DOCTOR'S MODULE

App controller list

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

1. **Patient profile**
    a. Just like the other patient profiles
    b. However, NO OPTIONS OF LAB PROFILE, INSTEAD IT IS **PATIENT FOLDER**

    Outpatient and Inpatient are the doctor's 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- My 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

    b. My Queue
        i. A list of all patients posted to me [A particular doctor], from frontdesk [Reception], with the following heading
            1. Name
            2. Hospital Number
            3. Age/Sex
            4. Specialty. [Specialist to see - Cardiology, GOPD etc]
            5. Doctor. [Particular doctor to see]
            6. Coverage. [Insurance Status - Private, Company, HMO]
            7. Folder status – Open or Closed.
                a. Open – means you can document in patient folder
                    i. Folder is automatically opened when patient is posted to a doctor
                b. Seen – Closed by doctor but not yet closed by nurse.
                    i. Folder is still open, but doctor's waiting time has stopped counting.
                c. Closed means you can't document.
                    i. Folder is closed if patient has an outstanding bill.
                    ii. Folder is closed after doctor has documented and finalized.
            8. Action
                a. scan case note.

i. A pop-up showing latest documentation for patient

b. Folder [EMR]

c. Close Folder

See totals – See total number of patients added to queue, see total patients attended to, see patients yet to be attended to.

c. All Queue

i. Same as my queue, just that it is directed to all specialty and all doctors.
See totals – See total number of patients added to queue, see total patients attended to, see patients yet to be attended to.

d. Specialist Queue

i. Same heading, Just that it has a drop down to select and sort by different specialties.
1. When clicked, By default it should be on the specialist queue the doctor belongs to.
a. E.g. If I'm a cardiologist, once I click specialist queue, the drop down to select will be automatically on cardiology specialty.
b. If I'm a Gynecologist, it will be on gynecology queue. Where I can see a list of all patients posted to gynecology, both to me and to any other gynecologist in the hospital,

See totals – See total number of patients added to particular specialist queue, see total patients attended to, see patients yet to be attended to.

3. <u>INPATIENT</u>

This is the patient on admission queue.

a. Just at the top like Payroll History, Manage Cadre and Pay salary, we have
i. My Inpatients
ii. All Inpatients
iii. Ward

NB- Ward is default on clicking Inpatient

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

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

b. My Inpatient

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.

c. **All Inpatients**.

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.

d. WARD

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
    d. Input output chart
    e. Early Warning score
    f. Pain score
    g. Folder [EMR]
    h. Drug administration
    i. Lab profile
    j. Radiographs
    k. Comment
        i. A pop-up box to drop a comment.

4. <u>FINANCES</u>

a. Bills
    i. Doctor 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

a. The internal messaging system.
    i. Personal messages
    ii. Staff group
        1. Group of all staff
    iii. Doctors group
        1. Group of all doctors
    iv. Care team

Purpose – To add people on duty same time, to discuss patient management related issues.

1. Created by admin,
2. Can add anyone

7. LOGOUT

PATIEN FOLDER [EMR]

At this point you have entered a particular patient's folder.

a. Just like when one clicks lab setup, where those assets, tax and co arrange. They following will arrange there.
    i. Patient Dashboard
        1. With Visit history embedded
    ii. Case note
    iii. Diagnosis History
    iv. Prescriptions
    v. Lab profile
    vi. Imaging Profile
    vii. Patient bills
    viii. Patient Alert
    ix. Appointments
    x. Referrals
    xi. Medical Reports
    xii. Discharge Summary
    xiii. Attachments
    xiv. Seen
        1. Makes patient folder mark status as seen
        2. Automatically takes you back to outpatient if patient is an outpatient.
        3. Automatically takes you back to Inpatient if patient is an Inpatient.
    xv. Back – Just takes you back to Inpatient or Outpatient.
    xvi. Discharge/Close
        1. Closes patient folder. – No more documentation possible.
        2. Lab results, Radiology and Pharmacy can still be going on.
        3. If patient is on admission, It will ask you If the discharge summary is ready.
        4. Note- It also takes you back to inpatient or outpatient as the case may be.

Fixed above is the picture and biodata of the patient.

App Controller	DashB Case N Vitals	Picture, Biodata.	
		Latest vitals passing like Christmas light	
		Current Prescription passing like Christmas light	

b. <u>PATIENT DASHBOARD</u>

A dashboard to give almost all info about patient

i. Fixed above
    a. Name
    b. Age
    c. Sex
    d. Hospital Number
    e. Phone number
    f. Status
        i. On Admission
            1. Specify room number
        ii. Clinic
            1. Specify the particular specialist to see.
    g. Diagnosis
    h. Insurance
    i. Pain score
    j. Early warning score
    k. Alarm

ii. Below it is also fixed
    1. A small row for latest vitals
        a. Show time inputted
        b. Vitals figure.
        c. Shows for the last 3 figures
            i. Has to be passing like Christmas light.

iii. 3rd Fixed row
    1. A small row for current medications
        a. Shows date and time prescribed
        b. Name of medication
        c. Shows all current medications.
            i. Has to be passing like Christmas light.

iv. The rest of the page – Dashboard
    List of **visit history** with the following heading

1. Date
2. Clinic [Clinic visited]
3. Diagnosis
4. Lab tests
5. Radiology tests
6. Prescriptions
    a. For 4&5 – You see number of tests
    b. For 6 – Yes or No.
7. Duration
    a. How long spent in the hospital
       Determined by Posted to doctor till folder is closed.
8. Seen by
    a. The doctor that saw
9. Action
    a. Read particular encounter notes – Pop up
    b. View lab tests
    c. View radiographs
    d. View Prescription.

If patient was admitted that visit history has to have a separate color.
The Duration will show in days.

c. <u>CASE NOTE</u>

i. See Helium Health.
    1. It has to be exactly like that with the following adjustments
        a. All
        b. Encounters
        c. Vitals
        d. Drug administration
        e. Fluid Chart
        f. Nursing Remark
        g. Surgical note
            i. Anesthetist chat
            ii. Operation note
        h. Results
        i. Immunizations
        j. Bills
        k. Discharge summary
        l. Referral
        m. Medical Report
        n. Attachment
        o. Comments

ii. All

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

iii. Encounters

Possibility of selecting the following format [Clerking, Clinic, SOAP, SBAR]

1. Clerking

a. Same as initial investigation in Helium but will be divided into 4 compartments like Old Maxsom
    i. Complaints
    ii. Examination
    iii. Diagnosis
    iv. Plan
        1. Complaints
            a. Presenting complaint
            b. History of presenting complaint
            c. Past Medical and Surgical History
            d. Gynecologic and Obstetric Hx
            e. Drug and Allergy History
            f. Family and social History
            g. Review of system
        2. Examination
            a. General examination
            b. CVS examination
            c. Respiratory examination
            d. Abdominal examination
            e. CNS examination
            f. Obstetric examination
            g. Gynecologic examination
            h. Others
        3. Diagnosis – See Maxsom emr
            a. ICD 11 Incorporated
                i. Capacity to search by ICD Code
            b. Capacity to select
                i. Acute
                ii. Chronic
                iii. Resolving
                iv. Provisional
            c. Remark
            d. Capacity to save as favorite
        4. Plan – See Maxsom emr
            a. Plan
                i. Text box for documentation
            b. Investigation
                i. Lab investigation
                ii. Imaging investigations
            c. Prescription

        Each should have a box to write in.
        It will show as a continuum with the above headings.
        Any not written in, that heading doesn't show.

2. Clinic notes
    a. Complaints – Plain box, no sub heading

b. Examination - Plain box, no sub heading
c. Diagnosis – Same as in Clerking
d. Plan – Same as in clerking

3. SOAP
    a. Complaints – Plain box, no sub heading
    b. Examination - Plain box, no sub heading
    c. Assessment – Plain box to write tex.
    d. Plan – Same as in clerking
4. SBAR
    a. Summary – Plain box to write patient summary
    b. Background – Plain box
    c. Assessment
    d. Treatment Received.
5. Plain
    a. Plain box

One can add comments to Encounters just as in helium.

Note an encounter saves with

Date and time at top left

Name of staff writing – Bottom right

Staff carder[Doctor, Nurse] – Bottom right, below name.

iv. Vitals

1. Follow Helium vitals
2. Vitals box should be smaller.
3. Possibility to add comment to vitals

v. Drug administration

1. See list of prescribed drugs with the following headings
    a. Name drug
    b. Date prescribed
    c. Dose
    d. Frequency
    e. Doses received
        i. No of times medication has been charted/no of times drug is supposed to have been charted E.g 6/6
    f. Due by – Next time drug is due.
    g. Date to be finished.
    h. Action
        i. Chart drug – Indicate that drug has been given.
            1. Drug can only be charted 1-2hr before or 1-2hrs after.
            2. 2-3 hrs interval – It is charted with reason for delay
            3. 3-6hrs – Rescheduled dose
            4. >6hrs – Missed dose [Next dose is due]
        ii. Skip dose
        iii. Discontinue Medication.
        iv. View
            1. See table of charted drugs.
                a. Date and time given

2. See list of administered Vaccination  differently color coded.
3. Possibility to add Prescription
    a. The prescription plan of it.
    b. Possibility to add vaccination.
        i. Exactly like the prescription part of it.

vi. Fluid Chart

1. See list of fluids given with the following heading
    a. Name of Fluid
    b. Input [amount]
    c. Output [amount]
    d. Comment

   Total at the bottom.
   Balance [Input – Output]
   Possibility to add fluid.
   Automatically does a Total Input, Total output, and Balance every 6am. Called 24hr Input output.
   Then one has to start a new one.

vii. **Nursing Remark** [Same model as Encounter]

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.

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

1. Anesthetist chat
    a. Surgery
    b. Indication
    c. Anesthesia
    d. Surgeon
    e. Assistant
    f. Anesthetist
    g. Mallampati Score
    h. ASA Grade
    i. Premedication
    j. Induction Time
    k. Note
2. Operation note

ix. Results

1. Lab Results
    a. Lab results show
    b. Possibility to enter lab profile.
2. Imaging Results
    a. Imaging results show
    b. Possibility to enter Imaging Profile.

x. Bills

1. See patient bills/ and of payments
    a. Just like bills in finance. Just note that you are already within a patients profile.

xi. Discharge summary

1. A page for writing summary of discharge
2. This page is visible on the patient app

xii. Referral Letter.

1. A page for writing summary of discharge
2. This page is visible on the patient app

xiii. Medical Report

1. A page for writing summary of discharge
2. This page is visible on the patient app

xiv. Attachment

1. All attachments made to patients' folder.

xv. Comments

1. Different color codes for Specialist
    a. Just a page for comment.

d. <u>DIAGNOSIS HISTORY</u>

i. List of diagnosis suffered by this patient
ii. Capacity to change diagnosis status
    1. Provisional
    2. Confirmed
    3. Chronic
    4. Query
    5. Resolved
iii. Date of onset and date resolved
iv. It should be searchable and sortable
    1. One can know how many times this person has had malaria

e. <u>PRESCRIPTIONS</u>

i. List of all medications ever prescribed for this patient
ii. Capacity to add prescription
    1. See MAXSOM emr
iii. Making a prescription

    Form Drug Dosage.Unit **<u>every</u>** Freq.Unit **<u>for</u>** duration.Unit

    1. Form Drug Dosage..Unit Frequency.Unit Duration..Unit
    2. Tab PCM 500 ….mg 8. Hrs 5… days
        a. Form
            i. Tab
            ii. Capsule
            iii. IV
            iv. IM
            v. Sc
            vi. Susp
            vii. Syr
            viii. Dispersible
            ix. GUTT[Eye]
            x. GUTT[Ear]
            xi. Topical

b. Drugs. – As many as registered by the pharmacy
c. Dosage – Any number
d. Unit [for dosage]
    i. mg
    ii. ml
    iii. g
    iv. ug
    v. L
    vi. Drops
    vii. tabs
e. Frequency – Any number
f. Unit [For frequency]
    i. Mins
    ii. Hours
    iii. Days
    iv. Week
g. Durations – Any number
h. Unit duration
    i. Days
    ii. Weeks

Bold - Default

f. LAB PROFILE

i. Request investigation
    1. Ability to see all possible tests being done in the hospital
    2. A list of frequently requested tests by that particular doctor.
ii. Enter lab profile of a patient

g. IMAGING PROFILE

i. Request investigation
    1. Ability to see all possible tests being done in the hospital
    2. A list of frequently requested tests by that particular doctor.
ii. Enter lab profile of a patient

h. PATIENT BILLS

i. See patient outstanding bills and payments
ii. Ability to add a particular charge to patient.

i. PATIENT ALERT

i. See list of all alerts from this patient
ii. Ability to create alert

j. APPOINTMENTS

i. A place for seeing patient appointments and booking appointments
ii. Any good format is okay

k. REFERRALS

i. A list of all referrals for the patient with the following heading
Each can be opened to read the referral note.
    1. Date
    2. Diagnosis
    3. Reason for referral
    4. Referring condition
    5. Referred to.

ii. Capacity to add a new referral
    1. The above headings must be filled in any new referral letter
    2. Just a blank document with a space above to fill the following.

l. MEDICAL REPORTS

i. A list of all Medical reports for the patient with the following heading
Each can be opened to read the medical report.
    1. Date
    2. Diagnosis
    3. Reason for report
    4. Patient's condition
    5. Requesting center

ii. Capacity to add a new medical report
    1. The above headings must be filled in any new Medical report
    2. Just a blank document with a space above to fill the following

m. DISCHARGE SUMMARY

i. A list of all Discharge summary for the patient with the following heading
Each can be opened to read the discharge summary
    1. Date
    2. Diagnosis
    3. Date of Admission
    4. Date of Discharge

ii. Capacity to add a new Discharge summary
    1. The above headings must be filled in any new discharge summary
    2. Just a blank document with a space above to fill the following

n. ATTACHMENTS

i. A list of all attached data for the patient with the following heading
Each can be opened to view the attachment.
    1. Date
    2. Name
    3. Description

ii. Capacity to add a new attachment
    1. The above headings must be filled in any new attachment

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

i. Place to select reason
    1. Deceased
    2. Court Order
    3. Hospital decision

a. Double folder
b. False folder
c. Others.

8. END