**Problem.** Most renal centres utilise computer databases in coordinating the care of patients. However, limitations of use are experienced due to difficulties with data extraction , reporting or adaptation to local requirements.

**Purpose.** This centre had a database in the past and due to commercial reasons, this database (Dbase A) could not be a supported or developed further. As a result, a new electronic patient record (EPR) had to be secured using a tender process,’ Dbase B’. Following the purchase of the new EPR, there were a number of difficulties in the effective use as well as the further development of the new system to cater for the needs of the service. A common problem encountered by many centres.

**Methods.** In 2015 Dbase B was installed in this centre and all historical data held in Dbase A was lost. Due to financial constraints, transfer of historical data between systems was not possible. As a result, this centre did have to invest in an extensive process of manually data entry of the active patients’ details into Dbase B. As part of the installation process, a training programme for all users was offered by the new supplier and a limited number of electronic reports were constructed to assist patient care.

Although, the new EPR offered a competent process in recording clinical data, it had a number of limitations in representing and analysing information, which had to be resolved. This issue has been experienced with other EPR applications. In 2017, a project was undertaken to dissect and interrogate the new EPR’s database’s structure and derive mechanisms to extract information and create comprehensive and clinically relevant reports .

After a period or research and development, the ‘Crystal Reports’ (CR) application has been utilised to present bespoke reports to aid all aspects of the service. Crystal Reports are hosted within the EPR and all valid users can gain immediate access to information in relevant to their areas.

**Results.** An extensive suite of interactive reports initially encompassing RRT modalities , chronic kidney disease, dietetics, vascular access and UK Renal Registry data have been designed locally. Clinical indicator dashboards have been derived offering real time access to patient data, with grouping and graphical representation of information. This approach offers reports tailored to suit the needs of the users and can be adapted with ease to meet the changing demands of the department. Examples of these reports will be presented

**Outcome.** This centre had to adopt a new EPR and it is now accessible in all areas of clinical activity, and contains a body of information for 25,000 persons. The local initiative has overcome a significant weakness of the new EPR, without severe financial penalty, and offers information and analyses, presented in a manner which is most relevant to the nephrology service. As a result, patient safety issues can be better managed, work patterns of the clinical staff has been improved and redundant processes have been removed.

**Implications.** The local innovation has enabled the Renal Unit in maximising it’s investment in an EPR, minimising expense and has overcome the struggles of meeting the changing and challenging clinical informatics needs of any renal service. The lessons learnt in effectively utilising a Renal EPR must be shared with all other centres and the informatics paradigm applied.