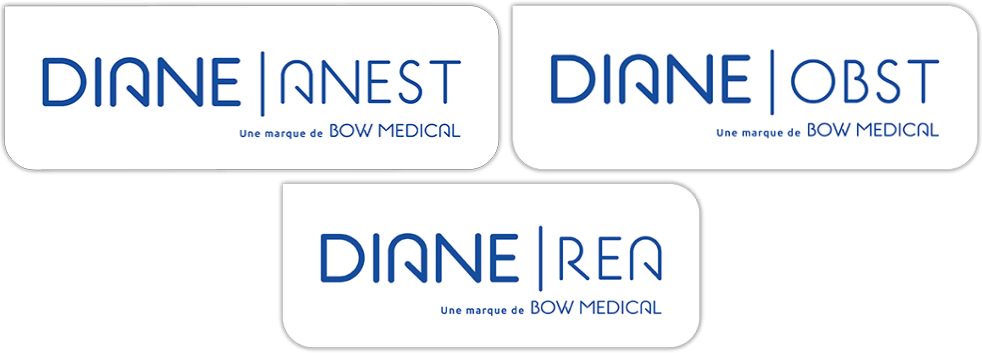
DIANE User Manual

Version 4.7



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1. Introduction

DIANE is a software suite for critical care in hospitals. Several modules are available allowing secure patient monitoring and that are catered to caregivers' needs:

- **DIANE ANAESTHESIA** enables patient monitoring from the preoperative assessment to the surgery to the recovery room.

- **DIANE ICU** enables patient monitoring in the ICU and continuous care unit.

- **DIANE OBSTETRICS** lets you monitor mums and neonates in the obstetrics unit and also women in gynaecology and family planning.

This manual explains how all the modules work to help start using the software.

The user manual can be accessed by hitting F1 on your keyboard. The help function is designed to go directly to the chapter of the manual corresponding to the tab you are in.

The **DIANE** software suite is configurable. It is therefore possible to arrange the layout, tabs and components differently.
This manual will show you the different data entry methods and the particularities of each module.

1.1 Reading the user manual

The user manual covers the different features of the **DIANE** software suite. Different parts will concern different users depending on what is present on their site.
To simplify things, read this manual as follows depending on the module you are used to working on.

- **DIANE ANAESTHESIA**:
  - Chapter 1: General information (*Introduction*)
  - Chapter 2: General framework (*General framework*). This chapter explains how to start up **DIANE** and the different data entry methods.
  - Chapter 3: **DIANE ANAESTHESIA** (*DIANE ANAESTHESIA*) which covers the preop assessment (*Selecting patient records in anaesthesia*), intraoperative and postoperative monitoring (*Intra and Postoperative*).

- **DIANE ICU**:
  - Chapter 1: General information (*Introduction*)
  - Chapter 2: General framework (*General framework*). This chapter explains how to start up **DIANE** and the different data entry methods.
  - Chapter 5: **DIANE ICU** (*DIANE ICU*). This chapter deals with all the functions of the intensive care module with an emphasis on prescriptions (*Prescription tab*, *Examples of prescriptions*), on the care plan (*Care plan tab*), and on the body diagram (*Body diagram*).

- **DIANE OBSTETRICS**:
  - Chapter 1: General information (*Introduction*)
  - Chapter 2: General framework (*General framework*). This chapter explains how to start up **DIANE** and the different data entry methods.
  - Chapter 4: Chapter 4 (*DIANE OBSTETRICS*) deals with the entire obstetrics module. However,

pregnancy monitoring is covered in chapters 4.1 to 4.13. Chapter 4.14 deals more particularly with gynaecological monitoring (*GYNAECOLOGY RECORD*) and chapter 4.15 with family planning monitoring (*FAMILY PLANNING RECORD*).

Other chapters deal with various features like coding (*Procedures/ICD-10*) or the query tool (*QUERIES*).

We have used the following fonts to help you read this manual:

Type of font	Refers to
DIANE ANAESTHESIA	The software suite concerned
Clinical examinations	A tab
Medical History	A component with this name
Stop button	A button labelled 'Stop'
Using DIANE on a laptop OFFLINE	Link giving direct access to a chapter

1.2 Administration and troubleshooting

At least one person is appointed to administer and manage **DIANE** to keep the database of lists up to date (create a user or multiple entry, add a drug, etc.)
Your site administrator can also help you use the **DIANE** software.
If there is an IT problem, tell your site administrator or your facility's IT department.

NB: In the event of a malfunction blocking the application, all **DIANE** applications can be closed using **DIANE MANAGER**. This avoids going through the Windows Task Manager. To do this, double-click on *DianeKiller.exe* then on the '**Stop** all **DIANE** processes' button.

CAUTION: **DIANE MANAGER** should be used exceptionally when there is no other solution as data entered recently can be lost.

1.3 Security

Access rights are assigned to each user. Each group of users has different levels of access to the application depending on their role. There are:

- Software permissions: giving access to the various **DIANE** applications,
- Application permissions: giving access to the different application functions,
- Administrator permissions: giving access to the configuration and the different reference lists.

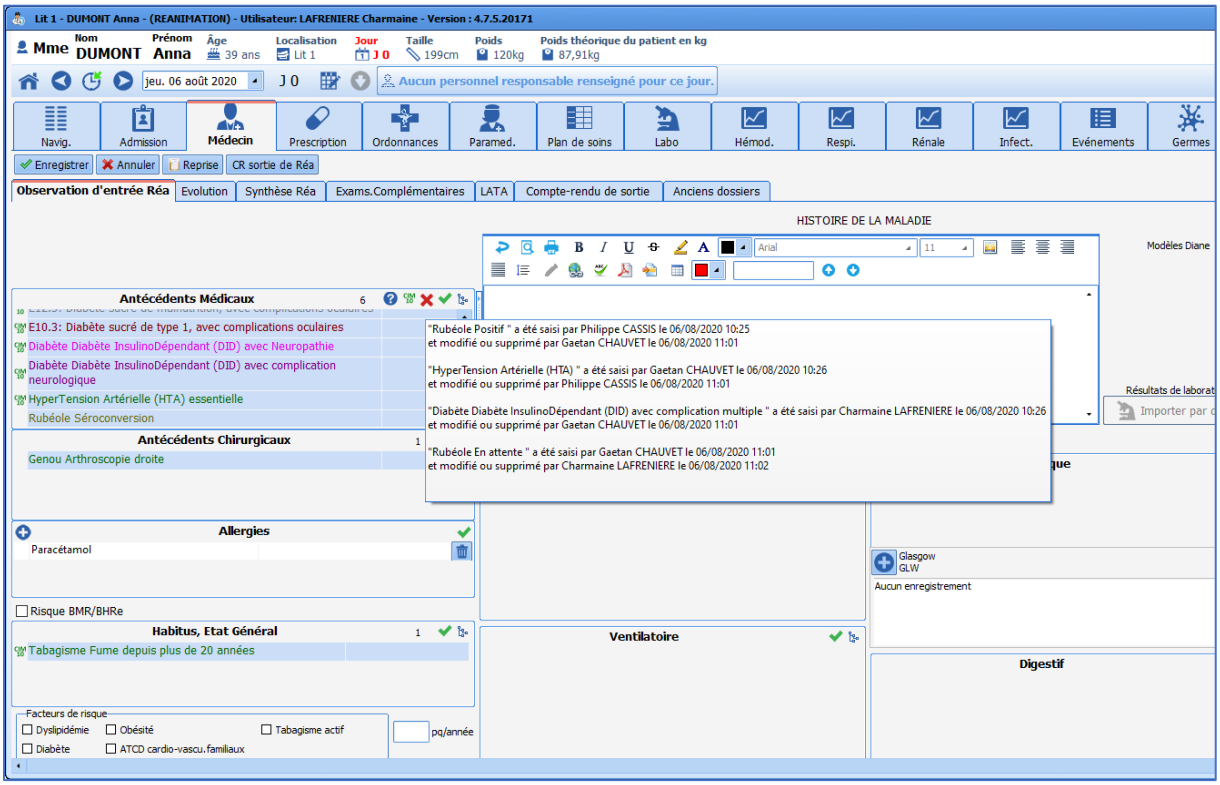
You can use the software securely if the connection is lost between the computer and the network or server. The workstations continue to save all the data on the computer and this data is sent the next time it is started up normally. This enables uninterrupted use.

1.4 Traceability in DIANE

The **DIANE** software tracks the data entered and who it is entered by. It is possible to view all the items entered in real time successively in the different fields by hovering over these fields.
This traceability is maintained when offline, both for data already available and data entered again.

In the application, a colour is assigned to each user who changes, adds or deletes information in a patient record.

In the screenshot below, you can see a red cross at the top right of the **Medical History** field. If you hover the mouse over this area, you can see a detailed description of all the data changed or deleted in this field.
This data entry traceability is available for all fields, including free text fields.



NB: There is no history for specific examinations (**Clinical examinations** tab) or configurable assessments (**Paraclinical** tab).

1.5 DIANE Manager

In the event of a malfunction blocking the application, all **DIANE** applications can be closed using **DIANE MANAGER**.

Using **DIANE MANAGER** may cause data to be lost from the relevant patient record. Ask a key user for instructions on how to use it.

This avoids going through the Windows Task Manager.

The following window opens to let you:

- Shut down **DIANE**: which forces the software to stop completely
- Restart **DIANE**: by shutting down completely then immediately restarting
- Do nothing (which allows you to close this window and go back to the portal).

1.6 Offline mode and connections between computers

The software can still be used if the server fails or the connection with the network or server is lost.
In offline mode, data provided locally by biomedical devices is still recorded. You can also create a new patient and carry out the entire related procedure.

The user can be changed in offline mode.

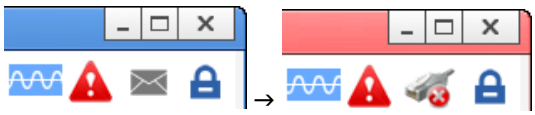
IMPORTANT: The offline mode should not be used for routine use. This mode simply avoids losing the work done when the network is disconnected. Restart **DIANE** as soon as the situation returns to normal.

NB: When the problem comes from the server, the computers will still be connected to each other. When there is a network problem, the disconnected computer will no longer have access to the other computers. The other computers in the unit will also no longer have access to the computer disconnected from the network.

1.6.1 Switch to offline mode

When you switch to offline mode, either when starting up the application or during use, you will see this message.

When you go offline, the top ribbon of the application turns red and an icon is displayed to show that you are no longer connected to the database.



1.6.2 Data resynchronization

When the network is lost, all data is stored on the primary computer.

Resynchronization is attempted when the application is closed. Resynchronization is also attempted when the patient is discharged.

On each reboot, **DIANE** tests the access to the network and sends the patient data saved locally to the central server. The data will be automatically resynchronized the next time the computer is connected.

If you switch to offline mode:

- Are the other computers in the unit also disconnected? If they are, it may be a general problem.
- Does the computer have intranet access? If it does not, there is a network connection problem.

- Has the computer been moved? Is the network cable still connected?

2. General framework

2.1 Starting up DIANE

2.1.1 User identification

To start up a DIANE application, select the application name in the **Start / Programs / Diane** menu, or double-click on the application icon on the Windows desktop.

CAUTION: do not move the original executable files on the desktop.

The **Alias** on the **Login** screen contains the server references.
Do not modify the content of this field.

Enter the username and password provided by the key users.

NB: The first time you log on, you will have to enter the username. This username will then be available in the drop-down menu.

NB: When the DIANE software was commissioned at your facility, BOW MEDICAL (or your site administrator) created your username and password for you to log on to DIANE. Therefore, when you log on for the first time, a message tells you to change your password. This message will be displayed until you save a new password.
You may then be asked to change your password every year.

The **Force to offline mode** checkbox lets you start up one or more DIANE applications in offline mode. This checkbox is useful when using a laptop where there is no internet connection. It is also used when the software is updated by the key users.

2.1.1.1 Login window icons

You can change your password by clicking on the Change password icon.
When you click on Change password, the change password window opens. Enter your old password, the new one and then confirm the new password. Click on **OK** or hit **`Enter`** on your keyboard to save the change.
You can change your password via different paths in the DIANE application:

- Via the **Options** button in the **Consultation** application, or via the specific buttons

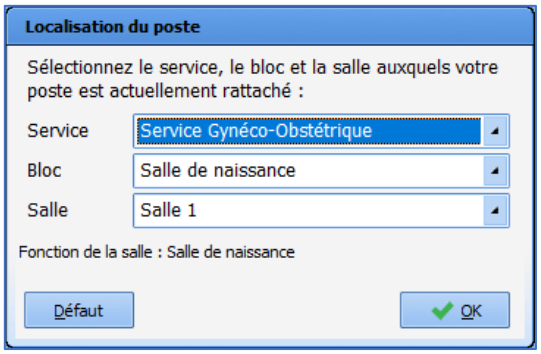
available in the DIANE ANAESTHESIA or DIANE ICU applications
- Via the **?** menu in the **Queries** application

You can lock the DIANE computer by clicking on the **Lock the DIANE computer** icon.
There are different ways to lock the DIANE computer:
- Via the **Options** button in the **Consultation** application
- Via the specific buttons available in the DIANE ANAESTHESIA or DIANE ICU applications
- Via the **?** menu in the **Queries** application

This **About…** icon shows which version of DIANE is installed on the computer. If there is a technical failure, this information will be useful to BOW MEDICAL's technical staff.

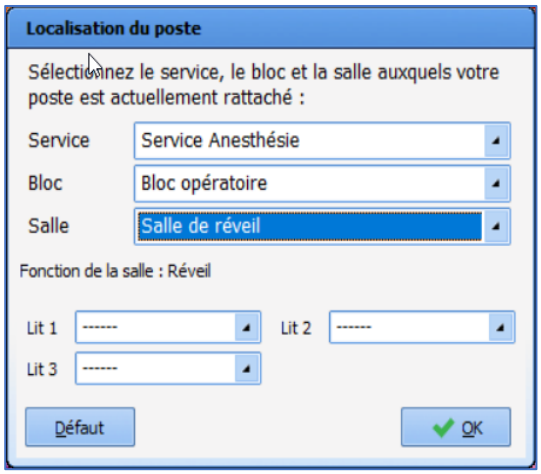
2.1.2 Computer location

When you log on for the first time, this window will prompt you to name the room in which the computer is located.



In units such as intensive care or the recovery room, one computer can manage several beds. In this case, when the computer is located you will be asked which beds are assigned to the computer.

The names **Bed 1**, **Bed 2** and **Bed 3** are just an idea of what you should enter... the choices are made using the drop-down menus.



2.1.3 Primary mode versus Mirror mode

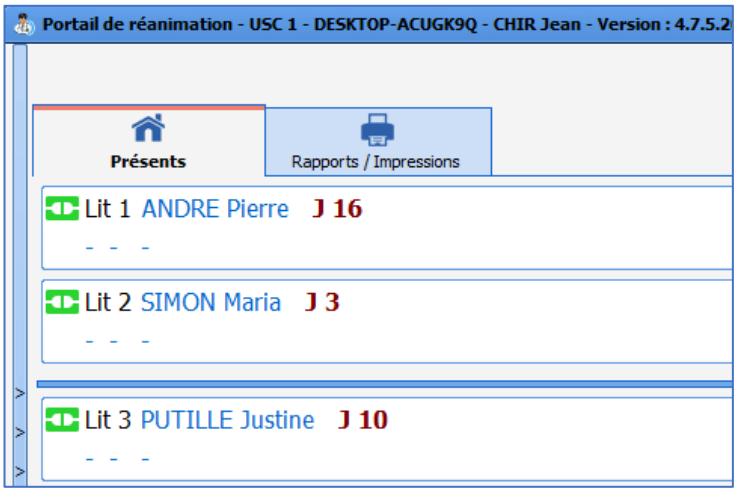
The DIANE software lets you document, log and centralize patient information. A patient's record is accessible from any computer in your unit on which the DIANE software has been installed.
The patient's record is linked to a single computer that we call the Primary computer. The Primary computer is the one that is connected to biomedical devices (often at the patient's bedside). Mirror computers are all the other computers that have access to the record.

Patients can only be admitted and discharged using the Primary computer. All of the other functions are accessible from any computer.

2.1.3.1 Direct and remote access to patient records

Direct access to a patient record means access from the Primary computer.
Remote access is access to the record from a Mirror computer.

In this illustration:

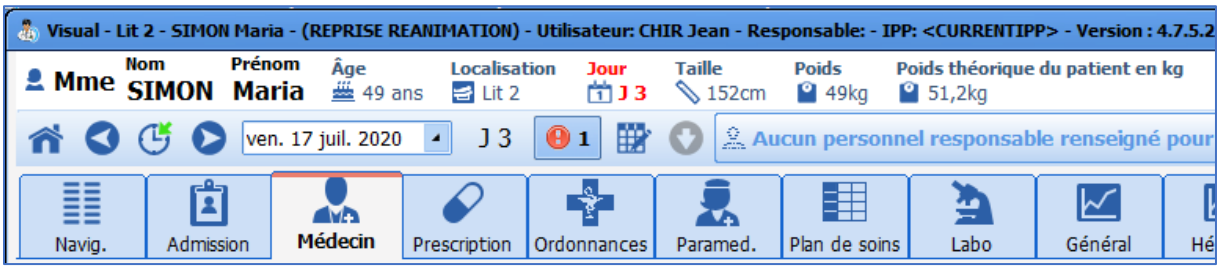


The records for ANDRE Pierre and SIMON Maria are on the Primary computer.

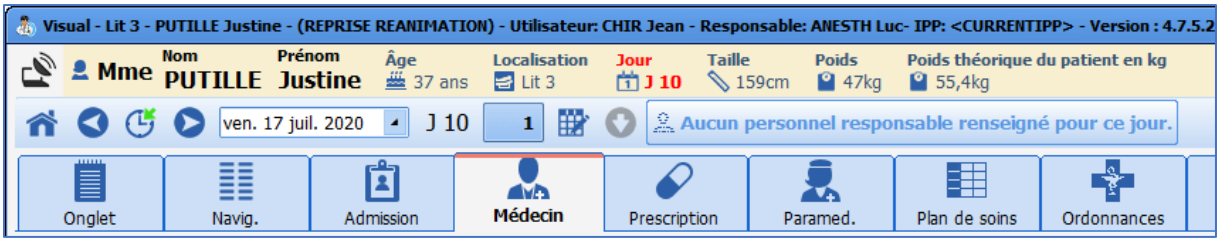
The horizontal blue line separates records managed on a Primary computer and records viewed in Mirror mode.

PUTILLE Justine's record is accessible in Mirror mode.

The record opened on the Primary computer appears with a top ribbon as follows:



When a record is accessed remotely, the top ribbon becomes yellow and the icon appears.



IMPORTANT: The Mirror computers give remote access to all of the unit's records and cannot be used to admit or discharge patients.

2.1.3.2 The different connection icons

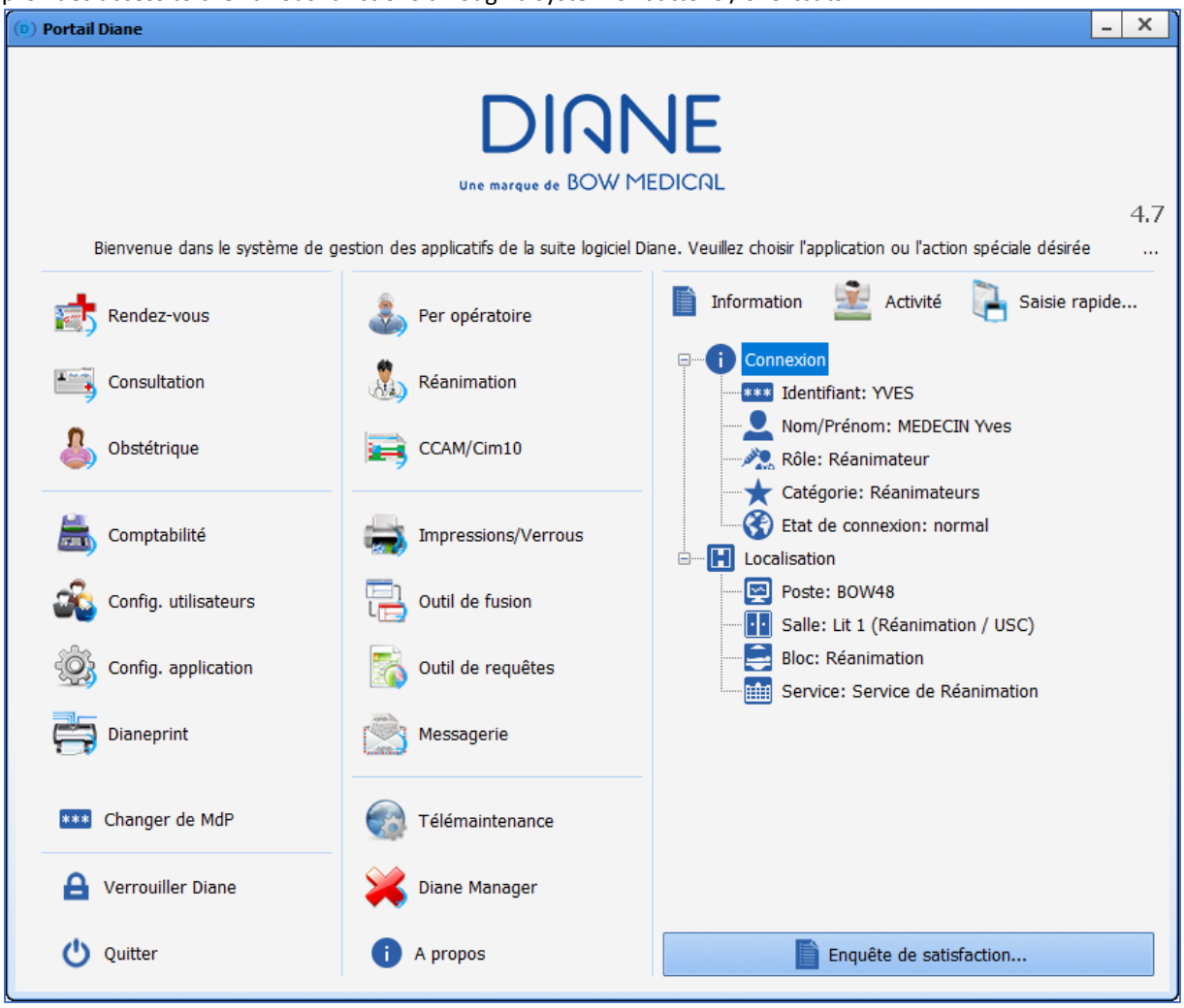
- The **green icon** in front of the records means that you can work on these records.
- The **red icon** means that no communication is possible, probably because the computer in that room

is switched off.

- A **yellow icon** means that a connection attempt is in progress.
- A **black icon** means that remote connection is not enabled.
- A **purple icon** means that the computer is not connected to the database.
- A **blue icon** means that the Primary computer and the Mirror computer versions are not the same.

2.1.4 DIANE home page - DIANE portal

Once the user is identified and the computer's location is confirmed, the DIANE portal opens. This portal provides access to the various functions through a system of buttons / shortcuts.



2.1.4.1 Home page icons

Buttons	Function
Rendez-vous	Gives access to **DIANE APPOINTMENTS**.
Consultation	Gives access to the **Preoperative assessment** module in **DIANE ANAESTHESIA**. See chapter on **Preoperative assessment** for how to use the application.

Per opératoire	Gives access to the **Intraoperative** and **Postoperative** modules in **DIANE ANAESTHESIA**. If the computer is configured in an operating theatre, the **Intraoperative** button will be visible. If the computer is configured in a recovery room, the **Postoperative** button will be visible. See **Intraoperative** and **Postoperative** chapters for how to use the application.
Obstétrique	Gives access to **DIANE OBSTETRICS**. See **Obstetrics** chapters for how to use the application.
Réanimation	Gives access to **DIANE ICU**. See chapter on **Intensive care** for how to use the application. If the computer is not configured in an ICU/CCU, the **Patient list** button will be visible.
Comptabilité	Gives access to the **DIANE ACCOUNTING** form.
Messagerie	Gives access to the **DIANE EMAIL CLIENT** to send messages between computers.

Activité	Lets you view surgeries that were finished or in progress over the last 24 hours (surgeries in progress, patients released from the operating theatre and currently in transit, patients in the recovery room, surgeries finished in the last 24 hours, patients being transferred from the recovery bed).
Information	Lets you see the identity of the person logged on and locate the computer you are working on.
Saisie rapide...	Lets you use queries to group patients according to criteria corresponding to patient record contents.

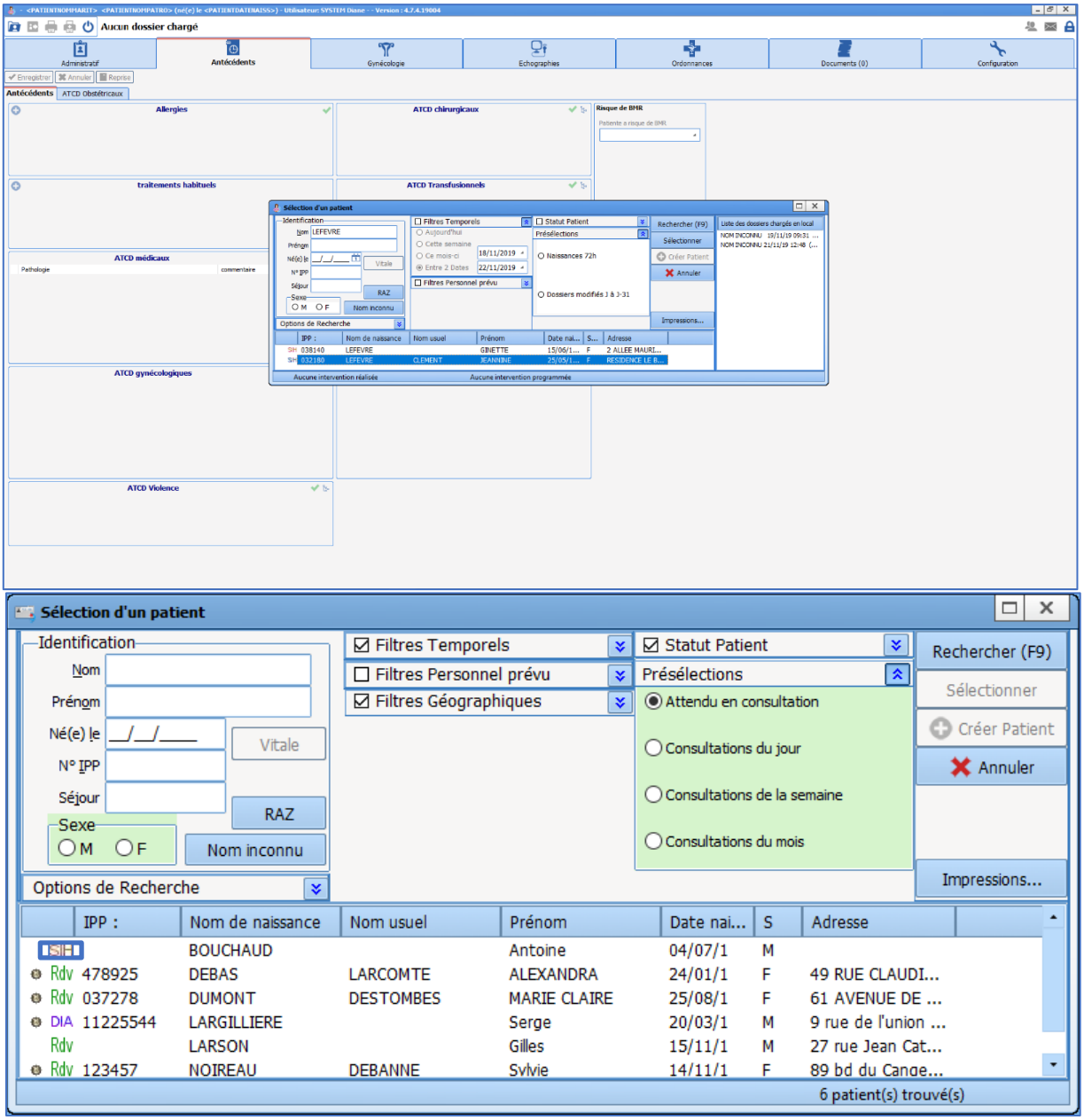
CCAM/Cim10	Gives access to the Entry form for **ICD-10 and procedure** codes. See chapter on **Procedure/ ICD-10** codes for how to use the application.
Config. utilisateurs	Lets you configure users, access rights and the site. This tool is for key users only.
Config. application	Lets you configure lists. This tool is for key users only.
Dianeprint	Gives access to the **DIANE PRINT** application.
Impressions/Verrous	Gives access to the print and lock manager. This tool is for key users only.

Outil de fusion	Gives access to the **Record** **merge tool**. This tool is for key users only.
Outil de requêtes	Lets you search the database. This tool is for key users only.
Diane Manager	Gives access to **DIANE MANAGER** to close all **DIANE** applications.
Changer de MdP	Lets you change the password of the logged in user.
Verrouiller Diane	Lets you lock the **DIANE** computer.
A propos	Lets you see which version of **DIANE** it is.
Télémaintenance	Gives direct access to the remote maintenance web page to give **BOW Medical** control of your computer via the Internet. Your IT department may require you to use another tool.
Quitter	Lets you exit the **DIANE** application.

NB: Some buttons may be greyed out. This happens when they are unavailable (insufficient user rights or offline mode for example).

2.1.5 Patient selection

When starting up an application module, the patient selection window opens automatically.



This window lets you select the patient whose record you wish to open.

The area located at the top left of the window is used to automatically search for a patient in both **DIANE** (DIA) and the Hospital Information System (HIS). This search can be done using the surname and/or married name. The search can also be done using the date of birth. After typing the first letters of the surname and/or first name, the list of all patients matching the search appears.

Each line corresponds to a patient matching the search criteria. At the beginning of each line, a pictogram gives information about the patient record. The list of pictograms is detailed in the '*Patient list icons*' chapter. If you hover the mouse over a patient in the list you will see more information (types of surgeries scheduled and carried out with surgery start and end times, etc.)

Once you have found the patient, select the patient record line then click on the **Select** button or double-click on their name.

If the patient has not been registered in the software and their administrative admission could not be done,

you can create this patient. The procedure is described in the chapter '*Patient record does not exist*'.

PLEASE NOTE: Some preset fields can let you display patients without having to enter additional information (for example a patient expected in the recovery room).
Selection filters can be enabled by default and/or manually. They will be detailed in the following chapters.

IMPORTANT: Patients must be admitted from the Primary computer.

2.1.5.1 The specific buttons of the Patient selection window

The **Reset** button is used to erase data inserted in the different fields in this area.

The **Unknown name** button lets you enter a fictitious surname (UNKNOWN NAME) and first name (Current date and time) to quickly create a patient who has not yet been identified.

The **Printouts** button displays a menu that lets you do different tasks including:
- Printing the list of patients selected in this window (UPI, Surname, Married name, First name and Date of birth).
- If you are a key user, opening the print manager to be able to mass print all records that have been changed since they were last printed.
- Installing or removing locks on certain records (only accessible to key users).

2.1.5.2 Patient list icons

Icons appear before each name on the list in the **Patient selection** window.

Symbols	Function
Appt	Patient created in **DIANE** when an appointment is made (using the RDV.exe application). This symbol is only visible when the **Appointment made** filter located in **Patient Status** is ticked or if none of the filters are ticked. The Appt symbol will be replaced by DIA as soon as this patient's preoperative assessment has been confirmed.
EHC	Patient identified with their electronic health card. Once this patient's preoperative assessment has been confirmed, this symbol will be replaced by DIA.
HIS	Patient whose identity is registered in the Hospital Information System.
DIA	The patient's identity is registered in the **DIANE** software AND is linked to an identity in the Hospital Information System.
DIA	The identity was created in **DIANE** and is not linked to the HIS
DIA	Changes were made in the HIS and were not reported in **DIANE**. When the patient record is opened, a window will prompt you to automatically update the administrative data.
DIA	The record is locked on another computer. A user is currently working on the record or this record has been preloaded onto a laptop. The record can only be opened in read-only mode. It cannot be changed. Hovering over this symbol with the mouse displays a tooltip showing the name of the user who locked this record, the date, time and the computer on which it is locked.

NB: Only a site administrator has the right to unlock one or more patient records (if a laptop is lost, for example). In this case, all data inserted during the appointment will be considered lost and cannot be recovered.

NB: If you right-click on a record you can:

- Attempt to link the patient record to an HIS identity: This option is only available for patients not linked to an identity in the Hospital Information System. This command gives direct access to the **Record Merge** module and lets you automatically search for an HIS identity matching the patient selected.

- Load in full access mode: This option lets you load locally onto the computer all of the patient's data (consultations and surgeries) in read/write mode to be able to change the patient's data when you are offline. See *'Using DIANE on a laptop OFFLINE'* chapter. This option places a lock on the patient in the database, preventing other users from changing the patient's data.

- Load in read-only mode: This option lets you load locally onto the computer all of the patient's data (consultations and surgeries) in read-only mode to be able to see the patient's data when you are offline. See *'Using DIANE on a laptop OFFLINE'* chapter. This option does not place a lock on the patient in the database.

2.1.5.3 Different filters and search options

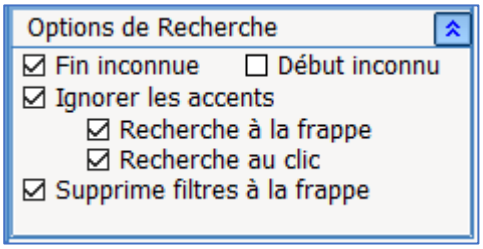
These areas in the **Patient selection** window let you refine the search based on the filters selected.
When the patient selection window opens, some filters are enabled by default. They can:

- Be opened or closed individually using the double arrows in the top right corner of the boxes.
- Be enabled or disabled using the checkboxes in the top left corner of the boxes.

2.1.5.3.1 Search options

Some of these options are based on the identification filters related to the patient's identity:

- **Unknown end** lets you search by entering only the start of the surname and/or first name
- **Unknown start** lets you search by entering only the end of the surname and/or first name
- **Ignore accents** does a search without taking into account accents in the patient's surname and/or first name.



If the first two options are ticked, you can just enter a few letters in the middle of the name.

The **Word completion** checkbox updates the list of patients after just a few letters of the surname and/or first name have been inserted.

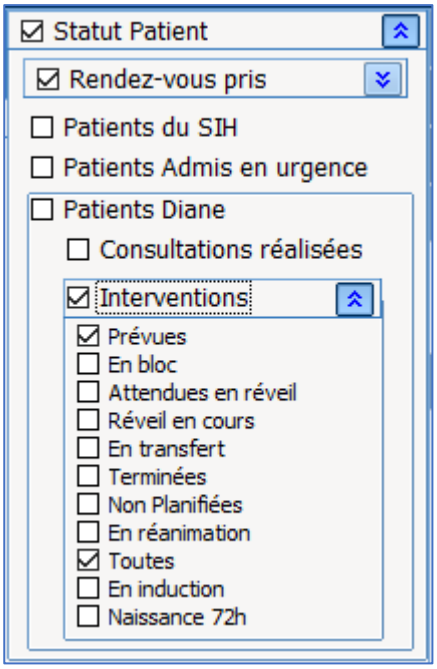
The **One-click search** box starts the search after enabling or disabling a filter.

If neither of these two options is activated, you must click on the **Search** button (or hit **F9** on your keyboard) to display the names of the patients matching the letters you have typed.

The **Deletes word completion filters** box cancels all the filters inserted as soon as the user starts to enter text in the search fields (surname, first name, etc.). This lets you search for the patient in the entire software database. This means a patient will be found even when the selection filters chosen are inappropriate.

2.1.5.3.2 Patient status filters

This area enables a search filter related to the status of the patient's record.



* **Appointment made:** corresponds to patients with an appointment scheduled through the RDV.exe application.

* **HIS patients:** corresponds to patients entered through the hospital software.

* **A&E patients:** corresponds to patients who arrived in the A&E and were registered at a later stage.

* **DIANE patients:** corresponds to patients who have already had a consultation or surgery using the **DIANE** software suite.

You can add restrictions for this last filter.
* **Consultations held:** lets you search for a patient who has already had a consultation in **DIANE**.

* **Surgeries** lets you search for:
  - a patient who has a surgery scheduled (with a scheduled date),
  - a patient who has an unscheduled surgery (no scheduled surgery date),
  - a patient who is currently in the operating theatre or recovery room,
  - a patient in transit between the operating theatre and the recovery room,
  - a patient whose surgery has already been performed.

NB: Patient Status does not apply to patients only registered in the HIS.

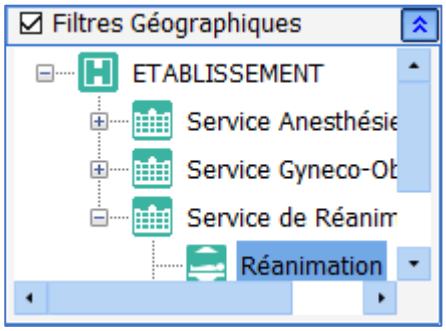
2.1.5.3.3 Time filters

This area is used to enable a search time filter.

Time filters can be applied at the same time as the **Patient Status** filter except when **Unscheduled surgeries** has been selected.
If the time filters are enabled and the **Patient Status** filter is not ticked, the dates automatically correspond to preoperative assessments.

NB: time restrictions do not apply to HIS patients because date-related searches are done using key dates in the **DIANE** record.

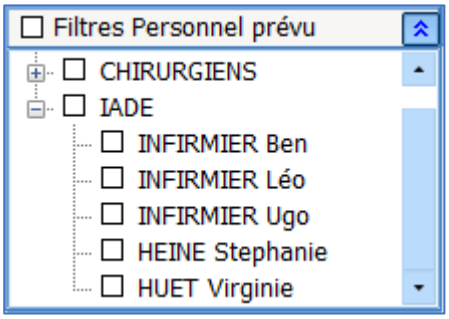
2.1.5.3.4 Location filters



This area lets you search in:

- The facility's sites,
- The entire facility,
- A unit,
- An operating theatre,
- A room, etc.

2.1.5.3.5 Scheduled staff filters

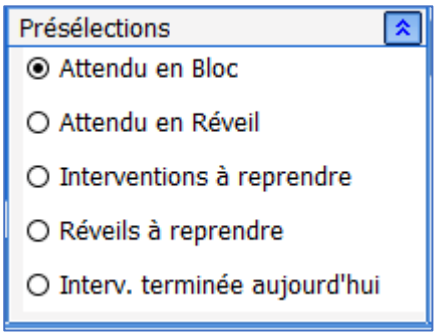


This area is used to enable a filter based on the staff scheduled to be present.
By expanding the staff categories you can limit the search to patients whose consultation or intraoperative or postoperative monitoring involves the selected staff.

When several staff members in the same category are selected, only one needs to have been entered for the search to find the record.

NB: Scheduled staff filters do not apply to patients in the HIS.

2.1.5.3.6 Presets



Presets let you search based on the status of the patient records.

This preset filter can be configured by a site administrator to be the default view.

If **Expected in theatre** is ticked, patients scheduled for today through the Consultation will be automatically displayed.

2.1.5.4 Possible scenarios

This chapter talks about special cases.

2.1.5.4.1 The search is not specific enough

If the search is likely to retrieve too many patients, a warning message appears. The user can still launch the search by confirming in the warning window. However, the search results may take several minutes to load.

If the user wishes to narrow the search, they can click on the **No** button in the warning window to add filters to narrow the search.

If a patient's name is entered and filters are enabled afterwards, there may be no search results. If this is the case, a message prompts you to disable all filters to find the patient.

2.1.5.4.2 Patient record does not exist

No patient records match the search. This can occur if the patient arrives in an emergency without an administrative admission. In this case you can create a temporary identity while they are receiving care. To do this:
Click on the **Create Patient** button after completing the mandatory **Surname** and **First name** fields or after selecting the **Unknown name** button.
The patient can receive care with this temporary identity.

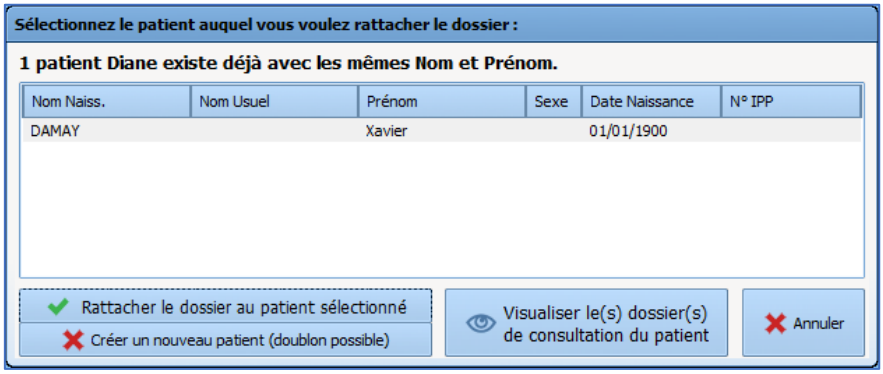
This feature can be disabled.

NB: It is vital to notify the key users when this procedure is used to subsequently link this record to the patient's administrative and hospital identity.

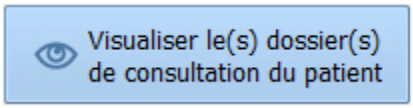
NB: Remember to check that you have entered the items correctly. You can also try searching using different information (UPI, date of birth, name, etc.).

2.1.5.4.3 The patient appearing in the list has the same name

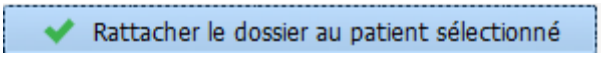
If the patient appearing in the list is another patient with the same name:
Click on the **Create Patient** button after completing the mandatory **Surname** and **First name** fields.
When you save, an **Information** window warns you that there is at least one other patient with the same surname and first name.
The window containing the list of patients with the same name opens. You can then link your new record to a patient who already exists.



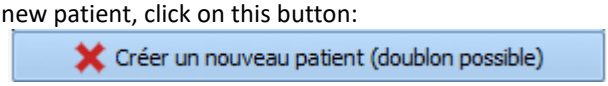
To avoid linking a record to the wrong patient, you can select the patient's consultation record and click on this button to view it:



To link the patient record to a patient who already exists, select the patient to whom you want to link the record then click on this button:



If you want to create a new patient, click on this button:



The software will then see if an HIS identity matches the new patient and will prompt you to link them.

2.1.6 Selecting a patient's record

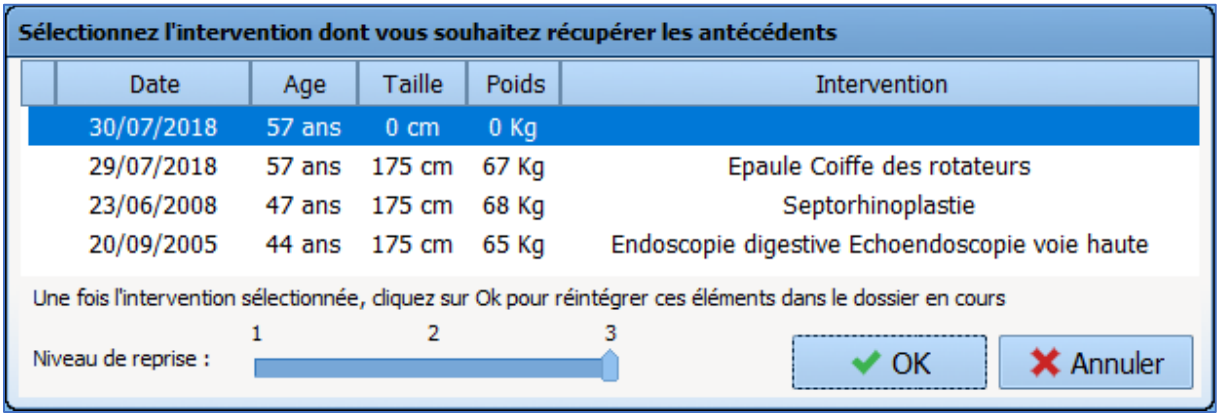
After choosing the patient as described in the '*Patient selection*' section, you must select the record concerned according to the care that will start.

As this selection depends on the unit providing the care, please refer to the relevant chapter:

- For anaesthesia: '*Selecting patient records in anaesthesia*'
- For obstetrics: '*Selecting patient records in obstetrics*'
- For the ICU: '*Selecting patient records in the ICU*'

2.1.7 Retrieving information from a previous record

After creating a new record, you can retrieve certain patient data if they have a previous record in **DIANE**.



There are two ways to retrieve data from previous records:

- After confirming the ***Schedule a surgery*** window, a message offers to automatically retrieve the history from the previous record.
  - If you click on **Yes**, the **History / Treatments** tab is completed with the history from the previous record.
  - If you click on **No**, only previous surgeries and intraoperative and postoperative complications entered into the **DIANE** software will be retrieved.
- Click on the **Retrieve** button. A menu lets you retrieve information from the previous record. The proposed retrieval levels 1, 2 or 3 correspond to the number of information items you want to retrieve (3 is the maximum retrieval level).

Antécédents chirurgicaux	4
Amygdalectomie Reprise avec Végétations Adénoïdes (AVA)	1986
Endoscopie digestive Echoendoscopie voie haute	20/09/2005
Septorhinoplastie	23/06/2008
Endoscopie ORL pour ablation de corps étranger	2010

Items retrieved automatically have a checkbox next to them. This lets you delete, change or add to the information retrieved.

The categories retrieved will depend on the configuration by the key user.

2.1.8 Patient discharge

A patient is discharged via a button in each module. There is a description of the process in the relevant chapters.

Please refer to the relevant chapter:

- For anaesthesia: '*Discharging patient records in anaesthesia*'
- For obstetrics: '*Discharging patient records in obstetrics*'
- For the ICU: '*Discharging patient records in the ICU*'.

However, please note that:

- The patient's discharge will prompt you to either transfer or close the record.

A transfer concerns a patient who will be retrieved in a **DIANE** module. *(e.g. departure from the operating theatre to the recovery room, departure from the operating theatre to the intensive care unit that has* **DIANE ICU**, *departure from intensive care to the operating theatre, etc.)*

A record is closed when the patient exits the **DIANE** environment.

Closing the record can automatically generate related tasks: printing the record, exporting the record to the electronic health record, etc.

2.2 Ways to enter data in DIANE

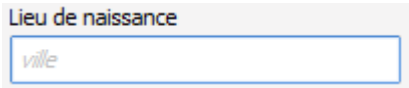
There are different ways to enter information and data in **DIANE**. The following chapters will list the different possibilities.

2.2.1 One-line input fields

This component lets you enter free text.
They may contain input prompts to guide the user. In this case, the field will only accept the type of data expected (no numbers for a town for example.)
This component accepts pasted information.

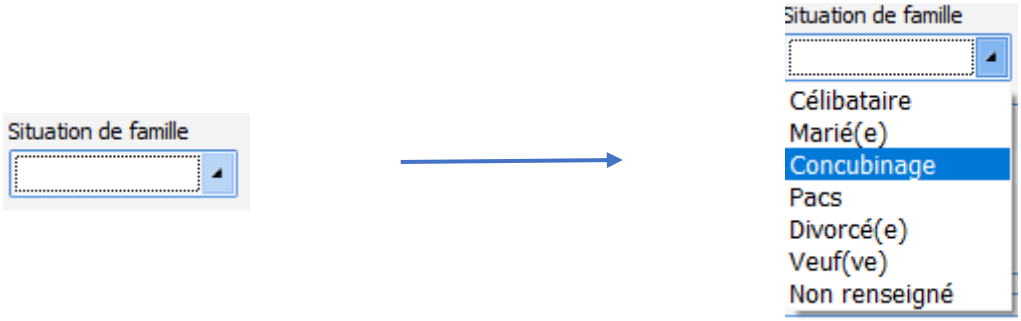
Example of input prompt:

- Greyed-out text showing the type of data expected (town in the example below)



2.2.2 Drop-down menus

If you click on this component, either on the arrow or the text box, the available options are displayed. You can click on any line in this box.



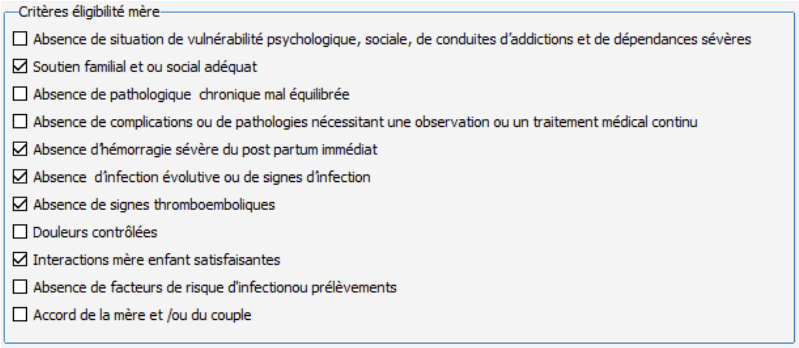
NB: You can browse through the choices offered using the up/down arrows on the keyboard.

2.2.3 Checkboxes

This feature lets you confirm information. You must use the mouse to click on it to switch from one status to another. You can also change the status of the checkbox using the space bar when the focus is on that checkbox.

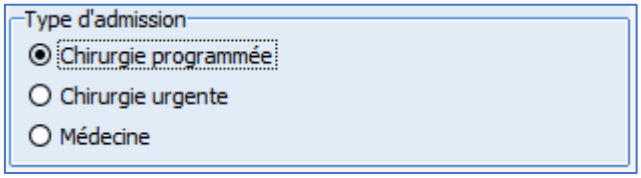
2.2.4 Checkbox groups

A checkbox group shows several choices that can be selected separately. You can therefore select several boxes in the same group.



2.2.5 Radio button groups

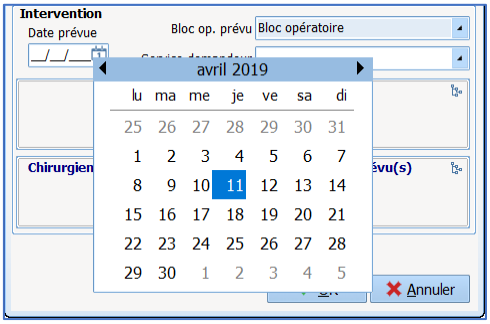
A radio button group only lets you select one item. If you click again on a radio button already selected, it will be deselected.



2.2.6 Dates and Calendar fields

The date fields let you enter a complete date in the day/month/year format.
The time can also be added in the __: __ format.
This field is completed either:

- By double-clicking to directly enter the current date.
- By entering the numbers in the date without spaces.
- If you hover the mouse over the field a calendar appears to select the desired date.

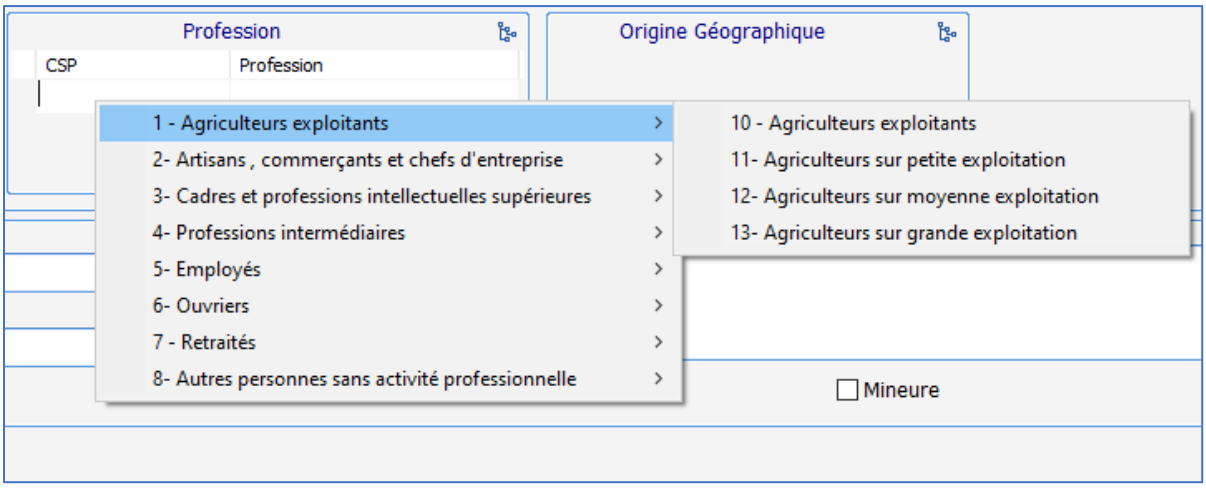


2.2.7 Input fields with a reference list

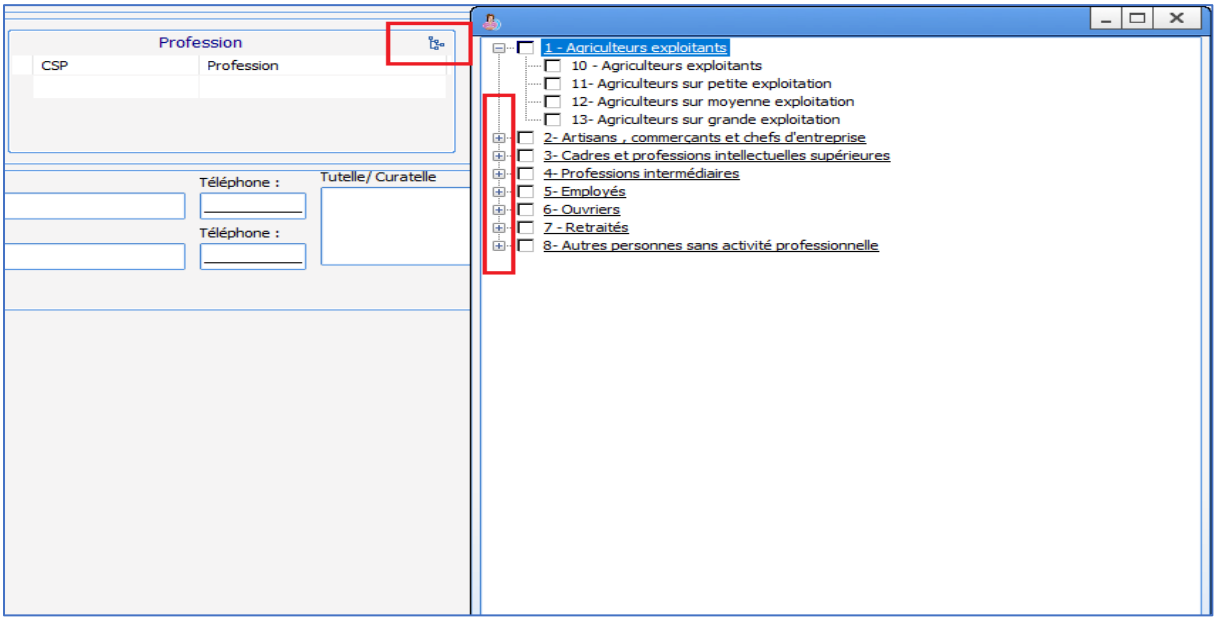
These fields let you enter information from a list and/or using free text. Free text will be used if the data sought does not already exist or to add to information.

There are three ways to access lists:

- By right-clicking in the relevant column. A list will appear. When there is an arrow at the end of the line this means that there are submenus. These are automatically displayed when the mouse hovers over. Only one data item can be entered at a time using this search mode.



- By clicking on the icon in the top right corner. A window containing the list appears. You can then tick one or more items in the list. You can display the subitems of a list by clicking on the '+' sign to the left of the lists.

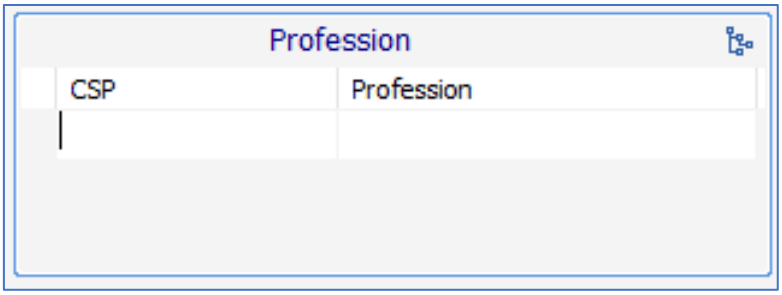


NB: some data in the list is purple. This means that the data is linked to an ICD-10 code.

- Manual entry: when you enter the first *n* letters (*n* can be configured by key users, generally 3 or 4), an automatic search will display the words recognized in the list. You can then select the desired content using the mouse.

You can access items that have not been configured for your unit but that were created for the hospital site by ticking the **View all items** box in the list display window.

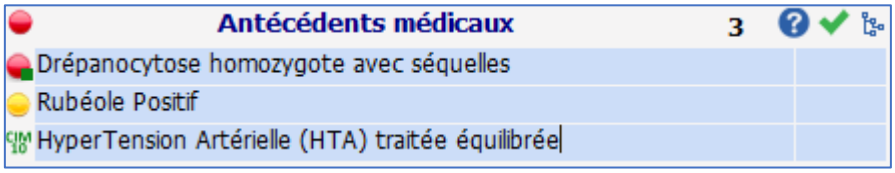
To enable free text input, simply click immediately under the title of each column and enter the desired text manually.



NB: these columns are invisible until data has been entered in them

In general:

- You can show the importance of a history item by clicking in the box on the left. This displays a red ball to show that this history item is important. If you click again in the same place a yellow ball will appear.



- You can click on to directly report that there is no significant history. For example, if you click on the green tick in the **Medical history** field, the words: 'no medical history' will appear. In each field, you can define a default value for this green tick.

  NB: It is always preferable to click on the green tick rather than not enter anything as this could suggest that the patient was not asked for this information.

- When a logo is visible at the top right, it means that only data with an ICD-10 code will be kept in the database (i.e. the data in the list that is purple).
- When there is a on the top right of a component, you can click on it for help. For example, if you click on the in the **Medical history**, you have direct access to Orphanet.

2.2.8 Buttons

Buttons have a call up function in **DIANE**.

Clicking on a button can call up:

- A contextual link: this gives direct access to other software (e.g. direct access to the laboratory or imaging software or even to the EHR).

- A detailed entry: this gives access to a consultation sheet, a score, etc.

- Printing: this gives access to a document that can be printed (e.g. consultation report, 8th day certificate, etc.).

- Multiple entries: this is a method that lets you enter a series of procedures rapidly.

- A list of events: this is available for intraoperative/postoperative monitoring and in the delivery room; certain buttons give access to a list of events

- A list of treatments: this is available for intraoperative monitoring and in the delivery room

Examples of buttons:

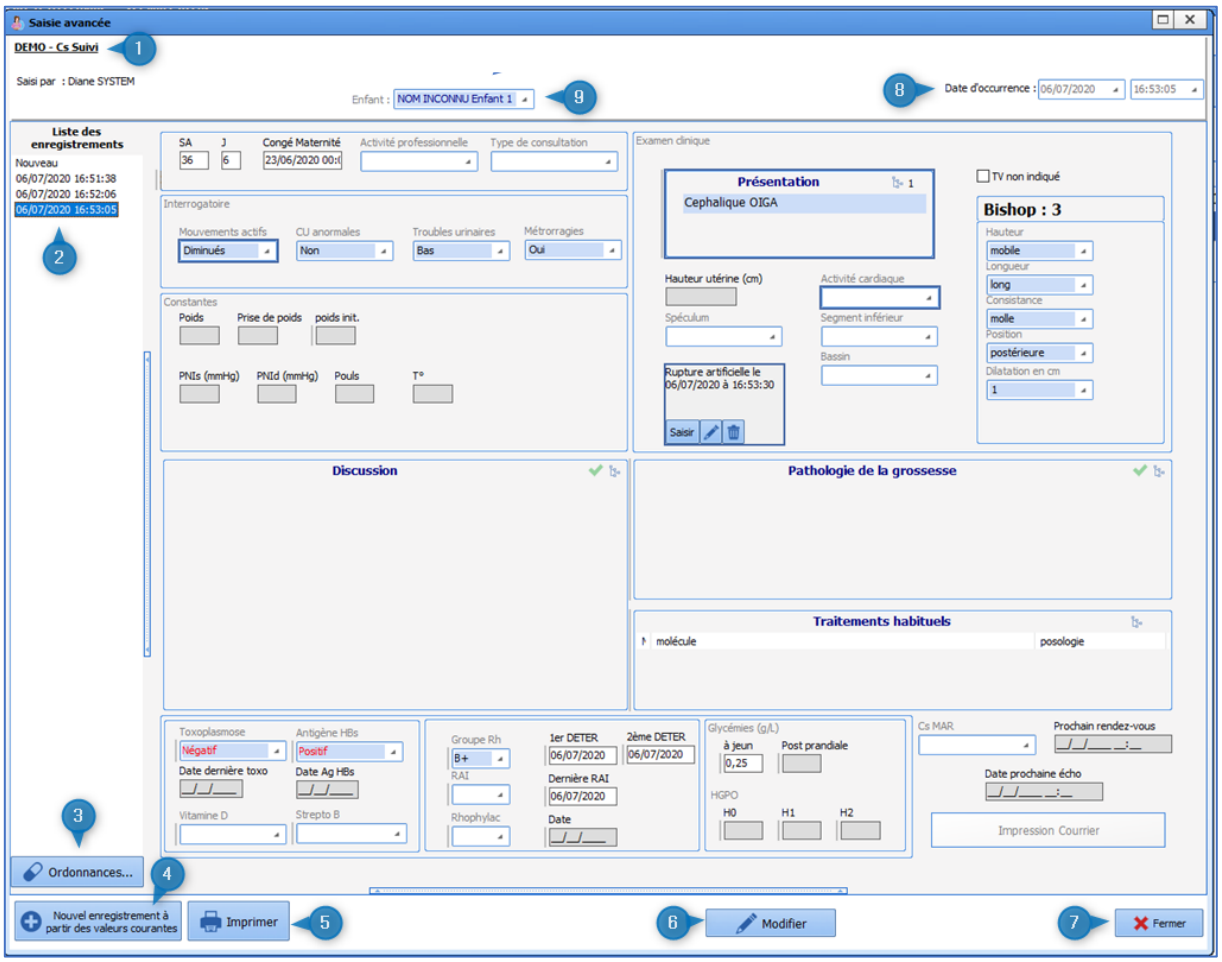
Drainage / Elimination	Located on the care plan, in the intensive care unit, this button gives access to the list of events related to drainage and elimination: placing a drain, removing a drain, fitting an indwelling urinary catheter, etc.
Glasgow	Glasgow score access button. When you click on this button a window opens for you to enter the Glasgow score.
SM Induc	Button to access multiple entries for **Induction**. Allows you to enter all the data needed to intubate a patient.

2.2.9 Detailed entries

Detailed entries are monitoring sheets accessed in different ways: detailed entry table, detailed entry display component with history, a button, menu in the 'entries' bar of the **MONITORING** tab during and after surgery, etc.
These sheets can be used in different ways depending on the situation. They can be used as a consultation sheet, score entry sheet, checklist, etc.

2.2.9.1 How detailed entries work

How it works: example of obstetrics follow-up consultation



1: Name of detailed entry

2: List of data registered: this column groups together all the detailed entries of the same type already registered for this file. You can view the other detailed entries by clicking on the registered data displayed in this column. If you click on **New** you can enter a new consultation. When you open a detailed entry, a new entry is displayed by default.

3: Prescription form button: lets you generate prescription forms directly from the detailed entry.

4: New record from current values: lets you open a new data entry sheet by retrieving all the data recorded in the previous detailed entry.

5: Print: lets you print the detailed entry.

NB: this button does not generate the consultation report. It prints the screen.

6: Change: lets you change a consultation sheet opened when it has already been completed and confirmed.

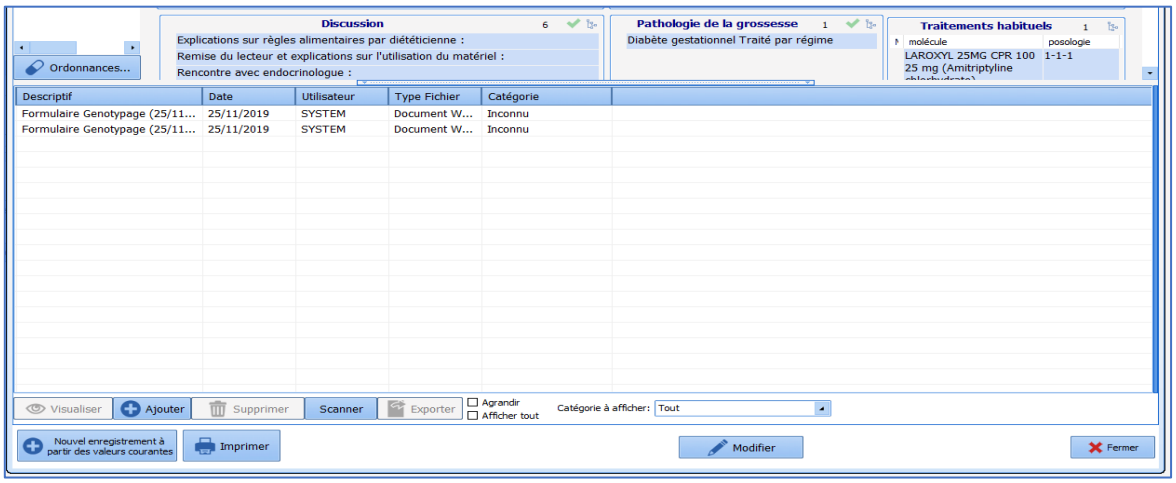
NB: A consultation sheet can only be changed by the caregiver who created it.

7: Confirm / cancel: lets you confirm or cancel the current entry.

8: Date of occurrence: lets you change the date and time of the entry (if the data was entered after the clinical examination, for example).

9: Choice of child menu: the fields outlined in dark blue are 'child' fields, i.e. they relate to data concerning the foetus. In a multiple pregnancy, you must choose another child (T2 for example for a twin pregnancy) to record the data for the examination of the second foetus. This choice is made using the drop-down menu. When you change the child, the outline of the data will change colour in the relevant fields.
NB: this menu is only available for the obstetrics module

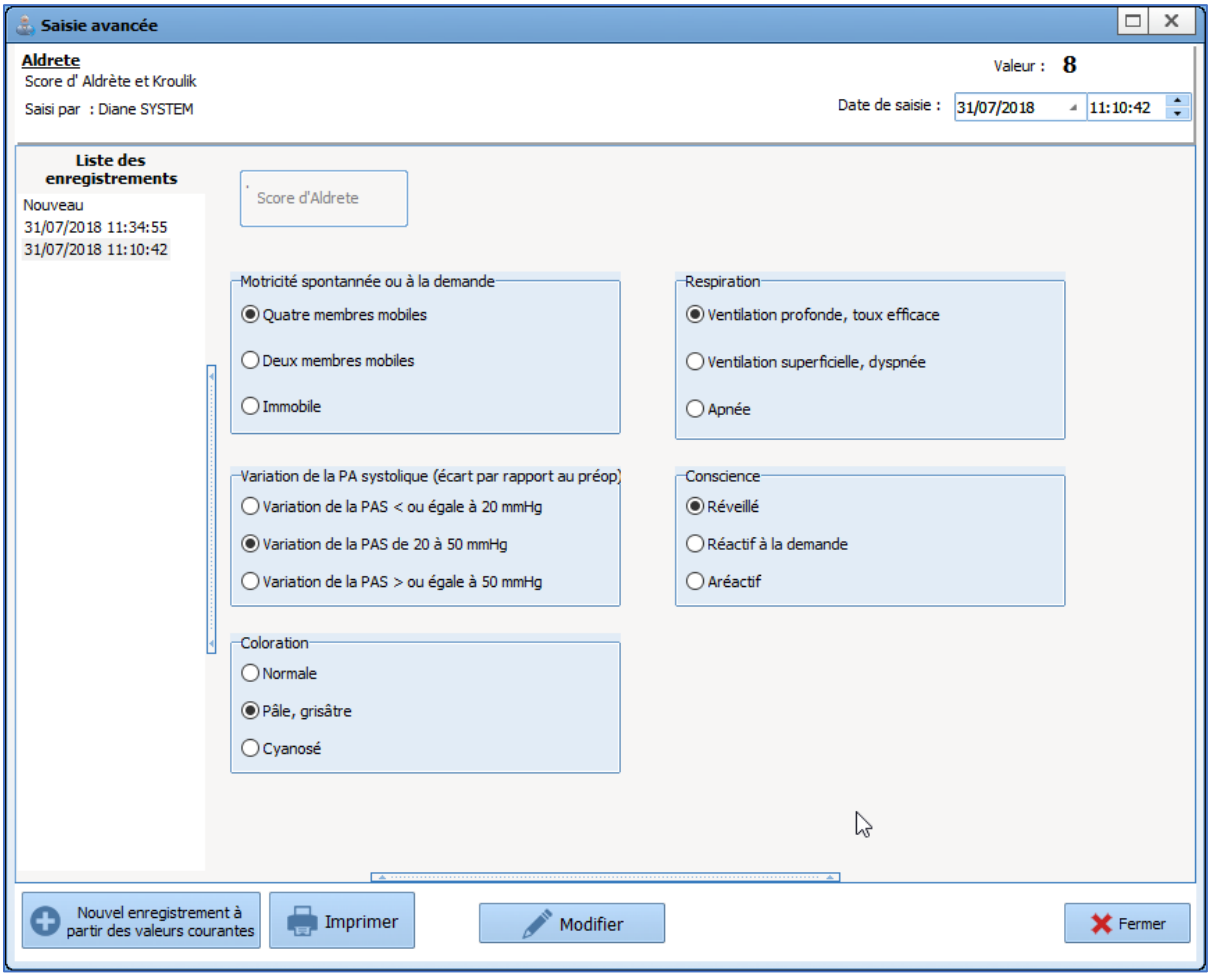
View documents: at the bottom of the detailed entry sheets is a blue bar marked with dots. If you click on this bar, a window appears containing the documents. It contains all the documents scanned, imported from other software or printed in **DIANE**.



2.2.9.2 Scores

DIANE lets you enter many different scores. These scores are accessed in the same way as detailed entries and work in a similar way.

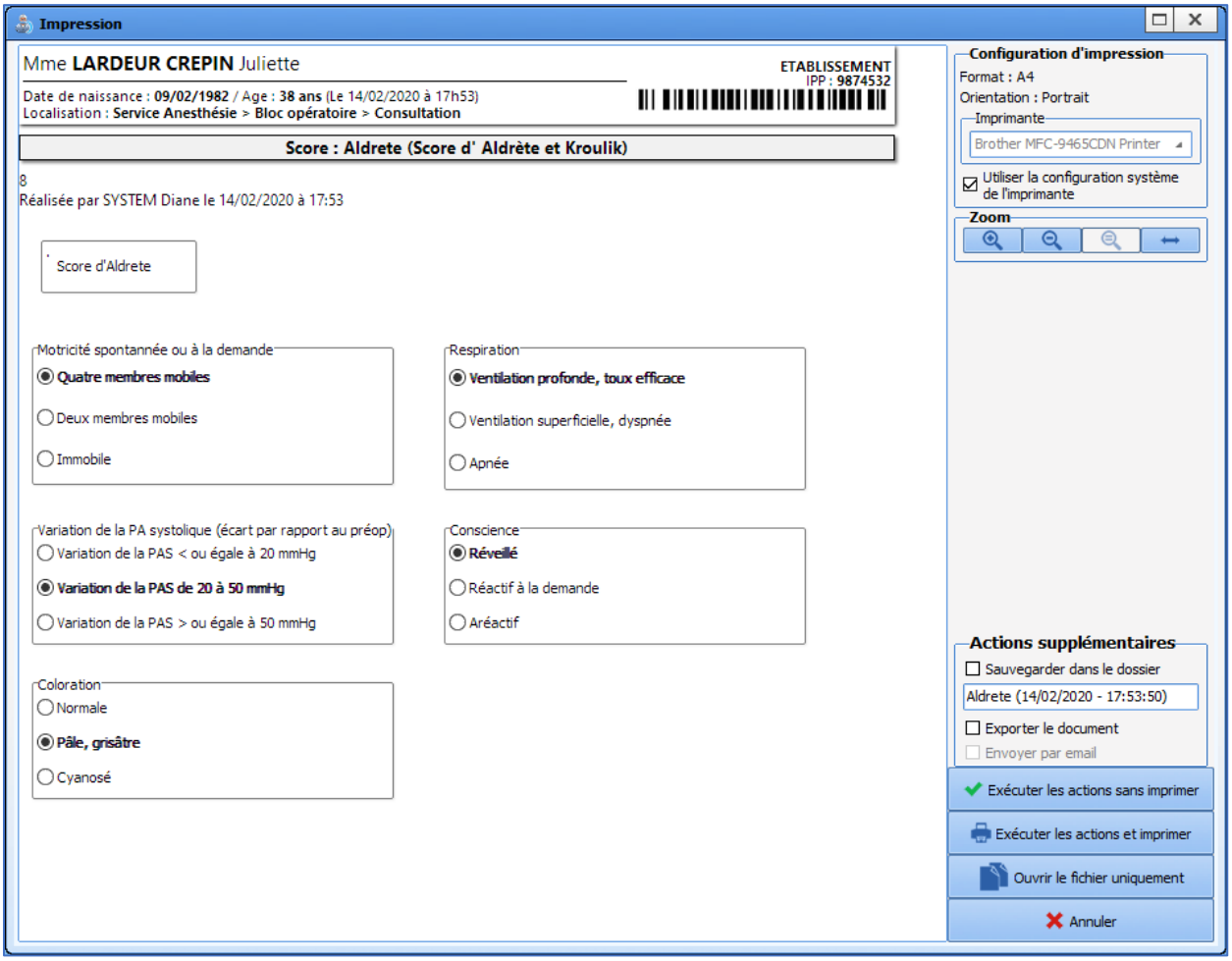
Example of the Aldrete score:



When you open the score, simply complete each of the fields required to calculate the score. Once you have finished, the score value is displayed at the top right of the data entry sheet.

NB: some scores do not result in a numerical value but some other type of data such as classification in an at-risk group. This is the case for the early onset neonatal infection score used in the **DIANE OBSTETRICS** module.

If you want to print out a score, it must be saved first. When you click on the **Print** button the following window appears.

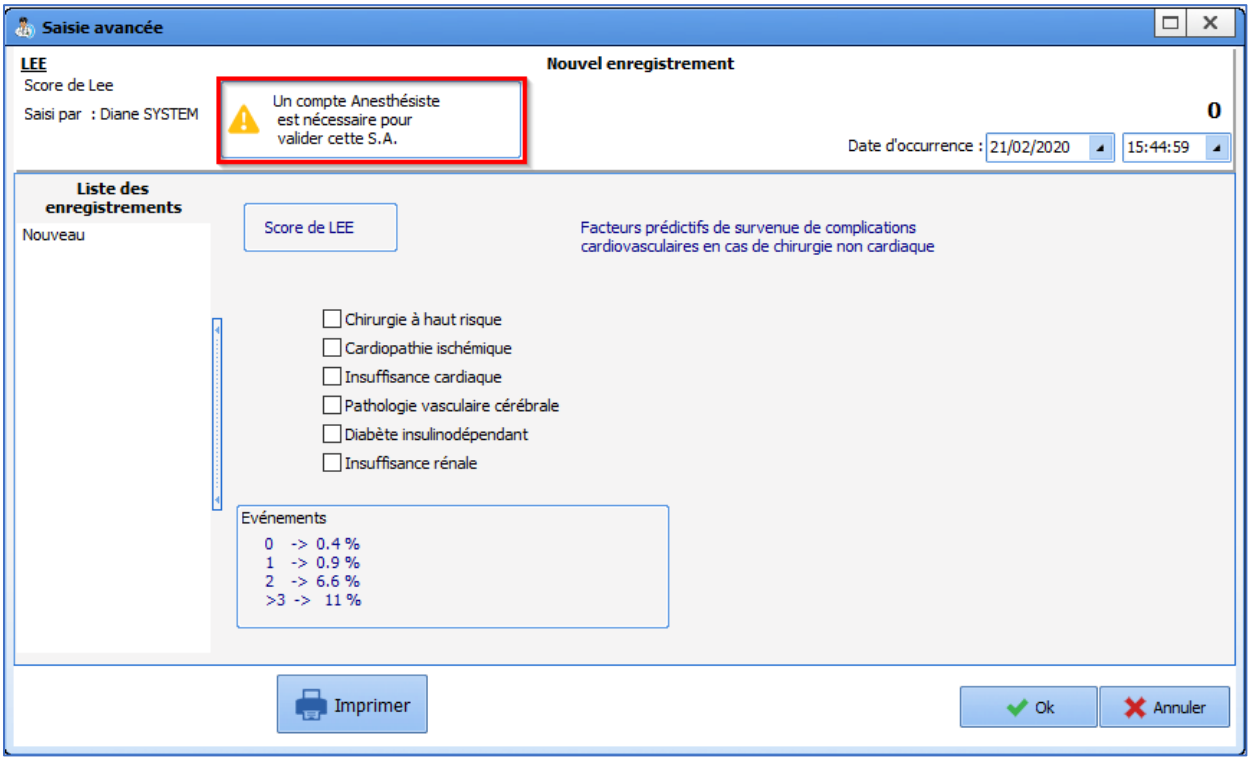


Score entries are in bold to see them more easily.

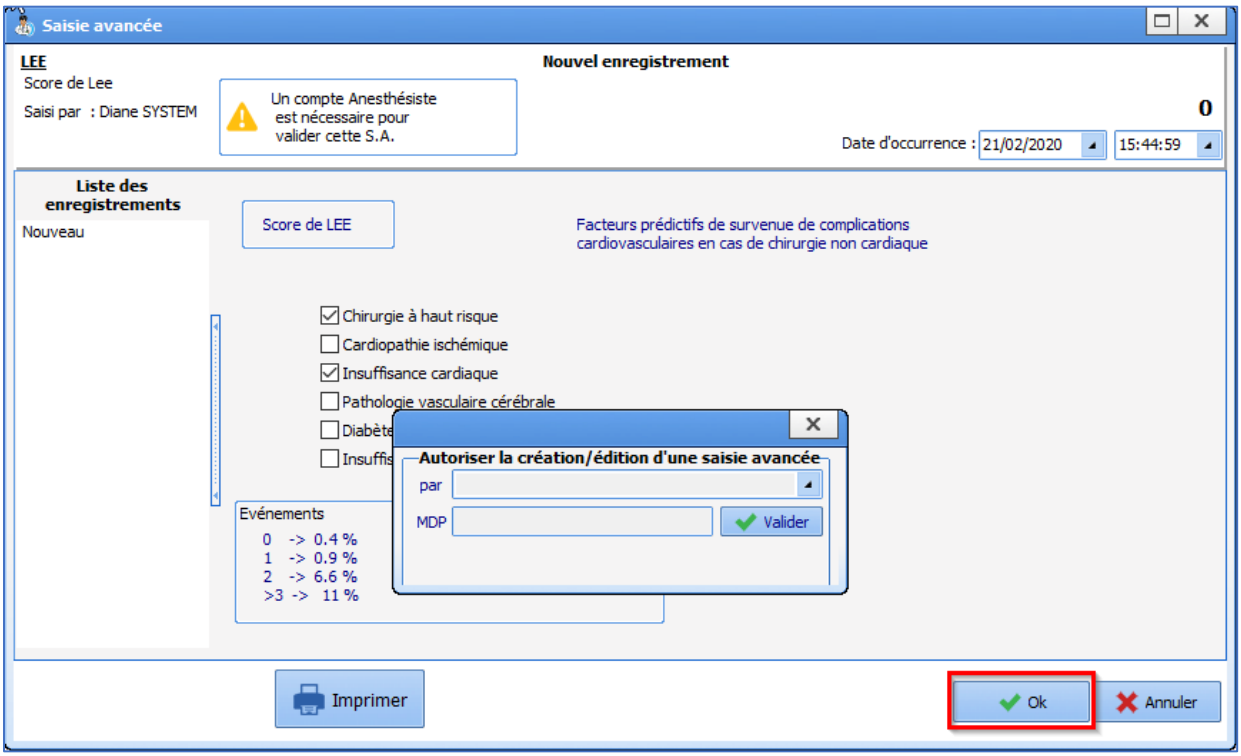
As with a form letter, you can save and/or export this document.

- **Execute actions w/o printing:** you will save and/or export the document without printing,
- **Execute actions and print:** you will save and/or export and print the document,
- **Open file only:** you will create and display a PDF of the document,
- **Cancel:** you will cancel all tasks

Some Detailed entries require the user logged on to have a certain function.



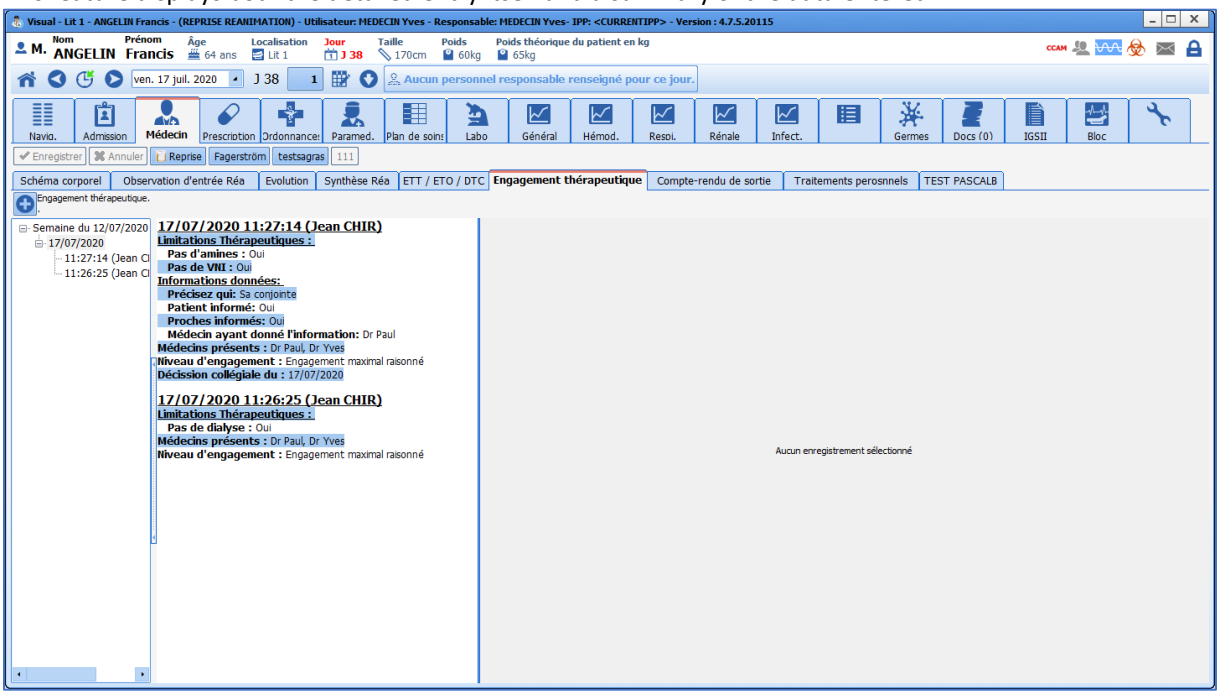
Some scores can only be entered by a given function. In the image above, a warning says that this score must be entered by an anaesthetist.



A window appears allowing the anaesthetist to enter their login and password.

2.2.9.3 Detailed entry display with History

This feature displays both the detailed entry itself and a summary of the data entered.



To add new information to the Detailed entry, click on the '+' button above the left column.
When you confirm what you have entered, it is inserted in the left column.

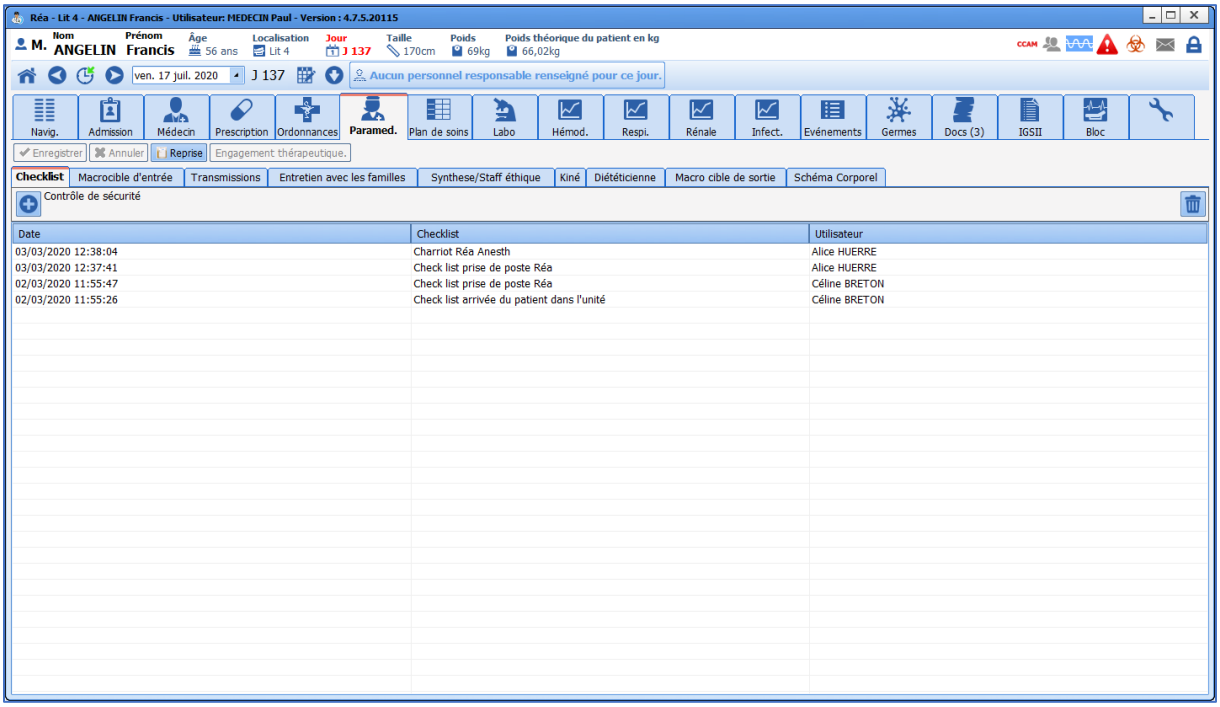
Left column
This column is the history of the Detailed entries recorded. You can view the different information recorded at any time by clicking on the relevant line. When you have clicked on a line in the past, the middle column and right column are updated.

Middle column
This column displays the summary of the detailed entry selected in the history column.

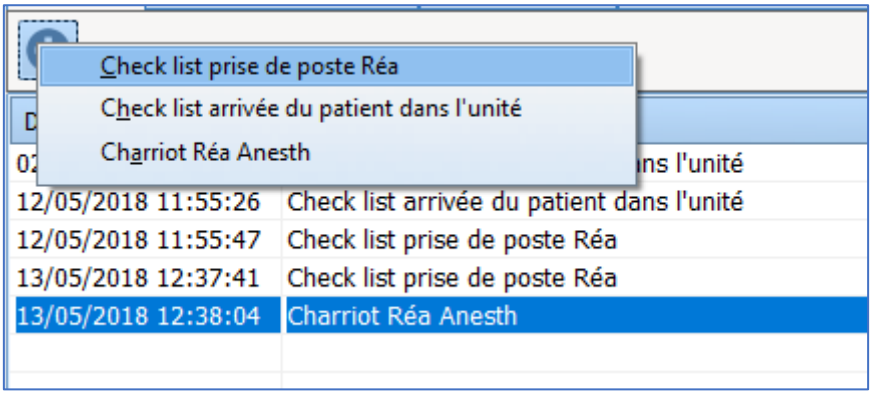
Right column
This column displays the detailed entry.

2.2.9.4 Display of Detailed entries as a list

The **Display of Detailed entries as a list** is a feature that lets you list detailed entries. Some data from the detailed entries appears in the table (configured by the key user).

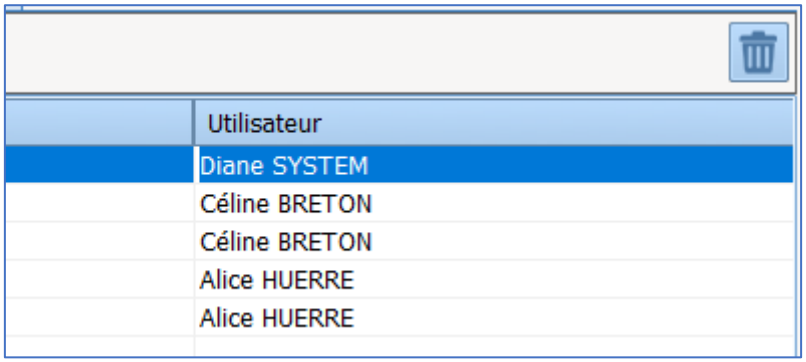


To call up a detailed entry, click on the 'plus' to the top left of the table. If more than one detailed entry is available, a list will appear for you to choose the desired data entry sheet.
Example: it is possible to list different scores in this way. This allows easy access to all types of scores needed.



- If you want to **change** a detailed entry, double-click on the line chosen and the corresponding Detailed entry opens for you to change.

- If you want to **delete a detailed entry**, click on the line chosen and then on the bin to delete the line.



NB: DIANE keeps a trace of all entries. Therefore, an entry can be found when needed.

2.2.10 Multiple entries

Multiple entries are a simple way of entering a series of procedures, drugs, consumables, detailed entries, etc.

This data entry method is used particularly for intraoperative and postoperative monitoring. It is configured by the facility's key user.

2.2.10.1 Triggering multiple entries

Multiple entries can use a button which will be at the top of the screen or can be accessed by right-clicking in the data entry bar of the above-mentioned modules.
The multiple entry clicked on opens.

2.2.10.2 Using multiple entries

Multiple entries can be short for a very specific task, such as installing the patient.
They can also be longer and include all items, for example from the patient's arrival to when they leave a room, which is particularly useful for short procedures (such as elective abortions, a tooth extraction or colonoscopy).

When you enter the data, you can choose to use all or just part of the multiple entry. Also, by clicking in the boxes, you can enter the drug dosages or change and/or supplement the preselected items.

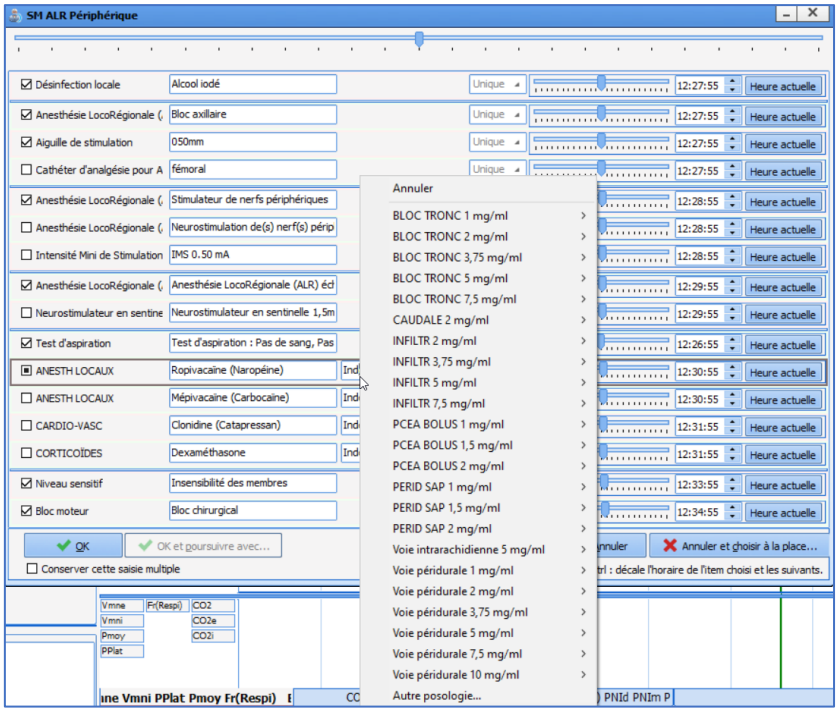
There is a tick mark on each line to select the actions to confirm. When you enter an item in the line, the tick mark is activated.
You can use each box present. The menu of the selected section can then be modified. The choices available will only be related to what is foreseen by the original predefined list.

2.2.10.3 Time management

The times, located to the right of the window, can be adjusted:

- either by entering the desired time directly,
- or by sliding the main cursor (at the top of the window): this will change all times while taking into account the preconfigured time gaps,
- or by clicking on the **Current time** button,
- or by sliding the cursor on a single line.

TIP: To slide the cursor on a line and also slide the following ones, keeping the time gaps for the following items, hold the **CTRL** key while sliding the desired cursor.



2.2.10.4 Close or cancel a multiple entry

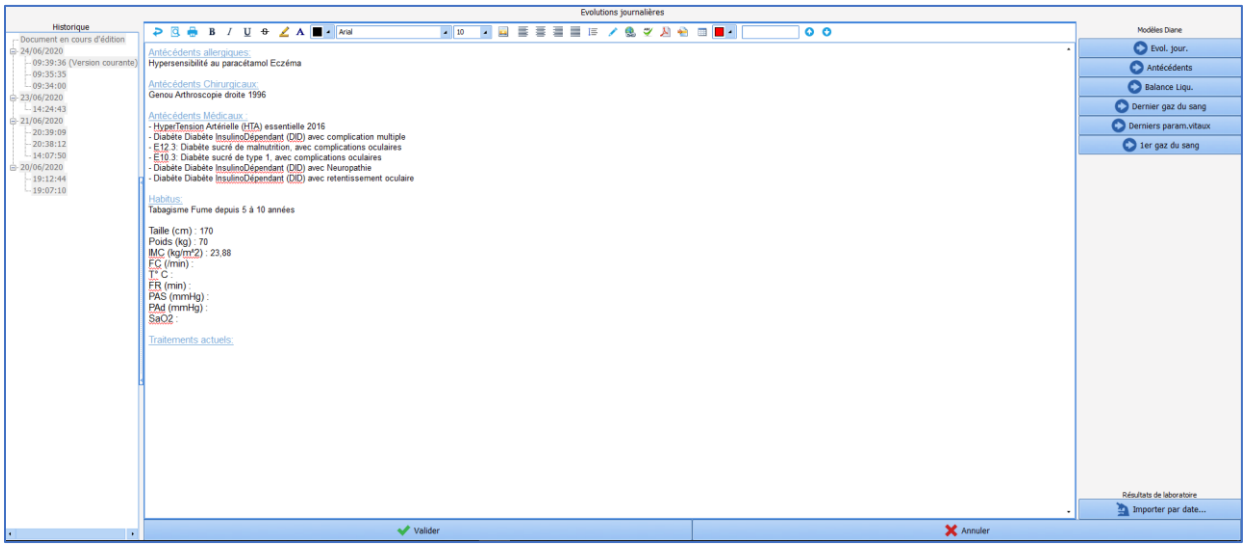
Once the multiple entry is complete, you can:

- Confirm and close it by clicking on the **OK** button,
- Confirm it and go on to another multiple entry (from a selection of multiple entries configured by your key user) by clicking on the **OK and go to...** button.

To cancel the current multiple entry, you can:

- Cancel and close it by clicking on the **Cancel** button,
- Cancel it and go on to another multiple entry (from a selection of multiple entries configured by your key user) by clicking on the **Cancel and instead choose...** button.

2.2.11 Document creation area



The document creation area is used in different situations such as for medical summaries, paramedical summaries or delivery reports.

This component lets you create the various reports either by manual entry or by using buttons to the right of the screen.

To start creating a report, you must first click on the **Add information** bar at the bottom.
You can then enter information in the central pane.
Most often, pre-existing templates can be used to create a report by automatically retrieving the data entered in the record.
In the example above, if you click on the **Daily changes** button you will automatically see the patient's history, allergies and the last recorded vitals in the central pane. You can therefore create the report you want by successively clicking on the buttons corresponding to the information you want to retrieve. The information will be added to where the mouse cursor was in the central pane.
Once the report is complete, simply click on **Confirm** at the bottom to save the changes.

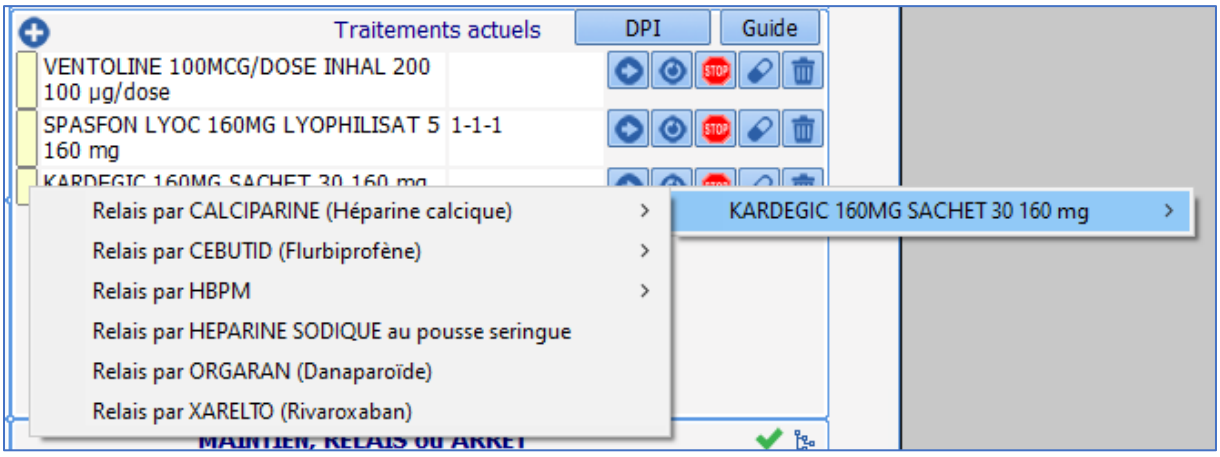
On the right, a retractable history pane gives access to all reports previously created.

2.2.12 Current treatments component

This field acts like all other data entry fields with a reference list, but has some additional options described below:

Clicking on the yellow rectangle to the left of each line gives direct access to the drug database (and the reference centre for teratogens (RCT) in the obstetrics module).

A drug management function can be enabled in this component. In this case, several icons are available on the right:



- Is used to continue the drug
- Is used to switch to another drug

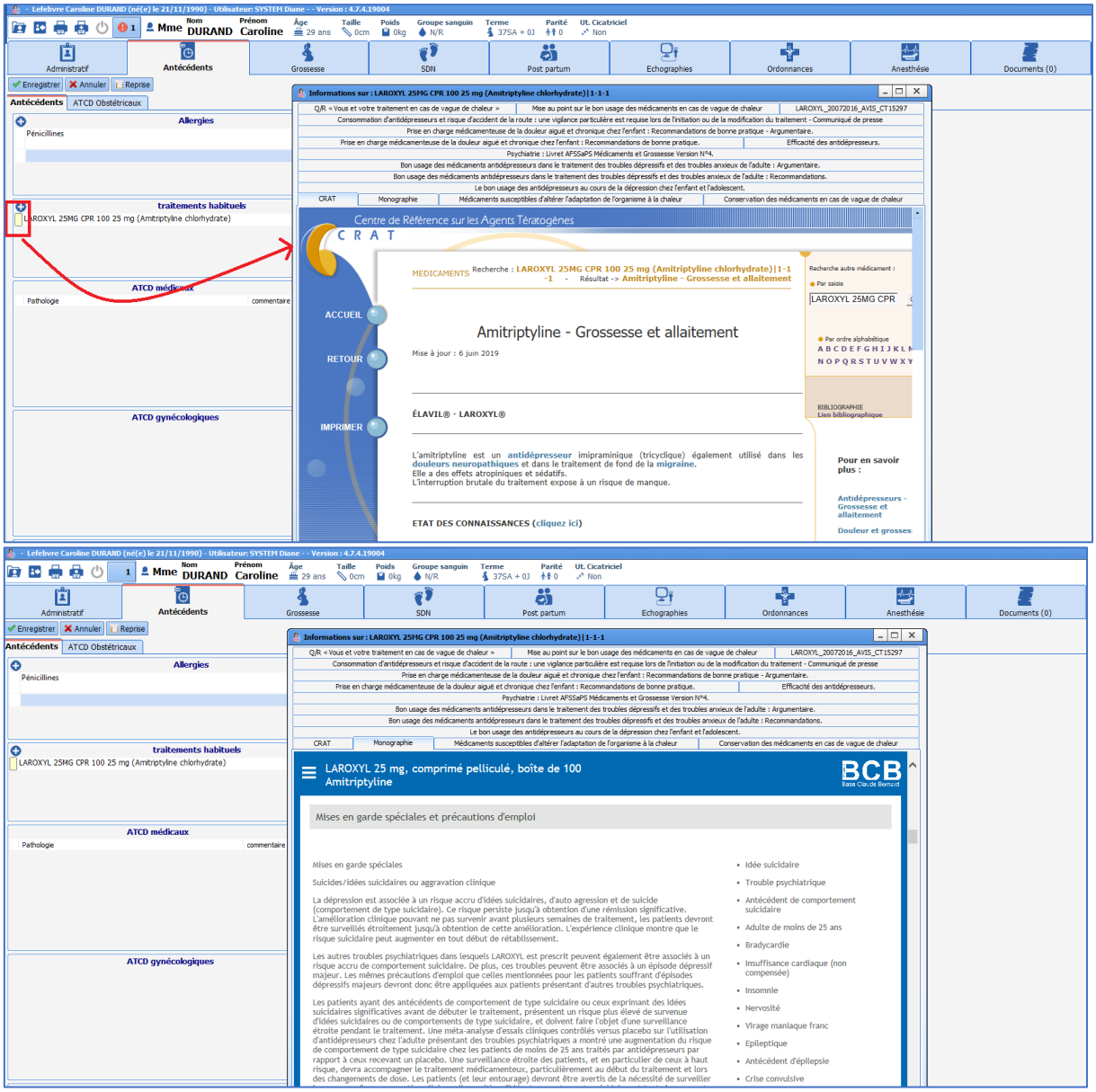
- Is used to stop using the drug
- Is used to send this drug to the premedication in the **Conclusion/Appointment** tab
- Is used to delete the line

2.2.12.1 Specifics of anaesthesia

For full use of this component in anaesthesia, it is commonly used with components called **CONTINUE, SWITCH or STOP**.
These components share information and decisions made are inserted into the second component. You can then issue a prescription form that specifically follows what is decided in **CONTINUE, SWITCH or STOP**.

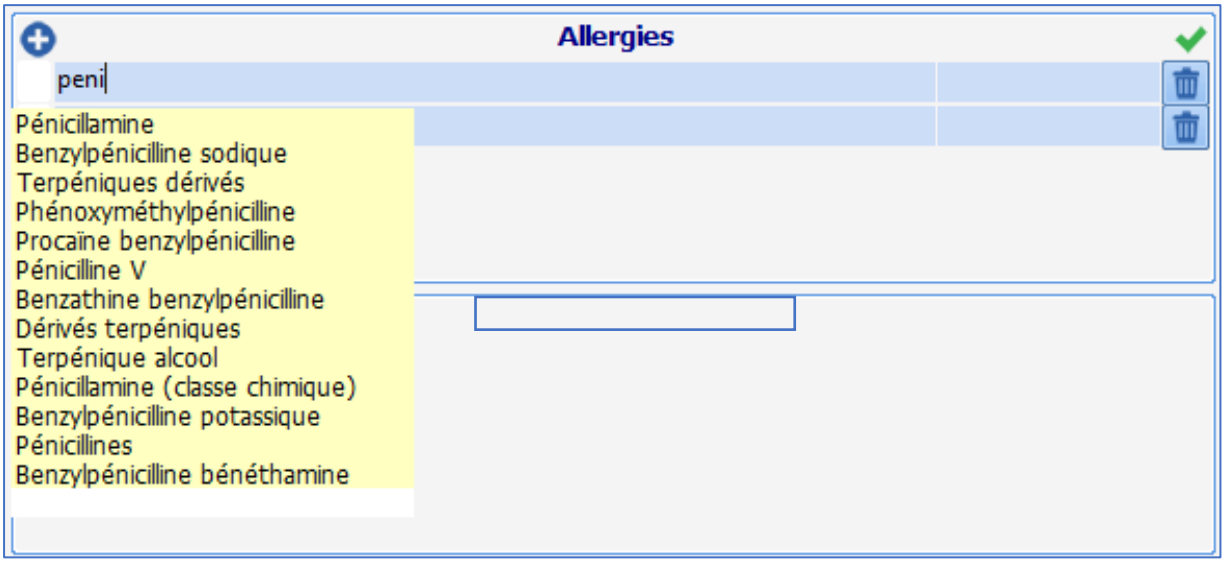
2.2.12.2 Specifics of obstetrics: Access to the Reference Centre for Teratogens

To the left of the treatment there is a yellow rectangle. Clicking on it gives **direct access to RCT** (the Reference Centre for Teratogens) on the page corresponding to the drug. It also gives access to the monograph of the drug (either from BCB or Vidal).

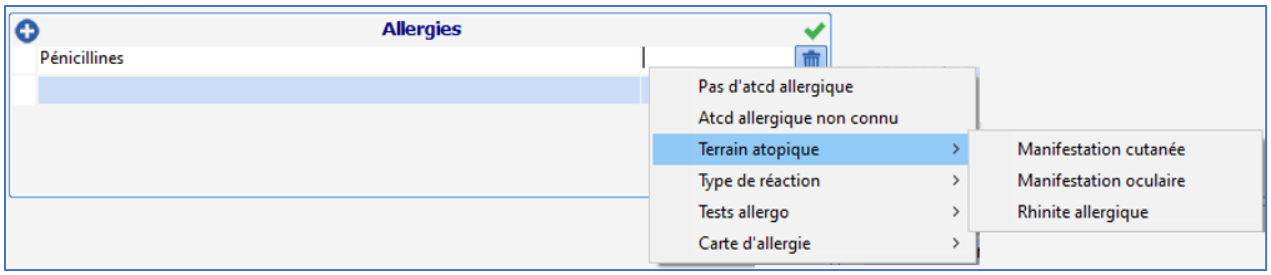


2.2.13 Allergies component

The **Allergies** field has two columns. The left column is used to enter the allergen. When you enter the first letters a list of allergens appears for you to choose from.

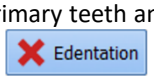


In the right column, right-click to access a list of allergic reactions caused by the product.



NB: There is a link between the **Allergies** component and the prescription. If the treatment prescribed mentions an allergen listed in the **Allergies** component, you will be warned that an allergy has been detected. This warning does not block the prescription.

2.2.14 Tooth chart

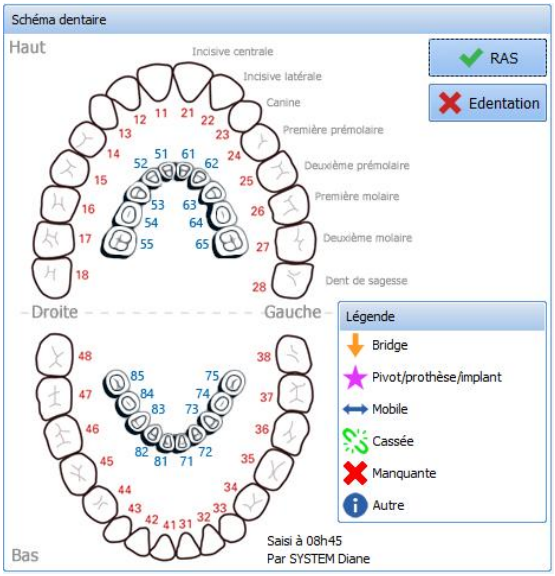
The tooth chart is suitable for adults and children as it shows both the primary teeth and permanent teeth. The features for both types of teeth are identical with the exception of the 

button which is only for permanent teeth.

Items are entered into this component in different ways:

- By clicking on a tooth: you can scroll through the different options available.
- By dragging and dropping: by dragging an item from the legend onto the relevant tooth.

The **NTR** button resets the diagram.

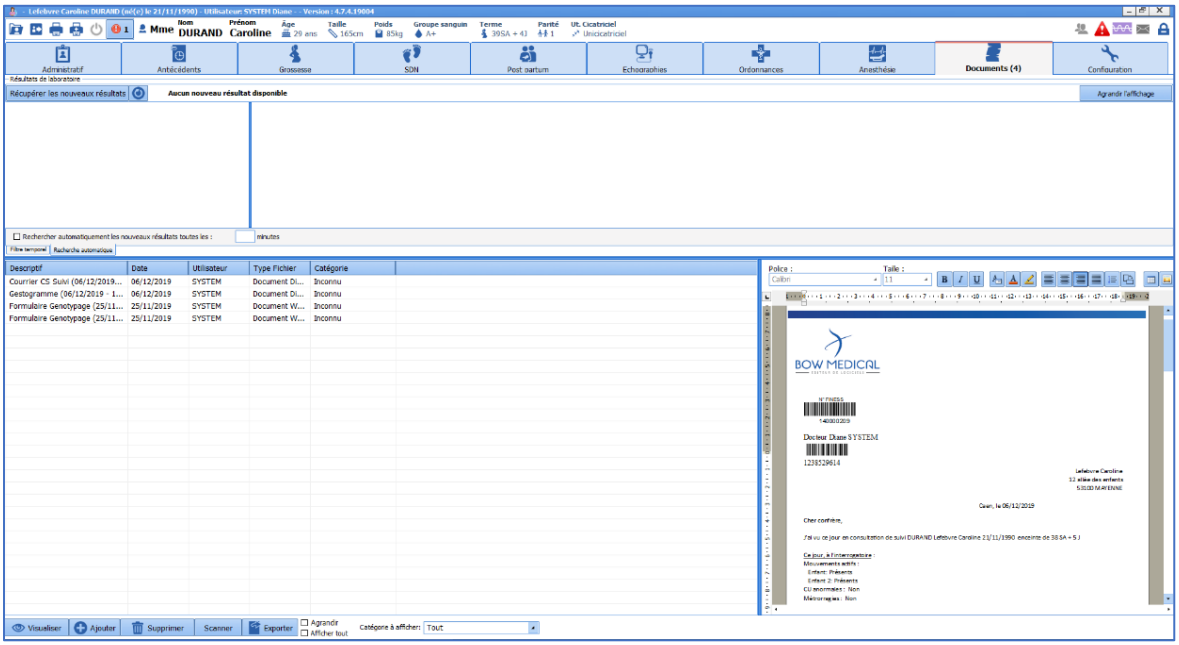


2.2.15 Common tabs

Some tabs are found in all modules. These tabs are explained below.

2.2.15.1 Documents tab

This tab lets you save and store the different documents from a patient's record. You can save and store documents created directly in **DIANE** but also attach documents that are not in the record such as scanned images or images imported from other software such as ECGs or X-rays.
These documents can be viewed by clicking on the corresponding line and can be generated and printed from this tab.



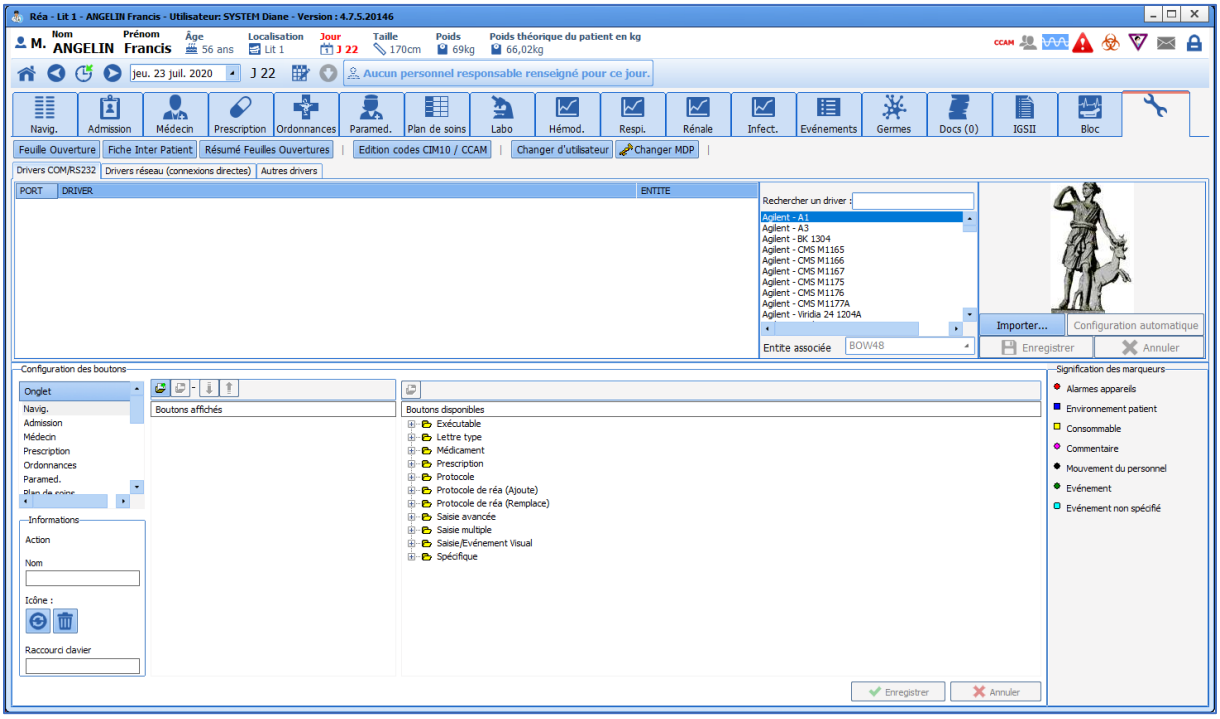
All this information is stored in the patient's record and can, if you wish, be exported to another software.

NB: You can make changes to a file saved in this tab.

2.2.15.2 Configuration tab

The **Configuration** tab lets you **configure the drivers** of biomedical equipment connected to the computer and **configure the buttons**.
We also see the meaning of the markers inserted in the **Events** line of the **Monitoring** tab or **views**.

The **Configuration** tab buttons give access to certain detailed entries (checklist, identity monitoring, etc.) and to generate ICD-10 and procedure codes.



2.2.15.2.1 Configuring connected devices

After connecting the biomedical equipment to the computer using the appropriate cable, it must be configured in **DIANE**. To do this, simply select the name of the device from the list and drag it with the mouse to the **Com Port** it is connected to.

NB: the value retrieved from the biomedical equipment and displayed in **DIANE** is the median of all values received over 30 seconds.

Right-click on the monitor connected to a Com Port to display a menu to **Restart**, **Configure**, **Remove the driver** or **Enable Debug mode**.

If there is a problem receiving the values from a monitor, you can **Reboot the driver**. If this does not solve the problem, contact your site administrator to check the configuration.

If the biomedical equipment in a room is changed, you can **Remove the driver** from the Com Port to free it up to install other biomedical devices.

The drivers are preconfigured to operate with biomedical equipment. However, if the equipment has a specific configuration, you must first **configure the driver** using the **Driver configuration** window.
This window is used to configure the **Communication settings** and the **Flow control** between the computer and the equipment. *See the monitor documents to find out the settings for each part of this window.*

2.2.15.2.2 Configuring buttons in the different tabs

You can create programmable buttons available in the application's different tabs. These buttons can be used for simple data entry (intubation, incision, closure, extubation, etc.), to open a multiple entry window, to calculate scores, etc.

To add a button to a tab, first, in the **Button configuration** area, select the **Tab** in which you want to insert your button. Then expand the tree of **Available buttons** and choose the button you want to insert. Using the mouse, drag and drop this button onto the list of **Displayed buttons**.

The table below shows the meaning of the different buttons in the **Configuration** window.

Buttons	Function
	These two buttons let you change the display order.
	When located above the displayed buttons area, this button lets you add a separator between button groups. The separators are created at the end of the list. Simply move them around using the arrows mentioned above. When located next to an **icon**, this button associates an icon with the button selected in the list of **displayed buttons**. Enter the icon's access path then click on the **Open** button.
	When located above the **displayed buttons** area, this button lets you delete a button or a separator from the selected **tab**. When located above the **displayed buttons** area, this button lets you delete a button from the configuration. When located next to an **icon**, this button is used to delete the icon associated with the button selected.

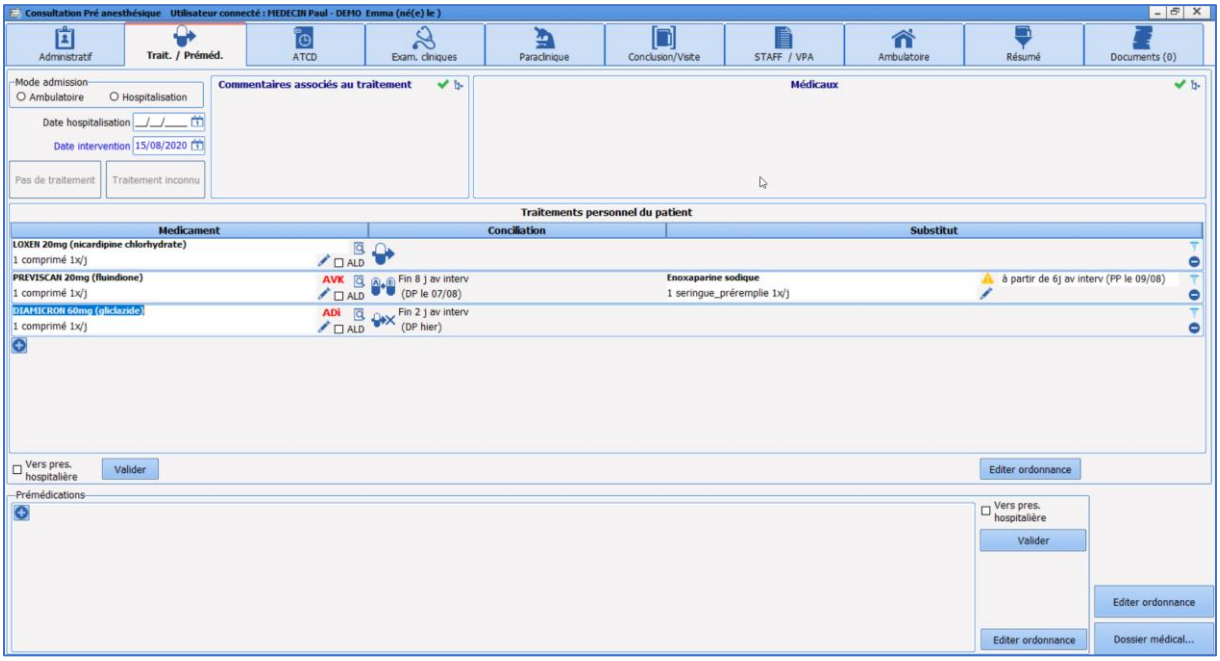
In the **Information** area, located on the left side of the **Button configuration**, you can change or delete the name of a button after selecting it from the list of **displayed buttons**.

2.2.15.3 Treatment / Premedication tab

This tab lets you replace the two components **Current Treatments** and **Continue, Switch and Stop**. It lets you enter the patient's current treatment and manage it.

You can enter the patient's treatment line by line and then, using favourites, manage switches, continued treatment or discontinuations.
You will then be able to generate the prescription form accordingly but also prepare the postoperative prescription.

Weight, height, gender and age are necessary to analyze the prescription. If these have not been entered beforehand, a window will automatically open asking you to enter them.



2.2.15.3.1 Buttons

The button lets you add a line.

Clicking on the button to the right of the line deletes that line.

NB: The line is actually deleted when you confirm by clicking on the **Confirm** button in the section concerned

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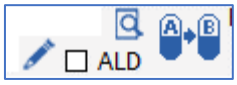
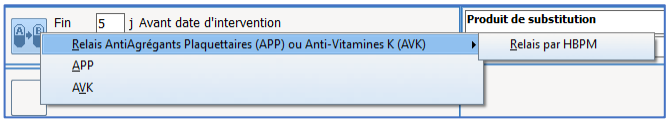


When you click on the dosage a specific window opens to enter the dosage easily.
To provide more information, you can use the pencil shown above.

By clicking on the magnifying glass you can enter the medical condition for which this drug has been prescribed. At the same time, this enters the information in the **Medical History** component. This data entry method enters the ICD-10 codes automatically.

By clicking on the capsule button, you can scroll through the different choices:

Switch: right click to see the switch menu



Drug continued

Drug discontinued

LD = Last Dose
FD = First Dose

2.2.15.3.2 Reconciliation

The reconciliation area shows what course of action has been decided for the drug: continuation, but particularly switches and discontinuation. In this area, you can adjust the number of days before the surgery the drug is stopped by clicking directly on the proposed number. If the surgery date has been entered, **DIANE** will calculate the date of the last dose (**LD**).

2.2.15.3.3 Substitution

The substitution area lets you enter the drug chosen for the switch, the dosage and the date of the first dose (**FD**) expressed as the number of days from the surgery date. You can change the default choice by clicking directly on the name of the drug or by using the pencil to the right of the replacement drug.

IMPORTANT: Note that all drugs can have favourites created by your key users.

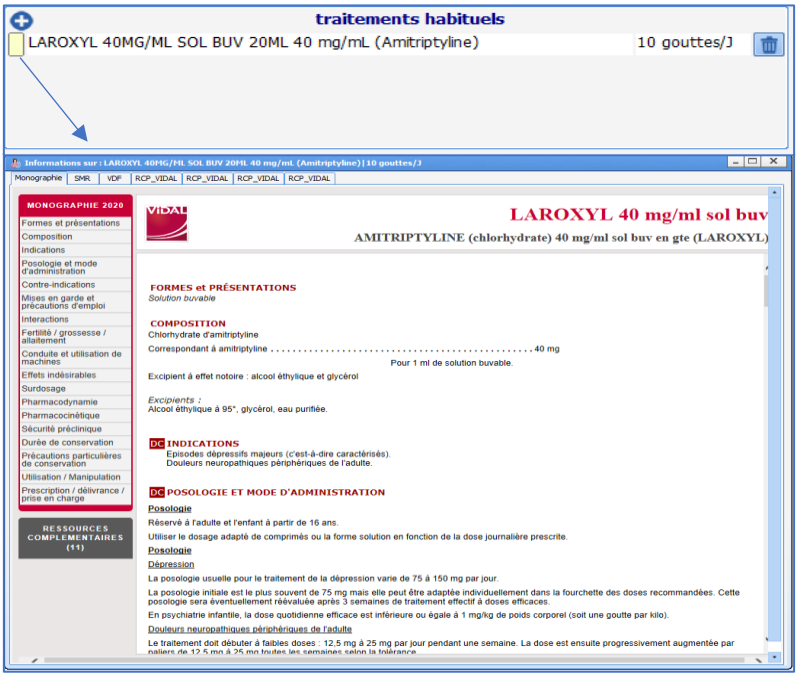
2.2.15.3.4 Confirm the prescription

Each area of the **Treatment / Premedication** tab has its own confirmation button. This confirmation is equivalent to an electronic signature.
If the **To hospital prescription** box is ticked, before confirmation, everything entered will be sent to the **Prescription** tab in **DIANE ANAESTHESIA** and/or **DIANE ICU**.

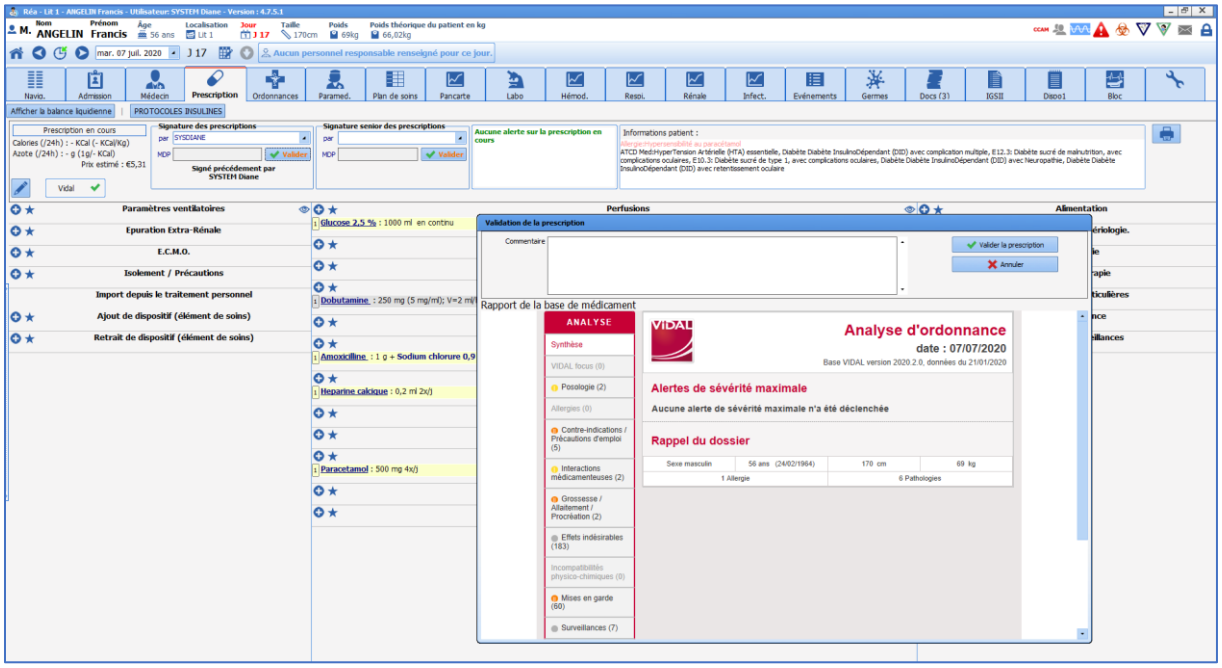
After confirming, you can print out the prescription by clicking on the **Issue prescription** button.

2.3 Link to drug databases

DIANE is linked to drug databases (Vidal® and Base Claude Bernard®) and facility formularies. This improves prescription safety.
When entering a treatment in the **Current treatments** component, clicking on the yellow rectangle next to the data entry line gives direct access to the drug monograph.



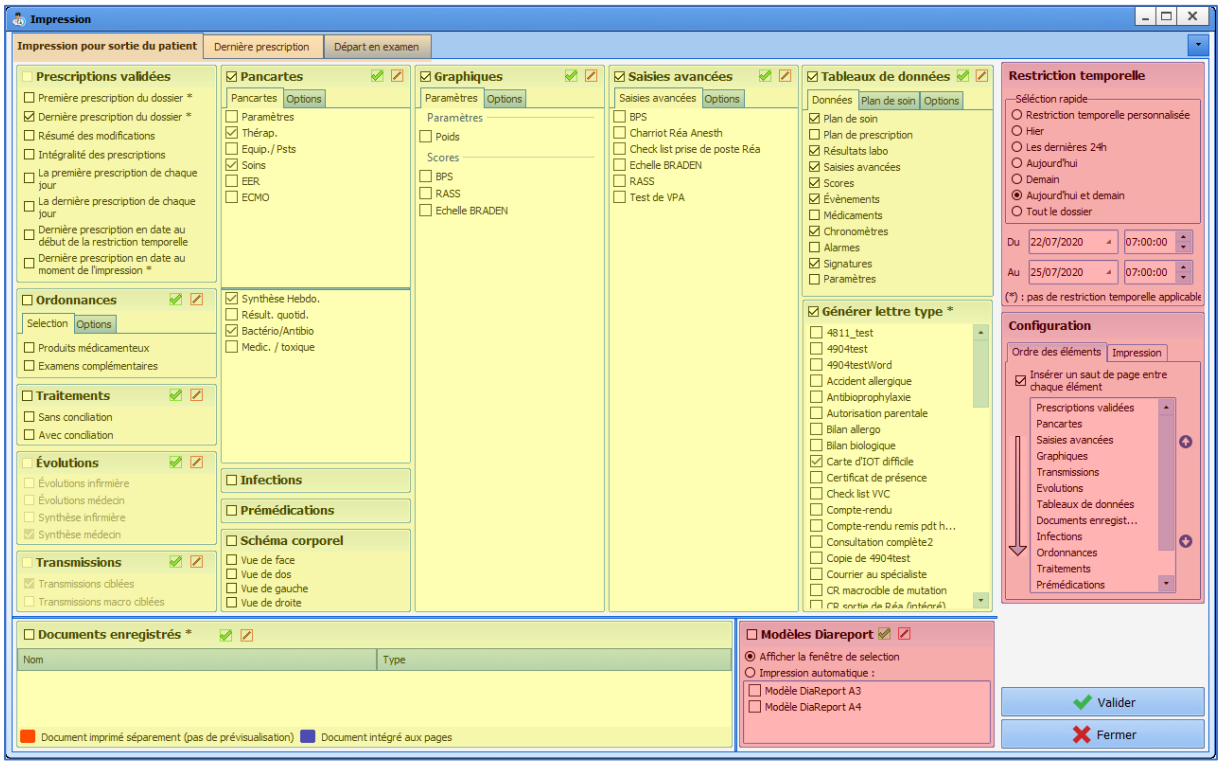
Likewise, when a prescription is signed, whether in the **Prescription** tab or from the Issue prescription form feature, a report from the drug database will be displayed automatically. This report summarizes potential drug interactions, related known allergies and possible overdoses.



NB: these warnings let you check the prescription but will not block it. The drug can always be prescribed.

2.4 Centralized printing

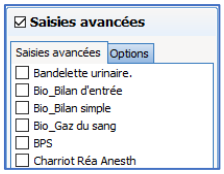
This page groups together all the printable items in the record.



This tool is organized into areas illustrated by colour above.

* In yellow:

The Yellow area is divided into nine sections: **Confirmed prescriptions, Prescription forms, Treatments, Status changes, Nursing notes, Views, Infections, Premedication, Body diagram, Charts, Detailed entries, Data tables, Generate form letter, Recorded documents**



Each of these sections has a series of checkboxes.

There is a checkbox to the left of the section heading to select all subsections.
You can select separately each item that you want to print by clicking on its checkbox.

Some boxes have two tabs, others have none and one has three.

* Views (2 tabs): the non-modifiable option indicates the display duration.

* Charts (2 tabs): used to configure the discontinuity of the curves, the printing scale, the height of the charts and to differentiate between values provided by biomedical equipment and manual data.

* Detailed entries (2 tabs): lets you print all the entries of the same detailed entry or only the last entry (e.g. if a score has been entered several times, you can print all the entries for this score or just the last one).

* Data tables (3 tabs): in the **Care plan** tab, you can filter according to the status of the care (To do, done, etc.), sort entries either by category or chronologically. The **Other options** tab lets you sort the entries, other than care plan, either by category or chronologically and define which vitals to display. The asterisk indicates that the time restrictions seen in the red area do not apply.

* In Red:

This area includes three boxes: **time restrictions**, **configuration** and the **DiaReport template**.

* Time restriction: lets you define the date and time of the start and end of data handling. The default time is the start of the ICU day.

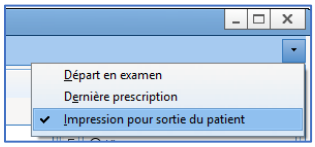
* Configuration: this box is organized into two tabs **Order of items** and **Printing**

- **Order of items**: lets you prioritize the printing of the tool categories. Click on a line and click on the arrow to print the tool category before and on to print the tool category later in the batch. If you want, you can insert a page break between each different tool category.

- **Printing**: lets you manage the way reports are printed or exported. In the Page subtab, you can manage the margins, orientation and size of the printed paper and also the font. With the Advanced subtab you can choose a specific printer and configure the document's export.

* In Orange:

This area groups together preconfigured tabs. Each of these tabs is linked to a context. In our example, three tabs have been configured: **Printout for patient discharge**, **Last prescription** and **Moved for examination**. The content of these three tabs is identical apart from the ticked boxes.
To the right of the bar containing the tabs, there is a box with an arrow pointing downwards: this provides the complete list of tabs.



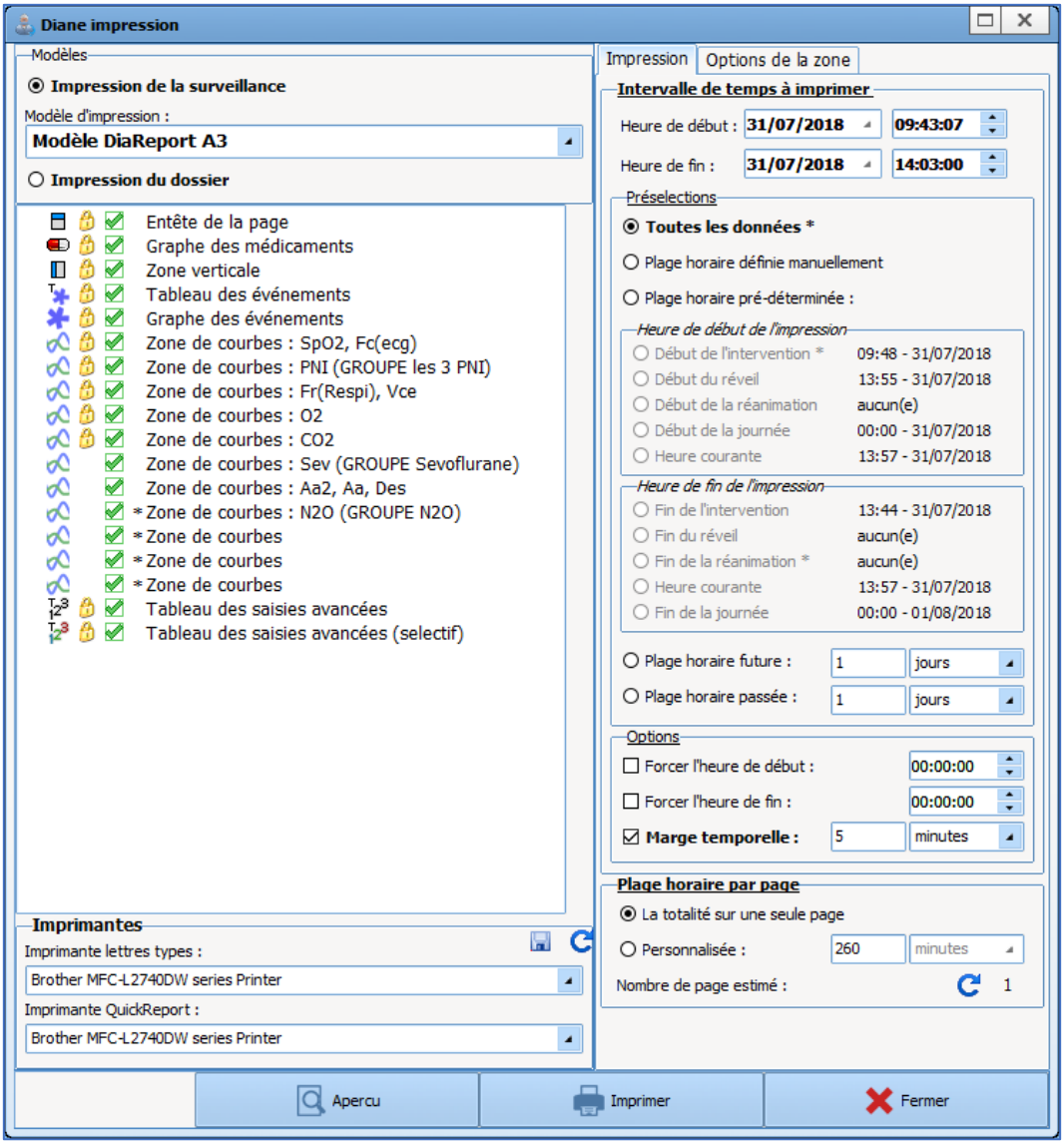
2.4.1 Viewing and printing a surgery

2.4.1.1 Printing intraoperative and postoperative monitoring

After clicking on the **Print surgery** button, a DIANE Printing window opens for default printing or to configure the printing as needed.

This can be done during or at the end of the surgery, when exiting the record or when viewing a previous record.

The initial layout is defined by the administrator but some changes can be made by the user.

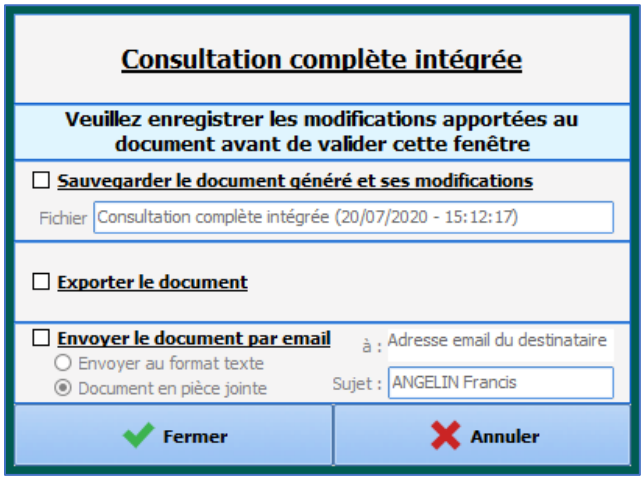


At the top right, it is possible to choose another print template (predefined by the site's key user). This can be useful for complicated surgeries or to have a more comprehensive document than usual.

It is also possible on the right part to customize the printing time slot and define the duration on each page. By default, the entire surgery is on one page.

The printer selected at the bottom left of the window is the computer's default printer. If other printers are

available on the network, you can, exceptionally, send the document to them using the drop-down menu.



When a document is actually printed, the window opposite opens. It lets you save, export or even send the printed document by email.

2.4.1.2 Buttons

The **Print** button lets you start printing without seeing a preview.
The **Preview** button lets you view the printout in the **Preview** window.
The **Request to save generated documents** checkbox is used to always confirm whether or not you want to keep the document generated in the **Documents** tab from the preoperative assessment.
The **Close** button cancels the current print request.

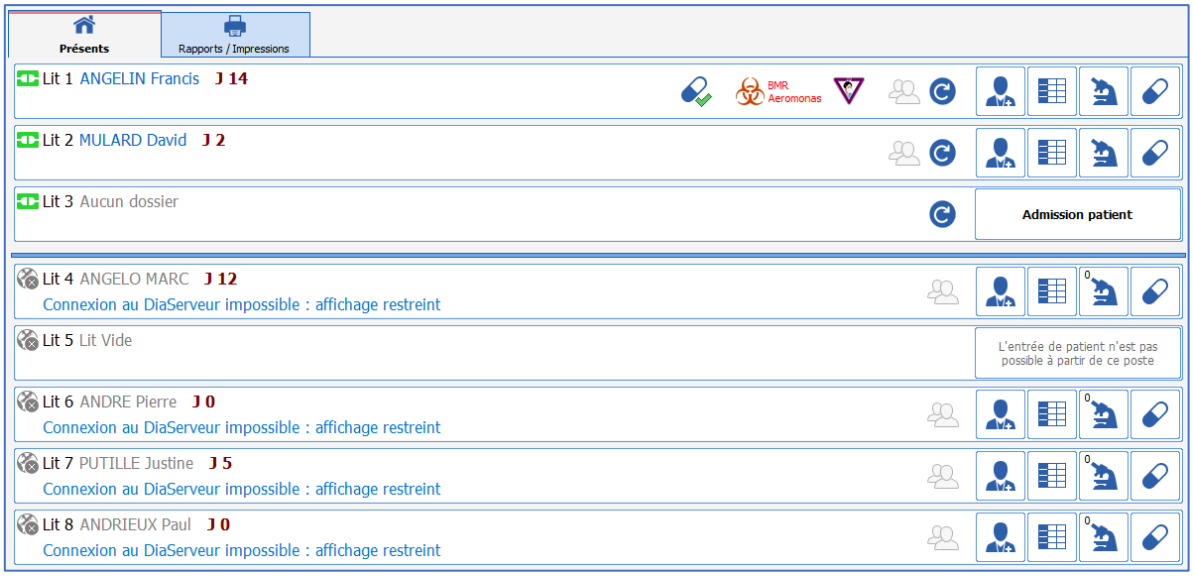
2.4.1.3 Viewing past surgeries

DIANE lets you view a surgery already performed, displaying all the physiological parameters retrieved from the monitors connected to the patient, the textual data (patient, surgery, preoperative and postoperative data), and all the manual entries during the surgery (drugs, events).
Click on the **Open patient record** button of the intraoperative and/or postoperative application. Select the Patient record and the relevant surgery then choose **View record**

NB: You can view all anaesthesia reports from any computer connected to the server.

2.5 The cockpit

The Cockpit is an overview of all the patients present in the unit. It gives quick access to patient records and essential medical information and helps share information between caregivers.



1 - Manage unavailabilities.

2 - View/Complete a record.

3 - Print grouped prescriptions.

4 - Print the list of hospitalized patients.

5 - Denials list.

6 - Open **DIANE** email client.

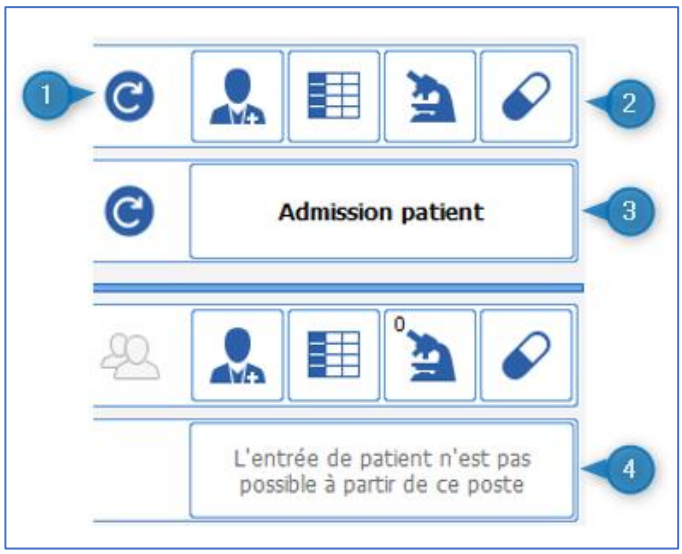
7 - Log out the current user (locks the **DIANE** computer and exits records opened remotely).

In the right part of the ribbon, the user also has access to various functions such as 'View/ Complete a record', 'Change user', etc.

NB: **DIANE** gives access to all of the unit's records from any computer in your unit.

The different lines represent patients with, from left to right, the bed number, name, number of days in hospital and potential infection.
The buttons on the right give access to the record's different tabs.

NB: The green icon next to the bed means that the patient's record is accessible remotely from a Mirror computer. If the black icon is present, it means that remote access is not possible (this may be due to a hardware or network problem).



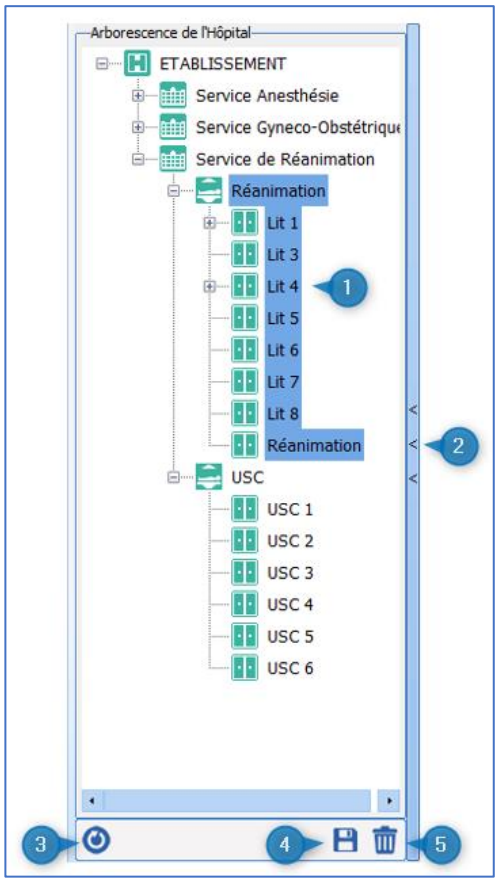
1 – Reboots the **DIANE** applications on the computer.

2 – Lets you directly access the record's different tabs.

3 – Lets you admit a new patient (opens the patient selection window).

4 – Patients can only be admitted on the Primary computer.

In the left part of the screen, if you click on the vertical bar where there are three arrows, you will have access to the hospital tree structure. By default, the application displays the patients in the unit. However, it is possible to change this display by clicking on the other items in the tree structure.



1 – The items in the area highlighted in blue are those displayed on the portal.

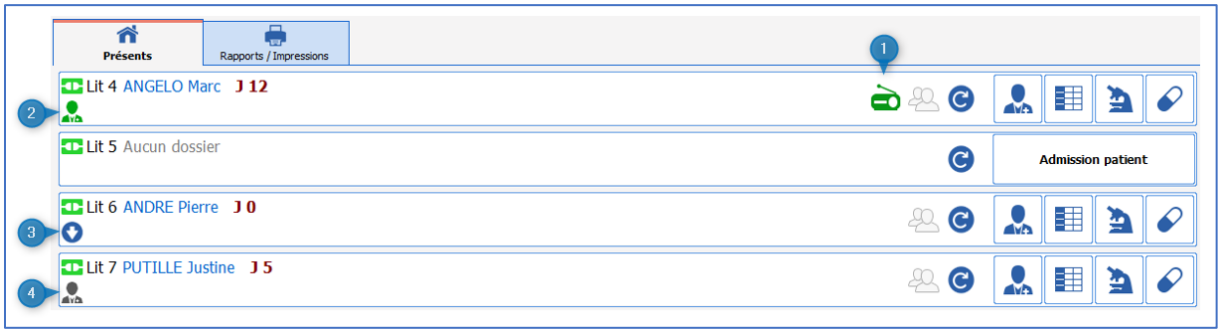
2 – Clicking on the blue bar with the 3 arrows opens (or closes) the hospital tree structure.

3 – Reloads the default location.

4 – Saves as the default location.

5 – Deletes the default location.

From the central part of the cockpit, you can 'Take responsibility for the current time slot' for a patient by clicking on this button . This means that the user says that they will take care of the patient for the defined time slot (only valid for **Doctor**, **Nurse** and **Nurse aide** profiles).



1 – Issue-based nursing notes in the last 24 hours.

2 – You are in charge of this record.

3 – Take responsibility for current time slot.

4 – Another person is responsible.

When someone takes responsibility the icon changes to .

2.5.1 List of hospitalized patients

This page provides an overview of your unit. The different buttons provide access to patient records.
From any computer in the unit, you have read and write access to all patient records.

NB: The green icon next to the bed means you have remote access to the patient's record. If this icon is red, it means that you do not have access to the record (this could be due to a hardware or network problem); if it is yellow, there is an attempt to connect to the bed and a black icon means that remote connection is not enabled.

Cockpit icons:

BMR Adenovirus	This icon lets you know if the patient has an infection. If you hover the mouse over it, the infection is displayed. If you click on this icon, you will be redirected to the **Germs** tab.
	This icon shows that the prescription is being changed.
	This icon shows that the current prescription is signed i.e. that the prescription is not being changed.
Lit 3 PUTILLE Justine - - -	The icon under the patient's name shows that nobody is in charge of the record. If you wish to be in charge of the record, click on this icon. Two people with different functions can claim responsibility for the patient: intensivists and registered nurses.
Lit 4 ANGELO Marc - MEDECIN Yves - -	The icon under the patient's name shows that you are in charge of the record.
Lit 3 PUTILLE Justine - SYSTEM Diane - -	The icon under the patient's name shows that somebody else is in charge of the record. You can see the name of the person in charge by hovering over the icon.
	The green radio icon means that an issue-based nursing note or a current situation nursing note is valid. When you click on the icon, you access the nursing note tab.
	These three icons relate to pharmacist actions. The pharmacist unreservedly accepts the prescription: no reservations or warnings are issued. The pharmacist accepts a prescription with reservations. To see what reservations have been issued, go to the **Prescription** tab: when a prescription line is associated with a reservation, the previously green icon changes to orange. The pharmacist warns that there is an inconsistency or danger. To see what warning has been issued, go to the **Prescription** tab: when a prescription line is associated with a warning, the previously green or orange icon changes to red.
	When there is a message, the icon automatically turns red and remains so for 24 hours (duration configurable).
	Clicking on this button takes you to the patient's medical record.
	Button to go to the care plan.
	Button to go to the **Lab** tab (biological parameters).

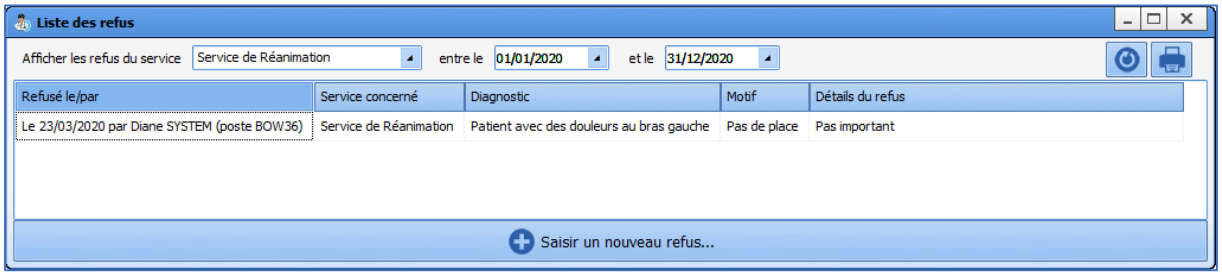
	Button to go to the **Prescription** tab.

NB: Some buttons may be greyed out. This happens when you do not have sufficient user rights or the buttons cannot be used (for example if you are offline).

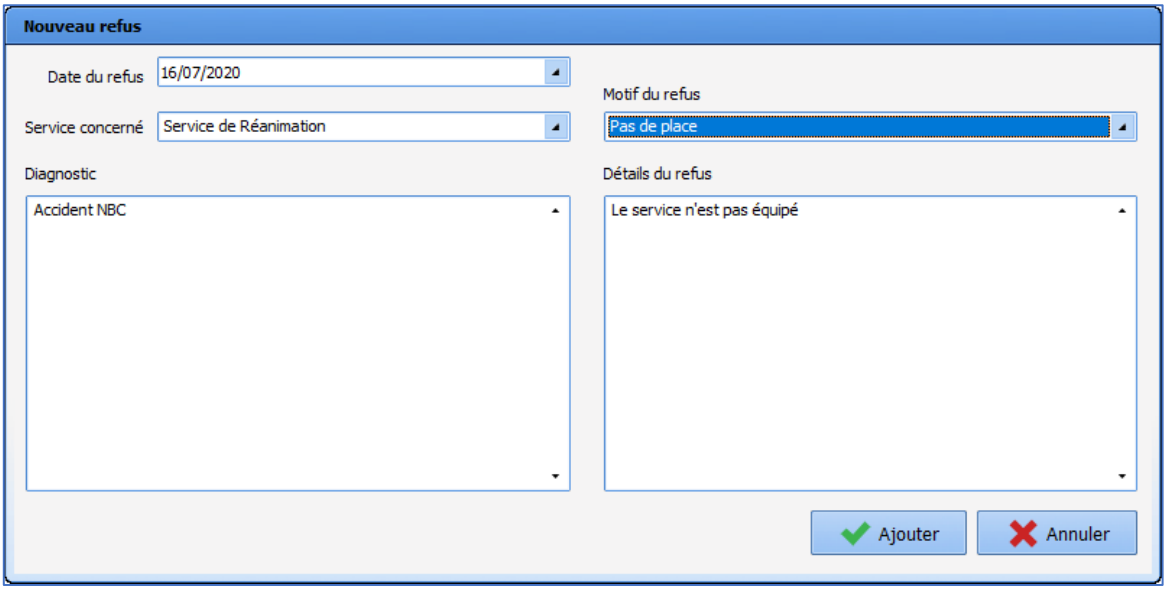
To take control of a patient remotely, just click on the patient's name and the software offers read-only access or write access.
The arrows to the left of the hospitalized patients list make it possible to view the entire unit and take control of the bed you want.

2.5.2 Managing denials

The button (**managing denials at the top right of the patient portal**) opens the window below. This shows the list of all the care denied in your unit, the date and the reason. You can add a denial by clicking on the **Enter a new denial…** button and choose the reason.



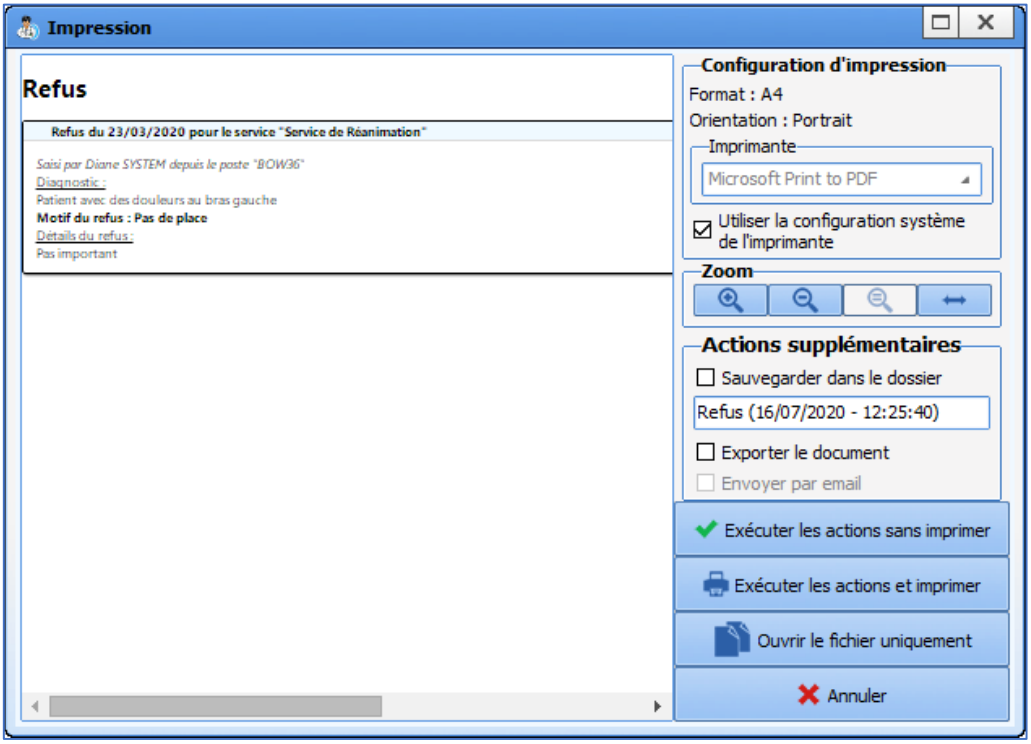
Enter a new denial:



Delete: to delete a denial reason line, right-click on your mouse and choose **Delete**. It is not possible to change a reason for denial. You must delete the reason and create a new one.

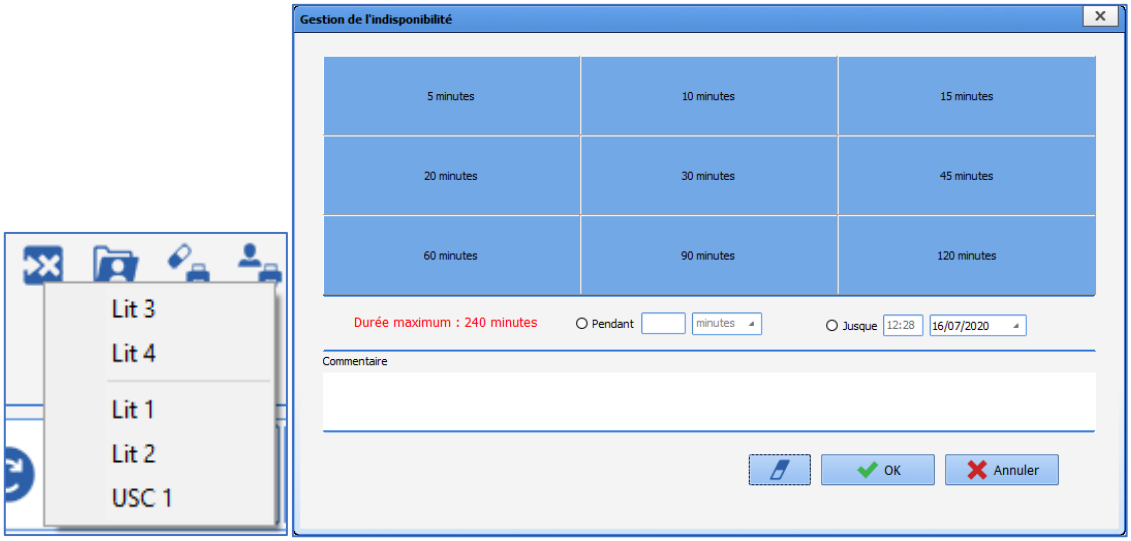
Update: to update the list of denials, click on . This button is useful to make sure you have all the information. Each computer therefore has the ability to create a reason for denial.

Print: to print the list of denials, click on . This opens the following window:



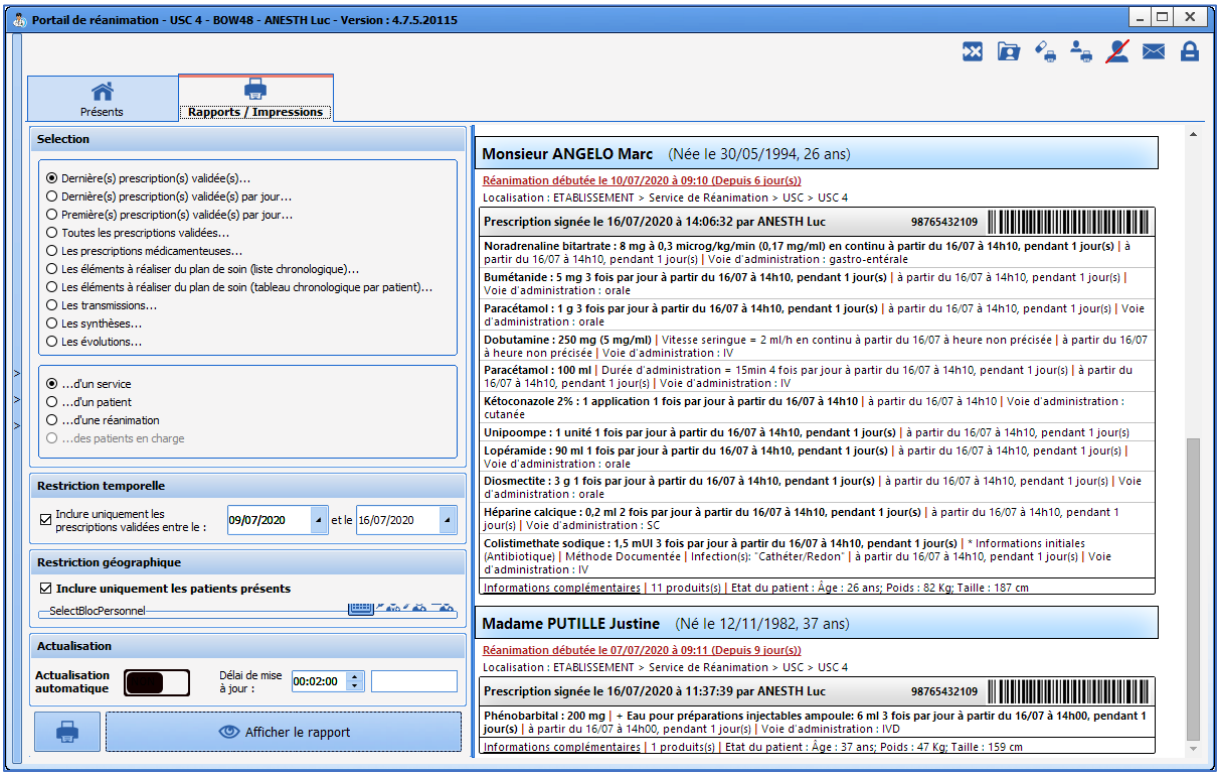
2.5.3 Bed unavailable

When you click on the bed unavailable button, a menu appears that lets you make a bed temporarily unavailable, for example to prepare the room between 2 patients.

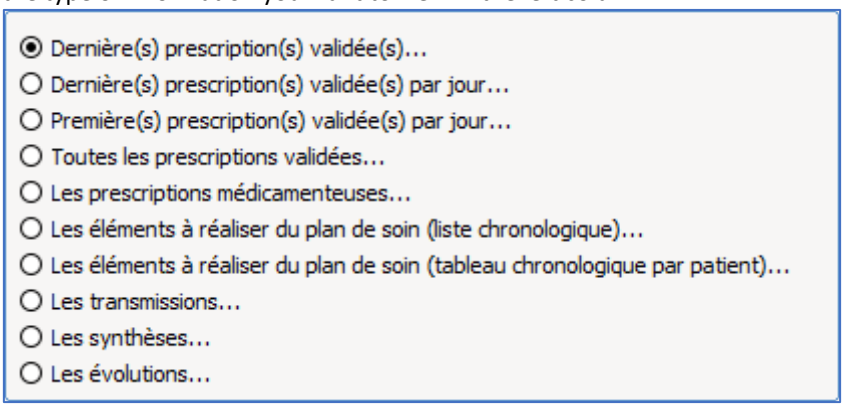


2.5.4 Print report

This page lets you view and print reports on patient record information.



You can select the type of information you want to view in the left column.



1: Last confirmed prescription(s)... (by default) - This option displays the latest prescription for each patient concerned by the other filters.

2: Last confirmed prescription(s) per day - This option displays the latest prescription for each patient.

3: First confirmed prescription(s) per day - This option displays the first prescription for each patient.

4: All confirmed prescription(s) - This option lets you display all prescriptions except those being written.

5: Care plan items to be executed (chronological list) - This option displays the items in the care plan that

have not yet been done (as a list).

6: Care plan items to be executed (chronological table per patient) - This option displays the items in the care plan that have not yet been done (as a table).

7: Nursing notes - This option displays the nursing notes between health workers (registered nurses, physiotherapists, dieticians, etc.).

8: Summaries - This option displays patient summaries.

9: Status changes - This option displays patient status changes.

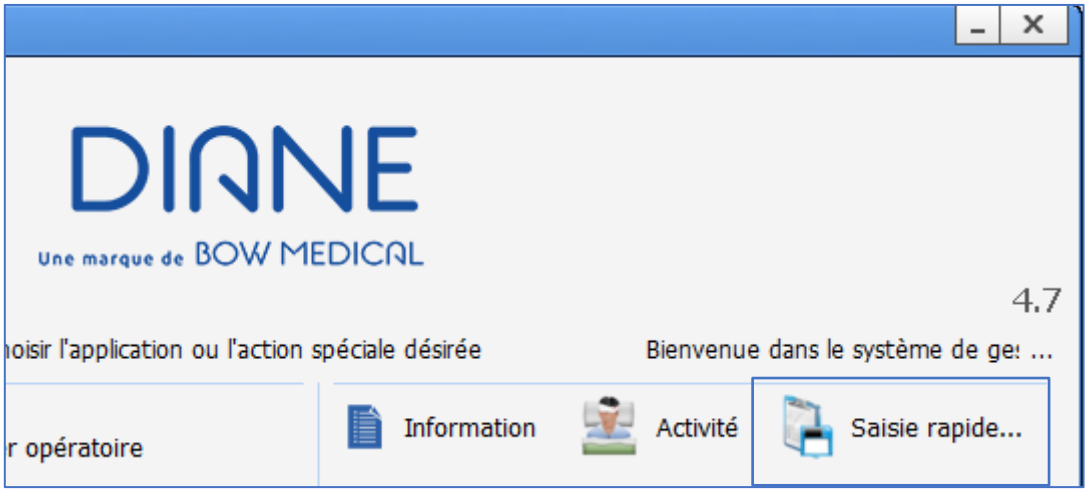
It is also possible to display previous data for the whole unit, for a patient, for an intensive care unit or for patients taken charge of.

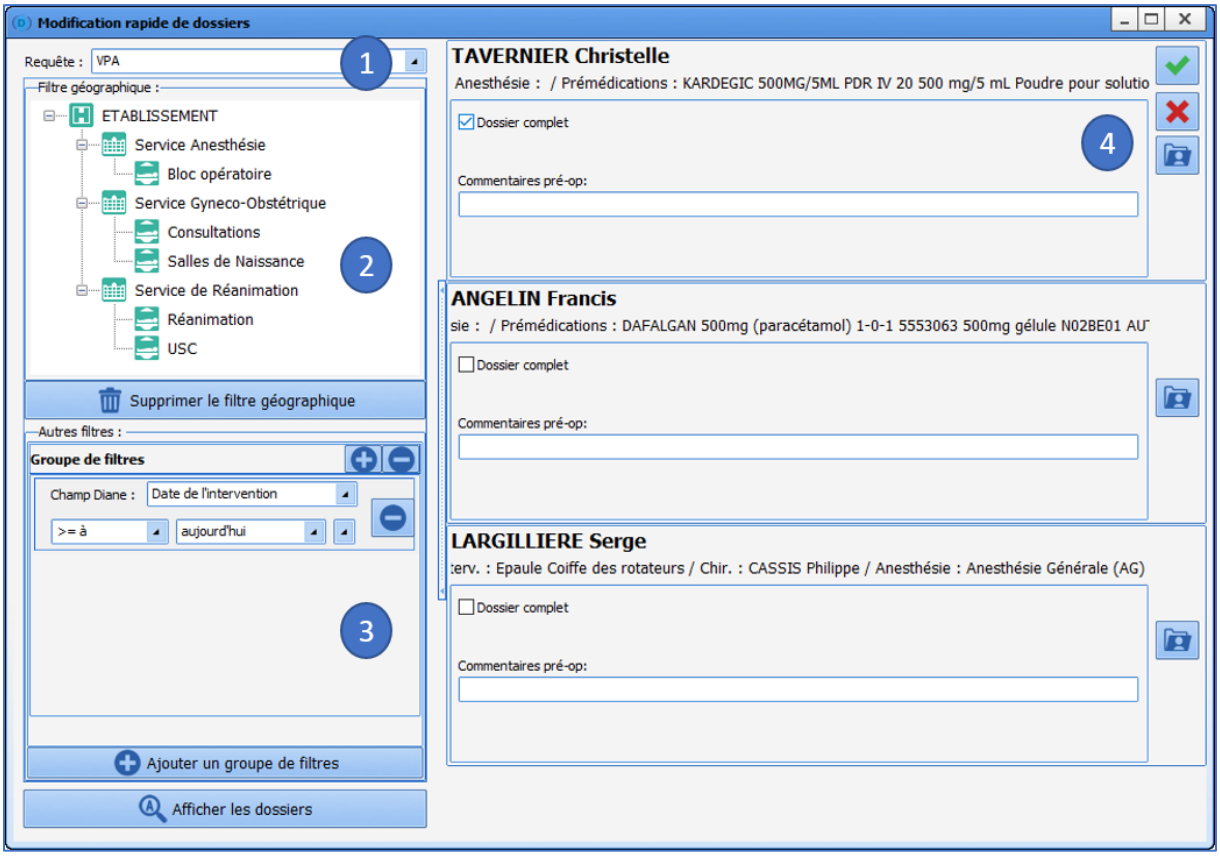
2.6 The Quick entry module

The DIANE portal **Quick entry** module lists the patient records and lets you interact directly with them.

The Preoperative assessment is a typical query for this module: for example, you can list all the patients having surgery today and complete the Preoperative assessment from this list.

To access the **Quick entry** module, click on the DIANE Portal **Quick entry** button.





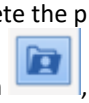
1 / Drop-down menu of the different patient queries configured. The first is the one proposed by default.

2 / Location filters to restrict the list to certain units or OTs.

3 / Filters relating to patient record data. You can change these filters to adapt a date or a number. In the example above, you can specify **Yesterday** instead of today.

4 / When the query is selected, and the filters are applied if necessary, the results appear by clicking on **Display records**.

The list appears on the right. You then have access to these records:

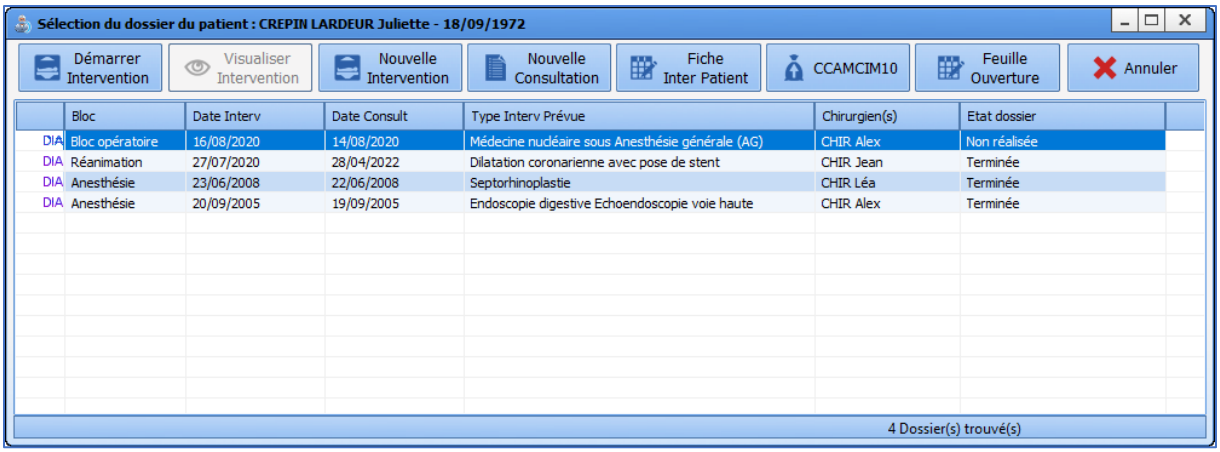
- Either to complete the proposed items directly,
- Or by clicking on  , the record opens and you can see additional items before completing it.

When you exit the record, you will automatically return to the list.

3. DIANE ANAESTHESIA

3.1 Selecting patient records in anaesthesia

After selecting the patient, the following window opens to choose what you want to do with the patient record.



By default, patient records are sorted in a given way, showing surgeries not yet completed first. The following records are sorted by place and date, taking into account the status of the record.

The surgery selected by default is the one that is in the current OT or unit, and that is scheduled to start the soonest.

From this window, and by using the buttons in the header, you can:

- **Start the surgery**: this button is used to start the surgery not yet performed that is selected in this window. You can start the surgery by double-clicking on the line you want.
- **Resume the surgery**: this button lets you restart a surgery that started less than 24 hours ago.
- **View the surgery**: this button is used to view a completed surgery.
- **New surgery**: this button is used to start a new surgery without a related consultation.
- **New consultation**: this button is used to create a new consultation.
- **Inter-patient checklist**: this button gives access to the inter-patient checklist.
- **Procedure/ICD-10:** this button gives access to the entry form for ICD-10 and procedure codes.
- **Safety checklist**: this button gives access to the safety checklist.

If the selected patient has no surgeries planned or performed, the user will be prompted to create a new surgery.
When you double-click on a surgery performed less than 24 hours ago, a message will appear suggesting to either resume this surgery or view it.
If you right-click on one of the lines corresponding to a surgery, a menu is available to **Start the consultation associated with this surgery**.

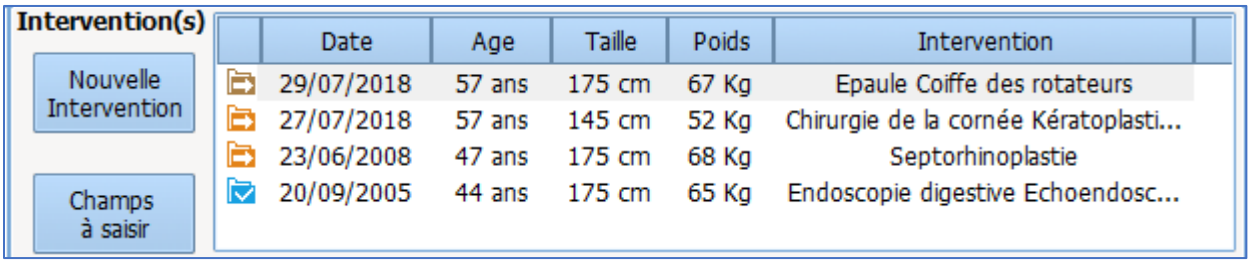
3.2 Preoperative assessment

3.2.1 Preoperative assessment buttons

Buttons	Function
Sélection du patient	Lets you select a patient's record. *See chapter entitled: 'Patient selection'.*
Nouvelle Intervention	Used to start a new consultation for a new surgery for the selected patient. *See chapter entitled: 'Scheduling a new surgery'*
Champs à saisir	Opens the **Fields to complete** window which highlights the fields considered important before closing the application. *See chapter entitled: 'Important items and critical items'.*
Enregistrer	Lets you save all the information entered (new items, changes made or items deleted from the selected patient's record). The consultation is saved automatically when you print or generate ICD-10 and procedure codes.
Annuler	Lets you exit the patient's record if the **Save** button is greyed out when you click on **Cancel**. If the **Save** button is active when you click on **Cancel**, you can cancel all information entered since the patient's record was last saved. A **Warning** window prompts you to confirm your choice. The **Yes** button in this window lets you keep the data you were about to delete. The **No** button cancels all the changes you have made to your patient's record since it was last saved. The **Cancel** button cancels your cancellation request.
Imprimer	Used to print the consultation for the selected patient. A **Print preview** window opens first. *See chapter entitled: 'Consultation printout'*
Options	Opens a context menu that lets you: - **Lock the DIANE computer** - **Change the user** - **Resynchronize** - **Change the password** - See the **Consultation help** - See the **About** window - **Exit** the Consultation application
Reprise	Opens the **Retrieval** window to retrieve all the data in the selected tab from a choice of previous consultations listed for a given patient.

3.2.2 Surgery(ies) pane

This pane, at the top of the application, displays a list of all the surgeries that the selected patient has already had during previous care in the DIANE software and lets you schedule a new surgery for the patient by using the **New surgery** button.



When a record is finished , by right-clicking on the line, you have a complete view of the surgery.

3.2.3 List of surgeries for the selected patient

The list of surgeries for the selected patient appears in the **Surgery(ies)** pane. Here, we can see the patient's **Age**, **Height** and **Weight** on the date of the surgery as well as the reason for surgery and **Date** of surgery.

Icon	**Date** column	**Surgery** column
Record open *The surgery has not been done or is in progress. The consultation can therefore be modified.*	Scheduled date of surgery if this has been entered OR Consultation date if the surgery date has not been entered	Surgery scheduled
Record closed *The surgery is finished and the patient is in the recovery room. The consultation can no longer be modified (except for exceptional access rights).*	Actual date of surgery	Surgery performed
Record locked Currently in RR Currently in OT Induction in progress *This record is locked on another computer (record already open or preloaded on a mobile device). You have read-only access to the record.*	Scheduled date of surgery if this has been entered OR Consultation date if the surgery date has not been entered OR Actual date of surgery if performed	Surgery scheduled or performed
Record not accessible *The surgery was performed or scheduled in another unit. You cannot view this record (except for exceptional access rights).*	Scheduled date of surgery if this has been entered OR Consultation date if the surgery date has not been entered OR Actual date of surgery if performed	Surgery scheduled or performed

You can sort the list of surgeries by clicking on the column headings (**Date**, **Age**, **Height**, **Weight**, **Surgery**).

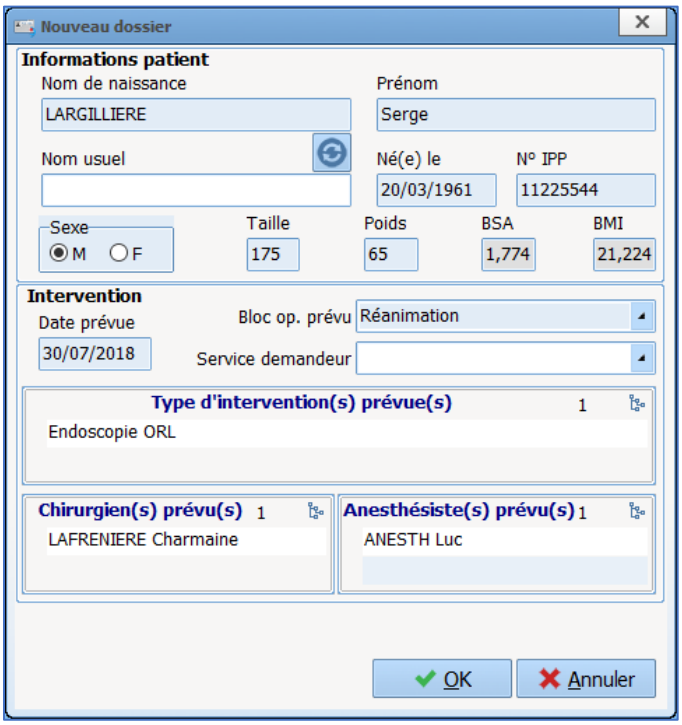
If the last consultation carried out is not selected, the background colour of this list will be orange.

You can view the surgery associated with a consultation by right-clicking on the surgery and selecting **See associated surgery**.

3.2.4 Scheduling a new surgery

When a patient's record is selected, click on the **New surgery** button.

When a new patient is created, the **Schedule a surgery** window opens automatically.



In this window you can complete the first fields.
(The **BSA** (**Body Surface Area**) and **BMI** (**Body Mass Index**) are calculated automatically).

When this window is opened, the operating theatre is, by default, the one where the computer is located.
Any change to this field will be kept during the same session for subsequent surgeries scheduled during the same session.

Click on the **OK** button or hit **`Enter`** on your keyboard to confirm this window.

The items are inserted in place.

After confirming this window, a confirmation message offers to automatically retrieve the history from the previous record.
If you click on **Yes** the proposed action will be done: the **History / Treatments** tab is prefilled with the history from previous records.
If you click on **No**, only intraoperative and postoperative complications and previous surgeries performed with the **DIANE** software will be retrieved in the **History / Treatments** tab.

3.2.5 Main preoperative assessment tabs

The anaesthesia data relating to the selected surgery is accessible in a tabbed folder and grouped, by default, into nine main categories: **Administrative, History / Treatments, Clinical examinations, Paraclinical, Conclusion / Appointment, Outpatient, Summary** and **Documents**.

NB: If you try to modify an old consultation record, a message will appear to tell you this. By default, this limit is set to 240 days.

3.2.5.1 Administrative tab

This tab contains all the administrative data concerning the patient and the details of the scheduled surgery.

These fields are filled in using the different methods seen in the chapter entitled '*Ways to enter data in DIANE*'.

NB: If an interface is in place, the administrative fields can be filled automatically. Also, these fields may not be accessible to fill in.

3.2.5.1.1 Surgery(ies) performed component

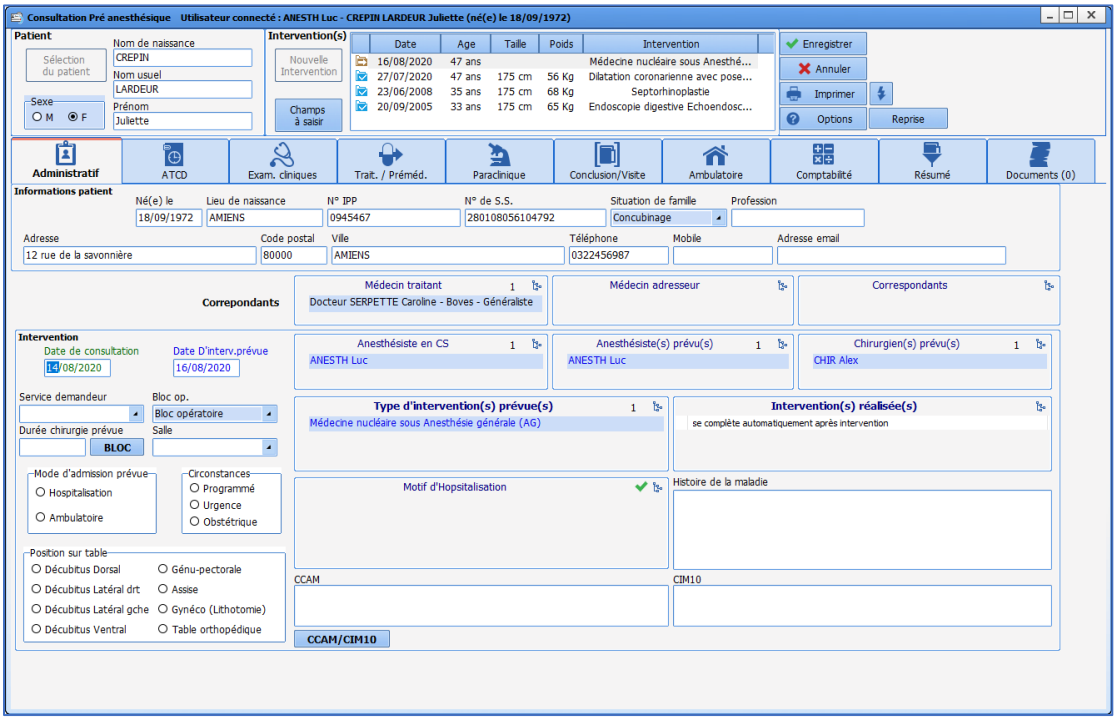
The **Surgery(ies) performed** field does not need to be completed. It will be automatically updated when your patient is in the intraoperative stage.
This lets you see the difference between the surgery scheduled and the surgery actually performed.

3.2.5.1.2 Scheduled staff components

Completing the **Scheduled anaesthetist(s)** and **Scheduled RNA(s)** during the surgery will automatically register them as present in the theatre.

3.2.5.1.3 Procedure/ICD-10 button

A **Procedure/ICD-10** button gives direct access to the entry form for ICD-10 and procedure codes. See chapter entitled *'Procedures/ICD-10'*. You must click on the **Procedure/ICD-10** button for the retrieved codes to be displayed in the relevant pane.



3.2.5.2 Treatment / Premedication tab

This tab can be used in other modules. It is therefore dealt with in the chapter entitled *'Treatment / Premedication tab'*.

3.2.5.3 History tab

This tab generally groups together everything related to the patient's history.

Remember that the green ticks ✔ are used to indicate default items for this field (e.g. NTR, no surgical history, etc.). Indeed, it is better to have an NTR type item than no information, which could mean that the patient may not have been asked about their history.

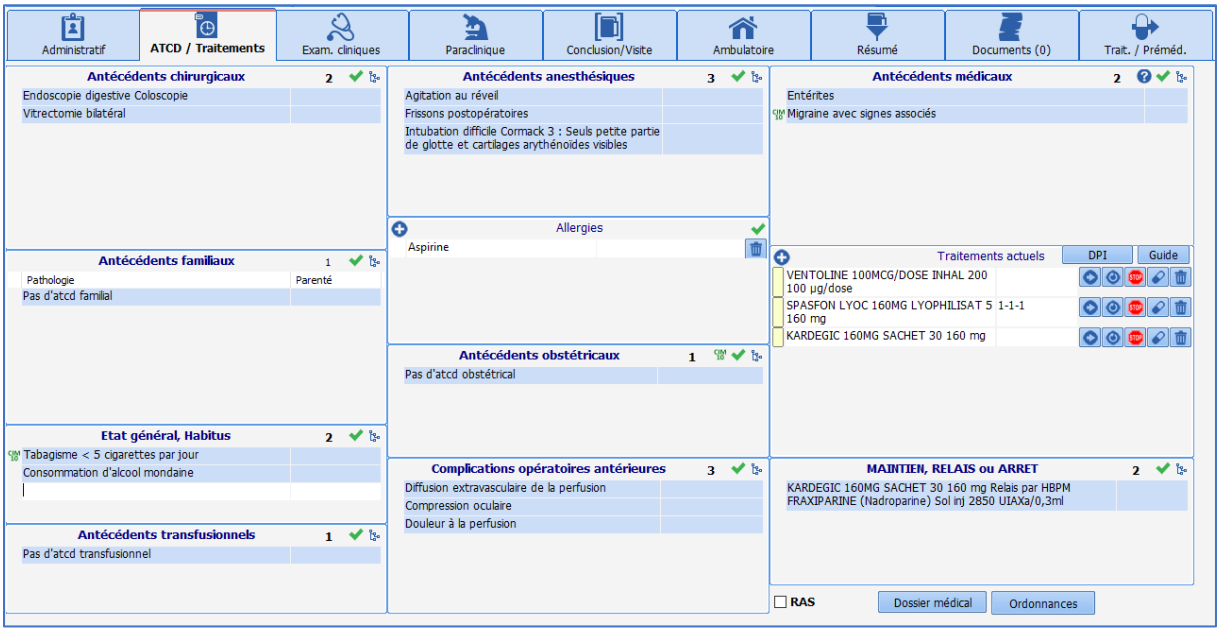
It is possible to send the data to the **Important items** field in the **Conclusion/Appointment** tab by right-clicking on the relevant item.

3.2.5.3.1 Surgical history, Surgical complications components

The **Surgical history, Previous surgical complications and Anaesthetic history** components are special components. They can be completed as normal but they also automatically retrieve the data from surgeries previously performed with **DIANE**.

3.2.5.3.2 NTR button

The **NTR** checkbox is used to fill in all the fields with a preset default item for a patient with little or no history.

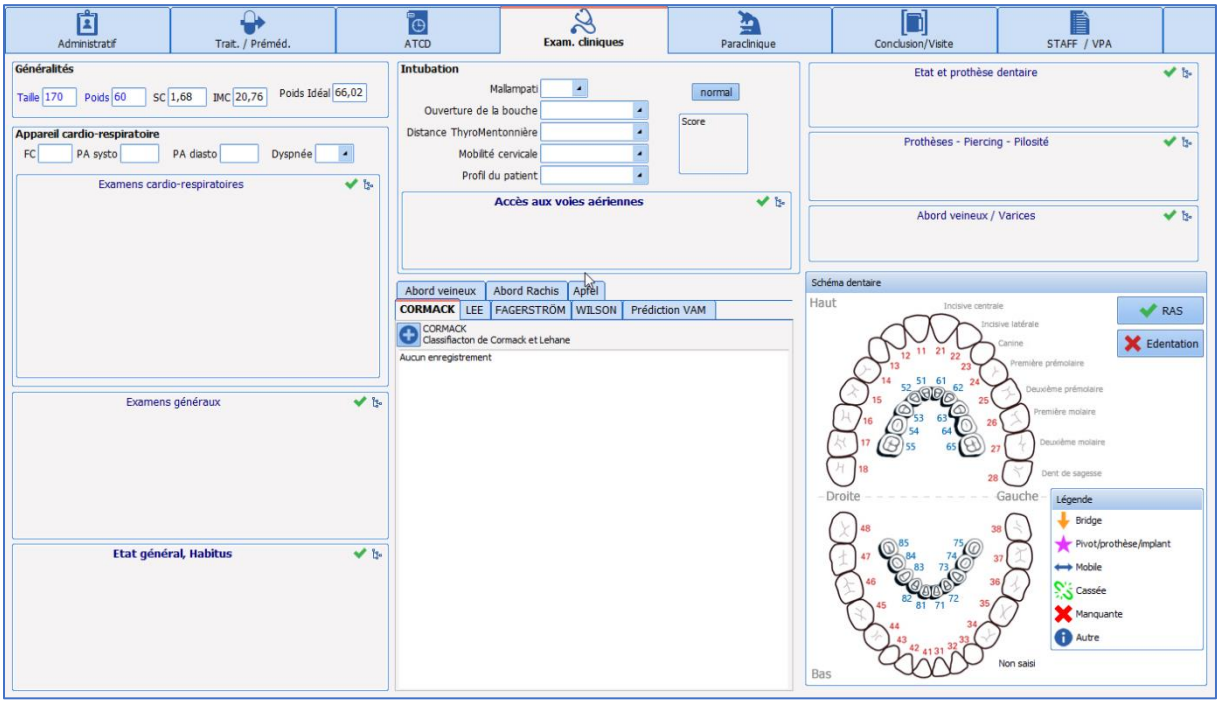


3.2.5.4 Clinical examinations tab

This tab is used to enter the patient's clinical examination on the day of the consultation.

You can use all types of consultation components. See chapter entitled *'Ways to enter data in DIANE'*.

Detailed entries are customizable and can be activated by clicking on the in the relevant tab. First you will be asked to save the consultation.



3.2.5.4.1 Intubation score

This score is calculated using the fields on the side: **Mallampati, Mouth Opening, Thyromental Distance, Cervical Mobility** and **Patient Profile**.
The score is between 5 (minimum score obtained by clicking on the **Normal** button, located opposite the **Mallampati** score) and 14. When this score is red, it has exceeded the critical threshold of 7.

3.2.5.5 Paraclinical tab

This tab is useful to request lab tests and specialist consultations and enter the results.

You can use all types of consultation components, see chapter entitled: *'Ways to enter data in DIANE'*.

The most frequently recurring assessments are shown (configured by the site's key user) and accessible via checkboxes. Once you have made your selection, the **Generate** button lets you generate the prescription form for the assessments based on what has been ticked.
You can also create letters for specialist consultations.

You can include an assessment that is not configured with the configuration you are using, by clicking on the button at the top right of the **Other assessments** pane. Once an assessment that does not belong to your configuration is completed, it will still be visible from the patient's consultation.

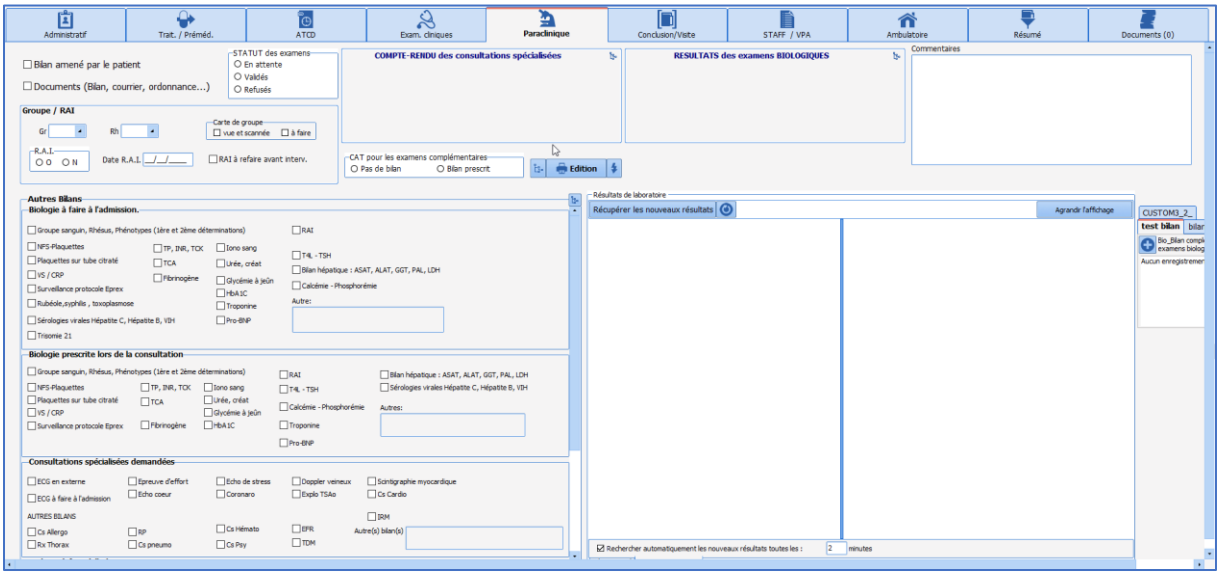
3.2.5.5.1 Generate button

Clicking on the button lets you directly print the selected letter without going through the preview window.

The button lets you print several letters at the same time. Select the letters you want to print by ticking the boxes then click on the **Preview** button if you want to preview these letters first or on **Print** to print without a preview.

NB: Lab results can be automatically retrieved from the lab results server if an interface is set up.

NB: All typical prescription letters and assessments can be fully configured by your site administrator. They are configured by unit, operating theatre, room, etc.



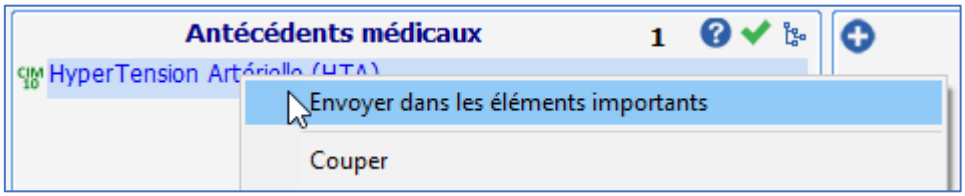
3.2.5.6 Conclusion/Appointment tab

In this tab, it is customary to fill in all the items relating to the anaesthesia strategy but also everything relating to the surgery authorizations, benefit/risk information, etc.

This tab has a **Printouts** button to manage the printing of surgery authorizations but also all types of documents such as informative documents, consent documents, etc. They are managed and made available by your key user. This button functions in exactly the same way as the one in the previous tab (see chapter entitled: *'Generate button'*)

3.2.5.6.1 SUMMARY / Important items component

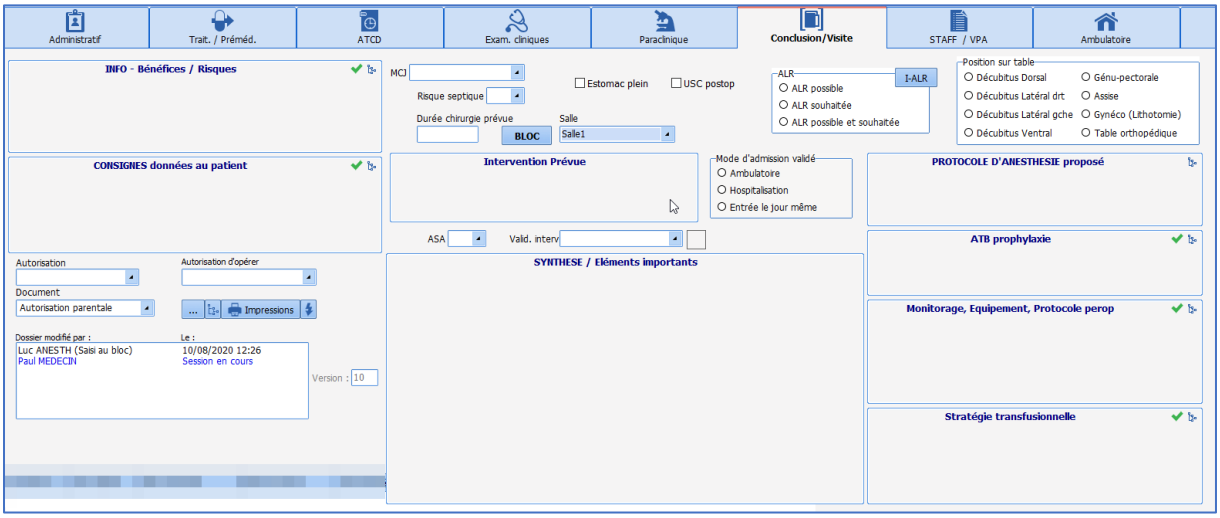
The **SUMMARY / Important items** component summarizes all the items during the consultation considered important. Indeed, for each component of the consultation, you can right-click to send items to this **Conclusion/Appointment** tab.
You can send a specific complete examination or a complete assessment to the table of important items by right-clicking directly on the name of the examination (**Clinical examinations** tab) or assessment (**Paraclinical** tab).



3.2.5.6.2 Record edited by component

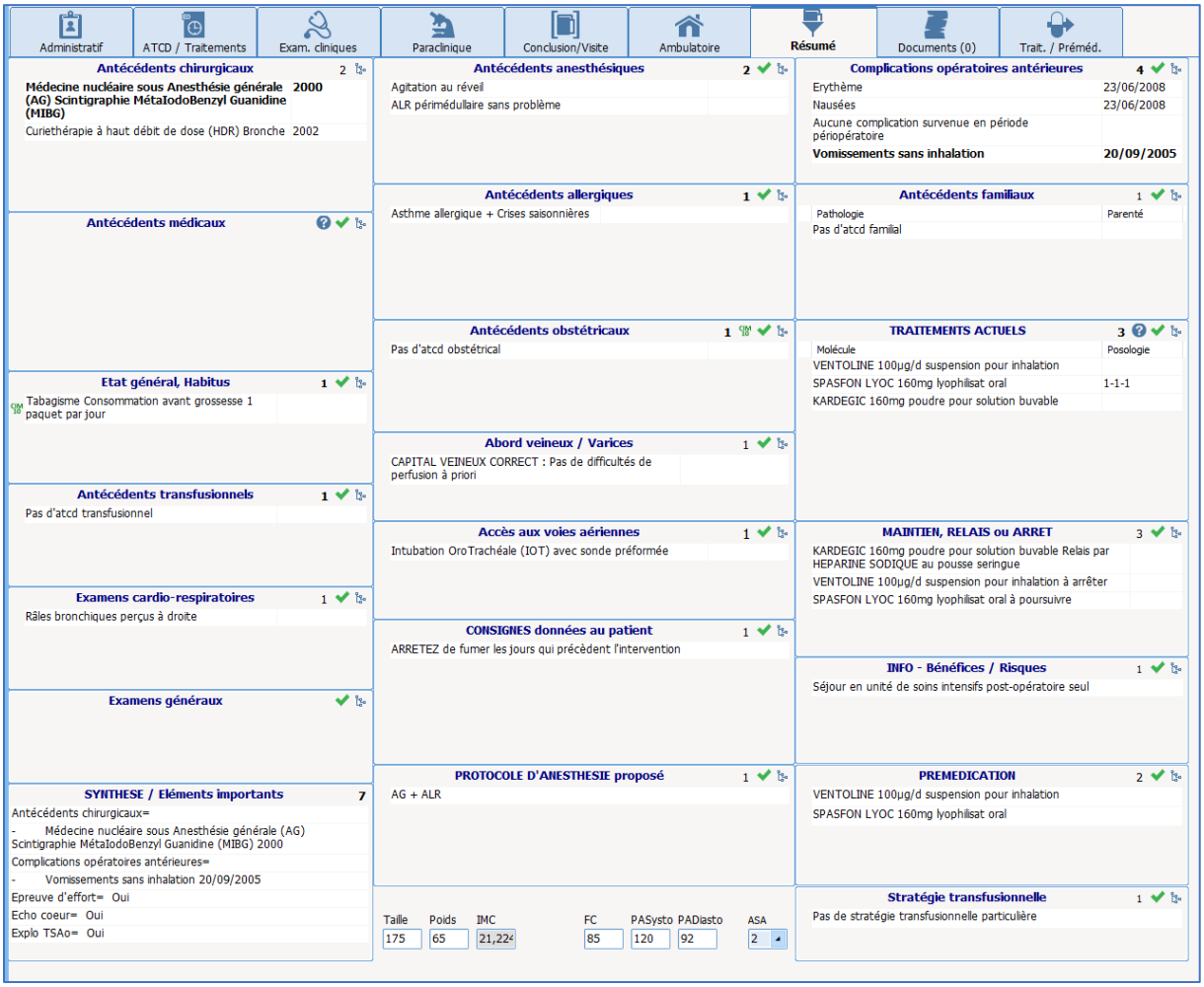
A **Record edited by** pane shows you the names of all the caregivers who have edited the consultation record. A different colour is allocated for each new session opened. This pane is completed automatically.

A version number, also present on the printout of the anaesthesia record, lets you know if the printed version is the same as the one that can be viewed and modified on the computer.



3.2.6 Summary tab

This tab lets you see all the components of the consultation on one page. It is fully configurable. These components are mirrors of those used in all of the other tabs.



NB: You can record your information directly from this tab.

3.2.7 Staff meeting / Preoperative assessment tab

It is possible to have a tab just for staff meetings and/or preoperative assessments.

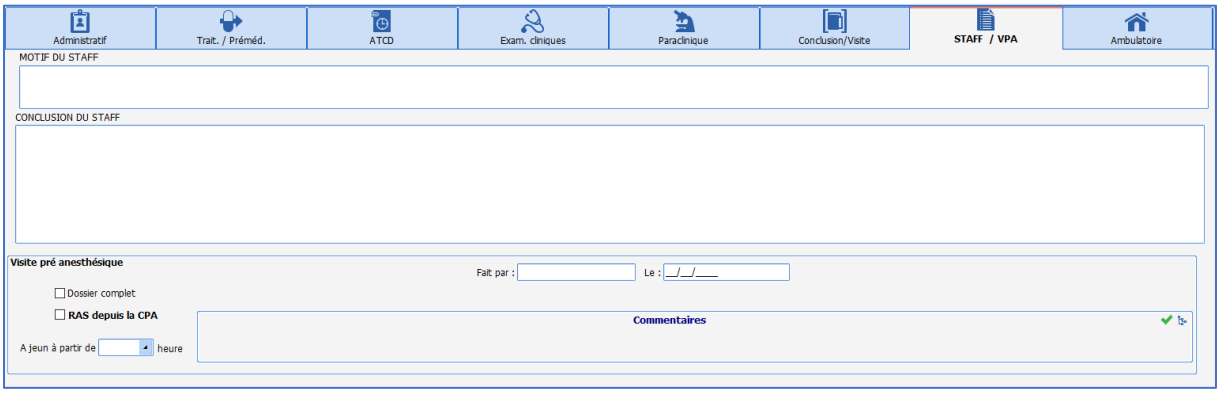
3.2.7.1 Anaesthesia staff meeting

This part can be used to track the items of the staff meeting (the reason for the meeting and conclusion).
Via the quick entry module, if the surgery has been confirmed on the **Record requiring staff meeting** status, you can find records that need to be reviewed by the team.
You must remember to change the status to **Staff meeting held and record confirmed** so that these records are no longer extracted during the next query.

3.2.7.2 Preoperative assessment (Preop)

Information from the Preoperative assessment can be entered in different ways. The organization can be configured by the key user.

When this part is filled in using the relevant fields (**Complete record, NTR from the Preop, Comments, Fasting from…**) the **Done by** and **On** components are automatically entered with the name of the doctor who entered the information and date of entry.



3.2.8 Exiting the patient consultation record and critical fields to fill in

3.2.8.1 Validation and status of the record

There are six possibilities for validating the surgery.
Each possibility is associated with a visual icon.
This validation will let you find these records via the quick entry module to complete them if necessary (record requiring staff meeting) but also manages alerts when the record is opened in the operating theatre.

Status	Icon	Effect in intraoperative stage
Date confirmed	Valid. interv Date validée	
Date postponed	Valid. interv Date différée	
Surgery cancelled	Valid. interv Intervention annulée	
Staff meeting required	Valid. interv A staffer	
Staff meeting held and record confirmed	Valid. interv Dossier staffé et validé	A window tells you that a staff meeting has been held for the record.
Patient rejected	Valid. interv Patient récusé	A window appears telling you that the patient has been rejected.

The status can be chosen in two ways:

- Either by choosing from the proposals in the **Surg. valid.** drop-down menu,
- Or by clicking on the icon: the order is then as follows: no status ⇨ **Date confirmed** ⇨ **Date postponed** ⇨ **Staff meeting required** ⇨ **Staff meeting held and record confirmed** ⇨ **Surgery cancelled** ⇨ **Patient rejected** ⇨ No status ⇨, etc.

3.2.8.2 Important items and critical items

When the consultation is saved or when you click on the **Fields to complete** button, a window opens.
This window lists the fields considered important or critical. A colour system is used to distinguish between fields that are not very important (green circle), important (yellow circle) and very important (red circle). If

red circles appear in the **Fields to complete** window, the record cannot be exited without these fields being completed.

NB: The level of importance is configurable. Only site administrators can modify the names of the fields to complete and their order of importance.

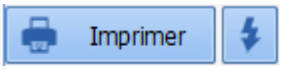
If you click on , the tab where this field is located will be displayed on the screen for you to complete it as normal.

You can also select the desired item directly from the drop-down menu in the window.

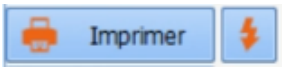
The button in front of lets you quickly insert a value. These quick entry values are fully configurable.

3.2.9 Consultation printout

Once the consultation is finished, the Anaesthesia Report is generated according to the settings entered by key users.
You can print the report directly, display the print preview or send it directly to the Patient Record.
You will need to click on the button to print:

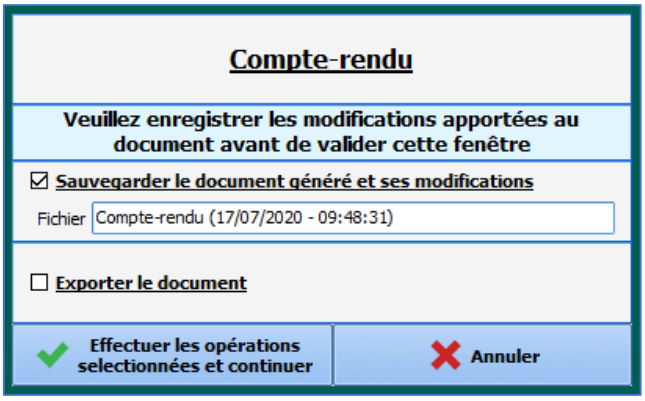


As soon as the document is generated, the colour of the button changes from blue to orange. In addition, if you hover over it with the mouse, you can see the date on which a report was last generated.



Each time you request a printout, the window below opens. This lets you see which document will be printed. You can choose to save the document, in which case it will be stored in the **Documents** tab. It can also be exported.

If this window appears, the document is exported or saved after clicking on the **Perform the selected operations and proceed** button.



On the right, the button sends the report directly to the printer then opens the window above.

3.3 Using DIANE on a laptop OFFLINE

You may need to see a patient in a remote location, for example perform anaesthesia at a site not equipped with the software. With a laptop computer that has the **DIANE** software, you can load the record onto the computer, carry out the consultation, the preop assessment, surgery, etc. then put it back on the network.

To do this, different steps must be carried out:

- The patient records are preloaded onto the computer.
- The relevant procedures are carried out.
- The data is resynchronized.

3.3.1 Preloading patient records

Before working offline, the relevant patient records must be loaded onto the computer.

To do this, you must search for the patient record then right-click to select **Load in full access mode**.
This loads and locks all the data from the record onto the computer. This record will be accessible only from this computer in read and write mode while offline.

Lock: this option places a lock on the patient in the database, preventing other users from changing data in the patient's record. Locked records show the lock symbol in the **Patient selection** window.

The selected records now appear in the **List of locally loaded records** pane.

When the upload is complete, you can close this window and follow the relevant procedure. The computer can be disconnected from the network.
Run the relevant application, ticking **Force to offline mode** in the login window. Forcing the application to work offline prevents the software from searching for the network.
In offline mode, the application is red. *See chapter entitled 'Offline mode and connections between computers'*.

You can now carry out the necessary actions: preoperative assessment, consultation, complete surgery, etc.

3.3.2 Data resynchronization

When the procedure is finished, you must reconnect the computer to the network. A data resynchronization is proposed

When you start up a **DIANE** application, the records found on the laptop are automatically transferred to the central server.

Only site administrators can unlock one or more patient records (if a laptop is lost, for example). In this case, all data inserted during the procedure will be considered lost.

NB: To load and unload patients from the laptop, the network connection must be working.

3.4 Intraoperative and postoperative modules

The **DIANE ANAESTHESIA** intraoperative and postoperative modules let you document the surgery in induction, the OT or recovery room. The most important tab in these modules is the **MONITORING** tab in which all the items entered in the record can be found.

The use of this module is similar in induction, in the local and regional anaesthesia room, operating theatre

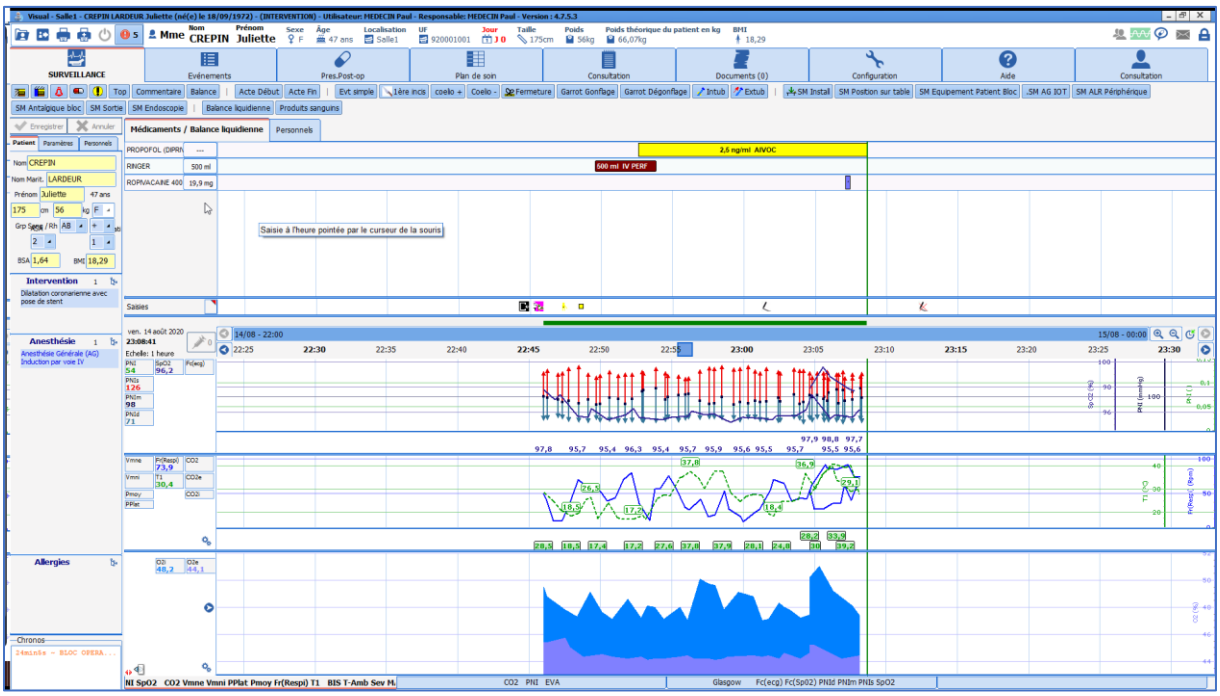
and recovery room. The differences will be seen at the end of the chapter.

The display is adapted to the work area where the computer is located.

Prescriptions for the recovery room and postoperative units are now managed taking into account the developments in place for intensive care, making it possible to generate structured prescriptions (see chapter entitled: '*Prescription tab*').

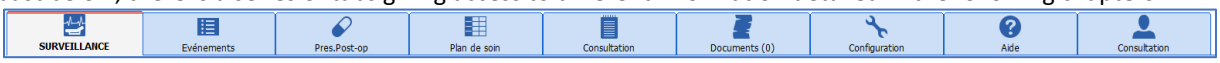
3.4.1 General appearance of the application

The application is divided into tabs, the main tab being the **MONITORING** tab.

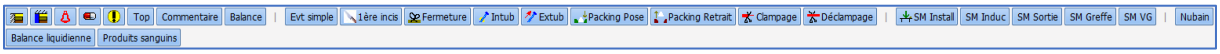


Above the tabs there is a ribbon containing information about the patient (marital status, age, weight, height, BMI, etc.).

Just below, there is a series of tabs giving access to different information detailed in the following chapters.



Below the tabs there are buttons for quick access to enter data.



On the left is an area with other types of tabs. And in the middle you can see the anaesthesia record.

3.4.1.1 Intraoperative and postoperative buttons

The table below shows the meaning of the application's different buttons.

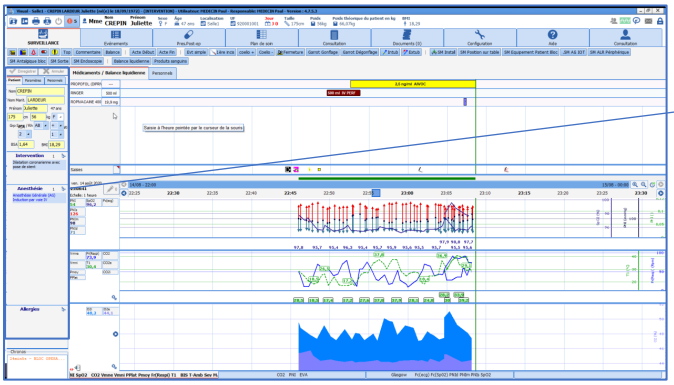
On the left there are buttons to open or exit the record.

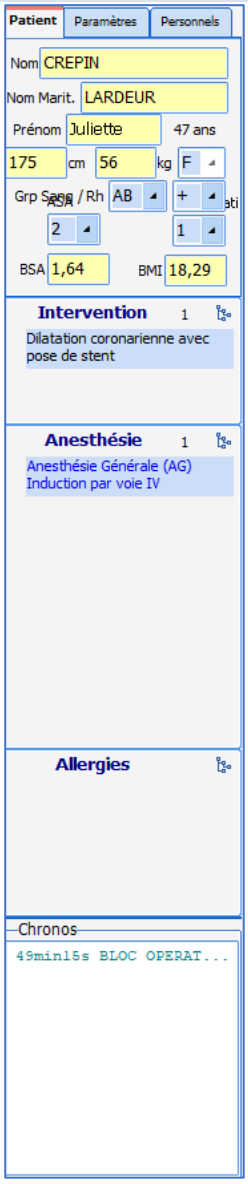
	Button to open record
	Button to exit record
1	Warning telling you that important actions have not been taken. Important items reminder button.
	One or two printers are used to manage default printing, but also specific printing (see chapter entitled: '*Centralized printing*')

On the right there are other buttons:

	Patient-oriented email client
	Status of data transmissions between biomedical devices and the software
	Warning telling you that prescriptions are awaiting confirmation
	Internal email client
	Button to log out while leaving the patient record open

3.4.1.2 Patient subtab





This tab summarizes important patient information. This data is retrieved from the consultation

These fields are writable during and after surgery to be able to readjust what was planned.

The name of the surgery comes from the consultation's **Surgery scheduled** field. When the record is closed, the **surgery performed** field will be completed.

NB: when you exit the software or close the record, this tab is automatically saved. It is also possible to save manually by clicking on the **Save** button above the **Patient** and **Parameters** tabs.

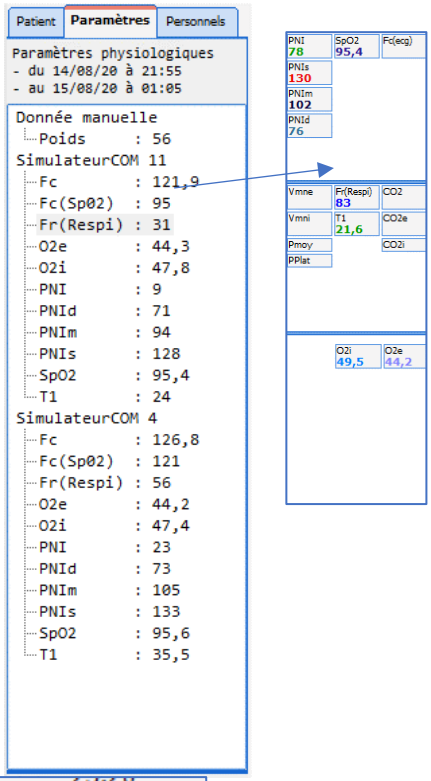
3.4.1.3 Parameters subtab

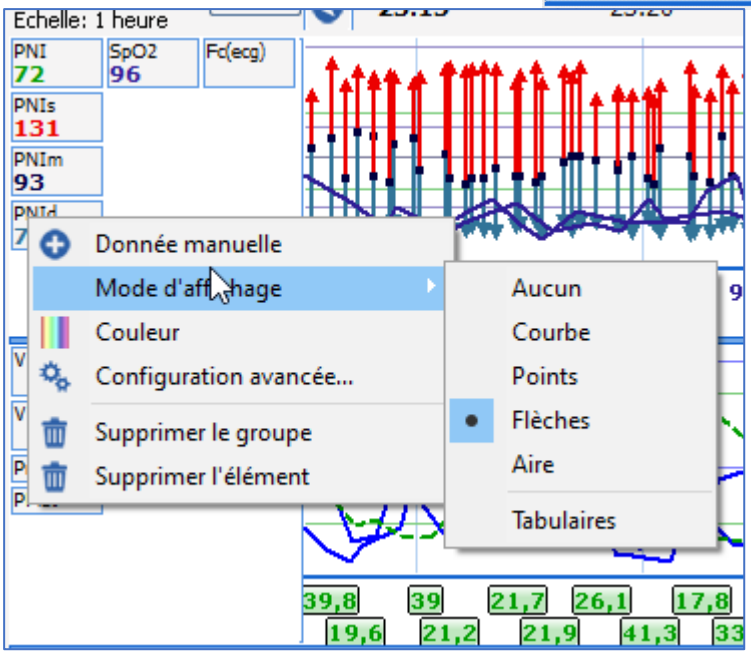
This tab shows you the data collected from biomedical devices and data entered manually.

It is this tab that will allow the user to customize their anaesthesia report. Indeed, you can drag and drop the relevant items to the appropriate place. They are then displayed with the default graphical configuration.

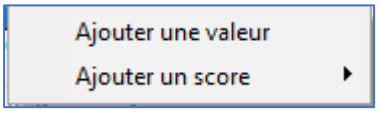
Once in place, you can right-click on the item to configure the type of display (curve, area, arrow, etc.) but also the tabular (= numerical) view or colour, etc.

Feel free to personalize your anaesthesia record. The data is recorded the same way regardless of the display used. Each user can therefore put the data they need on the screen according to the surgery, patient and conditions.

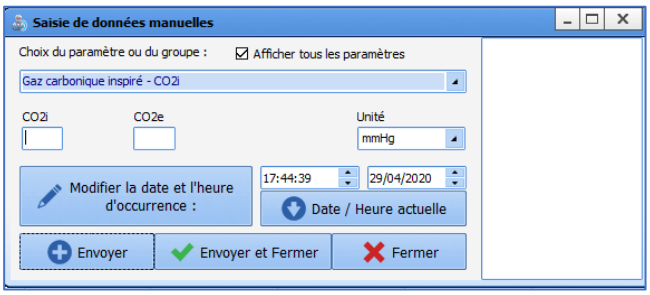




By right-clicking in the pane you can add a

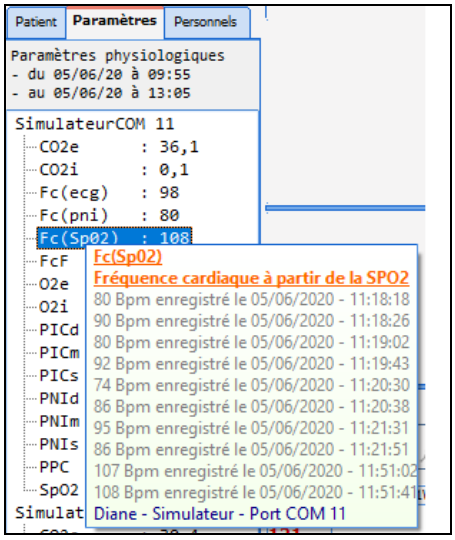


score or value manually.



When you hover the mouse over it, you can

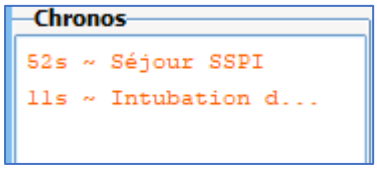
see the last 10 values sent.



3.4.1.4 Timers

This pane displays the timers triggered by certain events. There are two types of timers:

- Configurable automatic timers, with or without alerts.
- Manual timers.



3.4.1.4.1 Purpose of timers

Timers can be used for two purposes:

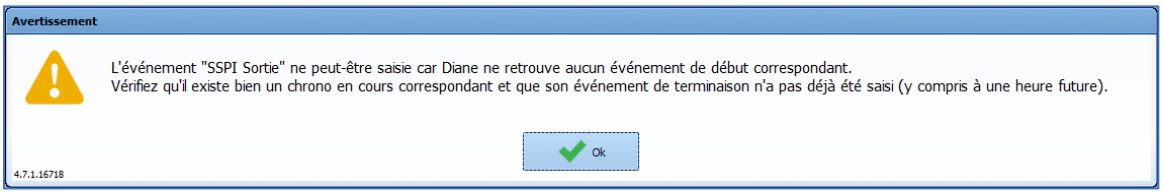
- To remind you of an action that needs to be repeated (repeat antibiotic injection, tourniquet time, etc.) via a pop-up.
- To simplify the entry of an action completed.

Indeed, triggering an action associated with a timer gives easy access to the closing event (see chapter entitled: *'Different ways to enter data during monitoring'*)

3.4.1.4.2 Automatic timers

Three items characterize an automatic timer: its name and its starting and stopping conditions. The **Intubation** timer is started by the Intubation event and will be stopped by the **Extubation** event. An alarm can be generated with an automatic timer.

NB: A **Timer warning** message is generated when the event ending the timer is entered before the event starting the timer.



3.4.1.4.3 Manual timers

If you right-click in the **Timers** pane, at the bottom left of the **MONITORING** tab, a menu is displayed to start a new timer manually. The **New timer** window opens for you to name the timer and choose the time interval between warnings, if you want warnings to be generated for your timer.

Right-clicking on a manual timer opens a menu that lets you **Stop**, **Start the timer**, or configure the time interval between warnings.

This is particularly useful for managing repeat injections of antibiotics or for clamping times for example.

3.4.1.5 Staff in the OT / Doctor in charge

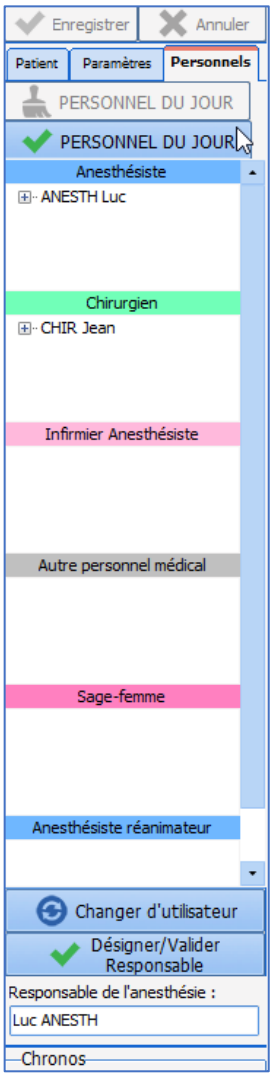
This tab is used to say which staff is present in the operating theatre.

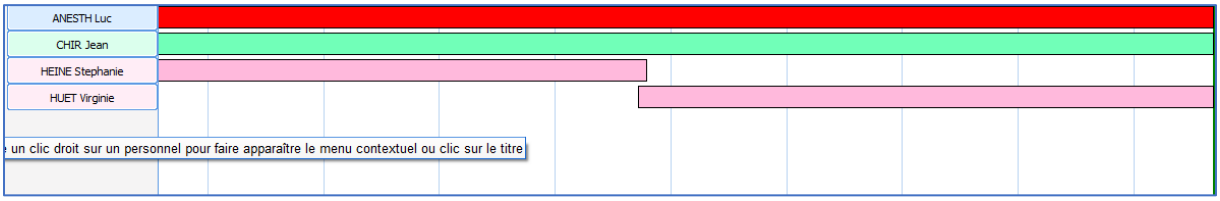
The **Today's staff** button at the top lets you say that the staff currently entered will be the staff for the current day. The staff will then be entered automatically for the next records.

At the bottom of this tab there is a **Designate/Confirm person in charge** button to name the doctor in charge of the anaesthesia.

This information can also be found by using the tab behind the drugs, which gives a different view of the people present.

These fields are currently not configurable.



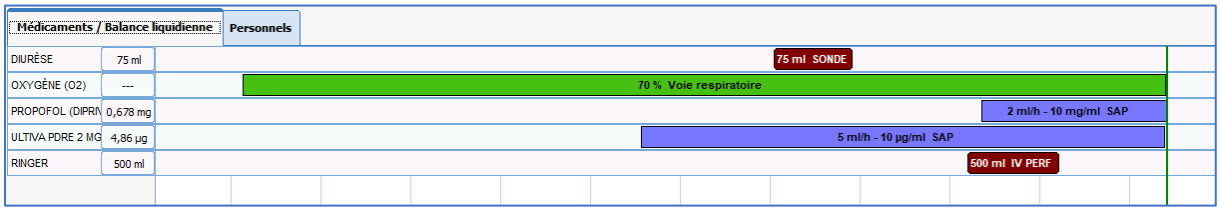


3.4.1.6 Drugs / Fluid balance ribbon

The ***Drugs / Fluid balance*** ribbon lets you enter products administered but also fluid loss such as bleeding, transepidermal water loss, urine output, etc.

The green vertical bar represents the current time.

The different ways to enter a product or output will be shown in the chapter entitled *'Different ways to enter data during monitoring'*.



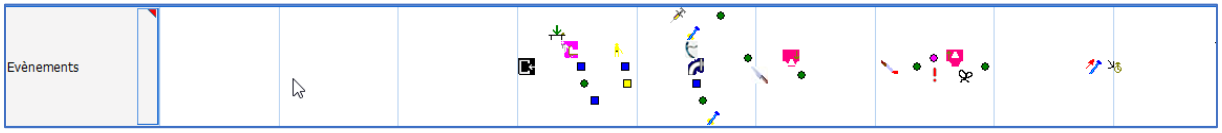
3.4.1.7 Events input pane

Located between the **Drugs / Fluid balance** ribbon and the parameter chart pane, this pane contains icons representing all events, consumables and scores that have been entered.
This pane tends to be narrow. When two items are entered for the same time, they overlap and a number replaces the icons. If you hold the **CTRL** key and click on the number they will be separated.

It is also possible to expand the pane by placing the curser on the blue line at the top or bottom.

If you hover the mouse over a marker on the line you will see a tooltip showing the event entered and the time of occurrence. The same applies for drugs.

You can change the time of occurrence of an entry by dragging and dropping the marker to the relevant time in the input pane. You will be prompted to confirm the change. You can also delete an entry by right-clicking on it.



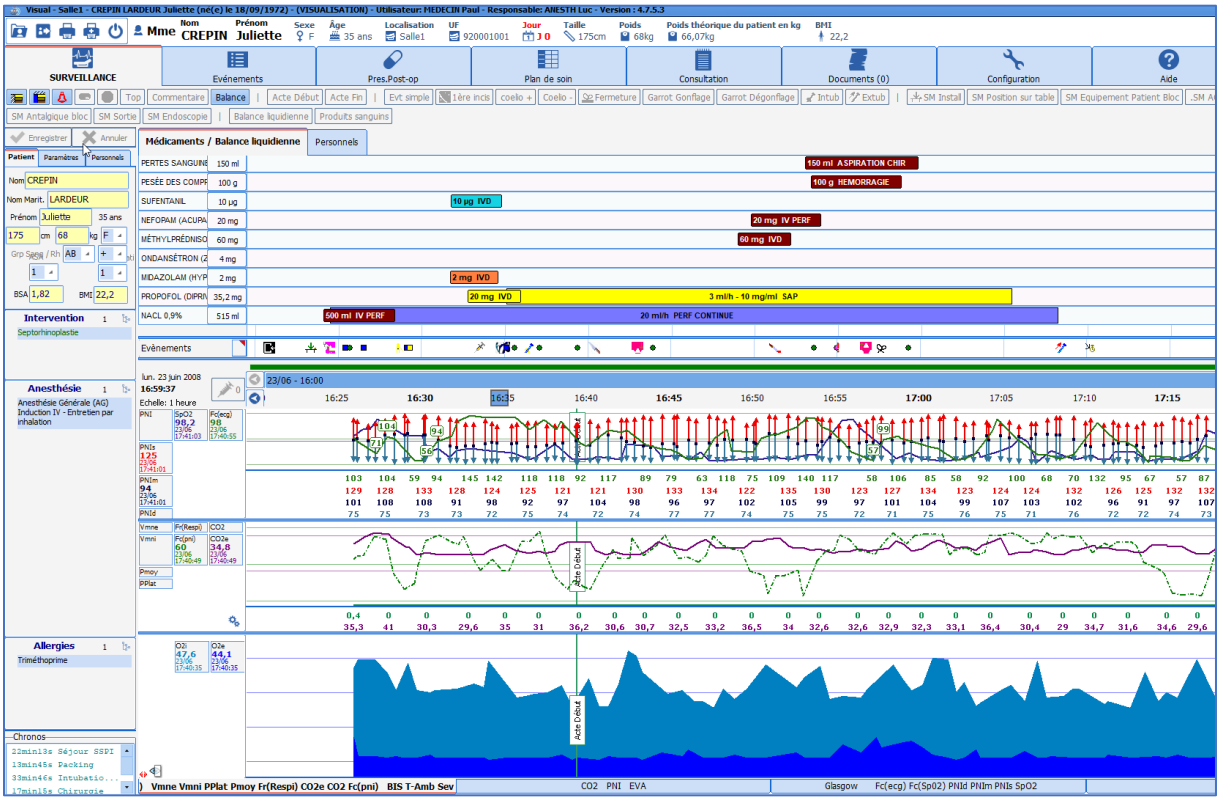
The different ways to enter a product or output will be shown in the chapter entitled *'Different ways to enter data during monitoring'*.

3.4.1.8 Parameters chart

The parameters chart is synchronized with the time bar. Parameters can be entered automatically by connecting biomedical devices to the computer or entered manually.

A chart pane can include as many parameters as you want. There are 3 different pages accessible using the tabs at the bottom of the page.

The size of the 3 chart panes can be changed. To do this, drag and drop the **blue line** separating each of the panes to change the size of the chart pane. Your cursor should look like this .

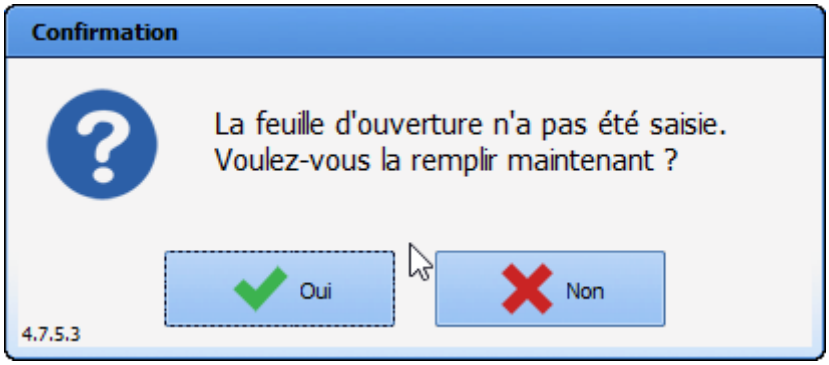


3.4.2 Important actions

When configuring the software, some items can be made mandatory. The **Safety Checklist** (or opening checklist) is adapted to each anaesthesia site and you are prompted to fill it in when opening the software. In the same way, inter-patient checklists can be offered.

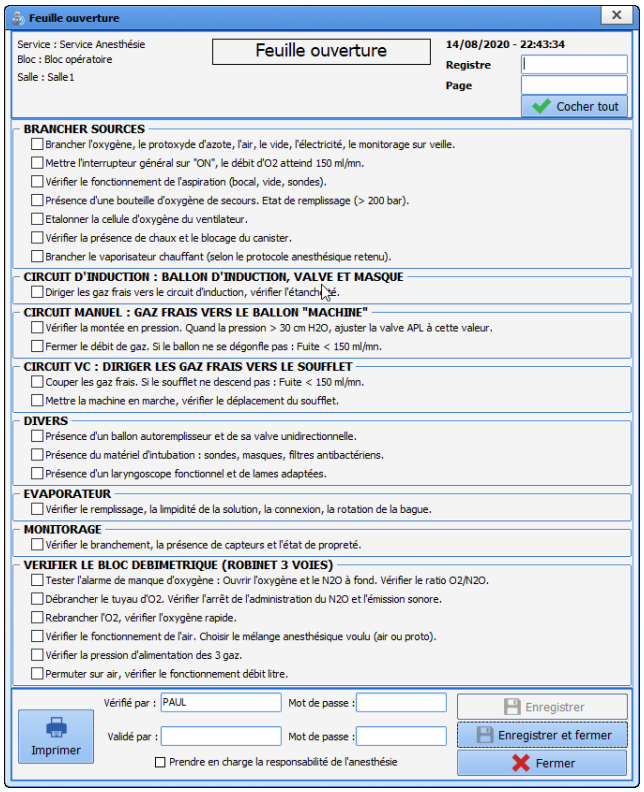
3.4.2.1 Entering and confirming the operating theatre Safety Checklist

As soon as the software is opened, you are prompted to complete the safety checklist.



In an emergency, you can skip this step by clicking on **No**. It can be completed later during the surgery and will be proposed automatically when the next record is opened, until it is completed. During the surgery, it can be accessed via the important items reminder button (see chapter entitled: *'Intraoperative and/or postoperative buttons'*). It is also accessible via the **Safety checklist** button in the Button **configuration** tab and in the patient record selection window.

Filling in this form is simplified by checkboxes and a **Tick all** button.



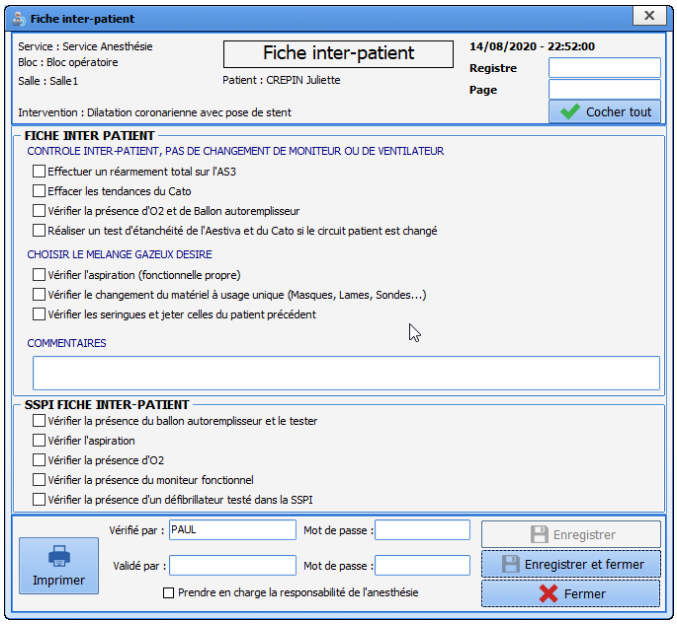
To confirm the entry, the person logged in must retype their password in the **Checked by** box. A medical profile in the **Confirmed by** box will confirm.
The rights are managed by the site's key user.

The Safety checklist must be completed every 24 hours. It is possible to set the time from which it is proposed (operating theatre opening time for example).

NB: The Safety checklist can be configured entirely by your site administrator. It is configured by unit, operating theatre, room, bed, etc.

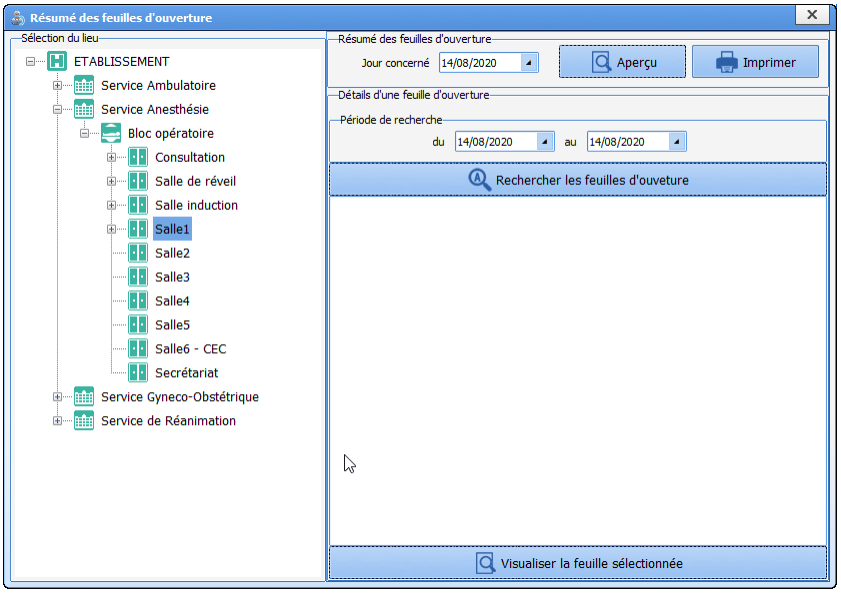
3.4.2.2 Entering and confirming the Inter-patient checklist

Between each patient, a message prompts you to complete the inter-patient checklist.
This checklist is completed, confirmed and printed in the same way as for the Safety checklist.



3.4.2.3 Safety checklist summary

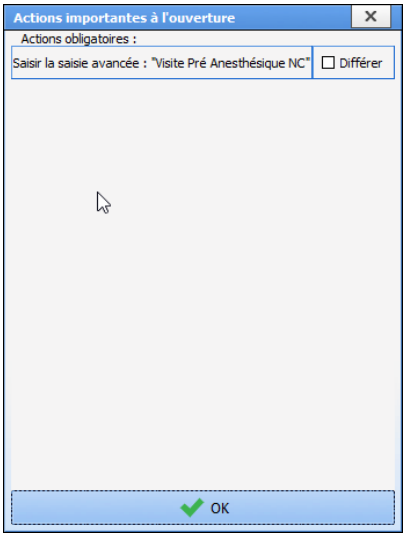
In the configuration tab, there is a button to access a Safety checklist search engine.
You can search for the Safety checklist by site, date, etc.



3.4.2.4 Other important actions

Your key users can set items as mandatory if they wish. These items are often chosen from official indicators to improve the quality and safety of care to ensure that medicolegal information has been entered (RR departure score, complications, pain assessment, name of the doctor in charge, preop entry, etc.).

You can determine that a detailed entry is needed when a surgery starts (e.g. Preop assessment when it is entered during the operation). In this case, you are prompted to enter the information as soon as the patient's record is opened. This action can be postponed. It will be accessible in the important events reminder button.

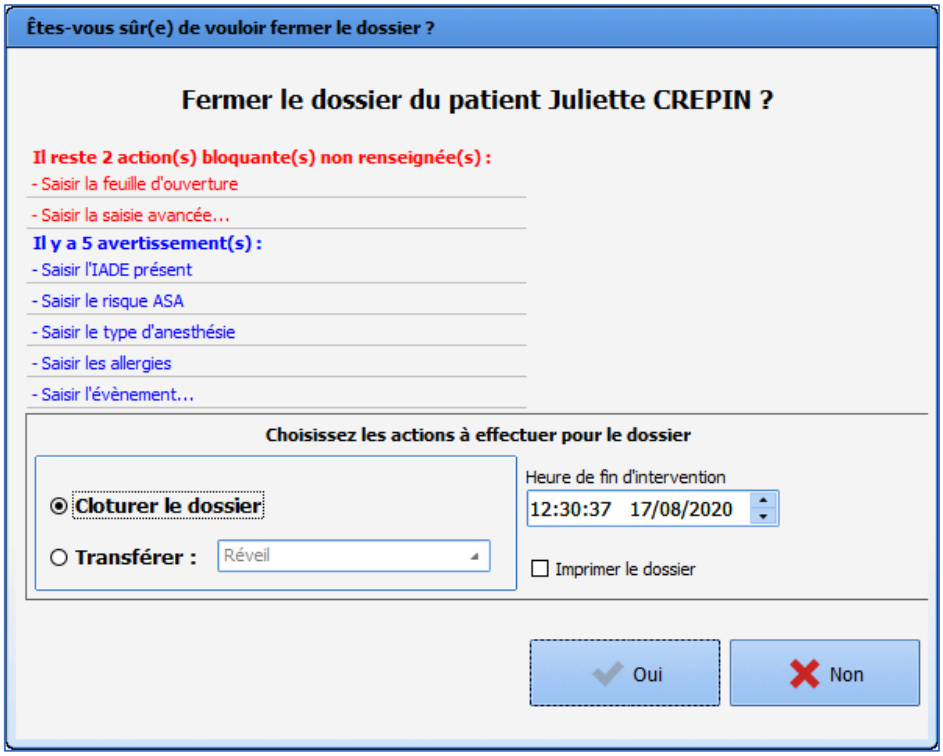


To complete the detailed entry, simply click on the relevant line.

If the **Postpone** box is active, you can enter this item later by clicking on the **OK** button.

If the **Detailed entry** is not filled in, a reminder will be given in the 'important events to enter' reminder button. By clicking on the button you can see and then enter items considered important.

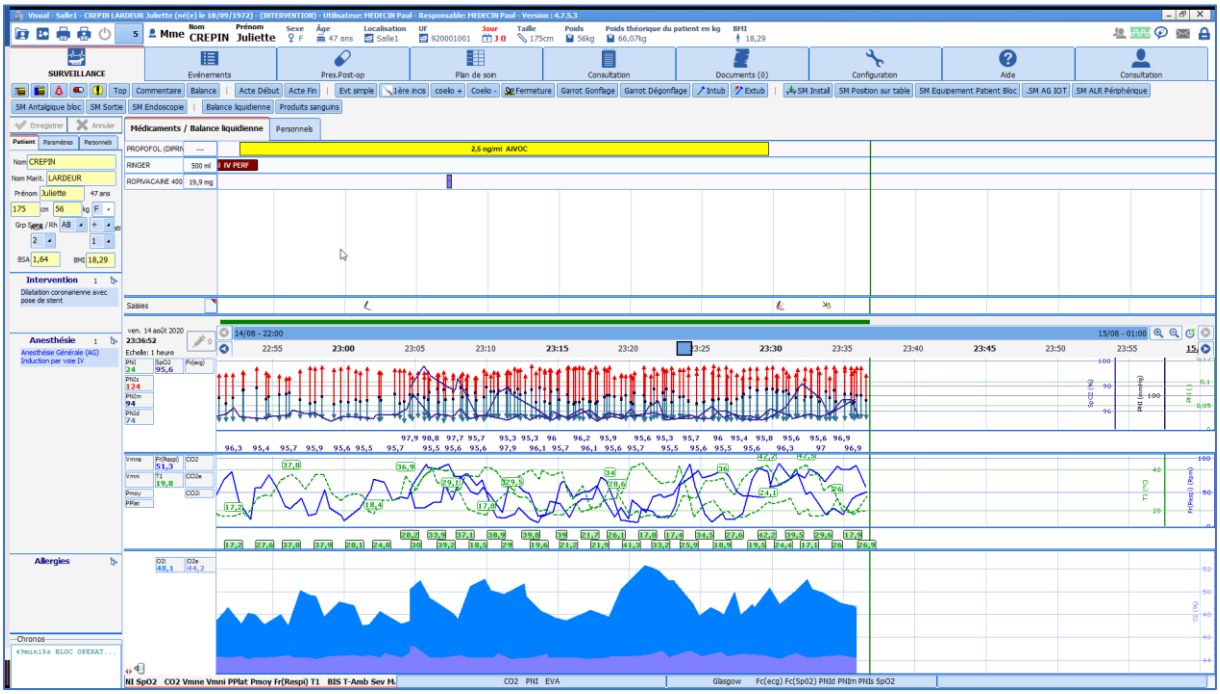
If these items are still not entered, you will be reminded when you exit the record.



3.4.3 Monitoring tab - anaesthesia record

Intraoperative and postoperative monitoring lets the user document the record as the surgery progresses.

All the information can be entered by choosing the corresponding entry in the menu that appears when you right-click on the events area.



If you hover the mouse over a marker on the line you will see a tooltip showing the event entered and the time of occurrence. The same applies for drugs.

NB: The monitoring sheet is preconfigured by key users. It can be adapted by the user during the procedure.

All the data entered and saved will be associated with the record even if the data is not configured for the display at the time of the procedure.

3.4.3.1 Different ways to enter data during monitoring

There are different data input methods for each item. Each method will take the item to where it should be. These different input methods are detailed in the following chapters. Different situations call for different methods.

Events and drugs can be entered in real time, in advance or afterwards.

You can change the time of occurrence of an entry by dragging the marker to the relevant time in the input pane. You will be prompted to confirm the change. You can also delete an entry by right-clicking on it.

You can also change the time of occurrence of the entry or delete it using the **Events** tab (see chapter entitled: *'Events tab'*) or using the specific buttons **Change an event**, **Delete an event**, **Change a drug** and **Delete a drug**.

3.4.3.1.1 Events, patient environments, complications and consumables

These items are accessed by right-clicking in the event input bar.

Events: This section contains events relating to anaesthesia (Induction, Intubation, etc.), surgery (1st incision, Clamping, etc.). The symbol is used for events. Entering events is easy. Simply browse in the drop-down context menu. Move the mouse cursor onto **Events**, then over to the event you want to enter. Only the last item of each branch will be saved.

Patient environments: You can insert all items concerning the patient such as position, type of ventilation, type of IV administration, etc. The symbol is used for patient environments where the patient's position is inserted. Patient environments are entered the same way as events.

Complications: All complications, whether allergy-related, cardiovascular, etc. can be inserted. The symbol is used for complications. Any complications that you have inserted during the surgery will be automatically retrieved when you schedule your patient's next operation. Complications are entered the same way as events.

Consumables: You can enter all the consumables used during the surgery such as compresses, needles, catheters, etc. The symbol is used for consumables. Consumables are entered the same way as events, apart from the fact that the last two items will be saved, rather than just the last one.
You can insert an event, a patient environment, a complication or a consumable that is not in the configured lists of your unit, your operating theatre, your room, etc. but which was created in the hospital's configuration by clicking on **Other choice…**

You can configure automatic event entries in the configuration tool when opening/exiting records (OT arrivals, OT departures, RR arrivals, RR departures, return to OT, etc.) from the **Automatic events when a record is opened and exited** section of the **Display settings** tab in the configuration tool.

NB: All of these lists can be configured entirely by your site administrator. They are configured by unit, operating theatre, room, etc.

3.4.3.1.2 Time markers

You can insert a time marker using the specific **Enter a time marker** button Top.
A **Time marker** is an unspecified event that can be entered to mark the time of an important event. This lets you pinpoint the exact time of a problem, such as a complication, and continue to care for your patient. The symbol is used for a time marker on the markers line. You must then assign the corresponding event to this time marker by right-clicking on it.

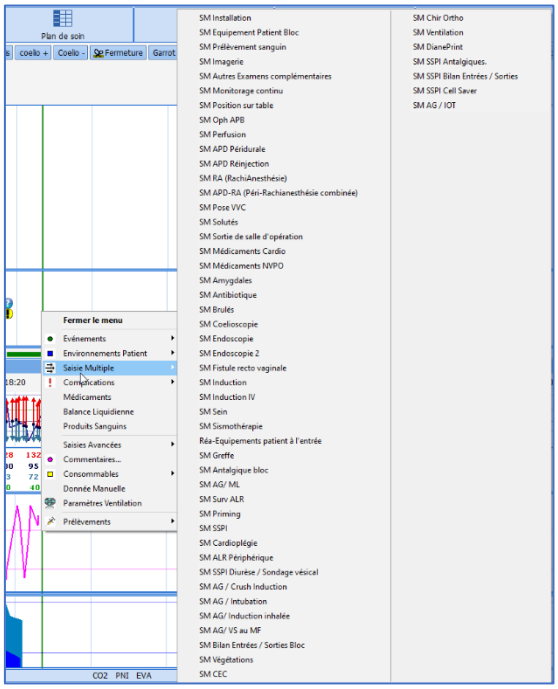
Please note, if the time marker is not renamed before the patient record is exited, it will not be saved.

3.4.3.1.3 Multiple entries

Multiple entries are particularly useful at certain key times for anaesthesia (patient's arrival, induction, when patient wakes up, etc.), when a lot of information has to be entered in a short time.

Multiple entries are accessed via buttons at the top of the application and/or by clicking in the **Entries >> Multiple entries** bar.

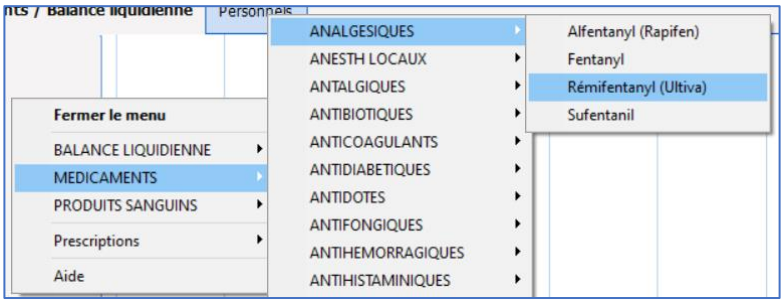
To use multiple entries, see the *'Multiple entries'* chapter.

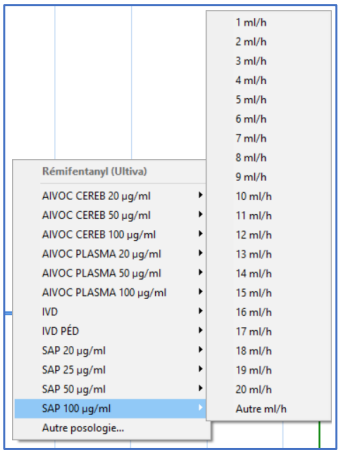


3.4.3.1.4 Drugs, fluid balance and blood products

3.4.3.1.4.1 Select a drug or fluid loss

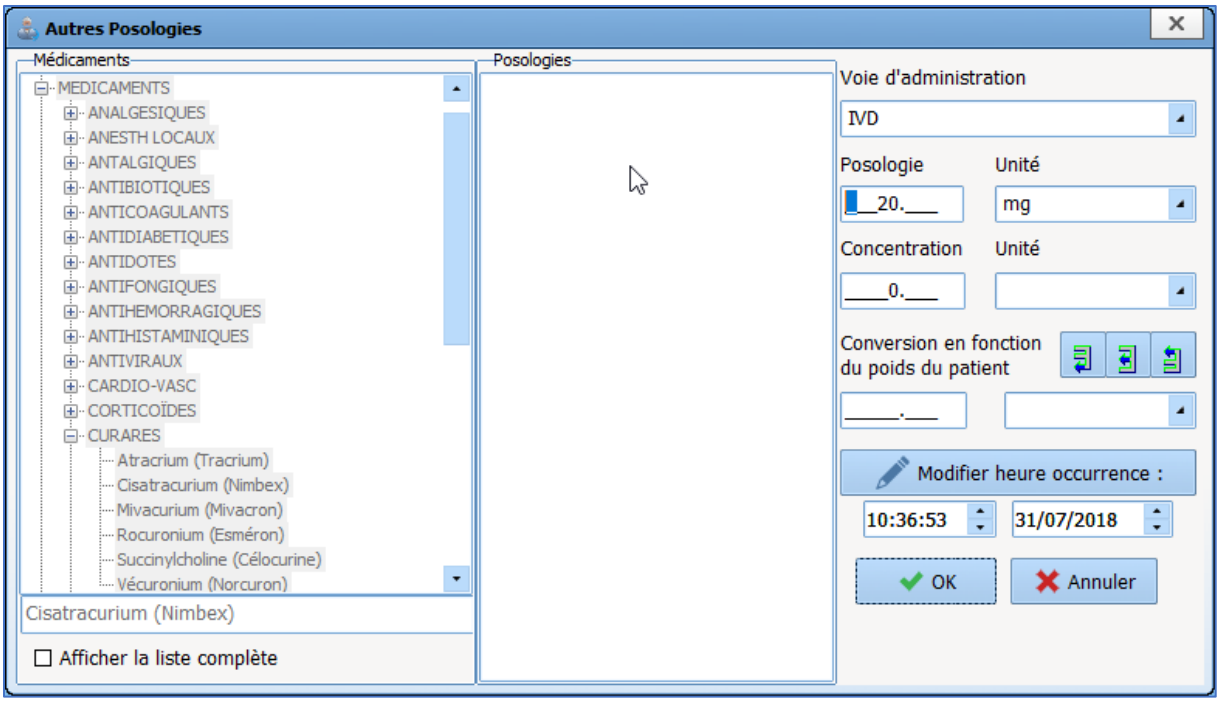
To enter a dose and/or fluid loss, click in the **Drugs / Fluid balance** pane to open a menu. Drugs are classified by therapeutic class. Once the drug is selected, you must choose the route of administration and dosage.





You can also use the specific button . You can type the first letters of the drug to quickly search for it. Drugs starting with those letters are displayed in the bottom window on the left. You must then select it to show on the right its location in the tree above and you can then select the route of administration and dosage.

If the drug, route of administration or dosage is not displayed in the list, click on **Other drugs** or **Other dosage**. The window below appears.



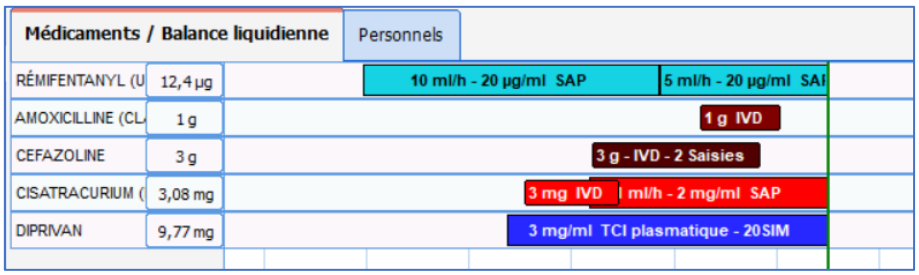
Enter the name of the drug at the bottom left of the window, if necessary. Otherwise, select it from the list. Also enter the **Route of administration**, **Dosage**, **Unit** and **Concentration** of your product.
If you wish to perform a conversion based on your patient's weight, you can use the different buttons provided in the window.

If you click on the button, you can calculate the mass dosage according to the dosage and concentration. To do this, you must enter the dosage, concentration and conversion unit.

If you click on the button, you can calculate the concentration according to the dosage and mass dosage. To do this, you must enter the dosage, conversion and concentration unit.

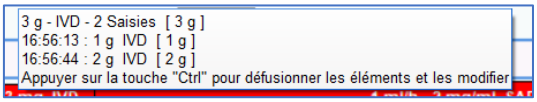
If you click on the button, you can calculate the dosage according to the mass dosage and concentration. To do this, you must enter the concentration, conversion and dosage unit.
You can change the time of occurrence before confirming the window by clicking on the **OK** button.
There are three different drug injection and display modes: syringe pump type drugs (continuous injection), ventilator type drugs and flash injections.

Syringe pump type injections can be entered manually or retrieved automatically: a progress bar is used to represent continuous injections. It is synchronized with the time bar.
When the flow rate changes or is stopped, the colour of the bar representing the former flow rate also changes. *You can see in the image below that **Ultiva** was injected using a syringe pump at a concentration of 20 µg/mL. The injection started with a dosage of 10 mL/h, then 5 mL/h.* The progress of this new flow rate continues in the same form as the previous progress bar. The total injected is shown in the box provided, to the right of the name of the drug.
You can enter a syringe pump drug without specifying a concentration, in which case the volume injected will be calculated automatically.

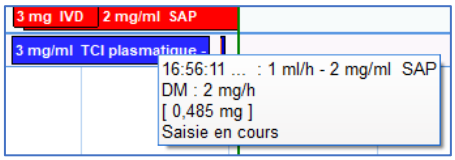


You can automatically retrieve data from a syringe pump. To do this, turn on the syringe pump. Install the syringe and enter the flow rate directly on the syringe pump. Once you have confirmed your flow rate (the green arrows on the syringe pump are flashing), you will be able to view the progress of your syringe pump on the screen. Depending on the type of equipment you are connected to, you may need to enter the name of the product by clicking on the button below **Entries**. *You can see that **Diprivan** was injected using a syringe pump at a dosage of 3 mg/mL.*

When two entries are too close together and risk overlapping, the system merges them together as you can see. Simply hover the mouse over to display a tooltip showing you the injection times, routes of administration and dosages.



To separate them, just press the **Ctrl** key. Likewise, if a syringe pump and a flash injection overlap, simply hover your mouse over the syringe pump for a tooltip to display the syringe pump start time, concentration and dosage.



3.4.3.1.4.2 Managing repeat injections

When a drug has already been entered during the surgery, you can enter a new dosage by clicking directly on the line of that drug.

- If you click on the name of the drug, the injection time will be the current time.

- If you click on the drug line, the injection time will be where you clicked.

When you click on the marker representing the injected drug or on the drug line, you can insert an **Other dosage**, **Resume** or **Stop the SP** or **Delete** it.

NB: You can view a certain amount of information by hovering over the entries with your mouse.

3.4.3.1.5 Written comments

In the context menu, move the mouse cursor over **Comments**. The **Enter a comment** window opens. Write in the box provided.
The symbol is used for comments on the markers line.

3.4.3.1.6 Ventilation parameters

If your ventilator does not have an RS232, local HL7 or network HL7 link to retrieve parameters automatically, these ventilation parameters can be entered manually.
In the context menu, move the mouse cursor to **Ventilation parameters.** A **Ventilation parameters** window opens. Enter the different ventilation parameter items using the drop-down lists (ventilation, vt(-), RR, I:E ratio, FiO2, PEEP, pressure, pressure support, NO, prone). The date and time of occurrence can be changed. Click on the **OK** button to confirm your entry.
The ◆ symbol is used for ventilation parameters on the markers line.
You can also insert a ventilation parameter using the specific **Ventilation parameters** button.

NB: Ventilation parameters can be configured by your site's key user.

3.4.3.1.7 Manual data

It is possible to enter data manually.
In the data entry bar menu, move the mouse cursor to **Manual Data**. A **Manual data entry** window opens. Choose the parameter or group of parameters that you want to enter manually using the drop-down list. You must then complete the various fields offered to you based on the parameter chosen previously. The date and time of occurrence can be changed.
Click on the **Send** button to confirm your manual entry. The **Send and close** button lets you close the **Manual data entry** window without having to click on the **Close** button.
This entry is displayed in the **Current Values** pane of the **Parameters** subtab (see chapter entitled: '*Parameters subtab*'). Like the other parameters, this parameter can be inserted in the chart pane to monitor changes (see chapter entitled: '*Adding or removing a parameter in the charts pane*').
You can also insert data manually using the specific **Manual data** button.

3.4.3.1.8 Artefacts

You can tell the software that an artefact is present using the specific **Enter an artefact** button.
The symbol is used for artefacts on the markers line.

3.4.4 Intraoperative and postoperative components

Quick presentation of the components usually encountered **during** and **after surgery**
The anaesthesia record is preconfigured by the site's key user. However, it can be personalized by the user in real time to take into account the specificities of the procedure in progress.

3.4.4.1 Adding or removing a parameter in the charts pane

To view a parameter in a chart, use the mouse to drag and drop this parameter from the **Current Values**

pane to the **Charts** pane. Hold down the left mouse click while the curser looks like this . For the parameter to be taken into account, your mouse cursor must look like this . As soon as you release the left click of your mouse, the parameter, symbolized by its abbreviation and instantaneous value(s), is displayed in the curve pane. Right-clicking on the parameter in the charts pane displays a menu that lets you remove that parameter from the charts area.

3.4.4.2 Parameter display mode

The parameters can be displayed in several ways. The table below shows the different display modes and our instructions to use them:

Display modes	Instructions
None	Does not display the parameter as a chart. Useful in conjunction with the **Tabular** mode.
Curve	Suitable for all parameters.
Tabular	Suitable for all parameters.
Arrow	Only concerns parameters measured discontinuously (e.g. NIP). Only a parameter with 3 physiological inputs will appear in the charts pane in this case.
Area	Applies to curve panes only containing one parameter with two inputs (e.g. gas inhaled and exhaled) or two parameters with one input but not intersecting.
Parameter zoom	From the **Current Values** area (*left column,* **Parameters** *tab*), double-click on one or more parameters to obtain a continuously visible zoom on the screen. This large number can be repositioned by the user. *See example of HR (SpO2).* This display mode is very useful to closely monitor a particular parameter.

3.4.4.3 Choice of timescale

Right-clicking on the time bar (between the markers line and the charts pane) brings up a context menu allowing you to choose a timescale.
You can display your charts over a 15 or 30 minute period for short surgeries, and over a period of one, two, four or eight hours depending on the length of the surgery you are performing. If you select the automatic scale, the scale will change on its own based on the length of surgery.

NB: Real time simply makes it possible to see the biomedical monitor data in real time in the scale chosen previously. The **Real time** option is not visible in **Read-only** mode.

3.4.4.4 Display colour changes

In the curve pane: If you right-click on the instantaneous value of the **Parameter** in the charts pane, the **Configure Parameter display** window is displayed. To change the colour, click on the **Colour** box and choose the colour you want from the palette. This colour palette is used in the same way as in Windows. You can also choose the **Thickness** and **Style** of the line (Continuous, Dotted, etc.).
By default, the **Automatic scale** item is preselected. You can set the parameter **Scale** manually by giving the **Min** and **Max** scale in the relevant boxes. We advise users to set these minimum and maximum scales rather

than using the automatic scale. This is because, if there is an artefact in the physiological data retrieved from biomedical equipment, the curves could be illegible (artefacts are always deleted during printing).
It is also possible to change the parameter display mode (chart, tabular, etc.) for the session that is open.
If you right-click in the parameters pane you can change the background colour of the different chart panes. This colour palette is used in the same way as in Windows.

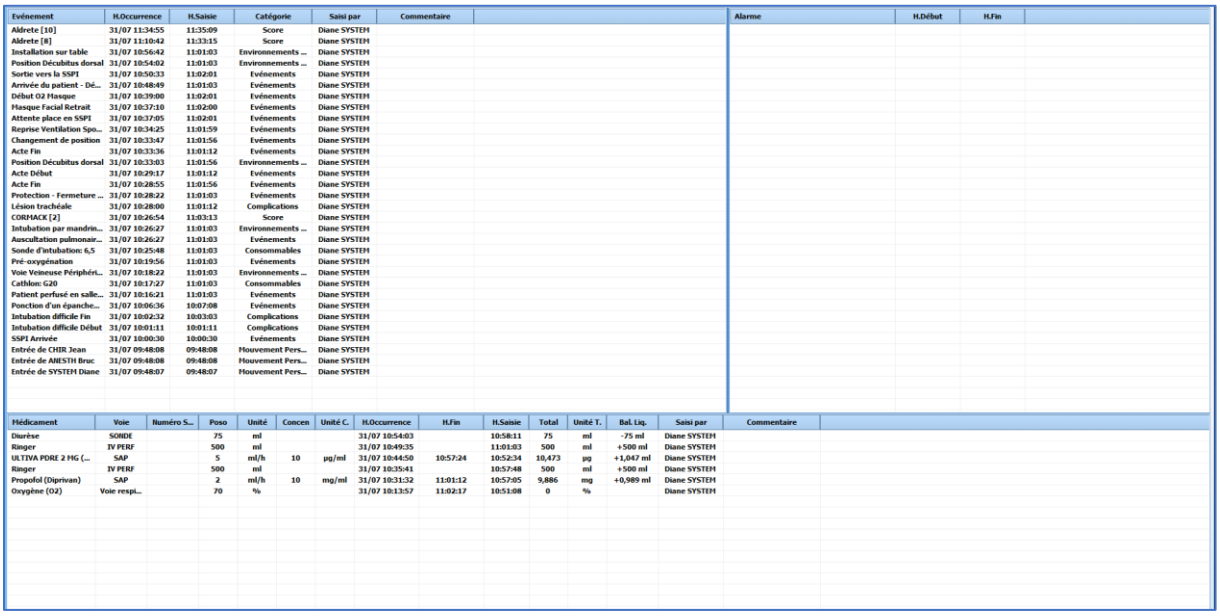
NB: The print colour of the curves is as configured on the computer requesting the printout of your patient's surgery.

3.4.4.4.1 Alarms

You can choose whether or not to activate alarms displayed on the markers line and in the **Alarms!** window by using the specific **Alarms On/Off** button.

A symbol next to the **Entries** pane will indicate that the alarms are displayed on the markers line.

3.4.5 Events tab



Evénement	H.Occurrence	H.Saisie	Catégorie	Saisi par	Commentaire
Aldrete [10]	31/07 11:34:55	11:35:09	Score	Diane SYSTEM	
Aldrete [8]	31/07 11:10:42	11:33:15	Score	Diane SYSTEM	
Installation sur table	31/07 10:56:42	11:01:03	Environnements ...	Diane SYSTEM	
Position Décubitus dorsal	31/07 10:54:02	11:01:03	Environnements ...	Diane SYSTEM	
Sortie vers la SSPI	31/07 10:50:33	11:02:01	Evénements	Diane SYSTEM	
Arrivée du patient - Dé...	31/07 10:48:49	11:01:03	Evénements	Diane SYSTEM	
Début O2 Masque	31/07 10:39:00	11:02:01	Evénements	Diane SYSTEM	
Masque Facial Retrait	31/07 10:37:10	11:02:00	Evénements	Diane SYSTEM	
Attente place en SSPI	31/07 10:37:05	11:02:01	Evénements	Diane SYSTEM	
Reprise Ventilation Spo...	31/07 10:34:25	11:01:59	Evénements	Diane SYSTEM	
Changement de position	31/07 10:33:47	11:01:56	Evénements	Diane SYSTEM	
Acte Fin	31/07 10:33:36	11:01:12	Evénements	Diane SYSTEM	
Position Décubitus dorsal	31/07 10:33:03	11:01:56	Environnements ...	Diane SYSTEM	
Acte Début	31/07 10:29:17	11:01:12	Evénements	Diane SYSTEM	
Acte Fin	31/07 10:28:55	11:01:56	Evénements	Diane SYSTEM	
Protection - Fermeture ...	31/07 10:28:22	11:01:03	Evénements	Diane SYSTEM	
Lésion trachéale	31/07 10:28:00	11:01:12	Complications	Diane SYSTEM	
CORMACK [2]	31/07 10:26:54	11:03:13	Score	Diane SYSTEM	
Intubation par mandrin...	31/07 10:26:27	11:01:03	Environnements ...	Diane SYSTEM	
Auscultation pulmonair...	31/07 10:26:27	11:01:03	Evénements	Diane SYSTEM	
Sonde d'intubation: 6,5	31/07 10:25:48	11:01:03	Consommables	Diane SYSTEM	
Pré-oxygénation	31/07 10:19:56	11:01:03	Evénements	Diane SYSTEM	
Voie Veineuse Périphér...	31/07 10:18:22	11:01:03	Environnements ...	Diane SYSTEM	
Cathlon: G20	31/07 10:17:27	11:01:03	Consommables	Diane SYSTEM	
Patient perfusé en salle...	31/07 10:16:21	11:01:03	Evénements	Diane SYSTEM	
Ponction d'un épanche...	31/07 10:06:36	10:07:08	Evénements	Diane SYSTEM	
Intubation difficile Fin	31/07 10:02:32	10:03:03	Complications	Diane SYSTEM	
Intubation difficile Début	31/07 10:01:11	10:01:11	Complications	Diane SYSTEM	
SSPI Arrivée	31/07 10:00:30	10:00:30	Evénements	Diane SYSTEM	
Entrée de CHIR Jean	31/07 09:48:08	09:48:08	Mouvement Pers...	Diane SYSTEM	
Entrée de ANESTH Bruc	31/07 09:48:08	09:48:08	Mouvement Pers...	Diane SYSTEM	
Entrée de SYSTEM Diane	31/07 09:48:07	09:48:07	Mouvement Pers...	Diane SYSTEM	

Alarme	H.Début	H.Fin

Médicament	Voie	Numéro S...	Poso	Unité	Concen	Unité C.	H.Occurrence	H.Fin	H.Saisie	Total	Unité T.	Bal. Liq.	Saisi par	Commentaire
Diurèse	SONDE		75	ml			31/07 10:54:03		10:58:11	75	ml	-75 ml	Diane SYSTEM	
Ringer	IV PERF		500	ml			31/07 10:49:35		11:01:03	500	ml	+500 ml	Diane SYSTEM	
ULTIVA PDRE 2 MG (...	SAP		5	ml/h	10	µg/ml	31/07 10:44:50	10:57:24	10:52:34	10,473	µg	+1,047 ml	Diane SYSTEM	
Ringer	IV PERF		500	ml			31/07 10:35:41		10:57:48	500	ml	+500 ml	Diane SYSTEM	
Propofol (Diprivan)	SAP		2	ml/h	10	mg/ml	31/07 10:31:32	11:01:12	10:57:05	9,886	mg	+0,989 ml	Diane SYSTEM	
Oxygène (O2)	Voie respi...		70	%			31/07 10:13:57	11:02:17	10:51:08	0	%		Diane SYSTEM	

You can sort the list of events, drugs and alarms by clicking on the column headings.

3.4.5.1 Events log

We can see a list of all the **Events** (*Events, Patient Environments, Complications, Consumables, Comments* and *Ventilation parameters*) entered throughout the surgery, with the **Occurrence** and **Entry** times.
These events appear in descending order of occurrence so that the most recent event inserted is always at the top of the **Events log**.
If you click on one of the entries, a menu lets you delete this event or change its time of occurrence. A **Confirmation** message will ask you to confirm each time you change or delete an entry.

NB: If this information was entered during a previous session, you can no longer change or delete it.

From the **MONITORING** tab, you can change the time of occurrence of an event by clicking and dragging it on the markers line or delete it by right-clicking on the marker. You can also delete or change an event using the specific buttons provided.

3.4.5.2 Alarm log

Here we find the list of alarms transmitted by the biomedical equipment with their **Start** and **End** times. More than 500 alarms can be transmitted by biomedical equipment connected via the RS232 link. These alarms appear in descending order of occurrence so that the most recent alarm triggered is always at the top of the **Alarm log**.

NB: The alarms cannot be changed or deleted.

3.4.5.3 Drug log

Here we find the list of all the drugs (*Drugs, Fluid balance* and *Blood products*) entered throughout the surgery, with their **Route** of administration, the equipment's **Serial number** if it is a product retrieved automatically, their **Dosage**, **Unit**, **Concentration** and **Concentration unit** if it is a syringe pump, and the **injection** time and **end** time (if it is a syringe pump) and **entry** time. These drugs appear in descending order of occurrence so that the most recent drug injected is always at the top of the **Drug log**.
If you click on one of the drugs, a menu lets you delete that drug, change its time of occurrence or stop the flow when the selected drug is injected continuously. A **Confirmation** message will prompt you to confirm the change or deletion.

NB: If this drug was entered during a previous session, you can no longer change or delete it.

From the **MONITORING** tab, you can change the time of occurrence of a drug by dragging and dropping it or delete it by right-clicking on it. You can also delete or change a drug using the specific buttons provided.

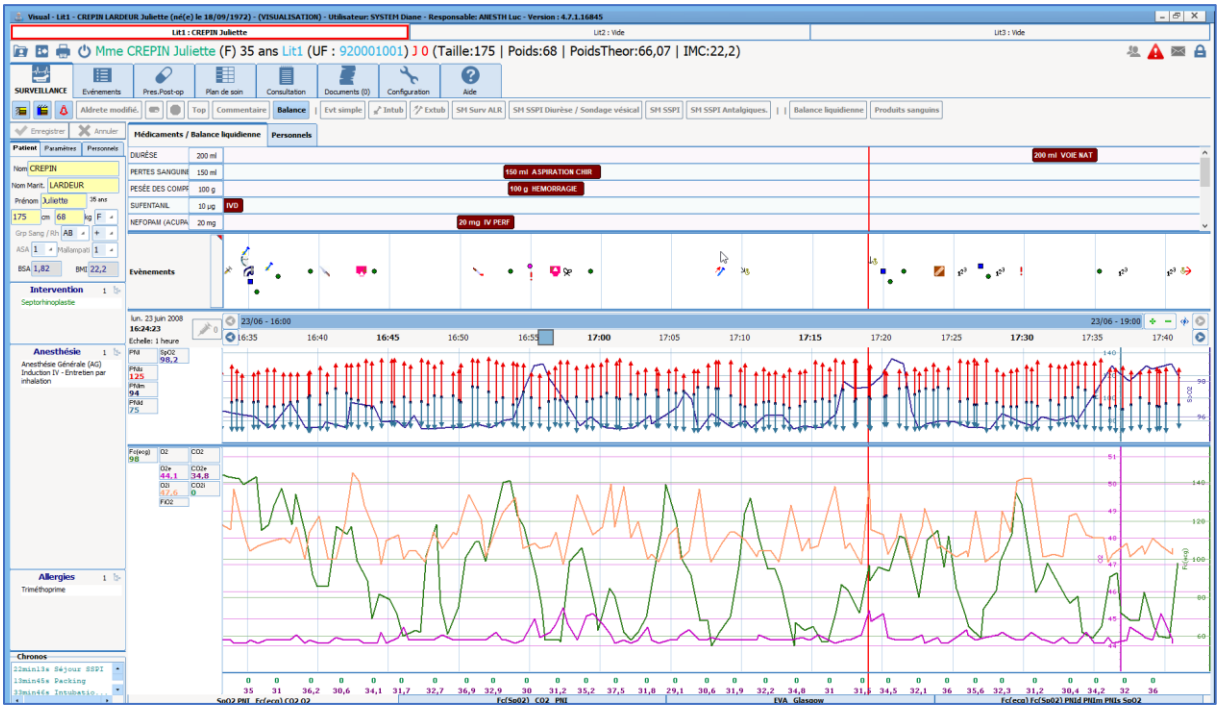
3.4.6 Consultation tab

This tab displays the preop assessment window relating to the current surgery. The information displayed (that you can view or modify depending on your access rights) adds information to the **Patient** subtab of the **MONITORING** tab.

You can obviously view or add information to the consultation of another patient by selecting it using the **Patient selection** button. See *'Preoperative assessment'* chapter for more information on how the **Consultation** application works.
To go back to the **MONITORING** tab, select the title bar that you see displayed above the **Consultation** application.

3.5 Specificities of the Postoperative application

The types of tools available in the **Postoperative** application are identical to those in the **Intraoperative** application.



Available beds and occupied beds are displayed at the top of the application as buttons, one of which is outlined in red to show the currently active bed. *In this example, the record belongs to patient Juliette Crépin in Bed 1. Beds 2 and 3 are empty.*
These buttons let you switch quickly and easily from one bed to another in the recovery room. These buttons show the name of the bed and the name of the current patient.

A red vertical line marks the move to the RR.

Before removing a patient record from the application, a person authorized to sign the discharge form must enter their username and password. Your key users can choose whether or not to activate this RR patient discharge form.

NB: you can transfer the patient to another recovery bed. To do this, you must exit the record and choose the **Transfer in Recovery** item in the **Exit** window. Open the correct bed and tend to the patient's arrival.

3.6 Discharging the patient

When a patient is discharged from a room the record must be exited. You can then choose to:

- Transfer the patient
- Close the record

The transfer will be used when the patient goes to an area/unit where they will be monitored using the **DIANE** software.

You should close the record when the patient will no longer be monitored by the software.

If there are important actions that have not been entered, the discharge window can display a reminder and you can enter the information directly from this space. See chapter entitled: '*Important actions'*.

3.6.1 Name and signature of doctor in charge

You can name a doctor in charge of the surgery. If it is an anaesthetist who has logged in to the software, they will automatically be considered as the person in charge of the surgery. You can name the doctor in charge if this person is not logged in, but in this case, they will have to confirm they are in charge by entering their password.
To name the doctor in charge, you can use the button at the top left of the application or the **Designate/Confirm person in charge** button in the **Staff** subtab of the **MONITORING** tab (see chapter entitled: '*Staff in the OT / Doctor in charge*').
There may be more than one doctor in charge of a surgery.

3.6.2 Signing postoperative prescriptions

When postoperative prescriptions have been entered in the application's **Prescription** tab, a doctor must sign these prescriptions by entering their name and password.
It is possible to sign these prescriptions using the button at the top left of the application or using the **Prescription** tab (see *'Prescription tab'* chapter).

3.6.3 RR discharge signature

When a patient is discharged from the recovery room, the discharge from the recovery room can be confirmed in the **DIANE** software.
It is possible to sign the discharge from recovery using the button at the top left of the application or using the **Prescription** tab (see *'Prescription tab'* chapter).

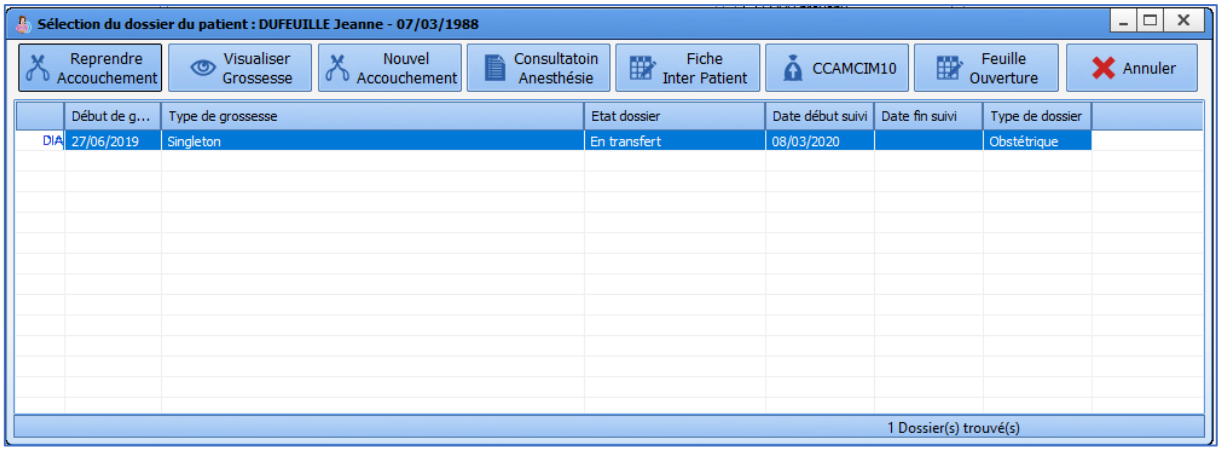
4. DIANE OBSTETRICS

DIANE OBSTETRICS lets you monitor obstetrics, gynaecology and family planning patients.
When a new record is opened, you will be asked whether you want to open a gynaecology, obstetrics or family planning record. The software configuration will change based on your choice to adapt the monitoring.

4.1 Selection of the record in obstetrics

To select the patient's record, see: *Patient selection*.

4.1.1 Selecting the type of record



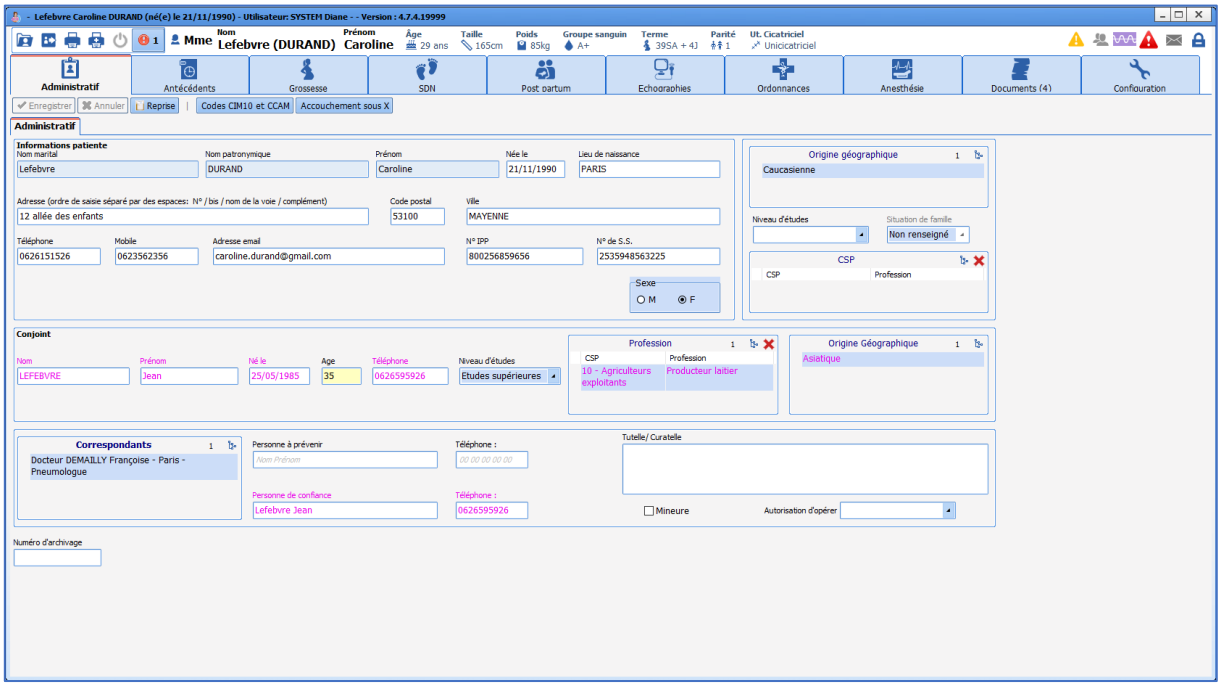
When the record has been selected, a new window opens offering different choices:
- **Resume delivery:** lets you continue monitoring a patient already registered in the unit.
- **New delivery:** lets you start monitoring a new pregnancy.

When a record is opened for the first time, a window will appear to enter the type of record. Three choices are available and will change the software configuration (obstetrics, gynaecology or family planning record). Some tabs will appear or disappear depending on the choice made.

NB: For obstetrics and family planning records, it is mandatory to enter the Pregnancy start date. This can be changed later.

4.2 General appearance of the application

The application is divided into tabs. Each tab corresponds to the different phases of pregnancy monitoring.



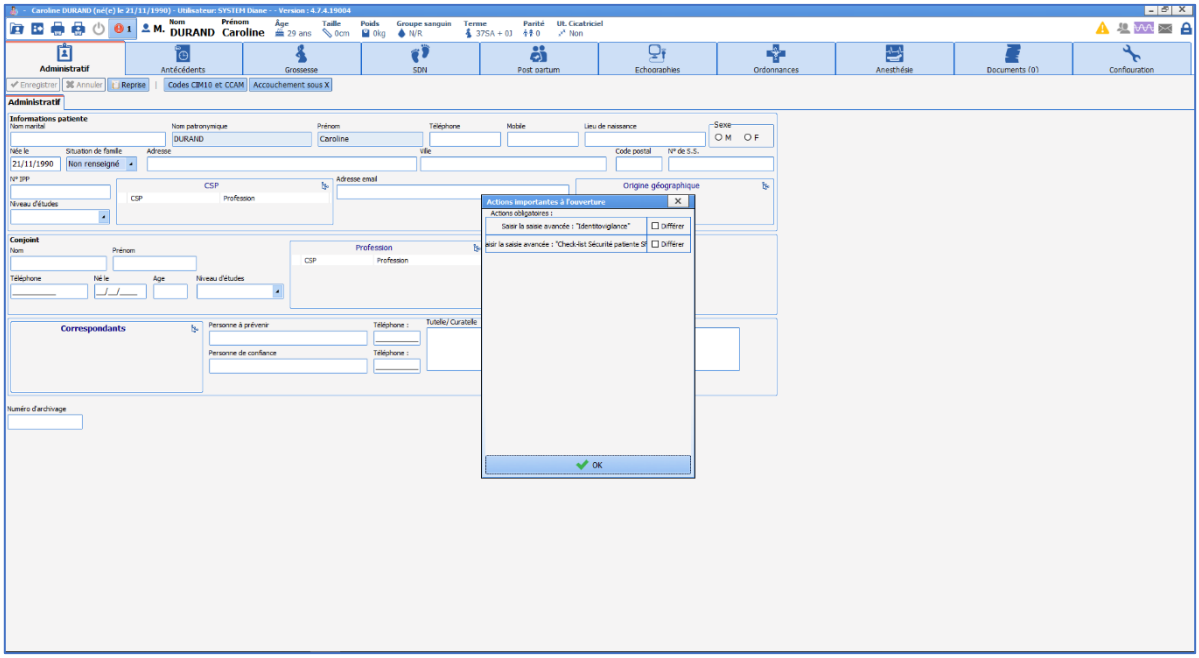
Above the tabs there is a ribbon containing information about the patient (marital status, age, weight, gestational age, uterine scars, parity, etc.).

On the right, there are buttons to open or exit the record.

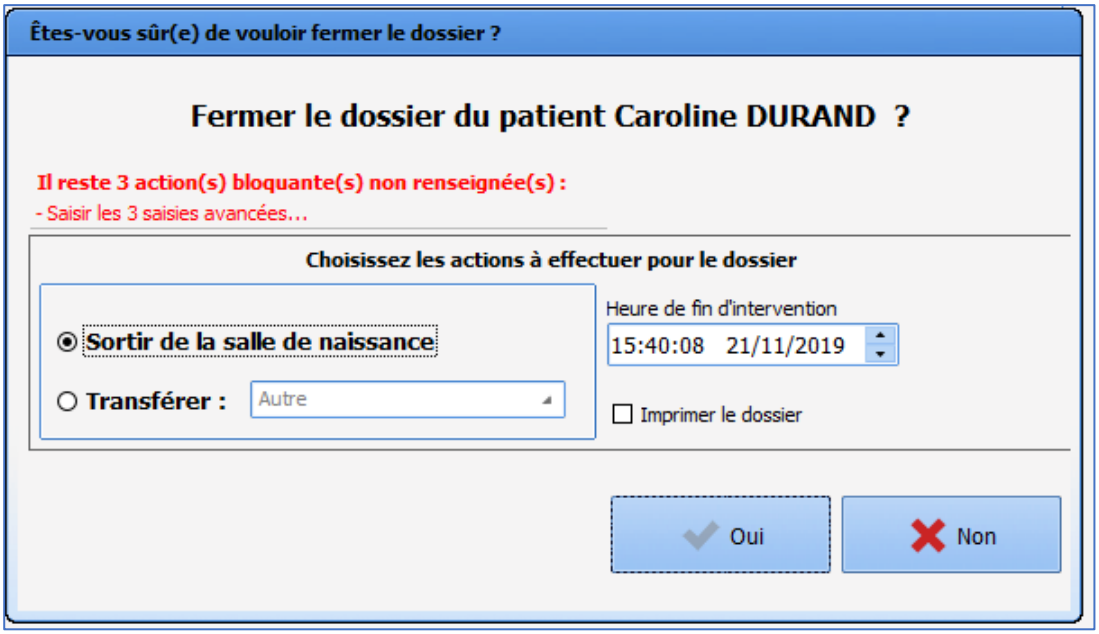
	Button to open record
	Button to exit record
1	Warning telling you that checklists (important actions) have not been done
	Warning telling you that serology tests have not been entered

4.3 Safety checklist

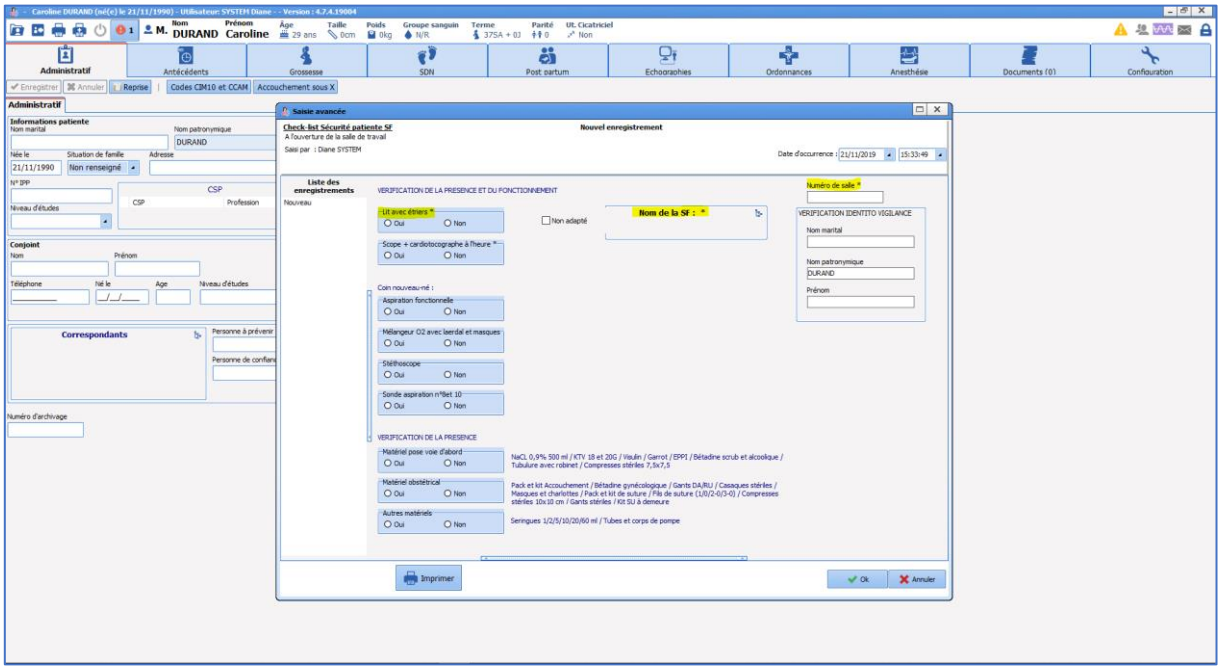
Checklists must be completed. They appear depending on where the computer is located. There are, for example, two checklists to be completed upon admission to the **Delivery Room**, but none for computers in consultations. Their completion can be postponed. However, this will prevent the record from being exited. They must always be completed.



The screenshot below shows that the checklists have not been completed. All you have to do is click on **Enter the 3 detailed entries** and enter the data. You can then exit the record.



Fields with an asterisk (screenshot below) are mandatory and prevent the checklist from being closed if they are not completed.



4.4 Administrative tab

Administrative information comes from the electronic health record (EHR) and is filled in automatically. You cannot change this information in **DIANE**.
If a record is created directly in **DIANE**, all of the data must be completed.

NB: the administrative data entered in **DIANE** is not sent to the EHR, so it is preferable in all cases to enter or change this information in the EHR to avoid inconsistencies.

This tab lets you enter information about the patient, spouse, correspondents (GP, private gynaecologist,

private midwife, etc.) and trusted person.

Specific features:

- The patient's gender is by default: 'F' but you can change it using the **Gender** checkbox at the top right of the **Patient information** pane.
- There is an automatic calculation that ticks the **Minor** box (at the bottom of the tab) according to the date of birth entered.

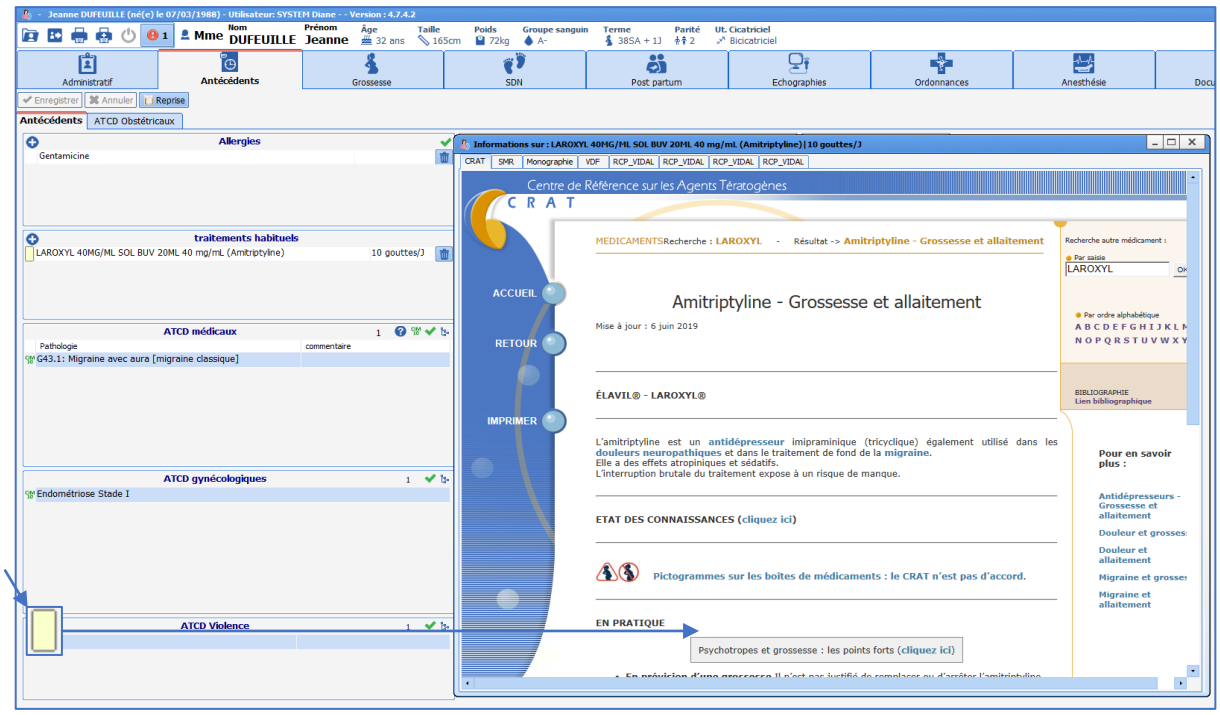
4.5 History tab

4.5.1 History subtab

The **History** subtab lets you enter the patient's medical history with the exception of the obstetric history. The tab is composed of input fields with a reference list. The **Allergies** and **Usual treatments** fields do not have an actual list. The list is called up directly when data is entered manually.

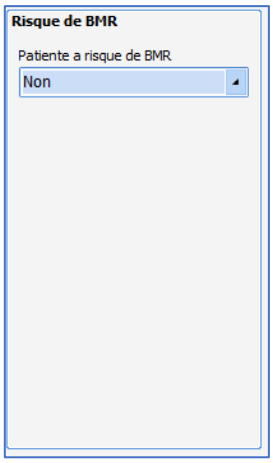
Usual treatments: access to the reference centre for teratogens

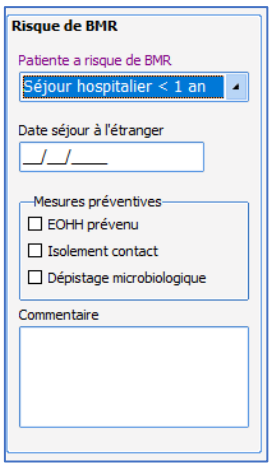
To the left of the treatment there is a yellow rectangle. If you click on it, you have **direct access to the reference centre for teratogens** page for the drug and monograph of the drug (either from BCB or Vidal).



The other fields in the **History** subtab have no particular function. They let you enter the medical, gynaecological, surgical, transfusion and family history of the patient and their spouse. These fields are filled in using the different methods described in the chapter entitled '*Ways to enter data in DIANE*'.

The **MDRO risk** pane is used to assess the measures to take in the event of a risk. The fields are invisible if the patient is not at risk for MDRO. The fields concerning preventive measures appear if you click on Yes on the drop-down menu to say that the patient is at risk for MDRO.



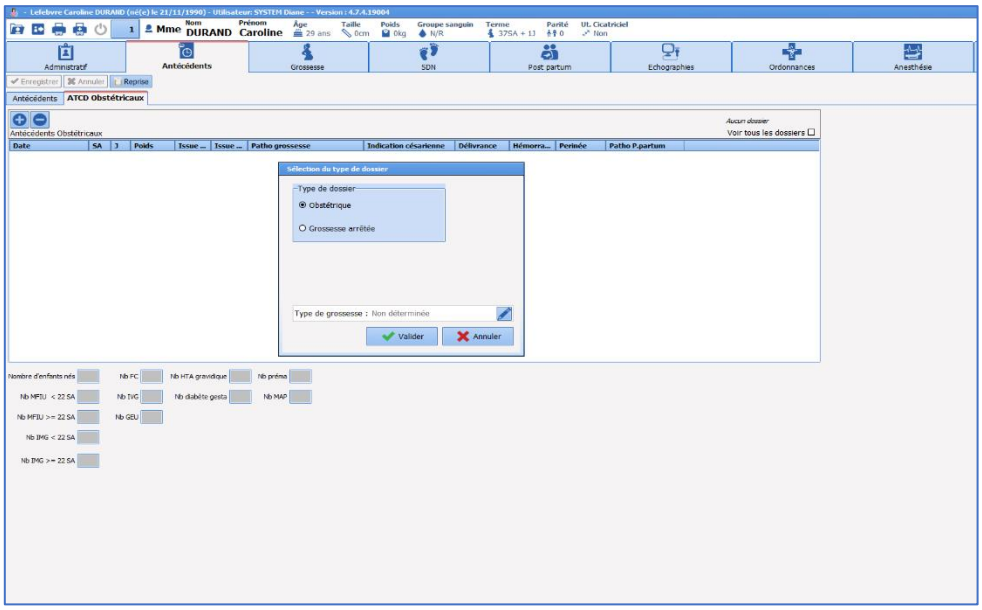


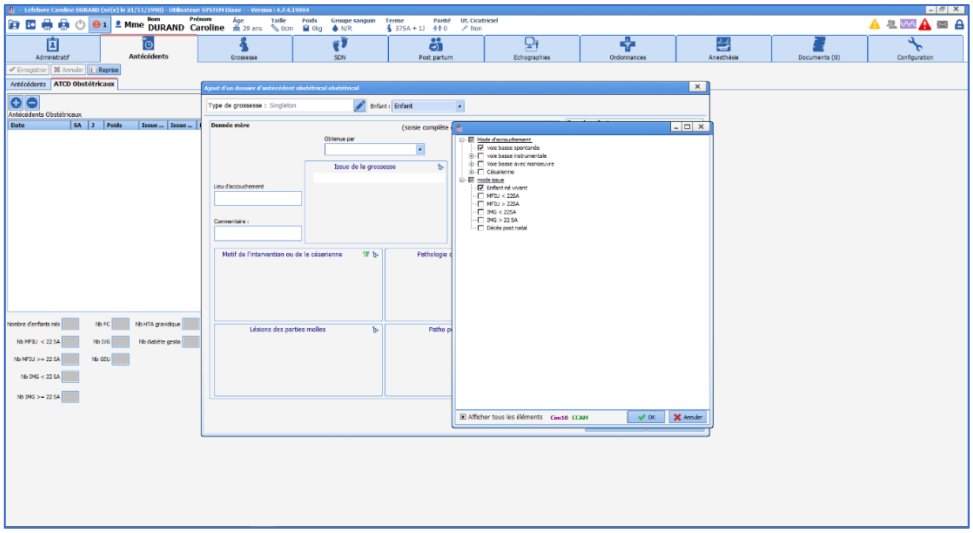
4.5.2 Obstetric history subtab

The **Obstetric history** subtab lets you enter previous pregnancies regardless of their outcome. This is where the **history** of deliveries, IUFD, therapeutic abortions, miscarriages and elective abortions will be recorded. The data is entered into a table. You can click on the sign at the top left to create a history item. To delete a **history** item, select the item in the table then click on the sign

NB: History items for pregnancies monitored in **DIANE** are created automatically and cannot be deleted from the software.

- **<u>Creating a pregnancy history item</u>:** when you click on the sign, a window appears to either create a pregnancy history item (including liveborn children, IUFD and therapeutic abortions), or to create a history item for a pregnancy stopped (including early miscarriages, late miscarriages, elective abortions and molar pregnancies).
  If you click on **Obstetrics** in the **Record type selection** window, a component appears for you to choose the type of pregnancy (singleton, twins, etc.). You can also choose inside the history creation window that appears when you have confirmed the type of history item you want to create.



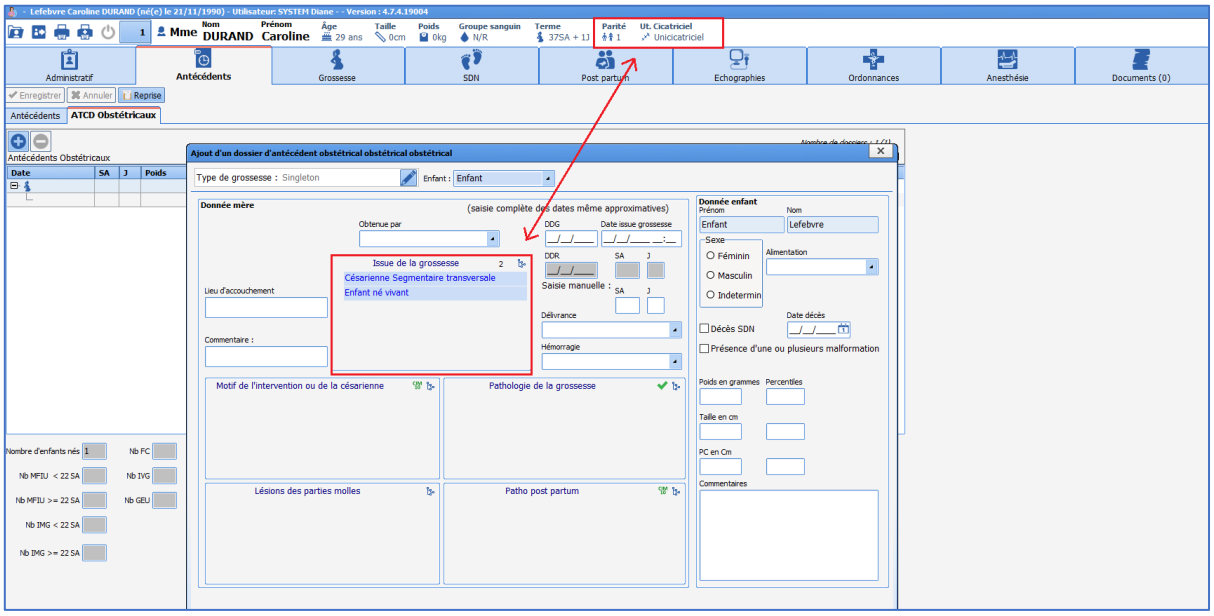


How the specific fields of the window for creating an obstetric history item work:

- **Pregnancy outcome** field: this field is the same as the one in the pregnancy summary.

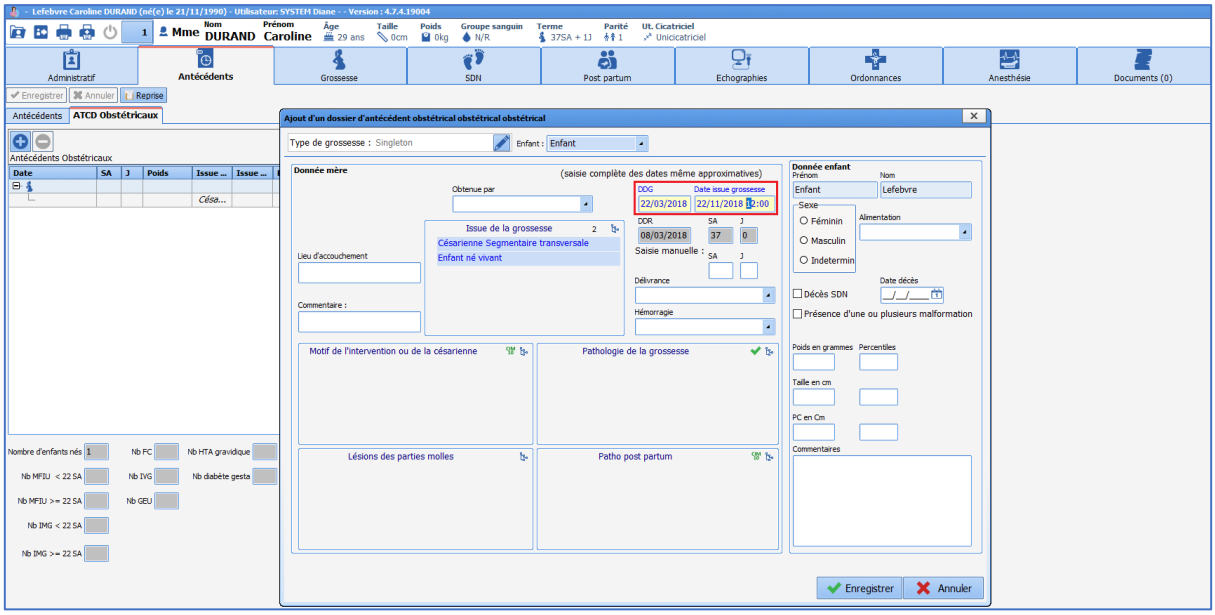
The list includes two subsections: one **Delivery method** section and one **Outcome** section:

It is VITAL to complete the 2 pieces of information (this list is used to calculate the data to enter the parity and number of uterine scars in the top ribbon). **<u>The delivery method AND the outcome</u>** must therefore always be entered. In the event of a multiple pregnancy, the information must be entered for each child.

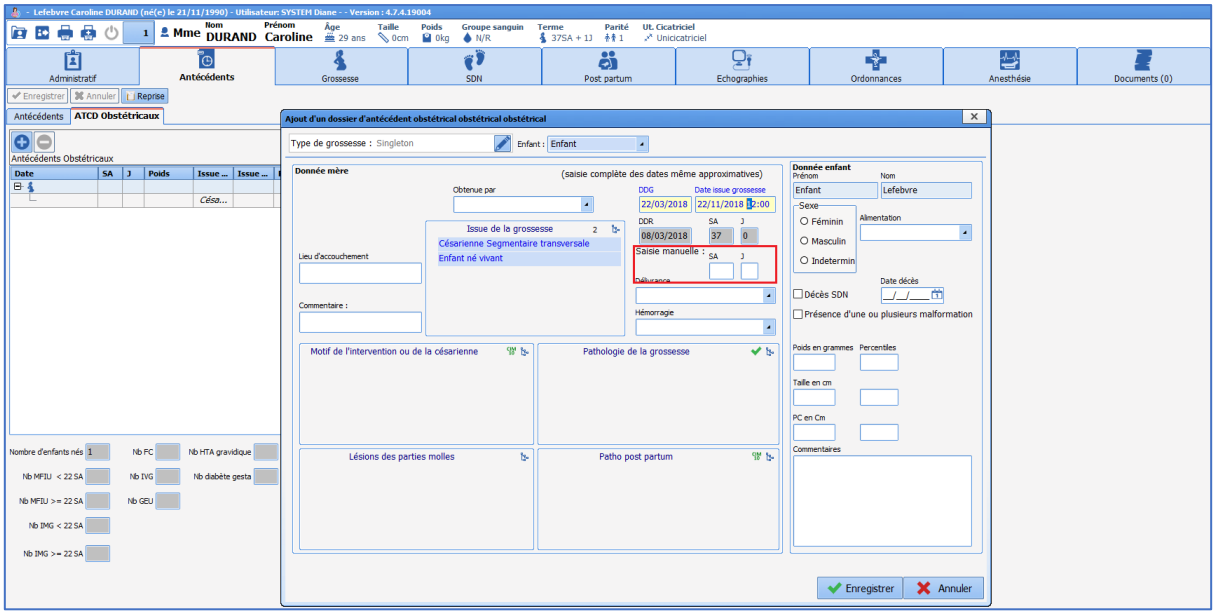


- Entering the gestational age: two options are possible
  - If the pregnancy start date and delivery date are known, simply enter them and the gestational age is calculated automatically.

NB: the delivery date and time must be entered even if they are only approximate.



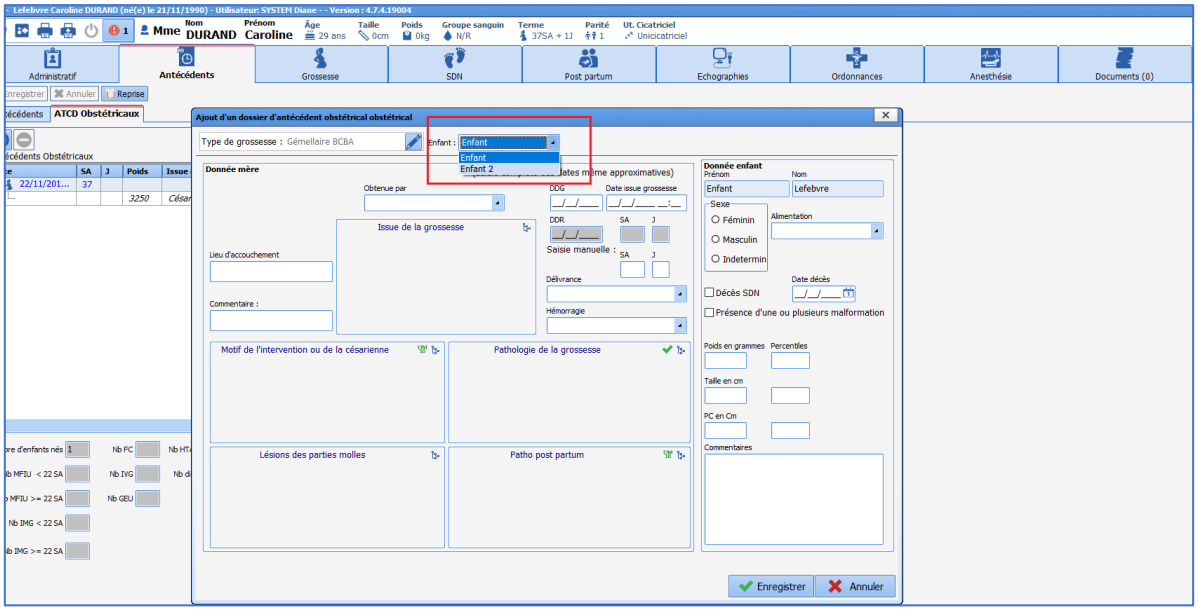
- You can also manually enter the gestational age directly in the manual input fields **WA** and **D**



- Measurements: the percentiles are calculated automatically. The measurements and the gestational age must be entered beforehand to enable this calculation.

- The **Reason for procedure or C-section** field concerns C-sections and also instrumental deliveries or obstetric manoeuvres.

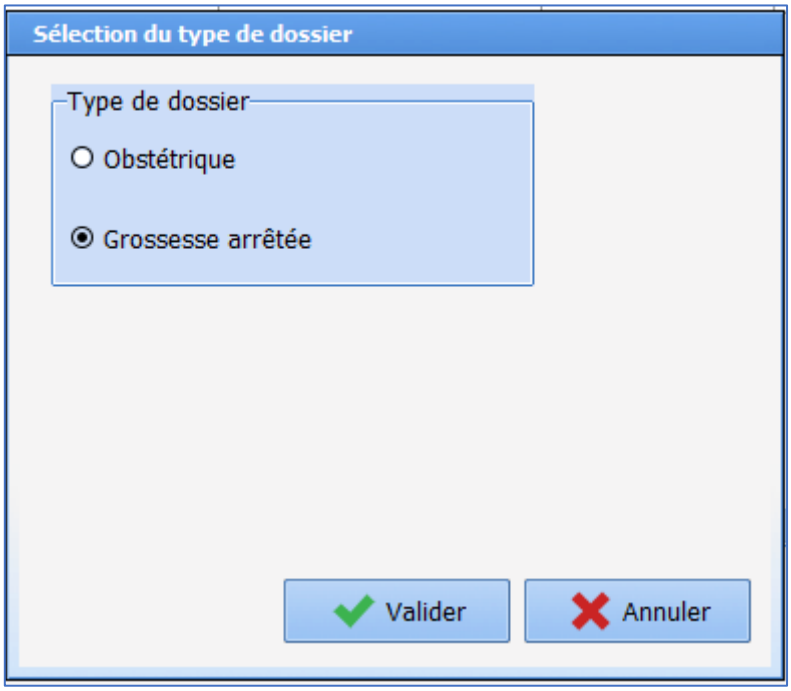
- In the event of a multiple pregnancy, simply select the child to whom the data belongs from the drop-down menu at the top of the window. The mother's data remains displayed. Only the data specific to each child can be re-entered.

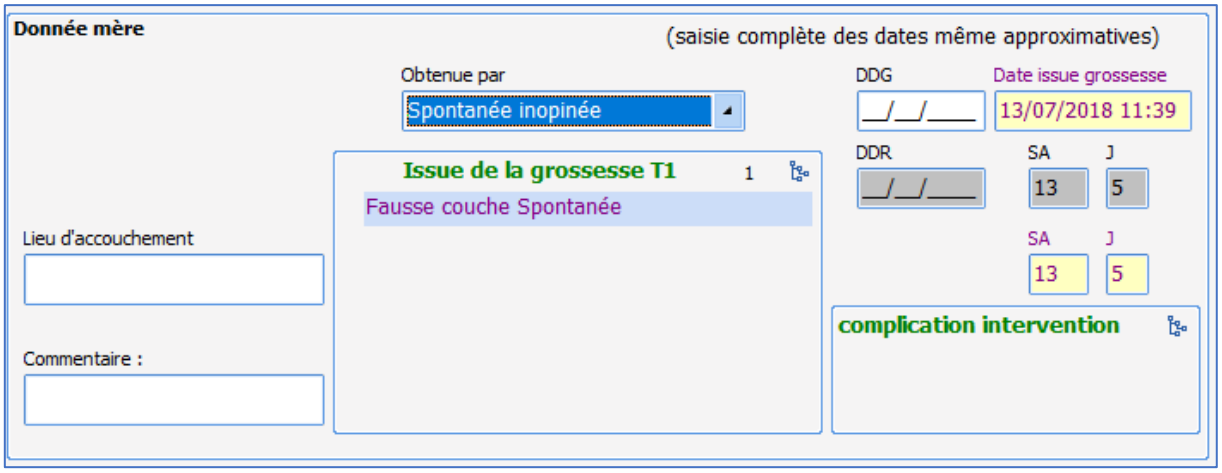


NB: remember to **fill in the <u>Pregnancy outcome</u> field for both children** because the delivery method and the outcome can be different for each child in multiple pregnancies. The data must be re-entered even if it is identical for both children. (In practice, if both children are liveborn by vaginal delivery you must enter this for each child).

- **<u>Creation of a 'Pregnancy stopped' history item: elective abortion, early miscarriage, late miscarriage, molar pregnancy</u>**

This works in the same way as for Obstetric history. You can choose **Pregnancy stopped** after clicking on the sign at the top left of the history summary table. This opens a specific window to enter a past pregnancy that stopped. This window has no particular function. In the same way as in obstetrics, a family planning history item entered in **DIANE** during a previous stay will be automatically included in this table.





The history items will be entered into the summary table as they are entered into the software and you can simply click on a history item to view or change it.

4.5.2.1 Calculated fields

Under the history summary table you can see several fields. These are automated calculations and cannot be changed manually:

Total children born: Counts the number of liveborn children (DiaListMemo **Pregnancy outcome**)

Total IUFDs < 22 WA: Counts the number of IUFDs < 22 WA (DiaListMemo **Pregnancy outcome**)

Total IUFDs > 22 WA: Counts the number of IUFDs > 22 WA (DiaListMemo **Pregnancy outcome**)

Total TABs < 22 WA: Counts the number of TABs < 22 WA (DiaListMemo **Pregnancy outcome**)

Total TABs > 22 WA: Counts the number of TABs > 22 WA (DiaListMemo **Pregnancy outcome**)

Total miscarriages: Counts the total number of miscarriages = early miscarriages + late miscarriages (DiaListMemo **Pregnancy outcome T1**)

Total EAB: Counts the number of elective abortions (DiaListMemo **Pregnancy outcome T1**)

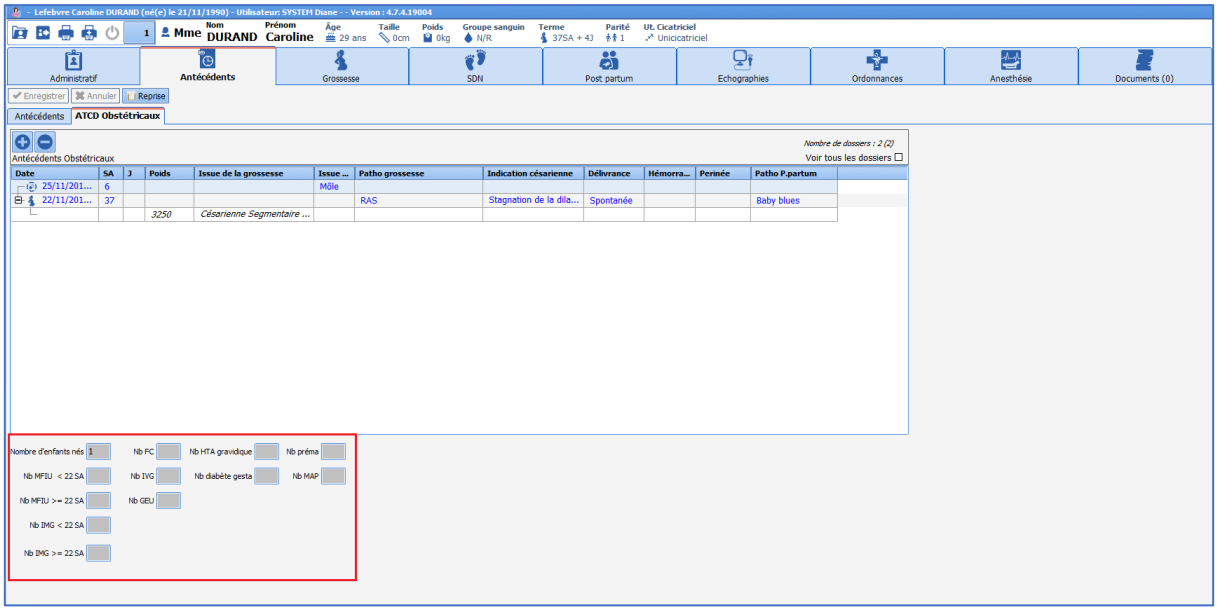
Total EP: Counts the number of ectopic pregnancies (DiaListMemo **Pregnancy outcome T1**)

Total PIH: Counts the number of pregnancies involving pregnancy-induced hypertension + preeclampsia (DiaListMemo **Pregnancy-related condition**)

Total gestational diabetes: Counts the number of pregnancies involving gestational diabetes. Any diabetes prior to the pregnancy is excluded from this calculation (DiaListMemo **Pregnancy-related condition**)

Total premature births: This calculation is automated if the following information is entered: Liveborn child (DiaListMemo **Pregnancy outcome**) and gestational age < 37 WA (WA + D entered in the history window)

Total RPB: Counts the number of risks of premature birth (DiaListMemo **Pregnancy-related condition**)



4.6 Pregnancy tab

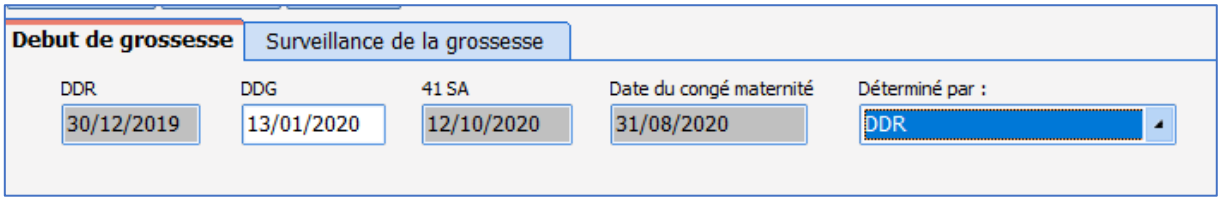
4.6.1 Pregnancy start subtab

4.6.1.1 General information

This subtab is used to enter information about the start of pregnancy usually collected when the patient has her first consultation. It is used to show the gestational age, type of pregnancy, blood type, serology tests, first trimester ultrasound data and potential information concerning the prenatal diagnosis, psycho-social context and addictions.

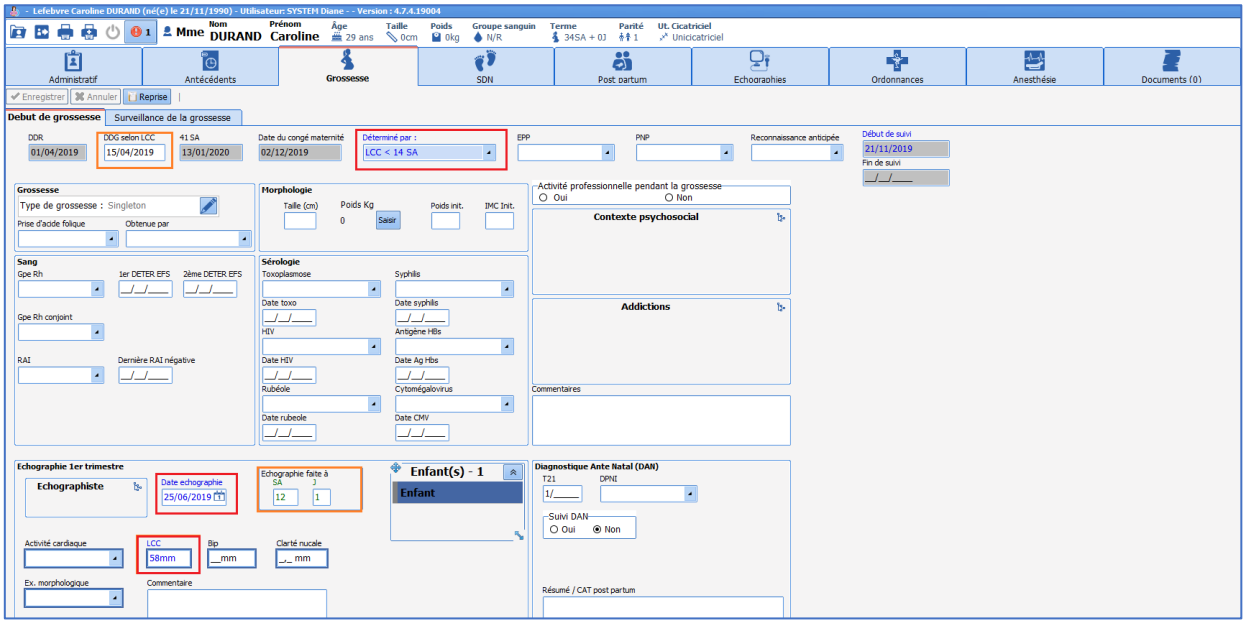
4.6.1.2 Calculation of the gestational age

When opening an obstetrics or family planning record, it is mandatory to enter the pregnancy start date. This will be automatically displayed at the top left of the screen. The LMP, 41 WA and date of maternity leave are calculated automatically based on the PSD. You can change the PSD by simply entering a new one. The **Determined by** drop-down menu is used to enter the PSD calculation method. In this menu, when the selected items are: **Ultrasound < 20 WA**, **LMP**, **Uncertain** or **Date of IVF**, the PSD must be entered manually.



Dating based on T1 ultrasound: in the **Determined by** drop-down menu, if **CRL < 14 WA** is selected, then the gestational age is calculated automatically based on the ultrasound data entered in the **1st trimester ultrasound** pane.

Simply enter the ultrasound date and CRL, and select that the **Gestational age** is determined by **CRL < 14 WA**. The gestational age will then be calculated automatically according to the ultrasound **CRL** measurement.



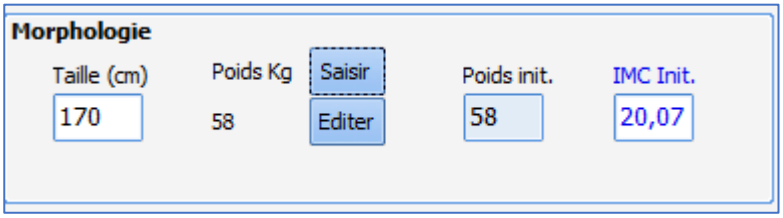
In red: data to enter In orange: automated calculations

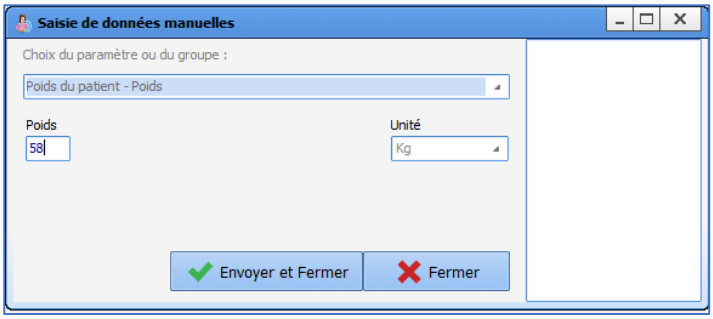
4.6.1.3 Blood

The **Blood** pane is used to enter the blood type of the patient and her spouse, and IAS. If a patient is Rhesus negative, fields regarding foetal genotyping and potential *Rhophylac* injection will appear.

4.6.1.4 Morphology

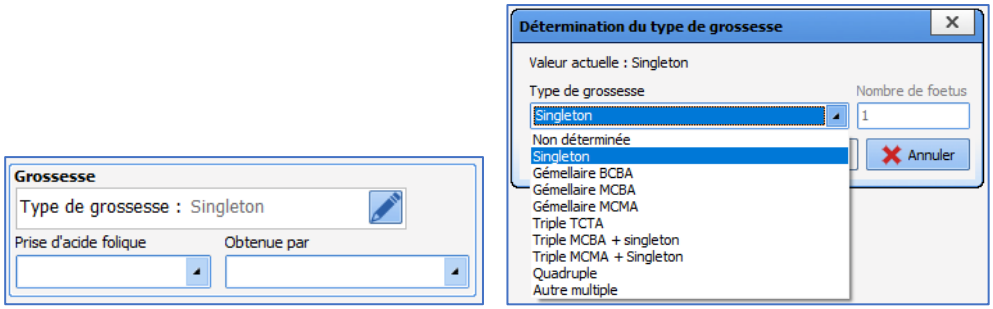
This pane is used to record the patient's weight and height at the start of pregnancy. To enter the weight, click on the blue **Enter** button. A window opens for you to enter the patient's initial weight, which will be displayed in the adjoining field. The body mass index is calculated automatically in the field to the right. Click on **Edit** to change the data.



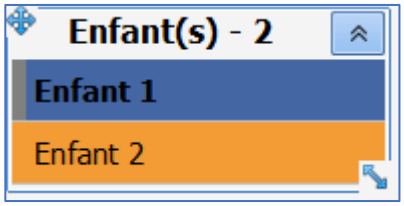


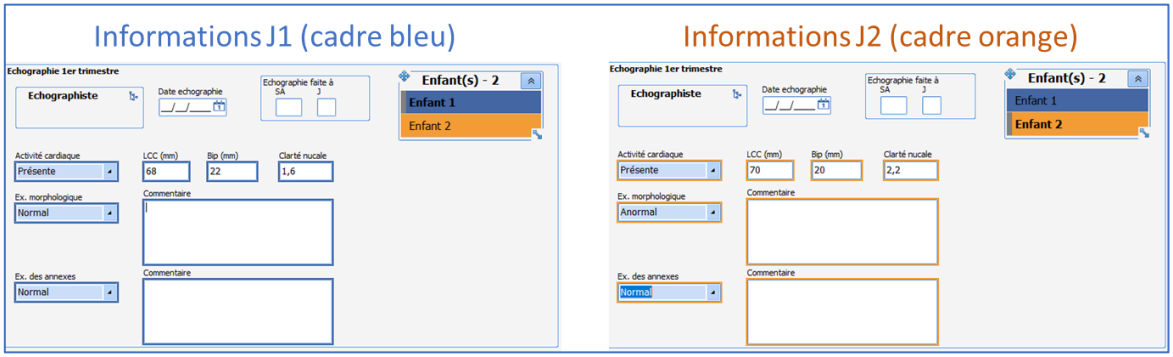
4.6.1.5 Pregnancy type

In the **Pregnancy** pane at the top left of the subtab, a specific component lets you select the type of pregnancy by clicking on the pencil sign. A window is then displayed for you to say whether it is a singleton, twin, triple pregnancy, etc.



In the event of a multiple pregnancy, a specific window throughout the record lets you choose which child the information entered is for by clicking on **Child 1** or **Child 2**.



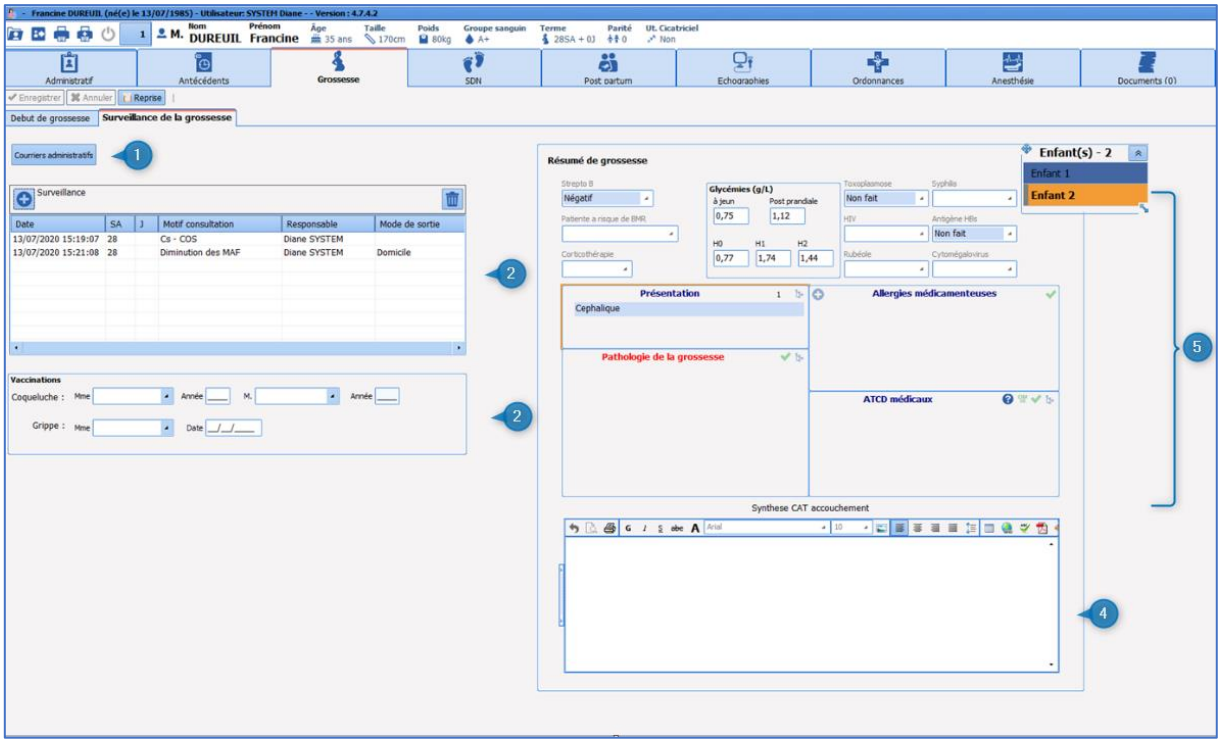


Data outlined in blue is for the first child. If you click on **Child 2**, you will notice that the relevant fields are empty and are outlined in orange, indicating that this is data for the second child and must therefore be entered.

The other fields in this window have no particular function.

4.6.2 Pregnancy monitoring subtab

This subtab will let you monitor the patient throughout pregnancy and has several parts:



1 **Administrative letters:** button calling up different printable letters:
- Pregnancy and Rhesus group: information letter for Rh negative patients.
- Pregnancy calendar: information letter to help plan pregnancy monitoring (consultations and ultrasounds).

NB: You can associate any type of letter with this button.

2 **Monitoring:** to call up the different types of consultation.

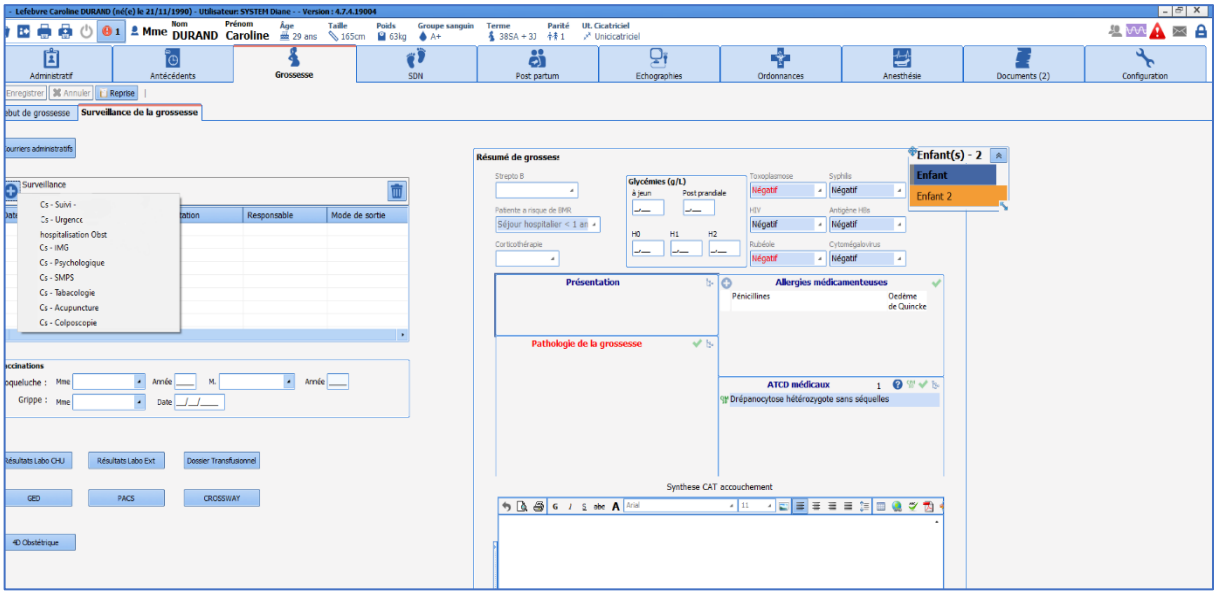
3 **Vaccination:** pane to provide information on pertussis and influenza vaccinations during pregnancy.

4 **Delivery WTD summary:** lets you enter important things to do or specific pregnancy-related events.

5 **Pregnancy summary:** this pane gives an overview of all the significant events during the pregnancy. This information is read-only and gives a rapid display of serology results, presentation or strep B presence.

4.6.2.1 Consultation tracking table

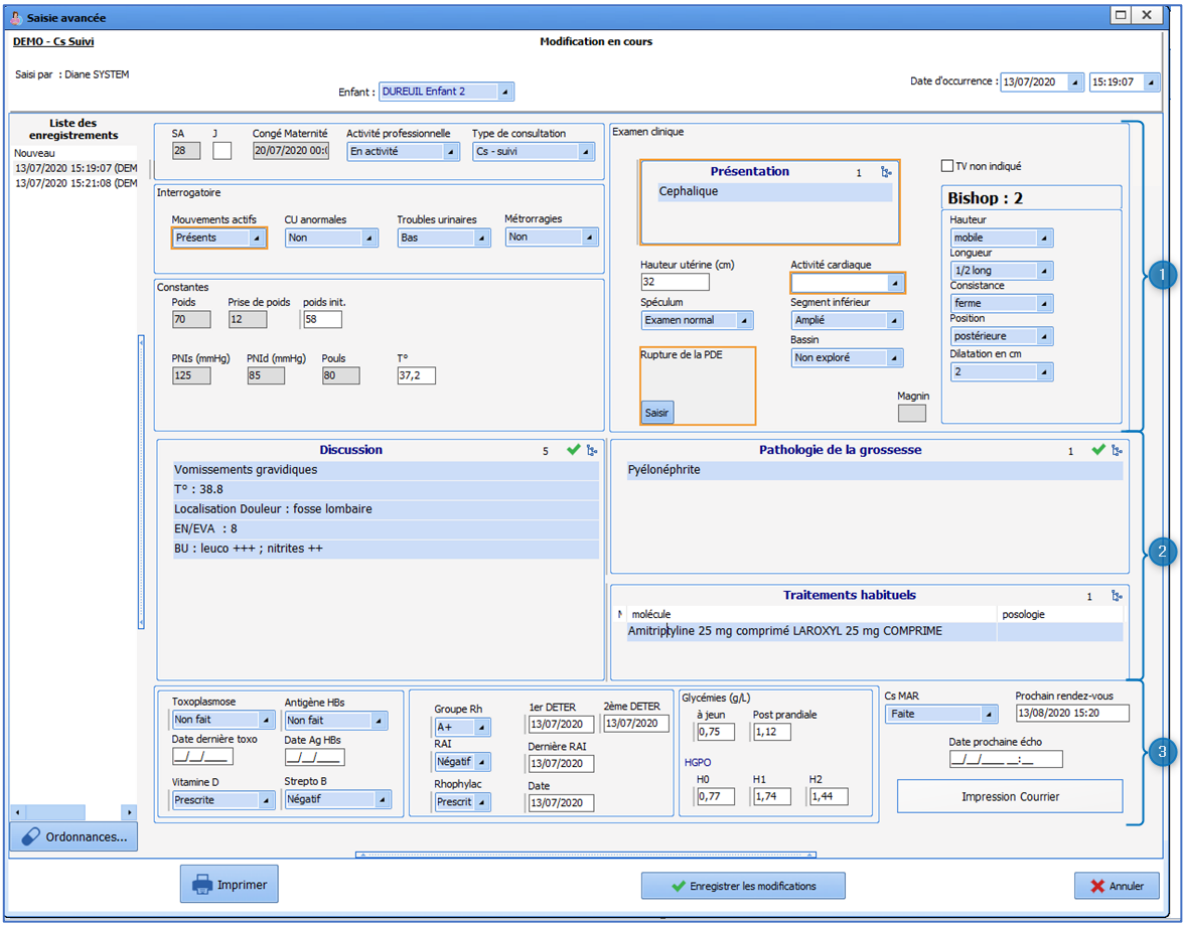
Several types of consultations are available. You can click on the sign at the top left of the table to call up the different templates.



Calling up one of these consultations opens a new **detailed entry** sheet (the way these sheets work is explained in the '*Detailed entries*' chapter).

4.6.2.2 The consultation

The consultation is divided into 3 parts:



1 Top part: this part contains general information, data from the patient interview and from the clinical examination.

Special features:

- (Systolic and diastolic) blood pressure must be entered in mmHg
- If the digital vaginal examination is not performed during the consultation, you must tick the **DVE not indicated** checkbox. This will hide the Bishop score.
- Rupture of membranes: if the membranes have ruptured, click on the

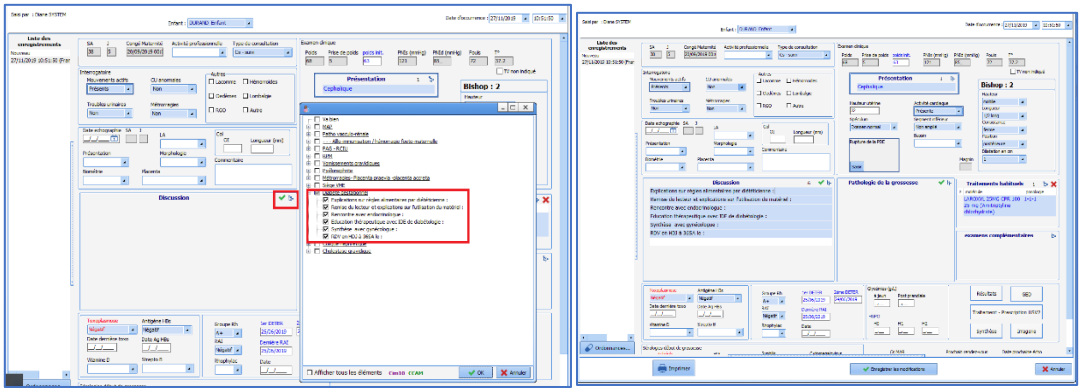
button located at the bottom of the **Rupture of membranes** box. Then select **artificial rupture** or **spontaneous rupture**. A window opens to enter the exact date and time of rupture.

NB: Entering the rupture of the membranes starts a **Time amniotic sac open** timer which will be stopped when the birth is entered.

2 Central part: lets you specify details of the clinical examination and diagnosis

- **Discussion** field: this field is used to enter specific clinical examinations. The associated list is of information gathered from the patient interview and from the clinical examination and is adapted to different conditions.

For example: if you click on **Gestational diabetes**, the list of subitems will be automatically ticked. Then by clicking on **OK** at the bottom of the list, the different items will be displayed in the relevant box.



You can then add to the data by typing in the box.

- **Pregnancy-related condition** field: this field is used to enter the diagnosis reached during the consultation.
- **Usual treatments** field: this field is the same as for the history items. It directly displays the patient's current treatments.

3 Bottom part: this part shows serology results, blood sugar levels and the blood type information. These data can be completed on this data entry sheet and will be automatically sent to the **Pregnancy summary** section and the **Pregnancy start** subtab.

4.6.2.3 Generating the consultation letter:

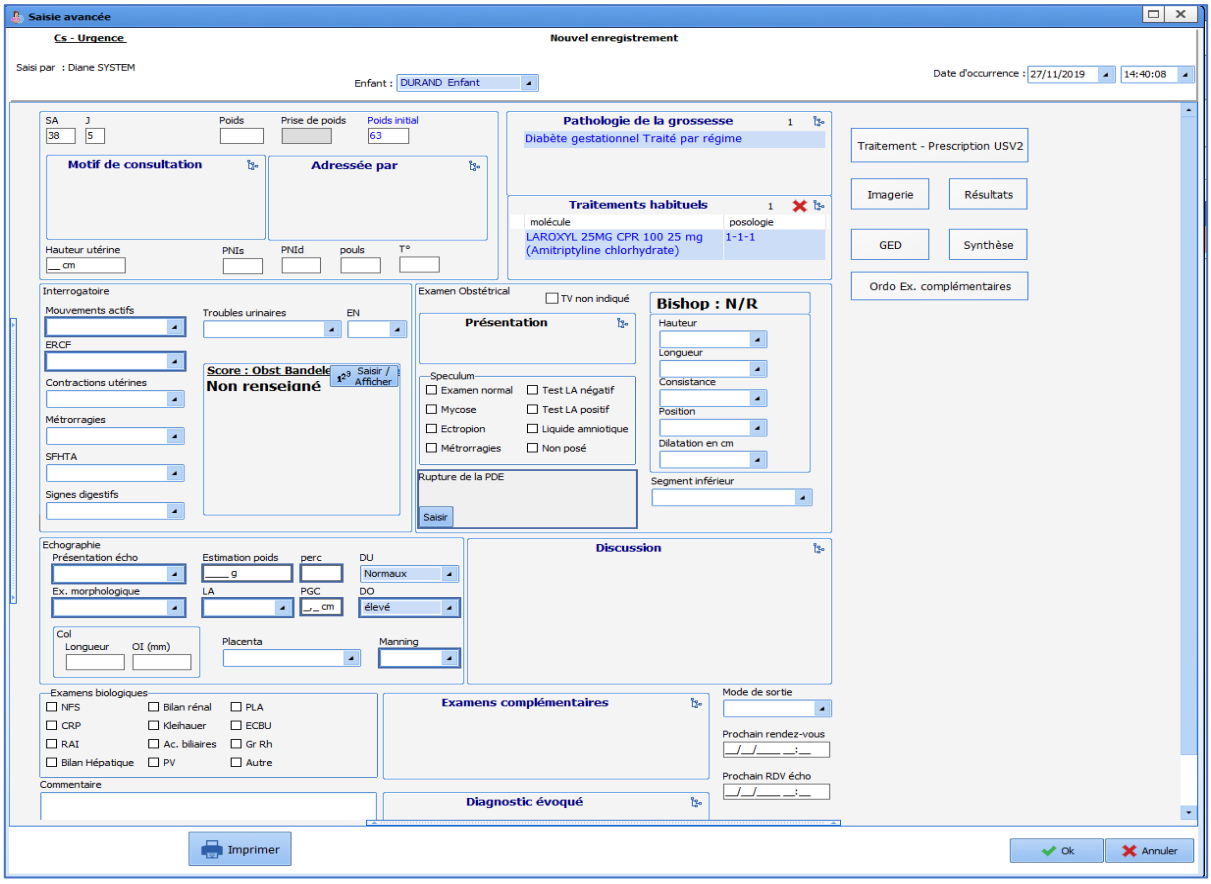
The consultation letter can be accessed from the Impression Courrier button at the bottom of the consultation sheet.
Clicking on the button calls up the template, which you can then print. This is designed to duplicate information in the event of multiple pregnancies. It also mentions treatments and additional examinations prescribed during the consultation.

NB: The data in the consultation letter comes directly from the data entered in the consultation sheet. This is automated, but in no way means that users should not check the information in the letter.

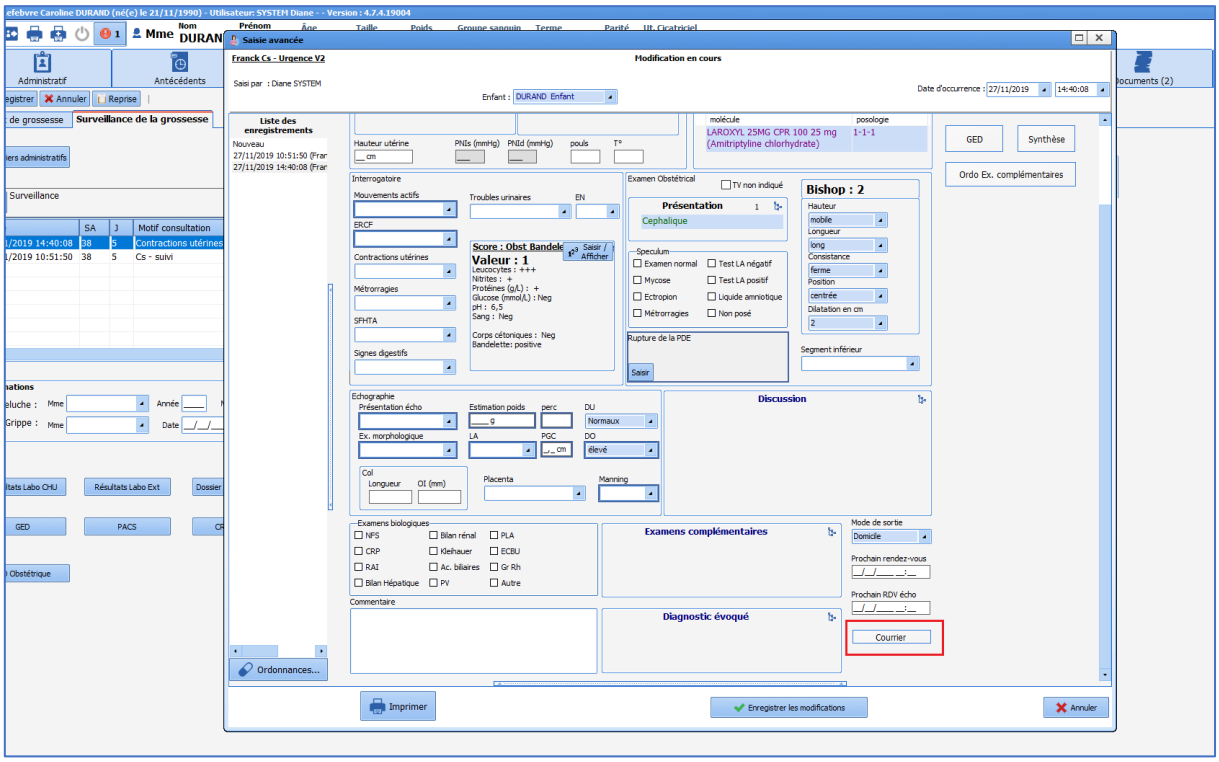
NB: to generate the consultation letter you must close the detailed entries. To simply things, the letter should therefore be printed last. However, it is possible to reopen and change the consultation afterwards.

4.6.2.4 Emergency consultation:

The emergency consultation lets you enter data adapted to the context of the obstetric emergency, including the possibility of entering a reason for consultation and a diagnosis called 'suspected diagnosis' because of the potential uncertainty in this emergency context. You can also enter the blood tests and dipstick results (in the form of a score).



As for the follow-up consultation, you can print a consultation letter by clicking on the button at the bottom.



The other types of consultation do not have any particular function.

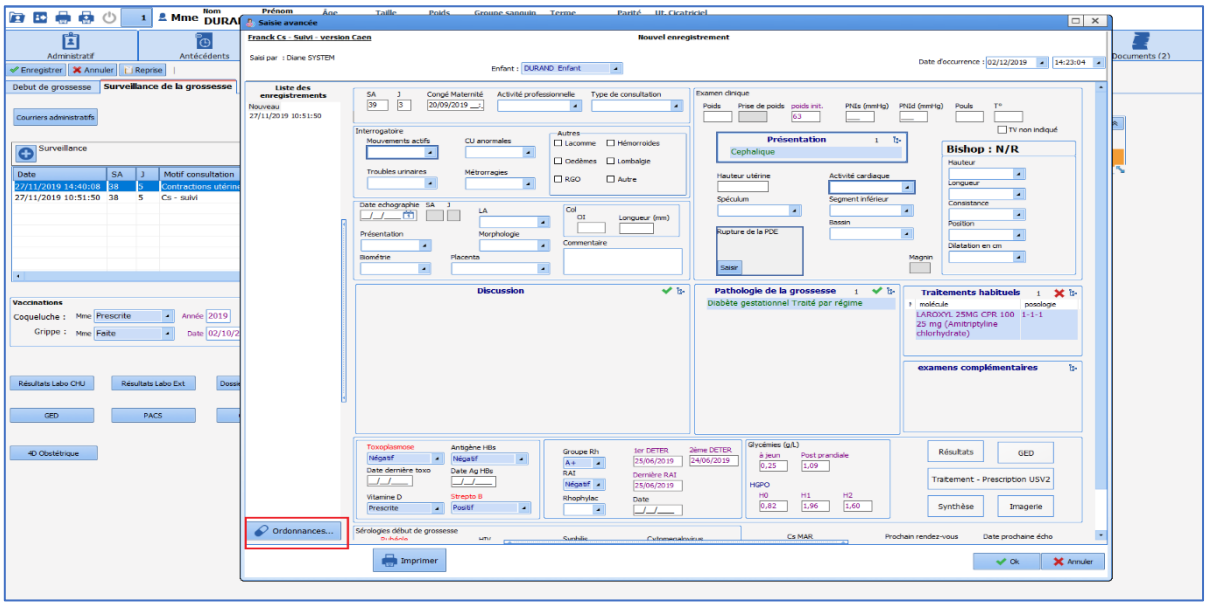
At each consultation, the information is sent both to the pregnancy summary and the consultation summary

table. This simplifies monitoring and access to the various consultations during pregnancy.

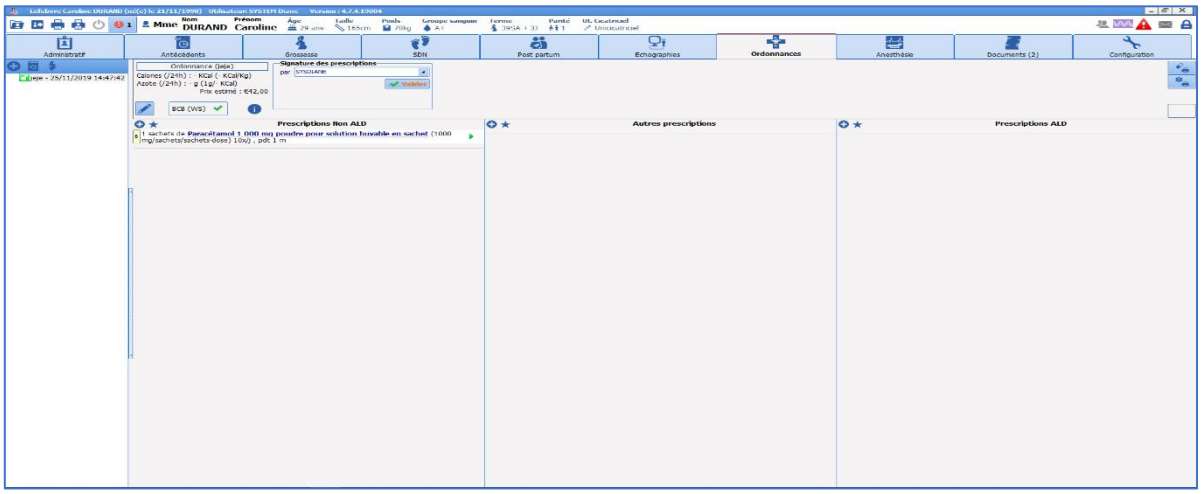
4.7 Prescription form management

There are 2 ways to generate a prescription form:

- By using the **Prescription form…** button found in each consultation (at the bottom left).

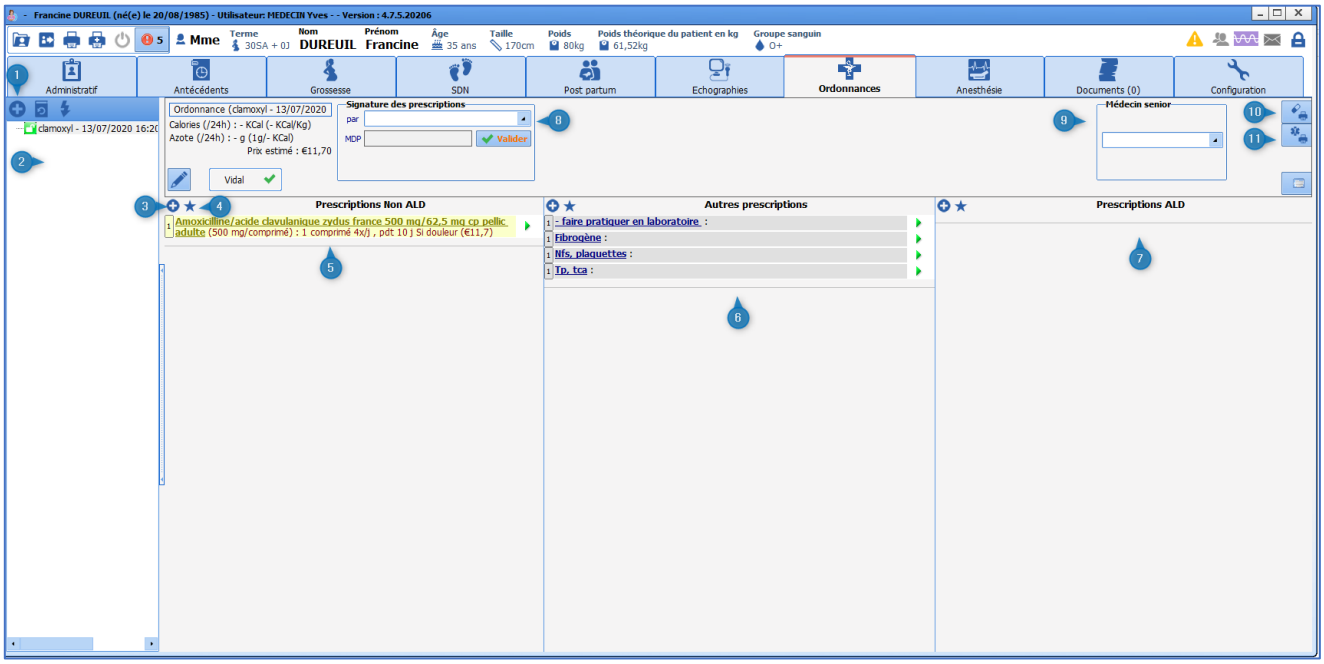


- Directly in the **Prescription forms** tab:



When accessing the prescription module via a detailed entry, you can enter prescriptions directly. From the **Prescription forms** tab, you must first create a new prescription form by clicking on the at the top right of the prescription window. A window then opens asking to name the new prescription form.

Below you can see the main features of the prescription module.

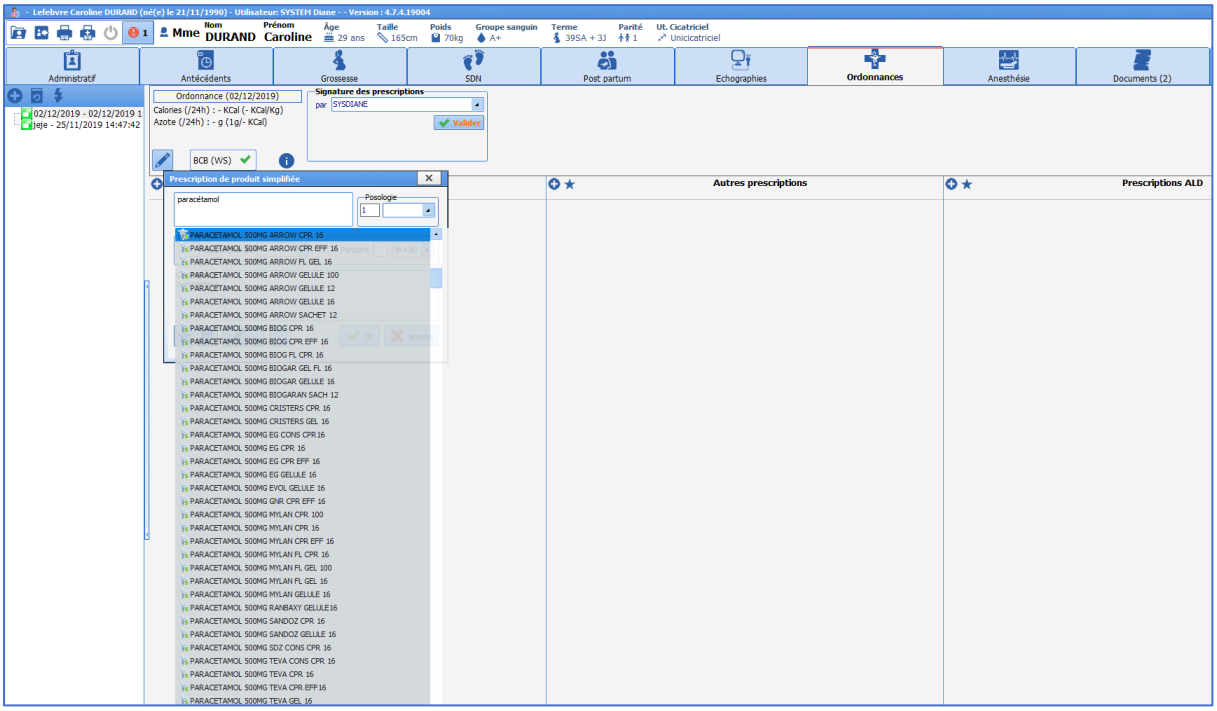


1 New prescription form: used to create a new prescription form
2 History pane: lets you see all the prescription forms issued during the pregnancy
3 New treatment: button to open the prescription window
4 Favourites: button to call up prescription favourites
5 Pane for non-LTC treatment prescriptions
6 Prescription pane for further tests and care
7 Pane for LTC treatment prescriptions
8 Signature for prescriptions
9 Senior doctor: lets you name the doctor in charge (if prescription issued by a foundation doctor)
10 Button to print the treatment prescription form
11 Button to print the prescription for further tests and care

4.7.1 Drug prescriptions

Click on the button at the top left of the **Non-LTC prescription** column. A prescription window appears.

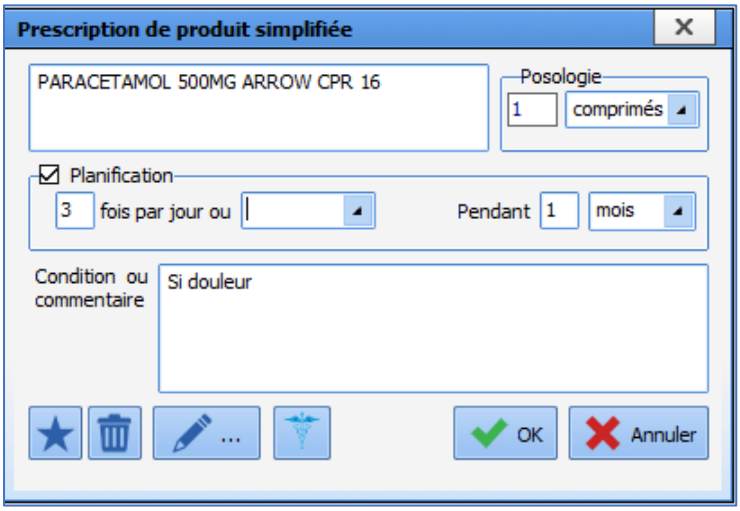
- Type the name of the drug (INN or brand name) in the top box. A list appears that is linked to the drug database.
- Choose the treatment you want.



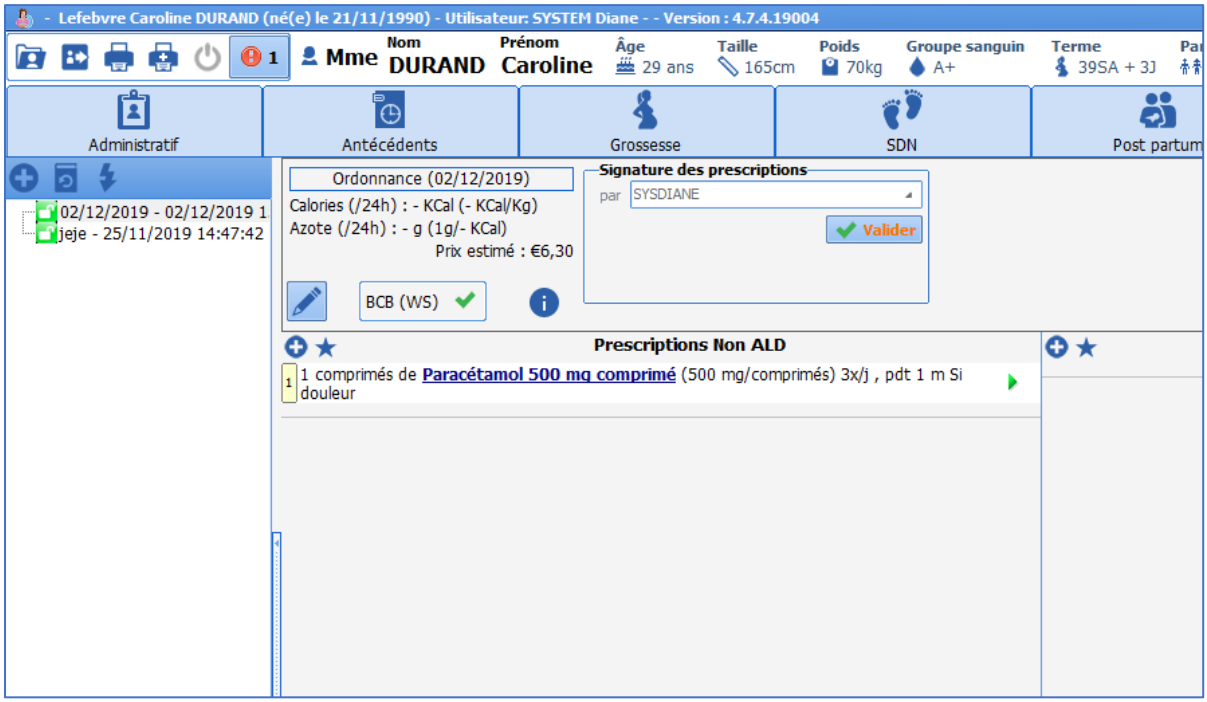
- In the **Dosage** box, choose the appropriate dosage.

  NB: By default, a dosage is proposed with the pharmaceutical form according to the choice in the drug database. If the treatment is entered without using the drug database suggestions, the dosage and pharmaceutical form cannot be prescribed properly.
  In other words, the treatment MUST be chosen from those suggested by the drug database.

- The **Schedule** box lets you choose the frequency and duration of treatment.
- The **Condition** box is used to add comments about the treatment (specify administration conditions, a specific indication, etc. (e.g. if pain).



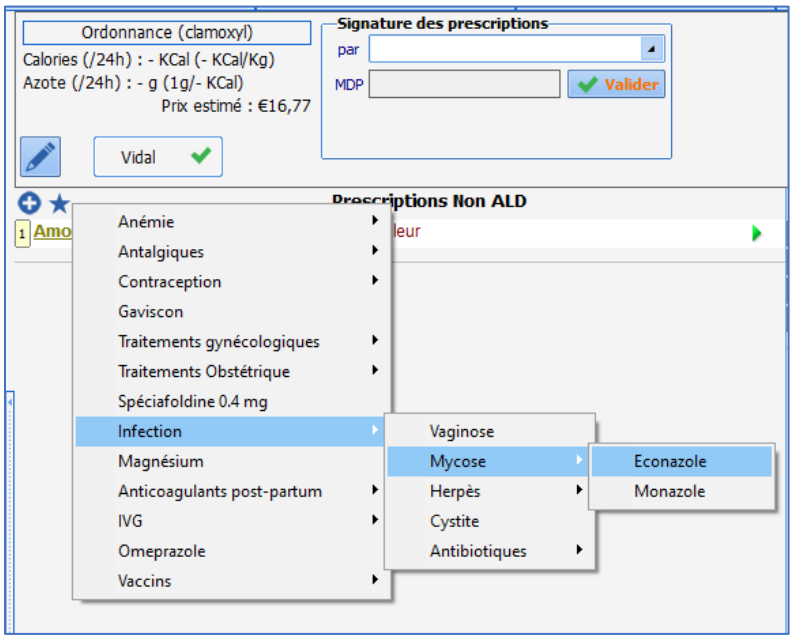
- Click on **OK.** A prescription line will appear in the corresponding column.



- Click on the button to add another drug.

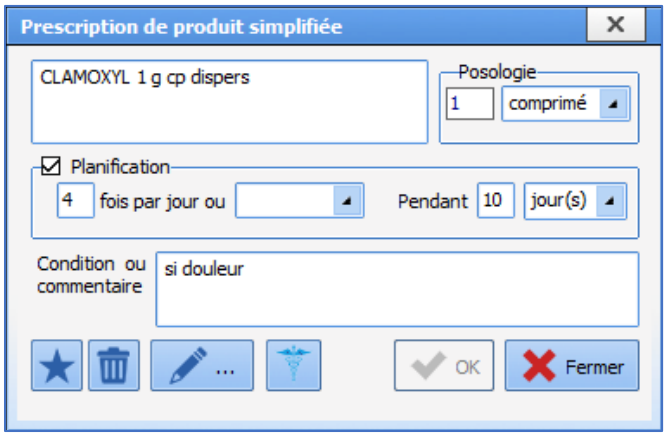
Favourites: certain treatments and further tests frequently used in Obstetrics have been preconfigured and are available in the favourites.
To access them:

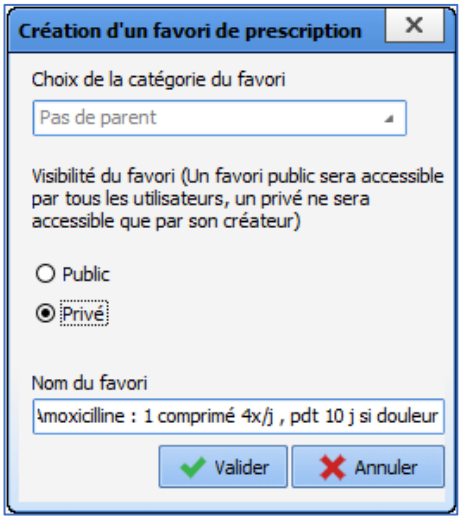
- Click on the ★ button at the top left of the relevant column.
- A list appears: select the appropriate treatment.



- Click on the treatment you want. The prescription line appears automatically with the prescheduled dosages, frequency and duration of administration.

*You can create your own favourites by clicking on the ★ button at the bottom of the prescription window. If you choose **Private** the favourite will only be available to its creator. The favourite will then be available by clicking on ★ .*

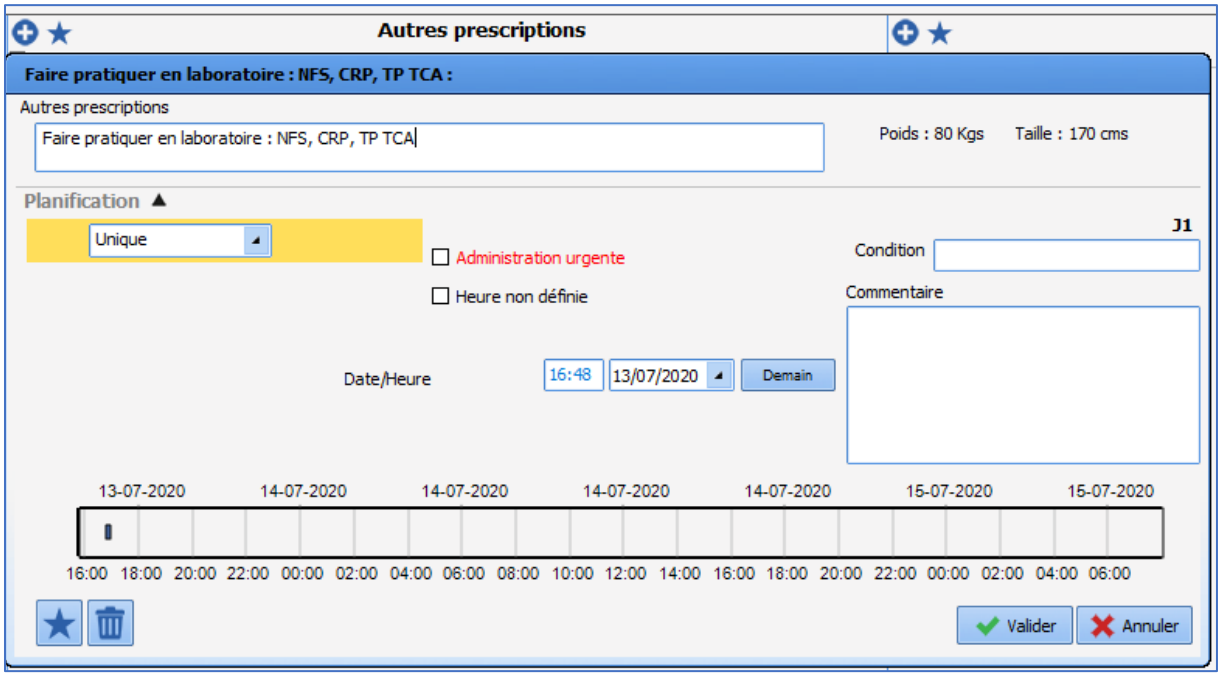




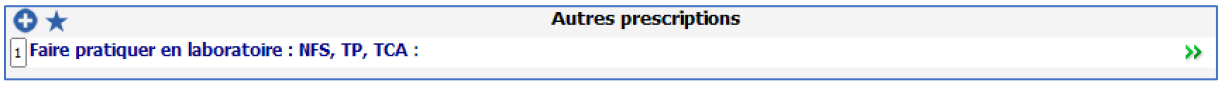
4.7.2 Prescriptions for further tests and care:

These prescriptions are issued by using the **Other prescriptions** column.

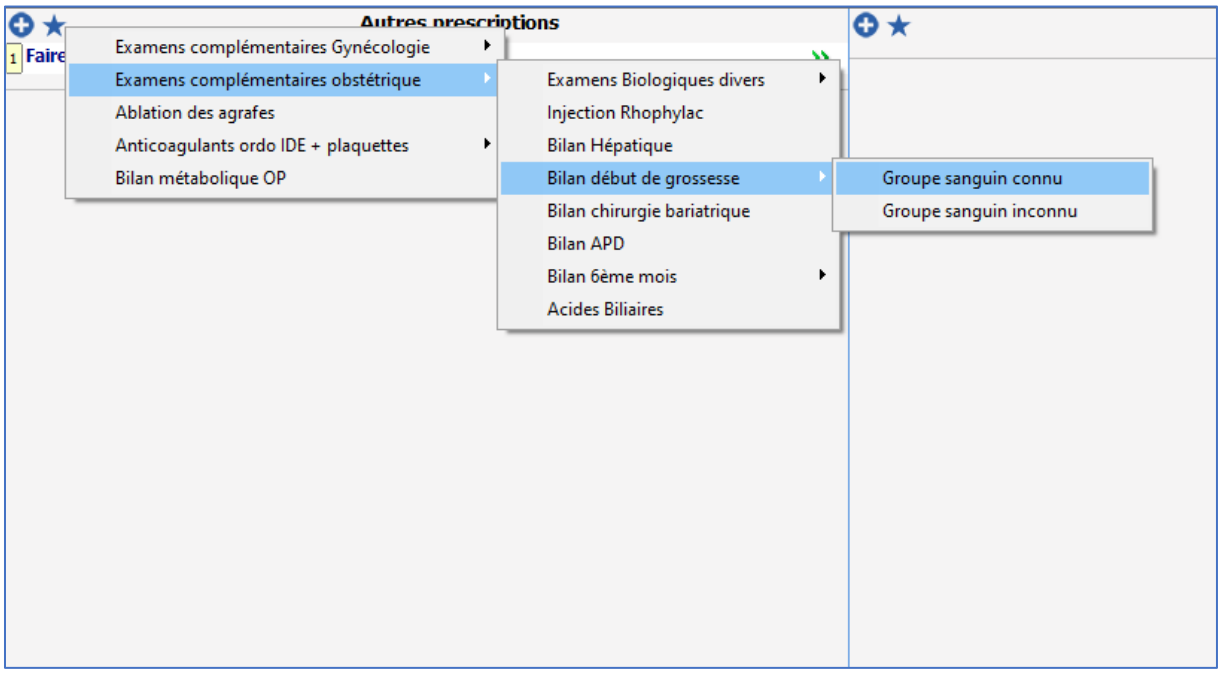
- Click on the button at the top left of the **Other prescriptions** column.
- In the top window, enter the test you need then click on **Confirm**.

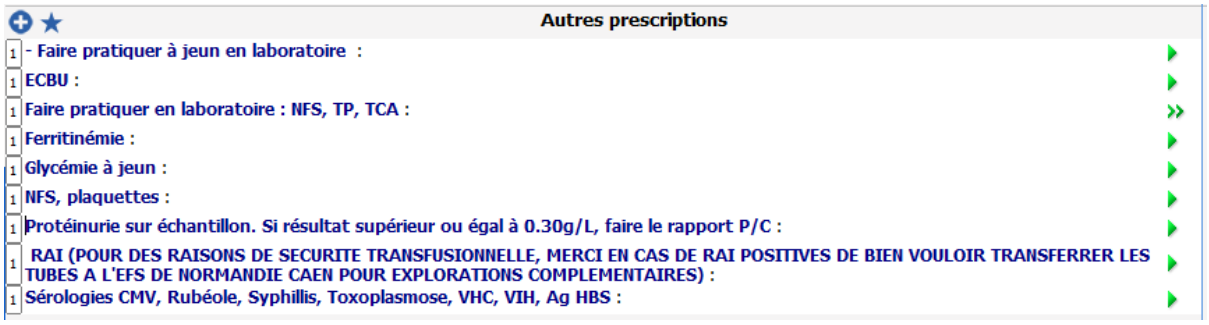


A line with the prescription appears in the **Other prescriptions** column.



In the same way as for drug prescriptions, favourites have been created and are accessed by using the ★ button.





4.7.3 LTC prescriptions

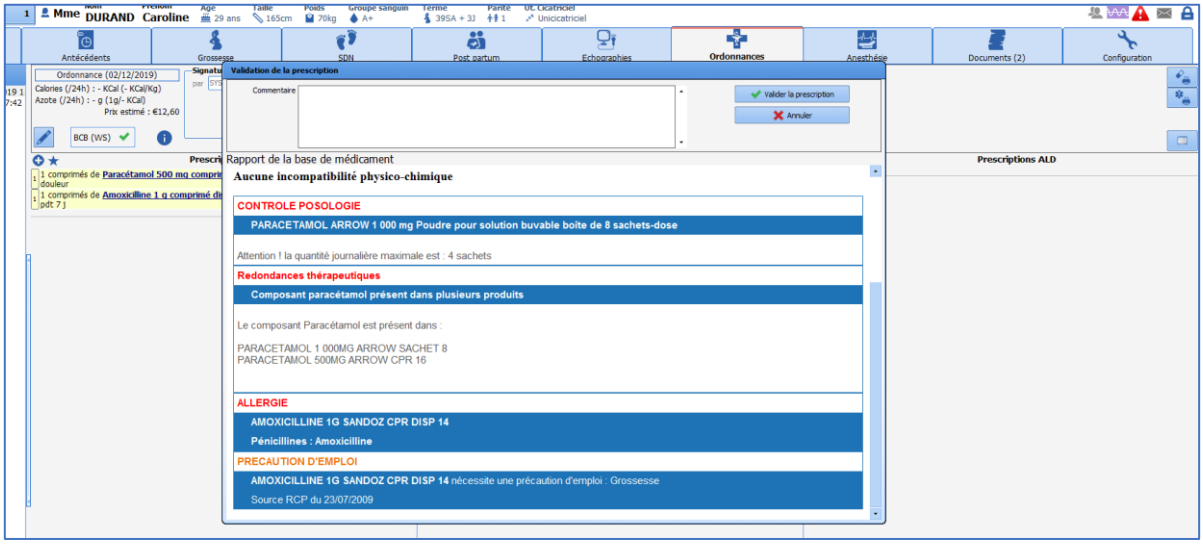
These work in the same way as non-LTC prescriptions but concern the specific treatments of long-term conditions.

4.7.4 Confirming a prescription

Once the prescription has been created, it must be validated using the **Signature for prescriptions** box (at the top left of the window). The prescriber enters their username and password in this box to sign the prescription and then click on **Confirm**.

NB: For midwives, a warning will appear if there is a prescription that is not in the prescription field.
For foundation doctors, the **Senior Doctor** box must be completed to name the person responsible for the prescription.

Drug database analysis: each prescription is analyzed by the drug database. A warning appears if there is a drug interaction, an incorrect dosage or allergy risk.
Below is an example of a warning when Clamoxyl is prescribed to a patient with a history of a penicillin allergy.

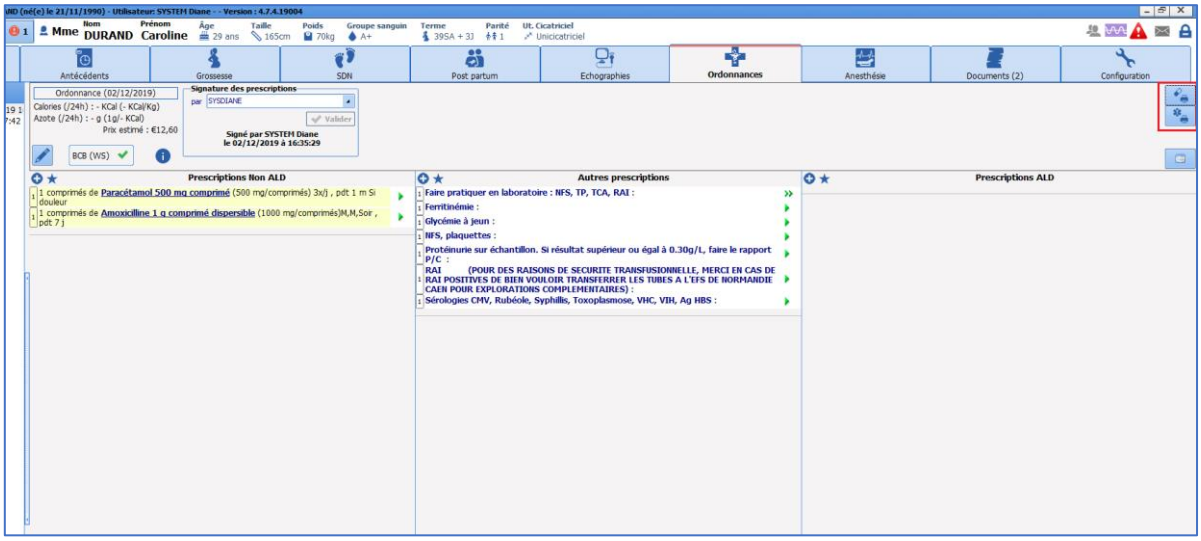


4.7.5 Printing prescription forms

Two buttons at the top right of the window let you print out prescription forms.

The button at the top lets you print drug prescriptions.

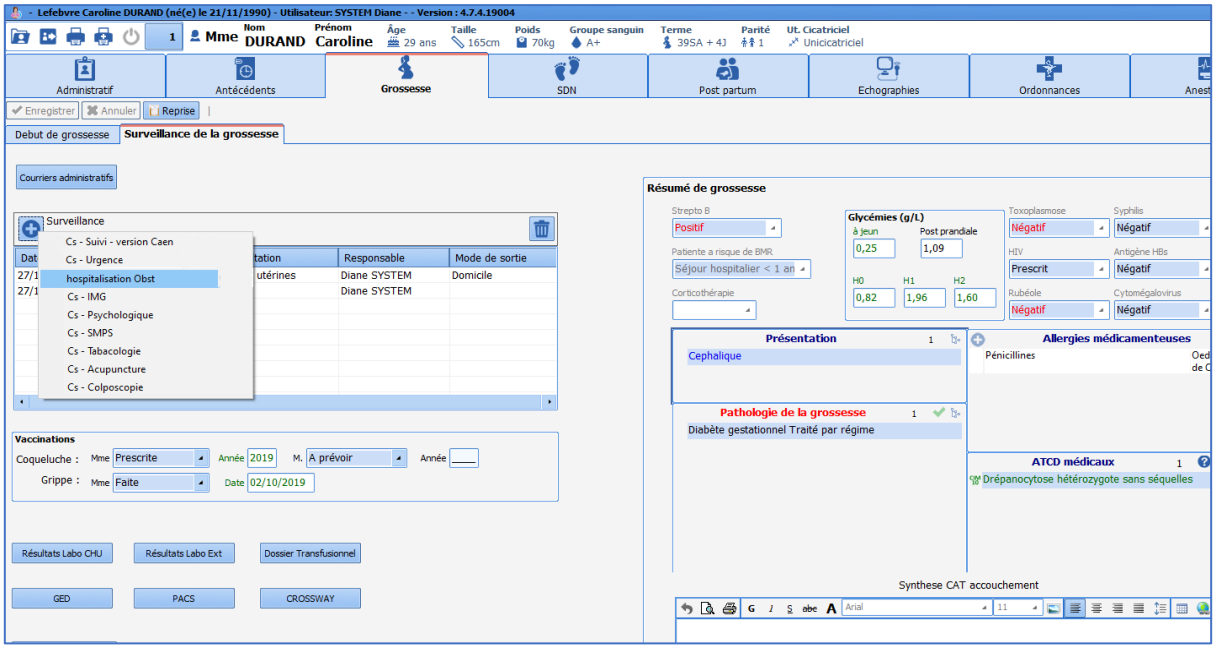
The lower button lets you print prescriptions for further tests and care.



NB: during consultations, the treatments appear automatically on the consultation letter only if they are prescribed using the **Prescription forms...** button present in the detailed entry.

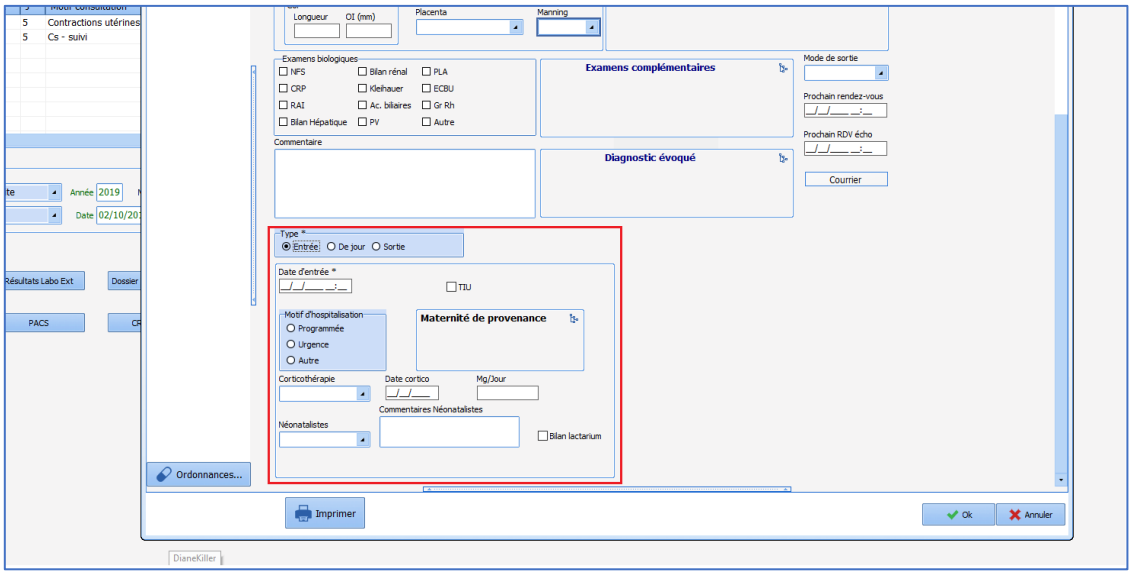
4.8 Hospitalizations

Hospitalizations will be monitored on the electronic health record. **DIANE** lets you fill in a hospitalization sheet and a discharge sheet (located in the **Pregnancy monitoring** table).

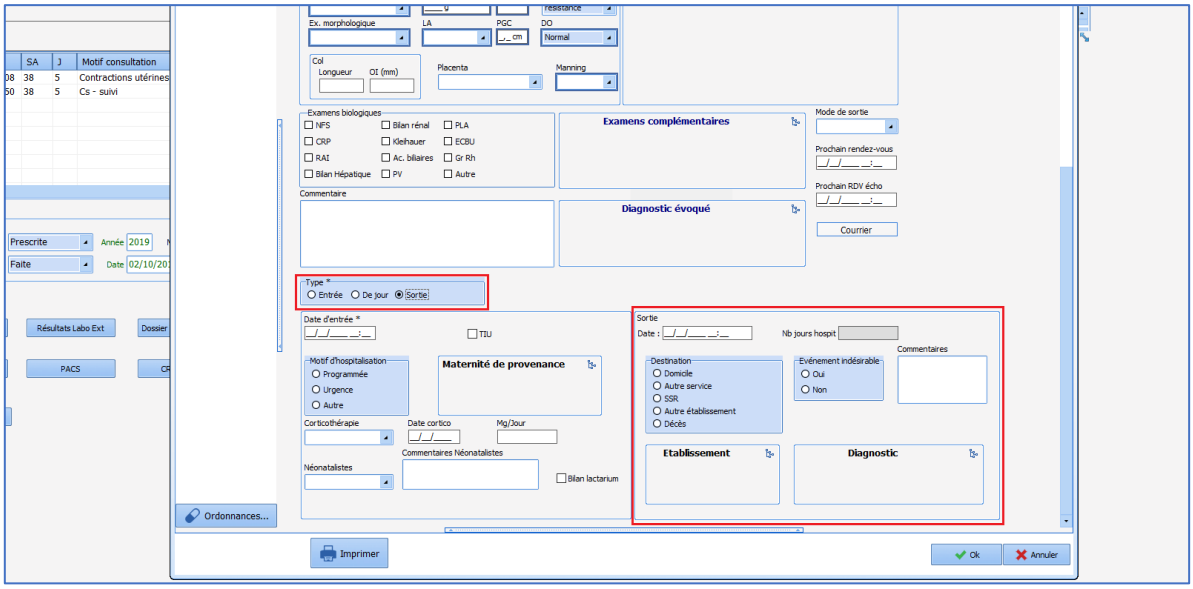


The hospitalization sheet is in the same format as the emergency consultation and is completed in the same way.

- The **Type** field at the bottom of the detailed entry is used to say whether it is outpatient care, a hospital admission or discharge. By clicking on **Admission**, a box will appear for you to enter the hospital admission information.



- When the patient is discharged, you must open the same sheet and click on **Discharge** in the **Type** box. This brings up a box for you to record the discharge information.



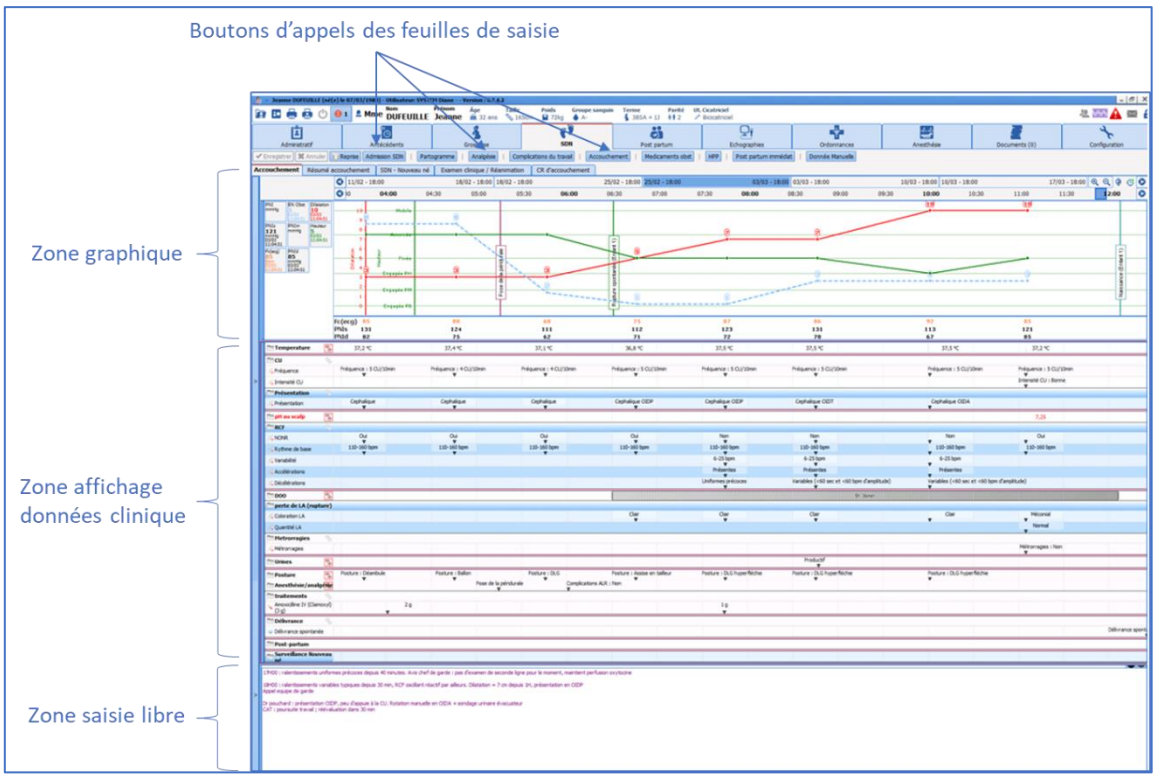
- Prescription forms can be generated from this hospitalization sheet by using the **Prescription form** button.
- You can generate the liaison letter by clicking on the **Liaison letter** button.

4.9 DR tab

4.9.1 Labour curve

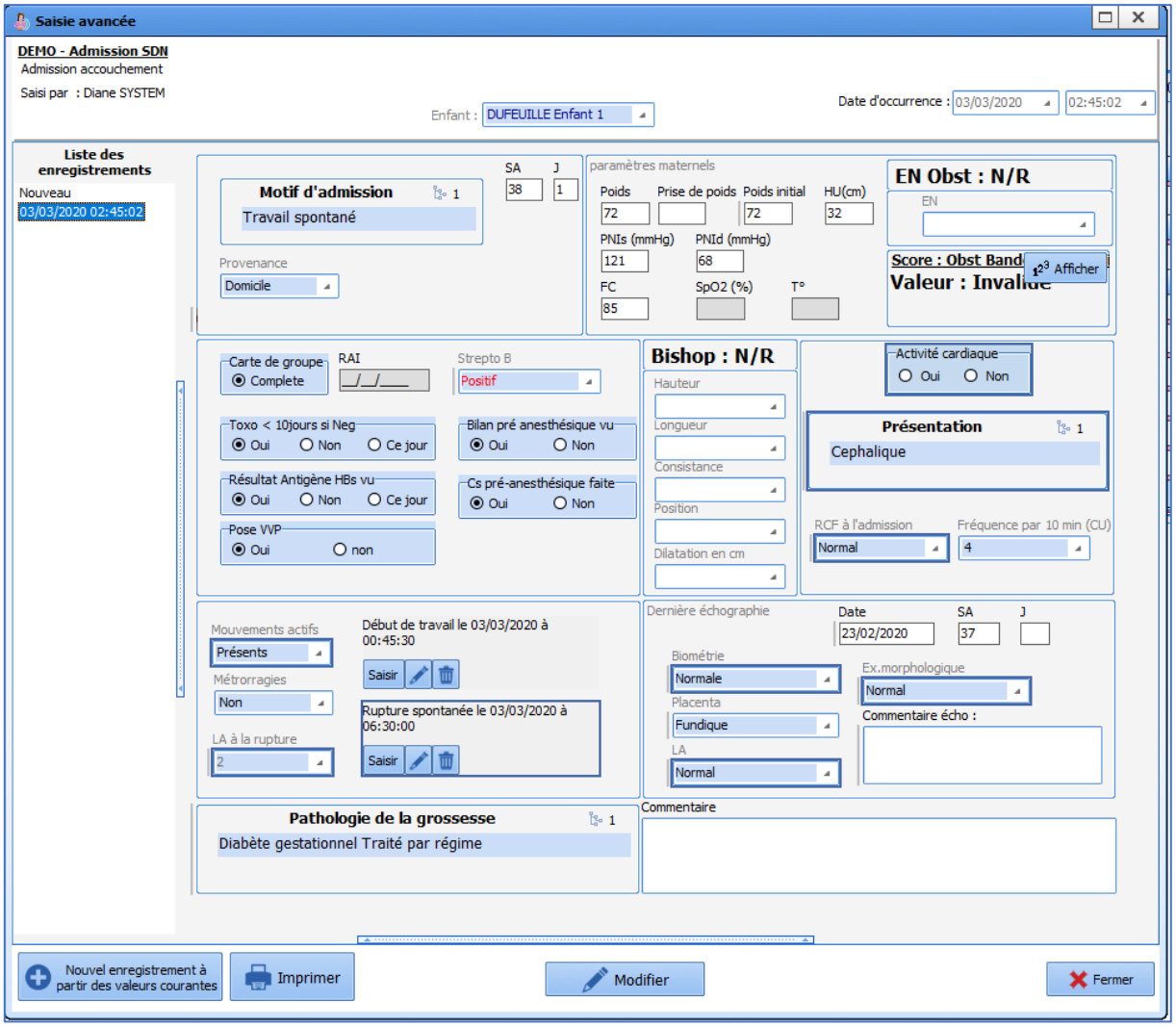
4.9.1.1 Entering data in the labour curve

The labour curve is accessible from the DR tab, **Delivery** subtab.
To record the patient monitoring data during labour and delivery, different buttons are available on the subtab's top ribbon.



- **DR admission** button:

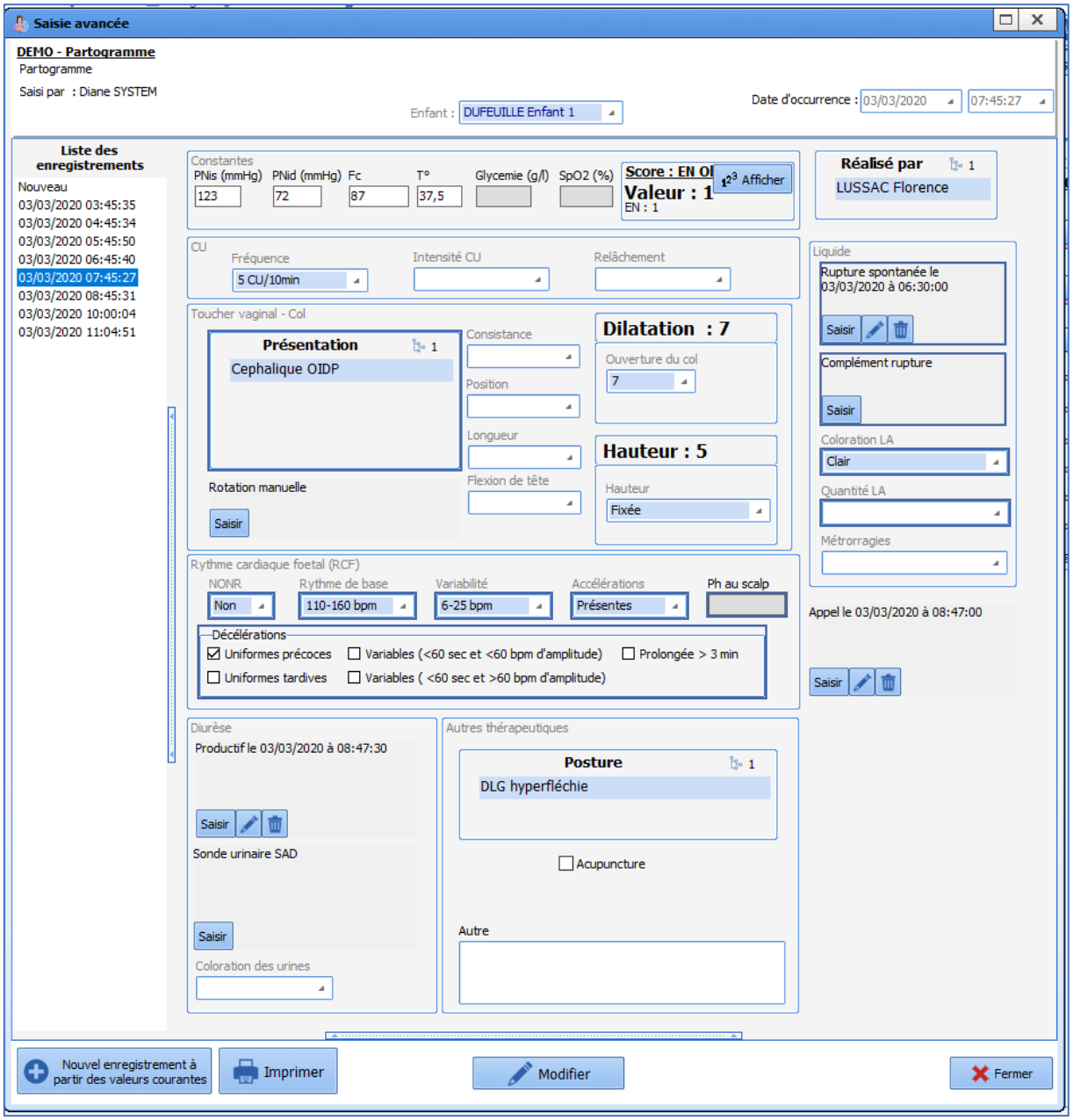
The **DR admission** detailed entry should be considered as a checklist to enter the main items of the clinical examination when the patient enters the delivery room and check certain items such as serology results, blood type information, etc.
At the top right are 2 scores to enter the NRS and dipstick at admission.
The **Start of labour** event is important and must be completed. This is used during labour to calculate the different phases of labour.



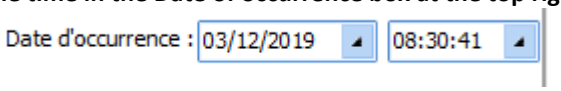
NB: the data entered in this sheet is not displayed in the labour curve. You must complete a **Labour curve** sheet after the DR admission sheet.

- **Labour curve** button:

This button calls up the detailed entry to enter the details of the clinical examination.



CAUTION: If the data is entered at a different time to the actual clinical examination, you must change the time in the Date of occurrence box at the top right.



There are several boxes in this data entry sheet:

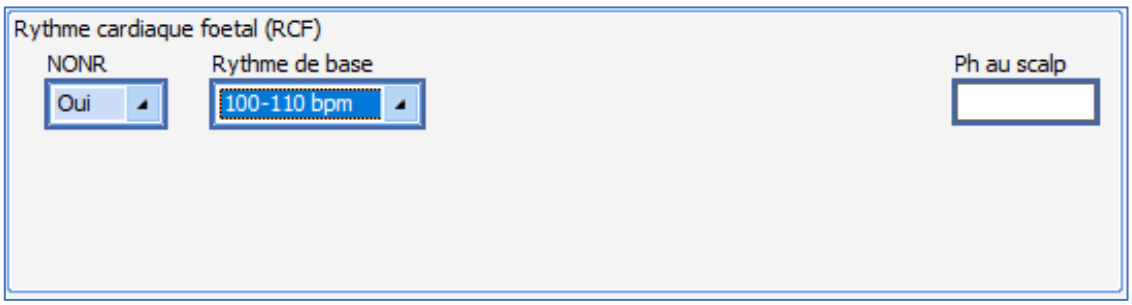
Vitals: the vitals are provided automatically by the monitors. There is no need to change them unless the data recorded is different.

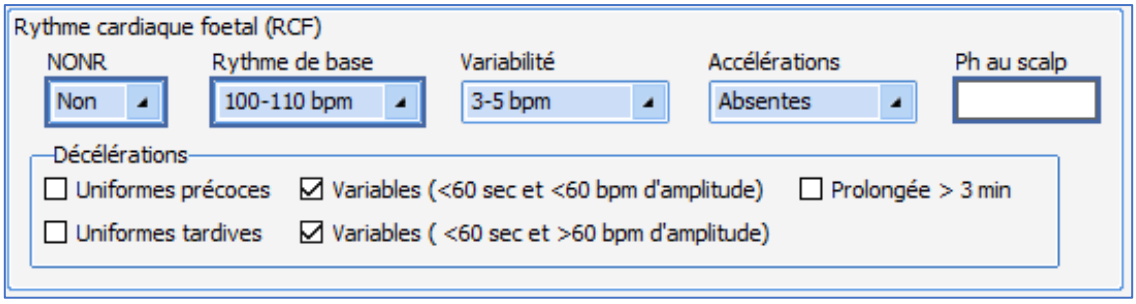
Uterine contractions: lets you enter data relating to the uterine dynamics

Digital vaginal examination: lets you fill in the data from the clinical examination

Foetal heart rate: lets you state that the FHR has normal variability and reactivity (NVR) and enter the baseline FHR. In the **NVR** drop-down menu, if you choose **NO**, then new fields appear for you to enter the

FHR characteristics.
The FHR analysis criteria correspond to the French society of Gynaecologists and Obstetricians' classification.





Urine output: lets you enter drainage catheter information or enter that an indwelling urinary catheter is fitted and report the urine colour.

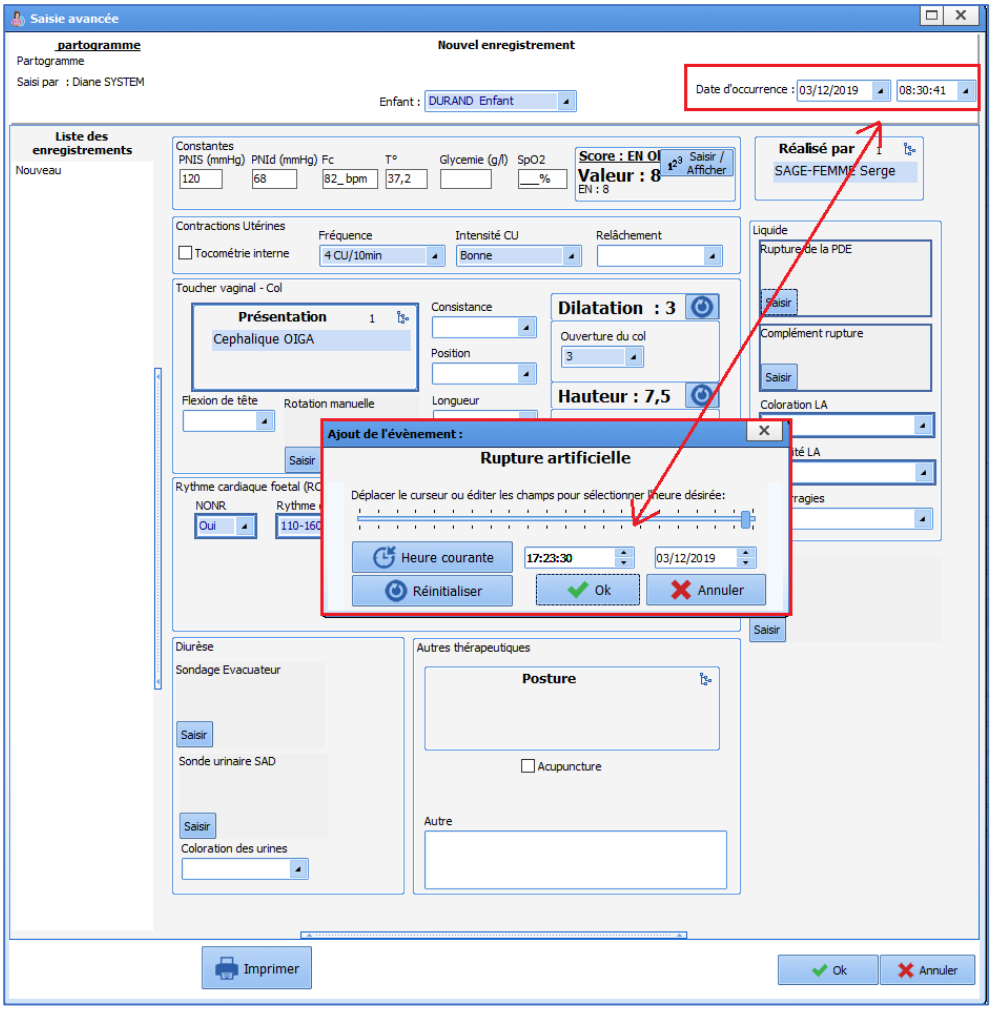
NB: By default, the last recording remains displayed but this does not prevent a new drainage catheter from being entered for example.

Other treatments: provides information about positions and non-drug therapies.

Fluid: provides information about the rupture of the membranes (spontaneous or artificial), any additional rupture and the colour of the fluid.

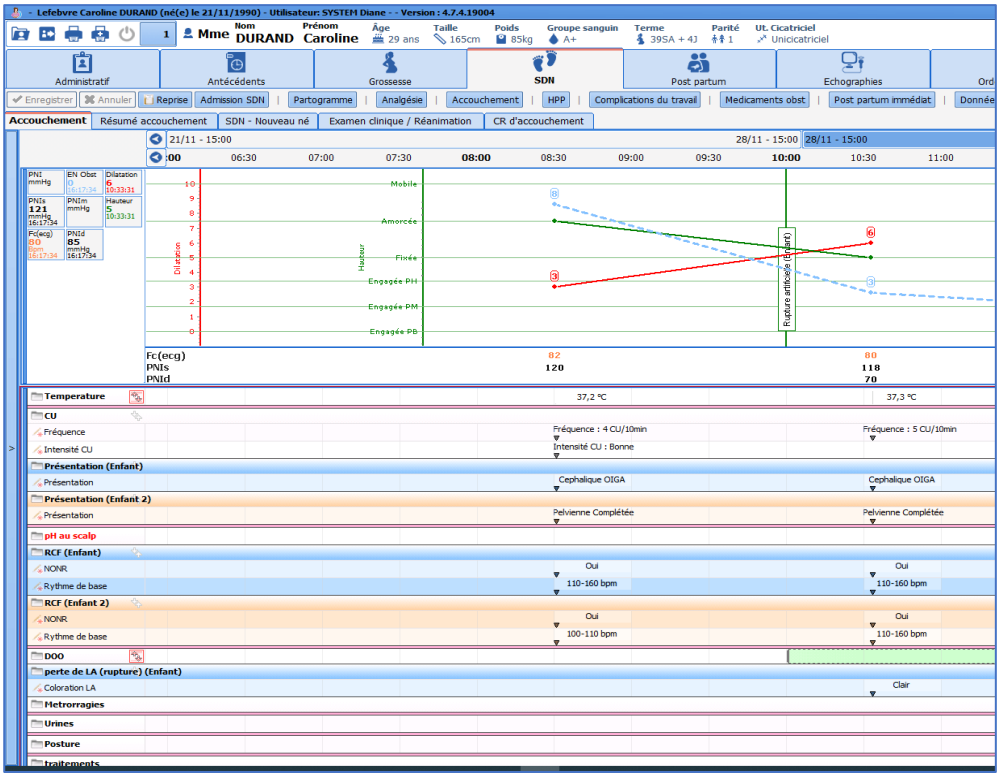
NB: It is not possible to enter the **rupture of membranes** twice: it is preconfigured to only be entered once.

CAUTION: the time of occurrence and time of entry of an event are different. It is important to check the time of the event (if wrong, it can be changed).



Once the detailed entry named **Labour curve** has been completed, click on **OK**. The labour curve will then be automatically displayed. In cases of multiple pregnancy, the data concerning the foetus(es) will be duplicated automatically.

As the data is entered, the labour curve will be built as labour progresses and the different clinical examinations are performed.



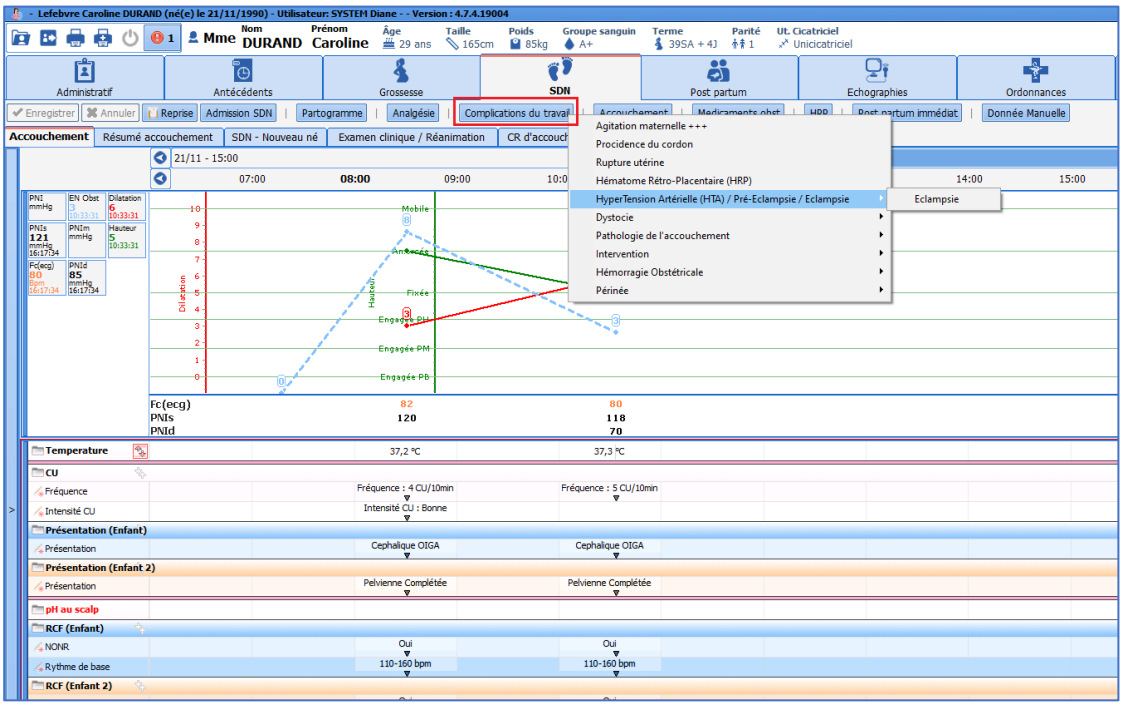
Timers:

Entering the **Rupture of membranes** event starts a timer. This is displayed in green on the labour curve under the name **TASO** (**Time amniotic sac open**). Entering the **birth** event stops the timer.

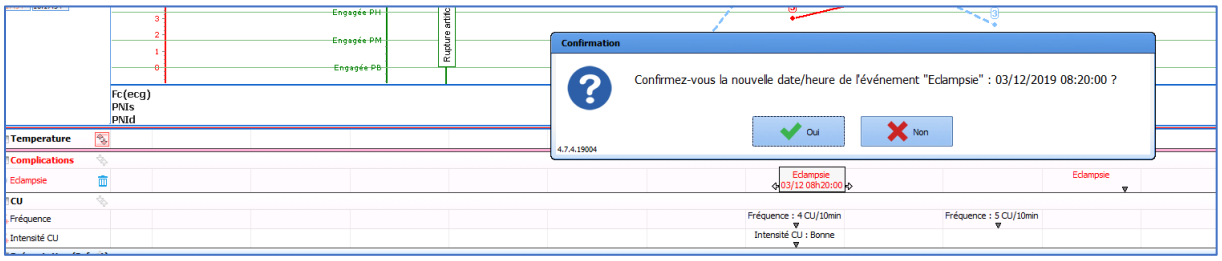
A warning will be displayed after 12 hours of TASO.

- **Complications** button:

This button calls up a list of labour complications to enter data quickly in an emergency. Selecting one of these complications results in an immediate display.

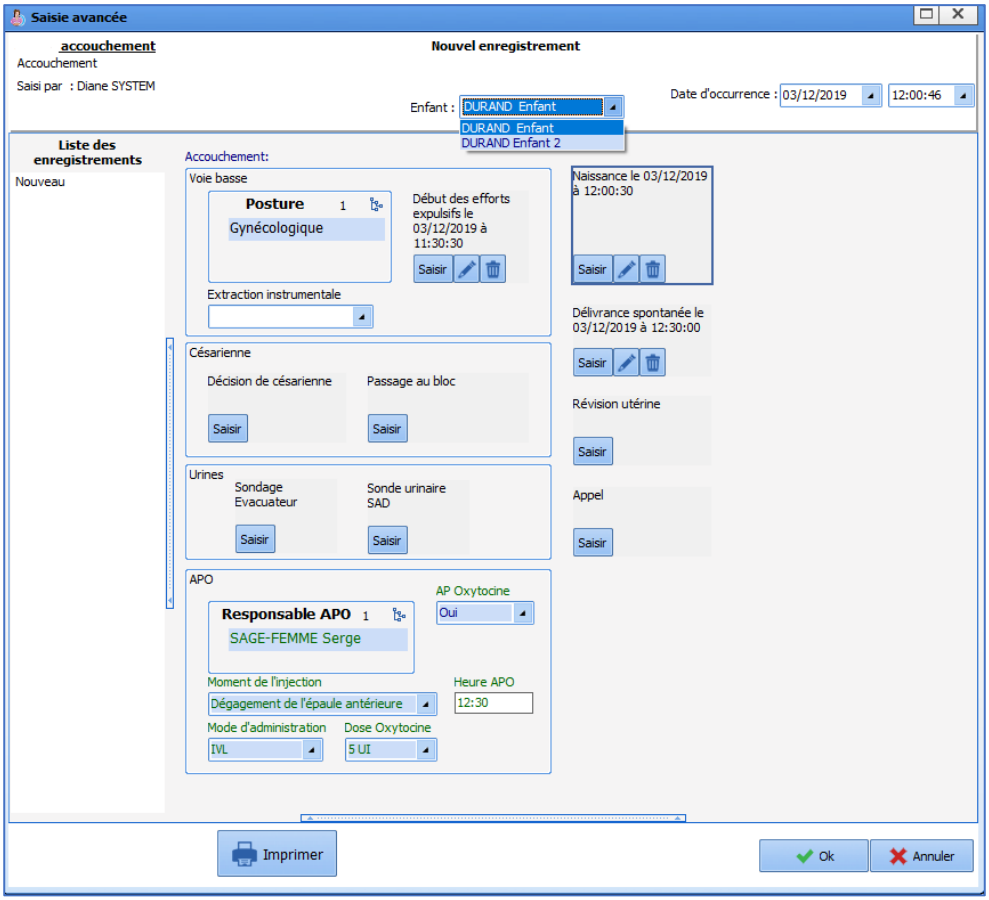


You can change the time of occurrence of the complication by clicking on it and dragging it from left to right on its display line.



- **Delivery** button:

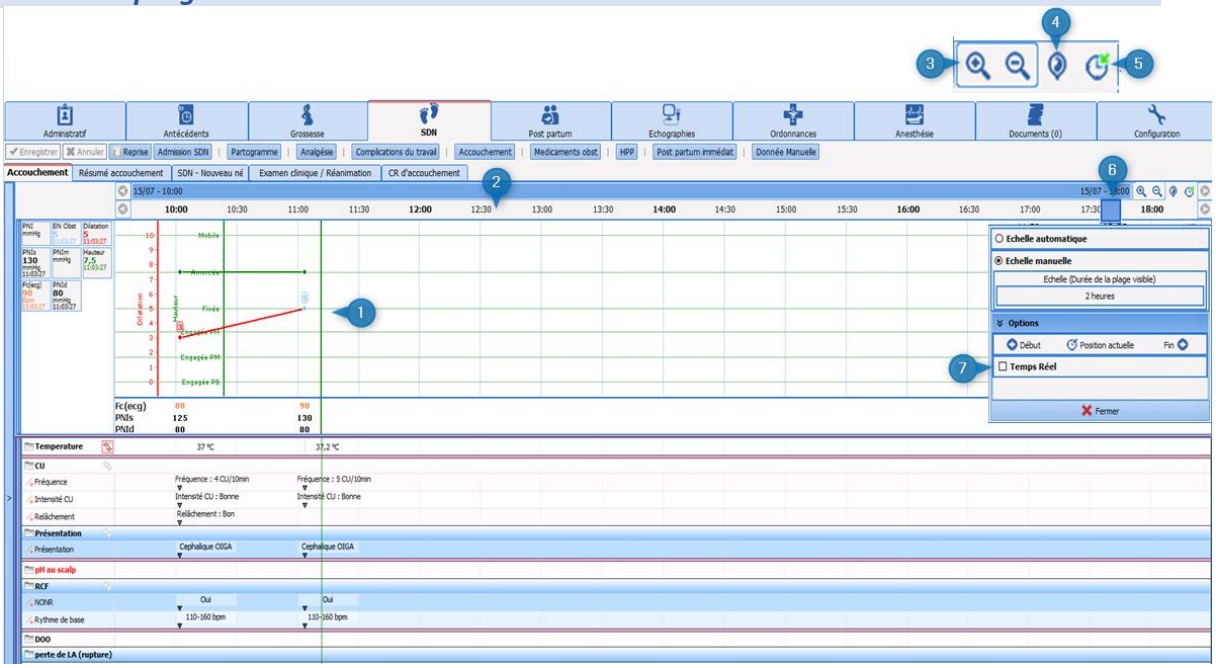
The **Delivery** button lets you record information about the delivery.
The **Vaginal delivery** box lets you enter the delivery position and the start time of expulsive efforts.
The **C-section** box lets you enter the time at which it was decided to perform a C-section and the time at which the patient entered the operating theatre.
The **Urine** box lets you record the urine drainage catheter or the time at which an indwelling urinary catheter is fitted if necessary.
The **PAO** (Prophylactic Administration of Oxytocin) box is used to name the person responsible for the PAO, the injection stage, the quantity of oxytocin, and the time and method of administration.
To the right of the sheet, you can record the time of birth, the time and method of the placental delivery, the performance of a uterine examination and the time at which the team was called if necessary.
NB: in the event of a multiple pregnancy, you must remember to enter the time of birth for each child by changing the child in the drop-down menu at the top of the sheet.



- **PPH** button: the PPH (postpartum haemorrhage) sheet lets you enter the time of diagnosis, the procedures performed, the quantity and cause of the PPH.

- **Immediate postpartum** button: used to record the monitoring of patients after delivery and until they leave the delivery room.

4.9.1.2 Time progression



1 Time progression pane

2 Time progression is materialized by a green bar moving along the labour curve.

3 Zoom in / out: lets you zoom in or out of the charts pane.

4 Lets you go back 6 hours before the delivery.

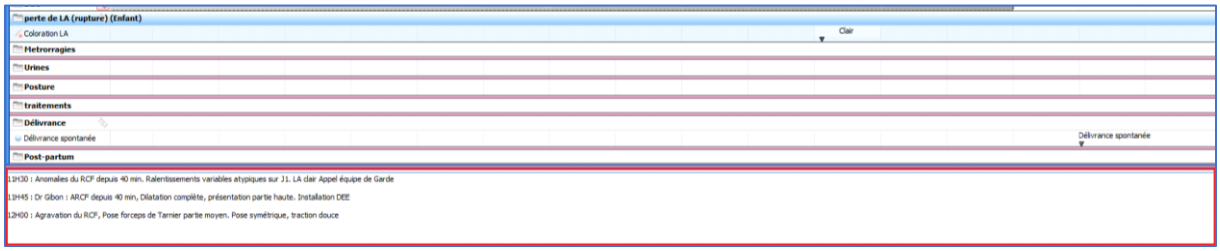
5 Go to the current position: this lets you go back to the present.

6 Blue cursor: lets you go to the time you want: simply click and drag the cursor to move it.

7 Block time progression: when you right-click on the time progression top ribbon this opens a window. The **Real time** box is ticked which means that the labour curve is progressing in real time. If you untick the box the time progression stops. You can also change the display range via this window.

4.9.1.3 Free text input box

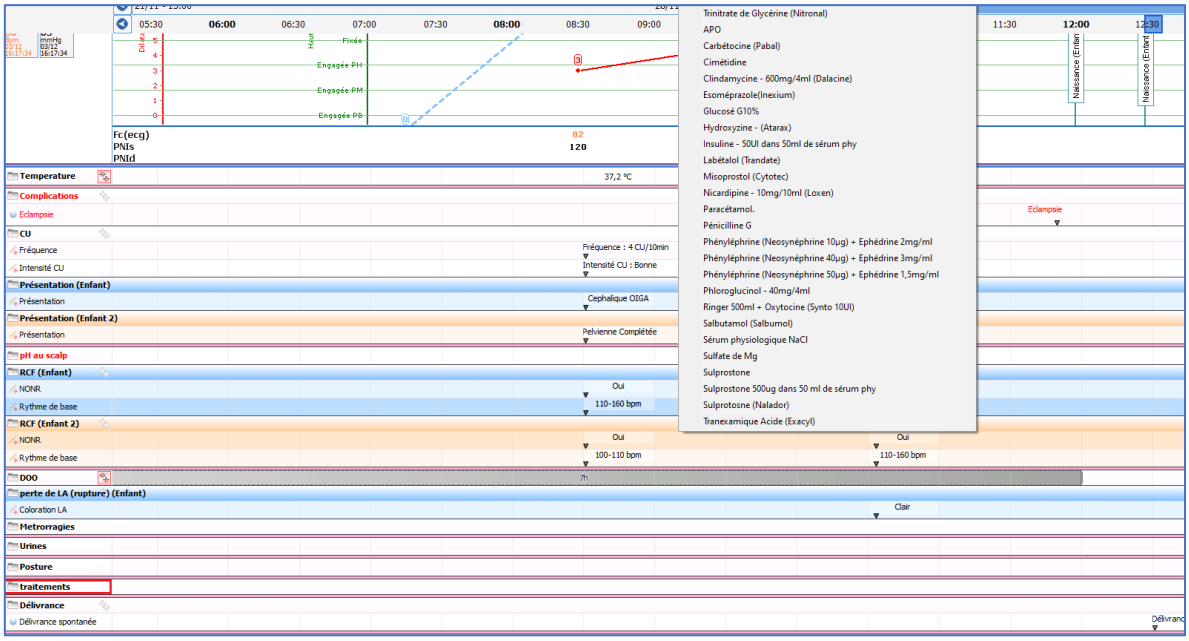
A box under the labour curve lets you enter comments manually to specify events occurring during labour if necessary.



4.9.2 Prescriptions during labour

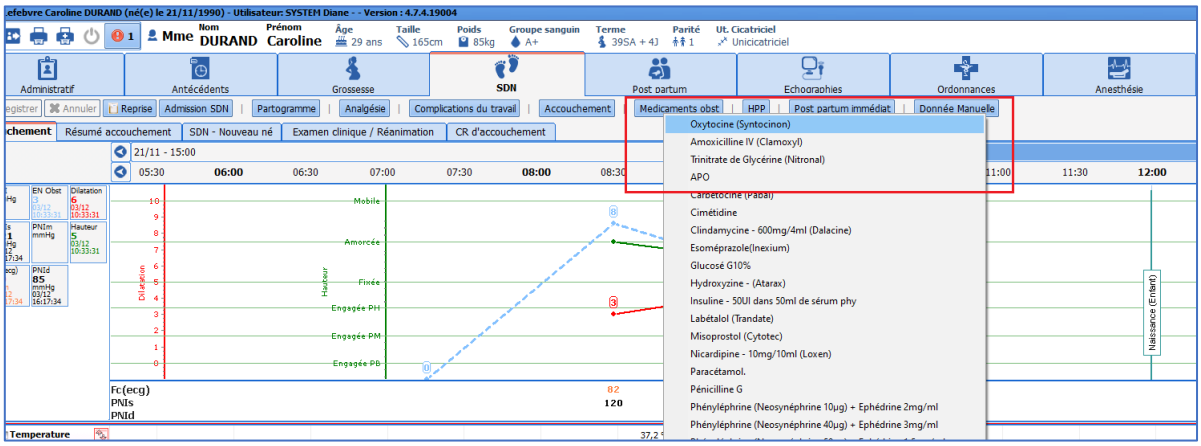
The treatments that can be administered during labour are accessible in two ways:

- Either by using the **Obst drugs** button at the top of the labour curve. This button calls up a list of treatments.
- Or by double-clicking on the 'record' icon to the left of the **Treatments** line in the clinical examinations display pane.

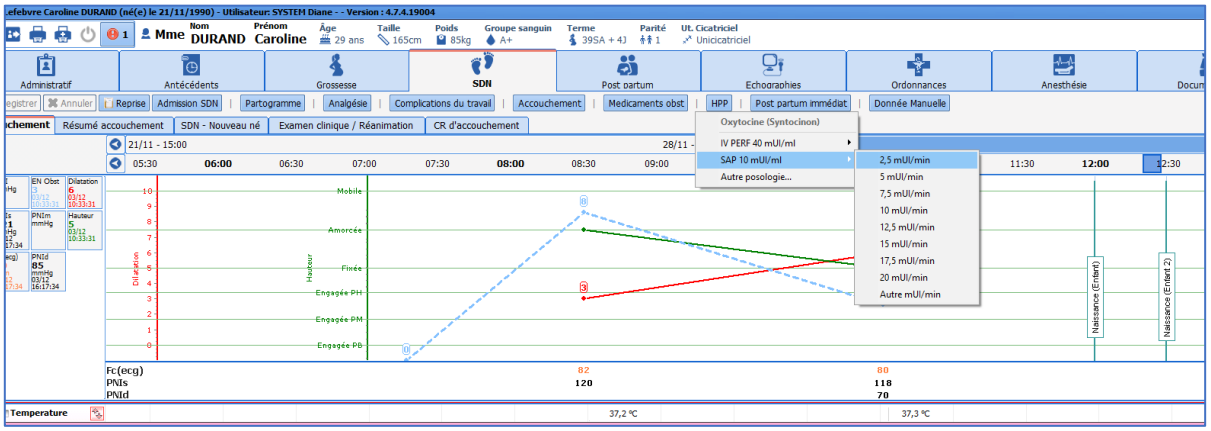


4.9.2.1 Prescription of slow IV/ SP treatments: example of oxytocin

- Click on 'Oxytocin' in the list of drugs.

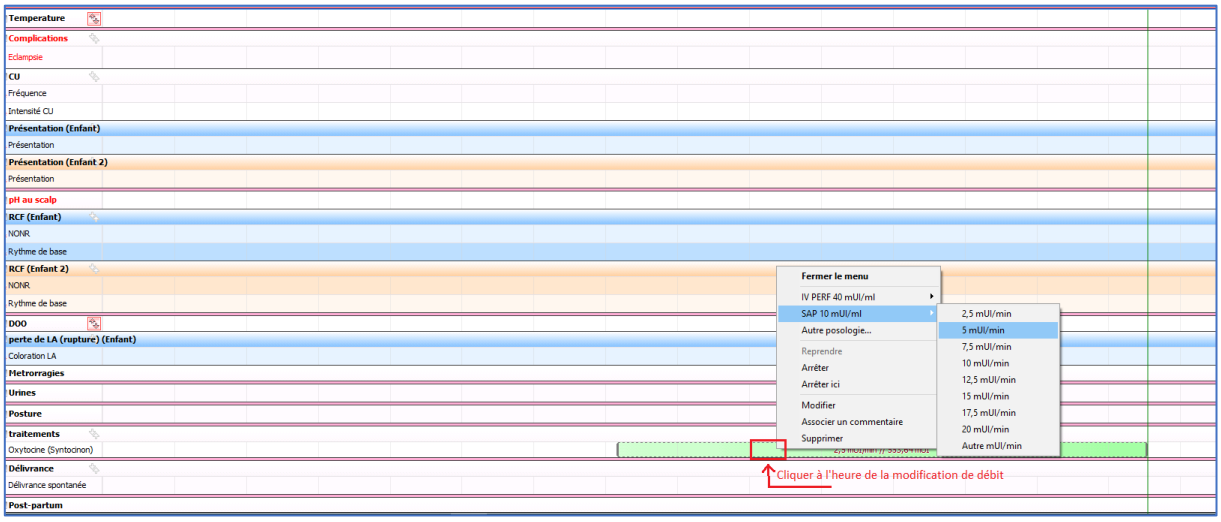


- In the window displayed, choose the appropriate dosage.

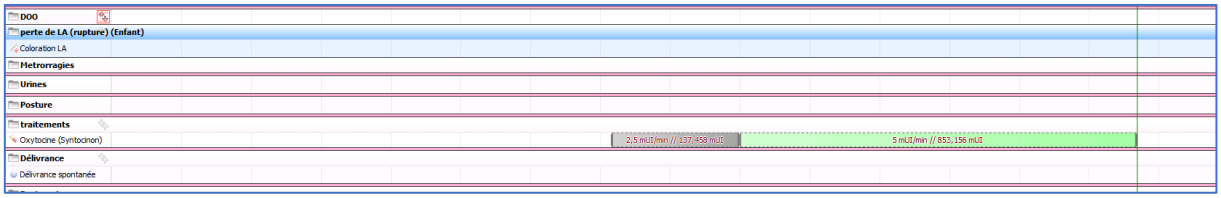


- The treatment is then displayed in the **Treatments** line.

- To change the start time, simply click on the left end of the prescription and drag it to the time you want.
- To change the flow rate: click on the relevant treatment line at the time when the rate was changed. Choose the new flow rate.



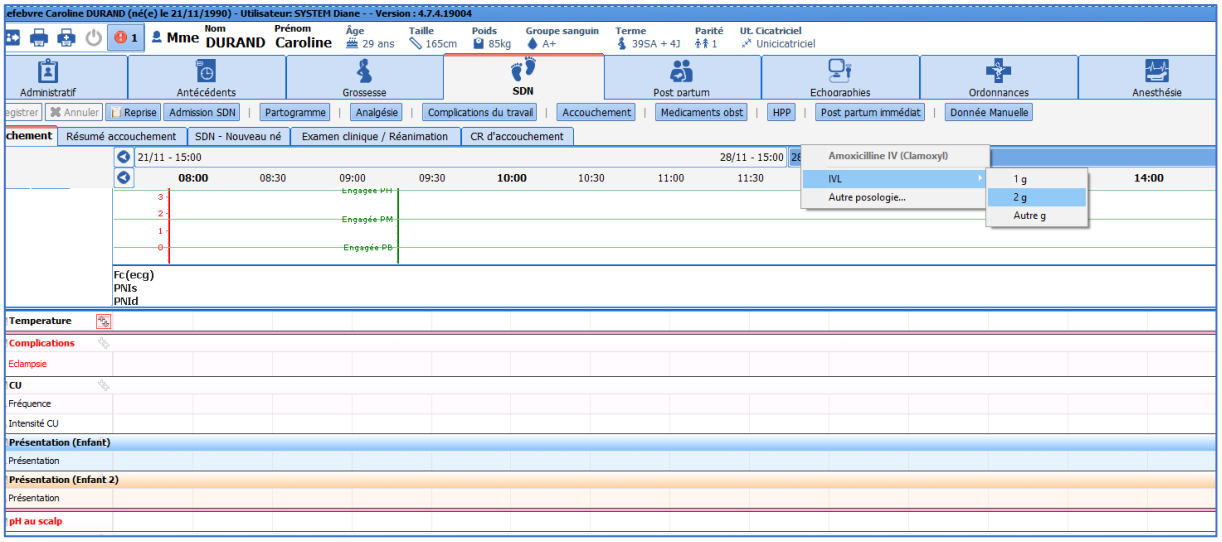
- The infusion with the old rate will turn grey, and the new rate will continue in green.



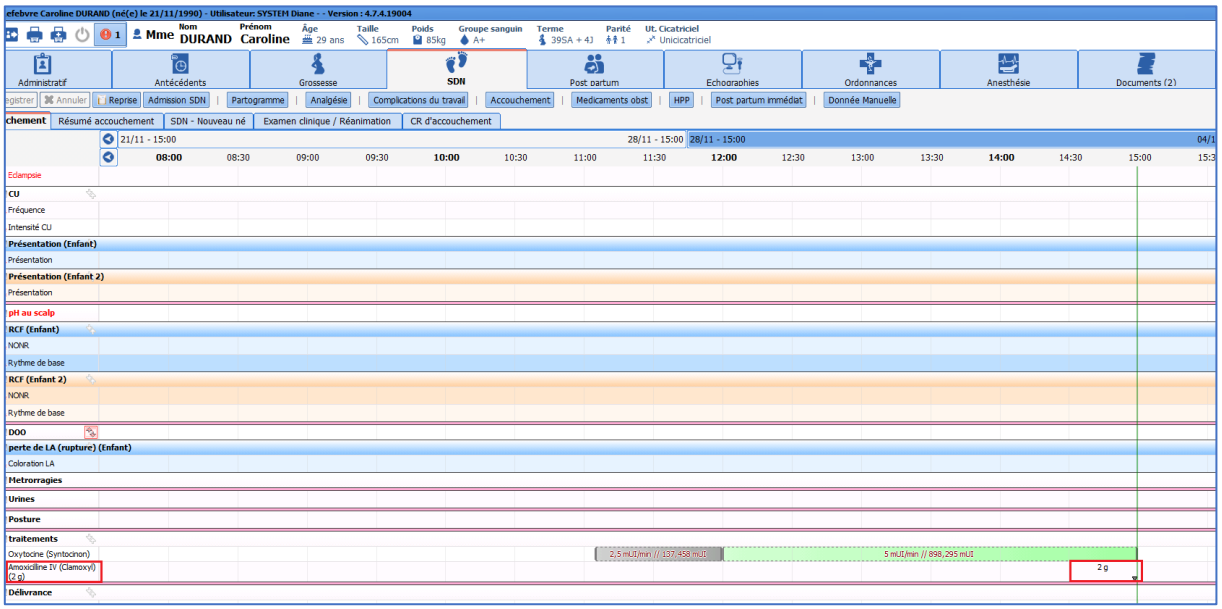
- To stop the infusion, double left-click on the infusion line (in green). Choose **stop** to stop the infusion immediately. Choose **stop here** to stop the infusion where you click. Choose **change** to enter a specific time to stop the infusion.

4.9.2.2 One-off treatment prescription: example of Clamoxyl during labour

- Choose Clamoxyl from the list of drugs then choose the appropriate dosage.



- The treatment is automatically displayed in the **Treatments** line.

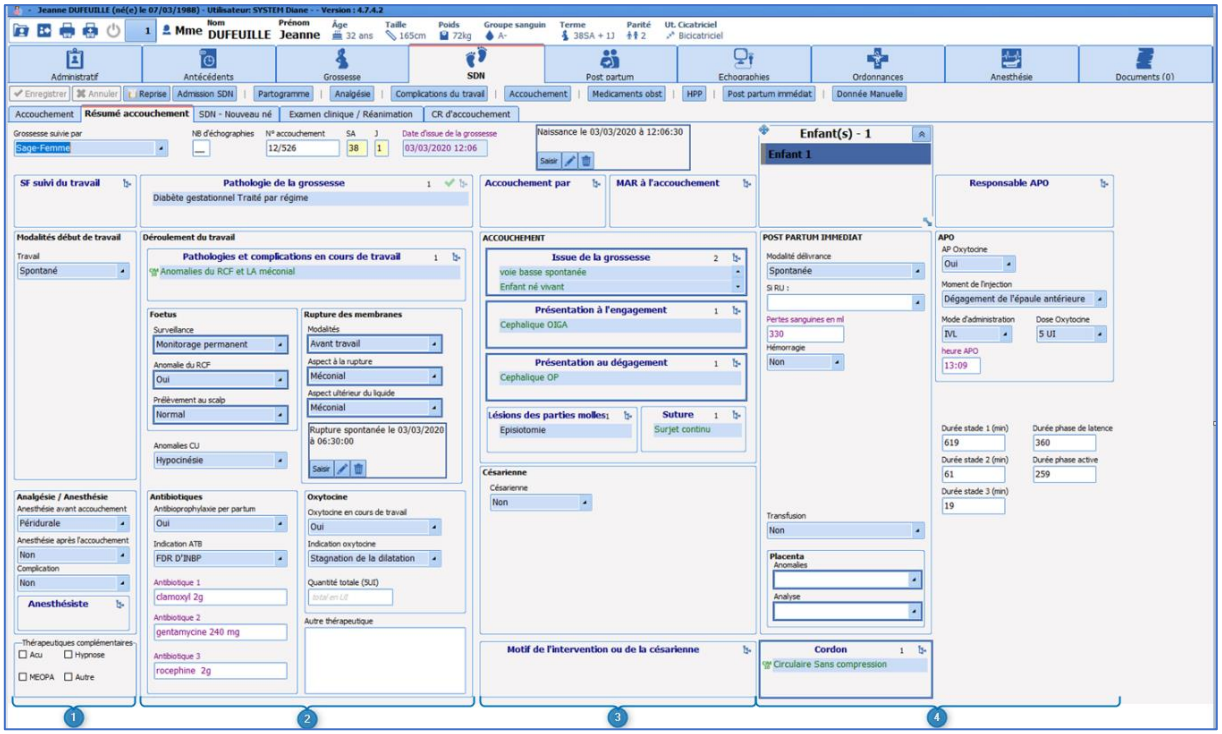


NB (1): you can change the time of administration of the treatment by clicking on the arrow under the dosage (2 g in the example above) and dragging it from left to right.

NB (2): the data entered in the labour curve is automatically visible in the **Anaesthesia** tab so that information is shared efficiently between the 2 specialties. In addition, when the administration of an epidural is recorded in the **Anaesthesia** tab by the anaesthetist, it is automatically displayed in the labour curve.

4.9.3 Delivery summary

The delivery summary is organized into 4 columns:



- Start of labour
- Labour process
- Delivery process
- Immediate postpartum

4.9.3.1 Start of labour

Fields appear depending on the start of labour method (e.g. if labour is induced, the **Reason** and **Induction method** fields appear).
The **Analgesia / anaesthesia** field lets you enter the type of anaesthesia used during labour or after delivery if necessary.

4.9.3.2 Labour monitoring

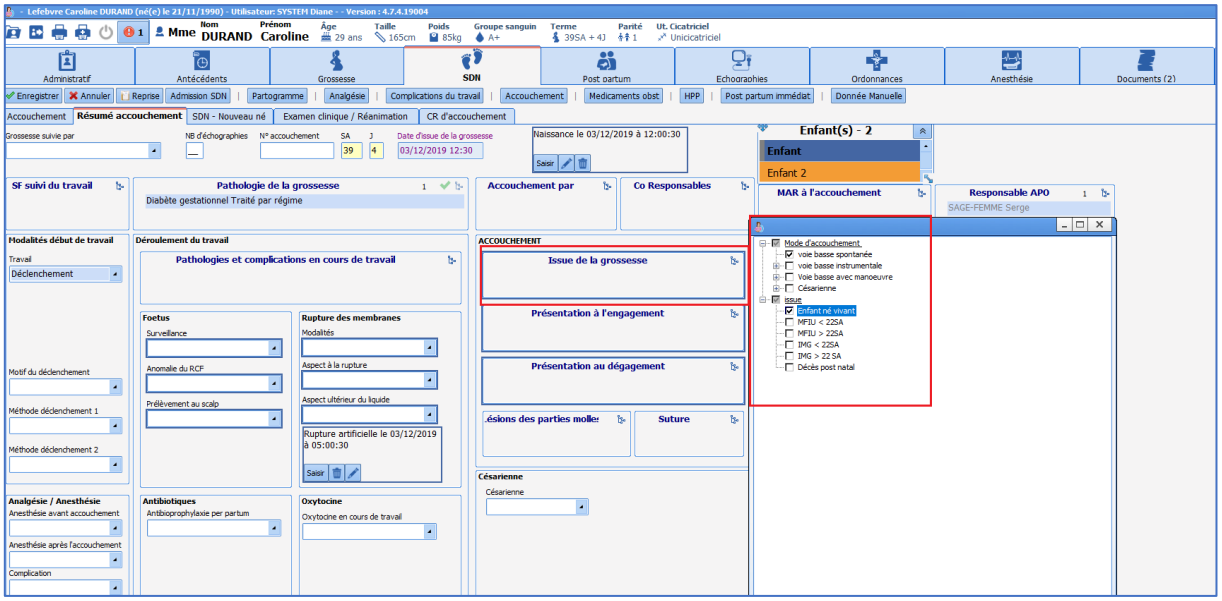
Lets you record information concerning foetal monitoring, the amniotic fluid and treatments during labour.

4.9.3.3 Delivery

Lets you record information about the delivery method.

Specific features:

- Pregnancy outcome: as in the **Obstetric history** tab, you must enter both the **delivery method and the outcome** for all children in the event of a multiple pregnancy.



- Presentation at engagement and expulsion: in the event of a C-section, it is the presentation at expulsion that will be taken into account when the reports are prepared. You can simply enter 'cephalic' without specifying the presentation direction.
- C-section drop-down menu: lets you display additional fields for C-sections, such as 'incision type', any additional procedures or complications.
- Reason for procedure or C-section: this box must be completed in the event of a manoeuvre, instrumental delivery or C-section.

4.9.3.4 Immediate postpartum

This lets you enter the placental delivery procedures. In the event of **postpartum haemorrhage**, fields appear for you to specify the care administered.
The **PAO** (**P**rophylactic **A**dministration of **O**xytocin) box is completed automatically from the **Delivery** detailed entry completed beforehand. However, it is possible to fill in the fields in the delivery summary.

4.9.3.5 Calculation of labour phases

The different labour phases are calculated automatically. To make these calculations possible, the following events must be entered: Start of labour (in **Delivery admission**), 10 cm dilation (in **Labour curve**), Birth (in **Delivery**), placental delivery (in **Delivery**).

4.9.4 DR – Neonate subtab

The **DR – Neonate** subtab lets you enter neonatal data relating to the birth conditions.

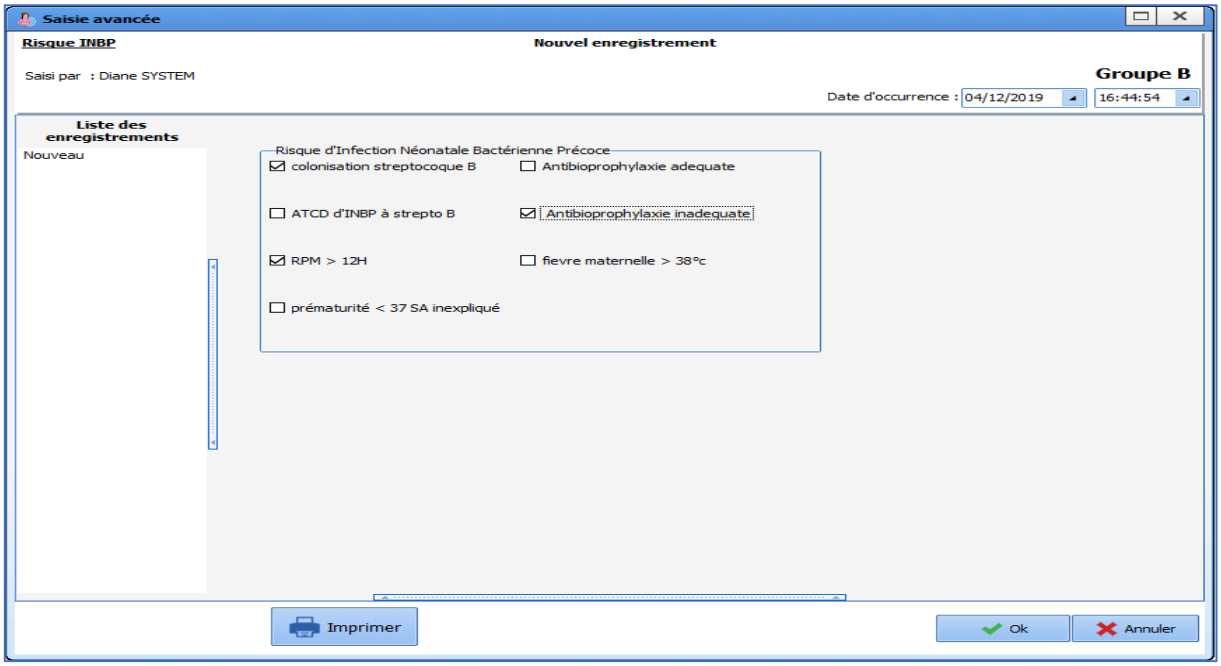
The top ribbon lets you enter the child's identity and gender.

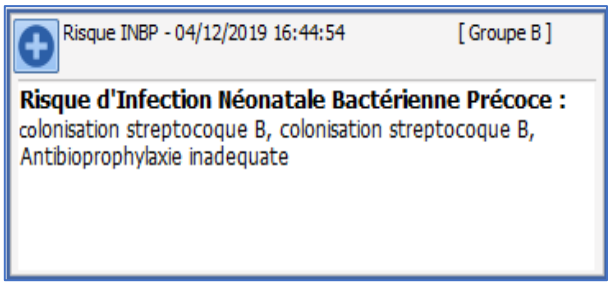
Apgar: the Apgar score is shown in the form of multiple drop-down menus containing all the criteria to calculate the score. You can enter the data more quickly by clicking on the 10 button at the bottom of each column.

Samples box: this box lets you record the different samples taken from the neonate.

The **EONI risk** (risk of **E**arly **O**nset **N**eonatal **I**nfection) component classifies the child according to the risk of early onset neonatal infection. Click on the ⊕ to the top left of the component. Enter the information in the window

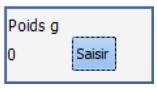
displayed. The component will tell you which EONI risk group the child is in.



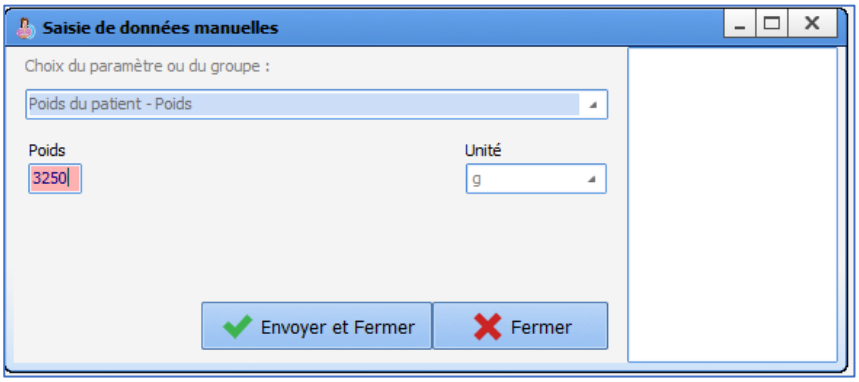


Measurements and percentiles box:

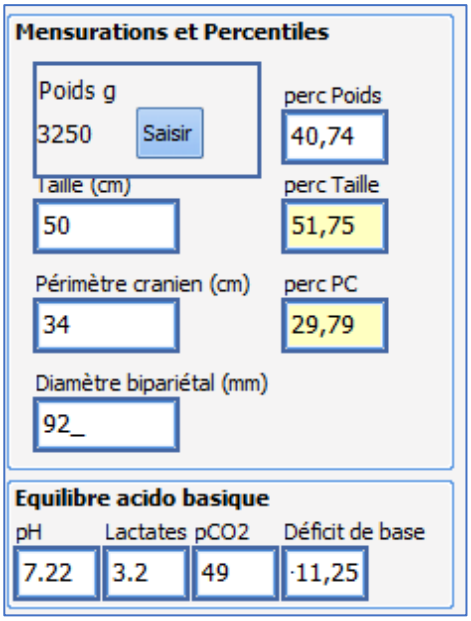
To enter the weight, click on **Enter** in the box.



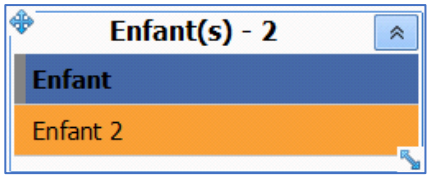
A window opens for you to enter and change the weight in the event of an error.



The length, head circumference and biparietal diameter are simply entered into the fields. The percentiles are calculated automatically.

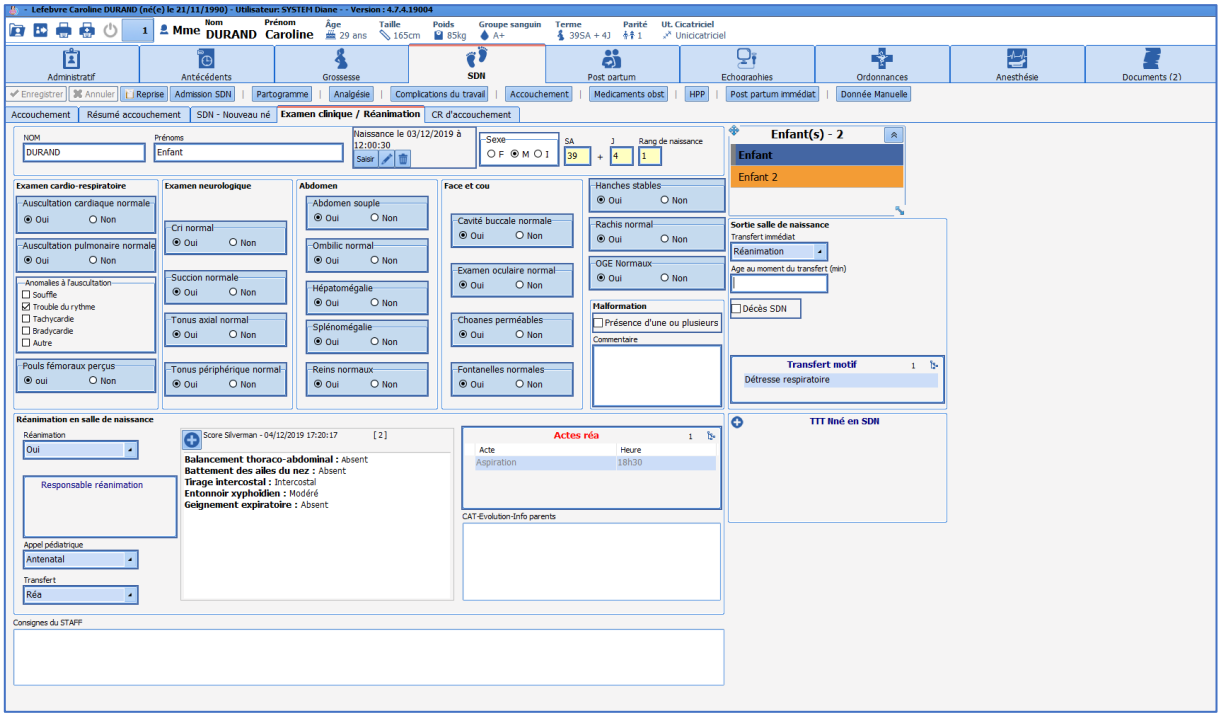


As in the entire record, you must enter the data for all the children by clicking on the component:

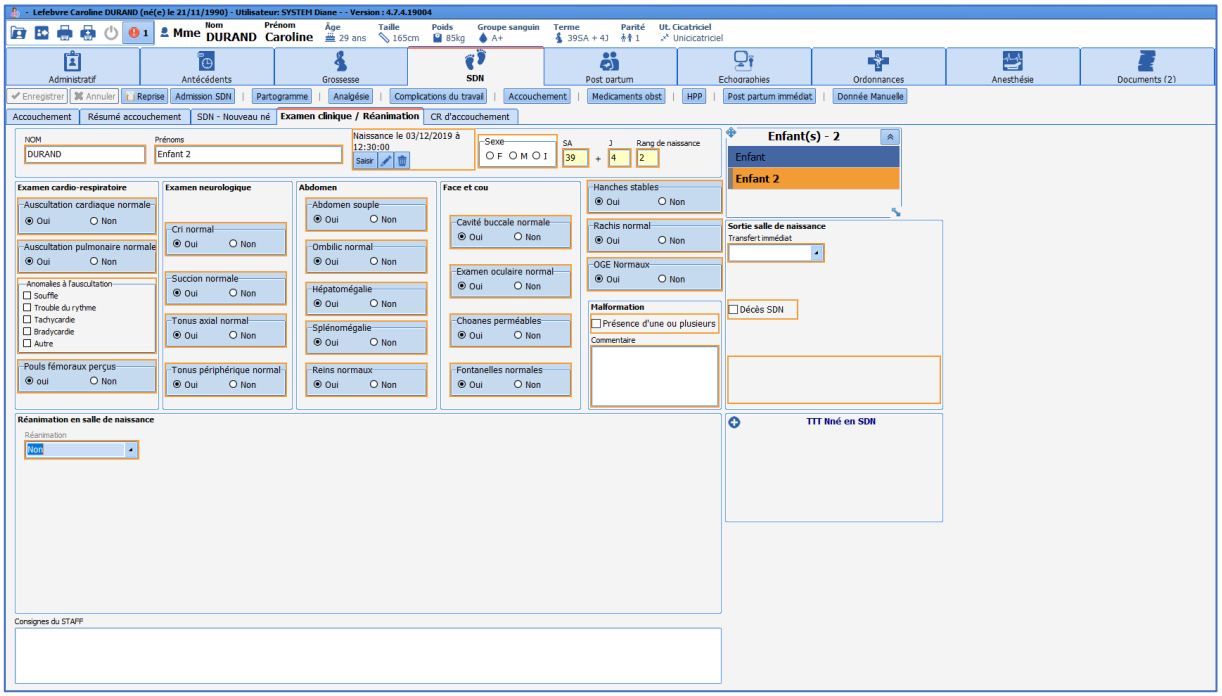


4.9.5 Clinical examination / Resuscitation subtab

The data from the neonatal clinical examination is entered simply using checkboxes.
A **Resuscitation** box is present at the bottom of the sheet. In the **Resuscitation** drop-down menu, if you enter **Yes**, fields appear for you to enter the Silverman score, procedures performed during resuscitation or instructions on what to do.
E.g.: Clinical examination Twin 1:



Clinical examination Twin 2:

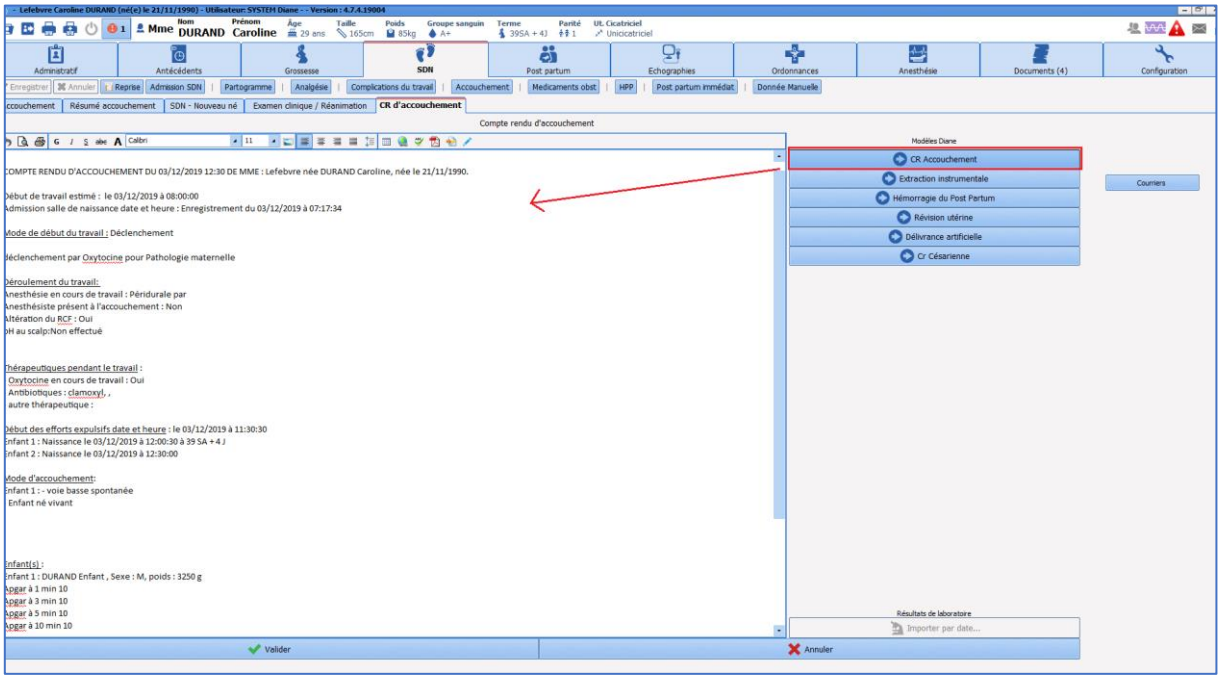


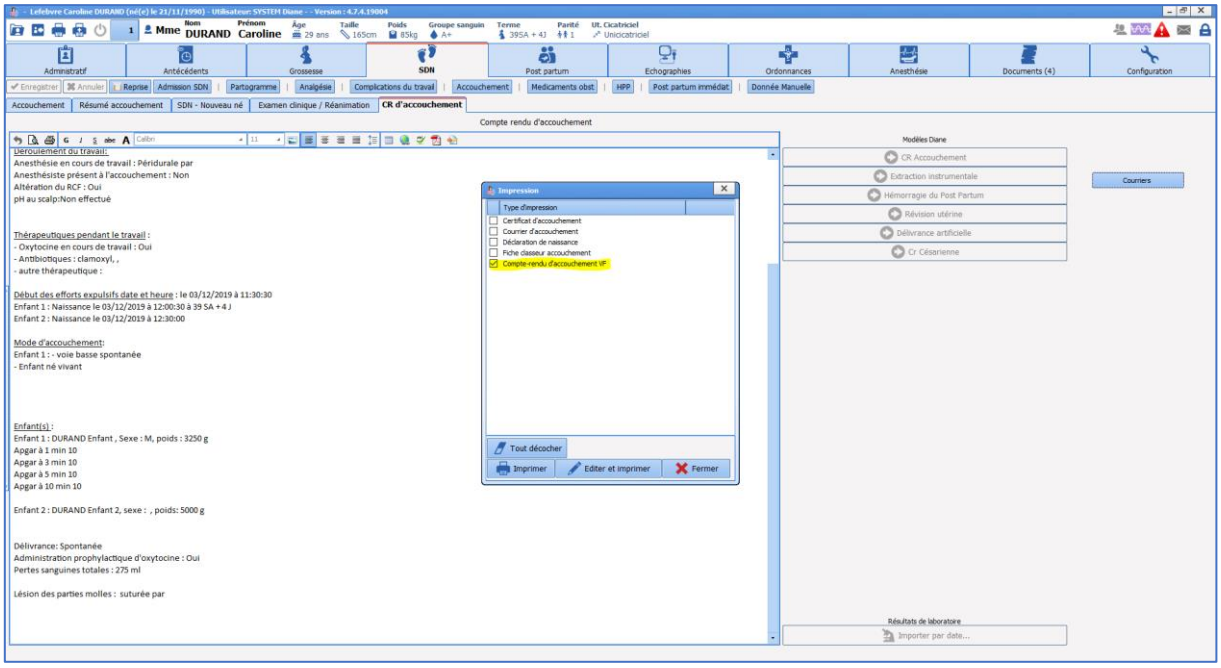
The **Neo TT in DR** component lets you enter the treatments administered. It has 2 columns. The left column lets you choose the treatment administered and the right column lets you enter the dosage and the child to whom the treatment was administered for a multiple pregnancy.

4.9.6 Delivery report subtab

This part is used to create the different delivery reports and certificates. The subtab contains a large data entry window, buttons to the right of the window to prepare the delivery report and a letters button (on the right) to print the different reports.

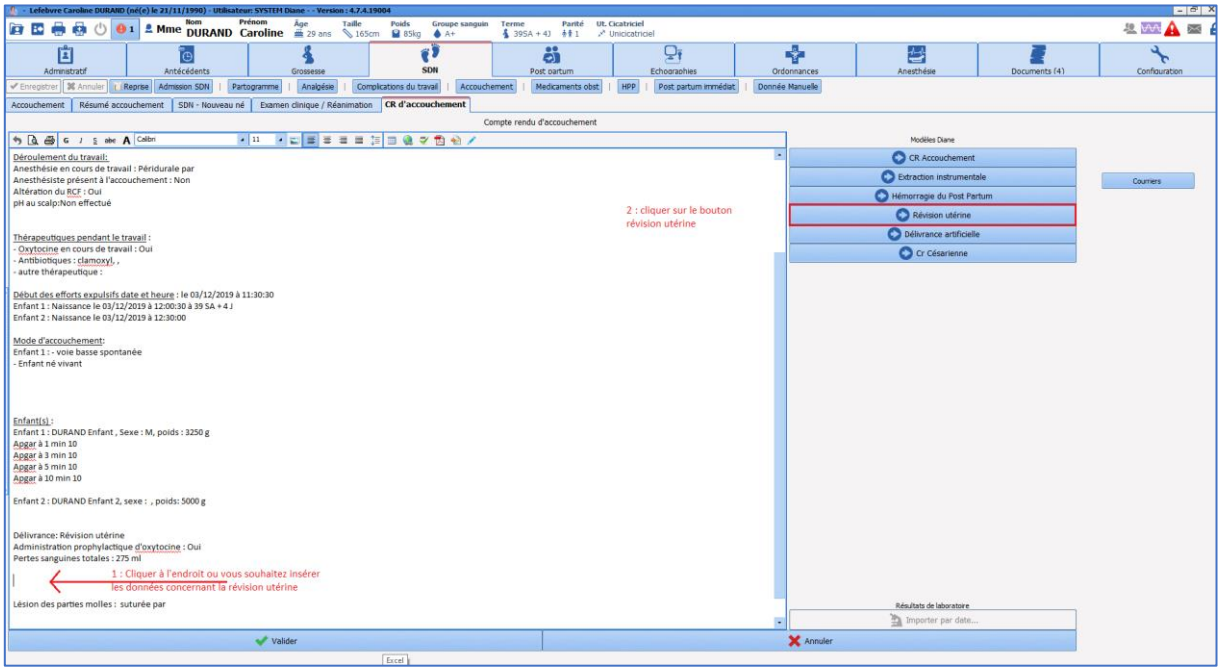
Example of a vaginal delivery: for a vaginal delivery, simply click on the **Delivery report** button. The report is automatically displayed in the data entry window. In most cases, you can simply print the report by clicking on the **Letters** button and choose: 'Delivery report'.

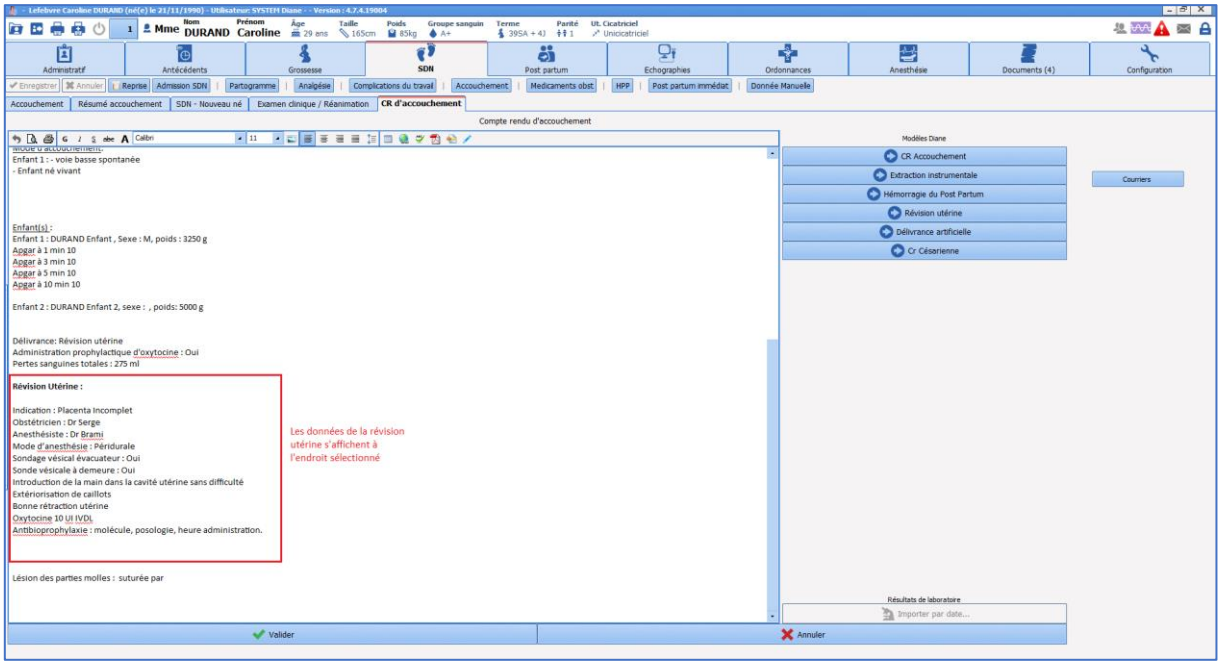




In the event of an instrumental delivery, PPH, uterine examination or artificial placental delivery, the corresponding buttons let you add specific information relating to these events.
Example of a uterine examination: click on the data entry window where you want the data to be added. Click on the **Uterine examination** button. The data will then be displayed where you want in the report.

You can then print the report.





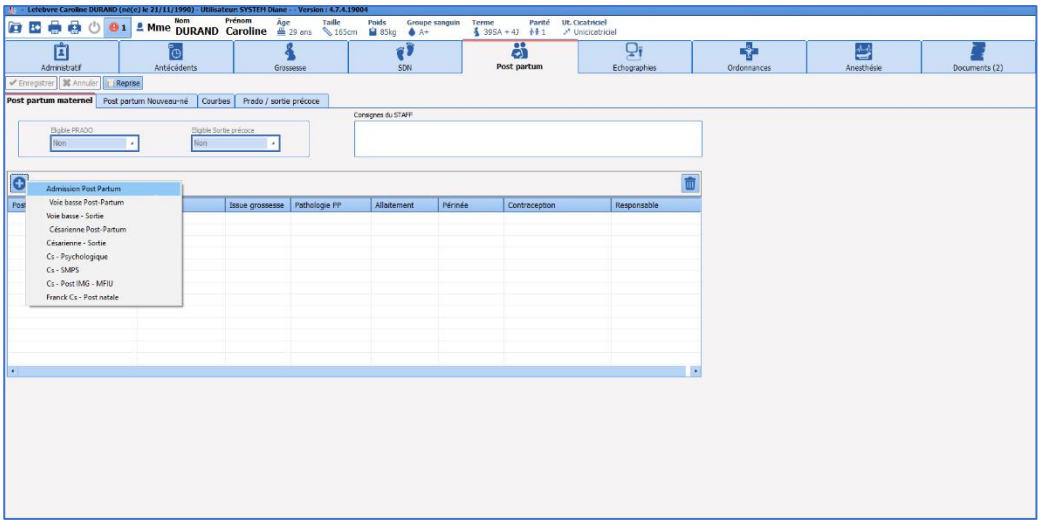
You can also print the birth declaration or the delivery report using the **Letters** button.

<u>NB: When reports are generated automatically you should check the data, which is under the responsibility of the healthcare provider.</u>

4.10 Postpartum tab

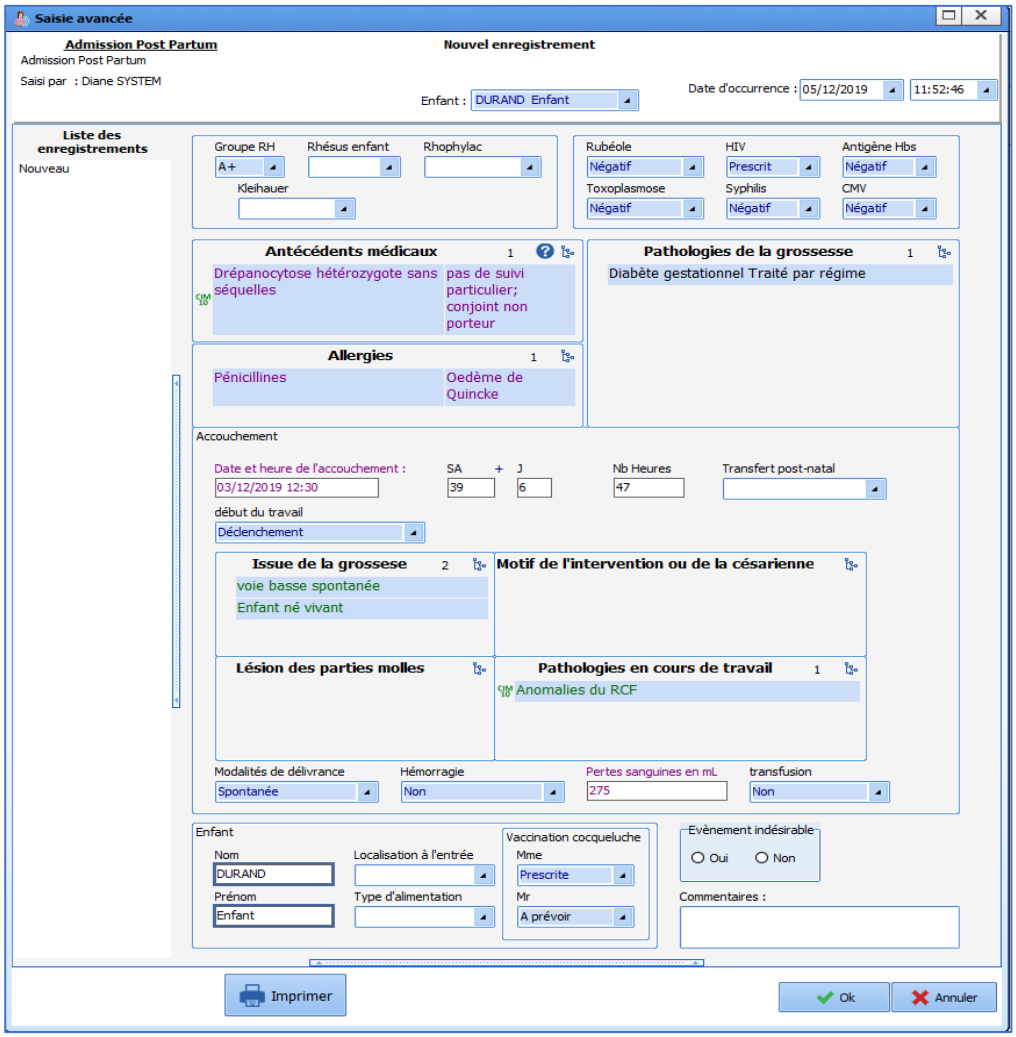
4.10.1 Maternal postpartum subtab

This subtab is used to monitor patients during the **Postpartum** stay. This subtab consists of a table for you to enter the different patient monitoring information for each day. The different detailed entries are available by clicking on the button at the top left of the table.



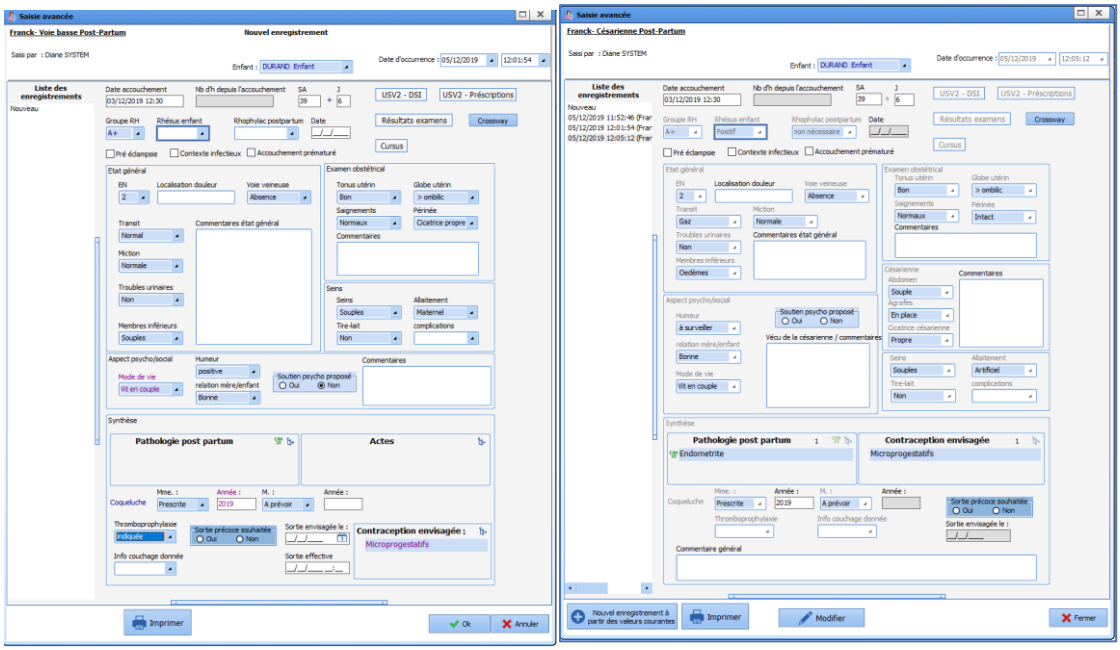
4.10.1.1 Postpartum admission

This monitoring sheet should be opened for each patient. It provides a summary of the patient's record. Most of the information is prefilled from the delivery summary.



4.10.1.2 Vaginal delivery and C-section postpartum monitoring

These sheets are used to monitor patients during their stay. The **Vaginal delivery** detailed entry is used for the follow-up of vaginal deliveries (spontaneous and instrumental extraction) and the **C-section** detailed entry is used for C-section deliveries.



The most important detailed entries are grouped together in the table of detailed entries for a quick overview. You can access the detailed entries by clicking on them.
NB: to change a detailed entry that already exists, you must click on the **Change** button at the bottom of the detailed entry. However, detailed entries can only be changed by their creator.

4.10.1.3 Vaginal delivery and C-section discharge sheet

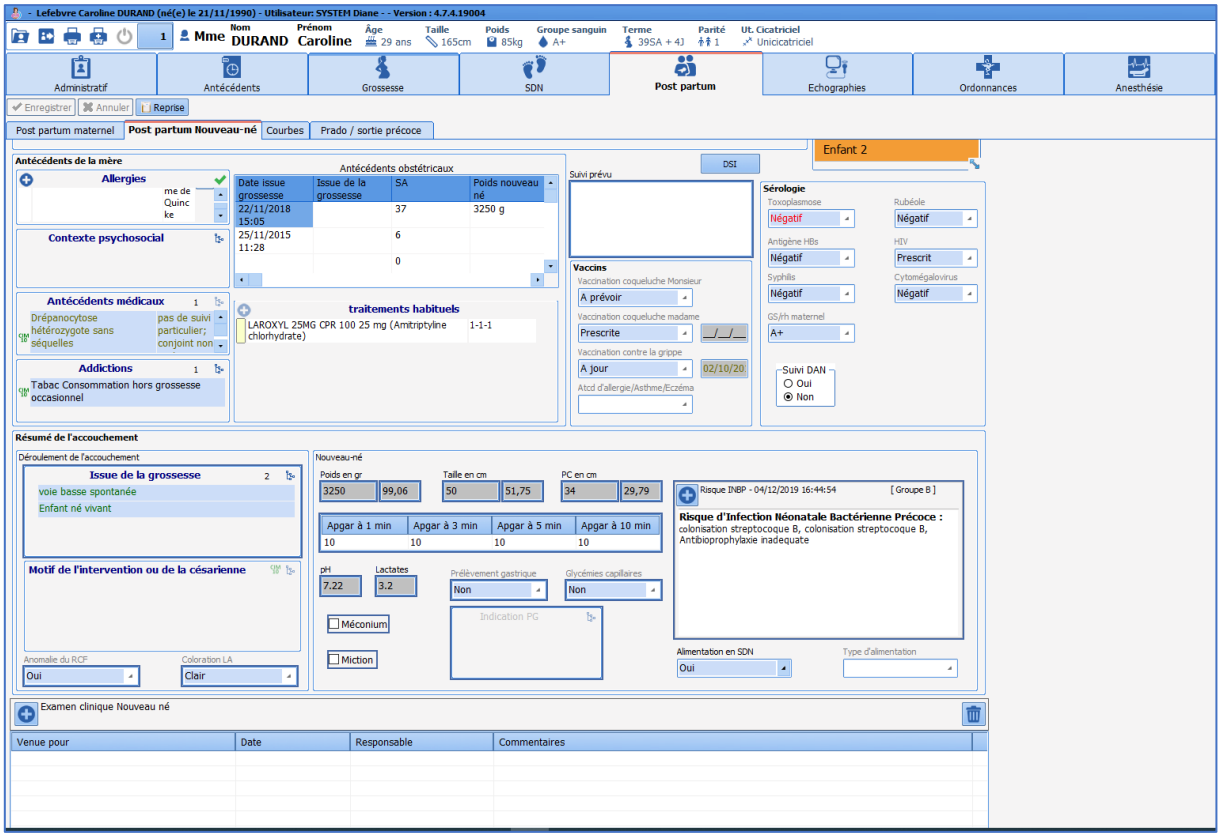
The **Vaginal delivery and C-section** discharge sheets must be completed when the patient is discharged. They are designed in the same way as the postpartum monitoring sheets but have an additional **Discharge** box for you to enter the discharge date and adverse events and generate letters. From this sheet you can generate the liaison letter for the GP. Discharge prescriptions are generated by using the **Prescription form** button.

4.10.1.4 Postnatal consultation:

The postnatal consultation is accessible from this same tab. In the same way as for the other detailed entries, you can generate the consultation report and the prescription forms from this consultation sheet. The consultation lets you fill in the data from the clinical examination and also the Edinburgh score. You can close the record following this consultation.

4.10.2 Neonatal postpartum subtab

This subtab is primarily designed for paediatricians. It gives a rapid overview of all the events of pregnancy and delivery concerning the neonate.



A table at the bottom of the subtab provides access to 2 detailed entries: **Neonatal clinical examination** (to enter the data from this examination if it is necessary during the stay) and **Discharge examination** to let paediatricians record their examination before the child is discharged.
Letters and prescription forms are accessible from these detailed entries.

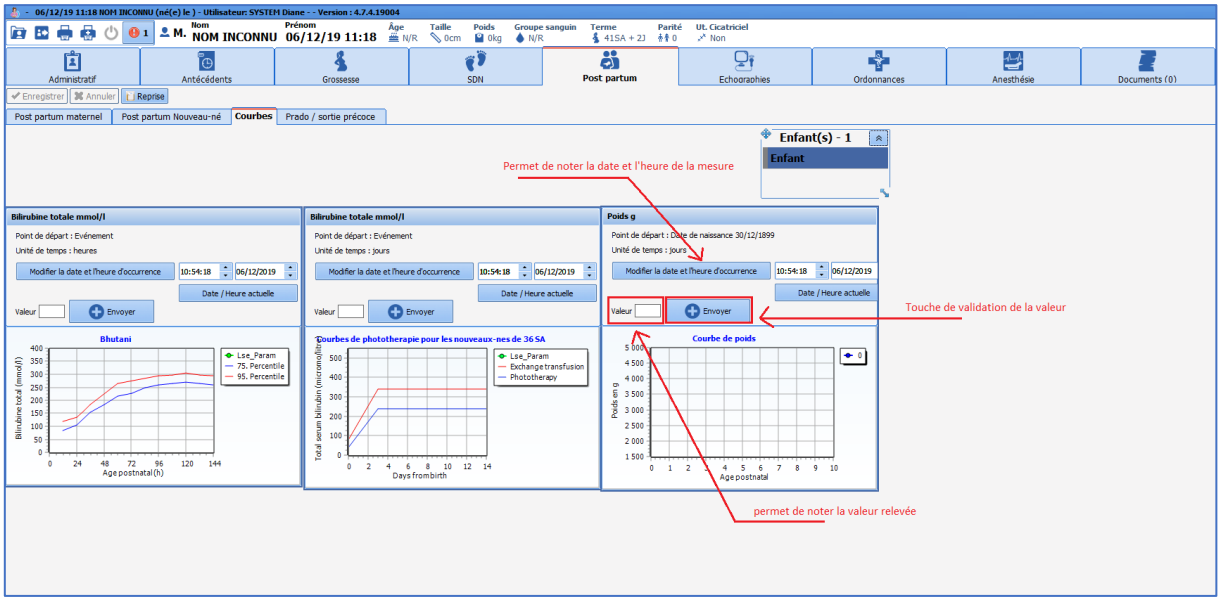
4.10.3 Curves subtab

In this window you can enter the daily weight and the bilirubin values.

To enter a value:

- enter the relevant value in the **Value** box,
- click on the **Send** button to confirm the value and display it on the curve.

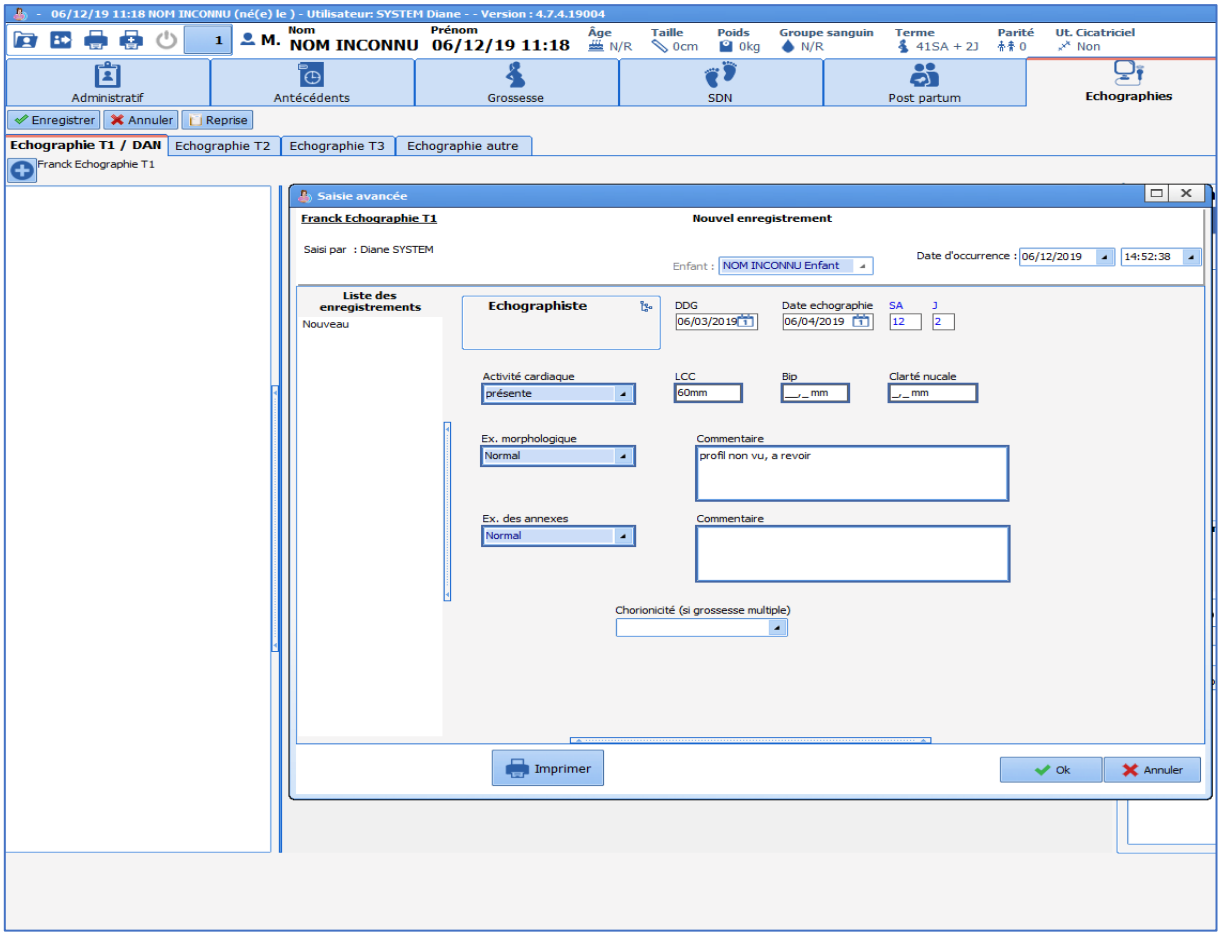
You can change the time and date of entry by clicking on **Change the date and time of occurrence** or directly in the date and time fields.



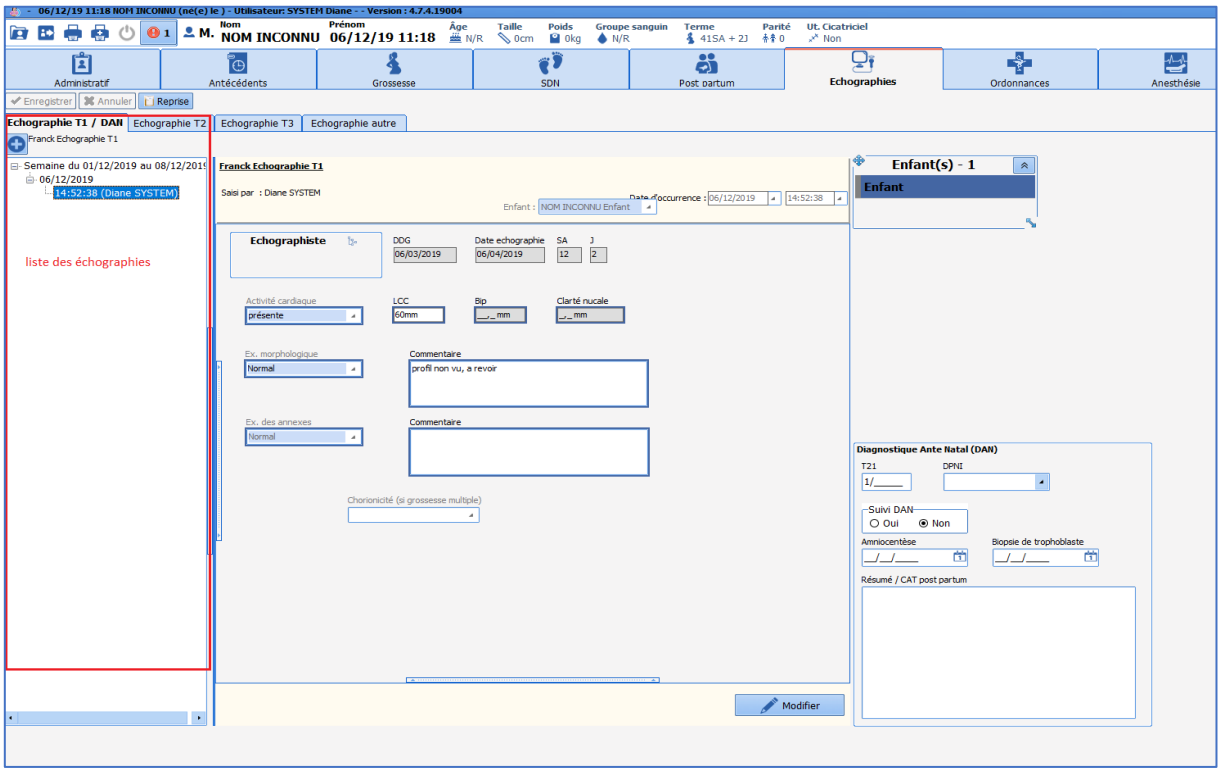
4.11 Ultrasounds tab

This tab lets you record information about the different ultrasounds. It has 4 subtabs to enter information about the 1st, 2nd and 3rd trimester ultrasounds or other additional ultrasounds.

To enter the data for an ultrasound click on the ultrasound's subtab. Click on the sign. A window to enter the data appears. Complete it and click on **OK** at the bottom of the data entry sheet.



In the column on the right, the list of ultrasounds appears. Click on the relevant ultrasound to display the data entered.

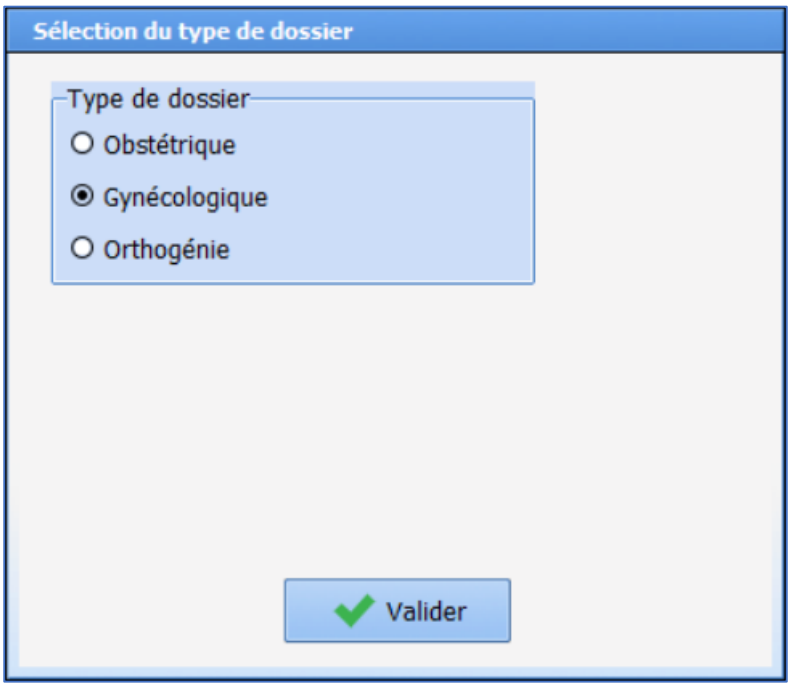


NB: The T1 ultrasound located in the **Ultrasound** tab is the same as the one in the **Pregnancy start** tab. As the gestational age calculation using the CRL is based on the CRL entered, it can be entered in either tab.

NB: Ultrasounds performed outside the maternity unit can be scanned. These will be stored in the **Documents** tab.

4.12 GYNAECOLOGY RECORD

The gynaecology configuration lets you manage consultations, hospital admission and discharge sheets, hospitalization reports and surgery reports.
When opening a record, choose Gynaecology.



In this configuration, the **Administrative**, **History**, **Gynaecology**, **Ultrasounds**, **Prescription forms**, **Documents** and **Configuration** tabs are present.
The **Administrative**, **History**, **Ultrasounds** and **Prescription forms** tabs function in the same way in the different configurations.
We will therefore only look at how the **Gynaecology** tab works in this part.
The **Gynaecology** tab consists of 2 buttons at the top of the data entry sheet. The **SR** button is used to generate the different surgery reports.

Morphology: this box lets you enter the patient's morphology in the same way as in the obstetrics configuration.
Blood: this box is used to enter the blood type and the date of the 2 blood type results.
Detailed entries table: this table is used to call up the different types of consultation. Several templates are available.

4.12.1 Gynaecology consultation

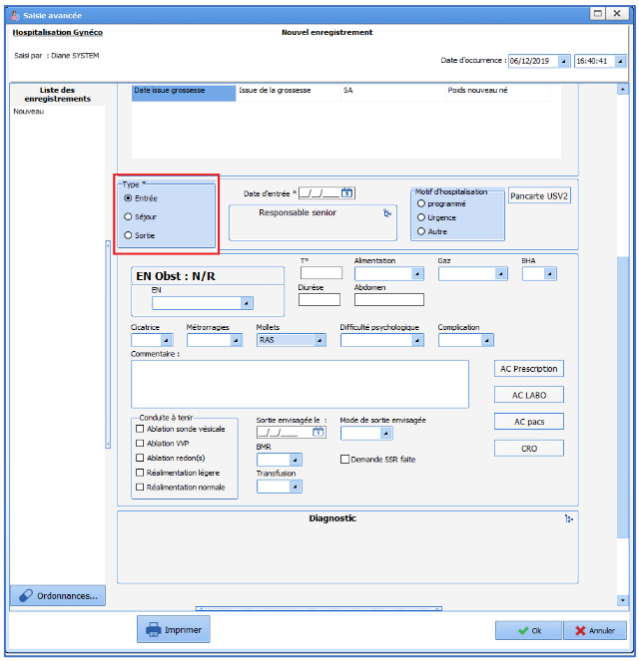
The gynaecology consultation is a simple detailed entry to enter all the data from the clinical examination. A special **Obstetric history** component provides a quick overview of the history.

The consultation is organized from top to bottom with the following sections: history, patient interview,

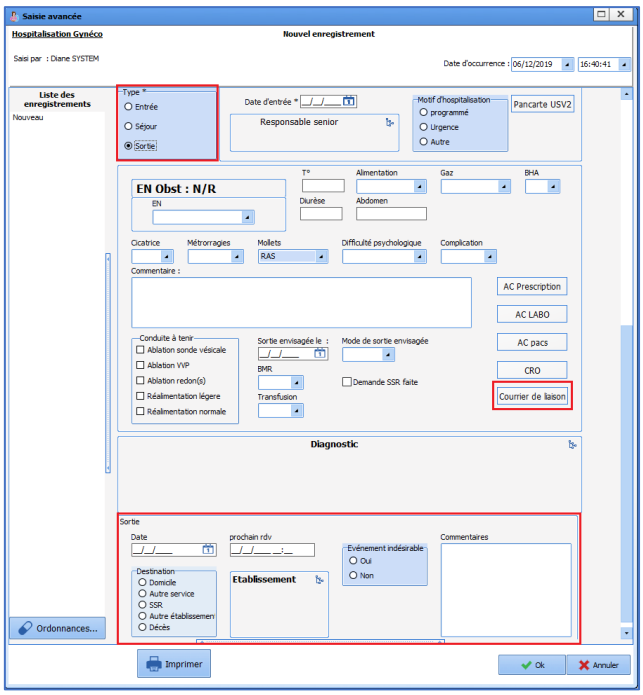
clinical examination, pelvic ultrasound, diagnosis.
You can generate prescription forms from the **Prescription form** button within the consultation.

4.12.2 Gynaecology hospitalization

This sheet is used to fill in the data when the patient is admitted and discharged. At admission, select **Admission** in the **Type** field and then fill in the data.



When the patient is discharged, use the same hospitalization sheet and click on **Discharge** in the **Type** box. A new box will appear at the bottom of the sheet to enter information about the patient's discharge. The **Liaison letter** button will appear for you to generate the hospitalization letter.



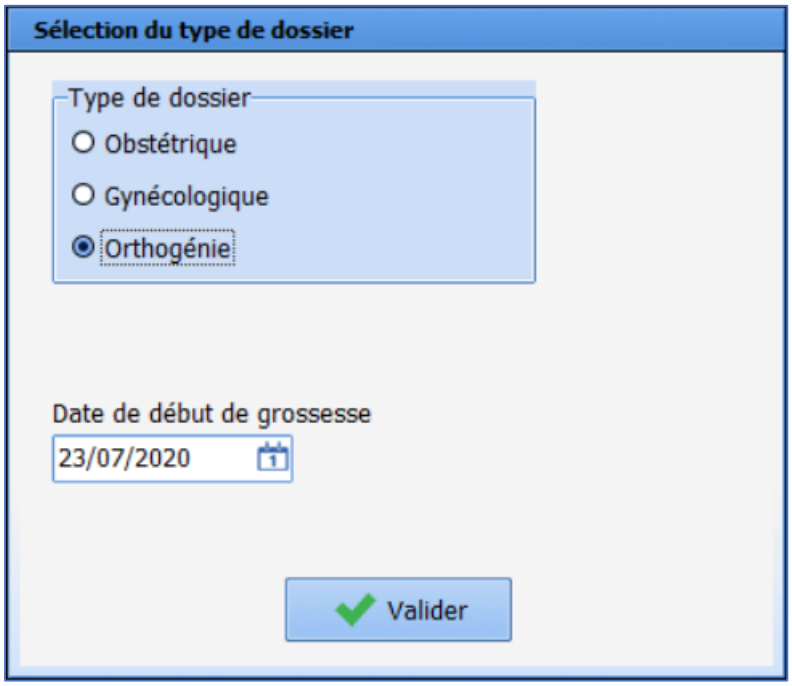
4.12.3 SC - Gynaecology acupuncture / SC - Gynaecology colposcopy

These two data entry sheets work in the same way as other detailed entries with data focused on acupuncture and the colposcopy. They do not have any particular functions.
When the patient is discharged or at the end of the consultation, the record should be closed if regular close monitoring is not foreseen.

4.13 FAMILY PLANNING RECORD

4.13.1 Introduction

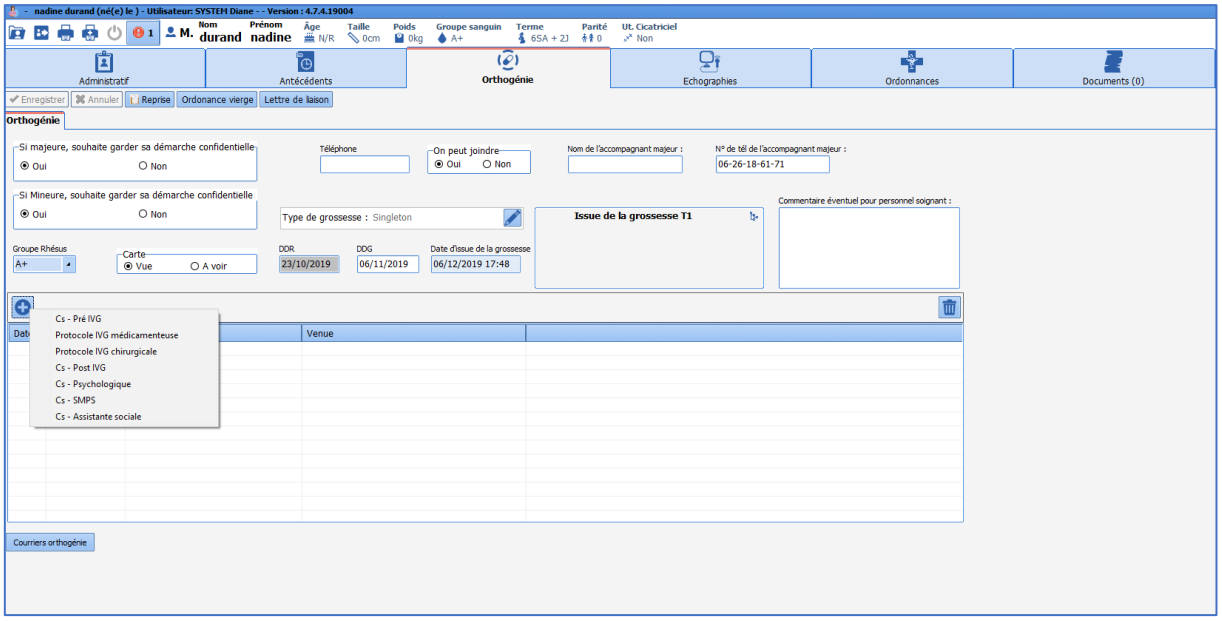
The family planning configuration allows elective abortions to be fully managed from the preop assessment to the postabortion assessment.
When opening a record, choose **Family planning**. At this stage you must enter the pregnancy start date (this can be changed later).



In this configuration, the **Administrative**, **History**, **Family planning**, **Ultrasounds**, **Prescription forms**, **Documents** and **Configuration** tabs are present.
The **Administrative**, **History**, **Ultrasounds** and **Prescription forms** tabs function in the same way in the different configurations.
We will therefore only look at how the **Family planning** tab works in this part.

4.13.2 Family planning monitoring

The top part of the family planning sheet lets you enter administrative data including information about the support person if the patient is a minor.
This part also lets you enter the outcome of the pregnancy in the **Pregnancy outcome T1** field. The data entered in this tab will be transferred automatically to the obstetric history for subsequent pregnancies.



In the detailed entries table, click on the sign to display the list of detailed entries available.

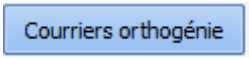
SC - Pre-abortion: the main purpose of this sheet is to collect the data from the patient interview and the clinical examination and collect the patient's consent.

- Medicated abortion / surgical abortion protocol: these 2 sheets are used to record the treatments prescribed to prepare for a surgical abortion or perform a medicated abortion.

SC - Postabortion: this consultation lets you fill in the data from the postabortion assessment.

The field automatically calculates the number of days since the elective abortion (entered in the **Pregnancy outcome date** box).

Others consultations are available: SC psychologist, first aid unit and social worker.

Under the consultation box is a call button 

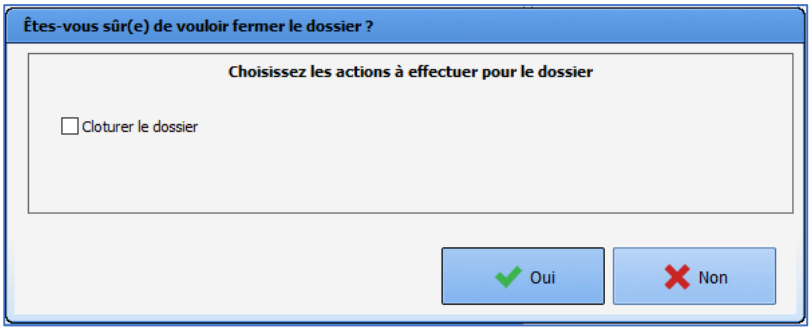
to generate the different family planning letters.

When an elective abortion record is exited, click on the **Close the record** checkbox. The record will then be finalized. The elective abortion history thus created will be automatically entered in the **Obstetric history** field during a subsequent pregnancy.

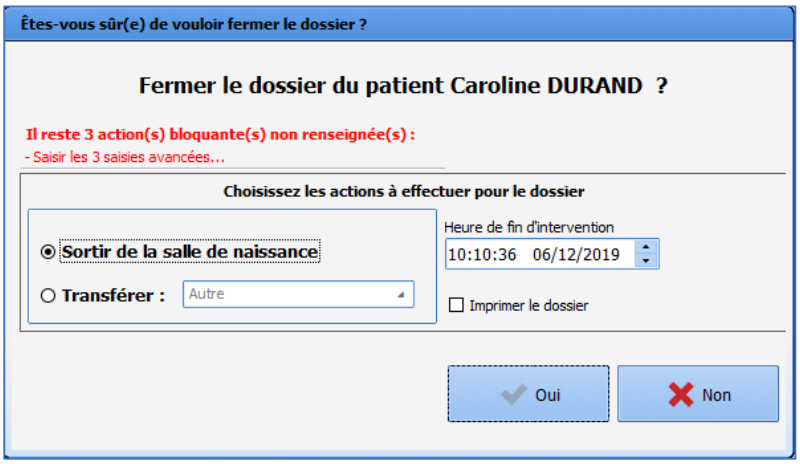
4.14 Exiting the record

A record is exited by clicking on the sign at the top left of the screen.

- **<u>In a consultation and postpartum</u>**, a window opens for you to exit the record. Click on **Yes** to simply exit the record. The **Close the record** checkbox closes the record permanently.



- **<u>In the delivery room</u>**, the same procedure opens the following window:



In red, critical actions prevent the record from being exited. These actions are the checklists that must be completed (identity monitoring and delivery room material checklist).
The **Discharge from delivery room** box lets you simply exit the record.
The **Transfer** box lets you transfer the record which can be opened in another unit (postpartum hospitalization for example). This box must be ticked after delivery when a patient is transferred to the postpartum unit.

5. DIANE ICU

The ICU module makes it possible for all healthcare providers to collect information and complete the entire patient's record. It is made up of tabs and subtabs corresponding to the different phases of medical and paramedical care.

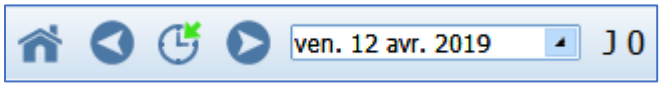
5.1 General appearance of DIANE ICU

The different parts of the software tailor the monitoring to each type of medical condition. Different components offer specific features to facilitate data collection and provide safe care.
Certain subtabs are used to collect administrative, medical and paramedical information. Specific data entry methods help to record developments and generate reports through a number of predefined templates. Also, a specific component lets you quickly enter issue-based nursing notes.
The care plan provides information about the different care provided throughout the ICU day. It also displays the various physiological and biological parameters recorded.
A comprehensive prescription tool lets you manage all the prescriptions used in intensive care.
Hybrid views let you combine a graphic display of physiological data (vitals, ventilation parameters, etc.) and therefore let you make a detailed visual analysis of the patient's clinical condition.

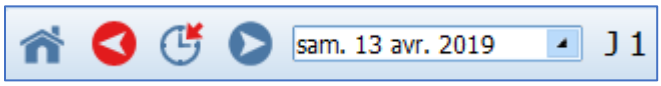
In **DIANE ICU** you browse through the different configured tabs. You can view the information contained in the patient record by clicking on the different tabs. Depending on the configuration chosen, you will not necessarily have access to all the tabs presented below and their names may be different.

Changing the time

On all of the application's tabs, you can change the time using the ribbon below.



If you click on one of the blue **arrows** you can move back or forward one day and therefore view the patient's data for that day (here, Friday, April 12, 2019).



If you click on the blue arrow button to the right, you will display the information for the next day, which is Saturday April 13, 2019.

Clicking on the **button** takes you to today. If you right-click on this button, the application will take you to the day the patient was admitted.
The drop-down menu lets you choose a specific day using a calendar.
The red items let you return to the present.

The button lets you return to the list of patients in the unit.

NB: When you change the view on one tab, the other tabs also change.

5.1.1 Top ribbon

The top ribbon is always visible on the screen and permanently displays certain information such as

- Surname, married name, first name, gender, age
- Location, service
- Length of stay
- Height, weight, theoretical weight, body mass index, etc.

On the right side of the ribbon there are different icons.

1 Procedure codes CCAM : when you hover with the mouse you can see the codes registered based on the information entered in the record. When you double-click on them, you can access the entry form for ICD-10 and procedure codes.

2 Patient-oriented email client : by clicking on the icon, you can write a message concerning the patient which will be visible when the mouse hovers over (also present on the portal). The icon turns red when there is a message in the record and turns grey again after 24 hours.

3 Data capture : dynamic icon (wave) that shows whether data from biomedical devices is captured.

4 Allergy icon: shows allergies when you hover the mouse over it.

5 Isolation icons: these icons are used to report isolation (MDRO, isolation from contact, isolation from droplets, etc.)

6 **DIANE EMAIL CLIENT** : by clicking on the envelope you have access to the **DIANE** email client to send messages.

7 Change user : by clicking on the padlock you lock the application. You or another user can log in again by entering your password in the login window located in the taskbar or by clicking on the **Change user** button on the green window that appears.

Estimated data : this icon will appear when a box has been ticked in the information window when a patient record is opened. By double-clicking on this icon you can view this estimated data and/or change it.

Other features of the top ribbon:

Today's date ven. 25 oct. 2019 Box displaying today's date by default. By changing the date, you can move to a specific date. When the box does not display today's date, it turns red.

Length of stay J 0 Counter of the patient's length of stay since being admitted with **DIANE**.

Entry of staff in charge Opens a window for you to name the team in charge of the patient (doctor, nurse, nurse aide) for the timeframe of the shift (depending on the ICU day configured: e.g. from 07:00 a.m. to 7:00 p.m.)

Take responsibility Directly names the logged-in user (choose from doctor, nurse or nurse aide) as in charge. This function is also directly accessible from the ICU portal. When someone takes responsibility the icon changes and turns green on the portal.

Staff in charge pane Aucun personnel responsable renseigné pour ce jour. Displays the function, the corresponding timeframe and the surname and first name of the persons entered as in charge of the patient (for the doctor, nurse and nurse aide categories).

Some icons specifically for containment measures may be displayed to the right of the bar:

Here are their meanings:

Airborne
Mask is mandatory

Droplets
Wear mask and goggles

Contact
Wear gloves

DI contact

CDI contact

eXDR contact

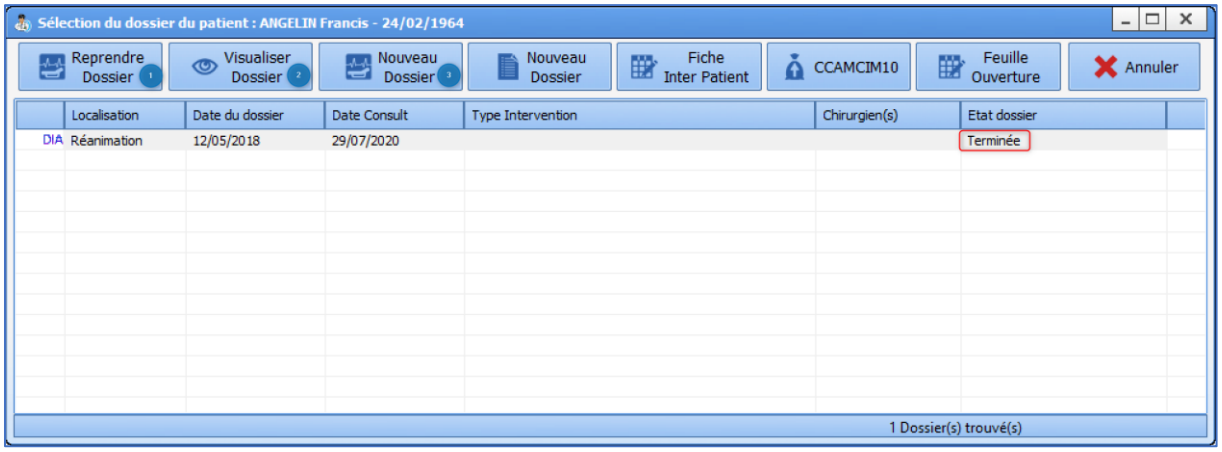
Protective

5.2 Patient admission and record selection

The patient can only be admitted and therefore the record can only be opened using the primary computer.

Click on the **Patient admission** button.

Select the patient (see chapter entitled: '*Patient selection*'). This opens the **Patient record selection** window.



This window has buttons in the header:

3. **New record:** this button is used to start a new stay in intensive care. Used to open a new record.
2. **Resume record:** this button lets you go back to a record already in use. For example: the patient is released from intensive care to the CCU; to ensure the continuity of the record, it is important to click on **Resume record**.
1. **View record:** this button is used to view the patient's old record in its entirety.

NB: When the patient already has several records in **DIANE**, the window displays at the top of the list the stay foreseen in the unit where you are; the list is then sorted by date then by the record status: completed, not completed, etc.

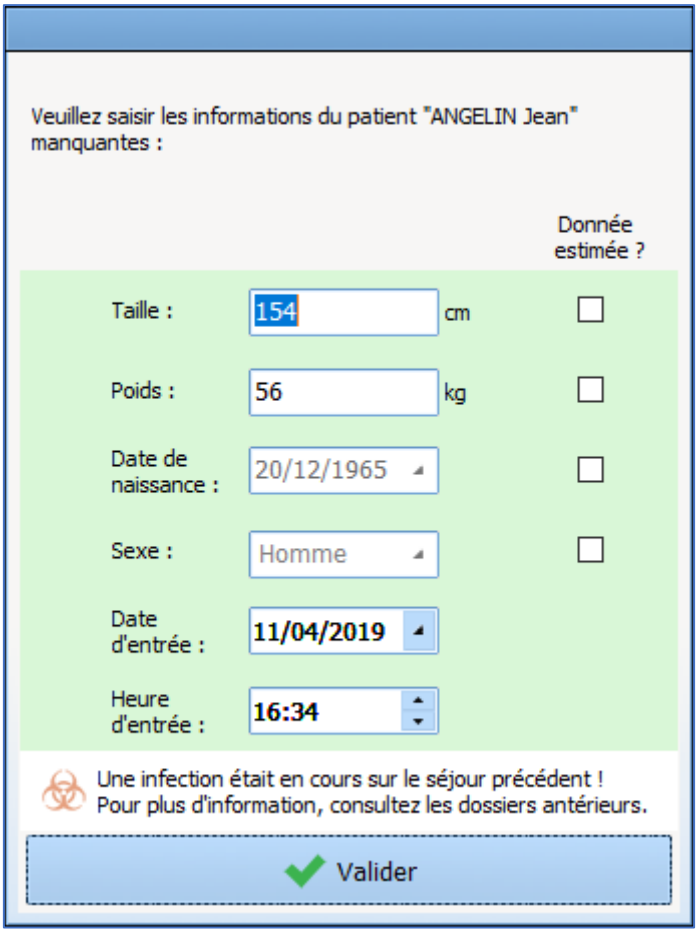
In the example above, the patient has already been in intensive care. The status of his record is **Completed**. No record is dated on the current day or has **Transfer to ICU** status, therefore the patient is not expected.

- If you click on the **New record** button this opens a window asking you to enter the mandatory data to manage the record such as the patient's weight and height.
- Enter the missing data.

Tick the **Estimated data** checkbox when you are not certain about the data. The estimated data can be completed later in the record.

- Click on the **Confirm** button.
- Loading and opening the record
- The patient has been admitted. You can start providing care.

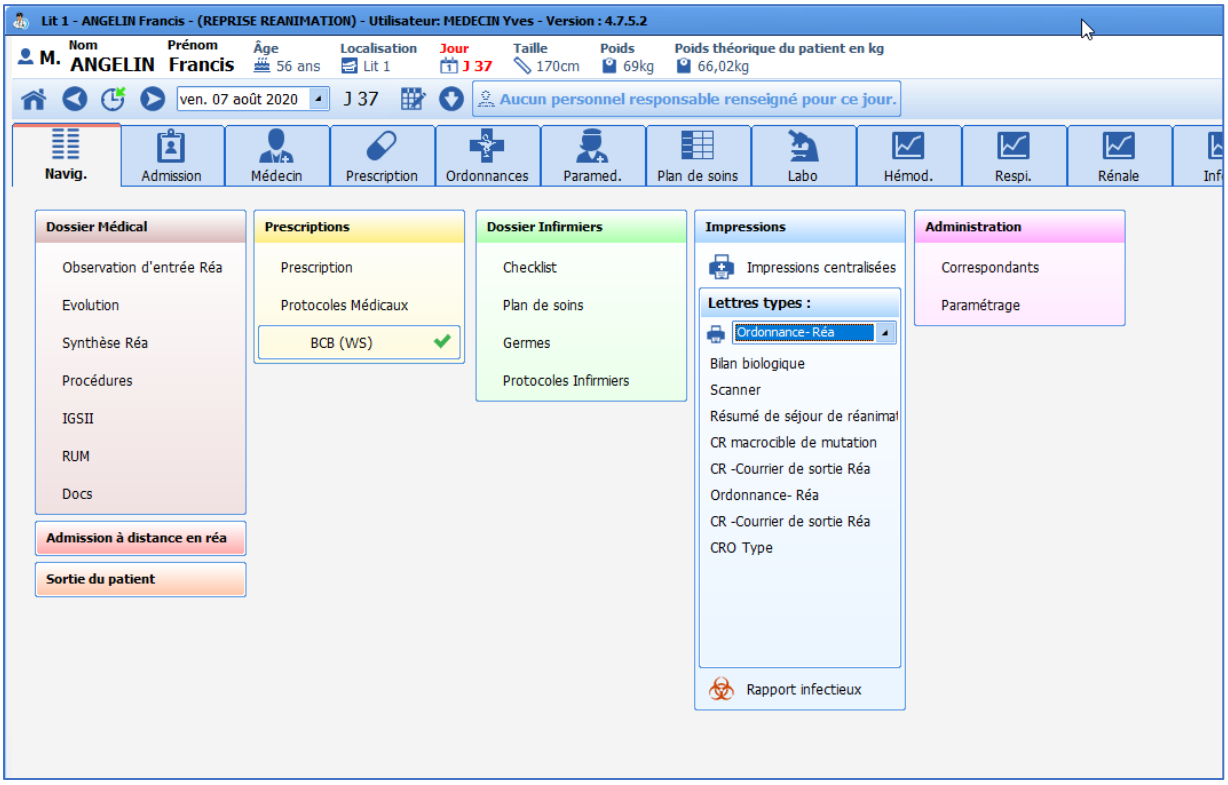
NB: If during their previous stay, the patient had an unresolved infection, the information will be included in this window.



5.3 Main menu tab

The **Main menu** tab gives access to all the application's tabs. These tabs can also be accessed directly by clicking on them.

The buttons on the **Main menu** tab are divided into five main sections, **Medical records**, **Prescriptions**, **Nurse record**, **Printouts** and **Administration**.



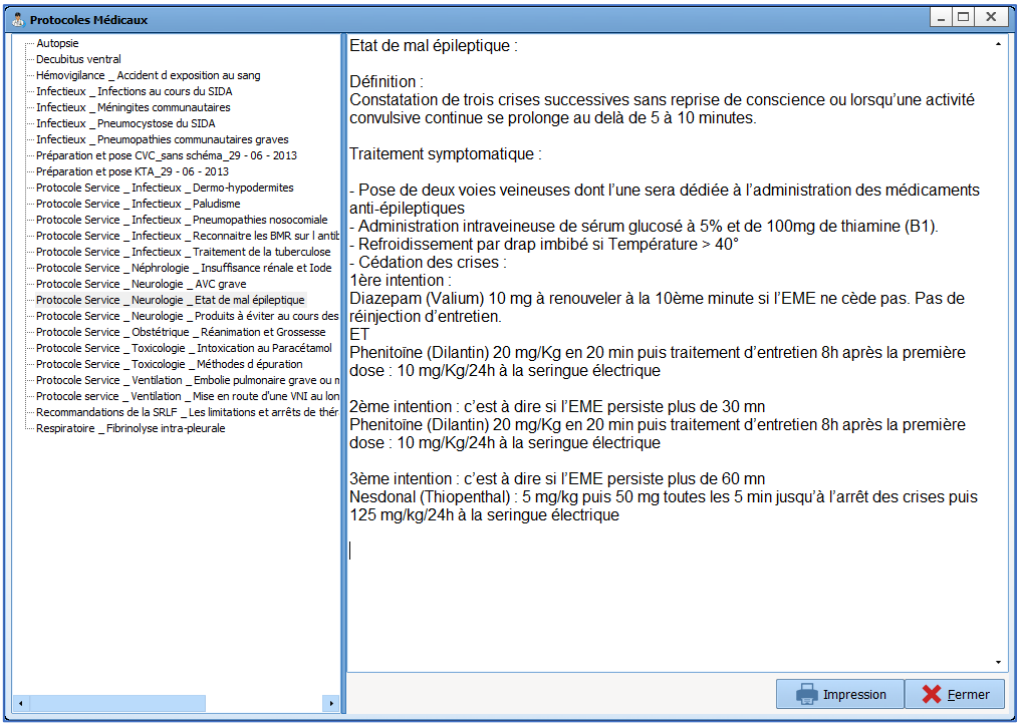
NB: Depending on the configuration in your facility, it is most likely that you will not have the same tabs displayed. You might also arrive on another tab.

NB: The **Main menu** tab is the only tab where you can discharge the patient.
To exit the patient's record, click on the **Patient discharge** button (see chapter entitled: '*Patient discharge*').

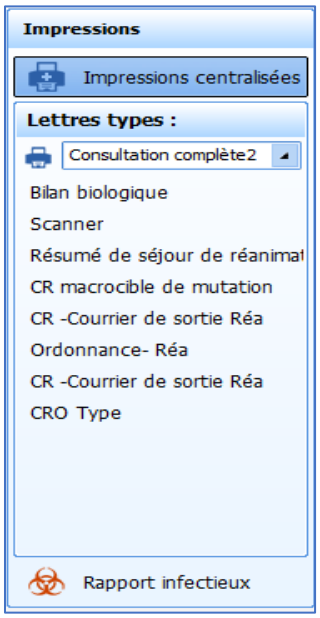
Some functions are only accessible from the **Main menu** tab such as access to medical protocols, centralized printing or patient discharge.

5.3.1 Medical protocols

This tool makes it possible to centralize the protocols used in the unit.
By clicking on **Medical protocols**, a window opens containing all of the unit's medical protocols. You can then select the protocol you want to view in the left column. It will then be displayed in the right column.



5.3.2 Printouts

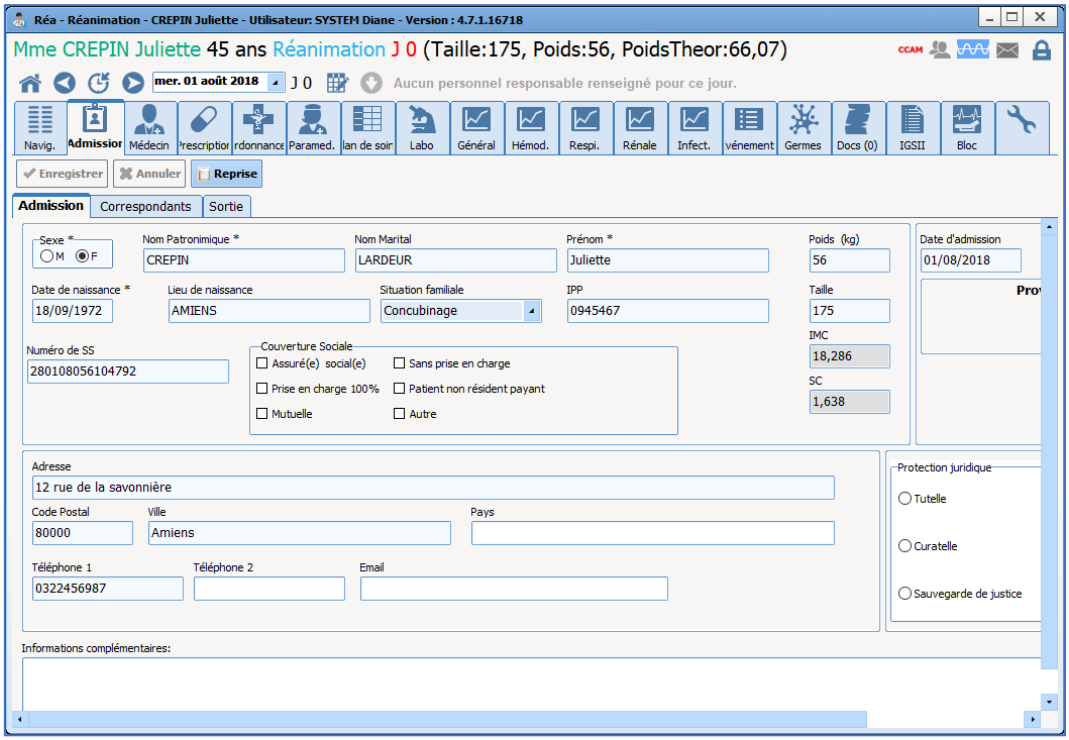


The **Printouts** column gives access to centralized printing (see chapter entitled: '*Centralized printing*')
It is also possible to directly create and print certain reports or letters by clicking on them.

The infection report makes it possible to generate a document summarizing all the patients who presented with an infection during their stay, such as a pneumopathy, catheter colonization or bacteraemia.

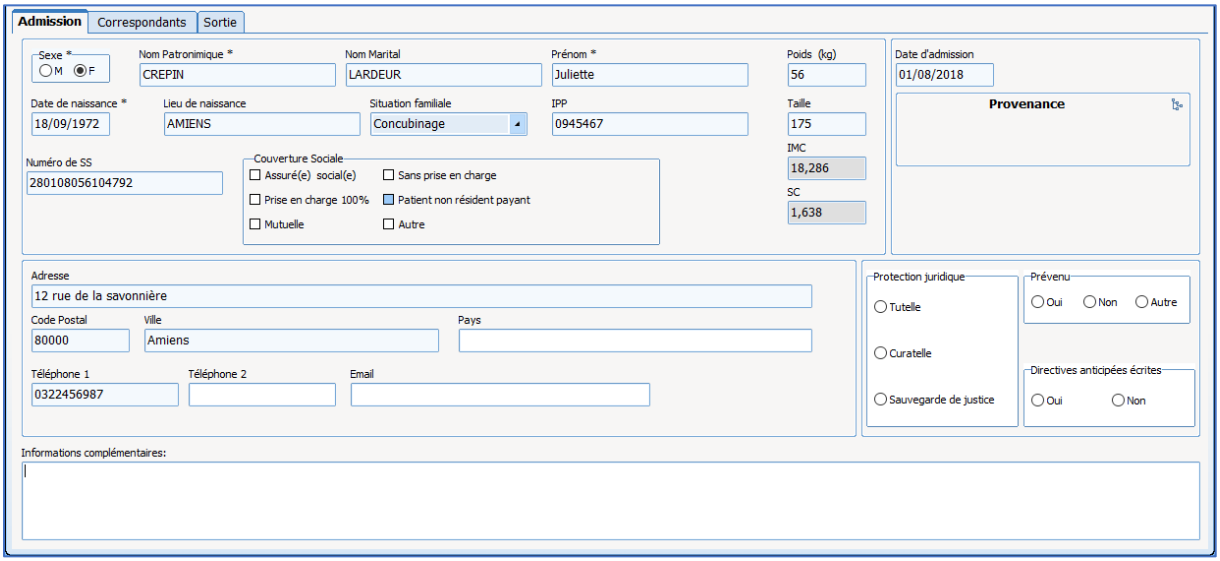
5.4 Admission tab

This tab contains the administrative aspects of the patient record from admission to discharge.



5.4.1 Admission subtab

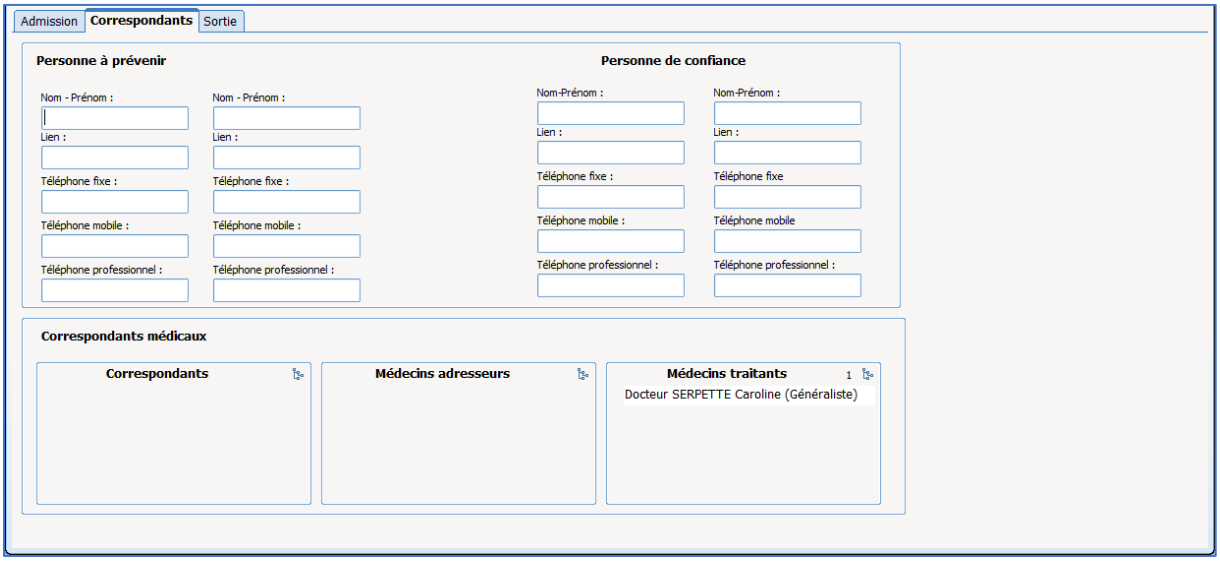
The **Admission** subtab lets you collect the patient's administrative information such as civil status or special preventive measures (guardianship, legal protection, authorization to operate on minors, etc.)



Most of the time, most of this information comes from the electronic health record and therefore does not need to be completed. In this case, this information cannot be modified. If a patient is registered in **DIANE** without creating the patient identity in the electronic health record, the information can be completed directly from this tab. In this case, when the patient identity has been created in the EHR, the software will offer to merge the records.

5.4.2 Correspondents subtab

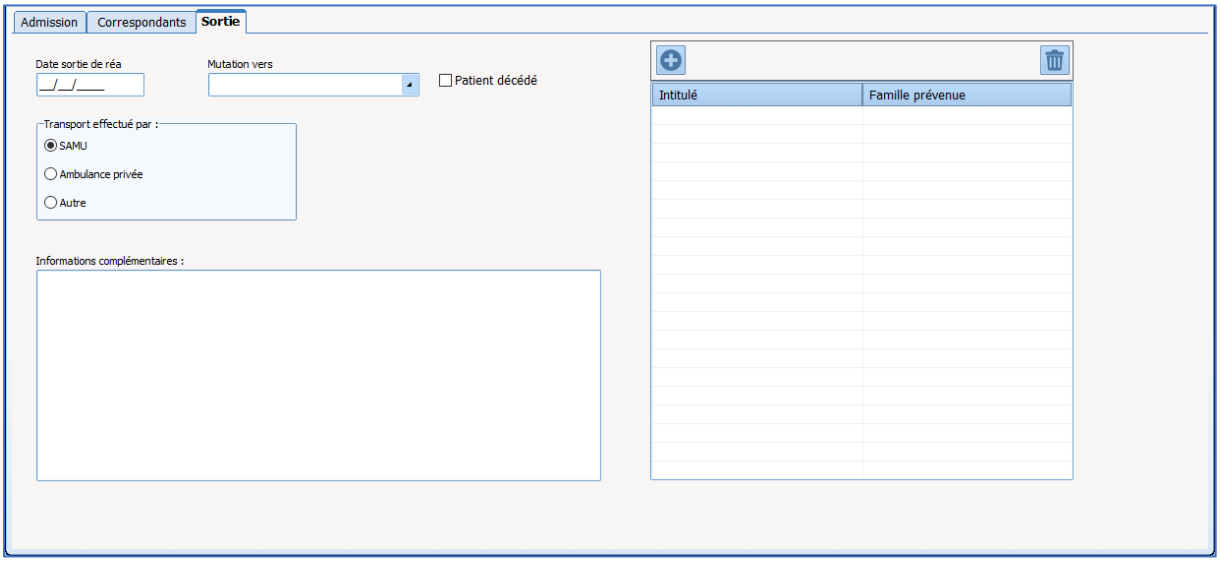
This tab is used to document all known information about the patient's correspondents. This information can be used in the reports to send letters and hospitalization reports.



5.4.3 Discharge subtab

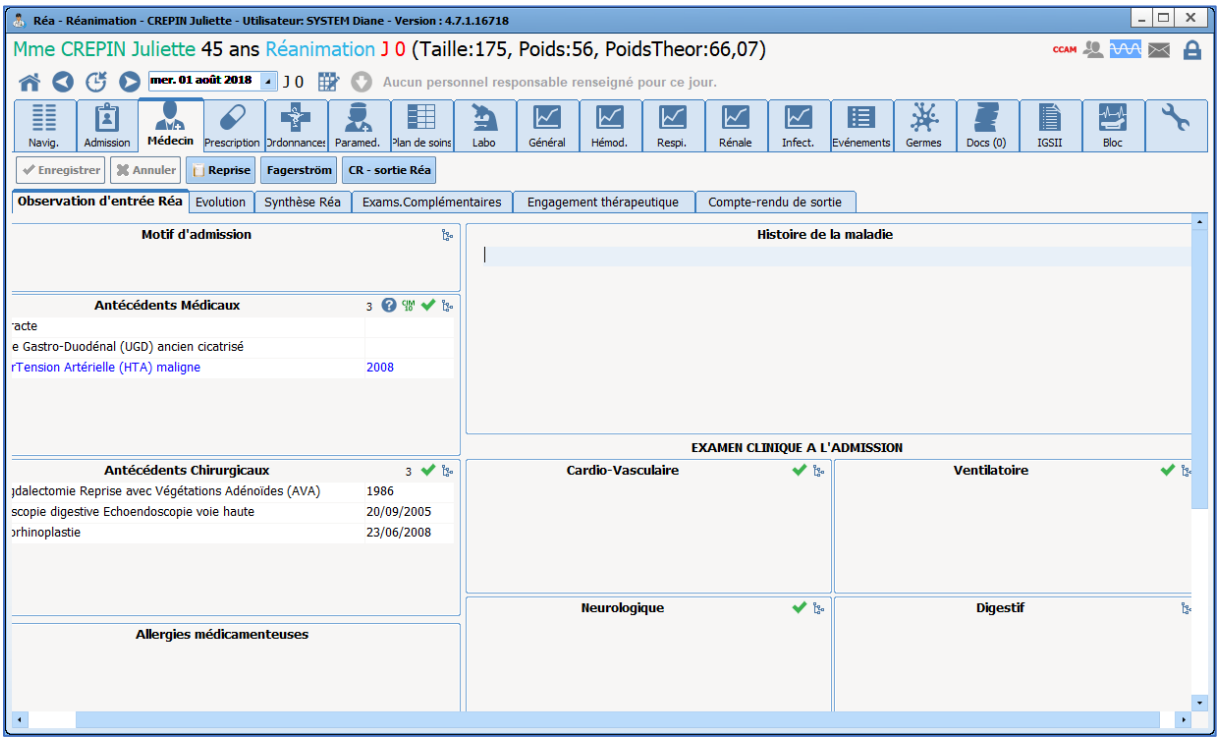
This subtab lets you record how the patient is discharged, for example where they are transferred to, transportation method, etc.
The **ICU discharge date** field cannot be filled in manually. It is completed automatically when the record is closed (or transferred).

REMINDER: the record is discharged via the **Patient discharge** button in the **Main menu** tab. The subtab presented here simply lets you enter certain data when the patient is discharged but not actually discharge the patient.



5.5 Doctor tab

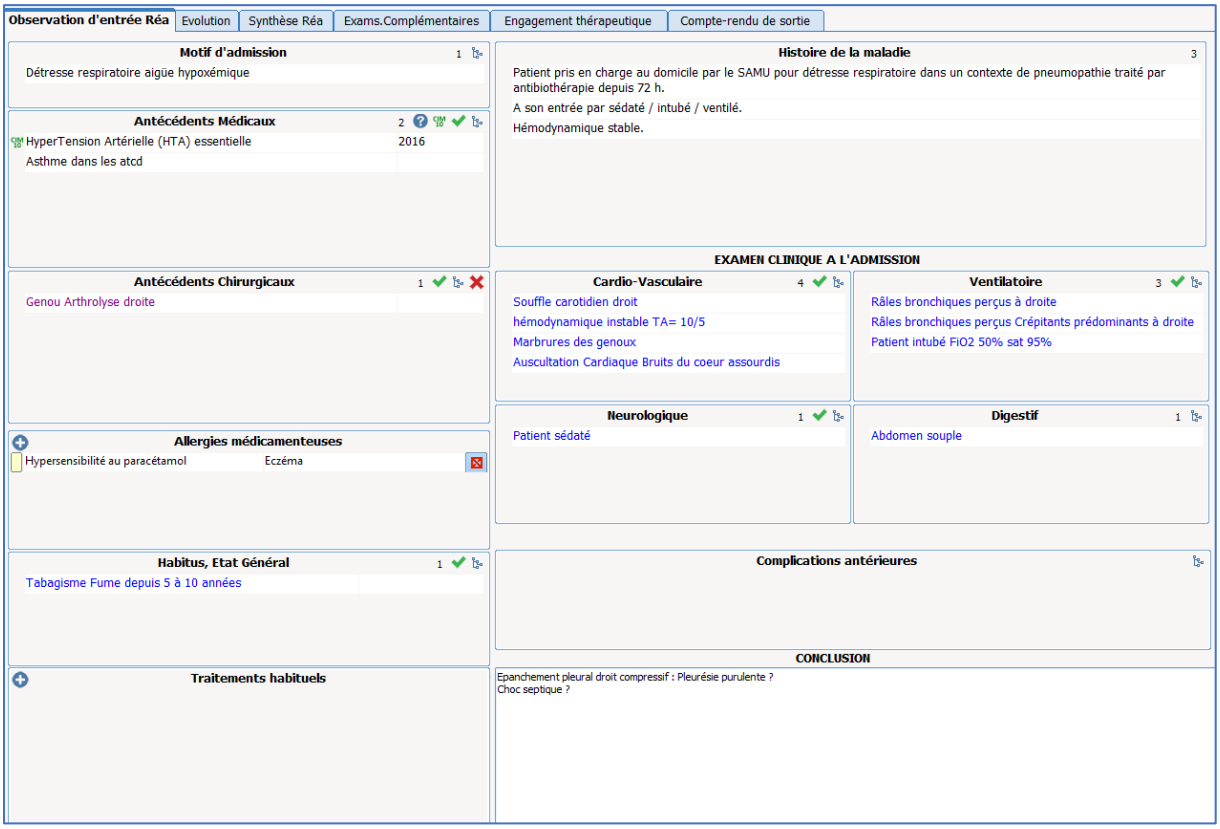
The **Doctor** tab is used to enter data from the patient interview, the clinical examination, hospitalization follow-up information and to prepare reports.
This tab is made up of several subtabs that are described in the next chapters. Some data from these tabs is available in the paramedical tabs. They are often programmed to be read-only so that medical data can only be completed by doctors.



5.5.1 ICU admission observations subtab

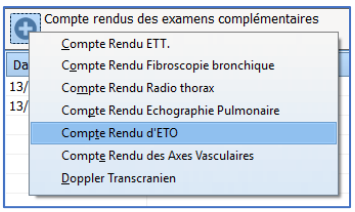
This subtab lets you enter the reason for admission, the patient's medical and surgical history, allergies and also the patient's usual treatments.
This subtab also lets you enter the history of the condition and the admission clinical examination manually. Some of this data (in particular the history) may come from previous records if the patient has already been monitored using the **DIANE** software.
Most often, these fields can be completed using lists of items accessed directly in each field. It is better to use the lists rather than enter the data manually, as this will facilitate matters for queries and clinical studies.

The chapter entitled '*Ways to enter data in DIANE*' explains how to use these fields.

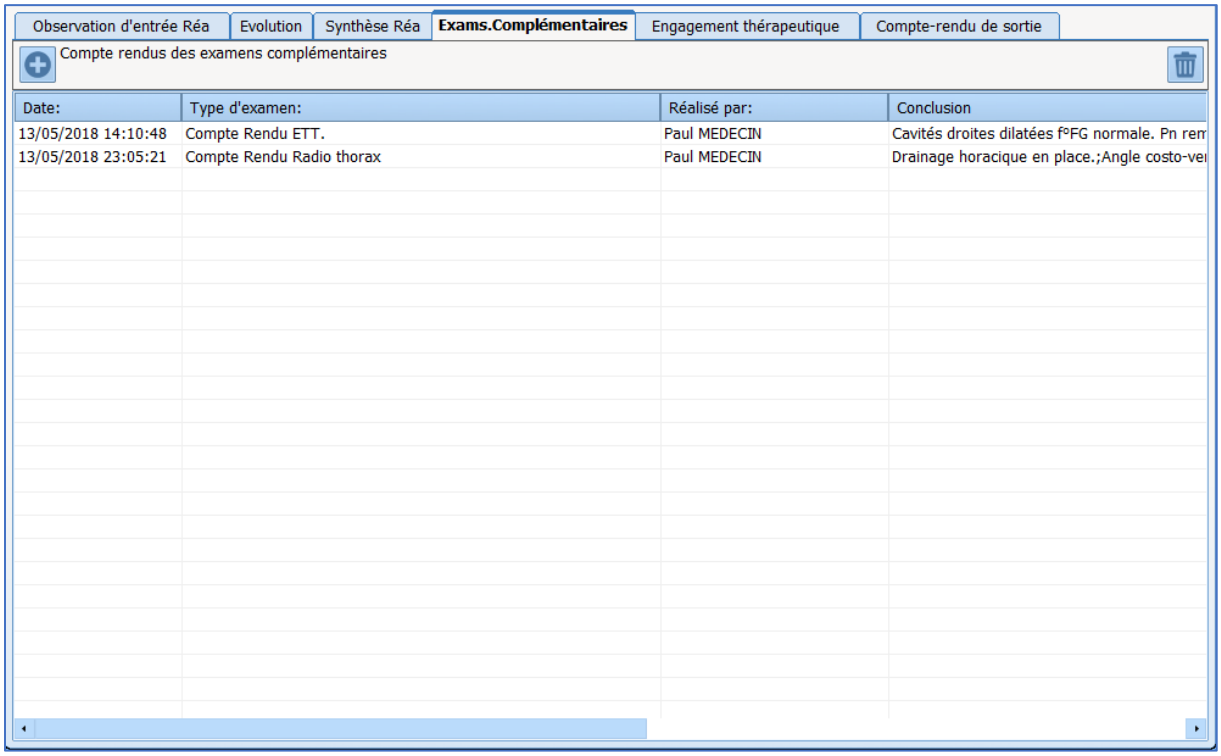


5.5.2 Further examinations subtab

The **Further examinations** subtab is a table for calling up different sheets to enter the results of the different additional examinations carried out in the unit. You can, for example, enter the results of a transthoracic ultrasound or a fibreoptic bronchoscopy.
To call up a data entry sheet, click on the icon at the top left of the table and then choose the relevant further examination using your mouse.



Then all you have to do is enter the data in the corresponding sheet. Once the data has been entered, click on **OK**. The sheet will close.
Some data is visible in the table, which lets you see all the examinations performed on the patient. Then simply click in the table, on the line you want, to see all the data.



5.5.3 Changes, ICU summary and Discharge report

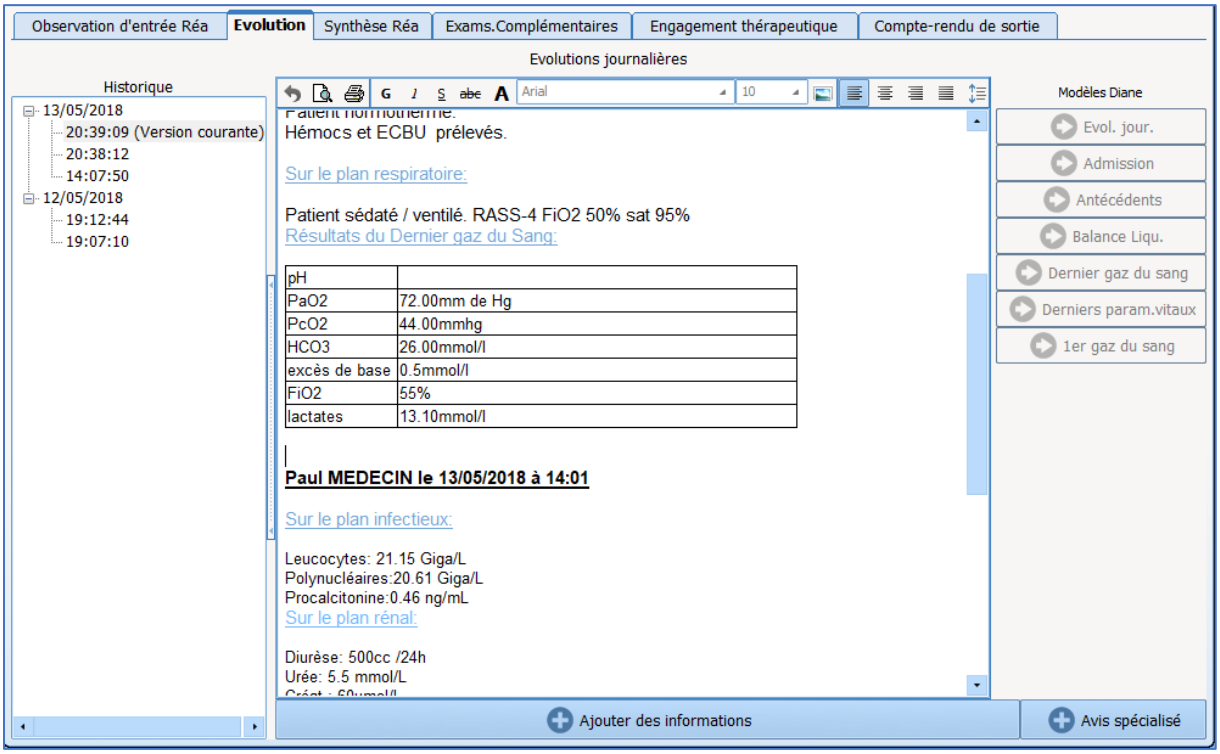
The **Changes**, **ICU summary** and **Discharge report** subtabs are used to generate documents (see chapter entitled: *'Document creation area'*). These components let you enter information manually while importing preconfigured templates. This method lets you incorporate data from the record such as vitals, history and lab results.

5.5.3.1 Example of the Changes subtab:

This subtab lets you record changes to the patient's medical data on a daily basis.
Depending on the settings:

1. Click on the **Add information** button at the bottom of the component then click inside the field. The user's first and last name and the date and time of data entry are automatically displayed.
2. A template can be displayed immediately when you click inside the component. Then simply enter the data.
3. On the right of the component, there are buttons to call up templates containing data taken directly from the record. Click where you want to be in the data entry field then click on the relevant button (for example: **Fluid balance**). The data will be entered automatically where you need in the field.

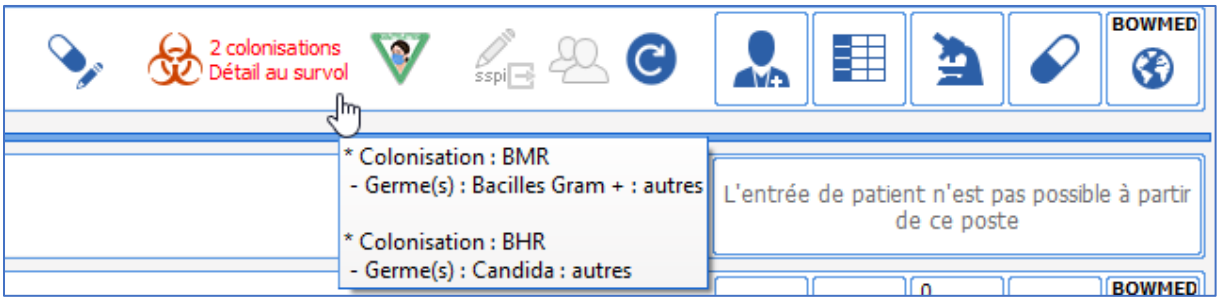
It is therefore possible to compile a daily report of the patient's clinical progress.



* **Integrated text editor**: for long and formatted text entries (bold, italics, colours, preconfigured templates, etc.)

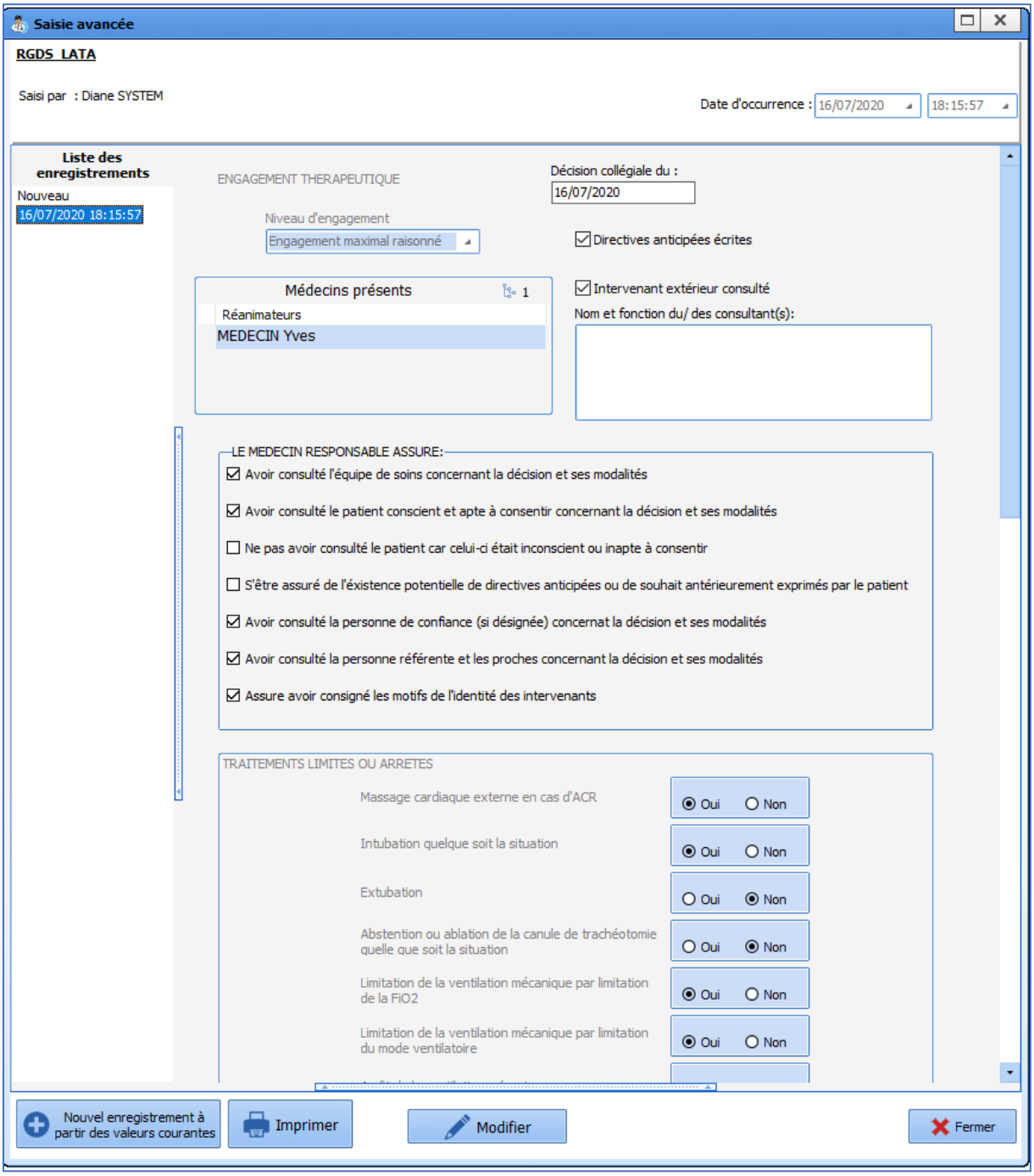
The **ICU summary** subtab works in the same way and lets you compile a summary of the patient's daily changes.

The **Discharge report** subtab works in the same way and lets you compile the patient's discharge report. The report can be printed from the **Main menu** tab and/or directly exported to the electronic health record.



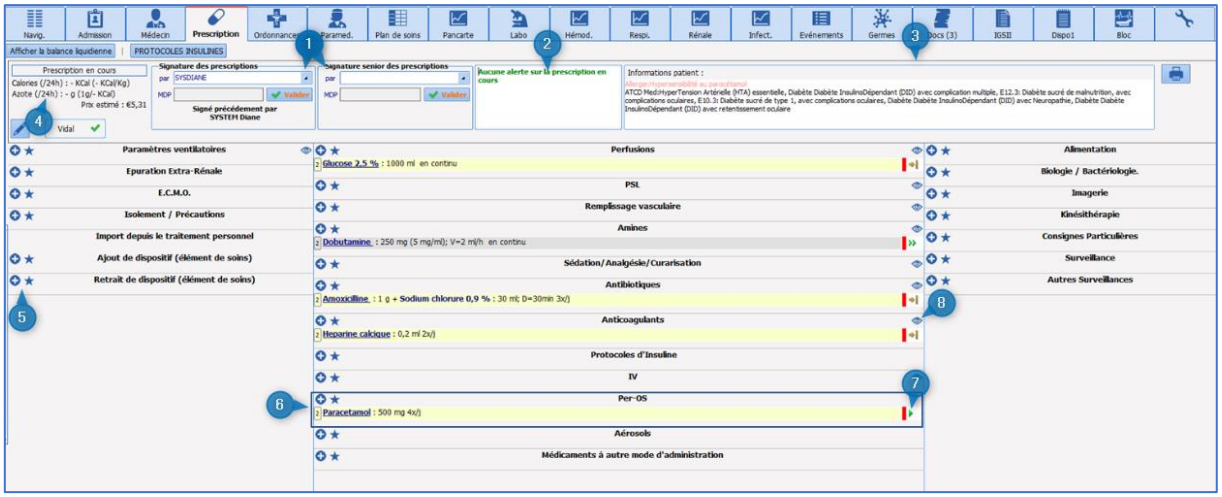
5.5.4 Limitation of Therapeutic Effort (LTE) subtab

This subtab includes one or more tables to call up data entry sheets and enter information about the level of therapeutic effort by the medical teams.
The data entered will be visible in the summary table to see the information easily.



5.6 Prescription tab

The **Prescription** tab allows users with application permissions to prescribe any necessary procedures or treatments for the patient. Signing prescriptions lets you generate the care plan.



The prescription tab is made up of different boxes called **Prescription fields** (e.g. IV, oral, etc.) to easily see current prescriptions.

1: Prescription signature: this box lets you validate the prescription

2: Prescription analysis: this box is used to create automatic warnings about potential drug incompatibilities, overdoses or allergies.

3: Patient information: this area is for feedback about the patient such as history or allergies.

4: Calorie and nitrogen calculation: this area lets you see the estimated number of calories over 24 hours and the quantity of nitrogen in the current prescription.

5: this area to the left of each prescription field is used to prescribe the relevant drugs, care or monitoring. The '+' sign opens the prescription window and the star sign gives direct access to prescription favourites.

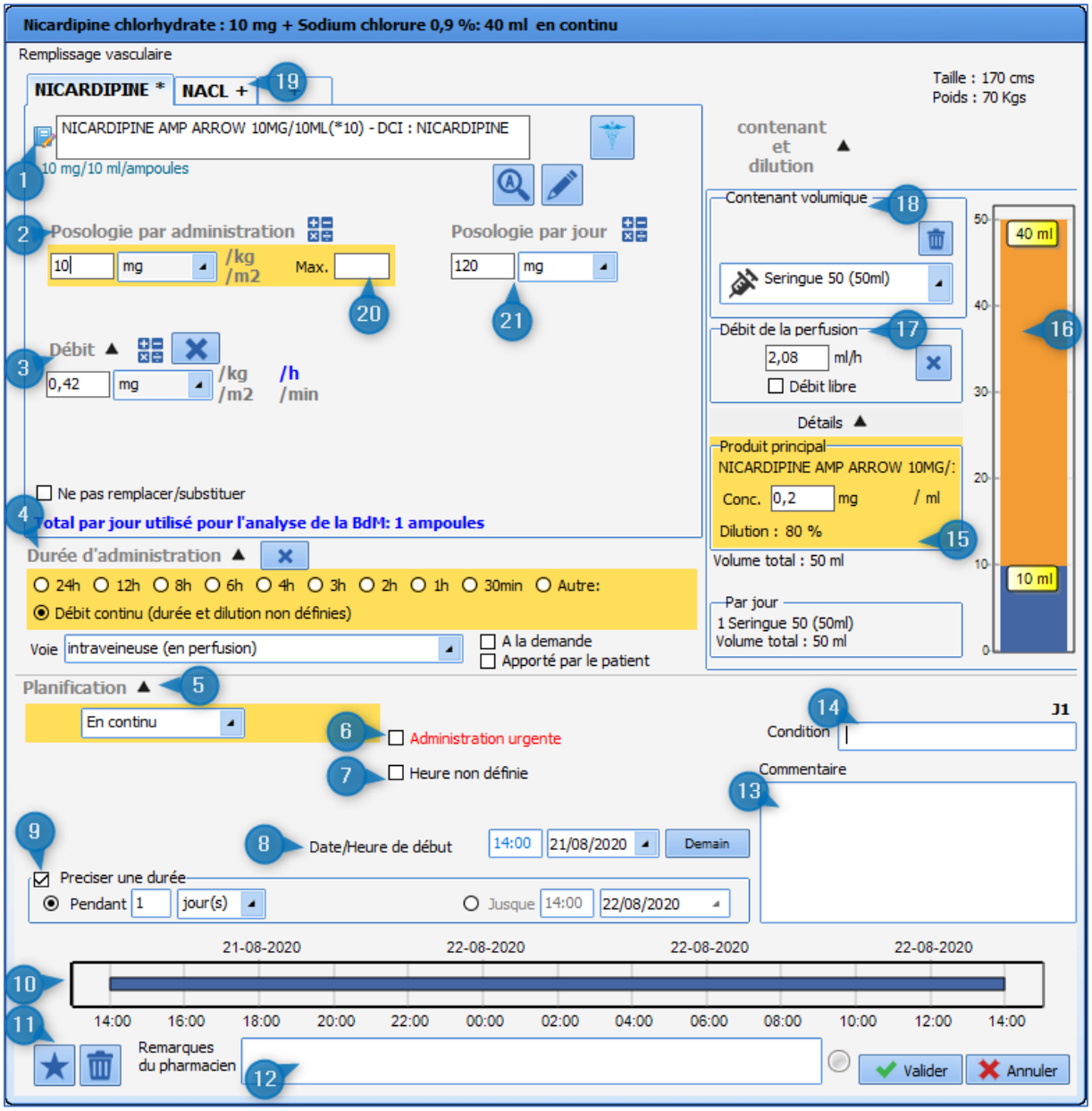
6: Prescription field: a prescription field is an area that groups together several prescriptions of the same type. For example, the **Antibiotics** prescription field is used to prescribe all antibiotics.

7: Prescription status: this area to the right of each prescription field is used to show its status using an icon system.

8: Contextual information indicator - eye: this provides information about the patient when you hover the mouse over it. For example, you can directly see the vitals or the latest lab results to help prepare the prescription.

5.6.1 Prescription window

Clicking on the '+' sign to the right of a drug prescription field opens the prescription window.



1 Product selection: this box lets you choose the product and its pharmaceutical form (e.g. Nicardipine: 10 mL ampoule containing 10 mg). When you start typing the letters in the input field, the list of corresponding drugs (from the facility's formulary and/or the drug database) appears. Simply choose the product and pharmaceutical form you want.

2 Dosage per administration: this box lets you choose the quantity of drug per dose. It is possible to change the unit (mg, drops, etc.) via the drop-down menu. You can adjust the dosage according to weight, body surface area or duration by clicking on **kg**, **m²**, **h** or **min**, to the right of the input fields.

NB: changing this box automatically changes the flow rate and dosage per day boxes.

3 Flow rate: this box is used to change the flow rate of the drug in units (mg, g, drops, etc.). In the case of an infusion using a syringe pump, the flow rate in mL/h (for example) is entered in the **Infusion flow rate** box (17).

4 Duration of administration: this box is used to enter the duration of treatment. If you choose 'continuous flow', it means that there are no interruptions between the different administrations.

5 Schedule: this box lets you enter the frequency of administration of a treatment (e.g. every 8 hours, single injection, etc.).

NB: to avoid prescription inconsistencies, when 'continuous flow' is selected in the duration of administration box, the schedule box will automatically display 'continuous'.

6 Emergency administration: this checkbox is used to show in the care plan, using the icon, that the treatment is administered in an emergency. The prescription summary font colour will be red.

7 Undefined time: this checkbox means you do not have to schedule a treatment start time. In the care plan, the nurse will be able to schedule the time of the first dose of treatment, which will automatically shift the following doses, maintaining the interval between each one. (For example: if Lovenox 4000 IU/24h is prescribed in the afternoon but injections are usually given in the unit at 7:00 p.m., the nurse can change the injection time and all the injections will be scheduled for every evening at 7 p.m.). This will also make it possible to schedule injections 6 hours after a patient comes out of the OT for example.

8 Start date/time: this box is used to schedule the date and time the treatment starts.

9 Specify duration: this box is used to specify the duration of the treatment (e.g. Clamoxyl 3 g/day **for 5 days**). You can also schedule the day the prescription should stop.

10 Chart display: this area shows the frequency of administration of the prescribed treatment in chart form. A solid blue bar means continuous administration (such as an infusion for example) and a treatment administered 3 times a day will be shown as 3 blue lines, each one every 8 hours.

11 Delete and favourites box: the 'bin' icon lets you delete the prescription being written and start from scratch. The star icon lets you create a favourite. For a prescription to become a private favourite (i.e. only visible to the user who created it), just click on this icon then click on **Private favourites**). Users with the necessary permissions can create a 'public favourite' that will be available to all prescribers.

12 Pharmacist's comments: prescriptions created in **DIANE** are checked by the pharmacist who can make comments that are visible in this section. Their level of importance can be shown using a coloured ball. The comment will be visible in the prescription summary area.

13 Notes: lets you enter notes about the prescription that will be visible in the care plan.

14 Condition: lets you specify a condition for the prescription (e.g. if systolic blood pressure > 16 mmHg).

15 Details: this area lets you see certain details about the content of a syringe or infusion bag (concentration of the drug after dilution, volume infused, etc.)

16 Dilution chart: this area shows the volume of each ingredient in the syringe as a chart.

17 Infusion rate: this area lets you enter the flow rate of a dilution in mL/h. Changes to this field modify the dosage per day (21), dosage per administration (2) and flow rate in mg/h (3) fields.

18 Volumetric container: this box lets you choose the type of container for IV administration (syringe or infusion bag) and its volume.

19 Diluent tab: this tab lets you combine several products in the same infusion. You must open one tab for each product. This can be used, for example, to combine ions in a base.

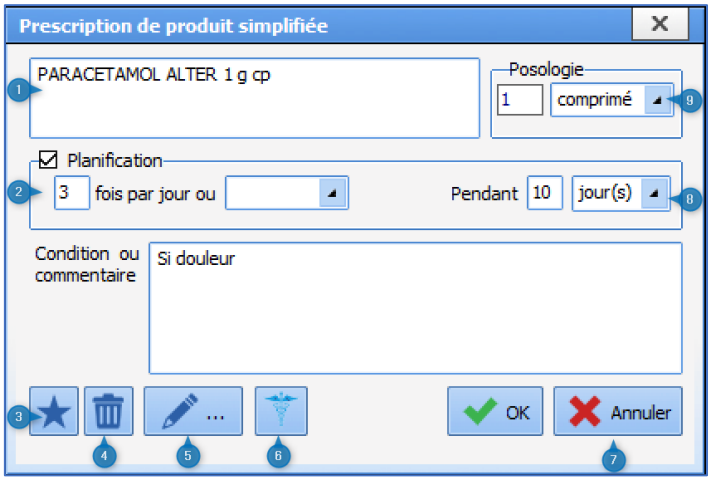
20 MAX: this field is used to limit the prescription to a maximum dose.

21 Dosage per day: this field is used to enter the daily dosage. This is calculated automatically when you enter

the dosage and frequency of administration of a treatment or enter the dosage and rate of an infusion.

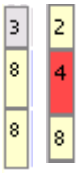
5.6.2 Simplified prescription pane

For oral treatment prescriptions you can use a simplified prescription window.
The *prescribing oral treatment* chapter describes how this works.



1 Product selection
2 Schedule
3 'Favourite' button
4 Bin icon
5 Pencil icon
6 Caduceus icon
7 Confirm / cancel prescription
8 Duration of treatment
9 Dosage

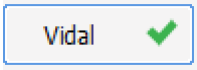
5.6.3 Prescription field icons



This box preceding the text in the prescription line shows how many days this prescription line has been active.
It can also be orange to show that there is an interaction on this prescription line (if you hover the mouse over it, the details of the interaction will appear).
It is blue-grey when this entry contains unsecurable units because the dosage of at least one product has been changed or could not be retrieved from the drug database due to incompatible dosages.

5.6.3.1 Drug database report:

The **DIANE** application is connected to a drug database to try to prevent interactions, overdoses and allergies.

The green icon 

next to Vidal or BCB shows that they are successfully connected. If this icon turns red, contact your IT team to reconnect.

A summary of the drug database report is displayed in the top ribbon of the **Prescription** tab. This tab is colour-coded as follows:
Red: allergy warning.
Orange: dosage, interaction, contraindication and medical condition warning.
Black: redundancies and precautions for use.

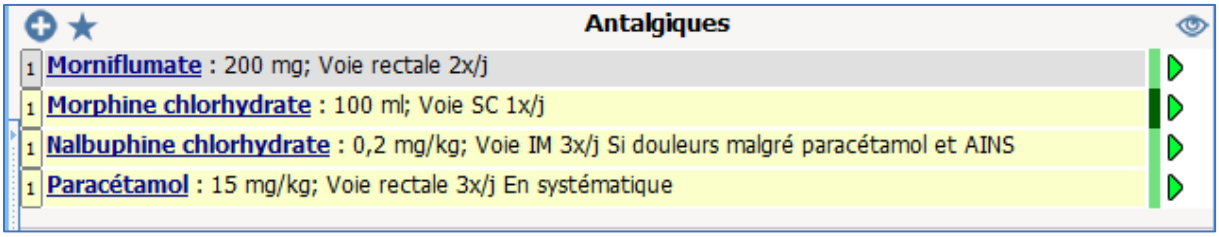
A colour code is also used in the prescription line to easily find the product(s) that triggered the warning.
The background colour of the prescription line depends on the drug analysis report:
- **Orange** interaction indicator: product interacts with another, interaction not recommended.
- **Red** interaction indicator: product interacts with another, interaction contraindicated.

- **Mauve**: product redundant with another.
- **Yellow**: product confirmed.
- **Grey**: product not found in the drug database.
- **White**: line not included in the drug database report.

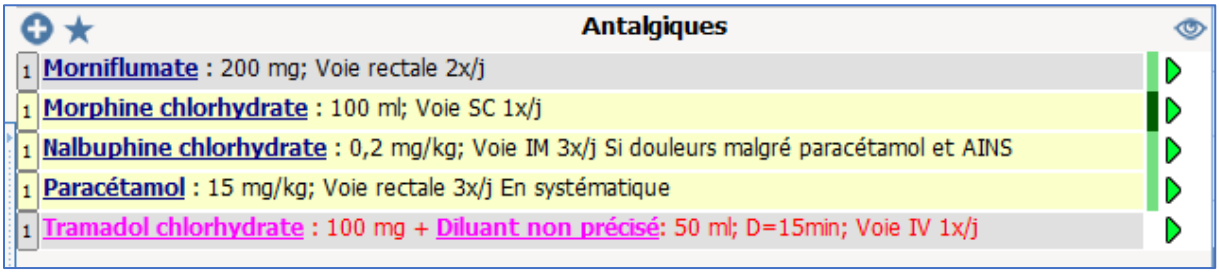
5.6.3.2 Colour coding of prescriptions:

The normal colour for a prescription is **Dark blue** for the main product and black for additional information. Clicking on the summary line opens the prescription creation window to view or change it.

When the prescription is signed the red bar turns green.



The dark green bar means a prescription has just been changed.
The light green bar means a current prescription.



The pink line means a verbal prescription administered by the nurse. This must be confirmed by the doctor.

5.6.3.3 Meaning of the icons to the right of the prescription lines:

: Current prescription.

: Current prescription without a scheduled end date.

: End scheduled (finished soon) – Scheduled to end that day. The prescription will be considered finished when the date and time have elapsed and will not be retained the following day.

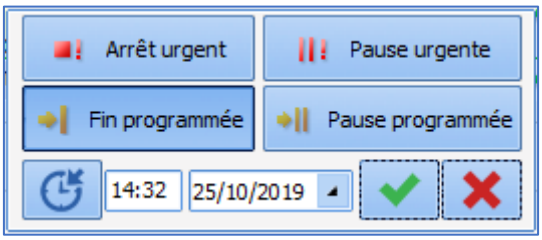
: Pause scheduled (pause soon) – Paused scheduled that day. The prescription will be considered paused when the end date and time have elapsed and will be retained over the coming days if its status does not change.

: Prescription finished

: Prescription paused

: Urgent stop – Unlike a typical stop, an urgent stop means that all occurrences with a '**To do**' status (including occurrences prior to the current time) will be removed from the care plan when the doctor signs.

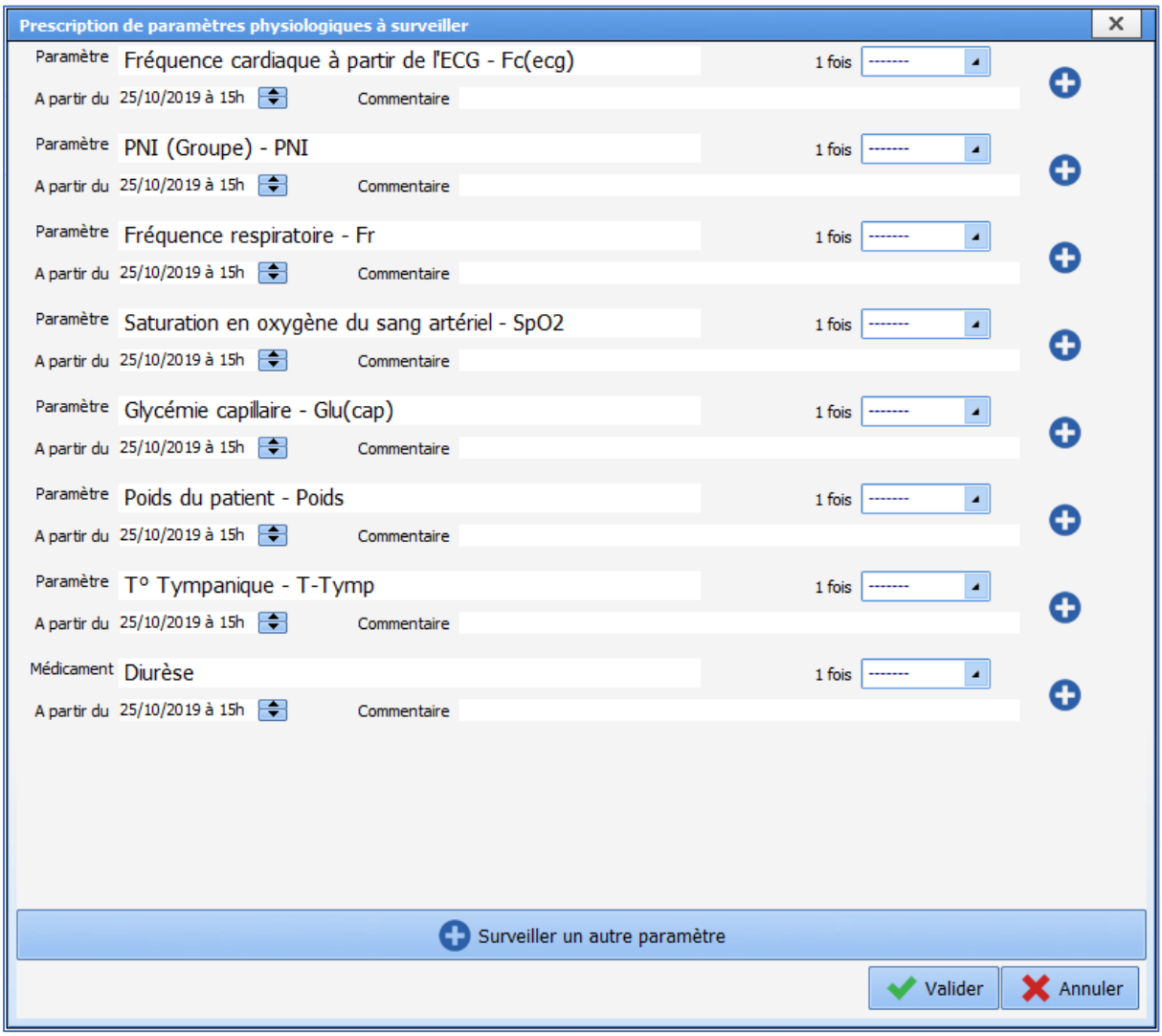
: Urgent pause – Unlike a typical pause, an urgent pause means that all occurrences with a '**To do**' status (including occurrences prior to the current time) will be removed from the care plan when the doctor signs.



By clicking on this icon you can stop, pause or restart a prescription.

5.7 Prescription examples

5.7.1 Prescribing clinical monitoring



To prescribe the monitoring of physiological parameters, you can add as much physiological data as you wish and choose from the monitoring frequency choices in the drop-down menu.

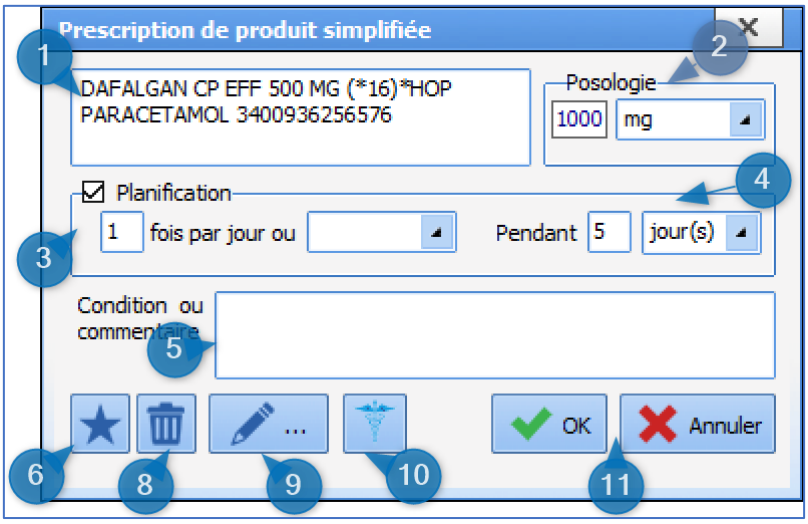
NB: once prescribed, you cannot (for now) remove a parameter from the list to reduce the amount of information in the window. Choose the 'zero' frequency to prevent the parameter from being displayed in the prescription.

5.7.2 Prescribing drugs

5.7.2.1 Prescribing oral treatments

Example: *prescription for Paracetamol 1 g X 3/day for 3 days.*

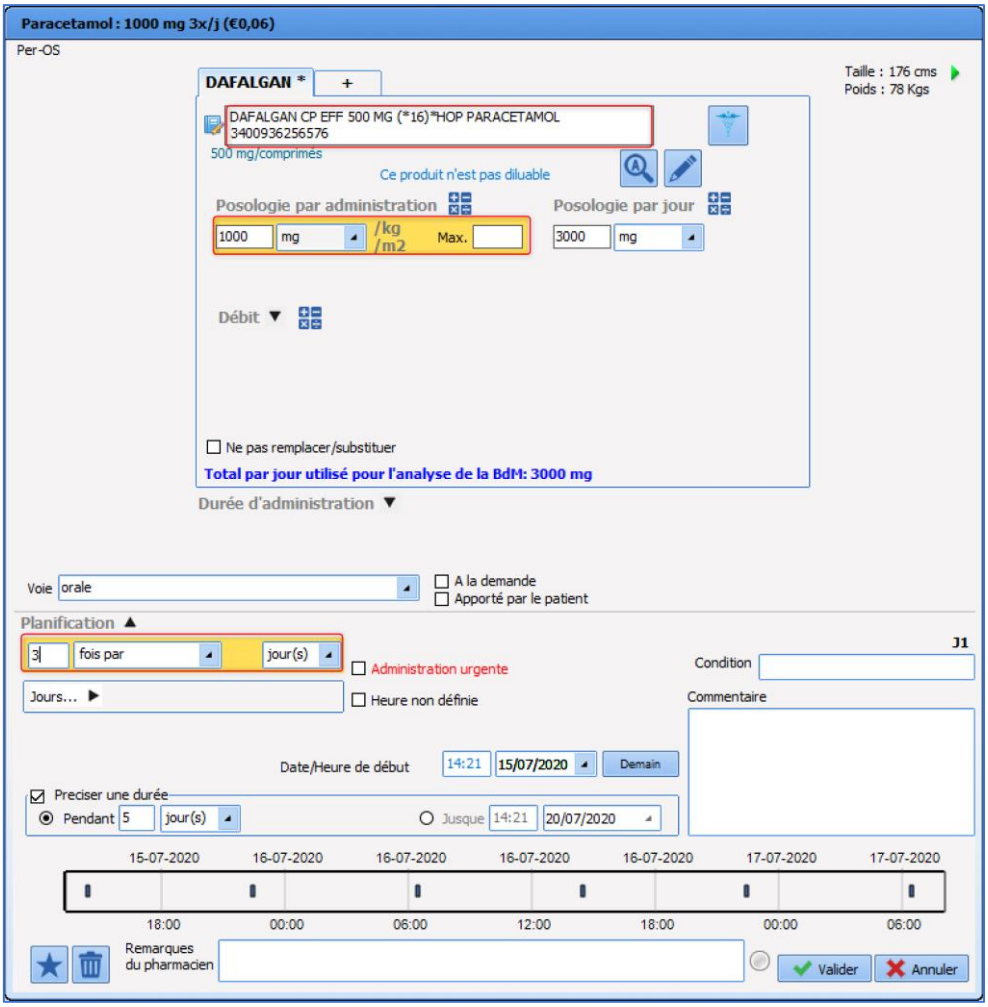
The application lets you use a simplified prescription window to quickly enter a simple prescription.



(1) Drug search: enter the first letters of the product. Choose from the list.
(2) Dosage: enter the chosen dosage.
(3) and **(4)** Schedule: lets you enter the frequency of administration and duration of treatment. Here, once a day for 5 days.
(5) Condition or note: lets you enter a note.
(6) Clicking on this star will save the prescription as a favourite. This favourite will be proposed to you in the field in which it was created. Here the **Per Os** field
(8) Bin icon: lets you delete the prescription selected.
(9) Pencil icon: opens the usual, non-simplified prescription window.
The information entered from the simplified window is outlined in red here.
(10) Caduceus icon: used to display the product monograph.
(11) **OK** or **Cancel** button: lets you confirm or cancel the prescription being written.

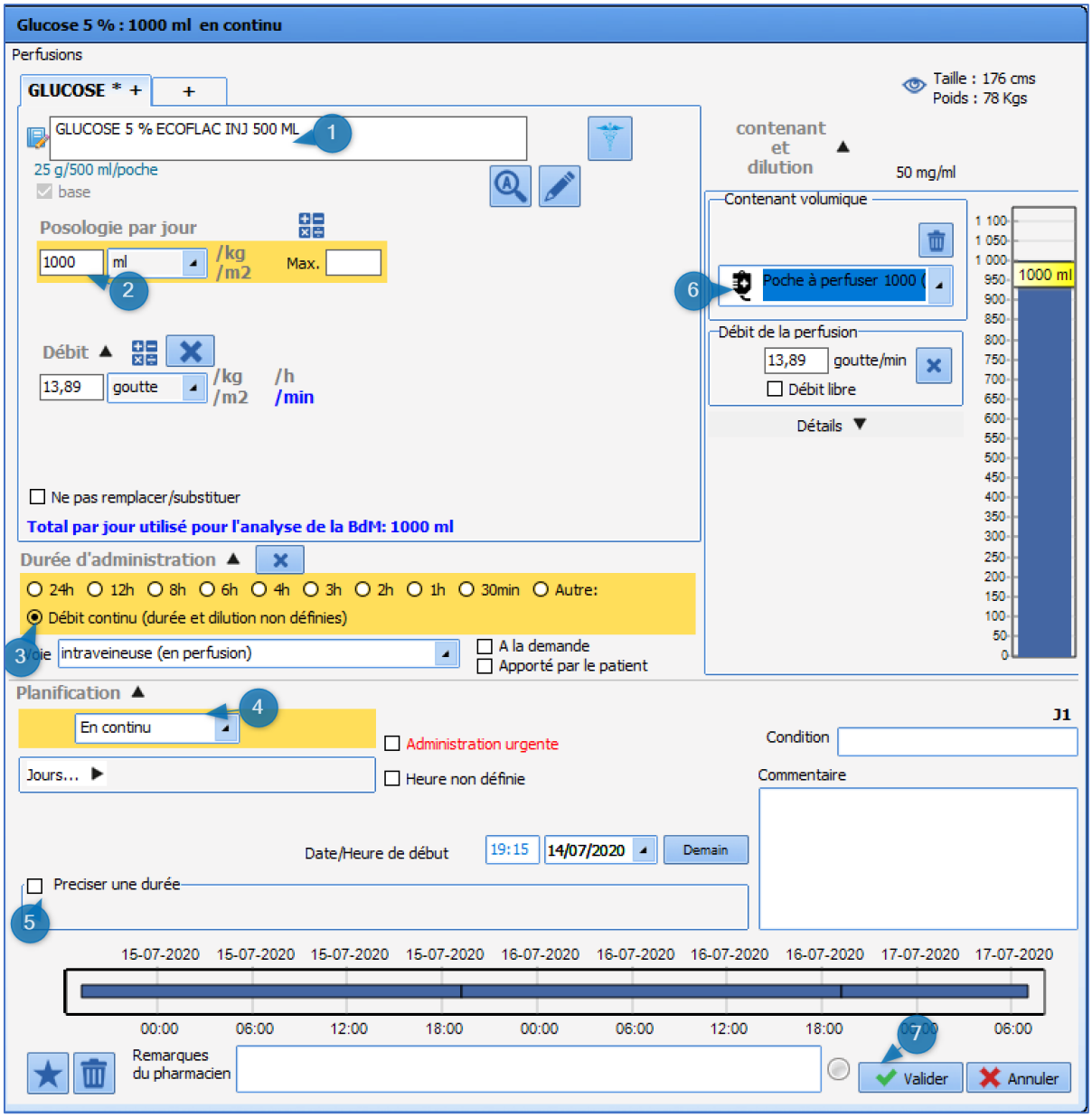
NB: the pharmaceutical form is automatically proposed according to the drug chosen in the product selection box. For example, if you choose paracetamol tablets, the 'tablet' form will be offered in this area.

Clicking on the **Pencil** button **(9)** opens the prescription window detailed below.



5.7.2.2 Prescribing an infusion

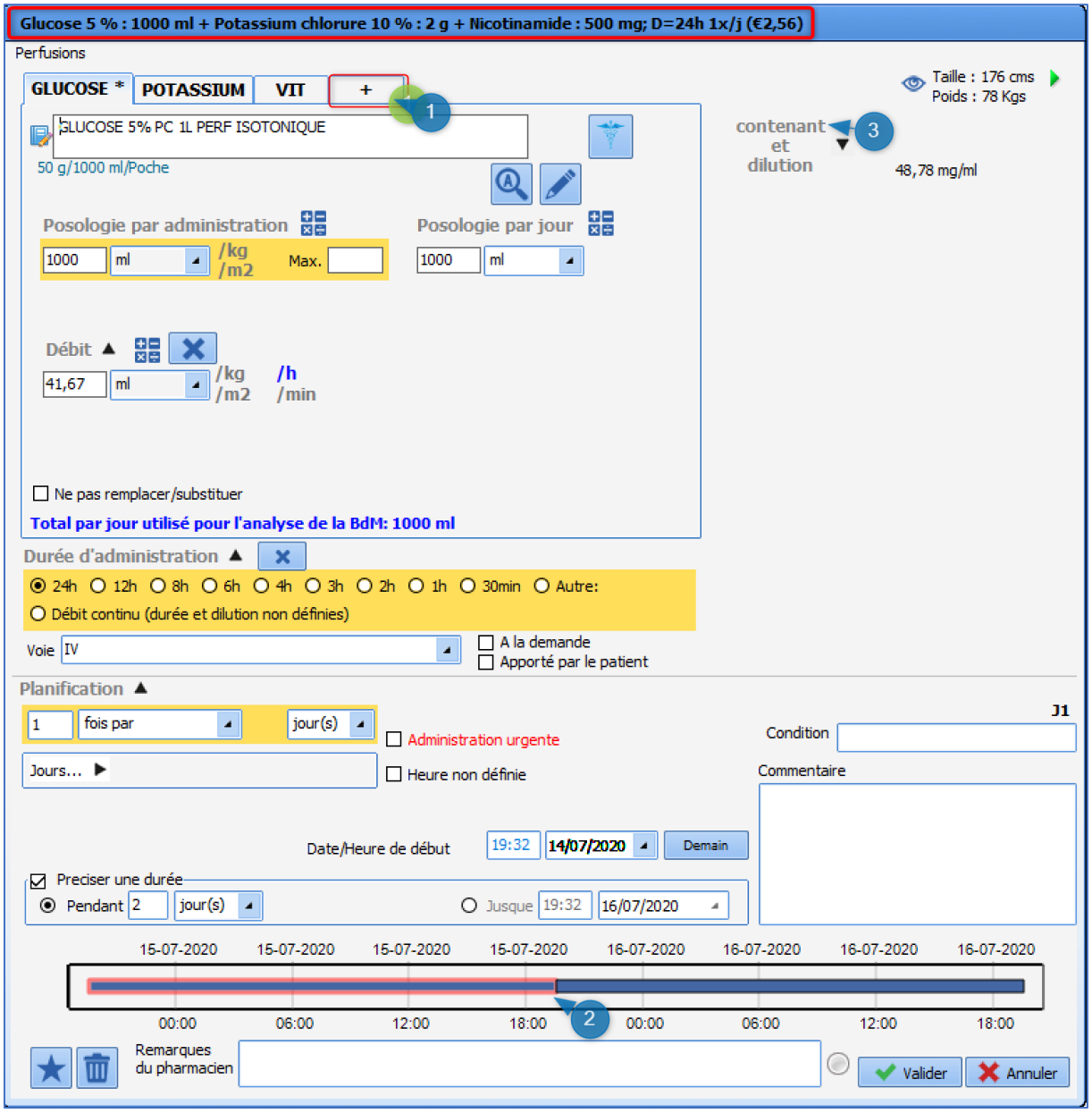
Example: *prescription of a continuous infusion of 1000 mL glucose 5% without a scheduled end date*.



Type the name of the product in the product selection box. A list of proposals is displayed. (1)

- Select the product matching your choice. The dosage, unit and route of administration are automatically entered.
- Adjust the dosage as necessary (2). In the example we have voluntarily chosen *500 mL glucose 5%* to modify the dosage.
- Enter the duration of administration (3).
- Uncheck the default 1-day schedule (5).
- Choose the volumetric container (6); a message tells you that the product will automatically be considered as a base.
- Click on confirm (7). Your prescription is now waiting to be signed.

Example 2: *Glucose 5% infusion 1000 mL/24h, to which we will add ions and vitamins, administered over 2 days*.

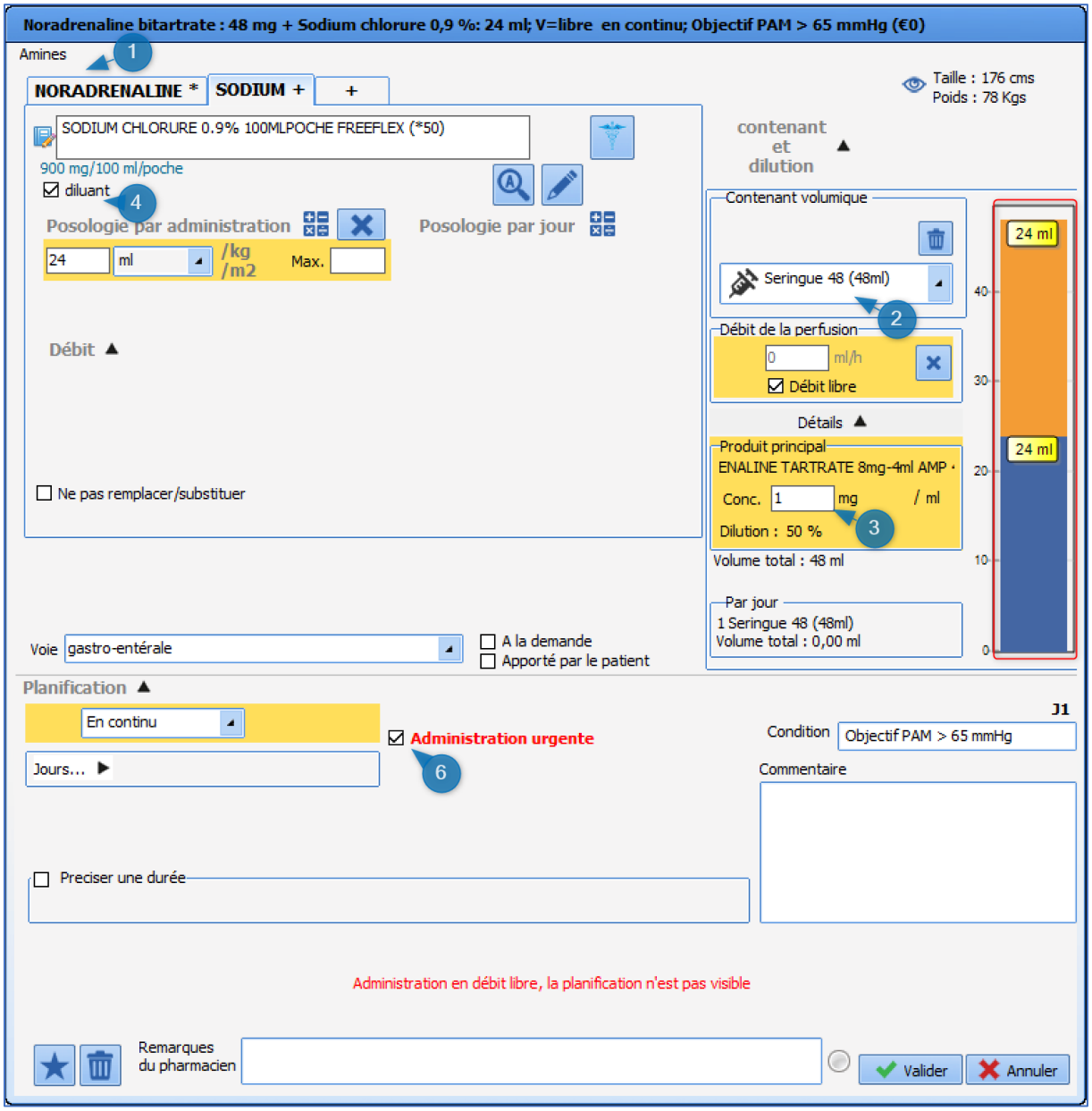


- Click on the plus sign (1) next to Glucose*, this opens a new product selection window. Add the product you want (here we have used Potassium), and the desired dosage.
- Repeat as needed.

NB: The summary in the blue ribbon at the top of the prescription lets you check that the prescription is correct.

5.7.2.3 Prescribing a syringe pump

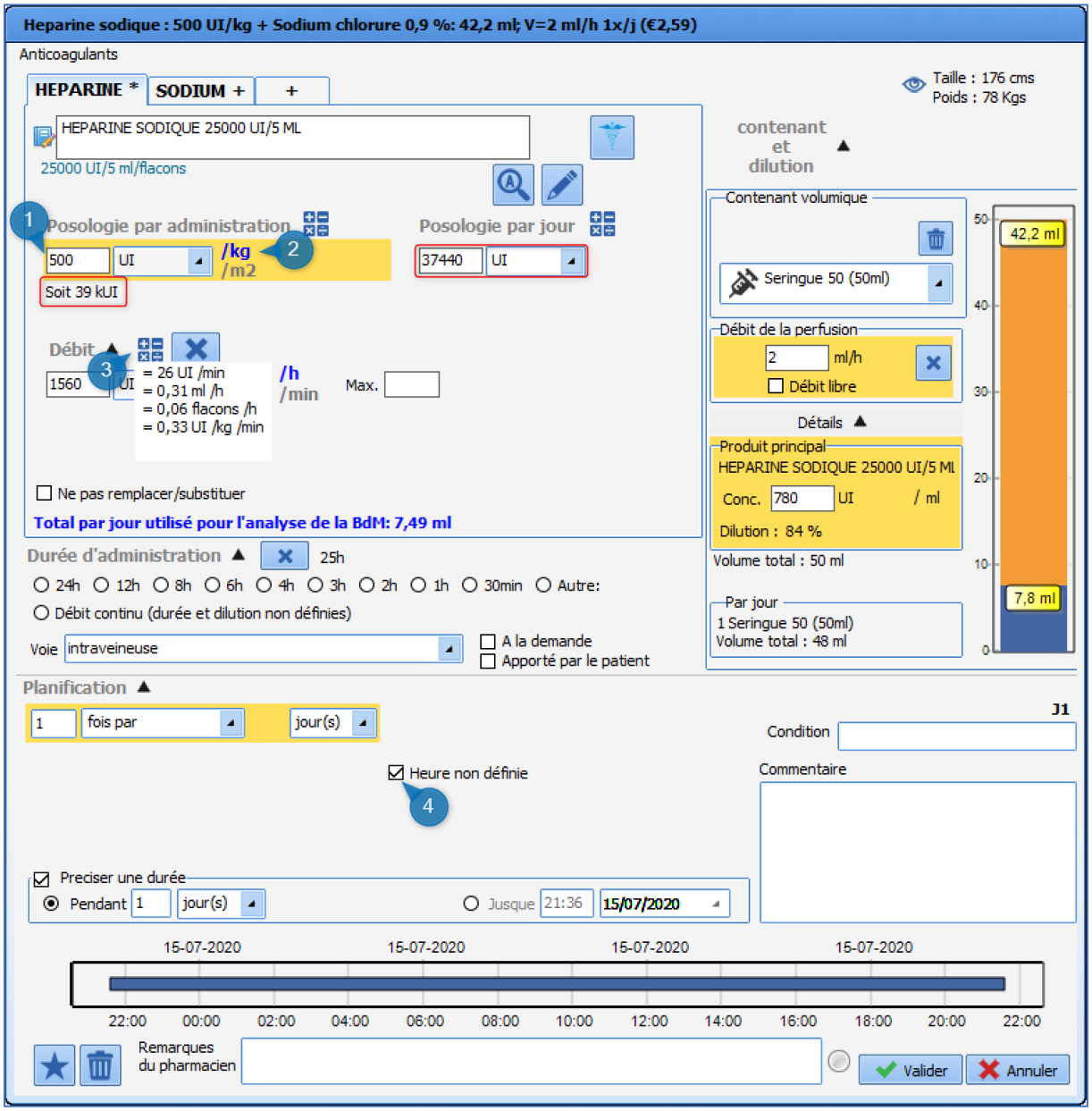
Example: *prescription of a syringe pump of Noradrenaline 1 mg/mL with flow rate as desired with target MAP > 65 mmHg for emergency administration*.



- Choose the relevant product by typing its name in the product search box.
- Select the **Volumetric container** (2). Here this is a 48 cc syringe.
- When selecting the volumetric container, check the **Flow rate as desired** box. The nurse will be able to start administration at the dose (s)he deems appropriate.
- Enter the desired **Concentration** in (3). The quantity of the main product and the quantity of solvent will be calculated automatically (division visible in the picture of the volume container).
- Enter the schedule and desired duration of administration (here the **Schedule** box says 'continuous'.
- Enter the diluent.
- If you tick the **Emergency administration** box (6), a pictogram will be visible on the care plan showing the importance of the administration.
- Fill in the **Condition** box by stating the objective. Using a condition creates a specific display on the care plan. The occurrences will be shaded to clearly show that the administration depends on an objective or assessment such as the VAS.
- Click on **Confirm**.

NB: In the capture, you can see that the sodium chloride was automatically recorded as a diluent.

Example: *prescription of a continuous flow of 500 IU/kg of Heparin over 24 hours with an undefined administration start time.*

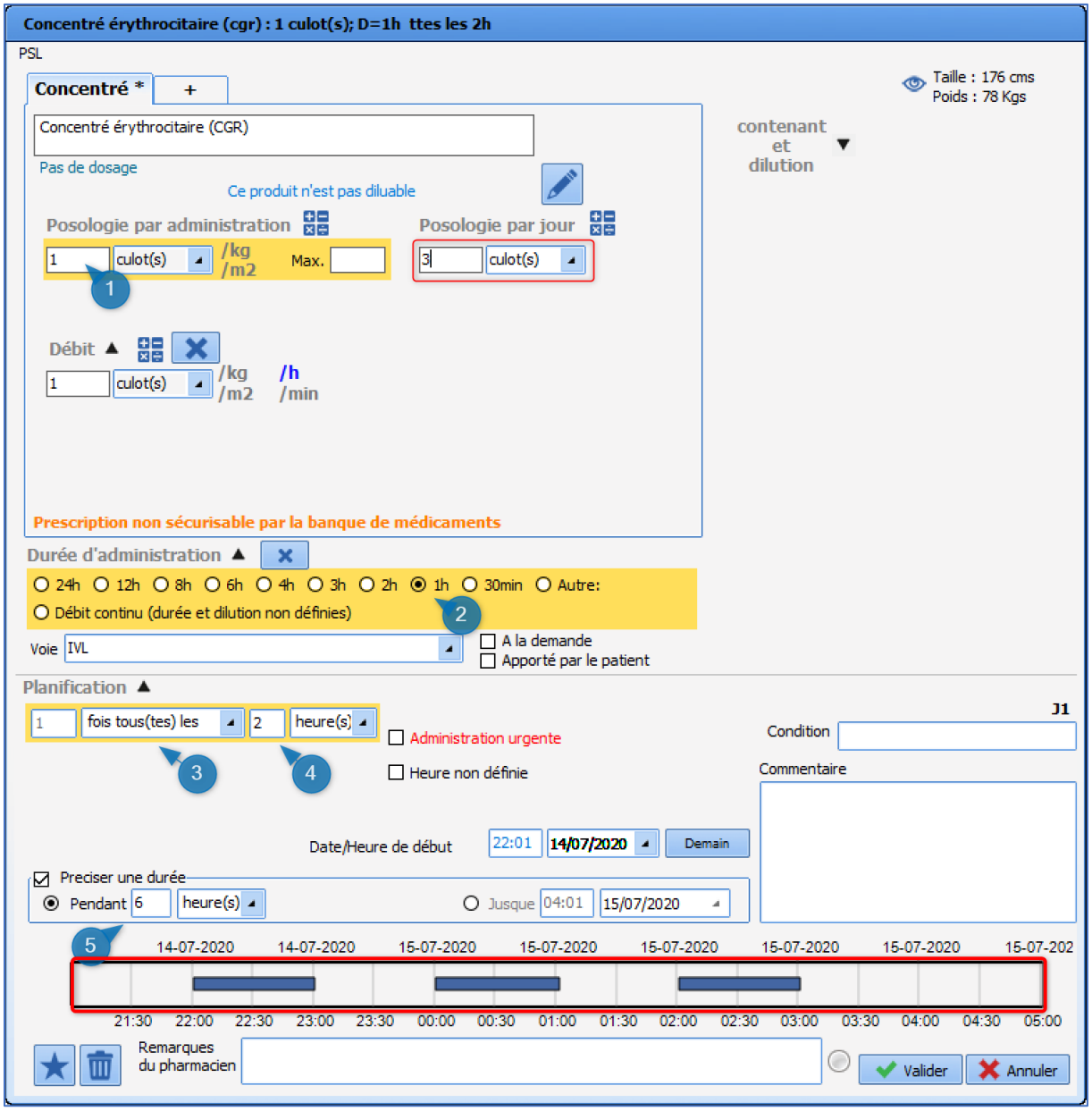


- Type in the first letters of the product
- Select the product you want (heparin) from the list.
- In the **Dosage per administration** field, enter the desired dosage (1) (500 here).
- Change the unit using the drop-down menu if the default unit does not apply.
- Click on **/kg** (2). The daily quantity is then calculated automatically and entered under the **Dosage per administration** field (outlined in red)
- Tick **Undefined time** (4). Ticking this box will allow the nurse to schedule the administration start time, 6 hours after the patient comes out of the OT for example.

NB: hovering over the calculator (3) lets you see the number of calculations performed according to the dosage entered. By double-clicking on one of the displayed values you can automatically use that value for the prescription.

5.7.2.4 Prescribing LBP

Example: *prescription of 3 PRBC*



For this prescription you must pay special attention to the schedule so that the care plan has 3 different occurrences.

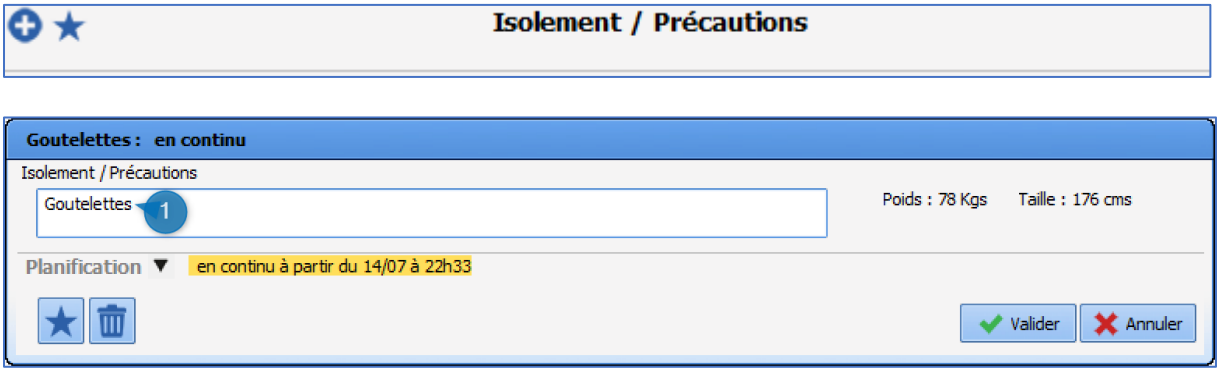
- Type in the first letters of the product.
- Select the blood product you want.
- Enter 1 PRBC in the **Dosage per administration** box (1) and choose the unit **PRBC**.
- Choose the **Duration of administration** (2). This is the time over which you want the PRBC to be administered.
- Enter the **Route** of administration (for labile blood products, the route of administration is not entered automatically, so it must be entered manually).
- Fill in the schedule (4). Here, it is important to enter a frequency of 'Every X hours' to register the time required between each PRBC.
- Lastly, specify a duration (5) (6 hours here). If you look at the chart display of the administrations

(overview of the care plan), you can see that each PRBC is administered over 1 hour with a one hour gap, and that only 3 PRBC (occurrences) will be available on the care plan. In addition, if you look at the **Dosage per day** box, you can see 3 PRBC.

5.7.2.5 Isolation/Precautions

Example: *Implementing 'Droplet' type precautions.*

To be able to use all the functions associated with this type of prescription, you must use the field provided for this purpose. Attached to this field are a list and the information icons that are displayed in the application's top ribbon and on the list of hospitalized patients registered in **DIANE**.

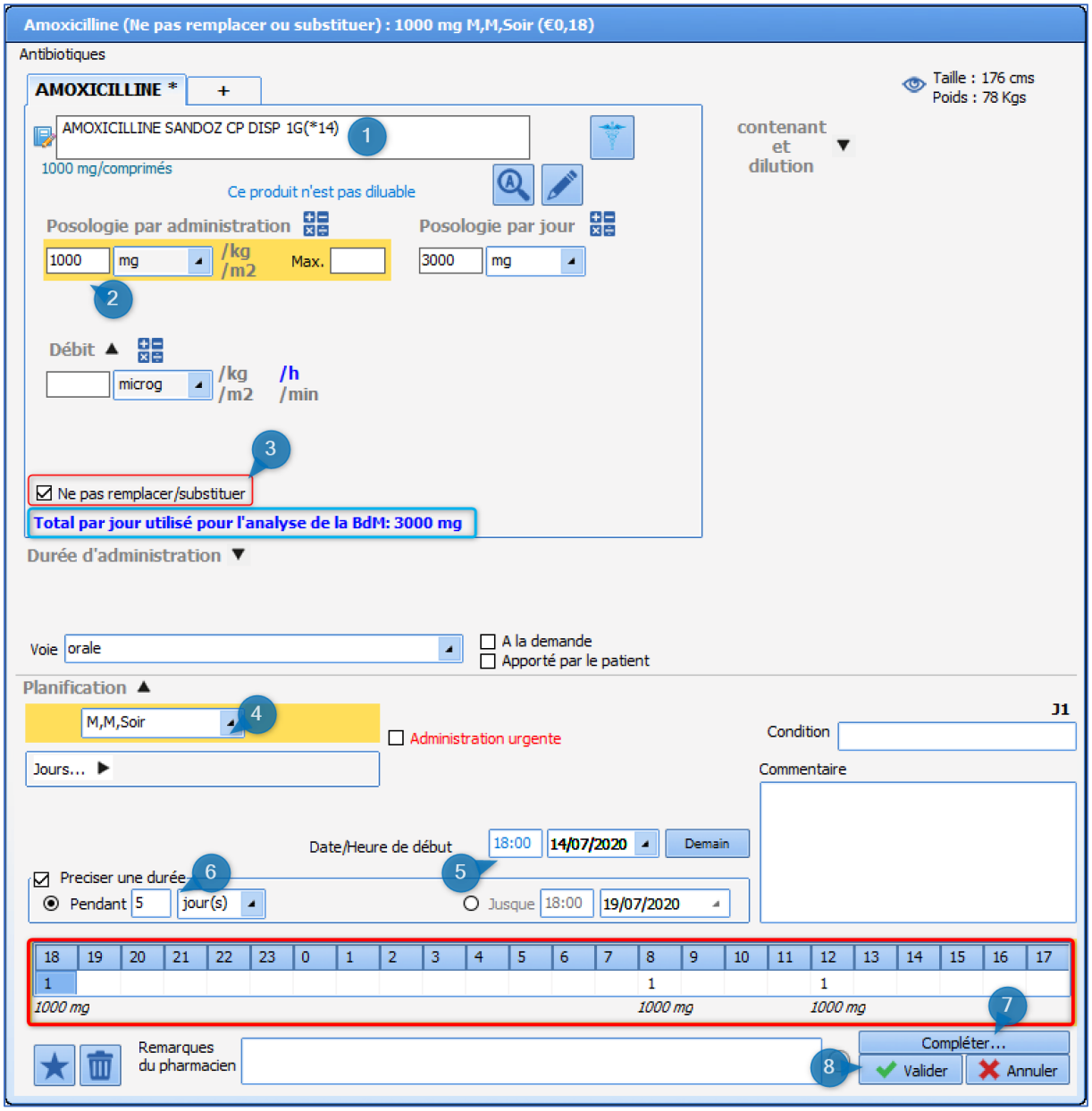


- In the search box (1), type in the first letters to start the search.
- Select the relevant item from the preconfigured list. Only items from this list can trigger the warning.
- By default, the schedule is 'continuous' with no end time. However, you can change it by clicking on the ▼ to access the drop-down menu.

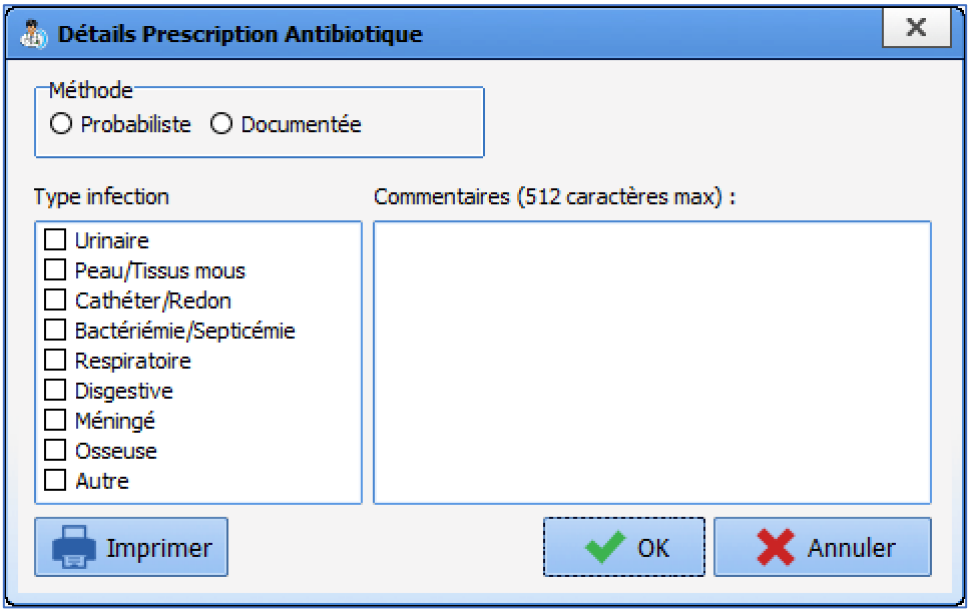
5.7.2.6 Special case of antibiotics

Example: *prescription of Amoxicillin 1 g morning, noon and evening from 6 p.m. tomorrow for 5 days*.

The application can make the monitoring and reassessment of the antibiotic therapy mandatory.



- Start the search by typing in the first letters of the product in the product box (1).
- Choose the antibiotic from the list.
- Check the dosage (2).
- Select the 'Morning, Noon, Evening' **Schedule** (the application lets you enter default times corresponding to the treatment distribution times, in the example 8 a.m. / noon / 6 p.m.).
  It is important to know that if the treatment is administered late, this schedule will not shift the following doses).
- Enter the **Duration of administration** (6) you want (5 days here).
- Enter the **Start date/time** (5) by changing the time shown, and by clicking on the **Tomorrow** button (NB: by default, the date/time shown is always current, so you only need to change this field when you wish to enter a specific administration start time).
- Click on the **Complete...** button (7). This opens a mandatory pop-up window (blocking the signing of the prescription if not filled) asking you to enter the indication for the antibiotic treatment and whether it is probabilistic or documented.
  Once completed, click on **OK**, then confirm (8) your prescription.

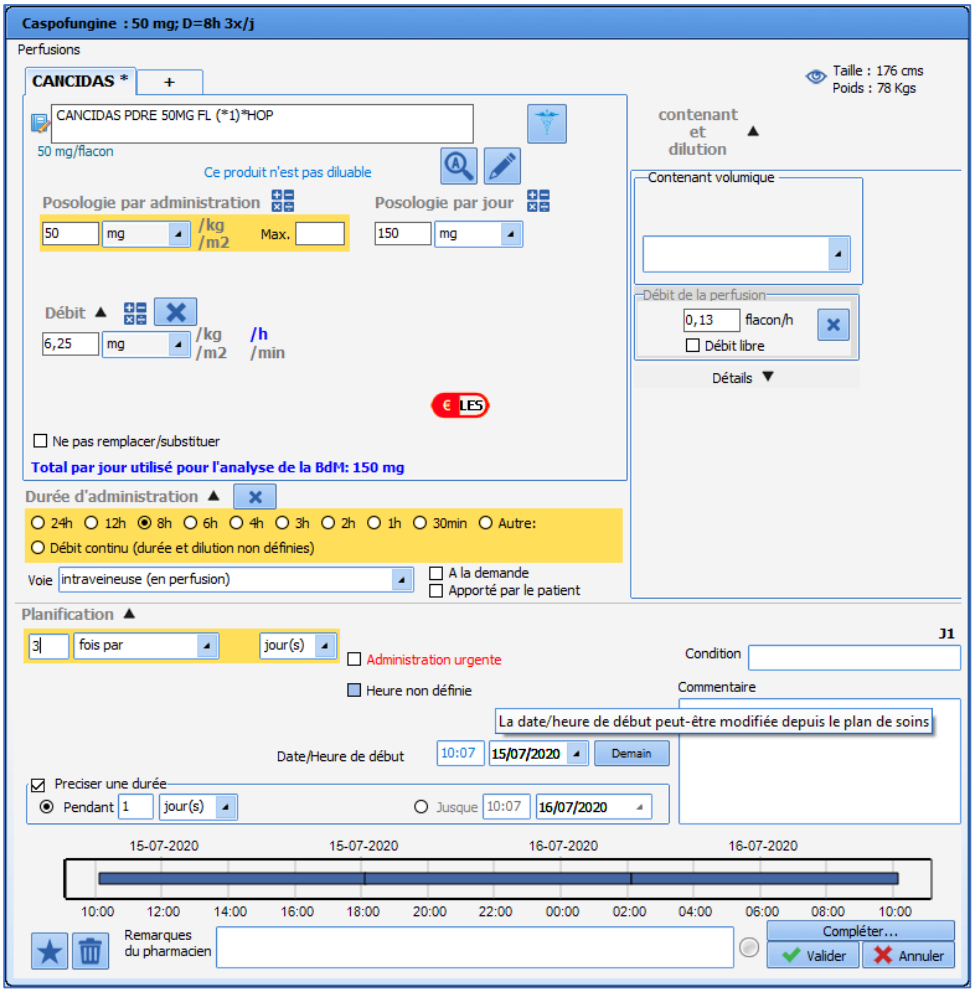


NB: In the screenshot you can see that the dosage used for the drug database dosage analysis is always shown. It is also possible to specify that a product 'Must not be replaced' (3).

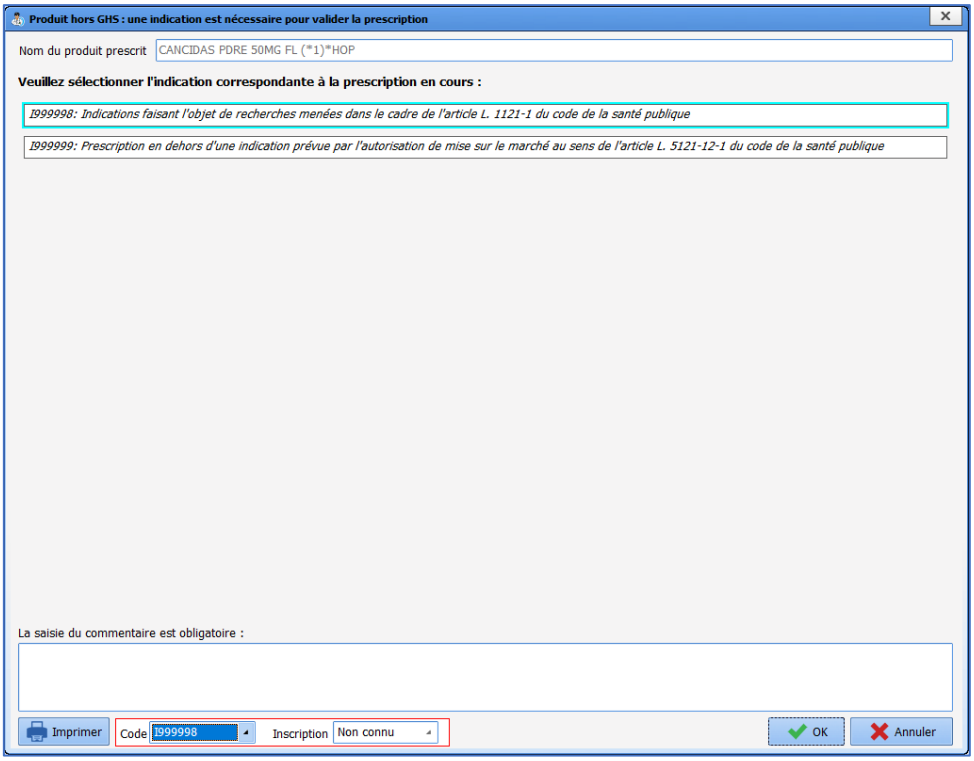
5.7.2.7 Special case of expensive drugs (list of additional billable drugs)

Example: *Cancidas 50 mg slow IV 3 times a day.*

The prescription of an expensive product is shown by an icon on the prescription window.
As with antibiotics, the application lets you make it compulsory to enter the indication for treatment.



- Select the product you want.
- Enter the items necessary for its administration: dosage, duration of administration, etc.
- Click on the **Complete...** button. A pop-up window will appear.



- Select the relevant indication (the indications offered are from the drug database). If there is no corresponding indication, use one of the following two generic codes:
  I999998: Product subject to biomedical research within the meaning of Article L. 1121-1 of the Public Health Code.
  I999999: Off-label indication but medically justified in accordance with Article L. 5121-12-1 of the Public Health Code.

When you use one of these two codes you must enter a comment.

- Click on the **OK** button then confirm your prescription.

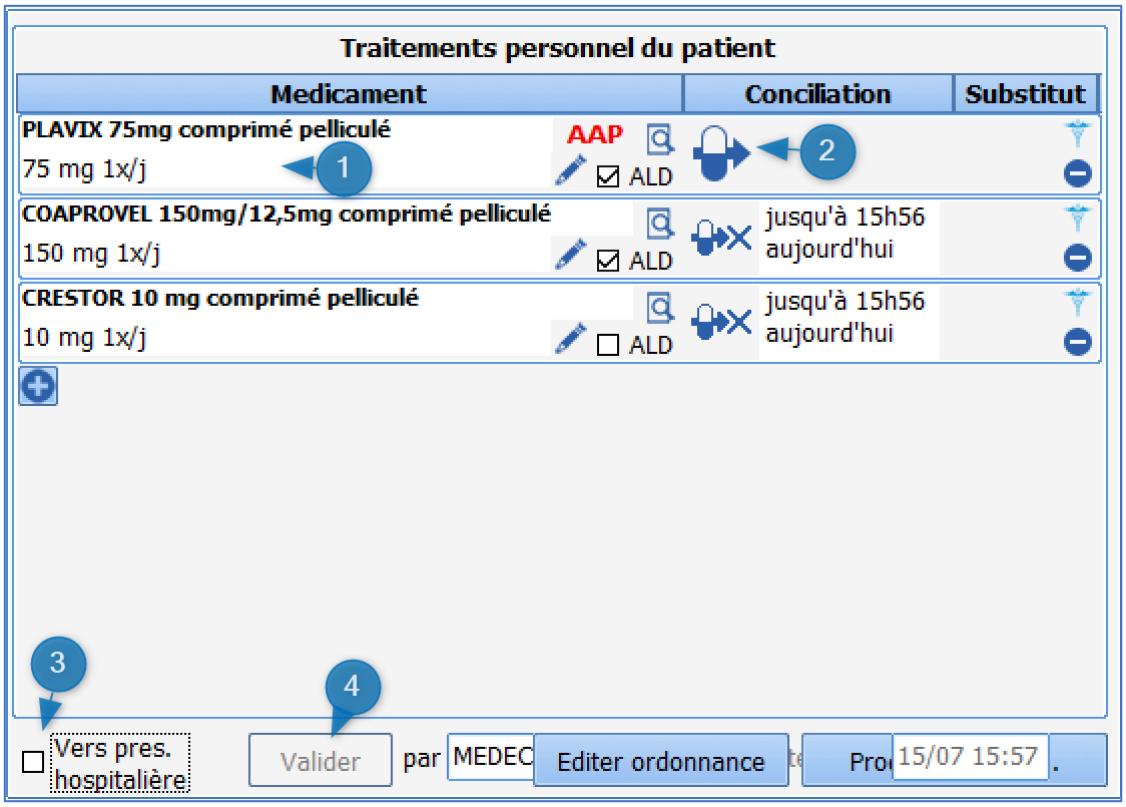
Indication code colours:

• € LES Red	• This means that the indication for this expensive drug has not been completed: click on the **Complete...** button.
• € LES Blue	• This means that you have validated the indication correctly for this expensive drug, but the reimbursement status is not known.
• € LES Green	• This means that you have validated the indication correctly for this expensive drug and that it will be reimbursed.

5.7.3 Import from personal treatment

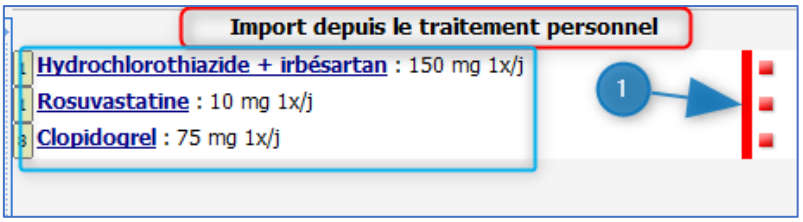
The application lets you copy the products entered in the **Patient's personal treatments** field in the **Doctor** tab into the prescription.
When the option is enabled, the products are entered in the **Import from personal treatment** prescription field.

Component for entering the patient's personal treatment in the **Doctor** tab:



Section 1: Area to enter product: click on the first line. Type in the first letters of the product. A list of suggestions opens. Choose the one you want. Enter the dosage and frequency of administration (here this is Plavix 75 mg once daily).
Section 2: The **Reconciliation** area lets you specify the treatment management: continue, switch or stop.
In the example above, the treatments are specified as stopped at the current time, which allows the patient's personal treatment to be paused, and only resumed at the appropriate time during their stay.
Section 3: **To hospital prescription**: ticking the **To hospital prescription** box lets you transpose the personal treatment into the **Import from personal treatment** field in the prescription tab.
Section 4: Click on the **Confirm** button: this opens a window to enter your password and confirm that you want to send the treatment to the prescription.

Import from personal treatment component in the **Prescription** tab:



The patient's personal treatment is now included in the prescription tab (the product's INN, dosage and frequency of administration are copied).
The red marker at the end of the line (1) clearly shows that the treatment has been stopped.

Depending on the option enabled in your facility, you will be able to either:

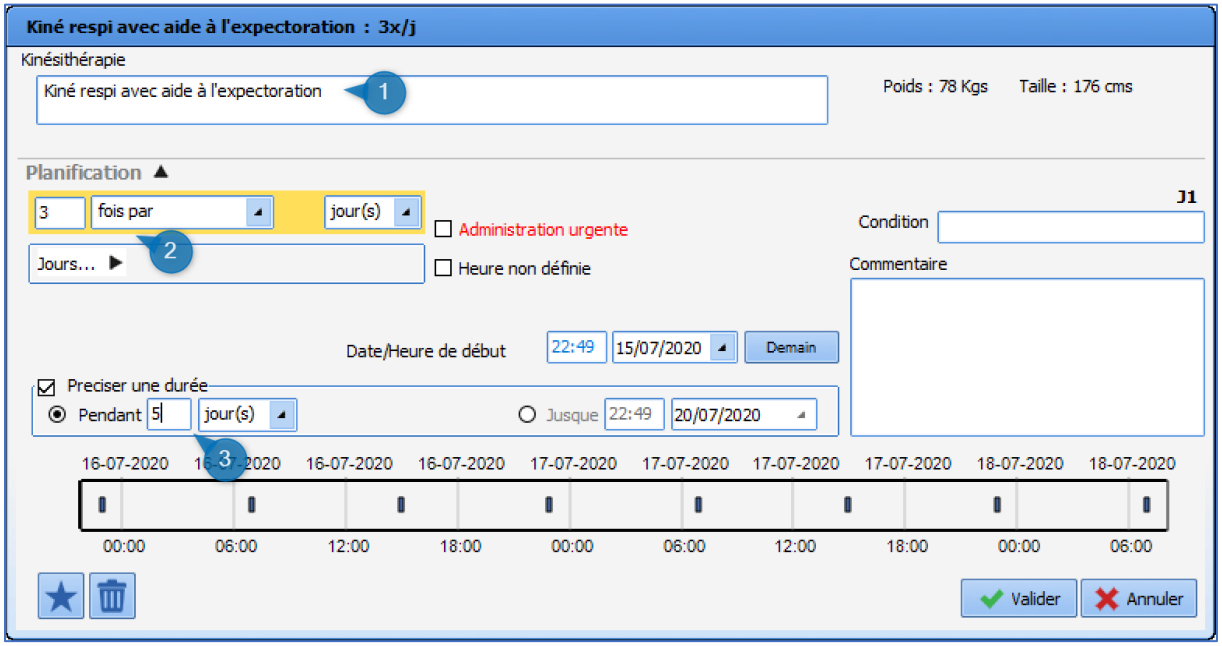
- renew the treatment by clicking on the red marker to change its status
- or re-enter the prescription in the appropriate field in the prescription tab. In this example the field

would be the **Per os** field.

5.7.4 Prescribing using free text (food, imaging, etc.)

Prescription fields can call up a specific list. When the field is configured in this way, you can enter free text.

Example: *prescription for respiratory physiotherapy twice a day for 5 days*.

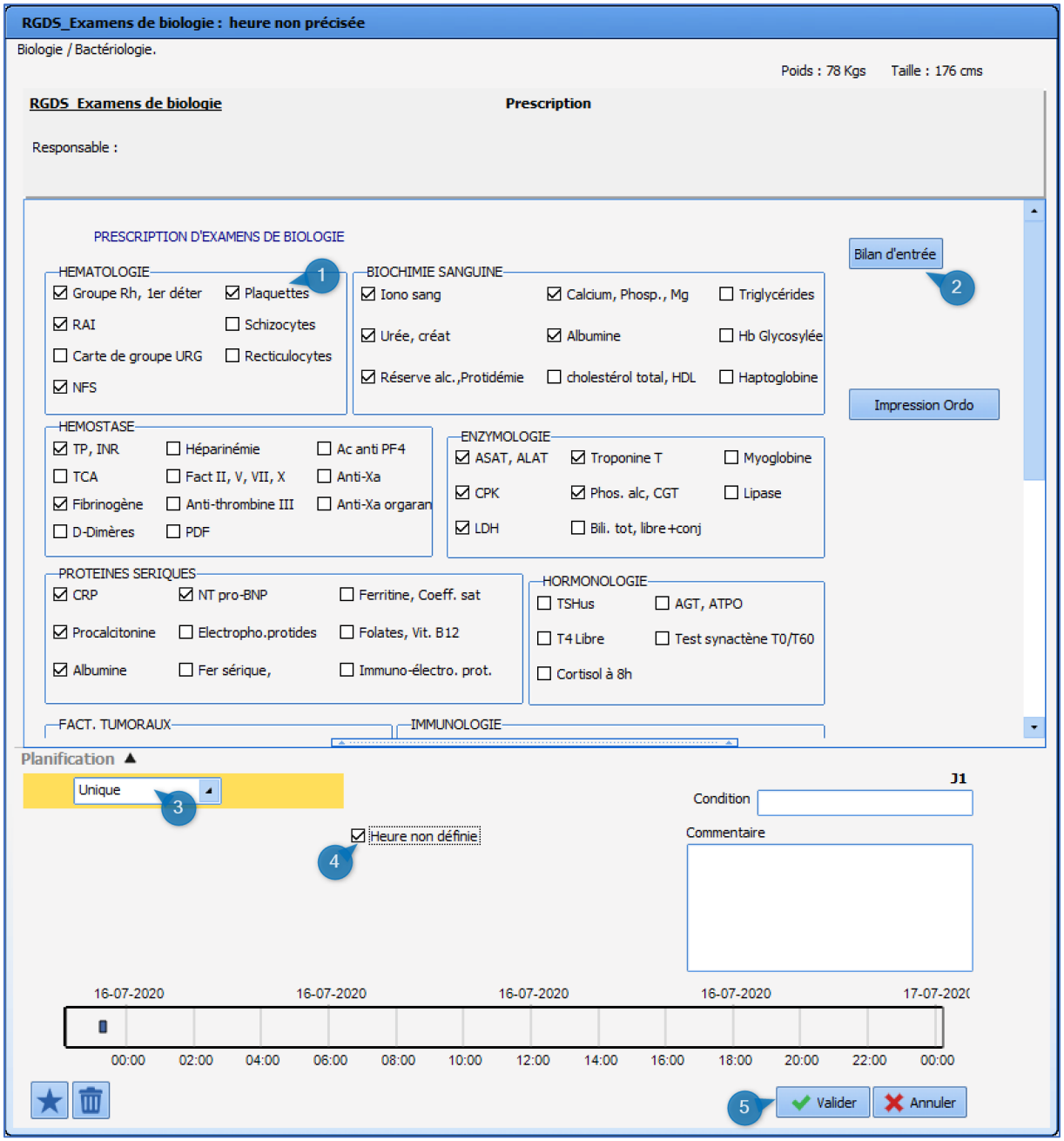


- Enter the desired prescription or instruction (1).
- Enter the frequency (2) (3 times a day here).
- Enter the duration to apply to this prescription (3). Here it is for 5 days.
- Click on the **Confirm** button.

5.7.5 Prescribing using a detailed entry (physiotherapy, lab test/bacteriology, ECMO, etc.)

For certain prescriptions such as lab tests, renal dialysis, etc. requiring a lot of information, you can use a form integrated into the prescription window.

Example: *prescription of a lab test when the patient is admitted to intensive care at an undefined time.*

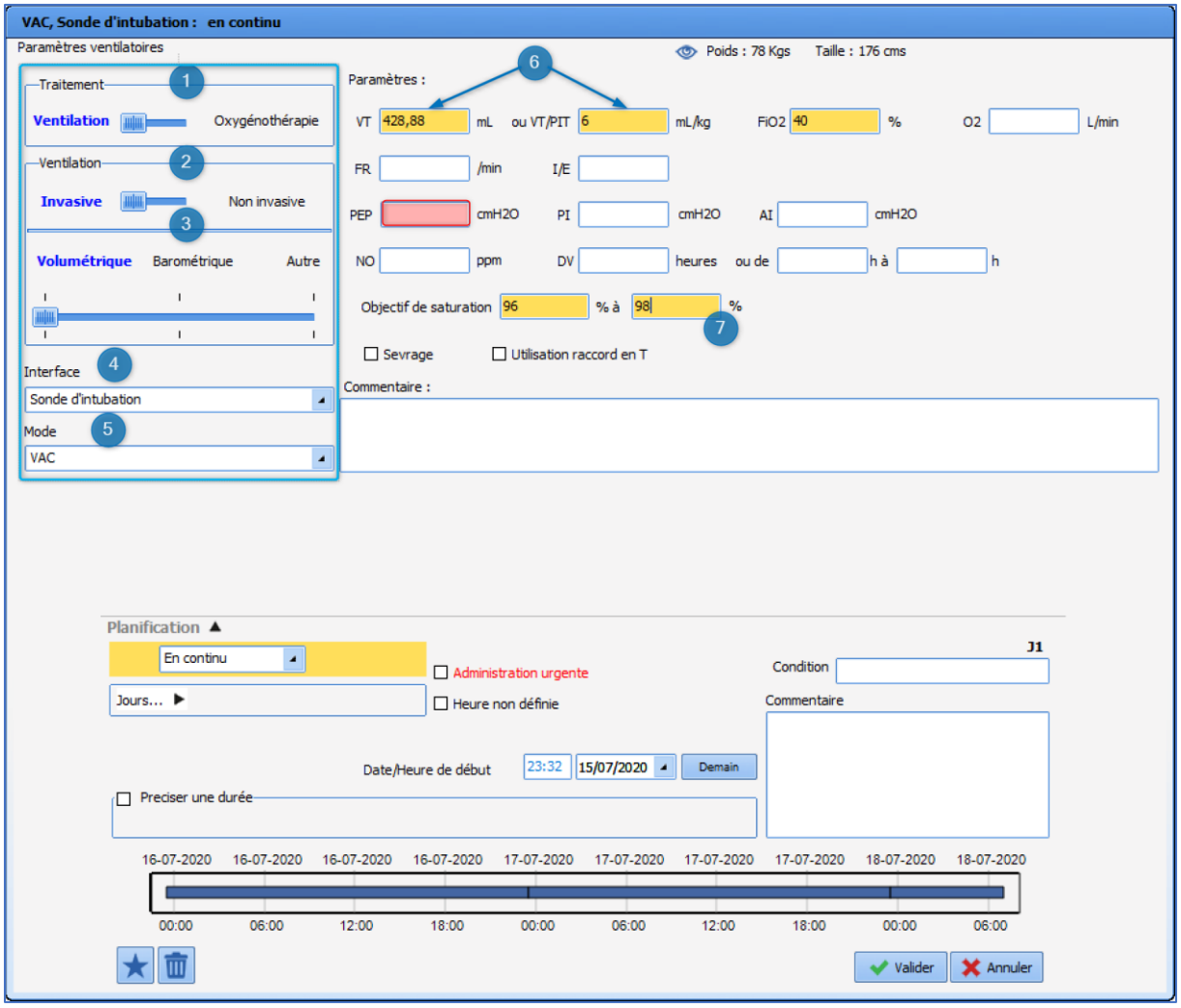


When the prescription window opens, the top part gives you access to the data entry form.

- Tick (1) the lab test items that you wish to prescribe.
- Default value buttons can be configured (2). This lets you save values ticked by default. Here, in this example, by clicking on the button (2), the lab test items are ticked automatically.
- Fill in the schedule (3). Here the 'one-off' choice means that the prescribed test is done once and will not be repeated. It will automatically be marked as stopped.
  Scheduling as 'one-off' will require you to create a new prescription if you decide to prescribe this test again.
- Tick **Undefined time** (4). This will allow the nurse to schedule the blood test time.
- Confirm your prescription by clicking on the button (5).

5.7.6 Prescribing ventilation parameters

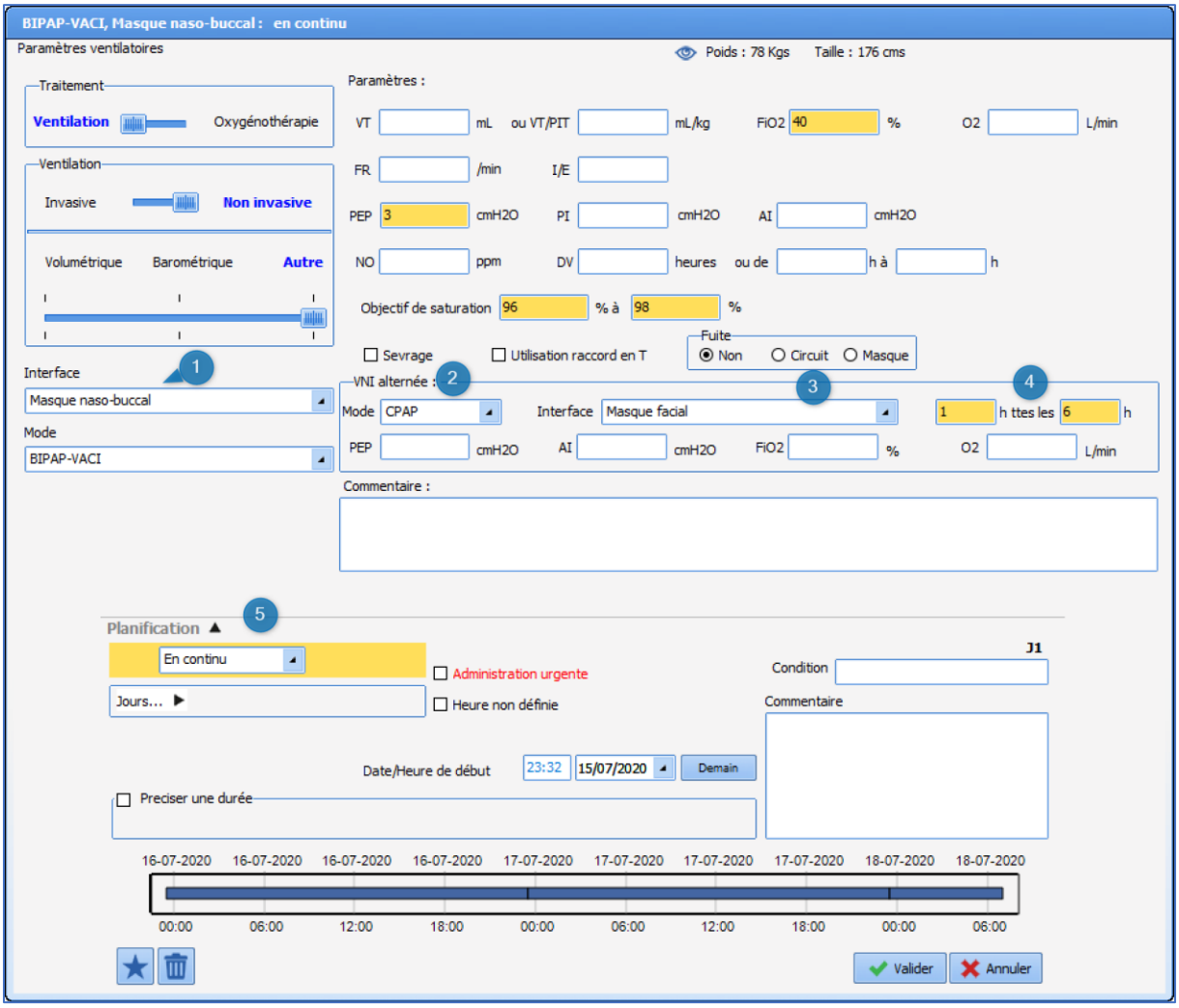
Ventilation or oxygen therapy is prescribed using a specific window adapted to the ventilation method chosen.



The left part of the window (blue outline) must be completed first.
This area lets you use the different input fields depending on the treatment and the ventilation method chosen.
It has five sections:

Section 1: **Treatment**: choose between **Ventilation** and **Oxygen therapy**.
Section 2: **Ventilation**: choose between **Invasive** and **Noninvasive ventilation**.
Section 3: choose between **Barometric**, **Volumetric** and **Other** ventilation method.
Section 4: **Interface**: used to enter the interface chosen for ventilation or oxygen therapy.
Section 5: **Method**: used to enter the ventilation method.

NB: In sections 1, 2 and 3, select your choice by moving the blue cursor from left to right.
The boxes with a pink background must be filled in. They are adapted to the ventilation method.
Section 6: lets you enter the VT/PBW in mL/kg. When you enter this the VT is calculated automatically.
Section 7: this section is used to enter the saturation targets.

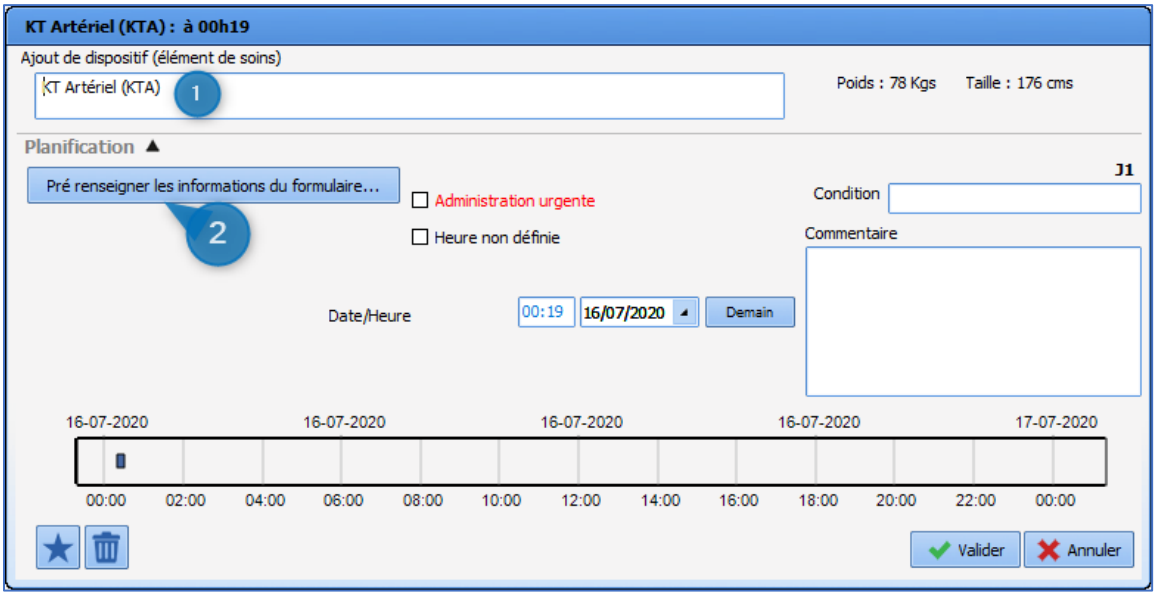


Depending on the method (1) chosen, it is possible to prescribe alternated ventilation (2) with NIV for example.
You can then enter two different interfaces in (1) and in (3), and enter the alternation pace you want (4).
In this configuration, the Schedule (5) applies to the primary method that is determined in the left part of the window.

5.7.7 Prescribing medical devices (placement and removal)

5.7.7.1 Adding a care item via the prescription tab

The placement of a care item is prescribed from the **Add device (care item)** field in the **Prescription** tab.

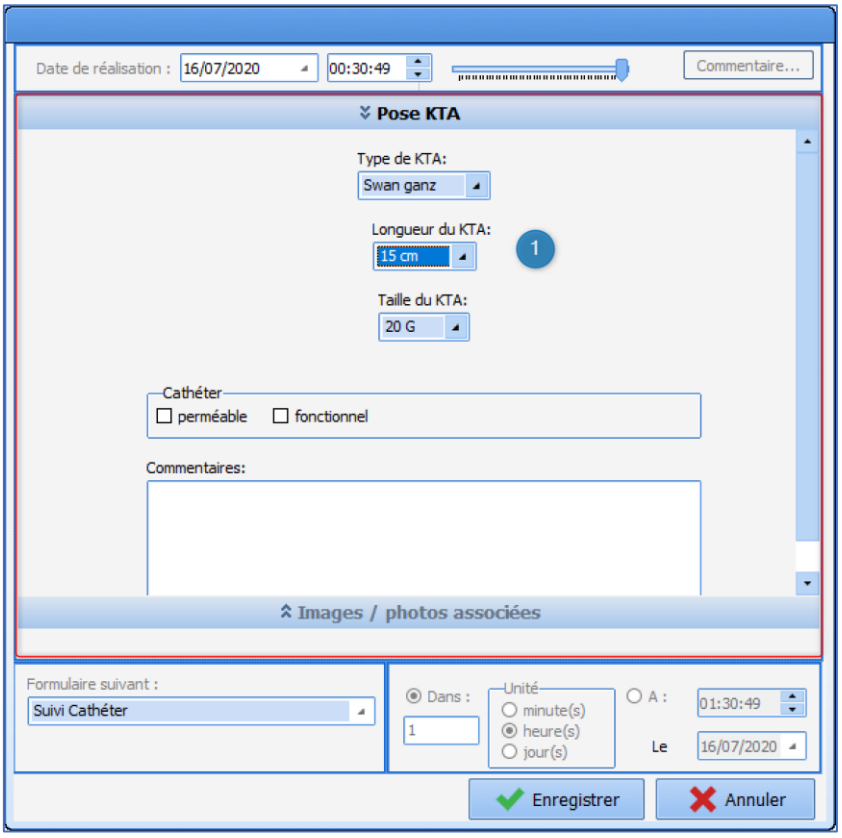


Area 1: Area to enter the device: area to enter the desired insertion.

- Click in the box and type in the first letters. A list opens showing the available devices. Double-clicking in this area (1) opens the complete list of devices.
- Select the device you want. Here this is 'Arterial cath'.

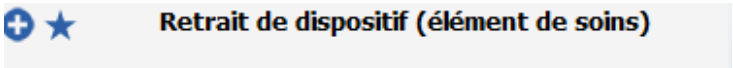
Area 2: Call button for the placement form: from the prescription you can complete the initial form to enter the details about the care item.

Only the form (1), outlined in red, can be completed.



5.7.7.2 Removing a care item via the prescription tab

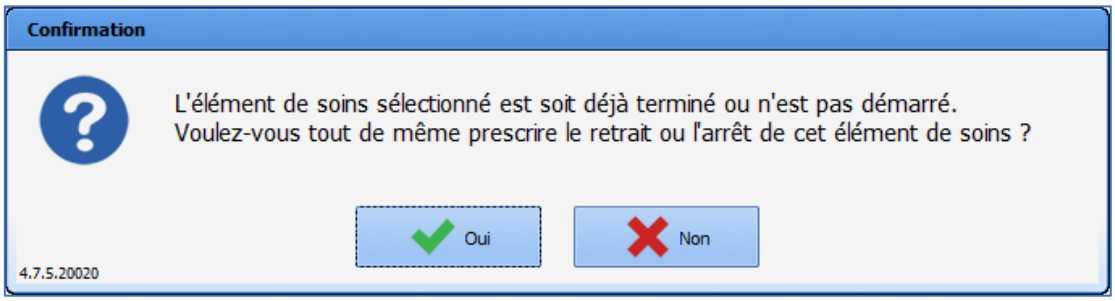
The removal of a device is prescribed from the **Remove device (care item)** field in the **Prescription** tab.



The window to prescribe the removal is identical to the placement window. They are used in the same way.

- In the search box (1) enter the type of device you would like to be removed. Choose from the list of proposals or double-click in the search box. Only care items with a removal form will be offered.
- You can prefill the removal form or not. (2)
- Enter the removal date/time.
- Confirm your prescription by clicking on the button.

NB: A warning is displayed if the removal prescribed is for a care item that is already finished or not started.



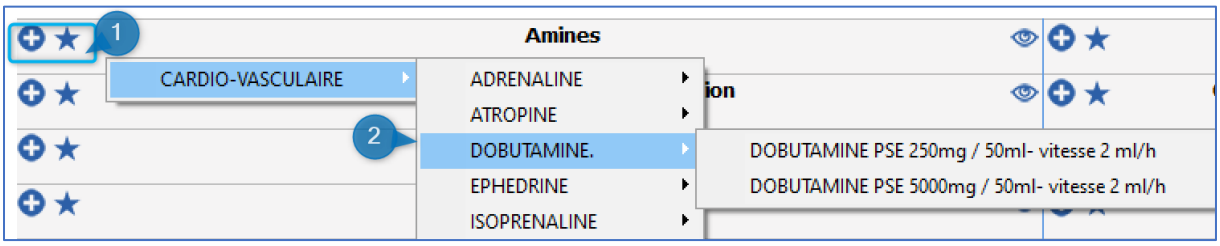
5.7.8 Prescription favourites

To make it easier to write prescriptions, several shortcuts have been designed in the application.

- 'Favourites': these are prefilled prescriptions available for each field.
- **Load a prescription (Add)**: these are protocols to fill in a set of prescriptions in different fields in one click.
- **Load a prescription (Replace)**: these let you replace the current prescriptions with a new protocol.

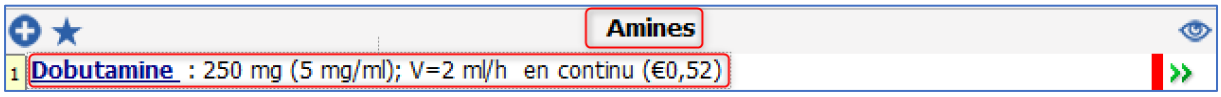
Using a favourite:

Favourites are configured for each prescription field. This lets you limit the list of suggestions.



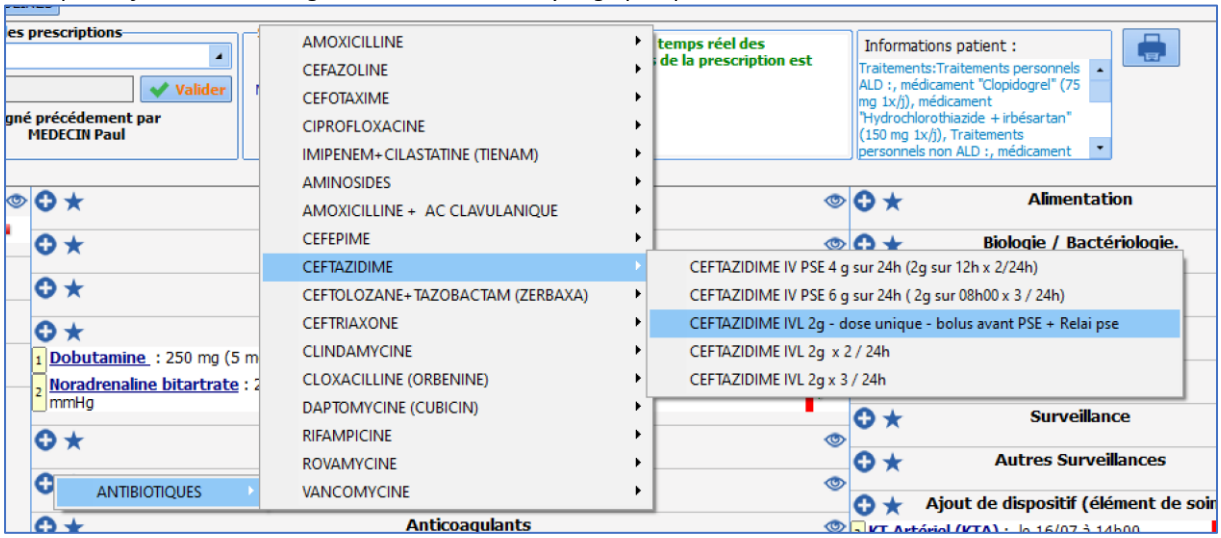
- Area (1): Area to create a favourite: Create the favourites menu accessible in the field. There are two ways:
  - Left-click on the star
  - Right-click on the plus sign

- Area (2): Favourites menu: the list of favourites available for the field opens. Here, in the example, we are in the **Amines** field, so only favourites belonging to the **Amines** field are offered.
- Click to select the favourite you want to prescribe. The favourite is automatically entered in the field.

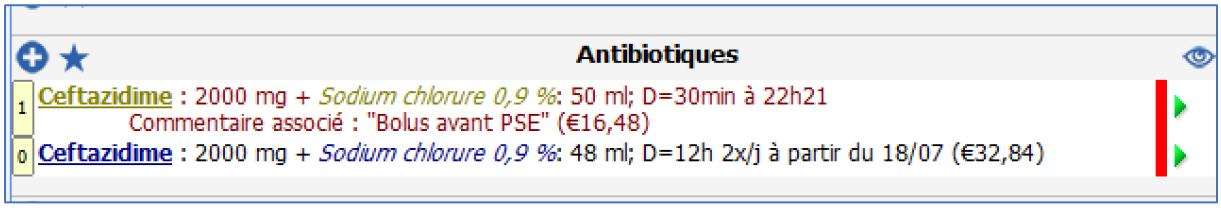


- If you want to change the prescription generated by the favourite or check its content, click on the product line to open the prescription window.

NB: using a single favourite you can prescribe multiple prescription lines in the same field.
Example: *Ceftazidime loading dose then switch to syringe pump*



- Select the favourite. Here CEFTAZIDIME slow IV 2 g - single dose - before syringe pump then switch to syringe pump.
  - The favourite is automatically entered into two separate prescription lines: The first giving the prescription of the loading dose, which is configured as a single dose so as not to be repeated.
  The second integrating the switch to the syringe pump, scheduled to start after a time lag of 12 hours, which will therefore be available on the care plan 12 hours later to make the switch and to avoid simultaneous administration.

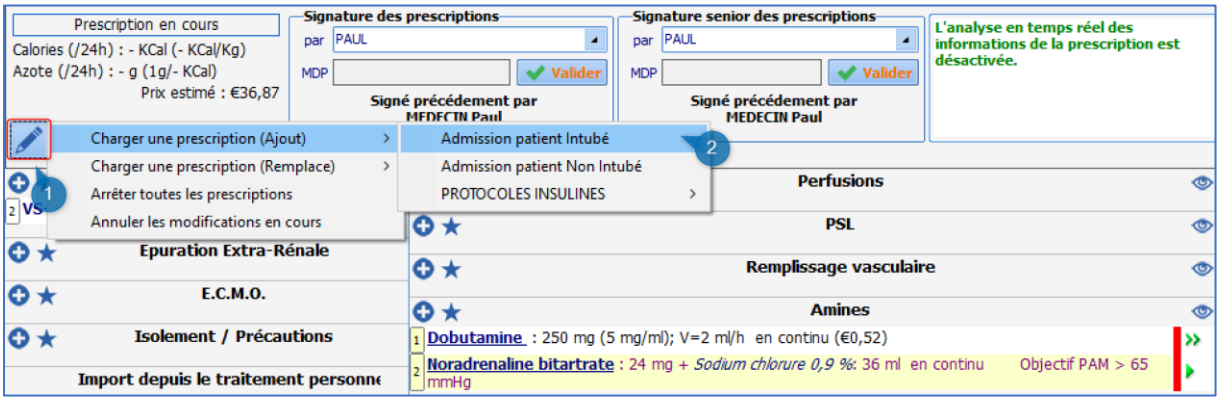


5.7.9 Prescription protocols

The application also lets you prescribe prescription favourites in several different fields with just one click. This

is done by using the pencil icon at the top left of the prescription tab.

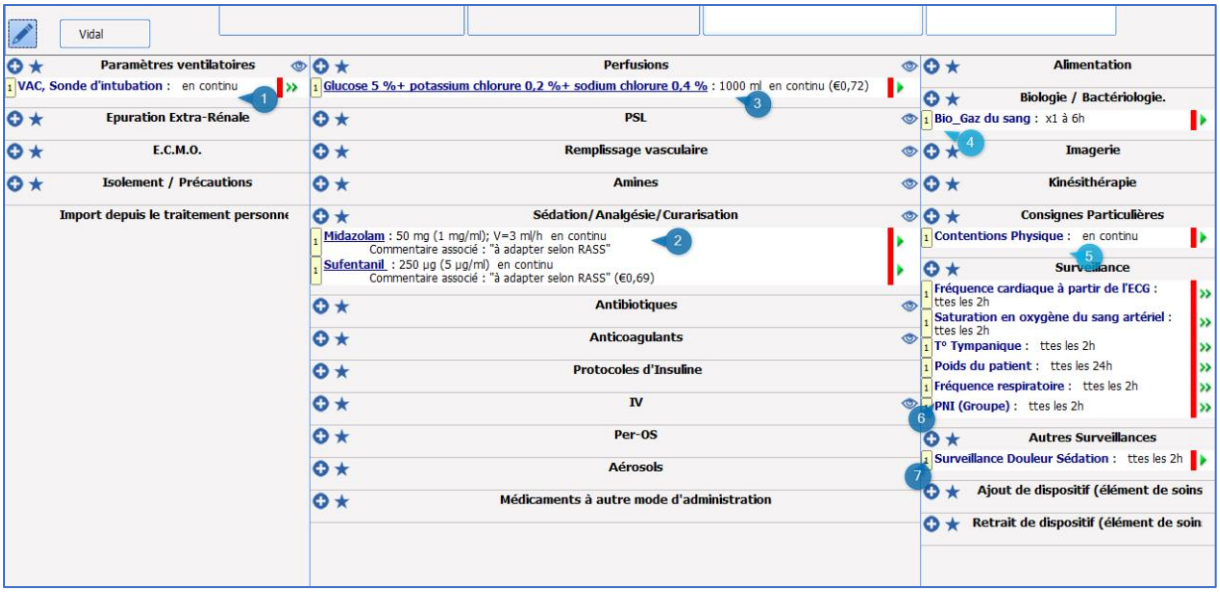
Load a prescription (Add): using presaved protocols this option lets you enter prescription favourites in several prescription fields at the same time.



Area (1): Pencil icon: area giving access to the protocol prescription menu.

- Click on the pencil icon.
- Select the **Load a prescription (Add)** option to open the add prescription menu (2).
- Click on the protocol you want to prescribe.
- This loads automatically.
- You can, if you wish, change or check the favourites loaded in this way by clicking on the prescription line.

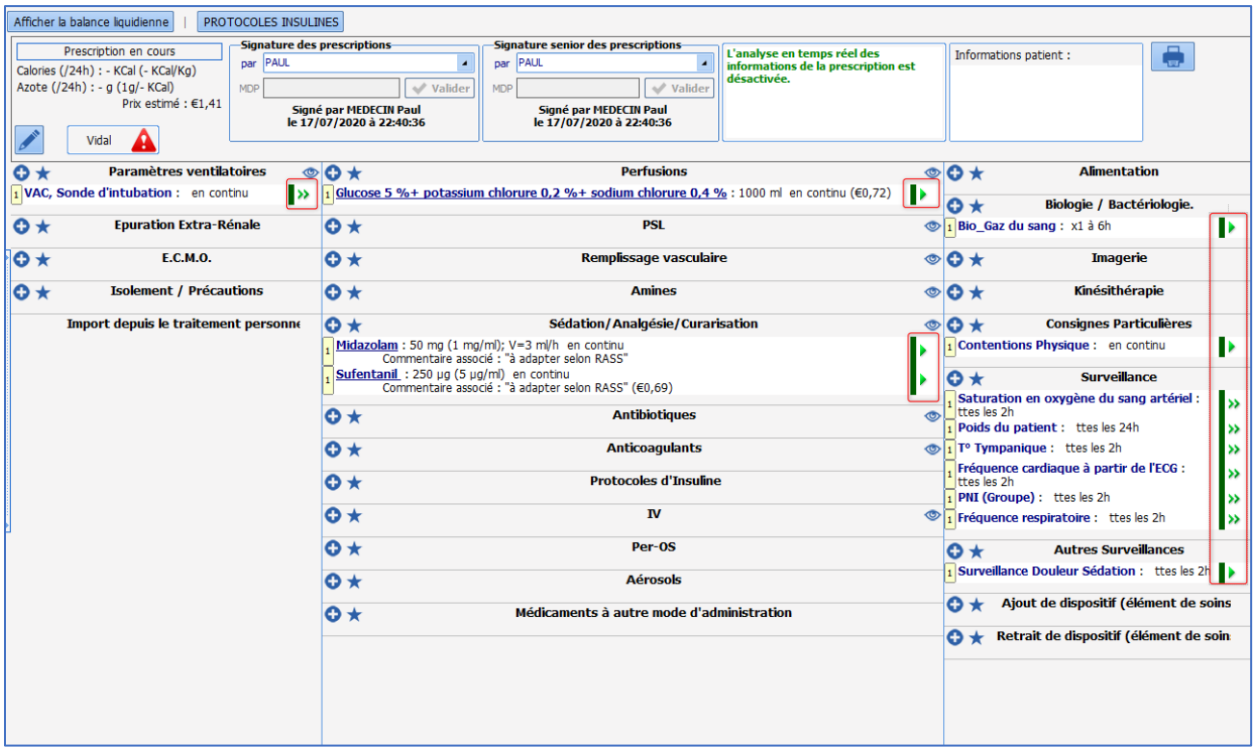
Example: *Load a prescription (Add): Intubated patient admission*



In this example, you can see that by calling up the protocol you can prescribe
Treatments: (2) in the **Infusion** field, (3) in the **Sedation / Analgesia / Curarization** field.
Monitoring and instructions: in the **Monitoring** field (6), **Other monitoring** (7) and in the **Special instructions** field.
Patient ventilation: in the **Ventilation parameters** field (1).

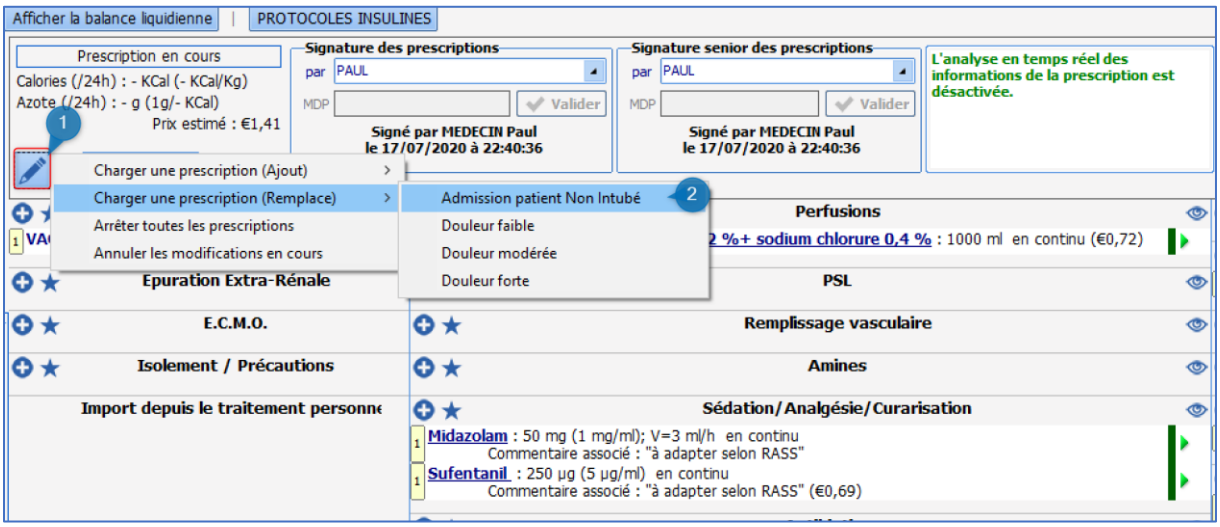
Load a prescription (Replace): This option will replace the current prescriptions.
The current prescriptions will be in stopped status and therefore will no longer be active in the care plan when you sign the prescription.

Example: let's keep the previous example where we **Load a prescription (Add)**: Intubated patient admission and let's use **Load a prescription (Replace)**: Non-intubated patient admission.



In the above screenshot all the **prescription lines are current**. They are **visible in the care plan (area outlined in red)**.

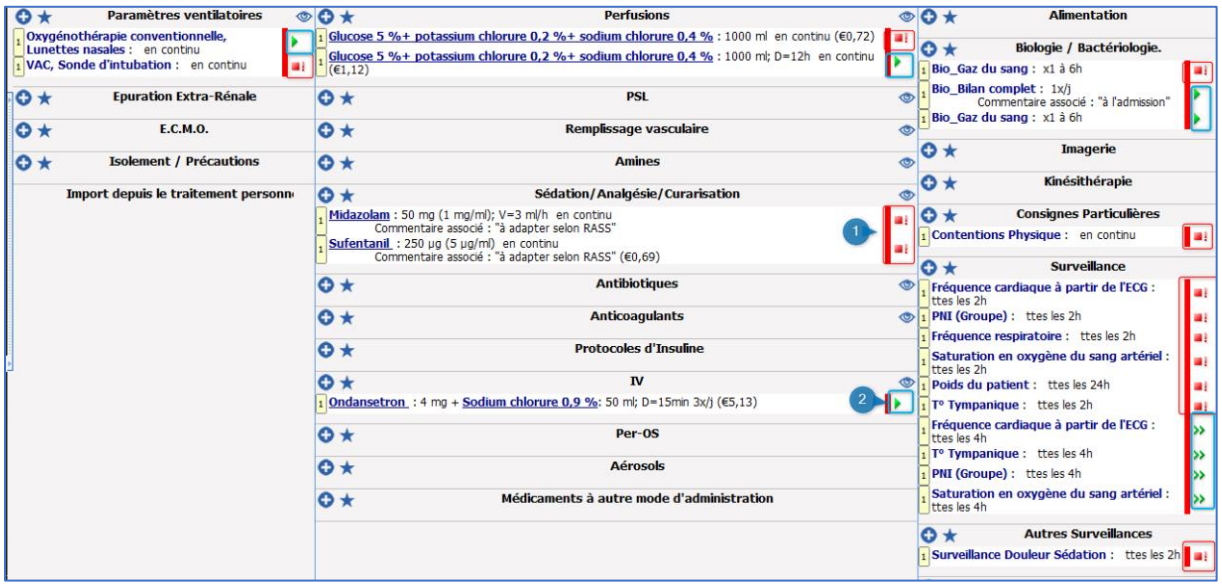
We will now **Load a prescription (Replace)**: Non-intubated patient admission.



Area (1): Pencil icon: area giving access to the protocol prescription menu.

- Click on the pencil icon.
- Select the **Load a prescription (Replace)** option to open the add prescription menu. (2)

- Click on the protocol you want to prescribe (Non-intubated patient admission here).
- All the current prescriptions are marked as stopped. (1)
- The chosen protocol is loaded automatically. It will therefore **Replace** the previous prescriptions. (2)

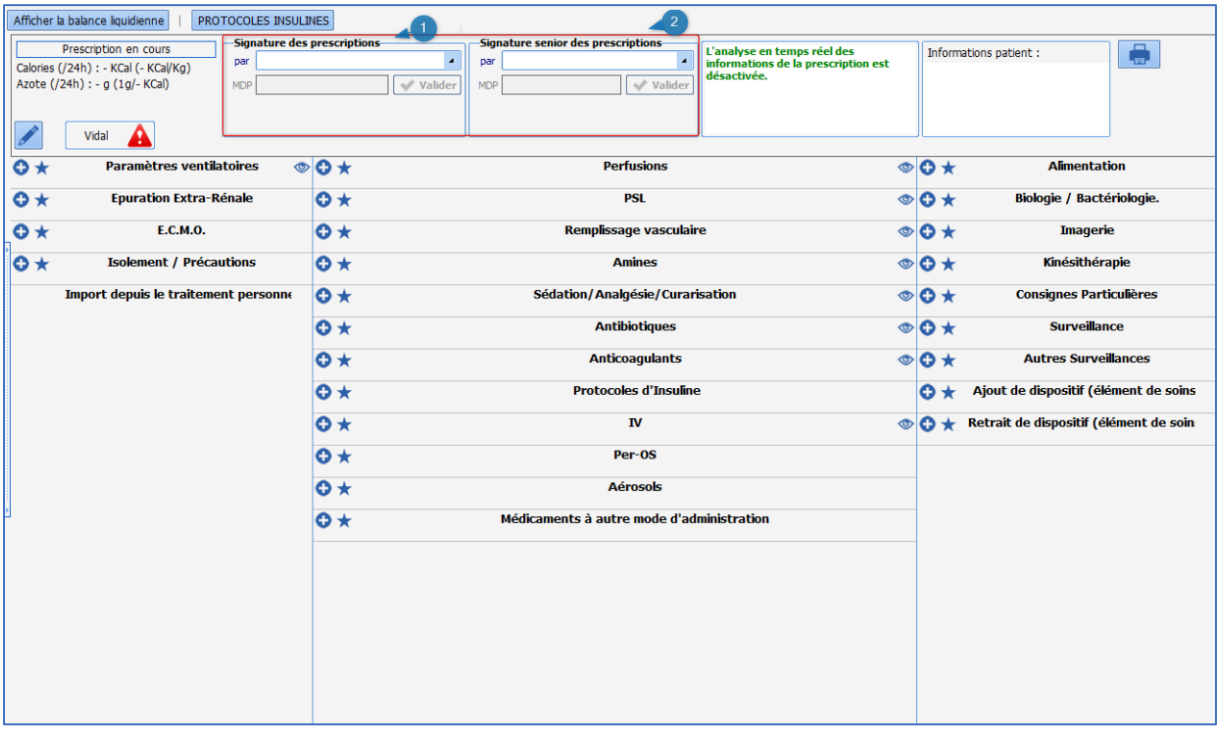


The pencil icon gives you access to other options:

- **Stop all prescriptions**: used to immediately stop all current prescriptions.
- **Cancel unsaved changes**: lets you delete all changes made since the prescription was last signed.

5.7.10 Confirming and signing the prescription

When you write prescriptions, to ensure they are actually created and therefore visible on the care plan, the prescription **MUST BE SIGNED**.
To do this, you must enter your login and password in the **Signature for prescriptions** component located in the prescription tab ribbon.

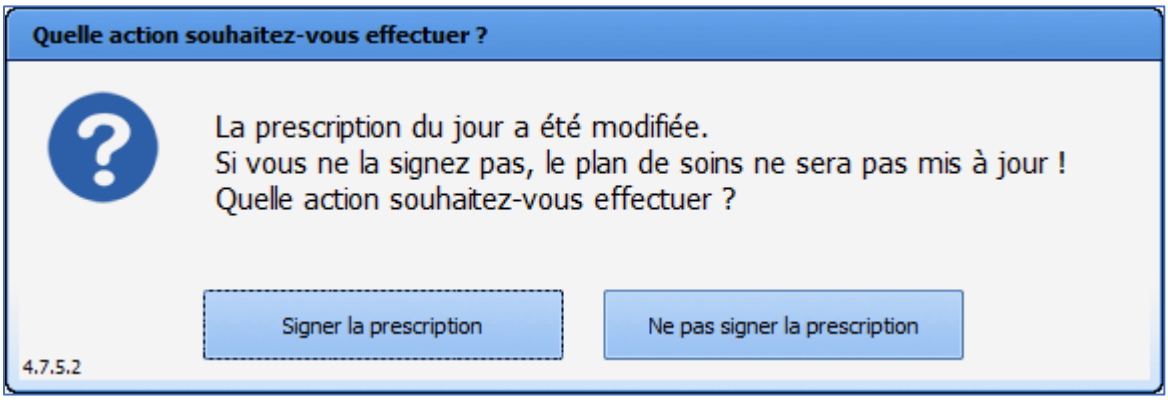


Two components can be available to be able to sign (1) and for the senior doctor to countersign (2) if your facility receives medical students.

Different permission options are possible with regard to prescribing and signing.

- **Prescribe without signature authorization**: the foundation doctor can write a prescription but the care plan will only be generated when the senior doctor signs.
- **Prescribe with signature authorization**: the foundation doctor can prescribe and sign the prescriptions. In this case the care plan is generated. The senior doctor's countersignature will confirm that the prescriptions have been checked.
- **Prescribe with partial signature authorization**: in this case, some prescription lines will only be visible in the care plan once the senior doctor has signed.
  For example: narcotics.

NB: When a prescription is being written, it is automatically saved, but does not generate the care plan until it is signed.
When you change tabs, a message will remind you to sign the prescription.

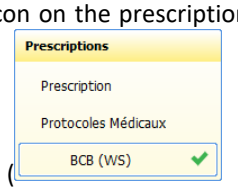


5.7.11 Drug database report

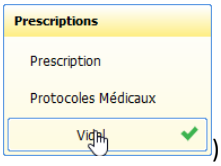
The **DIANE** application is connected via an API to a drug database (either Claude Bernard or Vidal database, chosen by your facility) to prescribe safely.
When the software is properly connected to the drug database you will see the ✔ icon on the prescription (

or

) and on the **Main menu** tab (

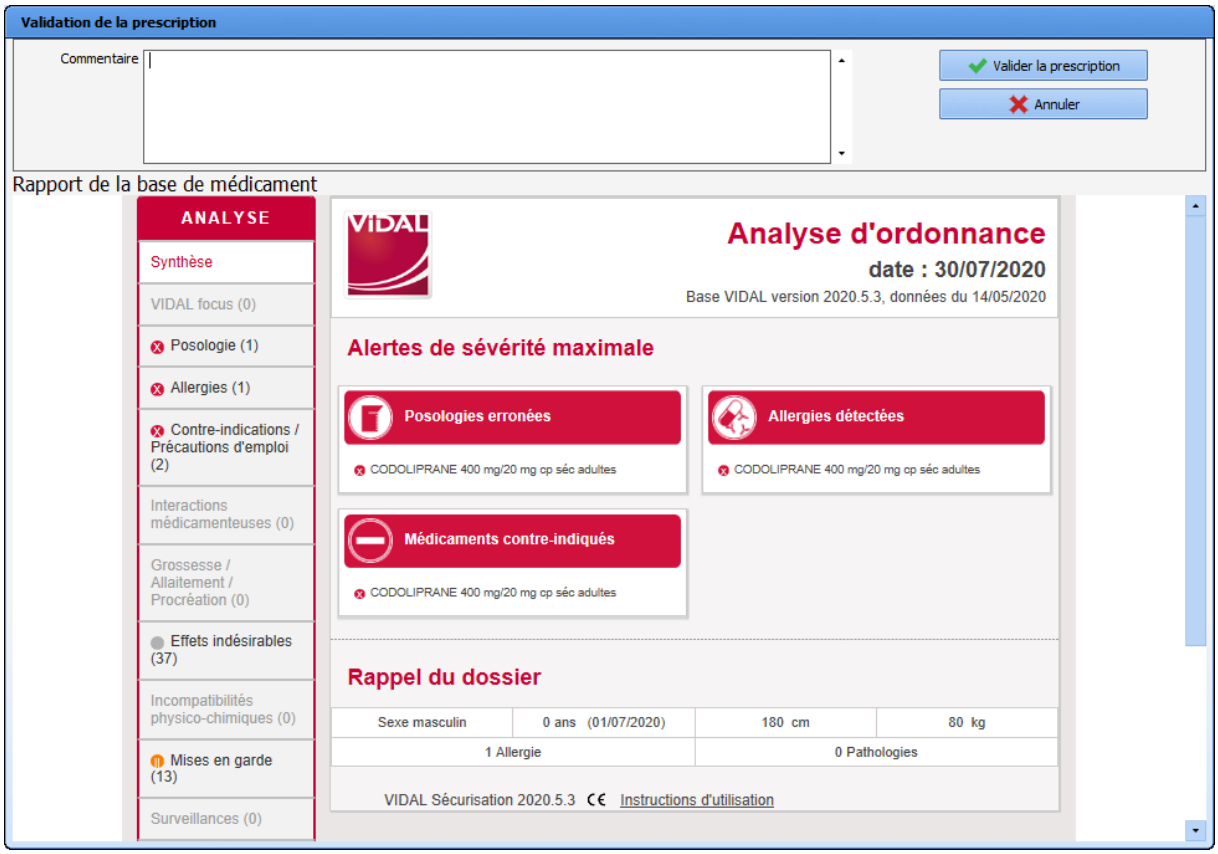


or



). However, if this icon is red ⚠, this means that there is a connection problem. You must contact your facility's IT department to reconnect.

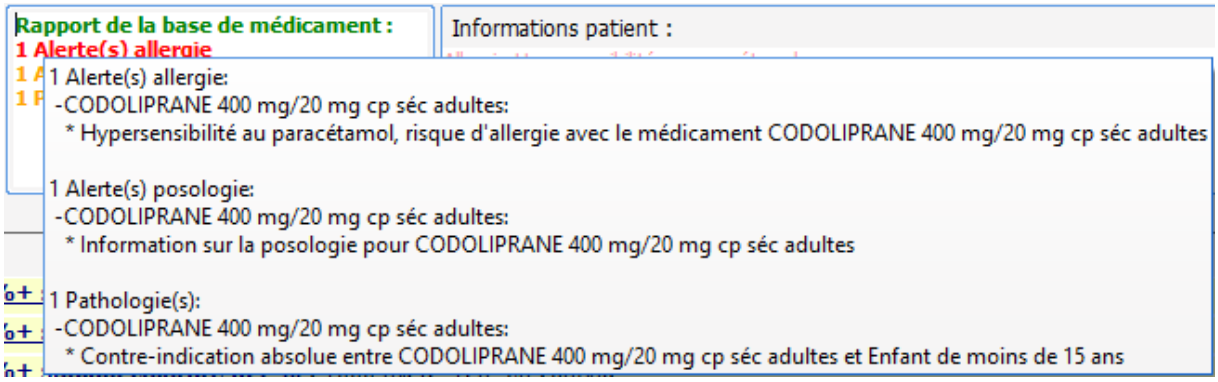
When the prescription is signed, a full report issued by the drug database opens, which you must confirm that you have read.



When you have clicked on the **Confirm prescription** button, the prescription is signed and the care plan is generated.

A summary is always visible in the **Prescription** tab showing any allergies, interactions, etc.

By hovering over this section you can view the details.



You can see the full report again at any time by double-clicking on the **Drug database report** area.

Colour code:

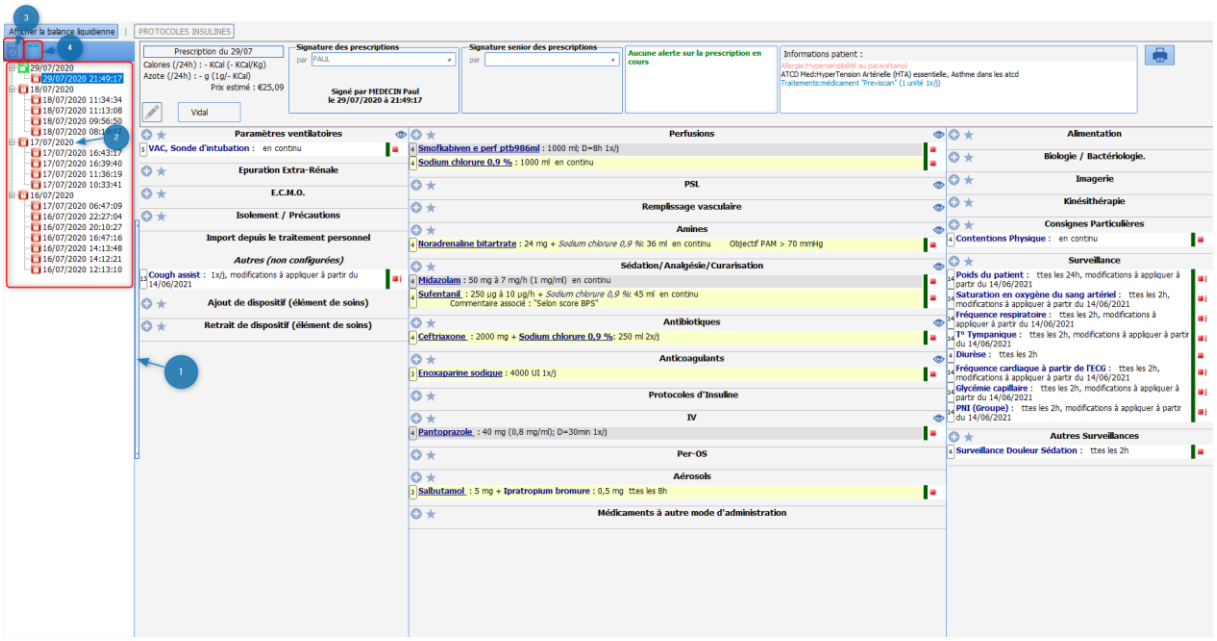
Red: Allergy warning.

Orange: Dosage, interaction, contraindication and medical condition warning.

Black: Redundancies and precautions for use.

5.7.12 Prescription history

The application lets you easily see the patient's prescription history.

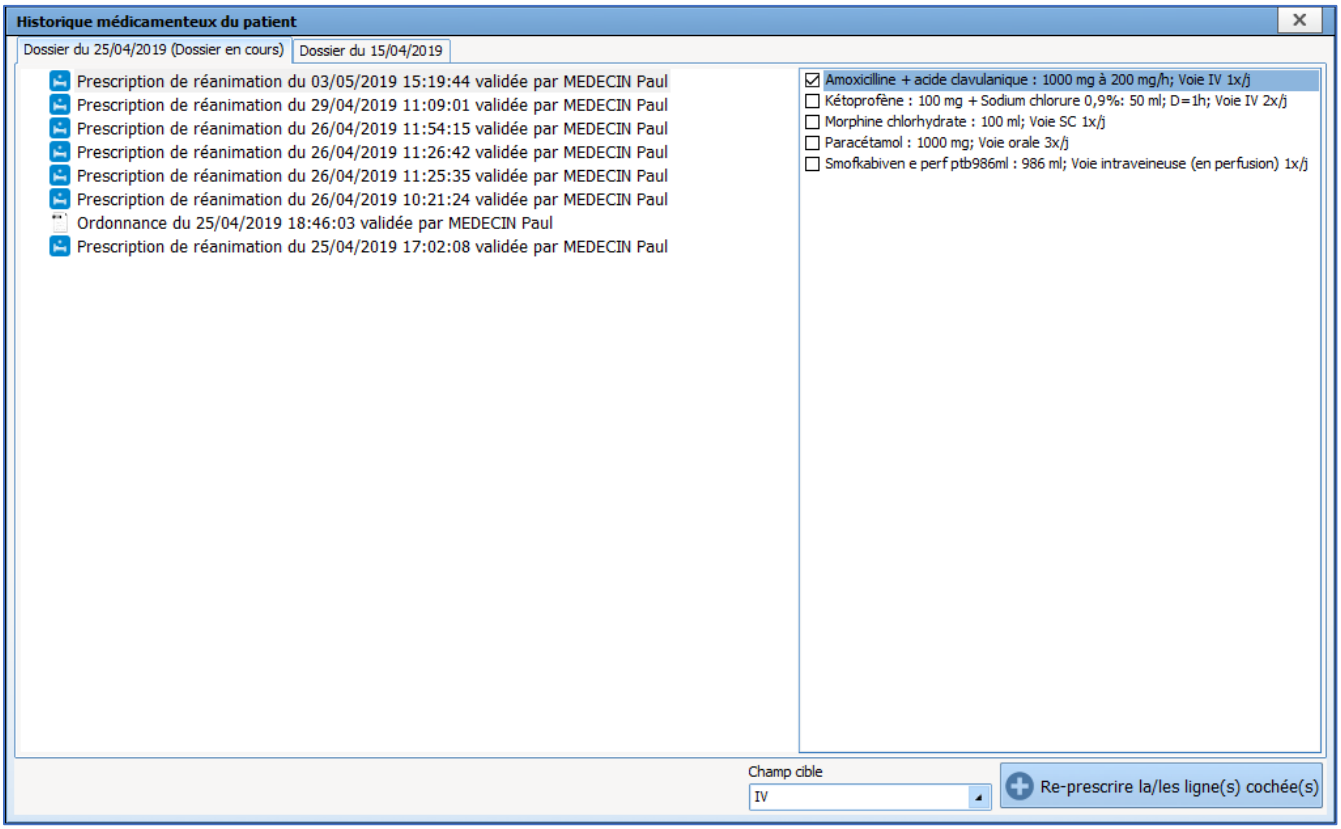


1. Prescription history:
   Shows the different changes made to the prescriptions during the stay.
   - Click on the arrows to the left of the prescription tab. (1)
   - Opens the signature history in chronological order. (2)
   - Select the date and time you want to see.
   - The prescription is then displayed as it was.

Icon legend:
Current prescription (not signed)
Past prescription (signed)

5.7.12.1 Patient's drug history

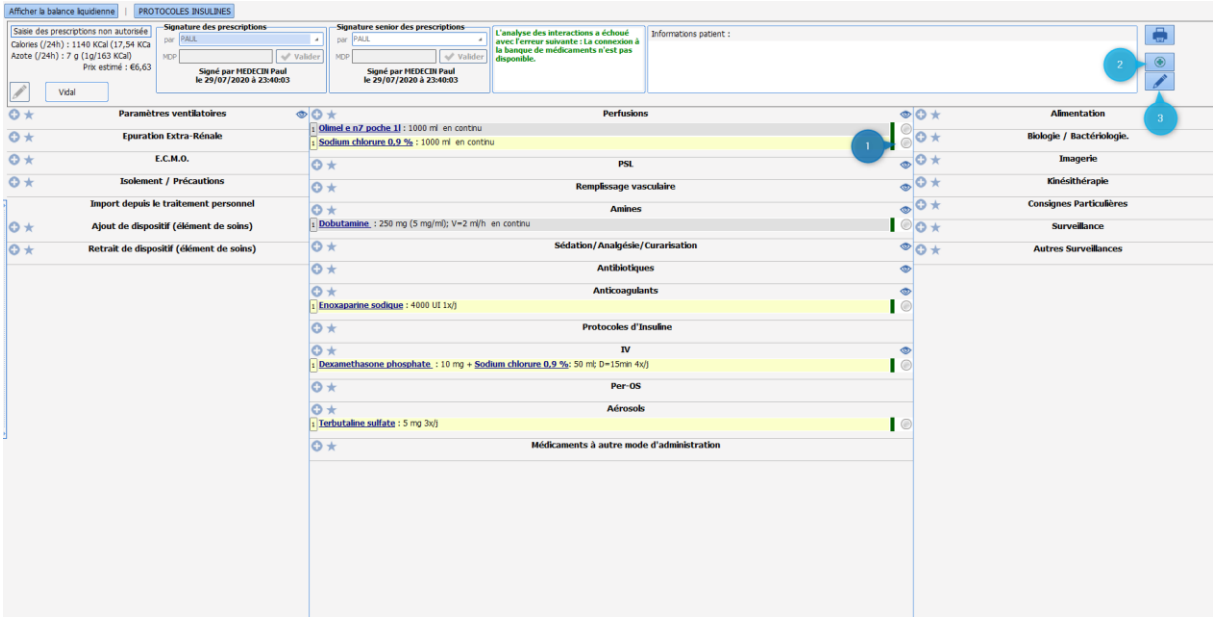
View patient's drug history (3):
Lets you see the different drugs prescribed to the patient during their different stays.



View history of the additional data associated with the record's prescriptions
Lets you see additional information entered when prescribing antibiotics and additional billable drugs.

5.8 Pharmacy confirmation

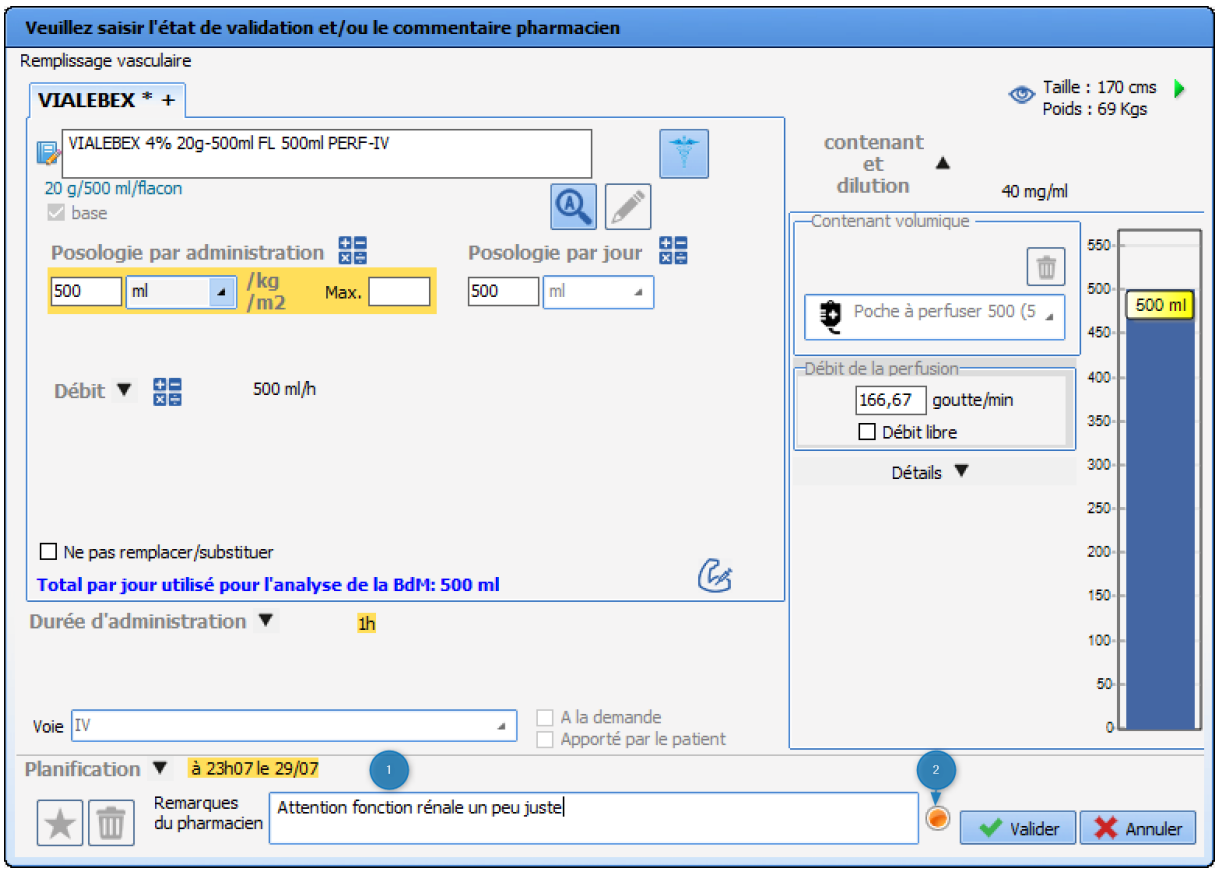
The application can manage pharmacy confirmations. To facilitate this, the entire record is accessible in read-only mode.



Several options are available for pharmacy confirmations.

5.8.1 Line-by-line confirmation:

- Click on the grey ball at the end of the line. The ball turns green. The prescription line is now confirmed.
- If you click again, the prescription window opens and you can add a comment in the line provided for this purpose.
- When a comment is entered the ball immediately turns orange.
- If you want to stress the importance of this comment, you can turn the ball red by clicking on it again.



5.8.2 Confirm whole prescription

Lets you confirm all the prescription lines at once.

- Click on the icon to the right of the tab (2).
- However, if there is a comment on one of the lines, it will not be modified and the line marked with an orange ball will stay the same.

5.8.3 General comment about the prescription

Lets you make a comment about the whole prescription.

- Click on the icon (3).
- Add your comment.

5.9 Care plan tab

The **Care plan** tab provides information about the different care provided to the patient throughout the ICU day. It also displays the various physiological and biological parameters recorded.

In the example below, the **Care plan** tab is split into different specific subtabs:

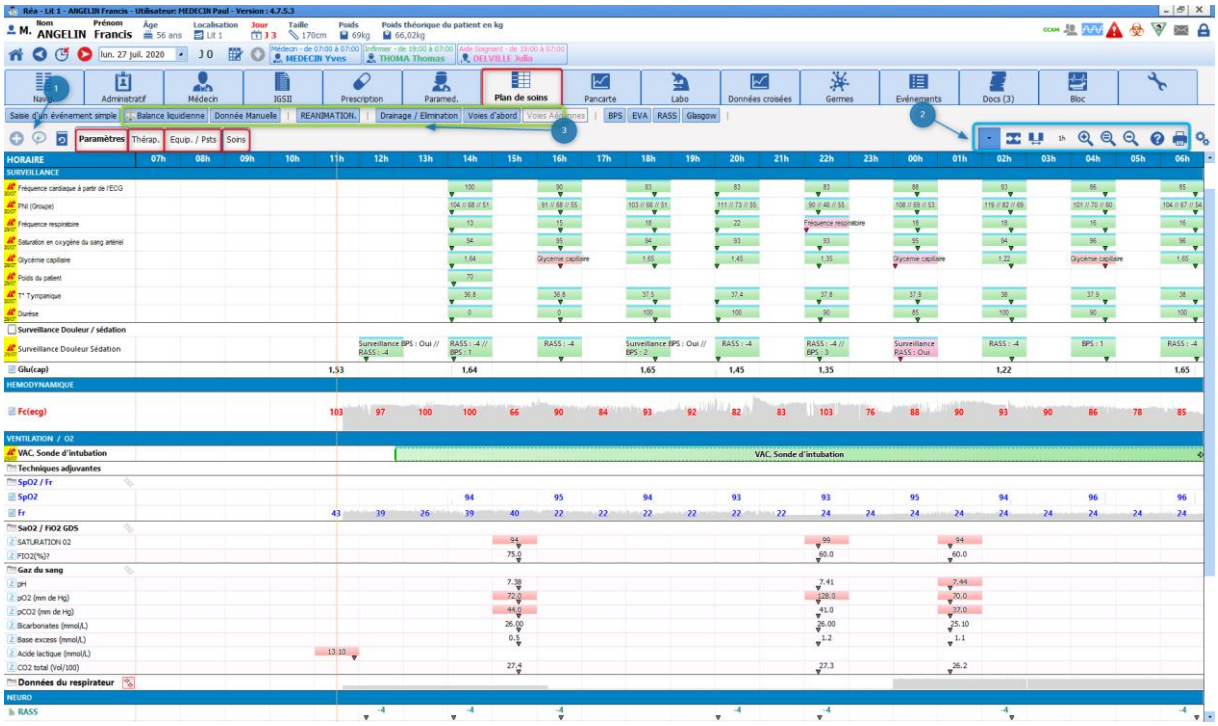
Parameters: this mainly includes the patient's physiological data (entered manually or reported from connected devices) and the reading of the liquid balance outputs.

Treatment: this information comes from the prescription and shows the treatment administered.

Equipment / dressings: this is based on the Body diagram, and is used to track placements / monitoring / removals and associated care.

Care: this lets you track different hygiene and comfort care provided to the patient.

The **Care plan** is by default configured for a 24-hour display corresponding to your ICU day and each column represents 1 hour.



5.9.1 Care plan icons

5.9.1.1 Icons visible in the headings

- : Line from a prescription.

: Nurse scheduling line.

: Data entry item line. Lets you enter one-off events.

: Shows that the display lines are merged. By clicking on this icon you can expand the display over several lines.

5.9.1.2 Icons visible in the menu bar (above the care plan)

: Displays a menu for you to enter a one-off event at the specified time

: Prescribe verbally

: Displays a record history window to search by type of data and filter by date

: Adjusts the display zoom level

: Changes the tab arrangement

: Centres the display on the marker. In this mode the care plan moves, the marker does not

: Displays a custom time slot

: Displays the care plan help tool and explains the colour codes used for occurrences.

: Used to print the screen

: Opens the care plan configuration window

5.9.1.3 Other icons also visible in the care plan

Types de données

- Paramètre physiologique
- Résultat de laboratoire
- Chronomètre
- Score
- Saisie avancée
- Champ de saisie avancée
- Evènement
- Médicament

Divers

- Présence d'un commentaire
- Affiche la somme des différentes saisies de la colonne
- Résultat de laboratoire mis à jour
- Fichier joint au résultat de laboratoire
- Déclenchement d'une alarme
- Element non disponible dans la configuration du poste
- Groupe de ligne replié (double clic pour déplier)

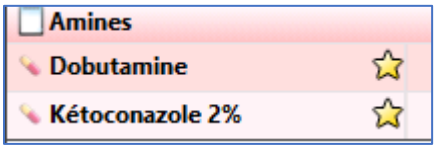
Elements de prescription

- Débit du produit incohérent par rapport à la prescription
- Elément prescrit relié à un appareil
- Prescription arrêtée
- Prescription mise en pause
- Prescription conditionelle
- Dépassement de l'heure d'arrêt prescrite

Filtrage des lignes

- Affichage du plan de soin
- Affichage des saisies
- Affichage par voie (médicaments)
- Affichage de la planification infirmière
- Affichage des saisies non configurées (par type)
- Affichage des signatures

When the prescription has been changed, a star appears on each changed line on the corresponding prescription in the care plan:



When you click on the star, you can see the time at which the prescription was signed.
The length of time the star is displayed can be configured by your key users. By default this is 1 hour.

5.9.2 Using the care plan

All of the patient's data can be viewed in this tab. You can also enter any new data you wish.

The **Care plan** provides information about all the different care provided to the patient. The data can be entered in different ways depending on the type of line: if from **Prescribing**, **Nurse scheduling** or a **Data entry item**.

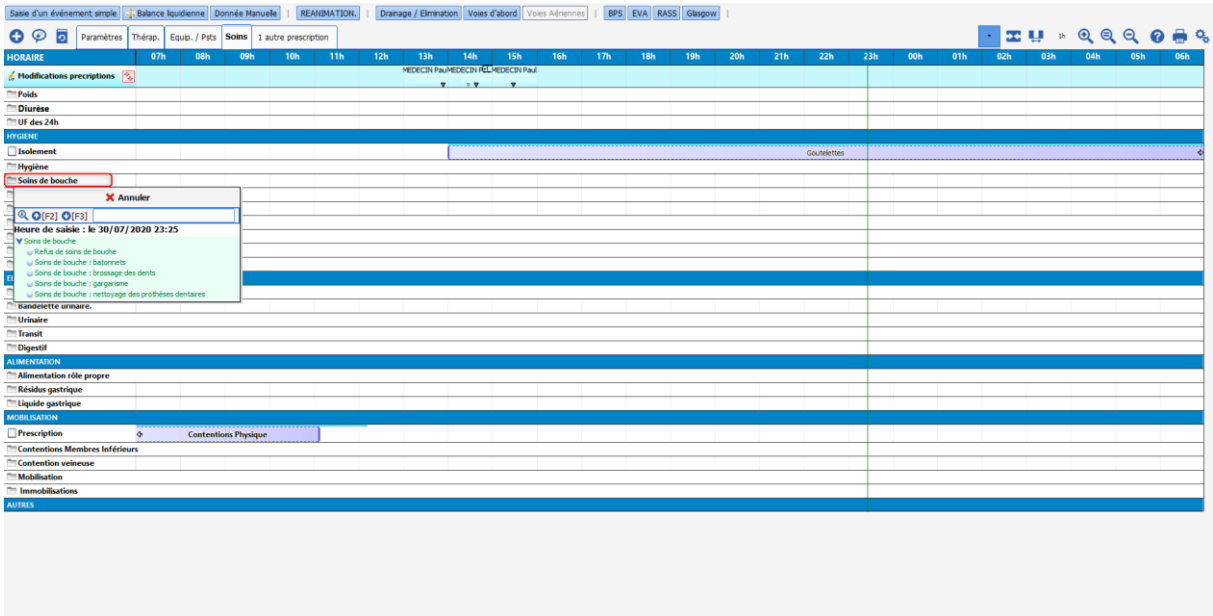
5.9.2.1 Data entry items

Almost all of the lines in the **Care plan** tab are in this category.

These lines are represented by the icon in the heading.

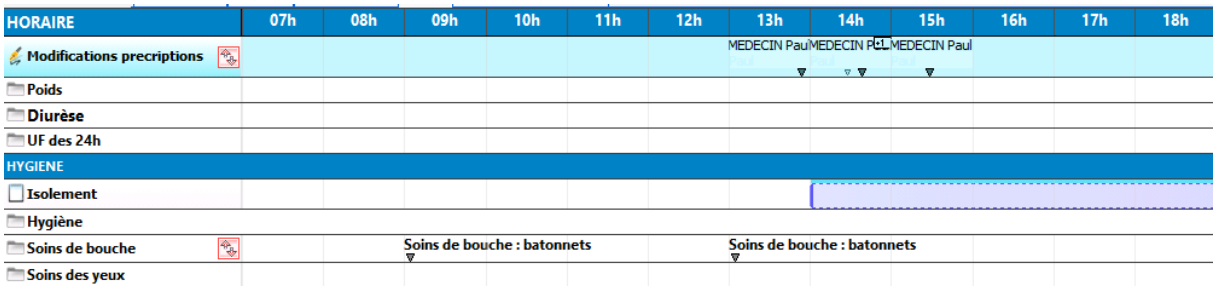
5.9.2.1.1 Adding an item from the Diagrid

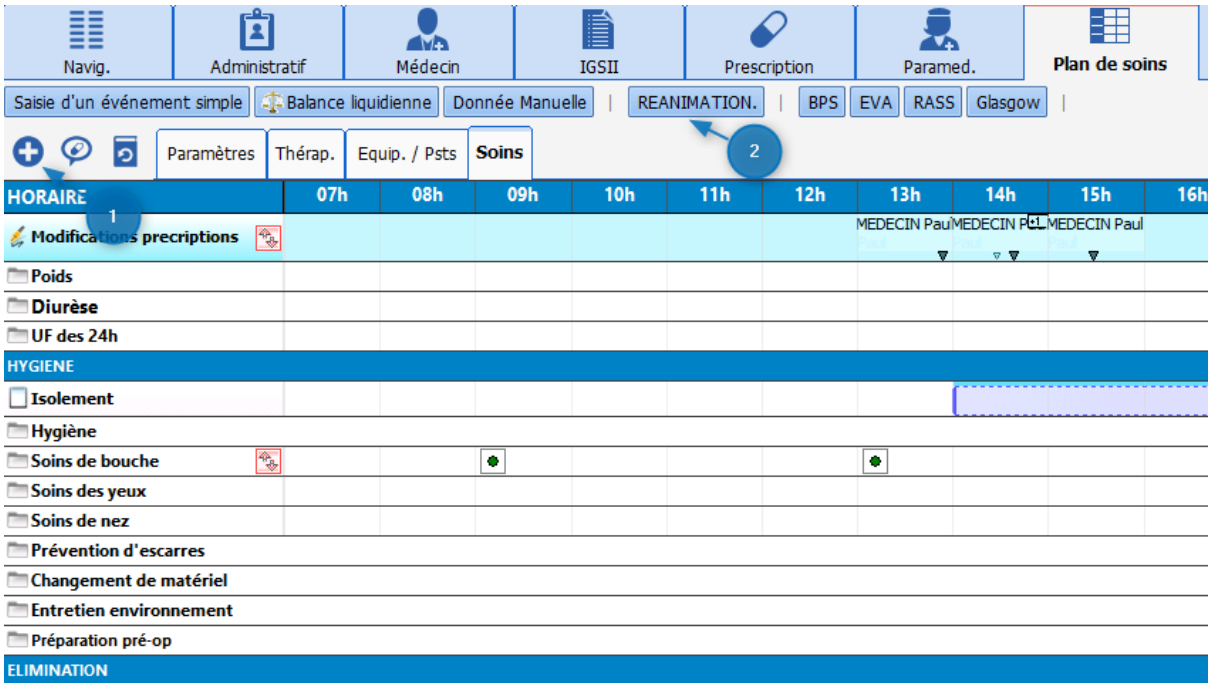
Example: Mouth care performed at 9 a.m. and 1 p.m.



- Double-click on the heading of the corresponding line.
- The menu window offering the available items opens.
- Select the **Mouth care: sticks** item.
- This will be automatically positioned in the current time column. Here this is 9 a.m.

- When you want to enter an identical item at a different time, simply double-click in the corresponding column, here at 1 p.m. The care is entered automatically.



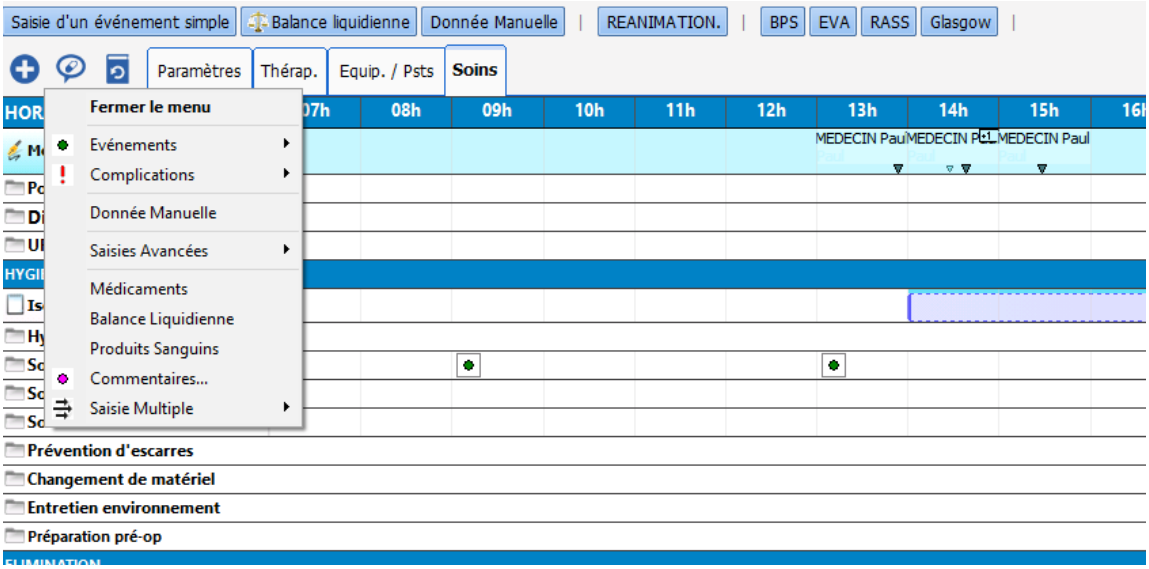


5.9.2.1.2 Adding an item from a 'quick entry' button (2) or from the Make an entry button (1)

The application offers quick entry buttons to enter data at the current time without necessarily being positioned in the tab displaying the data.

- Click on the **ICU** button (2)
- The menu opens
- Select the item you want
- The action is then entered in the **Care plan** at the current time

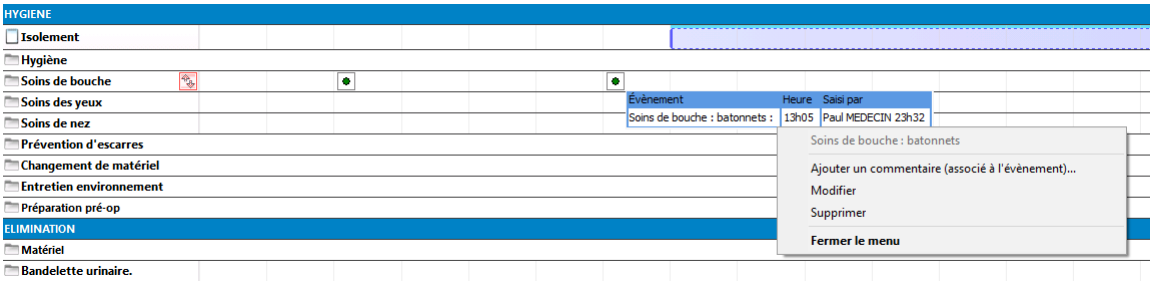
Likewise, you can use the **Make an entry** button located at the top left of the **Care plan**. **(1)**
This lets you access all the items available in your unit.



5.9.2.1.3 Add a comment, **change or delete an entry item**.

You can change an entry made. To do this:

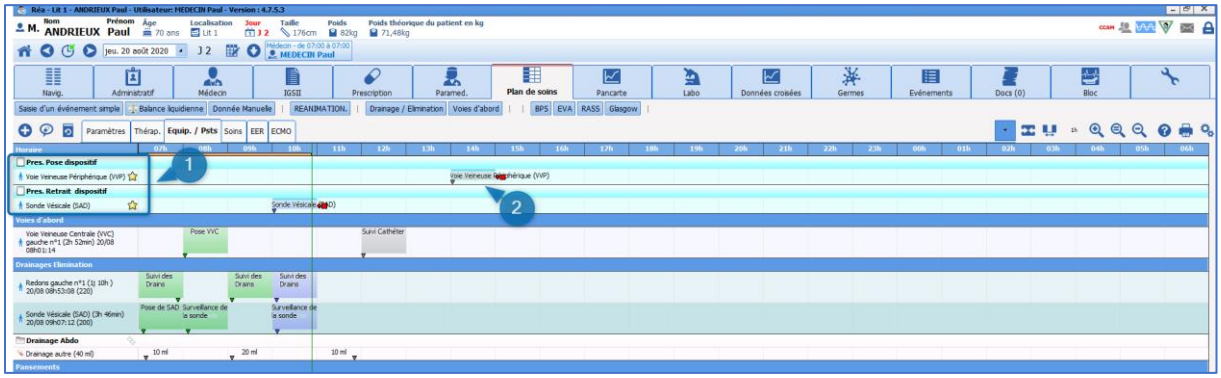
- Click on the entry to change or delete.
- The details window opens.
- Right-click on the details window.
- The options window opens.
- Select the relevant option.



NB: If you want to change the data entry time, just drag and drop the occurrence to the time you want. To delete the occurrence you can also drag it to the heading area.

5.9.2.2 Confirming device placements and removals

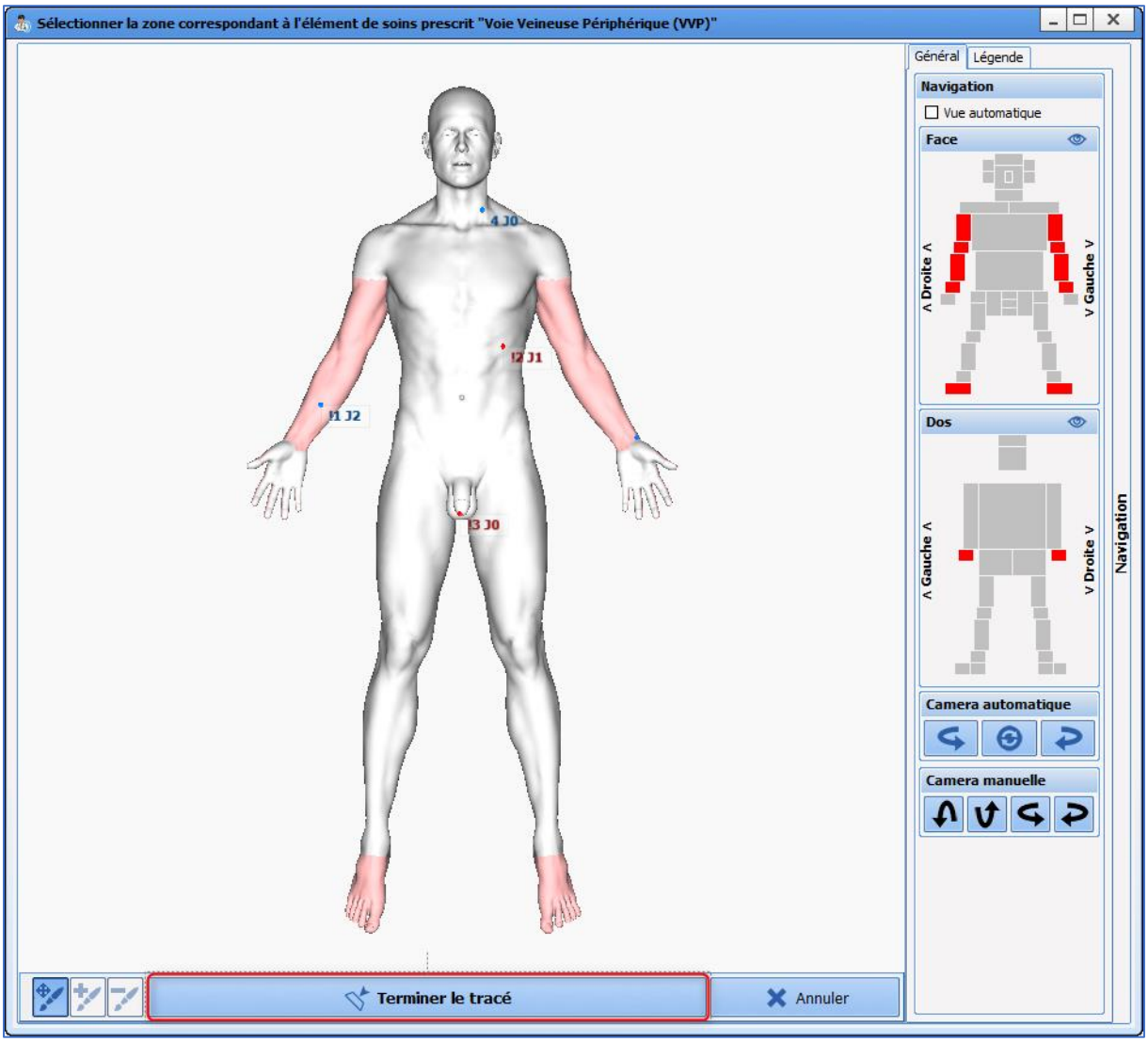
When a device placement or removal is prescribed, this information appears in the care plan like all other prescriptions. It is preceded by the icon.



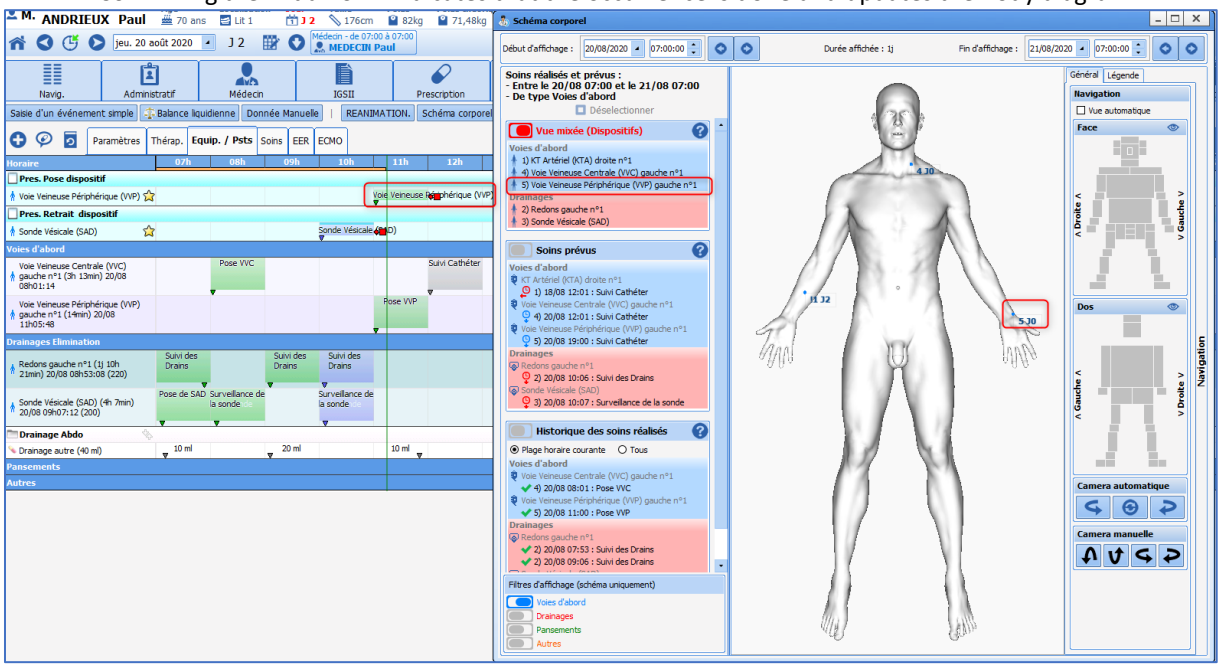
(1) Specific prescription lines to place and remove devices in connection with the related prescription fields.
(2) Occurrence to confirm the action carried out.

These prescriptions are only confirmed from the Care plan.

- Mark the occurrence as done by clicking on the 1st icon.
- When you click, the diagram pop-up window opens to let you show where the device is located.



- Position the device.
- Confirm by clicking on the '**Terminate drawing plot**' button.
- Now enter the device information as seen in the 'Body diagram' chapter.
  If the doctor pre-entered information when prescribing, this information will be available but not modifiable. The other information can be entered.
- Confirming the initial form indicates that the occurrence is done and updates the Body diagram.



To confirm a Device removal, the procedure is the same.

5.9.2.2.1 Items from a Prescription

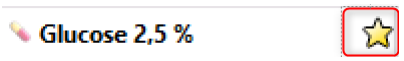
A prescription automatically generates the **Care Plan** lines when signed.

These lines are specific and can be recognized by the presence of the icon in the name headings.
They use the different categories present in the **Prescriptions** tab.

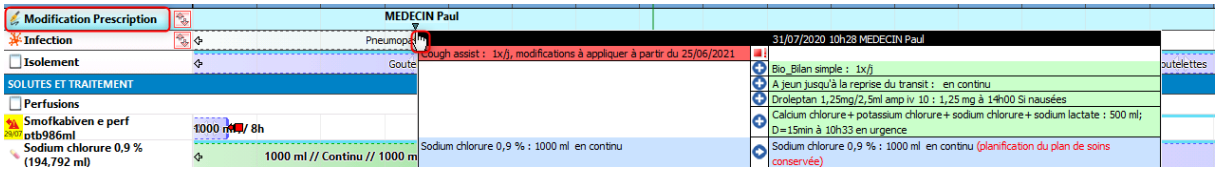
5.9.2.2.2 Indicators of changes or new prescriptions

With each new signature, a message is displayed in all the tabs to tell you what actions need to be taken.

Other indicators show that there are new prescriptions or that a particular line has been changed.

- The Star next to the name of the prescription line 

Clicking on the Star displays the time of the change.
- The **Prescription changes** line at the top of the **Care plan** shows you who signed for the change. When you click you can see a summary of the changes made.



5.9.2.2.2.1 Icons to confirm prescribed occurrences

In the care plan, occurrences are represented according to their duration of administration.
Above each one, a thin light blue line represents the Prescription plan.
This is the prescription as entered by the doctor. Its purpose is to keep the initial prescription.
When the administration is early, late or rescheduled, the two lines are separated.
The confirmation options will be different depending on the type of prescriptions involved.

Here are the different icons offered and their meaning.

				Libellé	Etat	Début	Prescripteur	Voie
				100 ml de Paracetamol 4x/j		14h44	MEDECIN Paul	IV
				100 ml de Paracetamol 4x/j	A Faire	14h44	MEDECIN Paul	IV

: show that the occurrence has been done

: show that the occurrence has been done and enter a comment (and change the time of completion)

: show that the occurrence has not been done

: display the details of the prescription (opens the editor)

							Libellé	Etat	Début	Fin	Prescripteur	Voie
							500 ml // Continu					
							500 ml de Glucose 10 % en continu		14h56	le 26/10/2019 à 14h56	MEDECIN Paul	intraveineuse (en perfusion)
							500 ml de Glucose 10 % en continu	A Faire	14h56	le 26/10/2019 à 14h56	MEDECIN Paul	intraveineuse (en perfusion)

: enter the dilution

: start the infusion

: start the infusion and enter a comment (and change the time of completion)

: used to change the flow rate and/or pause

: lets you start at another flow rate at a specific date/time

			Libellé	Etat	Début	Prescripteur	Dernière modif. par	Voie	Infos Suppl.
			100 ml de Paracetamol 4x/j		14h44	MEDECIN Paul		IV	
			100 ml de Paracetamol 4x/j	Réalisé	14h44	MEDECIN Paul	MEDECIN Paul	IV	100 ml - 10 mg/ml (Poche à perfuser 100) [1000 mg]

: 'cancels' the occurrence (returns to **To do** status)

: enter a comment about the completion of the occurrence

											Libellé	Etat	Début	Fin	Prescripteur	Dernière modif. par	Voie	Infos Suppl.
											50 mg de Midazolam (1 mg/ml) Dans 50 ml; V=3 ml/h en continu		14h31	le 26/10/2019 à 07h11	MEDECIN Paul		IV	
											50 mg de Midazolam (1 mg/ml) Dans 50 ml; V=3 ml/h en continu	Démarré	14h31	le 26/10/2019 à 07h11	MEDECIN Paul	MEDECIN Paul	IV	3 ml/h - 1 mg/ml (Seringue 50) DM : 3 mg/h [2,2 mg]

: stop the infusion

: stop the infusion and enter a comment

: pause the administration

: pause the administration at a scheduled date/time

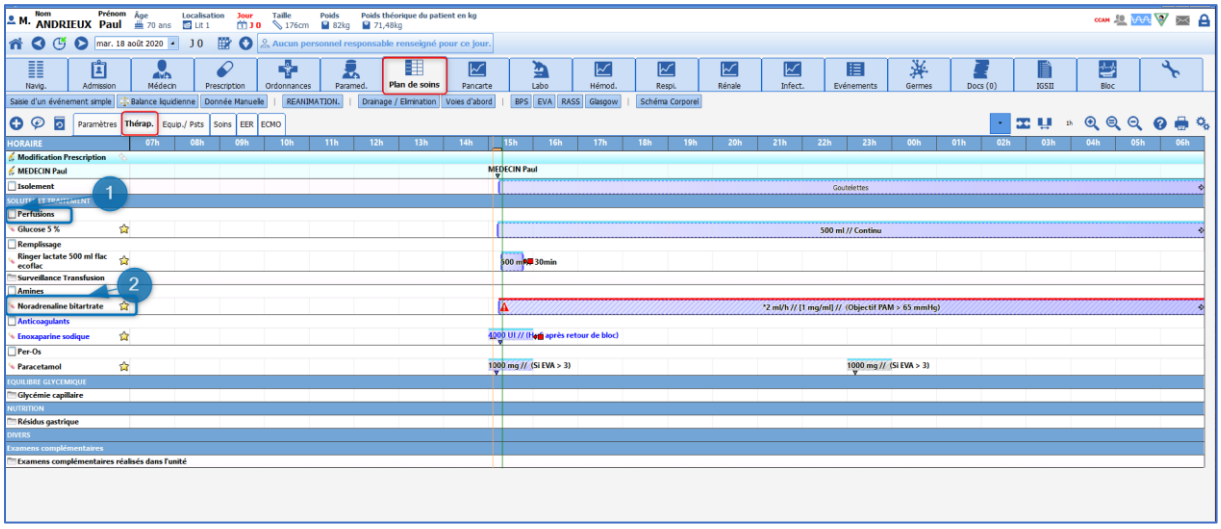
: clean the volumetric container

: clean the volumetric container at a scheduled date/time

					Libellé	Etat	Début	Prescripteur	Voie	Condition
					100 ml de Paracetamol 4x/j		20h44	MEDECIN Paul	IV	Si EVA > 4
					100 ml de Paracetamol 4x/j	A Faire	20h44	MEDECIN Paul	IV	Si EVA > 4

- : show that the occurrence has not been done because the condition is not met

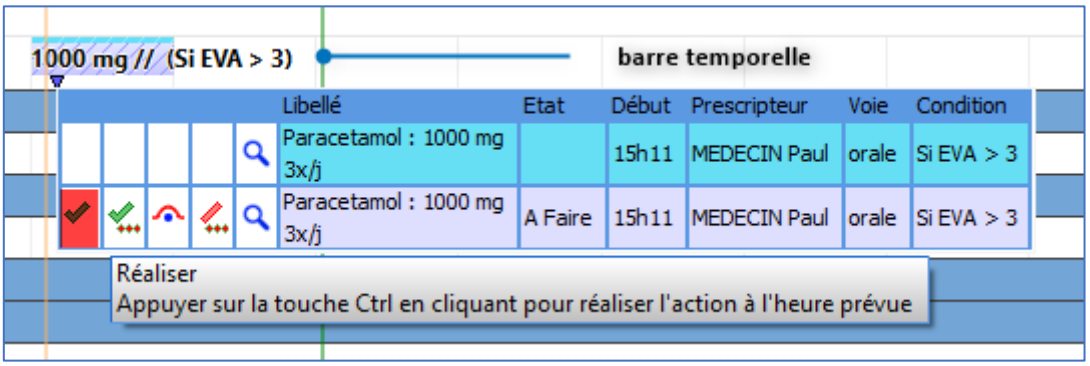
5.9.2.2.3 Examples of confirmation of prescribed items



Reminder:
(1) Icon showing that the line is from a prescription. The name is that of the corresponding prescription field.
(2) Icon showing a pharmaceutical prescription. The name is that of the prescribed product.

5.9.2.2.3.1 Drug prescribed as X per day with a condition

Example: prescription of Paracetamol per os 3 times a day if VAS > 4.



- Click on the 1st icon: Do: the occurrence will be marked as confirmed at the current time, represented by the green timeline

- Click on the 2nd icon: Do (changing the date/time or entering additional information).

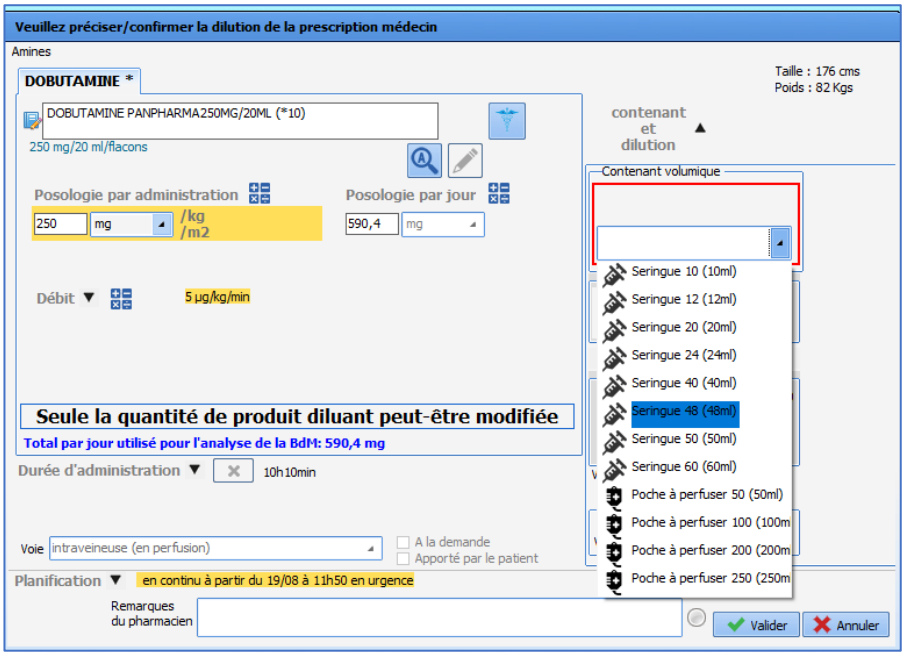
Used to enter the actual completion time: Example: administration done at 3 p.m. (scheduled time), but not confirmed in **DIANE**. By clicking on the Scheduled time button (4) the occurrence will be confirmed at 3 p.m. (You can also use the cursor (1) or the clock (2) to indicate the precise time.)
Or you can give additional information, e.g. the actual dose administered (3), here one 500 mg capsule and not two.
Click on the 3rd icon: the condition is not met: used to indicate that the drug has not been administered because the condition (here VAS > 3) is not met.

5.9.2.2.3.2 Treatment with a duration of administration

Dobutamine 5 µg/kg/min continuously without specified dilution prescribed in an emergency. (1) (indicator of urgency)

To ensure that the occurrences of the Care plan are representative of the speed of administration and the pace of syringe changes, before starting the administration you must enter the container used and therefore the dilution applied.

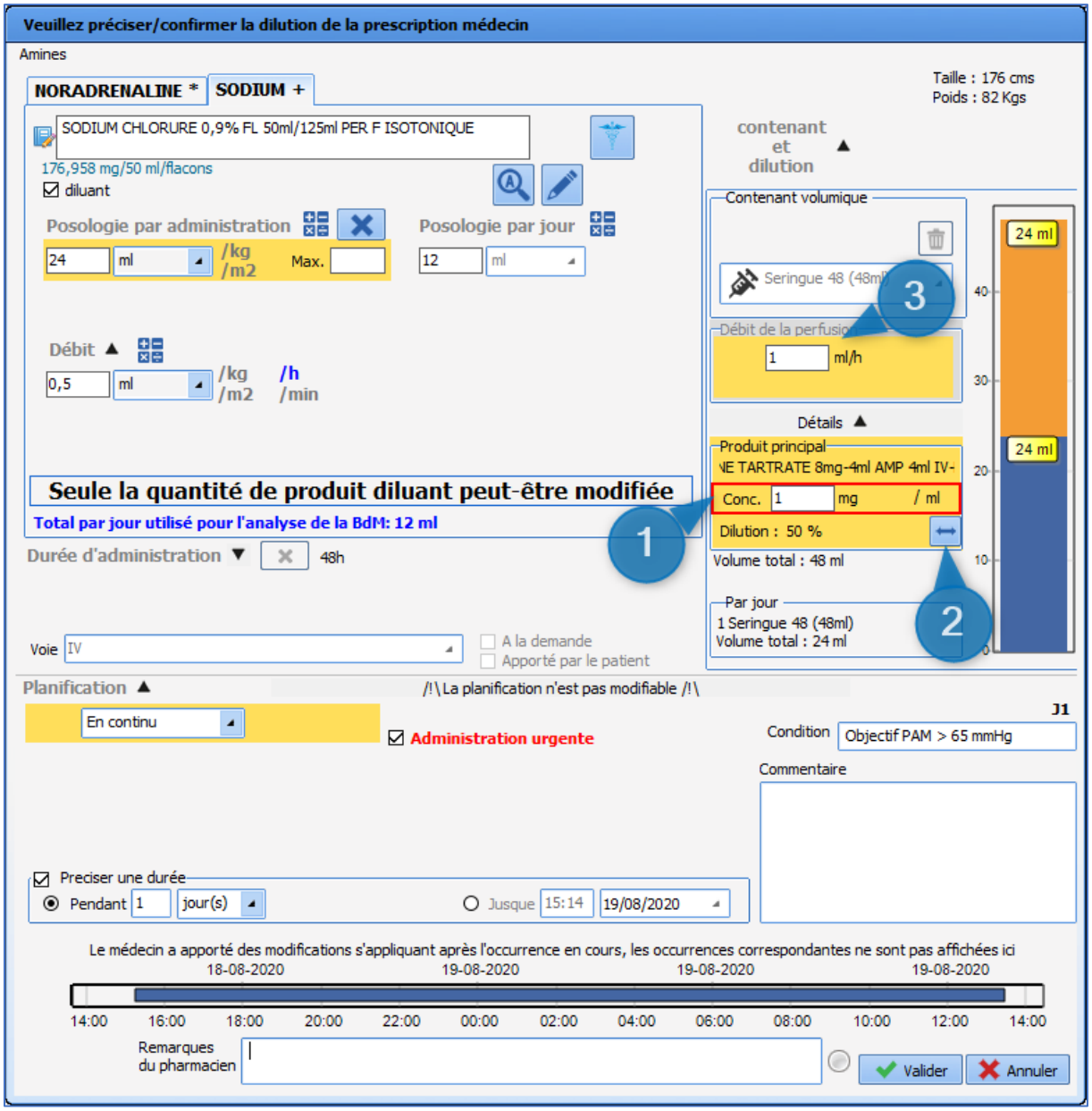
- Click on the 1st icon: Dilution information: used to enter the volumetric container used. This automatically calculates the dilution of the product.



- Now click on the 2nd icon: Start: to start the administration.

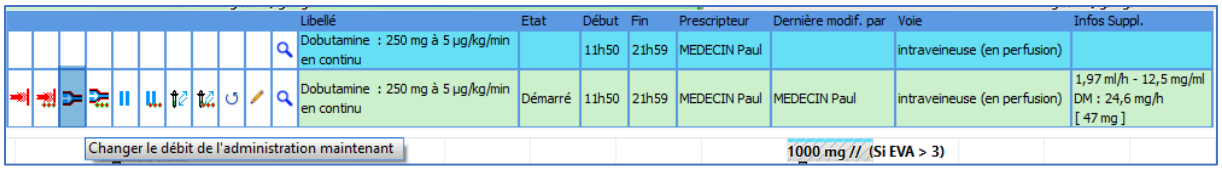
When necessary, it is also possible to **Change the product concentration** (e.g. need to double the concentration of Noradrenaline to be able to reduce the speed of administration).
To do this:

- Click on the 1st icon: 'Dilution information'
- Now enter the concentration of the product in the box **(1)**.
  If you wish, instead of entering the concentration, you can enter the quantity of main product present in the syringe.
  To do this, click on the double-sided arrow in area **(2)**.



For long (continuous) administrations, you can:

- **Change the flow rate.** Click on the 3rd icon: Change the administration rate now: Enter the desired flow rate in area **(3)** then confirm.



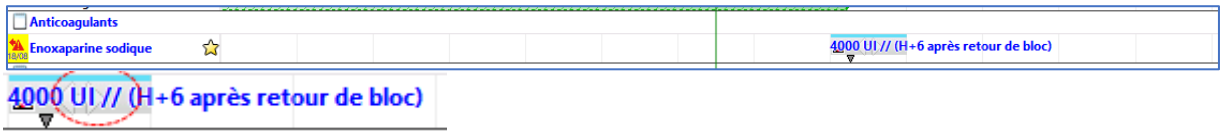
- **Stop current administration**: Click on 'Finish' (1st icon).

- **Pause administration**: Click on 'Pause administration' (5th icon).

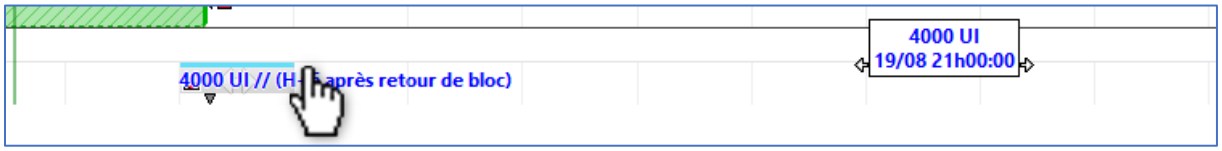
5.9.2.2.3.3 Confirming and scheduling a prescription for an 'undefined time'

When a prescription is written for an 'undefined time', you can schedule the administration at the desired time in the Care plan.
The confirmation of the first occurrence will schedule all the other occurrences taking into account the time of administration and the gap required between each administration.

Example: Enoxaparin 4000 IU once daily 6 hours after leaving the OT.



On this type of occurrence, a cell with a white arrow on each side shows that you can move the cell to schedule it. To do this, click on the occurrence, and drag and drop it to the desired time (9 p.m. here).

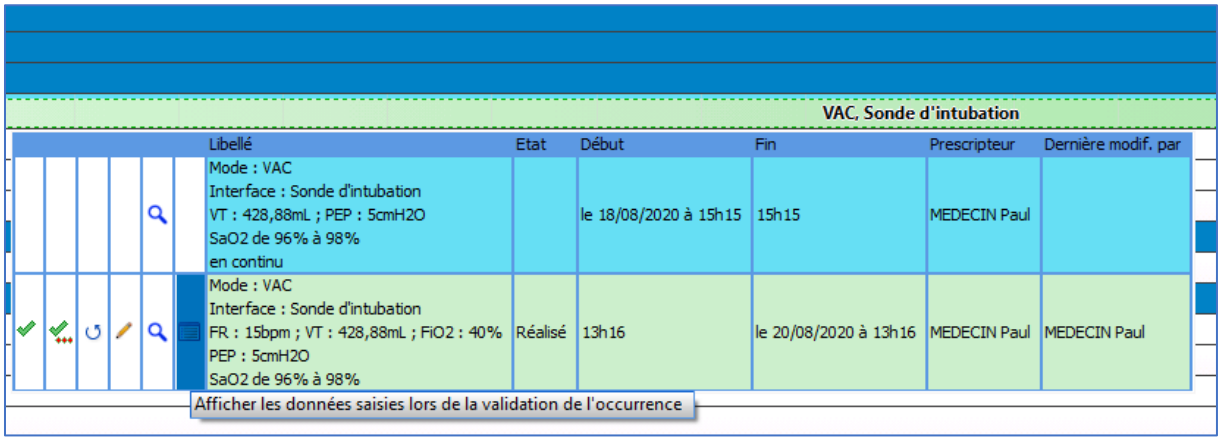


5.9.2.2.3.4 Special case of ventilation parameters

The ventilation parameters confirmation window lets you enter the patient's machine parameters without changing the prescription.

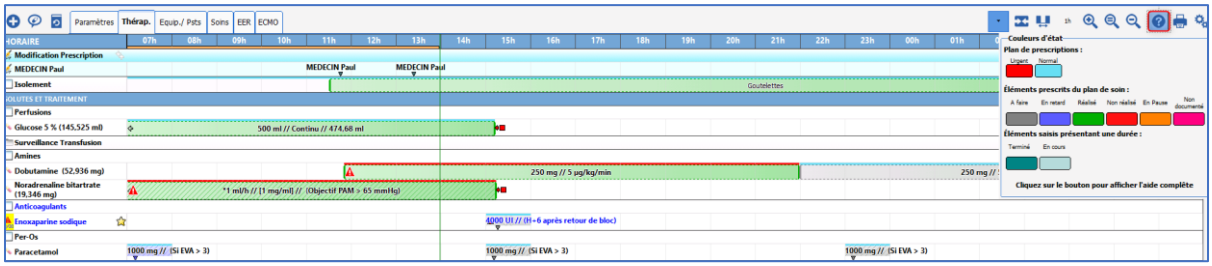
Click on the Do icon: this action opens the confirmation window. This window shows you the information in the prescription.
From this window, you can directly enter the patient's monitoring information and the patient's machine data.
Clicking on the last icon displays the content entered at confirmation.

-



When you confirm the occurrences in the Care plan, their background colour changes, showing the new status.

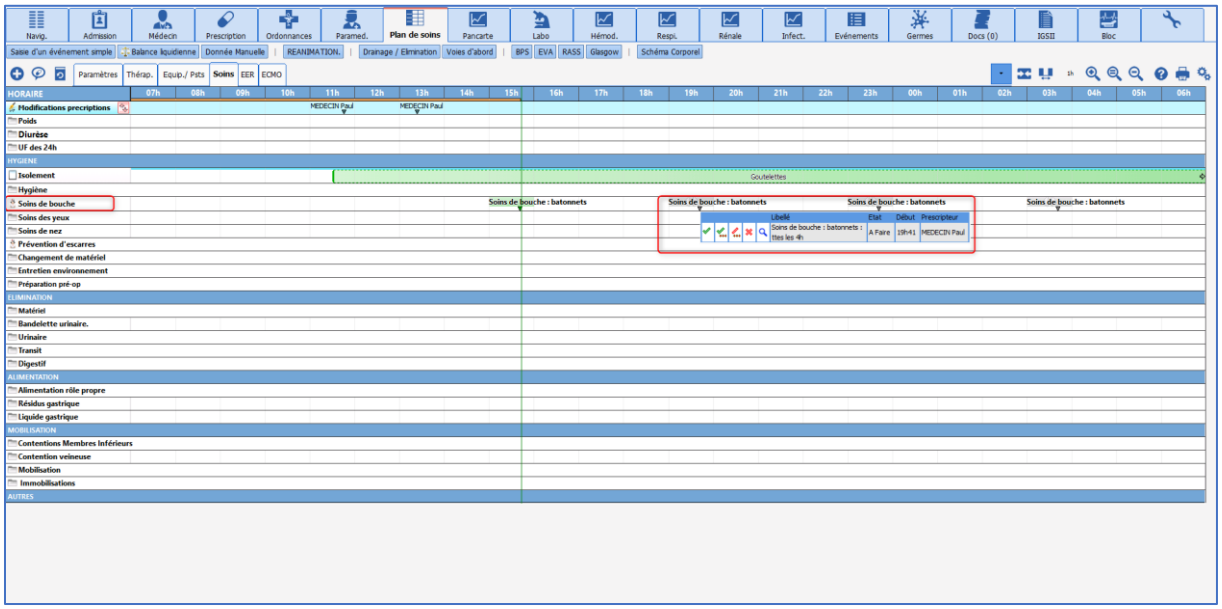
The colour code is accessible by hovering the mouse over the at the top right of the Care plan.



5.9.3 Nurse scheduling

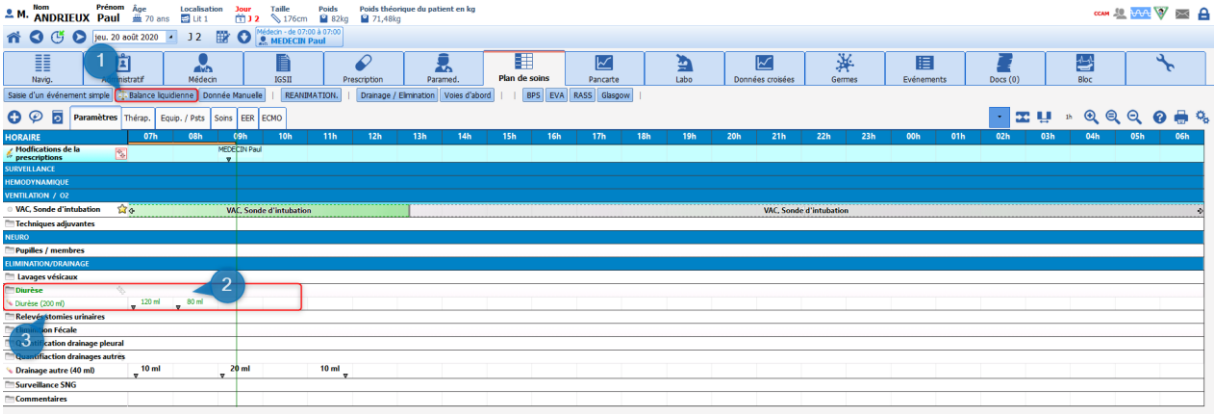
The application also lets you enter 'Scheduling' type information to schedule a series of care.

These items are shown in the care plan by the icon in the heading column.
These items are confirmed using the same procedure as for confirming the items from a prescription.



5.9.4 Overview of Inputs / Outputs

The application makes it easy to calculate the number of inputs / outputs.
'**Inputs**' are calculated from the administrations entered from the Care plan (including the quantities entered for product dilutions, which is why it is important to enter them before starting the administrations).
The '**Outputs**' are derived from the quantifications from the Care plan.



(1) Button displaying the Fluid balance.
(2) Display of the quantity entered during the reading.
(3) Daily total of the same output: this total is calculated over the display day, here from 7 a.m. to 6:59 a.m.

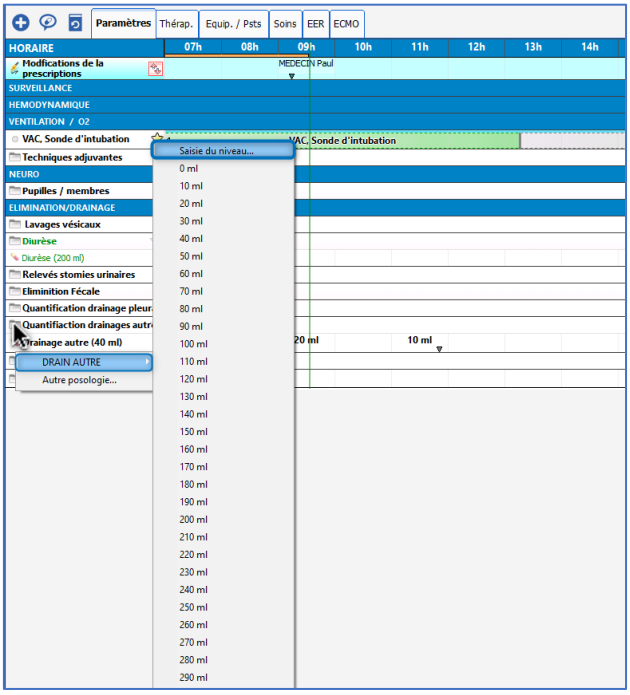
5.9.4.1 Quantification of 'Outputs':

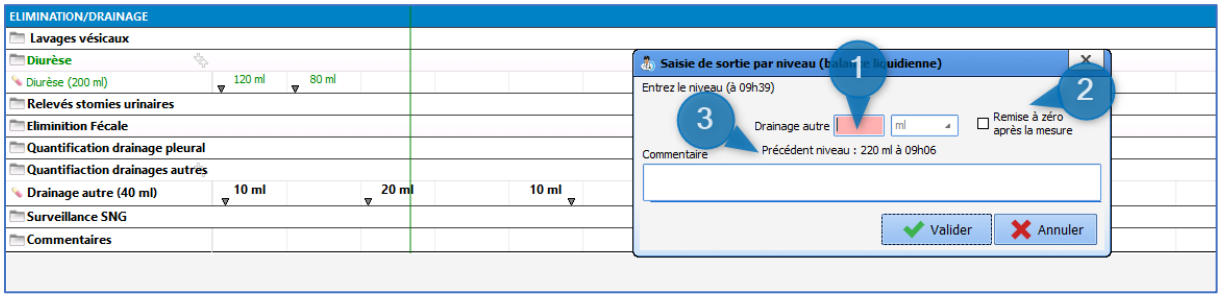
There are two ways to quantify 'Outputs':

- **Using the level:** during your reading, simply enter the total quantity in the container.
  - Double-click on the desired item in the heading column (Other drain here).
  - Select the 'Enter using level' option at the top of the list.
  - The pop-up window opens to enter the quantity.
  - Confirm.

The daily total is then displayed in the heading column, and the difference between the previous entry and the entry made is displayed in the cell of the current time slot.

NB: as long as no reset is carried out, the 'Previous level' (3) displayed in the pop-up window will show the total since the 1st entry.





(1) Box to enter the quantity in mL.
(2) Reset: checking this box lets you start quantification again from zero (when you change the container or empty it).
(3) Previous level indicator.

- **Using the standard deviation**:

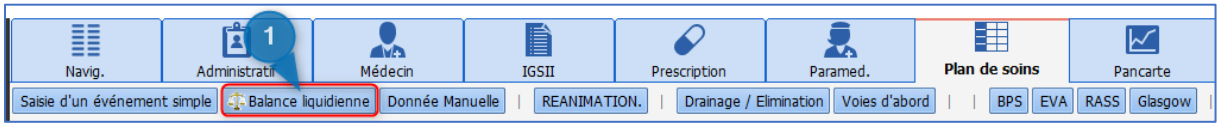
This method lets you enter the difference between the previous reading and the current reading.

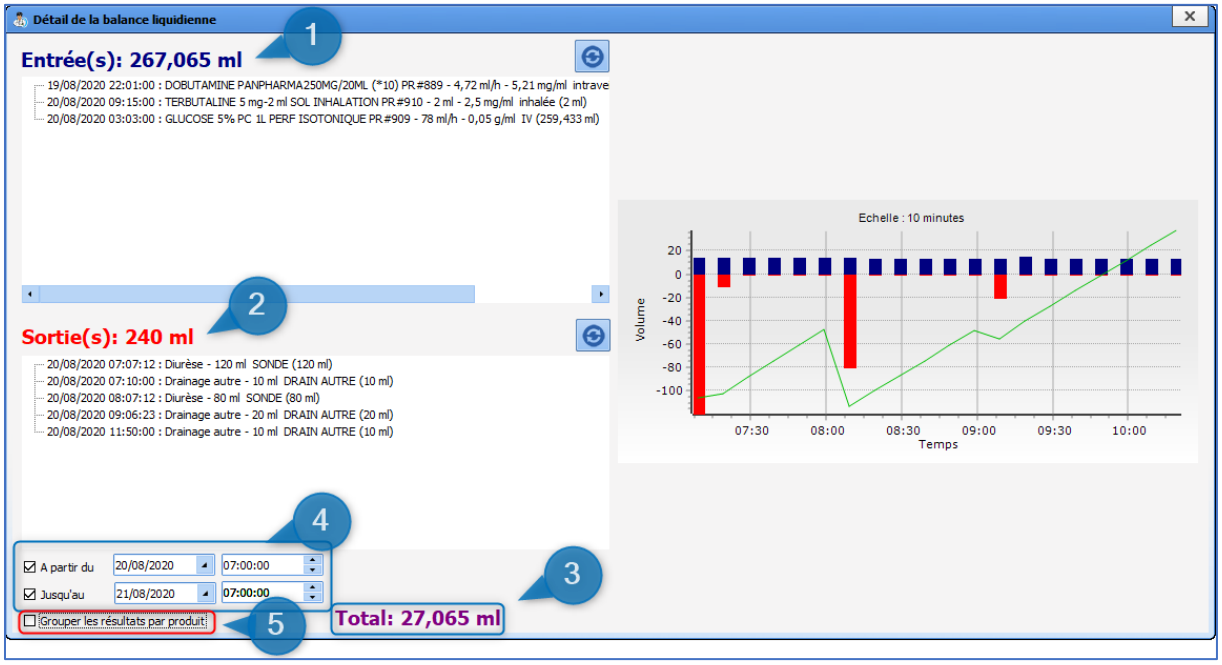
- Double-click on the desired item in the heading column (Other drain here).
- Select the desired quantity from the menu.
- The entry is automatically displayed in the current time slot.

NB: For the same 'Output' you can use both data entry methods. The application will do the calculation itself.

5.9.4.2 Viewing the overall Fluid balance:

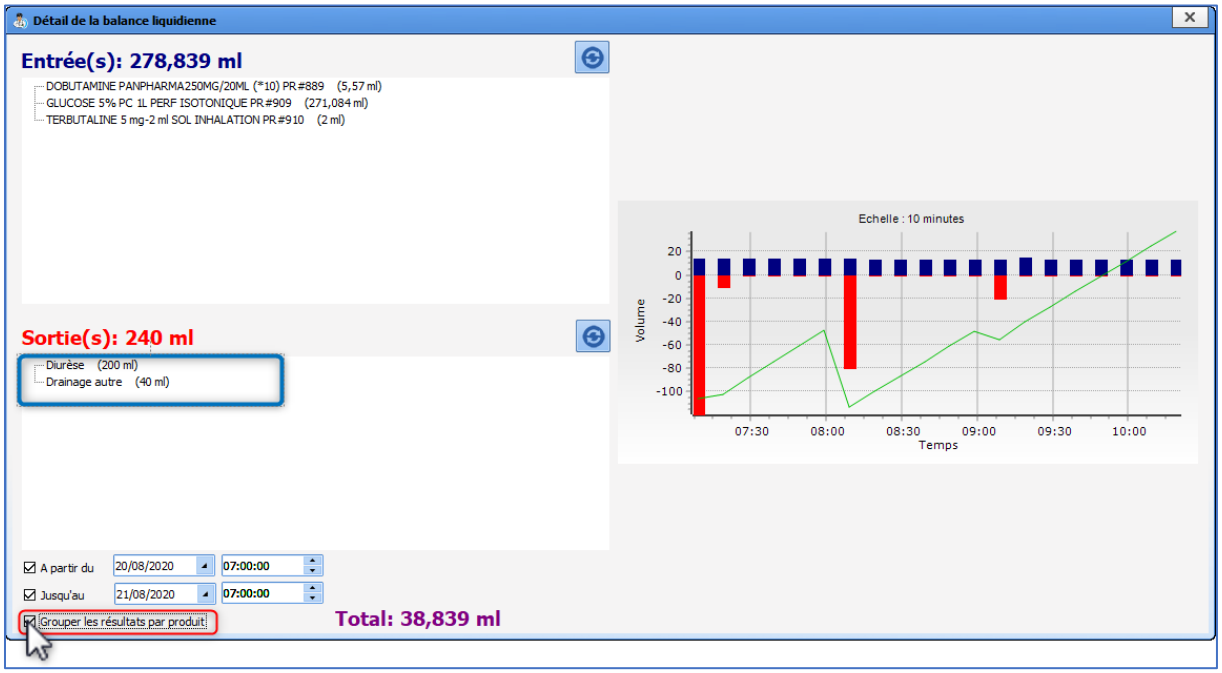
The patient's overall input / output report is displayed using a shortcut button under the tabs.





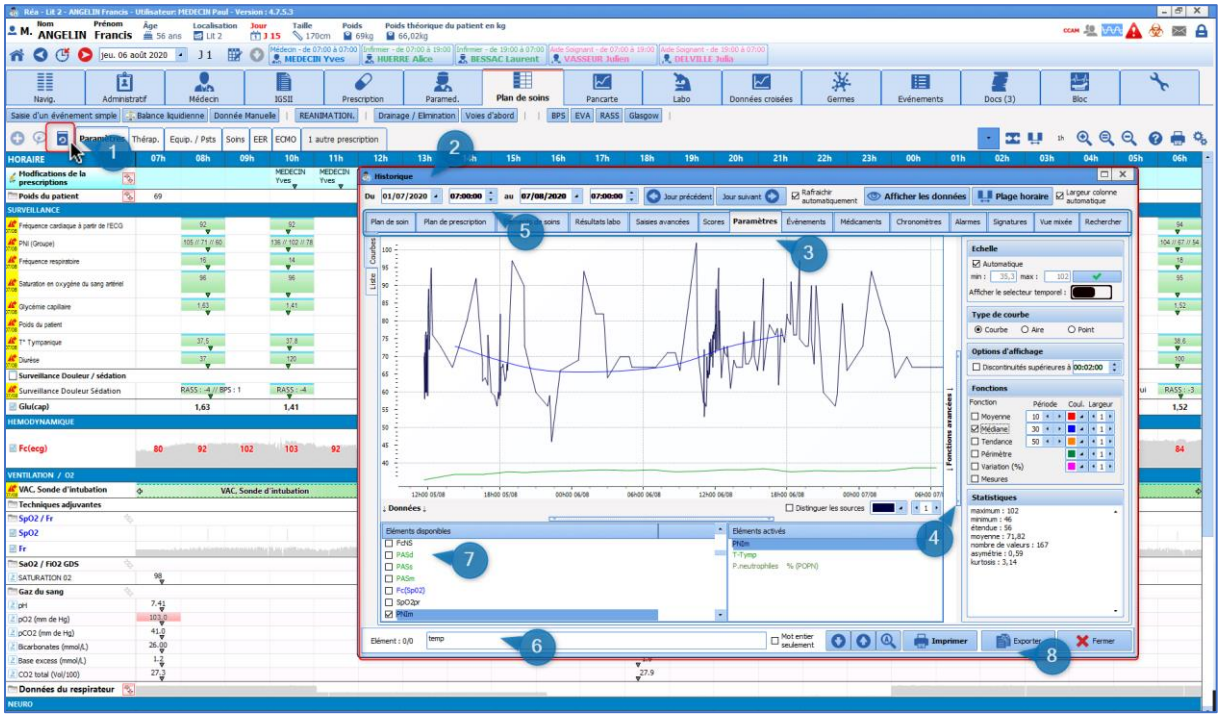
(1) Calculation of total inputs: the detail of each input is shown underneath.

(2) Total outputs: the detail is shown underneath.
(3) Total: calculation of the patient's total inputs / outputs
(4) Lets you select a customizable time slot. By default, this is the previous ICU day.
(5) Checkbox to group by product. When ticked, you can see the total for a given product or output. Example of Other drain.

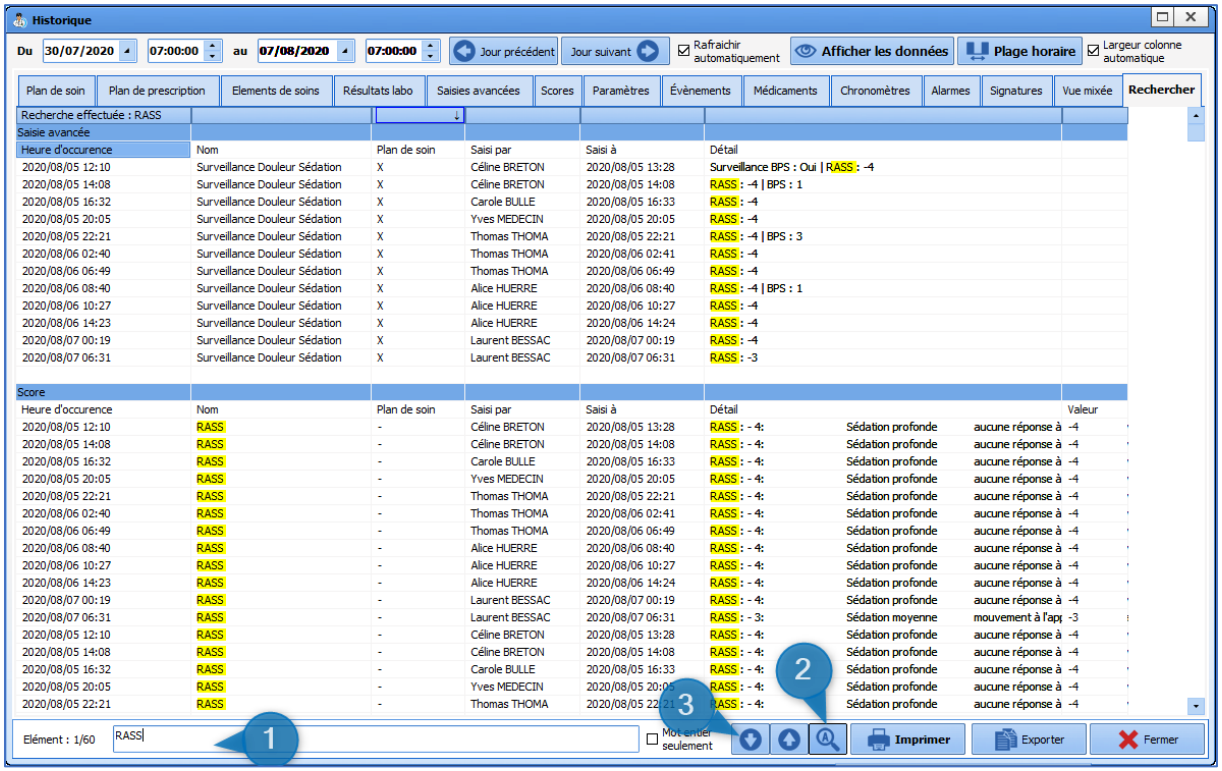


5.9.5 Care plan history

The Care plan history button lets you quickly view, group and analyze the data entered and collected in the Care plan.
Its search functions let you rapidly retrieve data in the record.
The 'Mixed view' function lets you analyze the data.
The data is presented in a table that can be printed or exported as a spreadsheet or in PDF format.



(1) '**History**' button.
(2) Record '**History**' pop-up window.
(3) Subtabs giving access to the different types of data available.
(4) Expandable area giving access to advanced curve processing functions.
(5) Area to select a customizable time slot.
(6) Text search box.
(7) Area to select available items.
(8) Export and print button.

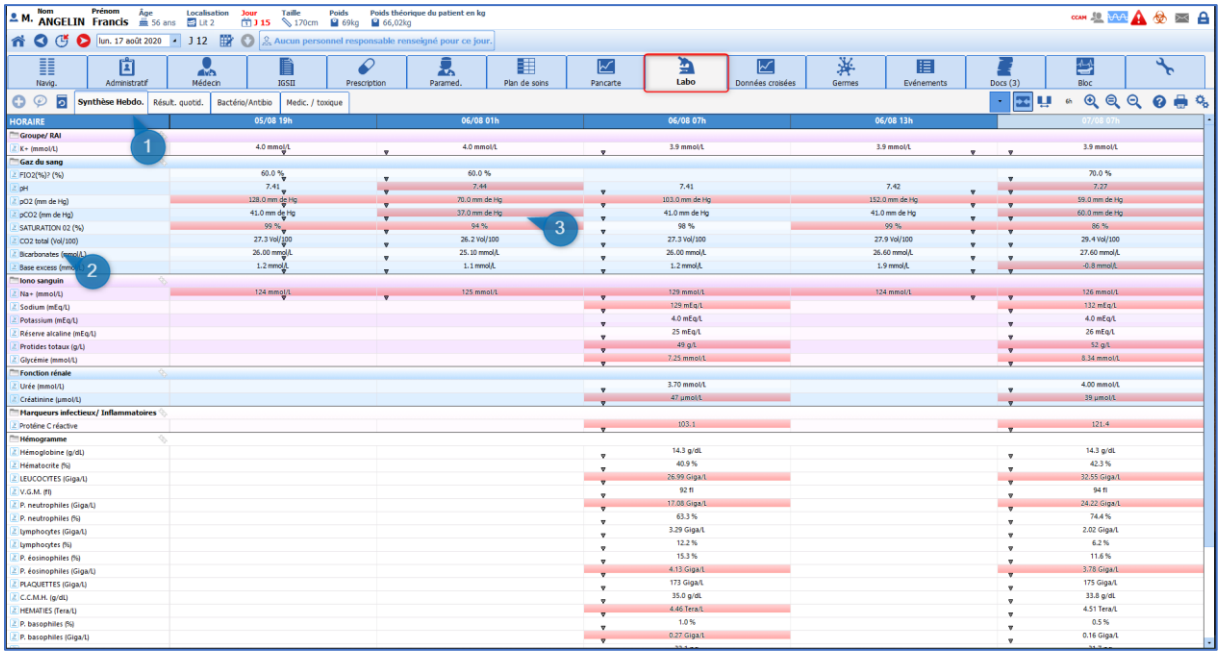


(1) Text search box.
(2) Lets you search for the keyword in all tabs except parameters. Here the RASS search displays the reports for the different entries made in the record during the stay.
(3) Directional arrow to move from one result to another.

5.10 Lab test tab

The application directly incorporates the patient's lab test results.
They are displayed in the form of a grid in a specific **Lab** tab. The entire PDF file containing the results sent by the laboratory can also be viewed.

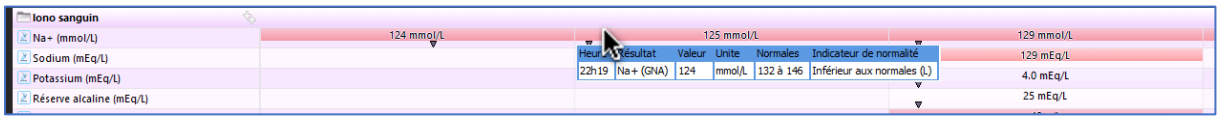
In the example below, this tab is divided into subtabs for you to split the different results according to category.
This organization also lets you see a summary of the patient's results over several days, here one week, to easily analyze changes.



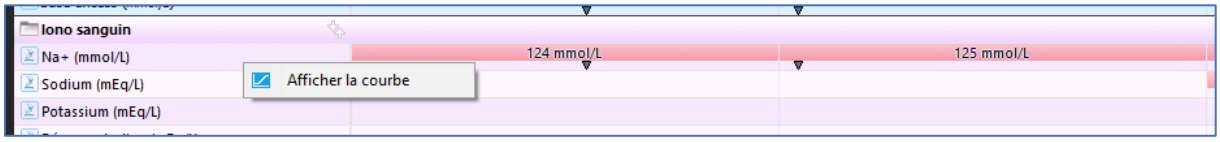
(1) Subtab to browse through the different categories.
(2) Heading area incorporating the parameter names used by the laboratory, and the units.
(3) Grid display area. The results are displayed by column.

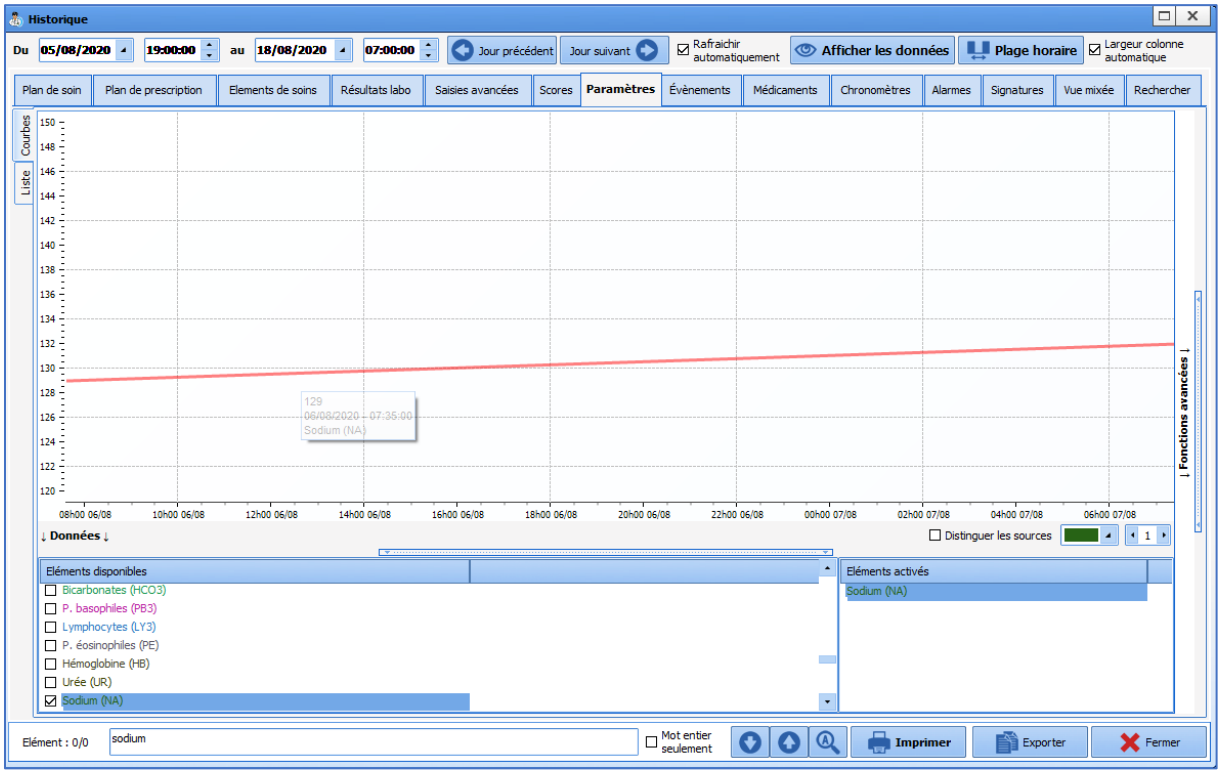
When the laboratory sends the results, it also sends us the units, normal ranges, comments and interpretations. All of this information is displayed in **DIANE**.

In the example above, the red cells show that the results are outside normal values.
Clicking on the cell displays the details of the test.



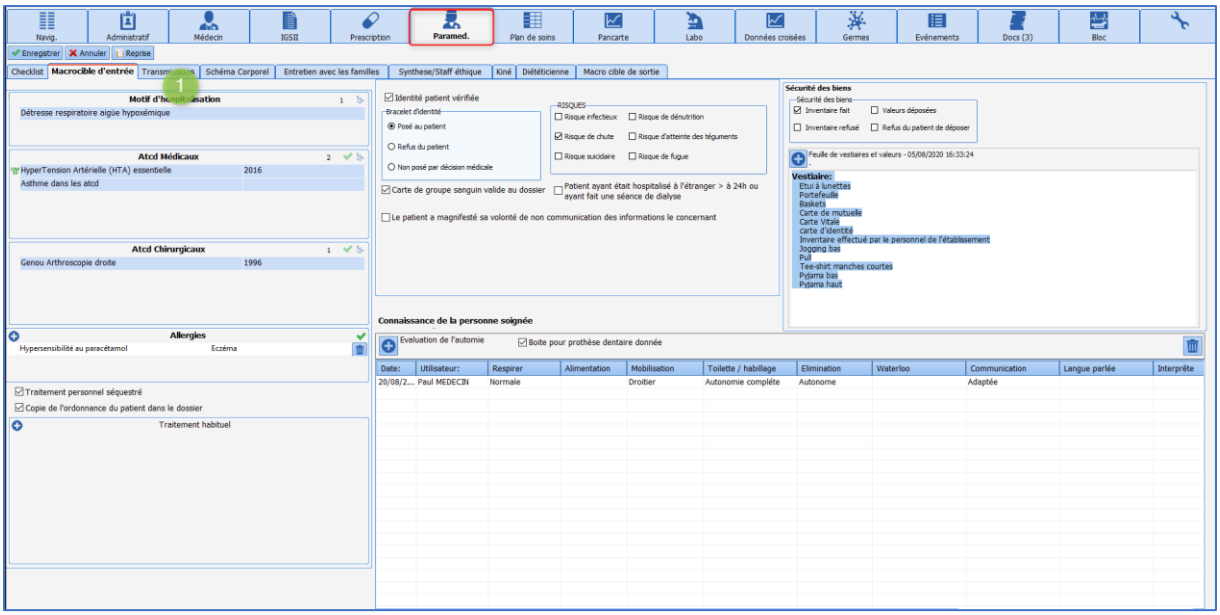
It is possible to display the results as a curve by right-clicking on the analysis you want to see.





5.11 Paramedical tab

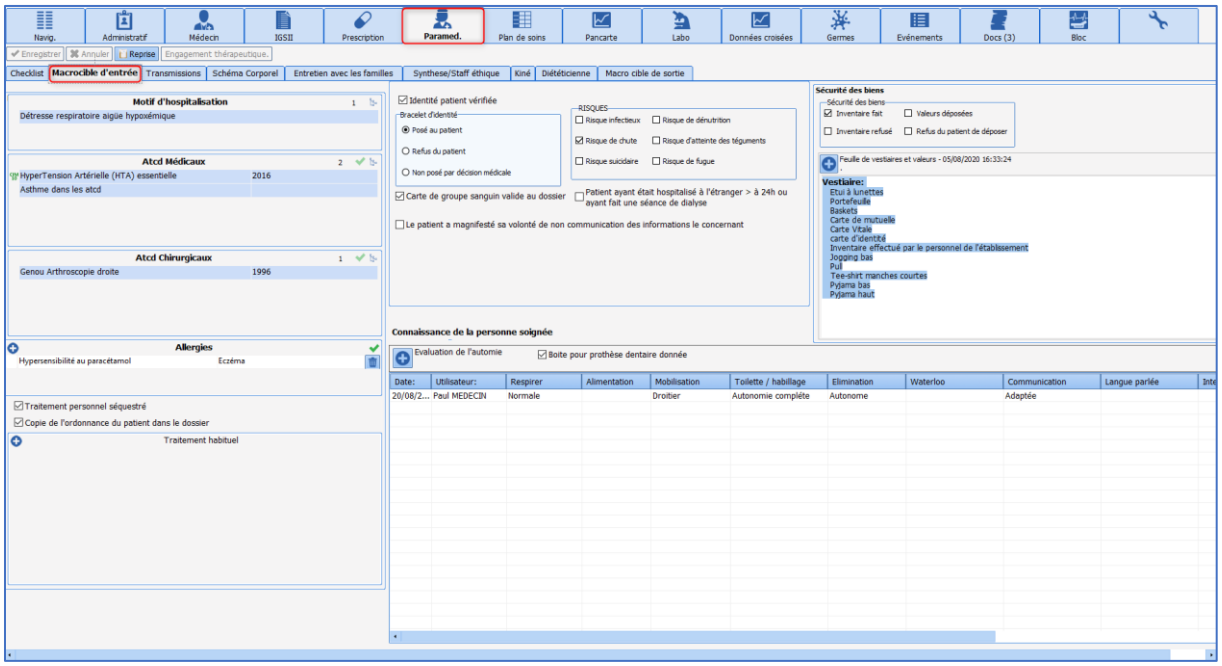
The **Paramedical** tab is used to collect patient information in connection with the paramedical professions. This tab is made up of several subtabs that are described in the next chapters.



5.11.1 Situation at admission subtab

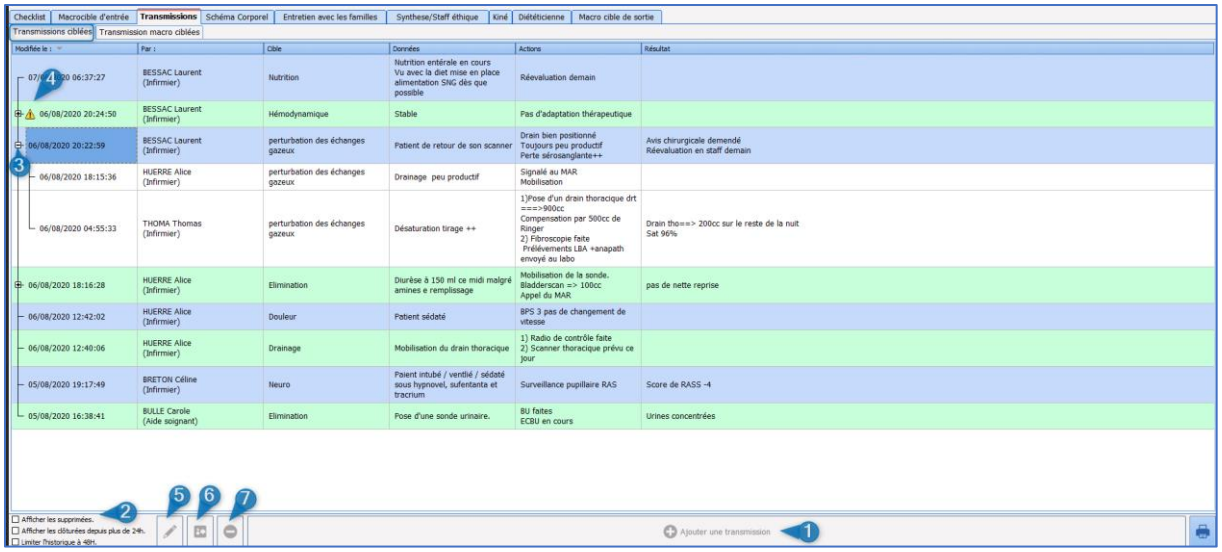
This subtab contains different information such as history, usual treatment, etc. which is information collected by the doctor in his admission observations. This information can be read-only, i.e. it cannot be modified from

this tab. This lets you quickly review information without having to switch between tabs while retaining limited writing access.
Other information is also present in this tab, which is collected and entered by paramedical staff. Example: checking the identity, the presence or absence of relatives, assessing autonomy and different risks, etc.



5.11.2 Issue-based nursing notes

A component here lets you enter nursing notes using issues based on the DAR model (Data - Actions - Results).

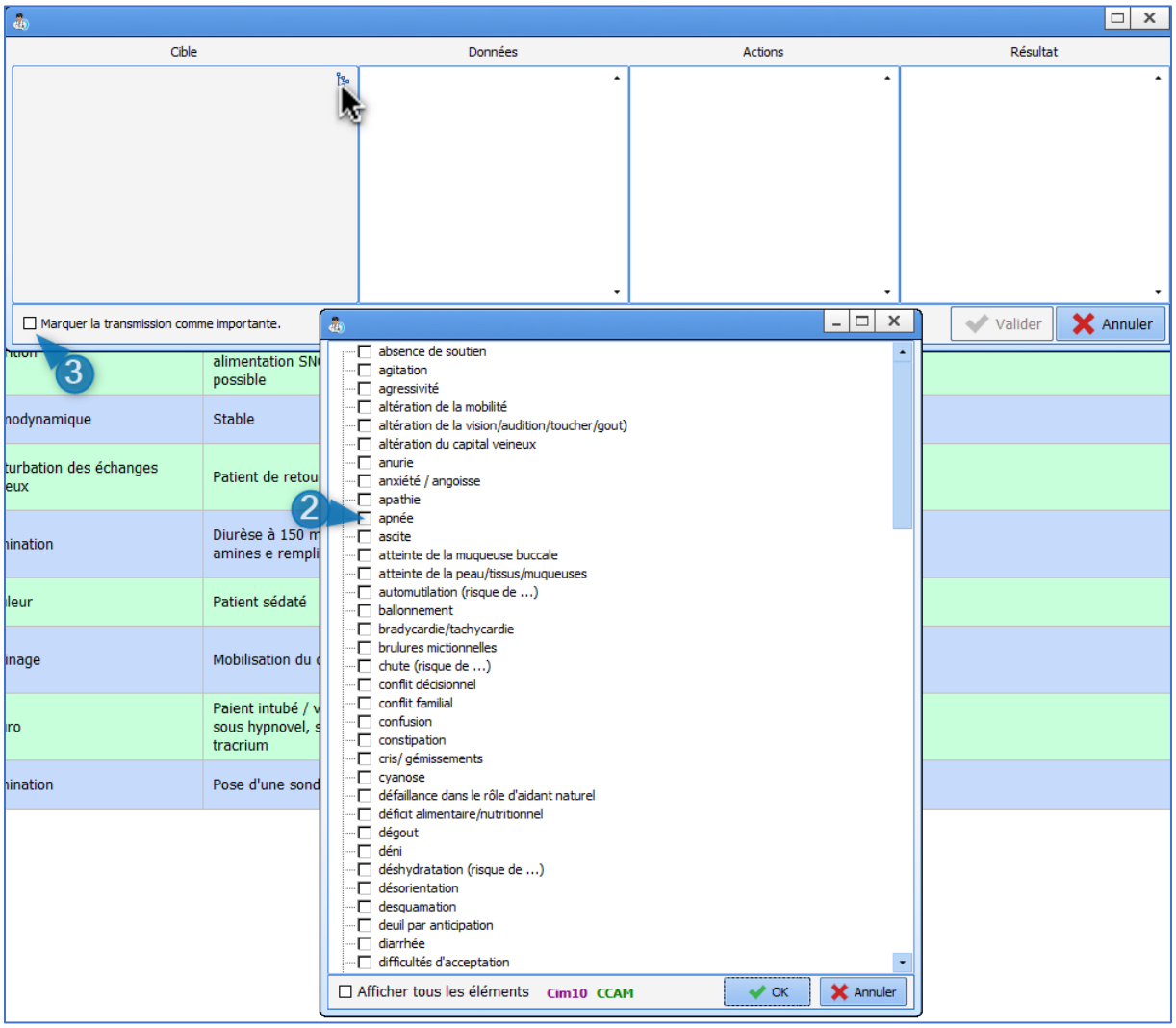


(1) Button to add a nursing note.
(2) Nursing note display options.
(3) History of nursing notes since the issue or problem.
(4) Issue importance marker.
(5) Lets you change the nursing note.
(6) Used to 'close' an issue. When the problem is no longer relevant, this lets you display only today's information. The information can be redisplayed by ticking the 'View closed for more than 24h' box.

(7) Used to delete a nursing note. Can only be done by the user who entered it.

5.11.2.1 Adding a new nursing note:

- Click on the Add a nursing note button **(1)**.
- The data entry window opens. This is made up of four columns: issues, data, actions and results. Only the first column uses a predefined list that is modifiable **(2)**. However, it is still possible to enter the information manually without using the list.
- To save the nursing note you must enter data in the first three columns (issues, data, actions).
- Lastly, you can mark the nursing note as important by ticking the box **(3)**.



5.11.2.2 Add to a nursing note or generate a nursing note using an issue already present

- Click on the issue you want to add to.
- The pop-up window opens with the previous data entered.

You can add to the information available. You can also delete the information present to enter new information. **This action will not remove the original content.**

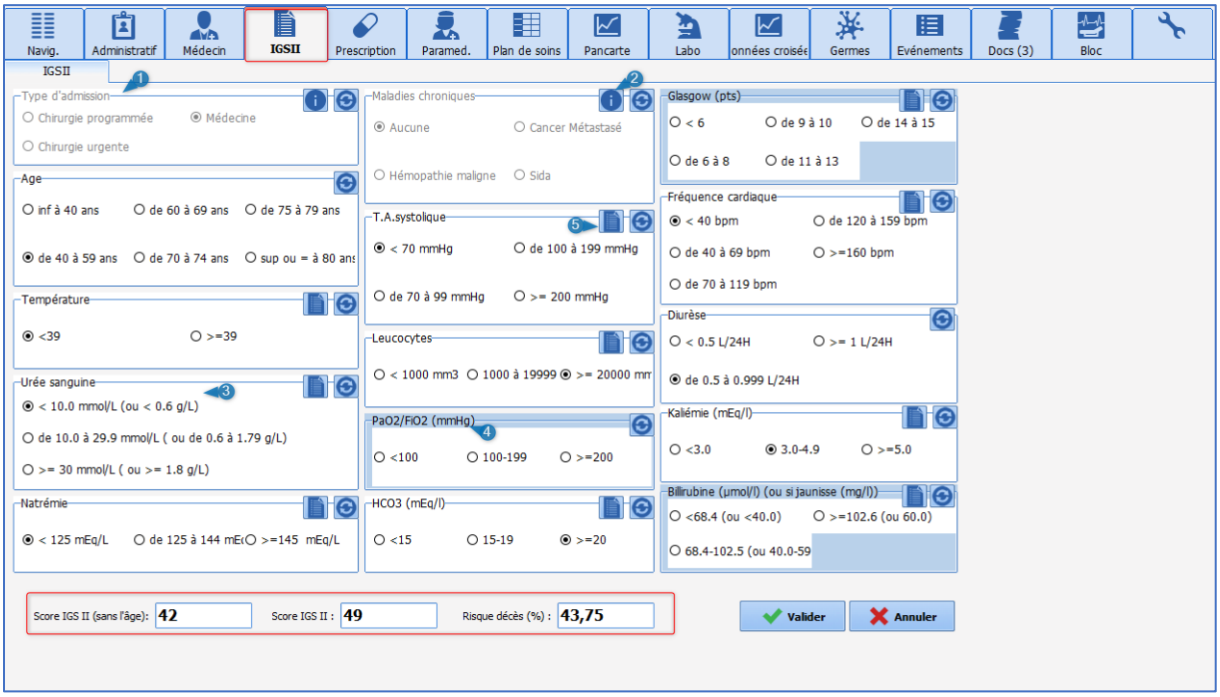
5.12 SAPS II tab

DIANE ICU has a specific tab to calculate the **SAPS II**.
The data extracted comes from the record's different sources. Only data from the first 24 hours of hospitalization is kept, so the score can be confirmed afterwards.
The worst data from the first 24 hours is entered in the fields.

5.12.1 Entering and confirming the SAPS II score

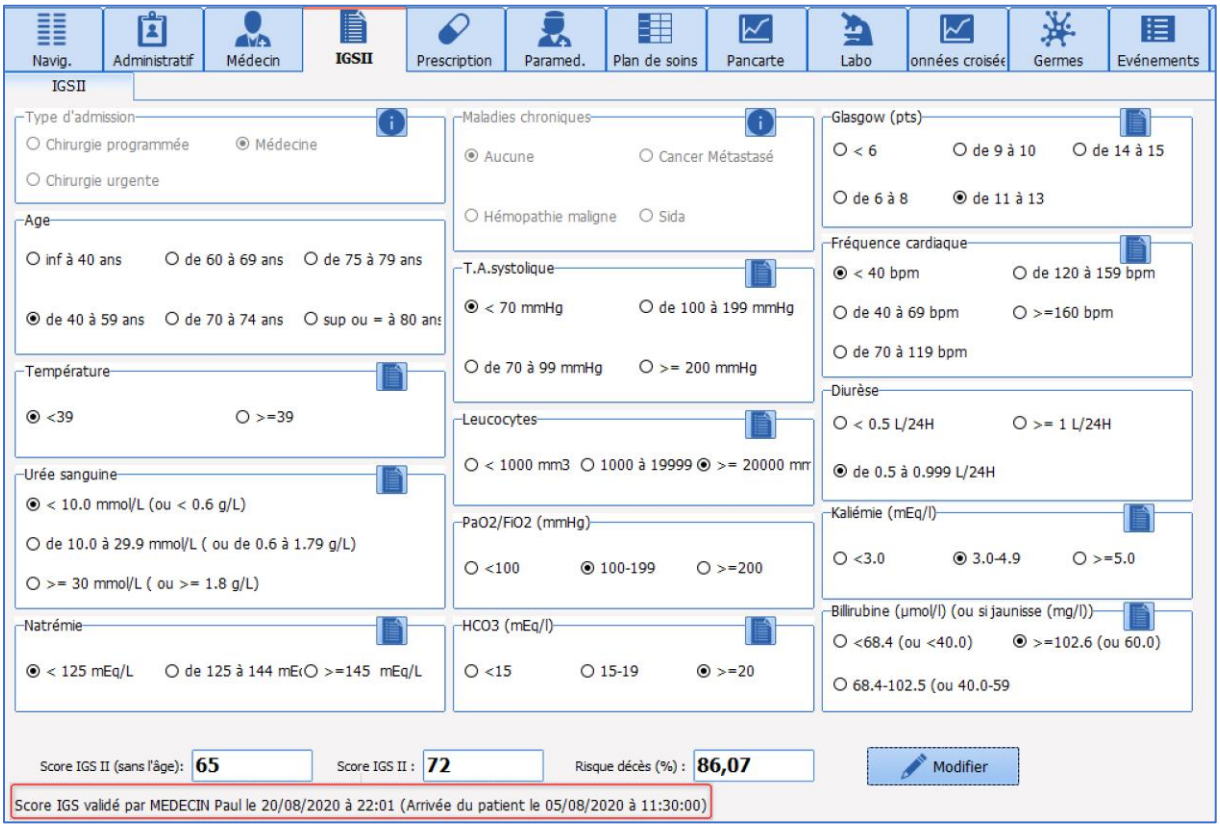
- When the tab opens, click on the **Enter** button.

- This gives you access to the data entry fields.



(1) and
(2) are specific fields communicating directly with the data entry fields present in the Admission observations as shown by the icon to the right of the component. These fields can only be filled and changed from the **Doctor** tab.
(3) Example of a field filled in by the application from the biological data in the record. Here the data used is the worst data over the first 24 hours. This data can be changed manually if it is not representative of the clinical situation.
(4) Fields circled in grey, like PaO2/FiO2 here, indicate that the data has not been recovered.
(5) Button to display the data in the record.

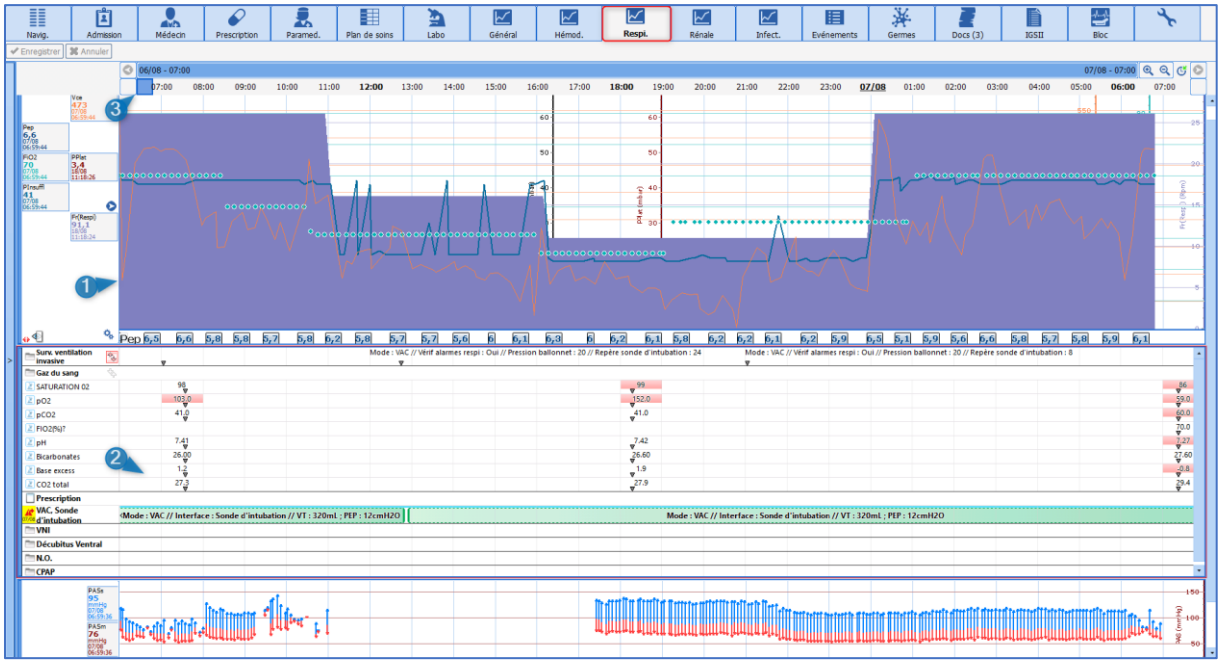
- Change the data if necessary.
- Complete the fields outlined in grey.
- The score is calculated automatically (area outlined in red).
- Confirm by clicking on the button.
- Enter your password.
- The score is now confirmed: the date and time and the name of the person in charge are automatically entered.



- The **Change** button is now available to let you go back and change the entry if necessary.

5.13 Cross-referenced data tabs: haemodynamic, respiratory, renal, etc.

Another type of tab is available in the application to give a combined display of the different data in the record. These tabs are dynamic and also let you enter information.
They are useful in that they enable a more detailed analysis of the clinical situation.
In the example below, the data displayed lets you see all of the different respiratory system data.
This dynamic display gives a quick view of the data over a longer or shorter period simply by sliding the time cursor in **(3)**.



(1) Curve pane displaying data retrieved from biomedical devices such as the ventilator. These curve panes also display data such as weight, lab results, etc.

(2) **Diagrid**-type display area to provide information from the **Care plan** but also enter it.

5.13.1 Alarm log

Here we find the list of alarms transmitted by the biomedical equipment with their **Start** and **End** times. More than 500 alarms can be transmitted by biomedical equipment connected to **DIANE** via the RS232 link. These alarms appear in descending order of occurrence so that the most recent alarm triggered is always at the top of the **Alarm log**.

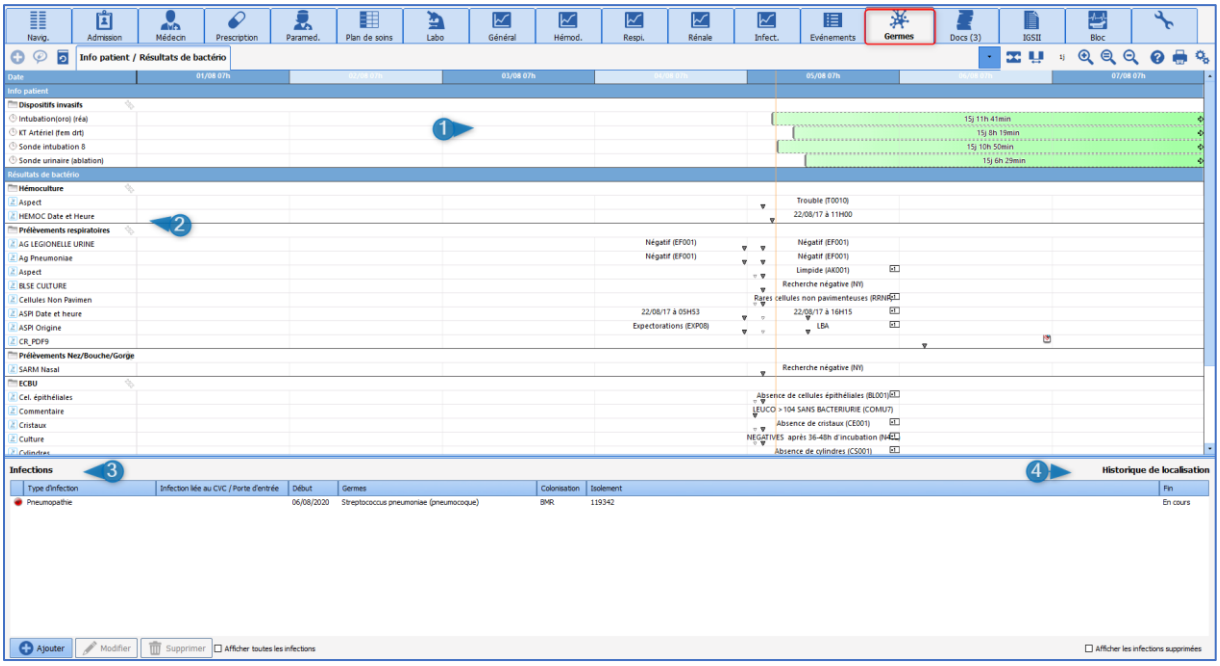
NB: The alarms cannot be changed or deleted.

You can display the alarms as a on the markers line using the specific **Alarms On/Off** button .

5.14 Germs tab

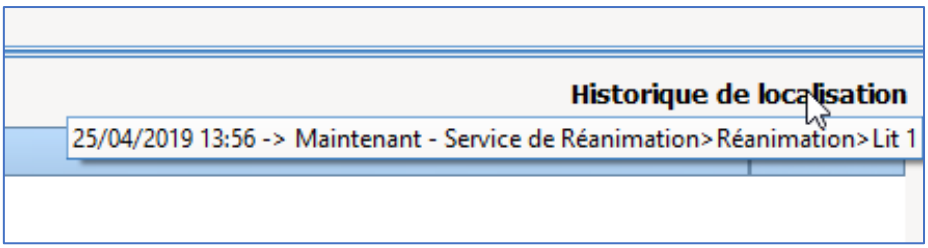
This tab lets you monitor the patient's infection status.

It has a configurable upper section showing the patient's different bacteriology results and how long the various invasive devices have been present, to help monitor nosocomial infections.



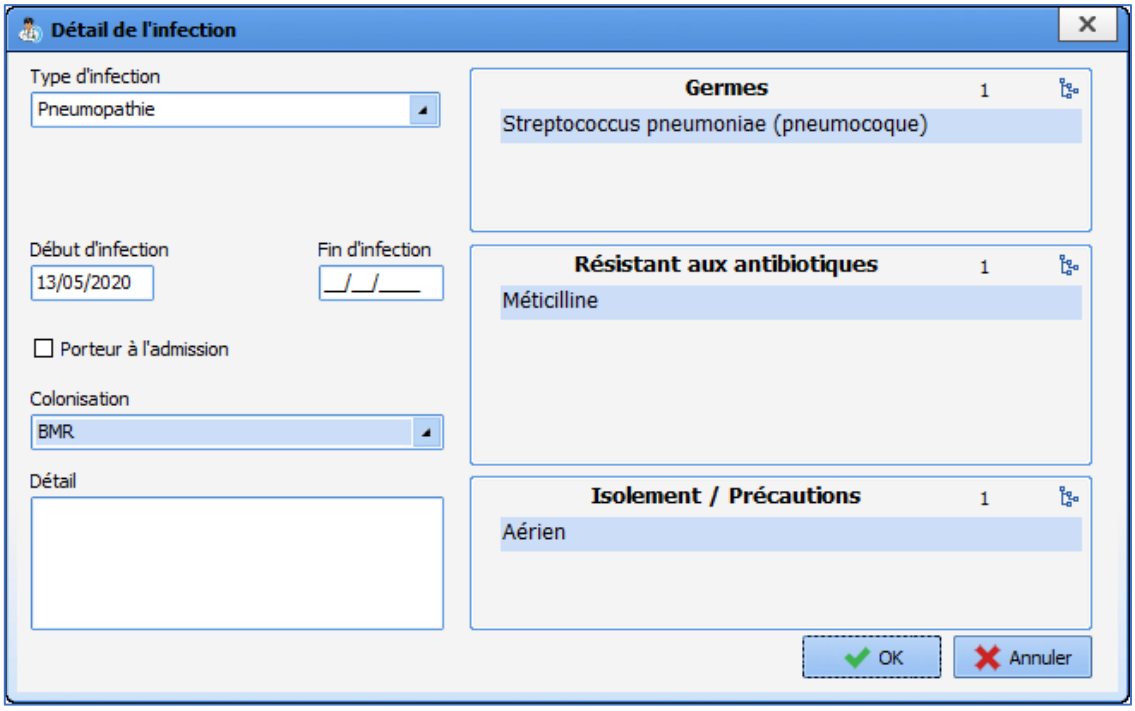
(1) Duration of presence of invasive devices.
(2) Patient's bacteriology results.
(3) Area to enter different information about infections.
(4) View of the patient's different geographical movements within the **DIANE** application to help track contact patients.

Example: cardiology OT 2, ICU room 6, CCU room 3. This information is visible when you hover over the title **Location history**.

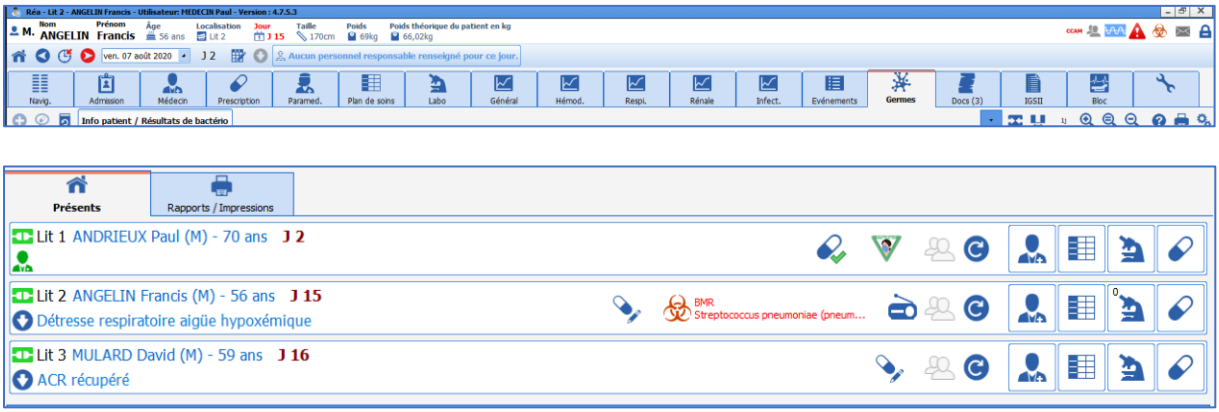


5.14.1 Add to / Enter the presence of an infection in the patient

- Click on the **Add** button at the bottom left of the tab.
- The pop-up window opens to complete the information.
- Enter the different information: type of infection, type of colonization, germ present and antibiotic resistance
- Confirm.



When an MDRO or XDRB type colonization is entered, a pictogram indicating the presence of an infection is visible on the application ribbon and on the cockpit.



5.15 Body diagram

A care item can be entered directly from the **Body diagram** subtab of the **Paramedical** tab.

The following steps must be carried out:

- Choose the area where the care item is applied,
- Choose the care item,
- Fill out the initial form and schedule the next form.

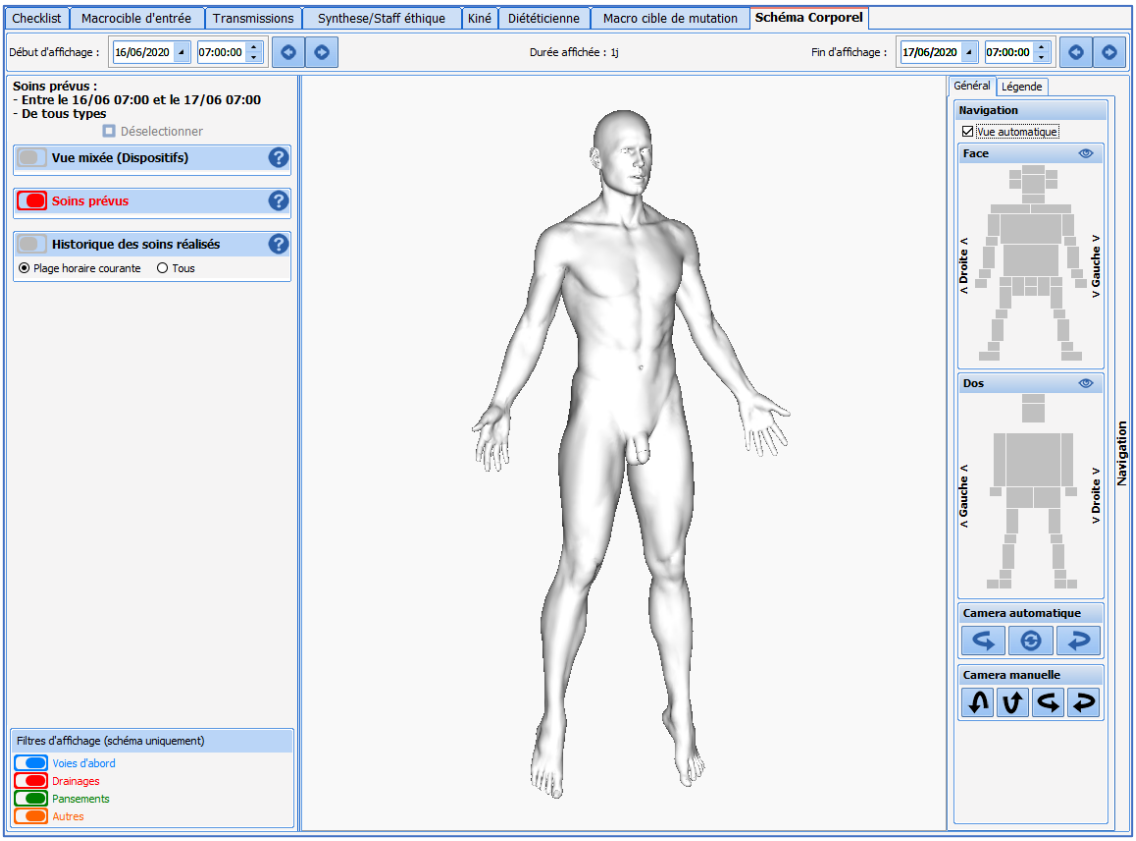
You can associate the care item with:

- A score,
- A fluid balance,

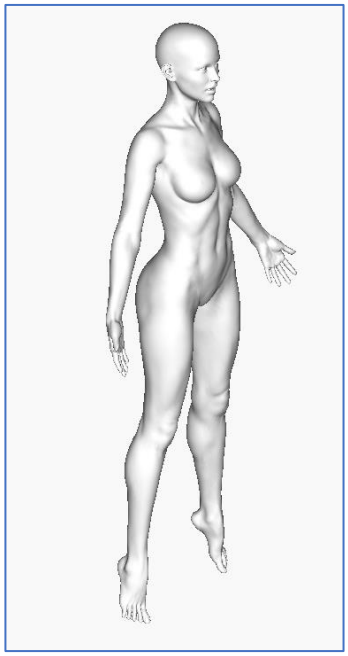
- Images.

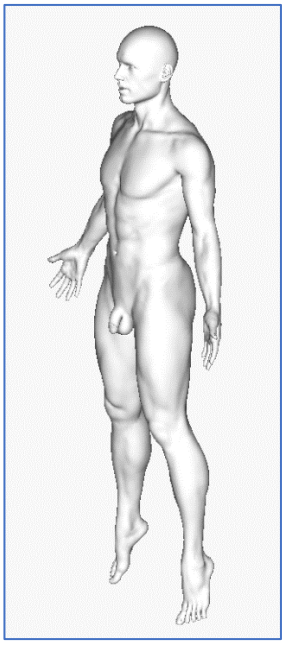
5.15.1 Positioning a medical device

The **body diagram** allows you to position the care directly on a 3D representation of the patient.



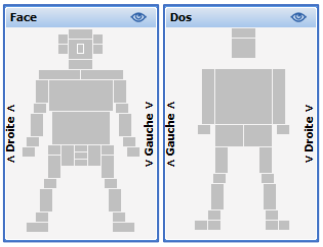
The 3D representation adapts to the patient's gender.





Woman Man

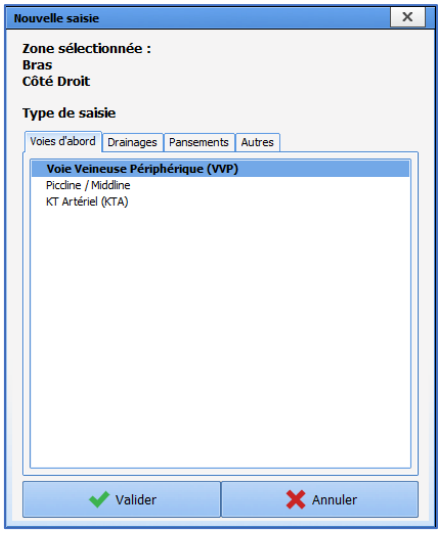
You can move around the model by clicking and holding your mouse button outside the model and then moving your mouse.
You can also directly zoom in on an area by clicking on the area you want on the right in the navigation pane.



Each grey rectangular area is active and lets you zoom in on the corresponding area of the body diagram.

5.15.2 Choosing the medical device

After clicking on the 3D diagram, a window opens with the different care items configured for the selected area. You can choose from several care items then confirm.



5.15.3 Completing the medical device placement form

The forms contain the following components:

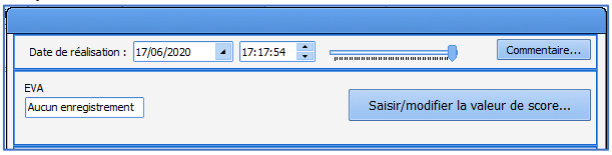
Component	Example
checkbox	☐ Aspiration ok
multi-line input field	Détails:

one-line input field	Type de cathéter:
radio button group	Intubation ○ Sans fibroscope ○ Avec fibroscope
checkbox group	Cathéter ☐ perméable ☐ fonctionnel
drop-down menu	Taille du KT: 24 G 22 G 20 G 18 G 16 G 14 G

Once the information has been entered, you can confirm the form by clicking on the **Save** button.

5.15.3.1 Associate a score

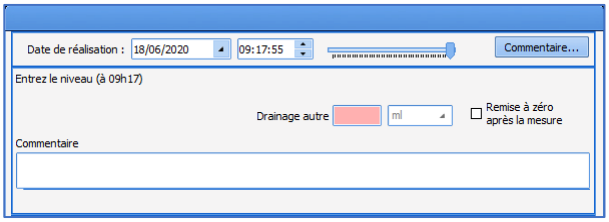
If a score is associated with the care item, it is entered when creating the forms. Clicking on the button displays the usual score entry window.



The score and entry time are displayed.

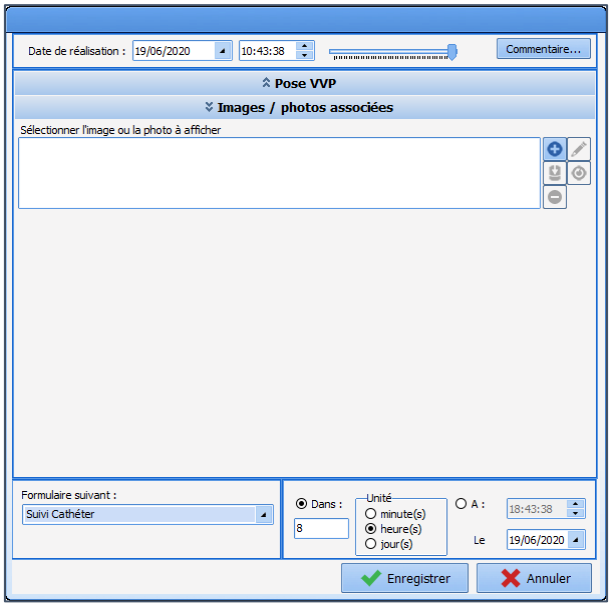
5.15.3.2 Associate a fluid balance

If a fluid balance is associated with a care item, it is entered when creating the forms.



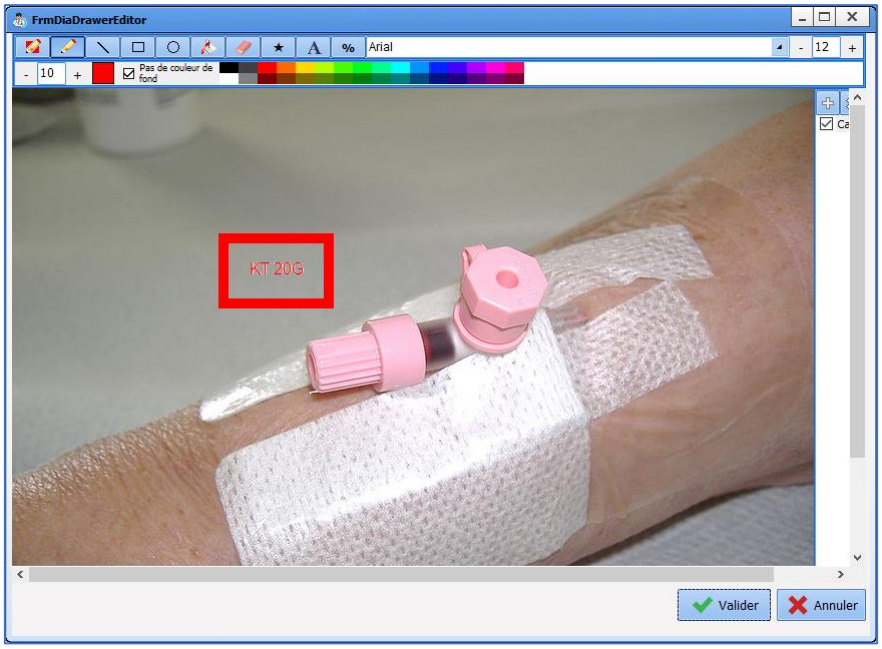
5.15.3.3 Associate images or photos

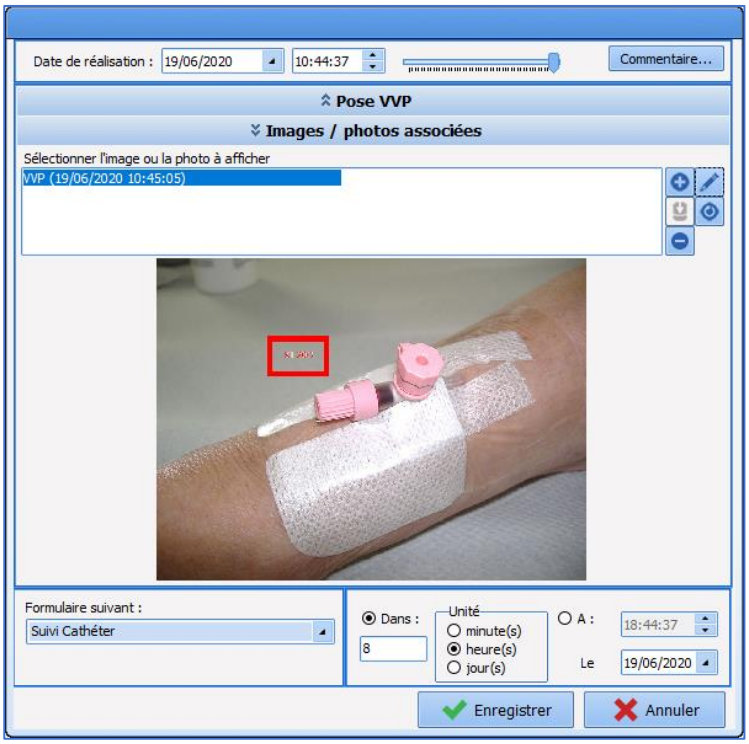
You can associate an image or photo with a care item:



The button lets you add an image that is on the computer used. If an image has been added to the **Documents** tab, it can be recovered using the button. In this case it is deleted from the list of documents.

You can change the image by clicking on the button. The button cancels the changes made. Only the image associated with the form being created can be modified: the images added in a previous form cannot be modified.

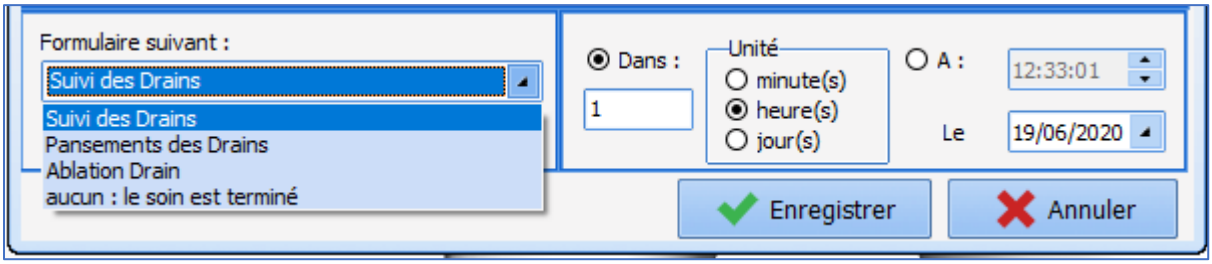




5.15.3.4 Choosing and scheduling the next form

The next form can be selected. You can choose:

- one of the configured monitoring forms,
- the removal form (if configured),
- no form (the care is finished).



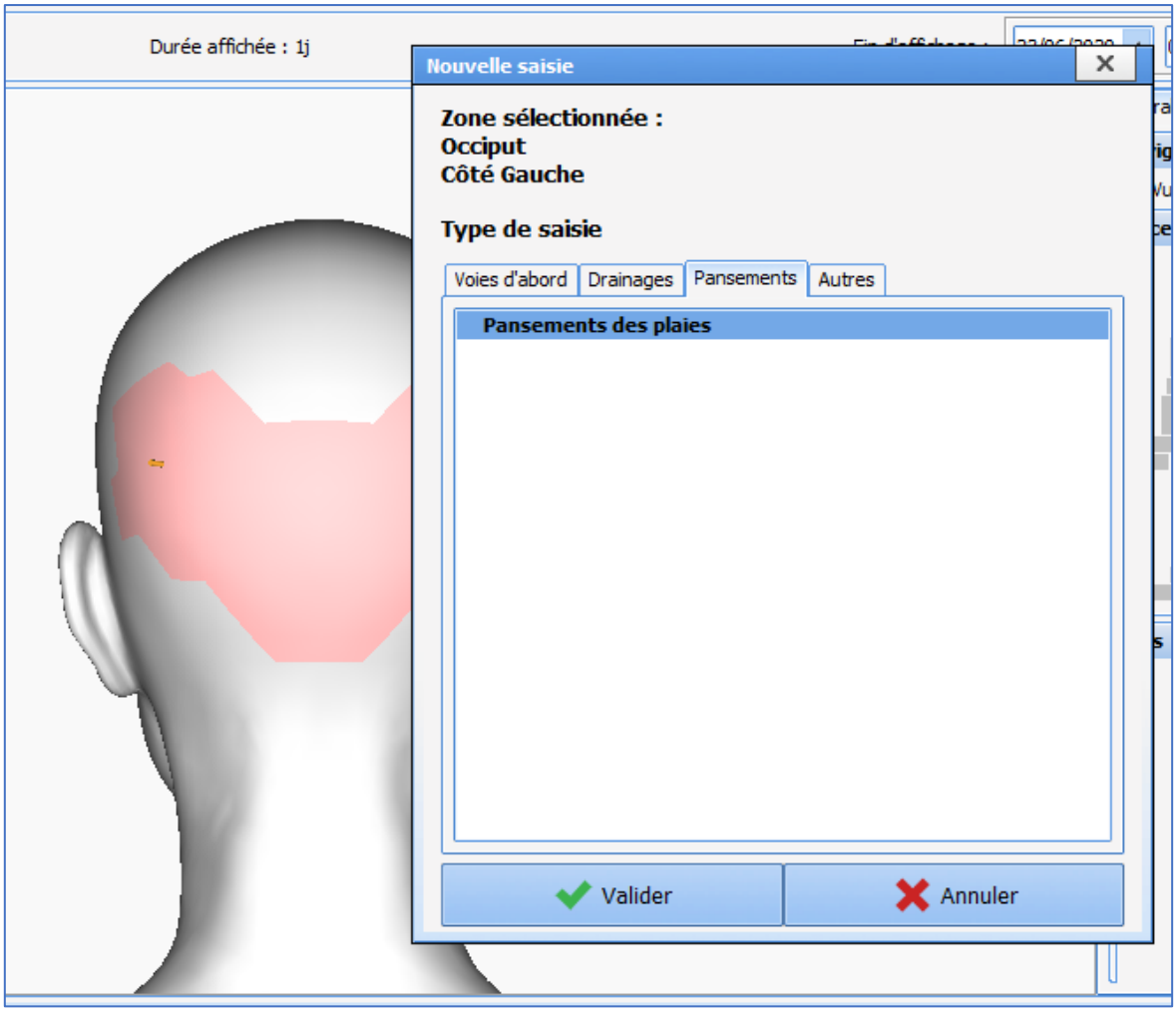
There are two ways to schedule the next form:

- by choosing an interval after the current form,
- by choosing the date and time.

5.15.3.5 Example: applying a dressing

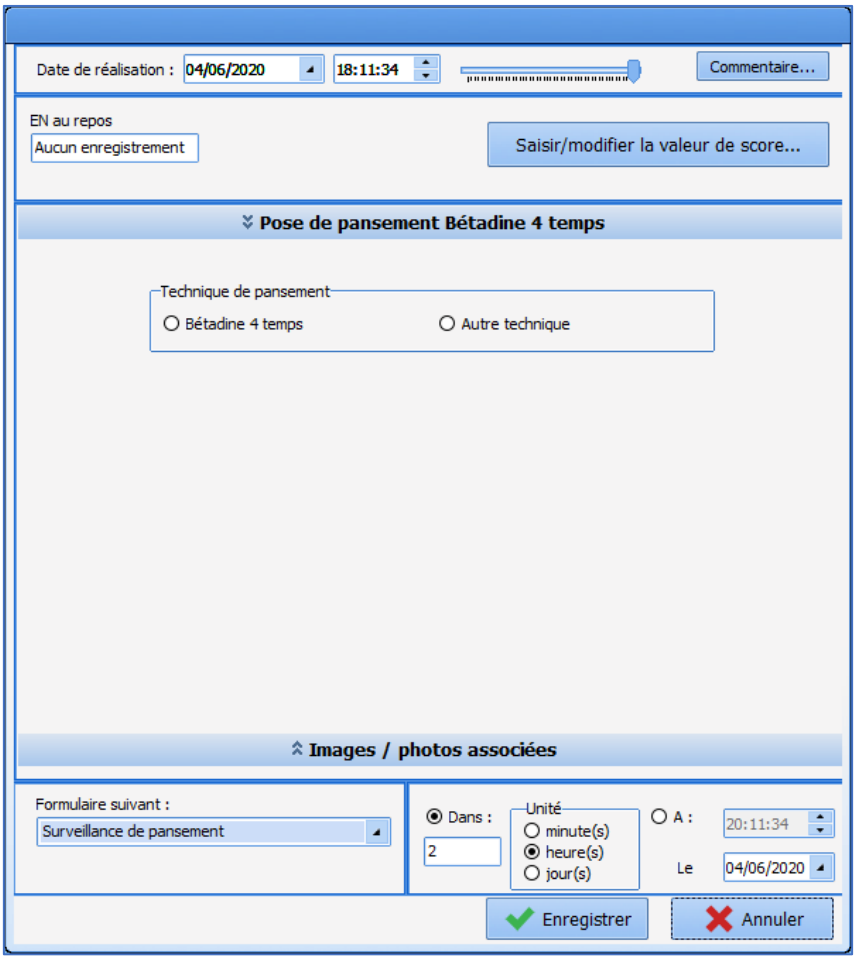
When you click anywhere on the model, a device window appears displaying the care items configured for the corresponding area.
These **care items** are divided into four categories:

- Access points,
- Drains,
- **Dressings**,
- Other.

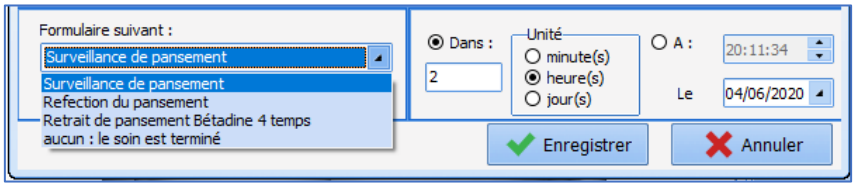


You can choose from four types of data entry:

In the rest of this chapter, we will look at the management of a dressing from placement to removal.



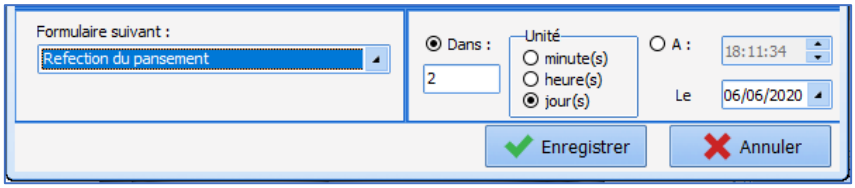
You have four choices:



In this menu you have the next forms. The first ones are for possible monitoring then there is the removal form.

NB: the option **none: the care is finished** is the only option that is always offered. The others are configured by your key users.

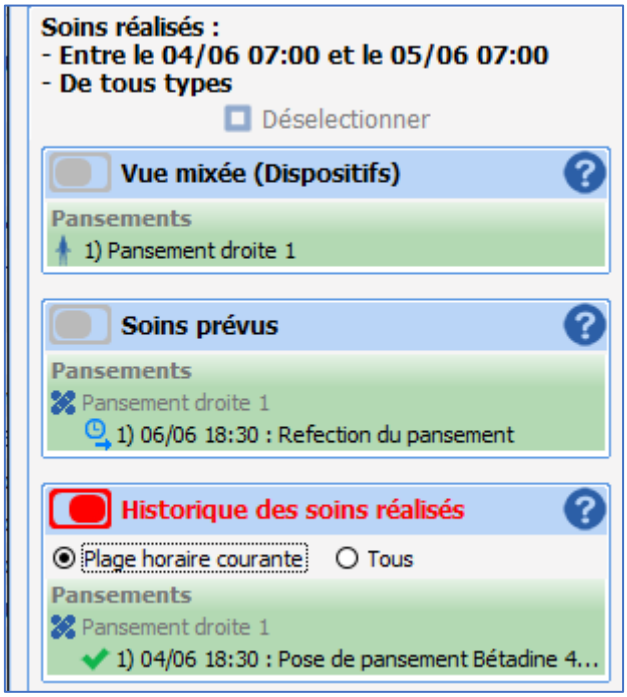
Each option has its own default timeline setting.



The sequence of monitoring care forms is built up as the situation progresses.

5.15.3.6 Example: removal of a dressing

After the removal is confirmed, the left column shows the list of devices in the mixed view, the upcoming care in the foreseen care and the history of the care administered.

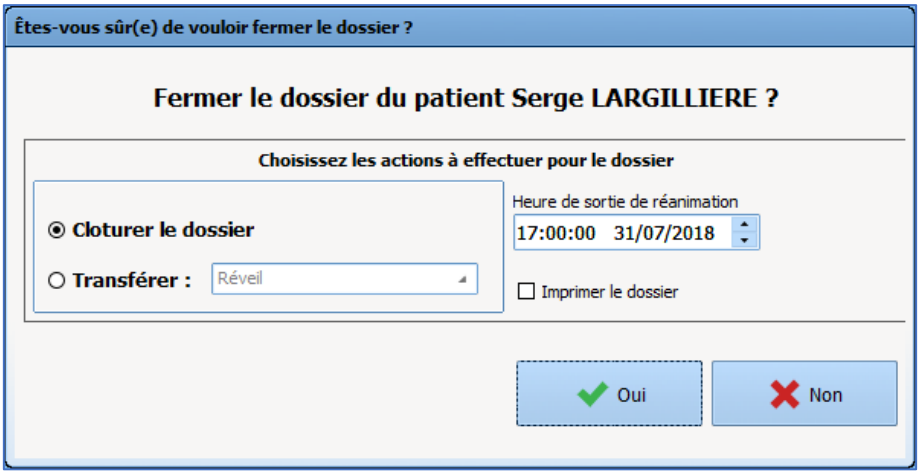


5.16 Discharging the patient

The patient is discharged using the **Patient discharge** button in the **Main menu** tab.

When you click on the **Sortie du patient** button at the bottom of the first column of the main menu tab, a window opens for you to choose to close the record or transfer the patient.
The record must be closed when the patient will no longer be monitored in **DIANE**, whereas the record must be transferred if the patient is monitored in another unit still using the **DIANE** software even if it is a different module.

For example: when a patient comes from the operating theatre and the OT uses **DIANE ANAESTHESIA**, the patient will be transferred when leaving the operating theatre. At the end of hospitalization, if the patient is transferred to a medical unit that does not use **DIANE**, the record must be closed. However, if the patient is hospitalized in a unit (e.g. CCU) that uses **DIANE**, the patient must be transferred.



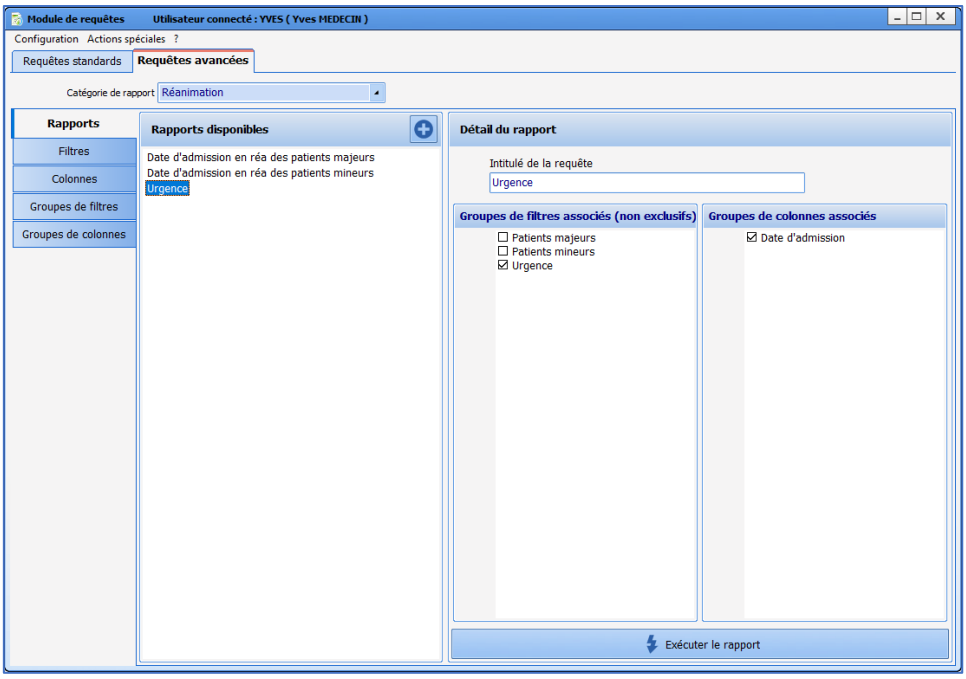
When the patient is discharged, some actions may be necessary to close or transfer the record (checklist not completed, current prescription, etc.). In this case **DIANE** will ask you to confirm the checklist and if you want to keep the current prescriptions. They can be maintained if the record is transferred. If the record is closed, it is better to stop all current prescriptions.

NB: Once discharged, you can reopen the patient's record by clicking on **Resume ICU** in the surgery selection window.

6. QUERIES

The query tool lets you extract information from the database to compile statistics (OT occupancy times, average duration and standard deviation of stay on the site, etc.). There are 3 categories of reports (Anaesthesia, ICU or Obstetrics).

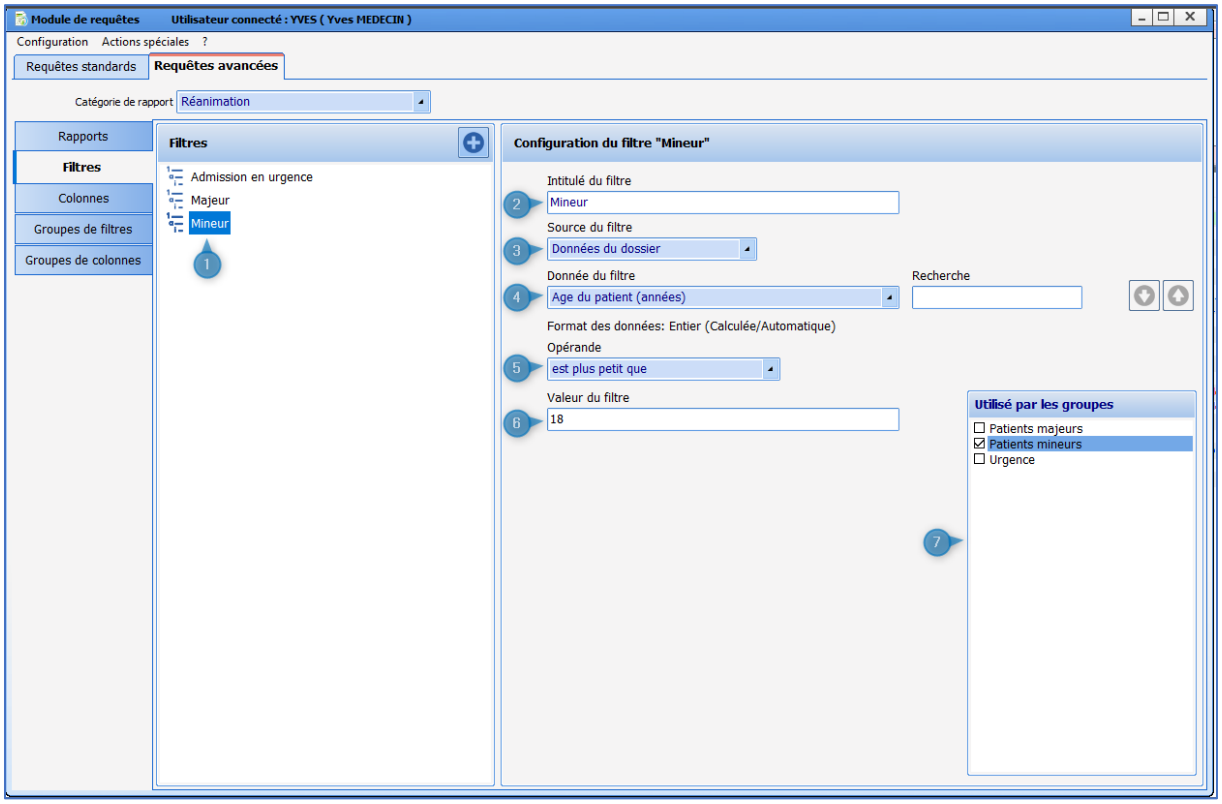
6.1 Queries module presentation



The queries module is used to generate reports. For each report, you can configure data filters and choose which columns to display.

6.2 Creating filters and filter groups

Filters are configured in the **Filters** subtab.



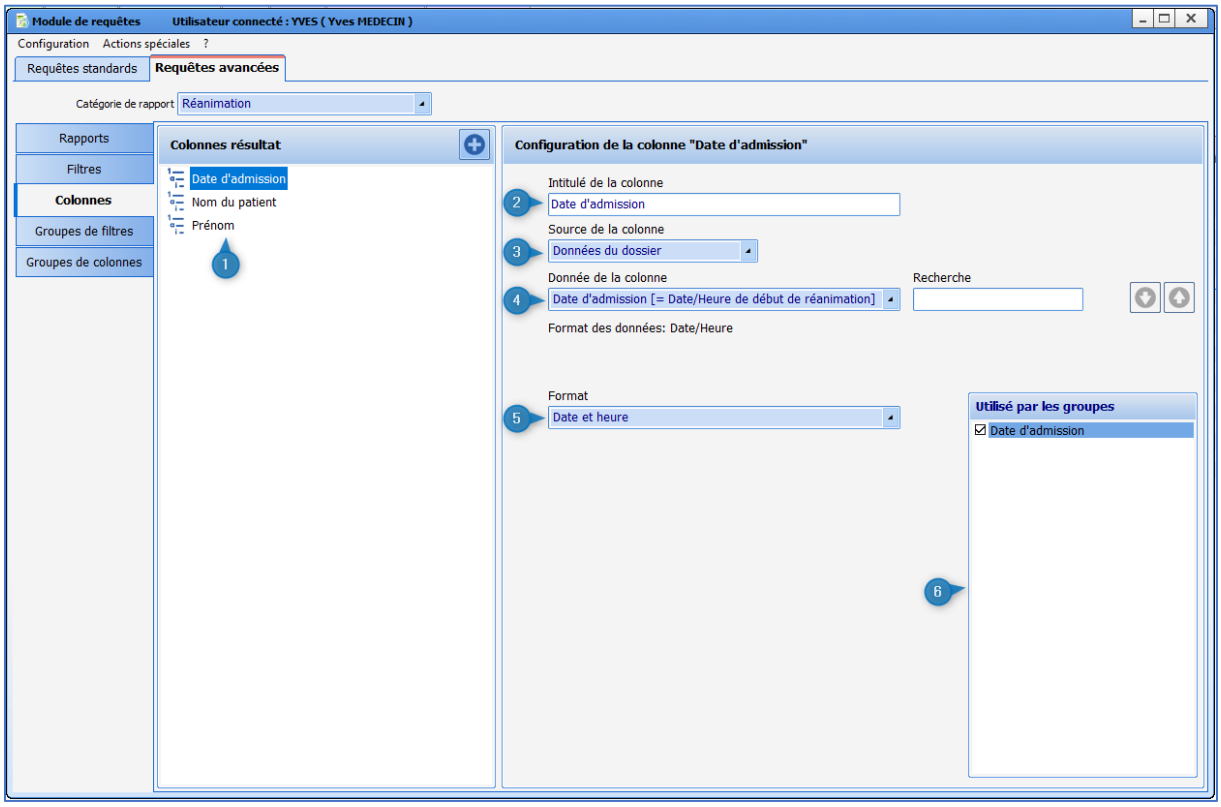
1. List of filters already configured
2. Filter name
3. Source of filtered data
4. Data on which the filter is based
5. Operand: depends on the type of data (number, date or text)
6. Value to which the data can be compared: depends on the operand and type of data
7. List of filter groups using the filter being configured: you can assign the filter to a filter group by ticking the box (or remove it by unticking the box)

To create a group of filters, click on the button, name the filter and tick the filters assigned to this group.

A filter group lets you select the data that is valid for all the filters in the group. For example, a group made up of the filters **Age ≥20** and **Age <30** will select patients aged 20 to 29.

6.3 Creating columns and column groups

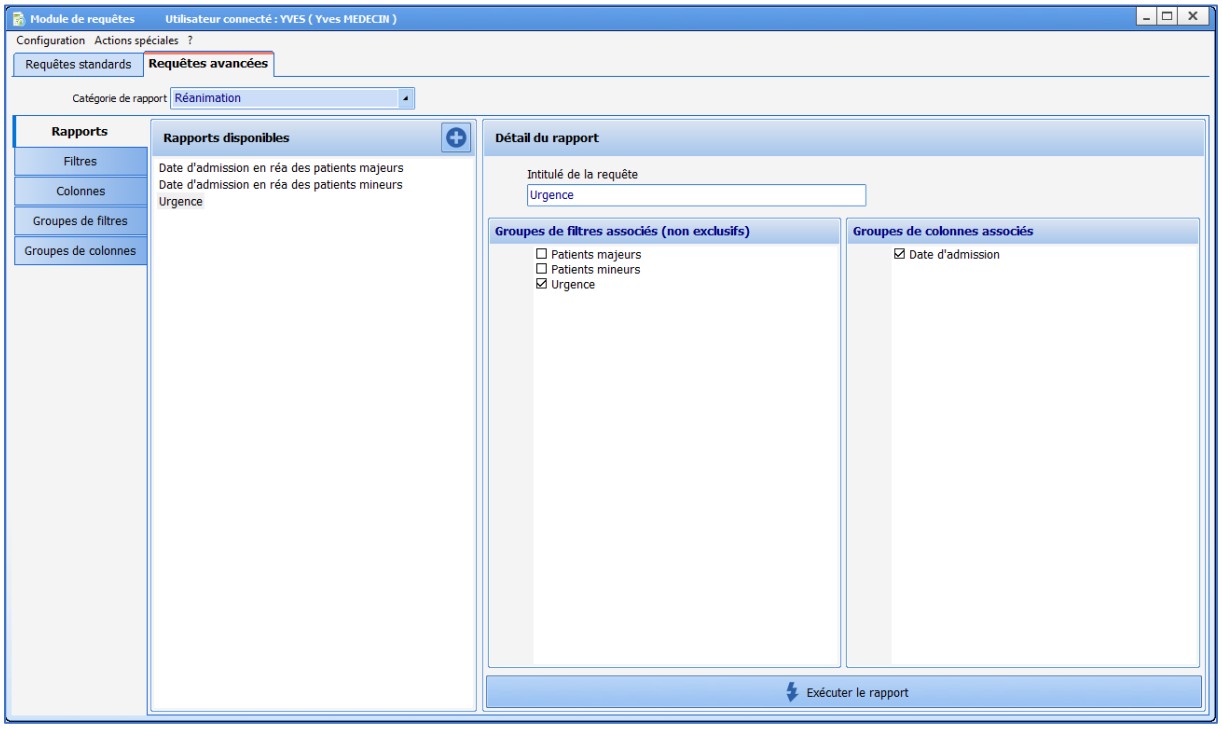
Columns are configured in the **Columns** subtab.



1. List of columns already configured
2. Column name
3. Data source used: it is possible to use data from the record, timers and detailed entry fields or score fields
4. Data used for the column (for detailed entries or scores, the field must also be selected)
5. Data format (only valid for Date/Time type data)
6. List of column groups using the column being configured: you can assign the column to a column group by ticking the box (or remove it by unticking the box)

A column group groups together one or more columns: the columns are (de)selected by (un)ticking them in the **Associated results columns** area. It is also possible to reorganize the columns by dragging and dropping them in the **Associated results columns** area.

6.4 Creating reports



A report displays the data filtered by one or more filter groups in a table whose columns are determined by the column group(s).

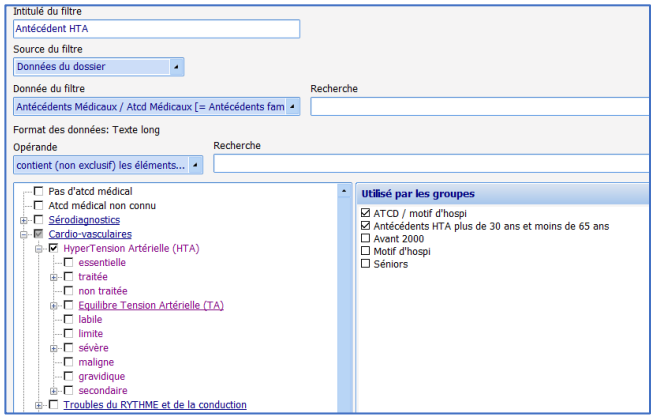
If more than one filter group is selected, the data displayed will be data that is valid for at least one of the filters. For example, **Age <20** and **Age >30** filter groups will select patients under 20 and those over 30.

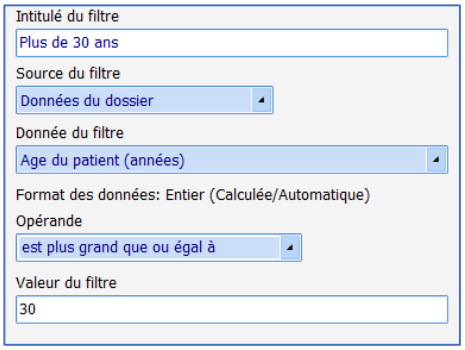
Caution: if a column is present in several filter groups, it will be displayed several times.

6.5 Example of report

View history and date of birth of patients aged 30 to 65 with a history of hypertension or aged over 65.

Create **History of HT**, **30 or over**, **Under 65** and **65 or over** filters





Intitulé du filtre
Moins de 65 ans
Source du filtre
Données du dossier
Donnée du filtre
Age du patient (années)
Format des données: Entier (Calculée/Automatique)
Opérande
est plus petit que
Valeur du filtre
65

Intitulé du filtre
Plus de 65 ans
Source du filtre
Données du dossier
Donnée du filtre
Age du patient (années)
Format des données: Entier (Calculée/Automatique)
Opérande
est plus grand que ou égal à
Valeur du filtre
65

Create the **History of HT**, **30 to 65** and **Elderly** filter groups

Intitulé du groupe de filtres
Antécédents HTA plus de 30 ans et moins de 65 ans
- ☐ Antécédent
- ☑ Antécédent HTA
- ☐ Avant 2000
- ☐ Intub
- ☑ Moins de 65 ans
- ☐ Motif d'hospitalisation
- ☑ Plus de 30 ans
- ☐ Plus de 65 ans

Intitulé du groupe de filtres
Séniors
- ☐ Antécédent
- ☐ Antécédent HTA
- ☐ Avant 2000
- ☐ Intub
- ☐ Moins de 65 ans
- ☐ Motif d'hospitalisation
- ☐ Plus de 30 ans
- ☑ Plus de 65 ans

Create the **Last name**, **First name**, **Medical history** and **Date of birth** columns

Intitulé de la colonne
Nom
Source de la colonne
Données du dossier
Donnée de la colonne
Nom / Nom de naissance [= Nom de naissance du patient]
Format des données: Texte

Intitulé de la colonne
Prénom
Source de la colonne
Données du dossier
Donnée de la colonne
Prénom [= Prénom du patient]
Format des données: Texte

Intitulé de la colonne
Date de naissance
Source de la colonne
Données du dossier
Donnée de la colonne
Date de naissance [= Date de naissance du patient]
Format des données: Date/Heure
Format
Format original

Intitulé de la colonne
Antécédents médicaux
Source de la colonne
Données du dossier
Donnée de la colonne
Antécédents Médicaux / Atcd Médicaux [= Antécédents fam
Format des données: Texte long

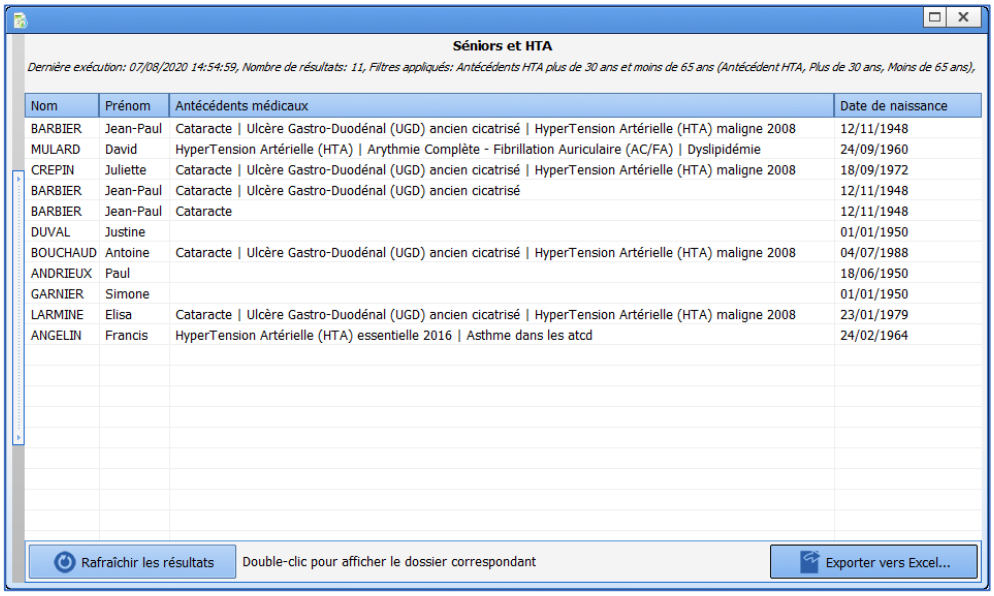
Create the **History and date of birth** column group

Intitulé du filtre
Antécédents et date de naissance
- ☑ Nom
- ☑ Prénom
- ☑ Antécédents médicaux
- ☑ Date de naissance
- ☐ Adresse
- ☐ CORMACK
- ☐ Durée d'intubation
- ☐ IGSII
- ☐ IMC
- ☐ Motif d'hospitalisation

Create the **Elderly and HT** report

Click on the **Execute report** button

The report is displayed:



Nom	Prénom	Antécédents médicaux	Date de naissance
BARBIER	Jean-Paul	Cataracte | Ulcère Gastro-Duodénal (UGD) ancien cicatrisé | HyperTension Artérielle (HTA) maligne 2008	12/11/1948
MULARD	David	HyperTension Artérielle (HTA) | Arythmie Complète - Fibrillation Auriculaire (AC/FA) | Dyslipidémie	24/09/1960
CREPIN	Juliette	Cataracte | Ulcère Gastro-Duodénal (UGD) ancien cicatrisé | HyperTension Artérielle (HTA) maligne 2008	18/09/1972
BARBIER	Jean-Paul	Cataracte | Ulcère Gastro-Duodénal (UGD) ancien cicatrisé	12/11/1948
BARBIER	Jean-Paul	Cataracte	12/11/1948
DUVAL	Justine		01/01/1950
BOUCHAUD	Antoine	Cataracte | Ulcère Gastro-Duodénal (UGD) ancien cicatrisé | HyperTension Artérielle (HTA) maligne 2008	04/07/1988
ANDRIEUX	Paul		18/06/1950
GARNIER	Simone		01/01/1950
LARMINE	Elisa	Cataracte | Ulcère Gastro-Duodénal (UGD) ancien cicatrisé | HyperTension Artérielle (HTA) maligne 2008	23/01/1979
ANGELIN	Francis	HyperTension Artérielle (HTA) essentielle 2016 | Asthme dans les atcd	24/02/1964

You can export the report to Excel and open the corresponding records by double-clicking on the patient line.

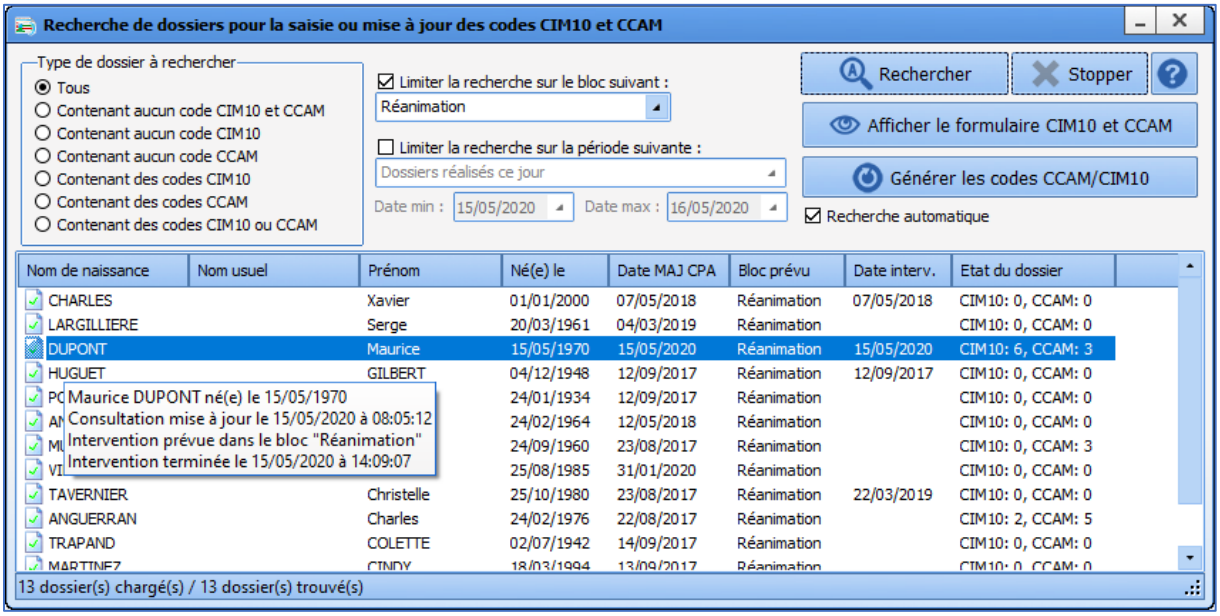
7. Procedure / ICD-10

7.1 Start up the Procedure / ICD-10 application

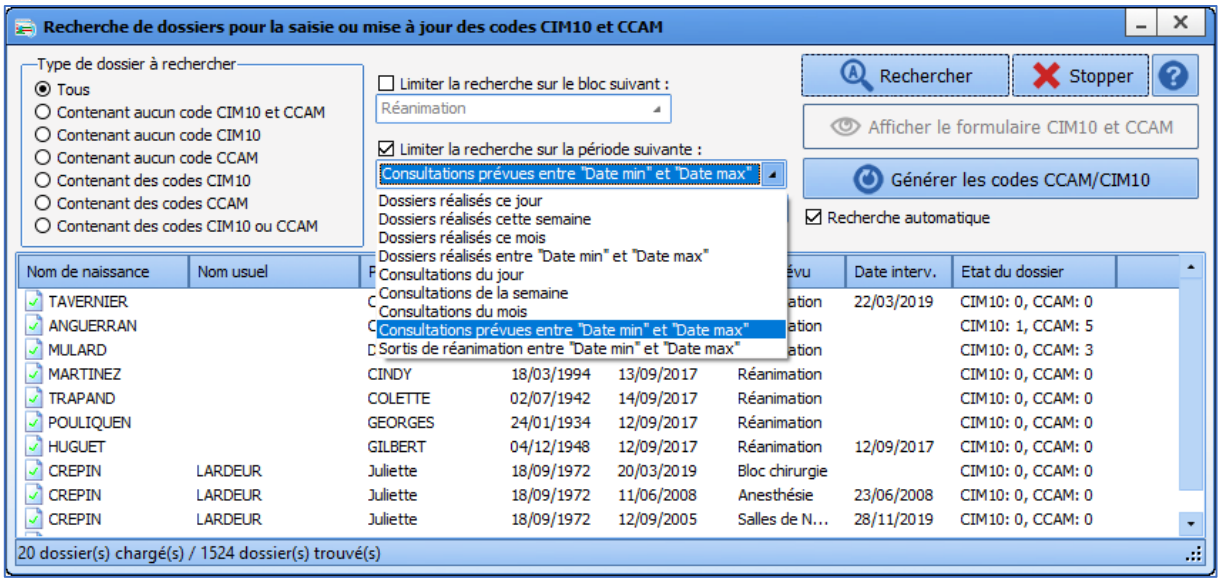
To start up the CCAMCIM10.exe application, select **Procedure / ICD-10** in the **Start/Programs/Diane** menu, or double-click on the icon on the Windows desktop. If the shortcut to this application has not been created, you will find the original executable file by following the path **C:\Program Files\Diane\CCAMCIM10.exe**.

CAUTION: do not move the original executable files on the desktop.

This application lets you search records to enter or update ICD-10 and procedure codes. You will scan the relevant patient records to retrieve the corresponding codes, confirm them and export them.



7.2 Searching for patient records



To make the patient record search window more compatible with ICU, the list of filtering queries includes an additional query: **Discharged between 'Min date' and 'Max date'**.
This query lets you display the records of patients who left the ICU between the two dates entered by the user.

7.2.1 Record type to search

In the **Record type to search** area, we can see seven different cases:

When the **All** filter is selected (type selected by default when the application opens), the patients in the list are patients whose complete anaesthesia record (preop assessment and intraoperative and/or postoperative information) contains or does not contain ICD-10 and procedure codes related to the patient's anaesthesia record.

When the **Containing no ICD-10 or procedure code** filter is selected, the patients in the list are patients whose complete anaesthesia record does not contain codes related to the anaesthesia record. The **Number of codes** column only displays records stipulating **ICD-10: 0, procedure: 0**.

When the **Containing no ICD-10 code** filter is selected, the patients displayed in the list are patients whose complete anaesthesia record does not contain ICD-10 codes related to the anaesthesia record. The **Number of codes** column displays records stipulating **ICD-10: 0**.

When the **Containing no procedure code** filter is selected, the patients in the list are patients whose complete anaesthesia record does not contain procedure codes related to the anaesthesia record. The **Number of codes** column displays records stipulating **Procedure: 0**.

When the **Containing ICD-10 codes** filter is selected, the patients displayed in the list are patients whose complete anaesthesia record contains ICD-10 codes related to the anaesthesia record. The **Number of codes** column displays records stipulating **ICD-10: 1 or 2 or ...**

When the **Containing procedure codes** filter is selected, the patients displayed in the list are patients whose complete anaesthesia record contains procedure codes related to the anaesthesia record. The **Number of codes** column displays records stipulating **Procedure: 1 or 2 or ...**

When the **Containing ICD-10 and procedure codes** filter is selected, the patients displayed in the list are patients whose complete anaesthesia record contains codes related to the anaesthesia record. The **Number of codes** column does not display records stipulating **ICD-10: 0** and **Procedure: 0**.

7.2.2 Selection filters

When the application is opened, the search is, by default, limited to the operating theatre in which your computer is configured. You can limit the search to a particular operating theatre. You can also not limit the search and display all the operating theatres in your hospital by unticking the **Narrow search to the following OT** box.

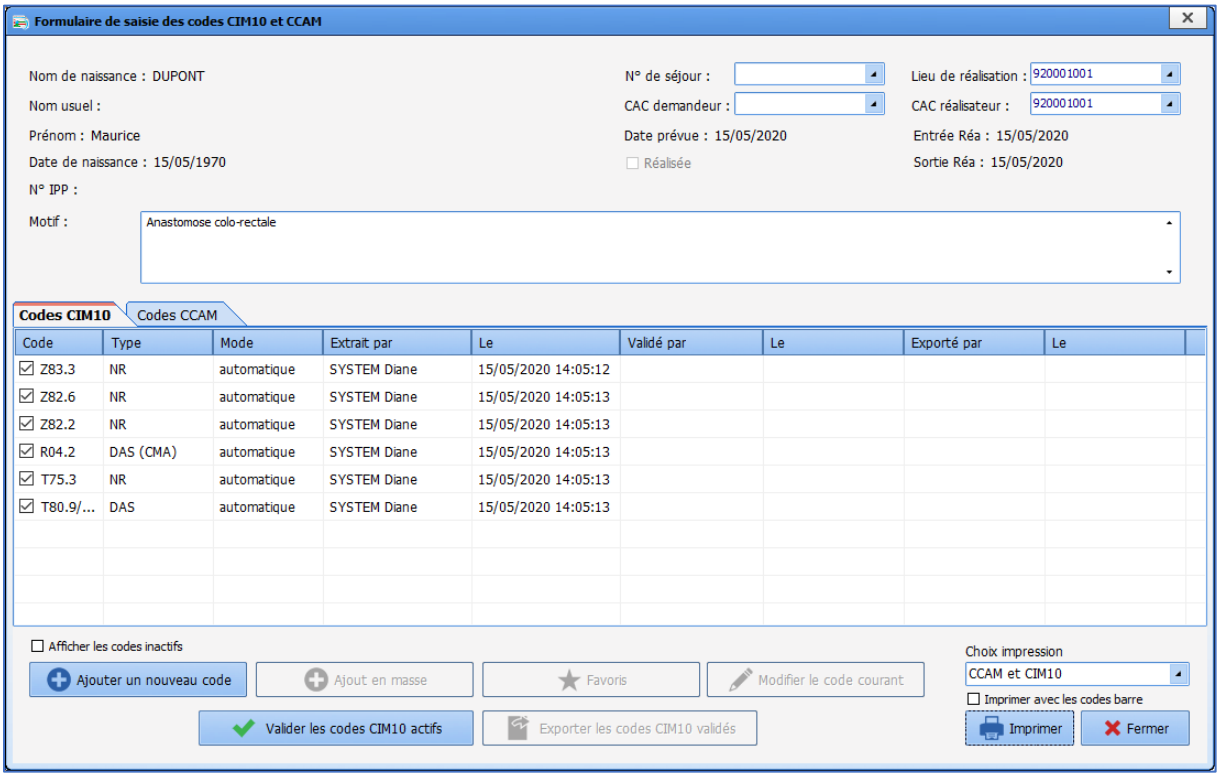
When the application is opened, the search is, by default, limited to surgeries performed that day. You can limit the search to a specific period, such as **Surgeries performed this month** or **This week's consultations**. You can also decide not to limit the search and display all the periods by unticking the **Narrow search to the following period** box.

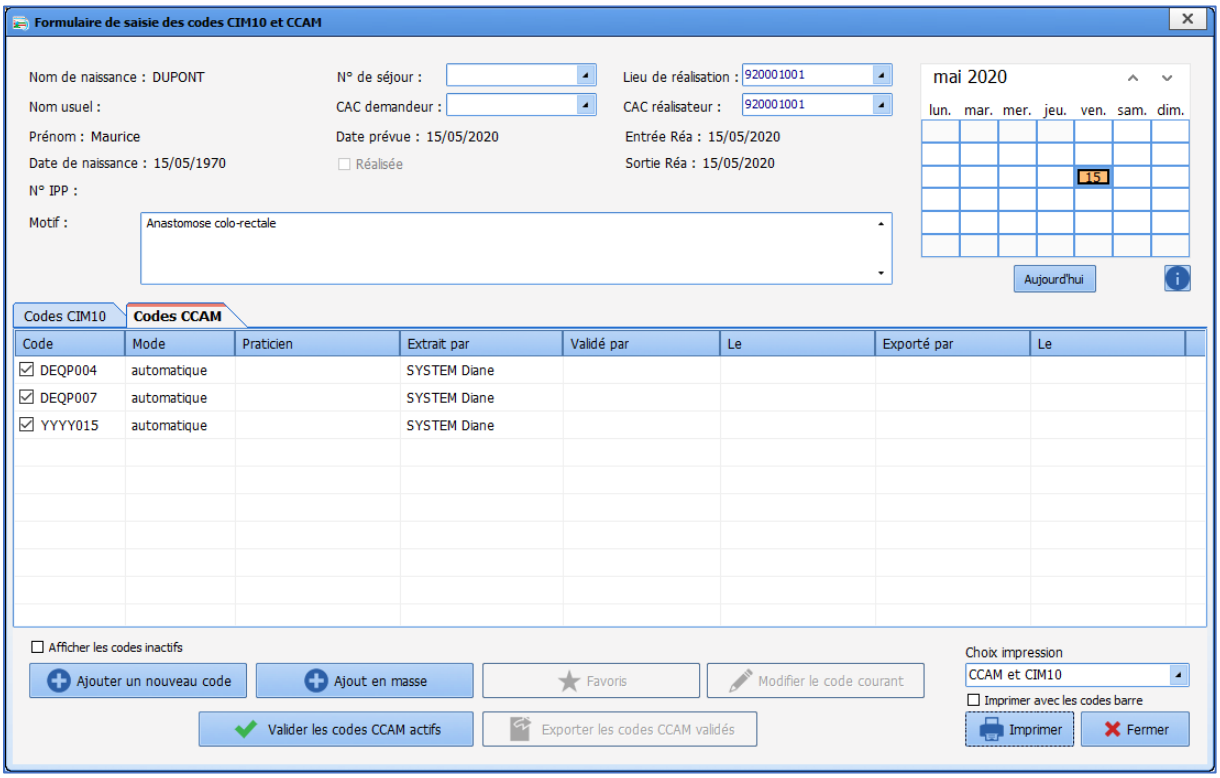
The **Start search** button lets you start searching for patients according to the filters you have inserted. The **Stop** button is used to stop the current search.
By default, the **Automatic search** checkbox to the right of the window is ticked. If this box is unticked, you must click on the **Start search** button to display the records you are looking for.

The **View ICD-10 & procedure form** button lets you access the **Entry form for ICD-10 and procedure codes**.

You can sort the list of patients displayed by clicking on the window column headings.

7.3 Entry form for ICD-10 and procedure codes





At the top of the **Entry form for ICD-10 and procedure codes**, you will find all the patient's administrative

information (surname, married name, first name, date of birth, UPI number), all the information related to the surgery (name of the surgery, date, a surgery completion indicator), and items related to your patient's stay (stay number, place where done, Requesting service and Service performing surgery).

In the **Stay No.** drop-down list, you will find the stay numbers corresponding to the surgery. Several numbers can be associated with the same surgery. The stay number selected by default is the last associated stay.

Regarding the fields **Place where done**, **Requesting service and Service performing surgery**, it is the list of existing services that is displayed. By default, the choices corresponding to the data previously entered in the consultation or intraoperative or postoperative monitoring record are displayed.

The **Requesting service** corresponds to the service of the unit requesting the surgery (value of the field entered in the **Administrative** tab of the consultation record).

The **Service performing surgery** corresponds to the OT service responsible for the surgery.

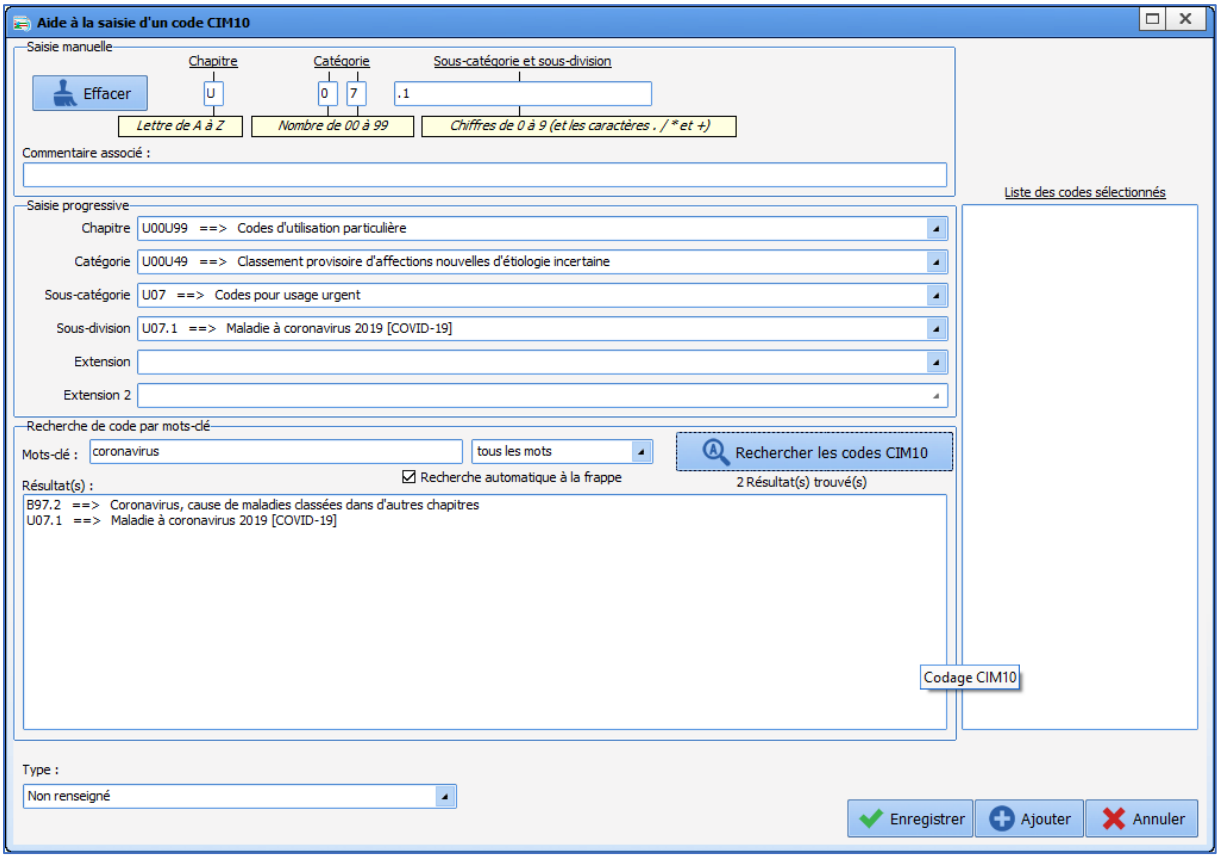
The **Place where done** corresponds to the service where the surgery took place.

7.3.1 ICD-10 codes (International Classification of Diseases)

When you open the Entry form for ICD-10 and procedure codes, you directly see all the ICD-10 codes related to the patient's anaesthesia record.
If several ICD-10 codes are assigned to the same item, you will need to select the one(s) you want in the **Select the ICD-10 code(s) associated with the entry** window. Once the code(s) have been selected, you will no longer need to select it/them again if the **Entry form for ICD-10 and procedure codes** is displayed again. You can add new codes or change existing codes using the buttons provided, but you cannot change a code that has been entered by another user.

NB: If you hover the mouse over any ICD-10 code this displays a tooltip indicating the ICD-10 code, the ICD-10 type, the Entry type, the Description (comment) and the Official wording of the item that generated this code (if there is one).

The **Add a new code** and **Edit current code** buttons display the **ICD-10 coding help** window.



There are three different ways to enter the International Classification of Diseases code.

If you know the International Classification of Diseases code for the selected item

In the **Manual entry** area at the top of the **ICD-10 coding help** window, enter the letter corresponding to the **Chapter**, the number corresponding to the **Category** and then the numbers corresponding to the **Subcategory and subdivision**. You can insert an **Associated comment**.

The **Entry by section** area is completed as you enter your code. Next click on the **Save** button.

NB: If the ICD-10 code you have entered is unknown, you can manually edit the Type, i.e. specify whether it is a Principal diagnosis, a Significant secondary diagnosis, an Informational secondary diagnosis or Related diagnosis.

If you know the International Classification of Diseases code sections for the selected item

In the **Entry by section** area, located in the middle of the **ICD-10 coding help** window, select in turn, using the drop-down lists, the **Chapter**, **Category**, **Subcategory**, **Subdivision** and if necessary **Extension** and **Extension 2**.

The **Manual entry** area is completed as you enter the various sections of your ICD-10 code. Next click on the **Save** button.

You are looking for the International Classification of Diseases code using a keyword

In the **Search code by keyword** area at the bottom of the **ICD-10 coding help** window, enter the keywords corresponding to the item you wish to code. You can use an entire expression as a keyword by placing it between ' '. Using the drop-down list, specify that you want to search for **All words** or **At least one of the words**, then click on the **Search for corresponding ICD-10 codes** button or hit `Enter` on your keyboard.

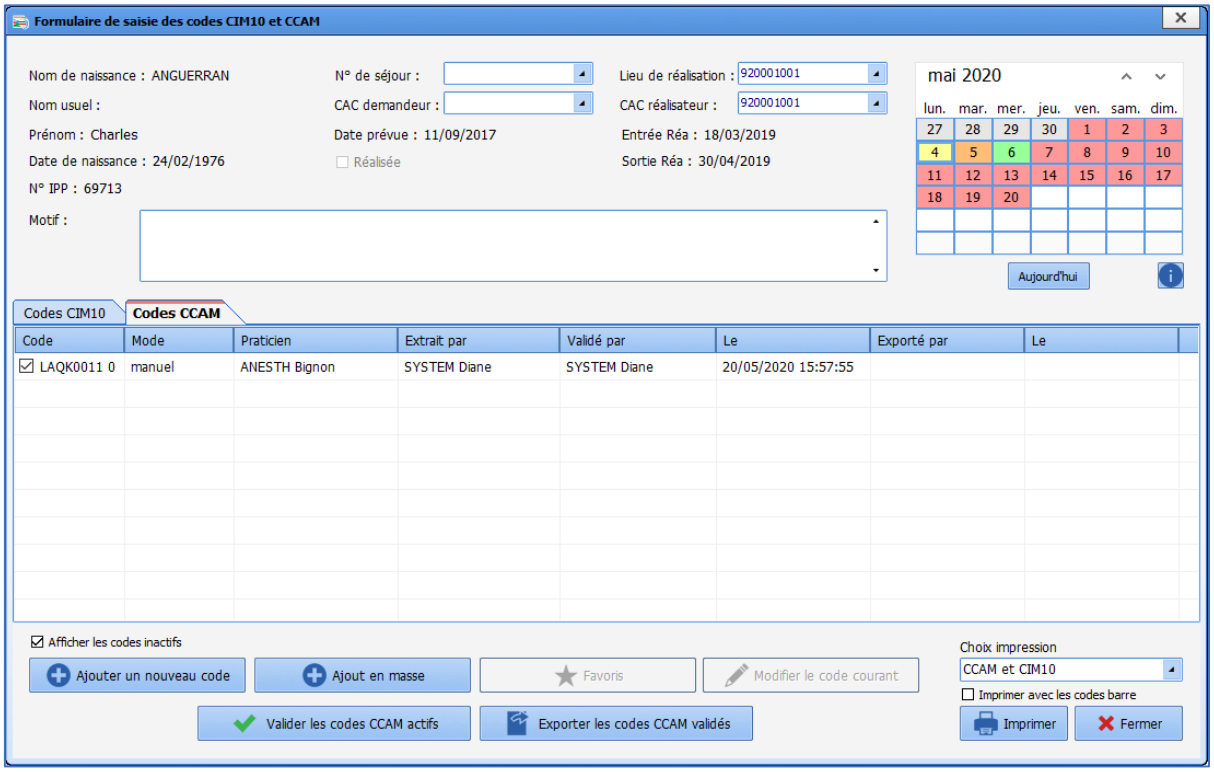
All the possible wordings are found in the **Result(s)** box. Simply choose the one you want and the **Manual entry** and **Entry by section** boxes are automatically completed based on the wording selected. Next click on the **Save** button.

ICD-10 codes can have 3 statuses:

- Extracted: only **Extracted by** and **On** columns are filled.

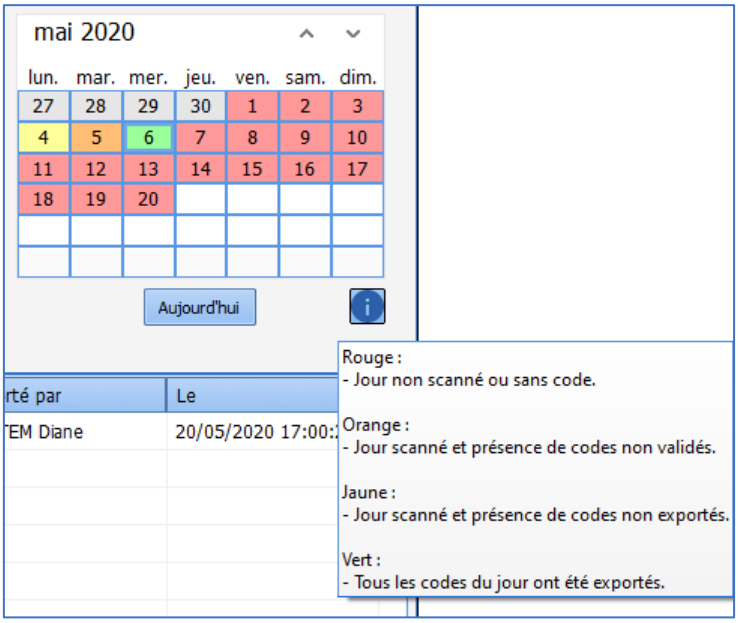
- Confirmed: the **Confirmed by** and **On** columns are filled in addition to the **Extracted by** column.
- Exported: this new status is defined by the new **Exported by** and **On** columns. These columns make it possible to monitor data sent to the interface and are filled once the ICD-10 codes have been exported. This status is in the ICD-10 code look-up table.

7.3.2 Procedure codes



A calendar is available to select a day and list any procedure codes for the chosen date. The colour of the calendar day shows the status of the procedure codes:

- **Red** = day not scanned or no codes for this day,
- **Orange** = there are unconfirmed codes for this day,
- **Yellow** = there are codes not exported for this day,
- **Green** = all codes have been exported for this day.



Clicking on a day on the calendar displays the codes entered on that day. You can only click on a date between the surgery start date and end date.

Procedure codes can have 3 statuses:

- Extracted: only **Extracted by** and **On** columns are filled.
- Confirmed: the **Confirmed by** and **On** columns are filled in addition to the **Extracted by** column.
- Exported: this new status is defined by the new **Exported by** and **On** columns. These columns make it possible to monitor data sent to the interface and are filled once the procedure codes have been exported. This status is in the procedure code look-up table.

7.3.3 Data export

You can untick the checkbox next to the code number to ignore it during the export.
The **View non-enabled codes** checkbox lets you display or not display in the Entry form any codes that have been unticked.
Once you have confirmed the ICD-10 and procedure codes you will be able to export them. The button enabling the export is greyed out until the surgery has taken place. This button will only be accessible when the patient arrives in the recovery room.

NB: Code confirmation is irreversible and no subsequent changes are possible. Once the codes are exported, they cannot be changed. In addition, these codes can only be exported after the surgery has been done.

NB: Procedure codes and ICD-10 codes can be exported and confirmed separately.

7.3.4 Printing codes

You can print the procedure and ICD-10 codes together or separately, and can choose to print just the codes or also their description and official wording. To do this, select what you want to print from the drop-down list and click on the **Print** button.

When a procedure code is added automatically, if the date on which it is added is a public holiday or a Sunday, the modifier 'Emergency procedures on a Sunday or public holiday' is added automatically.

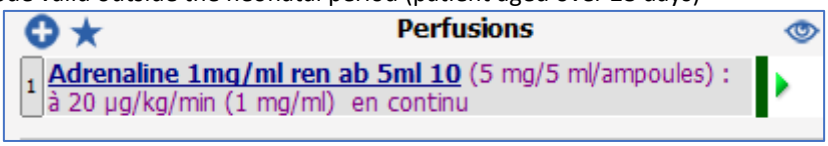
A number of automatic codes have been created in DIANE:

EQLF003: Procedure automatically added dobutamine / dopamine continuously rate > 8 µg/kg/min / adrenaline / Noradren excl. neonate / 24

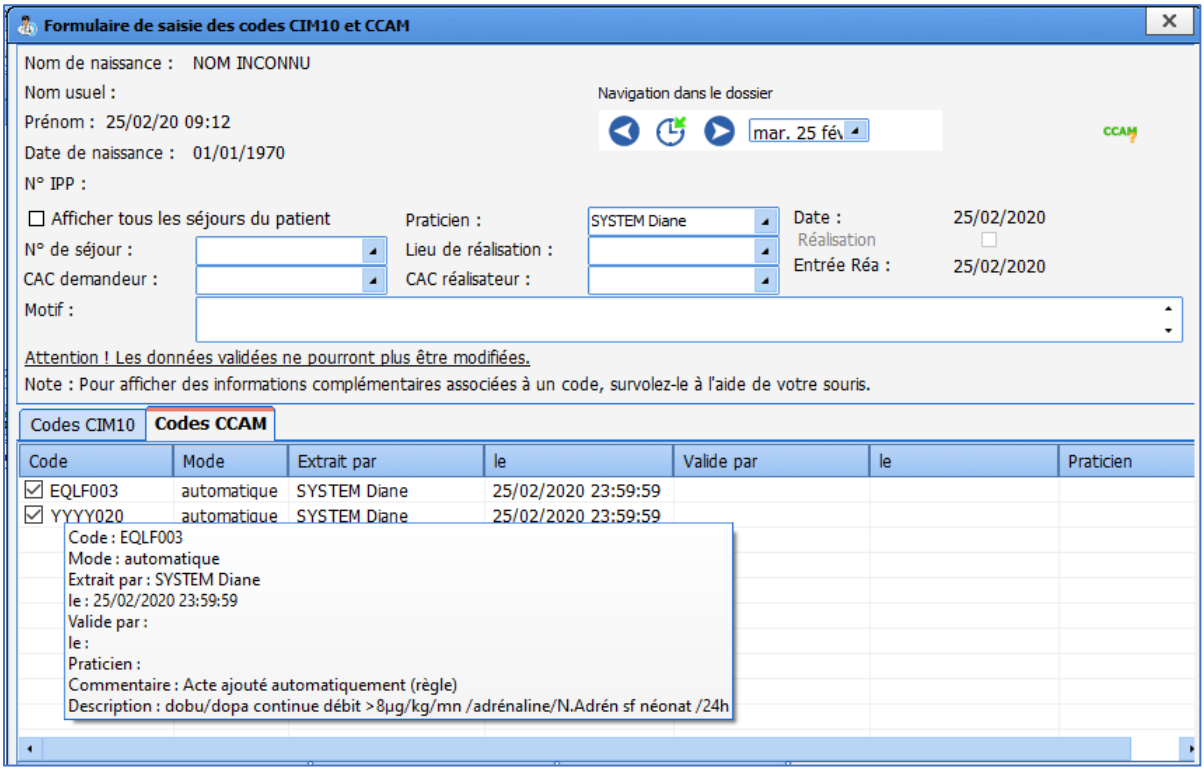
There are two ways to add this code:

- Continuous intravenous injection of dobutamine or dopamine at a rate greater than 8 micrograms per kilogram per minute [µg/kg/min] outside the neonatal period, per 24 hours -> code valid outside the neonatal period (patient aged over 28 days)

- Continuous intravenous injection of adrenaline or noradrenaline at a rate greater than 8 micrograms per kilogram per minute [µg/kg/min] outside the neonatal period, per 24 hours -> code valid outside the neonatal period (patient aged over 28 days)



The code is **automatically** added 5 min after starting the prescription and automatically adds the ICU package **B YYYY020**.

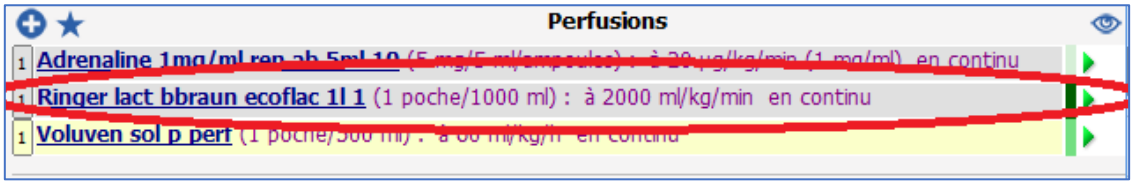


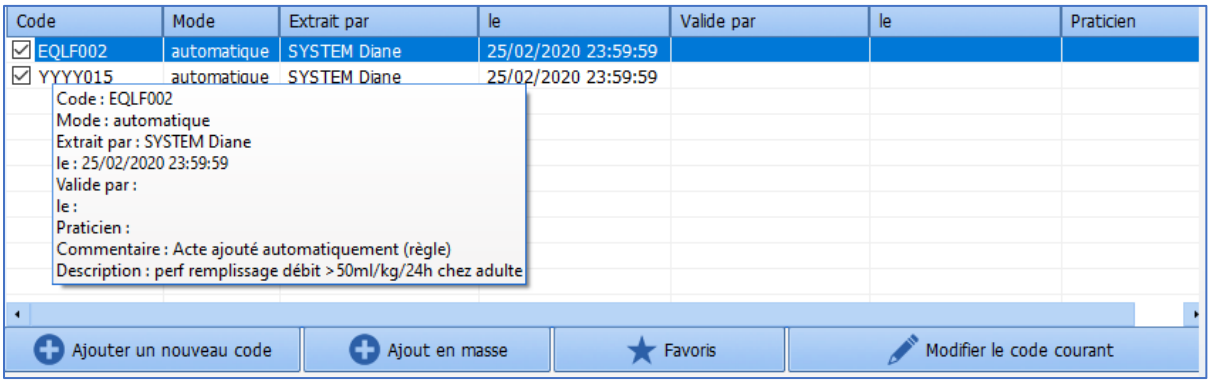
EQLF002: Infusion expander rate > 50mL/kg/24h in adults

The code is added when an intravenous infusion of an expander at a rate above 50 mL/kg is prescribed:

- Ringer Lactate (ATC: B05BB01)
- Voluven (ATC: B05AA07)
- NaCl09 (ATC: B05XA03)

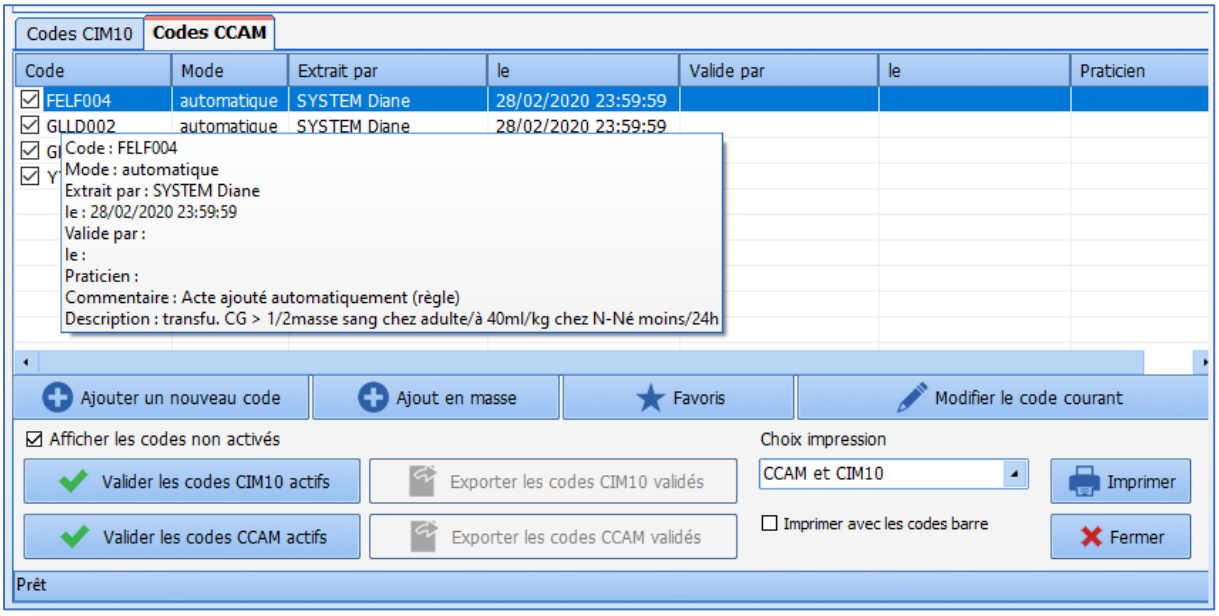
The code is only added once the patient has received a volume of product equivalent to 50 mL per kilo in under 24 hours. It comes with the automatic code YYYY015: ICU package A.





FELF004: PRBC transfusion > ½ blood volume in Adults / 40 mL/kg in neonates in under 24 hours

This code is added automatically if the patient has received a transfusion of packed red blood cells with a volume greater than half the blood volume in adults per kilogram [mL/kg] or 40 millilitres per kilogram [mL/kg] in neonates in under 24 hours.
Packed red blood cells have the following external ID: PS_CGR
The half blood volume of a male adult is 38 mL/kg and 34 mL/kg for a female adult.

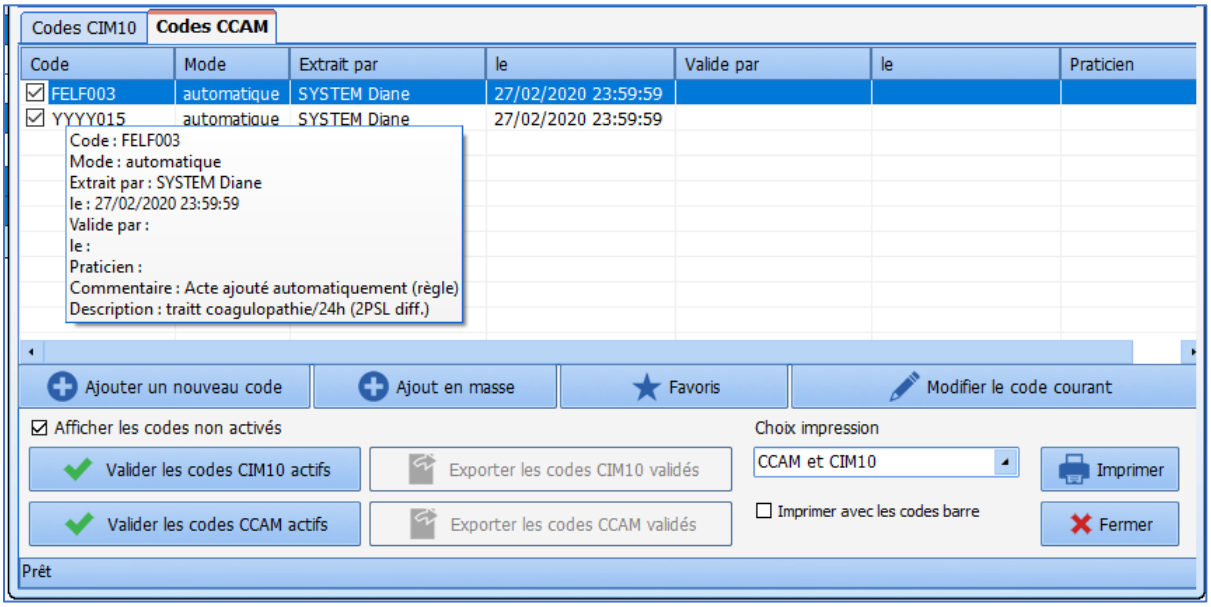


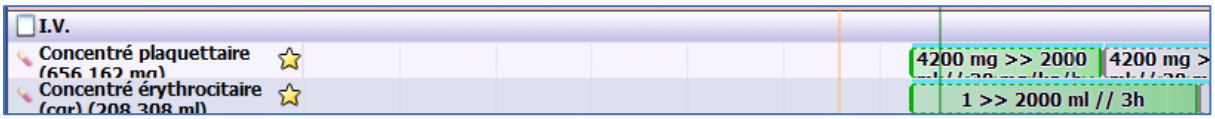
FELF003: Coagulopathy treatment / 24h (2 diff. LBP)

This code is added when there are at least two simultaneous intravenous prescriptions for the following

blood products administered continuously over 24 hours:

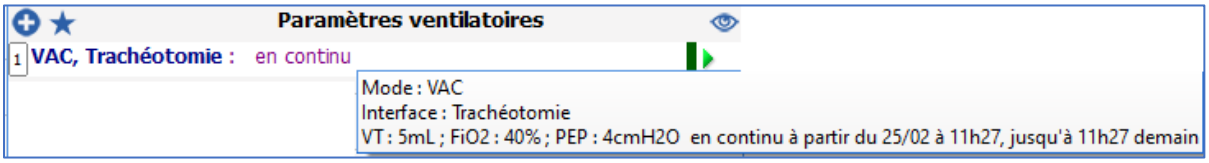
- Fresh frozen plasma (external ID: PS_PFC)
- Platelets / platelet concentrate (external ID: PS_CP)
- Antihaemophilic factor A or B (external ID: PS_FACT8 or PS_FACT9)
- Fibrinogen (external ID: PS_FACT1)
- Antithrombin III substitution for coagulopathy (external ID: PS_ATHRB3)

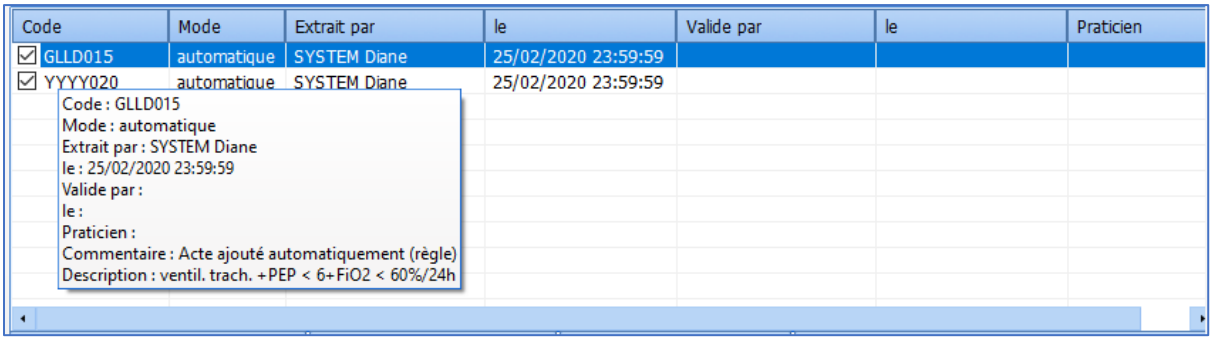




GLLD015: Trach ventilation. + PEEP < 6 + FiO2 < 60% / 24h

This code is added when there is a prescription for invasive ventilation by tracheotomy or intubation tube, provided that the FiO2 is less than 60% and the PEEP is less than or equal to 6.

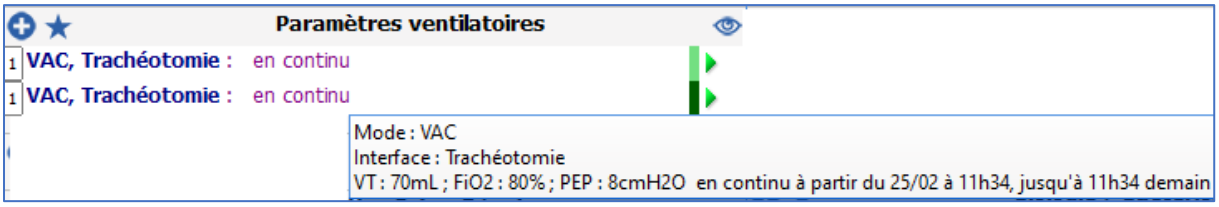


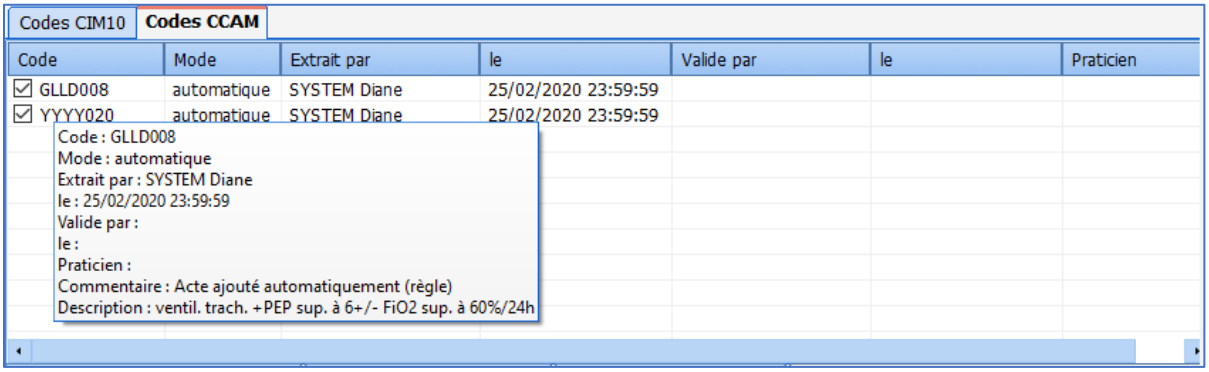


This code is added after 5 minutes and adds the ICU package **B YYYY020**.

GLLD008: Trach ventilation. + PEEP over 6 +/- FiO2 over 60% / 24h

This code is automatically added when there is a prescription for mechanical ventilation by intubation tube or tracheotomy with positive end-expiratory pressure (PEEP) greater than 6 and/or FiO2 greater than 60%, continuously over 24 hours.

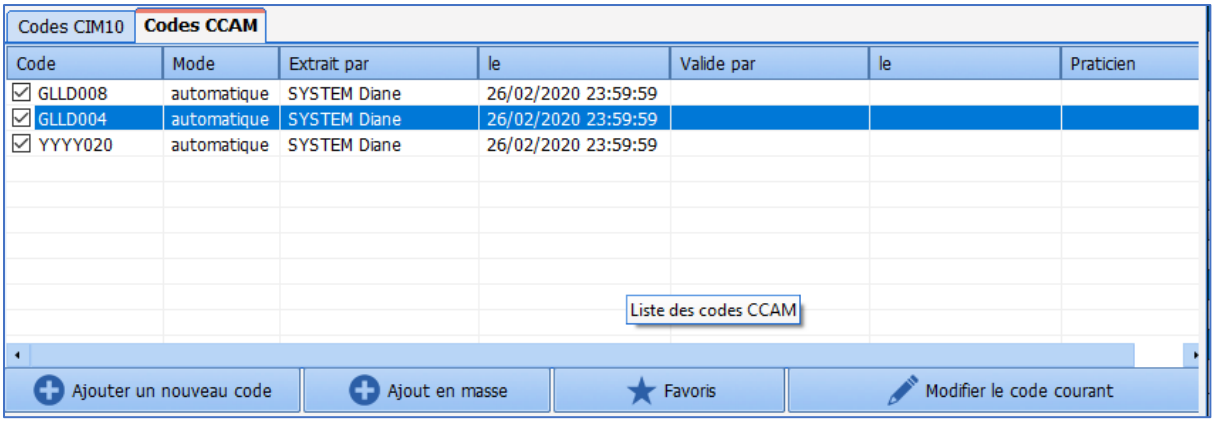




This code automatically adds the ICU package B YYYY020.

GLLD004: Trach. ventilation + PEEP > 6 +/- FiO2 > 60% + alternating prone / 24h

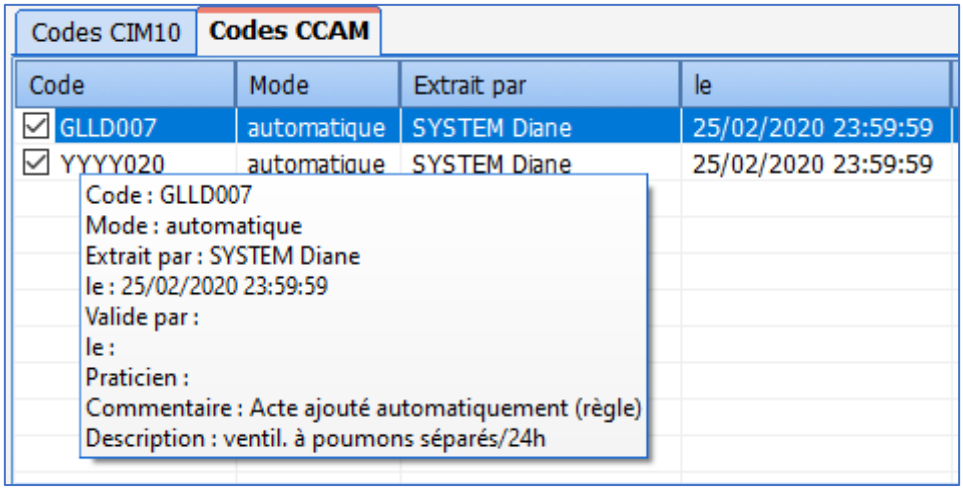
This code is added when there is a prescription for mechanical ventilation by intubation tube or tracheotomy with positive end-expiratory pressure [PEEP] greater than 6 and/or FiO2 greater than 60%, with the alternating prone technique continuously over 24 hours (prone parameter entered in hours or alternating hours).



The addition of this code is paired with the code GLLD008 and automatically adds the ICU package B YYYY020.

GLLD007: Ventil. of separate lungs / 24h

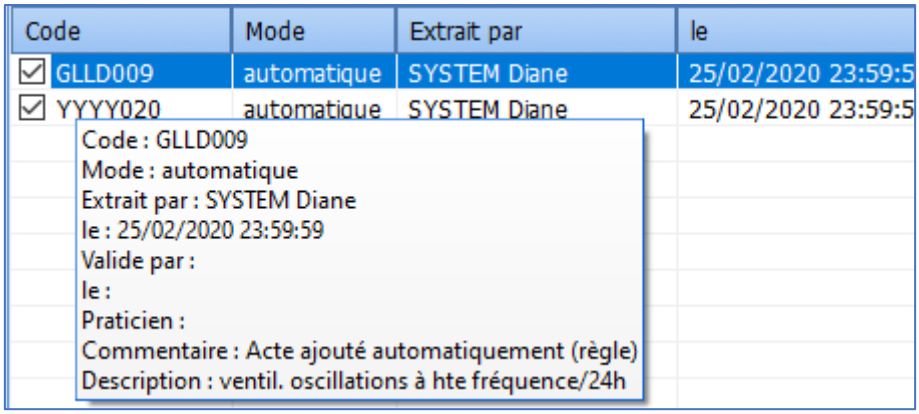
Automatic code that is added when prescribing mechanical **ventilation of separate lungs** continuously over 24 hours.



This code automatically adds the ICU package B YYYY020.

GLLD009: High frequency oscillation ventilation / 24h

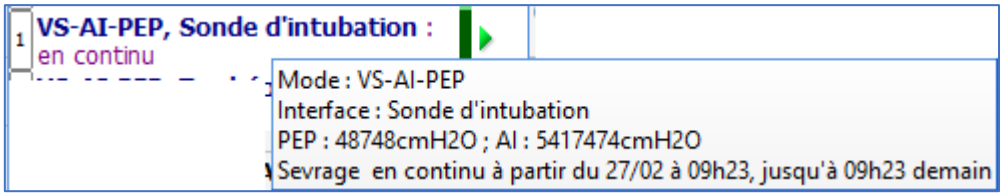
Automatic code that is added when prescribing mechanical ventilation using **High frequency oscillation** continuously over 24 hours.

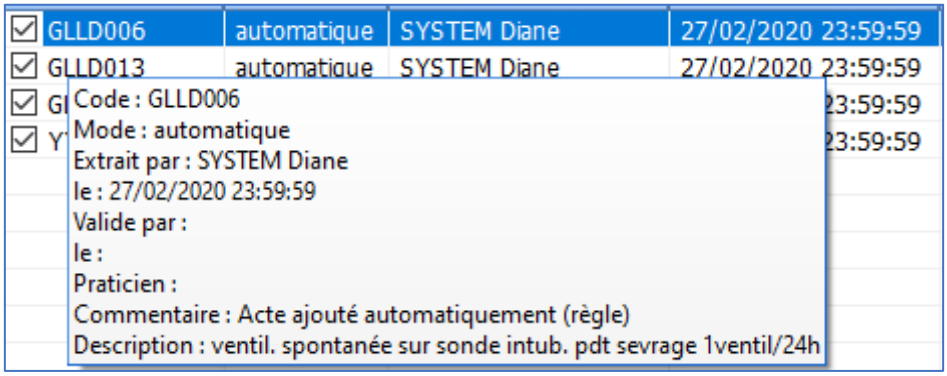


This code automatically adds the ICU package B YYYY020.

GLLD006: Spontaneous ventil. with intubation tube during weaning 1 ventil / 24h

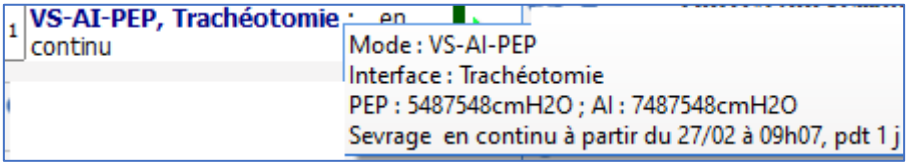
This code is only added when prescribing spontaneous ventilation using an intubation tube in **IPSSV/PEEP** mode during weaning from mechanical ventilation (in the parameters the **Weaning** checkbox is ticked), continuously over 24 hours.

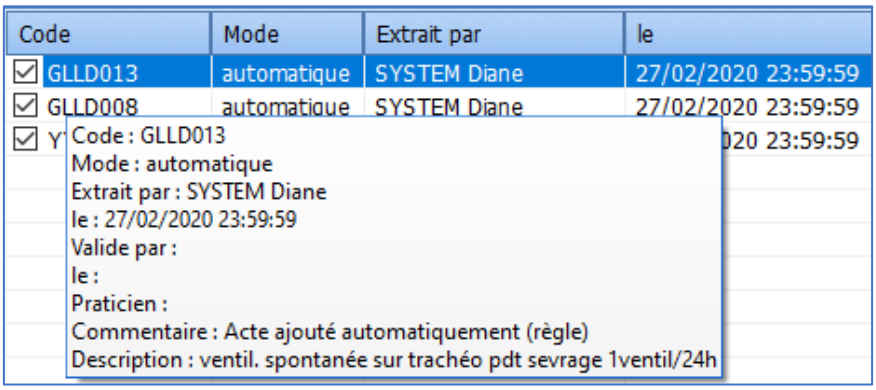




GLLD013: spontaneous ventilation using tracheo during weaning 1 ventil / 24h

This code is added when prescribing spontaneous ventilation using a tracheotomy in **IPSSV/PEEP** mode during weaning from mechanical ventilation (in the parameters the **Weaning** checkbox is ticked), continuously over 24 hours.

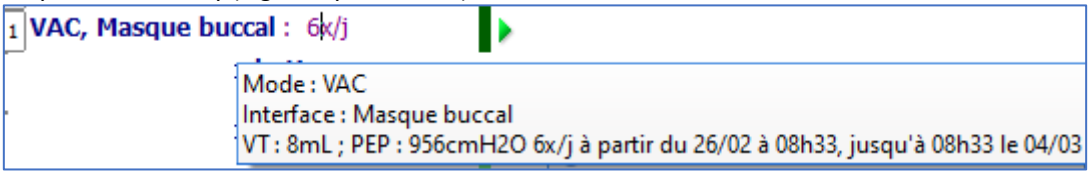


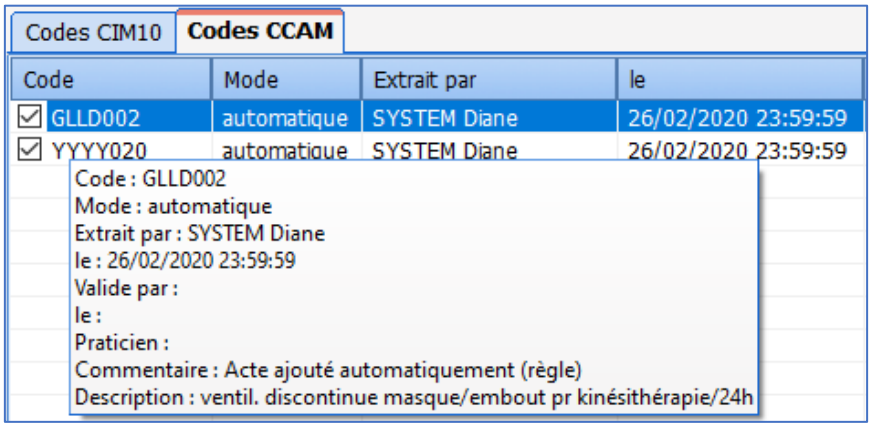


This code automatically adds the ICU package B YYYY020.

GLLD002: discontinuous mask / mouthpiece ventilation by physiotherapy / 24h

This code is added when prescribing mechanical ventilation using a face mask or mouthpiece scheduled over one day discontinuously (e.g. every two hours).

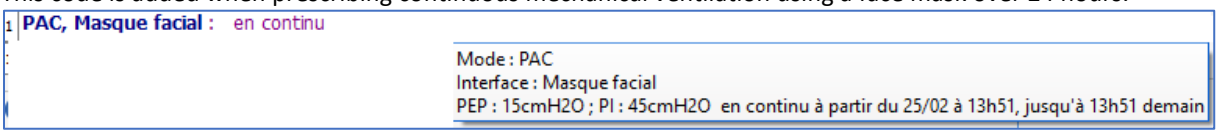


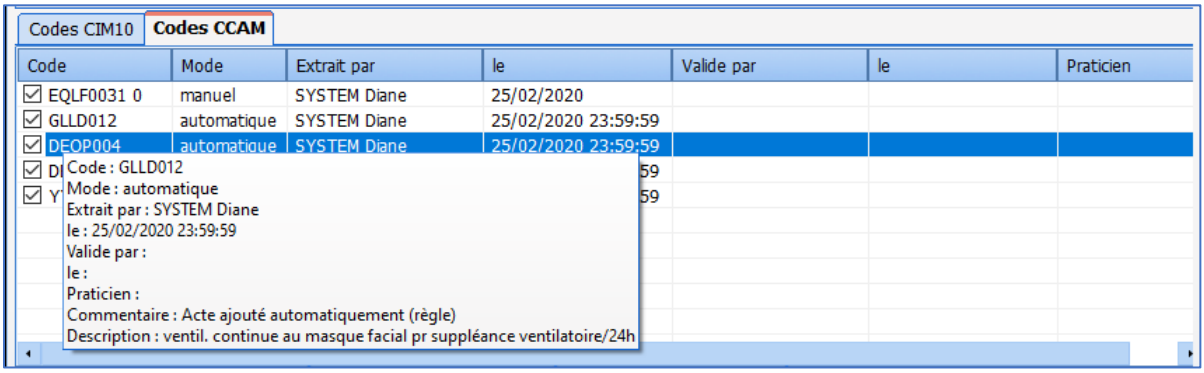


This code automatically adds the ICU package B YYYY020.

GLLD012: continuous ventilation with a face mask for ventilatory support / 24h

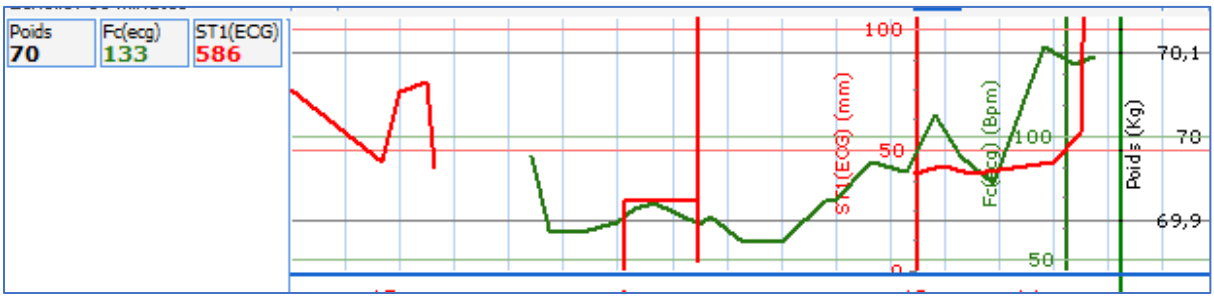
This code is added when prescribing continuous mechanical ventilation using a face mask over 24 hours.





DEQP004: Continuous scope / remote ECG / 24h

This code is added for continuously monitoring the electrocardiogram using an oscilloscope and/or remote monitoring, continuously monitoring the heart rate and/or level 1 ECG depression. The values of the HR (ECG) parameter and/or ST1 (ECG) parameter must be received continuously (break in values under 2 minutes) for at least 5 minutes.



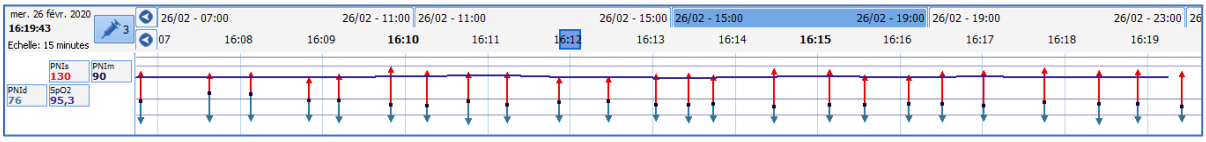
DEQP004	automatique	SYSTEM Diane	26/02/2020 23:59:59
DEQP007	automatique	SYSTEM Diane	26/02/2020 23:59:59
Y			26/02/2020 23:59:59

Code : DEQP004
Mode : automatique
Extrait par : SYSTEM Diane
le : 26/02/2020 23:59:59
Valide par :
le :
Praticien :
Commentaire : Acte ajouté automatiquement (règle)
Description : scope/téléecg continu/24h

This code automatically adds the ICU package A YYYY015.

DEQP007: Continuous scope / remote ECG + noninvasive blood pressure +/- SaO2 monitoring / 24h

This code is added for continuously monitoring the electrocardiogram using an oscilloscope and/or remote monitoring, continuously monitoring the intra-arterial blood pressure and/or arterial oxygen saturation. The values of the noninvasive systolic blood pressure monitoring or of the arterial oxygen saturation parameter must be received continuously (break in values under 2 minutes) for at least 5 minutes.



Codes CIM10 | Codes CCAM

Code	Mode	Extrait par	le	Valide par	le	Praticien
DEQP004	automatique	SYSTEM Diane	26/02/2020 23:59:59			
DEQP007	automatique	SYSTEM Diane	26/02/2020 23:59:59			
YYYY015	automatique	SYSTEM Diane	26/02/2020 23:59:59			

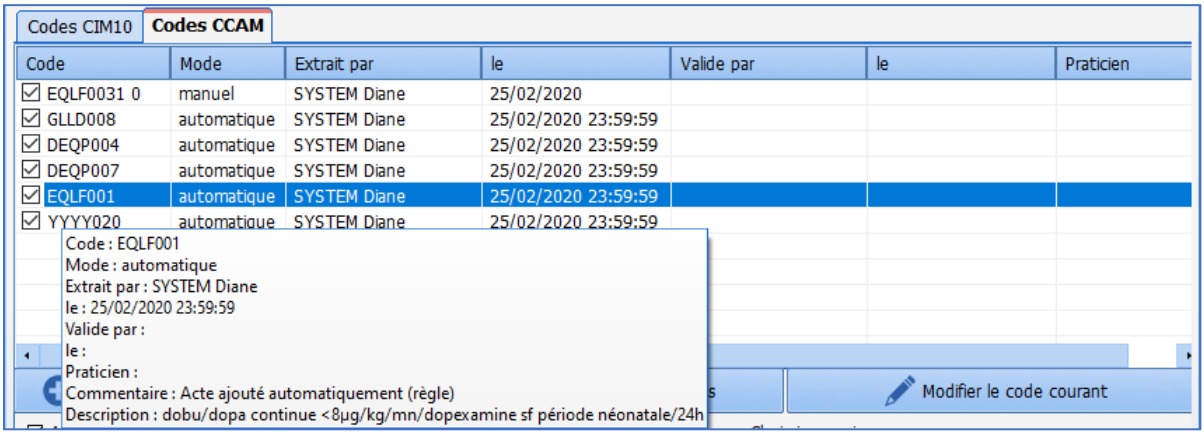
Code : DEQP007
Mode : automatique
Extrait par : SYSTEM Diane
le : 26/02/2020 23:59:59
Valide par :
le :
Praticien :
Commentaire : Acte ajouté automatiquement (règle)
Description : scope/téléECG continu +surv. press art+/-SaO2 non effractives/24h

This code automatically adds the ICU package A YYYY015.

EQLF001: Dobutamine / Dopamine continuous <8 µg/kg/min / Dopexamine excl. neonatal period / 24h

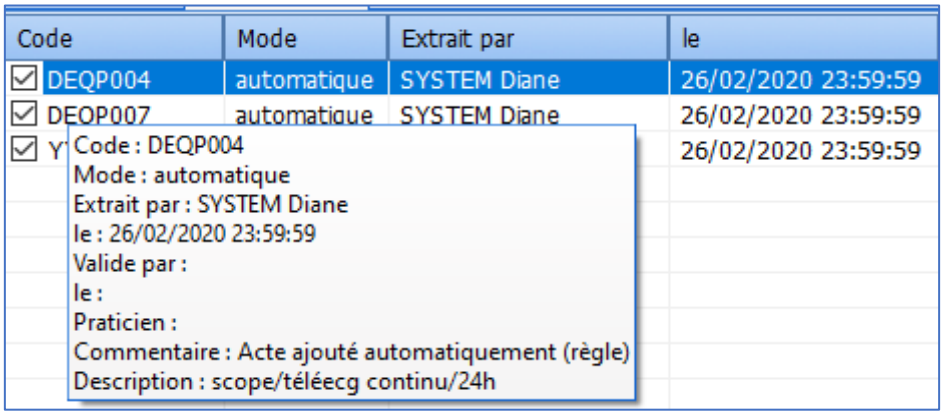
This code is added when prescribing a continuous intravenous injection of dobutamine or dopamine at a rate of less than 8 micrograms per kilogram per minute [µg/kg/min] or Dopexamine outside the neonatal period, per 24 hours -> code valid outside the neonatal period (patient aged over 28 days).

1 **Dobutamine 250mg/20ml panph fl 10** (250 mg/20 ml/flacons)
: 250 mg à 4 µg/kg/min en continu



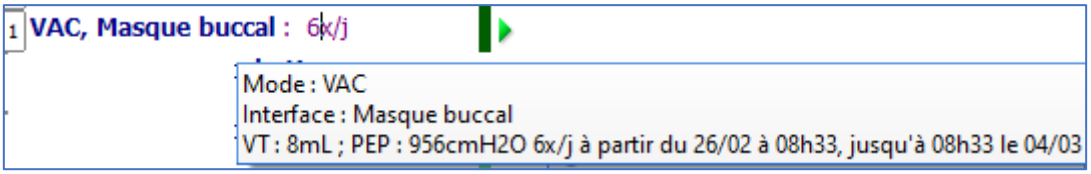
GLQP004: Continuous scope / remote ECG / 24h

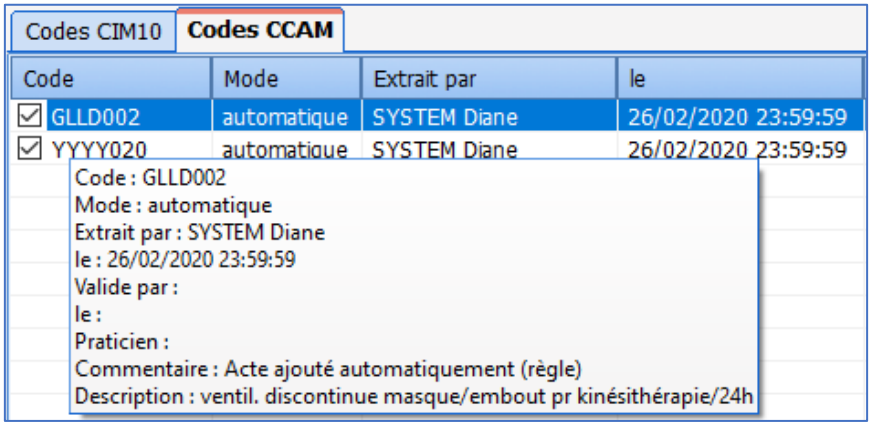
This code is added for continuous transcutaneous monitoring of the partial pressure of O2 by transcutaneous route (= paO2 / partial pressure of O2 by transcutaneous route = partial pressure of O2 in the arterial blood) or of the partial pressure of CO2 by transcutaneous route (= paCO2 / Partial pressure of CO2 by transcutaneous route = paCO2: partial pressure of CO2 in the arterial blood) for at least 5 consecutive minutes (without a break of more than 2 minutes) for a neonate (patient under 28 days).



GLLD002: discontinuous mask / mouthpiece ventilation by physiotherapy / 24h

This code is added when prescribing mechanical ventilation using a face mask or mouthpiece scheduled over one day discontinuously (e.g. every two hours).





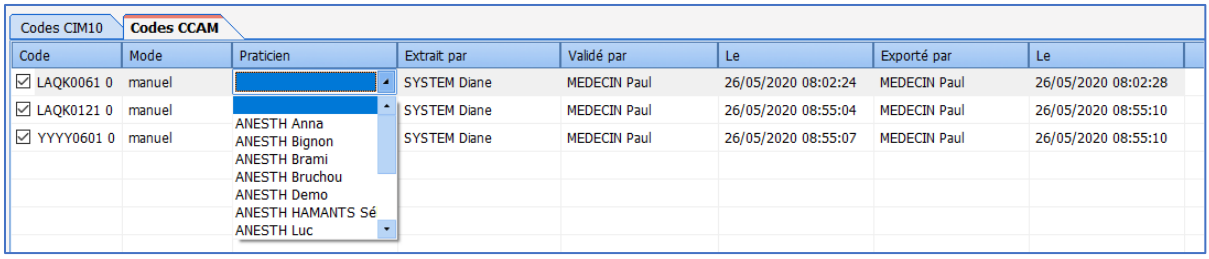
This code automatically adds the ICU package B YYYY020.

NB: Some procedure codes cannot currently be automated in **DIANE**:

EQMP001, EQMF003, GLJF010, GLLD003, GLLD019

7.4 Assigning the practitioner (procedure codes)

The practitioner is always assigned manually using the window to create/change the procedure code. But it can be changed directly in the **Practitioner** column where there is a drop-down list with all practitioners in alphabetical order.



7.5 Printing procedure and ICD-10 codes

The procedure and ICD-10 codes are printed in landscape mode for the six types of printouts available:

- Procedure and ICD-10 codes
- Procedure codes
- ICD-10 codes
- Detailed procedure and ICD-10 codes
- Detailed procedure codes
- Detailed ICD-10 codes

'Normal' printing:

Nom de naissance :	ANGUERRAN	Prénom :	Charles	Numéro d'établissement :	
Nom usuel :		Date naissance :	24/02/1976	Date d'admission :	18/03/2019 11:39
Numéro IPP :	69713	Numéro de séjour (NIP) :		Date de sortie :	30/04/2019 16:02
CAC demandeur :		CAC réalisateur :	920001001	Type d'admission :	
Lieu de réalisation :	920001001	Intervention réalisée :	Non	IGS2 :	N/R
Type du document:	CODEPMSI$	Numéro de dossier Emed:		IGS2 sans l'âge :	N/R
Intervention : (11/09/2017)					

Date du document: 25/05/2020 Page n° 1 / 2

Liste des codes CIM10 & CCAM rattachés au dossier du patient

Code CIM10	Type CIM10	Saisie	par	le	Validé par	le	Exporté par	le
I10/006	NR	automatique	MEDECIN Paul	20/03/2019	MEDECIN Paul	25/05/2020	MEDECIN Paul	25/05/2020
T88.4	NR	automatique	SYSTEM Diane	20/05/2020	MEDECIN Paul	25/05/2020	MEDECIN Paul	25/05/2020

Code CCAM	Saisie	par	le	Validé par	le	Exporté par	le
YYYY020	automatique	MEDECIN Paul	18/03/2019	SYSTEM Diane	20/05/2020	Non renseigné	N/R
DEQP007	automatique	MEDECIN Paul	18/03/2019	SYSTEM Diane	20/05/2020	Non renseigné	N/R

Detailed printing:

Nom de naissance :	ANGUERRAN	Prénom :	Charles	Numéro d'établissement :	
Nom usuel :		Date naissance :	24/02/1976	Date d'admission :	18/03/2019 11:39
Numéro IPP :	69713	Numéro de séjour (NIP) :		Date de sortie :	30/04/2019 16:02
CAC demandeur :		CAC réalisateur :	920001001	Type d'admission :	
Lieu de réalisation :	920001001	Intervention réalisée :	Non	IGS2 :	N/R
Type du document:	CODEPMSI$	Numéro de dossier Emed:		IGS2 sans l'âge :	N/R
Intervention : (11/09/2017)					

Date du document: 25/05/2020 Page n° 1 / 3

Liste des codes CIM10 & CCAM rattachés au dossier du patient

Code CIM10	Type CIM10	Saisie	par	le	Validé par	le	Exporté par	le
I10/006	NR	automatique	MEDECIN Paul	20/03/2019	MEDECIN Paul	25/05/2020	MEDECIN Paul	25/05/2020
Description = "HyperTension Artérielle (HTA) essentielle" Libellé officiel = "Hypertension essentielle (primitive)"								
T88.4	NR	automatique	SYSTEM Diane	20/05/2020	MEDECIN Paul	25/05/2020	MEDECIN Paul	25/05/2020
Description = "Intubation difficile Début" Libellé officiel = "Échec ou difficulté d'intubation"								

Code CCAM	Saisie	par	le	Validé par	le	Exporté par	le
YYYY020	automatique	MEDECIN Paul	18/03/2019	SYSTEM Diane	20/05/2020	Non renseigné	N/R
Acte ajouté automatiquement (règle)							

8. Glossary

A/N visit 1: 1st antenatal visit
AROM: Artificial rupture of membranes
BMI: Body mass index
BSA: Body surface area
Cath: Catheter
CCU: Continuous care unit
RCT: Reference centre for teratogens
CRL: Crown-rump length
D: Day
DDB: Drug database
DR: Delivery room
DVE: Digital vaginal examination
EAB: Elective abortion
ECG: Electrocardiogram
EHR: Electronic health record
EONI: Early onset neonatal infection
EP: Ectopic pregnancy
HC: Head circumference
HIS: Hospital information system
HR: Heart rate
HT: Hypertension
IAS: Irregular antibody screening
INN: International nonproprietary name
IPSSV/PEEP: inspiratory pressure support during spontaneous ventilation and positive end-expiratory pressure
IUFD: Intrauterine foetal demise
IUS: Intrauterine delivery system
IV: Intravenous
LMP: Last menstrual period
MDRO: Multidrug-resistant organism
MW: Midwife
NTR: Nothing to report
NVR: Normal variability and reactivity
OC: Oral contraceptive
PAO: Prophylactic Administration of Oxytocin
PBP: Preparation for birth and parenthood
PPH: Postpartum haemorrhage
Preop: Preoperative assessment
PSD: Pregnancy start date
RNA: Registered nurse anaesthetist
RPB: Risk of premature birth
SP: Syringe pump
SR: Surgery report
SRM: Spontaneous rupture of membranes
TAB: Therapeutic abortion
TASO: Time amniotic sac open
TT: Treatment
VAS: Visual analogue scale
WA: Weeks of amenorrhea
WTD: What to do
XDRB: Extensively drug-resistant bacteria

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http://www.bowmedical.com

The **DIANE** prescription engine is a class I medical device

Users should read all instructions carefully to ensure that the medical software is used properly.

Last revised on June 3, 2020