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Introduction

The Emergency Care Summary Management Module allows important patient information to be electronically shared with clinicians who do not have access to the core GP information. Depending on patient consent, relevant information is extracted from your clinical system and is uploaded as part of a scheduled upload to the SCI Store ready to be used if and when required.

Previously, Vision practices in Scotland had to access various parts of Vision in order to trigger an extract. In conjunction with NHS Scotland we have introduced an amalgamated and enhanced approach to Emergency Care Summary (ECS) extracts in order to simplify and speed up the process.

The main advantages of the new Emergency Care Summary Management screen are:

- Combined interface for Emergency Care Summary (ECS), Key Information Summary (KIS) and Palliative Care Summary (PCS) data entry
- Traffic light indicator of patient consents for ECS, KIS and PCS to enable easy identification of transmission status
- Fast update of consent status within the ECS Management screen
- Easy visibility of data common the both KIS and PCS
- Tick box selection of Medical History to include in upload, no need to use Problems
- List and select patients with KIS or PCS summaries from within the ECS Summary Management screen
- Direct access to the existing Palliative Care reports

Note - Please contact your health board to enable the new ECS screen (including KIS and ePCS), convert existing special notes and if applicable import special notes from Adastra out of hours service.
Overview

The ECS Summary Management screen currently includes:

- **Emergency Care Summary (ECS)** – ECS provides up to date information about allergies and GP prescribed medication for use in care contexts where clinicians do not have access to the core GP record. See *Emergency Care Summary* (page 18).

- **Key Information Summary (KIS)** – KIS is an extension to the ECS. It provides additional data to ECS for use in care contexts where clinicians do not have access to the core GP record. See *Key Information Summary* (page 20).

- **Electronic Palliative Care Summary (PCS)** – PCS is a method of recording information regarding the palliative and end of life needs of a patient for use in care contexts where clinicians do not have access to the core GP record. See *Palliative Care Summary* (page 31).

**Important** – Once the ECS Summary Management Module is enabled, the old ePCS guideline is defunct. All data previously added to the guideline is available on the new screen.

The sharing of any patient data via the ECS Management screen is dependent on the relevant patient consent being recorded. For details on how to record consent please refer to *Summary and Consent Status* (page 5).

This guide aims to explain how to access and record data using the ECS/PCS/KIS Summary Management screen.

Pre-requisites

To use the ECS Summary Management utility within Vision you must:

- Have Vision DLM 440 installed (your version of Vision can be checked from the *Vision front screen - Help - About*)

- Please contact your health board to enable the new ECS screen (including KIS and ePCS), convert existing special notes and if applicable import special notes from Adastra out of hours service.
Accessing the ECS Summary Management Module

To access the ECS Summary Management screen:

1. From Consultation Manager, select the patient and then select **List – ECS Summary Management**.

2. The ECS/PCS/KIS Summary Management Module is displayed.

![List - ECS Summary Management](image-url)
ECS/PCS/KIS Summary Management Module

- Patient Banner
- Consent Status
- Available Reports
- Tabs for adding and viewing data for each summary type
Patient Banner

A patient demographic banner is displayed at the top of the ECS/PCS/KIS Summary Management screen. The banner initially displays the following:

- Name
- Born - Date of birth (age)
- Gender
- CHI No
- Address
- Phone – Displays Home telephone number if recorded
- Language Spoken - Displayed next to Phone if recorded

To expand the banner, click . The expanded banner shows the above details plus:

- Address – In full
- All phone numbers - If recorded
- Email - If recorded

To collapse the patient banner, click .

Collapsed patient banner

Expanded patient banner
Summary and Consent Status

To view the patient consent status for all summaries; from Consultation Manager, select **List - ECS Summary Management**. The full patient’s summary and consent status is initially hidden, but a summary for each service is indicated by the consent status traffic lights.

<table>
<thead>
<tr>
<th>Summary and Consent Status: ECS:</th>
<th>KIS:</th>
<th>PCS:</th>
</tr>
</thead>
</table>

**Summary and Consent Status traffic lights**

The Consent Status traffic lights indicate the following:

**ECS**
- ![Inactive](image) (inactive) ECS not enabled
- ![Green](image) (green) ECS enabled and consented to by this patient
- ![Yellow](image) (yellow) ECS enabled, implied consent for patient in the absence of a specific record
- ![Red](image) (red) ECS enabled, consent is denied for this particular patient

The ECS Consent Report can be run to view all patients with an ECS Consent entry recorded. See **ECS Consent Report** (page 51) for details.

**KIS**
- ![Inactive](image) (inactive) ECS not enabled, or if ECS is enabled the patient does not have:
  - a KIS consent record
  - a decision to send
  - a special note

**Note** - This does not indicate an error, but suggests that the patient is probably not a 'KIS patient'

- ![Green](image) (green) KIS data will be sent
- ![Yellow](image) (yellow) This state does not occur
- ![Red](image) (red) KIS data will not be sent. If data has been sent previously a blank record is sent to clear the record.

**PCS**
- ![Inactive](image) (inactive) ECS not enabled or if ECS is enabled the patient has neither a PCS consent record nor a palliative care plan record

**Note** - This does not indicate an error, but suggests that the patient is probably not a 'PCS patient'.

- ![Green](image) (green) PCS upload is valid and consented to, a palliative care plan record exists
- (yellow) PCS upload is valid and consented to, but no palliative care plan record exists therefore is not valid for sending
- (red) PCS upload is disabled due to lack of consent (ECS and/or PCS)

Adding Consent Status

To add the consent status for a selected patient:

1. From Consultation Manager select **List - ECS/PCS/KIS Summary Management**, from Summary and Consent Status, click **More**.

2. The **Summary and Consent Status** section is displayed.

3. You can now view the **History** and **Change** the consent status for all potential upload types. See:
   - **Adding Consent Status for ECS** (page 8)
   - **Adding Consent Status for KIS** (page 9)
   - **Adding Consent Status for PCS** (page 16)

The resultant consents are summarised by the traffic lights on the tool bar and the short sentence at the bottom left corner of **Summary and Consent Status** section.
To view the date and time of the last upload for either ECS, KIS or PCS click on **History** under the relevant option:

![ECS Upload History](image)

**Adding Consent Status for ECS**

Consent for ECS is implied, therefore to stop the ECS extract from uploading to SCI Store, consent refused must be recorded.

**Recording Consent Refused for ECS**

1. From Consultation Manager, select **List - ECS/PCS/KIS Summary Management - Summary and Consent Status**, select **More**.
2. Click **Change** within the ECS column.
3. **Consent to ECS data upload** is displayed.
4. Select **Patient DOES NOT consent to upload of data**.
5. Click **OK** to save and close.
The refusal is also within **Registration - Registration Details - Consent - Consent refused to data sharing for emergency care.**

In order for a KIS extract to be uploaded, the last consent status recorded for the patient must be Consent Given, see **Adding Consent Status for ECS** (page 8), and there must be patient consent recorded for KIS.

**Note** - Consent for KIS is controlled through the ECS Summary Management Consent Status method, not KIS Consent Read codes.

**Adding Consent Status for KIS**

**Recording Consent for KIS**

1. From Consultation Manager, select **List - ECS/PCS/KIS Summary Management**
2. **Select Summary and Consent Status - More.**
3. Click **Change** within the KIS column.

**Summary and Consent Status - KIS - Change**
4. **Consent for KIS upload** is displayed.

![Consent for KIS upload](image)

5. Complete as required:

   - **KIS Consent Given** – Tick if the patient agrees to a KIS upload
   - **KIS Consent Declined** – Tick if the patient refuses a KIS upload
   - **Notes** – Enter as required

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

   **Note** - The KIS Status traffic light automatically turns Green if consent has been given or Red if consent has been refused.
If the patient refuses consent for a KIS upload, you can select to override the consent and send a KIS (if ECS consent is given or implied) or a KIS Special Note (if ECS consent is refused).

The **Override** section must be completed:

- **Override Consent** - Tick
- **Reason** - Select from the available list
- **Patient aware of override** - Tick if appropriate
- **Notes** - A short explanation of the override decision should be entered here
Decision to send/not send KIS

Once consent has been recorded, the KIS data and/or Special Note is not sent to ECS until an explicit decision to send is recorded.

The expanded Summary and Consent Status section contains explanatory text on the consent and decision to send options selected. The following examples show some of common consent/decision to send combinations that could cause queries:

**ECS Consent implied with KIS Consent Denied but Overridden**

- Decision to send has not been selected, until it is no data is sent.

**ECS and KIS Consent Denied but KIS Overridden**

- The decision to send has been updated, but as there is no ECS consent, nothing will be sent until you enter a Special Note.

**ECS and KIS Consent Denied, Kis Overridden and Special Note Added**

- A Special Note has been added and will be sent.
Recording a Decision to Send/Not Send KIS

1. From Summary and Consent Status - More, in the KIS column click Decision to send KIS.

   □ Decision to send KIS

   Decision to send KIS

2. Add new record is displayed.

   Add new record

   Decision to send KIS
   □ Decision NOT to Send KIS

   Event Date: 05 January 20

   [Input field for comments]

   Maximum 2048 characters

   □ Show Full Form

   OK

   Cancel

   Add new record

3. Select Decision to send KIS or Decision NOT to Send KIS as appropriate.

4. Enter comments as required.

   Note - Text over 2048 characters is not sent to ECS.

5. Click OK to save

   and return to the ECS Management screen.

   Note - You can reverse your decision at any time. If data has already been sent, selecting Decision Not to Send KIS removes the data from ECS.
**KIS Internal Review**

A practice review date is required as part of the KIS consent status. If a review has been recorded, **Practice review due** is displayed with the date for review, if no review date has been entered **No practice review set** is displayed.

<table>
<thead>
<tr>
<th>No Previous KIS data sent</th>
<th>History</th>
</tr>
</thead>
<tbody>
<tr>
<td>19/12/2012 KIS Consent given</td>
<td>Change</td>
</tr>
<tr>
<td>☑ 19/12/2012 Decision to send KIS</td>
<td>... +</td>
</tr>
<tr>
<td>Practice review due 31/03/2013</td>
<td>+</td>
</tr>
</tbody>
</table>

**Practice review due**

<table>
<thead>
<tr>
<th>No Previous KIS data sent</th>
<th>History</th>
</tr>
</thead>
<tbody>
<tr>
<td>No KIS consent status recorded</td>
<td>Change</td>
</tr>
<tr>
<td>☑ Decision to send KIS</td>
<td>+</td>
</tr>
<tr>
<td><strong>No practice review set</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Adding or Updating KIS Internal Review**

A practice review date is for internal use only and is not sent to ECS, however a reminder is displayed if you exit the ECS/PCS/KIS Summary Management form without recording one.

**KIS Practice Review message**

1. From **ECS Management - Summary and Consent Status**, click **More**.
2. The **Summary and Consent Status** section is displayed.
3. Click alongside **Practice review due** or **No practice review set**

4. **Recall – Add** is displayed.

![Recall - Add](image)

5. Complete as required:
   - **Set up Date** – Defaults to today’s date
   - **Clinician Setting Recall** – Defaults to the clinician logged in; if a member of staff is logged in in the default is either the Usual or Registered GP
   - **Recall Status** – Defaults to **Outstanding**, select from the available list if this is not the case
   - **Read Term for Recall Trigger** – This is completed automatically with the Read term essential for the KIS extract

**Important** - Do not change either the Read code or the free text comments which have been automatically entered. These are required when you do your recall searches.

- **Recall Date** – Enter the date you want to review the patient
- **Clinician to Action Recall** – Defaults to the clinician logged in, if a member of staff is logged in in the default is either the Usual or Registered GP. Select from the available list if required
- **Read Term for Recall Reason** - Defaults to the same Read code as **Read Term for Recall Trigger**. You can select a different Read code here should you require

- The first three words are completed automatically. Click to add further comments if required, and then click **Close**

**Important** - The free text can be appended to but it is essential for searching purposes that the first line is left as **KIS Internal Review**.
6. Click OK to close and save.

Adding Consent Status for ePCS
In order for an ePCS extract to be uploaded patient consent must be recorded.

Recording Consent for PCS

1. From Summary and Consent Status, click Change within the PCS column.

   Summary and Consent Status - PCS - No PCS consent status recorded before

2. PCS Consent is displayed.

   PCS Consent

3. Select as required:
   - **Yes** – To record consent to upload records to PCS
   - **No** - To record consent denied to upload records to PCS
   - **Cancel** – To leave this option without recording anything
The consent status is recorded within the Registration Module in **Registration Details - Consent - Consent given for palliative care data sharing**.

![Registration Details - Consent - Consent given for palliative care data sharing](image)

**Recording Consent for PCS Withdrawn**

1. From **Summary and Consent Status**, click **Change** within the PCS column.

   ![PCS Consent](image)

   **Summary and Consent Status - PCS-Consent previously given**

2. PCS Consent is displayed.

3. Select as required
   - **Yes** - To withdraw consent
   - **No** - To leave as consent given
   - **Cancel** - To leave this option without recording anything
The consent status is recorded within the Registration Module in **Registration Details - Consent - Consent given for palliative care data sharing.**

**Note** - The PCS Status traffic light automatically turns Green if consent has been given or Red if consent has been refused.
Emergency Care Summary

The Emergency Care Summary (ECS) is a subset of GP data held centrally in the SCI Store for every non-dissenting patient. It is intended to provide data for use in care contexts where clinicians do not have access to the core GP record eg Out of Hours, A & E.

To access the ECS Summary Management Summary screen:

1. From Consultation Manager select the patient required and open a consultation if one does not open automatically.
2. Select List - ECS Management Summary, the ECS Summary Management screen is displayed.
3. Click on the Emergency Care Summary tab.
4. The following sections are displayed:
   - **Current Medication** –
     - All Acutes issued dated in the last 6 months
   - **Repeat Medication** –
     - Active Repeat Masters
     - Active CMS Prescriptions
   - **Allergies and Adverse Reactions**
5. To expand the information displayed in any section, click.
6. Click Close to close the expanded window.

**Note** - Before the ECS Management screen is enabled, Repeat items that are prescribed out of practice are not automatically included in an extract for ECS. This is addressed once the ECS Management screen is switched on and all active repeats regardless of source are extracted.

**Note** - It is not possible to add data from here.
Note – The Current Medication title is inaccurate it only displays acute medication dated in the last six months, we are aware of this and it will be addressed shortly.
Key Information Summary

The Key Information Summary (KIS) is an extension to the ECS. It is intended to replace the manually faxed Special Notes currently sent by practices. The data uploaded via KIS consists of:

- **Special Note** - This is for use during weekend care and is the direct replacement for the 'Special Note' faxed, see *Adding or Updating a Special Note* (page 29)
- **Summaries for Out of Hours (OOH) agencies** - This can consist of information from the patient’s medical history if deemed clinically relevant and administration information, such as keypad numbers to assist OOH staff in gaining access to the patient home in an emergency

KIS is designed to be used for patients with:

- Long term conditions
- Mental health issues
- Unusual conditions who may have difficulty in remembering crucial details if they become ill

There is an overlap in some of the information that can be extracted for KIS and PCS, the ECS Summary Management screen shares this information so it only has to be recorded once and it is shared across extracts.

**Note** - For more information regarding the Key Information Summary please refer to NHS Scotland [http://www.ecs.scot.nhs.uk/kis](http://www.ecs.scot.nhs.uk/kis).

The following section details how to access and utilise the KIS tab of the ECS Summary Management screen:
Accessing the Key Information Summary

To access the Key Information Summary (KIS):

1. From Consultation Manager, select **List - ECS Summary Management**.
2. Select the **Key Information Summary** tab.
3. The Key Information Summary is displayed.
Adding Data to the Key Information Summary

Adding, editing and viewing data in the KIS screen is easy. There is a combination of tick boxes (see Tick Boxes (page 27)) and data entry panes (see Data Entry Panes (page 28)) for the following information:

**Note** - Categories with an asterisk* are shared with the Palliative Care Summary screen

- **Capacity information and Care Plan Details** – Displays and allows you to record the following:
  - **Has Guardianship Order** – 13lo.00 Has guardian appointd Adult with Incapacity (Scot)Act 2000
  - **Has Power of Attorney** – select from:
    - 13ln.00 Has welf attorney apt under Adults with Incap (Scot)Act 2000,
    - 9W0..00 Power of attorney applied for
    - 9W2..00 Power of attorney held
    - 9W4..00 Lasting power of attorney property and their affairs
    - 9W5..00 Lasting power of attorney personal welfare
    - 9W6..00 Enduring power of attorney
  - **Has Adult Incapacity Form** – 13lm.00 Subj cert auth issued Adults with Incapacity (Scot)Act 2000
  - **Has Single Shared Assessment Plan** – select from:
    - 9Ne..00 Single Assessment Process
    - 9Ne0.00 Single assessment process summary care plan completed
  - **Has Anticipatory Care Plan** – 8CMM.00 Has anticipatory care plan
- **Self-Management Plan details** – Displays and allows you to record the following Read codes:
  - 8CMA000 Patient has a written asthma personal plan
  - 8CR7.00 mental health personal health plan.
  - 661M. Clinical management plan agreed
  - 661M0 Angina self-management plan agreed
  - 661M1 Asthma self-management plan agreed
  - 661M2 Chronic kidney disease self-management plan agreed
  - 661M3 Chronic obstructive pulmonary disease self-management plan agreed
  - 661M4 Diabetes self-management plan agreed
  - 661M5 Heart failure self-management plan agreed
  - 661M6 Hypertension self-management plan agreed
  - 661M7 Stroke self-management plan agreed
  - 661N Clinical management plan review
  - 661N0 Angina self-management plan review
- **661N1** Asthma self-management plan review
- **661N2** Chronic kidney disease self-management plan review
- **661N3** Chronic obstructive pulmonary disease self-management plan review
- **661N4** Diabetes self-management plan review
- **661N5** Heart failure self-management plan review
- **661N6** Hypertension self-management plan review
- **661N7** Stroke self-management plan review
- **8CG6** Care programme approach
- **8CG60** Initial care programme approach review
- **8CG61** Ongoing care programme approach review
- **8CG62** Discharge care programme approach
- **8CMG1** Review of mental health care plan
- **8CR** Clinical management plan
- **8CR0** Asthma clinical management plan
- **8CR1** Chronic obstructive pulmonary disease clinical management plan
- **8CR2** Diabetes clinical management plan
- **8CR3** Hyperlipidaemia clinical management plan
- **8CR4** Hypertension clinical management plan
- **8CR5** Hypothyroidism clinical management plan
- **8CR6** Coronary heart disease risk clinical management plan
- **8CR7** Mental health personal health plan
- **8CR9** Benzodiazepine clinical management plan
- **8CRA** Ankle brachial pressure index management plan
- **8CRB** Transient ischaemic attack clinical management plan
- **8CRC** Cancer chemotherapy management plan
- **8CY** Mental health care programme approach
- **8BC1** Treatment plan given
- **8BC3** Cancer care plan given
- **8CS** Agreement of care plan
- **8CS0** Diabetes care plan agreed
- **8CS1** Multiple sclerosis care plan agreed
- **8CS2** Health and social care plan agreed
- **8CS3** Agreeing on leg ulcer treatment plan
- **8CS5** Agreeing on health professional actions in care plan
- **8CS6** Agreeing on patient actions in care plan
- **8CS7** Agreeing on mental health care plan
- **8CS8** Agreeing on care plan with legitimate patient representative
- **9HC2** Substance misuse clinical management plan agreed
- 9HC3 Substance misuse clinical management plan reviewed

- **Patient Contact List** - Displays all latest contacts for the patient and allows you to add new contact details. These details are from Registration contacts. Carer and Next of Kin details are recorded here.

- **Relevant Medical History** - Displays all medical history records with a priority of 1 and allows you to add further medical histories. See *Adding/Removing Items to/from Relevant Medical History* (page 28)

- **Access information** - Displays and allows you to record the following Read codes:
  - 9189 Key Holder
  - 9NFG Address instruction.

- **Other Agencies involved** - Displays and allows you to record the following Read codes:
  - 13G..00 Domiciliary services
  - 13G1.00 District nurse attends
  - 13G2.00 Health visitor visits
  - 13G5.00 Voluntary worker
  - 13G6100 Home help attends
  - 13G6300 Home help organised
  - 13G7.00 Meals on wheels
  - 13G8.00 Domiciliary chiropody
  - 13GZ.00 Domiciliary service NOS
  - 8HH0.00 Arrange care by relative
  - 8HH4.00 Arrange care attender
  - 8HH7.00 Referred to community specialist palliative care team
  - 8HHB.00 Referral to Social Services
  - 8HHJ.00 Referral to respiratory nurse specialist
  - 8HHN.00 Referral to voluntary service
  - 9N2i.00 Seen by diabetic liaison nurse
  - 9N2p.00 Seen by community heart failure nurse
  - 9NNA.00 Under care of practice nurse
  - 9NNK.00 Under care of dyspepsia specialist nurse
  - 9NNS.00 Under care of Macmillan nurse
  - 9NNY.00 Under multi-agency care
  - 9NNd.00 Under care of palliative care specialist nurse
  - 9Nh0.00 Under the care of community palliative care team
  - 9Nh1.00 Under care cancer primary healthcare multidisciplinary team

- **Special note** - Displays and allows you to submit additional free text information to assist OOH staff manage your patient’s care. See *Adding or Updating a Special Note* (page 29)
 Other useful palliative information* - Displays and allows you to record the following:

- Has DNACPR Form – enter free text as required. If a patient has a DNACPR Form, you should ensure the Resuscitation status that follows, matches. If you do not make this correction, the conflict is transferred to ECS.

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>23/06/2014</td>
<td>Has DNACPR Form</td>
<td></td>
</tr>
<tr>
<td>23/06/2014</td>
<td>Not for resuscitation</td>
<td></td>
</tr>
</tbody>
</table>

Correct DNACPR Form and Resuscitation status

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>23/06/2014</td>
<td>Has DNACPR Form</td>
<td></td>
</tr>
<tr>
<td>23/06/2014</td>
<td>For resuscitation</td>
<td></td>
</tr>
</tbody>
</table>

Conflicting DNACPR and Resuscitation status

- **Resuscitation Status** – Defaults to Priority 1 select from:
  - 1R0..00 For resuscitation
  - 1R00.00 For attempted cardiopulmonary resuscitation
  - 1R1..00 Not for resuscitation
  - 1R10.00 Not for attempted CPR (cardiopulmonary resuscitation)

- **Additional Drugs at Home** – enter free text as required

- **Catheter and Incontinence Equipment at Home** – select from:
  - 9NgX.00 Catheter care equipment available at home
  - 9NgY.00 Continence care equipment available at home

- **Moving and Handling Equipment at Home** – 13CX.00 Moving and handling equipment available at home

- **Has Oxygen for Home Use** – select from:
  - 6639.00 Home oxygen supply
  - 6639.11 Home oxygen supply started
  - 6639.12 Oxygen at home
  - 66Yj.00 Home oxygen supply – cylinder
  - 66Yk.00 Home oxygen supply – concentrator
  - 66YI.00 Home oxygen supply – liquid oxygen
  - 745E000 Home oxygen support

- **Preferred Place of Care** – select from:
  - 8Ce..00 Preferred place of care
  - 8Ce0.00 Preferred place of care – home
- **8Ce1.00** Preferred place of care – hospice
- **8Ce2.00** Preferred place of care – community hospital
- **8Ce3.00** Preferred place of care – hospital
- **8Ce4.00** Preferred place of care – nursing home
- **8Ce5.00** Preferred place of care – residential home
- **8Ce6.00** Preferred place of care – learning disability unit
- **8Ce7.00** Preferred place of care – mental health unit
- **8Ce8.00** Preferred place of care – discussed with patient
- **8Ce9.00** Preferred place of care – discussed with family
- **8CeA.00** Preferred place of care – patient unable to express preference
- **8CeB.00** Preferred place of care – patient declined to participate
- **8CeC.00** Preferred place of care for next exacerbation heart failure
- **8CeD.00** Preferred place of care for next exacerbation of COPD
- **8CeE.00** Preferred place of care – discussion not appropriate

- **Preferred Place of Final Care** – select from:
  - **94Z1.00** Preferred place of death: home
  - **94Z2.00** Preferred place of death: hospice
  - **94Z3.00** Preferred place of death: community hospital
  - **94Z4.00** Preferred place of death: hospital
  - **94Z5.00** Preferred place of death: nursing home

*those with an asterisk are shared with the PCS screen*

**Note** - Data added here cannot be deleted here. If you need to delete data added here, it must be deleted from the patient's Journal screen in the usual way.
**Tick Boxes**

To add data using the tick boxes, tick alongside the description required, select the appropriate Read code if a choice is available, change the Priority as per your practice protocols, enter any comments required and click **OK**.

**Note** – You can only add comments of up to the maximum number of characters within this quick form. To add longer comments you need to tick **Show full form**, but only the maximum number of characters is sent to ECS. Text that is outside the maximum number is shown in red.

To update a tick box record, click on + alongside the entry required (in this context, Update is adding to the patient record). The last entry is displayed, update as necessary and OK. The patient’s record is updated when you close their consultation with the new updated entry.

**Note** - It is not possible to edit or remove data entered via the tick boxes from within the ECS Summary Management module. To edit or remove data added in error, edit or delete in the usual way from the patient’s Journal screen.

**Data Entry Panes**

To add data using the Data Entry Panes click Add or Update (in this context, Update is adding to the patient record). Complete the forms offered following the prompts on screen, click **OK** to save and close.

**Note** – You can only add comments of up to the maximum number of characters within quick forms. To add longer comments you need to tick **Show full form**, but only the maximum number of characters is sent to ECS. Text that is outside the maximum number is shown in red.

To edit data displayed in a data entry pane, highlight the item and click on **Edit**. Click **OK** on the maximum number of characters warning and change the entry as required. Click **OK** to save the change.

**Note** - It is not possible to remove data entered via the Data Entry Panes from within the ECS Summary Management module. To remove data added in error, delete in the usual way from the patient’s Journal screen.

To maximise, click .
Adding/Removing Items to/from Relevant Medical History

Relevant Medical History records are sent to ECS. It is initially populated with all the patients Priority 1 Medical History.

1. From Relevant Medical History, click Update.
2. Maintain List – Relevant Medical History is displayed.

3. Select and deselect items as required:
   - Priority 1 Medical Histories displays those records that are automatically uploaded. To prevent them being uploaded, click on the check box to remove the tick.
   - Other Items displays records that are not included in an upload. To include them in an upload, click on the check box to enter a tick.

   **Note** - Text over 256 characters is not included in the extract.

4. Click OK to save and close.

   **Remember** - Once you have deselected an item, it stays deselected. New Priority 1 Medical Histories are automatically added to the Relevant History list and are included in uploads.
Adding or Updating a Special Note

1. From Key Information Summary - Special Note, click Update.

2. KIS Special Note is displayed.

3. Enter the information you want the OOH service to be aware of.

4. If this information has an expiry date, remove the tick from Never Expire and select an expiry date from the Expiry Date calendar.

5. Click OK to save and close.

6. The date the Special Note is created and the expiry date, if applicable, is displayed under the Special Note header.
**Note** - Only the most recently added Special Note is sent overwriting any previous Special Notes extracted. On expiry the Special Note is overwritten with a blank record.

**Important** - If ECS consent is withdrawn and KIS consent is overridden, a Special Note has to be recorded and only that is sent. In this scenario the KIS consent traffic light displays as green and the ECS traffic light displays as red.
Palliative Care Summary

Initially introduced as the Gold Standard Framework Scotland (GSFS) - Palliative Care, the project was renamed the Electronic Palliative Care Summary (ePCS). ePCS is a practice based system, designed to improve and optimise the organisation of palliative care for cancer patients. Now all aspects of the ePCS project have been brought together as part of the ECS Summary Management screen replacing the need for a Problem based record. Palliative Care Summary (PCS) is intended to provide additional palliative care data for use in care contexts where clinicians do not have access to the core GP record.

To turn the PCS extract on:

1. From the Vision front screen, select **Options - Setup - System**.
2. In **Other Options**, tick **Palliative Care Extract**.
3. Click **OK** to save and close.

Other Options

**Note** - During conversion, from ePCS Guideline to ECS Summary Management, any OOH Arrangement Notes that have previously been recorded are posted to the Special Notes section of the ECS Summary Management screen. See *Adding or Updating a Special Note* (page 29).

The activation of the new ECS Summary Management screen triggers a one off conversion of the following data types previously recorded:

- **Palliative Care Plan Notes** - Convert to Special Notes
- **OOH Arrangement Notes** - Convert to Special Notes
- **Additional Drugs at Home** - Converts to a Notepad entry
- **Moving and Handling Equipment** - Converts to a Read coded entry, 13CX.00 Moving and handling equipment available at home
- **Catheter and Continence Equipment at home** - Converts to a Read coded entry, either 9NgX.00 Catheter care equipment available at home or 9NgY.00 Continence care equipment available at home depending on the last entry made.

**Note** - Additional Drugs at Home, Moving and Handling Equipment and Catheter and Continence Equipment at home were all previously recorded on the OOH Arrangements structured data area (SDA) which must no longer be used.

**Note** - Palliative care information can only be sent to ECS for permanently registered patients, who have a CHI number recorded.
The following section details how to access and utilise the PCS tab of the ECS Summary Management screen:

**Accessing the Palliative Care Summary**

**To access the Palliative Care Summary (PCS):**

1. From Consultation Manager, select **List - ECS Summary Management**.
2. Select the **Palliative Care Summary** tab.
3. The Palliative Care Summary is displayed.

The status of the palliative care plan record is displayed at the top of the Palliative Care Summary tab:

- If there is no plan recorded, "There is no Palliative Care Plan record for this patient" is displayed with an option to **Add**. See **Recording an Initial Palliative Care Plan** (page 41).

If there is a plan recorded, the details of the latest plan are displayed with an option to **View/Update**.
Adding Data to the Palliative Care Summary

Adding, editing and viewing data in the Palliative Care Summary screen is easy. There is a combination of tick boxes and data entry panes for the following information:

**Note** - Categories with an asterisk* are shared with the KIS screen

- **Initial Palliative Care Plan** – Displays and allows you to record the initial details of the Palliative Care Plan. See *Recording an Initial Palliative Care Plan* (page 41)

- **Treatment Options** – Displays and allows you to record the following:
  - Radiotherapy (7M37100 Radiotherapy NEC)
  - Chemotherapy (8BAD000 Cancer Chemotherapy)
  - Palliative Treatment (8BJ1 Palliative Treatment)

- **Palliative Care Register (Qualifying Terms)**
  - 1Z01.00 Terminal illness – late stage
  - 8BA2.00 Terminal care
  - 8BAP.00 Specialist palliative care
  - 8BAS.00 Specialist care treatment – daycare
  - 8BAT.00 Specialist care treatment – outpatient
  - 8BJ1.00 Palliative treatment
  - 8CM1.00 On gold standards palliative care framework
  - 8H6A.00 Refer to terminal care consult
  - 8H7L.00 Refer for terminal care
  - 8H7g.00 Referral to palliative care service
  - 8HH7.00 Referred to community specialist palliative care team
  - 9EB5.00 DS 1500 Disability living allowance completed
  - ZV57C00 [V]Palliative care

- **Awareness and Understanding**
  - 1H...00 Awareness of diagnosis
  - 1H0..00 Patient aware of diagnosis
  - 1H0..11 Diagnosis known to patient
  - 1H1.00 Patient not aware of diagnosis
  - 1H2..00 Family aware of diagnosis
  - 1H3..00 Family not aware of diagnosis
  - 66W3.00 Aware of prognosis
  - 66W3000 Carer aware of prognosis
  - 66W3100 Relative aware of prognosis
  - 66W4.00 Unaware of prognosis
  - 66W4000 Carer unaware of prognosis
- 67D1.00 Informing patient of prognosis
- 67F1.00 Informing relative of prognosis
- Syringe Driver Use
  - 8BC2 Syringe Driver Commenced
  - 8BC5 Syringe Driver Discontinues

- Patient Contact List* - Displays all latest contacts for the patient and allows you to add new contact details. These details are from Registration contacts.

- Relevant Medical History* - Displays all medical history records with a priority of 1 and allows you to add further medical histories. See Adding/Removing Items to/from Relevant Medical History (page 28)

- Access information* - Displays and allows you to record the following Read codes:
  - 9189 Key Holder
  - 9NFG Address instruction.

- Other Agencies involved* - Displays and allows you to record the following Read codes:
  - 13G..00 Domiciliary services
  - 13G1.00 District nurse attends
  - 13G2.00 Health visitor visits
  - 13G5.00 Voluntary worker
  - 13G6100 Home help attends
  - 13G6300 Home help organised
  - 13G7.00 Meals on wheels
  - 13G8.00 Domiciliary chiropody
  - 13GZ.00 Domiciliary service NOS
  - 8HH0.00 Arrange care by relative
  - 8HH4.00 Arrange care attender
  - 8HH7.00 Referred to community specialist palliative care team
  - 8HHB.00 Referral to Social Services
  - 8HHJ.00 Referral to respiratory nurse specialist
  - 8HHN.00 Referral to voluntary service
  - 9N2i.00 Seen by diabetic liaison nurse
  - 9N2p.00 Seen by community heart failure nurse
  - 9NN.00 Under care of practice nurse
  - 9NN.00 Under care of dyspepsia specialist nurse
  - 9NN.00 Under care of Macmillan nurse
  - 9NN.00 Under multi-agency care
  - 9NNd.00 Under care of palliative care specialist nurse
  - 9Nh0.00 Under the care of community palliative care team
- **9Nh1.00** Under care cancer primary healthcare multidisciplinary team

- **Special note** - Displays and allows you to submit additional free text information to assist OOH staff manage your patient’s care. See *Adding or Updating a Special Note* (page 29)

- **Other useful palliative information** - Displays and allows you to record the following:
  - **Has DNACPR Form** – enter free text as required. If a patient has a DNACPR Form, you should ensure the Resuscitation status that follows, matches. If you do not make this correction, the conflict is transferred to ECS.

<table>
<thead>
<tr>
<th>Date</th>
<th>Has DNACPR Form</th>
<th>Resuscitation Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>23/06/2014</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>23/06/2014</td>
<td></td>
<td>+</td>
</tr>
</tbody>
</table>

**Correct DNACPR Form and Resuscitation status**

- **Resuscitation Status** – Defaults to Priority 1 select from:
  - **1R0..00** For resuscitation
  - **1R00.00** For attempted cardiopulmonary resuscitation
  - **1R1..00** Not for resuscitation
  - **1R10.00** Not for attempted CPR (cardiopulmonary resuscitation)

- **Additional Drugs at Home** – enter free text as required

- **Catheter and Incontinence Equipment at Home** – select from:
  - **9NgX.00** Catheter care equipment available at home
  - **9NgY.00** Continence care equipment available at home

- **Moving and Handling Equipment at Home** – 13CX.00 Moving and handling equipment available at home

- **Has Oxygen for Home Use** – select from:
  - **6639.00** Home oxygen supply
  - **6639.11** Home oxygen supply started
  - **6639.12** Oxygen at home
  - **66Yj.00** Home oxygen supply – cylinder
  - **66Yk.00** Home oxygen supply – concentrator
  - **66YI.00** Home oxygen supply – liquid oxygen

---

*Conflicting selection: If the patient has a DNACPR Form, they should not have for resuscitation selected*
- **745E000** Home oxygen support

**Preferred Place of Care** – select from:
- **8Ce..00** Preferred place of care
- **8Ce0.00** Preferred place of care – home
- **8Ce1.00** Preferred place of care – hospice
- **8Ce2.00** Preferred place of care – community hospital
- **8Ce3.00** Preferred place of care – hospital
- **8Ce4.00** Preferred place of care – nursing home
- **8Ce5.00** Preferred place of care – residential home
- **8Ce6.00** Preferred place of care – learning disability unit
- **8Ce7.00** Preferred place of care – mental health unit
- **8Ce8.00** Preferred place of care – discussed with patient
- **8Ce9.00** Preferred place of care – discussed with family
- **8CeA.00** Preferred place of care – patient unable to express preference
- **8CeB.00** Preferred place of care – patient declined to participate
- **8CeC.00** Preferred place of care for next exacerbation heart failure
- **8CeD.00** Preferred place of care for next exacerbation of COPD
- **8CeE.00** Preferred place of care – discussion not appropriate

**Preferred Place of Final Care** – select from:
- **94Z1.00** Preferred place of death: home
- **94Z2.00** Preferred place of death: hospice
- **94Z3.00** Preferred place of death: community hospital
- **94Z4.00** Preferred place of death: hospital
- **94Z5.00** Preferred place of death: nursing home

*those with an asterisk are shared with the KIS screen*

**Note** - Data added here can not be deleted here. If you need to delete data added here, it must be deleted from the patient's Journal screen in the usual way.
**Tick Boxes**

To add data using the tick boxes, tick alongside the description required, select the appropriate Read code if a choice is available, change the Priority as per your practice protocols, enter any comments required and click **OK**.

---

**Note** – You can only add comments of up to the maximum number of characters within this quick form. To add longer comments you need to tick **Show full form**, but only the maximum number of characters is sent to ECS. Text that is outside the maximum number is shown in red.

To update a tick box record, click on + alongside the entry required (in this context, Update is adding to the patient record). The last entry is displayed, update as necessary and OK. The patient’s record is updated when you close their consultation with the new updated entry.

---

**Note** – It is not possible to edit or remove data entered via the tick boxes from within the ECS Summary Management module. To edit or remove data added in error, edit or delete in the usual way from the patient’s Journal screen.

---

**Data Entry Panes**

To add data using the Data Entry Panes click Add or Update (in this context, Update is adding to the patient record). Complete the forms offered following the prompts on screen, click **OK** to save and close.

---

**Note** – You can only add comments of up to the maximum number of characters within quick forms. To add longer comments you need to tick **Show full form**, but only the maximum number of characters is sent to ECS. Text that is outside the maximum number is shown in red.

To edit data displayed in a data entry pane, highlight the item and click on **Edit**. Click **OK** on the maximum number of characters warning and change the entry as required. Click **OK** to save the change.

---

**Note** – It is not possible to remove data entered via the Data Entry Panes from within the ECS Summary Management module. To remove data added in error, delete in the usual way from the patient’s Journal screen.

---

To maximise, click .
Additional OOH Arrangements

Additional Out of hours arrangements for the patient are displayed here if recorded, if no OOH arrangements have been recorded *No data recorded* is displayed.

To add an OOH Arrangement:

1. From **Palliative Care Summary - Additional OOH Arrangements**, click **Add**.
2. **OOH Arrangements (Palliative Care) - Add** is displayed.

![OOH Arrangements (Palliative Care) - Add](image)

3. Complete as required:
   - **Date of Establishing Plan** – Defaults to today’s date, this can be changed if required
   - **Clinician** – Defaults to the clinician logged in, if a member of staff is logged in the default is either the Usual or Registered GP
   - **Read Term** – Defaults to the correct Read term – Do not change this
   - **Date Discussed with Patient** – Enter the date of your discussion here
   - **Patient Discussed Notes** – Enter your comments here if required
   - **Date Discussed with Carer** – Enter the date of your discussion here
   - **Carer Discussed Notes** – Enter your comments here if required
   - **GP Should Be Contacted OOH** – Tick if required
   - **GP OOH Contact Notes** – Enter your comments here if required
   - **GP Contact Number** – Enter a contact number for the GP to be contacted
• **Notes** – Enter any further comments here if required

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

**To update or view existing Additional OOH Arrangements:**

If additional OOH arrangements already exist, the details are displayed within Additional OOH Arrangements:

![Additional OOH Arrangements](image)

**Recording an Initial Palliative Care Plan**

**To record an initial palliative care plan:**

1. From Consultation Manager, select **List - ECS Summary Management - Palliative Care Summary**.

2. Click **Add**.

![Palliative Care Summary tab - Palliative Care Plan - Add](image)
3. **Palliative Care Plan – Add** is displayed.

4. Complete as required:
   - **Date of Establishing Plan** – Defaults to today’s date, change if appropriate
   - **Clinician** - Defaults to the clinician logged in, if a member of staff is logged in the default is either the Usual or Registered GP
   - **Read Term** – Defaults to the 8CS..Agreement of care plan Read term – Do not change this
   - **Date of Agreement** – Enter the appropriate date
   - **Last ECS Upload Date** – This completes automatically
   - **GP to Sign Death Cert** – Tick if appropriate
   - **Death Cert Notes** – Enter notes if appropriate
   - **GSFS Review Date** – Enter the date for a review
   - **Review Date Notes** – Enter review notes if required
   - **Notes** – Enter notes if required

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

6. The Palliative Care Plan details are displayed, in a truncated form, at the top of the Palliative Care Summary tab.
Reporting and List Patients

There are a number of ECS reports and lists you can run from the ECS Summary Management Module as follows.

List Patients

There are two report lists you can run to display patients:

- With a Palliative Care Plan
- With an Active Key Information Summary

To run the report:

1. From the ECS/PCS/KIS Summary Management screen, select

2. Select either With a Palliative Care Plan or With an Active Key Information Summary.

3. A list of patients that have both KIS Consent given and Decision to send KIS recorded is displayed on the screen.

4. The list displays the patient’s Surname, Forename, DOB and CHI no. You can double click on any patient name to view and update their ECS screen.

   **Note** - It is not possible to print from this List Patient reports.

5. Click Cancel to close.

   **Important** – It is possible to select another patient to the one already in consultation from List Patients and add data to them, the data does post to the correct patient but causes Consultation Manager to crash. This action is best avoided.

Reports

The following are available for reporting on the data collected by the ECS Management Module:

- Palliative Care Reports – these are detailed in the following sections:
  - MDT Meetings Reports – see *MDT Meetings Reports* (page 42)
  - Palliative Care Review Reports – see *Palliative Care Review Reports* (page 45)
  - Out of Hours Summary – see *Out of Hours Summary* (page 47)
- ECS Consent Report - see *ECS Consent Report* (page 51)

See Other Reports (page 54) for details on running:

- Practice Summary Report
- OOH Summary Report
- Decisions to Send
- Decisions Not to Send
**Reporting for Palliative Care**

The Palliative Care Reports are available from the ECS Summary Management screen and are also accessible from the Vision front screen Reporting - Palliative Care Reports.

From the ECS/PCS/KIS Summary Management screen, click and select Palliative Care Reports. Select the report you require:

- Multi-disciplinary Meetings Report - See MDT Meetings Report (page 44)
- Palliative Care Review Reports - See Palliative Care Review Reports (page 45)
- Out of Hours Summary - See Out of Hours Summary (page 46)

**MDT Meetings Reports**

The Multi-disciplinary Team (MDT) Meeting Report finds patients, according to specific criteria for use in the planning of patient care. This report is not sent in messaging and is for practice use.

**Running a MDT Meeting Report**

1. From the ECS/PCS/KIS Summary Management screen, click and select Palliative Care Reports.
2. Palliative Care Reports is displayed.
3. Click on File and select the MDT Meeting Report.
4. Palliative Care MDT Reports is displayed, select the New tab (or existing to run previously saved report).
5. Complete as required:

- **Select Palliative Care Type to be included in report** - Remove ticks from the Read code list to exclude from the report, leave them in to include them. Select all or Clear all can also be selected to speed up the process. The default is to include all palliative care Read codes.

- **Patients** - Select either **Registered & unregistered within the last month** or **Currently Registered**. The default is **Currently registered**.

- **Save** and **Load** - The MDT Meeting Report can be run without manual interaction. If you want to schedule your report to run automatically, click **Save**, the **Scheduled report options saved** message is displayed. Click **OK** to continue. Now click **Load** to load the saved scheduled options, the **Scheduled report options loaded** is displayed. Click **OK** to continue. See on screen help within the Reporting module for details on scheduling.

**Note** - If you want to see the options that are loaded, go to P:\Reports\GSFS\GSFSrpt.xml file for the selected Read codes - marked 'True' for the ones you selected and 'False' for the others.

6. Click **Search** to run.

7. A progress bar is displayed and then the **Summary of Palliative Care Patients for use at Multi-Disciplinary Team Meetings** report is displayed.

8. Select either:

- **File - Print** to print the report

- **File - Save** to save this report - **Save Report** is displayed, click **OK** to save.

9. Click **Close** to return to Palliative Care Reports and then select **X** to close Palliative Care Reports.
Palliative Care Review Reports

The Palliative Care Review Report lists patients with an upcoming or expired palliative care review date recorded. The report highlights patients that have reviews that are due within the next 3 days, 7 days and those that are already overdue. The Palliative Care Review Report is not sent in messaging, it is for practice use. To run the Palliative Care Review Reports:
Running Palliative Care Review Report

1. From the **ECS/PCS/KIS Summary Management** screen, click and select **Palliative Care Reports**.
2. **Palliative Care Reports** is displayed.
3. Click on **File** and select **Palliative Care Review Reports**.
4. Palliative Care Review Report is displayed.

5. Select New or Existing report, then Click **View**.
6. The **Report of Palliative Care Patients with Upcoming/Overdue Reviews** is displayed.
7. Select either:
   - **File - Print** to print the report
   - **File - Save** to save this report - **Save Report** is displayed, click **OK** to save.

8. Click **X** to close the report, and again to close Palliative Care Reports.

---

**Emergency Care Summary User Guide (Scotland)**
Out of Hours Summary
The Out of Hours (OOH) Summary Report summarizes the entries recorded for the OOH services. It can produce two reports:

- An individual patient report
- A report of a group of patients based on a selected criteria

Running an Individual Patient Out of Hours Report

1. From the ECS/PCS/KIS Summary Management screen, click and select Palliative Care Reports.
2. Palliative Care Reports is displayed.
3. Click on File and select Out of Hours Summary.
4. The Out of Hours Summary Report is displayed.
5. Click Search and select the patient required from Select Patient in the usual way.
6. A progress bar is displayed for a short time and then the **Palliative Care OOH Summary Report** is displayed.

7. Select **File - Print** - to print the report.

8. Click **X** to close the Palliative Care Review Report.

9. Click **Close** to return to the Palliative Care Reports screen.
Running a Patients Matching a Criteria OOH Summary Report

1. From the ECS/PCS/KIS Summary Management screen, click and select Palliative Care Reports.
2. Select Palliative Care Reports.
3. Palliative Care Reports is displayed.
4. Click on File and select Out of Hours Summary.
5. The Out of Hours Summary Report is displayed, select Patients Matching a Criteria.

6. Complete Selection Criteria as required:
   - **Review Date** - Select from:
     - Within the next seven days
     - Expired four weeks ago
     - Expired
     - All
   - **Patients** - Select from:
     - Registered & unregistered within the last month
     - Currently registered
     - All

Palliative Care Reports - File - Out of Hours Summary Report - Patients Matching a Criteria
• **Consent** - This is consent to data sharing for palliative care, select from:
  - **Given**
  - **Refused**
  - **Either**

7. Click **Search**.
8. Select **File** -
   - **Print** - to print the latest report
   - **Print All** - to print all the reports selected
9. If you have selected more than one report, click \[\times\] to close the report you are viewing and the next, in reverse date order, is displayed.
10. Click \[\times\] to close the Out of Hours Summary Report.
11. Click **Close** to return to the Palliative Care Reports screen.

**Note** - The Out of Hours Summary Report can be produced for any patient who has a Palliative Care Plan even if they have not consented to share the data.

---

**ECS Consent Report**

The ECS Consent Status Report enables you to view and print a list of patients by selected consent status.

1. In **Registration**, click **Report** - **ECS Consent Report**.
2. The **ECS Consent Report** screen is displayed.
3. Select the ECS Consent Status required by placing a tick in one or more of the following the check boxes (see examples at the bottom of the page):
   - **Include patients who have ECS consent given** - Tick this option to include patients who have expressly given consent for ECS. As consent is automatically implied for ECS, this option only returns patients who have previously dissented with:
     - "Patient DOES NOT consent to upload of data" selected on the ECS Management Summary screen in Consultation Manager or/and
     - "Consent refused to data sharing for emergency care" selected on their Registration screen
     and have subsequently consented with:
     - "Patient consents to data upload" selected on the ECS Management Summary screen in Consultation Manager or/and
     - "Consent refused to data sharing for emergency care" deselected on their Registration screen
     This report is not dependant on the recording of any Read codes.
   - **Include patients who have ECS consent refused** - Tick this option to include patients who have refused consent to the upload of data to ECS by either "Patient DOES NOT consent to upload of data" recorded in the ECS Management Summary screen within Consultation Manager
or "Consent refused to data sharing for emergency care" within the patients Registration being recorded.

- **Include patients who have ECS consent not recorded** - Tick this option for those patients that have not had a consent recorded in either the ECS Management Summary screen in Consultation Manager or their Registration screen.

**Note** - This report does not take into account any dissent Read codes recorded on the patient record.

4. Select one or more of the **Registration Status** options as required, or leave the default as **All**.

5. Click **OK**.

6. Select one of the following Output Type and click **OK**.
   - **Window** - the report is shown on screen and can be printed if required.
   - **Printer** - prints the report.
   - **File** - enter a filename and save as a text file.
7. The Report shows the patient details along with their consent details. A patient count is also included at the bottom of the report.

---

**Example Searches**

- If you want to search for all patients who consent to ECS, select:
  - Include patients who have ECS consent given
  - Include patients who have ECS not recorded

---

8. If you have opted to view the report, click **Close** to return to the Registration module or print the report as required.
- Include patients who have ECS consent refused.

![ECS Consent Report]

**Note** - Patient dissents Read codes (e.g. 9Nd1. No consent for electronic record sharing or 9Ndq. Dissent for Emergency Care summary upload), are not included in this report but you can always create an ad-hoc search to find patients with these Read codes.

**Other Reports**

1. From the ECS/PCS/KIS Summary Management screen, click 📋 Reports.
2. Select one of the following reports:
   - **Practice Summary Report** - lists all the data that is included in an extract for the patient selected. It is split into three sections by extract type. To run a Practice Summary Report.
   - **OOH Summary Report** - displays the data that can be sent to OOH for the patient selected.
   - **Decisions to Send** - displays a list of all patients with a KIS decision to send recorded.
   - **Decisions Not to Send** - displays a list of all patients with a KIS decision NOT to send recorded.
3. The report is displayed.
4. Click either:
   - **Print** to print this report
   - **Save** to save this report for future reference
5. Click close to return to the ECS/PCS/KIS Summary Management screen.

**Searches for KIS Data within Searches and Reports - Examples**

The following searches are examples of those that you may want to run:

1. From the Vision main menu, select **Reporting - Search and Reports**.
2. Click **New Ad-hoc Search** 🕵️‍♂️, **Search:New Search** is displayed.

**Note** - To select **Note Pad**, select **Add Entity - All Other Clinical Data - Miscellaneous - Note Pad**. The **Subject of Note** must be typed in precisely.
KIS Consent

Search input details for KIS Consent search

Special Note

Search input details for Special Note search
KIS Review date

Search input details for KIS Review Date
Emergency Care Summary Management Audits

There is a suite of 5 groups of audits introduced as part of SIS 10285 that can aid you in the monitoring of Emergency Care Summary data.

To access the audits:

1. From the Vision front screen, select **Reporting - Clinical Audit**.
2. Click **Scottish Audits - Emergency Care Summary Management** to view the 5 groups of audits:
   - **Anticipatory Care**

   ![Anticipatory Care Table]

   **Emergency Care Summary**

   ![Emergency Care Summary Table]

   **Key Information Summary**

   ![Key Information Summary Table]
- **Palliative Care**

<table>
<thead>
<tr>
<th>Palliative Care</th>
<th>[Version 14, 16/04/2014]</th>
</tr>
</thead>
<tbody>
<tr>
<td>5317</td>
<td>Total Practice Population</td>
</tr>
<tr>
<td>8</td>
<td>0.15%</td>
</tr>
<tr>
<td>8</td>
<td>100.00%</td>
</tr>
<tr>
<td>1</td>
<td>12.50%</td>
</tr>
<tr>
<td>1</td>
<td>100.00%</td>
</tr>
<tr>
<td>0</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

- **Resuscitation**

<table>
<thead>
<tr>
<th>Resuscitation</th>
<th>[Version 14, 16/04/2014]</th>
</tr>
</thead>
<tbody>
<tr>
<td>5317</td>
<td>Total Practice Population</td>
</tr>
<tr>
<td>2</td>
<td>0.04%</td>
</tr>
<tr>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>2</td>
<td>0.04%</td>
</tr>
<tr>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>2</td>
<td>100.00%</td>
</tr>
<tr>
<td>2</td>
<td>100.00%</td>
</tr>
</tbody>
</table>
**Information Extracted**

The following table shows the data that is extracted for each of the ECS schemes:

<table>
<thead>
<tr>
<th>Information Type</th>
<th>ECS</th>
<th>ePCS</th>
<th>KIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Identifier</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Practice Name</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Practice Address</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Practice Telephone</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient Title</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient Surname</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient Forenames</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient Address</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient CHI Number</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient Sex</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient Date of Birth</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient Main Home Telephone</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient Mobile</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient Emergency Number</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Current Medication (any medication Acute or repeat issued in the last 30 days)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Drug Allergies</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Registered GP</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Usual GP name</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Patient Contacts (one Carer and one Next of Kin)</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Other Agencies involved</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Access Information</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Medical Records (selected)</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Preferred Place of Care</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Preferred Place of Final Care</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

---

**Emergency Care Summary User Guide (Scotland)**
<table>
<thead>
<tr>
<th>Category</th>
<th>✔️</th>
<th>☑️</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resuscitation Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DNACPR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Drugs at Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moving and Handling Equipment at Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catheter and Continence Equipment at Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative Care Register</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative Care Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness and Understanding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syringe Driver Use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date Palliative Care Review is Due</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OOH Arrangements Discussed with Patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OOH Arrangements Discussed with Carer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Should GP be contacted out of hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP Home telephone/mobile/pager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will GP sign death certificate in normal circumstances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Additional Useful OOH Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Other Relevant Issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*KIS Special Note</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self Management Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anticipatory Care Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Shared Assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Oxygen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults with Incapacity Form in Place</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Guardianship with Welfare Decision Making Powers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power of Attorney in Place</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children and Young Persons Acute Deterioration Management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Items marked * share a data entry area.
Remember - If you enter more characters than the maximum stated on each comments box they are NOT included in the extract.
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