PATIENT REPORT FORM

The electronic Patient Report Form (ePRF)

St John is leading the work to introduce an ambulance electronic clinical record

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St John, supported by the Ministry of Health and ACC, is leading the work to introduce an ambulance electronic clinical record

As part of our commitment to providing the best possible patient care, St John is moving from hand-written clinical records to a new electronic Patient Report Form (ePRF) system.

By electronically capturing patient assessment and interaction information we aim to improve the quality and safety of our services and patients' experiences - due to the ability to share relevant and timely information with other healthcare providers involved in their care.

ePRF is a key component and facilitator of the Ministry of Health's strategy for integrated sector information systems. This will allow us to contribute more effectively to a better integrated healthcare system.

What will ePRF do?

- Replace our existing hand-written clinical records.
- Enable digital capture of patient clinical records.
- Enable better clinical decisions and improve patient outcomes.
- Improve the quality and usability of information at patient admission.
- Contribute to the collection of population health data.
- Capture information for review and audit that will enable us to improve our patient care and practices
- Connect our mobile workforce.
- Lay the foundations for electronic sharing of patient information with our partners in primary and secondary care.

What will be the benefits of ePRF?

For patients

- Ambulance officers' access to better patient information could make the difference between having to go to hospital or being able to stay at home.
- Better focused training informed by ePRF data will improve our officers' skills, that will lead to improved patient care and outcomes.
- Better care for patients we see repeatedly, due to better information available to the officers treating them.

For hospitals

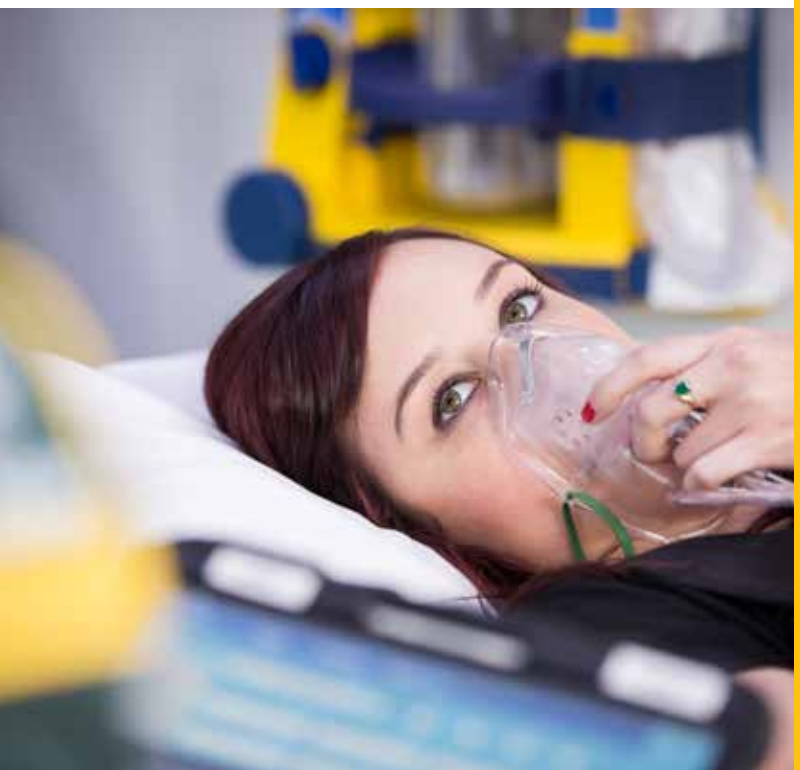
- Hospital receiving points (e.g. ED, Maternity) may choose to receive electronic advice of all incoming ambulances.
- Hand-written patient report forms will be replaced by digital documents that are legible, consistent and complete.
- Hospitals may choose in the future to receive ambulance data directly to their Clinical Workstation Systems.

For primary care, medical centres and other receiving facilities

- Transfer of care will be easier because the quality of patient documentation provided by ambulance will improve.
- Care planning will improve through ePRFs capturing more complete and up-to-date patient information.

What shortcomings will ePRF address?

- Hand-written patient report forms may be illegible or incomplete.
- Patient NHI number is not consistently collected.
- Hospitals are not always aware of incoming ambulance patients.
- Ambulance clinical record is not available digitally to hospitals and other receiving facilities.



How will people receive patient care information from St John?

For patients, hospitals and other partners receiving Transfer of Care for a patient (including A&Ms, GPs, district nurses, etc.)

- The Ambulance Officer will hand over an Ambulance Care Summary Advice sheet on which they record the secure Unique Access Code (or handover PIN) for the incident
- For a period of 7 days following our patient interaction, the Ambulance Care Summary will be available, using the secure Unique Access Code, from the Internet.
- The Ambulance Care Summary can be downloaded, printed or saved to the patient's or partner's files, as required.
- After the 7 day period, copies of the Ambulance Care Summary can be requested from St John.

In addition, hospitals may choose to receive Ambulance Care Summary data directly to their Clinical Workstation Systems. The data standard (HISO 10052) that hospitals' ICT teams may use to achieve this integration has been developed with and published by the Ministry of Health National Health IT Board.

ePRF will open the door for bigger opportunities in the future:

- If a patient is enrolled with a practice, their GP will receive details of their having been seen by an ambulance officer in their practice inbox on the following the day (the patient may choose to opt out of this).
- We will be able to work with hospitals and other destinations to speed up the handover process and reduce congestion in the triage area.
- ePRF can be integrated with the Shared Care Record to:
  - make Ambulance Care Summaries available electronically to all subscribers and
  - give ambulance officers access to relevant patient information at point of care.
- Partners' systems will be able to pass patient outcome data (e.g. confirmed diagnosis, disposition on leaving ED, 28 day mortality) to Ambulance for research purposes.
- ePRF will collect structured (CDA) and coded (SNOMED) patient data for further analysis by all of the healthcare sector.

How will ePRF enable interoperability with clinical information systems?

- The ePRF solution includes a Clinical Data Repository (CDR) hosted by St John.
- St John's CDR holds Ambulance Care Summaries in two formats: as PDF-format documents, available for online distribution, retrieval and printing; and as HL7 Clinical Document Architecture (CDA) files that will be readable by hospitals' systems in the future.
  - The data standard for our Ambulance Care Summary has been defined in consultation with the (NZ) National Health IT Board and has been promulgated by them, as HISO 10052. The standard as initially published will evolve over time, alongside information integration across the broader healthcare sector.
  - The CDA document includes, clinical observations made, medication administered, interventions performed and clinical impression; all SNOMED coded.
  - The SNOMED coded clinical impressions align with the recently agreed NZ Emergency Care Reference Set.
- Also in the future:
  - St John's CDR will be available on the Connected Health network. With appropriate security controls, Ambulance Care Summary data will be accessible by hospital Clinical Workstations and Shared Care Record systems.
  - An indexed Record Locator Service, to be provided by the Ministry of Health as part of the HISO 10040 Health Information Exchange, will also enable access to St John's Ambulance Care Summary documents in the CDR.

What do we need from our partners?

For ePRF to succeed, engagement and training with EDs and other patient destinations are vital.

- We will agree with each partner how transfer of care will work in their patient receiving points (e.g. in EDs, Admissions, A&Ms and surgeries); this cannot be 'one size fits all'.
- Each receiving point will need training and facilities so that Ambulance Care Summaries (replacing the hand-written paper patient report form) can be accessed, downloaded and/or printed for patients being delivered to them, using the Unique Access Code that our Ambulance Officers will provide.

In the longer term, DHBs may also choose to develop their clinical systems to:

- access the Ambulance Care Summaries directly from St John's CDR;
- interrogate the central Record Locator Service (proposed by the Ministry of Health) to discover available clinical records for a patient – this will include the Ambulance Care Summaries
- make information available back to ambulance regarding patient outcomes.

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For further information please contact our ePRF Information Desk by email or phone on:

ePRF.info@stjohn.org.nz
0800 STJOHN (0800 785 646)

or check our website for the latest on ePRF:
www.stjohn.org.nz/eprf

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