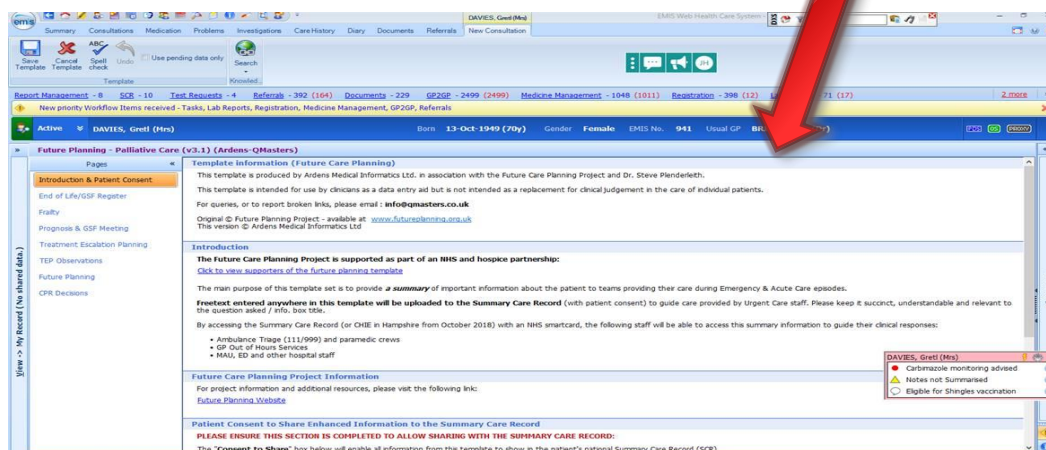
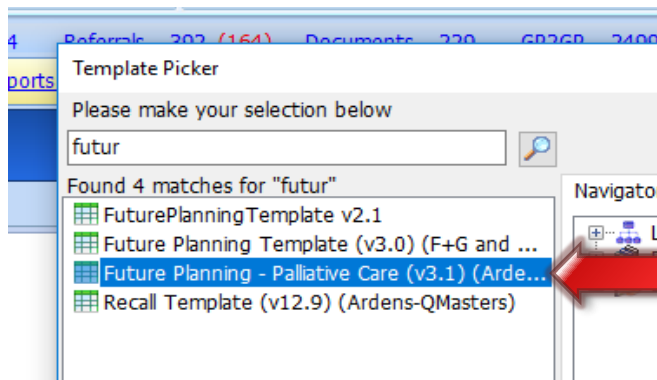
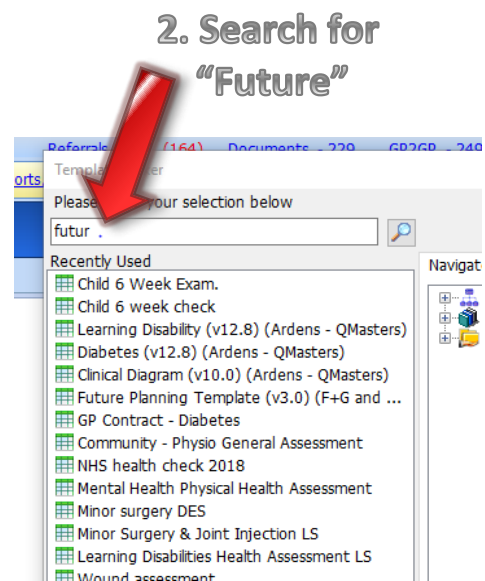
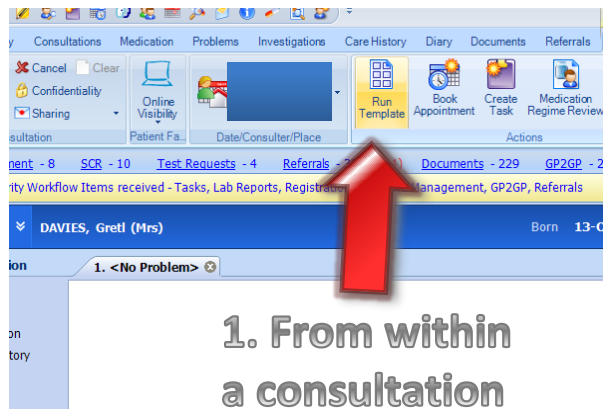


# Standard Operating Procedure: Entering “My Wishes” info into EMIS

This document assumes your CCG has already shared the **Future Planning** Ardens template across all EMIS practices in the CCG.

## How to find the template:

The term TAB is used rather than PAGE, when referring to the different sections of the **Future Planning** template.



## Page 1 of the “My Wishes” self-complete leaflet (Town & Country picture)

Please ensure you have opened the correct patient record.

Check details recorded in SystmONE are updated using details entered on this page.



## Page 2 . . .

**My Wishes** “Problems or Condition” and “How I would like this managed” should all be entered using the **Future Planning** “Treatment Escalation TEP” TAB in the “Anticipated Problems due to medical conditions” box.

All details in the **My Wishes** “Emergency Contacts” table should be entered on the same **Future Planning** “Treatment Escalation” TAB in the “Emergency Contact details” box.

*For your information - Emergency contacts information entered anywhere else in SystmONE is unlikely to be visible to acute care teams (999, 111, Out of Hours services and hospital) via the Summary Care Record or any other system that they access.*

## Page 3 . . .

**My Wishes** “My wishes for my care” information should be entered into the appropriate box in the **Future Planning** “My Wishes” TAB. These will go into either the “Patient, Family/NoK wishes & preferences for care” box or the “Wishes & requirements following death” box.

Information from **My Wishes** “. . . opinions of family/friends/carers . . .” may also go into either of these last two boxes. Please label patient and family wishes separately if these differ.

Finally, details from **My Wishes** “Information about my home . . .”, should be entered into the **Future Planning** “Treatment Escalation” TAB in the “Home access info & risks eg pets & other” box.

## Page 4 . . .

Of the **My Wishes** leaflet may contain the most important information recorded by a patient. Consenting to share Additional Information to the Summary Care Record allows all of the information in the **Future Planning** template: a patient's past medical history, involved teams, and appointments; to be viewed by clinical teams providing their emergency care alongside their medications and allergies on the Summary Care Record.

1. If signed and dated by the patient. Go to 4.
2. If signed and dated by someone other than the patient then please consider;
  - a. If a **parent, and the patient is under 10 years** of age. Go to 3.
  - b. If a **parent, and the patient is 10 years or older**. Please pass to the patients GP for them to consider the appropriateness of adding the consent. If the GP agrees go to 3.
  - c. If a **family member / carer with a valid Lasting Power of Attorney for Health and Welfare** form. Please pass the request to the patients GP to confirm that the patient lacks capacity to make their own decision about adding information to their record. If the GP agrees go to 3.
  - d. If a **circumstance other than those listed above**, please pass the form to the patients GP to advise on whether signing by a person other than the patient is appropriate and valid. If the GP agrees go to 3.
3. Please add the name of the person giving consent to the box alongside the next item.
4. On the **Future Planning** template "Intro" TAB "Check" the first tick box "Consent to share . . .". If this consent has already been added to the patient's record, as shown in the right-hand column of the template window, please add the consent again as this provides an update to the record.
5. Once "Consent to share" has been added please check in the patients EMIS record for any "Dissent to share" codes. These codes should show in the View on the "Intro" TAB. If any are present then they should be removed.

## For all Patients

If a patient or their representative submits a house keycode number or other access code, then please record this as detailed above. In addition, please contact the patient to let them know that they should inform their insurance company about sharing the code, otherwise their home insurance may be invalidated in the case of a burglary. Perhaps discuss how they would like to receive/collect their printed Future Care Plan at the same time – see last page.

This is clearly nonsense, and we have asked that it be raised at a national level, but in the meantime we appreciate your support.

Patients may submit a typed **My Wishes** leaflet that they have downloaded from the [www.futureplanning.org.uk](http://www.futureplanning.org.uk) website. A completed leaflet with their Name and Date, sent from their personal e-mail address should be considered as having a valid signature.

## On completion

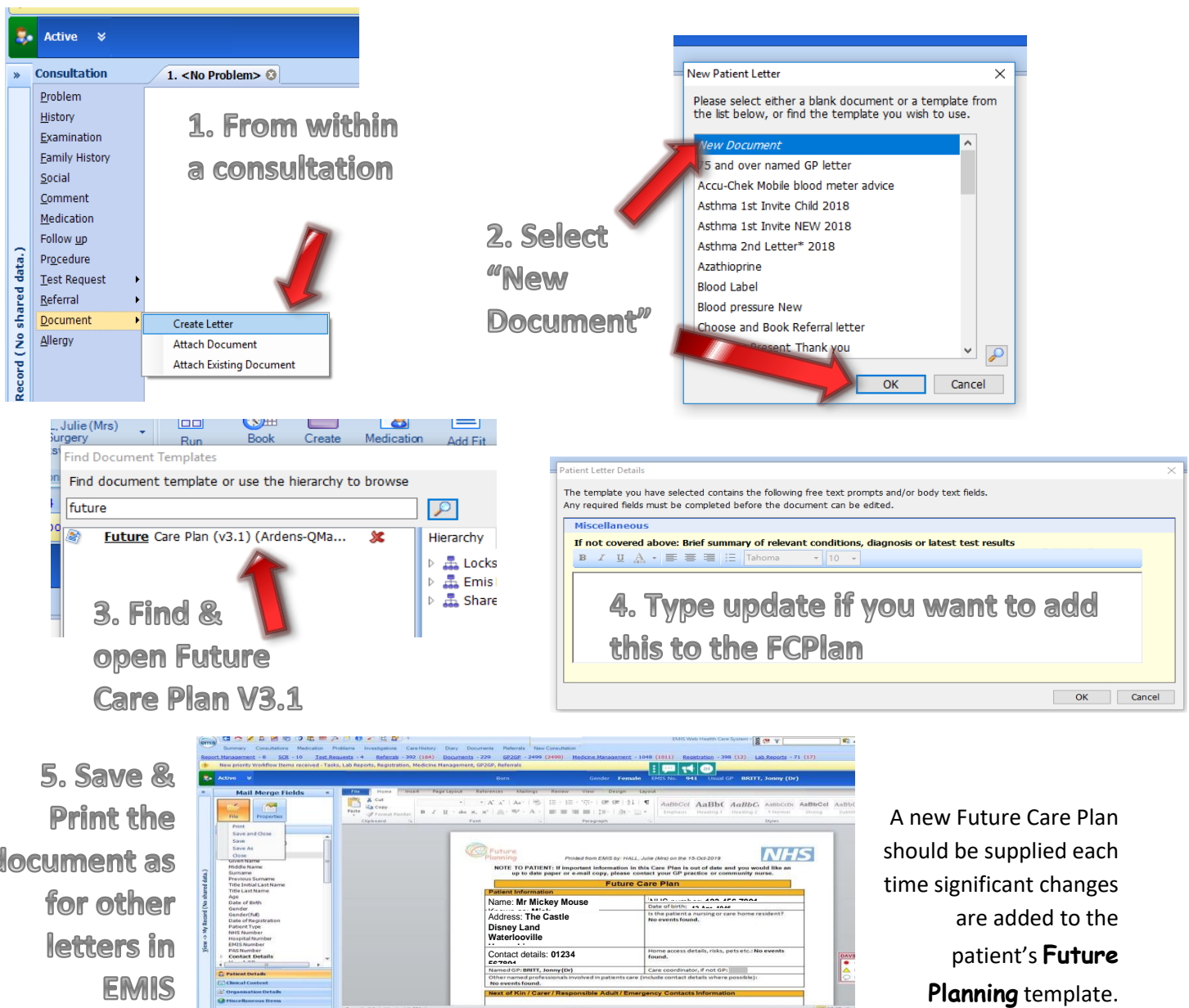
Now **OK** the template and **Save**, recording your activity as Clinical Admin.

Please inform the patient's named accountable GP, or if not available the duty doctor if significant new information has been added to the patients Future Planning template. Particularly, if:

- The patient wishes to discuss Cardiopulmonary resuscitation or tissue donation
- Preferences for management of medical problems have been submitted.

## Following review by GP

Please print a Future Care Plan from EMIS as detailed below. Please email, post or deliver to the patient via their preferred communication route.



**1. From within a consultation**

**2. Select "New Document"**

**3. Find & open Future Care Plan V3.1**

**4. Type update if you want to add this to the FCPlan**

**5. Save & Print the document as for other letters in EMIS**

A new Future Care Plan should be supplied each time significant changes are added to the patient's **Future Planning** template.

## Further Details

Regarding all facets of the Future Planning Project are available on [www.futureplanning.org.uk](http://www.futureplanning.org.uk)  
 Contact the project team via the website contact page.