Free and Open Source Software to store the electronic medical record

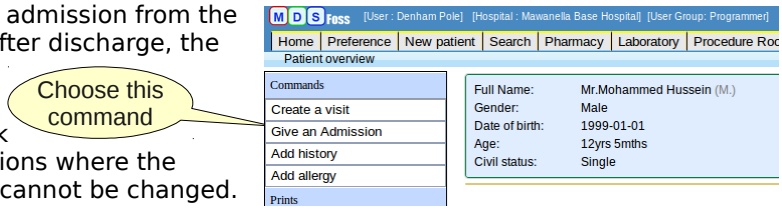
Admitting a patient

Before a patient can be admitted, they must first be registered (see Help-sheet 03). Selecting a patient by their Patient Register Number on the Search screen will show the *Patient Overview* screen (see Help-sheet 04).

Creating an admission

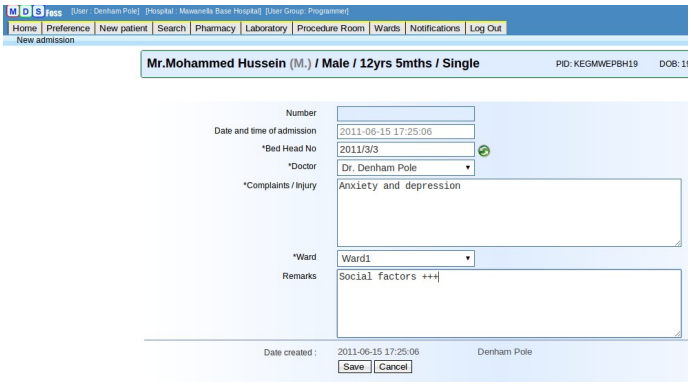
From the *Patient Overview* screen, create a new admission from the menu or choose a previous admission to view. After discharge, the admission data may no longer be changed.

After choosing to view a previous admission or to enter a new one, the screens that appear look the same. The difference is that data for admissions where the patient has been discharged can be viewed but cannot be changed. You can only add *Remarks*.



Entering admission information

The information to be entered is the same as that which is entered using the current manual documentation.



Date & time of admission

This defaults to the current time and date when the admission was registered. If wished this can be changed.

Onset date/time

This is chosen from a calendar - for this month just choose the number of the day. If earlier than that, the month must be chosen also.

Bed Head No.

This is the number of the *Bed Head Ticket (BHT)*. It will be calculated by the computer if possible, but you should check the result. Later you can search the list of patients using the BHT number.

Doctor

This is the name of the doctor who will look after the patient during this admission.

Complaint / injury

The reason the patient gives for coming to the hospital can be chosen from a pop-up list. You can add more complaints to this list in the Data Tables section of the database. All the notifiable disease are included - they show in red.

Ward

The ward in which the patient is currently placed. You can transfer the patient to another ward later if wished. The list of wards can be updated in the Data Tables section of the database.

Referred from

This opens a pop-up window for you to choose from a list of hospitals and MOH offices of the province from which the patient was referred. If an institution is not present in the list, it can be added in the maintenance section.

Remarks

Free text can be entered in this field. There are no restrictions on the data that can be entered.

Dead on admission

Note: if the patient was dead on arrival at the hospital or died before being admitted to a ward, they still need to be registered as an "Admission" as they have actually entered the hospital. It is also important to store the information relating to the death such as diagnosis for statistical purposes. In order to facilitate the storage of such patients it is recommended to create a ward called "*Dead on admission*" and store the patients there until they are recorded as dead in the "Discharge" module. In this way the data will be easily integrated with the rest of the database.

Save

Clicking on this button confirms the entry and checks the input for validity. If there were errors on the screen or missing information, these must be corrected before the computer can store the corrections in the database.

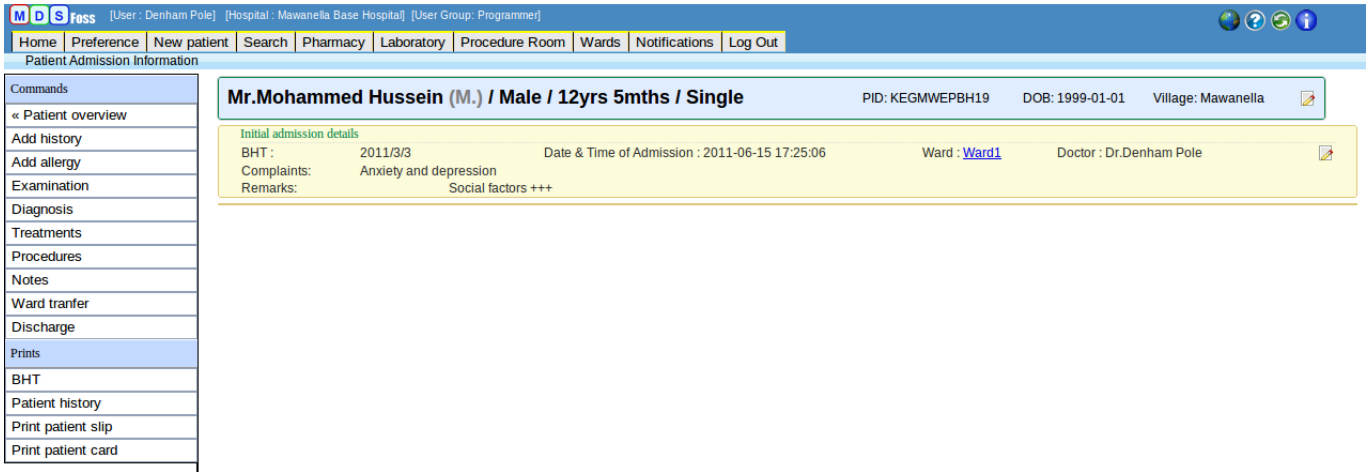
Cancel

Leave the screen without changing any information in the database.

Patient Admission Information screen

In order to keep the system as easy to use as possible by hospital staff, all the admission information is summarised on one screen, the *Patient Admission Information* screen. All additional information will be entered during an admission from this screen. As additional information is stored in the different modules, a window will open up in this screen where it will be summarized. This gives the clinical staff a transparent and logical view of the clinical data as it accumulates during an admission. Each window can be minimized by clicking on its green title and enlarged by clicking on the pencil-icon on the right.

The appearance of this screen initially is shown below. An example of the same screen after the addition of additional admission information is shown in Help-sheet 12.



Main modules

These are shown as a row of buttons across the top of the screen. Staff in different groups will only see the choices appropriate to their job in the hospital.

Commands

These will open up the different sections of the admission information and will be used by the clinical staff in the wards (see Help-sheet 12).

Prints

The reports that can be produced on this patient and this admission are shown in the second section of the left menu. A separate Help-sheet (07) describes how to use these reports. The individual reports will not be described in detail in these sheets.