

# Patient health records usage in patients admitted to hospital – a workshop by the Royal College of Physicians' Health Informatics Unit

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## Aims

To explore current practice and scope of personal health records for patients admitted to hospital.

## Methods

Patient health records (PHRs) are thought to offer benefits to patients in primary care and chronic disease programs, and are promoted by health policy makers and some healthcare systems. A review of PHRs in primary healthcare was published previously by the Royal College of Physicians (RCP).

We conducted a 1-day workshop hosted by the Health Informatics Unit at the RCP in November 2017.

A group of patient representatives, healthcare professionals and information technology experts explored the issues and possible future for PHRs in relation to hospital admissions. The group considered the value of PHRs to patients and others, the challenges to usage and widespread adoption, and identified the practical and research questions that need to be answered.

Participants discussed five cases of hypothetical patients admitted to hospital: One of the patients was for an elective admission for prostate surgery, one a semi-elective admission for a renal transplant, and three patients had emergency admissions for chest pain, diabetic ketoacidosis and pneumonia with delirium.

Participants charted how a PHR / electronic patient record (EPR) could support a patient to a) become more informed about their health condition (including their safety) and receive care in a way they would like to, b) enable them to do more to care for themselves, and c) make a comment useful to care providers (eg incorrect information, most troubling symptoms).

## Results

There is currently little published evidence on use of PHRs by hospital patients or staff, before during or after hospital encounter,

nor an understanding of potential impact. This is despite the fact that a number of providers offer functionality in their EPR. Participants thought that PHRs could be used in elective/planned admissions to inform patients, allow patients insight into progress and facilitate care post-discharge.

Participants suggested that PHRs could be used in unplanned/emergency admissions to reconcile medication schedules, give information about newly diagnosed conditions and contain schedules for investigations or appointments with clinical teams. PHRs could facilitate monitoring of pain and other patient-centred outcome measures. This could be shared with clinical teams to inform responsive care.

Patient representatives wondered what challenges will arise around those who would like to opt out of the digital healthcare market or those with limited information technology literacy. These challenges are very comparable with the changes in the banking sector where less and less branches are available to offer face-to-face service. Heterogeneity of access to PHR could lead to a two-tier system. Some patients might have significantly more opportunities to participate in their own healthcare and this could drive commissioning and funding decisions with more resources allocated to areas with high engagement and visibility of need or less resources allocated as patients become more self-sufficient.

In order to achieve spread participants felt that patients would appreciate the ability to model on peers as demonstrated in the network 'PatientsLikeMe': To witness patients or patient testimonies from patients with comparable conditions or pathways using a PHR could facilitate uptake and spread.

Participants were worried that PHRs should augment and not replace human touch and capabilities: Information about a condition or patient questionnaires about concerns and pain can be made available prior a personal conversation and facilitate a focus on complex and difficult questions.

## Conclusion

PHRs might be able to support patients during admission to hospital. Data safety and equitable access for those with and without digital literacy were key concerns. ■

## Conflict of interest statement

None declared.

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