**THE KEY INFORMATION SUMMARY (KIS) / EMIS**

**INTRODUCTION**

This guidance is principally to assist GP practices in using the Key Information Summary (KIS) for patients with palliative care needs. Clearly though, KIS is very useful for other cohorts of patients as well. In the description that follows the data fields most relevant to patients with palliative care needs have additional explanatory text. The other fields are included for completeness.

KIS was piloted in Scotland in 2012 and introduced throughout GGC in 2013. Basically KIS supersedes the electronic Palliative Care Summary (ePCS). Almost all GGC practices are now using KIS.

**KIS & ePCS**

It is helpful to consider the advantages of KIS. First the organisational layout of KIS is significantly more user friendly than ePCS.

For example KIS opens at the consent tab (0 – Consent) highlighting the importance of the consent process and the need for this to be completed for data upload to occur. In addition the individual tab headings are more intuitive to follow.

Second there is vastly more free text space – always a recurrent criticism of ePCS.

Third, and perhaps most important, because KIS is not just for patients deemed to have palliative needs it is both easier to decide who should have a KIS record and also to broach the subject with patients.

The major disadvantage of KIS is that some of the fields don’t appear where they might be expected e.g. care at home that basically alludes to the presence of a syringe pump appears under the ‘care and support’ tab, or in rather interesting combinations e.g. the presence of capacity issues along with moving and handling equipment!

Apart from GGC OOH Medical Service KIS records can be viewed by NHS24, all Acute Receiving Units, the Scottish Ambulance Service (though not by the Emergency Medical Dispatch Centres) and by the GGC Hospices. An important development is that the Community Nursing Services in the Glasgow & Clyde area can access the KIS summary in both the in-hours and OOH periods.

**USING KIS FOR PALLIATIVE CARE - PATIENT SELECTION**

Basically, which palliative care patients should have an KIS record?

This is now easier as KIS has been designed to be relevant from earlier in a patients illness/disease trajectory and so consideration of proximity to end of life is much less relevant.

The most important issue remains the potential need for information to be available to the OOH services regarding any patient with a life threatening illness.

A useful starting point would be consideration of the practice Palliative Care register and any pre-existing Gold Standards Framework register. In addition practices might wish to consider their CDM registers e.g. heart failure, COPD & ‘multiple appearances’ and any patients who are say housebound or in a care home due to ill health.

**KIS INFORMATION TRANSFER**

Information transfer is now much easier than it was at the outset. The steps below must be taken to ensure all KIS and ePCS information is uploaded.

* **‘KIS Upload decision’ set to ‘allow data upload’ and date set**
* **‘Patient consented?’ set to ‘yes’ and date set**

Data transfer is thought to be fool proof but practices can check if a KIS record is available by logging on to ECS.

**USING KIS**

To enter data in KIS Consultation Mode must be used.

‘8 – KIS’ will open the KIS dialogue box.

The KIS dialogue box consists of 6 tabs:

* 0 – Consent
* 1 : Demographics
* 2 : Current Situation
* 3 : Care & Support
* 4 : Resuscitation & Preferred Place Of care
* 5 : Palliative Care

**‘0 – Consent’**

* **KIS Upload decision**

When KIS is opened the ‘0 – Consent’ tab is the active tab.

‘KIS upload decision’ is the first field in the ‘0 – Consent’ tab. If data is to be uploaded the ‘allow data upload’ option must be selected and the date that this entry is valid from set.

* **Patient consent**

As has always been the case consent must be given by the patient for transfer of information from GP practices to OOH medical services.

KIS consent is very explicit and, as with ePCS, forms part of the trigger for upload.

If the patient has consented then this option should be chosen and the date that this entry is valid from should be added. Where patient consent has been given (the vast majority of situations) the remainder of the ‘Patient consent’ fields do not need to be completed.

If, however, the patient is either not aware of the decision to upload or has refused consent then the remaining fields in ‘Patient consent’ need to be completed.

* **Apply Special Note**

If a Special Note is wished then the ‘Apply Special Note’ box should be ticked and a free text special note added. This can be given an expiry date if wished.

The Special Note section is one of the most important fields within the system allowing a large quantity of very varied information felt to be relevant to the patients management and care to be made readily and available to other services.

Whether or not a Special Note is added has no bearing on data upload.

* **KIS Review Date**

Though not needed for data upload this box must be ticked and a review date chosen.

**Data Upload**

‘KIS Upload decision’ and ‘Patient consent’ must be completed for data to upload.

**1 : Demographics**

* **Patient Details**
* **Practice Details**
* **Usual GP**

These are all pre-filled

* **Contact Numbers**

A useful addition is the ability to add an additional contact number

* **Carers**

Carers can be added as before

* **Next of Kin**

There is now additional space to note NoK, remembering that NoK does not afford any legal status.

* **Access Information**

‘Key holder’ and ‘Address instructions’. Both are very useful and have adequate free text space.

**2 : Current Situation**

* **Medical History**

To add a diagnosis to the KIS click ‘Modify/Edit’ then click on the relevant Problems and click ‘OK’. This is an important contractual area as the Palliative Care DES currently stipulates ‘diagnosis’ as a minimum requirement for Anticipatory Care Planning.

* **Self Management Plan**

More relevant to the other uses of KIS

* **Anticipatory Care Plan**

Ticking this box and adding free text can add more extensive ACP information. This is probably one of the most important fields within KIS.

* **Single Shared Assessment**
* **Oxygen**

The presence of home oxygen can be noted here, perhaps particularly important when caring for people with conditions such as COPD who are entering their end of life phase.

* **Additional Drugs Available at Home**

This field allows the addition of information on Just in Case/Anticipatory Prescribing medication. In palliative care situations it can be argued that proactive prescribing remains one of the most important tasks of in-hours general practice and so this filed is a welcome reminder to consider this issue of care/management.

* **Catheter and Continence Equipment at Home**

**3 : Care & Support**

* **Agency Contacts**

This contains an extensive drop down pick-list of those involved in the patient’s care.

* **Moving and Handling Equipment at Home**

Self explanatory!

* **Care at Home**

Basically this deals with the presence of a syringe ‘driver’ (should really be pump!).

* **Adults with Incapacity Form**
* **Power of Attorney**
* **Guardianship with Welfare Decision Making Powers**

All of these can be documented with free text to allow information e.g. name and contact number of PoA.

The presence of the second heading does seem slightly strange along with these!

**4 : Resuscitation & Preferred Place Of Care**

* **Preferred Place of Care**

This can be set from an 8-option pick list

* **DNACPR**

Resuscitation status can be set to either ‘For resuscitation’ or ‘Not for resuscitation’ and whether a DNACPR form is / is not in place.

* **CYPADM**

For children / young people whether a CYPADM (Children and Young People Acute Deterioration Management) form is / is not in place.

**5 : Palliative Care**

* **Palliative care register**

This field is used to add the patient to the practice’s palliative care register. It also prompts for a palliative care review date.

* **OOH arrangements**

There are three sub headings in this field – ‘Have arrangements been discussed with patient / carer’, ‘GP sign death certificate in normal circumstances’ and ‘GP should be contacted OOH’ are tick box options and all have attached free text space.

* **GP OOH Contact Number(s)**

There is a separate free text space for these details

* **Patient’s / Carer’s Understanding**

Understanding of diagnosis and prognosis is also included in this section. This can be detailed for both the patient and their carers. The wording in the drop down options for prognosis remains a little strange! Knowing who knows what can be extremely helpful for practitioners seeing patients in the out of hours period.

* **Palliative care and treatment**

An extensive drop down pick list of options around these two areas.

**KIS BENEFITS**

As with ePCS there are considerable benefits for patients, their carers, primary care (in and out of hours) and indeed the NHS.

**Patients**

A group that clearly matters – there is only one chance at caring for the dying

Tend to have a lot of rapidly changing need

Earlier identification of needs

Earlier planning of care

Information transfer is much better

If seen OOH visiting GP will be better informed/prepared

Reassurance and feeling of safety for patients / carers

**Primary care - *In hours***

Makes information transfer very simple

Much easier to update information

More effective and less work

Fits with both the GSF and the Palliative Care DES

**Primary care *- OOH***

More information

Legible information

No more laborious transcription

More pro-activity from in hours should lead to less OOH medical contacts

**NHS**

Clearly will lead to a better service for the reasons already mentioned

Less inappropriate actions e.g. 999 ambulances

Less work for OOH services

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