# Patient File
# User Manual

**Version 2.0**

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# Contents

**1. Introduction....3**
1.1. Launching Patient File....3
1.2. Patient selection....3
**2. Patient File structure....4**
2.1. Navigation Panel....4
2.2. Data Area....6
2.3. Command bar....7
**3. Data Entry....8**
3.1. Data entry examples....8
3.1.1. Drop down lists....10
3.1.2. Multiple choice....10
3.1.3. Co-related fields....11
3.1.4. Free text fields....11
3.1.5. Selection window....12
3.1.6. Codefinder call....13
3.1.7. Nurse Scores....14
3.1.8. Disabled fields....15
3.2. History....15
3.3. Sibling pages....17
3.4. Dedicated workflows....20
3.4.1. “Change Bed” and “Isolation” shortcuts....20
3.4.2. Allergies/Intolerances....22
3.4.3. Injuries/Skin lesions....25
3.4.4. Clinical discharge....30

*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 "Patient File", described in this document.*

# 1. Introduction

Digistat Patient File provides a complete digital patient documentation on an easy navigable web environment. Patient information is intuitively 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 Patient File

To launch Digistat 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**.

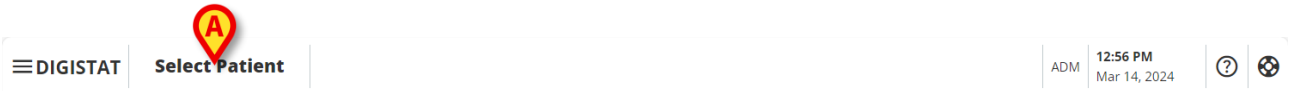


**Fig 1**

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. 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**).

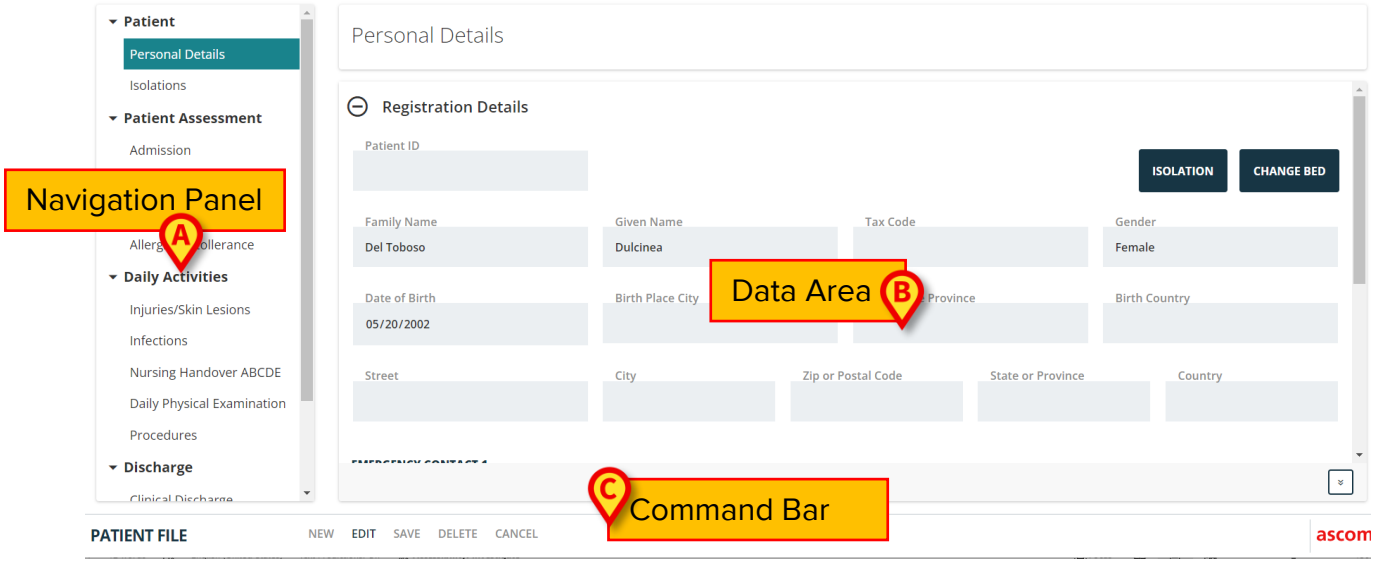


**Fig 2**

## 2.1. Navigation Panel

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

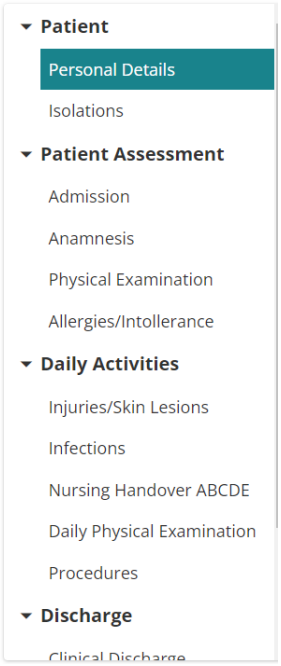


**Fig 3**

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

Each section contains different forms, each one dedicated to a specific topic.
**Patient** → Personal details, Isolation.
**Clinical Assessment** → Admission, Anamnesis, Physical Examination, Allergies/Intolerances.
**Daily Activities** → Injuries/Skin lesions, Infections, Nursing Handover, Daily Examination, Procedures.
**Discharge** → Clinical Discharge, Nursing Discharge.
**Utilities** → 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.

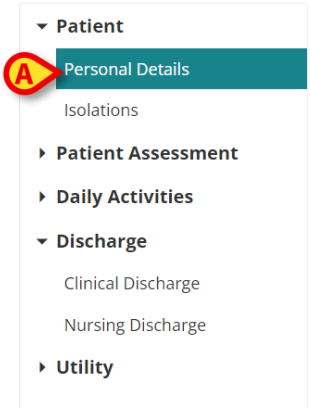


**Fig 4**

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 "Allergy/Intollerance" (Fig 5).

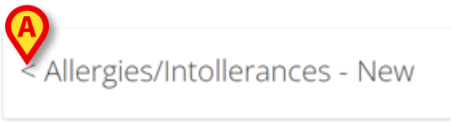


**Fig 5**

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 "Allergies/Intollerances" page is described in section 3.4.2.

# 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. These are described in section 3.1. For example, the “Personal details” page displays the patient personal data, and data related to possible previous admissions (Fig 6).

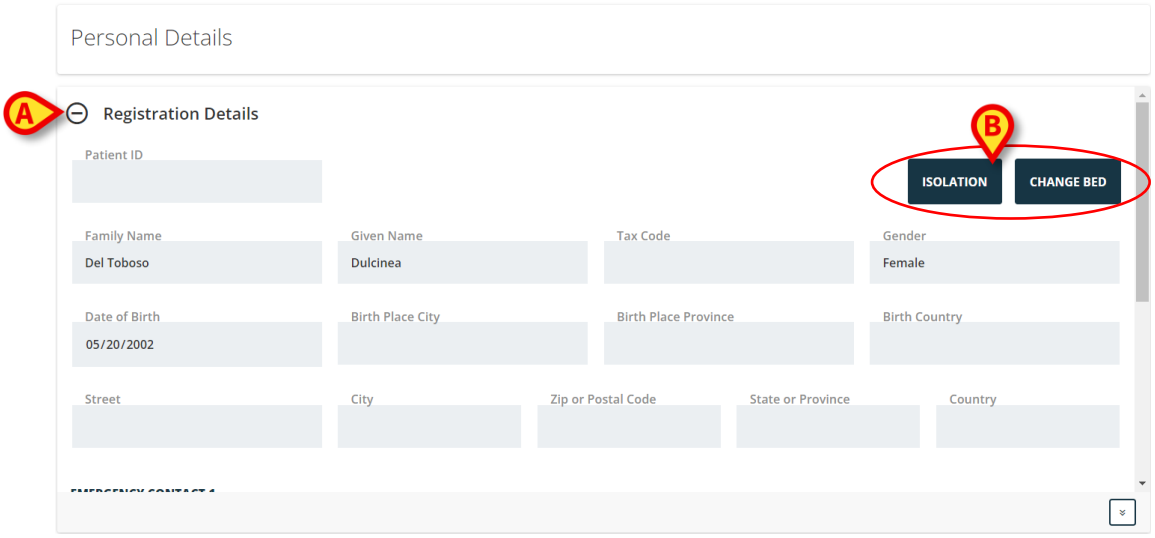


**Fig 6**

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**).

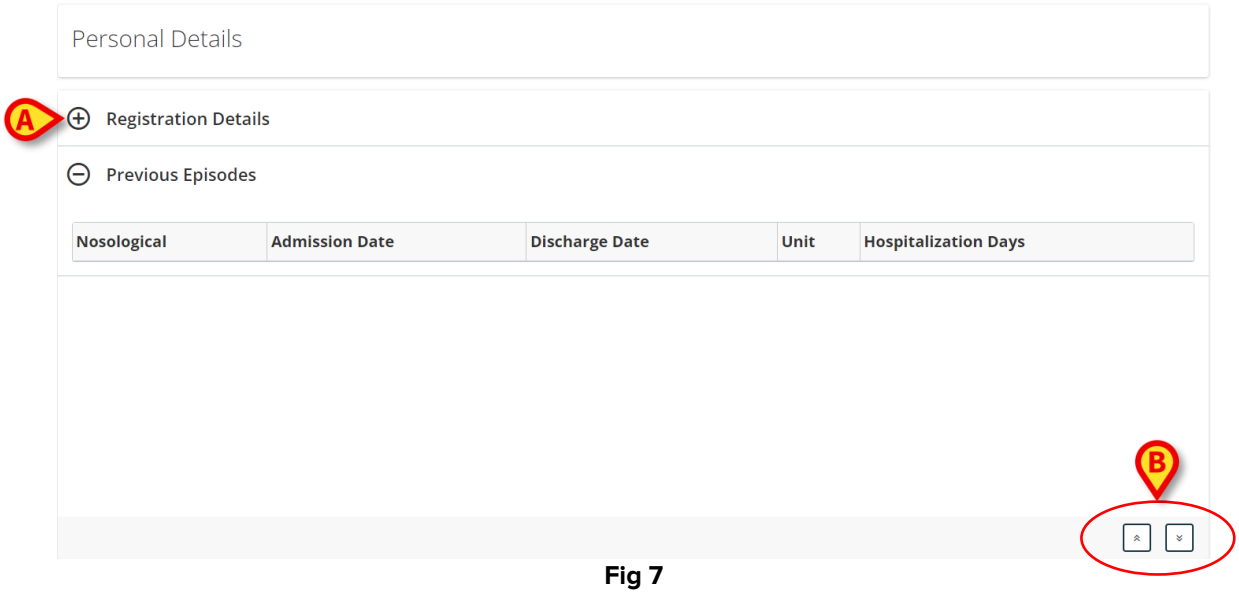


**Fig 7**

- 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 3.4.1).

# 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 (Patient File) 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 (Fig 9).

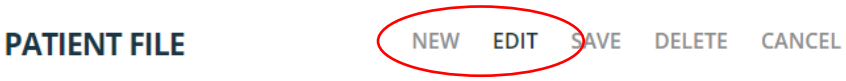


**Fig 9**

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

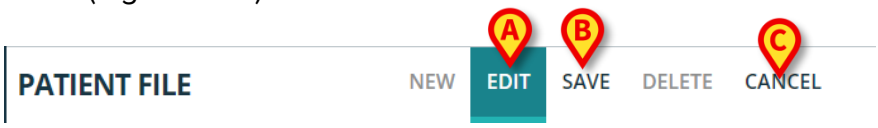


**Fig 10**

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

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

## 3.1. Data entry examples

The Patient Admission page is here described to exemplify the most common data entry modes.

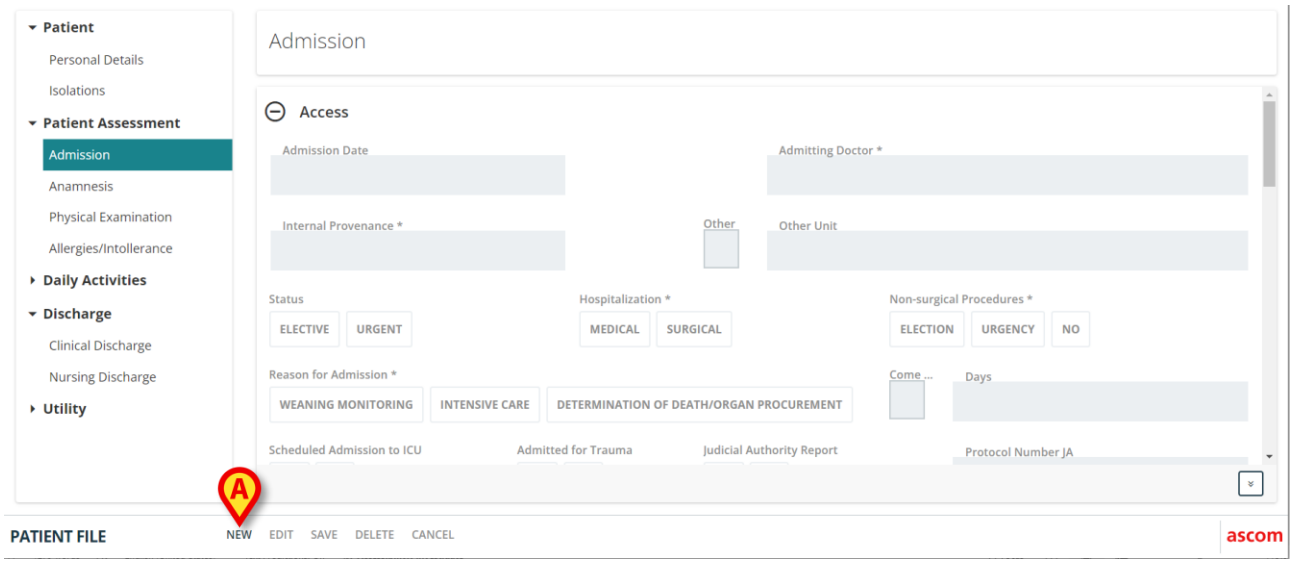


**Fig 11**

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

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

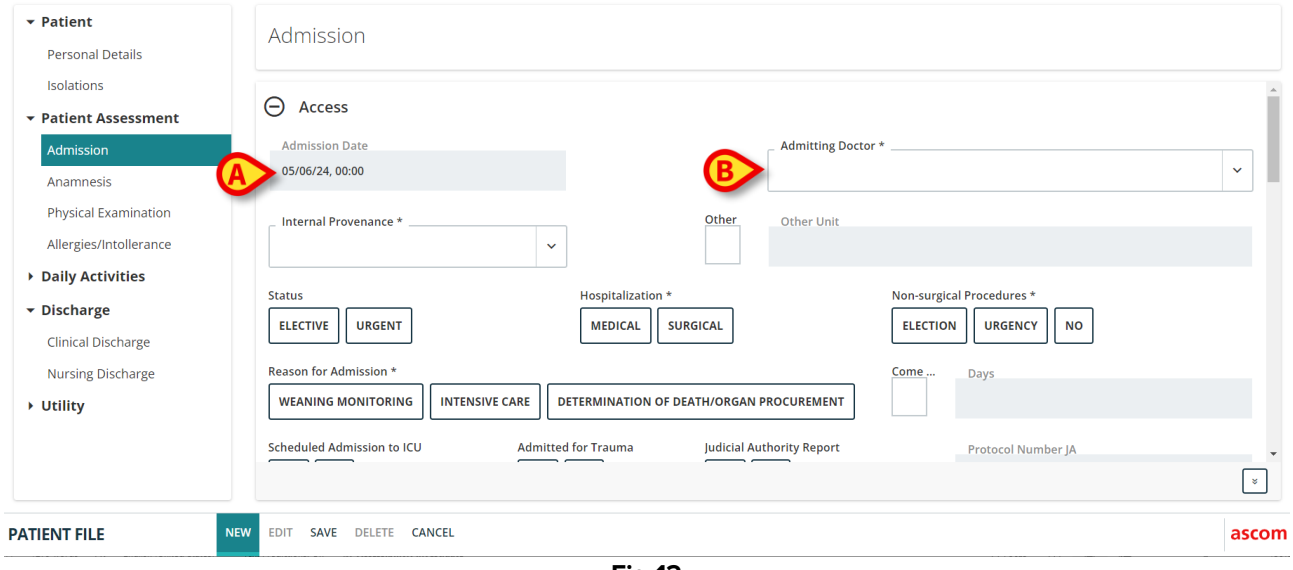


**Fig 12**

The admission date field is automatically filled if the patient is already admitted (Fig 12 **A**). The fields with an asterisk are required, as, for instance, "Admitting doctor" (Fig 12 **B**, Fig 13).


**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).

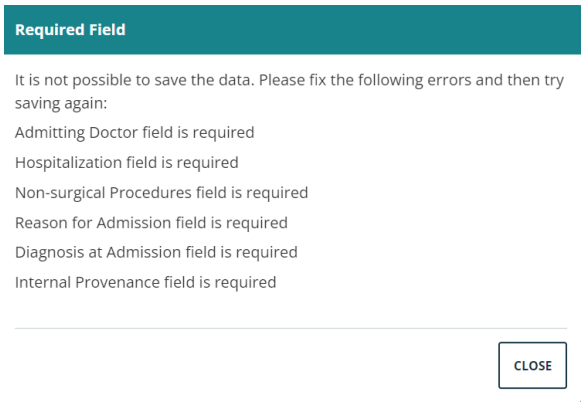


**Fig 14**

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

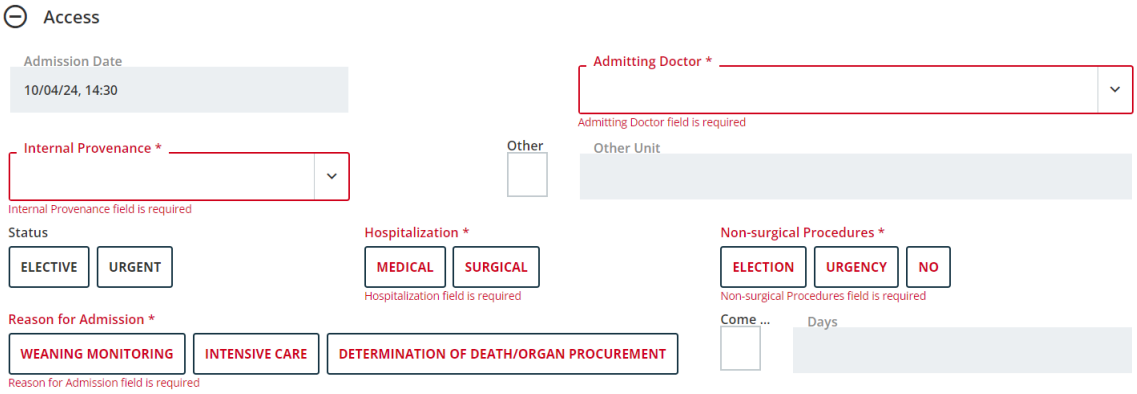


**Fig 15**

## 3.1.1. Drop down lists

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

The admission doctor, for example, can be selected on a drop-down menu containing the names of all those that can serve as admission doctors (Fig 16).

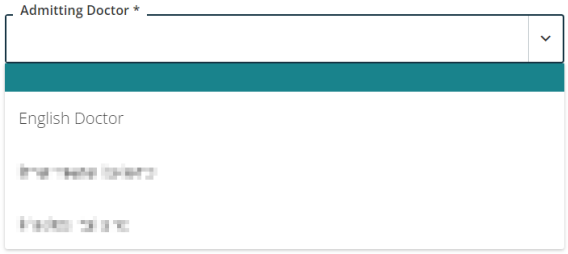


**Fig 16**

## 3.1.2. Multiple choice

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

- Click an option to select it.

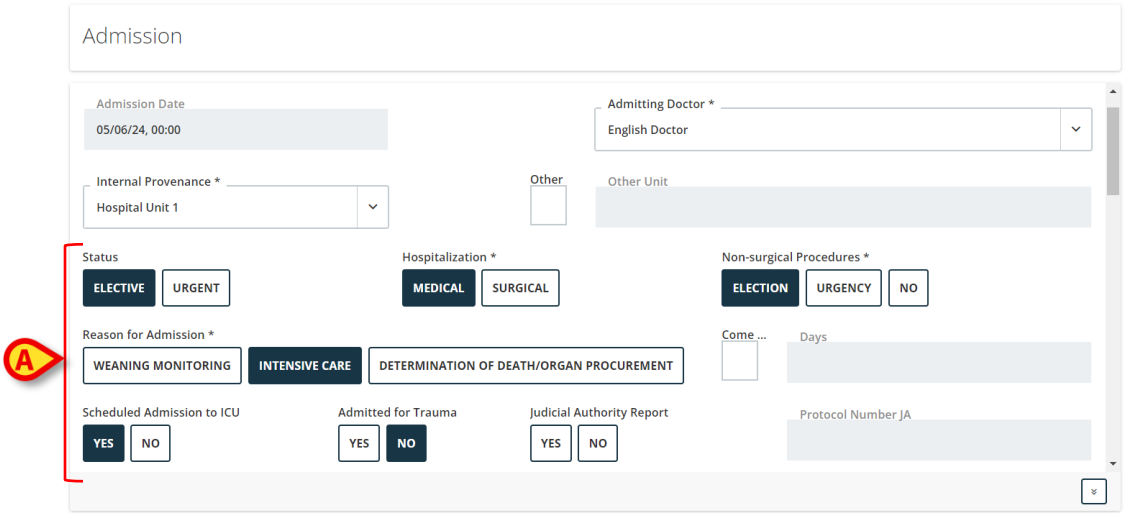


**Fig 17**

## 3.1.3. Co-related fields

Some options enable further specification. It is the case, for example, of the “Other” and “Come back” checkboxes that, if checked, require the specification of the department of origin and the number of days after which the patient returned. Also, if a judicial authorities report is indicated as present, the “Protocol number” field is enabled (Fig 18 **A** - **B** - **C**).

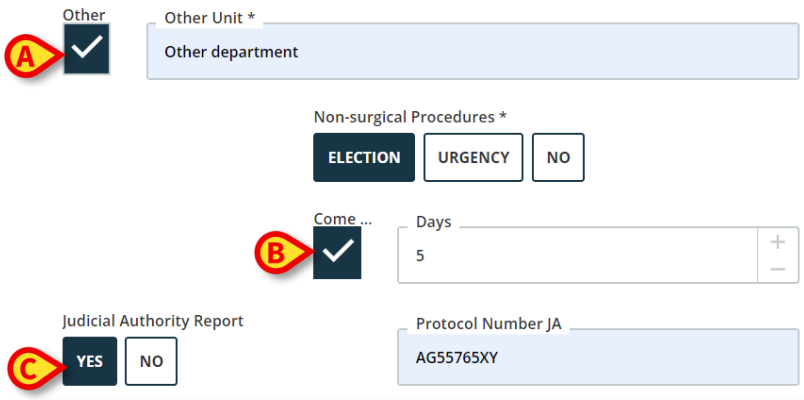


**Fig 18**

## 3.1.4. Free text fields

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

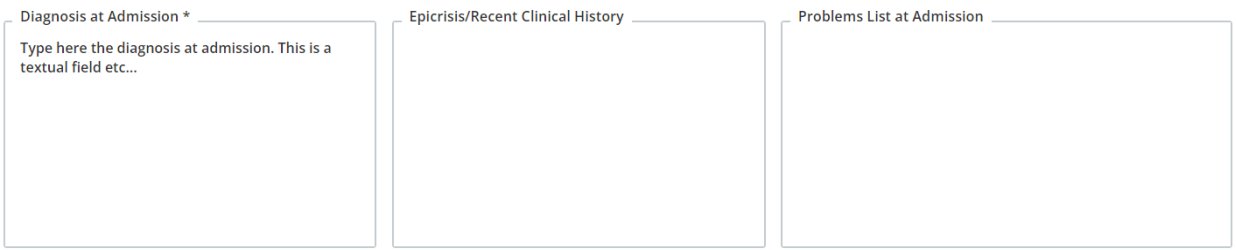


**Fig 19**

## 3.1.5. Selection window

Some fields open a selection window allowing to specify the required information. See, for instance, the specification of the Disease at Admission on the Admission page.


**Fig 20**

To indicate a disease

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

A dedicated selection window opens (Fig 21).

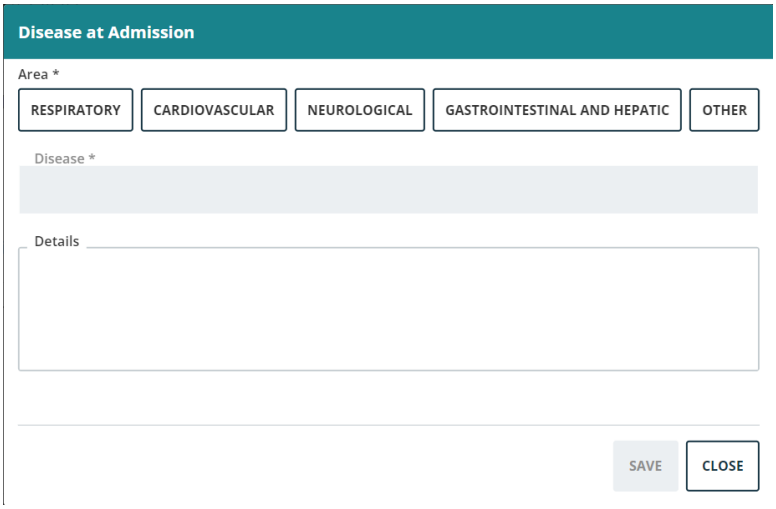


**Fig 21**

- Select the Area (Fig 22 **A**).

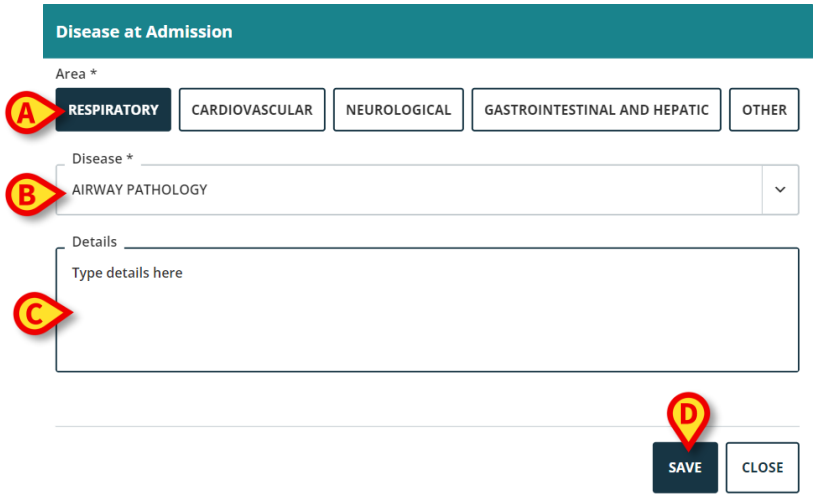


**Fig 22**

- Select the disease in the contextual drop-down list (Fig 22 **B**).
- Type a more detailed description if necessary (Fig 22 **C**).
- Click **Save** (Fig 22 **D**).

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

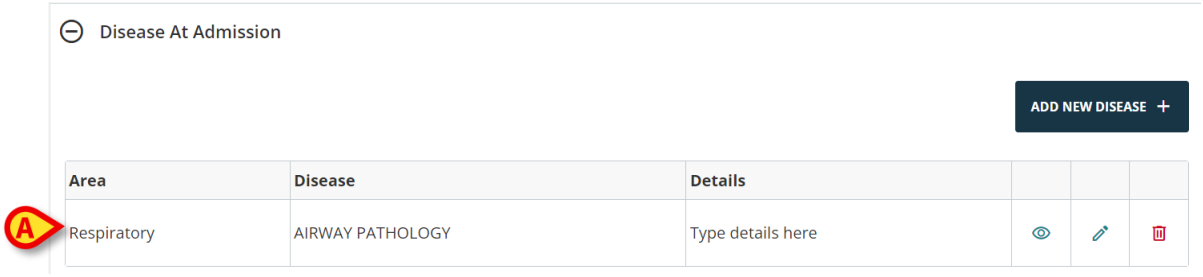


**Fig 23**

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

## 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 module (see document *USR ENG Codefinder Web* for the description of the Codefinder module). The following example shows the diagnosis selection procedure on the “Admission” page (Fig 24).

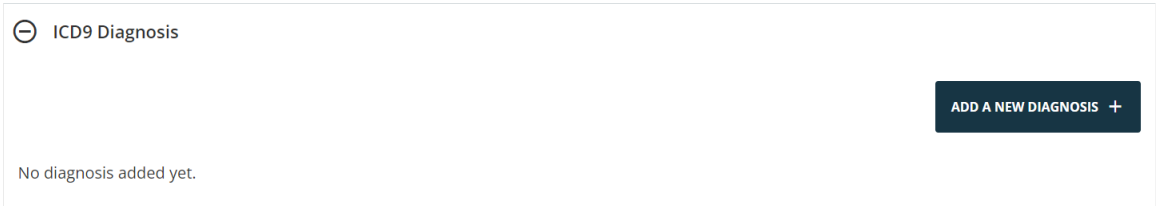


**Fig 24**

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

The Codefinder module opens (Fig 25)

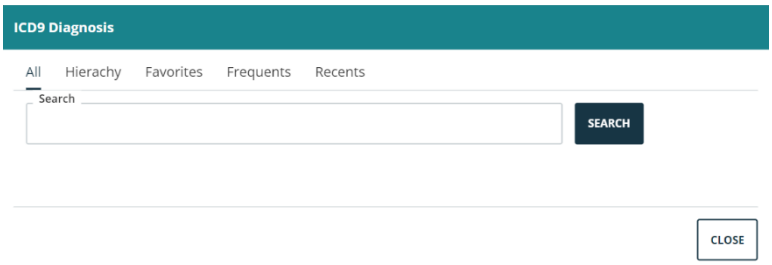


**Fig 25**

- Search the required diagnosis (Fig 26)

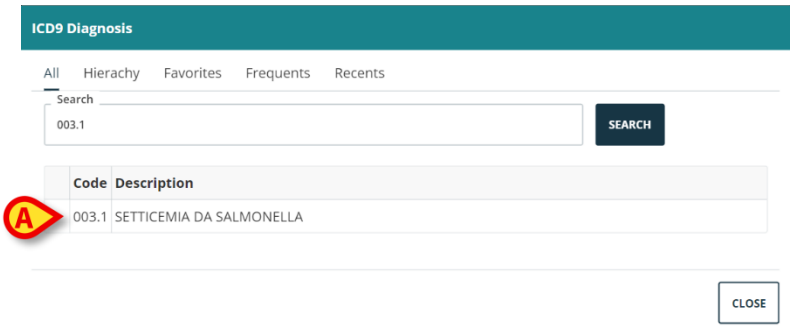


**Fig 26**

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

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

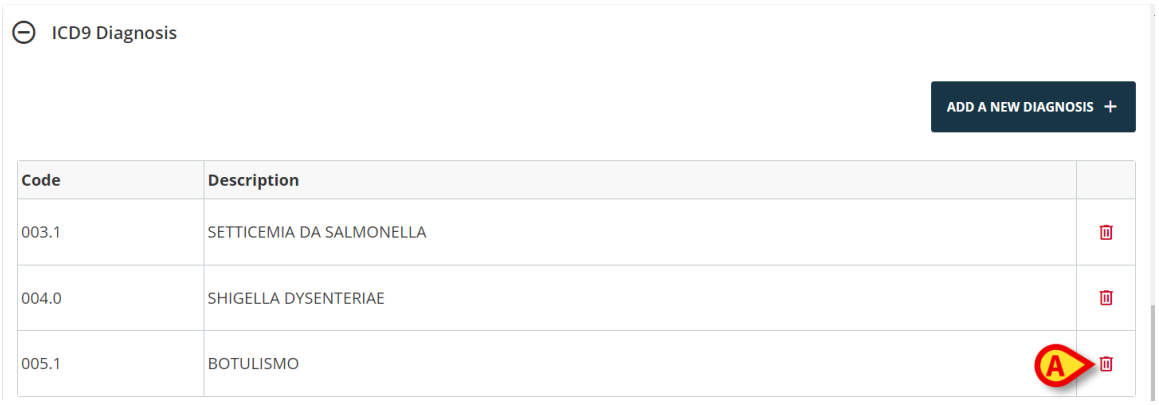


**Fig 27**

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

## 3.1.7. Nurse Scores

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

Different nurse scores can be contextually documented on different pages. See for example, on the Admission page, the Injury Severity Score (ISS - Fig 28).


**Fig 28**

To document a score:

- Insert all the required evaluations (Fig 29 **A**).


**Fig 29**

- Click the **Calculate** button (Fig 29 **B**).

The overall score is then displayed in a result field (Fig 29 **C**).

### 3.1.8. Disabled fields

Some fields can be disabled or read-only. Patient personal data in the “Patient data” section, for example, are inherited from the hospital ADT and are read-only on the Patient File module. Fields can be disabled due to user permissions (in case a user is not allowed to perform a specific procedure)

## 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 30 **A**).

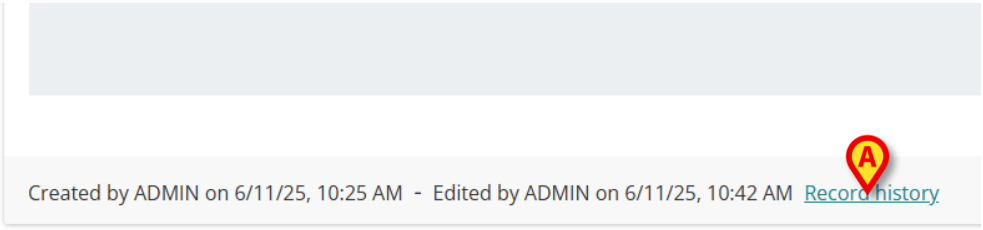


**Fig 30**

- Click the link to display the following window (Fig 31)

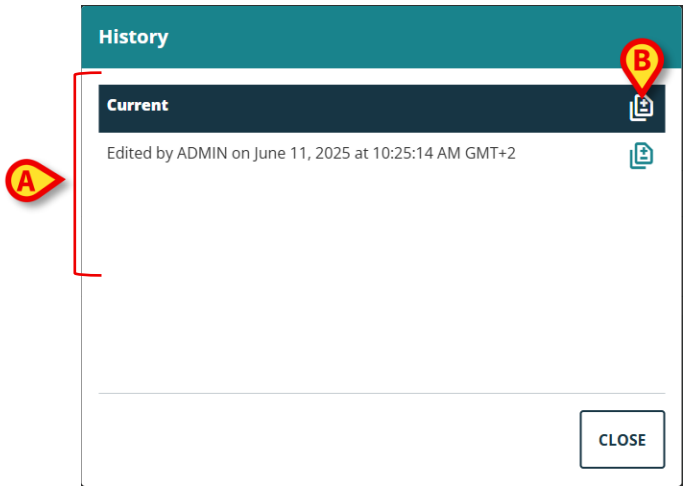


**Fig 31**

The window lists all the editings performed to the record. Each row corresponds to a specific editing (Fig 31 **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 31 **B**) opens a window that compares the selected version with the previous version (Fig 32). The icon is visible only to users having specific permissions.


**Fig 32**

# 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 33).

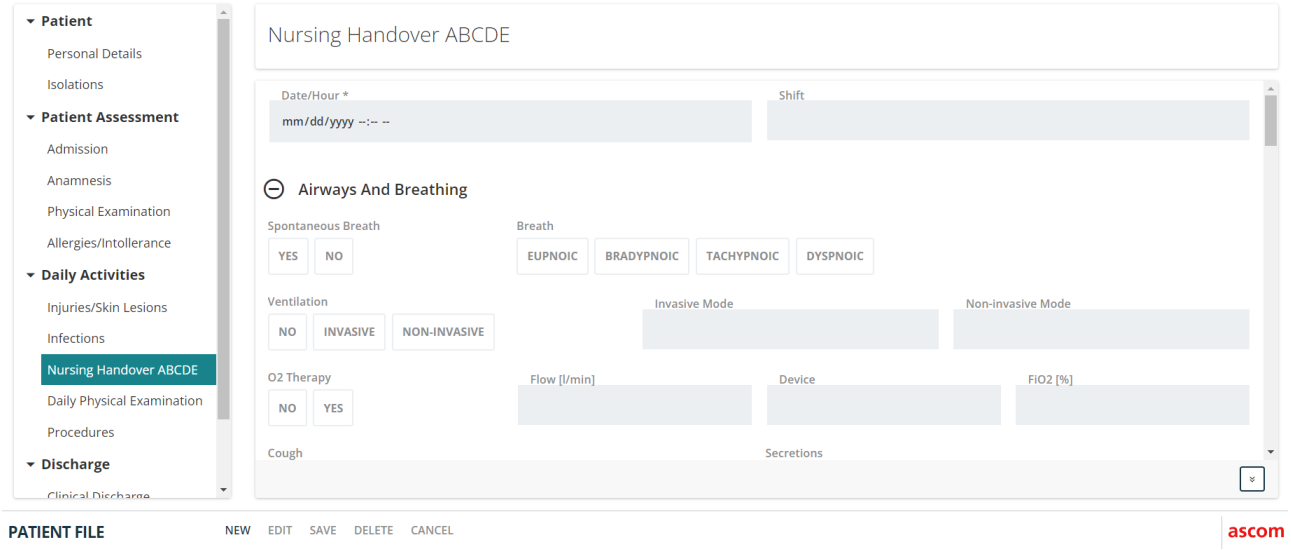


**Fig 33**

To create a new Nursing Handover

- Click the **New** button on the command bar (Fig 33 **A**).

The page turns to "Edit mode" (Fig 34).

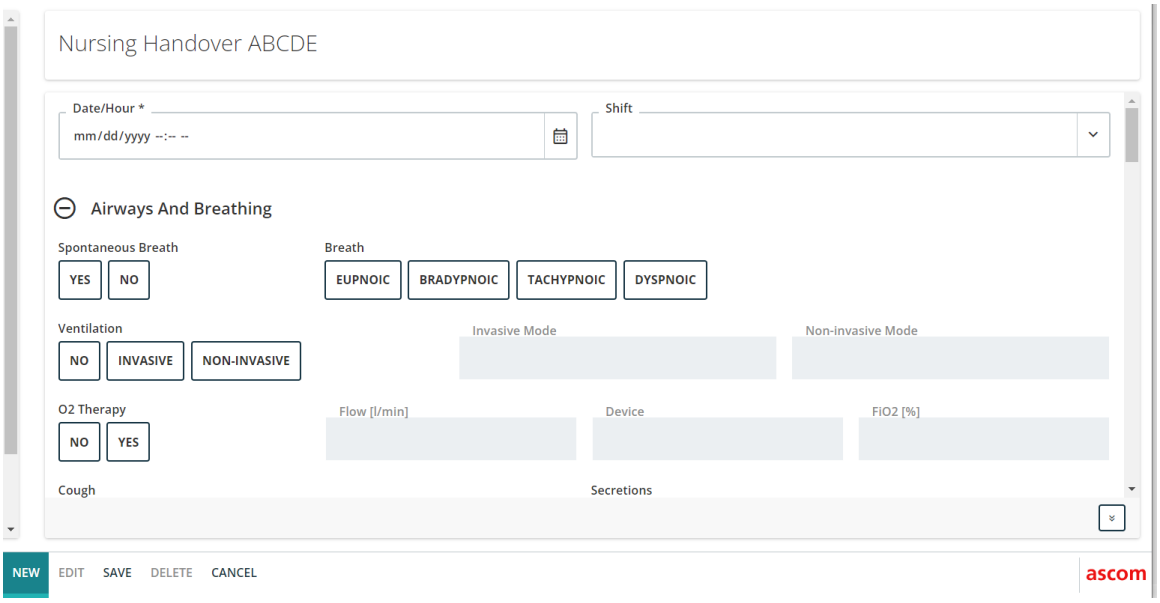


**Fig 34**

- Fill all the required fields (Fig 35).

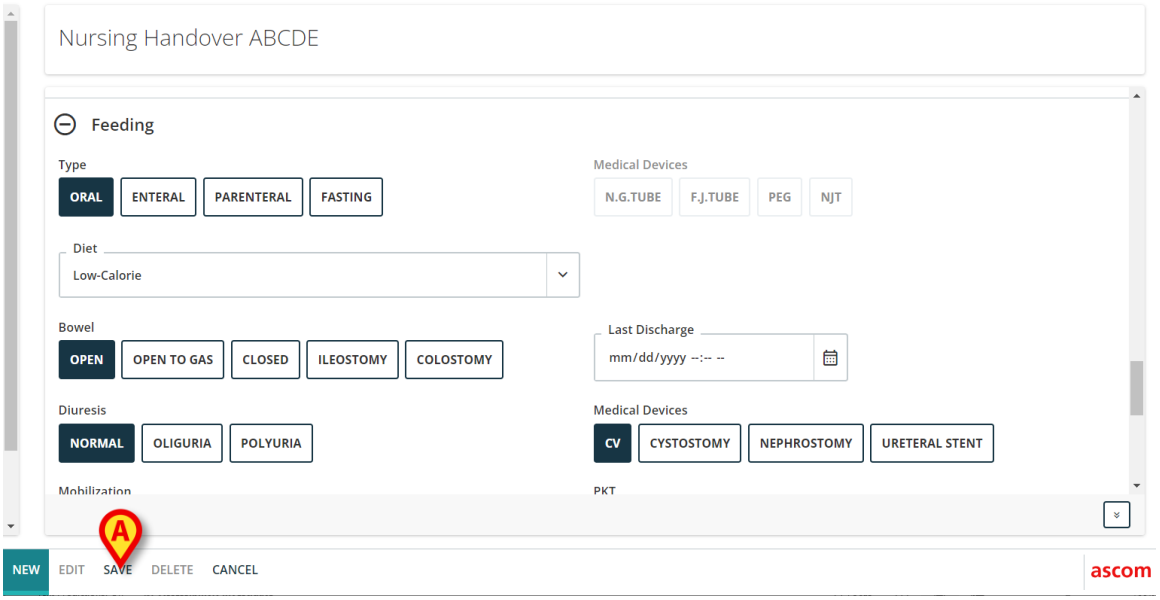


**Fig 35**

- Click **Save** when done (Fig 35 **A**).

The record is saved (Fig 36).

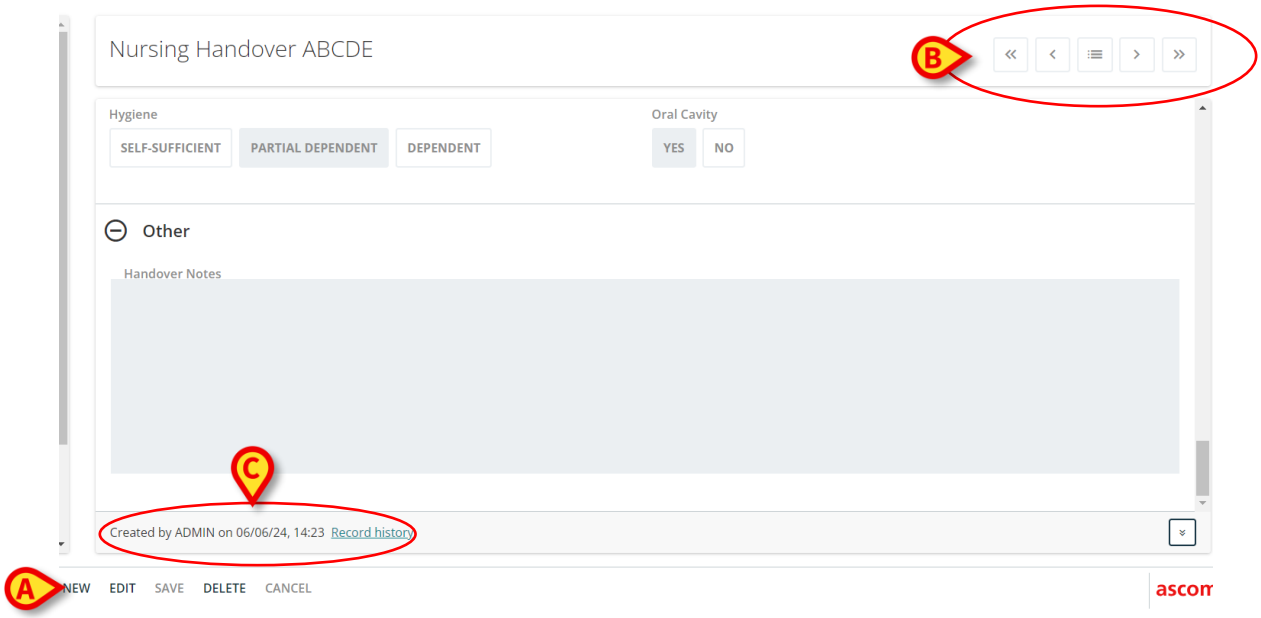


**Fig 36**

On the command bar the following buttons are enabled (Fig 36 **A**):

**New** – allowing to create a new record of the same type. When creating a new record it is possible to choose whether copying or not the existing data to the new record.
**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 36 **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 37).

| Created On | Shift | Date/Hour |
|---|---|---|
| 06/06/2024 | Morning | 05/06/2024 |
| 06/06/2024 | Afternoon | 05/06/2024 |
| 06/06/2024 | Night | 05/06/2024 |

**Fig 37**

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

# 3.4. Dedicated workflows

## 3.4.1. “Change Bed” and “Isolation” shortcuts

Specific buttons are present on some pages as shortcuts to related procedures. See, for example, on the “Personal Detail” page, the **Change bed** and **Isolation** buttons (Fig 38 **A**).

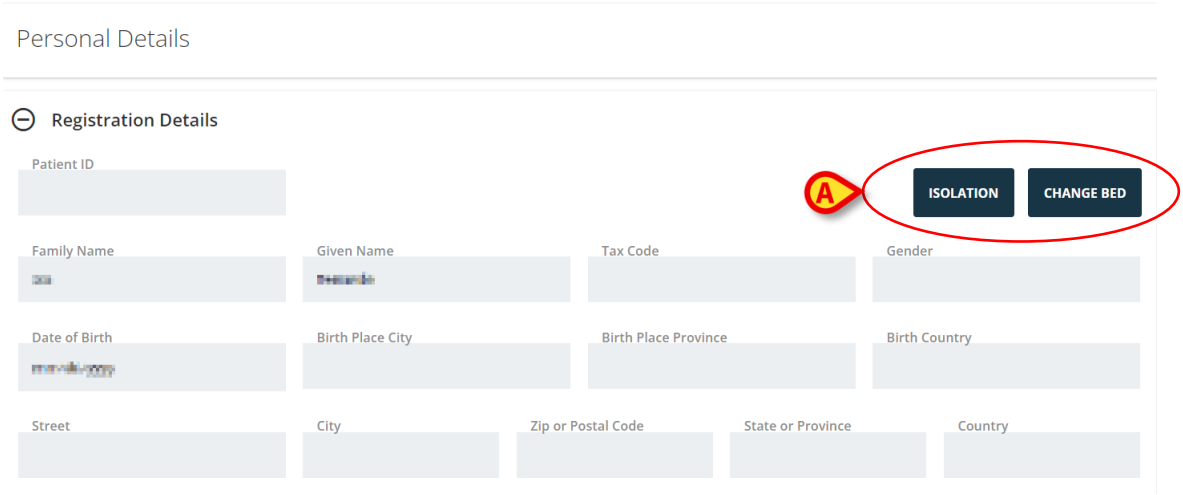


**Fig 38**

**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

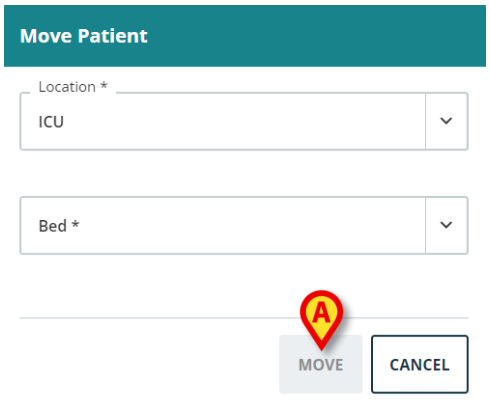


**Fig 39**

- Select the destination department and bed on the window and then click **Move** (Fig 39 **A**).

**Isolation**

- Click **Isolation** to directly access the “Isolations” page, that allows to document the patient isolation periods (Fig 40).

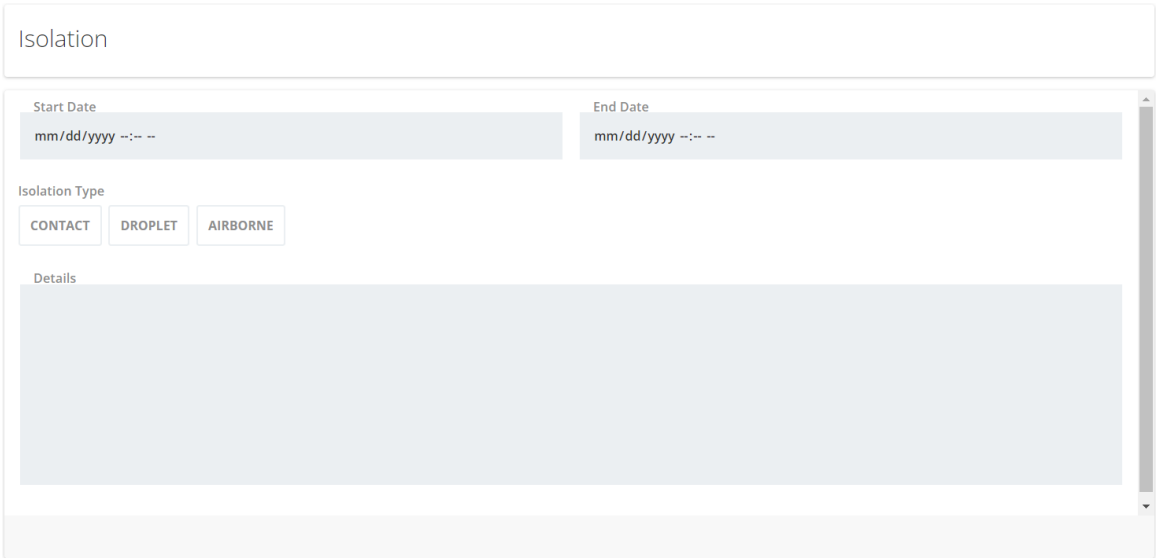


**Fig 40**

If an isolation period was started (the start date is specified) but not ended (end date not specified) as in Fig 41,

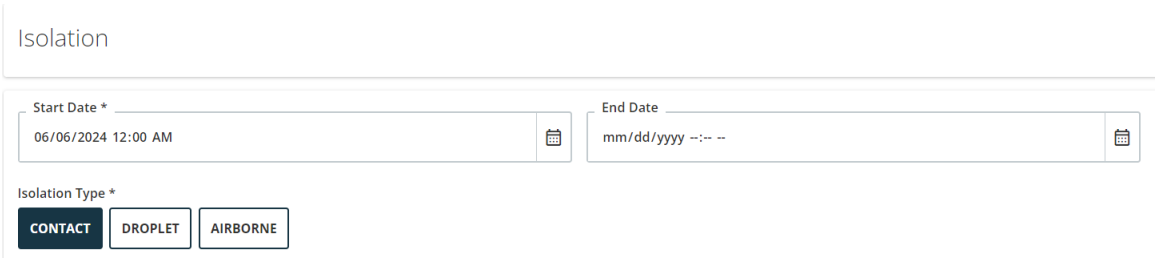


**Fig 41**

then the Isolation button is highlighted red on the “Personal Details” page (Fig 42).

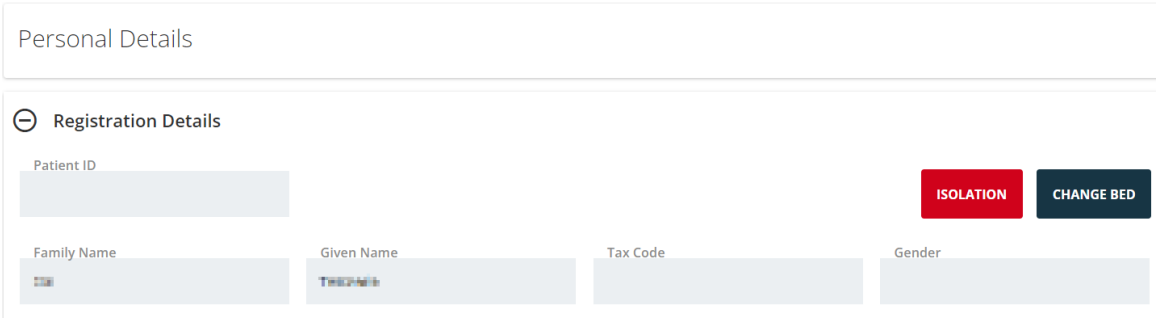


**Fig 42**

- 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).

## 3.4.2. Allergies/Intolerances

A specific workflow is dedicated to the documentation of the patient's allergies and intolerances.

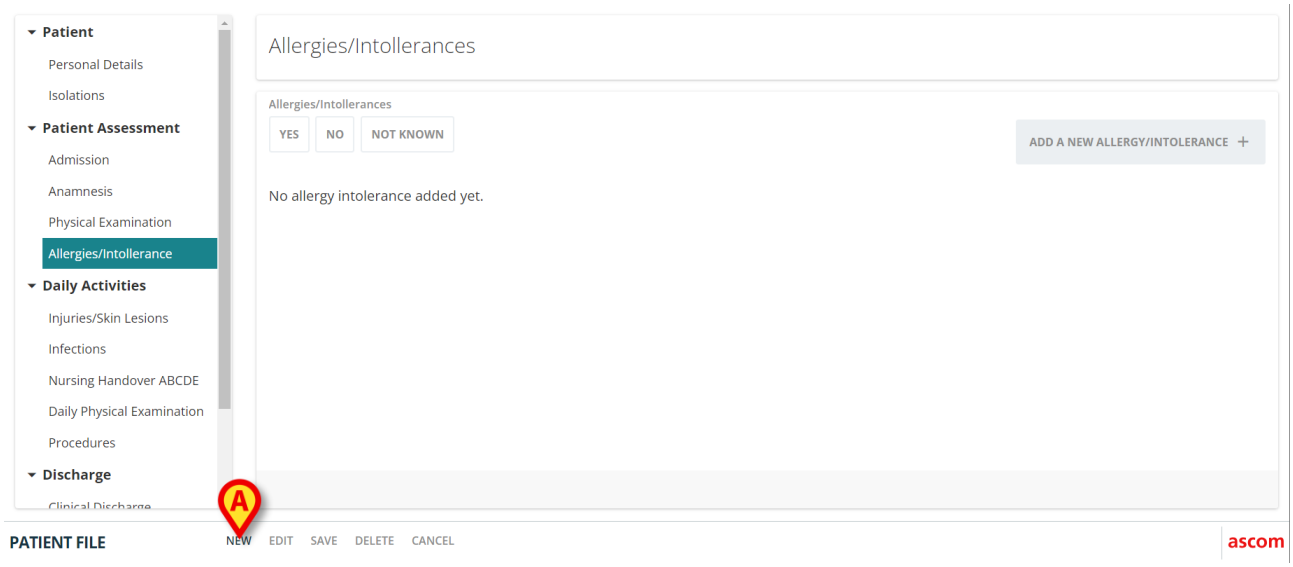


**Fig 43**

To indicate the allergies and intolerances

- Click the **New** button on the command bar (Fig 43 **A**).

The screen turns to **Edit** mode (Fig 44).

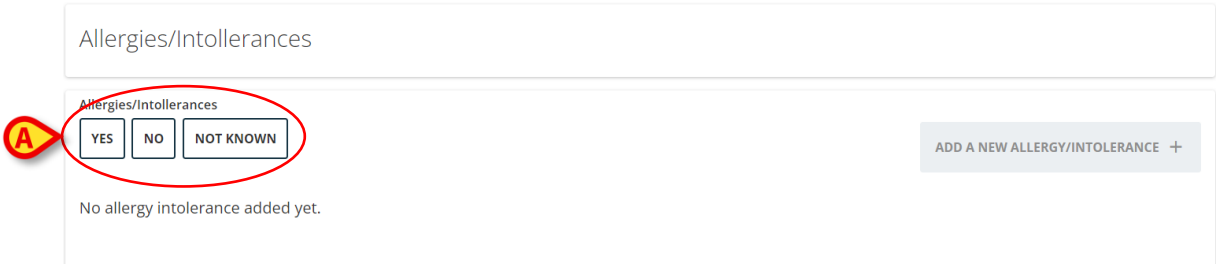


**Fig 44**

- Select one of the options indicated in Fig 44 **A**. The choice is automatically saved.

*Whatever option is selected on the "Allergies" page, it is immediately and automatically saved. There is no need to click the **Save** button to save the selection made. The selection can then be changed using the **Edit** procedure.*

After selecting **YES** (Fig 45 **A** - meaning that there are allergies/intolerances), the **Add new Allergy/Intolerance** button is enabled (Fig 45 **B**).

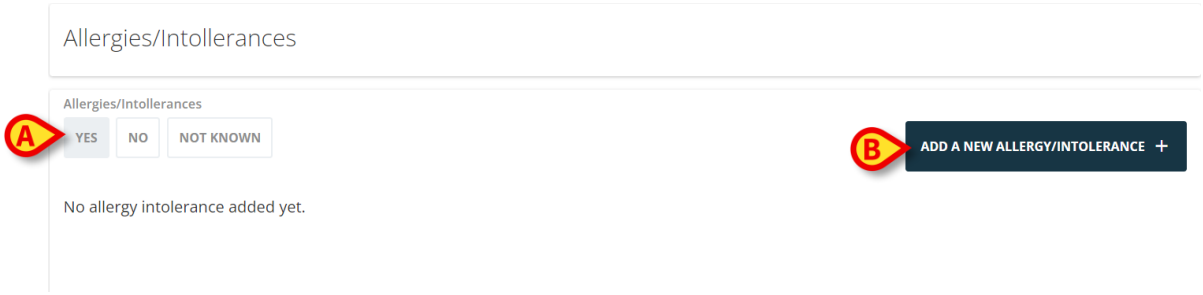


**Fig 45**

To specify the allergies for the patient

- Click the **Add new Allergy/Intolerance** button.

A dedicated form is displayed (Fig 46)

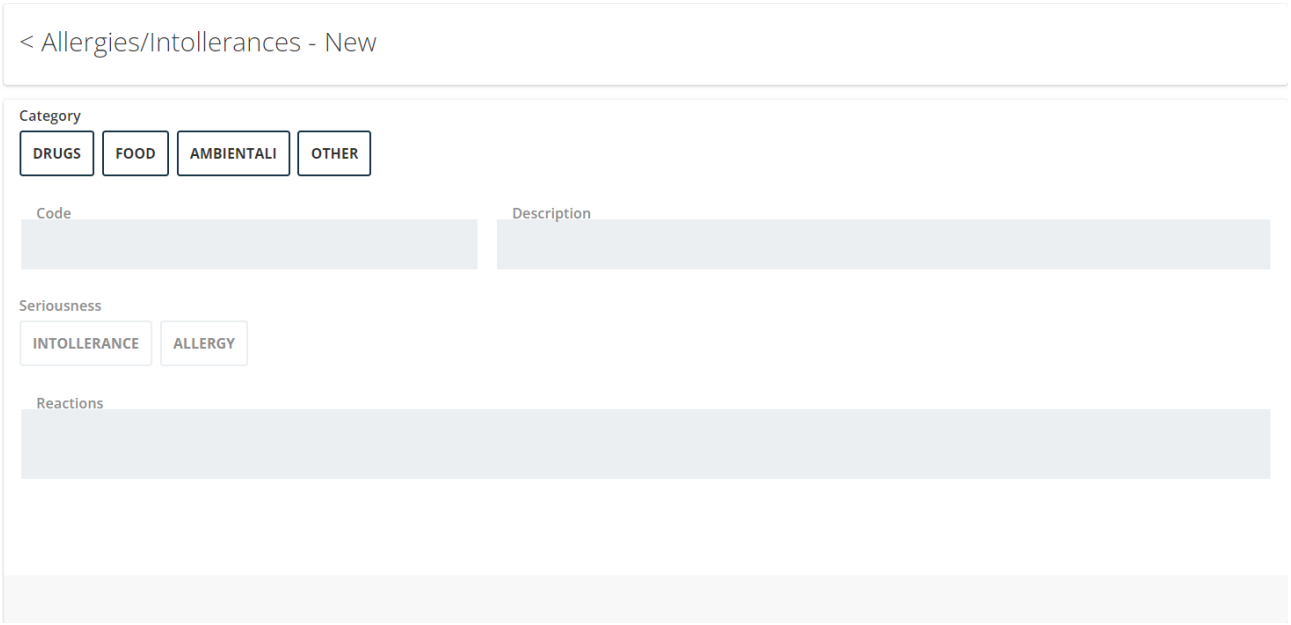


**Fig 46**

- Fill in the form (Fig 47 - a specifically configured Codefinder window is provided for this purpose).

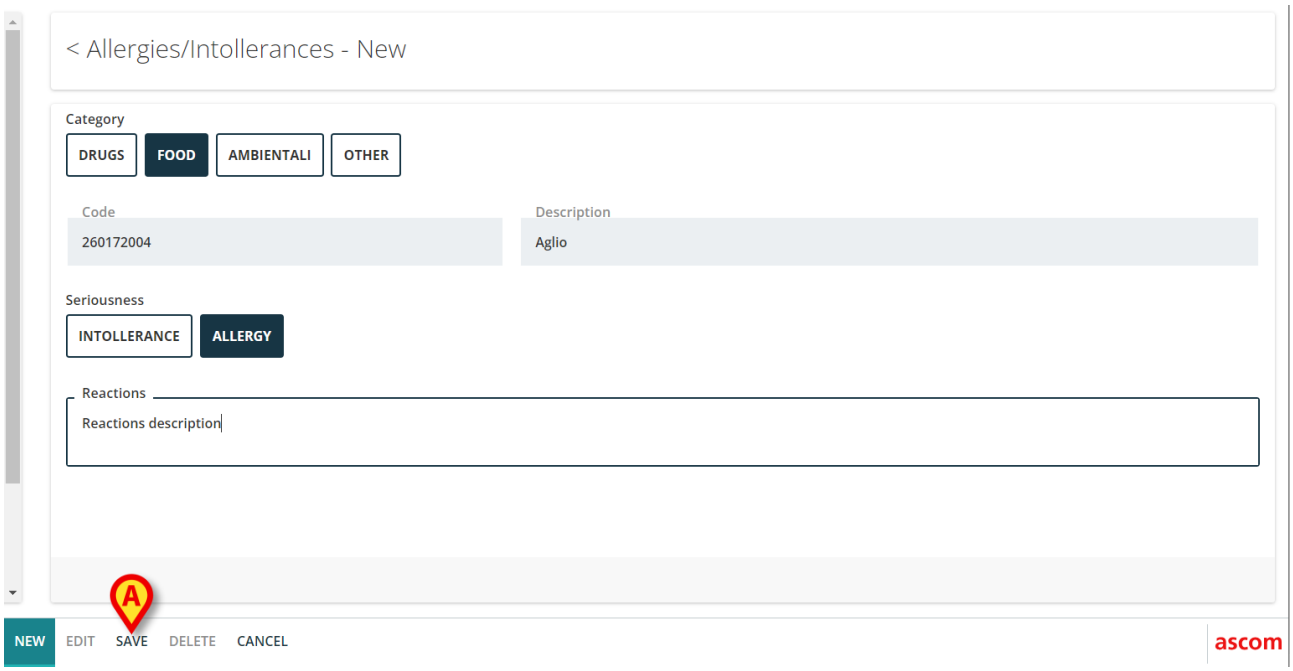


**Fig 47**

- Click **Save** on the command bar (Fig 47 **A**).

The selected items are displayed in a table (Fig 48).

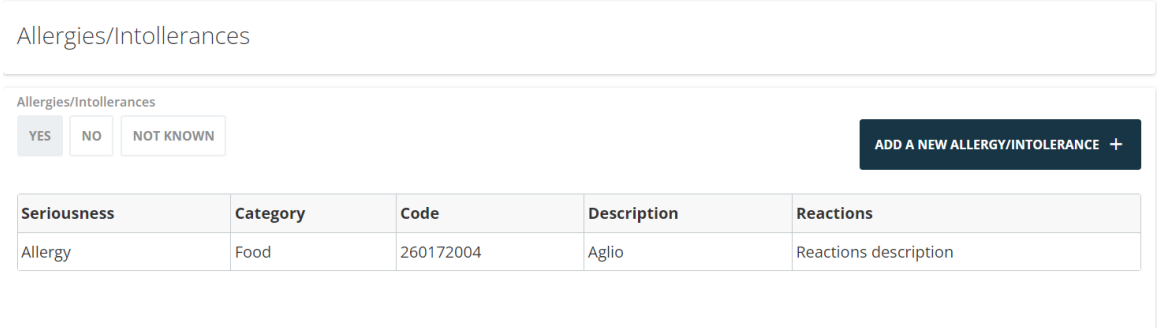


**Fig 48**

## 3.4.3. Injuries/Skin lesions

A specific procedure is dedicated to the patient injuries and skin lesions documentation (Fig 49).

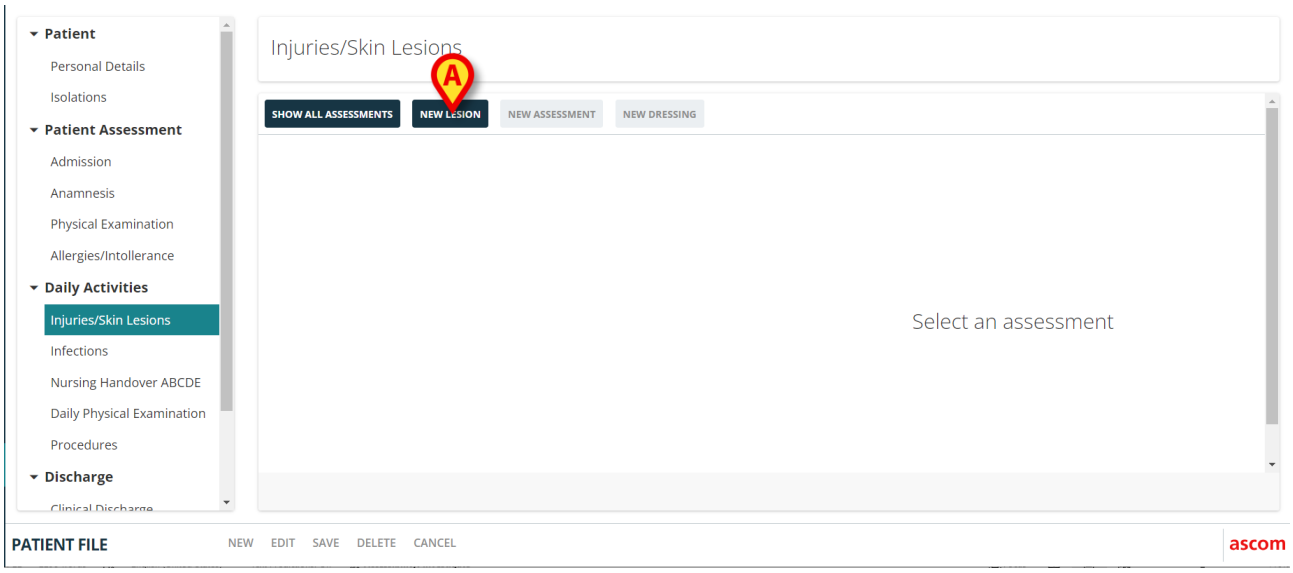


**Fig 49**

To indicate a lesion:

- Click the **New Lesion** button (Fig 49 **A**). The screen changes in the following way (Fig 50).

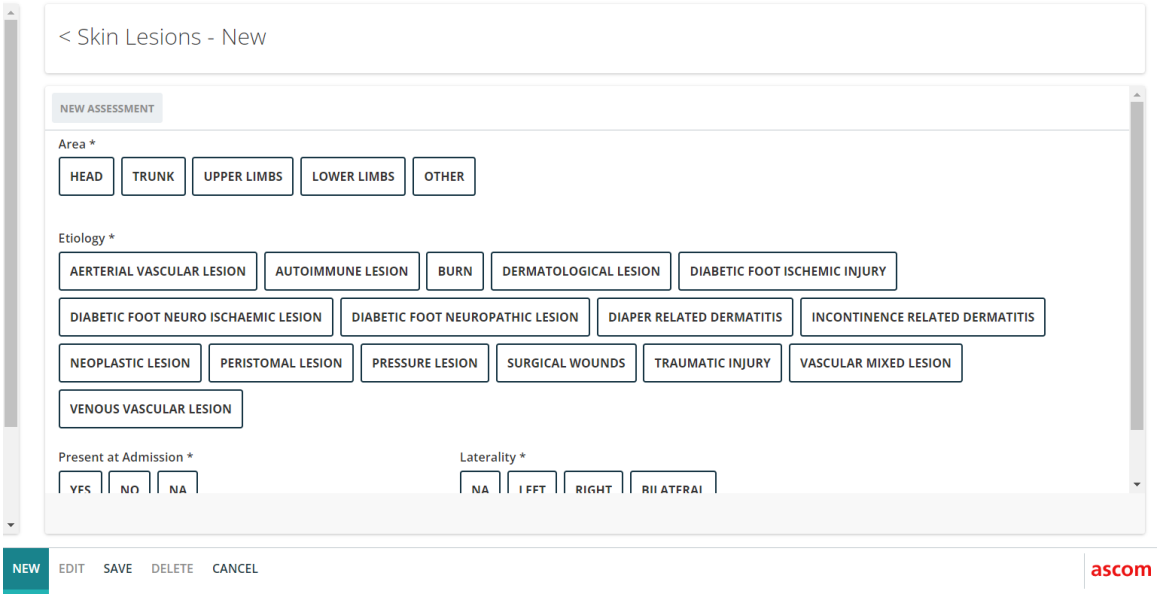


**Fig 50**

- Insert the required information (Fig 51).

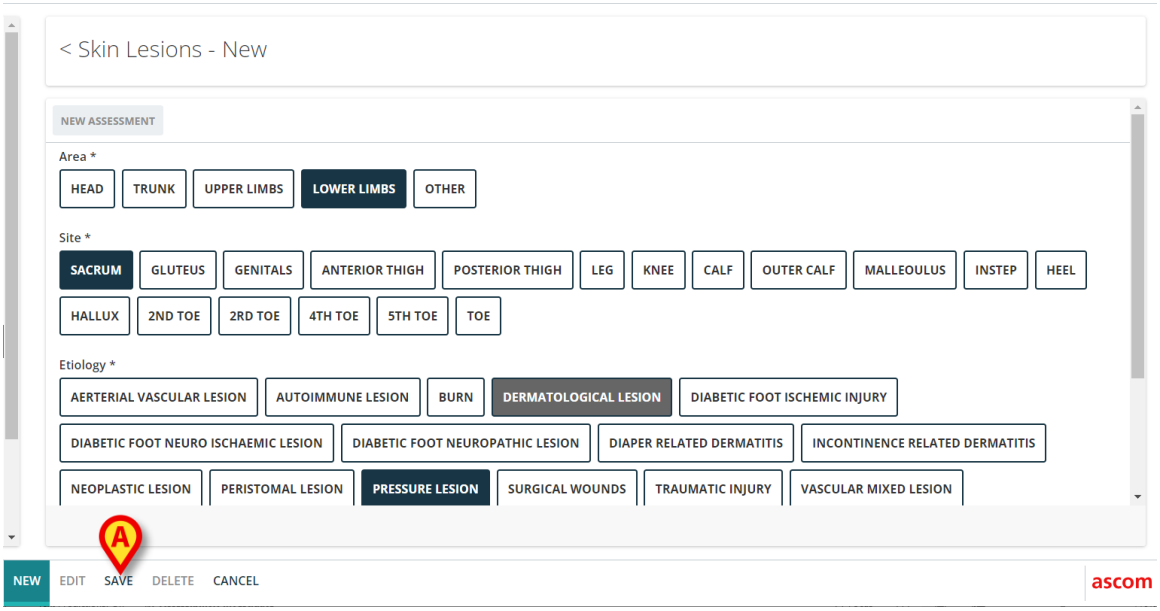


**Fig 51**

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

Data is saved (Fig 52).

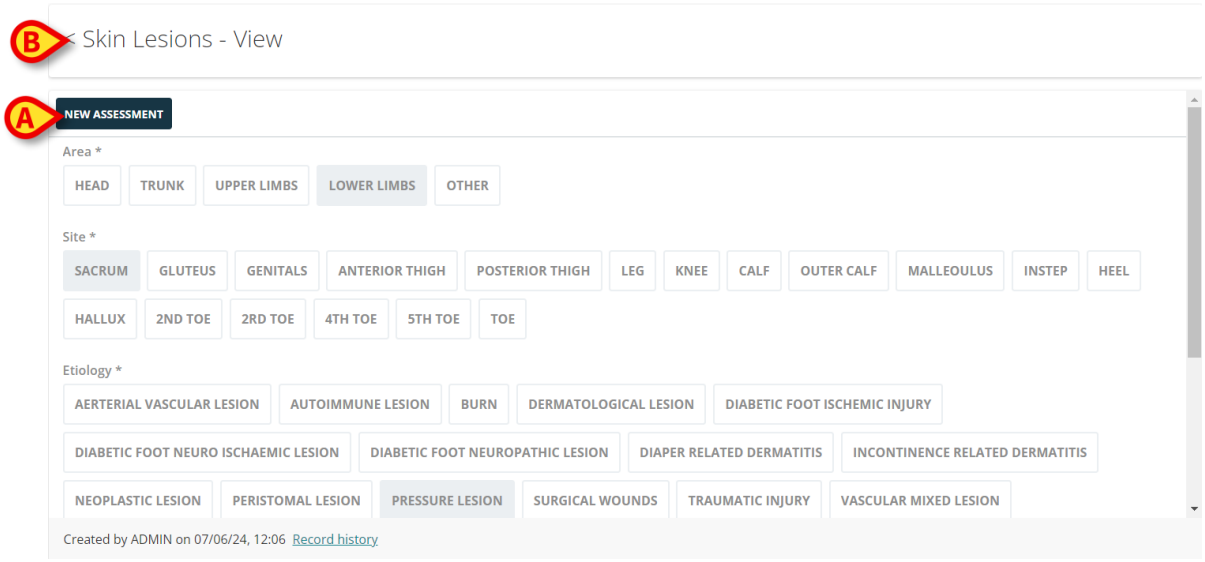


**Fig 52**

It is now possible to either document an assessment for the indicated lesion (click the **New Assessment** button - Fig 52 **A**) or go back to the lesions/injuries summary page (Fig 53 - click the **Back** arrow indicated in Fig 52 **B**).


**Fig 53**

Use the **New Lesion** button again to document additional lesions. All the documented lesions/injuries are listed on the page (Fig 54).

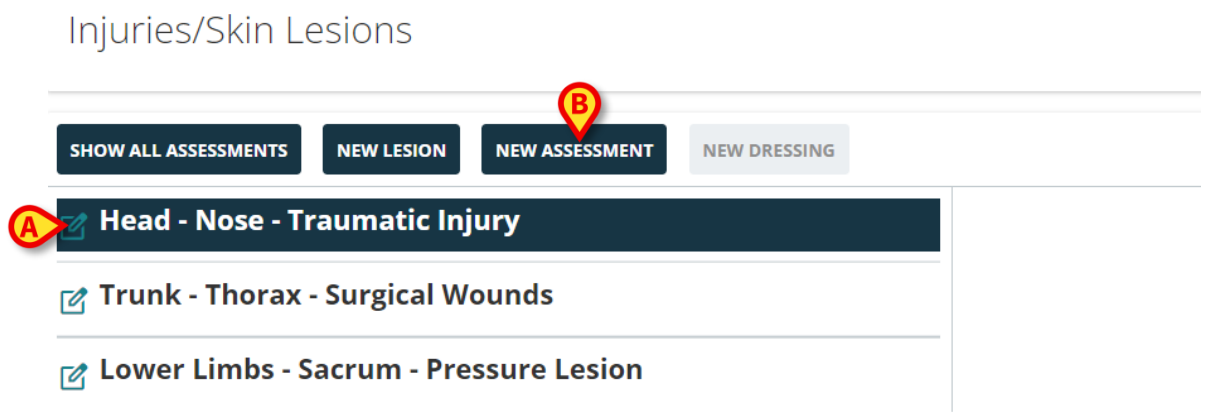


**Fig 54**

Periodic assessments can be documented for each lesion. To do that:

- Select the lesion to be assessed. The corresponding row is highlighted (Fig 54 **A**).
- Click the **New Assessment** button (Fig 54 **B**)

The "Assessment" form opens.

- Insert the required information and click **Save** on the command bar.

The assessment data is this way saved (Fig 55).

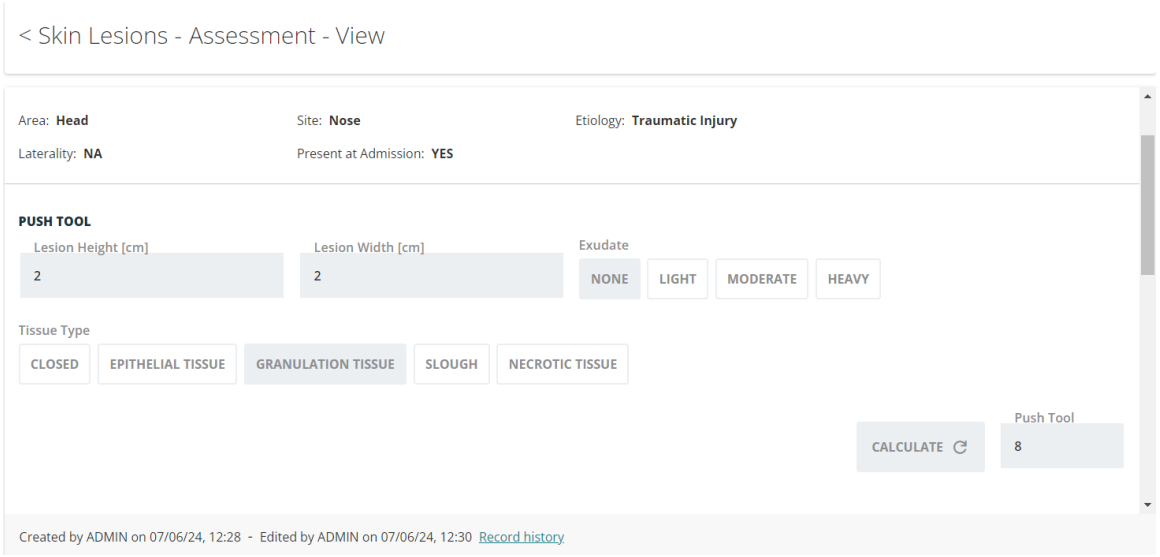


**Fig 55**

The assessments are listed on the injuries/lesions page, under the related injury (Fig 56)

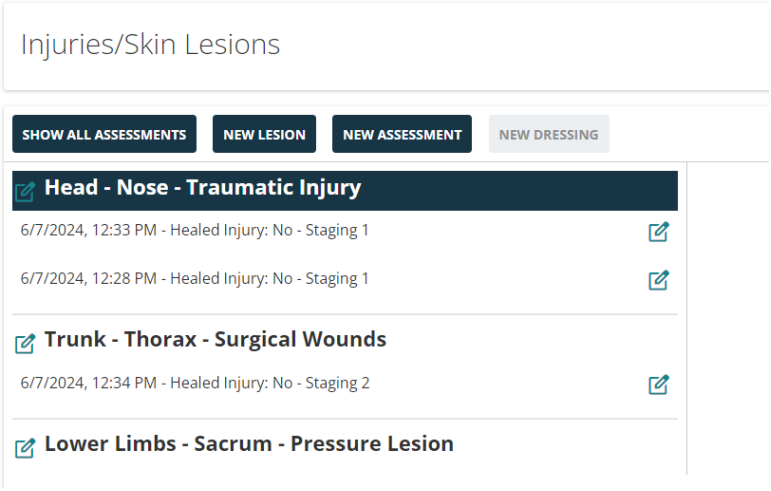


**Fig 56**

Possible successive dressings can be documented for a specific assessment. To do that:

- Click the relevant assessment. The corresponding row is highlighted (Fig 57 **A**).

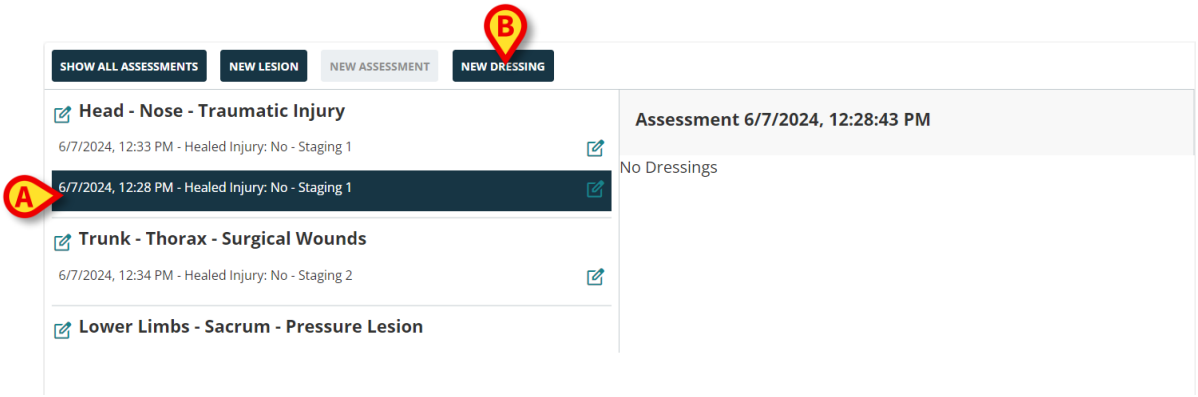


**Fig 57**

- Click the **New Dressing** button (Fig 57 **B**).

The “Dressing” form opens.

- Insert the required information and click **Save** on the command bar.

The dressing data is this way saved (Fig 58).

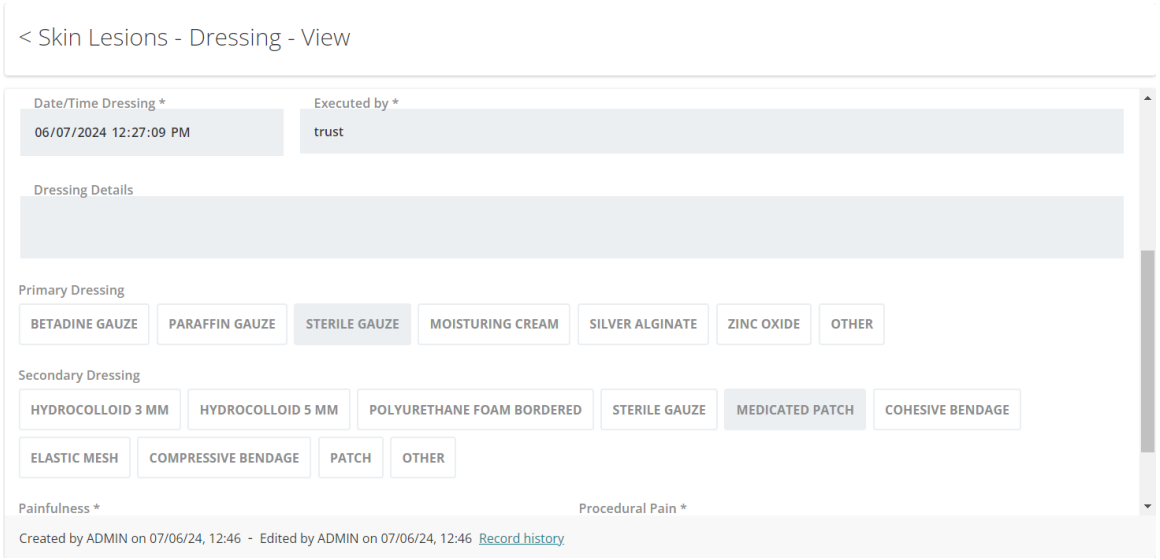


**Fig 58**

The dressings data is displayed on the "Injuries/Lesions" main page when the related assessment is selected (Fig 59 on the right).

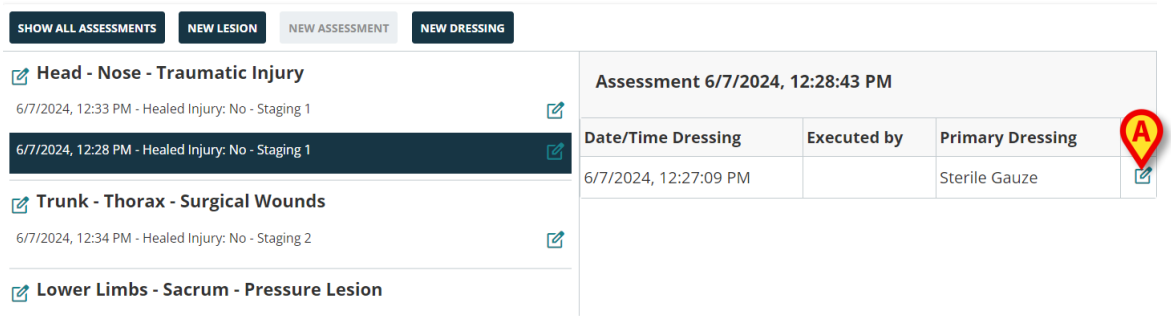


**Fig 59**

To quickly access and edit any item:

- Click the icon placed alongside the item (see, for example, Fig 59 **A**).

---

*The "Injuries/Skin lesions" documentation is structured this way:*

- *Multiple injuries can be documented for a patient.*
- *Multiple assessments can be documented for an injury.*
- *Multiple dressings can be documented for an assessment.*

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## 3.4.4. Clinical discharge

The data entry procedures in the “Clinical Discharge” form are like those described in the previous paragraphs, but, at the end of the discharge documentation, after all the relevant information is indicated, a specific procedure is required.

On this form the information related to the active therapies is inherited from the Digistat Therapy Web module, while the information related to the Examinations/Consultations is inherited from the Digistat Diary Web module.

*The Discharge procedure requires that at least one therapy is active for the patient on the Digistat “Therapy Web” module and that the Diary Web notes are correctly configured. See, for more information, the Digistat Therapy Web user manual (USR ENG Therapy Web) and the Diary Web user manual (USR ENG Diary Web).*

At the end of the patient stay, when all the fields in the “Discharge” form are filled, it is necessary to perform a final validation procedure. To do that, on the “Final Validation Actions” section on the “Clinical discharge” form,

- Click the **Lock therapy and discharge patient** button (Fig 60 **A**).

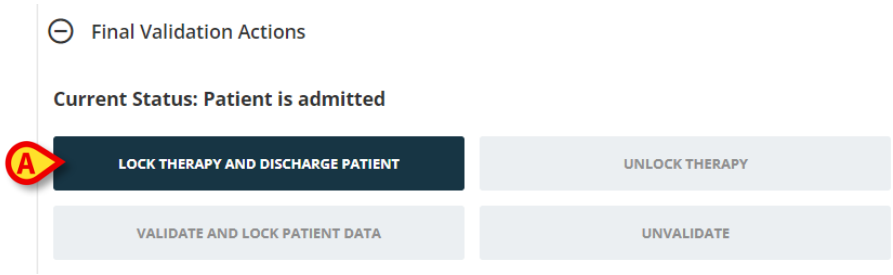


**Fig 60**

The patient is this way discharged, the therapies on the Patient Therapy Web module are locked. The **Unlock Therapy** and **Validate and Lock Patient Data** buttons are enabled (Fig 61).

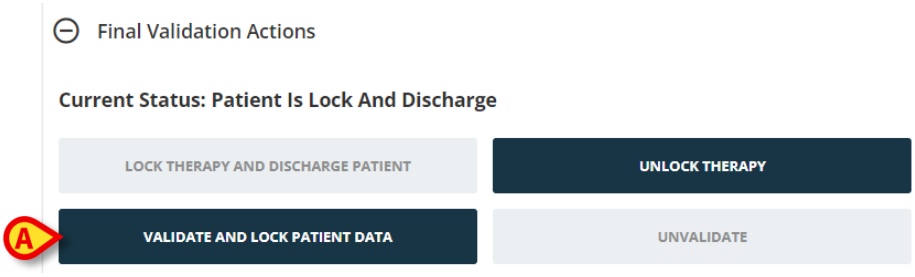


**Fig 61**

- Click **Validate and Lock Patient Data** (Fig 61 **A**).

The clinical record is this way validated. The patient data on the different Patient File forms turns to read-only mode. The **Unvalidate** button is enabled.

Use the **Unlock Therapy** and **Unvalidate** buttons as “Undo” buttons for the **Lock Therapy** and **Validate** procedures. In both cases, a reason for Unlocking/Unvalidating must be explicitly specified by the user on a dedicated pop-up window (Fig 62).


**Fig 62**

To do that:

- Type the reason in the textual field indicated in Fig 62 **A**.
- Click **Confirm** (Fig 62 **B**).

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