Minimum Required Data for CMC Care Plan Approval

Introduction: Coordinate My Care (CMC) is a clinical NHS service that supports patients in situations requiring urgent care. Together with their clinicians, patients may record their preferences and wishes within an electronic personalised urgent care plan that also includes clinical information and relevant medical history. This care plan can be accessed by health and social care professionals, and urgent care providers involved in the patient's care, twenty four hours a day, seven days a week. The aim is for the patient to be at the heart of their own healthcare and to ensure the patient gets the right care from the right team in the right place. Sharing the right information is key to this.

Care Plan: The personalised urgent care plan contains clinical information about the patient's diagnosis, allergies, medications and resuscitation status as well as their wishes and preferences on where they would prefer to be cared for and, if known and relevant , where they would wish to be at the very end of their life. It can also include any cultural and religious beliefs that are important to the patient. The plan also holds the clinical perspective on what is clinically appropriate to do if the patient deteriorates.

Minimum Required Data for Care Plan Approval: Some fields like 'Contacts' are not required but if you choose them, they behave in a 'required' way to 'secure' a meaningful capture of information e.g. it does not allow a name only. We encourage clinicians to fill out as much **relevant** information as necessary to ensure **the most useful** picture is available to the urgent care services for **your patient**. This should include the patient's preferences if held and clear clinical guidance on what to do when there is deterioration. The aim of the plan is to provide meaningful information to the Urgent Care teams responding to the patient during a significant deterioration. Only published care plans are visible to the urgent care services. Some areas are very important but not required (Expected Symptoms & Actions). Most 'Required' items are selected through a quick tick box. Navigating the care plan looking for **red** (dot, asterisk, text) 'required' areas is a time saver. The minimum information required for a care plan to be approved/published is as follows:

1. **Patient Consent Screen**

- Patient details – first name, surname, NHS number, gender & DOB (auto-populated from NHS spine/in-context link)
- Type of patient consent - including justification if the care plan is being created following a clinician 'best interests' or Lasting Power of Attorney (LPA) decision taken on behalf of the patient if they lack mental capacity (Lasting Power of Attorney refers to Health and Welfare option only).
- Date consent obtained

2. **Patient Details Screen** (auto-populated from NHS spine/in-context link)

- First name
- Surname
- Date of Birth
- Gender
- Main (primary) address (including postcode)
- GP practice and/or name of GP

- NHS number

3. **Significant Medical Background Screen**

- Main diagnosis (only other relevant diagnoses should be added)
- WHO performance status & date
- Prognosis – Years down to days (assists urgent care to ensure the best patient care pathway is pursued)

4. **Preferences Screen**

- Preferred place of care in the context of deterioration (options for 'not yet discussed' etc. available)
- At least one preferred place of death (if known/appropriate - options for 'not yet discussed' etc. available)

5. **Cardiopulmonary Resuscitation Discussion Screen (based on Resuscitation Council UK model form)**

- Has discussion about resuscitation taken place with patient or LPA?
    - Date of discussion
    - Summary of discussion with patient or LPA or reason why not discussed
- Has discussion about resuscitation taken place with the family?
    - Date of discussion
    - Summary of discussion or reason why not discussed
- Should CPR Commence? 'Decision Not Yet Made' is available
- If answer YES no further action except to record the date which auto-populates as today
- If answer NO, there are 8 further fields (mostly drop down options in line with Resus Council model form) or you can attach an existing DNACPR form. If not attaching, you need to fill out the components on screen.
    - Date of CPR decision
    - Mental capacity?
    - Aware of advance decision?
    - Is there LPA for Health and Welfare?
    - Reasons why CPR would be inappropriate, unsuccessful, or not in the patient's best interests (summary)
    - Clinician RECORDING the decision (clinician who RECORDS the decision but not necessarily who authorises the DNACPR decision)
    - Date and time
    - Name of the Clinician ENDORSING (the clinician who authorises the DNACPR decision)

6. **Clinical recommendation** (ceiling of treatment) **-** mandatory and requires consistency with the CPR decision

7. **Medication Screen – Allergies**

- NB: If no allergy information is available, record a category of 'No Known Allergies' and then (drop down options) either 'I don't know' or 'No allergies known by patient'

8. **Approval Screen**

- Review Date (default 3 mths. Can be decreased or increased up to a year – whatever is clinically appropriate)
- Clinician (who will review the CMC care plan). Only registered CMC users can be searched for here.