

# DIANE Settings Guide

Version 4.9

DIANE | ANESTHESIE

Une marque de BOW MEDICAL

DIANE | OBSTÉTRIQUE

Une marque de BOW MEDICAL

DIANE | REA

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# BOW MEDICAL

— EDITEUR DE LOGICIELS —

# Warning

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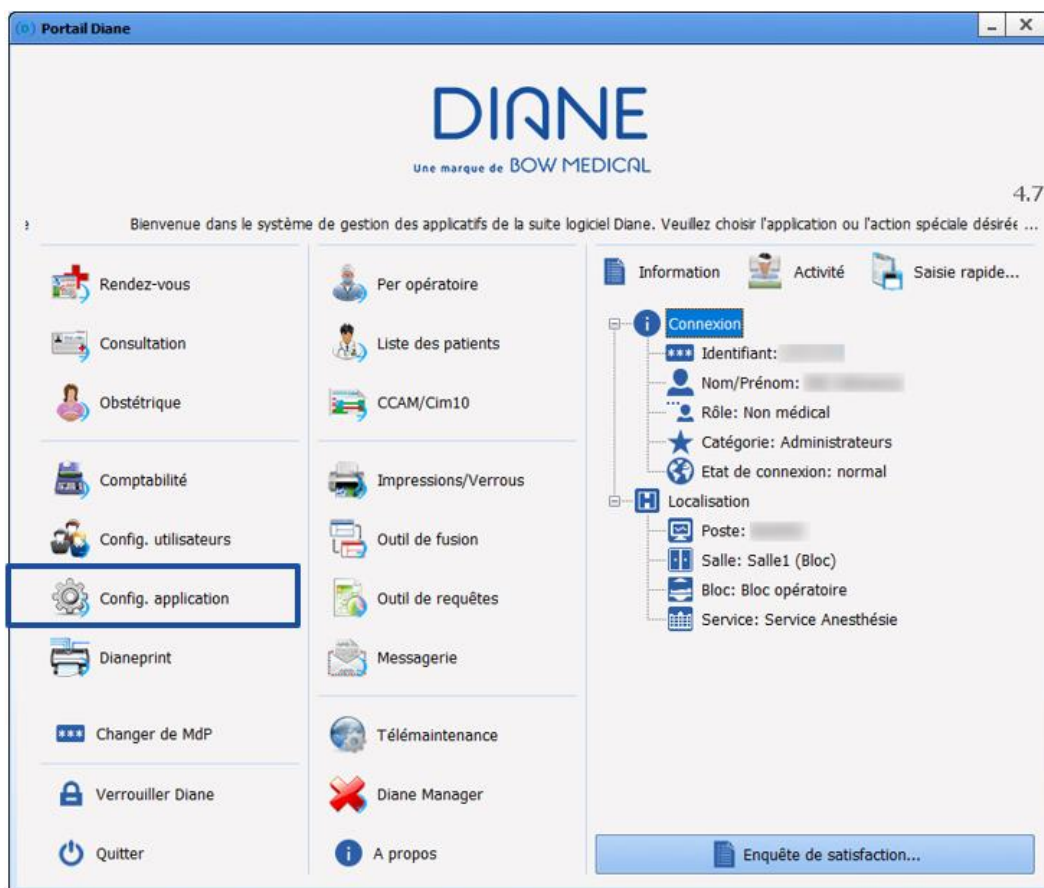
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## 1 General information

The settings tool can be accessed from the **DIANE** portal by clicking **config. application**. Settings are only accessible to **DIANE** experts to whom permission has been granted (see *Configuration of users (and facility organisation)* ).



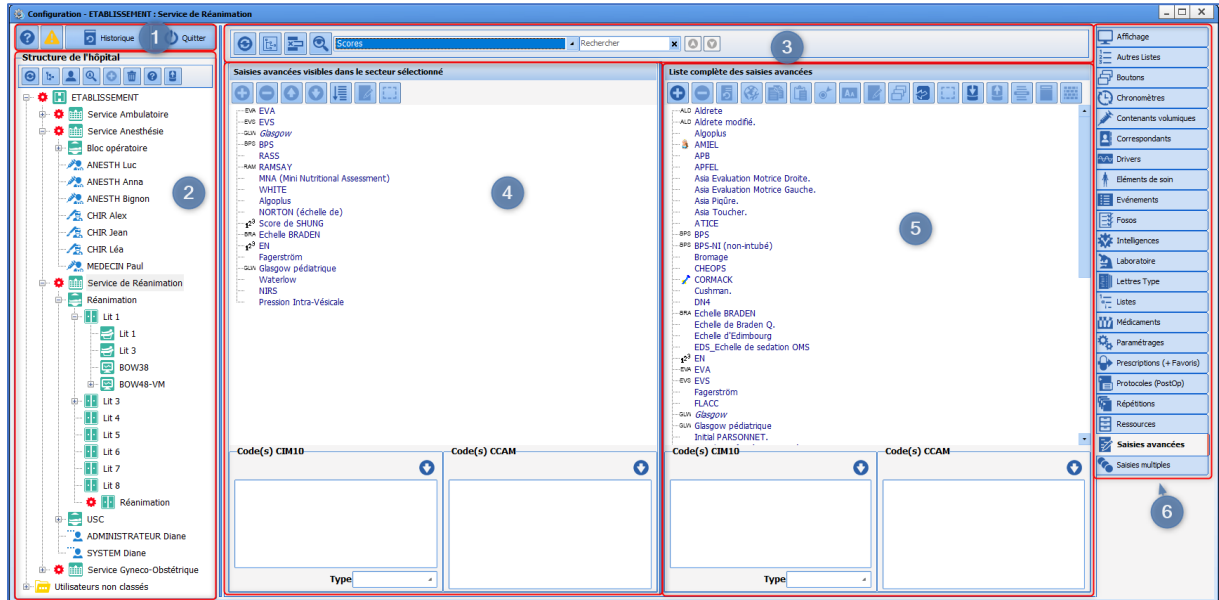
This module can be used to configure **DIANE ANAESTHESIA (Consultation and Visual (IntraOp and PostOp))**, **DIANE OB-GYN** and **DIANE ICU**.

The screenshots shown in this manual are for information purposes only.



## 1.1 Presentation of the application configuration module

The following window opens when the configuration module is launched:



Pane 1 provides access to general functions such as **DIANE data field management** and **History** of recent actions carried out in the module. (Chapters "*Error reports list tools*" and "*DIANE data field management*").


The **Hospital organisation** column (pane 2) shows the facility tree structure as configured in "*configuration of users*". Each row can have its own configuration, represented by the "gear".

The *right column* (pane 5) shows all the available items.

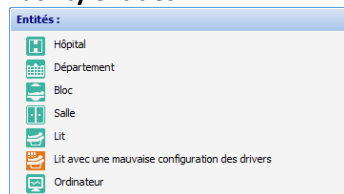
The *middle column* (pane 4) shows the item(s) in the right column applied to the entity and its descendants with a gear.

## 1.2 Glossary

### Gear

The  icon represents a configuration; each entity can have its own 'gear'.

### Facility entities



Each entity can have its own configuration (gear). Any entity that does not have its own configuration will use the first configuration found when ascending the tree structure.

### Configuration

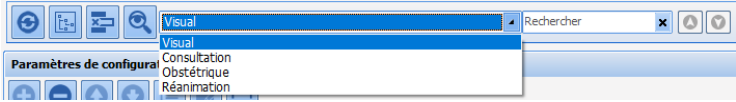
Configuration module for **DIANE** modules.

### Configuration of users

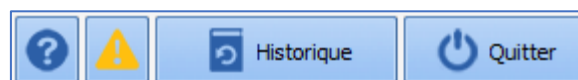
Configuration module for users, their permissions for modules and the facility tree structure.




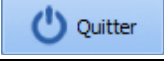
### Configuration menu (Pane 3)

Most of the configuration tabs have a drop-down menu for selecting an item to configure.

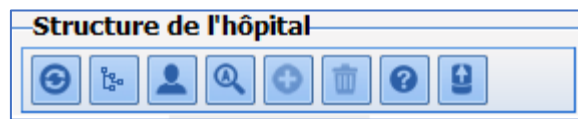
	For example, for the <b>View</b> tab
	
<b>Configuration tab</b> (Pane 6)	These are the tabs at the right of the configuration interface. They allow the user to set the actions and appearance of <b>DIANE</b> modules.
<b>Toggled item</b>	Toggled items are items that are available, visible or useful for using <b>DIANE</b> in the entity in which the computer is located.
<b>Facility entities column</b> (Pane 2)	The left column contains the tree structure of the <b>facility entities</b> with <b>gears</b> .
<b>List of available items</b> (Pane 5)	The right column contains all items that can be used for all <b>gears</b> . To be used and available, the item must be moved into the visibility column in the middle.
<b>List of configured items in the entity</b> (Pane 4)	The middle column contains <b>toggled items</b> .
<b>Component configuration information</b>	A component with data that should be included in the <b>Patient record</b> must have an <b>ActiveX</b> and a <b>data ID</b> . This set of information is used in some configuration tabs.
<b>Patient record</b>	A <b>patient record</b> is a collection of boxes containing information entered by users on <b>DIANE screens</b> .
<b>DIANE screen</b>	A <b>DIANE</b> screen contains some of the components of the patient record organised in the form of tabs. Almost all <b>DIANE</b> screen components have <b>configuration information</b> in the form of an <b>ActiveX</b> .
<b>ActiveX</b>	Cannot be separated from the <b>Data ID</b> , allows data entries made by the user in a component to be saved in the <b>patient record</b> .
<b>Data ID</b>	Cannot be separated from the <b>ActiveX</b> , allows data entries made by the user in a component to be saved in the <b>patient record</b> .
<b>Contextual link</b>	Link providing access to a website or other program.









### 1.3 Configuration module tools (pane 1)



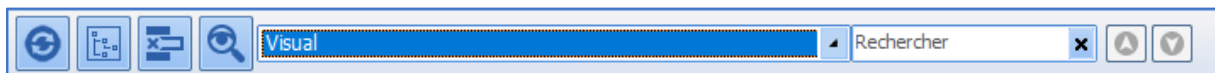
	Start online assistance.
	Start <b>Diane data field management</b> or <b>Error console</b> .
	Start <b>History of changes made to the lists</b> tool.
	Close the application.








## 1.4 Hospital structure tools (pane 2)



	Used to update the facility tree structure.
	Used to expand the facility tree structure.
	Used to show and hide users included in the tree structure.
	Used to search for an entity using all or part of the name.
	Used to create a configuration: a gear appears on the entity selected.
	Used to delete the configuration associated with the selected entity.
	Used to show the icon legend for the logical tree structure of the facility.
	Used to export the current tree structure to a file.

## 1.5 Configuration tools (pane 3)



<b>Configuration menu</b> 	Found on most configuration tabs, used to select the item to be configured.
<b>Refresh lists</b> 	Refreshes lists to provide an updated list. Cancels the expansion of lists or hospital tree structure.
<b>Expand the lists or hospital tree structure</b> 	Displays the whole tree structure for the active pane (highlighted) ( <b>Hospital organisation</b> , <b>List of configured items in selected pane</b> (on left) and <b>List of available items</b> (on right)).
<b>Show or hide deleted items</b> 	In some tabs, deleting an item is reversible: the item is no longer visible but still exists in the database. It can be shown and added back.
<b>Search in lists</b> 	Used to find an item in the list of available items. The number of hits is shown. Move from one hit to another using the arrows or the F3 button.
<b>Display a preview of the configured safety checklist</b> ( <b>Safety checklist</b> tab) 	Shows the configured safety checklist.
<b>Preview the selected form letter</b> ( <b>Form letter</b> tab) 	Shows a preview of the document structure.

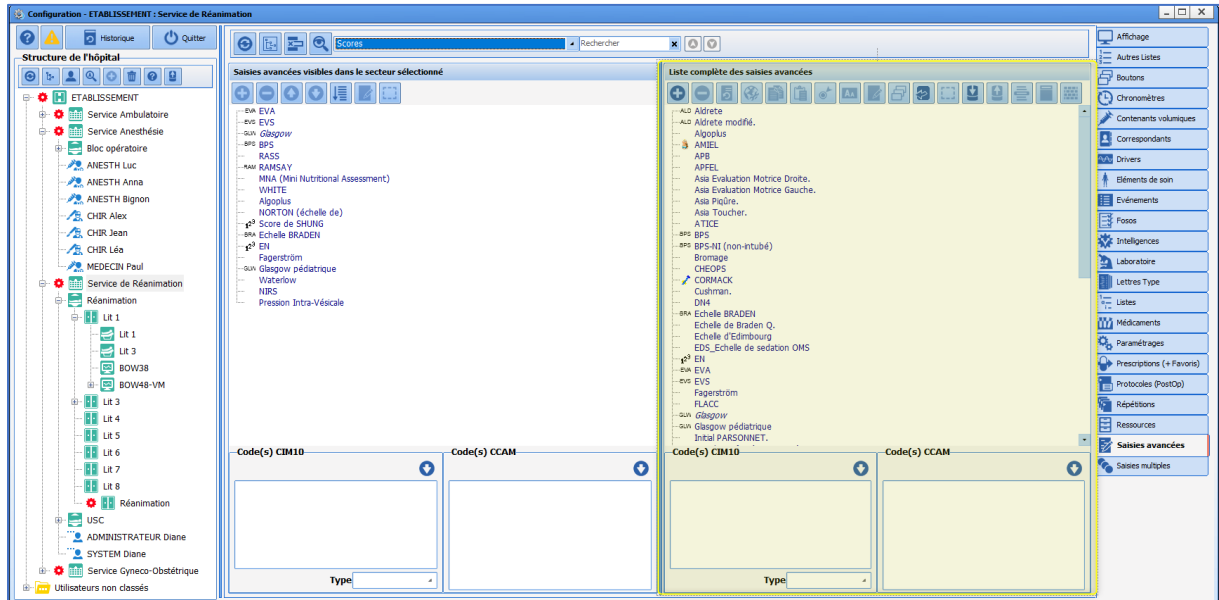
## Add a root (List tab)



Used to create a new list: a new line is added to the drop-down menu.

## 1.6 List of available items tools (right)

The buttons are active if they are available for the selected tab.



Create a new item.



Delete one or more items.

Warning: deleting an item may make the **Patient records** in which it is included illegible.



Add back one or more deleted items and any associated items.



Edit external identifier of item: used to modify internal parameters for the software to which this item is sent.



Copy one or more items.



Paste one or more items: copying is only possible if the parent item is a selector.



Toggle the item to selector or not (a selector is an item that is used to group other items without appearing for use).



Rename item.














Edit item.



Toggle one or more configured items into the entity being configured.



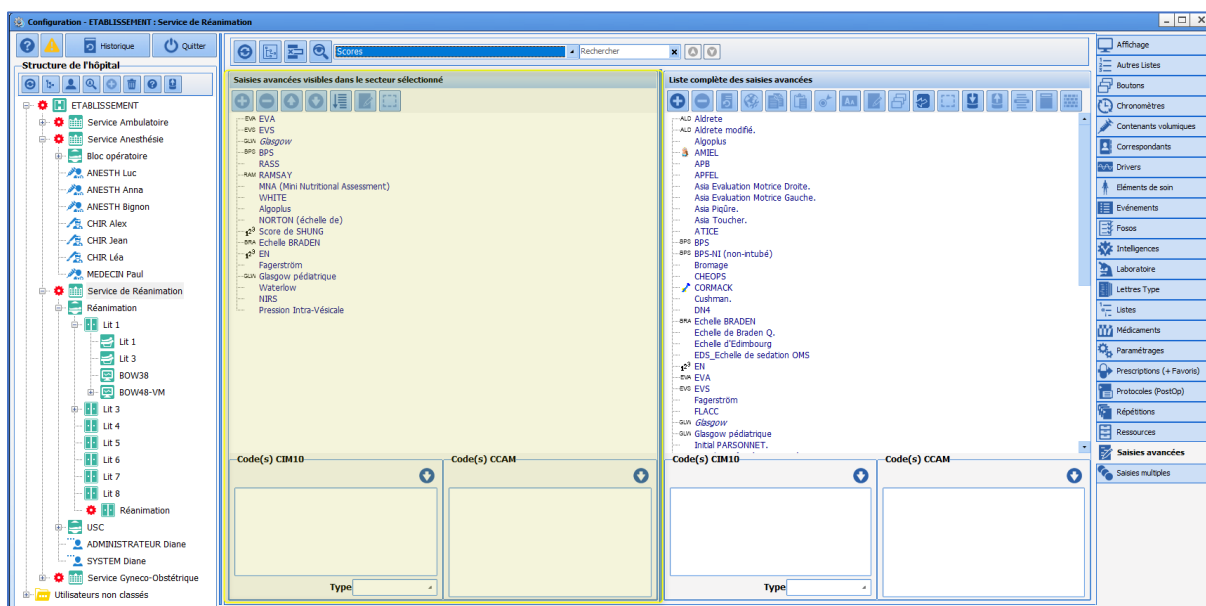
Deselect all.








	Import one or more previously exported items.
	Export one or more items.
	Add a separator to the root (to improve readability).
	Define a header for the document(s) selected ( <b>Form letter</b> tab)
	Assign a page background to the selected documents ( <b>Form letter</b> tab).
	Generate items from procedure codes ( <b>Events</b> tab).
	Associate the item with a configurable button
	Pharmaceutical alternatives ( <b>Formulary</b> tab).
	Assign a colour to the selected drug(s) ( <b>Drugs</b> tab).
	Delete colour of the selected drug(s) ( <b>Drugs</b> tab).
	Edit an Ambucare XML ( <b>Resources</b> tab).

## 1.7 List of toggled items tools

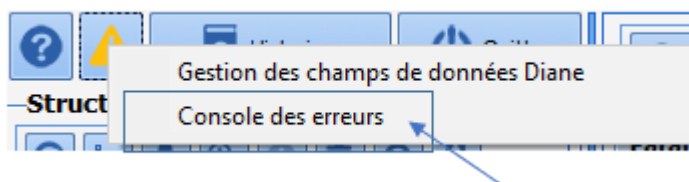
The buttons are active if they are available for the selected tab.


To make searching easier, double-clicking an item in this list automatically selects it in the list of available items (list on right). It is also possible to search for an item via the drop-down **search** menu at the top of the window.



	Create a new item.
	Delete one or more item(s).
	Move item up one level.
	Move the item down one level.
	Sort items in alphabetical order.
	Edit item ( <b>Events</b> and <b>Detailed entries</b> tabs).
	Deselect all.

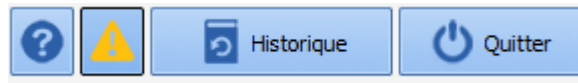
## 1.8 Error reports list tool



This tool, accessed via  then selecting **Error console**, provides information on errors encountered in order to facilitate problem-solving.

Id	Date	Version	Configuration du poste	Nom du poste	Nom de l'utilisateur	Nom de l'exécutable
102296	15/02/2021 12:09:10	4.8.0.20909	Maitre	BOW38	SYSDIANE	DianeReav.exe
102297	15/02/2021 12:09:11	4.8.0.20909	Maitre	BOW38	SYSDIANE	DianeReav.exe
102413	24/02/2021 11:39:03	4.8.0.20968	Maitre	BOW38	SYSDIANE	DianeReav.exe
102488	25/02/2021 14:07:40	4.8.0.20972	Maitre	BOW38	SYSDIANE	DianeReav.exe
102489	25/02/2021 14:17:11	4.8.0.20972	Maitre	BOW38	SYSDIANE	DianeReav.exe
102490	25/02/2021 14:20:01	4.8.0.20972	Maitre	BOW38	SYSDIANE	DianeReav.exe
102508	25/02/2021 15:43:43	4.8.0.20972	Maitre	BOW38	SYSDIANE	Configuration.exe
102509	25/02/2021 16:20:20	4.8.0.20972	Maitre	BOW38	SYSDIANE	DianeReav.exe
102535	26/02/2021 10:03:28	4.8.0.20972	Maitre	BOW38	SYSDIANE	DianeReav.exe
102536	26/02/2021 10:03:44	4.8.0.20972	Maitre	BOW38	SYSDIANE	DianeReav.exe
102539	26/02/2021 10:37:02	4.8.0.20972	Maitre	BOW38	SYSDIANE	DianeReav.exe
102540	26/02/2021 10:43:56	4.8.0.20972	Maitre	BOW38	SYSDIANE	DianeReav.exe
102541	26/02/2021 10:50:51	4.8.0.20972	Maitre	BOW38	SYSDIANE	DianeReav.exe
102542	26/02/2021 10:51:56	4.8.0.20972	Maitre	BOW38	SYSDIANE	DianeReav.exe
102543	26/02/2021 12:11:25	4.8.0.20972	Maitre	BOW38	SYSDIANE	DianeReav.exe
102544	26/02/2021 13:30:44	4.8.0.20972	Maitre	BOW38	SYSDIANE	DianeReav.exe
102545	26/02/2021 13:30:45	4.8.0.20972	Maitre	BOW38	SYSDIANE	DianeReav.exe
102546	26/02/2021 14:47:17	4.8.0.20972	Maitre	BOW38	SYSDIANE	DianeReav.exe
102547	26/02/2021 14:49:14	4.8.0.20972	Maitre	BOW38	SYSDIANE	DianeReav.exe
102622	01/03/2021 11:43:35	4.8.0.20977	Maitre	BOW38	SYSDIANE	DianeReav.exe
102749	04/03/2021 15:59:41	4.8.0.20988	Maitre	BOW38	SYSDIANE	DianeReav.exe
102750	04/03/2021 15:59:46	4.8.0.20988	Maitre	BOW38	SYSDIANE	DianeReav.exe

## 1.9 History tool



This tool provides traceability with regard to changes to configuration (**Changes to lists**), user access, patient record access, resynchronisations, locks and access to modules.

### 1.9.1 History of configuration changes

Id	Date Modification	Utilisateur	Éléments modifiés	Description associée
4822	06/08/2020 14:14:14	MEDECIN Paul	Liste : Fichier de paramétrage	Liste "ListeParametrages" -> Edition de l'élément n°57 dans liste complète de filtre = 9 ("Demo Style 1 (intelligence activée)")
3712	22/07/2020 12:37:30	MEDECIN Yves	Liste : Entité	Déplacement de l'entité DESKTOP-ACUGK9Q(Ordinateur) de l'ancien parent Salle de réveil(Salle) au nouveau parent Lit 1(Salle)
3713	22/07/2020 12:37:35	MEDECIN Yves	Liste : Entité	Déplacement de l'entité BOW48(Ordinateur) de l'ancien parent Salle de réveil(Salle) au nouveau parent Lit 1(Salle)
3984	24/07/2020 09:48:10	MEDECIN Yves	Liste : Apparence de Visual	Liste "ListeParamsVisual" -> Edition de l'élément n°71 dans liste complète de filtre = 2 ("Demo 1920x1080")
3985	24/07/2020 10:47:02	MEDECIN Yves	Liste : Apparence de Visual	Liste "ListeParamsVisual" -> Edition de l'élément n°71 dans liste complète de filtre = 2 ("Demo 1920x1080")
3987	24/07/2020 10:48:26	MEDECIN Yves	Liste : Apparence de Visual	Liste "ListeParamsVisual" -> Edition de l'élément n°71 dans liste complète de filtre = 2 ("Demo 1920x1080")
3990	24/07/2020 11:02:55	MEDECIN Yves	Liste : Apparence de Visual	Liste "ListeParamsVisual" -> Edition de l'élément n°71 dans liste complète de filtre = 2 ("Demo 1920x1080")
3991	24/07/2020 11:04:30	MEDECIN Yves	Liste : Apparence de Visual	Liste "ListeParamsVisual" -> Edition de l'élément n°71 dans liste complète de filtre = 2 ("Demo 1920x1080")
3992	24/07/2020 11:09:26	MEDECIN Yves	Liste : Apparence de Visual	Liste "ListeParamsVisual" -> Edition de l'élément n°71 dans liste complète de filtre = 2 ("Demo 1920x1080")
3993	24/07/2020 11:11:07	MEDECIN Yves	Liste : Apparence de Visual	Liste "ListeParamsVisual" -> Edition de l'élément n°71 dans liste complète de filtre = 2 ("Demo 1920x1080")
3994	24/07/2020 11:11:58	MEDECIN Yves	Liste : Apparence de Visual	Liste "ListeParamsVisual" -> Edition de l'élément n°71 dans liste complète de filtre = 2 ("Demo 1920x1080")
4661	04/08/2020 17:25:52	MEDECIN Yves	Liste : Entité	Déplacement de l'entité BOW48(Ordinateur) de l'ancien parent Consultation(Salle) au nouveau parent Lit 1(Salle)
4783	05/08/2020 14:31:58	MEDECIN Yves	Liste : Fichier de paramétrage	Liste "ListeParametrages" -> Edition de l'élément n°65 dans liste complète de filtre = 5 ("Modèle DiReport A4")
4784	05/08/2020 14:40:42	MEDECIN Yves	Liste : Automatisation avancée...	Liste "ListeIntelligences" -> Edition de l'élément n°116 dans liste complète de filtre = 1 ("486ZTest")
4801	06/08/2020 08:59:34	MEDECIN Yves	Liste : Apparence de Visual	Liste "ListeParamsVisual" -> Renommage élément n°213 ("Copie de Copie de Réa GDS") en "testMenuRadioCases" (nouveau n°...
4802	06/08/2020 08:59:37	MEDECIN Yves	Liste : Apparence de Visual	Liste "ListeParamsVisual" -> Suppression récursive dans la liste configurée n°54 d'un ou plusieurs éléments = "133 (Nom du premi...
4803	06/08/2020 08:59:38	MEDECIN Yves	Liste : Apparence de Visual	Liste "ListeParamsVisual" -> Ajout récursif dans la liste configurée n°54 d'un ou plusieurs éléments = "213 (Nom du premier élém...
4804	06/08/2020 09:03:36	MEDECIN Yves	Liste : Apparence de Visual	Liste "ListeParamsVisual" -> Edition de l'élément n°213 dans liste complète de filtre = 4 ("testMenuRadioCases")
4805	06/08/2020 09:04:00	MEDECIN Yves	Liste : Apparence de Visual	Liste "ListeParamsVisual" -> Edition de l'élément n°213 dans liste complète de filtre = 4 ("testMenuRadioCases")
4806	06/08/2020 09:30:07	MEDECIN Yves	Liste : Utilisateur	Mise à jour de l'utilisateur CASSIS Philippe (CASSIS)
4807	06/08/2020 09:30:54	MEDECIN Yves	Liste : Utilisateur	Mise à jour de l'utilisateur CHAUVET Gaetan (GAETAN)
4808	06/08/2020 09:31:03	MEDECIN Yves	Liste : Utilisateur	Mise à jour de l'utilisateur CASSIS Philippe (CASSIS)
4809	06/08/2020 09:31:28	MEDECIN Yves	Liste : Utilisateur	Mise à jour de l'utilisateur LAFRENIERE Charmaine (CHARMAINE)
4810	06/08/2020 09:31:36	MEDECIN Yves	Liste : Utilisateur	Mise à jour de l'utilisateur CASSIS Philippe (PHILIPPE)
4811	06/08/2020 09:32:36	MEDECIN Yves	Liste : Utilisateur	Mise à jour de l'utilisateur LUSSAC Florence (FLORENCE)
4812	06/08/2020 09:34:27	MEDECIN Yves	Liste : Utilisateur	Mise à jour de l'utilisateur BESSAC Laurent (LAURENT)
4813	06/08/2020 09:34:38	MEDECIN Yves	Liste : Utilisateur	Mise à jour de l'utilisateur BRETON Céline (CELINE)

## 1.9.2 History of patient record access and opening

Date	Utilisateur	Entité	Action	Patient	Date Interv.	Module
16/09/2020 17:05:28	Diane SYSTEM	BOW48	Accès intervention	16/09/20 15:34 NOM INCONNNU [01/09/2020]	16/09/2020	DianeRea
16/09/2020 16:34:07	Diane SYSTEM	BOW48	Accès intervention	16/09/20 15:34 NOM INCONNNU [01/09/2020]	16/09/2020	DianeRea
16/09/2020 16:04:11	Diane SYSTEM	BOW48	Accès intervention	16/09/20 15:34 NOM INCONNNU [01/09/2020]	16/09/2020	DianeRea
16/09/2020 15:35:04	Diane SYSTEM	BOW48	Intervention créée	16/09/20 15:34 NOM INCONNNU [01/09/2020]	16/09/2020	DianeRea
16/09/2020 15:35:04	Diane SYSTEM	BOW48	Accès intervention	16/09/20 15:34 NOM INCONNNU [01/09/2020]	16/09/2020	DianeRea
15/09/2020 17:03:19	Yves MEDECIN	BOW48	Accès intervention	Test CCAM [15/09/2020]	15/09/2020	Visual
15/09/2020 17:03:19	Yves MEDECIN	BOW48	Intervention créée	Test CCAM [15/09/2020]	15/09/2020	Visual
15/09/2020 16:32:21	Yves MEDECIN	BOW48	Accès intervention	Christelle TAVERNIER IPP : 789854 [25/10/1980]	15/09/2020	Consultation
15/09/2020 16:23:12	Yves MEDECIN	BOW48	Accès intervention	Christelle TAVERNIER IPP : 789854 [25/10/1980]	15/09/2020	Visual
15/09/2020 16:04:47	Yves MEDECIN	BOW48	Accès intervention	Christelle TAVERNIER IPP : 789854 [25/10/1980]	15/09/2020	Consultation
15/09/2020 16:04:47	Yves MEDECIN	BOW48	Intervention créée	Christelle TAVERNIER IPP : 789854 [25/10/1980]	15/09/2020	Consultation
16/07/2020 14:39:14	Jean CHIR	DESKTOP-ACU...	Accès intervention	Marc ANGELO IPP : 7510174 [07/09/1953]	15/07/2020	DianeRea
16/07/2020 14:36:28	Jean CHIR	DESKTOP-ACU...	Accès intervention	Marc ANGELO IPP : 7510174 [07/09/1953]	15/07/2020	DianeRea
16/07/2020 14:33:42	Jean CHIR	DESKTOP-ACU...	Accès intervention	Marc ANGELO IPP : 7510174 [07/09/1953]	15/07/2020	DianeRea
16/07/2020 14:28:01	Paul MEDECIN	BOW48	Accès intervention	Marc ANGELO IPP : 7510174 [07/09/1953]	15/07/2020	DianeRea
16/07/2020 14:17:00	Jean CHIR	DESKTOP-ACU...	Accès intervention	Marc ANGELO IPP : 7510174 [07/09/1953]	15/07/2020	DianeRea
15/07/2020 16:11:26	Yves MEDECIN	DESKTOP-ACU...	Accès intervention	Marc ANGELO IPP : 7510174 [07/09/1953]	15/07/2020	DianeRea
15/07/2020 14:24:00	Luc ANESTH	DESKTOP-ACU...	Accès intervention	Marc ANGELO IPP : 7510174 [07/09/1953]	15/07/2020	DianeRea
15/07/2020 14:15:33	Luc ANESTH	DESKTOP-ACU...	Accès intervention	Marc ANGELO IPP : 7510174 [07/09/1953]	15/07/2020	DianeRea
15/07/2020 11:50:49	Luc ANESTH	DESKTOP-ACU...	Accès intervention	Marc ANGELO IPP : 7510174 [07/09/1953]	15/07/2020	DianeRea
15/07/2020 11:47:14	Luc ANESTH	DESKTOP-ACU...	Accès intervention	Marc ANGELO IPP : 7510174 [07/09/1953]	15/07/2020	DianeRea
15/07/2020 11:47:14	Luc ANESTH	DESKTOP-ACU...	Intervention créée	Marc ANGELO IPP : 7510174 [07/09/1953]	15/07/2020	DianeRea
22/07/2020 10:22:39	Diane SYSTEM	DESKTOP-ACU...	Accès intervention	Justine PUTILLE IPP : 7415897 [23/04/1972]	15/07/2020	Visual
21/07/2020 09:53:34	Test TEST	DESKTOP-ACU...	Accès intervention	Justine PUTILLE IPP : 7415897 [23/04/1972]	15/07/2020	DianeRea

## 1.10 ActiveX, data ID and print tags

In order to save the information entered in patient records, **DIANE** must store it in a database. For this, each component has an ActiveX/data ID pair (Ax/ID) (except for detailed entries, room safety checklists, form letters, buttons and "Diane text editor" components...).


An ActiveX corresponds to a data set (history, for example).

Each piece of data is identified by its data ID (anaesthetic history, for example).

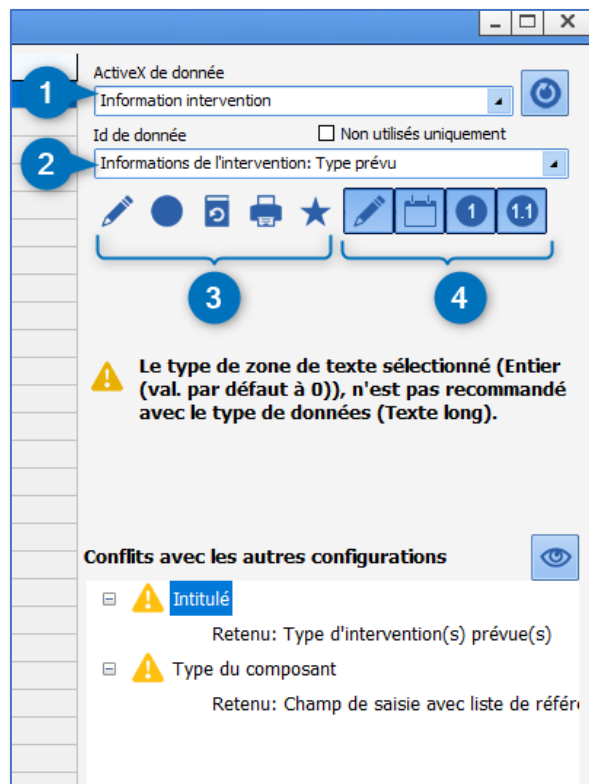
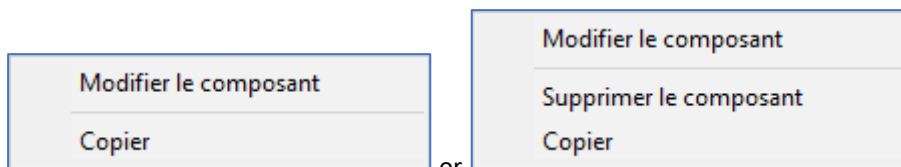
A print tag is associated with each Ax/ID: this allows data to be retrieved and included in form letters.

If two fields have the same Ax/ID, and are set up identically in different areas of the application, the data entered in one area will be included in the other.

Right-clicking on the component provides access to the following menu in order to configure the Ax/ID pair:

The  icon indicates that the component does not have an Ax/ID.





1. Component ActiveX
2. Component data ID
3. Data ID settings:
  - : indicates data type (text, date/time, number or decimal)
  - : indicates data type (normal or calculated/automatic)
  - : indicates archived data
  - : Print tag (indicated on hovering with the mouse)
  - : Data ID used (hovering with the mouse shows the component(s) using the data)
4. Data ID selection filters (text, date/time, number or decimal)

### 1.10.1 Choosing an ActiveX / Data ID

Some Ax/ID have a dedicated objective. Others can be used for any type of component and can take on other roles than their name.

The list of Ax/ID pairs is provided in an annex to this document. IDs are classified by Ax. For each one, the print tag and any specificities are listed.

Caution is required for IDs with specific names. They may be configured with specific behaviour.

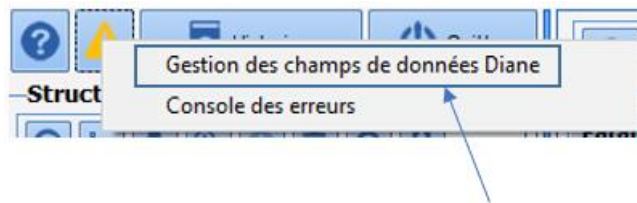
For example, all IDs in the Ax list = **Preoperative assessment** are linked to each other. Filling in a component on

this list will automatically fill in components with the IDs “*Done by*” and “*On*”.

Another example: the BMI Ax/ID (**Patient information/BMI**) uses the result of this calculation. It must therefore be reserved for this usage.

To help with selecting an Ax/ID, a tool called “**DIANE data field management**” (accessed from the main page of the **application configuration** module or directly from the component settings window (by clicking on the eye)) shows whether the Ax/ID pair in question is used and to see its settings in other configurations.

## 1.10.2 DIANE data field management tool



This tool, accessed by clicking  and selecting **Diane data field management**, shows any configuration differences in **DIANE** data fields.

**Informations du champ**

Identifiant interne Diane: diafidCPAREa3CHAMP01 - 311  
 Nom du champ: CPAREa3\_CHAMP01  
 Description du champ: Données de réanimation 3 : Champ 01


AX de référence: Données de réanimation 3 - raCPAREa3 - 21  
 Identifiant de donnée: 1  
 Type de donnée: Normale - dfkNormal - 0  
 Type (base de données): Texte long - ddbftClob - 11  
 Tag d'impression associé: CPAREa3-CHAMP01

**Utilisation du champ dans les configurations**

	Réa complète avec ong	Saisie avancée	Saisie avancée
Nom de la section	CUSTOM_13_340_		
Emplacement	Paramed. > Macroble	RGDS_Surveillance Trai	RGDS_Surveillance Trai
Intitulé	Identité patient vérifié	Complications transfusi	Complications transfusi
Type du composant	Case à cocher (AX)	Champ de saisie avec li	Champ de saisie avec li
Valeurs possibles	O=ON=N		
Type de zone de saisie			
Masque de saisie			
Nombre de chiffres max			
Niveau de la reprise	0		
Valeur de saisie "RAS"			
Nombre de colonnes		2	2
Séparateur de valeurs			

3 fichier(s) de configuration détectés. Voir le détail des configurations au survol.


If two fields use the same Ax/ID pair, data is shared between the two fields. The configuration must be similar (e.g. a one-line input field and a drop-down menu cannot have the same Ax/ID pair as the information entered in these fields does not have the same format). This tool shows conflicts between fields with the same Ax/ID pair in order to avoid errors.

The column on the left shows all fields present and the fields with conflicts are marked with . When an Ax/ID pair is selected, the right side of the window highlights any conflicts in red.

If the **current configuration only** box is checked, the comparison is only carried out for configurations in use. Unchecking this box allows all existing configurations to be compared.

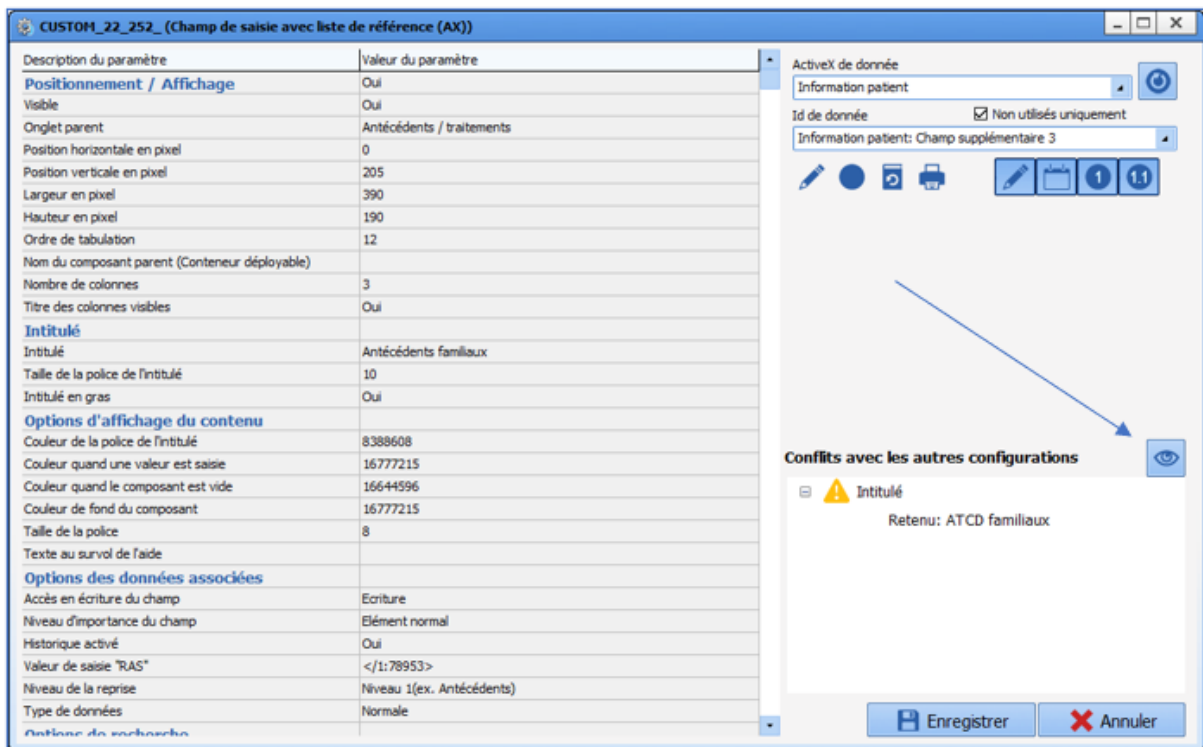
## 1.10.3 DIANE data field management tool from the component

This management tool can also be accessed from a component settings window.

For this, click  found in the lower right part of the window.

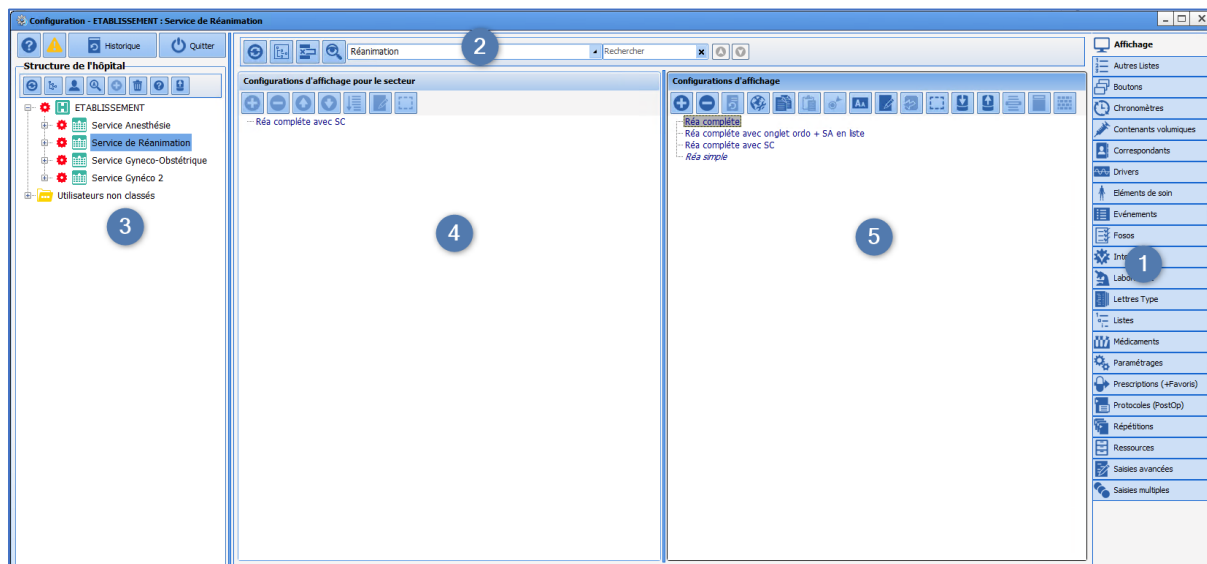
Clicking the eye opens the window described in the previous chapter.

It is possible to view the information directly. In the example below, the name is not exactly the same. To apply the suggested name directly, double-click the suggestion.



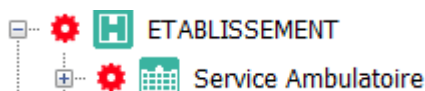
## 2 Settings in DIANE - General information

Applying settings in **DIANE** always follows the same process:



- 1 Select the tab
- If there is a drop-down menu 2, specify the type of settings
- In the tree structure 3 select the area for the settings to be applied
- Middle:
  - 4. Items available for the area selected in 3.
  - 5. Complete list of available items in the software

### 2.1 Gears



Applying a gear to a specific pane allows the pane to be isolated and different settings and/or configurations to be applied.

The main gears are applied during initial set-up. It may be necessary to add new ones if the configuration of an area changes, or to test a new configuration without impacting the whole sector. In this case, they should be deleted at the end of the tests.

The gear can be applied to a whole sector or just one room. It can also be applied to users.

#### 2.1.1 Applying a gear:

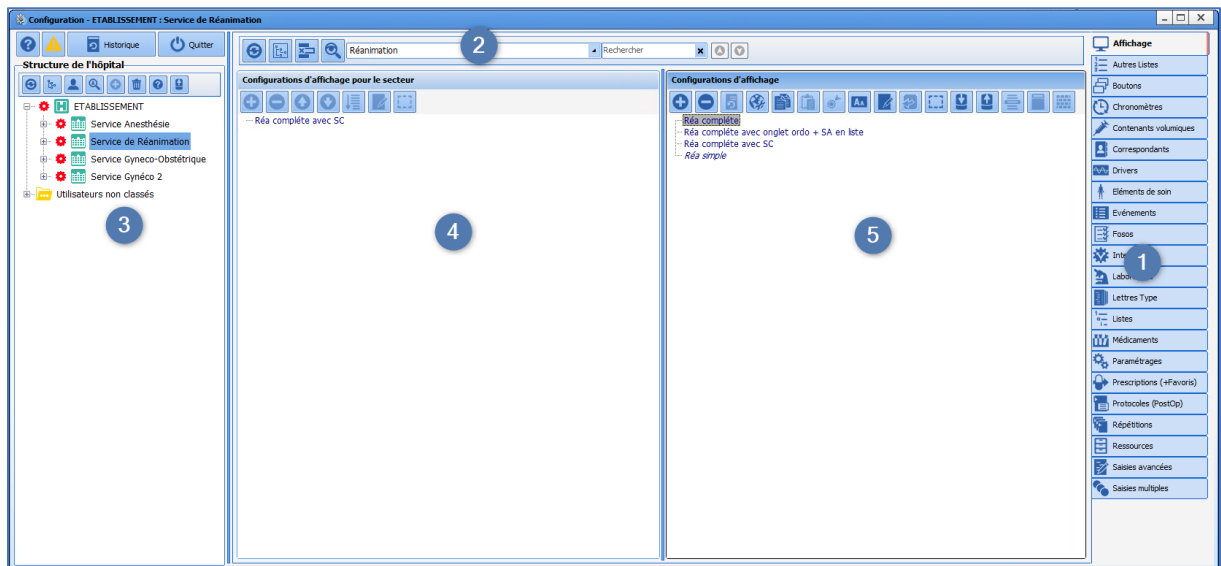
- Right-click on the required location >> **Create a new configuration**
- Click to confirm
- Click to retrieve a copy of the first version found.

## 2.1.2 Deleting a gear:

- Right-click the sector with the gear >> **Delete configuration**

This deletion will return the sector/room/workstation to the same configuration level as that just above it.



## 2.2 Some rules for settings



### 2.2.1 Work pane


Work is carried out in the central pane on the right (pane 5). In this column, items can be created, configured...

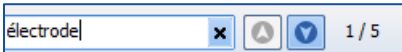
The left central column (pane 4) simply displays the items available for the sector selected in the tree structure (pane 3). In this column, it is possible to:

- Include items from the list on the right,
- Delete items that are not required for the selected sector,
- Rearrange the display order using 
- Sort items in alphabetical order using 

### 2.2.2 Tips for searching for items in lists

Double-clicking an item in the left column (pane 4) automatically selects the item on the right (pane 5).

Clicking  (next to pane 2) means that the list on the right only shows items used in the selected sector (pane 3). The list on the right is then identical to the list used.

Entering a word in the search bar (next to pane 2)  shows how many times the item exists in the list. Use the arrows on the right or the F3 button to move from one item to another.

### 2.2.3 Delete/add back an item on the list

Deleting an item does not remove it from the database, so that information from old records in which this item


was used can still be seen. It can be added back if necessary.

**You MUST ensure that the item is not used in another configuration or by another service.** If several services coexist, deleting items is strongly discouraged.

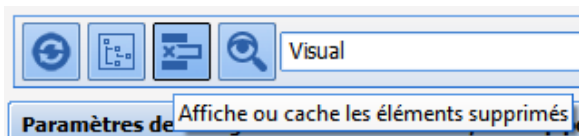
Before deleting an item, it is preferable to rename it so that the name can be reused. Otherwise, having several items with the same name can lead to confusion. Duplicates are not recommended. Rename items by starting the name with several Zs.


With the exception of this specific case, items should not be renamed, in particular for giving them another purpose. This could corrupt older information. For example, the item “Wisdom tooth extraction” should not be renamed “Appendectomy”. Instead, a new item should be created.


### 2.2.3.1 To delete an item:

- Select the unwanted item
- Rename the item by adding several Zs to the start of the name.  
This action means the name can be reused for a new item.
- Click  at the top of the column
- Confirm the action in the pop-up window.

### 2.2.3.2 To add back an item:



- Click the button to show deleted items **Display deleted items** 
- Deleted items are added to the list. They are shown in grey and crossed out.

- Select an item to add back
- Add back the deleted item by clicking  .

## 2.3 Components found in all modules

Regardless of the configuration, the available components are largely the same. Some components are specific to a single module, in which case they are presented by module.

How to add a new component is given for each module.  
Settings are applied component by component.

Right-clicking on a component opens its settings. Each settings window corresponds to the type of component selected. Some items are shared, others are specific.

Please note that saving is carried out step by step. It may therefore be necessary to save the changes made in different places.

For example, you must save the change to a component then save the overall configuration of the area where this component is applied.

## 2.3.1 Settings common to all components

### LOCATION / DISPLAY

**“Visible”:** makes the component visible. Making a component invisible means it can be prepared before being shown to users. (Components being set up, for example) The crossed-out eye symbol is then shown on the component



**“Parent tab”:** references the tab in which the component is located

Clicking the box displays a drop-down menu showing the other tabs available.

This is necessary when adapting a configuration and allows the component to be moved to a different tab without having to recreate it.

**“Horizontal position in pixels”**

**“Vertical position in pixels”**

Shows the position of the component with regard to the edges of the tab. These settings can be used to adjust the location, for example to ensure proper alignment. Rarely/never used, as the component can also be moved using drag and drop.

**“Width in pixels”**

**“Height in pixels”**

Used to enter the width and height of the component.

It is also possible to adjust these settings by selecting the bottom corner or line of the component.

This makes it easier to harmonise the appearance.

**“Tab order”:** used to manage the tab order of the components on the tab.

**“Parent component name (deployable container):** not used

DiaAxEdit7 (Champ de saisie simple (AX))	
Description du paramètre	Valeur du paramètre
<b>Positionnement / Affichage</b>	
Visible	Oui
Onglet parent	Administratif
Position horizontale en pixel	930
Position verticale en pixel	160
Largeur en pixel	160
Hauteur en pixel	22
Ordre de tabulation	27
Nom du composant parent (Conteneur déployable)	
<b>Intitulé</b>	
Intitulé	Profession
Emplacement de l'intitulé	A gauche
Taille de la police de l'intitulé	9
<b>Options d'affichage du contenu</b>	
Couleur de la police de l'intitulé	0
Couleur quand une valeur est saisie	16777215
Couleur quand le composant est vide	-16777211
Couleur de fond du composant	16777215
Taille de la police	9
Texte d'aide à la saisie	
Suffixe (par exemple "kg")	
<b>Options des données associées</b>	
Accès en écriture du champ	Ecriture
Type de zone de saisie	Normal
Masque de saisie	
Valeur maximale (entier, 0=désactivé)	0
Valeur minimale (entier, 0=désactivé)	0
Affiche des "0" pour compléter le nombre de chiffres max.	(Non)
Nombre de chiffres maximal avant la virgule	7
Nombre de chiffres maximal après la virgule	2
Niveau d'importance du champ	Élément normal
Historique activé	Oui
Valeur de saisie "RAS"	
Niveau de la reprise	Niveau 1(ex. Antécédents)
Type de données	Normale



## NAME

**“Name”**: component name

**“Location of name”**: clicking this box shows a drop-down menu with the various possible locations of the name for the component (Above, below, left, right).

Available for one-line input fields, multi-line input fields, drop-down menus

**“Name font size”**: used to determine the size of the font of the component name

DiaAxEdit7 (Champ de saisie simple (AX))	
Description du paramètre	Valeur du paramètre
<b>Positionnement / Affichage</b>	
Visible	Oui
Onglet parent	Administratif
Position horizontale en pixel	930
Position verticale en pixel	160
Largeur en pixel	160
Hauteur en pixel	22
Ordre de tabulation	27
Nom du composant parent (Conteneur déployable)	
<b>Intitulé</b>	
Intitulé	Profession
Emplacement de l'intitulé	A gauche
Taille de la police de l'intitulé	9
<b>Options d'affichage du contenu</b>	
Couleur de la police de l'intitulé	0
Couleur quand une valeur est saisie	16777215

## CONTENT DISPLAY OPTIONS

**“Name font colour”**

**“Colour when a value is entered”**

**“Colour when component is empty”**

**“Component background colour”**:

used to determine the background colour of the component and the colour of the name Default: white and black. Clicking at the end of the row opens a colour palette to select a choice.

**“Font size”**: used to determine the size of the font of text entered by the user. Default = 11

Available for all components with content

**“Input help text”**: used to enter text that will appear in italics and greyed out in the component in order to show the user what type of text is expected.

Available for one-line input fields and multi-line input fields

Code postal

**“Suffix”**: used to position the expected unit in order to guide the user.

Available for one-line input fields

Taille

DiaAxEdit7 (Champ de saisie simple (AX))	
Description du paramètre	Valeur du paramètre
<b>Positionnement / Affichage</b>	
Visible	Oui
Onglet parent	Administratif
Position horizontale en pixel	930
Position verticale en pixel	160
Largeur en pixel	160
Hauteur en pixel	22
Ordre de tabulation	27
Nom du composant parent (Conteneur déployable)	
<b>Intitulé</b>	
Intitulé	Profession
Emplacement de l'intitulé	A gauche
Taille de la police de l'intitulé	9
<b>Options d'affichage du contenu</b>	
Couleur de la police de l'intitulé	0
Couleur quand une valeur est saisie	16777215
Couleur quand le composant est vide	-16777211
Couleur de fond du composant	16777215
Taille de la police	9
Texte d'aide à la saisie	
Suffixe (par exemple "kg")	
<b>Options des données associées</b>	
Accès en écriture du champ	Ecriture
Type de zone de saisie	Normal
Masque de saisie	
Valeur maximale (entier, 0=désactivé)	0
Valeur minimale (entier, 0=désactivé)	0
Affiche des "0" pour compléter le nombre de chiffres max.	(Non)
Nombre de chiffres maximal avant la virgule	7
Nombre de chiffres maximal après la virgule	2
Niveau d'importance du champ	Élément normal
Historique activé	Oui
Valeur de saisie "RAS"	
Niveau de la reprise	Niveau 1(ex. Antécédents)
Type de données	Normale

## ASSOCIATED DATA OPTIONS

This is the aspect that varies most from one component to another.

This will be handled by component type

**“Write access to field”**: used to determine whether the field is read-and-write or read-only.

This is set using the drop-down menu, shown on clicking.

**Write / Always read-only / Always read-and-write** (not functional)

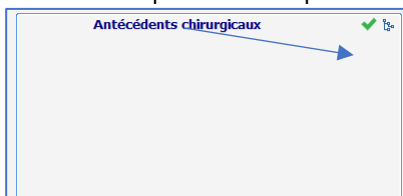
**“Input box type”**: used to determine the data format (date, name, ...). These choices will be presented later.

**“Field importance level”**: used to determine the importance of the field at the time the record is saved/closed.

Four levels: Normal / With warning / Important / Mandatory

**“History enabled”**: used to track input changes in the field.

**“NTR” entry value**: Corresponds to the quick entry value.



**“Retrieval level”**: used to determine whether the field will be included when the record is reopened.

Four levels: Never retrieved / Level 1 (no change) / Level 2 (little change) / Level 3 (much change)


**“Reset”**: used to release the field when the record is opened following transfer to a different department.

Options des données associées	
Accès en écriture du champ	Ecriture
Type de zone de saisie	Non renseigné
Masque de saisie	
Valeur maximale (entier, 0=désactivé)	0
Valeur minimale (entier, 0=désactivé)	0
Accepte les valeurs positives et/ou négatives (entier, 0=to	Tout
Affiche des "0" pour compléter le nombre de chiffres max. (	Non
Nombre de chiffres maximal avant la virgule	7
Nombre de chiffres maximal après la virgule	2
Niveau d'importance du champ	Elément normal
Historique activé	Oui
Valeur de saisie "RAS"	
Niveau de la reprise	Jamais repris
Type de données	Normale
Remise à zéro	Oui

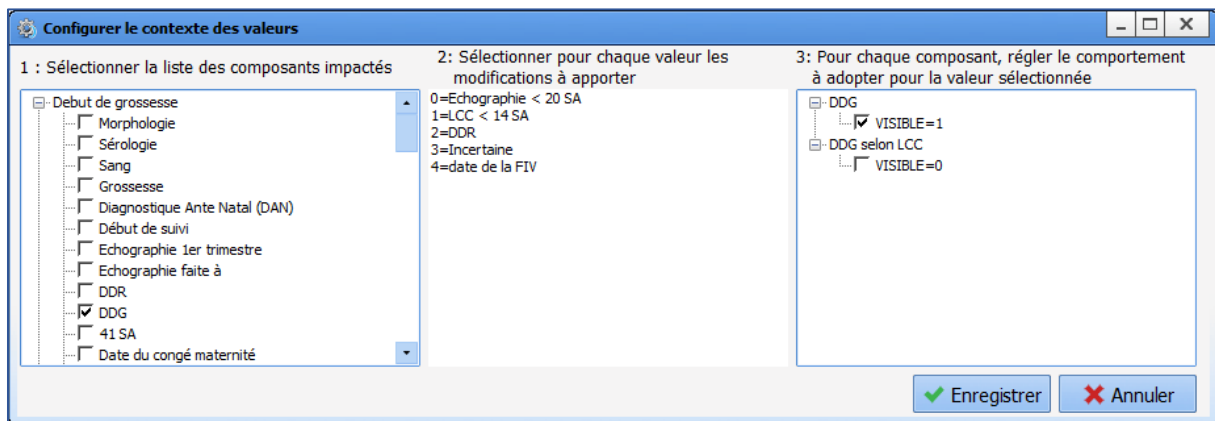
## 2.3.2 Context to update

The context to update is a setting that concerns check boxes, drop-down menus and radio button groups. Depending on the values of these components, other components may or may not be shown.

### 2.3.2.1 Accessing the context to update window

- **Edit the component** (right-click the component) to start this action
- Select the row **context to update**
- Click on the button 
- Configure the device
- Save using the **Save** button (bottom right)
- Save using the component settings window button
- Save the display configuration.

### 2.3.2.2 Setting the context to update



Column 1 lists all the available components that can be used for the context to update.

In a detailed entry, only the components of the detailed entry will be proposed.

In consultation mode, it is possible to change all consultation components.

In Visual or ICU mode, the components of a tab can be changed.

Column 2 shows all the values of the trigger component.

Column 2 shows the visibility of the components.

Step-by-step:

- Select the relevant components in column 1
- Select the first value in column 2
- For each component in column 3, define whether or not they are visible (1 = yes, 0 = no)
- Select the second value in column 2
- For each component in column 3, define whether or not they are visible
- Repeat for each value in column 2
- Save

### 2.3.3 Components available for display configuration and in Detailed Entries

- Label
- Check box
- One-line input field
- Multi-line input field
- Drop-down menu
- Radio button group
- Check box group
- Input field with a reference list (Dialist memo)
- DiaAllergie
- Container
- Treatment component/tab
- Intubation score
- Tooth chart
- Action button

### 2.3.3.1 Label

This component is for writing text that the user cannot modify. In particular, this is used to include explanations to make the page easier to understand.

Description du paramètre	Valeur du paramètre
<b>Positionnement / Affichage</b>	
Visible	Oui
Onglet parent	Admission
Position horizontale en pixel	1275
Position verticale en pixel	105
Largeur en pixel	107
Hauteur en pixel	16
Nom du composant parent (Conteneur déployable)	
<b>Intitulé</b>	
Intitulé	CUSTOM_18_119_
Taille de la police de l'intitulé	0
Intitulé en gras	Non
<b>Options d'affichage du contenu</b>	
Couleur de la police de l'intitulé	0
Couleur de fond du composant	16053493
Taille de la police	10

**Essential settings:** Visible, Parent tab and Name.

The size does not automatically adjust to the content, the section must be stretched manually so that the text is shown correctly. To do this, click the corner of the component and drag it, or enter the width manually under “Width in pixels”

- **Display configurations:**

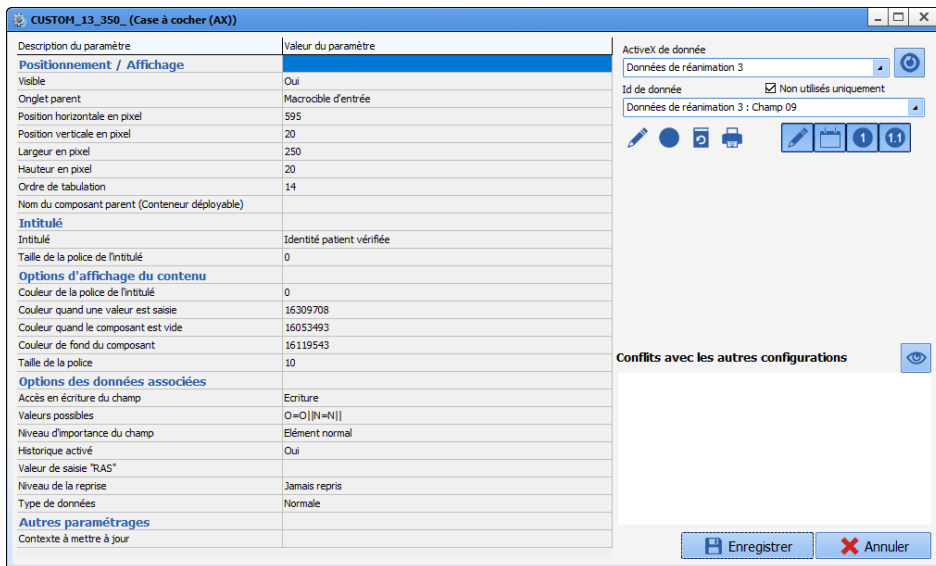
The component is not multi-line: to show several lines of text, a label must be created for each line to be displayed.

- **Detailed entry configurations:**

Multi-line component.

### 2.3.3.2 Check box

 Identité patient vérifiée



**Essential settings:** Visible, Parent tab, Name and Possible values.  
The Possible values field cannot be edited.

### 2.3.3.3 One-line input field

**Text type:**

**Date type:**

**Digital data type:**

These components are used to collect short pieces of information.  
It is possible to set up an Input help text to tell the user what they are expected to enter. (Greyed out and in italics in the examples above).  
A suffix can also be included to ensure that all users use the same format. (Height in cm and Weight in kg)  
Selecting a date field type allows a calendar to be displayed to the user.

Description du paramètre	Valeur du paramètre
<b>Positionnement / Affichage</b>	
Visible	Oui
Onglet parent	Admission
Position horizontale en pixel	130
Position verticale en pixel	30
Largeur en pixel	200
Hauteur en pixel	24
Ordre de tabulation	1
Nom du composant parent (Conteneur déployable)	
<b>Intitulé</b>	
Intitulé	Nom de naissance
Emplacement de l'intitulé	Au dessus
Taille de la police de l'intitulé	8
<b>Options d'affichage du contenu</b>	
Couleur de la police de l'intitulé	0
Couleur quand une valeur est saisie	16644596
Couleur quand le composant est vide	-16777211
Couleur de fond du composant	16777215
Taille de la police	10
Texte d'aide à la saisie	Dupont
Suffixe (par exemple "kg")	
<b>Options des données associées</b>	
Accès en écriture du champ	Ecriture
Type de zone de saisie	Normal
<b>Masque de saisie</b>	
Valeur maximale (entier, 0=désactivé)	0
Valeur minimale (entier, 0=désactivé)	0
Affiche des "0" pour compléter le nombre de chiffres max.	Non
Nombre de chiffres maximal avant la virgule	7
Nombre de chiffres maximal après la virgule	2
Niveau d'importance du champ	Élément normal
Historique activé	Non
Valeur de saisie "RAS"	
Niveau de la reprise	Niveau 1(ex. Antécédents)
Type de données	Normale

ActiveX de donnée: Patient

Id de donnée:  Non utilisés uniquement

Nom de naissance du patient

Confits avec les autres configurations

Enregistrer Annuler

**Essential settings:** Visible, Parent tab and Name.

**Optional settings:** Label location, Input help text, Suffix and Input box type

There are several input box types:

- **Normal:** no format constraints.
- **Whole (default value 0):** only whole numbers
- **Decimal (default value 0):** only decimal numbers
- **Date:** only dates
- **First name:** automatically capitalises the first letter. (Example: bow => Bow).
- **Last name:** automatically capitalises all letters. (Example: Bow => BOW).
- **Future date:** used to enter a date after the current date.
- **Date of birth:** used to enter a date of birth (must be before today's date).
- **Past date:** used to enter a date before the current date.
- **Unspecified:** no format constraints (like **Normal**).
- **Whole (default value -1):** only whole numbers
- **Decimal (default value -1):** only whole numbers
- **Day, month and time:** used to enter a short date (day and month) and a time.
- **Time: Minute:** used to enter a time.
- **IP address:** used to enter an IP address.
- **Email address:** used to enter a valid email address.
- **Date and time:** used to enter a date (day, month and year) and a time.

It is possible to set up a data-entry mask, except for date and/or time fields.

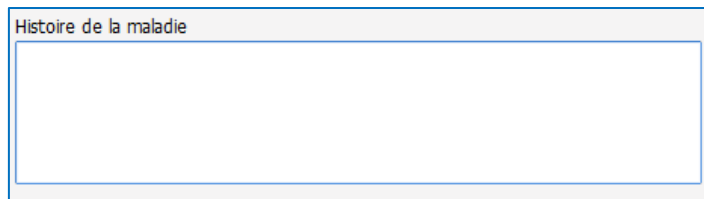
For numbers (whole and decimal), a minimum and/or maximum value can be set (these thresholds must be whole numbers).

Other settings are available for decimals:

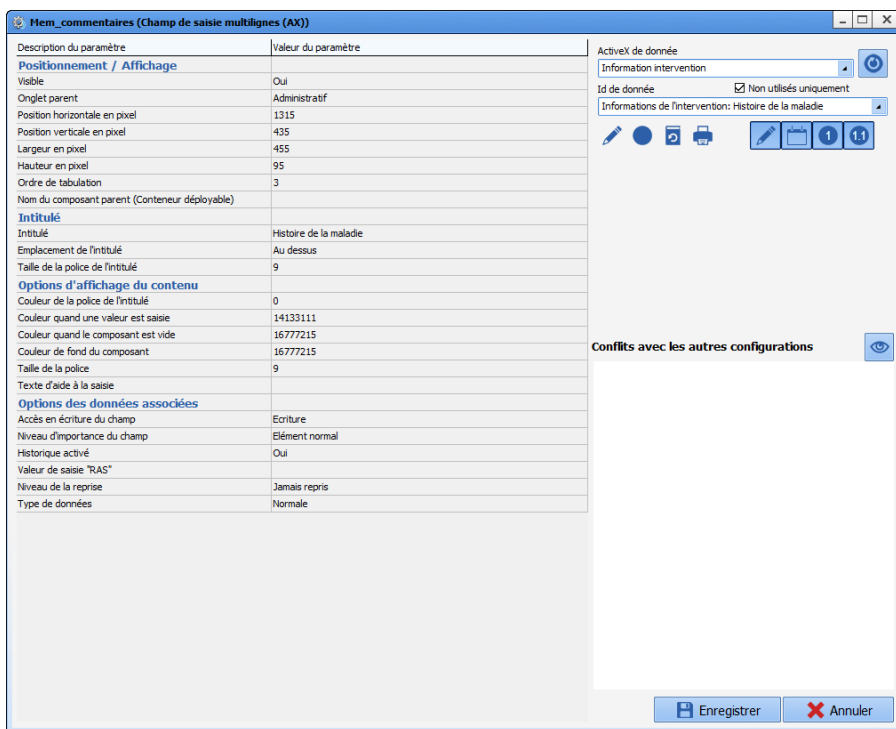
- Show "0" to add the max. number of figures (e.g. 001.20)
- Maximum number of figures before the decimal point (used if the previous setting is activated)
- Maximum number of figures after the decimal point

### 2.3.3.4 Multi-line input field

This component allows the user to enter free text.



Histoire de la maladie



**Mem\_commentaires (Champ de saisie multilignes (AX))**

Description du paramètre	Valeur du paramètre
<b>Positionnement / Affichage</b>	
Visible	Oui
Onglet parent	Administratif
Position horizontale en pixel	1315
Position verticale en pixel	435
Largeur en pixel	455
Hauteur en pixel	95
Ordre de tabulation	3
Nom du composant parent (Conteneur déployable)	
<b>Intitulé</b>	
Intitulé	Histoire de la maladie
Emplacement de l'intitulé	Au dessus
Taille de la police de l'intitulé	9
<b>Options d'affichage du contenu</b>	
Couleur de la police de l'intitulé	0
Couleur quand une valeur est saisie	14133111
Couleur quand le composant est vide	16777215
Couleur de fond du composant	16777215
Taille de la police	9
Texte d'aide à la saisie	
<b>Options des données associées</b>	
Accès en écriture du champ	Ecriture
Niveau d'importance du champ	Élément normal
Historique activé	Oui
Valeur de saisie "RAS"	
Niveau de la reprise	Jamais repris
Type de données	Normale

ActiveX de donnée: Information intervention  
Id de donnée: Non utilisés uniquement  
Informations de l'intervention: Histoire de la maladie

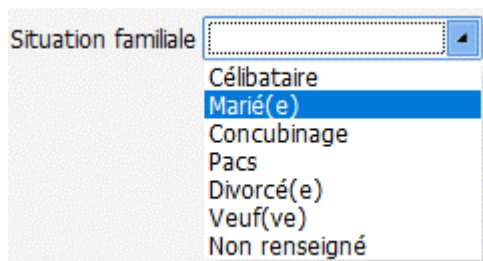
Conflits avec les autres configurations

Enregistrer Annuler

**Essential settings:** Visible, Parent tab and Name.

**Optional settings:** Input help text.

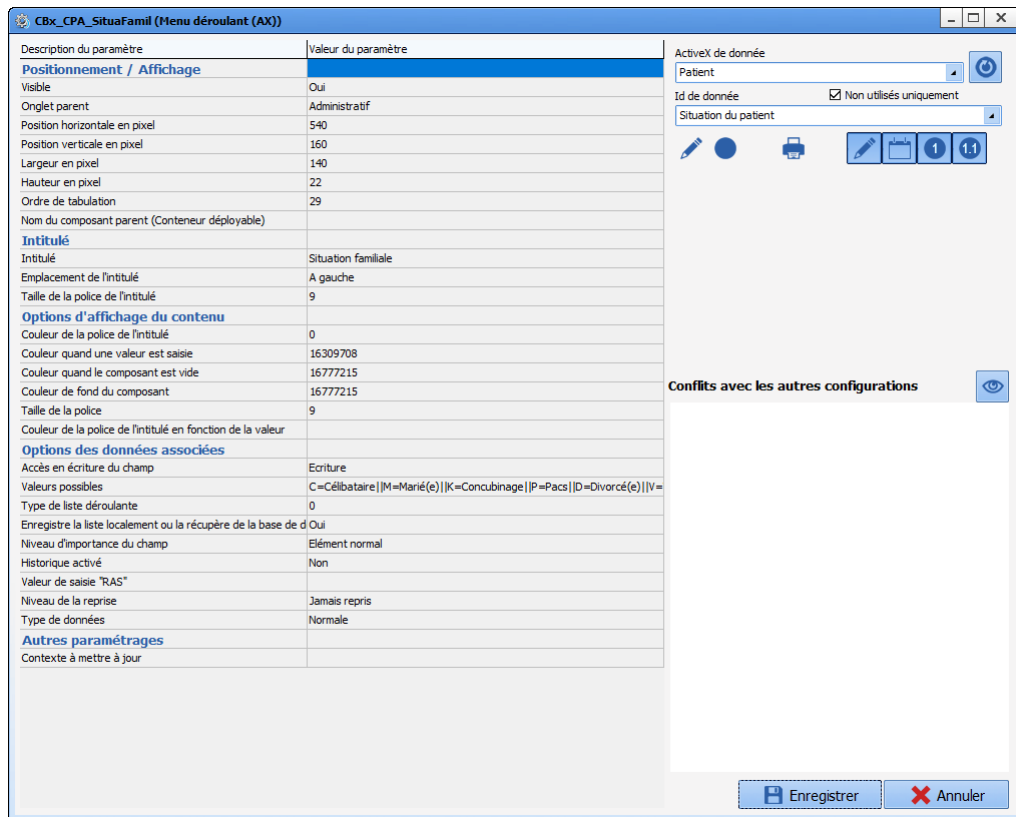
### 2.3.3.5 Drop-down menu



Situation familiale

- Célibataire
- Marié(e)
- Concubinage
- Pacs
- Divorcé(e)
- Veuf(ve)
- Non renseigné

The drop-down menu offers users several choices, with one possible response.



**Essential settings: Visible, Parent tab, Name and Possible values.**

### 2.3.3.6 Radio button group

Protection juridique

Mineur accompagné de ses parents

Patient sous Tutelle

Patient sous Curatelle

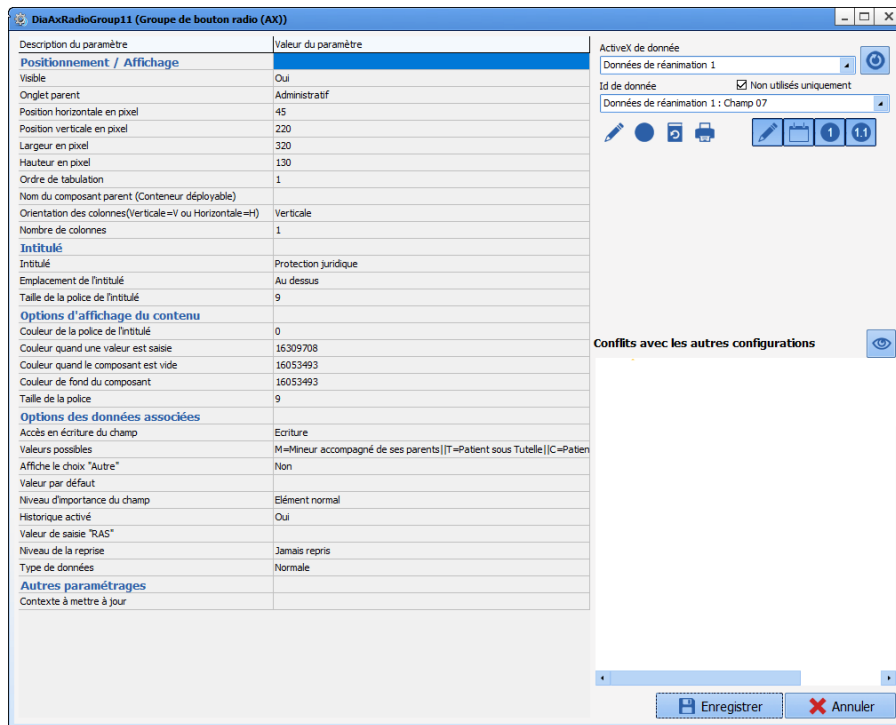
Patient sous Sauvegarde de justice

Radio button groups offer users several choices. Only one response can be entered.

This differs to drop-down menus as follows:

- Option to propose "Other" as a choice, which then opens a input field next to the choice.
- The various options are visible without clicking.





**Essential settings:** Visible, Parent tab, Number of columns, Column orientation, Name, Possible values  
**Optional settings:** Column orientation, number of columns and Show "Other".

### 2.3.3.7 Check box group

**Couverture Sociale**

Assuré(e) social(e)     Sans prise en charge

Prise en charge 100%     Patient non résident payant

Mutuelle                       Autre

The check box group allows the user to select several responses.

**CUSTOM\_18\_104\_ (Groupe de cases à cocher (AX))**

Description du paramètre	Valeur du paramètre
<b>Positionnement / Affichage</b>	
Visible	Oui
Onglet parent	Admission
Position horizontale en pixel	235
Position verticale en pixel	120
Largeur en pixel	425
Hauteur en pixel	95
Ordre de tabulation	9
Nom du composant parent (Conteneur déployable)	
Orientation des colonnes(Verticale=V ou Horizontale=H)	Verticale
Nombre de colonnes	2
<b>Intitulé</b>	
Intitulé	Couverture Sociale
Emplacement de l'intitulé	Au dessus
Taille de la police de l'intitulé	8
<b>Options d'affichage du contenu</b>	
Couleur de la police de l'intitulé	0
Couleur quand une valeur est saisie	16309708
Couleur quand le composant est vide	16053493
Couleur de fond du composant	16777215
Taille de la police	10
<b>Options des données associées</b>	
Accès en écriture du champ	Ecriture
Valeurs possibles	AS=Assuré(e) social(e)  P=Prise en charge 100%  M=Mut
Affiche le choix "Autre"	Oui
Niveau d'importance du champ	Élément normal
Historique activé	Non
Valeur de saisie "RAS"	
Niveau de la reprise	Jamais repris
Type de données	Normale
<b>Autres paramètres</b>	
Séparateur de valeurs à l'impression	

ActiveX de donnée  
Données de réanimation 1

Id de donnée  Non utilisés uniquement  
Données de réanimation 1 : Champ 02

Conflicts avec les autres configurations

Enregistrer Annuler

**Essential settings:** Visible, Parent tab, Number of columns, Name, Possible values  
**Optional settings:** Column orientation, number of columns and Show "Other".

### 2.3.3.8 Input field with a reference list (DiaList memo)

Antécédents familiaux	
Pathologie	Parenté

Input fields with a reference list are components that can be used to combine manual entry with structured entries. They use a list managed in the **List** tab of the configuration module.

**CUSTOM\_22\_252\_ (Champ de saisie avec liste de référence (AX))**

Description du paramètre	Valeur du paramètre
<b>Positionnement / Affichage</b>	
Visible	Oui
Onglet parent	Antécédents / traitements
Position horizontale en pixel	0
Position verticale en pixel	205
Largeur en pixel	390
Hauteur en pixel	190
Ordre de tabulation	12
Nom du composant parent (Conteneur déployable)	
Nombre de colonnes	3
Titre des colonnes visibles	Oui
<b>Intitulé</b>	
Intitulé	Antécédents familiaux
Taille de la police de l'intitulé	10
Intitulé en gras	Oui
<b>Options d'affichage du contenu</b>	
Couleur de la police de l'intitulé	8388608
Couleur quand une valeur est saisie	16777215
Couleur quand le composant est vide	16644596
Couleur de fond du composant	16777215
Taille de la police	8
Texte au survol de l'aide	
<b>Options des données associées</b>	
Accès en écriture du champ	Ecriture
Niveau d'importance du champ	Elément normal
Historique activé	Oui
Valeur de saisie "RAS"	</!:78953>
Niveau de la reprise	Niveau 1(ex. Antécédents)
Type de données	Normale
<b>Options de recherche</b>	

ActiveX de donnée  
 Information patient  
 Id de donnée  Non utilisés uniquement  
 Information patient: Champ supplémentaire 3

Confits avec les autres configurations  
 Intitulé  
 Retenu: ATCD familiaux

Enregistrer Annuler

**CUSTOM\_22\_252\_ (Champ de saisie avec liste de référence (AX))**

Description du paramètre	Valeur du paramètre
<b>Options de recherche</b>	
Recherche automatique à la frappe	Oui
Nombre de caractères avant recherche automatique	4
Etendre la recherche au catalogue CIM10	Désactivée
Premiers caractères à considérer lors de la recherche dans	
<b>Options de la saisie avec liste de référence</b>	
Type de la première colonne	Tricolore
Largeur de la première colonne	15
Liste générale de la première colonne	0
Root de référence de la première colonne	
Intitulé de la première colonne	
Option de saisie de la première colonne	1 0 0 0 1
Type de la deuxième colonne	Texte
Largeur de la deuxième colonne	275
Liste générale de la deuxième colonne	Consultation
Root de référence de la deuxième colonne	ROOTLIBRE3
Intitulé de la deuxième colonne	Pathologie
Option de saisie de la deuxième colonne	Arbre + Menu + TexteLibre
Type de la troisième colonne	Texte
Largeur de la troisième colonne	91
Liste générale de la troisième colonne	Consultation
Root de référence de la troisième colonne	Parenté
Intitulé de la troisième colonne	Parenté
Option de saisie de la troisième colonne	1 0 0 0 1
Sélectionner automatiquement les éléments fils	Non
Restreindre la saisie à une seule ligne	Non
<b>Autres paramétrages</b>	
Séparateur de valeurs à l'impression	
Commande à lancer lors de l'appel de l'aide	

ActiveX de donnée  
 Information patient  
 Id de donnée  Non utilisés uniquement  
 Information patient: Champ supplémentaire 3

Confits avec les autres configurations  
 Intitulé  
 Retenu: ATCD familiaux

Enregistrer Annuler

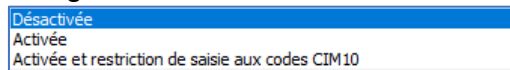
This component has specific settings:

**Number of columns:** must be between 2 and 4 (the first column must be **Three-colour** and the others must be **Text**)

- **Visible column titles:** display or hide column titles.
- **Autocomplete:** enable/disable automatic completion from X characters entered (X defined using

the **Number of characters before autocomplete** setting).

- **Extend search to ICD-10 catalogue:**




- **Disabled:** the search is not extended to the ICD-10 catalogue.
- **Enabled:** the search is extended to the ICD-10 catalogue.
- **Enabled and restricted to ICD-10 code entries:** searching is limited to the ICD-10 catalogue (items entered that are not associated with an ICD-10 code are not saved).

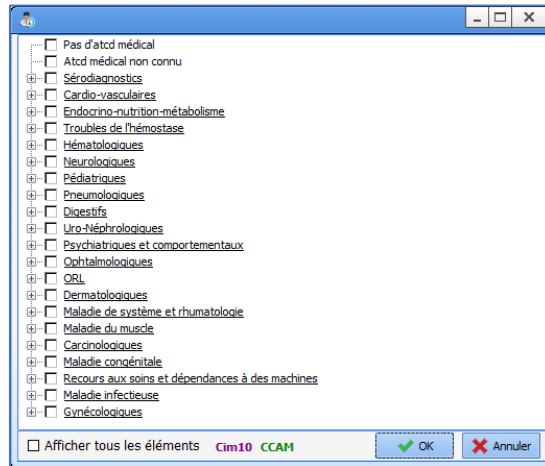
- **Column X general list:** determines the list type used for the reference list from the following options:

- **Consultation** ⇒ **List** tab
- **Visual event** ⇒ **Events** tab
- **Supplement** ⇒ **Other lists** tab
- **Drug** ⇒ **Drugs** tab
- **User** ⇒ **User / Role configuration**
- **Correspondents** ⇒ **Correspondents** tab

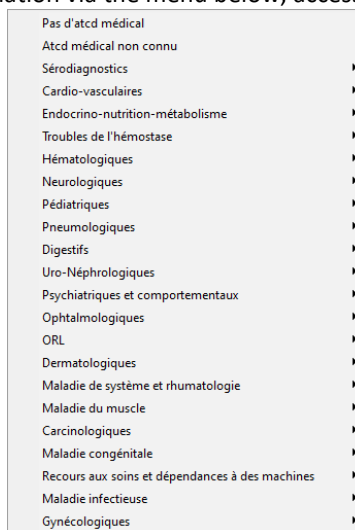
- **Column X reference root:** determines the list used for the reference list (based on previous setting)

- **Column X entry option:** determines the entry mode for items from the following options:

- **Tree** (one column of the component only): used to input information via  and the window below



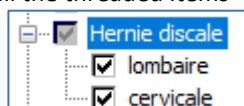
- **Menu:** used to input information via the menu below, accessed by right-clicking



- **Free text:** used to input information via the keyboard

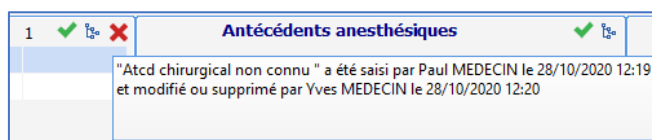
- **Automatically select threads:** if this setting is enabled, selecting a parent item automatically selects

all the threaded items



In this example, the user selects **Herniated disc** and the items **Lumbar** and **Cervical** are automatically selected

- **Restrict entry to one row:** if this setting is enabled, only one row can be entered
- **History enabled:** allows users to see what changes have been made to the field.

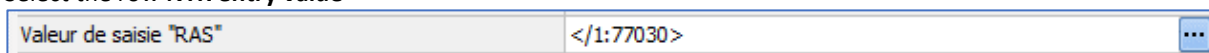



The red cross shows the user that an entry from a previous session (potentially entered by another user) was changed or deleted. Hovering over this red cross shows who entered what and when.

- **“NTR” entry value:** if this setting is selected, a green tick is shown at the top right of the component. This green tick allows the user to enter the value preselected during set-up.

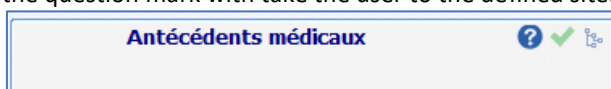
For this setting to be enabled, the configuration must be completed, in particular the reference root selection. It may be necessary to save the component settings then return to the settings window.

- Select the row **NTR entry value**



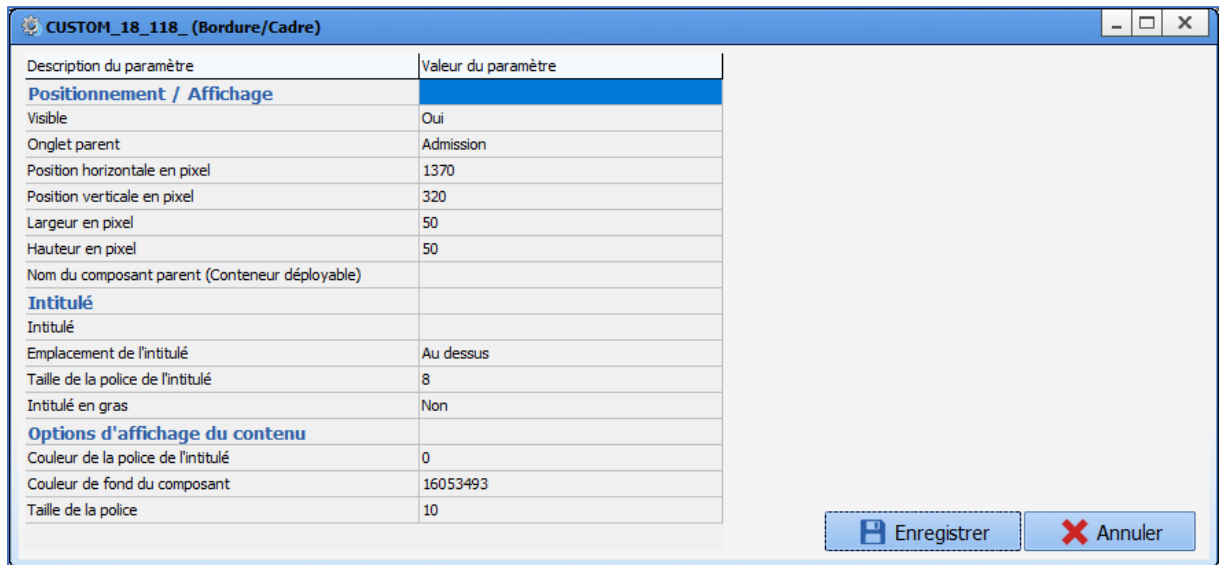
- Click 
- The configured tree structure is shown
- Select the NTR value(s).
- Confirm the selection with **OK** at the bottom right of the window
- Save the change to the component with the **Save** button at the bottom right of the settings window

- **Command to execute when launching help:** the URL of a website or an intranet address can be entered. Clicking on the question mark will take the user to the defined site.



### 2.3.3.9 Border/Frame

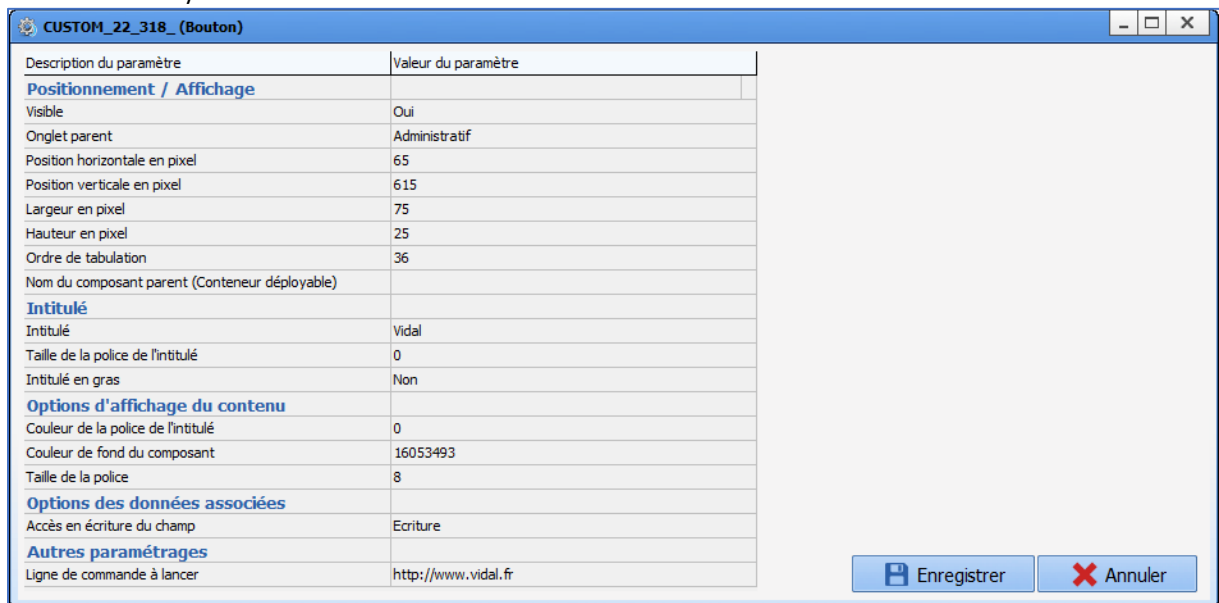
This component is used to group together components with a similar concept. This visual grouping makes the page easier to read and understand.



**Note:** this component is not a container, it does not support components placed within it. It is a visual element for organising display and making the page easier to read.


### 2.3.3.10 Button / Bouton (AX)

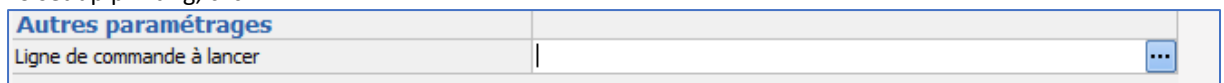
This component is used to create buttons for launching form letter printing, starting executables or accessing a website directly.



**Essential settings:** Visible, Parent tab, Name and Command line to execute

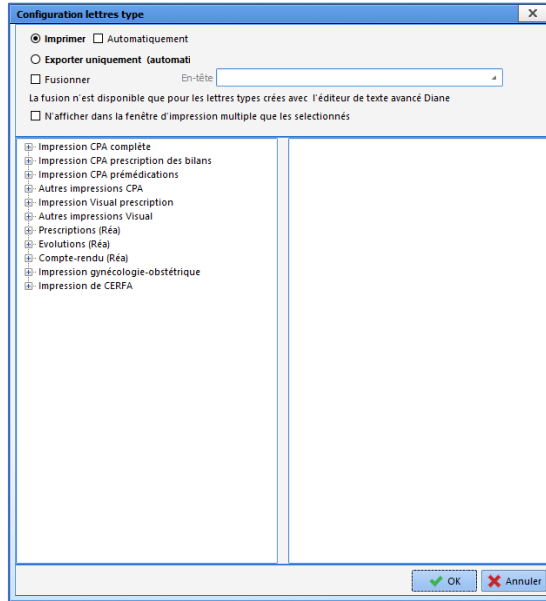
The key setting for this component is **Command line to execute:**

- To set up printing, click .

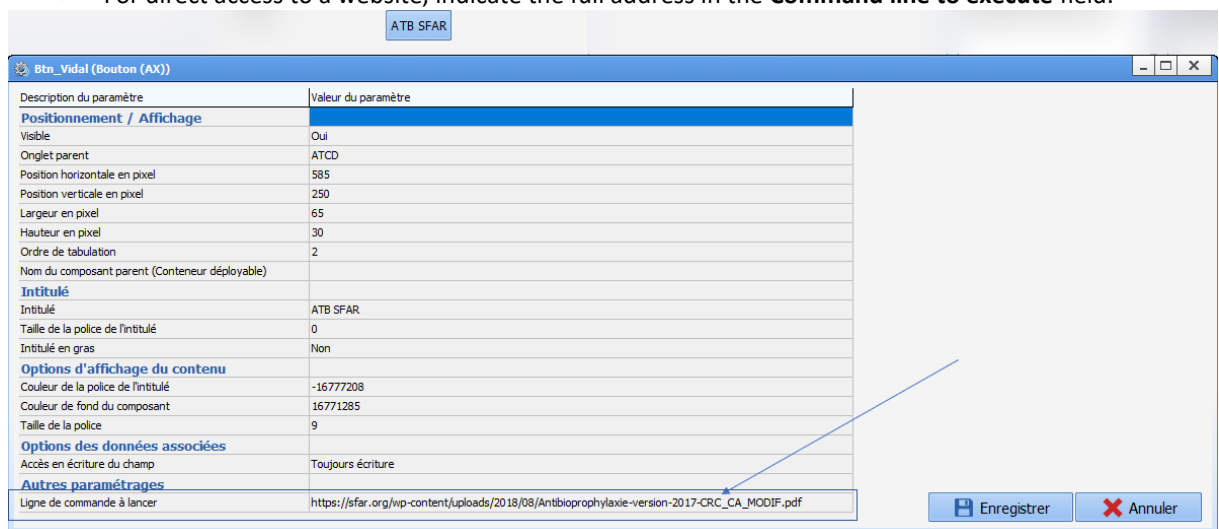


The following window is shown to configure the form letter(s) to be printed by drag-and-dropping

them into the right column.

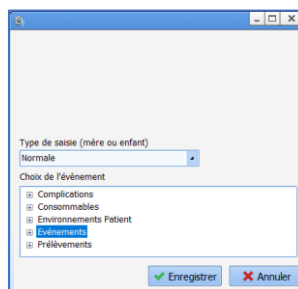


- To set up an executable, indicate the full pathway in the **Command line to run** field. This setup is made available by the BOW MEDICAL interface service.
- For direct access to a website, indicate the full address in the **Command line to execute** field.



### 2.3.3.11 Event entry via button

This component is used to configure a button to add an **Event** item.  
This component is used to enter an **Event** from the detailed entry form.



## 3 Configuration tabs

### 3.1 Display

This configuration tab is used to modify the appearance and operation of the screens shown to users of **DIANE ANAESTHESIA (Consultation and Visual (IntraOp and PostOp))**, **DIANE OB-GYN** and **DIANE ICU**.

**Visual** is used to configure **DIANE ANAESTHESIA Visual** modules (IntraOp et PostOp). If no configuration is defined for the **ICU** module, this is the configuration that is applied.

**Consultation**: used to configure the **DIANE ANAESTHESIA Consultation** module.

**OB-GYN**: used to configure the **DIANE OB-GYN** module.

**ICU**: used to configure the **DIANE ICU** module. If no configuration is defined for this module, the **Visual** configuration is applied.


Each sector **MUST** have a configuration applied for each module. In order to view anaesthesia records during consultations, the IntraOp module needs to know what configuration to open.

Only one display configuration can be toggled.

#### 3.1.1 Display configuration (excluding Consultation)

For **DIANE ANAESTHESIA Visual** (IntraOp and PostOp), **DIANE OB-GYN** and **DIANE ICU**, the presentation is the same. The following buttons are found top left:



 Save and close the display configuration





Close the display configuration without saving

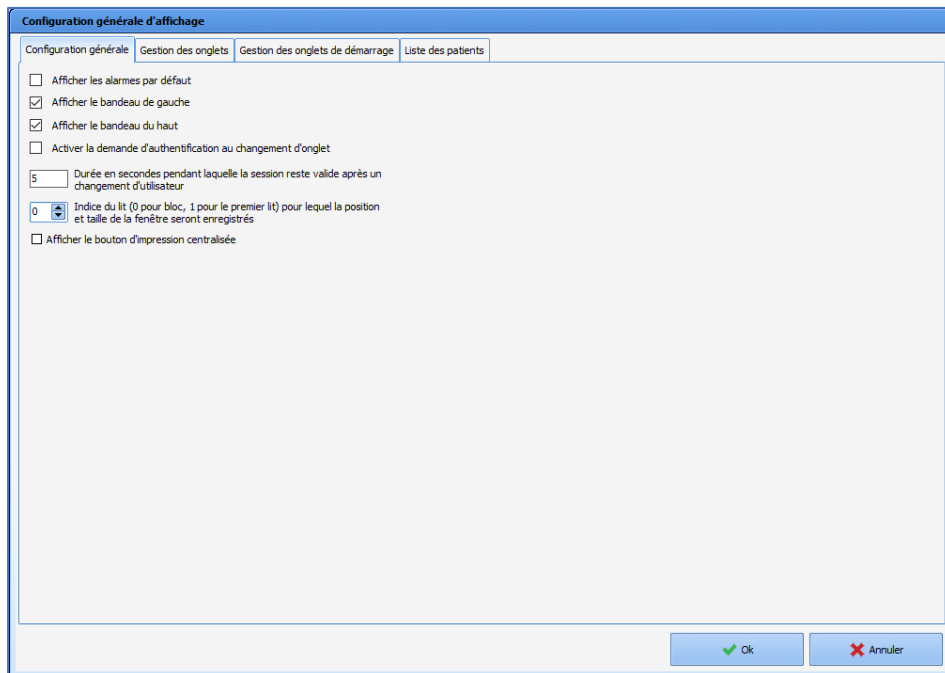


Show online assistance



Open the general module configuration window

### 3.1.1.1 General configuration window: general configuration tab



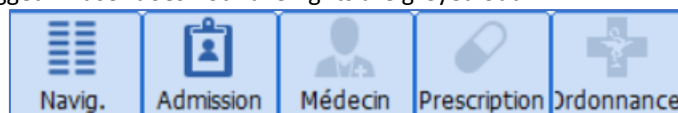
This **General configuration tab** offers the possibility to show or hide the left ribbon and top ribbon by default.

This is where it is possible to **Enable authentication request at tab change**. This option limits write-access to certain roles. Other users will have read-only access for the tab in question.

To enable this option:

- Select the box “**Enable authentication request at tab change**”.
- Go to the **Tab management** tab,
- Select the **configured tab** in question,
- Deselect “**Allow all profiles**”
- Select the profiles to be allowed write-access from the list.

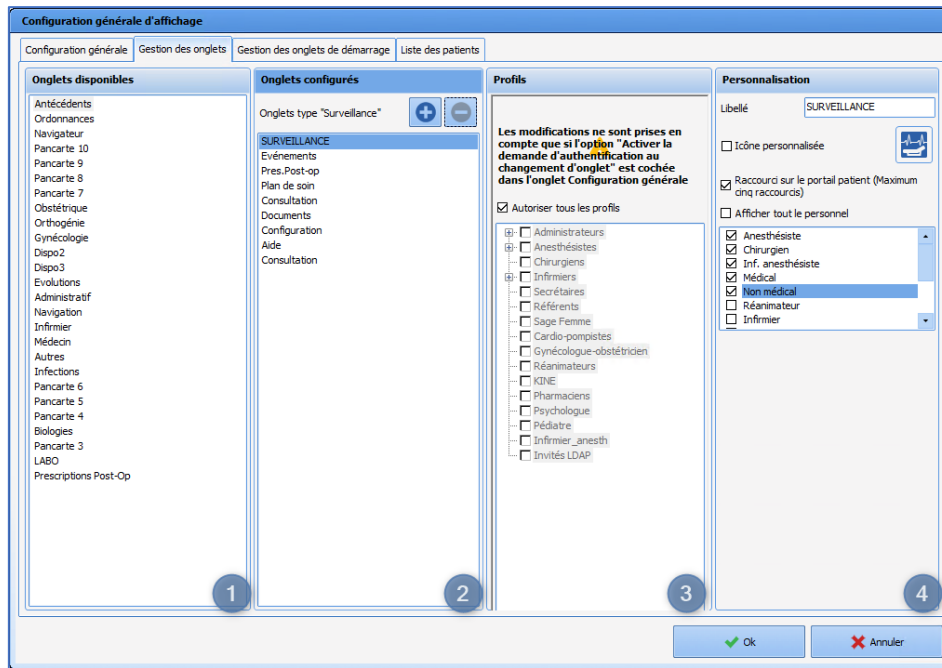
Tabs for which the logged-in user does not have rights are greyed out.



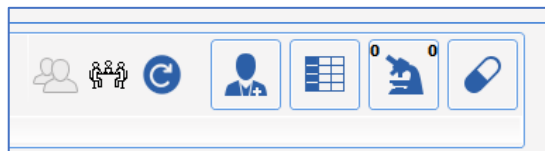
**View centralised printing button** allows users to access centralised printing from the top ribbon.

### 3.1.1.2 General configuration window: tab management tab

The **Tab management** tab is used to define the tabs to be displayed and their order.



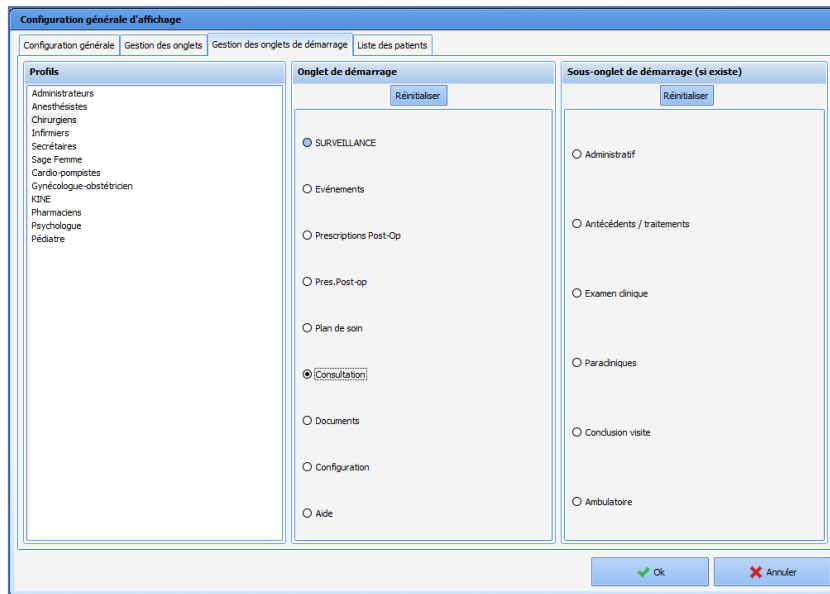
1. **Available tabs:** drag and drop to add an available tab.
2. **Configured tabs:**
  - Drag and drop to change the order of tabs.
  - A configured tab can be deleted by drag-and-dropping into the **Available tabs** pane.
  - Only new “Monitoring” tabs can be created.
3. **Profiles:** For each configured tab, user roles can be defined to give write-access. Other users will have read-only access for the tab in question. This is only applied if the **Enable authentication request at tab change** option in the **General settings** tab is selected.
4. **Customisation:**
  - The tab can be renamed and the associated icon changed (selected from a catalogue).
  - It is possible to include a shortcut on the patient portal (patient list), limited to max. 5 tabs.



- Specific case of **MONITORING** tab in **DIANE Anaesthesia**: it is possible to select roles to be shown in the **Staff** subtab. The **Show all staff** check box can be used to select all boxes with one click.

### 3.1.1.3 General configuration window: Startup tab management tab


The **Startup tab management** tab is used to determine the tab (or subtab) opened on starting up the module for each user profile. This option is only available for **DIANE ANAESTHESIA Visual** (IntraOp and PostOp) settings.

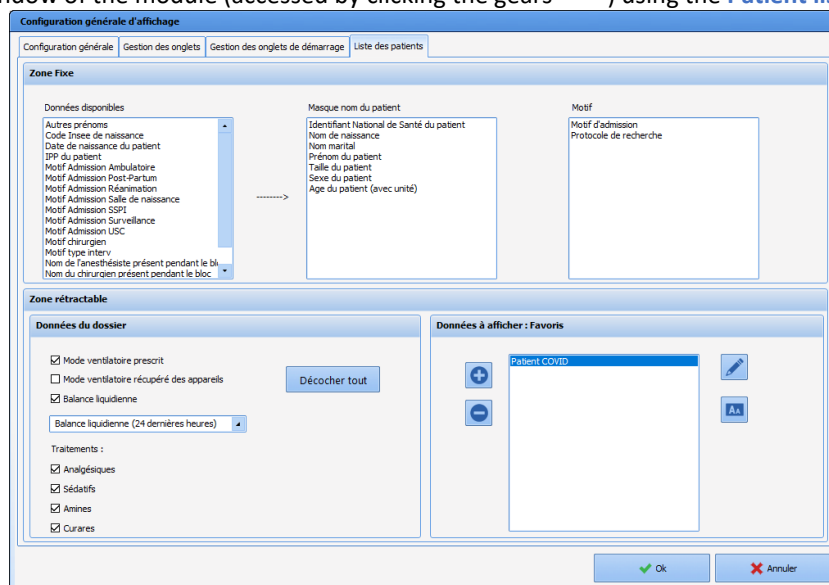


- Select the relevant profile
  - Select the relevant tab to be displayed on start-up
- If subtabs are available for the selected tab, they are shown on the right.
- Select the relevant subtab.

If this is not set up, the session will open on the first tab.

### 3.1.1.4 General configuration window: patient list tab

The display configuration for the patient list is carried out directly in the relevant module, using the general configuration window of the module (accessed by clicking the gears ) using the **Patient list** tab.

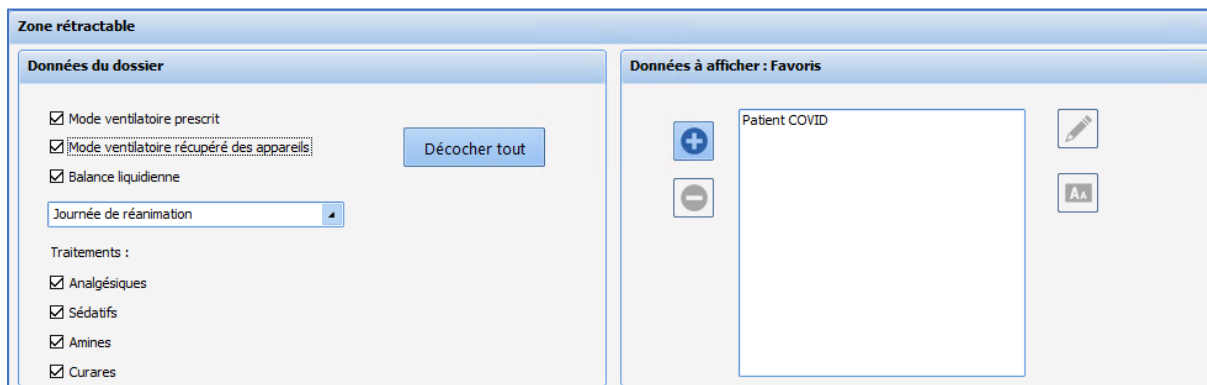


- The **set pane** shows the patient identity and the reason for admission.

 Lit n4 0945467 CREPIN LARDEUR Juliette F 48 ans 170 cm 56 Kg J 0  
Pneumopathie

The various data available can be shown in the first row (**Patient name mask**) or the second row (**Reason**) by drag-and-dropping them to the relevant pane. They can then be ordered by using drag and drop within the same box. To hide a piece of information, drag and drop it into the **Available data** pane.

- **The retractable pane** comprises 3 panes (in use), 2 of which can be configured:



- On the left, there is information relating to **record data**: Ventilation method, Fluid balance and Treatments.  
For ventilation method, it is possible to choose the **Prescribed ventilation method** and/or the **Ventilation method retrieved from connected devices**.

Three time slots are available for fluid balance:

- Last 24 hours
- ICU day (current)
- ICU day (previous)

The treatments shown in this pane can be:

- Analgesia
- Sedatives
- Amines
- Muscle relaxants

Information about treatments is linked to drug ATC class. If a drug in the muscle relaxant ATC class is prescribed, the term “muscle relaxant” appears on the portal.

The same applies to the other drug classes listed above.

- Data that can be entered ‘on the fly’ and is not set up during configuration is found in the middle of the retractable pane. This is for information purposes only and not saved in the patient record.
- On the left, **data to be displayed** can be personalised: it is possible for configure favourites to add the most-commonly displayed information from the following categories in one click:
  - Scores
  - DIANE data
  - Vital signs
  - Events
  - Complications
  - Timers
  - Care items

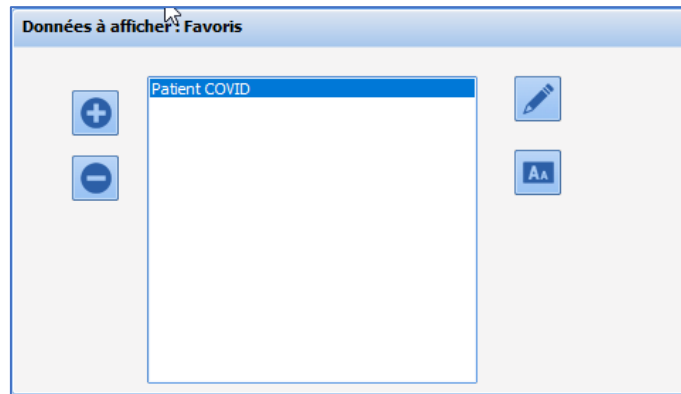
#### Configuration of data to be displayed:


BOW MEDICAL SAS, 43, Avenue d'Italie  
34 87  
80090 Amiens – FRANCE  
DIANE Settings Manual: Version: 4.9

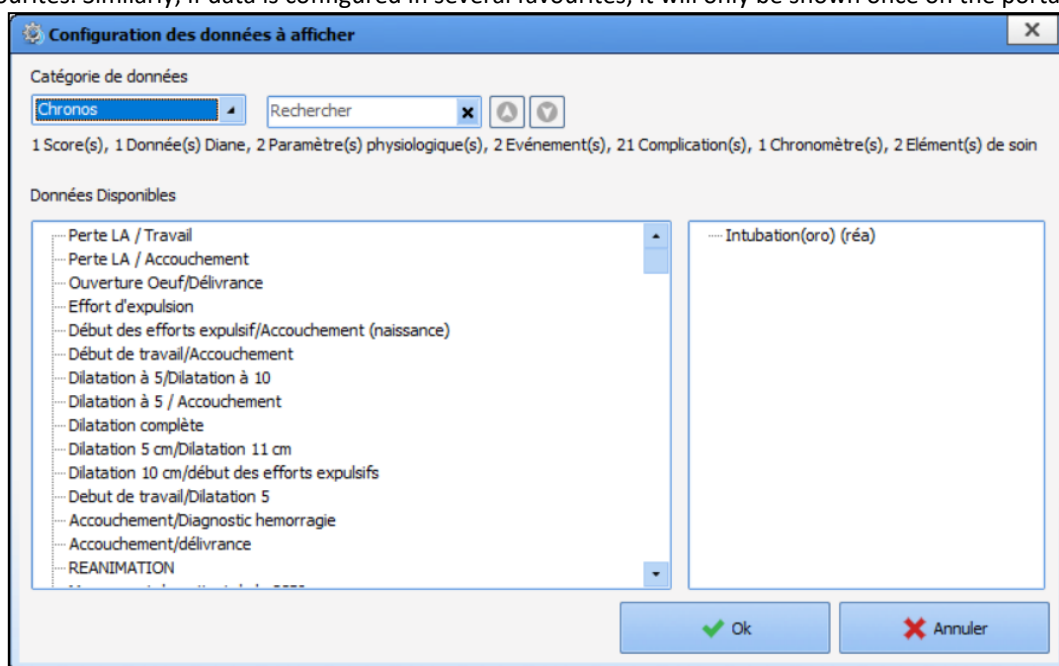
Tel.: +33(0)3 60 03 24 68 - Fax: +33(0)9 72 29

Email: [contact@bowmedical.com](mailto:contact@bowmedical.com)




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The  button is used to create a new favourite. The **Configuration of data to be displayed** window opens and is used to select the data to be displayed. In use, it is possible to add other data and/or remove configured data in favourites. Similarly, if data is configured in several favourites, it will only be shown once on the portal.



Data can be added by drag-and-dropping into the **Available data** pane towards the right. Drag and drop in the other direction to remove configured data. For each category of data, the number of configured items is shown.

An existing favourite can be deleted with the  button or modified with the  button, which opens the **Configuration of data to be displayed** window. The  button is used to rename the favourite.

### 3.1.2 Specifics of Consultation

Contrary to the other modules, it is not possible to create new components in the **DIANE ANAESTHESIA Consultation** app: tabs that are not used for display are stock tabs.

**A component is not created or deleted:** it is moved to or from stock tabs. It is not possible to create a tab. Tabs can be hidden if they are not used.

#### 3.1.2.1 Available tabs for Consultation

The version provided on installation is then set up to adapt to users' habits.  
Traditionally, the original version is as follows:

<b>Administrative</b> 	<p>This tab gathers “administrative” data concerning the patient and the scheduled surgery.</p> <p>If the “patient movement” interface is installed, components relating to the patient’s identity are completed automatically. If the “Theatre schedule” interface is installed, components relating to the scheduled surgery, data and surgeon name are also completed automatically.</p>
<b>Medical history/Treatments</b> 	<p>This tab is generally used to enter the patient’s history and current treatments.</p>
<b>Clinical exams</b> 	<p>This tab is often used to track information collected during the consultation.</p>
<b>Paraclinical</b> 	<p>By default, this tab presents components used to establish prescriptions for laboratory tests, print them, and indicate/show results.</p> <p>If a laboratory interface is installed, laboratory results can be viewed directly.</p>
<b>Conclusion/Visit</b> 	<p>This tab is used to enter information on recommendations given to be patient and the conclusion of the consultation.</p>
<b>Ambulatory</b> 	<p>This tab is used to enter the phases before and after the patient’s ambulatory care. Interaction with the <b>Ambucare</b> module is possible. This tab can be used by nurses coordinating the care plan.</p>
<b>Misc.</b> 	<p>This module is generally used to ‘store’ components. In the <b>DIANE ANAESTHESIA Consultation</b> app, a component cannot be created or deleted. Instead, it is moved to a stock tab. This tab can be renamed and made visible if an additional tab is required.</p>
<b>Free 1</b> 	<p>This module is generally used to ‘store’ components. In the <b>DIANE ANAESTHESIA Consultation</b> app, a component cannot be created or deleted. Instead, it is moved to a stock tab. This tab can be renamed and made visible if an additional tab is required.</p>
<b>Free 2</b> 	<p>This module is generally used to ‘store’ components. In the <b>DIANE ANAESTHESIA Consultation</b> app, a component cannot be created or deleted. Instead, it is moved to a stock tab. This tab can be renamed and made visible if an additional tab is required.</p>
<b>Accounting</b> 	<p>This tab cannot be modified. It is connected to the <b>DIANE</b> accounting module. It can be hidden if not in use.</p>
<b>Summary</b> 	<p>This tab comprises components synchronised with the components in other tabs. It provides an overview of the consultation.</p>
<b>Documents</b> 	<p>This tab lists any saved Summaries, Prescriptions, Scans or Images. The tooth chart in this tab can be replaced by the tooth chart component to great effect.</p>
<b>Browser</b>	<p>This tab contains a component used to display website or intranet pages,</p>



such as some online medical tools.

### Treatments and premedications



and

This tab can be used to replace the **Treatments** and **Relay** components on the **History / Treatment** tab.


#### 3.1.2.1.1 Configure tabs

To access tab settings, right-click the tab header or on the tab (not on a component).

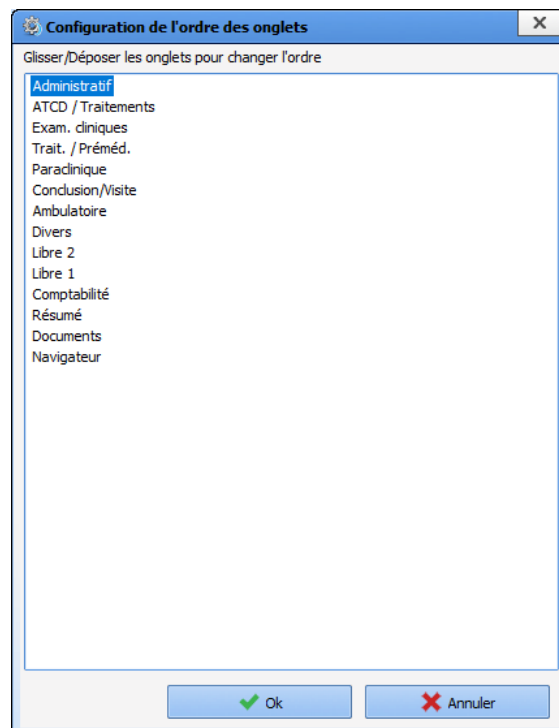
The **Visible** option is used to determine whether or not the tab is visible to the user. In order to guide the user, the name should be changed to match the content. ("**Name**" row).

Description du paramètre	Valeur du paramètre
<b>Tbs_Administratifs (Onglet)</b>	
<b>Positionnement / Affichage</b>	
Visible	Oui
<b>Intitulé</b>	
Intitulé	Administratif
<b>Options d'affichage du contenu</b>	
Couleur de fond du composant	0
Taille de la police	10



Click  at the top left of the screen to change the tab display order.

Drag and drop the tabs into the required order. Once this has been done, click **OK** to return to the consultation display settings window.



### 3.1.2.2 Components available for use in consultation

The available components for consultation are as follows:

- Check box
- Check box group
- One-line input field
- Multi-line input field
- Drop-down menu
- Radio button group
- Input field with reference list
- Button
- Label
- Laboratory results component

#### 3.1.2.2.1 Reminder of settings for each component

For more details see *Components found in all modules*.

##### Settings to configure:

- Visible (yes or no)
- Parent tab (tab showing the component)
- Tab order (once tab settings are completed)
- Name (of component)
- Field importance level (**Normal**, **With warning** 🟢, **Important** 🟠 or **Mandatory** 🔴)
- Retrieval level:
  - Never retrieved**
  - Level 1** (example: history = does not change)
  - Level 2** (example: height = little change)
  - Level 3** (example: weight = much change)

For check boxes, check box groups, drop-down menus and radio button groups:

- Possible values (drop-down menus, check box groups, radio button groups)  
**Key1=Value1 || Key2=Value2 || ... ||**  
**KeyX** can be one or more letters (without spaces) or a number  
**ValueX** is the option the user has selected  
**Use [AltGr] + 6 to obtain the two |**



For check boxes, drop-down menus and radio button groups:

- Context to update

For check box groups and radio button groups:

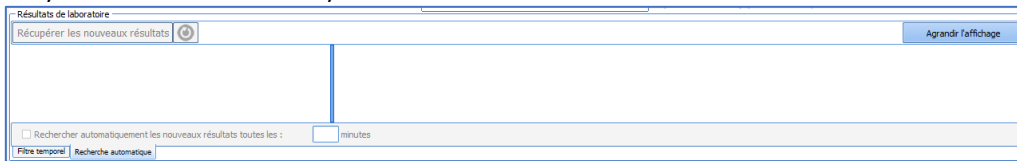
- Column orientation (Vertical=V or Horizontal=H)
- Number of columns
- Show "Other" (if selected, this option adds an "Other" choice to allow the user to enter text with further information)

Data type must be set to **Normal: Mother** and **Child** are used for the **DIANE OB-GYN** module.



### 3.1.2.2 Lab results component

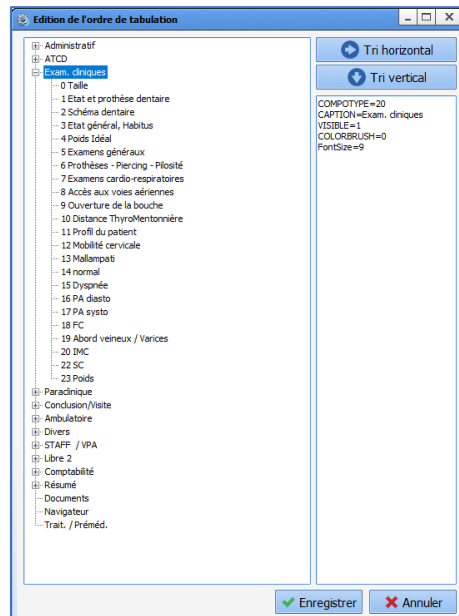
Settings for this component are not available. They are applied by the BOWMEDICAL interface service. Only the size and location may be modified.



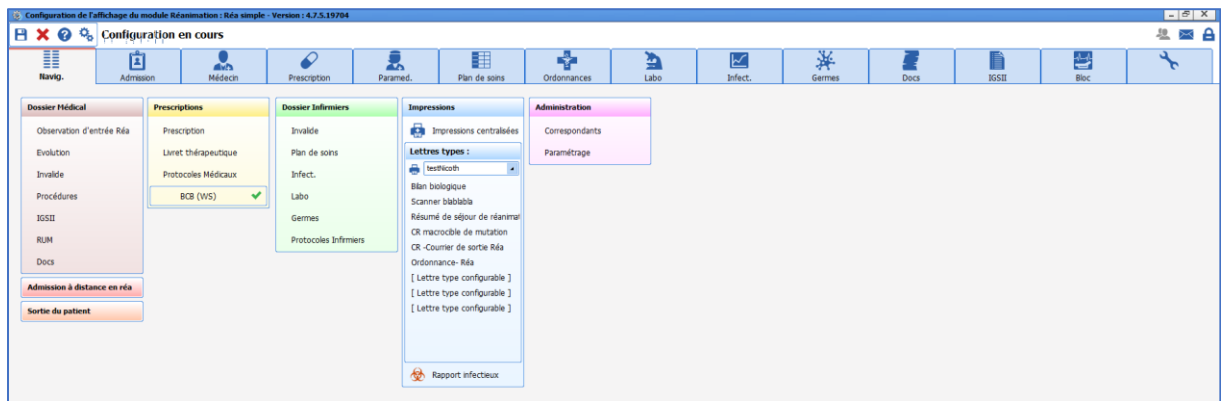
### 3.1.2.3 Managing component tab order

Component tab order within the tab is managed AFTER the tab has been fully configured.

- Open the component settings window
- Select **Tab order**
- Click on the button at the end of the row
- Open the tab to be put in order
- Take each component in the list and position it using drag and drop
- Click **SAVE** at the bottom of the window



### 3.1.3 Specifics of ICU

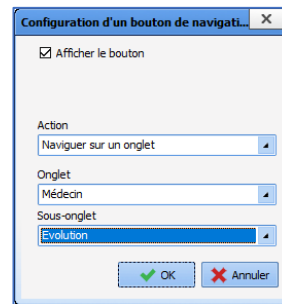


The **Navigation** tab is only used by the ICU module. It comprises panels of configurable links. In configuration, all links are visible: links that are not visible during use are shown in italics.

Left-click the link to configure the buttons. A button can be displayed or not, and its action configured.

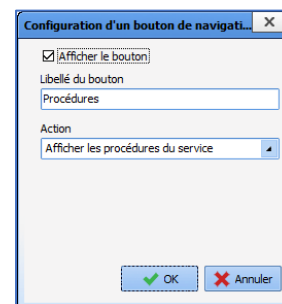
#### 3.1.3.1 Browse a tab

This is a shortcut to another tab in the module, and potentially a subtab if available.



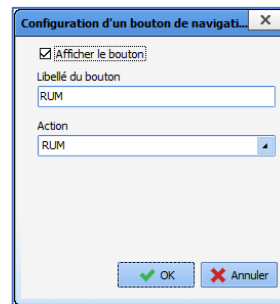
#### 3.1.3.2 View unit procedures

This action opens the **Procedures** window. The unit procedures concerned can be configured in "**Resources | Procedures (\*.rtf)**".



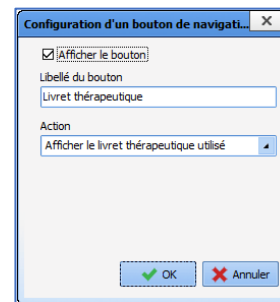
### 3.1.3.3 RUM

This action opens the ICD-10 and Procedure code entry form.



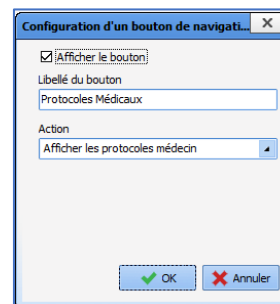
### 3.1.3.4 View formulary used

This action opens the formulary.



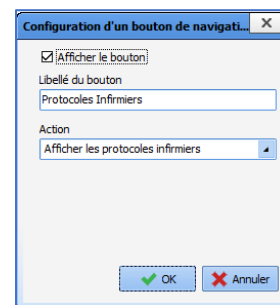
### 3.1.3.5 View doctor protocols

This action opens the **Medical protocols** window.  
The unit procedures concerned can be configured in "**Resources | Medical protocols (\*.rtf)**".



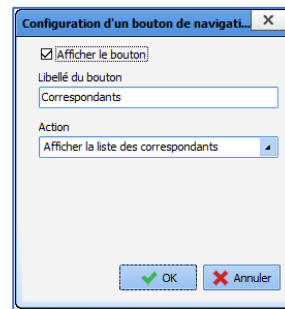
### 3.1.3.6 View nursing protocols

This action opens the **Nursing protocols** window.  
The unit procedures concerned can be configured in "**Resources | Nursing protocols (\*.rtf)**".



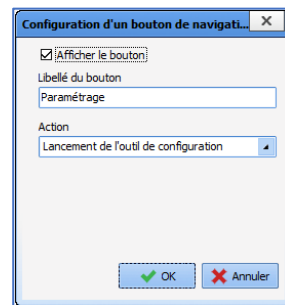
### 3.1.3.7 View list of matches

This action opens the configuration module.  
This link is only visible and available to DIANE experts.

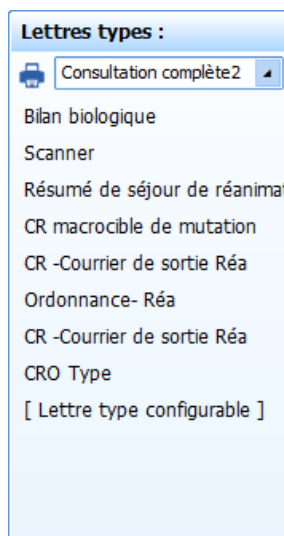


### 3.1.3.8 Launching of the configuration tool

This action opens the configuration module.  
This link is only visible and available to DIANE experts.




### 3.1.3.9 Form letters

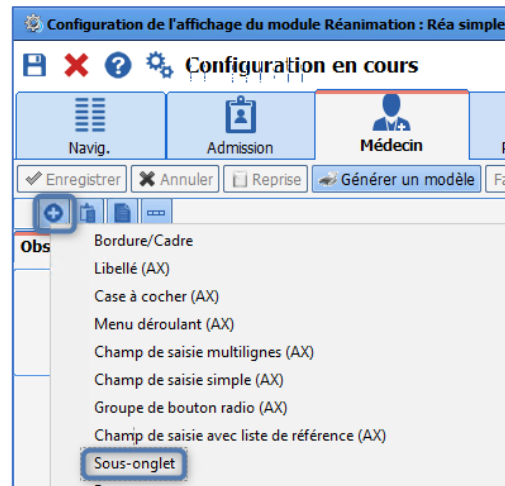


Used to preview and/or print the available form letters.

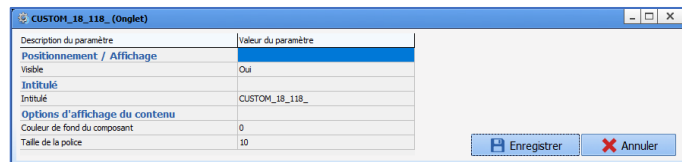
Shortcut buttons to launch printing for the most frequently used form letters.

### 3.1.4 Add a subtab

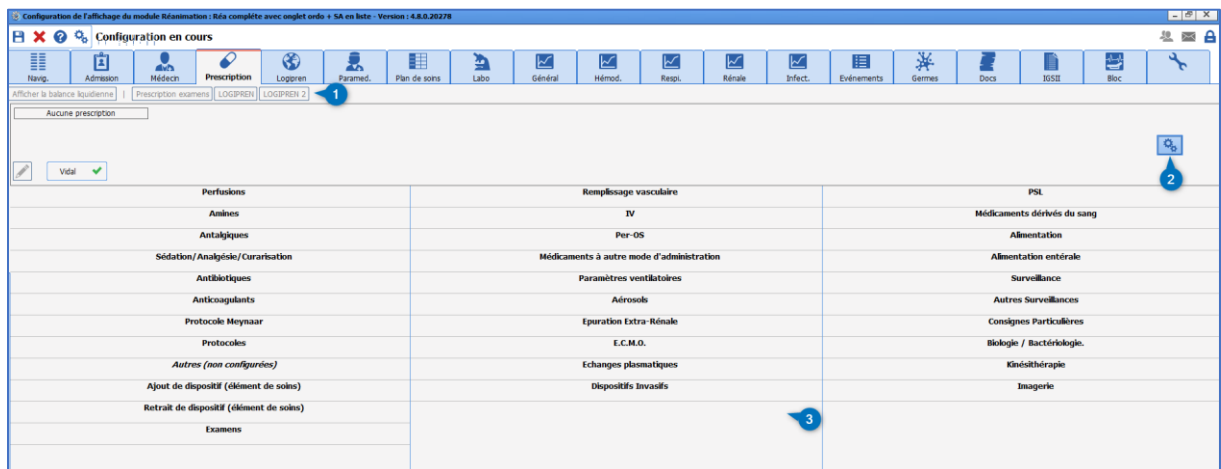
In some tabs (except for **Consultation**), it is possible to create a subtab by clicking  and selecting **Subtab**.



The window opposite appears. The subtab name should be entered in the row: **Name** instead of CUSTOM\_18\_118\_.




### 3.1.5 Medication Orders tab

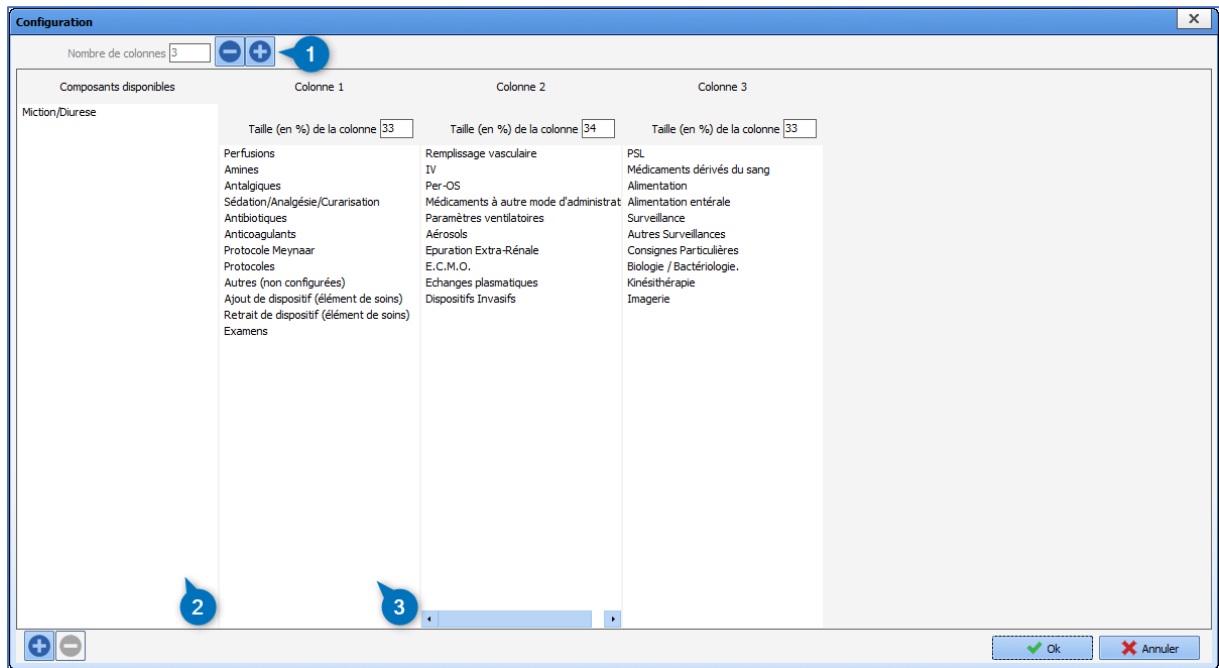


Pane 1 corresponds to the buttons set up in the **Configuration** tab. The button  (2) is used to configure the appearance and operation of the **Medication order** tab.


Pane 3 shows the display as it will appear to the user.

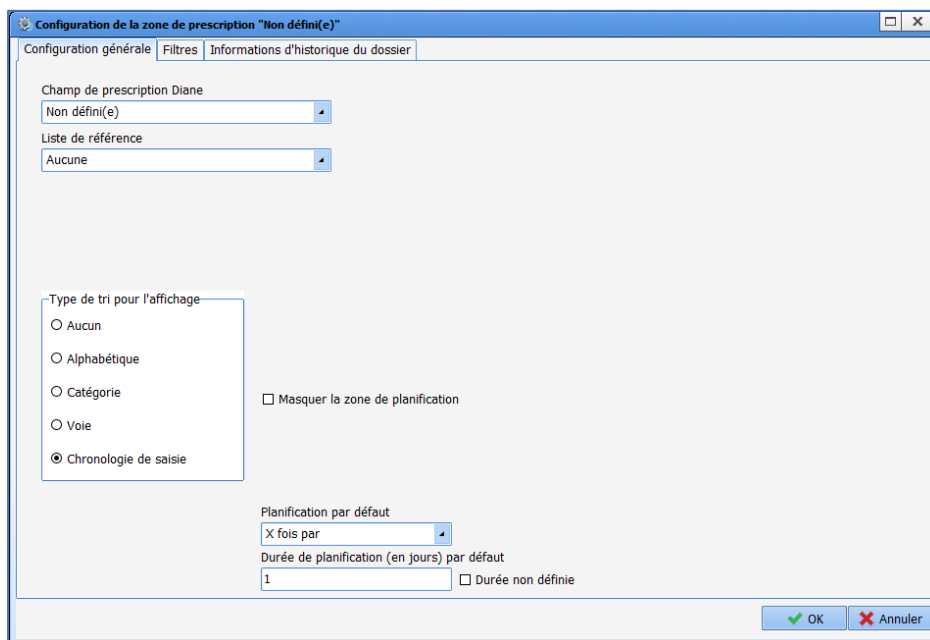
#### 3.1.5.1 Configuration of the medication order category table

The number of columns and order of items on the **Medication order** tab can be configured using the  button on the **Medication order** tab.



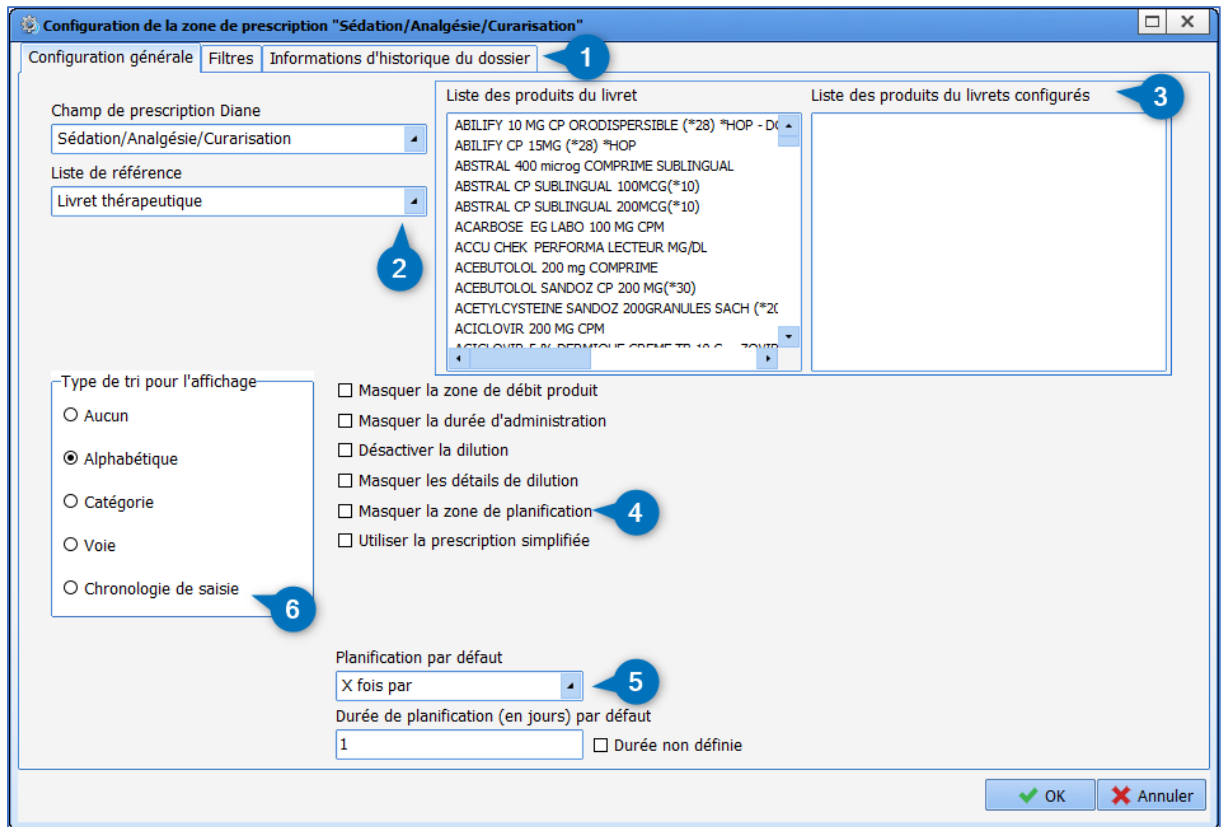
Pane 1 is used to define the number of columns required (3 by default). If this number is lowered, the components in the deleted columns are automatically moved to the list of available components (pane 2). The components selected can be moved in pane 3 using drag and drop. To add an available component, it must be moved to pane 3 using drag and drop.

New medication order components can be created by clicking  at the bottom right. The following window appears:

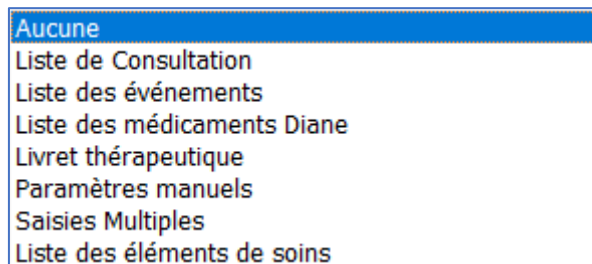


### 3.1.5.2 Configuration of a medication order category

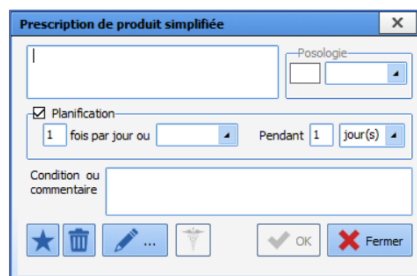
To edit an existing medication order category, double-click the name.



1. Configuration window tabs
2. DIANE medication order field

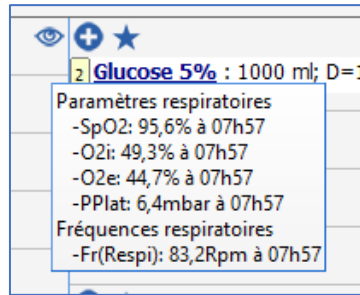


3. List of products (for the **Formulary** reference list), list of vital signs and drugs (for the **Manual vital signs** reference list) or list of multiple entries (for the **Multiple entries** reference list)
4. Configuration of the medication order window appearance  
The **Use the simplified medication order** option shows a medication order window that is better adapted to **oral** treatments.

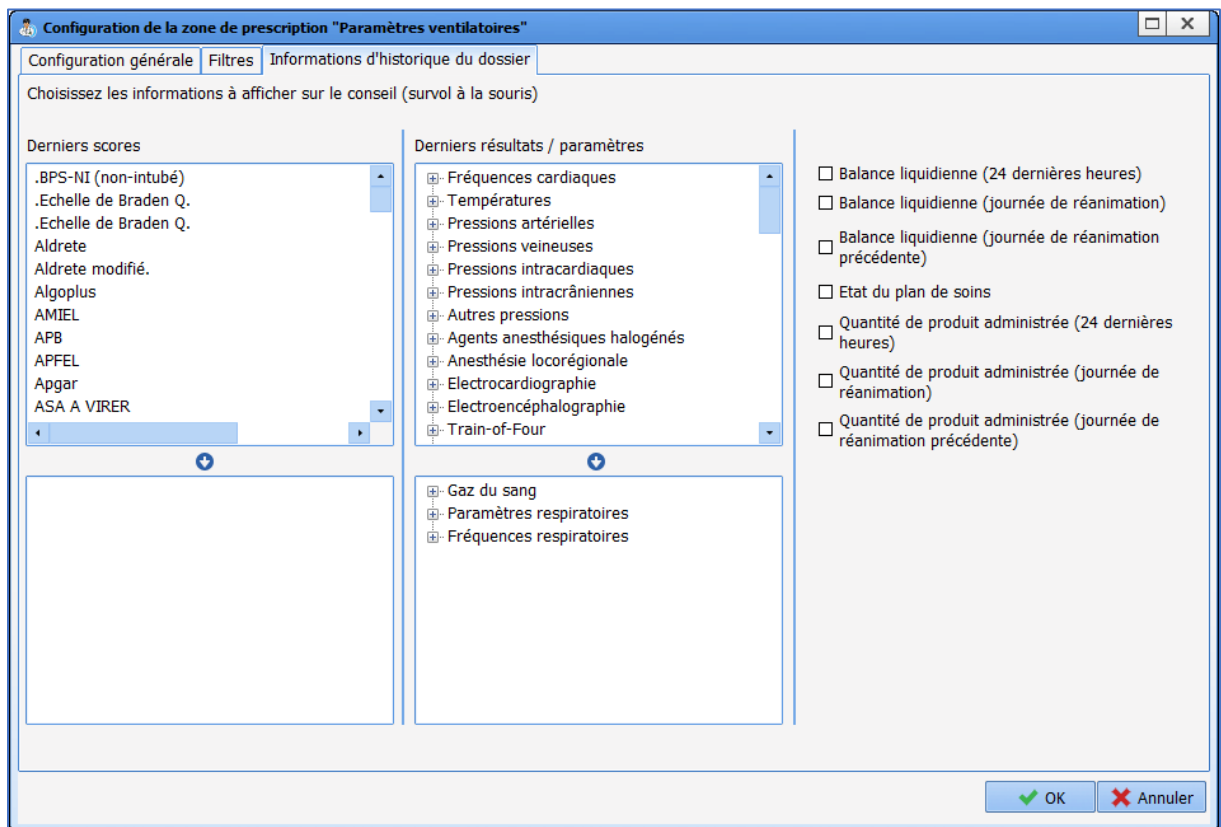


5. Default scheduling
6. Sort type for display

The data shown when hovering over the eye can be set up in the **Record history information** tab.



The scores, results and vital signs to be displayed are moved into the lower part of the screen with drag and drop.

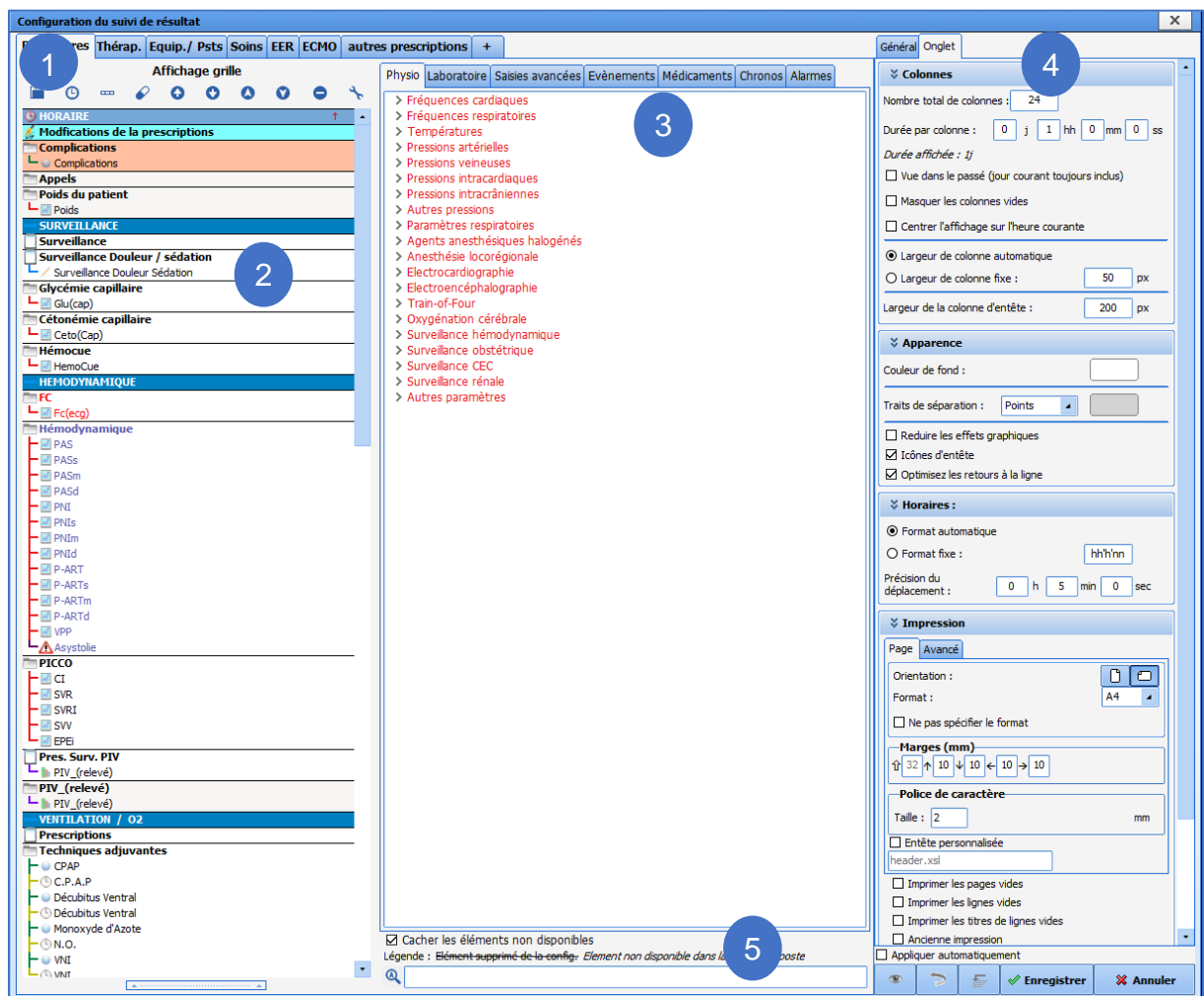
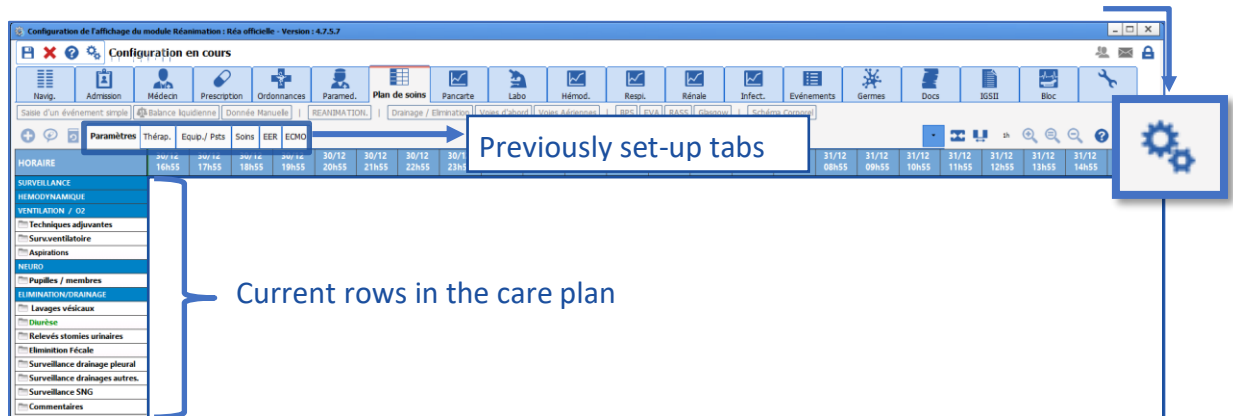




## 3.1.6 Care plan


### 3.1.6.1 Care plan settings

Access care plan settings using the gears (top right)











1. Vital signs tab.  
Right-clicking allows the tab to be modified

- ✕ Supprimer l'onglet
- 📄 Dupliquer l'onglet
- 🏷️ Renommer l'onglet
- ◀️ Déplacer l'onglet à gauche
- ▶️ Déplacer l'onglet à droite

The  button on the right of the tabs can be used to create a new one.

2. Configured rows in the selected tab.
3. Configurable items grouped by category.
4. Line, tab and care plan settings (General).
5. Search box for an item in the configurable list.

Several buttons are used to set up the display:

	Add a data row
	Add a schedule row
	Add a separator line
	Add medication orders => import all categories of medication order (see <a href="#">Treatment</a> tab)
	Move up/down
	Move to top/bottom
	Delete the selected row
	Reset row colours

### 3.1.6.1.1 General tab

Used to set up the general care plan display. The different colours can be changed and may differ depending on the settings chosen.

#### Medication order plan:

**Plan de prescriptions :**

Normal Urgent

#### Colour of Statuses of ordered items:


**Couleurs d'état des éléments prescrits :**

A faire    Action à réaliser    Réalisé    Non réalisé    En Pause    Non documenté

#### Edited medication orders:

**Prescriptions modifiées**

Distinguer les saisies de prescriptions modifiées par un médecin dans les : 3 dernières heures

When a medication order is edited, the relevant care plan rows are identifiable thanks to the  icon.

#### Move authorised:

**Déplacement autorisé :**

Première occurrence à faire

Aucun déplacement

Première occurrence à faire

Status validation not completed:

**Validation de l'état non réalisé :**

Commentaire obligatoire

Commentaire possible (non obligatoire)

Commentaire désactivé

Commentaire obligatoire

Automatic saving:

**Sauvegarde automatique :**

Après chaque modification

Automatiquement toutes les  minute(s)

Format de fichier :

Mode Login Mot de passe

file

Passive mode (FTP)

Export vers... Masque de fichier

\\share-server\dossiers\an: PlanDeSoin\_<PATIENTNOM

Indure  jour(s) passé(s) et  jour(s) futur(s)

Provisions:

**Dispositions :**

Onglets à gauche, horizontal

Boutons d'actions à droite

Onglets à gauche, horizontal

Onglets à gauche, vertical

Onglets en haut, horizontal

Onglets en bas, horizontal

Onglets à droite, horizontal

Onglets à droite, vertical

Boutons d'actions à droite

Boutons d'actions à droite (intérieur)

Boutons d'actions à gauche

Boutons d'actions à gauche (intérieur)

Boutons d'actions en haut

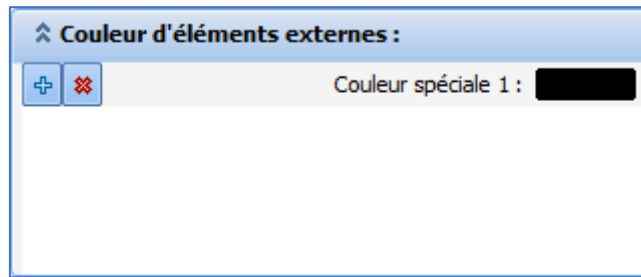
Boutons d'actions en bas

Items with a duration:

**Éléments saisis présentant une durée :**

Terminé En cours

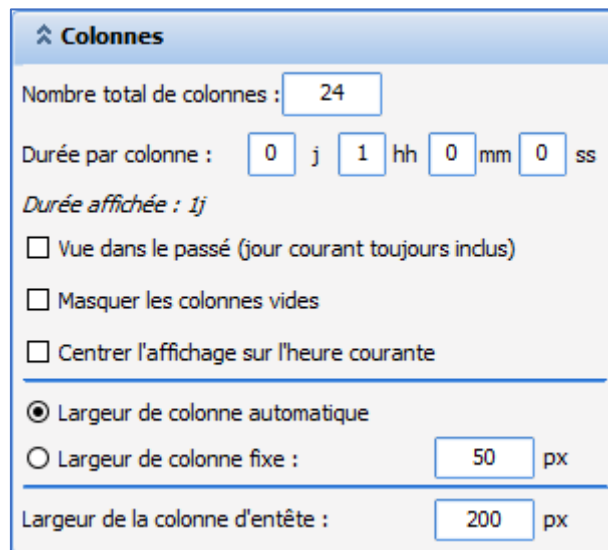
Colour of external items:



### 3.1.6.1.2 Tab tab

Used to set up the display of each tab.

#### Columns:

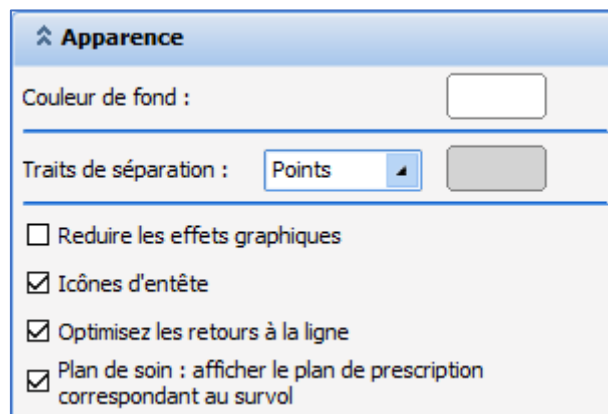


The **Columns** area is used to choose the number of columns to display and the duration associated with a column.

**Hide empty columns:** Used to hide columns with no content.

**Centre the display on the current time:** moves the current time to the centre of the tab display

#### Appearance:

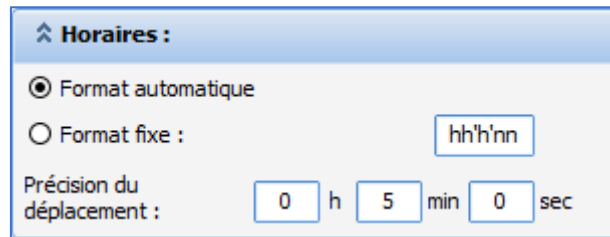


**Background colour:** Not used

**Separators:** Used to select the appearance of column separators. They can be shown as dots, continuous lines or none. The separator colour can be personalised.

**Header icons:** If selected, the icon for the relevant data is shown at the start of each row.

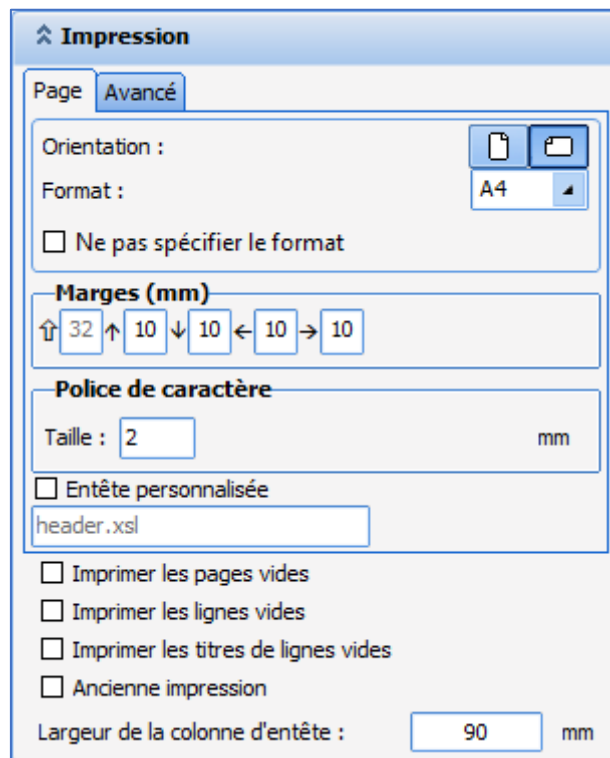
## Times:



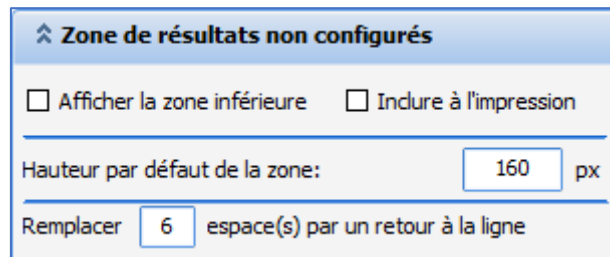
Used to select whether times are shown in automatic format (the smaller the time interval displayed, the more precise the time) or in fixed format.

**Movement precision:** used to select how precisely an occurrence on the care plan should be rescheduled when moved using drag-and-drop.

## Printing:



## Unconfigured results area:



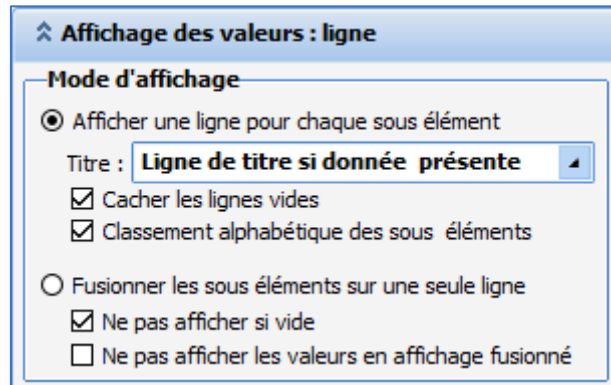
### 3.1.6.1.3 Row tab

Tab only available is a row has already been selected.

## Value display: columns

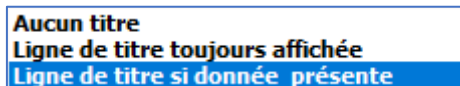


Value display: rows



Used to select a row display for each item or merged display for sub-items.

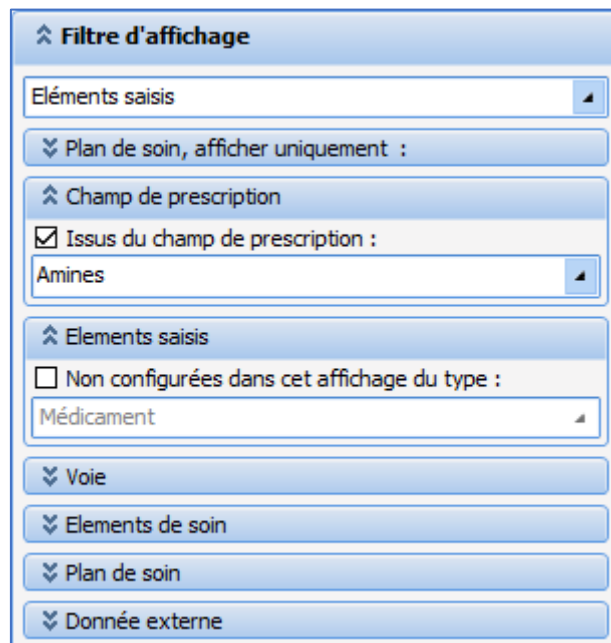
If a user chooses row display for each sub-element, the drop-down menu **Title** can be used to select whether or not the row title should be displayed. **Row name always displayed** allows manual entry. No title does not allow manual entry.



It is possible to hide empty rows (select **Hide empty rows**).

The **Alphabetical display of sub-items** check box is used to sort items in a category in alphabetical order. If not selected, items are shown in the order in which they were added.

Display filter:



Area used to select the information to be shown in the row.

The top drop-down menu contains the following data:

Eléments saisis
<b>Plan de prescription</b>
Plan de soin
Planification infirmière
Voie
Donnée externe
Element de soin

- **Items entered:** Used to select whether or not to show items entered.

⤴ **Filtre d'affichage**

Eléments saisis

⤴ Plan de soin, afficher uniquement :

⤴ Champ de prescription

Issus du champ de prescription :

Amines

⤴ Elements saisis

Non configurées dans cet affichage du type :

Médicament

⤴ Voie

⤴ Elements de soin

⤴ Plan de soin

⤴ Donnée externe

- **Medication order plan:** Used to select whether or not to show the medication order plan associated with a selectable medication order field in the drop-down menu **Taken from medication order plan**.  
Note: this mode cannot be used to validate occurrences. It is only used to display medication orders.

⤴ **Filtre d'affichage**

**Plan de prescription**

⤴ Plan de soin, afficher uniquement :

⤴ Champ de prescription

Issus du champ de prescription :

Amines

⤴ Elements saisis

⤴ Voie

⤴ Elements de soin

⤴ Plan de soin

⤴ Donnée externe

- **Care plan:** Used to select whether or not to show the care plan and medication order plan associated with a selectable medication order field in the drop-down menu **Taken from medication order plan**.

The **Care plan items to be carried out** and **that are overdue** check boxes are accessible. The check box “Not configured in this standard display” is not selected and greyed out.



^ **Filtre d'affichage**

Plan de soin

^ Plan de soin, afficher uniquement :

Les éléments de plan de soin à réaliser  
 qui sont en retard

v Champ de prescription

v Elements saisis

v Voie

v Elements de soin

^ Plan de soin

**Filtre 1**

Champ de prescription

Alimentation  
 Alimentation entérale  
 Alimentation entérale (LGP)  
 Alimentation parentérale  
 Amines  
 Analgésie  
 Analgésie Locorégionale  
 Analgésie systémique  
 Analgésie/Sédation/Curares (LGP)  
 Antalgiques  
 Antalgiques/Analgésie

**Filtre 2**

Voie

intrapéricardique  
 intrapéritonéale  
 intrapleurale  
 intrathécale  
 intratumorale  
 intra-utérine  
 intraveineuse  
 intraveineuse (en perfusion)  
 intraventriculaire  
 intravésicale  
 intravitréenne

**Filtre 3**

Codes ATC

Code ajouté (niveau parent)  
 Code ajouté implicitement (sous niveau)  
 Code non ajouté, mais ayant un sous niveau ajouté  
 Code non ajouté, sans sous niveau ajouté

C - systeme cardiovasculaire

C01 - médicaments en cardiologie

C01A - glucosides cardiotoniques  
 C01B - antiarythmiques, classe i et iii  
 C01C - stimulants cardiaques, glucoside  
 C01D - vasodilatateurs en cardiologie  
 C01E - autres médicaments en cardiolo

C02 - antihypertenseurs  
 C03 - diurétiques  
 C04 - vasodilatateurs périphériques

Ajouter     Retirer    Lister

v Donnée externe

Several display filters are available and applicable by row: Medication order field, Method of administration and ATC code.

It is therefore possible to have a display that is decorrelated from the medication order which is not set on the Medication order fields.

### How is this display set up?

Take the example of a display row only containing OPIOIDS, prescribed from the IV medication order field.

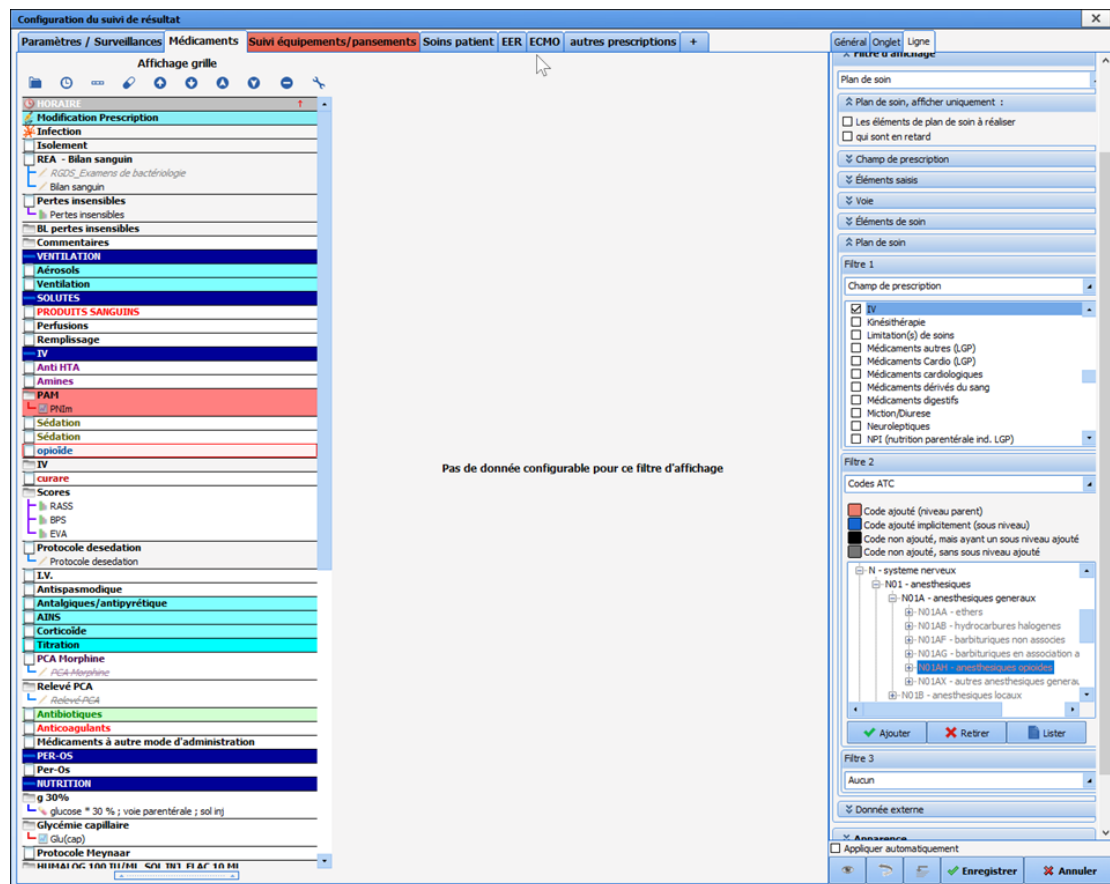
To do this:

Display filter: select **Care plan**

Filter 1: select **Medication order field**

Filter 2: select **ATC class**. Then select the category to be displayed.

Once this is done, for the display row only referencing the IV medication order field, “Opioids” must be excluded for this row to avoid duplicate displays.



- **Nurse schedules:** Used to show nurse schedules.

^ Filtre d'affichage  
 Planification infirmière  
 Plan de soin, afficher uniquement :  
 Champ de prescription  
 Elements saisis  
 Voie  
 Elements de soin  
 Plan de soin  
 Donnée externe

- **Method of administration:**

^ Filtre d'affichage  
 Voie  
 Plan de soin, afficher uniquement :  
 Champ de prescription  
 Elements saisis  
 Voie  
 Normale (courte)  
 Elements de soin  
 Plan de soin  
 Donnée externe

- **External data:** Used to display external data from those that can be selected in the drop-down menu Source under the **External data** section: **External care plan (Maincare) / PN13 file / External care plan (Logipren)**

^ Filtre d'affichage  
 Donnée externe  
 Plan de soin, afficher uniquement :  
 Champ de prescription  
 Elements saisis  
 Voie  
 Elements de soin  
 Plan de soin  
 Donnée externe  
 Source      Regroupement  
 Aucune

- **Care item::** Display care scheduled using the body diagram. The category of care item to be displayed is selected in the **Care item** drop-down menu from the following options: **Ports / Drains / Dressings / Other**.

**^ Filtre d'affichage**

Element de soin

Plan de soin, afficher uniquement :

Champ de prescription

Elements saisis

Voie

^ Elements de soin

**Voies d'abord**

Plan de soin

Donnée externe

**Appearance:**

**^ Apparence**

Mode d'affichage :

Texte

Apparence

Texte : [Color swatch] [Icon]

Fond : [Color swatch]

Donnée affichée dans les cellules :

Aucun  Heures  Utilisateur

Noms  Valeurs  Détail

**Valeurs présentant une durée :**

Affichage des libellés : Toutes les valeurs

- **Display mode:** used to select the display mode of the data.

Texte

Texte et courbe

Icône

- **Appearance:** used to define the font, font colour and background colour of the row.
- **Data shown in cells:** used to configure information to be shown for occurrences. The option **None** takes precedence over other options.
- **Values with a duration:** used to show or hide all values or just those in progress.

Toutes les valeurs

Valeurs en cours uniquement

**Misc.:**

⤴ **Divers**

- Afficher le nom de l'élément parent (si applicable)
- Données saisies de même couleur que les éléments réalisés
- Afficher l'unité de chaque valeur
- Afficher l'unité de la dernière valeur reçue dans l'entête
- Afficher le détail du dernier élément de plan de soin dans l'entête
- Afficher le volume (plan de soin et saisies de médicament)
- Elements de soins : afficher sous forme de chronomètre

**Printing:**

⤴ **Impression**

Donnée imprimée dans les cellules :

Aucun  Heures  Utilisateur

Noms  Valeurs  Détail

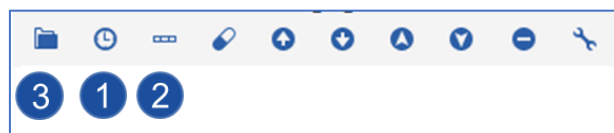
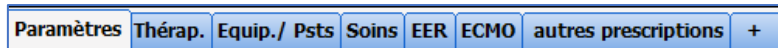
Imprimer le détail en annexe si le texte dépasse :  caractères

Intercaler la prescription avec le plan de soin

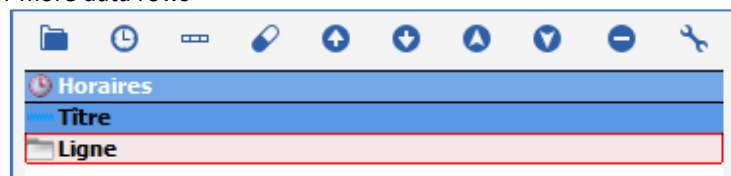
Placer les annexes en dessous de la ligne

### 3.1.6.2 Adding a new tab

To add a new tab to the care plan, click **+** to the right of the existing tabs and name the new tab.



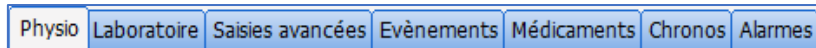
1. Start by adding a time row.
2. Add a separator line
3. Add one or more data rows



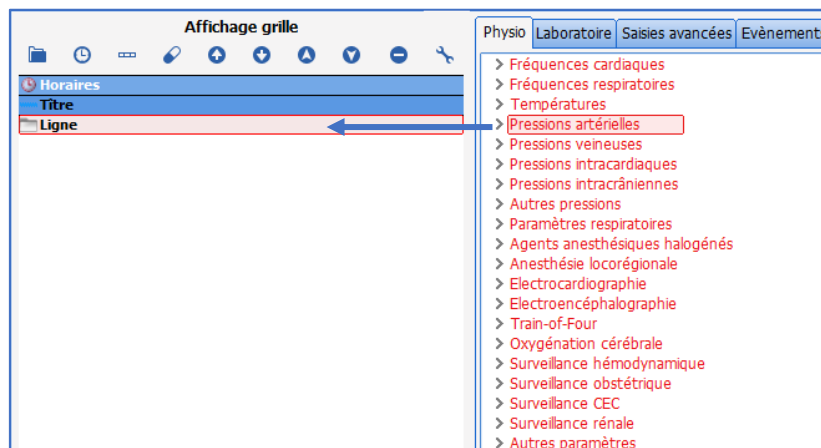
#### 3.1.6.2.1 Creating an entered item row

The default data row type is **Entered item**.

This type of row is used to show (using drag and drop) an item selected from vital signs, laboratory data, detailed entries, events, drugs, timers or alarms.



For example, to create a row showing the scope AP, the arterial pressure group must be drag-and-dropped into the row.



The same procedure is used for lab results, detailed entries, events, etc.

### 3.1.6.2.2 Creating a Care plan row

This type of row is used to show medication orders by category (medication order field)

*For example: amines*

^ Filtre d'affichage  
 Plan de soin  
 ^ Plan de soin, afficher uniquement :  
 Les éléments de plan de soin à réaliser  
 qui sont en retard  
 v Champ de prescription  
 v Éléments saisis  
 v Voie  
 v Éléments de soin  
 ^ Plan de soin

Filtre 1  
 Champ de prescription  
 Amines  
 Analgésie  
 Analgésie Locorégionale  
 Analgésie systémique  
 Analgésie/Sédation/Curares (LGP)  
 Antalgiques  
 Antalgiques/Analgésie  
 Antibio./Anti-infectieux  
 Anticoagulants  
 Anticoagulants/antiagrégants  
 Antidotes

Filtre 2  
 Aucun

Filtre 3  
 Aucun

v Donnée externe



NB: only the categories configured in the **Medication order tab** may be used.

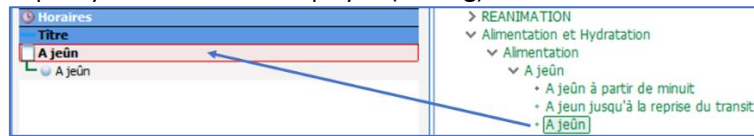
**Specific cases:**

1. Event medication orders:

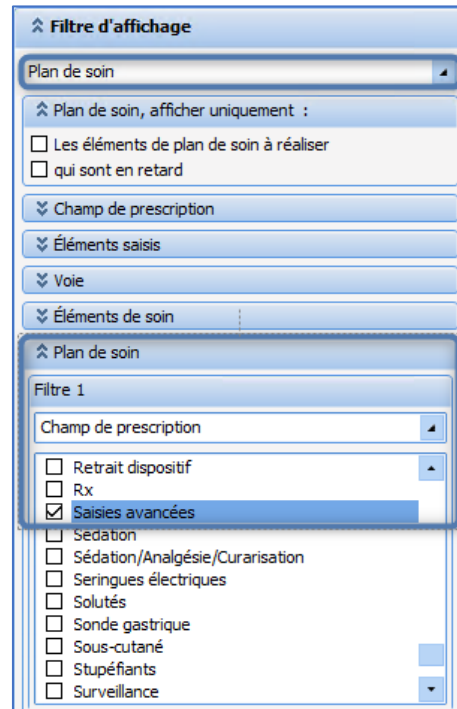
^ Filtre d'affichage  
 Plan de soin  
 ^ Plan de soin, afficher uniquement :  
 Les éléments de plan de soin à réaliser  
 qui sont en retard  
 v Champ de prescription  
 v Éléments saisis  
 v Voie  
 v Éléments de soin  
 ^ Plan de soin

Filtre 1  
 Champ de prescription  
 Aérosols  
 Alimentation  
 Alimentation entérale  
 Alimentation entérale (LGP)  
 Alimentation parentérale  
 Amines  
 Analgésie  
 Analgésie Locorégionale  
 Analgésie systémique  
 Analgésie/Sédation/Curares (LGP)  
 Antalgiques

Example: in the nutrition field, only display the event **Fasting**. Use the middle column, **Event** tab, and drag and drop only what should be displayed (**Fasting**).



2. Detailed entry medication order:



1. The middle column must be used, reading all the available detailed entries and drag and dropping those that are required.

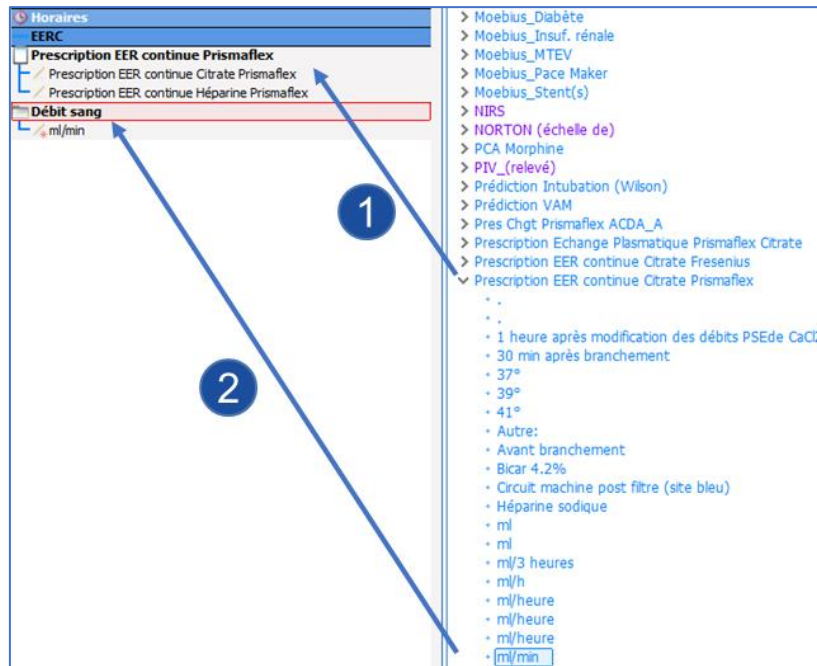
Example: renal replacement therapy medication orders



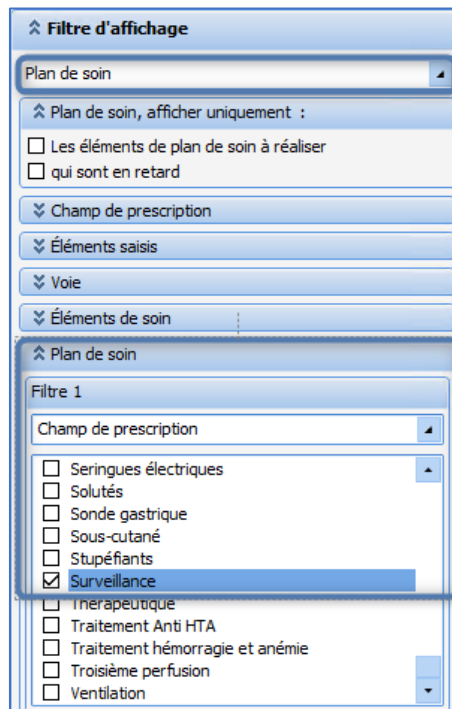
Note: ensure that all configured detailed entries are drag-and-dropped into the **Prescriptions** tab. If the detailed entry is not in the care plan, the medication order will not be shown.

2. It is possible to extract a field from the detailed entry and show it in a new row.



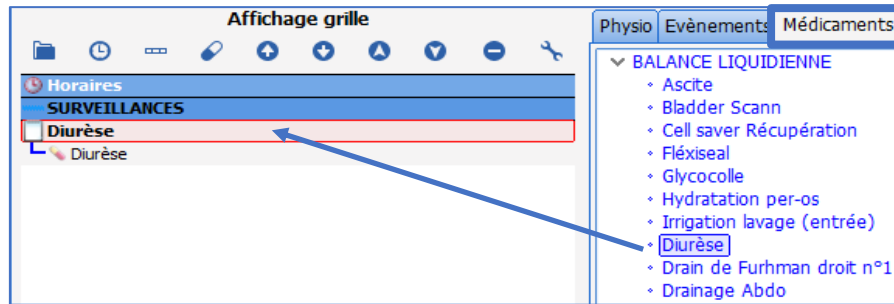


### 3. Monitoring medication orders:



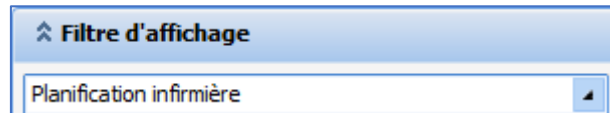
Used to display ALL monitoring prescribed (vital signs AND fluid balance).

It is possible to show only fluid balance monitoring (diuresis, for example) using the central column of the drug tab.

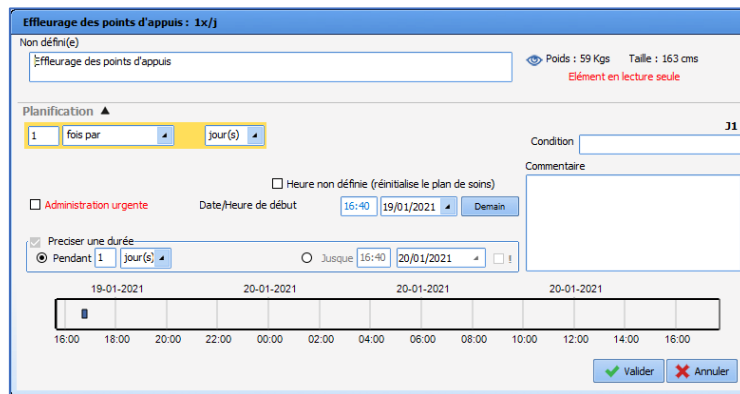


### 3.1.6.2.3 Creating a Nurse scheduling row

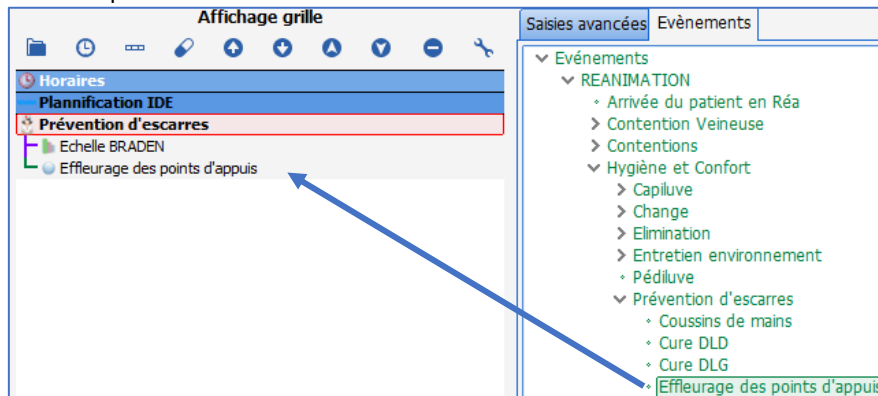
Nurse scheduling concerns detailed entries and EVENTS.



In use, this brings up this window:

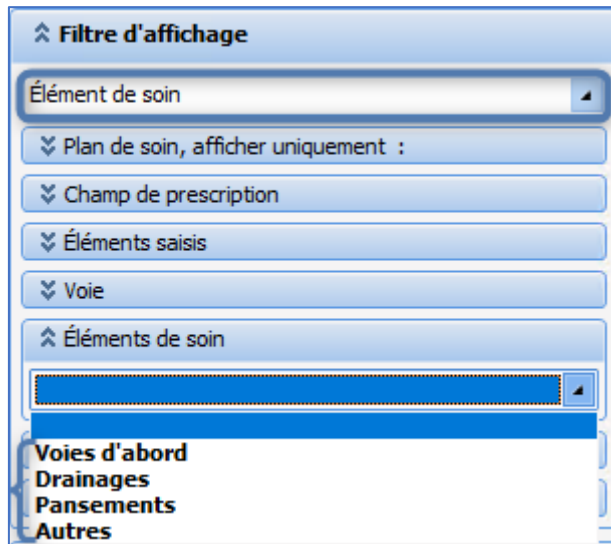


Example: pressure ulcer prevention event and Braden score



### 3.1.6.2.4 Creating a Care items row

This type of row is used to show devices and body diagram monitoring form scheduling.

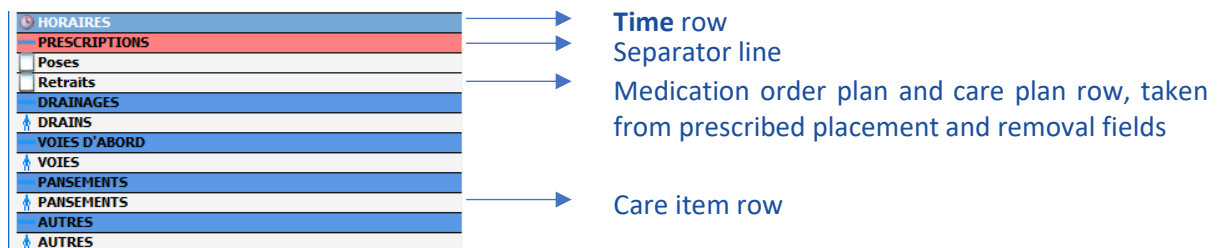


Each row can correspond to a category of care item (Ports, Drains, Dressings and Other). A data row must be configured for each care item type in the care plan display configuration.

If a **Body diagram** tab is created in the care plan, it can be useful to have a Medication order plan and care plan row showing the prescribed placements and removals of devices.

**Example Body diagram tab:**

	07h	08h	09h	10h	11h	12h	13h	14h	15h	16h	17h	18h	19h	20h	21h
<b>PRESCRIPTIONS</b>															
<input type="checkbox"/> Poses															
Voie Veineuse Centrale (VVC)				Pose Voie Veineuse Centrale (VVC)											
<input type="checkbox"/> Retraits															
Voie Veineuse Périphérique (VVP)				Voie Veineuse Périphérique (VVP)											
<b>DRAINAGES</b>															
<b>DRAINS</b>															
<b>VOIES D'ABORD</b>															
<b>VOIES</b>															
Voie Veineuse Centrale (VVC) droite n°2 (2min) 20/01 10h11:45				Pose VVC											Suivi Cathéter
Voie Veineuse Périphérique (VVP) droite n°1 (2h) 20/01 10h16:06		Pose VVP		Ablation KT (ou aiguille de Huber)											
<b>PANSEMENTS</b>															
<b>PANSEMENTS</b>															
<b>AUTRES</b>															
<b>AUTRES</b>															



Display as timers

In the **Display filter** area, the user must select the **Care item** option then select the category of care item to be displayed in the **Care item** drop-down menu.

It is possible to display care items in the form of timers in the care plan. To do this, check the **Display as timer** box under **Misc**. It is only visible for displaying care items:

Afficher le nom de l'élément parent (si applicable)  
 Données saisies de même couleur que les éléments réalisés  
 Afficher l'unité de chaque valeur  
 Afficher l'unité de la dernière valeur reçue dans l'entête  
 Afficher le détail du dernier élément de plan de soin dans l'entête  
 Afficher le volume (plan de soin et saisies de médicament)  
 Elements de soins : afficher sous forme de chronomètre

The list of care items is filled with the different care item types (Ports / Drains / Dressings / Other).

The display for each care item configured to be displayed in the care plan is as follows:

<b>Drainages</b> Drain pleural péricardique Thorax droite n°1; 3h 80 ml					Drain pleural BL=30 ml				Surveillance Drain Pleural
<b>Chronomètres</b>									
<b>Drainages</b> Drain pleural péricardique Thorax droite n°1 80 ml									3h

### 3.1.6.2.5 Creating a Medication order modification row

This row shows the name of the prescriber and the changes they made.

**Filter d'affichage**  
 Éléments saisis  
 Plan de soin, afficher uniquement :  
 Champ de prescription  
 Éléments saisis  
 Non configurées dans cet affichage du type :  
 Signature

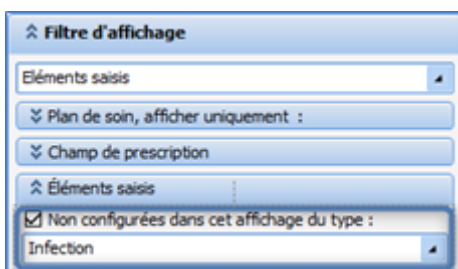
In the view filter, select **Not configured in this display of type:** and select **Signature** in the drop-down menu below.

**Affichage des valeurs : ligne**  
**Mode d'affichage**  
 Afficher une ligne pour chaque sous élément  
 Titre : Aucun titre  
 Cacher les lignes vides  
 Classement alphabétique des sous éléments  
 Fusionner les sous éléments sur une seule ligne  
 Ne pas afficher si vide  
 Ne pas afficher les valeurs en affichage fusionné

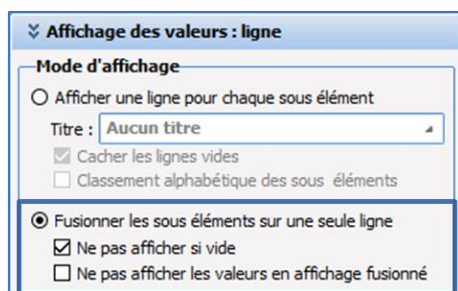
For a better view, selecting the display mode options above is recommended.

### 3.1.6.2.6 Creating an Infections row

This row shows current infections of the patient if they have been entered by the doctor in the **Pathogens** tab.

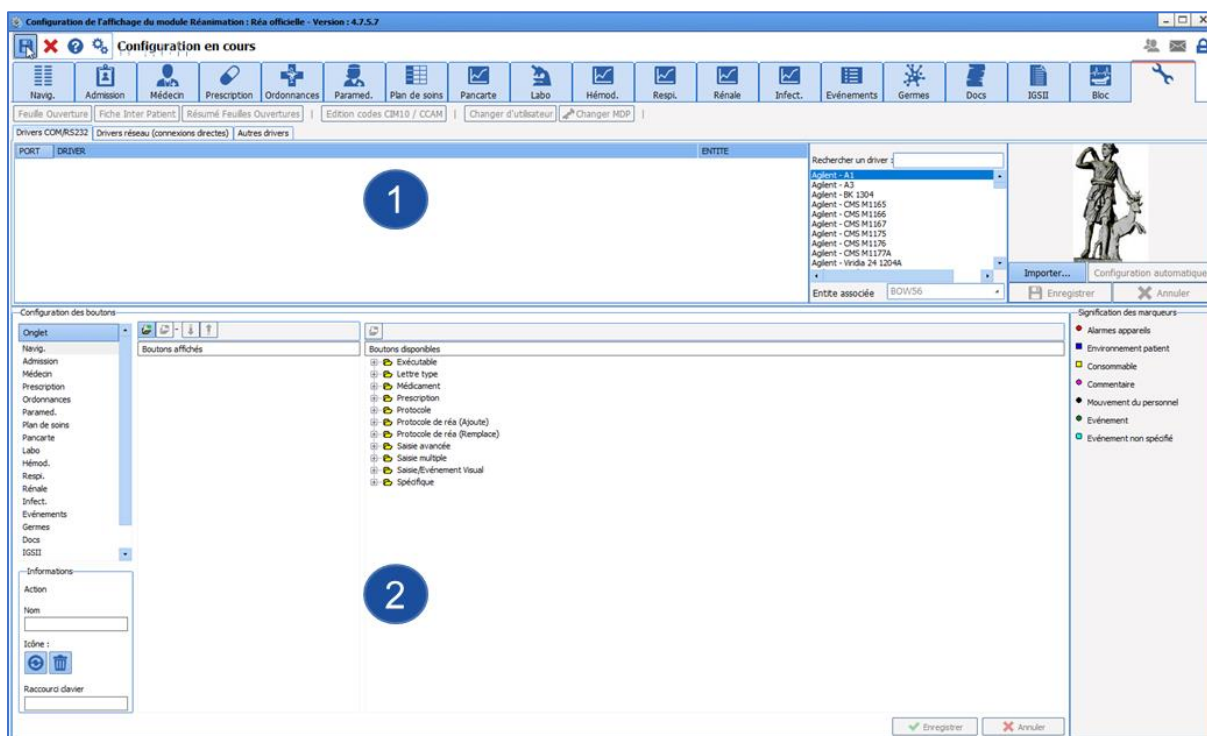


In the view filter, select **Not configured in this display of type:** and select **Infections** in the drop-down menu below.

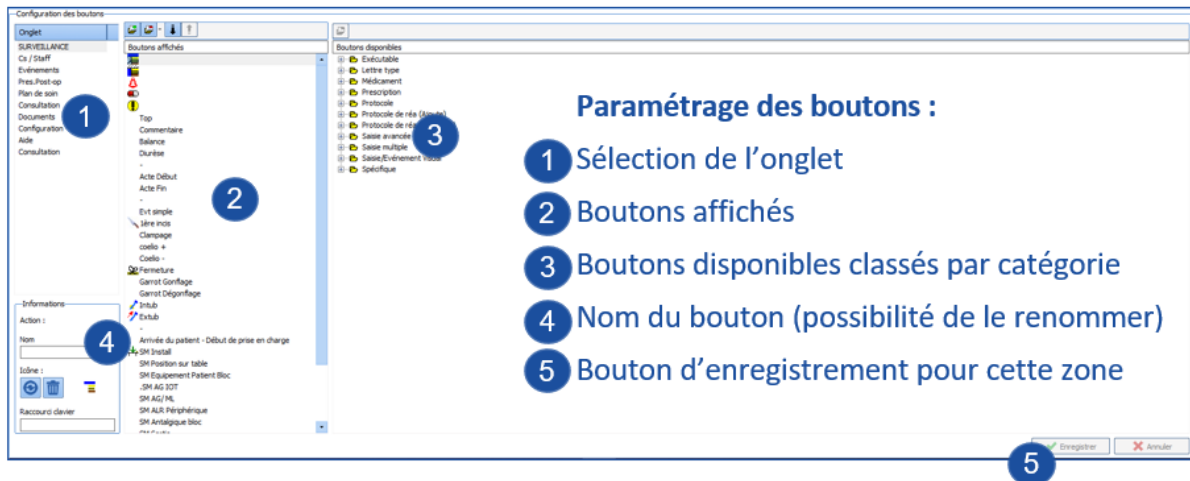


For a better view, selecting the display mode options above is recommended.

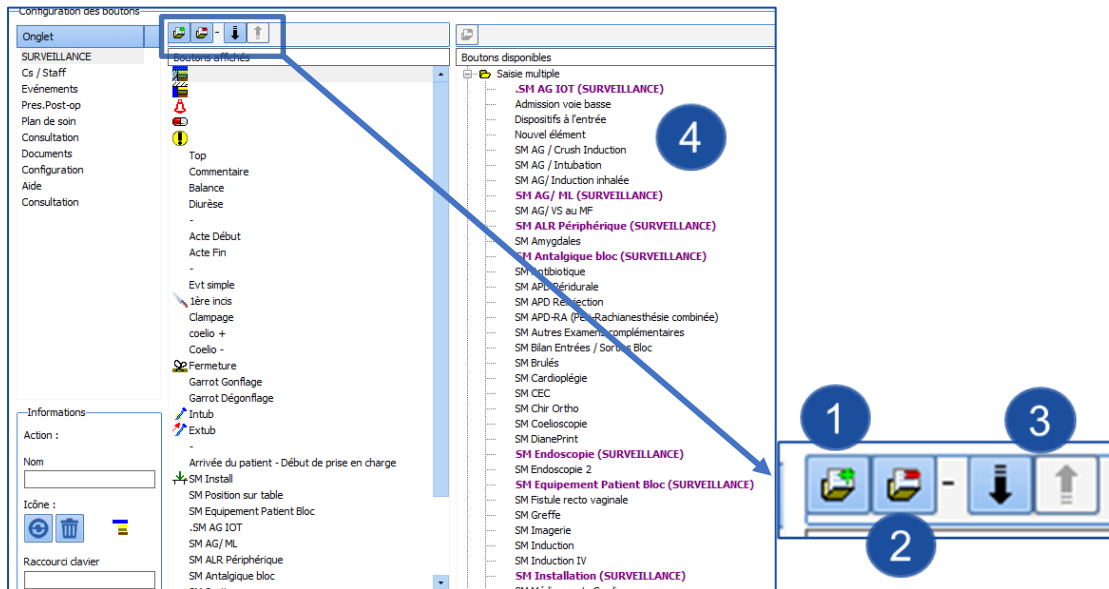
### 3.1.7 Configuration tab



The pane **1** is used to attribute drivers. The pane **2** is used to configure buttons tab by tab.

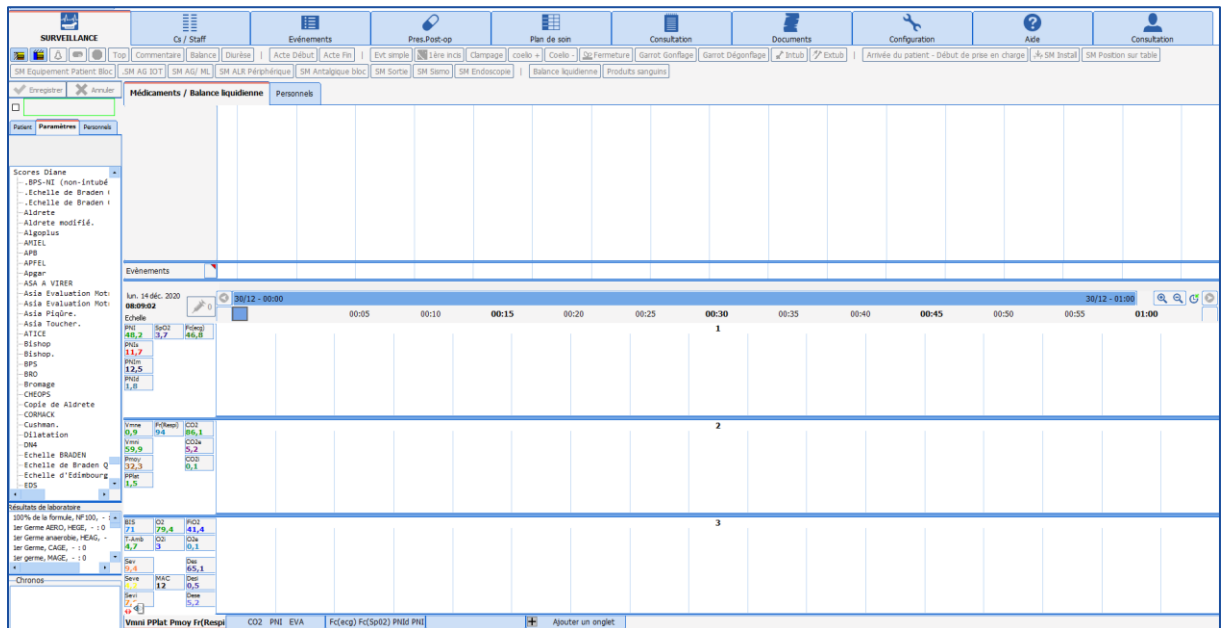


Settings must be saved a second time using the display configuration save button.



1. Add a separator.
2. Delete the selected button.
3. Move the selected button (up or down).
4. List of buttons: buttons in use are purple, and the tabs displaying them are given in brackets.

### 3.1.8 Monitoring tab (DIANE ANAESTHESIA) / Operating theatre tab (DIANE ICU)



#### 3.1.8.1 Drugs graph

**Configuration des médicaments**

**Configuration générale**

Activer la zone des médicaments

**Couleurs**

Interface

Couleur de fond médicament pair

Couleur de fond médicament impair

Saisies

Injection flash (IVD, IV PERF ...)

PSE (Pousse Seringue Electrique) manuel

PSE (Pousse Seringue Electrique) connecté

RESPI (appareil respirateur)

Saisie Longue

Séparateur saisies longues

Aucun filtre sur l'affichage des médicaments

Aucun filtre sur la saisie des médicaments

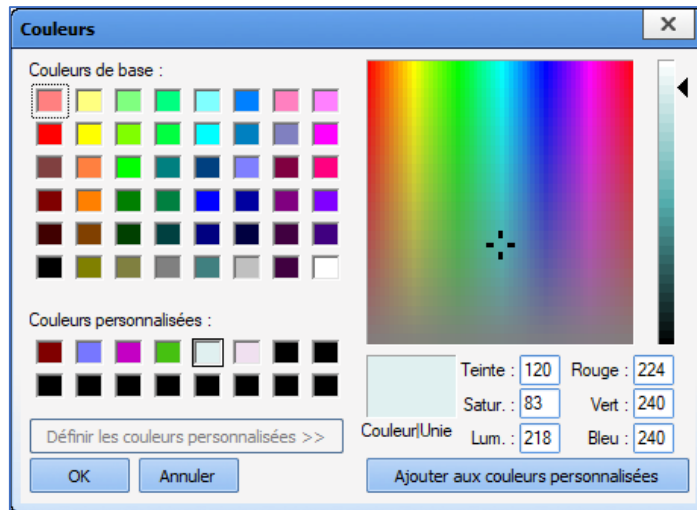
Liste complète des médicaments

- BALANCE LIQUIDIENNE
- MEDICAMENTS
- PRODUITS SANGUINS

Intégrer systématiquement les PSEs

The drugs graph can be configured:

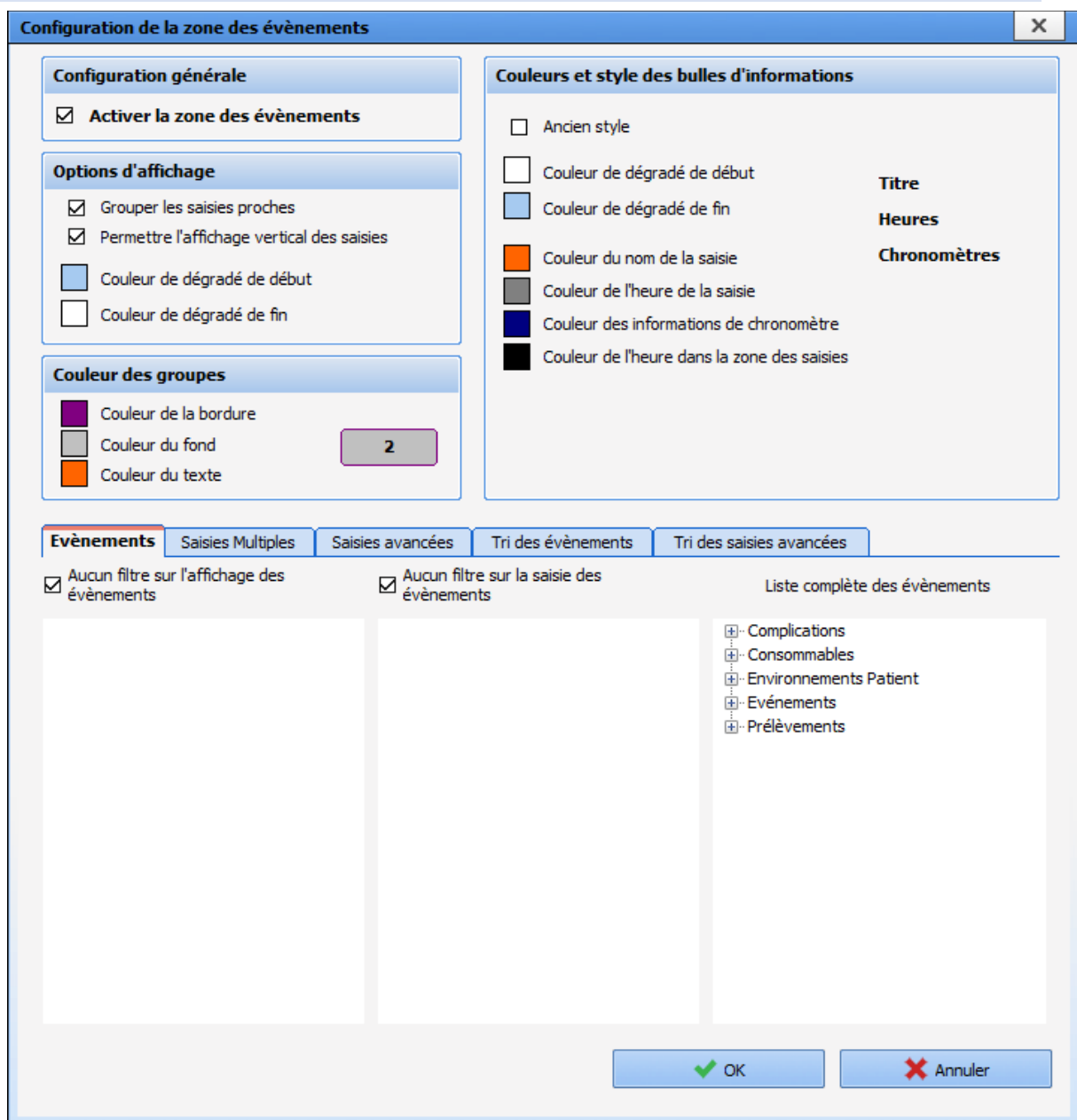
- Visible or not
- Colours can be changed: : to modify drug colours, see **DIANE Drugs**



- Display and drug entry can be filtered.



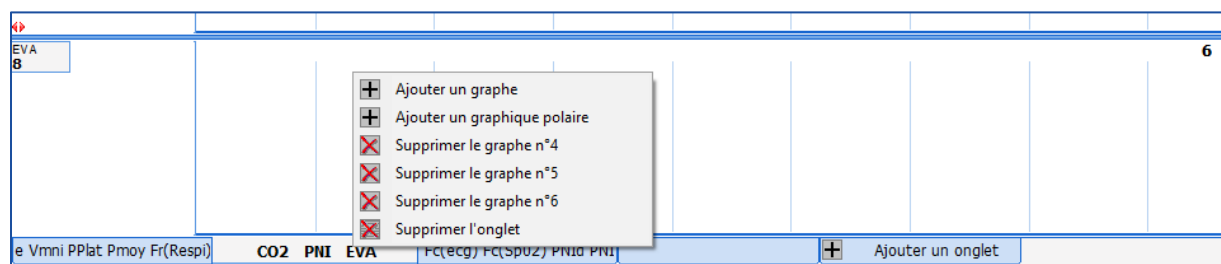
### 3.1.8.2 Events pane



The events pane can also be configured:

- Visible or not
- Colours can be modified.
- Event display and entry, detailed entries and multiple entries can be filtered.

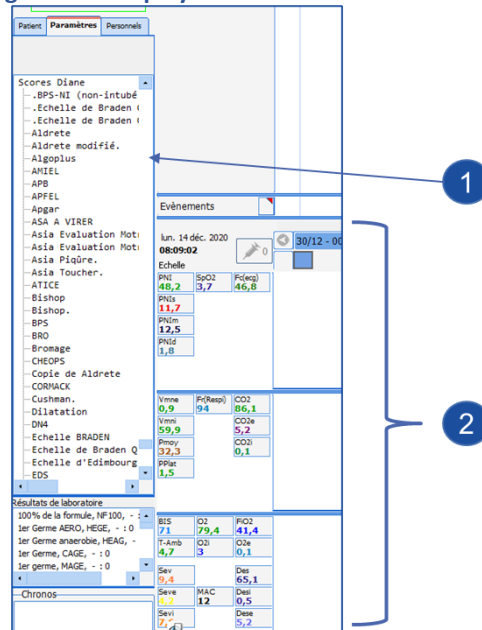
### 3.1.8.3 Bottom tabs



The bottom tabs can be configured:

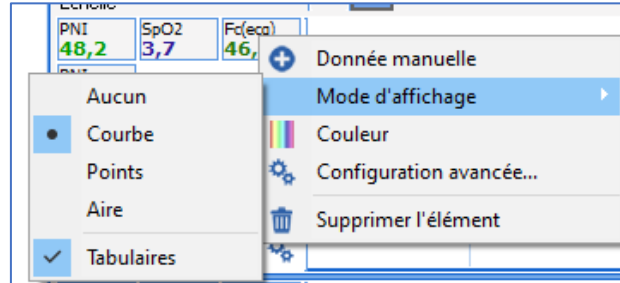
- For each tab, a graph can be added or deleted by right-clicking the tab.
- A tab can be added by clicking **Add a tab**.

### 3.1.8.3.1 Configuring the vital signs to be displayed



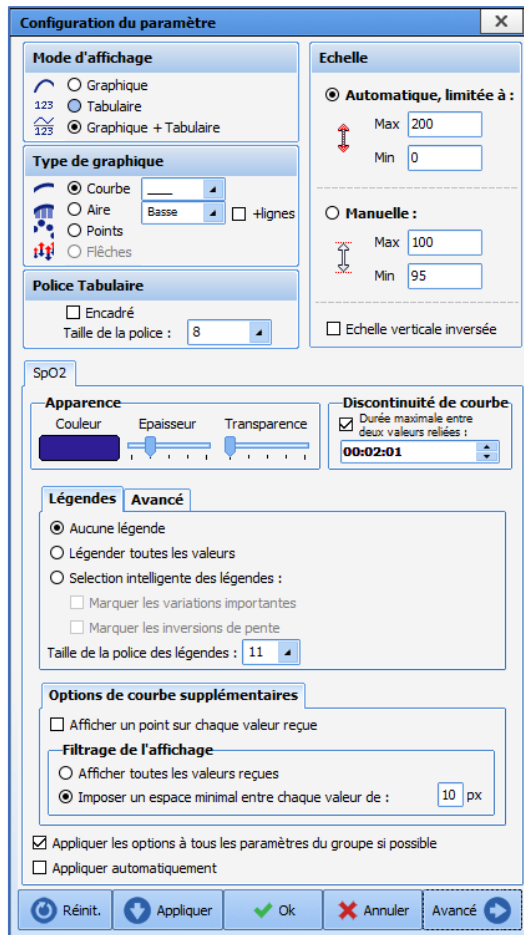
1. Select the vital sign to be displayed from the list on the left
2. Drag and drop the selected vital sign into one of the three panes on the right

Right-clicking a vital sign shows its display configuration.



View mode offers the usual displays (**curve**, **points**, **area** or **none** for graph display and **tabular** for digital display).

**Advanced configuration...** shows a configuration window with more options.



## 3.2 Other lists

The drop-down menu on this tab has three entries:

**CONDITION:** used to configure a list used in the **PostOp Medication Order** tab of the **DIANE ANAESTHESIA** module (*on return from theatre, morning, noon and evenings, etc.*).

**ICU CONDITION:** used to configure a list used only in the **Medication order** tool of the **DIANE ICU** module.

**DURATION:** used to configure a list used in the **PostOp Medication Order** tab of the **DIANE ANAESTHESIA** module (*until tomorrow morning, for 3 weeks, etc.*).

In use, the **ICU CONDITION** list is available on typing or double-clicking in the **Condition** field of the medication order window.

**Amoxicilline : 1000 mg + Diluant non précisé: 50 ml; D=30min 3x/j a**

Antibio./Anti-infectieux

**AMOXICILLINE \*** Diluant + +

AMOXICILLINE PANPHARMA 1 g/5 ml pdre/solv p sol inj IM

200 mg/ml

Taille : 180 cms  
Poids : 80 Kgs

Posologie par administration: 1000 mg /kg /m2 Max.

Posologie par jour: 3000 mg

Débit: 2 g /kg /h /m2 /min

Ne pas remplacer/substituer

**Total par jour utilisé pour l'analyse de la Bdm: 3000 mg**

Durée d'administration: 30min

Voie: Intramusculaire

A la demande  
 Apporté par le patient

Planification: 3 fois par jour(s)

Administration urgente

Date/Heure de début: 15:15 13/06/2022

Préciser une durée: Pendant 1 jour(s)

13-06-2022 14-06-2022 14-06-2022

16:00 18:00 20:00 22:00 00:00 02:00 04:00 06:00 08:00 10:00

Remarques du pharmacien

Contenant et dilution: 18,18 mg/ml

Contenant volumique: Poche à perfuser 50 (50)

Débit de la perfusion: 110 ml/h


Débit non précisé

Détails

Condition: J1

Commentaire: A la demande  
Selon ATICE  
Si température > 38,5°, maxi 3 x/24h  
Si Tension < à  
Si EVA >  
Pour Ramsay 2/3  
Objectif PAM  
+/- 0.1 pour PAM>70  
Objectif PAM > 65 mmHg  
Objectif PAM > 70 mmHg  
Ouvrir les gélules, diluer dans un peu d'eau et administrer par SNG  
Si nausées  
Si nausées / vomissements

### 3.3 Buttons

**WARNING! This configuration tab cannot be used to create buttons (with exceptions). It can only be used to rename or delete them. Buttons are created using the button  (Associate the item with a configurable button) in the configuration tabs of compatible items.**

	Description	Creation tab
<b>Executable</b>	Contextual link buttons These are the only buttons that can be created in the <b>Buttons</b> tab.	<b>Buttons</b>
<b>Form letter</b>	Buttons for opening a form letter (prescription, summary, etc.)	<b>Form letters</b>
<b>Drug</b>	Buttons for documenting a drug - or list of drugs in a category - in <b>DIANE ANAESTHESIA (IntraOp and PostOp)</b> .	<b>Drugs</b>
<b>Medication order</b>	Buttons for documenting medication orders for the <b>Medication Order PostOp</b> tab of <b>DIANE ANAESTHESIA (IntraOp and PostOp)</b> .	<b>Protocols (PostOp)</b>
<b>Protocol</b>	Buttons for documenting protocols for the <b>Medication Order PostOp</b> tab of <b>DIANE ANAESTHESIA (IntraOp and PostOp)</b> .	<b>Protocols (PostOp)</b>
<b>ICU protocol (Add)</b>	Buttons for documenting the medication order <b>Load a medication order (Add)</b> in the <b>Medication order</b> tab.	<b>Medication orders (+ Favourites)</b>
<b>ICU protocol (Replace)</b>	Buttons for documenting the medication order <b>Load a medication order (Replace)</b> in the <b>Medication order</b> tab.	<b>Medication orders (+ Favourites)</b>

<b>Detailed entries</b>	Buttons used to open a detailed entry (or score).	<a href="#">Detailed Entries</a>
<b>Multiple entries</b>	Buttons for opening a multiple entry.	<a href="#">Multiple entries</a>
<b>Visual entry/event</b>	Buttons for documenting events, complications, consumables and patient environments.	<a href="#">Events</a>
<b>Specific</b>	Buttons for various actions... <b>This list cannot be modified.</b>	

### 3.4 Timers

This tab is used to configure the timers used in [DIANE ANAESTHESIA](#), [DIANE OB-GYN](#) and [DIANE ICU](#).

All the items available that can be included in a timer are found in the **List of available events** pane. These events can be used as launch or stop conditions via drag and drop. There must be at least one launch condition and one stop condition to create a timer. A timer can have several launch/stop conditions.

Before creating a timer, ensure that the events to be used as launch and stop conditions exist.

An alarm can be associated with a timer. The data taken into account is duration in minutes. Duration in hours and in days are used to enter a duration without having to convert it into minutes.

### 3.5 Volumetric containers

This menu is used to configure volume containers (**syringe** and **bag**).

**Syringe:** used to configure volume containers for drug medication orders in the [Medication order](#) tab of [DIANE ICU](#).

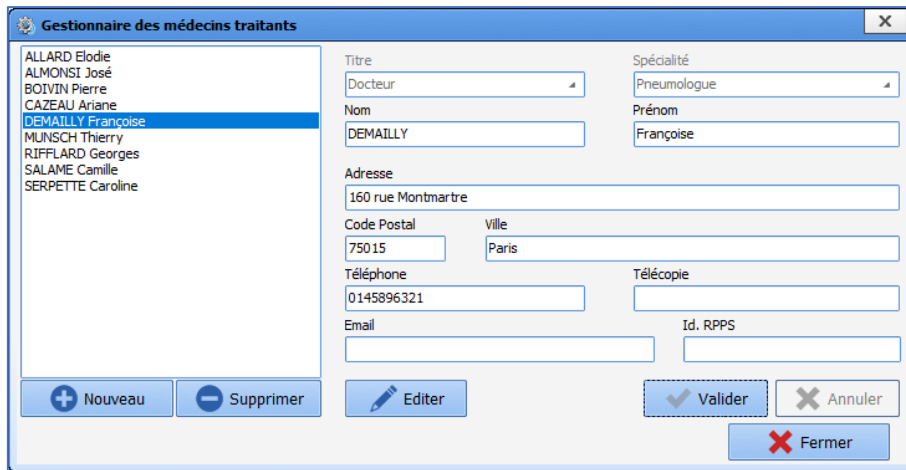
The volume of the syringe, conventional flow rate unit and potentially the bolus flow rate (bolus flow rate unit is the conventional flow rate unit, entered just above) must be entered.

**Bag:** The corresponding page is used to configure volume containers for drug medication orders in the **Medication order** tab of **DIANE ICU**.

The volume of the bag, its maximum volume and the conventional flow rate unit must be entered.

## 3.6 Correspondents

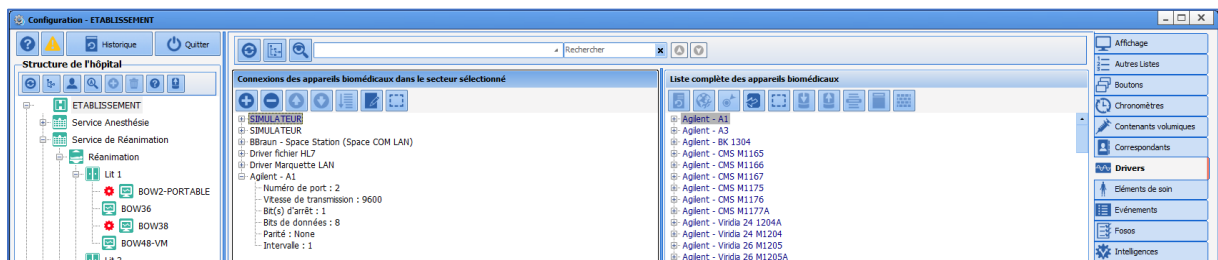
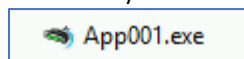
This tab is used to configure the correspondents used in **DIANE**.



This configuration tab does not use the facility entities: there is one general list of correspondents for the whole facility.

### 3.7 Drivers

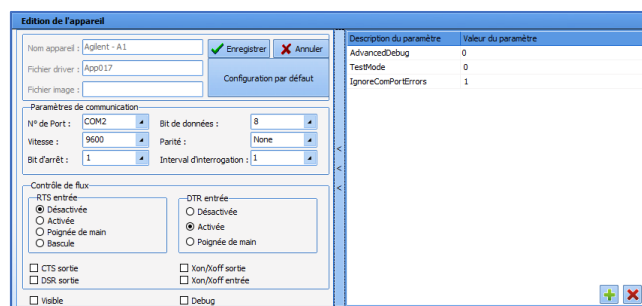
The full list of biomedical devices cannot be modified. It is generated automatically based on the presence of **AppXYZ.exe** files in the **DIANE** installation directory.



At the **hospital organisation** level, the configuration (gear) is created automatically when the list of toggled devices is edited.


**Driver settings must not be changed. Settings ensure drivers work correctly. DIANE experts may be asked to access these functions in case of malfunction. This is done under the supervision of the BOWMEDICAL technical support team.**

Editing driver settings in the list of toggled devices allows settings to be modified for the workstation in question.

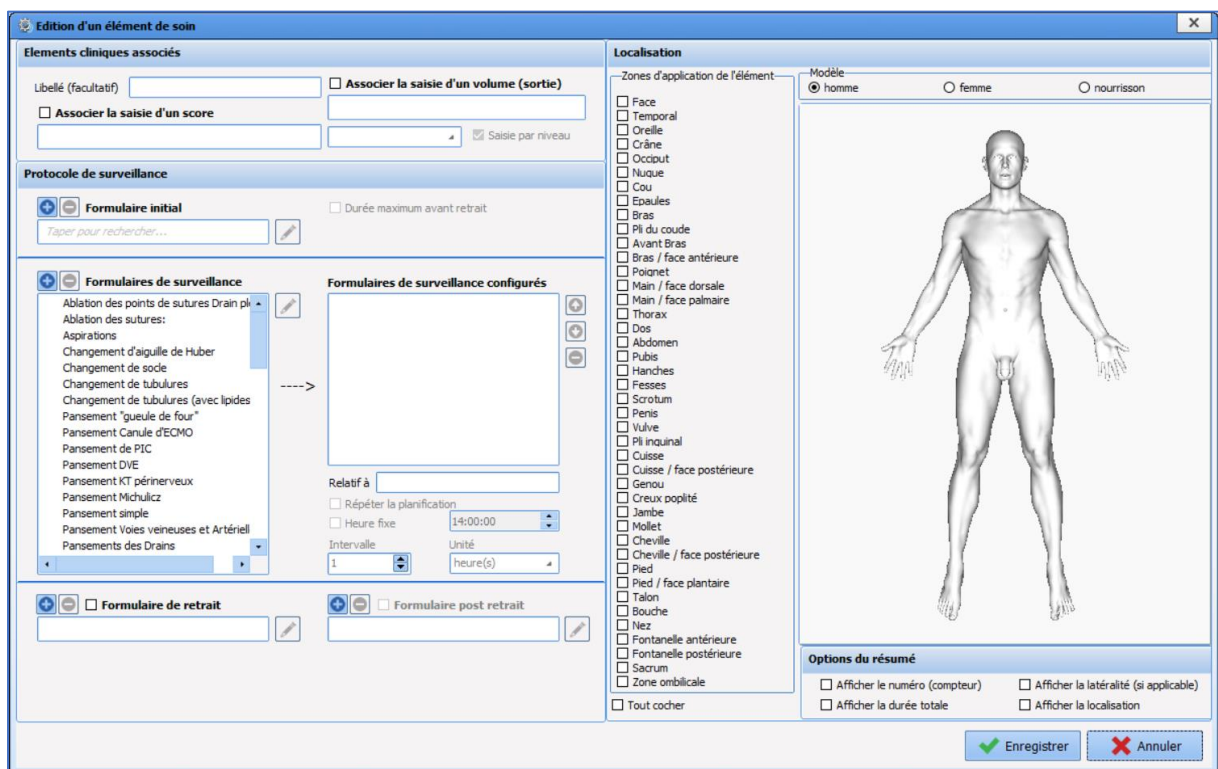


## 3.8 Care items



1. Device categories.
  - Ports
  - Drainage
  - Dressings
  - Other
2. Full list of devices for the selected category.
3. List of toggled devices for the selected sector (gear).
4. Create a new device (click )

### 3.8.1 Editing of a care item window



The Location pane is used to specify the possible locations of a device.

The **Show number (counter)** option is used to differentiate between identical devices (e.g. VVP No. 1, VVP No. 2).

The **Show total duration** option is a timer that shows how long a device has been in place.

The **Show side (if applicable)** option is used to differentiate left and right.

The **Show location** option is used to show the pane in which the device is used.




### Associated clinical items:

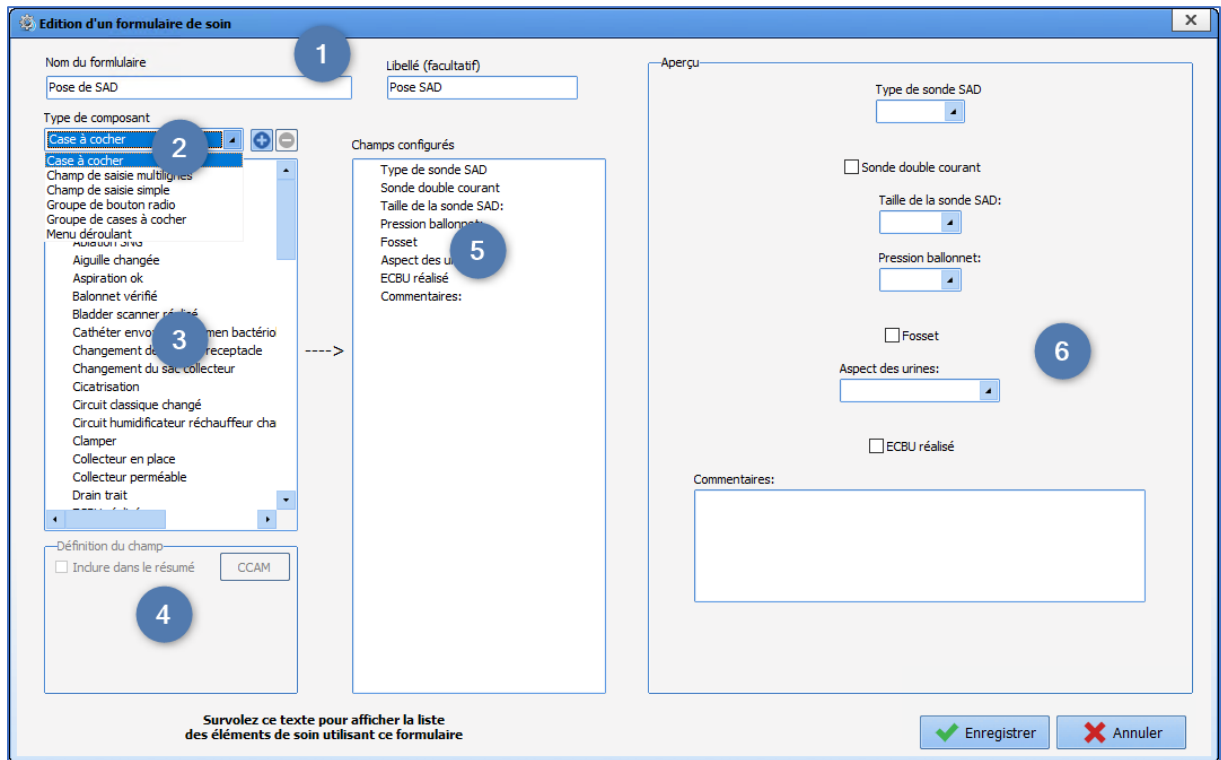
1. Show a title to replace the care item name
2. Associate the entry of a score with a form (e.g. *tracheal tube associated with Cormack*).
3. Associate the entry of a volume with a form = fluid balance output.  
It is possible to select the corresponding fluid balance item in the drop-down menu below. The **Entry by level** check box can be used to enter this volume by level.

### Monitoring protocol:

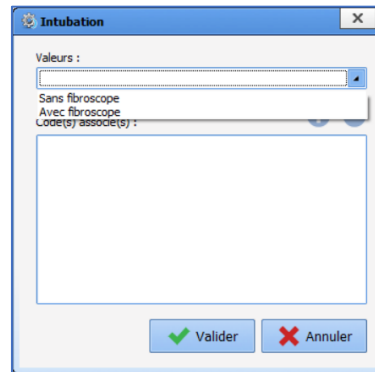
4. Initial form pane (placement): it is possible to define a maximum placement duration (e.g. *urinary catheter => max. duration 30 days*).
5. Follow-up form pane, available forms on left, forms used for device on right. Default scheduling can be defined.  
It is possible to:
  - Schedule a monitoring form based on the initial form, with a set interval in hours or minutes (minimum 5 minutes).
  - Schedule a monitoring form based on another monitoring form (*in the example above, the scheduling of the **Drain management** form is related to the **Pleural drain monitoring** form*). In this case, scheduling depends on whether or not the parent form is carried out (*here, the **Drain management** form is only scheduled if the **Pleural drain monitoring** form is carried out*).
Scheduling can also be repeated.
6. Removal and post removal form pane. Default scheduling can be defined.

## 3.8.2 Editing of a care form window

The four types of form available for planning care item tracking (initial, monitoring, removal and post-removal) are configured using the following window, accessed by clicking .



1. Name of form (a shorter label can be used for ease of reading)
2. Type of components
3. List of components available for selected type.
4. Creation of a component of the selected type.
4. Possible values pane for check box groups, radio button groups or drop-down menus. It is also possible to select the type associated with a one-line input field. For check box, radio button group, check box group and drop-down menu items, it is possible to associate a procedure code with a value entered in the form:



5. Form components, drag and drop to change order.
6. Preview of form (components are centred, one after the other, only their order can be changed).

**!** A care item used in production cannot be edited, it must be copied and reworked.

### 3.8.3 Editing of a care item

#### Location:

The **Location** pane is used to specify the possible locations of a device.

This area contains a radio button group **Model: male/female/child** associated with a list of check boxes **Areas where care item is applied** listing the different parts of the body to which the care item can apply.

#### Summary option:


This is used to set up what is displayed in a section at the top left of the diagram when a care item is clicked.

The **Show number (counter)** option is used to differentiate between identical devices (e.g. PVC 1, PVC 2).

The **Show total duration** option is a timer that shows how long a device has been in place.


The **Show side (if applicable)** option is used to differentiate left and right.

The **Show location** option is used to include the location of the device (e.g. chest) in the label.

1. Associate with entry of a score (e.g. tracheal tube associated with Cormack).
2. Associate with entry of a volume = fluid balance output.
3. Initial form pane (placement) (mandatory): it is possible to define a maximum placement duration (e.g. urinary catheter => max. duration 30 days).
4. Follow-up form pane, available forms on left, forms used for device on right. Specific default scheduling can be defined for each form. To remove a form that has been set up, drag and drop it outside the monitoring form box or select it and click .
5. Removal and post removal form pane. Default scheduling can be defined.
6. Label (optional) is used to enter a short label for the device.

### 3.8.4 Editing of a care form

7. Form name.
8. Type of components
9. List of components available for selected type.
10. Creation of a component of the selected type.
11. Possible values pane for check box or radio button groups.
12. Form components, drag and drop to change order.
13. Preview of form (components are centred, one after the other, only their order can be changed).

 A care item used in production cannot be edited, it must be copied and reworked.

## 3.9 Events

Events are items organised in the form of lists that allow users to add information to patient records. They are available directly on clicking in the input box of **DIANE ANAESTHESIA (IntraOp and PostOp)** and **DIANE OB-GYN** and in the three types of view in **DIANE REA**.

**Names in this list cannot and should not be changed.**



Items in the following categories can be changed and configured:

- Complications
- Consumables
- Patient Environments
- Events
- Samples

Other categories cannot be edited in this tab.

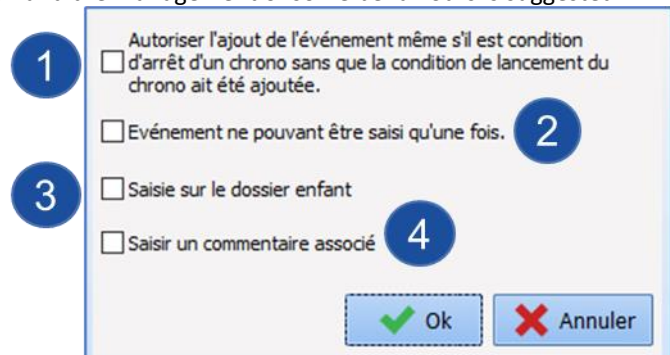
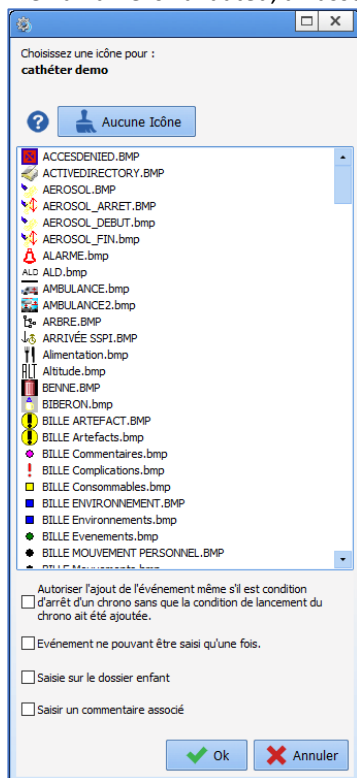
**Fluid balance, Drugs** and **Blood products** can be edited in the **Drugs** tab.

Detailed entries and multiple entries can be edited in the relevant tabs with the same name.

As a reminder, **Comments** allows the user to open a free text window.

The **Manual entry** and **Ventilation parameters** windows can be configured in the **Settings** tab.

When a name is validated, an associated icon and the management of some behaviours is suggested.



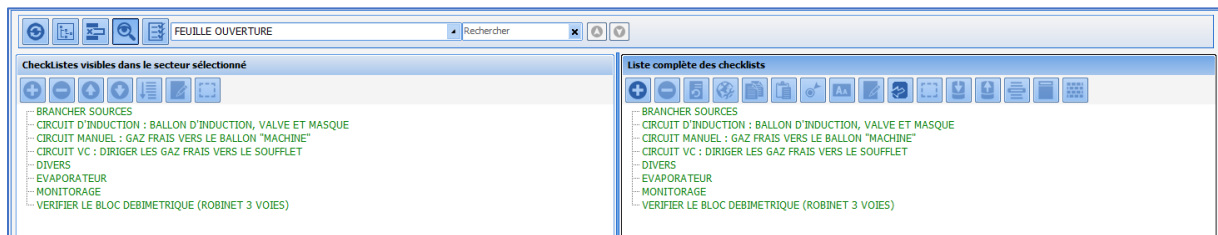
- 1 Relevant for some items. It may be necessary to extubate a patient who arrived intubated, or to deflate a tourniquet that was applied prior to hospitalisation.
- 2 Avoid duplicate entries.
- 3 Used for OB-GYN.
- 4 Automatically open a free text window to add a comment associated with the selected item.



## 3.10 Room safety checklists: Room safety checklist/Inter-patient checklist

The **Room safety checklist** tab is used to configure safety checklists and inter-patient checklists.

### 3.10.1 Configuration of safety checklists and inter-patient checklists









These checklists are organised by pane (sublists), which allow the lists to be segmented, titles and paragraphs to be obtained and information common to several safety checklists or inter-patient checklists to be reused.



The safety checklist comprises toggled panes. The order of these panes can be defined using drag-and-drop or with the   buttons.

Pay attention to sublist titles: these are used in the **Room safety checklist** formatting.

Sublists to be used for safety checklists and inter-patient checklists are edited in a similar way to detailed entries. However, fewer components are available and they cannot be associated with **ActiveX/Data ID** pairs. The presentation is also different. The operation of these components is described in the *annex*.

	<b>Add title</b>	Adds text to the Room safety checklist. <b>Reminder:</b> the name of the sublist is shown in the room safety checklist.
	<b>Add a checked text input box</b>	Adds a check box.
	<b>Add a one-line input box</b>	Adds a one-line input box. The data type can be configured (text, date/time, number, decimal, etc.)
	<b>Add a comment box</b>	Adds a multi-line input box.
	<b>Add a drop-down menu</b>	Adds a drop-down menu: this component allows an option to be selected from a list.
	<b>Add an optional text input box</b>	Adds a radio button group: as with the drop-down menu, this component allows an option to be selected from a list.
	<b>Add a border</b>	Used to group other components within a frame to improve readability.
	<b>Add a separator</b>	<b>This component must not be used. It is present for reasons of backward compatibility.</b>

### 3.10.2 Settings for safety checklists and interpatient checklists

Settings are changed in the **Settings** tab, **Safety checklist and inter-patient checklist** and **Important actions** for each of the applications **DianeICU**, **DianeOB-GYN** and **Visual**.

Paramétrage de l'application

Nom du paramétrage : **Defaut**  
 Application ou module à paramétrer : **Visual**

Recherche d'un paramètre

Champ(s) à considérer pour la recherche : Tous

Texte à rechercher :  Rechercher

Vers le bas  
  Vers le haut  
  Différencier Min/Maj  
  Mot entier

Description du paramètre	Valeur du paramètre
<b>Configuration générale de Visual</b>	
<b>Gestion des pousSES-seringue</b>	
<b>[DEBUG]</b>	
<b>Fiche de sortie/fermeture de dossier</b>	
<b>Position et taille de la fenêtre, utilisé si la clé Maximized &lt;&gt; 1</b>	
<b>Feuille d'ouverture et fiche inter patient</b>	
Afficher un avertissement si la Feuille d'Ouverture n'a pas été complétée en sall	1
Afficher un avertissement si la Feuille d'Ouverture n'a pas été complétée en blo	1
Afficher un avertissement si la Fiche inter patient n'a pas été complétée en bloc	1
Afficher un avertissement si la Fiche inter patient n'a pas été complétée en salle	1
Activer la demande de validation des Feuilles d'ouverture en bloc	1
Activer la demande de validation des Feuilles d'ouverture en salle de réveil	1
Activer la demande de validation des Fiches inter patient en bloc	1
Activer la demande de validation des Fiches inter patient en salle de réveil	1
Afficher le bouton "cocher tout" dans la feuille d'ouverture et la fiche inter patie	1
Rattachement des feuilles d'ouverture à un patient (1=oui, 0=non)	1
<b>Signatures</b>	
<b>Avertissements</b>	
<b>Actions importantes</b>	
<b>Configuration des couleurs de Visual</b>	
<b>DESCRIPTION</b>	

Propriétés du paramètre

Propriétés du paramètre :

Feuille d'ouverture et fiche inter patient

Type de saisie :

Section

Choix possibles :

Masque de saisie :

Nombre de caractères maximum :

0

Lecture seule

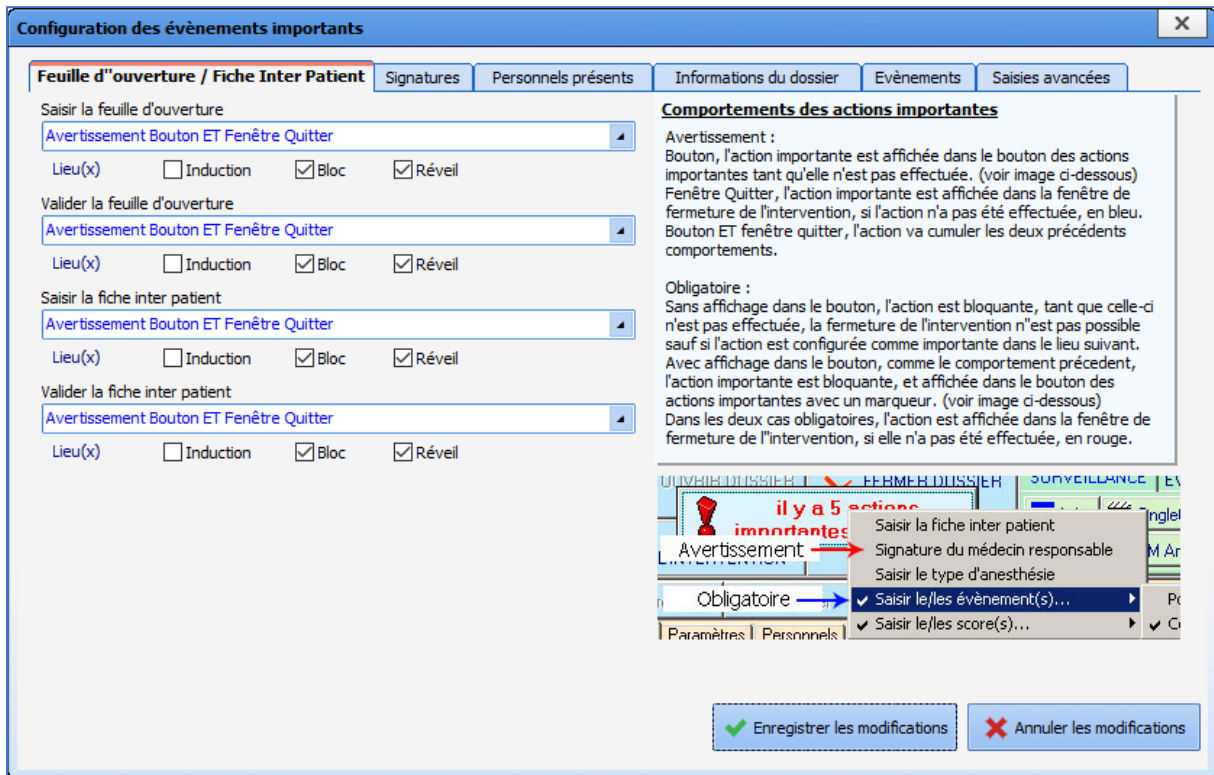
Ok  
 Annuler

Clé actuelle : [FO-FIP]

309 Ligne(s) chargée(s) en 00 min 00 s 050 ms.

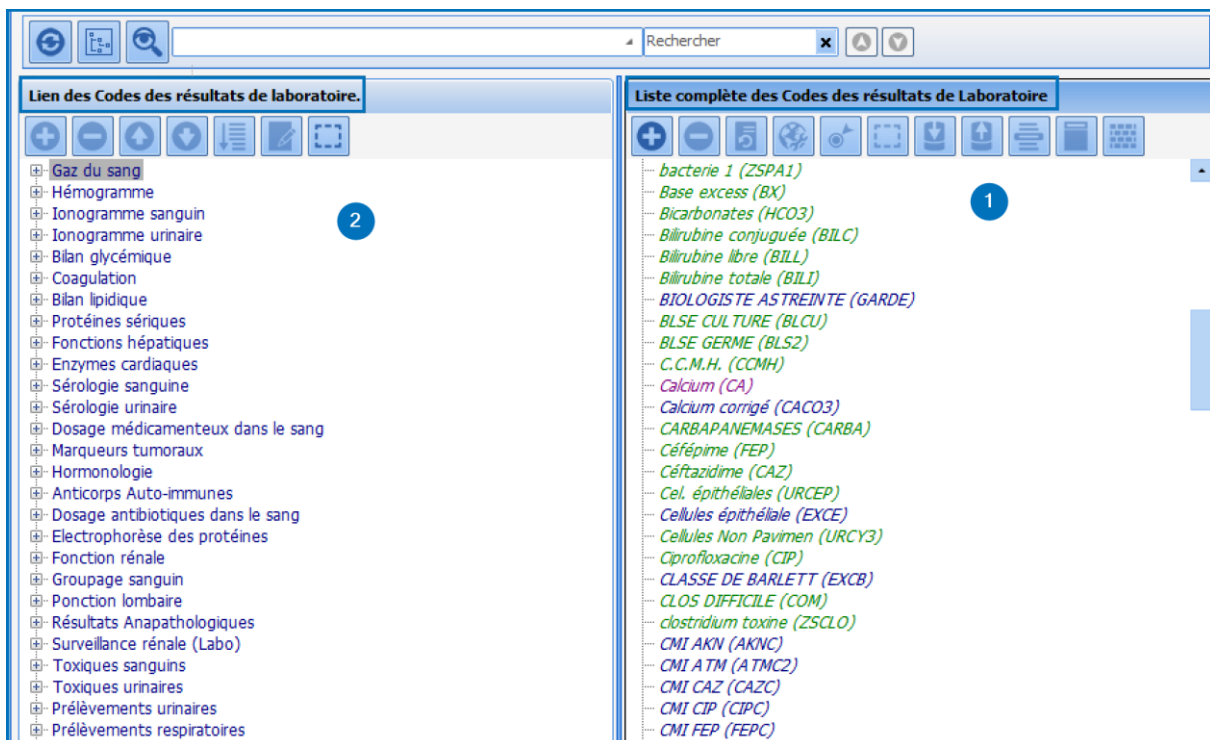
Enregistrer  
 Annuler





### 3.11 Laboratory

This tab is used to associate laboratory test result codes with the analysis type. Associating the items sent by the laboratory as raw data with **DIANE** items means these data can be used in the various parts of **DIANE** for example; **eye** in the medication order, etc.



1. **Full list of lab result codes:** column using an interface flow to integrate raw data sent by the laboratory. Each row corresponds to an analysis code, e.g. total bilirubin (BILI).
2. **Laboratory result code link:** Column listing DIANE result categories.

3. To be associated, the result codes must be drag-and-dropped to the corresponding Diane category.  
*Example: Free bilirubin (BILI) associated with the item Free bilirubin (Free bil.) in the Liver function category.*

If an item is **green** this means it is linked to a Diane item. Clicking this item means it can be easily found in the left column.

If an item is **blue**, it is not linked.

**NB:** Mapping is only required if the Laboratory interface is available in the hospital.

## 3.12 Form letters

### 3.12.1 Placement of editing buttons for form letters in the Modules

The location of the different categories of form letter means the document(s) to be created or modified can be found quickly. The drop-down menu comprises categories of letter, linked to a specific module or function. Locations are presented for reference only, given that a hospital may change the display.

CONSULTATION	1	Impression CPA complète
	2	Impression CPA prescription des bilans
	3	Impression CPA prémédications
	4	Autres impressions CPA
VISUAL	5	Impression Visual prescription
	6	Autres impressions Visual
Applicable to all modules	7	Entêtes et pieds de page
ICU	8	Prescriptions (Réa)
	9	Evolutions (Réa)
	10	Compte-rendu (Réa)
Applicable to all modules	11	Modèles Diane
ICU	12	Lié à une prescription (Réa)
Applicable to all modules	13	Fonds de page
OB-GYN	14	Impression gynécologie-obstétrique
Applicable to all modules	15	Impression de CERFA
	16	Traitements/Prémédications

#### 3.12.1.1 Printing of the Consultation module

##### 3.12.1.1.1 Printing the full consultation (Cat. 1):

Location: **CONSULTATION** module - main Print button.

Consultation Pré anesthésique Utilisateur connecté : SYSTEM Diane - DUPONT Jean (né(e) le 01/02/1975)

Patient: Nom de naissance: DUPONT, Nom usuel: Jean, Sexe: M, Prénom: Jean

Date	Age	Taille	Poids	Intervention
20/07/2020	45 ans	180 cm	70 Kg	Colectomie gauche

Buttons: Enregistrer, Fermer..., Imprimer (highlighted), Options, Reprise

##### 3.12.1.1.2 Printing of Pre-Op test medication order

Location: **CONSULTATION** module - **Paraclinical** tab

Consultation Pré anesthésique Utilisateur connecté : SYSTEM Diane - DUPONT Jean (né(e) le 01/02/1975)

Patient: Nom de naissance: DUPONT, Nom usuel: Jean, Sexe: M, Prénom: Jean

Date	Age	Taille	Poids	Intervention
20/07/2020	45 ans	180 cm	70 Kg	Colectomie gauche

Buttons: Enregistrer, Fermer..., Imprimer (highlighted), Options, Reprise

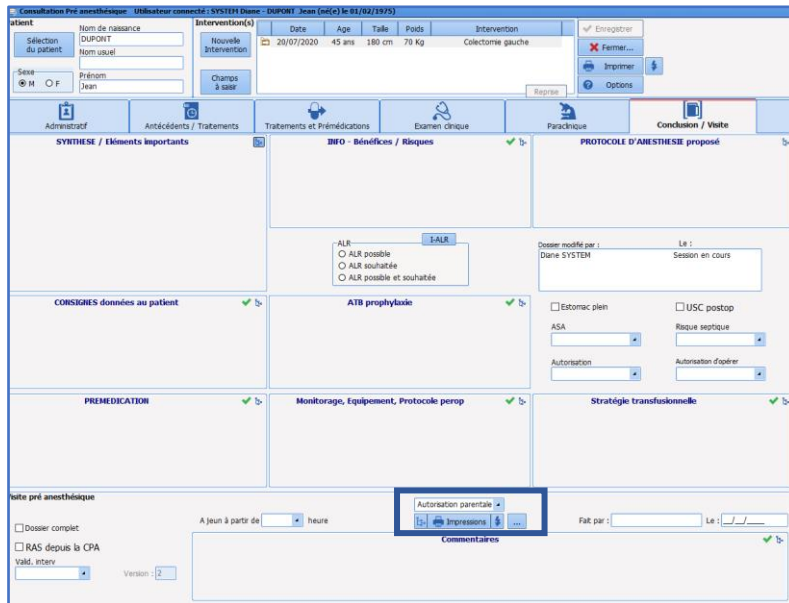
Navigation tabs: Administratif, Antécédents / Traitements, Traitements et Prémédications, Examen clinique, **Paraclinique**, Conclusion / Visite, Ambulatoire, Résumé, Documents (0)

Form fields: CAT pour les examens complémentaires: Pas de bilan demandé, Bilan prescrit

Footer: Ordo (Cerfa N°12078) Edition

##### 3.12.1.1.3 Pre-op premedications and other consultation printing

Location: **CONSULTATION** module - **Conclusion/Visit** tab



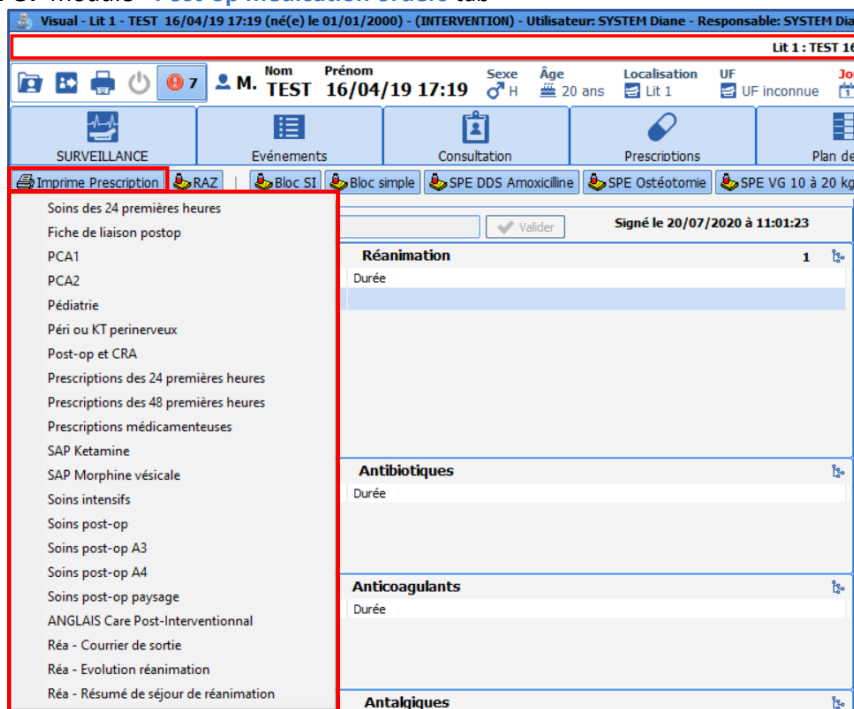
### 3.12.1.2 Printing in the VISUAL module

The **VISUAL** module includes the following phases:

- Induction
- Intraoperative
- Postoperative

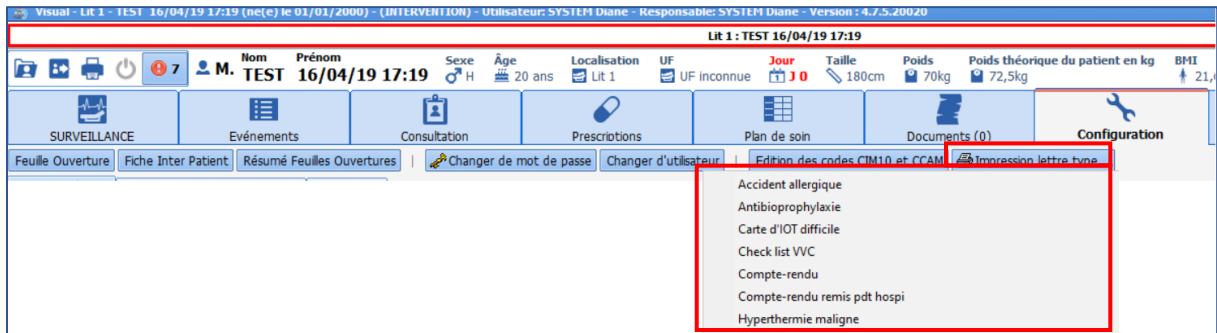
#### 3.12.1.2.1 Visual medication order printing

Location: **INTRA-OP** Module - **Post-op medication orders** tab



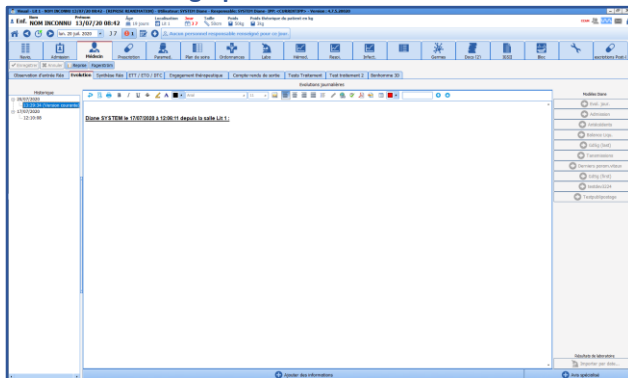
#### 3.12.1.2.2 Other VISUAL printings

Location: **INTRAOPERATIVE** module - **CONFIGURATION** tab



### 3.12.1.3 Printing in DIANE ICU

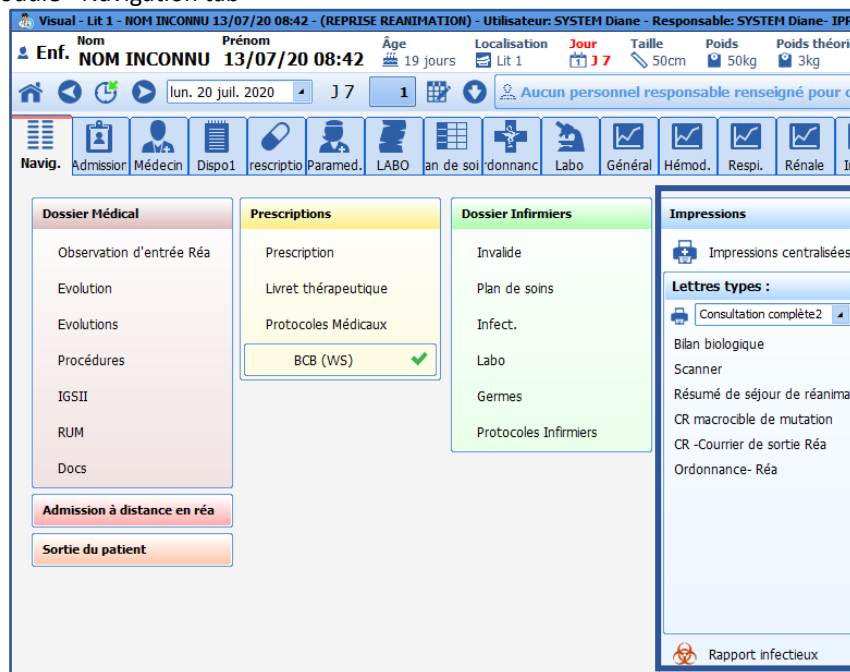
#### 3.12.1.3.1 Setting up DIANE models



In use, **DIANE** models are used to prefill some tabs with automatic formatting and text. (Here the **Doctor** tab, **Developments** subtab, in the ICU module). Creations and modifications are carried out as for form letter using the integrated **DIANE** editor (see Form letters with integrated **DIANE** editor).

#### 3.12.1.3.2 Printing of ICU module

Location: ICU module - Navigation tab

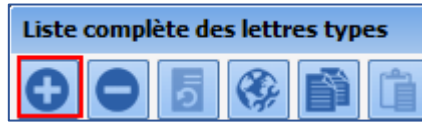


### 3.12.1.4 Printing the Treatment/Premedication component

The **Treatment/Premedication** form letter is printed using the **Edit...** button in the **Treatment/Premedication** component.

### 3.12.2 Creation of a letter

Form letter settings are accessed from the application configuration, **Form letter** tab, then by selecting the relevant category from the drop-down menu.



Click the form letter creation button:

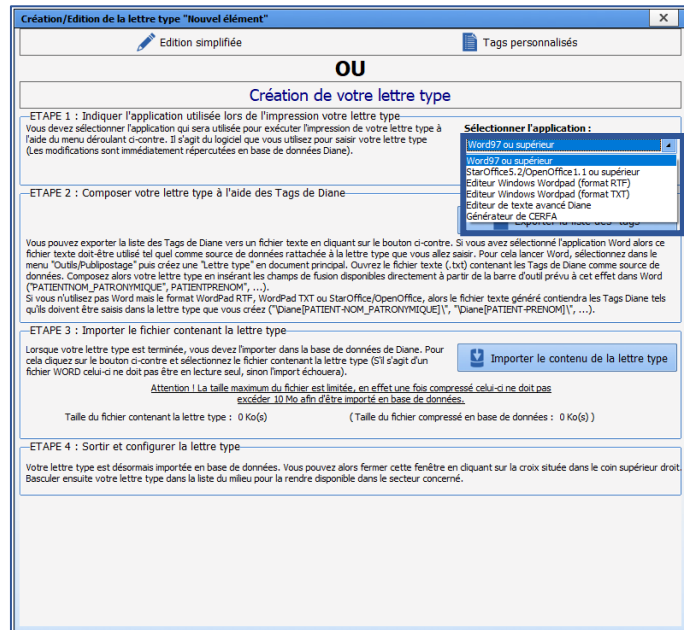
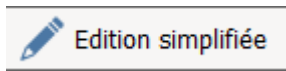
First, choose the format used for this letter.

This document presents the following formats:

- **WORD97** or later
- **DIANE** advanced text editor

The **DIANE** text editor is a simplified text editor that is quick and easy to set up.

After selecting the format, click Simplified editing.

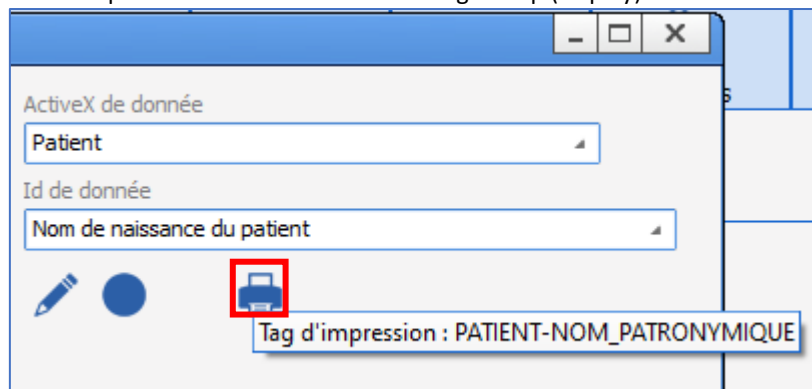


#### 3.12.2.1 Finding tags

Tags are linked to ActiveX and Data IDs for the components found in all **DIANE** modules.

This information is accessed by clicking the component to be explored while holding down **CTRL** and **Shift** (left side of keyboard). The component must have a green border before being clicked for this to work. This window can also be accessed by right-clicking when setting up module display.

The window that opens is the same one used during set-up (display) but is not editable (read-only).

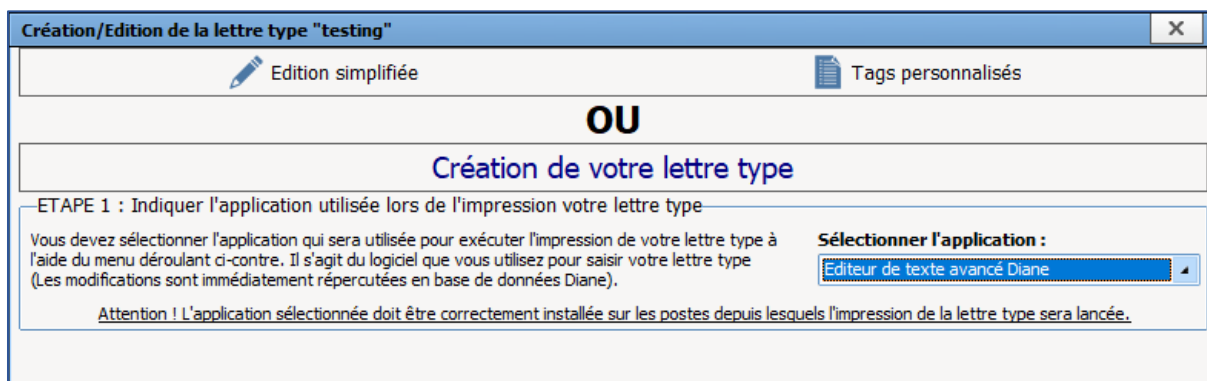
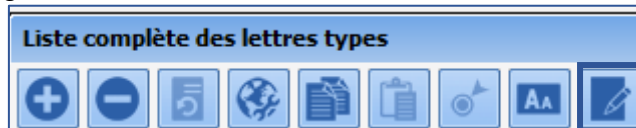


Hovering over the print icon shows the tag corresponding to the component, the value of which should be entered in the form letter.

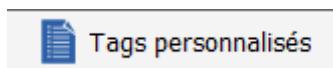
### 3.12.2.2 Creation of custom tags

A tag is a mailing field. It is a special location in the document able to accept specific data from the current patient record. There are two tag categories. **Fixed tags** are associated with ActiveX/Data ID pairs for **DIANE** components. **Custom tags** are tags generated by most tools such as detailed entries, vital signs, laboratory results, events, timers, drugs and fluid balance. These categories of **custom tag** will be presented below.

In the application configuration, **Form letter** tab, select the category from the drop-down menu, select the required letter from the right column then edit it.



To create or modify **custom tags** (merge fields), click the button.



Custom tags do not depend on the editing tool used. However, they are linked exclusively to the selected form letter. If a **form letter** is copied, the **custom tags** will also be copied.

#### 3.12.2.2.1 Detailed entry custom tags


When the **custom tag** creation tool, the **detailed entry** tag tab opens.

A **custom tag** management page shows three columns, progressing from left to right.

- The left column contains the stock of all **detailed entries**.
- The middle column contains previously created **custom tags**. Drag and drop the required **detailed entry** into the document.
- The right column appears when a **custom tag** is selected in the middle column. This column is used to select the relevant options. It is possible to modify the options of a **custom tag** at any time without having to modify the **form letter**.

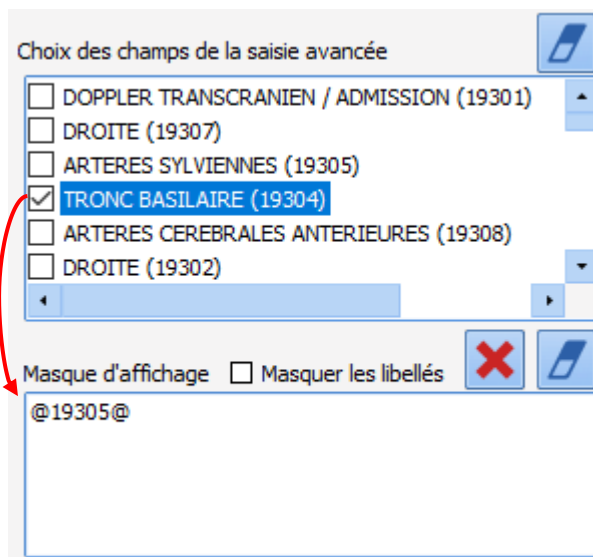
**Detailed entry** custom tags have the following settings options:

- **View occurrence date/time:** date and time visible in the patient record.
- **View date and time of entry:** actual data and time of entry.
- **View user:** full name.
- **View score value:** calculation value, available for 'score' detailed entries.
- **Hide name:** name of detailed entry or score.
- **Hide description:** description of detailed entry or score.
- **Hide 'No value' text if no data:** when it is important to know that there is no data.
- **Select entry selection in record:** six options, from *all records without medication orders* to *last medication order in record*.
- **Selection of detailed-entry fields:** All components are listed so that the tag can be created with the important information to be printed in the form letter.

All boxes can be deselected using .



- **Display mask:**



The display mask can be used to structure how **detailed entry** fields appear in the form letter.


In the image, the information “BASILAR ARTERY” from the **detailed entry** appears as follows:

BASILAR ARTERY: *Value*


**NB:** Only information that has previously been selected can be drag-and-dropped.

If **Hide labels** is selected, only the value will be shown. It is also possible to add text and formatting to be included in the form letter.



Click  to remove the display mask pane.

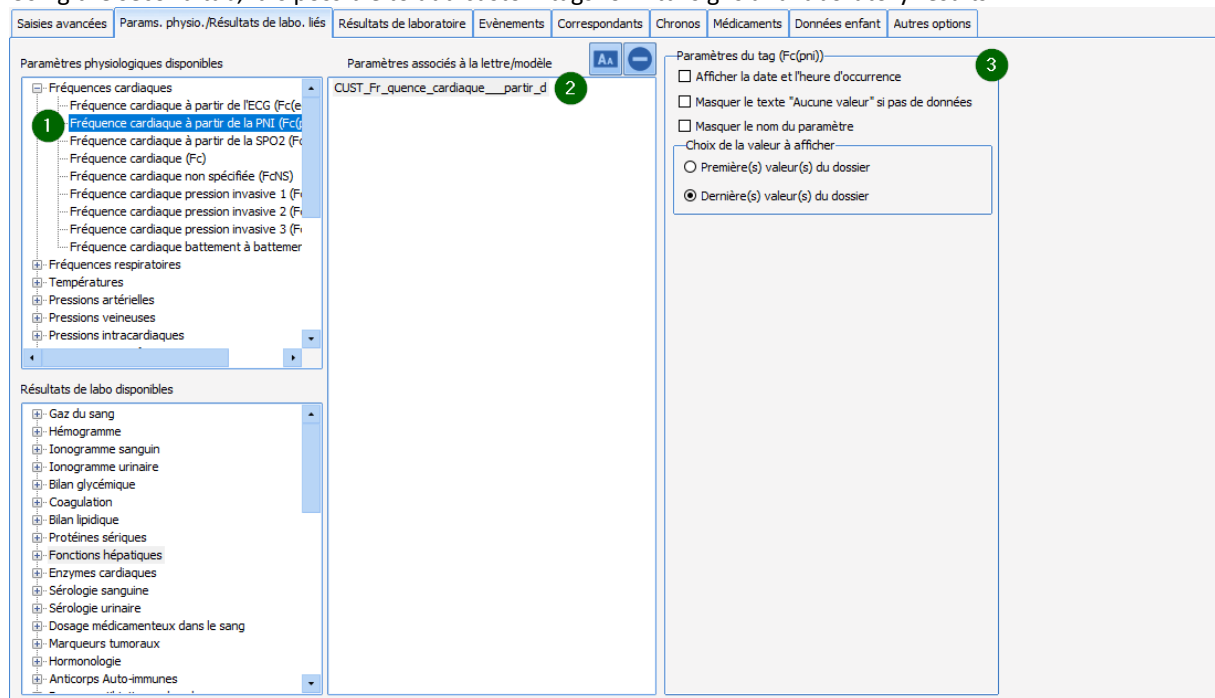


Click  to remove everything added since the tool was opened.

**NOTE:** if a **detailed entry** or a **score** are modified using copy-paste, remember to update the tags using the new detailed entry then replace this tag in the form letter.

### 3.12.2.2 Vital sign and laboratory result custom tags

Using the second tab, it is possible to add custom tags for vital signs and laboratory results.



Click the second tab of the tool. A **custom tag** management page shows three columns, progressing from left to right.

- The left column contains the available stock of **vital signs** and **laboratory results**.
- The middle column contains previously created **custom tags**. Drag and drop the required **vital sign** into the document.
- The right column appears when a **custom tag** is selected in the middle column. This column is used to select the relevant options. It is possible to modify the options of a **custom tag** at any time without having to modify the **form letter**.

**Vital sign** custom tags have the following settings options:

- **View occurrence date/time:** date and time visible in the patient record.
- **Hide 'No value' text if no data:** when it is important to know that there is no data.
- **Hide vital sign name**
- **First or last value in record.**

**Laboratory result** custom tags have the following settings options:

- **View date and time of occurrence:** date and time visible in the patient record.
- **Hide 'No value' text if no data:** when it is important to know that there is no data.
- **Hide vital sign name**
- **First or last value in record.** When a laboratory result is selected in the middle column, the **column on the right** changes as shown.


Paramètres du tag (SaO2 (GDS))

Afficher la date et l'heure d'occurrence

Choix de la valeur à afficher

Première(s) valeur(s) du dossier

Dernière(s) valeur(s) du dossier

Paramètres supplémentaires (glisser/déposer les paramètres de la liste de gauche) 


PtO2 Artériel (Gaz du sang) (PtO2 Artériel (GDS))

PtO2 Veineux (Gaz du sang) (PtO2 Veineux (GDS))

PtCO2 Artériel (Gaz du sang) (PtCO2 Artériel (GDS))

PtCO2 Veineux (Gaz du sang) (PtCO2 Veineux (GDS))



To delete an additional vital sign, click the entry then .

### 3.12.2.2.3 Laboratory result custom tags

Using the third tab, it is possible to add custom tags for laboratory results.

Saisies avancées	Params. physio./Résultats de labo. liés	Résultats de laboratoire	Evènements	Correspondants	Chronos	Médicaments	Données enfant	Autres options
Résultats disponibles		Résultats associés à la lettre/modèle	Paramètres du tag (1er Germe AERO)					
<ul style="list-style-type: none"> <li>100% de la formule (NF100)</li> <li>1er Germe (CAGE)</li> <li>1er germe (MAGE)</li> <li>1er Germe (PLGE)</li> <li>1er germe (URGE1)</li> <li><b>1er Germe AERO (HEGE)</b> <span style="color: green; font-weight: bold;">1</span></li> <li>1er Germe anaerobie (HEAG1)</li> <li>2e germe (URGE2)</li> <li>2E Germe anaerobies (MAAG2)</li> <li>2ème germe (CAG2)</li> <li>2ème Germe (EXG2)</li> <li>2ème germe (MAG2)</li> <li>2ème germe (PLG2)</li> <li>2ème Germe AERO (HEG2)</li> <li>2ème Germe ANA (HEAG2)</li> <li>2eNumét anaerobie (MAAN2)</li> <li>3e germe (URGE3)</li> <li>3e Germe anaerobies (HEAG3)</li> <li>3E Germes anaerobies (MAAG3)</li> <li>3E Mycoses (PLMY3)</li> <li>3E Numération (CANM3)</li> <li>3E Numération (MANM3)</li> <li>3E Numération (PLNM3)</li> <li>3ème germe (CAG3)</li> <li>3ème Germe (EXG3)</li> <li>3ème germe (MAG3)</li> <li>3ème germe (PLG3)</li> <li>3ème Germe AERO (HEG3)</li> <li>3EME Mycoses (CAMY3)</li> <li>3EME Mycoses (MAMY3)</li> <li>3eNumét anaerobie (MAAN3)</li> <li>4e germe (URGE4)</li> <li>4E Germes anaerobies (MAAG4)</li> <li>4ème germe (CAG4)</li> <li>4ème Germe (EXG4)</li> </ul>		<ul style="list-style-type: none"> <li>CUST_1er_Germe_AERO__HEGE_ <span style="color: green; font-weight: bold;">2</span></li> </ul>	<input type="checkbox"/> Afficher la date et l'heure d'occurrence <input type="checkbox"/> Masquer le texte "Aucune valeur" si pas de données <input type="checkbox"/> Masquer le nom du résultat Choix de la valeur à afficher <input type="radio"/> Première valeur du dossier <input checked="" type="radio"/> Dernière valeur du dossier <span style="color: green; font-weight: bold;">3</span>					

Click the third tab of the tool: a **custom tag** management page shows three columns, progressing from left to right.

- The left column contains the stock of all **available results**.
- The middle column contains previously created **custom tags**. Drag and drop the required **laboratory result** into the document.
- The right column appears when a **custom tag** is selected in the middle column. This column is used to select the relevant options. It is possible to modify the options of a **custom tag** at any time without having to modify the **form letter**.

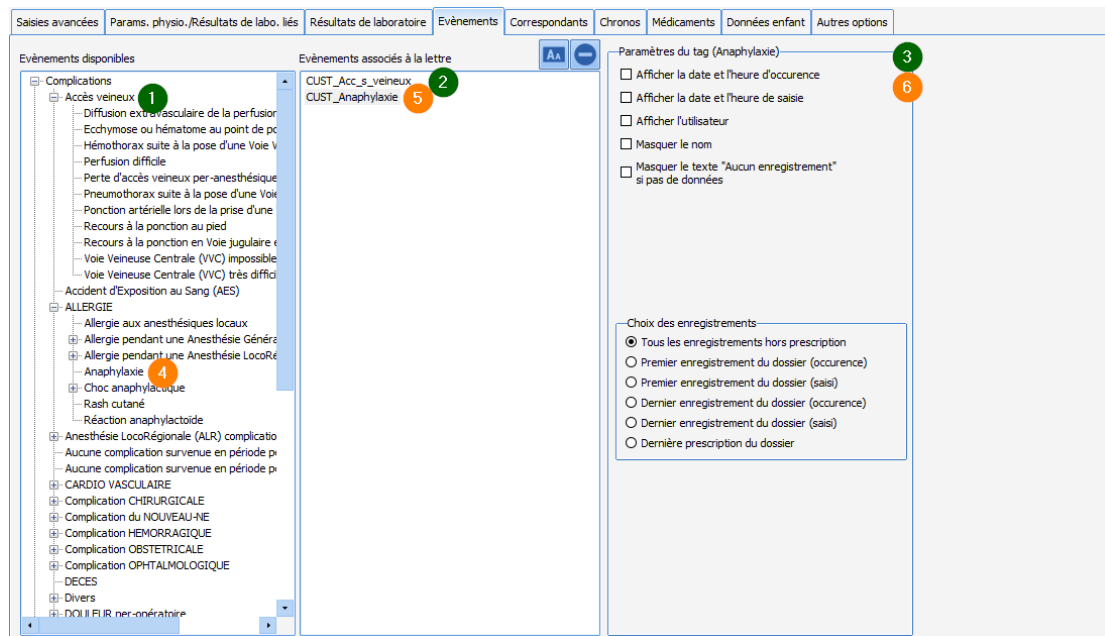
**Laboratory result** custom tags have the following settings options:

- **View occurrence date/time:** date and time visible in the patient record.

- **Hide 'No value' text if no data:** when it is important to know that there is no data.
- **Hide result name**
- **First or last value in record.**

### 3.12.2.2.4 Event custom tags

Using the fourth tab, it is possible to add custom tags for events.



Click the fourth tab of the tool: a **custom tag** management page shows three columns, progressing from left to right.

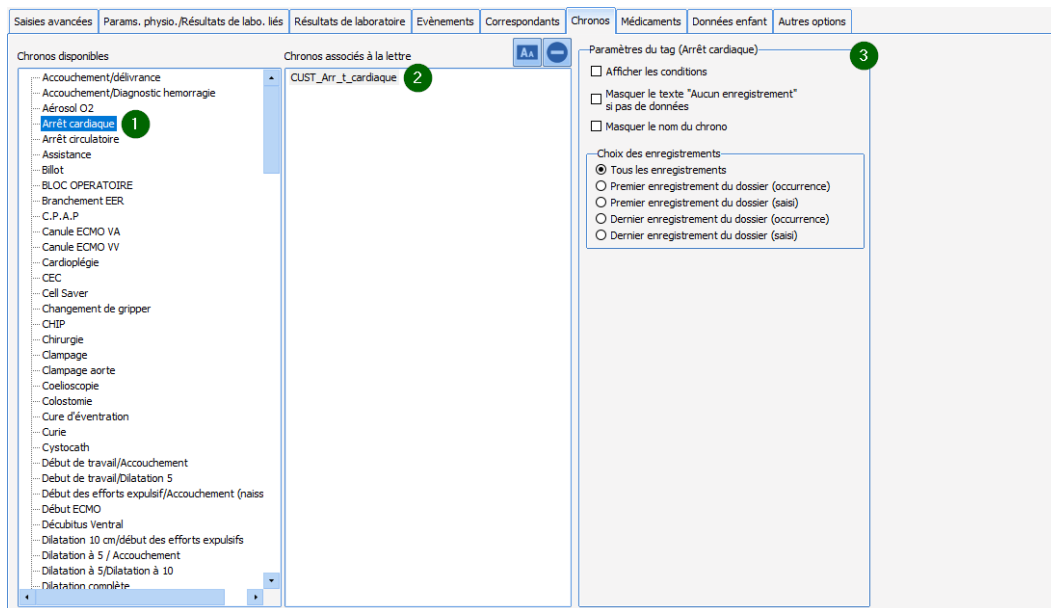
- The left column contains the stock of all **events**.
- The middle column contains previously created **custom tags**. Drag and drop the required **event** into the document.
- The right column appears when a **custom tag** is selected in the middle column. This column is used to select the relevant options. It is possible to modify the options of a **custom tag** at any time without having to modify the **form letter**.

**Event** custom tags have the following settings options:

- **View occurrence date/time:** date and time visible in the patient record.
- **View date and time of entry:** actual data and time of entry.
- **View user:** full name.
- **Hide name:** used to write the name differently in the form letter.
- **Hide 'No value' text if no data:** when it is important to know that there is no data.
- **Entry selection.**

### 3.12.2.2.5 Timer custom tags

Using the sixth tab, it is possible to add custom tags for timers.



Click the sixth tab of the tool: a **custom tag** management page shows three columns, progressing from left to right.

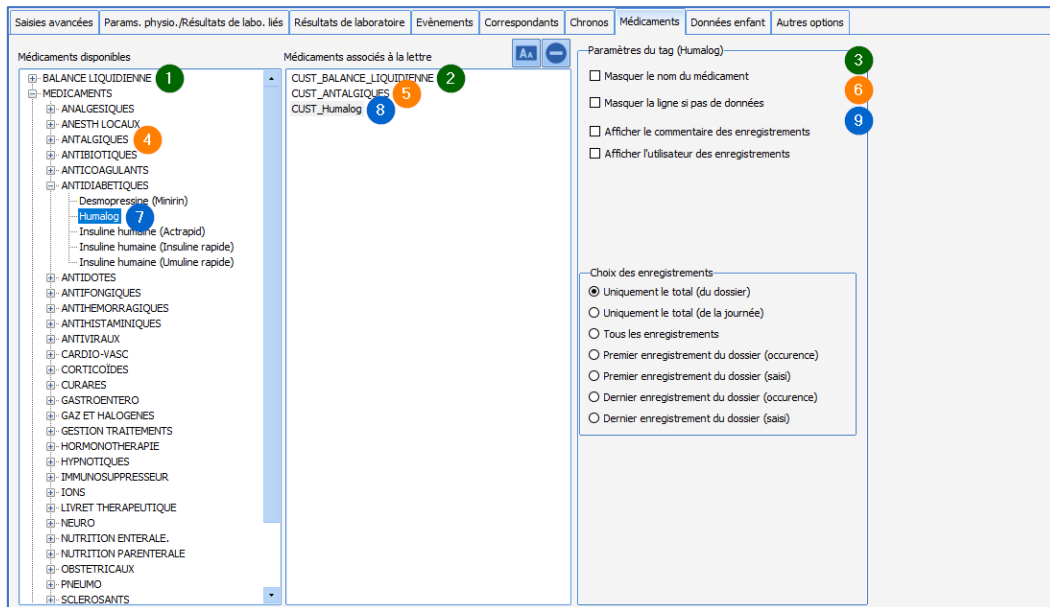
- The left column contains the stock of all **timers** .
- The middle column contains previously created **custom tags**. Drag and drop the required **timer** into the document.
- The right column appears when a **custom tag** is selected in the middle column. This column is used to select the relevant options. It is possible to modify the options of a **custom tag** at any time without having to modify the **form letter**.

**Timer** custom tags have the following settings options:

- **View conditions.**
- **Hide 'No value' text if no data:** when it is important to know that there is no data.
- **Hide timer name:** used to change the name of the timer in the form letter.
- **Entry selection.**

### 3.12.2.2.6 Drug custom tags

Using the seventh tab, it is possible to add custom tags for drugs.



Click the seventh tab of the tool: a **custom tag** management page shows three columns, progressing from left to right.

- The left column contains the stock of **fluid balances, theatre drugs** and **blood products**.
- The middle column contains previously created **custom tags**. Drag and drop the required **product** into the document.
- The right column appears when a **custom tag** is selected in the middle column. This column is used to select the relevant options. It is possible to modify the options of a **custom tag** at any time without having to modify the **form letter**.

**Drug** custom tags have the following settings options:

- **Hide drug name:** used to change the name of the drug in the form letter.
- **Hide 'No Rows text if no data:** when it is important to know that there is no data.
- **View entry comments:** comments linked to occurrences.
- **Entry selection.**

**NOTE:** it is possible to have a tag for all drugs, and another for a drug category. This is very useful to avoid modifying the form letter each time a drug is added to a category.

### 3.12.2.3 Form letters using the integrated DIANE editor

Form letters in **DIANE** can be edited in two formats. This chapter presents the integrated **DIANE** editor format. The following chapter presents form letters in **Word** format.

#### 3.12.2.3.1 Requirements, advantages and disadvantages

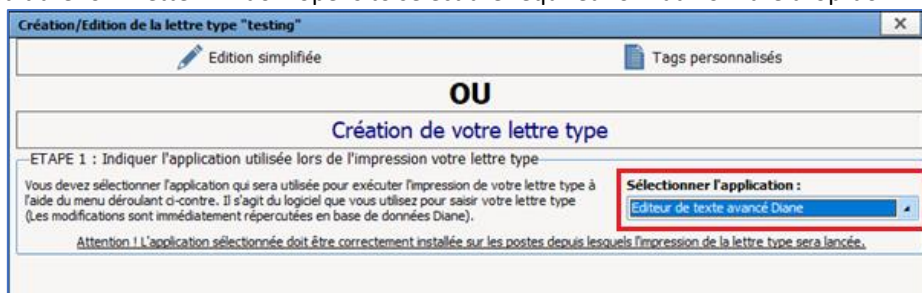
The integrated **DIANE** editor is an internal editor, with advantages and disadvantages in comparison to **Word**.

- **Requirements:**
  - **DIANE** version 4.6.24.8 or later
- **Advantages:**
  - This integrated editor provides independence from external applications such as **Word** or **OpenOffice**. This makes deployment considerably easier and ensures high-quality operation and printing in line with the requirements of the person in charge of writing these documents.
  - Responsiveness is superior to **Word** and **OpenOffice**. This is because there is no external application to launch.

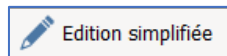
- Formatting functions are basic, giving greater stability to form letter settings.
- The presence of a tag search engine facilitates form letter creation.
  - **Disadvantages:**
- It is impossible to create a read-only protected form document like in **Word**.
- Formatting options are more limited than in **Word** or **OpenOffice**.

### 3.12.2.3.2 Create a form letter

To create a form letter, in the application configuration select the **Form letter** tab, then in the drop-down menu select the category of document required, then see Section 3 for creating a form letter. Once this has been done, the Create/edit the form letter window opens to select the required format from the drop-down menu.



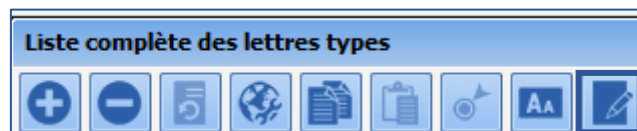
To create an **Integrated form letter**, select the **DIANE advanced text editor**. Click on the Simplified editing button.



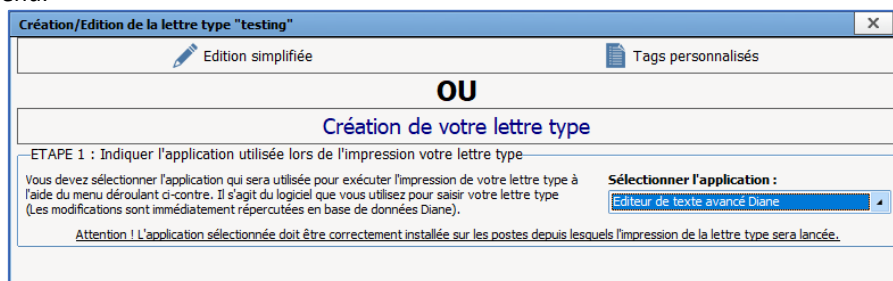
The integrated **DIANE** editor opens a text editor with a blank document.  
**NOTE:** once a document has been created, its type cannot be changed.

### 3.12.2.3.3 Modify a form letter

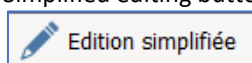
To edit a form letter, in the application configuration select the **Form letter** tab, then in the drop-down menu select the category of document required, then select the required form letter from the column on the right to edit it.



Once this has been done, the Create/edit the form letter window opens to select the required format from the drop-down menu.



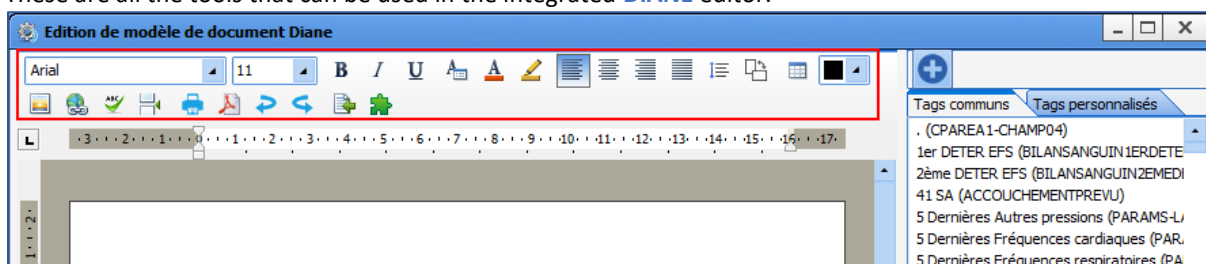
To modify an **Integrated form letter**, click the Simplified editing button.



The integrated editor opens on the previously saved document.

### 3.12.2.3.4 Using the integrated DIANE editor

These are all the tools that can be used in the integrated **DIANE** editor.



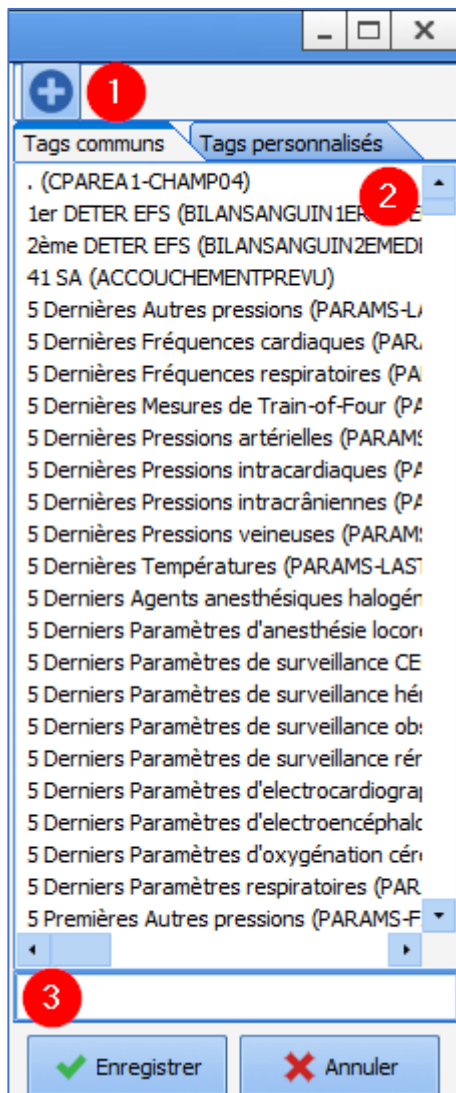
Typography, alignment, paragraph spacing, page orientation, table management, image insertion, hyperlink creation and page breaks can all be controlled.

	List of <b>typography options</b> available on the DIANE expert's workstation. Defines the <b>typography</b> of the selected text in the editor or <b>changes</b> the editing to this new typography from the cursor.
	Defines the size of the <b>typography</b> of the selected text in the editor or <b>changes</b> the editing to this new size from the cursor.
	Makes the selected text in the editor <b>bold</b> or <b>changes</b> the editing to <b>bold</b> from the cursor.
	<b>Italicises</b> the selected text in the editor or <b>changes</b> the editing to <b>italics</b> from the cursor.
	<b>Underlines</b> the selected text in the editor or <b>changes</b> the editing to <b>underlined</b> from the cursor.
	Opens the <b>typography</b> editor to change the appearance of the selected text in the editor or change editing to the new text appearance.
	Defines the <b>colour</b> of the selected text in the editor or <b>changes</b> the editing to this new colour from the cursor.
	Defines the <b>highlighting</b> of the selected text in the editor or <b>changes</b> the editing this new highlighting from the cursor.
	Defines the <b>justification</b> of the selected lines in the editor OR defines the <b>justification</b> for the text from the cursor.
	Defines <b>paragraph spacing</b> .
	Defines the document page <b>orientation</b> as landscape or portrait.
	These two palettes are used to create a table in the editor (left button) and select the cell background colour (right button).
	Insert an image in the editor where the cursor is placed.
	Insert a hyperlinked word into the form letter
	Spell check
	Page break
	Printing Send print without preview to the default printer of the user's workstation.
	Create a PDF file to be saved on the user's workstation.
	These two functions, go to a previous version and return to present, are also accessed with the keyboard shortcuts <b>CTRL + Z</b> and <b>CTRL + MAJ + Z</b>
	Import a copy of content from another form letter
	Show a check box. Boxes are used in some documents, such as antibiotic documentation.



### 3.12.2.3.5 Insert a tag or custom tag in the form letter

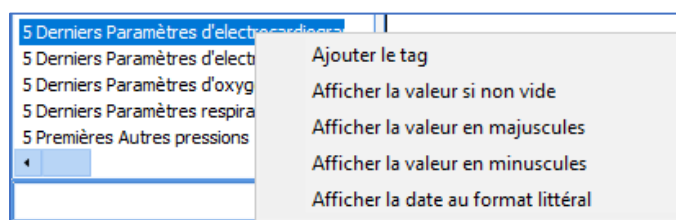
To insert custom tags in a document, they must first be created (see Creation of custom tags). Once this has been done, previously created tags can be inserted into a document in the integrated **DIANE** editor.



The right column contains (first tab) **Common tags**: Point 2, all ActiveX / data ID tags.

The tag search engine can be used to find a tag to insert: Point 3. Searches cover the tag name and the title of the component configured with this tag.

To insert a tag in the document, double-click or right-click the required tag.

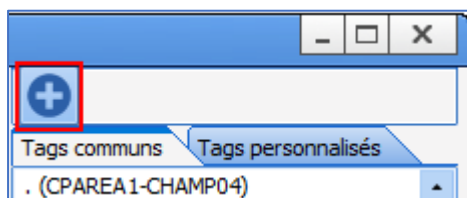


Right-clicking opens a menu used to rapidly set up formatting, without using conditions.

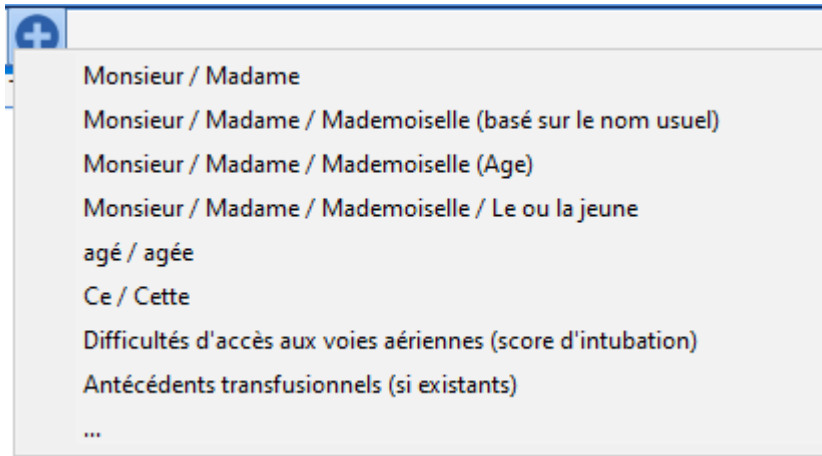
- Add tag,
- View value if not empty,
- View the value in uppercase,
- View the value in lowercase,
- View date in literal format.

The second tab shows custom tags, as described earlier in this document (**Creation of custom tags**). They are inserted in exactly the same way as **common tags**.

#### 3.12.2.3.5.1 Creating a tag with simple conditions



The button at the top of the right column is used to open the **"Conditions menu"**. The usual forms of address are presented.



The list of forms of address is as follows:

- **Mr / Mrs / Ms**  
According to gender
- **Mr / Mrs / Ms / Miss**  
According to name known by
- **Mr / Mrs / Miss**  
According to age
- **Mr/Mrs/Ms/Miss/Master/Miss**
- **Aged**  
According to age
- **Difficulty accessing the airway**  
According to intubation score in [DIANE ANAESTHESIA](#) Consultation
- **Transfusion history**

The last option “...” shows the condition builder. This can be used to create a custom condition. Detailed example: the expression “Minor patient” will be shown in the form letter if the patient is under 18 years of age.

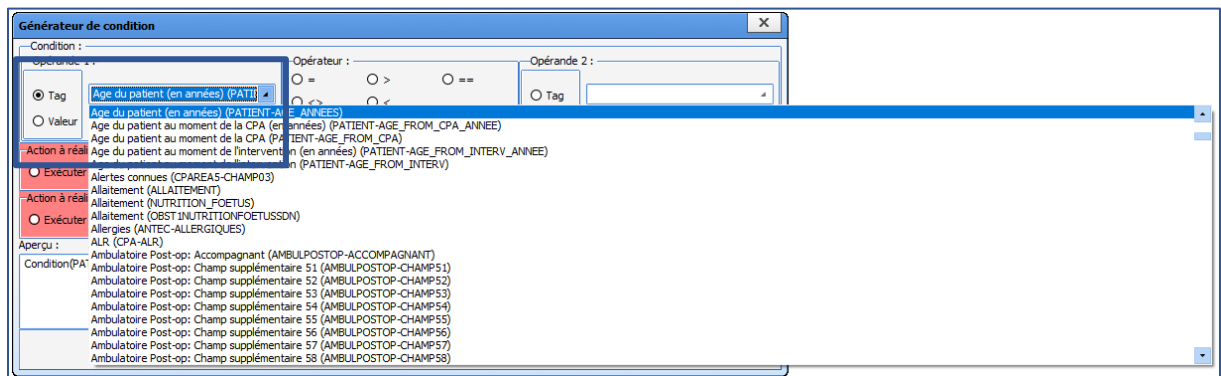
The condition builder comprises three horizontal panes:

- Condition: This is used to define the basis or criteria for setting up the required condition.
- Action to take: This is used to select the result depending on whether the condition is true or false.
- Preview: This shows the formula of the condition.

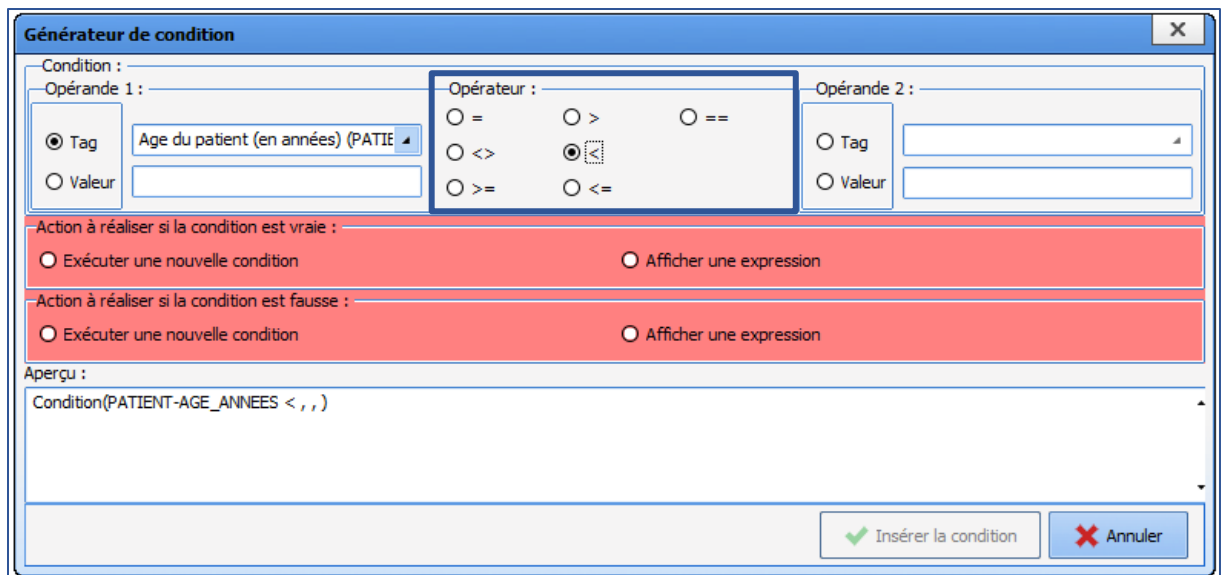
### Condition pane:

This comprises three parts, to be completed from left to right:

- *Operand 1:* This is used to define a tag or value as the reference for the required condition. In this example, the tag **PATIENT-AGE-YEARS** is selected as it is linked to a component that calculates the patient's age in number of years based on the date of birth and current date. **Reminder:** To locate a tag, please see "Finding a tag".



- *Operator:* This pane is used to define a 'lower/higher than or equal to' criterion or similar. In this example, this is the "<" symbol (lower than).



- *Operand 2:* This is used to define a tag or value as the result for the required condition. In this example, the value **18** is selected. It is important to know the format used for the tag selected in operand 1 in order to select the value.

### Action to take pane:

This pane is used to indicate what will be written when the condition is true, and what will be written when it is false. Before this is configured, the **Action to take** pane is shown in red. Both actions must be filled in and have a green background in order to be able to insert the condition.

If one of the actions is not useful, click **View an expression** and insert the condition without modification in the expression builder.

To show free text, it must be entered in the window.

To show a tag if the condition is true/false, select this tag in the right column.

In this example, if the **PATIENT-AGE-YEARS** tag is lower than **18** and this condition is true, the expression *Minor patient* must be shown. When **View an expression** is selected, the expression builder is used to select the tag or text to be displayed.

In this example, **View an expression** is selected for **Action to take if condition is true**. In the pane on the left, the following text must be entered: *Minor patient*.  
Confirm expression.

If the condition is false, i.e. the **PATIENT-AGE-YEARS** tag is higher than **18**, nothing is shown. **View an expression** must therefore be selected in **Action to take if condition is false**.

The expression builder window opens again.

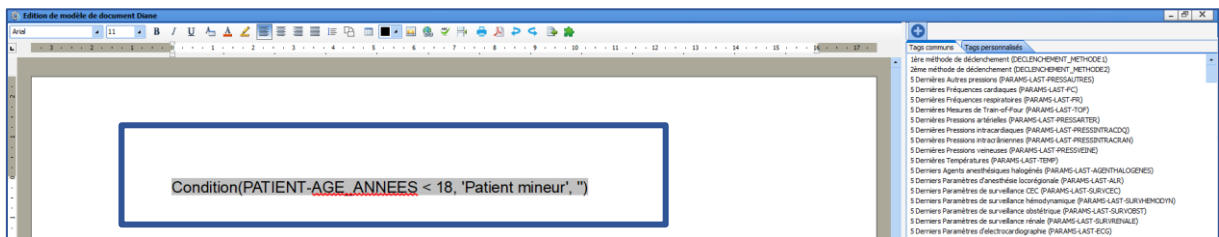
In this example, no other information must be added to the letter if the **PATIENT-AGE-YEARS** tag is higher than **18**. The expression can be confirmed without entering text or selecting tags.

After the two actions (true and false) are inserted, the pane changes to green.

### Preview pane:

This is used to view the appearance of the condition that has been created. In this example: Condition(PATIENT-AGE-YEARS < 18, “Minor patient”, “”).

Finally, select **Insert condition**.



The condition will be automatically inserted into the text. It can be moved or modified (see Modifying a conditioned tag).

This condition is then used to automatically enter the term “Minor patient” in the form letter when the component PATIENT-AGE-YEARS is lower than 18 and enter nothing when the patient is an adult.

### 3.12.2.3.5.2 Creating a tag with advanced conditions

It is frequently useful to create a tag in a form letter that includes several different conditions and actions. Example: the term *Minor patient* is indicated if the patient is younger than 18 years old, and *Adult patient* is indicated if the patient is older than 18 years.

Dans ce cas, 3 conditions seront imbriquées. La première est basée sur l’âge, puis les 2 suivantes sont configurées avec le composant **PATIENT-SEXE**.

La première étape est de définir le tag **PATIENT-AGE\_ANNEES**, telle que la partie précédente. Les 2 conditions suivantes vont être insérer via le choix **Exécuter une nouvelle condition**.

**Générateur de condition**

Condition :

Opérande 1 :  Tag Age du patient (en années) (PATIE)  Valeur

Opérateur :  =  >  ==  <>  <  >=  <=

Opérande 2 :  Tag  Valeur 18

Action à réaliser si la condition est vraie :  Exécuter une nouvelle condition  Afficher une expression

Action à réaliser si la condition est fausse :  Exécuter une nouvelle condition  Afficher une expression

Aperçu :  
Condition(PATIENT-AGE\_ANNEES < 18, , )

Cliquer sur **Exécuter une nouvelle condition**, le générateur de condition s'ouvre une seconde fois pour configurer cette 2<sup>e</sup> condition. Dans cet exemple, la condition imbriquée est basée sur le tag **PATIENT-SEXE**, est égal à **F** (valeur possible du composant sexe du patient).

**Générateur de condition**

Condition :

Opérande 1 :  Tag Sexe (PATIENT-SEXE)  Valeur

Opérateur :  =  >  ==  <>  <  >=  <=

Opérande 2 :  Tag  Valeur F

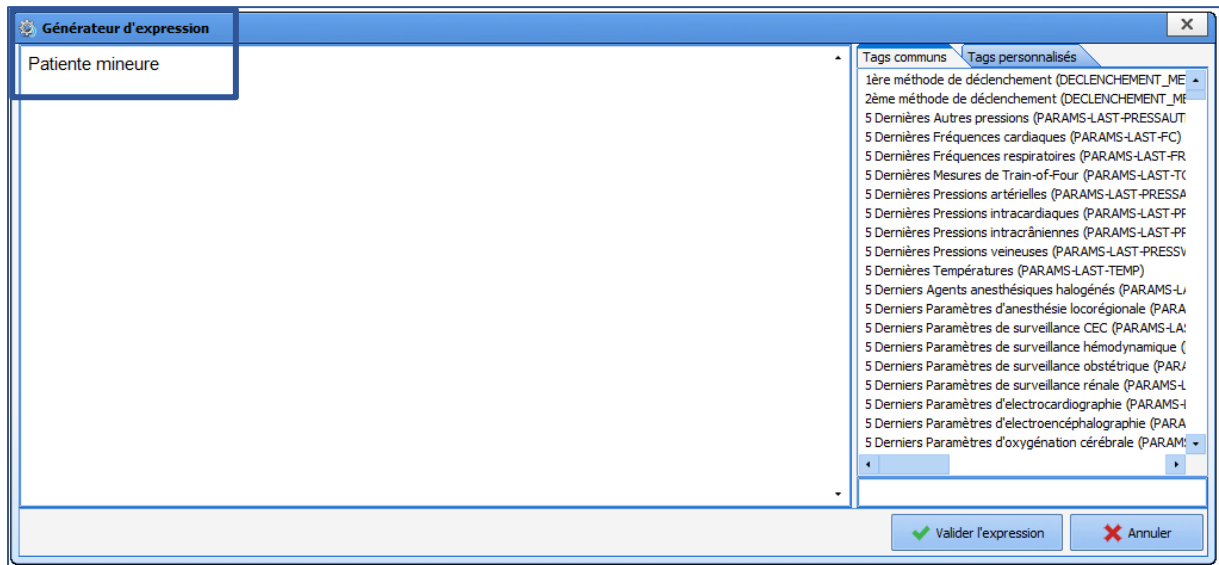
Action à réaliser si la condition est vraie :  Exécuter une nouvelle condition  Afficher une expression

Action à réaliser si la condition est fausse :  Exécuter une nouvelle condition  Afficher une expression

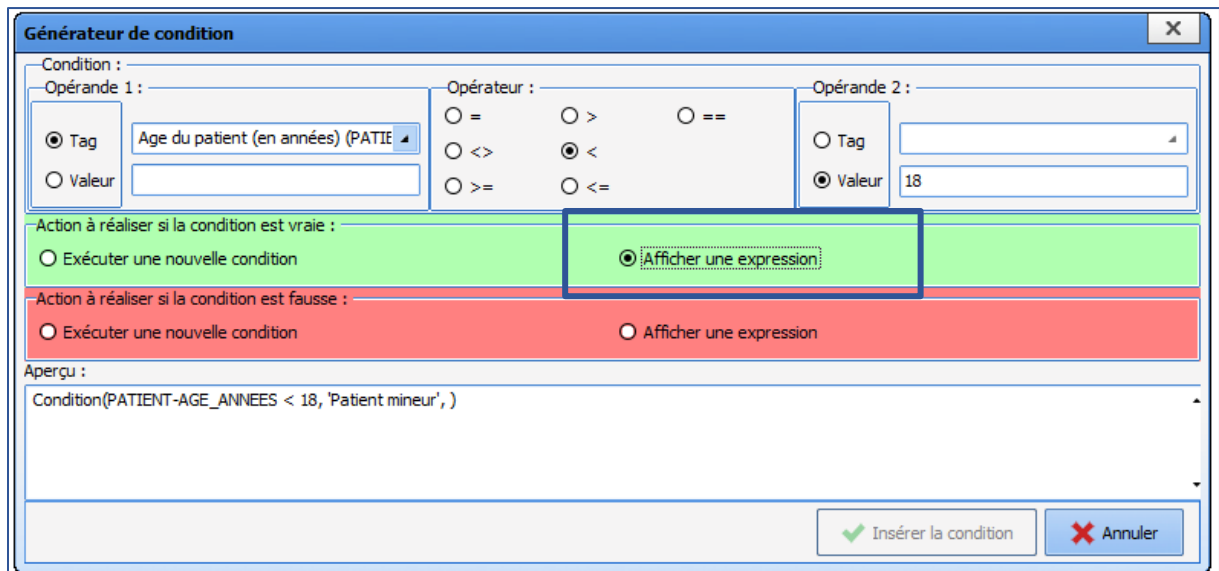
Aperçu :  
Condition(PATIENT-SEXE = 'F', , )

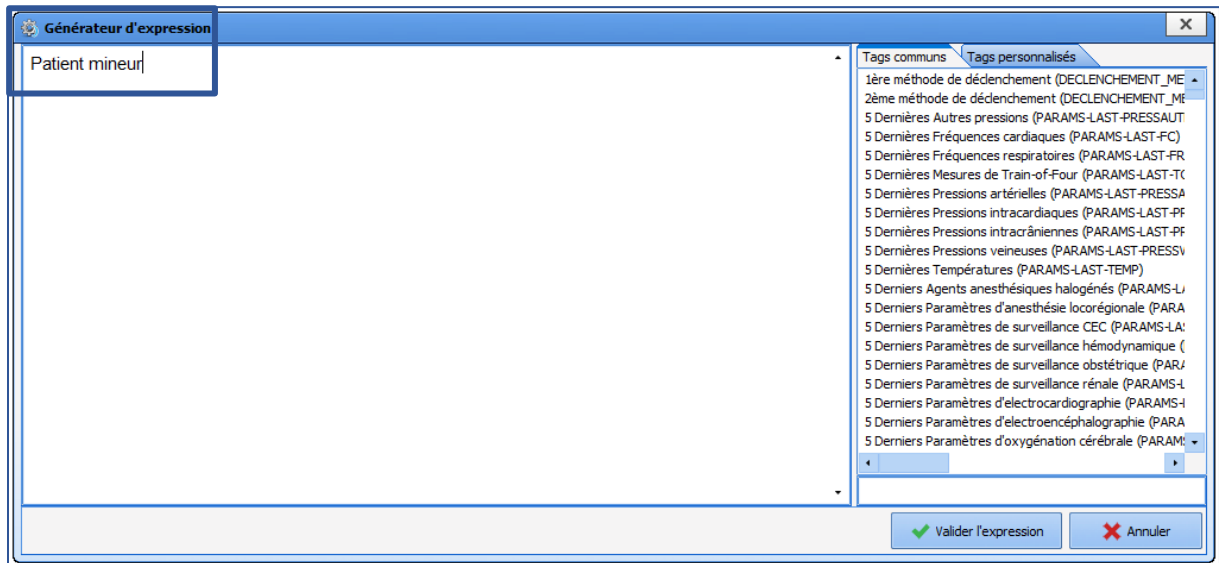
Puis sélectionner **Afficher une expression**, et saisir l'expression ou le tag souhaité. Dans cet exemple, si le sexe est égal à **F**, il faut afficher *Patiente mineure*.



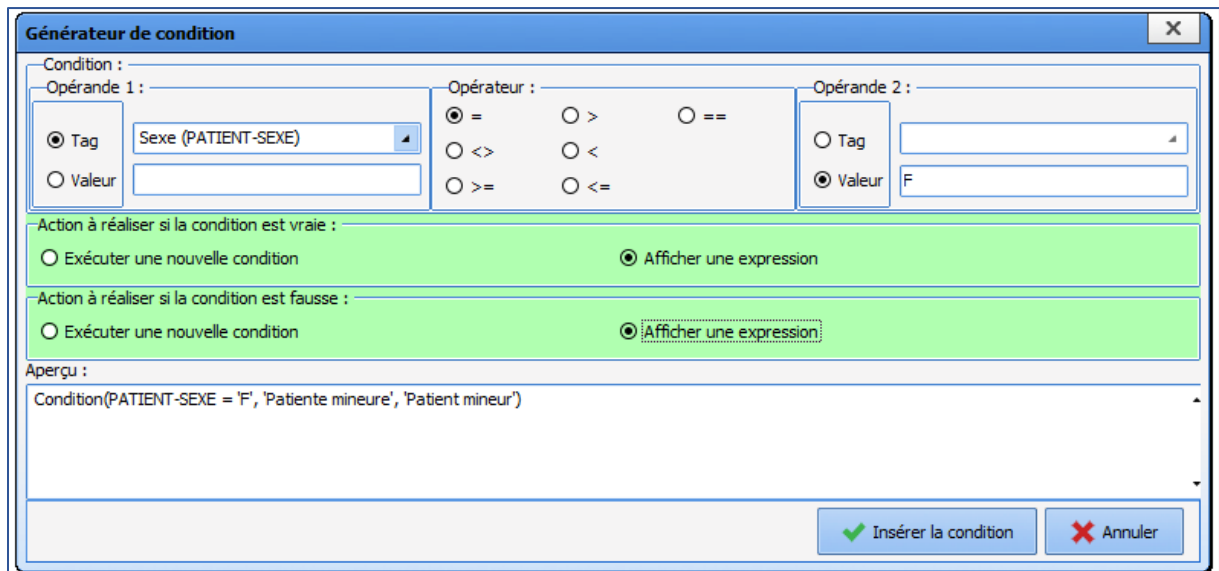


Si la condition est fausse, il faut alors indiquer *Patient mineur*. (Action to take if condition is false).





This second condition is then set up. **Insert condition** must be selected.



The condition generator for the first condition is not open to complete set-up.

The **Action to take if condition is false** must be configured. Dans cet exemple, il faut indiquer *Patient majeur* pour un homme, et *Patiente majeure* pour une femme. Il est donc nécessaire d'imbriquer une 3<sup>e</sup> fonction avec **Exécuter une nouvelle condition**, dans **Action à réaliser si la condition est fausse**.

De la même façon que précédemment, il faut sélectionner l'opérande 1, l'opérateur, l'opérande 2, puis les actions à réaliser si vraie / fausse (dans cet exemple : patiente majeure, patient majeur). La condition (3<sup>e</sup> condition) est ensuite insérée. Le générateur revient alors sur la 1<sup>re</sup> condition dans laquelle, l'ensemble des 3 conditions est visible dans l'aperçu.

Sélectionner **Insérer la condition**, pour que la condition soit affichée dans la lettre type.

Le résultat des conditions est le suivant :

- Si le patient a moins de 18 ans et est féminin = écrire *Patiente mineure*
- Si le patient a moins de 18 ans et n'est pas féminin = écrire *Patient mineur*
- Si le patient a 18 ans ou plus et est féminin = écrire *Patiente majeure*
- Si le patient a 18 ans ou plus et n'est pas féminin = écrire *Patient majeur*

The **Preview** zone shows all the embedded conditions.

**Reminder:** Save the form letter before closing the editor window.

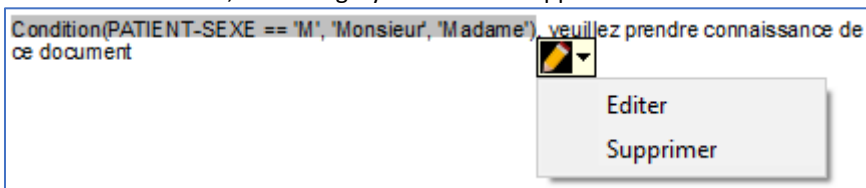
### 3.12.2.3.5.3 Modifying a conditioned tag

This is the result of the Mr/Mrs forms of address form as shown in the editor.

`Condition(PATIENT-SEXE == 'M', 'Monsieur', 'Madame'), veuillez prendre connaissance de`

A condition is always shown as a single grey block. It is not possible to delete part of the condition or edit the content directly.

To edit the condition, click the grey box. A menu appears.



Click **Edit** to open the condition editor as when confirmed. There is no difference in practice between creating and modifying conditions.

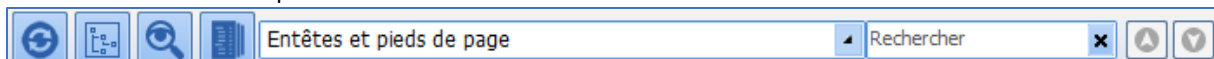
### 3.12.2.3.6 Adding a header to a form letter

A form letter header is a form letter in itself, holding the content of the header. It is used to centralise headers. To change the facility logo, for example, it is possible to modify it in the header template and all prescriptions that use this header will automatically be updated.

Using headers independent of letters means that documents can be modified while maintaining a shared graphic charter, the information in the header can be protected and centralised, and if necessary the header can be modified and applied to only the relevant documents (without modifying every letter).

Headers using the integrated **DIANE** editor format can only be used with form letters using the integrated **DIANE** editor format.

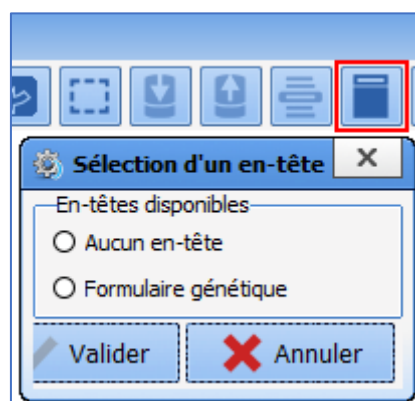
To create or modify a header, select the **FORM LETTER** tab in the application configuration, then select **Headers and footers** from the drop-down menu:



Create a document as shown in: **Form letters using the integrated DIANE editor**

**NOTE:** Headers must also be toggled in the **Visible form letters in the selected area** column.

To link a form letter to a header, select the category of form letter in which the document is found in the drop-down menu (e.g. Pre-op consultation printing). Click the document in the right column, then click the link button underneath on the right.



The header linking tool automatically filters headers compatible with the integrated **DIANE** editor format.

Radio buttons only allow one item to be selected from the available choices. Click **Generic form** and confirm to link the document. To unlink a document so that it no longer has a header, click **No header** and confirm.

**NOTE:** the header applied is visible during use but not during configuration. Don't forget to restart **DIANE** using

**DIANE MANAGER** to see the results of the changed settings.

### 3.12.2.3.7 Adding a background to a form letter

A form letter background is a form letter in itself. It contains content of its own in the form of images or text. It is most often used to create prescriptions that have a column on the left or right containing the names of the facility doctors. In this case, the modify the list, the doctor is added to the background form letter and all prescriptions that use this background are automatically updated.

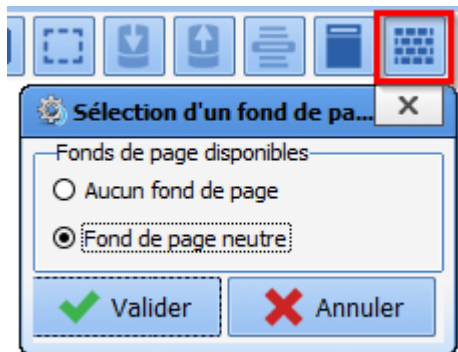
**NOTE:** The background and form letter with which it is linked can be considered as layers. It is important to check that the page set up gives the expected result.

To create or modify a background:



Create a document as shown in: **Form letters using the integrated DIANE editor**

**NOTE:** Ensure that background are moved to the middle column for the entities where this makes sense.



To link a form letter to a background, select the category of form letter in which the document is found from the menu. Click the document and click the link button underneath on the right.

The background link tool presents all the existing backgrounds. Page backgrounds only work with the integrated editor.

Radio buttons only allow one item to be selected from the available choices. Click **Neutral background** and confirm to link the document. To unlink a document so that it no longer has a background, click **No header** and confirm.

**NOTE:** the background applied is visible during use but not during configuration. Don't forget to restart **DIANE** using **DIANE MANAGER** to see the results of the changed settings.

## 3.12.2.4 Form letters in WORD format

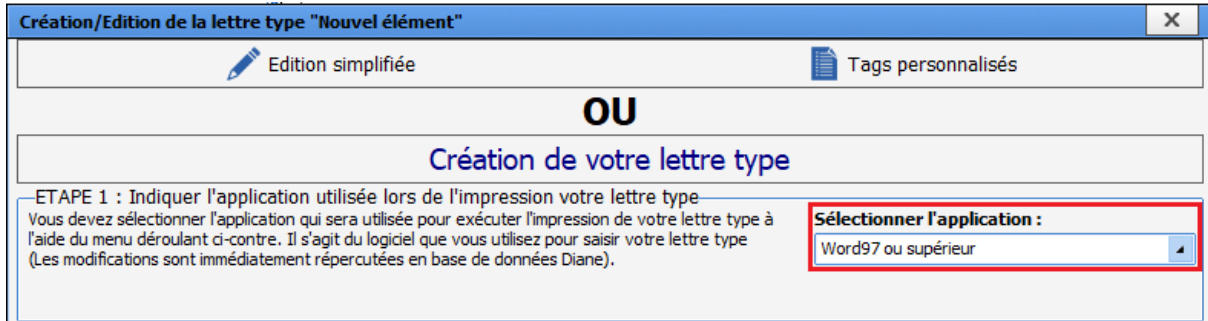
It is possible to use **Word** to create form letters. Given the complexity of this tool, please see the **Word** user manual, as its functions and use may differ from version to version.

### 3.12.2.4.1 Requirements, advantages and disadvantages

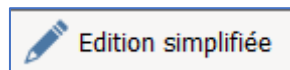
- **Requirements:**
  - There are no requirements other than deploying **Word** on all workstations that may generate form letters - prescriptions, summaries, etc.
  - Moderate proficiency in using **Word** for users, and advanced proficiency for DIANE experts.
- **Advantages:**
  - Enables elaborate formatting and deeper integration into some facility IT systems.
  - Documents can be protected in read-only mode (with the exception of check boxes). This function is questionable as potentially important information may not be present in the **DIANE** patient record.
- **Disadvantages:**
  - The lack of a Tag engine makes searching for tags more complicated.
  - Loading documents for editing takes longer than with the integrated **DIANE** editor.

#### 3.12.2.4.2 Creating a Word form letter

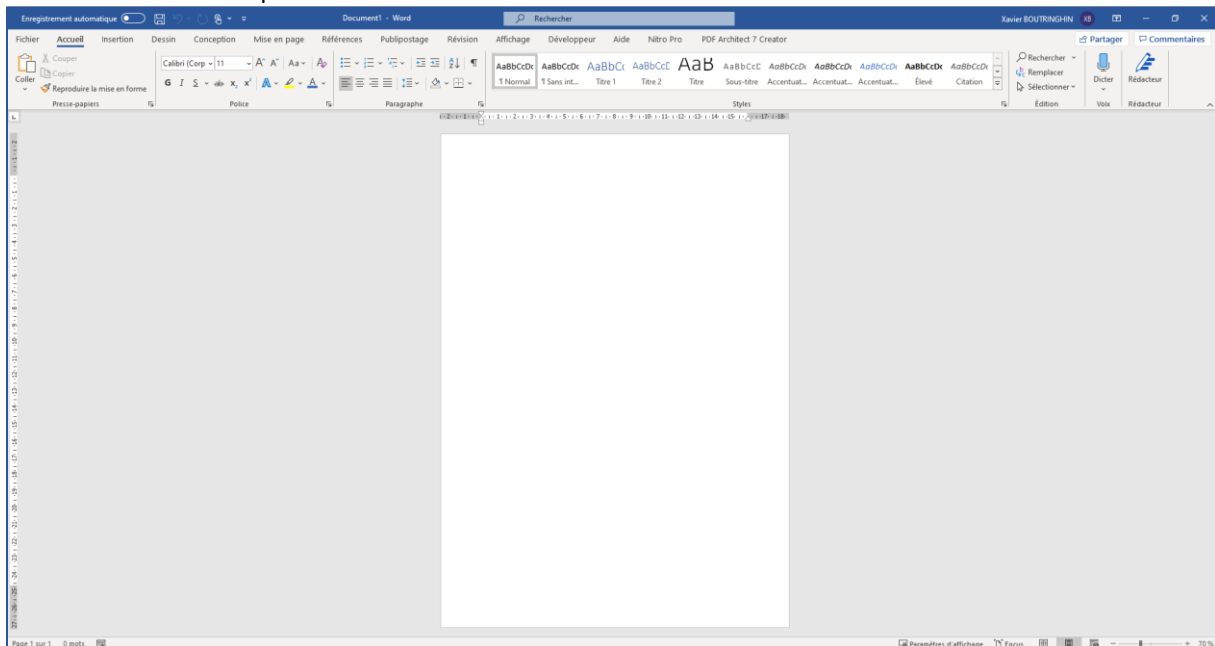
To create a form letter, in the application configuration select the **Form letter** tab, then in the drop-down menu select the category of document required, then see Section 3 for creating a form letter. Once this has been done, the Create/edit the form letter window opens to select the required format from the drop-down menu.



To create a **Word form letter**, select **Word 97 or later**. Click on the Simplified editing button.



The **Word** editor then opens with a blank document.



**NOTE:** once a document has been created, its type cannot be changed.

#### 3.12.2.4.3 Protecting in read-only, exporting and importing form letters

Exporting and importing form letters is mainly used to restrict modifications to these documents. The two most commonly seen cases are the creation of a document with check boxes and the modification of **DIANE** documents on a computer that doesn't have the software.

Création/Édition de la lettre type "Consultation complète1"
X

Edition simplifiée
 Tags personnalisés

## OU

### Création de votre lettre type

**ETAPE 1 : Indiquer l'application utilisée lors de l'impression votre lettre type**  
 Vous devez sélectionner l'application qui sera utilisée pour exécuter l'impression de votre lettre type à l'aide du menu déroulant ci-contre. Il s'agit du logiciel que vous utilisez pour saisir votre lettre type (Les modifications sont immédiatement répercutées en base de données Diane).

**Sélectionner l'application :**  
Word97 ou supérieur

**ETAPE 2 : Composer votre lettre type à l'aide des Tags de Diane**

Exporter la liste des "tags"

Vous pouvez exporter la liste des Tags de Diane vers un fichier texte en cliquant sur le bouton ci-contre. Si vous avez sélectionné l'application Word alors ce fichier texte doit être utilisé tel quel comme source de données rattachée à la lettre type que vous allez saisir. Pour cela lancer Word, sélectionnez dans le menu "Outils/Publipostage" puis créez une "Lettre type" en document principal. Ouvrez le fichier texte (.txt) contenant les Tags de Diane comme source de données. Composez alors votre lettre type en insérant les champs de fusion disponibles directement à partir de la barre d'outil prévu à cet effet dans Word ("PATIENTNOM\_PATRONYMIQUE", PATIENTPRENOM, ...).  
 Si vous n'utilisez pas Word mais le format WordPad RTF, WordPad TXT ou StarOffice/OpenOffice, alors le fichier texte généré contiendra les Tags Diane tels qu'ils doivent être saisis dans la lettre type que vous créez ("Diane[PATIENT-NOM\_PATRONYMIQUE]", "Diane[PATIENT-PRENOM]", ...).

**ETAPE 3 : Importer le fichier contenant la lettre type**

Lorsque votre lettre type est terminée, vous devez l'importer dans la base de données de Diane. Pour cela cliquez sur le bouton ci-contre et sélectionnez le fichier contenant la lettre type (S'il s'agit d'un fichier WORD celui-ci ne doit pas être en lecture seul, sinon l'import échouera).

Importer le contenu de la lettre type

Attention ! La taille maximum du fichier est limitée, en effet une fois compressé celui-ci ne doit pas excéder 10 Mo afin d'être importé en base de données.

Taille du fichier contenant la lettre type : 132,61 Ko(s)      ( Taille du fichier compressé en base de données : 64,95 Ko(s) )

**ETAPE 4 : Sortir et configurer la lettre type**

Votre lettre type est désormais importée en base de données. Vous pouvez alors fermer cette fenêtre en cliquant sur la croix située dans le coin supérieur droit. Basculer ensuite votre lettre type dans la liste du milieu pour la rendre disponible dans le secteur concerné.

### Edition d'une lettre type déjà existante :

**ETAPE A : Exporter la lettre type existante vers un fichier**

Si vous souhaitez apporter des modifications à votre lettre type, vous devez d'abord l'exporter vers un fichier en cliquant sur le bouton ci-contre.

Exporter le contenu de la lettre type

**ETAPE B : Réaliser les modifications et mettre à jour dans la base de données**

Une fois votre lettre type exportée vers un fichier, vous pouvez apporter toutes les modifications que vous souhaitez en l'éditant à l'aide de l'application utilisée (celle stipulée à l'étape 1 de la création d'une lettre type). Reprenez ensuite à partir de l'étape 3 de la création d'une lettre type.

Step-by-step guide to obtaining a Word document with **DIANE** tags on the workstation:

- Create or edit a **Word** document on the workstation or export a **DIANE Word** form letter.
- Export list of tags
- Link tag list with previous document  
*See next chapter for linking*  
*Use **Word** help if difficulties arise.*
- Write the document and insert tags. Refer to **Inserting a tag in a form letter** below
- Insert any form components (check boxes, free text... )  
*Use **Word** help if difficulties arise.*
- Protect the document if necessary  
*Use **Word** help if difficulties arise.*
- Import the document into **DIANE**

#### 3.12.2.4.4 Linking the tag list to a Word document

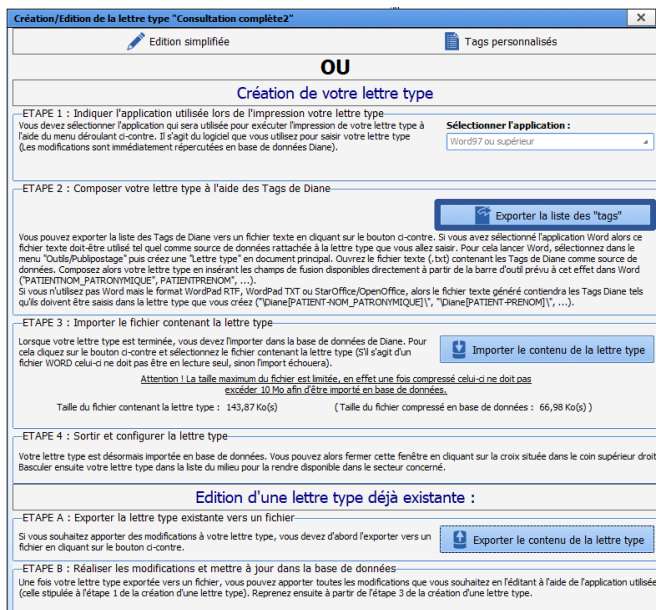
Mailing can be used to automate letters and reports based on information included in the **DIANE** patient record. In order to use this, the document must be connected to a database, which contains **DIANE** tags (in turn connected to a component).

For example, the tag PATIENT-NAME\_FAMILY-NAME corresponds to the field containing the patient's family name. Inserting the PATIENT-NAME\_FAMILY-NAME tag in the document therefore enables the patient's family



name to be written automatically.

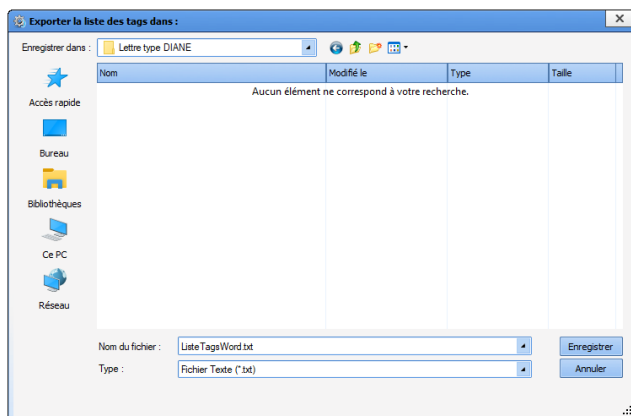
When working on the formatting of a form letter, with the exception of simplified editing (i.e. when **DIANE** is not used), the tag list must be linked to the relevant form letter. To do this, please proceed as follows:



## 1- Export tag list to a selected directory:

In the application configuration, form letter section, select the required letter domain and edit the document to be modified. (In this example, the form letter named **Full consultation 2**)

When the form letter creation window opens, select **Export the form letter's contents**.



## 2 - Select the location of the file containing the list of tags

The list of tags must be saved to the workstation. Select the required location using the icons on the right and/or the drop-down menu.

Select the **Save** button.

The list of tags is now downloaded to the required location (in this example: folder named **DIANE form letter**)



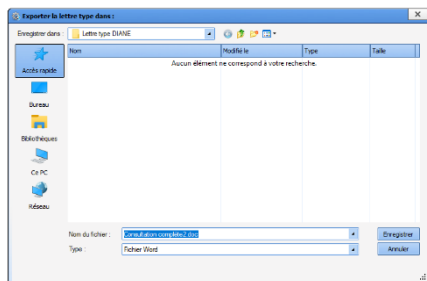
### 3a - First case:

A form letter that already exists in **DIANE** is used.

Edit the form letter in the application configuration then, in the **Creation/edition** window, export the form letter and save it to the relevant directory.

### 3b - Second case:

An existing **Word** document or a blank document is used. This step is therefore not necessary.

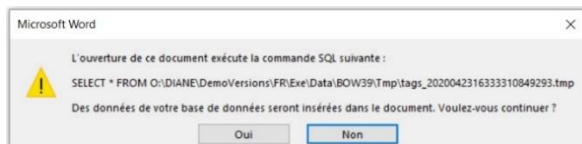


In the first situation, select the required location using the icons on the right and/or the drop-down menu.

Select **Save**.

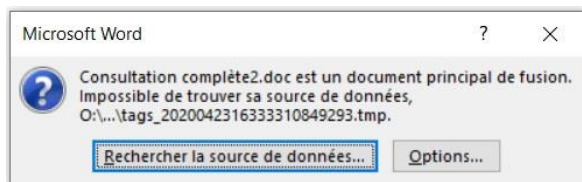
At this stage, the form letter can be opened using **Word**. The document can be found in the previously chosen location. In this example, the document is saved in the folder named **DIANE form letter**.

### 4 - In the case of a pre-existing document in **DIANE**:

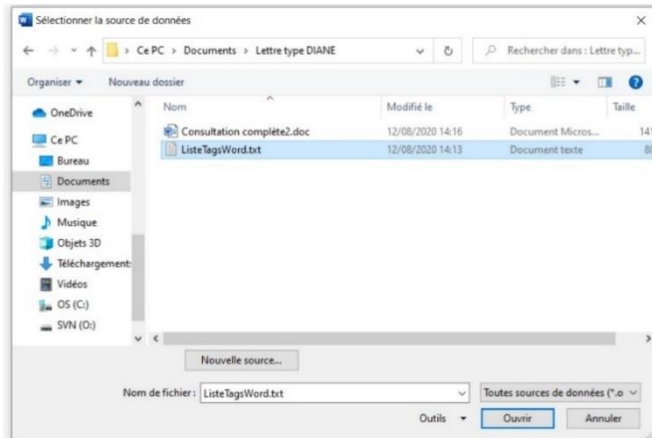


When a **Word** document that already exists in **DIANE** is opened, the software automatically opens a window to link the list of tags with the **Word** document.

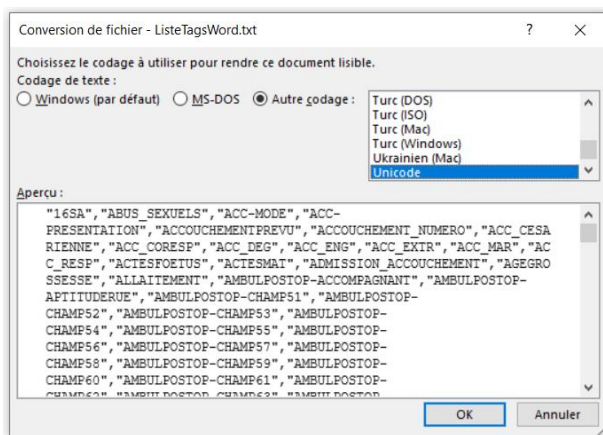
Select **YES**.



Then in the next window, select **Search for data source**.



The data source selection window is used to select the location in which the list of tags was previously saved (in this example, in the folder named **DIANE form letter**). Then click **Open**.



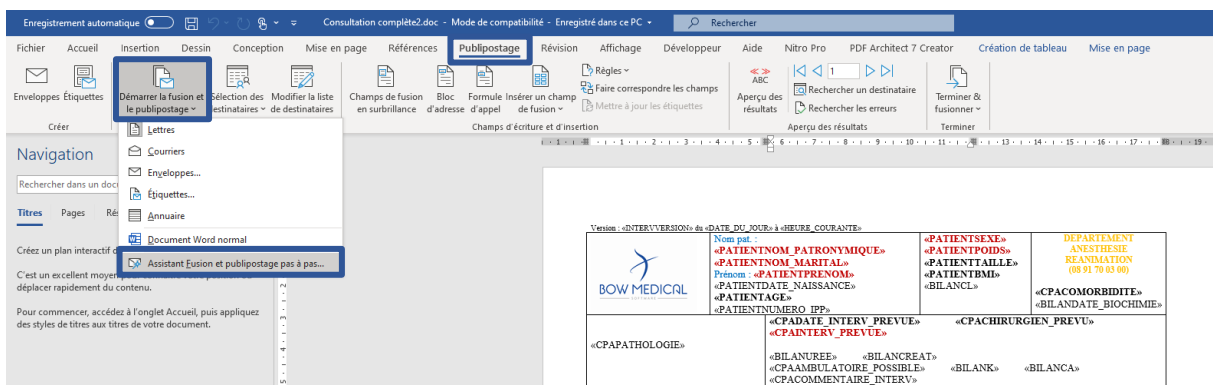
Finally, select **OK** in the file conversion window, with no modifications.

The **Word** document is now open and linked to the list of tags. Formatting can then be started.

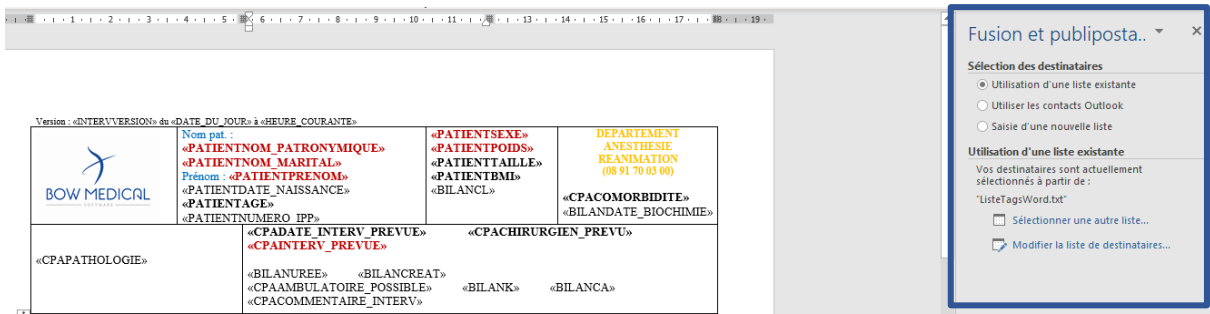
End of step 4 for documents already present in **DIANE**. Step 4 consists of presenting the same procedure for a blank document or one not found in **DIANE**.

#### 4 b - In the case of a newly created document (from scratch).

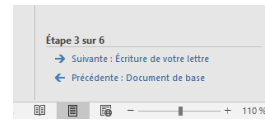
The working document may be a blank document or a previously prepared **Word** document. Open the document, then in the **Word** menu, **Mailings** tab, click **Start mail merge**. Select **Step-by-Step Mail Merge Wizard**.



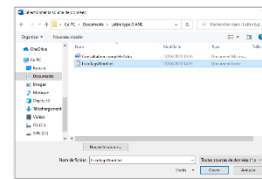
Depending on the version of **Word**, the program will open a help window or a help pane on the right. In this example, **Word** opens a browser to the right of the document.



At the bottom of the merge pane, select **Next: Write your letter**



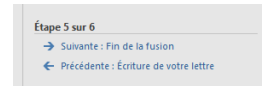
The location selection window opens automatically. Select the location in which the list of tags was previously saved. Select **Open**



Select **Next: Preview your letters**

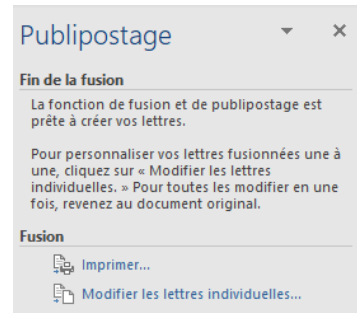


Select **Next: Complete the merge**



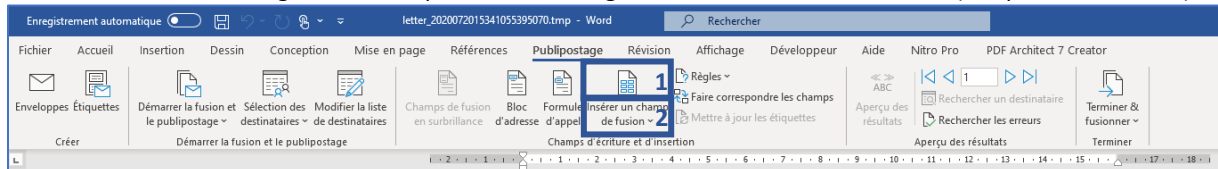
The list of tags is now linked to the form letter. It is now possible to start formatting the **Word** document.

In the **Mailings** section, it is possible to access the list of tags with the **Insert merge field** button. (see following section)

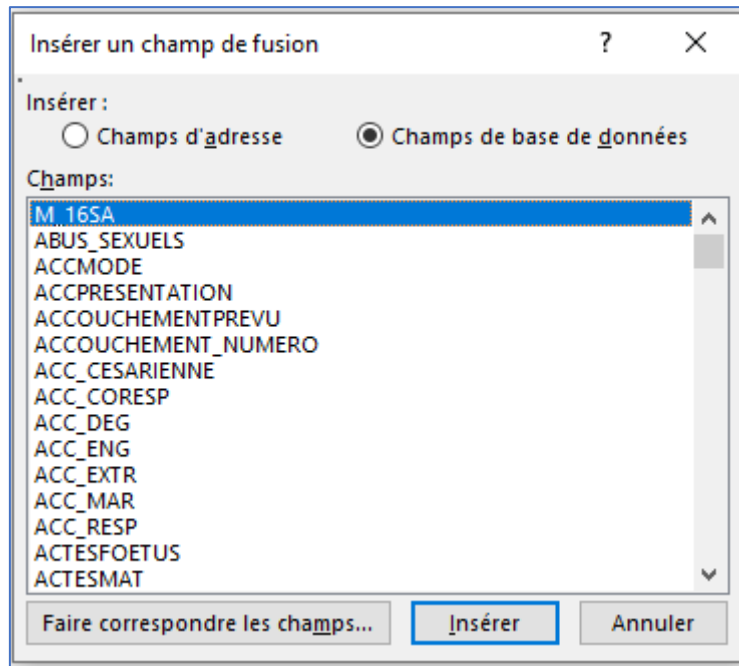


### 3.12.2.4.5 Inserting a tag in a form letter

To insert a tag, select the **Mailings** section. Click **Insert merge field**. If the document has been exported to the workstation, the list of tags must be exported and configured to link it to the **Word** file. (see previous section)



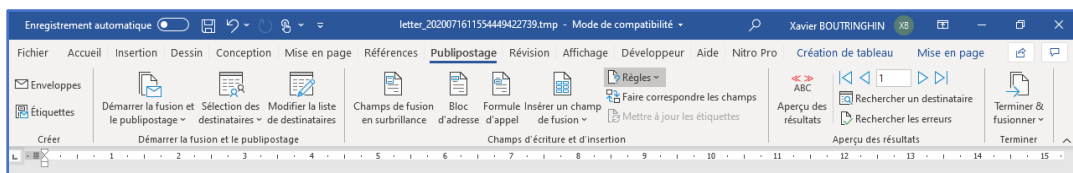
Clicking the top part (1) of the **Insert merge field** pane opens a window for selecting the tag to be inserted, Entering several letters of the tag allows it to be accessed more quickly. Clicking the lower part (2) opens a drop-down menu showing the list of tags. Quick entry is not available for this section.



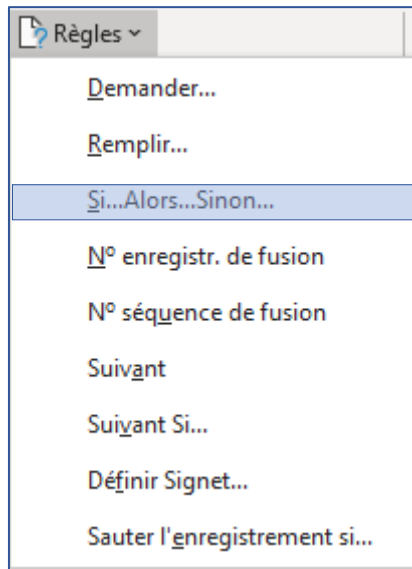
### 3.12.2.4.6 Creating a tag with simple conditions (rules)

**Example:** creating a rule to automatically write Mr or Mrs depending on the gender given in the patient record.

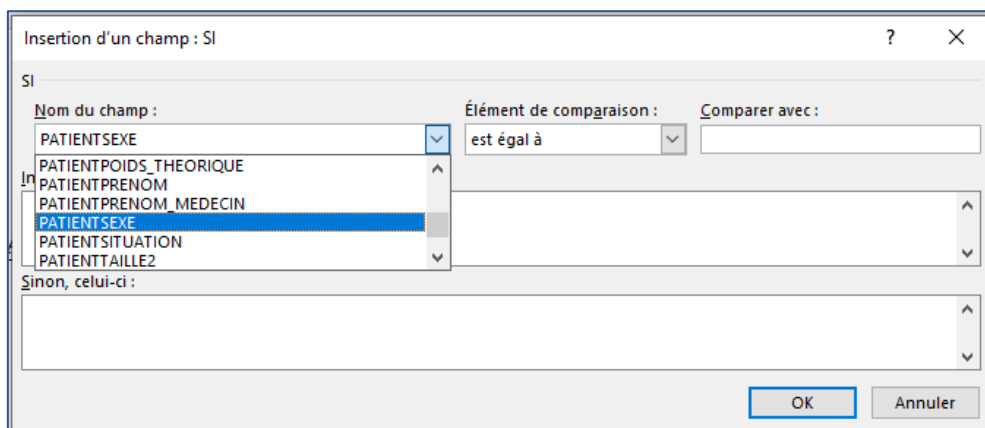
- Open the relevant form letter.
- Mailings tab > Rules.



- Clicking the **Rules** button makes it possible to choose the type of rules to apply.
- Use the function: If... Then... Otherwise...



- The Field insertion window opens. The drop-down menu is used to select the reference field. Here, the **PATIENTSEXE** tag is selected. See **Finding tags** if necessary to see which tags correspond to which data.



- Then, select **is equal to** in the list of comparisons. See **Finding tags** to see the possible values for comparison.

Options des données associées	
Accès en écriture du champ	Ecriture
Valeurs possibles	M=M  F=F

- Enter **M** in the field **Compare with**: Then the text to appear depending on the result. The first pane is used to show the text **Mr** if the result is positive. The second pane is used to show the text **Mrs** if the result is negative.

### 3.12.2.4.7 Creating a tag with advanced conditions

Where required, in particular where rules are too simple.

- Complex condition (and/or),
- The text to be inserted contains a tag or another test
- ...

A **Word** document with mailing has two different views. In the usual view, tags are shown in grey surrounded by quotation marks (" "). A second view, where tags are much more detailed and, importantly, modifiable, is also available.

Important terms and keyboard shortcuts:

**MERGEFIELD:** Merge field

**ALT + F9:** Show/hide detailed mode in **Word**:

**CTRL + F9:** Insert curly brackets In a tag formula, classic curly brackets make formulas fail.

"" : Double quotation marks mean "do not write anything" or "nothing". Text between double quotation marks means the text must be written.

*Example:* {si{ MERGEFIELD PATIENTNOM\_MARITAL }="" "" "Monsieur" } The condition means that if the married name component is empty, nothing is written, otherwise write Mr.

Here is the tag diagram for **Word**. Add spaces between quotation marks (" """) to prevent errors and improve readability.

The logic behind how a tag is formed with advanced conditions can be illustrated as shown:

{If {TAG}="compare with TAG" "result if true" "result if false"}

#### ▪ Example for surname:

«PATIENTNOM\_MARITAL»

Here is an example of how settings work with ALT+F9:

{ IF { MERGEFIELD PATIENTNOM\_MARITAL }="" "" "Nom marital : " } { MERGEFIELD PATIENTNOM\_MARITAL }

Translation: This condition corresponds to: If champ PATIENTSURNAME\_MARRIED is empty, write nothing, otherwise insert PATIENTSURNAME\_MARRIED merge field

- **Example for date of birth and age:**

Shown without ALT+F9:

«PATIENTDATE\_NAISSANCE»  
«PATIENTAGE»

Shown with ALT+F9:

```
{ IF { MERGEFIELD PATIENTDATE_NAISSANCE } = "" "" "Né{ IF { MERGEFIELD PATIENTSEXE } = "M" ""  
"e" \* MERGEFORMAT } le : " \* MERGEFORMAT } { MERGEFIELD PATIENTDATE_NAISSANCE }  
{ IF { MERGEFIELD PATIENTAGE } = "" "" "Age : " \* MERGEFORMAT } { MERGEFIELD PATIENTAGE }
```

**Explanation:**

If the merge field PATIENTDOB is not completed, nothing, otherwise write DOB: ....

**Translation:**

If the date of birth is not entered, nothing is written. Otherwise, “DOB:” is written, the “date of birth” field inserted and, if the age is zero, nothing is written otherwise write age:, insert the “age” field while maintaining the current font. (in bold)

**Result:** no text is written if the information is missing. However, if the information is present, the following text will be shown:

DOB: date entered (XX/XX/XXX)

Age: **Age entered. (xx years)**

### 3.12.2.4.8 Creating a form with check boxes and input boxes

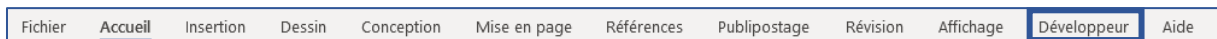
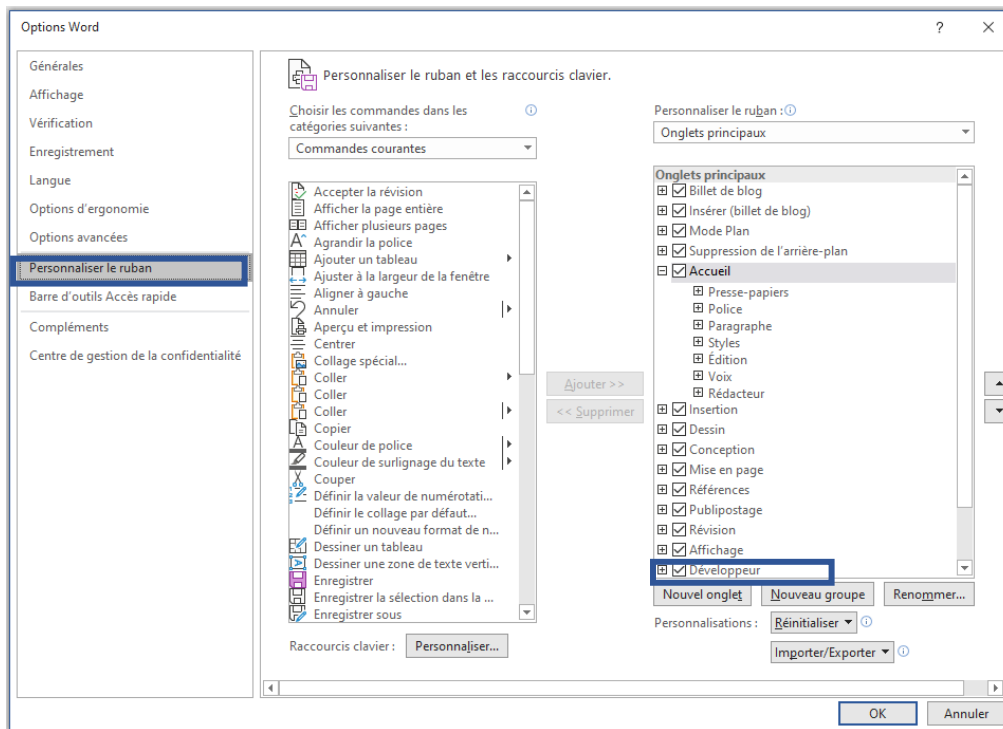


To add check boxes to a **Word** document, the **DEVELOPER** tab is required. If this is not the case in **Word** settings, click **FILE**.

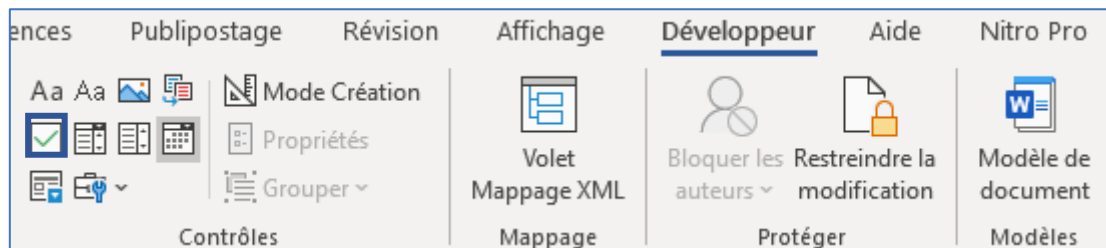
At the bottom left of the window, select **OPTIONS**.

Then select the **CUSTOMISE RIBBON** option in the pop-up window. Select the developer tab then click **OK**. The **DEVELOPER** tab then appears in the **Word** task bar.





Then, select the location in the document where you wish to insert a check box, and select the check box icon in the **DEVELOPER** tab.



The check box is then shown in the location that was clicked:



Click the check box to select and deselect.

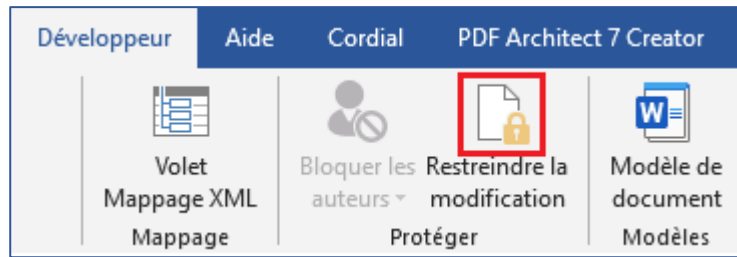
(e.g.

**Prescriptions on 01/02/2020:**

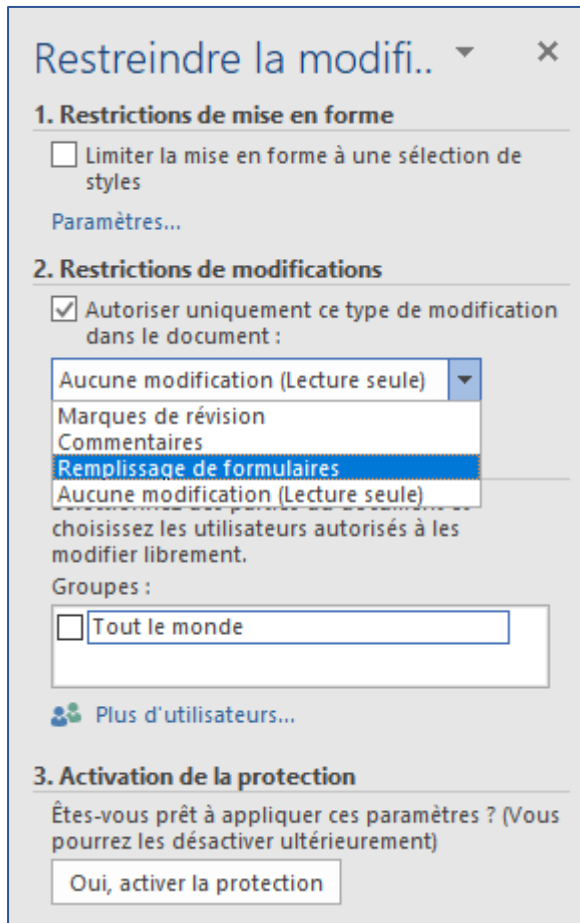
- 1 Box of PARACETAMOL 500mg
- 1 Box of PARACETAMOL 1000mg

**3.12.2.4.9 Protecting the document**

A document with check boxes or input boxes must be protected so that users can use these parts of the form. It is also possible to protect a document so that it is no longer modifiable by the user once integrated into **DIANE**.



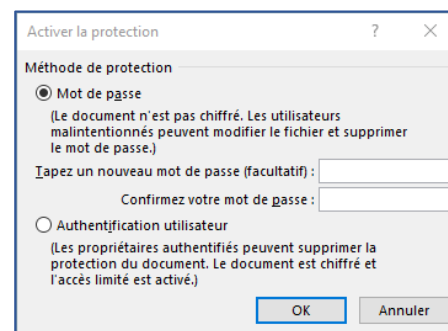
Click Restrict editing as shown above.



Select **Only authorise this type of change**.

Select the **Fill in forms** option from the drop-down menu.

Then move to point number 3, click **Yes, enable protection**.



Do not enter a password and click **OK**: the document is now protected. Only forms can be modified.

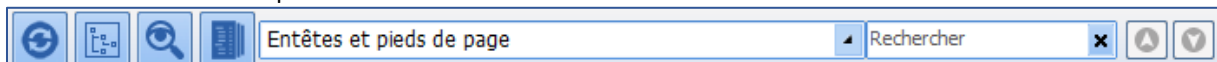
#### 3.12.2.4.10 Adding a header to a Word form letter

A form letter header is a form letter in itself, holding the content of the header. It is used to centralise headers. To change the facility logo, for example, modify it in the header template and all prescriptions that use this header will automatically be updated.

Using headers independent of letters means that documents can be modified while maintaining a shared graphic charter, the information in the header can be protected and centralised, and if necessary the header can be modified and applied to only the relevant documents (without modifying every letter).

Headers using **Word** format can only be used with form letters using **Word** format.

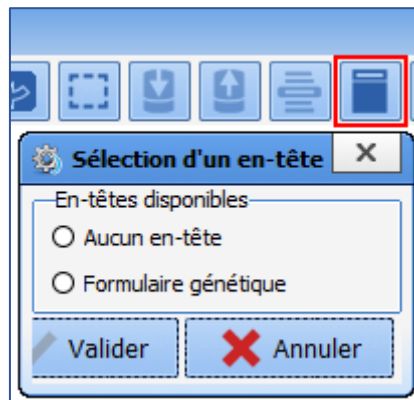
To create or modify a header, select the **FORM LETTER** tab in the application configuration, then select **Headers and footers** from the drop-down menu:



Create a document as shown in: **Creating a Word form letter**

**NOTE:** Headers must also be toggled in the **Visible form letters in the selected area** column.

To link a form letter to a header, select the category of form letter in which the document is found in the drop-down menu (e.g. Pre-op consultation printing). Click the document in the right column, then click the link button underneath on the right.



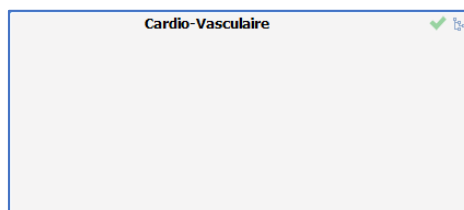
The header linking tool automatically filters headers compatible with the **Word** format.

Radio buttons only allow one item to be selected from the available choices. Click **Generic form** and confirm to link the document. To unlink a document so that it no longer has a header, click **No header** and confirm.

**NOTE:** the header applied is visible during use but not during configuration. Don't forget to restart **DIANE** using **DIANE MANAGER** to see the results of the changed settings.

### 3.13 Lists

Lists are used with **Input field with reference list** components.



This is the list called up on clicking  or typing the first letters of the word.

It is possible to:

- Create a new list
- Add to an existing tree structure

Lists taken from the **Lists** tab are consultation lists. The **Reference root** is the name of the list used. The list is

BOW MEDICAL SAS, 43, Avenue d'Italie  
34 87

80090 Amiens – FRANCE

**DIANE Settings Manual:** Version: 4.9

Tel.: +33(0)3 60 03 24 68 - Fax: +33(0)9 72 29

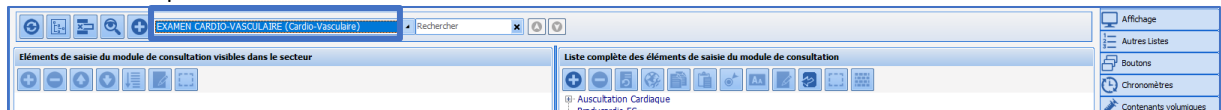
Email: [contact@bowmedical.com](mailto:contact@bowmedical.com)

Page: 139 / 332

attributed in component settings:



Liste générale de la deuxième colonne	Consultation
Root de référence de la deuxième colonne	EXAMEN CARDIO-VASCULAIRE

The general list is always **Consultation**. The reference root is the name of the list indicated in the drop-down menu at the top of the **List** tab.




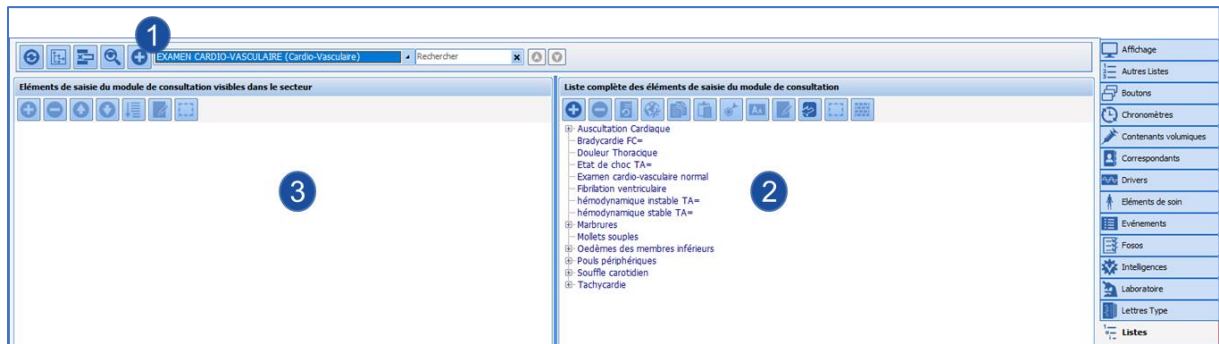
### 3.13.1 Configuration of a list







A list is a set of items. In this example, the list is used to enter the patient's gastrointestinal history. An item can be a "child item" and depend on another item and/or a "parent item" and have descendants. The  button is used to deploy and the  button used to hide the **tree structure** comprising child items and their possible descendants.

An item configured as a selector (underlined) is not repeated when the user selects one of its child items. In this example, "Colon" is configured as a selector, unlike "colitis". If the user selects "pseudomembranous", this is written as "pseudomembranous colitis".

To change an item into a selector, select it and click .



- 1 Selection or creation using the  of a root (= name of list).
- 2 Items in the selected list, use   to add or delete an item. ( before adding an item, ensure its location is selected)
- 3 All items in the list are available by default, the left column is useful for only used some of the items in the list. In this case, only items moved to the left will be visible in use. After selecting the items to be available for the sector, the order in which they are shown can be reorganised.



used to move the selected item up the list



used to move the selected item down the list



used to sort the whole list in alphabetical order

### 3.13.2 Colour code for list items

- Nothing to note for the item
- Underlined items are selectors (used to sort the list but does not appear in use)
- *Items in italics (regardless of colour) have an external ID for a specific use*
- One or more ICD 10 codes are associated with the item
- One or more procedure codes are associated with the item

## 3.14 Formulary

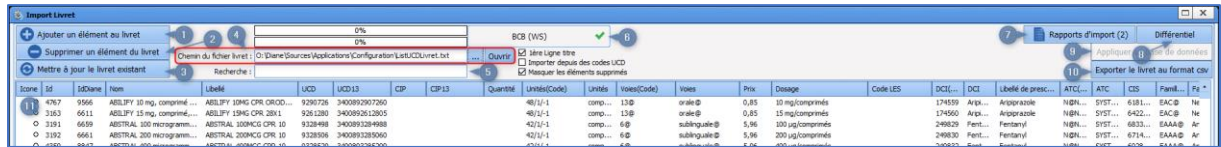
This tab is used to manage drugs used in medication orders (formulary and pharmaceutical alternatives). It is possible to:

- Manage the formulary by adding, deleting or importing products used in the facility so that they can be used in medication orders.
- Set up pharmaceutical alternatives, i.e. replacing one product with another on medication orders.

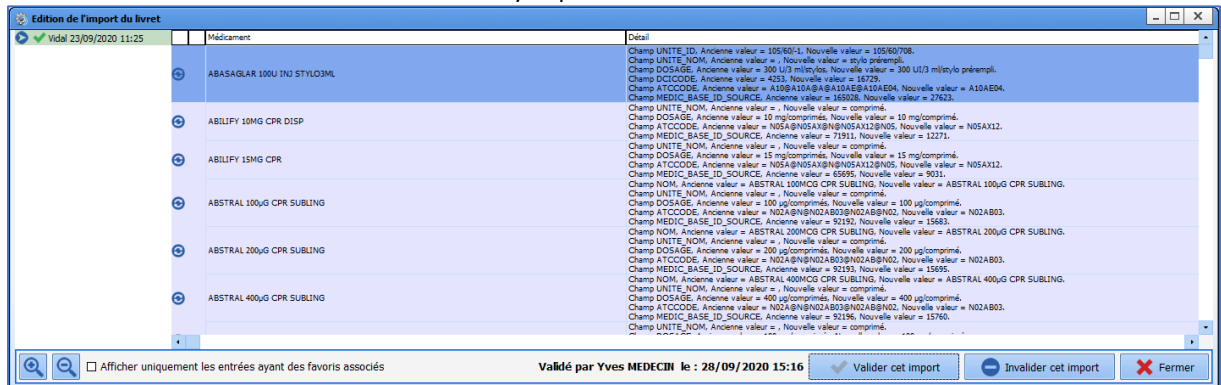
In the same database, it is possible to use several formularies (e.g. one formulary for the anaesthesia department and another for ICU). If the database is shared over several sites, it is also possible to use difference drug databases.

### 3.14.1 Import formulary

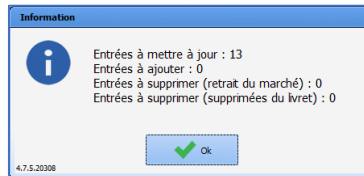
Formulary configuration is accessed via the **Formulary** tab.



- Used to add an item to the formulary.
- Used to delete an item from the formulary or recover a deleted item (visible if **Hide deleted items** is not selected).
- Update the existing formulary from the configured drug database (Pane 6).
- Used to import a formulary from a CSV file:
  - If the first row contains column titles, the box **First row title** must be selected.
  - If the import is from UCD codes, the box **Import from UCD codes** must be selected.
- Used to search for an element in the formulary.
- Name of configured drug database (BCB or Vidal) and connection status.
- Used to edit and confirm the formulary import.



- Shows differences between the database and the list items.



- Applies database changes: without this action, formulary updates/imports are not carried out.
- Export existing formulary in CSV format
- Show formulary items: deleted items are visible if **Hide deleted items** is not selected.

### 3.14.2 Edit formulary

It is possible to add, edit and delete items in a formulary.

The field **Find a drug** is used to add an item: enter a product name, active substance, or UCD, UCD13, CIP or CIP13 code to directly retrieve information from the configured drug database.

**Édition d'un élément du livret thérapeutique**

ID Livret	ID Diane	Quantité	Unités(Code)	Unité(UCD)	Quantité d'azote par contenant
-1	-1				0
CIP	CIP13	Prix	Voies(Code)	Voies	
UCD	UCD13	CIS	DCI(Code)	DCI	
Nom			ATC(Code)	ATC	
Libellé			Famille(Code)	Famille	
Dosage			Forme(Code)	Forme	

Recherche de médicament:  CIP trouvés:

Base de médicament configurée : Vidal

Base de médicament de l'élément :

Quantité Max. (/J/Kg)  Quantité Max. (/J)

Valeur létale (/J/Kg)  Valeur létale (/J)

Poids patient (utilisé pour le calcul des valeurs maximales et létales)  Kg

Libellé de prescription:

Codes LES:

Commentaires pour prescripteurs:

Commentaires pour IDEs:

**DIANE** identifies the corresponding CIP code(s) and displays the corresponding products:

Recherche de médicament	CIP trouvés
<input type="text" value="DOLIPRANE 1000 mg cp"/>	<input type="text" value="DOLIPRANE 1000MG CPR"/> <input type="text" value="DOLIPRANE 1000MG CPR"/>

Double-clicking the product label retrieves the information from the configured drug database.

The **Re-import from drug database** button is used to update the information about the item.

It is possible to update the whole formulary using the **Update existing formulary** button.

It is possible to delete an item with the **Delete a formulary item** button. The deletion is not permanent; a deleted item can be re-entered. To do this, deselect **Hide deleted items** (1). The deleted items are identifiable from the value 0 in the **Visible** column (2). To restore the item, first select it then click **Restore item to formulary** (3).

The fields **Comments for prescribers** and **Comments for nurses** allow the pharmacist to enter information that can be seen by the prescriber on the product medication order form (1 and 2) and nurses on the care plan (3).



**DOLIPRANE \*** +

DOLIPRANE 1000MG CPR 1

1000 mg/comprimé

Ce produit n'est pas diluable

Taille : 180 cms  
Poids : 80 Kgs

Posologie par administration + - x -

Posolo Commentaire pharmacien

1000 mg /kg Max. 1000 mg

**Commentaires pharmaciens livret** □ ×

DOLIPRANE 1000MG CPR

**4 g/jour maximum et 4h entre 2 prises**

2

Prescriptions						
	Libellé	Etat	Début	Prescripteur	Voie	Infos Suppl.
	Paracetamol : 1000 mg 1x/j		09h23	SYSTEM Diane	orale	administration si douleur
	Paracetamol : 1000 mg 1x/j	A Faire	09h23	SYSTEM Diane	orale	<span style="border: 1px solid black; border-radius: 50%; padding: 2px;">3</span>

Comments for prescribers (2) can be formatted using HTML tags.

### 3.14.3 Pharmaceutical alternatives

Produit Source	Produit Cible	Période de substitution
KETAMINE PANPHARMA 50 mg/5 ml sol inj IV IM	NUTRYELT sol diluer p perf	Substitution permanente
NOVORAPID FLEXPEN 100 U/ml sol inj en stylo prérempli	ANTIBIO SYNALAR sol p instil auric	Substitution permanente
GINKOLIS crème contour des yeux	8882 lunette nautisme catégorie 3 anti-infrarouge	Substitution permanente
CALCIPARINE 12 500 UI/0,5 ml sol inj sous cutanée	KARNODYL 5 mg/5 ml sol inj en ampoule	Substitution permanente
BRIDION 100 mg/ml sol inj	SUGAMMADEX (sodique) 100 mg/ml sol inj	Substitution permanente
DOLIPRANE 100 mg pdre p sol buv en sachet-dose	DOLIPRANE 100 mg suppos sécable	Substitution permanente
PARACETAMOL B BRAUN 10 mg/ml sol p perf	BRIDION 100 mg/ml sol inj	Substitution permanente
DOLIPRANE 100 mg suppos sécable	DOLIPRANE 150 mg pdre p sol buv en sachet-dose	Substitution permanente
ASPIRINE DU RHONE 500 mg cp	ASPIRINE UPSA 500 mg cp efferv	Du 28/09/2020 au 15/10/2020

Substitution de: [dropdown] active  du 28/09/2020 au 15/10/2020  en permanence

[+]

[-]

Valider

Annuler

Produit par produit  
Produit par dénomination commune  
Dénomination commune par dénomination commune

1. List of alternatives
2. Add an alternative.
3. Delete the selected alternative.
4. Set type of substitution.
5. Substitution period.
6. Products concerned by substitution.
7. Confirm changes
8. Cancel changes

### 3.14.4 Mandatory dilution

Some products (formulary) must be diluted (=mandatory dilution).

For these products, it is possible (not mandatory) to associate one or more diluents.

In use, if the option **Dilution required** is activated, the medication order window can only be confirmed if the diluent is specified:

If no diluent is configured, any diluent can be chosen.

If one diluent is configured, it is selected automatically.


If several diluents are configured, only one of these diluents can be chosen.

Mandatory diluents are set up in the **Application configuration, Formulary** tab. For each of the products with which a diluent must be associated, the **Editing of a formulary item** window must be opened by double-clicking the row of the relevant drug.

**Edition d'un élément du livret thérapeutique**

ID Livret 4536	ID Diane 9145	Quantité 	Unités(Code) 57/60/138	Unité(UCD) flacon	Quantité d'azote par contenant 0
CIP	CIP13	Prix 0	Voies(Code) 33	Voies intraveineuse (en perfusion)	<a href="#">Voir la monographie</a>
UCD 9389270	UCD13 3400893892701	CIS 68011537	DCI(Code) 1641	DCI ACIDE ZOLEDRONIQUE 4 mg/:	Base de médicament configurée : Vidal
Nom ACID.ZOLEDRONIQU.MYL 4MG/5ML			ATC(Code) M05BA08	ATC ACIDE ZOLEDRONIQUE	Base de médicament de l'élément : Vidal
Libellé ACIDE ZOLEDRONIQUE 4mg-5ml FL PERF-IV			Famille(Code) 269	Famille Cancérologie - Hématologie	<a href="#">Ré-importer depuis la BdM</a>
Dosage 4 mg/5 ml/flacon			Forme(Code) 453	Forme solution à diluer pour perfusio	Quantité Max. (/J/Kg) <input type="text"/> Quantité Max. (/J) <input type="text"/>
Recherche de médicament	CIP trouvés			Libellé de prescription ACIDE ZOLEDRONIQUE	Valeur létale (/J/Kg) <input type="text"/> Valeur létale (/J) <input type="text"/>
				Codes LES	Poids patient (utilisé pour le calcul des valeurs maximales et létales) <input type="text" value="70"/> Kg



Click  to define the mandatory diluent(s). This opens the **Change of dosage/dilution/product packaging** window.

**Modification du dosage/dilution/conditionnement du produit** [X]

**ACID.ZOLEDRONIQ.MYL 4MG/5ML**

Quantité de produit exprimé par conditionnement  
 Veuillez saisir une valeur et une unité  
*exemple : "250 mg" (par cp), "200 Uli" (pour 10 ml), "5 mol" (par ml)*

Conditionnement ou volume exprimé par conditionnement  
 Veuillez saisir une valeur (par défaut 1) et une unité  
*exemple : "10 ml", "(1) cp", "(1) dose", "(1) bouffée"...*

Marquer ce produit comme diluable sans volume de préparation associé

Conditionnement  
 Veuillez saisir une unité de conditionnement (ex: flacon, ampoule, etc.)

Grammes d'azote contenu dans une unité de conditionnement

Dilution

Dilution obligatoire

Concentration minimale  mg/ml


Ancien dosage : 4 mg/5 ml/flacon (Dosage "sécurisable" par Vidal)


Nouveau dosage : 4 mg/5 ml/flacon







Then, click **Dilution required** and enter the diluents. Word completion can be used to quickly find the diluents in the formulary items.


Dilution


Dilution obligatoire






-  NACL 0.9% TROCARDABLE POCHE INJ 3000 ML
-  NACL 0.9 % FLAC 1000 ML ECOFLAC = CHLORURE DE SODIUM
-  NACL 0.9 % FLAC 100 ML ECOFLAC = CHLORURE DE SODIUM
-  NACL 0.9 % FLAC 250 ML ECOFLAC = CHLORURE DE SODIUM
-  NACL 0.9 % FLAC 500 ML ECOFLAC = CHLORURE DE SODIUM
-  NACL 0.9 % FLAC 50 ML ECOFLAC = CHLORURE DE SODIUM


Ancien  SODIUM CHLORURE 0.9% LITRE NACL POCHE (par Vidal)





Once the diluent is selected, it must be confirmed by clicking .

Dilution

Dilution obligatoire










It is then possible to specify a minimum concentration that must be respected to confirm the medication order in use.

Dilution

Dilution obligatoire









Concentration minimale  mg/ml


As many mandatory diluents as required can be set up.

Dilution

Dilution obligatoire









Concentration minimale  mg/ml




Click  to remove the diluent from the list: the product is then crossed out and no longer available amongst the diluents in use.

Dilution

Dilution obligatoire




~~NACL 0.9 % FLAC 500 ML ECOFLAC = CHLORURE DE SODIUM  
GLUCOSE 5% PC 500 ml PERF ISOTONIQUE~~



Concentration minimale  mg/ml

Right-clicking a crossed-out diluent can make it available again.

**Information**

 Êtes-vous sûr de vouloir de nouveau rendre disponible ce diluant ?

Oui  Non

4.8.0.21004

## 3.15 Drugs

This tab is used to manage **fluid balance** (blood loss, diuresis, etc.), **medication** (drugs, medicines, solutions, etc.) and **blood product** (RBCs, platelets, FibCLOT, etc.) items administered in the OT.

### 3.15.1 Presentation of the Drugs tab

This tab is used to configure drugs, fluid balances and blood products. Their use in **DIANE ANAESTHESIA (IntraOp and PostOp)** is only possible if the items **Drugs**, **Fluid balance** and **Blood products** have been included in the list of **Visible events in the selected area** under the **Events** tab.

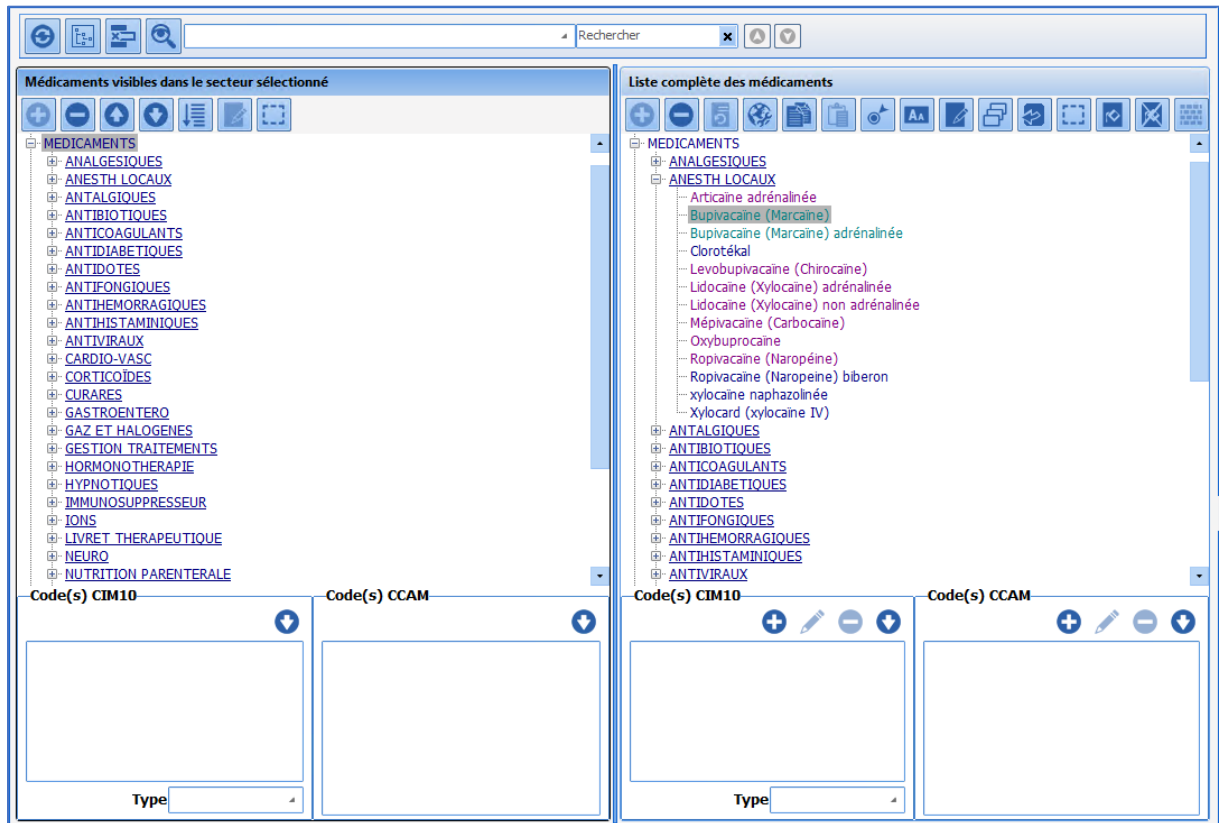
These names cannot and should not be changed! The same applies for categories (analgesics, antibiotics, etc.).

For each category, it is possible to:

- create new items,
- create new dosages and new concentrations.

In anaesthesia, there is no communication with drug databases (BCB/Vidal).

To simplify the lists, managing the available drugs by sector is recommended.



Drug colour legend:

No dosage configured and no prescription configured

At least one dosage configured and no prescription configured

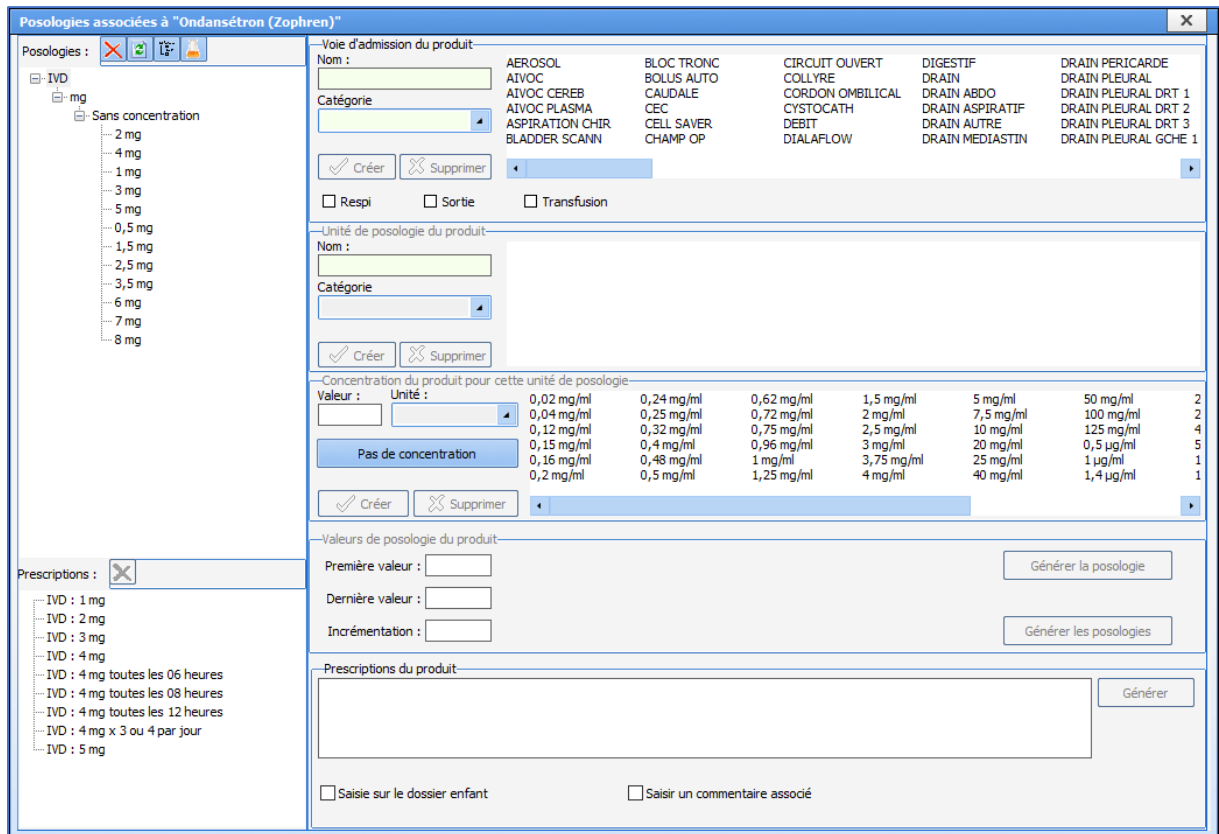
No dosage configured and at least one prescription configured

At least one dosage configured and at least one prescription configured

### 3.15.2 Creation, modification and deletion of dosages

It is possible to edit all items by adding, editing or deleting dosages.

Please note that it is impossible to rename the categories **Analgesics**, **Antibiotics**, **Anticoagulants**, **Ions** and **Solutions** as these lists are used to create post-op medication orders in **Visual**. It is also impossible to duplicate a drug.



In the **Route of administration of product** pane, select a route of administration such as IV for example. If the route of administration does not exist, it must be created by entering its **Name** and **Category**. The **Respiratory** route is used for manually recording anaesthetic gases and aerosols, and the **Output** route concerns fluid losses. The **Transfusion** route is used for blood transfusions. The **Auto BOLUS**, **Auto SP** and **Auto TCI** routes are reserved for connected devices. In the **Product dosage unit** pane, select the unit of the new dosages (a new unit can be created by entering its name and category).

For the creation of continuous injection dosages (e.g. automatic syringes or infusion pumps), a concentration can be selected from the **Product concentration** pane (a new concentration can be created by entering its **Value** and **Unit**). If no concentration is required, click **No concentration**.

The drug **Dosages** must then be entered in the **Product dosage values**. For this, it is possible to enter information value by value, by completing the **First value** field then clicking **Generate dosage**.

To enter a large number of dosages with a regular interval between each value, enter **First value** (minimum value), **Last value** (maximum value) and **Incrementation** (interval), then click **Generate dosages**.

Valeurs de posologie du produit

Première valeur :

Dernière valeur :

Incrémentation :


- 100 mg
- 150 mg
- 200 mg
- 250 mg
- 300 mg
- 350 mg
- 400 mg
- 450 mg
- 500 mg

For example, this entry creates the following dosages:



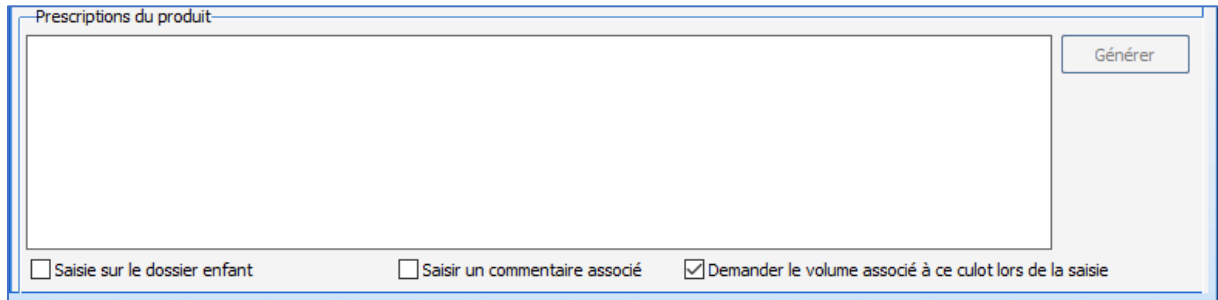
To delete a **Route of administration**, a **Dosage unit** or a **Concentration**, select the item to be deleted and click the corresponding **Delete** button.

**Note: in this case, all associated dosages will also be deleted.**

It is possible to delete one or more **Dosages** using the  button. It is also possible to delete one or more dosages by right-clicking. Use Shift + Control on the keyboard to select multiple options. To delete all the dosages for a route of administration, a unit or a concentration, delete the route of administration, unit or concentration directly.

It is still possible to create dosages on the fly during use, but this is not really practical.

#### Settings options:



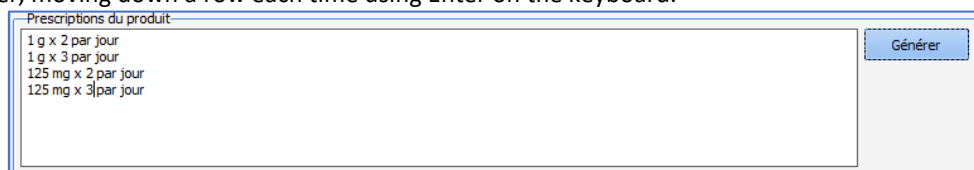
The screenshot shows a window titled "Prescriptions du produit". It features a large empty text area on the left and a "Générer" button on the right. Below the text area, there are three checkboxes: "Saisie sur le dossier enfant" (unchecked), "Saisir un commentaire associé" (unchecked), and "Demander le volume associé à ce culot lors de la saisie" (checked).

Several settings options are available in the lower part of the window:

- **Enter on child record** is used in obstetrics.
- **Enter an associated comment:** for products requiring traceability, it is possible to have a comment window that opens automatically on entry.
- **Ask for the volume associated with this blood bag when entering:** for products administered in bags (with variable volumes), a window is used to enter the bag volume.

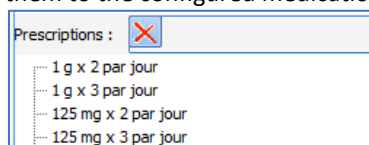
### 3.15.3 Creation, editing and deletion of medication orders

Medication orders are used in the former **Medication order** tab of **DIANE ANAESTHESIA Visual (IntraOp and PostOp)**. In the **Product medication orders** pane, the various medication orders must be entered one after the other, moving down a row each time using Enter on the keyboard.



The screenshot shows the "Prescriptions du produit" window with a list of medication orders in the text area: "1 g x 2 par jour", "1 g x 3 par jour", "125 mg x 2 par jour", and "125 mg x 3 par jour". The "Générer" button is visible on the right.

The **Generate** button is used to add them to the configured medication orders in the left column.

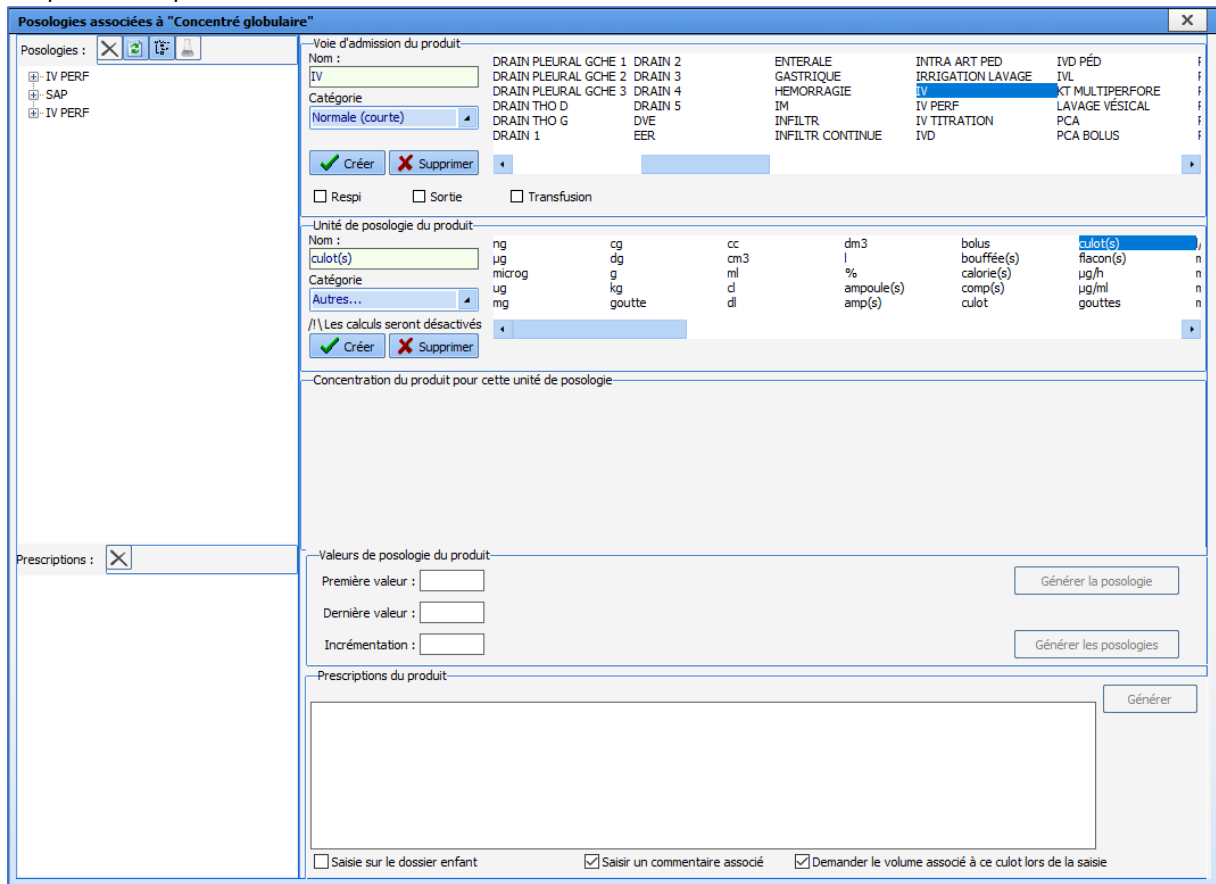


The screenshot shows a dialog box titled "Prescriptions :". It has a red X button in the top right corner and a list of medication orders: "1 g x 2 par jour", "1 g x 3 par jour", "125 mg x 2 par jour", and "125 mg x 3 par jour".

### 3.15.4 Associate a volume with a blood bag

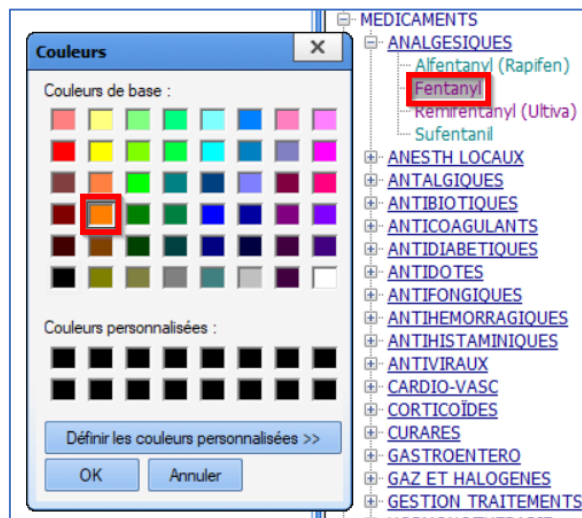
If the product dosage unit is in blood bag, blood bags, blood bag(s), bag, bags or bag(s), it is possible to request the associated volume when entered. For this, the check box **Ask for the volume associated with this blood bag**

when entering appears to the bottom right of the window. This choice is applied to all PRBC and bag dosages of the product in question.



### 3.15.5 Associating colours with drugs

Drugs can be associated with colours in **DIANE**. The  button is used to open the **Colour** window, which is used to associate a colour with the selected drug(s). In this example, orange is attributed to **fentanyl**.



When fentanyl is used, it appears in orange in the **Monitoring** tab of **Visual** or the **Operating theatre** tab of **DIANE**

ICU.

Médicaments / Balance liquidienne		
FENTANYL	0,857 µg	2 ml/h - 25 µg


## 3.16 Settings

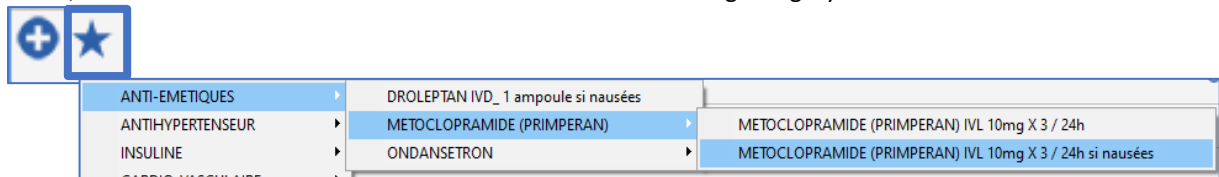
See chapter: *Setups*

## 3.17 Medication orders (+ Favourites)

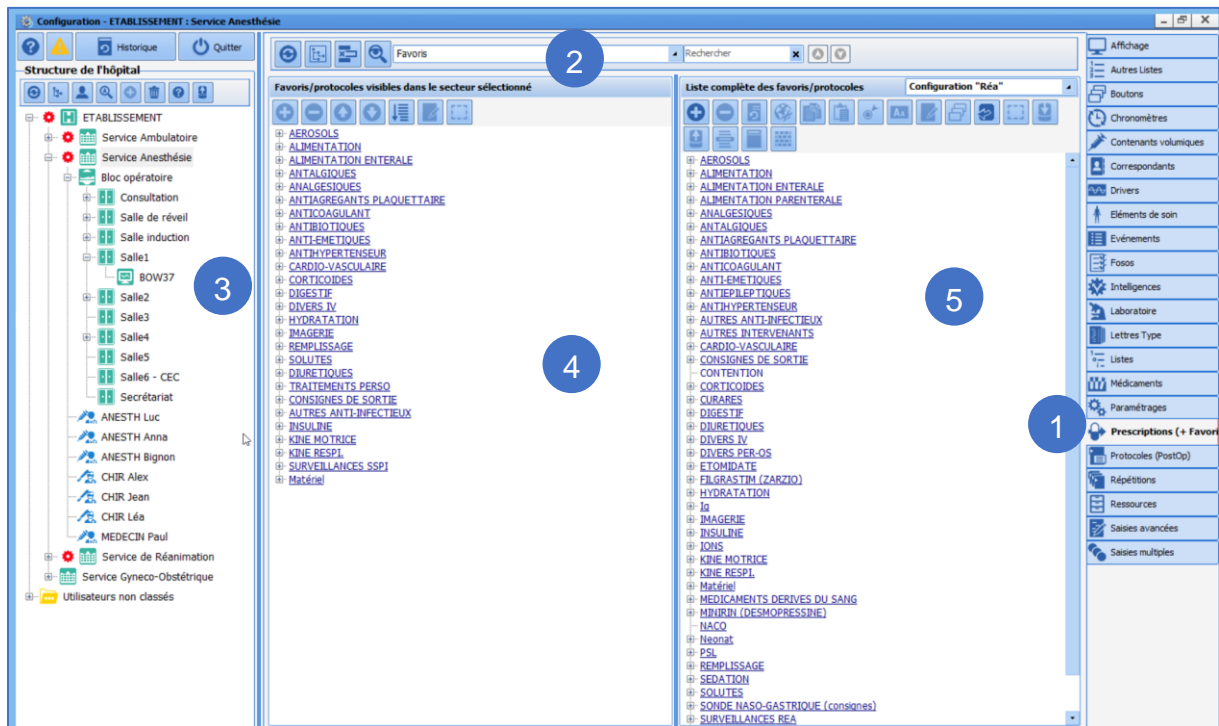
To set up medication order favourites, it is possible to edit existing favourites or create new ones.

**!** The formulary must be imported before favourites are created. When formulary updates are carried out, it is essential to check whether any favourites have been affected.

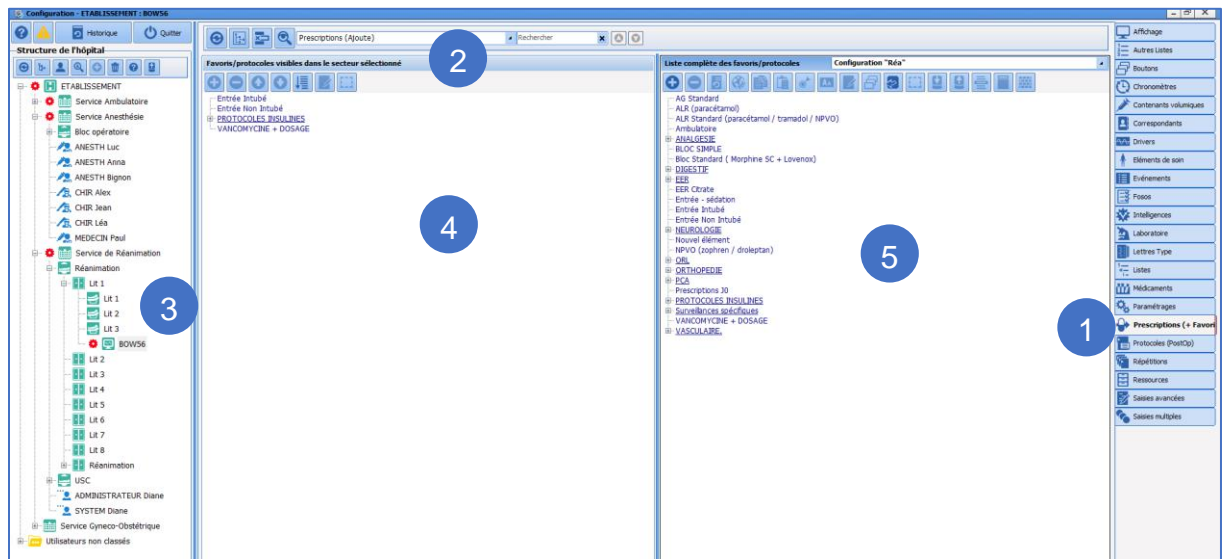
In use, favourites are accessible via the star  in the selected drug category in the **Medication order** tab.




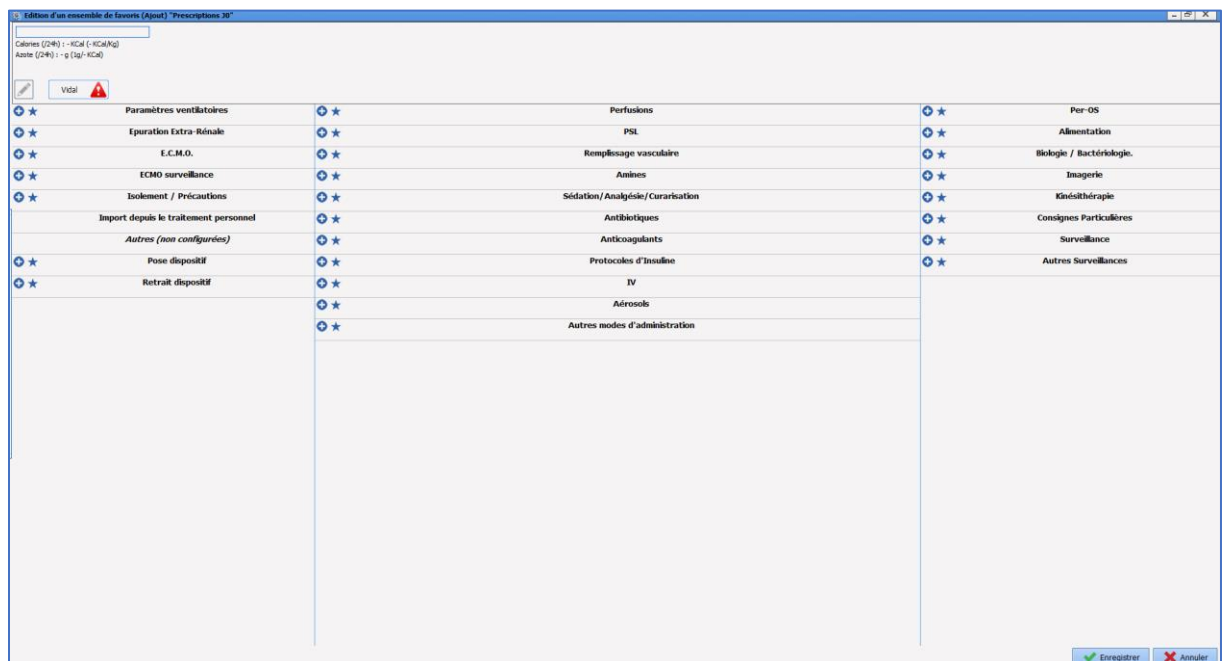
### 3.17.1 Favourites

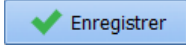


### 3.17.2 Protocols



1. To create a protocol (group of medication orders) select the **Medication orders (+ Favourites)** tab.
2. Select **Medication order (Add)** from the drop-down menu.
3. Select the sector in which the protocols should be applied (gear).
4. The column on the left shows the favourite protocols in the selected sector.
5. To modify a protocol, select and edit it. To create a protocol, select a category and click .



Create the different medication orders required for the protocol, then click  (bottom right).

### 3.17.3 Validation/approval of medication order favourites

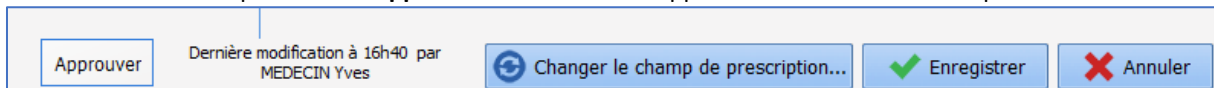
Public medication order favourites/protocols are subject to approval (this does not apply to private favourites). Only users with **Medication order favourite/protocol approval** rights can approve medication order favourites/protocols.

<input type="radio"/> Droits logiciels	<input checked="" type="radio"/> <b>Droits applicatifs</b>	<input type="radio"/> Droits administratifs
<b>Consultation</b>		
<input checked="" type="checkbox"/> Créer un patient (modification des données administratives seules)		
<input checked="" type="checkbox"/> Visualiser un dossier		
<input checked="" type="checkbox"/> Créer/Modifier un dossier		
<input checked="" type="checkbox"/> Modifier un dossier clôturé		
<input checked="" type="checkbox"/> Imprimer un dossier		
<input checked="" type="checkbox"/> Imprimer les prémédications		
<input checked="" type="checkbox"/> Imprimer l'ordonnance de bilans		
<b>RDV</b>		
<input checked="" type="checkbox"/> Créer/Modifier des rendez-vous		
<b>Visual / Liste des patients / DianeObst</b>		
<input checked="" type="checkbox"/> Créer un dossier en bloc		
<input checked="" type="checkbox"/> Créer un dossier en réveil		
<input checked="" type="checkbox"/> Créer un dossier en induction		
<input checked="" type="checkbox"/> Réaliser une reprise en bloc		
<input checked="" type="checkbox"/> Réaliser une reprise en réveil		
<input checked="" type="checkbox"/> Réaliser une reprise en induction		
<input checked="" type="checkbox"/> Visualiser un dossier		
<input checked="" type="checkbox"/> Créer ou modifier un dossier en ambulatoire		
<input checked="" type="checkbox"/> Créer ou modifier un dossier d'obstétrique		
<input checked="" type="checkbox"/> Cloturer un dossier d'obstétrique		
<input checked="" type="checkbox"/> Accouchement sous X		
<input checked="" type="checkbox"/> Modifier les données de la mère		
<input checked="" type="checkbox"/> Modifier les données enfant		
<input checked="" type="checkbox"/> Voir les dossiers d'IVG confidentiels		
<input checked="" type="checkbox"/> Responsable de l'anesthésie		
<input checked="" type="checkbox"/> Autoriser la sortie SSPI d'un patient		
<input checked="" type="checkbox"/> Imprimer un dossier		
<input checked="" type="checkbox"/> Valider une feuille d'ouverture de salle / une fiche inter-patients		
<input checked="" type="checkbox"/> Signature des prescriptions (Hospitalières / Ordonnances)		
<input checked="" type="checkbox"/> Approbation des favoris/protocoles de prescription		

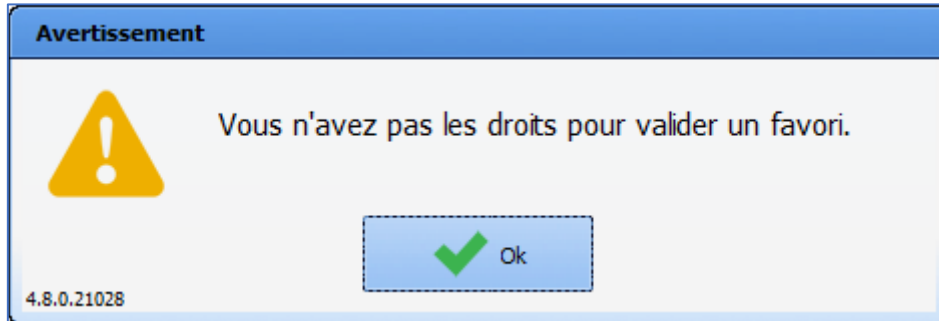
These rights are attributed during configuration. Protocols and favourites that have not been approved are shown in red in the **Medication orders (+ Favourites)** tab.

<input checked="" type="checkbox"/> <b>FILGRASTIM (ZARZIO)</b>
<input type="checkbox"/> Gaz du sang : x1 à 22h, x1 à 8h
<input type="checkbox"/> Glucose 5 %+ potassium chlorure 0,2 %+ sodium chlorure 0,4 % : 1000 ml en continu
<input checked="" type="checkbox"/> <b>HYDRATATION</b>
<input type="checkbox"/> Hydroxyethylamidon 130 000 6 %+ sodium chlorure 0,9 % : 500 ml; D=1h 2x/j
<input checked="" type="checkbox"/> <b>Ig</b>
<input checked="" type="checkbox"/> <b>PLASMA</b>

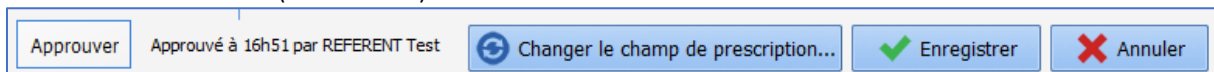
If the protocol/favourite has not yet been approved, the date of the last modification and the user who made this modification are specified. An **Approve** button is used to approve the medication order protocol or favourite.



If the user does not have these rights, they are not authorised to approve.



Once approved, the data of approval and approving user are indicated and the protocol/favourite appear in blue in the Medication orders (+ Favourites) tab.





If a user without approval rights modifies a protocol/favourite, it must be approved again. However, if the editing user has approval rights, the protocol/favourite is automatically approved.

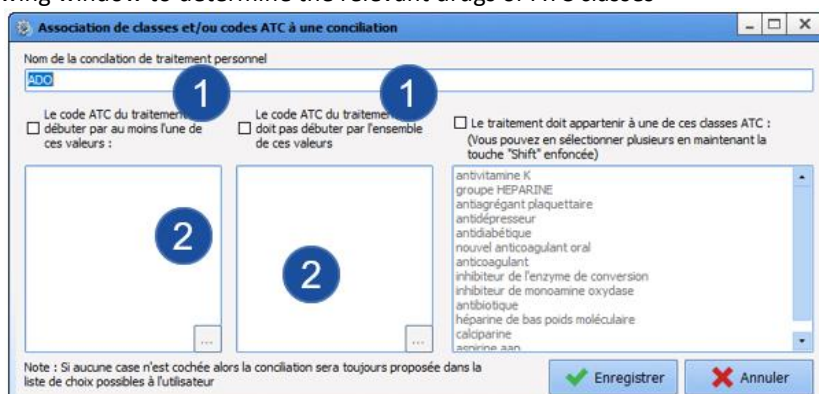
### 3.17.4 Conversion (treatment) // Stoppage (treatment)

Treatment conversions and stoppages proposed during consultation in the **Treatments/Premedications** tab are managed in this part of the **Medication orders (+ Favourites)** tab.



This is done by ATC class.

These favourites are created as follows:

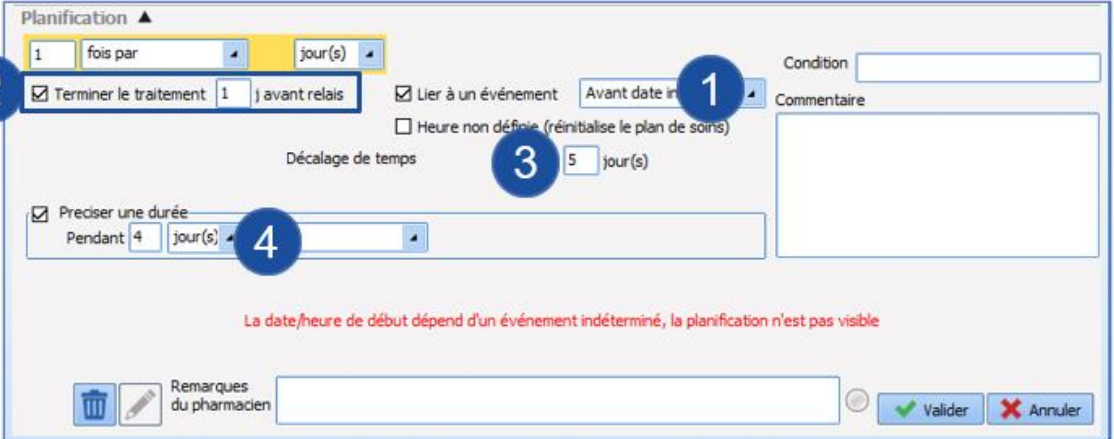
- Create a new group via  and name it
- Select and click 
- Use the following window to determine the relevant drugs or ATC classes



- In this window, select the box 1 that meets your requirements
- The button at the bottom of pane 2 is used to access the existing classes and select those concerned by the current settings.

- **Save**
- Edit the form using the  button
- Click  to access the drug settings window
- In the top part, enter the drug that will be used for the conversion with its dosage and route of administration.

The lower part is used to organise the date of interruption of the usual treatment, start date of the conversion treatment, and duration of conversion treatment.



The screenshot shows a 'Planification' form with the following fields and callouts:

- Callout 1:** Points to the 'Avant date in' dropdown menu.
- Callout 2:** Points to the 'Terminer le traitement' checkbox and the '1 j avant relais' input field.
- Callout 3:** Points to the 'Décalage de temps' input field, which is set to '5 jour(s)'.
- Callout 4:** Points to the 'Pendant 4 jour(s)' input field.

Other visible fields include: '1 fois par jour(s)', 'Condition', 'Commentaire', 'Lier à un événement', 'Heure non définie (réinitialise le plan de soins)', 'Préciser une durée', 'Remarques du pharmacien', and buttons for 'Valider' and 'Annuler'.

Pane 1 is used to show that this conversion will be planned around the surgery date.

Pane 2 is used to determine the delay between the date on which the patient stops their usual treatment and the date on which the conversion treatment is started.

Pane 3 determines the start date of the conversion drug

Pane 4 determines the number of days for which the conversion treatment must be taken

In this example:

- The conversion is planned around the surgery date.
- The usual treatment will be stopped the day before the conversion treatment is started.
- The conversion treatment will be started 5 days before the surgery date and taken for 4 days.

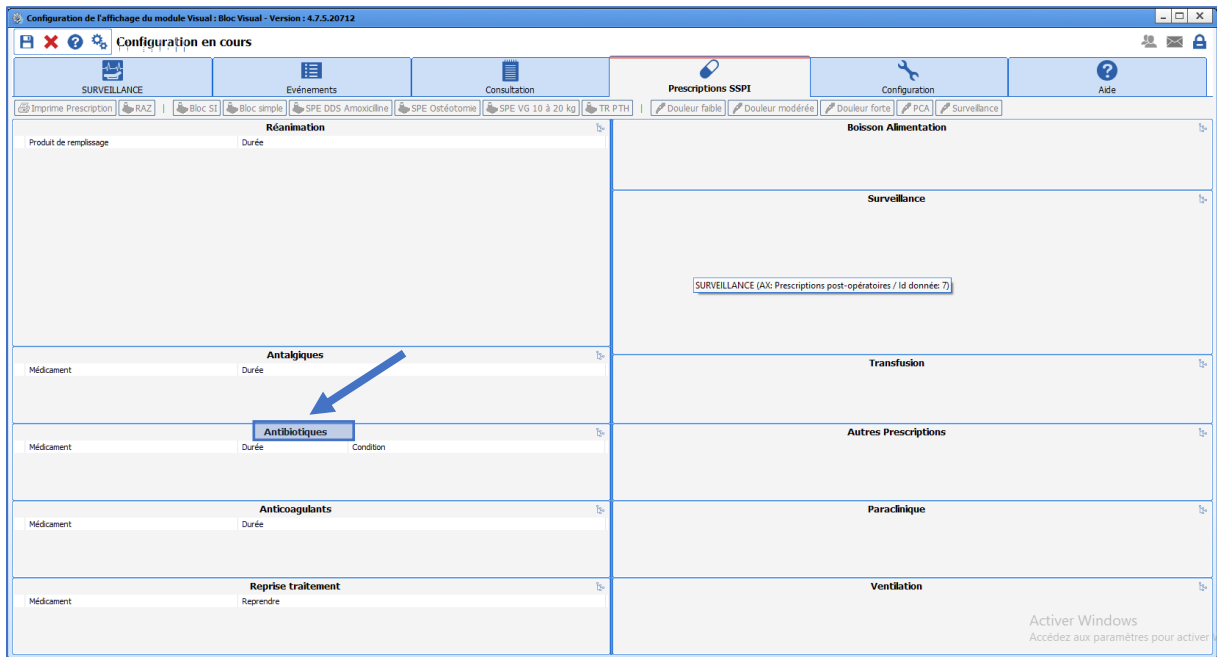
## 3.18 Protocols (PostOp)

This tab is used to configure all postoperative protocols and medication orders used as buttons in the **Medication order** tab of **Visual**.

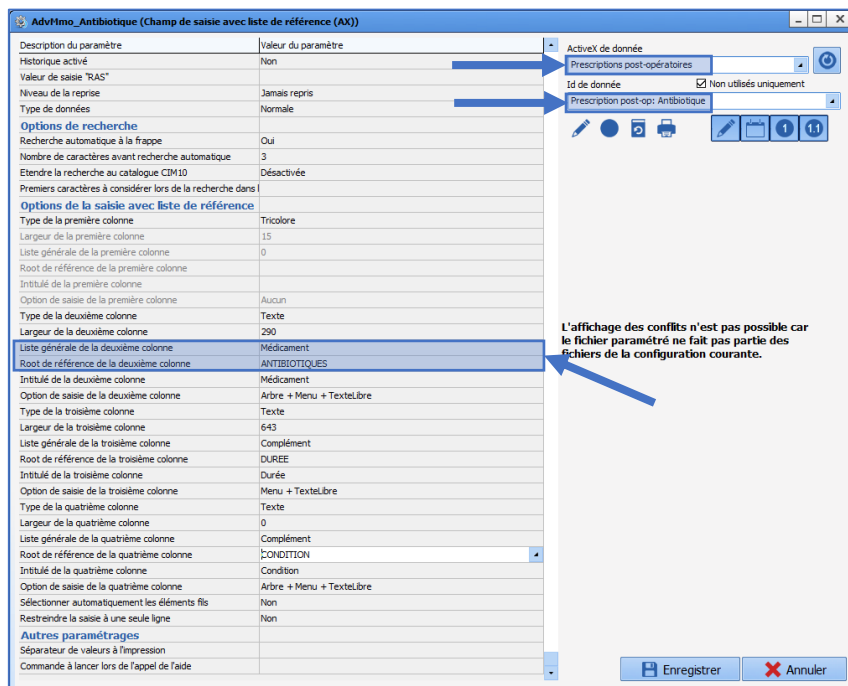
### 3.18.1 Create a new medication order configuration

The **View** tab is used to create or modify a medication order configuration for **Visual**. Then, select the configuration in which the medication order tab is found.



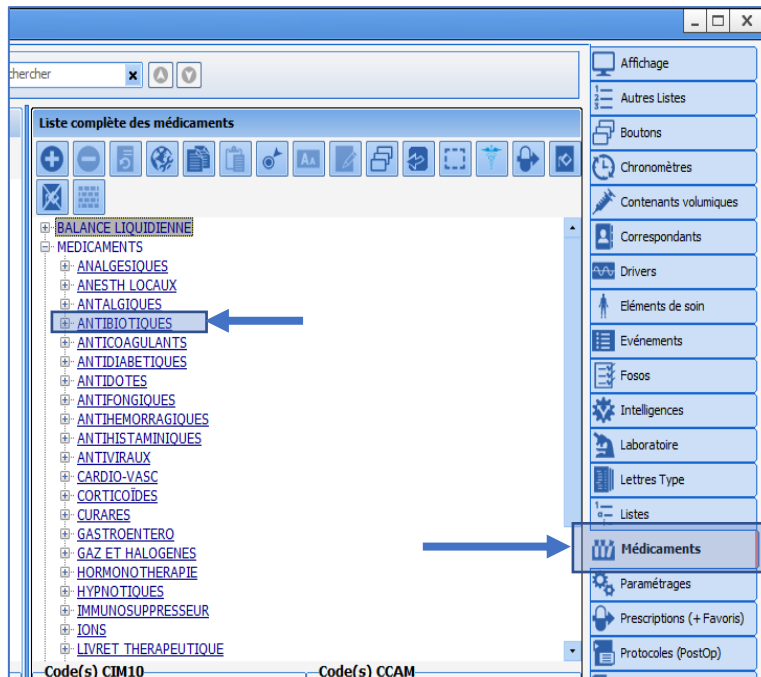


In this example, the configured item is the **Antibiotics** field. Right-clicking brings up a menu to access the component configuration.

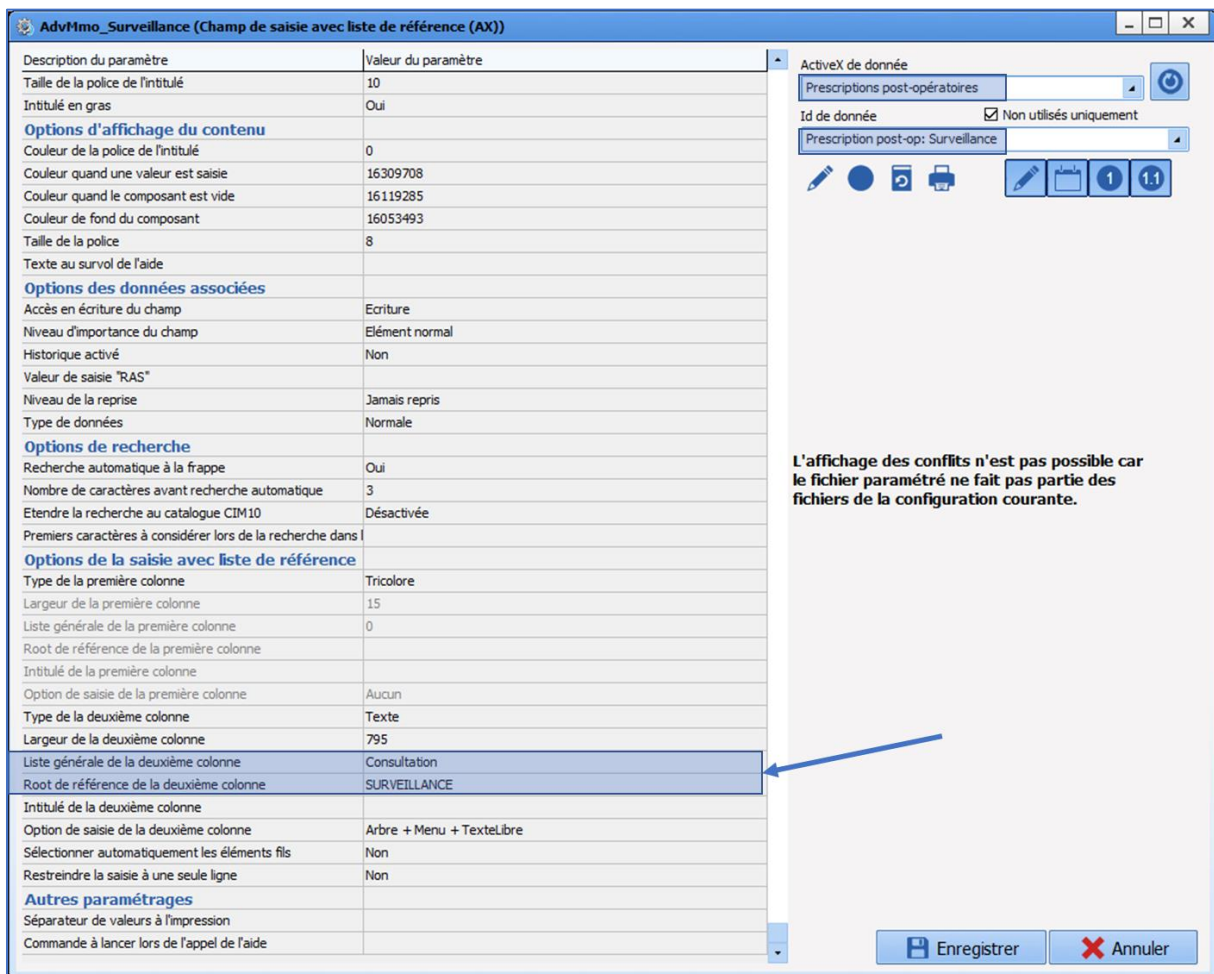


To configure the component, first configure the required ActiveX and data ID (in this example: **Post-operative medication order/Antibiotic**) and choose the title.


Ensure that the **Drug** general list and reference root are included (in this example: **ANTIBIOTICS**). This uses the categories found in the drug section.

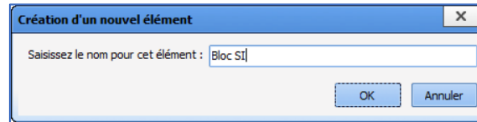
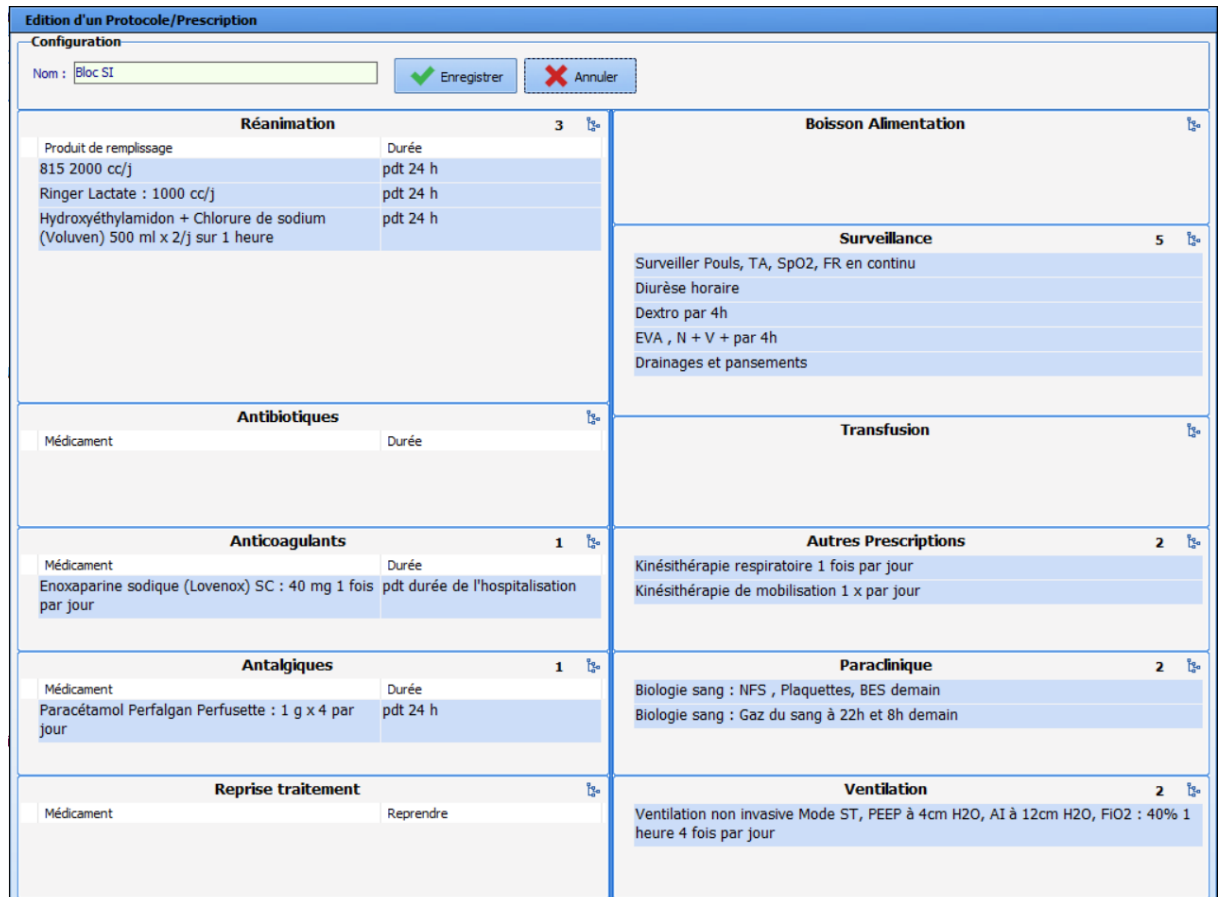


Monitoring, lab tests, nutrition etc. use the **Consultation >> MONITORING... PARACLINICAL ... NUTRITION ...** lists.




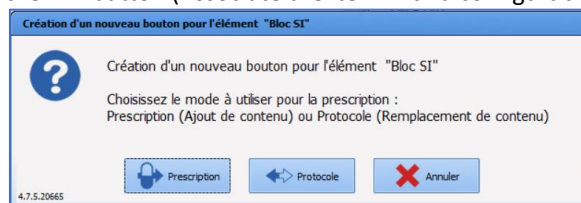
### 3.18.2 Creating a new protocol or a new medication order

- Click  (Create a new protocol or a new medication order).
- Indicate the protocol or medication order name.

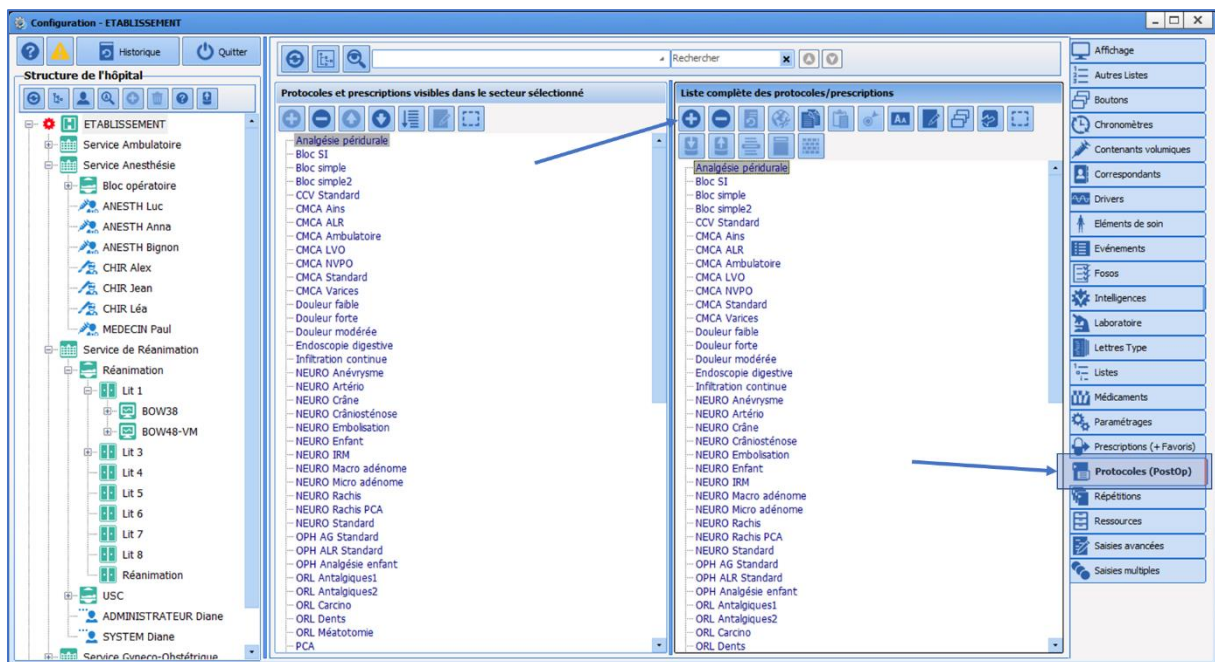
Configuration										
Nom : Bloc SI	<input type="button" value="Enregistrer"/> <input type="button" value="Annuler"/>									
<b>Réanimation</b> 3 <table border="1"> <thead> <tr> <th>Produit de remplissage</th> <th>Durée</th> </tr> </thead> <tbody> <tr> <td>815 2000 cc/j</td> <td>pdt 24 h</td> </tr> <tr> <td>Ringer Lactate : 1000 cc/j</td> <td>pdt 24 h</td> </tr> <tr> <td>Hydroxyéthylamidon + Chlorure de sodium (Voluven) 500 ml x 2/j sur 1 heure</td> <td>pdt 24 h</td> </tr> </tbody> </table>	Produit de remplissage	Durée	815 2000 cc/j	pdt 24 h	Ringer Lactate : 1000 cc/j	pdt 24 h	Hydroxyéthylamidon + Chlorure de sodium (Voluven) 500 ml x 2/j sur 1 heure	pdt 24 h	<b>Boisson Alimentation</b>	
Produit de remplissage	Durée									
815 2000 cc/j	pdt 24 h									
Ringer Lactate : 1000 cc/j	pdt 24 h									
Hydroxyéthylamidon + Chlorure de sodium (Voluven) 500 ml x 2/j sur 1 heure	pdt 24 h									
<b>Antibiotiques</b> <table border="1"> <thead> <tr> <th>Médicament</th> <th>Durée</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> </tbody> </table>	Médicament	Durée			<b>Surveillance</b> 5 <table border="1"> <tbody> <tr> <td>Surveiller Pouls, TA, SpO2, FR en continu</td> </tr> <tr> <td>Diurèse horaire</td> </tr> <tr> <td>Dextro par 4h</td> </tr> <tr> <td>EVA , N + V + par 4h</td> </tr> <tr> <td>Drainages et pansements</td> </tr> </tbody> </table>	Surveiller Pouls, TA, SpO2, FR en continu	Diurèse horaire	Dextro par 4h	EVA , N + V + par 4h	Drainages et pansements
Médicament	Durée									
Surveiller Pouls, TA, SpO2, FR en continu										
Diurèse horaire										
Dextro par 4h										
EVA , N + V + par 4h										
Drainages et pansements										
<b>Anticoagulants</b> 1 <table border="1"> <thead> <tr> <th>Médicament</th> <th>Durée</th> </tr> </thead> <tbody> <tr> <td>Enoxaparine sodique (Lovenox) SC : 40 mg 1 fois par jour</td> <td>pdt durée de l'hospitalisation</td> </tr> </tbody> </table>	Médicament	Durée	Enoxaparine sodique (Lovenox) SC : 40 mg 1 fois par jour	pdt durée de l'hospitalisation	<b>Transfusion</b>					
Médicament	Durée									
Enoxaparine sodique (Lovenox) SC : 40 mg 1 fois par jour	pdt durée de l'hospitalisation									
<b>Antalgiques</b> 1 <table border="1"> <thead> <tr> <th>Médicament</th> <th>Durée</th> </tr> </thead> <tbody> <tr> <td>Paracétamol Perfalgan Perfusette : 1 g x 4 par jour</td> <td>pdt 24 h</td> </tr> </tbody> </table>	Médicament	Durée	Paracétamol Perfalgan Perfusette : 1 g x 4 par jour	pdt 24 h	<b>Autres Prescriptions</b> 2 <table border="1"> <tbody> <tr> <td>Kinésithérapie respiratoire 1 fois par jour</td> </tr> <tr> <td>Kinésithérapie de mobilisation 1 x par jour</td> </tr> </tbody> </table>	Kinésithérapie respiratoire 1 fois par jour	Kinésithérapie de mobilisation 1 x par jour			
Médicament	Durée									
Paracétamol Perfalgan Perfusette : 1 g x 4 par jour	pdt 24 h									
Kinésithérapie respiratoire 1 fois par jour										
Kinésithérapie de mobilisation 1 x par jour										
<b>Reprise traitement</b> <table border="1"> <thead> <tr> <th>Médicament</th> <th>Reprendre</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> </tbody> </table>	Médicament	Reprendre			<b>Paraclinique</b> 2 <table border="1"> <tbody> <tr> <td>Biologie sang : NFS , Plaquettes, BES demain</td> </tr> <tr> <td>Biologie sang : Gaz du sang à 22h et 8h demain</td> </tr> </tbody> </table>	Biologie sang : NFS , Plaquettes, BES demain	Biologie sang : Gaz du sang à 22h et 8h demain			
Médicament	Reprendre									
Biologie sang : NFS , Plaquettes, BES demain										
Biologie sang : Gaz du sang à 22h et 8h demain										
	<b>Ventilation</b> 2 <table border="1"> <tbody> <tr> <td>Ventilation non invasive Mode ST, PEEP à 4cm H2O, AI à 12cm H2O, FIO2 : 40% 1 heure 4 fois par jour</td> </tr> </tbody> </table>	Ventilation non invasive Mode ST, PEEP à 4cm H2O, AI à 12cm H2O, FIO2 : 40% 1 heure 4 fois par jour								
Ventilation non invasive Mode ST, PEEP à 4cm H2O, AI à 12cm H2O, FIO2 : 40% 1 heure 4 fois par jour										

This is also the tab used to create medication order and protocol buttons to be used in intra and /or post-op. This can be done with the  button (Associate the item with a configurable button).




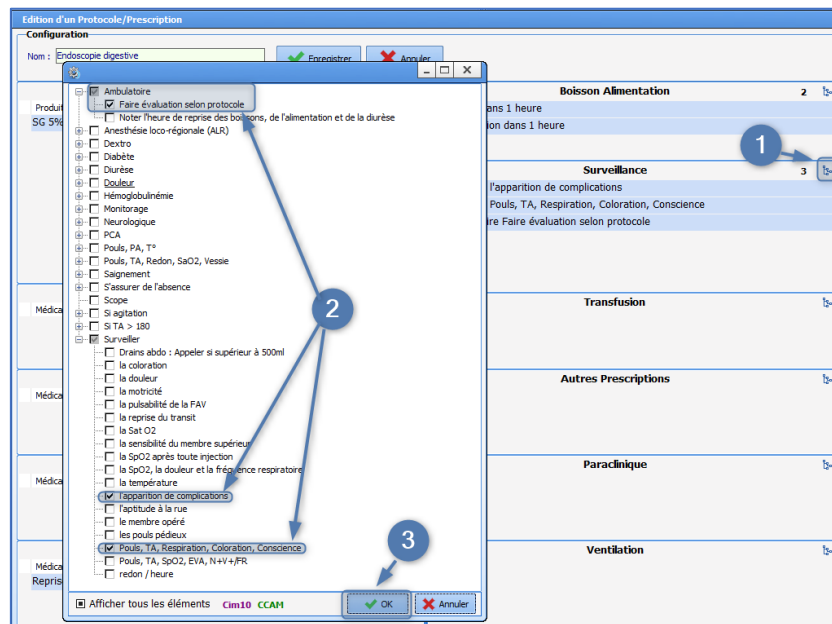
### 3.18.3 Creating a POST OP protocol

In the **Protocols (PostOp)** tab, click : this brings up the form as configured in the **VISUAL** tab.




To create the protocol or medication order, the various medication order fields must be completed. There are several ways to do this:




- Manually by entering the text directly,
- By opening the tree with the various configured items using ,
- By double-clicking to show the tree with the various configured items,
- By right-clicking to show the menu with the various configured items.



Click **OK** to confirm then **Save** at the top of the window.

All the available items have been configured via the **Drugs** tab (**Solutions for ICU, Analgesics, Antibiotics, Anticoagulants**, and all drugs for **Resumption of treatments**), via the **Other lists** tab (for Duration and Condition); or via the Lists tab (for **Liquids/Food, Monitoring, Ventilation, Paraclinical, Transfusion, Other medication orders** medication orders).

To modify a protocol or medication order, select it from the full list and click  (Edit item). It is possible to add, delete or edit items in a protocol or medication order. After editing or creating a protocol or medication order, click **Save**.

Edition d'un Protocole/Prescription			
Configuration			
Nom : Endoscopie digestive		<input type="button" value="✓ Enregistrer"/> <input type="button" value="✗ Annuler"/>	
<b>Réanimation</b>		<b>1</b>	
Produit de remplissage	Durée		
SG 5% 250ml	jusqu'à reprise alim		
<b>Boisson Alimentation</b>		<b>2</b>	
Boisson dans 1 heure			
Alimentation dans 1 heure			
<b>Surveillance</b>		<b>3</b>	
Surveiller l'apparition de complications			
Surveiller Pouls, TA, Respiration, Coloration, Conscience			
Ambulatoire Faire évaluation selon protocole			

## 3.19 Repetitions


This tab is used to set up the repetitions used in time scheduling and treatment scheduling (“Morning, noon, evening”, “1-0-1”, “Evening”, etc.). This is done to define the default times that correspond with the unit routine, e.g. Evening = 6pm.

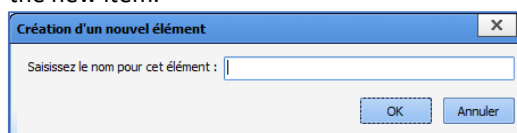
## 3.20 Resources

This tab contains all the images, models, procedures, nursing and medical protocols, print templates and videos set up in the program:

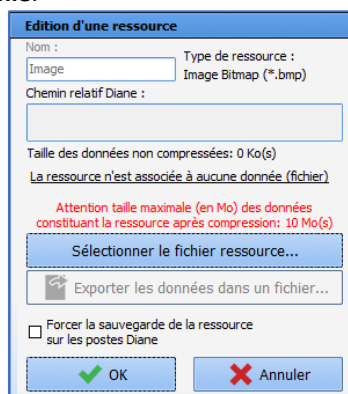
- **Annotations** (\*.bmp and \*.jpg files)  
Files in the **Documents** tab
- **Files** (\*. \* files)
- **Icons** (\*.ico files)
- **Bitmap image** (\*.bmp files)  
Icons associated with buttons found in the **Configuration** tab of **Visual**, **Diane ICU** and **Diane OB-GYN**.
- **JPEG image** (\*.jpg files)  
Images from biomedical devices to which **DIANE** can connect: these images are visible in the **Configuration** tab of **Visual**, **Diane ICU** and **Diane OB-GYN**.
- **PNG image** (\*.png files)
- **DiaReport template** (\*.rtf files)
- **Procedures** (\*.rtf files)
- **Nursing protocols** (\*.rtf files)
- **Medical protocols** (\*.rtf files)
- **XSL print templates** (\*.xsl files)
- **Video** (\*.avi files)

To import a new file, select the file type to be inserted from the drop-down list:

- Click  (Create a new resource).
- Enter the name of the new item.



- Click **Select the resource file**.



Files **MUST** be saved in the **DIANE** program directory (C:\Program Files\Diane\Data\)) in order to be imported.

Once the file is selected, its relative path in the **Diane** directory is shown. It is possible to export the file into another folder and delete the relative path using the **Delete data associated with resource** button (this does not delete the resource or the file).

**Edition d'une ressource**

Nom : Image Type de ressource : Image Bitmap (\*.bmp)

Chemin relatif Diane : Icones\IMAGE.bmp

Taille des données non compressées: 0,2 Ko(s)

Supprimer les données associées à la ressource

Attention taille maximale (en Mo) des données constituant la ressource après compression: 10 Mo(s)

Sélectionner le fichier ressource...

Exporter les données dans un fichier...

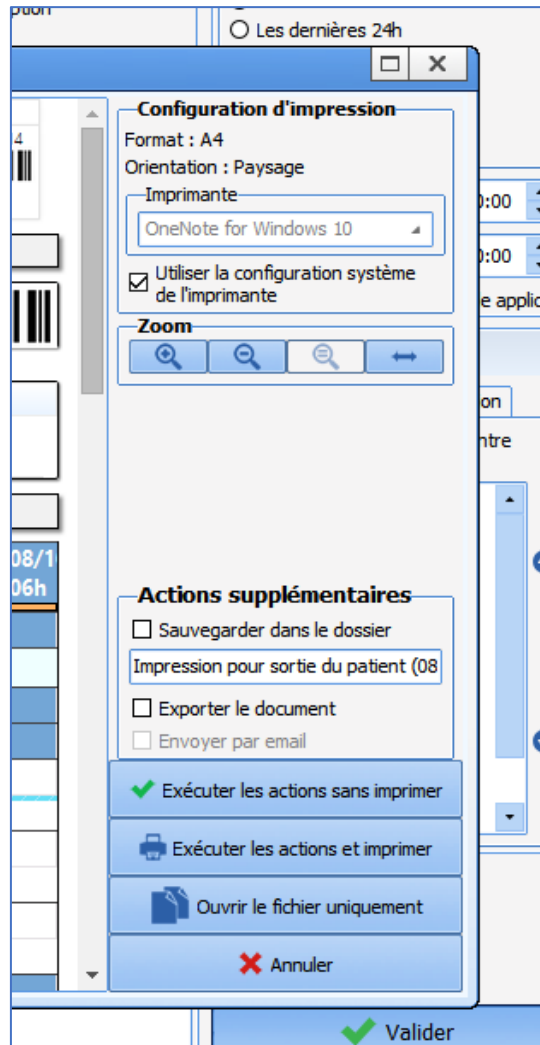
Forcer la sauvegarde de la ressource sur les postes Diane

OK Annuler

### 3.20.1 Activate a custom header for HTML prints

It is possible to activate a custom header for “HTML” prints. For this, an XSL file with the required changes to the default header is required.

This principle is applicable to all “HTML” prints, corresponding to the use of this window:



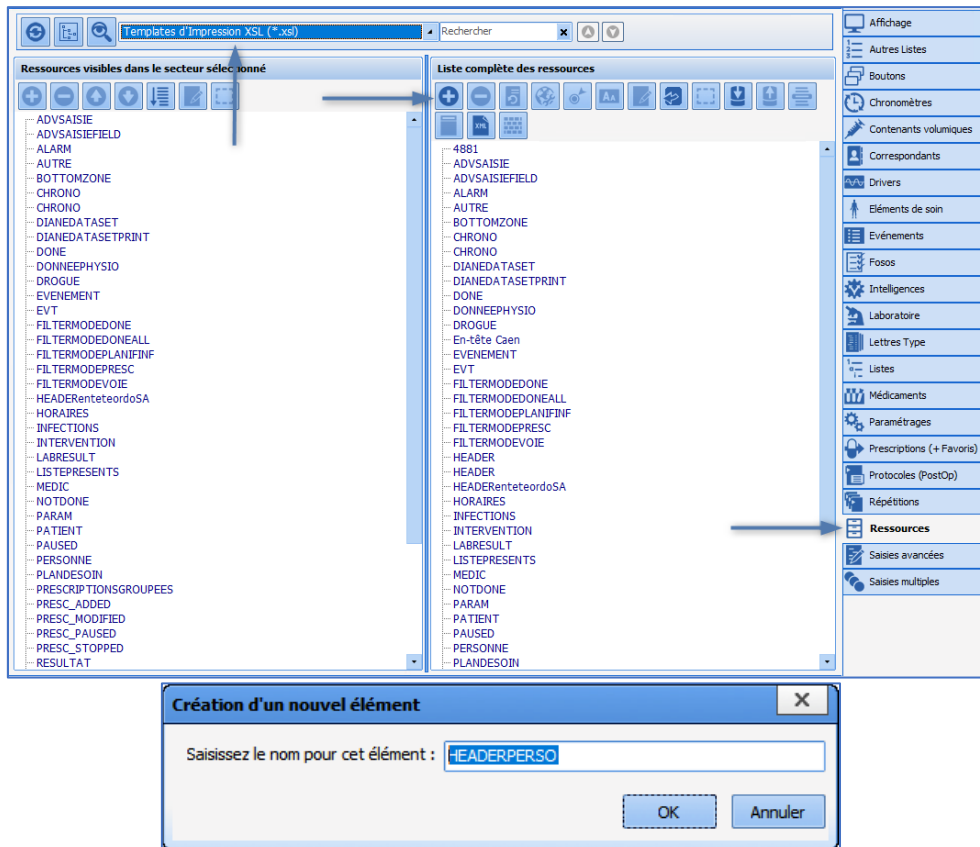
In this example, the XSL file provided is named "headerperso.xsl", but the name can be different and more specific, e.g. "headerprescription.xsl"). Note: the file name is important for subsequent set-up.

*All the following steps must be carried out in the configuration tool.*

- **Importing the resource**

Go to the [Resources](#) tab, **XSL print templates** category and create a new resource.

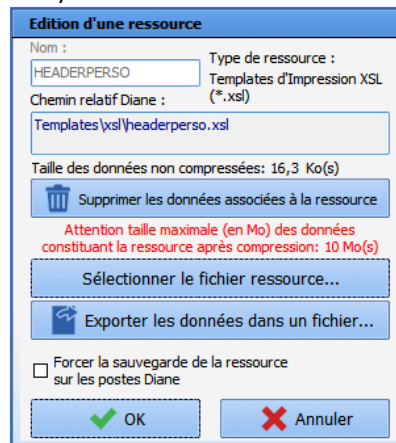




It is important to ensure consistency with the file name provided (here “headerperso.xml”) to avoid confusion later. For this example, the resource is therefore named “HEADERPERSO”.

**Ensuring consistency between the resource name and the file name is strongly recommended. The majority of problems encountered during configuration are the result of confusion at this level.**

The XSL file “headerperso.xml” must be placed in the **DIANE** directory “... \Data\xxx\Templates\xsl” and the file “headerperso.xml” imported into the newly created resource.

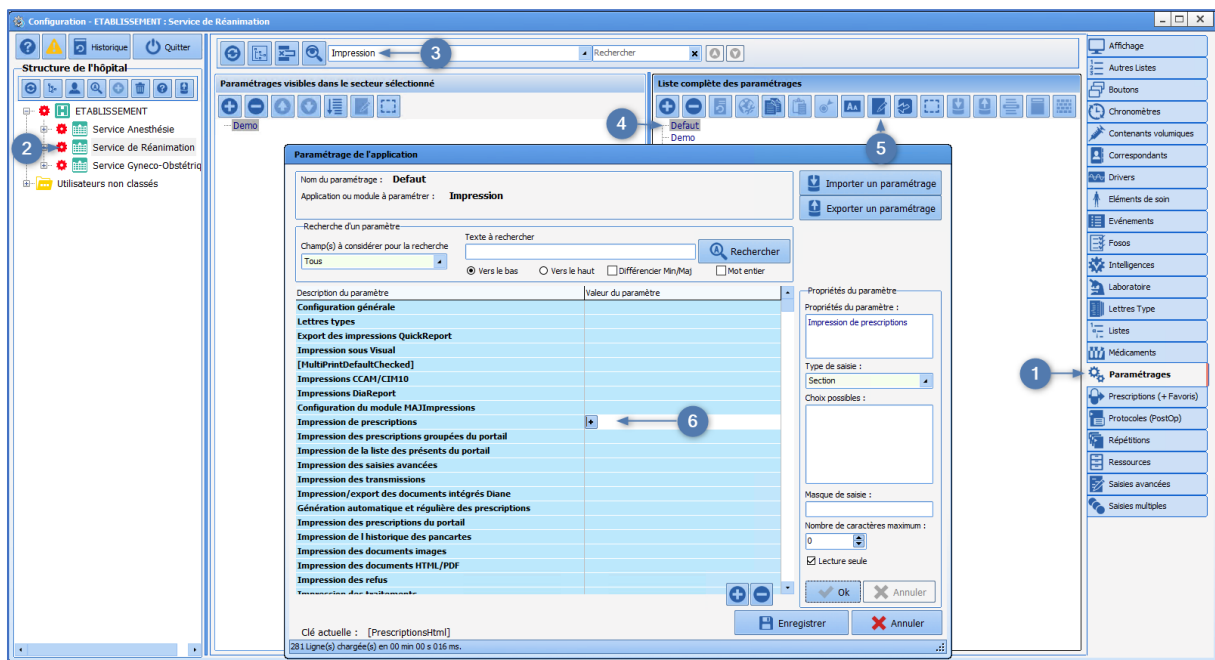


**Do not forget to toggle the resource “HEADERPERSO” to make it available.** Once the resource has been correctly imported and named, it can be activated.

- **Header activation**

Activation is set up in the **Settings** tab, **Printing** category.

Edit the corresponding configuration at the required location in the tree structure.



Various print-outs are listed in these settings (Medication orders, Detailed entries, etc.): the custom header must be set up for each print-out where it will be used. This means that different custom headers can be activated (or not) for each “HTML” print.

**Example with medication order printing:**

The values of these two keys must be changed:

- **Use of a custom header** => select to change to 1
- **Name of resource used as custom header** => type the name of the previously imported file: in this example “headerperso.xml”

Description du paramètre	Valeur du paramètre
<b>Impressions DiaReport</b>	
<b>Configuration du module MAJImpressions</b>	
<b>Impression de prescriptions</b>	
Format de la page	A4
Orientation de la page	Portrait
Impression en niveaux de gris	0
Impression des couleurs de fond	1
Marge supérieure (mm)	15
Marge de droite (mm)	15
Marge inférieure (mm)	15
Marge de gauche (mm)	15
Taille de l'entête (mm)	67
Informations de debug	0
Configuration des export	Enabled=-1  Save=2  Export=2  Email=2  ApiCr=0
Utilisation d'un header personnalisé	1
Nom de la ressource utilisée en tant que header personnalisé	
Taille du texte en mm (entre 1 et 7 inclus)	3
Nom de l'imprimante par défaut (si différente de celle système)	""
Utilisation de la configuration par défaut du système	1
<b>Impression des prescriptions groupées du portail</b>	

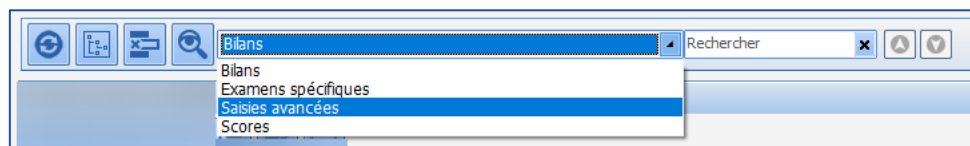
**Note:** it is the filename, with the extension .xml, that must be entered.

Confirm all, restart **DIANE** with the usual procedure and print a test document for which this header has been activated (in this example, a medication order).

## 3.21 Detailed entries (DE)

A detailed entry is a form used to enter items, calculate a score, prescribe lab tests, etc.

Four types of detailed entry are available in the application: Laboratory tests / Specific examinations / Detailed entries / Scores.



The **Laboratory tests** and **Specific examinations** detailed entries are only used with the **DIANE** consultation module.

**Detailed entries** and **scores** can be used anywhere in **DIANE**.

Note that **Scores** detailed entries can take Visual back to the previous consultation. For the Cormack classification, for example, a **Scores** detailed entry must be used to enter this in Intraoperative so that it is visible during subsequent consultations.

### 3.21.1 General information on detailed entries


The Detailed entries tab is used to create or edit detailed entries.

A detailed entry used in production can no longer be modified. It must then be duplicated to be edited.

Once this has been done, it must be made available for the sectors that will use it and its integration into the application managed. (Setting up of important actions, view in multiple entries, buttons, medication orders ,etc.).

There is no Ax/ID for a detailed entry. It is fully saved.

#### 3.21.1.1 Creation of a detailed entry

- Select the section for which the detailed entry is to be created (Laboratory tests / Specific examinations / Detailed entries / Scores)
- Click 
- Name the detailed entry
- Compose the part using the components proposed
- Each component is positioned using drag and drop
- Save the detailed entry


Ensure it is made available for the relevant sectors by dragging it into the left column.

#### 3.21.1.2 Configuration of a detailed entry

1. Input box for description of the detailed entry	
2. Addition of a new component	
3. Associate the detailed entry with an icon	

<p>4. Determine whether the entry is restricted to a specific role</p>	
<p>5. Advanced settings button for selected component</p>	
<p>6. "Parent" detailed entry: integration of a pre-existing detailed entry into the detailed entry currently being edited</p>	
<p>7. Ability to:</p> <ul style="list-style-type: none"> <li>- Select the position of the title of the selected component</li> <li>- Hide the title of the selected component</li> </ul>	

To manage tabulation from one component to the next:

- Complete the creation of the detailed entry in its entirety
- Edit one of the components
- Select **Tab order**
- Click on the button 
- Manage the component order.

**NB:** Tab order is used to make entry easier, but also determined the summary display order.

### 3.21.1.3 Available components for detailed entries

- Label
- Check box
- One-line input field
- Multi-line input field
- Drop-down menu
- Radio button group
- Check box group
- Input field with a reference list (Dialist memo)
- Border/Frame
- Button
- Button (AX)
- Subscore
- Predefined values button
- DIANE data
- Subscore (integrated display)
- Event entry via button
- Display patient records as text

Libellé

Permet d'ajouter un **texte**.  
Le texte se rédige dans  
la partie **Libellé**.

Score permettant d'évaluer la probabilité  
de nausées / vomissements post-opératoires (N/VO)

Case à cocher

Ajoute une **case à cocher**.  
Son intitulé se saisit dans  
la case **Libellé**.

Urgence

Menu déroulant

Ajoute un **menu déroulant**.  
Son intitulé se saisit dans  
la case **Libellé**.

type de respirateur

- Primus
- Perseus

Les différentes valeurs  
se définissent comme suit :

1=...  
2=...

Liste de choix possibles :

- 1=Primus
- 2=Perseus

Bordure/Cadre

Crée un **bordure/cadre** (esthétique)  
Nécessité d'associer un titre (*libellé*).

Bouton

Permet d'ajouter un **bouton** auquel  
pourra être associé un comportement  
(appel contextuel, impression etc)

Impressions

Bouton (AX)

*Ne pas utiliser le bouton (AX).*

Bouton de valeurs prédéfinies

Ajoute un **bouton** pour lequel il  
sera possible d'associer  
des **valeurs** par défaut.

Donnée Diane

Permet d'**afficher une donnée saisie dans  
le dossier** (labo, paramètres  
physiologiques).

Saisie d'évènement via bouton

Equivaut à un **bouton de saisie  
d'évènement** (comme les raccourcis).


Affichage des dossiers du patient sous forme de texte

Affichage des **dossiers** du patient sous  
forme de **texte**.

Champ de saisie avec liste de référence (AX)

Permet la saisie à partir de **listes de référence**.

Sous-score

Ce composant permet de **saisir facilement un score dans une saisie avancée**. Il suffit de choisir le score et de dimensionner le composant. L'utilisateur clique sur le bouton  pour afficher la fenêtre de saisie du score.

Sous-score (affichage intégré)

Comme le précédent, ce composant permet de saisir facilement un score dans une saisie avancée. Il suffit de choisir le score et de dimensionner le composant. **La saisie du score s'effectue directement dans ce composant**, contrairement au précédent.

#### 3.21.1.4 Change a detailed entry

A detailed entry used in production can no longer be edited. This is to ensure that it can be viewed in its entirety when an old record is opened.

To modify a detailed entry:

- Duplicate the entry and modify the new version.
- Rename the old version by adding several Zs to the start of the name
- Rename the new version so that it is coherent for users
- Remove the old version from view and replace it with the new version

#### 3.21.1.5 Ax/ID and detailed entries

It is possible to assign AX/IDs to the components of the detailed entry. This will allow the items of the detailed entry to communicate without external components.

To do this:

- Select the relevant component
- Click **Edit component** (bottom left of the window)

This opens the settings window for the component described in *Available components in the application*.

#### 3.21.2 Specificities of Laboratory tests detailed entries

**Laboratory tests** detailed entries can only be used in the dedicated component in consultation. They are used to edit the associated prescriptions.

Take care when choosing the name of the laboratory test as this will be included in the prescription.

There is a tag to edit all the detailed entries of this component: "specificlabs". This tag is used to edit only the check boxes of the various entries available.

If each detailed entry gives a different prescription, a custom tag must be created when the form letter is created.

(See *Form letters* chapter)

Please note that some general features are not available for these detailed entries.

### 3.21.3 Specificities of Specific examinations detailed entries

**Specific examinations** detailed entries can only be used in the dedicated component. (predominantly used in consultation)

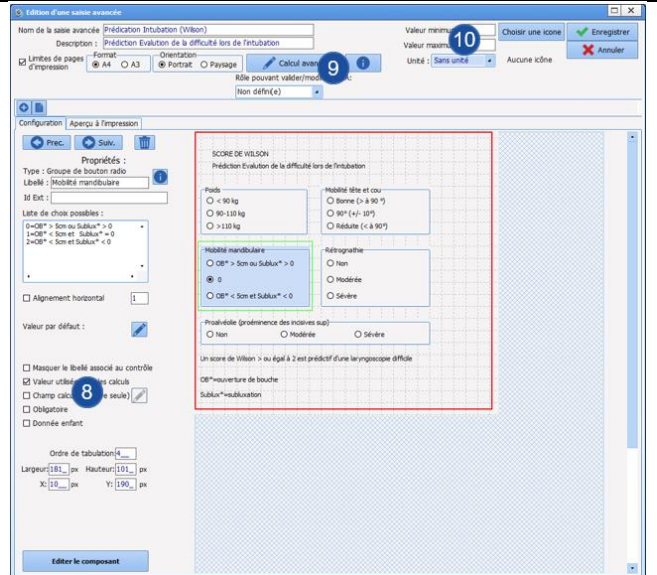
Take care when choosing the name of the laboratory test as this will be included in the print-out.

The print tag for editing all detailed entries used is “specificexaminations”.

Please note that some general features are not available for these detailed entries.

### 3.21.4 Specificities of Scores detailed entries

#### 3.21.4.1 Specificities of settings for Scores detailed entries

<p>8. Ability to:</p> <ul style="list-style-type: none"><li>- Hide label</li><li>- Include value in a calculation</li><li>- Set the field to read-only and result of calculation</li><li>- Mandatory field</li><li>- Child data (OB-GYN module)</li></ul>	
<p>9. Access to <b>calculation settings</b> and <b>score legend</b> pane settings.</p>	
<p>10. Settings for possible min/max values and unit for score</p>	

#### 3.21.4.2 Score calculation settings for detailed entries

Before setting up the calculation, the detailed entry must be created like a normal detailed entry. The difference is in how the possible choices are written.

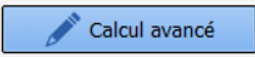
For drop-down menus, check box groups and radio buttons, these have been written as:

A=choice 1 || B=choice 2 ...

For a calculation, the letters are replaced by the value used for the calculation:

1= choice 1 || 2= choice 2...

- For the fields used in the calculation of the score, ensure the “**Value used in calculations**” box is selected.
- Enter the unit in which the score will be shown (“No unit” is available in the middle of the list).
- Enter the possible minimum and maximum values for the score. Do not forget that check boxes can have several selections in the same component.

- Use  to access the calculation formula settings

- The name of the variables includes the title of the components by default. They can be rewritten to simplify writing the formula in the dedicated pane.
- Write calculation formula
- Test formula

Formule utilisée pour le calcul

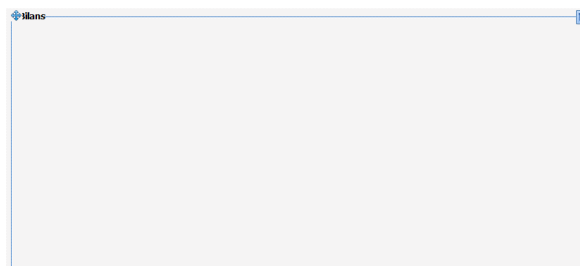
Possibilité de renommer les variables via un double clic dans la case

Nom du champ	Nom de la variable	valeur (test)
Motricité spontané	A	1
Variation de la PA :	B	1
Conscience	C	1
Coloration	D	1
Respiration	E	1
.	.6	1

### 3.21.5 Display modes for detailed entries in consultation


#### 3.21.5.1 Viewing Laboratory tests detailed entries

In the consultation module, there is a component called “**LabGroupBox (Examination)**”.



Right-click to access the settings window and determine the **parent tab, title** and various additional functions.

To position it in the tab, move it and click a second time in the required place. The arrow found bottom right is used to change the height and width of the component.

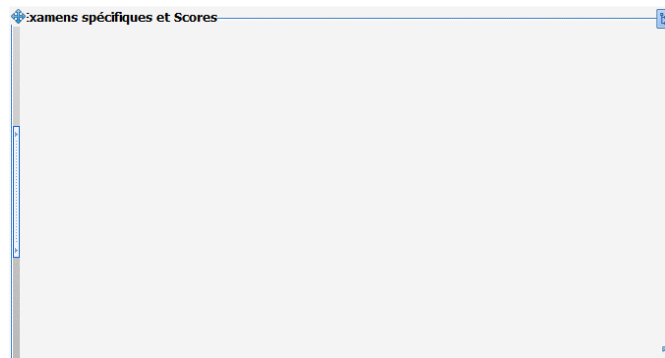
Click  to open the Available detailed entries selection window and select those to be displayed. This tree structure is also available for users. The detailed entries will be those in the **Laboratory tests** list available for the sector in question.



An editing button must be provided close to this component so that editing associated with the relevant selection can be carried out.


### 3.21.5.2 Viewing Specific examinations detailed entries

In the consultation module, there is a component called “**ExaminationsGroupBox (Examinations)**”.



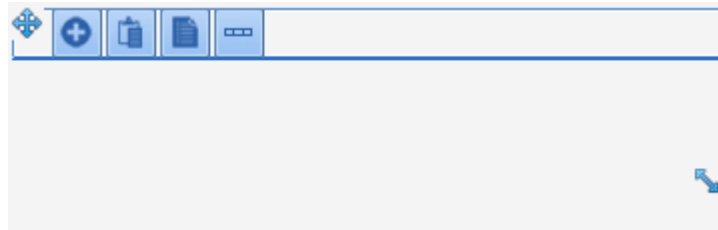
Right-click to access the settings window and determine the **parent tab, title** and various additional functions.

To position it in the tab, move it and click a second time in the required place. The arrow found bottom right is used to change the height and width of the component.

Click  to open the Available detailed entries selection window and select those to be displayed. This tree structure is also available for users. The detailed entries will be those in the **Specific examinations** list available for the sector in question.



### 3.21.5.3 Viewing Detailed entries and Scores detailed entries

In each consultation tab, there is a container as shown below. This becomes visible when a detailed entry is set up.



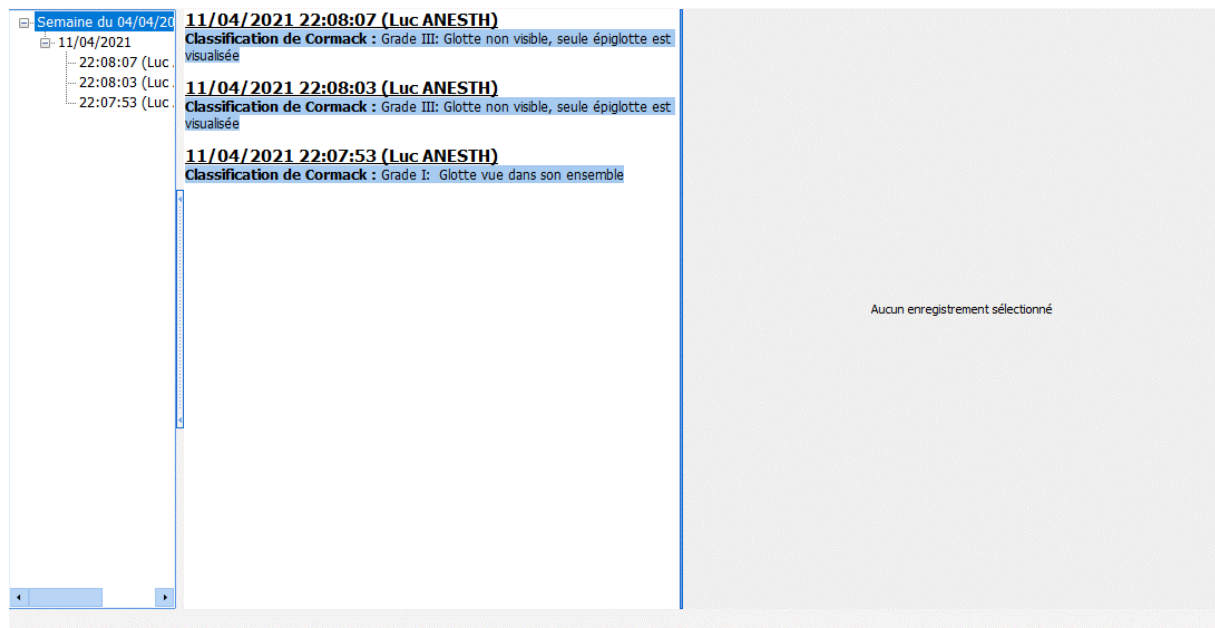
The container is used to view **Detailed entries** and **Scores** detailed entries. A single detailed entry can be viewed per tab. It is possible to add as many tabs as detailed entries required.

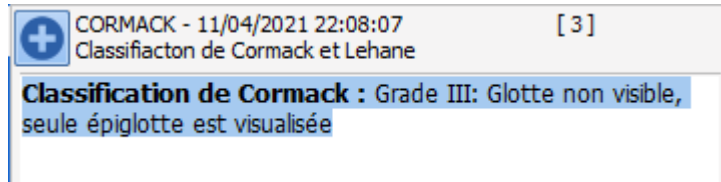
To view a detailed entry in this container:

- Click 
- Select **Tab**
- Enter a title for this tab in the window that opens
- **Save**
- Click  again
- Select **Detailed entry (basic view)** or **Detailed entry (multiple view)**
- Right click the location of the future detailed entry
- Select **Edit**
- From the drop-down menu, select the required detailed entry
- Select **View this component only**
- Select the required display order (ascending or descending)
- **Save**

Difference between **Detailed entry (basic view)** or **Detailed entry (multi-view)**:

- Basic view will show only one form. (First or last record depending on settings)
- Multiple view shows all entries on the form.





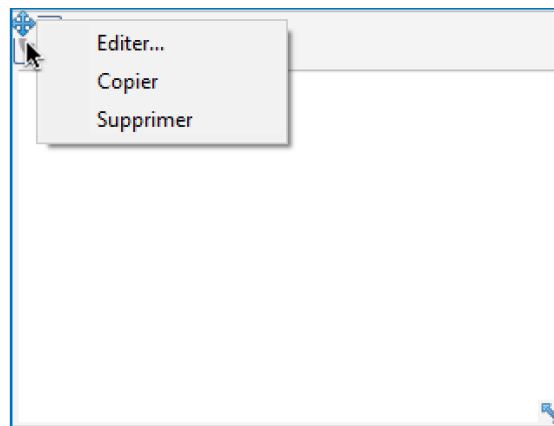
### 3.21.6 Display modes for detailed entries in Visual and DianeICU

Detailed entries can be shown in tabs such as **Doctor** and **Paramedical** and in tabs such as **Avail 3**, in three different forms.

#### 3.21.6.1 Basic view (Detailed entry basic view)

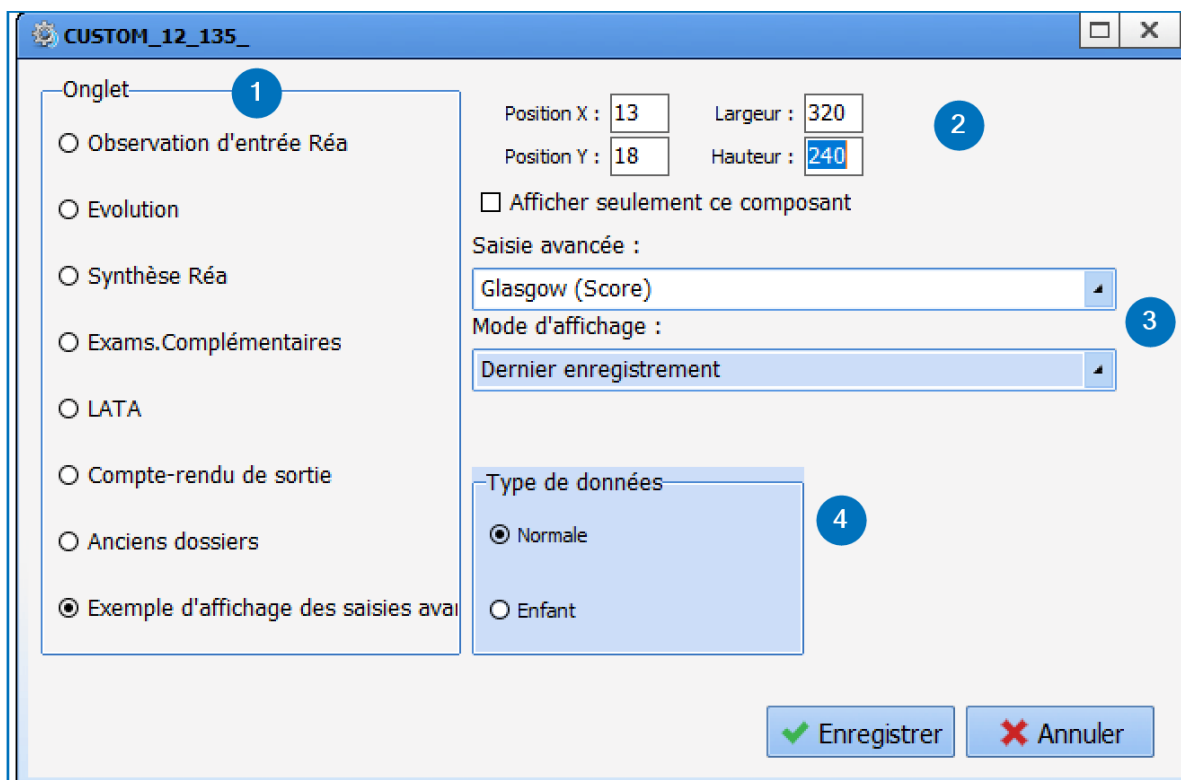
In this view, only one **detailed entry** can be selected. This is used to show a summary of data entered but also to restrict the display so that only the score result is seen, for example.

Choice of component from list: **Detailed entry (basic view)**



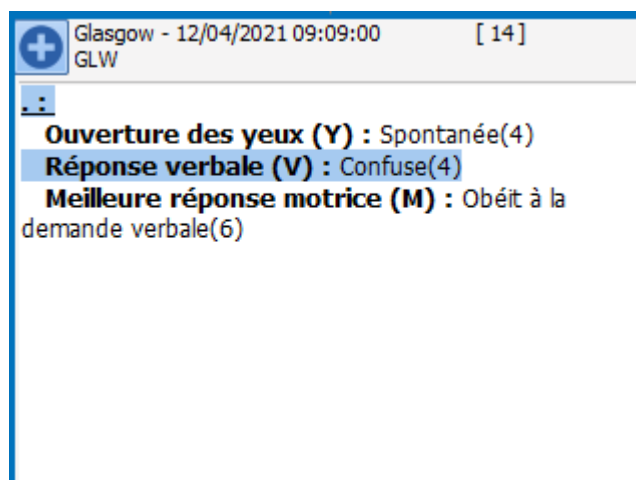
Choice of component from list: **Detailed entry (basic view)**

Right-click **Edit**



1. Pane used to select the parent **tab**: by default this is the tab being edited
2. Pane used to **set height and width** of the component. The option **View this component only** is used to automatically adjust the component size to the screen.
3. **Detailed entry**: opens the list of available **detailed entries** and **scores**.
4. **Data type**: used to assign the data to the Child record in **Diane OB-GYN**.

#### Preview of display:



### 3.21.6.2 Multiple view (Detailed entry multi-view)

This display mode comprises three columns:

- Column one: Entry history
- Column two: Summary of information entered
- Column three: Preview of the detailed entry as a whole with formatting.

Choice of component from list: [Detailed entry \(multi-view\)](#)

- Right-click [Edit](#)

1. [Display order](#): determines the order of display
2. [Size of the central summary pane](#): used to determine the width of the second column.

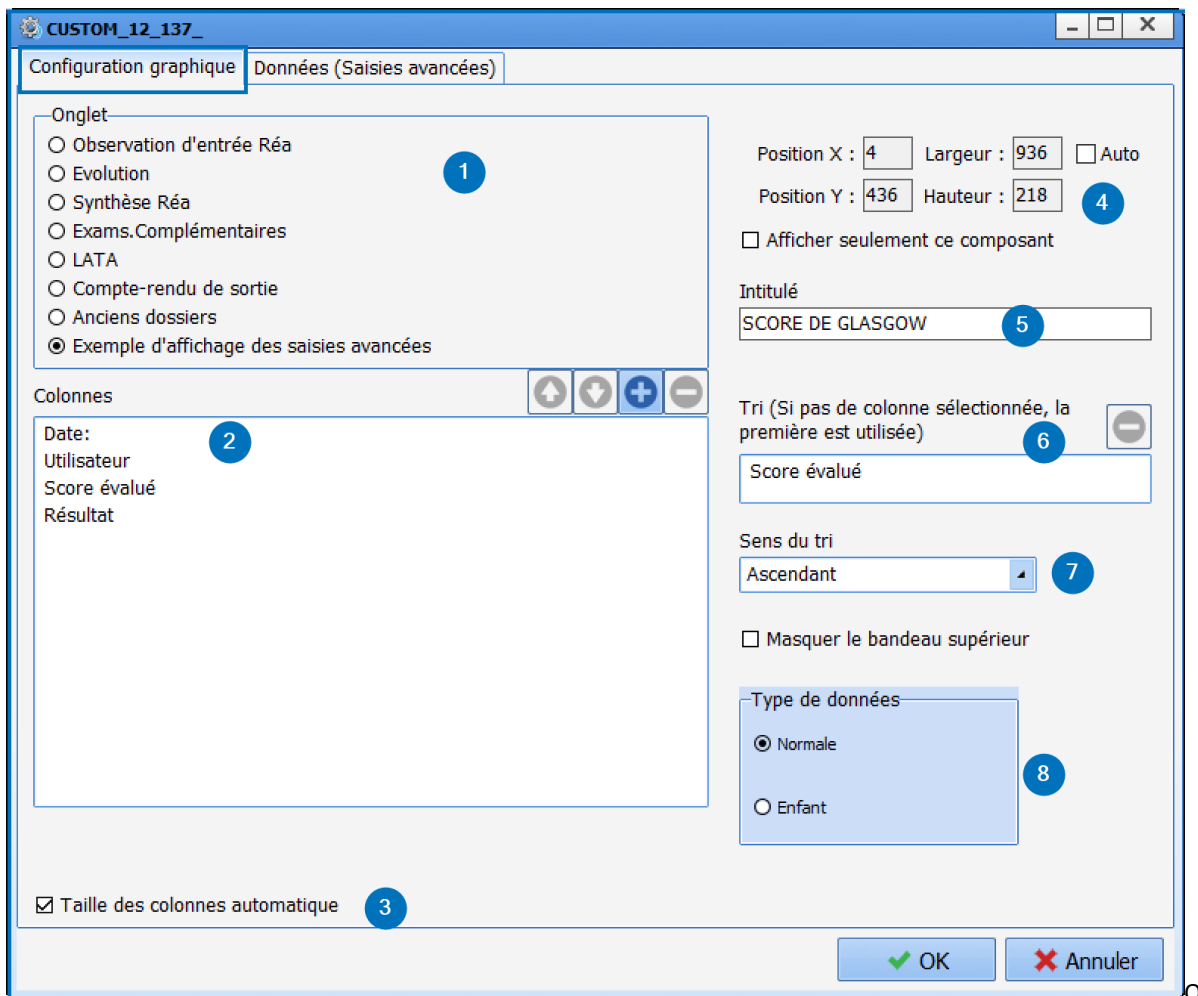
**Preview of view:**

### 3.21.6.3 Detailed entry table (Display detailed entries as list)




This mode is used to create a summary table with configurable columns.

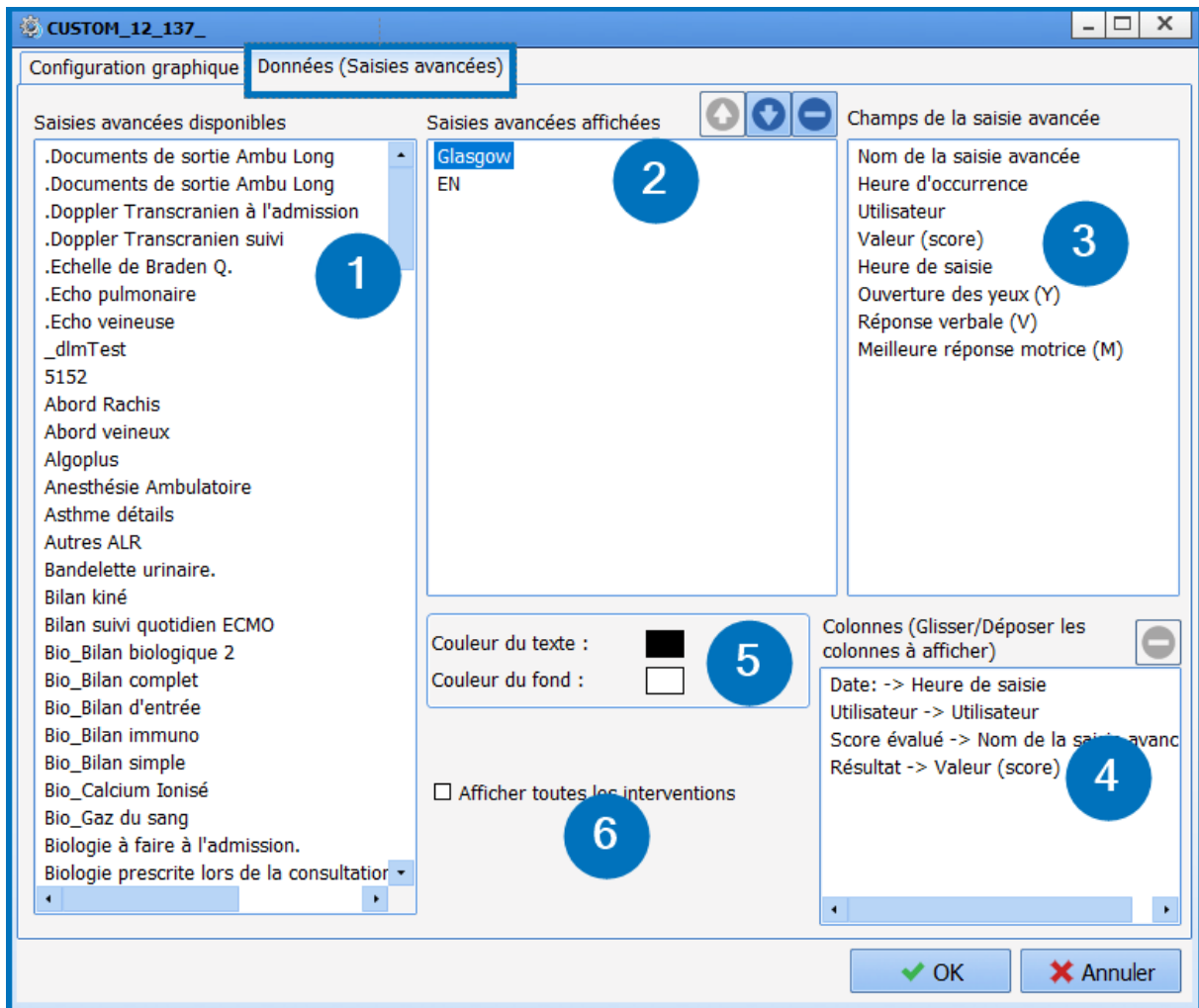
Unlike the other two display modes, it can be used to configure several **detailed entries**.

- Choice of component from list: [Detailed entries as list](#)
- Right-click [Edit](#)



The settings window has two subtabs:

- **Chart configuration:** used to construct the table: assign columns, a title, etc.
  1. **Tab:** used to determine the display tab
  2. **Columns:** used to create and name columns in the table. To add a column, click , and click  in the pane to enter the title. Use the arrows  to change the order of the columns
  3. **Automatic column size:** automatically adjusts the width of the columns based on their content
  4. **Management of height and width** of the component. The **Auto** option adapts the width to the size of the screen. The option **View this component only** allows the table to take up the width of the display.
  5. **Title:** used to give the table a title.
  6. **Sort:** used to select the column and data type for sorting, e.g. by date, by title, etc.
  7. **Sort direction:** used to choose between ascending or descending sorting.
  8. **Data type:** used to assign the data to the Child record in **Diane OB-GYN**.



- **Data (detailed entries):** used to assign data to be displayed in the columns.
  1. **Available detailed entries:** list of available **detailed entries** and **scores**.
  2. **Displayed detailed entries:** drag and drop the **detailed entries** to be entered and shown in the table.
  3. **Detailed-entry field:** repeats the various fields and information belonging to the **detailed entry**
  4. Pane used to assign column content using drag and drop Example: Value (score) is assigned to the column "Result".
  5. Option used to assign different colours for background and text. This is specific to each **detailed entry** set up.
  6. **View all procedures:** this option is used to repeat all entries, not only for the current record but for all patient records.

#### Preview of display:

SCORE DE GLASGOW			
Date:	Utilisateur	Score évalué	Résultat
12/04/2021 09:09:17	Luc ANESTH	EN	3
12/04/2021 09:09:26	Luc ANESTH	EN	6
12/04/2021 09:09:05	Luc ANESTH	Glasgow	14

### 3.21.7 Detailed entry printing

When setting up the detailed entry, a print preview can be accessed via the dedicated tab. Special care must be taken with detailed entries to be printed.

For each detailed entry (normal or score), the orientation (portrait or landscape) can be selected.

If this is not set up, the overall settings will be taken into account (**Settings** tab – **Printing**). The page format is also configured in this settings file.



## 3.22 Multiple entries

A multiple entry is a tool that simplifies the entry of various items by creating scenarios such as patient arrival in operating theatre, infusion, intubation, surgical procedure, etc.

The screenshot shows the 'Edition de la Saisie Multiple' window. At the top, there is a header with the title and a search field. Below the header, there are two rows of tabs: 'Médicament', 'Environnement', 'Prélèvement', 'Saisie avancée', 'Séparateur', 'RAZ temps', 'Enregistrer', 'Annuler' in the first row; and 'Consommable', 'Evénement', 'Complication', 'Saisie Multiple', 'Donnée manuelle', 'Élément de soin' in the second row. The main area contains a list of items with checkboxes, text descriptions, and time input fields. The items include: 'Perfusion' (Patient perfusé en secteur d'hospitalisation), 'Voie veineuse' (Voie Veineuse (VV) posée en secteur hospitalier), 'Perfusion' (Patient perfusé en salle d'induction), 'Perfusion' (Patient perfusé en salle d'opération), 'Voie veineuse' (Voie Veineuse Périphérique (VVP) main gauche), 'Obturbateur' (20G), 'Cathlon' (G20), 'SOLUTES' (Ringer, IV PERF 500 ml), 'Anesthésie' (Pré-oxygénation), 'Monitoring' (ECG 3 branches, PNI, SpO2), 'O2 Masque' (Début O2 Masque 06L/min), and 'Anesthésie' (Patient perfusé, scopé, installé pour Anesthésie LocoRégionale (AL)). At the bottom, there are two panels: 'Saisies multiples enchaînées' and 'Saisies multiples alternatives', each with 'Ajouter', 'Supprimer', 'Monter', and 'Descendre' buttons. Numbered callouts 1 through 11 point to various elements in the interface.

### 1. Menu of items available for use in multiple entries:

<b>Médicament</b>	Add a drug, fluid balance or blood product from the <b>Drugs</b> tab: the first column is used to define a Drug or Drug category, and the second to indicate the posology or allow the user to choose.
<b>Environnement</b>	Add an item from the <b>Environment</b> tree structure on the <b>Events</b> tab.
<b>Prélèvement</b>	Add an item from the <b>Sample</b> tree structure on the <b>Events</b> tab.
<b>Saisie avancée</b>	Add a Detailed entry or Score from the <b>Detailed entries</b> tab.
<b>Séparateur</b>	Add a separator row between blocks to improve readability.
<b>Consommable</b>	Add an item from the <b>Consumables</b> tree structure on the <b>Events</b> tab.
<b>Evénement</b>	Add an item from the <b>Events</b> tree structure on the <b>Events</b> tab.
<b>Complication</b>	Add an item from the <b>Complications</b> tree structure on the <b>Events</b> tab.

<b>Saisie Multiple</b>	Add an existing multiple entry.
<b>Donnée manuelle</b>	Add a manual entry.
<b>Élément de soin</b>	Add an item from the <b>Care items</b> tab.

**NB:** The required items must be created in advance and be the same as those configured in the care plan displayed so that the care plan is completed as multiple entries are made.

2. Reset scheduling (see 9).
3. Save and quit multiple entry editing.
4. Quit multiple entry editing without saving.
5. Boxes to preselect or deselect items on opening the multiple entry.

<input checked="" type="checkbox"/> Scores	Glasgow
<input type="checkbox"/> Comportement	Indéterminé
<input type="checkbox"/> Sommeil	Indéterminé

In the case of an “**undetermined**” item, the box is replaced by a black square: in use, the box will be selected when the item has been specified.

6. Types of item added to the multiple entry.
7. Names of items added to the multiple entry. If only the category of the item is entered, **Undetermined** is shown. The user must enter it when entering multiple entries.
8. Route and quantity for drugs.
9. Time pane for scheduling the entry of various items: move the cursors to change the time intervals, up or down, from the time the multiple entry was opened. The **Ctrl** button is used to move all items at the same time. The movement is shown to the right of the cursor.
10. Settings for chained multiple entries (proposal(s) accepted by selecting **ok and continue with in use**)  
The **Add** button provides access to the full list of multiple entries available in the application.  
*Example:* after the **Infusion** multiple entry, it is possible to continue with the **GA / RSI** multiple entry.
11. Settings for alternative multiple entries (to be entered instead of the current multiple entry).  
*Example:* instead of the **Infusion** multiple entry, it is possible to carry out the **GA / RSI** multiple entry.

It is possible to delete, go up (**Previous**) or go down (**Next**) a row in the manual entry by right-clicking. The following menu is displayed:

Supprimer
Avant
Après

It is also possible to move the row with drag and drop: to do this, select the row by clicking the left edge,

which turns green: 

To avoid multiple entries that are too long and/or nested, it is possible to select the multiple entries to be shown automatically on closing the current multiple entry. It is also possible to not enter the current multiple entry and show an alternative.

Multiple entries are generally associated with buttons to make them simpler: the buttons must be made visible in display settings.



## 4 Settings

### 4.1 Key principles of settings

#### 4.1.1 Consultation

The screenshot shows the 'Paramétrage de l'application' window for 'Consultation'. The window title is 'Paramétrage de l'application'. The 'Nom du paramétrage' is 'Demo 1280x800 EMed Optim' and the 'Application ou module à paramétrer' is 'Consultation'. There are buttons for 'Importer un paramétrage', 'Exporter un paramétrage', and 'Configuration avancée'. A search section includes a 'Recherche d'un paramètre' field, a 'Texte à rechercher' input, a 'Champ(s) à considérer pour la recherche' dropdown (set to 'Tous'), and search options: 'Vers le bas', 'Vers le haut', 'Différencier Min/Maj', and 'Mot entier'. A table lists parameters with columns 'Description du paramètre' and 'Valeur du paramètre'. The table is currently empty. To the right, the 'Propriétés du paramètre' section shows 'Configuration générale' selected, 'Type de saisie' set to 'Section', and 'Choix possibles' empty. There are also fields for 'Masque de saisie', 'Nombre de caractères maximum' (set to 0), and a 'Lecture seule' checkbox. At the bottom, there are 'Ok', 'Annuler', 'Enregistrer', and 'Annuler' buttons. The status bar shows 'Clé actuelle : [GENERAL]' and '13591 Ligne(s) chargée(s) en 00 min 01 s 456 ms.'

#### 4.1.1.1 General configuration

##### 4.1.1.1.1 Request confirmation of workstation location on consultation start-up (ConfigurePoste)

Demander la confirmation de l'emplacement du poste au démarrage de la consu	1
Délai en minute avant fermeture automatique de la consultation	60
ConfigurePoste (Demander la confirmation de l'emplacement du poste au démarrage de la consultation)	

This setting requests confirmation that the computer is in the right location: this is important in particular for emergency stations.

##### 4.1.1.1.2 Time in minutes before the consultation is closed automatically (AutoCloseTime)

Délai en minute avant fermeture automatique de la consultation	60
AutoCloseTime (Délai en minute avant fermeture automatique de la consultation)	

This setting is used to define the time (in minutes) before the consultation is closed automatically.

#### 4.1.1.1.3 Time in minutes before the current user is logged out (AutoDelogTime)

Délai en minute avant déconnexion automatique de l'utilisateur courant	30
Empêcher la création de patients non rattachés au SIH	Création autorisée
AutoDelogTime (Délai en minute avant déconnexion automatique de l'utilisateur courant)	

This setting is used to define the time (in minutes) before the current user is logged out.

#### 4.1.1.1.4 Prevent creation of patients not found in HIS (CannotCreateDIAPat)

Empêcher la création de patients non rattachés au SIH	Création autorisée
CannotCreateDIAPat (Empêcher la création de patients non rattachés au SIH)	Création toujours

This setting is used to allow (with or without confirmation) or block the creation of patients who are not found in the HIS. For rooms with emergency admissions, blocking their creation is not recommended.

Création autorisée
Création bloquée
Confirmation demandée

#### 4.1.1.1.5 Prevent editing of HIS data (CannotModifySIHData)

Empêcher la modification des données provenant du SIH	Modification toujours possible
CannotModifySIHData (Empêcher la modification des données provenant du SIH)	

This setting is used to authorise or disable the editing of HIS data. If editing is disabled, any changes will be “deleted” when the record is reopened and the HIS data will be recovered.

Modification toujours autorisée
Modification autorisée si IPP non renseigné
Modification toujours bloquée

#### 4.1.1.1.6 Ask to run automatic retrieval when a new operation is created (AskForRepriseAuto)

Demander pour lancer la reprise automatiquement lors de la création d'une nouvelle intervention (antécédents,6= Choisir le dossier pour tout reprendre)	Onglet Antécédent seul avec demande de confirmation
AskForRepriseAuto (Demander pour lancer la reprise automatiquement lors de la création d'une nouvelle intervention (antécédents,6= Choisir le dossier pour tout reprendre))	Reprise des items niveau 3 (comme le poids)

This setting determines the retrieval strategy on creation of a new consultation (for patients who already have a record).

Inactif
Onglet Antécédent seul avec demande de confirmation
Onglet Antécédent seul invisible
Toute la consultation avec demande de confirmation
Toute la consultation silencieuse
Choisir le dossier pour les antécédents
Choisir le dossier pour tout reprendre

#### 4.1.1.1.7 Retrieval level from which items are retrieved in the consultation (DefaultNivReprise)

Niveau de reprise à partir duquel les items sont repris dans la consultation	Reprise des items niveau 3 (comme le poids)
DefaultNivReprise (Niveau de reprise à partir duquel les items sont repris dans la consultation)	

This setting determines the retrieval level (1, 2 or 3) from which items are retrieved in the consultation when the creation of a new consultation is proposed.

- Reprise des items niveau 3 (comme le poids)
- Reprise des items niveau 1 (comme les antécédents)
- Reprise des items niveau 2 (comme la taille)
- Reprise des items niveau 3 (comme le poids)

#### 4.1.1.1.8 Default Tab (DefaultTabIndex)

Onglet à sélectionner par défaut	Administratifs
DefaultTabIndex (Onglet à sélectionner par défaut)	sur la croix (windows 0
Activer le mode debug	0

This setting determines the tab shown on opening the consultation.

### 4.1.1.2 Printing

#### 4.1.1.2.1 Word printing used by default (IMPRCPAWORD)

Impression Word utilisée par défaut (Si=1,c'est le document que vous aurez co	1
IMPRCPAWORD (Impression Word utilisée par défaut (Si= 1,c'est le document que vous aurez configuré	
Activer l'impression du champ 3 (Antecedents obstetricaux a Lille)	0

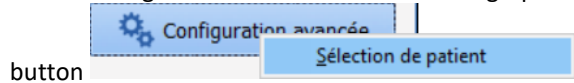
This setting determines the **Word** printing used by default. If the setting is 1 (yes), the document configured from the **Configuration** application, **Form letters / Full pre-op consultation printing** tab will be used.

### 4.1.1.3 Patient selection window

The patient selection window for the consultation can be configured via the settings keys.

Description du paramètre	Valeur du paramètre
<b>Fenêtre de sélection de patient</b>	-
Couleur du mode connecté	13432022
Couleur du mode dégradé	10921727
Définition des colonnes à l'affichage	"23,80 1,120 2,120 3,120 5,70 4,36 6,115"
Indice de la colonne triée par défaut	2 4
Ordre de tri par défaut	-1
Nom à utiliser lors du clic sur "Patient Inconnu"	"Nom Inconnu"
Prénom à utiliser lors du clic sur "Patient Inconnu"	"<Date> <Heure>"
Affiche le type de recherche par défaut	1
Coche par défaut "Début inconnu"	0
Coche par défaut "Fin inconnue"	1
Coche par défaut "Ignorer les accents"	1
Coche par défaut "Recherche à la frappe"	1
Coche par défaut "Recherche au clic"	1
Nombre de caractère minimum avant recherche automatique	3
Interdit la recherche automatique à l'ouverture de la fenêtre	0
Message indiquant le manque de droit	"Vous n'avez pas les droits"
Affiche les filtres patient par défaut	1
Active les filtres patient par défaut	1
Active la recherche dans les identités du SIH	0
Active la recherche dans les identités du mode de codes yeux	0

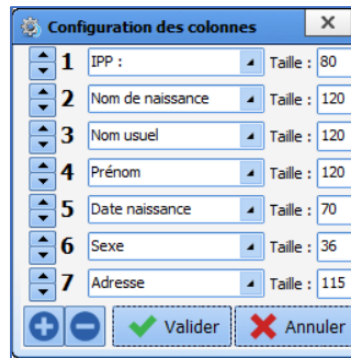
These settings can also be accessed via the graphic display, via the **Advanced configuration / Patient selection**



button

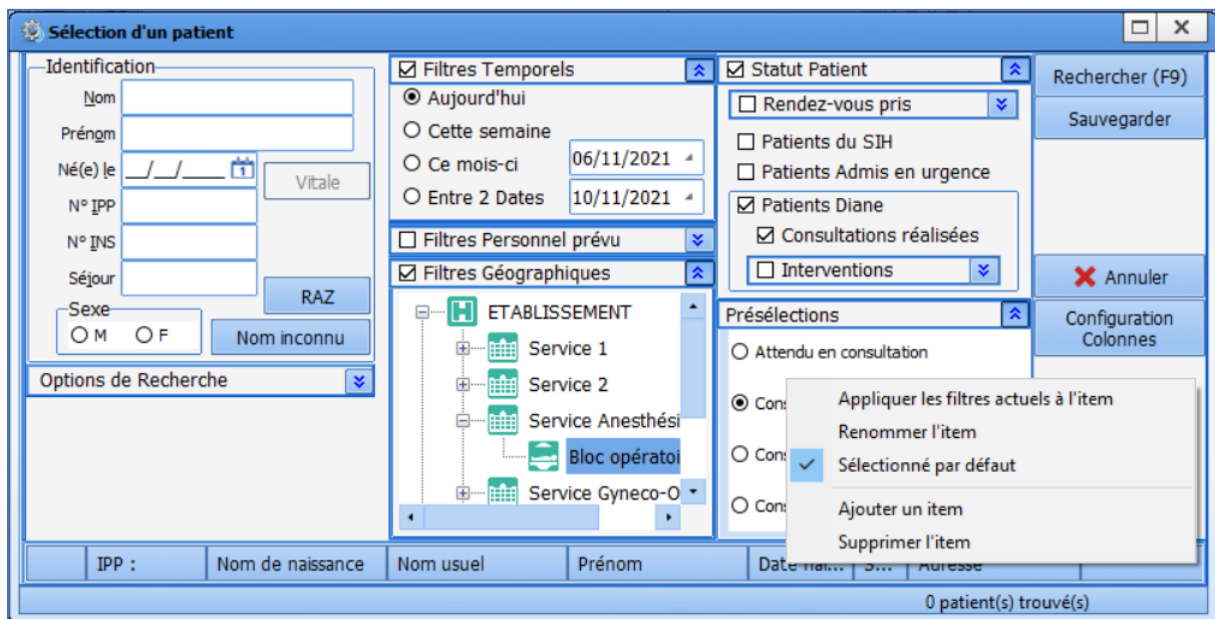
#### 4.1.1.3.1 Column configuration

This interface is used in particular to facilitate column configuration:



#### 4.1.1.3.2 Preselection configuration

It is possible to configure preselections (filter favourites).

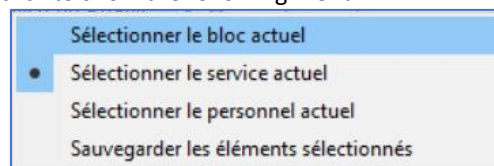


Right-clicking a preselection item displays a menu to:

- Apply current filters to the item: used to modify an existing preselection or apply filters to a new preselection.
- Rename the item: used to change/correct the title of a preselection.
- Default selection: used to choose the preselection applied on opening the patient selection window.
- Add an item: used to create a new preselection.
- Delete item: used to delete the selected preselection.

#### **Special case: location filter**

To save the location filter, right-click to show the following menu:



Once the location filter has been configured, the correct option must be selected:

- Select current OT: selects the OT in which the computer is located



- Select current department: selects the department in which the computer is located
- Select current staff member: displays the patients for whom the consultation was carried out by the current user
- Save selected items: selects the configured OT(s) or department(s), regardless of computer location

#### 4.1.1.4 Mandatory information for surgery creation

##### 4.1.1.4.1 Require patient's date of birth to authorise surgery creation (NeedDateNaiss)

Rendre obligatoire la saisie de la date de naissance pour autoriser la demande de création	0
NeedDateNaiss (Rendre obligatoire la saisie de la date de naissance pour autoriser la demande de création)	
Rendre obligatoire la saisie du type d'intervention prévue pour autoriser la demande de création	0

This setting makes entering the patient's date of birth mandatory for authorising a surgery creation.

##### 4.1.1.4.2 Require patient's sex to authorise surgery creation (NeedSex)

Rendre obligatoire la saisie du sexe du patient pour autoriser la demande de création	0
NeedSex (Rendre obligatoire la saisie du sexe du patient pour autoriser la demande de création)	

This setting makes entering the patient's sex mandatory for authorising a surgery creation.

##### 4.1.1.4.3 Require scheduled surgery type to authorise surgery creation (NeedTypeIntervPrev)

Rendre obligatoire la saisie du type d'intervention prévue pour autoriser la demande de création	0
NeedTypeIntervPrev (Rendre obligatoire la saisie du type d'intervention prévue pour autoriser la demande de création)	
Rendre obligatoire la saisie de la date d'hospitalisation pour autoriser la demande de création	0

This setting makes entering the scheduled surgery type mandatory for authorising a surgery creation.

##### 4.1.1.4.4 Require scheduled surgery date to authorise surgery creation (NeedDateIntervPrev)

Rendre obligatoire la saisie de la date d'intervention prévue pour autoriser la demande de création	0
NeedDateIntervPrev (Rendre obligatoire la saisie de la date d'intervention prévue pour autoriser la demande de création)	
Rendre obligatoire la saisie du chirurgien prévu pour autoriser la demande de création	0

This setting makes entering the scheduled surgery date mandatory for authorising a surgery creation.

##### 4.1.1.4.5 Require date of hospitalisation to authorise surgery creation (NeedDateHospPrev)

Rendre obligatoire la saisie de la date d'hospitalisation pour autoriser la demande de création	0
NeedDateHospPrev (Rendre obligatoire la saisie de la date d'hospitalisation pour autoriser la demande de création)	
Date d'hospitalisation dans la fenêtre "Programmation d'une nouvelle intervention"	0

This setting makes entering the scheduled admission date mandatory for authorising a surgery creation.

##### 4.1.1.4.6 Require scheduled surgeon to authorise surgery creation (NeedPreviousChir)

Rendre obligatoire la saisie du chirurgien prévu pour autoriser la demande de création	0
NeedPreviousChir (Rendre obligatoire la saisie du chirurgien prévu pour autoriser la demande de création)	
Date d'hospitalisation dans la fenêtre "Programmation d'une nouvelle intervention"	0

This setting makes entering the scheduled surgeon mandatory for authorising a surgery creation.

#### 4.1.1.4.7 Require scheduled anaesthetist to authorise surgery creation (NeedPreviousAnesth)

Rendre obligatoire la saisie de l'anesthésiste prévu pour autoriser la demande de création	1
NeedPreviousAnesth (Rendre obligatoire la saisie de l'anesthésiste prévu pour autoriser la demande de création)	
Rendre obligatoire la saisie du service demandeur pour autoriser la demande de création	0

This setting makes entering the scheduled anaesthetist mandatory for authorising a surgery creation.

#### 4.1.1.4.8 Date of hospitalisation in "Schedule a new procedure" window (UseNormalDateHosp)

Date d'hospitalisation dans la fenêtre "Programmation d'une nouvelle intervention"	1
UseNormalDateHosp (Date d'hospitalisation dans la fenêtre "Programmation d'une nouvelle intervention")	

#### 4.1.1.4.9 Require requesting unit to authorise surgery creation (NeedServiceDemandeur)

Rendre obligatoire la saisie du service demandeur pour autoriser la demande de création	1
NeedServiceDemandeur (Rendre obligatoire la saisie du service demandeur pour autoriser la demande de création)	

This setting makes entering the requesting unit mandatory for authorising a surgery creation.

### 4.1.2 DIANEICU

**Paramétrage de l'application**

Nom du paramétrage : **Rea 1920-1080 Vidal bow.**  
 Application ou module à paramétrer : **DianeRea**

Recherche d'un paramètre

Champ(s) à considérer pour la recherche : Tous  
 Texte à rechercher :

Vers le bas  Vers le haut  Différencier Min/Maj  Mot entier

Description du paramètre	Valeur du paramètre
<b>Configuration générale de DianeRéa</b>	
Número de version (Chiffres uniquement)	"4.7.5"
Número d'archive (Chiffres uniquement)	4
Demander la confirmation de l'emplacement du poste au démarrage de l'applica	1
Délai en minutes à attendre avant la fermeture automatique de l'application	120
Délai en minutes à attendre avant la déconnexion de l'utilisateur en cours	110
Délai en secondes avant la déconnexion automatique du dossier lors de l'utilisat	0
Empêcher la création de patients non rattachés au SIH	Création autorisée
Empêcher la modification des données provenant du SIH	Modification toujours autorisée
Empêcher le lancement de plusieurs instances de l'application simultanément (0=	Toujours
Case "Imprimer le dossier" cochée par défaut en sortie de salle	En salle de réveil (Dossier en écriture)
Type de document généré (impression ou export automatique à la clôture)	Document DiaReport
Sauvegarde automatique du dossier sur le changement d'onglet (1=oui, 0=non)	1
Cocher par défaut la demande de conservation de fichier à l'édition des prescrip	1
Activer la récupération des interventions provenant du module de rendez-vous	0
Cocher la recherche étendue par défaut dans la fenêtre de recherche de drogu	1
Compatibilité écran tactile (1=Saisie bouton droit, 2=Saisie bouton gauche, 3=Saisie bouton droit	
Intervalle du clignotement des pousse-seringues en ms	0
Activer les chronomètres multiples (permet de démarrer un même chronomètre	0
Activer le lancement de la recherche F9 automatiquement	0
Activer la récupération d'interventions prévues par interface	1

Clé actuelle : [GENERAL]

328 Ligne(s) chargée(s) en 00 min 00 s 016 ms.

Importer un paramétrage

Exporter un paramétrage

Configuration avancée

Propriétés du paramètre

Propriétés du paramètre :  
Configuration générale de DianeRéa

Type de saisie :  
Section

Choix possibles :

Masque de saisie :

Nombre de caractères maximum :  
0

Lecture seule

Ok Annuller

Enregistrer Annuller

#### 4.1.2.1 DIANEICU general configuration

##### 4.1.2.1.1 Request confirmation of workstation location on application start-up (ConfigurePoste)

Demander la confirmation de l'emplacement du poste au démarrage de l'application	<input checked="" type="checkbox"/>
ConfigurePoste (Demander la confirmation de l'emplacement du poste au démarrage de l'application)	

This setting requests confirmation that the computer is in the right location: this is important in particular for emergency stations.

##### 4.1.2.1.2 Time in minutes before the consultation is closed automatically (AutoCloseTime)

Délai en minutes à attendre avant la fermeture automatique de l'application	120
AutoCloseTime (Délai en minutes à attendre avant la fermeture automatique de l'application)	

This setting is used to define the time (in minutes) before the application is closed automatically.

##### 4.1.2.1.3 Prevent creation of patients not found in HIS (CannotCreateDIAPat)

Empêcher la création de patients non rattachés au SIH	Création autorisée
CannotCreateDIAPat (Empêcher la création de patients non rattachés au SIH)	Création toujours autorisée

This setting is used to allow (with or without confirmation) or block the creation of patients who are not found in the HIS. For rooms with emergency admissions, blocking their creation is not recommended.

Création autorisée
Création bloquée
Confirmation demandée

##### 4.1.2.1.4 Prevent editing of HIS data (CannotModifySIHData)

Empêcher la modification des données provenant du SIH	Modification toujours autorisée
CannotModifySIHData (Empêcher la modification des données provenant du SIH)	Modification toujours autorisée

This setting is used to authorise or disable the editing of HIS data. If editing is disabled, any changes will be “deleted” when the record is reopened and the HIS data will be recovered.

Modification toujours autorisée
Modification autorisée si IPP non renseigné
Modification toujours bloquée

##### 4.1.2.1.5 Display mask for the upper ribbon of the module (UpperBandDisplayMask)

Masque d'affichage du bandeau supérieur du module	"<PATIENT_CIVILITE> <PATIENTFORMATEDNAMES>
UpperBandDisplayMask (Masque d'affichage du bandeau supérieur du module)	

This setting is used to configure the identity monitoring ribbon in DIANEICU.

Nom	Prénom	Âge	Localisation	Jour	Taille	Poids	Poids théorique du patient en kg	
M.	ANGELIN	Francis	56 ans	Lit 3	J 96	170cm	69kg	66,02kg

Settings keys can be found in *Information tags shown in ribbon of Visual / DIANE ICU / DIANE OB-GYN.*

## 4.1.2.2 Medication order

### 4.1.2.2.1 Management of prophylactic antibiotic treatment (AntibioProfilaxisSettings)

nom	Masquer le nom commercial du produit dans le résumé des soins du plan de soin
	Gestion de l'Antibioprophylaxie : Permet d'activer des contrôles sur les prescriptions [1=-1,1  3=-1,2  7=-1,3]
	Activer la signature des prescriptions sans mot de passe (si le compte connecté)
AntibioProfilaxisSettings (Gestion de l'Antibioprophylaxie : Permet d'activer des contrôles sur les prescriptions d'antibiotiques en associant un nombre de	

This setting is used to activate controls for antibiotic medication orders by associating a number of days of medication order with a DIANE template ID and/or internal form to be associated with the entry.

**Paramétrage des saisies complémentaires de prescription**

Veillez cocher les jours pour lesquelles la prescription doit-être complétée:  
 Pour chaque jour coché veuillez sélectionner le modèle de document et/ou le formulaire souhaité.

Note : Vous pouvez éditer/ajouter des modèles de document via l'onglet des lettres types dans l'outil de configuration (section "Lié à une prescription (Réa)")

	Modèle de document :	Fiche interne de validation :
<input checked="" type="checkbox"/> Jour 1	[dropdown]	Informations initiales (Antibiotique)
<input type="checkbox"/> Jour 2	[dropdown]	[dropdown]
<input checked="" type="checkbox"/> Jour 3	[dropdown]	Evaluation (Antibiotique)
<input type="checkbox"/> Jour 4	[dropdown]	[dropdown]
<input type="checkbox"/> Jour 5	[dropdown]	[dropdown]
<input type="checkbox"/> Jour 6	[dropdown]	[dropdown]
<input checked="" type="checkbox"/> Jour 7	[dropdown]	Ré-Evaluation (Antibiotique)

OK Annuller

non défini
Informations initiales (Antibiotique)
Evaluation (Antibiotique)
Ré-Evaluation (Antibiotique)
Indication (Produit hors GHS)
Enregistrement de Document

## 4.1.2.3 Care plan

### 4.1.2.3.1 Validation limit time (in minutes) for future care plan items (FutureCarePlanValidLimitTime)

Plan de soin	
Limite (en minutes) de validation des éléments futurs du plan de soin	720
Arrêter automatiquement les perfusions manuelles en cours arrivées à échéance	
FutureCarePlanValidLimitTime (Limite (en minutes) de validation des éléments futurs du plan de soin)	
Nombre de jours de génération du plan de soin (le par défaut)	

This setting is used to limit the ability to carry out/start occurrences in advance.

### 4.1.2.3.2 Automatically stop ongoing manual infusions due to end (AutoStopStartedCarePlanOccurrencesAfterDelayInMin)

Lit 6	Arrêter automatiquement les perfusions manuelles en cours arrivées à échéance 1
AutoStopStartedCarePlanOccurrencesAfterDelayInMin (Arrêter automatiquement les perfusions manuelles en cours arrivées à échéance depuis 'x' minutes (défaut))	

This setting enables/disables the automatic stopping, on the care plan, of manual infusions that are due to end after 'x' minutes: x=0 disable autostop, 1 = stop at scheduled time, otherwise stop at current time once scheduled time has been passed.

#### 4.1.2.3.3 Number of days for which care plan is generated (2 by default) (CarePlanGenerateDayCount)

Nombre de jours de génération du plan de soin (2 par défaut)	2
CarePlanGenerateDayCount (Nombre de jours de génération du plan de soin (2 par défaut))	
Transmissions ciblées	

This setting is used to specify the number of days to be generated for the care plan: if a treatment is prescribed for 7 days, only the first two days will be shown in the care plan.

#### 4.1.2.3.4 Show the dosage in the product header in the care plan (ShowDosageInCarePlanHeader)

Afficher le dosage sur l'entête des produits sur le plan de soin	0
ShowDosageInCarePlanHeader (Afficher le dosage sur l'entête des produits sur le plan de soin)	
Documents intégrés	

This setting is used to show or hide the dosage in product headers.

#### 4.1.2.3.5 Connection with SP: disable strict check of dilution match between medication order and device to be associated with a care plan occurrence (without this check, connecting is simpler but this can cause inconsistencies on the care plan) (DisabledCheckDeviceDilutionCompleteApplication)

test salle attente	Liaison au PSE : désactiver le contrôle strict de la correspondance de dilution en	<input type="checkbox"/>	Lecture seule
DisabledCheckDeviceDilutionCompleteApplication (Liaison au PSE : désactiver le contrôle strict de la correspondance de dilution entre la prescription et l'appareil à lier à une occurrence de plan de soins (sans ce contrôle strict la liaison est plus simple mais cela peut entrainer des incohérences sur le plan de soins) (1=oui, 0=non. Oui par défaut)			

Where there is a care plan occurrence associated with an SP, this setting is used to disable the strict checking of the dilution match between the medication order and the device to be associated with a care plan occurrence. Without this strict check, connecting is simpler but this can cause inconsistencies on the care plan. (1=yes=check disabled, 0=no=check enabled. Yes by default)

#### 4.1.2.4 Important actions

Actions importantes	
Afficher la saisie de la Feuille d'Ouverture comme action importante (0=Non, 1=3  6	
Afficher la validation de la Feuille d'Ouverture comme action importante (0=Non, 1=3  6	
Afficher la saisie de la Fiche Inter Patient comme action importante (0=Non, 1=3  6	
Afficher la validation de la Fiche Inter Patient comme action importante (0=Non, 1=3  6	
Afficher la signature de sortie de réveil comme action importante (0=Non, 1=Avertissement Bouton	
Afficher la signature des prescriptions comme action importante (0=Non, 1=Avertissement Bouton	
Afficher la saisie du médecin responsable comme action importante (0=Non, 1=3  2	
Afficher la validation du médecin responsable comme action importante (0=Non, 1=3  2	
Afficher la saisie de l'anesthésiste présent (0=Non, 1=Avertissement Bouton, 2=3  2	
Afficher la saisie du chirurgien présent (0=Non, 1=Avertissement Bouton, 2=Avertissement Bouton, 3  2	
Afficher la saisie de l'IADE présent (0=Non, 1=Avertissement Bouton, 2=Avertissement Bouton, 3  2	
Afficher la saisie du réanimateur présent (0=Non, 1=Avertissement Bouton, 2=0  8	
Afficher la saisie de l'infirmier présent (0=Non, 1=Avertissement Bouton, 2=Avertissement Bouton, 0  8	
Afficher la saisie de l'aide soignant présent (0=Non, 1=Avertissement Bouton, 2=Avertissement Bouton, 0  8	
Afficher la saisie du risque ASA (0=Non, 1=Avertissement Bouton, 2=Avertissement Bouton, 0  2	
Afficher la saisie du type d'anesthésie (0=Non, 1=Avertissement Bouton, 2=Avertissement Bouton, 0  2	
Afficher la saisie du type d'intervention (0=Non, 1=Avertissement Bouton, 2=Avertissement Bouton, 3  2	
Afficher la saisie des allergies (0=Non, 1=Avertissement Bouton, 2=Avertissement Bouton, 0  2	
Liste des évènements (ou catégorie) importants (A configurer comme suit : Comportement(0=Non, 1=3  2	
Liste des scores importants (A configurer comme suit : Comportement(0=Non, 1=3  2	
Afficher la saisie de l'IGS2 (0=Non, 1=Avertissement Bouton, 2=Avertissement Bouton, 0  8	

Important actions are used to make specific patient record entries mandatory. How to set up important actions



### 4.1.2.7 Task list configuration

**Paramétrage de l'application**

Nom du paramétrage : **Defaut**  
 Application ou module à paramétrer : **DianeRea**

Recherche d'un paramètre  
 Texte à rechercher :   
 Champ(s) à considérer pour la recherche : **Tous**   
 Vers le bas  Vers le haut  Différencier Min/Maj  Mot entier

Description du paramètre	Valeur du paramètre
<b>Onglet navigation</b>	
<b>Feuille d'ouverture et fiche inter patient</b>	
<b>Plan de soin</b>	
<b>Transmissions ciblées</b>	
<b>Documents intégrés</b>	
<b>CCAM/CIM10</b>	
<b>Fiche de sortie/fermeture de dossier</b>	
<b>Actions importantes</b>	
<b>Configuration du portail de réanimation</b>	
<b>Configuration des paramètres des fréquences cardiaques</b>	
<b>Configuration des icônes d'isolement</b>	
<b>Configuration de la liste des tâches</b>	
Filtre temporel	Horaire glissant
Heure de début (Horaire fixe, -1=heure par défaut)	-1
Heure de fin (Horaire fixe, -1=heure par défaut)	-1
Nombre d'heures futures à inclure (Horaire glissant)	12
Nombre de minutes passées à inclure (Horaire glissant)	5
Etat des soins à inclure	Tous les soins
Type de soins à inclure (elements de soin  planification infirmière  Plan de soin)	"1  1  1"
<b>[EXTERNAL_NOTIFIER]</b>	

Clé actuelle : [TODOLIST]  
 343 Ligne(s) chargée(s) en 00 min 00 sec 024 ms.

Propriétés du paramètre : Configuration de la liste des tâches  
 Type de saisie : Section  
 Choix possibles :  
 Masque de saisie :  
 Nombre de caractères maximum : 0  
 Lecture seule

#### 4.1.2.7.1 Time filter (TodoFilterType)

Filtre temporel	Horaire glissant
Heure de début (Horaire fixe, -1=heure par défaut)	-1
Heure de fin (Horaire fixe, -1=heure par défaut)	-1
TodoFilterType (Filtre temporel)	

This setting determines the default time interval:

- **Sliding time** shows care for the next X hours
- **Fixed time** shows care during a set period of time

#### 4.1.2.7.2 Start time (TodoFilterHDebut)

Heure de début (Horaire fixe, -1=heure par défaut)	-1
TodoFilterHDebut (Heure de début (Horaire fixe, -1=heure par défaut))	1
Nombre de minutes passées à inclure (Horaire glissant)	2

This setting determines the start time if the time interval is fixed.

#### 4.1.2.7.3 End time (TodoFilterHFin)

Heure de fin (Horaire fixe, -1=heure par défaut)	-1
TodoFilterHFin (Heure de fin (Horaire fixe, -1=heure par défaut))	12
Nombre de minutes passées à inclure (Horaire glissant)	5

This setting determines the end time if the time interval is fixed.

#### 4.1.2.7.4 Number of future hours (TodoFilterNbHeures)

Nombre d'heures futures à inclure (Horaire glissant)	12
TodoFilterNbHeures (Nombre d'heures futures à inclure (Horaire glissant))	

This setting determines the duration of the time interval to be shown in sliding time.

#### 4.1.2.7.5 Number of past minutes to include (TodoFilterNbMinPast)

Nombre de minutes passées à inclure (Horaire glissant)	5
TodoFilterNbMinPast (Nombre de minutes passées à inclure (Horaire glissant))	

This setting determines the past duration if the time interval is sliding.

#### 4.1.2.7.6 Care status to include (TodoFilterEtatSoin)

Etat des soins à inclure	Tous les soins
TodoFilterEtatSoin (Etat des soins à inclure)	

This setting is used to select the **Care status** filter used:

- 0=All care
- 1=Overdue care only
- 2=Urgent care only

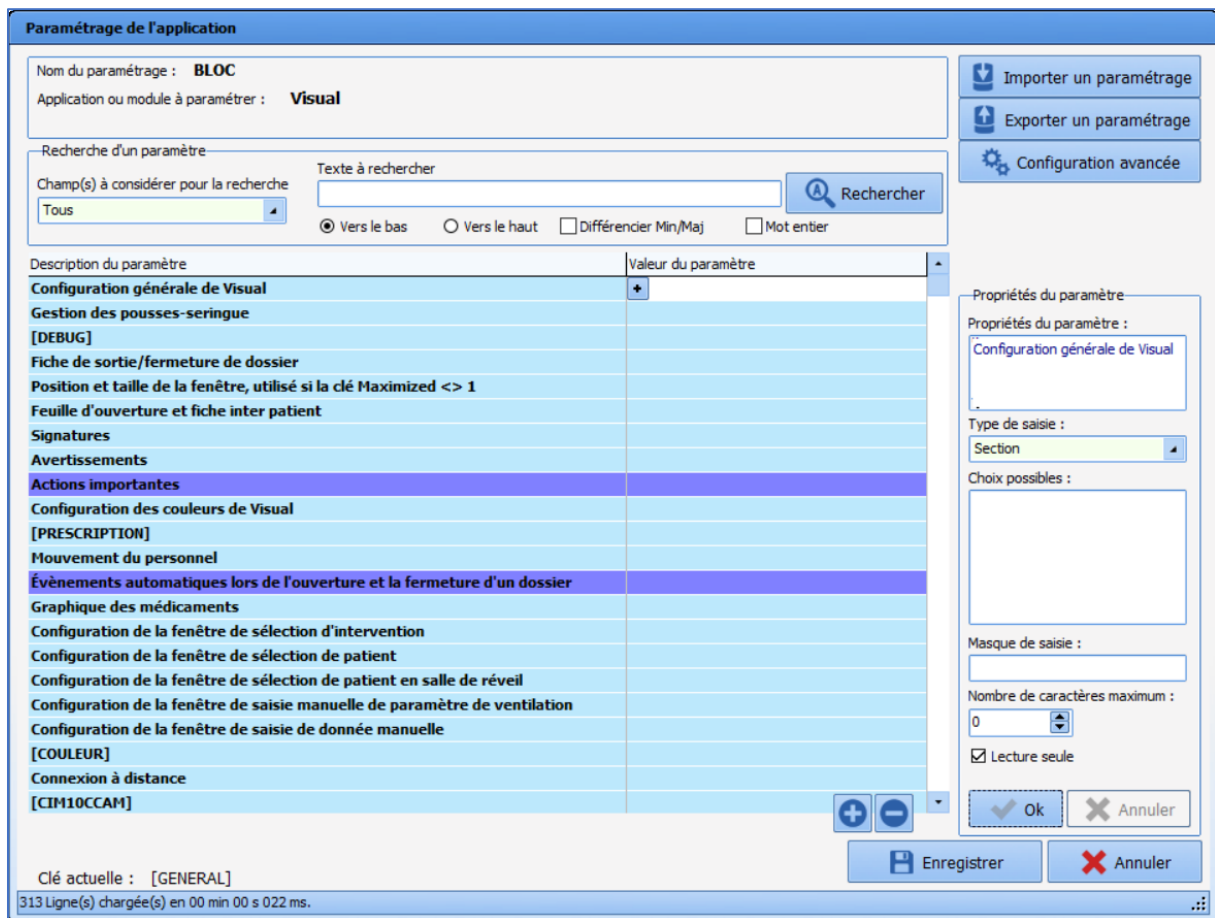
#### 4.1.2.7.7 Care type to include (TodoFilterTypeSoin)

Type de soins à inclure (elements de soin  planification infirmière  Plan de soin)	"1 1 1 1"
TodoFilterTypeSoin (Type de soins à inclure (elements de soin	

This setting is used to select the **Care type** filter used with the following order “Care items(=Devices/dressings) | Nurse schedule | Care plan(=Medication orders)” and **1** to select the care type and **0** to not select it.



## 4.1.3 Visual



### 4.1.3.1 Visual general configuration

#### 4.1.3.1.1 Request confirmation of workstation location on post-op start-up (ConfigurePoste)

Demander la confirmation de l'emplacement du poste au démarrage du per et/o	1
D ConfigurePoste (Demander la confirmation de l'emplacement du poste au démarrage du per et/ou postopérateur)	
Délai en minutes à attendre avant la déconnexion de l'utilisateur en cours	110

This setting requests confirmation that the computer is in the right location: this is important in particular for emergency stations. This location request is sent if the Visual shortcut is used to open the software (shortcut used to access the app directly without going via the **DIANE** portal).

#### 4.1.3.1.2 Time in minutes before the intra/post-operative application is closed automatically (AutoCloseTime)

Délai en minutes à attendre avant la fermeture automatique de l'application per	120
AutoCloseTime (Délai en minutes à attendre avant la fermeture automatique de l'application per et/ou postopérateur)	

This setting is used to define the time (in minutes) before the application is closed automatically. This is relevant for operating theatres, but be aware that some rooms need a longer time of inactivity.

#### 4.1.3.1.3 Time in minutes before the current user is logged out (AutoDelogTime)

Délai en minutes à attendre avant la déconnexion de l'utilisateur en cours	110
Er AutoDelogTime (Délai en minutes à attendre avant la déconnexion de l'utilisateur en cours)	
Empêcher la modification des données provenant du SIH	

This setting is used to define the time (in minutes) before the current user is logged out. This is relevant for recovery rooms, to encourage users to log in correctly.

#### 4.1.3.1.4 Prevent creation of patients not found in HIS (CannotCreateDIAPat)

Empêcher la création de patients non rattachés au SIH	Création autorisée
Er CannotCreateDIAPat (Empêcher la création de patients non rattachés au SIH) ation autorisée si IPP non renseigné	
Case "Imprimer le dossier" cochée par défaut en sortie de salle	

This setting is used to allow (with or without confirmation) or block the creation of patients who are not found in the HIS. For rooms with emergency admissions, blocking their creation is not recommended.

Création autorisée
Création bloquée
Confirmation demandée

#### 4.1.3.1.5 Prevent editing of HIS data (CannotModifySIHData)

Empêcher la modification des données provenant du SIH	Modification autorisée si IPP non renseigné
Er CannotModifySIHData (Empêcher la modification des données provenant du SIH) on (Dossier en écriture et clôture)	
Type de document généré (admission, export, automatique à la copie) Document Diareport	

This setting is used to authorise or disable the editing of HIS data. If editing is disabled, any changes will be “deleted” when the record is reopened and the HIS data will be recovered.

Modification toujours autorisée
Modification autorisée si IPP non renseigné
Modification toujours bloquée

#### 4.1.3.1.6 “Print record” box selected by default on departure from room (AutoPrintOnExit)

Case "Imprimer le dossier" cochée par défaut en sortie de salle	En réanimation (Dossier en écriture et clôture)
Er AutoPrintOnExit (Case "Imprimer le dossier" cochée par défaut en sortie de salle) aReport	
Type de document généré (admission, export, automatique à la copie) Document Diareport	

This setting automatically selects the **Print record** option when leaving the room.

#### 4.1.3.1.7 Maximum duration in hours of a procedure (IntervTimeLimit)

Durée maximum en heures d'une intervention	24
Er IntervTimeLimit (Durée maximum en heures d'une intervention)	24

This setting determines the maximum duration of a procedure: the duration is traditionally less than 24 hours, but this must be changed for delivery rooms.

#### 4.1.3.1.8 Maximum duration in hours of a procedure resumption (RepriseTimeLimit)

Délai maximum en heures d'une reprise d'intervention	24
Er RepriseTimeLimit (Délai maximum en heures d'une reprise d'intervention)	
Compatibilité écran tactile / Saisie bouton droit / Saisie bouton gauche / Saisie b	

This setting determines the duration for which it is possible to resume a completed procedure.

The countdown starts when the record is closed.

Caution: this key and the preceding one may be incompatible. For example, a record is closed after 12 hours of presence (OT + RR). If it is resumed 13 hours after closure (i.e. 25 hours after the start of the procedure), it cannot take place because the procedure duration for the record will have exceeded the 24 hours set by the **Maximum duration in hours of a procedure** key.

In this case, creating a new record is strongly recommended.

#### 4.1.3.1.9 Select extended search by default in drug search window (SearchDrogueEtendue)

Cocher la recherche étendue par défaut dans la fenêtre de recherche de drogue	0
SearchDrogueEtendue (Cocher la recherche étendue par défaut dans la fenêtre de recherche de drogues)	

This setting is usually 0.

### 4.1.3.2 Record closure/departure sheet

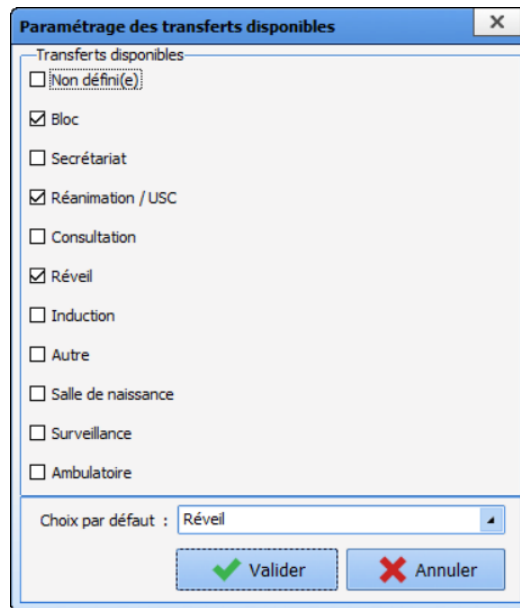
#### 4.1.3.2.1 Selection available transfer rooms (ConfigurePoste)

Choix de transfert de salle disponibles	*1  3  5,5†	...
Def TransferChoices (Choix de transfert de salle disponibles)	1	

This setting is used to select the room types proposed for transfer when a record is closed (to be correlated with the scope of **DIANE**):

<input type="radio"/> Cloturer le dossier
<input checked="" type="radio"/> Transférer :
<input type="text" value="Réveil"/>
Bloc
Réanimation / USC
Réveil

Click  to show the following settings window:



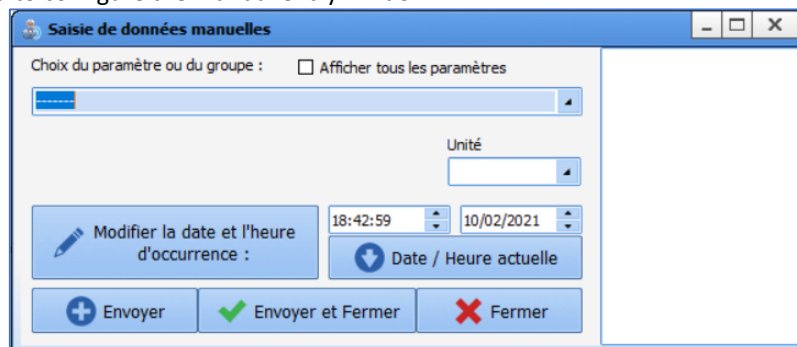
#### 4.1.3.3 Signatures

Signatures	
Activer la demande de signature de sortie de salle de réveil	1
Activer la demande de signature de medecin senior (prescription de Réa unique)	0
Activer la demande de signature du médecin responsable de l'anesthésie	1
Activer la demande de signature des prescriptions postopératoires (0=Jamais, 1=En bloc)	En bloc
Utiliser la liste des anesthésistes prévus pour afficher les utilisateurs pouvant si	1
Utiliser la liste des anesthésistes prévus pour afficher les utilisateurs pouvant si	1
Obliger la saisie du mot de passe du vérifiant de la FIP en Bloc (1=oui, 0=non)	1
Obliger la saisie du mot de passe du vérifiant de la FIP en Salle de réveil (1=oui, 0=non)	1
Affiche le composant de signature senior des prescriptions de réanimation, 0 pa	0
Supprimer l'autorisation de sortie de réveil lors de la modification des prescriptio	0

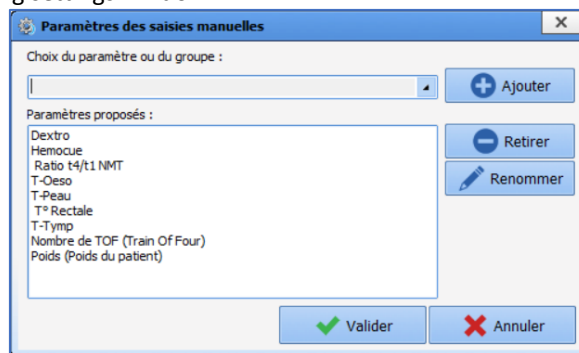
#### 4.1.3.4 Configuring the manual entry window

Configuration de la fenêtre de saisie de donnée manuelle	
Liste des paramètres à afficher	four)##15  450=Poids (Poids du patient)##37
ParamList (Liste des paramètres à afficher)	1

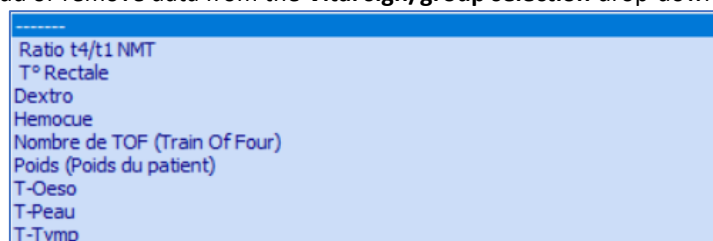
This setting is used to configure the manual entry window:



Click  to show the following settings window:



It is then possible to add or remove data from the **Vital sign/group selection** drop-down menu:



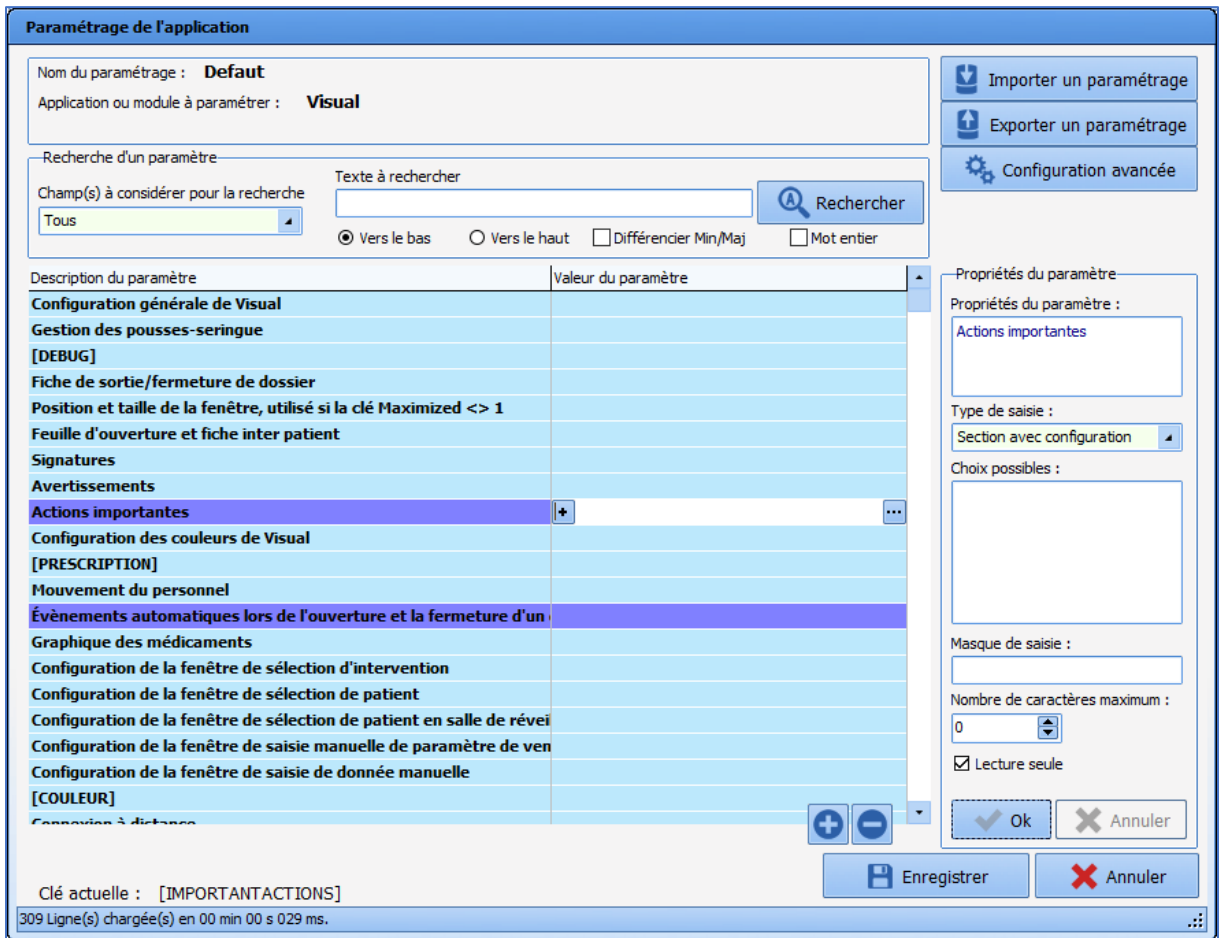
If the **Show all vital signs** box is selected, this selection is no longer taken into account and all vital signs are shown.

## 4.2 Configuring important actions

Managing mandatory and important items is essential for ensuring the right balance between the legal obligations of some items and ease of use of the program.

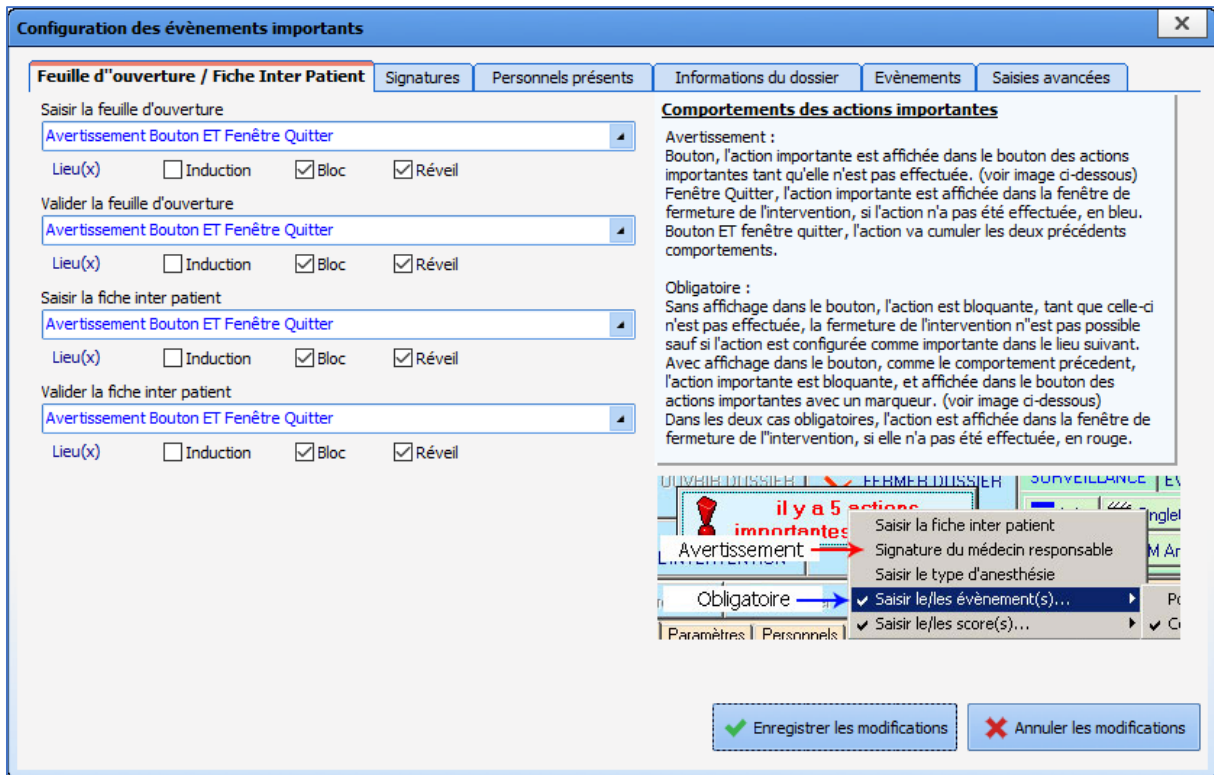
To define **mandatory and important items** in **DIANE ICU**, open the configuration and select **Settings / Visual**. The same set-up is possible for DIANE ICU (Settings/DianeICU).

This settings window opens:



Select the first purple row (**Important actions**) and click  to the right of the row.

The **Configuration of important events** window opens:

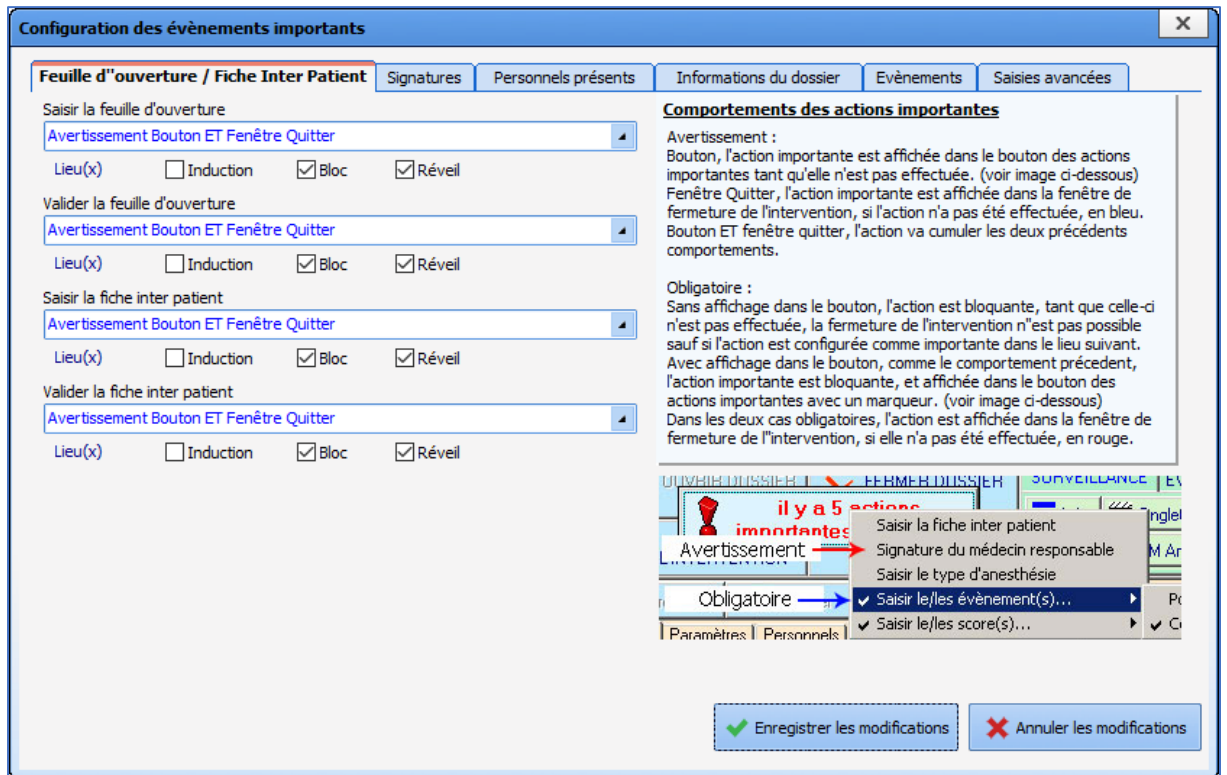


For each item, six possible levels of importance are available (only one choice can be selected):

<b>Disabled</b>	The item is not important or mandatory: no impact on record closure.
<b>Button warning</b>	The important item appears in the flashing red button in the top ribbon of the section but is not mandatory.
<b>Exit window warning</b>	Reference to the importance of the item is included in the patient exit window, but item is not mandatory.
<b>Button warning and Exit window warning</b>	Both of the previous levels are applied together; item is not mandatory.
<b>Mandatory without display in the button</b>	The item must be entered. Not shown in the flashing red button in the top ribbon of the section. The only reference to the mandatory item is in the patient departure window.
<b>Mandatory with display in the button</b>	The item must be entered. The mandatory item is shown in the flashing red button and in the patient departure window.

#### 4.2.1 Room safety checklist/Inter-patient checklist

This tab concerns room safety checklists and inter-patient checklists.



There are four items to configure:

<b>Room safety checklist entry</b>	Signature of the person who checked the room and its equipment on entering the room
<b>Room safety checklist validation</b>	Signature of the doctor who takes responsibility
<b>Inter-patient checklist entry</b>	Signature of the person who checked the room and its equipment between two patients
<b>Inter-patient checklist validation</b>	Signature of the doctor who takes responsibility

For each item, the level of importance must be selected (only one choice can be selected): **Disabled**, **Button warning**, **Exit window warning**, **Button warning and Exit window warning**, **Mandatory without display in the button** or **Mandatory with display in the button**.

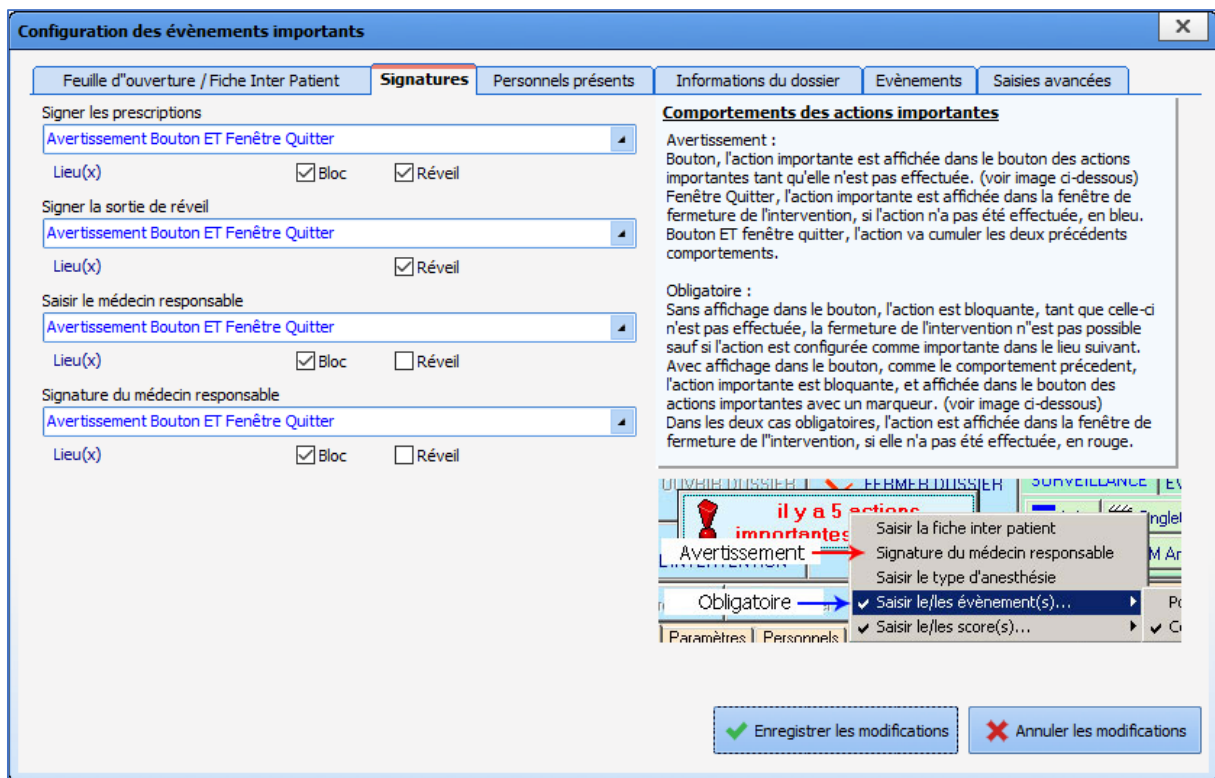
Finally, it is possible to select the place(s) - room type(s) - in which these settings will be applied:

<b>Induction</b>
<b>OT</b>
<b>Recovery</b>

## 4.2.2 Signatures

This tab is used to set up medicolegal obligations.





Four items can be configured:

Sign the medication orders <b>Sign RR release</b>	Suggest or require signing of medication orders
<b>Enter doctor in charge</b>	Suggest or require that an anaesthetist enters a signature before a patient can leave recovery
<b>Signature of doctor in charge</b>	Suggest or require that an anaesthetist be defined during the operation <b>See: Anaesthesia responsibility</b>
	Suggest or require the signature of the doctor in charge

For each item, the level of importance must be selected (only one choice can be selected): **Disabled, Button warning, Exit window warning, Button warning and Exit window warning, Mandatory without display in the button** or **Mandatory with display in the button**.

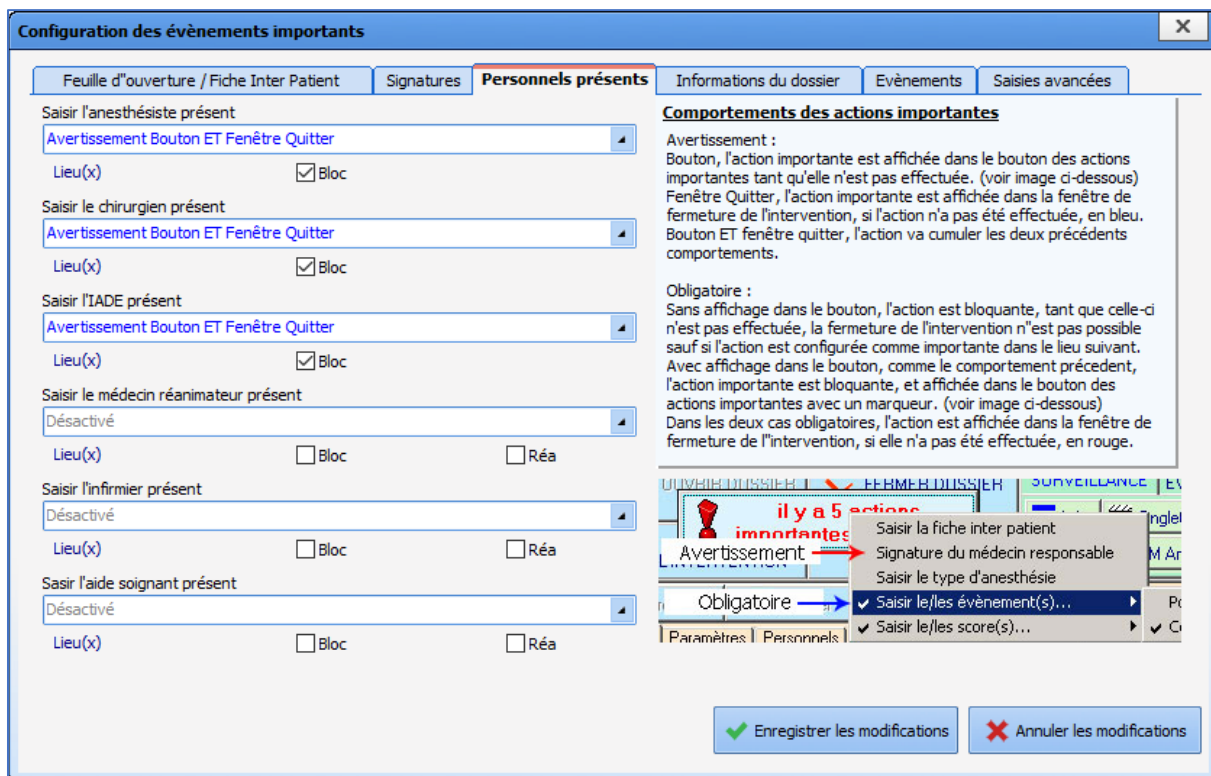
Finally, it is possible to select the place(s) - room type(s) - in which these settings will be applied:

**OT**

**Recovery**

### 4.2.3 Staff members present

This tab is used to set up the staff members to be included in a patient record.



Six items can be configured:

<b><i>Enter anaesthetist present</i></b>	Suggest or require the entry of an anaesthetist present during the procedure
<b><i>Enter surgeon present</i></b>	Suggest or require the entry of a surgeon present during the procedure
<b><i>Enter registered nurse anaesthetist present</i></b>	Suggest or require the entry of a registered nurse anaesthetist present during the procedure
<b><i>Enter intensivist present</i></b>	Suggest or require the entry of an intensivist present during the procedure or resuscitation
<b><i>Enter nurse present</i></b>	Suggest or require the entry of a nurse present during the procedure or resuscitation
<b><i>Enter nurse's aide present</i></b>	Suggest or require the entry of a nurse's aide present during the procedure or resuscitation

This can be used if this information was not entered in advance during a consultation, or in emergency cases.

For each item, the level of importance must be selected (only one choice can be selected): **Disabled**, **Button warning**, **Exit window warning**, **Button warning and Exit window warning**, **Mandatory without display in the button** or **Mandatory with display in the button**.

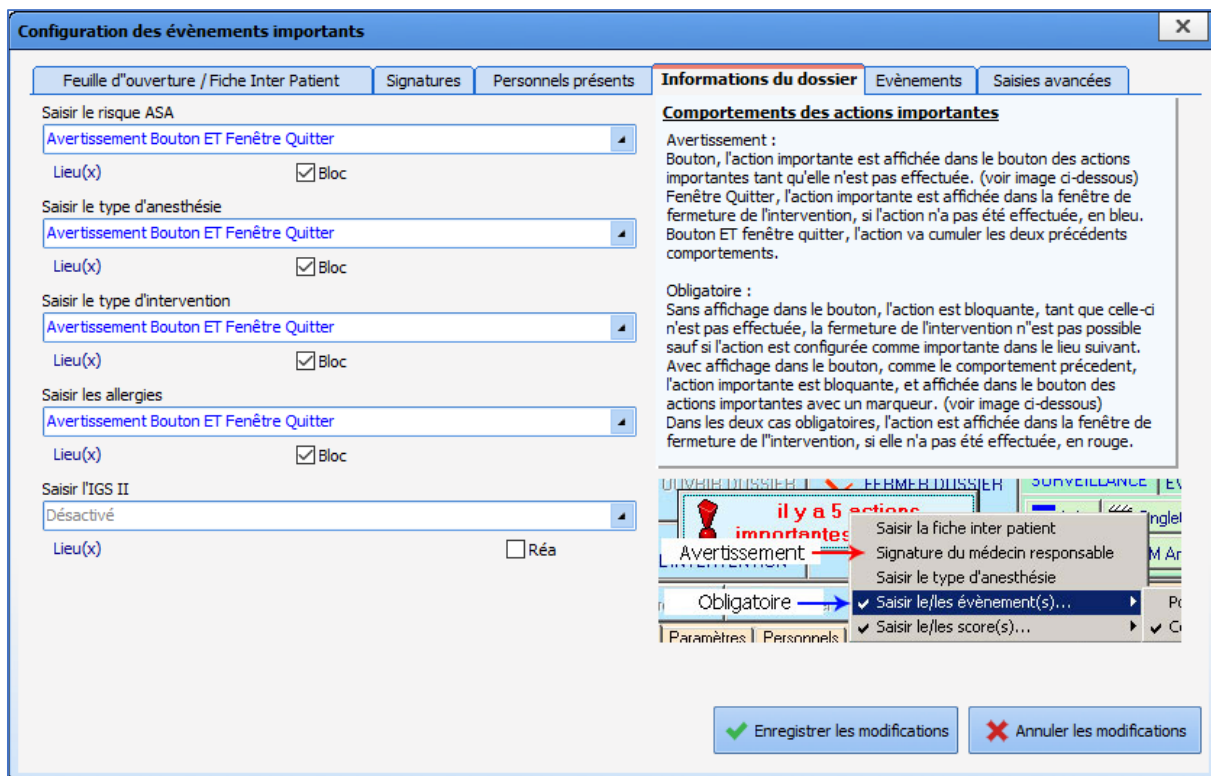
Finally, it is possible to select the place(s) - room type(s) - in which these settings will be applied:

**OT**

**ICU (resuscitation area or CCU)**

## 4.2.4 Record information

This tab is used to enter information missing from the record.



Five items can be configured:

<b>Enter ASA score</b>	Suggest or require inclusion of an ASA score (ASA can be entered in consultation)
<b>Enter anaesthesia type</b>	Suggest or require inclusion of the anaesthesia type (anaesthesia type can be suggested in consultation)
<b>Enter procedure type</b>	Suggest or require inclusion of the procedure type (procedure type comes from the consultation)
<b>Enter allergies</b>	Suggest or require that allergies must be included at least (include 'no allergies' so users are not inconvenienced)
<b>Enter SAPS II score</b>	Suggest or require inclusion of the SAPS II score

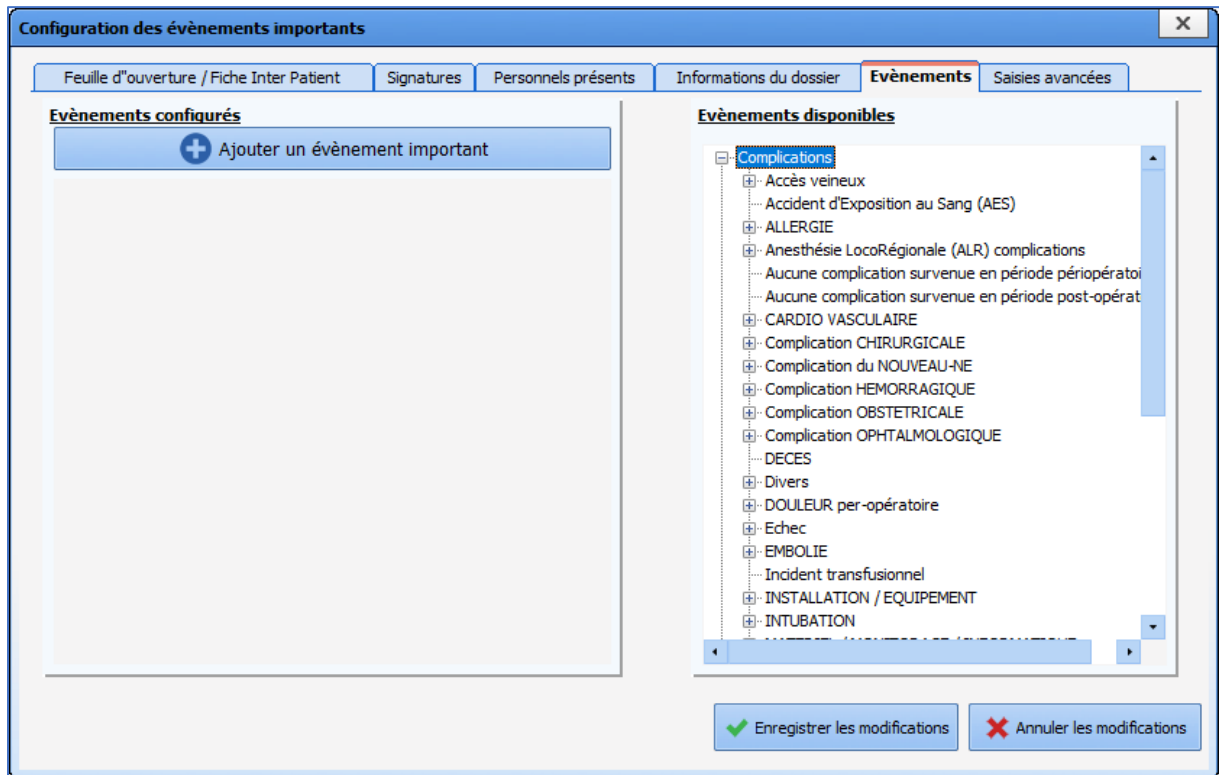
For each item, the level of importance must be selected (only one choice can be selected): **Disabled**, **Button warning**, **Exit window warning**, **Button warning and Exit window warning**, **Mandatory without display in the button** or **Mandatory with display in the button**.

Finally, it is possible to select the place(s) - room type(s) - in which these settings will be applied:

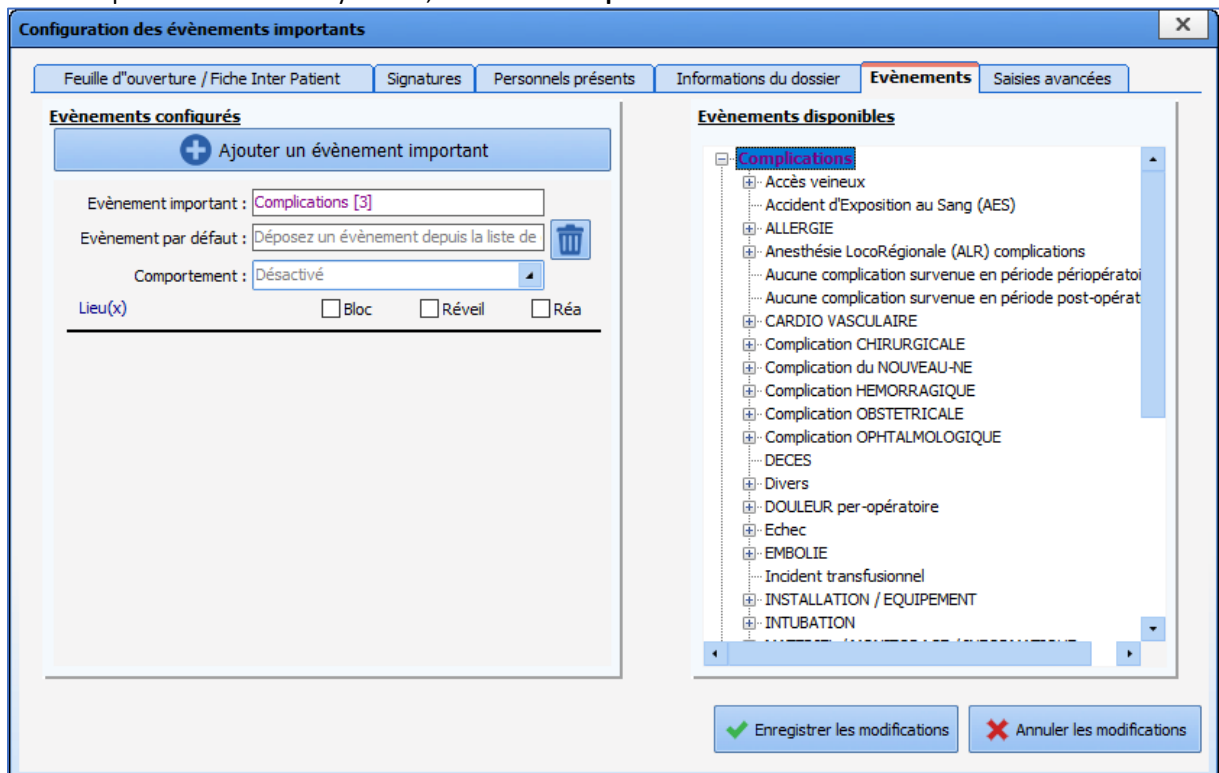
<b>OT</b>	Except for <b>Enter SAPS II score</b>
<b>ICU (resuscitation area or CCU)</b>	Only for <b>Enter SAPS II score</b>

## 4.2.5 Events

This tab is used to configure important or mandatory events.

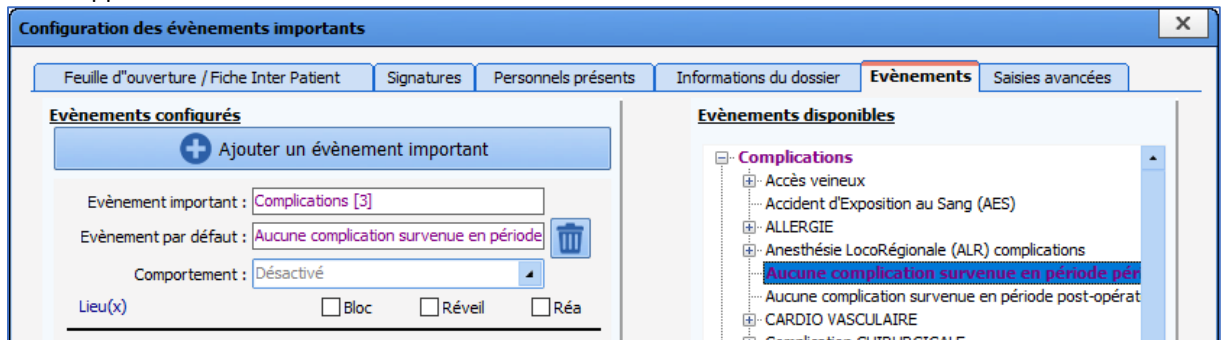


To add important or mandatory events, click **Add an important event**.



In the example above, the **Complications** event category has been drag-and-dropped into the box on the left entitled **Important event** (the number 3 in brackets is an internal reference ensuring there are no duplicates due to use of the same name).

To provide users with quick data entry for complications, one of the underlying complications can be drag-and-dropped.



For each item, the behaviour (level of importance) must be selected: **Disabled, Button warning, Exit window warning, Button warning and Exit window warning, Mandatory without display in the button or Mandatory with display in the button.**

Finally, it is possible to select the place(s) - room type(s) - in which these settings will be applied:

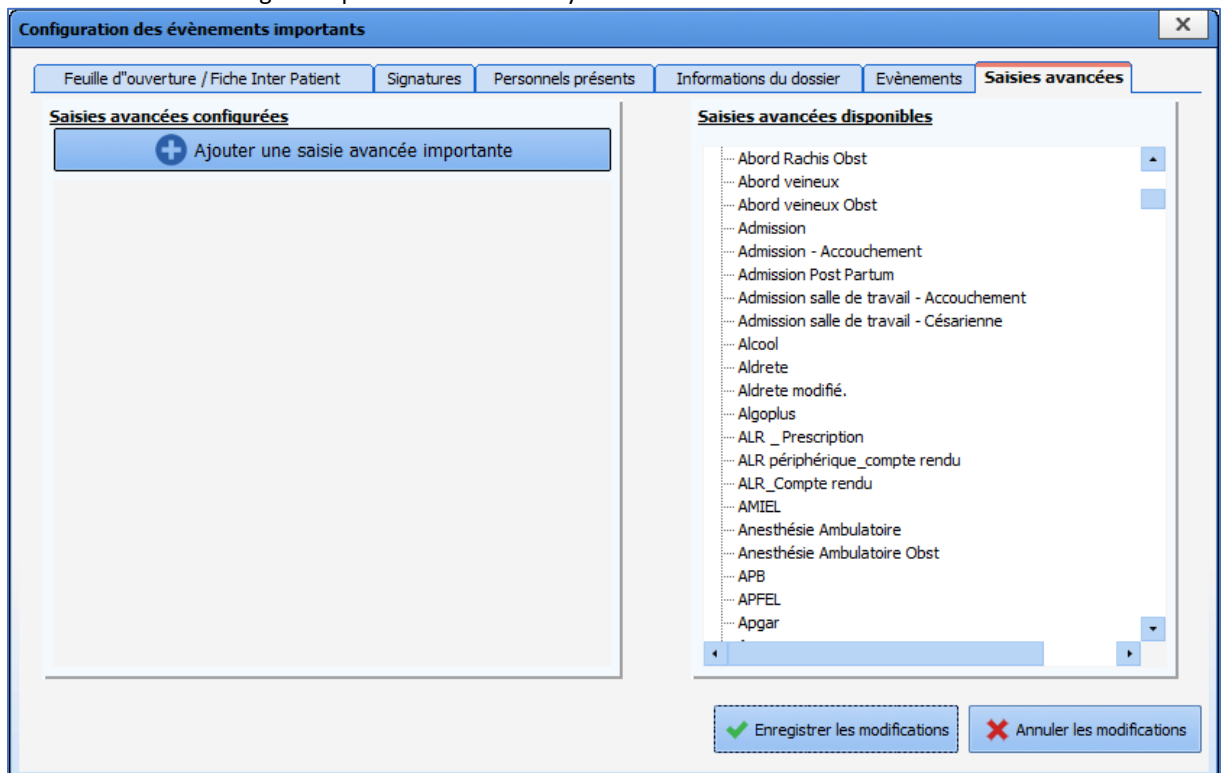
**OT**

**Recovery**

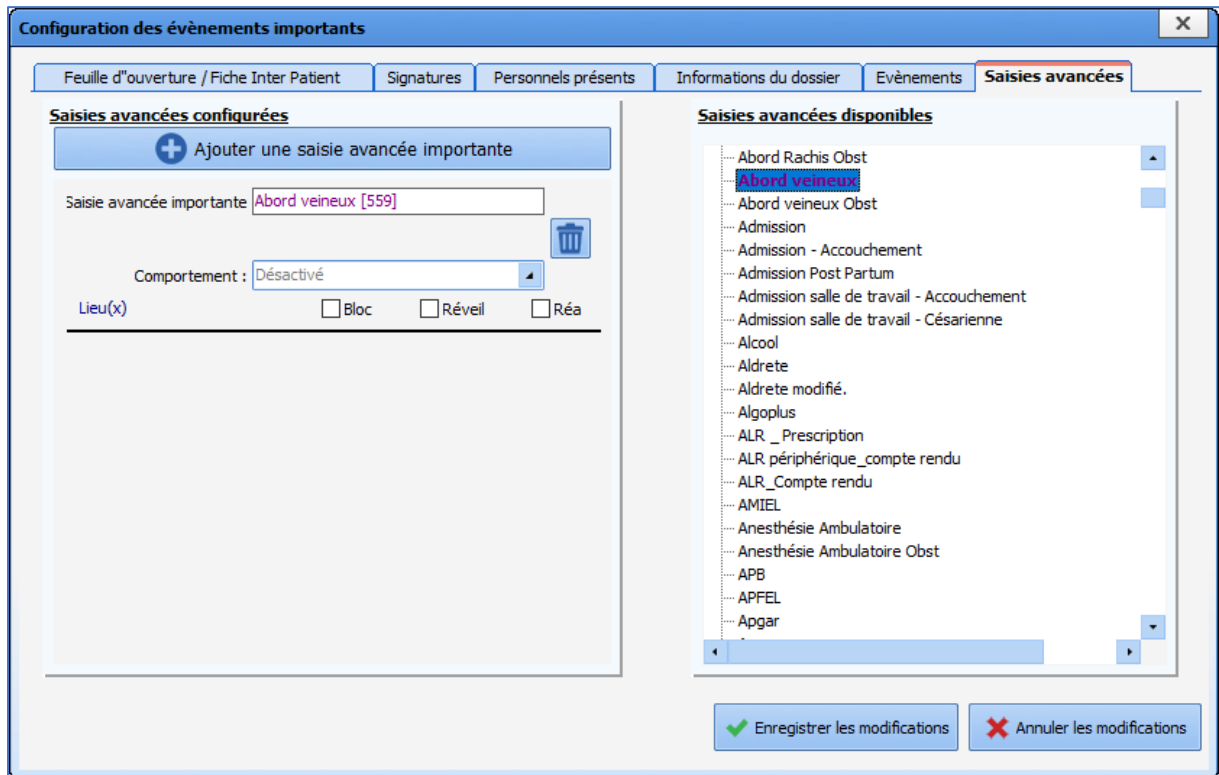
**ICU (resuscitation area or CCU)**

#### 4.2.6 Detailed entries

This tab is used to configure important or mandatory detailed entries.



To add important or mandatory detailed entries, click **Add an important detailed entry.**



In the example above, the **Venous access** detailed entry has been drag-and-dropped into the box on the left entitled **Important detailed entry** (the number 559 in brackets is an internal reference ensuring there are no duplicates due to use of the same name).

For each item, the behaviour (level of importance) must be selected: **Disabled, Button warning, Exit window warning, Button warning and Exit window warning, Mandatory without display in the button** or **Mandatory with display in the button**.

Two other options are available:

<b>When the record is opened</b>	The record cannot be opened unless the detailed entry has been completed.
<b>When the record is opened (postponable)</b>	The user is asked to complete the detailed entry before the record is opened, but the entry can be postponed: the record can be opened but the detailed entry must be completed to close the record.

Finally, it is possible to select the place(s) - room type(s) - in which these settings will be applied:

**OT**

**Recovery**

**ICU (resuscitation area or CCU)**

## 4.2.7 Saving edits

For edits to be taken into account, they must be saved by clicking the **Save changes** button in the **Configuration of important items** window.

## 4.3 Editing the maximum duration of a procedure

Visual general configuration >> Maximum procedure duration in hours -> *Enter required duration.*

The screenshot shows the 'Configuration - ETABLISSEMENT - Service de Réanimation' application. The 'Paramétrage de l'application' dialog is open, displaying the 'Configuration générale de Visual' section. The 'Durée maximum en heures d'une intervention' parameter is highlighted with a blue selection bar and a red circle labeled '3'. A red circle labeled '2' points to the 'Paramétrages' menu item in the right-hand sidebar. A red circle labeled '1' points to the 'Visual' tab in the top navigation bar. The interface includes a search bar, a list of parameters, and various configuration options.

Description du paramètre	Valeur du paramètre
<b>Configuration générale de Visual</b>	
Numéro de version (Chiffres uniquement)	4.7.5
Numéro d'archive (Chiffres uniquement)	20665
Demander la confirmation de l'emplacement du poste au démarrage du per et/o	
Délai en minutes à attendre avant la fermeture automatique de l'application per	120
Délai en minutes à attendre avant la disconnection de l'utilisateur en cours	110
Empêcher la création de patients non rattachés au SIH	Création autorisée
Empêcher la modification des données provenant du SIH	Modification autorisée si IPP non renseigné
Case "Imprimer le dossier" cochée par défaut en sortie de salle	En réanimation (Dossier en écriture et clôture)
Type de document généré (Impression ou export automatique à la clôture)	Document DialReport
Sauvegarde automatique du dossier sur le changement d'onglet (1=oui, 0=non)	1
Cocher par défaut la demande de conservation de fichier à l'édition des prescrip	1
<b>Durée maximum en heures d'une intervention</b>	<b>24</b>
Délai maximum en heures d'une reprise d'intervention	24
Cocher la recherche étendue par défaut dans la fenêtre de recherche de diag	1
Compatibilité écran tactile (1=Saisie bouton droit, 2=Saisie bouton gauche, 3=Saisie boutons droit et gauche)	0
Intervalle du dignotement des perfusions en cours en ms (0=pas de dignotem	0
Activer la récupération des interventions provenant du module de rendez-vous	0
Activer les chronomètres multiples (permet de démarrer un même chronomètre	1
Activer le lancement de la recherche F9 automatiquement	1
Activer la réinitialisation des paramètres de l'application	1

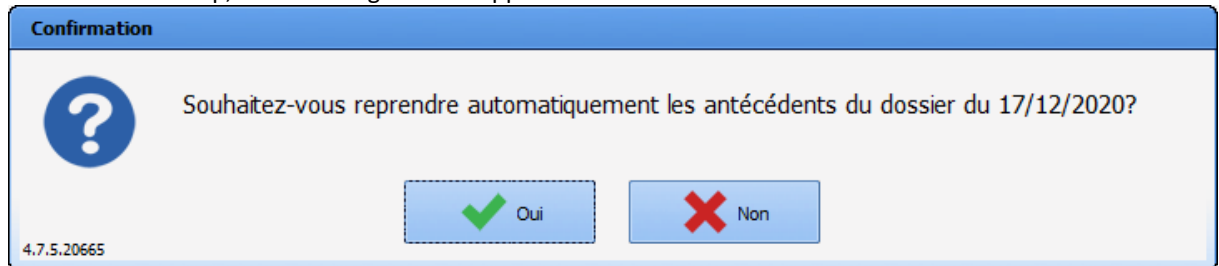
## 4.4 Configuration of the retrieval mechanism (Consultation)

Consultation information retrieval can occur in different ways depending on the configuration in place. It can be manual, automatic or separate in three levels. This flexibility ensures the best possible result.

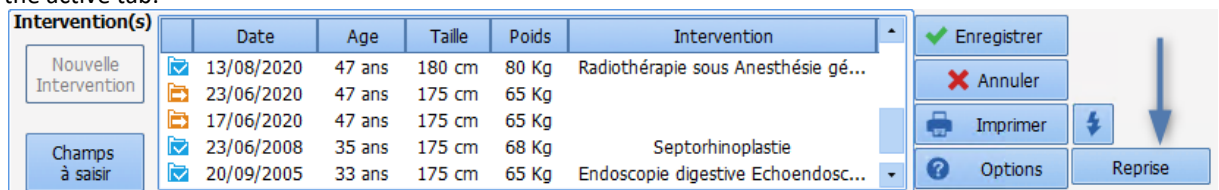
### 4.4.1 Retrieval level and manual retrieval

- **In use:**

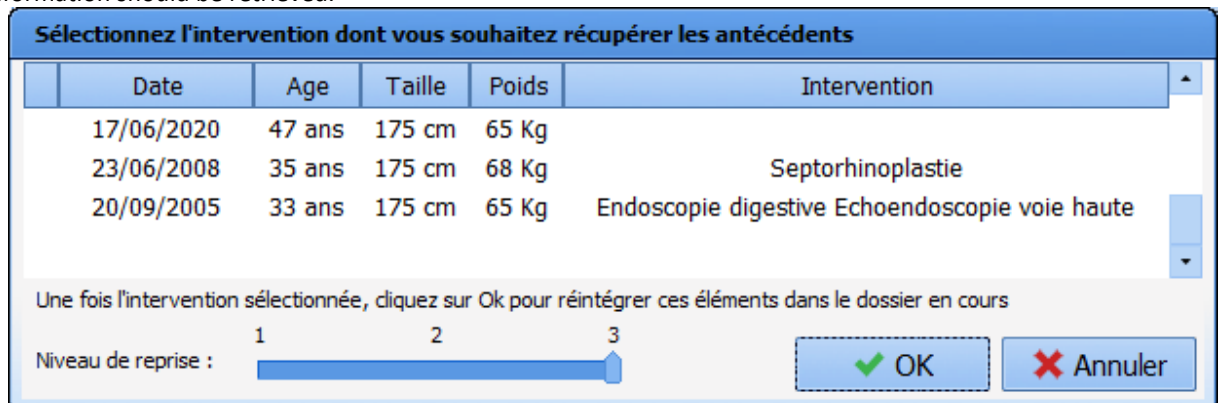
If this option has been set up, the following window appears:



It is possible to retrieve information from old records using the **Retrieve** button. This button is used to recover items in the active tab.



When the **Retrieve** button is clicked, a selection window opens for specifying the consultation/procedure from which information should be retrieved.



Once the retrieval level has been validated (as 1, 2 or 3), the current tab changes and check boxes are added to most components on the page.

In the example below, if the box shown with the arrow is not selected, this means that all boxes for the Surgical history component are not selected: all check boxes for the component are automatically unselected and none of the items listed will be retrieved. If, for example, only the box for **Septorhinoplasty** is not selected, only this item will not be retrieved.



<input checked="" type="checkbox"/>	<b>← Antécédents chirurgicaux</b>	<b>4</b> <input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Septorhinoplastie	23/06/2008
<input checked="" type="checkbox"/>	Radiothérapie sous Anesthésie générale (AG) cranio-encéphalique	13/08/2020
<input checked="" type="checkbox"/>	Dilatation coronarienne avec pose de stent	17/12/2020
<input checked="" type="checkbox"/>	Endoscopie digestive Echoendoscopie voie haute	20/09/2005

○ **In configuration:**

In the **View** tab, the level of sensitivity for the retrieval of the various consultation fields can be set up.

Description du paramètre	Valeur du paramètre
<b>Positionnement / Affichage</b>	
Visible	Oui
Onglet parent	ATCD / Traitements
Position horizontale en pixel	0
Position verticale en pixel	5
Largeur en pixel	405
Hauteur en pixel	195
Ordre de tabulation	0
Nom du composant parent (Conteneur déployable)	
Nombre de colonnes	3
Titre des colonnes visibles	Non
<b>Intitulé</b>	
Intitulé	Antécédents chirurgicaux
Taille de la police de l'intitulé	10
Intitulé en gras	Oui
<b>Options d'affichage du contenu</b>	
Couleur de la police de l'intitulé	8388608
Couleur quand une valeur est saisie	16777215
Couleur quand le composant est vide	16644596
Couleur de fond du composant	16777215
Taille de la police	10
Texte au survol de l'aide	
<b>Options des données associées</b>	
Accès en écriture du champ	Ecriture
Niveau d'importance du champ	Elément normal
Historique activé	Oui
Valeur de saisie "RAS"	</1:77030>
Niveau de la reprise	Niveau 1(ex. Antécédents)
Type de données	Jamais repris
<b>Options de recherche</b>	
Recherche automatique à la frappe	Niveau 1(ex. Antécédents)
	Niveau 2(ex. Taille)
	Niveau 3(ex. Poids)
Nombre de caractères avant recherche automatique	4
Etendre la recherche au catalogue CIM10	Désactivée
Premiers caractères à considérer lors de la recherche dans	
<b>Options de la saisie avec liste de référence</b>	
Type de la première colonne	Tricolore
Largeur de la première colonne	15
Liste générale de la première colonne	Consultation
Root de référence de la première colonne	

**Level 0 represents data that is never retrieved.** Example: premedication.

**Level 1 represents data that is stable over time.** Example: history.

**Level 2 represents data that varies little over time.** Examples: height, general practitioner.

**Level 3 represents data that changes the most.** Examples: weight, usual treatment and conversions.

## 4.4.2 Setting up the Retrieval mechanism

In the **Settings** tab, three keys control how retrieval works in consultation.

**“Authorise retrieval of the entire consultation”**

**“Ask to run automatic retrieval when a new operation is created”**

**“Retrieval level from which items are retrieved in the consultation”**

Description du paramètre	Valeur du paramètre
<b>Configuration générale</b>	
Numéro de version (Chiffres uniquement)	"4.7.5"
Numéro d'archive (Chiffres uniquement)	20665
Titre apparaissant en haut de l'application	Consultation Pré anesthésique Utilisateur connecté
Nom du fichier d'aide	CONSULTATION.HLP
Titre apparaissant dans la barre des tâches ou dans le Splashscreen	Consultation
Demander la confirmation de l'emplacement du poste au démarrage de la consu	1
Délai en minute avant fermeture automatique de la consultation	60
Délai en minute avant déconnexion automatique de l'utilisateur courant	30
Empêcher la création de patients non rattachés au SIH	Création autorisée
Empêcher la modification des données provenant du SIH	Modification toujours possible
Nombre de jours au-delà duquel la modification d'une ancienne consultation déc	800
Afficher et mettre à jour les couleurs d'affichage des patients du module de ren	1
Niveau d'importance à partir duquel la fenêtre des éléments à saisir apparaît au	0
Afficher les boutons des saisies rapides dans la fenêtre des champs à saisir	1
Autoriser la reprise de toute la consultation	0
Demander pour lancer la reprise automatiquement lors de la création d'une nou	Onglet Antécédent seul avec demande de confirmatio
Niveau de reprise à partir duquel les items sont repris dans la consultation	Reprise des items niveau 3 (comme le poids)
Texte décrivant un historique saisi à partir du bloc opératoire	Saisi au bloc
Texte décrivant un historique saisi à partir du réveil	Saisi au réveil
Texte décrivant un historique saisi à partir de la Réa	Saisi en réa

- **“Authorise retrieval of the entire consultation”**: 0 represents **No** and 1 represents **Yes**.
- **“Ask to run automatic retrieval when a new operation is created”**: Allows the user to choose whether or not to retrieve the previous consultation. For the possible values, the following options are available:
  - Inactive
  - History tab only with confirmation request
  - History tab only invisible
  - Entire consultation with confirmation request
  - Entire consultation in silent mode
  - Select record for history
  - Select record for entire retrieval

- **“Retrieval level from which items are retrieved in the consultation”**: Retrieval level from which items are retrieved in the consultation, used to refine how the first two keys mentioned above work. The possible values are 1, 2 or 3.

## 4.5 Configuration of the quick-entry module

The quick-entry module is used to extract consultation records based on queries. These records are then presented in the form of a list which can be used for:

- Direct access
- Adding information without opening the record, using preset fields.

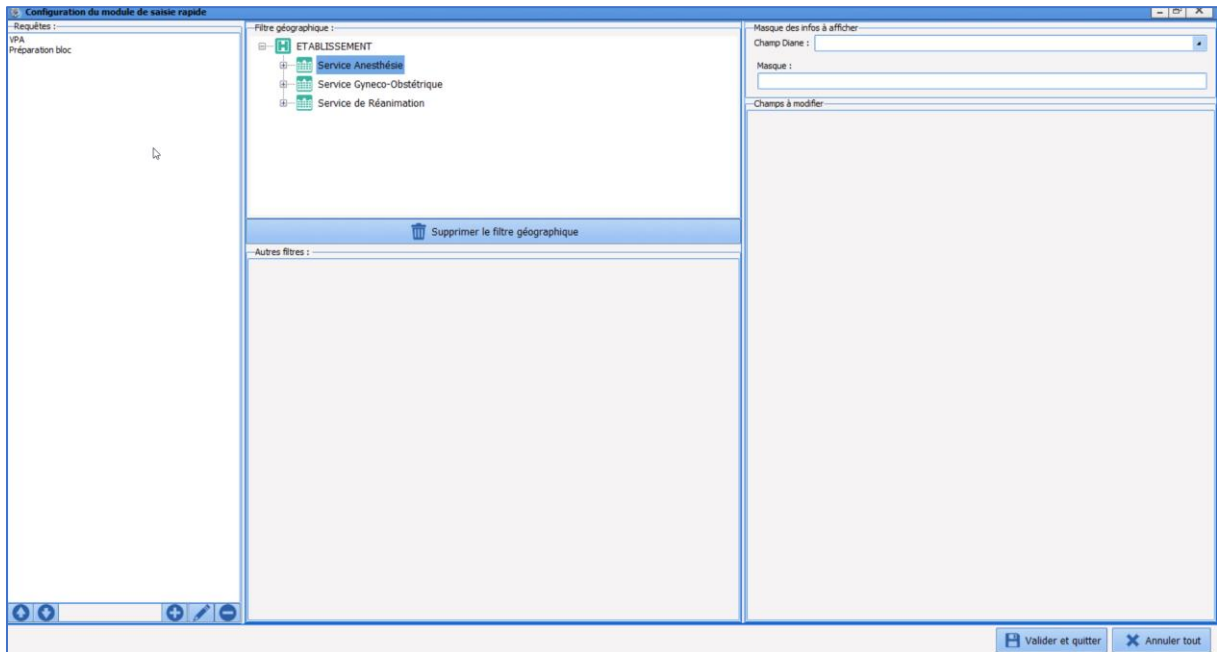
This module can be useful for facilitating the entry of pre-operative visits (POV), accessing records to be staffed and finding incomplete records.

NB: filling in a record without opening does not generate a new edition.

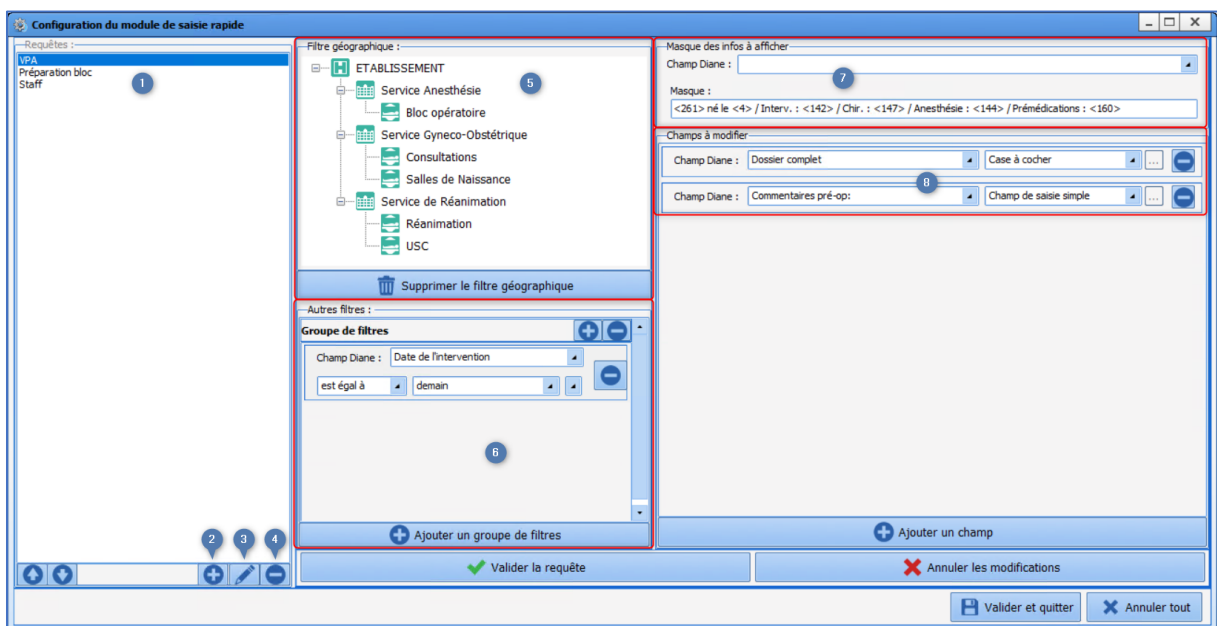
### 4.5.1 Opening the configuration

The configuration can be accessed via the **Settings** tab, by selecting **Diane** from the menu. Click .

The following window appears:



## 4.5.2 Configuration window tabs



1. Query list
2. New query
3. Edit selected query
4. Delete selected query
5. Location filter
6. Record selection criteria
7. Selection of fields to appear on patient selection
  - Select the required information from the patient record in the **Diane field** drop-down menu

- Drag-and-drop to the Mask field (the information appears in the form of a number between angle brackets (*example: <261>*))
  - Write the text in full if required (*example: born on*)
8. Selection of modifiable fields
- Next click on the **Add a field** button at the bottom right
  - Select the Diane field to be edited
  - Select the type of component for the selected field

Once the query has been set up, it must be validated with the **Confirm query** button.

The **Confirm and exit** button confirms the configuration and closes the **Entry module configuration** window. Then click Save in the **Application settings** window.

The screenshot shows the 'Paramétrage de l'application' window. At the top, it displays 'Nom du paramétrage : **Default**' and 'Application ou module à paramétrer : **Diane**'. Below this is a search section with a dropdown for 'Champ(s) à considérer pour la recherche' (set to 'Tous'), a 'Texte à rechercher' input field, and a 'Rechercher' button. There are also radio buttons for search direction and checkboxes for 'Différencier Min/Maj' and 'Mot entier'. A table lists parameters with columns for 'Description du paramètre' and 'Valeur du paramètre'. The table contains two entries: 'Configuration générale' with sub-items '[DEBUG]' and 'Configuration du module de saisie rapide'. To the right, the 'Propriétés du paramètre' panel shows 'Configuration générale' selected, a 'Type de saisie' dropdown set to 'Section', an empty 'Choix possibles' list, a 'Masque de saisie' input, a 'Nombre de caractères maximum' spinner set to '0', and a checked 'Lecture seule' checkbox. At the bottom, there are '+', '-' buttons, an 'Enregistrer' button, and an 'Annuler' button. The status bar at the bottom indicates 'Clé actuelle : [GENERAL]' and '14 Ligne(s) chargée(s) en 00 min 00 s 015 ms.'

### 4.5.3 Filter configuration

It is possible to configure one or more filters and/or filter groups.

To be displayed, records must be checked by at least one of the filters in each filter group.

Autres filtres :

**Groupe de filtres** + -

Champ Diane : Date de l'intervention  
 est égal à  -

Champ Diane : Date de l'intervention  
 est égal à  -

**Groupe de filtres** + -

Champ Diane : Anesthésiste en CS  
 est égal à  -

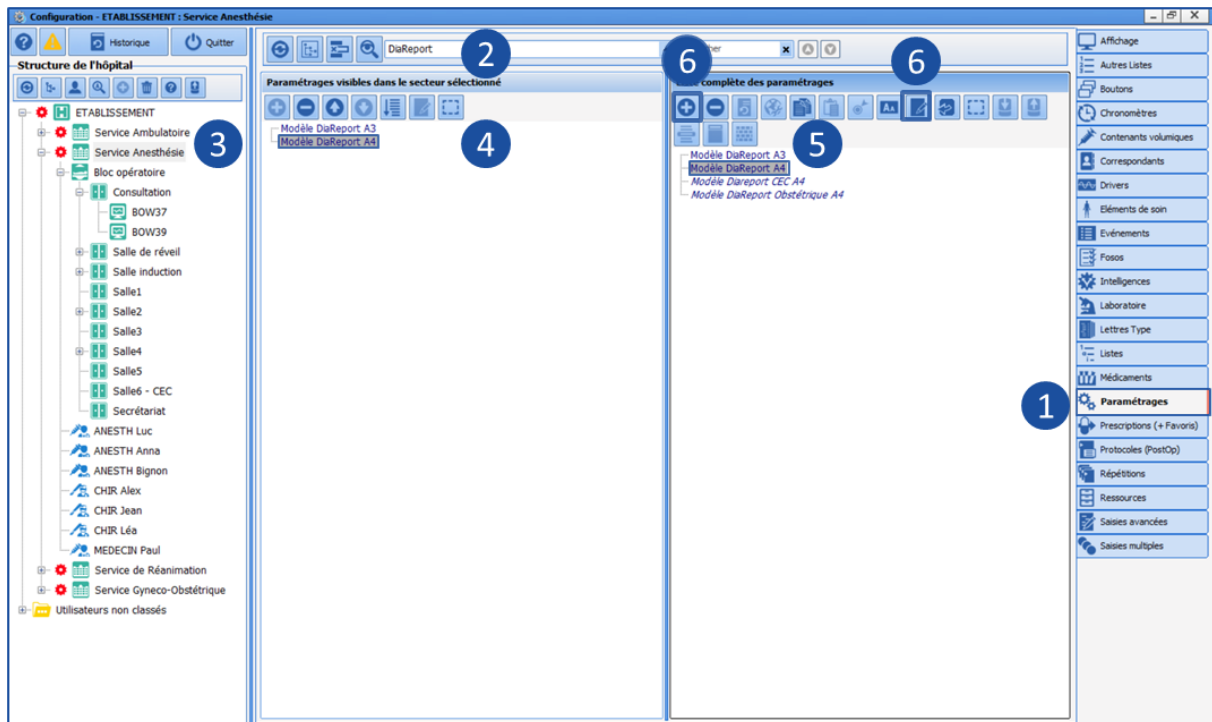
Champ Diane : Anesthésiste(s) prévu(s)  
 est égal à  -

In this example, the records that will be displayed are those with a procedure date of today **OR** tomorrow **AND** with ANAESTH Anna as the consultation anaesthetist **OR** scheduled anaesthetist.

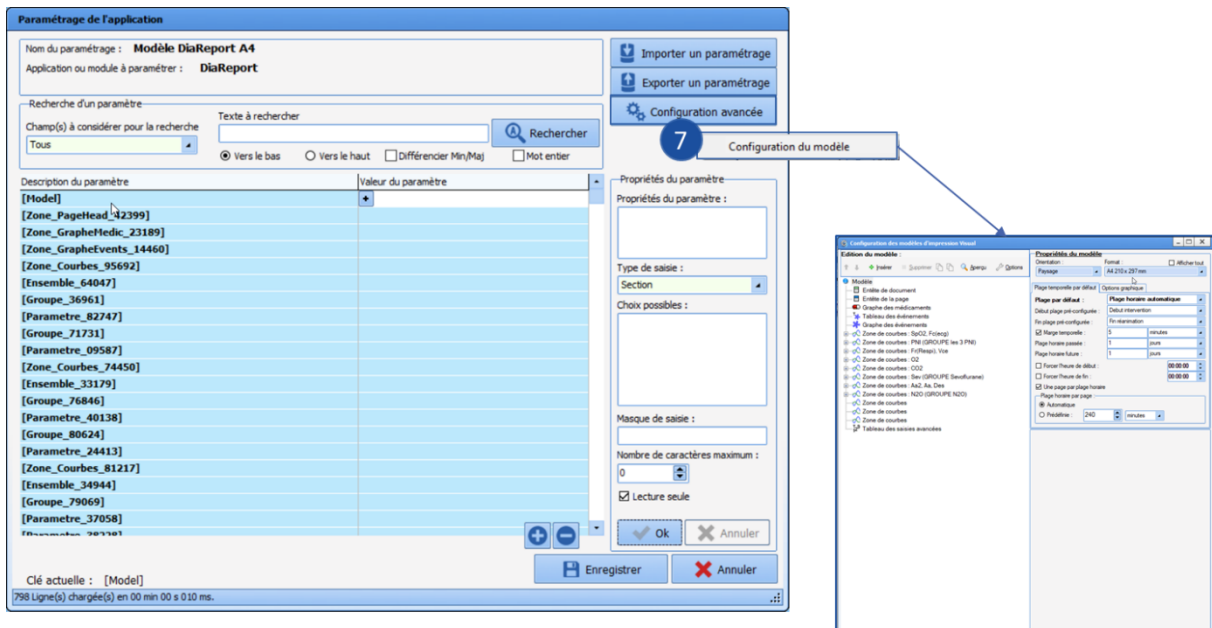
## 4.6 DiaReport settings

DiaReport is used to set up the structure of the anaesthesia record. It is exported automatically when the **DIANE** record is closed. As a reminder, when a patient leaves the **DIANE** circuit, the record must be closed.

Printer selection: the software retrieves the workstation settings. Adding or changing a default printer is done in **Windows**. **DIANE** will show the printers set up for the workstation on a drop-down menu.



1. Settings tab
2. DiaReport section
3. Sector selection (gear)
4. DiaReport applied to sector
5. DiaReport selection to be edited
6. Edit the existing template or create a new template



## 4.7 Locks management

### 4.7.1 Introduction

#### 4.7.1.1 General information

Locks in **DIANE** are used to ensure that the same patient record is not open in write-access mode in two different locations.

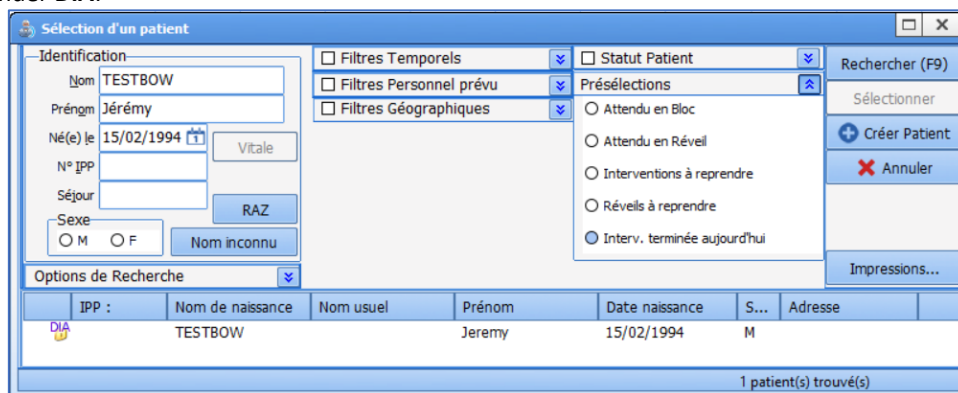
When a patient record is opened in Consultation, Induction, OT, RR or ICU, in write-access mode (not view-only), the workstation on which it has been opened has exclusive write access.

**DIANE** locks means that if a patient record is opened in write-access mode, the whole patient record and its procedures are also opened, so that there are no data conflicts if another user attempts to access the record from another computer.

#### 4.7.1.2 How are locks presented?

##### 4.7.1.2.1 In search windows

If a patient record is locked elsewhere, a lock icon is shown at the start of the row in the **Patient selection** window, under **DIA**:



The same applies for patient procedures in **Patient record selection**:



Selection du dossier du patient : TESTBOW Jeremy - 15/02/1994

Démarrer... Visualiser Dossier Démarrer... Nouvelle Consultation Fiche Inter Patient CCAMCIM10 Feuille Ouverture Annuler

	Bloc	Date Interv	Date Consult	Type Interv Prévue	Chirurgien(s)	Etat dossier
	USC	12/01/2021	12/01/2021			Clôturé
	USC	02/02/2021	02/02/2021			Clôturé
	Réanimation	21/01/2021	21/01/2021			Clôturé
	Consultation d'...	31/12/2020	31/12/2020	test Seclin		Interv. non réalisée
	Consultation d'...	18/06/2020	31/12/2020			Transfert en bloc
	Réanimation	15/04/2019	15/04/2019			Clôturé

6 Dossier(s) trouvé(s)

#### 4.7.1.2.2 In Consultation

In Consultation, if a locked record is opened elsewhere without removing the lock (opened in read-only mode), the following message appears to inform the user:



In the upper part of the window, in the list of patient records, there are several possible icons in the first column:

	Date	Age	Taille	Poids	Intervention
	02/02/2021	26 ans			
	21/01/2021	26 ans	175 cm	70 Kg	
	12/01/2021	26 ans	175 cm	70 Kg	
	31/12/2020	26 ans			test Seclin
	18/06/2020	26 ans			

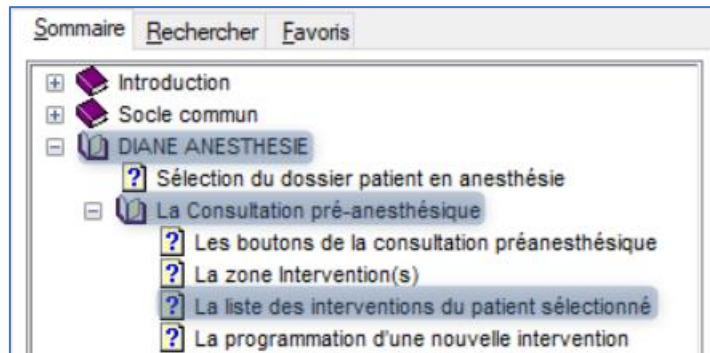
Reprise

If the icon is blue, the user does not have write-access, mainly due to the record being locked elsewhere. It is therefore possible to encounter various icons indicating that a visible consultation cannot be edited:

- Dossier fermé
- Dossier verrouillé
- Réveil en cours
- Bloc en cours
- Induction en cours
- Dossier non accessible



More information on an icon can be found by pressing **F1** on your keyboard when **DIANE Consultation** is open and active. This opens the help window. You can then move to the relevant help topic to find the information mentioned above:

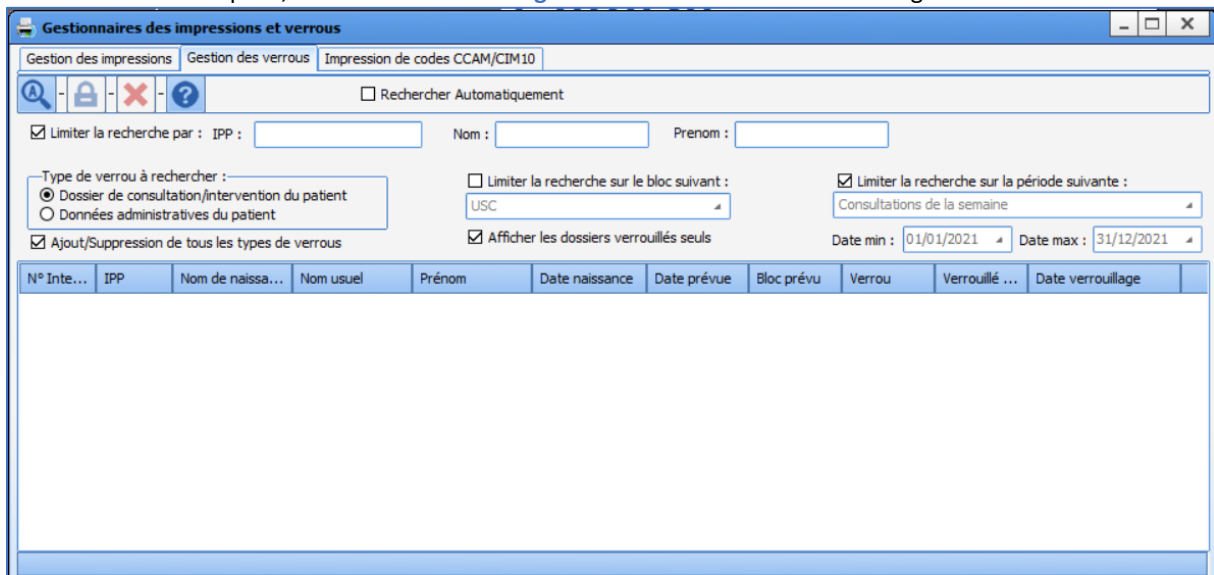


## 4.7.2 Locks management tool

### 4.7.2.1 Open the tool

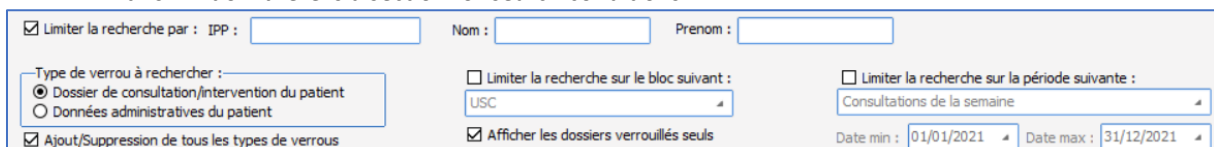
On the **DIANE** portal, click the **Printing/Locks** button or run **MAJImpressions.exe**.

In the window that opens, select the **Locks management** tab: this is the Locks management tool.



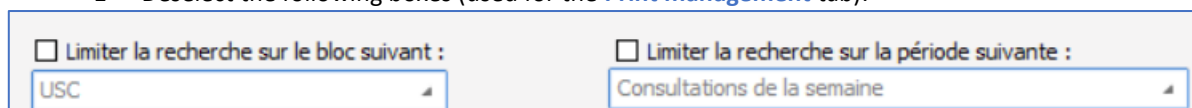
### 4.7.2.2 Carrying out a search

In this window there is a section for search conditions:



When searching for a “blocked patient to unlock”, the user must:

- 1- Deselect the following boxes (used for the **Print management** tab):




- 2- Select the following box:  Limiter la recherche par :
- 3- Use the following fields for the search:

IPP :  Nom :  Prénom :

4- Select  Afficher les dossiers verrouillés seuls

When searching for a “patient to be locked”, the same actions must be taken but with

Afficher les dossiers verrouillés seuls deselected:

After defining the search conditions as above, click  unless this box is selected

Rechercher Automatiquement

#### 4.7.2.3 Releasing locks on a record

To release the locks on a patient record, ensure all rows associated with the patient are displayed. Where possible and to avoid errors, avoid having several patients in the results. Otherwise, check which patients are selected very carefully so that records in use elsewhere are not made unusable.

In addition, ensure all rows for the patient are selected.

For example, here:

N° Inte...	IPP	Nom de naissa...	Nom usuel	Prénom	Date naissance	Date prévue	Bloc prévu	Verrou	Verrouillé ...	Date verrouillage
36741		TESTBOW		Jeremy	15/02/1994	12/01/2021	USC	Bow1	SYSTEM Di...	02/02/2021 16:54:07
36821		TESTBOW		Jeremy	15/02/1994	21/01/2021	Réanimation	Bow1	SYSTEM Di...	02/02/2021 16:54:10
34031		TESTBOW		Jeremy	15/02/1994	15/04/2019	Réanimation	Bow1	SYSTEM Di...	02/02/2021 16:54:16
36681		TESTBOW		Jeremy	15/02/1994	31/12/2020	Consultati...	Bow1	SYSTEM Di...	02/02/2021 16:53:58
36361		TESTBOW		Jeremy	15/02/1994	18/06/2020	Consultati...	Bow1	SYSTEM Di...	02/02/2021 16:54:04
36921		TESTBOW		Jeremy	15/02/1994			Bow1	SYSTEM Di...	02/02/2021 16:54:17

Do not select just one row in an attempt to only release the procedure required, as this may just block the record further:

N° Inte...	IPP	Nom de naissa...	Nom usuel	Prénom	Date naissance	Date prévue	Bloc prévu	Verrou	Verrouillé ...	Date verrouillage
36741		TESTBOW		Jeremy	15/02/1994	12/01/2021	USC	Bow1	SYSTEM Di...	02/02/2021 16:54:07
36821		TESTBOW		Jeremy	15/02/1994	21/01/2021	Réanimation	Bow1	SYSTEM Di...	02/02/2021 16:54:10
34031		TESTBOW		Jeremy	15/02/1994	15/04/2019	Réanimation	Bow1	SYSTEM Di...	02/02/2021 16:54:16
36681		TESTBOW		Jeremy	15/02/1994	31/12/2020	Consultati...	Bow1	SYSTEM Di...	02/02/2021 16:53:58
36361		TESTBOW		Jeremy	15/02/1994	18/06/2020	Consultati...	Bow1	SYSTEM Di...	02/02/2021 16:54:04
36921		TESTBOW		Jeremy	15/02/1994			Bow1	SYSTEM Di...	02/02/2021 16:54:17

To select several rows, it is possible to:

- Click the first row, then press and hold  while clicking on the last row to select all rows displayed;

- Click each row to be selected while holding down ;


- Use the mouse to click under the list of results and, without releasing the mouse button, move the cursor up to select rows one by one:

N° Inte...	IPP	Nom de naissa...	Nom usuel	Prénom	Date naissance	Date prévue	Bloc prévu	Verrou	Verrouillé ...	Date verrouillage
36741		TESTBOW		Jeremy	15/02/1994	12/01/2021	USC	Bow1	SYSTEM Di...	02/02/2021 16:54:07
36821		TESTBOW		Jeremy	15/02/1994	21/01/2021	Réanimation	Bow1	SYSTEM Di...	02/02/2021 16:54:10
34031		TESTBOW		Jeremy	15/02/1994	15/04/2019	Réanimation	Bow1	SYSTEM Di...	02/02/2021 16:54:16
36681		TESTBOW		Jeremy	15/02/1994	31/12/2020	Consultati...	Bow1	SYSTEM Di...	02/02/2021 16:53:58
36361		TESTBOW		Jeremy	15/02/1994	18/06/2020	Consultati...	Bow1	SYSTEM Di...	02/02/2021 16:54:04
36921		TESTBOW		Jeremy	15/02/1994			Bow1	SYSTEM Di...	02/02/2021 16:54:17

Relâcher le curseur

Clïc avec le curseur



When the rows to be unlocked have been selected,  is no longer shown in grey. Click the button to delete the locks and make the patient record and all its procedures available in write-access for another computer.

You can also right-click the highlighted rows and click the row highlighted in yellow:

N° Inte...	IPP	Nom de naissa...	Nom usuel	Prénom	Date naissance	Date prévue	Bloc prévu	Verrou	Verrouillé ...	Date verrouillage
36741		TESTBOW		Jeremy	15/02/1994	12/01/2021	USC	Bow 13	SYSTEM Di...	09/02/2021 11:46:16
36821		TESTBOW		Jeremy	15/02/1994	21/01/2021	Réanimation	Bow 13	SYSTEM Di...	09/02/2021 11:46:16
34031		TESTBOW		Jeremy	15/02/1994	15/04/2019	Réanimation	Bow 13	SYSTEM Di...	09/02/2021 11:46:16
36681		TESTBOW		Jeremy	15/02/1994	31/12/2020	Consultati...	Bow 13	SYSTEM Di...	09/02/2021 11:46:16
36361		TESTBOW		Jeremy	15/02/1994	18/06/2020	Consultati...	Bow 13	SYSTEM Di...	09/02/2021 11:46:16
36921		TESTBOW		Jeremy	15/02/1994			Bow 13	SYSTEM Di...	09/02/2021 11:46:16

#### 4.7.2.4 Claiming write-access for a record

Just as locks can be removed for a patient record and its procedures, they can also be added. This allows write access to be claimed for a record.

However, this function may only be used in one case: if the patient record locks were already present on the workstation on which you are working, but following an error/lock issue, they are no longer there. Following the instructions below allows the user to reclaim write-access and thus avoid data loss.

Please note that it is only possible to do this on the workstation from which the record should be accessed in write-access mode. If this is done from another workstation, the other workstation will obtain the write-access.

First, search for the patient and select all corresponding rows (see previous chapter for instructions on how to do this).

For example:

Limiter la recherche par : IPP :  Nom :  Prénom :

Dossier de consultation/intervention du patient  
 Données administratives du patient

Ajust/Suppression de tous les types de verrous

Limiter la recherche sur le bloc suivant :

Limiter la recherche sur la période suivante :

Afficher les dossiers verrouillés seuls Date min :  Date max :

N° Inte...	IPP	Nom de naissa...	Nom usuel	Prénom	Date naissance	Date prévue	Bloc prévu	Verrou	Verrouillé ...	Date verrouillage
36741		TESTBOW		Jeremy	15/02/1994	12/01/2021	USC			
36821		TESTBOW		Jeremy	15/02/1994	21/01/2021	Réanimation			
34031		TESTBOW		Jeremy	15/02/1994	15/04/2019	Réanimation			
36681		TESTBOW		Jeremy	15/02/1994	31/12/2020	Consultati...			
36361		TESTBOW		Jeremy	15/02/1994	18/06/2020	Consultati...			
36921		TESTBOW		Jeremy	15/02/1994					



Then, click the following button which is no longer shown in grey:

You can also right-click the highlighted rows and click the row highlighted in yellow:

N° Inte...	IPP	Nom de naissa...	Nom usuel	Prénom	Date naissance	Date prévue	Bloc prévu	Verrou	Verrouillé ...	Date verrouillage
36741		TESTBOW		Jeremy	15/02/1994	12/01/2021	USC			
36821		TESTBOW		Jeremy	15/02/1994	21/01/2021	Réanimation			
34031		TESTBOW		Jeremy	15/02/1994	15/04/2019	Réanimation			
36681		TESTBOW		Jeremy	15/02/1994	31/12/2020	Consultati...			
36361		TESTBOW		Jeremy	15/02/1994	18/06/2020	Consultati...			
36921		TESTBOW		Jeremy	15/02/1994					

Write-access for the patient record in question is thus retrieved by associating the corresponding locks.

### 4.7.3 Lock configuration

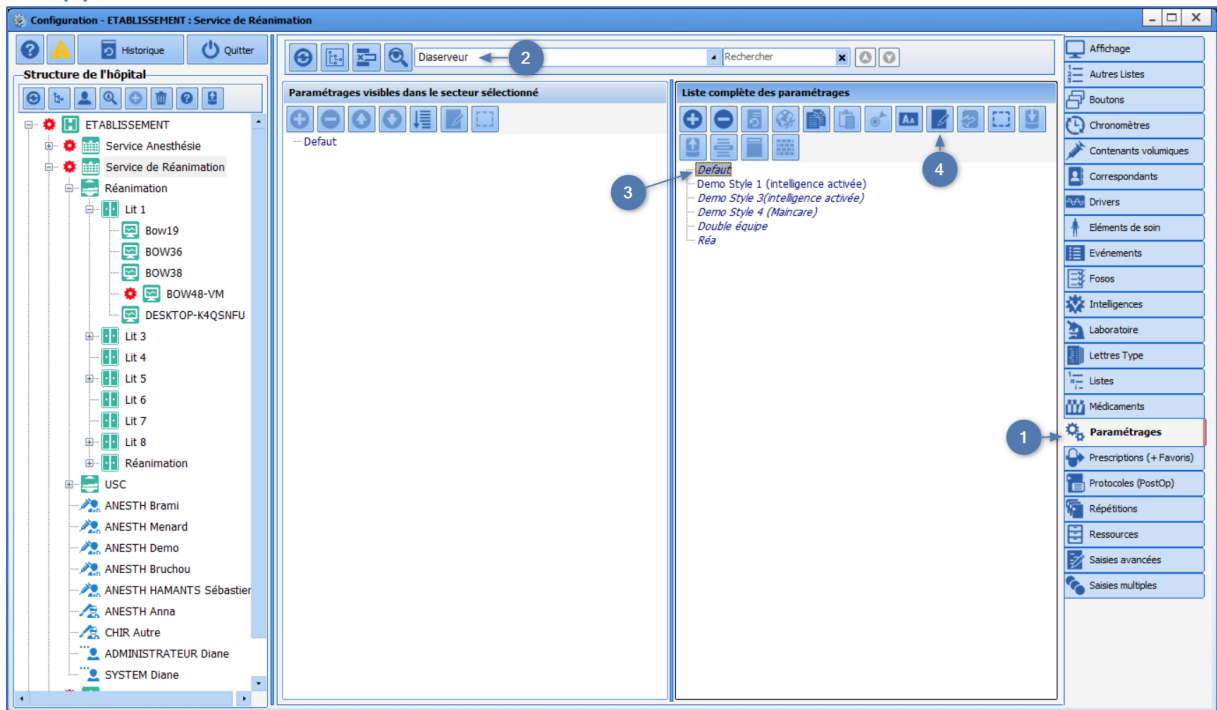
#### 4.7.3.1 Locks prioritization

In order to open a record that is locked elsewhere, it is possible to assign the record locks and override the data being written on the other workstation.

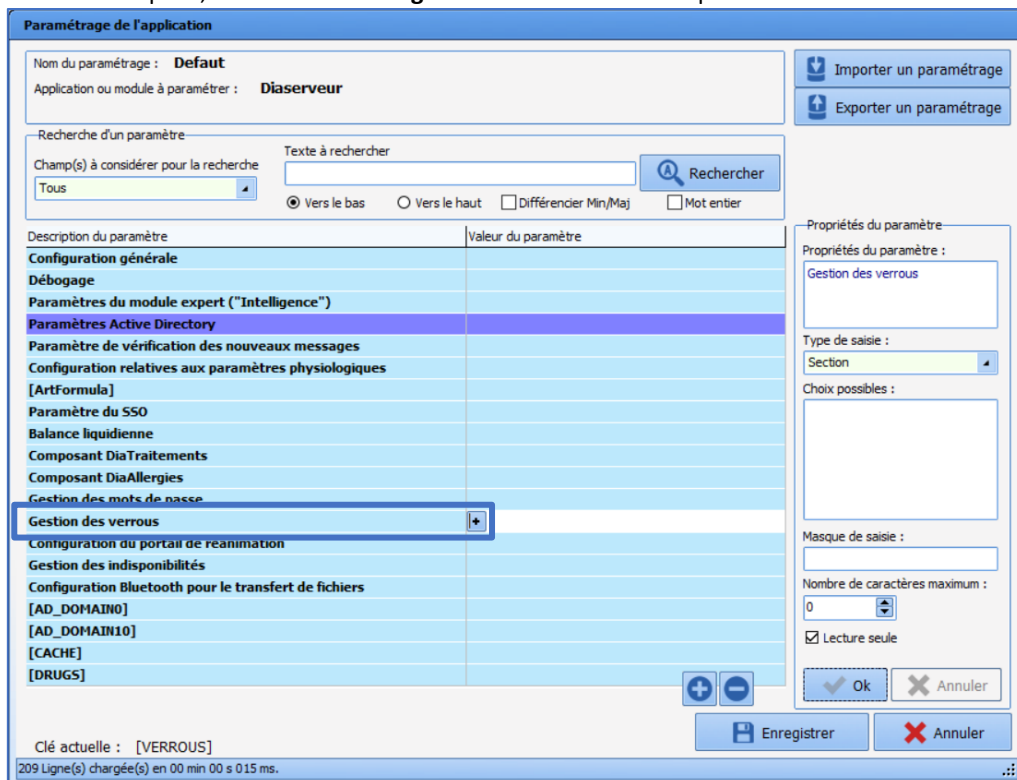
However, this can be partially set up. It is possible to define the room types (Induction, OT, RR, ICU and other) with priority over others in terms of locks.

To this, go to the **Application configuration** module.

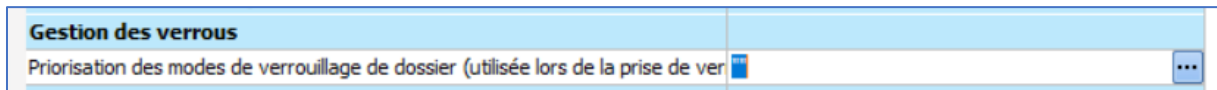
Select the **Settings (1)** tab, **DiaServeur** menu (2), click the configuration to be modified (3), click **Edit** item (4):



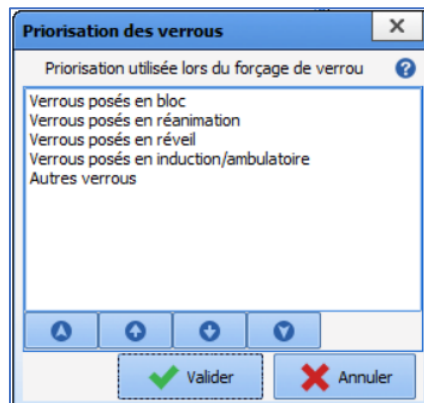
On the window that opens, select **Locks management** and click **+** to expand the row:



Select the expanded row and click **...** at the end of the row:



This window appears:



Rows in the central block show from bottom to top which room type has priority over the others in terms of locks prioritisation. Here, this means that the OT has priority for locking records, even if the record is currently open in RR.

This order can be changed by selecting one of the rows and clicking the buttons above as follows:



The first button is used to move an item to first place instantly.



The second button is used to move an item up one place.

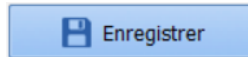


The third button is used to move an item down one place.



The fourth button is used to move an item to last place instantly.

Once the final order has been defined, click  at the bottom of the window, then



to save the configuration with these new settings. You must then restart **DIANE** on the workstations using this configuration.

#### 4.7.3.2 Activating logs to monitor changes to locks

It is possible to activate logs (text files used to analyse errors that occur in **DIANE**) to monitor the claiming and release of locks. This can be used to see what is happening on client workstations if recurrent lock issues occur. These logs are deactivated by default.

Once activated, these logs are generated in the **Diane/Data/\*Workstation name\*/Log** folder of the workstation and can be sent to **Bow Medical** for analysis.

To activate these logs, go to **Application configuration, Settings** tab, **DiaServeur** menu to select and edit the configuration (see previous chapter for how to do this).

Once the settings keys window is open, search for **LockLog**:

**Paramétrage de l'application**

Nom du paramétrage : **Defaut**  
 Application ou module à paramétrer : **Diaserveur**

Recherche d'un paramètre

Champ(s) à considérer pour la recherche : Tous  
 Texte à rechercher : logverrou Rechercher

Vers le bas  Vers le haut  Différencier Min/Maj  Mot entier

Description du paramètre	Valeur du paramètre
<b>Configuration générale</b>	
<b>Débogage</b>	
Log les requêtes de type "Select" (0=Non, 1=Oui)	0
Log les requêtes de type "Insert" (0=Non, 1=Oui)	0
Log les requêtes de type "Update" (0=Non, 1=Oui)	0
Log les requêtes de type "Delete" (0=Non, 1=Oui)	0
Log les prises et libération de verrou	0
Log des requêtes Active Directory	0
Envoi des logs via FTP	0

Change the key value to "1":

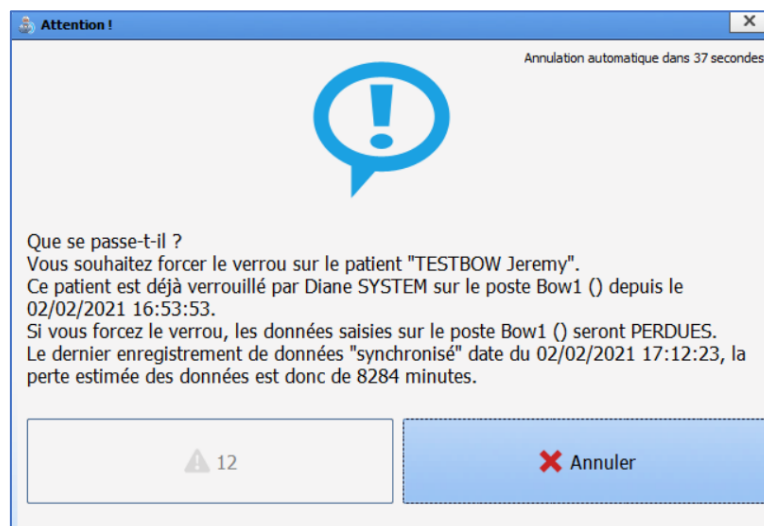
Log les prises et libération de verrou	1	<input checked="" type="checkbox"/>
--	---	-------------------------------------

Click Enregistrer and restart **DIANE** on the workstations using this configuration.

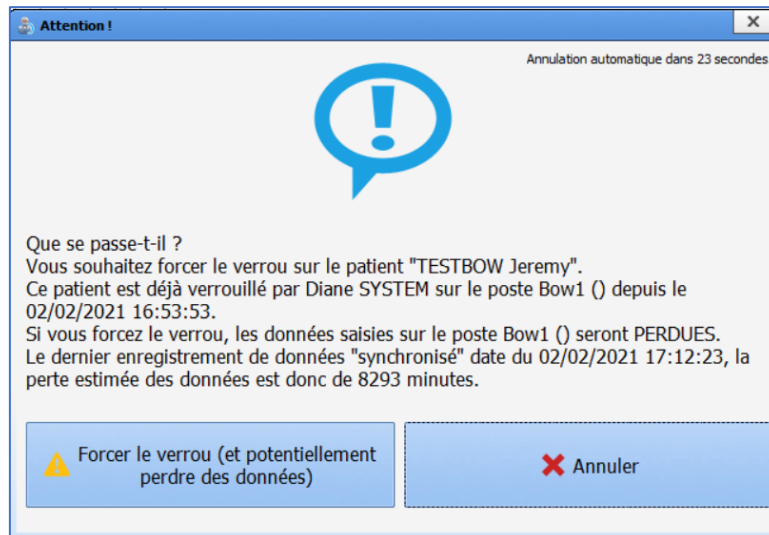
## 4.7.4 Known issues

### 4.7.4.1 Locks stolen by another user

If a user tries to force write-access on a different workstation to the one with locks, the following message appears:



After 15 seconds, it changes to:



Clicking the button with the yellow panel will force the locks. If the record was being used elsewhere, other users will see an error message and no longer be able to work.

If the record was blocked on another workstation for no valid reason, this is a way to get back the record, but this may result in data loss.

#### 4.7.4.2 Lock blocked in OT after transfer to RR

Sometimes, following a record transfer from the OT to the RR, the record cannot be opened in the RR as the previous lock was not properly released.

In this case, it must first be ensured that the record is truly no longer open on the OT workstation. If the record has been closed or transferred from the OT workstation and therefore no longer accessed from there, the locks must be removed from the record. Otherwise, wait until it has been closed and then check in the RR that the record can be opened with write-access.

If the problem persists, go to the **Locks management** tool and check if the locks can be released here. If this can be done, the record should be available in write-access again when the locks have been released.

If no solution can be found or the problem persists despite manual release of the locks, restart **DIANE** with a **DianeKiller**, option **Stop**, on the OT workstation. After this, **DIANE** can be reopened on the OT workstation with no issues. The record should then be available after the operation.

If the problem persists, please contact **Bow Medical**.



## 4.8 Setting up ICD-10 and procedure codes

### 4.8.1 Configuring ICD-10 and procedure codes

This is done in the **Settings – Misc.** tab.

**Paramétrage de l'application**

Nom du paramétrage : **Default**  
Application ou module à paramétrer : **Misc**

Recherche d'un paramètre  
Champ(s) à considérer pour la recherche : Tous  
Texte à rechercher :  
Rechercher

Vers le bas  Vers le haut  Différencier Min/Maj  Mot entier

Description du paramètre	Valeur du paramètre
<b>Configuration des web services spécifiques à Maincare</b>	
<b>Configuration des appels contextuels avec MAINCARE</b>	
<b>Configuration de la CIM10 et de la CCAM</b>	
Actes ajoutés automatiquement, à configurer comme suit : <Acte automatique>=<Acte déclencheur 1>,<Acte déclencheur 2>,...,<Acte déclencheur N>	15, GLLD008, GLLD004, GLLD007, GLLD009, GLJF010,
Onglet de démarrage du formulaire de saisie des codes CCAM/CIM10	CIM10
Renseigner dans la date de saisie de l'acte, l'heure d'ouverture du formulaire, ou la date de cloture	0
Libellé de la zone "CAC Demandeur"	
Conseil de la zone "CAC Demandeur"	
Libellé de la zone "CAC Réalisateur"	
Conseil de la zone "CAC Réalisateur"	
Libellé de la zone "Lieu de réalisation"	
Conseil de la zone "Lieu de réalisation"	
Codes ATC utilisés pour le déclenchement des codes CCAM liés au remplissage (EQLF002)	"B05BB01 B05AA07 B05XA03 B05XA02"
<b>Configuration du Webservice DopaSoins</b>	
<b>Configuration du Webservice Ambucare</b>	
<b>Configuration du Webservice Doctolib</b>	
<b>Configuration des appels contextuels et du Web Service Logipren</b>	
<b>Configuration du Webservice Moebius</b>	
<b>Configuration du simulateur</b>	
<b>Anamnèse</b>	

Clé actuelle : CCAM\_AutoAddedActes  
333 Ligne(s) chargée(s) en 00 min 00 sec 031 ms.

#### 4.8.1.1 Procedures added automatically

This key is set up as follows:

<Acte automatique 1>=<Acte déclencheur1>,<Acte déclencheur2>,...,<Acte déclencheurN> , | <Acte automatique 2>=<Acte déclencheur1>,<Acte déclencheur2>,...,<Acte déclencheurN>

(e.g.

"YYYY015=DEQP004,DEQP007,GLQP004,EQLF001,EQLF002,FELF003, || YYYY020=EQLF003,FELF004,EQMP001,EQMF003,GLLD006,GLLD013,GLLD002,GLLD012,GLLD015,GLLD008,GLLD004,GLLD007,GLLD009,GLJF010,"

#### 4.8.1.2 ICD-10 and Procedure code entry form start-up tab

This key determines the tab shown by default when the **Procedure/ICD-10** module is launched.

Possible values:

0=ICD-10

1=Procedure code

#### 4.8.1.3 Include form opening time, or record closing time if closed, in the procedure entry date

Default is 0, corresponding to 23:59.

Labels and advice for **Requesting service**, **Service performing surgery** and **Place where done**

These keys are used to modify the labels and advice on hovering over the corresponding entry fields in the **Procedure code** tab of the **Procedure/ICD-10** module.

N° de séjour	<input type="text"/>	Lieu de réalisation	Uf-124578
CAC demandeur	Cardiologie	CAC réalisateur	Uf-124578

If these keys are empty, the app shows the default values.

#### 4.8.1.4 ATC codes used to trigger procedure codes associated with filling (EQLF002)

This set-up shows the ATC codes used to trigger the code EQLF002 (when a filler product is prescribed).  
(e.g.

ATC codes used to trigger procedure codes associated with filling (EQLF002)

## 4.8.2 DianeICU settings

This is done in the **Settings – DianeICU** tab.

**Paramétrage de l'application**

Nom du paramétrage : **Rea 1280-800**  
 Application ou module à paramétrer : **DianeRea**

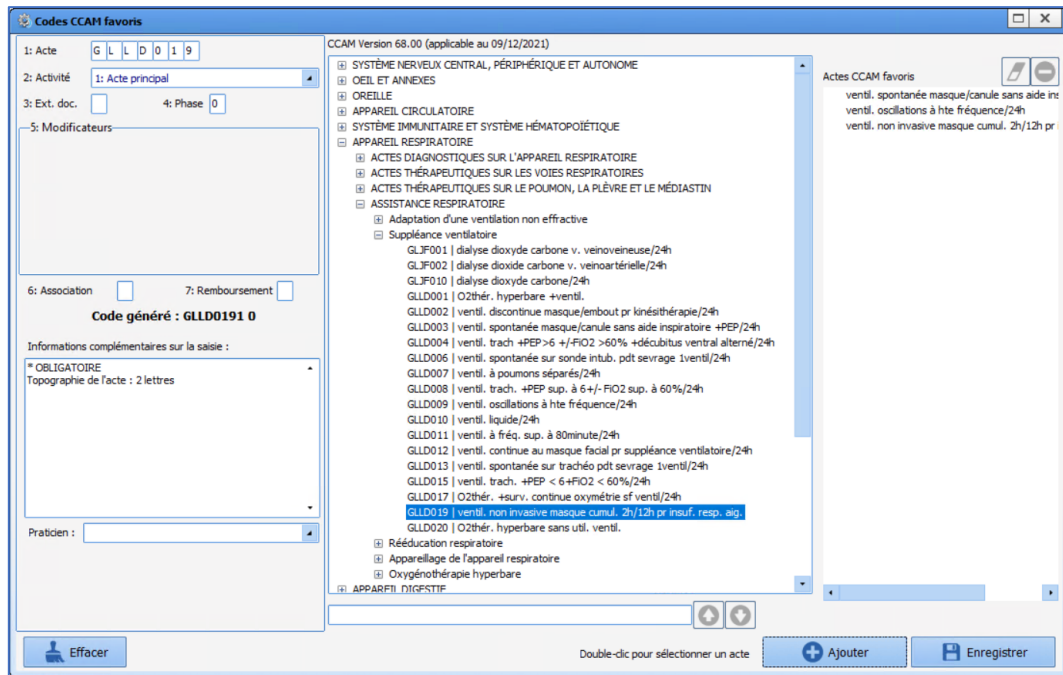
Recherche d'un paramètre  
 Champ(s) à considérer pour la recherche : Tous  
 Texte à rechercher :   
 Vers le bas  Vers le haut  Différencier Min/Maj  Mot entier

Description du paramètre	Valeur du paramètre
<b>Configuration de la fenêtre de saisie de donnée manuelle</b>	
<b>Mouvement du personnel</b>	
<b>Configuration des couleurs de DianeRea</b>	
<b>[DEBUG]</b>	
<b>Avertissements</b>	
<b>Connexion à distance</b>	
<b>Graphique des médicaments</b>	
<b>Onglet navigation</b>	
<b>Feuille d'ouverture et fiche inter patient</b>	
<b>Plan de soin</b>	
<b>Transmissions ciblées</b>	
<b>Documents intégrés</b>	
<b>CCAM/CIM10</b>	
Actes CCAM favoris	
Actes CCAM à prédéterminer	7  8  9  10  11  12  13  14  15  16  17  18  19*
<b>Fiche de sortie/fermeture de dossier</b>	
<b>Actions importantes</b>	
<b>Configuration du portail de réanimation</b>	
<b>Configuration du calcul du score IGS2</b>	
<b>[EXTERNAL_NOTIFIER]</b>	

Propriétés du paramètre  
 Propriétés du paramètre : Actes CCAM à prédéterminer  
 Type de saisie : Fenêtre de configuration  
 Choix possibles :   
 Masque de saisie :   
 Nombre de caractères maximum : 0  
 Lecture seule

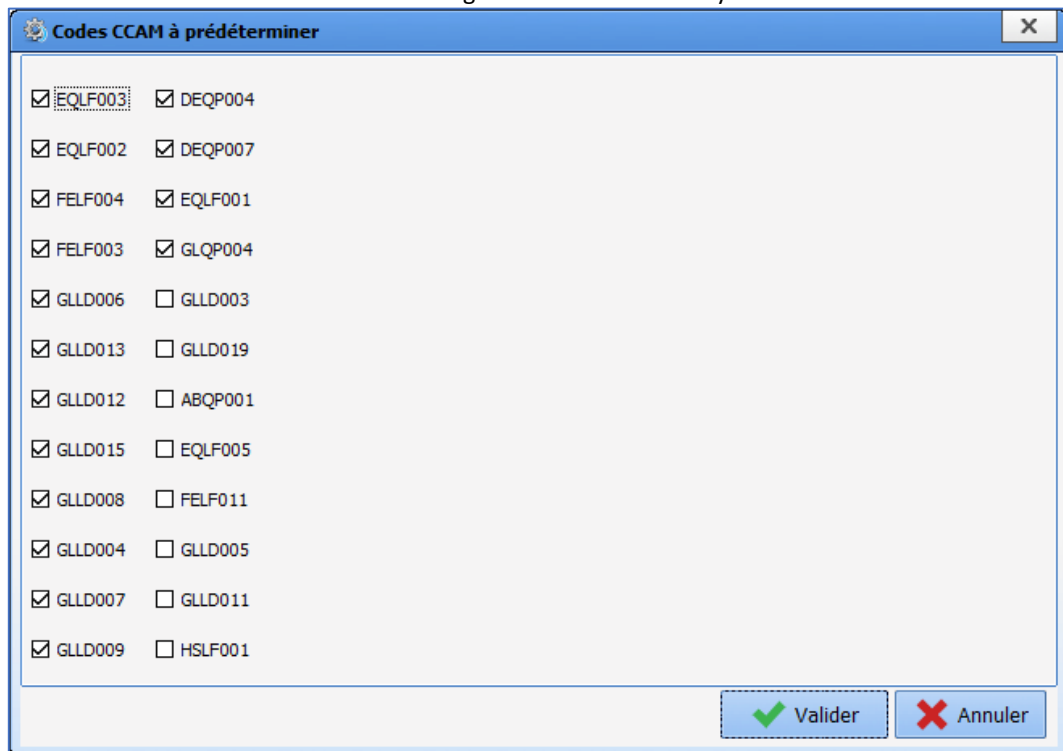
Clé actuelle : PredeterminedCCAMCodes  
 318 Ligne(s) sauvegardée(s) en 00 min 00 sec 000 ms.

#### 4.8.2.1 Favourite Procedure codes



#### 4.8.2.2 Predetermined Procedure codes

Some codes are automated in DIANE. The codes generated automatically are those selected in this window.



#### 4.9 Setting up Ax field remote modification alerts

Alerts for modified fields are set up in **Settings – Misc**.

Description du paramètre	Valeur du paramètre
<b>Configuration générale</b>	-
Numéro de version (Chiffres uniquement)	"4.8"
Numéro d'archive (Chiffres uniquement)	9
URL du serveur (adresse par défaut : https://213.151.172.131:8444/support.p	
Choix du navigateur intégré	IE
Afficher l'environnement utilisé (alias de connexion) dans la barre de titre des fe	0
Avertissement lors de modifications des champs du dossier à partir d'autres pos	"133  132  131  92  959  135  958  263  112  62"
<b>Interface DXCare</b>	
Avertissement lors de modifications des champs du dossier à partir d'autres pos	63  132  131  92  959  135  958  263  112  62"
<b>Interface DXCare</b>	

Click ... to show the following window:

**Paramétrage des alertes des champs modifiés** X

<ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Allergies (Allergiques)</li> <li><input type="checkbox"/> ALR (ALR)</li> <li><input type="checkbox"/> Ambulatoire (Eligible ambulatoire)</li> <li><input type="checkbox"/> Anesthésiste en CS (Anesthésiste en consultation (compl</li> <li><input type="checkbox"/> Anesthésiste en CS (Anesthésiste réalisant la consultation</li> <li><input type="checkbox"/> Anesthésiste(s) prévu(s) (Anesthésiste(s))</li> <li><input checked="" type="checkbox"/> Antécédents anesthésiques (Anesthésiques)</li> <li><input checked="" type="checkbox"/> Antécédents Chirurgicaux (Chirurgicaux)</li> <li><input checked="" type="checkbox"/> Antécédents familiaux (Champ supplémentaire 3)</li> <li><input checked="" type="checkbox"/> Antécédents familiaux (Médicaux inactifs)</li> <li><input checked="" type="checkbox"/> Antécédents Médicaux (Familiaux)</li> <li><input checked="" type="checkbox"/> Antécédents médicaux (Médicaux actifs)</li> <li><input type="checkbox"/> Antécédents obstétricaux (Obstétricaux)</li> <li><input type="checkbox"/> Antécédents obstétricaux (Suivi post-opératoire)</li> <li><input type="checkbox"/> Antécédents Transfusionnels (Transfusionnels)</li> <li><input type="checkbox"/> Antibiotiques (Antibiotique)</li> <li><input type="checkbox"/> Anticoagulants (Anticoagulant)</li> <li><input type="checkbox"/> ASA (Risque ASA)</li> <li><input type="checkbox"/> ATB prophylaxie (Antioprophylaxie)</li> <li><input type="checkbox"/> ATB prophylaxie (Na)</li> <li><input type="checkbox"/> Autopsie (Champ 19)</li> <li><input type="checkbox"/> Autorisation (Autorisation)</li> <li><input type="checkbox"/> Autorisation d'opérer (Phosphore)</li> <li><input type="checkbox"/> Autorisation d'opérer (Type naissance)</li> <li><input type="checkbox"/> Autres examens cliniques (Champ 10)</li> <li><input type="checkbox"/> Autres Prescriptions (Autres)</li> </ul>	<p>Utilisation du champ</p> <p>Visual Consultation -&gt; Antécédents / traitements)   Allergies</p> <p>Consultation 7 Résumé   Antécédents allergiques 1 ATCD   Allergies</p> <p>Réanimation Paramed. -&gt; Macrocycle d'entrée)   Allergies Médecin -&gt; Antécédents)   Allergies</p>
<input checked="" type="checkbox"/> Afficher uniquement les champs utilisés	<input type="button" value="✓ Valider"/> <input type="button" value="✗ Annuler"/>

For each toggled display configuration (**Consultation**, **Visual**, **ICU** and **OB-GYN**), the area on the right shows the components using the selected Ax/ID and the relevant tab.

## 4.10 Setting up fluid balance

This is done in the **Settings – DiaServeur** tab.

**Paramétrage de l'application**

Nom du paramétrage : **Defaut**  
 Application ou module à paramétrer : **Diaserveur**

Recherche d'un paramètre  
 Champ(s) à considérer pour la recherche : Tous  
 Texte à rechercher :   
  
 Vers le bas  Vers le haut  Différencier Min/Maj  Mot entier

Description du paramètre	Valeur du paramètre
<b>Configuration générale</b>	
<b>Débugage</b>	
<b>Paramètres du module expert ("Intelligence")</b>	
<b>Paramètres Active Directory</b>	
<b>Paramètre de vérification des nouveaux messages</b>	
<b>Configuration relatives aux paramètres physiologiques</b>	
<b>[ArtFormula]</b>	
<b>Paramètre du SSO</b>	
<b>Balance liquidienne</b>	-
Décalage (en minutes) pour la date/heure de début de calcul de la balance liqui	0
Décalage (en minutes) pour la date/heure de fin de calcul de la balance liquidier	0
Remise à zéro de la balance liquidienne à l'entrée du patient dans un service	0
Cacher la date et l'heure des éléments dans la balance liquidienne. 0 (désactivé)	0
Valeur par défaut pour l'affichage de la balance liquidienne des X dernières heur	24
Case à cocher "De la veille" cochée par défaut. 1 (activé) par défaut	1
<b>Composant DiaTraitements</b>	
<b>Composant DiaAllergies</b>	
<b>Gestion des mots de passe</b>	
<b>Gestion des verrous</b>	
<b>Configuration du portail de réanimation</b>	
<b>Section des indisponibilités</b>	

Propriétés du paramètre  
 Propriétés du paramètre : Balance liquidienne  
 Type de saisie : Section  
 Choix possibles :  
 Masque de saisie :  
 Nombre de caractères maximum : 0  
 Lecture seule

Clé actuelle : [BL]  
 214 Ligne(s) chargée(s) en 00 min 00 sec 012 ms.

#### 4.10.1 Define fluid balance calculation start time

**OffsetStartDateTimeInMin:** Time difference (in minutes) for the fluid balance calculation start date/time (used for ICU for which fluid balance is automatically based on the ICU day). Default 0 e.g. -60=> starts one hour earlier.

The settings key **OffsetStartDateTimeInMin** is used to define the fluid balance calculation start date/time versus the ICU day start time. This is the time difference, in minutes, versus the ICU day start time. This key must be a whole number, either positive or negative.

#### 4.10.2 Define fluid balance calculation end time

**OffsetEndDateTimeInMin:** Time difference (in minutes) for the fluid balance calculation end date/time (used for ICU for which fluid balance is automatically based on the ICU day). Default 0 e.g. -60=> ends one hour earlier.

The settings key **OffsetEndDateTimeInMin** is used to define the fluid balance calculation end date/time versus the ICU day start time. This is the time difference, in minutes, versus the ICU day start time. This key must be a whole number, either positive or negative.

### 4.10.3 Reset fluid balance on transfer of patient to another unit

**ConstrainedToLocationStartDateTime:** Reset fluid balance when a patient is admitted to a unit.

The settings key **ConstrainedToLocationStartDateTime** is used to reset fluid balance when the patient enters a new unit. This is a **Yes/No** key.

### 4.10.4 Hide date and time of fluid balance items

**HideDateTime:** Hide the date and time of fluid balance items. 0 (disabled) by default.

The settings key **HideDateTime** is used to hide the item date/time. This is a **Yes/No** key.

### 4.10.5 Default value for displaying fluid balance for X hours

**DefaultValueTimeFilter:** Default value for displaying fluid balance for the last X hours. Default 24.

The settings key **DefaultValueTimeFilter** is used to configure the default value for the **Last X hours** in the **Fluid balance display** area of the **Fluid balance** tab. This setting also affects the fluid balance display in the cockpit and record history information display in the **Medication order tab**. This key must be a positive whole number.

### 4.10.6 Previous day check box checked by default

**ShowDayBeforeChecked:** **Previous day** check box checked by default. 1 (enabled) by default.

The settings key **ShowDayBeforeChecked** is used to automatically select **Previous day** in the **Fluid balance display** area of the **Fluid balance** tab. This is a **Yes/No** key.

## 4.11 Password settings

This is done in the **Settings – DiaServeur** tab.

**Paramétrage de l'application**

Nom du paramétrage : **Defaut**  
 Application ou module à paramétrer : **Diaserveur**

Recherche d'un paramètre  
 Champ(s) à considérer pour la recherche : Tous  
 Texte à rechercher :   
  
 Vers le bas  Vers le haut  Différencier Min/Maj  Mot entier

Description du paramètre	Valeur du paramètre
<b>Composant DiaAllergies</b>	
<b>Gestion des mots de passe</b>	-
Expiration des mots de passe	Activé (message d'avertissement à l'expiration)
Durée de validité d'un mot de passe (en jours, 365 par défaut)	365
Taille minimale d'un mot de passe (en caractères, 6 par défaut)	6
Nombre de chiffres minimum dans le mot de passe (-1=chiffres interdits)	0
Nombre de lettres minuscules minimum dans le mot de passe (-1=lettres minuscules)	0
Nombre de lettres majuscules minimum dans le mot de passe (-1=lettres majuscules)	0
Nombre de caractères spéciaux minimum dans le mot de passe (-1=caractères)	0
Permettre de changer de mot de passe par l'utilisateur	1
Nombre de tentative avant que le compte soit bloqué (0=pas de limite)	0
Historisation du mot de passe	1
<b>Gestion des verrous</b>	
<b>Configuration du portail de réanimation</b>	
<b>Gestion des indisponibilités</b>	
<b>Configuration Bluetooth pour le transfert de fichiers</b>	
[AD_DOMAIN0]	
[AD_DOMAIN10]	
[CACHE]	
[DRUGS]	

Propriétés du paramètre  
 Propriétés du paramètre :  
 Gestion des mots de passe  
 Type de saisie :  
 Section  
 Choix possibles :  
  
 Masque de saisie :  
  
 Nombre de caractères maximum :  
 0  
 Lecture seule

Clé actuelle : [PASSWORD]

215 Ligne(s) chargée(s) en 00 min 00 sec 017 ms.

#### 4.11.1 Password expiration

**PasswordExpiration:** Password expiration.

The settings key **PasswordExpiration** determines whether or not passwords have a limited duration. Three settings are possible:

- **Disabled:** passwords do not expire.
- **Enabled (warning message on expiration):** when the password expires, a message informs the user.
- **Enabled (mandatory change on expiration):** when the password expires, the user must set a new password to log in.

#### 4.11.2 Password duration

**PasswordDuration:** Password duration (in days, 365 by default).

The settings key **PasswordDuration** is used to define the duration of password validity in days.

### 4.11.3 Minimum password length

**PasswordMinLength:** Minimum password length (in characters, 6 by default).

The settings key **PasswordMinLength** is used to define the minimum length of a password.

### 4.11.4 Minimum number of digits in password

**PasswordMinDigits:** Minimum number of digits in password (-1=numbers forbidden).

The settings key **PasswordMinDigits** is used to define the minimum number of digits a password must contain. If this key is set to -1, passwords may not contain numbers.

### 4.11.5 Minimum number of lower-case letters in password

**PasswordMinSmallLetters:** Minimum number of lower-case letters in password (-1=lower-case letters forbidden).

The settings key **PasswordMinSmallLetters** is used to define the minimum number of lower-case letters a password must contain. If this key is set to -1, passwords may not contain lower-case letters.

### 4.11.6 Minimum number of upper-case letters in password

**PasswordMinCapitalLetters:** Minimum number of upper-case letters in password (-1=upper-case letters forbidden).

The settings key **PasswordMinCapitalLetters** is used to define the minimum number of upper-case letters a password must contain. If this key is set to -1, passwords may not contain upper-case letters.

### 4.11.7 Minimum number of special characters in password

**PasswordMinSpecialChar:** Minimum number of special characters in password (-1= special characters forbidden).

The settings key **PasswordMinSpecialChar** is used to define the minimum number of special characters a password must contain. If this key is set to -1, passwords may not contain special characters.

### 4.11.8 Allow user to change password

**CanModifyPassword:** Allow the user to change their password.



The settings key CanModifyPassword is used to define whether the user can change their own password, or if this must be done by an administrator. This is a **Yes/No** key.

#### 4.11.9 Number of attempts before account is blocked

**PasswordFailure:** Number of attempts before account is blocked (0=no limit).



The settings key **PasswordFailure** is used to define how many times the user can attempt to enter their password before the account is temporarily blocked. The account is then blocked for one minute before any more attempts. The duration doubles each time the number of attempts is reached.

#### 4.11.10 Password history

**PasswordHistory:** Password history

The settings key **PasswordHistory** is used to define whether or not passwords are archived. If so, a password that has already been used cannot be reused. This is a **Yes/No** key.

### 4.12 Cockpit settings for anaesthesia

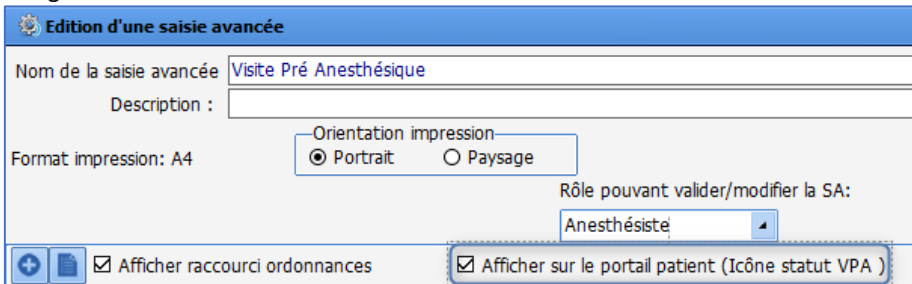
The cockpit (patient list) allows an icon  to be displayed if used in anaesthesia. This icon changes to blue  when a POA is signed using the relevant detailed entry.

#### 4.12.1 Activation of the POA icon

For this icon to be displayed, the settings key **DisplayVPAStatusOnPanel** in **Dianerea.ini** must be activated.

#### 4.12.2 Configuration of POA detailed entries

For a detailed entry to be used for POA signature, the box **Display on patient portal (icon POA status)** must be selected on editing.



<b>Edition d'une saisie avancée</b>	
Nom de la saisie avancée	Visite Pré Anesthésique
Description :	
Format impression: A4	Orientation impression: <input checked="" type="radio"/> Portrait <input type="radio"/> Paysage
	Rôle pouvant valider/modifier la SA: Anesthésiste
<input checked="" type="checkbox"/> Afficher raccourci ordonnances	<input checked="" type="checkbox"/> Afficher sur le portail patient (Icône statut VPA )

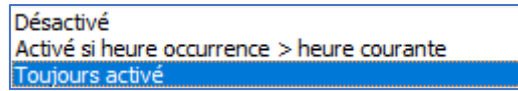
## 4.13 Multiple entry settings

This is done in the **Settings – Visual** tab.

### 4.13.1 Activate synchronisation

**SynchronizeNextSM**: Activate synchronisation of chained multiple entries with regard to the last time of occurrence of the previous multiple entry: disabled by default.

The settings key **SynchronizeNextSM** activates synchronisation of chained multiple entries with regard to the last time of occurrence of the previous multiple entry. This key can have the following 3 values:



### 4.13.2 Activation of the Keep this multiple entry checkbox

**AfficheRepriseSM**: Display the Retrieve multiple entry checkbox (default 1).

The settings key **AfficheRepriseSM** is used to define whether the **Keep this multiple entry** checkbox is shown in multiple entries. This is a **Yes/No** key.

### 4.13.3 Select default occurrence mode

**SMOccurrenceMode**: Indicates the default occurrence mode for a multiple entry item (0=single, 1=multiple. Default=single).

The settings key **SMOccurrenceMode** is used to define whether multiple entry items are single or multiple by default (in this case, a window is used to plan them).

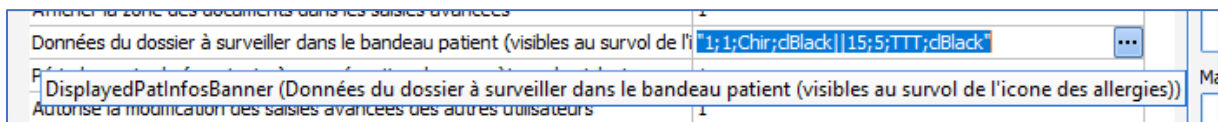
### 4.13.4 Allow occurrence mode to be set

**SMCanSetOccurrenceMode**: Indicates whether the occurrence mode for multiple entry items can be edited (1=yes, 0=no. Default=no)

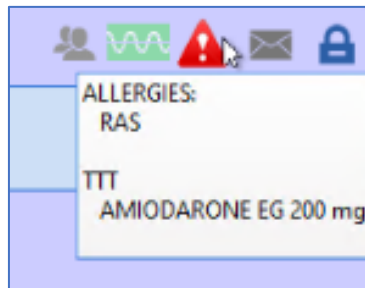
The settings key **SMCanSetOccurrenceMode** is used to define whether the occurrence mode for multiple entry items can be changed.

## 4.14 Settings for information shown on hovering over the allergy icon

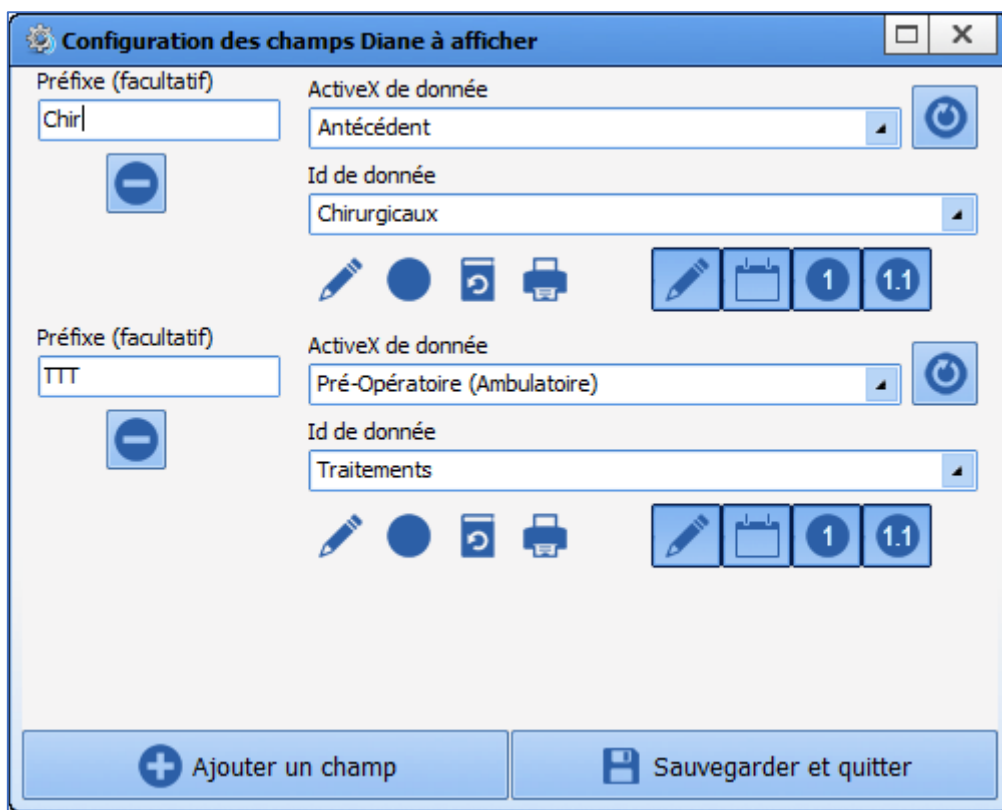
This is done in the **Settings – Visual** or **DianeICU** tab.



Hovering over the allergy icon can display other information in addition to the allergies entered in the relevant component.



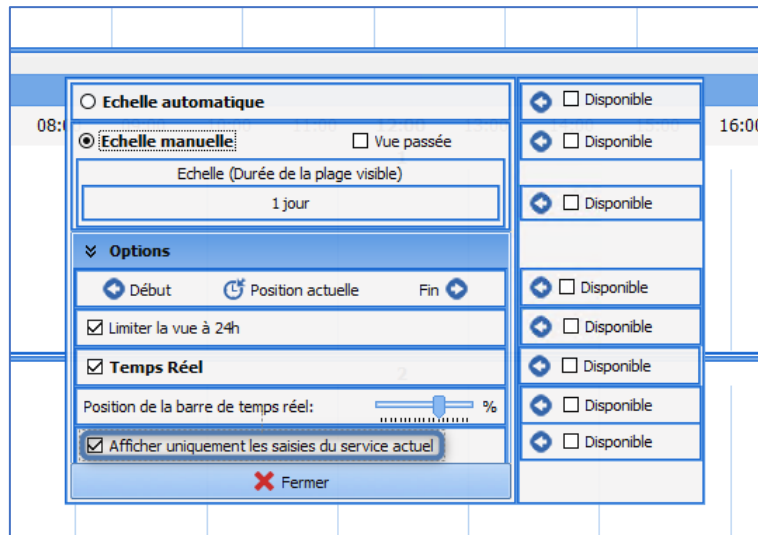
This additional information can be selected from the various data ActiveX using the **Configuring Diane fields to display** window. This window can be accessed using the ... button at the end of the settings key row.



#### 4.15 Settings for preventing data from other units being displayed

When a patient is transferred to another unit, such as an ICU patient undergoing an anaesthetic procedure, the data related to the ICU record may interfere with the readability of the anaesthesia record.

It is possible to set up the display to only shown data from the current unit. The display is thus not overloaded with data from the patient's referring unit. To do this, the **Only show the current unit's entries** checkbox is used to configure the display of the **OT** or **Monitoring** tabs or type-3 views.



## 4.16 Settings for treatments and premedications

This is done in the **Settings – DiaServeur** tab.

**Paramétrage de l'application**

Nom du paramétrage : **Demo Style 1 (intelligence activée)**

Application ou module à paramétrer : **Diaserveur**

Recherche d'un paramètre

Champ(s) à considérer pour la recherche : Tous

Texte à rechercher : [ ]

Rechercher

Vers le bas  Vers le haut  Différencier Min/Maj  Mot entier

Description du paramètre	Valeur du paramètre
<b>Composant DiaTraitements</b>	-
Demande à l'utilisateur de choisir l'unité et la voie du médicament sélectionné	0
Nombre de caractères à entrer avant la recherche automatique dans la base	4
Délai (en ms) avant de d'interroger la BdM durant la saisie d'un médicament.	300
Pattern pour le libellé personnalisé dans la listbox (<default>, <shortname>, <dosage> (<principeactif>)	<shortname> <dosage> (<principeactif>)
Pattern pour le libellé personnalisé du médicament dans le composant (<default> <shortname> <dosage> (<principeactif>)	<shortname> <dosage> (<principeactif>)
La recherche doit-elle utiliser des jokers type * (Utilisé dans la liste box)	Avant & Après
Level 1 (Utilisé dans la liste box)	Nom ATC
Level 2 (Utilisé dans la liste box)	Nom du médicament
Level 3 (Utilisé dans la liste box)	
ActiveX de référence pour les antécédents médicaux (par défaut table "ANTECI	1
Identifiant de la donnée pour le mode d'admission (par défaut champ "MEDICAL	5
Valeurs possible pour le composant "mode d'admission" (par défaut="A=Ambul;A=Ambulatoire  H=Hospitalisation	
ActiveX de référence pour le mode d'admission (par défaut "CPA_INFO_INTER	10
Identifiant de la donnée pour le mode d'admission (par défaut nouveau champ	19
ActiveX de référence pour les commentaires associées aux traitements habituel	10
Identifiant de la donnée pour le mode d'admission (par défaut nouveau champ	18
Ligne de commande pour l'accès au Dossier Patient Informatisé depuis l'onglet (<https://bowmedical.atlassian.net/plugins/servlet/ac/c	
Texte pour indiquer qu'il n'y a pas de traitement personnel du patient (= "Aucun	
Texte pour indiquer que le traitement personnel du patient n'est pas connu (= "	
Etat de la page à charger "Envoyer vers les prescriptions hospitalières" pour les	

Propriétés du paramètre

Propriétés du paramètre : Composant DiaTraitements

Type de saisie : Section

Choix possibles : [ ]

Masque de saisie : [ ]

Nombre de caractères maximum : 0

Lecture seule

Ok Annuler

Enregistrer Annuler

Clé actuelle : [DIATRAITEMENTS]

222 Ligne(s) chargée(s) en 00 min 00 sec 000 ms.

**IdUnitRouteNeeded:** Asks the user to choose the unit and method of administration of the selected drug  
This is a **Yes/No** key.

**MinCharacterBeforeSearchInBase:** Number of characters to be entered before automatic search in the drug database starts

This key must be a whole number.

**DelayBeforeSearchInBase:** Delay (in ms) before the drug database is searched when entering a drug.

This key must be a whole number.

**ListBoxMedicNamePattern:** Pattern for the personalised name in the listbox (<default>, <shortname>, <dosage>, <forme>, <atccode>, <atcname>, <principeactif>)

This key is text.

**ComponentMedicNamePattern:** Pattern for the personalised drug name in the component (<default>=Drug database name <dosage>, <forme>, <atccode>, <atcname>, <medicname> = Listbox name, <cip>, <posology>)

This key is text.

**Jokerize:** Defines whether or not jokers like \* must be used (used in the listbox)

Possible values: 0 = None

1 = Before

2 = After

3 = Before & After

**ListBoxLV1:** Level 1 (used in the listbox)

Possible values: <atcname>= ATC name

<atccode>= ATC code

<forme>= Form name

<dosage>= Dosage

<medicname>= Drug name

**ListBoxLV2:** Level 2 (used in the listbox)

Possible values: <atcname>= ATC name

<atccode>= ATC code

<forme>= Form name

<dosage>= Dosage

<medicname>= Drug name

**ListBoxLV3:** Level 3 (used in the listbox)

Possible values: <atcname>= ATC name

<atccode>= ATC code

<forme>= Form name

<dosage>= Dosage

<medicname>= Drug name

**AntecMedicauxRefDiaAX:** Reference ActiveX for medical history (by default, "ANTECEDENTS" table)

This key must be a whole number.

**AntecMedicauxDataId:** Data ID for the admission mode (by default "MEDICAUX" field in "ANTECEDENTS" table)

This key must be a whole number.

**AdmissionModePossibleValues:** Possible values for admission mode component (by default "A=Ambulatoire|H=Hospitalisation|")

This key is text.

**AdmissionModeRefDiaAX:** Reference ActiveX for mode of admission (by default, "CPA\_INFO\_INTERVENTION")

This key must be a whole number.

**AdmissionModeDataId:** Data ID for the admission mode (by default new “admission mode” field)  
This key must be a whole number.

**CommentairesRefDiaAX:** Reference ActiveX for comments associated with usual treatments (by default "CPA\_INFO\_INTERVENTION")  
This key must be a whole number.

**CommentairesDataId** Data ID for the admission mode (by default new “comments” field)      Whole number

**DPIPathToLaunch:** Command line for accessing the electronic health record from the personal treatments and premedications tab.  
This key is text.

**NoTreatmentText:** Text to indicate that the patient has no personal treatments (= “Aucun traitement” by default/if not entered)  
This key is text.

**UnknownTreatmentText:** Text to indicate that the patient’s personal treatment is unknown (=“Traitement inconnu” by default/if not entered)  
This key is text.

**SendSubstitutesToReaPrescription:** Status of “Send to hospital medication orders” checkbox for treatment conversions (disabled=0 by default)  
This is a **Yes/No** key.

**SendPremedsToRealPrescription:** Status of “Send to hospital medication orders” checkbox for premedications (disabled=0 by default)  
This is a **Yes/No** key.

**TimeMorningTreatment:** Default morning time for treatments.  
This key must be a whole number.

**TimeMiddayTreatment:** Default midday time for treatments.  
This key must be a whole number.

**TimeEveningTreatment:** Default evening time for treatments.  
This key must be a whole number.


**TimeBedTimeTreatment:** Default bed time for treatments.  
This key must be a whole number.

**ReprisePremed:** The button “Retrieve treatment from previous record” also retrieves the premedications (disabled = 0 by default)  
This is a **Yes/No** key.

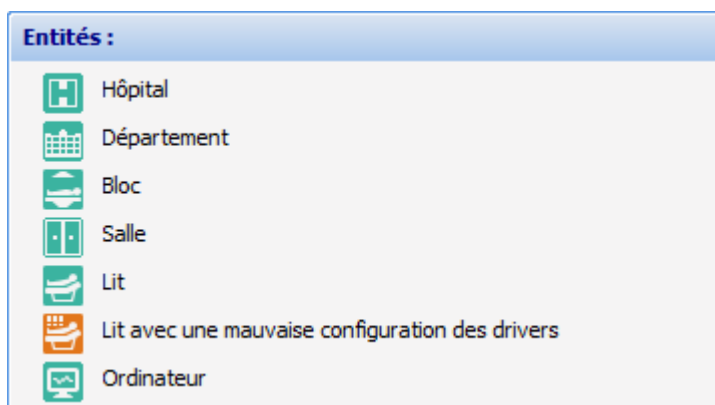
## 5 Configuration of users (and facility organisation)

### 5.1 Glossary

#### Gear

The  icon represents a configuration; each entity can have its own 'gear'.

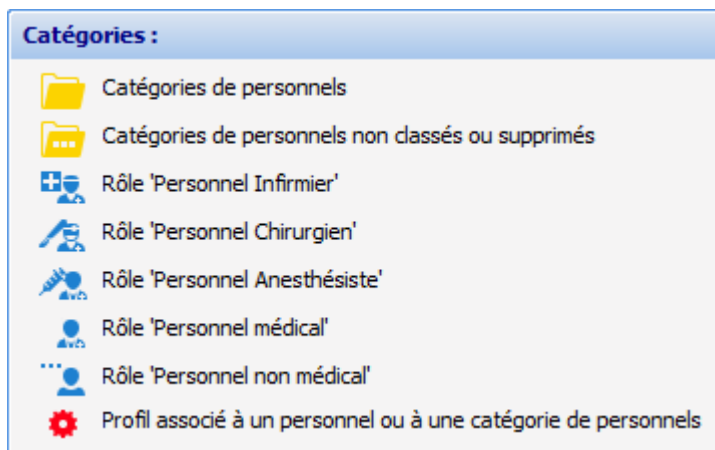
#### Facility entities





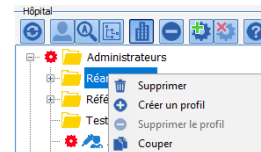
Each entity can have its own configuration (gear).

Any entity that does not have its own configuration will use the first configuration found when ascending the tree structure.

#### Staff categories and Roles



Categories divide users by profession. Each first-level category should have a gear . It is possible, if necessary, to create a profile for a row. To do this, select the row, then either right-click to see a menu (**Create profile**) or select the  from the toolbar below.



#### Properties panel











This panel contains all relevant information for the **Category** or **Role**. The fields are different for **Staff category** and **Role**.

#### Tools for Staff categories and Roles

The tools for **Staff category** or **Role** are as follows:



Used to refresh the list, close the tree structure and deselect the current workstation or user

	Used to hide or show set-up user accounts
	Used to search for a user account or facility entity
	Used to expand the tree structure. To close it, use 
	Used to show hospital entities or staff categories
	Used to show users
	Used to delete an entity, a staff category or a staff member
	Used to create a user account or facility entity
	Used to delete a user account or facility entity
	Show icon meanings

Some buttons may be shown in grey if they are not used in the current context.

### Workstation connection information

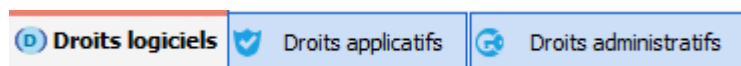
This panel only appears if a **Computer** is selected.

Informations de connexion		
Version du poste : 4.7.5.1	Dernier utilisateur : MEDECIN Paul (PAUL)	Dernier type d'alias : MSAcc
Nombre de connexions : 36	Dernière connexion : 22/06/2020 09:53:37	Dernier driver : O:\Diane\DemoVersions\FR\Database\DianeDemo475
	Dernier alias : DianeDemo475Rea	Dernier TNS : O:\Diane\DemoVersions\FR\Exe\

This is a summary of the last workstation use.

### Permissions associated with a gear

Each Staff category and Role is associated with Permissions, divided across three tabs



## 5.2 Configuration of users

This chapter describes how to create a new user account or edit an existing account.

It is simple to deselect a user, category or entity in the **UserConfiguration** application tree. To do this, right-click in the white area below the tree (after closing the submenu by left-clicking outside the submenu), left-click the white area below the tree or press the **Esc** key.

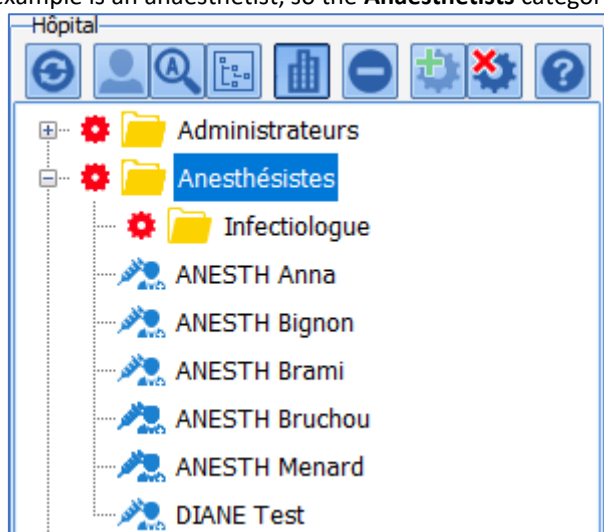
### 5.2.1 Create a user account

A user must be associated with a **Staff category** in **DIANE**. The staff category corresponds to a row on the



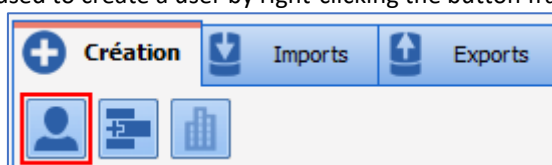
left of the user configuration.

The user created in this example is an anaesthetist, so the **Anaesthetists** category must be selected:



Here, several anaesthetists are already configured, as is a sub-category of staff: **Infectious diseases specialists** with their own configuration (gear).

The **section on the right** is used to create a user by right-clicking the button framed in red below.



**Propriétés**

Nom :  Prénom :  Rôle :

Identifiant :  Mot de passe (5 cars. min) :  Confirmation :

Numéro ADELI :  Id RPPS :  CPS :

Signature...  Identifiant externe :

Adresse mail :  Titre :

Médecin senior depuis/prévu le :  Appliquer date du jour Supprimer date

Compte désactivé à partir du :  03/03/2022

Enregistrer Annuler

**L. name and First name** The user's name is shown when **DIANE** modules are in use. In order to distinguish between the two accounts used by DIANE experts, if they are healthcare staff, **Expert** is generally written before their **last name** and **first name**. The two accounts have different permissions and purposes, so it is important that the **last name** and **first name** allow them to be identified.

**Role** The Role affects some behaviour in **DIANE** modules. The anaesthetist is the only Role able to sign recovery room departures. Pharmacists and doctors have different permissions with regard to medication orders.

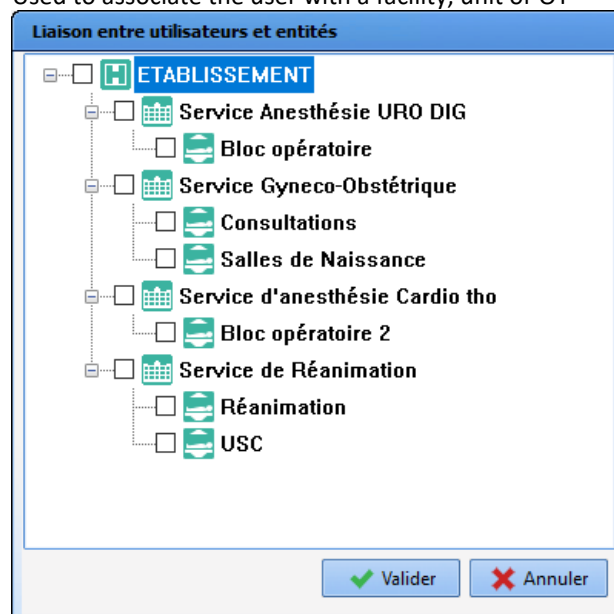
**ID** Together with the **Password**, the **ID** affects access to the software. The ID must be unique within the facility.

**Password and** The minimum requirements for passwords in terms of capital letters and numbers can be set in the **Application configuration**. The same password must be entered in

<b>Confirmation</b>	<b>Password and Confirmation.</b>
<b>Health professional registry number</b>	This information can be automatically added to letters and prescriptions generated in <a href="#">DIANE</a> .
<b>HCP ID</b>	This information can be automatically added to letters and prescriptions generated in <a href="#">DIANE</a> .
<b>CPS</b>	Health Professional Code
<b>Signature</b>	This content can be added to letters and prescriptions.
<b>External ID</b>	Used by the interface service and IT department to create context-based calls.
<b>Email address</b>	Used in prescription sending settings to set up the email sender address.
<b>Title</b>	User title.
<b>Senior doctor</b>	The senior doctor can countersign signatures of junior doctors. This permission is associated with a start date for this option. A specific date cannot be generated. The date is generated on clicking <b>Apply current date</b> and stopped on clicking <b>Delete date</b> .
<b>Disabled account</b>	Used to limit the duration for which an account is used without requiring specific disabling. Useful for trainees, for example.




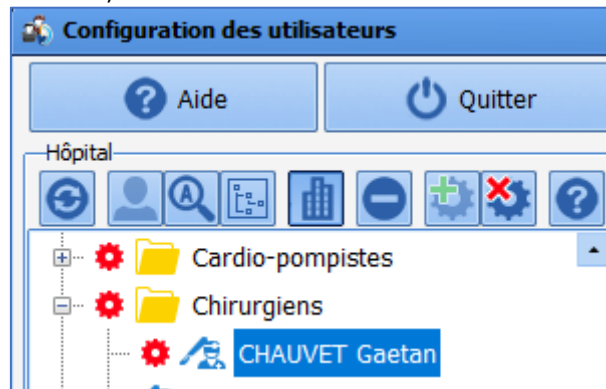
Used to associate the user with a facility, unit or OT



By default, if the user is not assigned to a specific entity, they are assigned to all entities.

## 5.2.2 Edit a user account

In order to edit a user account or component, the user must be selected directly in the category (it is also possible to use the search tool ).



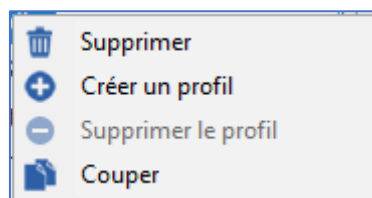
Once located, click the name of the user to be edited.

Click **Save** to save changes.

## 5.2.3 Delete a user account

A user account configured in **DIANE** does not completely disappear, it is just disabled. Keeping disabled user accounts maintains consistency in terms of record display and archiving.

To delete a user, right-click the user to be disabled.



In this menu, select **Delete**: a confirmation window limits the risk of mistakes.



There are two ways to reactivate an account:


- Drag and drop the user to the relevant **User category**
- Right-click the user and select **Cut**. The user name is shown in grey and italics, and can then be pasted (with a right-click) into the relevant category.

## 5.2.4 Using the User signature feature

The signature feature is used to construct a signature with text and image (barcode, scanned handwritten signature, etc.) that is automatically added to the end of prescriptions.

To do this, a signature must be created for each user in **Wordpad** or **Word** (not possible with the integrated editor) and pasted into the window that opens on clicking the **Signature...** button.



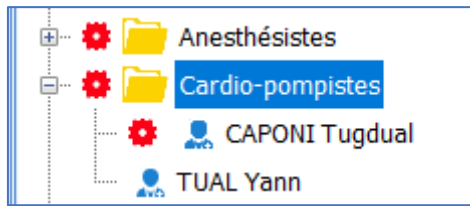
Once validated, a  logo appears to the left, indicating that this user has a signature.

It is also possible to import signatures in RichText format (.rtf).

## 5.2.5 Creating user categories

In this example, the category of trainee perfusionists is created.

In order to create a new user category, select the parent user category.



Création Imports Exports

Nom : Cardio-pompistes

Définir comme profil Invité pour Active Directory / Interfaces intégration utilisateurs

Rôle par défaut pour ce profil

Enregistrer Annuler

After clicking the user category creation button (shown in red below), this window appears:

Création Imports Exports

Nom :

Définir comme profil Invité pour Active Directory / Interfaces intégration utilisateurs

Rôle par défaut pour ce profil


Enregistrer Annuler

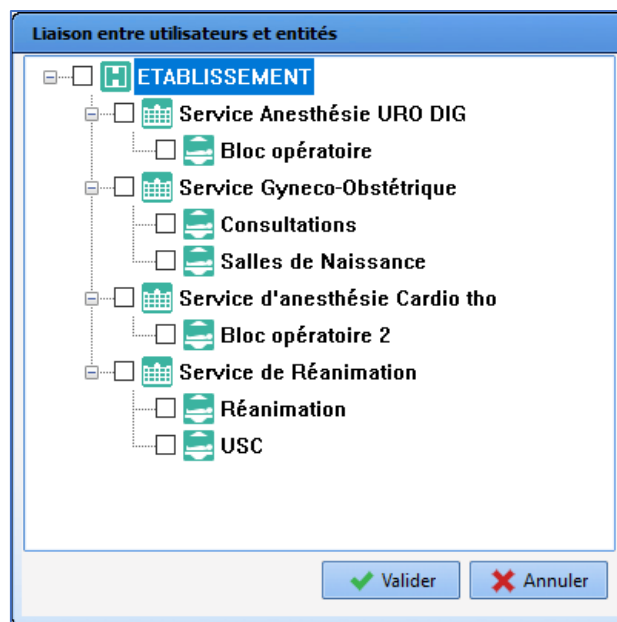
The name of the user category is entered in the **Name** field. The role associated with the user category is selected from the drop-down menu **Default role for this profile** from the following:

- Anaesthetist
- Surgeon

- Nurse anaesthetist
- Medical
- Non-medical
- Intensivist
- Nurse
- Caregiver
- Obstetrician
- Midwife
- Gynaecologist
- Paediatrician
- Anesth. Intensivist

It is possible to associate a user category with one or more entities using the following window, accessed by

clicking .



The list of configured entities such as **Hospital, Unit** and **OT** is shown.

It is possible to select the entities to which the user category should be assigned by clicking. The association is validated by clicking **Validate**. By default, if the user category is not assigned to a specific entity, it will be available across the whole facility.

**Note:** Deleting an entity updates the table where user/entity associations are saved. If a user was only assigned to the deleted entity, they are then accessible across the whole facility as they are no longer associated with a specific entity.

**NOTE:** The **Set as profile... user integration** check box is used to connect **DIANE** with the facility directory: this is done by the IT department.

## 5.2.6 Editing a user category

To edit a user category, right-click the category.

Création Imports Exports

Propriétés

Nom :

Définir comme profil Invité pour Active Directory / Interfaces intégration utilisateurs

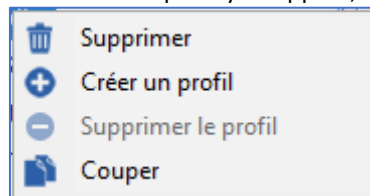
Rôle par défaut pour ce profil

Enregistrer Annuler

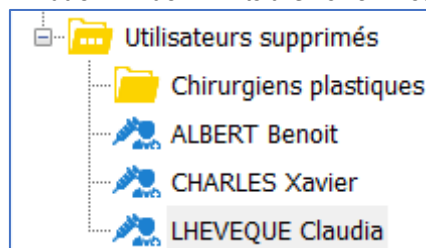
Edit the **Name** of the user category and save the modification with the **Save** button.

## 5.2.7 Deleting a user category

A user category configured in **DIANE** does not completely disappear, it is just disabled.



In this menu, select **Delete**: a confirmation window limits the risk of mistakes.

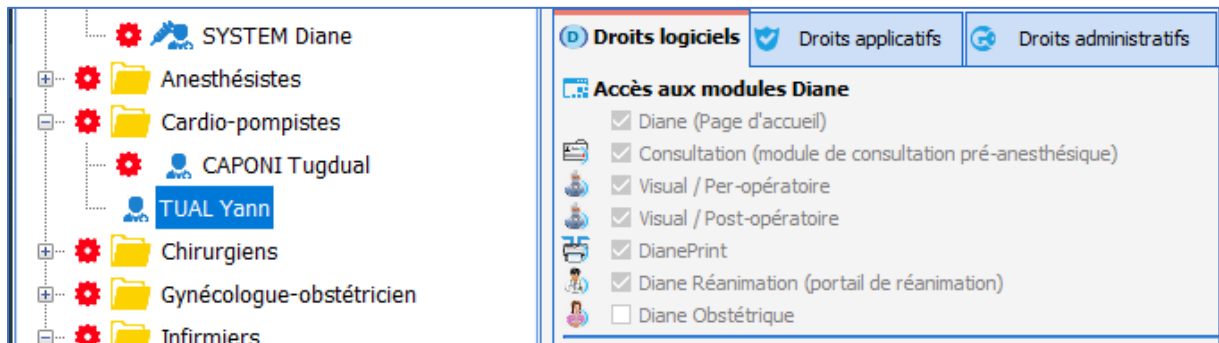
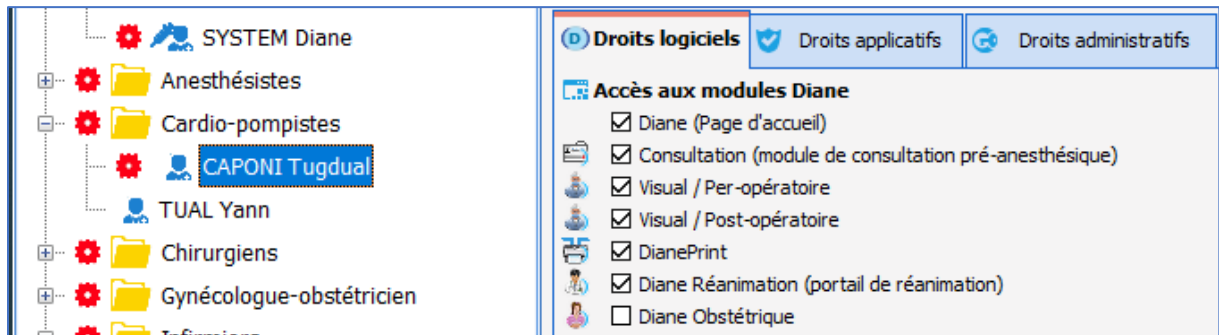


There are two ways to reactivate a category:

- Drag and drop the user to the relevant **User category**
- Right-click the user and select **Cut**. The category is shown in grey and italics, and can then be pasted (with a right-click) into the relevant category.

## 5.2.8 Gears

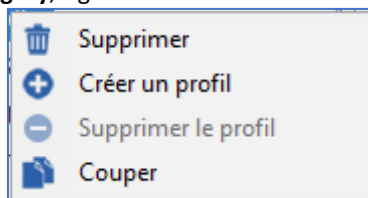
Permissions are managed using gears . It is not possible to modify permissions associated with a category or user if there is no gear allocated to the row.



In the example above, the permissions of Yann Tual are those set up for the **user category** perfusionists.

If the settings for the **user category** perfusionists are modified, only *Yann Tual* will be affected by the modifications. *Tugdual Caponi* is not affected: he has his own configuration.

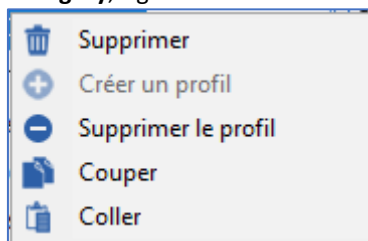
To **add a gear** to a **user** or **user category**, right-click the row.



Select **Create a profile**: the settings for this new **gear** will be those of the next row with a **gear** when moving up the tree structure.

In the example above, if a gear is created for *Yann Tual*, it will have the same settings but this will be modifiable. A “copy” of the settings from the **user category** perfusionists will be attributed.



To **delete a gear** from a **user** or **user category**, right-click the row.




Select **Delete a profile**: the settings now applied to this row will be those of the next row with a **gear** when moving up the tree structure.

In the example above, if the **gear** on *Tugdual Caponi* is deleted, he will share the same configuration as *Yann Tual*, i.e. that of perfusionists.



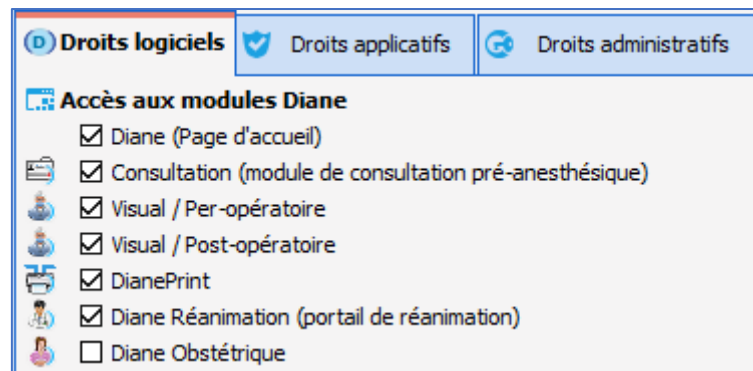
There is another way to **Create a profile** or **Delete a profile** without using a right-click: the corresponding buttons:  and .

## 5.2.9 Permission management

For a row with a gear , it is possible to modify the permissions associated with the category or user depending on the situation.

A permission is represented by a label and a check box.

The image below shows that for the row with a gear , it is possible to launch all modules except **DIANE OB-GYN**.



In order to grant permission to launch **DIANE OB-GYN**, check the box and save the change.

Permissions are divided into three categories:

### Software permissions:

These permissions control the launching of the modules. The most simple example is to compare user accounts and DIANE expert account: users are not able to launch the two configuration tools, unlike experts.

Droits logiciels	Droits applicatifs	Droits administratifs
<b>Accès aux modules Diane</b>		
<input checked="" type="checkbox"/>	Diane (Page d'accueil)	
<input checked="" type="checkbox"/>	Consultation (module de consultation pré-anesthésique)	
<input checked="" type="checkbox"/>	Visual / Per-opérateur	
<input checked="" type="checkbox"/>	Visual / Post-opérateur	
<input checked="" type="checkbox"/>	DianePrint	
<input checked="" type="checkbox"/>	Diane Réanimation (portail de réanimation)	
<input checked="" type="checkbox"/>	Diane Obstétrique	
<input checked="" type="checkbox"/>	RDV (Gestion des rendez-vous)	
<input checked="" type="checkbox"/>	DiaCompta (Module de comptabilité)	
<input checked="" type="checkbox"/>	CCAM / CIM10 (Gestion des codes CIM10/CCAM)	
<input checked="" type="checkbox"/>	MAJImpressions (Gestion des impressions et des verrous)	
<input checked="" type="checkbox"/>	Requêtes (Interrogation de la base de données Diane)	
<input checked="" type="checkbox"/>	FusionDossier (Fusion des dossiers en doublon)	
<input checked="" type="checkbox"/>	DiaMessagerie (Messagerie inter-postes)	
<input checked="" type="checkbox"/>	Configuration (Configuration des listes)	
<input checked="" type="checkbox"/>	UserConfig (Configuration des utilisateurs)	
<b>Fenêtre de selection de patient</b>		
<input checked="" type="checkbox"/>	Changer de site dans les filtres de recherche	
<input checked="" type="checkbox"/>	Visualiser un dossier d'un autre secteur (concerne Visual et la Consultation)	

#### Application permissions:

These permissions control the possible actions in the different modules, for example for the **Consultation** module:

Droits logiciels	Droits applicatifs	Droits administratifs
<b>Consultation</b>		
<input checked="" type="checkbox"/>	Créer un patient (modification des données administratives seules)	
<input checked="" type="checkbox"/>	Visualiser un dossier	
<input checked="" type="checkbox"/>	Créer/Modifier un dossier	
<input type="checkbox"/>	Modifier un dossier clôturé	
<input checked="" type="checkbox"/>	Imprimer un dossier	
<input checked="" type="checkbox"/>	Imprimer les prémédications	
<input checked="" type="checkbox"/>	Imprimer l'ordonnance de bilans	

#### Administrative permissions:

These permissions are used to limit where experts can intervene. This can be done to specialise or to avoid mistakes.

Droits logiciels	Droits applicatifs	<b>Droits administratifs</b>
<b>Droits de modification des listes complètes (listes sur la droite dans l'application Configuration)</b> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Listes de CONSULTATION</li> <li><input checked="" type="checkbox"/> Listes des EVENEMENTS</li> <li><input checked="" type="checkbox"/> Listes des MEDICAMENTS</li> <li><input checked="" type="checkbox"/> Listes des CHRONOMETRES</li> <li><input checked="" type="checkbox"/> Listes des EXAMENS et des BILANS</li> <li><input checked="" type="checkbox"/> Listes des SAISIES MULTIPLES</li> </ul>		

**NOTE:** default permissions allow the different modules to be used coherently. They can be modified but with caution: there are interactions between the permissions.

## 5.3 Configuration of facility organisation

This facility configuration tool is used to modify the organisation of rooms and the potential location of workstations in the facility.

### 5.3.1 Tree structure organisation

The facility is subdivided according to the hierarchy **Hospital > Unit > OT > Room > Bed > Computer**. The facility hierarchy is created on installation. This tool is used to add, delete or rename entities (**Hospital, Unit, OT, Room or Bed**) and move or delete workstations (computers).

**NOTE:** in this tool, the notion of gears is not used and therefore does not appear.

### 5.3.2 Add a workstation

This tool is not used to add a workstation. When a workstation is to be configured in **DIANE**, start the computer and launch **DIANE**. Once access has been validated, the workstation location is requested.

**Localisation du poste**

Sélectionnez l'établissement, le service, le bloc et la salle auxquels votre poste est actuellement rattaché :

Etablissement

Service

Bloc

Salle

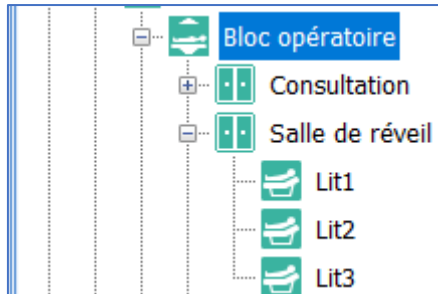
Fonction de la salle : Réanimation / USC

Once this initial location selection has been completed, the workstation appears in the tool in the location indicated.

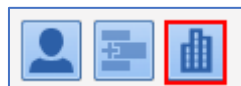
### 5.3.3 Adding an entity to the facility tree structure

Adding an entity to the tree structure allows the facility tree structure to be kept up to date. It also allows for some special features to be used.

To add, click the entity to which the new entity should be added. In this example, a second **Recovery room** is added by clicking on the **Operating Theatre** row.



To the top right of the screen, select the entity addition button:



It is then possible to create the new entity:

The 'Propriétés' form contains the following fields and controls:

- Nom :
- Identifiant Externe :
- Couleur :
- Type :
- UF :
- Fonction :
- Email :
- Téléphone :
- Finess :
- Buttons: Enregistrer (with green checkmark), Annuler (with red X), and Plan...

The **name** appears in the facility tree structure.

The **type** corresponds to the hierarchical level of the entity:

<b>Hospital</b>	Corresponds to the facility.
<b>Unit</b>	Groups together several <b>OTs</b> .
<b>OT</b>	Groups together all rooms for a patient care plan.
<b>Room</b>	Groups together at least one <b>computer</b> - it is often the <b>room</b> , rather than the <b>computer</b> , that is configured.
<b>Bed</b>	To be taken into account, a bed must be associated with a computer.
<b>Computer</b>	A computer can be assigned several beds - for recovery or CCU for example.

**Function** is only relevant for the **room**:

<b>OT</b>	Classic configuration of OT.
<b>Secretariat</b>	Used to assign a patient to a workstation.
<b>ICU/CCU</b>	Used to function in <b>Main - Mirror</b> mode. A <b>Mirror</b> computer is used to access a record opened on the <b>Main</b> computer remotely.
<b>Consultation</b>	Used to automate the creation of a new consultation, with the current user as the consultation anaesthetist and the current date as the consultation date.
<b>Recovery</b>	Enables anaesthesia signature management for authorising patient departures. Ensure at least one recovery bed is assigned to the workstation found in the recovery room. Otherwise, the portal considers it to be an OT: recovery room signature is nevertheless maintained.
<b>Induction</b>	Functions as a recovery room but with no recovery departure signature and it must be before the OT: this allows the patient to be found in the scheduled list in the OT.
<b>Other</b>	
<b>Delivery room</b>	
<b>Monitoring</b>	Used to configure workstations on mobile trolleys so that the user can care for their assigned patients without logging in each time they change patient. Patient admission is not possible.
<b>Ambulatory</b>	Used to discharge a patient remotely.

### 5.3.4 Searching for a workstation, room or user

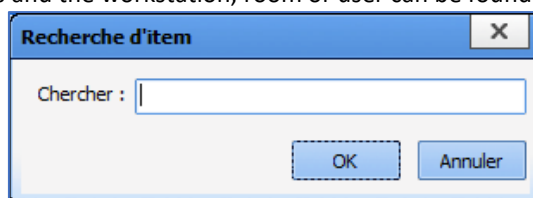
On opening, the tool selects the current workstation. Click the refresh button to find the current workstation:



To find a workstation, you can search for it in the facility tree structure.



The following window opens and the workstation, room or user can be found using part of their name.



If the row suggested by the search engine is not correct, click **F3** on the keyboard to access the **list** of search engine suggestions.

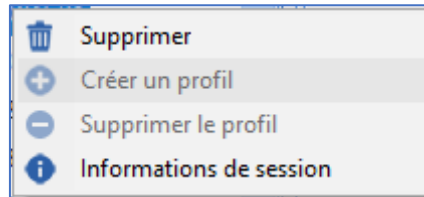
NOTE: the presence of users in this tool is only useful for the **DIANE Appointment** module.

### 5.3.5 Adding a user for the Appointment module

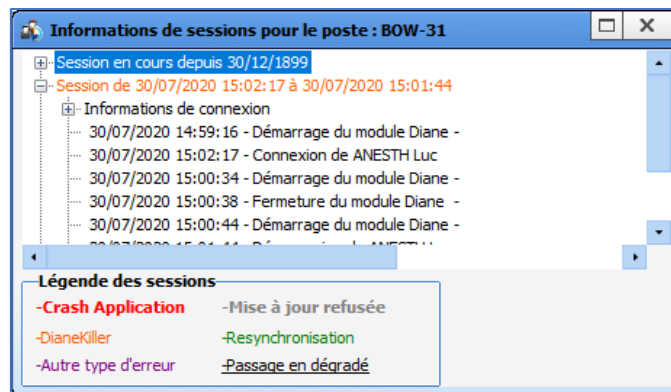
It is possible to add a user in this part of the tool. Users created in the user part of this tool are found at the bottom of the facility tree structure in the **Unclassified users** category. They must then be moved to the relevant unit. It is possible to find them by name using the search engine and move them into the relevant unit with drag-and-drop or cut-paste.

### 5.3.6 Inspecting workstation history

Right-clicking a workstation in the facility tree structure shows this menu:

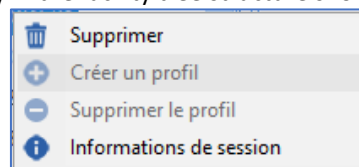


The Session information option shows log-in information for this workstation in the following window.



### 5.3.7 Deleting a workstation or room

Right-clicking a workstation or entity in the facility tree structure shows this menu:



Delete moves the workstation or entity to the bottom of the facility tree structure in the **Deleted entities** category. Following the instructions to **Move a workstation, room or user**, it is possible to move these rows with the mouse using drag and drop.

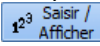
It is also possible to delete a workstation or entity using the delete button in the button bar at the top of the facility tree structure:

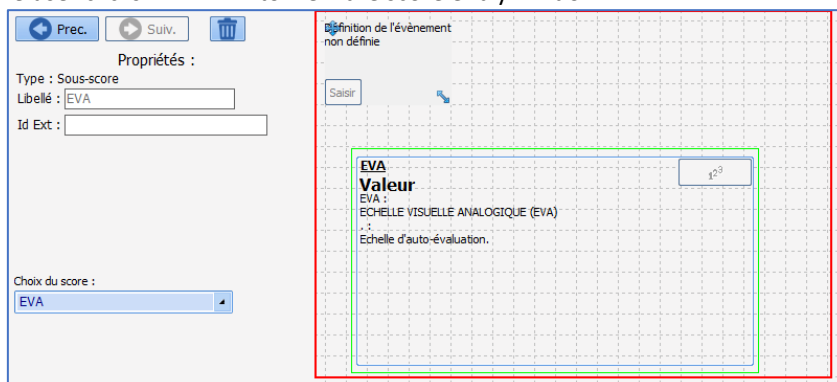


## 6 ANNEXES

### 6.1 Components exclusively used in detailed entries

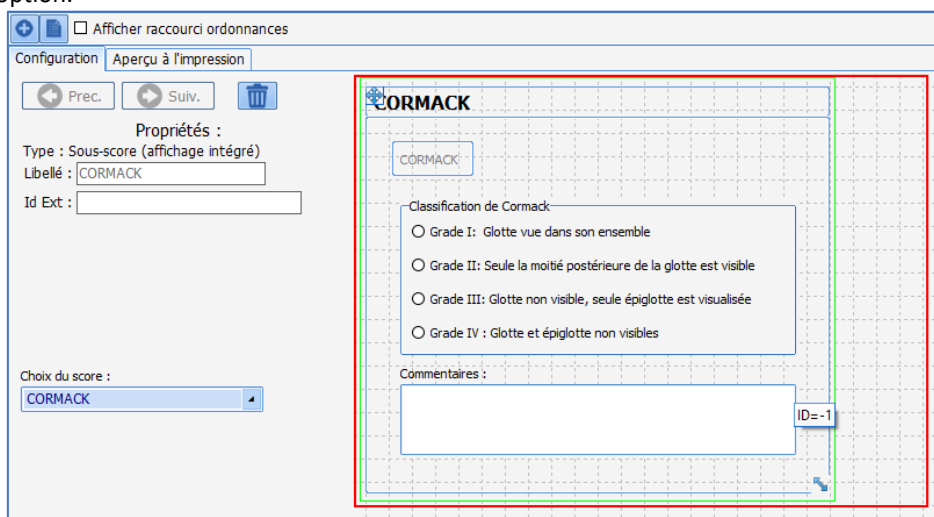
#### 6.1.1 Subscore

This component is used to easily enter a score in a detailed entry. Simply select the score and resize the component. The user clicks  to view the score entry window.



#### 6.1.2 Subscore (integrated display)

As with the previous component, this component is used to easily enter a score in a detailed entry. Simply select the score and resize the component. The score is entered directly in the component, unlike the previous option.



#### 6.1.3 Predefined values button

This component is used to complete the various components (check boxes, radio button and/or check box groups, one-line and/or multi-line input fields, etc.) with values set up during configuration. It is possible to determine whether or not deleting the data entered in the components remaining blank during editing of

the component using the check box **Do not reset other fields**.

ne pas RAZ autres champs

## 6.1.4 DIANE data

This component is used to display 3 types of **DIANE** data:

- **Record data** (associated with an ActiveX and a data ID)

Configuration du champ de données Diane  
 Type de données Diane: Données du dossier  
 ActiveX de donnée: Antécédent  
 Id de donnée: Antécédents allergiques

- **Vital signs:**

Configuration du champ de données Diane  
 Type de données Diane: Paramètres physiologiques  Données non modifiables  
 Paramètres physiologiques:  
 Fc(ecg) - Fréquence cardiaque à partir de l'ECG  
 Fc(pn) - Fréquence cardiaque à partir de la PNI  
 Fc(SpO2) - Fréquence cardiaque à partir de la SPO2  
 SpO2 - Saturation en oxygène du sang artériel  
 PNIs - Pression artérielle systolique par voie non invasive  
 PNIIm - Pression artérielle moyenne par voie non invasive  
 PNIId - Pression artérielle diastolique par voie non invasive  
 PIs - Pression invasive systolique 1  
 PIm - Pression invasive moyenne 1  
 Paramètre(s) sélectionné(s): Poids

- **Laboratory results:**

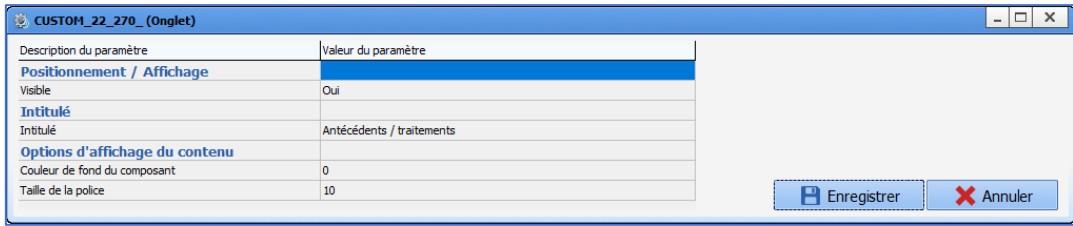
Configuration du champ de données Diane  
 Type de données Diane: Résultats de laboratoire  Données non modifiables  
 Résultats de laboratoire disponibles:  
 FNC (ZSFNC)  
 G.G.T. (GGT)  
 Gentamicine (GEN)  
 Germe (GRMDY)  
 Germe 1 (EXGE)  
 Germe anaérobies (MATAG)  
 Glycémie (GLY)  
 Gram 1 (EXGR)  
 Gram 1 (POGR1)  
 Gram 1 (URGRA)  
 Gram 2 (EXGR2)  
 Gram 2 (URGR2)  
 Résultats de laboratoire paramétrés pour le champ:  
 Globules rouges (HEMA)  
 Globules blancs (LEUCO)

## 6.1.5 Components only used in display configuration

### 6.1.5.1 Tab

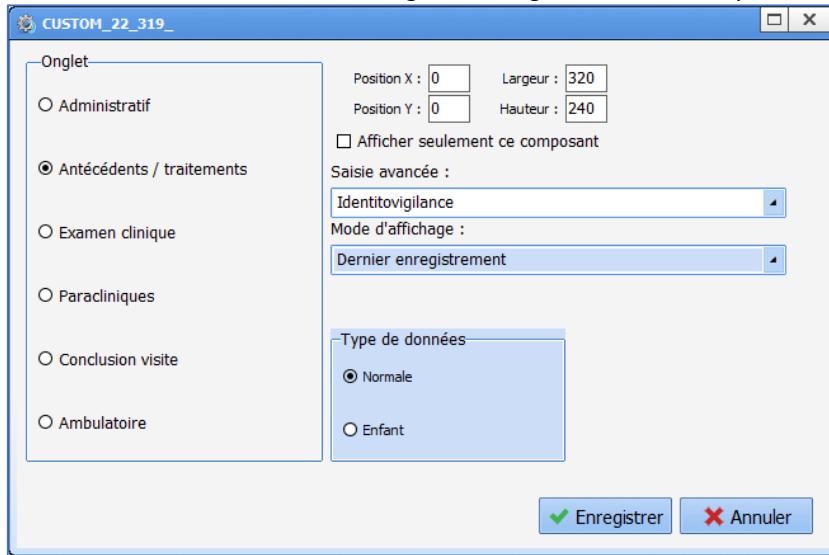
This component is used for the configurations of **DIANE ANAESTHESIA (Visual (IntraOp and PostOp))**, **DIANE OB-GYN** and **DIANE ICU**. It is used to add a subtab to tabs that allow this.





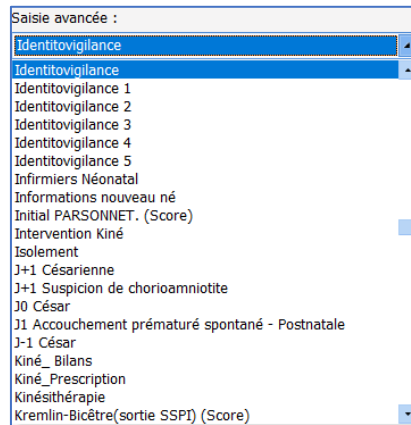
### 6.1.5.2 Detailed entry (basic view)

This component is used to view items entered during the editing of a detailed entry.

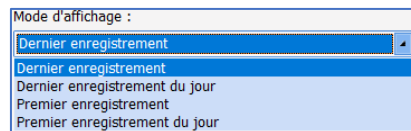


The two settings for this component are:

- **Detailed entry:**



- **Display mode:**



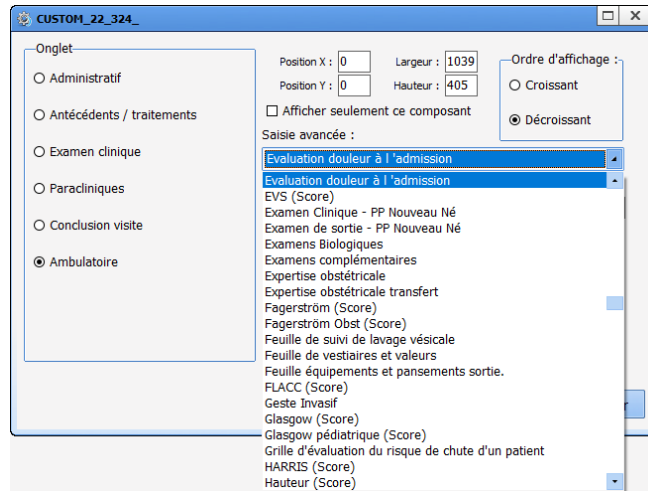
The check box **View this component only** changes the component size so it takes up the whole tab.

It is also possible to use non-toggled detailed entries.

### 6.1.5.3 Detailed entry (multi-view)

As with the previous option, this component is used to show detailed entries, although previous entries remain fully visible and displayable. It is also possible to use non-toggled detailed entries.

Here, the only settings are the selection of the **Detailed entry** and the **Display order (Ascending or Descending)**.



### 6.1.5.4 Nursing notes

The **Nursing notes** (specific and summary) component cannot be resized (it always takes up the whole subtab), moved from one subtab to another, or edited.

It must simply be given a subtab, no settings are required.

### 6.1.5.5 Treatments

This component is used to synchronise and thus retrieve the usual treatments entered in Consultation.

Description du paramètre	Valeur du paramètre
<b>Positionnement / Affichage</b>	
Visible	Oui
Onglet parent	Traitements
Position horizontale en pixel	0
Position verticale en pixel	0
Largeur en pixel	468
Hauteur en pixel	315
Ordre de tabulation	0
Nom du composant parent (Conteneur déployable)	
<b>Intitulé</b>	
Intitulé	Traitements
Taille de la police de l'intitulé	10
Intitulé en gras	Oui
<b>Options d'affichage du contenu</b>	
Couleur de la police de l'intitulé	0
Couleur quand une valeur est saisie	0
Couleur quand le composant est vide	16053493
Couleur de fond du composant	16053493
Taille de la police	10
<b>Options des données associées</b>	
Accès en écriture du champ	Ecriture
Niveau d'importance du champ	Élément normal
Historique activé	Oui
Valeur de saisie "RAS"	
Niveau de la reprise	Jamais repris
<b>Options de la saisie avec liste de référence</b>	
Liste générale de la première colonne	Consultation
Liste générale de la deuxième colonne	Consultation
Root de référence de la deuxième colonne	

ActiveX de donnée

Antécédent

Id de donnée  Non utilisés uniquement

Antécédents: Traitements

Cacher les boutons

Forcer saisie voie et unité

**Conflicts avec les autres configurations**

Enregistrer Annuler

It is important that the ActiveX/data ID pain used in the Consultation module is copied.

**NOTE: By default, the component connects to the Vidal or BCB database cache.**

### 6.1.5.6 Deployable container



The deployable container is a component used to simplify the display: it is possible to insert other components that are only visible when the container is expanded.

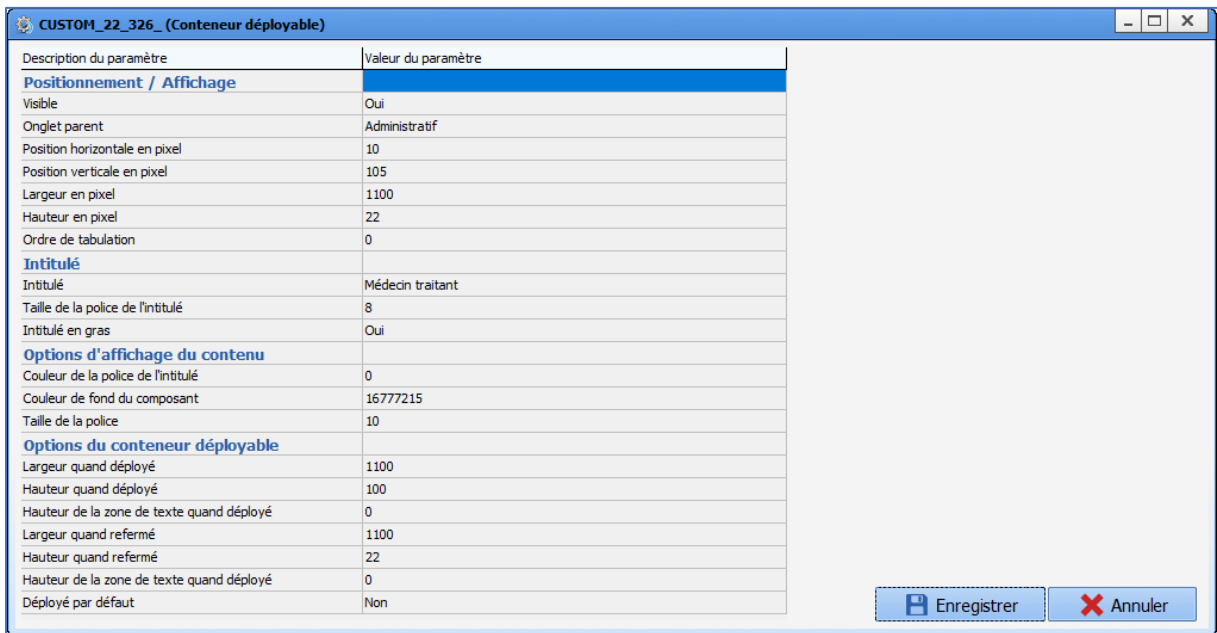
*Folded container:*

<b>Informations patient</b>		Né(e) le	Lieu de naissance	N° IPP	N° de S.S.	Situation de famille	Profession
Adresse		Code postal	Ville	Téléphone	Mobile	Adresse email	
<b>Médecin traitant</b>							
<b>Intervention</b>		Anesthésiste en CS		Chirurgien(s) prévu(s)			
Date de consultation	Date Prévue d'intervention						
Service demandeur	Durée chirurgie prévue						

*Expanded container:*

<b>Informations patient</b>		Né(e) le	Lieu de naissance	N° IPP	N° de S.S.	Situation de famille	Profession
Adresse		Code postal	Ville	Téléphone	Mobile	Adresse email	
<b>Médecin traitant</b>							
<b>Médecin traitant</b>		Nom		Prénom		Adresse	
		Code postal		Ville			

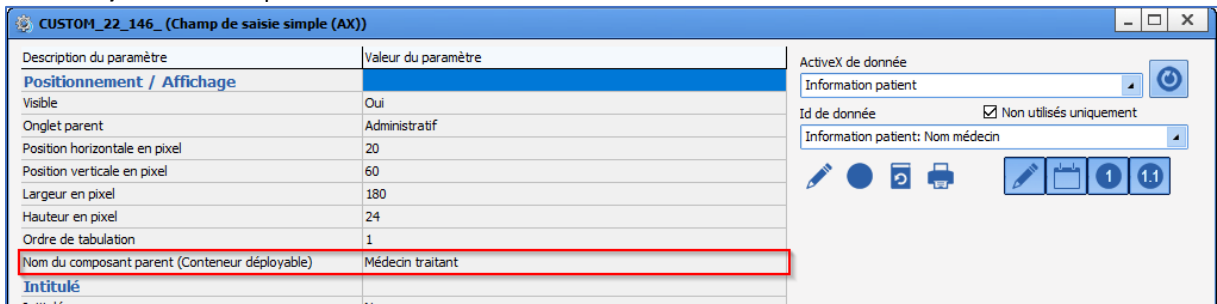
The container is expanded using  and folded using .



Description du paramètre	Valeur du paramètre
<b>Positionnement / Affichage</b>	
Visible	Oui
Onglet parent	Administratif
Position horizontale en pixel	10
Position verticale en pixel	105
Largeur en pixel	1100
Hauteur en pixel	22
Ordre de tabulation	0
<b>Intitulé</b>	
Intitulé	Médecin traitant
Taille de la police de l'intitulé	8
Intitulé en gras	Oui
<b>Options d'affichage du contenu</b>	
Couleur de la police de l'intitulé	0
Couleur de fond du composant	16777215
Taille de la police	10
<b>Options du conteneur déployable</b>	
Largeur quand déployé	1100
Hauteur quand déployé	100
Hauteur de la zone de texte quand déployé	0
Largeur quand refermé	1100
Hauteur quand refermé	22
Hauteur de la zone de texte quand déployé	0
Déployé par défaut	Non

The important settings for this component are its folded and expanded size.

To add each component to be included in the container, the setting **Parent component name (deployable container)** must be completed:



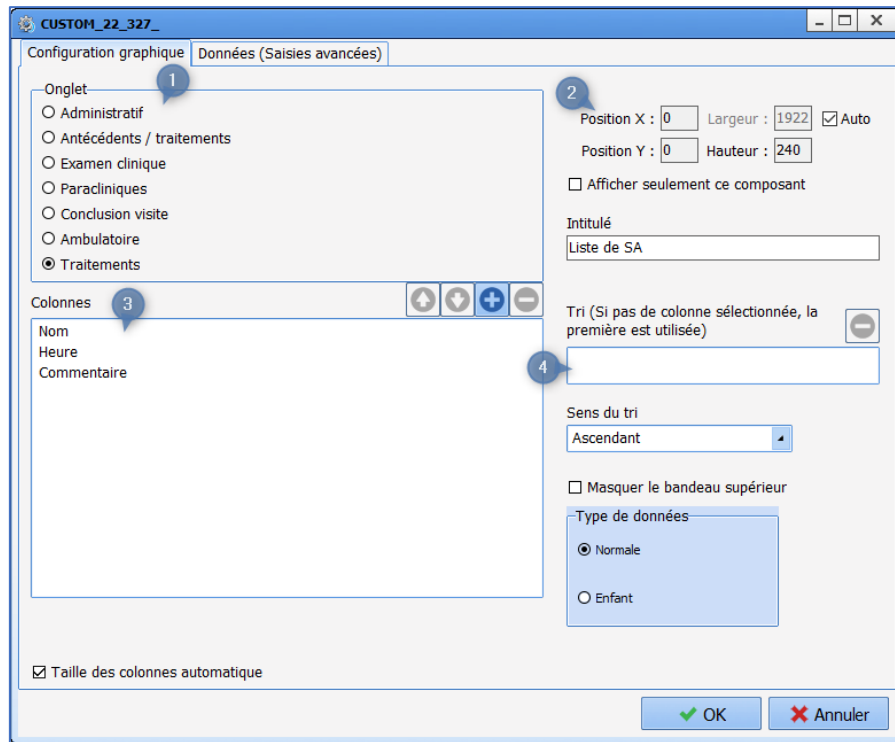
Description du paramètre	Valeur du paramètre
<b>Positionnement / Affichage</b>	
Visible	Oui
Onglet parent	Administratif
Position horizontale en pixel	20
Position verticale en pixel	60
Largeur en pixel	180
Hauteur en pixel	24
Ordre de tabulation	1
Nom du composant parent (Conteneur déployable)	Médecin traitant
<b>Intitulé</b>	
Intitulé	Nom


The location of components inside the container is set using **Horizontal position in pixels** and **Vertical position in pixels**.

### 6.1.5.7 Display detailed entries as list


This component is used to show various detailed entry fields in the form of a table. Settings are carried out using two tabs:

The first **Chart configuration** tab is used to configure the appearance of the component.

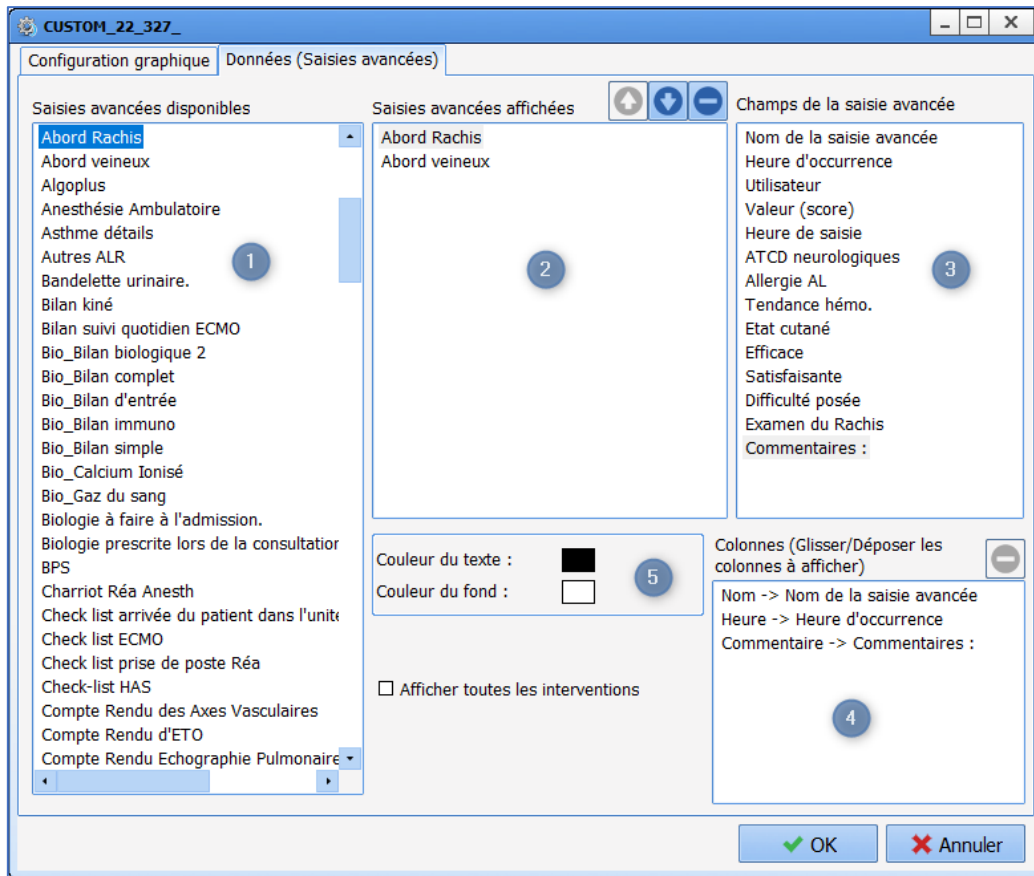


1. This pane is used to select the subtab in which the component appears.
2. This pane is used to select the position of the component in the subtab and its size. The check box **View this component only** means that only this component is displayed in the subtab: it then takes up the whole surface of the subtab. The name corresponds with the displayed component name.
3. This pane is used to configure the table columns displayed in the component:  
The content of the columns can be **Text**, **Date/time** or **Number**.  
The buttons  are used to change the column order, add or delete columns. The name can be changed: to do this, click the label to be changed twice (not quickly) to activate editing.
4. This pane is used to sort information: by default, sorting is carried out according to the first column, but it is possible to sort using a different column by selecting it (drag and drop to **Sort** field).



To sort using a different column, the previously set column must first be removed using .

The second tab **Data (Detailed Entries)** is used to define the detailed entries the user can enter:



1. List of available detailed entries and scores (toggled or not).
2. List of detailed entries and scores shown in the component.
3. Detailed entry field selected in pane 2.
4. Fields used by various columns (to be set up for each detailed entry or score shown).
5. For each detailed entry or score, it is possible to set the text and background colour for easier identification.

Liste de SA		
Nom	Heure	Commentaire
Abord Rachis	06/11/2020 10:27:33	
Abord veineux	06/11/2020 10:27:41	

### 6.1.5.8 Allergies

This component is used to synchronise and thus retrieve the allergy history entered in Consultation.

**CUSTOM\_18\_120\_ (Allergies)**

Description du paramètre	Valeur du paramètre
<b>Positionnement / Affichage</b>	
Visible	Oui
Onglet parent	Admission
Position horizontale en pixel	1320
Position verticale en pixel	500
Largeur en pixel	410
Hauteur en pixel	189
Ordre de tabulation	34
Nom du composant parent (Conteneur déployable)	
<b>Intitulé</b>	
Intitulé	Allergies médicamenteuses
Taille de la police de l'intitulé	10
Intitulé en gras	Non <input type="checkbox"/>
<b>Options d'affichage du contenu</b>	
Couleur de la police de l'intitulé	0
Couleur quand une valeur est saisie	16309708
Couleur quand le composant est vide	16053493
Couleur de fond du composant	16053493
Taille de la police	10
<b>Options des données associées</b>	
Accès en écriture du champ	Ecriture
Niveau d'importance du champ	Élément normal
Historique activé	Oui
Valeur de saisie "RAS"	
Niveau de la reprise	Jamais repris
<b>Options de la saisie avec liste de référence</b>	
Liste générale de la première colonne	0
Root de référence de la première colonne	
Liste générale de la deuxième colonne	0
Root de référence de la deuxième colonne	
Largeur de la première colonne	0
Largeur de la deuxième colonne	0

ActiveX de donnée: Antécédent

Id de donnée: Antécédents allergiques  Non utilisés uniquement

Confits avec les autres configurations

Enregistrer Annuler

It is important that the ActiveX/data ID pair used in the Consultation module is copied.

**NOTE: By default, the component connects to the Vidal or BCB database cache.**

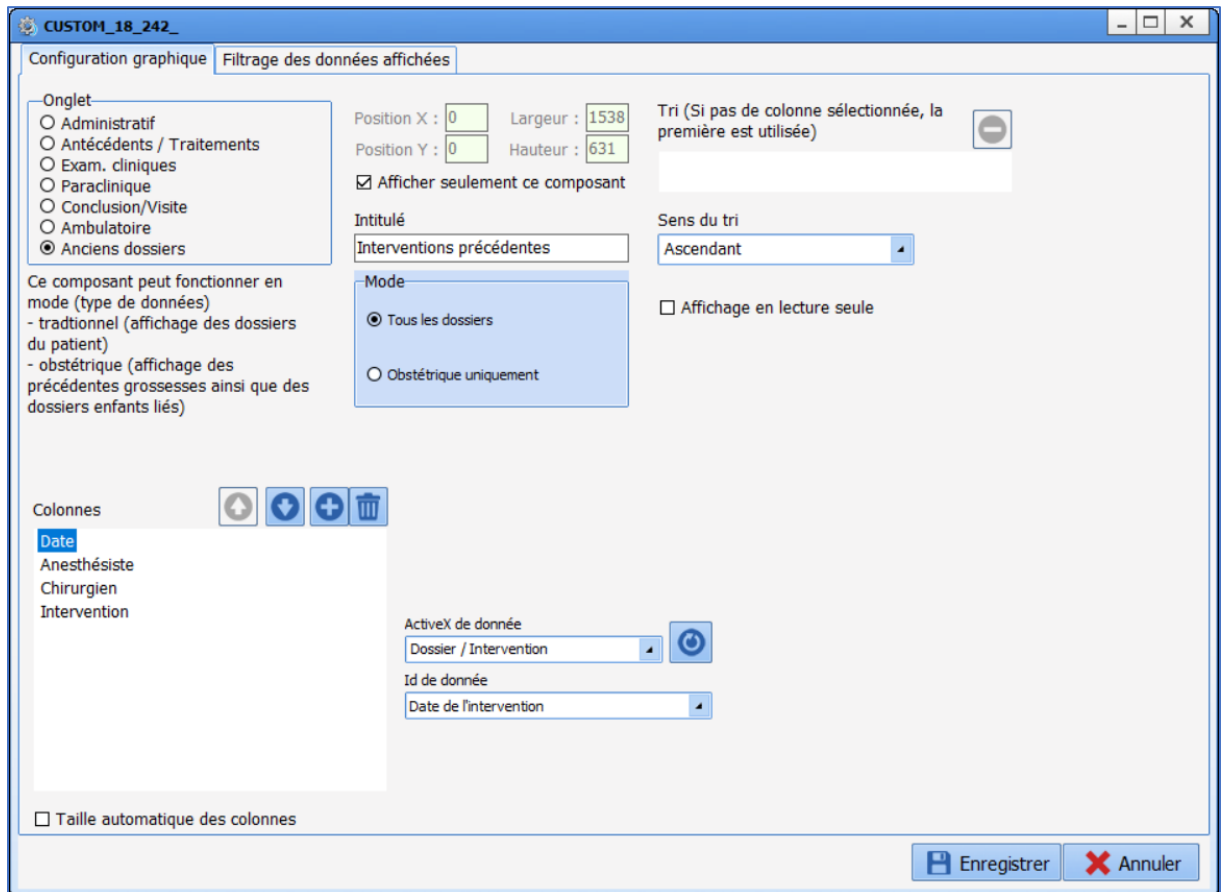
### 6.1.5.9 Display patient records as a list

This component is used to view information from previous patient records.

Nombre de dossiers : 1 (1)

Interventions précédentes				
Date	Anesthésiste	Chirurgien	Intervention	
18/12/2020	ANESTH Anna	CHIR Jean	Ablation du fil métallique	

The columns can be configured (number, names, content). The content is determined by the ActiveX/data ID pair.

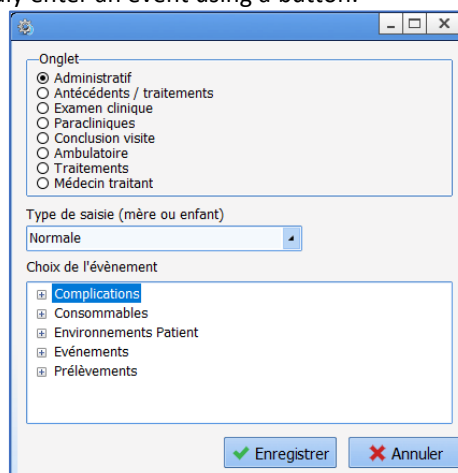


#### 6.1.5.10 Selector of child records to be processed

This component is only useful for **DIANE OB-GYN**. No settings are required, it must simply be sized and moved to the required location.

#### 6.1.5.11 Event entry via button

This component is used to rapidly enter an event using a button.



Any event can be selected, regardless of whether it is toggled in the **Events** tab, from the categories **Complications**, **Consumables**, **Patient environments**, **Events** and **Samples**.



### 6.1.5.12 View (type 3)

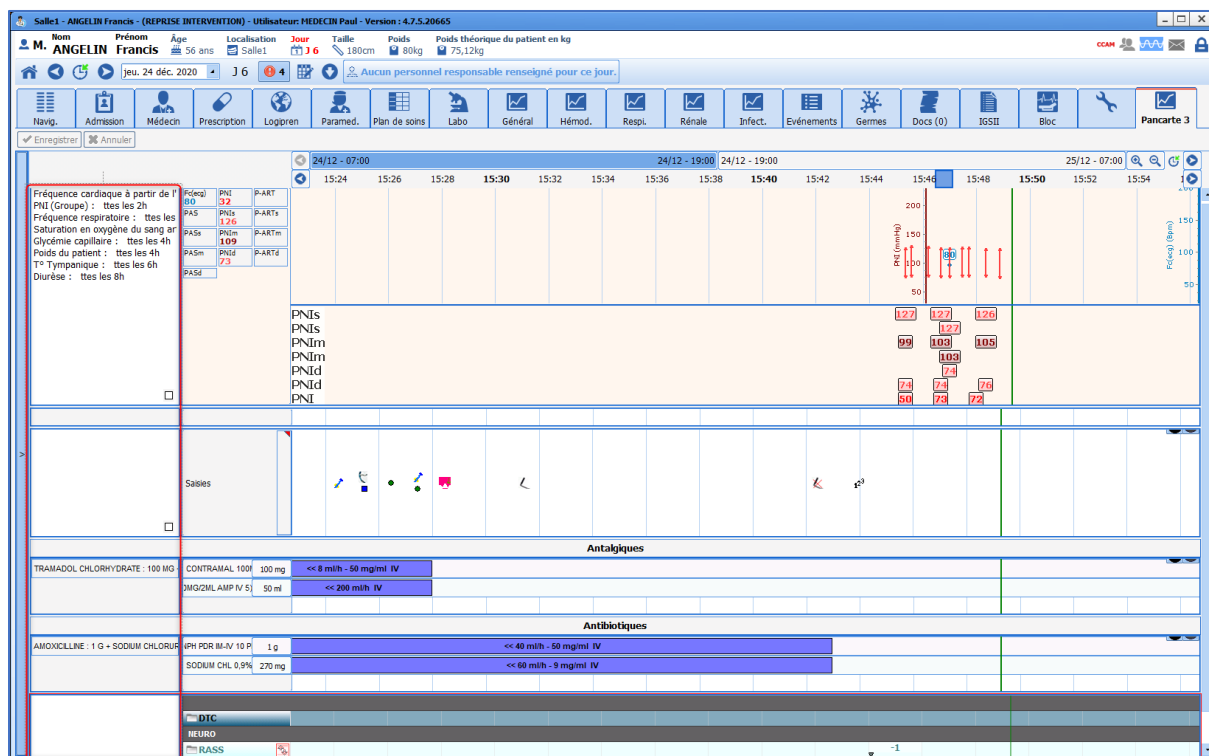
View 3 is a hybrid view, combining the functions of the monitoring view and the care plan view.

It is possible to see all the data available in the patient record:

- Graphically for **vital signs, scores, drugs, fluid balance and blood products.**
- As a table for **events, blood products, fluid balance, detailed entries.**

The **entry bar** found in the monitoring view is also available.

The left side (framed in red) is the dedicated pane for **medication orders**. Once validated by the doctor, medication orders automatically appear in this pane.

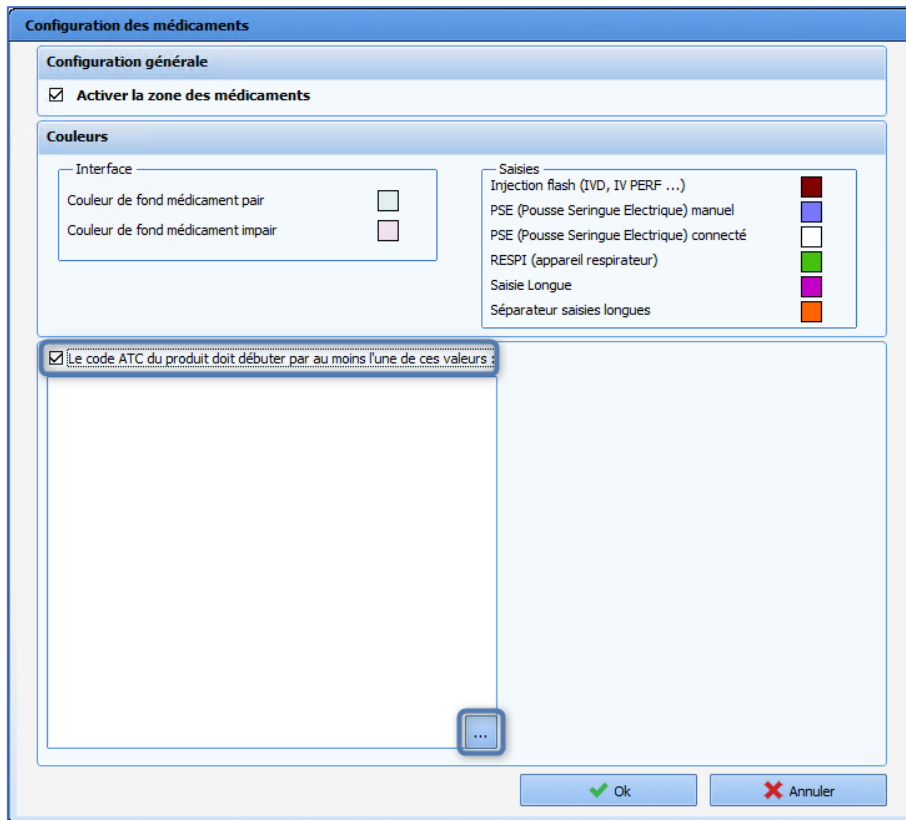


The number of bands can be set. A band can contain:

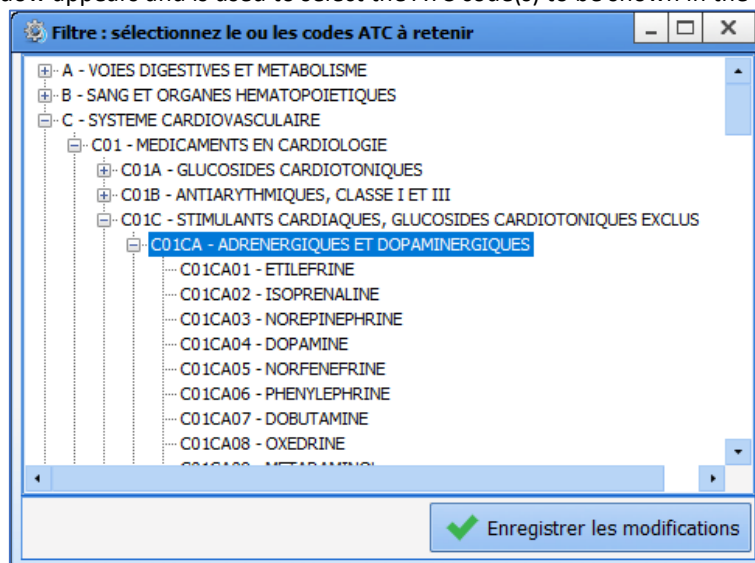
- A **DIANE** grid.
- A chart of prescribed drugs.
- A chart of vital signs.
- An events bar.
- A free text pane.
- A chart of non-prescribed drugs.
- A chart of drugs.
- A field pane.

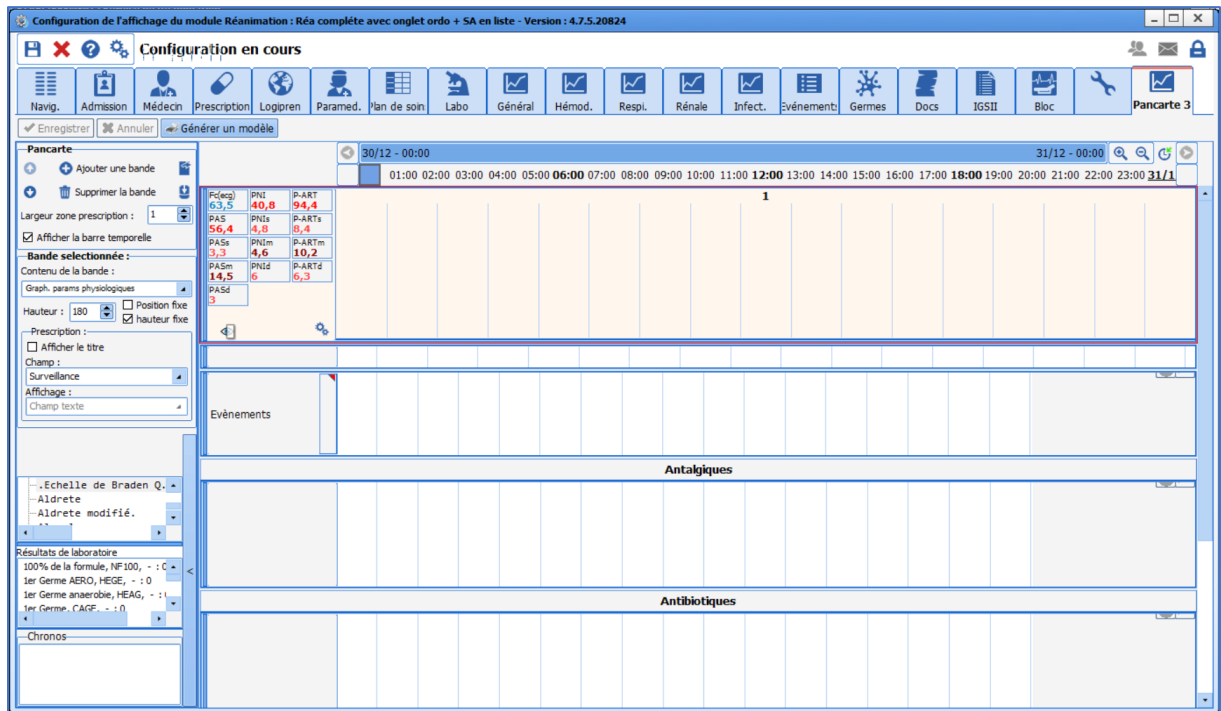
#### Special case: prescribed drugs chart:

It is possible to filter prescribed drugs using their ATC code by ticking the **ATC code must start with at least one of these values** box:



The following window appears and is used to select the ATC code(s) to be shown in the chart.





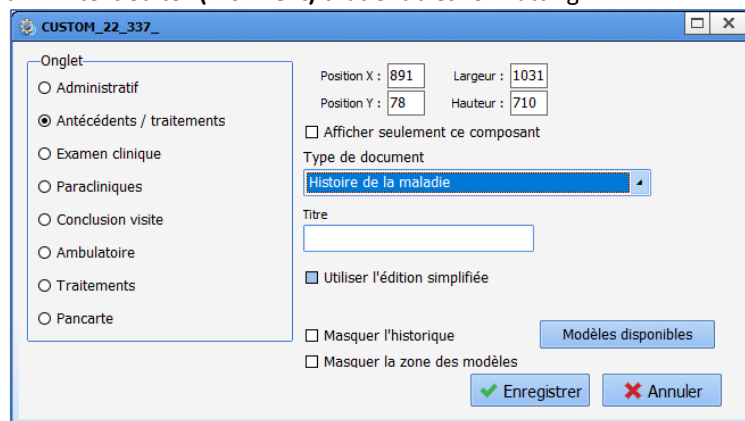
The configuration of the display of vital signs is identical to the **Monitoring (DIANE ANAESTHESIA) / Operating Theatre (DIANE ICU)** tab: *Setting up vital signs for display.*

### 6.1.5.13 Pregnancy type selection

This component is only useful for **DIANE OB-GYN**. No settings are required, it must simply be sized and moved to the required location.

### 6.1.5.14 Document editing pane

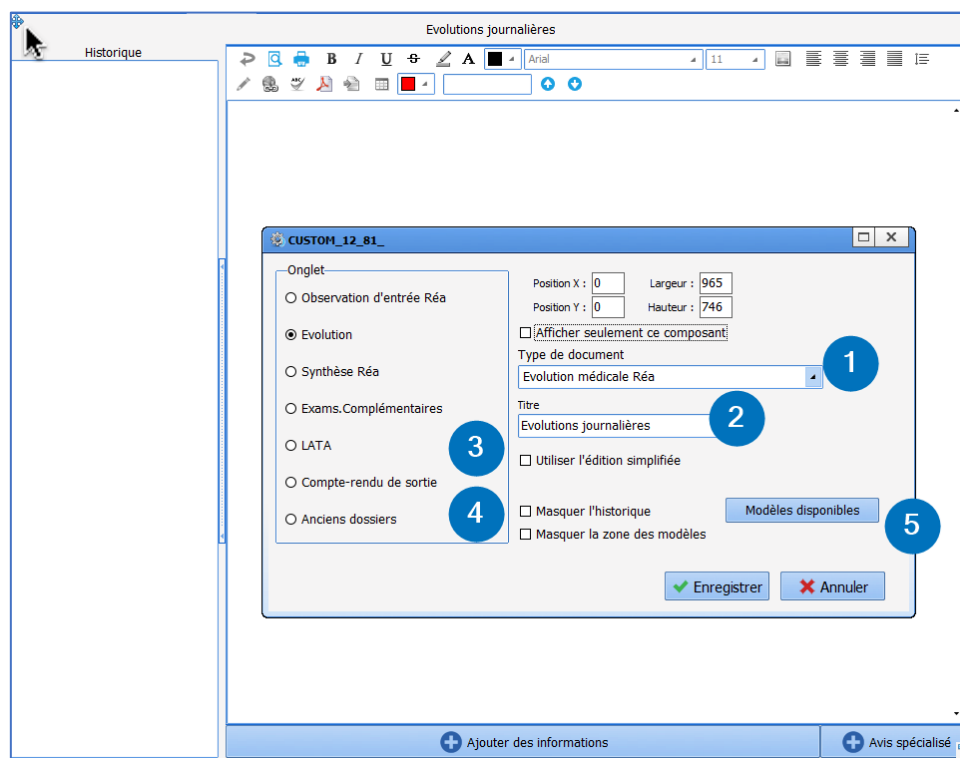
This component is a mini text editor (**Rich Text**) that enables formatting.



It is used to edit various document types:

- What to do (Obstetrics)
- Obstetric summary
- Anaesthesia discharge report
- Other discharge report
- ICU discharge report
- CCU discharge report
- Medical developments Anaesthesia

- Medical developments ICU
- Medical developments CCU
- Paramedical developments Anaesthesia
- Paramedical developments ICU
- Paramedical developments CCU
- Obstetric notes
- Clinical examination on admission
- Paraclinical examinations
- Disease history Anaesthesia
- Disease history ICU
- Disease history CCU
- Other medical summary
- Medical summary ICU
- Medical summary CCU
- Paramedical summary other
- Paramedical summary ICU
- Paramedical summary CCU



Right click the **blue icon** to the top left of the component to **edit** the settings window.

1. **Document type:** used to select a type of document (e.g. medical developments ICU...) The **document type** is used to record information in the database in the same way as ActiveX/data IDs. To use several different text boxes in the app, the same document type must not be selected.
2. **Title:** used to enter the name.
3. **Use simplified editing:** this function is used to enter information in the component without using the

- “Add information” button.
4. **Hide history:** used to hide the history pane on the left of the component. It can be opened by clicking the arrows.
  - Hide the template pane:** used to reduce the template selection pane when no template is configured.
  5. **Available templates:** used to configure templates to be made available from this component.

Drag and drop to select the available templates.

### Modèles paramétrés

Veuillez choisir le ou les modèles qui pourront être importés dans le composant

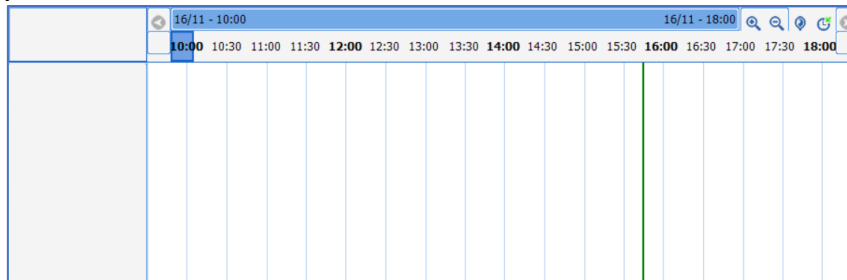
Liste des modèles	Modèles paramétrés
1er gaz du sang Admission Antécédents Balance Liqu. CR_Sortie de Réa Dernier gaz du sang Derniers param.vitaux Evol. jour. Résumé de Séjour Tansmissions	Antécédents Balance Liqu. Derniers param.vitaux Evol. jour. 1er gaz du sang Dernier gaz du sang

OK  Annuler

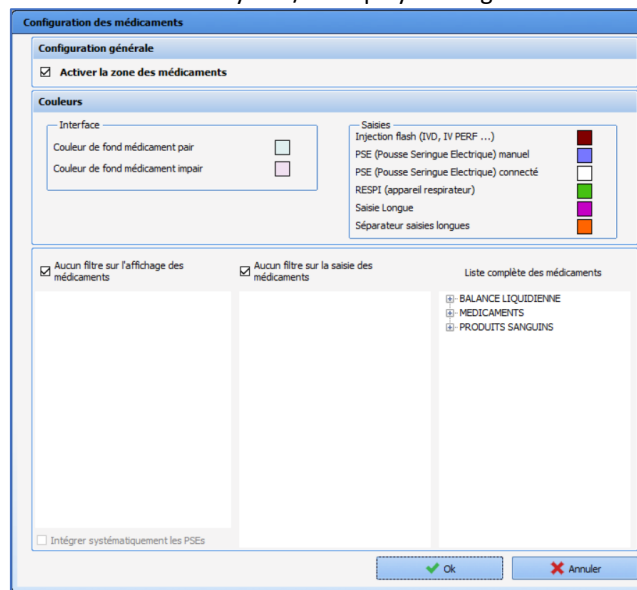
**NB:** It is possible to determine an automatic template on first editing the component.

### 6.1.5.15 Children drugs pane

This component is used to add a drug pane (see illustration below) for each child using the **Selector of child records to be processed**.

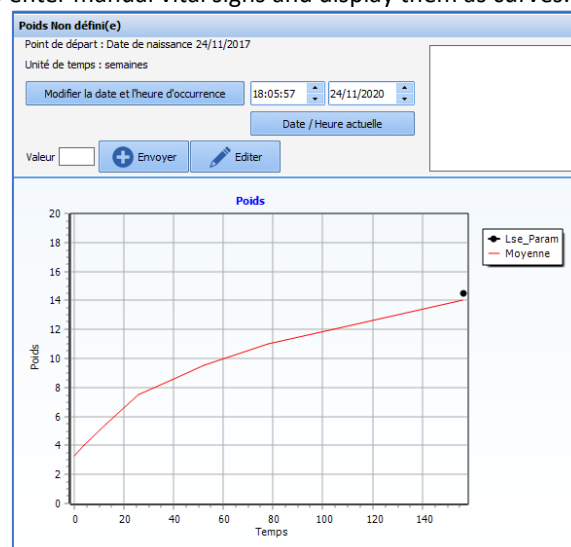


It is possible to set colours and filter the entry and/or display of drugs.



### 6.1.5.16 Curve pane for manual vital signs

This component is used to enter manual vital signs and display them as curves.



To configure this component, first select the manual vital sign (or group). The curve colour can be changed

and it is possible to show values on the chart. Data type must be **Normal**, except for OB-GYN records (**Mother** or **Child**).

The x-axis and y-axis can be set up. The time units available for use are hours, days and weeks. The starting item may be start of intervention, date of birth, start of pregnancy or an event. For an event, it must be chosen from the events (toggleed or not).

Reference curves can show, for example, percentile or average curves. To configure them, first click **Add a curve**, then **Coordinates**. The following window opens, from which you can define a curve by entering the coordinates of its points, with the units defined in the **General configuration** of the component for the y-axis data and in **X-axis** for time.

**Ajout de coordonnées**

+ Ajouter une ligne...

X	Y
0	3.3
4	4
13	5.5
26	7.5
39	8.5
52	9.5
78	11
104	12
156	14

✓ Valider    ✗ Annuler

### 6.1.5.17 List of documents from old records

This component is used to show documents entered in previous patient records.

Anciens documents (Evolutions médecin)

Dossier du 24/11/2020 au 24/11/2020    Dossier du 13/06/2020 au 14/08/2020

Maintien de la noradrénaline à 2mg /h.

[Sur le plan neurologique:](#)

Patient sédaté. RASS-4. Pupilles réactives. Essai de réveil ce jour pour évaluation neuro.

**Paul MEDECIN le 25/08/2017 à 00:38**

[Sur le plan hémodynamique:](#)

Episode de tachycardie ventriculaire > à 200 Bpm / min. Puis ACR ayant nécessité un massage cardiaque externe et dose d'adré. et choc électrique externe.  
 3 gr de sulfate de magnésium.  
 300 mg de cordarone + relai PSE 600mg /jour .  
 100 mg de lidocaïne  
 3 gr de KCL en PSE.

Maintien de la prise en charge. ETT dans la matinée. Avec contrôle bio.

Entretien à prévoir avec la famille.

**CUSTOM\_18\_243\_**

Onglet

- Administratif
- Antécédents / Traitements
- Exam. cliniques
- Paraclinique
- Conclusion/Visite
- Ambulatoire
- Anciens dossiers

Position X :     Largeur :

Position Y :     Hauteur :

Afficher seulement ce composant

Type de document

✓ Enregistrer    ✗ Annuler

The available documents are:

- Doctor's notes



- Doctor summary
- Nursing notes
- Nurse summary
- Clinical examination on admission
- Paraclinical examinations
- Discharge report
- Disease history
- Obstetric summary
- Obstetric notes
- What to do (Obstetrics)

Only one document type can be configured per component.

### 6.1.5.18 Button for adding manual vital signs

This component is used to rapidly enter and/or edit a manual entry. Select the vital sign (or group of vital signs) and the unit.

### 6.1.5.19 Treatments and/or premedications pane

This component is used to view the patient's treatments and/or premedications.

Seven display modes are available depending on user needs:

- **Full display** (treatments and premedications): panes 1, 2 and 3

- **Reduced treatments and premedications:** panes 2 and 3
- **All treatments:** panes 1 and 2
- **Treatments with signature:** pane 2
- **Treatments in read-only:** pane 2 without the yellow area or lower banner
- **Premedications with signature:** pane 3
- **Premedications in read-only:** pane 3 without the yellow area or lower band

In addition to these modes, it is possible to display or hide treatment conversions in the treatment area.

#### 6.1.5.19.1 Configuring the tab in the consultation module

In the consultation, the component is shown as a tab. It is configured via the consultation settings keys.

Nom du paramétrage : <b>Demo 1280x800 EMed Optim</b>	
Application ou module à paramétrer : <b>Consultation</b>	
Recherche d'un paramètre	
Champ(s) à considérer pour la recherche Tous	Texte à rechercher <input type="text"/> <input type="button" value="Rechercher"/>
<input checked="" type="radio"/> Vers le bas <input type="radio"/> Vers le haut <input type="checkbox"/> Différencier Min/Maj <input type="checkbox"/> Mot entier	
Description du paramètre	Valeur du paramètre
<b>Configuration générale</b>	
<b>Configuration de l'envoi des traitements en relais ou prescription d'entrée</b>	
ActiveX de référence pour les relais (ancien fonctionnement)	InfoPat
Identifiant de la donnée pour les relais (ancien fonctionnement)	21
ActiveX de référence pour les prescriptions d'entrée (ancien fonctionnement)	Consignes
Identifiant de la donnée pour les relais (ancien fonctionnement)	2
Mode d'affichage du nouvel onglet des traitements et prémédications, complet par défaut (=0)	Traitements sans signature
Mode d'affichage des traitements dans le nouvel onglet des traitements et prémédications, normal par défaut (=	Complet
Niveau de reprise des traitements du dossier	Traitements et prémédications avec signature Traitements complets Traitements avec signature Traitements sans signature
<b>Interaction avec le module RDV</b>	
<b>[DEBUG]</b>	
<b>Impressions</b>	Prémédications avec signature Prémédications sans signature

#### 6.1.5.19.2 Configuring the component in Visual or DIANE ICU

In **Visual** or **DianeICU**, the component can be placed in a subtab, alone or with other components.

**CUSTOM\_12\_114\_** □ ×

Onglet

Observation d'entrée Réa

**Traitements et prémédications**

Evolution

Synthèse Réa

Exams.Complémentaires

Engagement thérapeutique

Compte-rendu de sortie

Affichage des traitements  
 Complet     Sans conciliation

Position X :     Largeur :

Position Y :     Hauteur :

Afficher seulement ce composant

Mode d'affichage

Affichage complet

Traitements et prémédications réduits

Traitements complet

Traitements avec signature

Traitements en lecture seule

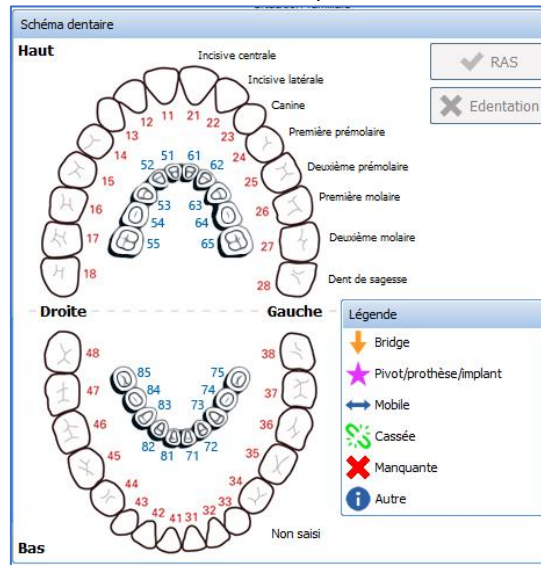
Prémédications avec signature

Prémédications en lecture seule

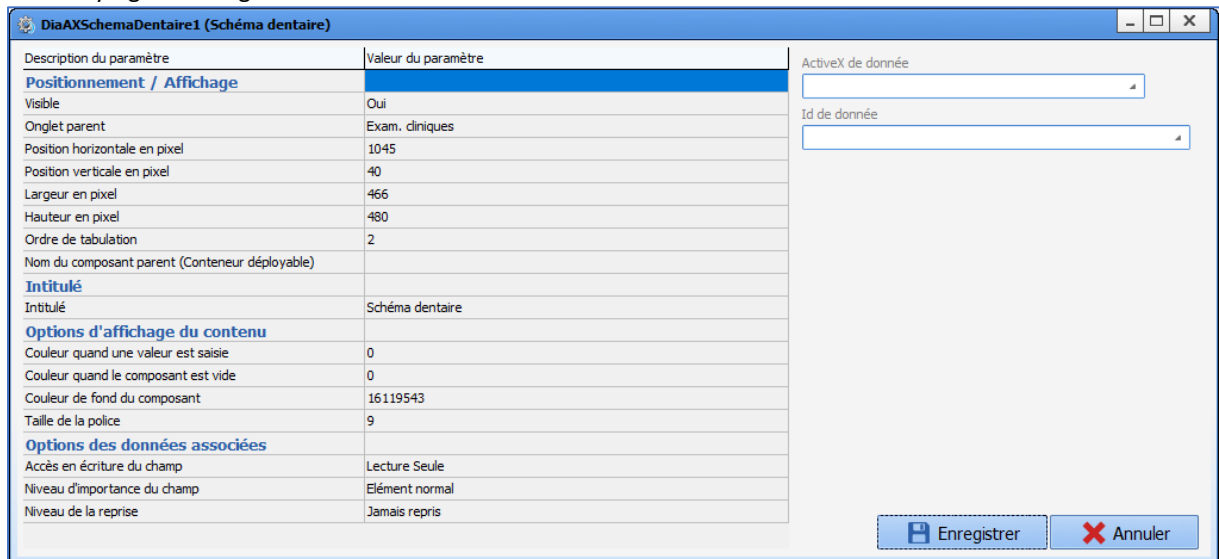
Ancré gauche     Ancré haut     Ancré droite     Ancré bas

### 6.1.5.20 Tooth chart

This component is used to list the tooth condition of the patient.

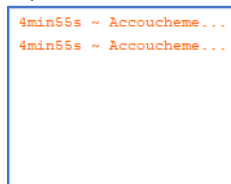


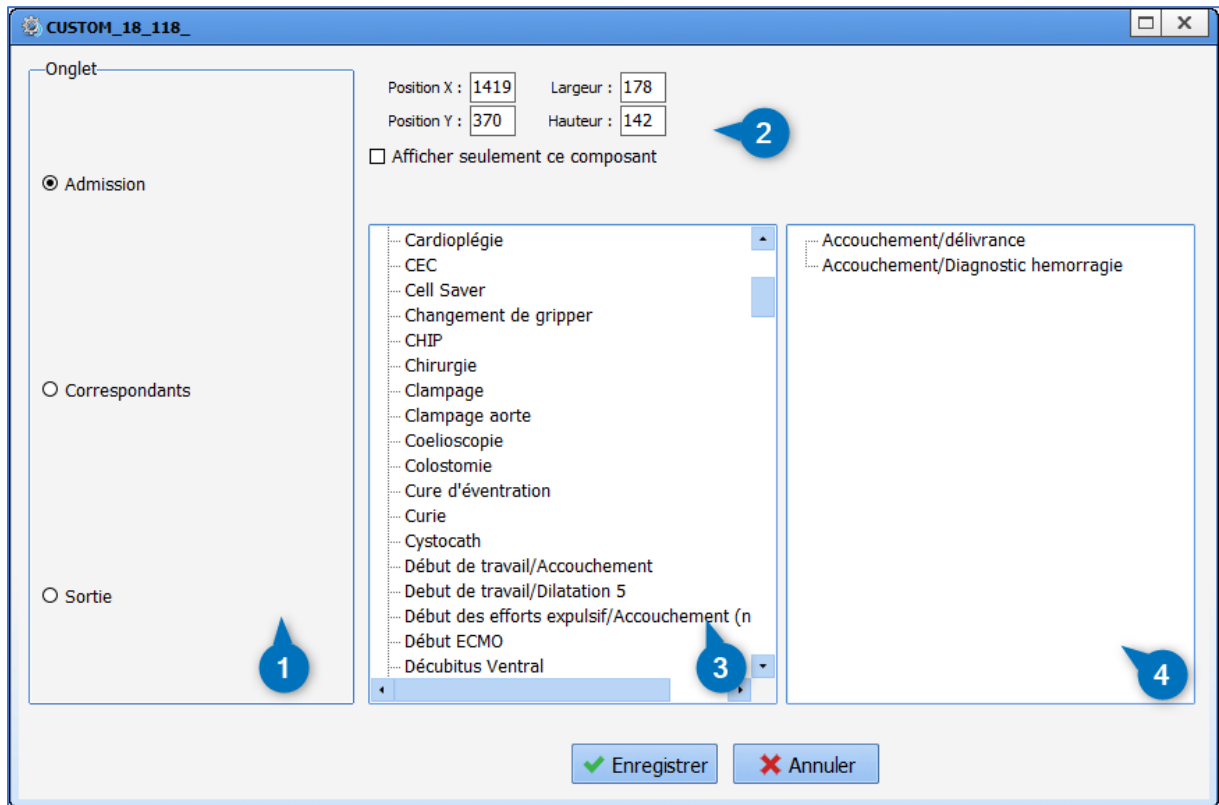
It can be moved by left-clicking the mouse on the component as a whole and cannot be resized. It can be edited by right-clicking.



### 6.1.5.21 Editable timers

This component shows a window with timers, similar to the one found on the **Monitoring** tab in **Visual**.

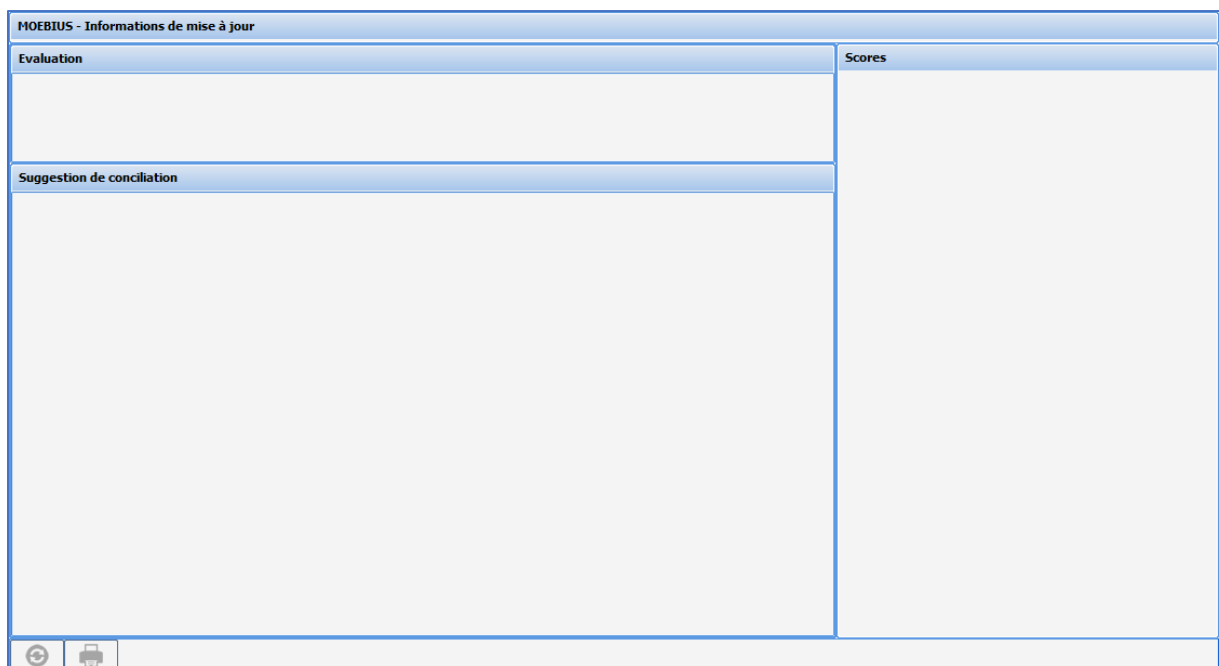


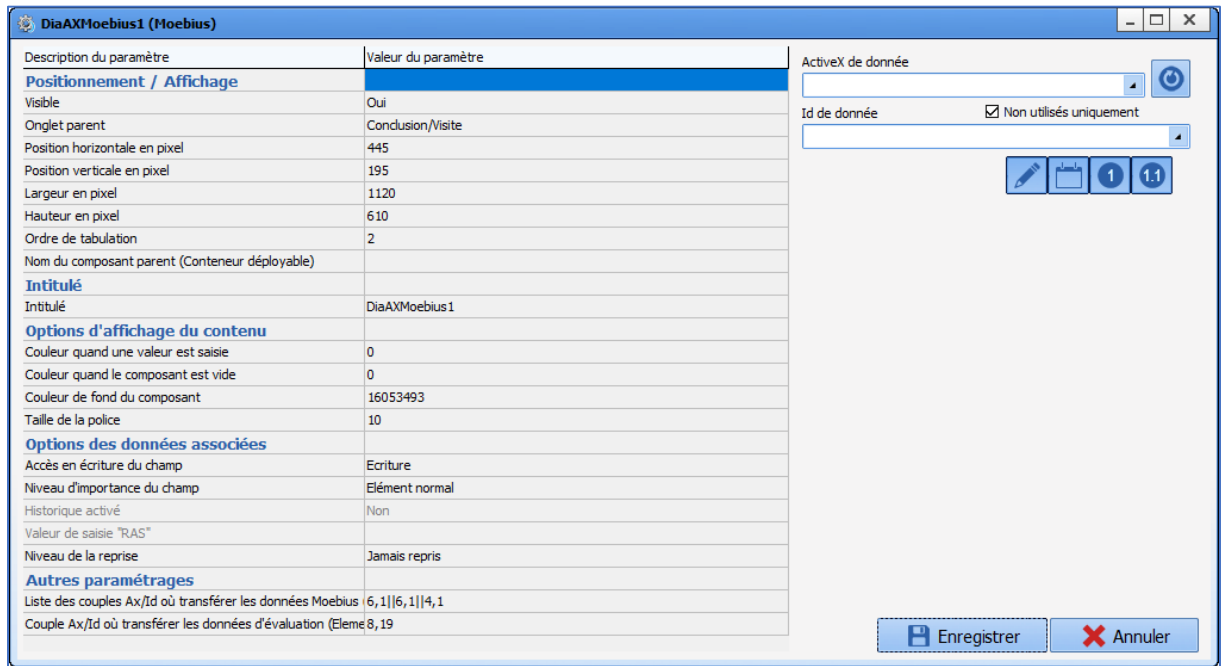


1. Tab on which the component appears.
2. Component position and size.
3. List of timers (toggled or not).
4. Configured timers (NB: only timers that have been toggled in the configuration are shown).

### 6.1.5.22 Moebius

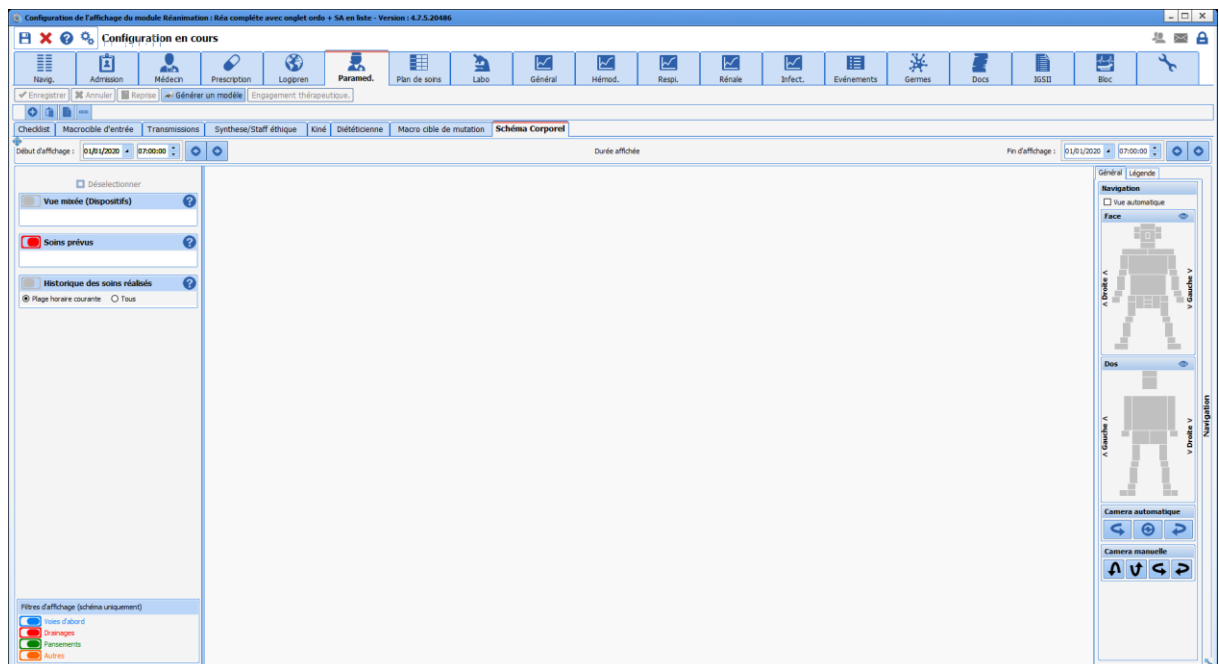
Moebius is a risk evaluation tool. It suggests suitable patient care and risk mapping.



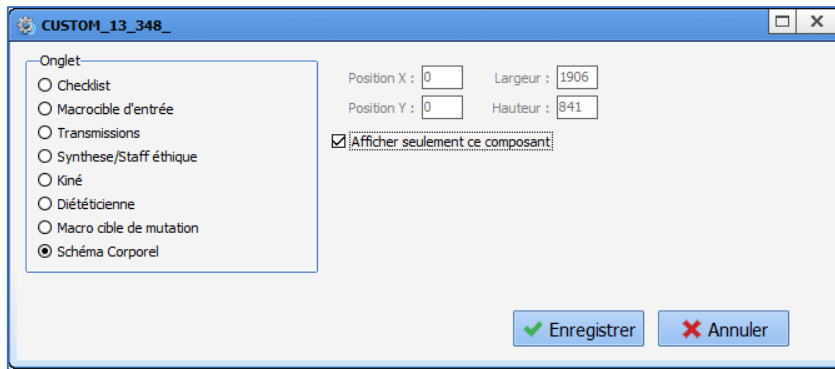


### 6.1.5.23 3D annotation diagram (Care plan)

This component is used to locate care directly on a 3D representation of the patient.



The only settings for this component are its location and size. The check box **View this component only** displays the component on the whole tab.




For the user to use it, forms must be created in the [Care items](#) tab.


## 6.2 List of ActiveX and Data IDs


Ax/ID pairs are used, amongst other things, to save patient data and print them if necessary. Some Ax/ID pairs cannot be used for anything other than their predefined role.

Below are lists of Ax and lists of the IDs relating to these Ax. Those with a specific role have an associated comment.

### Legend:

: calculated data (click the icon to shown information on the calculation)

: data print tag





: read-only data

### 6.2.1 List of ActiveX

- *Medical history*
- *Cardio/Respiratory examinations*
- *Intubation*
- *Biochemical testing*
- *Haematological examination*
- *Strategy (and order for blood products)*
- *Blood test*
- *Patient information*
- *Preoperative assessment*
- *Record information*
- *Record/Procedure*
- *Patient*
- *Post-op medication orders*
- *Ambulatory: Pre Op*
- *Ambulatory: Post Op*
- *ICU data*
- *Additional patient information*
- *OB-GYN data*
- *POA conclusion*
- *Clinical examination*
- *POA PED*
- *POA Obstetrics*
- *Stay field*
- *Other*











### 6.2.2 List of Data IDs

#### 6.2.2.1 ActiveX: Medical history














- |                      |   |
|----------------------|---|
| • <b>Allergic</b>    |  : ANTEC-ALLERGIQUES   |
| • <b>Anaesthesia</b> |  : ANTEC-ANESTHESIQUES |
| • <b>Cardiac</b>     |  : ANTEC-CARDIAQUE     |
| • <b>Surgical</b>    |  : ANTEC-CHIRURGICAUX  |

• Comment	 : ANTEC-COMPLICATIONS
• Surgical complication	 : ANTEC-COMPLICATION_OPERATOIRE
• Spouse: Habits, tobacco use etc.	 : ANTEC-CONJOINT
• Digestion	 : ANTEC-DIGESTIF
• Misc.	 : ANTEC-COMPORT_DIVERS
• Endocrinology	 : ANTEC-ENDOCRINOLOGIE
• Family	 : ANTEC-MEDICAUX
• Gravity	 : ANTEC-GESTITE
• Active gynae	 : ANTEC-GYNECO_ACTIFS
• Inactive gynae	 : ANTEC-GYNECO_INACTIFS
• Gynaecology	 : ANTEC-GYNECOLOGIE
• Habits, tobacco use etc.	 : ANTEC-HABITUS_TABAGISME
• Active medical	 : ANTEC-MEDICAUX_ACTIFS
• Inactive medical	 : ANTEC-MEDICAUX_INACTIFS
• Neurology	 : ANTEC-NEUROLOGIQUE
• Obstetrical	 : ANTEC-OBSTETRICAUX
• Ophthalmology	 : ANTEC-OPHTALMOLOGIE
• Parity	 : ANTEC-PARITE
• Pulmonary	 : ANTEC-PULMONAIRE
• NTR	 : ANTEC-RAS
• Renal	 : ANTEC-RENALE
• Risk of haemorrhage	 : ANTEC-RISQUE_HEMORRAGIQUE
• Snoring	 : ANTEC-RONFLEUR
• Treatments	 : ANTEC-TRAITEMENTS_ACTUELS
• Transfusional	 : ANTEC-TRANSFUSIONNELS
• Transfusional 2	 : ANTEC-TRANSFUSIONNELS_2
• Vascular	 : ANTEC-VASCULAIRE

### 6.2.2.2 ActiveX: Cardiopulmonary assessment











• CAT consultation other	 : EXAMEN_CARDIO-CAT_CONSULT_AUTRE
• Request for expert opinion	 : EXAMEN_CARDIO-DEMANDE_AVIS_SPECIALISE
• ECG	 : EXAMEN_CARDIO-ECG
• Cardio exam	 : EXAMEN_CARDIO-EXAMEN_CARDIO
• Additional pre-op exam	 : EXAMEN_CARDIO-EXAMEN_COMPLEMENTAIRE_PRE_OP
• Pulmo exam	 : EXAMEN_CARDIO-EXAMEN_PNEUMO
• Examinations	 : EXAM-CARDIO_RESPI
• Heart rate	 : EXAM-FC
• General	 : EXAMEN_CARDIO-GENERAL
• NYHA	 : EXAM-DYSPNEE














• Diastolic arterial pressure	 : EXAM-PA_DIASTO
• Average arterial pressure	 : EXAMEN_CARDIO-PRESSION_ARTERIELLE_MOYENNE
• Systolic arterial pressure	 : EXAM-PA_SYSTO
• NTR	 : EXAMEN_CARDIO-RAS
• Consultation summary other	 : EXAMEN_CARDIO-RESUME_CS_AUTRE
• Consultation summary cardio	 : EXAMEN_CARDIO-RESUME_CS_CARDIO
• Consultation summary pulmo	 : EXAMEN_CARDIO-RESUME_CS_PNEUMO
• RP	 : EXAMEN_CARDIO-RP
• Sat	 : EXAMEN_CARDIO-SAT
• ECG status	 : EXAMEN_CARDIO-STATUT_ECG
• RP status	 : EXAMEN_CARDIO-STATUT_RP
• Temp	 : EXAMEN_CARDIO-TEMP
• Vein	 : EXAM-VEINE

### 6.2.2.3 ActiveX: Intubation

















These Ax/ID pairs all correlate. These components can be completed using the “normal” button (without Ax/ID). Intubation score is calculated automatically.

• Dental condition	 : INTUB-ETAT_DENTAIRE
• Incisor	 : INTUB-INCISIVES
• Intubation	 : INTUB-TECHNIQUE
• Mallampati	 : INTUB-MALLAMPATI
• Cervical mobility	 : INTUB-MOBILITE
• Mouth opening	 : INTUB-OUVERTURE
• Patient profile	 : INTUB-PROFIL
• Dentures	 : INTUB-PROTHESE
• Intubation score 	 : INTUB-SCORE





### 6.2.2.4 ActiveX: Laboratory examination

• Ca	 : BILAN-CA++
• Cl	 : BILAN-CL-
• Serum creatinine	 : BILAN-CREAT
• Date/time	 : BILAN-DATE_BIOCHIMIE
• Blood sugar	 : BILAN-GLYCEMIE
• K	 : BILAN-K+
• Na	 : BILAN-NA+
• Phosphorus	 : BILAN-PHOSP
• Protein	 : BILAN-PROT
• Urea	 : BILAN-UREE
• Confirmed	 : BILAN-VALID_BIOCHIMIE












### 6.2.2.5 ActiveX: Haematological examination

• CAT	 : EXAMEN_HEMATO-CAT
• Date/time	 : BILAN-DATE_HEMATOLOGIE
• Documents tests scanned	 : EXAMEN_HEMATO-DOCS_BILANS_SCANNES
• Documents tests seen	 : EXAMEN_HEMATO-DOCS_BILANS_VU
• WBC Used by "NTR" intelligence for anaesthesia consultation	 : BILAN-GB
• WBC	 : EXAMEN_HEMATO-GBLANCS
• RBC	 : BILAN-GR
• HB	 : BILAN-HB
• Excl. taxes	 : BILAN-HT
• Platelets	 : BILAN-PLAQ
• Results tests bio	 : EXAMEN_HEMATO-RESULTATS_BILAN_BIO
• Exam status	 : EXAMEN_HEMATO-STATIT_EXAMENS
• APTT	 : BILAN-TCA
• PT	 : BILAN-TP
• BT	 : BILAN-TS
• Confirmed	 : BILAN-VALID_HAMATOLOGIE

### 6.2.2.6 ActiveX: Strategy (and order for blood products)

















• Command	 : CPA-COMMANDE_PRODUITS
• Instructions	 : CPA-CONSIGNES
• Premedication	 : CPA-PREMEDICATIONS
• PREMEDICATIONS OUTSIDE OF HOSPITAL	 : CPA-PREMEDICATIONS_HORS_HOPITAL

### 6.2.2.7 ActiveX: Blood test

• 1ST BB DETER	 : BILANSANGUIN1ERDETER
• 2ND BB DETER	 : BILANSANGUIN2EMEDETER
• Results brought	 : BILAN_SANGUIN-BILAN_AMENE
• Results scanned	 : BILAN_SANGUIN-BILAN_SCANNE
• Results seen	 : BILAN_SANGUIN-BILAN_VU
• CAT Group	 : BILAN_SANGUIN-CAT_GROUPE
• CAT IAS	 : BILAN_SANGUIN-CAT_RAI
• Comment	 : BILAN-COMMENTAIRE
• IAS validity criteria	 : BILAN_SANGUIN-CRITERES_VALIDITE_RAI
• IAS date/time	 : BILAN-DATE_RAI
• Last negative IAS	 : LABBLOODLASTNEGAS

• Blood sugar 2	 : POSTPANDRIAL_BLOOD_SUGAR
• Fasting blood sugar g/L	 : FASTING_BLOOD_SUGAR
• Blood sugar H0	 : GLYH0
• Blood sugar H1	 : GLYH1
• Blood sugar H2	 : GLYH2
• Blood sugar H3	 : BILANSANGUINGLYH3
• Fasting blood sugar g/L	 : FASTING_BLOOD_SUGAR
• Blood type	 : BILAN-GROUPE
• HbA1C	 : BILAN_SANGUIN-HB1AC
• Hepatitis B	 : BILAN-HEP_B
• Hepatitis C	 : BILAN-HEP_C
• HIV	 : HIV
• INR	 : BILAN_SANGUIN-INR
• Number of determinants	 : BILAN-NB_DETERM
• PCR	 : BILAN_SANGUIN-PCR
• IAS (Irregular Antibody Screening)	 : BILAN-RAI
• Redo IAS	 : BILAN-REFAIRE_RAI
• Result exam bio	 : BILAN_SANGUIN-RESULTAT_EXAMEN_BIO
• Result exam complete	 : BILAN_SANGUIN-RESULTAT_EXAMEN_COMPLETER
• Rhesus	 : BILAN-RHESUS
• Group card status	 : BILAN_SANGUIN-STATUT_CARTE_GROUPE
• Covid status	 : BILAN_SANGUIN-STATUT_COVID
• RAI status	 : BILAN_SANGUIN-STATUT_RAI
• ACT ratio	 : BILAN_SANGUIN-TCA_RATIO



### 6.2.2.8 ActiveX: Patient information







• Doctor's address	 : PATIENT-ADRESSE_MEDECIN
• Patient's age (with unit)	 : PATIENTAGEWITHUNIT
• ALR	 : CPA-ALR
• Ambulatory	 : CPA-AMBULATOIRE_POSSIBLE
• Authorisation	 : CPA-AUTORISATION
• Autotransfusion	 : CPA-AUTOTRANSFUSION
• Other information	 : CPA-INFOS_DONNEES
• BMI 	 : PATIENT-BMI
• Initial BMI 	 : PATIENT-BMI_INITIAL
• BSA 	 : PATIENT-BSA
• Doctor's post code	 : PATIENT-CODE_POSTAL_MEDECIN
• Comments	 : ANTEC-RELAIS
• Comments outside of hospital	 : CPA-RELAIS-HORS-HOPITAL

• Hospitalisation date	 : CPA-DATE_HOSPITALISATION
• Protection document given	 : INFOPAT-DOC_PROTEC_DONNE
• Protection document scanned	 : INFOPAT-DOC_PROTEC_SCANNE
• Protection document signed	 : INFOPAT-DOC_PROTEC_SIGNE
• Full stomach	 : CPA-ESTOMAC_PLEIN
• General examinations	 : EXAM-GENERAUX
• Entity ID	 : CPA-SERVICE_HOSPITALISATION
• Liver failure	 : INFOPATLIVERFAILURE
• Chronic diseases	 : CHRONIC_DISEASES
• Minor	 : INFOPAT-MINEUR
• Doctor's name	 : PATIENT-NOM_MEDECIN
• Room number	 : CPA-NUMERO_CHAMBRE
• Doctor's phone number	 : INFOPATDOCTORTELE
• Supplementary health policy number	 : PATIENT-NUMERO_MUTUELLE
• Usual NIPd	 : PATIENT-PNID_HABITUELLE
• Usual NIPs	 : PATIENT-PNIS_HABITUELLE
• Adjusted patient weight in kg 	 : INFOPATADJUSTEDWEIGHT
• Patient weight in kg	 : PATIENT-POIDS2
• Theoretical patient weight in kg 	 : PATIENT-POIDS_THEORIQUE
• Doctor's first name	 : PATIENT-PRENOM_MEDECIN
• Parent present	 : INFOPAT-PRESENCE_PARENTS
• Weight gain/loss (%) 	 : PRISE_PERTE_POIDS_PAGE
• Weight gain/loss (kg) 	 : PRISE_PERTE_POIDS
• Legal protection	 : INFOPAT-PROTEC_JURIDIQUE
• ASA score	 : CPA-ASA
• Risk of sepsis	 : CPA-RISQUE_SEPTIQUE
• Requesting unit	 : CPA-SERVICE_DEMANDEUR
• Summary	 : CPA-ELEMENTS_IMPORTANTS
• Height	 : PATIENT-TAILLE2
• Entry type	 : CPA-TYPE_ENTREE
• Doctor town	 : PATIENT-VILLE_MEDECIN
• Predicted maximum tidal volume 	 : PATIENT-VC_MAX_PREDIT
• Predicted minimum tidal volume 	 : PATIENT- VC_MIN_PREDIT

### 6.2.2.9 ActiveX: Preoperative visit








These Ax/ID pairs all correlate. Completing one of these items automatically completes the “done by” and “date” items.

- Fasting  : CPA-A\_JEUN
- Comment  : CPA-COMMENTAIRE\_VISITE





























• Date/time of pre-operative visit 	 : POVDATETIME
• Full record	 : CPA-DOSSIER_COMPLET
• Full name of user who carried out the preoperative assessment 	 : POVUSERNAME
• NTR since pre-op assessment	 : POVNTRSINCEPOV

### 6.2.2.10 ActiveX: Record information

• Anaesthesia	 : CPA-TECHNIQUE_ANESTHESIQUE
• Anaesthetist in consultation (automatically completed) Used by to automatically enter the name of the anaesthetist who carries out the consultation.	 : CPA-COMORBIDITE
• Anaesthetist carrying out anaesthesia consultation	 : CPA-ANESTH
• Anaesthetist(s)	 : CPA-ANESTHESISTE_PREVU
• Surgeon(s)	 : CPA-CHIRURGIEN_PREVU
• Circumstances	 : INTERV-CIRCONSTANCES
• Comment	 : CPA-COMMENTAIRE_INTERV
• Comments associated with personal treatment	 : COMMENT_TREATMENT
• Anaesthesia consent	 : INTERV-CONSETEMENT_ANESTH
• Transfusion consent	 : INTERV-CONSETEMENT_TRANSFUSION
• Date of preoperative assessment	 : DATE_PREOP
• Scheduled date	 : CPA-DATE_INTERV_PREVUE
• Supplementary fees	 : INTERV-DEPASSEMENT_HONORAIRE
• Expected duration	 : INTERV-DUREE_PREVUE
• Disease history	 : DISEASE_HISTORY
• Registered nurse anaesthetist(s)	 : CPA-INFIRMIER_PREVU
• Room ID	 : CPA-SALLE_PREVUE
• OT ID	 : CPA-BLOC_PREVU
• Recovery bed ID	 : CPA-LIT_PREVU
• Procedure information: admission type	 : ADMISSION_TYPE
• Information from EHR	 : INTERV-INFOS_PROVENANCE_DPI
• Location	 : INFOPROCEDURELOCATIONINFO
• Mode of admission (used for personal treatments)	 : ADMISSION_MODE
• Mode of admission validated	 : INTERV-MODE_ADMISSION_VALIDE
• Outpatient admission reason	 : MOTIF-HOSPI-AMBU
• Postpartum admission reason	 : MOTIF-HOSPI-PP
• ICU admission reason	 : MOTIF-HOSPI-REA
• Delivery room admission reason	 : MOTIF-HOSPI-SDN
• RR admission reason	 : MOTIF-HOSPI-SSPI
• Monitoring admission reason	 : MOTIF-HOSPI-SURV

• CCU admission reason	 : MOTIF-HOSPI-USC
• Pathology	 : CPA-PATHOLOGIE
• Position on table	 : INTERV-POSITION_TABLE
• Postoperative follow-up	 : ANTEC-SUIVI_POST_OP
• Remote consultation	 : INTERV-TELECONSULTATION
• Type	 : CPA-INTERV_REALISEE
• Scheduled type	 : CPA-INTERV_PREVUE

### 6.2.2.11 ActiveX: Record/Procedure

• Procedure anaesthetist	
• Procedure surgeon	
• Procedure date	 : CPA-DATE_INTERVENTION
• Procedure update date 	
• ICU start date/time	 : REA-DATE_DEBUT
• Recovery start date/time	 : INTERV-HEURE_DEBUT_REVEIL
• ICU end date/time	 : REA-DATE_FIN
• Recovery end date/time	 : INTERV-HEURE_FIN_REVEIL
• Date/time of discharge authorisation	 : INTERV-DATE_AUTORISATION_SORTIE
• Consultation printing update date/time	 : PROCEDUREDATEUPDATEPRINTPREOP
• Recovery medication order signature date/time 	 : INTERV- DATE_SIGNATURE_PRESCRIPTION
• Surgery status (ongoing, recovery, transit, etc.) 	
• Procedure start time	 : INTERV-HEURE_DEBUT
• Procedure end time	 : INTERV-HEURE_FIN
• Patient ID history 	
• Procedure registered nurse anaesthetist	
• DIANE ID of the mother's associated pregnancy record	 : PROCEDUREIDPREGNANCY
• Procedure OT ID	
• Procedure patient ID 	
• External procedure ID 	
• Internal ID of record 	
• Portal "To Do" list	
• Name of procedure OT	 : INTERV-BLOC
• Surgery record internal version number 	
• Custom portal display settings	
• Anaesthesia responsibility 	 : INTERV-RESPONSABILITE_ANESTHESIE
• Signatory of recovery discharge authorisation	 : INTERV-AUTORISATION_SORTIE
• Signatory of recovery medication orders 	 : INTERV-SIGNATURE_PRESCRIPTION
• Obstetrics record type 	 : TYPEDOSSIER-
• Pregnancy type	 : PROCEDUREPREGNANCYTYPE












### 6.2.2.12 ActiveX: Patient

These Ax/ID pairs are generally used by the interfaces to retrieve administrative data








• Patient's email address	 : PATIENT-EMAIL
• Patient's postal address	 : PATIENT-ADRESSE
• Patient age (years) 	
• Other first names of patient	 : PATIENT-AUTRES_PRENOMS
• Insee birth code:	 : PATIENT-NAISS_CODE_INSEE
• Patient's post code	 : PATIENT-CODE_POSTAL
• Correspondents	 : PATIENT-CORRESPONDANTS
• Patient's date of death	 : PATIENT-DATE_DECES
• Patient's date of birth	 : PATIENT-DATE_NAISSANCE
• Patient's UPI history	
• Diane ID of birth mother 	 : PATIENTID-BIRTH_MOTHER
• Patient's National Health Identifier	 : PATIENT-INS_VALUE
• Unique patient identifier (UPI)	 : PATIENT-NUMERO_IPP
• Regional unique patient identifier (UPI)	 : PATIENT- NUMERO_IPPREGIONAL
• Patient's birthplace	 : PATIENT-LIEU_NAISSANCE
• General practitioner	 : PATIENT-MEDEecin_TRAITANT
• Type of patient's NHI	 : PATIENT-INS_NATURE
• Patient's birth name	 : PATIENT-NOM_PATRONYMIQUE
• Name gone by	 : PATIENT-NOM_MARITAL
• Patient social security number	 : PATIENT-NUMERO_SS
• Additional patient phone number	 : PATIENT-TELEPHONE2
• Patient's phone number	 : PATIENT-TELEPHONE1
• Mother's geographic origin	 : ORIGINE-GEO-MERE-
• Dark-skinned patient	 : PATIENT-PEAU_NOIRE
• Patient's country	 : PATIENT-PAYS
• Patient's first name	 : PATIENT-PRENOM
• Name gone by	 : PATIENT-PRENOM_USUEL
• Patient's profession	 : PATIENTPROFESSION
• Patient's sex	 : PATIENT-SEXE
• Patient situation	 : PATIENT-SITUATION
• Patient's status	 : PATIENT-INS_STATUS
• Patient town	 : PATIENT-VILLE

### 6.2.2.13 ActiveX: Post-op medication orders


















These Ax/ID pairs are needed to print/export treatments from post-op medication orders.

• Food	 : PRESCRIPTION-BOISSON_ALIMENTATION
• Analgesic	 : PRESCRIPTION-ANTALGIQUE
• Antibiotic	 : PRESCRIPTION-ANTIBIOTIQUE
• Anticoagulant	 : PRESCRIPTION-ANTICOAGULANT
• Other	 : PRESCRIPTION-AUTRES
• Paraclinical	 : PRESCRIPTION-PARACLINIQUE
• ICU	 : PRESCRIPTION-REANIMATION
• Monitoring	 : PRESCRIPTION-SURVEILLANCE
• Treatment	 : PRESCRIPTION-REPRISE_TRAITEMENT
• Transfusion	 : PRESCRIPTION-TRANSFUSION
• Ventilation	 : PRESCRIPTION-VENTILATION









#### 6.2.2.14 ActiveX: Ambulatory: Pre Op

• Comment	 : AMBULPREOP-COMMENTAIRE
• Known orders	 : AMBULPREOP-CONSIGNES_CONNUES
• Admission time	 : AMBULPREOP-HEURE_ARRIVEE
• Time of last food intake	 : AMBULPREOP-HEURE_DERNIERE_ALIMENTATION
• Time of last fluid intake	 : AMBULPREOP-HEURE_DERNIERE_BOISSON
• Signature	 : AMBULPREOP-PERSONNEL
• Treatments	 : AMBULPREOP-TRAITEMENTS




#### 6.2.2.15 ActiveX: Ambulatory: Post Op

• Support person	 : AMBULPOSTOP-ACCOMPAGNANT
• Discharge criteria	 : AMBULPOSTOP-APTITUDERUE
• Ability to get up	 : AMBULPOSTOP-SELEVER
• Food	 : AMBULPOSTOP-COLLATION
• Comments	 : AMBULPOSTOP-COMMENTAIRES
• Consciousness	 : AMBULPOSTOP-CONSCIENCE
• Difficulty	 : AMBULPOSTOP-DIFFICULTE
• Urine output	 : AMBULPOSTOP-DIURESE
• Time of first food intake	 : AMBULPOSTOP-HEURE_PREMIERE_ALIMENTATION
• Time of first fluid intake	 : AMBULPOSTOP- HEURE_PREMIERE_BOISSON
• Discharge time	 : AMBULPOSTOP- HEURE_SORTIE
• Motor function	 : AMBULPOSTOP-MOTRICITE
• Nausea 1	 : AMBULPOSTOP-NAUSEES1
• Nausea 2	 : AMBULPOSTOP-NAUSEES2
• Support person's name	 : AMBULPOSTOP-NOM_ACCOMPAGNANT
• Patient's phone number	 : AMBULPOSTOP-NUM_TEL_PATIENT
• Pain treatment	 : AMBULPOSTOP-PEC_DOULEUR



• Surgeon appointment	 : AMBULPOSTOP-RDV_CHIRURGIEN
• Return	 : AMBULPOSTOP-RETOUR
• Return to home	 : AMBULPOSTOP-RETOUR_A_DOMICILE
• Bleeding	 : AMBULPOSTOP-SAIGNEMENT
• Satisfaction	 : AMBULPOSTOP-SATISFACTION
• Signature	 : AMBULPOSTOP-PERSONNEL
• Sleep	 : AMBULPOSTOP-SOMMEIL
• Relieved by TT	 : AMBULPOSTOP-SOULAGE_PAR_TTT

### 6.2.2.16 ActiveX: ICU data







































• Research protocol	 : CPAREA1-PROTOCOLE_RECHERCHE
• Nursing notes	 : CPAREA1-TRANSMISSIONS_MEDICALES
• Sent by	 : PATIENT-MEDECIIN_ADRESSEUR










































### 6.2.2.17 ActiveX: Additional patient information

• Age of spouse 	 : INFOPATADDSPOUSEAGE
• Spouse's medical history	 : SPOUSEMEDICHIST
• Mother's occupational code	 : MOTHERPROCEDURE
• Spouse's occupational code	 : SPOUSEPROCEDURE
• Spouse's birth date	 : SPOUSEBIRTHDATE
• Spouse's blood type	 : SPOUSEBLOODTYPE
• Mother's highest educational level	 : MOTHEREDULEVEL
• Spouse's highest educational level	 : SPOUSEEDULEVEL
• Guardian's name	 : GUARDIANLASTNAME
• Name of person to notify	 : PERSONTONOTIFYNAME
• Trusted person's name	 : TRUSTEDPERSONNAME
• Tutorship holder's last name	 : NOMTUTELLE
• Spouse's name	 : SPOUSENAME
• Guardian's phone number	 : GUARDIANPHNUM
• Guardian's phone number	 : TUTORPHNUM
• Spouse's phone number	 : SPOUSEPHNUM
• Spouse's geographic origin	 : SPOUSEORIGIN
• Guardian's first name	 : GUARDIANFIRSTNAME
• Guardian's first name	 : GUARDIANFIRSTNAME
• Spouse's first name	 : GUARDIANFIRSTNAME
• Profession of spouse	 : SPOUSEPROFESSION
• Phone of person to notify	 : PERSONTONOTIFYTEL
• Trusted person's phone	 : TRUSTEDPERSONTEL
• Tutorship/Guardianship	 : INFOPATADDTUTORSHIPGUARDIANSHIP





### 6.2.2.18 ActiveX: OB-GYN data


• 1: Field 194	: DAYSAMENORRHOEA
• 16SA	: 16SA
• First method of delivery	: DECLENCHEMENT_METHODE1
• Second method of delivery	: DECLENCHEMENT_METHODE2
• Delivery: Date	: PREGNANCY_OUTCOME_DATE
• Delivery admission	: DELIVERY_ADMISSION
• Age in minutes at time of transfer	: OBST1CHAMP08
• Age of pregnancy	: PREGNANCYAGE
• Patient age (years)	: PATIENTAGEINYEARSINTEGER
• Delivery room supply	: OBST1NUTRITIONFOETUSSDN
• Breastfeeding	: BREASTFEEDING
• Foetal nutrition	: NUTRITION_FOETUS
• ALPHAFP	: OBST1ALPHA_FP
• Amniocentesis	: OBST1AMNIOCENTESE
• Placental analysis	: PLACENTA_ANALYSIS
• Postpartum anaesthesia	: ANAES_MODE_AFTER
• Anaesthetists	: ANAES_ANAESTHETIST
• Pertussis vaccination year Mrs/Ms	: PERTUSSISVACYEAR
• Intensivist	: DEL_INT
• Medical leave	: SICKLEAVE
• History of allergy/asthma/eczema	: OBST1ATCDALLERGIEASTHMEECZEMA
• Authorisation for surgery	: OBST1CHAMP03
• Other samples	: OBST1AUTRESPRELEVEMENT
• Other treatments	: OBST1AUTRESTRAITEMENTS
• Trophoblast biopsy	: OBST1BIOPSIETROPHOBLASTE
• ID bracelet	: BRACELET_IDENTIFICATION
• Pregnancy start date calculation	: CALCPSD
• C-section	: DEL_CAESAREAN
• C-section: Complications	: CAESAR_COMPLICATION
• Field 112	: OBST1EC_RESP
• Field 113	: OBST1EC_CARDIAQUE
• Field 114	: OBST1EC_TONUSPERIPH
• Field 115	: OBST1EC_CAVITEBUCCALE
• Field 116	: OBST1EC_HANCHES
• Field 117	: OBST1EC_OGE
• Field 118	: OBST1EC_OCULAIRE
• Field 119	: OBST1EC_POULSFEMORAUX

• <b>Field 120</b>	 : OBST1EC_ECHOCHANCHE
• <b>Field 121</b>	 : OBST1EC_TONUSAXIAL
• <b>Field 122</b>	 : OBST1EC_ORTHOPEDIQUE
• <b>Field 123</b>	 : OBST1EC_MALFORMATIONPATHO
• <b>Field 124</b>	 : OBST1EC_SORTIEPRECOCEENVISAGEE
• <b>Field 125</b>	 : OBST1EC_EXAMENSAPREVOIR
• <b>Field 126</b>	 : OBST1EC_CONSIGNES
• <b>Field 127</b>	 : OBST1EC_SURVEILLANCE
• <b>Field 128</b>	 : OBST1EC_CONSULTATIONULTERIEURE
• <b>Field 129</b>	 : OBST1ES_POULSFEMORAUX
• <b>Field 130</b>	 : OBST1ES_AUSCULTATIONCARDIAQUENORMALE
• <b>Field 131</b>	 : OBST1ES_EXAMNORMAL
• <b>Field 132</b>	 : OBST1ES_ICTERE
• <b>Field 133</b>	 : OBST1ES_CONCLUSIONICTERE
• <b>Field 134</b>	 : OBST1ES_ICTEREVALEURMAX
• <b>Field 135</b>	 : OBST1ES_ICTEREDATEVALEUR
• <b>Field 136</b>	 : OBST1ES_RISQUEINFECTIEUX
• <b>Field 137</b>	 : OBST1ES_ALIMENTATION
• <b>Field 138</b>	 : OBST1ES_SORTIE
• <b>Field 139</b>	 : OBST1ES_OEAPEA
• <b>Field 140</b>	 : OBST1ES_TRANSFERTNEONAT
• <b>Field 141</b>	 : OBST1ES_DEPISTAGEGUTHRIE
• <b>Field 142</b>	 : OBST1ES_DEPISTAGECARDIOCONG
• <b>Field 143</b>	 : OBST1ES_CONCLUSIONSEJOUR
• <b>Field 144</b>	 : OBST1ES_INFOCOURIERSORTIE
• <b>Field 145</b>	 : OBST1ES_COMMENTAIRES
• <b>Field 146</b>	 : OBST1SEJOUR
• <b>Field 147</b>	 : OBST1PATHOPOSTPARTUM
• <b>Field 148</b>	 : OBST1ACCOUCHEMENTLIEU
• <b>Field 149</b>	 : OBST1ACCOUCHEMENTCOMMENTAIRE
• <b>Field 150</b>	 : OBST1IVGTYPE
• <b>Field 151</b>	 : OBST1ECHODATE
• <b>Field 152</b>	 : OBST1ECHOBIOMETRIE
• <b>Field 153</b>	 : OBST1ECHOEXMORPHO
• <b>Field 154</b>	 : OBST1ECHOECHOGRAPHISTE
• <b>Field 155</b>	 : OBST1ECHOLA
• <b>Field 156</b>	 : OBST1ECHOPLACENTA
• <b>Field 157</b>	 : OBST1ECHOPRESENTATION

• Field 158	 : OBST1ECHOLONGUEURCOL
• Field 159	 : OBST1ECHOOI
• Field 160	 : OBST1ECHOCOMMENTAIRE
• Field 163 	 : OBST1NBENFANTSNES
• Field 164 	 : OBST1NBMFIUINF22
• Field 165 	 : OBST1NBMFIUSUP22
• Field 189	 : OBST1SORTIEPRECENF
• Field 190	 : OBST1SORTIEPRECMERE
• Field 191 	 : OBST1SORTIEPRECINDIC
• Field 193 	 : SEMAINESAMENORRHEE
• Field 198	 : ABUS_SEXUELS
• Field 199	 : VIOLENCE
• Field 200	 : VIOLENCE_COMMENTAIRE
• Field 201	 : PREIVG_SUIVI
• Field 202	 : BIP
• Field 215	 : HOSPIT-ENTREE
• Field 217	 : ACTESMAT
• Field 220	 : ACTESFOETUS
• Field 221	 : DELIVRANCE-HEMO-TYPE
• Field 226	 : COMNEONAT
• Field 238	 : BHCGBDATE1
• Field 239	 : BHCGBDATE2
• Field 240	 : BHCGBDATE3
• Field 241	 : BHCGBDATE4
• Field 242	 : BHCGBTAUX1
• Field 243	 : BHCGBTAUX2
• Field 244	 : BHCGBTAUX3
• Field 245	 : BHCGBTAUX4
• Field 246	 : OBST_DEPRECATED
• Field 248	 : HABITUS_MODEDEVIE
• Field 250	 : HABITUS_AUTREMODEDEVIE
• Field 252	 : FILNO
• Field 40	 : OBST1GLYCEMIECAPILAIRES
• Field 87	 : DEL_MODALITE
• Field T21	 : OBST1CHAMP404
• NT	 : OBST1NT
• Child comment	 : OBST1COMMENTAIREENFANT
• Complication	: ANETH-COMPLICATION
• Uterine contractions: Recording	: OBST1CUENREGISTREMENT

• Uterine contractions: Quality		: OBST1CUQUALITE
• Umbilical cord: Anomalies		: OBST1CORDONANOMALIES
• Umbilical cord: Insertion		: CORDON_INSERTION
• Assistant		: ACC_CORESP
• Postnatal care at home eligibility criteria child		: OBST1PRADOENF
• Postnatal care at home eligibility criteria mother		: OBST1PRADOMERE
• Cytomegalovirus		: CYTOMEGALOVIRUS
• Expected delivery date		: ACCOUCHEMENTPREVU
• Breastfeeding start date		: OBST1DEBUTALLAITEMENT
• Pregnancy start date		: DEBUTGROSSESSE
• Possible start date: 7th month anaesthesia consultation		: CONSULTANESTHSEPTIEMEMOISDEBUT
• Possible start date: 3rd month consultation		: CONSULTTROISIEMEMOISDEBUT
• Possible start date: 4th month consultation		: CONSULTQUATRIEMEMOISDEBUT
• Possible start date: 5th month consultation		: CONSULTCINQUIEMEMOISDEBUT
• Possible start date: 6th month consultation		: CONSULTSIXIEMEMOISDEBUT
• Possible start date: 7th month consultation		: CONSULTSEPTIEMEMOISDEBUT
• Possible start date: 8th month consultation		: CONSULTHUITIEMEMOISDEBUT
• Possible start date: 9th month consultation		: CONSULTNEUVIEMEMOISDEBUT
• Possible start date: First trimester T21 screening		: DATEDEBUTDEPISTAGET21T1
• Possible start date: Second trimester T21 screening		: DATEDEBUTDEPISTAGET21T2
• Possible start date: Gestational diabetes test - 75g OGTT		: DEBUTHPGO75
• Possible start date for first ultrasound		: DATEDEBUTECHOT1
• Possible start date for second ultrasound		: DATEDEBUTECHOT2
• Possible start date for third ultrasound		: DATEDEBUTECHOT3
• Possible start date for streptococcus bovis testing		: DEBUTSTREPTOB
• Deadline end date: First trimester T21 screening		: DATEFINDEPISTAGET21T1
• Deadline end date: Second trimester T21 screening		: DATEFINDEPISTAGET21T2
• Deadline end date: Gestational diabetes test - 75g OGTT		: FINHPGO75
• Deadline end date for first ultrasound		: DATEFINECHOT1
• Deadline end date for second ultrasound		: DATEFINECHOT2
• Deadline end date for third ultrasound		: DATEFINECHOT3
• Deadline end date for streptococcus bovis testing		: FINSTREPTOB
• Possible end date: 7th month anaesthesia consultation		: CONSULTANESTHSEPTIEMEMOISFIN
• Possible end date: 3rd month consultation		: CONSULTTROISIEMEMOISFIN

• Possible end date: 4th month consultation			: CONSULTQUATRIEMEMOISFIN
• Possible end date: 5th month consultation			: CONSULTCINQUIEMEMOISFIN
• Possible end date: 6th month consultation			: CONSULTSIXIEMEMOISFIN
• Possible end date: 7th month consultation			: CONSULTSEPTIEMEMOISFIN
• Possible end date: 8th month consultation			: CONSULTHUITIEMEMOISFIN
• Possible end date: 9th month consultation			: CONSULTNEUVIEMEMOISFIN
• PP end date			: DATE_SORTIE_PP
• Flu vaccination date			: OBST1VACGRIPPEDATE
• Last menstrual period (entered)			: DERNIEREREGLESSAISIE
• Last menstrual period			: DERNIERESREGLES
• Date of death			: OBST1DATEDECES
• CRL Date			: OBST1MESURELCC
• Deadline: Gestational diabetes test - fasting blood sugar			: DATEGLYCEMIEAJEUN
• Deadline for pregnancy declaration			: DATELIMITEDECLARGROSSESSE
• Deadline for EAB			: DATELIMITEIVG
• Deadline for prenatal interview			: DATEENTRETIENPRENATAL
• Rhophylac date			: OBST1DATERHOPHYLAC
• Start of doctor-ordered leave			: DEBUTCONGEPATHO
• Delivery room death			: OBST1CHAMP07
• OP/OA			: ACC_DEG
• Placental delivery: Associated Procedures			: DEL_ACTEASSOCIES
• Placental delivery: Administered by			: DEL_HEMORRAGIE
• Placental delivery: AP Oxytocin			: OBST1DELIVRANCEOXYADMINPAR
• Placental delivery: Time after delivery in min			: DEL_OXYTOCINE
• Placental delivery: haemorrhage			: DEL_PERTES_SANGUINES
• Placental delivery: Modality			: DEL_DELAI
• Placental delivery: Transfusion			: DEL_TRANSFUSION
• T21 screening			: DEPISTAGE_T21
• DEPRECATED			: OBST1CHAMP236
• Biparietal diameter in mm			: DIAMETRE_BIPARIETAL
• OB-GYN data 1: Field 161			: OBST1DATEDEBUTSUIVI
• OB-GYN data 1: Field 162			: OBST1DATEFINSUIVI
• OB-GYN data 1: Field 237			: DATEIVG
• NIPT			: OBST1DPNI
• Duration of active phase			: PHASE_ACTIVE
• Duration of latent phase			: PHASE_LATENCE
• Duration of doctor-ordered leave			: DUREECONGEPATHO
• Stage 1 duration			: STADE1

• Stage 2 duration 	 : STADE2
• Stage 3 duration 	 : STADE3
• Duration from rupture of membranes to start of labour 	 : PERTE_LA_DEBUT_TRAVAIL
• Done by	 : OBST1ACCOUCHEMENTEFFECTUEPAR
• Engagement	 : DEL_ENG
• ENTRETIENT4EME	 : ENTRETIENT4EME
• EPP	 : EPP
• Acid-base balance: Base deficit	 : OBST1DEFICITDEBASE
• Acid-base balance: Lactates	 : OBST1LACTATES
• Acid-base balance: pCO2	 : OBST1PCOE
• Acid-base balance: pH	 : EAB_PH
• ESTRIOL	 : OBST1ESTRIOL
• Extraction	 : DEL_EXTR
• Foetus: Foetal heart rhythm anomalies	 : FOETUS_ANOMALIE_RCF
• Foetus: IUFD DATE	 : OBST1FOETUSMFIUDATE
• Foetus: State (Do not use)	 : FOETUS_ETAT
• Foetus: Scalp sample	 : FOETUS_SCALP
• Foetus: Monitoring	 : FOETUS_SURVEILLANCE
• Genotyping	 : GENOTYPAGE
• Gravidity 	 : GESTITE
• Capillary blood glucose: time	 : OBST1GCHEURE
• Capillary blood glucose: value	 : OBST1GCVALEUR
• HBS	 : HBS
• HCG	 : HCG
• HEPATITISC	 : HEPATITEC
• HIV	 : HIV
• Postnatal care at home eligibility indicator 	 : OBST1PRADOINDIC
• Gastric analysis or PCT indication	 : INDICATION_PGCT
• Indications antenatal diagnosis follow-up	 : OBST1INDICATIONSUIVIDAN
• Additional surgeries	 : CESAR_INTERVCOMPL
• Pregnancy outcome	
• Pregnancy outcome?	 : ISSUEGROSSESSE
• Manually entered days of amenorrhoea	 : OBST1SAISIEJ
• Days of amenorrhoea based on first trimester ultrasound 	 : OBST1JECHOT1
• Minor patient? 	 : IS-MINOR
• The patient is a minor	 : ISMINOROLD
• Soft-tissue lesions	 : LPM






• <b>Soft-tissue lesions: Associated with</b>	 : OBST1LPM_ASSOCIEA
• <b>Malformation Comment</b>	 : OBST1MOLFORMATIONCOMMENTAIRE
• <b>Manoeuvre</b>	 : OBST1ACCOUCHEMENTMANOEUVRE
• <b>maturation?</b>	 : MATURATION_METHODE
• <b>Meconium</b>	 : MECONIUM
• <b>Pregnancy determination method</b>	 : DETERMINATIONTERME
• <b>Maturation method</b>	 : MATURATION
• <b>Urination</b>	 : URINATION
• <b>Method of death</b>	 : OBST1CHAMP09
• <b>Delivery method</b>	 : ACC-MODE
• <b>Anaesthesia method</b>	 : ANESTH_MODE_AVANT
• <b>Reason for procedure or c-section</b>	 : CESAR_MOTIF
• <b>Reason for maturation</b>	 : MATURATION_MOTIF
• <b>Reason for induction</b>	 : DECLENCHEMENT_MOTIF
• <b>NEONATOLOGIST</b>	 : NEONATALISTE
• <b>Number c-sections  </b>	 : NB_CESAR
• <b>Number of gynaecologic surgery scars (excluding C-sections)</b>	 : NB-CICATRICES-GYNECO
• <b>Number of molar pregnancies  </b>	 : OBST1NBMOLE
• <b>Number of pregnancies with diabetes  </b>	 : OBST1NBDIABETE
• <b>Number of pregnancies with hypertension  </b>	 : OBST1NBHTA
• <b>Number of extrauterine pregnancies  </b>	 : OBST1NBGEU
• <b>Number of days of amenorrhoea (if number of weeks is not ...  </b>	 : OBST1JOURSAMENORRHEE
• <b>Total number of days of amenorrhoea  </b>	 : JOURSTOTALAMENORRHEE
• <b>Number of premature births  </b>	 : NUMBER_PREMATURE
• <b>Number of weeks of amenorrhoea  </b>	 : OBST1WEEKSAMENORRHOEA
• <b>Number of children expected by patient  </b>	 : NOMBRE_ENFANTS
• <b>Number of hypotrophic children  </b>	 : OBST1NBHYPO
• <b>Number of children with malformations  </b>	 : OBST1NBMALFORM
• <b>Number of stillbirths  </b>	 : NOMBRE_MORTSNES
• <b>Number TABs &lt; 22 WA  </b>	 : OBST1NBIMGINF22
• <b>Number TABs &gt; 22 WA  </b>	 : OBST1NBIMGSUP22
• <b>Number EABs  </b>	 : OBST1NBIVG
• <b>Number of miscarriages  </b>	 : OBST1NBFC
• <b>Number</b>	 : OBST1NBFC
• <b>Obstetrics: Date of T1 ultrasound</b>	 : OBST-DATE-ECHO-T1
• <b>Obstetrics: Free field 1</b>	 : OBST-FREE-1
• <b>Obstetrics: Free field 2</b>	 : OBST-FREE-2









• Family planning: Confidentiality	 : ORTHO_COMPLICATIONS
• PAPP_A	 : OBST1PAPP_A
• Parity 	 : PARITE
• Pregnancy-related condition	 : PATHOGROSSESSE
• Conditions and complications during labour	 : PATHOCOMPLICATIONTRAVAIL
• Cord blood PCT	 : PCTCORDON
• Pelvic ultrasound: BISPINOUS	 : OBST1BIEPINEUX
• Pelvic ultrasound: MAGNIN	 : OBST1MAGNIN
• Pelvic ultrasound: PRP	 : OBST1PRP
• Height percentile 	 : OBST1PERCTAILLE
• Head circumference percentiles 	 : OBST1PERCPC
• Weight percentiles 	 : OBST1PERCPOIDS
• Head circumference in cm	 : PCCM
• Placenta: Anomalies	 : PLACENTA_ANOMALIES
• Newborn's weight (g)	 : POIDS-NN
• Gastric sample	 : PRELEVEMENT_GASTRIQUE
• Samples comments	 : OBST1PRLVTCOMMENTAIRES
• Preparation for birth and parenthood	 : PMP
• Presence of gynaecologic surgery scars (excluding C-sections)	 : PRESENCE-CICATRICES-GYNECO
• Presence of malformation	 : OBST1MALFORMATIONPRESENCE
• Presentation	 : ACC-PRESENTATION
• Folic acid administration	 : OBST1CHAMP04
• Weight gain	 : PRISEPOIDS
• Rhophylac administration	 : OBST1ROPPHYLAC
• Full prophylaxis	 : PROPHYLAXIE_COMPLETE
• Ocular prophylaxis	 : PROPHYOCULAIRE
• Birth rank	 : OBST1CHAMP195
• OT resuscitation: Procedures	 : OBST1REAACTES
• OT resuscitation: Comments	 : OBST1REACOMMENTAIRES
• OT resuscitation: Transfer	 : OBST1REATRANSFERT
• DR resuscitation: Paediatric call	 : OBST1REAAPPELPEDIATRIQUE
• OT resuscitation: Person in charge	 : OBST1REARESP
• Early acknowledgement of parenthood	 : RECOANTICIPEE
• Inchg	 : ACC_RESP
• Full summary	 : OBST1CHAMP254
• Rubella	 : RUBEOLE
• Rupture of membranes: Appearance	 : MEMBRANES_ASPECT_RUPTURE
• Rupture of membranes: Appearance AF	 : MEMBRANES_ASPECT_ULTERIEUR_C























• Rupture of membranes: Modality	 : OBST1MEMBRANESMODALITERUPTURE
• Manually entered weeks of amenorrhoea	 : OBST1SAISIESA
• Weeks of amenorrhoea based on first trimester ultrasound  	 : OBST1SAECHOT1
• Patient discharge	 : SORTIEPATIENT
• Group B strep	 : STREPTOB
• Antenatal diagnosis follow-up	 : OBST1SUIVIDAN
• Syphilis	 : SYPHILIS
• Term of pregnancy	 : TERMETHEORIQUEGROSSESSE
• Term of labour, number of days of amenorrhoea  	 : JOURS_AMENORRHEE
• Term of labour, number of weeks of amenorrhoea  	 : SEMAINES_AMENORRHEE
• Term of labour, number of weeks+days of amenorrhoea  	 : SEMAINES_JOURS_AMENORRHEE
• Complementary therapies	 : ANESTH_THERAPEUTIQUE_COMPLEMENTAIRE
• THROMBUS	 : OBST1THROMBUS
• IUT	 : TIU
• Toxoplasmosis	 : TOXOPLSAMOSE
• TPelvicUltrasound: Effective transverse diameter	 : OBST1TMU
• Immediate transfer	 : TRANSFERT_IMMEDIAT
• Reason for transfer	 : TRANSFERT_MOTIF
• Labour	 : MODALITE_TRAVAIL
• Labour during pregnancy	 : TRAVAILPDTGROSSESSE
• Fertilization type, obtained by	 : OBST1CHAMP05
• Scarred uterus	 : UTERUS-CICATRICIEL
• Flu vaccination	 : OBST1VACGRIPPE
• Pertussis vaccination father	 : VACCOQUELUCHEMRANNEE
• Pertussis vaccination mother	 : VACCOQUELUCHE
• Pertussis vaccination father	 : VACCOQUELUCHEMR
• Vitamin D	 : OBST1CHAMP06
• Field 29	 : OBST2ATCDGYNINACTIF
• Field 30	 : OBST2ATCDMEDINACTIF

### 6.2.2.19 ActiveX: POA conclusion








• Ambulatory validated	 : CONCLUSION_CPA-AMBULATOIRE_VALIDE
• Prophylactic antibiotics	 : CONCLUSION_CPA-ANTIPPROPHYLAXIE
• Compression stockings	 : CONCLUSION_CPA-BAS-CONTENTION
• Staff conclusion	 : CONCLUSION_CPA-CONCLUSION_STAFF
• Eligible for ambulatory	 : CONCLUSION_CPA-ELIGIBLE_AMBULATOIRE

• Management of support person	 : CONCLUSION_CPA-GESTION_ACCOMPAGNANT
• Monitoring planned	 : CONCLUSION_CPA-MONITORAGE_PREVU
• Staff reason	 : CONCLUSION_CPA-MOTIF_STAFF
• Pain treatment	 : CONCLUSION_CPA-PEC_DOULEUR
• Postoperative ICU	 : CONCLUSION_CPA-REA_POST_OP
• Postoperative CCU	 : CONCLUSION_CPA-USC_POST_OP










### 6.2.2.20 ActiveX: Clinical examination

• Addiction	 : EXAMEN_CLINIQUE-ADDICTION
• Apfel	 : EXAMEN_CLINIQUE-APFEL
• Cardiac	 : EXAMEN_CLINIQUE-CARDIAQUE
• General status	 : EXAMEN_CLINIQUE-ETAT_GENERAL
• General	 : EXAMEN_CLINIQUE-GENERAL
• Habits	 : EXAMEN_CLINIQUE-HABITUS
• Travel sickness	 : EXAMEN_CLINIQUE-MAL_DES_TRANSPORTS
• MTEA	 : EXAMEN_CLINIQUE-MTEA
• MTEV	 : EXAMEN_CLINIQUE-MTEV
• Neurology	 : EXAMEN_CLINIQUE-NEUROLOGIE
• PONV	 : EXAMEN_CLINIQUE-NVPO
• Weight before pregnancy	 : EXAMEN_CLINIQUE-POIDS_AVANT_GROSSESSE
• Current weight	 : EXAMEN_CLINIQUE-POIDS_DU_JOUR
• Weight gain	 : EXAMEN_CLINIQUE-PRISE_DE_POIDS
• Spine	 : EXAMEN_CLINIQUE-RACHIS
• Breathing	 : EXAMEN_CLINIQUE-RESPIRATOIRE
• Withdrawal	 : EXAMEN_CLINIQUE-SEVRAGE
• Cardio findings	 : EXAMEN_CLINIQUE-SIGNES_FONCTIONNELS_CARDIO
• Pulmo findings	 : EXAMEN_CLINIQUE-SIGNES_FONCTIONNELS_NEURO
• Infection status	 : EXAMEN_CLINIQUE-STATUT_INFECTIEUX
• Viral status	 : EXAMEN_CLINIQUE-STATUT_VIRAL
• Vascular	 : EXAMEN_CLINIQUE-VEINEUX

### 6.2.2.21 ActiveX: POA PED

• Food	 : CPA_PED-ALIMENTATION
• APGAR birth	 : CPA_PED-APGAR_NAISSANCE
• Prematurity complications	 : CPA_PED-COMPLICATIONS_PREMATURITE
• Birth weight	 : CPA_PED-POIDS_NAISSANCE
• Suspicion stenosis	 : CPA_PED-SUSPICION_STENOSE
• Capillary refill time	 : CPA_PED-TEMSP_RECOLORATION_CUTANEE
• Birth type	 : CPA_PED-TYPE_NAISSANCE

### 6.2.2.22 ActiveX: POA Obstetrics




• Patient choice of technique	 : CPA_OBST-CHOIX_TECHNIQUE_PATIENTE
• Obstetrical context	 : CPA_OBST-CONTEXTE_OBSTETRICAL
• Info baby	 : CPA_OBST-INFO_BEBE
• Information epidural	 : CPA_OBST-INFORMATION_APD
• Obstetrical pathology	 : CPA_OBST-PATHOLOGIE_OBSTETRICALE
• Preparation for birth	 : CPA_OBST-PREPA_NAISSANCE
• Obstetrical risk	 : CPA_OBST-RISQUE_OBSTETRICAL
• Type of delivery	 : CPA_OBST-TYPE_ACCOUCHEMENT
• Patient experience	 : CPA_OBST-VECU_PATIENTE

### 6.2.2.23 ActiveX: Stay field

These data IDs are locked for the interfaces.

- IDEXTERN
- IDPATIENT
- DATEIN
- DATEOUT
- STAYTYPE
- SV\_MEDICAL
- SV\_ACCOMMODATION
- ROOM
- LIT

### 6.2.2.24 ActiveX Other

- Sent by : PATIENT-MEDEecin\_ADRESSEUR
- Tooth chart : SCHEMA\_DENTAIRE\_GRAPHIC  
: SCHEMA\_DENTAIRE\_TEXT

## 6.3 List of calculated fields

### 6.3.1 Consultation data

#### 6.3.1.1 Body surface area calculation (BSA) (Patient information/BSA):

For the consultation, body surface area is calculated using:

- the Haycock formula, which gives:  
Formula used:  
 $0.02426 * \text{Weight in kg}^{0.5378} * \text{Height in cm}^{0.3964}$
- the Mosteller formula, which gives:  
Formula used:  
 $(\text{Weight in kg} * \text{Height in cm} / 3600)^{0.5}$

The formula to be used can be selected in the **Settings** tab, **Diaserveur** subtab.

Choix de l'algorithme pour le calcul de la surface corporelle	Formule de Mosteller
FormulaBodySurface (Choix de l'algorithme pour le calcul de la surface corporelle)	

This value can only be calculated if the weight in kg and height in cm of the patient are entered (not 0). The result is rounded to three decimal places.

The body surface area is calculated if:

- Patient weight is updated (**Patient information/Weight**)
- Patient height is updated (**Patient information/Height**)

### 6.3.1.2 Body mass index (BMI) calculation (BMI (Patient information/BMI)):

Formula used:

**Weight in kg / ((Height in cm /100) <sup>2</sup>)**

This value can only be calculated if the weight in kg and height in cm of the patient are entered. The result is rounded to three decimal places.

The BMI is calculated automatically if:

- Patient weight is updated (**Patient information/Weight**)
- Patient height is updated (**Patient information/Height**)

### 6.3.1.3 Initial BMI calculation (BMI (Patient information/Initial BMI)):

Formula used:

**Initial weight in kg / ((Height in cm /100) <sup>2</sup>)**

This value can only be calculated if the initial weight in kg and height in cm of the patient are entered. The result is rounded to three decimal places.

The initial BMI is calculated automatically if:

- Initial patient weight is updated (**Patient information/Initial weight**)
- Patient height is updated (**Patient information/Height**)

### 6.3.1.4 Intubation score calculation (Intubation/Score):

1. If the Mallampati drop-down list (Intubation.Mallampati) is selected with a value  $\geq 5$  (Refuses to open mouth, Impossible to open mouth, Child under 10 years) or not entered, the intubation score cannot be calculated.
  - If the Mallampati score is 1, the intubation score increases by 1.
  - If the Mallampati score is 2, the intubation score increases by 2.
  - If the Mallampati score is 3 or higher, the intubation score increases by 3.
  - If the list is not selected and at least one other list is selected, the score increases by 1.
2. If the mobility drop-down list is Normal, the score increases by 1.
  - If the mobility drop-down list is Reduced, the score increases by 2.
  - If the mobility drop-down list is Immobilised or other, the score increases by 3.
  - If the list is not selected and at least one other list is selected, the score increases by 1.
3. If the Patient profile drop-down list is N (Normal), the intubation score increases by 1.
  - If the Patient profile drop-down list is P (Prognathism), the score increases by 2.
  - If the Patient profile drop-down list is anything else, the score increases by 3.
  - If the list is not selected and at least one other list is selected, the score increases by 1.
4. If the Mouth opening drop-down list is 2 (2 fingers), the intubation score increases by 3.
  - If the Mouth opening drop-down list is 1 (2-3 fingers), the intubation score increases by 2.

If the Mouth opening drop-down list is anything else, the score increases by 1.  
If the list is not selected and at least one other list is selected, the score increases by 1.

5. If the Thyromental distance (inter-incisor) drop-down list is O (< 65 mm), the score increases by 2.  
If the Thyromental distance is anything other than O, the intubation score increases by 1.  
If the list is not selected and at least one other list is selected, the score increases by 1.

The intubation score is updated each time the Mallampati, Mouth opening, Thyromental distance, Neck mobility and Patient profile drop-down lists are modified.

#### **6.3.1.5 Theoretical weight (Patient information: theoretical patient weight in kg):**

The theoretical or ideal weight can only be calculated with the patient height. If the sex is not filled in, the default sex is male (only useful for calculating the weight of an adult). If the age is not filled in, the default age is 20 years. If the patient height is less than 152.4 cm or the Lorentz formula is required and:

- The patient is under 2.5 years old, the following formula is used to determine the patient's theoretical weight:  $(\text{Height in cm}) - 35 - ((\text{Height in cm} - 34) * 0.75)$
- The patient is under 6 years old, the following formula is used to determine the patient's theoretical weight:  $(\text{Height in cm}) - 100 - ((\text{Height in cm} - 123) * 0.7)$
- The patient is under 14 years old, the following formula is used to determine the patient's theoretical weight:  $(\text{Height in cm}) - 100 - ((\text{Height in cm} - 125) * 0.5)$
- The patient is under 18 years old, the following formula is used to determine the patient's theoretical weight:  $(\text{Height in cm}) - 100$
- The patient is 18 years or older and male, the following formula is used to determine the patient's theoretical weight:  $(\text{Height in cm}) - 100 - ((\text{Height in cm} - 150) * 0.25)$
- The patient is 18 years or older and female, the following formula is used to determine the patient's theoretical weight:  $(\text{Height in cm}) - 100 - ((\text{Height in cm} - 150) * 0.4)$

Otherwise, the Devine formula is used:

- If the patient is male, the following formula is used to determine the patient's theoretical weight:  $50 + (0.91 * (\text{Height in cm} - 152.4))$
- If the patient is female, the following formula is used to determine the patient's theoretical weight:  $45.5 + (0.91 * (\text{Height in cm} - 152.4))$

The result is rounded to two decimal places.

The theoretical weight is recalculated if:

- The patient's date of birth is modified (**Patient/Date of birth**)
- The patient's sex is edited (**Patient/Sex**)
- The patient's height is edited (**Patient information/Height**)

#### **6.3.1.6 Predicted minimum tidal volume (Patient information/Predicted minimum tidal volume):**

This value is 6 times the patient's theoretical weight. The value is not rounded. This value is recalculated if the theoretical weight is modified (**Patient information/Theoretical patient weight in kg**).

#### **6.3.1.7 Predicted maximum tidal volume (Patient information/Predicted maximum tidal volume):**

This value is 8 times the patient's theoretical weight. The value is not rounded. This value is recalculated if the theoretical weight is modified (**Patient information/Theoretical patient weight in kg**).

#### **6.3.1.8 Spouse's age (Additional patient information/Spouse's age):**

The patient's spouse's age is calculated if the spouse's date of birth is entered (**Administrative tab**> Spouse's

date of birth) (system date - spouse's date of birth).

Data automatically recalculated if the spouse's date of birth is updated (**Additional patient information/Spouse's date of birth**).

#### 6.3.1.9 Adjusted patient weight (Patient information/Adjusted weight in kg):

The patient's adjusted weight is calculated using the theoretical weight and the last weight value entered.

Adjusted weight: Theoretical weight + 0.4 (current weight – theoretical weight)

The result is rounded to two decimal places.

The adjusted weight is updated if:

- Theoretical patient weight is updated (**Patient information/Theoretical patient weight in kg**)
- Patient weight is updated (**Patient information/Weight**).

#### 6.3.1.10 Weight gain/loss in kg (Patient information/Weight gain/loss (kg)):

Calculates the patient's weight gain or loss in kg based on the patient's initial weight (**Patient information/Weight**) and the last weight entered.

This data is updated each time the patient's weight is edited.

#### 6.3.1.11 Weight gain/loss in % of patient's initial weight (Patient information/Weight gain/loss (%)):

Calculates the patient's weight gain or loss as a percentage based on the patient's initial weight (**Patient information/Weight**) and the last weight entered.

This data is updated each time the patient's weight is edited (**Patient information/Weight**).

#### 6.3.1.12 Patient's age (Patient/Patient's age (years)):

Difference in years between the patient's date of birth (**Patient/Date of birth**) and today.

Data updated each time record is loaded and if the patient's date of birth is modified.

### 6.3.2 Diane OB-GYN data

#### 6.3.2.1 Weight percentile (diafldObst1PercPoids):

The newborn's weight percentile is calculated if weight (diafldObst1PoidsNouveauNe) and number of weeks of amenorrhoea are entered (diafldObst1AFFICHESA).

Percentile = percentile (Score)

Score = (NL(NewbornWeight) – mean) / Standard\_deviation

If the baby is a boy:

Standard\_deviation:  $-4.3397226739 + 0.402861345256 * AFFICHESA - 0.01167844789 * AFFICHESA(2) + 0.000109863095 * AFFICHESA(3)$

Average:  $11.06869318192 - 0.63463603736 * AFFICHESA + 0.025385311114 * AFFICHESA(2) - 0.00028343446 * AFFICHESA(3)$

Or:  $-4.13667133974 + 0.382827233935 * AFFICHESA - 0.01101958925 * AFFICHESA(2) + 0.000102753287 * AFFICHESA(3)$  ;

Average:  $10.57756060268 - 0.60716320319 * _SA + 0.024851303008 * AFFICHESA(2) - 0.00028027298 * AFFICHESA(3)$

#### 6.3.2.2 Height percentile (diafldObst1PercTaille):

The newborn's height percentile is calculated if height (Patient information/Height) and number of weeks of amenorrhoea are entered (diafldObst1AFFICHESA).

Percentile = percentile (Score)

Score = (NL(Height) – mean) / Standard\_deviation

If the baby is a boy:

Standard\_deviation:  $-56.0552816179 + 5.194038268674 * AFFICHESA - 0.1506625261 * AFFICHESA(2) +$

0.001424420272 \* AFFICHESA(3)

Average: 50.06894254422 - 4.00572135523 \* AFFICHESA + 0.186686129219 \* AFFICHESA(2) - 0.00215574049 \* AFFICHESA(3)

Otherwise

Standard\_deviation: -59.2880238464 + 5.39802559522 \* AFFICHESA - 0.15428184703 \* AFFICHESA(2) + 0.001437350107 \* AFFICHESA(3)

Average: 30.91419685296 - 2.42950191347 \* AFFICHESA + 0.142594920869 \* AFFICHESA(2) - 0.00175207738 \* AFFICHESA(3)

### 6.3.2.3 Head circumference percentile (DiafIdObst1PercHC):

The newborn's head circumference percentile is calculated if head circumference (Obst1HCCM) and number of weeks of amenorrhoea are entered (diafIdObst1DISPLAYWA).

Percentile = percentile (Score)

Score = (NL(HCCM) – mean) / Standard\_deviation

If the baby is a boy:

Standard\_deviation: -24.3709774685 + 2.247143950431 \* AFFICHESA - 0.06380758661 \* AFFICHESA(2) + 0.000592765847 \* AFFICHESA(3)

Average: 2.527172432982 + 0.053793497931 \* AFFICHESA(2) - 0.00083642534 \* AFFICHESA(3)

Otherwise

Standard\_deviation: -31.7149671255 + 2.892529318957 \* AFFICHESA - 0.08237590311 \* AFFICHESA(2) + 0.000767371911 \* AFFICHESA(3)

Average: 1.722279782298 + 0.054867246533 \* AFFICHESA(2) - 0.0008605794 \* AFFICHESA(3)

### 6.3.2.4 Last menstrual period (OB-GYN data 1 DERNIERESREGLESCALC):

This field displays the value of the diafIdObst1DernieresReglesSaisie field if this is entered manually, otherwise 14 days is subtracted from the pregnancy start date.

This field is updated each time the following are updated:

- Pregnancy start date (Obst1DebutGrossesse)
- Last menstrual period entered (Obst1DernieresReglesSaisie)
- Term determination (Obst1DeterminationTerme)
- First trimester ultrasound date (ObstDateEchoT1)
- First trimester CRL measurement (Obst1MesureLCC)

### 6.3.2.5 Expected delivery date (diafIdObst1AccouchementPrevu):

If the date of last menstrual period (diafIdObst1DernieresReglesCalc) is entered, the delivery date is given as **DLP + 287 D**. If the date of the last menstrual period is not entered, the expected delivery date is given the DLP, i.e. 0 (this is logical as “no date of last menstrual period” means “no pregnancy start date”).

Data updated if Date of last menstrual period field (DernieresReglesCalc) is updated.

### 6.3.2.6 Date of medical leave (diafIdObst1ArretTravail):

This date is calculated based on the Expected delivery date (diafIdObst1AccouchementPrevu) and parity (diafIdObst1Parite) which corresponds to the number of children already born.

The date of medical leave is only calculated if the pregnancy type is indicated in the record (not zero).

- If the pregnancy type (diafIdIntervTypeGrossesse) is 1 and the parity is more than or equal to two, the medical leave date is calculated as follows: **Expected delivery date - 56 days**
- If the pregnancy type (diafIdIntervTypeGrossesse) is 1 and the parity is equal to one, the medical leave date is calculated as follows: **Expected delivery date - 42 days**
- If the pregnancy type is between 2 and 4, the medical leave date is calculated as follows: **Expected delivery date - 84 days**



- If the pregnancy type is between 5 and 10, the medical leave date is calculated as follows: [Expected delivery date - 168 days](#)

This data is updated if:

- Pregnancy outcome date is edited (Obst1AccouchementPrevu)
- Parity is edited (Obst1Parite)
- Pregnancy type is edited (IntervTypeGrossesse)

#### **6.3.2.7 Minor (diafIdObst1IsMinor):**

The “Minor” check box found on the administrative tab is automatically selected if the patient is a minor. To verify this information, the patient’s date of birth must be entered. If the difference in years between the current date and the date of birth is less than 18, the check box is selected. Otherwise, it is deselected.

This data is updated if the patient’s date of birth is edited (Patient/DOB).

#### **6.3.2.8 Medical history: Number of children born: diafIdObst1NbEnfantsNes:**

The calculation of number of children depends on how DIANE OB-GYN is set up. The section TOTALOBST key Foetus in DianeOB-GYN settings must be completed with the “Pregnancy Outcome” DLM data associated with a live birth (Live birth. Postnatal death).

The calculation of the number of children born uses the patient’s obstetrical history to find the pregnancy outcomes associated with a live birth. A counter increases with each value found to then complete diafIdObst1NbEnfantsNes.

Data updated following editing of obstetrical history (diafIdIntervINTERV\_EC).

#### **6.3.2.9 Medical history: Number of pregnancies ending in Intrauterine Foetal Death < 22 weeks amenorrhoea (diafIdObst1NbMFIUInf22):**

The calculation of the number of pregnancies resulting in IUFD < 22 weeks depends on how DIANE OB-GYN is set up. The section TOTALOBST key IUFDF22 in DianeOB-GYN settings must be completed with “Pregnancy outcome” DLM data associated with an IUFD < 22 WA. The calculation of the number of IUFD uses the patient’s obstetrical history to find the pregnancy outcomes associated with an IUFD < 22 WA. A counter increases with each value found to then complete diafIdObst1NbMFIUInf22.

Data updated following editing of obstetrical history (diafIdIntervINTERV\_EC).

#### **6.3.2.10 Medical history: Number of pregnancies ending in Intrauterine Foetal Death > 22 weeks amenorrhoea (diafIdObst1NbMFIUSup22):**

The calculation of the number of pregnancies resulting in IUFD > 22 weeks depends on how DIANE OB-GYN is set up. The section TOTALOBST key IUFDSup22 in DianeOB-GYN settings must be completed with “Pregnancy outcome” DLM data associated with an IUFD > 22 WA. The calculation of the number of IUFD uses the patient’s obstetrical history to find the pregnancy outcomes associated with an IUFD > 22 WA. A counter increases with each value found to then complete diafIdObst1NbMFIUSup22.

Data updated following editing of obstetrical history (diafIdIntervINTERV\_EC).

#### **6.3.2.11 Medical history: Number of therapeutic abortions after 22 weeks (diafIdObst1NbIMGSup22):**

The calculation of number of TABs > 22 WA depends on how DIANE OB-GYN is set up. The section TOTALOBST key TABSup22 in DianeOB-GYN settings must be completed with the “Pregnancy Outcome” DLM data associated with a TAB > 22 WA.

Data updated following editing of obstetrical history (diafIdIntervINTERV\_EC).

#### **6.3.2.12 Medical history: Number of therapeutic abortions before 22 weeks (diafldObst1NbIMGInf22):**

The calculation of number of TABs < 22 WA depends on how DIANE OB-GYN is set up. The section TOTALOBST key TABInf22 in DianeOB-GYN settings must be completed with “Pregnancy outcome” DLM data associated with a TAB < 22 WA.

Data updated following editing of obstetrical history (diafldIntervINTERV\_EC).

#### **6.3.2.13 16 weeks of amenorrhoea (diafldObst116SA):**

Shows the date of the 16th week of amenorrhoea for the pregnancy, starting from the PSD and adding 112 days.

Data updated following editing of obstetrical history (diafldIntervINTERV\_EC).

#### **6.3.2.14 Medical history: Number of EABs (diafldObst1NbIVG):**

Shows the number of elective abortions for the patient, if the settings of the TOTALOBST section key EAB in DianeOB-GYN are entered with the field corresponding with a history of EAB. The calculation is based on Pregnancy outcome T1 (PREGNANCYOUTCOMEold) DLM entries found in the Obstetrical History tab.

Data updated following editing of obstetrical history (diafldIntervINTERV\_EC).

#### **6.3.2.15 Medical history: Number of c-sections (diafldObst1NbCesar):**

Shows the number of c-sections the patient has already had, if the settings of DianeOB-GYN> TOTALOBST > C-section are correctly configured. The calculation then verifies whether the DLM Pregnancy outcome (PREGNANCYOUTCOME) contains the data set up in C-section (C-section).

Data updated following editing of obstetrical history (diafldIntervINTERV\_EC).

#### **6.3.2.16 Medical history: Number of risk of preterm labour (diafldObst1NbMAP):**

Requirements: Setting up of TOTALOBST section, DianeOB-GYN Map key with DLM pathological pregnancy data.

Data updated following editing of obstetrical history (diafldIntervINTERV\_EC).

#### **6.3.2.17 Medical history: Pregnancy-induced hypertension (diafldObst1NbHTA):**

Requirements: Setting up of TOTALOBST section, DianeOB-GYN HT key with DLM pathological pregnancy data.

The diafldObst1NbHT field increases automatically based on the data given in the patient’s obstetrical history.

Data updated following editing of obstetrical history (diafldIntervINTERV\_EC).

#### **6.3.2.18 Medical history: Number of premature births (diafldObst1NbPrema):**

Uses the patient’s history to count the number of live births born between 22 and 37 weeks of amenorrhoea. (The section TOTALOBST key Foetus in DianeOB-GYN settings must be completed with the “Pregnancy Outcome” DLM data associated with a live birth (Live birth. Postnatal death))

Data updated following editing of obstetrical history (diafldIntervINTERV\_EC).

#### **6.3.2.19 Medical history: Number of miscarriages (diafldObst1NbFc):**

Requirements: Setting up of TOTALOBST section, DianeOB-GYN Miscarriage key with DLM PREGNANCYOUTCOMEold data.

Data updated following editing of obstetrical history (diafldIntervINTERV\_EC).

#### **6.3.2.20 Medical history: Number of pregnancies with diabetes (diafldObst1NbDiabete):**

Requirements: Setting up of TOTALOBST section, DianeOB-GYN Diabetes key with DLM PATHOPREGNANCY data.

Data updated following editing of obstetrical history (diafldIntervINTERV\_EC).

#### **6.3.2.21 Medical history: Number of molar pregnancies (diafldObst1NbMole):**

Requirements: Setting up of TOTALOBST section, DianeOB-GYN Molar key with DLM PREGNANCYOUTCOMEold data.

diafldObst1NoMolar field updated following modification of pregnancy outcome in obstetrical history.

#### **6.3.2.22 Medical history: Number of HYPO (diafldObst1NbHypo):**

Counts the number of live births with a weight percentile < 10.

Data updated following editing of obstetrical history (diafldIntervINTERV\_EC).

#### **6.3.2.23 Medical history: Number of children with malformations (diafldObst1NbMalform):**

Counts live births with a malformation (Malformation\_presence=0). Data updated following editing of obstetrical history (diafldIntervINTERV\_EC).

Data updated following editing of obstetrical history (diafldIntervINTERV\_EC).

#### **6.3.2.24 Medical history: Number of extrauterine pregnancies (diafldObst1NbGeu):**

Requirements: Setting up of TOTALOBST section, DianeOB-GYN EUP key with DLM PREGNANCYOUTCOMEold data. diafldObst1NoMolar field updated following modification of pregnancy outcome in obstetrical history.

diafldObst1NoMolar field updated following modification of pregnancy outcome in obstetrical history.

#### **6.3.2.25 Postnatal care at home eligibility indicator (diafldObst1PradoIndic):**

Used to automatically complete the drop-down list "Eligible for postnatal care at home" (Prado\_Indic) in the Post partum > Postnatal care at home / Early discharge tab.

The check boxes 1 to 10 for Prado-mother and the check boxes 1 to 10 for Prado-child must be selected for the "Eligible for postnatal care at home" drop-down list to change to yes.

Field updated following modification of:

- diafldObst1PradoMere
- diafldObst1PradoEnf

#### **6.3.2.26 Early discharge eligibility indicator (diafldObst1SortiePreIndic):**

Automatic setting of the drop-down list Eligible Early Discharge on the Post partum > Postnatal care at home / Early discharge tab to "Yes".

If the 15 boxes in the "Early discharge child" and the 11 boxes of the "Eligibility criteria mother" are selected, the list changes to Yes. Otherwise, it remains on No.

Field updated following modification of:

- diafldObst1SortiePrecMere
- diafldObst1SortiePrecEnf

#### **6.3.2.27 SHOWWA (diafldObst1):**

The SHOW WA (ENTERWA) field in birth monitoring show the number of weeks of amenorrhoea (WeeksAmenorrhoea) at which the child was born by default. If a value is entered manually in the input box **Enter WA** (ENTERWA), this value is automatically repeated in the SHOW WA field.

Field updated if:

- Number of weeks of amenorrhoea is edited (diafldObst1WeeksAmenorrhoea or diafldObst1ENTERWA)

#### **6.3.2.28 SHOWD (diafldObst1):**

The SHOW D (ENTERD) field in birth monitoring show the number of days in addition to the number of weeks of

amenorrhoea (DaysAmenorrhea) at which the child was born by default. If a value is entered manually in the input box **Enter D** (ENTERD), this value is automatically repeated in the SHOW D field.

Field updated if:

- Number of days of amenorrhoea is edited (diafIdObst1DaysAmenorrhoea or diafIdObst1ENTERD)

### 6.3.2.29 Number of c-sections (diafIdObst1Cesarienne):

This field is automatically completed based on the labour\_method and del\_csection data.

If labour (labour\_method) is entered with a value "e" (elective c-section) of the incision type is not specified (del\_csection), C-section changes to "Y". Otherwise, it remains "N".

Field updated following modification of:

- diafIdObst1AccouchementCesarienne
- diafIdObst1Travail



### 6.3.2.30 Gravidity number: (diafIdObst1Gestite):

This field increases with each Obstetrical (1) or Pregnancy termination (3) patient procedure.

Field updated following modification of:

- diafIdIntervINTERV\_EC
- diafIdObst1TypeDossierDeprecated

### 6.3.2.31 Number of parity: diafIdObst1Parite:

Terme	Parité
 41SA + 2J	 4








The Parity field counts the number of live births, number of therapeutic abortions > 22 WA (NO\_TAB\_>\_22) and number of intrauterine foetal deaths (NO\_IUFD\_>22).

Field updated following modification of pregnancy outcome in obstetrical history.

Field updated following modification of:

- diafIdIntervINTERV\_EC
- diafIdObst1PregnancyOutcome

### 6.3.2.32 Scarred uterus (diafIdObstUterusCicatriciel):

Nom	Prénom	Âge	Taille	Poids	Groupe sanguin	Terme	Parité	Ut. Cicatriciel	
M.	test	nbenfant	 N/R	 0cm	 0kg	 N/R	 N/R	 1	 B bicatriciel

Scarred Uterus is calculated from the total number of c-sections (diafIdObst1NbCesar) and the number of gynaecological scars (diafIdObstCicatriceGyn).

Depending on this total, the display of the number of uterine scars is adjusted:

- 0: No
- 1: Single scar
- 2: Two scars
- 3: Three scars
- 4: Four scars
- 5: Five scars
- 6 or more: Greater than 5

Field updated if:

- Number of c-sections is edited (diafIdObst1NbCesar)

- Number or type of gynaecological scars is edited (diafldObstCicatriceGyn / diafldObstNbCicatriceGyn)

#### **6.3.2.33 Total days of amenorrhoea (diafldObst1JoursTotalAmenorrhee):**

Total duration in days from start of amenorrhoea to birth. Corresponds to the duration in weeks x 7 + duration in days.

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.34 Number of weeks of amenorrhoea (diafldObst1SemainesAmenorrhee):**

Number of weeks of amenorrhoea is calculated using the TotalDaysAmenorrhoea field divided by 7.

Field updated following editing of diafldObst1TotalDaysAmenorrhoea.

#### **6.3.2.35 Number of days of amenorrhoea in addition to number of weeks (diafldObst1JoursAmenorrhee):**

Number of days of amenorrhoea is calculated using the TotalDaysAmenorrhoea field modulo 7.

Field updated following editing of diafldObst1TotalDaysAmenorrhoea.

#### **6.3.2.36 Start date first trimester ultrasound (diafldObst1DateDebutEchoT1):**

This date is calculated using Pregnancy start date + 63 days (9 weeks).

Field updated if:

- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.37 End date first trimester ultrasound (diafldObst1DateFinEchoT1):**

This date is calculated using Pregnancy start date + 83 days (11 weeks and 6 days).

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.38 Start date for first trimester T21 screening (diafldObst1DateDebutDepistageT21T1):**

This date is calculated using Pregnancy start date + 63 days (9 weeks).

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.39 End date for first trimester T21 screening (diafldObst1DateFinDepistageT21T1):**

This date is calculated using Pregnancy start date + 83 days (11 weeks and 6 days).

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.40 Deadline for EAB (diafldObst1DateLimiteIVG):**

This date calculated using Pregnancy start date + 84 days

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.41 Deadline fasting blood sugar diabetes test (Obstétrique1/DateLimiteGlycemieAJeun):**

This date calculated using Pregnancy start date + 97 days (13 weeks and 6 days).

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.42 Prenatal consultation date (diafldObst1DateEntretienPrenatal):**

This date calculated using Pregnancy start date + 92 days (13 weeks).

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.43 Deadline pregnancy declaration (diafldObst1DateLimiteDeclarationGrossesse):**

This date calculated using Pregnancy start date + 98 days (14 weeks).

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.44 Start date for second trimester T21 screening (diafldObst1DateDebutDepistageT21T2):**

This date calculated using Pregnancy start date + 84 days (9 weeks).

Field updated if:

BOW MEDICAL SAS, 43, Avenue d'Italie  
34 87  
80090 Amiens – FRANCE  
DIANE Settings Manual: Version: 4.9

Tel.: +33(0)3 60 03 24 68 - Fax: +33(0)9 72 29

Email: [contact@bowmedical.com](mailto:contact@bowmedical.com)

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- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.45 End date for second trimester T21 screening (diafldObst1DateFinDepistageT21T2):**

This date calculated using Pregnancy start date + 112 days (16 weeks).

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.46 Start date for second trimester ultrasound (diafldObst1DateDebutEchoT2):**

This date calculated using Pregnancy start date + 126 days (18 weeks).

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.47 End date for second trimester ultrasound (diafldObst1DateFinEchoT2):**

This date calculated using Pregnancy start date + 161 days (23 weeks).

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.48 Start date oral glucose tolerance test (diafldObst1DebutHPGO75):**

This date calculated using Pregnancy start date + 154 days (22 weeks).

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.49 End date oral glucose tolerance test (diafldObst1FinHPGO75):**

This date calculated using Pregnancy start date + 182 days (26 weeks).

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.50 Start date for third trimester ultrasound (diafldObst1DateDebutEchoT3):**

This date calculated using Pregnancy start date + 196 days (28 weeks).

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.51 End date for third trimester ultrasound (diafldObst1DateFinEchoT3):**

This date calculated using Pregnancy start date + 231 days (33 weeks).

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)
- diafldObst1MesureLCC

#### **6.3.2.52 Start date for Strep B testing (diafldObst1DebutStreptoB):**

This date calculated using Pregnancy start date + 224 days (32 weeks).

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.53 End date for Strep B testing (diafldObst1FinStreptoB):**

This date calculated using Pregnancy start date + 252 days (36 weeks).

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.54 Patient age (Patient/AgelInYearsInteger)**

Field calculated based on patient date of birth (PatientDATENAIS). If this date is not zero, the Patient age field corresponds to the difference in years between the current date and patient's date of birth.

Field modified following update to Patient/DOB.

#### **6.3.2.55 Start date for 3-month consultation (diafldObst1ConsultationTroisiemeMoisDebut):**

Date calculated using Date of last period + 84 days (12 weeks)

Field updated if:

- Pregnancy start date is edited (diafldObst1DebutGrossesse)
- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)



- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.56 End date for 3-month consultation (DiafldObst1ConsultationTroisiemeMoisFin):**

Date calculated using Date of last period + 91 days (13 weeks)

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.57 Start date for 4-month consultation (diafldObst1ConsultationQuatriemeMoisDebut):**

Date calculated using Date of last period + 112 days (16 weeks)

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.58 End date for 4-month consultation (diafldObst1ConsultationQuatriemeMoisFin):**

Date calculated using Date of last period + 140 days (20 weeks)

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.59 Start date for 5-month consultation (diafldObst1ConsultationCinquiemeMoisDebut):**

Date calculated using Date of last period + 140 days (20 weeks)

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.60 End date for 5-month consultation (diafldObst1ConsultationCinquiemeMoisFin):**

Date calculated using Date of last period + 168 days (24 weeks)

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.61 Start date for 6-month consultation (diafldObst1ConsultationSixiemeMoisDebut):**

Date calculated using Date of last period + 196 days (28 weeks)

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.62 End date for 6-month consultation (diafldObst1ConsultationSixiemeMoisFin):**

Date calculated using Date of last period + 224 days (32 weeks)

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.63 Start date for 7-month consultation (diafldObst1ConsultationSeptiemeMoisDebut):**

Date calculated using Date of last period + 224 days (32 weeks)

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

#### **6.3.2.64 End date for 7-month consultation (diafldObst1ConsultationSeptiemeMoisFin):**

Date calculated using Date of last period + 238 days (34 weeks)

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

### **6.3.2.65 Start date for 7-month anaesthesia consultation (diafldObst1ConsultationAnesthSeptiemeMoisDebut):**

Date calculated using Date of last period + 196 days (28 weeks)

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

### **6.3.2.66 End date for 7-month anaesthesia consultation (diafldObst1ConsultationAnesthSeptiemeMoisFin):**

Date calculated using Date of last period + 224 days (32 weeks)

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

### **6.3.2.67 Start date for 8-month consultation (diafldObst1ConsultationHuitiemeMoisDebut):**

Date calculated using Date of last period + 196 days (28 weeks)

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

### **6.3.2.68 End date for 8-month consultation (diafldObst1ConsultationHuitiemeMoisFin):**

Date calculated using Date of last period + 252 days (36 weeks)

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

### **6.3.2.69 Start date for 9-month consultation (diafldObst1ConsultationNeuviemeMoisDebut):**

Date calculated using Date of last period + 252 days (36 weeks)

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)

- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

### **6.3.2.70 End date for 9-month consultation (diafldObst1ConsultationNeuviemeMoisFin):**

Date calculated using Date of last period + 266 days (38 weeks)

Field updated if:

- Date of last period is edited (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is edited (diafldObst1IssueGroDate)
- Term determination type is edited (diafldObst1DeterminationTerme)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)
- First trimester CRL measurement is edited (diafldObst1MesureLCC)

### **6.3.2.71 Number of children for current pregnancy (diafldObst1NombreEnfants):**

This field is equal to the number of fetuses for the current pregnancy. The status of the baby during the pregnancy/at birth is not taken into account.

Field edited following update to diafldIntervTypeGrossesse field.

### **6.3.2.72 Number of weeks of amenorrhoea at time of first-trimester ultrasound (diafldObst1SAEchoT1):**

Calculation of number of weeks of amenorrhoea at time of first trimester ultrasound using date field Obst\_date\_echo\_t1.

Field updated if:

- First trimester CRL measurement is modified (diafldObst1MesureLCC)
- First trimester ultrasound date is modified (diafldObstDateEchoT1)

### **6.3.2.73 Number of days of amenorrhoea at time of first-trimester ultrasound (diafldObst1JEchoT1):**

Calculation of number of days in addition to number of weeks of amenorrhoea at time of first trimester ultrasound using date field Obst\_date\_echo\_t1.

Field updated if:

- First trimester CRL measurement is modified (diafldObst1MesureLCC)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)

### **6.3.2.74 Calculation of PSD according to CRL (diafldDDGCalc):**

Requirement: the "Determined by" drop-down list (DeterminationGrossesse) must be initialised with the value 1 (CRL < 14WA). The Ultrasound date (Obstr\_date\_echo\_t1) and CRL value (mesure\_LCC) must be completed in the First trimester ultrasound section.

PSD = (Date T1 ultrasound - ((WACRL \* 7) + DCRL)) + two weeks

The WACRL and DCRL values are stored on the hard drive in Diane:

CRL measurement	WACRL
6 to 9	6
10 to 15	7
16 to 23	8
24 to 32	9

33 to 43	10
44 to 55	11
56 to 68	12
69 to 83	13
84 to 85	14

CRL measurement	DCRL
6, 11, 17, 25, 34, 35, 45, 46, 57, 58, 71, 72	1
18, 26, 36, 47, 59, 60, 73, 74	2
7, 12, 19, 27, 28, 37, 38, 48, 49, 61, 62, 76, 77	3
13, 20, 29, 39, 50, 51, 63, 64, 78, 79	4
8, 14, 21, 22, 30, 40, 41, 52, 53, 65, 66, 80, 81	5
9, 15, 23, 31, 32, 42, 54, 55, 67, 68, 82, 83	6
43	7

Field updated if:

- Term determination is edited (diafldObst1DeterminationTerme)
- First trimester CRL measurement is modified (diafldObst1MesureLCC)
- First trimester ultrasound date is edited (diafldObstDateEchoT1)

### 6.3.2.75 Latent phase (DiafldObstPhaseLatence):

Duration in minutes from start of labour (AE DR admission) and 5cm dilation (AE Labour curve).

The latent phase is calculated:

- If the dilation is edited/deleted
- If an event such as start of labour is added
- If the start of labour is deleted
- If the time of an event such as start of labour is updated

### 6.3.2.76 Active phase (DiafldObstPhaseActive):

Duration in minutes between dilation at 5 (AE labour curve) and dilation at 10

The active phase is calculated:

- If the dilation is edited/deleted
- If an event such as start of labour is added
- If the start of labour is deleted
- If the time of an event such as start of labour is updated

### 6.3.2.77 Stage 1 duration: Labour (diafldObstStade1)

The duration of stage 1 corresponds to the difference in minutes between the Start of labour (AE DR admission) and the entry time for cervical dilation at 10 or more (AE labour curve).

Stage 1 is recalculated:

- If the dilation is edited/deleted
- If an event such as start of labour is added
- If the start of labour is deleted
- If the time of an event such as start of labour is updated

### 6.3.2.78 Stage 2 duration: Descent and birth of the baby (diafldObstStade2)

The duration of stage 2 corresponds to the difference in minutes between the entry time for cervical dilation at 10 and the birth of the child.

This duration is recalculated:

- If Pregnancy outcome date (diafIdObst1IssueGroDate) is edited
- If the dilation is modified/deleted

### **6.3.2.79 Stage 3 duration (diafIdObstStade3):**

The duration of stage 3 corresponds to the difference in minutes between the birth of the child and the delivery of the placenta (AE Delivery).

The duration is calculated if:

- the Delivery is added
- the Placenta delivery entry time is edited
- the Delivery is deleted
- the Pregnancy outcome date is edited (diafIdObst1IssueGroDate)

### **6.3.2.80 Term of labour (diafIdObstTermeMiseTravailSAJ):**

Terme

 41SA + 1J

This calculated field is the result of the concatenation of two calculated fields:

- diafIdObstTermeMiseTravailSA: calculated based on the difference between the Date of last period (DernieresReglesCalc) and the date of the Start of labour event divided by 7.
- diafIdObstTermeMiseTravailJ: calculated based on the difference in days between the Date of last period (DernieresReglesCalc) and the date of the Start of labour event modulo 7.

The term is calculated if:

- the calculated date of last period is edited (diafIdObst1DernieresReglesCalc)
- If an event such as start of labour is added
- If the start of labour is deleted
- If the time of an event such as start of labour is updated

### **6.3.2.81 Rupture of membranes: diafIdObstPerteLADebutTravail**

Calculated field corresponding to the duration in minutes between the start of labour event (AE DR admission) and the rupture of membranes event. If several membrane ruptures take place (multiple pregnancy), this is calculated based on the first event.

### **6.3.2.82 History: Number of stillbirths (diafIdObstNbMortsNés):**

Counts the number of stillbirths in the patient's obstetrical history. Calculated on the basis of the total of the calculated fields diafIdObst1NbMFIUSup22 and diafIdObst1NbIMGSup22.

The term is calculated if:

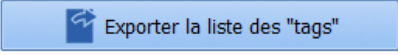
- The number of Intrauterine foetal deaths after 22 weeks is updated (diafIdObst1NbMFIUSup22)
- The number of Medical terminations after 22 weeks is updated (diafIdObst1NbIMGSup22)

## 6.4 List of tags

### 6.4.1 Print tags

It is possible to extract the list of **Word** tags by editing any **Word** form letter and clicking the following button **Export list of "tags"**.


ETAPE 2 : Composer votre lettre type à l'aide des Tags de Diane



Vous pouvez exporter la liste des Tags de Diane vers un fichier texte en cliquant sur le bouton ci-contre. Si vous avez sélectionné l'application Word alors ce fichier texte doit être utilisé tel quel comme source de données rattachée à la lettre type que vous allez saisir. Pour cela lancer Word, sélectionnez dans le menu "Outils/Publipostage" puis créez une "Lettre type" en document principal. Ouvrez le fichier texte (.txt) contenant les Tags de Diane comme source de données. Composez alors votre lettre type en insérant les champs de fusion disponibles directement à partir de la barre d'outil prévu à cet effet dans Word ("PATIENTNOM\_PATRONYMIQUE", PATIENTPRENOM", ...).

Si vous n'utilisez pas Word mais le format WordPad RTF, WordPad TXT ou StarOffice/OpenOffice, alors le fichier texte généré contiendra les Tags Diane tels qu'ils doivent être saisis dans la lettre type que vous créez ("Diane[PATIENT-NOM\_PATRONYMIQUE]", "Diane[PATIENT-PRENOM]", ...).

The print tag associated with a **DIANE** data field is easily located as follows:


- Open the configuration tool.
- Open the "**DIANE** data field management" tool (top left, click ).
- Select the relevant field.

**Informations du champ**

Identifiant interne Diane: diafidPatientNOMMARITAL - 3  
Nom du champ: NOMMARITAL  
Description du champ: Nom usuel du patient

AX de référence: Patient - raPatient - 12  
Identifiant de donnée: 3  
Type de donnée: Normale - dfkNormal - 0  
Type (base de données): Texte - ddbftString - 6  
Tag d'impression associé: PATIENT-NOM\_MARITAL

#### 6.4.1.1 Print tags associated with traceability

A print tag **INTERV-TRACABILITE** (traceability of different patient transfers in the record) is used to display the chronology (timeline) of the selected procedure, as does hovering over the  icon in the patient selection window.

There is also a print tag for each category of patient transfer:

**INTERV-TRANSFERT**: Transfer period

**INTERV-INDUCTION**: Induction period

**INTERV-BLOC**: Period of admission to OT

**INTERV-REVEIL**: Recovery period

**INTERV-REA**: Period in ICU/CCU

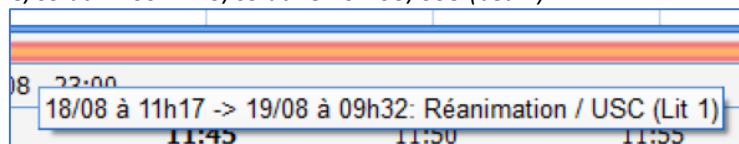
**INTERV-CONSULTOBS**: Period in obstetric consultation

**INTERV-SALLENAISS**: Period in delivery room

**INTERV-AMBU**: Period in ambulatory

**INTERV-CLOTURE** Record closure

(e.g. **INTERV-REA** → 18/09 at 12:00 → 19/09 at 18:45: ICU/CCU (bed 1)



#### 6.4.1.2 Print tags associated with treatments and premedications

**PREMEDICATIONS\_PERSOS\_SIGNES\_LE**: Patient premedications signature date/time

**PREMEDICATIONS\_PERSOS\_SIGNES\_PAR**: Full name of doctor signing the patient premedications

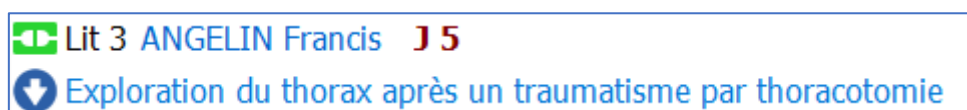
**CPA-PREMEDICATIONS**: Premedication

**PRESCR-Premedications\_ALD**: Premedications - Long-term condition

**PRESCR-Premedications\_NonALD:** Premedications - Not long-term condition  
**PRESCR-REA\_PREMEDICATIONS:** ICU medication orders - Import from premedications  
**SIGNATURE\_IMAGE\_MEDECIN\_PREMED:** Signature of doctor signing the patient premedications  
**TRAITEMENTS\_PERSOS\_SIGNES\_LE:** Date and time of validation of patient's personal treatments  
**COMMENTAIRE\_TRAITEMENT:** Disease history  
**TRAITEMENTS\_PERSOS\_SIGNES\_PAR:** Full name of doctor validating the patient's personal treatments  
**PRESCR-TraitementPersonnel\_ALD:** Personal treatment - Long-term condition  
**PRESCR-TraitementPersEtRelais\_ALD:** Personal treatment - Not long-term condition  
**PRESCR-TraitementPersEtRelais\_NonALD:** Personal treatment and conversion: Long-term condition  
**PRESCR-TraitementPersonnel\_NonALD:** Personal treatment and conversion: Not long-term condition  
**CPA-RELAIS-HORS-HOPITAL:** Personal treatment - Display substitutes associated with drug database  
**CPA-PREMEDICATIONS\_HORS\_HOPITAL:** Premedications - Display premedications associated with drug database

## 6.4.2 Information tags shown in DIANE ICU portal (versions before V4.8)

Tags relating to the **DIANE ICU** portal:



"Patient name mask in list of patients present" key in DianeRea.ini (first row):

Tag	Action
<PATIENTFORMATEDNAMES>	Patient name formatted as set up in "Select patient name display type" key in the DiaServeur.ini file
<PATIENTNOMPATRO>	Patient's birth name
<PATIENTNOMMARIT>	Name gone by
<PATIENTPRENOM>	Patient's first name
<PATIENTSEXE>	Patient's sex (M or F)
<PATIENTAGE>	Patient's age (including unit)
<PATIENTIPP>	UPI
<PATIENTDATENAISS>	Patient's date of birth in regional format of the operating system
<PATIENT_HEIGHT>	Patient's height (including unit)
<PATIENT_WEIGHT>	Patient's weight (including unit)

"Reason for admission" key in DianeRea.ini (second line):

Tag	Action
<MOTIF_ADMISSION>	Value of ActiveX "CPAInterv", "PATHOLOGIE "=2 data
<MOTIF_TYPE_INTERV> and <TYPE_INTERV>	Value of ActiveX "CPAInterv", "TYPINTER "=5 data
<MOTIF_CHIRURGIEN>	Value of ActiveX "CPAInterv", "CHIRURGIEN "=9 data
<MOTIF_REA_RESP>	Full name of doctor in charge of the current ICU time slot
<MOTIF_INF_RESP>	Full name of nurse in charge of the current ICU time slot
<MOTIF_ASN_RESP>	Full name of caregiver in charge of the current ICU time slot


"Additional information (if available) to be added to the reason for admission" key in DianeRea.ini (second line):

Tag	Action
<UPOP_CHIR>	Name of surgeon present during surgery (used for post-op unit)
<UPOP_ANESTH>	Name of anaesthetist present during surgery (used for post-op unit)



### 6.4.3 Information tags shown in title bar of Visual/DIANE ICU/ DIANE OB-GYN

The tags concern the title pane (at the top of the window):

 Lit 3 - ANGELIN Francis - (REPRISE REANIMATION) - Utilisateur: MEDECIN Yves - Version : 4.7.5.2

“Information mask in application title bar” key for Visual/ DIANE ICU / DIANE OB-GYN:

Tag	Action
<USER>	Logged-in user's ID (=login)
<USERNOM>	Logged-in user's last name
<USERPRENOM>	Logged-in user's first name
<USERADELI>	Health professional registry number of the logged-in user
<CURRENTLOCATION>	Patient location (name of room or bed as applicable)
<PATIENTFORMATEDNAMES>	Patient name formatted as set up in “Select patient name display type” key in the DiaServeur.ini file
<PATIENTNOMPATRO>	Patient's birth name
<PATIENTNOMMARIT>	Name gone by
<PATIENTPRENOM>	Patient's first name
<PATIENTSEXE>	Patient's sex (M or F)
<PATIENTAGE>	Patient's age (including unit)
<PATIENTIPP>	UPI
<PATIENTDATENAISS>	Patient's date of birth in regional format of the operating system
<TYPELOCATION>	Current record mode (Induction, Procedure, Copy, etc.)
<RESPONSABLE>	Full name of person responsible for procedure (only for OT/RR)

Key “Title shown at top of application” for Consultation module:

Tag	Action
<USER>	Logged-in user's ID (=login)
<USERNOM>	Logged-in user's last name
<USERPRENOM>	Logged-in user's first name
<USERADELI>	Health professional registry number of the logged-in user
<DATABASENAME>	Name of alias of current database
<PATIENTFORMATEDNAMES>	Patient name formatted as set up in “Select patient name display type” key in the DiaServeur.ini file
<PATIENTNOMPATRO>	Patient's birth name
<PATIENTNOMMARIT>	Name gone by
<PATIENTPRENOM>	Patient's first name
<PATIENTSEXE>	Patient's sex (M or F)
<PATIENTAGE>	Patient's age (including unit)
<PATIENTIPP>	UPI
<PATIENTIEP>	Stay number
<PATIENTDATENAISS>	Patient's date of birth in regional format of the operating system
<PATIENTSERVRESP>	Medical unit admitting patient

### 6.4.4 Information tags shown in ribbon of Visual/DIANE ICU/ DIANE OB-GYN

These tags correspond to what is shown in the top ribbon:

 M.	Nom <b>ANGUERRAN</b>	Prénom <b>Charles</b>	Âge  45 ans	Localisation:  Lit n°3	Jour  J 178	Taille  170cm	Poids initial  53kg	Poids  53kg	Poids théorique  66,02kg
--	-------------------------	--------------------------	---	--	---	---	---	---	--

This is the **Module top ribbon display mask key**.

Tag	Action
<PATIENT_CIVILITE>	Patient title
<PATIENTFORMATEDNAMES>	Patient name formatted as set up in "Select patient name display type" key in the DiaServeur.ini file
<PATIENTNOMPATRO>	Patient's birth name
<PATIENTNOMMARIT>	Name gone by
<PATIENTPRENOM>	Patient's first name
<PATIENTAGE>	Patient's age (including unit)
<PATIENTDATENAISS>	Patient's date of birth in dd/mm/yyyy format
<CURRENTLOCATION>	Patient location (name of room or bed as applicable)
<PATIENT_INTERV_DAY>	Number of days (zero-based) from start of record (for example, for the first day, "D 0" will be shown)
<PATIENT_HEIGHT>	Patient's height (not including unit)
<PATIENT_WEIGHT>	Patient's weight (not including unit)
<PATIENT_INITIAL_WEIGHT>	Initial patient weight
<PATIENT_THEORETICAL_WEIGHT>	Theoretical patient weight according to the formula set up in the DiaServeur.ini file, key "Choice of algorithm for calculating theoretical weight" (not including unit)
<PATIENT_ADJUSTED_WEIGHT>	Adjusted weight calculated according to the formula: <i>Theoretical weight</i> +0.4 × ( <i>Current weight</i> - <i>Theoretical weight</i> ) (not including unit)
<BMI>	IMC
<BSA>	Body surface area (not including unit)
<PATIENTSEXE>	Patient's sex (M or F)
<UF>	Functional unit of current item (workstation): The Functional unit shown corresponds to the first unit found in parent items, recursively
<IPP>	UPI
<BILAN_GROUPE>	Patient blood group (corresponds to the data in the ActiveX "Blood", Data "GROUPE"=1)
<IEP>	Stay number corresponding to record, found by searching based on data of OT start or ICU start (as applicable)
<OBST_SAJ>	Week(s) and Day(s) of amenorrhoea
<OBST_UT_CICAT>	Scarred uterus
<OBST_PARITE>	Parity

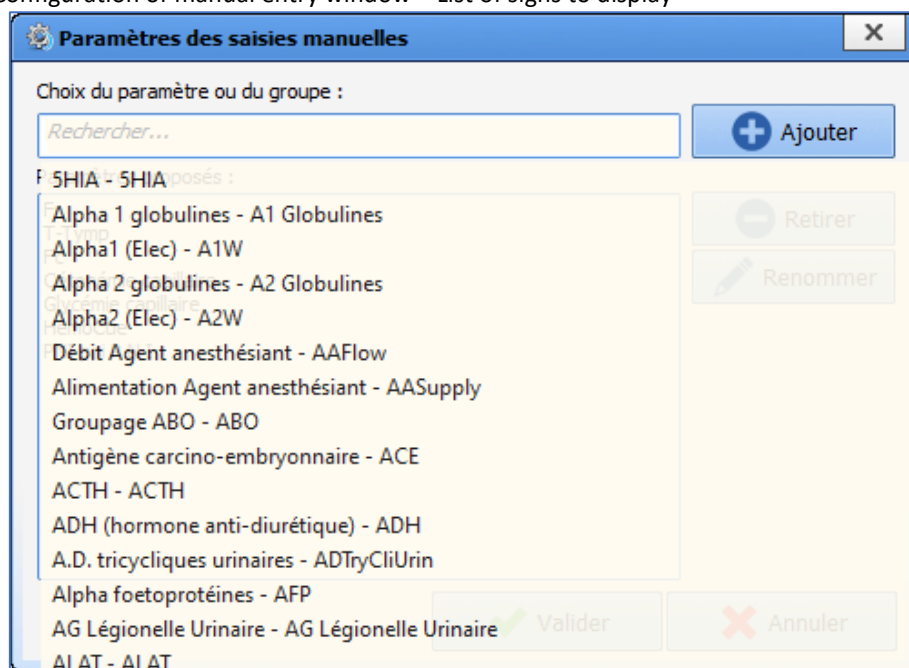
#### 6.4.5 Tags for integrated document items (Notes, Summary, etc.)

Tag	Action
<NEWLINE>	New line
<CURRENTROOM>	Displays name of current room
<CURRENTBLOC>	Displays name of current OT
<CURRENTBED>	Displays name of current recovery bed
<CURRENTPC>	Displays computer name
<USER>	Displays user name of logged-in user
<USERNOM>	Displays name of logged-in user
<USERPRENOM>	Displays first name of logged-in user
<USERROLE>	Displays role of logged-in user
<USERPROFIL>	Displays profile/category of logged-in user
<USERADELI>	Displays health professional registry number of logged-in user
<USERIDEXT>	Displays external ID of logged-in user
<USERIDEXT:APPLI>	If user has several external IDs: Shows username for APPLI application

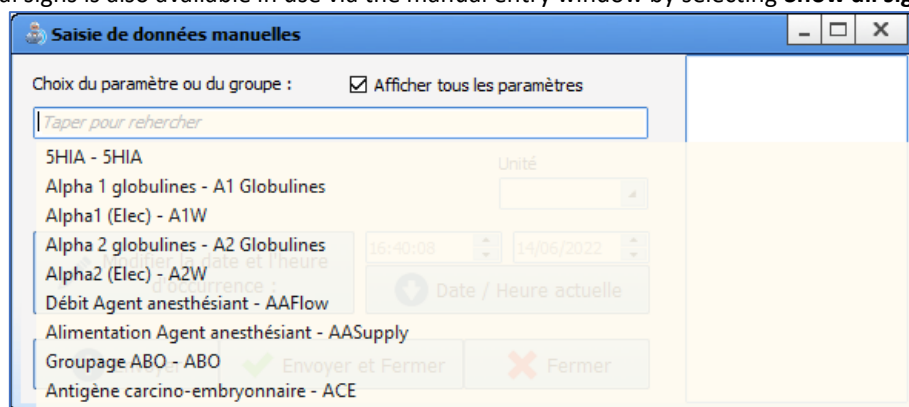
<DATENOW:dd/mm/yyyy>	Shows current date Date format can be configured: dd/mm/yyyy for France (default) mm/dd/yyyy for USA Separator / can be replaced.
<DATENOW:hh:nn:ss>	Shows current time (hh:nn:ss by default) Time format can be configured: E.g.: hh:nn to hide seconds Separator: can be replaced.

## 6.5 Vital signs lists

**DIANE** contains over 1,000 vital signs. The list is available in configuration via the **Settings** tab, **Visual**, key ParamList – Configuration of manual entry window – List of signs to display




The list of vital signs is also available in use via the manual entry window by selecting **Show all signs**.





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 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 04/07/2022