Introduction to EPR and Clinical IT Systems

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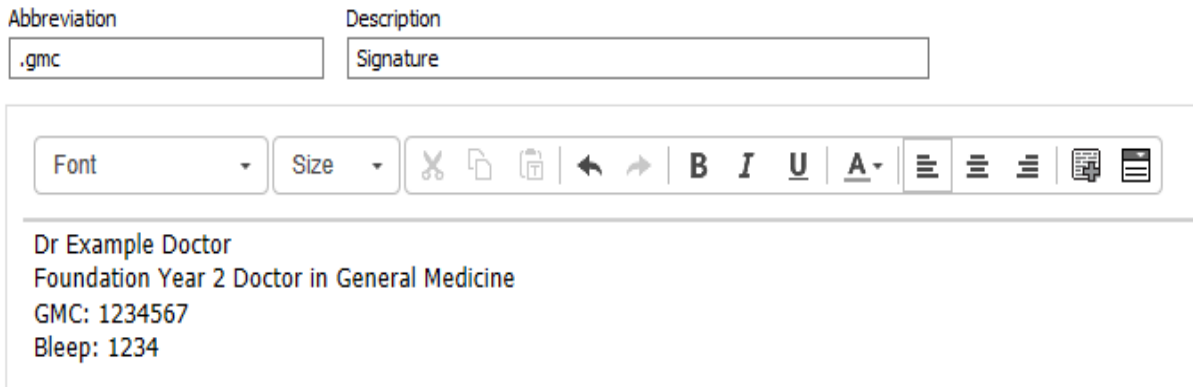
Documentation

Digital documentation standards are important

- All admitted patients should have an **admission clerking** which includes presenting complaint, clinical findings and the plan for investigations and treatment
- There should be a **daily ward round entry** made by a clinical decision-maker for all patients
- Patient reviews should consist of a clinical assessment, a review of vital signs and test results and a plan for continuing clinical care

Include your name, GMC and contact details in every entry in the patient record

- All free text documentation **must** include the name of the person completing the record with their professional registration and contact details
- Create an Autotext template including your name, GMC number and contact details to add into every entry that you make in the patient record



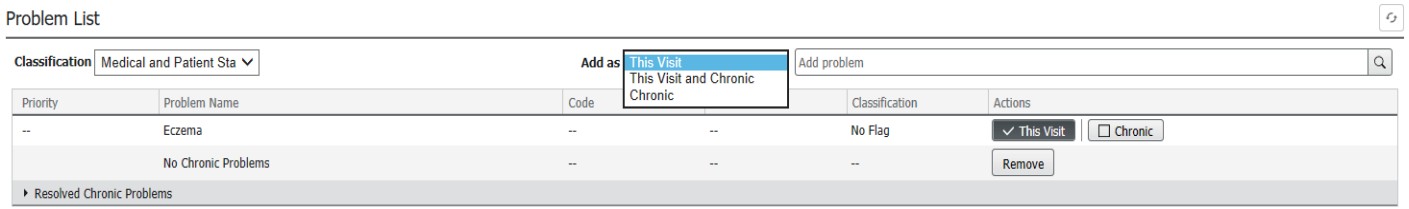
The final step of documentation is creating a note

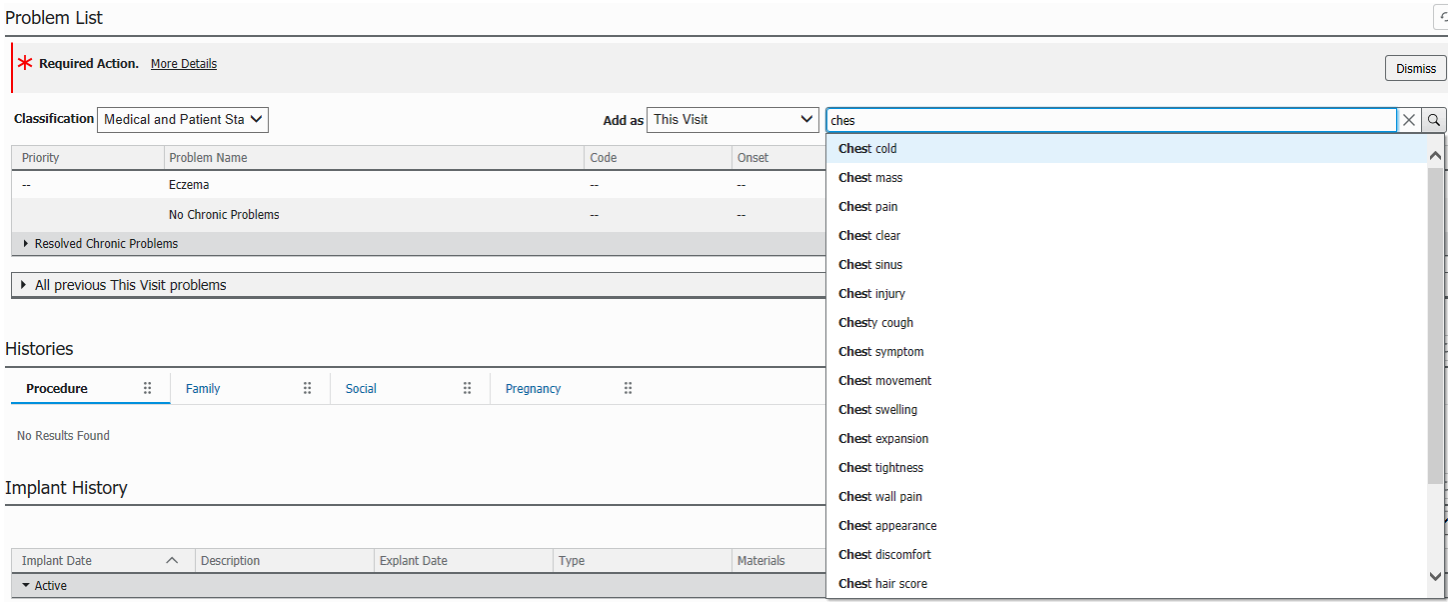
- After documenting within EPR you **MUST create a note** to save your entry to the patient record
- **If you do not create a note, your entry will not be saved to the patient record**
- Sheets of paper forming part of the patient's clinical record require a PID label with a barcode on it. This will ensure that the results are scanned onto EDM following discharge
- When writing a Discharge Summary, the **'Inpatient Discharge Summary'** is the only Note Type/Template that should be used

Document Diagnoses and Chronic Problems in the Problem List

- **Diagnosis** is the **'this visit' problem** i.e. what the patient has been admitted with
- **Chronic Problems** are the patient's **Past Medical History**
- Both are added using the **Problem List** section of the record
  - This enhances visibility of the patient's current issue(s) and Past Medical History to the wider MDT
- The Problem List is used for clinical coding

Problem List





Resuscitation Status

- Resuscitation Status defaults to ‘Full Resuscitation’ for every patient on admission to hospital
- It is the responsibility of the admitting medical team to ensure a patient’s Resuscitation status is updated and accurate on EPR.
- The two options to select are:

  Resus:CPR attempts recommended **OR** **Resus:CPR attempts NOT recommended**

- If either of these 2 options appear in the blue banner, this confirms the Resuscitation Status has been updated
- **All patients where ‘CPR attempts NOT recommended’ is selected MUST have a ReSPECT plan completed. The ReSPECT plan remains on paper.** It should be accessible in the front of the patient’s bedside folder.
- **If a patient is admitted to hospital without their ReSPECT plan, a new plan MUST be completed in consultation with the patient and/or family, along with any associated MCA if required.**

Message Centre and Reviewing, Endorsing and Forwarding Results

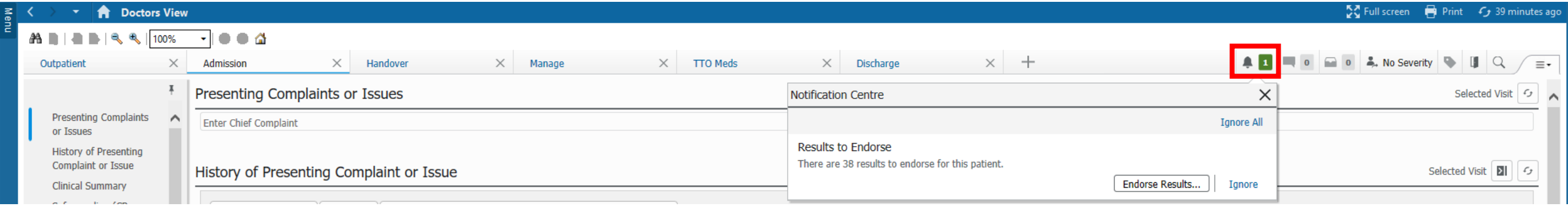
Viewing and Endorsing Results in EPR

- Message Centre is an EPR-specific inbox showing results, documents and messages sent through EPR relating to patient care
- There are three ways to view and endorse results at the same time:
  - **Message Centre Inbox:** view and endorse results that **you have requested**
  - **Bell icon within patient record:** view and endorse the results that have been requested for that patient **[preferred method of endorsing results for inpatients]**
  - **Lead Clinician Pool in Message Centre:** displays results requested by the Lead Clinician **and** results requested on their behalf by members of their team
    - Team members can subscribe to Lead Clinicians' Pools to view and endorse results from the Pool

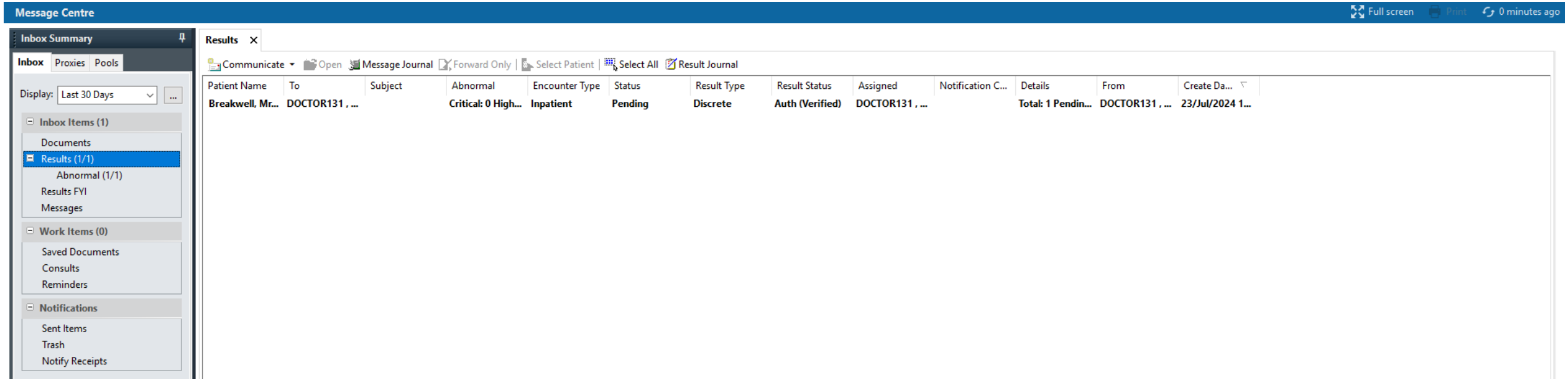
Results Endorsement is an essential component of good clinical practice

- Understand your department's approach to results endorsement and use of Lead Clinician 'Pools'
- **You should check your Message Centre Inbox regularly to view and endorse results that you have requested**
- **It is your responsibility to check for results of both routine and urgent tests you have requested and action them as appropriate. If you are going on leave, you must ensure that you handover pending results to a colleague**
- **Before leaving the Trust for another role, you need to ensure that you have endorsed all your inbox results and handed over pending results to a colleague**

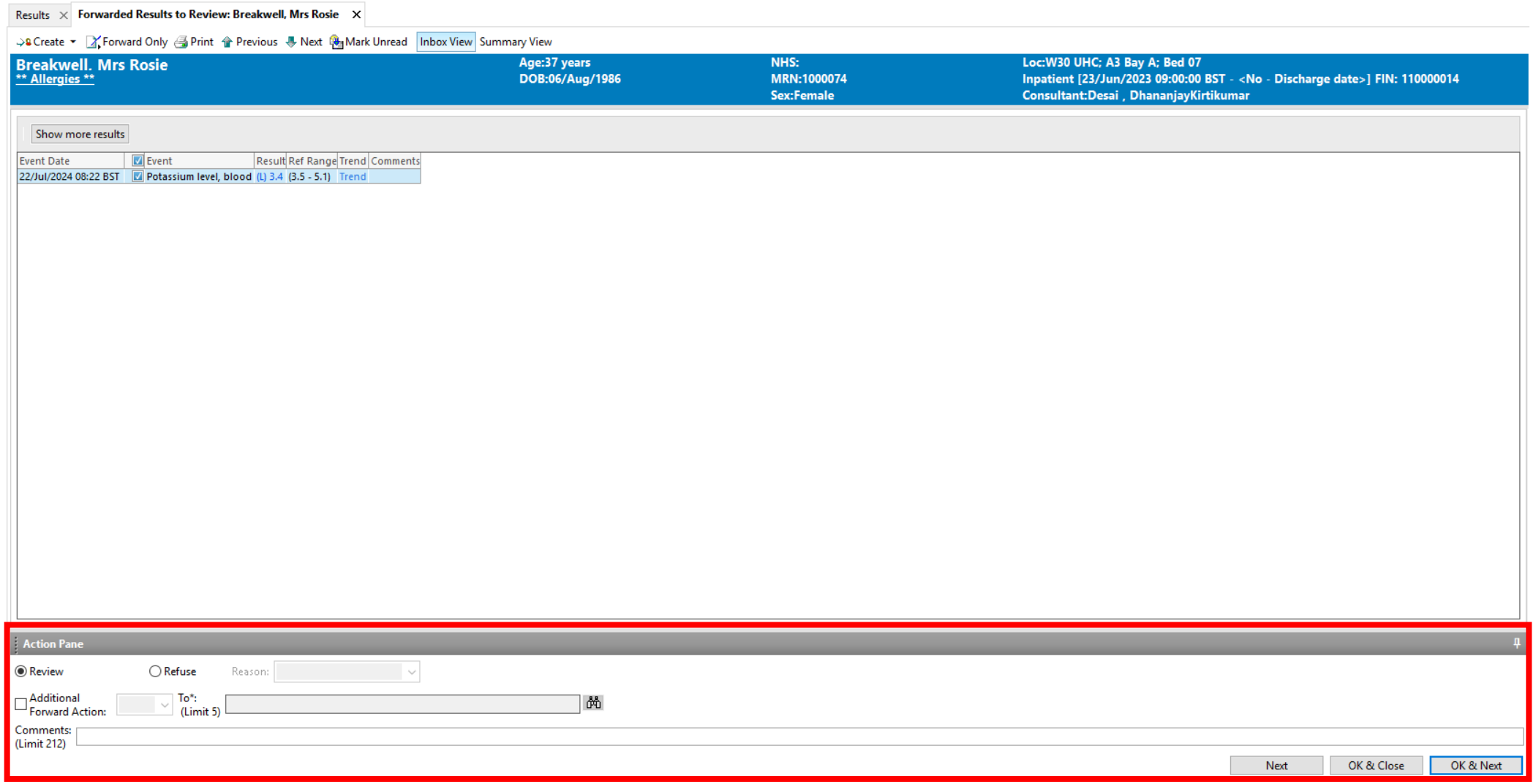
For inpatients, use the bell icon within the patient record to view and endorse results



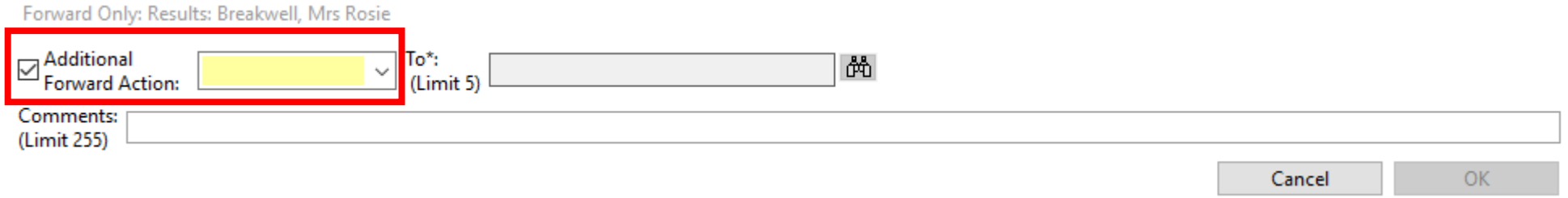
Message Centre Inbox



Message Centre Action Pane



Escalate abnormal tests to a Consultant for senior input if needed





Results and the transfer of care

- Where inpatients have been transferred between either teams or wards during their admission, **the responsibility for endorsing and actioning results lies with the team caring for the patient at the time the result is published**
- Do not assume that a consultant or team has checked and actioned an urgent result, it is good practice to let them know

Prescribing

Prescribing Good Practice I

- Patients admitted into the hospital must have all regular medication prescribed with the **correct dose** and at the **correct time** (particularly important for time-critical medications)
- Any alteration to patient's regular medications should be clearly documented with the **reason for the change in the Discharge Summary**

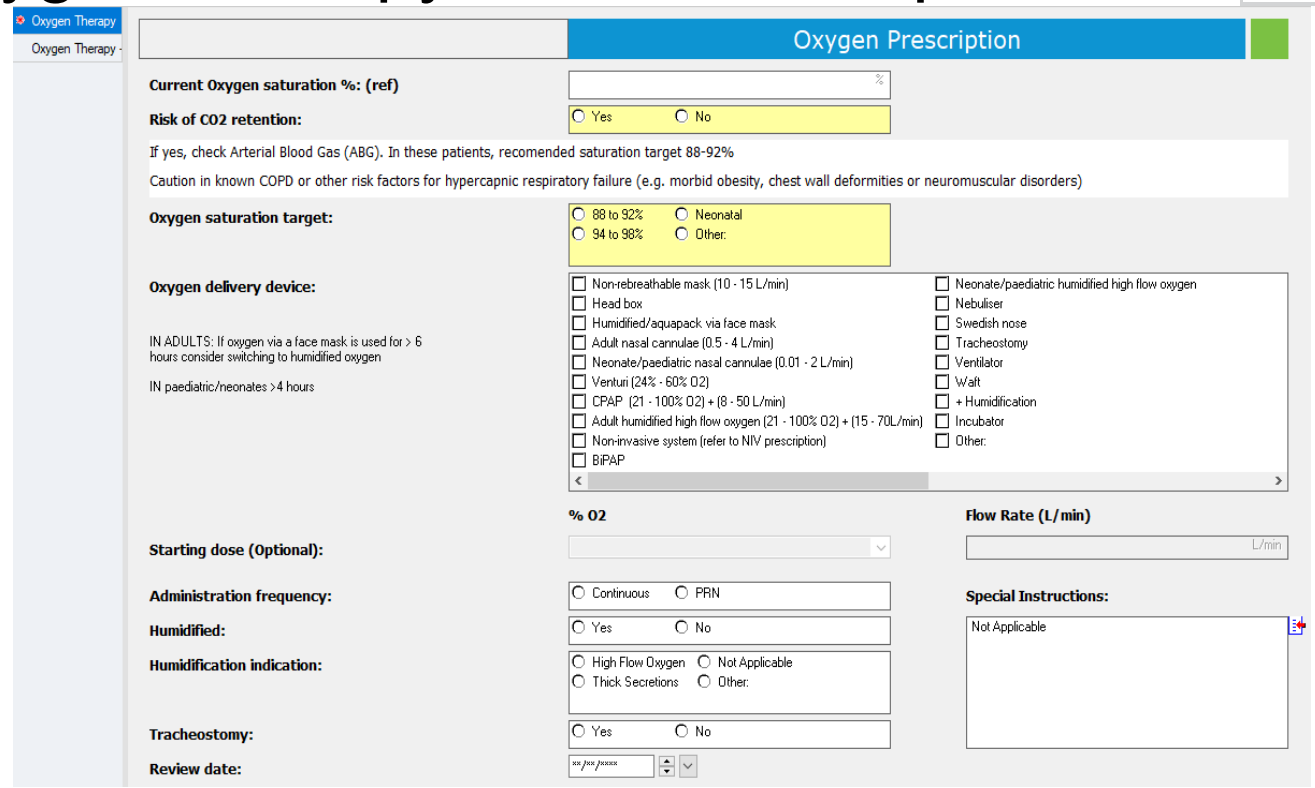
Prescribing Good Practice II

- The clinical team looking after the patient is responsible **reviewing the drug chart daily** and ensure that prescriptions are started/discontinued/suspended/resumed as clinically indicated
- Document medication changes and medication review points in the ‘Plan’ of your clinical entry to **increase visibility of outstanding actions across the clinical team**
- **Verbally inform the nursing team** looking after the patient if any changes are made to a patient’s medications to increase awareness

Oxygen

- Oxygen is a medication and therefore **must be prescribed** on the Drug Chart
- Use the Oxygen Therapy Care Plan to prescribe



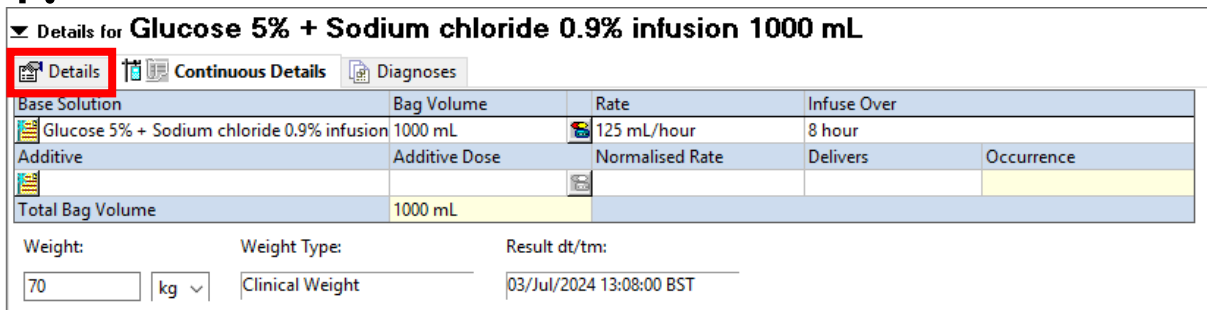


Prescribing IV Fluids I

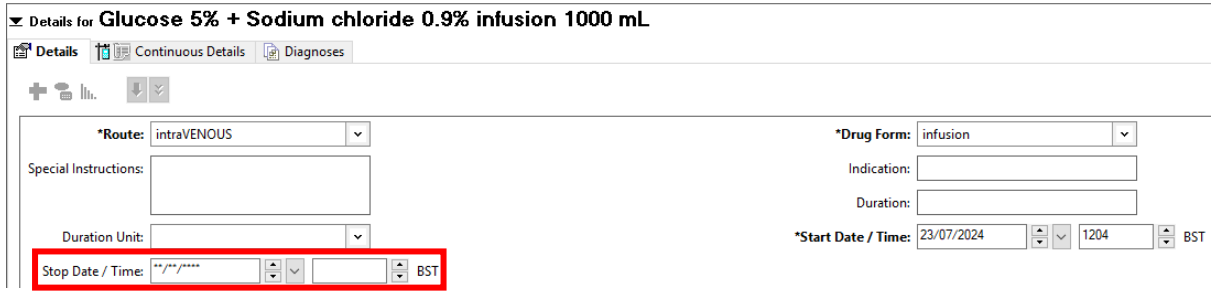
- When ordering IV Fluids you **MUST specify the duration (i.e. number of bags)** you want the patient to receive
- **If you do not specify the duration, the IV fluid order will default to a continuous infusion order** where further bags of IV fluids will be available for nursing staff to administer until a doctor discontinues the order
- At UHCW, IV fluids are prescribed by the **bag**

Prescribing IV Fluids II

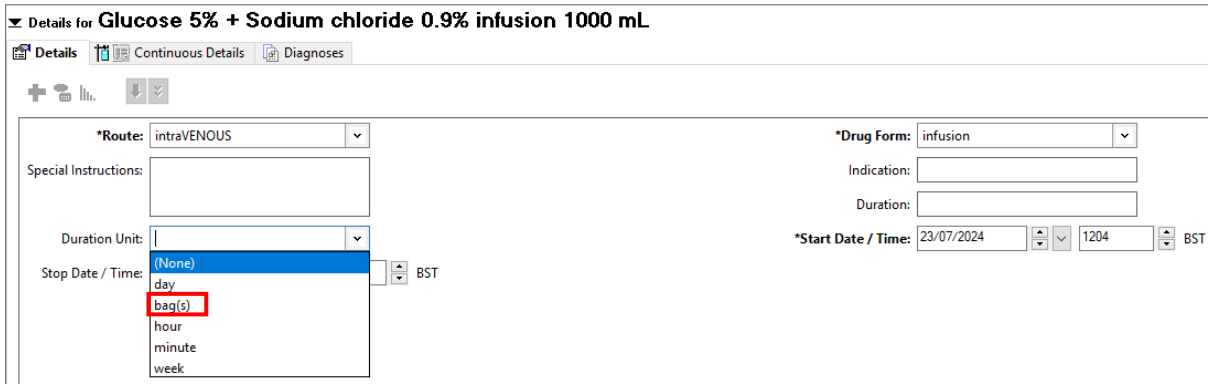
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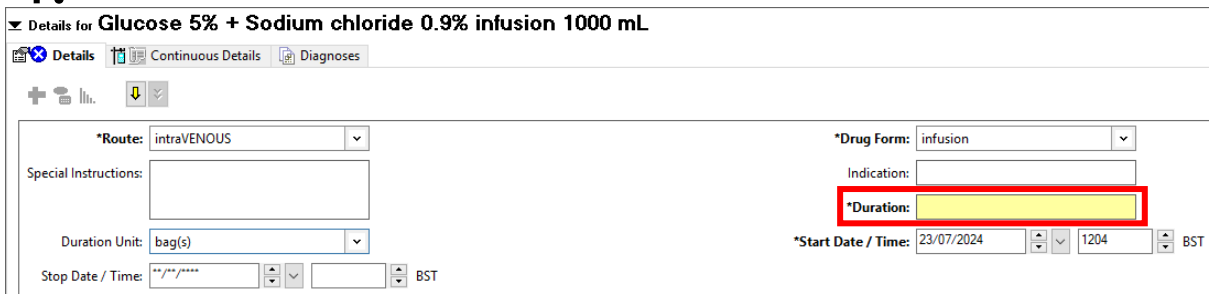
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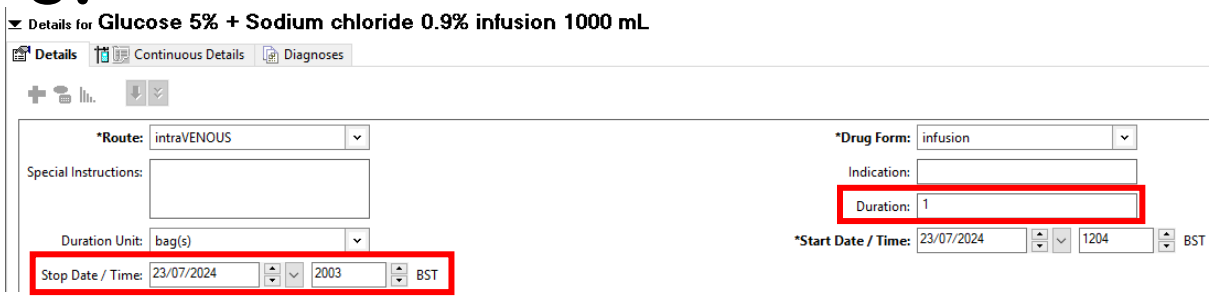
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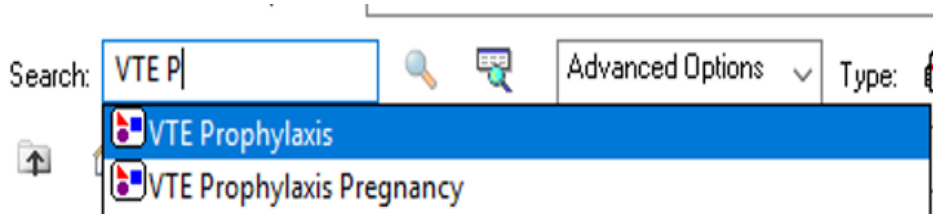
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VTE

- VTE Risk Assessment is tasked on Admission and must be completed within 12 hours
- Re-Assessment must be completed within 24 hours
- Complete the risk assessment, then use the **‘VTE Prophylaxis Care Set’** to prescribe thromboprophylaxis and stockings etc.

VTE Prophylaxis Care Set



Careset - VTE Prophylaxis

Breakwell. Mrs Rosie
** Allergies **
CP-IS: Not Performed
TDD:
Age:37 years
DOB:06/Aug/1986
Resus:Full Resuscitation
Isolation:
NHS:
MRN:1000074
Sex:Female
Loc:W30 UHC; A3 Bay A; Bed 07
Inpatient [23/Jun/2023 09:00:00 BST - <No - Discharge date>] FIN: 110000014
Consultant:Desai , DhananjayKirtikumar

Component	Order Details
Normal Renal Function	
The daily dose of Enoxaparin is 40 mg ONCE a day. Accumulation of LMWH can occur in renal impairment. For patients with creatinine clearance between 15 and 30 ml/min use enoxaparin 20 mg ONCE a day. Please select the appropriate dose for this patient.	
enoxaparin	DOSE: 40 mg - ROUTE: subCUTANEOUS - injection - ONCE a day (evening)
enoxaparin	DOSE: 20 mg - ROUTE: subCUTANEOUS - injection - ONCE a day (evening)
Severe Renal Impairement	
Accumulation of LMWH can occur in renal impairment. Patients with creatinine clearance <15 ml/min should be prescribed Unfractionated Heparin	
heparin	DOSE: 5,000 unit - ROUTE: subCUTANEOUS - injection - TWICE a day - for: Thromboprophylaxis
Consider the following monitoring:	
Full blood count	
Stockings	
Antiembolic Stockings	Requested Start Date/Time T;N, once ONLY
Intermittent Compression Device	Requested Start Date/Time T;N, once ONLY

Platelet Count	
340	25/Jul/2024 08:22...
Weight Measured	
69	25/Jul/2024 08:23...

Details

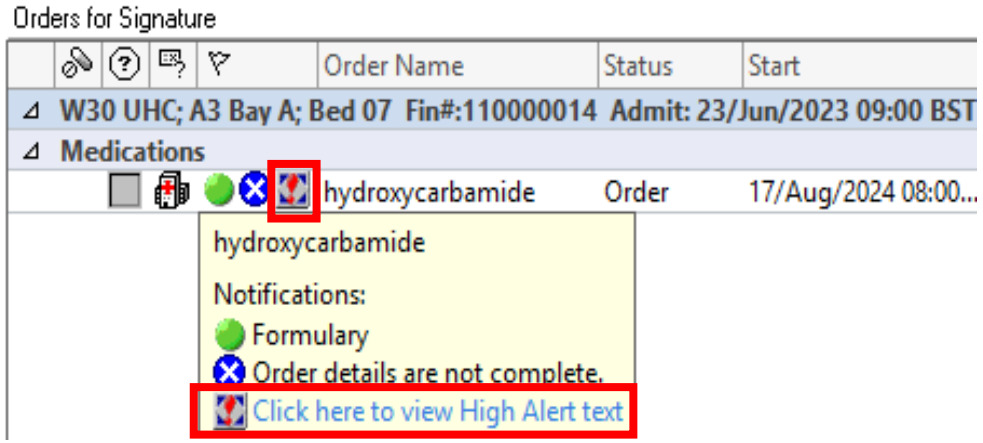
Send To:

Prescribing High-Risk Medications I

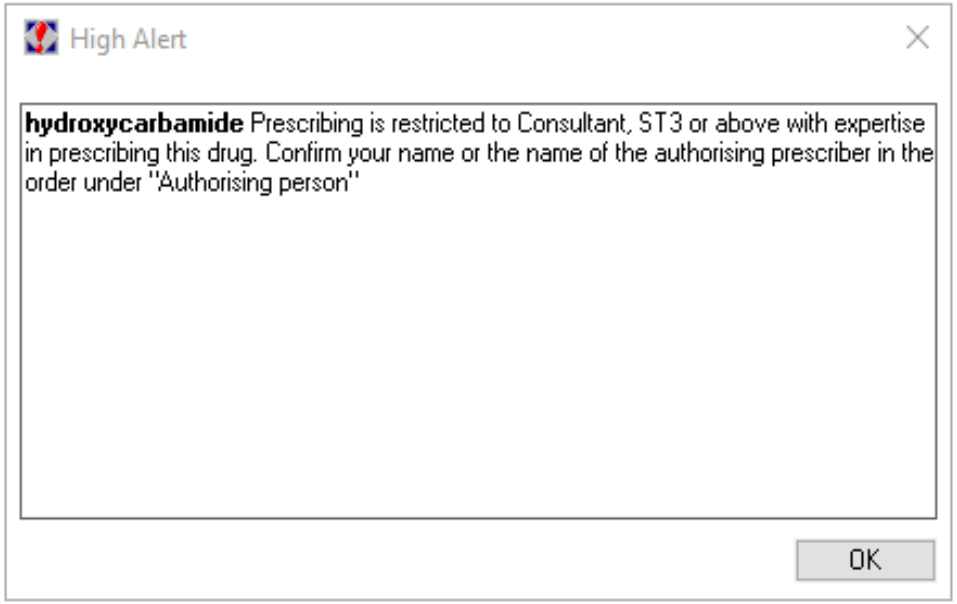
- In EPR, high-risk medications are denoted by an exclamation point icon  at the point of prescribing
- Review the 'High Alert' text to find out more:
  - Some high-risk medications should only be prescribed by doctors of a certain level of seniority (usually ST3 and above) who must complete the **'Authorising Person'** field when signing the medication order.
  - There are other high-risk medications which can be prescribed by any grade of doctor, and **do not** require an 'Authorising Person' e-signature
- **If the prescription of a high-risk medication is outside of your scope of practice, you should not prescribe it and instead escalate this to a Consultant**

Prescribing High-Risk Medications II

Hover over the icon and click to view the High Alert text for the medication



The text will provide information including any prescribing restrictions etc.



Referrals

Referral to Nurse Anticoagulation Clinic

- Search for and complete the '**Referral to OP Anticoagulation**' form
- Remember to sign your order after submitting the form

Discharge

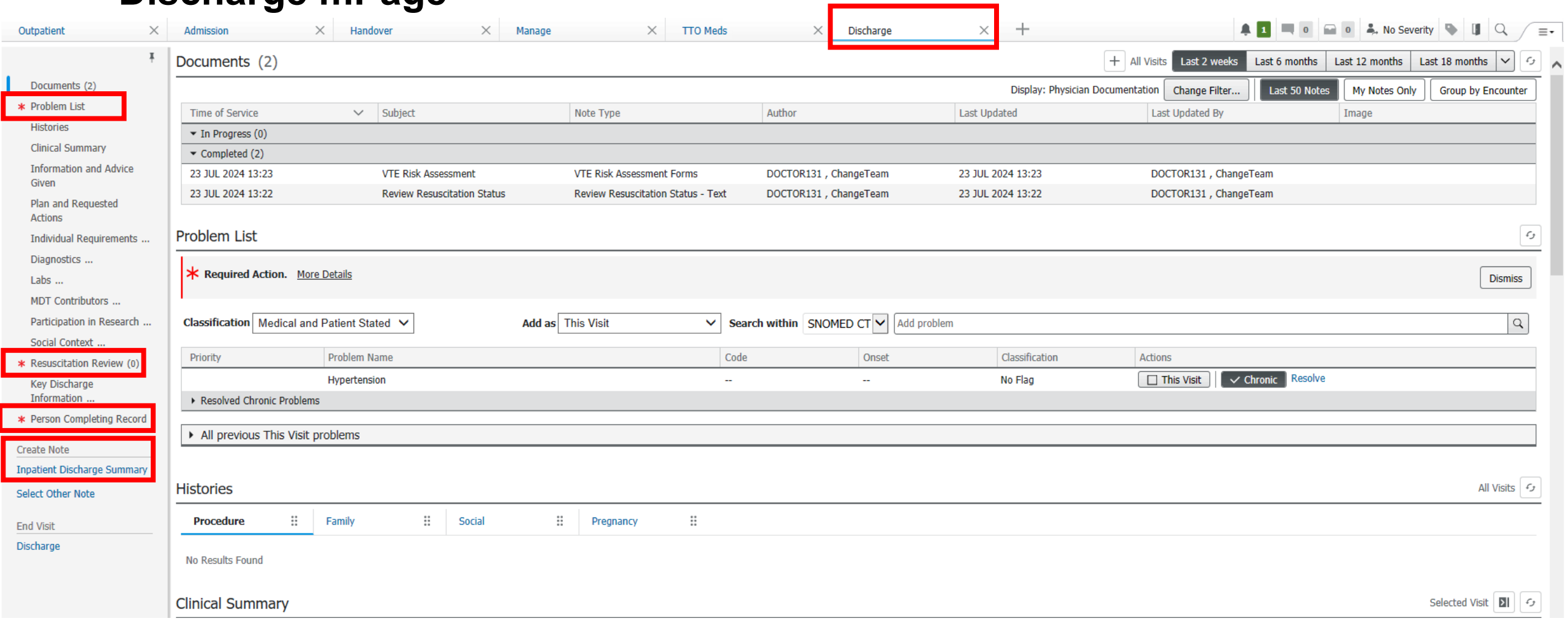
Discharge Summaries

- **All results for the current episode of care should be endorsed before discharge**; including results for orders placed by other teams (e.g. ED) prior to the patient coming under your care
- Start compiling the **Discharge mPage** from the day of admission
- Complete the Discharge Reconciliation for TTOs at least 1-2 days before discharge to allow Pharmacy time to process the TTOs
- Complete discharge summaries for deceased patients

Discharge Process

- All compulsory fields in the Discharge mPage (*) must be completed for the Discharge Summary to be sent to the GP once the patient is discharged
- **If compulsory fields are not completed, the GP will not receive the Discharge Summary. This can affect patient care**
- **If a patient requires follow-up after discharge, you must place the appropriate follow-up order**

Discharge mPage



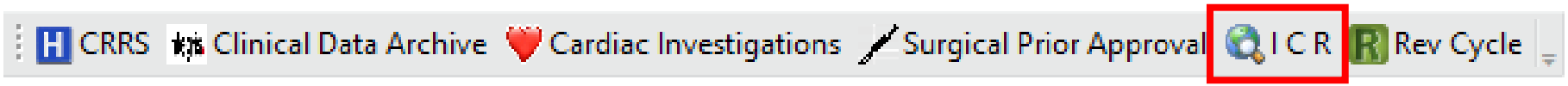
Follow-up appointment orders

- **Post Admission Appointment** order is used to request follow-up with the **same specialty** as the one the patient has been admitted under
- **'Referral to OP'** orders are used to request follow-up with a **different specialty** to the one the patient was admitted under (*and between outpatient specialties*)
- **If you are unsure how to book post-discharge follow-up, contact the specialty**

Other IT Solutions outside of EPR

Integrated Care Record

- Test results requested by the **GP** will display in the **ICR**
- There is a link to the ICR within the EPR toolbar



EDM

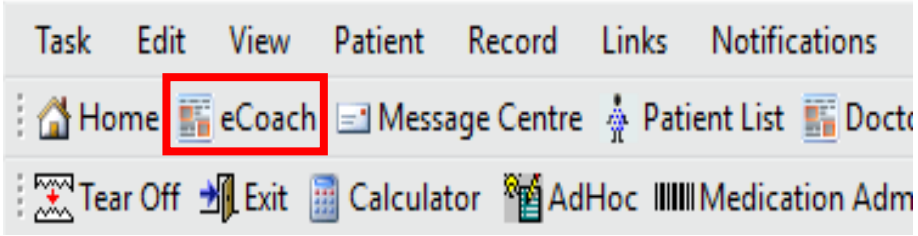
- Electronic Document Management System
- Accessible directly from EPR toolbar
- Quickly and easily view images of scanned paper documents
- **You will be able to view all documents/clinical letters from CRRS (system used prior to EPR) on EDM**
- Any paperwork generated for current episodes will be collected daily from the dedicated scanning box in clinical areas and scanned into EDM

What is remaining on Paper?

- ReSPECT forms
  - Upon each admission, patients' resuscitation status defaults to 'Full Resuscitation'
  - If the patient has a ReSPECT form, the resuscitation status can be amended within EPR as required
- Consent forms
  - Trust will move towards digital consent in the near future
- Amber Pathway
- Printed copy of Controlled Drug TTO/Outpatient Prescription
- Group and Save and Transfusion specimen request forms (stick printed labels on the paper form)
- For Group and Save and Transfusion specimens, the blood bottle label should be **HANDWRITTEN**

How to Access help with EPR

- EPR Handbook for New Starters
- Revisit the e-learning modules on the Learning Hub
- UHCW EPR QRG YouTube page
- Quick Reference Guides on eCoach (from the grey toolbar within EPR)



Link for EPR Handbook

- On TrustNav
- EPR > Frequently Asked Questions > Training FAQs