General Ward 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
Nursing • Adult Basic Admission Assessment • Activities of Daily Living • Summary Views (Care Compass) • Decision Support Rules (triggers any ongoing assess) • Clinical Note Types • Clinical Orders Catalogue • Fluid Balance • Nursing Assessment Forms • Care Plans • Adult specific assessments • Patient Isolation Status • Orders • Depart process • RRT • Reporting Functionality • Vitals • DNaCPR decision recorded on the system	• Pathways of Care (Stroke, #NOF etc) • Any pathway that has pre, peri, post and recovery phases • Enhanced recovery • This is me • Safeguarding – as current process • DNaCPR paper process on paper
Doctors • VTE assessment • Dementia and Delirium assessment • Patient clerking • Ward round and handover clerking • Patient dashboards including patient lists • Discharge including electronic discharge • Hospital @night • Level 1 pathway	• Patient pathways • Paediatrics • Theatre clerking and operation notes • Specialist bespoke software

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
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	• No FP10 Outpatient Prescribing option. • Not used intra-operatively to record anaesthetic drugs / gases administered.
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 • Phlebotomy ward rounds • Point of care testing	• ECG's requests but results not available electronically • Paper request for tertiary hospitals • Consent forms
PAS • Real time ADT • 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.