Electronic Prescribing in Hospitals

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DEMYSTIFYING THE HEALTH CARE MAZE

Dr S  Mr/s D
What are the benefits of paperless

Clinical diagnosis

Patient & staff experience

Safety

Reduce burden & improve efficiency

We owe patients a seamless, paperless NHS, but if they want a letter - fine
General Practice as part of Integrated Care

NHS E-referrals – integrating care
- Improved functionality
- Easier to use
- Information for commissioners
- Online services for patients

E-Prescribing
- Increased uptake
- E-prescribing in hospitals
- Online services for patients

SCR
- Increasing uptake in Urgent & Emergency Care
- Summary Care Records
  - Your emergency care summary

NHS Number as primary identifier to link across all services
Patient Online will empower patients to take greater control of their health and wellbeing by increasing online access to services.
Audit shows preventable diabetes complications are still occurring

Jacqui Wise | LONDON

More than 60 hospital inpatients with diabetes had diabetic ketoacidosis, a life-threatening but entirely preventable complication, in just one week in England and Wales, a national audit report shows.

The National Diabetes Inpatient Audit also documented 232 cases of severe hypoglycaemia requiring injectable treatment. The audit report, commissioned by the NHS Healthcare Quality Improvement Partnership, said that these findings were "shocking" as these life-threatening harms were preventable.

The audit, carried out by the NHS Health and Social Care Information Centre working with the charity Diabetes UK, collected data over five days in September 2012 from 1.34 million patients with diabetes in 336 trusts in England and six local health boards in Wales. Most of the patients were admitted to hospital for reasons other than their diabetes, just 8.2% in England and 9.6% in Wales.

The report found no improvement on previous years in the proportion of patients developing diabetic ketoacidosis. In England 59 inpatients (0.5%) developed diabetic ketoacidosis after admission in 2012, similar to the 65 (0.6%) in 2011 and 44 (0.4%) in 2010. In Wales two patients (0.3%) developed diabetic ketoacidosis in the current audit, similar to the three patients (0.3%) in 2011.

The audit’s lead, Gerry Rayman, a consultant physician at the Diabetes and Endocrine Centre at Ipswich Hospital NHS Trust, said, “It is of grave concern that some patients are developing diabetic ketoacidosis, which is a potentially life-threatening complication in hospital. This is due to their needs being neglected and should simply never happen.”

Bridget Turner, director of policy and care improvement at Diabetes UK, said, “Even a single case of diabetic ketoacidosis developing in hospital is unacceptable because it suggests that insulin has been withheld from that person for some time. The fact that this is regularly happening raises serious questions about the ability of hospitals to provide even the most basic level of diabetes care.”

The audit found that more than a third of patients with diabetes experienced a medication error. The most common was insulin not being increased when blood glucose concentrations were persistently high. Other errors included insulin not being reduced when appropriate, staff failing to note that they had given insulin, and insulin being given at the wrong time. However, numbers of medication errors have fallen slightly from 44.5% of patients in 2010 to 39.8% of inpatients in 2012.
• NICE patient safety guidance 1 (Dec 07):

‘The aim of medicines reconciliation on hospital admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission.’

• SCR can play a key role in medicines management for patients

• SCR potential frees up time for both hospital pharmacists and GP surgeries
“An individual without information can’t take responsibility.

With great power comes great responsibility.

An individual with information can’t help but take responsibility”

Jan Carlzon, business leader (QuoteDaddy)
THIS REPORT SAYS MEDICAL ERRORS SUCH AS INDECIPHERABLE PRESCRIPTIONS CAUSE THE DEATHS OF 98 PATIENTS A YEAR, OR IS THAT 98,000? IT'S HARD TO READ THIS. IN ANY CASE, WE'RE SUPPOSED TO REPORT THEM, OR IS THAT REPEAT THEM?

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Medicines are at the very heart of modern medicine

• The medications we use have increased in number and complexity. This demands more knowledge and understanding from clinical staff

• This also leads to greater concern over the risk of errors and the harm they cause

• Medication errors are indeed identified as a major preventable source of harm in healthcare
Medicines safety is a key concern

• Errors do occur, UK studies show that:
  o Prescribing errors occur in 1.5-9.2% of medication orders written for hospital inpatients
  o Dispensing errors are identified in 0.02% of dispensed items
  o Medication administration errors occur in 3.0-8.0% of non-intravenous doses and about 50% of all intravenous doses

• The use of ePrescribing can help reduce such errors

Source: Vincent C, Barber N, Franklin BD, Burnett S. The contribution of pharmacy to making Britain a safer place to take medicines.

ePrescribing: the utilisation of electronic systems to facilitate and enhance the communication of a prescription or medicine order, aiding the choice, administration and supply of a medicine through knowledge and decision support and providing a robust audit trail for the entire medicines use process.

(NHS Connecting for Health, 2007)

http://www.connectingforhealth.nhs.uk/systemsandservices/eprescribing/baselinefunctspec.pdf
A survey of 101 hospitals in England indicated 69% used some form of electronic prescribing, but there was wide variation in the systems used.

"This kind of technology can help reduce prescribing errors, enable more efficient administration of medicines and free up staff time to spend with patients - not paperwork."
ePrescribing is easy conceptually.
ePrescribing is actually surprisingly complex.
Percentage of trainees reporting routine use of safe prescribing practices

- Checked prescription information: 89%
- Checked for drug allergies: 75%
- Double-checked dosage calculations: 59%
- Checked for renal impairment: 56%
- Checked for potential drug-drug interactions: 30%

Legibility & Completeness

- Reduced risk of misinterpretation
- Reduced time for transcription & re-writing
  - Medical and pharmacy
- Reduced risk of transcription error
  - 50% error rate on some discharge prescription audits
ePrescribing – The basics

Reduction in chart annotation
125 days per year
Efficiency gains

- Improved communication
  - between different departments and care settings
- Reductions in paperwork-related problems
  - e.g. fewer lost prescriptions
- Clearer and more complete audit trails
Medication Error

- Decreased risk of medication errors
  - more legible and complete prescriptions
  - guidance for inexperienced prescribers
  - alerts for contra-indications, allergic reactions and drug-drug interactions
  - support for timely and accurate medicines administration
Non-antibiotics - % Missed

Initial Gradient
-0.01 Percentage Points per Week
p=0.01

Step Change
-0.92 Percentage Points
p<0.001

Step Change
-0.33 Percentage Points
p=0.045

% Missed Non-Antibiotics

% Missed Doses
Parsimonious Model
Intervention
Period of Data Removed
Quality Initiatives.....

CLINICAL DASHBOARD

University Hospital Birmingham
NHS Foundation Trust

Go To Bas Management Tool
Click here for walk through

You are currently viewing wards: E2A

Back To Floor Feedback:

Last visited by: Alison Page
On: 12/11/2008
No. of visits (last 12 months): 5
Comments: Click here to see comments in more detail

Dependency:

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<th>Level</th>
<th>0</th>
<th>1a</th>
<th>1b</th>
<th>2</th>
<th>3</th>
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% Of Patient Feedback

Missed Antibiotics

Missed Non-Antibiotics

Missed-Nutritional Supplements

Click here to see Experience Gauces

Click for list (RESTRICTED USER ACCESS)

Click for list (RESTRICTED USER ACCESS)

Click for list (RESTRICTED USER ACCESS)
Clinician benefits

“There are many occasions where patients have gone into A&E for an urgent problem, didn't know what their medication was and they've ended up staying a few days, just for the hospital to find out what medication they were on before they could make the changes”

• Improved appropriateness of clinical care
• Faster recognition of critical clinical need
• An end to "flying blind" with access to medication history for confused or non-verbalising patients
Respiratory Summary

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<td></td>
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<tr>
<td>Co-Careldopa 25/100 tablets</td>
<td></td>
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<tr>
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<td>Naproxen 250mg tablets cause</td>
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How does a commissioning body influence anything?

• Mandatory elements in contracts
• Funding projects
  • National
  • Local
• Transfer of good practice
  • Gallery of examples /Awards
  • “Do once and share”
• Influence by... influence
NHS TREASURE MAP
Innovations – Promote, Share & Spread your GEMS

Mobile Working
Education
Sharing Information

REGION BORDER
COUNTY BORDERS
CITIES
TOWNS
Technology Funds

Safer Hospitals, Safer Wards Tech Fund 1

Nursing Tech Fund

Process for Tech Fund 2

Benefits & VFM ratios to inform future Tech Funds

Economic analysis to underpin case for investment – revenue as well as capital for ongoing sustainable operations
Welcome to the ePrescribing Toolkit for the NHS

Designed to support NHS hospitals in the planning, implementation and use of ePrescribing and Medicines Administration systems, the toolkit offers you tools, resources and information to help you every step of the way.

Put together by the NIHR funded ePrescribing Research Programme, the toolkit is aimed at NHS managers, IT specialists, doctors, nurses, pharmacists, allied health professionals and patients. Find out more by visiting our FAQ pages or by clicking on the links below.

Planner
A series of mini ‘How to’ guides to support you at every stage of the process

Case Study Showcase
Best practice showcase drawn from the Programme’s case study sites

Interact
Get in touch with us, or talk to suppliers, other hospitals and staff in your hospital

Quick Reference
Key points to remember, potential pitfalls, top tips and FAQs

Tools
Practical tools to estimate costs, evaluate safety and monitor user satisfaction

News and Documents
Papers, reports, references, news and other key documents
Promoting and developing current and future clinical information leaders

What is the CCIO Leaders Network?
The CCIO Leaders Network has been established to promote and develop current and future clinical information leaders across the NHS. The network is being developed in partnership with the Royal College of Physicians and the British Computer Society. It has been made possible thanks to the support of foundation sponsors BT, Cerner and iSoft.

In 2012, the CCIO Leaders Network will deliver an extensive programme of partner events, culminating in the first annual CCIO Forum held at EHI Live 2012. This will be backed by the CCIO Leaders Network website, providing online resources, interviews, case studies and community features.

Sign up to receive information about forthcoming events or join the CCIO Group on EHI Groups to contribute to discussions on clinical leadership, best practice and the professional development pathway for future CCIOs.

CCIO videos

The EHI CCIO Leaders Network launch
Watch the key moments of the CCIO Leaders Network events launch, find out what those attending made of it all, and see why so many people are backing the idea of clinical information champions in the NHS.
Implementing ePrescribing is a challenge, a major project and a substantial change in the way care is delivered.

But it is achievable, and others have achieved it and gained many benefits.

Once it is in use most health care professionals would not want to go back to paper.
Thank you