Patient Access to Electronic Medical Record and Automatic Arrival System

Introduction

The last 15 years has seen cultural and ethical changes in the way patients are involved in their own health care and well-being. There has also been a change in the methods used to support this process. Several high profile cases such as the Bristol Royal Infirmary and Shipman affairs have served to highlight the need for healthcare professionals and patients to share information.

'We want to develop a culture of openness, honesty and trust; to ensure that patients have the information they need to make informed choices; and to enable patients to become equal partners with health care professionals in making decisions about treatment and care' DOH Response to the Kennedy Report 2001 [1].

The fact is patients have the right to see their medical records, though in practice much communication between healthcare professionals is not available to the patient concerned. Patients often do not know why they are being referred, or what is being said about them. Patients do, after all, have a right to their medical data and we must look at ways of ensuring that they are able to access it.

Giving patients access to their medical record is part of the NHS plan, and an electronic viewing system is thus essential given the development of the electronic medical record (EPR). Record access is a pre-requisite to empowerment.

What is the Patient Access to Electronic Medical Record System (PAERS)?

The PAERS system consists of two separate units:
- The Medical Record Viewing and Patient Education Portal kiosk and
- The Automated Patient Arrival System

At the moment the PAERS systems work with the EMIS medical records system, but we are currently working to extend this to include other electronic medical record providers.

The PAERS system had been designed and developed by clinicians and patients, ensuring it is a robust but simple to use system that presents the data in an accurate but ‘patient friendly’ format.

The PAERS Medical Records Viewing system

‘A self-contained system which allows patients to access and navigate around their GP electronic medical record autonomously and which provides them with the information that they need to understand the medical terminology.’

Functionality

- GP Electronic Medical Record Access
- Patient education and information linked to diagnoses
- General health improvement education
- Patient communication with practice
- All information can be printed and taken away by the patient
- Authentication of the patient by their fingerprint
- Issuing the patient their medical record on CD which can
be viewed from most internet enabled PCs any where in the world via the PAERS Website.

The PAERS Kiosk is easily accessible by all patients using:
• Touch screen or mouse interface
• Simple instructions
• Easy navigation

What information is displayed?
The PAERS system takes a patient through their medical record in a simple and structured way. It is broken down into logical sections and straightforward language is used so the patient can understand the content. The following sections are available:

• Consultations:
  • Date, practitioner seen, reason for visit, history, examination, outcome, investigations etc.
• Medical Record:
  • Summary Medical Record shows all diagnoses, investigations, and procedures
  • Full Medical Record shows all entries from the medical record.
• Allergies.
• Patient Information Leaflets linked from the patient’s diagnosis in the medical record section.
• Results:
  • Summary Results shows the most recent result from the common investigations e.g. FBC, LFT, BP etc.
  • Full Results shows all results for the patient.
  • For each test the previous results can be seen in tabular and graph form.
• Vaccinations.
• Medication.
• All current prescriptions displayed with last date of issue.
• Letters to and from the GP.

Patient Education and Information Linked to Diagnoses
• Patients are provided with explanatory information, contact names and numbers linked directly from their individual diagnoses.
• Provides patients with education about their individual diagnosis and further sources of help and information

General Health Improvement Education
• Patient is offered relevant information and education relevant to their age/sex/health to assist in general health improvement. For example:
  • Cervical Smear
  • Prostate/Testicular checking
  • Smoking/exercise advice
  • Breast awareness
  • Flu Vaccinations

Patient Communication with Practice
• The patient can send requests or comments to the practice and practitioners
• The Patient is able to point out errors in medical record. For example:
  • Inaccurate medical history
  • Missing vaccinations or allergies
  • Inaccurate personal details
Authentication of Patient by their fingerprint

- Secure, repeatable, reliable and accurate method for authentication of patients
- NHS suitable method for authentication
- No 'swipe card' or password to be forgotten or lost

Advantages to the Practice/PCT

- Meets many of the DOH and RCGP guidelines for increasing patient access to medical information and involvement in their health care.
- New GP Contract – financial incentive to improve the patient experience.
- Provides Patients access to their medical record, increasing their involvement in their care
- Enables patients to view letters written about them from GPs or Hospitals.
- Improves health education.
- Allows patients to collect results quickly
- Allows provision of equality of access to all patients regardless of age, IT literacy and internet access.

Advantages to the Patients

- No queuing to get results
- Allows patients to check for the accuracy of their medical record
- Empowers patients to become more involved in their medical care
- Provide equality of access for those patients without internet access

Reasons to Improve Patients Access to Medical Records

  - ‘Access by patients of their own records is an important corollary of access by clinicians. Only when patients know the contents of their record can they ensure its accuracy and give informed consent for disclosure’

  - ‘The quality framework will also provide a strong financial incentive for practices to consider the patient’s experience........... This development will allow the patients of the practice to comment on numerous aspects of their care including the physical environment, the convenience and accessibility of the services offered, the practice/patient relationship, the helpfulness of support staff and the appropriateness and timeliness of the whole episode of care.’

- The Public View on Electronic Health Records, Which and NPfIT, August 2003
  - ‘Overall, patients felt most comfortable with the idea of accessing their record at the GP surgery’

- Reasons to Improve Patients Access to Medical Records Kennedy Report DOH Response 2001 [1]:
  - ‘We want to develop a culture of openness, honesty and trust; to ensure that patients have the information they need to make informed choices; and to enable patients to become equal partners with health care professionals in making decisions about treatment and care.’ ‘Involving patients and the public in health care’

- The NHS Plan, Information to empower patients [6]:
‘Patients have the right to see their medical records, though in practice much communication between professionals is not available to the patient concerned. Patients often do not know why they are being referred, or what is being said about them.’

‘letters between clinicians about an individual patient’s care will be copied to the patient as of right…’

**CODE OF PRACTICE ON OPENNESS IN THE NHS, NHS Executive [7]:**

‘Information Which Must be Provided ………. information about how people can have access to their own personal health records.’

**What is the PAERS Arrival System?**

The PAERS arrival system is a self-contained system which allows patients to autonomously arrive themselves using their fingerprint for an appointment at the practice. The patient is informed of who they are seeing and the approximate wait until their appointment. The practice administrative system is updated to reflect the arrival of the patient

- Frees up receptionist time to deal with other patient issues
- Reduces time patients arriving for appointments have to queue

**Evidence**

At Wells Park Practice, London patients have been shown their records on paper for many years. Their published experience, which includes investigating the reactions of patients with cancer to seeing their records, suggests the following conclusions (so long as simple safety procedures are carried out) [2]:

- Record access is a safe procedure, even when bad news is involved.
- It enhances communication between clinician and patient.
- It increases the onus on the clinician to tell the truth
- It increases patient satisfaction
- It enables patients to correct data errors, the commonest ones being demographic data, but the errors can also be about clinical process and outcomes.
- Patients feel better informed and almost always reassured, even when they read bad news.
- Patients feel they understand about 70% of what they read.

**Advantages of the PAERS System**

- Meets many of the DOH and RCGP guidelines for increasing patient access to medical information and involvement in their health care.
- The New GMS Contract indicates that ‘The quality framework will also provide a strong financial incentive for practices to consider the patient’s experience……’ [3]
- Fulfils the initiative the government is calling ‘Copying Notes to Patients’ - a process which the whole NHS is meant to embrace by April 2004
- Allows patients to collect results quickly.
- Allows patients to check for the accuracy of their medical record.
- Provides equality of access for those patients without internet access at home.
- Frees up receptionist time to deal with other patient issues.
- Reduces reception queues.
- No ‘swipe card’ or password to be forgotten or lost.

**References**
