IMO Follow up to the Special Committee on Covid-19 Response regarding

IT deficits within healthcare in Ireland.

July 2020

Background:

The benefits of Information and Communication technology in health care are well-known. Electronic health records can enhance patient safety and quality of care, reduce repetition and errors in diagnostics and treatments and lead to administrative efficiencies. eHealth is key to integrated care, supporting the smooth transfer of patients between settings. The collection of data also allows for the advance of medical knowledge, management of disease and health service planning

While Electronic Healthcare Records have been piloted in some hospitals, the majority of hospitals in Ireland are still using paper-based notes systems as the main patient record as well as paper-based systems for tracking patient referrals, Out Patient appointments etc

Laboratory results and radiology are largely accessible as online systems. However mostly the laboratory system is unique to each hospital and while there is a national radiology system this has not had universal up-take. Accessing these systems in community services, such as psychiatry, outside of the hospital system is very poor.

Communication between different health services is usually done via the post. Some hospital/GP units when referring have moved to a system of emailed letters via the "healthmail.ie" system however this has not had universal uptake either.

Communication between hospital sites to retrieve old records can be incredibly laborious with the requesting site often being forced to send a written consent to release information from one HSE hospital to another HSE hospital before the other site will send any information.

In General practice, the majority of GPs have recognised the value of eHealth invested significantly in practice management systems.

Under the deal reached between the IMO and the HSE and Department of Health in 2019 there was agreement to support GPs in the development of their practice systems and the roll-out of key ehealth initiatives over the next 4 years including:

- The Rollout of the Individual health identifiers (for which the legislation is already in place):
- Continued and expanded use of eReferrals;
- Co-operation with the specific agreed e Prescribing model
- Use of NImis for ordering of diagnostic imaging services;
- Use of the summary and shared care records system;

- Cooperation with the development and rollout of an integrated system management of immunisations;
- Continued and expanded use of Healthlink;
- Continued and expanded use of Healthmail;
- Co-operation with the initial rollout of Medlis for the ordering of blood tests.
- Continued use of PCRS suite;

This co-operation is subject the HSE having the necessary developments in place and the continued honouring of the reversal of FEMPI process over the course of the agreement.

Issues with paper-based health records

- Patients who are known to a particular hospital and attend the Emergency Department in that hospital will have to get their medical record chart retrieved to the ED to find their past history. This can lead to significant wait times in the ED department if there is a delay in getting the chart (weekends and evenings) from the medical records department. This leads to a longer wait in the Emergency Department with knock on effects to trolleys; waiting times and deficits in acute care. Alternatively it can lead to a duplication of tests or patients being treated with suboptimal information.
- For patients who have been recently discharged or recently attended an Outpatient appointment, their records can be difficult or impossible to locate as most hospitals operate a paper-based tracking system. Sometimes these charts can be stored in places that are not accessible out of hours.
- Many hospitals are running clinics in off-site areas (either smaller hospitals or Primary Care Centres). In order to facilitate this the patients who are due to attend have their medical records transported to that site in advance to the clinic site. However if the patient attended the Emergency Department while the chart was “in transit” that chart might not be available within the hospital at all. This can mean that vital information is lost and not available.
- Patients who attend a hospital for a longer period of time or have had multiple admissions often need their medical records split into a number of actual physical “charts”. Due often to size issues the older charts aren’t able to be stored on the ward with the patient or are inconveniently located. This can lead to important information being located in an older chart and thus getting lost and missed.
- Paper charts make it very hard to identify important and critical information from less important day to day type information. For example, if a patient has an allergy to a drug they received during an admission in 2009 and the details of that event are recorded in chart number 3 of their record. If they have a number of admissions in the meanwhile and are admitted in 2019 they could be on chart number 14. For the allergy to be noted they would require someone to physically note it on the front of the new chart every-time a chart is opened. If that is missed once it is unlikely to be recorded again and they are now at risk of another allergic type reaction and possible catastrophe.
- With paper based notes there is always the risk of poor handwriting; charts getting lost or pages falling out and thus getting lost. Of note those pages which are most important are often the most read and at higher risk of falling out.
- With the increase in “checklist” type medical notes (often patient will have daily paper based record of their fluid volume consumed and their urine output for example) this can lead to a

large volume of notes being records. It also makes it hard to spot important trends in certain variables due to the notes being filed in the wrong order; in older charts etc….

Issues associated with paper-based records and care provided in multiple locations:

- With the specialisation of medicine and reconfiguration of the hospital system, patients often have to attend more than one hospital due to either a) specialist care only being available in one hospital rather than another or b) or the Emergency Department in the hospital they normally attend now operates from 8am-8pm Again, this means that often the patient is delayed in the Emergency Department waiting for notes to be transferred, duplication of tests, or patients being treated with suboptimal information available .
- In a paper based system when a patients is transferred/referred from one hospital to another hospital a large amount of time is taken in writing very detailed referral letters and/or photocopying notes (often being done by doctors as no other staff are available). An IT system that allows access to background notes to the second hospital would allow for the referring hospital to write shorter referral notes as the receiving team could access the medical record directly.

Communication Issues/Case Conferences/MultiDisciplinary Team Meetings:

- Effective inter-professional collaboration and team work is essential to the delivery of quality, safe healthcare. In order to participate in case conference or multi-disciplinary team meetings both health records and team members must travel to one location. number Given the high number of "stand-alone" medical facilities (ie Paediatric Hospitals; Maternity Hospitals; Psychiatry Services etc...) this can mean a number of professionals travelling (taking travel time away from clinical duties) as well as the risk of notes being lost.

Issues relating to the use of paper-based records in Psychiatry:

- Patients with chronic and Enduring mental illness die approximately 10 years earlier than the rest of the population. This is not due to suicide or accidents but rather due to medical health problems specifically cardiovascular disease; diabetes; hormonal difficulties etc. Due to the move to Primary Care centres the patients medical care notes are often located with the local hospital (where they may attend the Diabetic Clinic) or with their GP. The information is not with their treating psychiatrist who then has to make decisions about medication and other management in a vacuum of information.
- In Ireland annually over 12,000 people present to hospitals following an episode of self-harm. They require an urgent mental health assessment at that time however this is almost always required to be done in a General Hospital ED as they also require treatment for their episode of self-harm (stitching; poison antidote etc…) Given that the community Out Patient record are now stored in the site of Primary Care Centres this means that the patient is being poorly assessed due to absence of background history and can lead to poorly informed treatment decisions.

COVID 19 Challenges:

- In the light of the current COVID19 pandemic patients have been moved from different clinical sites at an unprecedented volume. This is likely to continue to happen as we get second wave type outbreaks which may happen in a regional manner requiring overwhelmed hospitals in one area transferring patients to hospitals in other sites. This

often involves patients making more than one move as they transfer to the other site and then require to transfer back to the original hospital.

- In response to the COVID19 pandemic we have also seen an attempt to move to on-line and remote consultations with patients as well as on-line Team Meetings and case discussions. However issues have arisen in relation to security and compatibility of software. There is also a dire lack of up-to-date hardware (ie computers without camera or microphones) to allow for consultations or conferencing to happen.

Healthcare is primarily a knowledge and information driven activity more than almost any other modern human activity. Even before the COVID19 pandemic the suggested reforms of "SlainteCare" were going to put severe stress on the information with the proposals to move large quantities of patient care to the community and off site locations. In the interest of integrated care and improving patient safety urgent investment is needed in information and communication technology.

Recommendations:

1. **Investment in the roll out of electronic health records across all hospitals and community health centres Each hospital or CHO may have different systems provided systems cans communicate and allow for embedding of national summary patient records;**
2. **Investment in IT infrastructure so that every outpatient sites; Primary Care centres and other health care sites have at least one room that is adequately equipped with microphones and screens to allow for remote patient consultations where safe to do so.**
3. **Investment is a secure system that allows for integrated team working that each member of a multi-disciplinary team can access via remote and desk top devices and allows for access to OPD lists, new patient referrals.**
4. **Investment in a system that allows for remote Professional to professional consultation (with the possibility of patient access as well) that will allow for document sharing; shared viewing of radiological scans etc.**
5. **Ensure on-going investment and cooperation in the development of eHealth in General Practice in line with the agreement between the IMO, the HSE and the Dept of Health.**