



Neonatal Patient File User Manual

Version 1.0

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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.

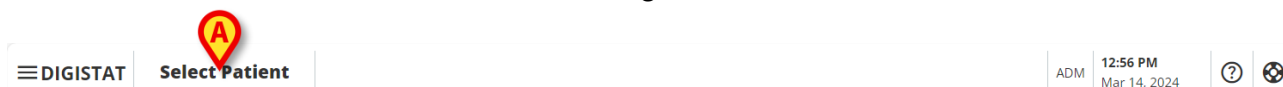


Fig 1

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**).

The screenshot displays the 'Personal Details' page of the Neonatal Patient File. On the left, a 'Navigation Panel' (labeled A) lists categories: Patient (Personal Details, Consents, Isolations), Patient Assessment (Admission, Physical Exam, Nursing Physical Exam, Neonatal Family History, Obstetric Anamnesis, Labor/Birth/3° Stage), and Daily Activities (Nursing Handover, Daily Visit, Transfusions). The main 'Data Area' (labeled B) shows 'Registration Details' for a patient with ID 554223, born 06/09/2025, named Lee Van Cleef, male, from the Netherlands. It includes fields for Address, City, Province, Country, Birth Date and Time, Gestational Age, and Birth Weight [g]. At the top right of the data area are 'ISOLATION' and 'CHANGE BED' buttons. At the bottom, a 'Command Bar' (labeled C) contains buttons for NEW, EDIT, SAVE, DELETE, and CANCEL. The footer shows 'PATIENT FILE NEO' and the 'ascom' logo.

Fig 2

2.1. Navigation Panel

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

This image provides a detailed view of the 'Navigation Panel' (labeled A in Fig 2). It is a vertical list of links organized into three expandable sections: 'Patient' (containing 'Personal Details', 'Consents', and 'Isolations'), 'Patient Assessment' (containing 'Nets', 'Birth', 'Admission', 'Physical Exam', 'Nursing Physical Exam', 'Neonatal Family History', 'Obstetric Anamnesis', and 'Labor/Birth/3° Stage'), and 'Daily Activities' (containing 'Nursing Handover', 'Daily Visit', and 'Transfusions'). The 'Personal Details' link is currently selected and highlighted in teal.

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.

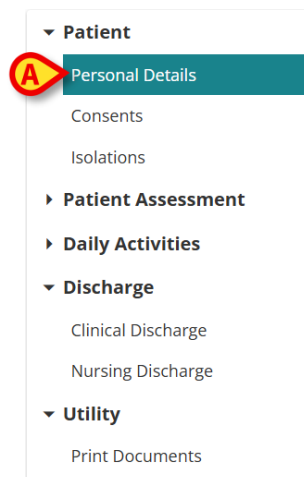


Fig 4

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).

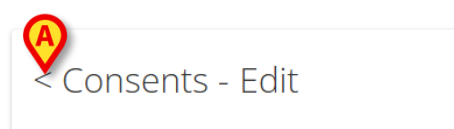


Fig 5

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.

Personal Details

A Registration Details

Patient ID

Patient Code: 554223

Date of Birth: 06/09/2025

Ethnicity

Family Name: Van Cleef

Given Name: Lee

Fiscal Code

Gender: Male

Address

City

Province

Country

Birth Date and Time: mm/dd/yyyy --:-- --

Gestational Age

Birth Weight [g]

B ISOLATION CHANGE BED

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**).

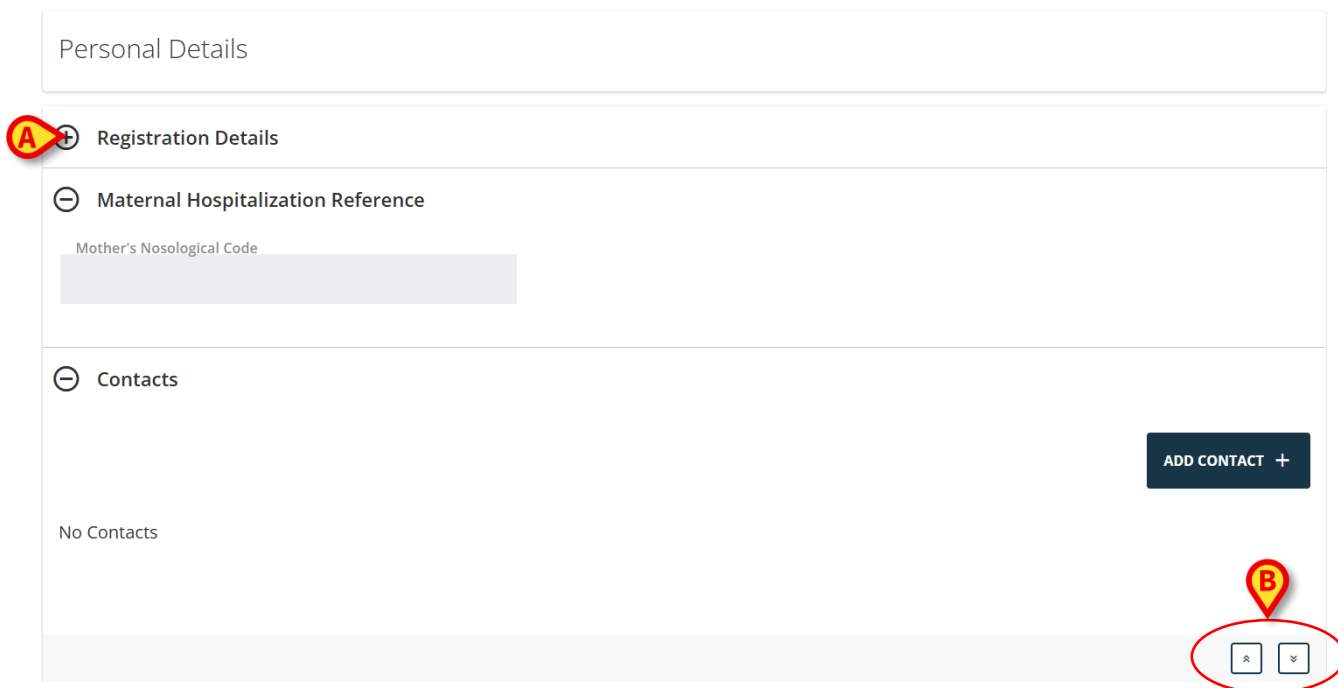


Fig 7

- 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).

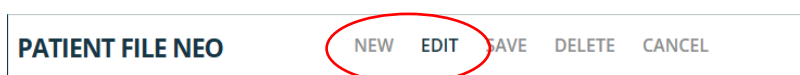


Fig 9

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.

Patient

- Personal Details
- Consents
- Isolations

Patient Assessment

- Nets
- Birth
- Admission**
- Physical Exam
- Nursing Physical Exam
- Neonatal Family History
- Obstetric Anamnesis
- Labor/Birth/3° Stage

Daily Activities

- Nursing Handover
- Daily Visit
- Transfusions

Admission

Admission Date: mm/dd/yyyy -- --

Admitting Doctor:

Birth Date and Time: mm/dd/yyyy -- --

Admission Age:

Blood Type: A+ A- B+ B- AB+ AB- O+ O-

Admission Age cannot be calculated unless Birth Date and Time or Admission Date is provided.

Internal Provenance:

External:

External Provenance:

Admission Reason:

TRANSIENT TACHYPNEA OF NEWBORN (TTN) NEONATAL RESPIRATORY DISTRESS SYNDROME (RDS) MECONIUM ASPIRATION SYNDROME

PERSISTENT PULMONARY HYPERTENSION OF THE NEWBORN (PPHN) NEONATAL SEPSIS NEONATAL PNEUMONIA CONGENITAL VIRAL INFECTIONS

NEONATAL JAUNDICE DUE TO HEMOLYSIS NEONATAL HYPERBILIRUBINEMIA PRETERM BIRTH EXTREMELY LOW BIRTH WEIGHT

NEONATAL FEEDING DIFFICULTIES NECROTIZING ENTEROCOLITIS (NEC) INTRACRANIAL LACERATION AND HEMORRHAGE BRACHIAL PLEXUS INJURY

PATIENT FILE NEO **NEW** EDIT SAVE DELETE CANCEL **ascom**

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).

Patient

- Personal Details
- Consents
- Isolations

Patient Assessment

- Nets
- Birth
- Admission**
- Physical Exam
- Nursing Physical Exam
- Neonatal Family History
- Obstetric Anamnesis
- Labor/Birth/3° Stage

Daily Activities

- Nursing Handover
- Daily Visit
- Transfusions

Admission

Admission Date: 06/09/2025 12:00 AM

Admitting Doctor: ADMIN

Birth Date and Time: mm/dd/yyyy -- --

Admission Age:

Blood Type: A+ A- B+ B- AB+ AB- O+ O-

Admission Age cannot be calculated unless Birth Date and Time or Admission Date is provided.

Internal Provenance:

External:

External Provenance:

Admission Reason:

TRANSIENT TACHYPNEA OF NEWBORN (TTN) NEONATAL RESPIRATORY DISTRESS SYNDROME (RDS) MECONIUM ASPIRATION SYNDROME

PERSISTENT PULMONARY HYPERTENSION OF THE NEWBORN (PPHN) NEONATAL SEPSIS NEONATAL PNEUMONIA CONGENITAL VIRAL INFECTIONS

NEONATAL JAUNDICE DUE TO HEMOLYSIS NEONATAL HYPERBILIRUBINEMIA PRETERM BIRTH EXTREMELY LOW BIRTH WEIGHT

NEONATAL FEEDING DIFFICULTIES NECROTIZING ENTEROCOLITIS (NEC) INTRACRANIAL LACERATION AND HEMORRHAGE BRACHIAL PLEXUS INJURY

PATIENT FILE NEO **NEW** EDIT SAVE DELETE CANCEL **ascom**

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).

< Transfusions - New

Type: RED BLOOD CELLS, PLASMA, PLATELETS

Blood Type: A+, A-, B+, B-, AB+, AB-, O+, O-

Cross Test Carried Out: YES, NO

Positive Checklist: YES, NO

Bag Id: [text input]

Start Datetime: mm/dd/yyyy --:-- --

Registering User Start: ADMIN

Guthrie Performed *

Parental Consent *

If the system option of the cosent code of Parental Consent is set, this field is set to True

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).

Validation Errors

It is not possible to save the data. Please fix the following errors and then try saving again:

- Guthrie Performed field is required
- Parental Consent field is required

CLOSE

Fig 14

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

< Transfusions - New

Type: RED BLOOD CELLS, PLASMA, PLATELETS

Blood Type: A+, A-, B+, B-, AB+, AB-, O+, O-

Cross Test Carried Out: YES, NO

Positive Checklist: YES, NO

Bag Id: 54b

Start Datetime: mm/dd/yyyy --:-- --

Registering User Start: ADMIN

Guthrie Performed *

Parental Consent *

Parental Consent field is required

Guthrie Performed field is required

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).

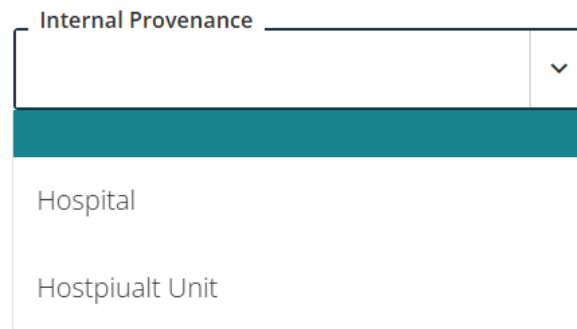
A screenshot of a web form showing a drop-down menu. The label 'Internal Provenance' is above a text box. The text box is open, showing a list of options: 'Hospital' and 'Hostpialt Unit'. The first option, 'Hospital', is highlighted with a teal background. A small downward arrow is visible in the top right corner of the text box.

Fig 16

3.1.2. Multiple choice

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

- Click an option to select it.

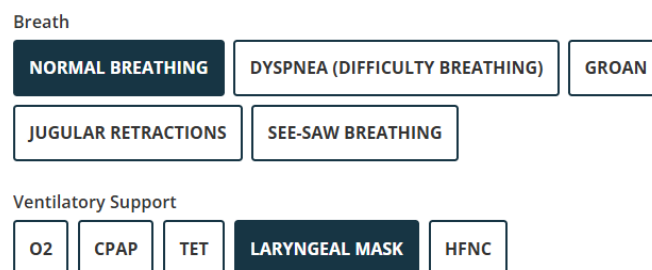
A screenshot of a web form showing two sections of multiple-choice buttons. The first section is labeled 'Breath' and contains five buttons: 'NORMAL BREATHING' (highlighted in blue), 'DYSPNEA (DIFFICULTY BREATHING)', 'GROAN', 'JUGULAR RETRACTIONS', and 'SEE-SAW BREATHING'. The second section is labeled 'Ventilatory Support' and contains five buttons: 'O2', 'CPAP', 'TET', 'LARYNGEAL MASK' (highlighted in blue), and 'HFNC'.

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).

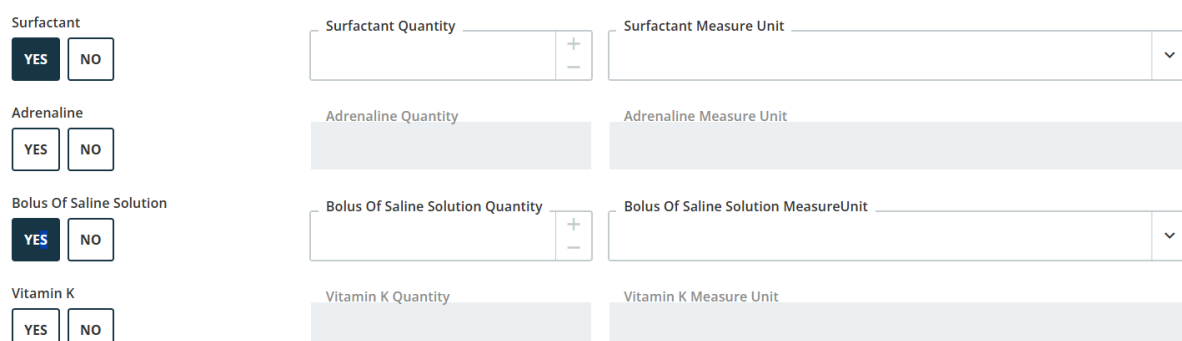
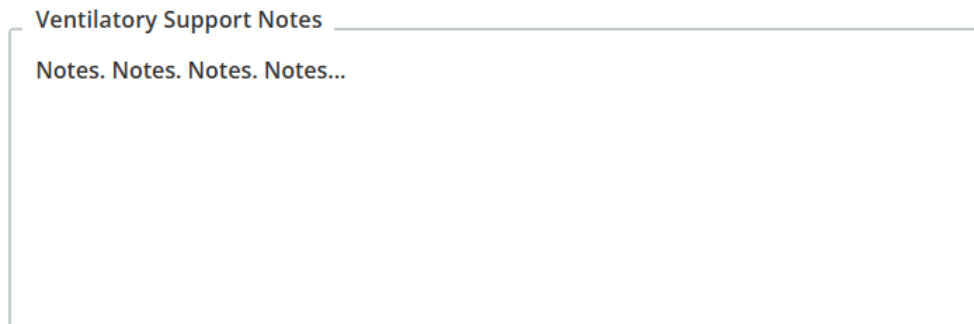
A screenshot of a web form showing four sections of co-related fields. Each section has a checkbox on the left and two input fields on the right. 1. 'Surfactant' section: 'YES' checkbox is checked. Input fields are 'Surfactant Quantity' (with '+' and '-' buttons) and 'Surfactant Measure Unit' (with a dropdown arrow). 2. 'Adrenaline' section: 'YES' checkbox is unchecked. Input fields are 'Adrenaline Quantity' and 'Adrenaline Measure Unit'. 3. 'Bolus Of Saline Solution' section: 'YES' checkbox is checked. Input fields are 'Bolus Of Saline Solution Quantity' (with '+' and '-' buttons) and 'Bolus Of Saline Solution MeasureUnit' (with a dropdown arrow). 4. 'Vitamin K' section: 'YES' checkbox is unchecked. Input fields are 'Vitamin K Quantity' and 'Vitamin K Measure Unit'.

Fig 18

3.1.4. Free text fields

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



Ventilatory Support Notes

Notes. Notes. Notes. Notes...

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.

Problems



SHOW CLOSE ADD PROBLEM +

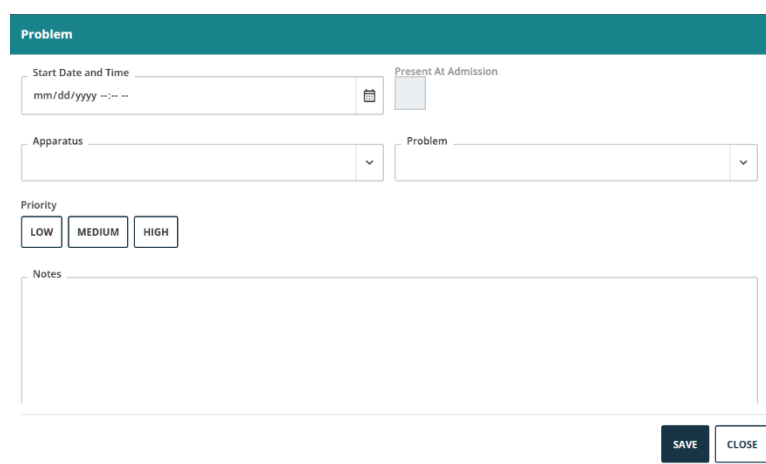
No Problems

Fig 20

To indicate a problem

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

A dedicated selection window opens (Fig 21).



Problem

Start Date and Time mm/dd/yyyy --:-- -- Present At Admission

Apparatus Problem

Priority LOW MEDIUM HIGH

Notes

SAVE CLOSE

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**).

Problems				<div>SHOW CLOSED</div> <div>ADD PROBLEM +</div>		
Start Date and Time	Apparatus	Problem	Priority			
A 6/9/25, 12:00 AM	Respiratory	Dyspnea (shortness of breath)	Low			

Fig 23

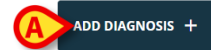
- Click the icon to fully display the details.
- Click the icon to edit the existing item.
- Click the icon to delete the item.

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).

Diagnosis



No diagnosis added yet

Admission Condition

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).

Diagnosis

ADD DIAGNOSIS +

Code	Description	
002.2	PARATIFO B	

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).

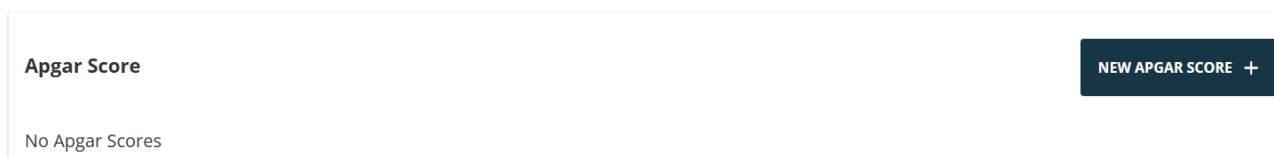


Fig 28

To document a score:

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

The following window opens (Fig 29).

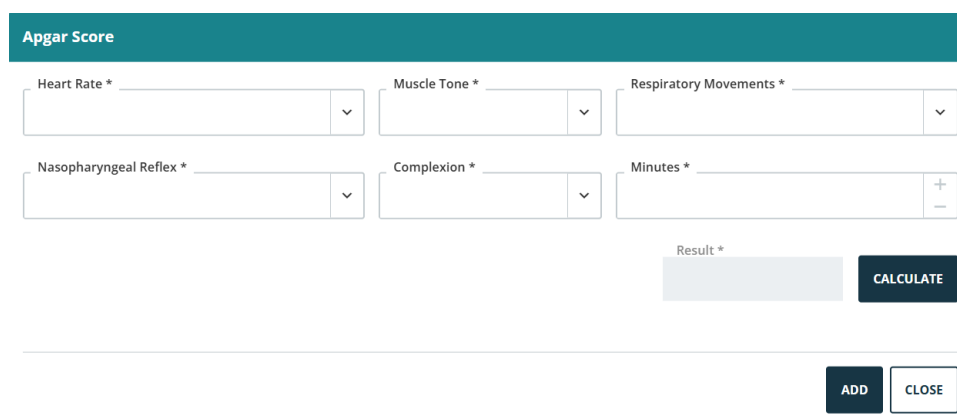


Fig 29

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

The form is titled "Apgar Score" and contains several input fields with dropdown menus. A red bracket labeled 'A' groups the first three fields: "Heart Rate *" (Less than 100 bpm), "Muscle Tone *" (Some flexion of extremities), and "Respiratory Movements *" (Slow breathing). Below these are "Nasopharyngeal Reflex *" (Strong cry, cough or sneeze with stimulation) and "Complexion *" (Completely pink). To the right is a "Minutes *" field with the value 30. A "Result *" field shows the value 7, with a red arrow 'C' pointing to it. A "CALCULATE" button is labeled 'B'. At the bottom right, there are "ADD" and "CLOSE" buttons, with a red arrow 'D' pointing to the "ADD" button.

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).

Apgar Score NEW APGAR SCORE +

Heart Rate	Respiratory Movements	Muscle Tone	Nasopharyngeal Reflex	Complexion	Minutes	Result			
Less than 100 bpm	Slow breathing	Some flexion of extremities	Grimace or weak cry with stimulation	Pink body, blue extremities	30	5			

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.

Registration Details

Patient ID

ISOLATION

CHANGE BED

Patient Code

554223

Date of Birth

06/09/2025

Ethnicity

Family Name

Van Cleef

Given Name

Lee

Fiscal Code

Gender

Male

Address

City

Province

Country

Birth Date and Time

06/08/2025 10:00 PM

Gestational Age

32 days and 4

Birth Weight [g]

1.9

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).

Created by ADMIN on 6/11/25, 10:25 AM - Edited by ADMIN on 6/11/25, 10:42 AM

Record history

Fig 33

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

History

Current

Edited by ADMIN on June 11, 2025 at 10:25:14 AM GMT+2

CLOSE

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.

Differences

9

Before

After

Expand 11 lines ...

12 "AdmissionCondition": "",

13 "ExternalProvenance": "",

14 "PatientId": 16,

15 - "DiagnosisICD9List": []

12 "AdmissionCondition": "",

13 "ExternalProvenance": "",

14 "PatientId": 16,

15 + "DiagnosisICD9List": [

16 + {

17 + "Id": 2,

18 + "Code": "002.2",

19 + "Description": "PARATIFO B",

20 + "AdmissionId": 4

21 + }

22 +]

CLOSE

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).

The screenshot shows the 'Nursing Handover' form in a 'View mode' (indicated by a minus icon in the Assessment header). On the left is a sidebar menu with categories: 'Patient' (Personal Details, Consents, Isolations), 'Patient Assessment' (Nets, Birth, Admission, Physical Exam, Nursing Physical Exam, Neonatal Family History, Obstetric Anamnesis, Labor/Birth/3rd Stage), and 'Daily Activities' (Nursing Handover, Daily Visit, Transfusions). The 'Nursing Handover' item is highlighted. The main form area has a title bar 'Nursing Handover' and a scrollable content area. The 'Assessment' section includes: 'Breath' with buttons for NORMAL BREATHING, DYSPNEA (DIFFICULTY BREATHING), GROAN, INTERCOSTAL RETRACTIONS, NASAL FLARING, EPIGASTRIC RETRACTIONS, JUGULAR RETRACTIONS, and SEE-SAW BREATHING; 'Ventilatory Support' with buttons for O2, CPAP, TET, LARYNGEAL MASK, and HFNC; and 'Reactivity' with YES and NO buttons. To the right of these sections are two large text input areas labeled 'Ventilatory Support Notes' and 'Reactivity Notes'. A small 'x' icon is in the bottom right corner of the form area.

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).

The screenshot shows the 'Nursing Handover' form in an 'Edit mode' (indicated by a plus icon in the Assessment header). The layout is identical to Fig 36, but the text input areas for 'Ventilatory Support Notes' and 'Reactivity Notes' are now empty and outlined with a thin border, indicating they are ready for text entry. The sidebar menu and buttons remain the same. A small 'x' icon is in the bottom right corner of the form area.

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.

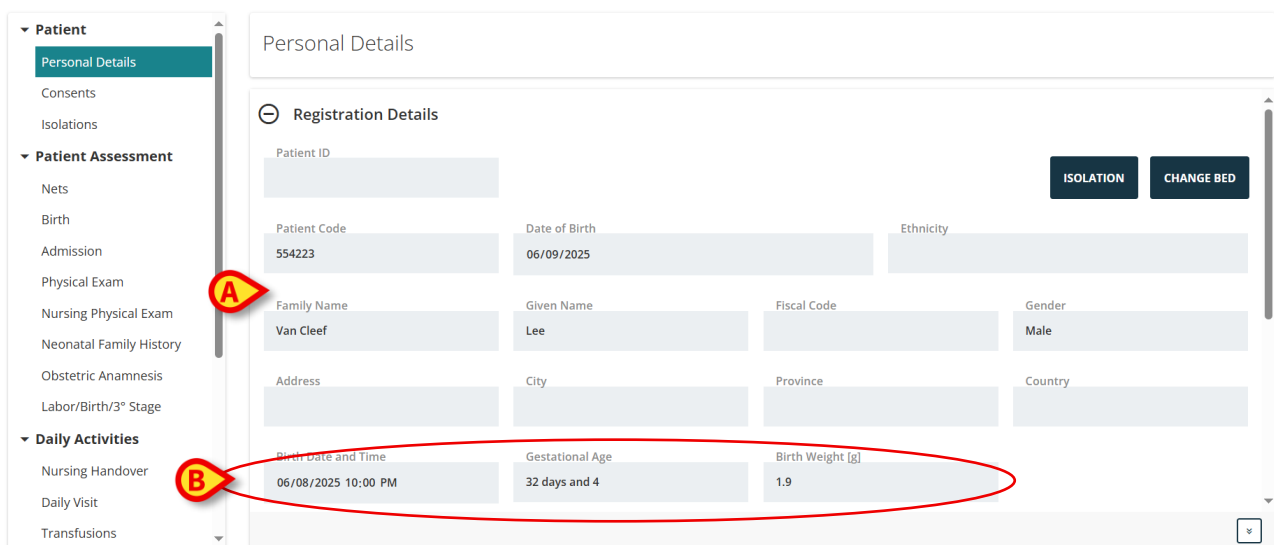
4. Workflows detail

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.



Personal Details

Registration Details

Patient ID

Patient Code: 554223

Date of Birth: 06/09/2025

Ethnicity

Family Name: Van Cleef

Given Name: Lee

Fiscal Code

Gender: Male

Address

City

Province

Country

Birth Date and Time: 06/08/2025 10:00 PM

Gestational Age: 32 days and 4

Birth Weight [g]: 1.9

ISOLATION

CHANGE BED

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.

Move Patient

Location *

ICU

▼

Bed *

10

▼

A

MOVE

CANCEL

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).

Isolations

Start Date

mm/dd/yyyy --:-- --

End Date

mm/dd/yyyy --:-- --

Type

CONTACT

AIRBORNE

DROPLET

Notes

Fig 45

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

Isolation

Start Date *

06/06/2024 12:00 AM

End Date

mm/dd/yyyy --:-- --

Isolation Type *

CONTACT

DROPLET

AIRBORNE

Fig 46

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

Personal Details

⊖ Registration Details

Patient ID

Patient Code

554223

Date of Birth

06/09/2025

Ethnicity

ISOLATION

CHANGE BED

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.

Consents					
Acquisition Datetime	Code	Description	Outcome	Notes	Doctor
	00.01	TERAPIA AD ULTRASUONI DEI VASI DI TESTA E COLLO	Not Proposed		

Fig 48

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

< Consents - View

Code: 00.01 Description: TERAPIA AD ULTRASUONI DEI VASI DI TESTA E COLLO

Acquisition Datetime: mm/dd/yyyy --:-- -- Doctor:

Outcome: YES NO PARTIAL NOT PROPOSED

Notes:

Created by ADMIN on 6/10/25, 12:33 PM [Record history](#)

NEW EDIT SAVE DELETE CANCEL

ascom

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 & paediatric 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.

Nets

Temperature [°C] Heart Rate Respiratory Rate SaO2

ASSISTANCE DURING TRANSPORT

In The Transferring Center

- Ventilazione meccanica:
- CPAP con nasocannule:
- FIO2/SaO2:
- Infusione CDC / Vena periferica:
- Farmaci:
- Altro:

During Transfer

- Utilizzo di ventilazione meccanica non invasiva
- Applicazione di CPAP attraverso nasocannule
- Monitoraggio livelli FIO2 e SaO2
- Infusione venosa periferica di soluzioni
- Farmaci in corso di somministrazione
- Procedure aggiuntive

Upon Arrival

Default text value for ArrivalAssistance field

Arrival Date and Time

mm/dd/yyyy --:--

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.

Birth

Birth Date and Time

mm/dd/yyyy --:-- --

Birth Register Code

Weight [g]

Min Weight Percentile [%]

Max Weight Percentile [%]

Height [cm]

Min Height Percentile [%]

Max Height Percentile [%]

Head Circumference [cm]

Min Head Circumference Percentile [%]

Max Head Circumference Percentile [%]

Gestational Age [weeks]

Gestational Age [days]

Presentation

VERTEX

BREGMA

FOREHEAD

BUTTOCKS

SHOULDER

OTHER

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).

Birth

Birth Date and Time

06/09/2025 12:00 AM

Birth Register Code

Weight [g]

Min Weight Percentile [%]

Max Weight Percentile [%]

1.9

0

P1

Online Clinical Date and Time: 6/9/25, 12:00 AM

Height [cm]

Min Height Percentile [%]

Max Height Percentile [%]

45

P01

P1

Online Clinical Date and Time: 6/9/25, 12:00 AM

Head Circumference [cm]

Min Head Circumference Percentile [%]

Max Head Circumference Percentile [%]

31

P01

P1

Online Clinical Date and Time: 6/9/25, 12:00 AM

Gestational Age [weeks]

Gestational Age [days]

32

4

Presentation

VERTEX

BREGMA

FOREHEAD

BUTTOCKS

SHOULDER

OTHER

Created by ADMIN on 6/10/25, 2:53 PM - Edited by ADMIN on 6/11/25, 10:19 AM [Record history](#)

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.

Admission

Admission Date
06/09/2025 12:00 AM

Admitting Doctor
ADMIN

Birth Date and Time
06/09/2025 12:00 AM

Admission Age
0 day/s and 0 hour/s

Blood Type
A+ A- B+ B- AB+ AB- O+ O-

Admission Age cannot be calculated unless Birth Date and Time or Admission Date is provided.

Internal Provenance

External

External Provenance

Admission Reason

TRANSIENT TACHYPNEA OF NEWBORN (TTN) NEONATAL RESPIRATORY DISTRESS SYNDROME (RDS) MECONIUM ASPIRATION SYNDROME

PERSISTENT PULMONARY HYPERTENSION OF THE NEWBORN (PPHN) NEONATAL SEPSIS NEONATAL PNEUMONIA CONGENITAL VIRAL INFECTIONS

NEONATAL JAUNDICE DUE TO HEMOLYSIS NEONATAL HYPERBILIRUBINEMIA PRETERM BIRTH EXTREMELY LOW BIRTH WEIGHT

NEONATAL FEEDING DIFFICULTIES NECROTIZING ENTEROCOLITIS (NEC) INTRACRANIAL LACERATION AND HEMORRHAGE BRACHIAL PLEXUS INJURY

Created by ADMIN on 6/11/25, 10:25 AM - Edited by ADMIN on 6/11/25, 10:42 AM [Record history](#)

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).

Physical Exam

Growth Chart Provider * spvd ▼ Compiling Doctor ADMIN ▼

Weight [g] 1.9 Online Clinical Date and Time: 6/9/25, 12:00 AM	Min Weight Percentile [%] 0	Max Weight Percentile [%] P1
Height [cm] 45 Online Clinical Date and Time: 6/9/25, 12:00 AM	Min Height Percentile [%] P01	Max Height Percentile [%] P1
Head Circumference [cm] 31 Online Clinical Date and Time: 6/9/25, 12:00 AM	Min Head Circumference Percentile [%] P01	Max Head Circumference Percentile [%] P1

Risk Factors ADD RISKFACTOR +

No RiskFactors

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.

The screenshot shows the 'Daily Visit' form with the following fields and values:

Visit Date		Compiling Doctor	
06/11/2025 01:01 PM		ADMIN	
Weight [g]	Min Weight Percentile [%]	Max Weight Percentile [%]	
2.2	0	P1	
Online Clinical Date and Time: 6/11/25, 1:01 PM			
Height [cm]	Min Height Percentile [%]	Max Height Percentile [%]	
46	0	P01	
Online Clinical Date and Time: 6/11/25, 1:01 PM			
Head Circumference [cm]	Min Head Circumference Percentile [%]	Max Head Circumference Percentile [%]	
32	0	P01	
Online Clinical Date and Time: 6/11/25, 1:01 PM			
Visit Notes			

Created by ADMIN on 6/11/25, 12:59 PM - Edited by ADMIN on 6/11/25, 1:03 PM [Record history](#)

Red callout box **B** points to the 'Visit Date' field. Red callout box **A** points to the 'Weight [g]', 'Height [cm]', and 'Head Circumference [cm]' fields.

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.

Daily Visit

<<
<
≡
>
>>

Problems

SHOW CLOSED
ADD PROBLEM +

Start Date and Time	Apparatus	Problem	Priority		
6/9/25, 12:00 AM	Cardiovascular	Cyanosis	Medium		
6/9/25, 12:00 AM	Respiratory	Dyspnea (shortness of breath)	Low		

Assessments

SHOW DELETED
ADD ASSESSMENT +

No Assessments

Created by ADMIN on 6/11/25, 12:59 PM - Edited by ADMIN on 6/11/25, 1:03 PM [Record history](#)

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**).

Problems

SHOW CLOSED

ADD PROBLEM +

Start Date and Time	Apparatus	Problem	Priority			
6/9/25, 12:00 AM	Cardiovascular	Cyanosis	Medium			
6/9/25, 12:00 AM	Respiratory	Dyspnea (shortness of breath)	Low			

Assessments

SHOW DELETED

ADD ASSESSMENT +

6/12/25, 8:00 AM

Notes

ADMIN

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**).

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			

NEW EDIT SAVE DELETE CANCEL

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).

< Transfusions - New

Type: **RED BLOOD CELLS** PLASMA PLATELETS

Blood Type: A+ A- B+ B- AB+ AB- **O+** O-

Cross Test Carried Out: YES NO

Positive Checklist: YES NO

Parental Consent * ☒
 If the system option of the cosent code of Parental Consent is set, this field is set to True

Bag Id: 3245

Guthrie Performed * ☒

Start Datetime: 06/12/2025 12:00 AM

Registering User Start: ADMIN

Reactions: No reaction

NEW EDIT SAVE DELETE CANCEL

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**).

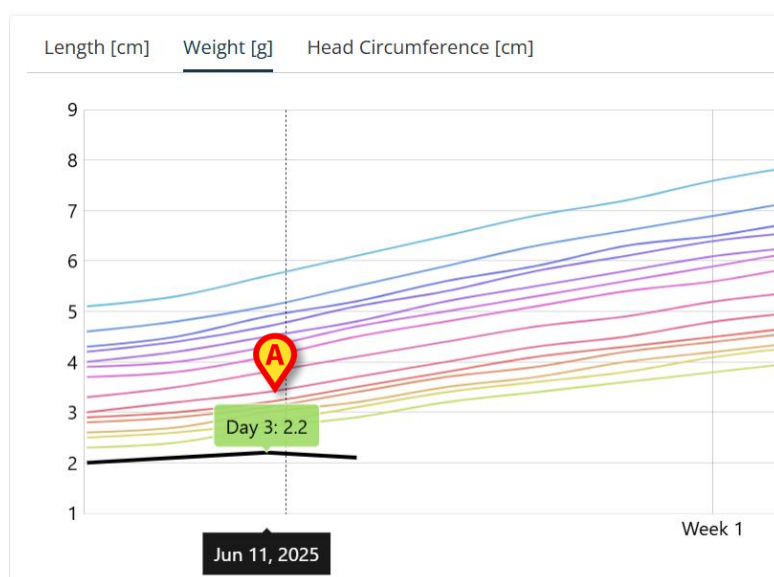


Fig 66

4.3.7. Item Delivery

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

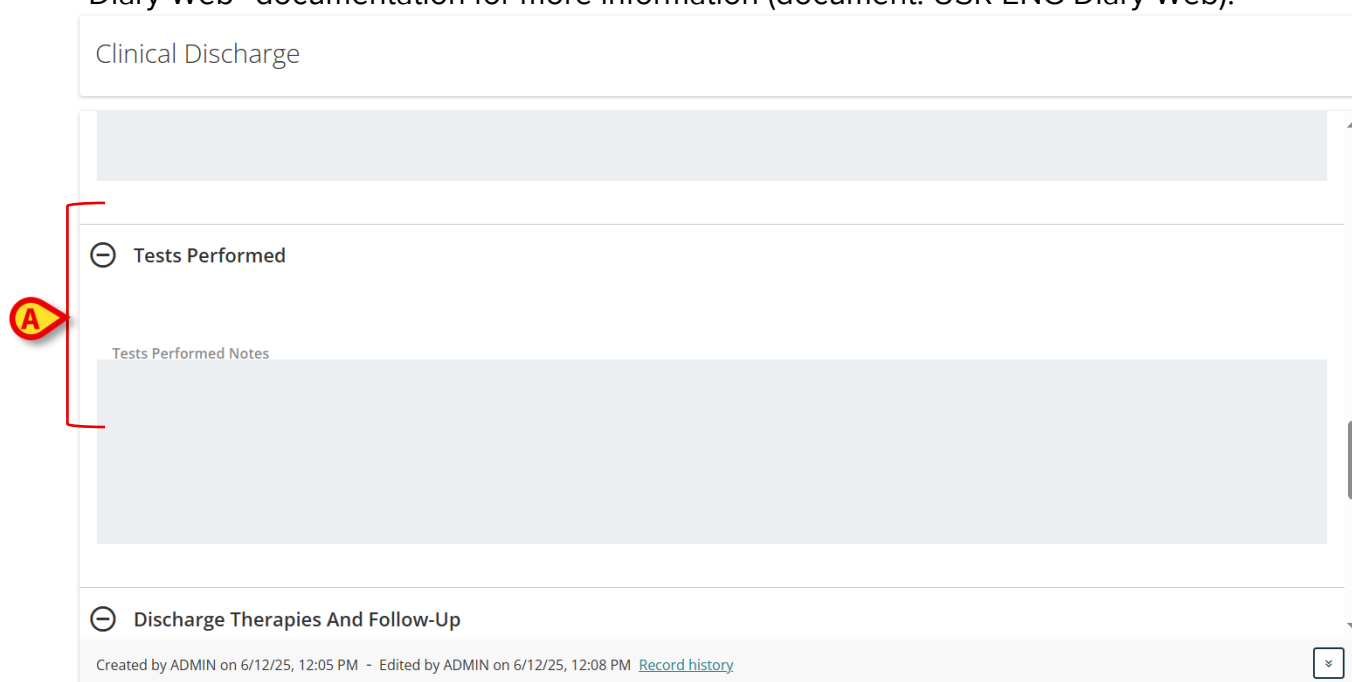
4.4. Discharge

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).



The screenshot shows a web form titled "Clinical Discharge". It has a light blue header bar. Below the header, there is a section titled "Tests Performed" with a minus icon to its left. Under this section is a large text area labeled "Tests Performed Notes". Below the "Tests Performed" section is another section titled "Discharge Therapies And Follow-Up" with a minus icon to its left. At the bottom of the form, there is a footer area containing the text "Created by ADMIN on 6/12/25, 12:05 PM - Edited by ADMIN on 6/12/25, 12:08 PM" and a link "Record history". A red bracket on the left side of the form highlights the "Tests Performed" section, and a yellow circle with the letter "A" is placed next to it.

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).

Clinical Discharge

Follow Up

Final Validation Actions

Current Status: Patient Is Admitted

DISCHARGE PATIENT READMIT PATIENT

VALIDATE AND LOCK PATIENT DATA UNVALIDATE

NEW EDIT SAVE DELETE CANCEL

ascom

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**).

Final Validation Actions

Current Status: Patient Is Admitted

DISCHARGE PATIENT READMIT PATIENT

VALIDATE AND LOCK PATIENT DATA UNVALIDATE

Fig 69

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

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

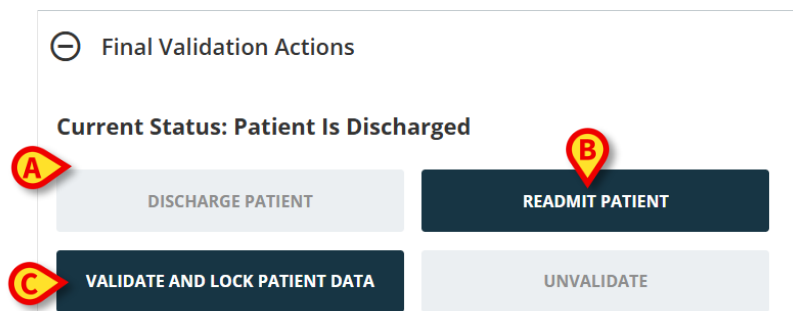


Fig 70

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.

- Click **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**).

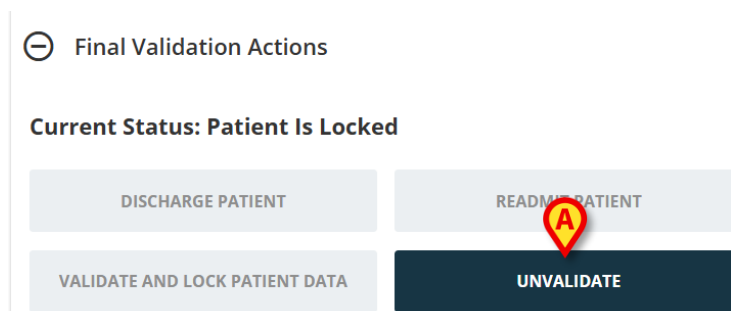


Fig 71

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.

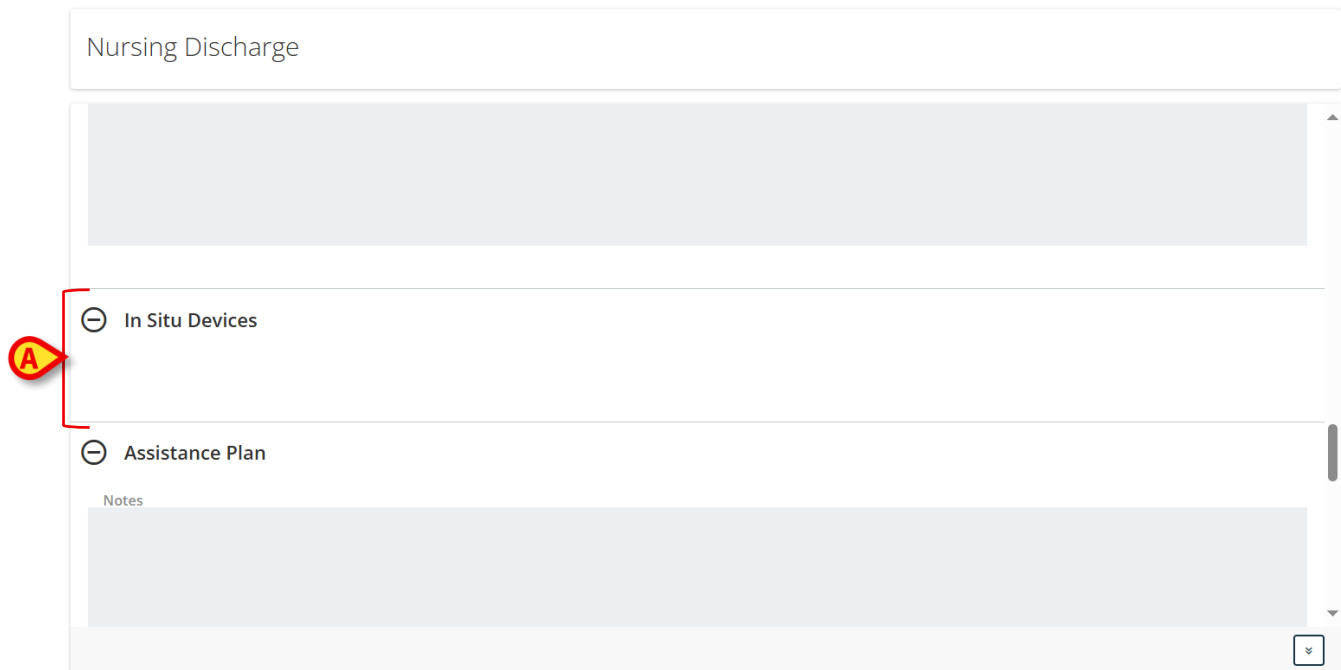


Fig 72

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.

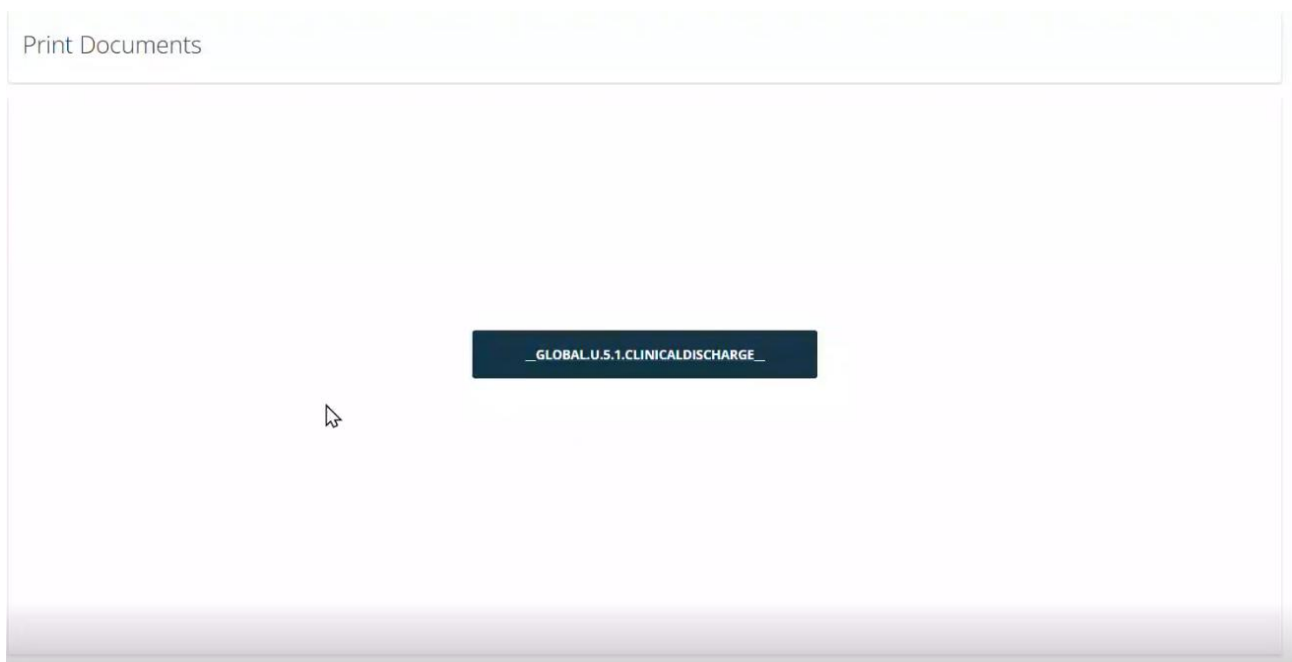


Fig 73