DIANE

A BOW MEDICAL brand

V 4.9

Evolution of Diane
in version 4.9

BOW MEDICAL
SOFTWARE

Improve the safety of care

Cognitive assistance for bed recognition

In the Recovery Room, it is possible to manage several patients on the same computer. Each connected «bed» is displayed as a tab. Switch from one patient to another by changing the tab.

To avoid input errors when a patient is admitted to the hospital unit, a visual aid ensures that you are in the correct patient file at a glance.

Each «bed» tab is colour coded, here we have 3 beds: pink, blue and green.
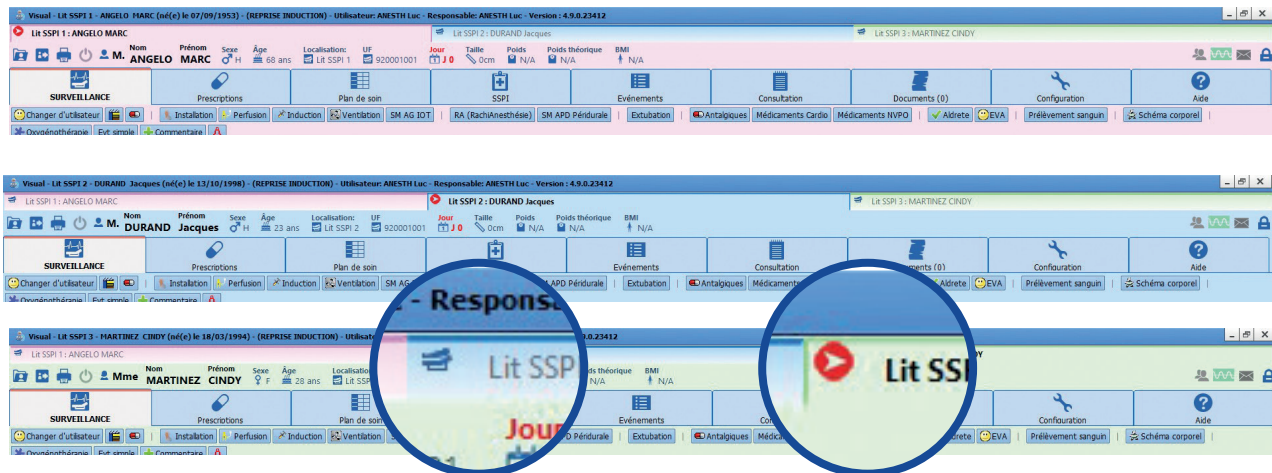
The bed icon represents the active patient's bed tab,

While «inactive» beds will display a red icon.

A different colour is assigned to the connected beds by default. These colours can be customized in the setup of the feature.

Facilitate the assessment of the clinical situation

Display of the dosage on the care plan

In the prescription window, it is possible to determine treatment with a dosage in mg/h or gamma/kg/min.

Here, we wish to prescribe a syringe of concentration of 0.5 mg/h and an initial administration dosage of 0.5 gamma/Kg/min

After changing the flow rate in the right part of the window, the latter is highlighted in yellow.

• The display of norepinephrine done in gamma/kg/min, and the unit are shown on the care plan.

• The dexdor and the flow rate are in ml/h, and the concentration appear on the care plan.

• Once validated and signed off, the medical orders will appear on the care plan.
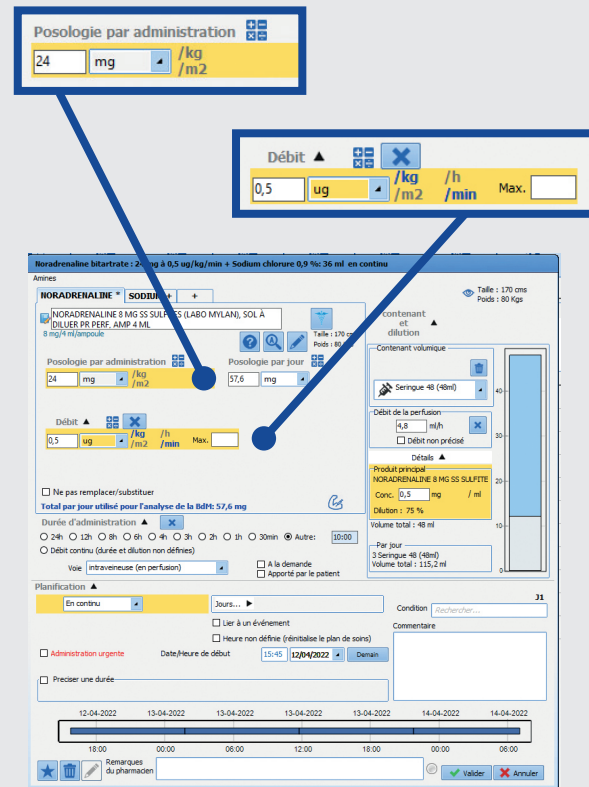
The medical order will be displayed in gamma/kg/min in the patient's care plan.
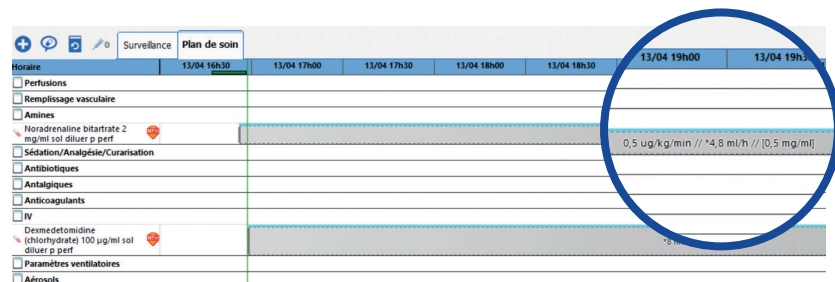
A On the prescription tab, it is possible to adjust or modify the flow rate, to change either the dosage in gamma/ Kg/min or the administration rate in ml/hr.
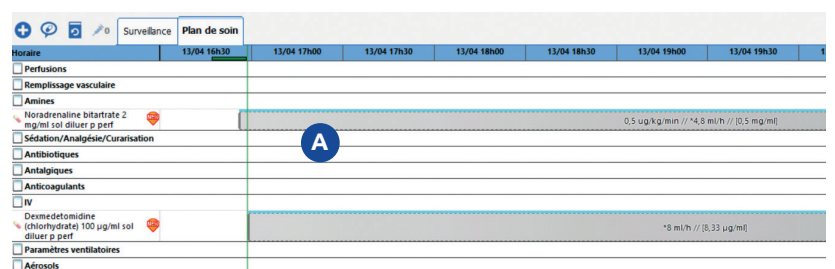
B If the prescription is in gamma/Kg/min, the flow rate can be adjusted in two areas.
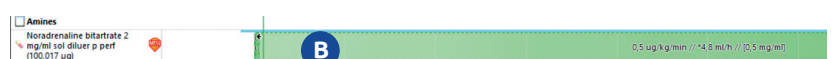
C If the prescription is in ml/hr, only the flow rate in ml/hr can be modified.
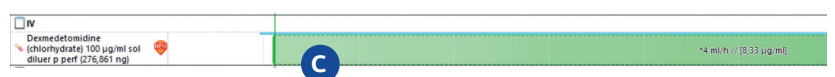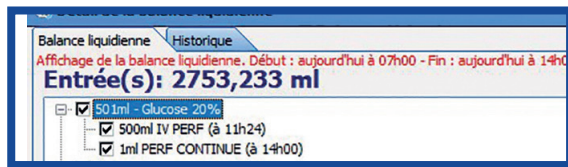

If the connected electric syringe pump is in use, the operation is the same, and the display on the administration occurrences of the care plan will respect the prescription mode.

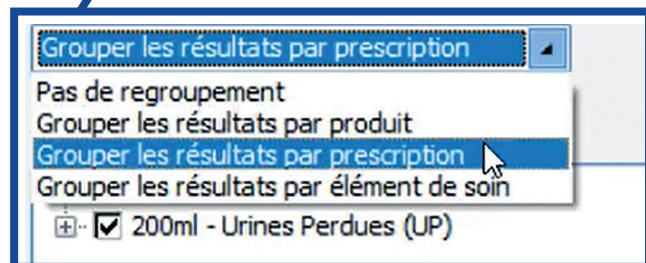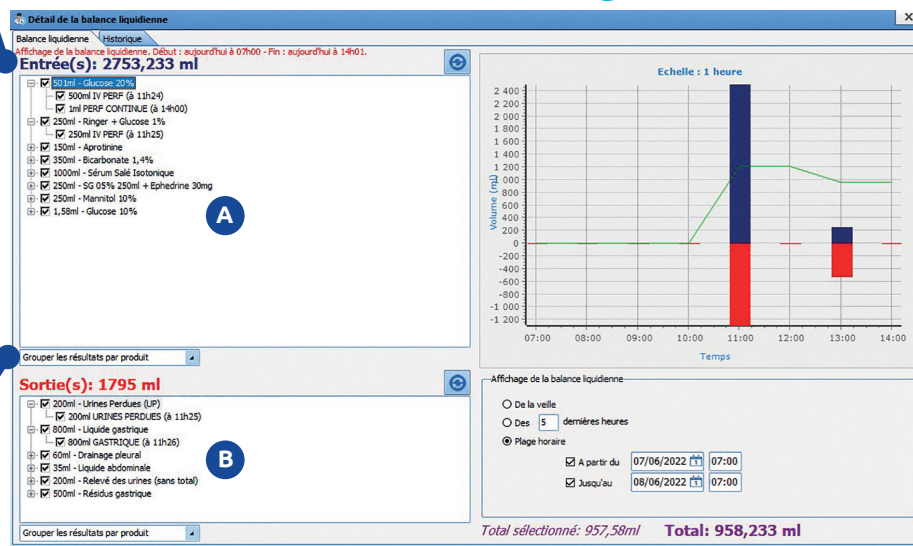## Evolution of the display of the fluid balance

The fluid balance window is composed of different areas divided into two tabs.

• **At the top of this zone, is the time limits of the current fluid balance.** It indicates the beginning and the end of it.
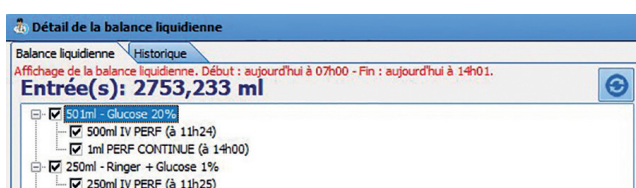
Left side   Right side

• **At the bottom of this area, there is also a drop-down list** which allows to group entries by product, prescription, or element of care.

The left side of the window

A **The first zone** is the cumulative fluids in «entry». The volume of each fluid balance input is displayed at the beginning of the line. The details of some items are displayed below. The detail, shows the day and time of the corresponding input.

B **The second zone** concerns the cumulative output fluids. The output fluids and the volume of each element are at the beginning of the line. Then the details of the date and time below. Finally the drop-down list filters the outputs.

The right side of the window

Zone 1:

This graph shows the inputs in blue and the outputs in red. The green curve corresponds to the calculation of the input/output balance.

• The vertical scale adjusts automatically according to the volume.

• The horizontal scale is adjusted according to the number of days to be displayed. .

Zone 2:

Allows to configure the display of the fluid balance by:

• The checkbox of the day before

• Last X hours

• The time slot
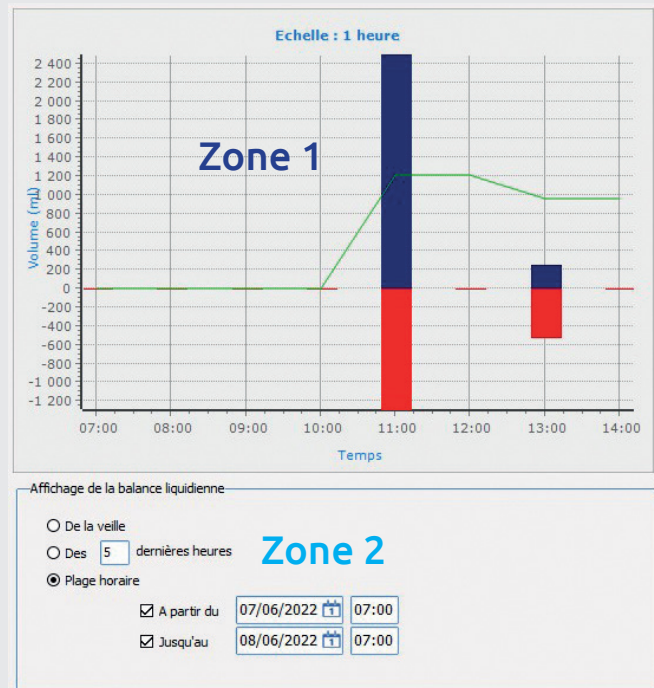
History tab

This tab allows visualizing the record of a patient's fluid balance over a given period.

The graph shows:

— **In green,** the curve of the total fluid balance in terms of time.

▬ **In blue,** the entries of the fluid balance, with their exact volume written above.

▬ **In red,** the outputs, with their exact volume written below.

— **On the right,** the legend means a transfer to the OR. The day of the transfer is also indicated.

Strengthen information sharing within health care teams

Transfer information from a previous monitoring while using the body diagram
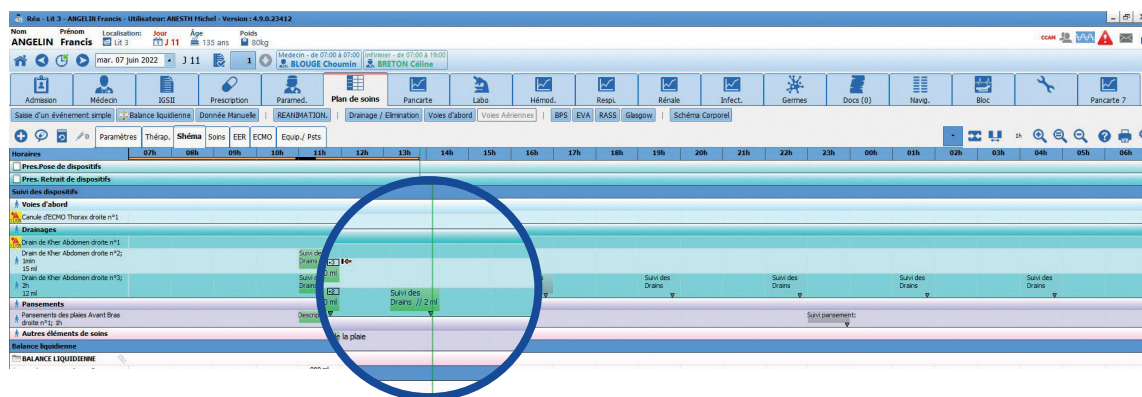
• **In the body diagram,** it is possible to visualize or retrieve information from a previous monitoring.

• If the information we wish to enter is identical to the information already completed, it is possible to use the same values.

Example: A surveillance was carried out at 2pm, and we would like to complete the next one at 5pm.

A The previous forms can be consulted via a fold-out section on the left-hand side of the page.

B The forms are sorted by date and time of entry.

C The forms are available from two places by clicking on **«Return to current form»**

or

**D** Under the **«Take over values from the selected form»** section.

Strengthen communication within health care teams

The list of patients in Anaethesia

This portal allows you to display and view the files currently opened in DIANE. By default, the beds displayed are those of the unit.

To access to another unit, clicking on the blue banner allows selecting another area, room, or bed to be viewed. It is possible to access other departments and beds at any time.
A setup in the feature allows saving the sector displayed by default.
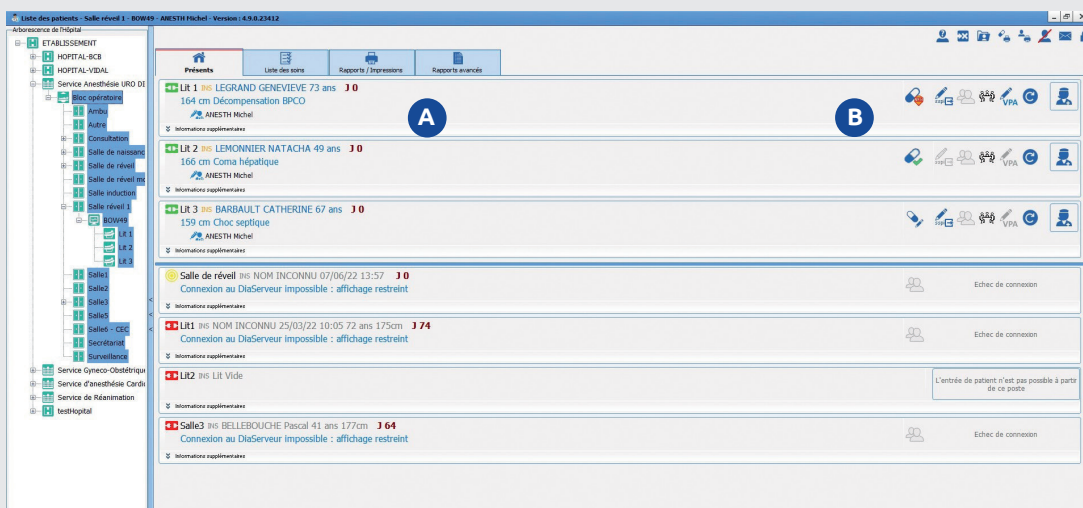
A On the anaesthesia cockpit one can easily find the following information :

Information about the patient :

• Patient identification
• Title of surgery
• Staff in charge of the patient

B The status of the medical orders for the recovery room :

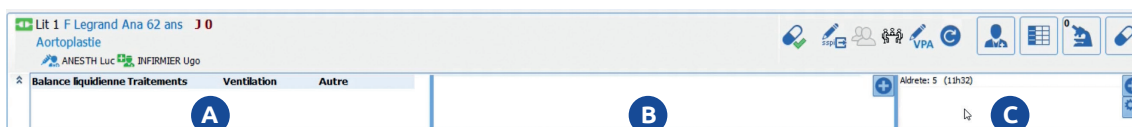**A newly signed medical order**

A medical order in the process of being modified

Signed medical orders

The Pre-Anaesthesia Consultation signature requires the opening of the file and the exit signature. Both can be done directly from the portal

A The retractable part, on the left, is associated with the structured prescription tab.

B The central part is the equivalent of a whiteboard. Information is written directly on it. These entries are not saved on the file.

Example: room ready at 2 pm.

C The right-hand side allows to display items from the folder on the hover or via favourites. It is possible to add any type of information.

For example, display the heart rate.

Securing the medical record

Manage the transfer of data
## during a patient's transfer

It is possible to choose whether or not to maintain the elements of the patient's record when the latter is transferred between two units.

Example:

In the case of a transfer from the intensive care unit to the continuing care unit, it is possible to determine the elements that we would like to keep or not, such as:

At the moment of the transfer, is possible to fix certain data (daily evolutions, the hospitalization report...) while preserving the continuity of the rest of the file (the prescriptions, the care plan...).
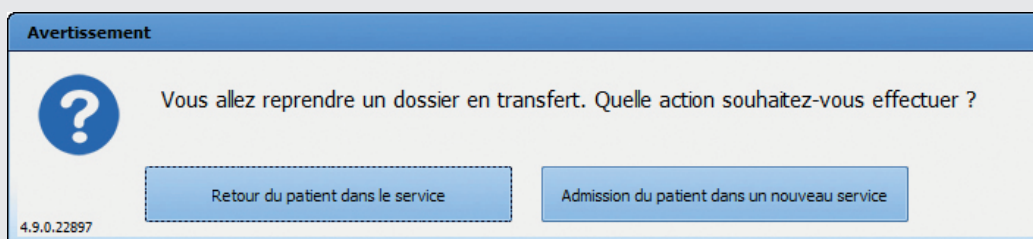
This feature also allows entering a SAPS II code per unit.
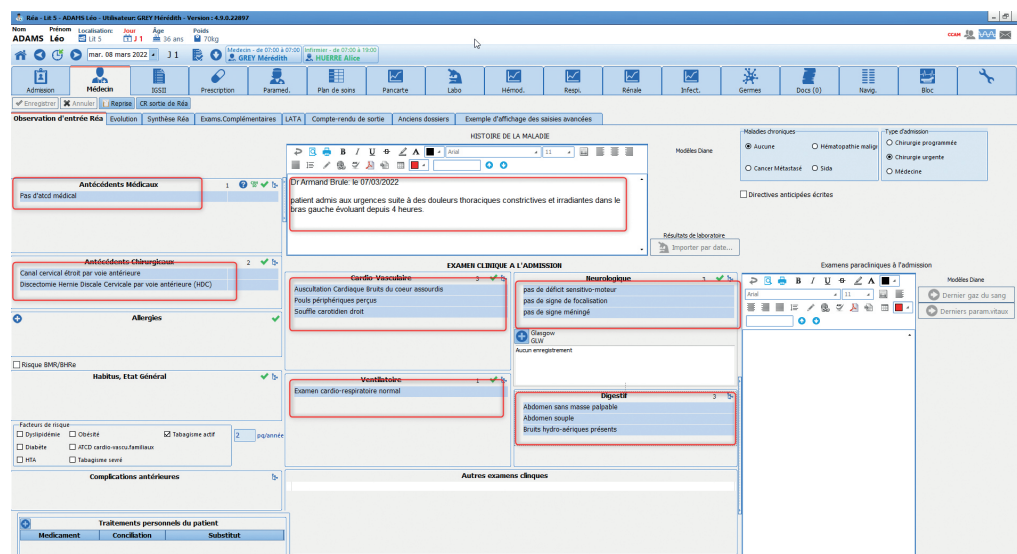
In this example, the information kept during the transfer to Continuing Care Unit (CCU) is:

• **Targeted transmissions**
• **Medical Orders**
• **The SAPS II of a stay in the intensive care unit.**

When the file is transmitted,
the receiving service has two options:

• **Return of the patient to the unit:** This option allows the entire file to be retrieved, including its modifications. For example, a readmission to the ICU after a stay in surgery.

• **The Admission of the patient to a new department** allows applying the recovery settings from a blank page. When the file is open, the information of the components is erased.

The medical observation tab in the CCU tab retrieves the following information:

• Retaining information related to the patient's background

• Reset the background of illness and clinical examinations on admission

• The content of the history of illness recorded in ICU.

• The follow-up of the daily evolutions allows access to the content entered in the previous unit.

• SAPS II validated in the ICU will be available to be re-evaluated in the CCU.

• Paramedical transmissions remain identical in the CCU

• The other parts of the file are: the medical orders, the care plan, transmissions, etc. Which continuity is necessary, kept, modifiable and re-evaluated.
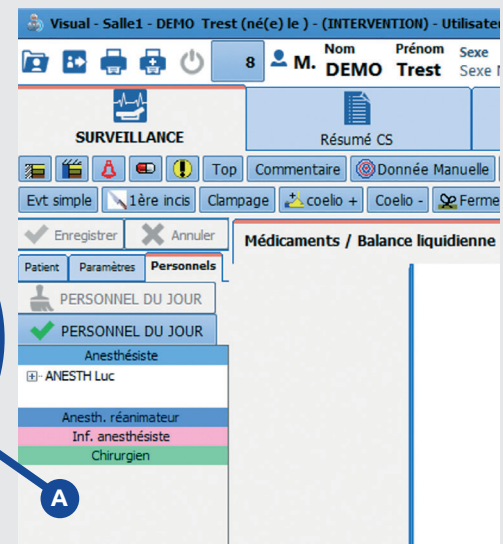
Management of staff categories

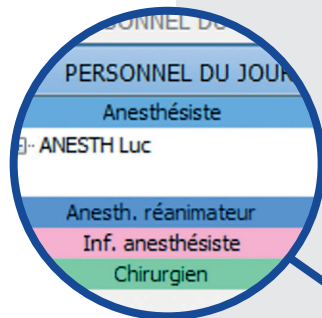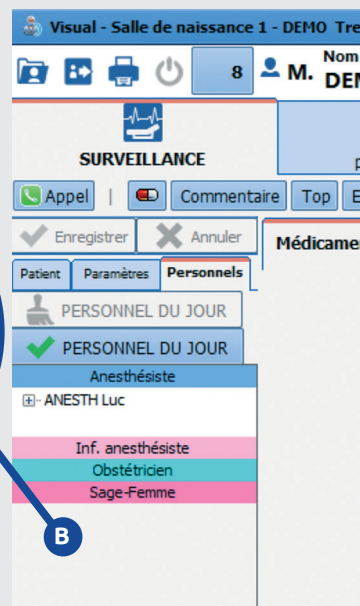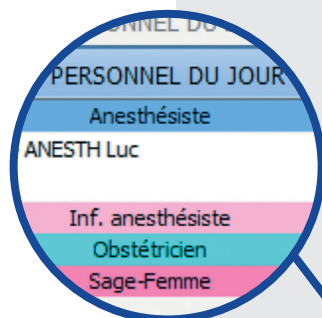**It is possible to choose the type of staff displayed in each unit.**

(A) Thus, in a multi-purpose hospital unit, we can find different categories such as:
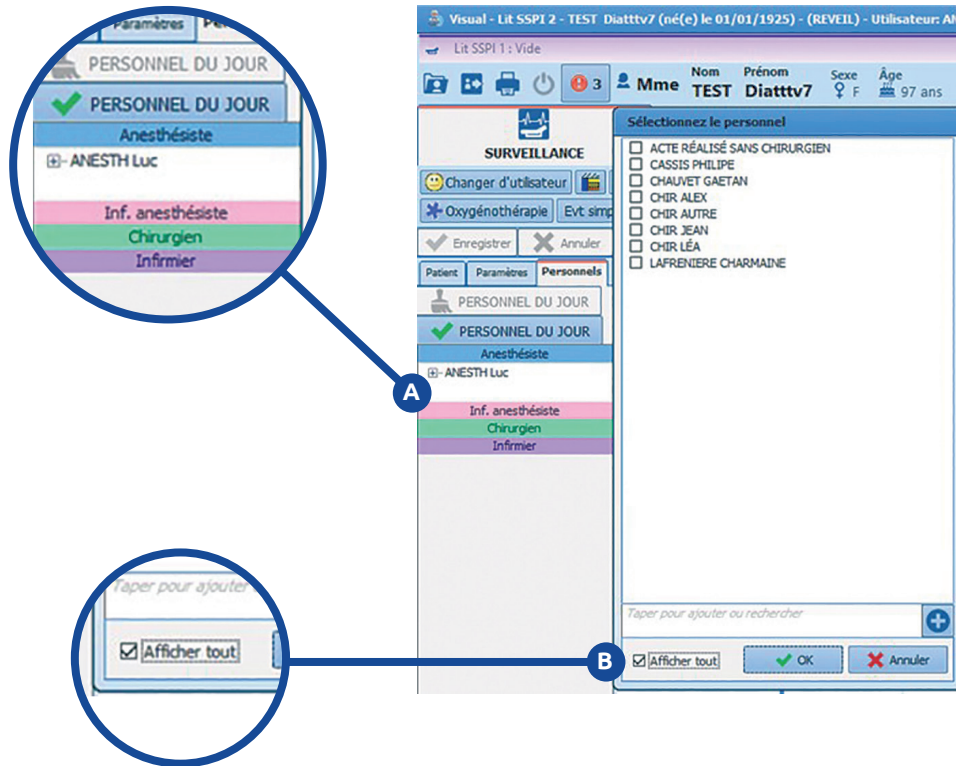- **Surgeons**
- **Anaesthetists**
- **Technician Nurse (ICU & Anaesthesia)**

(B) And in a delivery room, the staff will be rather:

- **Anaesthetist**
- **Technician Nurse (ICU & Anaesthesia)**
- **Obstetrician**
- **Midwife**

In a practical case:
Example of ICU staff

A In order to enter the staff in service, we start by selecting the role and the appropriate person from the list.

B The box «show all» displays all staff (including their role). From here, we can assign the caregiver to a unit.

C While typing in the search box, the caregiver role and name are highlighted in the list.

D Clicking on the + button will add the staff indicated in the search, which are present but not listed.
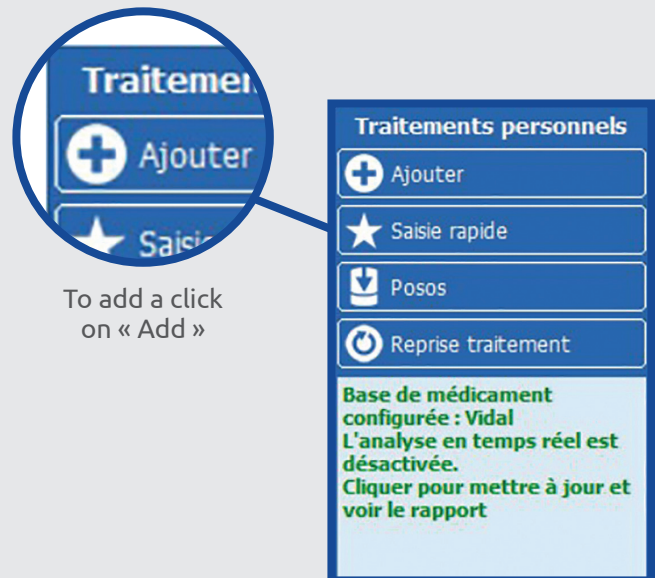
Resumption of patients' previous treatments

On the consultation module, the treatment tab facilitates the entry and management of the patient's usual treatment.

Adding a new treatment

Adding a treatment can be done in several ways:

1- Scheduling a stop date
2- Scheduling the maintenance
3- Out-of-hospital relay
4- Inpatient care

To add a click
on « Add »

It is possible to manage the usual treatments directly when adding a treatment. This will be explained through the following examples:

**1- Adding a treatment with premedication, scheduling a stop date**

Adding Doliprane 500 with stop one day before the procedure.

A This icon means that the treatment has been stopped.

B The «Validate and add new» button allows to minimize the window, and to go directly a to a new addition.

C In the comment area, it is possible to add indications of the treatment dosage, and recommendations.

2- Adding a treatment with premedication and scheduling its maintenance
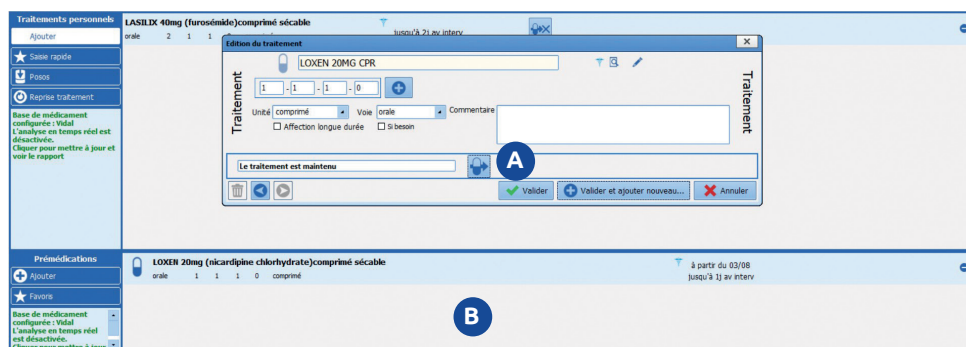
A This icon indicates that the treatment will be maintained.

B The «Copy the substitute to premedication» automatically adds the information to the premedication area. It is possible to change the due date of this treatment.
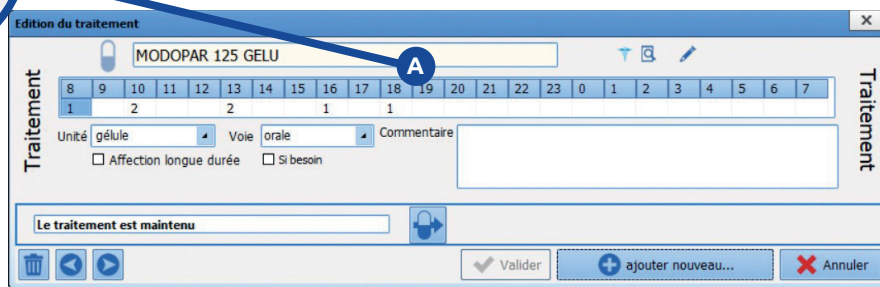
A The treatment is prescribed in capsule intake. It is possible to specify the schedule.
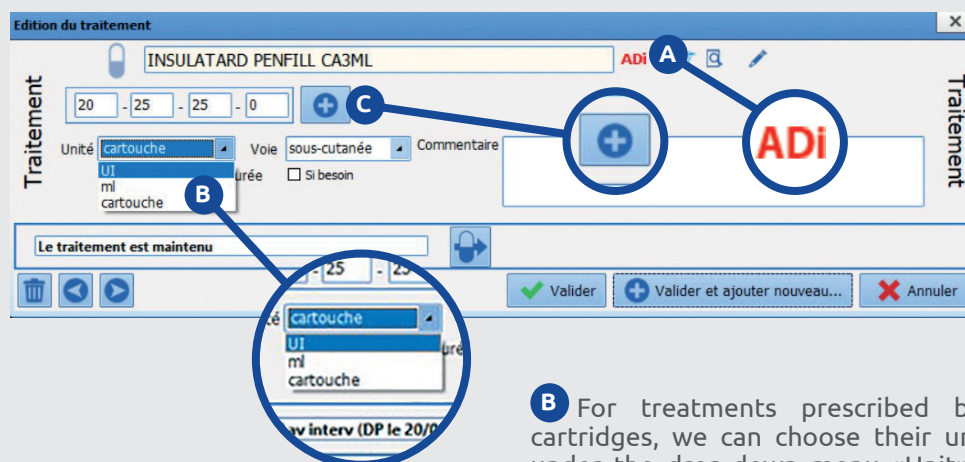
A The red letters, are the abbreviation of the name of the group to which the treatment belongs.

B For treatments prescribed by subcutaneous cartridges, we can choose their unit. For example, under the drop-down menu «Unit», we can choose «International Unit».

C Clicking on the **+** button unfolds a timeline for times different from the classic ones (morning, noon and night).

3- Adding a treatment with premedication relay

**An out-of-hospital relay means the treatment
and the therapy booklet are not connected.**

A In this case, we would like to carry out a relay on a treatment.

This icon, indicates that an «out of hospital» relay is programmed for the treatment.

• To the right of the icon we find the time limit for the initial treatment.

• On the left we find the time frame for taking the indicated substitute.

If needed, the starting date for the dosage of the substitute and its duration can be modified.

B In the substitute area:

This icon indicates that substitute treatment is searched outside the therapy booklet.

**Adding a treatment with premedication and programming
with in-hospital maintenance**

C In the substitute area:

Indicates that the search is done in the therapy booklet.

Clicking on the pencil icon will open the advanced prescription window allowing to modify the details of the substitute.

In this example, we want to maintain the treatment in hospital.

D

This icon indicates that the treatment is maintained in its dosage, but substituted by Alprazolam.

4- Adding a premedicated treatment and its maintenance for inpatient care

Premedication Zone

(A) A. It is possible to «add premedication directly from the designated area by clicking on «add».

It is only required to fill in the data in the same way as for a treatment.

When validated, a line corresponding to our prescription is added to the premedication section.

The set of treatments added as premedication appears as follows:

In front of each pre-medication line an icon appears.

• If the icon is blue, this indicates that the search is in progress outside the therapy booklet.

• If the icon is red, it means that the search is inside the therapy booklet.

Global signature

En signant, vous indiquez avoir pris connaissance des interactions affichées par la banque de médicaments

Identifiant LUC

Mot de passe

☐ Copier la conciliation vers Diane prescription
☐ Copier les prémédications vers Diane prescription

✔ Signer   ✖ Annuler

Traitements personnels
Validé à 16h59

➕ Ajouter
⭐ Saisie rapide
📥 Posos
🔄 Reprise traitement

Rapport de la base de médicament :
5 Alerte(s) posologie
1 Redondance(s)

Cliquer pour voir le rapport

If the treatments interact with each other, *an alert message* **window appears.**

In order to proceed, a mandatory signature is required.

The remarks on regards of the possible interactions between treatments along with other important information are in the comments zone.

Imprimer les traitements/conciliations et prémédications
Imprimer les traitements seuls
Imprimer les traitements et conciliations
Imprimer les conciliations "hors hôpital"
Imprimer les prémédications complètes
Imprimer les prémédications hors hôpital
Imprimer une lettre type...

Dossier médical   Editer... **A**   ✔ Valide **B**

A At the bottom of the page there is also a button allowing to start different printouts.

B The «Validate» button means that all the additions to the personal treatment are now taken into account.

In the event of a new intervention, the treatments will be added to the record automatically.

Patient selection for consultation

When selecting a patient for consultation, two options are available:
• **Create a new file**
• **Modify/Consult an existing file**

When creating a new file, if the patient record is already registered, a window proposes to automatically resume the consultation of the file concerned.

The usual treatments previously entered for the patient will be retrieved.

Confirmation

Veuillez sélectionner une action :

➕ Créer un nouveau dossier   ▶ Modifier/Consulter un dossier existant

4.9.0.23412

Note: pre-medication can be completed in two methods:
• *Directly from the designated area by clicking on «add».*
• *Or by adding a new treatment.*

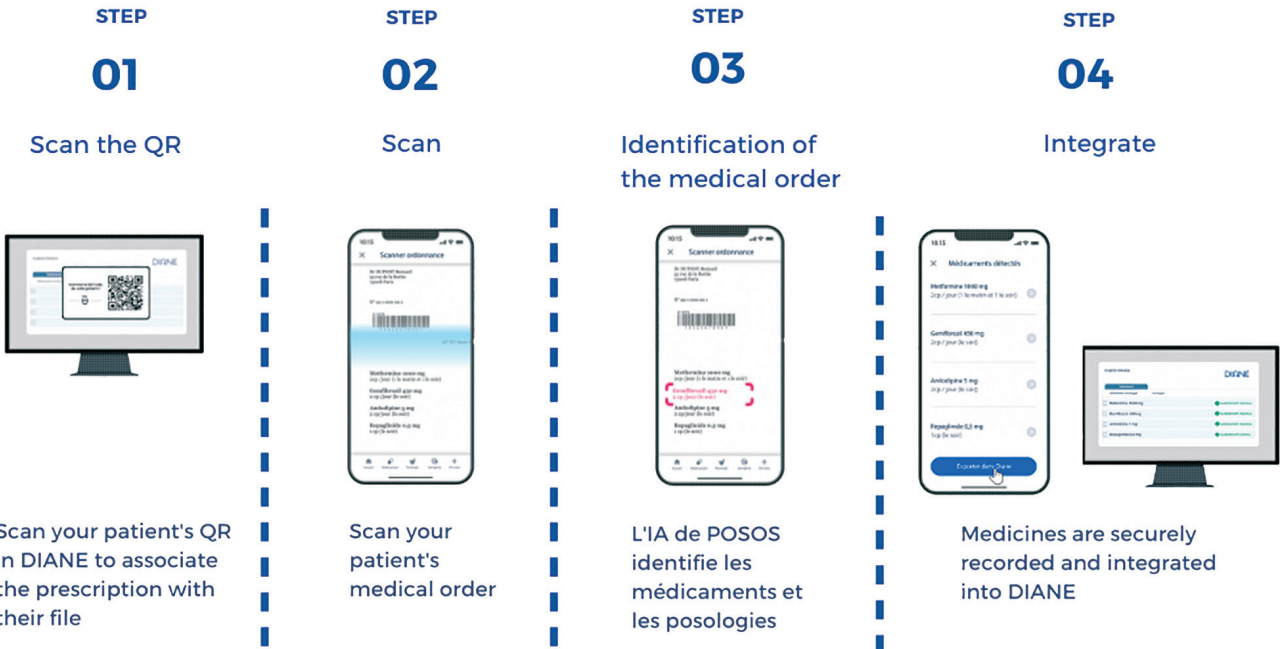# Accelerate the transcription of paper medical orders

The technology proposed by our partner POSOS allows to identify treatments and dosages of a prescription and export them into the DIANE ANAESTHESIA prescription screen.
This feature accelerates and ensures the transcription of paper medical orders by anaesthetists.

The objective is multiple:
• to save time for health professionals
• to provide safer care by reducing the risk of error in entering and analysing treatments.

During the anaesthesia consultation, it is only required to take a photo with a telephone of a patient's code, then to the patient's prescription. The software will identify all the drugs, their galenic forms, and their dosages.

The data collected is then automatically integrated thanks to the FHIR interoperability standard into DIANE, which cross-references it with the patient code. The information is incorporated into the patient's record without recopying it.

STEP 01	STEP 02	STEP 03	STEP 04
Scan the QR	Scan	Identification of the medical order	Integrate

Scan your patient's QR in DIANE to associate the prescription with their file

Scan your patient's medical order

L'IA de POSOS identifie les médicaments et les posologies

Medicines are securely recorded and integrated into DIANE

The infant's body diagram

**The body diagram illustrating the morphology
of an infant is available in version 4.9
The diagram is available until the age of 3 years**
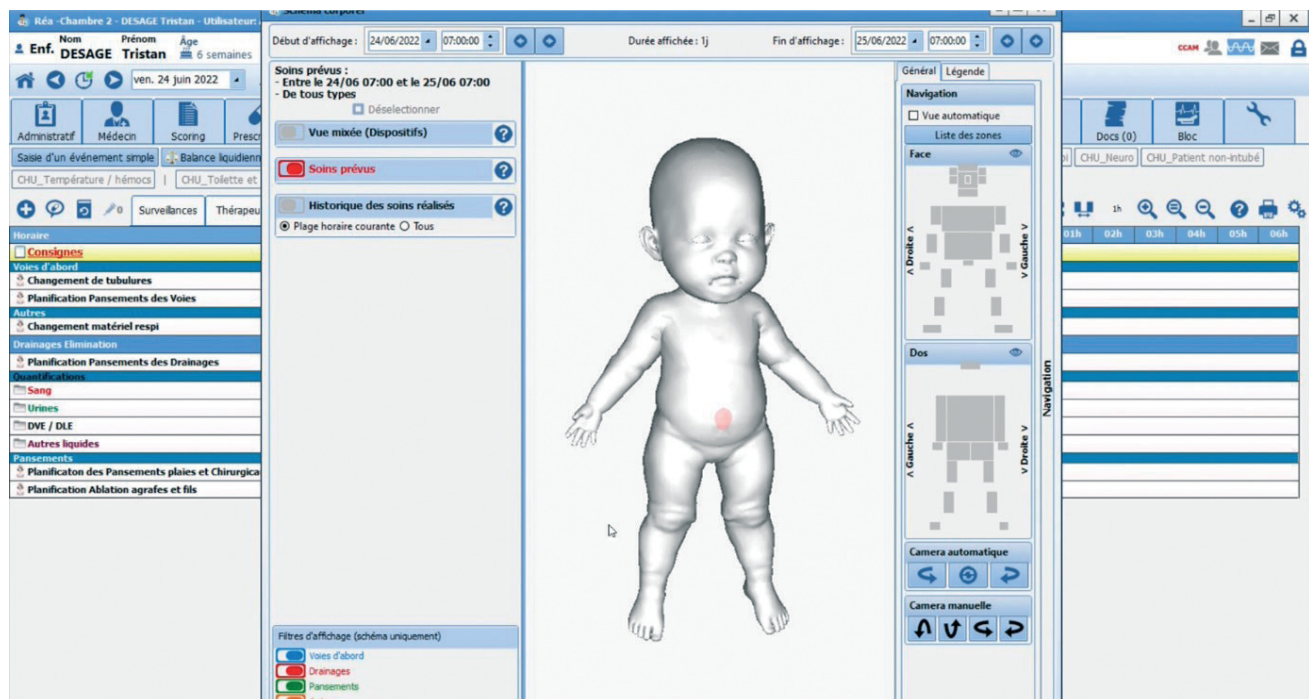
This feature allows the placement of areas suited to infants such as: the umbilical zone, the sacrum and so on.

**Here a catheter follow-up is planned every hour.
But, we can modify it to every 2 hours.**

B In the example above, two actions are scheduled. Removal of the catheter in 5 days and a dressing in 3 days.

The information filled in in this window will automatically added to the care plan.

A The button at the bottom left of the window allows adding a schedule,

A It is possible to make an additional dressing without changing its original schedule.

To do this, we can choose the proper care form with a click. We notice here no associated planning. The new care is included into the existing care form.

It is also possible to replace a treatment in progress.

This action will change all the initial planning. It is possible to choose the desired care form and to enter the new information along with the latest care plan.

The care plan is updated accordingly.

BOW MEDICAL

S O F T W A R E

43 avenue d'Italie
80090 AMIENS
+33 (0)3 60 03 24 68
contact@bowmedical.com

w w w . b o w m e d i c a l . c o m