Neonatal Patient File User Manual

Version 3.0

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Contents

For information about the Product environment, precautions, warnings and intended use see USR ENG Digistat Care and/or USR ENG Digistat Docs (depending on the modules installed - for the Digistat Suite EU) or USR ENG Digistat Suite NA (for Digistat Suite NA). The knowledge and understanding of the appropriate document are mandatory for a correct and safe use of "Neonatal Patient File", described in this document.

1. Introduction

Neonatal Patient File is specifically designed for Neonatal Intensive Care units. It provides a complete digital patient documentation on an easy navigable web environment. Patient information is organized in general areas and specific sections that match the department clinical workflows.

This module is part of Digistat Docs, the non-medical device product of the Digistat Suite. Make sure to read the intended use of Digistat Docs before working on the module.

1.1. Launching Neonatal Patient File

To launch Neonatal Patient File:

- Click the  icon on the lateral bar.

A screen is displayed, showing the data of the patient currently selected. If no patient is currently selected, an empty screen is displayed, requiring to select a patient. See section 1.2.

1.2. Patient selection

To select a patient,

- Click the **Patient** button indicated in Fig 1 **A**.

Fig 1

The "Patient Explorer Web" module opens. See the Digistat® "Patient Explorer Web" user manual (*USR ENG Patient Explorer Web*) for further instructions on patient management functionalities.
When a patient is selected, the module displays the data of the selected patient. The page displayed by default is the "Personal details" form.

Other modules can be configured for the patient selection in place of "Patient Explorer Web", depending on the choices of the healthcare organisation. If this is the case, see the specific documentation for instructions.

2. Neonatal Patient File structure

Each page is formed of three main sections:

- A lateral navigation panel, allowing to quickly access the specific pages (Fig 2 **A**).
- The data area, displaying the contextual data (Fig 2 **B**).
- A command bar, allowing to operate on the page contents (Fig 2 **C**).

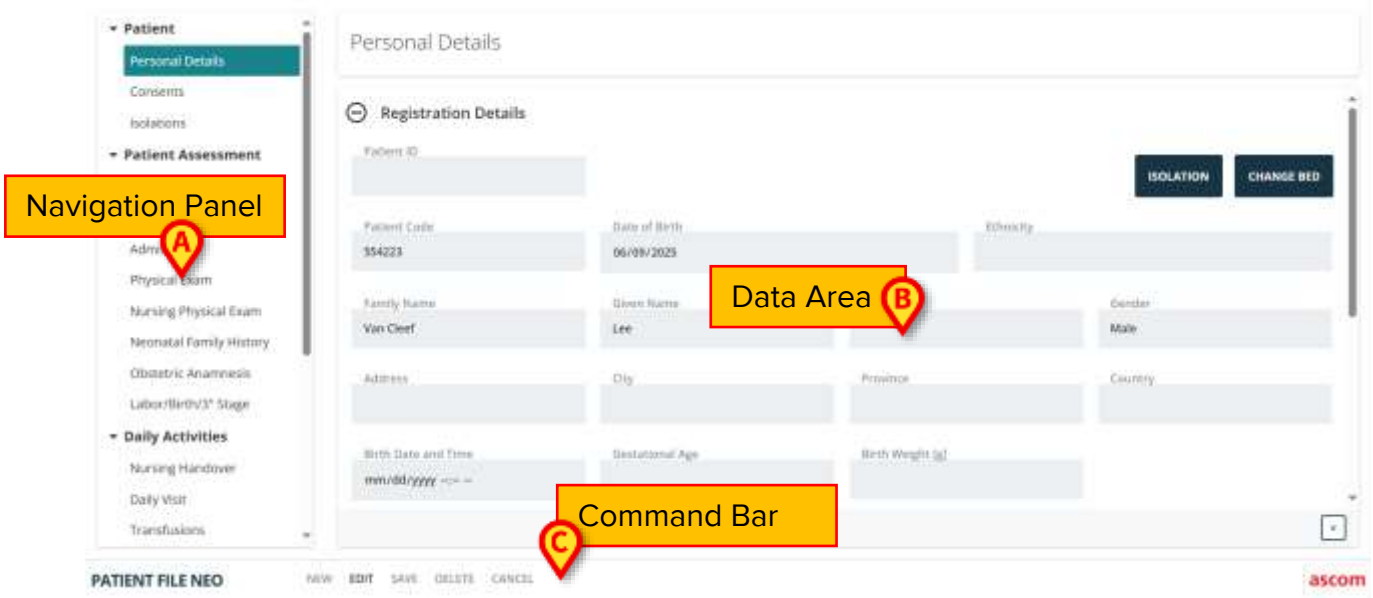

Fig 2

2.1. Navigation Panel

On the left a navigation panel is available, listing all the available pages (Fig 2 **A**, Fig 3).

Fig 3

The different pages are organized into 5 sections: Patient, Patient Assessment, Daily Activities, Discharge, Utilities.

Each section contains different forms, each one dedicated to a specific topic.
Patient → Personal details, Consents, Isolation.
Patient Assessment → Nets, Birth, Admission, Physical Exam, Nursing Physical Exam, Neonatal Family History, Obstetric Anamnesis, Labor/Birth/3rd Stage.
Daily Activities → Nursing Handover, Daily Visit, Transfusions, Malformations, Interviews, Growth Charts, Item Delivery.
Discharge → Clinical Discharge, Nursing Discharge.
Utility → Print Documents.

Not all the sections/pages are always available, due to configuration and/or to user permissions. This manual describes a full standard configuration for users granted with all permissions.

The sections names can be clicked to collapse/expand the related pages. See, for example, Fig 4.

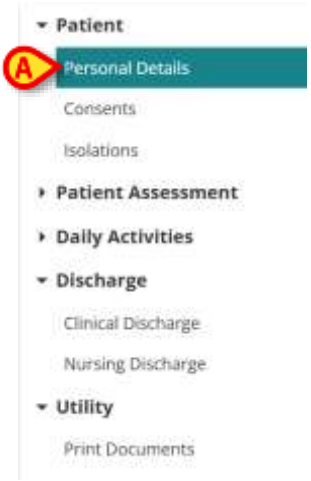

Fig 4

The page currently selected is highlighted (Fig 4 **A**).

- Click the name of a page to select it and directly navigate to a specific content.

Also, to facilitate navigation, a back button is provided on the heading of the page on records that are "Children" of a certain form. Examples are the records relating to a specific "Consents" (Fig 5).

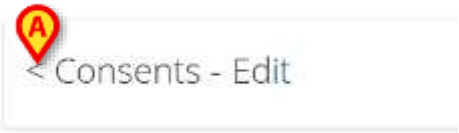

Fig 5

Whenever the left arrow indicated in Fig 5 **A** is present on the heading, you can

- Click it to go back to the "Mother" higher level form.

The “Consents” page is described in section 4.1.2.

2.2. Data Area

Each page contains data relating to a specific topic. Different tools, data entry modes and data display modes are available, depending on the kind of data that is contextually specified. For example, the “Personal details” page (Fig 6) contains the patient personal data, the mother’s hospitalization reference (Mother’s nosological code) and the available contacts. The different data entry tools and modes are described in section 3.1.

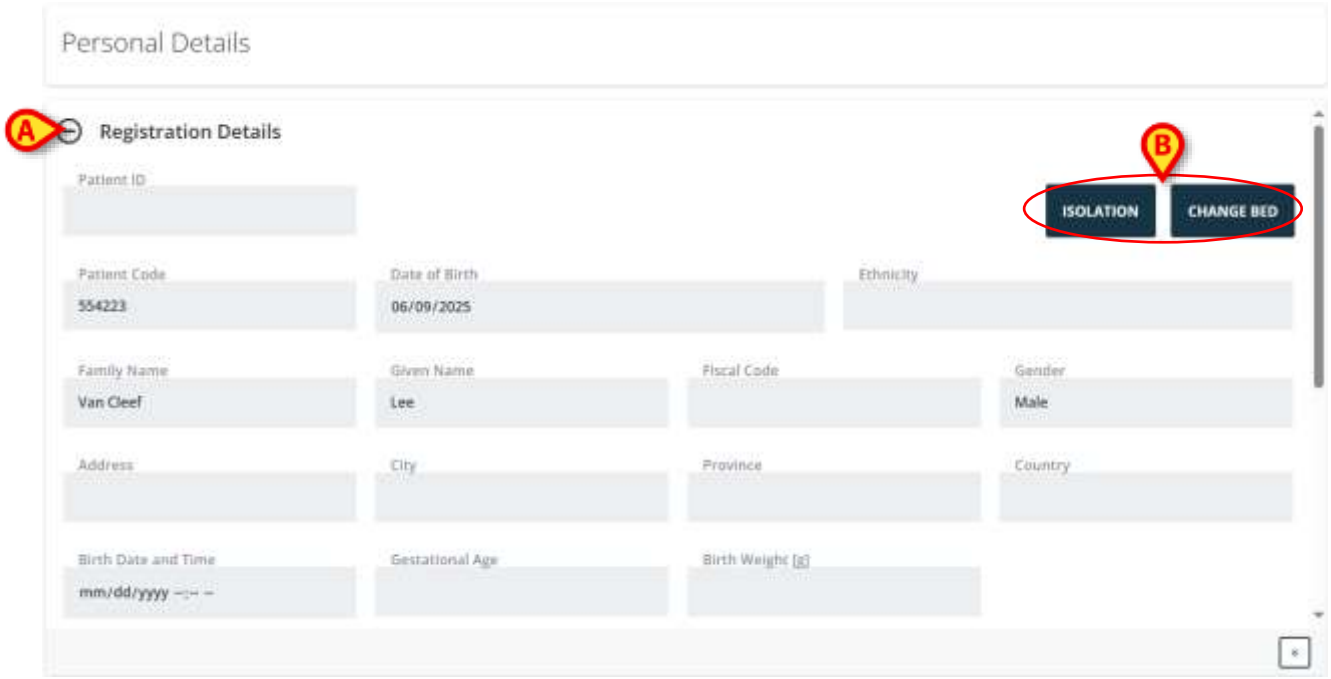

Fig 6

On each page, data is grouped by topic. Each “topic section” is defined by a heading (Fig 6 **A**).

- Click the heading to expand/collapse a section.

In Fig 7, for example, the “Registration details” section is collapsed (Fig 7 **A**).

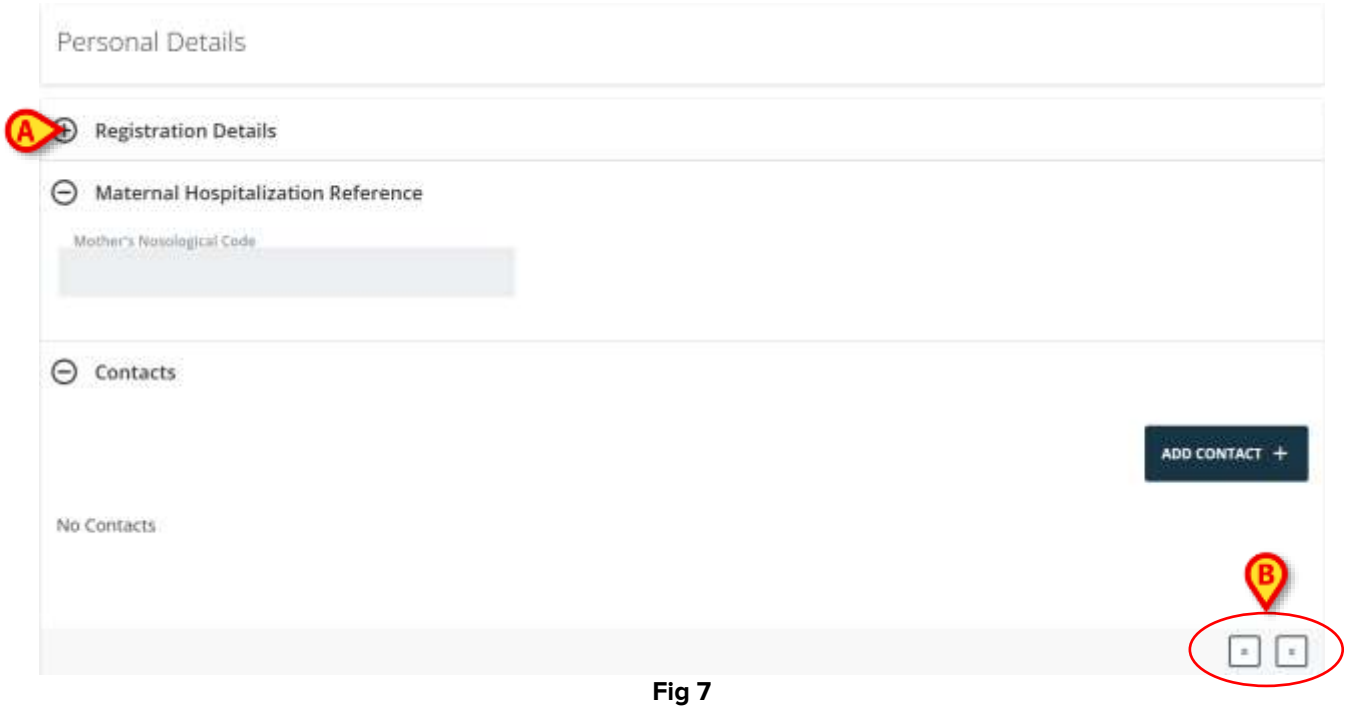

Fig 7

- Use the buttons indicated in Fig 7 **B** to either expand ( ) or collapse ( ) all sections.

Special buttons can be available on a page to access other pages or procedures that are directly related to the ones on the page currently displayed. This is the case of the **ISOLATION** and **CHANGE BED** buttons indicated in Fig 6 **B** (see section 4.1.1.1).

2.3. Command bar

The command bar (Fig 8) contains the buttons allowing to operate on the screen contents.

Fig 8

The name of the module is shown on the left. The buttons are:

New – allows to create a new form. This can happen either where "sibling" pages are possible (it is the case, for example, of "Nursing handovers", where a new handover is usually created at the end of each shift) or the first time a page is edited (for example, the first time the admission data is entered for a patient).

Edit – enables data entry (the page turns to "Edit mode").
Save – allows to save the changes after editing.
Delete – allows to delete a page, where possible.
Cancel – allows to discard the changes made to a page.

The buttons on the command bar are enabled/disabled depending on context (for example: the **Save** button is only enabled in "Edit mode") and/or on user permissions (i.e.: some procedures can only be performed by specific users).

3. Data Entry

The first time a record is accessed for a patient, the **New** button on the command bar is enabled, allowing to create a new record for that patient. At successive accesses, for pages that are only filled one time, the **New** button is disabled while the **Edit** button is enabled, allowing to modify the data on the existing page. For records with multiple instances (for example the "Daily Visit" record), the **New** button remains enabled at successive times as well.

To enter data:

- Click either the **Edit** or the **New** button on the command bar, depending on context (Fig 9).

Fig 9

The page turns to "Data entry mode". The clicked button is highlighted (Fig 10 **A**). The **Save** and **Cancel** buttons are enabled (Fig 10 **B** - **C**).

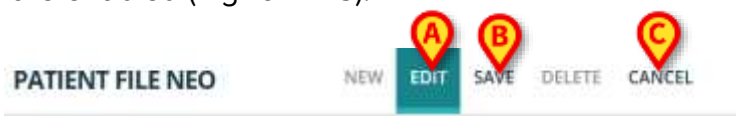

Fig 10

- Enter data.

- Click **Save** to save the changes or click **Cancel** to discard the changes.

There are various possible data entry modes, depending on the kind of data to be entered. These are described in the following section.

3.1. Data entry examples

This section exemplifies the most common data entry modes. The great part of data entry on Neonatal Patient File is performed according to the procedures described here. Other different procedures, related to specific forms, are described contextually.

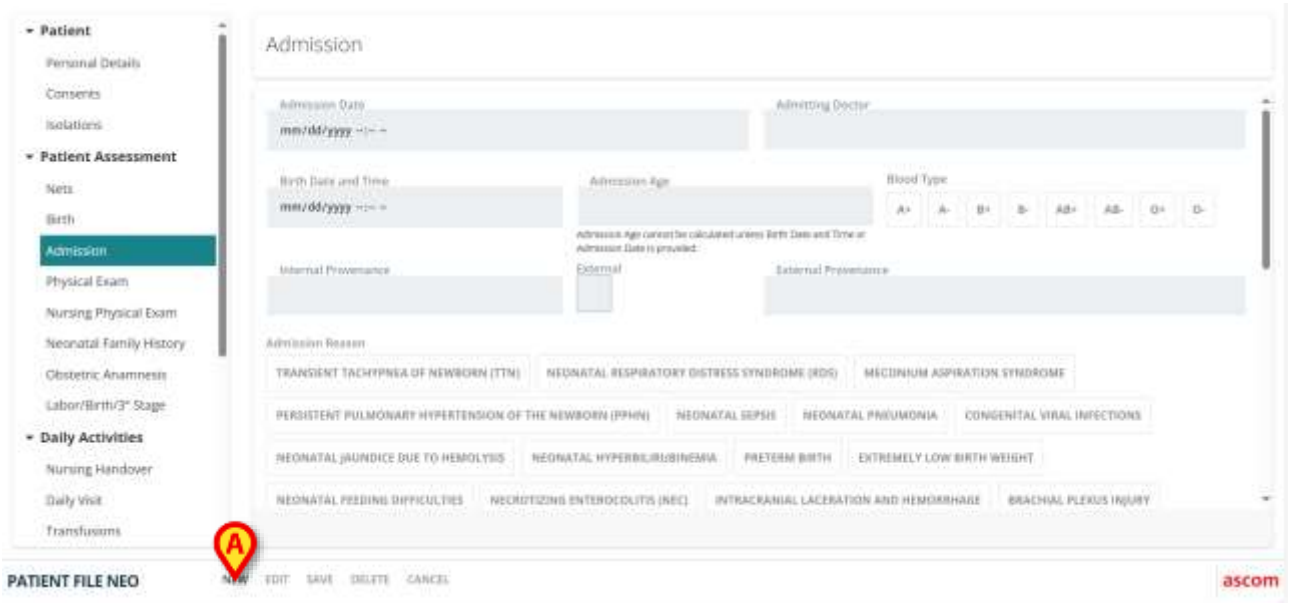

Fig 11

In Fig 11 the “Admission” form is displayed as example.

In general, to enter data:

- Click **New** on the command bar to create a new record for the patient (Fig 11 **A**).

The screen turns to “Data entry mode”; data entry is enabled. On the command bar, the **New** button is highlighted, the **Save** and **Cancel** buttons are enabled (Fig 12).

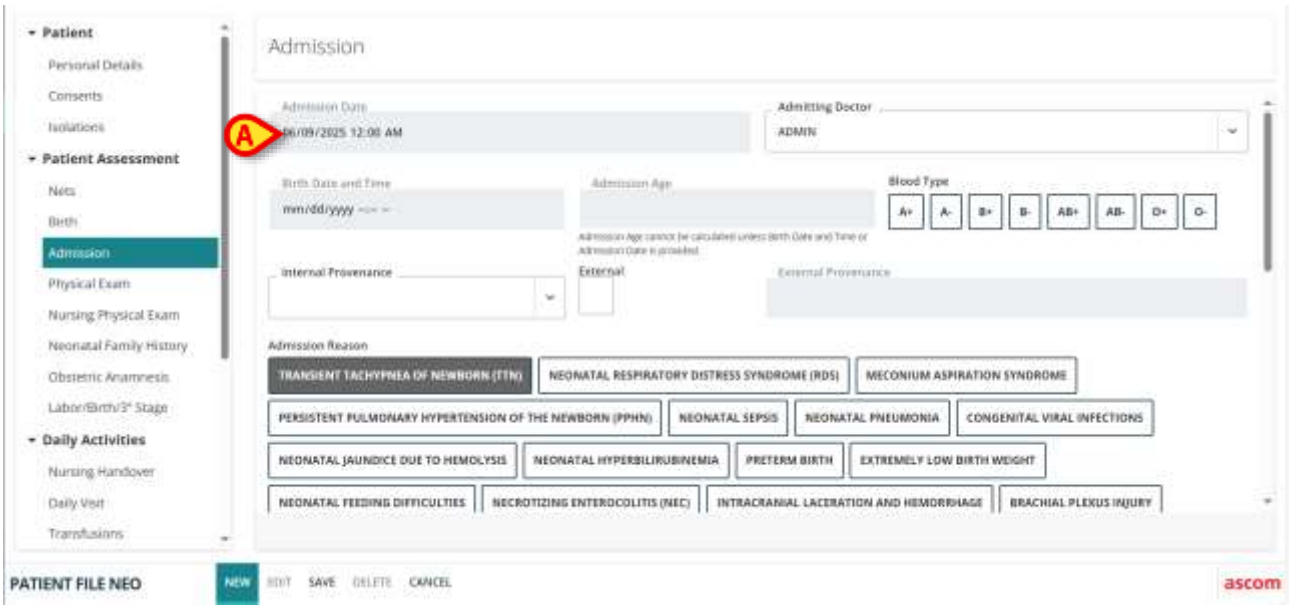

Fig 12

Some fields are read-only and automatically filled. These will be described contextually in the next paragraphs. For example, the data in the field indicated in Fig 12 **A** are inherited from the hospital ADT, while the “Birth Date and time” come from the “Birth” form.

The fields with an asterisk are required, as, for instance, “Guthrie Performed” and “Parental Consent” in the “Transfusions” page (Fig 13 **A**).

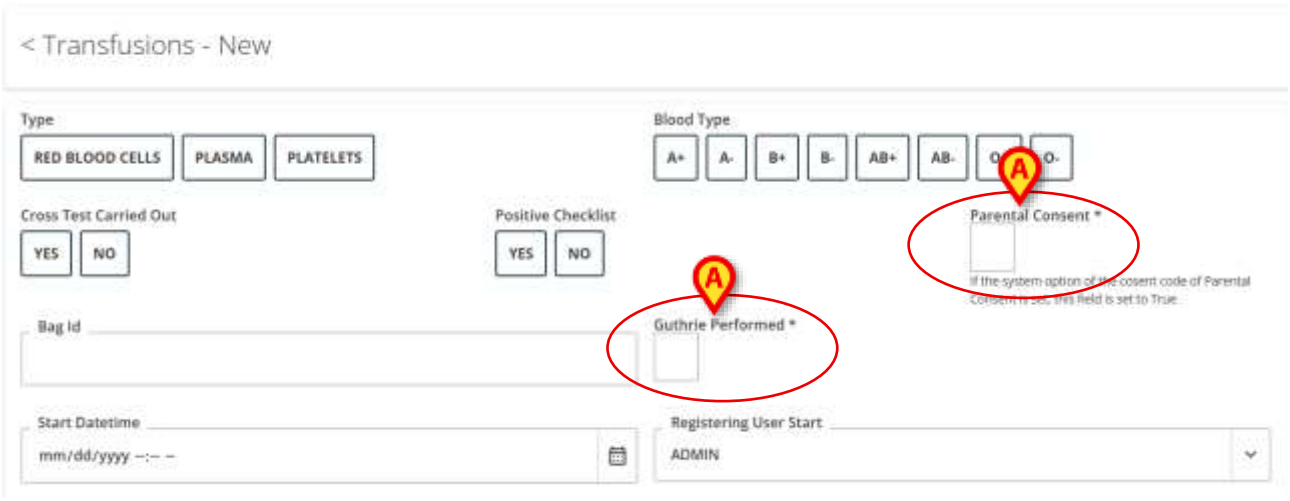

Fig 13

A page cannot be saved if not all the required fields are filled. If a user tries to save a record with incomplete data a pop/up window is displayed, listing all the missing required information (Fig 14).

Fig 14

Also, the missing required fields are highlighted (Fig 15 **A**).

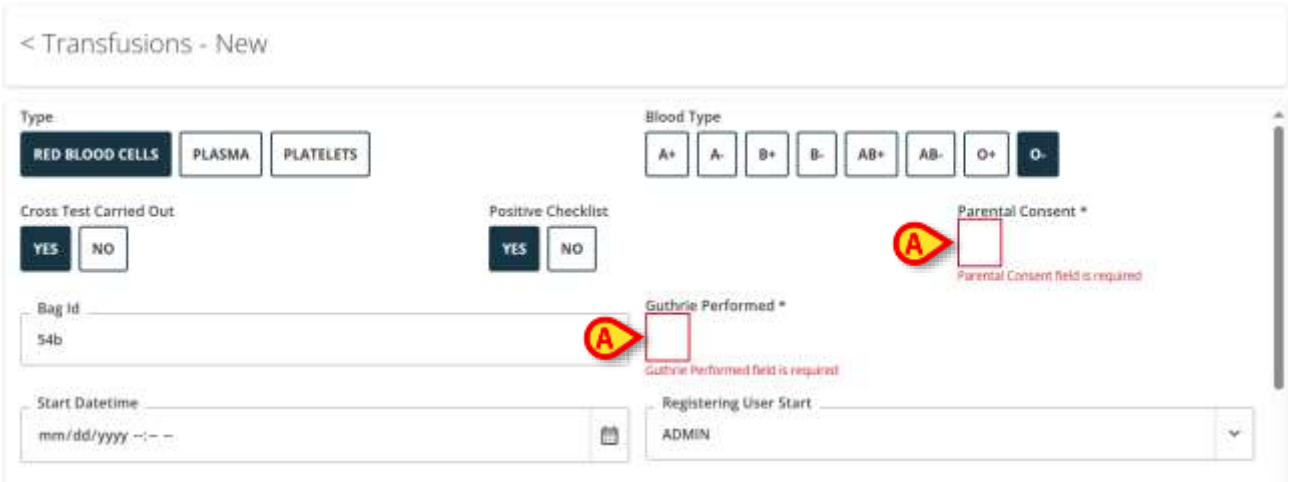

Fig 15

3.1.1. Drop down lists

- Click a name on the list to fill a drop-down list field.

The “Internal provenance” field, for example, can be selected on a drop-down menu containing the possible – configured - provenances (Fig 16).

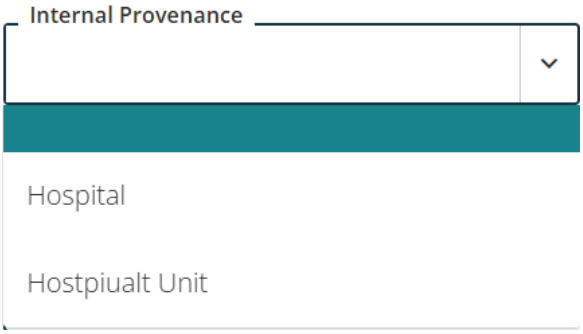

Fig 16

3.1.2. Multiple choice

In case of multiple-choice fields, as in Fig 17,

- Click an option to select it.

Fig 17

The selected option is highlighted (the selected options are the blue ones).

3.1.3. Co-related fields

Some options enable further specification. It is the case, for example, of the “Surfactant”, “Adrenaline”, “Bolus of saline solution” and “Vitamin K” checkboxes on the “Birth” form that, if checked, enable the specification of the related quantities and unit of measures (Fig 18).

Fig 18

3.1.4. Free text fields

Type the required text to fill in the field. See for instance Fig 19.

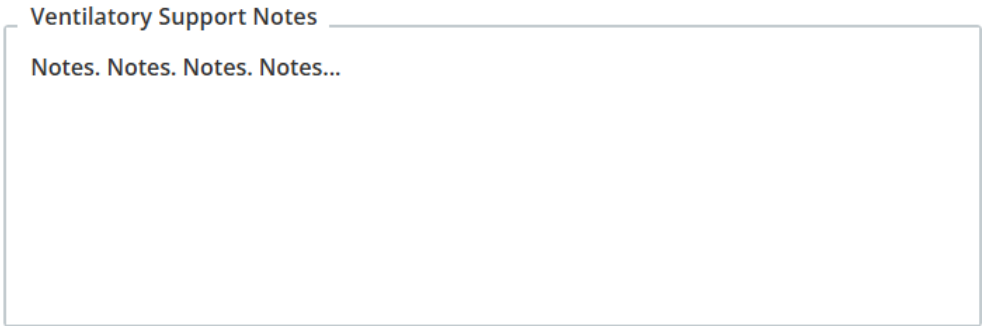

Fig 19

3.1.5. Selection window

Some fields open a selection window allowing the user to specify the required information. See, for instance, the specification of Problems on the “Daily Visit” page.

Fig 20

To indicate a problem

- Click the **Add Problem** button (Fig 20 **A**).

A dedicated selection window opens (Fig 21).

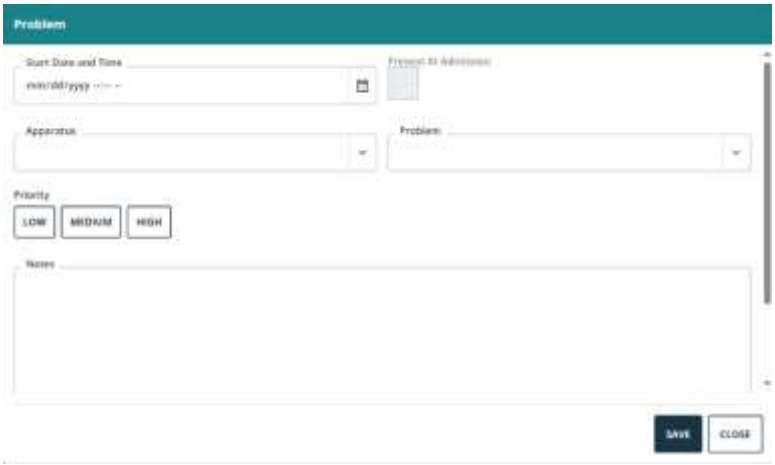

Fig 21

- Select the Start date and time (Fig 22 **A**).

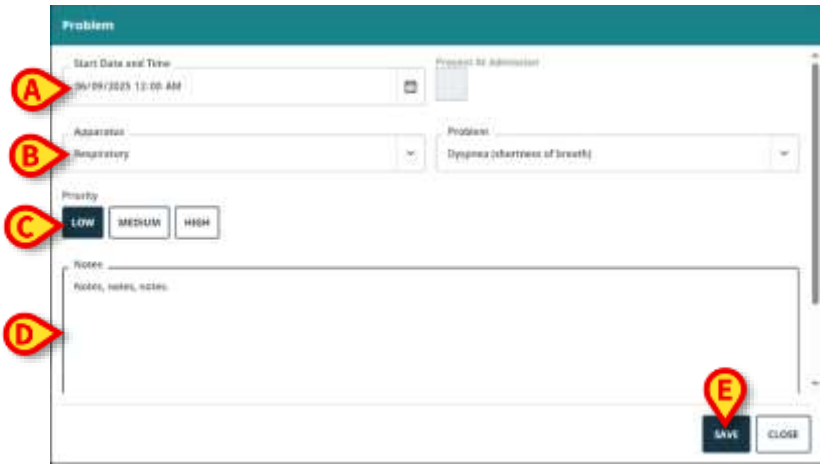

Fig 22

- Select the apparatus and problem in the contextual drop-down list (Fig 22 **B**).
- Indicate the priority (Fig 22 **C**).
- Type a more detailed description if necessary (Fig 22 **D**).
- Click **Save** (Fig 22 **E**).

The selected items are listed in a table (Fig 23 **A**).

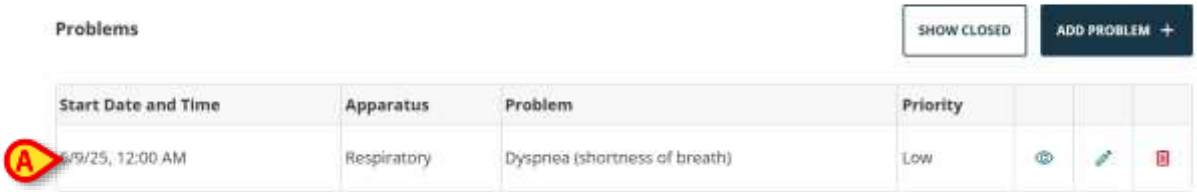

Fig 23

- Click the icon to fully display the details.
- Click the icon to edit the existing item.
- Click the icon to delete the item.

More information on the “Problems specification” functionality is provided in paragraph 4.3.2.

3.1.6. Codefinder call

The ICD9 diagnosis and procedures can be selected via the Digistat “Codefinder Web” Module. In these cases, a specific button calls the “Codefinder Web” module (see document *USR ENG Codefinder Web* for the description of the “Codefinder Web” module). The following example shows the diagnosis selection procedure on the “Admission” page (Fig 24).

Fig 24

- Click the **Add diagnosis** button (Fig 24 **A**).

The "Codefinder Web"module opens (Fig 25)

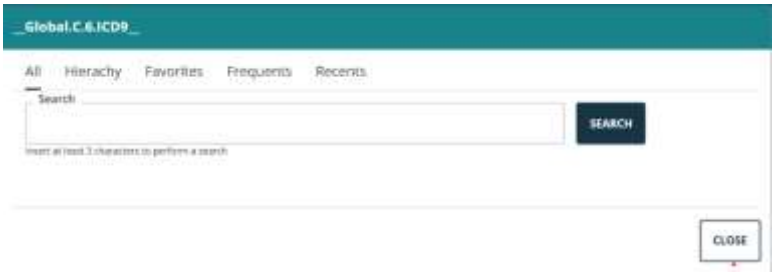

Fig 25

- Search the required diagnosis (Fig 26)

Fig 26

- Click the required diagnosis to select it (Fig 26 **A**).

The selected item is displayed on "Neonatal Patient File", on a table listing all the selected items (Fig 27).

Fig 27

- Use the icon to delete an item on the table (Fig 27 **A**).

3.1.7. Nurse Scores

By default, "Neonatal Patient File" shows pre-configured examples of nurse scores that can be modified during configuration. These nurse scores are configured on the Vitals Web configuration application (See the document CFG ENG Digistat Suite). These scores are for documentation purposes only.

At the moment, in the standard configuration, only one nurse score is present on "Neonatal Patient File": the "Apgar Score" on the "Birth" form (Fig 28).

Fig 28

To document a score:

- Click the **New Apgar Score** button (Fig 28 **A**).

The following window opens (Fig 29).

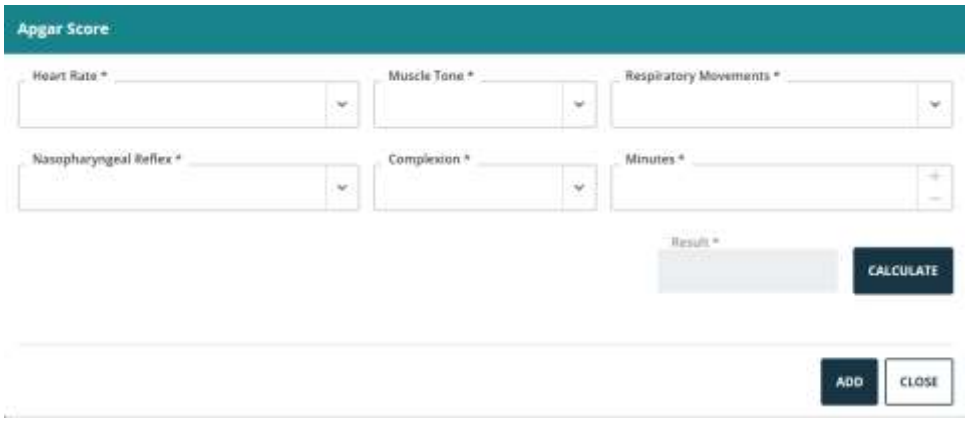

Fig 29

- Insert all the required evaluations (to be selected on drop down menus, in this case - Fig 30 **A**).

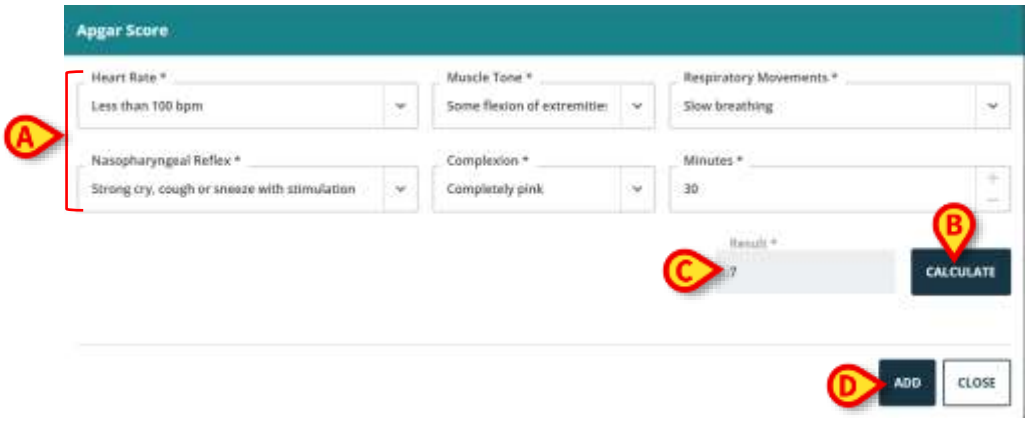

Fig 30

- Click the **Calculate** button (Fig 30 **B**).

The overall score is then displayed in a result field (Fig 30 **C**).

- Click the **Add** button (Fig 30 **D**).

The calculated score will be displayed in a table, on the relevant form ("Birth" in this case - Fig 31 **A**).

Fig 31

3.1.8. Disabled fields

Some fields can be disabled or read-only. Fields can be disabled due to user permissions (in case a user is not allowed to perform a specific procedure).

Some data is inherited from the hospital ADT. Patient personal details (name, surname, birthdate etc...) in the "Personal details screen" form, for example, are inherited from the hospital ADT and are read-only on "Neonatal Patient File" (Fig 32 **A**).

Another source for read-only fields can be a different page of "Neonatal Patient File", or an external Digistat application. For example: the data required to fill in the read-only fields indicated in Fig 32 **B** ("Personal details" page) come from the "Birth" page and are originally acquired from the Digistat "Online Web" module. See section 4.2.2 for the description of the "Birth" form.

Fig 32

3.2. History

The data relating to the record creation and last edit are always displayed on the bottom-left corner of each record.
Also, users who have adequate permissions can access the history of the changes made to a record. When this possibility is enabled, a specific “Record history” link is displayed on the page, beside the creation and editing information (Fig 33 **A**).

Fig 33

- Click the link to display the following window (Fig 34)

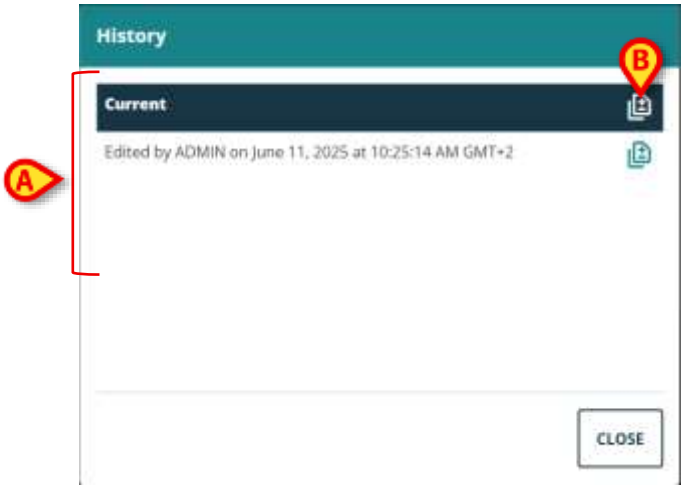

Fig 34

The window lists all the editings performed to the record. Each row corresponds to a specific editing (Fig 34 **A**). On top is the current version. It is possible to:

- Click a row to display a previous version of the record.

The previous versions displayed are read-only.

The icon on the right of each row (Fig 34 **B**) opens a window that compares the selected version with the previous version (Fig 35). The icon is visible only to users having specific permissions.

Fig 35

3.3. Sibling pages

Some activities are performed multiple times during the patient's stay. This results in multiple records of the same type for the same patient. It is the case, for example, of the "Nursing handover" record, that is usually completed and saved by the nursing staff at the end of each shift (Fig 36).

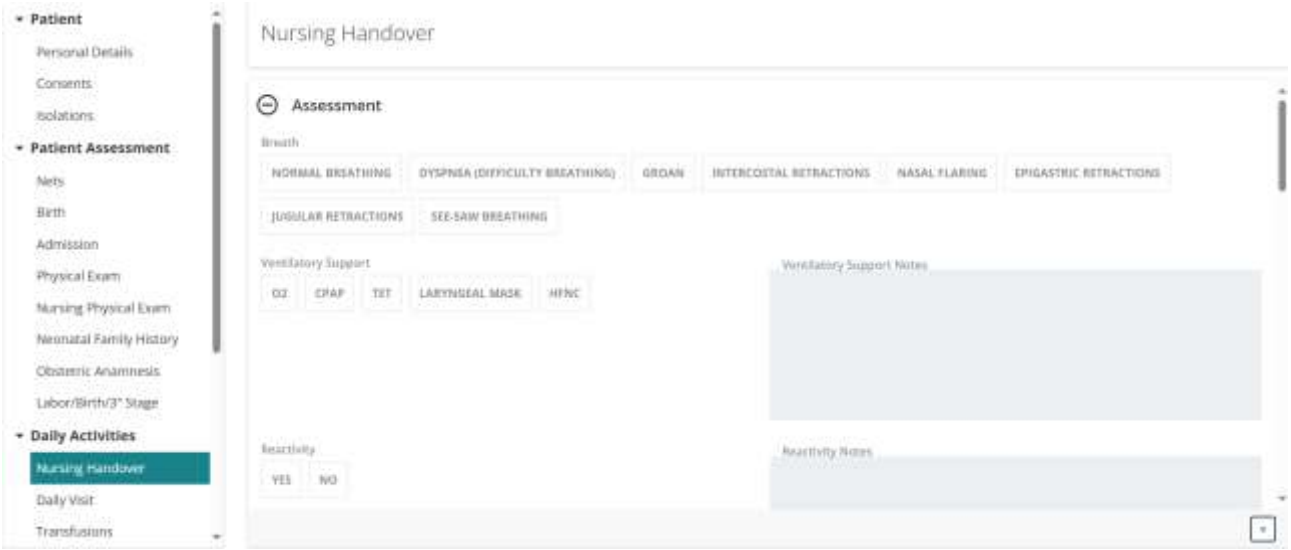

Fig 36

To create a new "Nursing handover":

- Click the **New** button on the command bar (Fig 36 **A**).

The page turns to "Edit mode" (Fig 37).

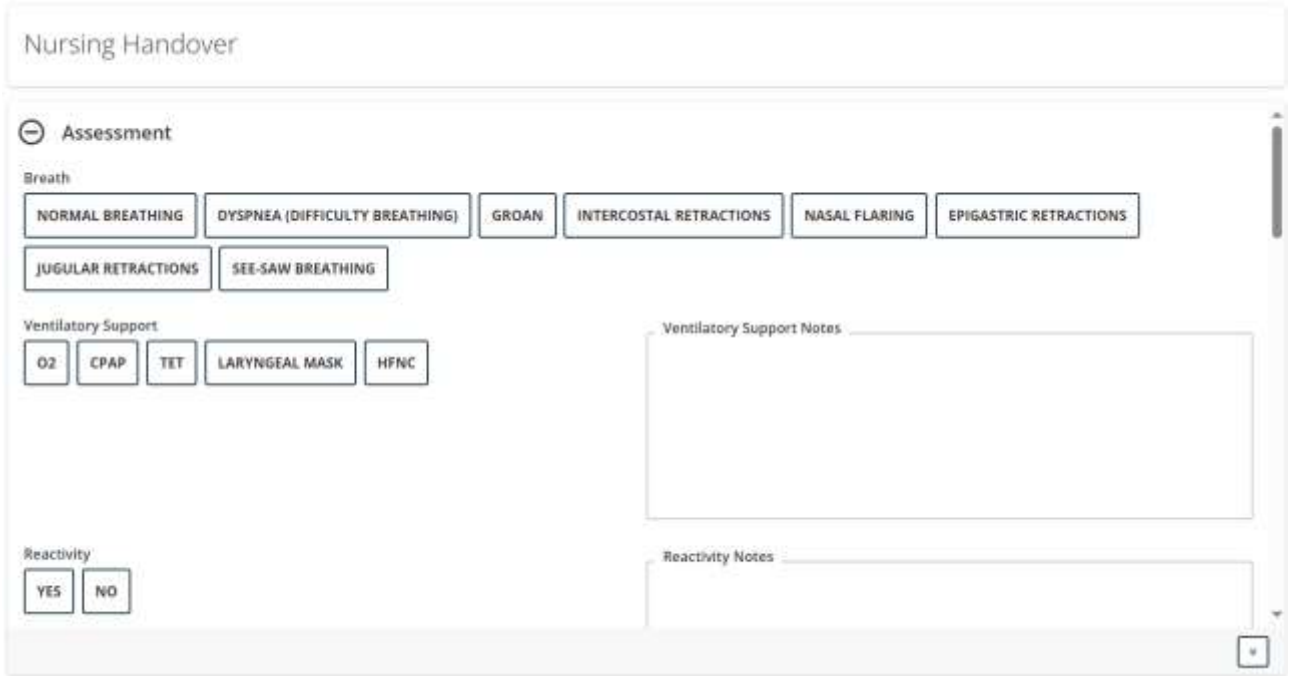

Fig 37

- Fill all the required fields (Fig 38).

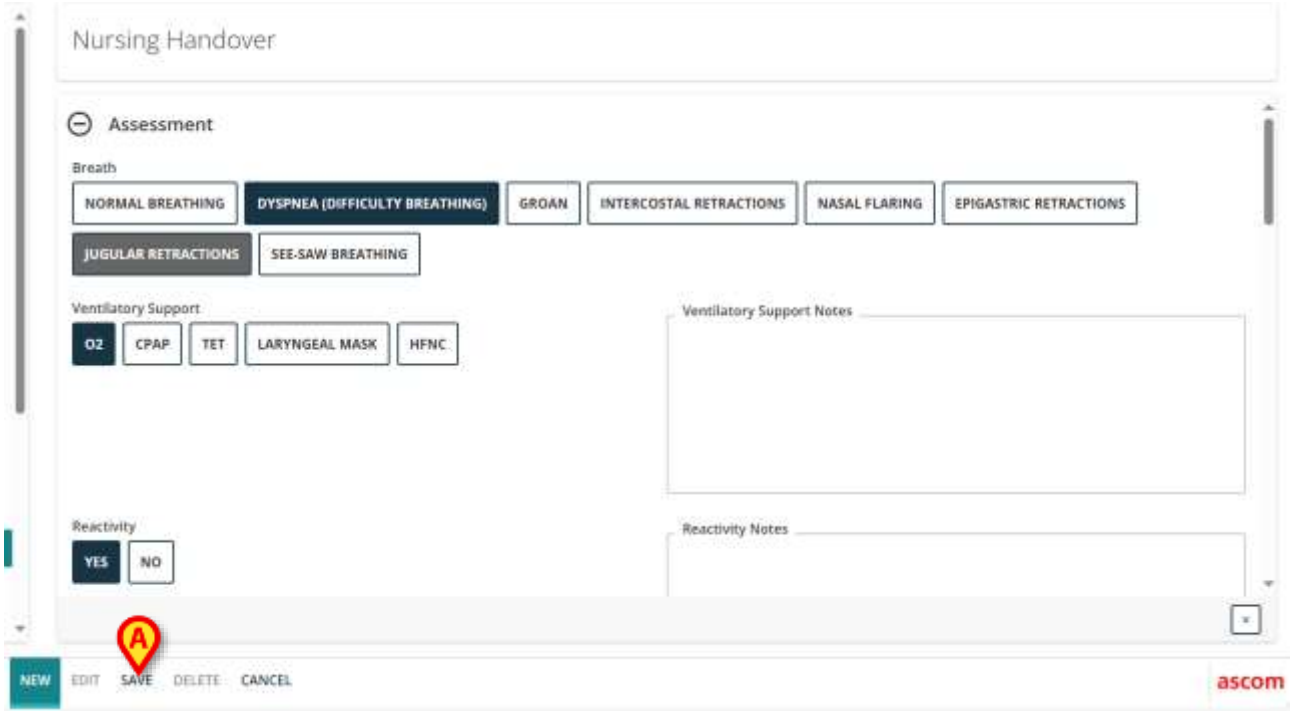

Fig 38

- Click **Save** when done (Fig 38 **A**).

The record is saved (Fig 39).

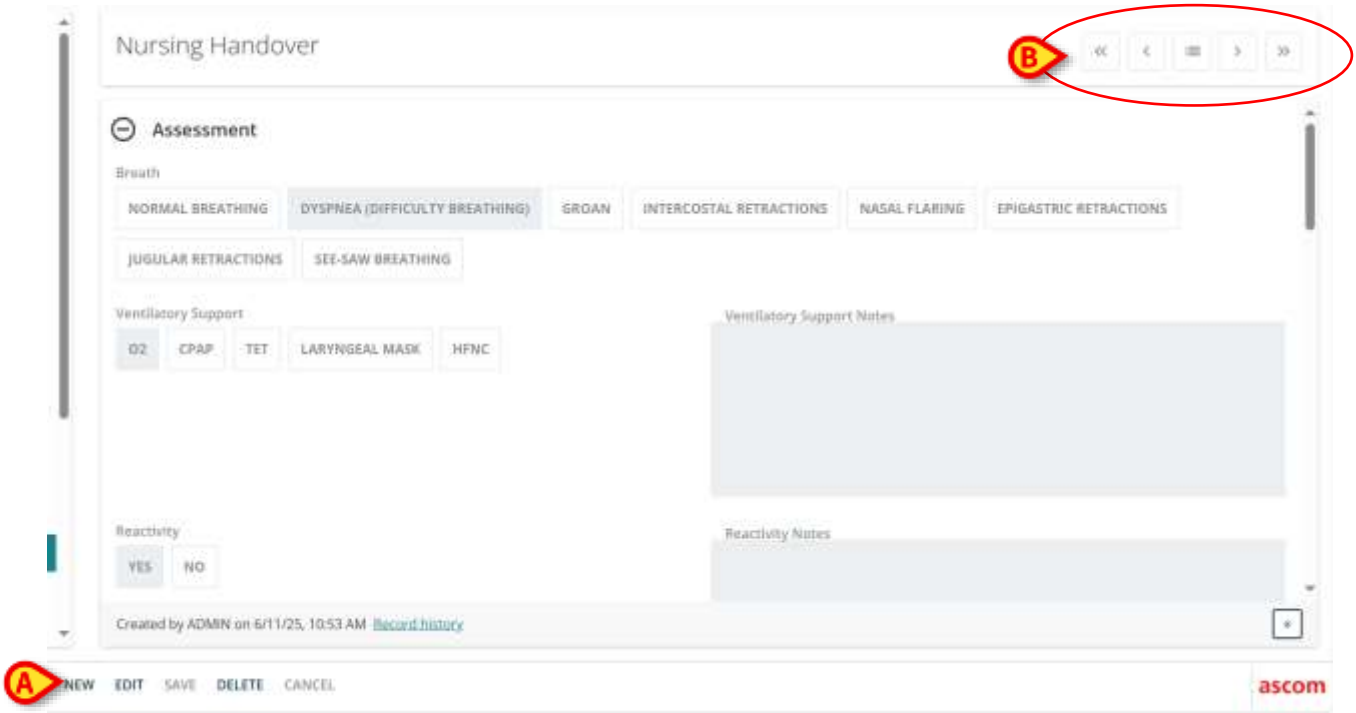

Fig 39

On the command bar the following buttons are enabled (Fig 39 **A**):

New – allowing to create a new record of the same type.

Edit – allowing to edit an existing record.
Delete – allowing to delete a record.

When multiple records are present, it is possible to navigate to the different records using the buttons indicated in Fig 39 **B**.

Click the  button to display the next record.

Click the  button to display the previous record.

Click the  button to display the last record (the most recent).

Click the  button to display the first record (the oldest).

Click the  button to display a table that lists all the existing records (Fig 40).

DateCreatedUtc	Breath	VentilatorySupport
6/11/25, 10:53 AM	Dyspnea (difficulty breathing)	O2
6/11/25, 10:56 AM	Dyspnea (difficulty breathing)	O2
6/11/25, 10:57 AM	Dyspnea (difficulty breathing)	O2

Fig 40

The yellow row indicates the record currently displayed. Click a row to display the corresponding record.

4. Workflows detail

This section lists and explains all the single records of “Neonatal Patient File”. If the data entry mode is one of those described in chapter 3.1, chapter 3.1 is referenced for instructions. Some records instead require specific, dedicated workflows. These are described contextually.

4.1. Patient

4.1.1. Personal details

The “Personal details” record contains all the personal information of the selected patient.

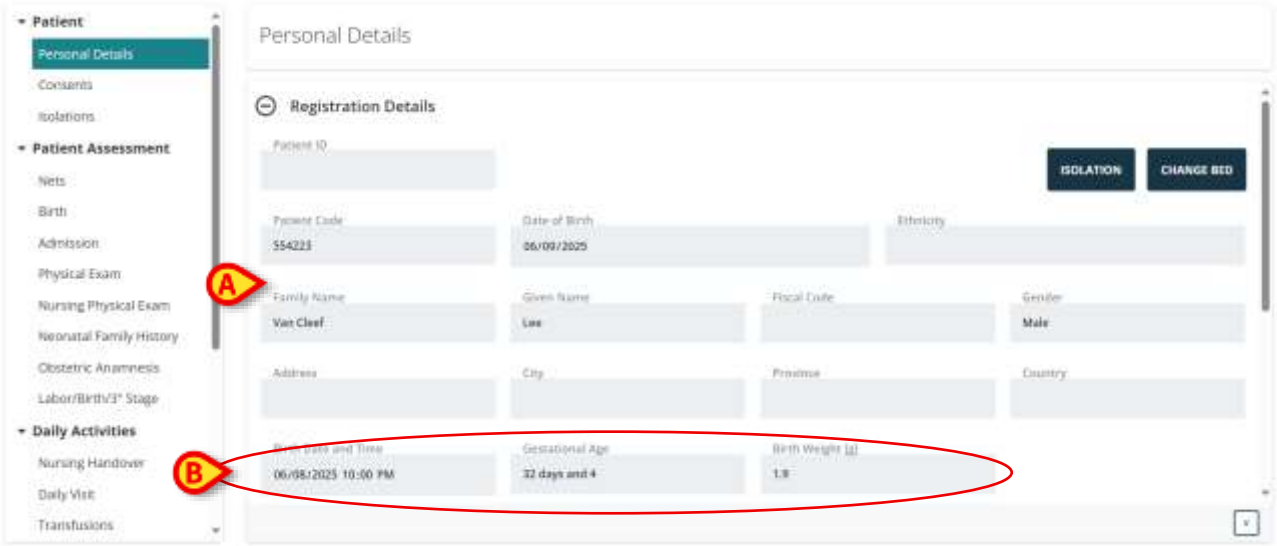

Fig 41

The data contained in the read-only fields indicated in Fig 41 **A** comes from the hospital ADT. The data contained in the read-only fields indicated in Fig 41 **B** comes from the “Birth” record. See section 4.2.2.

- Click the **Add Contacts** button placed below, in the “Contacts” area (Fig 42 **A**) to indicate contacts information. See section 3.1.5 for instructions.

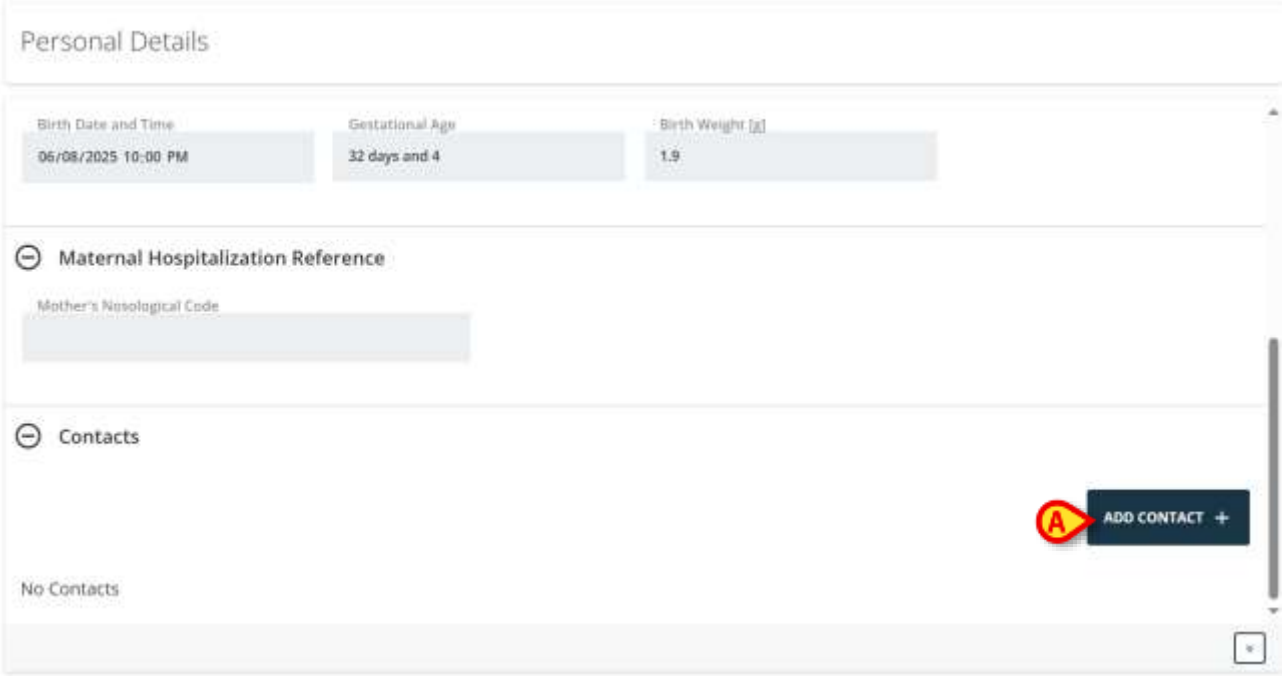

Fig 42

4.1.1.1. **“Change Bed” and “Isolation” shortcuts**

Two buttons are present on this page as shortcuts to related procedures. These are the **Change bed** and **Isolation** buttons (Fig 43 **A**).

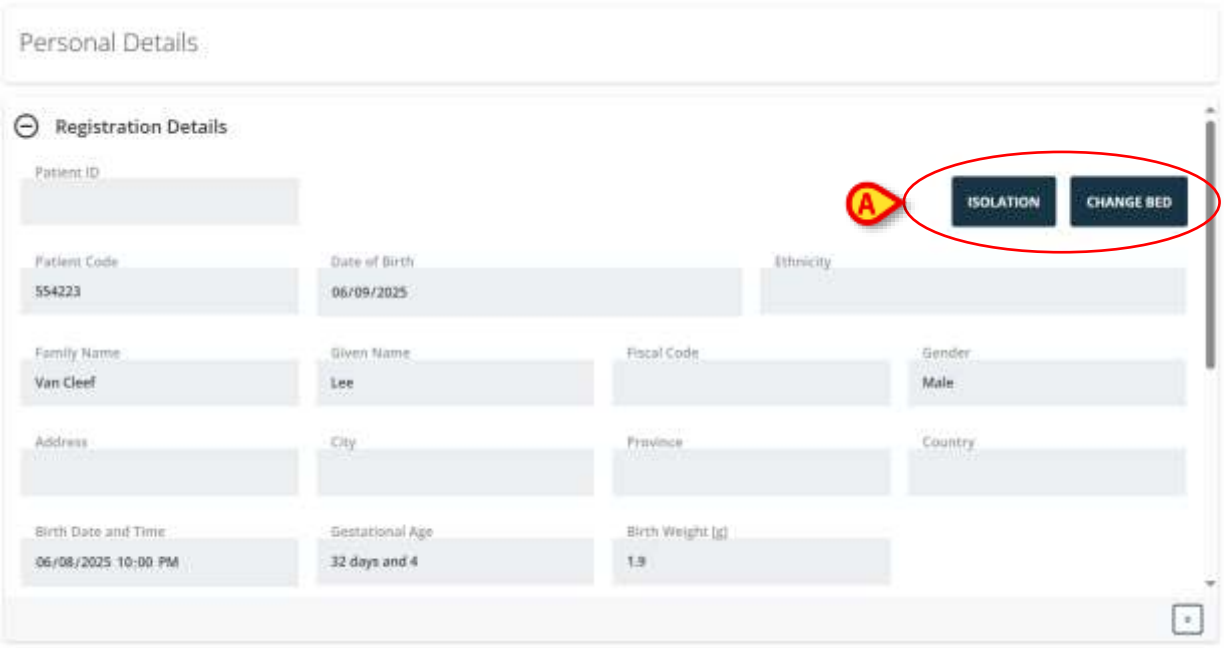

Fig 43

Change Bed

The Change Bed button can be used to quickly record the fact that the patient was moved to another bed.

- Click **Change bed** to open the “Move patient” window

Fig 44

- Select the destination department and bed on the window and then click **Move** (Fig 44 **A**).

Isolation

- Click **Isolation** to directly access the "Isolations" page, that allows to document the patient isolation periods (Fig 45).

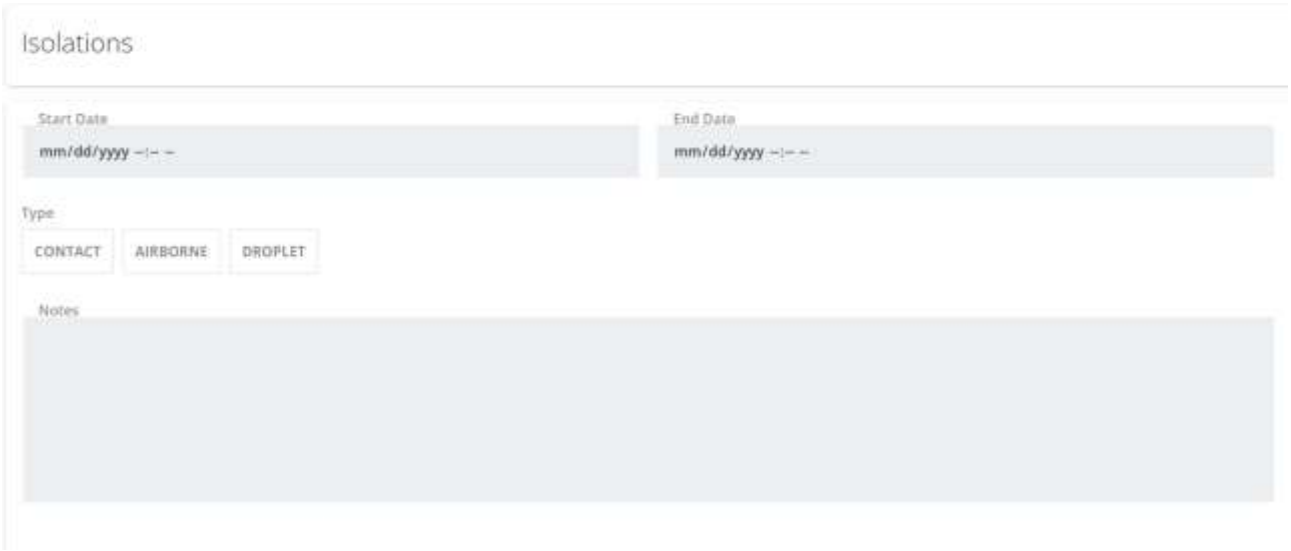

Fig 45

If an isolation period was started (the start date is specified) but not ended (end date not specified) as in Fig 46,

Fig 46

then the Isolation button is highlighted red on the “Personal Details” page (Fig 47).

Fig 47

- Click the button again to access the page again and specify the end date.

Multiple “Isolation” records can be created. The required condition to create a new “Isolation” record is that the previous one must be completed (i.e. it must have an end date).

4.1.2. Consents

The “Consents” record allows to track the status of the necessary consents provided by the patient/family.

A configuration option makes it possible to pre-upload a number of default consents. In Fig 48 there is one pre-uploaded consent.

Fig 48

- Click one of the rows to open the corresponding consent (Fig 49).

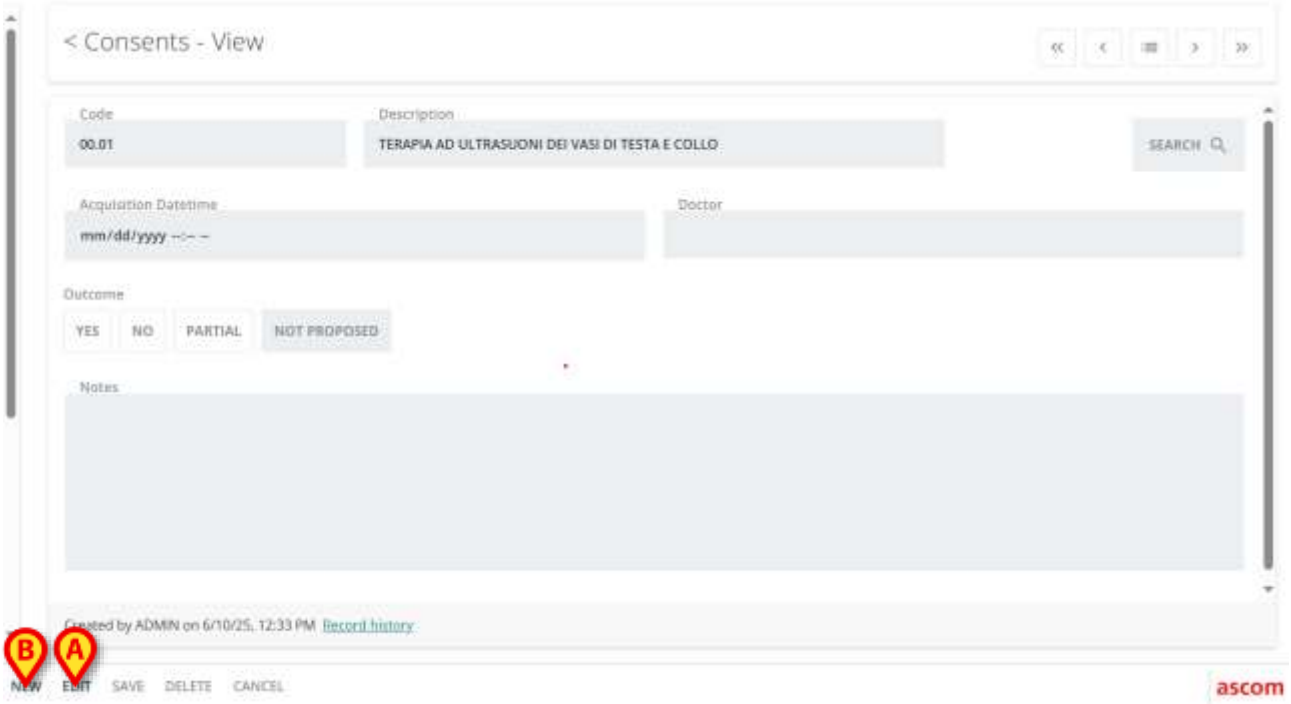

Fig 49

- Click the **Edit** button on the command bar (Fig 49 **A**).

The form turns to “Data entry” mode (Fig 50).

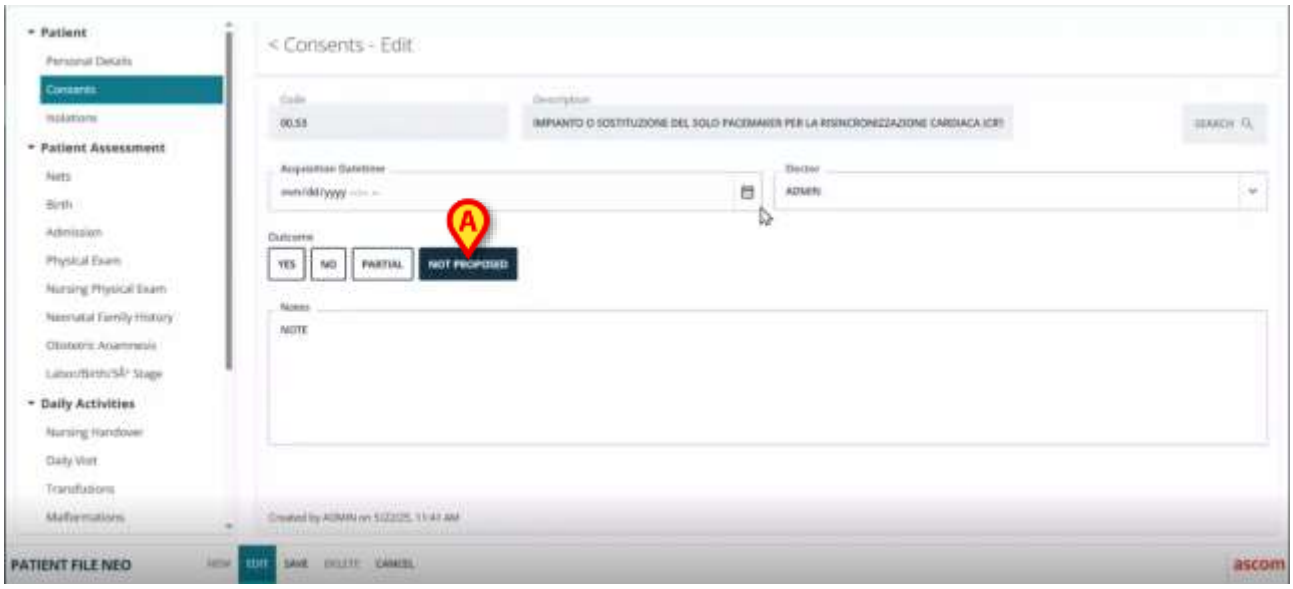

Fig 50

All consents are in state “Not Proposed” at first opening (Fig 50 **A**).

- Click a different outcome to change the consent status (Yes, No, Partial).

If a consent that is different from those listed by default is required, it is possible to upload and select a different consent. To do that:

- Click the **New** button on the command bar (Fig 49 **B**).

The following screen opens (Fig 51).

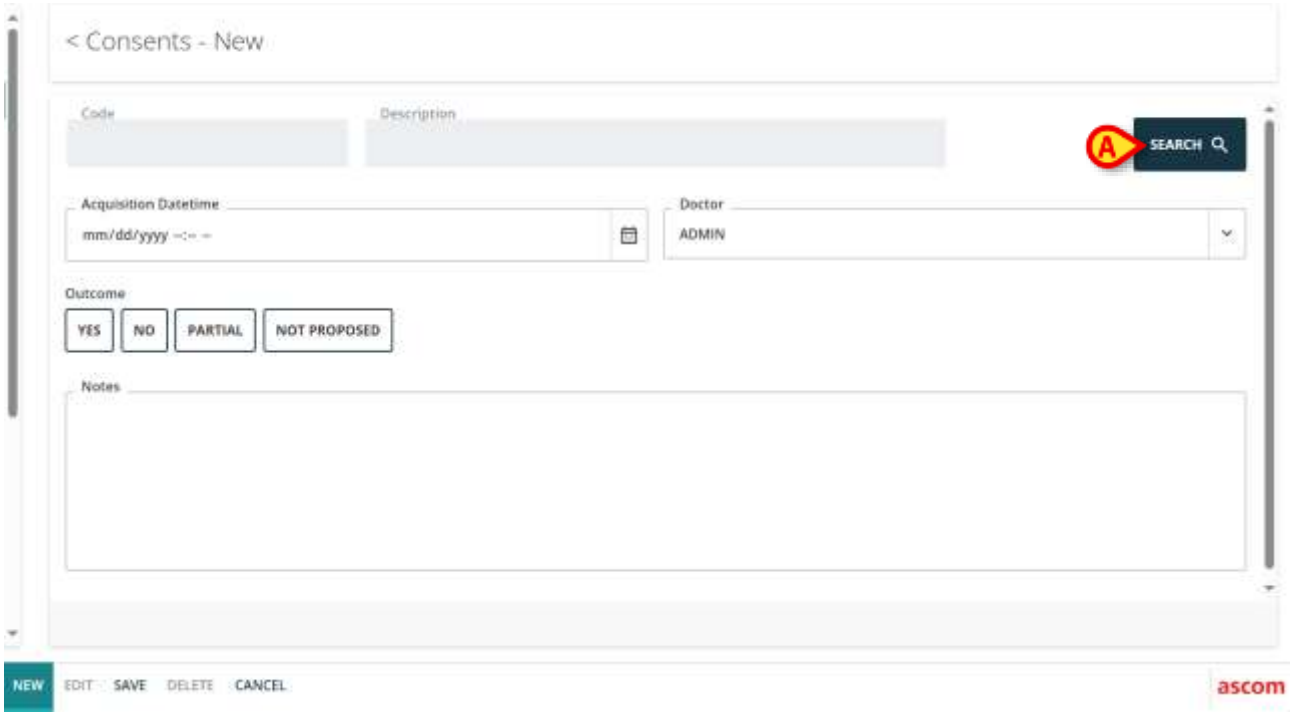

Fig 51

- Click the **Search** button (Fig 51 **A**).

A “Digistat Codefinder” instance will open. See section 3.1.6 for selection instructions. The new selected consent will be added to the consents list (the one shown in Fig 48).

4.1.3. Isolations

See section 4.1.1.1.

4.2. Patient assessment

4.2.1. NETS (Newborn & pædiatric Emergency Transport Service)

Refer to the general data entry instructions for the data entry procedures on this page. See section 3.1.

A configuration option allows to pre-fill the fields indicated in Fig 52 **A**. These fields are free-text fields. The pre-filled default content is a template that can be used to speed up the filling process or deleted if not relevant.

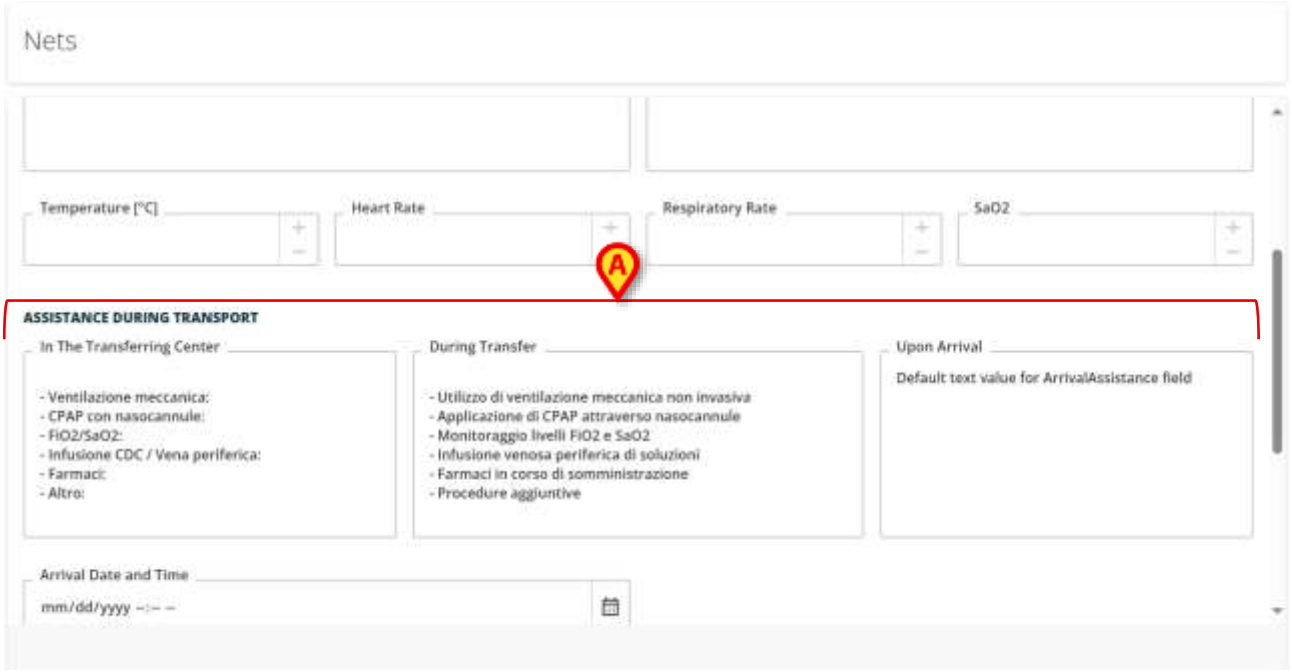

Fig 52

4.2.2. Birth

Part of the “Birth” data is imported from the Digistat “Online Web” module, where a dedicated table is configured to enter this data.

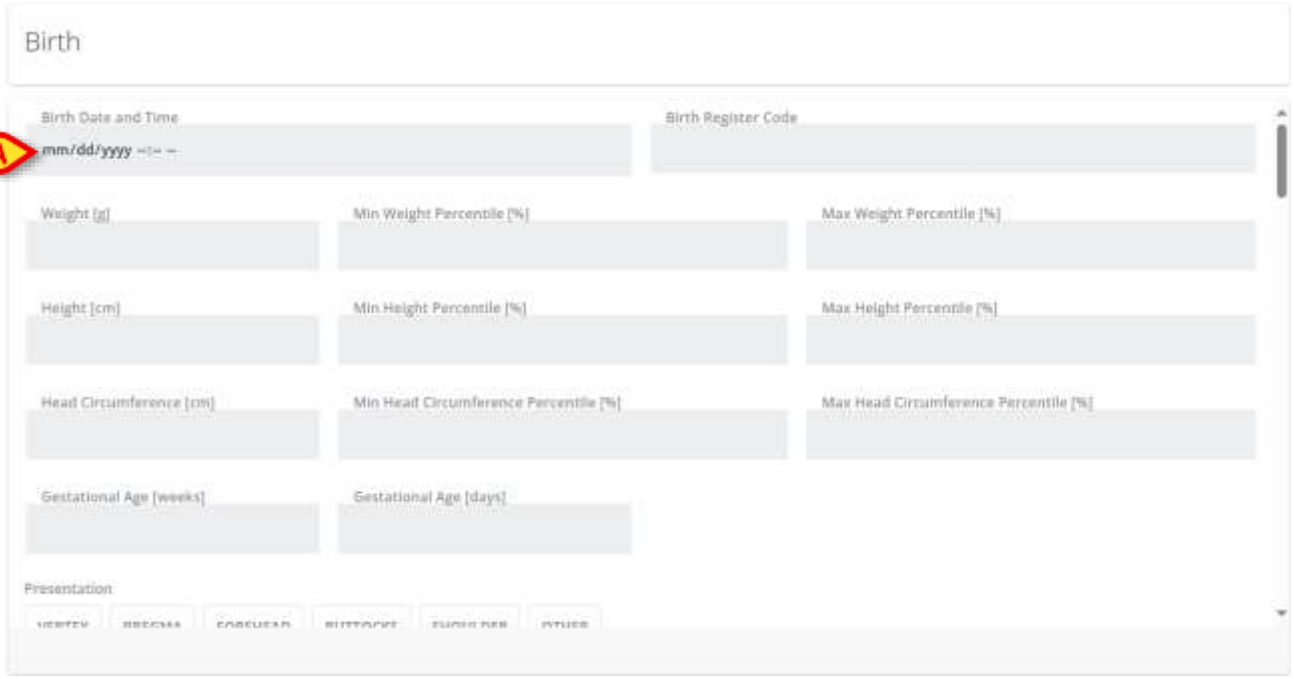

Fig 53

To import this data

- Insert the birth date and time in the field indicated in Fig 53 **A**.

The birth date and time must be the same specified on the relevant column on “Online Web”.

Then, the “Online Web” data will be displayed (Fig 54). Also, the related percentiles are automatically calculated according to the growth chart considered. The growth chart is selected on the “Physical Examination” form (section 4.2.4).

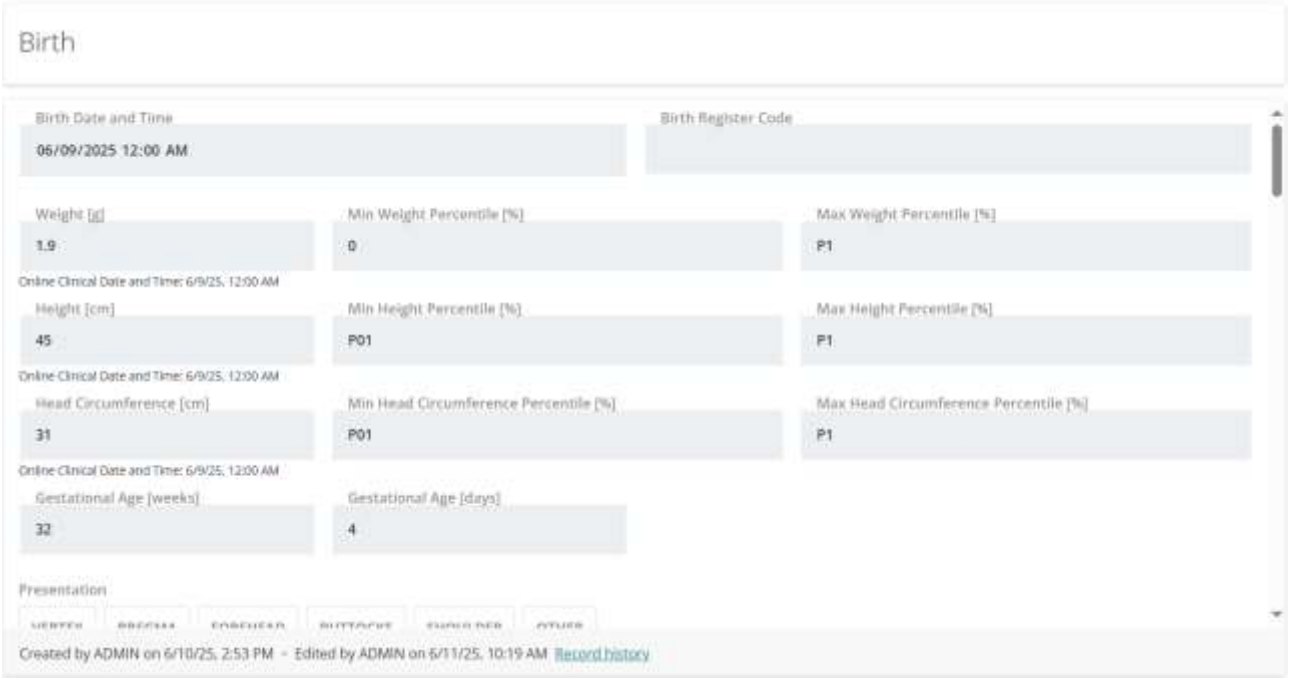

Fig 54

These filled fields are read only on “Neonatal Patient File”.

Refer to the general data entry instructions for the other data entry procedures on this page. See section 3.1.

4.2.3. Admission

If the information is available, the fields “Admission Date”, “Birth Date and Time” and “Admission Age” are automatically filled out when the admission record is created (click on **New** on the command bar). Birth date and time come from the “Birth” form; the “Admission date” is the one specified on the Digistat “Patient Explorer” Module at admission time; the “Admission Age” is calculated if the previous data is available.

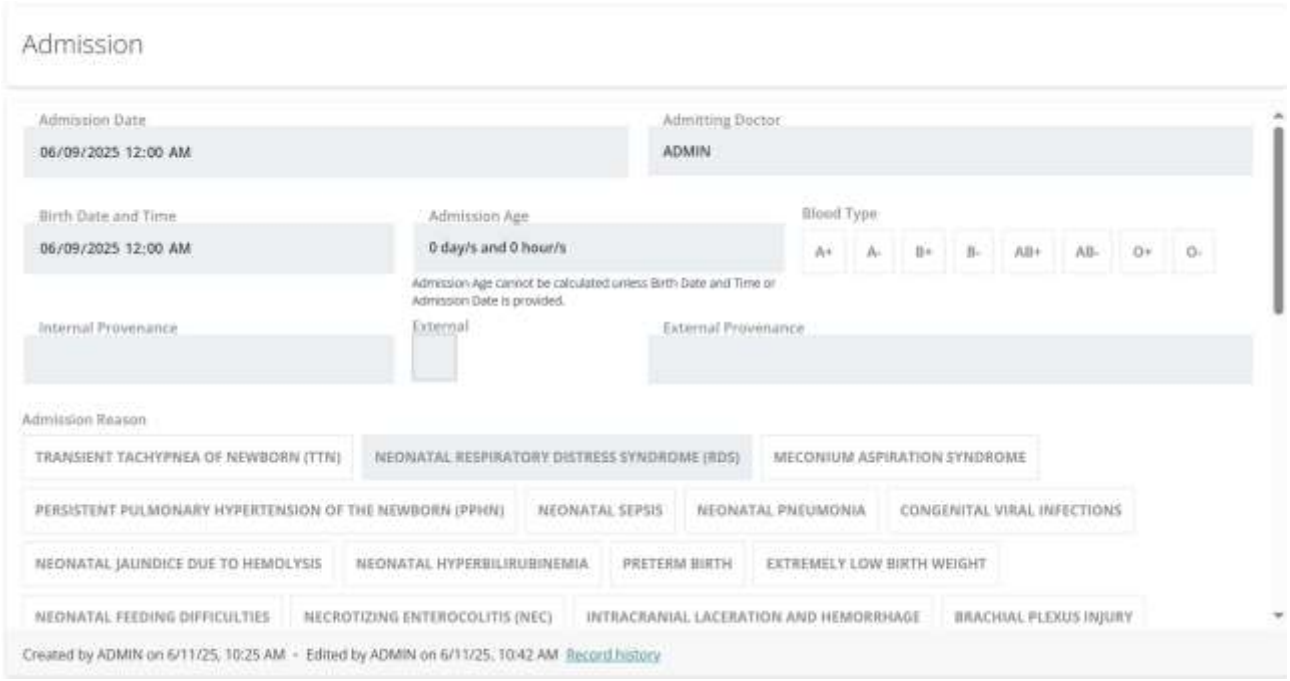

Fig 55

Refer to the general data entry instructions for the other data entry procedures on this page. See section 3.1.

4.2.4. Physical examination

The field indicated in Fig 56 **A** (“Growth chart provider”) is a drop-down menu making it possible to select the specific growth chart that will be applied to calculate the percentiles. Therefore, the choice made here affects other forms as well (“Birth”, “Daily Visit” and “Growth Charts”).

The growth chart provider cannot be changed if at least one “Daily Visit” is saved (paragraph 4.3.2).

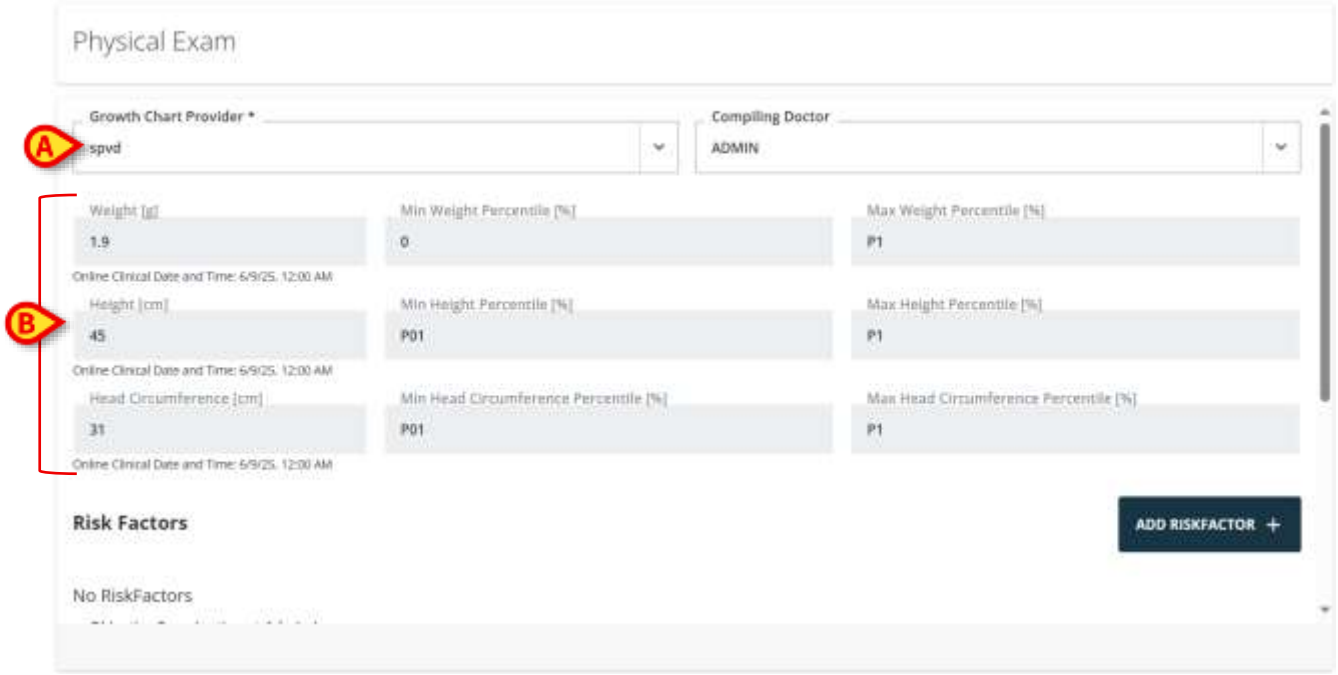

Fig 56

The “Weight”, “Height” and “Head Circumference” fields (Fig 56 **B**) are automatically filled out. These data are imported from the Digistat “Online Web” module, where the actual data entry is performed. The percentiles are automatically calculated according to the selected growth chart.

Refer to the general data entry instructions for the other data entry procedures on this page. See section 3.1.

4.2.5. Nursing Physical Exam

Refer to the general data entry instructions for the data entry procedures on this page. See section 3.1.

4.2.6. Neonatal family history

Refer to the general data entry instructions for the data entry procedures on this page. See section 3.1.

4.2.7. Obstetric anamnesis

Refer to the general data entry instructions for the data entry procedures on this page. See section 3.1.

4.2.8. Labor/Birth/3 Stage

Refer to the general data entry instructions for the data entry procedures on this page. See section 3.1.

4.3. Daily activities

The daily activities are performed multiple times during the patient's stay. Therefore, multiple records can be created for every activity. See section 3.3 for a general description of the functionalities related to this type of records and instructions on how to navigate the different records.

4.3.1. Nursing handover

Refer to the general data entry instructions for the data entry procedures on this page. See section 3.1.

4.3.2. Daily visit

The upper part of the "Daily Visit" page contains the daily measurement of Weight, Height and Head Circumference (Fig 57 **A**). This part is updated every time a new "Daily Visit" record is created.

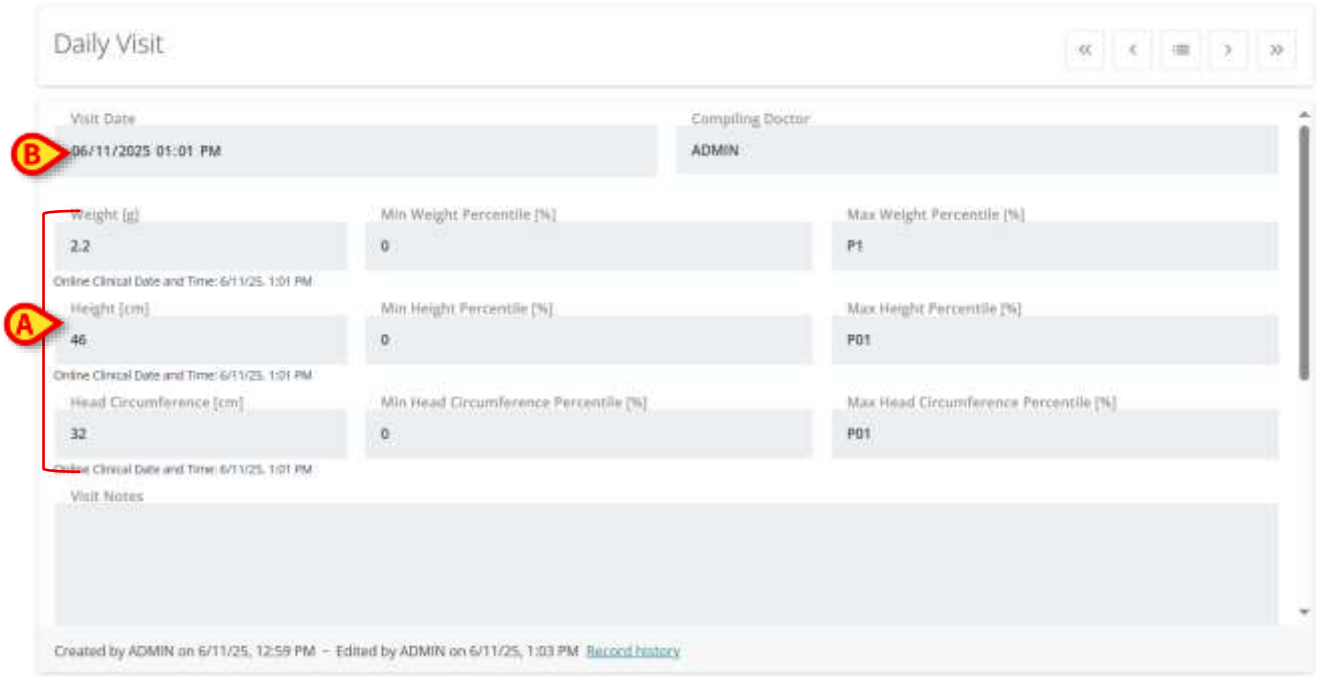

Fig 57

The "Weight", "Height" and "Head Circumference" fields (Fig 57 **A**) are automatically filled out when the visit date/time is inserted in Fig 57 **B**. These data are imported from the Digistat "Online Web" module, where the actual data entry is performed. The percentiles are automatically calculated according to the growth chart selected on the Physical Examination page (section 4.2.4). See the document USR ENG Online Web for the description of the Digistat "Online Web" module.

Data acquired on "Online Web" are, in the appropriate configured table, those contained in the most recent column placed in a configured time span preceding the date and time here specified. The specific time span is defined by a system option.

*If data is changed on "Online Web", the changes will be displayed on Neonatal Patient File when the page turns to "Data Entry" mode. I.e.: when the **Edit** button on the command bar is clicked.*

The lower part of the "Daily Visit" screen lists the patient's problems (Fig 58 **A**). The existing problems must be visible on each new record, therefore they remain visible on each instance of the "Daily Visit" record unless they are deleted or marked as closed.

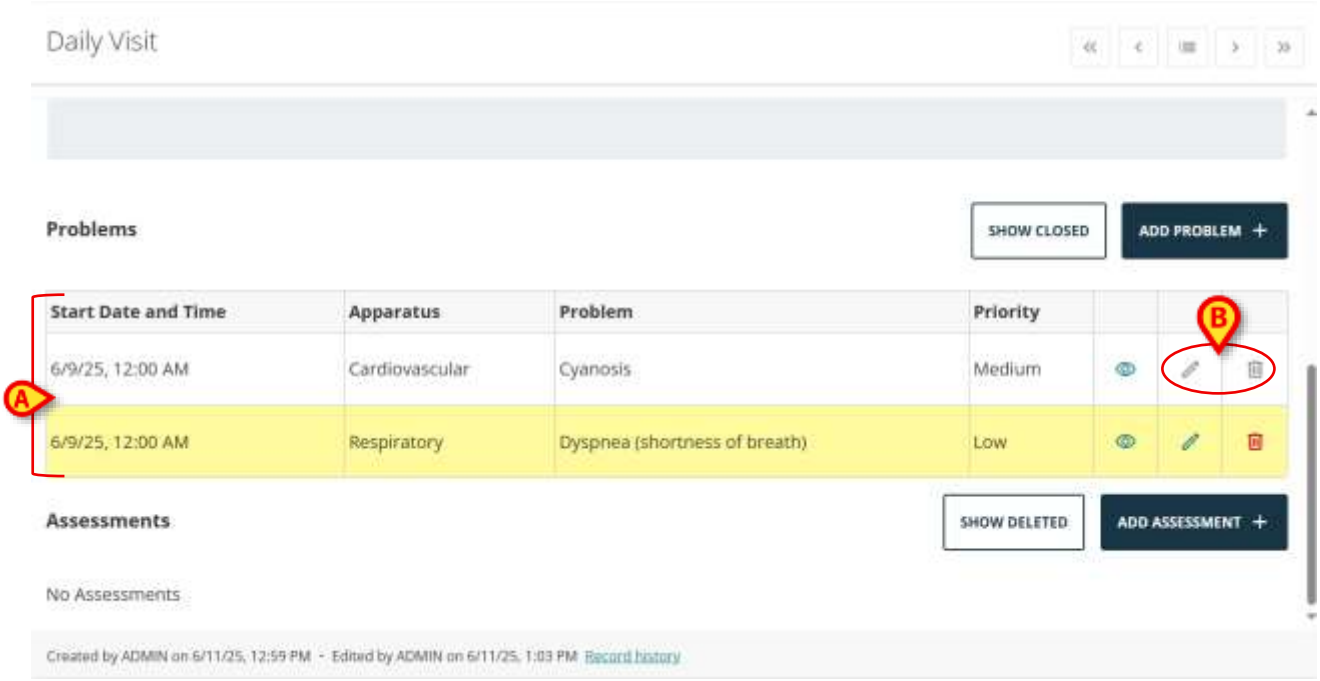

Fig 58

The problems table lists both the problems added on this page ("Daily Visit" – click the **Add Problem** button as described in section 3.1.5) and those indicated on the "Physical Examination" page. The ones added on the "Physical Examination" page cannot be edited or deleted here (the icon-buttons are disabled; see for instance Fig 58 **B**).

For each problem, a number of assessments can be documented.

To document an assessment:

- Click the row corresponding to the problem to be assessed.

The row will be highlighted (Fig 59 **A**). The **Add Assessment** button will be enabled (Fig 59 **B**).

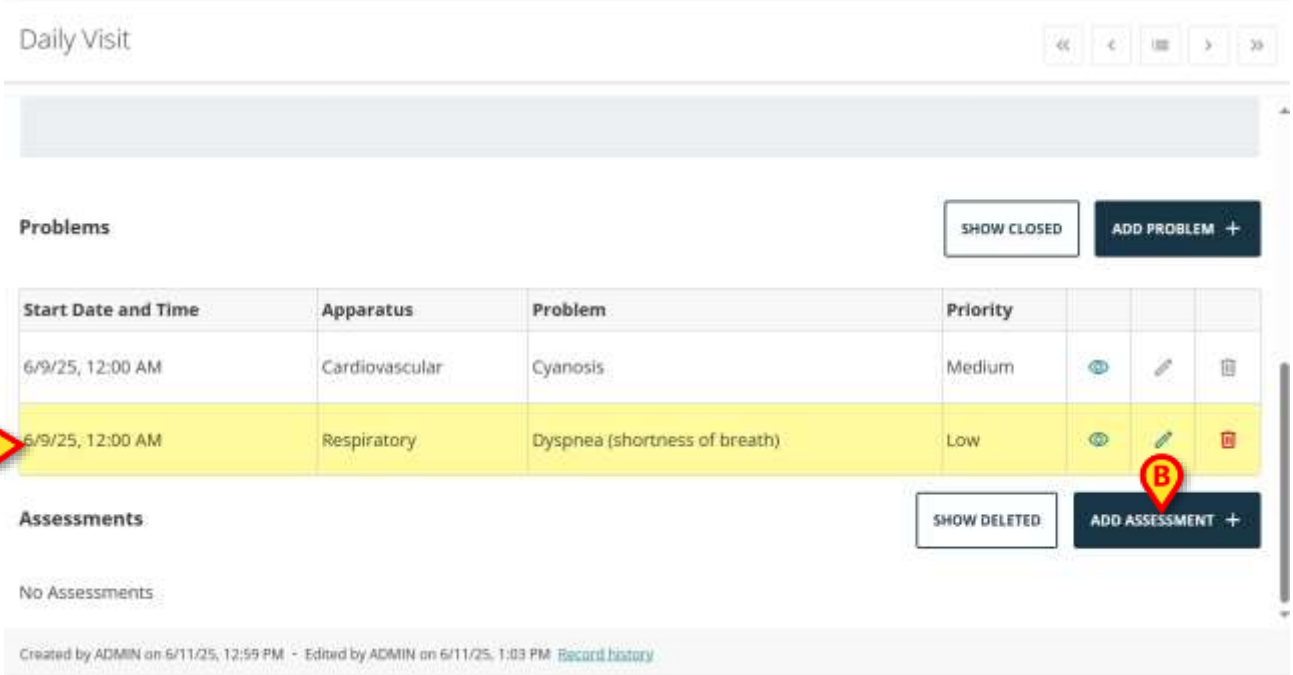

Fig 59

- Click the **Add Assessment** button (Fig 59 **B**).

The following window will open.

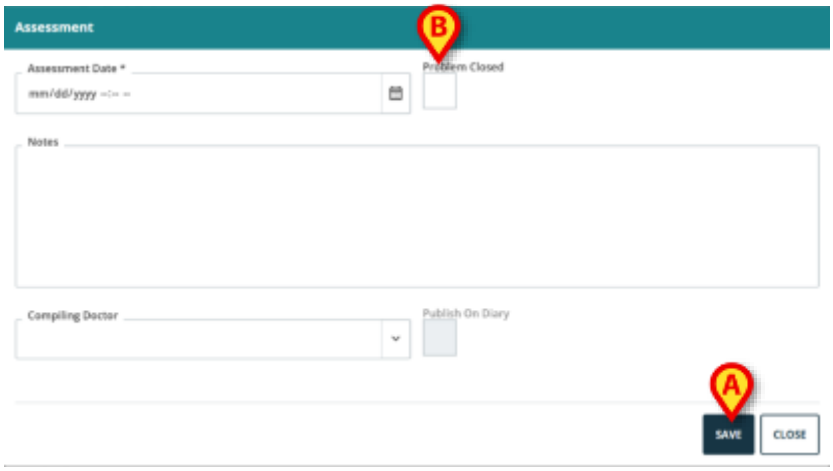

Fig 60

- Fill in the fields (Date/Time, Compiling Doctor, Notes). Assessment date is required.
- Click the **Save** button (Fig 60 **A**).

The assessment will be displayed on a dedicated table (Fig 61 **A**). The assessments related to a problem are displayed when the specific problem is selected. I.e.: it is necessary to click on the row corresponding to a problem to display the existing assessments for that specific problem.

Fig 61

The “Problem Closed” checkbox on the assessment specification window (Fig 60 **B**) allows to document that a problem is closed.
Closed problems are not displayed on the problems table unless the **Show Closed** button is selected (Fig 61 **B**).
The **Show Deleted** button allows to display the deleted assessments (Fig 61 **C**).

If the “Close problem” assessment is deleted, the problem goes back to the open problems list.

Refer to the general data entry instructions for the other data entry procedures on this page. See section 3.1.

4.3.3. Transfusions

The “Transfusions” page lists in a table all the transfusions performed (Fig 62 **A**).

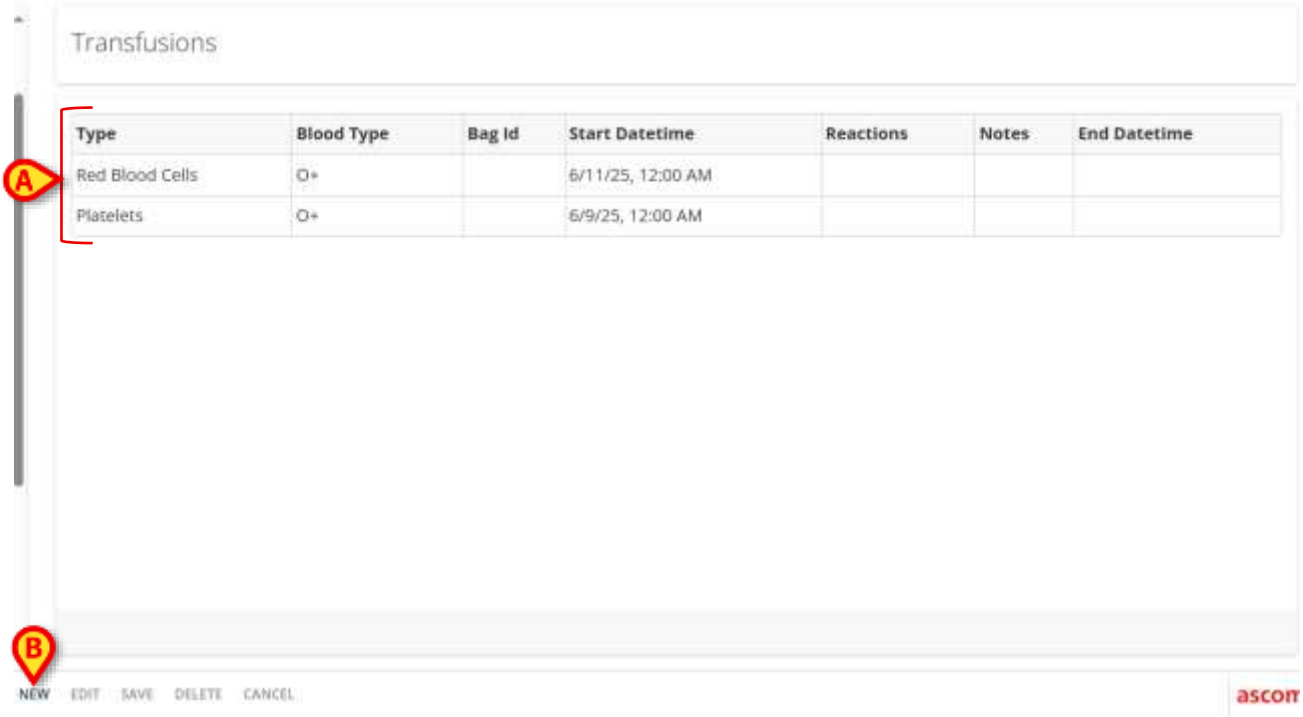

Fig 62

To document a new transfusion:

- Click the New button on the command bar (Fig 62 **B**).

The following form will open (Fig 63).

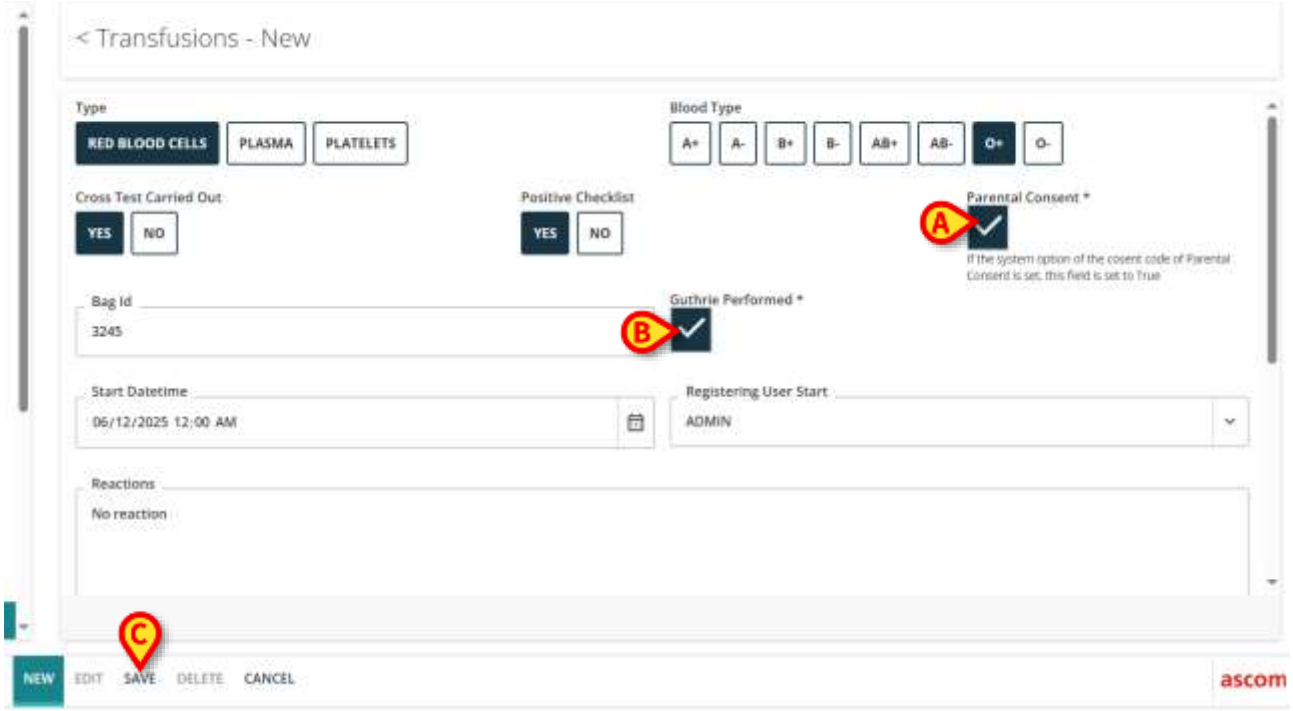

Fig 63

Fill in all the required information. The “Parental Consent” and “Guthrie Performed” checkboxes must be selected, otherwise the page cannot be saved (Fig 63 **A** - **B**).

A configuration option allows to pre-select the "Parental Consent" if already specified as acquired on the "Consents" page (see section 4.1.2).

Refer to the general data entry instructions for the other data entry procedures on this page. See section 3.1.

- Click the **Save** button on the command bar (Fig 63 **C**) to add a new transfusion to the list (Fig 64).

Transfusions

Type	Blood Type	Bag Id	Start Datetime	Reactions	Notes	End Datetime
Red Blood Cells	O+		6/11/25, 12:00 AM			
Platelets	O+		6/9/25, 12:00 AM			
Red Blood Cells	O+	3245	6/12/25, 12:00 AM	No reaction		

Fig 64

4.3.4. Malformations

Refer to the general data entry instructions for the data entry procedures on this page. See section 3.1.

4.3.5. Interviews

Refer to the general data entry instructions for the data entry procedures on this page. See section 3.1.

4.3.6. Growth Chart

This page displays in charts the patient's growth trends and percentiles, relating them to the selected standard charts.
The specific chart here applied is selected on the "Physical Examination page" ("Growth chart provider" field - Fig 56 **A**, section 4.2.4)

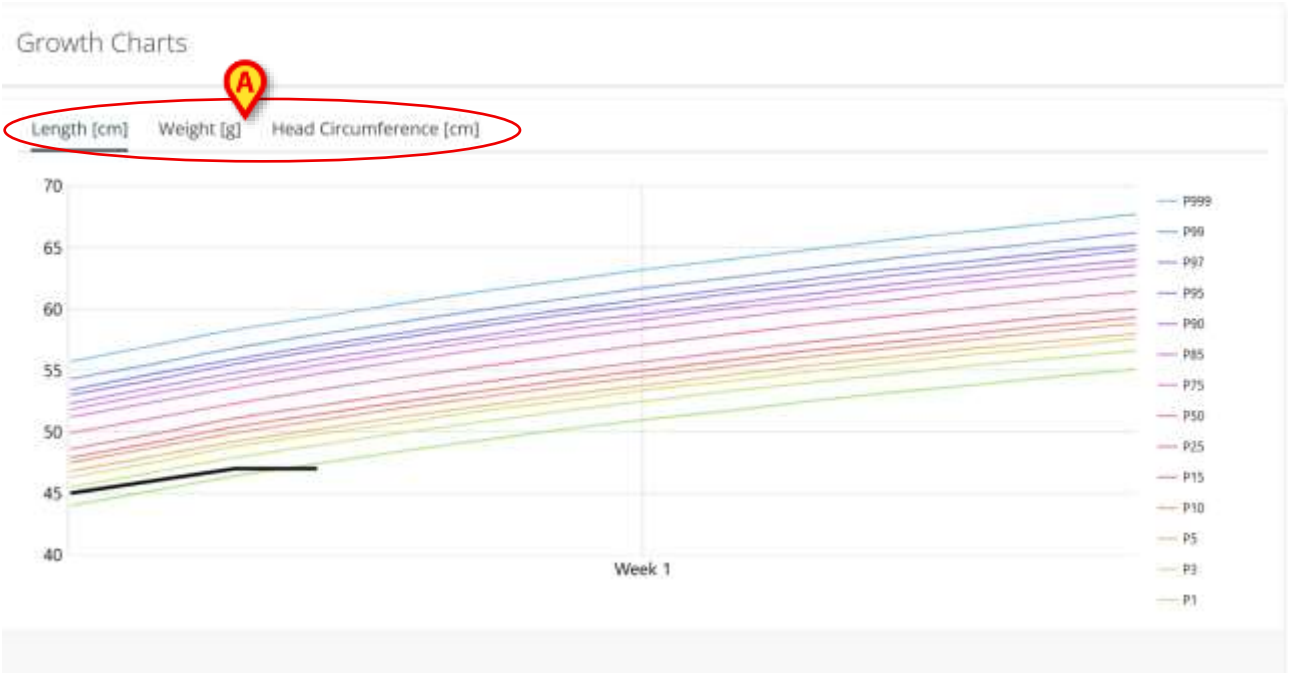

Fig 65

The colored lines represent the selected growth chart. Each curve refers to a percentile. The black line represents the patient's actual data.

Click the tabs indicated in Fig 65 to switch to a different chart (Height, Weight, Head Circumference are available).

Click the chart to display a bar indicating the exact values at a specific time (Fig 66 **A**).

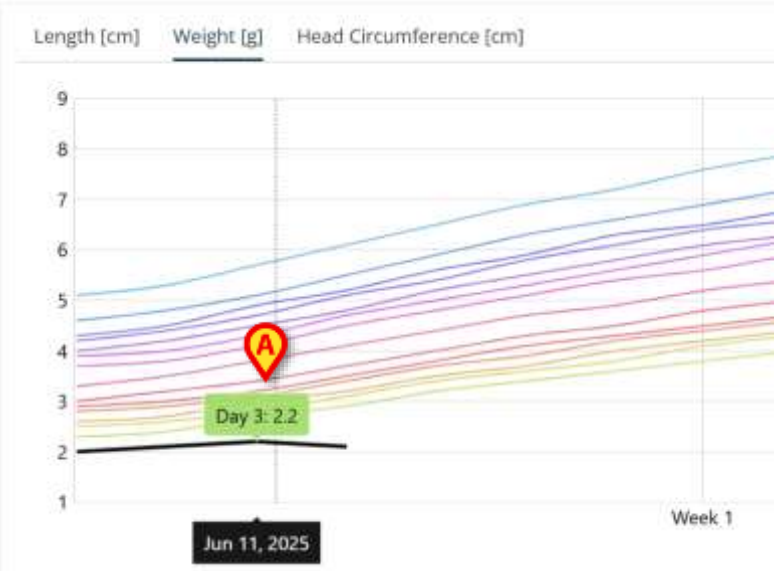

Fig 66

4.3.7. Item Delivery

Refer to the general data entry instructions for the data entry procedures on this page. See section 3.1.

4.4. Discharge

4.4.1. Clinical discharge

The data entry procedures on the “Clinical Discharge” page are those described in section 3.1.

There are two exceptions.

1 - The “Tests Performed” information (Fig 67 **A**) is inherited from the Digistat “Diary Web” module, that must be appropriately configured. Specific categories can be configured on Digistat “Diary Web”, that will be displayed here at patient discharge time. See the Digistat “Diary Web” documentation for more information (document: USR ENG Diary Web).

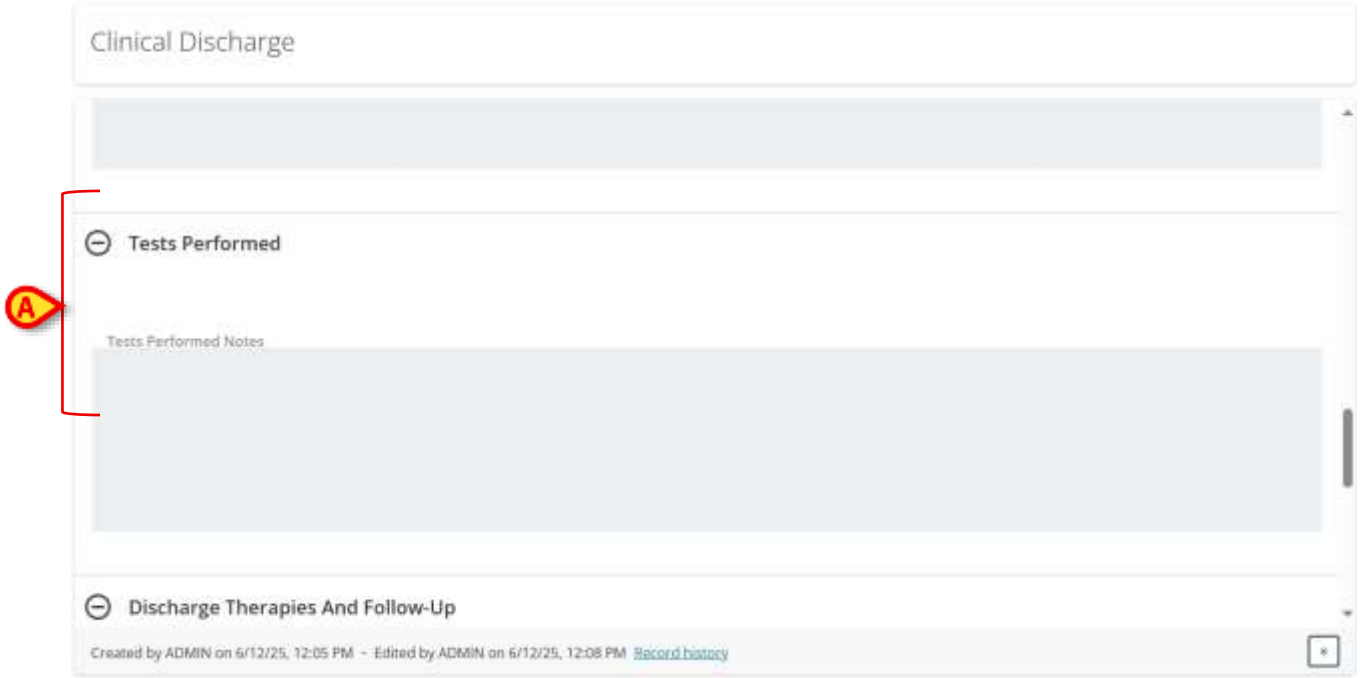

Fig 67

2 – Final Validation Actions - The patient discharge procedure is specific. Four buttons are present in the “Final Validation Actions” area of the page (Fig 68 **A**). These buttons are disabled while editing the page. Also, this area indicates the patient’s current status (“Patient is admitted” in Fig 68).

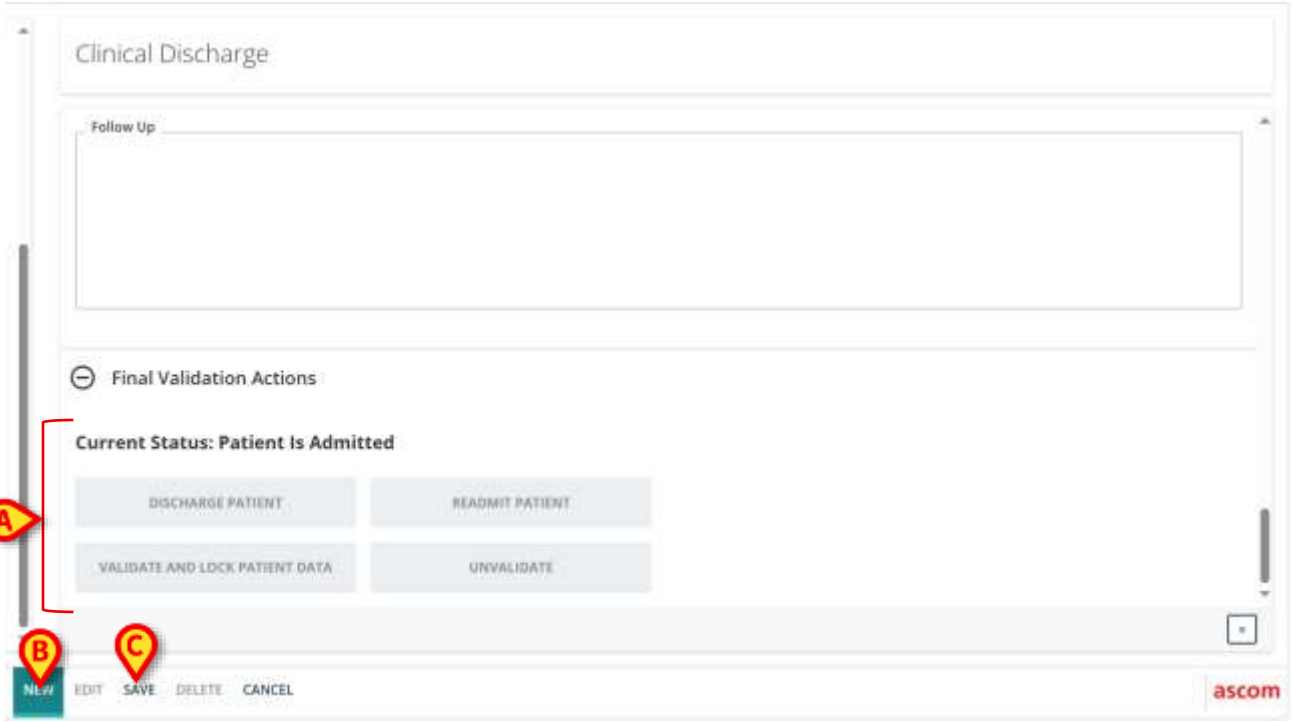

Fig 68

To discharge a patient:

- Click the **New** button on the command bar (Fig 68 **B**), to create a new "Discharge" record.
- Enter the required data in the existing fields on the page.
- Click the **Save** button on the command bar (Fig 68 **C**).

After the record is saved, the **Discharge Patient** button is enabled (Fig 69 **A**).

Fig 69

- Click the **Discharge Patient** button (Fig 69 **A**).

User confirmation is required. After confirmation the patient is discharged (Fig 70 **A**).

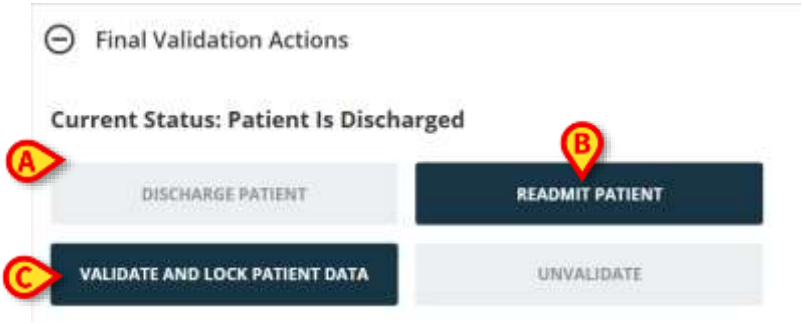

Fig 70

Two actions are now possible.

- Click the **Readmit Patient** button to readmit the patient (Fig 70 **B**).

A pop-up window is then displayed, requiring to specify the re-admission reason.

- Clik **Validate and Lock Patient Data** to validate the record and lock its data (Fig 70 **C**).

No changes are possible anymore when patient data are locked.

After validation it is possible to **Unvalidate** and go back to the previous state (Fig 71 **A**).

Fig 71

4.4.2. Nursing discharge

Refer to the general data entry instructions for the data entry procedures on this page. See section 3.1.
The data relating to the “In situ devices” are inherited from the Digistat “Body Graph” module (Fig 72 **A**). See the document USR ENG Body Graph for more information on the Digistat “Body Graph” module.

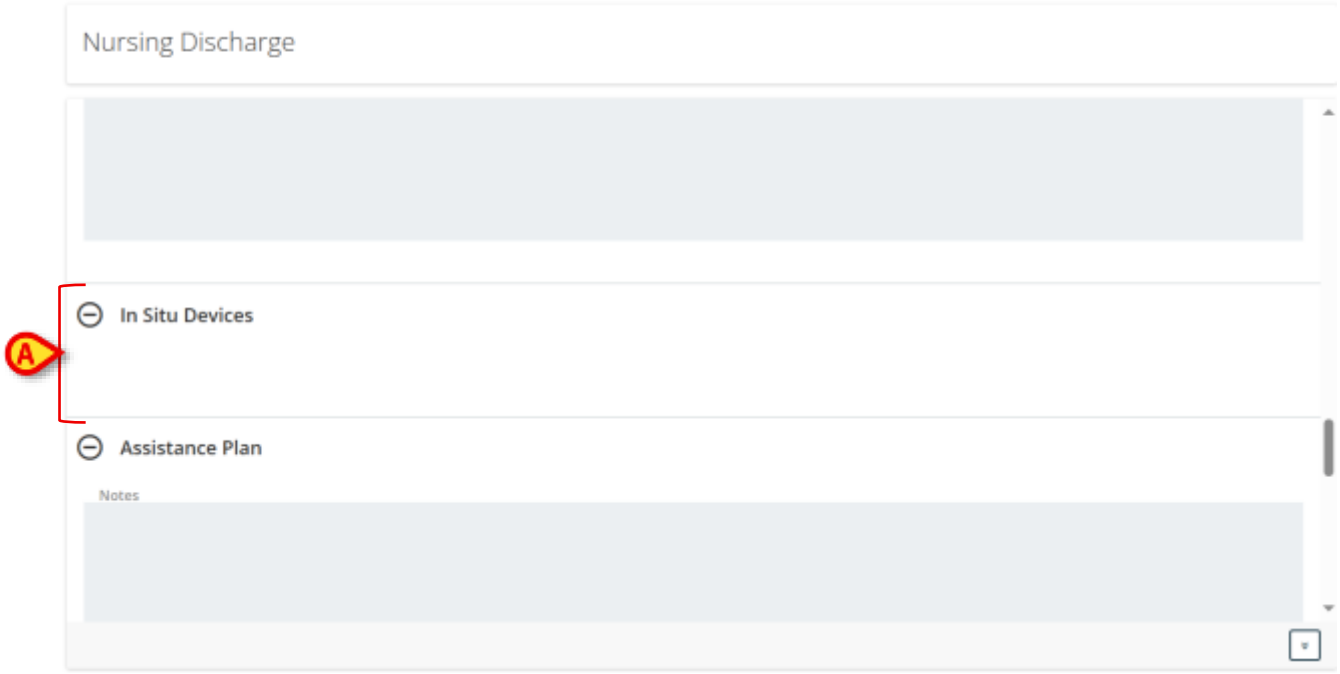

Fig 72

4.5. Utility

4.5.1. Print documents

This page contains the configured available documents that can be printed (Fig 73). Each button corresponds to a document. Click the button to launch the print of the corresponding document.

Fig 73