

HIMS | Specialties & Ancillaries

MOTHER & BABY DOCUMENTATION

The need is the beginning of the story

Most healthcare facilities have unique Mother-Baby Programs which require extensive documentation of the care of mothers and infants through labour and delivery. This includes the need for inter-professional documentation, medication management, inter-professional communication, linking of mother and infant(s) records, integration with fetal monitoring and other monitoring devices, and use of protocols and any other functionality that would benefit the Mother-Baby Program. These capabilities are not generally available in EMR and hence there is a need for a custom module that supports the use of related protocols and workflows including how information is presented to clinicians for assessment including graphing, normal ranges, suggested actions, interprofessional communication and interprofessional documentation.

About the module

The Mother and Baby module of Harris Flex is implemented in the Maternal / Labor / Delivery / Neonatal Intensive Care Units. Documentation during all phases of delivery are captured in this module.

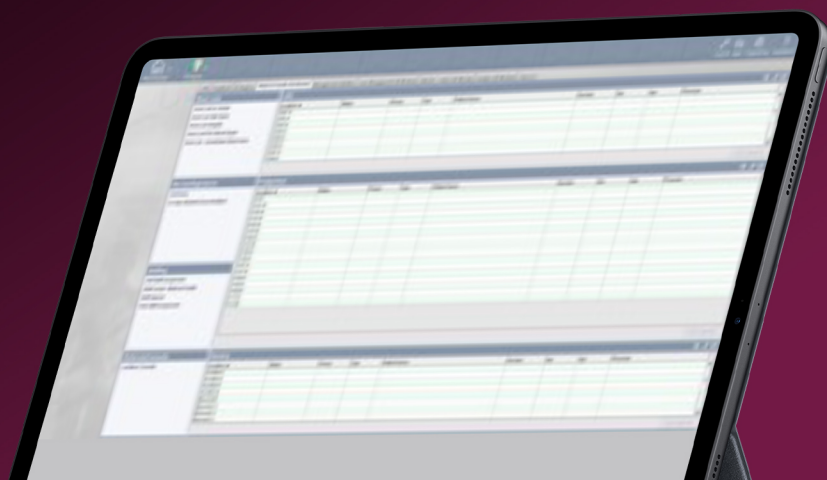
The functionality available in Flex for the hospital will also be available for the Maternal and Child Care areas and be fully integrated with the EHR. These include Registration/ADT, Laboratory, Radiology, Pharmacy, Provider Inbox, Interactive Care Grid, Order Entry/ CPOE, Clinical Documentation, Chart Review, Result Review, Problem List, Medication profile, Nursing Documentation, Physician Documentation, Charge/Credit Processor, Email, Printer control, Provider Assignment, Work-lists, Reports, Clinical Decision Support, Medication Reconciliation, Reports, Patient Education, Transition of Care documentation etc.

The Newborn registration function is used to register the baby(s) and link a mother's registration record to her newborn child's record. The flexible flowsheet configuration allows for the display of all clinical parameters required for the critical care areas including hemodynamics, respiratory parameters, intake & output, and vital signs.

The module includes a summary screen that displays all the relevant obstetrical information such as obstetric history, current obstetric status etc. for a streamlined view of key intrapartum information. Tailored assessment and note templates can be built to meet the needs of all maternity/obstetrical care areas.

Module Highlights

- 01 Comprehensive clinical documentation for antepartum, intrapartum and post-partum care.
- 02 Epidural Documentation
- 03 Medical Device Interface
- 04 Links to Evidence based practices
- 05 New-born registration and link to Mother



Key Features

Captures unique assessments for intrapartum care while preparing for cesarean section and regular delivery.

Capable of documenting delivery complications and risk factors; epidural assessment, medication, dose changes and top up (e.g. bolus).

Documents Intra-Uterine Pressure catheter management.

Documents the code pink interventions and obstetrical emergency.

Identifies and easily retrieves high-risk pregnancy issues (e.g.. flag for multiple birth, pregnancy induced hypertension).

Maintains a pregnancy summary interfaced with obstetrical central monitoring system to facilitate a comprehensive intrapartum admission assessment that includes obstetric history, medical history, current obstetric status, psychosocial factors for the current pregnancy.

Physicians and other ordering providers can create specific Order Sets relevant to their discipline which can be part of their favorites and invoked automatically when a certain problem is entered, or a certain condition met. It supports the documentation of APGAR and other neonatal scores as well as growth charts.

Clinicians are able to analyze fetal monitor strip components and have automatic flow into patient record including fetal heart rate baseline, temperature, variability, accelerations decelerations and define the category.

Data is displayed on tracking board that is viewable and updatable on birthing unit, postpartum, neonatal intensive care unit and remotely.

Captures assessment parameters including Fetal Health Surveillance.

Configured data are automatically calculated i.e. birth log book used to capture monthly/yearly births.

Capable of documenting intervention for systematic fetal health assessment and for intrauterine resuscitation.

Documentation of the partogram labour stages, dilation to be generated in graph format.

Maintains a history of risk factors (as identified in other areas/forms such as the Antenatal form , Obstetric summary sheet for intrapartum risk factors, which also includes allergies, immunization history).

Enables mother chart to link with the baby chart and information flow between the two records.

Ensures post partum specific documentation questions do not appear on a general gynaecological patient.

Integrates data from emergency department and to/from other clinics e.g. bilirubinemia clinic, antenatal clinic.

Benefits

Easy-to-use, cost-effective paperless platform for managing and accessing all information relating to pregnancy.

Improved Workflows and levels of clinical collaboration, resulting from the ability to exchange Maternity related clinical information between facilities and care providers through leading edge interoperability capabilities and perform detailed reporting.

Improved patient safety and care during the maternity process, as a result of immediate access to detailed health records.

Complete, compliant and customisable maternity records in line with all national requirements and legislation.

Effectively manage nursing resource utilization based on patient's needs for care.

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