

William's Story

How will the new Electronic Patient Record support William's care





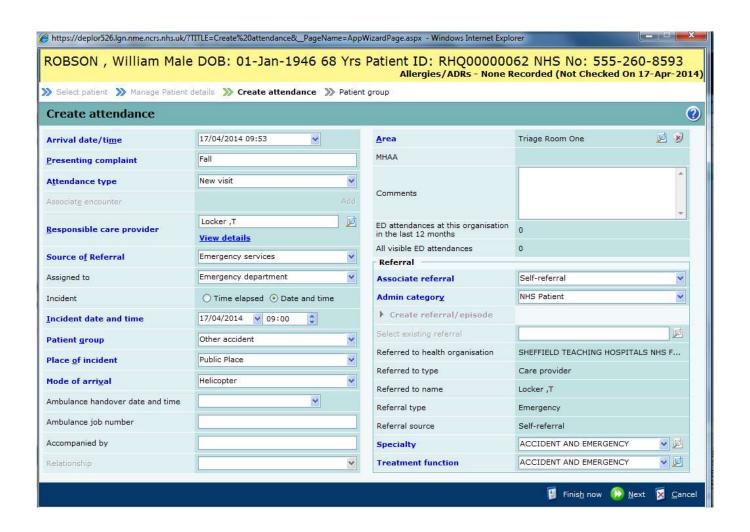
William's Story

- William sustains a fall in the Peak District
- Emergency services are contacted
- Due to the location, a helicopter is dispatched to take him to ED
- William arrives at Northern General Hospital
- An ambulance transports him to the ED
- The following slides show how William's care will be delivered supported by the new Electronic Patient Record System which replaces our current PAS in Autumn 2015

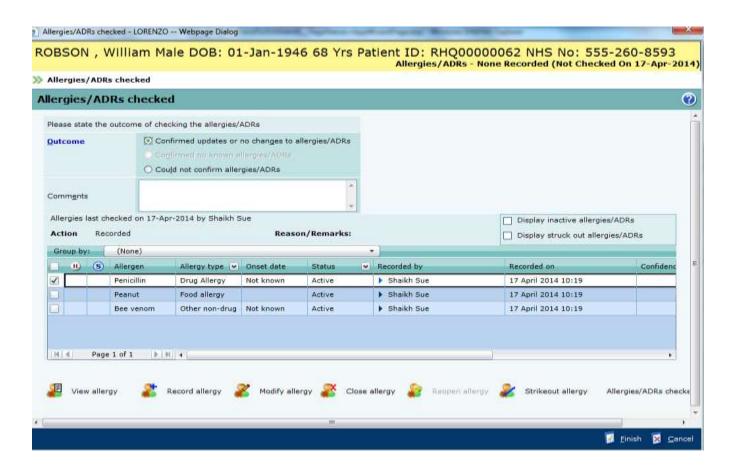
William's personal details are fictional for illustration purposes



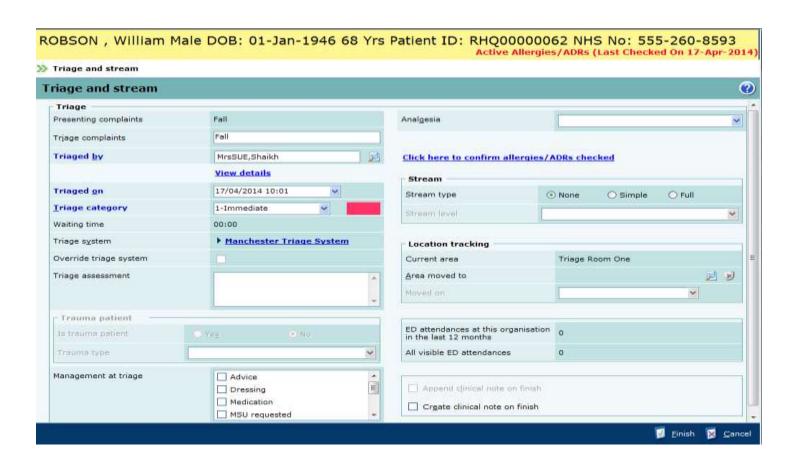
William is booked into ED



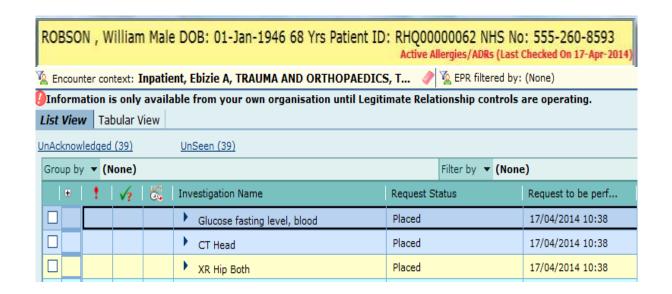
Triage nurse records allergies



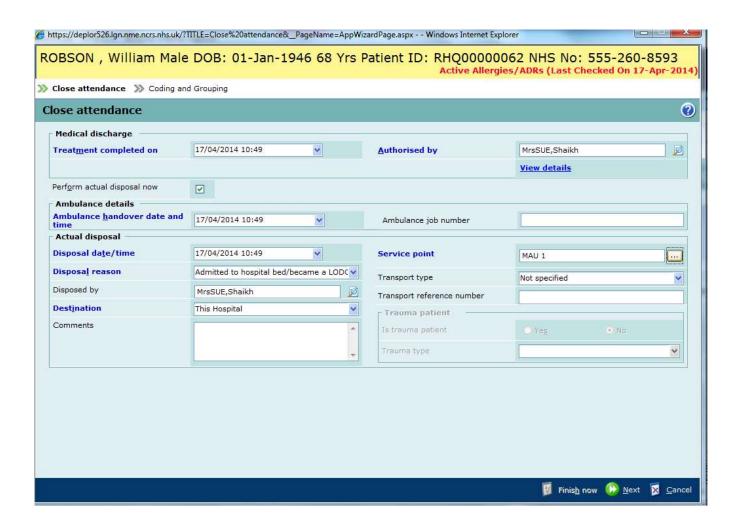
Patient banner is now displaying active allergies against William



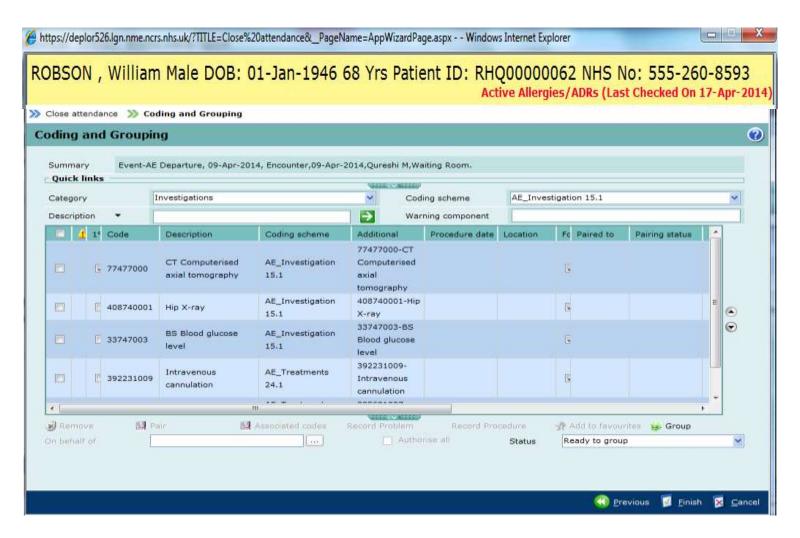
Triage Nurse and Consultant places requests



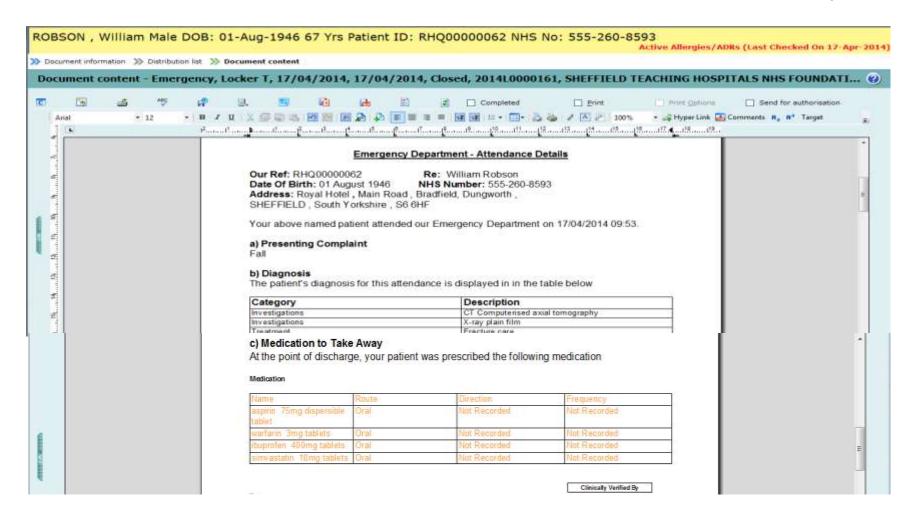
William is ready to go to the ward



Coding is completed in ED



ED Letter to GP created and sent electronically

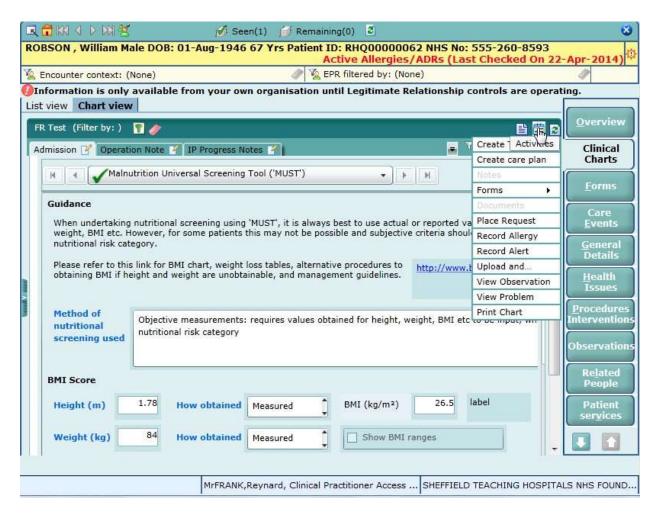


William is now admitted to the ward

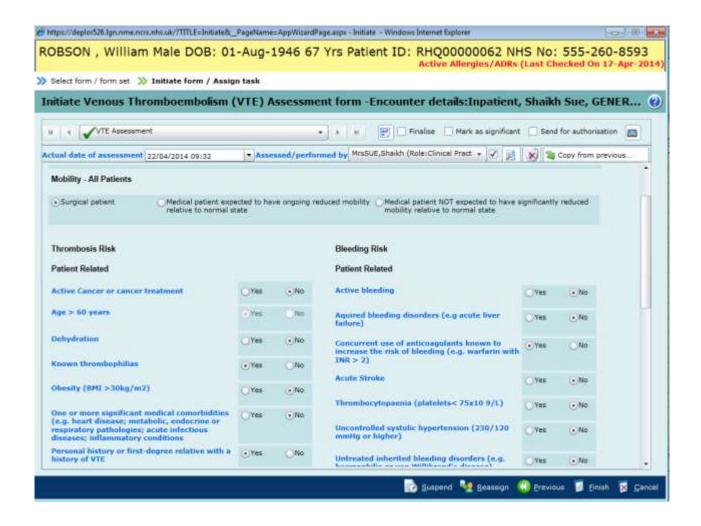


Clinical Charting

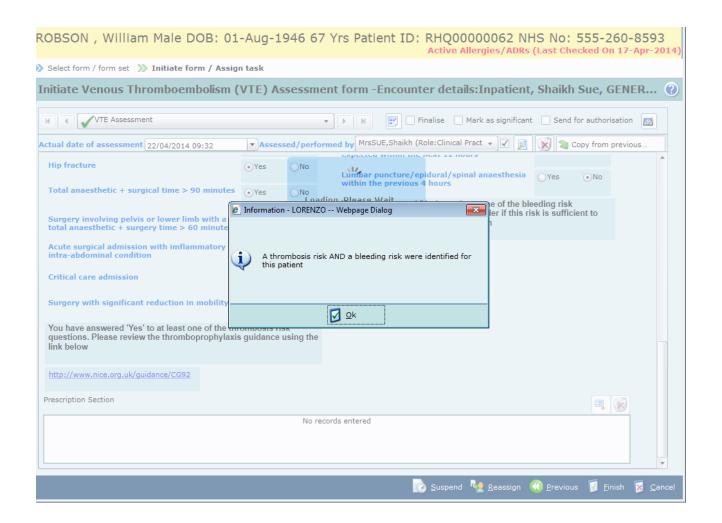
The tabs can be configured and attached to the appropriate clinical notes/docs/forms in order to access information expeditiously and record clinical detail



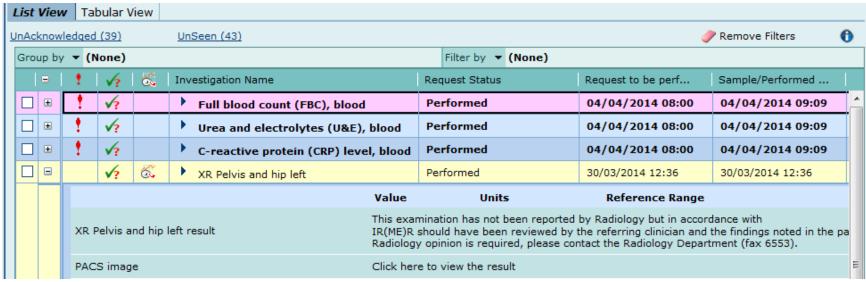
VTE Form is completed via Clinical Charting



Bleeding risk identified for patient

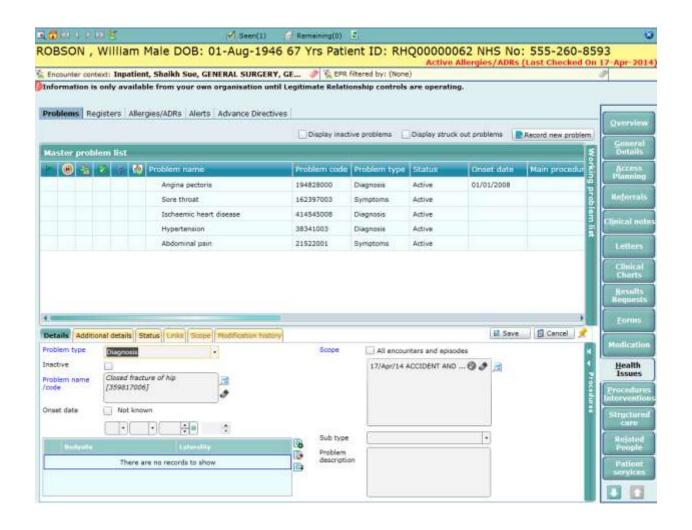


Results of investigations are available for review PACS Image can be viewed via the hyperlink

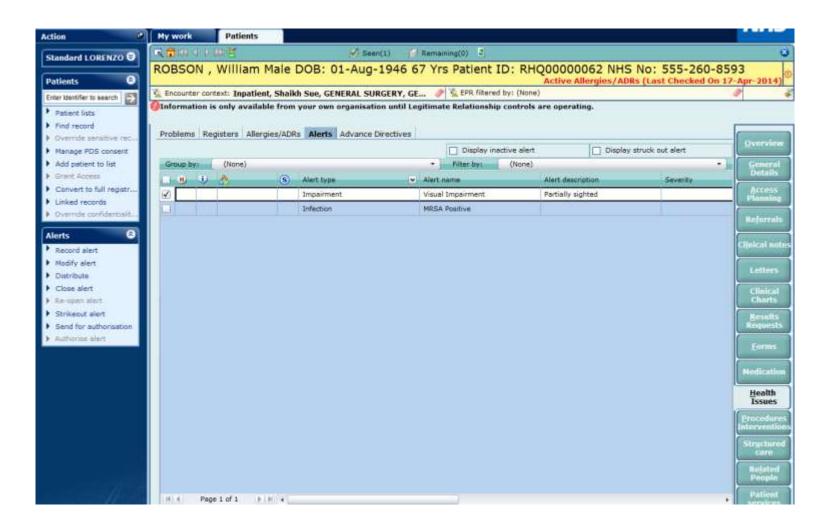




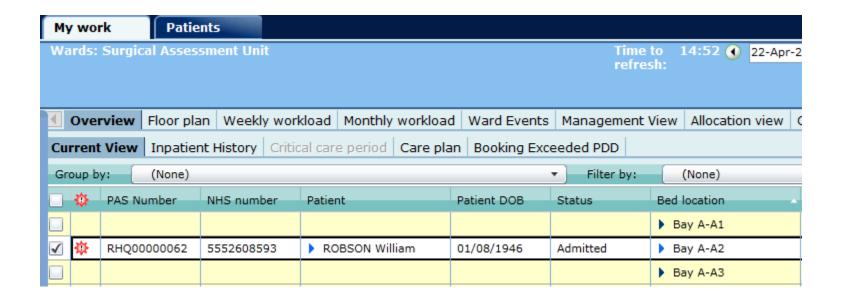
Problems viewed and recorded



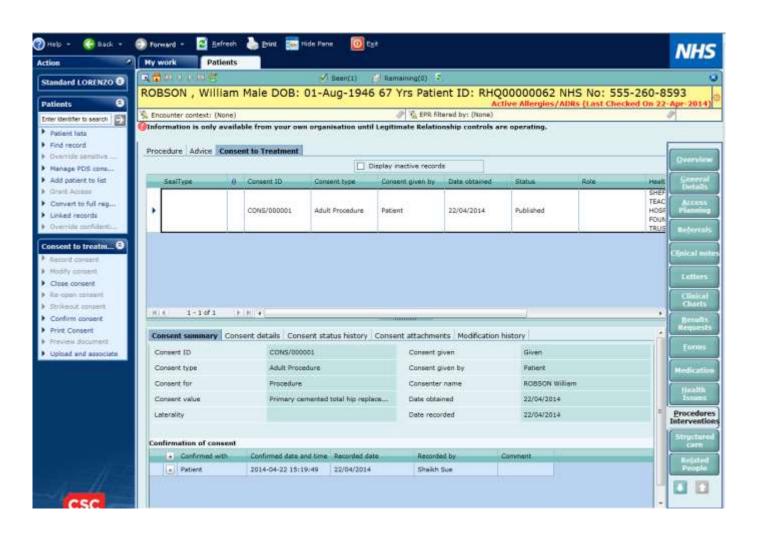
Alerts viewed/recorded



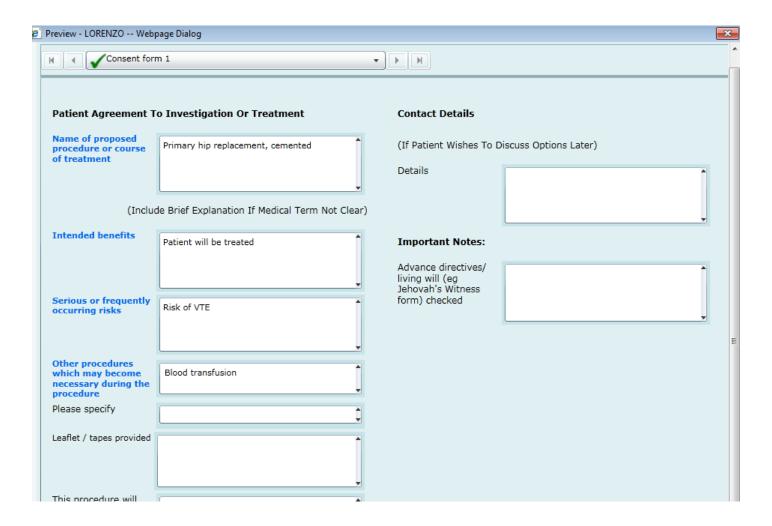
Starburst indicating patient has alerts recorded in their record



Consent has been obtained from patient and recorded in EPR



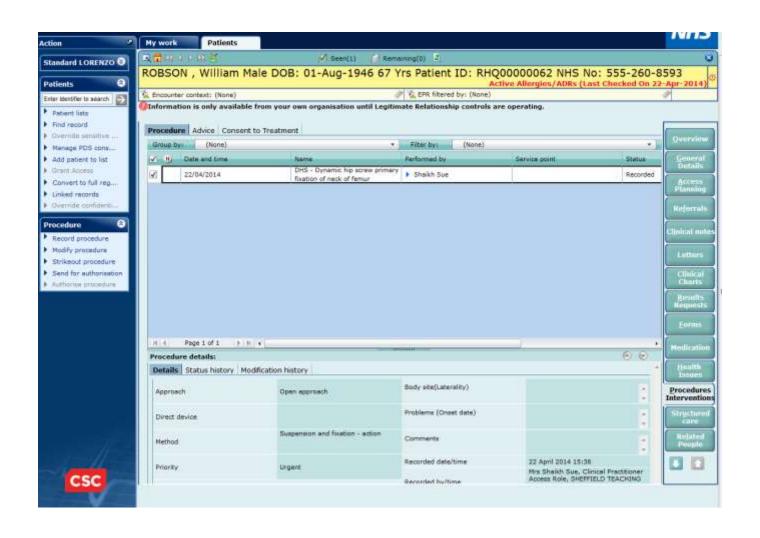
Consent form completed



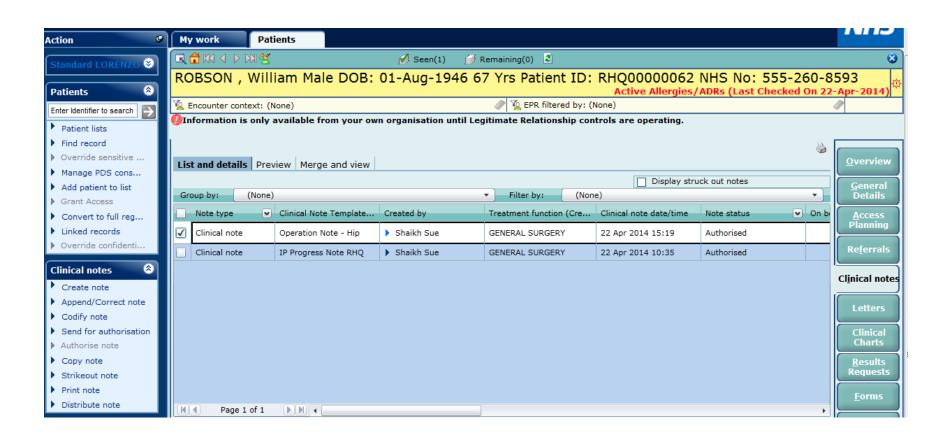
William taken to theatre, procedure is recorded within the operation note via the procedure heading and cited back into the note – templates are configurable

>> Templete selection >> Clinical Note content										Total Control	
Clinical Note content - Inpatient,	ihaikh Sue, Gl	NERAL S	URGE	RY, GENERA	AL SUF	GERY, 2	2/04/	2014,	Open,	2014L0000167, SHEFFIELD TE	ACHING
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	Surgeon De	rtails									
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e e	Operating s	urgeon gra	de:		Fin	t assistan	t grade)	
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E.	Food aflergy			ate(Allergic Spor		ouse					
The state of the s	Other non-drug	Bee vanon	Minth		Spouse						

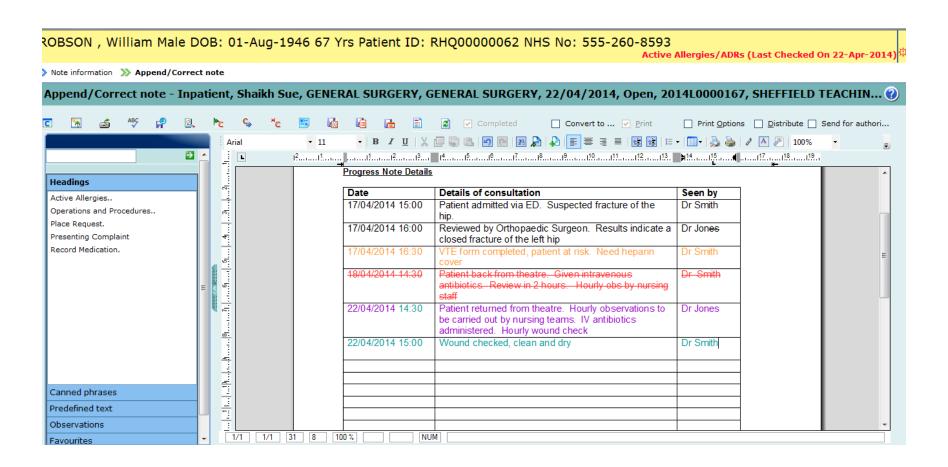
Procedure populates patient's record



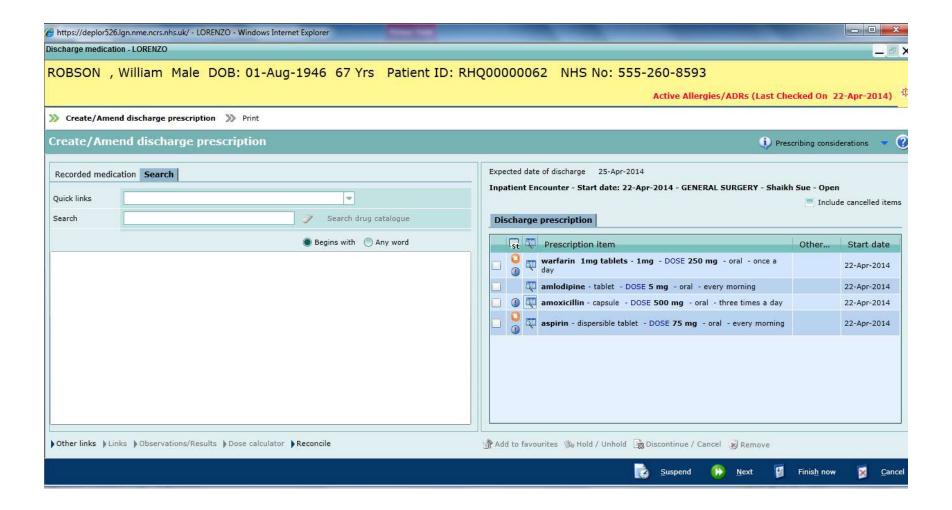
Operation note populates patient record



Progress/Ward round note updated



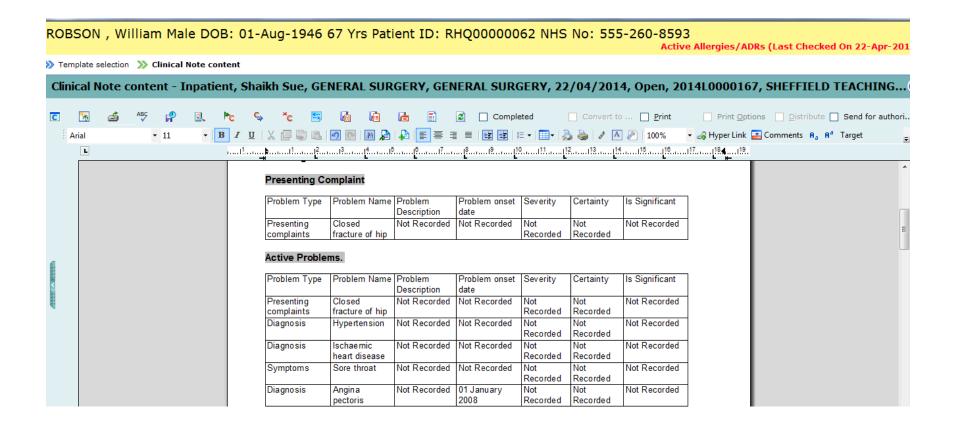
Discharge meds recorded



Discharge meds recorded, conflict with allergy



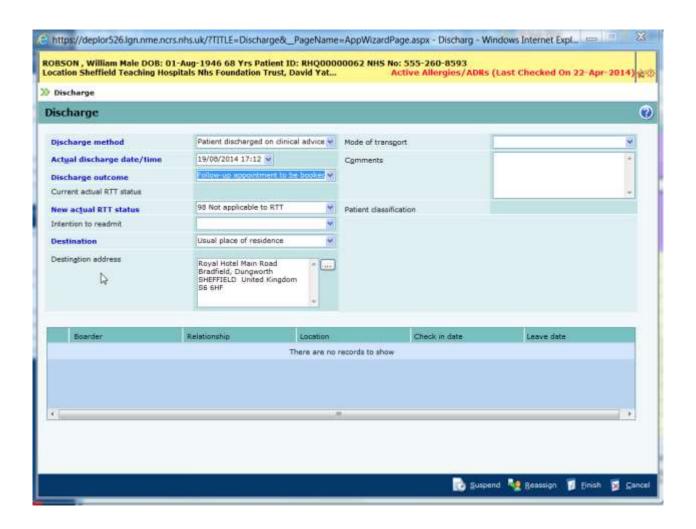
Trust wide discharge summary created, containing clinical detail recorded throughout the patient stay – Slide 1 of 2



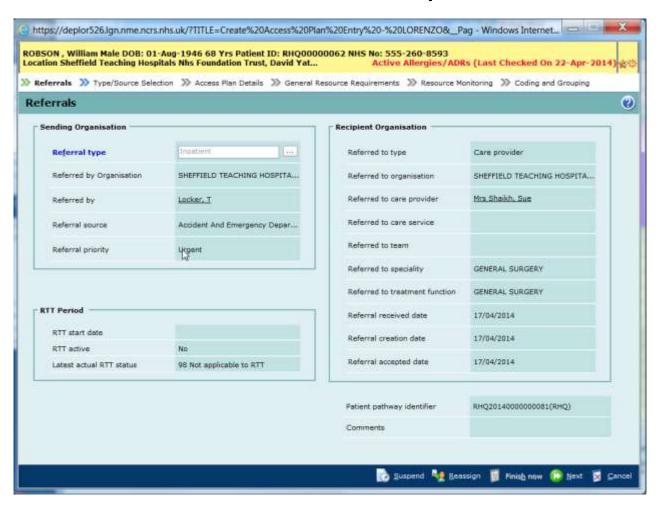
Slide 2

Operations and	Operations and Procedures									
Procedure code	Coding s	scheme P	rocedure name	Procedure performed of	Status					
239286007	SNOME	hi	HS - Dynamic ip screw prima xation of neck smur		4 Record	ed				
Clinical narrative Patient was adm		n emergency	following a fa	II. He sustaine	ed a closed frac	ture of his l	eft hip			
Active Allergies										
Allergen	Allergen		eaction		Severity	Onset date		-		
Penicillin				ck	Severe		Not known			
Peanut	Peanut				Moderate		Not Recorded			
Bee venom	Bee venom		Hiv es		Mild	Not k	Not known			
				on Discharge						
On discharge, where stated. V	this patie Mere a m	edicine is req	uired chronic	complete cou ally or long-ten of each medici	rse of treatment m, the patient h	where appr as been sup	opriate a plied with	nd n at		
where stated. V	Mere a m	edicine is req le	uired chronic	ally or long-ten	m, the patient h	where appr as been sup ription Date	plied with	at at		
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where stated. V	Mere a m	edicine is req le	uired chronic east ten days	ally or long-ten of each medici	m, the patient h	ription Date Clinically Veri	plied with e:22 April	at at		
Prescription no	Mere a m	edicine is req le 00034	uired chronic east ten days	ment Additional comments	m, the patient h ne. Presc	ription Date Clinically Veri	plied with e:22 April	at at		
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Where stated. V Prescription no. NewMedication Medication Name warfain fing solets	RHQPR0	edicine is required to the second sec	Route Treat to do Oral Not Reco	ment Additional comments Not Recorded ded Not Recorded ded	Prescriber Sue Shakh	ription Date Clinically Veri Forename Sur Not Not Not Recorded Not Recorded	e:22 April	at at		

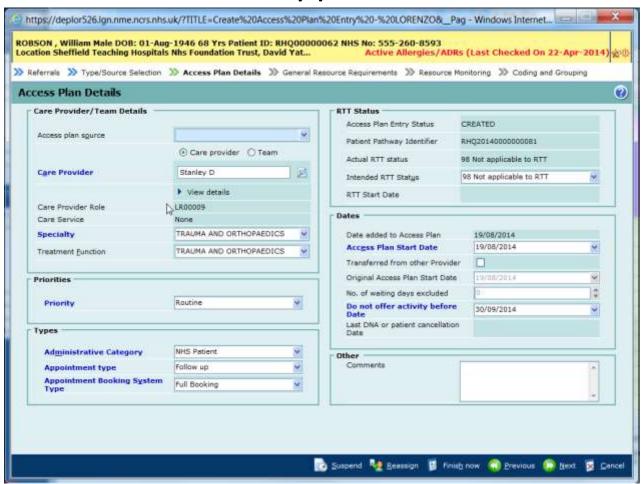
William is ready to be discharged Ward Clerk/Nurse discharges patient



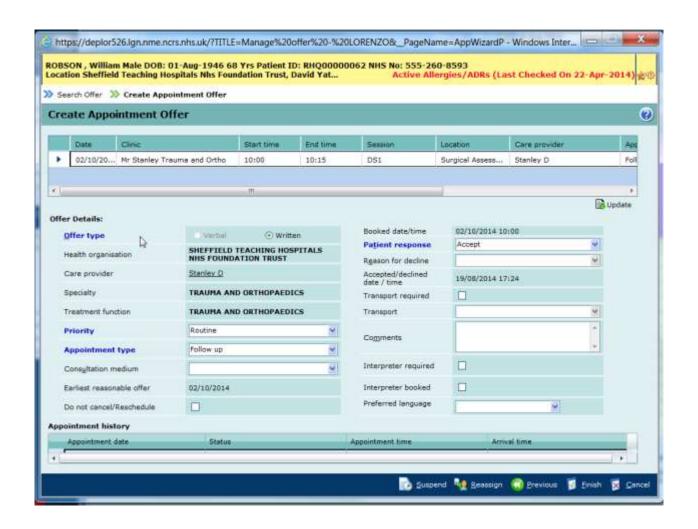
William is added to an Access Plan as he needs a 6/52 follow-up



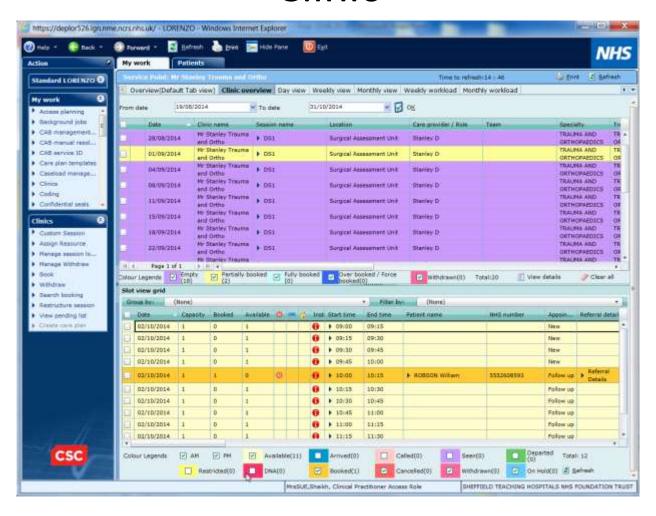
Outpatient Clerk will manage the waiting list and finds a convenient appointment for William



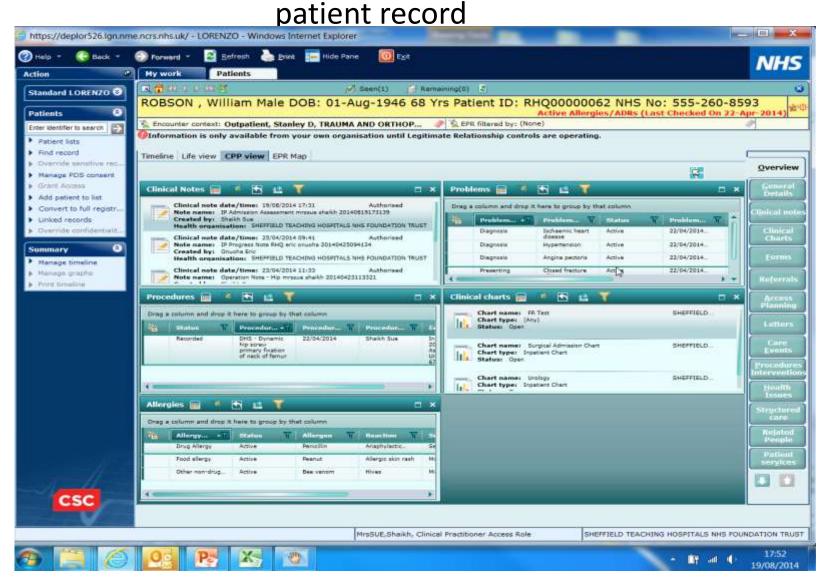
6/52 Appointment agreed with William



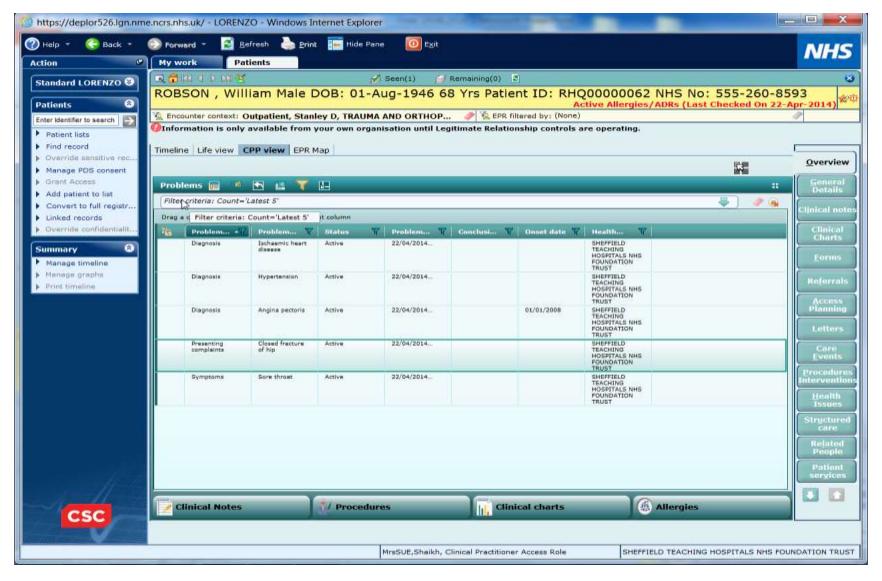
William is now booked onto the Outpatient Clinic



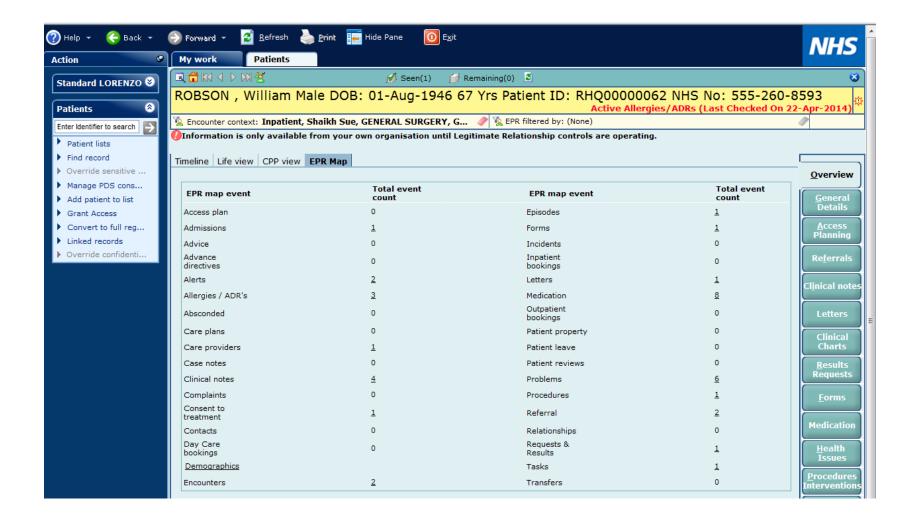
Consultation Preview Pane (CPP) view of care, enriching the



Summary view expanded



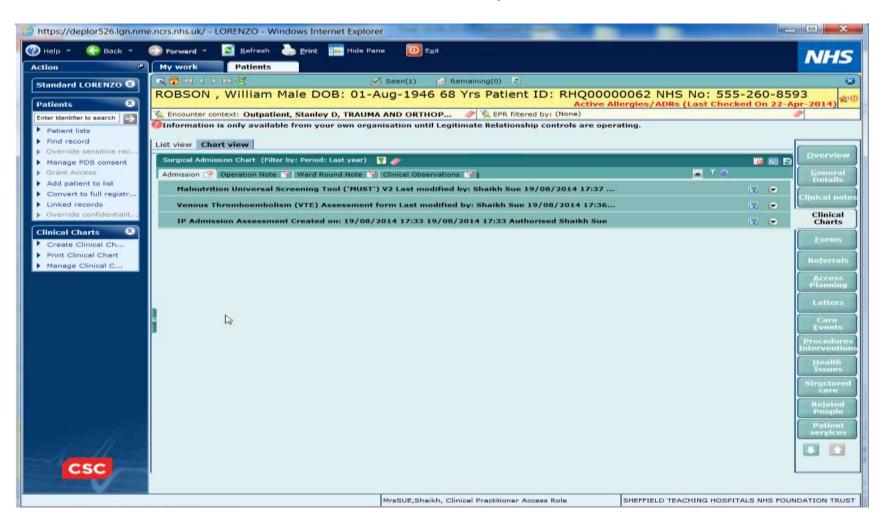
EPR Map



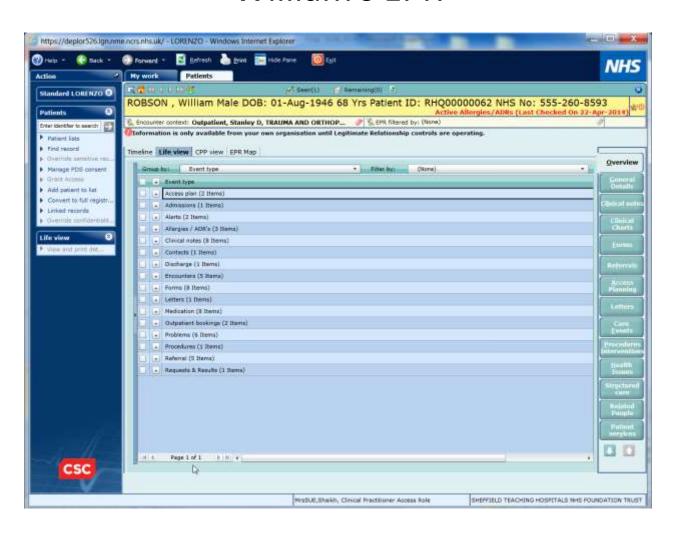
Clinical Charting

The tabs can be configured and attached to the appropriate clinical notes/docs/forms in order to access information expeditiously and record clinical detail

Chart view as an example below



Life View showing all events and transactions within William's EPR



Get involved

- If you would like to find out more about how the EPR will support how you deliver care contact your Operational Change Lead or email: transformation@sth.nhs.co.uk
- Visit <u>www.sth.nhs.uk/transformation</u>
- Make time for your training now

