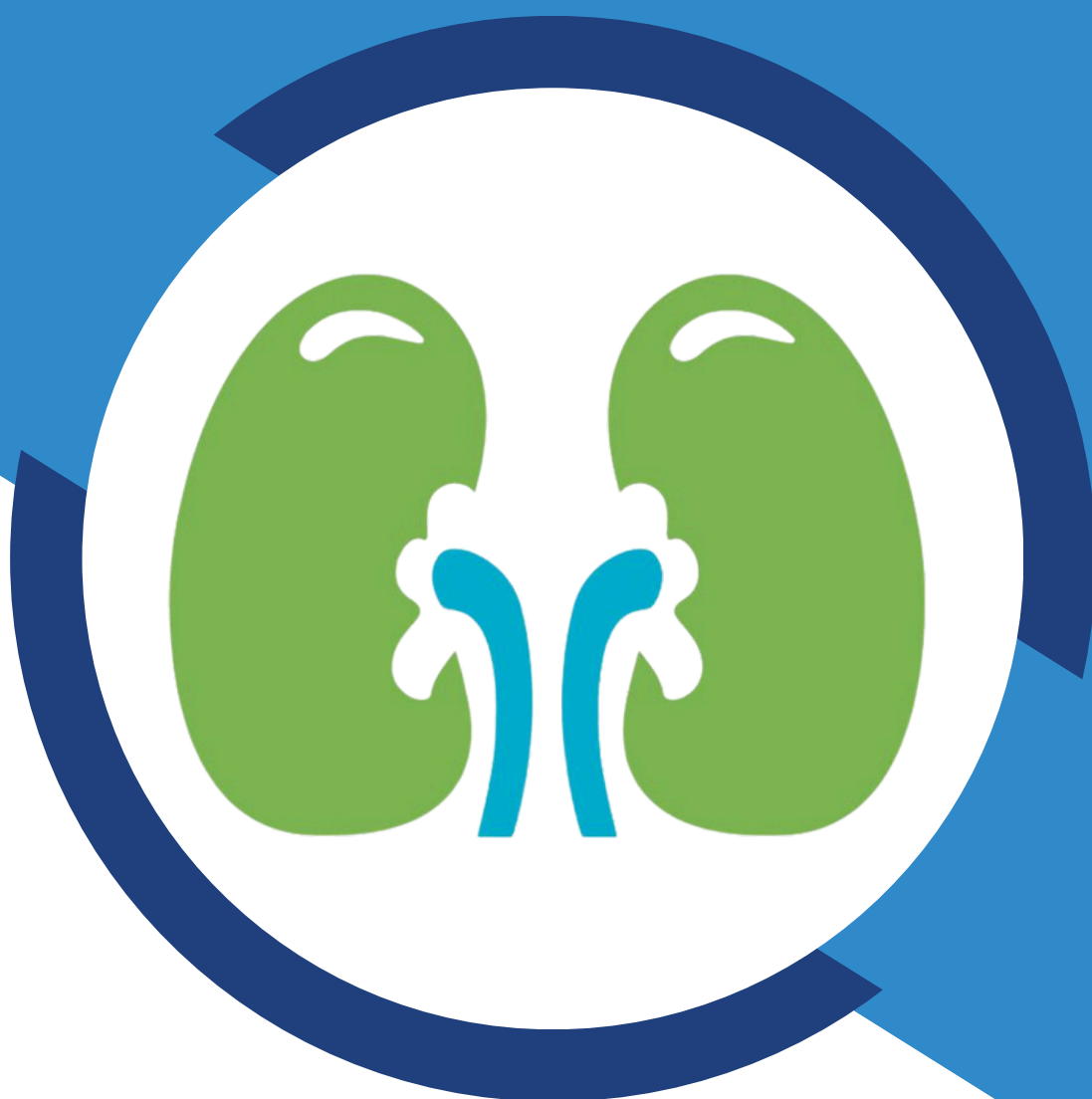


How-to Guide

Transition to Paperless Clinical Documentation



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 **UKKA**
UK Kidney Association

How-to Guide: Transition to Paperless Clinical Documentation

Project: Sustainable Kidney Care – Implementing Best Practice

Collaboration: UK Kidney Association and Centre for Sustainable Healthcare

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Although this guide has been developed by experts in sustainability and sustainable kidney care, local teams should use their discretion in its implementation according to local context and requirements

Introduction



This guide provides a structured, practical approach to implementing paperless practices across several key clinical processes. It emphasises stakeholder engagement, risk management, and adherence to digital safety standards (NHS England, 2023; NHS Central Commercial Function, 2023). Each section outlines step-by-step considerations for achieving safe, effective, and compliant digital transformation in specific areas of renal and inpatient care.

Step-by-Step Implementation

1. Blood Test Requesting

- Review current test requesting process (paper forms, telephone, or electronic systems).
- Evaluate electronic requesting systems available (e.g., ICE, Sunquest) through consultation with IT and pathology services (Wachter, 2016).
- Identify gaps in training or hardware/software accessibility that could impede electronic requesting.
- Conduct staff engagement sessions to highlight patient safety benefits and potential efficiency gains (NHS England, 2023).
- Develop new SOPs for requesting tests electronically.
- Trial the system in a single unit, obtain feedback, and make necessary adjustments.
- Roll out system-wide with ongoing support and monitoring (Department of Health and Social Care, 2018).

2. Blood Test Reporting

- Review existing process for reviewing and documenting blood test results.
- Determine availability of electronic results reporting with the lab/IT department.
- Discuss workflow implications with clinical teams, especially regarding visibility, escalation of abnormal results, and medico-legal considerations (Wachter, 2016).
- Agree on new SOP for reviewing and documenting results electronically.
- Obtain Medical Director's approval to cease paper reports, presenting safety/risk assessment findings.

- Inform the Medical Records department for traceability and audit trail of affected notes (NHS England, 2023).
- Assign location codes to dialysis units; configure pathology systems for electronic-only reporting.
- Educate staff on correct sample booking using these location codes.

3. Dialysis Session Records

- Assess current method of documenting dialysis sessions (paper flowsheets vs electronic systems like eMed, Renalware).
- Consult IT on capabilities for paperless documentation, ensuring integration with lab and patient record systems (Wachter, 2016).
- Engage multidisciplinary teams to review changes in workflow and data accessibility.
- Design and pilot a digital documentation template.
- Formalise the process post-pilot, with defined roles for data entry and quality checks.
- Provide training sessions and establish support mechanisms.

4. Inpatient Records Including Observation Charts

- Audit how inpatient data and observations are currently recorded.
- Transition to electronic health records (EHRs) such as EPIC or Cerner where available (Department of Health and Social Care, 2018).
- Ensure the digital solution includes vital sign charts, fluid balances, and early warning scores.
- Pilot digital observation charts in selected wards and evaluate user feedback (Royal College of Physicians, 2017).
- Develop guidance for escalation procedures and handover using electronic records.
- Educate clinical staff to ensure compliance and accurate documentation.

5. Correspondence with GPs

- Map existing process for GP communication (letters, faxes, emails).
- Transition to secure NHS email or electronic referral systems (e.g., e-RS).
- Create templates for common clinical communications (e.g., discharge summaries, clinic letters).
- Liaise with GP practices to ensure compatibility and agreed format (NHS England, 2023).
- Train administrative staff on document handling and confidentiality protocols.

6. Prescriptions

- Review how prescriptions are written and transcribed (handwritten vs electronic).
- Implement electronic prescribing and medicines administration (EPMA) systems where possible (Wachter, 2016).
- Ensure integration with allergy records and drug interaction alerts.
- Conduct risk assessment and obtain pharmacy leadership input.
- Provide role-specific training and real-time support for prescribers and nurses.

7. Handover Notes

- Evaluate format and reliability of current handover methods (paper, verbal, or spreadsheets).
- Introduce standardised electronic handover tools embedded within the EHR (Royal College of Physicians, 2017).
- Align handover templates with SBAR (Situation, Background, Assessment, Recommendation) or similar models.
- Train clinical teams on secure and accurate use.
- Encourage use during MDT meetings and ward rounds for continuity of care.

8. MDT Meeting Notes

- Transition from handwritten or typed minutes to direct digital input using secure platforms (e.g., MS Teams, EHR modules).
- Use shared templates to record decisions, plans, and assigned actions.
- Ensure MDT notes are integrated into the patient's electronic record (NHS England, 2023).
- Provide access to all relevant team members, including allied health professionals.



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