impairment	Hearing impairment	27-Jun-2014	Oxygen		
Physical disability	Physical disability	27-Jun-2014	Home oxygen	Home oxygen supply - liquid oxygen	27-Jun-20
Mobility	Housebound	27-Jun-2014	Other Relevant Issues or Pr	eferences about Provision of Care	
Personal care activity	Unable to perform personal care activity	27-Jun-2014	 Organ donation 	Consent to donate organs given	27-Jun-201

Any comments or suggestions for future updates of this guide? Please send to Stephen Burrows – stephen.burrows@nhs.net