The Walton Centre NHS Foundation Trust

CONFIRMED

Minutes of Clinical Safety Group - IT Digital Systems
Thursday 11th March 2021
14.00- 15.30

Present:

[redacted]

Item No	Action Points
1	**Apologies noted:** [redacted]
2	**Minutes of Previous Meeting** The Minutes of the previous meeting have been approved.
3	**Matters Arising/Action Tracker** Updates have been provided in each agenda item.
4	**Safety Incident Management Log** **New Items** **Request ID 157409** - DOLS were sent to wrong council, The users are selecting incorrect councils for the Dols submission when it is picked up on email checks by CST on [redacted] ward. Users are advised to speak to the councils to disregard and ensure the document is sent to correct patient council. **Request ID 158439** - DOLS were sent to wrong council, The users are selecting incorrect councils for the Dols submission when it is picked up on email checks by CST on [redacted] ward. Users are advised to speak to the councils to disregard and ensure the document is sent to correct patient council. **Request ID 159096**- Inappropriate information was added to a eP2 form, it was a conversation between two colleagues that has gone against a patient record, a staff member has looked into it and it was removed from eP2. **Request ID 160708** - DOLS were sent to wrong council, The users are selecting incorrect councils

	for the Dols submission when it is picked up on email checks by CST on [redacted] ward. Users are advised to speak to the councils to disregard and ensure the document is sent to correct patient council. **Request ID 160708** - DOLS were sent to wrong council, The users are selecting incorrect councils for the Dols submission when it is picked up on email checks by CST on [redacted] ward. Users are advised to speak to the councils to disregard and ensure the document is sent to correct patient council. **Request ID 161265** - DOLS were sent to wrong council, The users are selecting incorrect councils for the Dols submission when it is picked up on email checks by CST on [redacted] ward. Users are advised to speak to the councils to disregard and ensure the document is sent to correct patient council. **Request ID 161772** – Incorrect surgical procedure selected on listing form, A Secretary had to contact CST to advise that consultant had completed a listing form in clinic for surgery where he had listed for an incorrect procedure. The outcome form was unlocked as requested which meant this also removed the document from the secretary dashboard for a new outcome to be completed. **Request ID 162007 -** Digital Dictation letter not required in patient case note, Service desk Request [redacted] received from Divisional Manager to remove a document from EDMS. When queried why the removal was required the Manager advised that the MDT outcome had already been recorded in the patients notes; the letter to be removed was not intended to be included in the patient case notes; rather a letter directly to the treating consultant about the appropriateness of who should deliver the patients care. The document was removed from EDMS and Digital Dictation as requested and the manager confirmed a copy of the document was kept in the Consultants personal file.
5	**System Issues and New Hazards** Falls prevention group- Staff that are using the EWS system while inputting blood pressure couldn't see any data or information when doing so regarding the lying/standing blood pressure, as a whole this needs more awareness from a nursing perspective. **Action: NS advised this needs taking back to senior nursing staff so they can share this with the training team/various nursing groups also to make sure there is more awareness from a nursing perspective.** Nurse specialists looking at pain thresholds, requesting changes to pain threshold rating/grading, the requested change wanted is from 0-5 to 0-10 to give a wider understanding of a patient's pain. **Action: NS advised this to be reviewed with development team based on how the system has been built and if these changes can be accommodated. Feedback will be given via the nursing documentation group.** The Order comms system for radiology has a problem; Patients who are transferred from one consultant to another post radiology order have results against a previous consultant. CRIS can bulk change consultants but EP2 can only change consultants via a manual process, which is passed from CST to the developers. When a consultant is changed in CRIS prior to a result coming through to eP2, eP2 does not acknowledge the change and instead feeds to the prior consultant. **Action: Defer to next meeting.**
6	**Hazard Log** **Open Items:**

	68- External visiting staff entering into patient case-note will not be seen by WCFT users, User entries on paper may have content for medical teams to advise/action which would be missed, there are gaps in decision making if a full patient record is not viewed at the time of care and/or advice has not been actioned delaying patient care. **Update- NS advised there have been occasions where staff are not informing visiting staff of Ep2 entries and guest access to digital entries. These have previously been marked with a sticky label on the continuation sheet as a reminder but has since stopped over a period of time. MW requested for this process to be reviewed again and agreed to contact CIO at Aintree to seek options of improving communication within their hospital.** 76- Relating to the DOLS council problem- Users are unaware that the DOLS referral has been sent to the wrong council, Users are selecting the wrong council from the drop down options this causes a delay in a Council being aware of the application and having steps in place to liaise with trust on patient pathway. **Update- NS to share at nursing documentation group.** 79- PMO Toolkit- Incorrect information is showing on a patient clinical note, Users have added incorrect data entry onto a patient record, Incorrect information on display whilst record is to be fixed through Service Desk. **Update- NS advised group to increase the score. Having added the strike through function for users to amend clinical notes when written in error or against wrong patient, the option to enter a reason for change is not a mandatory field so this needs to be reviewed by means of a mandatory field or a warning message. Group agreed a score change. NS to action.** **The following hazards were discussed and closed:** 69- Medics noting issue- Variation in how trainee doctors are completing digital entries, New trainee doctors are not completing digital noting/entries as explained at their inductions, Gaps in health records and/or variation in how documentation is completed to expected standards, The IT induction needs to emphasise the key digital functions in eP2 relating to medics module. **NS Reason for closure- scored as a one, quality issue more than a clinical issue.** 74- Counter limitation- Users are adding too many characters into a field causing the OCS order not being successfully received in CHRIS, Evidence of copy/paste of information into a field causes this issue to occur and a failed order this causes a delay in radiology scan as another manual order has to be submitted. **NS Reason for closure- No further issues as system has been changed.** 77- Risks in eP2 do not include EPMA risk alerts- Users were unaware of Patient Risks on EP2 are only the PAS risk alerts and do not Drug related risks, User has seen a small sample of allergy risks and assumed all other types should be visible, this caused a confusion on accuracy of patient care. **NS Reason for closure- Information bar has been added to eP2, this is to ensure users are aware the risks in eP2 don't include EPMA.**
	<u>Clinical Safety Case Report</u> Strikethrough On Clinical Notes **NS Update -** Case report in-situ. Everything has been tested, signed off and agreed. Changes to be added once an additional fix can be accommodate**.** IVIG calculator

	NS Update - Case report in-situ. Needs to be signed off from UAT point of view. All previous stages have been tested and is available for use on the Trust intranet. Risks are using the wrong calculations, for example grams per day being incorrect but are a. low risk rating. EPR Scanning **Update NS -** No case report yet. For discussion at next meeting.
8	**Planned upgrades to existing / new systems** 2 new releases since January as part of the new paper lite module, 7 new forms are available for occupational therapy, physio therapy and speech and language since the end of January, also the new mental capacity assessments have been rolled out onto the wards Removal of two old versions that are already on eP2 giving staff the ability to refer patients with acute pain. A new e-from for MDT meetings.
9	**AOB** External agency Ep2 documentation. No incident report from the outage yet. The files for all hazard logs are on SharePoint but will need adding to MS teams in the future for easier access for staff while on calls/in meetings.
10	**Governing Body** Terms of Reference will be circulated back out to the group and sent to Quality Committee for approval. Group agreed for meetings to remain as a Thursday afternoon at 2pm, second week of each month.
11	**Date of Next Meeting** Next meeting 15th April 2021, 2.00pm