Policy on Electronic Recording of Healthcare Records within Drogheda Services for Older People, specifically Epicare	
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1.0. Introduction. Epicare

The responsibility for the use of Epicare for electronically recording healthcare information within The Village Residence Drogheda Services for Older People is the Director of Nursing. All enquiries with regards to Epicare and its use should be forwarded to the Office of the Director of Nursing.

All MDT members using The Epicare System are responsible to maintain their professional code of practice and adhere to the guidelines regarding recording clinical practice as set out by their regulating body. The same principles apply to electronic recording as to written.

2.0. Policy Statement

Epicare has been introduced to Drogheda Services for Older People to ensure seamless sharing of information between all disciplines involved in the Residents care. This knowledge and information will be available in electronic form for access, storage and retrieval throughout the three sites within Drogheda Services for Older People

3.0. Access to the Epicare System

3.1. All staff will have access to the Epicare system. Their level of access will be determined by their Grade and they will have access to information relevant to their role only. This will include relief workers who are on duty between the multiple sites.

3.2. Regular agency staff will have their own licence granted to them.

3.3. Intermittent Agency staff will be allocated a generic licence relevant to their role on each shift. Any entries will be recorded as being made by an agency HCA or agency Nurse. Each site can use this option for an agency nurse, agency healthcare assistant or a fetac care assistant specific to their site. Their name and grade will be recorded on the duty roster which will inform the records of the author of each entry when their name is not specifically identified as the author.

3.4. Each staff member will be allocated a generic password when they are initially set up on the system.

3.5. On their first log on to the system they must change this password to a password specific to them that they will only know.

3.6. This password must be between 6 and 12 characters with at least one capital letter, one number and one symbol.

3.7. This new password and the site code is their unique identifier. It confirms their identity, authorises their access to the system and is their electronic signature. As such it should remain secure to that individual staff member and should not be shared with anybody else. It should also be protected securely and not written down or recorded where others might see. It should be changed if it is suspected that another person has become aware of it.

3.8. Epicare can be accessed in multiple locations. These locations are limited to the 3 Hospital sites and remote access is not permitted off site by staff members.

3.9. The support centre will be able to access the system in their head office in order to provide support to all staff on site using the system; however they are governed by the same rules of confidentially.

4.0. Record of Entry

4.1. Each entry will automatically record the date and time of the entry and also the name and grade of staff making the entry. This is true for each individual entry i.e. an admission may have multiple entries over the first 12 hours by different staff members. Each individual entry will be recorded separately identifying the author of each entry.

5.0. Documenting Errors

5.1. The system will document errors, voided entries and corrections; to include date, time, author and reason for error.

5.2. The recorded errors, voided entries and corrections will remain on the system with easy access for review should this be necessary

5.3. All recorded errors, voided entries and corrections will be stored in chronological order.

6.0. Scanned Files

6.1. Files can be uploaded to Epicare to “Scanned files” for each individual Patient. The system will record the date and time they were uploaded to the system

6.2. The identity of the person uploading the documents will be recorded as the person uploading and not the creator of the documents.

7.0. Co Signatures

7.1. There is no facility for co signatures and therefore it must be recorded in the notes who was involved in the decision making process or activity if more than one person was involved in the decision making process.

8.0. Support

8.1. All staff will be inducted on the use of the system and will be supported by the Clerical staff and experienced colleagues.

8.2. Epicare support centre can also be used as a support network when all other support systems have been unsuccessful.

8.3. A user guide is also available on each ward and can also be accessed on the Epicare System by clicking the open book icon on the tool bar when Epicare is open. (Appendix 1).

9.0. Data protection

9.1. As with all medical and nursing records the Epicare system complies with the data protection Act and all information is stored securely using cloud computing. (Appendix 2.)

References

E Commerce Act 2000
NMBI guidelines on Communication
Data Protection Act 1988
Recording of Clinical Practice (NMBI)