Royal College of Emergency Medicine

RCEM Informatics Committee

Advice for clinicians involved in ED IT procurement

December 2022

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IT system procurement is usually undertaken at a Trust level and can be bewildering for clinicians involved in the process. We suggest that these issues should be considered during the process. This is clearly not an exhaustive list, and members of the Informatics Committee are happy to help with specific questions.

- Single sign-in: the entire system should be accessible from a single login, without a need to re-enter usernames or passwords.
- Persistent sessions – when moving between screens, switching users, the state of each user's last interaction with the record system should be maintained to prevent replication of work. User sessions should expire after a sensible period or when the patient is discharged.
- The system should have integrated access to core clinical functions:
    - Pathology ordering and results
    - Radiology requesting, reports and images
    - Inpatient and clinic letters from the rest of the hospital
    - Electronic prescribing and medicines administration - for e-prescribing to be safer than routine care patient name bands should be incorporated.
    - Electronic referrals to specialty teams
- Consider whether integration with clinical hardware (e.g., automatic electronic observation capture, recording of POCUS images) is required.
- There should be a link within the system to shared care records (e.g., primary care, mental health, social care, 3rd sector) – this should not require a separate login.
- The system should integrate with the NHS spine for demographics and safeguarding alerts.
- The system should send FH-IR Transfer of Care messages to allow electronic distribution of ED discharge letters.
- Consider compatibility with other relevant EDs e.g., in a trauma network.
- Ease of use: the interface should not impact on clinical flow i.e. number of clicks per task should be minimised. For further information on this and System Usability see https://emj.bmj.com/content/38/6/410.long
- Internal consistency: processes for e.g., pathology and radiology should be the same; allergies/diagnoses should be presented consistently through the system.
- Tasks (e.g., ECG, plaster application) and coding should be captured and timestamped automatically within the clinical workflow.
- Command and control functionality for shift leaders: how does the system display a "whiteboard"? Can this be subdivided by different clinical areas/acuity? Can it display real-time summary statistics e.g., numbers waiting for triage, bed requests.
- The system should have resilience to service interruption e.g., is there an ability to "print all" in a business continuity incident?

- Training burden: what is the time commitment to train existing and new staff on the system?
- Will a new system require a change to the department's processes?
- Ease of updates: if the department changes its patterns of workflow how easily can the system be modified to affect this?
- All systems must be implemented with accompanying data strategies (storage, access, analytics, national opt-out etc.) to support quality improvement and research.

Some trusts will procure a single electronic record across all clinical areas; others will have a stand-alone ED information system. Where a standalone ED system is procured consideration should be given to how deeply integrated this is with the rest of the trust to minimise switching between systems.

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