Implementing a multidisciplinary hospital-wide clinical EPR system at Homerton University Hospital NHS Foundation Trust

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Development of a comprehensive, multi-professional clinically-led hospital patient records at Homerton University Hospital NHS Foundation Trust, using a collaborative design approach.
The Homerton University Hospital NHS Foundation Trust…… Who are we?

- Acute and Community Services
- 3500+ Staff
- One of the most deprived square miles in the country
- One of the most ethnically diverse areas in the country
- Trauma Centre, RNRU, NICU, Specialist Services
The ACE Programme

Moving from this.....

To this....

Connecting what matters
WHY Did We do it?

- Government aim to be a ‘paperless NHS’ by 2018
- Homerton aim to be a hospital at the forefront of this change
- Wanting to find new ways of working and supporting our staff
- Improving Medication Safety
- Improving access and visibility of notes
- Easier audit and data collection
- Easier information sharing between agencies

*The NHS must let go of the old ways by 2018*

The clock is ticking.

*it’s time for a PAPERLESS NHS*
On Saturday July 4th/5th 2015 – Big Bang Go-Live with the following:

- Medications
- Powernotes (electronic clinical clerking)
- Nursing Documentation
- iView (interactive solution allowing direct entry of results such as observations)
- Devices Integration (sending vital signs to electronic record directly from vital signs machines)
- Patient Safety Tools

Alongside pre-existing electronic functions
HOW? Key Principles

- Co-creation and Co-Production
- Multi-Disciplinary Clinician-Led Team
- All Clinical Disciplines and all levels of staff
- Pre-existing Expert Back-Office Clinical Information systems team
- Process-mapping
- Lean
- ‘Two clicks and you are there……’
- Patient stories/flows (thank you Ethel!)
- Cost effectiveness
What really happened in the Design and testing phase?

- Current state and future state mapping
- Adapted QI approach (*PDSA* cycles were tested and used in a non-live domain)
- A lot of ‘animated discussion’
- A lot of local build
- A lot of collaboration between Clinicians/ IT and Cerner
- A lot of hard decisions
- A lot of re-designing before Go-Live when testing identified up problems
- Shadowing mock ward rounds, drug rounds etc…
Who did this?

A small but perfectly formed team.....

- An ACE Board
- A small key team – 2 full time nurses, 2 part time doctors, 2.5 full time pharmacists, 1 part-time therapist + admin and project support
- Our pre-existing CIS team
- 3 separate design weeks where 80+ clinical staff came together
- 4 workstreams A small training team of 7.5 wte
Training?

- Critical Mass - 97% of Appropriate staff trained **and passed** a skills test
- 2200+ Clinical staff trained fully (Doctors, Nurses, Midwives, HCAs, ODPs, Therapists) From all areas.
- 500+ Bank and agency staff trained and 400+ admin staff trained in short bespoke sessions
- Classroom based – using computers – backed up with a (limited) play domain and materials on the Intranet
GO-LIVE

A BRAVE APPROACH....
Treated as an Internal Major Incident, along with business continuity

- Communications Saturation
- Big Bang for Medicines
- Fairly Big Bang’ for everything else
- Support - 24 hour technical and Floor-walking team
- Extra Staffing

(Took advice from other Trusts about what worked well and didn’t work well, and from previous implementations)

And we took the paper away.....
Other Considerations…

- Equipment Numbers
- Equipment type
- Wi-Fi
- Network Points and Plugs
- Locum/ Bank Access
- Downtime solutions
- Reporting
Costs… the thorny issue…

£4million

This includes:
- Equipment
- Wi-Fi Upgrade and re-wiring
- Project Staff Costs
- Cerner fees
- Cerner licences
- Upgrading electronic storage
- Downtime solutions
- Backfill costs for releasing staff for training
- Extra technical and support staffing around ‘Go-Live’
Yes we are…There has been no back-tracking, the hospital is digital

- **All** clinical documentation, all nursing documentation and all observations are electronic (apart from NICU)
- **All** medications are electronic (apart from NICU)
- **All** therapies activity is electronic
- Specialist teams manage their referrals from EPR
Benefits…Some but not all….

- Increased reporting
- 50+% reduction in medication incidents with harm
- Earlier discharges
- CQUINs
- Drug round reduced by 15+ minutes per bay of 6
- Clinical clerking reduced by 10+ minutes per patient
- Improved documentation and escalation of Early warning scores
- Electronic Treatment Escalation and DNAR / CPR flow
- Inpatient decisions being shared with our GPs
- Earlier referrals
- Real time dashboards
- Increased staff satisfaction in staff survey
Any questions?

Thanks for listening!

Any Questions?

No?

SUPER!