NURSING MODULE

App controller list

A. DASHBOARD
B. PATIENT PROFILE
C. OUT PATIENT QUEUE
D. WARD MANAGEMENT
E. FINANCES
F. MY PROFILE
G. MESSAGES
H. LOGOUT

1. **Patient profile**
    a. Just like the other patient profiles
    b. ACTION
        i. No lab profile.
        ii. View Profile
            1. Capacity to edit
        iii. **Check in**
            A list of possible people to send the patient to.
            1. GOPD – Means to Nurses and Doctors All patient queue
            2. Specialist Clinic – To All Patient Queue and Specialist queue.
                a. Capacity to select the exact specialty.
            3. Lab Profile
            4. Imaging Profile.

            Capacity to post a patient to queue, That is from all patients to queue.
        iv. View patient folder

    Outpatient and Ward Management are the Nurses patient queue system.
2. **OUTPATIENT**

    This is the walk-in, walk-out patient queue.
    a. Just at the top like Payroll History, Manage Cadre and Pay salary, we have
        i. My Queue
        ii. All Queue
        iii. Specialist Queue

        NB- All queue is default on clicking out patient

        Each to have capacity for All entries and Today's entries. NB- Today's entries is default on clicking any of the above 3

        The nurse has the capacity to post to a Particular doctor or Nurse, making it to enter the doctors my queue

    b. My Queue
        i. Exactly as the doctors queue.
        Difference is after opening the folder, nurse can only document in nursing remark.
            Others for her are View only.

    c. All Queue
        i. Same as doctors

d. Specialist Queue

i. Same as doctors.

3. <u>WARD MANAGEMENT</u>

This is the patient on admission queue.

a. Just at the top like Payroll History, Manage Cadre and Pay salary, we have

i. Taxiing
ii. My Inpatient
iii. All Inpatients
iv. Ward
v. Ward Management

NB- **Ward is default on clicking Inpatient**

My Inpatients and All Inpatients to have capacity for All entries and Today's entries.

Today's entries to be called **new admission**

NB- Today's entries is default on clicking any of the above 3

b. Taxiing

i. List of patients admitted awaiting to be given a room.
ii. Action
1. Assign Ward.
a. Add Deposit slip receipt code to admit.

c. My Inpatient

<u>Same as for doctor</u>

i. Similar to My Queue
1. Once a patient is admitted under a particular doctor it goes to his my inpatient and also All patient.
2. Instead of Folder status – Ward and Bed. E.g. Female Ward Bed 1.

See totals – See total number of patients in my inpatients, see total patients attended to today, see patients yet to be attended to today.

d. **All Inpatients**.

Same as doctor

i. Similar to All Queue
1. Once a patient is admitted under a particular doctor it goes to his my inpatient and also All Inpatient.
2. Instead of Folder status – Ward and Bed. E.g. Female Ward Bed 1.

See totals – See total number of patients in all inpatients, see total patients attended to today, see patients yet to be attended to today.

e. WARD

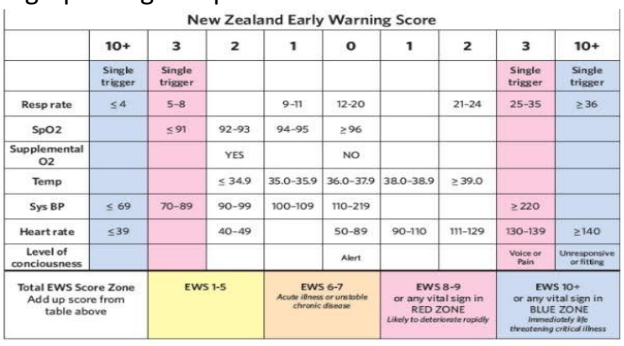
Same as doctor but with capacity for Ward Management

i. A pictorial representation of the wards arranged according to hospital plan.
1. Hover with Mouse
a. Name
b. Age
c. Sex
d. Hospital Number
e. Room No.
f. Diagnosis
g. Admitting Doctor
h. Days on admission.

i. Alarm

2. Click on it
    a. Scan case note
    b. Alarm
        i. List of alarms
            1. Doctors note
            2. Due medication [Time for drug]
            3. Time for vitals check
            4. Vitals documentation
            5. Lab result posted
            6. Radiology result posted
    c. Vitals
        i. Directs you to case note to see and input vitals
    d. Input output chart
        i. Directs you to case note to see and input fluid chart
    e. Early Warning score
        i. Directs you to case note to see and input early warning score [A Unique part our Maxsom]
            1. Respiratory Rate
            2. Oxygen Saturation
            3. Supplemental Oxygen
            4. Systolic Blood pressure
            5. Pulse rate
            6. Consciousness
            7. Temperature

        Scores each 0, 1, 2, 3 or 10.
        A graphical guide pasted there for them.



New Zealand Early Warning Score

	10+	3	2	1	0	1	2	3	10+
	Single trigger	Single trigger						Single trigger	Single trigger
Resp rate	≤ 4	5–8		9–11	12–20		21–24	25–35	≥ 36
SpO2		≤ 91	92–93	94–95	≥ 96				
Supplemental O2			YES		NO				
Temp			≤ 34.9	35.0–35.9	36.0–37.9	38.0–38.9	≥ 39.0		
Sys BP	≤ 69	70–89	90–99	100–109	110–219			≥ 220	
Heart rate	≤ 39		40–49		50–89	90–110	111–129	130–139	≥ 140
Level of conciousness					Alert			Voice or Pain	Unresponsive or fitting
Total EWS Score Zone Add up score from table above		EWS 1-5		EWS 6-7 Acute illness or unstable chronic disease		EWS 8-9 or any vital sign in RED ZONE Likely to deteriorate rapidly		EWS 10+ or any vital sign in BLUE ZONE Immediately life threatening critical illness	

From Campbell, 2018

Table 1. **The adapted NEWS tool**

Element	Score						
	3	2	1	0	1	2	3
Respiratory rate	≤8		9-11	12-20		21-24	≥25
SpO_2	≤91	92-93	94-95	≥96			
Oxygen		Yes		No			
Systolic blood pressure	≤90	91-100	101-110	111-219			≥220
Pulse	≤40		41-50	51-90	91-110	111-130	≥131
ACVPU				A			C,V,P,U
Temperature, °C	≤35.0		35.1-36.0	36.1-38.0	38.1-39.0	≥39.1	

Score ≥3: discuss with duty nurse or senior colleague; score ≥6: immediate discussion with ACT advanced practitioner or ACT doctor. Concern about patient or difficulty obtaining any single parameter should lead to escalation regardless of score. Complete a sepsis screen on all patients with NEWS ≥3 with signs of infection.

ACT = acute clinical team; ACVPU = Alert, Confusion, Voice, Pain, Unresponsive; SPO_2 = peripheral capillary oxygen saturation; NEWS = National Early Warning Score.

f. Pain score
    i. 0-10
    ii. Use facial expression smiley 😊 to also indicate
g. Folder [EMR]
    i. Enter Patient information Folder
h. Drug administration
    i. Enter Drug administration page
i. Lab profile
    i. Enter lab profile
j. Imaging Profile
    i. Enter imaging profile
k. Comment
    i. A pop-up box to drop a comment.

ii. WARD MANAGEMENT

1. Capacity to
    a. Create Ward/Suite
    b. Create Bed
    c. Edit ward
    d. Edit bed
    e. Add charges per night to bed
    f. Add deposit fee [3 x Per night charge]

4. <u>FINANCES</u>

a. Bills
    i. Nurses should be able to see bills in the exact way finance sees it.
    ii. Nothing else

5. <u>MY PROFILE</u>

a. Just like other staff profile. Nothing else

6. MESSAGES

1. Just as doctor

7. LOGOUT

PATIENT FOLDER [EMR]

Just like Doctors own, few changes will be indicated

a. <u>PATIENT DASHBOARD</u>

Same as doctor.

Difference

Instead of visit history to be showing

- Nursing task will be showing there.
  - See Nursing task below.

b. <u>CASE NOTE</u>

Same as doctor

i. All

Click on all to view all aspects of case note in a row.

ii. Encounters

Nurse can only see encounters; she cannot create an encounter.

iii. Vitals

1. Nurses can input vitals

iv. Drug administration

Exactly as doctor

v. Fluid Chart

Exactly as doctor

vi. **Nursing Remark** [Same model as Encounter, but here is where Nurses document. A doctor cannot document here]

1. Possibility of selecting the following – SBAR, Comment]
   a. SBAR – Just as SBAR
      i. Summary – Plain box to write patient summary
      ii. Background – Plain box
      iii. Assessment
      iv. Treatment Received.
   b. Nursing comment
      i. Plain text box.

vii. Surgical note – Just as encounter but with the following

1. Nurses can only see

viii. Results

1. Same as doctor

ix. Bills

1. Same as doctor

x. Discharge summary

1. Nurses can only see

xi. Referral Letter.

1. Nurses can only see

xii. Medical Report

1. Nurses can only see

xiii. Attachment

1. Same as doctor

xiv. Comments

a. Same as doctor

c. **DIAGNOSIS HISTORY**
    1. Same as doctor, but only view
d. **PRESCRIPTIONS**

Same as doctor

e. **LAB PROFILE**
    i. Same as doctor
f. **IMAGING PROFILE**
    i. Same as doctor
g. **NURSING TASK**

Exactly a nursing to do list.

i. A list of all requests made for patient
    1. E.g Medications
    2. Lab requests
    3. Vitals request
    4. Capacity to add new nursing task.
        a. Note that it will have the following headings
            i. Name of task
            ii. Next time task is due.

h. **PATIENT BILLS**
    i. Same as doctor
i. **PATIENT ALERT**
    i. Same as doctor
j. **APPOINTMENTS**
    i. Same as doctor
k. **REFERRALS**
    1. Nurses can only see
l. **MEDICAL REPORTS**
    1. Nurses can only see
m. **DISCHARGE SUMMARY**
    1. Nurses can only see
n. **ATTACHMENTS**
    i. Same as doctor
o. **SEEN**
    i. Makes patient folder mark status as seen
    ii. Automatically takes you back to outpatient if patient is an outpatient.
    iii. Automatically takes you back to Inpatient if patient is an Inpatient.
p. **BACK** – Just takes you back to Inpatient or Outpatient.
q. **DISCHARGE/CLOSE**
    i. Closes patient folder. – No more documentation possible till next visit to hospital, or made open again.
    ii. Lab results, Radiology and Pharmacy can still be going on.
    iii. If patient is on admission, It will ask you If the discharge summary is ready.
    iv. Note- It also takes you back to inpatient or outpatient as the case may be.
r. **FINALIZE CASE NOTE**
        a. Same as doctor

8. END