

Key Information Summary

The **Key Information Summary (KIS)** is an extension to the **ECS**. It replaces the manually faxed **Special Notes** sent by practices. The data uploaded via **KIS** consists of:

- **Special Note** - This is for use during weekend care and is the direct replacement for the 'Special Note' faxed, see [Adding or Updating a Special Note](#) on page [9](#).
- **Summaries for Out of Hours (OOH) agencies** - This can consist of information from the patient's medical history if deemed clinically relevant and administration information, such as keypad numbers to assist OOH staff in gaining access to the patient home in an emergency.

KIS is designed to be used for patients with:

- Long term conditions.
- Mental health issues.
- Unusual conditions who may have difficulty in remembering crucial details if they become ill.

There is an overlap in some of the information that can be extracted for **KIS** and **PCS**, the **ECS Summary Management** screen shares this information so it only has to be recorded once and it is shared across extracts.



For more information regarding the Key Information Summary please refer to NHS Scotland <http://www.ecs.scot.nhs.uk/kis>.

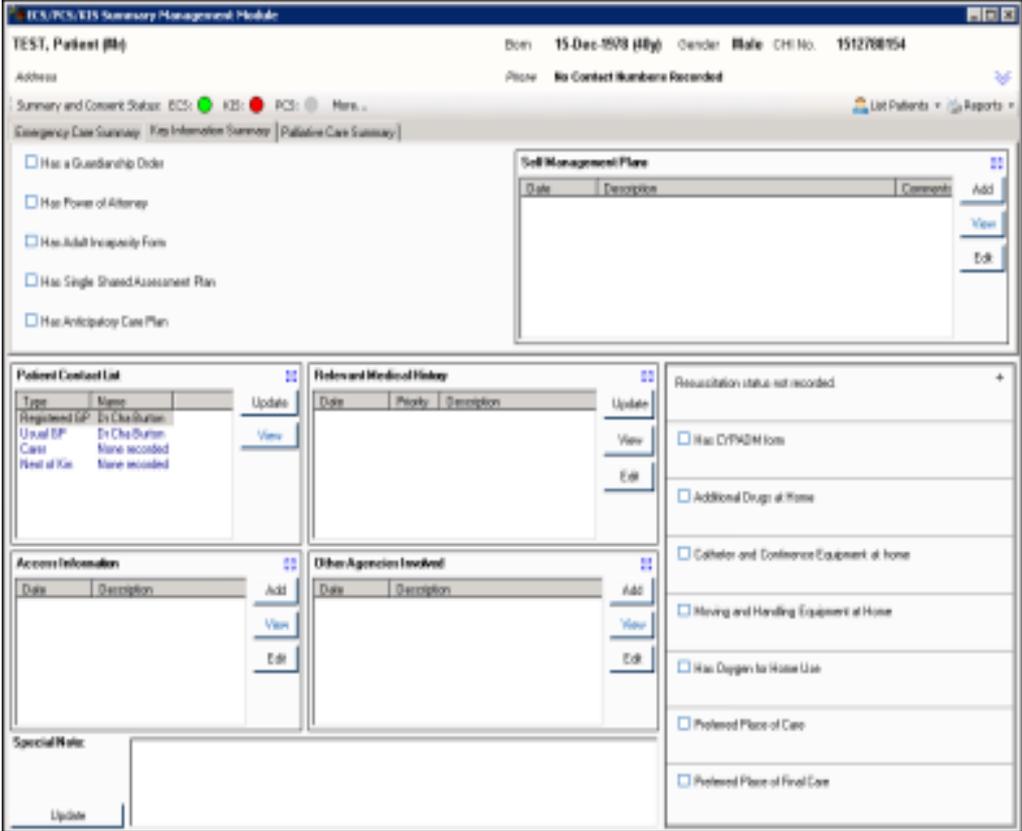


See [Accessing the Key Information Summary](#) on page [2](#) and [Adding Data to the Key Information Summary](#) on page [7](#) for details.

Accessing the Key Information Summary

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

1. From **Consultation Manager**, select **List - ECS Summary Management**.
2. Select the **Key Information Summary** tab.
3. The **Key Information Summary** displays:



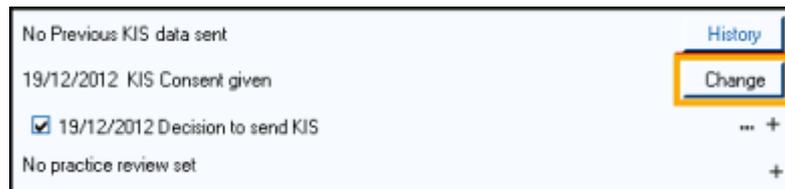
The screenshot displays the 'ECS/PCS/EIS Summary Management Module' for a patient named 'TEST, Patient (M)'. The patient's details include a birth date of 15 Dec 1978 (88y), gender Male, and CHI No. 1512708154. The 'Summary and Consent Status' shows ECS as active (green dot), KIS as active (red dot), and PCS as inactive (grey dot). The 'Emergency Care Summary' tab is selected, showing options for 'Fit Information Summary' and 'Palliative Care Summary'. Below this, there are several sections:

- Consent and Planning:** A list of checkboxes for 'Has a Guardianship Order', 'Has Power of Attorney', 'Has Adult Incapacity Form', 'Has Single Shared Assessment Plan', and 'Has Anticipatory Care Plan'. To the right is a 'Self Management Plan' table with columns for Date, Description, and Comments, and buttons for Add, View, and Edit.
- Patient Contact List:** A table with columns for Type, Name, and Update. It lists 'Registered GP: Dr Chi Suran', 'Usual GP: Dr Chi Suran', 'Care: None recorded', and 'Next of Kin: None recorded'. A 'View' button is present.
- Relevant Medical History:** A table with columns for Date, Priority, and Description, with 'Update', 'View', and 'Edit' buttons.
- Access Information:** A table with columns for Date and Description, with 'Add', 'View', and 'Edit' buttons.
- Other Agencies Involved:** A table with columns for Date and Description, with 'Add', 'View', and 'Edit' buttons.
- Special Note:** A text area with an 'Update' button.
- Resuscitation status:** A section titled 'Resuscitation status: not recorded' with a '+' icon and several checkboxes: 'Has DNR/DNI form', 'Additional Drugs at Home', 'Catheter and Continence Equipment at Home', 'Moving and Handling Equipment at Home', 'Has Oxygen to Home Use', 'Preferred Place of Care', and 'Preferred Place of Final Care'.

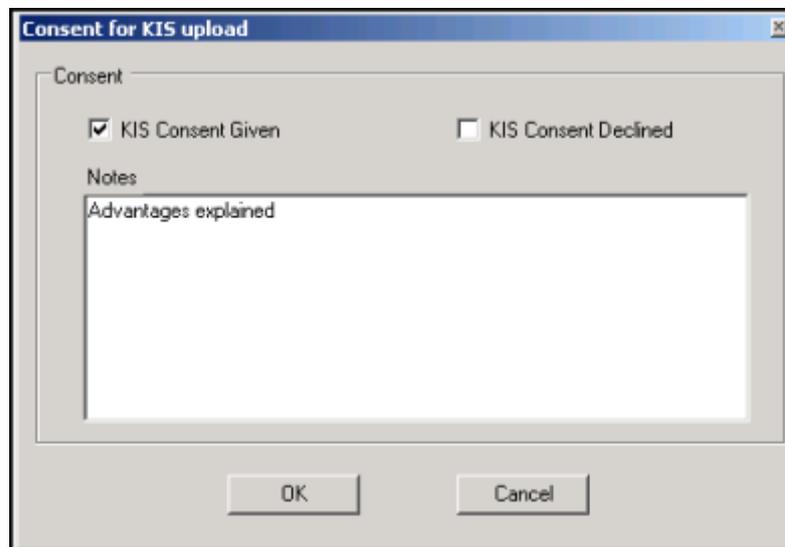
Recording Consent for KIS

To record consent for KIS:

1. From **Consultation Manager**, select **List - ECS/PCS/KIS Summary Management**.
2. Select **Summary and Consent Status - More**.
3. Select **Change** within the **KIS** column:



4. The **Consent for KIS upload** screen displays:

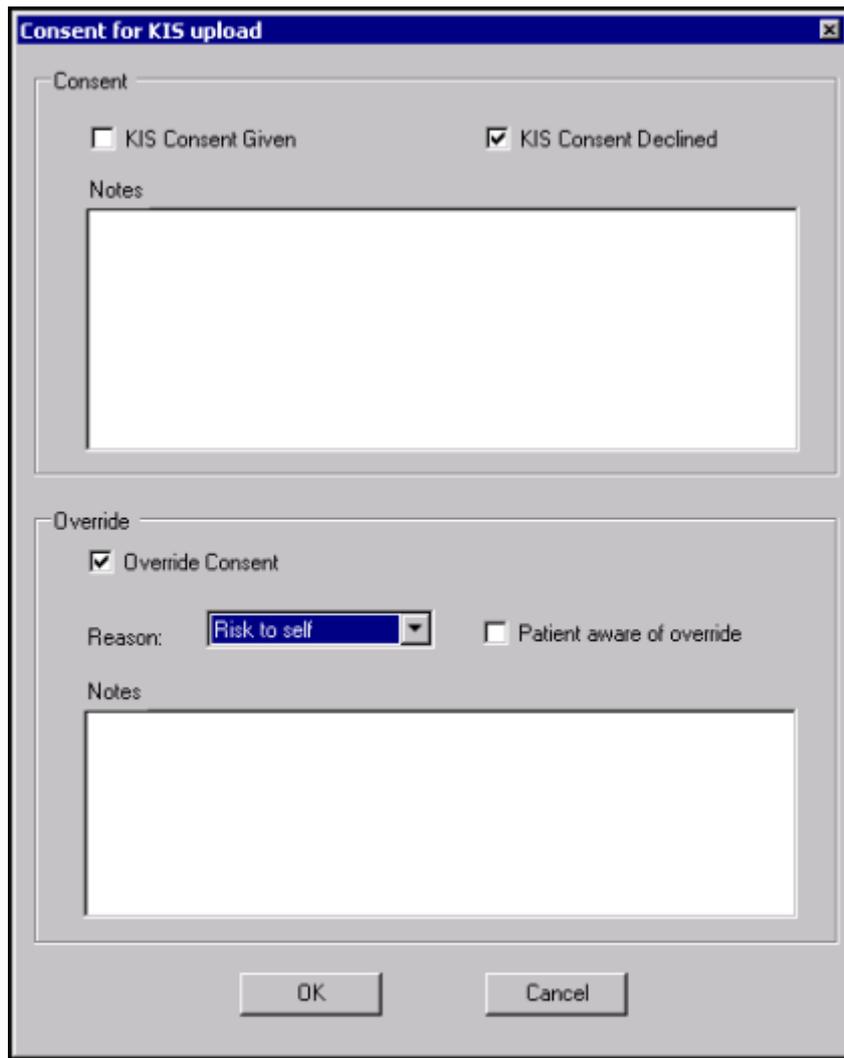


5. Complete as required:
 - **KIS Consent Given** – Tick if the patient agrees to a KIS upload.
 - **KIS Consent Declined** – Tick if the patient refuses a KIS upload.
 - **Notes** – Enter as required.
6. Select **OK** to save and close.

 **Note** - The KIS Status traffic light automatically turns Green if consent is given or Red if consent is refused.

If the patient refuses consent for a KIS upload, you can select to override the consent and send:

- A KIS, if ECS consent is given or implied, or
- A KIS Special Note, if ECS consent is refused.



Consent for KIS upload

Consent

KIS Consent Given KIS Consent Declined

Notes

Override

Override Consent

Reason: Patient aware of override

Notes

OK Cancel

With **KIS Consent Declined** ticked, the **Override** section must be completed:

- **Override Consent** - Tick to override the patients choice.
- **Reason** - Select from the available list.
- **Patient aware of override** - Tick if you have made the patient aware.
- **Notes** - Enter a short explanation of the override decision.

Decision to Send/Not Send KIS

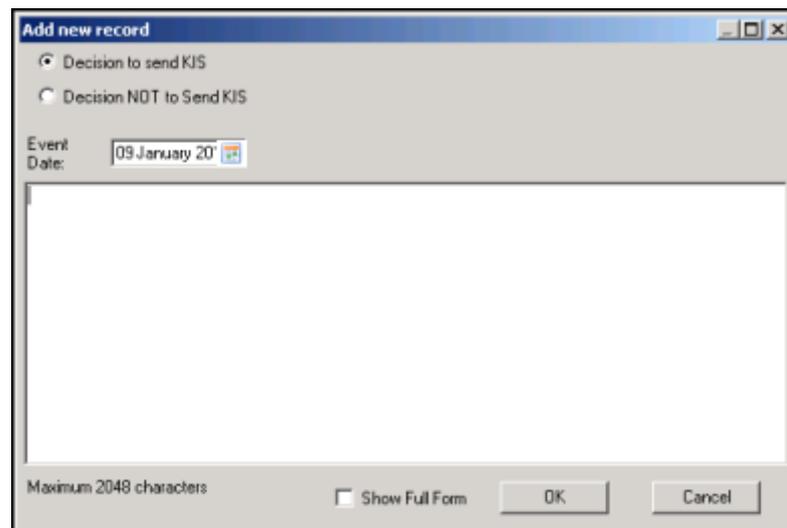
Once consent has been recorded, the KIS data and/or Special Note is not sent to ECS until an explicit decision to send is recorded.

To record a decision to send/not send KIS:

1. From **Summary and Consent Status - More**, in the **KIS** column tick **Decision to send KIS**:



2. The **Add new record** screen displays:


 A screenshot of a dialog box titled "Add new record". It contains two radio buttons: "Decision to send KIS" (which is selected) and "Decision NOT to Send KIS". Below the radio buttons is a date field labeled "Event Date:" with the value "09 January 20". There is a large empty text area for comments. At the bottom, it says "Maximum 2048 characters" and has a "Show Full Form" checkbox, "OK", and "Cancel" buttons.

3. Select **Decision to send KIS** or **Decision NOT to Send KIS** as appropriate.
4. Enter comments as required.



Note - Text over 2048 characters is not sent to ECS.

5. Select **OK** to save and return to the **ECS Management** screen.



Note – You can reverse your decision at any time. If data has already been sent, selecting **Decision Not to Send KIS** removes the data from ECS.

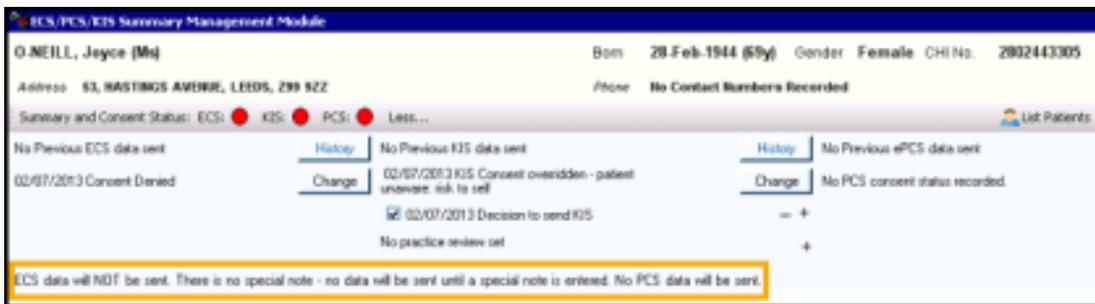
The expanded **Summary and Consent Status** section contains explanatory text on the consent and decision to send options selected. The following examples show some of common consent/decision to send combinations that could cause queries:

ECS Consent Implied with KIS Consent Denied but Overridden



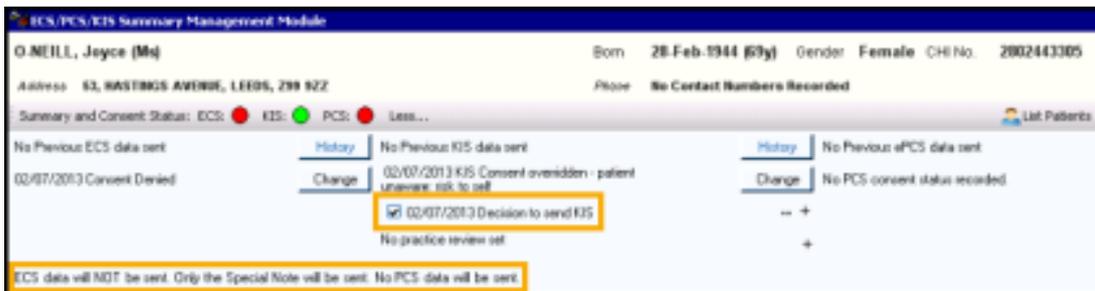
- Decision to send is not selected, until it is no data is sent.

ECS and KIS Consent Denied but KIS Overridden



- The decision to send updates, but as there is no ECS consent, nothing is sent until you enter a **Special Note**.

ECS and KIS Consent Denied, KIS Overridden and Special Note Added



- A **Special Note** is added and sent.

Adding Data to the Key Information Summary

Adding, editing and viewing data in the **KIS** screen is easy. There is a combination of tick boxes, see [Tick Boxes](#) on page 7 and data entry panes, see [Data Entry Panes](#) on page 8 for the following information:

 **Note** - Data added here cannot be deleted here. If you need to delete data added here, it must be deleted from the patient's Journal screen in the usual way.

Tick Boxes

To add data using the tick boxes, tick alongside the description required, select the appropriate clinical term if a choice is available, change the **Priority** as per your practice protocols, enter any comments required and select **OK**.

 **Note** – You can only add comments of up to the maximum number of characters within the KIS form. To add longer comments you need to tick **Show full form**, but only the maximum number of characters is sent. Text that is outside the maximum number displays in red.

To update a tick box record, select **+** alongside the entry required (in this context, **Update** is adding to the patient record). The last entry displays, update as necessary and select **OK**. The patient's record is updated when you close their consultation with the new updated entry.

 **Note** - It is not possible to edit or remove data entered via the tick boxes from within the **ECS Summary Management** module. To edit or remove data added in error, edit or delete in the usual way from the patient's **Journal** screen.

Data Entry Panes

To add data using the **Data Entry Panes** select **Add** or **Update** (in this context, **Update** is adding to the patient record). Complete the forms offered following the prompts on screen and then select **OK** to save and close.

 **Note** – You can only add comments of up to the maximum number of characters within quick forms. To add longer comments, tick **Show full form**, but only the maximum number of characters is sent to ECS. Text that is outside the maximum number displays in red.

To edit data displayed in a data entry pane:

1. Highlight the item required and select **Edit**.
2. Select **OK** on the maximum number of characters warning.
3. Update the entry as required.
4. Finally, select **OK** to save the change.

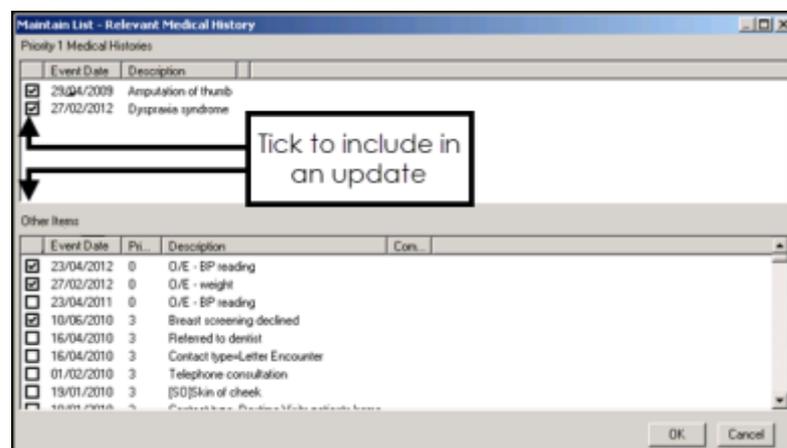
 **Important** - It is not possible to remove data entered via the **Data Entry Panes** from within the **ECS Summary Management** module. To remove data added in error, delete in the usual way from the patient's **Journal** screen.

To maximise a data pane, select **Maximise** .

Adding/Removing Items to/from Relevant Medical History

Relevant Medical History records are sent to **ECS**. It is initially populated with all the patient's Priority 1 Medical History.

1. From **Relevant Medical History**, select **Update**.
2. The **Maintain List – Relevant Medical History** screen displays:



3. Select and deselect items as required:

- **Priority 1 Medical Histories** displays those records that are automatically uploaded. To prevent them being uploaded, click on the check box to remove the tick.
- **Other Items** displays records that are not included in an upload. To include them in an upload, enter a tick.



Note - Text over 256 characters is not included in the extract.

4. Select **OK** to save and close.

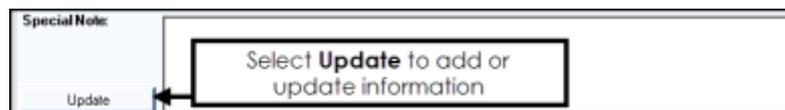


Remember - Once you have deselected an item, it stays deselected. New Priority 1 Medical Histories are automatically added to the Relevant History list and are included in uploads.

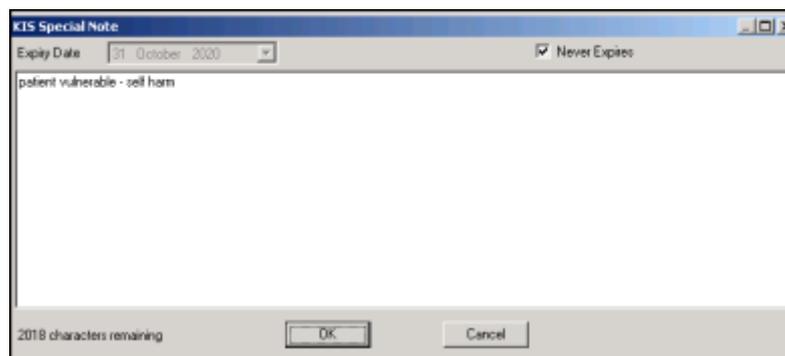
Adding or Updating a Special Note

To add or update a **Special Note**:

1. From **Consultation Manager**, select **List - ECS Summary Management**.
2. From **Special Note** in the bottom left corner, select **Update**:



3. The **KIS Special Note** screen displays:



4. Enter the information you want the out of hours service to be aware of.



Note - Text over 2048 characters is not included in the extract.

5. If this information has an expiry date, remove the tick from **Never Expires** and select an expiry date from the **Expiry Date** calendar.

6. Select **OK** to save and close.

The date the Special Note is created and the expiry date, if applicable, displays under the **Special Note** header:

Special Note:	
Created 09/01/2020	Patient can be vague and is very wary of new people
No expiry date	
Update	

and Read code **9bK5.00 Special patient note** is added to the patient record:

Date	Description
20/11/19	H _a Special patient note Patient vulnerable - Self harm
01/09/19	2/ Electrocardiogram

If a **Special Note** has an expiry date, a **Recall** is added to the patient record.

 **Note** - Only the most recently added **Special Note** is sent overwriting any previous **Special Notes** extracted. On expiry the **Special Note** is automatically overwritten with a blank record.

 **Important** - If **ECS consent** is withdrawn and **KIS consent** is overridden, a **Special Note** has to be recorded and it is the only thing sent. In this scenario the **KIS** consent traffic light displays as green and the **ECS** traffic light displays as red.
