VIRTUS

INFORMATICS

HIMS | Electronic Medical Record

NURSING

The need is the beginning of the story

Today's health systems face multiple challenges including a global shortage of nurses, raised patient expectations for quality care and safety. Therefore nurses need an intuitive application to document the care they provide to their patients and a solution that provides them with robust clinical decision support to prevent medical and medication errors. The solution needs to be accessible from anywhere at anytime and from any device. It shall allow to quickly select from pertinent predefined lists to help expedite the documentation process, while providing the flexibility to document the out of the ordinary. The system must also allow a nurse to leverage previously documented information.

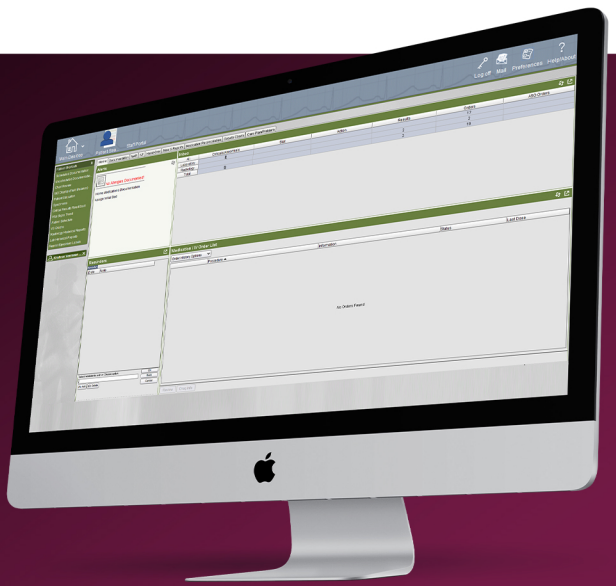
About the module

Flex Nursing module automates all aspects of clinical documentation for Nursing including: Assessments, Notes, Intake and Output, Care Plans, Problem List, eMAR, Allergies, Immunizations, Order Entry, Chart Review, Staffing assignment and more. It effectively supports the documentation and nursing workflows of all care areas including that of clinics owned and operated by hospitals.

Flex Nursing module enables Nursing and Allied Health Professionals across the enterprise to access to complete their documentation tasks and review patient data from anywhere at any time. Its two-pane approach combines key patient data review on the left with full clinical documentation narrative on the right which allows to review and quickly incorporate key information, such as lab results, allergies, vital signs into their notes.

Module Highlights

01 Nursing Assessments
02 Nursing Notes
03 Patient Care Schedule
04 Shift Summary
05 Care Planning
06 Nurse Review Queue
07 Interactive Care Grid
08 Chart Review
09 Nurse Review Queue
10 Barcode Medication Administration (BCMA)
11 Nurse Specimen Collection
12 Nurse Staffing/Assignment
13 Work Management Queues
14 Management Report



Key Features

- **Nursing Assessments** - Flex includes many industry standards, best practice templates for documenting all types of assessments which can be edited by the facility as needed. Supports all types of scoring tools also (GCS, Apache, TISS etc..)
- **Nursing Notes** - All types of Notes including Progress, Admission, Transfer, Discharge etc..
- **Patient Care Schedule** - A tool to assist in organizing patient care – includes tasks performed and tasks scheduled in the future
- **Shift Summary** - An efficient means for nurses to review pertinent patient information needed at the beginning of each shift.
- **Care Planning** - Defines patient specific problems and develop care plans to address them. Care plans are guided by patient-specific goals and interventions
- **Nurse Review Queue** – The system routes abnormal and/or critical results to the queue for nursing to keep abreast of patient care needs Result data displays in different font, depending on its criticality
- **Interactive Care Grid** - A summary, highly customizable view of all key information on the patient. Displays vital signs, lab results, radiology results, assessments, etc.. Care Units can select the time interval at which the information displays according to their standards
- **Chart Review** - Based on security, the system allows the user to view the patient's entire electronic medical record
- **Order Processing** - Nursing orders can be entered into the system without requiring co-signature, based on security rights
- **Nurse Review Queue** – Orders Routes new/changed patient orders to keep abreast of patient care needs. Order priority (i.e., STAT) displays in a different font for easy recognition
- **Barcode Medication Administration (BCMA)** – supports the safe administration of medications with 5 rights
- **Intake & Output** -, including all types of IV solutions, TPN, Nasogastric feeds, and all type of drains and tubes. automatically calculate fluid balance scores such as 8, 12, 24 fluid intake output and balance. The output can also be automatically calculated in mls/kg/hour.
- **Nurse Specimen Collection** - The system supports documentation of nursing collected specimens and updates the event status automatically
- **Nurse Staffing/Assignment** - The system provides a mechanism by which a nurse or nurse manager can assign nurses to patients for a shift. The system provides lists and work queues that are filtered by nurse assignment
- **Work Management Queues** - Tool for organizing patient care needs. Queues are security based and are customized to your facility's needs
- **Management Report** - Nursing management reports are available for monitoring nursing documentation or other needs

Benefits

Harris Flex, along with Novus ClinDoc for nurses', help streamline the documentation process while standardizing care and enforce departmental protocols/best practices. It helps clinicians in all care areas of a hospital save precious time that they can spend with patients.

Through its robust clinical decision support it helps reduce medical and medication errors. Many automated processes embedded in the solution safeguard patients and ensures they receive the best care possible. Harris Flex enhances interdisciplinary collaboration and communication between healthcare providers.

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Provision shall exist to manage following types of patient related orders received from Physicians such as Laboratory tests, Radiology examinations, Medications, Dietary, Treatment requests, Request for Patient charts, Request for special items and Operation Theatre Bookings

May allow to place Clinical orders based on privileges.

System shall facilitate placing following types of non-patient related orders such as Ward stock-medications, Ward stock-sterile items, Ward stock-general items.

Patient information

This module is able to access demographic and medical history details of the patient

Based on Admission request formalities completion, nurses shall be able to allocate beds in Wards.

System shall allow transfer of beds in same ward or between wards and transfer of patient's treating doctor. Labels with new ward / bed information can be printed

Different functions track normal and emergency transfers

Discharge planning is carried out based on intimation of expected discharge to the discharge desk on raising of a discharge advice

On actual discharge, bed occupied by patient is released either immediately or after blocking for a period, which is required for any housekeeping tasks

Patient Assessment & Classification

This Module facilitates screening incoming patient for potential problems or issues at an early stage.

Patient assessment varies depend on type of ward/disease indication.

Assessment of past history includes physical characteristics, social life type assessment, past surgical and hospitalization history.

Additional Assessment shall be provided depending on the patient condition and/or Medical Specialization needs

Provisions shall exist to setup assessment conditions separately for each unit/ward.

In patient assessment screen, demographic details are automatically displayed

On completion of patient assessment, each assessed patient shall be assigned patient classification index.

Whenever condition of patient changes, the patient classification index is updated.

Patient classification index is converted during required nursing hours.

Cumulative nursing care required is calculated for each unit/ward.

Cumulative nursing care required is compared with actual and various reports shall be generated

Maintains care plan at 'Element of Care' (EOC) level.

EOC is linked to a specific medical diagnosis and age range.

EOC required by individual patients is identified from standard care plan during admission assessment.

Standard Statement, Nursing action and outcome standard is defined by EOC

EOC is classified as core and general.

Provision exists to assign more than one EOC to a patient.

System facilitates linking EOC with either Medical diagnoses or nursing diagnoses.

EOC shall be assigned separately for primary and secondary diagnoses.

Multiple care plans shall be merged together to generate a single care plan, which is unique to each patient.

Care plans shall be regularly updated based on the patient's condition.

Provisions shall exist to add or discontinue EOC. Whenever a care plan is updated, the system captures sign on code of the nurse who is updating the care plan and appends her name, designation, date and time of alteration to the altered care plan.

System generates nursing work sheets, which can be used by nurse to record patient information like expected discharge date, changes in patient classification, height and weight (with changes), respiration (pulse, blood pressure, temperature) containing initial values and changes with dates of changes, personal care, psychological and spiritual needs, nutrition care and shall record diet restrictions, required tests and examinations, medications and allergies.

Nursing actions and nursing notes contained on the plan shall be regularly reviewed by nurses as part of their day-to-day nursing actions.

Provision shall exist to enter new codes on the system.

System automatically includes date, time and author of all notes recorded.

Nursing notes is displayed in chronological order within each type of note.

Nurses shall review and modify text, examination and medication requirements for patient. This list shall remind nurses of orders to be placed.

Placing orders and receiving result is carried out using order entry and reporting system, based on privileges.

System Capabilities | Nursing

Nurses shall be able to review patient's test / examination schedules at any time by interfacing with appointment scheduling and order entry systems. These schedules are modified only through requests to the order entry system.

Medication profile set up for each patient includes name of drug, date / time and mode of administration and dosage, including intravenous solutions.

Nurses shall review medication profile regularly to ensure that necessary drugs have been received for patients and that all medication has been administrated.

Discharge planning and patient education shall also be listed as Element of Care on every initial care plan.

Generic Discharge Planning shall be listed in majority of EOC set.

Condition specific Discharge Planning shall be listed for major patient categories like Adult-Onset, Diabetics, Post Coronary Artery Bypass and other Cardiology Specific categories.

Provision shall exist to define any number of EOC's under patient education.

Possible referral options are automatically displayed during discharge planning

When take-home medicine is selected, the system automatically prints medication details including dosage and administration instructions

A link is provided from Discharge planning to patient education literature.

When patient is discharged, information is automatically updated on admission record in the Inpatient Module and bed shall be released for housekeeping purposes.

Facility shall exist to enter additional discharge information in free text format.

Facility to give a follow-up appointment date in Out-patient department upon discharge.

Quality Assurance

Audit reports assessing whether goals have been met, whether

intervention have taken place, whether medication has been administered is provided to ensure quality in the nursing process.

Incidents / events

Infection incidents - type of infection, action taken and quality assurance follow up

Medication incidents including patient and employee information. In this case a degree of severity code shall also be attached to the incident

Blood transfusion outcome

Drug interaction/problems

General incidents that have occurred to staff / patients

Reports and queries of incidents/events

Nursing information

This module provides various details such as CSSD (central sterile services department) pack details, instrument handling details, infection control procedures, nursing procedures and drugs details, which the nurses can inquire

CSSD pack includes pack number, description, list of items in the pack in terms of instrument, linen, metal ware, gauzes, etc., and their qualities

Instrument Handling details includes information on handling contaminated instruments and CSSD recommended instrument

Infection control procedures are available on-line to enable nurses to take appropriate action and preventive measures in case of hospital-acquired infections

Nurses are able to view the nursing procedures based on the expertise and requirement. This facility works as an on-line reference manual

Nurses are able to view details about the drugs available in pharmacy with respect to their description, properties, dosage details, contra-indications and reactions

Ward Management

System shall facilitate placing following types of non-patient related orders for ward management such as Ward stock-medications, Ward stock-sterile items, Ward stock-general items.