

# Digitalising Documentation- A review and summary of the transition towards a paperless service

## Situation

Liaison Psychiatry is a branch of the Mental Health and Learning Disability Service based in Ashgrove House, Aberdeen Royal Infirmary. Though part of MH&LDs The Liaison Psychiatry Department has a unique placement within services and must adapt to the changes and development of the Acute Sector, including the transition towards a paperless service. As areas within NHSG transition to use of electronic patient records (EPR) it is important to identify how best to document our assessment records in a paperless form. The aim of this review is to gather information regarding the positive impact of digitalisation of services, identify any strategies to improve current use and explore future developments within our department.

## Previous SH Psychiatric Consultation form



## New online clinical note

## Background

The role of the Liaison Psychiatry Department can be summarised as providing specialist mental health assessment and treatment for patients attending the general hospital setting. Information and support is provided to multiple disciplines across various areas, this can range from medication advice to individualised management plans for patients with a range of mental health presentations, established or transient.

NHS Grampian continues to adapt services in line with national standards to become a paperless service- this is reflected in the introduction of electronic patient records, digital wards and the rolling out of HEPMA (Hospital Electronic Prescribing and Medications Administration). As these advances occur it is important to identify how this could impact our service, both positively and negatively.

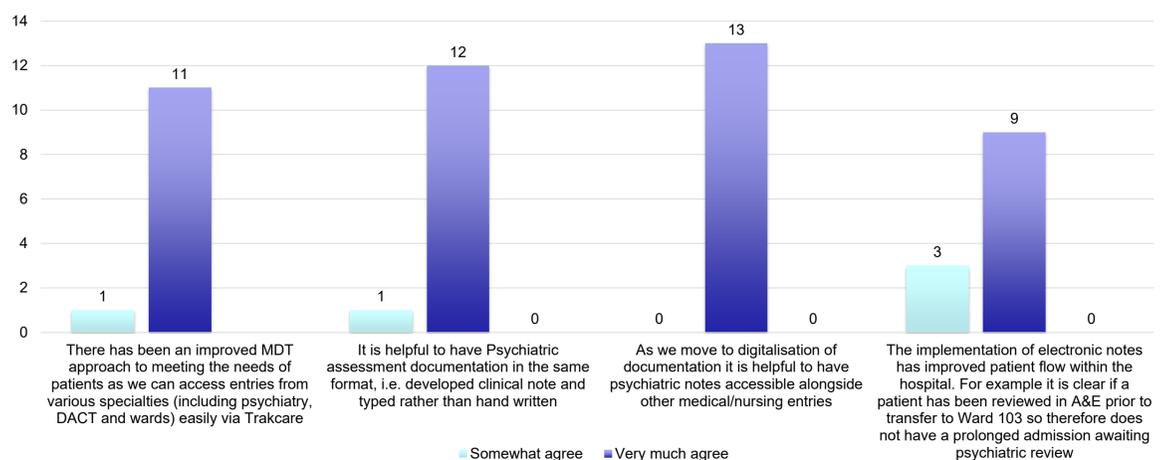
The format of existing self-harm assessment paperwork highlighted duplicate documentation which was extending the workload of the team. Therefore it was felt important to streamline our paperwork. The outcome of this included replacing written documentation with a typed, formatted template. Once individual patient information is added it can then be uploaded to the EPR and Trak Care clinics. This replaces the need for previous posting of assessment documents to GP colleagues, which is not time efficient, nor in line with the Governments Net Zero Agenda. Information being available immediately via Sci-Store ensures up to date patient information which will improve continuity of assessment/input across services.

*"This makes reading the information much easier and little room for misinterpretation/error"*

*"Particularly useful as clear to understand capturing the details and cutting down on our carbon footprint as we strive towards meeting targets of net zero"*

## Assessment

Qualitative information was collated through the distribution of a questionnaire consisting of 6 questions, with an additional 2 questions aimed at Liaison Psychiatry staff only. 71% of questionnaires distributed were returned completed, results are below as well as additional comments shown



## What is next...

- Our department is in the progress of developing a direct ward referral via Trak care
- Do we need to consider the online availability of mental health specific paperwork, i.e. MH Act documents?
- Engaging with GP's to gather feedback related to use of clinical contact note?
- Consideration of further education for ARI staff on the difference between Liaison Psychiatry and Unscheduled Care/On call team at RCH?

*"The clinical note saves time as all entries in one place. No requirement to track down paper notes"*