

MedicaPlus[®]

On-Line Medical Record Overview

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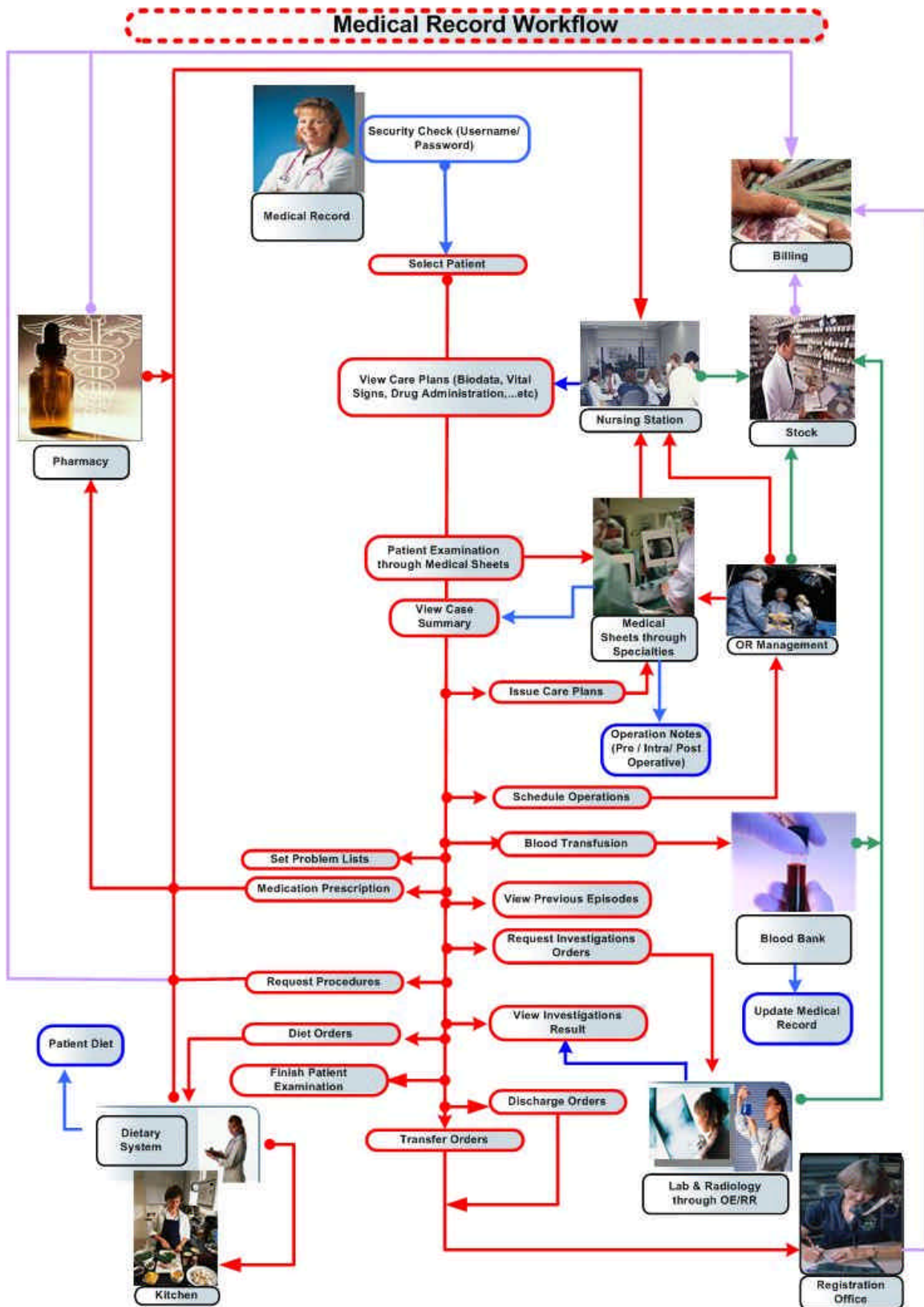
❖ ONLINE MEDICAL RECORD INTRODUCTION

The Medical Records department within any healthcare providing institution represents one of the most information sensitive and often administratively strategic functional units. Practically speaking, a smooth and efficient workflow process within a hospital relies very heavily on the availability of complete and accurate information where needed. The daunting task of ensuring that such information is readily available and easily accessible by duly authorized healthcare professionals is the responsibility of the Medical Records department. In any Hospital Information System (HIS), the Online Medical Record represents the information backbone on which the interoperability of the entire system often depends. MedicaPlus is no different. The MedicaPlus Online Medical Record application is the central information repository which contains all and any kind of medical, administrative, demographic, biographic and financial information concerning patients.

Where an offline paper Medical Record file exists for a patient, the MedicaPlus Chart Tracking tool handles the task of monitoring the physical file movement of this record throughout the hospital and attempts to keep as close an eye on this file as it does the Online Medical Record stored within the system.

FEATURES

- User Configurable View
- Patient Profile. This displays relevant patient data
- Online access to all patient demographic and clinical data contained within the OLMR
- Dynamic case summary generation based upon the current episode's encounter sheets and orders
- Intelligent Clinical Data Sheets
- Multiple intelligent sheet template definition for summary generation
- Specialty-specific encounter sheets
- Support for free text entry, sheet specific data, images and diagrams
- Investigation requests and orders
- Definition of differential, provisional and final diagnoses. ICD 9/10 or hospital-defined standards can be used for diagnosis selection
- Merging multiple records for a single patient, thus eliminating repetition and redundancy
- POMR & SOAP
- Support for existing scanned paper documents
- Drug Prescription using intuitive point and click functionality
- Procedure Orders (including therapeutic procedures)
- Surgical Procedures (coded to ICD or hospital defined standards)
- Operative notes documentation. This includes pre, intra and post-operative notes
- Diet Orders according to hospital defined standards
- Vital Signs history. This is graphically displayed for easy interpretation
- Transfer Orders
- Blood Transfusion Orders
- Discharge Orders
- Investigation Results
- Drug Administration history
- Reordering



MEDICAL RECORD APPLICATION			
PID	4853 FATMA MOHAMMED ALAAM .	Age	54 Y(s) 0 M(s) 11 D(s) Female
BED	BED 201 - 3	WT	0 HT 0 BSA 0
Diganosis		Other Diseases	
Diet	Not yet set	Allergies	
		Specialty	CHEST
		Nationality	Citizen
		Acuity Level	0
		Doctor	MOHAMED S. SOUROUR

Exit	List Patients	Search	Discharge	Detail >>	Episodes	Inpatient 14/07/2004 to Outpatient at: 17- EMERGENCY CLINIC 14/07/2004 to 14/07/2004
Configuration	View and Print	Re Order	Cancel			

Investigation Request(s)	Medication Prescription(s)	Created on 15/07/2004 21:16 by doctor MOHAMED MOSTAFA ABD ELSALAM ----- Date: 15/07/2004 21:16 by doctor Unknown THE PT IS CONCIIOUS COOPRATIVE V/S STABLE CHEST FINE LETHARY CRIPITATION O2 SAT IS 90 ON SAME MEDICATION OF DR SALAH SROUR ----- Created on 16/07/2004 09:50 by doctor MOHAMED MOSTAFA ABD ELSALAM ----- Date: 16/07/2004 09:50 by doctor Unknown the pt is conscious but hallucination v/s stable chest lethary cripitations on ventory 60% yesterday was 40 ABG was ordered dr salsah srour said no need for mvj ----- Created on 17/07/2004 06:45 by doctor MONTASER FAROUK ABU EL YAZID ----- CONSIUOS , ORIENTED ON VENTORI 60% SO2 97% CHEST LETHARY CREPITATION
Medical Procedure(s)	Schedule a Surgery(s)	
New Patient Problem(s)	Blood Transfusion Request(s)	
Basic data	My view data	

Description	Date/Time
Admission Sheet	
BIO Data	
Vital Signs	
CULTURE & ANTIBIOGRAM	Sun, 18/07/2004-07:53
NEBULIZER SET ONCE	Sun, 18/07/2004-05:19
NEBULIZER SET ONCE	Sun, 18/07/2004-05:19
RINGER SOLUTION OTSUKA	Sun, 18/07/2004-01:00
BISOLVON AMP	Sun, 18/07/2004-01:00
FORTECORTIN AMP	Sun, 18/07/2004-00:13
CLEXANE 40 MG SYRING	Sun, 18/07/2004-00:11
SODIUM BICARB 8.4 AMP	Sat, 17/07/2004-20:33
DEXAMETHASONE AMP	Sat, 17/07/2004-20:33
CLEXANE 40 MG SYRING	Sat, 17/07/2004-20:33
ZYLORIC 100 MG TAB	Sat, 17/07/2004-20:33
NORMAL SALINE 0.9% 500ML OTSUKA	Sat, 17/07/2004-20:33
CONSULTANT CALL FROM OUTSIDE T...	Sat, 17/07/2004-19:30
BLOOD GASES/ONCE	Sat, 17/07/2004-18:33
NURSING NOTES	Sat, 17/07/2004-14:59
SELECTIVAL TAB.	Sat, 17/07/2004-14:34

Medical Record

USER CONFIGURABLE VIEW

- The system allow user to redesign the view of the medical record screen according to his preferences.
- The system allow user to save this preferences.
- User chooses to select between all patient episodes or per episode.

Configuration

General options

Select data to be added to the My View tab :

Tab Data
<input checked="" type="checkbox"/> Basic data
<input checked="" type="checkbox"/> Medical Sheet/Form(s)
<input checked="" type="checkbox"/> Investigation Request(s)
<input checked="" type="checkbox"/> Medication Prescription(s)
<input checked="" type="checkbox"/> Medical Procedure(s)
<input checked="" type="checkbox"/> Schedule a Surgery(s)
<input checked="" type="checkbox"/> New Patient Problem(s)
<input checked="" type="checkbox"/> Blood Transfusion Request(s)

Default Tab :

View Type

Per Episode All Episodes

Select Sort Criteria For Data Inside Tabs

Tab
















Sort Options	Additional Sort Options
<input checked="" type="radio"/> Descending Date	<input checked="" type="radio"/> Problem
<input type="radio"/> Ascending Date	<input type="radio"/> Type

Apply Restore Defaults Set As Default Exit

Configure User View Preference

INVESTIGATION RESULT VIEWING

The Online Medical Record for each patient displays a detailed investigation result sheet. This may be used for information viewing and/or report generation. In addition, investigation results may be graphically displayed to provide an intuitive and practical understanding a patient's condition development.

ADEL ALY NOUR					
Name	Value	Unit	Status	Normal Range	
RBCs_Haemoglobin					
Haemoglobin	13	g/dl	Low	(13.5 - 17.5)	
Red cell count	5	mil/cm	Normal	(4.5 - 5.5)	
PCV	50	%	Normal	(40 - 50)	
MCV	83	fl	Normal	(83 - 101)	
MCH	39	pg	High	(27 - 32)	
MCHC	34	g%	Normal	(31 - 35)	
Reticulocytes	1	%	Normal	(0.5 - 2.5)	
TOTAL LEUCOCYTIC COUNT	3000	/cmm	Low	(4000 - 10000)	
DIFFERENTIAL LEUCOCYTIC COUNT					
-Basophils	1	%	Normal	(0 - 1)	
-Eosinophils	7	%	High	(1 - 6)	
-Staff	90	%	High	(40 - 80)	
-Segments	50	%	Normal	(40 - 80)	
-Lymphocytes	89	%	High	(20 - 40)	
-Monocytes	8	%	Normal	(2 - 10)	
PLATELET COUNT	300000	/cmm	Normal	(150000 - 400000)	

View test results

MEDICATION PRESCRIPTION HISTORY & ADMINISTRATION MONITORING

- Ability to order / view and print the medication administration information in a drug sheet display.
- The drug sheet (medication profile) includes all the requested information. Printouts of the profile can be printed as will. The profile will also display additional information such as administration instructions, drug information (indications, contra-indications, cautions, side-effects and doses).
- Ability to view drug-to-drug interaction, drug precautions, drug contra-indications and many other drug data through the interface of third party databases/components

Orders Entry

PID: 4748 YASSEN MOHAMED EL MELEGY ... Age: 15 Y(s) 2 M(s) 10 D(s) Male Specialty: CHEST
 BED: BED 510/1 (Companion) WT: 167 HT: 45 BSA: 0 Nationality: Citizen
 Diagnosis: Other Diseases: Acuity Level: 0
 Diet: Not yet set Allergies: Doctor: MOHAMED S. SOURCOUR

Problems List

Problem Description	Date/Time	Sta...

Drug Groups

- Gastro-intestinal system
- MOTILITY STIMULANTS (PROKINETIC DRUGS)
- ANTISPASMODICS
- DRUGS THAT PROMOTE HEALING OF PEPTIC ULCERS
- ANTIARRHOEAL
- Laxatives
- MEDICATIONS FOR TREATMENT OF HEPATIC DISEASE
- Drugs affecting intestinal secretions

Search

By Name: olf

Clear Select List

Order Detail

None

- ZANTAC AMP 1 AMP Every 8 Hour(s) For 1 Week(s)
- OLFEN 75 DA CAP 1 CAP Every 8 Hour(s) For 1 Week(s)

Selected Drugs

Selected Drugs	Date	Notes	Dose	Every	Hour(s)	For	Week(s)
<input checked="" type="checkbox"/> OLFEN 75 DA CAP	25/07/2004		1	CAP	8	1	Week(s)
<input type="checkbox"/> OLFEN AMP	25/07/2004						
<input type="checkbox"/> OLFEN 25MG LACTABS TAB	25/07/2004						
<input type="checkbox"/> OLFEN SR 100 MG CAP	25/07/2004						
<input type="checkbox"/> OLFEN RECTOCAPS RECTOCAP	25/07/2004						
<input type="checkbox"/> OLFEN GEL	25/07/2004						
<input type="checkbox"/> OLFEN GEL LARGE	25/07/2004						
<input type="checkbox"/> OLFEN50MG20LACTAB	25/07/2004						

Drug Information:

INDICATIONS:
 pain and inflammation in rheumatic disease (including juvenile arthritis) and other musculoskeletal disorders; acute gout; postoperative pain and inflammation in rheumatic disease (including juvenile arthritis) and other musculoskeletal disorders; acute gout; postoperative pain.
 inhibition of intraoperative miosis during cataract surgery (but does not possess intrinsic mydriatic properties); postoperative inflammation in cataract surgery, strabismus surgery or argon laser trabeculoplasty; pain in corneal epithelial defects after photorefractive keratectomy, radial keratotomy or accidental trauma; seasonal allergic conjunctivitis

CONTRA-INDICATIONS:

Confirm Order Close

Drug order

Within the drug administration sheet view, the user will see a drug sheet allowing him/her to input the amount of drug dispensed at a given time within the day. All the drug administration history is available through this view. Moreover, the user can view the drug information by moving the mouse over the drug name. Doctors may request to stop, continue or reorder any medication and can view the dosage administered to the patient (dose taken, nurse and date & time of administration)

Drug List

ZANTAC AMP

1.00 AMP(s) Every: 8 hour(s) For 2 Day(s)

INDICATIONS:
bowel sterilisation before surgery,
bacterial inf

CONTRA-INDICATIONS:
bowel sterilisation before surgery,
bacterial inf

CAUTIONS:
too toxic for systemic use,
pregnancy , renal imp

SIDE - EFFECTS:
too toxic for systemic use,
pregnancy , renal imp

DOSE:
by mouth, pre-operative bowel sterilisation, 1 g e

Prescribing by: **MOHAMED ADEL AFARAA**

Drug Informations Continue Drug Stop Drug

Course is :2 STRIPS(s)

Notes: Taken on empty stomach, be sure of patient fasting.

Prescription Date: **06/07/2004**

LACTULOSE SYRUP SMALL

15.00ML(s) Every: 8 hour(s) For 2 Day(s)

Prescribing by: **MOHAMED ADEL AFARAA**

Drug Informations Continue Drug Stop Drug

Course is :1 SYRUP(s)

Notes: No need for rectal enema, just use this medication.

Medication Administration

PROCEDURE HISTORY & STATUS VIEWING

Medical Records personnel have the ability to Order Procedures.

Medical Records personnel have access to the history of Ordered Procedures and their status for each patient.

The status for each procedure indicates whether the procedure has been completed and the date, time and any other notes which may have been recorded at the time of completion.

Orders Entry		
PID	4746 YASSEN MOHAMED EL MELEGY -	Age 15 Y(s) 2 M(s) 10 D(s) Male
BED	BED 610/1 (Companion)	WT 167 HT 45 BSA 0
Diagnosis		Other Diseases
Diet	Not yet set	Allergies
		Specialty CHEST
		Nationality Citizen
		Acuity Level 0
		Doctor MOHAMED S. SOUROUR

Problem Description	Date/Time	Sta...

Procedure Groups	Search
<ul style="list-style-type: none"> <input type="checkbox"/> AMBULANCE <input type="checkbox"/> GENERAL SERVICES <input type="checkbox"/> ICU <input type="checkbox"/> NICU <input type="checkbox"/> OPERATION ROOM DEVICES <input checked="" type="checkbox"/> ORTHOPEDICS <input type="checkbox"/> UROLOGY <input type="checkbox"/> CARDIOLOGY <input type="checkbox"/> GENERAL SURGERY <input type="checkbox"/> PAEDIATRIC <input type="checkbox"/> REMOVAL OF MEDICAL STITCH / SUTURE 	By Name: <input type="text"/> <input type="button" value="Clear Select List"/>

Order Detail	Selected Procedures																										
None BELOW ELBOW CAST --> 1 Time(s) One Per Week	<table border="1"> <thead> <tr> <th colspan="2">ORTHOPEDICS</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> PULLED ELBOW</td> <td>No. of Times <input type="text"/> One Per <input type="text"/></td> </tr> <tr> <td><input type="checkbox"/> BELOW KNEE CAST</td> <td>No. of Times <input type="text"/> One Per <input type="text"/></td> </tr> <tr> <td><input type="checkbox"/> BELOW KNEE CAST PED</td> <td>No. of Times <input type="text"/> One Per <input type="text"/></td> </tr> <tr> <td><input checked="" type="checkbox"/> BELOW ELBOW CAST</td> <td>No. of Times <input type="text" value="1"/> One Per <input type="text" value="Days"/></td> </tr> <tr> <td><input type="checkbox"/> BELOW ELBOW CAST PED</td> <td>No. of Times <input type="text"/> One Per <input type="text"/></td> </tr> <tr> <td><input type="checkbox"/> ABOVE KNEE CAST</td> <td>No. of Times <input type="text"/> One Per <input type="text"/></td> </tr> <tr> <td><input type="checkbox"/> ABOVE KNEE CAST PED</td> <td>No. of Times <input type="text"/> One Per <input type="text"/></td> </tr> <tr> <td><input type="checkbox"/> ABOVE ELBOW CAST ADULT</td> <td>No. of Times <input type="text"/> One Per <input type="text"/></td> </tr> <tr> <td><input type="checkbox"/> ABOVE ELBOW CAST PED</td> <td>No. of Times <input type="text"/> One Per <input type="text"/></td> </tr> <tr> <td><input type="checkbox"/> THOMAS SPLINT</td> <td>No. of Times <input type="text"/> One Per <input type="text"/></td> </tr> <tr> <td><input type="checkbox"/> LOCAL HEEL INJECTION</td> <td>No. of Times <input type="text"/> One Per <input type="text"/></td> </tr> <tr> <td><input type="checkbox"/> INTRA-ARTICULAR INJECTION</td> <td>No. of Times <input type="text"/> One Per <input type="text"/></td> </tr> </tbody> </table>	ORTHOPEDICS		<input type="checkbox"/> PULLED ELBOW	No. of Times <input type="text"/> One Per <input type="text"/>	<input type="checkbox"/> BELOW KNEE CAST	No. of Times <input type="text"/> One Per <input type="text"/>	<input type="checkbox"/> BELOW KNEE CAST PED	No. of Times <input type="text"/> One Per <input type="text"/>	<input checked="" type="checkbox"/> BELOW ELBOW CAST	No. of Times <input type="text" value="1"/> One Per <input type="text" value="Days"/>	<input type="checkbox"/> BELOW ELBOW CAST PED	No. of Times <input type="text"/> One Per <input type="text"/>	<input type="checkbox"/> ABOVE KNEE CAST	No. of Times <input type="text"/> One Per <input type="text"/>	<input type="checkbox"/> ABOVE KNEE CAST PED	No. of Times <input type="text"/> One Per <input type="text"/>	<input type="checkbox"/> ABOVE ELBOW CAST ADULT	No. of Times <input type="text"/> One Per <input type="text"/>	<input type="checkbox"/> ABOVE ELBOW CAST PED	No. of Times <input type="text"/> One Per <input type="text"/>	<input type="checkbox"/> THOMAS SPLINT	No. of Times <input type="text"/> One Per <input type="text"/>	<input type="checkbox"/> LOCAL HEEL INJECTION	No. of Times <input type="text"/> One Per <input type="text"/>	<input type="checkbox"/> INTRA-ARTICULAR INJECTION	No. of Times <input type="text"/> One Per <input type="text"/>
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Procedure order

ACTIVE MEDICAL SHEETS(AMS)

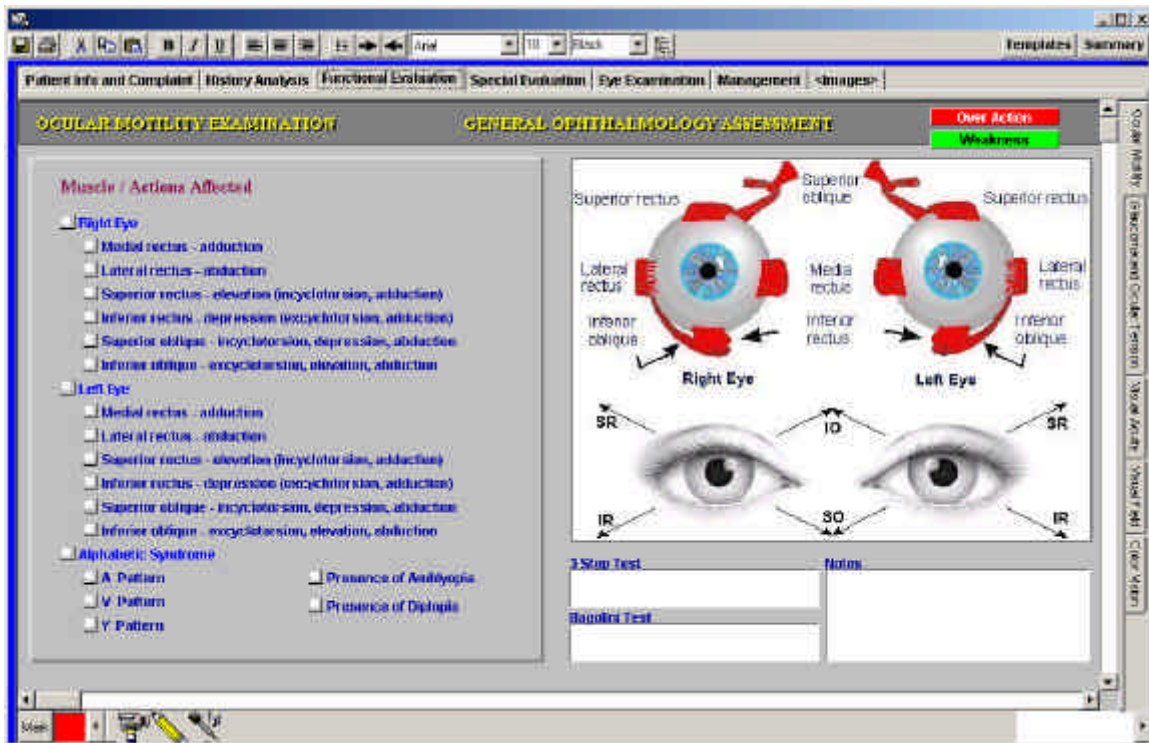
- MedicaPlus Active Medical Sheet Framework is utilized to design, create and accommodate knowledge-based information in the form of Clinical Pathways as well as standardized medical protocol browser whereby text, rich text or web URL pages can be configured under groups and sub-groups.
- The active medical sheets can be configured to view the specific relevant information within the context of the purpose of the medical sheet.
- Through the use of the medical record, the assigned medical sheets may be invoked to check the patient.
- All events/interventions in the medical record can be related to a patient problem.
- Encounter sheets are based on the Subjective/Objective/Assessment/Plan model, where by different tabs are designed to accommodate each stage of the **SOAP** model.
- **CPGs** are available through the use of supplied Active Medical Sheets for different specialties and sub-specialties. Other guidelines are also available as Clinical Pathway sheets for specific patient conditions. In addition, the Medical Protocol Browser component facilitates access to standard procedures/policies/guidelines from various parts of the system.
- **Clinical Pathways** are designed and maintained using the MedicaPlus Active Medical Sheet Framework, which is a general component that is extremely customizable.
- Active Medical Sheets shipped with different type of sheets with pre-defined fields to capture and record nursing notes, instructions, diagnosis, follow-up sheets, assessments, patient past history, vital signs, treatments, etc., for each patient. All records in the encounter sheets are automatically recorded to the electronic medical record
- All past events prior to any patient encounter with the hospital are recorded in the patient history sheet.
- The history sheet allows the configuration of data elements including past history to be encoded in any desired nomenclature.
- Active Medical Sheets can be used to create different medical specialties components. Medical encounter sheets; which plays the key role in patient's clinical assessment such as cardiology assessment sheets, ophthalmology, orthopedics, pediatrics, and labor records.
- Medical follow up sheets; with records to follow patient's medical condition e.g. intra operative assessment flow charts or physiological progress e.g. ante natal assessment record with multiple visits recording and comparative data gathering helping obstetricians to decide best lines of treatment and second steps to be done.

MEDICAL SPECIALTIES

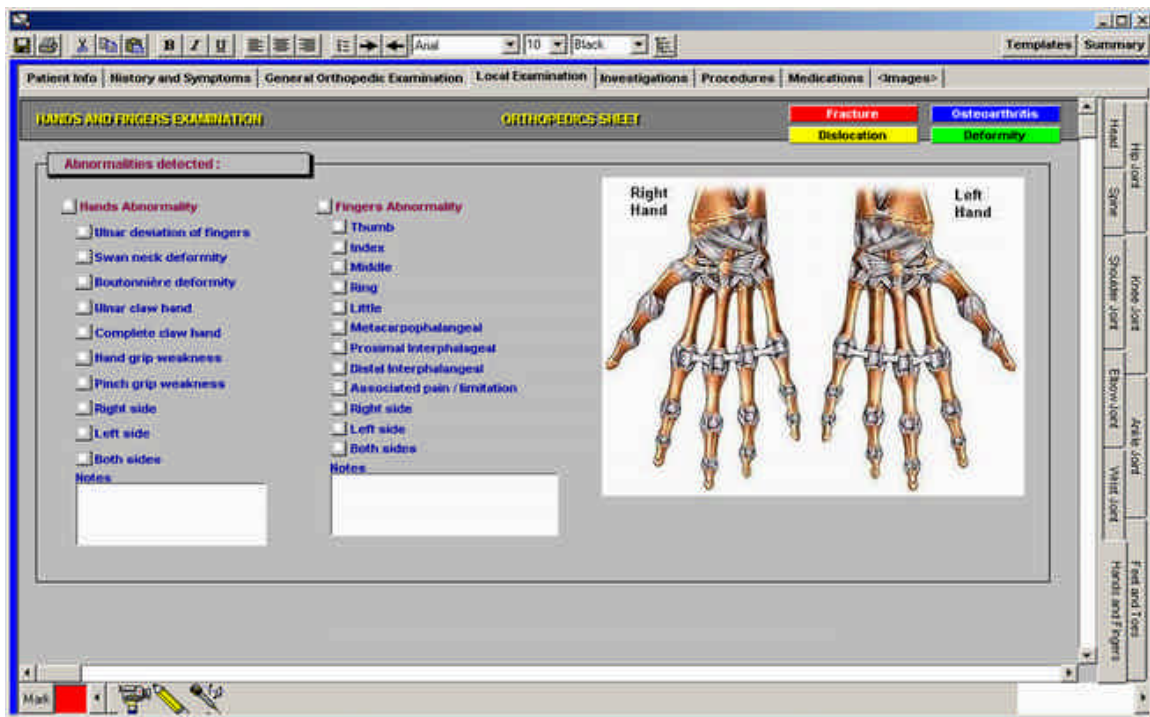
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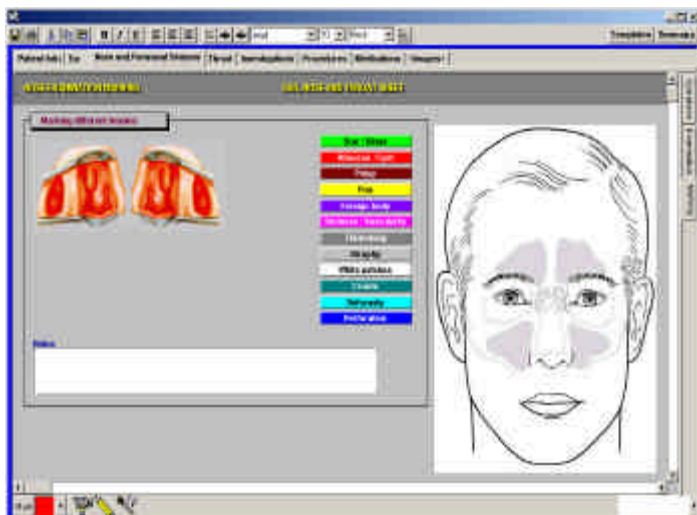
DICOM images

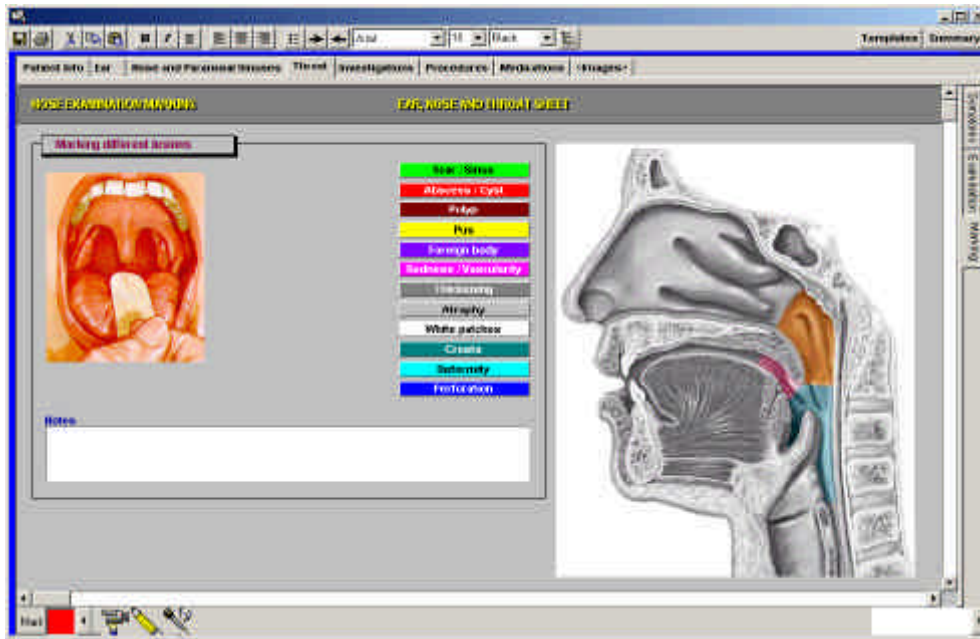


Ocular motility assessment sheet

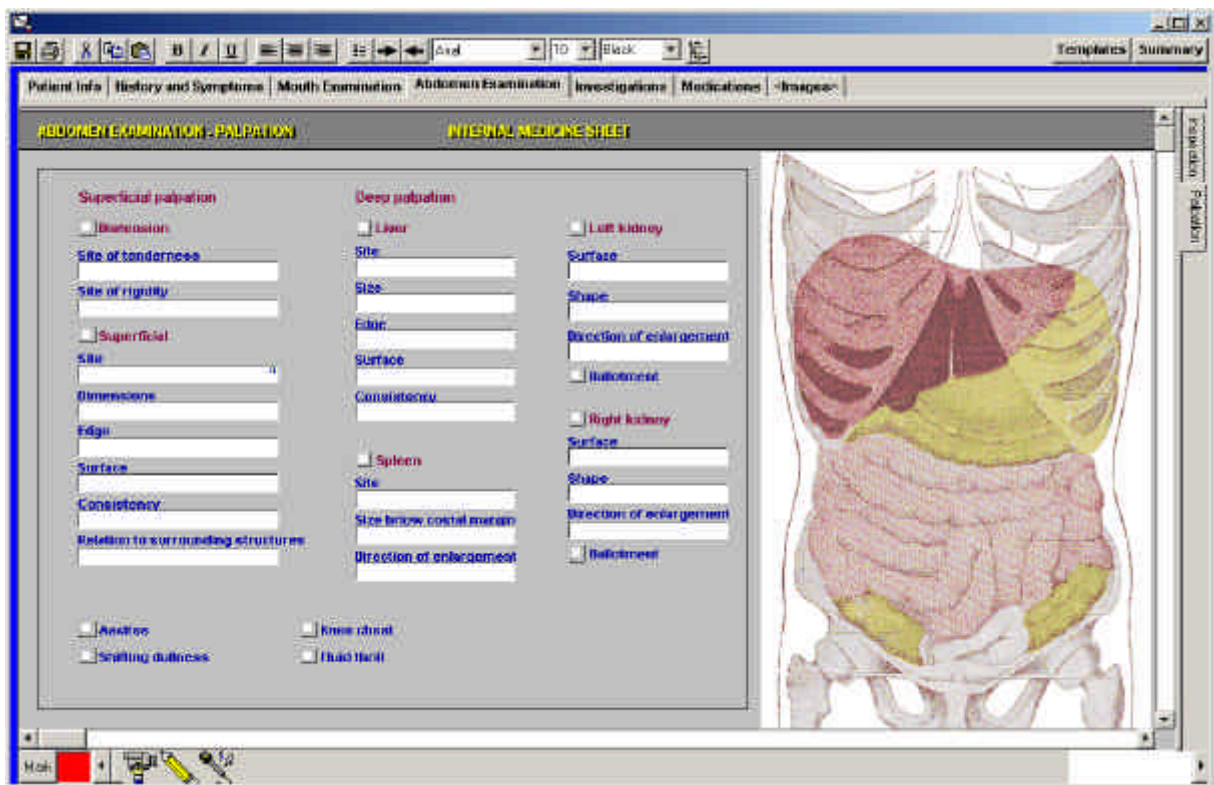


Hand joints examination

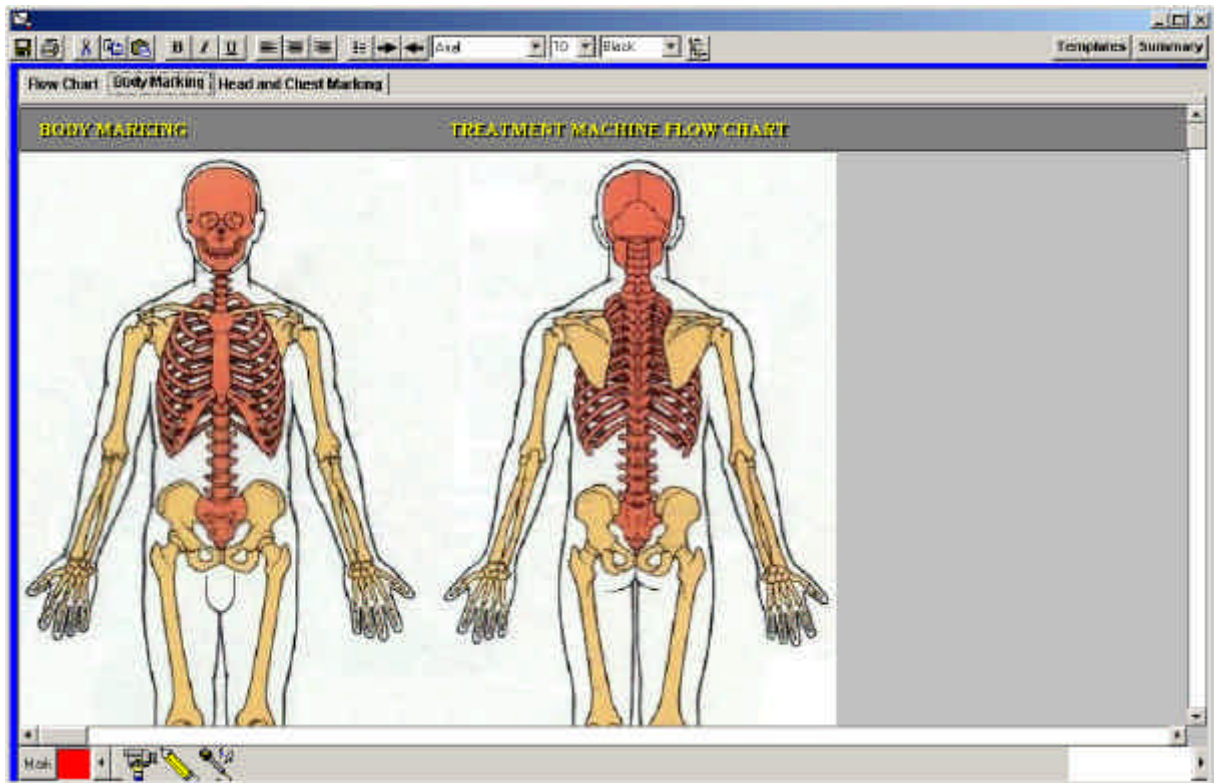




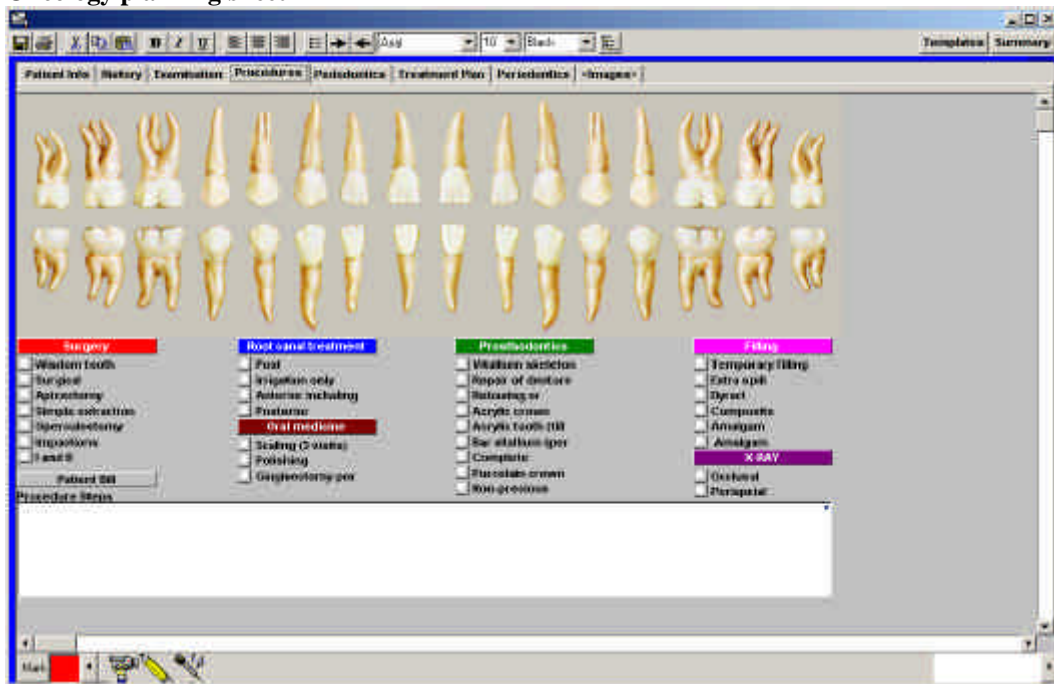
ENT Sheets



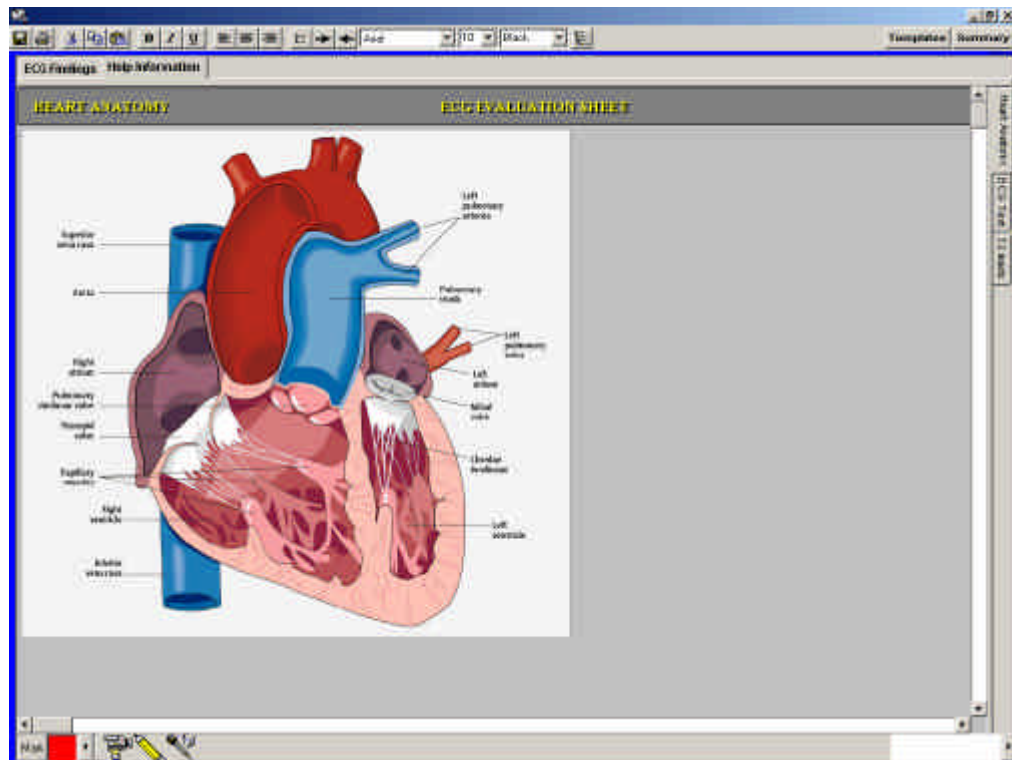
Internal Medicine sheet



Oncology planning sheet



Dentistry sheet



Cardiology / ECG assessment

Please refer to the MedicaPlus Active Medical Sheet documentation for further description of the medical sheet Specialists.

OPERATION HISTORY & OPERATIVE NOTES VIEWING

Medical Records personnel have the ability to Schedule / View a list of all operations conducted on a certain patient. In addition, the various operative notes (including pre, intra and post-operative notes) for each operation may be filled, viewed and printed.

Surgery Schedule

Operative reports are available for all surgical procedures in the form of user definable active medical sheets. They include pre-operative assessment data, holding area data, post anesthesia recovery room data, anesthesia records/notes and intra-operative data. Additional surgery specific registry sheets are available for more detailed information on select types of surgeries or to accommodate linking to international registries. The system even allows for incorporating existing paper forms for operative records as a background for the electronic operative notes while super-imposing intelligent fields on top to capture data in a streamlined manner. This technique helps maintain the familiarity of users with the screens they are accustomed on using manually.

Andalus 10 Black Summary

Pre-Operative Anaesthesia Intra-Operative Recovery

ANAESTHETIST:

Times				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepare Pt.	Induce Anes.	Leave O.R.	Rec. Rm.	General	Regional	Monitor

PRE OP DIAG.

POST OP DIAG.

PROCEDURE (MAJOR PROC. FIRST)

Invasive Monitoring (Circle)
A-Line PA CVP

		(24 hr system) Time												TOTAL	
AGE	A G E N T S	02													
SEX															
HT															
WT															
HCT															
PHYS. STATUS															
ECG															
CH X-RAY															
TIME RECENT MEAL															

BLOOD LOSS

Mark

Sample Aesthesia Record

BLOOD TRANSFUSION HISTORY VIEWING

The MedicaPlus Online Medical Record displays a list of all blood transfusions conducted for the active patient. Information displayed includes the following:

- Patient name
- Patient location within the hospital
- Patient blood group
- Patient RH Factor
- Number of whole blood units transfused
- Number of FFP units transfused
- Number of PLTC units transfused
- Number of PRC units transfused
- Number of CRYO units transfused

Transfusion Order

PID

Bed

Blood Group

RH Factor

Type	No. of units
Whole Blood	<input type="text"/>
FFP	<input type="text"/>
PLTC	<input type="text"/>
PRC	<input type="text"/>
CRYO	<input type="text"/>

PATIENT PROFILE

The MedicaPlus patient profile is a handy application which provides instant and dynamically updated information on the active patient. The application has been configured to be informative by providing the user with some of the most commonly requested patient information such as the following:

- ID (Case number)
- Name
- Age
- Weight
- Height
- Body Surface Area (BSA)
- Specialty
- Diagnosis
- Other Diseases
- Diet
- Allergies
- Treating Physician

The Patient Profile appears at the top of all MedicaPlus clinical modules, thus serving as a practical and easy to access tool.

MEDICAL RECORD APPLICATION

PID	4748 YASSEN MOHAMED EL MELEGY -	Age	15 Y(s) 2 M(s) 10 D(s) Male	Specialty	CHEST
BED	BED 610/1 (Companion)	WT	167 HT 45 BSA 0	Nationality	Citizen
Diganosis		Other Diseases		Acuity Level	0
Diet	Not yet set	Allergies		Doctor	MOHAMED S. SOUROUR

<ul style="list-style-type: none"> Exit List Patients Search Discharge Details >> 	Episodes Inpatient 16/07/2004 to
--	-------------------------------------

New Patient Problem(s) Blood Transfusion Request(s) Basic data My view data Medical Sheet/Form(s) Investigation Request(s) Medication Prescription(s) Medical Procedure(s) Schedule a Surgery(s)	SPECIALIST CALL INSIDE THE HOSPITAL (INPATIENT) ♦ Session Number 1 Done at: 07/17/2004 By: AHMED ABDEL AZIZ GHANEM
---	---

Description	Date/Time
SPECIALIST CALL INSIDE THE HOSPIT...	Sat, 17/07/2004-15:15
CONSULTANT CALL FROM OUTSIDE T...	Fri, 16/07/2004-17:15

ATEVENING

PATIENT BIO-DATA

The Online Medical Record application displays a patient's bio-data, including demographic and biographic data. The Patient Bio Data window provides a detailed view of the information displayed in the Patient Profile .

The screenshot shows a window titled "Patient Bio Data" with a blue header. The main area contains the following fields:

- Patient Name: ABD EL-AAL MOHAMMED ALSOGHAIR .
- Date Of Birth: 26/06/1946 (with a dropdown arrow)
- Weight : 80
- Height : 170
- Surface Area: 3

Below the data fields is a grid of buttons for navigation:

- Diet Orders
- Allergies
- Other Diseases
- Diagnosis
- Patient Acuity
- Inpatient Admission
- Transfer Order
- Discharge Order

Below the grid is a button labeled "Change Treating Doctor". At the bottom of the window are "Ok" and "Close" buttons.

PATIENT VITAL SIGNS

During examination of the patient, MedicaPlus gives physicians the ability to record various Vital Signs readings. This includes measurements of Temperature, Blood Pressure, Pulse Rate and Respiratory Rate. Medical Records personnel have the ability to view Vital Signs recordings, which are graphically charted to provide an intuitive display of the patient's case development.

MEDICAL RECORD APPLICATION

PID 4748 YASSEN MOHAMED EL MELEGY - Age 15 Y(s) 2 M(s) 10 D(s) Male Specialty CHEST
 BED BED 610/1 (Companion) WT 167 HT 45 BSA 0 Nationality Citizen
 Diagnosis Other Diseases Acuity Level 0
 Diet Not yet set Allergies Doctor MOHAMED S. SOUROUR

Episodes Inpatient 16/07/2004 to

Investigation Request(s) Medication Prescription(s)
 Medical Procedure(s) Schedule a Surgery(s)
 New Patient Problem(s) Blood Transfusion Request(s)
 Basic data My view data Medical Sheet/Form(s)

Description	Date/Time
Admission Sheet	
BIO Data	
Vital Signs	
REMOVAL OF INTERNAL FIXATION OF A...	Sun, 25/07/2004-18:46
CHEST & HEART PA	Sat, 17/07/2004-20:09
NURSING NOTES	Sat, 17/07/2004-19:28
SPECIALIST CALL INSIDE THE HOSPIT...	Sat, 17/07/2004-15:15
NURSING NOTES	Sat, 17/07/2004-07:23
CBC	Fri, 16/07/2004-17:41
CONSULTANT CALL FROM OUTSIDE T...	Fri, 16/07/2004-17:15
NURSING NOTES	Fri, 16/07/2004-17:11
NURSING NOTES	Fri, 16/07/2004-14:13
ROCEPHIN IV 1 GM VIALS	Fri, 16/07/2004-13:22

Remove Add

Temperature 25/07/2004

Time	Temperature
12:00 AM	37.625
01:00 AM	38.5
02:00 AM	37.625

Blood Pressure 25/07/2004

Time	Systolic	Diastolic
12:00 AM	120	80
12:15 AM	120	80
12:30 AM	120	80

Pulse Rate 25/07/2004

Time	Pulse Rate
12:00 AM	70
01:00 AM	70
03:00 AM	70
04:45 AM	70

Respiratory Rate 25/07/2004

Time	Respiratory Rate
12:00 AM	16
01:00 AM	16
03:00 AM	16
04:45 AM	16

PREVIOUS EPISODE REFERENCE

Previous episode and visit data are kept available in the Online Medical Record for future reference. Each episode contains all patient data recorded during his/her stay or visit in a read-only format. Events can be sorted by problem/diagnosis, chronologically or by event type (e.g. encounter sheets, problems, diagnostic investigations, medication prescriptions, surgeries, etc.).

MEDICAL RECORD APPLICATION

PID	4653 FATMA MOHAMMED ALAAM .	Age	54 Y(s) 0 M(s) 11 D(s) Female	Specialty	CHEST
BED	BED 201 - 3	WT	0	HT	0
Diagnosis		BSA	0	Nationality	Citizen
Diet	Not yet set	Other Diseases		Acuity Level	0
		Allergies		Doctor	MOHAMED S. SOUROUR

Exit List Patients Search Discharge Details >> Configuration View and Print Re Order Cancel

Episodes: Inpatient 14/07/2004 to Outpatient at: 17-EMERGENCY CLINIC 14/07/2004 to 14/07/2004

Investigation Request(s)	Medication Prescription(s)	Created on 15/07/2004 21:16 by doctor MOHAMED MOSTAFA ABD ELSALAM
Medical Procedure(s)	Schedule a Surgery(s)	Date: 15/07/2004 21:16 by doctor Unknown
New Patient Problem(s)	Blood Transfusion Request(s)	THE PT IS CONSCIOUS COOPRATIVE
Basic data	My view data	V/S STABLE
	Medical Sheet/Form(s)	CHEST FINE LETHARY CRIPITATION

Description	Date/Time	
Admission Sheet		
BIO Data		
Vital Signs		
CULTURE & ANTIBIOGRAM	Sun, 18/07/2004-07:53	Created on 16/07/2004 09:50 by doctor MOHAMED MOSTAFA ABD ELSALAM
NEBULIZER SET ONCE	Sun, 18/07/2004-05:19	Date: 16/07/2004 09:50 by doctor Unknown
NEBULIZER SET ONCE	Sun, 18/07/2004-05:19	the pt is conscious but hallucination
RINGER SOLUTION OTSUKA	Sun, 18/07/2004-01:00	vis stable
BISOLVON AMP	Sun, 18/07/2004-01:00	chest lethary cripitations
FORTECORTIN AMP	Sun, 18/07/2004-00:13	on ventory 60% yesterday was 40
CLEXANE 40 MG SYRING	Sun, 18/07/2004-00:11	ABC was ordered
SODIUM BICARB.8.4 AMP	Sat, 17/07/2004-20:33	dr salseh srour said no need for mv]
DEXAMETHASONE AMP	Sat, 17/07/2004-20:33	Created on 17/07/2004 06:45 by doctor MONTASER FAROUK ABU EL YAZID
CLEXANE 40 MG SYRING	Sat, 17/07/2004-20:33	CONSIUOS , ORIENTED
ZYLORIC 100 MG TAB	Sat, 17/07/2004-20:33	ON VENTORI 60% 502 97%
NORMAL SALINE 0.9% 500ML OTSUKA	Sat, 17/07/2004-20:33	CHEST LETHARY CREPITATION
CONSULTANT CALL FROM OUTSIDE T...	Sat, 17/07/2004-19:30	
BLOOD GASES/ONCE	Sat, 17/07/2004-18:33	
NURSING NOTES	Sat, 17/07/2004-14:59	
SELECTIVAL TAB.	Sat, 17/07/2004-14:34	

CHART MANAGEMENT

The chart management system is embedded within the MedicaPlus Online Medical Record. The system keeps track of all data entered for the patient and gives alerts in case of incomplete data (i.e. missing pre-admission investigations, incomplete orders, etc).

Most of the chart data is entered automatically as the users of the system add data to the patient.

The system has the ability to generate various reports for chart management. These reports may be generated on-demand or as per a pre-defined schedule. Reports may then be elevated to concerned staff (i.e. department heads, hospital management and administration, etc)

PROBLEM ORIENTED MEDICAL RECORD AND SOAP

MedicaPlus allows users to associate events (such as investigations, medication prescriptions, procedures, etc) to identified patient problems. In doing so, the Online Medical Record allows for convenient viewing of all events per specific problem if needed.

All events/interventions in the medical record can be related to a patient problem. Encounter sheets are based on the Subjective/Objective/Assessment/Plan model, where by different tabs are designed to accommodate each stage of the SOAP model.

Patient Problem List

PID	4653 FATMA MOHAMMED ALAAM	Age	54 Y(s) 0 M(s) 11 D(s) Female	Specialty	CHEST
BED	BED 201 - 3	WT	0	HT	0
Diagnosis		BSA	0	Nationality	Citizen
Diet	Not yet set	Other Diseases		Acuity Level	0
Diagnosis		Allergies		Doctor	MOHAMED S. SOUROUR

Patient type Private

ICD Diagnosis

- PROCREATIVE MANAGEMENT
- OUTCOME OF DELIVERY
- ANTENATAL SCREENING
- OBSERVATION AND EVALUATION OF NEWBORNS AND INFANTS FOR SUSPECTED CONDITION NO
- HEALTH SUPERVISION OF INFANT OR CHILD
- CONSTITUTIONAL STATES IN DEVELOPMENT
- NORMAL PREGNANCY
- SUPERVISION OF HIGH-RISK PREGNANCY
- POSTPARTUM CARE AND EXAMINATION
- CONTRACEPTIVE MANAGEMENT
- PROCREATIVE MANAGEMENT
- OUTCOME OF DELIVERY
- ANTENATAL SCREENING
- OBSERVATION AND EVALUATION OF NEWBORNS AND INFANTS FOR SUSPECTED CONDITION NO
- LIVEBORN INFANTS ACCORDING TO TYPE OF BIRTH (V30-V39)
- PERSONS WITH A CONDITION INFLUENCING THEIR HEALTH STATUS (V40-V49)
- PERSONS ENCOUNTERING HEALTH SERVICES FOR SPECIFIC PROCEDURES AND AFTERCARE (V50-V59)
- PERSONS ENCOUNTERING HEALTH SERVICES IN OTHER CIRCUMSTANCES (V60-V69)
- PERSONS WITHOUT REPORTED DIAGNOSIS ENCOUNTERED DURING EXAMINATION AND INVESTIGATION C
- GENERAL MEDICAL EXAMINATION
- OBSERVATION AND EVALUATION FOR SUSPECTED CONDITIONS NOT FOUND
- SPECIAL INVESTIGATIONS AND EXAMINATIONS
- SPECIAL SCREENING EXAMINATION FOR VIRAL AND CHLAMYDIAL DISEASES
- SPECIAL SCREENING EXAMINATION FOR BACTERIAL AND SPIROCHETAL DISEASES
- SPECIAL SCREENING EXAMINATION FOR OTHER INFECTIOUS DISEASES
- SPECIAL SCREENING FOR MALIGNANT NEOPLASMS
- SPECIAL SCREENING FOR ENDOCRINE, NUTRITIONAL, METABOLIC, AND IMMUNITY DISORDERS
- SPECIAL SCREENING FOR DISORDERS OF BLOOD AND BLOOD-FORMING ORGANS
- SCREENING FOR IRON DEFICIENCY ANEMIA
- SCREENING FOR OTHER AND UNSPECIFIED DEFICIENCY ANEMIA
- SCREENING FOR SICKLE-CELL DISEASE OR TRAIT
- SCREENING FOR OTHER HEMOGLOBINOPATHIES
- SCREENING FOR OTHER DISORDERS OF BLOOD AND BLOOD-FORMING ORGANS
- SCREENING FOR UNSPECIFIED DISORDER OF BLOOD AND BLOOD-FORMING ORGANS

Search

Selected Problem(s)

- SCREENING FOR OTHER AND UNSPECIFIED DEFICIENCY ANEMIA
- SCREENING FOR SICKLE-CELL DISEASE OR TRAIT

Close Confirm

CASE SUMMARY

This feature displays a brief summarization of the active patient's case without the need to open each individual event on file. Case summaries are based on summaries of encounter sheets and follow up sheets for the patient during the episode in addition to admission information, diagnostic procedures (laboratory test results, radiology reports, medications, medical procedures and surgeries..

4653 FATMA MOHAMMED ALAAM.			
PID	4653 FATMA MOHAMMED ALAAM.	Age 54Y(s) 0 M(s) 11 D(s) Female	Specialty CHEST
BED	BED 201-3	WT 0 HT 0 BSA 0	Nationality Citizen
Diganosis		Other Diseases	Acuity Level 0
Diet	Notyet set	Allergies	Doctor MOHAMED S. SOUROUR

Print Case Summary Refresh

PID 4653 FATMA MOHAMMED ALAAM .
Patient came to the hospital at:14/07/2004

Patient was suffering from the following problems

(1) SCREENING FOR OTHER AND UNSPECIFIED DEFICIENCY ANEMIA
(1) SCREENING FOR SICKLE-CELL DISEASE OR TRAIT

These are the investigations ordered for the patient

S. CREATININE

Result Description	Result Value	Status	Normal Range
S. CREATININE	2.6		

BI. UREA

Result Description	Result Value	Status	Normal Range
BI. UREA	70		

S. URIC ACID

Result Description	Result Value	Status	Normal Range
S. URIC ACID	9		

CBC

Result Description	Result Value	Status	Normal Range
HEMOGLOBIN (Hb)	11.0		

PATIENT CHARTING

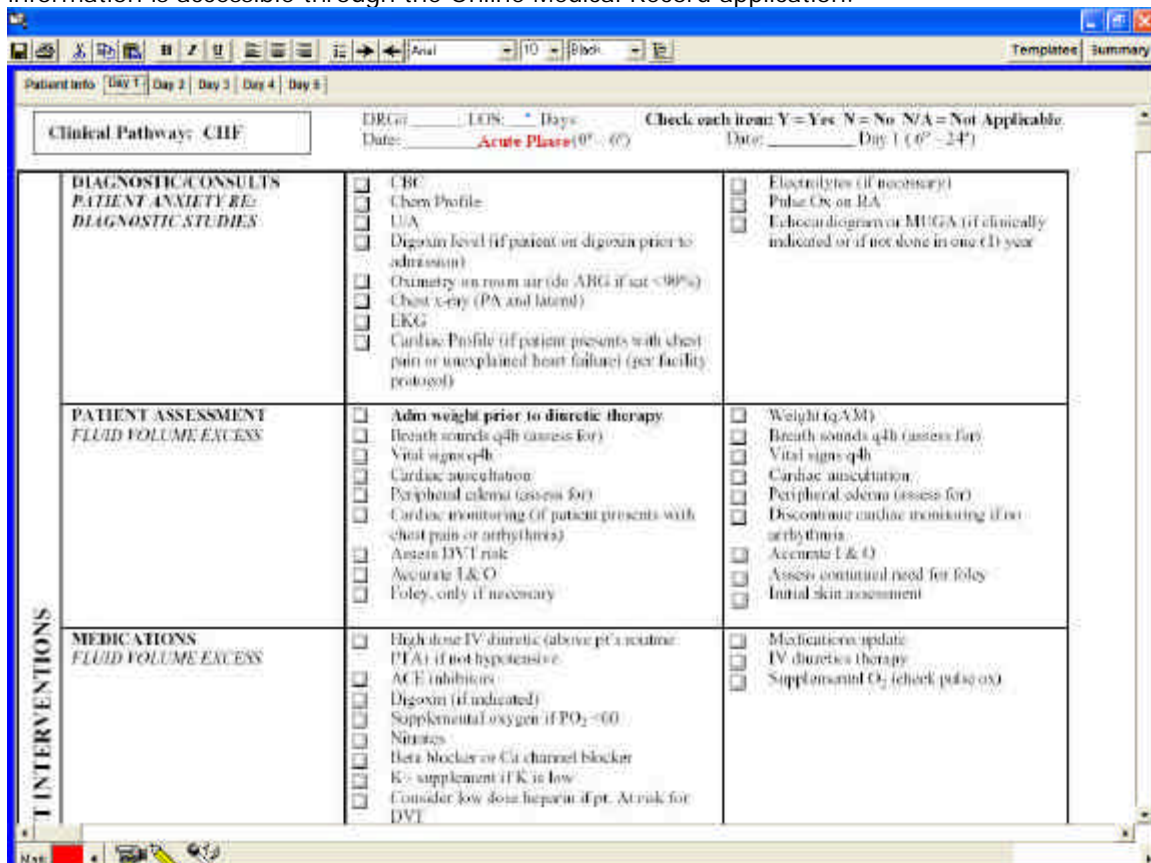
Provides an episode summary for the selected patient based on summaries of encounter sheets during the episode.

Ability to record and display patient vital signs.

- Ability to record and display patient allergies.
- Ability to record and display patient chronic diseases.
- Ability to record and display patient provisional and final diagnosis.
- Ability to add and record encounter sheets from a variety of hospital definable encounter sheets. Encounter sheets may include history, complaints, symptoms, examination (general and local), investigations (including laboratory, radiology, etc), medical procedures and medication prescriptions. Summaries of the encounter sheets constitute the episode summary.
- Follow up sheets are created automatically based on the most recent encounter sheet and its data.
- Ability to examine the online medical record of the patient and view previous episodes including all their detailed events and services

Clinical Pathways

Ability to add a hospital defined specific clinical pathway to a patient in an open episode. Clinical pathways are diagnosis, condition or procedure related protocols that are based on accumulated knowledge and/or statistics. They might include diagnostic studies, consults, patient assessment, medications; activity related protocols, nutrition, psycho/social/spiritual requirements, health teaching as well as discharge planning. Medical practitioners may override the pathway settings if so wished. Procedures are automatically dispatched from the clinical pathway to the appropriate departments when selected by the user. Custom pathways can be developed by the hospital to fit its own environment. Once designed, such pathways would be available for immediate use by the hospital staff. This information is accessible through the Online Medical Record application.



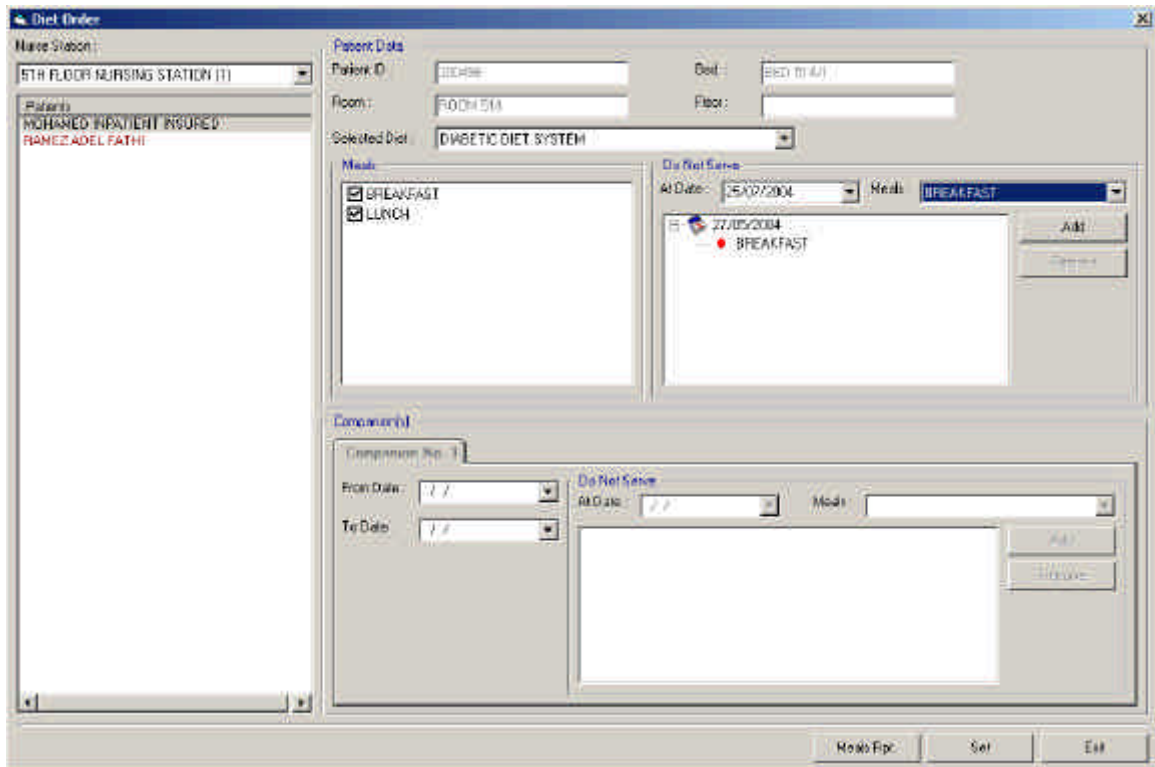
DIETARY INFORMATION / ORDER

The Online Medical Record application displays the type of diet on which the patient was put during the selected episode.

Diet Order is where the physicians/nurses are allowed to assign patients to the diet systems defined previously. Also, they are given the capability of defining exclusion days on which patients will not going to have specific meals as a result of having a surgery for example.

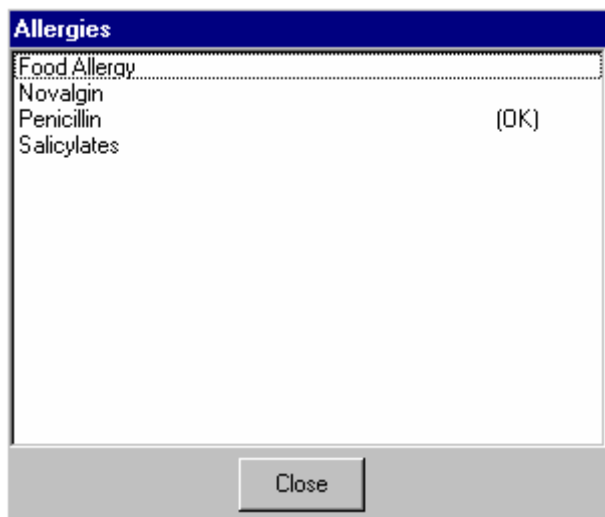
Diet Order module assigns, by default, patient's companions to the default diet systems but the physician/nurse is still able to define exclusion days for these companions as well.

The type of diet differs according to the patient's condition.



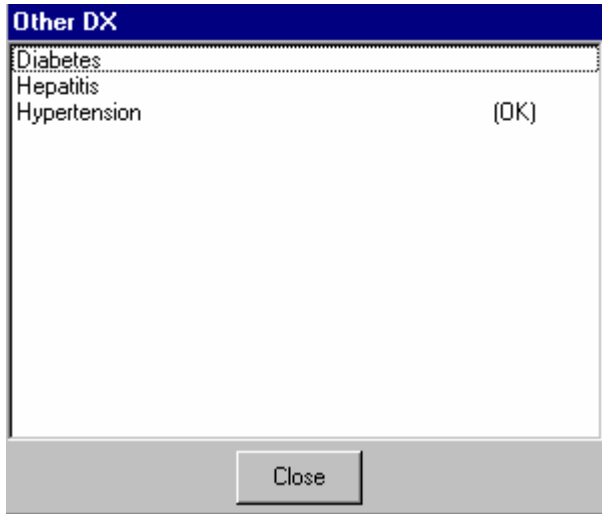
PATIENT ALLERGIES

This feature displays the various allergies which were specified by the patient's treating doctor at the time of examination.



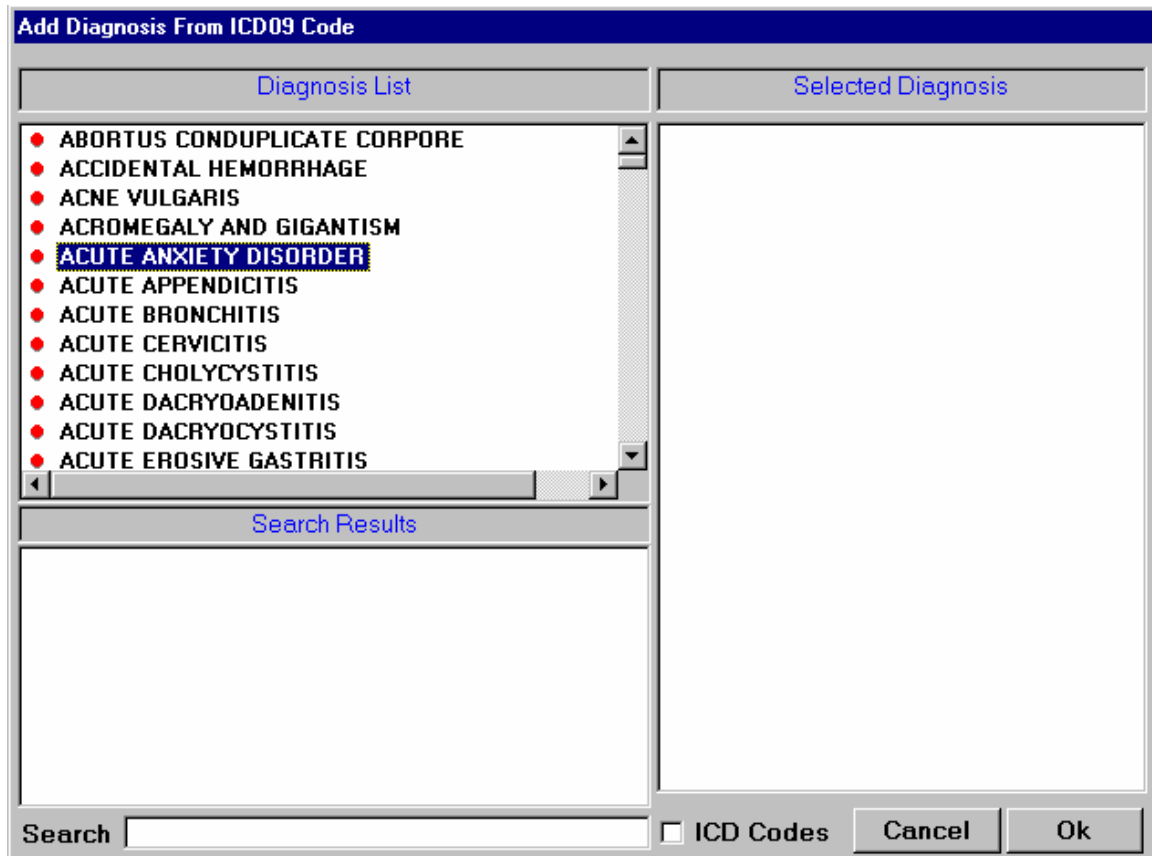
PATIENT CHRONIC DISEASES

This feature displays the diseases which the patient was determined as having by the treating doctor at the time of examination.



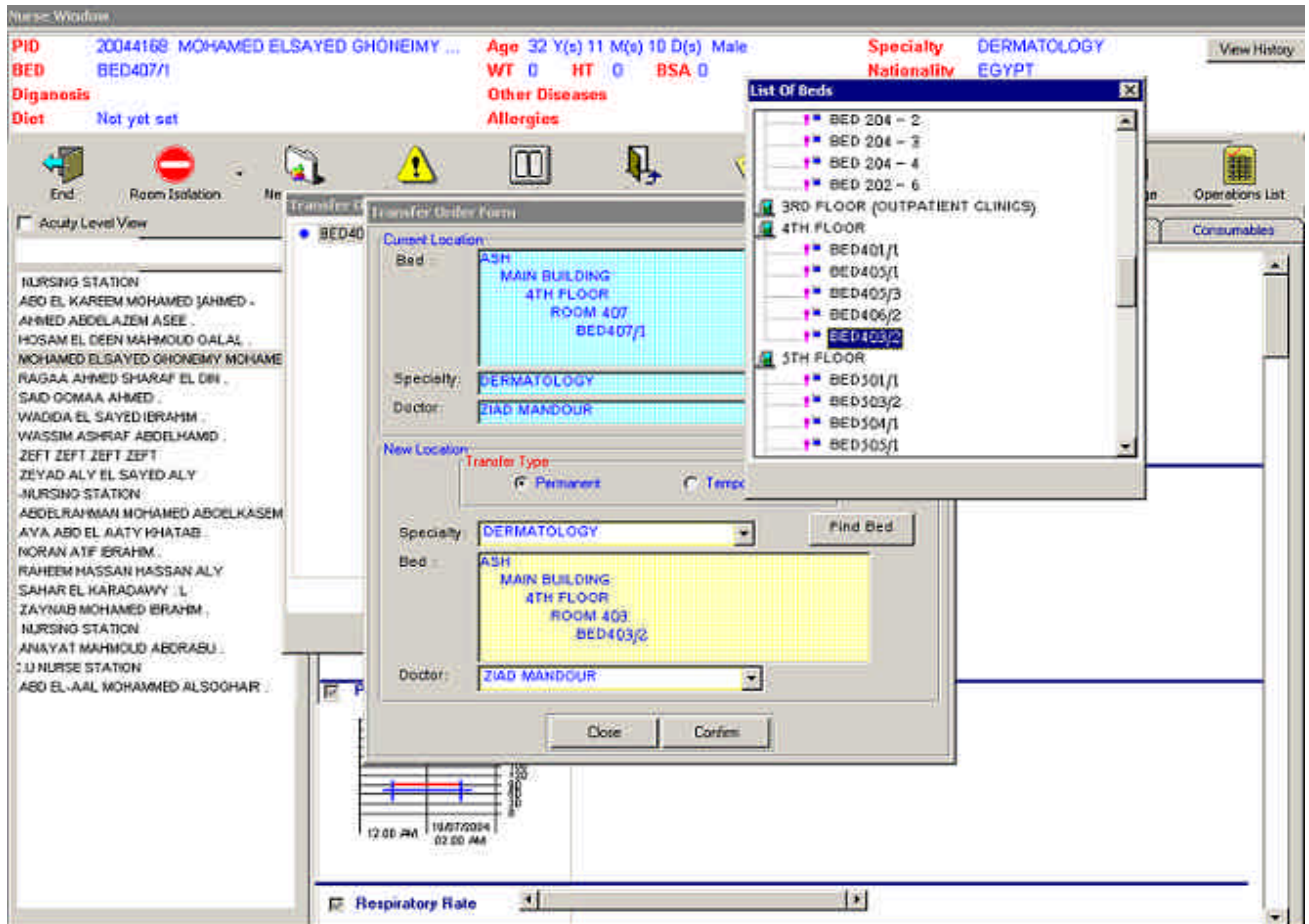
DIAGNOSES

The Online Medical Record displays the various diagnoses which were added to the patient's record by the treating physician. The diagnosis record may contain provisional and final diagnoses and are relevant to the selected episode within the patient's file. Both ICD9-CM or ICD10-AM are supported. In addition, hospital local diagnosis codes are also supported.



PATIENT TRANSFERS

The Online Medical Record contains a history of the transfers which the patient had undergone during a given episode. This includes information about the location, date, physician and specialty involved in the transfer process.



DISCHARGE ORDERS

The Medical Records department has access to a list of discharged patients and the discharge status for each patient as specified by the treating doctor at the time of discharge.

Discharge process is done in two steps:

- The discharge ordering which enables all concerned department to finalize all the outstanding issues by alerting them using the Tickler Module.
- Confirming the patient discharge is done through the Discharge List component which contains the list of all patients marked for discharge.

The screenshot shows a web-based medical form for a discharge order. The interface includes a toolbar at the top with standard editing tools and a menu bar with 'Templates' and 'Summary'. The main content area is divided into several sections:

- Patient Medical Data:**
 - Provisional Diagnosis on Admission:** Acute abdomen (النشخيص الإبتدائي عند الدخول)
 - Definitive Diagnosis on Discharge:** Appendicular abscess (النشخيص النهائي)
 - Associated Conditions:** Peptic ulcer (الأمراض المصاحبة)
 - Surgical Operations:** Appendectomy (العشبات الجراحية)
 - Medications and Therapeutic Procedures:** IV Antibiotics and analgesics (الإجراء العلاجي والأدوية)
 - Medications Allergies:** Penicillin (الحساسية للأدوية)
 - Procedures:** Guided Biopsy, Arterial Catheter, Endoscopy, Ureteric Catheter, CVP, and others (الإجراءات التداخلية)
- Risk Factors:** Diabetes
- Specific Tests Results:** CBC, leucocytosis, ESR; raised (نتائج أبحاث ذات مؤثر)
- Discharge Medications and Recommendations:** Home follow up (التوصيات وخطة العلاج)
- General Notes:** bed rest for 1 week (ملاحظات أخرى)

There are also several checkboxes for patient status and follow-up, such as 'Traumatic', 'Inflammatory', 'Congenital', 'Immunologic', 'Haematologic', 'Neoplastic', 'Parasitic', 'Metabolic', 'Hereditary', and '!!!!!!'. Additional checkboxes include 'متابعة', 'شفاء', 'حسب الطلب', 'وفاة', 'نحسن', and 'مزمّن'.

Discharge Request (Discharge sheet; is a routine check up step done to patients before they leave the hospital. definite diagnosis, home care instructions, medications and warning signs are included in this sheet type)

The doctor can then print the discharge status summary for a specific patient from the list. If the patient's account was not balanced, the system will refuse to process the discharge function. All transactions that are occurred on the patient location are traced and archived on the system, accordingly, the bed occupancy are well managed.

The screenshot shows a window titled "Discharge List" with a table containing three rows of patient data. The third row is highlighted in blue. An error dialog box titled "Medica Plus Alert" is overlaid on the window, displaying an information icon and the message: "Patient Bill Not Balanced. The system can't discharge the patient." The dialog box has an "OK" button. At the bottom of the "Discharge List" window, there are "Close" and "Discharge Patient" buttons.

Order Date	Patient Name	Account
20/07/2004	[20044168] MOHAMED ELSAYED GHONEIMY MOHAMED	Not Balanced
21/07/2004	[20044169] ZEFT ZEFT ZEFT ZEFT	Balanced
21/07/2004	[4099] AYA ABD EL AATY KHATAB .	Not Balanced

Discharge list (Confirming the request for discharge)

CHART TRACKING TOOL

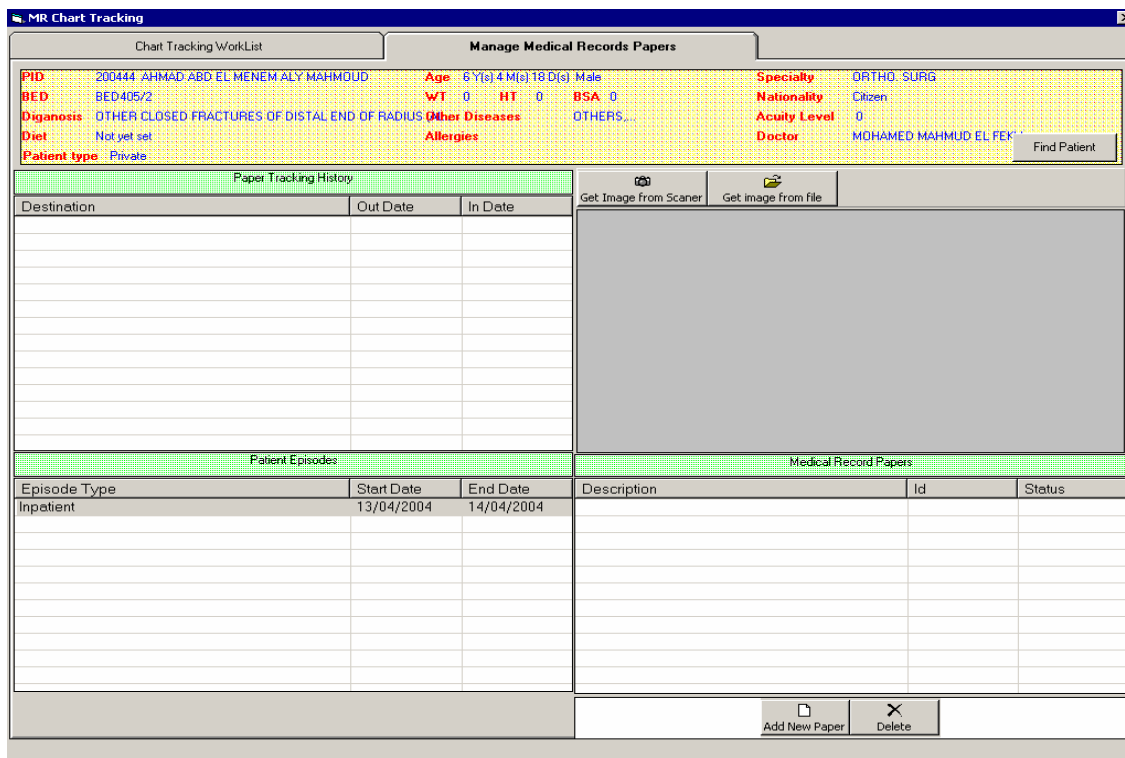
The Chart Tracking tool enables the Medical Records department to keep track of the physical movement of any paper file throughout the hospital.

The chart management system is embedded within the MedicaPlus Online Medical Record. The system keeps track of all data entered for the patient and gives alerts in case of incomplete data (i.e. missing pre-admission investigations, incomplete orders, etc).

Most of the chart data is entered automatically as the users of the system add data to the patient.

The system has the ability to generate various reports for chart management. These reports may be generated on-demand or as per a pre-defined schedule. Reports may then be elevated to concerned staff (i.e. department heads, hospital management and administration, etc)

- Medical Record History:
Ability to view the previous and current status of the patient's Medical record to find out the location of the medical record for the current episode.
- Episode Information Editing:
Ability to edit patient's episode information to complete missing data.
- Pass in and out Medical Record:
Ability to pass in a medical record for a certain entity.
- Support for existing scanned paper documents



REORDERING

The system allow for easy reordering for stopped / cancelled medications, procedures and investigations without reentering same data again(Ex: Drug order dose, duration)

Sheet Orders Entry

Problem Description	Date/Time
SCREENING FOR OTHER AND UNSPE...	25/07 07:08 PM
SCREENING FOR SICKLE-CELL DISE...	25/07 07:08 PM

Drug Order

BISOLVON AMP

Dose: 1 AMP

For: 12 Hour(s)

Every: 1 Day(s)

Order Notes

Cancel Confirm