Background Our organisation has been using SystmOne as our electronic patient record since 2012. In 2014, a comprehensive review of how different teams were using the system identified that data was inconsistently recorded and key information was difficult to locate, proving frustrating and time-consuming.

Our goal was to standardise data entry, to improve accuracy and reduce duplication of data within the patient record.

Aims To improve the use of an electronic patient record so that clinicians can view previous entries more clearly, reduce duplication, avoid missing data and facilitate reporting measures to enhance patient care.

Methods The organisation worked as a collective to create a bespoke and comprehensible holistic template that could meet the needs of all teams (excluding Lymphoedema). The new template included sections around ‘patient insight and information needs’, ‘carer needs’ and ‘family bereavement issues’, responding to the suggested National Dataset Outcome Measures (MDS) and a local audit on bereavement needs.

An agreed ‘Go live’ date was publicised, training was provided and staff supported through the transition.

Results

• Improved quality of the shared patient record
• Key information more accessible
• Comprehensive demographic and geographic information as per MDS requirements
• Provides detailed clinical information to the senior management team and the board to make strategic decisions on the future development of the care provision
• Helps to deliver coordinated care across the multi-disciplinary teams
• Integrated advance care planning via the use of agreed coding with external health and social care providers
• New way of recording patient measure (Phase of illness, Australian Karnofsky Performance Status and Integrated Palliative Outcome Score) supporting clinical staff to provide more personalised care
• New assessment domains allowing key areas to be covered
• Incorporation of built-in views to avoid duplication and to identify missing information.

Conclusion The new holistic template is viewed as an example of best practice and our organisation is now sharing the template with other providers.

Electronic Palliative Care Co-ordination Systems (EPaCCS) are an electronic means of communication and coordination at end-of-life. Arguably implementation of EPaCCS should now be a high priority for all, it will contribute significantly to achieving Ambitions 2015–2020, it is an outcome for end-of-life care in NHS England’s Sustainability Transformational Plans (STPs) and supports general practice now that CQC are inspecting against the end-of-life domain.

Information technology (IT) enables the EPaCCS outcomes and anticipated benefits to be achieved; but it is not in isolation. Implementation requires multiple interdependent factors to ensure utilisation of EPaCCS and realise patient benefits. These include, but are not isolated to, engagement and training, change...