Bath and North East Somerset,
Swindon and Wiltshire Partnership
Working together for your health and care

End of Life ICR User Guide

April 2024

EOL ICR (EPaCCS) – How does it work?

- Direct entry care plan accessible from within the BSW ICR
- You can view, create and edit the EOL-ICR document
- This is alongside other Health Care Professionals (HCPs) in the locality – It is a shared responsibility, designed for the whole MDT, enabling proactive and joined up care
- Basic information is required to create and publish a care plan. However, it is designed to be a fluid document that changes with the patient over time, HCPs can add to and update it, as the patient progresses through their journey
- All localities within the CCG will eventually be able to view the document (alongside digital ReSPECT and contingency plans) – including SWASFT!
- Please initiate for all appropriate BSW patients.
- You do not have to fill in everything, mandatory fields can be marked 'n/a' if information not known at the time of completion

EOL ICR Content

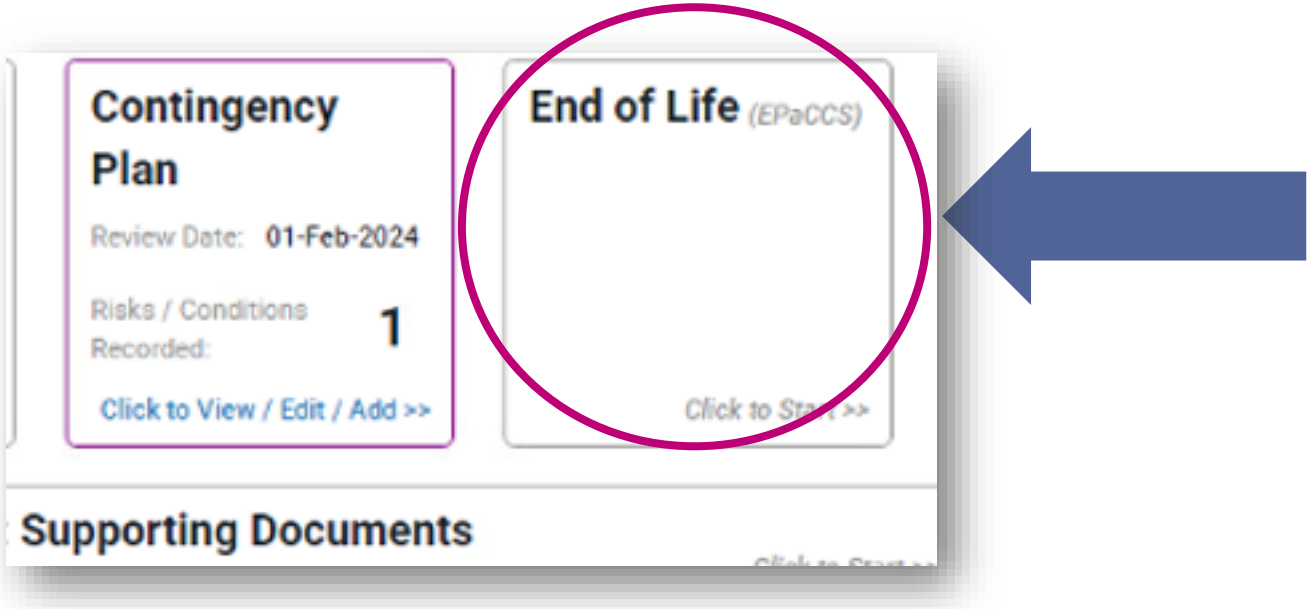
- Diagnosis & Prognosis including Gold Standard Framework (GSF)
- Special requirements (e.g., language, disabilities, performance status)
- Preferred place of care and death
- Advance care planning
- Anticipatory medications
- Resuscitation status
- Life sustaining treatment plans
- Other concerns & bereavement
- GSF & MDT Reviews
- Next Review

Accessing the EOL ICR

- When the ICR has launched, scroll through the blue tiles and select the **Care Plans** tile:

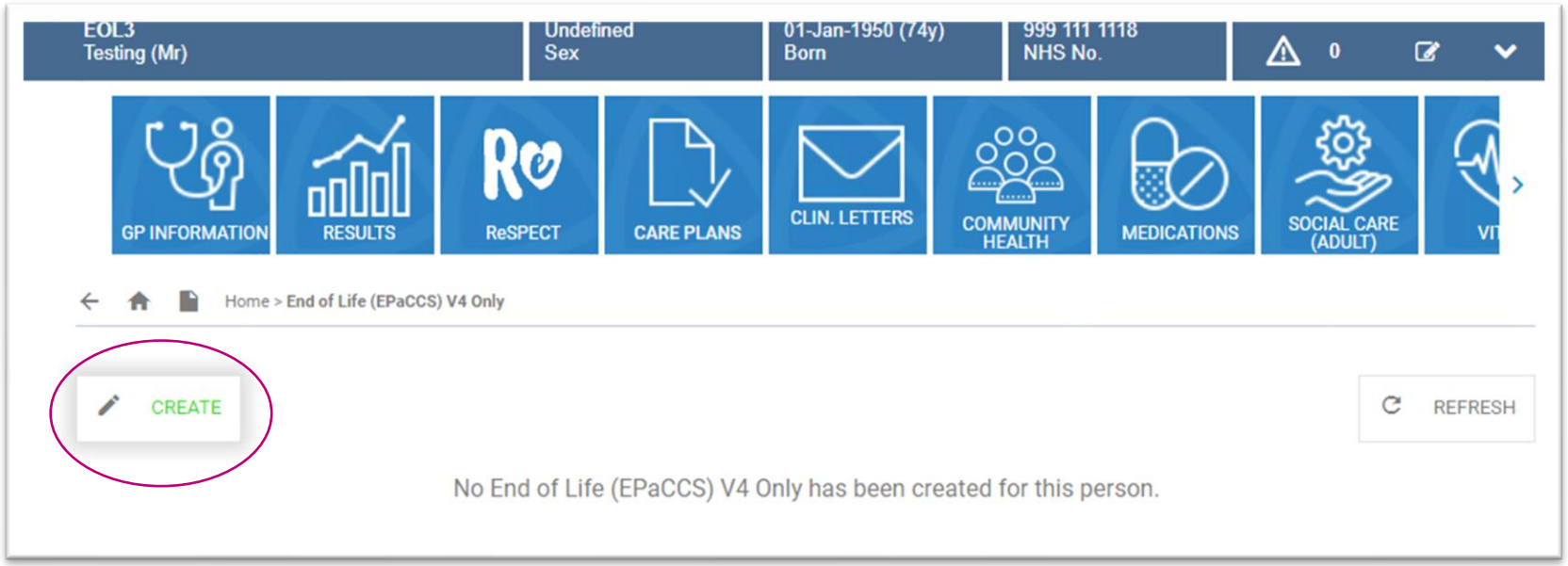
Arrows either side of the blue tile strip let you scroll right and left

- Next, within Care Plans, click End of Life (EPaCCS)



EOL ICR Creation

- To start a new care plan, click CREATE



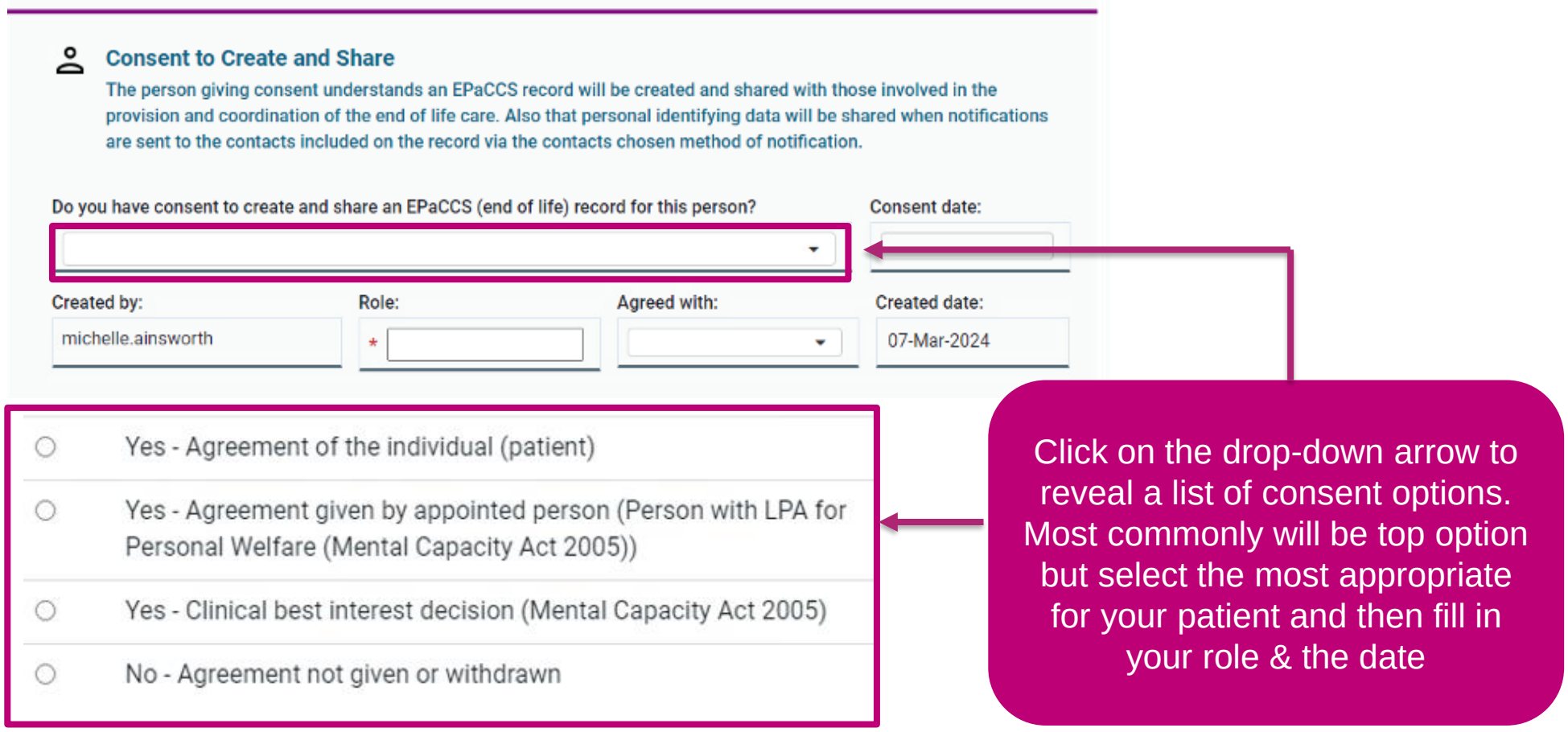
EOL ICR creation, consent and empowering the patient

- When you first create a EOL ICR it will ask about consent
- As the patient has an ICR they have already consented to data sharing so you can assume consent
- However, if patient in front of you, always good practice to ask consent to both ***create and share*** the EOL ICR
- Explain that current IT don't allow important discussions and documentation to be shared with other HCPs outside your organisation
- Thus, the hope is that this will reduce unnecessary repetition for them and allow delivery of care in line with their wishes
- Please use this as ***an opportunity to empower the patient***

"Please see my Integrated Care Record"

EOL ICR Consent

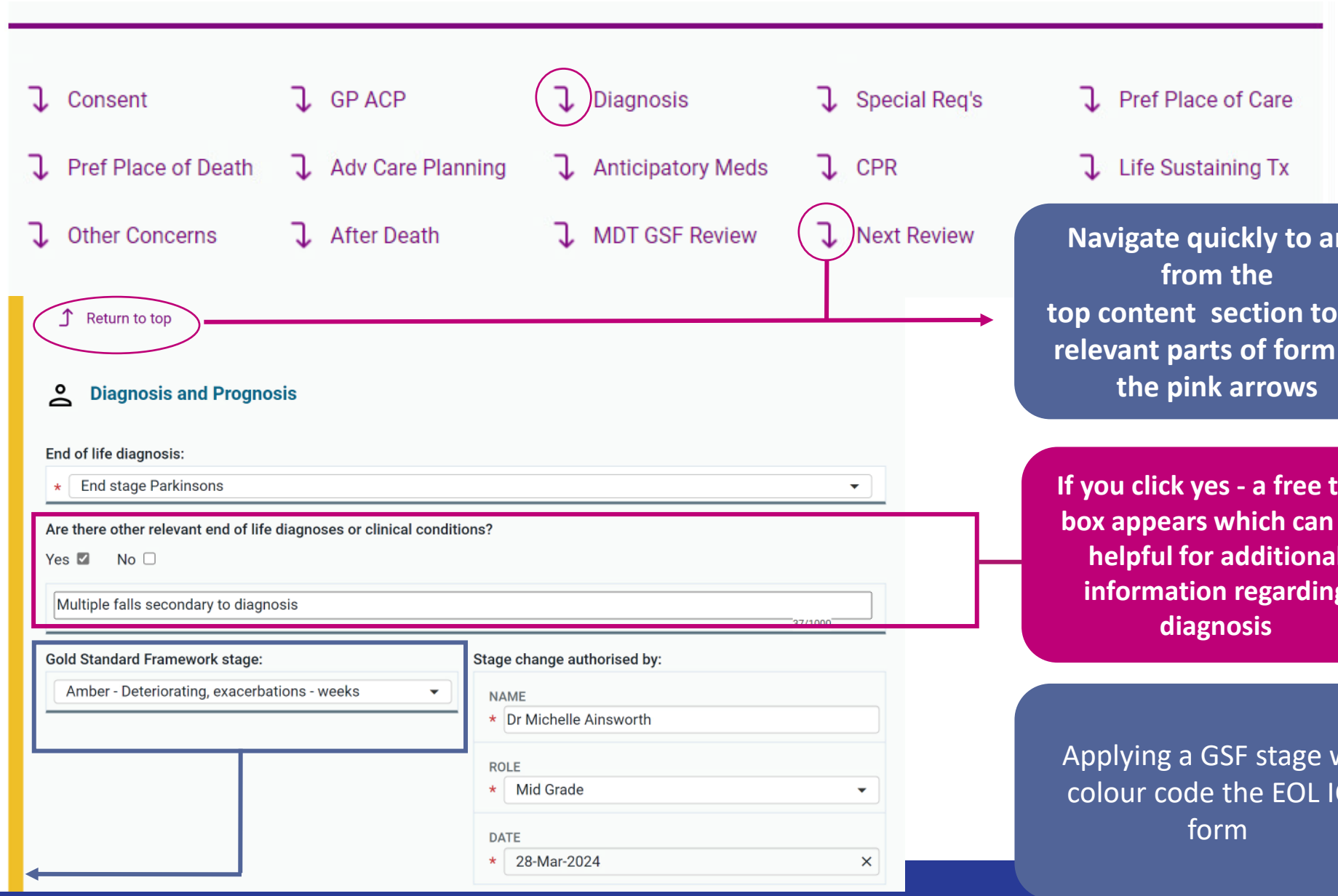
- You won't be able to access the form until you complete the consent section



EOL ICR Creation

- Then complete the form based on your conversation with the patient and the available information to you at that time
- Sections are a mixture of tick-box, drop-down menus and free-text boxes.
- Some sections are mandatory but if you don't have the information to hand you can type 'n/a' or 'discussion not appropriate' into these boxes and still publish the plan
- You are **NOT** expected to complete every section, just key highlights. It is designed to be completed by different members of the MDT as the patient's condition progresses
- The care plan will be completed by hospital teams, hospice teams, primary care and other community providers

EOL ICR Completion



Navigate quickly to and from the top content section to the relevant parts of form via the pink arrows

If you click yes - a free text box appears which can be helpful for additional information regarding diagnosis

Applying a GSF stage will colour code the EOL ICR form

Gold Standard Framework Note

- The Gold Standard Framework (GSF) stages are a way of colour-coding patients based on their expected prognosis
- It is relevant to anyone with a life limiting illness
- A prognosis can be very helpful to colleagues who have never met the patient before

- In addition to colour coding the EOL-ICR form for a visual prompt, it also automatically pulls through this information for another bit of software (the dashboard) that primary care frequently use
- This helps them filter their patients appropriately

EOL ICR Completion

1st preferred place of care:

Hospice

* Dorothy House Winsley

22/400

2nd preferred place of care:

* Hospital

* RUH Bath

8/400

Has this been discussed with the person?	Yes ☑	No ☐
Has this been discussed with the person's family?	Yes ☑	No ☐

Summary of what has been discussed and with whom:

* discussed with Mr Test & his Wife. They are going to discuss with their two children Jack and Jill. He Would like to die/be cared for in Dorothy House but understands there may not be a bed available when the need arises. However, he is very clear that he does NOT want to die at home therefore 2nd option would be hospital but for EOL measures and care only. He doesn't want his wife to struggle with him being @ home and thinks this would be traumatic for her and affect how she feels about the family home after his death.

525/1000

- ○ at Home
- ○ Care Home
- ○ Community Hospital
- ○ Hospice
- ○ Hospital
- ○ Learning Disability Unit
- ○ Mental Health Unit
- ○ Nursing Home
- ○ Relative's Home
- ○ Residential Home
- ○ Unable to express a preference
- ○ Undecided
- ○ Discussion not appropriate
- ○ Discussion declined
- ○ Other

PPD and PPC drop-down options are both the same. Options available if discussion not appropriate or declined

Example text to illustrate

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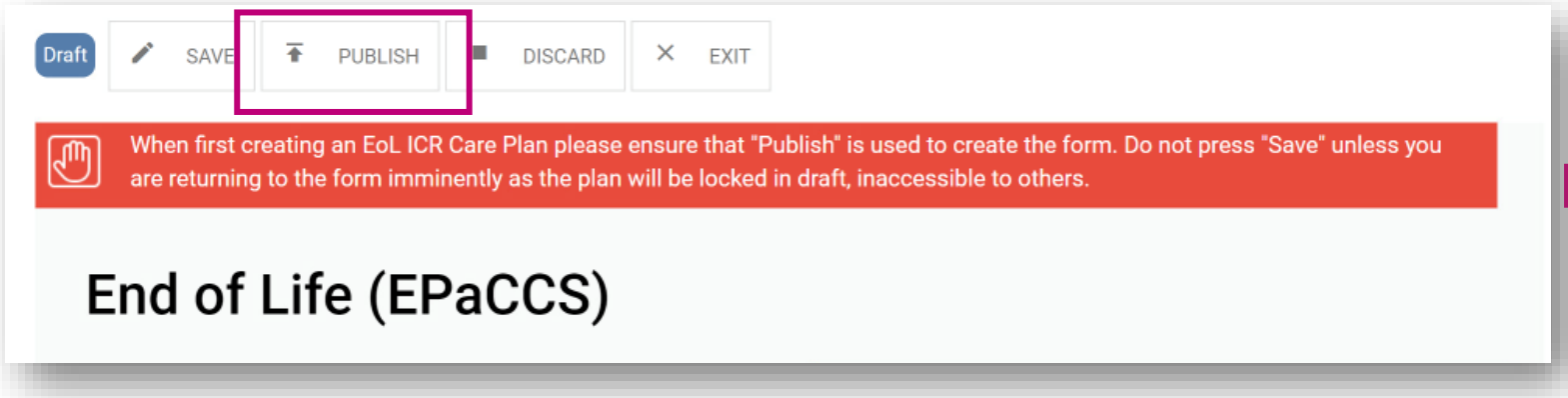
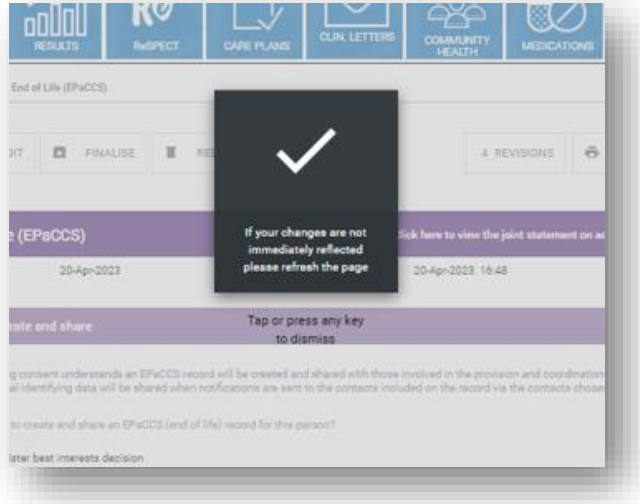
Example text to illustrate

EOL ICR - Newly Created – How to Save

PUBLISH = make the care plan available to other professionals

Once the EOL-ICR has been CREATED follow the instructions on the red banner at the top of the ICR page. Please hit PUBLISH!





SAVE – Save changes without publishing them – only you will be able to see the draft form. Prevents others from accessing or editing the plan.
PUBLISH – Makes the care plan available to other users. They can then view and contribute to it
DISCARD – delete the care plan (only do this if created in error e.g. wrong patient)