palCentre

User Guide

User guide

palCentre is a software program that has been purpose built for services participating in the Palliative Care Outcomes Collaboration (PCOC).

It has been designed as an easy to use tool for services to collect information about patients, the interventions they receive and their outcomes.

This is a guide for staff using the palCentre software to enter PCOC Version 3 data set and/or the profile data collection.

Each section provides both a video and set of step-by-step instructions to help guide you through the data entry process.

Important details will be highlighted using one of four information boxes:

Handy tips

Warning

Additional information

Important information

Below is a list of pages that will walk you through how to use the palCentre software:

The user guide can also been downloaded as a pdf - click here to download

If you have any questions or feedback, please contact either:

Sam Burns (02) 4298 1141
Linda Foskett (02) 4221 5092

or email pcoc@uow.edu.au

Getting started with palCentre

To open palCentre:

1. Double click on the palCentre shortcut on your desktop

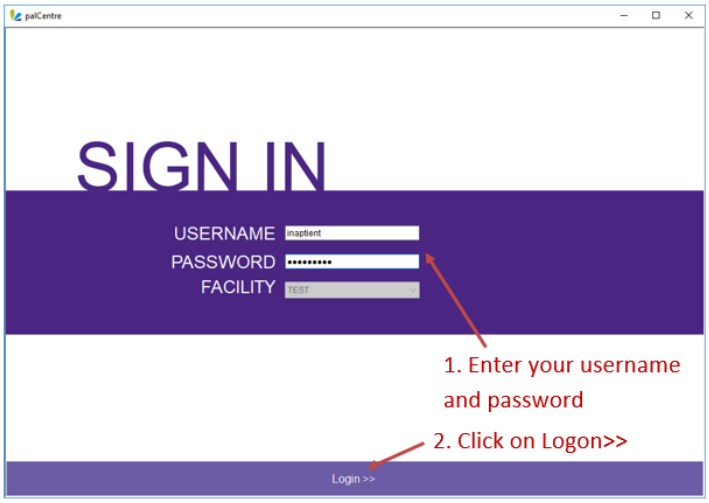
OR

2. click Start All Programs palCentre (windows 7)

OR

3. type 'pal' into the search area and click on palCentre when it appears (windows 10)

Login to palCentre using your username, password and select the appropriate facility. Click on login.



If you do not know your username or password, contact either Sam Burns on (02) 4298 1141, Linda Foskett on (02) 4221 5092 or via email pcoc@uow.edu.au

If you open palCentre and the login screen above does not appear then your database may not be configured correctly. Please contact PCOC for further information on how to correctly configure the database.

Once you have logged into epiCentre, the main screen will appear as below:

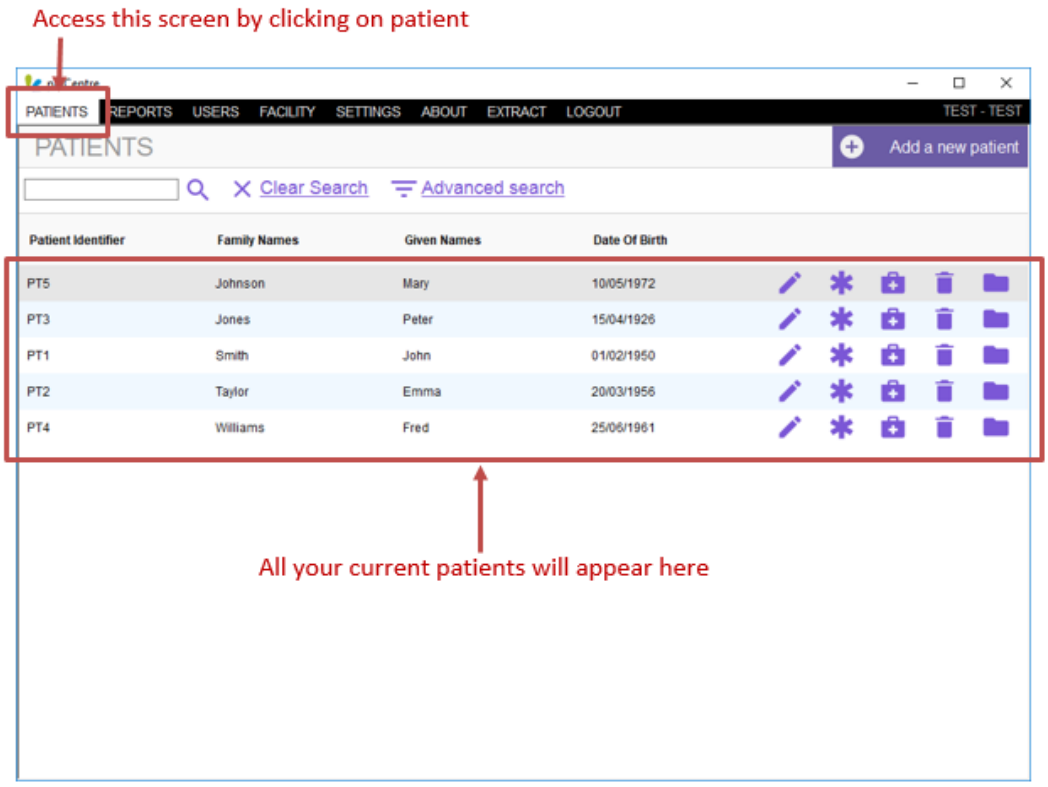
The black strip at the top of the screen is the navigation menu bar. The possible selections are:

Selection	Purpose
PATIENTS	All data entry is completed here and is the main screen that you will use in palCentre.
REPORTS	Information on current patients (i.e. patients with an open episode) can be found here.
SETTINGS	These are the settings for your user. You can change your password and defaults in this screen.
ABOUT	Provides information about the version of palCentre you are using
EXTRACT	Allows for the extraction of data to be submitted to PCOC
LOGOUT	Logs the user out of palCentre

On the right hand side of the navigation menu bar, you can see your facilities name and 4 digit code assigned by PCOC. If you enter data for multiple facilities, it is important to check the name on the right hand side of the screen before commencing data entry to ensure you are entering data under the correct facility.

The patient screen

The patient screen is the main screen you will use in palCentre. It is used for all data entry. It can be accessed by clicking on the 'Patient' option in the navigation menu bar.



When you open the screen, all current patients can be seen. Each patient is represented by a row in the patient screen. Icons to the right hand side of the patient allows the user to:

Icon	Functionality
	view and edit the patient details
	view and edit the episode and assessment information for a patient
	view and edit the profile collection for a patient
	delete a patient
	archive a patient

At the top of the screen there is a search bar which allows you to search for the patients identifier or name. If you require additional search options, click on the *'Advanced search'* link and more options will appear.

You can create a new patient by clicking on the '*Add a new patient*' button on the top right corner of the screen.

> If your patients have been imported from SNAPshot, they may not appear on the patient screen. This is because all patients imported from SNAPshot are defaulted to archived. To view these patients, you need to click on advanced search, check the 'inactive patients' box and click on search. All the archived patients will appear in the search list in a greyed out colour.
>
> To make a patient appear in the current patient list, click on the folder icon and click 'Yes' when the 'Confirm Patient Restore' box appears.
> You cannot edit a patient's details or assessment if that patient is archived.

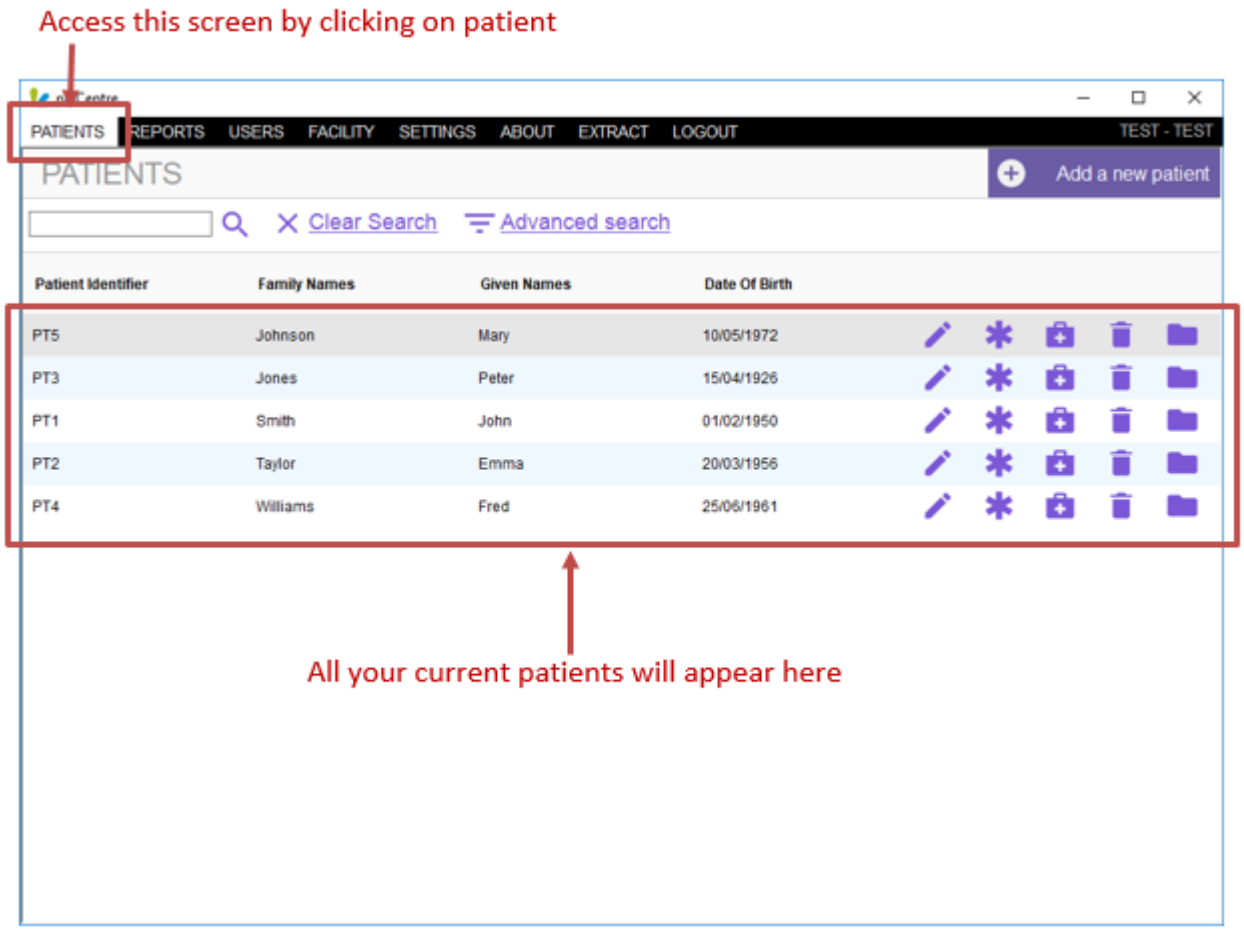
Entering patient information

This page contains information related to entering the patient information within palCentre. To navigate quickly to a section within this page, please use the menu below:

If this is the first time you are entering data into palCentre, PCOC recommends you watch this video on entering patient information.

Accessing the patient screen

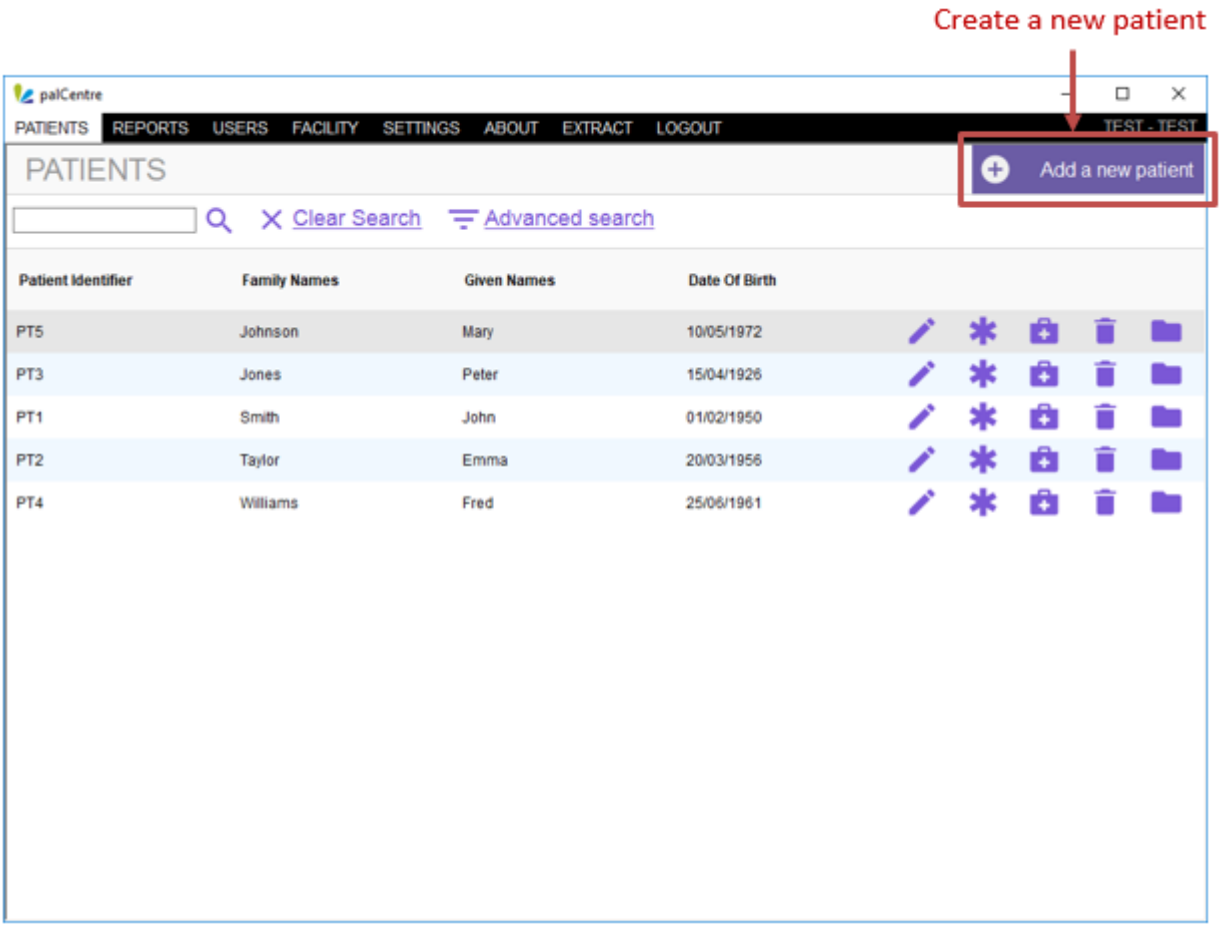
To enter patient information, you need to be on the patient screen in palCentre. It can be accessed by clicking on the *'Patient'* option in the navigation menu bar.



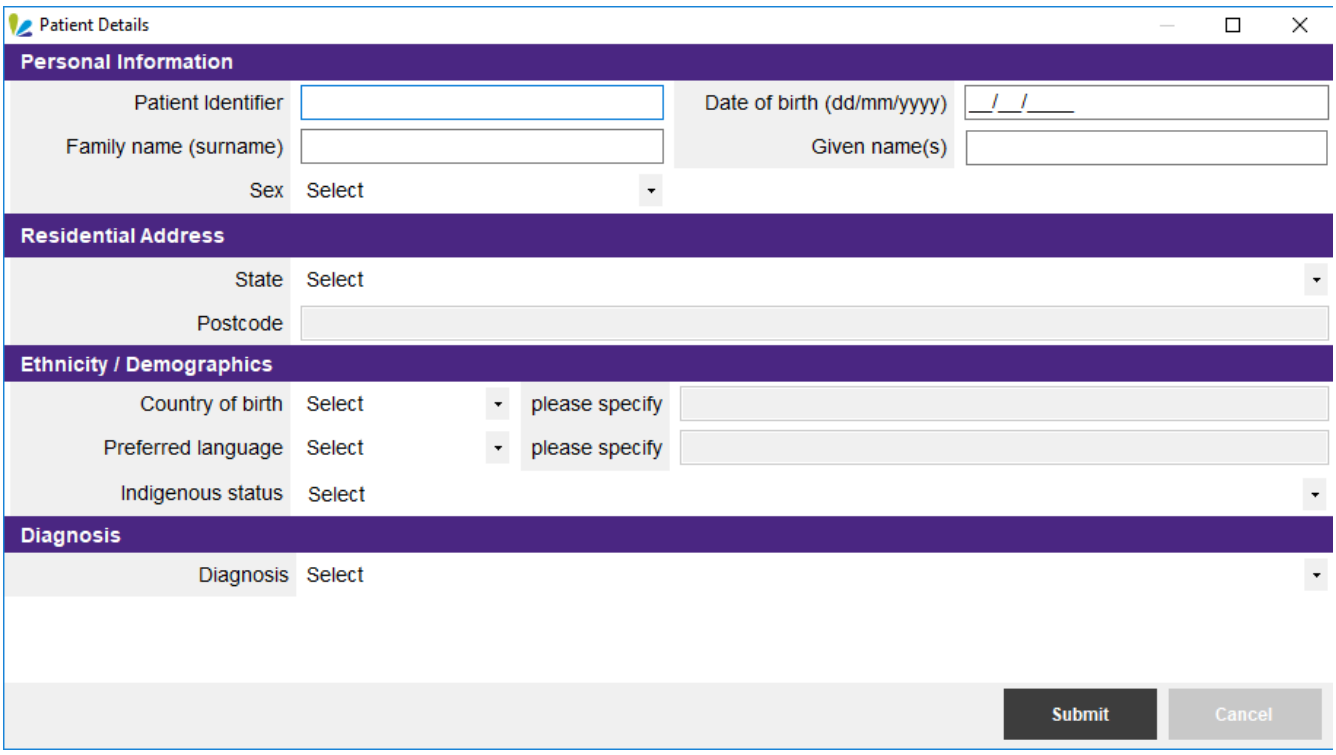
When you open the screen, all current patients can be seen. Each patient is represented by a row in the patient screen.

Creating a new patient

To create a new patient, click on the purple *'Add a new patient'* button in the top right hand corner of the screen.



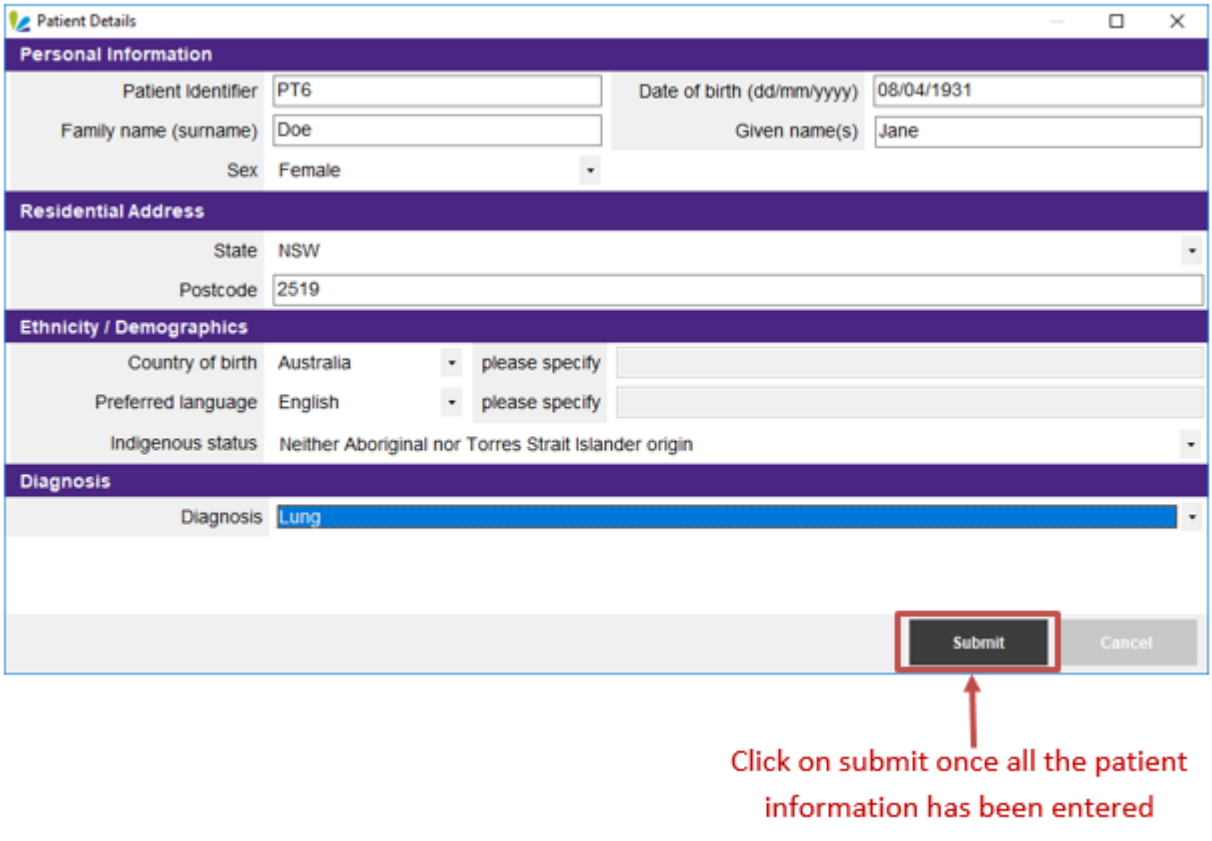
The patient details form will appear:



The following information needs to be entered into this screen:

Item to be entered	Additional information
Patient identifier	The unique identifier assigned to the patient by your service. This is a mandatory item - you cannot submit this screen without this information.
Date of birth	
Family name	This data is not submitted to PCOC but is required to generate the statistical linkage key.
Given name	This data is not submitted to PCOC but is required to generate the statistical linkage key.
Sex	
State	
Postcode	
Country of birth	If the country of birth is Australia, select this from the drop down menu. Otherwise select 'other' from the drop down menu and start typing the country of birth into the please specify field. Once you start typing a drop down list of counties will appear, select the appropriate country. If the country of birth is not stated, select this from the drop down menu.
Preferred language	If the preferred language is English, select this from the drop down menu. Otherwise select 'other' from the drop down menu and start typing the preferred language into the please specify field. Once you start typing a drop down list of languages will appear, select the appropriate language. If the preferred language is not stated, select this from the drop down menu.
Indigenous status	
Diagnosis	This is the principal life limiting illness for the patient

Once all the information has been entered, click on submit.

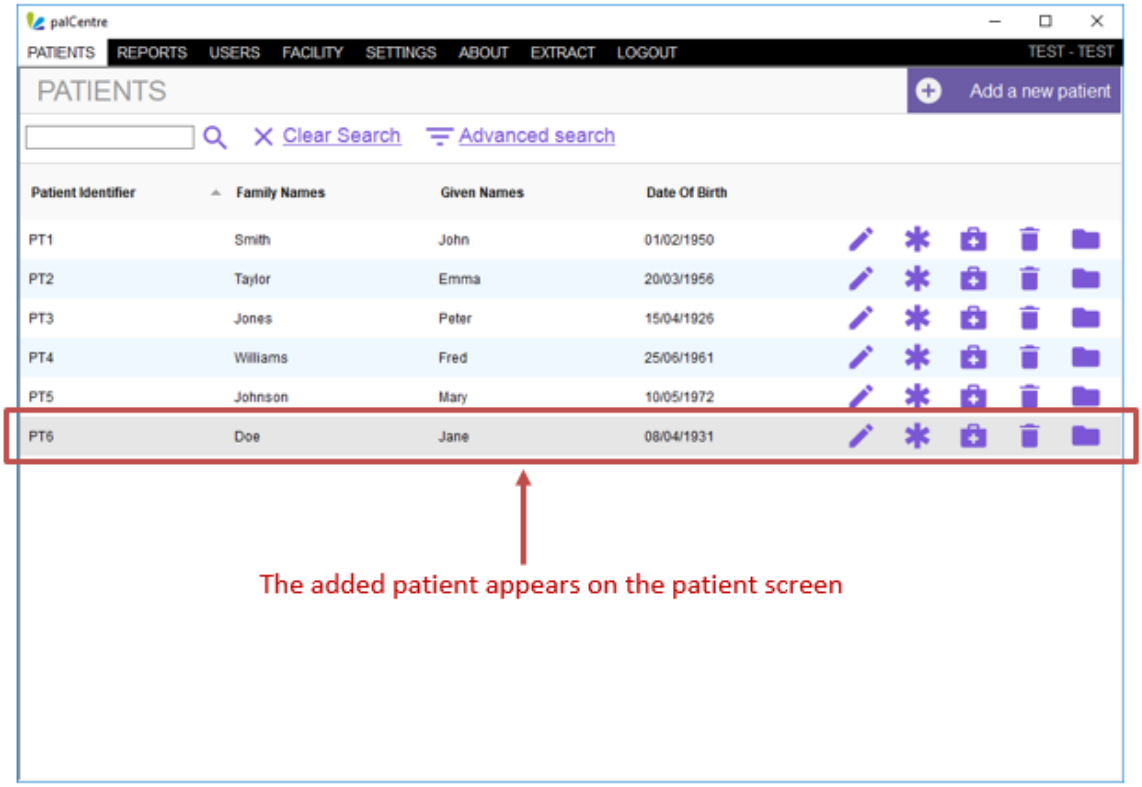


Before the patient details are saved, palCentre will check to see if the patient name and/or patient identifer already exists. This functionality avoids duplicate patients being entered. If this warning does appear, please check that the patient identifer and patients name is correct. If they are correct, you will need to exit from this form and search for the patient.

If the country of birth, preferred language, Indigenous status or diagnosis is not entered into the form at time of creating a new patient, you will be prompted to enter this information in the episode form. This ensures that your patient information is as complete as possible.

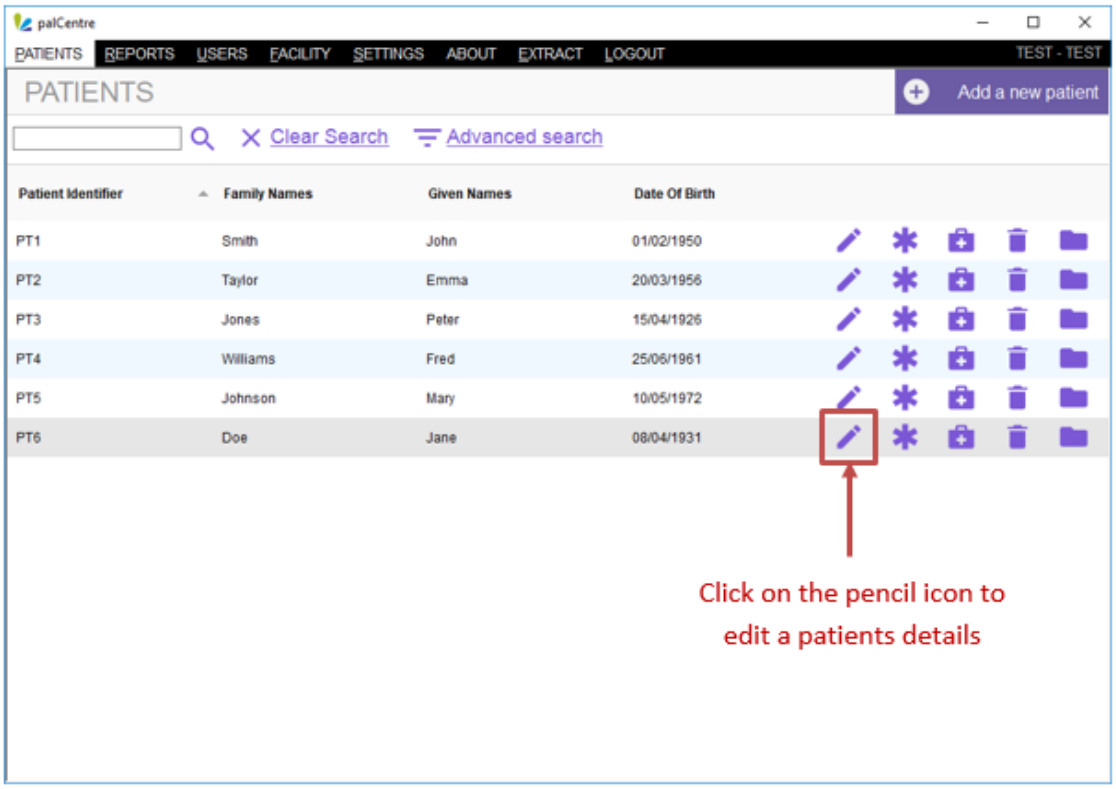
To avoid having blank data items appear on your data quality report, select the 'Not stated' or 'Unknown' option in instances where this information has not been provided.

Once the form has been saved, the patient will now appear in the list on the patient screen.

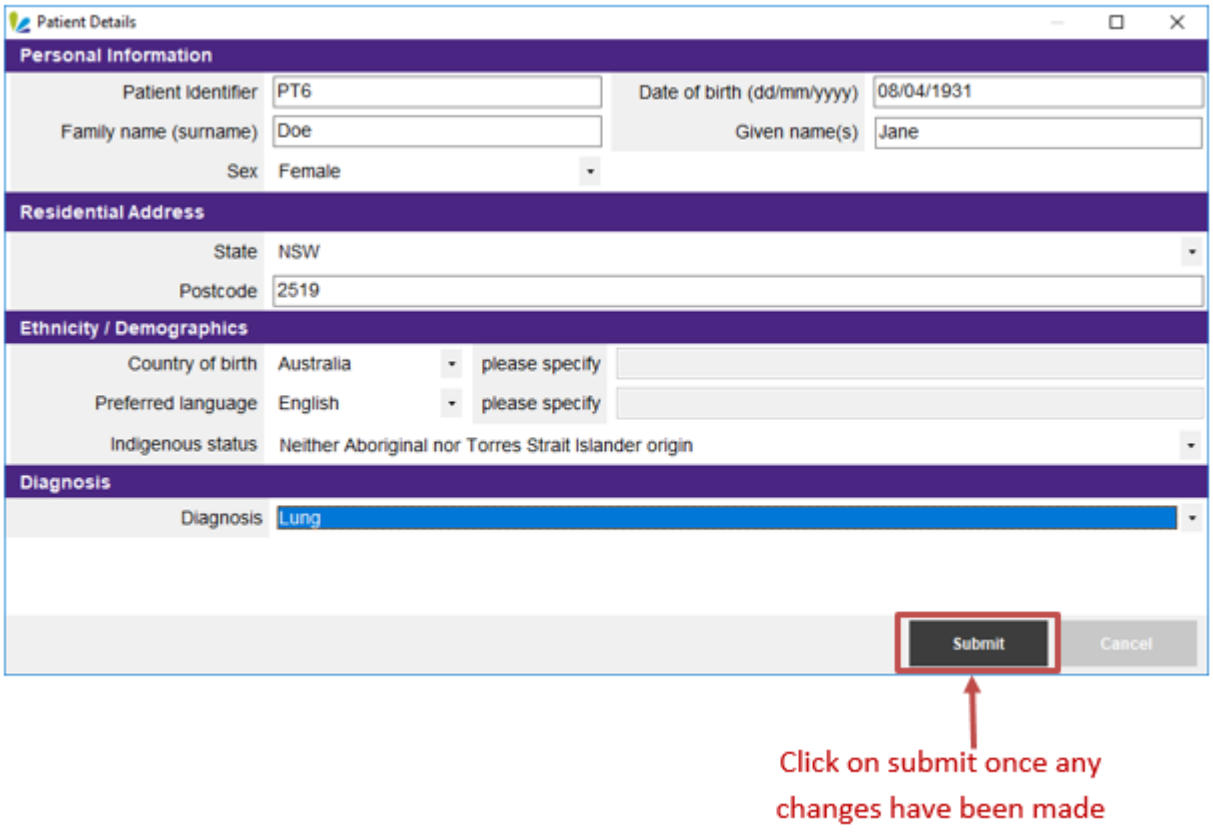


Changing a patients details

To change any of the patient details, click on the  to the right of the patients you wish to change.



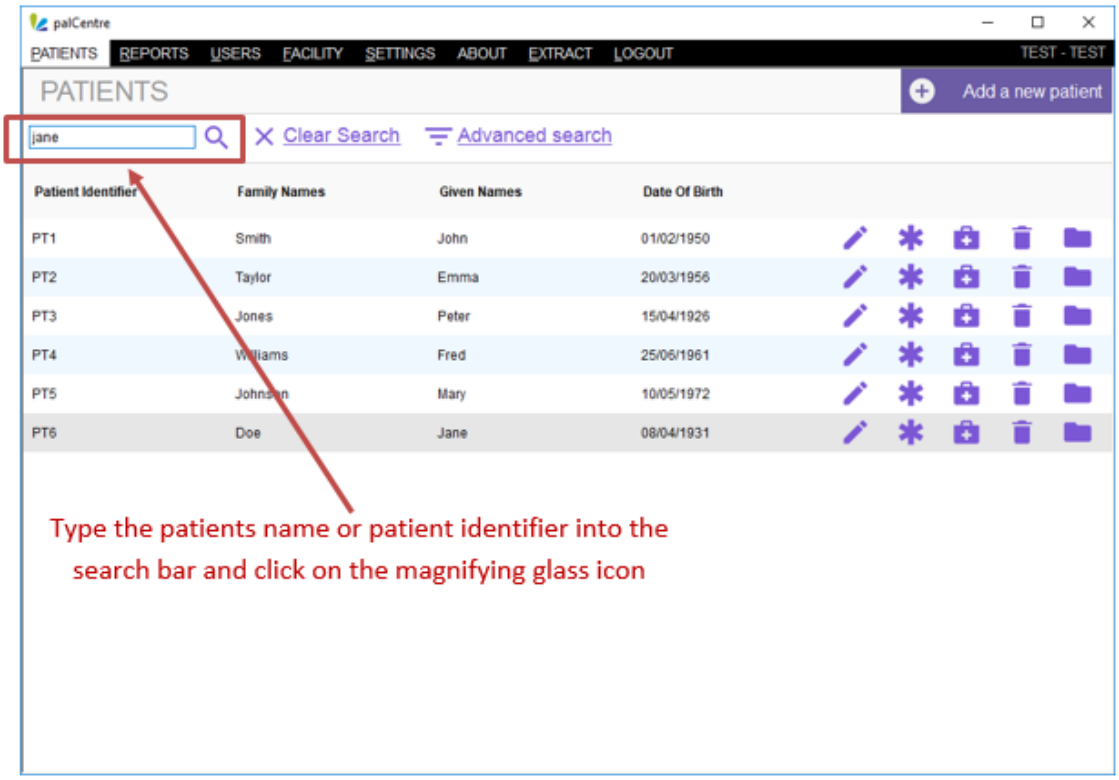
This will open the patient details form to add or change any details. Click on submit once you have made the changes.



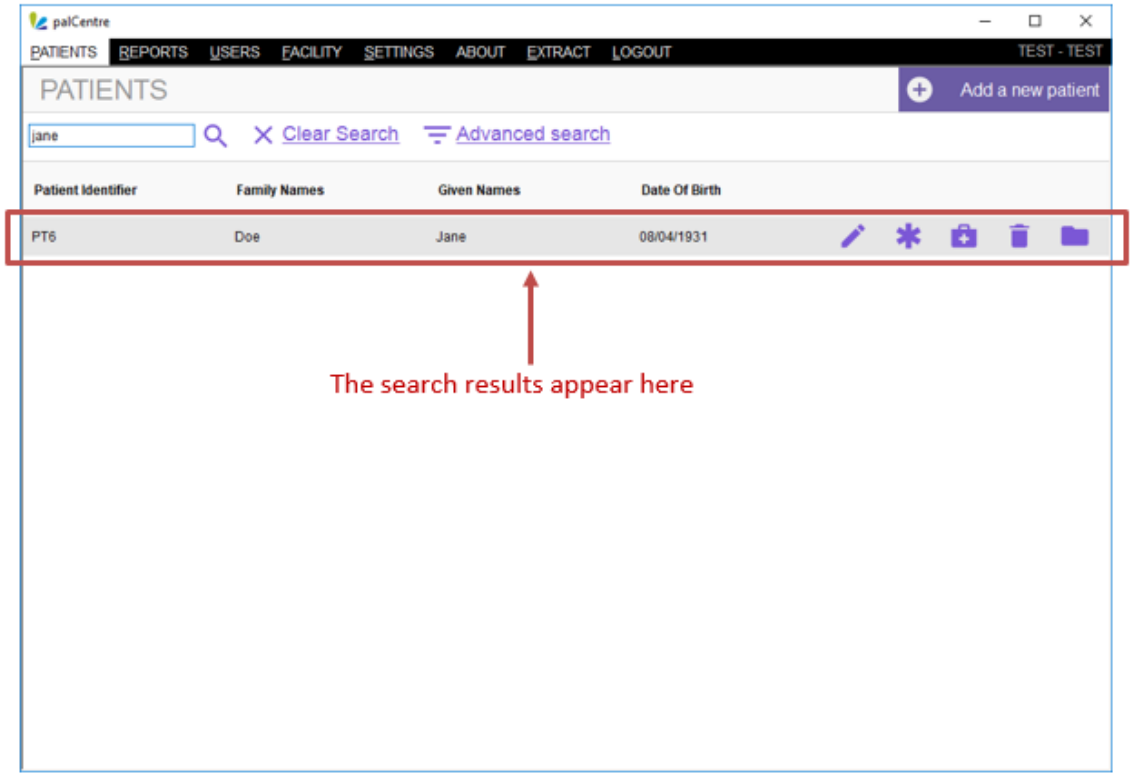
The patient information is now updated.

Searching for a patient

To search for a patient, type their patient identifer or their name in the seach bar in the top left hand side of the screen. Then click on .

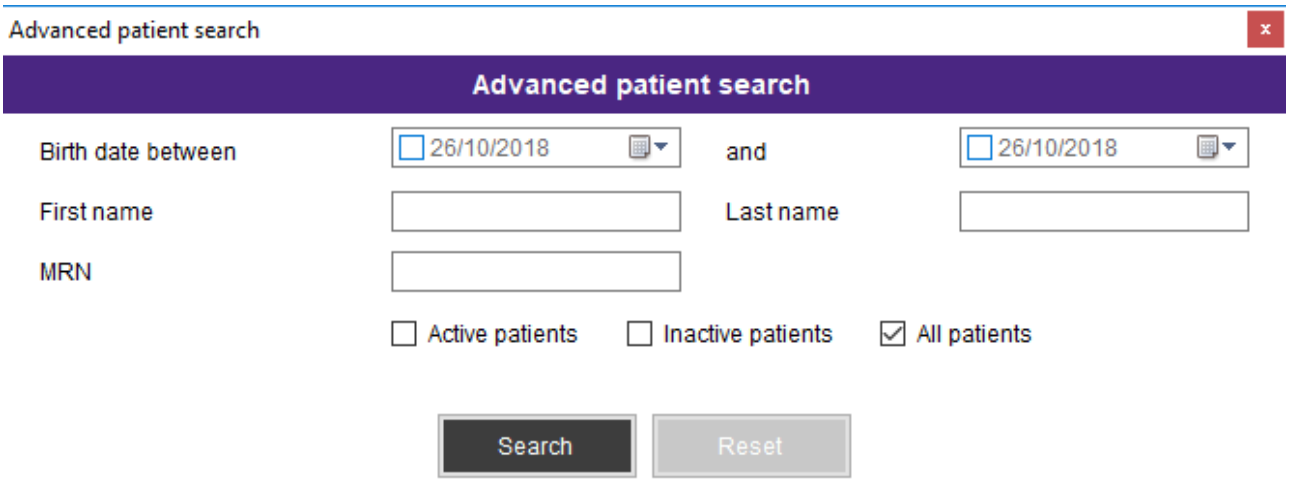


The results of the search will appear below.



If the patient does not appear below, you may need to do an advanced search. Click on the *'Advanced search'* link. This will open a pop-up window that will allow you to search for:

- Date of birth date range
- First name
- Last name
- Patient identifier
- If the patient is active, inactive or all patients



Click on *'Search'* after entering your seach parameters. The results of this search will appear on the patient screen.

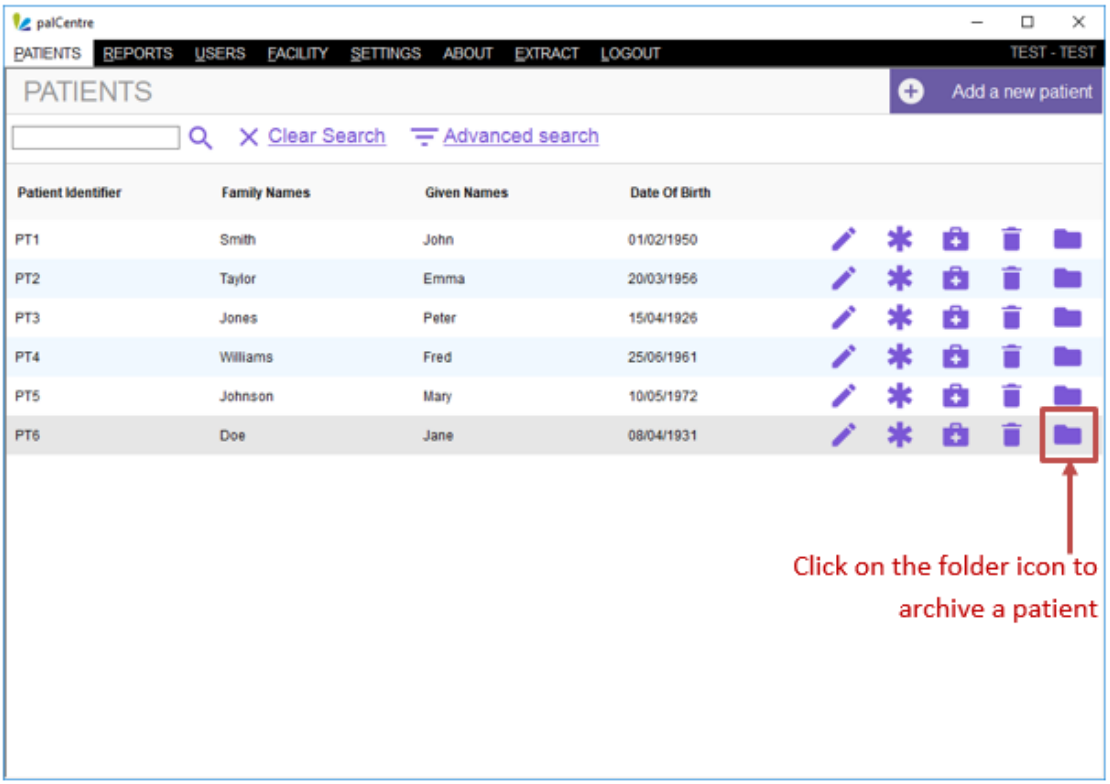
To remove any search parameters, click on the *'Reset'* button in the Advanced Patient Search or the *'Clear Search'* option on the patient screen. This will allow you to see you to see the full list of current patients that appeared when opening palCentre.

Archiving a patient

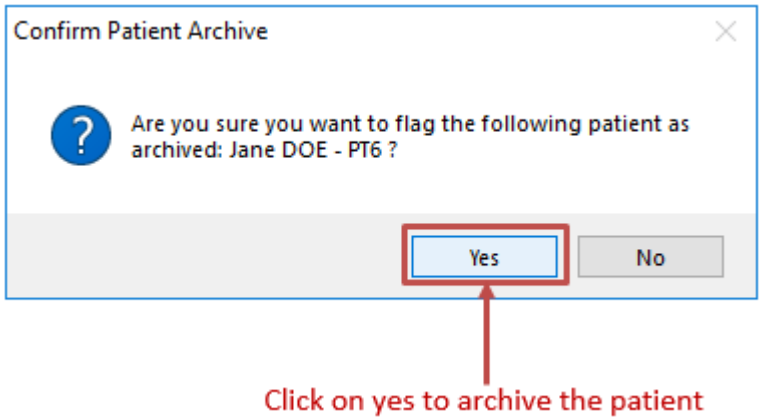
When a patient is no longer active in a service, they can be archived (inactive). This means they will no longer be seen on the patient screen.

> All archived patients will still be included in the data that is extracted and reported to PCOC. Archiving patients will remove them from the patient list when opening the patient screen in palCentre.

To archive a patient, click on the the  to the right of the patients you wish to archive.



The following warning will appear, click on *'Yes'*.

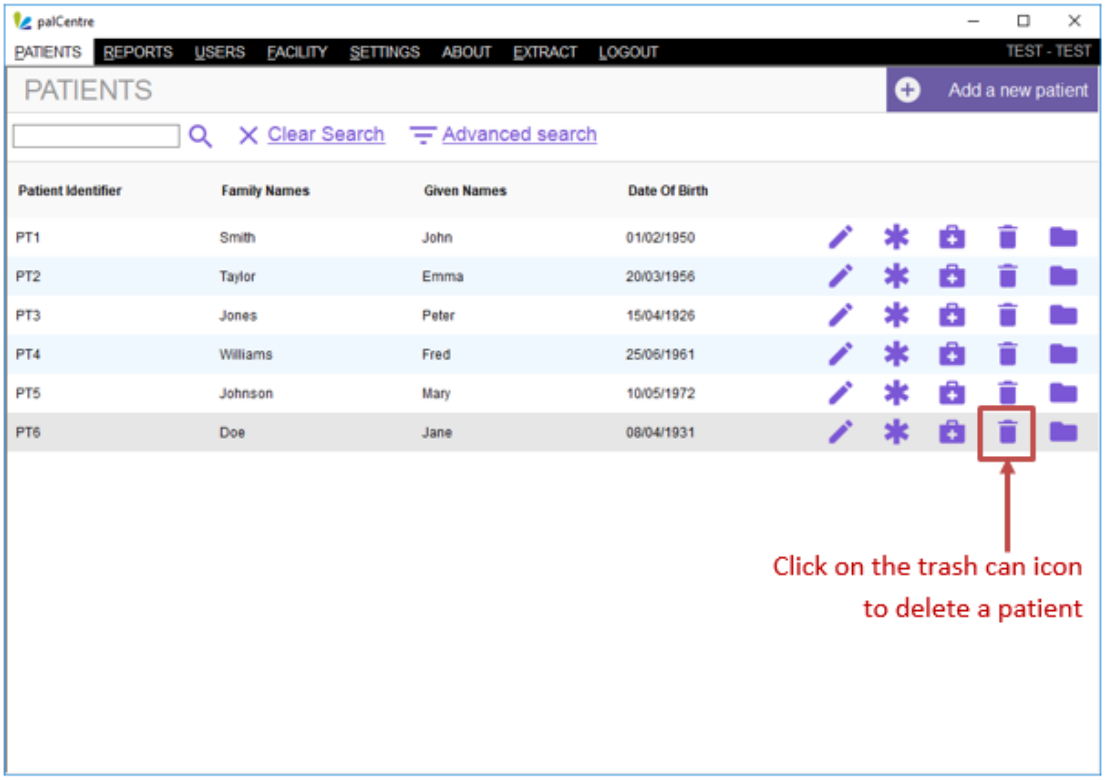


The patient has now been archived.

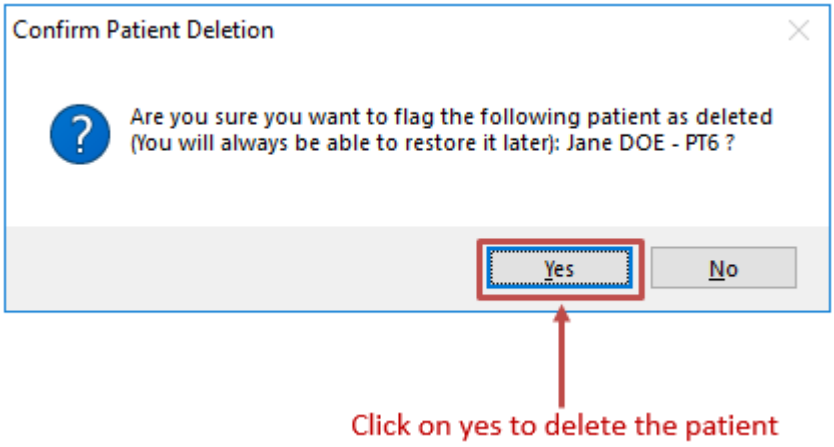
Deleting a patient

> Deleting a patient means they will not be included in the data that is extracted and reported to PCOC. Please ensure you only delete patients that are a mistake and should not be in your PCOC data.

To delete a patient, click on the the  to the right of the patients you wish to delete.



The following warning will appear, click on *'Yes'*.



The patient has now been deleted.

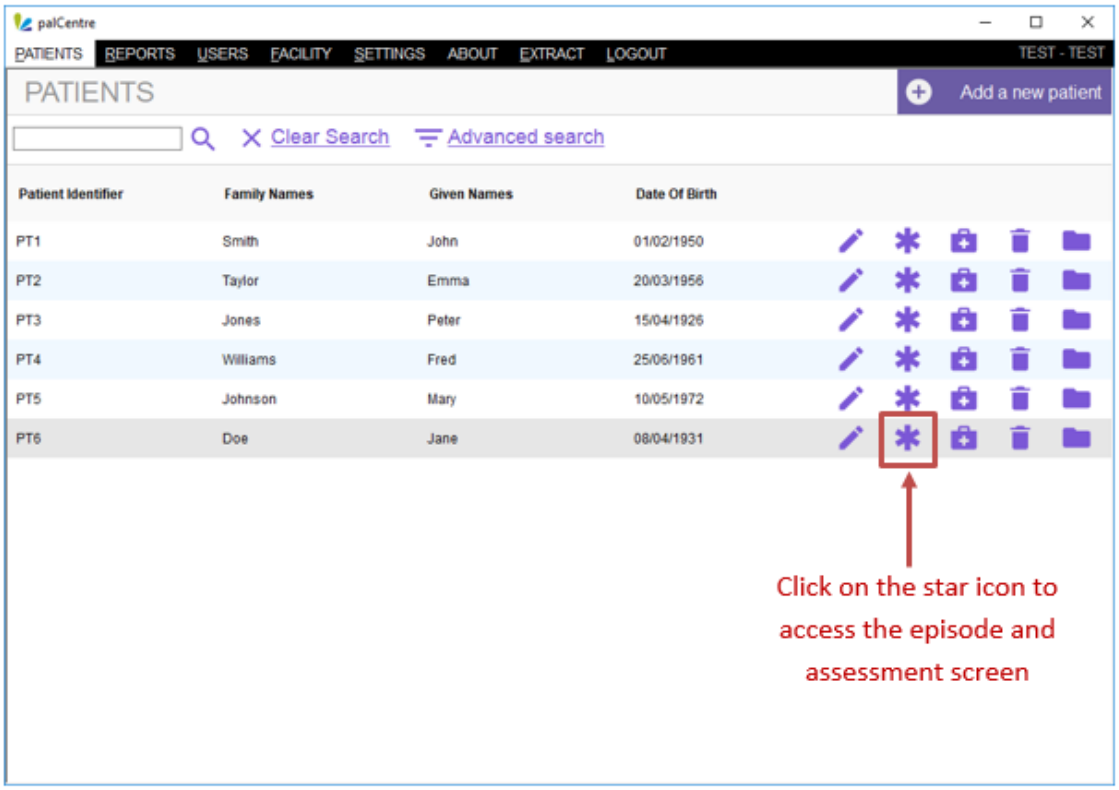
Entering episode information

This page contains all information related to entering the episode information into palCentre. To navigate quickly to a section within this page, please use the menu below:

If this is the first time you are entering data into palCentre, PCOC recommends you watch this video on entering episode information.

Accessing the episode and assessment screen

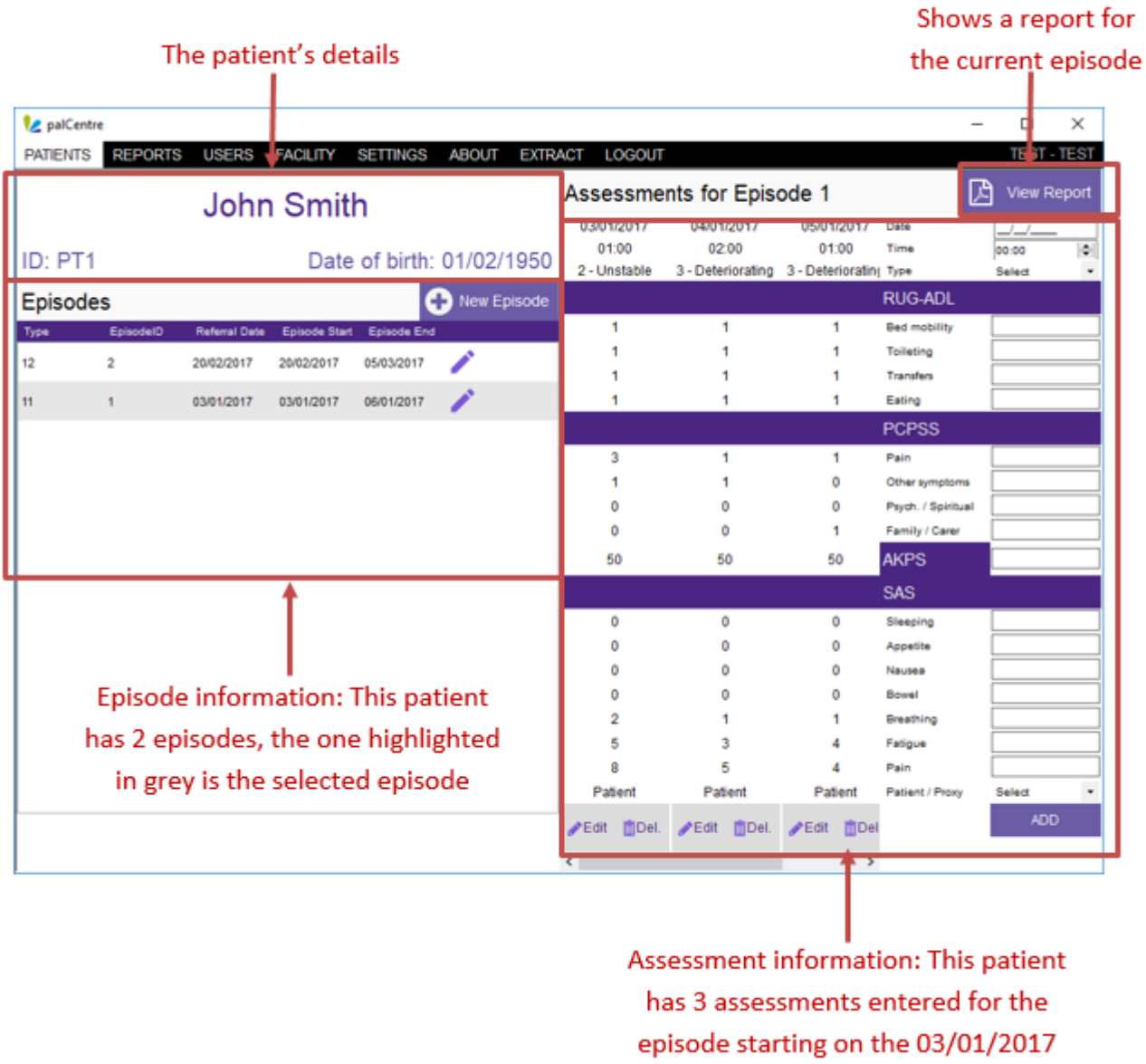
Once a patient has been created in palCentre, you can then add in episode information for that patient. To access the episode screen, click on the  next to the patient name.



The following *'episode and assessments'* screen will appear.
The episode information is on the left hand side of the screen and the patient's details can be found above the episode information. This includes the patient name, patient identifier and date of birth.

The assessment information is on the right hand side of the screen. This information relates to the episode that is highlighted on the left hand side. To look at the assessments for different episodes, highlight the episode that you are interested in by clicking on the episode.

In the top right hand corner of the screen is a *'View Report'* button. This button will create a report for the current episode including all the patient, episode and phase information.



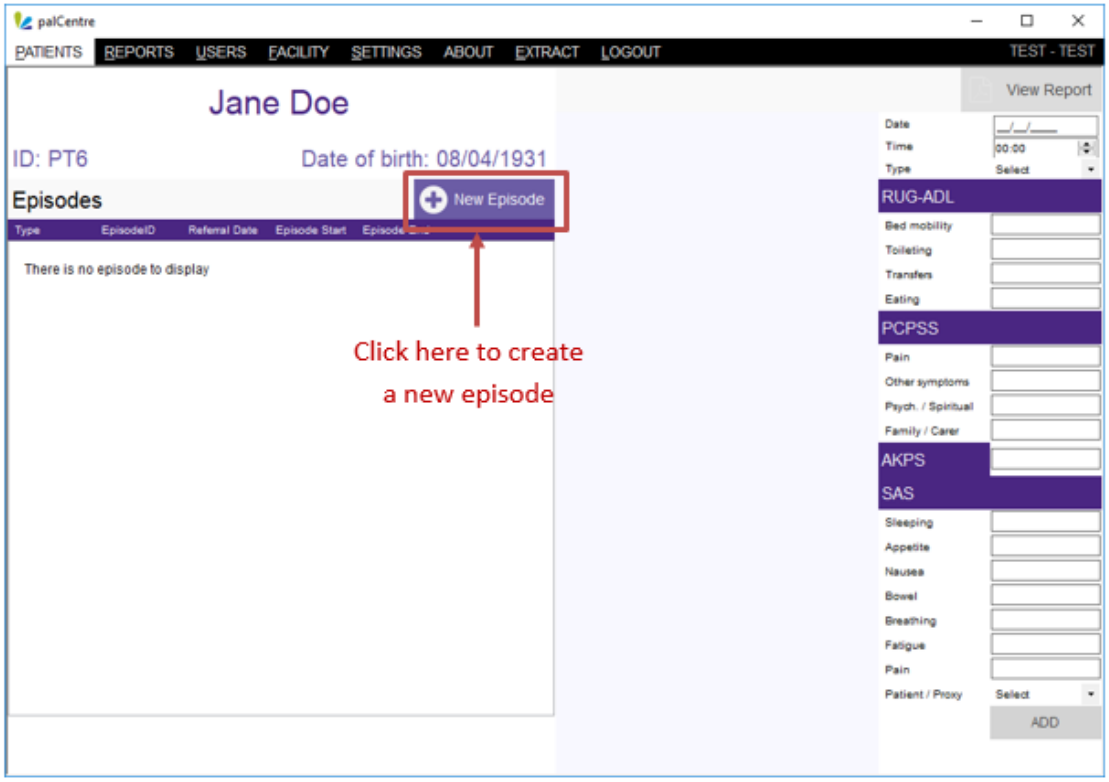
PCOC episodes cannot overlap. For the purposes of PCOC, an episode of care is defined as a continuous period of care for a patient in one setting (i.e. hospital - dedicated inpatient bed, hospital - non-dedicated inpatient bed, private residence, residential age care facility, etc.)

Under this definitions, a patient receiving palliative care is likely to have more than one episode.

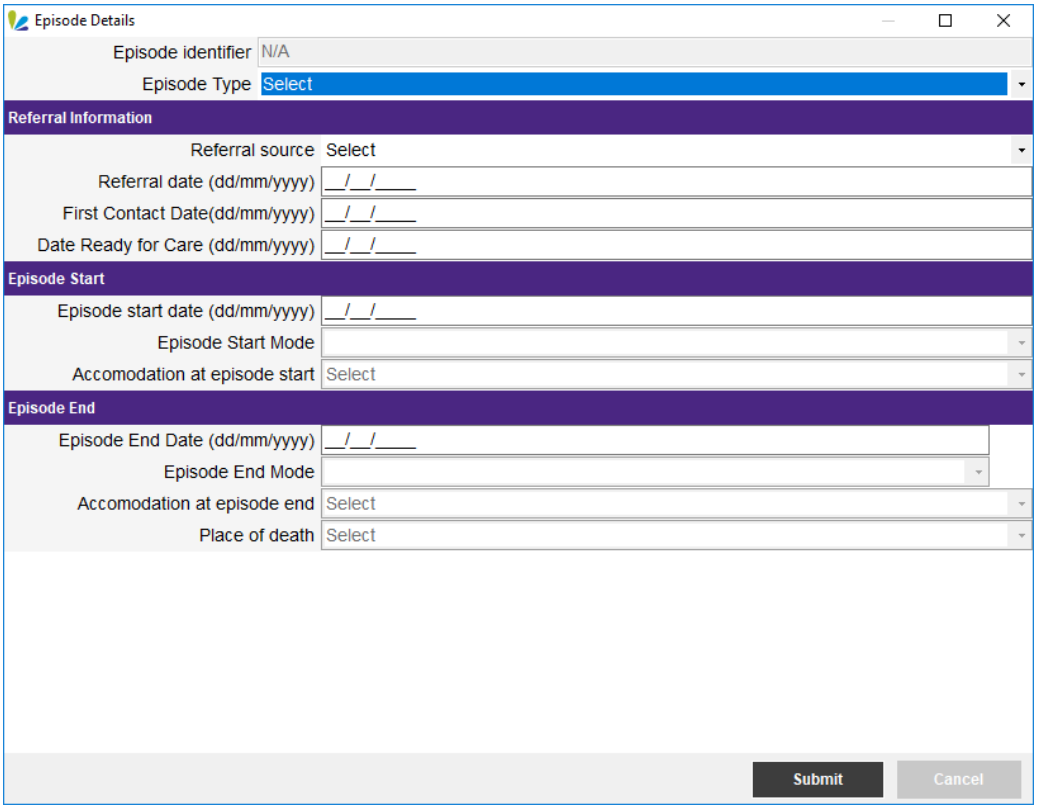
Creating an episode

> You cannot create a new episode if there is an episode already open for the patient. If you need to create an episode and the *'New episode'* button is grey, make sure all episodes in the episode list have an episode end date associated with them.

To create an episode, click on the *'New Episode'* button on the left hand side of the screen.



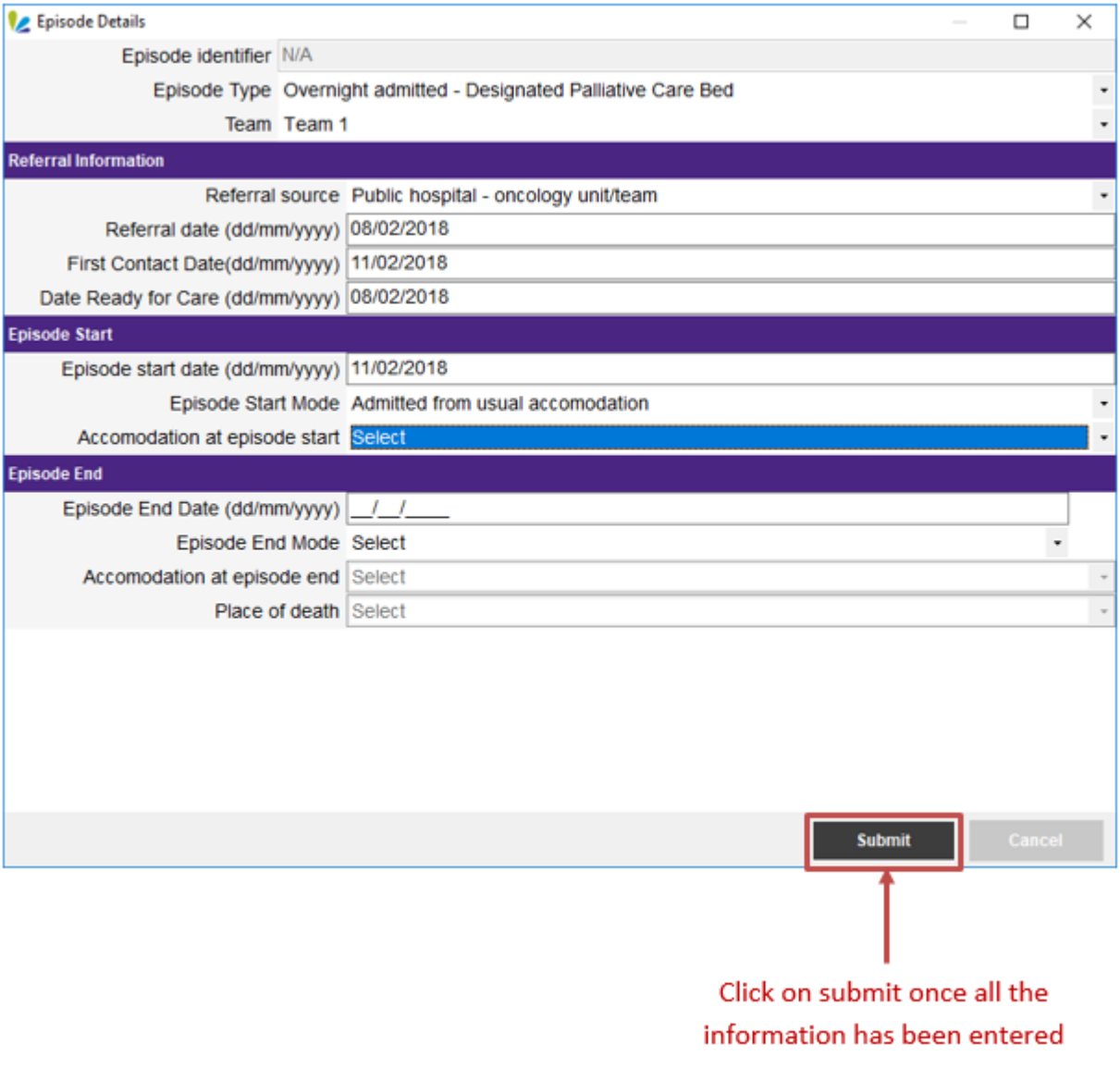
The episode form will appear:



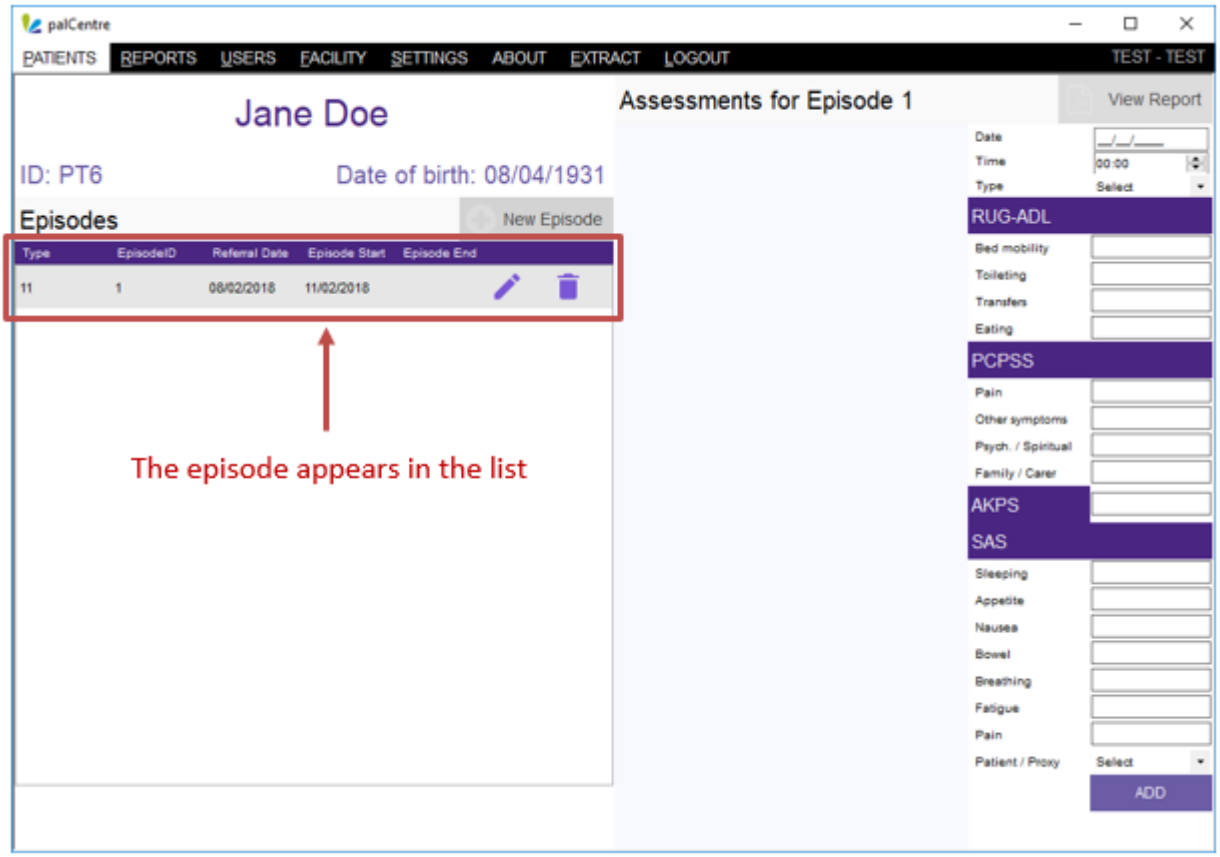
To start an episode, the following information needs to be entered into this screen:

Item to be entered	Additional information
Episode type	This item can be defaulted if you always enter the same type of episode type. This is a mandatory item - you cannot submit this screen without this information.
Team	Only required if you have more than one team entering data. This value can also be defaulted in your user settings.
Referral source	
Referral date	
First contact date	This date must be after the referral date and before the episode start date.
Date ready for care	This date must be after the referral date and before the episode start date.
Episode start date	This is a mandatory item - you cannot submit this screen without this information.
Episode start mode	
Accommodation at episode start	

Once all the information has been entered, click on submit.



The episode information will now appear on the left hand side of the screen.

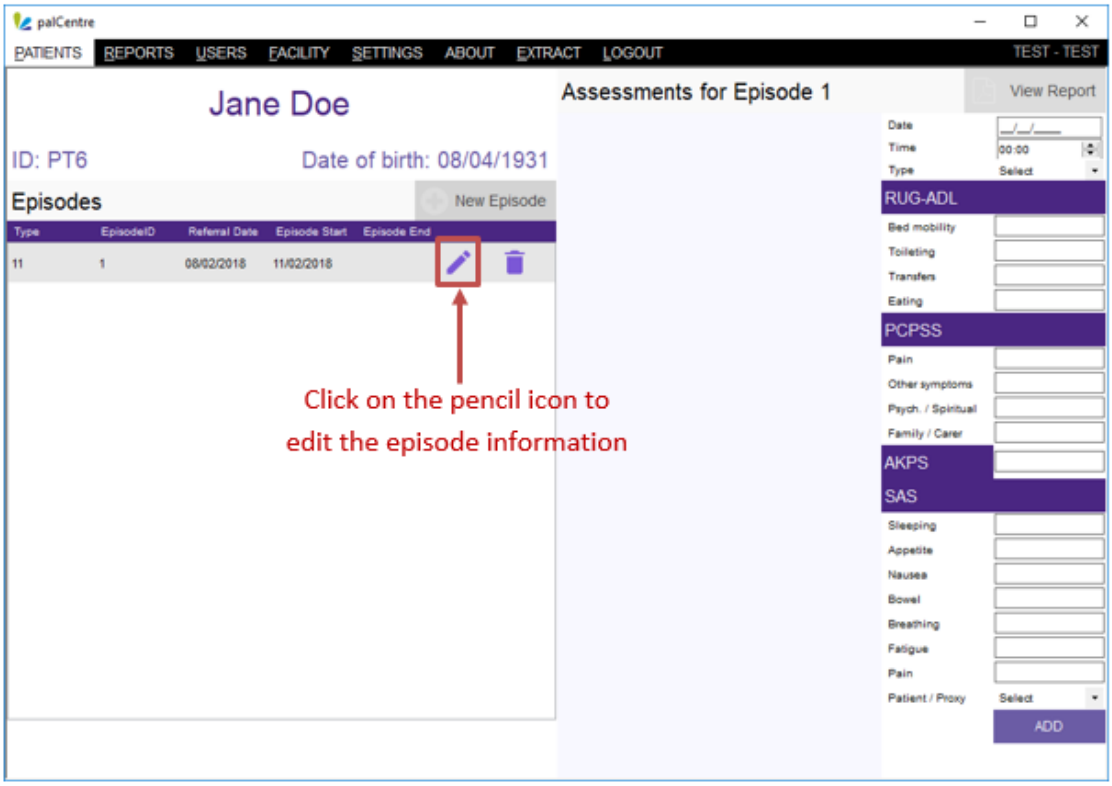


If you are entering data retrospectively, you can also enter the episode end information at the time of creating the episode.

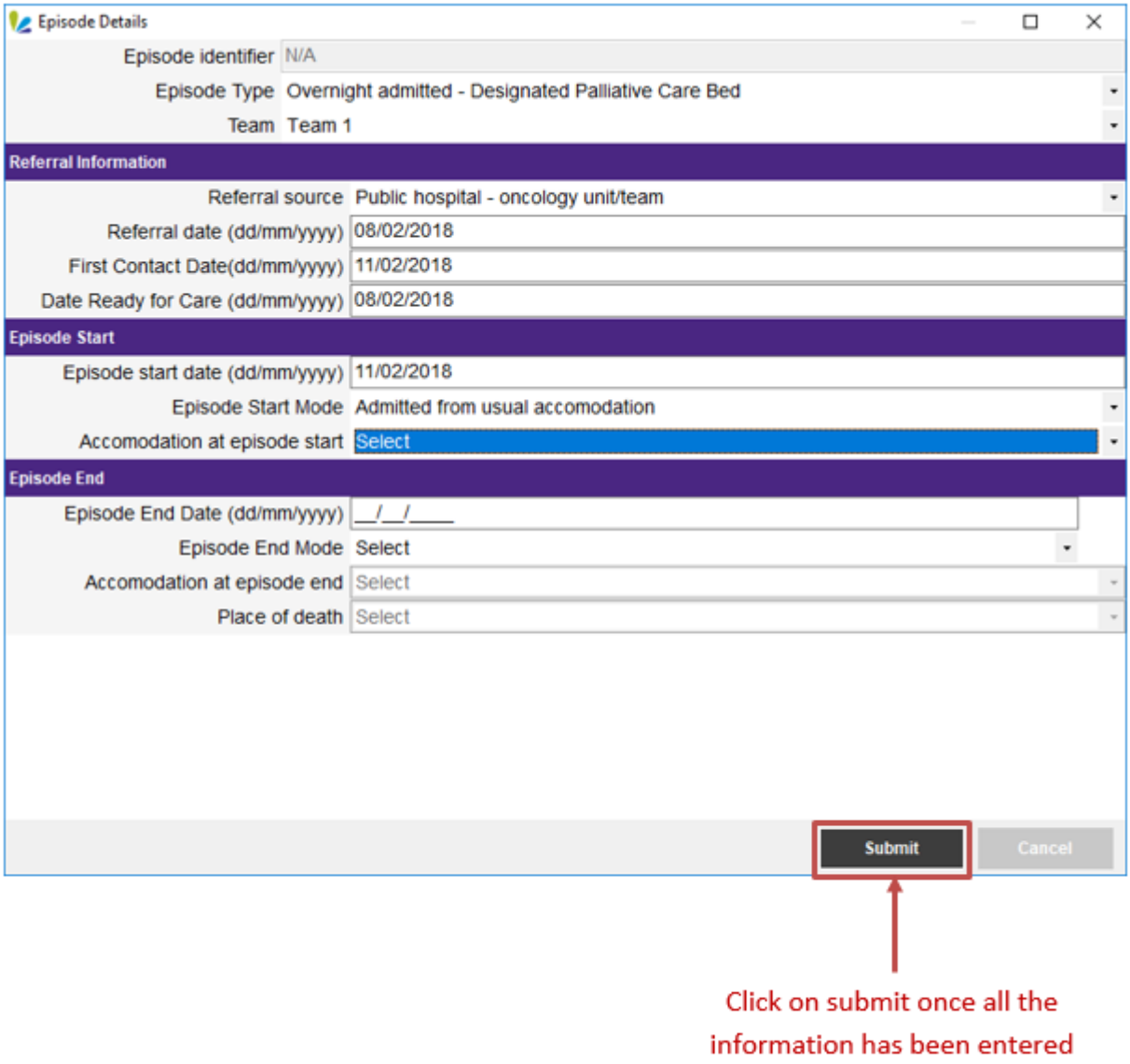
If the patient is currently with your service, you only need to enter the episode start information. Once the patient has left your service, you will need to come back to this screen and enter the episode end information.

Changing episode information

To change any of the episode details, click on the pencil icon next to the episode you wish to change 



This will bring up the episode details form to add or change any details.



Click on submit once you have edited the details.

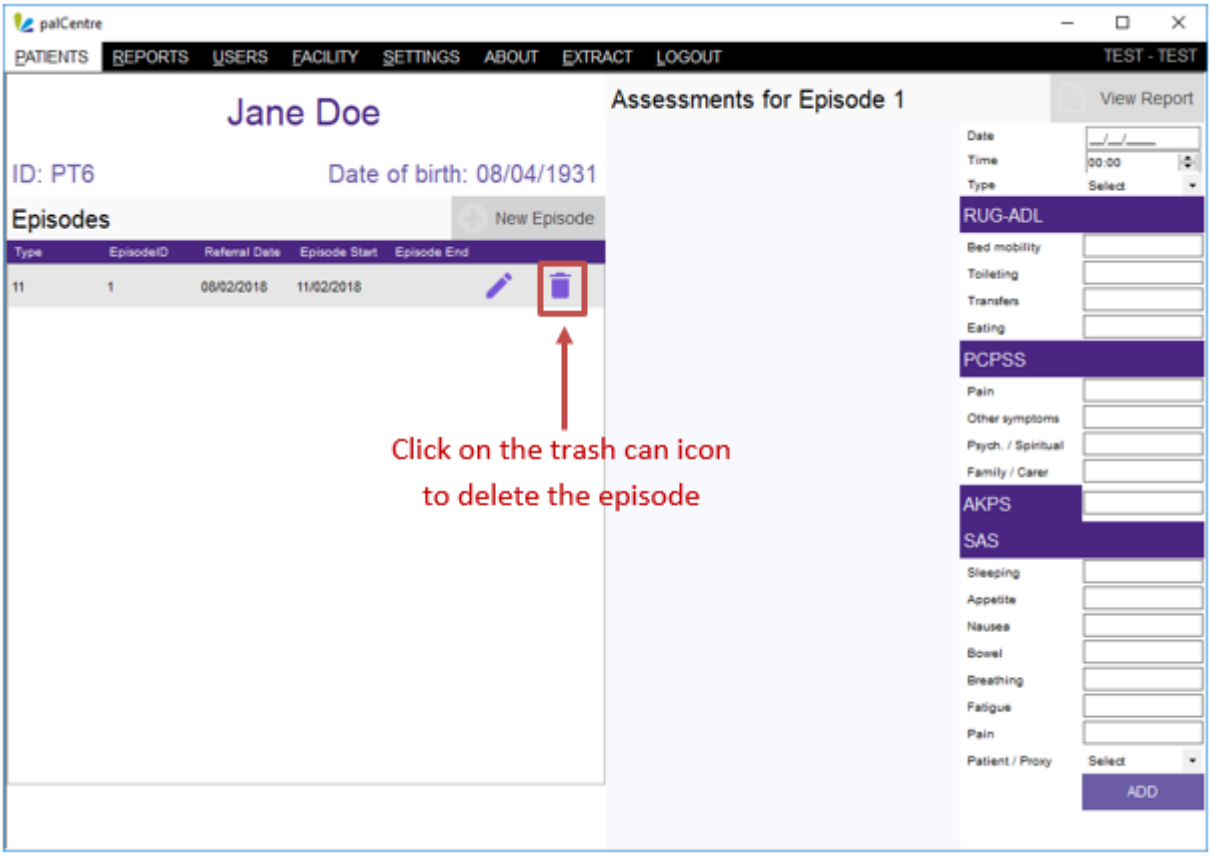
> It is important to remember to fill out the episode end details once the patient has been discharged from your service or the patient has died.
>
> This will ensure you have minimal items on your data quality report and ensures that your episode information is as complete as possible.

Deleting an episode

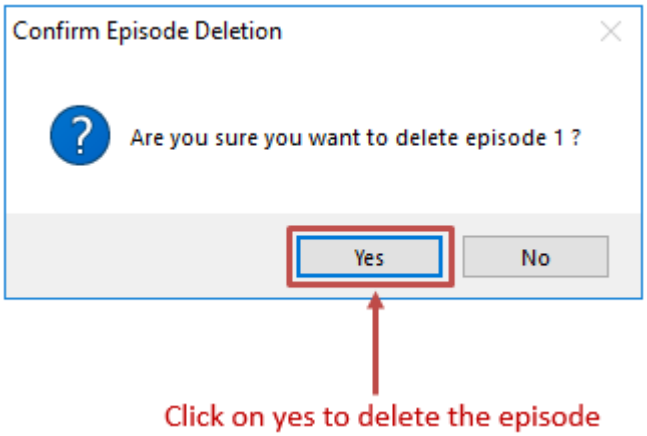
> You cannot delete an episode if there is assessment level data associated with the episode. You must first delete all the assessments on the right hand side of the screen. Once this has been completed, then you can delete the episode.

Once you have deleted all the assoicated assessment data, exit to the patient screen.

Click on the  next to the patient and the  should now be next to the episode with no assessements. Click on the  .



The following warning will appear, click on *'Yes'*.



The episode has now been deleted.

Entering assessment information (phase level information)

This page contains all information related to entering the assessment information into palCentre. To navigate quickly to a section within this page, please use the menu below:

If this is the first time you are entering data into palCentre, PCOC recommends you watch this video on entering assessment information.

Assessment level information vs phase level information

The clinical assessments are assessed daily for inpatient or at each community patient contact. They are reported at admission, when the phase changes and at discharge. Thus there are two ways that data can be entered into palCentre – assessment level or phase level.

Assessment level
palCentre allow services to enter all routine assessments as per the service protocol. Some services record daily assessments and some more, some less frequent. The benefits of entering assessment level data are:

- If data is entered in real time, the reporting function tracks the patient journey with all clinical assessments.
- Since all assessments are entered there is no separate data entry protocol to specify what to enter.
- On average each patient requires approx. 7 minutes to enter.

Phase level
palCentre also allow services to enter data on admission, phase change and discharge. This is referred to as phase level data. The benefits of entering phase level data are:

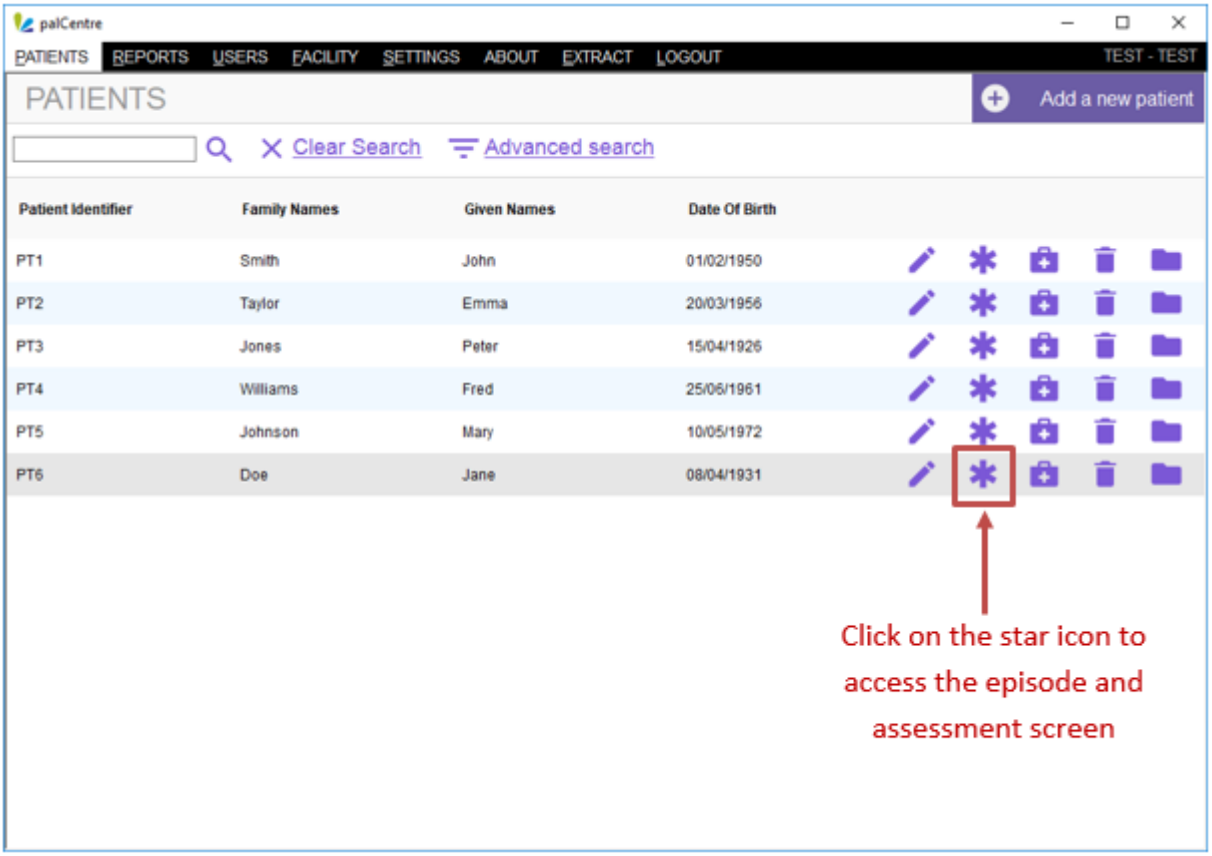
- Since only phase change data needs to be entered less time for data entry is required.
- On average each patient requires approx. 4 minutes to enter.
- A separate data entry to the assessment protocol is required to specify the entry of phase change only
- Additional training for the data entry person is required to understand which assessments to enter.
- Printable reports of the patient journey will only include admission, phase change and discharge assessments. It will be missing any assessments that have occurred in-between.

NB: The legacy system SNAPshot system only allows for phase level data to be collected.

Your service will need to decide if you will be entering assessment level data or phase level data into palCentre before starting data entry. Please follow the appropriate instructions below for data entry.

Accessing the episode and assessment screen

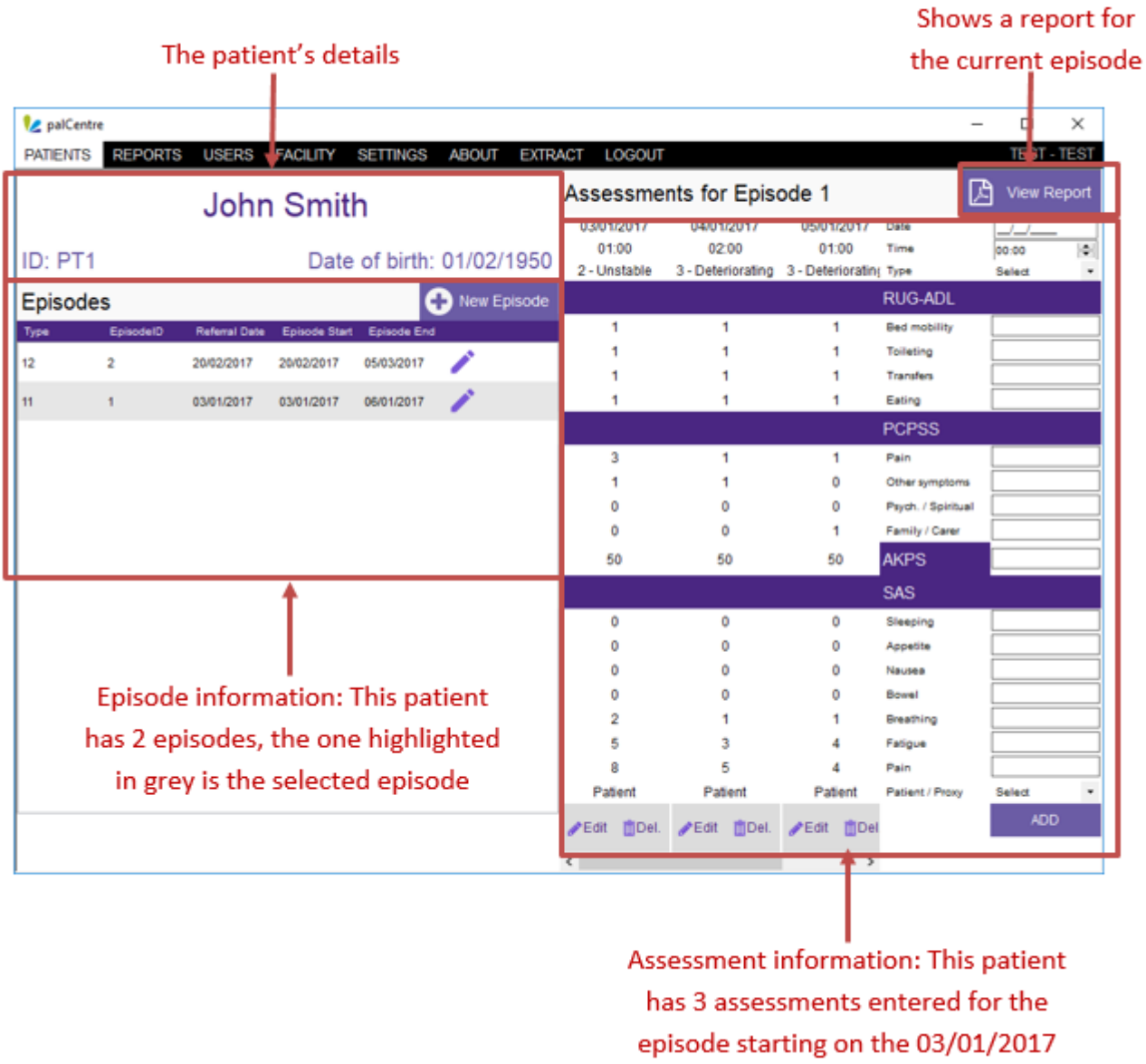
Once an episode has been created, you can enter the assessment information for that episode. To access the episode and assessment screen, click on the * next to the patient name.



The following *'episode and assessments'* screen will appear.
The episode information is on the left hand side of the screen and the patient's details can be found above the episode information. This includes the patient name, patient identifier and date of birth.

The assessment information is on the right hand side of the screen. This information relates to the episode that is highlighted on the left hand side. To look at the assessments for different episodes, highlight the episode that you are interested in by clicking on the episode.

In the top right hand corner of the screen is a *'View Report'* button. This button will create a report for the current episode including all the patient, episode and phase information.



Assessment level information can only been entered if an episode has been created for the patient. Assessment dates must be on or after episode start date and on or before the episode end date.

Entering assessment level information

The clinical assessments occur daily for inpatient or at each community patient contact. All assessments will be entered into palCentre. To demonstrate how to enter assessment level data, the following instructions will use this form to show how to enter assessment level information:

Palliative Assessment and Clinical Response																(Please complete or affix Label here)
St. Example's Inpatient Palliative Care Service																UPI: 20000146 Surname: Doe First name: Jane DOB: 08/04/1931
Assess on admission, daily, at phase change and on discharge																
Year 2013	**Date**	11/02	12/02	13/02	14/02											
	Time	11:34	12:01	10:59	11:02											
Clinician Rated Score	**Palliative Care Phase (1-4 Died or D/C)** *Refer to complete definition* **Stable** = Monitor **Unstable** = Urgent action required **Deteriorating** = Review plan of care **Terminal** = Provide EOL care **Died** = record date, no further assessment required **Discharge (D/C)** = assess at discharge															
	Palliative Care Phase	2	2	1	D/C											
	RUG-ADL *Refer to complete definition* **4 - 5** = Monitor **6 - 10** = assist x 1 **10+** = assist x 1, consider equipment, staff requirements, falls risk, referral **15+** = as above, pressure area risk, consider carer burden and MDT review **18** = as above, full care assistance x 2															
	Bed mobility	3	3	3	3											
	Toileting	3	3	3	3											
	Transfers	3	3	3	3											
	Eating	1	1	1	1											
	Total RUG ADL (4-18):	10	10	10	10											
	Problem Severity Score Actions (0-3) *Refer to complete definition and rate each domain* 0 = Continue care 1 = Monitor and record 2 = Review/change plan of care; referral, intervention as required 3 = Urgent action															
	Pain	3	2	1	1											
	Other Symptoms	3	2	1	1											
	Psychological / Spiritual	0	0	0	0											
	Family / Carer	2	1	1	1											
	Australia-modified Karnofsky Performance Status Scale (10-100) *Refer to complete definition* Consider MDT review at score of 50 or below															
	AKPS	50	50	50	50											
Patient Rated Score	**Symptom Assessment Scale (0-10)** *Rate experience of symptom distress over a 24hr period* *0 = absent 10 = worst possible* 0 = Continue care 1 -3 = Monitor and record 4-7 = Review/change plan of care; referral, intervention as required 8-10 = Urgent action															
	Distress from difficulty sleeping	5	4	4	4											
	Distress from Appetite	6	5	5	4											
	Distress from Nausea	8	5	3	3											
	Distress from Bowels	2	2	1	1											
	Distress from Breathing	0	0	0	0											
	Distress from Fatigue	8	8	5	4											
	Distress from Pain	8	5	2	2											
	Completed by Patient Fam/Carer or Clinician Use codes = Pt, FC, Cl	pt	pt	pt	pt											
Staff Initials																

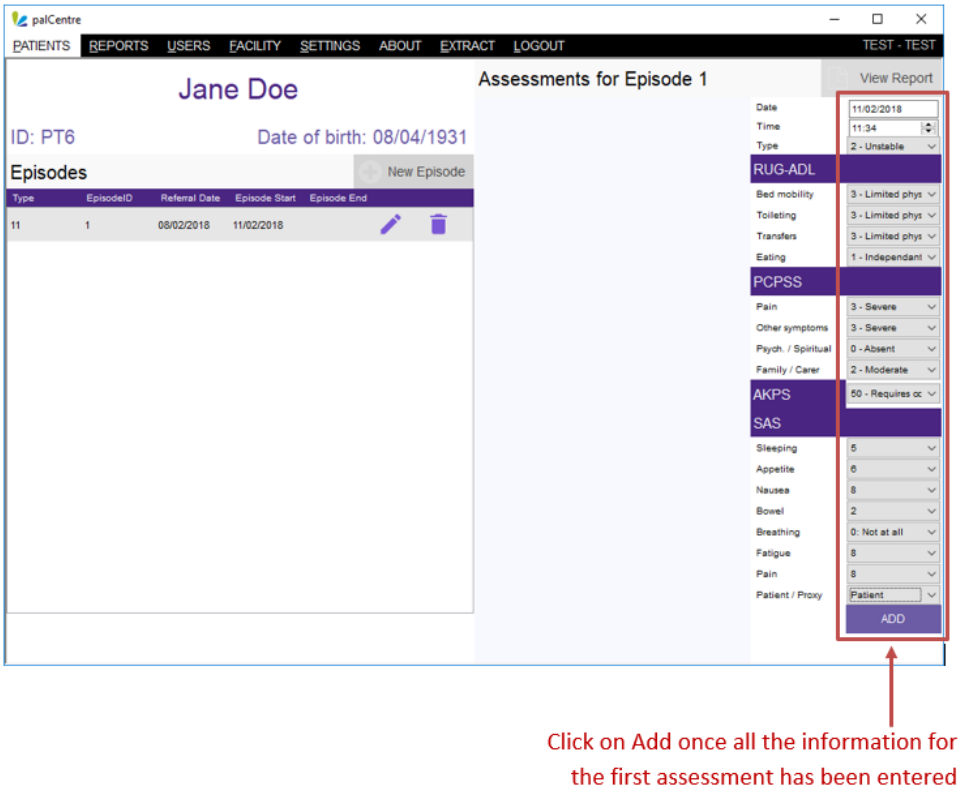
The form above has four columns that have been completed by the clinical team, reflecting clinical assessments made each day of the patients episode. To enter assessment level data, all four columns of information need to be entered.

Entering the first assessment

In the episode and assessment screen, make sure you have selected the correct episode on the left hand side of the screen. On the right hand side of the screen enter the following details:

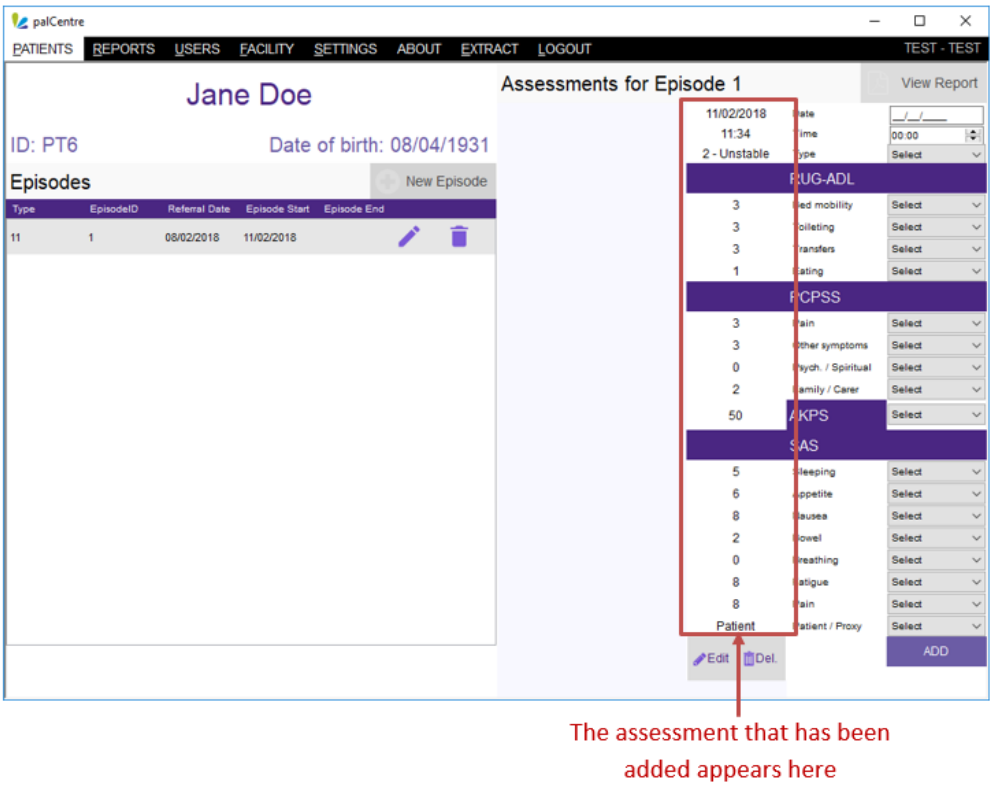
Item to be entered	Additional information
Date	The date the assessment was completed. This is a mandatory item - you cannot submit an assessment without this information.
Time	Optional field. The time of the assessment.
Type	The phase type for the assessement. This is a mandatory item - you cannot submit an assessment without this information.
RUG-ADL	The RUG-ADL consists of four items (bed mobility, toileting, transfer and eating) and measures the patients function.
PCPSS	The PCPSS consists of four items (pain, other symptoms, psychological/spiritual and family/carer) with a score between 0 and 3 and screens the severity of palliative care problems.
AKPS	The AKPS consists of one item with a score between 10 and 100 and measures a patient's ability to perform ordinary tasks.
SAS	The SAS is a patient rated tool with a score between 0 and 10 that measures the patient's distress across seven domains (difficulty sleeping, appetite problems, nausea, bowel problems, fatigue and pain). There is also a field to capture if the patient or a proxy completed these assessments.

The information for the first assessment is entered as below. Once all the information has been added, click on the purple *'ADD'* button.



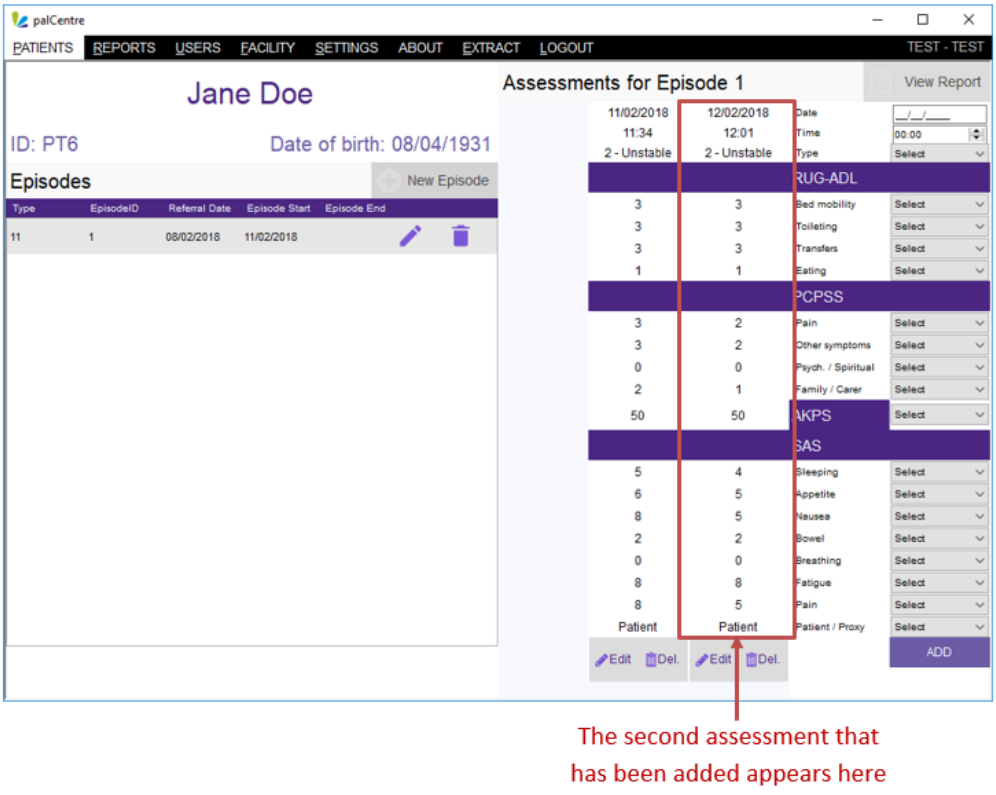
Click on Add once all the information for the first assessment has been entered

Once the assessment information has been added, it will appear on the left hand side of the assessment data entry screen as below.

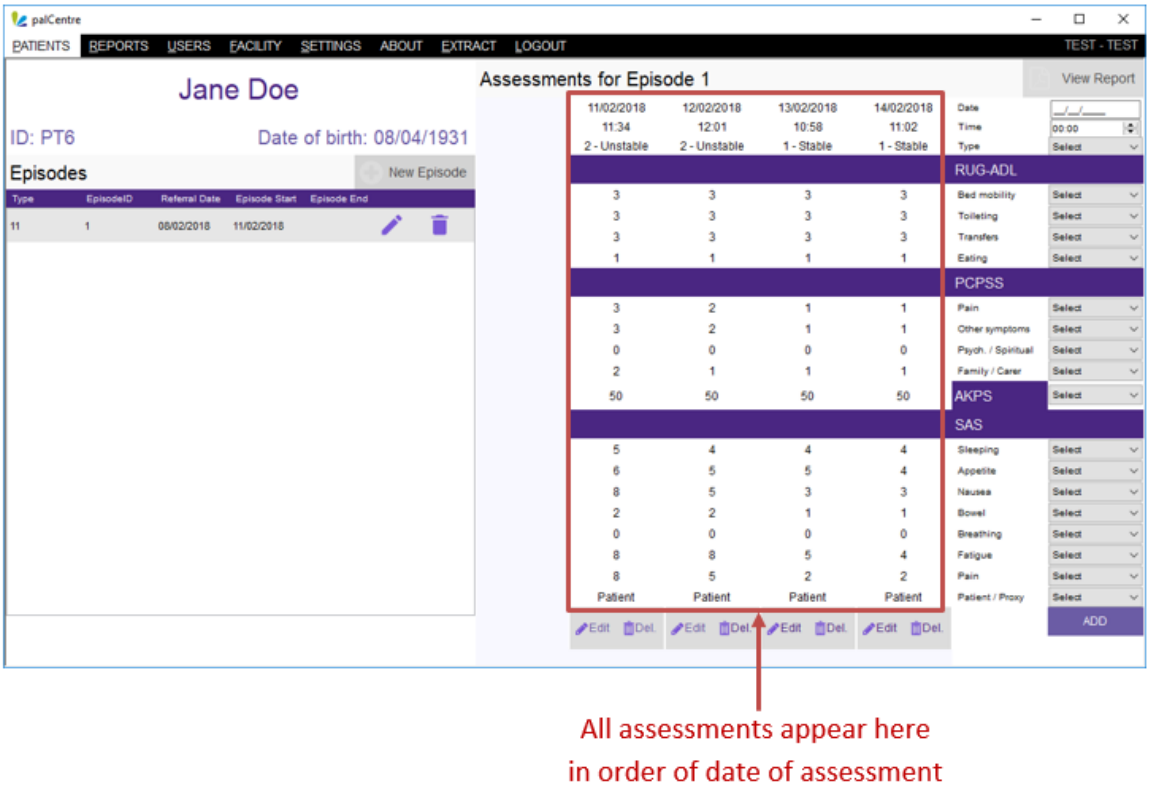


Entering the additional assessment

Next we add the second assessment on the form and click on *'ADD'*. The assessment will appear on the left hand side of the data entry screen.



Continue to add the assessments on the form until all the assessments have been added into palCentre



You have now added all the assessment for this episode.

If an item has not been recorded on the form, use the 'Not Assessed' code in the drop down menu. This will ensure you have minimal items appearing on your data quality report.

Assessments can be added in any order into palCentre. Once an assessment is added, palCentre will check the date against all other assessment dates and then order all assessments by date.

If you miss adding an assessment by accident, add the assessment into the data entry section on the right hand side of the screen and palCentre will place it in the correct order.

Entering phase level information

The clinical assessments are assessed daily for inpatient or at each community patient contact. They are reported at admission, when the phase changes and at discharge. When entering phase level information, you only need to add assessments into palCentre on admission, where the phase changes and when the patient is discharged. To demonstrate how to enter assessment level data, the following instructions will use this form to show how to enter assessment level information:

Palliative Assessment and Clinical Response

St. Example's Inpatient Palliative Care Service

PCOC palliative care outcomes collaboration

(Please complete or affix Label here)

UPI: 20000146

Surname: Doe

First name: Jane

DOB: 08/04/1931

Assess on admission, daily, at phase change and on discharge

Year 2013	**Date**	11/02	12/02	13/02	14/02										
	Time	11:34	12:01	10:59	11:02										
Clinician Rated Score	**Palliative Care Phase (1-4 Died or D/C)** *Refer to complete definition* **Stable** = Monitor **Unstable** = Urgent action required **Deteriorating** = Review plan of care **Terminal** = Provide EOL care **Died** = record date, no further assessment required **Discharge (D/C)** = assess at discharge														
	Palliative Care Phase	2	2	1	D/C										
	RUG-ADL *Refer to complete definition* **4 - 5** = Monitor **6 - 10** = assist x 1 **10+** = assist x 1, consider equipment, staff requirements, falls risk, referral **15+** = as above, pressure area risk, consider carer burden and MDT review **18** = as above, full care assistance x 2														
	Bed mobility	3	3	3	3										
	Toileting	3	3	3	3										
	Transfers	3	3	3	3										
	Eating	1	1	1	1										
	Total RUG ADL (4-18):	10	10	10	10										
	Problem Severity Score Actions (0-3) *Refer to complete definition and rate each domain* 0 = Continue care 1 = Monitor and record 2 = Review/change plan of care; referral, intervention as required 3 = Urgent action														
	Pain	3	2	1	1										
	Other Symptoms	3	2	1	1										
	Psychological / Spiritual	0	0	0	0										
	Family / Carer	2	1	1	1										
	Australia-modified Karnofsky Performance Status Scale (10-100) *Refer to complete definition* Consider MDT review at score of 50 or below														
	AKPS	50	50	50	50										
Patient Rated Score	**Symptom Assessment Scale (0-10)** *Rate experience of symptom distress over a 24hr period* *0 = absent 10 = worst possible* 0 = Continue care 1 -3 = Monitor and record 4-7 = Review/change plan of care; referral, intervention as required 8-10 = Urgent action														
	Distress from difficulty sleeping	5	4	4	4										
	Distress from Appetite	6	5	5	4										
	Distress from Nausea	8	5	3	3										
	Distress from Bowels	2	2	1	1										
	Distress from Breathing	0	0	0	0										
	Distress from Fatigue	8	8	5	4										
	Distress from Pain	8	5	2	2										
	Completed by Patient Fam/Carer or Clinician Use codes = Pt, FC, Cl	~~pt~~	~~pt~~	~~pt~~	~~pt~~										
Staff Initials															

The form above shows four columns have been completed by the clinical team, reflecting clinical assessments made each day of admission. To capture the information for these four columns in when entering phase level assessments, you only need to create /enter records for admission, phase change and discharge. As such, you only need to enter the following 3 records.

1. A record with:
   The information in the first column i.e. Phase = 2 (unstable) and date of 11/02/2018.

2. A record with:
   The information from the third column i.e. Phase= 1 (stable) and date of 13/02/2018.
   NOTE: we have skipped the second column of data as the phase is unchanged (i.e. still 2 - unstable). A new record only needs to be entered when the phase changes

3. A record with:
   The information from the fourth column i.e. Phase = 1 (stable) and a date of 14/02/2018.
   NOTE: This assessment must be included as it is the discharge assessment regardless of whether the phase has changed or not.

If a patient is discharged from your service, it is important to enter the final assessment into palCentre. This will ensure you have minimal items on your data quality report and ensures that your assessment information is as complete as possible.

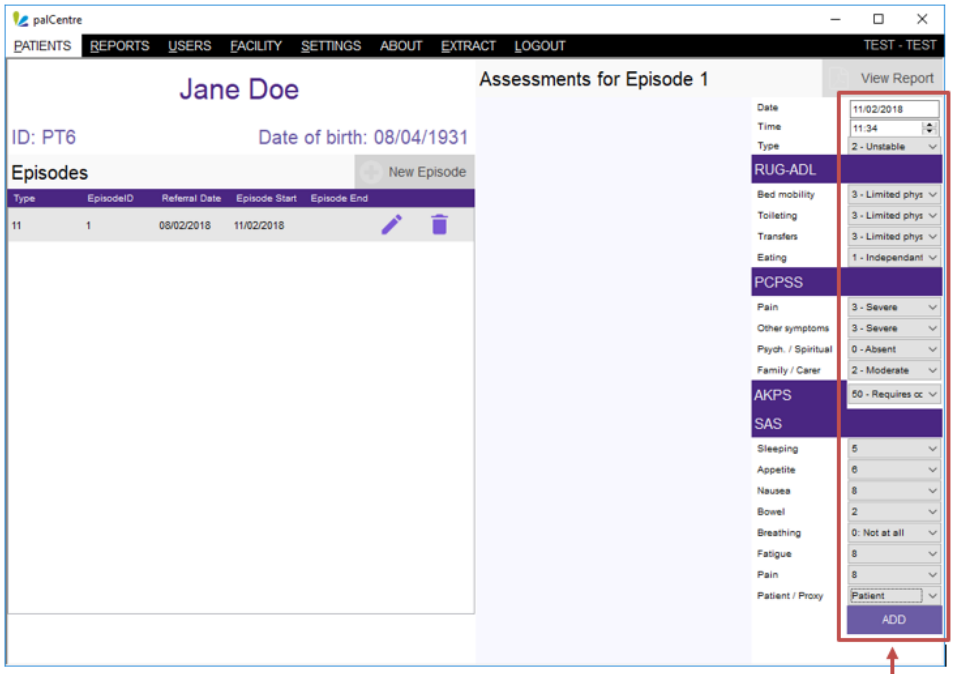
If a patient dies with your service, no final assessment is required.

Entering the first assessment

In the episode and assessment screen, make sure you have selected the correct episode on the left hand side of the screen. On the right hand side of the screen enter the following details:

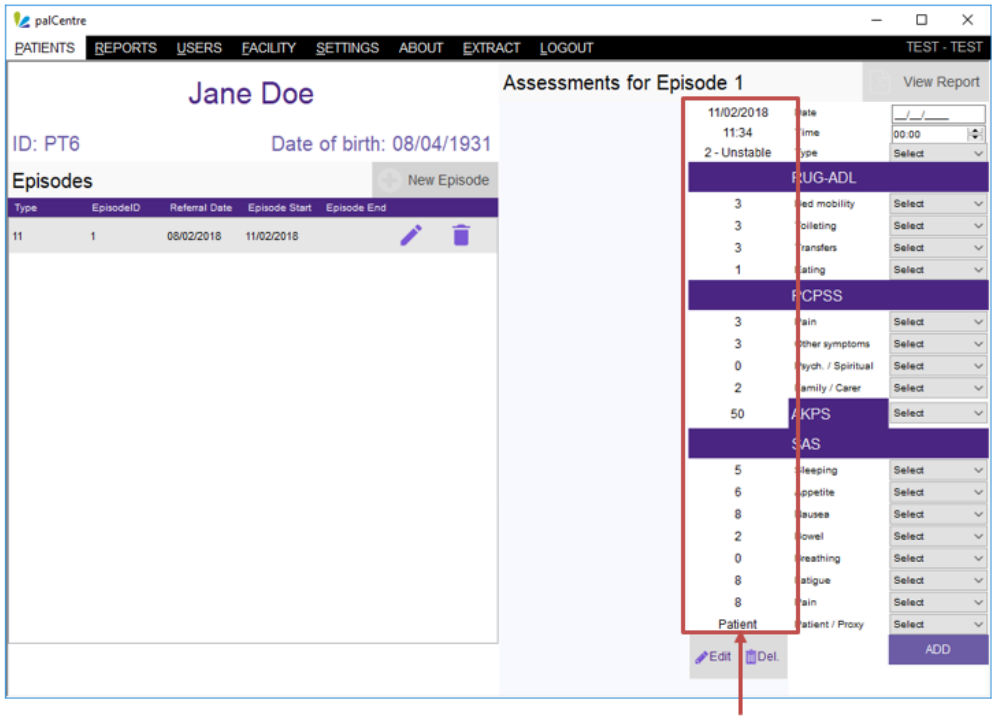
Item to be entered	Additional information
Date	The date the assessment was completed. This is a mandatory item - you cannot submit an assessment without this information.
Time	Optional field. The time of the assessment
Type	The phase type for the assessment. This is a mandatory item - you cannot submit an assessment without this information.
RUG-ADL	The RUG-ADL consists of four items (bed mobility, toileting, transfer and eating) and measures the patients function.
PCPSS	The PCPSS consists of four items (pain, other symptoms, psychological/spiritual and family/carer) with a score between 0 and 3 and screens the severity of palliative care problems.
AKPS	The AKPS consists of one item with a score between 10 and 100 and measures a patient's ability to perform ordinary tasks.
SAS	The SAS is a patient rated tool with a score between 0 and 10 that measures the patient's distress across seven domains (difficulty sleeping, appetite problems, nausea, bowel problems, fatigue and pain). There is also a field to capture if the patient or a proxy completed these assessments.

The information for the first assessment is entered as below. Once all the information has been added, click on the purple *'ADD'* button.



Click on Add once all the information for the first assessment has been entered

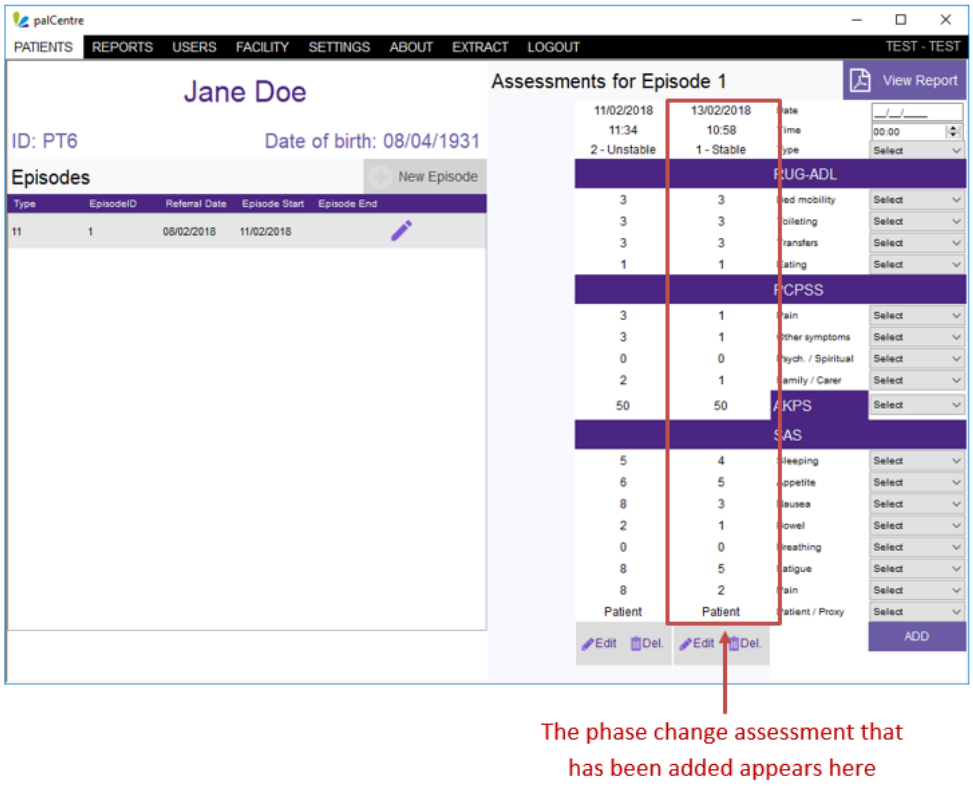
Once the assessment information has been added, it will appear on the left hand side of the assessment data entry screen as below.



The assessment that has been added appears here

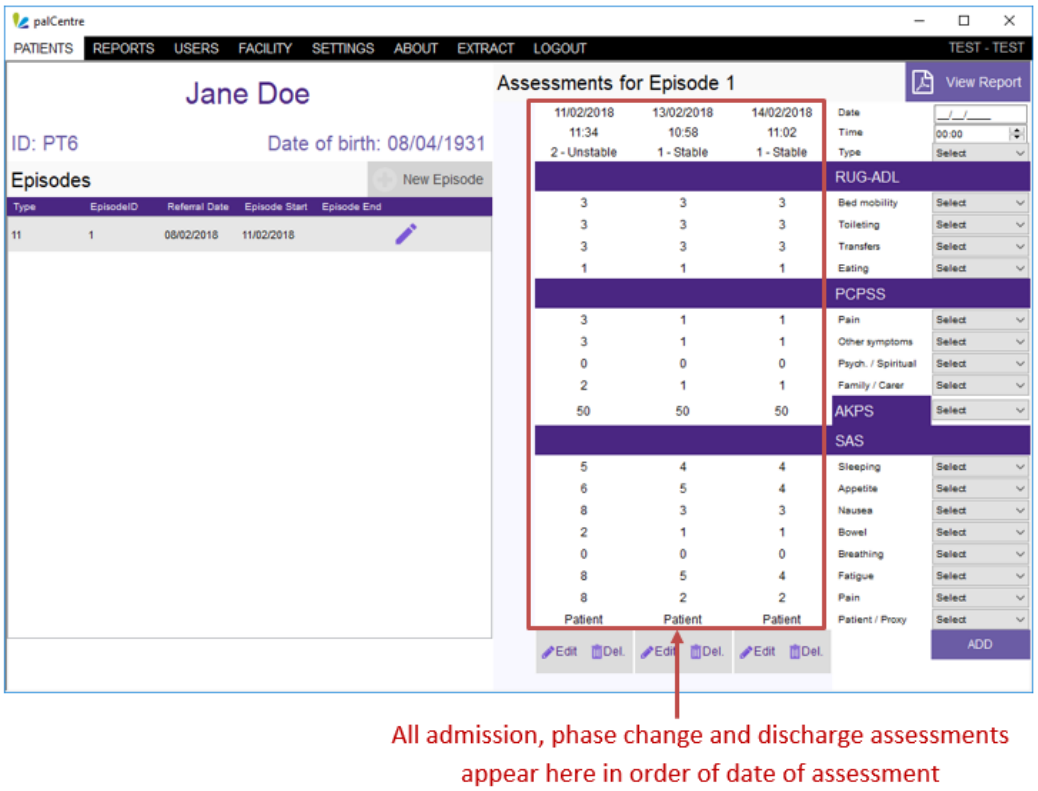
Entering additional phase change assessments

Next we add the third assessment on the form (the phase change) and click on *'ADD'*. The assessment will appear on the left hand side of the data entry screen.



Entering the discharge assessment

Finally we add the forth assessment (the discharge assessment) on the form and click on *'ADD'*. The assessment will appear on the left hand side of the data entry screen.



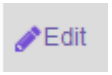
All admission, phase change and discharge assessments appear here in order of date of assessment

You have now added all the assessment for this episode.

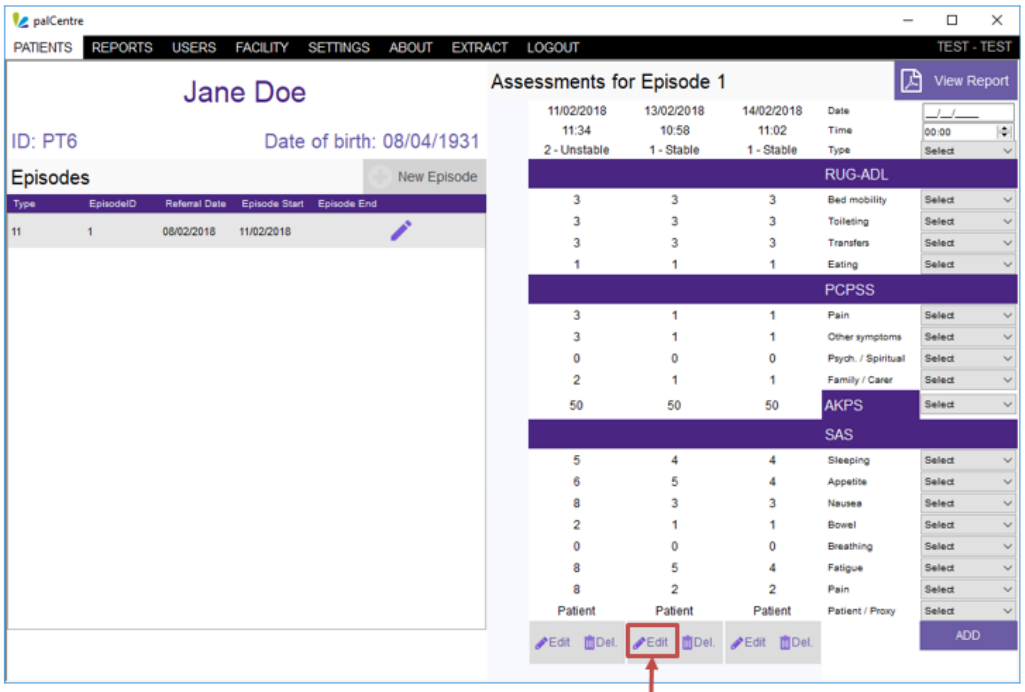
> If an item has not been recorded on the form, use the 'Not Assessed' code in the drop down menu. This will ensure you have minimal items appearing on your data quality report.

> Assessments can be added in any order into palCentre. Once an assessment is added, palCentre will check the date against all other assessment dates and then order all assessments by date.
>
> If you miss adding an assessment by accident, add the assessment into the data entry section on the right hand side of the screen and palCentre will place it in the correct order.

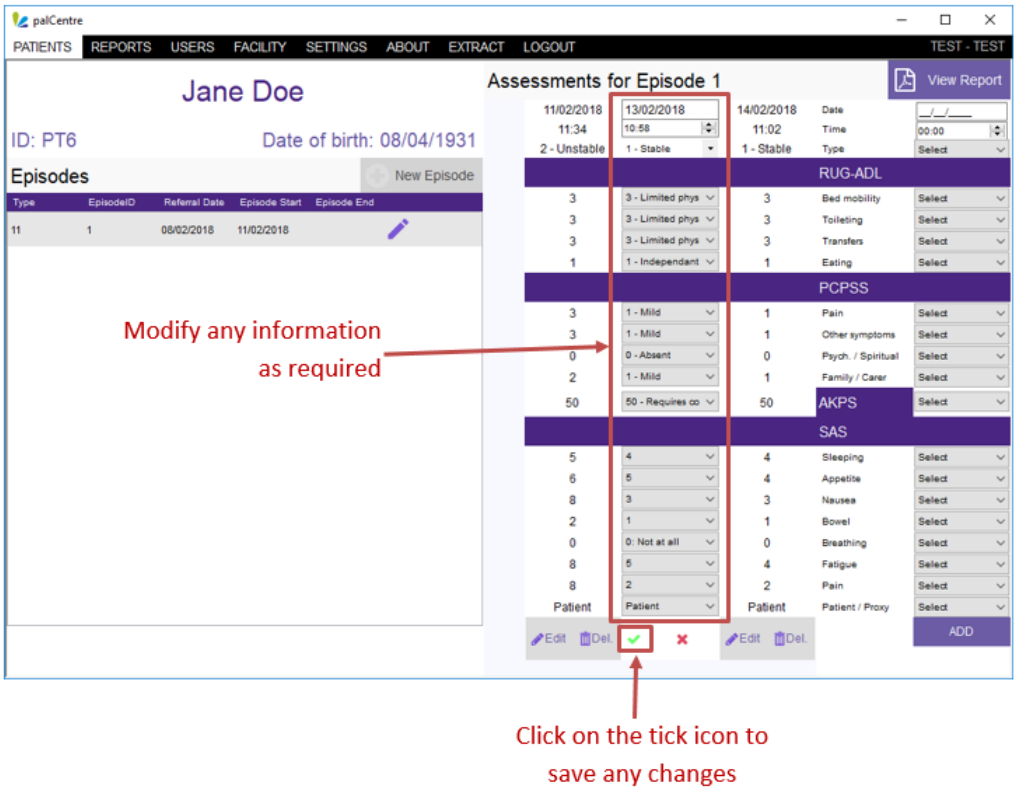
Modifying an assessment

To modify an assessment that has already been entered, click on the 

button below the assessment you wish to change.



Once any modifications have been made to the assessment values, click on the  at the bottom of the assessment you are modifying to save the changes..

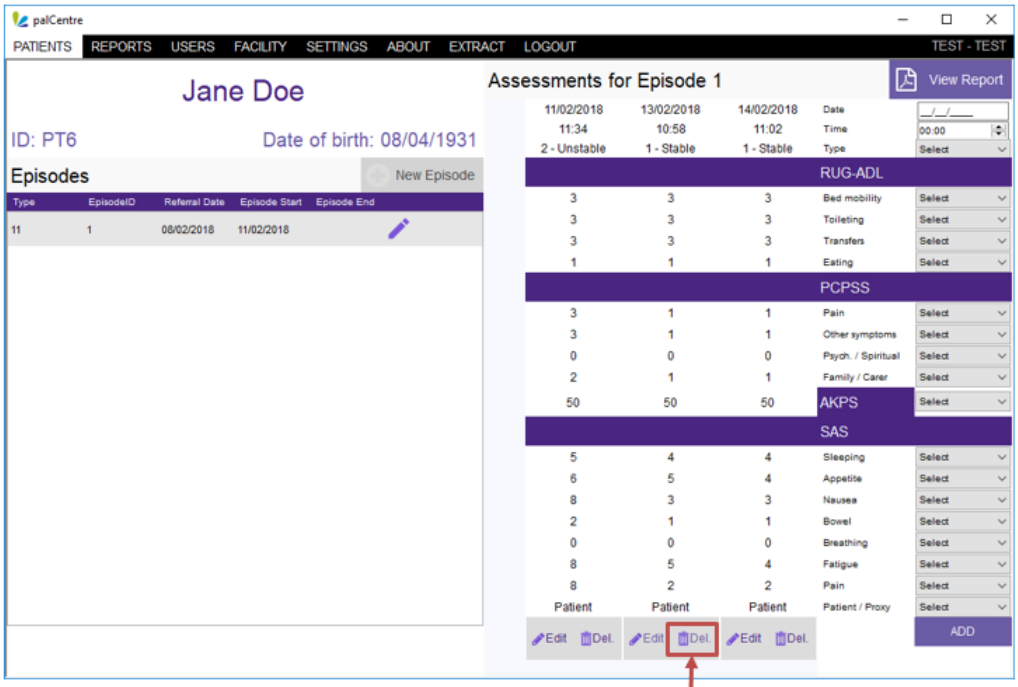


The assessment has now been modified.

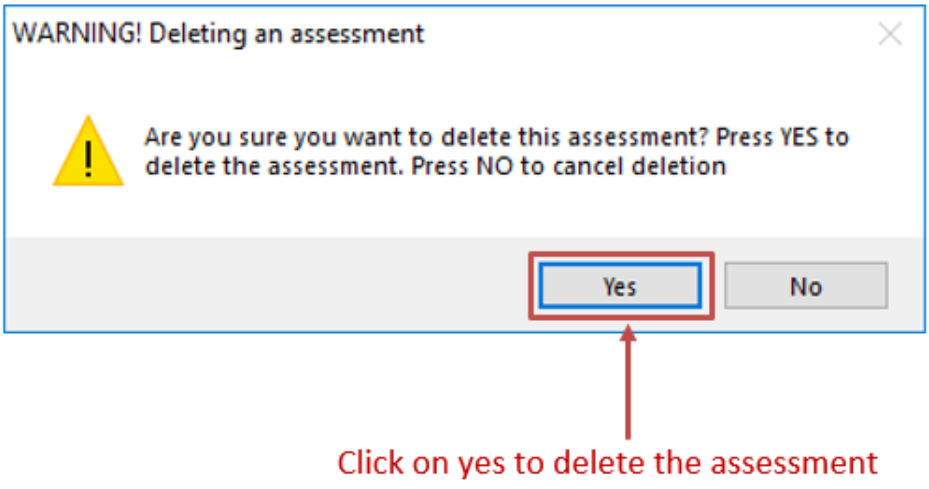
Deleting an assessment

To delete an assessment, click on the 

button below the assessment you wish to delete.



The following warning will appear, click on *'Yes'*.



The assessment has now been deleted.

Entering profile data

This page contains all information related to entering the profile collection into palCentre. To navigate quickly to a section within this page, please use the menu below:

If this is the first time you are entering data into palCentre, PCOC recommends you watch this video on entering profile information.

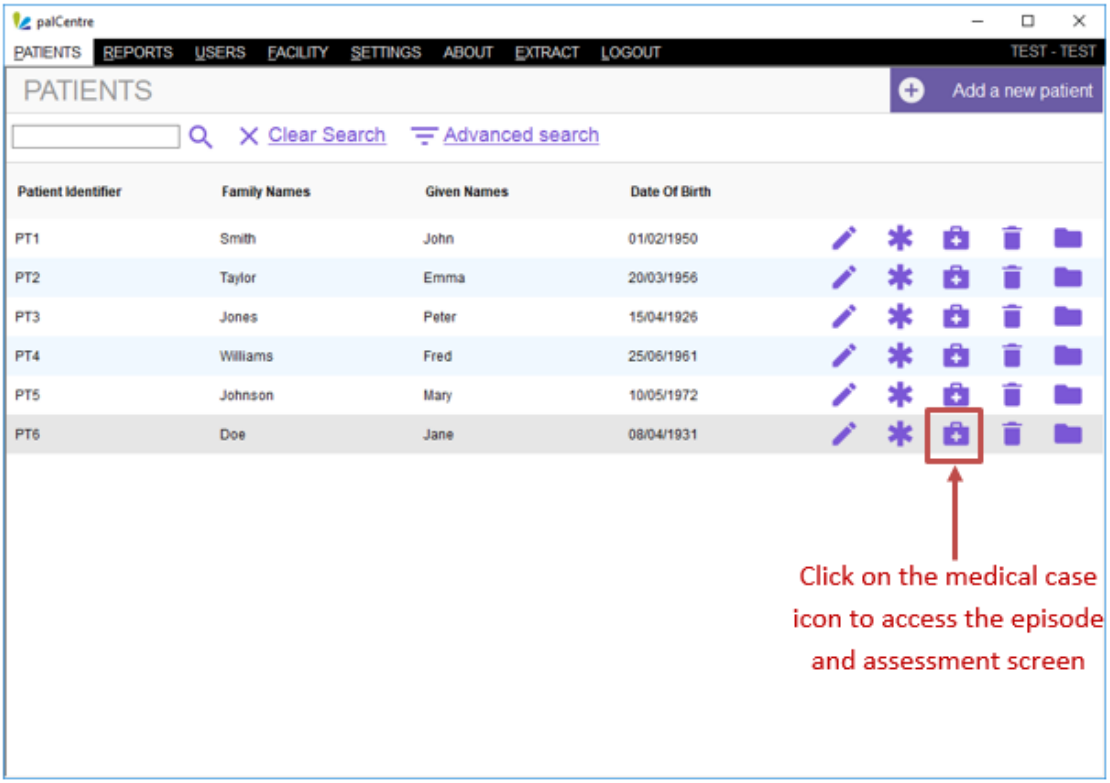
Profile collection overview

The profile data collection reflects a single point of assessment occurring in any setting at any time, depending on the data collection protocol. The intent of the collection is to provide a comprehensive profile of patients with identified palliative care needs in situations where the outcome collection is neither suitable nor possible.

> The profile data collection is separate from the outcome data collection. A single patient can have both outcome collection data and profile instances.
>
> If you need more information on the type of data you are entering please contact PCOC.

Accessing the profile screen

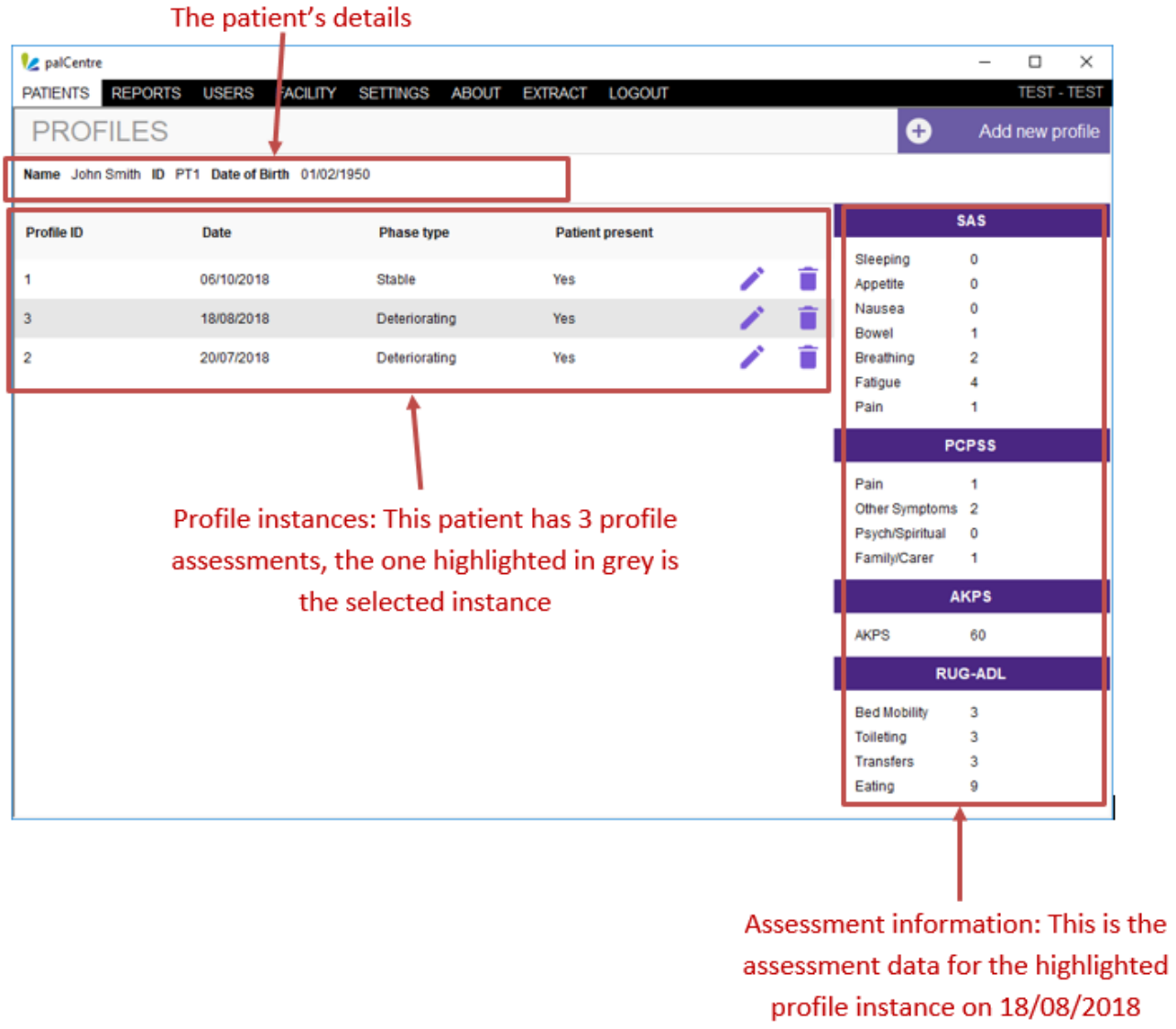
Once a patient has been created in palCentre, you can then add in a profile instance for that patient. To access the profile screen, click on the  next to the patient name.



The profile collection screen will appear.

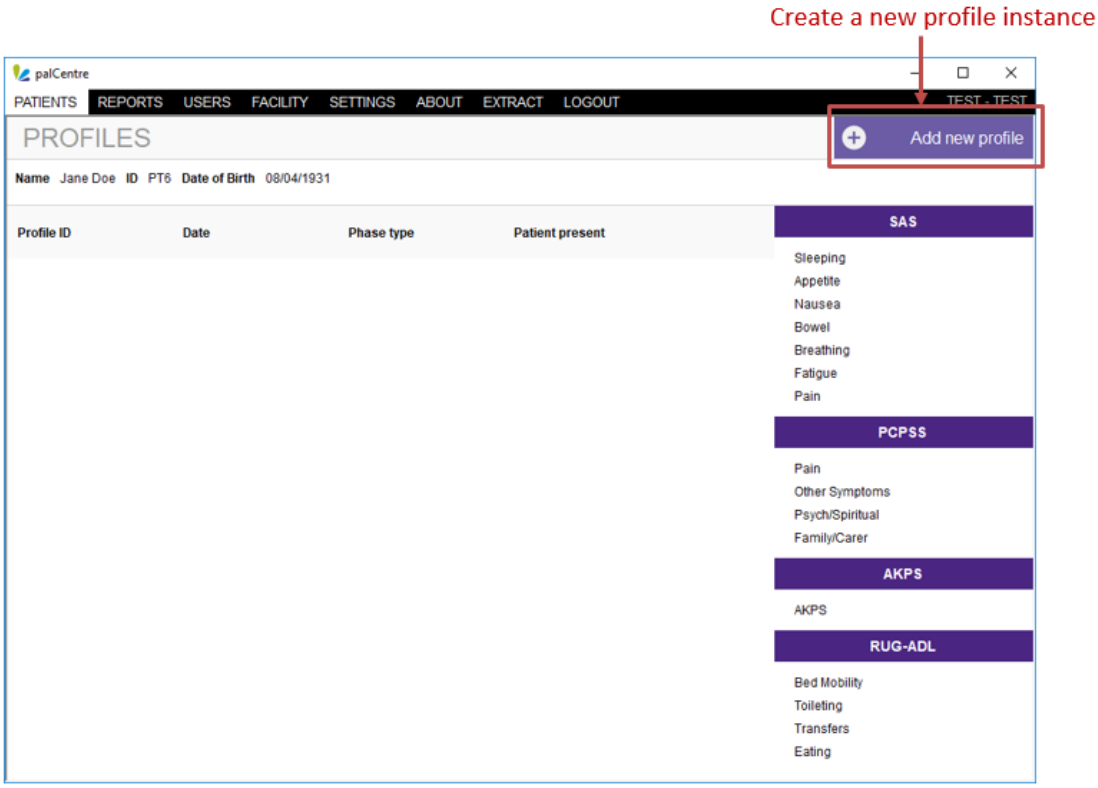
Profile instances that have been completed for a patient will appear in the list on the left hand side of the screen. The patient's details appear above the list of profile instances.

On the right hand side of the screen, the assessment scores associated with the profile instance that is highlighted on the left hand side of the screen. To look at the assessments for a different profile instance, highlight the profile instance that you are interested in on the left hand side of the screen.

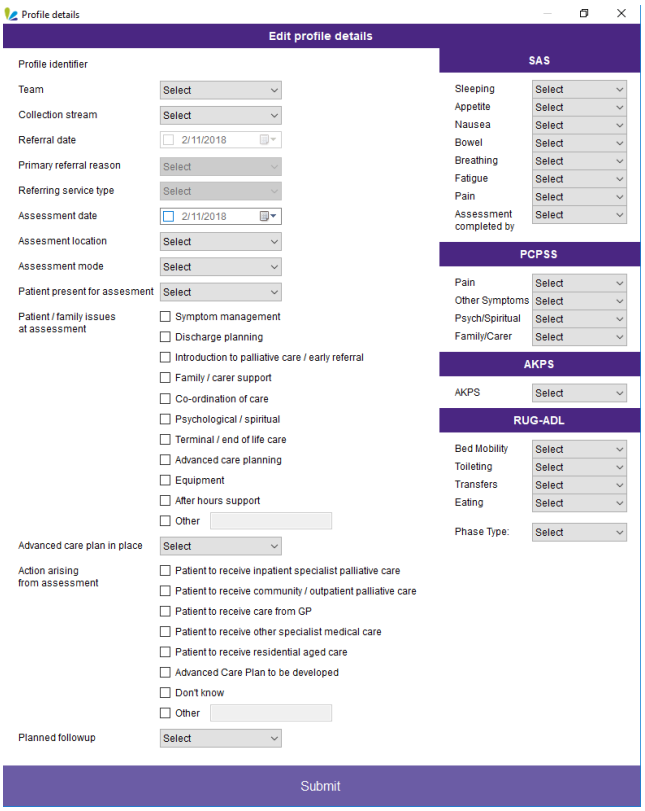


Creating a profile instance

To create a profile instance, click on the purple *'Add new profile'* button in the top right hand corner of the screen.



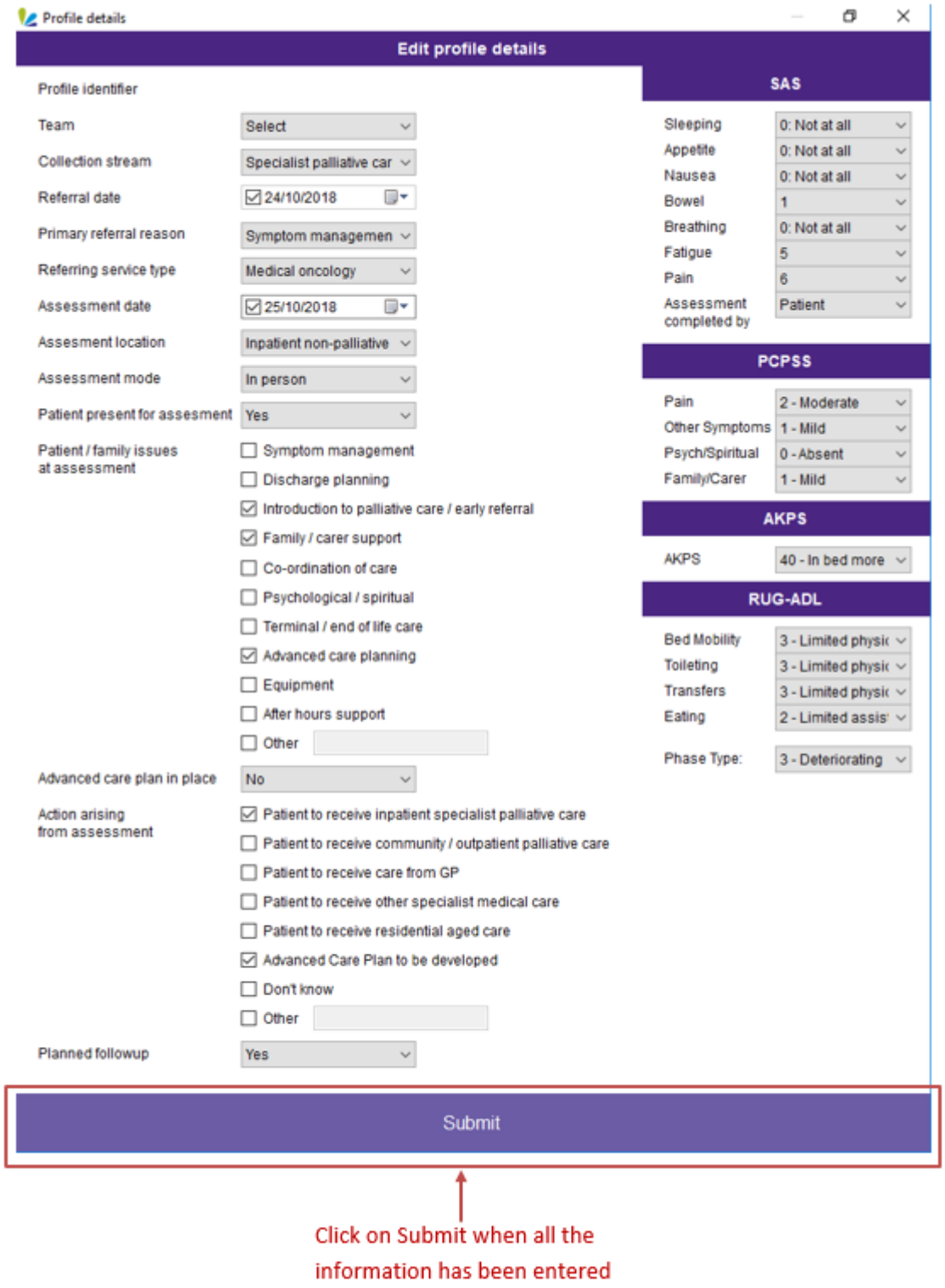
The data entry box below will appear. All data entry occurs in a single screen for the profile data collection.



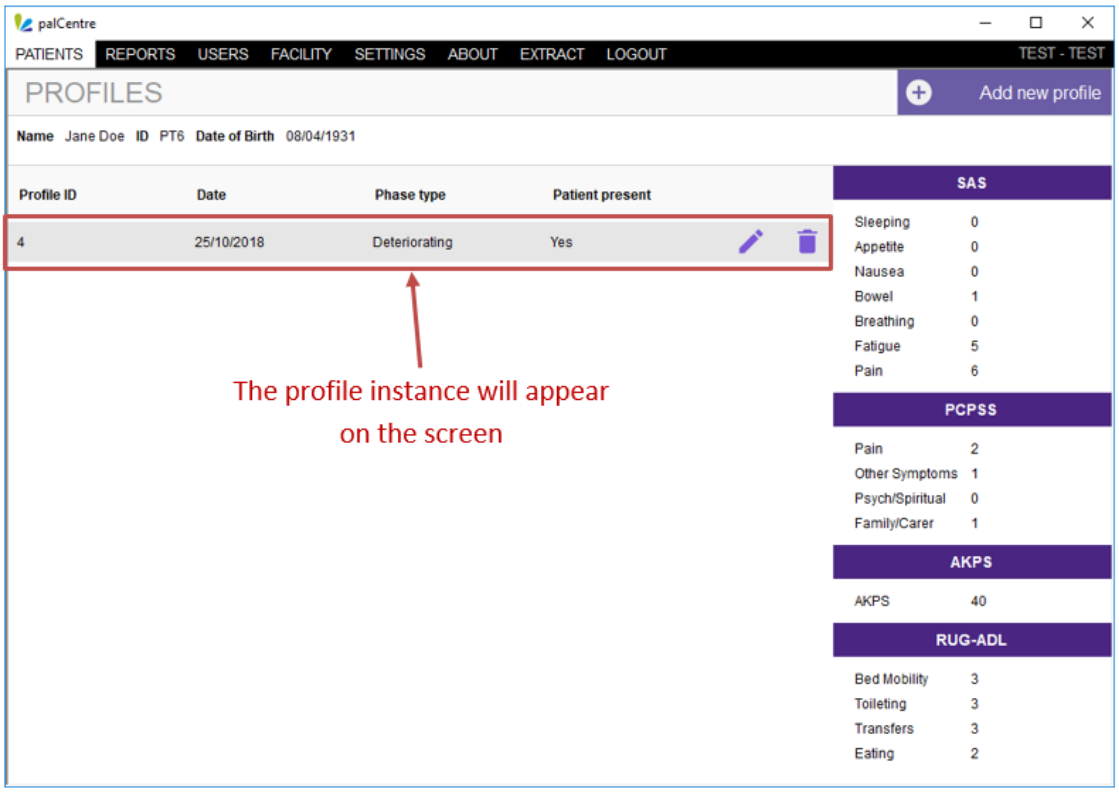
The following information needs to be entered on this screen:

Item to be entered	Additional information
Team	Only required if you have more than one team entering data. This value can also be defaulted in your user settings.
Collection stream	This is a mandatory item - you cannot submit this screen without this information. This value can also be defaulted in your user settings.
Referral date	Only required for patients that are part of the collection streams Specialist Palliative Care - Adults and Specialist Palliative Care - Paediatrics
Primary reason for referral	Only required for patients that are part of the collection streams Specialist Palliative Care - Adults and Specialist Palliative Care - Paediatrics
Referring service type	Only required for patients that are part of the collection streams Specialist Palliative Care - Adults and Specialist Palliative Care - Paediatrics
Assessment date	This is a mandatory item - you cannot submit this screen without this information.
Assessment location	
Assessment mode	
Patient present for assessment	
Patient/family issues at assessment	Tick all that apply
Advanced care plan in place	
Actions arising from assessment	Tick all that apply
Planned followup	
SAS	The SAS is a patient rated tool with a score between 0 and 10 that measures the patient's distress across seven domains (difficulty sleeping, appetite problems, nausea, bowel problems, fatigue and pain). There is also a field to capture if the patient or a proxy completed these assessments.
PCPSS	The PCPSS consists of four items (pain, other symptoms, psychological/spiritual and family/carer) with a score between 0 and 3 and screens the severity of palliative care problems.
AKPS	The AKPS consists of one item with a score between 10 and 100 and measures a patient's ability to perform ordinary tasks.
RUG-ADL	The RUG-ADL consists of four items (bed mobility, toileting, transfer and eating) and measures the patients function.

Once all the information has been entered, click on *'Submit'*.



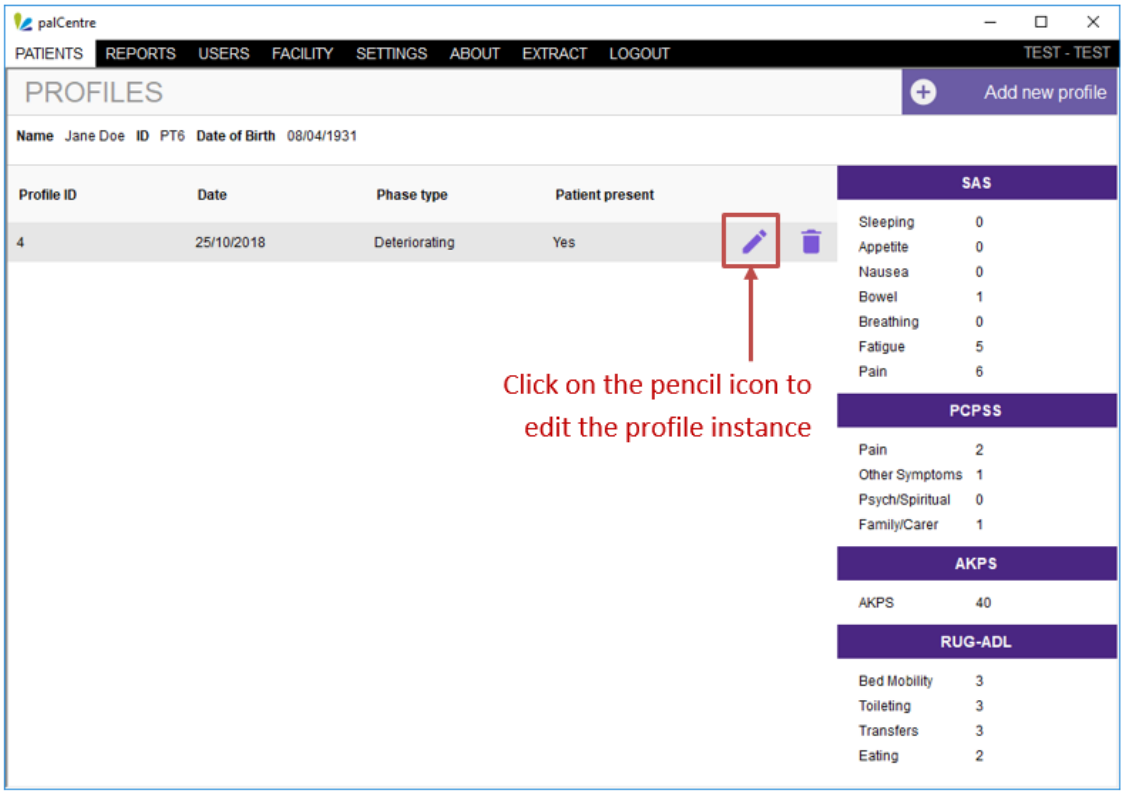
The profile instance then appear in the list on the profile screen



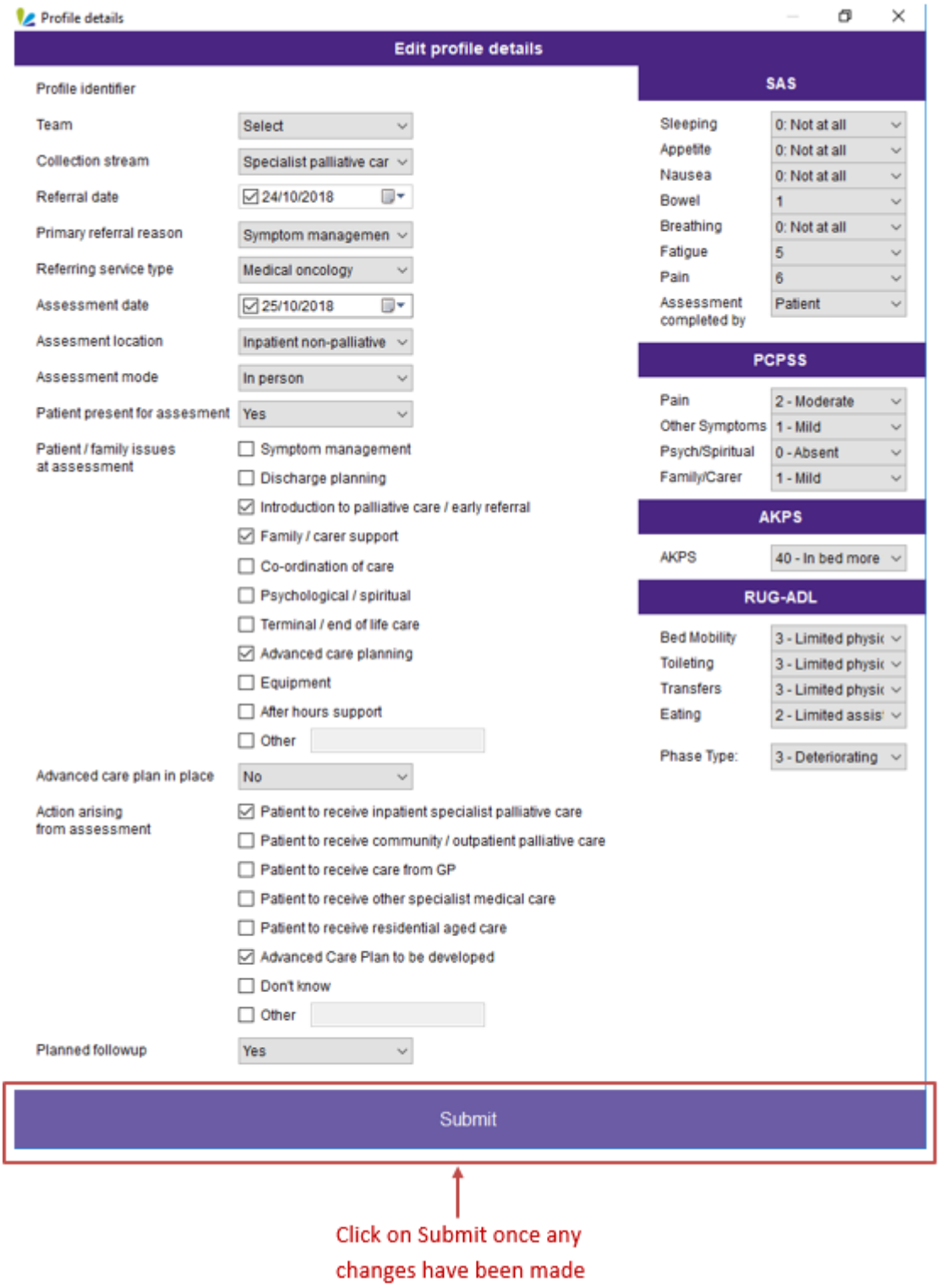
If an item has not been recorded on the form, use the 'Not Assessed' or 'Not Recorded' code in the drop down menu. This will ensure you have minimal items appearing on your data quality report.

Editing a profile instance

To change any of the profile instance details, click on the  next to the profile instance you wish to change.



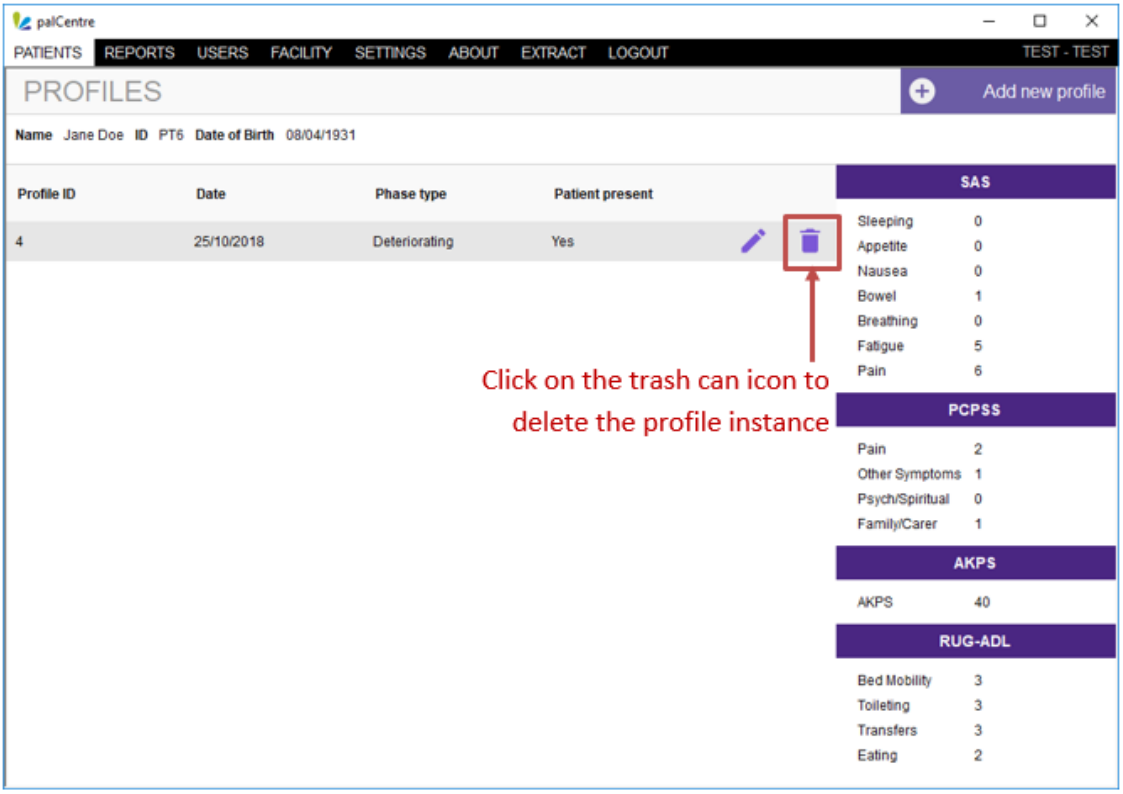
This will bring up the profile form to add or change any details. Click on submit once you have edited the details.



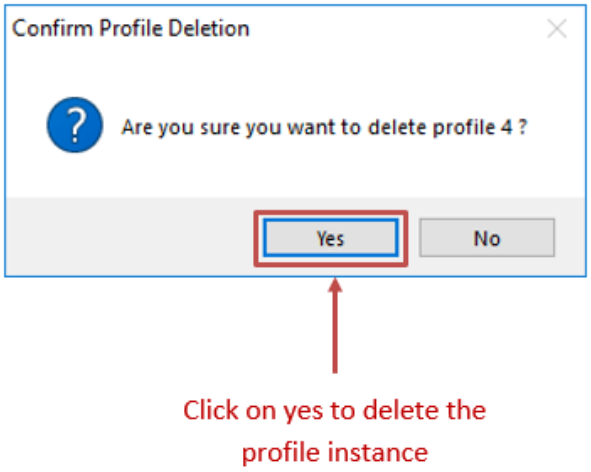
The profile instance has now been modified.

Deleting an profile instance

To delete a profile instance, click on the  next to the profile instance you wish to delete.



A warning box will come up to check that you wish to delete this profile instance. Click on 'Yes'



The profile instance has now been deleted.

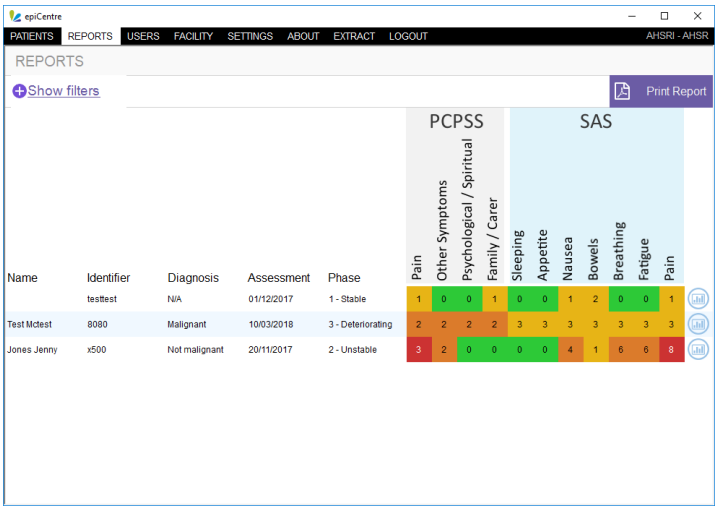
Reporting

The reporting screen in palCentre will show information for open episode only. The last assessment entered for the patient will appear on the reporting screen.

When palCentre is used in real time, this screen allows you to see what phase all your current patients are in as well as their SAS and PCPSS scores.

Only patients in the outcome data collection are included in this reporting function. The patients in the profile data collection are not included at the present time.

To access the reports in palCentre, click on 'Reports' in the navigation menu bar. The reporting screen will appear:



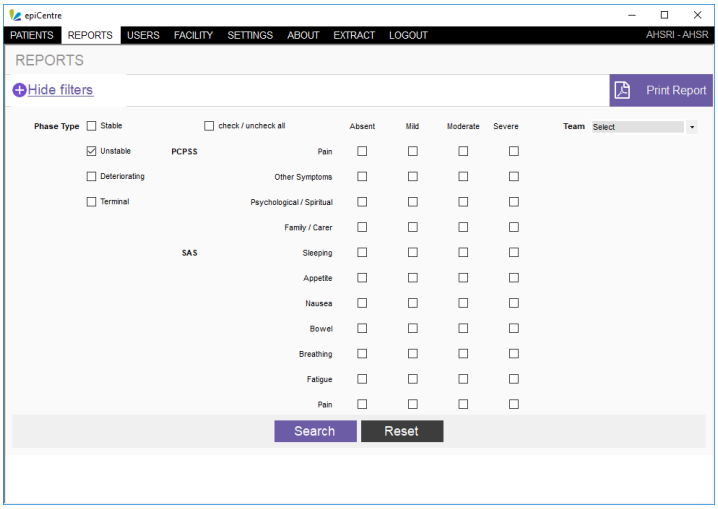
A list of patients are on the left hand side of the screen and the latest patient assessments are on the right hand side of the screen. The assessments are colour coded, absent are green, mild are yellow, moderate are orange and severe are red.

You can print this report by clicking on the purple 'Print Report' button at the top of the screen. This report will run and popup as a pdf file to be printed or saved as required.

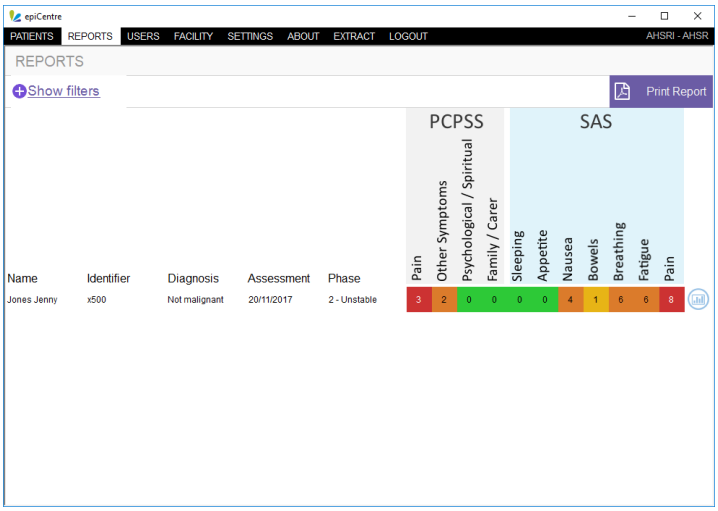
You can print an individual's patient journey by click on the blue icon next to the patient's assessment scores on the right hand side of the screen. This report will include all the patient information, current episode information and all assessment scores. This report will run and popup as a pdf file to be printed or saved as required.

Filtering the report

There are a list of filter options available in this report. Click on the show filter link on the top left hand side of the screen and a list of options will appear. You can filter patients based on phase type, team or PCPSS and SAS scores. Check the filters as required and click on the purple 'Search' button.



This will refine your report with the filters used.



Extracting and submitting data

Palliative care services participating in PCOC submit data at the following times:

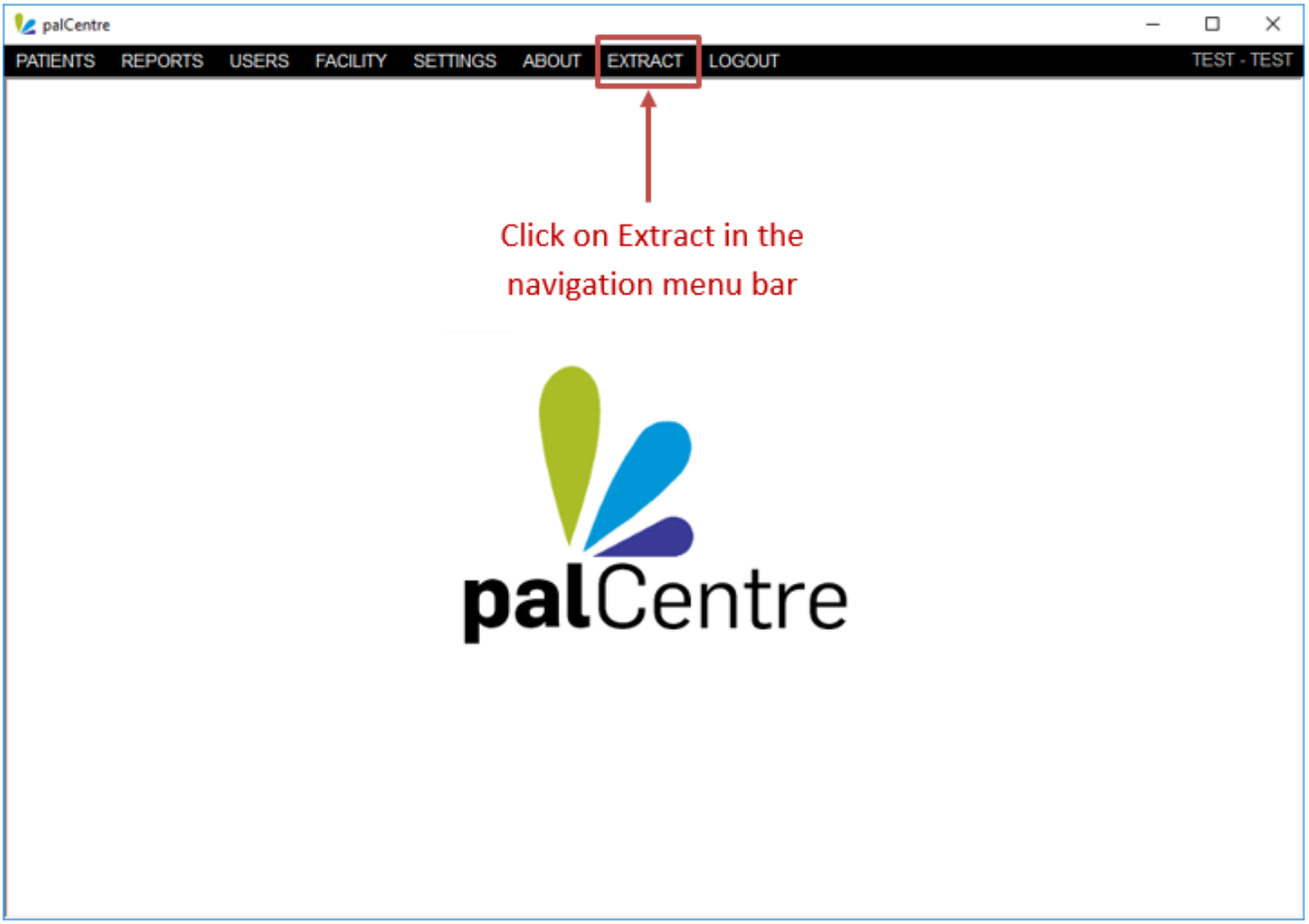
- January - February (for the previous July – December reporting period)
- July - August (for the previous January – June reporting period)

Data extracts are loaded into the database for the purpose of data validation and quality checking. Data quality reports are produced automatically and sent to services promptly so that identified data errors can be reviewed, corrected and resubmitted before being included in the national database.

Data can be submitted outside these reporting periods at the discretion of PCOC. If you would like to submit data outside the above reporting period for data validation and quality checking, please contact PCOC at pcoc@uow.edu.au.

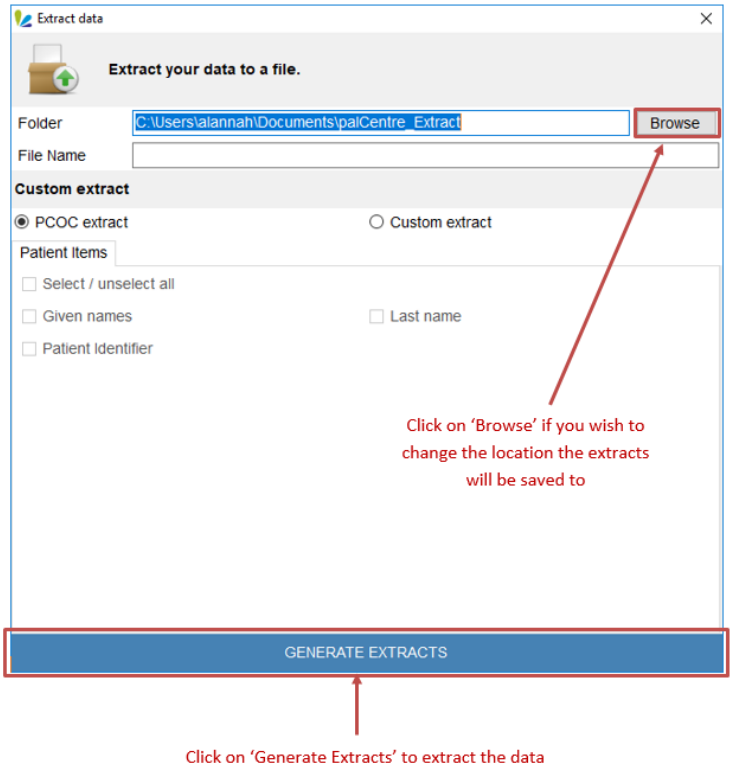
Extracting data from palCentre

To extract your data, click on the *'Extract'* option in the navigation menu bar.

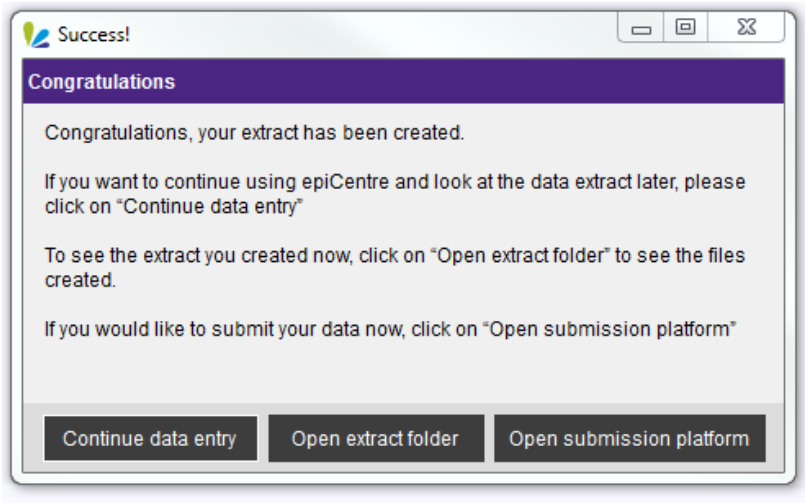


The extraction form will appear. The default extraction folder is in the *'Documents'* folder on your computer. If you wish to store the extracts somewhere else, click on *'Browse'*.

Then click on generate extracts at the bottom of the form.

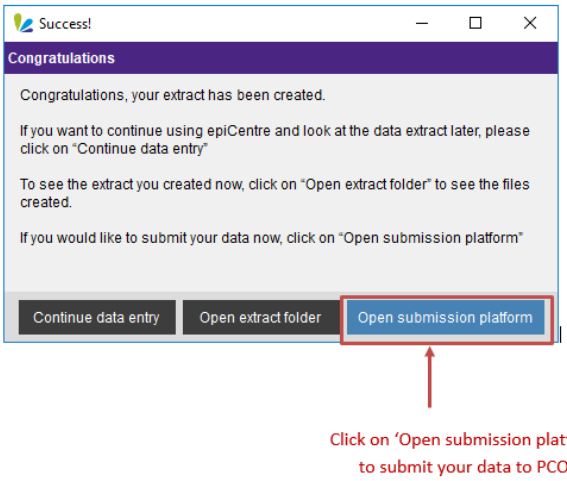


The data has now been extracted. A pop-up window as below will appear with options to continue data entry, open the extract folder or open the submission platform.



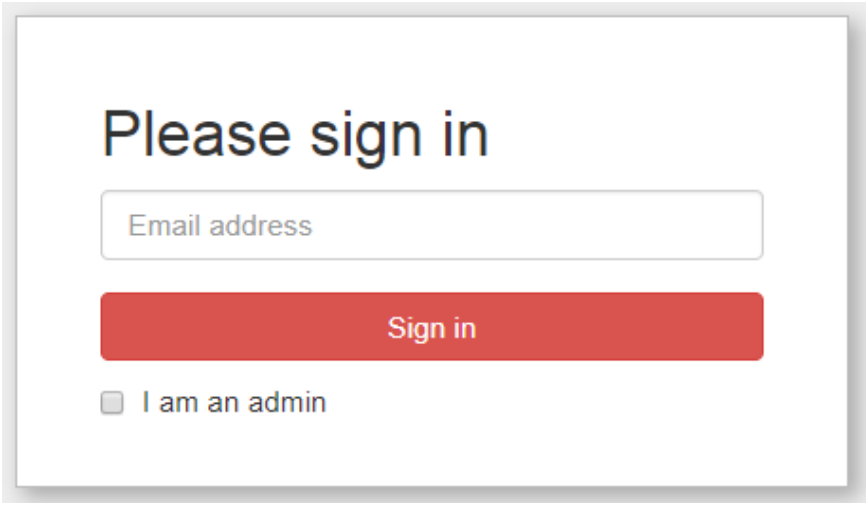
Submitting data to PCOC

After successfully generating extracts, click on the *'Open submission platform'* button in the pop-up window.



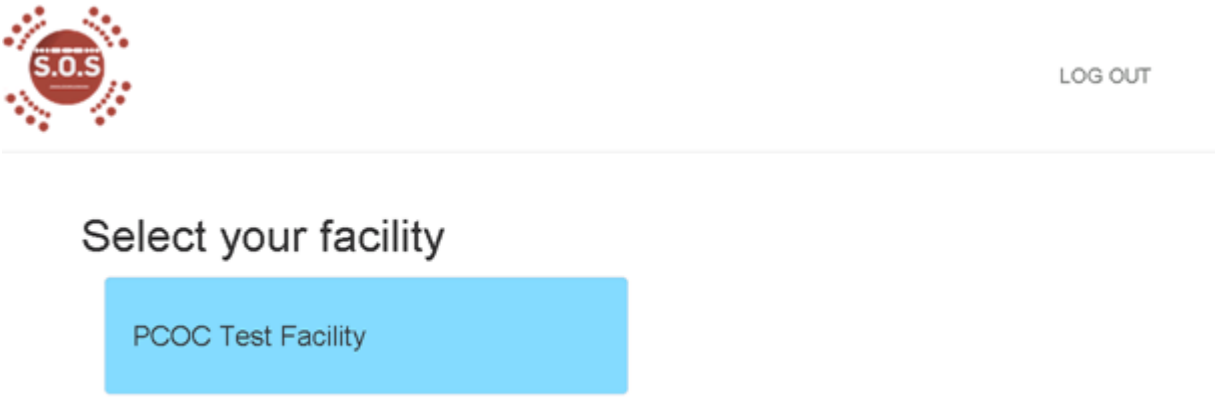
This will launch the Secured Online Submission portal (SOS).

1. Log into SOS by entering your email address and clicking *'Sign In'*.
   Please leave *'I am an admin'* unticked.

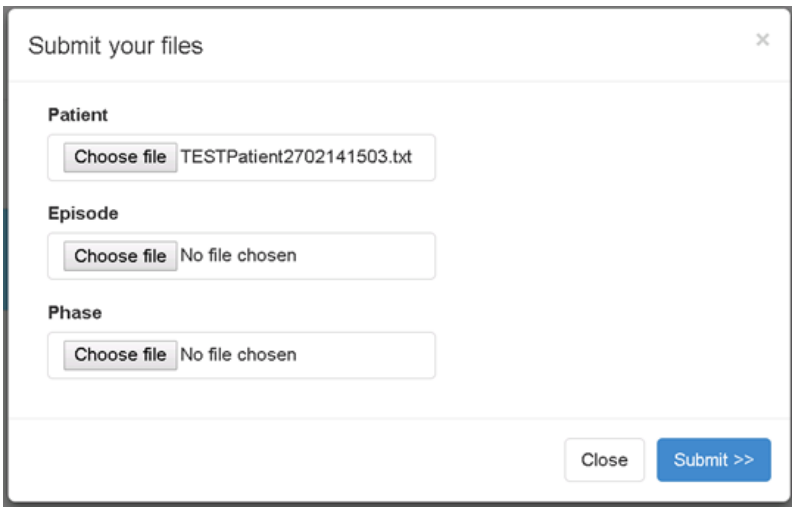


If SOS does not accept your email address, please contact Linda Foskett, PCOC Admin Officer on 02 4221 5092 or lindaf@uow.edu.au for assistance.

2. Click on the facility you wish to submit data for (most users will only have one option).



3. Under Patient click on ‘Choose file’ and select the Patient data file you wish to submit.



Repeat this for the Episode and Phase data files.

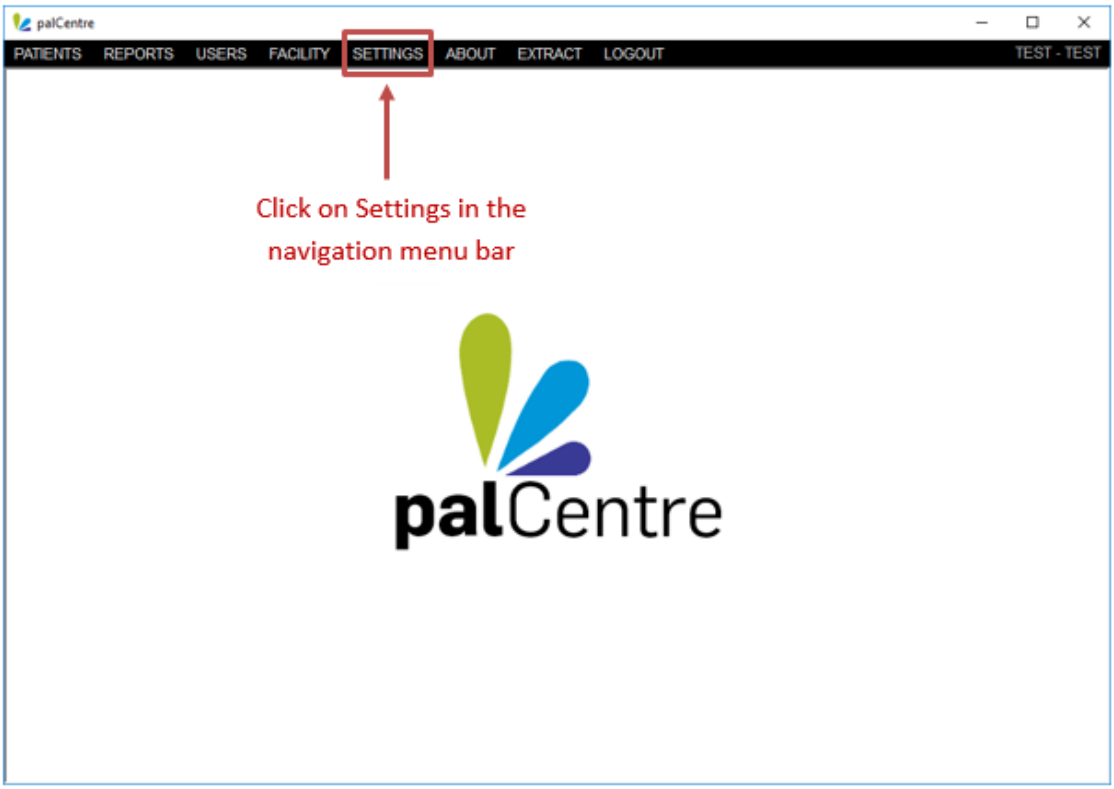
4. Once you have added all three files, click on *Submit >>*

Administration options

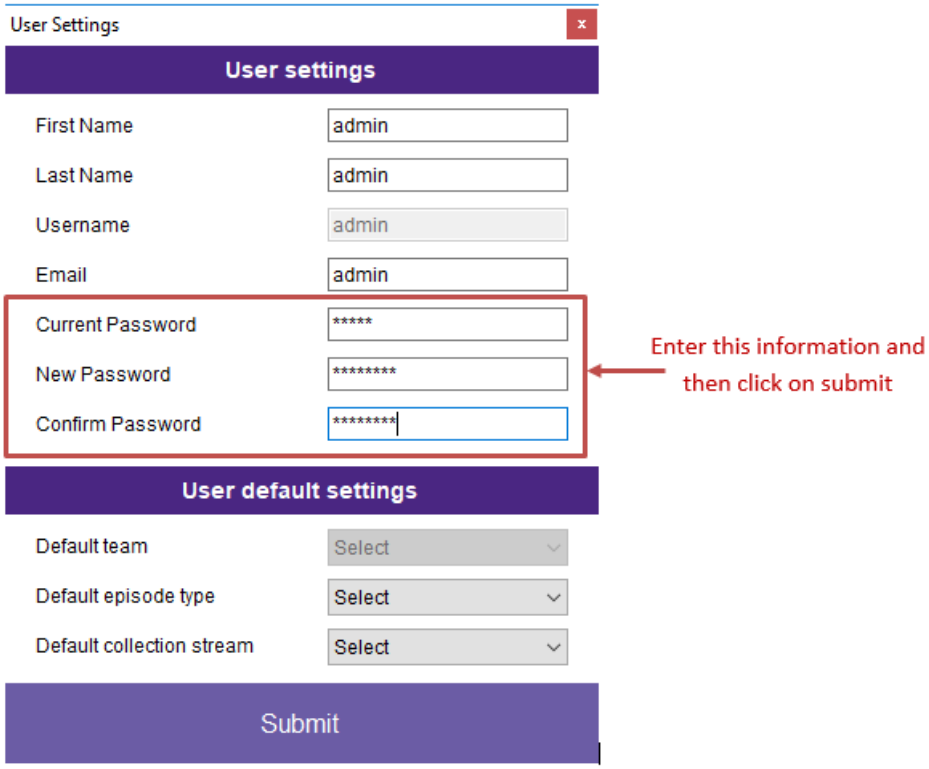
This page contains all information related to administration options within palCentre. To navigate quickly to a section within this page, please use the menu below:

Changing your password

To change your password, click on the *'Settings'* option in the navigation menu bar.



This will open a form with the user settings. Type in your current password, your new password and confirm the new password. Click on submit.



Your password has now been changed.

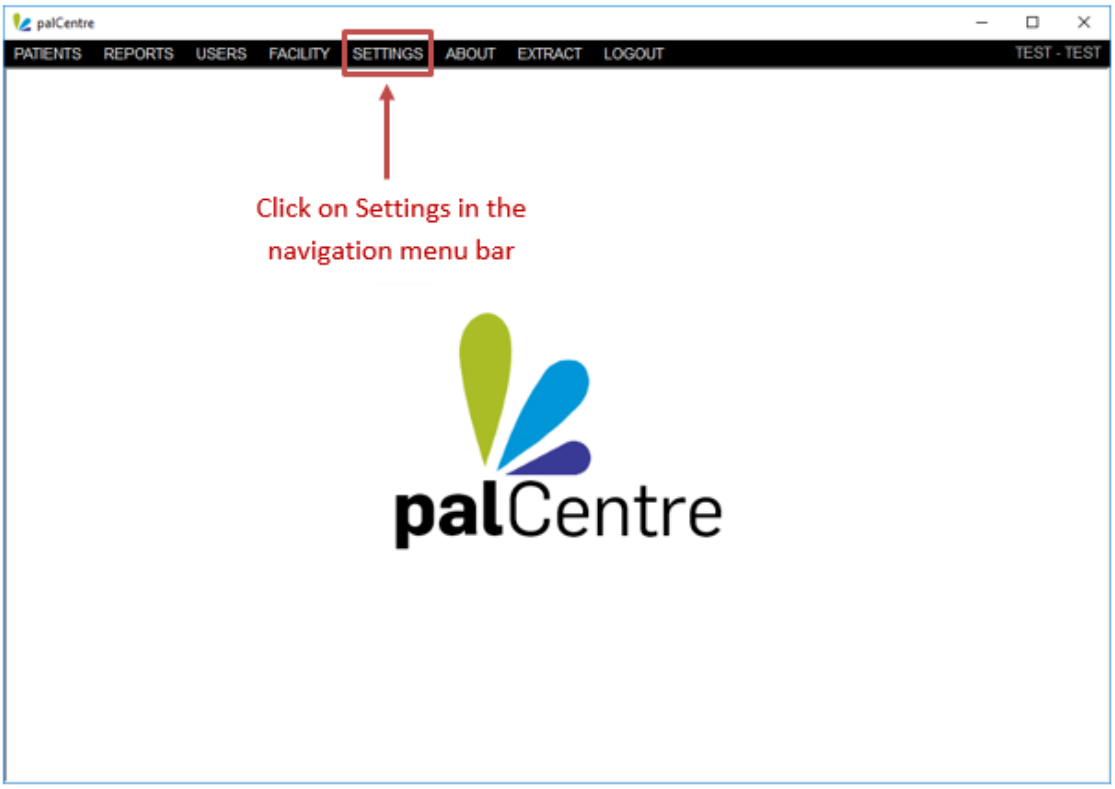
> If you have forgotten your password and cannot login to palCentre, an administrator can change your password for you. If you know the administrator username and password for palCentre, you can login with this. Otherwise contact Sam Burns on (02) 4298 1141 or Alanna Connolly (02) 4221 5640 or via email at pcoc@uow.edu.au.

Default settings

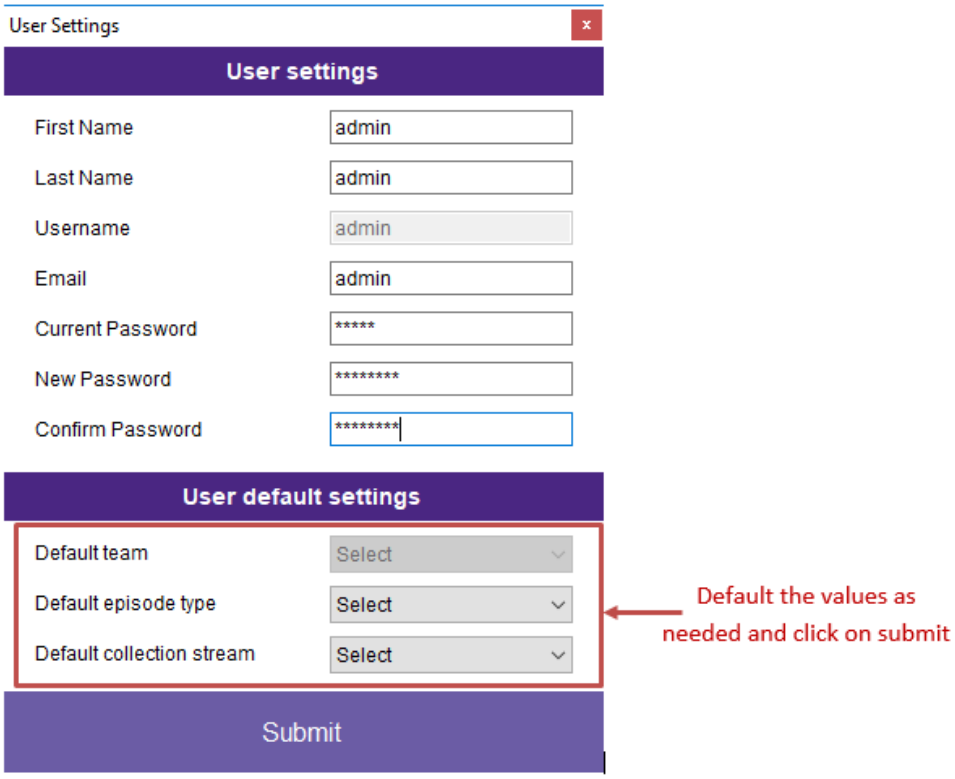
In palCentre, you can default the following items:

Item	Additional information
Team	Team is used at both the episode level and for the profile data collection and is an optional data item. If you are entering data for multiple teams, please do not default this value.
Episode Type	This item is used at the episode level. If you only enter one Episode Type, this value can be defaulted.
Collection stream	This items is used for the profile data collection. Your service will usually only enter one collection stream and this item should be defaulted.

To default the above items in palCentre, click on the *'Settings'* option in the navigation menu bar.



This will open a form with the user settings. Choose the defaults as needed and click on submit.

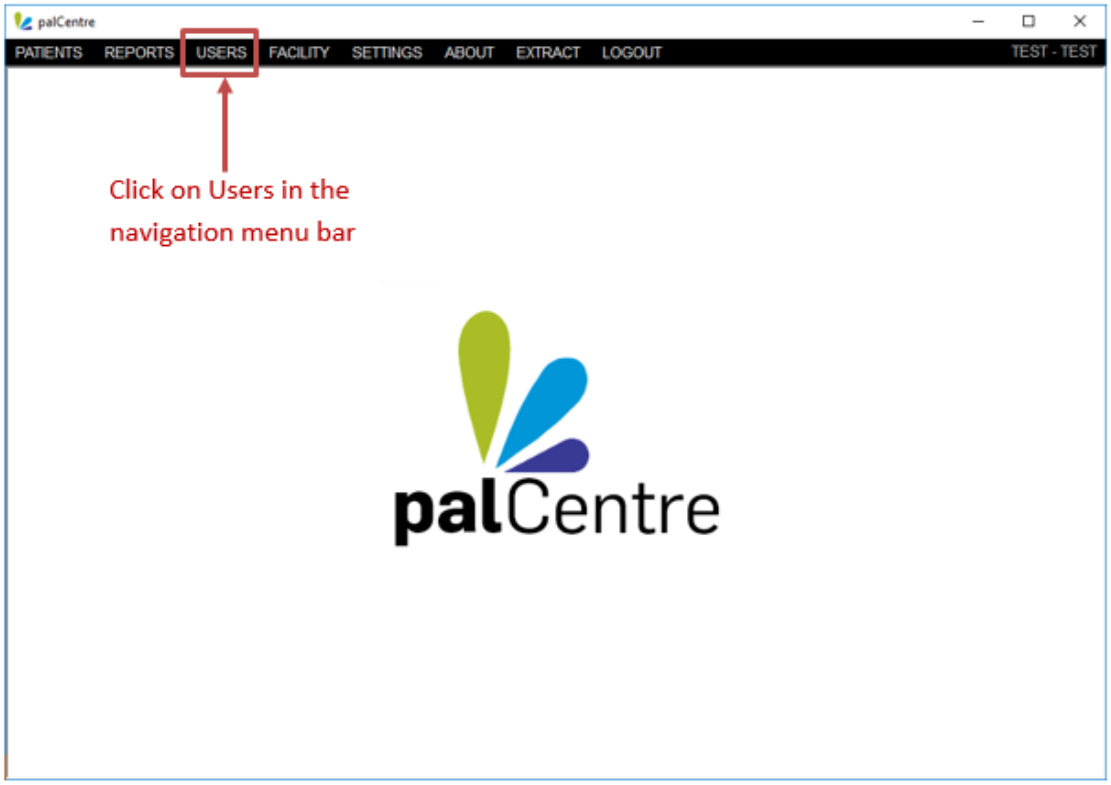


The defaults have now been set.

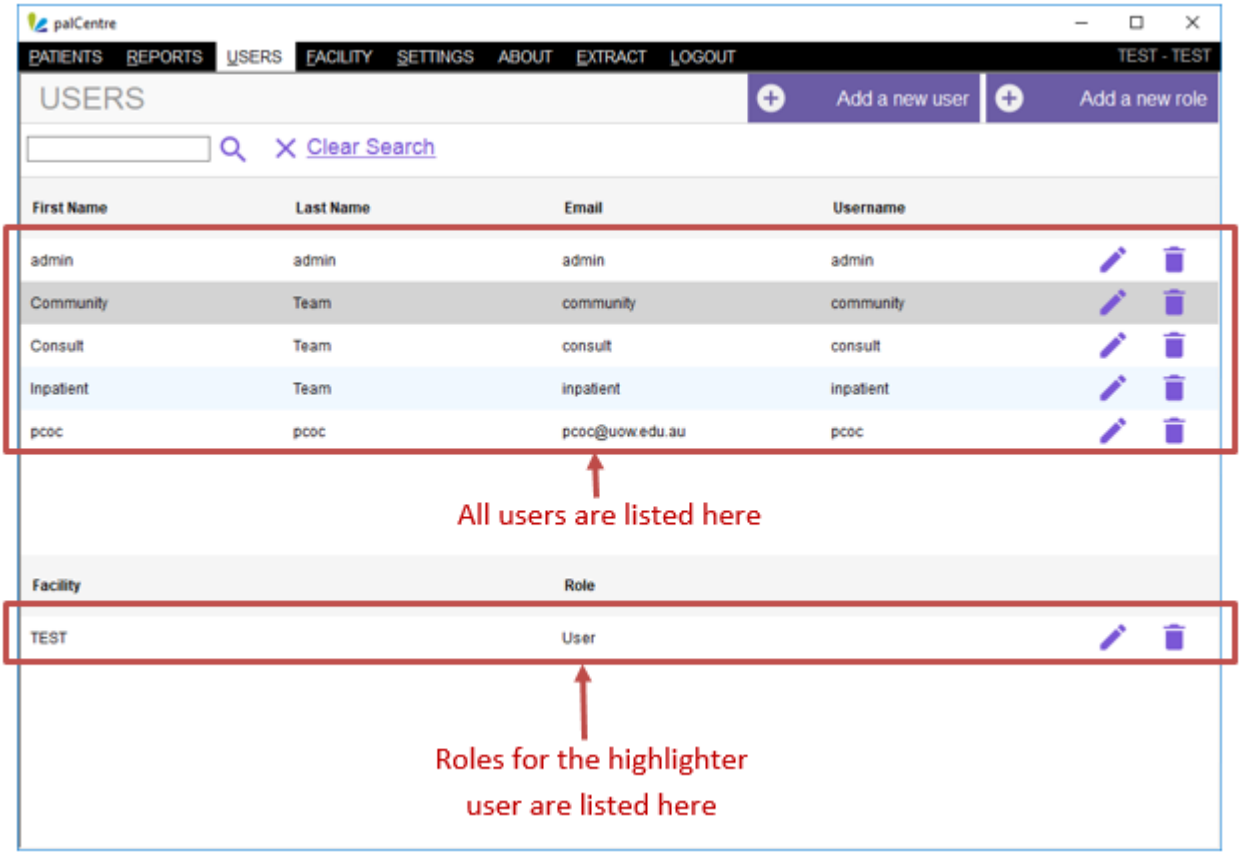
> Defaults are linked to the user account in palCentre. Different users can default different values.

Adding a user

To add a user in palCentre, you must be an administrator. Login to palCentre as an administrator and click on *'Users'* in the navigation menu bar. A list of current users will appear:



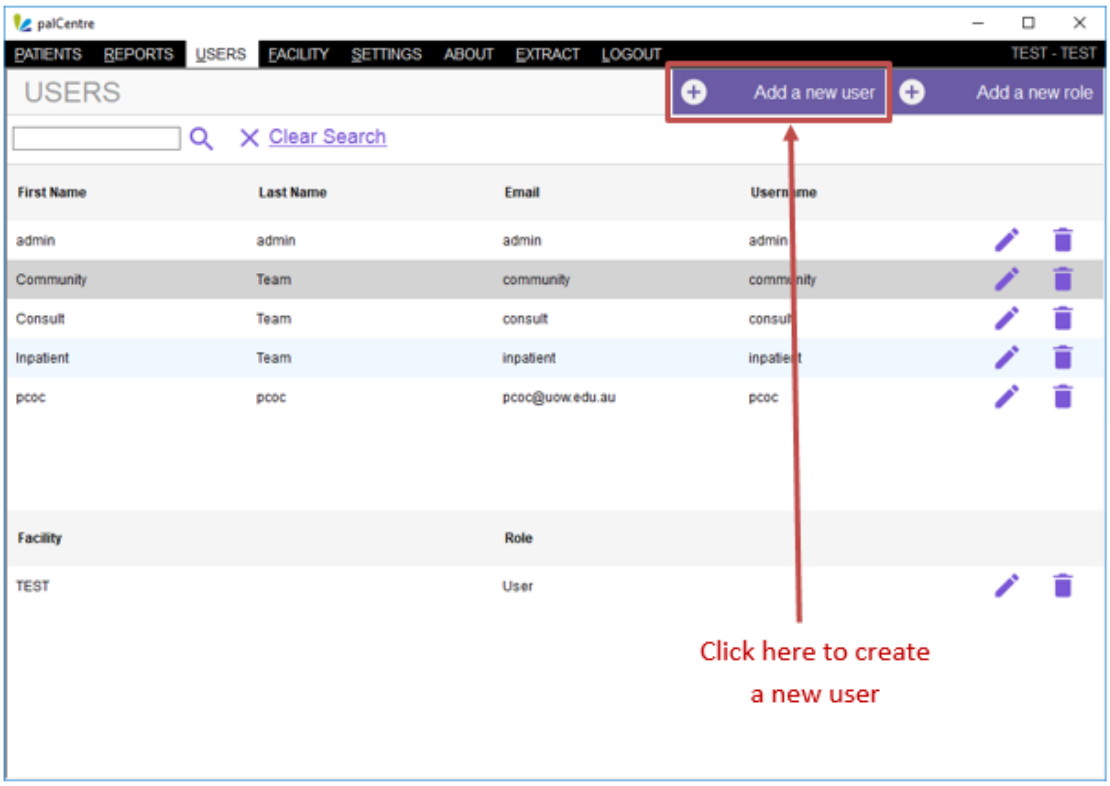
The user screen will appear. There are two sections to the user screen, The top half of the page contains a list of users and the bottom half of the screen contains the roles assigned to the selected user. At the top of the screen there is a



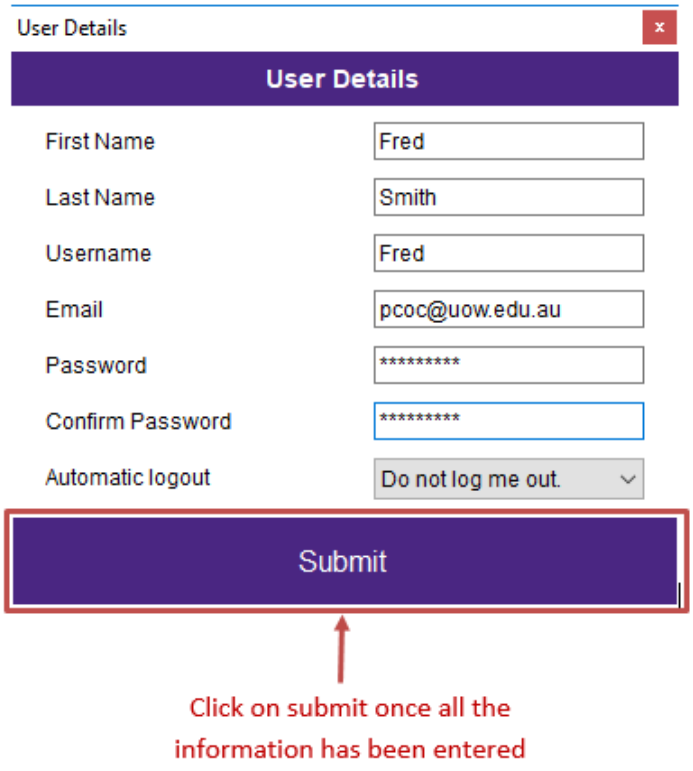
There are 2 steps to creating a new user. You need to create the user themselves and then assign a role to that user.

Create the user

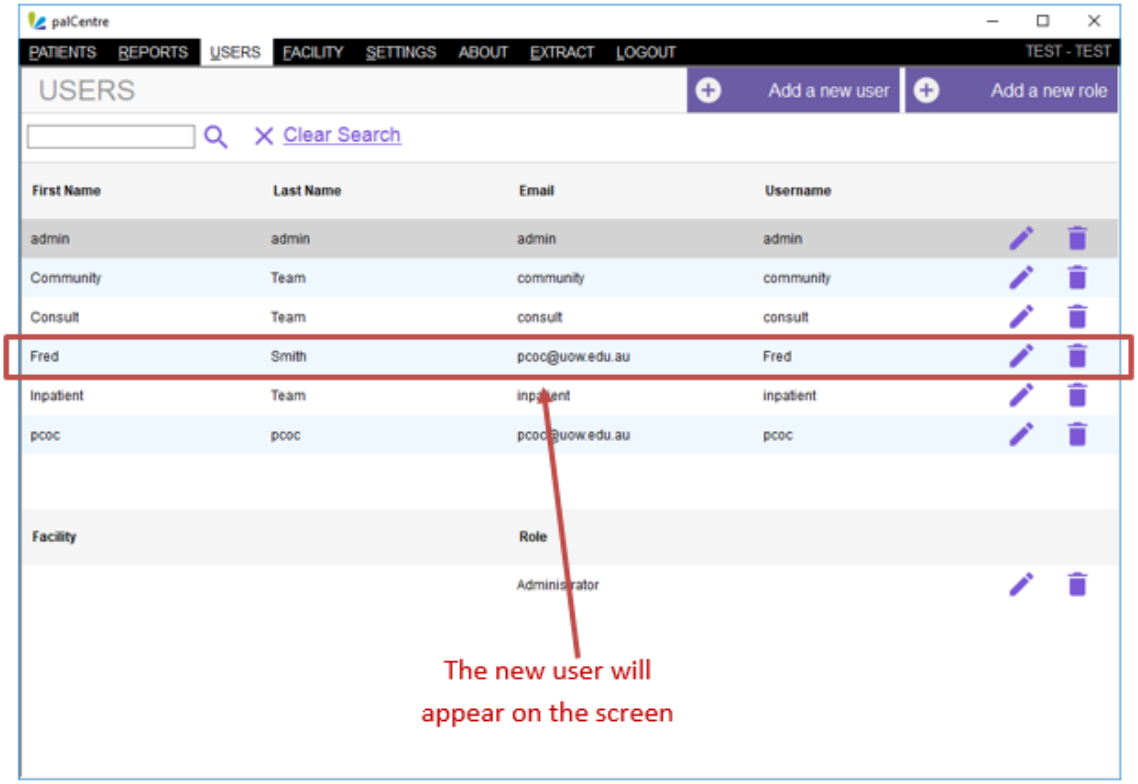
To create a new user, click on the purple *'Add a new user'* button at in the top right hand corner of the screen.



The following form will appear. Add the new users first name, last name, username, email, password and confirm the password. Click on submit.



The user will now appear in the list of users.

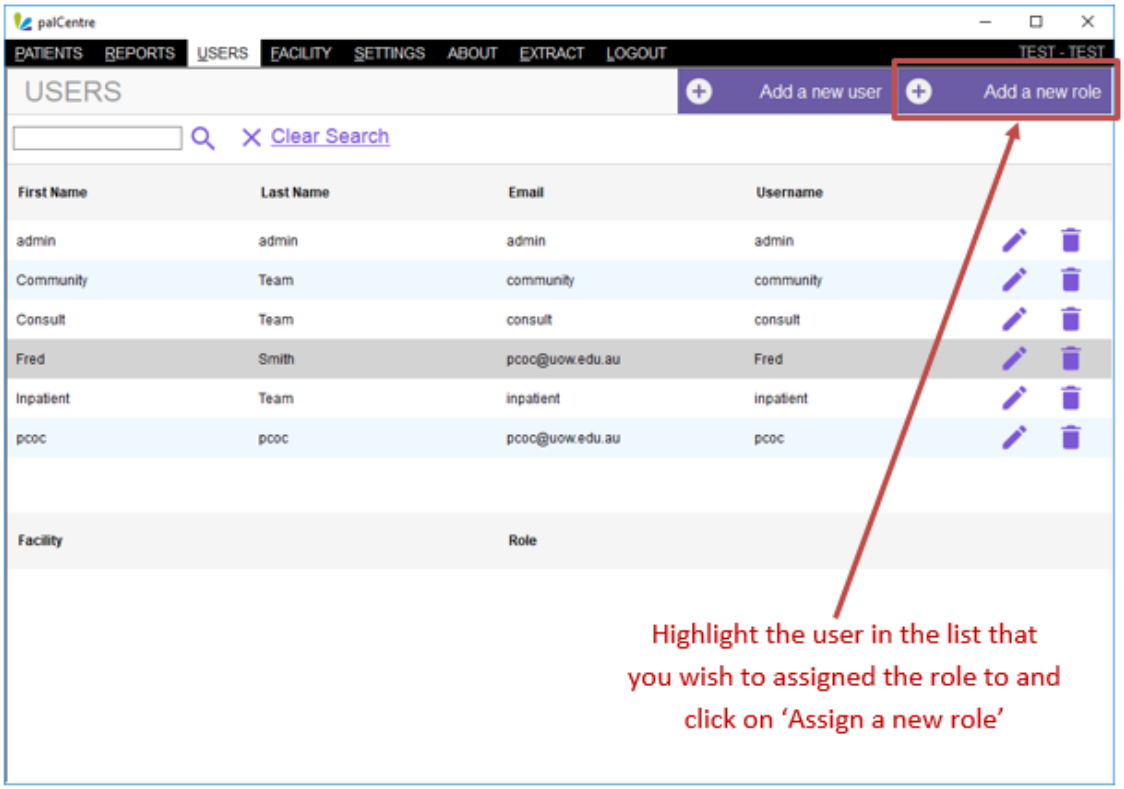


Assign a role

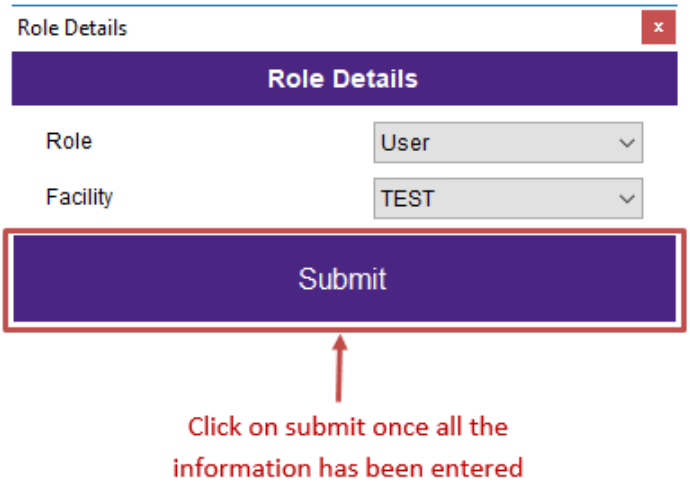
You also need to assign a role to the user. The following options are available:

Role	Description
Administrator	Create and delete facilities Create and delete users Add, edit and delete patients, episodes, assessments and profile data collection
Manager	Create and delete users Add, edit and delete patients, episodes, assessments and profile data collection
User	Add, edit and delete patients, episodes, assessments and profile data collection
Reader	View ONLY patients, episodes, assessments and profile data collection only

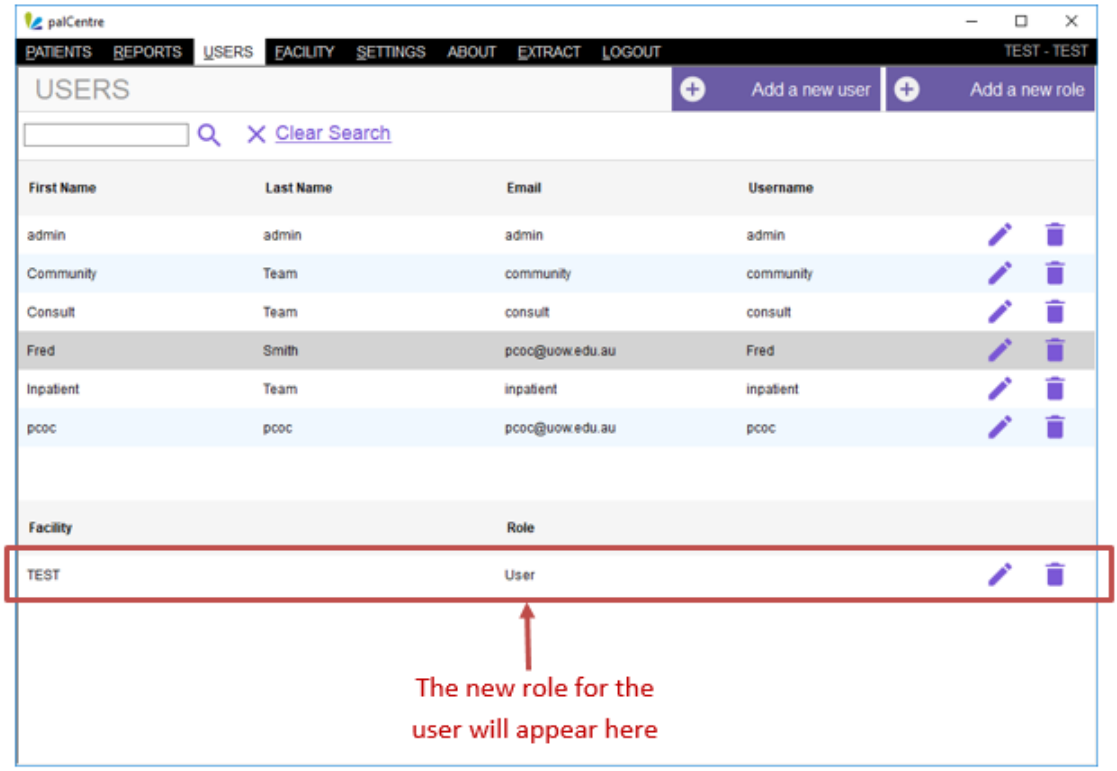
To assign a role to a user, highlight the user you wish to assign a role to in the *'Users'* screen and click on the purple *'Add a new role'* button in the top right hand corner of the screen:



The following form will appear. Add a role and a facility for the user and click on *'Submit'*.



The user role will then appear in the bottom half of the screen when the user is highlighted in the top half of the screen.

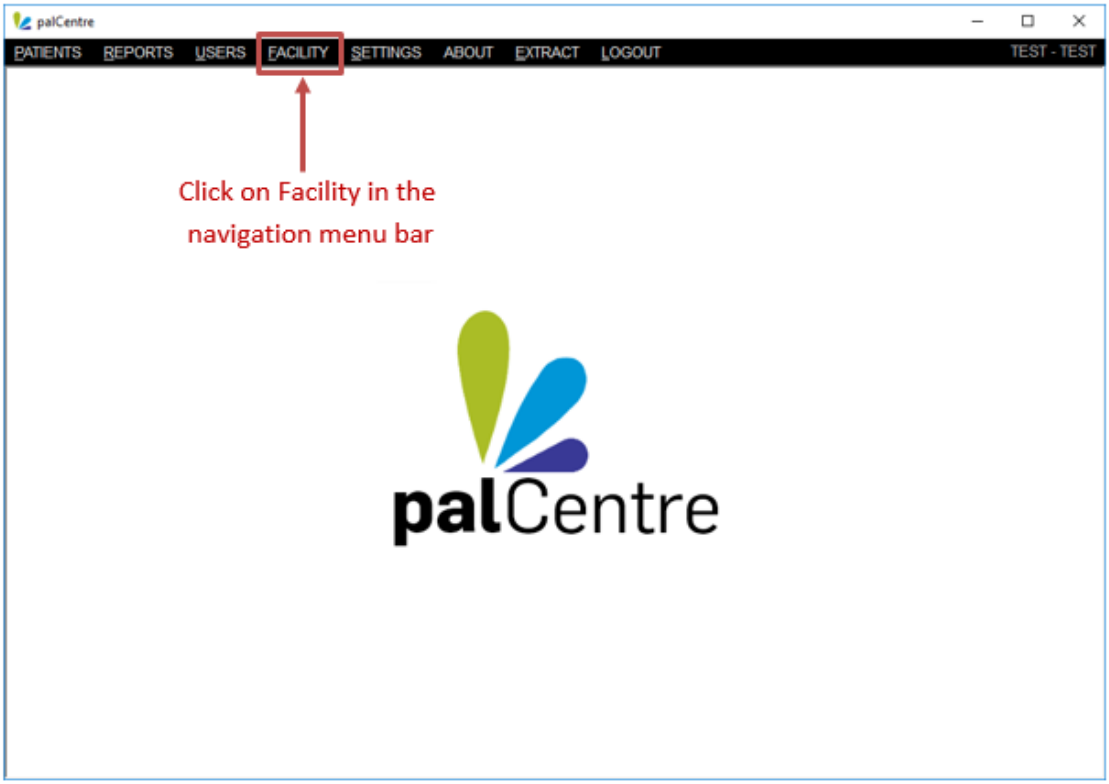


Adding or editing a facility

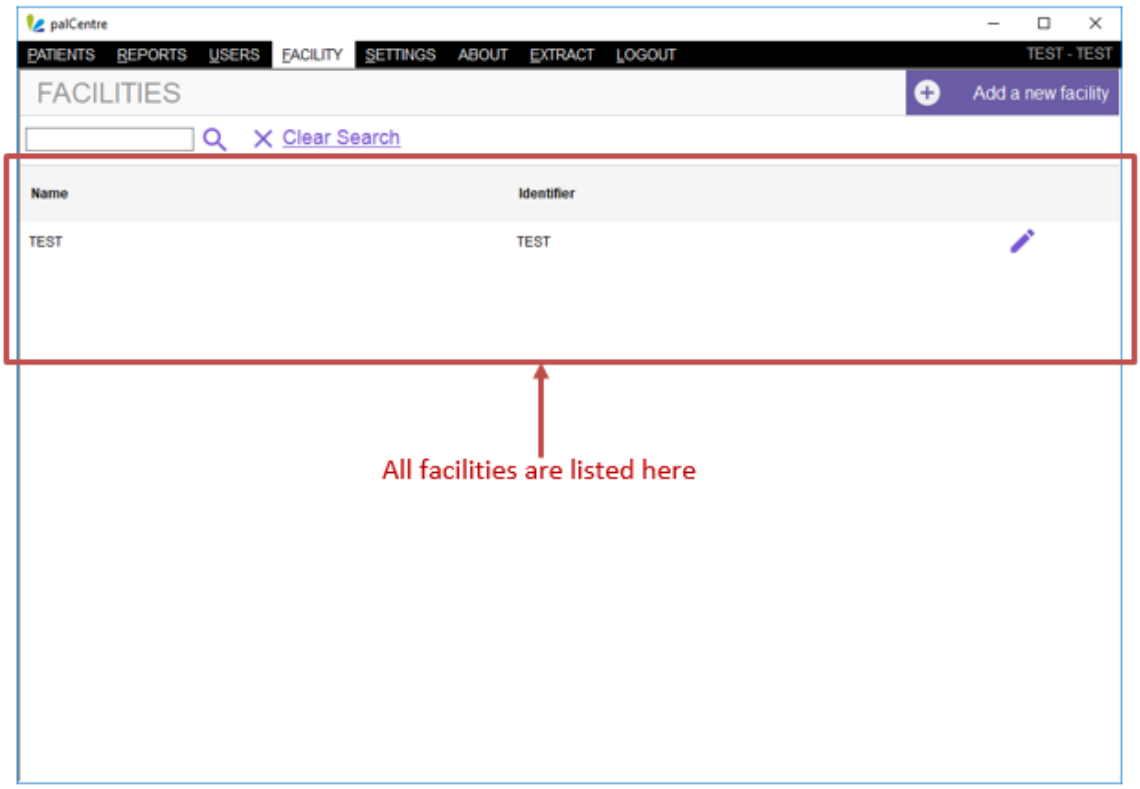
Facility identifiers are issued by PCOC and are unique to your facility. Your facility identifier is intrinsically linked to how data is submitted and processed by PCOC. If you wish to create a new facility, please first contact Alanna Connolly (02) 4221 5640 or Sam Allingham on (02) 4221 4476 or via email pcoc@uow.edu.au

Failure to contact PCOC and ensure the facility identifier has been issued correctly could result in any data entered under the new code not being able to be submitted to PCOC and you may lose any data that has been entered.

To create or modify a facility, you must be an administrator. Login to palCentre as an administrator and click on *'Facility'* in the navigation menu bar.

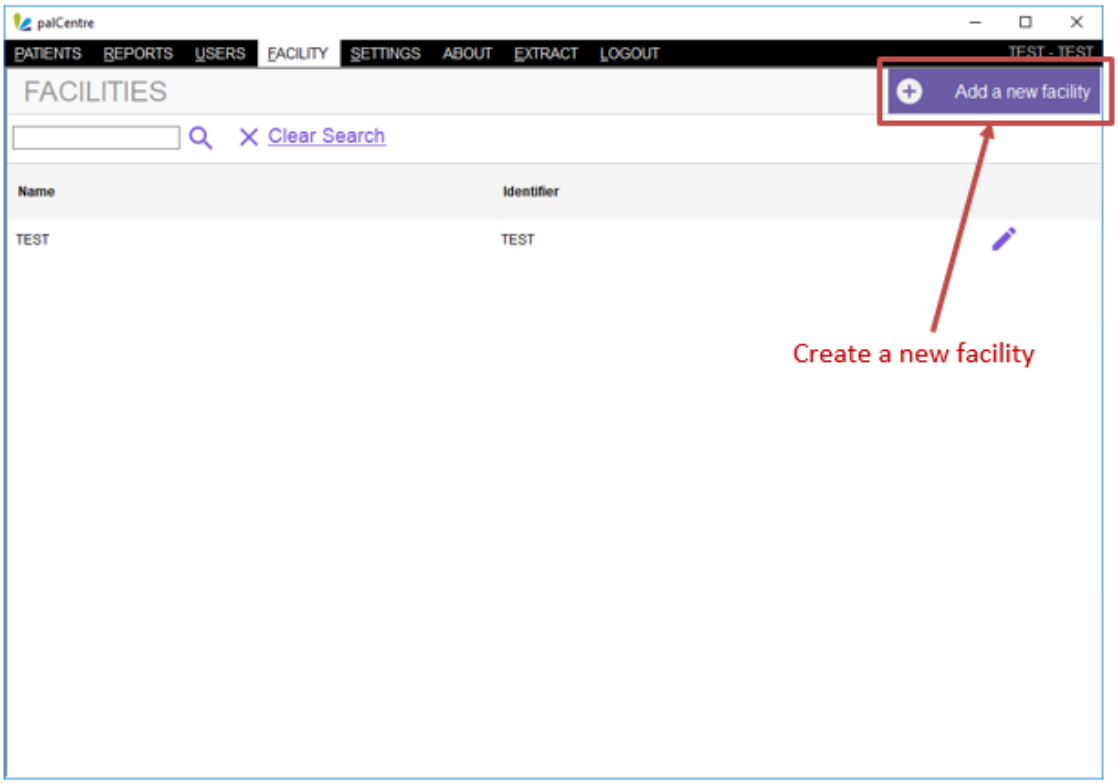


All current facilities will appear in the list on the facilities screen.

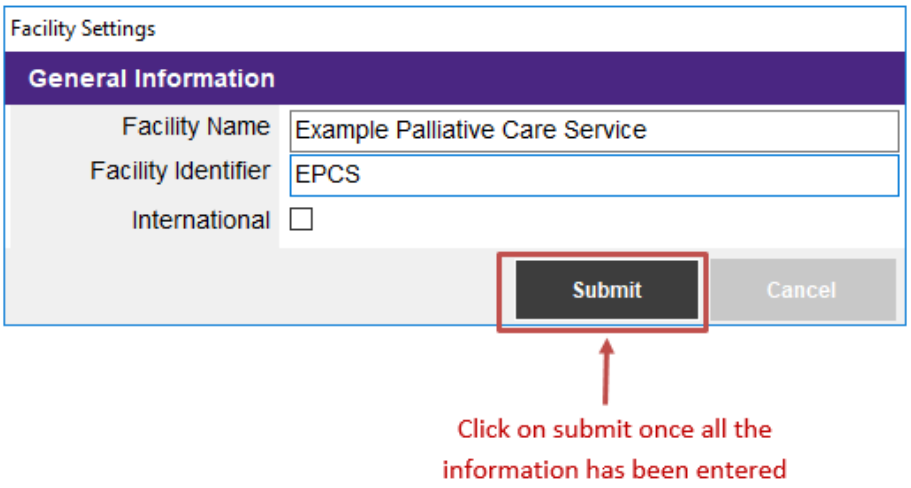


Creating a new facility

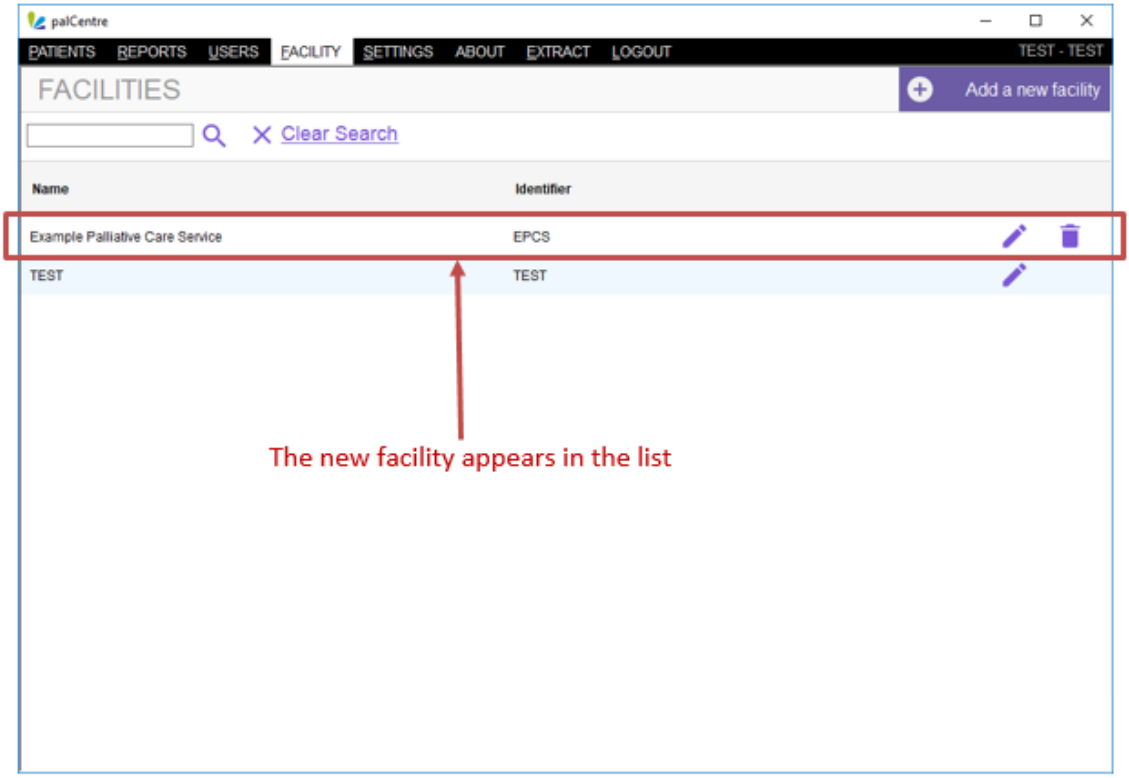
To create a new facility click on the purple *'Add a new facility'* button in the top right hand corner of the screen.



The follow form will appear.
Fill in the facility name and facility identifier. If you are outside Australia, check the international box. Click on submit.



Your facility will now appear in the list of facilities in this screen.



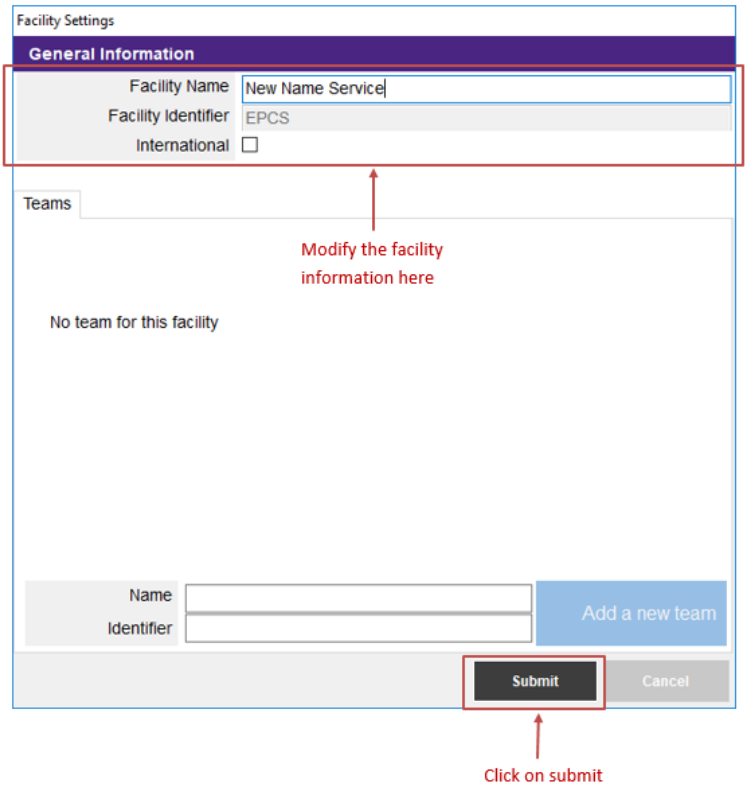
If current users will be entering data for the new facility, you will need to assign a user role for your current users to access the new facility created.

See the section on this page for creating new users for more information on how to assign roles to users.

Modifying a facility

To modify a facility, click on the  next to the facility you wish to modify.

The following form will appear. The only modifications you can complete are changing the facility name and the international option. Click on submit once the changes have been made.



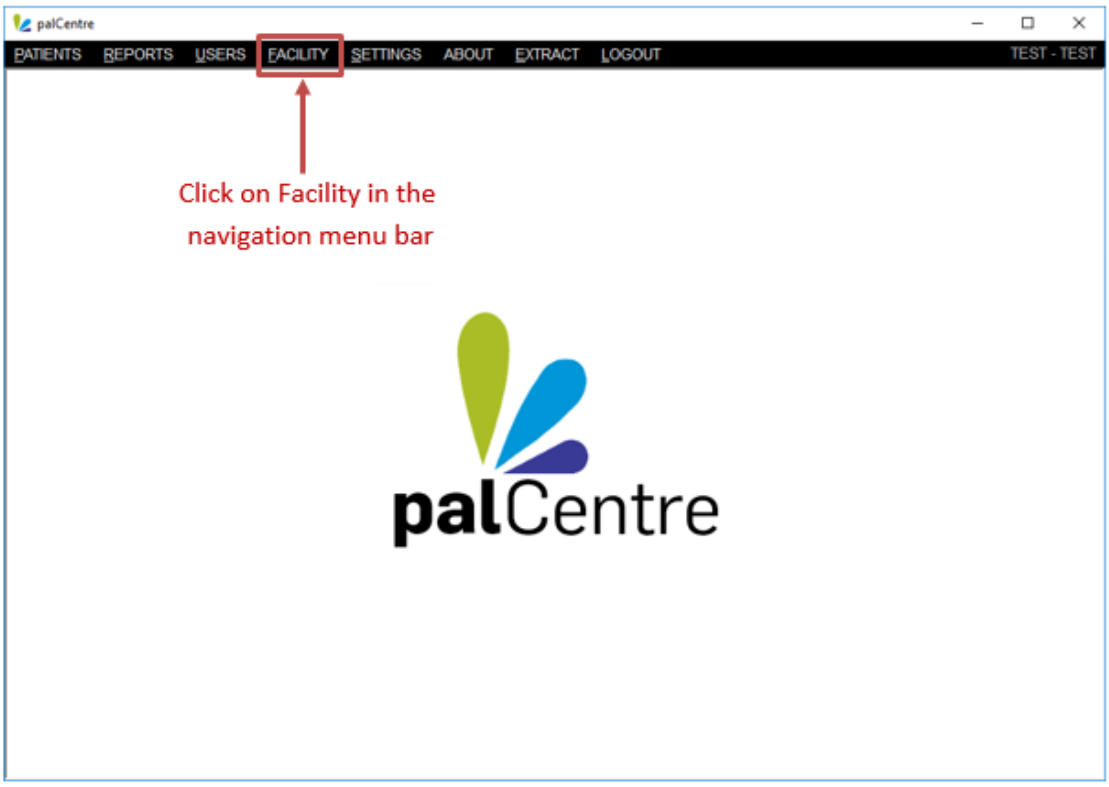
Your facility has now been modified.

Adding a team

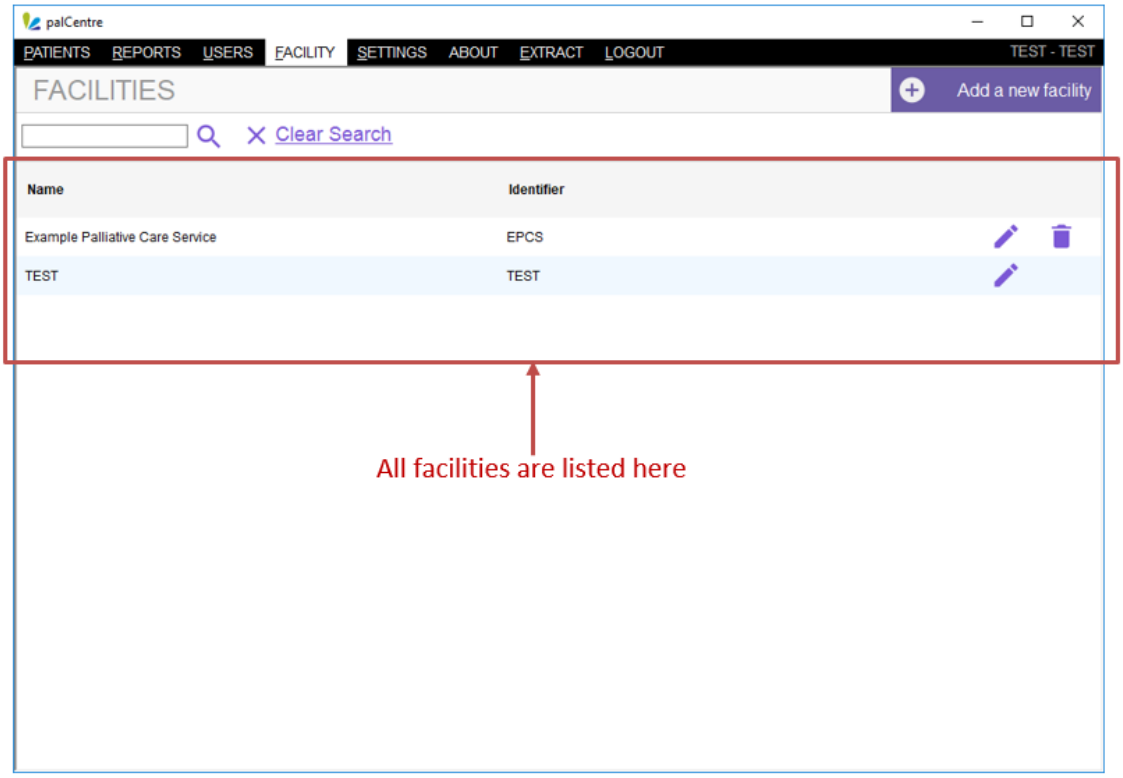
Team identifiers are issued by PCOC. Team identifiers are intrinsically linked to how data is submitted and processed by PCOC. If you wish to create a new team, please first contact Alanna Connolly (02) 4221 5640 or or Sam Allingham on (02) 4221 4476 or via email pcoc@uow.edu.au

Failure to contact PCOC and ensure the team identifier has been issued correctly could result in any data entered under the new team not being able to be submitted to PCOC and you may lose any data that has been entered.

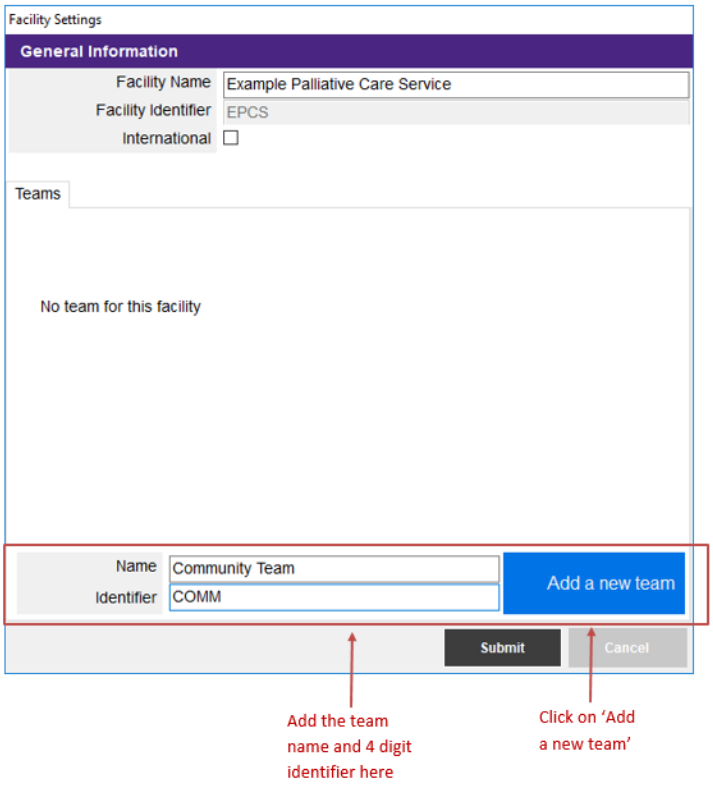
To create or modify a team, you must be an administrator. Login to palCentre as an administrator and click on *'Facility'* in the navigation menu bar.



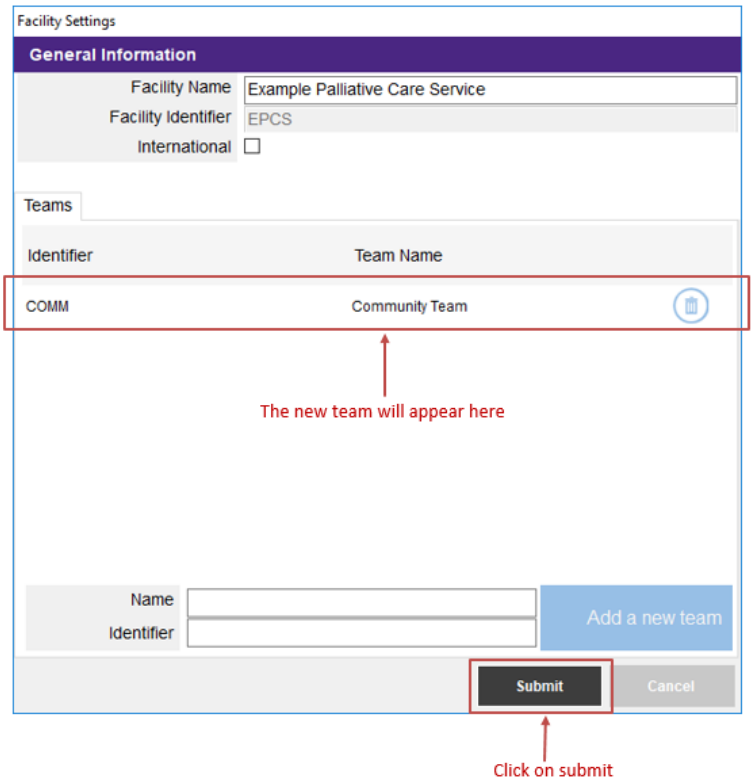
All current facilities will appear in the list on the facilities screen.



Click on the pencil icon next to the facility you wish to add a team to. The following form will appear.
Add the team name and 4 digit identifier at the bottom of this screen and click on the blue *'Add a new team'* button.



The team will appear in the teams list on this screen. Click on submit to save this information.



You have now created a new team.

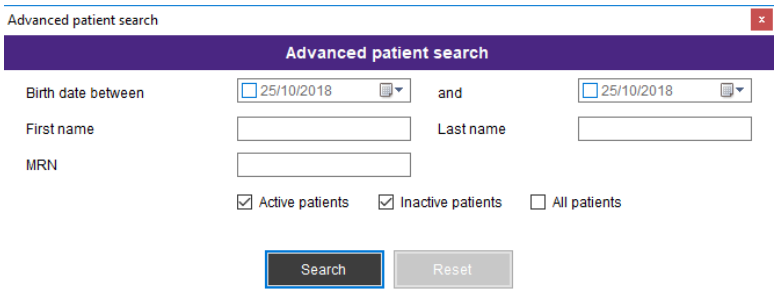
Frequently asked questions

These are common questions we have been asked about palCentre. If you have additional questions not answered here, please contact Alanna Connolly on (02) 4221 5640 or Sam Burns on (02) 4298 1141 or via email at pcoc@uow.edu.au

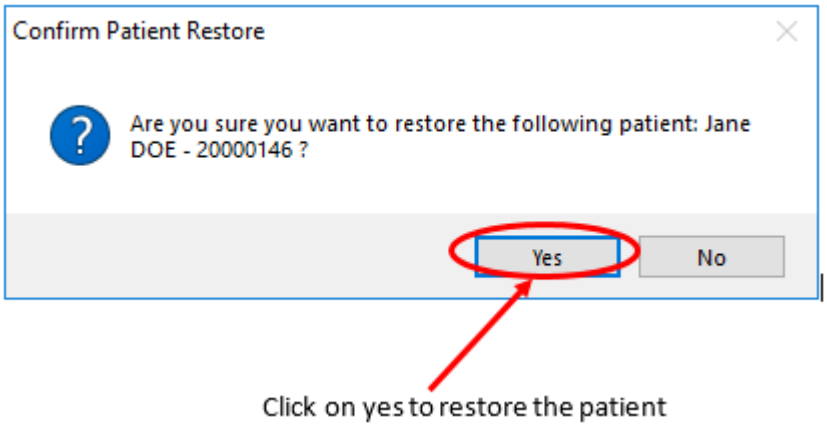
I can't find a patient that was in my SNAPshot database

Any patient that has been migrated from your SNAPshot database will automatically be archived. To commence data entry for this patient, you will need to restore them.

You need to first locate the patient. This can be done by clicking on the advanced search and ticking the 'inactive patients' box and searching for the patient id.



Once you have located the patient, click on the file icon next to the patient. The following warning will appear, click on 'Yes'

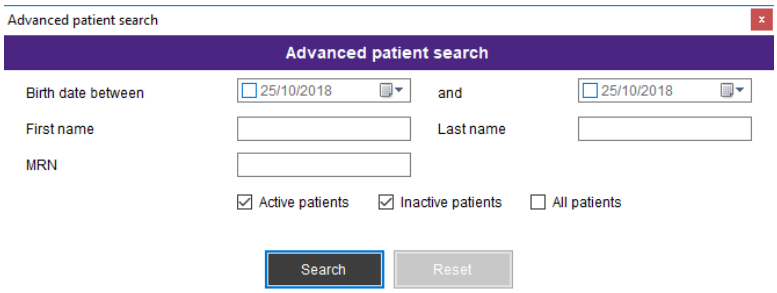


You can now start entering information for this patient.

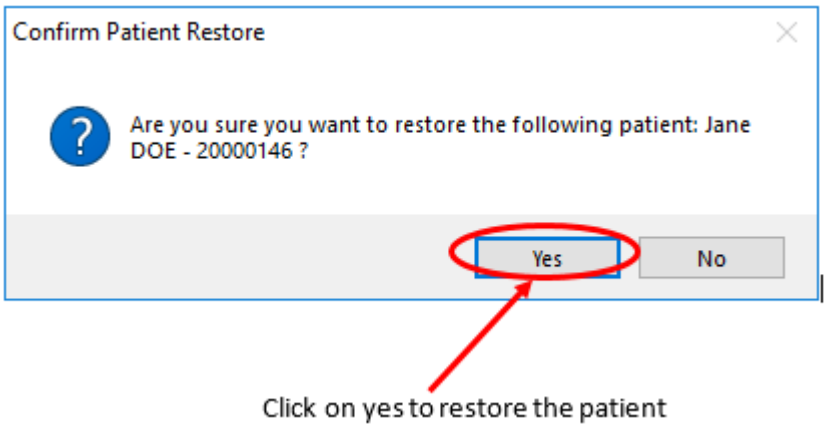
I can't find a patient previously entered into palCentre

If you cannot find a patient that has been previously entered into palCentre, they may have been archived. To find an archived patient, use the following steps:

You need to first locate the patient. This can be done by clicking on the advanced search and ticking the 'inactive patients' box and searching for the patient id.



Once you have located the patient, click on the file icon next to the patient. The following warning will appear, click on 'Yes'



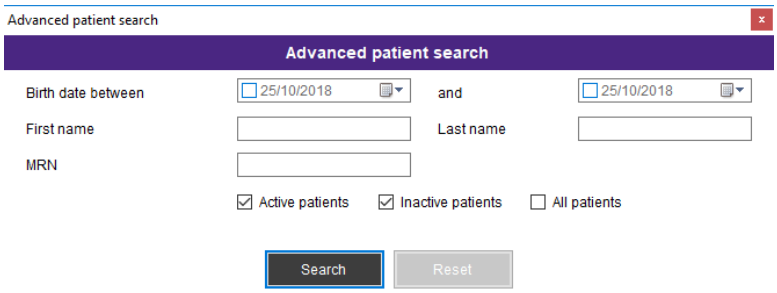
You can now start entering information for this patient.

I accidentally deleted a patient, can I get that patient back?

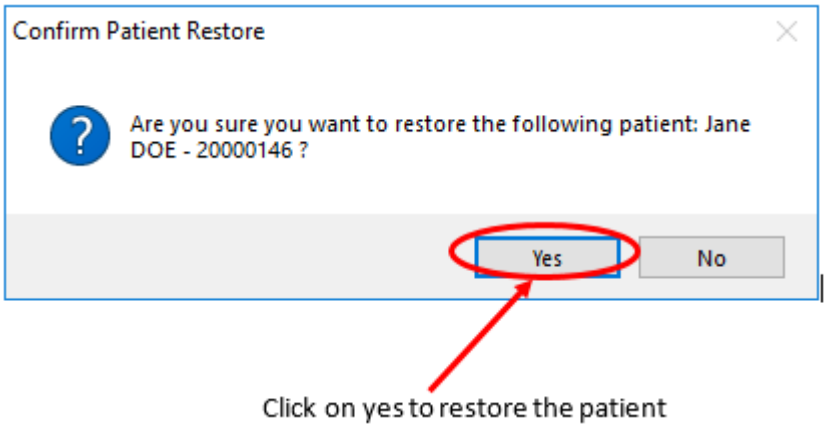
palCentre retains information for patients that have been deleted. Please note if a patient has been deleted, they will not be included in the extracts that are submitted to PCOC. Deleted patients should only be deleted test patients or patients created by mistake.

To restore a deleted patient, use the following steps:

You need to first locate the patient. This can be done by clicking on the advanced search and ticking the 'All patients' box and searching for the patient id.



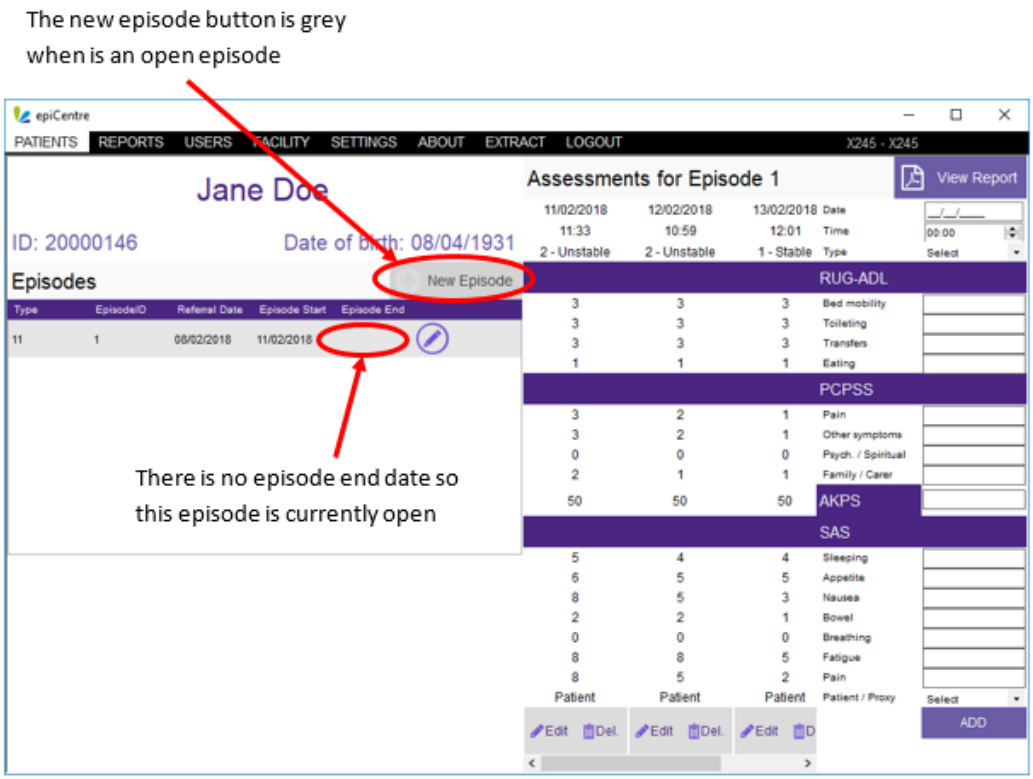
Once you have located the patient, click on the deleted icon next to the patient. The following warning will appear, click on 'Yes'



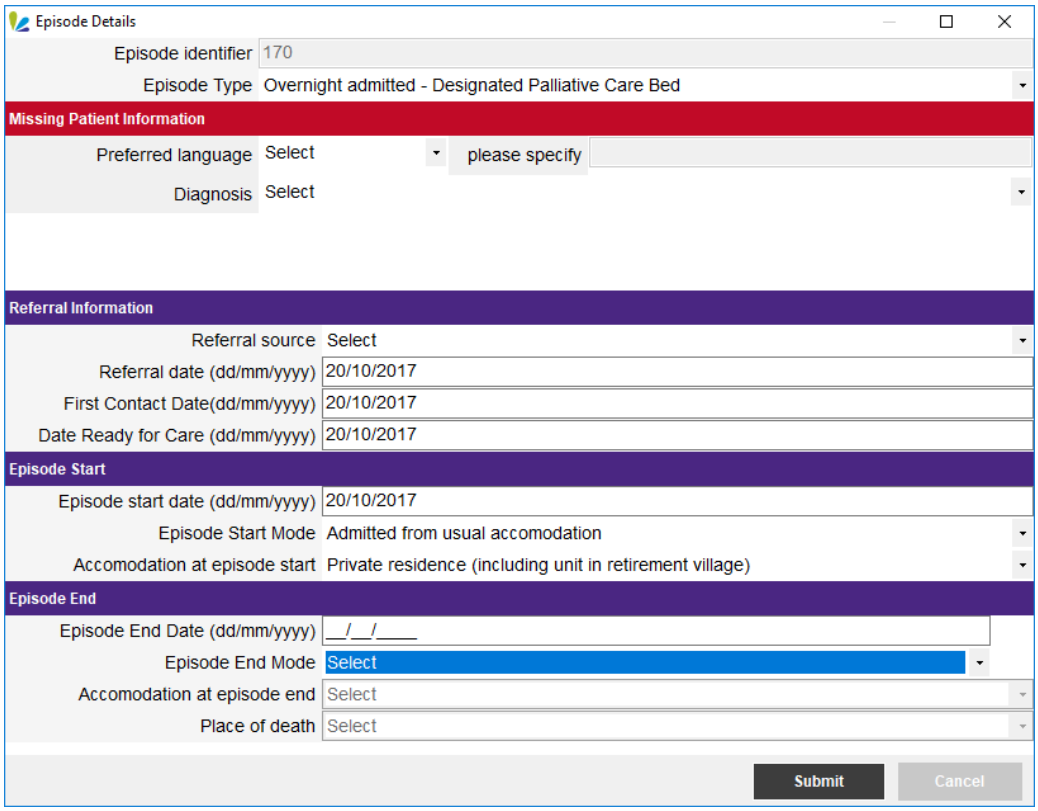
Your patient is no longer deleted.

The new episode button is greyed out. How can I create a new episode?

You cannot create a new episode if there is an episode already open for the patient. If you need to create an episode and the 'New episode' button is grey, make sure all episodes in the episode list have an episode end date associated with them.



To close an episode, click on the pencil icon next to the episode without an end date. Fill out the episode end section of the form that appears and click on submit.



You can now create a new episode.

I have forgotten my password and/or login

If you have forgotten your password or logon, please contact either Sam Burns on (02) 4298 1141, Linda Foskett on (02) 4221 5092 or via email pcoc@uow.edu.au

I have a new team entering data. How do I set this up in palCentre.

If you have a new team entering data, we may also need to amend the way reporting is conducted for your service. You will need to contact PCOC if a new team needs to be setup and we can walk you through the process.

Please contact either Sam Burns on (02) 4298 1141, Alanna Connolly on (02) 4221 5640 or via email pcoc@uow.edu.au

I have a new computer, how do I install and configure palCentre?

PCOC can send you the install process for palCentre.

Please note that palCentre stores the data in either a SQL server database or a SQL compact database. You may need the location of this database to install correctly. It is recommend that this is database is stored on a network drive, however, it can also be saved on a computer locally. If it is stored locally on your PC, you will need to make sure this file is saved onto your new computer.

Please contact either Sam Burns on (02) 4298 1141, Alanna Connolly on (02) 4221 5640 or via email pcoc@uow.edu.au