



may be more helpful than others. As practitioners, our impression is that P2P has contributed significantly to containment of a high level of disturbance in a reduced therapeutic community programme, allowing highly challenging work, more usually associated with 5-day or in-patient therapeutic communities, to proceed without compromise. We believe that adoption of this system makes the development of many more local therapeutic communities a cost-effective and realistic proposition, and that such communities should be central to the development of new community-based personality disorder services.

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Declaration of interest

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End of the paper trail: moving towards a paperless ward round

The use of electronic notes is fast becoming the ideal towards which the modern National Health Service (NHS) strives. Electronic note-keeping and records have many advantages. Legibility ceases to be problematic, information can more readily be shared among professionals (who may be considerably separated geographically), information is far less likely to be misplaced and bulky notes do not have to be stored and transported.

Baggaley *et al* (2005) described the introduction of a liquid crystal display (LCD) projector to the ward round. They documented many advantages, including the fuller involvement of the multidisciplinary team in the ward process, since all were able to clearly see the information and feed into what was being recorded. The trust in which the new system was being implemented already had an electronic note system that was being used throughout the trust. We describe the introduction of a similar system of electronic records in a trust which was still relying on paper notes.

Use of generic text-based software

The system we describe was set up in Bourne Lea, a specialist in-patient unit for assessment and treatment of people with mental health needs and learning disabilities.

Previously, the ward had been run on very traditional lines (i.e. the junior doctor would furiously transcribe the discussions of the team, without the team checking the accuracy of the notes). Reviewing past notes would mean transferring a heavy file round to each individual member of the team. The unit itself was remote from the community mental health learning disability service, social services and generic mental health services. This meant that the transfer of information was cumbersome at best.

Lacking a dedicated local clinical information system, we developed our own note-keeping system utilising Microsoft Word. A template was made for use at the weekly ward round. This contained important information about attendance at ward round, status under the Mental Health Act 1983 (including need for second opinions and tribunals), care programme approach (CPA) and risk assessment dates, current medication and capacity.

Prior to the ward round, a senior nurse would summarise the nursing notes for the week, which would be entered onto the template for each individual patient. At the ward round, each patient would thus have a ready template with the summary projected via LCD projector for all to view. We found this system highly effective in streamlining the ward round.



The ward round would then proceed in the manner described by Baggeley *et al* (2005), with notes being directly entered onto the template. Once the review had been completed, the document was saved onto a memory stick which holds copies of all previous notes from the ward rounds. Hence, previous notes could quickly be accessed for reference during the round. Other important documents could also be held on the memory stick for review during the ward round. We have at times used CPA documentation, video capture of behaviour, external reports, results of blood tests (including links for clozapine monitoring) and spreadsheets (such as Excel) for psychological and behavioural assessments in the course of the ward round. The ability to rapidly access such information has improved the efficiency of the ward round immensely.

All ward round documents were printed and signed manually after the ward round, since the use of generic documentation did not give any form of electronic signature. Hence, we could not move to a truly paperless system. However, the paper records were considerably more legible, accurate, thorough and compact than under the previous pen-and-paper system.

Advantages and further directions

We found particular advantages of using a commercially available generic text-based system such as Microsoft Word as opposed to specialised trust-wide systems. The wide availability of generic software as well as the relatively low cost of equipment, such as a laptop computer and an LCD projector, allow for this system to be widely applied even in services with the greatest cash restrictions. By virtue of their familiarity, these programs can be used without specialist training.

The use of this system opens up interesting possibilities for individually tailoring the format of the records according to the capacity of the patient. Although this is especially relevant to patients with learning disabilities, we believe it could be of benefit to patients across a broad range of psychiatric illnesses, producing a more appropriate format to facilitate understanding and involvement in their care. With the pen-and-paper system, or potentially with closed specialist systems, patients and carers may feel excluded from the process and view it as covert, or even malign.

Working with people with neurocognitive problems, it is particularly challenging to involve patients in their care. However, these challenges are not limited to the field of learning disability psychiatry, and similar issues occur in many areas of mental health. We have found that the transparency of the above system has helped in this regard.

As always, there can be a difficulty in balancing the need to record concise and accurate clinical information for clinical staff and making such information accessible and understandable to patients and carers. It may be possible to further develop the system to provide patients with modified care plans and case notes, tailored to their individual needs and understanding.

Potential problems may of course arise as the NHS moves towards integration of its computer systems with the implementation of the NHS National Programme for IT (NPFIT). As more trust-wide clinical information systems are implemented, and eventually linked across the country, individual ward or team-based systems such as ours must be integrated or replaced. Although this presents logistical problems of data transfer and reformatting, these problems should be minimised by the ubiquity of the software employed. The system described here also has potential advantages as a piloting scheme for any new systems in terms of what is needed and what works.

Confidentiality

The use of such generic documents allows widespread distribution via email to other agencies (e.g. social services, advocates, unpaid carers, relatives and the patient themselves), which is not possible with specialist systems. However, there are significant issues regarding confidentiality. The patients' permission must of course be sought before distribution. When the patient does not have capacity to consent to distribution of notes, great care and thought must be put into a decision regarding the patient's best interests. Relaying information by email should always be subject to the appropriate confidentiality and Caldicott guidelines (Caldicott Report, 1997). This would involve, at the very minimum, encryption and password protection. Access to records could also be controlled by the use of smart cards which use chip and pin technology to further prevent unauthorised access. The system could be directly linked with NHS Net, a corporate email and directory service available to all staff working in the NHS in England and Wales. This service can be accessed via any enabled personal computer at any site in the NHS, has the highest level of security and as such has the approval of the British Medical Association for the purposes of clinical messaging.

A further consideration is the secure storage of electronic information: whether it is on the computer's hard drive or a removable storage device, all information should be treated as securely as standard patient notes and conform to the *NHS Records Management Code of Practice* (Department of Health, 2006).

Declaration of interest

None.

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