ED Blueprint

Milton Keynes University Hospital is implementing the eCARE clinical system which will increase patient safety and improve patient care. The eCARE system will provide improved access to clinical information and decision support which will enabling a more efficient way of working.

What will be available at Go Live in the eCARE system	What will not be available in the eCARE system at Go Live and will continue on paper as current process

ED FirstNet
- Pre- Arrival documentation
- Ambulance handover
- Patient Triage and Assessment including Paeds
- Launchpoint Tracking Board
- Dynamic Documentation - patient letters /notes
- ED Real Time Dashboard
- Activities of Daily Living
- Decision Support Rules (triggers any ongoing assess)
- Clinical Note Types including Paeds
- Clinical Orders Catalogue
- Fluid Balance
- Patient Isolation Status
- Orders
- Depart process including Paeds
- Safeguarding including Paeds
- Reporting Functionality
- Vitals
- DNaCPR decision recorded on the system
- Sepsis
- Point of care testing
- VTE assessment
- Dementia and Delirium assessment
- ED Patient clerking including Paeds
- ED Pre - Coded Discharge including including Paeds

- Paeds Vitals
- ECG's, TARN information collection
- Consent & self discharge forms
- Pathways of Care (Stroke, #NOF etc)
- This is me
- DNaCPR paper process on paper
- Paeds sepsis

What will be available at Go Live in the eCARE system	What will not be available in the eCARE system at Go Live and will continue on paper as current process

Doctors
- VTE assessment
- Dementia and Delirium assessment
- In Patient clerking
- Discharge including electronic discharge

- Patient pathways
- Paediatrics
- Theatre clerking and operation notes
- DoCC

AHP's – Physio/OT/SaLT/Dietitians
- Electronic referrals (IP only)
- Electronic 'contact forms' (IP only)
- Scheduling of clinics and appointments (OP and Community – excluding SaLT)
- Review of all clinical information, including documentation, observations and results
- Summary view of relevant clinical information
- Progress note per main therapy (SOAP note format)
- Electronic ordering/prescribing
- Discharge planning and discharge letters

- Specialist assessment documentation
- SaLT outpatients
- OP/community referrals

EPMA
- Allergy Recording
- Medicines History
- Medicines Reconciliation - Admission & Discharge (TTO's)
- Meds Order Catalogue
- Decision Support - Allergy interactions
- Care Plans and I.V. Sets
- Pharmacy verification and Intervention
- Medicines Administration

- Paediatric EPMA
- No FP10 Outpatient Prescribing option.

Order Comms
- Favourite folders for commonly requested tests which can be tailored to clinician, specialty discipline or patient condition
- Electronic results endorsing, view results and document action taken
- Trend results
- Clinical messaging including transfer of patients results to another clinician
- Point of care testing

- ECG's requests but results not available electronically
- Paper request for tertiary hospitals
- Consent forms

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PAS
- Automatic modifying of follow up appointments
- Offer Forms - to cancel appointments with correct logic reasons
- Logic to stop encounters being utilized more than once for first appointments
- Ward discharge requests for follow up appointments
- Order Comms requests for follow up appointments

- The ability to remove the existing encounter when rescheduling an appointment.