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Elizabeth Finn Homes CEO Richard Hawes shares his views with the panel

THE EMEDS REVOLUTION

OUR PANEL OF INDUSTRY EXPERTS DISCUSSES THE BENEFITS OF EMEDICATION SYSTEMS ADOPTION IN CARE HOMES.

CHP: What led you to e-medication implementation and what benefits have you seen?

Paula Keys (PK): I passionately believe in what emeds can do for us. We spent a few years piloting a number of the technologies that were available in the UK before making a decision on who to partner with. Having made that decision, we now have emeds in about 30 homes and we will roll-out across the rest of our homes over the next couple of years. It's early days, but we are seeing the things we would expect: there has been an almost immediate improvement in compliance so that such a thing as a missing signature on a MAR chart has disappeared overnight.

We have seen an improvement in safety, efficiency and improved governance. We get much better management information that allows us to see what's happening with medicines at every level in the organisation, as well as what is happening in

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medicine management. We are getting better regulatory compliance and the homes that are operational don't have any regulatory medicines issues, so that's great. That's a big plus for us. The benefit that we are starting to see, and that we expected to see as emeds embeds and our teams get used to it, is a shortening of medicines administration so it becomes more efficient. So we are not just getting safety, we are seeing improved efficiency. What is important to us is that this is an efficiency of time that we will reallocate into quality of life for those residents. We are seeing a movement of time for carers and nurses to devote to quality of care and quality of life. For me, that's a huge benefit and is the single biggest advantage we hoped for. All of the others benefits we expected, but if we can make this happen across more than 300 services with 17,000 residents in HC-One, that's fundamentally a huge change for us and a great step forward in us being able to provide the best quality of life to residents living in our homes.

Laura Wood (LW): The Fremantle Trust are looking at electronic care plans. We're looking at an instant reporting system and obviously we're looking at emar.

Helen Nethercott (HN): We only have one home in Wales that is using emeds currently and they just grabbed it with both hands. They are only using the medicines monitoring system but they have been very successful. It's partly because you need to have a stable team first and not too much agency before making the change. They have done really well and they have got a stable team there now. It's part of the whole package of improvements in its turnaround. It was a home that was facing potential closure. That has been part of their success in not having gaps in medication. We have seen a lot of improvement in the space between medicines rounds. Sometimes you have nurses who just want to give out the medicines so it feeds into the start of the next round.

Richard Hawes (RH): There's a bit of me that sees this as a piece of equipment for running a care home. I can remember the implementation of air mattresses and people seeing them almost as an optional piece of equipment. I feel now that with electronic meds management, we've got to that phase where it should be an essential part of equipment within a care home, because it protects people, it safeguards people from damage - no different to an air mattresses. But as an industry we don't see it the same way. Ten years ago we didn't see air mattresses like that, so there's a bit of me that thinks actually it's almost a piece of equipment that should be standard in every care home in the country.

ATTENDEES:

Richard Hawes Chief Executive of Elizabeth Finn Homes
Laura Wood, Director of Care Quality and Compliance, The Fremantle Trust
Helen Nethercott, Director of Quality & Clinical Practise, Healthcare Management Solutions
Paula Keys, COO at HC-One
Lisa Rutherford, Operations Manager, Boots
Craig Flood, Head of Care Partnerships, Access Health and Social Care
Lloyd Evans, Senior Business Development Manager, Access Health and Social Care

Craig Flood (CF): Emeds is not just about completing administration records. Each home will do hundreds upon hundreds of administrations day in day out. It's when we start looking at things like embedding work flow processes and adapting the software to suit the policies and procedures of an organisation that the systems become invaluable. It allows providers to feel safe and secure in the knowledge that if people do get something wrong and miss a piece of information, then the technology will support them and highlight the potential risks.

PK: I think the information around this is phenomenal. You can see that at every level. At HC-One, we administer, at a conservative estimate, about 87 million doses of medicines every year. That makes it one of the biggest and riskiest things you do in a care home because of the sheer volume. It takes just one incorrect medicine, or one medicine administered incorrectly to harm a resident and so any emeds system that helps us as social care providers to get the right medicines to the right resident every time is a valuable introduction to what we do. Emeds does all those other things: compliance with regulatory standards, it gives us more time which helps us

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Richard Hawes and Lisa Rutherford

to improve the residents' quality of life, but first and foremost, it helps us make medicines in care homes safer. It helps you prevent that one in a million dose of medicines that could be fatally wrong and that's got to be the right thing to do.

CF: Again for me it's around helping every individual to use the software and feel like they're able to rely on the software to help them so that they are solely focused on ensuring that they've got the right medication, they're doing the right thing in doing all their relevant checks and ensuring that the person they're looking after, the person that they're providing this medication to, is no longer at risk.

PK: At HC-One we have a care assistant development programme that takes carers and develops them through to nursing assistants and a key part of that programme is medicines management training, which supports nursing assistants to support the nurse by administering medicine, amongst other things. Ideally, in a nursing home the medicines administration process is not reliant on the clinical nurse and whilst that nurse may oversee medicines administration, having support in the form of a nursing assistant means that the nurse's skills can be used more effectively. In HC-One, we've found that nurses get much better job satisfaction if we can train carers and senior care assistants to become nursing assistants and give them the confidence and competency to administer medicines. The emeds technology and all the safety measures around that helps us to do that in the best way. It's been a key part of us developing our care assistant development programme.

RH: These systems have to provide information for lots of different groups of people and so there's no point in me as an executive saying actually the system's brilliant, it does everything we want it to do and the carer and the nurse are saying they can't use it in the home. It had to be a system that would work for everyone so we had to make sure we chose the best system for everybody's needs, there's always compromise. The second part of that was we could then justifiably go to people who were saying they didn't want to do this and tell them their colleagues had been involved in the choosing of this, so if they've got real concerns they could go and talk to them about it as a peer, and talk to us

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Paula Keys

as well. That's really helped with the implementation of it in them being able to talk to a colleague who was in that group saying 'yeah, we're going to go with this company'.

CHP: Should emeds be introduced in tandem with ecare planning systems?

RH: Yes. When you look at return on investment it isn't financial, it's around quality of life. Part of the reason we did ecare and emeds together was to maximise that time investment because with a short gap between implementing the two systems you realise that benefit to residents much sooner.

LW: How do you find managing inspections and people who come into visit who want access to information when you have electronic care planning systems?

RH: We recently had an inspection where we went from Good to Outstanding. Part of that was the

"WE ARE SEEING A MOVEMENT OF TIME FOR CARERS AND NURSES TO DEVOTE TO QUALITY OF CARE AND QUALITY OF LIFE"

leadership of the home and the manager, which is always the case in any Outstanding home, it's about leadership. But what it was also about was the transparency this system gives you. Make no bones about it, if you don't do things right in the care home, this will show it up. The system makes it really easy for regulators and your own internal audit system to pick up poor practice and poor record keeping. The inspectors generally like it because it's systematic. They can look at one set of notes and if they want to look at pressure care, for instance, that's where they look at it. It's always in exactly the same place and they will find it in the same way. The system allows you to find things really easily. We have some inspectors who have said 'can you print me those records?' We have others who have wanted to sit down with us and we have gone through them together.

Generally, the CQC inspectors are really interested in it and see it as being innovative because there are still more people using paper records. CQC are really open to it and really positive about it but don't be mistaken that because you have electronic records it's a tick for CQC. It's how you use those electronic records.

LW: It's a big driver with CQC. They have been highlighting technology for ages. I read somewhere that adult social care is the slowest industry to implement technology. They are expecting to see it adopted now.

RH: Some of that is about staffing patterns as well. I don't have any evidence to support it but I have a strong belief that staff turnover will be reduced as well because staff are under less pressure, therefore, retention and reduction of agency should become easier. My staff now could not imagine working for an organisation that doesn't have electronic data recording. I think it's going to be a real tick for some staff over whether they work for you or for somebody else.

CHP: Would you like to say something about what you are


Helen Nethercott

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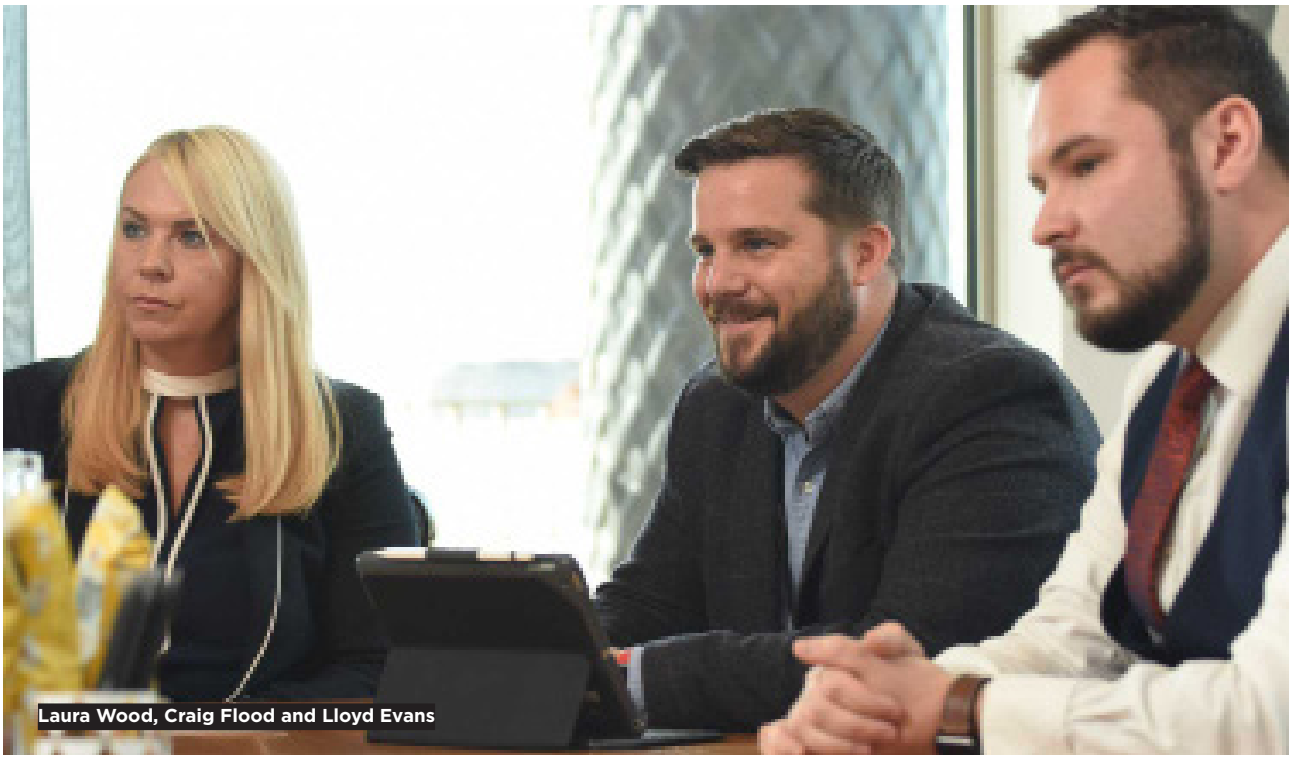

Laura Wood, Craig Flood and Lloyd Evans

doing in terms of pharmacy integration, Craig?

CF: We manage multiple pharmacy integrations. It's not easy. There aren't many who do multiple integrations. What we have found over the last six years is that pharmacy service is critical. If the pharmacy service isn't right it makes the whole adoption of technology much more challenging because it's the key driver for the data that flows through to the system. We have spent five years working very closely with Boots and have made many inroads in terms of the partnership we have built together. It's a partnership that is built and founded on trust in that we understand each other as two businesses and have a shared goal in what we are trying to achieve in being able to provide a packaged solution of software that helps providers adopt technology.

We are client led, we can't align ourselves to a single pharmacy, we need to be able to give options out there, which is the same position that Boots are in. We can explore whether they want to have a pharmacy led implementation of technology or whether they want to be technology led. We may have multiple pharmacy providers across our estate. We are able to work across a number of dyanmics.

Lisa Rutherford (LR): From a pharmacy point of view, communication still remains key because the systems will absolutely alert you and improve this ability but you still have to keep communicating with that pharmacy because if there is late medication you need to understand what the source of the issue is. If the system is telling you that, and you don't take action, then the issue isn't going to go away, so there's still other things that feed into why that medication might be late, but definitely you can be more proactive in facing that challenge.

Lloyd Evans (LE): I've had feedback from homes that have been using the application as well. It just gives them more control over their order so they know when that data leaves the home. It's accurate and when the medicine then arrives, that's what they should expect. You can't always guarantee that when you're using paper systems.

CF: You can harness various aspects of the software to try and look at it. It's an emeds system not just an emar system. It's not just about the medication record, it's about using things like task centres that exist within them to create tasks that remind us to create audit trails around simple things like whether you've done your order and signed it off, and creating a record. If it doesn't get done then we know about it straight away. We don't know about it because the pharmacy phoned and said 'I haven't seen a single prescription yet.' All these things just act as little prompts and reminders to help embed practice within a facility or a larger organisation. It gives you that safeguard that sits in place for everyone within the home who is extremely busy and it's very easy. We all do it, we all forget about a certain job that we should have done, whether it was a very small and insignificant job or whether it was something vital. It's very simple things that we all forget. CHP