eHealth Programme
Business Services Organisation (BSO)

# KEY INFORMATION SUMMARY

## USER GUIDE

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# Key Information Summary (KIS) – User Guide

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# Accessing the Key Information Summary

**To access the Key Information Summary (KIS):**

1. Select a patient and open a consultation.

2. Select **List** and **ECS Summary Management (see Figure 1).**

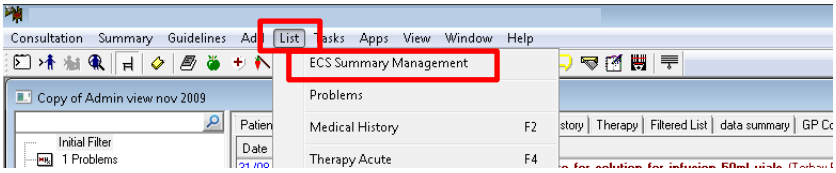



**Figure 1**

3. Select the **Key Information Summary** tab **(see Figure 2).**

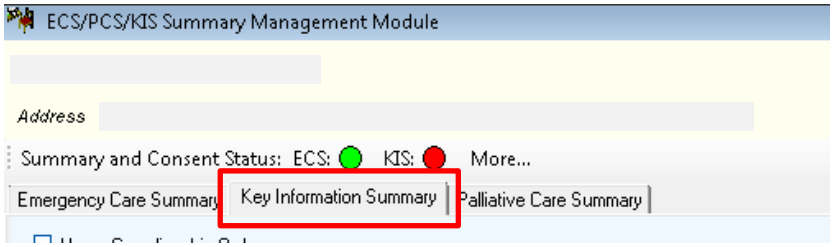



**Figure 2**

# Recording Consent for KIS

There are 2 stages to recording consent and both need to be completed to ensure the Key Information Summary information is available in NIECR.

If the KIS consent button is **RED**, no KIS information will be available/shown in NIECR.

When the KIS consent button is **GREEN**, information is being shared with NIECR and will be uploaded on a daily basis.

## Stage 1 – Recording Consent

1. Select **More** in the **Summary and Consent Status bar** to open the Consent window **(see Figure 3).**

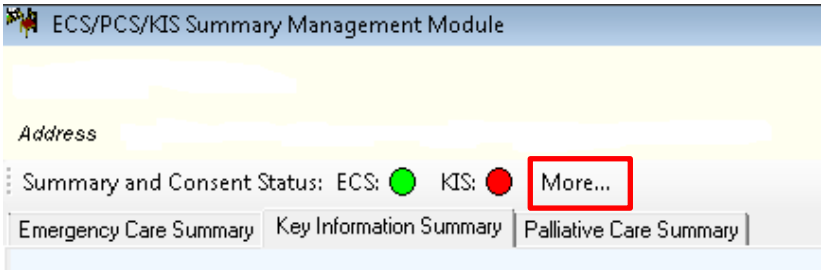



**Figure 3**

*Please note – the ECS button will either be red or green – this has no impact or implication for Key Information Summary.*

2. Click **Change (see Figure 4)** beside 'No KIS consent status recorded'**.**

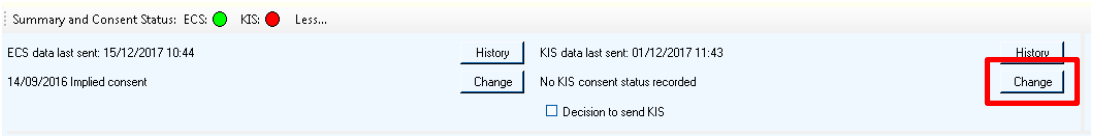



**Figure 4**

3. The KIS Consent screen is displayed **(see Figure 5).**

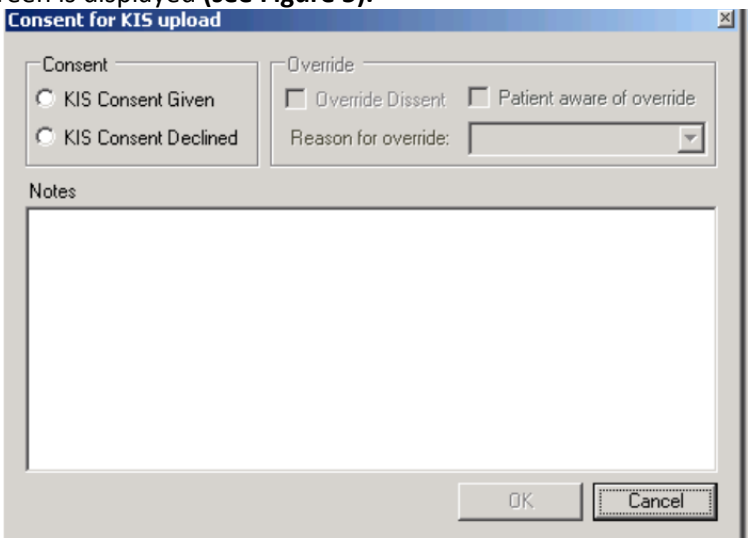



**Figure 5**

4. If the patient has consented to share the Key Information Summary in NIECR, select **KIS Consent Given (see Figure 6).**

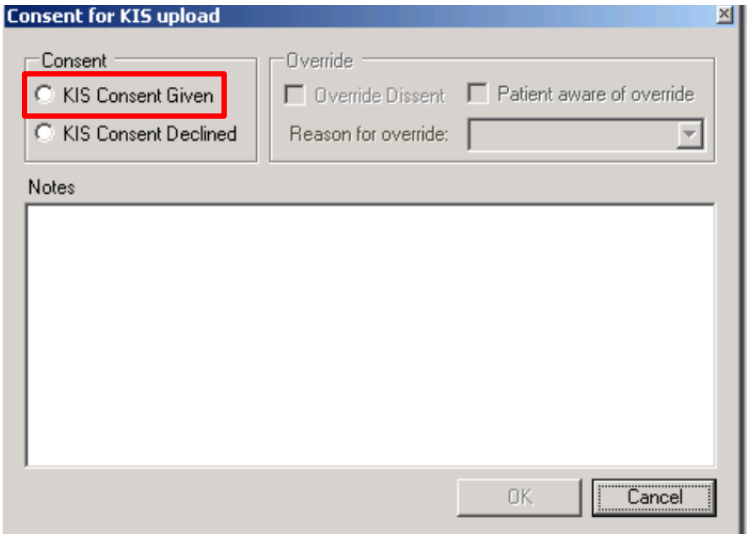



**Figure 6**

5. If you are acting as the patient advocate or decide that this information is in the patient's best interest to be shared in NIECR, use the override function. To activate the override option choose **KIS Consent Declined** and tick the Override Dissent check box and provide a reason from the drop down list **(see Figure 7).**

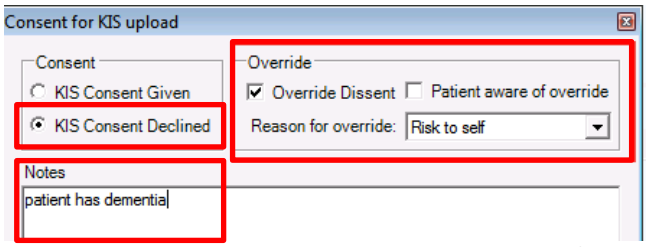



**Figure 7**

The Override section must be completed:

- **Override Consent** – Tick

- **Reason for override** - Select from the available list

- **Patient aware of override** - Tick if appropriate

- **Notes** - short explanation of the override decision

6. Complete as required, add any notes and click **OK** to save and return to the KIS screen.

**Please note that if you select KIS Consent Declined and Override, you will need to add some additional information in the Special Note box at the bottom of the screen to confirm the GP override option.**

## Stage 2 – Recording the Decision to Send/Not Send KIS

The Key Information Summary record will **ONLY** be shared when the option **Decision to send KIS (see Figure 8)** has been chosen.

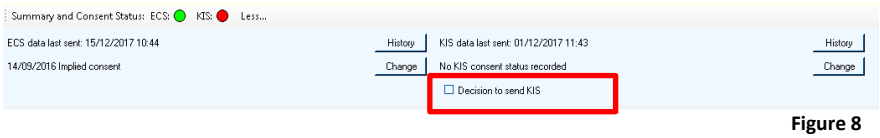



**Figure 8**

The following menu is displayed (**see Figure 9**).

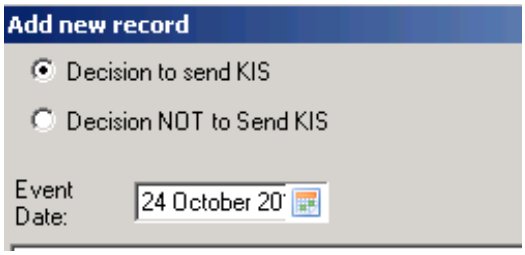



**Figure 9**

1. Select **Decision to send KIS** or **Decision NOT to Send KIS** as appropriate.

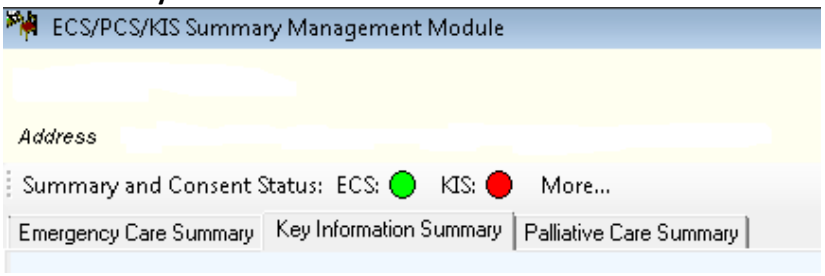
2. Enter comments as required.

3. Click **OK** to save and return to the KIS screen.

## Practice Review Date

You are required to input a practice review date for reviewing the patient's Key Information Summary. A MDT Assessment and Palliative Care Review can also be set but a Practice Review is required for each patient with a Key Information Summary. The system will prompt you to enter a recall date when you close the Key Information Summary if it is not entered.

1. Click **More** on the **Summary and Consent Status** bar.




2. The **Summary and Consent Status** section is displayed **(see Figure 10).**

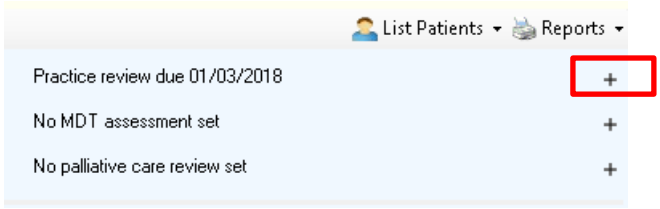



**Figure 10**

3. Click + alongside the review you wish to enter.

4. The following screen is displayed **(see Figure 11).**

**Recall Date:**

Enter a Recall date to review the Key Information Summary

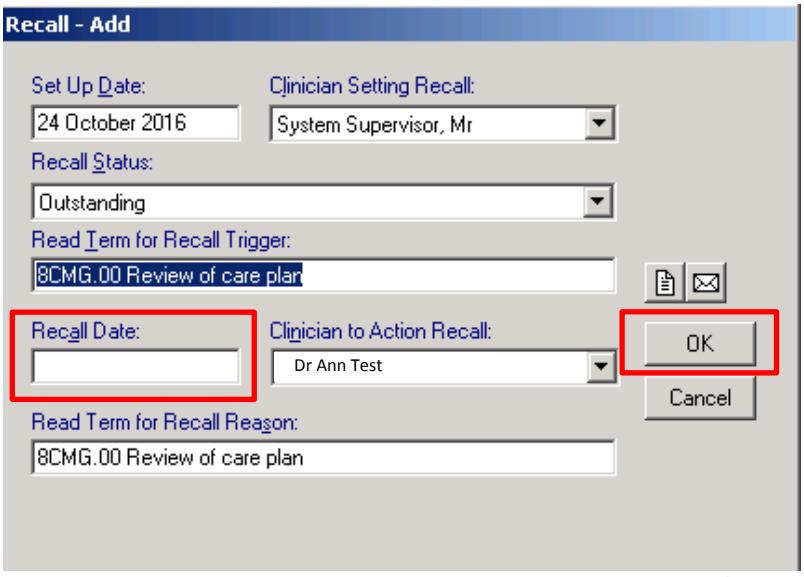



**Figure 11**

5. Click **OK** to save and return to the KIS screen

## Adding Data to the Key Information Summary

Tick the boxes which are appropriate for the patient **(see Figures 12 & 13).** This will open a new window and you can add Comments as required, change the Priority Code and Show Full Form:

Allows you to record details regarding **Power of Attorney** information

Does the patient have a **Single Shared Assessment Plan**?

Does the patient have an **Advanced Decision to Refuse Treatment** in place or retracted?

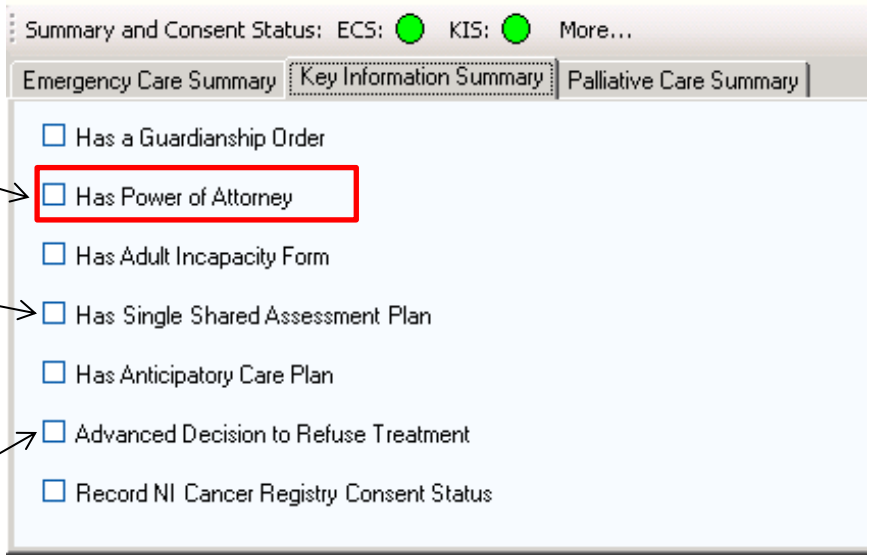



**Figure 12**

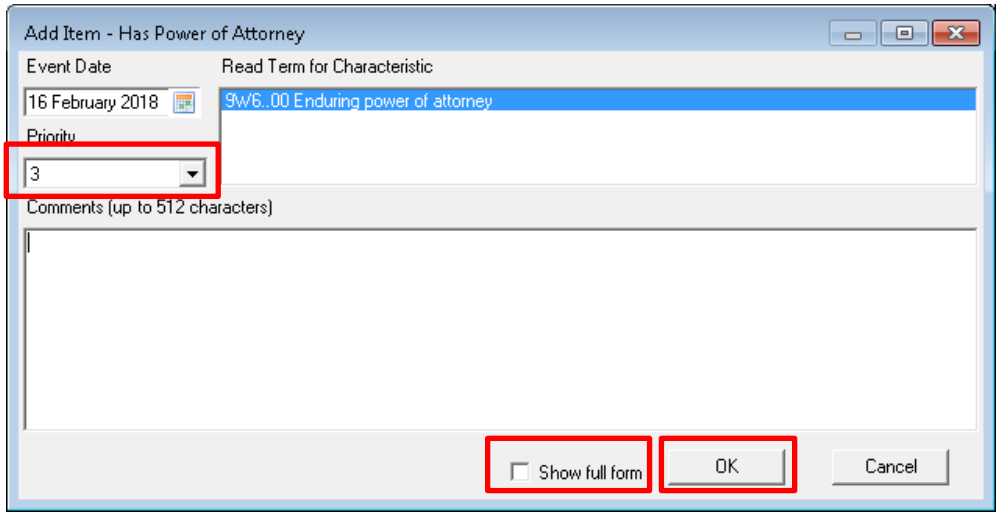



**Figure 13**

Tick the appropriate check box to input additional information and click OK to save and return to the KIS screen. Please be aware that if you change the priority, this will also show up in the **Relevant Medical History** section.

## Self Management Plans and Care Plan information

Click **Add** to input a Self Management Plan or Other Care Plans.

Self Management Plans and Other Care Plans which are already recorded on practice patient record along with the read codes will auto-populate along with any comments.

A number of Care Plans can be input **(see Figures 14 & 15).**

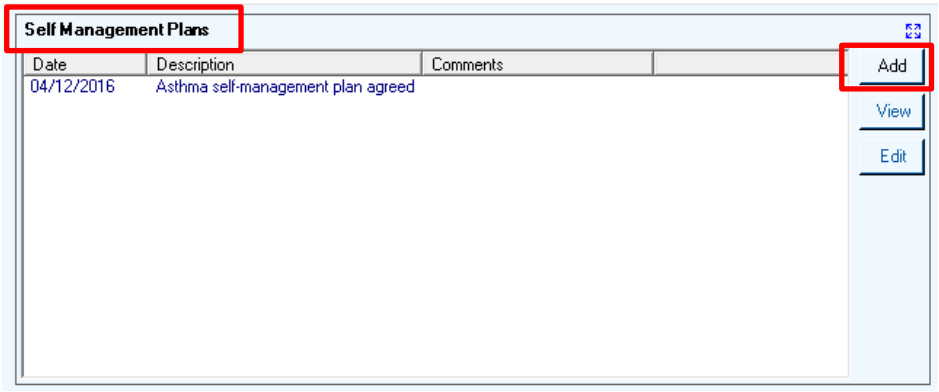



**Figure 14**

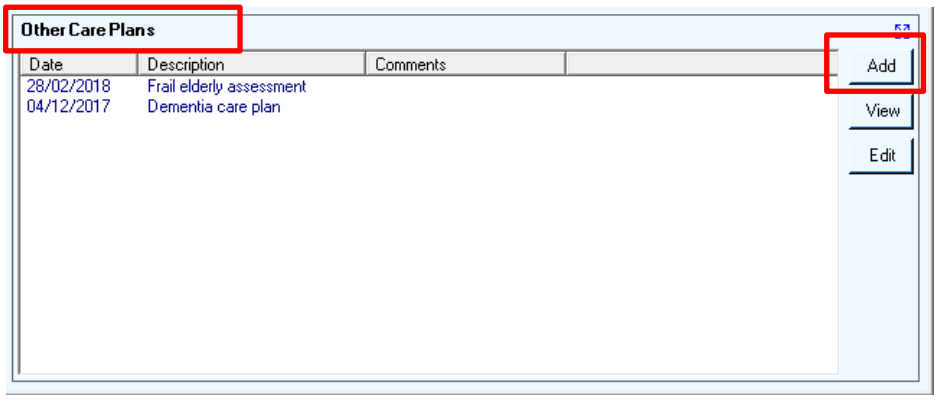



**Figure 15**

The Dementia Care Plan is available to select within **Other Care Plans.**

## Patient Contact List

This allows you to record **Carer, Next of Kin** and **EoL (End of Life) Key Worker** information for the patient.

If any of this information is already recorded on the clinical system, it will automatically appear on the KIS record. If the information is recorded in the KIS record, this will show up in the patient registration screen.

To update **Carer, Next of Kin** or **EoL Key Worker**, you must select the relevant option and select the **Update** option. **(see Figure 16).**


**Figure 16**

Select **Add** to add a contact **(see Figure 17).**

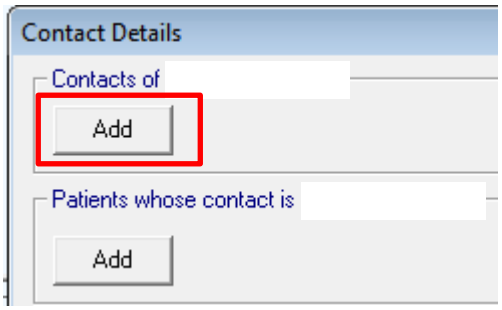



**Figure 17**

An **Add Contact** screen is displayed where you can enter a surname and a forename and search. The system will search to see if the contact is an existing patient on the system **(see Figure 18).**

Enter the **Next of Kin/Carer** name

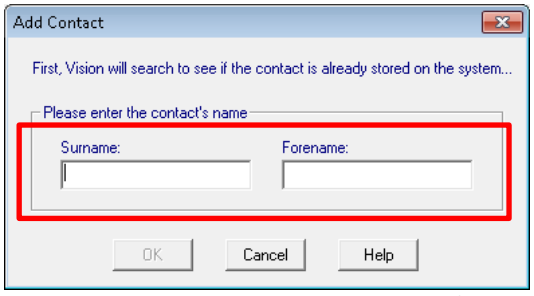



**Figure 18**

If the contact is a patient, their details will be displayed **(see Figure 19).**

Press **Select** if you wish to use this contact

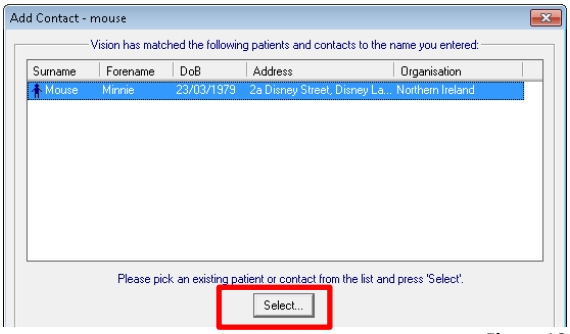



**Figure 19**

If the Carer/Next of Kin is not a patient, click **Add**. The following window is displayed **(see Figure 20).**

Select **Add** to input an **address (only town needs to be completed, but this does not come through to ECR.** and **telephone number** for the contact

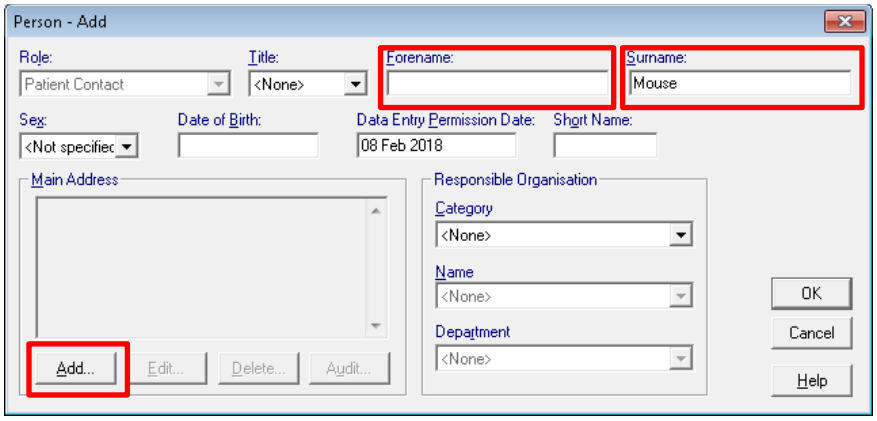



**Figure 20**

Input the **Relationship to Patient** information and tick the **Carer** and/or **Next of Kin** check boxes as appropriate (**see Figure 21**).

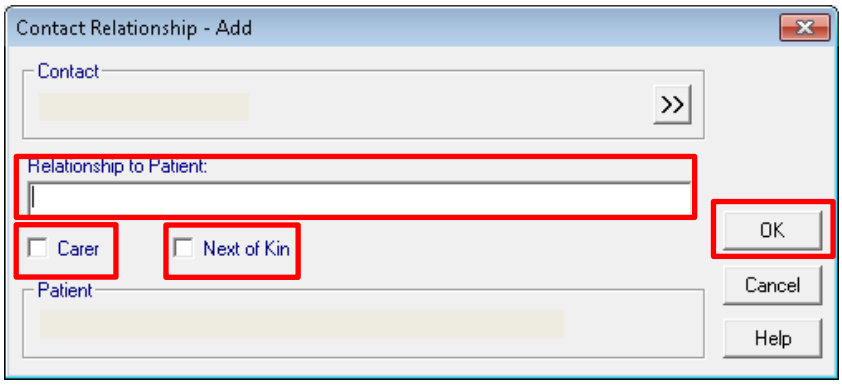



**Figure 21**

Click **OK** to save and return to the KIS screen.

## Relevant Medical History

The system will display all of the patient's Priority 1 Medical History **(see Figure 22).**

If you wish to edit the information which is shared with NIECR click **Update.**


**Figure 22**

The following window will be displayed (**see Figure 23**).

**Priority 1 Medical Histories** are displayed at the top half of the screen. You can remove any items which you do not wish to share with NIECR by unticking the relevant check box.

All other Medical History items are displayed at the bottom half of the screen.

Please review this list and select any other items which you wish to include in the Relevant Medical History for this patient by ticking the check box.

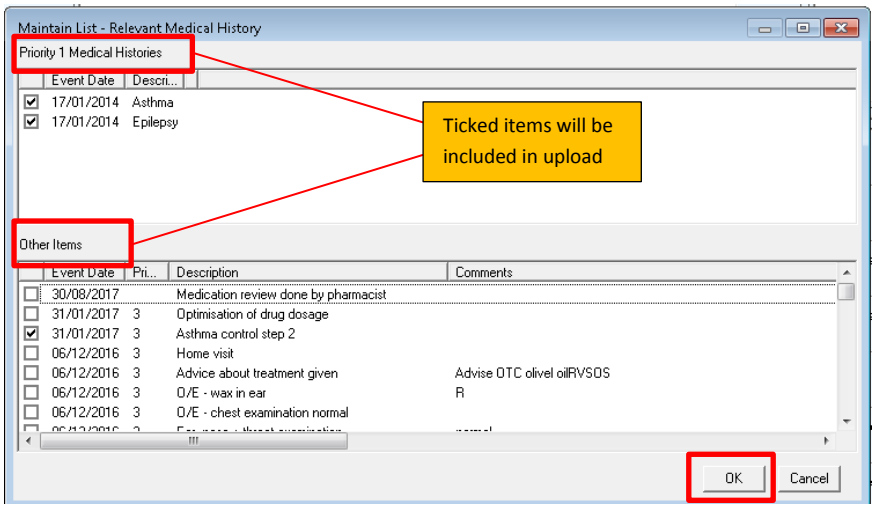



**Figure 23**

Click **OK** to save and return to the KIS screen**.** The updated list will display in the Key Information Summary.

## Access Information

Allows you to record access information – Key holder information, address instructions (such as front door locked, use side entrance) and patient door access code (**see Figure 24**).

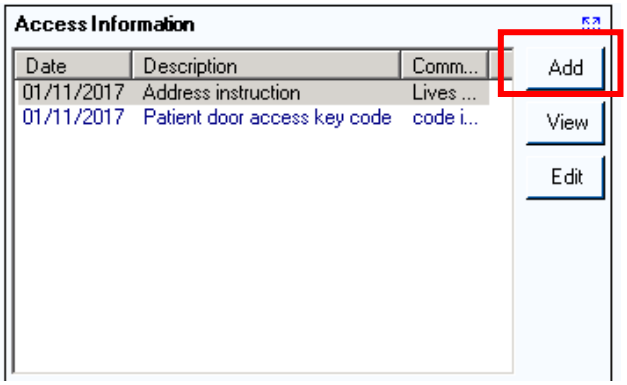



**Figure 24**

Click **Add** to input access information and add any comments as required.

Click **OK** to save and return to the KIS screen.

## Other Agencies Involved

Allows you to record any agencies involved with the patient, for example District Nurse attends, meals on wheels, etc. **(see Figure 25).**

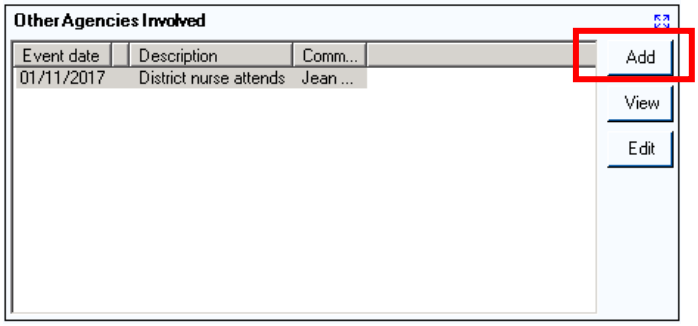



**Figure 25**

Click **Add** to input information regarding other Agencies involved and add any comments as required.

Click **OK** to save and return to the KIS screen.

## Adding Additional Information to the Key Information Summary

Displays and allows you to record the following (**see Figure 26**):

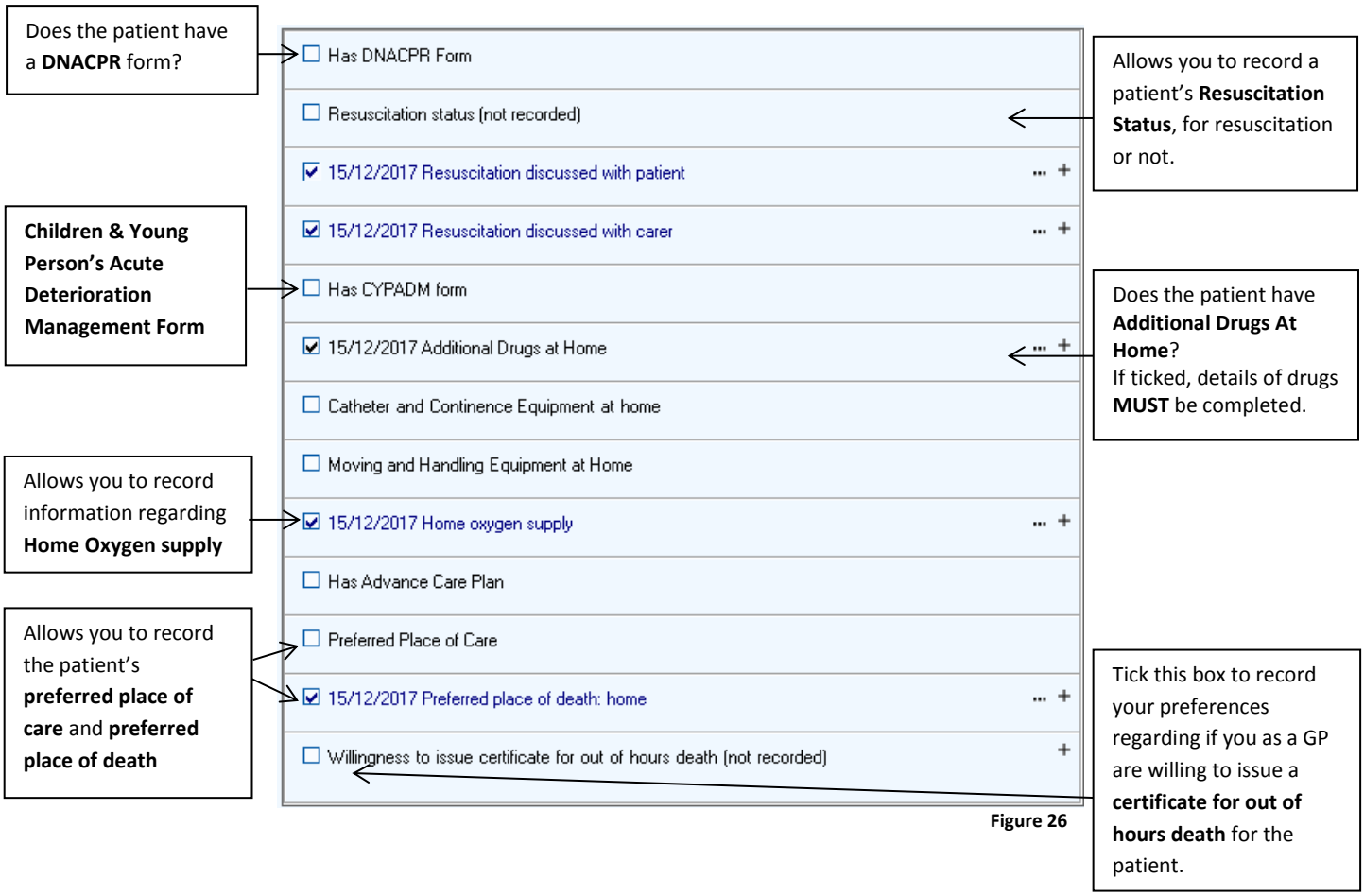



**Figure 26**

Tick the appropriate check box to input additional information and click **OK** to save and return to the KIS screen.

## Adding a Special Note

At the bottom of the screen is a **Special Note** text box. Use the **Special Note** to enter any other information or anything you wish to draw attention to, for Out Of Hours services or secondary care to be aware of.

Click **Update** and enter any information (**see Figure 27**).


**Figure 27**

Click **OK** to save and return to the KIS screen.

## Accessing the Palliative Care Summary

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

1. Select the **Palliative Care Summary** tab **(see Figure 28).**

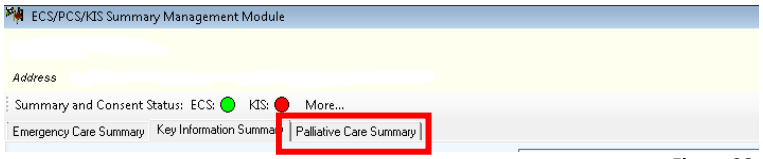



**Figure 28**

2. The **Palliative Care Summary** is displayed; the bottom two thirds of the screen are shared with **Key Information Summary (see Figure 29).**

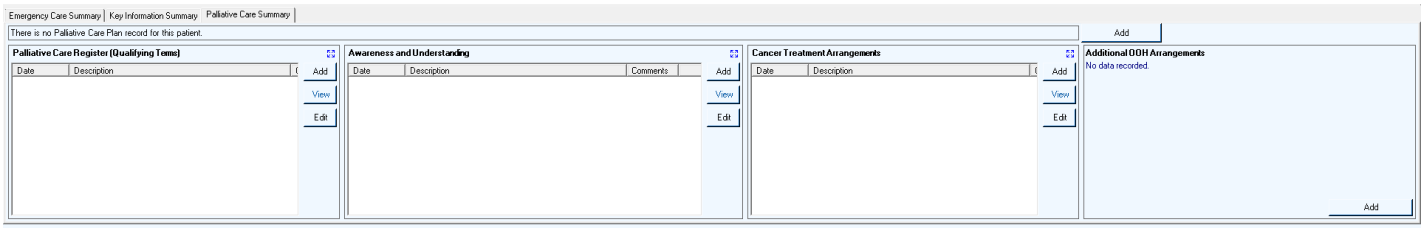



**Figure 29**

## Palliative Care Register (Qualifying Terms)

Allows you to record Palliative Care Register information (**see Figure 30**):

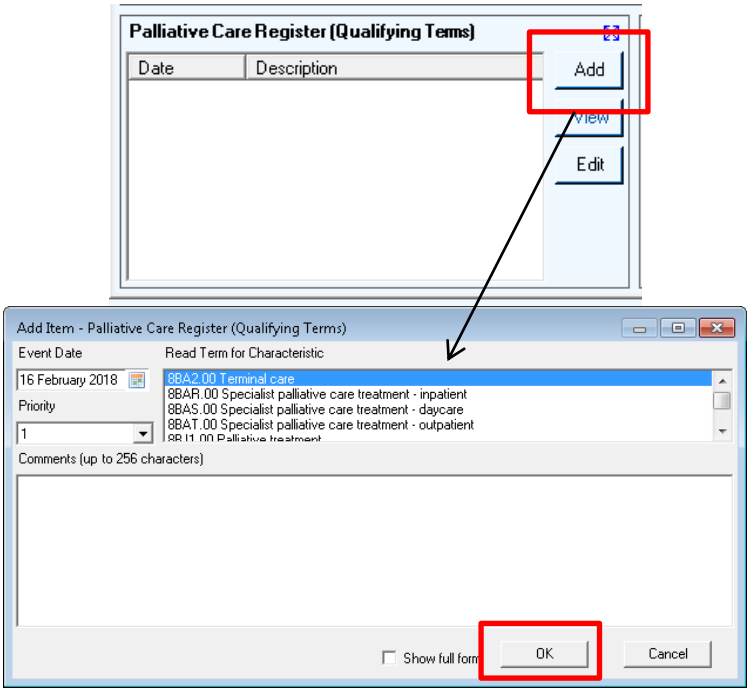



**Figure 30**

Click **OK** to save and return to the Palliative Care Summary screen.

## Awareness and Understanding

This allows you to indicate whether the patient and family are aware/unaware of the diagnosis and/or prognosis **(see Figure 31).**

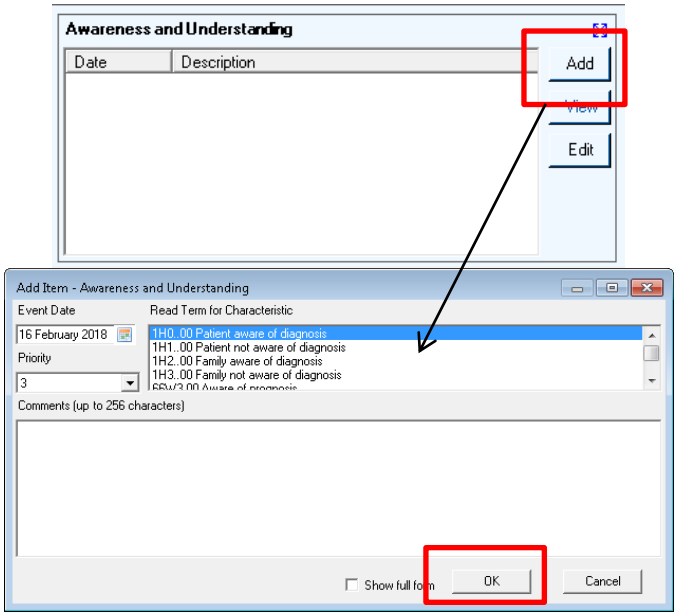



**Figure 31**

Click **OK** to save and return to the Palliative Care Summary screen.

## Cancer Treatment Arrangements

This allows you to detail the patient's **Cancer Treatment Arrangements (see Figure 32).**

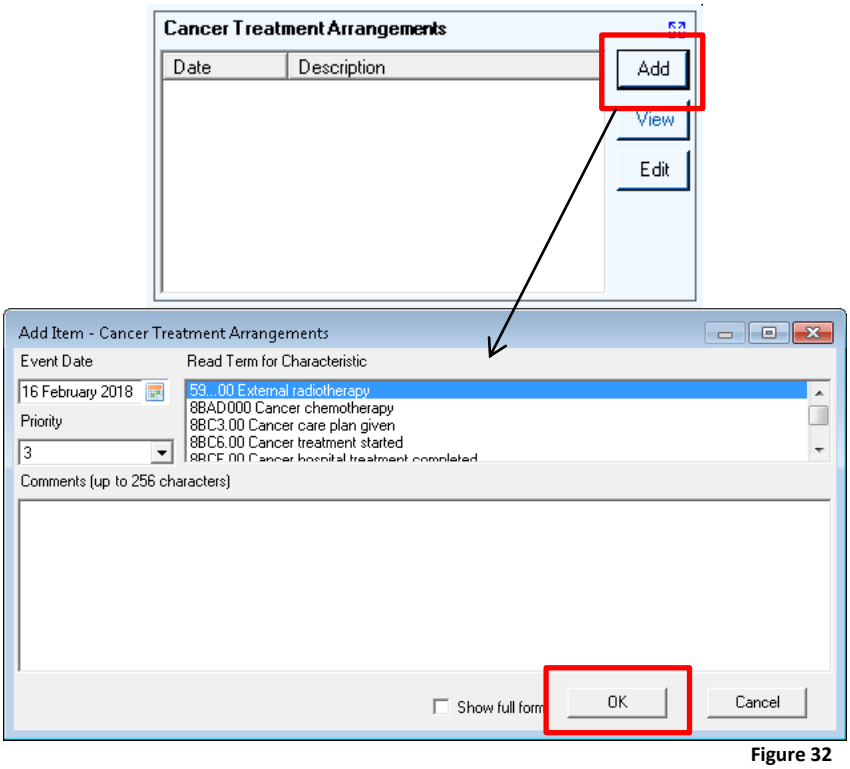
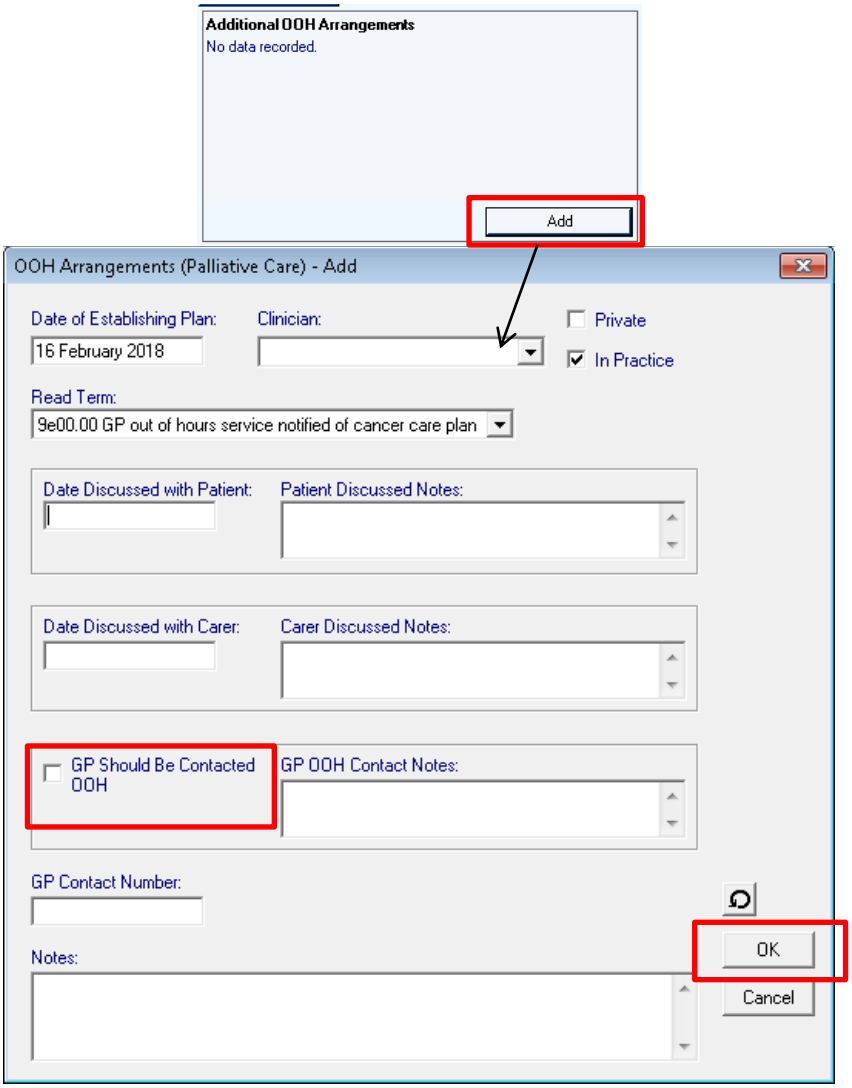



**Figure 32**

Click **OK** to save and return to the Palliative Care Summary screen.

## Additional Out of Hours Arrangements

This option allows you to indicate if the GP Out of Hours service has been notified of the cancer care plan and allows you to detail **Patient Discussed Notes** and **Carer Discussed Notes (see Figure 33).**




Tick here if you wish to be contacted and add **Notes** and **GP Contact Number**

**Figure 33**

Add notes as required and then select **OK** to save and return to the **Palliative Care Summary** screen.

## Palliative Care Plan

This option allows you to record if there is a palliative care plan for the patient (**see Figure 34**).

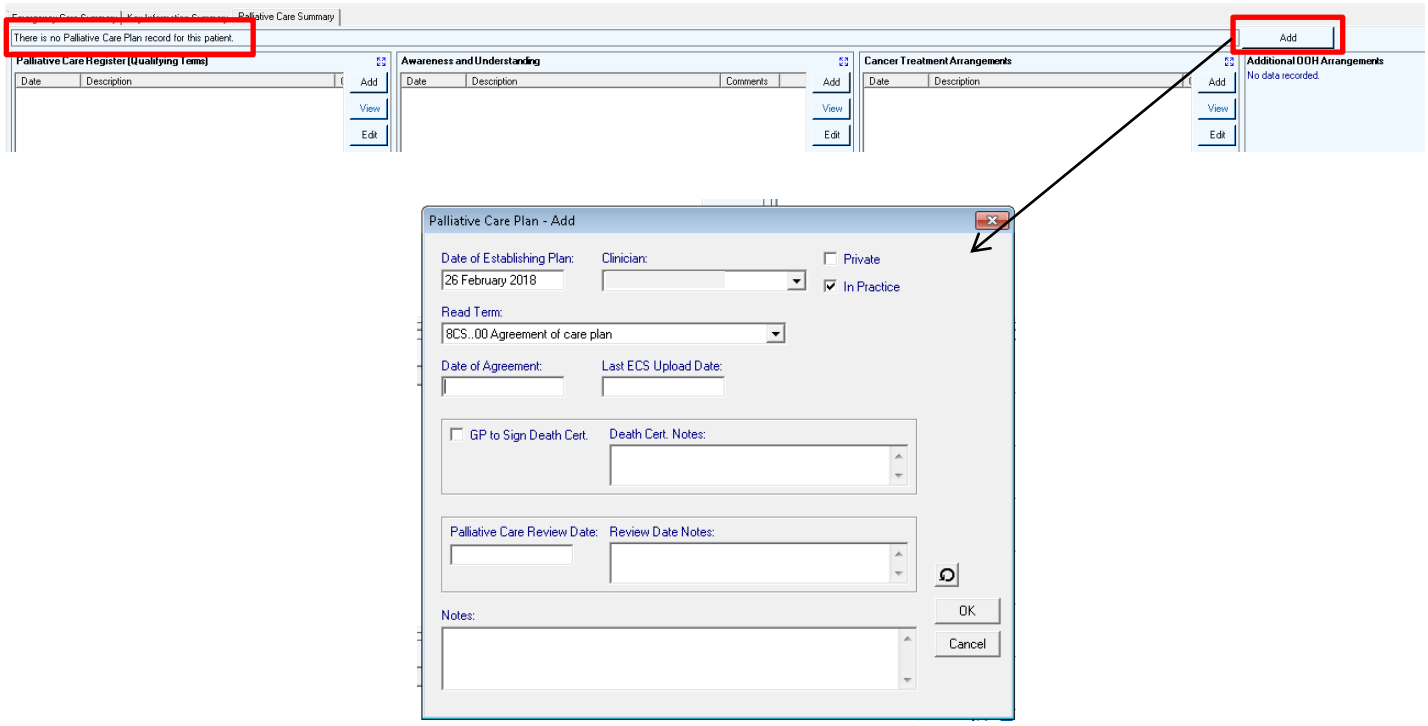



**Figure 34**

## Standard Reports

There are a number of reports available to view/print (**see Figure 35**).

- **Practice Summary Report –** the Practice Summary Report allows you to print off a copy of all the information held in the Key Information Summary for the patient. This includes current medication, repeat medication, relevant medical history and contact information.
- **OOH Summary Report –** the OOH Summary Report allows you to print off a copy of the information held within the Key Information Summary that shows only data to be sent to Out of Hours services.
- **Decisions to Send –** provides a list of patients with an Active KIS with decision to send.
- **Decisions Not to Send –** provides a list of patients with a specific Decision NOT to send a Key Information Summary.
- **Special Notes Expiry Report –** presents a list of patients who's Special Notes are due to expire.
- **Special Notes Changes Report –** provides a list of Special Notes Changes and allows you to filter changes since a specific date.
- **KIS Consent Report –** allows to filter a list of patients by consent status; consent, dissent, dissent overridden with patient aware and dissent overridden, patient unaware.
- **Bulk OOH Summaries –** provides a list of Out Of Hours Summary reports, allowing you to filter by review date and consent status.
- **MDT Reviews Report –** provides a list of multi-disciplinary assessments that are due for a review.
- **Palliative Care Reviews Report –** provides a list of palliative care patients that are due a review.
- **Practice Reviews Report –** provides a list of patients that are due a practice review.

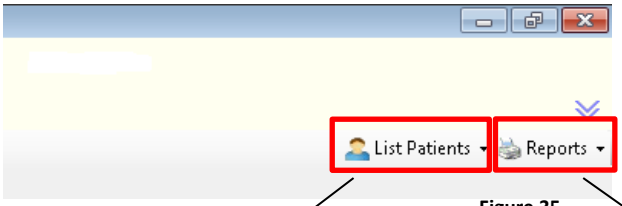
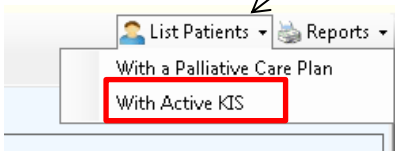
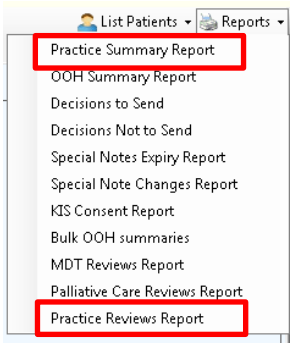



**Figure 35**

Click **List Patients** and select **With Active KIS** to view patients who have a KIS recorded.




Click **Reports** and select **Practice Summary Report** to list all the data that is included in an extract for the patient selected.

Click **Reports** and select **Practice Reviews Report** to get a report on practice review date for patients.

## General Information

**Please note the following:**

- Consent is a two-stage process – both stages need to be complete to enable the system to share the information with NIECR. **Consent** and **Decision to Send**.
- The Key Information Summary will **ONLY** be shared with NIECR when the KIS consent button is green.
- If you override Patient decision, please add a note in the **Special Note** box at the bottom of the KIS screen.
- If the patient's Journal contains entries using the appropriate Read Code information, it will populate the corresponding item in the Key Information Summary for the patient.
- Priority codes can be updated for most items in the Key Information Summary.
- **Show full form** is available for most items and can be completed at that stage.
- Items which have been added/ticked in error can be removed in the patient's Journal by selecting the entry and selecting **delete**, apart from Relevant Medical History.
- If you enter patient Next of Kin/Carer information, it will update the **Patient Details** – **Contacts** tab for the patient.

**PLEASE NOTE:** When you are completing any Notes/Comments/free text boxes on your clinical system that you be as precise as possible, as NIECR will only show the first 100 characters of the free text box. We are aware that your clinical system may allow you to input more than 100 characters however this will not be visible on NIECR. Please keep any important information that you wish to highlight within the first 100 characters.

The only exception to this is the Special Note box which holds up to 2048 characters and will be shared.

We are working on a resolution to increase the number of characters and will let practices know when this is in place.

**If you require any further assistance, please do not hesitate to contact Kieran Nugent or Joanne Hillocks by emailing KISinformation@hscni.net or by telephone 028 9536 2220 (Kieran) or 028 9536 2322 (Joanne)**