



User Guide

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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:

- Getting started with palCentre
- Entering patient information
- Entering episode information
- Entering assessment information (phase level information)
- Entering profile data
- Reporting
- Extracting and submitting data
- Administration options
- Frequently asked questions

The user guide can also be 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



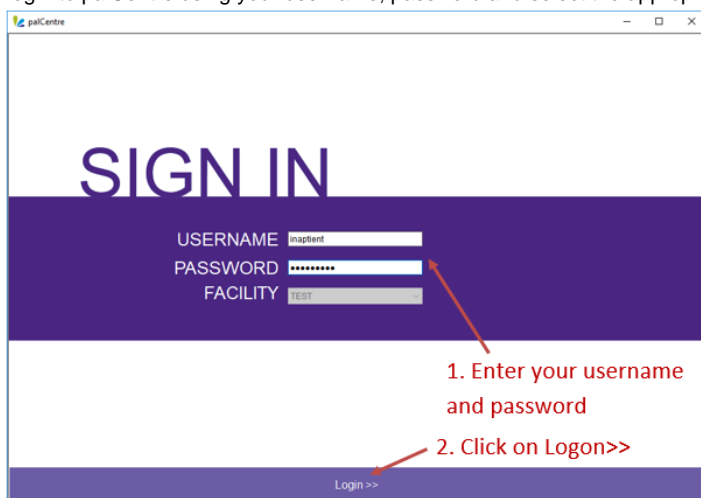
OR

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.

A screenshot of the palCentre login interface. The window title is 'palCentre'. The main heading is 'SIGN IN' in large purple letters. Below this is a dark purple horizontal bar containing three input fields: 'USERNAME' with the value 'inpatient', 'PASSWORD' with masked characters '*****', and 'FACILITY' with the value 'TEST'. At the bottom of the page, there is a 'Login >>' button. Two red arrows point from the text instructions to the password field and the 'Login >>' button.

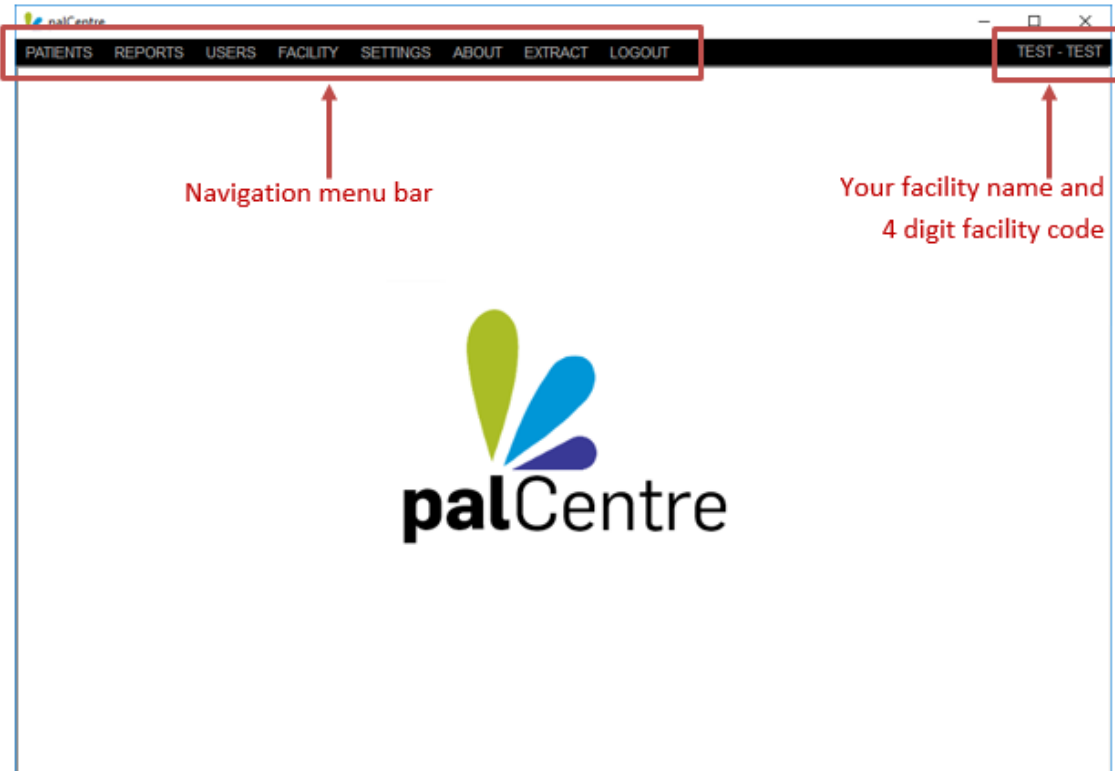
1. Enter your username and password

2. Click on Logon>>

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:

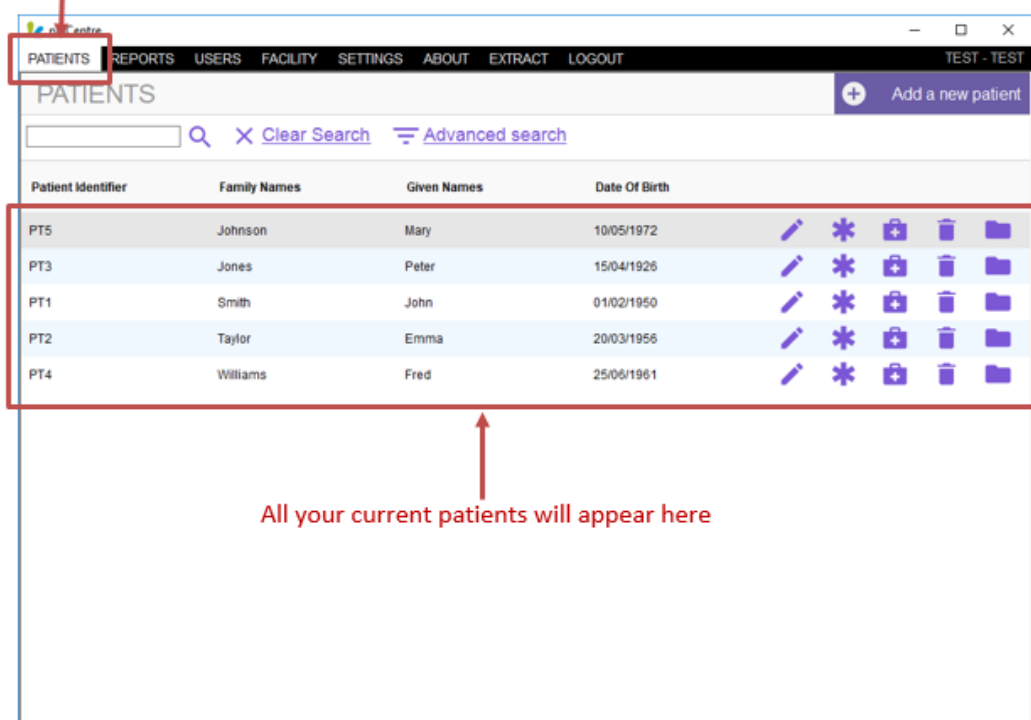
Selection	Purpose
PATIENTS	All data entry is completed here and is the main screen that you will use in palCentre.
REPORTS	Information on current patients (i.e. patients with an open episode) can be found here.
SETTINGS	These are the settings for your user. You can change your password and defaults in 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.

Access this screen by clicking on patient



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:

- Accessing the patient screen
- Creating a new patient
- Changing a patients details
- Searching for a patient
- Archiving a patient
- Deleting a patient

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.

Access this screen by clicking on patient

Patient Identifier	Family Names	Given Names	Date Of Birth					
PT5	Johnson	Mary	10/05/1972					
PT3	Jones	Peter	15/04/1928					
PT1	Smith	John	01/02/1950					
PT2	Taylor	Emma	20/03/1956					
PT4	Williams	Fred	25/06/1961					

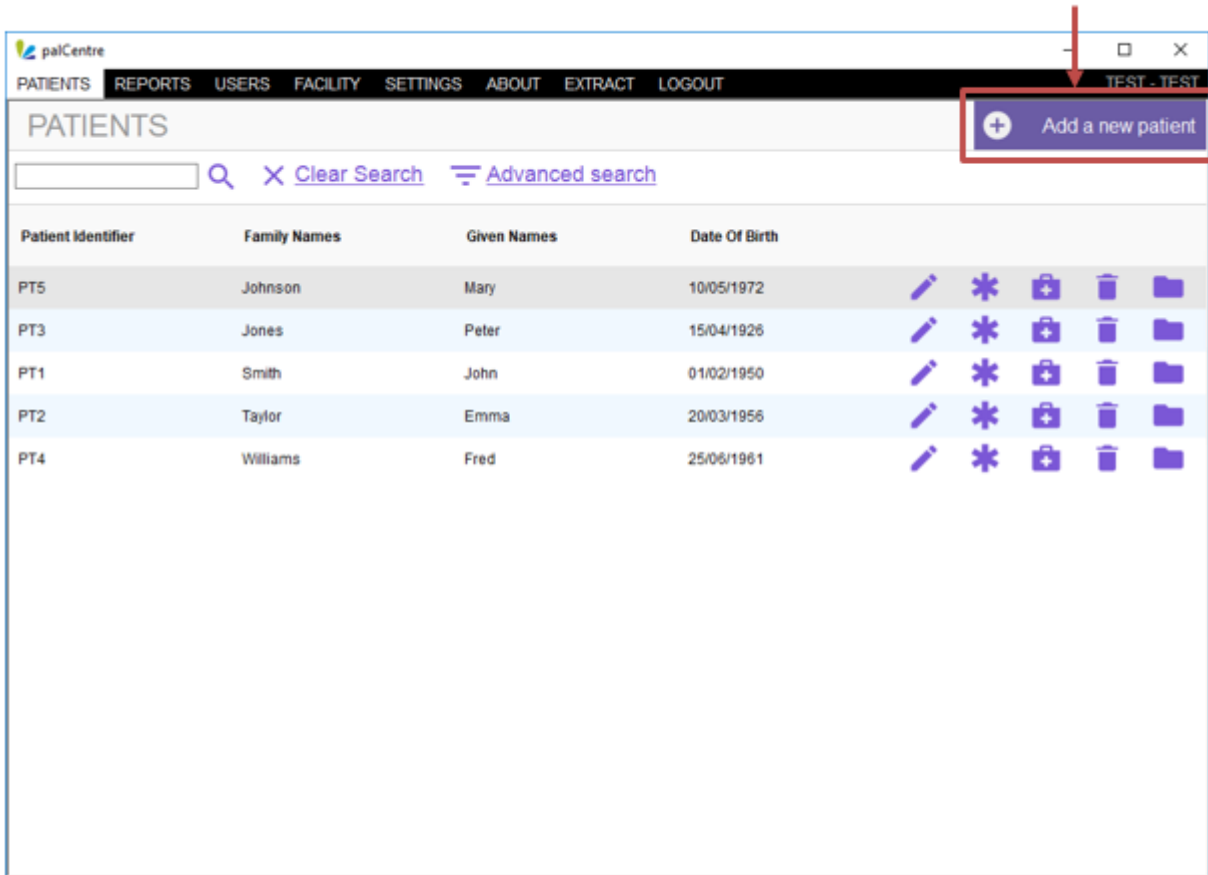
All your current patients will appear here

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.

Create a new patient

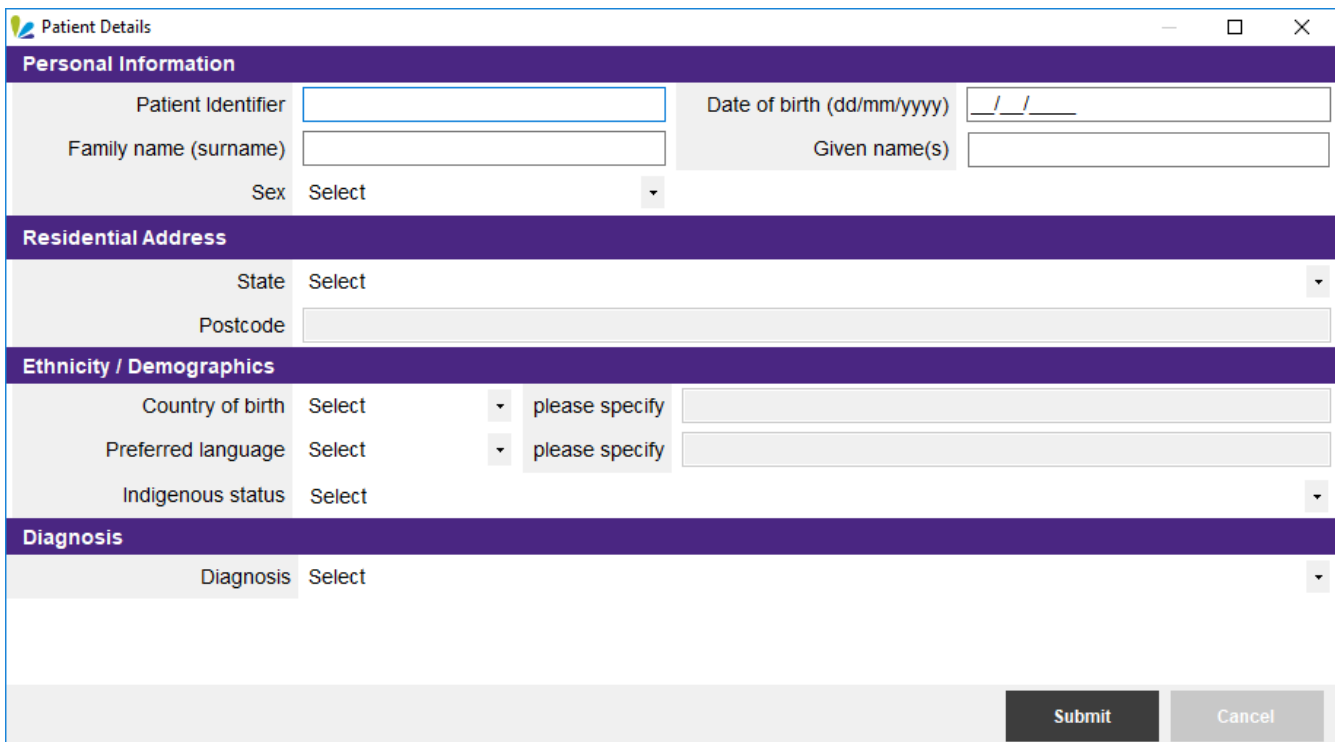


The screenshot shows the 'palCentre' interface with a navigation bar at the top containing 'PATIENTS', 'REPORTS', 'USERS', 'FACILITY', 'SETTINGS', 'ABOUT', 'EXTRACT', and 'LOGOUT'. The main content area is titled 'PATIENTS' and features a search bar with a magnifying glass icon, a 'Clear Search' button, and an 'Advanced search' link. Below the search bar is a table of patient records. The table has columns for 'Patient Identifier', 'Family Names', 'Given Names', and 'Date Of Birth'. The records are as follows:

Patient Identifier	Family Names	Given Names	Date Of Birth					
PT5	Johnson	Mary	10/05/1972					
PT3	Jones	Peter	15/04/1926					
PT1	Smith	John	01/02/1950					
PT2	Taylor	Emma	20/03/1956					
PT4	Williams	Fred	25/06/1961					

In the top right corner of the patient list area, there is a purple button with a white plus sign and the text 'Add a new patient'. This button is highlighted with a red rectangular box, and a red arrow points to it from the text 'Create a new patient' located above the screenshot.

The patient details form will appear:



The 'Patient Details' form is displayed in a window. It is organized into several sections, each with a purple header:

- Personal Information:** Contains fields for 'Patient Identifier', 'Date of birth (dd/mm/yyyy)', 'Family name (surname)', and 'Given name(s)'. There is also a 'Sex' dropdown menu with 'Select' as the current option.
- Residential Address:** Contains a 'State' dropdown menu with 'Select' as the current option, and a 'Postcode' text input field.
- Ethnicity / Demographics:** Contains three rows of dropdown menus: 'Country of birth' (with 'please specify' and a text input), 'Preferred language' (with 'please specify' and a text input), and 'Indigenous status'.
- Diagnosis:** Contains a 'Diagnosis' dropdown menu with 'Select' as the current option.

At the bottom right of the form, there are two buttons: 'Submit' and 'Cancel'.

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.

The screenshot shows a web form titled "Patient Details" with the following sections and fields:

- Personal Information:** Patient Identifier (PT6), Date of birth (08/04/1931), Family name (Doe), Given name(s) (Jane), Sex (Female).
- Residential Address:** State (NSW), Postcode (2519).
- Ethnicity / Demographics:** Country of birth (Australia), Preferred language (English), Indigenous status (Neither Aboriginal nor Torres Strait Islander origin).
- Diagnosis:** Lung.

The "Submit" button is highlighted with a red box, and a red arrow points to it from the text below.

Click on submit once all the patient information has been entered

Before the patient details are saved, palCentre will check to see if the patient name and/or patient identifier already exists. This functionality avoids duplicate patients being entered. If this warning does appear, please check that the patient identifier 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.

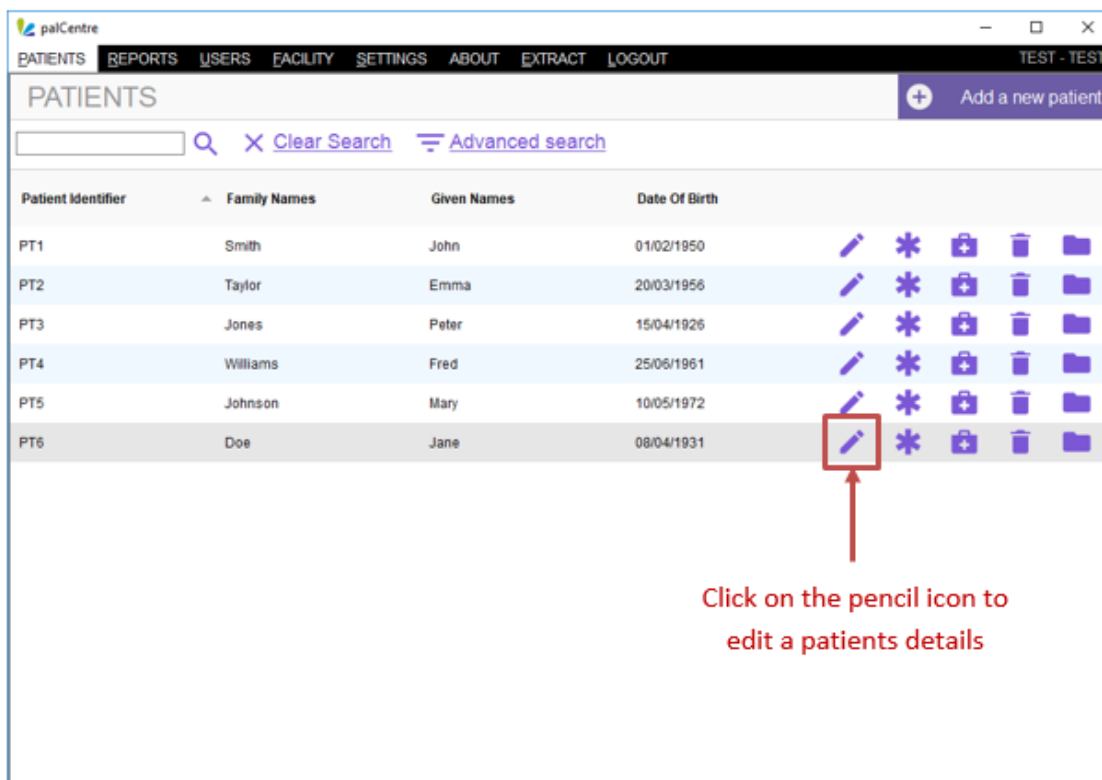
The screenshot shows the 'palCentre' interface with a 'PATIENTS' tab selected. The main area displays a table of patients with columns for Patient Identifier, Family Names, Given Names, and Date Of Birth. The patient 'PT6' (Doe, Jane, 08/04/1931) is highlighted in a red box. Below the table, a red arrow points to the highlighted row, and the text 'The added patient appears on the patient screen' is displayed in red.































Patient Identifier	Family Names	Given Names	Date Of Birth					
PT1	Smith	John	01/02/1950					
PT2	Taylor	Emma	20/03/1956					
PT3	Jones	Peter	15/04/1926					
PT4	Williams	Fred	25/06/1961					
PT5	Johnson	Mary	10/05/1972					
PT6	Doe	Jane	08/04/1931					

The added patient appears on the patient screen

Changing a patients details

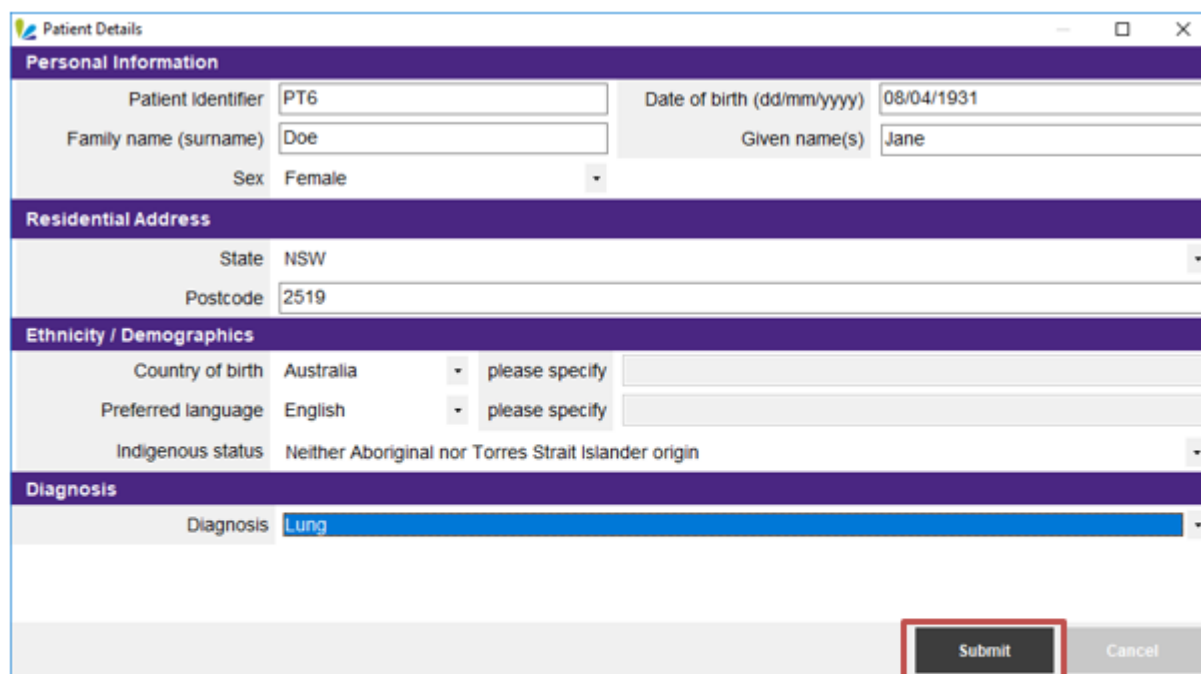
To change any of the patient details, click on the  to the right of the patients you wish to change.



Patient Identifier	Family Names	Given Names	Date Of Birth	
PT1	Smith	John	01/02/1950	    
PT2	Taylor	Emma	20/03/1956	    
PT3	Jones	Peter	15/04/1926	    
PT4	Williams	Fred	25/06/1961	    
PT5	Johnson	Mary	10/05/1972	    
PT6	Doe	Jane	08/04/1931	    

Click on the pencil icon to edit a patients details

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



Personal Information

Patient Identifier: PT6 Date of birth (dd/mm/yyyy): 08/04/1931
Family name (surname): Doe Given name(s): Jane
Sex: Female

Residential Address

State: NSW
Postcode: 2519

Ethnicity / Demographics

Country of birth: Australia please specify
Preferred language: English please specify
Indigenous status: Neither Aboriginal nor Torres Strait Islander origin

Diagnosis

Diagnosis: Lung

Submit Cancel

Click on submit once any changes have been made

The patient information is now updated.

Searching for a patient

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



palCentre

PATIENTS | REPORTS | USERS | FACILITY | SETTINGS | ABOUT | EXTRACT | LOGOUT | TEST - TEST

PATIENTS + Add a new patient

Q X Clear Search ≡ Advanced search

Patient Identifier	Family Names	Given Names	Date Of Birth					
PT1	Smith	John	01/02/1950					
PT2	Taylor	Emma	20/03/1956					
PT3	Jones	Peter	15/04/1926					
PT4	Williams	Fred	25/06/1961					
PT5	Johnson	Mary	10/05/1972					
PT6	Doe	Jane	08/04/1931					

Type the patients name or patient identifier into the search bar and click on the magnifying glass icon

The results of the search will appear below.

palCentre

PATIENTS | REPORTS | USERS | FACILITY | SETTINGS | ABOUT | EXTRACT | LOGOUT | TEST - TEST

PATIENTS + Add a new patient

Q X Clear Search ≡ Advanced search

Patient Identifier	Family Names	Given Names	Date Of Birth					
PT6	Doe	Jane	08/04/1931					

The search results appear here

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

Advanced patient searchx

Advanced patient search

Birth date between	<input type="text" value="26/10/2018"/>	and	<input type="text" value="26/10/2018"/>
First name	<input type="text"/>	Last name	<input type="text"/>
MRN	<input type="text"/>		
<input type="checkbox"/> Active patients <input type="checkbox"/> Inactive patients <input checked="" type="checkbox"/> All patients			
<div style="display: flex; justify-content: center; gap: 20px;"><div style="background-color: #333; color: white; padding: 5px 15px; border: 1px solid #ccc; cursor: pointer;">Search</div><div style="background-color: #ccc; padding: 5px 15px; border: 1px solid #ccc; cursor: pointer;">Reset</div></div>			

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

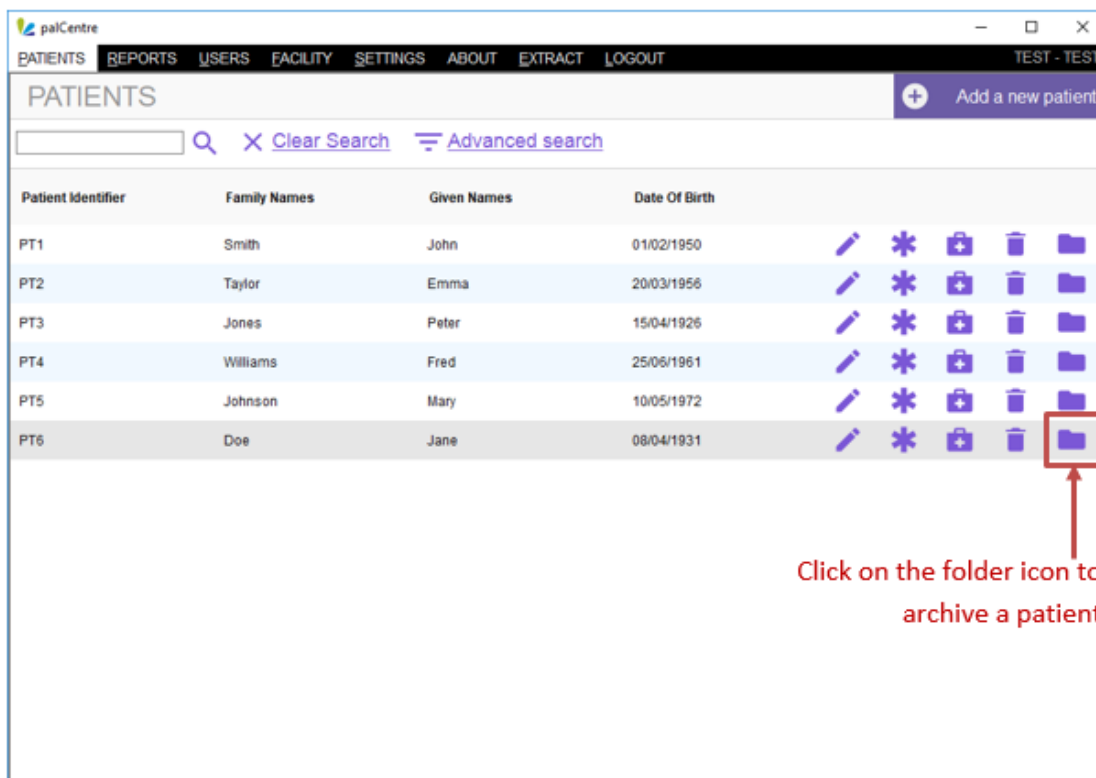
To remove any search parameters, click on the *'Reset'* button in the Advanced Patient Search or the *'Clear Search'* option on the patient screen. This will allow you to see you to see the full list of current patients that appeared when opening palCentre.

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.

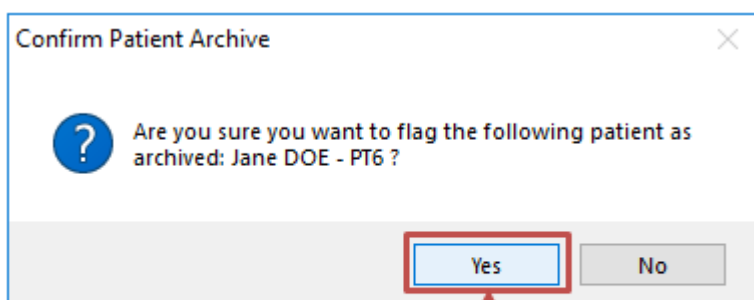
To archive a patient, click on the  to the right of the patients you wish to archive.



The screenshot shows the 'PATIENTS' screen in palCentre. The table lists six patients (PT1 to PT6) with columns for Patient Identifier, Family Names, Given Names, and Date Of Birth. To the right of each row are icons for editing (pencil), deleting (trash), and archiving (folder). The folder icon for PT6 is highlighted with a red box, and a red arrow points to it with the text 'Click on the folder icon to archive a patient'.

Patient Identifier	Family Names	Given Names	Date Of Birth
PT1	Smith	John	01/02/1950
PT2	Taylor	Emma	20/03/1956
PT3	Jones	Peter	15/04/1926
PT4	Williams	Fred	25/06/1961
PT5	Johnson	Mary	10/05/1972
PT6	Doe	Jane	08/04/1931

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



The dialog box titled 'Confirm Patient Archive' contains a question mark icon and the text 'Are you sure you want to flag the following patient as archived: Jane DOE - PT6 ?'. Below the text are two buttons: 'Yes' and 'No'. The 'Yes' button is highlighted with a red box, and a red arrow points to it with the text 'Click on yes to archive the patient'.

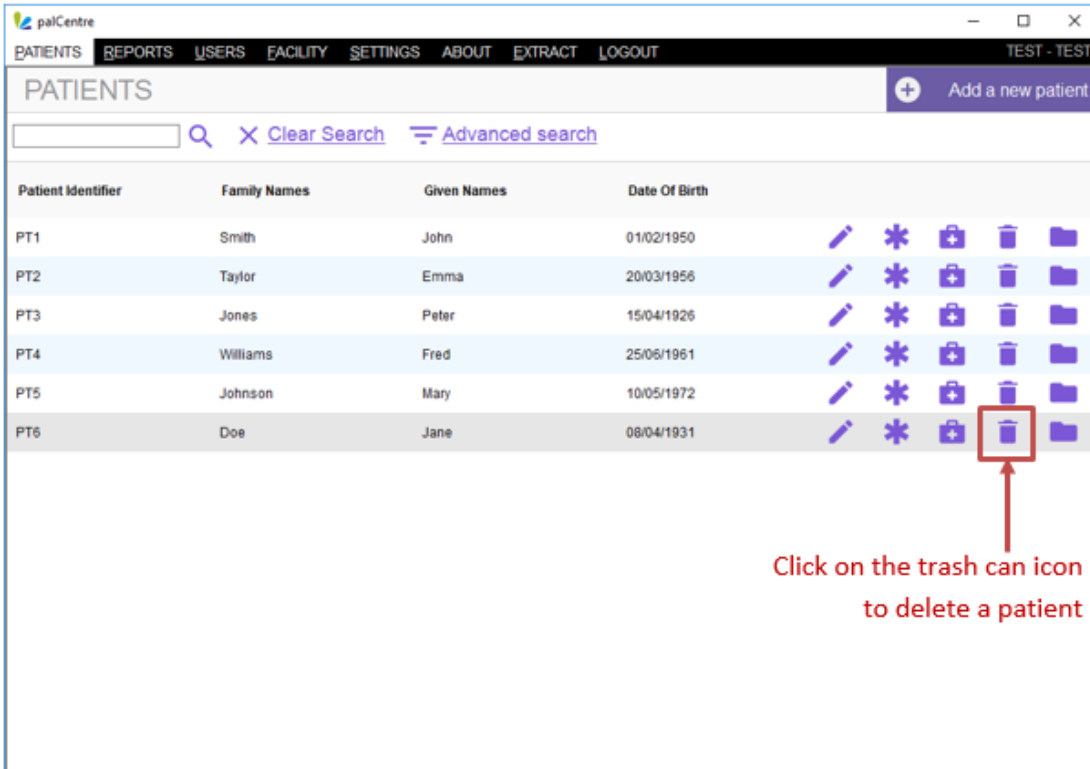
Click on yes to archive the patient

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.

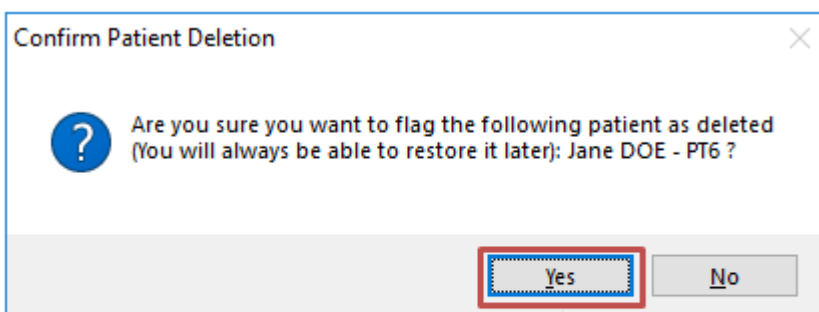
To delete a patient, click on the  to the right of the patients you wish to delete.



The screenshot shows the 'PATIENTS' section of the palCentre application. A table lists six patients (PT1 to PT6) with columns for Patient Identifier, Family Names, Given Names, and Date Of Birth. To the right of each row are several icons: a pencil (edit), an asterisk (flag), a plus sign in a box (add), a trash can (delete), and a folder (archive). The trash can icon for patient PT6 (Jane Doe) is highlighted with a red box and a red arrow pointing to it. Below the screenshot, a red arrow points to the trash can icon with the text: "Click on the trash can icon to delete a patient".

Patient Identifier	Family Names	Given Names	Date Of Birth
PT1	Smith	John	01/02/1950
PT2	Taylor	Emma	20/03/1956
PT3	Jones	Peter	15/04/1926
PT4	Williams	Fred	25/06/1961
PT5	Johnson	Mary	10/05/1972
PT6	Doe	Jane	08/04/1931

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



The screenshot shows a dialog box titled "Confirm Patient Deletion". The text inside reads: "Are you sure you want to flag the following patient as deleted (You will always be able to restore it later): Jane DOE - PT6 ?". At the bottom of the dialog are two buttons: "Yes" and "No". The "Yes" button is highlighted with a red box and a red arrow pointing to it. Below the screenshot, a red arrow points to the "Yes" button with the text: "Click on yes to delete the patient".

Click on yes to delete the patient

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:

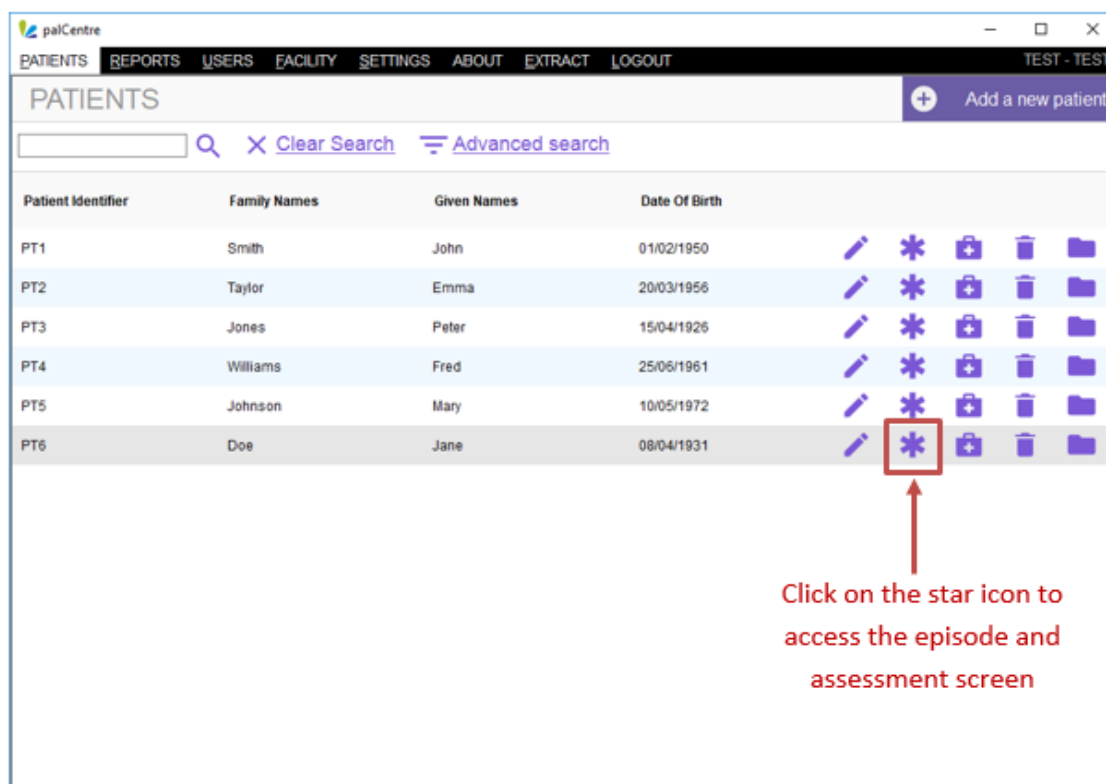
- [Accessing the episode and assessment screen](#)
- [Creating an episode](#)
- [Changing episode information](#)
- [Deleting an episode](#)

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 screenshot shows the palCentre interface with a 'PATIENTS' table. The table has columns for Patient Identifier, Family Names, Given Names, and Date Of Birth. Each row has a set of icons: a pencil, a star, a first aid kit, a trash can, and a folder. The star icon for patient PT6 (Doe, Jane, 08/04/1931) is highlighted with a red box and a red arrow pointing to it. Below the screenshot, a red text box says: 'Click on the star icon to access the episode and assessment screen'.

Patient Identifier	Family Names	Given Names	Date Of Birth					
PT1	Smith	John	01/02/1950					
PT2	Taylor	Emma	20/03/1956					
PT3	Jones	Peter	15/04/1926					
PT4	Williams	Fred	25/06/1961					
PT5	Johnson	Mary	10/05/1972					
PT6	Doe	Jane	08/04/1931					

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.

The patient's details

Shows a report for the current episode

Episode information: This patient has 2 episodes, the one highlighted in grey is the selected episode

Assessment information: This patient has 3 assessments entered for the episode starting on the 03/01/2017

Patient Details	
John Smith	
ID: PT1	Date of birth: 01/02/1950

Episodes				
Type	EpisodeID	Referral Date	Episode Start	Episode End
12	2	20/02/2017	20/02/2017	05/03/2017
11	1	03/01/2017	03/01/2017	06/01/2017

Assessments for Episode 1				
Date	Time	Type		
03/01/2017	01:00	2 - Unstable		
04/01/2017	02:00	3 - Deteriorating		
05/01/2017	01:00	3 - Deteriorating		

RUG-ADL				
1	1	1	Bed mobility	
1	1	1	Toileting	
1	1	1	Transfers	
1	1	1	Eating	

PCPSS				
3	1	1	Pain	
1	1	0	Other symptoms	
0	0	0	Psych. / Spiritual	
0	0	1	Family / Carer	

AKPS				
50	50	50		

SAS				
0	0	0	Sleeping	
0	0	0	Appetite	
0	0	0	Nausea	
0	0	0	Bowel	
2	1	1	Breathing	
5	3	4	Fatigue	
8	5	4	Pain	

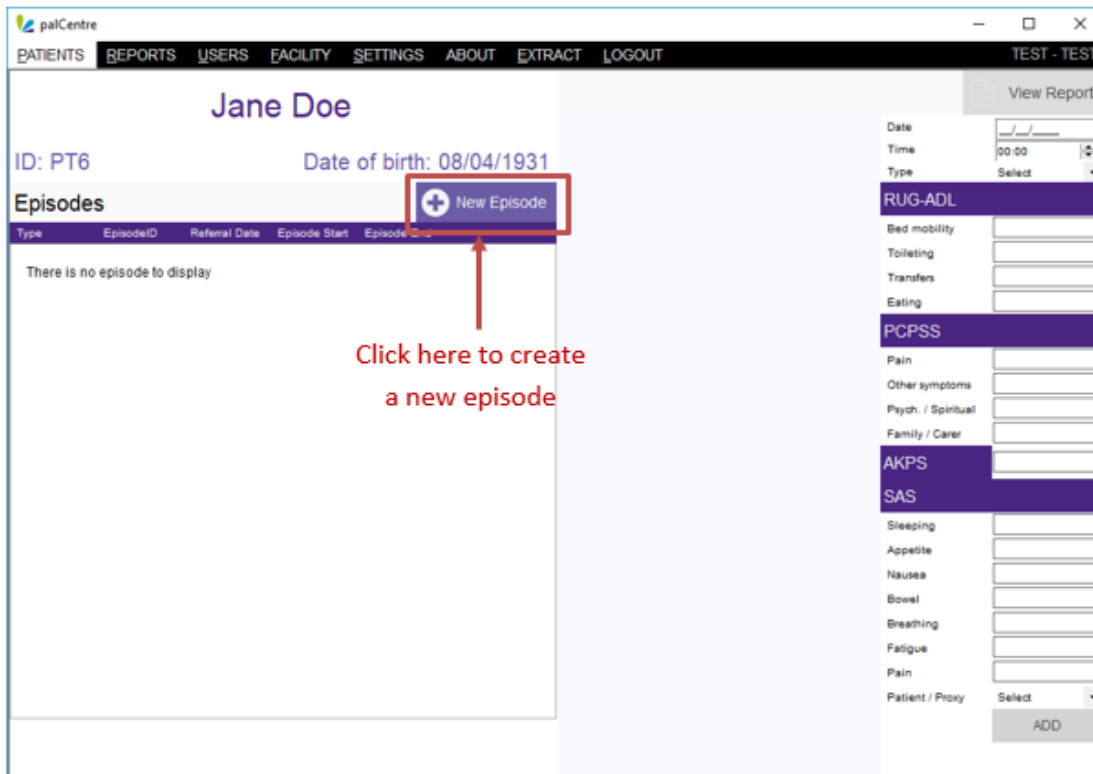
PCOC episodes cannot overlap. For the purposes of PCOC, an episode of care is defined as a continuous period of care for a patient in one setting (i.e. hospital - dedicated inpatient bed, hospital - non-dedicated inpatient bed, private residence, residential age care facility, etc.)

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:

The 'Episode Details' form is shown with the following fields:

- Episode identifier: N/A
- Episode Type: Select
- Referral Information**
 - Referral source: Select
 - Referral date (dd/mm/yyyy): __/__/__
 - First Contact Date(dd/mm/yyyy): __/__/__
 - Date Ready for Care (dd/mm/yyyy): __/__/__
- Episode Start**
 - Episode start date (dd/mm/yyyy): __/__/__
 - Episode Start Mode: [dropdown]
 - Accommodation at episode start: Select
- Episode End**
 - Episode End Date (dd/mm/yyyy): __/__/__
 - Episode End Mode: [dropdown]
 - Accommodation at episode end: Select
 - Place of death: Select

Buttons: Submit, Cancel

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 screenshot shows a web form titled "Episode Details" with the following sections and fields:

- Episode identifier:** N/A
- Episode Type:** Overnight admitted - Designated Palliative Care Bed
- Team:** Team 1
- Referral Information:**
 - Referral source: Public hospital - oncology unit/team
 - Referral date (dd/mm/yyyy): 08/02/2018
 - First Contact Date(dd/mm/yyyy): 11/02/2018
 - Date Ready for Care (dd/mm/yyyy): 08/02/2018
- Episode Start:**
 - Episode start date (dd/mm/yyyy): 11/02/2018
 - Episode Start Mode: Admitted from usual accomodation
 - Accommodation at episode start: Select
- Episode End:**
 - Episode End Date (dd/mm/yyyy): _/_/_
 - Episode End Mode: Select
 - Accommodation at episode end: Select
 - Place of death: Select

At the bottom right, there are two buttons: "Submit" (highlighted with a red box) and "Cancel". A red arrow points from the text below to the "Submit" button.

Click on submit once all the information has been entered

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

The screenshot shows the palCentre interface for patient Jane Doe. The top navigation bar includes PATIENTS, REPORTS, USERS, FACILITY, SETTINGS, ABOUT, EXTRACT, and LOGOUT. The patient's name, ID (PT6), and date of birth (08/04/1931) are displayed. The 'Assessments for Episode 1' section is active, showing a 'View Report' button and input fields for Date, Time, and Type. Below this are assessment categories: RUG-ADL (Bed mobility, Toileting, Transfers, Eating), PCPSS (Pain, Other symptoms, Psych. / Spiritual, Family / Carer), AKPS, and SAS (Sleeping, Appetite, Nausea, Bowel, Breathing, Fatigue, Pain). A 'Patient / Proxy' dropdown and an 'ADD' button are at the bottom right.

The 'Episodes' section on the left contains a table with one entry highlighted by a red box:

Type	EpisodeID	Referral Date	Episode Start	Episode End
11	1	08/02/2018	11/02/2018	

A red arrow points from the text 'The episode appears in the list' to the highlighted row in the table.


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

The screenshot shows the palCentre interface for patient Jane Doe. The main header includes the patient name and 'Assessments for Episode 1'. Below this, there are fields for 'ID: PT6' and 'Date of birth: 08/04/1931'. A table titled 'Episodes' contains one entry with columns for Type, EpisodeID, Referral Date, Episode Start, and Episode End. A red box highlights a pencil icon in the 'Episode End' column of the first row. A red arrow points from this icon to the text 'Click on the pencil icon to edit the episode information'. To the right of the table is a 'New Episode' button and a 'View Report' button. Further right is a form for 'RUG-ADL' and 'PCPSS' assessments, with various input fields and a dropdown menu for 'Patient / Proxy'. An 'ADD' button is at the bottom right of the form.

Type	EpisodeID	Referral Date	Episode Start	Episode End
11	1	08/02/2018	11/02/2018	

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

Episode Details	
Episode identifier	N/A
Episode Type	Overnight admitted - Designated Palliative Care Bed
Team	Team 1
Referral Information	
Referral source	Public hospital - oncology unit/team
Referral date (dd/mm/yyyy)	08/02/2018
First Contact Date(dd/mm/yyyy)	11/02/2018
Date Ready for Care (dd/mm/yyyy)	08/02/2018
Episode Start	
Episode start date (dd/mm/yyyy)	11/02/2018
Episode Start Mode	Admitted from usual accomodation
Accommodation at episode start	Select
Episode End	
Episode End Date (dd/mm/yyyy)	___/___/___
Episode End Mode	Select
Accommodation at episode end	Select
Place of death	Select

Click on submit once all the information has been entered

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.

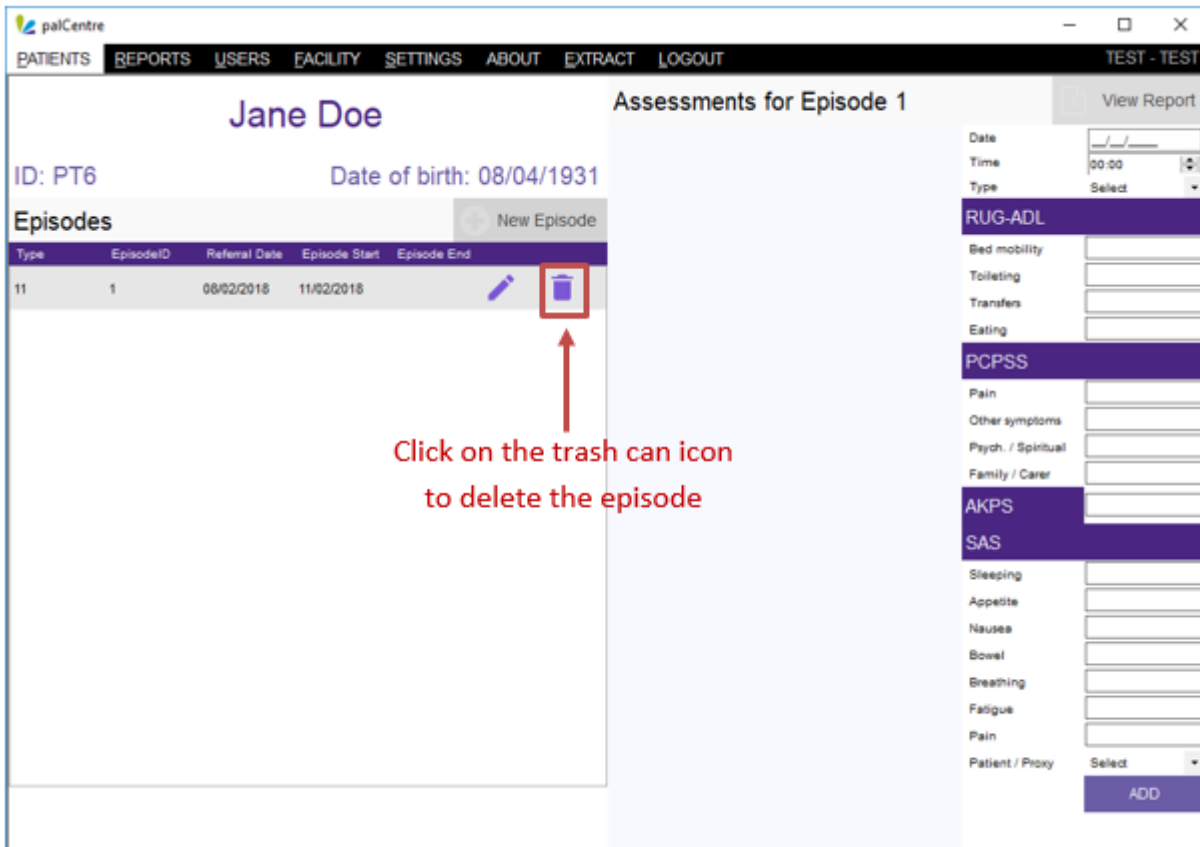
This will ensure you have minimal items on your data quality report and ensures that your episode information is as complete as possible.

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 associated assessment data, exit to the patient screen.

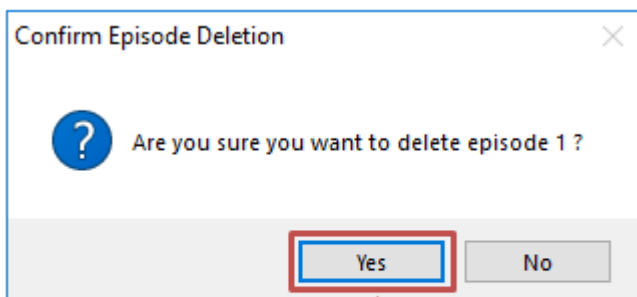
Click on the  next to the patient and the  should now be next to the episode with no assessments. Click on the .



The screenshot shows the 'Assessments for Episode 1' screen for Jane Doe. The 'Episodes' table has one row with a trash can icon highlighted by a red box and an arrow pointing to it. A red text label says 'Click on the trash can icon to delete the episode'.

Type	EpisodeID	Referral Date	Episode Start	Episode End
11	1	08/02/2018	11/02/2018	

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



The screenshot shows a 'Confirm Episode Deletion' dialog box. The dialog asks 'Are you sure you want to delete episode 1?' and has 'Yes' and 'No' buttons. The 'Yes' button is highlighted with a red box and an arrow pointing to it.

Click on yes to delete the episode

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:

- [Assessment level information vs phase level information](#)
- [Accessing the episode and assessment screen](#)
- [Entering assessment level information](#)
- [Entering phase level information](#)
- [Modifying an assessment](#)
- [Deleting an assessment](#)

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:

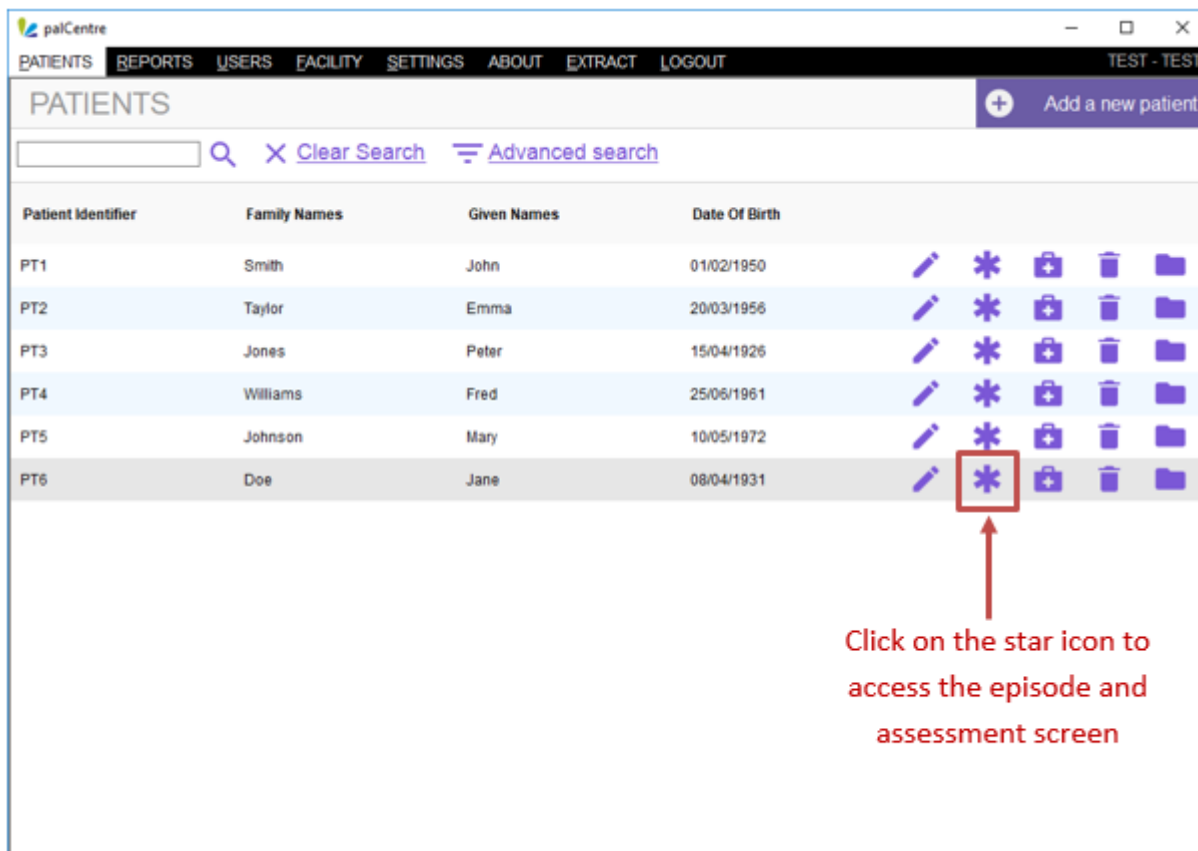
- Since only phase change data needs to be entered less time for data entry is required.
- On average each patient requires approx. 4 minutes to enter.
- A separate data entry to the assessment protocol is required to specify the entry of phase change only
- Additional training for the data entry person 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 screenshot shows the 'PATIENTS' section of the palCentre application. It includes a search bar with 'Clear Search' and 'Advanced search' options, and a table of patient records. The table has columns for Patient Identifier, Family Names, Given Names, and Date Of Birth. Each row contains a set of icons: a pencil (edit), a star (access episode and assessment), a first aid kit (add new patient), a trash can (delete), and a folder (view details). The star icon for the patient 'Doe, Jane' is highlighted with a red box and an arrow pointing to it.

Patient Identifier	Family Names	Given Names	Date Of Birth	Icons
PT1	Smith	John	01/02/1950	[Pencil] [Star] [First Aid Kit] [Trash] [Folder]
PT2	Taylor	Emma	20/03/1956	[Pencil] [Star] [First Aid Kit] [Trash] [Folder]
PT3	Jones	Peter	15/04/1926	[Pencil] [Star] [First Aid Kit] [Trash] [Folder]
PT4	Williams	Fred	25/06/1961	[Pencil] [Star] [First Aid Kit] [Trash] [Folder]
PT5	Johnson	Mary	10/05/1972	[Pencil] [Star] [First Aid Kit] [Trash] [Folder]
PT6	Doe	Jane	08/04/1931	[Pencil] [Star] [First Aid Kit] [Trash] [Folder]

Click on the star icon to access the episode and assessment screen

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.

The patient's details

Shows a report for the current episode

Episode information: This patient has 2 episodes, the one highlighted in grey is the selected episode


Assessment information: This patient has 3 assessments entered for the episode starting on the 03/01/2017

John Smith		Assessments for Episode 1			View Report																																			
ID: PT1	Date of birth: 01/02/1950	03/01/2017	04/01/2017	05/01/2017	Date																																			
Episodes <table border="1"> <thead> <tr> <th>Type</th> <th>EpisodeID</th> <th>Referral Date</th> <th>Episode Start</th> <th>Episode End</th> </tr> </thead> <tbody> <tr> <td>12</td> <td>2</td> <td>20/02/2017</td> <td>20/02/2017</td> <td>05/03/2017</td> </tr> <tr style="background-color: #e0e0e0;"> <td>11</td> <td>1</td> <td>03/01/2017</td> <td>03/01/2017</td> <td>06/01/2017</td> </tr> </tbody> </table>		Type	EpisodeID	Referral Date	Episode Start	Episode End	12	2	20/02/2017	20/02/2017	05/03/2017	11	1	03/01/2017	03/01/2017	06/01/2017	<table border="1"> <thead> <tr> <th>Time</th> <th>Type</th> <th>03/01/2017</th> <th>04/01/2017</th> <th>05/01/2017</th> </tr> </thead> <tbody> <tr> <td>01:00</td> <td>2 - Unstable</td> <td>1</td> <td>1</td> <td>1</td> </tr> <tr> <td>02:00</td> <td>3 - Deteriorating</td> <td>1</td> <td>1</td> <td>1</td> </tr> <tr> <td>01:00</td> <td>3 - Deteriorating</td> <td>1</td> <td>1</td> <td>1</td> </tr> </tbody> </table>				Time	Type	03/01/2017	04/01/2017	05/01/2017	01:00	2 - Unstable	1	1	1	02:00	3 - Deteriorating	1	1	1	01:00	3 - Deteriorating	1	1	1
Type	EpisodeID	Referral Date	Episode Start	Episode End																																				
12	2	20/02/2017	20/02/2017	05/03/2017																																				
11	1	03/01/2017	03/01/2017	06/01/2017																																				
Time	Type	03/01/2017	04/01/2017	05/01/2017																																				
01:00	2 - Unstable	1	1	1																																				
02:00	3 - Deteriorating	1	1	1																																				
01:00	3 - Deteriorating	1	1	1																																				
RUG-ADL																																								
1	1	1	1	1	Bed mobility																																			
1	1	1	1	1	Toileting																																			
1	1	1	1	1	Transfers																																			
1	1	1	1	1	Eating																																			
PCPSS																																								
3	1	1	1	1	Pain																																			
1	1	1	0	0	Other symptoms																																			
0	0	0	0	0	Psych. / Spiritual																																			
0	0	0	1	1	Family / Carer																																			
50	50	50	50	50	AKPS																																			
SAS																																								
0	0	0	0	0	Sleeping																																			
0	0	0	0	0	Appetite																																			
0	0	0	0	0	Nausea																																			
0	0	0	0	0	Bowel																																			
2	1	1	1	1	Breathing																																			
5	3	4	4	4	Fatigue																																			
8	5	4	4	4	Pain																																			

Assessment level information can only be 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	pt	pt	pt	pt																
Use codes = Pt, FC, Cl																				
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 assesment. 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.

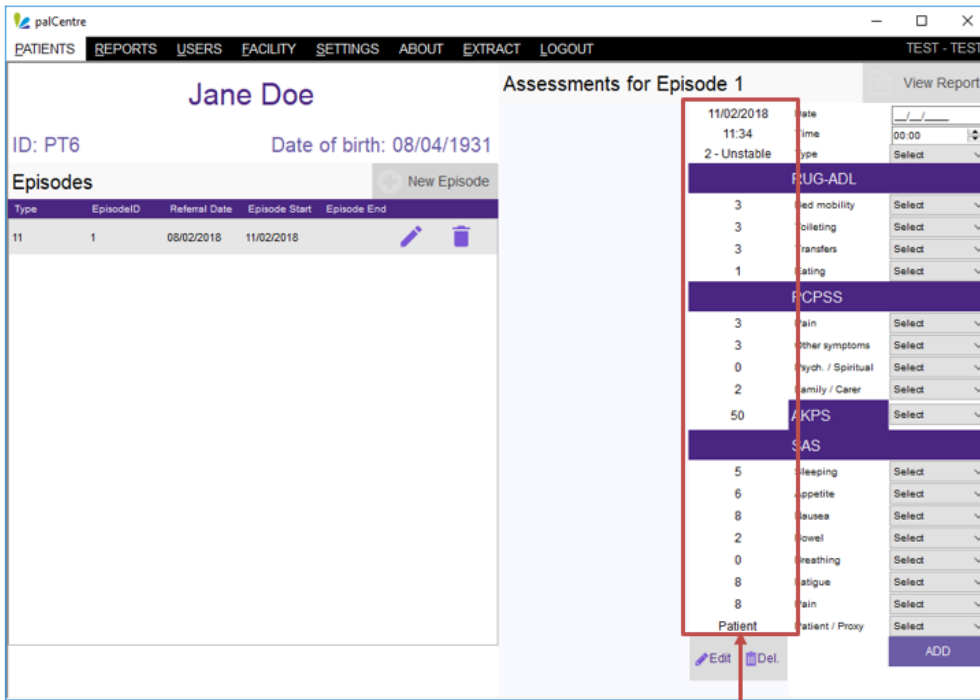
The screenshot shows the 'Assessments for Episode 1' screen in the palCentre application. The patient's name is Jane Doe, ID: PT6, and her date of birth is 08/04/1931. The assessment form is populated with the following data:

- Date: 11/02/2018
- Time: 11:24
- Type: 2 - Unstable
- RUG-ADL:
 - Bed mobility: 3 - Limited phys
 - Toileting: 3 - Limited phys
 - Transfers: 3 - Limited phys
 - Eating: 1 - Independant
- PCPSS:
 - Pain: 3 - Severe
 - Other symptoms: 3 - Severe
 - Psych / Spiritual: 0 - Absent
 - Family / Carer: 2 - Moderate
- AKPS: 50 - Requires cc
- SAS:
 - Sleeping: 5
 - Appetite: 6
 - Nausea: 8
 - Bowel: 2
 - Breathing: 0 - Not at all
 - Fatigue: 8
 - Pain: 8
- Patient / Proxy: Patient

A red box highlights the 'ADD' button at the bottom of the form, with a red arrow pointing to it from the text below.

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

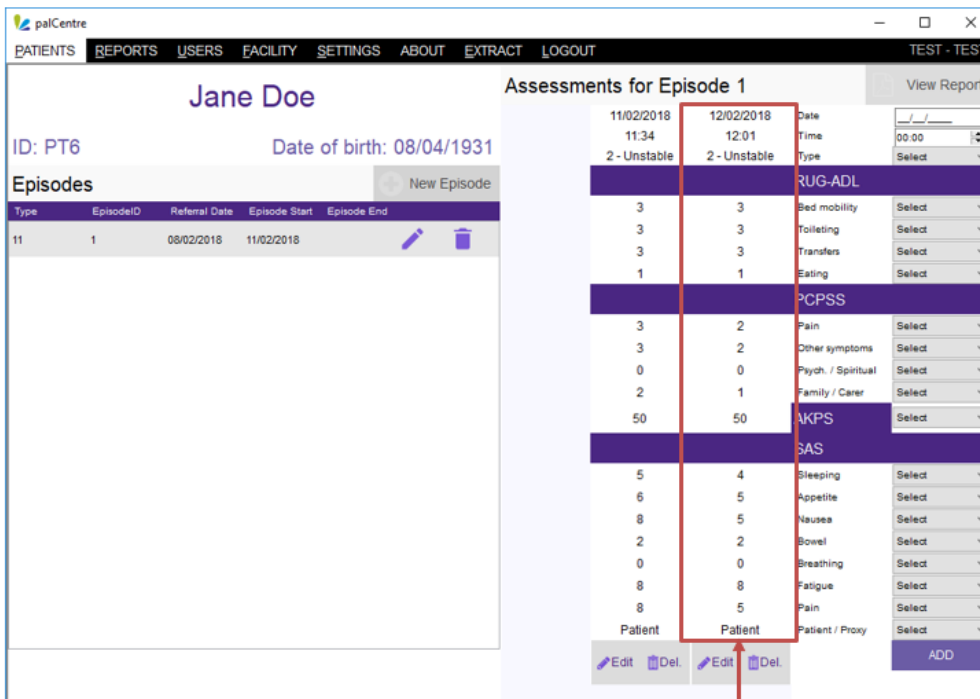
Once the assessment information has been added, it will appear on the left hand side of the assessment data entry screen as below.



The assessment that has been added appears here

Entering 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.



The second assessment that has been added appears here

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

All 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.

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					(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													
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														
Symptom Assessment Scale (0-10) Rate experience of symptom distress over a 24hr period 0 = Continue care 1-3 = Monitor and record 4-7 = Review/change plan of care; referral, intervention as required 8-10 = Urgent action 0 = absent 10 = worst possible																			
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		pt	pt	pt	pt														
Use codes = Pt, FC, CI																			
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.

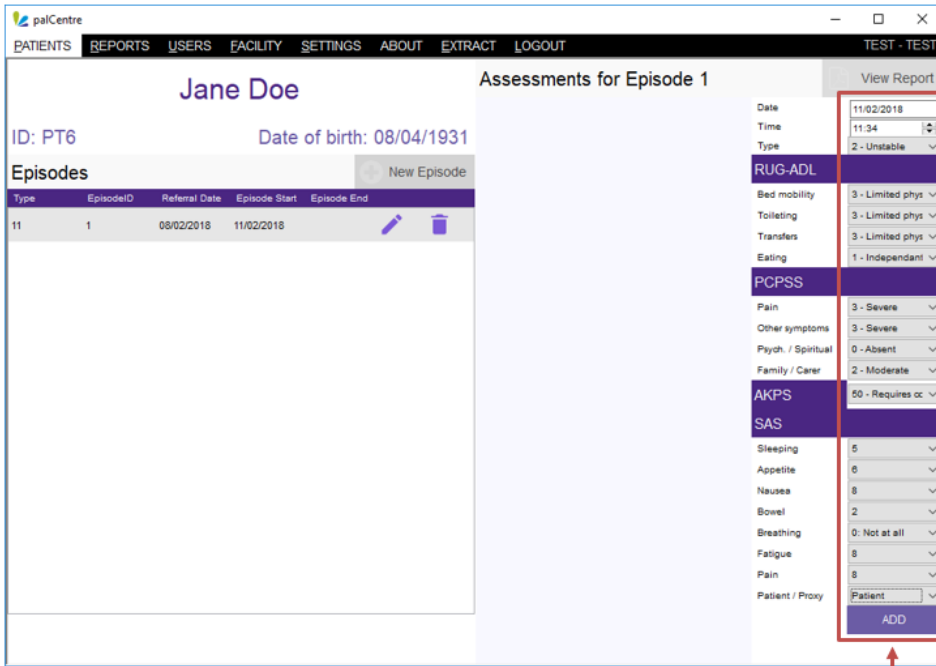
If a patient dies with your service, no final assessment is required.

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:

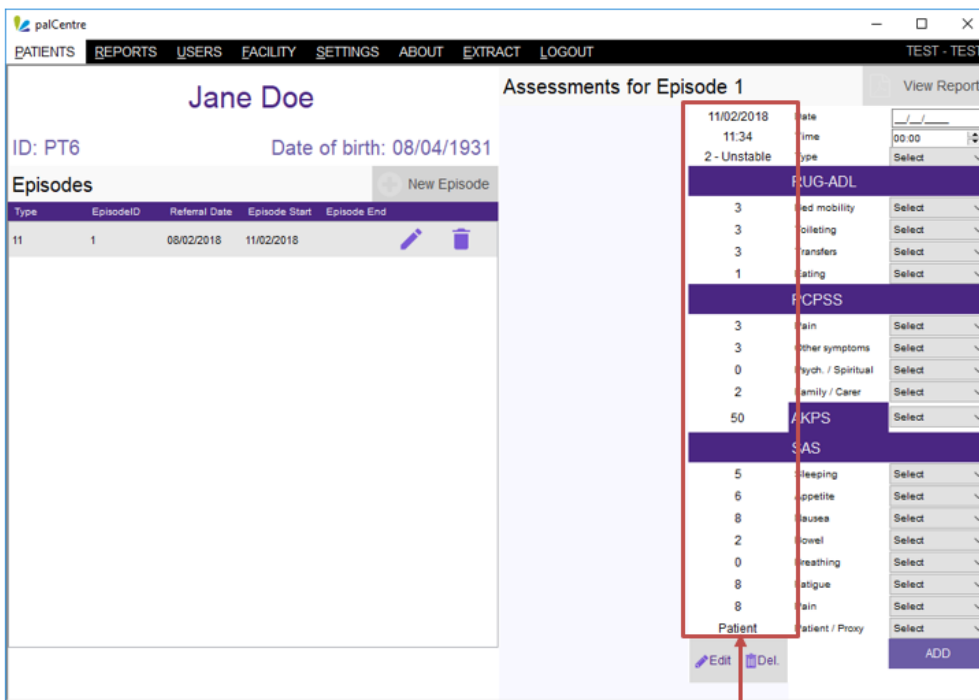
Item to be entered	Additional information
Date	The date the assessment was completed. This is a mandatory item - you cannot submit an assessment without this information.
Time	Optional field. The time of the assessment
Type	The phase type for the assessment. This is a mandatory item - you cannot submit 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.

The screenshot shows the 'Assessments for Episode 1' section of the palCentre interface. The patient is Jane Doe (ID: PT6, Date of birth: 08/04/1931). The interface displays a table of assessments with columns for Date, Time, and Type. A red box highlights the entry for 13/02/2018 at 10:58, which is a phase change assessment. Below the table, there are 'Edit' and 'Del.' buttons for each assessment, and an 'ADD' button at the bottom right.

Date	Time	Type
11/02/2018	11:34	2 - Unstable
13/02/2018	10:58	1 - Stable

The phase change assessment that has been added appears here

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.

The screenshot shows the 'Assessments for Episode 1' section of the palCentre interface. The patient's name is Jane Doe, ID: PT6, and date of birth is 08/04/1931. The 'Episodes' table shows one episode starting on 08/02/2018 and ending on 11/02/2018. The 'Assessments for Episode 1' table is as follows:

	11/02/2018	13/02/2018	14/02/2018		
	11:34	10:58	11:02	Date	MM/DD/YYYY
	2 - Unstable	1 - Stable	1 - Stable	Time	00:00
				Type	Select
RUG-ADL					
3	3	3	Bed mobility	Select	▼
3	3	3	Toileting	Select	▼
3	3	3	Transfers	Select	▼
1	1	1	Eating	Select	▼
PCPSS					
3	1	1	Pain	Select	▼
3	1	1	Other symptoms	Select	▼
0	0	0	Psych. / Spiritual	Select	▼
2	1	1	Family / Carer	Select	▼
50	50	50		Select	▼
AKPS					
SAS					
5	4	4	Sleeping	Select	▼
6	5	4	Appetite	Select	▼
8	3	3	Nausea	Select	▼
2	1	1	Bowel	Select	▼
0	0	0	Breathing	Select	▼
8	5	4	Fatigue	Select	▼
8	2	2	Pain	Select	▼
			Patient / Proxy	Select	▼

At the bottom of the assessment table, there are three 'Patient' entries, each with 'Edit' and 'Del.' buttons. An 'ADD' button is located at the bottom right of the assessment section.

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

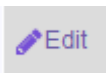
You have now added all the assessment for this episode.

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 **Edit** button below the assessment you wish to change.

Click on edit to change an assessment record

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 screenshot shows the 'Assessments for Episode 1' section for Jane Doe. The interface includes a navigation menu at the top, patient information on the left, and a table of assessments on the right. A red box highlights the 'Del.' button at the bottom of the assessment table.

Date	Time	Type	Assessment	Value
11/02/2018	11:34	2 - Unstable	RUG-ADL	3
13/02/2018	10:58	1 - Stable	RUG-ADL	3
14/02/2018	11:02	1 - Stable	RUG-ADL	3
			Bed mobility	3
			Toileting	3
			Transfers	3
			Eating	1
			PCPSS	3
			Pain	1
			Other symptoms	1
			Psych. / Spiritual	0
			Family / Carer	2
			AKPS	50
			SAS	5
			Sleeping	4
			Appetite	5
			Nausea	3
			Bowel	1
			Breathing	0
			Fatigue	8
			Pain	5
			Pain / Proxy	2

Click on the delete button to delete and assessment

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

WARNING! Deleting an assessment

Are you sure you want to delete this assessment? Press YES to delete the assessment. Press NO to cancel deletion

Yes No

Click on yes to delete the assessment

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:

- [Profile collection overview](#)
- [Accessing the profile screen](#)
- [Creating a profile instance](#)
- [Editing a profile instance](#)
- [Deleting an profile instance](#)

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.

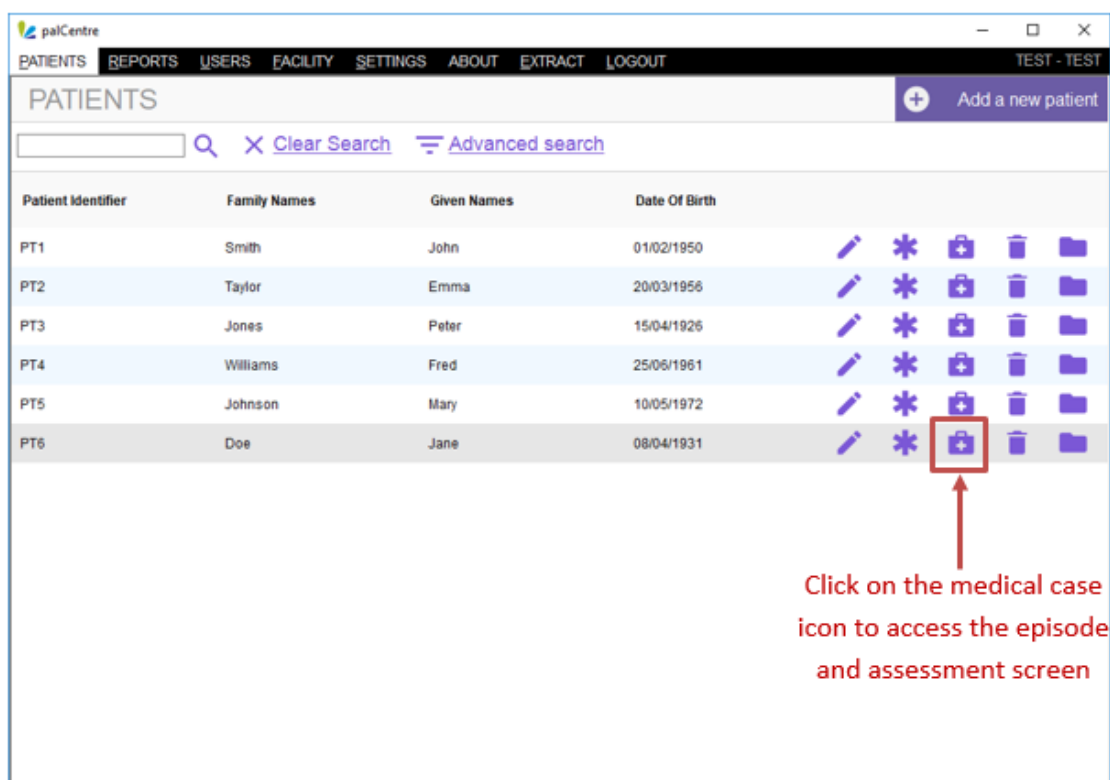
The profile data collection is separate from the outcome data collection. A single patient can have both outcome collection data and profile instances.

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.



Patient Identifier	Family Names	Given Names	Date Of Birth					
PT1	Smith	John	01/02/1950					
PT2	Taylor	Emma	20/03/1956					
PT3	Jones	Peter	15/04/1926					
PT4	Williams	Fred	25/06/1961					
PT5	Johnson	Mary	10/05/1972					
PT6	Doe	Jane	08/04/1931					

Click on the medical case icon to access the episode and assessment screen

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.

The patient's details

Name	ID	PT1	Date of Birth
John Smith	PT1		01/02/1950

Profile ID	Date	Phase type	Patient present
1	06/10/2018	Stable	Yes
3	18/08/2018	Deteriorating	Yes
2	20/07/2018	Deteriorating	Yes

SAS	
Sleeping	0
Appetite	0
Nausea	0
Bowel	1
Breathing	2
Fatigue	4
Pain	1

PCPSS	
Pain	1
Other Symptoms	2
Psych/Spiritual	0
Family/Carer	1

AKPS	
AKPS	60

RUG-ADL	
Bed Mobility	3
Toileting	3
Transfers	3
Eating	9

Profile instances: This patient has 3 profile assessments, the one highlighted in grey is the selected instance

Assessment information: This is the assessment data for the highlighted profile instance on 18/08/2018

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.

Create a new profile instance

The screenshot shows the 'palCentre' interface with a navigation menu at the top: PATIENTS, REPORTS, USERS, FACILITY, SETTINGS, ABOUT, EXTRACT, LOGOUT, and TEST - TEST. The main heading is 'PROFILES'. Below the heading, there is a patient summary: Name Jane Doe, ID PT6, Date of Birth 08/04/1931. A table with columns 'Profile ID', 'Date', 'Phase type', and 'Patient present' is currently empty. To the right of the table are several purple header boxes for assessment categories: SAS (Sleeping, Appetite, Nausea, Bowel, Breathing, Fatigue, Pain), PCPSS (Pain, Other Symptoms, Psych/Spiritual, Family/Carer), AKPS (AKPS), and RUG-ADL (Bed Mobility, Toileting, Transfers, Eating). In the top right corner, a purple button with a plus sign and the text 'Add new profile' is highlighted with a red box. A red arrow points from the text 'Create a new profile instance' above to this button.

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

The screenshot shows the 'Profile details' data entry form, titled 'Edit profile details'. The form is organized into several sections. On the left, there are dropdown menus for 'Team', 'Collection stream', 'Referral date' (with a calendar icon), 'Primary referral reason', 'Referring service type', 'Assessment date' (with a calendar icon), 'Assessment location', 'Assessment mode', and 'Patient present for assessment'. Below these are checkboxes for 'Patient / family issues at assessment' including Symptom management, Discharge planning, Introduction to palliative care / early referral, Family / carer support, Co-ordination of care, Psychological / spiritual, Terminal / end of life care, Advanced care planning, Equipment, After hours support, and Other. There is also a dropdown for 'Advanced care plan in place'. The bottom left section, 'Action arising from assessment', includes checkboxes for Patient to receive inpatient specialist palliative care, Patient to receive community / outpatient palliative care, Patient to receive care from GP, Patient to receive other specialist medical care, Patient to receive residential aged care, Advanced Care Plan to be developed, Don't know, and Other. A 'Planned followup' dropdown is at the bottom left. On the right side, there are several purple header boxes for assessment categories: SAS (Sleeping, Appetite, Nausea, Bowel, Breathing, Fatigue, Pain, Assessment completed by), PCPSS (Pain, Other Symptoms, Psych/Spiritual, Family/Carer), AKPS (AKPS), and RUG-ADL (Bed Mobility, Toileting, Transfers, Eating, Phase Type). A 'Submit' button is located at the bottom center of the form.

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	<p>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).</p> <p>There is also a field to capture if the patient or a proxy completed these assessments.</p>
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 screenshot shows a web application window titled "Profile details" with a sub-header "Edit profile details". The form is organized into several sections:

- Profile identifier:** Team (Select), Collection stream (Specialist palliative car), Referral date (24/10/2018), Primary referral reason (Symptom management), Referring service type (Medical oncology), Assessment date (25/10/2018), Assessment location (Inpatient non-palliative), Assessment mode (In person), Patient present for assessment (Yes).
- Patient / family issues at assessment:** Symptom management, Discharge planning, Introduction to palliative care / early referral, Family / carer support, Co-ordination of care, Psychological / spiritual, Terminal / end of life care, Advanced care planning, Equipment, After hours support, Other.
- Advanced care plan in place:** No.
- Action arising from assessment:** Patient to receive inpatient specialist palliative care, Patient to receive community / outpatient palliative care, Patient to receive care from GP, Patient to receive other specialist medical care, Patient to receive residential aged care, Advanced Care Plan to be developed, Don't know, Other.
- Planned followup:** Yes.
- SAS:** Sleeping (0: Not at all), Appetite (0: Not at all), Nausea (0: Not at all), Bowel (1), Breathing (0: Not at all), Fatigue (5), Pain (6), Assessment completed by (Patient).
- PCPSS:** Pain (2 - Moderate), Other Symptoms (1 - Mild), Psych/Spiritual (0 - Absent), Family/Carer (1 - Mild).
- AKPS:** AKPS (40 - In bed more).
- RUG-ADL:** Bed Mobility (3 - Limited physik), Toileting (3 - Limited physik), Transfers (3 - Limited physik), Eating (2 - Limited assis), Phase Type: (3 - Deteriorating).

A red rectangular box highlights the "Submit" button at the bottom of the form. A red arrow points upwards from the text "Click on Submit when all the information has been entered" to the "Submit" button.

Click on Submit when all the information has been entered

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

The screenshot shows the 'palCentre' application interface. At the top, there is a navigation bar with 'PATIENTS', 'REPORTS', 'USERS', 'FACILITY', 'SETTINGS', 'ABOUT', 'EXTRACT', and 'LOGOUT'. The current page is titled 'PROFILES' and includes an 'Add new profile' button. Below the header, patient information is displayed: Name Jane Doe, ID PT6, Date of Birth 08/04/1931. A table lists profile instances with columns for Profile ID, Date, Phase type, and Patient present. The first instance (ID 4, Date 25/10/2018, Phase type Deteriorating, Patient present Yes) is highlighted with a red box and an arrow pointing to it from the text 'The profile instance will appear on the screen'. To the right of the table, there are several assessment score sections: SAS (Sleeping: 0, Appetite: 0, Nausea: 0, Bowel: 1, Breathing: 0, Fatigue: 5, Pain: 6), PCPSS (Pain: 2, Other Symptoms: 1, Psych/Spiritual: 0, Family/Carer: 1), AKPS (AKPS: 40), and RUG-ADL (Bed Mobility: 3, Toileting: 3, Transfers: 3, Eating: 2).

Profile ID	Date	Phase type	Patient present
4	25/10/2018	Deteriorating	Yes

SAS

Sleeping	0
Appetite	0
Nausea	0
Bowel	1
Breathing	0
Fatigue	5
Pain	6

PCPSS

Pain	2
Other Symptoms	1
Psych/Spiritual	0
Family/Carer	1

AKPS


AKPS	40
------	----

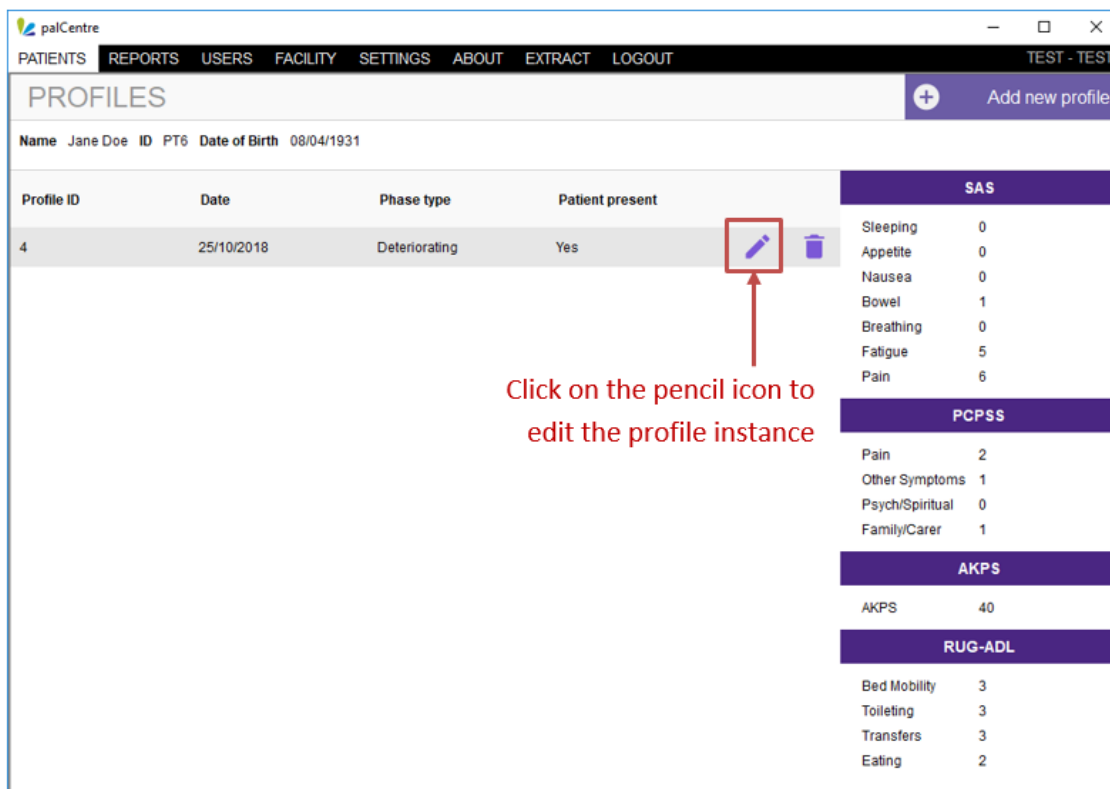
RUG-ADL

Bed Mobility	3
Toileting	3
Transfers	3
Eating	2

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.



The screenshot shows the 'PROFILES' section of the palCentre application. At the top, there is a navigation bar with 'PATIENTS', 'REPORTS', 'USERS', 'FACILITY', 'SETTINGS', 'ABOUT', 'EXTRACT', and 'LOGOUT'. Below this, the patient's name 'Jane Doe' and ID 'PT6' are displayed. A table lists profile instances with columns for 'Profile ID', 'Date', 'Phase type', and 'Patient present'. The first instance has ID '4', date '25/10/2018', phase type 'Deteriorating', and 'Patient present' 'Yes'. A red box highlights a pencil icon next to this instance, with a red arrow pointing to it and the text 'Click on the pencil icon to edit the profile instance'. To the right of the table, there are several scorecards: 'SAS' (Sleeping: 0, Appetite: 0, Nausea: 0, Bowel: 1, Breathing: 0, Fatigue: 5, Pain: 6), 'PCPSS' (Pain: 2, Other Symptoms: 1, Psych/Spiritual: 0, Family/Carer: 1), 'AKPS' (AKPS: 40), and 'RUG-ADL' (Bed Mobility: 3, Toileting: 3, Transfers: 3, Eating: 2).

Profile ID	Date	Phase type	Patient present
4	25/10/2018	Deteriorating	Yes

SAS

Sleeping	0
Appetite	0
Nausea	0
Bowel	1
Breathing	0
Fatigue	5
Pain	6

PCPSS

Pain	2
Other Symptoms	1
Psych/Spiritual	0
Family/Carer	1

AKPS

AKPS	40
------	----

RUG-ADL

Bed Mobility	3
Toileting	3
Transfers	3
Eating	2

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

Edit profile details

Profile identifier

Team: Select

Collection stream: Specialist palliative car

Referral date: 24/10/2018

Primary referral reason: Symptom management

Referring service type: Medical oncology

Assessment date: 25/10/2018

Assesment location: Inpatient non-palliative

Assessment mode: In person

Patient present for assesment: Yes

Patient / family issues at assessment:

- Symptom management
- Discharge planning
- Introduction to palliative care / early referral
- Family / carer support
- Co-ordination of care
- Psychological / spiritual
- Terminal / end of life care
- Advanced care planning
- Equipment
- After hours support
- Other

Advanced care plan in place: No

Action arising from assessment:

- Patient to receive inpatient specialist palliative care
- Patient to receive community / outpatient palliative care
- Patient to receive care from GP
- Patient to receive other specialist medical care
- Patient to receive residential aged care
- Advanced Care Plan to be developed
- Don't know
- Other

Planned followup: Yes

SAS

Sleeping: 0 - Not at all

Appetite: 0 - Not at all

Nausea: 0 - Not at all

Bowel: 1

Breathing: 0 - Not at all

Fatigue: 5

Pain: 6

Assessment completed by: Patient

PCPSS

Pain: 2 - Moderate

Other Symptoms: 1 - Mild

Psych/Spiritual: 0 - Absent

Family/Carer: 1 - Mild

AKPS

AKPS: 40 - In bed more

RUG-ADL

Bed Mobility: 3 - Limited physic

Toileting: 3 - Limited physic

Transfers: 3 - Limited physic

Eating: 2 - Limited assis

Phase Type: 3 - Deteriorating


Submit

Click on Submit once any changes have been made

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.

The screenshot shows the 'PROFILES' page in the palCentre application. At the top, there is a navigation bar with 'PATIENTS', 'REPORTS', 'USERS', 'FACILITY', 'SETTINGS', 'ABOUT', 'EXTRACT', and 'LOGOUT'. Below this, the page title 'PROFILES' is displayed, along with a '+ Add new profile' button. The main content area shows a table of profile instances for 'Jane Doe' (ID PT6, Date of Birth 08/04/1931). The table has columns for 'Profile ID', 'Date', 'Phase type', and 'Patient present'. One instance is listed with Profile ID 4, Date 25/10/2018, Phase type Deteriorating, and Patient present Yes. To the right of the table, there are several scorecards: SAS (Sleeping: 0, Appetite: 0, Nausea: 0, Bowel: 1, Breathing: 0, Fatigue: 5, Pain: 6), PCPSS (Pain: 2, Other Symptoms: 1, Psych/Spiritual: 0, Family/Carer: 1), AKPS (AKPS: 40), and RUG-ADL (Bed Mobility: 3, Toileting: 3, Transfers: 3, Eating: 2). A red box highlights the trash can icon in the 'Patient present' column for the first instance, with a red arrow pointing to it. A red text box below the icon says 'Click on the trash can icon to delete the profile instance'.

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

The screenshot shows a 'Confirm Profile Deletion' dialog box. The dialog has a title bar with a close button (X). Inside the dialog, there is a question mark icon and the text 'Are you sure you want to delete profile 4?'. At the bottom of the dialog, there are two buttons: 'Yes' and 'No'. The 'Yes' button is highlighted with a red box, and a red arrow points to it from below.

Click on yes to delete the profile instance

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:

The screenshot shows the 'epiCentre' interface with a navigation bar at the top containing 'PATIENTS', 'REPORTS', 'USERS', 'FACILITY', 'SETTINGS', 'ABOUT', 'EXTRACT', and 'LOGOUT'. The 'REPORTS' section is active, displaying a table of patient assessments. The table has columns for 'Name', 'Identifier', 'Diagnosis', 'Assessment', and 'Phase'. To the right of the table are two columns of scores: 'PCPSS' and 'SAS'. The 'PCPSS' column includes sub-columns for 'Pain', 'Other Symptoms', 'Psychological / Spiritual', and 'Family / Carer'. The 'SAS' column includes sub-columns for 'Sleeping', 'Appetite', 'Nausea', 'Bowels', 'Breathing', 'Fatigue', and 'Pain'. The scores are color-coded: green for absent, yellow for mild, orange for moderate, and red for severe. A 'Print Report' button is located at the top right of the table area.

Name	Identifier	Diagnosis	Assessment	Phase	PCPSS				SAS						
					Pain	Other Symptoms	Psychological / Spiritual	Family / Carer	Sleeping	Appetite	Nausea	Bowels	Breathing	Fatigue	Pain
testtest		N/A	01/12/2017	1 - Stable	1	0	0	1	0	0	1	2	0	0	1
Test Mctest	8080	Malignant	10/03/2018	3 - Deteriorating	2	2	2	2	3	3	3	3	3	3	3
Jones Jenny	x500	Not malignant	20/11/2017	2 - Unstable	3	2	0	0	0	0	4	1	6	6	8

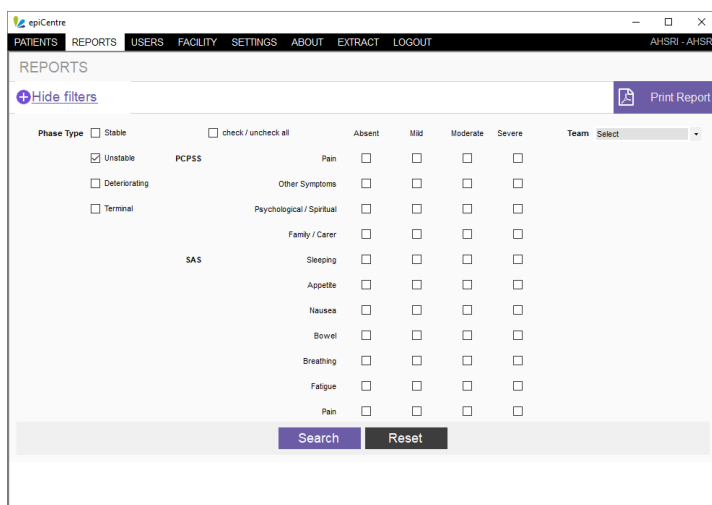
A list of patients are on the left hand side of the screen and the latest patient assessments are on the right hand side of the screen. The assessments are colour coded, absent are green, mild are yellow, moderate are orange and severe are red.

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.

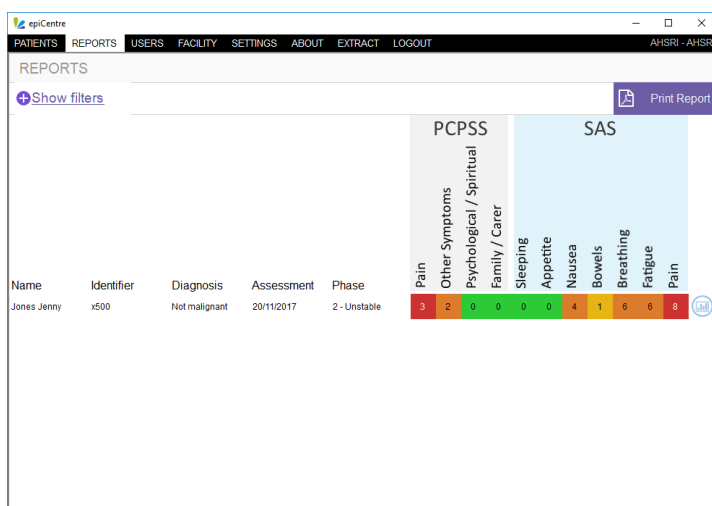
You can print an individual's patient journey by click on the blue icon next to the patient's assessment scores on the right hand side of the screen. This report will include all the patient information, current episode information and all assessment scores. This report will run and popup as a pdf file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

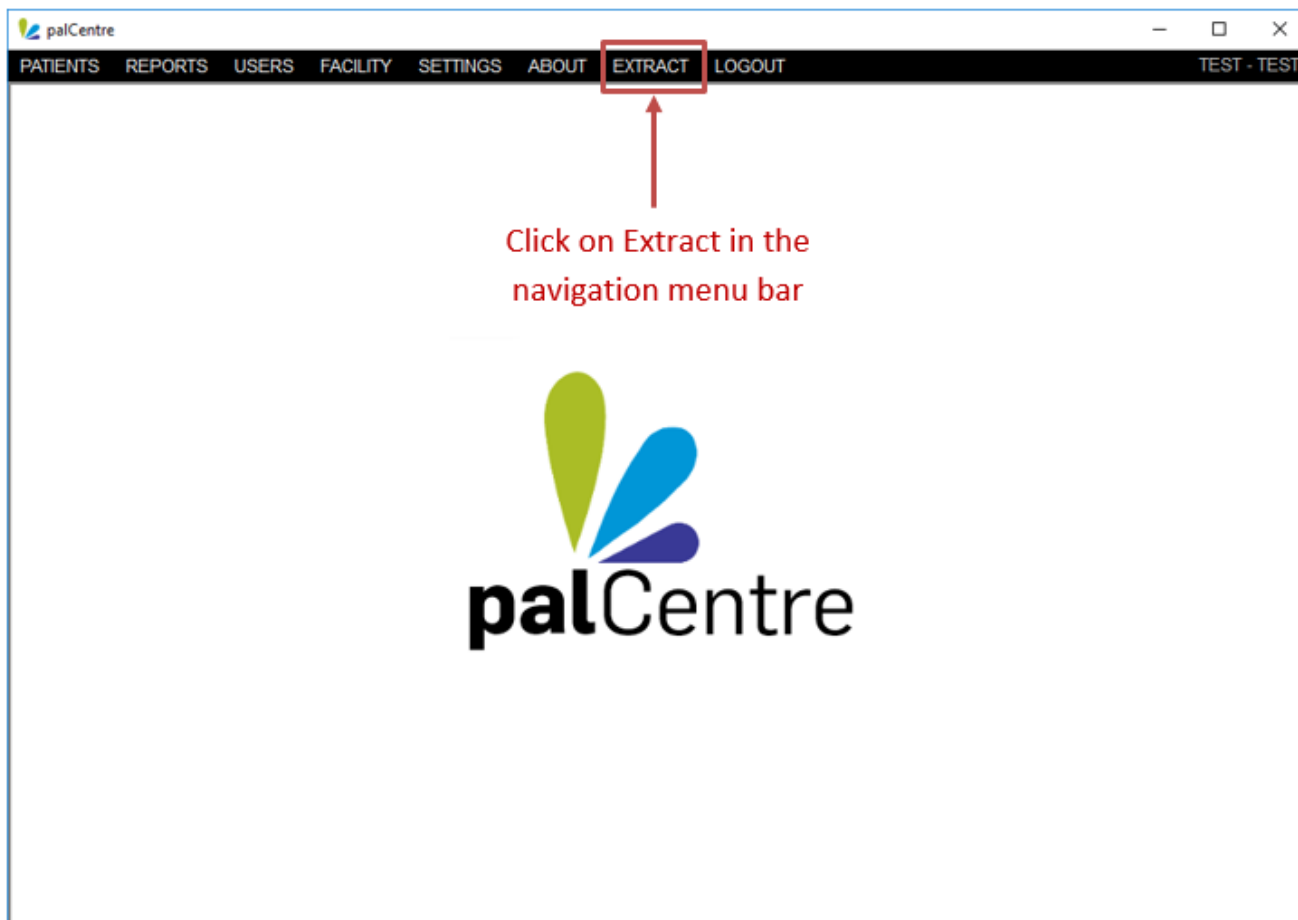
- January - February (for the previous July – December reporting period)
- July - August (for the previous January – June reporting period)

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.

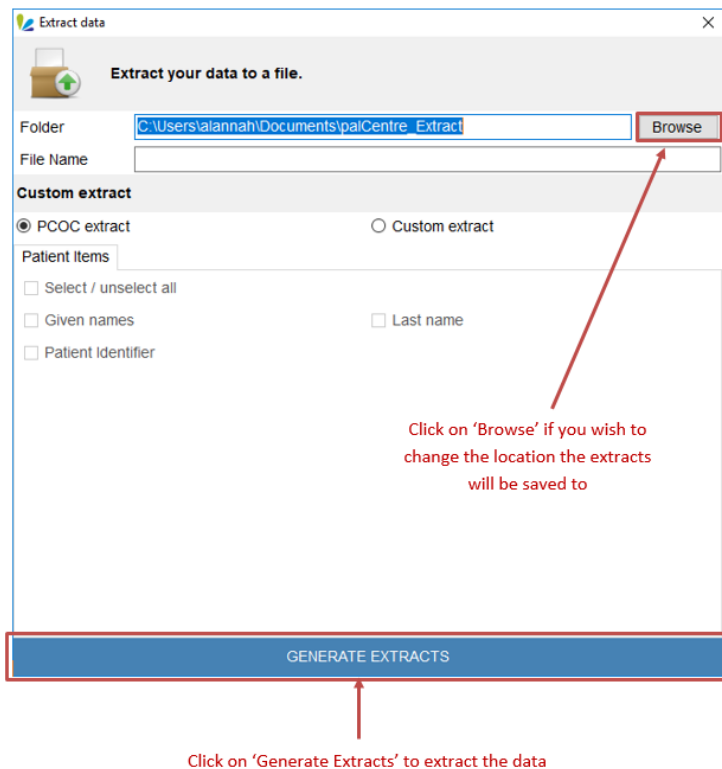
Extracting data from palCentre

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

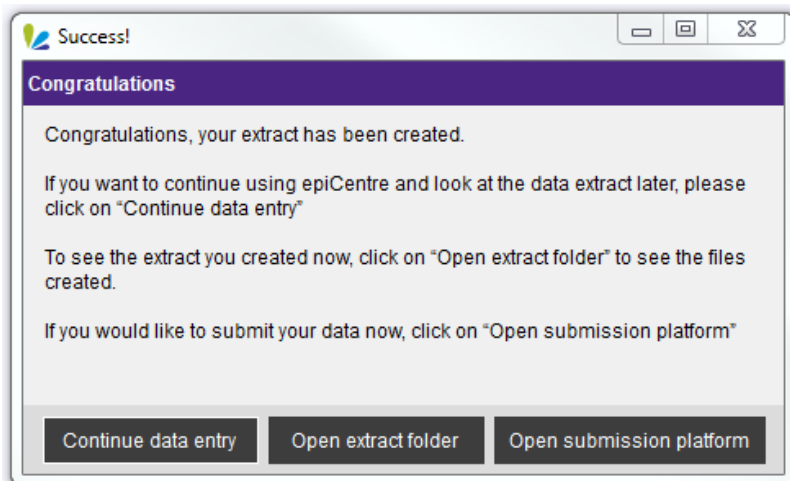


The extraction form will appear. The default extraction folder is in the 'Documents' folder on your computer. If you wish to store the extracts somewhere else, click on 'Browse'.

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

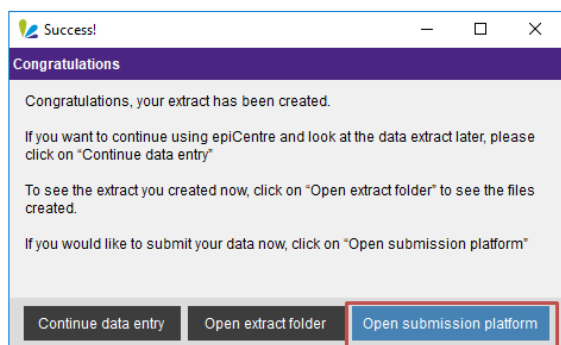


The data has now been extracted. A pop-up window as below will appear with options to continue data entry, open the extract folder or open the submission platform.



Submitting data to PCOC

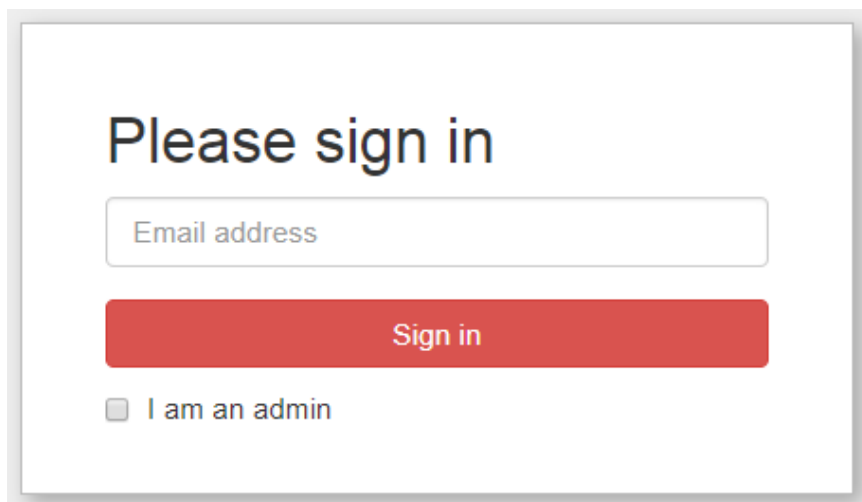
After successfully generating extracts, click on the *'Open submission platform'* button in the pop-up window.



Click on *'Open submission platform'* to submit your data to PCOC

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.



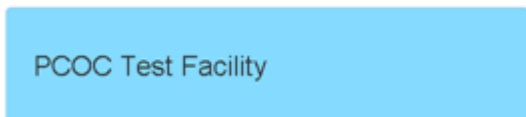
If SOS does not accept your email address, please contact Linda Foskett, PCOC Admin Officer on 02 4221 5092 or lindaf@uow.edu.au for assistance.

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



LOG OUT

Select your facility



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

Submit your files

Patient
Choose file TESTPatient2702141503.txt

Episode
Choose file No file chosen

Phase
Choose file No file chosen

Close Submit >>

Repeat this for the Episode and Phase data files.

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

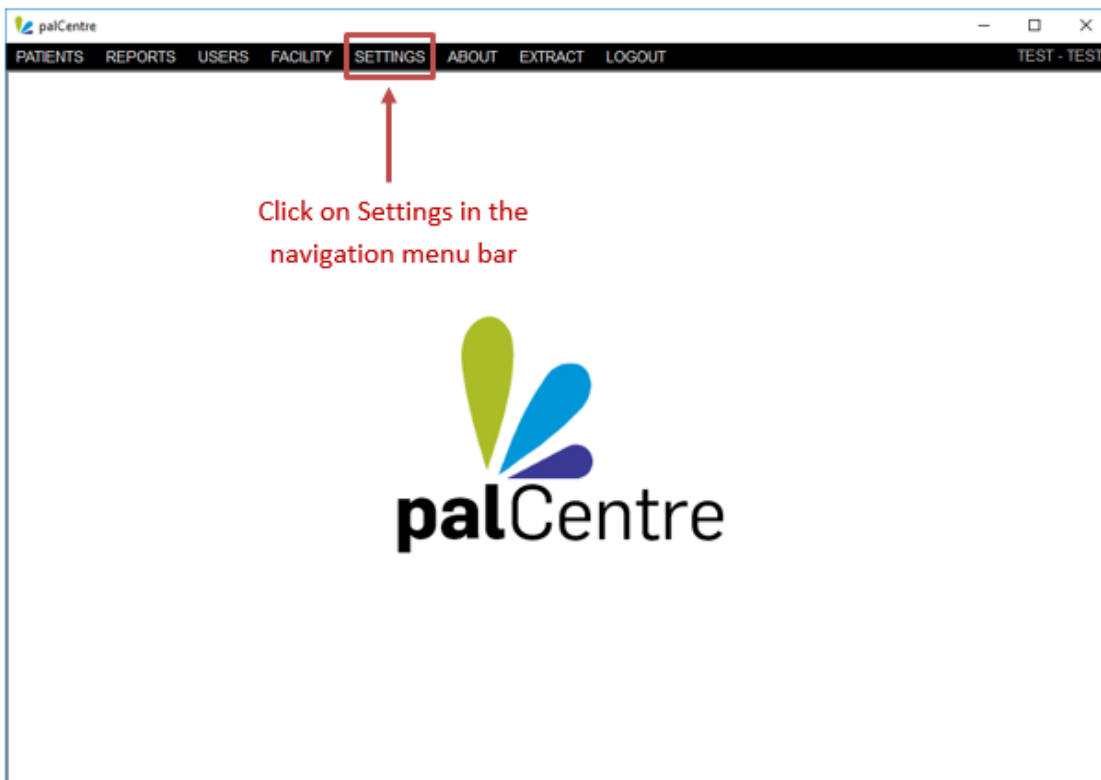
Administration options

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
- Default settings
- Adding a user
- Adding or editing a facility
- Adding a team

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.

User Settings ✕

User settings

First Name

Last Name

Username

Email

Current Password

New Password

Confirm Password

User default settings

Default team

Default episode type

Default collection stream

Enter this information and then click on submit

Your password has now been changed.

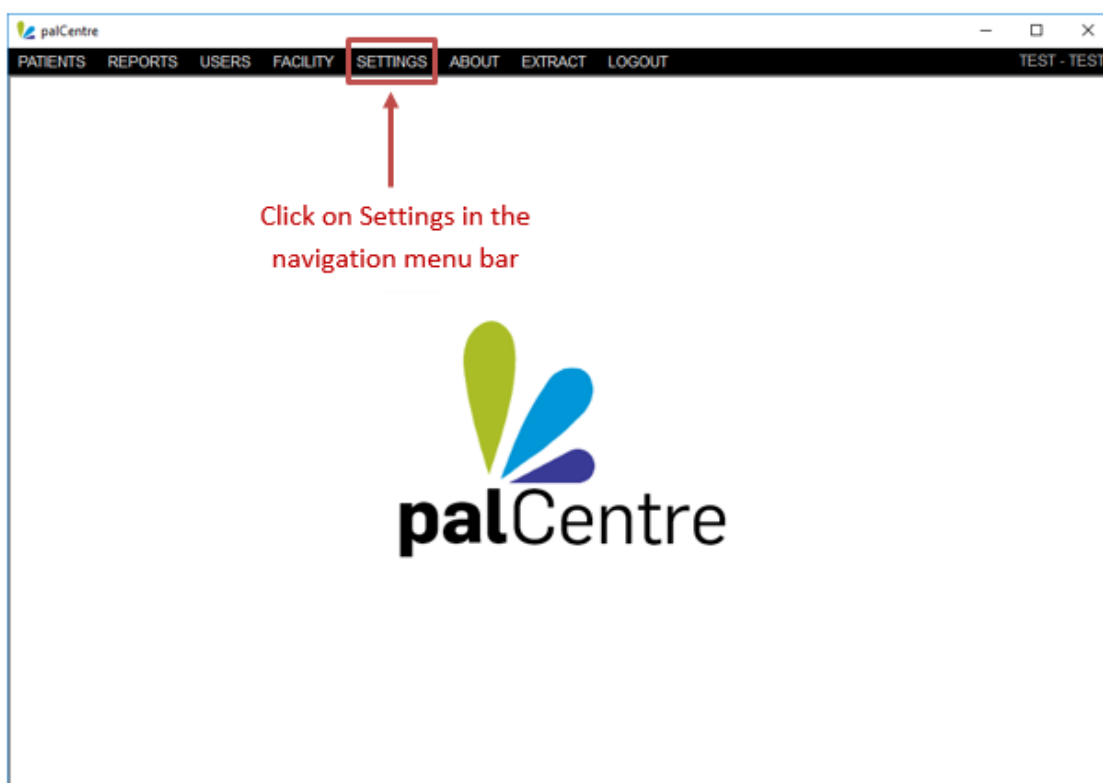
If you have forgotten your password and cannot login to palCentre, an administrator can change your password for you. If you know the administrator username and password for palCentre, you can login with this. Otherwise contact Sam Burns on (02) 4298 1141 or Alanna Connolly (02) 4221 5640 or via email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

User Settings ✕

User settings

First Name	<input type="text" value="admin"/>
Last Name	<input type="text" value="admin"/>
Username	<input type="text" value="admin"/>
Email	<input type="text" value="admin"/>
Current Password	<input type="password" value="*****"/>
New Password	<input type="password" value="*****"/>
Confirm Password	<input type="password" value="*****"/>

User default settings

Default team	<input type="text" value="Select"/>
Default episode type	<input type="text" value="Select"/>
Default collection stream	<input type="text" value="Select"/>

Submit

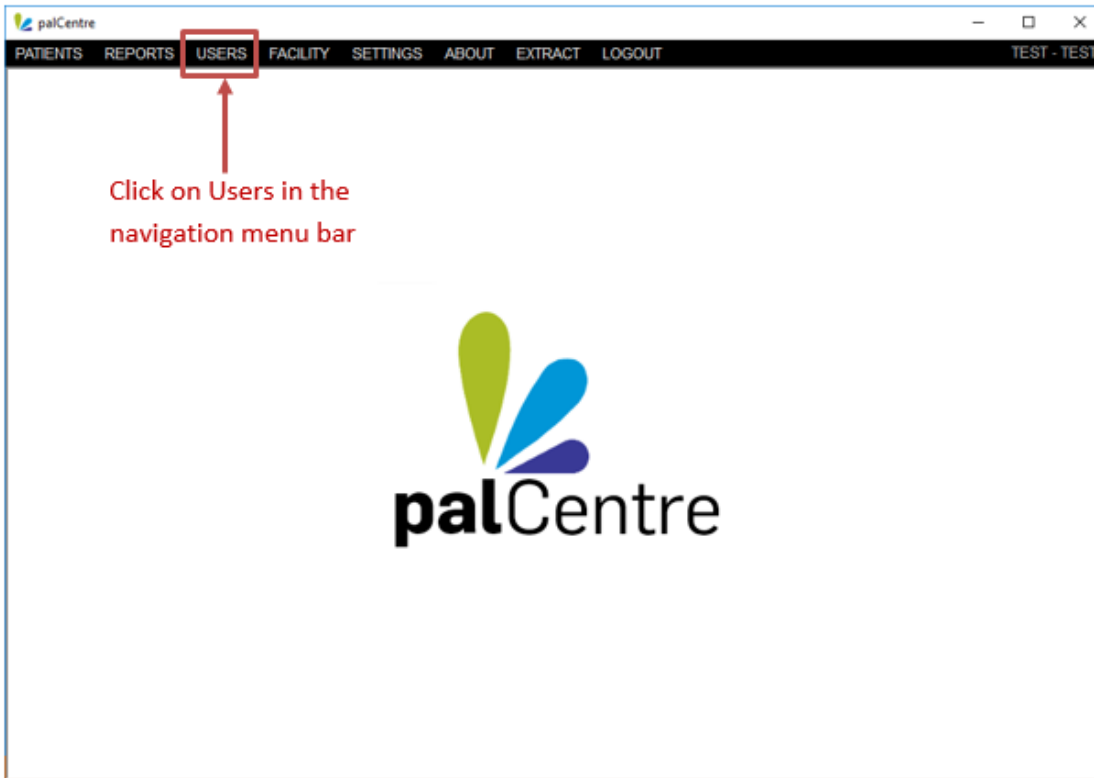
← Default the values as needed and click on submit

The defaults have now been set.

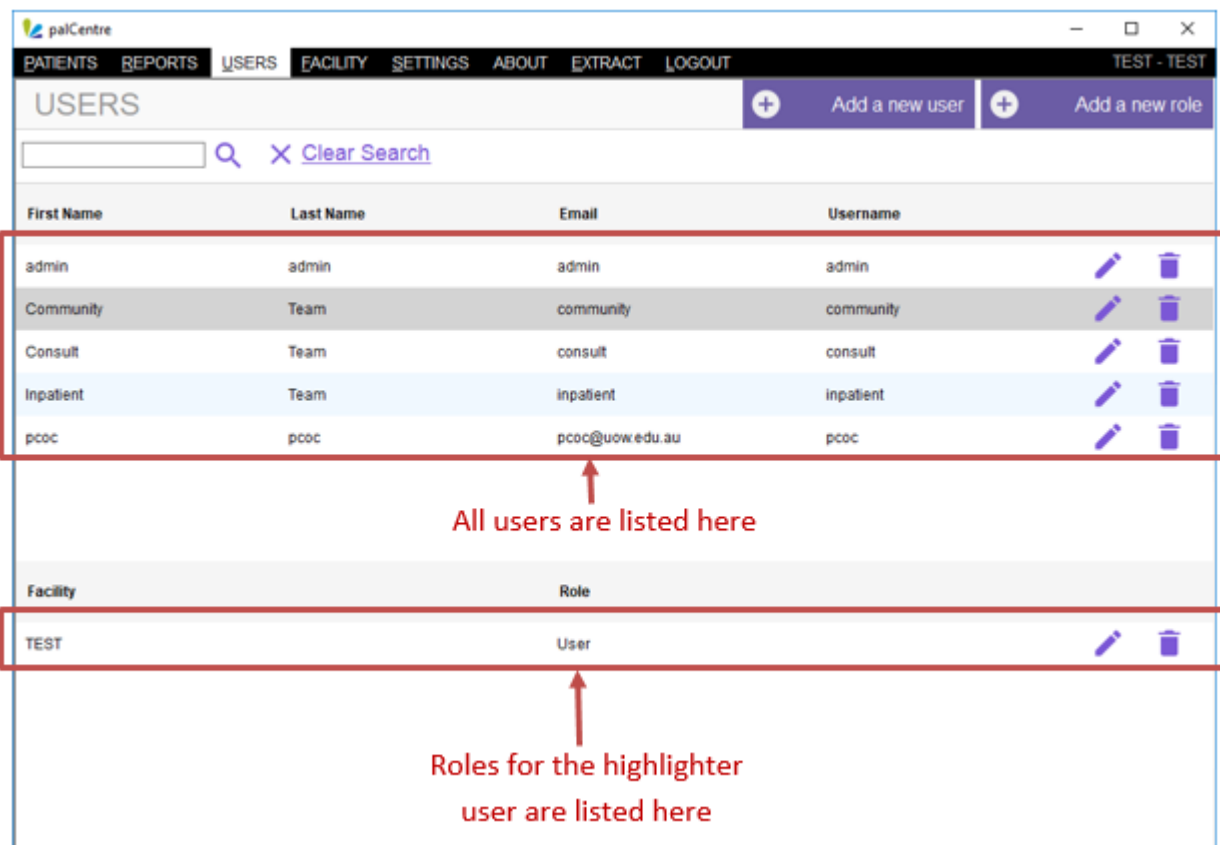
Defaults are linked to the user account in palCentre. Different users can default different values.

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:



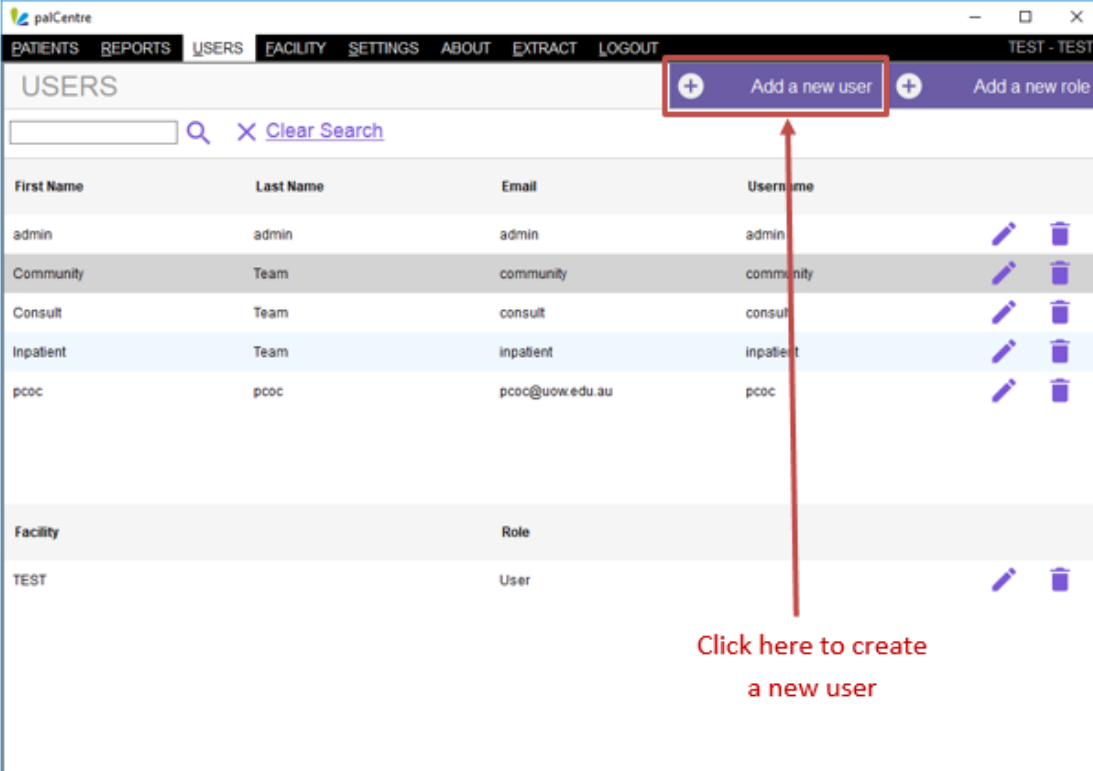
The user screen will appear. There are two sections to the user screen, The top half of the page contains a list of users and the bottom half of the screen contains the roles assigned to the selected user. At the top of the screen there is a



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

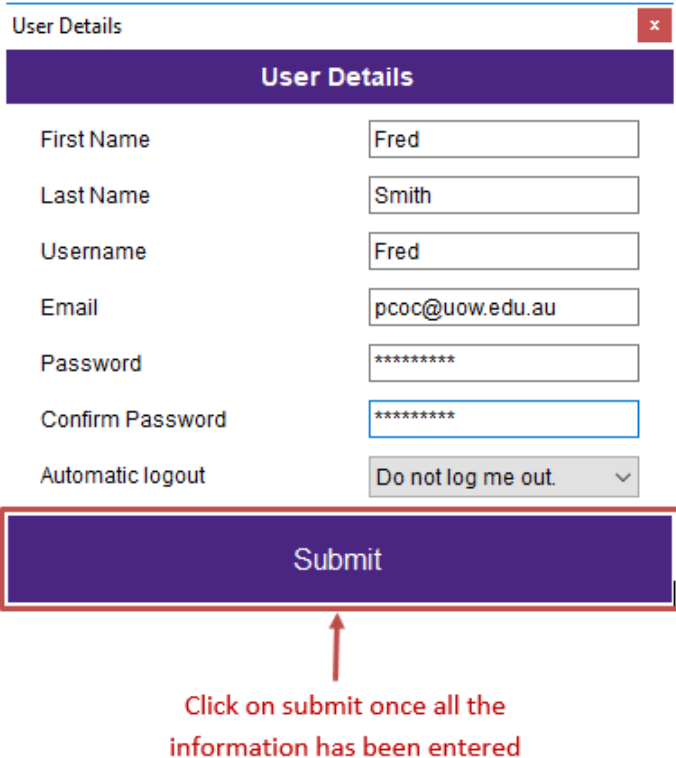
Create the user

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



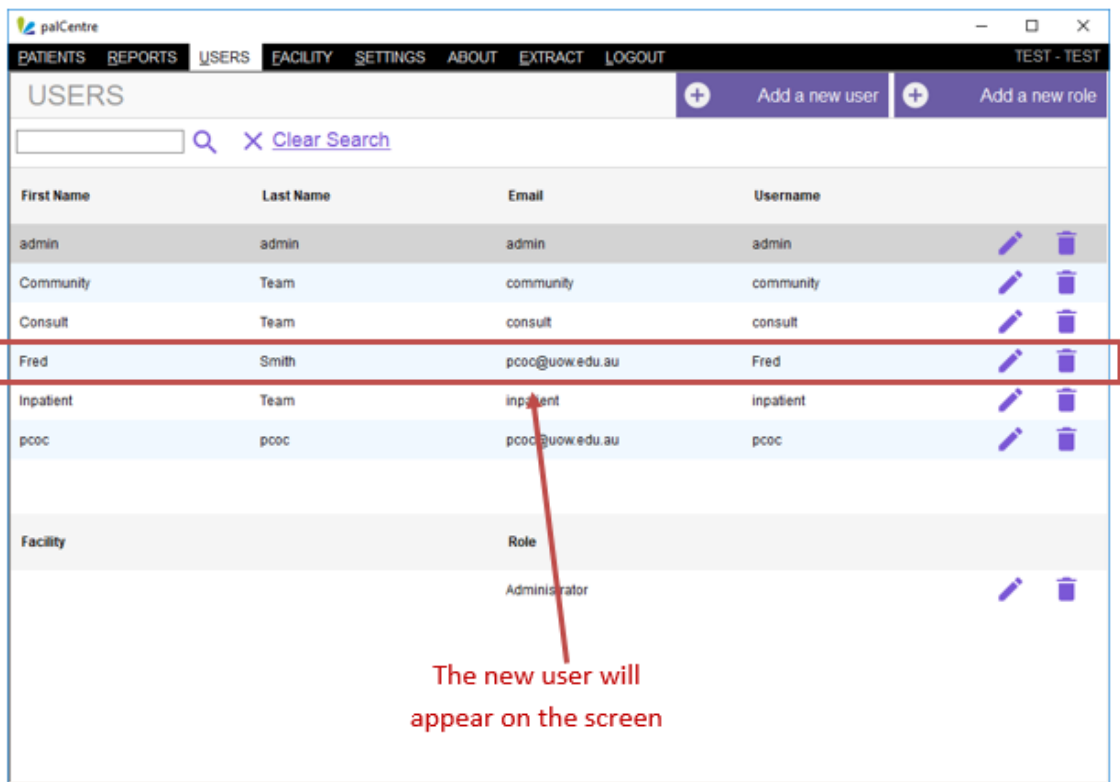
The screenshot shows the 'palCentre' application interface. At the top, there is a navigation bar with tabs for PATIENTS, REPORTS, USERS, FACILITY, SETTINGS, ABOUT, EXTRACT, and LOGOUT. The 'USERS' tab is active. Below the navigation bar, the page title is 'USERS'. There are two purple buttons with white plus signs: 'Add a new user' and 'Add a new role'. A red box highlights the 'Add a new user' button, and a red arrow points from it to a red text label below the screenshot that says 'Click here to create a new user'. Below the buttons is a search bar with a magnifying glass icon and a 'Clear Search' link. The main content area contains a table with columns for First Name, Last Name, Email, and Username. The table lists several users: admin, Community, Consult, Inpatient, and pcoc. Each user row has edit and delete icons. Below the table, there are sections for Facility and Role, with a 'TEST' facility and 'User' role listed.

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



The screenshot shows a 'User Details' form. The form has a title bar with 'User Details' and a close button. The form fields are: First Name (Fred), Last Name (Smith), Username (Fred), Email (pcoc@uow.edu.au), Password (*****), Confirm Password (*****), and Automatic logout (Do not log me out). A red box highlights the 'Submit' button at the bottom of the form, and a red arrow points from it to a red text label below the screenshot that says 'Click on submit once all the information has been entered'.

The user will now appear in the list of users.

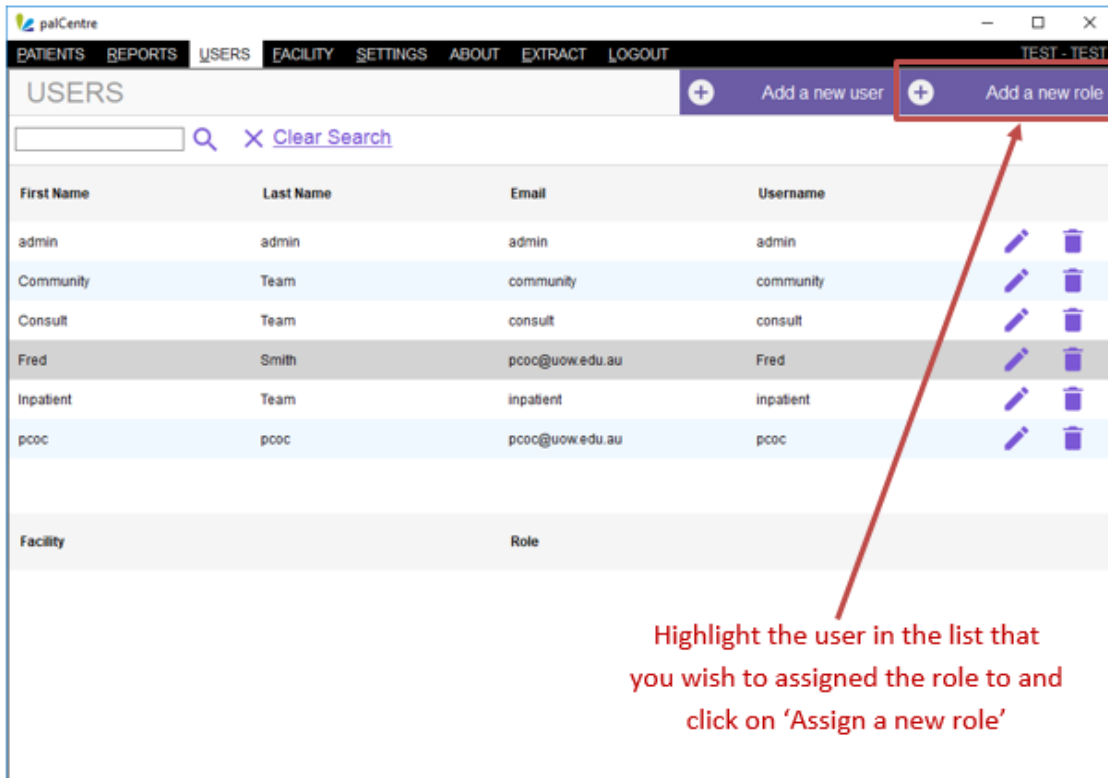


Assign a role

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

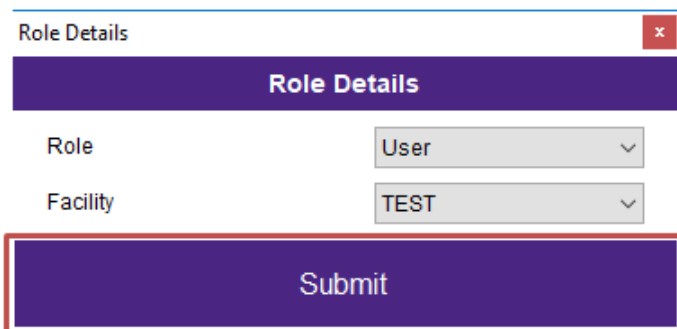
To assign a role to a user, highlight the user you wish to assign a role to in the 'Users' screen and click on the purple 'Add a new role' button in the top right hand corner of the screen:



The screenshot shows the 'Users' screen in the palCentre application. The top navigation bar includes 'PATIENTS', 'REPORTS', 'USERS', 'FACILITY', 'SETTINGS', 'ABOUT', 'EXTRACT', and 'LOGOUT'. The 'USERS' tab is active. Below the navigation bar, there are two buttons: 'Add a new user' and 'Add a new role'. The 'Add a new role' button is highlighted with a red box. A red arrow points from this button to the 'Fred Smith' user in the table below. The table has columns for 'First Name', 'Last Name', 'Email', and 'Username'. The 'Fred Smith' row is highlighted in grey. Below the table, there is a section for 'Facility' and 'Role'.

Highlight the user in the list that you wish to assigned the role to and click on 'Assign a new role'

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



The screenshot shows a 'Role Details' form. It has a title bar with 'Role Details' and a close button. The form contains two dropdown menus: 'Role' with 'User' selected and 'Facility' with 'TEST' selected. Below the dropdowns is a large purple 'Submit' button, which is highlighted with a red box.

Click on submit once all the information has been entered

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.

The screenshot displays the 'USERS' management interface in palCentre. The top navigation bar includes 'PATIENTS', 'REPORTS', 'USERS', 'FACILITY', 'SETTINGS', 'ABOUT', 'EXTRACT', and 'LOGOUT'. The 'USERS' section has a search bar and two buttons: 'Add a new user' and 'Add a new role'. Below this is a table of users:

First Name	Last Name	Email	Username		
admin	admin	admin	admin		
Community	Team	community	community		
Consult	Team	consult	consult		
Fred	Smith	pcoc@uow.edu.au	Fred		
Inpatient	Team	inpatient	inpatient		
pcoc	pcoc	pcoc@uow.edu.au	pcoc		

Below the user table is a table for roles:

Facility	Role		
TEST	User		

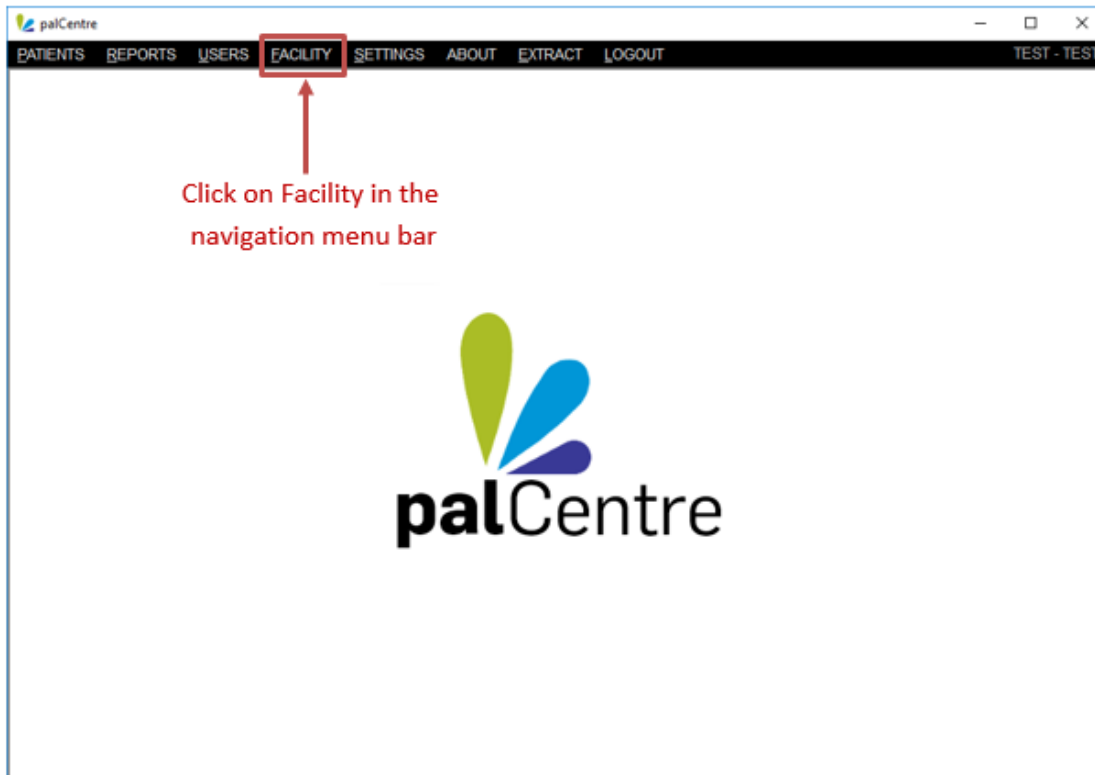
A red box highlights the 'User' role in the bottom table, and a red arrow points to it with the text: 'The new role for the user will appear here'.

Adding or editing a facility

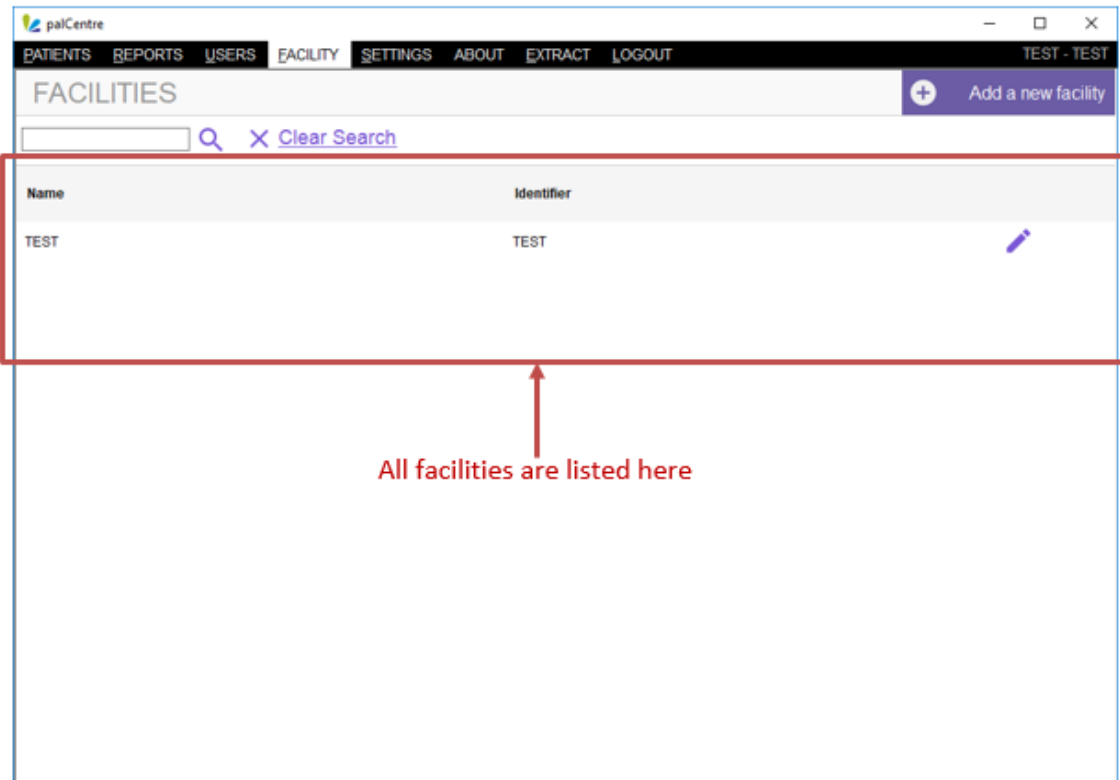
Facility identifiers are issued by PCOC and are unique to your facility. Your facility identifier is intrinsically linked to how data is submitted and processed by PCOC. If you wish to create a new facility, please first contact Alanna Connolly (02) 4221 5640 or Sam Allingham on (02) 4221 4476 or via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

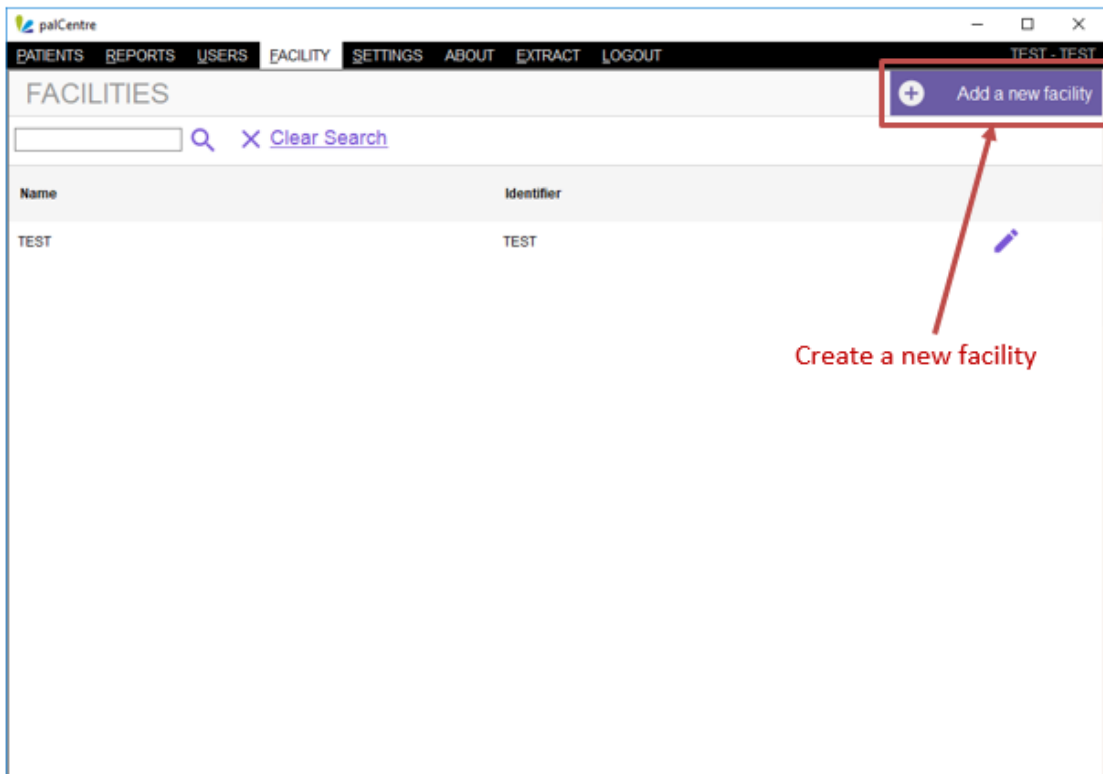


All current facilities will appear in the list on the facilities screen.

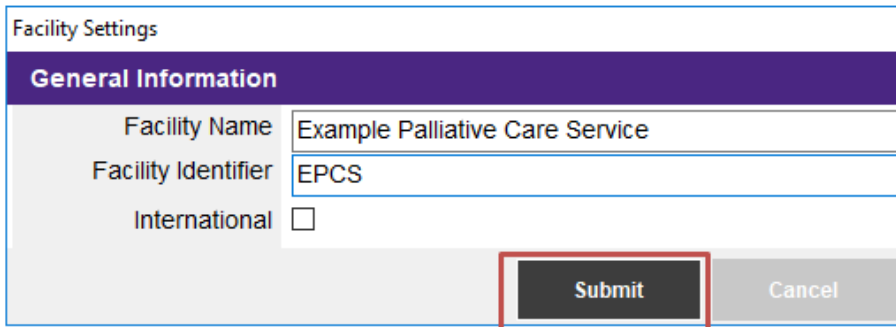


Creating a new facility

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



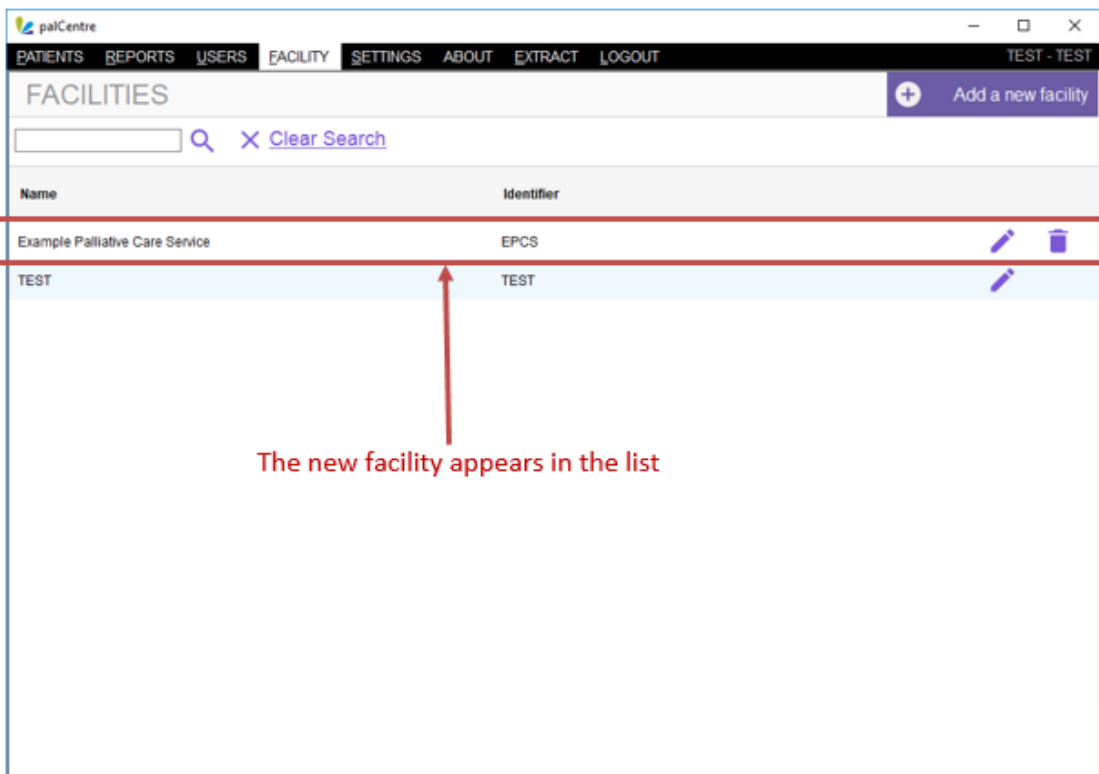
The follow form will appear.
Fill in the facility name and facility identifier. If you are outside Australia, check the international box. Click on submit.






The image shows a 'Facility Settings' form with a purple header. Under the 'General Information' section, there are three input fields: 'Facility Name' containing 'Example Palliative Care Service', 'Facility Identifier' containing 'EPCS', and 'International' with an unchecked checkbox. At the bottom right, there are two buttons: 'Submit' (highlighted with a red box) and 'Cancel'.

Click on submit once all the information has been entered

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



The screenshot shows the 'FACILITIES' page in the palCentre application. The navigation bar includes 'PATIENTS', 'REPORTS', 'USERS', 'FACILITY', 'SETTINGS', 'ABOUT', 'EXTRACT', and 'LOGOUT'. The 'FACILITIES' section has a search bar and a '+ Add a new facility' button. A table lists facilities with columns 'Name' and 'Identifier'. The first row, 'Example Palliative Care Service' with identifier 'EPCS', is highlighted with a red box. Below it is a 'TEST' facility. A red arrow points from the text below to the first row.

Name	Identifier	
Example Palliative Care Service	EPCS	 
TEST	TEST	

The new facility appears in the list

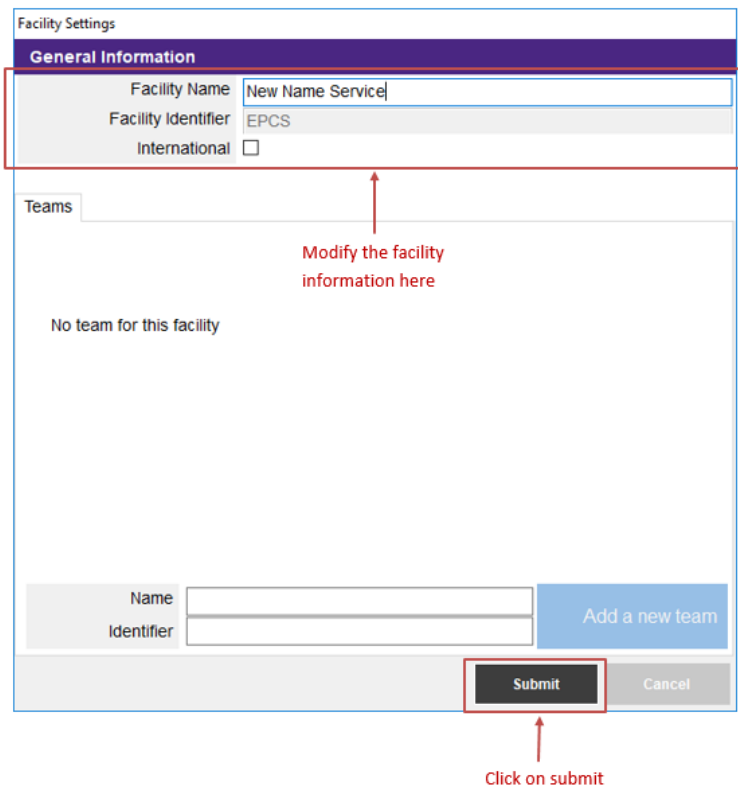
If current users will be entering data for the new facility, you will need to assign a user role for your current users to access the new facility created.

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.



The screenshot shows a web form titled "Facility Settings". The "General Information" section is highlighted with a red border and contains the following fields:

Facility Name	<input type="text" value="New Name Service"/>
Facility Identifier	<input type="text" value="EPCS"/>
International	<input type="checkbox"/>

Below this is a "Teams" section with the text "No team for this facility". At the bottom of the form, there is a "Submit" button highlighted with a red box and an arrow pointing to it with the text "Click on submit".

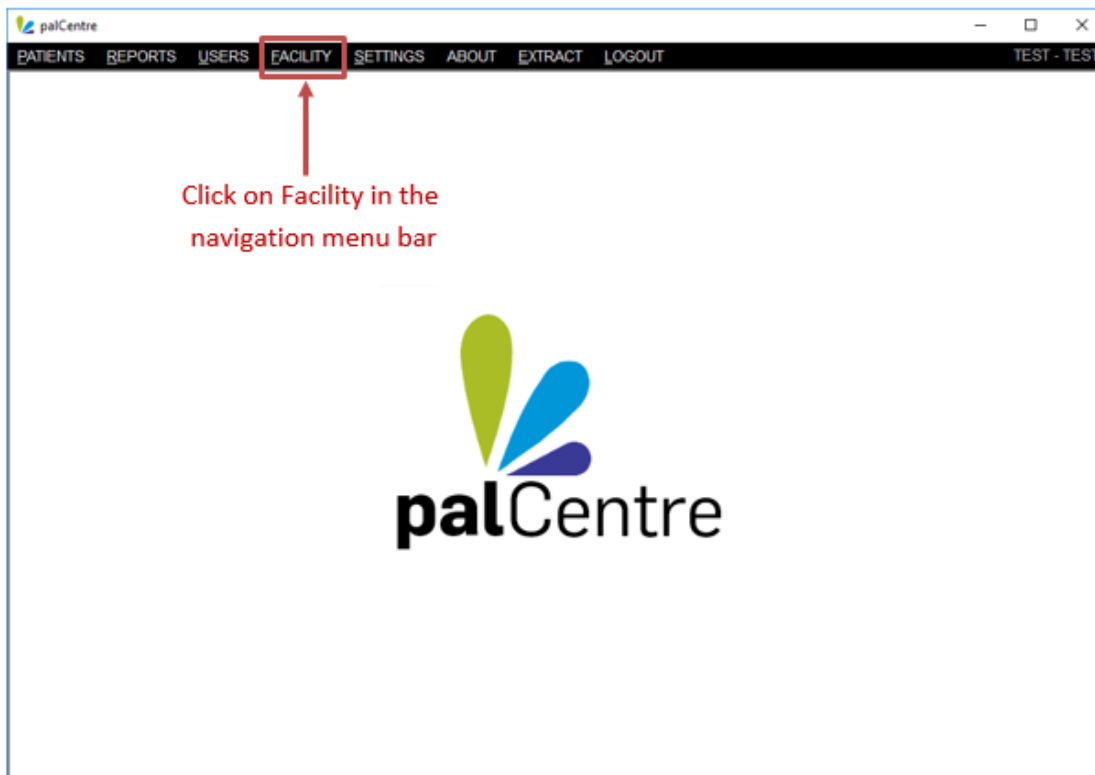
Your facility has now been modified.

Adding a team

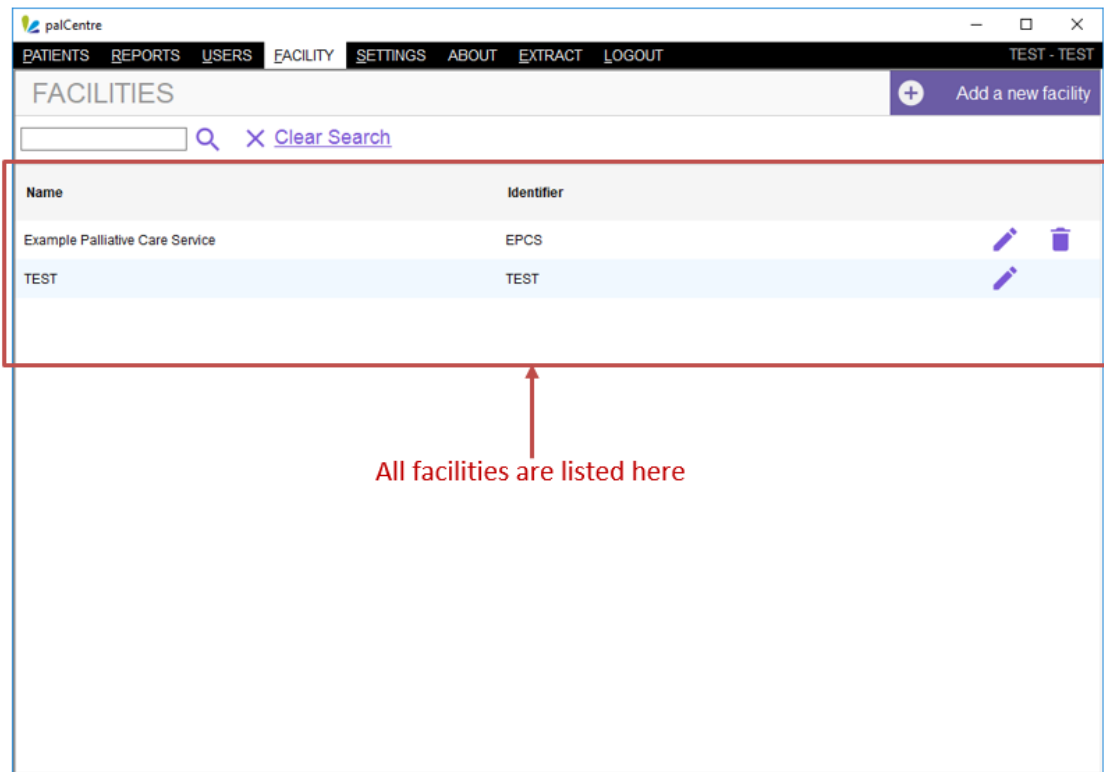
Team identifiers are issued by PCOC. Team identifiers are intrinsically linked to how data is submitted and processed by PCOC. If you wish to create a new team, please first contact Alanna Connolly (02) 4221 5640 or or Sam Allingham on (02) 4221 4476 or via email pcoc@uow.edu.au

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.

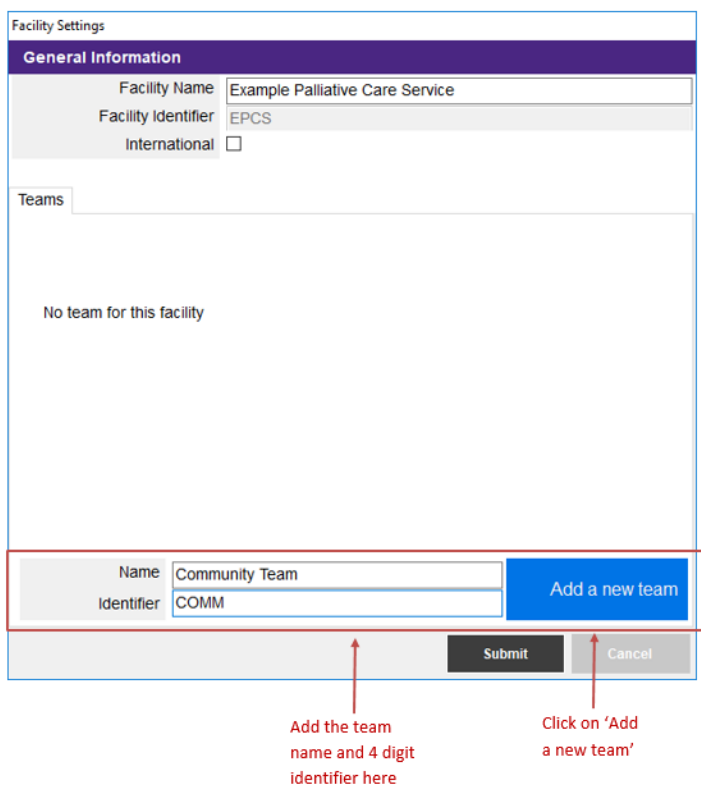
To create or modify a team, you must be an administrator. Login to palCentre as an administrator and click on *'Facility'* in the navigation menu bar.



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.

The screenshot shows a web interface for 'Facility Settings'. It has two main sections: 'General Information' and 'Teams'.
In 'General Information', there are fields for 'Facility Name' (Example Palliative Care Service), 'Facility Identifier' (EPCS), and an 'International' checkbox.
The 'Teams' section contains a table with columns 'Identifier' and 'Team Name'. One team is listed: 'COMM' with 'Community Team'.
Below the table is a form to 'Add a new team' with 'Name' and 'Identifier' fields.
At the bottom are 'Submit' and 'Cancel' buttons.
Red annotations include:
- A red box around the 'COMM' team entry.
- A red arrow pointing from the text 'The new team will appear here' to the 'COMM' team entry.
- A red box around the 'Submit' button.
- A red arrow pointing from the text 'Click on submit' to the 'Submit' button.

You have now created a new team.

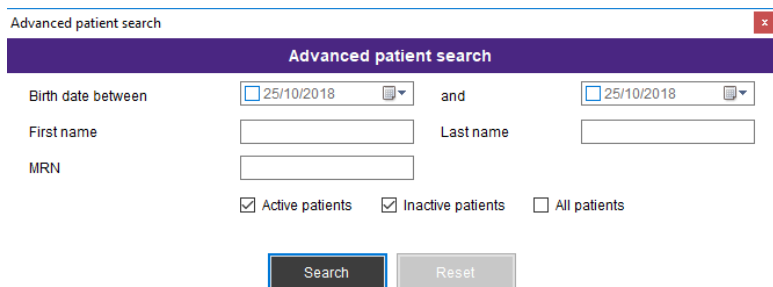
Frequently asked questions

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.



Advanced patient search

Advanced patient search

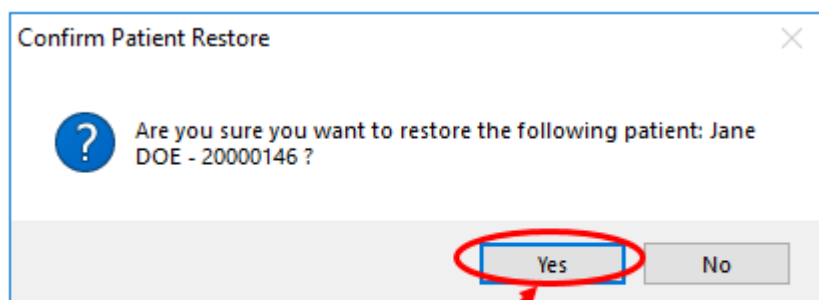
Birth date between and

First name Last name

MRN

Active patients Inactive patients All patients

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



Confirm Patient Restore

Are you sure you want to restore the following patient: Jane DOE - 20000146 ?

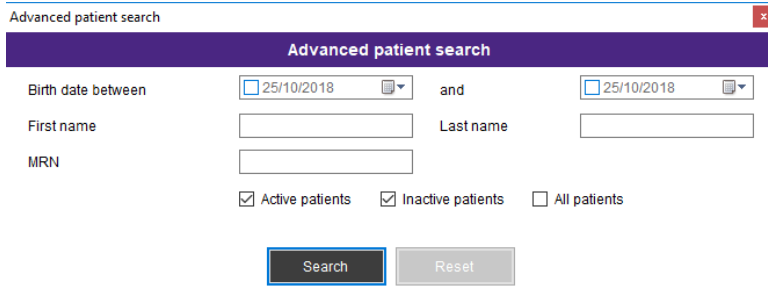
Click on yes to restore the patient

You can now start entering information for this patient.

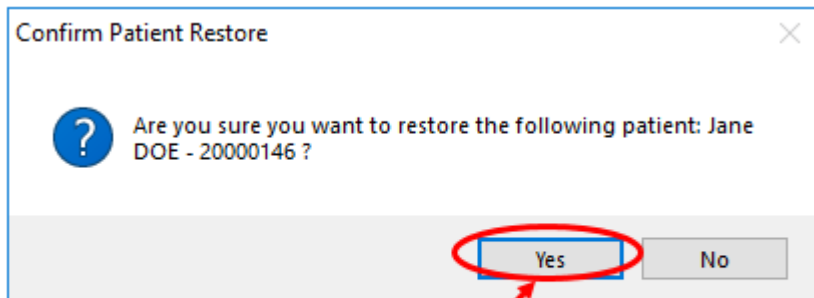
▼ I can't find a patient previously entered into palCentre

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'



Click on yes to restore the patient

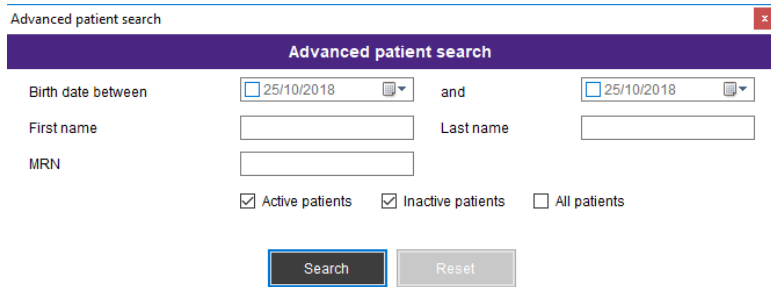
You can now start entering information for this patient.

▼ 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.



Advanced patient search

Advanced patient search

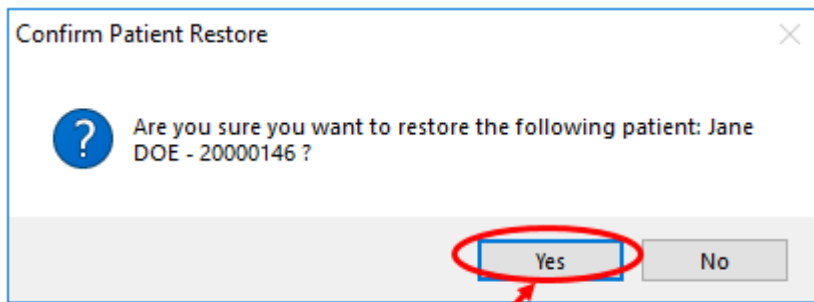
Birth date between and

First name Last name

MRN

Active patients Inactive patients All patients

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



Confirm Patient Restore

Are you sure you want to restore the following patient: Jane DOE - 20000146 ?

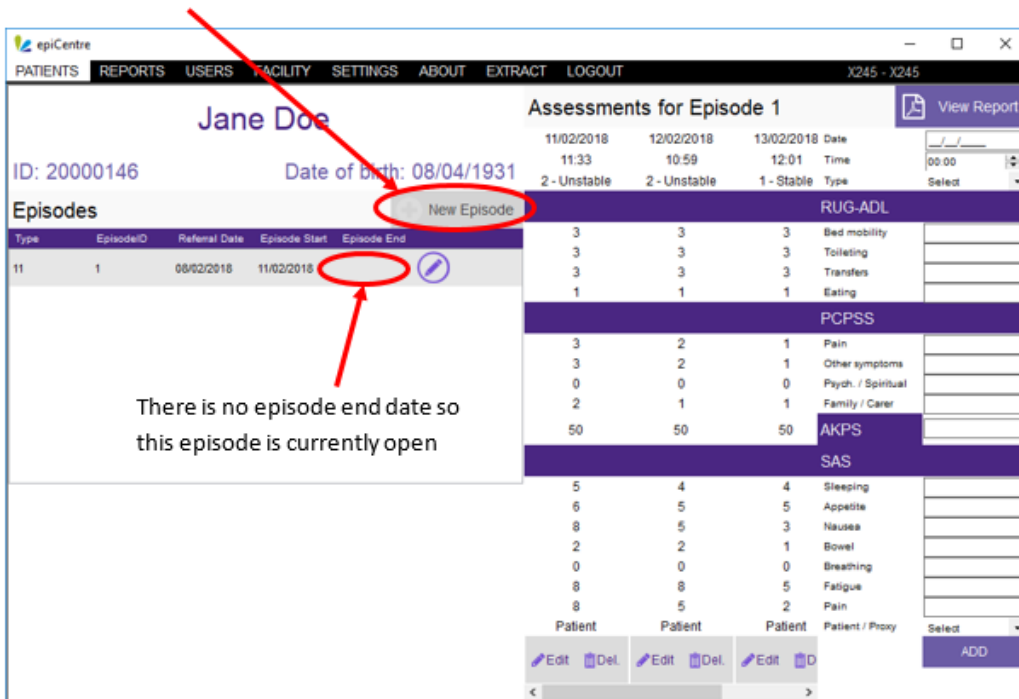
Click on yes to restore the patient

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.

The new episode button is grey when is an open episode



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.

The 'Episode Details' form contains the following sections and fields:

- Episode identifier:** 170
- Episode Type:** Overnight admitted - Designated Palliative Care Bed
- Missing Patient Information:** Preferred language (Select), please specify; Diagnosis (Select)
- Referral Information:** Referral source (Select), Referral date (20/10/2017), First Contact Date (20/10/2017), Date Ready for Care (20/10/2017)
- Episode Start:** Episode start date (20/10/2017), Episode Start Mode (Admitted from usual accomodation), Accommodation at episode start (Private residence (including unit in retirement village))
- Episode End:** Episode End Date (dd/mm/yyyy) (empty), Episode End Mode (Select), Accommodation at episode end (Select), Place of death (Select)

At the bottom right, there are 'Submit' and 'Cancel' buttons.

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