



sammanchester

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Evaluation of Electronic Prescribing: Positives, Pitfalls and Lessons Learnt.

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- Background
- The methodology
- The key findings
 - The positives
 - The pitfalls (negatives)
- What did we learn and how will that influence future rollouts?

UHL Background

- UHL approx 70 ward over 3 sites
- ePMA live on 27 wards on 1 site
- Longest live area 4 years
- Most recent go live 2.5 years ago
- Changing to new e.prescribing system as part of move to EPR late 2016

Evaluation methodology

- Thematic analysis of Incident forms with primary coding of medication for 6 months prior to rollout of epma, and 6 months post rollout within the largest user area (Emergency and specialist medicine)
- Thematic analysis of incident forms over same periods in non live epma area which most closely mirrored ESM case mix
- Questionnaire to all staff in all live areas

Thematic analysis

Little change in incident type

Except for

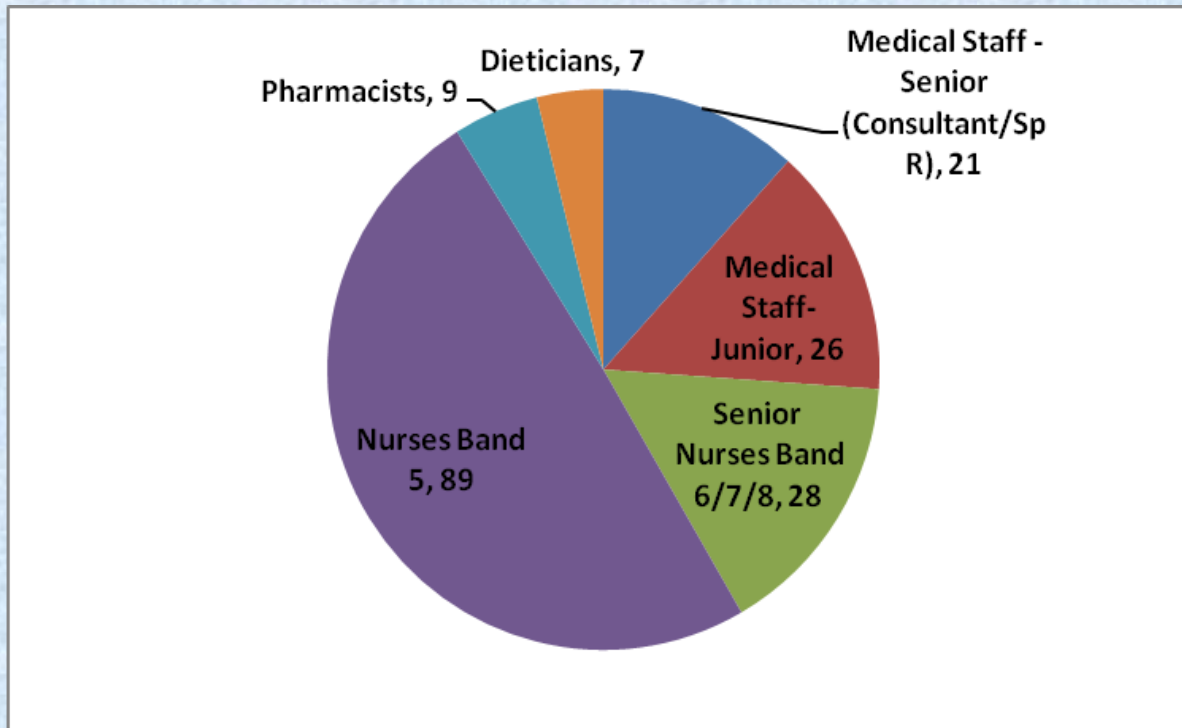
- Decrease in incorrect prescription of TTOs
- No illegible charts
- No missing charts

But

We know there is massive under-reporting of incidents, therefore difficult to draw wider conclusions

Questionnaires

- 180 returns



Paper v Electronic?

Of the respondents who stated a preference:

- Overall 60% preferred ePMA to paper charts

BUT...

- 75% of band 5 RNs preferred ePMA
- 72% of Doctors preferred Paper
- RNs of more than 10years experience preferred paper

Positives

- Reduces drug errors (56%)
- Allows remote prescribing (42%)
- No lost charts/ chart re-writes
- Complaints/ SI investigations easier to undertake

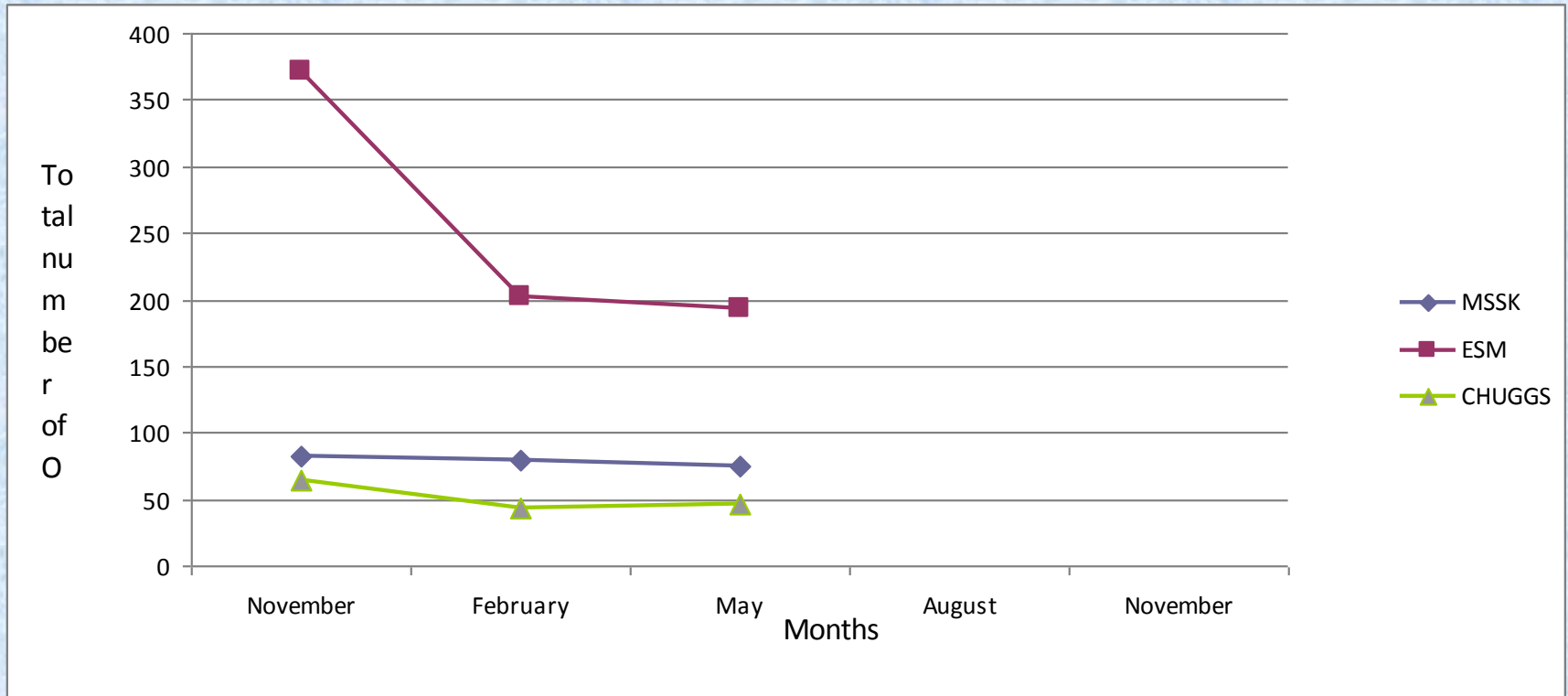
Negatives

- Insufficient working equipment
- Slow system, perceived as unreliable – 91% of respondents indicated system was slow
- Difficulty getting equipment fixed
- Poor integration into care

What we did

- ePMA is not fully integrated into patient care
 - Consolidation work with nursing and medical teams
 - Evaluate the effectiveness of the consolidation work
 - E.prescribing group with frontline users involved
- Deal with 'the great fire of London effect'!!! AKA ePMA is to blame for everything....

Missed Dose audit



What we did -2

- Perceived poor levels of operational/ usable equipment
 - Work undertaken to simplify reporting and undertake bulk battery replacements
-but we still cannot teach people to plug things in!!

Lessons learnt

- There was strong support for e.prescribing just not for the system we were using
- A well functioning system can save time and increase patient safety/ aid investigation
- Early engagement
- It is easier to loose people than to engage them
- Learn to speak computer

Thank you

