RE: Urgent messages regarding EPR documentation for in-patients.

Dear all,

As we are all very aware, EPR continues to present challenges to us all and we remain a long way from realising the benefits that an effective EPR system should bring. The EPR team are currently working to develop a standardised 'CDDFT way' of interacting with EPR for inpatient documentation, as well as on improving the functionality of Drs worklist so that it can be a useful tool for handover and task management. News on this will follow as soon as system changes have been implemented and we can be sure that what is planned will work reliably.

In the mean time we would like to request your support in promoting 3 key messages regarding how we use EPR for inpatient documentation. This is to help address issues identified during incident reviews and note reviews, as well as challenges faced with coding that have resulted in a rapidly deteriorating SHMI.

The 3 messages we would like to focus on are:

1. **Please enter past medical history in to the Doctor's View problem list**
    - Ideally this would be as part of using the admission MPage for the initial clerking, but if this is not happening reliably then PMH can be entered on subsequent review (Problem list appears on all MPages).
    - Adding past medical history in this way has the advantage that it populates future admissions so that you only have to collect the information once.
2. **Please ensure that a diagnosis is entered into the notes as soon as one is made**
    - Ideally add this diagnosis to the problem list as a 'this visit' condition and ensure that is listed as discharge diagnosis (left click on relevant problem in the problem list, then click modify in the box on the right hand side if it is not displaying as 'discharge'). This means that the correct diagnosis will auto-populate the discharge letter.
    - Please use the terms 'probable, 'presumed' or 'treat as' and NOT '?', 'likely', 'impression', 'possible' or 'suspected' if you are documenting a diagnosis in free text.
3. **Please use the 'free text note' template for documentation of ongoing care**
    - The use of 'progress note' or other note templates is leading to note bloat, making notes difficult to read. This is particularly problematic at present because the clinical summary box is not being updated reliably (so documentation from the time of admission appears to be the current situation throughout an admission)
    - Therefore, for the present time we request that after an initial clerking is completed, that the 'free text note' template is used for subsequent ward rounds and patient reviews (autotext can still be used to populate the free text template if required) until the point of discharge (Discharge MPage must be completed to send a discharge letter)

We would be extremely grateful for your assistance with promoting the above messages to junior medical staff as well as implementing them when you are making notes in EPR.

Many thanks in anticipation.