

Standard Operating Procedure: Entering “My Wishes” info into SystemONE

This document assumes your CCG has already shared the **Future Planning** template version 3.3 or higher across all S1 practices in the CCG.

How to find the template: when in a patient record, type “Future” into the Search Features box at the bottom left of the screen. Several options may appear but select Future Planning Version 3.3 (or higher). In some areas this may be called Future Planning GP version 3.3

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 SystemONE are updated to match 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 SystemONE 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 SystmONE 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.

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 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

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

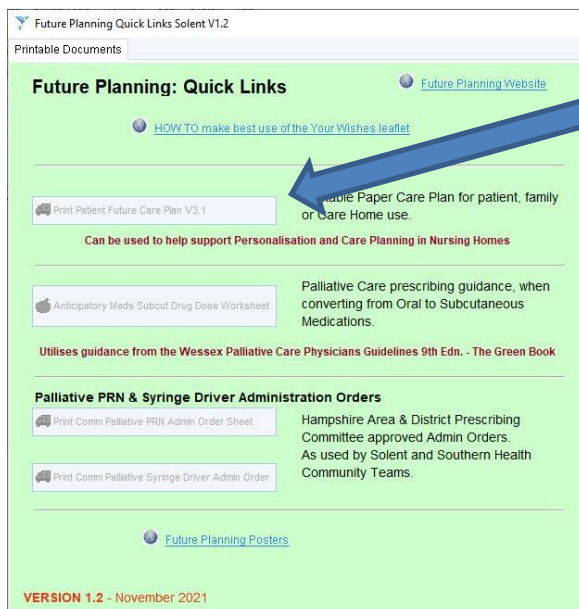
Please inform the patient's named accountable GP, or if not available the duty doctor, that new information has been added to the patients Future Planning template. Particularly if;

- 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 SystmONE as detailed below. Please email, post or deliver to the patient via their preferred communication route.

When back in the patient record, type "Future" into the Search Features box at the bottom left of the screen. A number of options may appear but select "Future Planning – Quick Links V1.2" (or higher).



Future Planning Quick Links Solent V1.2

Printable Documents

Future Planning: Quick Links [Future Planning Website](#)

[HOW TO make best use of the Your Wishes leaflet](#)

[Print Patient Future Care Plan V3.1](#) **Printable Paper Care Plan for patient, family or Care Home use.**

Can be used to help support Personalisation and Care Planning in Nursing Homes

[Anticipatory Meds Subcut Drug Dose Worksheet](#) Palliative Care prescribing guidance, when converting from Oral to Subcutaneous Medications.

Utilises guidance from the Wessex Palliative Care Physicians Guidelines 9th Edn. - The Green Book

Palliative PRN & Syringe Driver Administration Orders

[Print Comm Palliative PRN Admin Order Sheet](#) Hampshire Area & District Prescribing Committee approved Admin Orders. As used by Solent and Southern Health Community Teams.

[Print Comm Palliative Syringe Driver Admin Order](#)

[Future Planning Posters](#)

VERSION 1.2 - November 2021

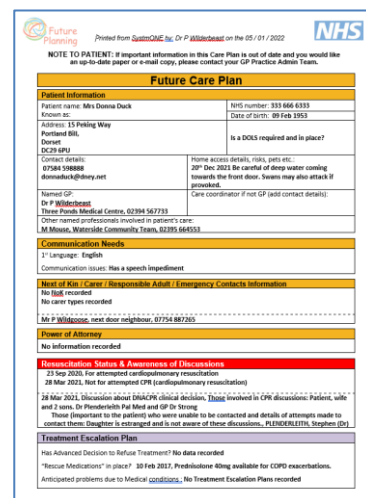
Select Print Patient Future Care Plan and follow instructions as usual for generating a SystmONE document from a Word template.

Please email, post or deliver the resulting document to the patient via their preferred communication route.

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
Contact the project team via the website contact page.



Printed from SystmONE by: Dr P Willcockson on the 05/01/2022

NOTE TO PATIENT: If important information in this Care Plan is not of date and you would like an up-to-date paper or e-mail copy, please contact your GP Practice Admin Team.

Future Care Plan

Patient Information

Patient name: Mrs Doreen Duck	MRG number: 333 666 6333
Known as:	Date of birth: 09 Feb 1953
Address: 15 Priory Way	is a DCCS required and in place?
Postcode: RG11 1JH	
Denset	
EC29 8JH	
Contact details:	Home access: Retail, risks, pets etc.:
07946 58888	20 th Dec 2021 Be careful of deep water coming towards the front door. Swims may attack if provoked.
doreenack@btinternet	
Named GP:	Line coordinator if not GP (add contact details):
Dr P Willcockson	
Three Roads Medical Centre, 62394 56733	
Other named professionals involved in patient's care:	
Mr Moore, Waterloose Community Team, 01754 664553	

Communication Needs

1st Language: English

Communication issues: Has a speech impediment

Name of Kin / Carer / Responsible Adult / Emergency Contacts Information

No kin recorded

No carer types recorded

Mr P Willcockson, next door neighbour, 07754 887265

Power of Attorney

No information recorded

Resuscitation Status & Awareness of Discussions

23 Sep 2020: For attempted cardiopulmonary resuscitation

28 Mar 2021: Not for attempted CPR (cardiopulmonary resuscitation)

28 Mar 2021: Discussion about DNACPR clinical decision; Those involved in CPR discussion: Patient, wife and 2 sons, Dr Henderson Pal Med and GP Dr Strong

Those (important to the patient) who were unable to be contacted and details of attempts made to contact them: Stephen is estranged and is not aware of these discussions. PLENKOWITZ, Stephen (D)

Treatment Escalation Plan:

Has Advanced Decision to Refuse Treatment? No data recorded

"Rescue Medication" in place? 10 Feb 2017, Prednisolone 40mg available for COPD exacerbations.

Anticipated problems due to Medical conditions; No Treatment Escalation Plans recorded