



## EMIS: GP User Guide on Uploading and sharing Key Information Summaries

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1. **Choose a patient that you feel would benefit clinically from having their medical information shared** with emergency healthcare staff in the form of an anticipatory care plan. SPARRA/HHG/Frailty Index lists can help with this, but clinical judgement is most important.
2. Talk to the patient, and the carers/relatives if appropriate, using a conversation structure such as [RED-MAP](http://www.spict.org.uk/red-map/) ([www.spict.org.uk/red-map/](http://www.spict.org.uk/red-map/)). Get consent to share this information unless there are very clear indications to not share. Explore any specific wishes they may have in the event of deterioration.
3. **Open up the patient record** in consultation mode or medical records. **Click KIS** on the toolbar, **or press 8** on the keyboard. This opens up the KIS screen. If you are in consultation mode all the information on the KIS will be added to an open consultation. This may be appropriate or it may clutter your consultation.
4. The screen opens up on the consent tab. **Choose the appropriate patient consent** (consent given or consent declined). If you chose one of the consent override options you must fill in the free text field on the right to provide some explanation.
5. At the bottom of the screen **tick the box for review date** and set the practice review date – it is **suggested this could be 1 year**
6. You should work through each tab in turn to ensure you have added appropriate information.
7. You must explicitly **add past medical history** on the ‘Current Situation’ tab, the edit button on the right hand side lets you see currently active problems or you can remove this filter and see a “Full History” view, click on items that you feel are appropriate to share to add them to the KIS.
8. To ensure a consistent approach across health boards and to avoid confusion for clinicians reading the KIS at the other end, current advice is to enter **all free-text information in the special notes tab of the KIS screen rather than in the ACP box**. The **special notes box** will default to “never expires” unless a specific date is set. **Here clinicians**



**can add the additional personalised patient info that isn't covered in the pre-populated data or the drop downs** which you think would be useful to share with emergency users. Consider including info about:

- baseline functional status
  - when and how to escalate treatment
  - how far treatment should go
  - any patient specific wishes
  - who are the key individuals and services involved in their care and how to contact them.
9. Entering the date you have reviewed the KIS can be useful although on some hospital/ooh systems the date when the special notes were last edited is clear to users.
  10. **If the KIS being created is to be used as an ACP rather than for just basic special note-type information**, also **click on the Current Situation tab** then **select Has an Anticipatory Care plan** from one of the dropdowns about half way down the screen (which this then adds Read code 8CMM.00 to the patient record). This also allows the practice to run specific searches for ACPs.
  11. Once ready to go, **go back to the consent tab click on “decision to send KIS” button**, and then **click Ok to save** the KIS data to the system.
  12. **If there is red writing along the message bar at the top of the page** then either the consent process has not been completed, the decision to send is not confirmed or the review date has expired.
  13. **Print off copy of ACP for all care home patients and consider for other patients** too, such as those with regular carers. To print a KIS report. Access Medical Record (F11) screen, Click KIS or press 8; The Key Information Summary screen is displayed, click Report View or press R. You can elect to print without medication by clicking a bottom of the page. The KIS information is displayed in report format and then Click Print HTML Report.
  14. **GP2GP record transfer will import old special notes from a previous practice**. Be aware that any KIS special notes you create in the few days between registration and GP2GP taking place will be replaced by the previous practice's version. If this occurs the special note you have created can be found in 'full history' under the readcode 9bK5. Editing that version taking into account the information from the previous practice will import a combined version into the KIS.

For more detailed information, and patient information leaflets see  
<http://www.ecs.scot.nhs.uk/kis>

This resource was adapted by Dr Andrew Mackay, GP Advisor on ACP, on behalf of the Long Term Conditions Programme, Edinburgh Health and Social Care Partnership.

### **For more information and advice**

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