

DIANE Settings Guide

Version 4.12

DIANE | ANESTHESIE
Une marque de BOW MEDICAL

DIANE | OBSTÉTRIQUE
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DIANE | REA
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DEV-EN-035 Settings Guide **DIANE**
DIANE version: 4.12
Medical device version: 3.38
UDI: (01)3760404900005(10)0338
Document version : 1

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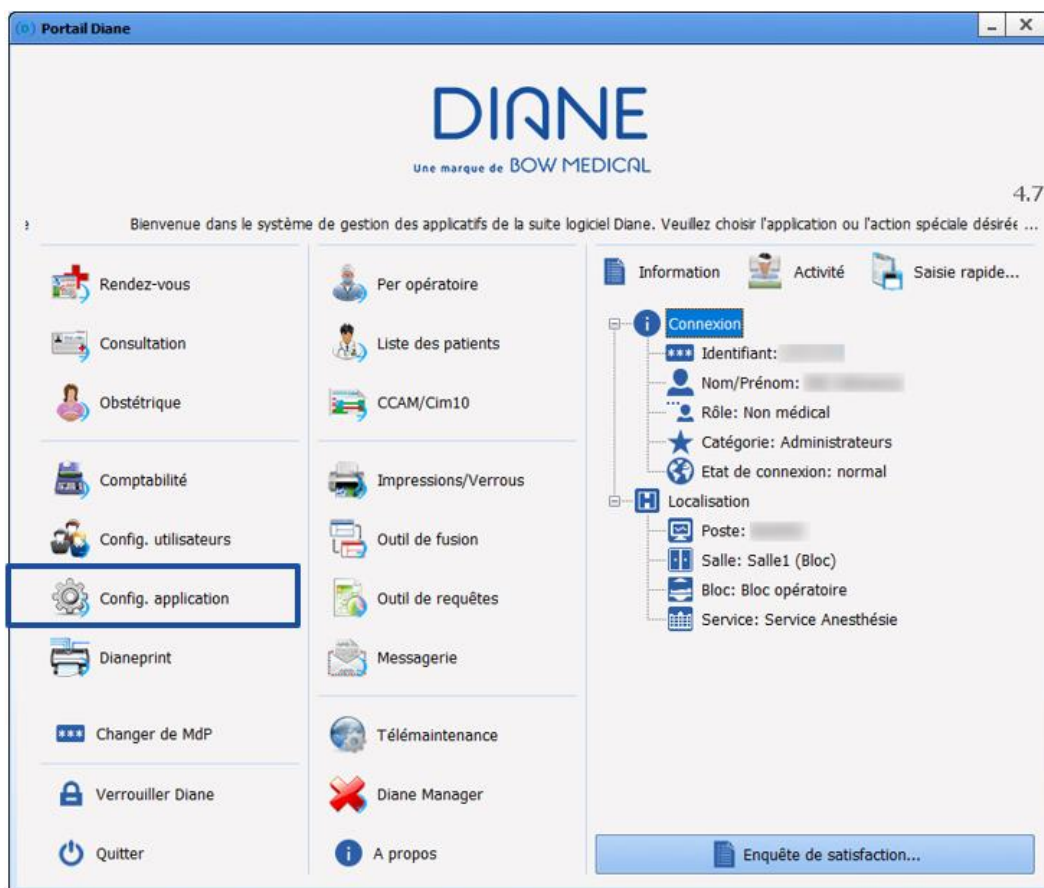


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1 General information

The configuration tool can be accessed from the **DIANE** portal by clicking **config. application**. Configuration is 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 included in this guide are for information purposes only.



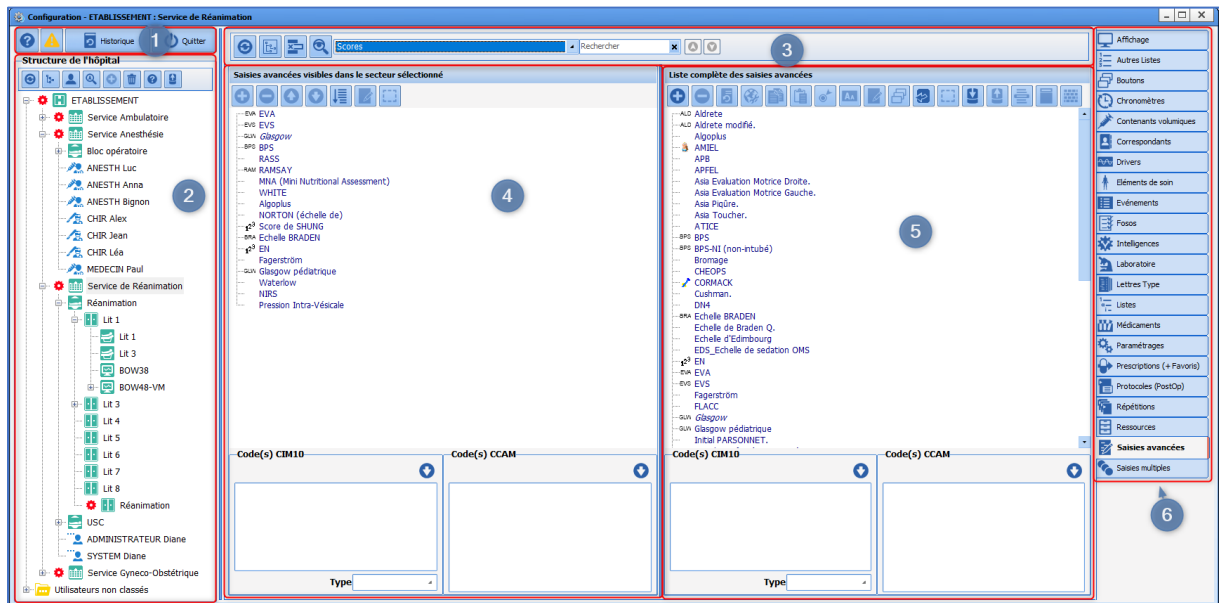
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1.1 Presentation of the application configuration module

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 line can have its own configuration, represented by the ‘gear’.

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

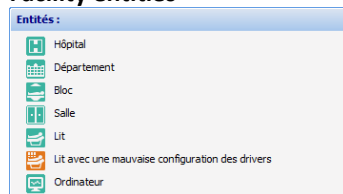
The *middle column* (pane 4) shows the item(s) in the right column applied to the entity and its descendants with a gear.

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)

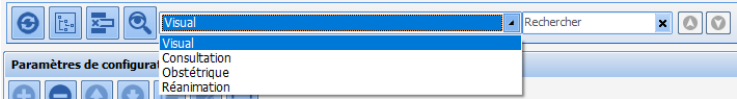
Most of the configuration tabs have a drop-down menu for selecting an item to configure. For example, for the **View** tab



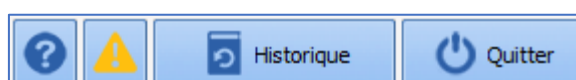
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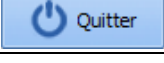


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Configuration tab (Pane 6)	These are the tabs at the right of the configuration interface. They allow the user to set the actions and appearance of DIANE modules.
Toggled item	Toggled items are items that are available, visible or useful for using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

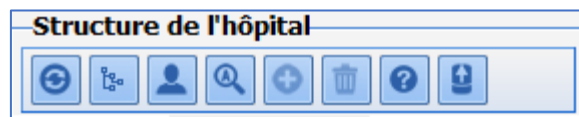
1.3 Configuration module tools (pane 1)











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

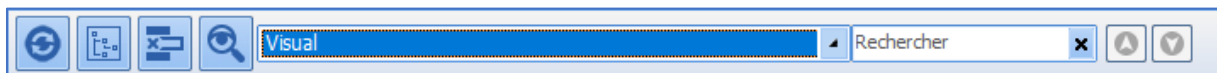








1.4 Hospital structure tools (pane 2)



	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 entity selected.
	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)



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





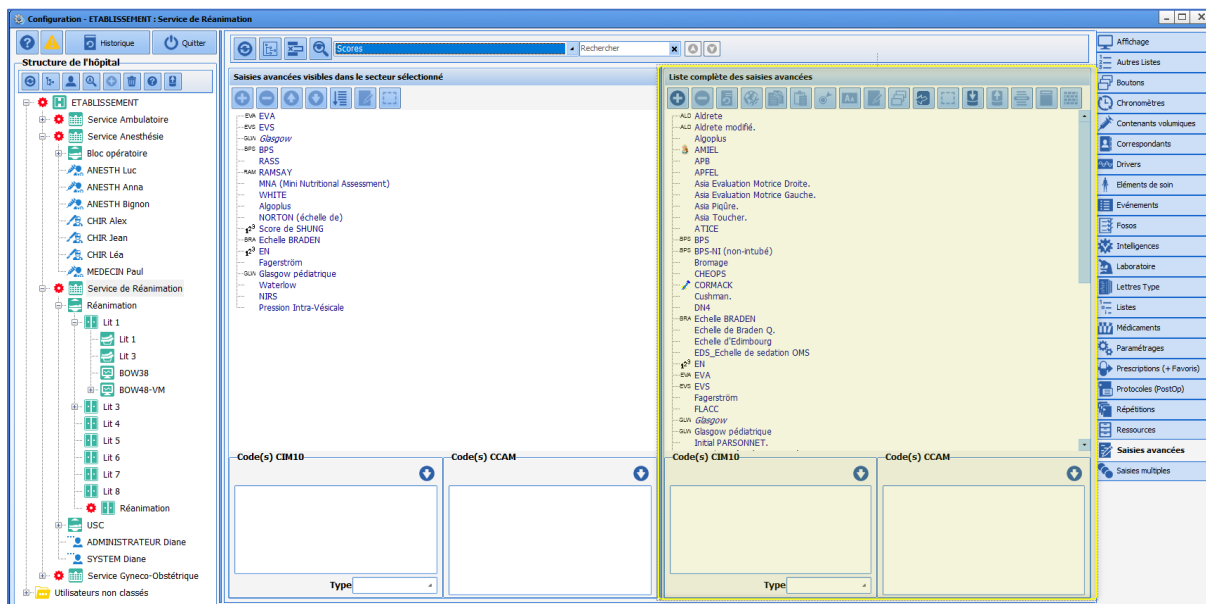
Add a root (List tab)



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.



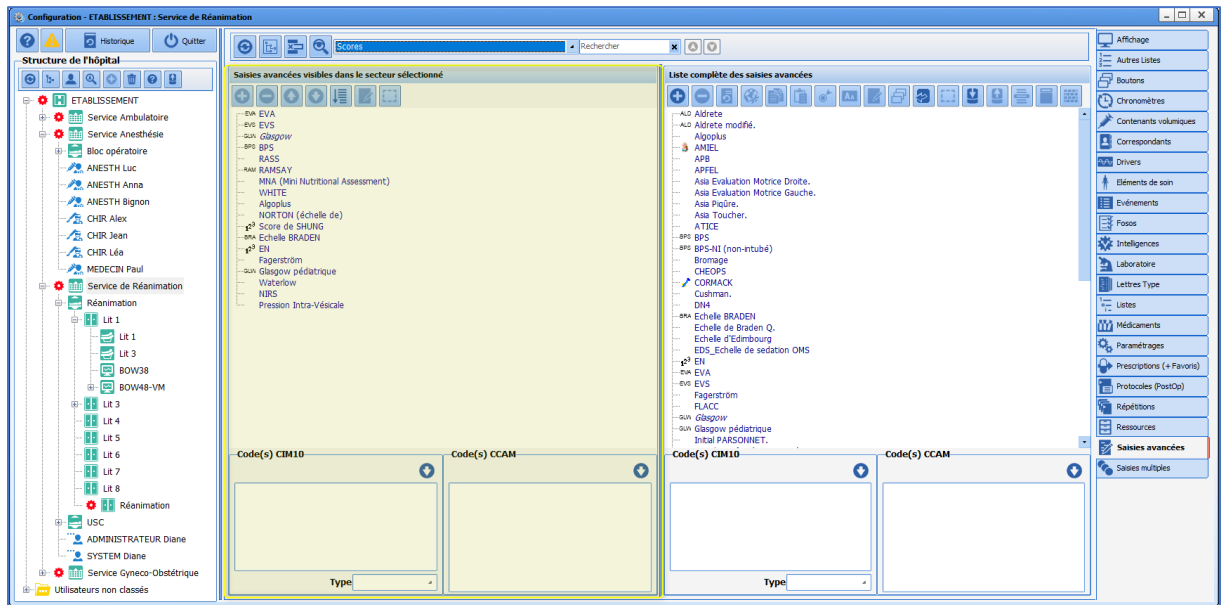
	Toggle one or more configured items into the entity being configured.
	Deselect all.
	Import one or more previously exported items.
	Export one or more items.
	Add a separator to the root (to improve readability).
	Define a header for the document(s) selected (Form letter tab)
	Assign a page background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








1.7 List of toggled items tools

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

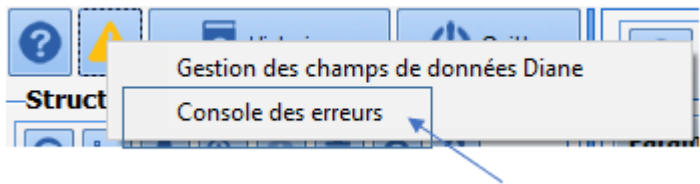
To make searching easier, double-clicking an item in this list automatically selects it in the list of available items (list on right). It is also possible to search for an item via the drop-down **search** menu at the top of the window.





-  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 (**Events** and **Detailed entries** 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.



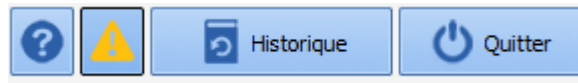
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Liste des rapports d'erreur						
Id	Date	Version	Configuration du poste	Nom du poste	Nom de l'utilisateur	Nom de l'exécutable
102296	15/02/2021 12:09:10	4.8.0.20909	Maitre	BOW38	SYSDIANE	DianeReaV.exe
102297	15/02/2021 12:09:11	4.8.0.20909	Maitre	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.



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1.9.1 History of changes made to configuration

Historique des modifications apportées sur les listes				
Modifications sur les listes				
Période de recherche :				
<input type="radio"/> Aucun <input type="radio"/> Jour <input type="radio"/> Semaine <input type="radio"/> Mois <input type="radio"/> Année <input type="radio"/> Entre 2 dates : 08/09/2020 et 18/09/2020				
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 Diareport 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 ("4862Test")
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)
4814	06/08/2020 09:34:47	MEDECIN Yves	Liste : Utilisateur	Mise à jour de l'utilisateur BRETON Gaetan (GAETAN)

1.9.2 History of access and patient record opening

Historique des modifications apportées sur les listes							
Modifications sur les listes							
Accès / Ouverture de dossiers							
Accès utilisateur							
Patients / Interventions							
Resynchronisation							
Verrous							
Accès aux modules							
Période de recherche							
Entre		18/09/2020	ou	<input checked="" type="checkbox"/> Le plus ancien			
et		18/09/2020	ou	<input checked="" type="checkbox"/> Maintenant			
Éléments à afficher							
<input checked="" type="checkbox"/> Création de patient		<input checked="" type="checkbox"/> Fermeture de patient					
<input checked="" type="checkbox"/> Ouverture de patient en Lecture		<input checked="" type="checkbox"/> Création d'intervention					
<input checked="" type="checkbox"/> Ouverture de patient en Ecriture		<input checked="" type="checkbox"/> Accès à une intervention					
Rechercher							
Filtres							
Nom :		Prénom :		Entité :			
Filtres Patient							
Nom :		Nom Usuel :					
Prénom :		IPP :		Date de naissance : / /			
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 INCONNU [01/09/2020]	16/09/2020	DianeRea	
16/09/2020 16:34:07	Diane SYSTEM	BOW48	Accès intervention	16/09/20 15:34 NOM INCONNU [01/09/2020]	16/09/2020	DianeRea	
16/09/2020 16:04:11	Diane SYSTEM	BOW48	Accès intervention	16/09/20 15:34 NOM INCONNU [01/09/2020]	16/09/2020	DianeRea	
16/09/2020 15:35:04	Diane SYSTEM	BOW48	Intervention créée	16/09/20 15:34 NOM INCONNU [01/09/2020]	16/09/2020	DianeRea	
16/09/2020 15:35:04	Diane SYSTEM	BOW48	Accès intervention	16/09/20 15:34 NOM INCONNU [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	



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1.10 ActiveX, data IS and print tags

In order to save the information entered into 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...).


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

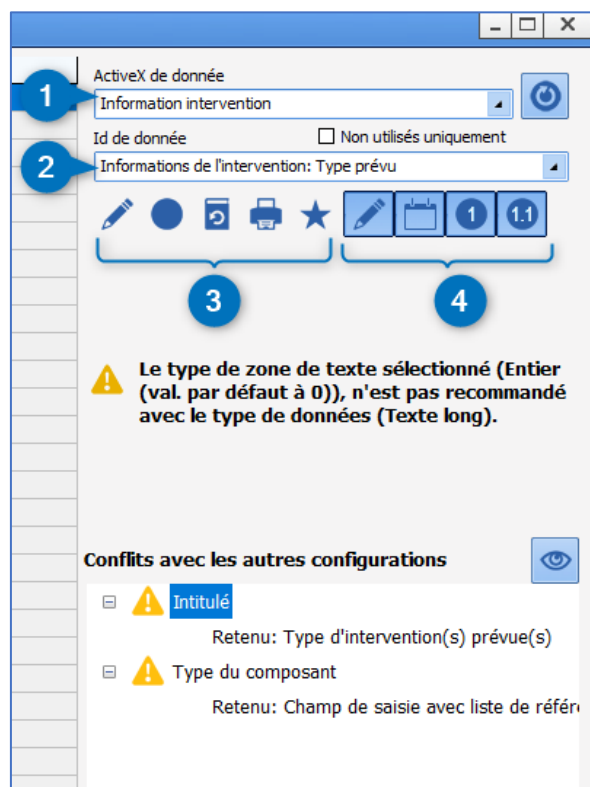
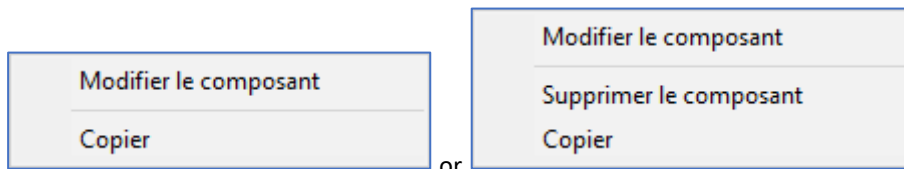
Each piece of data is identified by its data ID (anaesthetic history, for example).

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 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)



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-  : 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 with IDs with specific names. They may be configured with specific behaviour.

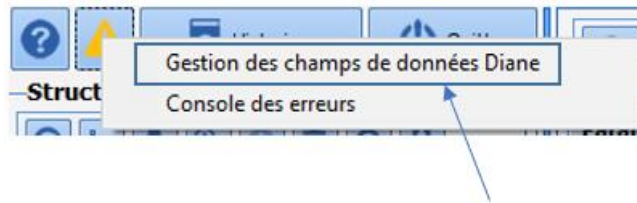
For example, all IDs in the Ax list = **Preoperative assessment** are connected to each other. Filling in a component on this list will automatically fill in components with the IDs “Done by” and “On”.

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 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.

Champs de donnée Diane

- ✓ CPAREa1_CHAMP21 (Données de réanimation 1 : ...)
- ✓ CPAREa1_CHAMP22 (Données de réanimation 1 : ...)
- ✓ CPAREa1_CHAMP23 (Données de réanimation 1 : ...)
- ✓ CPAREa1_CHAMP24 (Données de réanimation 1 : ...)
- ✓ CPAREa1_CHAMP25 (Données de réanimation 1 : ...)
- ⚠ CPAREa2_CHAMP01 (Données de réanimation 2 : ...)
- ✓ CPAREa2_CHAMP02 (Données de réanimation 2 : ...)
- ✓ CPAREa2_CHAMP03 (Données de réanimation 2 : ...)
- ✓ CPAREa2_CHAMP04 (Données de réanimation 2 : ...)
- ✓ CPAREa2_CHAMP05 (Données de réanimation 2 : ...)
- ✓ CPAREa2_CHAMP06 (Données de réanimation 2 : ...)
- ✓ CPAREa2_CHAMP07 (Données de réanimation 2 : ...)
- ✓ CPAREa2_CHAMP08 (Données de réanimation 2 : ...)
- ⚠ CPAREa2_CHAMP10 (Données de réanimation 2 : ...)
- ✓ CPAREa2_CHAMP11 (Données de réanimation 2 : ...)
- ⚠ CPAREa2_CHAMP12 (Données de réanimation 2 : ...)
- ✓ CPAREa2_CHAMP15 (Données de réanimation 2 : ...)
- ✓ CPAREa2_CHAMP16 (Données de réanimation 2 : ...)
- ✓ CPAREa2_CHAMP18 (Données de réanimation 2 : ...)
- ⚠ CPAREa3_CHAMP01 (Données de réanimation 3 : ...)
- ✓ CPAREa3_CHAMP02 (Données de réanimation 3 : ...)

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			

Configurations courantes uniquement 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.



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1.10.3 DIANE data field management tool from the component

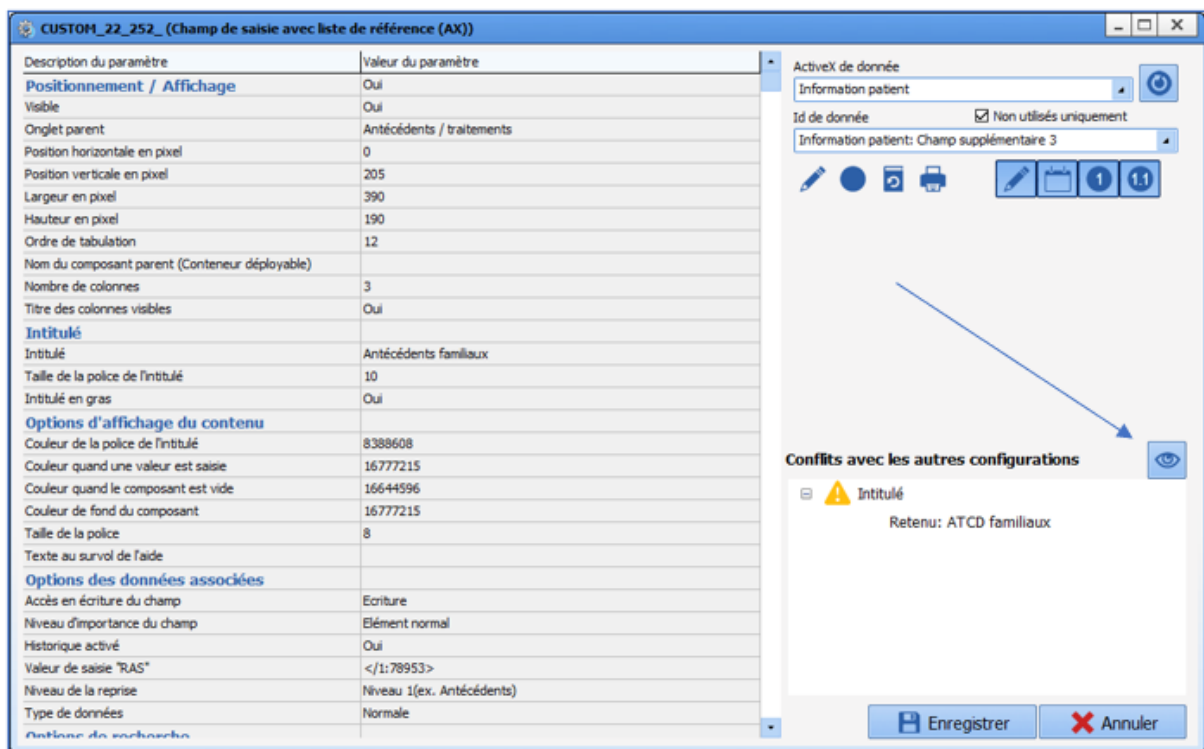
This management tool can also be accessed from a component settings window.



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

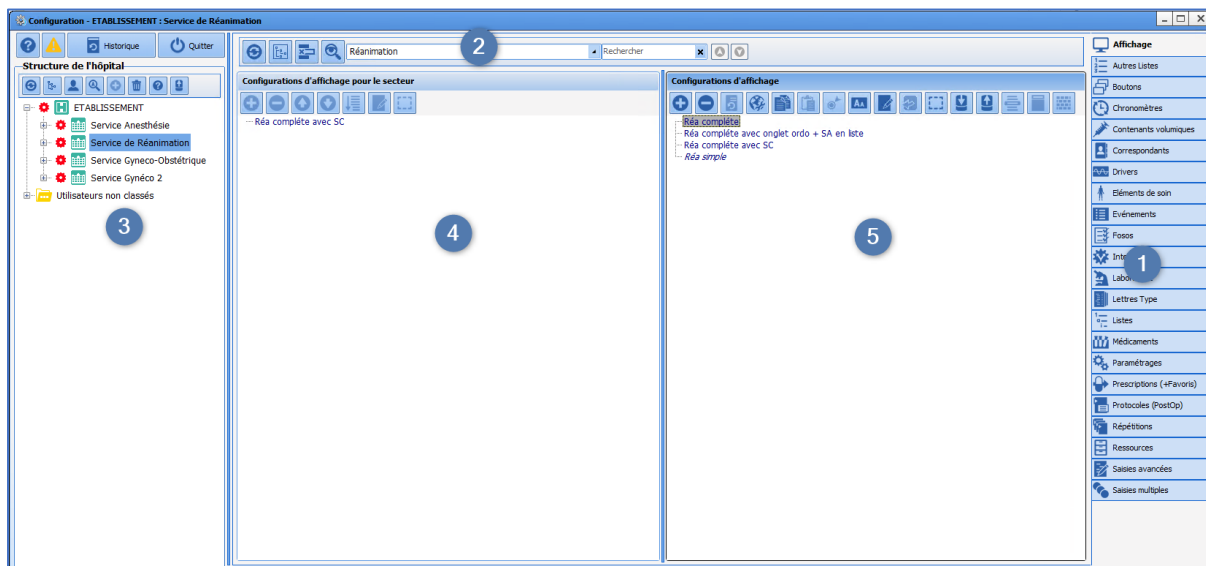
Clicking the eye opens the window described in the previous chapter.

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



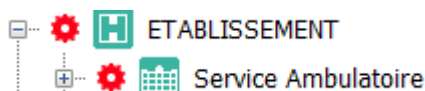
2 Settings in DIANE - General information

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 the required location >> **Create a new configuration**
- Click to confirm
- Click to accept a copy the first Version found.



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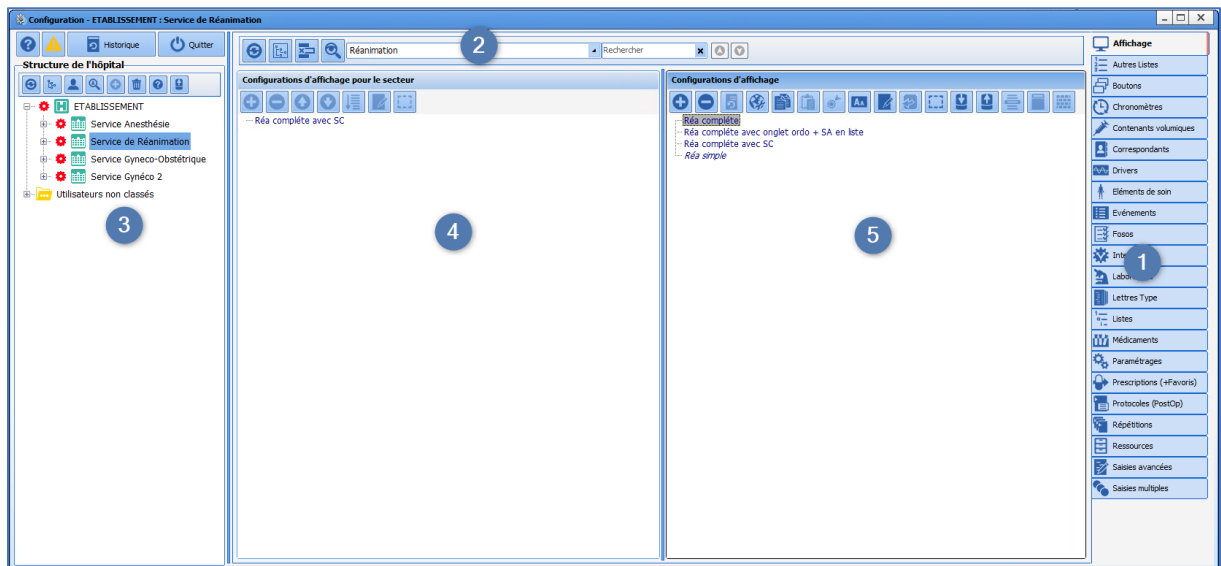
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2.1.2 Deleting a gear:

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

This deletion will return the sector/room/computer 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.

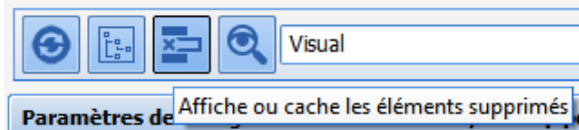
Before deleting an item, it is preferable to rename it so that the name can be reused. Otherwise, having several items with the same name can lead to confusion. Duplicates are not recommended. Rename items by starting the name with several Zs.


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 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.




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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																																																																											
<p>“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</p> <div style="text-align: center;">  </div> <p>“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.</p> <p>“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.</p> <p>“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 entering the bottom corner or line of the component. This makes it easier to harmonise the appearance.</p> <p>“Tab order”: used to manage the tab order of the components on the tab.</p> <p>“Parent component name (deployable container): not used</p>	<table border="1"> <thead> <tr> <th colspan="2">DiaAxEdit7 (Champ de saisie simple (AX))</th> </tr> <tr> <th>Description du paramètre</th> <th>Valeur du paramètre</th> </tr> </thead> <tbody> <tr> <td colspan="2">Positionnement / Affichage</td> </tr> <tr> <td>Visible</td> <td>Oui</td> </tr> <tr> <td>Onglet parent</td> <td>Administratif</td> </tr> <tr> <td>Position horizontale en pixel</td> <td>930</td> </tr> <tr> <td>Position verticale en pixel</td> <td>160</td> </tr> <tr> <td>Largeur en pixel</td> <td>160</td> </tr> <tr> <td>Hauteur en pixel</td> <td>22</td> </tr> <tr> <td>Ordre de tabulation</td> <td>27</td> </tr> <tr> <td colspan="2">Nom du composant parent (Conteneur déployable)</td> </tr> <tr> <td colspan="2">Intitulé</td> </tr> <tr> <td>Intitulé</td> <td>Profession</td> </tr> <tr> <td>Emplacement de l'intitulé</td> <td>A gauche</td> </tr> <tr> <td>Taille de la police de l'intitulé</td> <td>9</td> </tr> <tr> <td colspan="2">Options d'affichage du contenu</td> </tr> <tr> <td>Couleur de la police de l'intitulé</td> <td>0</td> </tr> <tr> <td>Couleur quand une valeur est saisie</td> <td>16777215</td> </tr> <tr> <td>Couleur quand le composant est vide</td> <td>-16777211</td> </tr> <tr> <td>Couleur de fond du composant</td> <td>16777215</td> </tr> <tr> <td>Taille de la police</td> <td>9</td> </tr> <tr> <td>Texte d'aide à la saisie</td> <td></td> </tr> <tr> <td>Suffixe (par exemple "kg")</td> <td></td> </tr> <tr> <td colspan="2">Options des données associées</td> </tr> <tr> <td>Accès en écriture du champ</td> <td>Ecriture</td> </tr> <tr> <td>Type de zone de saisie</td> <td>Normal</td> </tr> <tr> <td colspan="2">Masque de saisie</td> </tr> <tr> <td>Valeur maximale (entier, 0=désactivé)</td> <td>0</td> </tr> <tr> <td>Valeur minimale (entier, 0=désactivé)</td> <td>0</td> </tr> <tr> <td>Affiche des "0" pour compléter le nombre de chiffres max.</td> <td>(Non)</td> </tr> <tr> <td>Nombre de chiffres maximal avant la virgule</td> <td>7</td> </tr> <tr> <td>Nombre de chiffres maximal après la virgule</td> <td>2</td> </tr> <tr> <td>Niveau d'importance du champ</td> <td>Élément normal</td> </tr> <tr> <td>Historique activé</td> <td>Oui</td> </tr> <tr> <td>Valeur de saisie "RAS"</td> <td></td> </tr> <tr> <td>Niveau de la reprise</td> <td>Niveau 1(ex. Antécédents)</td> </tr> <tr> <td>Type de données</td> <td>Normale</td> </tr> </tbody> </table>	DiaAxEdit7 (Champ de saisie simple (AX))		Description du paramètre	Valeur du paramètre	Positionnement / Affichage		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)		Intitulé		Intitulé	Profession	Emplacement de l'intitulé	A gauche	Taille de la police de l'intitulé	9	Options d'affichage du contenu		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")		Options des données associées		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
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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
Positionnement / Affichage	
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)	
Intitulé	
Intitulé	Profession
Emplacement de l'intitulé	A gauche
Taille de la police de l'intitulé	9
Options d'affichage du contenu	
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 line 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
Positionnement / Affichage	
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)	
Intitulé	
Intitulé	Profession
Emplacement de l'intitulé	A gauche
Taille de la police de l'intitulé	9
Options d'affichage du contenu	
Couleur de la police de l'intitulé	0
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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")	
Options des données associées	
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



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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)

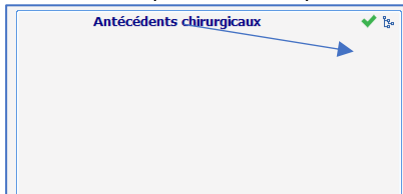
“Input box type”: used to determine the data format (date, name, ...). These choices will be presented later.

“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.



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

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


“Reset”: used to empty the field when a record is opened following a transfer to another unit.

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	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	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 checkboxes, 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 line **context to update**
- Click the  button
- Configure the device
- Save using the **Save** button (bottom right)
- Save using the component settings window button
- Save the display configuration.

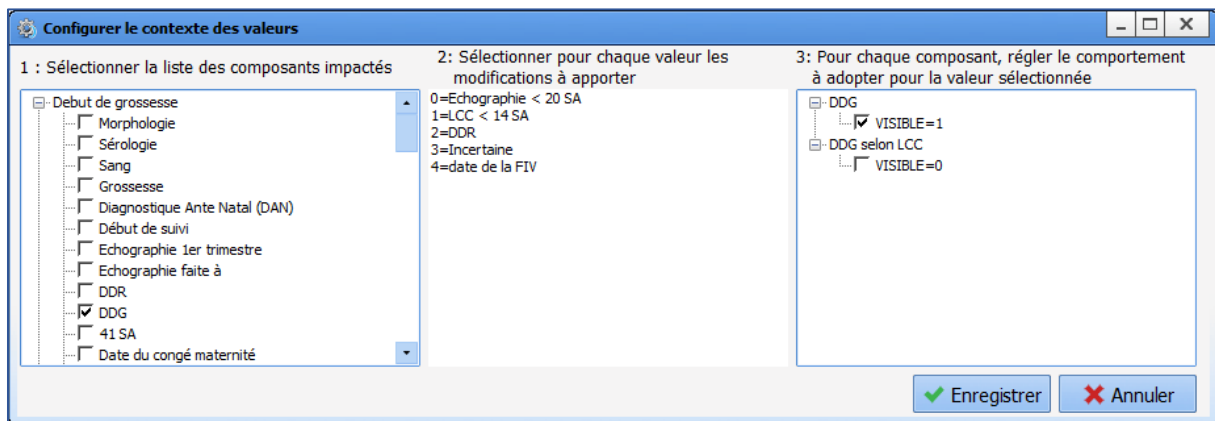


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2.3.2.2 Setting the context to update



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
- Switch button



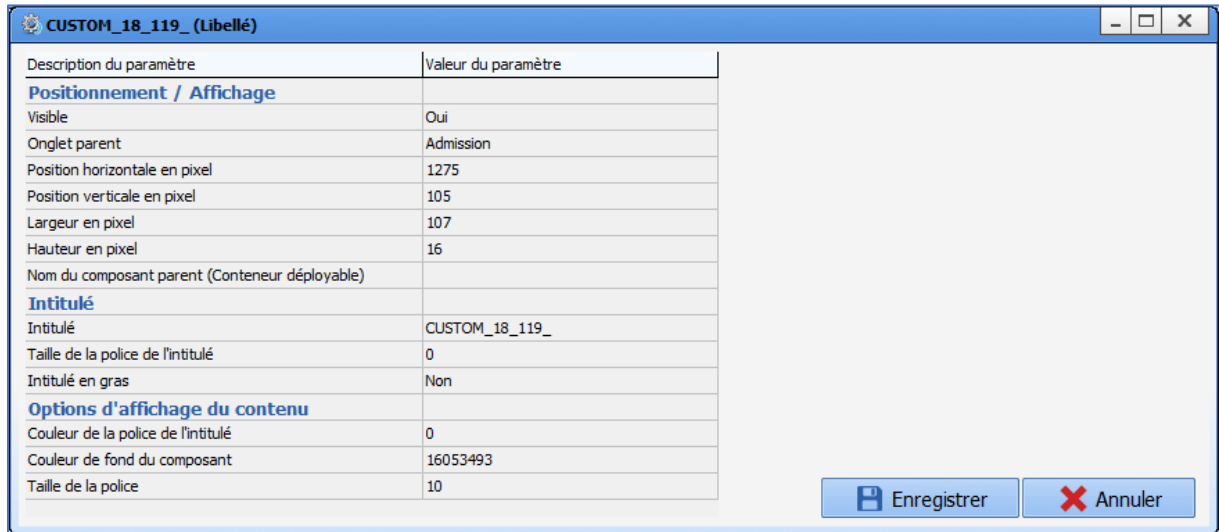
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2.3.3.1 Label

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
Positionnement / Affichage	
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)	
Intitulé	
Intitulé	CUSTOM_18_119_
Taille de la police de l'intitulé	0
Intitulé en gras	Non
Options d'affichage du contenu	
Couleur de la police de l'intitulé	0
Couleur de fond du composant	16053493
Taille de la police	10

Enregistrer Annuler

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:**

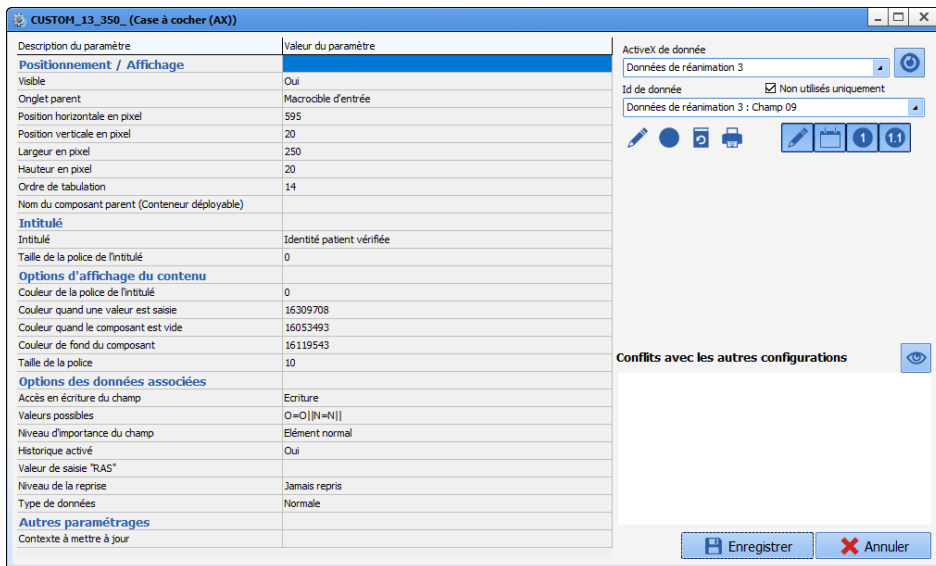
The component is not multi-line: to show several lines of text, a label must be created for each line to be displayed.

- **Detailed entry configurations:**

Multi-line component.

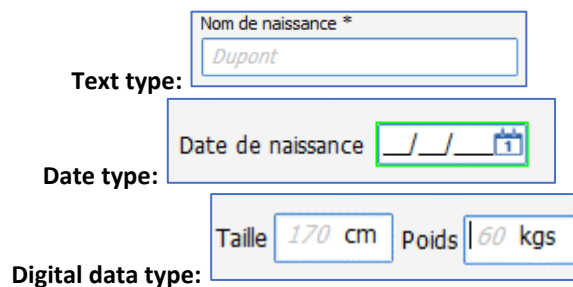
2.3.3.2 Check box

 Identité patient vérifiée



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

2.3.3.3 One-line input field



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
Positionnement / Affichage	
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)	
Intitulé	
Intitulé	Nom de naissance
Emplacement de l'intitulé	Au dessus
Taille de la police de l'intitulé	8
Options d'affichage du contenu	
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")	
Options des données associées	
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	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, moth 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 an 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 enabled)
- Maximum number of figures after the decimal point



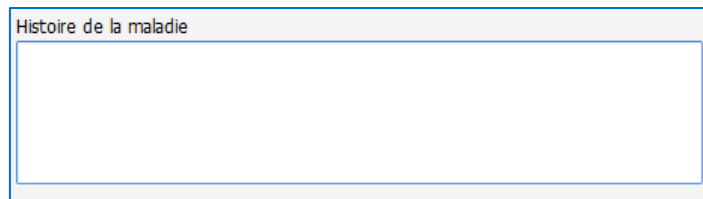
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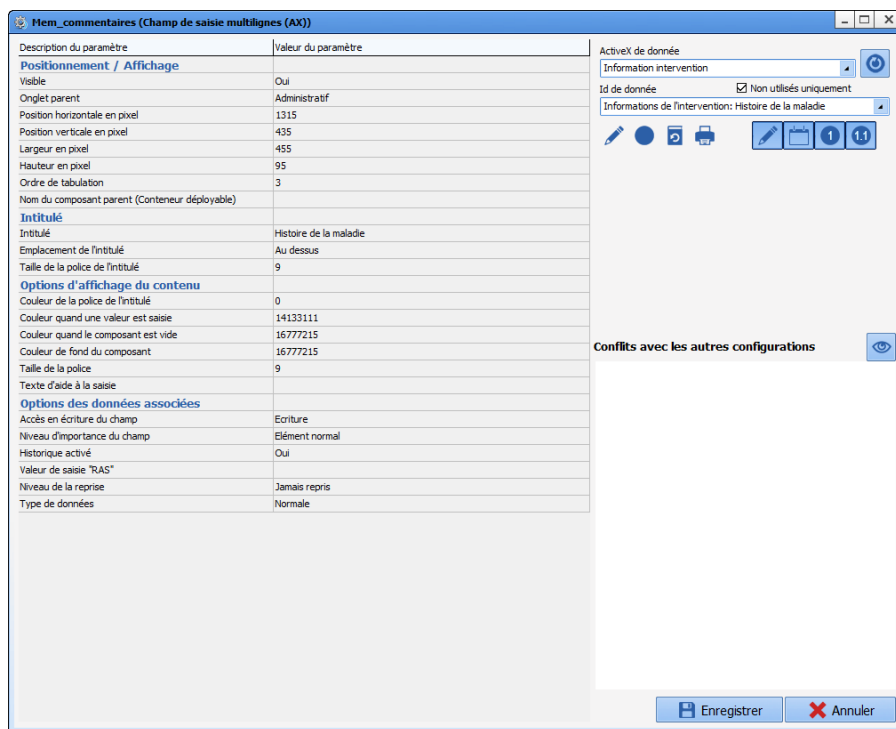
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2.3.3.4 Multi-line input field

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
Positionnement / Affichage	
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)	
Intitulé	
Intitulé	Histoire de la maladie
Emplacement de l'intitulé	Au dessus
Taille de la police de l'intitulé	9
Options d'affichage du contenu	
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	
Options des données associées	
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

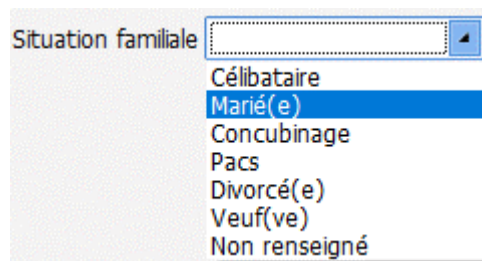
Conflits avec les autres configurations

Enregistrer Annuler

Essential settings: Visible, Parent tab and Name.

Optional settings: Input help text.

2.3.3.5 Drop-down menu

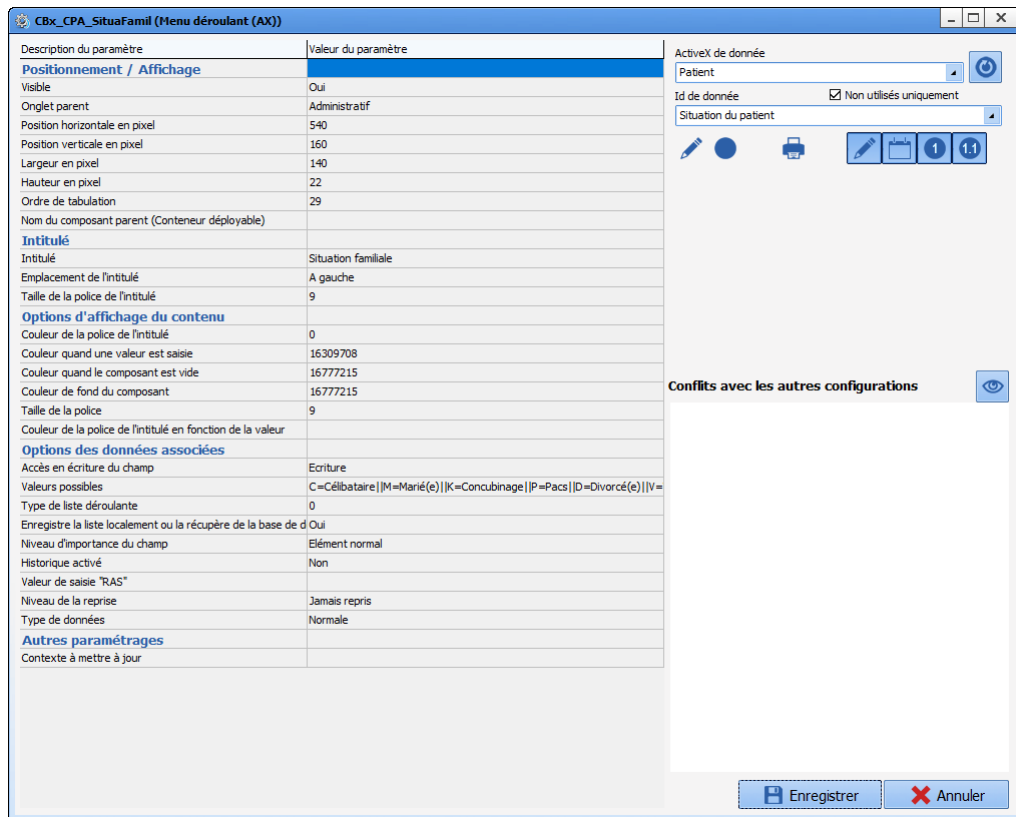


Situation familiale

- 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:

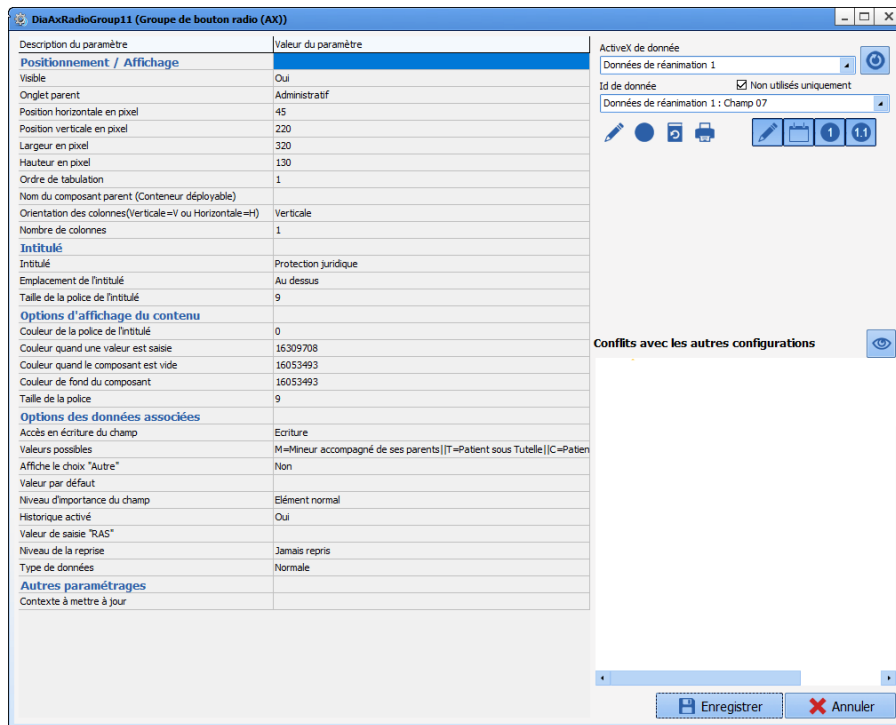
- Option to propose "Other" as a choice, which then opens a input field next to the choice.
- The various options are visible without clicking.



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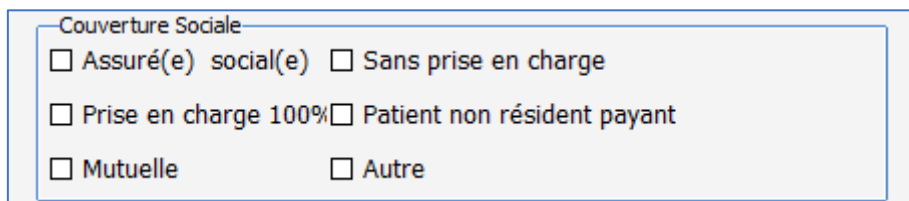


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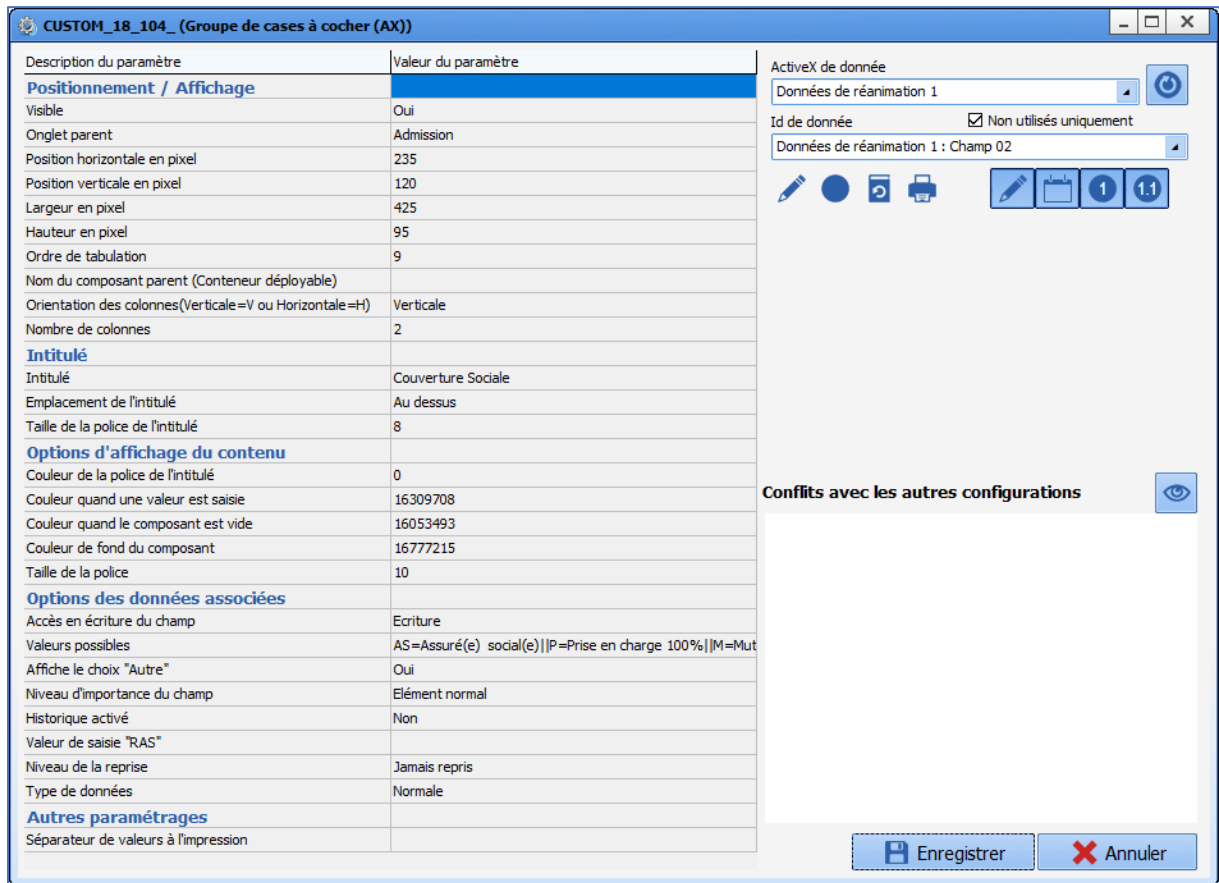
Essential settings: Visible, Parent tab, Number of columns, Column orientation, Name, Possible values
Optional settings: Column orientation, number of columns and Show "Other".

2.3.3.7 Check box group



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





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)



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.



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CUSTOM_22_252_ (Champ de saisie avec liste de référence (AX))

Description du paramètre	Valeur du paramètre
Positionnement / Affichage	
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
Intitulé	
Intitulé	Antécédents familiaux
Taille de la police de l'intitulé	10
Intitulé en gras	Oui
Options d'affichage du contenu	
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	
Options des données associées	
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

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
Options de recherche	
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	
Options de la saisie avec liste de référence	
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
Autres paramétrages	
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



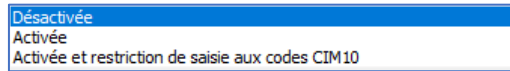
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the **Number of characters before autocomplete** setting).

- **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).

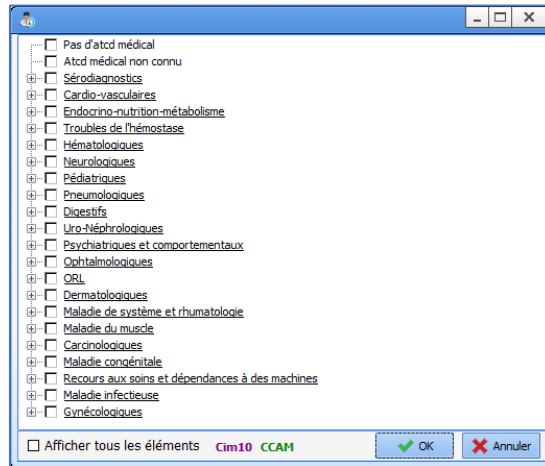
- **Column X general list:** determines the list type used for the reference list from the following options:

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

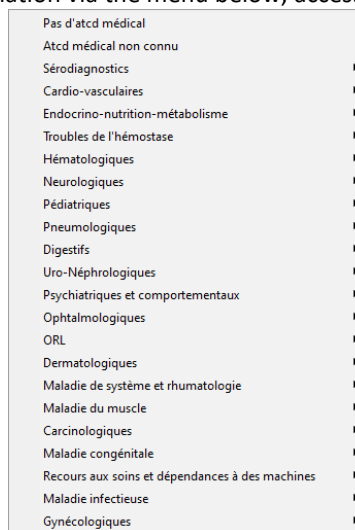
- **Column X reference root:** determines the list used for the reference list (based on previous setting)

- **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

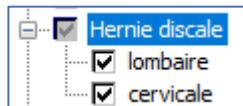


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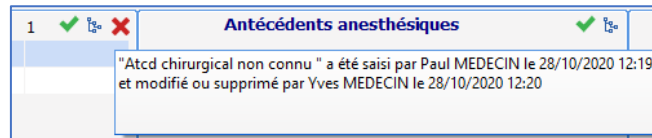
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- **Automatically select threads:** if this setting is enabled, selecting a parent item automatically selects all the threaded items



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.

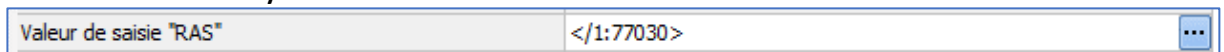


The red cross shows the user that an entry from a previous session (potentially entered by another user) was changed or deleted. Hovering over this red cross shows who entered what and when.

- **“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 the question mark with 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.



Description du paramètre	Valeur du paramètre
Positionnement / Affichage	
Visible	Oui
Onglet parent	Admission
Position horizontale en pixel	1370
Position verticale en pixel	320
Largeur en pixel	50
Hauteur en pixel	50
Nom du composant parent (Conteneur déployable)	
Intitulé	
Intitulé	
Emplacement de l'intitulé	Au dessus
Taille de la police de l'intitulé	8
Intitulé en gras	Non
Options d'affichage du contenu	
Couleur de la police de l'intitulé	0
Couleur de fond du composant	16053493
Taille de la police	10

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/Button (AX)


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

Description du paramètre	Valeur du paramètre
Positionnement / Affichage	
Visible	Oui
Onglet parent	Administratif
Position horizontale en pixel	65
Position verticale en pixel	615
Largeur en pixel	75
Hauteur en pixel	25
Ordre de tabulation	36
Nom du composant parent (Conteneur déployable)	
Intitulé	
Intitulé	Vidal
Taille de la police de l'intitulé	0
Intitulé en gras	Non
Options d'affichage du contenu	
Couleur de la police de l'intitulé	0
Couleur de fond du composant	16053493
Taille de la police	8
Options des données associées	
Accès en écriture du champ	Ecriture
Autres paramètres	
Ligne de commande à lancer	http://www.vidal.fr

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

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

- To set up printing, click .

Autres paramètres	
Ligne de commande à lancer	

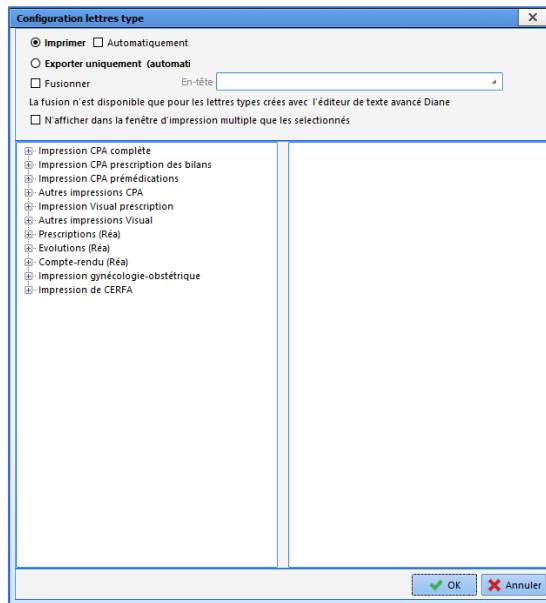


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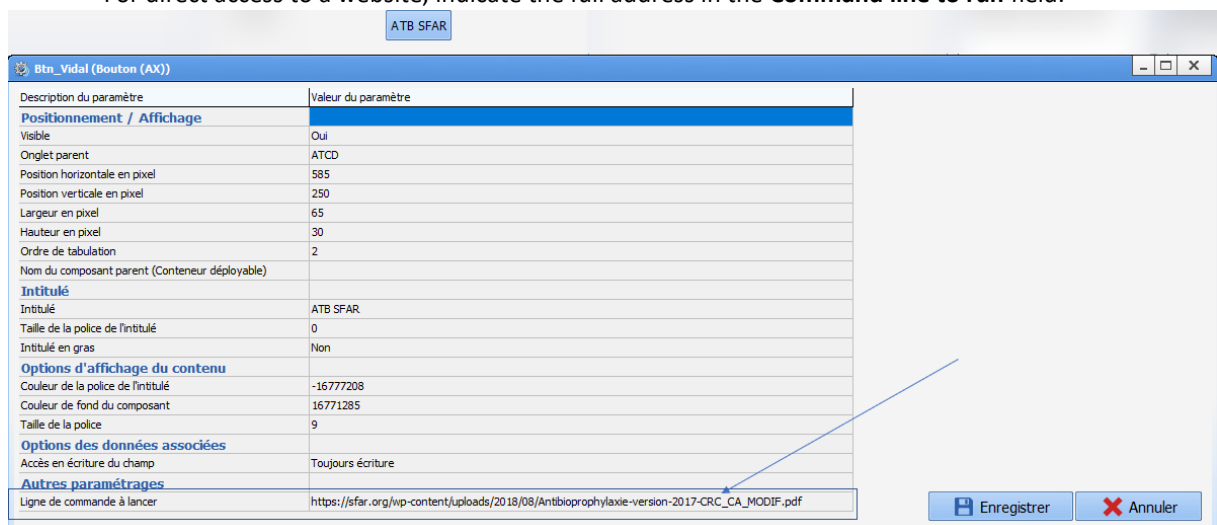


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The following window is shown to configure the form letter(s) to be printed by drag-and-dropping them into the right column.



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



2.3.3.11 Event entry via button

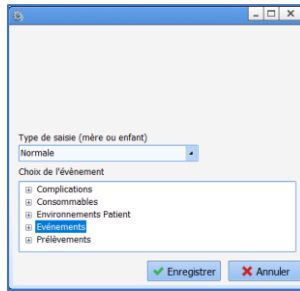
This component is used to configure a button to add an **Event** item.
 This component is used to enter an **Event** from the detailed entry form.



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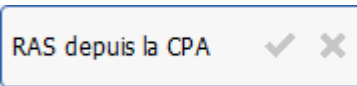
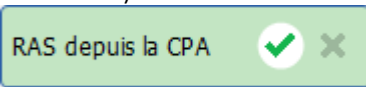
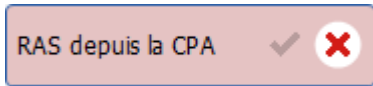


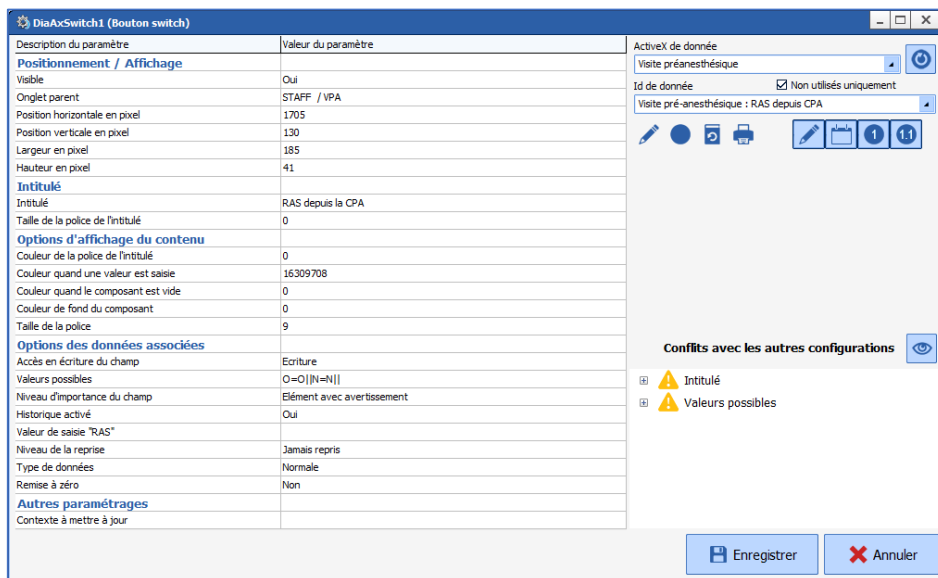
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2.3.3.12 Switch button

This component has three states:

- No value (not entered): 
- Yes value: 
- No value: 



Essential settings: Visible, Parent tab and Name.

The **Possible values** field cannot be modified.



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



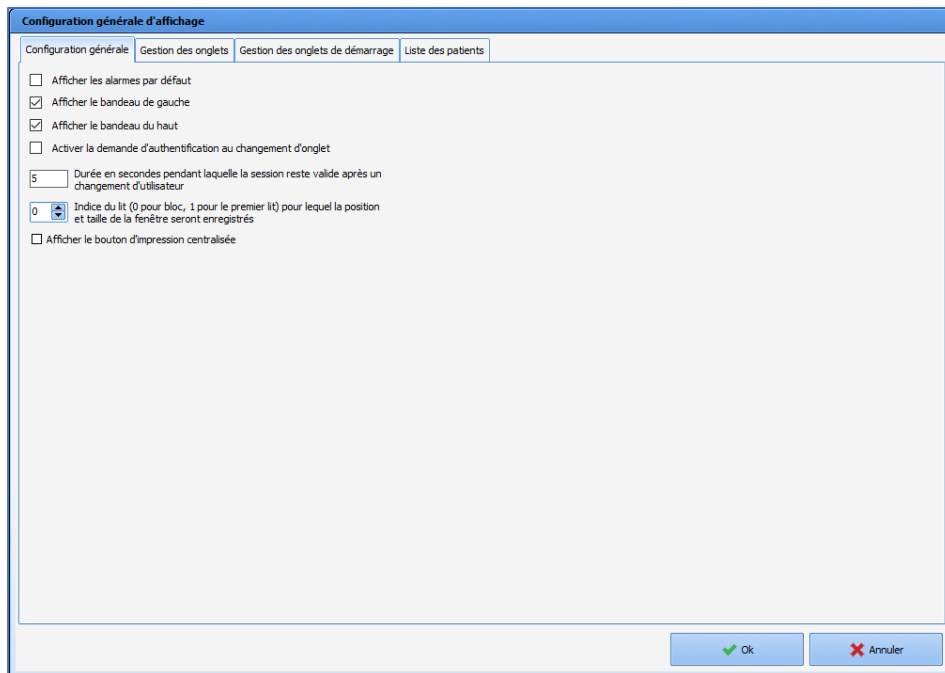
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-  Close the display configuration without saving
-  Start online assistance
-  Open the general module configuration window

3.1.1.1 General configuration window: general configuration tab



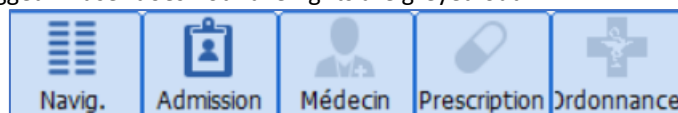
This **General configuration tab** offers the possibility to show or hide the left ribbon and top ribbon by default.

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.

Display main tab icons lets you choose whether or not to display the icons of the buttons in the **Visual** or **DIANEREA** tabs.



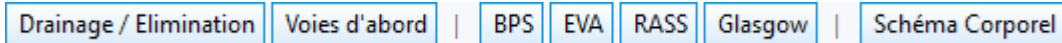
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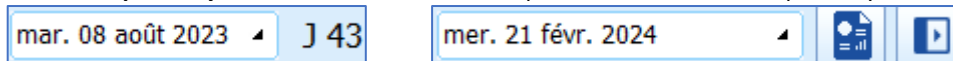
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Configurable button size lets you change the font size of the buttons to make them easier to read.

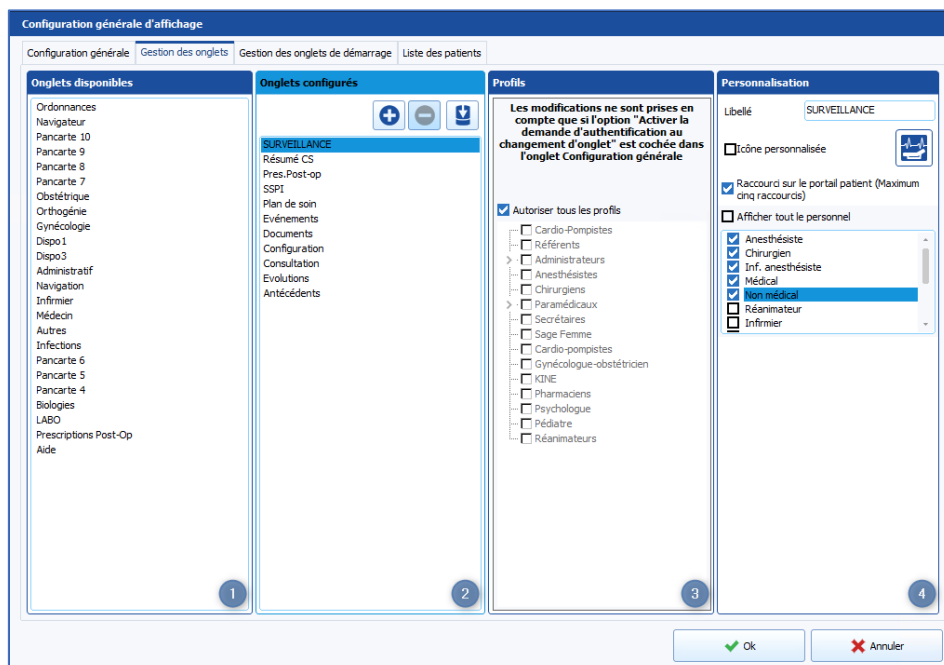





Hide number of hospital days in calendar area hides the patient's number of hospital days from view.



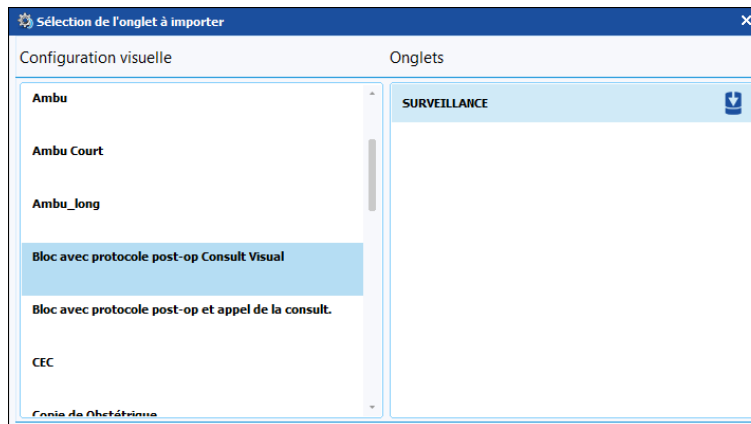
3.1.1.2 General configuration window: tab management tab

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



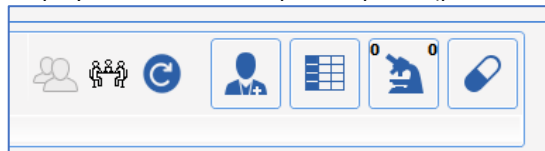
1. **Available tabs:** drag and drop to add an available tab.
2. **Configured tabs:**
 - Drag and drop to change the order of tabs.
 - A configured tab can be deleted by drag-and-dropping into the **Available tabs** pane.
 - You must use the  button if you wish to create new 'Monitoring' tabs. To delete a tab, click the .
 - The current tab can be replaced by a tab from any display configuration (**Visual, ICU or Obstetrics**). To do so, click the .





A tab of the same type (**Care plan, Medication Order, OT, View 3, configurable tab**) can be imported. The **Help, Documents, Events, Browser, Navigation** and **Prescriptions** tabs cannot be imported.

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 display a shortcut on the patient portal (patient list), limited to max. 5 tabs.

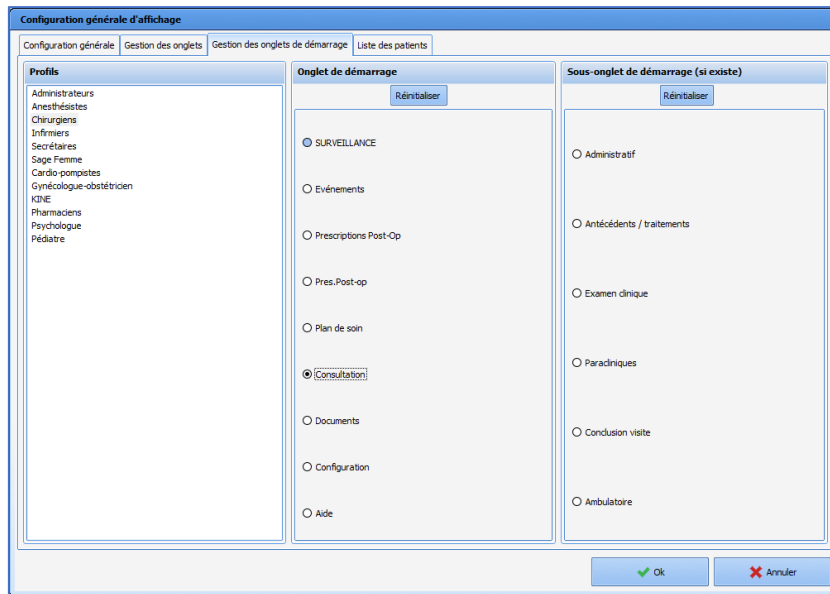


- Specific case for **DIANE Anaesthesia MONITORING** tab: the roles to be displayed can be selected in the **Staff** subtab. The **Display all staff** check box can be used to select all with one click.

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.




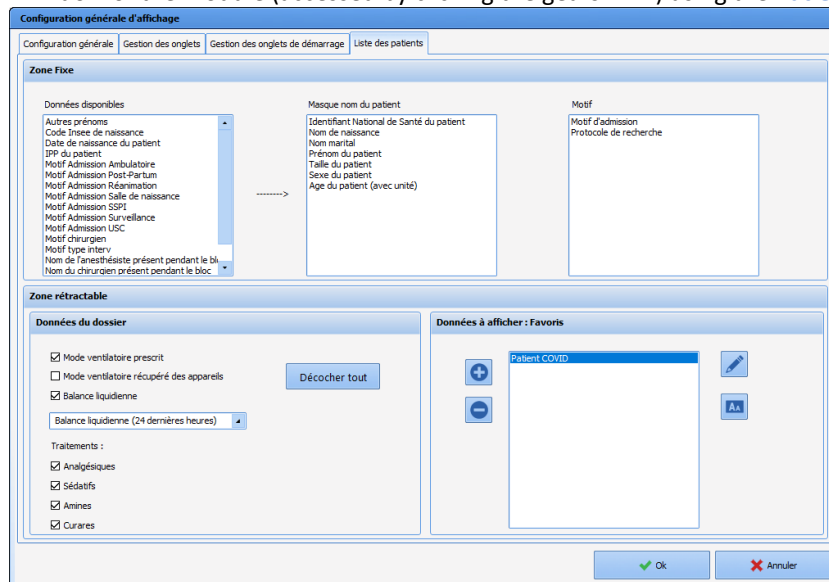


- Select the relevant profile
 - Select the relevant tab to be displayed on start-up
- If subtabs are available for the selected tab, they are shown on the right.
- Select the relevant subtab.

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.



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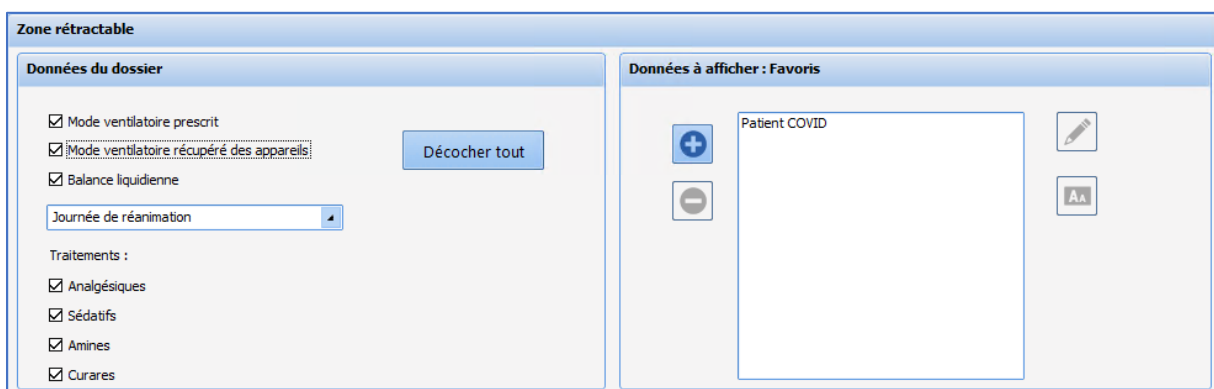
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The various data available can be shown on the first line (**Patient name mask**) or the second line (**Reason**) by drag-and-dropping them to the relevant pane. They can then be ordered by using drag and drop within the same box. To hide a piece of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

List of available data:

- Patient's age (with unit)
- Other names
- Insee birth code
- Patient's birth date
- Patient's national health identifier
- UPI
- Reason for admission ambulatory
- Reason for admission postpartum
- Reason for admission ICU
- Reason for admission delivery room
- Reason for admission RR
- Reason for admission monitoring
- Reason for admission CCU
- Reason for surgeon
- Reason for admission
- Reason type of procedure
- Name of anaesthetist present during surgery
- Birth name
- Name of surgeon present during surgery
- Married name
- Patient's weight
- Patient's first name
- Research protocol
- Patient's sex
- Patient's height

- **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 the ventilation method, it is possible to select the Prescribed ventilation method and/or Ventilation method retrieved from smart 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:

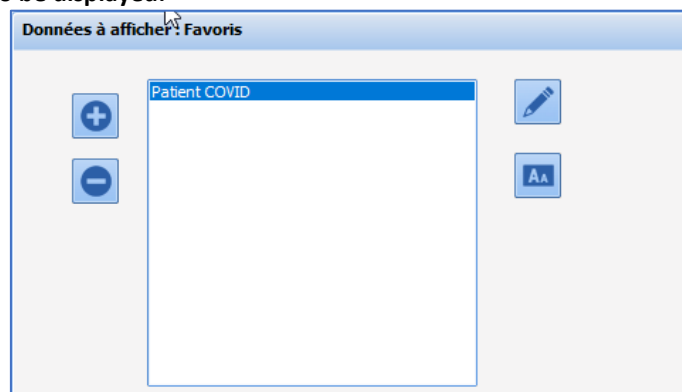
- **Analgesia:** Displays **Analgesia** on the portal if the patient currently has analgesics prescribed on their care plan (ATC codes: N01AH and N02AB)
- **Sedation:** Displays **Sedation** on the portal if the patient currently has sedatives prescribed on their care plan (ATC codes: N01AF, N01AX and N05CA).
- **Amines:** Displays **Amines** on the portal if the patient currently has amines prescribed on their care plan (ATC codes: C01CA)
- **Muscle relaxants:** Displays **Muscle relaxants** on the portal if the patient currently has muscle relaxants prescribed on their care plan (ATC codes: M03AB and M03AC)


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.

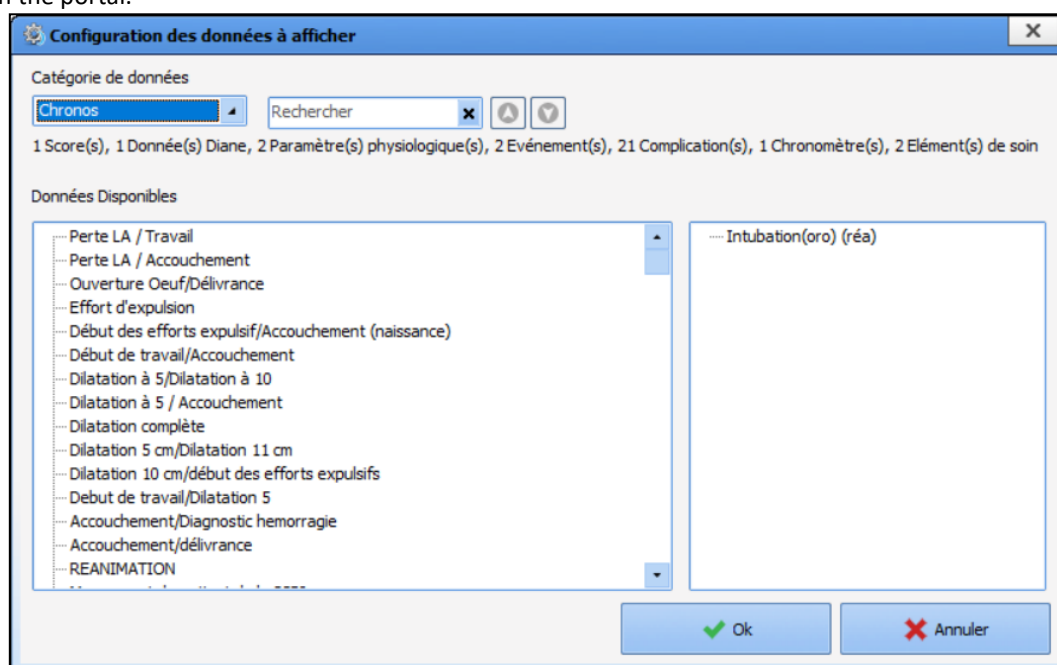
- Data that can be entered 'on the fly' and is not set up during configuration is found in the middle of the retractable pane. This data is for information purposes only and not saved in the patient record.
- On the left, **data to be displayed** can be personalised: It is possible for configure favourites to add the most-commonly displayed information from the following categories in one click:
 - **Score:** Display on the portal if data is entered
Score label: score + unit + (Date/time of score entry).
Example: Apgar: 3 (01/02 15:20)
 - **DIANE data:** Display on the portal if data is entered
Name of constant associated with Diane data + Data entered
Example: Pathology: Pain
 - **Vital signs:** Display on the portal if data is entered
Sign label: Value + unit + (Date/time of sign entry).
Example: HR: 95 bpm (16:22)
Score entry date is only shown if it is not today's date.
 - **Events:** Display on the portal if data is entered
Event label + Time of occurrence
 - **Complications:** Displays on the portal if data is entered
Complication label + Time of occurrence
 - **Timers:** Display on the portal if data is entered:
Duration + Timer label
If several timers of the same type are running, they are all shown on the portal.
A timer disappears from the portal 24h after it stops.
 - **Care items:** List of care items **Ports, Drains, Dressings, Other:** Displays on the portal only the scheduled care act and its scheduled date. The care act disappears from the portal once it has been carried out.



Configuration of data to be displayed:



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.

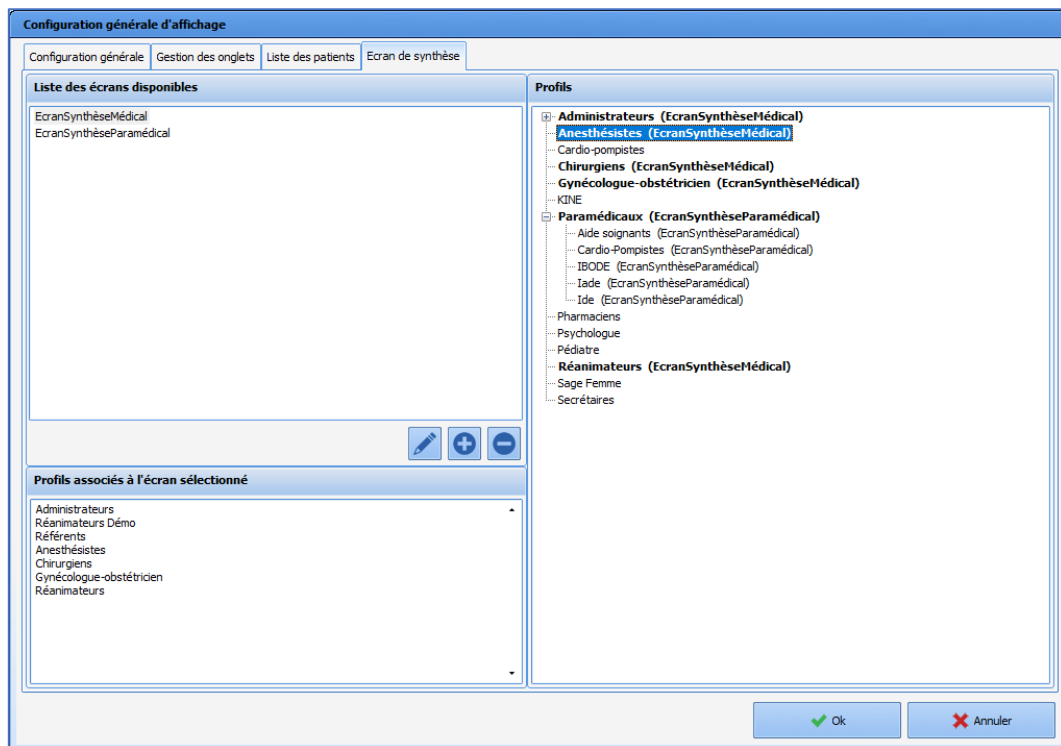
The **Search** field can be used to find data in the selected category. Items matching the search are highlighted, and the arrows to the right of the search pane are used to move to the next or previous items. The number of hits is indicated.

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.




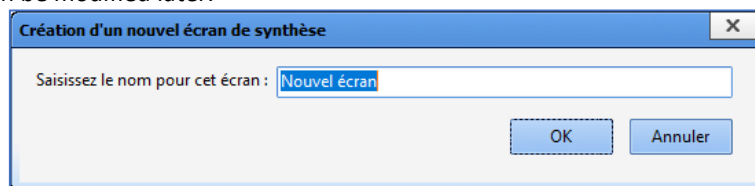
3.1.1.5 General configuration window: “Summary screen” tab

The summary screen is specific to **DIANE ICU**. It is a summary view allowing all ICU users to access essential information from the patient’s medical record. This view allows nurses to pass on information efficiently and doctors to better understand the clinical situation in order to make the most appropriate decisions for the patient.



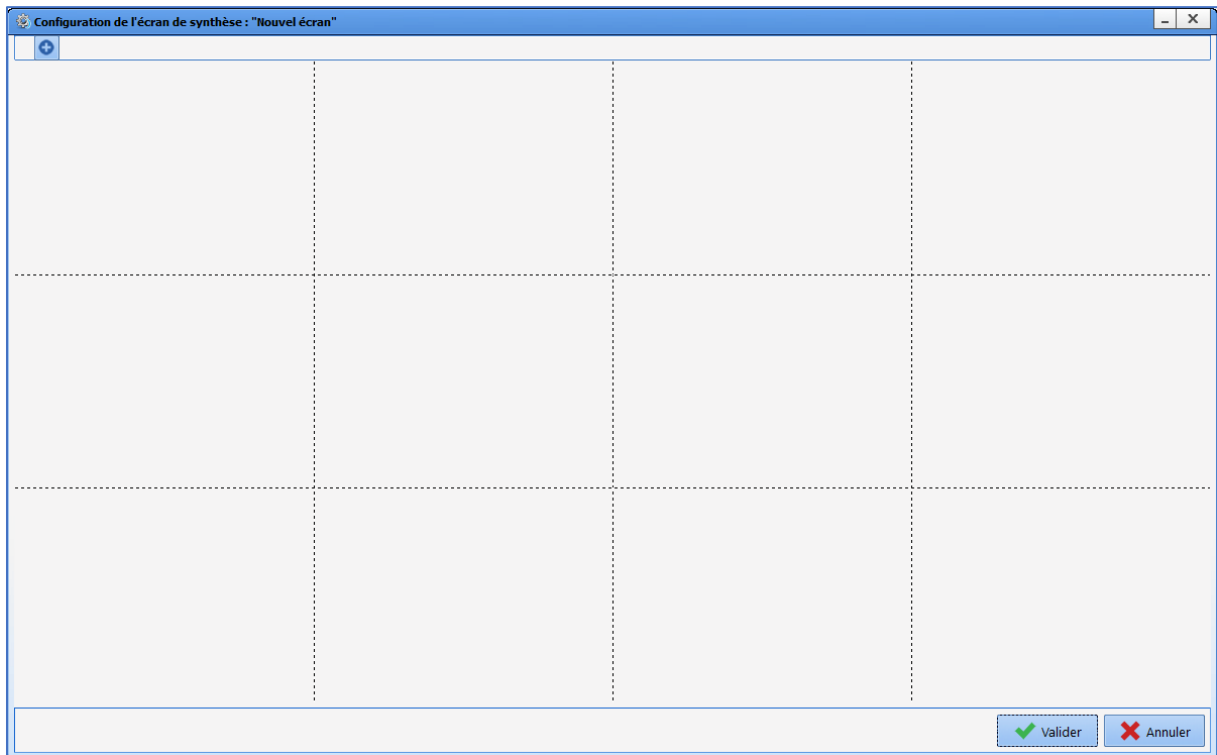
3.1.1.5.1 Adding a summary screen

A new summary screen is added by clicking . A window is then used to enter the name. The summary screen name can be modified later.




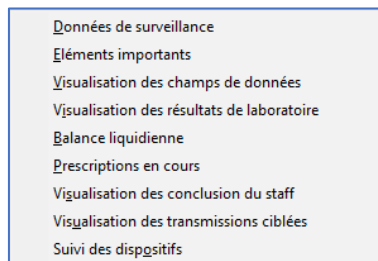
Once the name is entered and confirmed using the OK button, the **Summary screen set-up** window is shown.






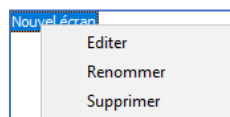
The title of the window is the same as the name of the screen: **New screen** in the example below.

The  button is used to add an element from a menu:




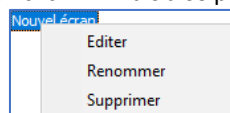
3.1.1.5.2 Edit a summary screen

To edit a summary screen, select it then click . It is also possible to double-click the name, or right-click the name and click **Edit**.



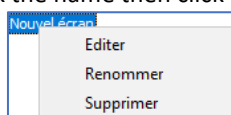
3.1.1.5.3 Delete a summary screen

To delete a summary screen, select it then click . It is also possible to right-click the name and click **Delete**.



3.1.1.5.4 Rename a summary screen

To rename a summary screen, right-click the name then click **Rename**.



Then enter the new name . It is also possible to rename the screen by selecting it and left-clicking.

3.1.1.5.5 Assign a summary screen to a user profile

To assign a screen to a user, drag and drop the screen from the **List of available screens** pane to the relevant profile on the **Profiles** pane.

Only one screen can be assigned per user profile. For profiles with sub-profiles, the default summary screen for the sub-profile is identical to that of the parent profile. However, a different summary screen can be assigned if required.





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:

 Administrative	This tab gathers "administrative" data concerning the patient and the scheduled surgery. 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.
 Medical history/Treatments	This tab is generally used to enter the patient's history and current treatments.
 Clinical exams	This tab is often used to track information collected during the consultation.
 Paraclinical	By default, this tab presents components used to establish prescriptions for laboratory tests, print them, and indicate/show results. If a laboratory interface is installed, laboratory results can be viewed directly.
Conclusion/Visit	This tab is used to enter information on recommendations given to be



	patient and the conclusion of the consultation.
Ambulatory 	This tab is used to enter the phases before and after the patient's ambulatory care. Interaction with the Ambucare module is possible. This tab can be used by nurses coordinating the care plan.
Misc. 	This module is generally used to 'store' components. In the DIANE ANAESTHESIA Consultation 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.
Free 1 	This module is generally used to 'store' components. In the DIANE ANAESTHESIA Consultation 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.
Free 2 	This module is generally used to 'store' components. In the DIANE ANAESTHESIA Consultation 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.
Accounting 	This tab cannot be modified. It is connected to the DIANE accounting module. It can be hidden if not in use.
Summary 	This tab comprises components synchronised with the components in other tabs. It provides an overview of the consultation.
Documents 	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.
Browser 	This tab contains a component used to display website or intranet pages, such as some online medical tools.
Treatments and premedications 	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**" line).


TbS_Administratifs (Onglet)	
Description du paramètre	Valeur du paramètre
Positionnement / Affichage	
Visible	Oui
Initulé	
Initulé	Administratif
Options d'affichage du contenu	
Couleur de fond du composant	0
Taille de la police	10

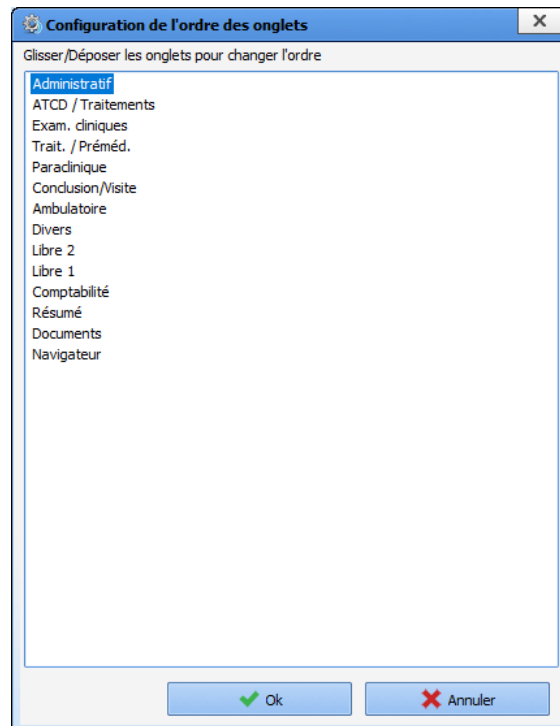


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Click  at the top left of the screen to change the tab display order. Drag and drop the tabs into the required order. Once this has been done, click **OK** to return to the consultation display settings window.



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*
- *Lab 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)



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- Field importance level (**Normal**, **With warning** 🟢, **Important** 🟡 or **Mandatory** 🔴)
- Resumption level:
 - Never included**
 - Level 1** (example: history = does not change)
 - Level 2** (example: height = little change)
 - Level 3** (example: weight = much change)

For checkboxes, checkbox groups, drop-down menus and radio button groups:

- Possible values (drop-down menus, checkbox 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 checkboxes, drop-down menus and radio button groups:

- *Context to update*

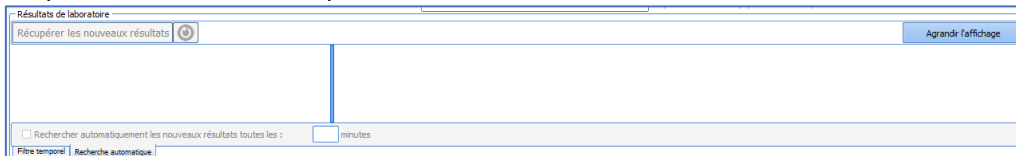
For checkbox groups and radio button groups:

- 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.

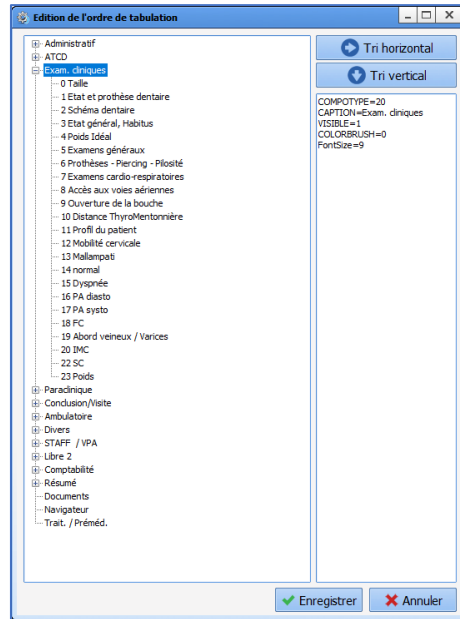


3.1.2.3 Managing component tab order

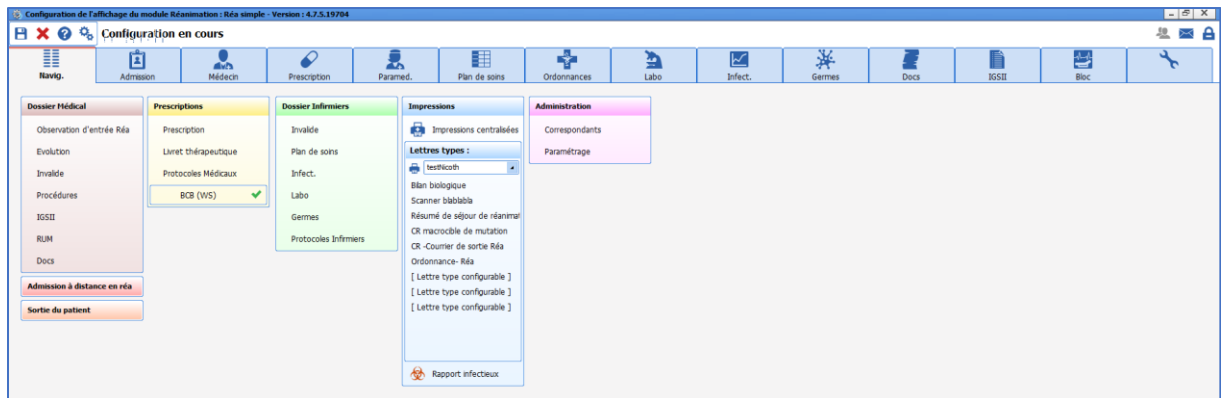
Component tab order within the tab is managed AFTER the tab has been fully configured.

- Open the component settings window
- Select **Tab order**
- Click the button at the end of the line
- 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

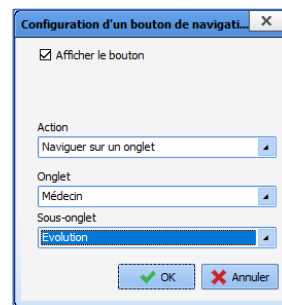


The **Navigation** tab is only used by the ICU module. It comprises panels of configurable links. In configuration, all links are visible: links that are not visible during use are shown in italics.

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

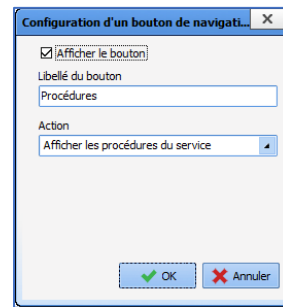
3.1.3.1 Browse a tab

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



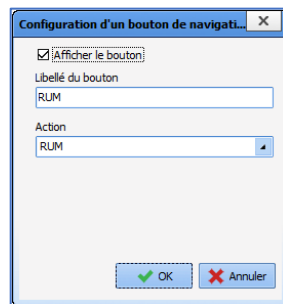
3.1.3.2 View unit procedures

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



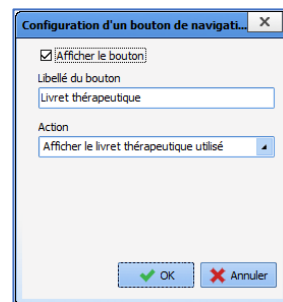
3.1.3.3 RUM

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



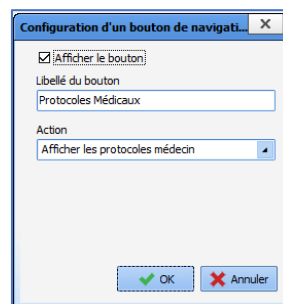
3.1.3.4 View formulary used

This action opens the formulary.



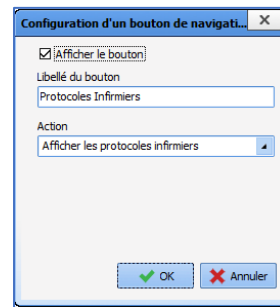
3.1.3.5 View doctor protocols

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



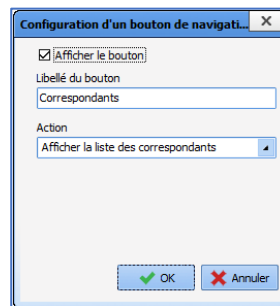
3.1.3.6 View nursing protocols

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



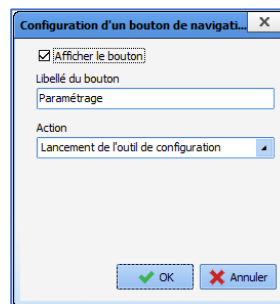
3.1.3.7 View list of matches

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

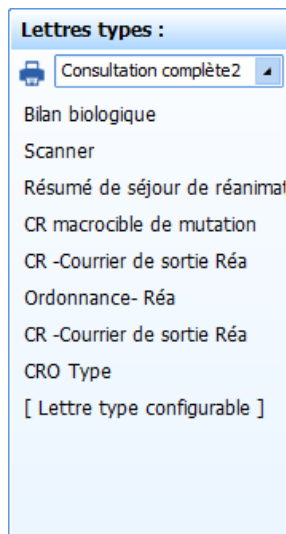


3.1.3.8 Launching of the configuration tool

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 Configuring components in the overview screen and side ribbons

Each type of component can be specifically configured. To access their configuration, click the gears.

3.1.4.1 Configuring components common to the summary screen (DIANE REA) and the side ribbons (DIANE REA and VISUAL)

This import method will work **ONLY** if a connection to a drug database has been set up.
For environments **WITHOUT** a connection to a drug database, please refer to the appendix titled 'Importing the drug formulary **WITHOUT** a connection to a drug database'.



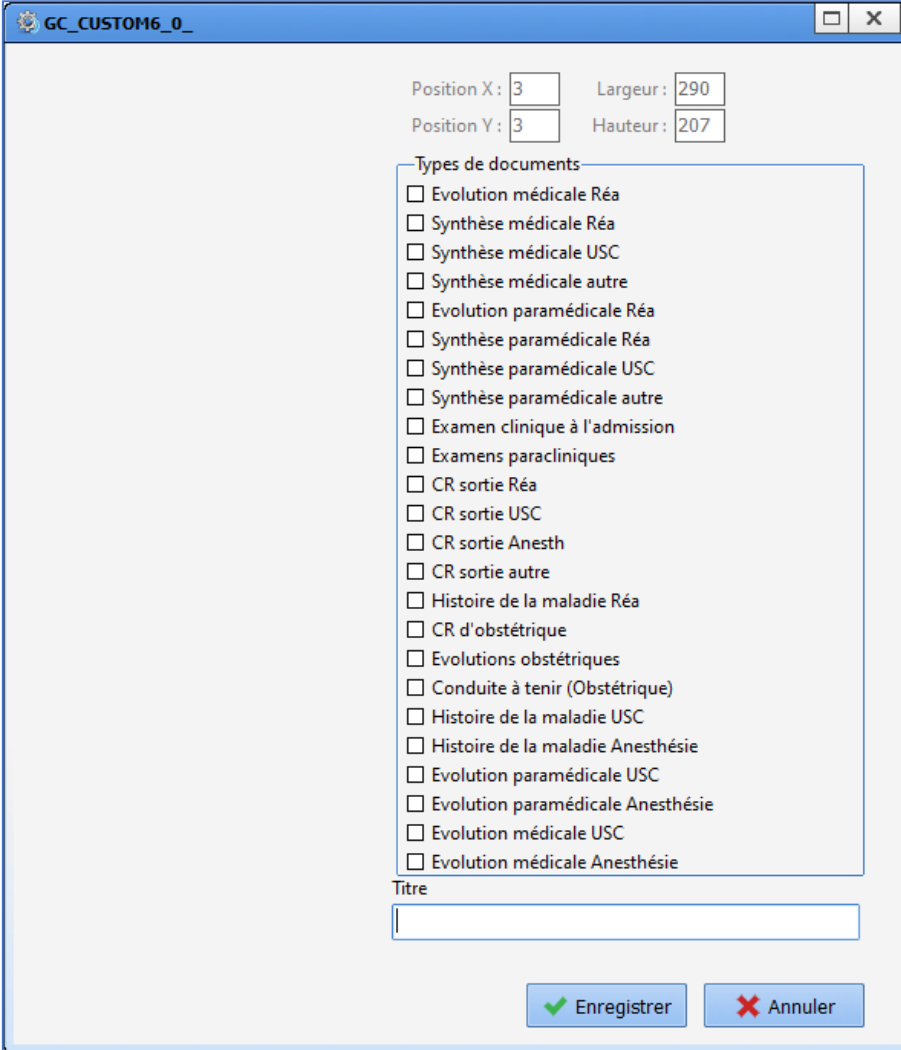
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3.1.4.1.1 Important items

Editing this component opens the following window:



Position X : Largeur :

Position Y : Hauteur :

Types de documents

- Evolution médicale Réa
- Synthèse médicale Réa
- Synthèse médicale USC
- Synthèse médicale autre
- Evolution paramédicale Réa
- Synthèse paramédicale Réa
- Synthèse paramédicale USC
- Synthèse paramédicale autre
- Examen clinique à l'admission
- Examens paracliniques
- CR sortie Réa
- CR sortie USC
- CR sortie Anesth
- CR sortie autre
- Histoire de la maladie Réa
- CR d'obstétrique
- Evolutions obstétriques
- Conduite à tenir (Obstétrique)
- Histoire de la maladie USC
- Histoire de la maladie Anesthésie
- Evolution paramédicale USC
- Evolution paramédicale Anesthésie
- Evolution médicale USC
- Evolution médicale Anesthésie

Titre

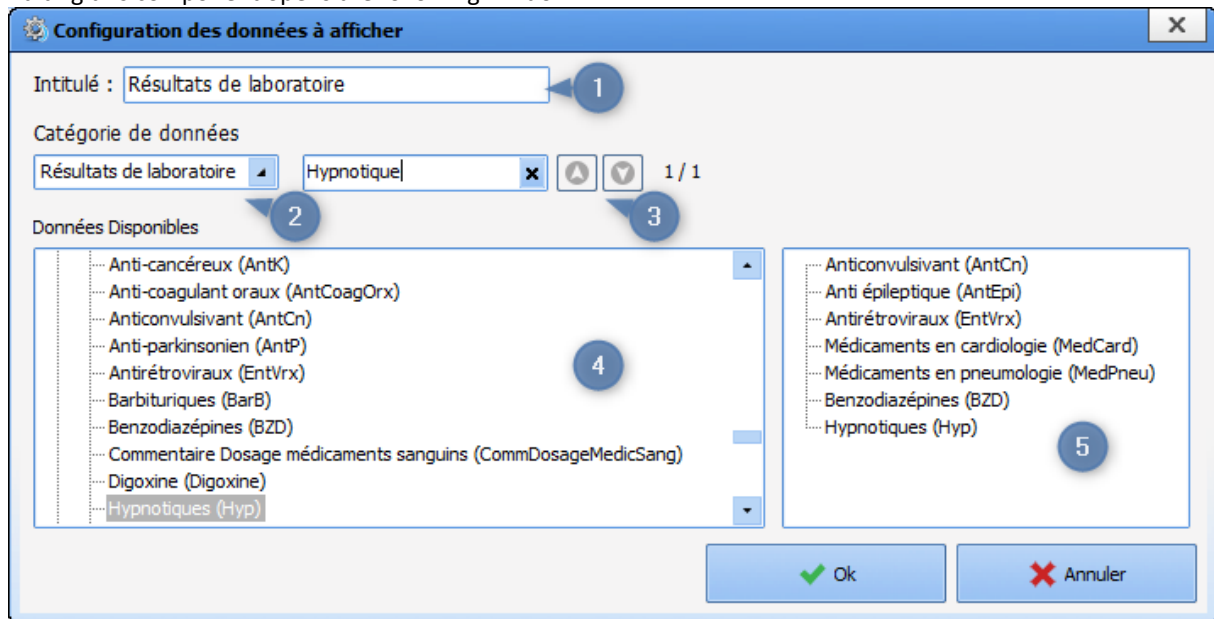
It is possible to select the documents for which items marked as important should be shown in the component among the list of editable documents from a document editing pane.
To display the contents of a document type in the important items viewing component, select the checkbox in front of its name.

Title is used to select the component label shown on the summary screen. If this field is blank, the default title is **Important items**.



3.1.4.1.2 Lab results view

Editing this component opens the following window:



Configuring this component makes it possible to choose the component name shown on the summary screen in the **Name** input box (1). The default name is as follows: **Lab results**

The drop-down menu (2) (Lab results or Vital signs) can be used to select whether or not the list of laboratory data or manual parameters is shown in the column on the left (4).

Data are displayed using the categories already found in configuration mode. To make them visible during use, the data must be dragged and dropped into the column on the right (5). It is possible to reorganise the list of configured items using drag and drop. The configuration order is the display order used on the summary screen.

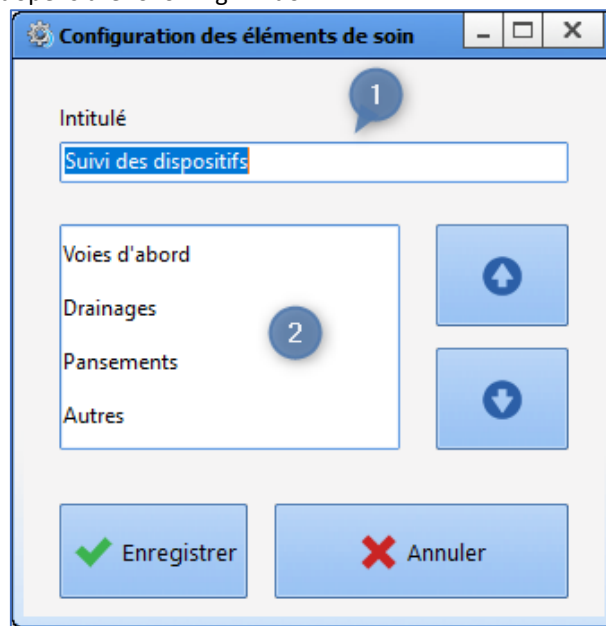
A search pane (3) is used to carry out a text search within the list of data found in pane (4). The arrows can be used to move from one item to another.

It is not possible to toggle a whole branch (category) of lab results. Only “child” items can be toggled.



3.1.4.1.3 Device monitoring

Editing this component opens the following window:

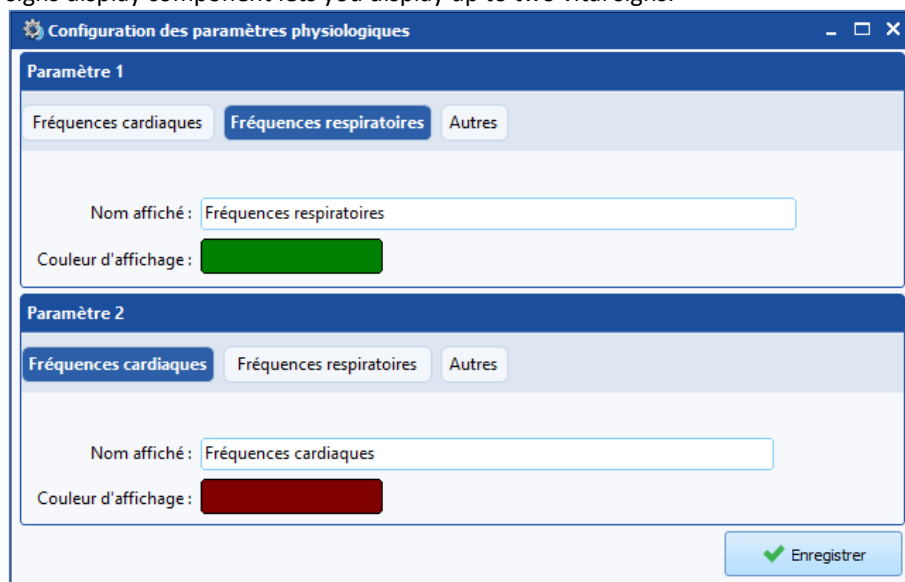


Configuring this component makes it possible to choose the component name shown on the summary screen in the **Name** input box (1). The default name is as follows: **Device monitoring**

Pane (2) shows the list of device categories: Ports, drains, dressings, other. This pane can be used to set the display order of items on the screen using the arrows on the right.

3.1.4.1.4 Vital signs

The vital signs display component lets you display up to two vital signs.



To configure the heart rate and respiratory rate settings, simply click the shortcut button **Fréquences cardiaques** **Fréquences respiratoires**. To display another vital sign, select Other. A search field will appear to let you enter the vital sign you wish to display.



Paramètre 1

Fréquences cardiaques Fréquences respiratoires **Autres**

Pression non |

Pression non définie (Groupe) - PND
 Pression non invasive continue (Groupe) - PNIC
 Pression non invasive continue diastolique - PNICd
 Pression non invasive continue moyenne - PNICm
 Pression non invasive continue systolique - PNICs


The name displayed during use can be configured (limit of 20 characters). The colour is configurable as well.


3.1.4.2 Configuring the components of the summary screen

3.1.4.2.1 Monitoring data

Editing this component opens the following window:














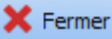
Information


 Ce composant se configure en cliquant sur la barre horaire, la roue crantée ou le bouton "+" visibles en déplaçant le curseur sur la zone de paramétrage à gauche du graphique.



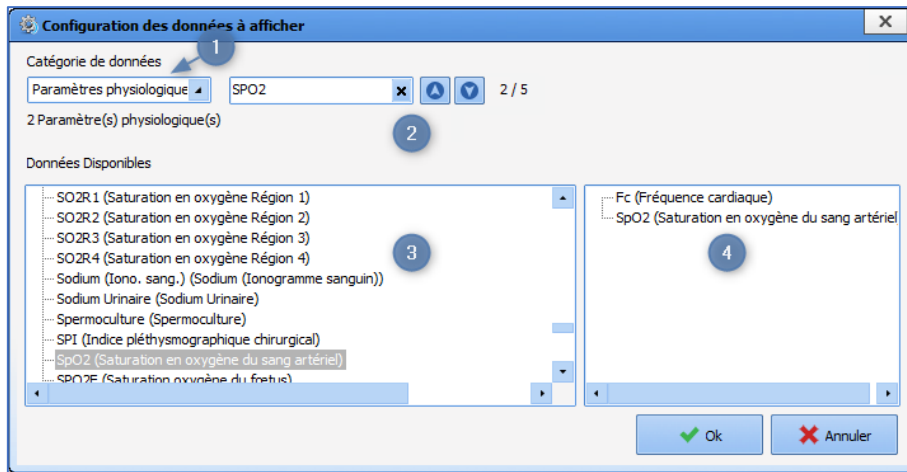
4.10.0.23901

Clicking the time bar of the component displays the following configuration window:

<input type="radio"/> Echelle automatique	 <input type="checkbox"/> Disponible
<input checked="" type="radio"/> Echelle manuelle <input type="checkbox"/> Vue passée	 <input type="checkbox"/> Disponible
Echelle (Durée de la plage visible) 1 heure	 <input type="checkbox"/> Disponible
Options	
 Début  Position actuelle Fin 	 <input type="checkbox"/> Disponible
<input type="checkbox"/> Limiter la vue à 24h	 <input type="checkbox"/> Disponible
<input checked="" type="checkbox"/> Temps Réel	 <input type="checkbox"/> Disponible
 Position de la barre de temps réel:  %	 <input checked="" type="checkbox"/> Invisible
<input type="checkbox"/> Afficher uniquement les saisies du service actuel	 <input type="checkbox"/> Disponible
	

Clicking the button  in the vital signs display pane displays the following configuration window:




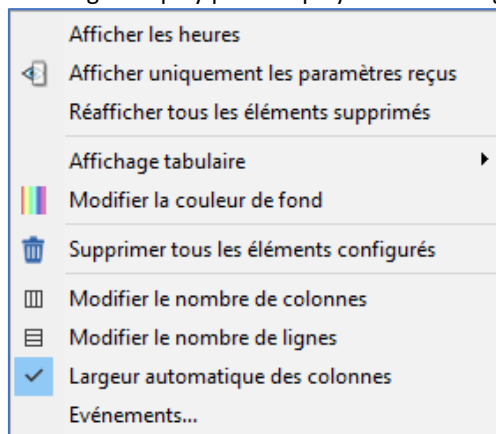


The **Data category** drop-down menu (1) is used to select the signs to be shown in the ribbon (vital signs or listed signs).

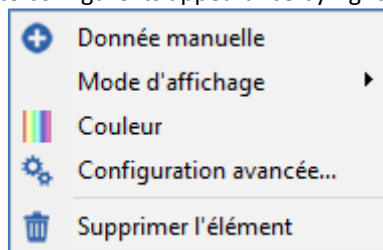
Pane (3) gives the full list of vital signs. To make them visible during use, the data must be dragged and dropped into the column on the right (4). It is possible to reorganise the list of configured items using drag and drop. The configuration order is the display order used on the summary screen.

A search pane (2) is used to carry out a text search within the list of data found in pane (3). The arrows can be used to move from one item to another.

Clicking the button  in the vital signs display pane displays the following configuration window:



For each data item, it is possible to configure its appearance by right-clicking its label:



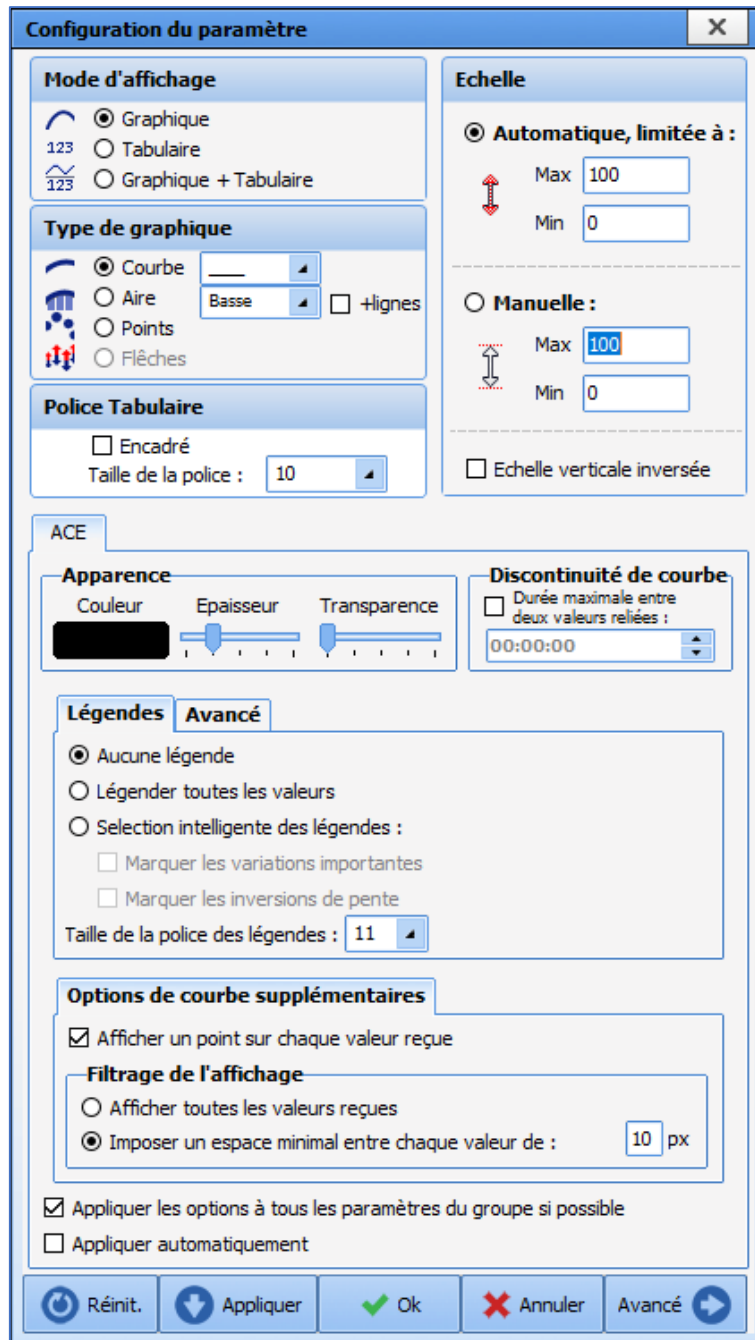
Advanced configuration... brings up the following window:



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3.1.4.2.2 Data field view

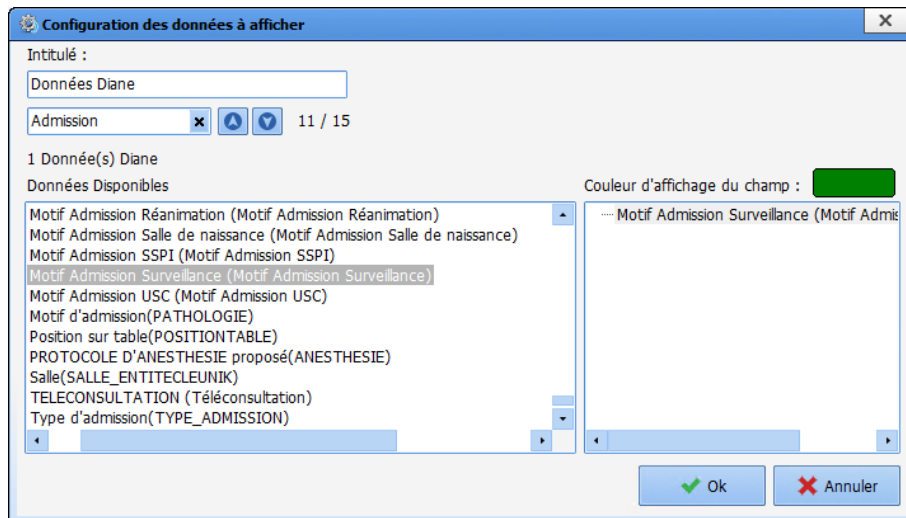
Editing this component opens the following window:



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Configuring this component makes it possible to choose the component name shown on the summary screen in the **Name** input box (1). The default name is as follows: **DIANE data**.

The column on the left (3) shows the list of Diane data fields. To make them visible during use, the data must be dragged and dropped into the column on the right (4). It is possible to reorganise the list of configured items using drag and drop. The configuration order is the display order used on the summary screen.

A search pane (2) is used to carry out a text search within the list of Diane data. The arrows can be used to move from one item to another.

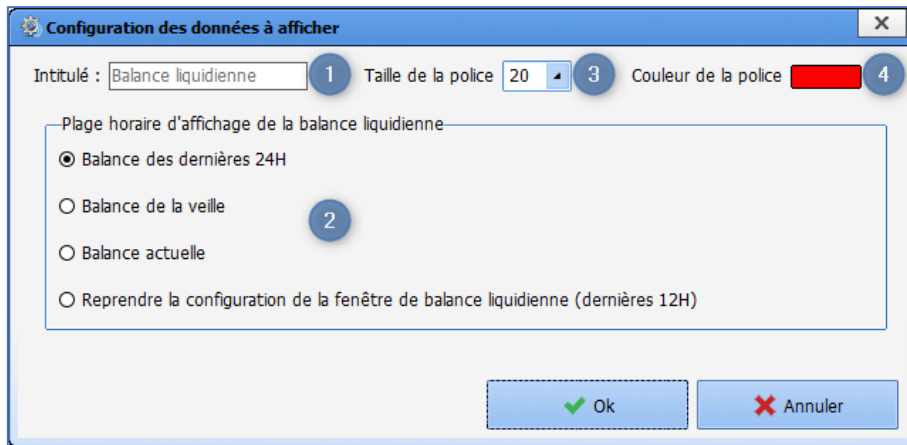
Each configured data can have a specific colour. Clicking the data displays a square the same colour as the font (5) (default colour is black). The font colour can be changed by clicking this square. After validation, the square changes to the selected colour.



3.1.4.2.3 Fluid balance

Editing this component opens the following window:





The name of the pane (1) is in read-only mode as it is not shown on the summary screen. Its value is **Fluid balance**.

The time slot of the fluid balance shown on the summary screen can be configured using the radio button group (2):

- **Balance over last 24H:** corresponds to the fluid balance of the previous 24 hours, using the current date as reference.
- **Yesterday's balance:** balance for previous ICU day.
- **Current balance:** balance for current ICU day.
- **Copy configuration of fluid balance window (last X hours):** X corresponds to the value of the `DefaultValueTimeFilter` setup key. The configuration window shows the configured X value.

The drop-down menu (3) is used to select the font size from the following options: 8, 9, 10, 11, 12, 14, 16, 18, 20, 22, 24, 26, 28, 36 and 48.

The font colour can be changed by clicking the square (4). After validation, the square changes to the selected colour. The default colour is black.

3.1.4.2.4 Current medication orders

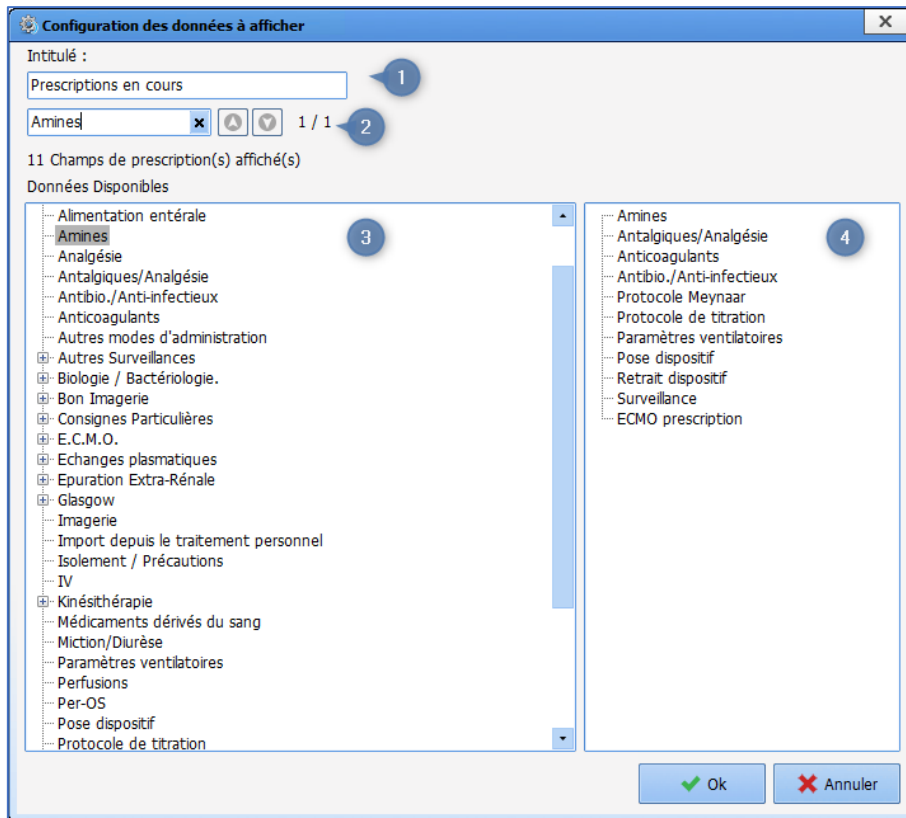
Editing this component opens the following window:



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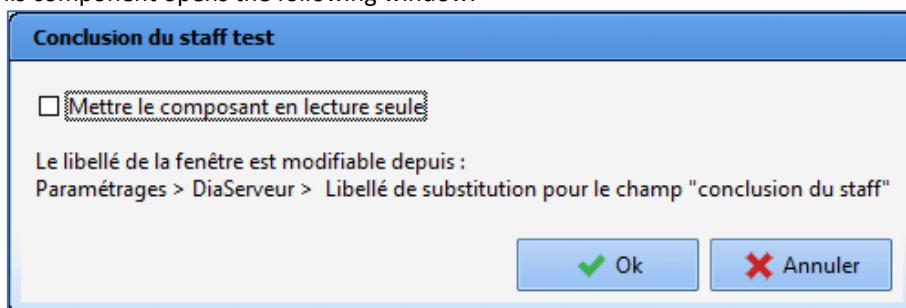
Configuring this component makes it possible to choose the component name shown on the summary screen in the **Name** input box . The default name is as follows: **Current medication order**

A search pane (2) is used to carry out a text search within the list of data found in pane (3). The arrows can be used to move from one item to another.

The column on the left (3) lists the medication order field found in the medical orders tab associated with the current configuration. If the medication orders field is associated with detailed entries, each detailed entry is listed under the medication order field. To make them visible during use, the category must be dragged and dropped into the column on the right (4). It is possible to reorganise the list of configured items using drag and drop. The configuration order is the display order used on the summary screen.

3.1.4.2.5 Personnel conclusion

Editing this component opens the following window:



The title is configured in the settings/Diaserver section via the **Substitution label for "Personnel conclusion" field.**

The default field title is: **Personnel conclusion.**



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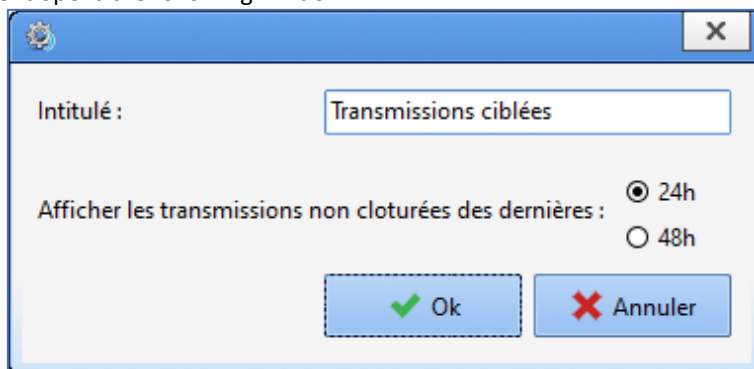


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To display the component without allowing users to make changes, the box **Make component read-only** must be selected.

3.1.4.2.6 Targeted nursing notes

Editing this component opens the following window:



Configuring this component makes it possible to choose the component name shown on the summary screen in the **Name** input box . The default name is as follows: **Targeted nursing notes**

Show unclosed nursing notes from the last 24h/48h is used to define the period during which nursing notes are displayed in the component.

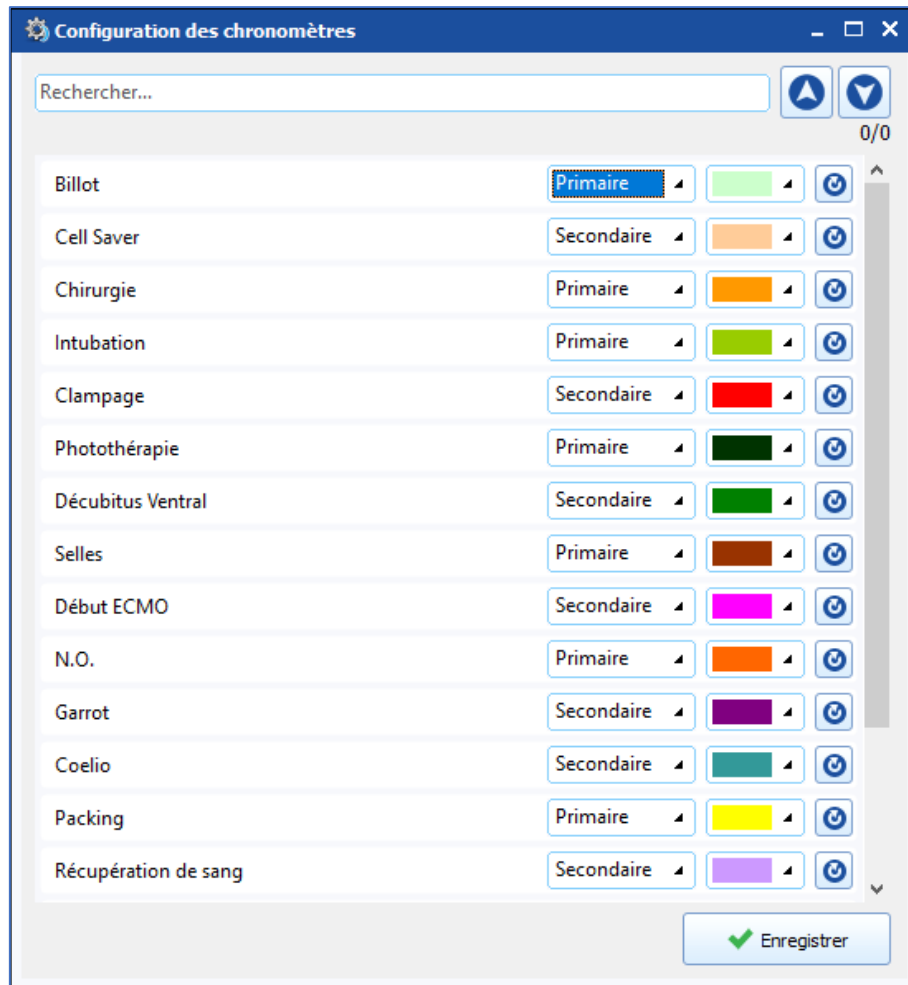
The default period is 24 hours.

3.1.4.3 Configuring the specific components of the side ribbons (DIANE REA and VISUAL)

3.1.4.3.1 Primary/secondary timers

The timer display component shows the various times set in the record. The default settings are those configured in the **Timers** tab.





These settings can be modified by changing the display type (primary or secondary) or colour. When this is done, the ⚙️ icon appears at the beginning of the row. To reload the default configuration, click the ⚙️ button.

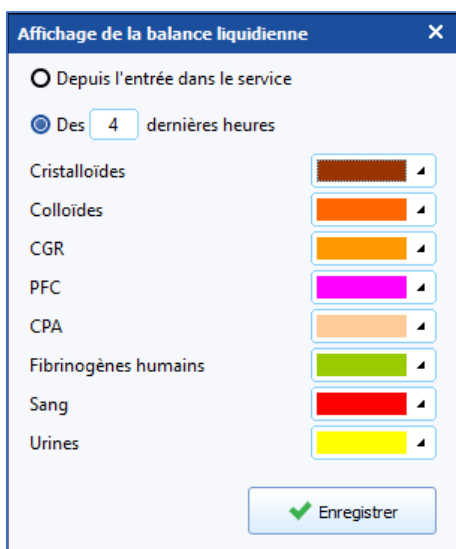


3.1.4.3.2 Filtered fluid balance


The filtered fluid balance component displays six categories of intake (crystalloids, colloids, RBC, FFP, PC and fibri) as well as outputs of blood and urine. Depending on the fluid, these categories must be configured in advance in the **Drugs** or **Drug formulary** tabs.

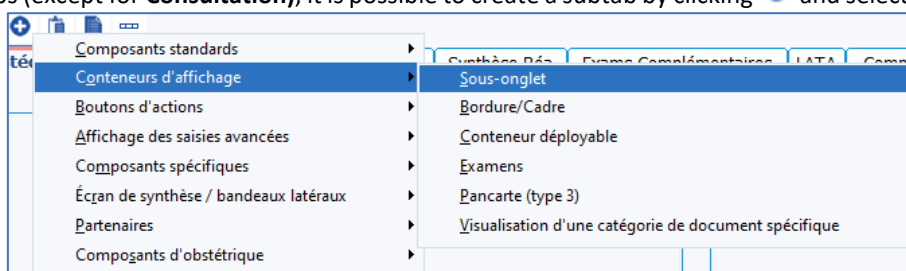
Configuring this component consists in defining the display colour for each category and determining the time range to be displayed (either 'since admitted to unit' or over the last 1 to 72 hours).



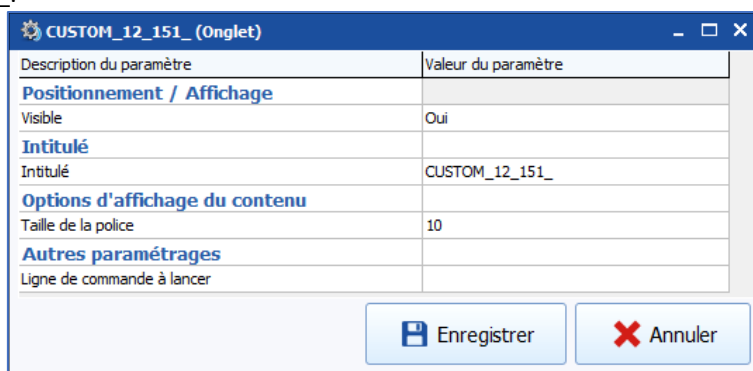


3.1.5 Add a subtab

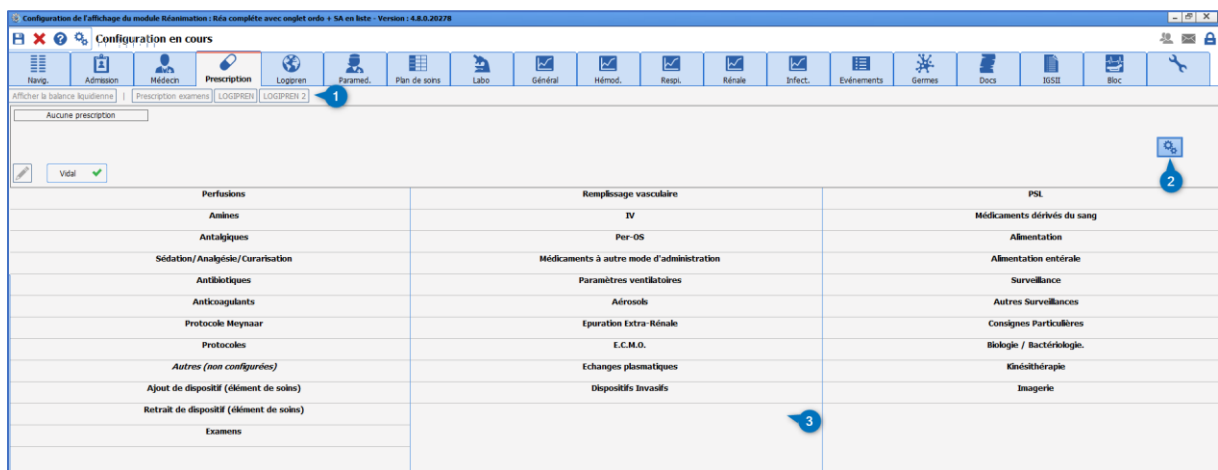
In some tabs (except for **Consultation**), it is possible to create a subtab by clicking  and selecting **Sub-Tab**.



The windows opposite appears. The subtab name should be entered in the line Name instead of CUSTOM_12_151_.




3.1.6 Medication Orders tab

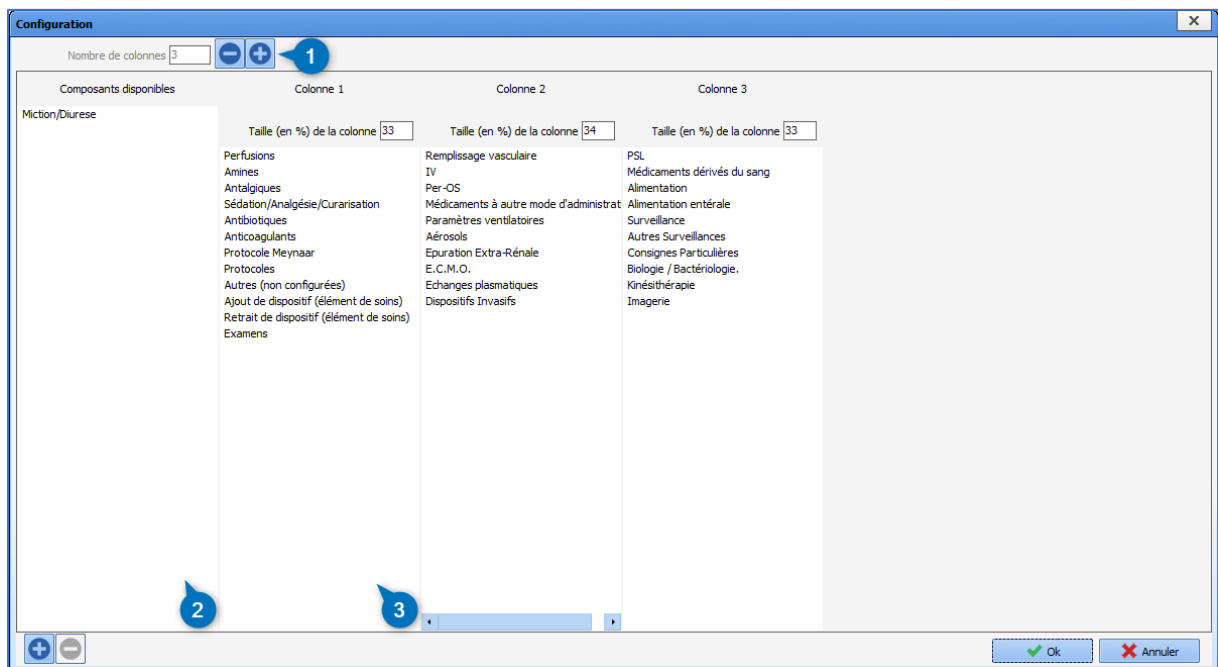


Pane 1 corresponds to the buttons set up in the **Configuration** tab. The button  (2) is used to configure the appearance and operation of the **Medication order** tab.

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

3.1.6.1 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.

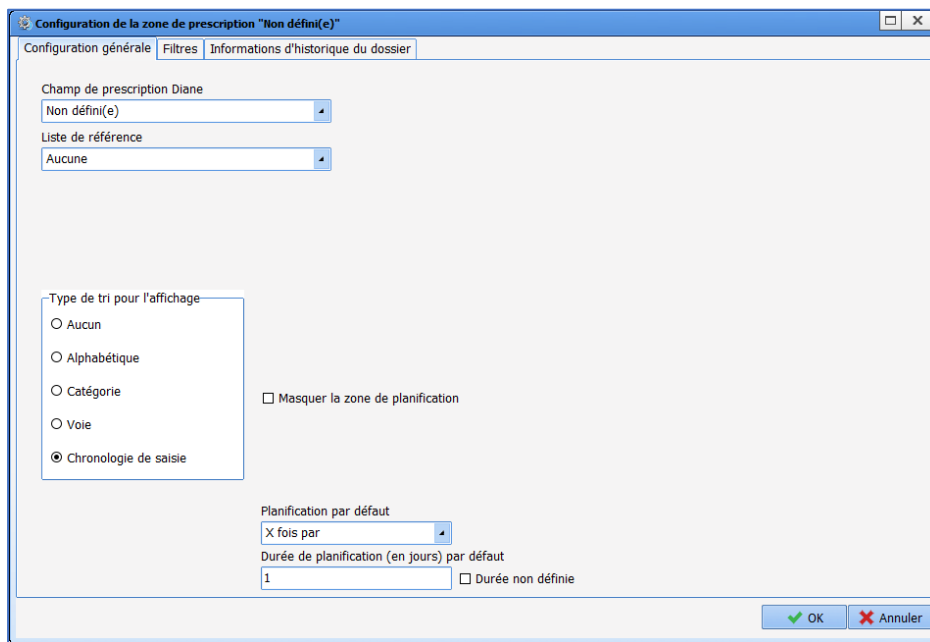


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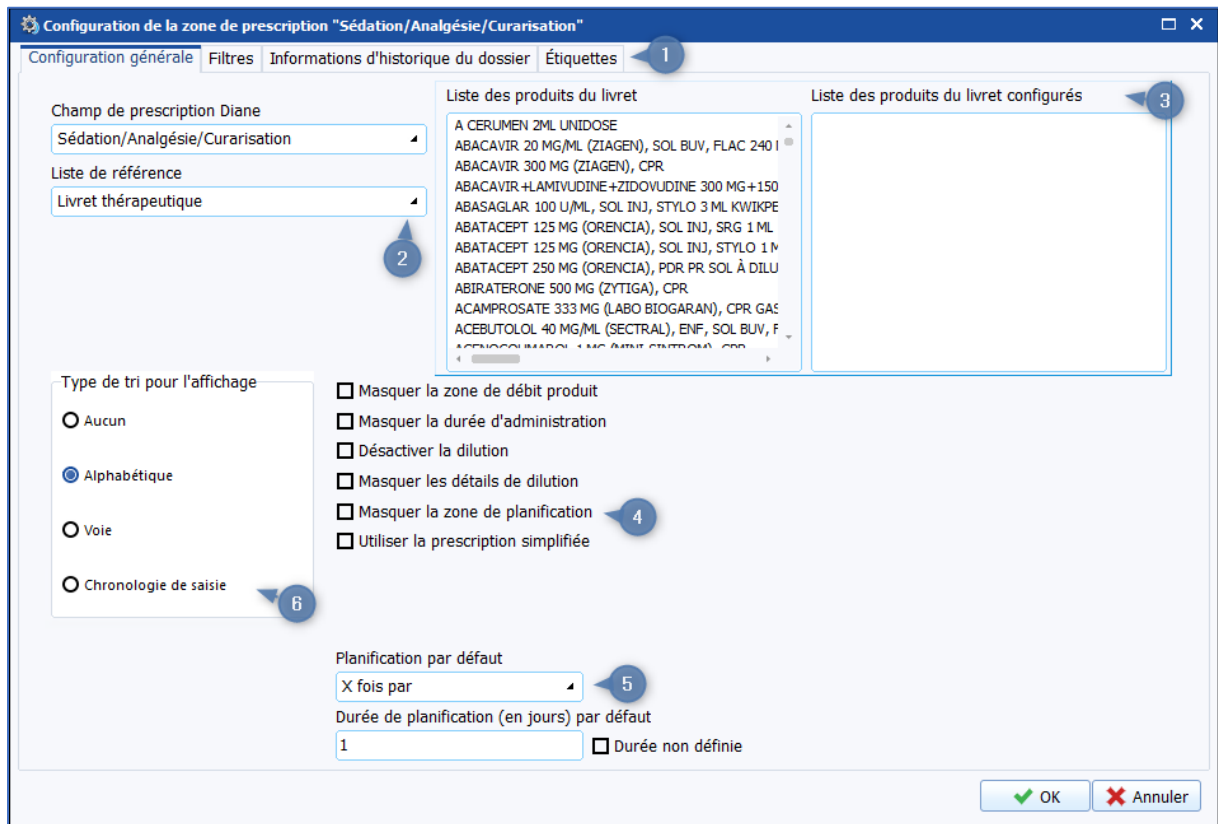
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New medication order components can be created by clicking  at the bottom right. The following window appears:



3.1.6.2 Configuration of a medication order category

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



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1. Configuration window tabs
2. Diane medication order field and reference list

DIANE medication order field:

- | | | |
|--|----------------------------------|-------------------------------------|
| - Adjuvants | - Examinations | - Per os |
| - Verbally requested administrations | - Examinations | - Device insertion |
| - Aerosols | - Wheelchair/Up | - First infusion |
| - Food | - Imaging | - Prevention of PONV |
| - Enteral nutrition | - Immunosuppressants | - Prevention of thromboembolism |
| - Enteral nutrition (Logipren) | - Import from personal treatment | - Gastric ulcer and GERD prevention |
| - Parenteral nutrition | - Import from premedications | - Blood products |
| - Amines | - Insulin protocol | - Titration protocol |
| - Analgesia | - Insulins | - Meynaar protocol |
| - Local and regional analgesia | - Ventilation interface | - Protocols |
| - Systemic analgesia | - Isolation/Precautions | - PLS |
| - Analgesia/Sedation/Muscle relaxants (Logipren) | - IV | - Fourth infusion |
| - Analgesics | - Physical therapy | - Clinical research |
| - Analgesics/Analgesia | - Withdrawal of treatment | - Pharmacist's comments |
| - Antibio./Anti-infectives | - Other drugs (Logipren) | - Filling |
| - Anticoagulant | - Cardiac drugs (Logipren) | - Volume expander |
| - Anticoagulants/antiplatelet agents | - Cardiology drugs | - Device removal |
| - Antidotes | - Blood derivatives | - Rx |
| - Anti-infectives (Logipren) | - GI drugs | - Detailed entries |
| - ATB | - Urination/Diuresis | - Sedation |
| - Other | - Neuroleptics | - Sedation/Analgesia/Curarization |
| - Other (Logipren) | - Undefined | - Syringe pumps |
| - Other methods of administration | - NIP | - Solutes |
| - Bio/Bacterio | - NPS | - Gastric tube |
| - Chemotherapy | - Nutrition | - Subcutaneous |
| - Comments | - Oxygen therapy and ventilation | - Narcotics |
| - Restraints | - Dressings | - Monitoring |
| - Muscle relaxants/Antagonization | - Paraclinical | - Therapeutic |
| - Second infusion | - Ventilation parameters | - HTN treatment |
| - Invasive devices | - PCA, PCEA | - Bleeding and anaemia treatment |
| - Diuretics | - Infusions | - Third infusion |
| - Misc. | | - Ventilation |
| - Drains | | |

Reference lists:

- **None**
- **Consultation list** (Drop-down menu **Root (or parent element)** used to choose the consultation list to be used)
- **Events list** (Drop-down menu **Root (or parent element)**: Events/Patient environments/Samples)
- **Diane drug list** (Drop-down menu **Root (or parent element)**: Fluid balance/Drugs/Blood products). The following options can be configured from the medication order window:
 - o Hide product flow rate pane
 - o Hide administration duration

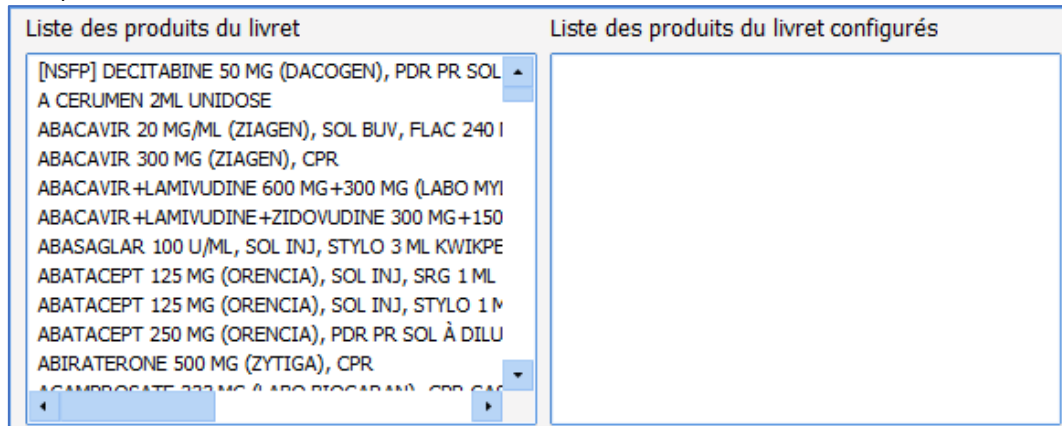


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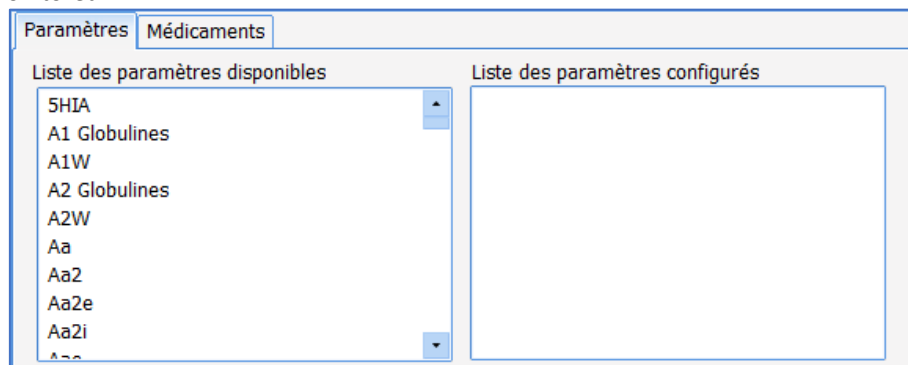


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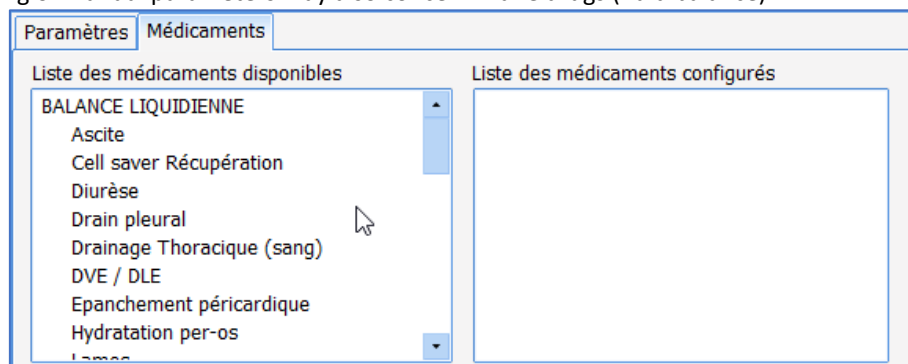
- Disable dilution
 - Hide dilution details.
- **Formulary:** used to select which formulary items can be prescribed in this pane. Products that can be prescribed in this medication order pane should be dragged from **Formulary list** to **Configured formulary list**. If no items are dropped into the pane on the right, all formulary products can be prescribed.



- **Manual parameters:** medication order pane used to prescribe monitoring of manual parameters from the list available in the **Parameters** tab. Parameters that can be monitored should be dragged from the **List of available parameters** pane to the **List of configured parameters** pane. If no items are dropped into the pane on the right, all parameters can be monitored.

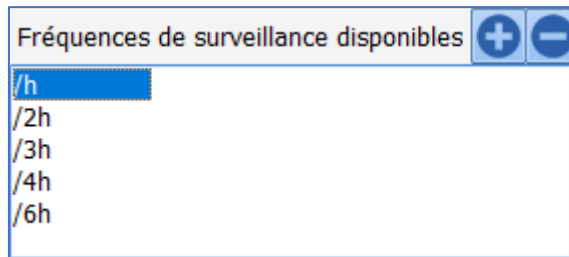



Monitoring of manual parameters may also concern Diane drugs (fluid balance).

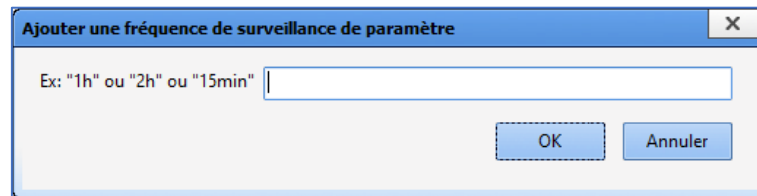


Suggested parameter monitoring frequency can be configured from the same tab:



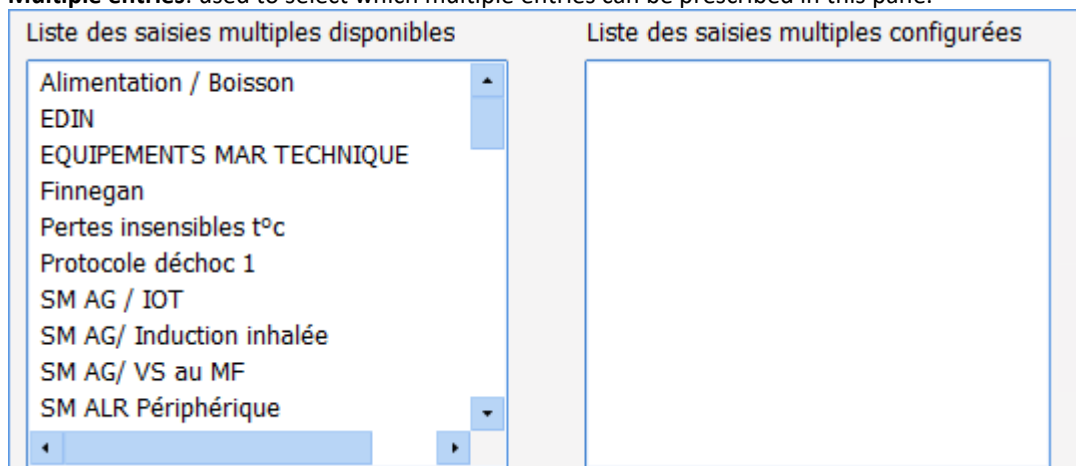


 is used to add a new frequency by entering a whole number followed by **h** for hours or **min** for minutes:



 is used to delete a frequency.

- **Multiple entries:** used to select which multiple entries can be prescribed in this pane.

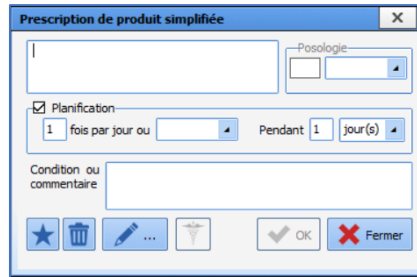


Multiple entries that can be prescribed in this medication order pane should be dragged from **List of available multiple entries** to **List of configured multiple entries**. If no items are dropped into the pane on the right, all multiple entries can be prescribed.

- **Lists of care items**

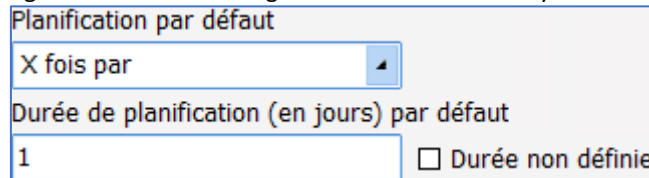
3. List of products (for the **Formulary** reference list), list of vital signs and drugs (for the **Manual vital signs** reference list) or list of multiple entries (for the **Multiple entries** reference list)
4. Configuration of the medication order window appearance
The **Use the simplified medication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





5. Default scheduling

It is possible to configure default scheduling to be used automatically in the medication order window:



Default scheduling: Drop-down list with the following options:

- Manual
- One time only
- X times per
- X time(s) every
- X times in
- Continuously

Default schedule duration (in days): number input box, optional if **Undefined duration** is selected, starts from 1.

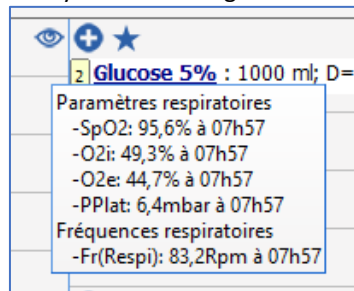
The scheduling pane can be hidden if **Hide scheduling pane** is selected.

6. Sort type for display

For each Diane medication order field, one of three sort types can be selected for the display:

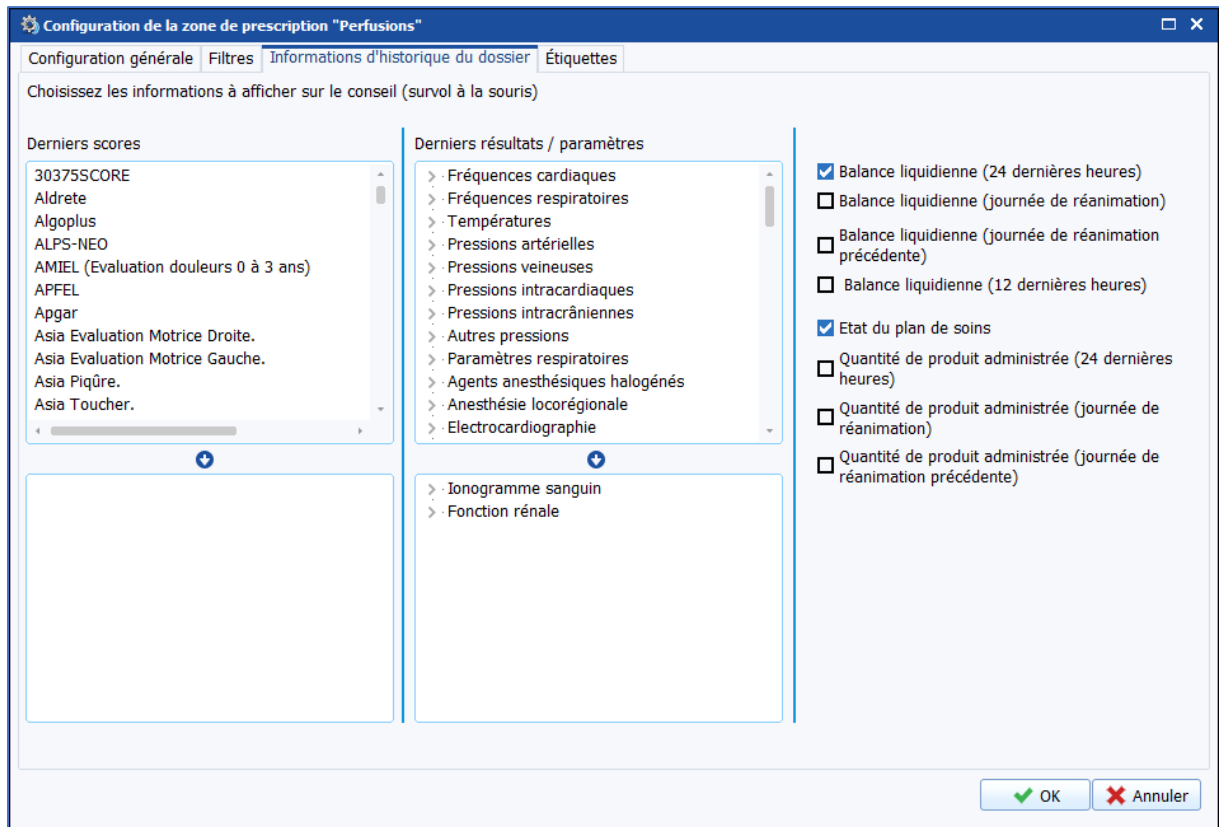
- None
- Alphabetical
- Category
- Route
- Timeline entry

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

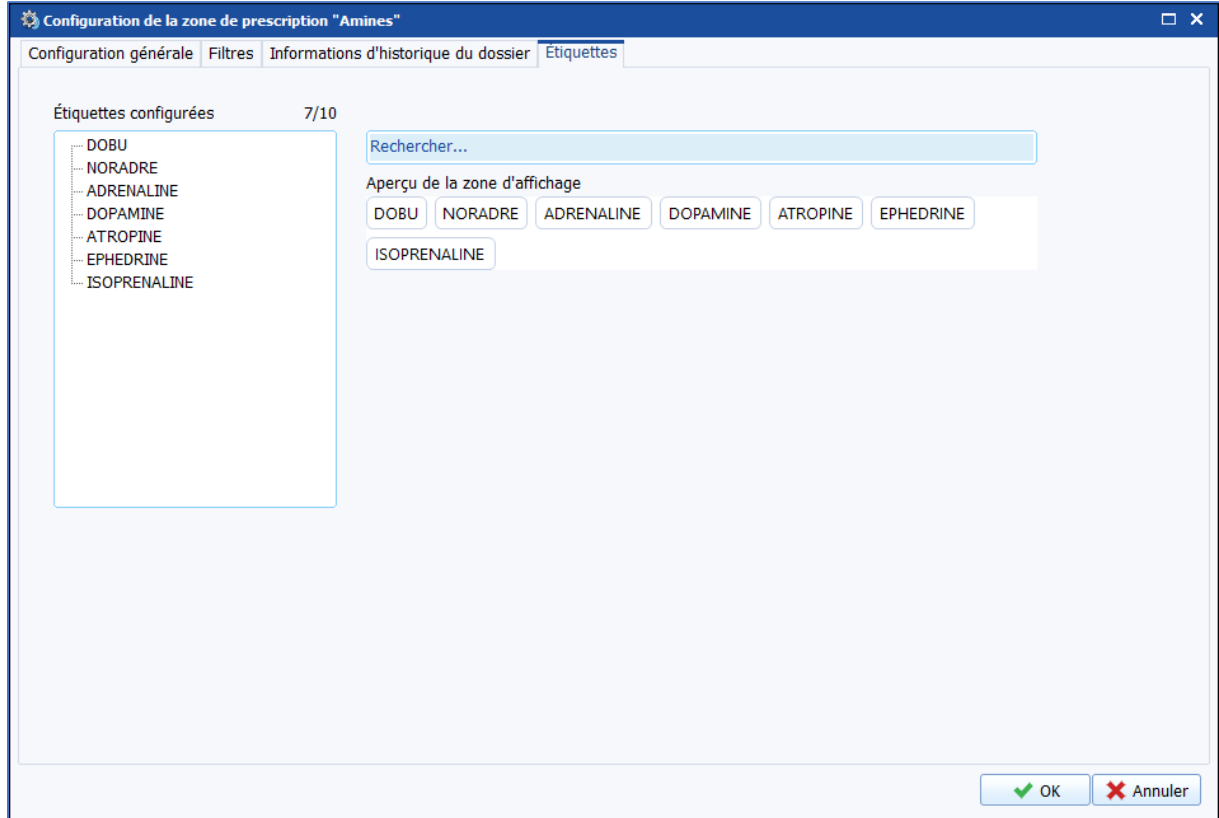


The scores, results and vital signs to be displayed are moved into the lower part of the screen with drag and drop.

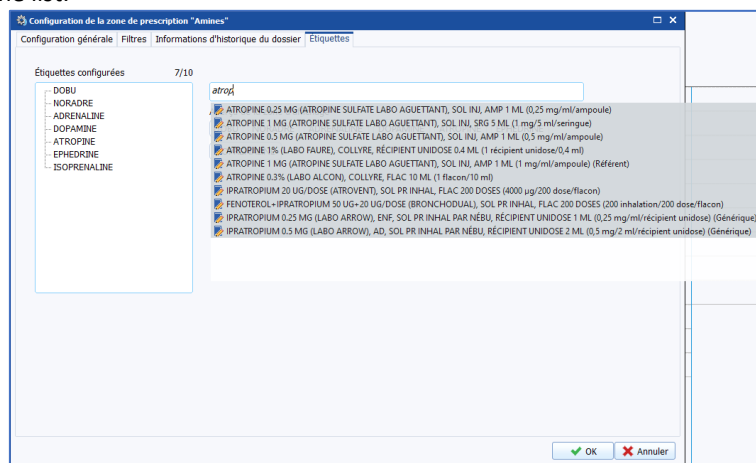




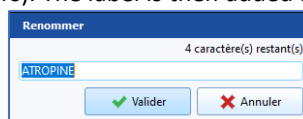
Labels in the guided medication order window can be configured in the **Labels** tab. These labels let you add products most frequently used to the medication order field in just one click.



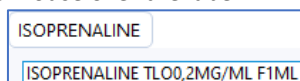
Up to 10 labels can be configured. To add a label, start typing the name of a product and select the relevant suggestion from the list.



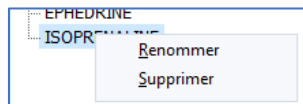
Confirm the name (limit of 12 characters). The label is then added automatically.



To display the product name, hover the mouse over the label.



To rename or delete a label, simply right-click the label in the **Configured labels** menu on the left side.

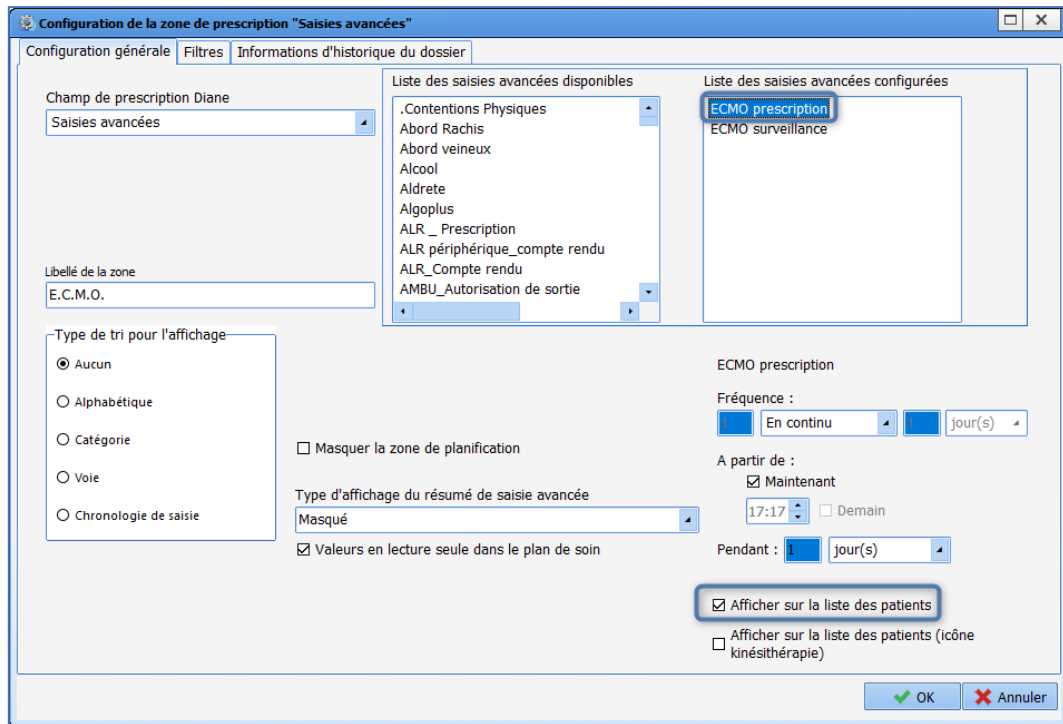


3.1.6.3 Displaying detailed entries on the cockpit (patients list)

3.1.6.3.1 Display in the Other column of the retractable pane

To display the label of current detailed entries with continuous scheduling on the patients list, go to the visual configuration of the module, **Medication order** tab and double-click the pane containing the detailed entries to be displayed.

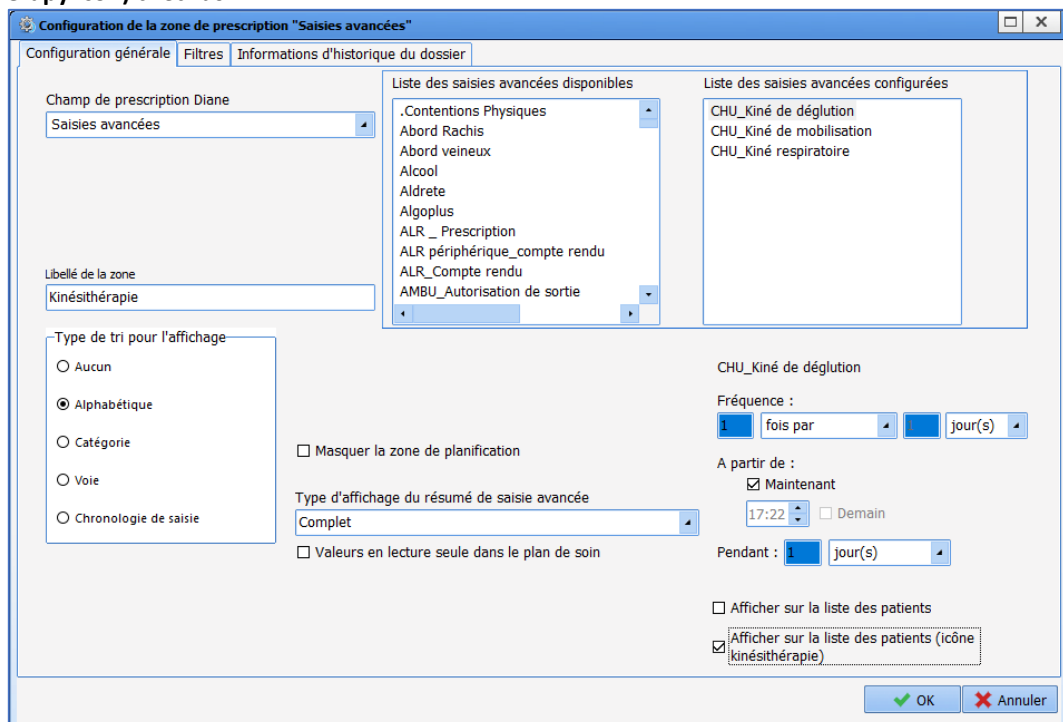




The checkbox **Display on patients list** is associated with each item found in the **Configured detailed entries** pane and used to select whether or not the detailed entry should be displayed.

3.1.6.3.2 Display the Physical therapy icon

To display the physical therapy icon on the patient portal, go to the visual configuration of the module, **Medication order** tab and double-click the pane containing the detailed entries to be displayed, then configure the detailed entries associated with physical therapy using the **Show on patients list (physical therapy icon)** checkbox.



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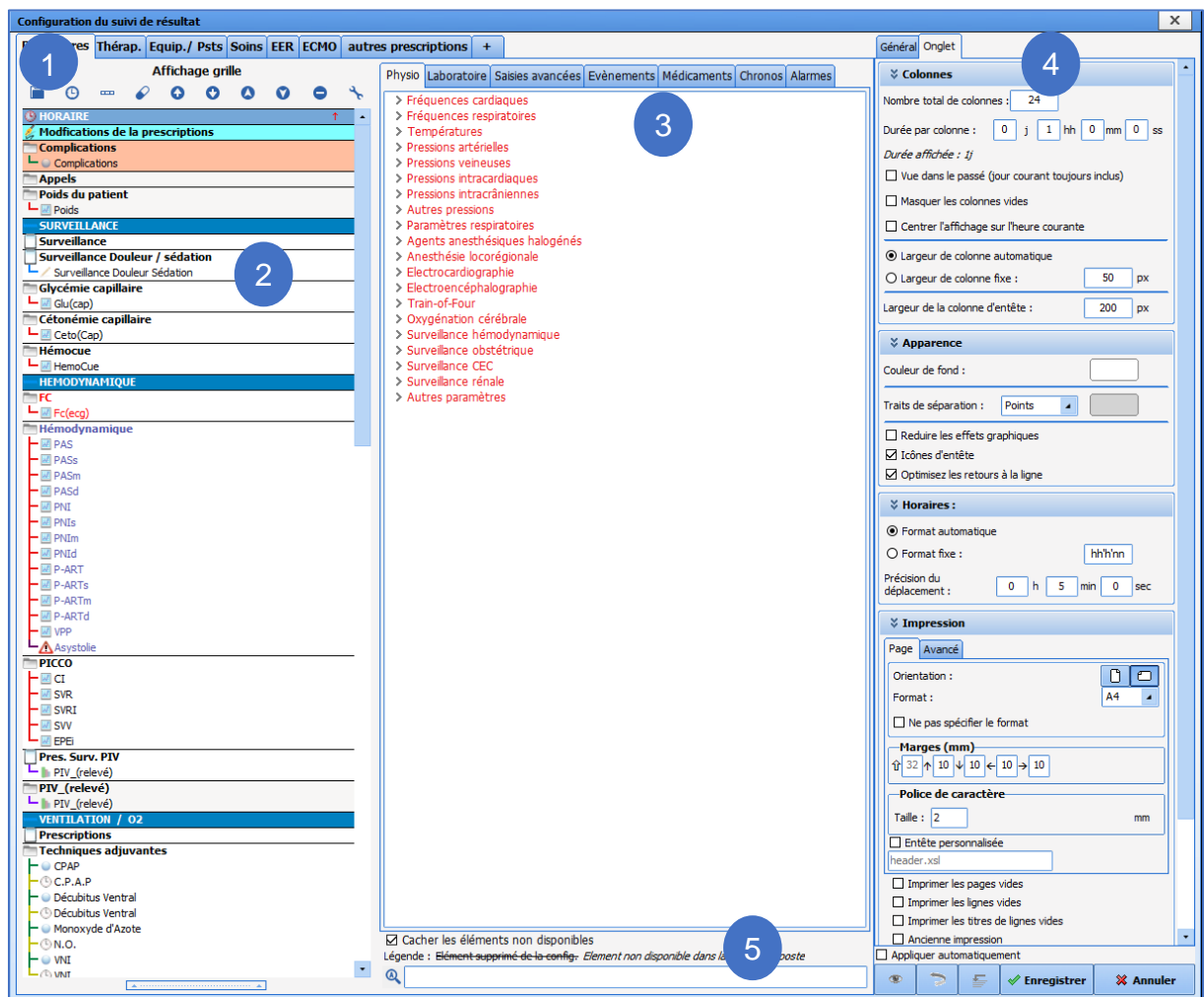
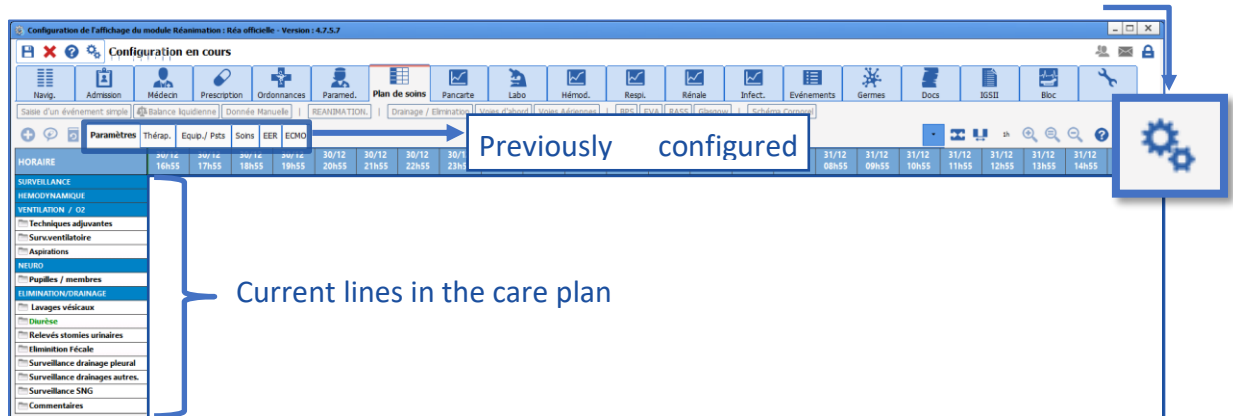


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3.1.7 Care plan

3.1.7.1 Care plan configuration

Access care plan configuration using the gears (top right)

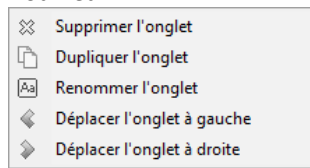


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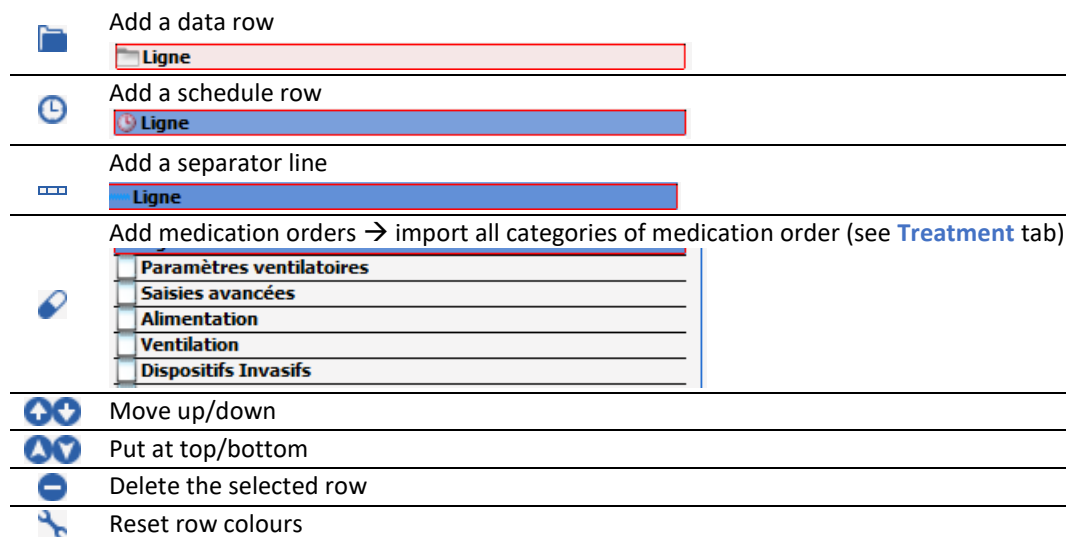
- Parameters tab.
Right-clicking allows the tab to be modified



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

- Configured lines in the selected tab.
- Configurable items grouped by category.
- Line, tab and care plan settings (General).
- Search box for an item in the configurable list.

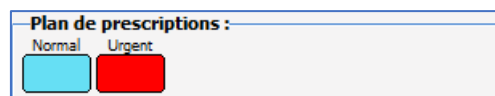
Several buttons are used to configure the display:



3.1.7.1.1 General tab

Used to configure the general display of the care plan. The colours can be changed and may be different depending on set-up.

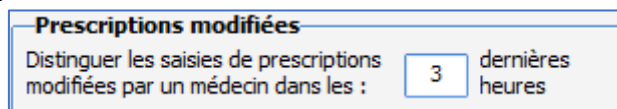
Medication order plan:



Status colours of prescribed items:



Edited medication orders:



If a medication order has been edited, the care plan rows affected can be identified from the icon.



Authorised movement:

Déplacement autorisé :

Première occurrence à faire

Aucun déplacement

Première occurrence à faire

Status confirmation not performed:

Validation de l'état non réalisé :

Commentaire obligatoire

Commentaire possible (non obligatoire)

Commentaire désactivé

Commentaire obligatoire

Auto save:

Sauvegarde automatique :

Après chaque modification

Automatiquement toutes les minute(s)

Format de fichier :

Mode Login Mot de passe

Passive mode (FTP)

Export vers... Masque de fichier

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

Arrangements:

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 entered with a duration:

Éléments saisis présentant une durée :

Terminé En cours

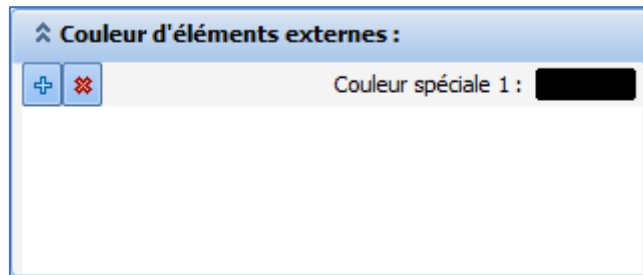
External item colour:



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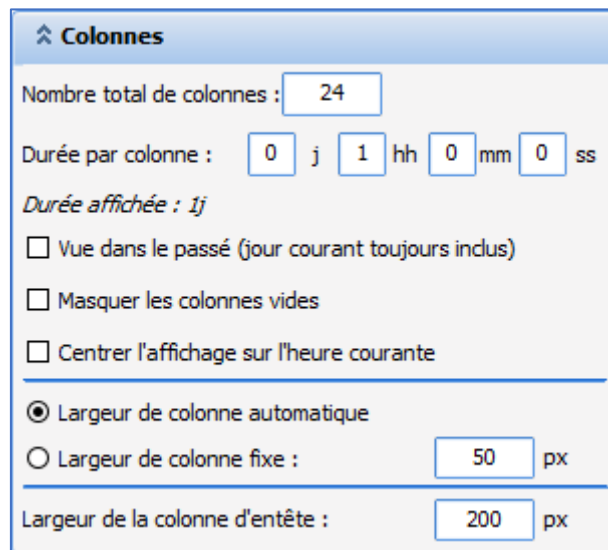
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3.1.7.1.2 'Tab' tab

Used to configure the display of each tab.

Columns:

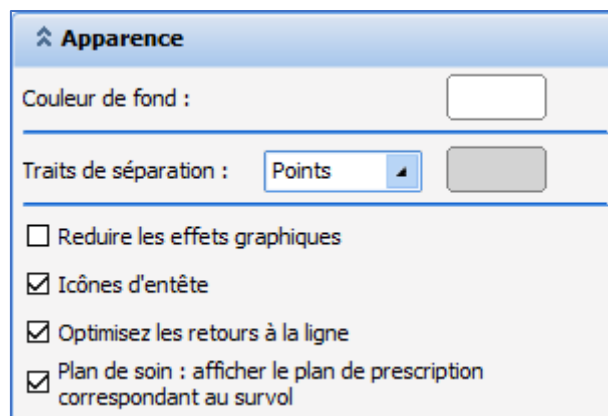


The Columns pane is used to select the number of columns to be shown and the duration associated with a column.

Hide empty columns: Hide columns with no occurrences.

Centre display on current time: centres the tab display on the current time.

Appearance:



Background colour: Not used

Separator lines: Used to select the appearance of column separator lines. It is possible to display dots, continuous lines or no separation. The colour of the separators can be personalised.



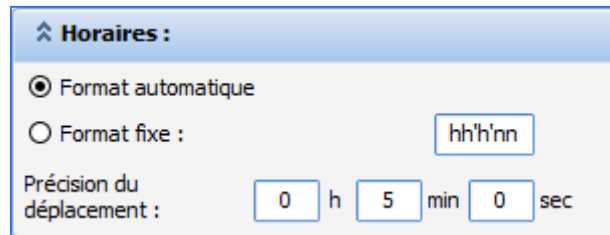
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Header icons: If selected, the icon corresponding to the data shown is displayed at the start of each row.

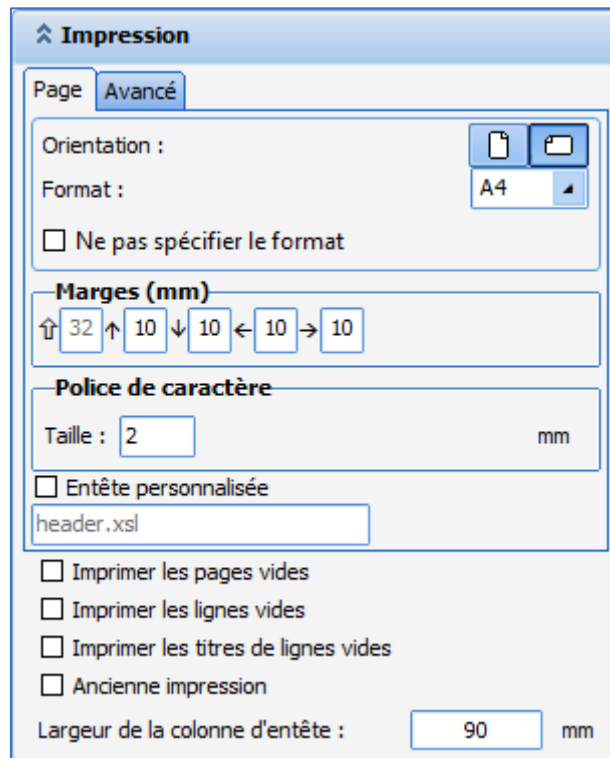
Schedule:



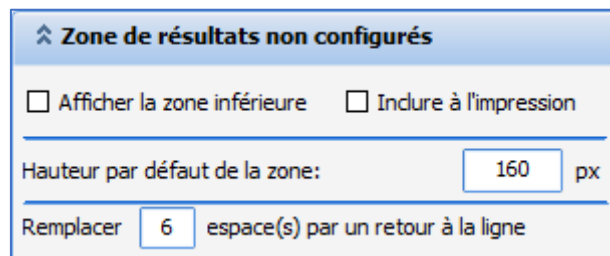
Used to select whether the times shown are in automatic (the smaller the time slot shown, the more precise the time) or fixed format.

Movement details is used to select details to be added to the rescheduling of an occurrence on the care plan when rescheduled using drag and drop.

Printing:



Unconfigured results pane:



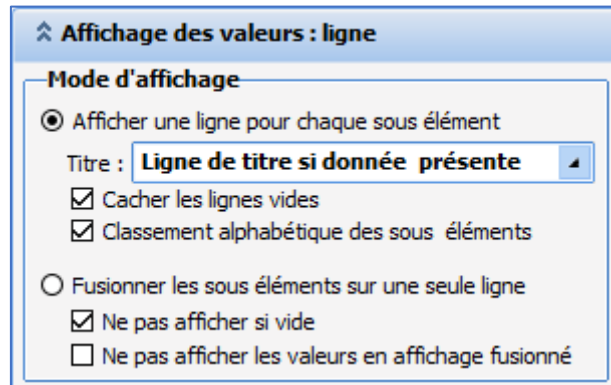
3.1.7.1.3 Row tab

Tab only available if a row has previously been selected.

Display values: columns

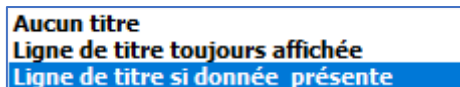


Display values: rows



Used to select a row display for items or merged display of subitems.

If the user chooses row display for each subitem, it is possible to display or hide the title of the row via the **Name** drop-down menu. **Row name always displayed** allows manual entry. No name does not allow manual entry.



Empty rows can be hidden (**Hide empty rows** checkbox)

The **Alphabetical order of subitems** checkbox is used to sort items in a category by alphabetical order. If not selected, items are displayed in the order in which they were added.

View filter:



^ 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

Pane used to select information to be shown in each row.
 The top drop-down menu contains the following data:

Eléments saisis
 Plan de prescription
 Plan de soin
 Planification infirmière
 Voie
 Donnée externe
 Element de soin

- **Entered items:** Used to select whether entered items are displayed.

^ 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 the medication order plan associated with a medication order field that can be selected from the **From medication order field** drop-down list is displayed.



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Note that occurrences cannot be validated in this mode. 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 the care plan and medication order plan associated with a medication order field that can be selected from the **From medication order field** drop-down list is displayed. The **Care plan items to do** and **Care plan items that are overdue** checkboxes are accessible. The **Not configured in this display of type** checkbox is unticked 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 cardiologie
 C02 - antihypertenseurs
 C03 - diurétiques
 C04 - vasodilatateurs périphériques
 v Donnée externe

Several view filters are available and can be applied per row: Medication order field, Route and ATC code. It is therefore possible to have an uncorrelated view of the medication order that is not fixed on the Medication order fields.



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How to configure the view

Example: a display row only showing "OPIOIDS", prescribed from the IV medication order field.

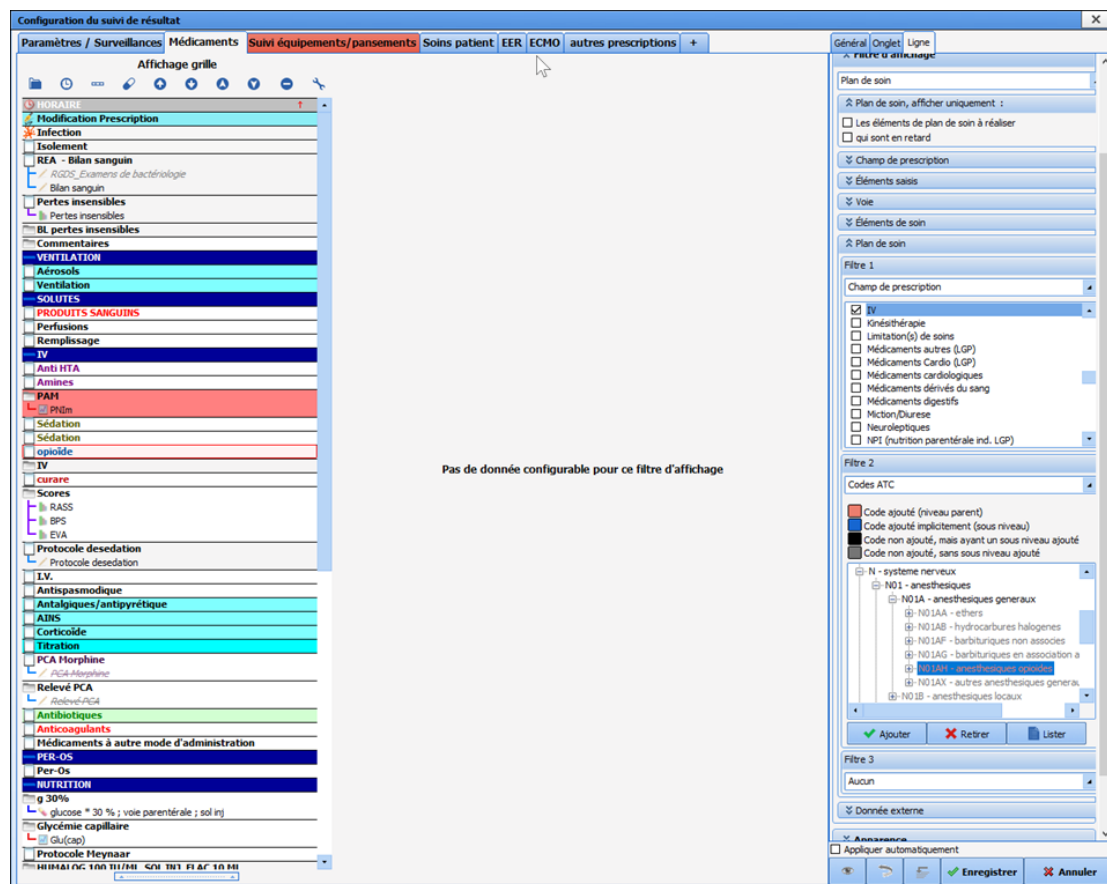
To do this:

View filter: select **Care plan**

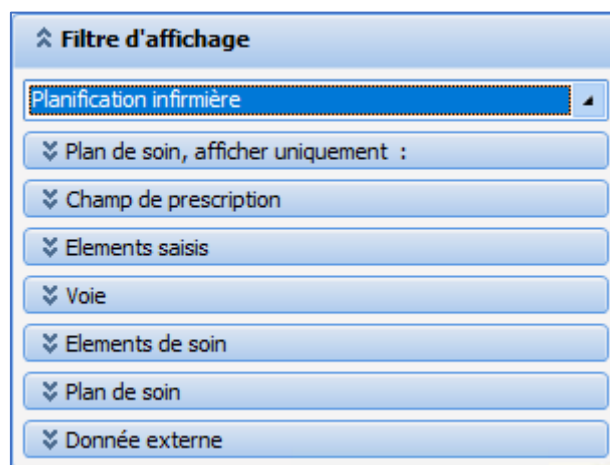
Filter 1: select **Medication order field**

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

Then, on the display row only referring to the **IV** medication order field, exclude "Opioids" for this row to avoid duplicates.



- **Nurse scheduling:** Used to display nurse scheduling



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- **Route:**

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

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



Appearance:

- **Display mode:** for choosing between data display modes.

- **Appearance:** used to define the font, font colour and background colour of the row.
- **Data displayed in cells:** used to configure the information shown for occurrences. The option **None** takes precedence over other options.
- **Values having a duration:** used to display all values or only current ones.

Misc.:



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⤴ **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

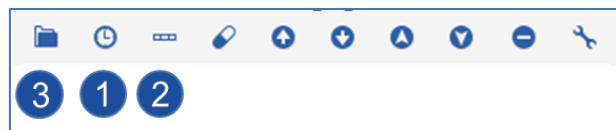
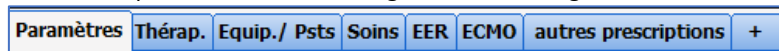
Imprimer le détail en annexe si le texte dépasse : caractères

Intercaler la prescription avec le plan de soin

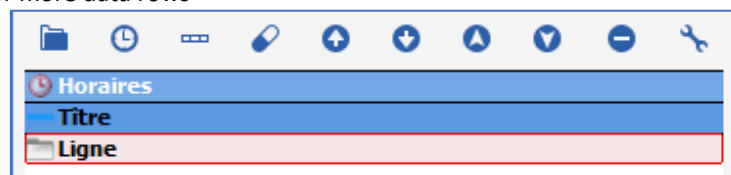
Placer les annexes en dessous de la ligne

3.1.7.2 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.

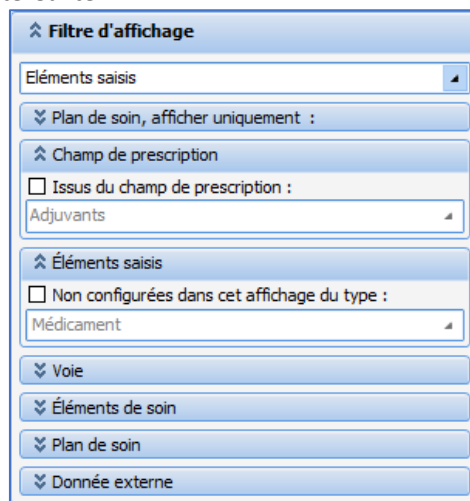


1. Start by adding a time row.
2. Add a separator line
3. Add one or more data rows

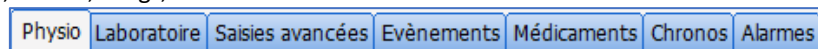


3.1.7.2.1 Creating an entered item row

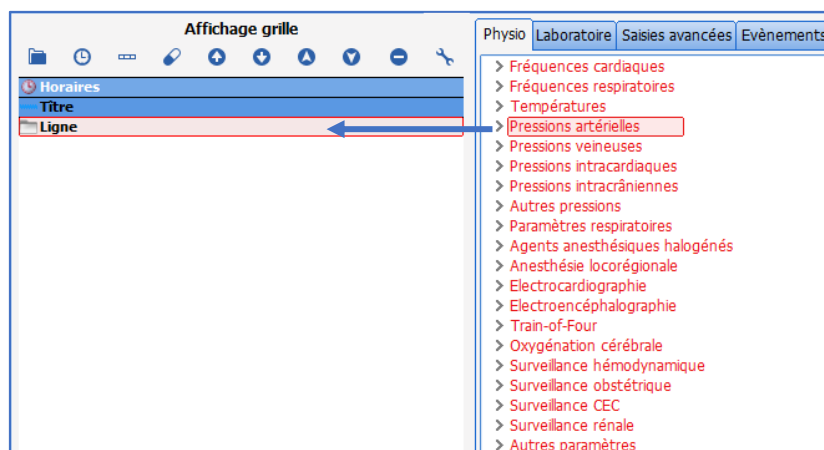
The default data row type is **Entered item**.



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.



3.1.7.2.2 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

↳ Champ de prescription

↳ Éléments saisis

↳ Voie

↳ 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

↳ Donnée externe



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

Specific cases:

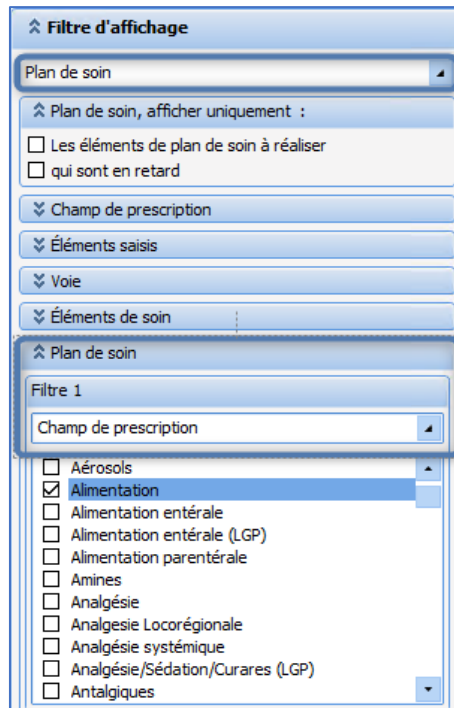
1. Event medication orders:



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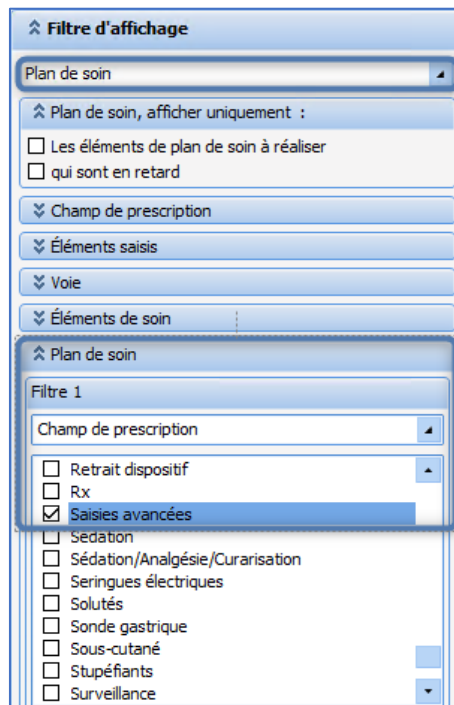
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Example: in the nutrition field, only display the event **Fasting**. Use the middle column, **Event** tab, and drag and drop only what should be displayed (**Fasting**).



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.

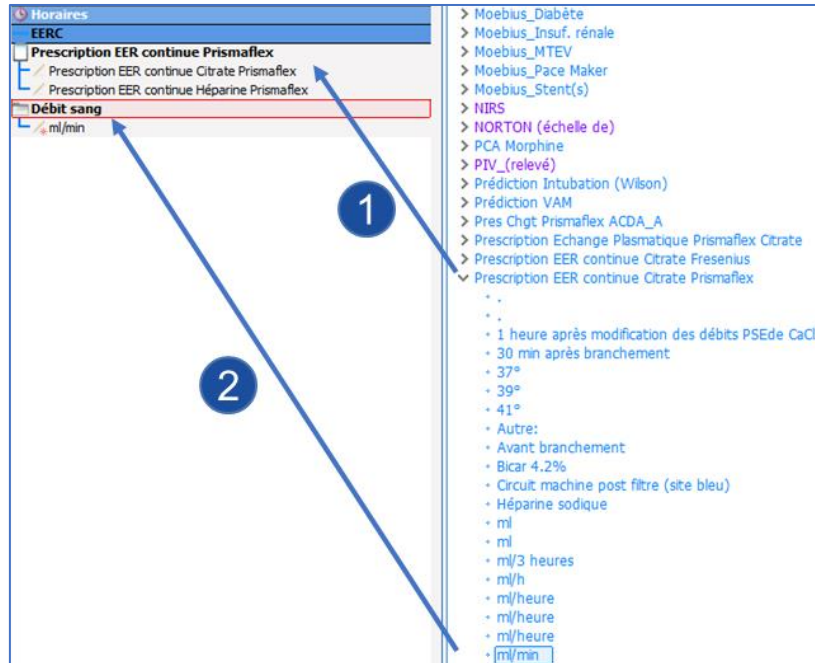


Example: doctor-ordered renal dialysis

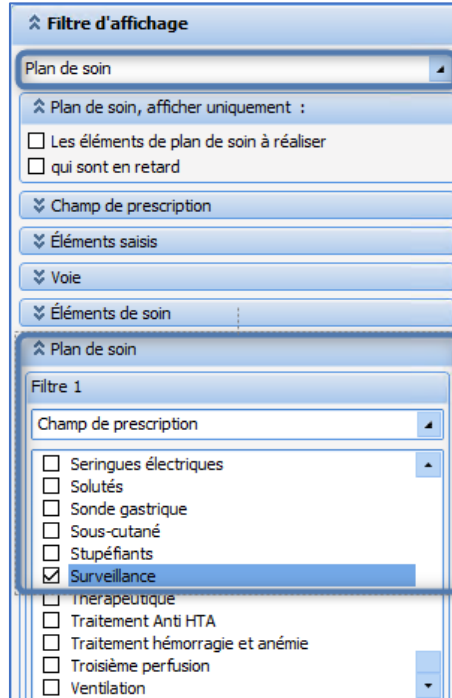


Note: remember to drag and drop all detailed entries set up in the **Medication order** tab if the detailed entry is not in the care plan, the medication order will not appear.

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



- 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.



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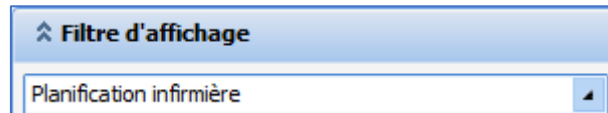


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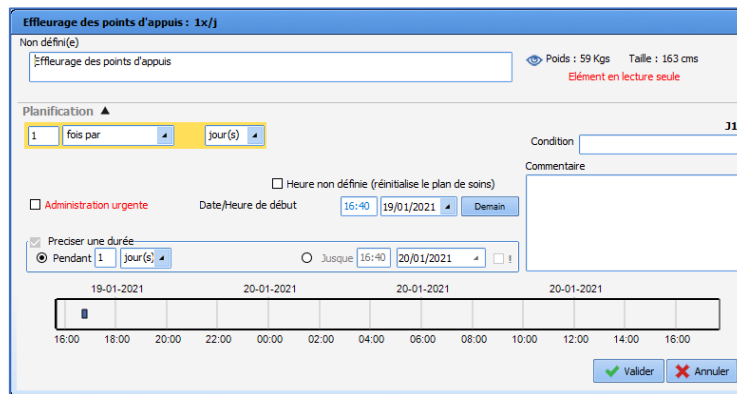


3.1.7.2.3 Creating a Nurse scheduling row

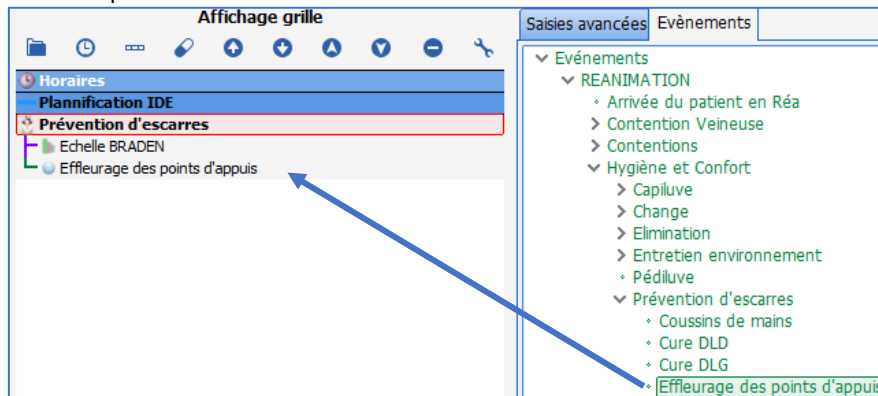
Nurse scheduling concerns detailed entries and EVENTS.



In use, this brings up this window:



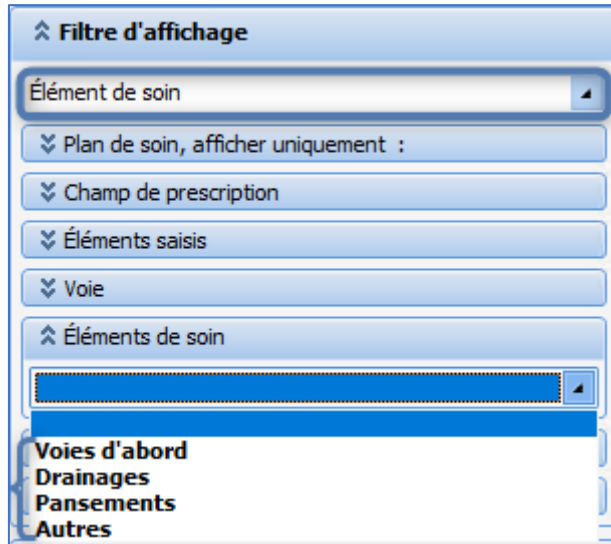
Example: pressure ulcer prevention event and Braden score



3.1.7.2.4 Creating a Care items row

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



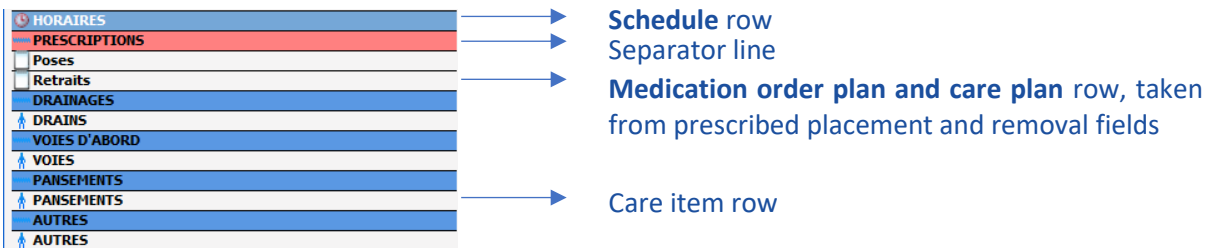


Each row can correspond to a category of care item (Ports, Drains, Dressings and Other). A data row must be configured for each type of care item in the care plan display configuration.

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
PRESCRIPTIONS															
<input type="checkbox"/> Poses															
Voie Veineuse Centrale (VVC)				Pose Voie Veineuse Centrale (VVC)											
<input type="checkbox"/> Retraits															
Voie Veineuse Périphérique (VVP)				Retrait Voie Veineuse Périphérique (VVP)											
DRAINAGES															
DRAINS															
VOIES D'ABORD															
VOIES															
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)											
PANSEMENTS															
PANSEMENTS															
AUTRES															
AUTRES															



Display as timers

In the **View filter** pane, the user must select the **Care item** option then select the category of the care item to be shown in the **Care items** drop-down list.

It is possible to display care items as timers in the care plan. To do this, select **Display as timers** in the **Misc.** section. It is only visible for displaying care items:



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⤴ 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

The care item list is generated from the different types of care item (ports, drains, dressings, other).

For each configured care item to be shown in the care plan, the display is as follows:

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

3.1.7.2.5 Creating a Medication order modification row

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

⤴ Filtre d'affichage

Eléments saisis

Plan de soin, afficher uniquement :

Champ de prescription

⤴ Eléments 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

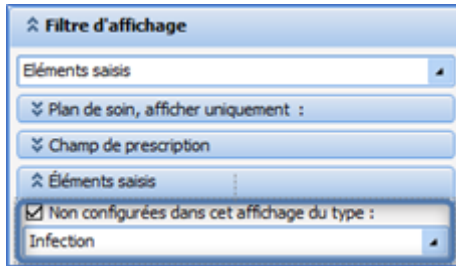
Ne pas afficher les valeurs en affichage fusionné

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

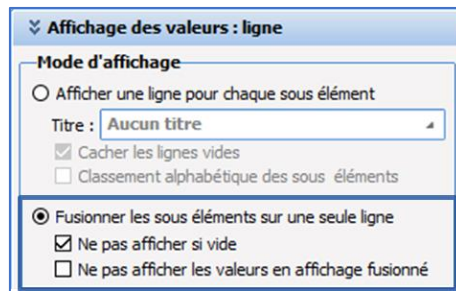
3.1.7.2.6 Creating an Infections row

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



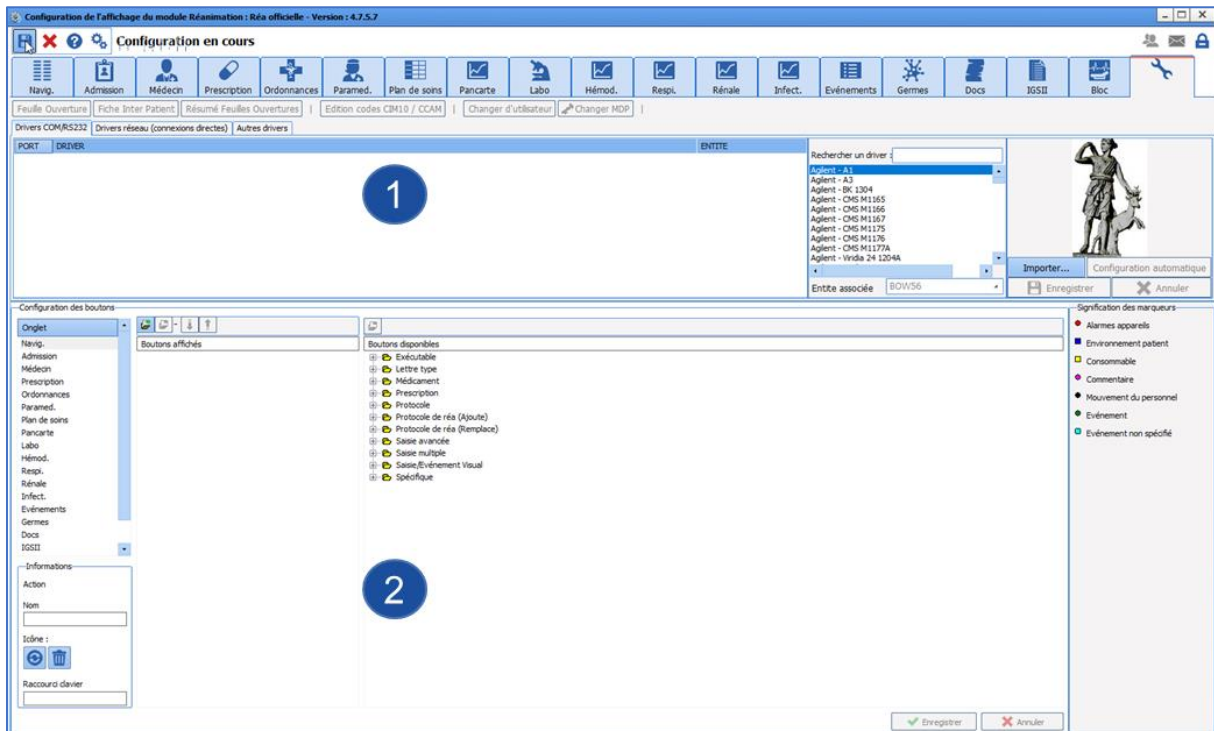


In the view filter, select **Not configured in this display of type:** and select **Infections** in the drop-down menu below.



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

3.1.8 Configuration tab



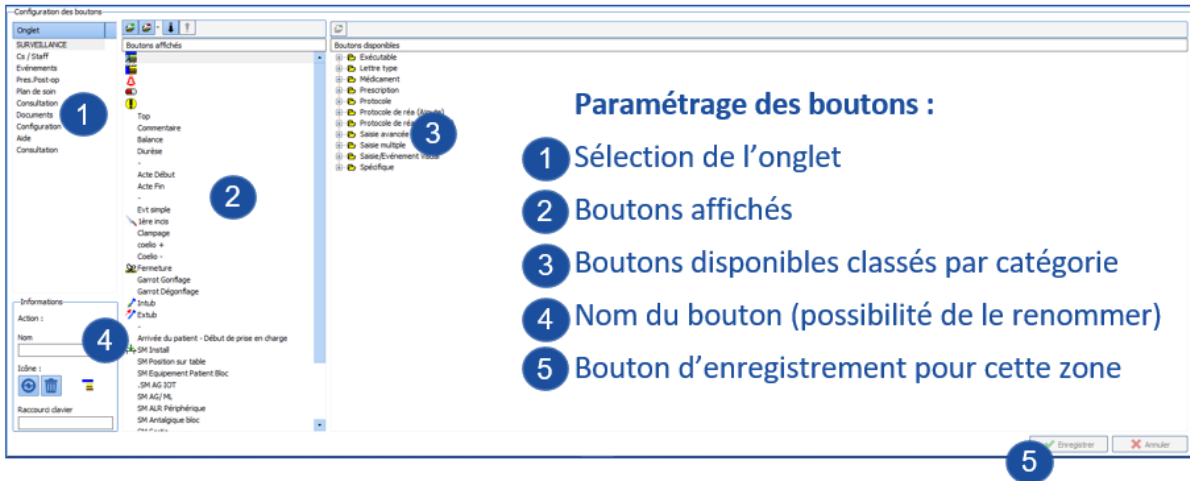
The pane **1** is used to attribute drivers. The pane **2** is used to configure buttons tab by tab.



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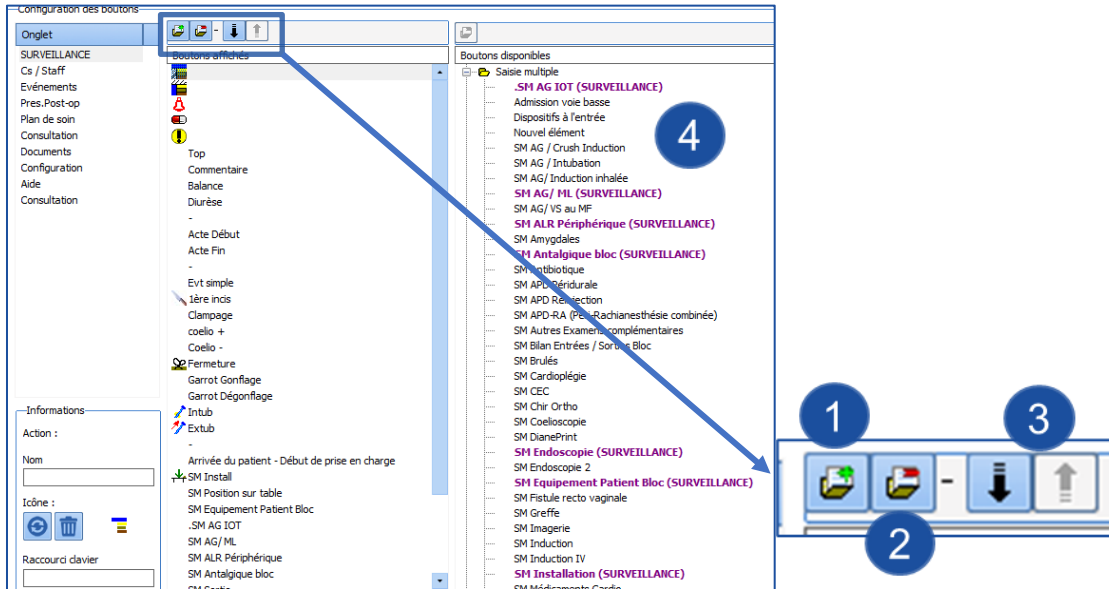
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Paramétrage des boutons :

- 1 Sélection de l'onglet
- 2 Boutons affichés
- 3 Boutons disponibles classés par catégorie
- 4 Nom du bouton (possibilité de le renommer)
- 5 Bouton d'enregistrement pour cette zone

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.

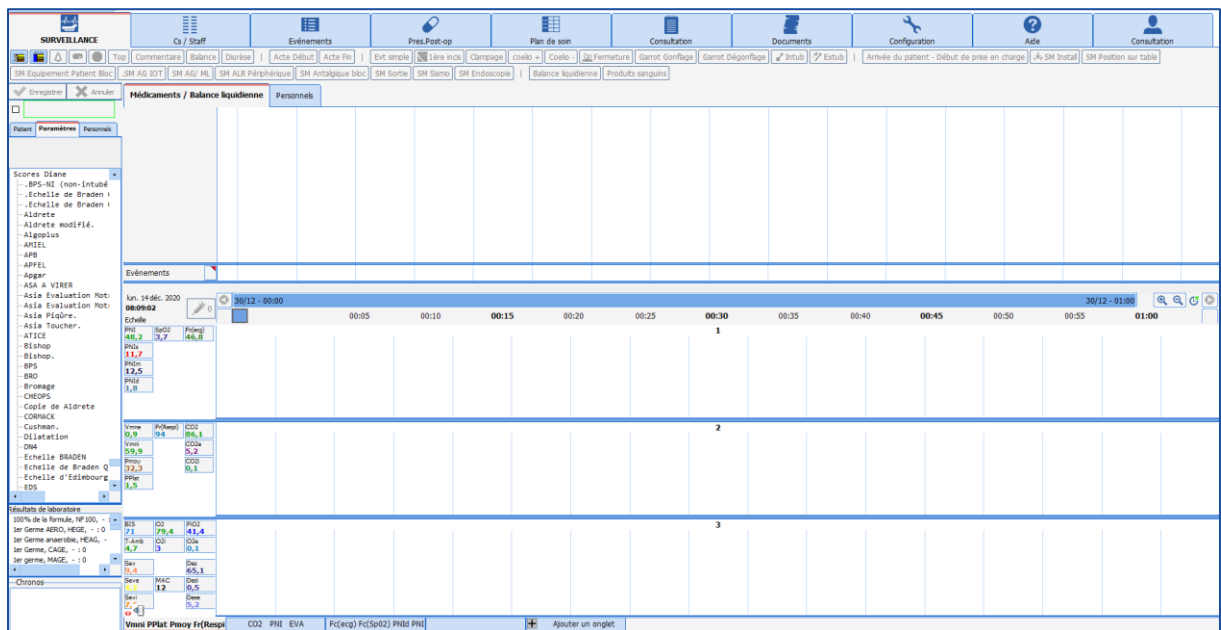


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3.1.9 Monitoring tab (DIANE ANAESTHESIA)/Operating theatre tab (DIANE ICU)



3.1.9.1 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:

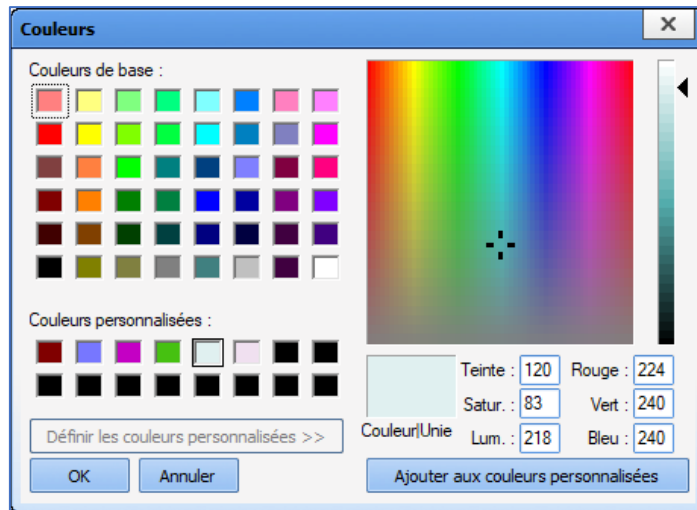
- Visible or not
- Colours can be modified: in order to personalise drug colours, see **DIANE Drugs**



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- Display and drug entry can be filtered.



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3.1.9.2 Events pane

Configuration de la zone des événements

Configuration générale

Activer la zone des événements

Options d'affichage

Grouper les saisies proches

Permettre l'affichage vertical des saisies

Couleur de dégradé de début

Couleur de dégradé de fin

Couleur des groupes

Couleur de la bordure

Couleur du fond **2**

Couleur du texte

Couleurs et style des bulles d'informations

Ancien style

Couleur de dégradé de début

Couleur de dégradé de fin

Couleur du nom de la saisie

Couleur de l'heure de la saisie

Couleur des informations de chronomètre

Couleur de l'heure dans la zone des saisies

Evènements Saisies Multiples Saisies avancées Tri des événements Tri des saisies avancées

Aucun filtre sur l'affichage des événements

Aucun filtre sur la saisie des événements

Liste complète des événements

- Complications
- Consommables
- Environnements Patient
- Evènements
- Prélèvements

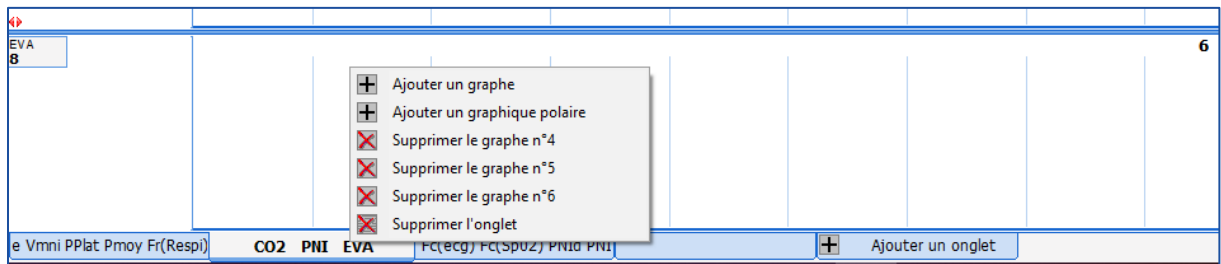
OK Annuler

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.



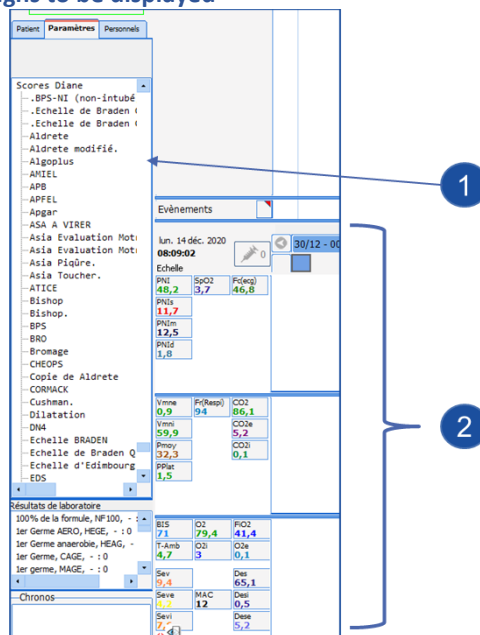
3.1.9.3 Bottom tabs



The bottom tabs can be configured:

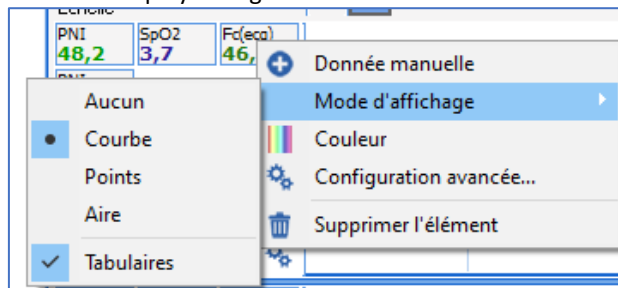
- For each tab, a graph can be added or deleted by right-clicking the tab.
- A tab can be added by clicking **Add a tab**.

3.1.9.3.1 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

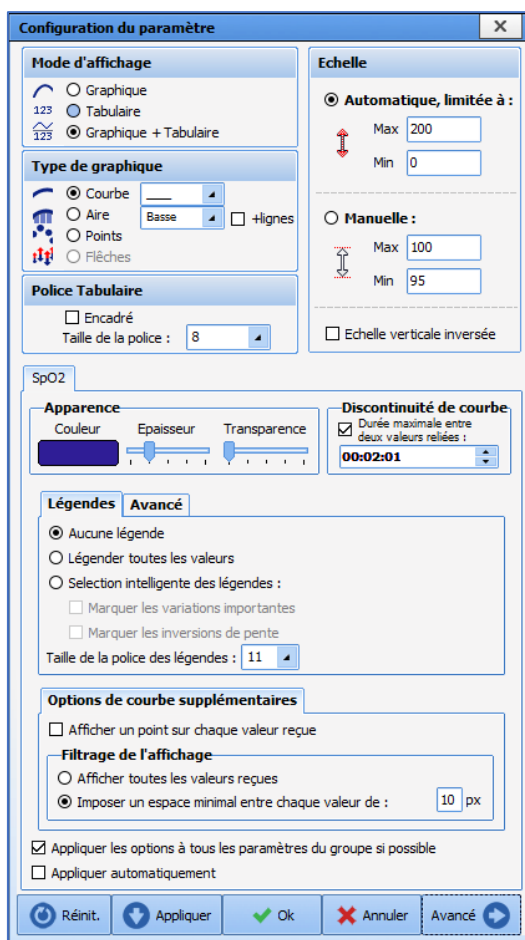
Right-clicking a vital sign shows its display configuration.



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

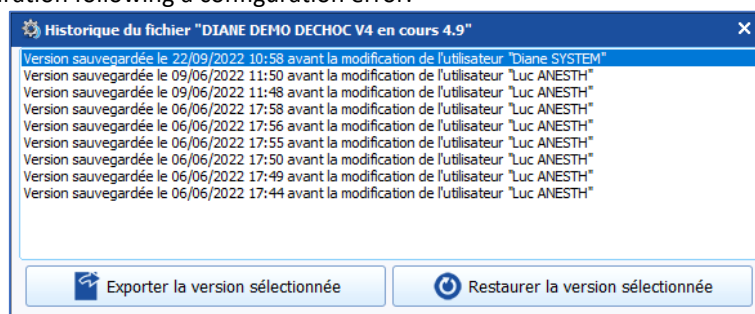
Advanced configuration... shows a configuration window with more options.





3.1.10 Change history

Right-clicking a display configuration lets you view the record's entire history and, if need be, restore a functional configuration following a configuration error.



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.



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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.

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
Executable	Contextual link buttons These are the only buttons that can be created in the Buttons tab.	Buttons
Form letter	Buttons for opening a form letter (prescription, summary, etc.)	Form letters
Drug	Buttons for documenting a drug - or list of drugs in a category - in DIANE ANAESTHESIA (IntraOp and PostOp) .	Drugs
Medication order	Buttons for documenting medication orders for the Medication Order PostOp tab of DIANE ANAESTHESIA (IntraOp and PostOp) .	Protocols (PostOp)



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Protocol	Buttons for documenting protocols for the Medication Order PostOp tab of DIANE ANAESTHESIA (IntraOp and PostOp) .	Protocols (PostOp)
ICU protocol (Add)	Buttons for documenting the medication order Load a medication order (Add) in the Medication order tab.	Medication orders (+ Favourites)
ICU protocol (Replace)	Buttons for documenting the medication order Load a medication order (Replace) in the Medication order tab.	Medication orders (+ Favourites)
Detailed entries	Buttons used to open a detailed entry (or score).	Detailed Entries
Multiple entries	Buttons for opening a multiple entry.	Multiple entries
Visual entry/event	Buttons for documenting events, complications, consumables and patient environments.	Events
Specific	Buttons for various actions... This list cannot be modified.	

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.

Each timer can be assigned a specific colour for easy identification in the **Timers** component of the side ribbons. The type of timer (primary or secondary) displayed in this component can also be configured.

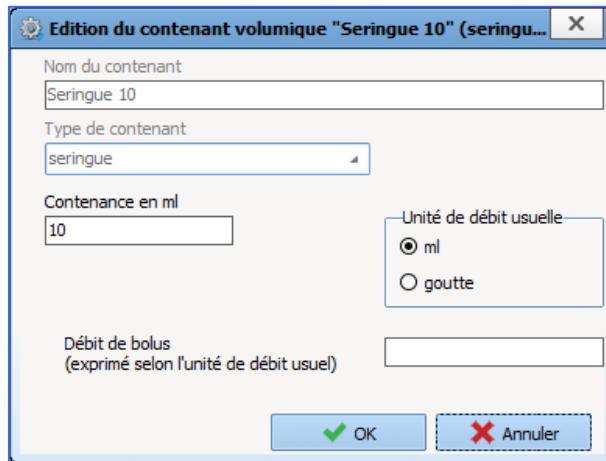
An alarm can be associated with a timer. The data taken into account is duration in minutes. Duration in hours and in days are used to enter a duration without having to convert it into minutes.



3.5 Volume 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**.

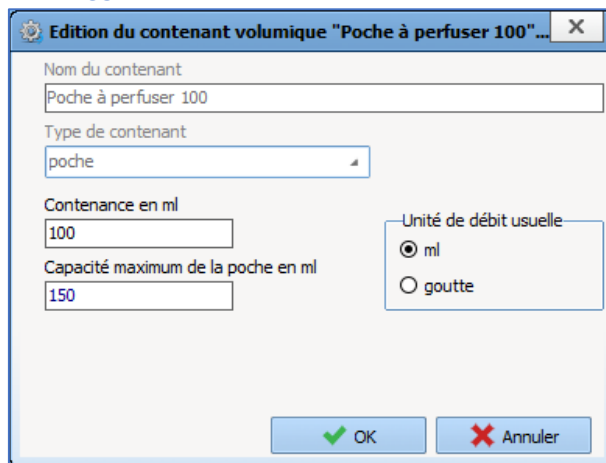


The screenshot shows a dialog box titled "Edition du contenant volumique 'Seringue 10' (seringu...)". It contains the following fields and options:

- Nom du contenant: Seringue 10
- Type de contenant: seringue
- Contenance en ml: 10
- Unité de débit usuelle: ml, goutte
- Débit de bolus (exprimé selon l'unité de débit usuel): [empty field]
- Buttons: OK (green checkmark), Annuler (red X)

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 screenshot shows a dialog box titled "Edition du contenant volumique 'Poche à perfuser 100' ...". It contains the following fields and options:

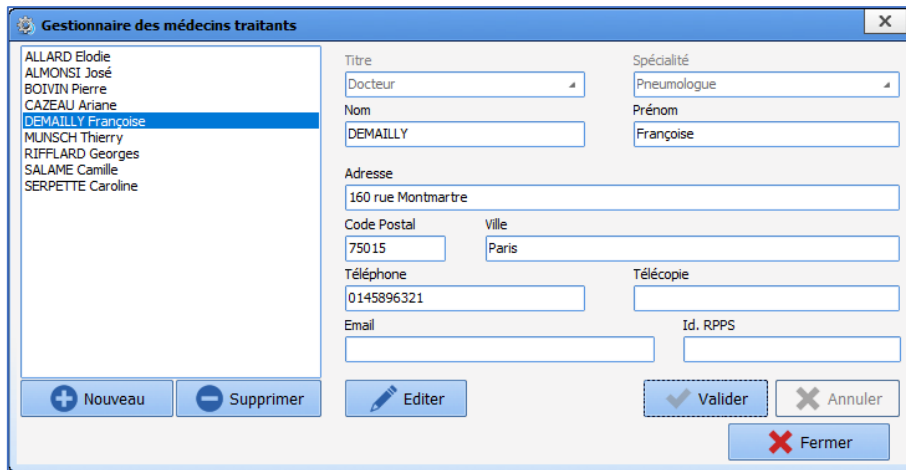
- Nom du contenant: Poche à perfuser 100
- Type de contenant: poche
- Contenance en ml: 100
- Capacité maximum de la poche en ml: 150
- Unité de débit usuelle: ml, goutte
- Buttons: OK (green checkmark), Annuler (red X)

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**.

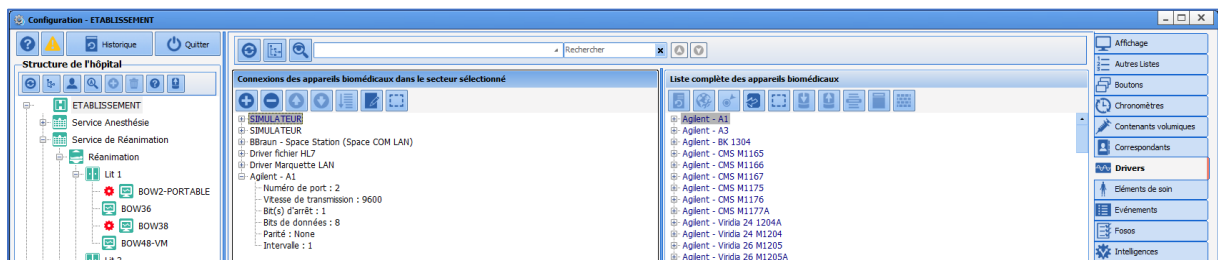
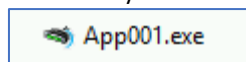




This configuration tab does not use the facility entities: there is one general list of correspondents for the whole facility.

3.7 Drivers

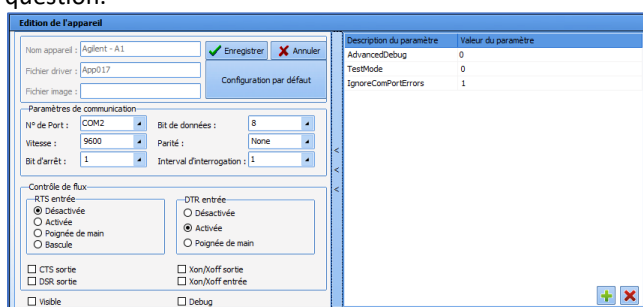
The full list of biomedical devices cannot be modified. It is generated automatically based on the presence of **AppXYZ.exe** files in the **DIANE** installation directory.



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

Driver settings must not be modified. 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 computer in question.

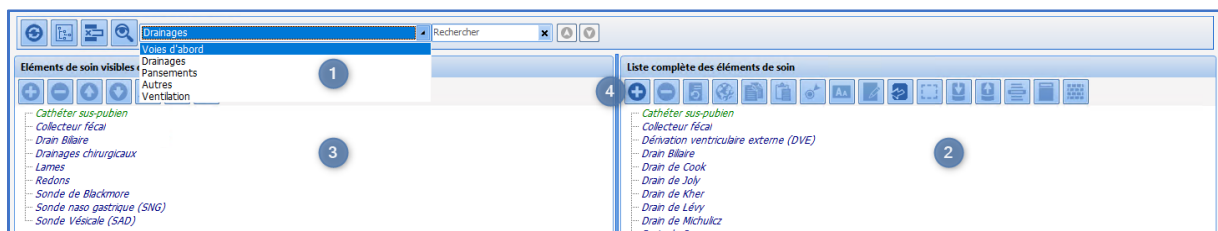



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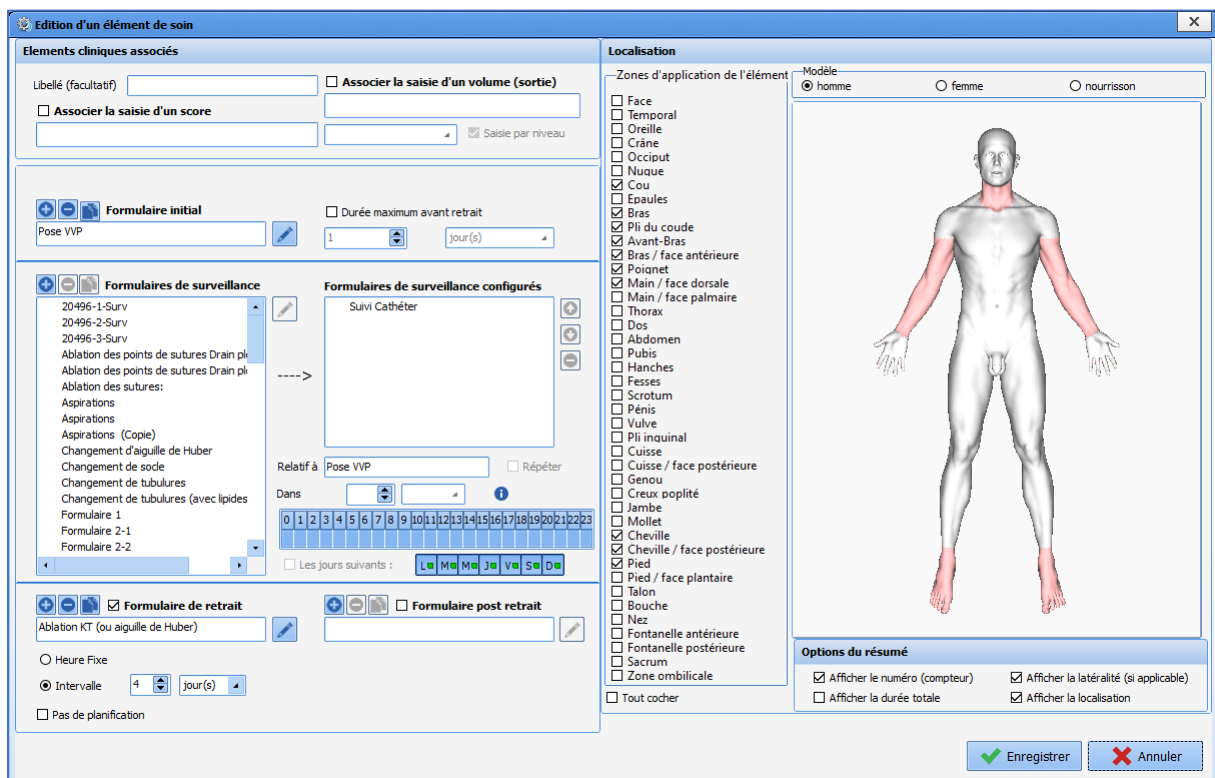
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3.8 Care items



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

3.8.1 Editing 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.



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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 list below. The **Enter level** checkbox is used to enable volume entry 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
 - Schedule a monitoring form based on another monitoring form (in the example above, the scheduling of the **Drain dressings** form is related to the **Drain monitoring** form). In this case, scheduling depends on whether or not the parent form is carried out (here, the **Drain dressings** form is only scheduled if the **Drain monitoring** form is carried out).



In the case of one-off scheduling, it is possible to set up the form:

- at a fixed interval of X days, hours or minutes from the reference form:

- at a fixed time:


Scheduling can also be repeated:

- at a fixed interval of X days, hours or minutes from the reference form:

- at fixed times:


Scheduling can also be set for specific days. In this case, it is not possible to schedule with an interval of days: only intervals in hours or minutes are possible.

6. Removal and post removal form pane. Default scheduling can be defined.

The  button is used to duplicate a form in order to facilitate the creation of similar forms.



3.8.2 Editing a care form window

The four types of form available for scheduling care item monitoring (initial, monitoring, removal and post-removal) are configured via 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.



Creation of a component of the selected type.

4. **Field definition:** pane showing possible values for checkbox groups, radio button groups or drop-down menus. It is also possible to select the type associated with a one-line input field.
The checkbox **Include in summary** is used to show the information entered in the field on the device summary.
The **Show initial form value on other forms** is used to show the information entered in the field when entering the initial form on the monitoring forms.
For checkboxes, radio button groups, checkbox groups and drop-down menus, it is possible to associate a procedure code with a value entered on the form:




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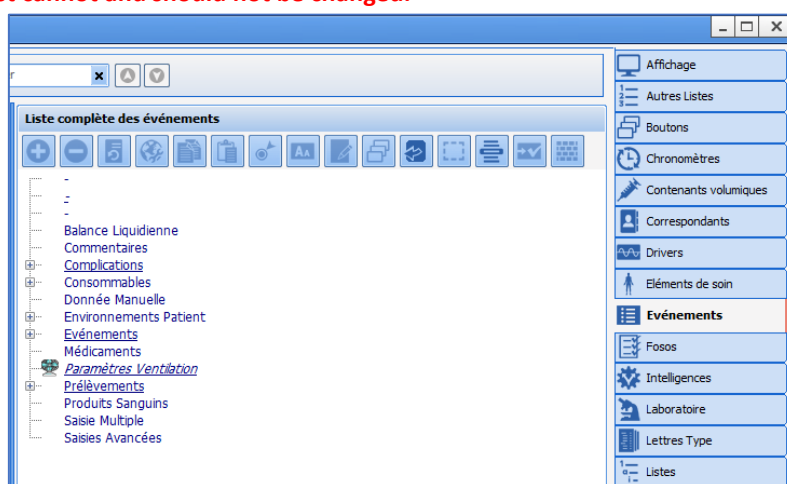
5. **Configured fields:** form components, drag and drop to change order.
6. **Form preview** (components are centred, one after the other, only their order can be changed).

 A care item used in production cannot be changed, 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 modified in this tab.

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

Detailed entries and multiple entries can be modified 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.

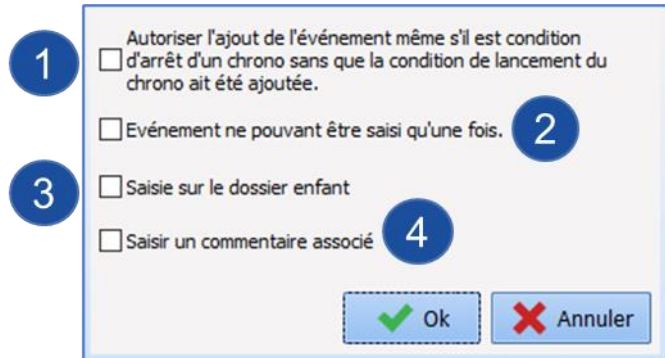
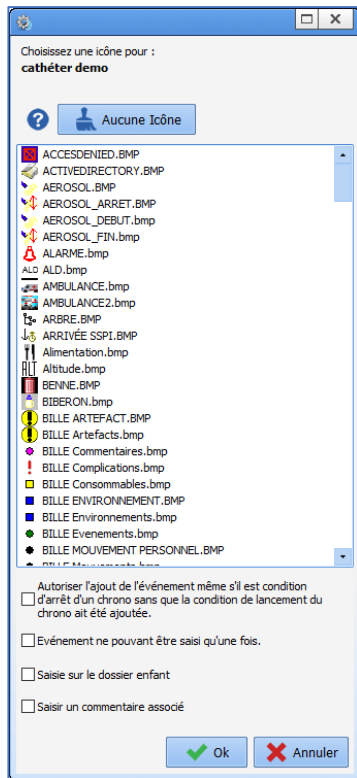
When a name is validated, an associated icon and the management of some behaviours is suggested.



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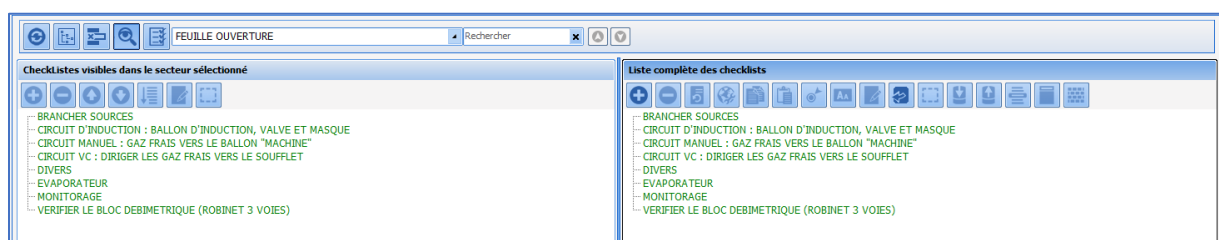
- 1 Relevant for some items. It may be necessary to extubate a patient who arrived intubated, or to deflate a tourniquet that was applied prior to hospitalisation.
- 2 Avoid duplicate entries.
- 3 Used for OB-GYN.
- 4 Automatically open a free text window to add a comment associated with the selected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

3.10 Safety checklists: Safety checklist/Inter-patient checklist

The **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 included in the **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*.



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

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 [Anaesthesia \(Visual\)](#).



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 :

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

Description du paramètre	Valeur du paramètre
Configuration générale de Visual	
Gestion des poussettes	
[DEBUG]	
Fiche de sortie/fermeture de dossier	
Position et taille de la fenêtre, utilisé si la clé Maximized <> 1	
Feuille d'ouverture et fiche inter patient	-
Afficher un avertissement si la Feuille d'Ouverture n'a pas été complétée en salle	1
Afficher un avertissement si la Feuille d'Ouverture n'a pas été complétée en bloc	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 patient	1
Rattachement des feuilles d'ouverture à un patient (1=oui, 0=non)	1
Signatures	
Avertissements	
Actions importantes	
Configuration des couleurs de Visual	
DESCRIPTION	

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

Clé actuelle : [FO-FIP]

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

Configuration des événements importants

Feuille d'ouverture / Fiche Inter Patient | Signatures | Personnels présents | Informations du dossier | Evènements | Saisies avancées

Saisir la feuille d'ouverture
 Avertissement Bouton ET Fenêtre Quitter
 Lieu(x) Induction Bloc Réveil

Valider la feuille d'ouverture
 Avertissement Bouton ET Fenêtre Quitter
 Lieu(x) Induction Bloc Réveil

Saisir la fiche inter patient
 Avertissement Bouton ET Fenêtre Quitter
 Lieu(x) Induction Bloc Réveil

Valider la fiche inter patient
 Avertissement Bouton ET Fenêtre Quitter
 Lieu(x) Induction Bloc Réveil

Comportements des actions importantes

Avertissement :
 Bouton, l'action importante est affichée dans le bouton des actions importantes tant qu'elle n'est pas effectuée. (voir image ci-dessous)
 Fenêtre Quitter, l'action importante est affichée dans la fenêtre de fermeture de l'intervention, si l'action n'a pas été effectuée, en bleu.
 Bouton ET fenêtre quitter, l'action va cumuler les deux précédents comportements.

Obligatoire :
 Sans affichage dans le bouton, l'action est bloquante, tant que celle-ci n'est pas effectuée, la fermeture de l'intervention n'est pas possible sauf si l'action est configurée comme importante dans le lieu suivant.
 Avec affichage dans le bouton, comme le comportement précédent, l'action importante est bloquante, et affichée dans le bouton des actions importantes avec un marqueur. (voir image ci-dessous)
 Dans les deux cas obligatoires, l'action est affichée dans la fenêtre de fermeture de l'intervention, si elle n'a pas été effectuée, en rouge.

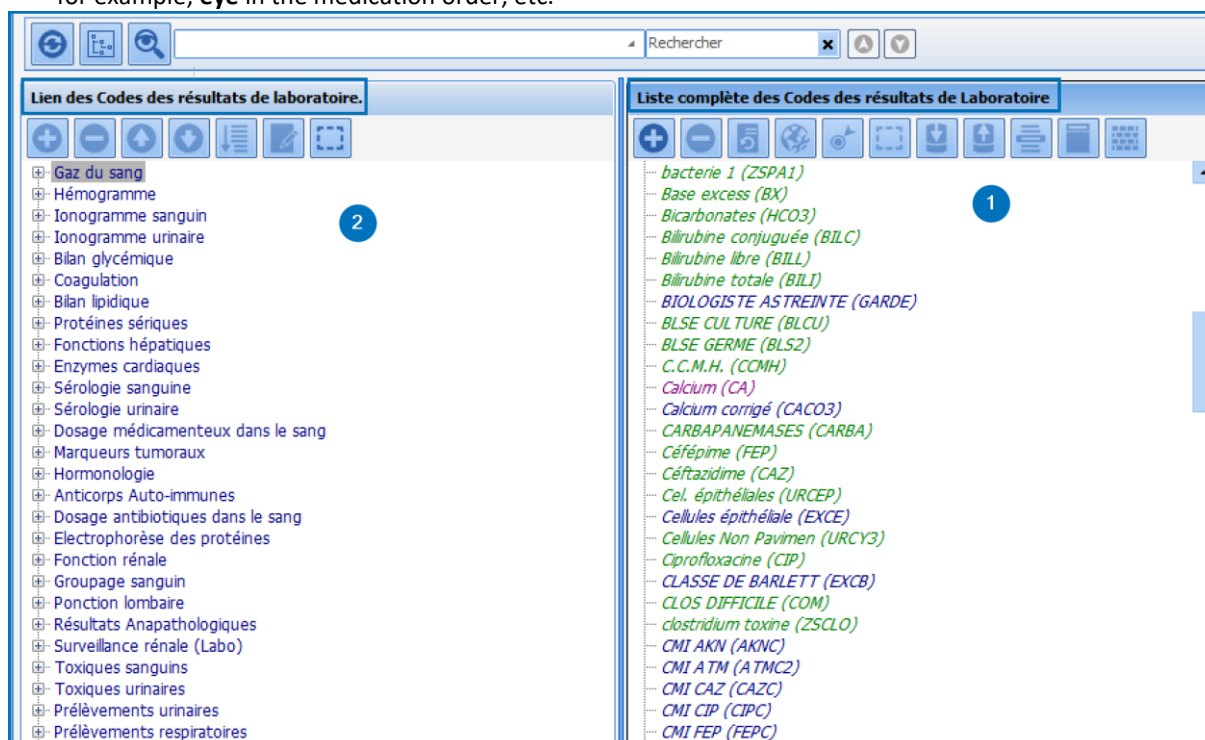
il y a 5 actions importantes

- Saisir la fiche inter patient
- Signature du médecin responsable
- Saisir le type d'anesthésie
- Saisir le/les évènement(s)...
- Saisir le/les score(s)...

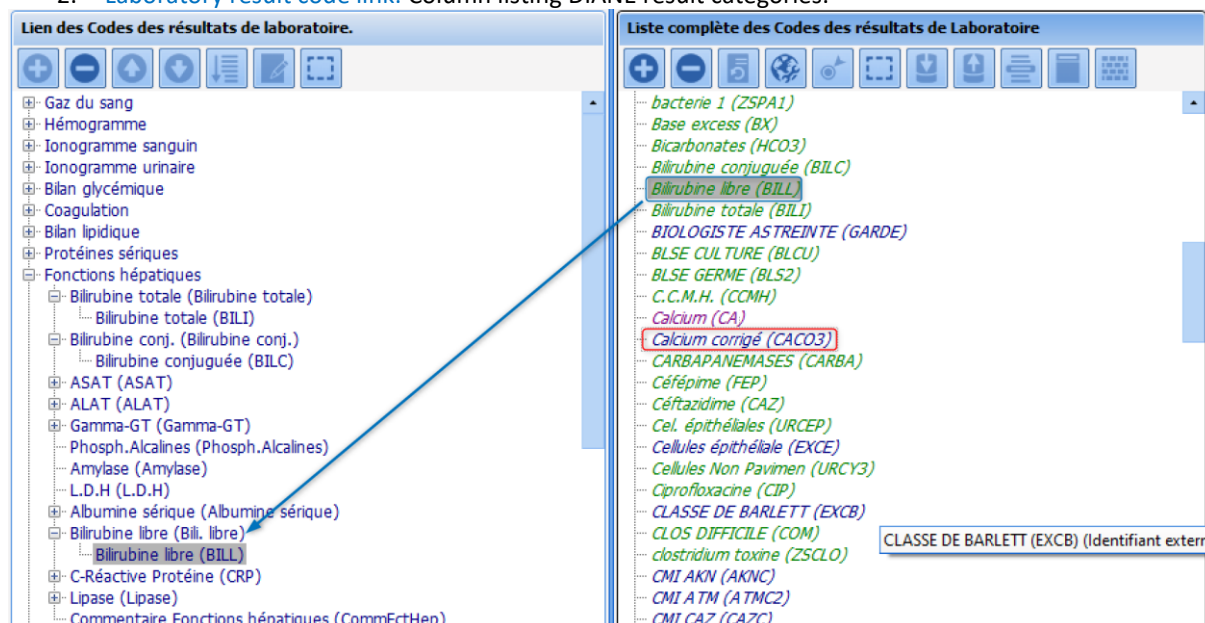


3.11 Laboratory

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 (BILL).
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 categories.
Example: Free bilirubin (BILL) associated with the item Free bilirubin (Free bil.) in the Liver function category.



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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.



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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)
Applicable to all modules	10	Compte-rendu (Réa)
ICU	11	Modèles Diane
	12	Lié à une prescription (Réa)
Applicable to all modules	13	Fonds de page
OB-GYN	14	Impression gynécologie-obstétrique
	15	Impression de CERFA
Applicable to all modules	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)

Footer: Ordo (Cerfa N°12078), Edition

3.12.1.1.3 Pre-op premedications and other consultation printing

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



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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

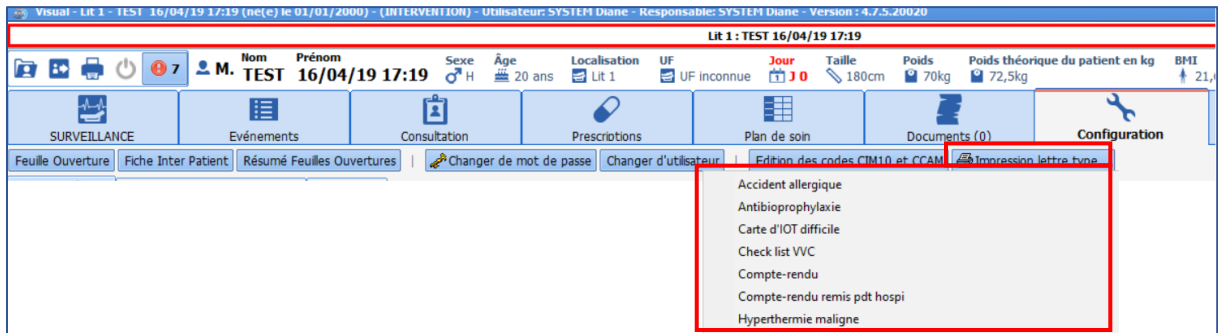
Location: **INTRAOPERATIVE** module - **CONFIGURATION** tab



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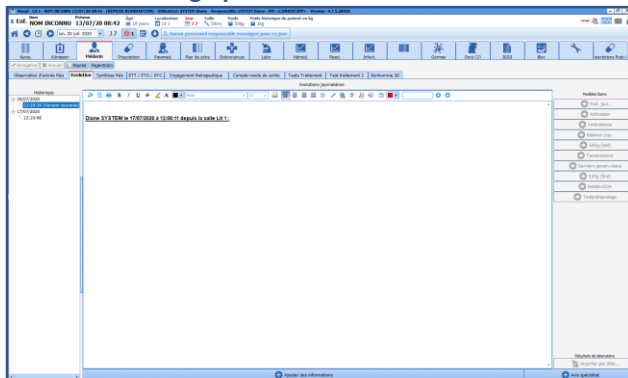


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3.12.1.3 Printing in DIANE ICU

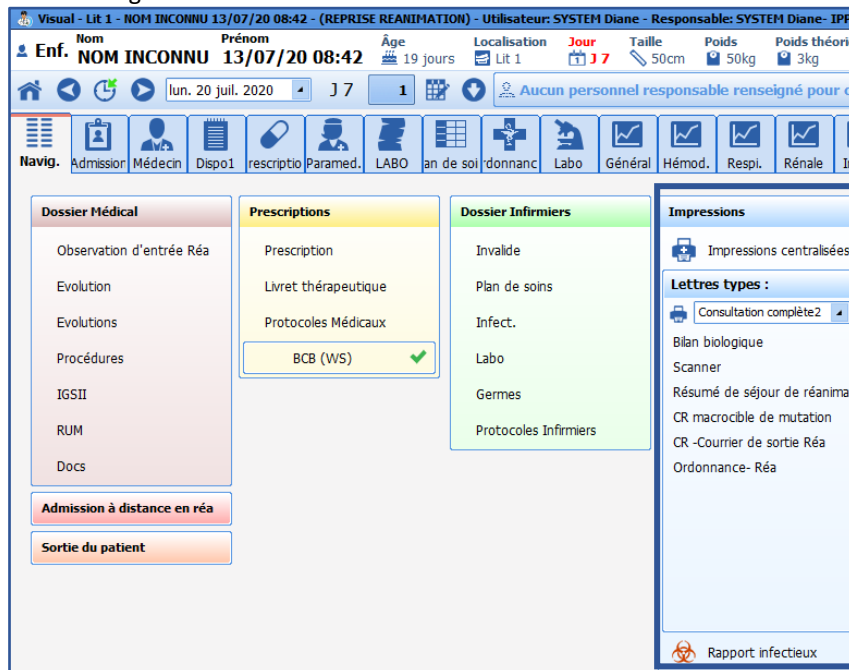
3.12.1.3.1 Setting up DIANE models



In use, **DIANE** models are used to prefill some tabs with automatic formatting and text. (Here the **Doctor** tab, **Developments** sub-tab, 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



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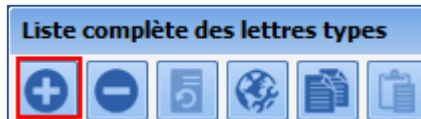
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3.12.1.4 Printing Treatments/Premedications

The **Treatments/Premedications** form letter is printed using the **Edit...** button in the **Treatments/Premedications** 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:

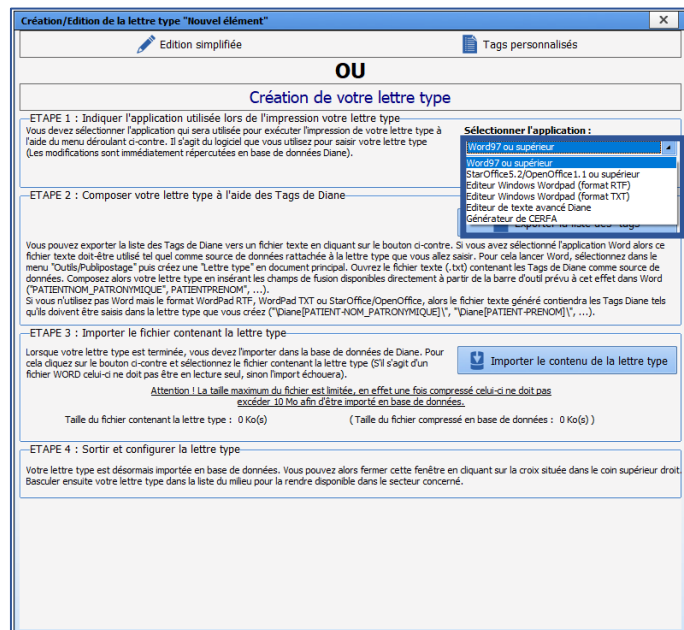
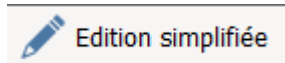
First, choose the format used for this letter.

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.

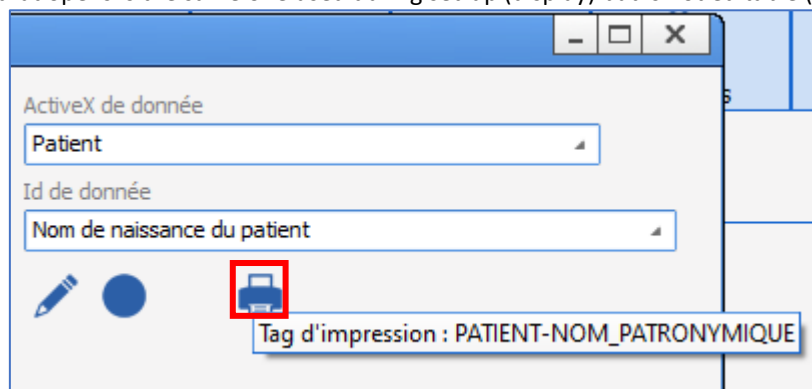


3.12.2.1 Finding tags

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).



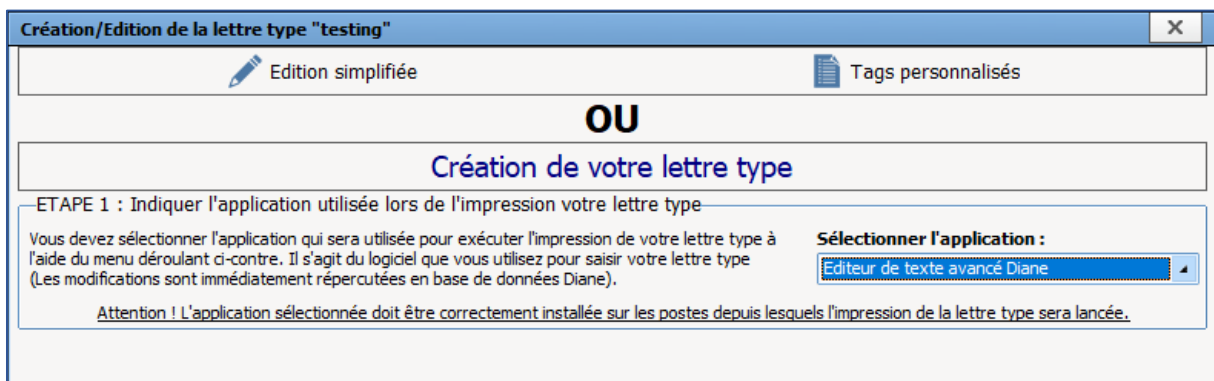
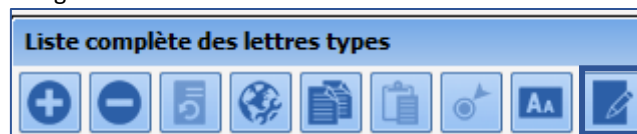
Hovering over the print icon shows the tag corresponding to the component, the value of which should be entered in the form letter.

3.12.2.2 Creation of custom tags

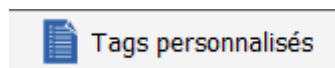
A tag is a mailing field. It is a special location in the document able to accept specific data from the current patient record. There are two tag categories. **Fixed tags** are associated with ActiveX/Data ID pairs for **DIANE** components.

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 opens, 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 date and time of occurrence:** 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 .

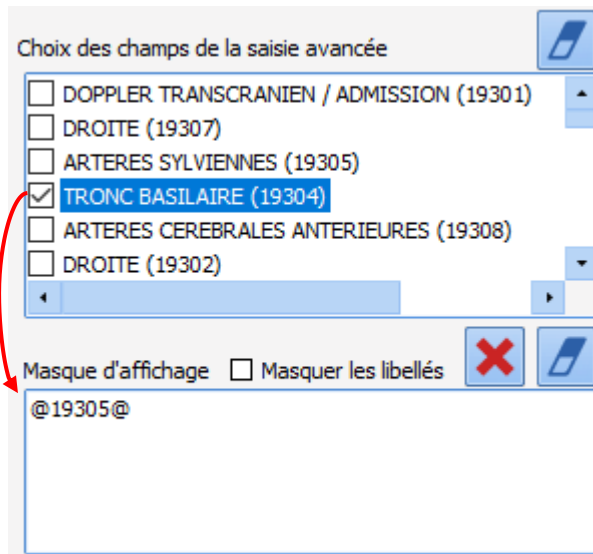


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- **Display mask:**




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.

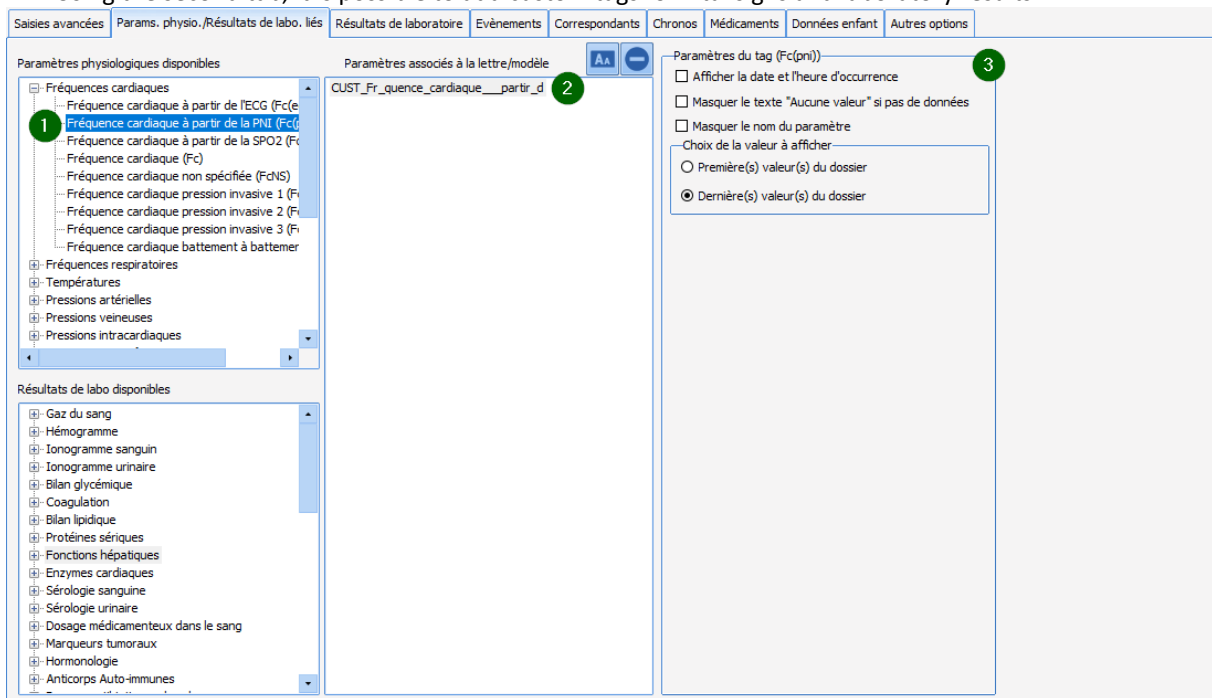
Click  to remove everything added since the tool was opened.

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 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.**

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 .

3.12.2.3 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"> 100% de la formule (NF100) 1er Germe (CAGE) 1er germe (MAGE) 1er Germe (PLGE) 1er germe (URGE1) 1er Germe AERO (HEGE) 1 1er Germe anaérobie (HEAG1) 2e germe (URGE2) 2E Germe anaérobies (MAAG2) 2ème germe (CAG2) 2ème Germe (EXG2) 2ème germe (MAG2) 2ème germe (PLG2) 2ème Germe AERO (HEG2) 2ème Germe ANA (HEAG2) 2eNumét anaérobie (MAAN2) 3e germe (URGE3) 3e Germe anaérobies (HEAG3) 3E Germes anaérobies (MAAG3) 3E Mycoses (PLMY3) 3E Numération (CANM3) 3E Numération (MANM3) 3E Numération (PLNM3) 3ème germe (CAG3) 3ème Germe (EXG3) 3ème germe (MAG3) 3ème germe (PLG3) 3ème Germe AERO (HEG3) 3EME Mycoses (CAMY3) 3EME Mycoses (MAMY3) 3eNumét anaérobie (MAAN3) 4e germe (URGE4) 4E Germes anaérobies (MAAG4) 4ème germe (CAG4) 4ème Germe (EXG4) 		<ul style="list-style-type: none"> CUST_1er_Germe_AERO_HEGE_ 2 	<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					

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:



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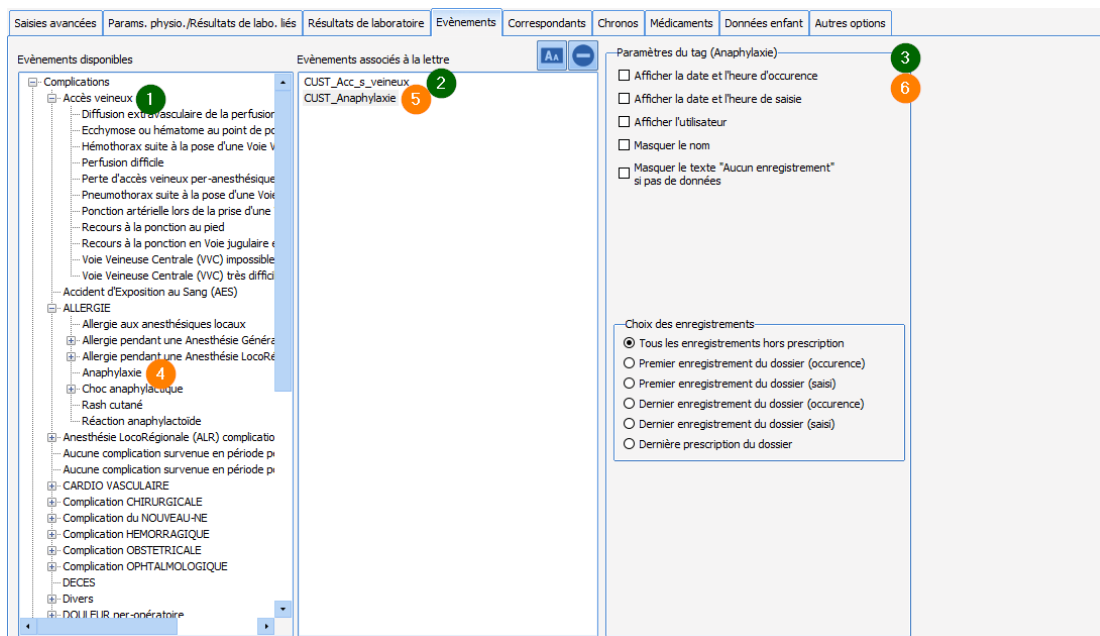


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- **View date and time of occurrence:** date and time visible in the patient record.
- **Hide 'No value' text if no data:** when it is important to know that there is no data.
- **Hide result name**
- **First or last value in record.**

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 date and time of occurrence:** 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.**



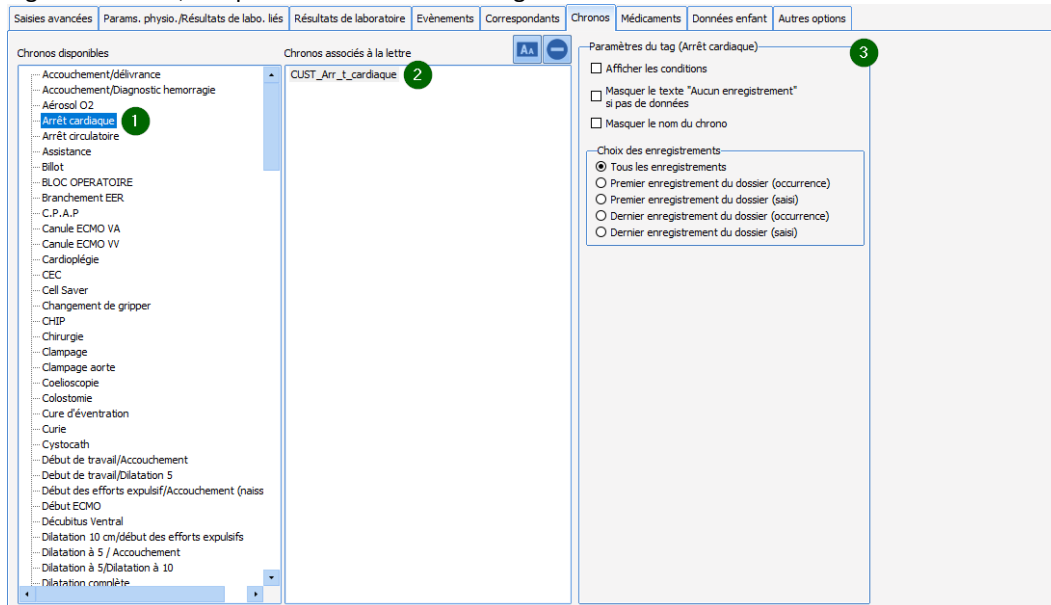
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3.12.2.2.5 Timer custom tags

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**.

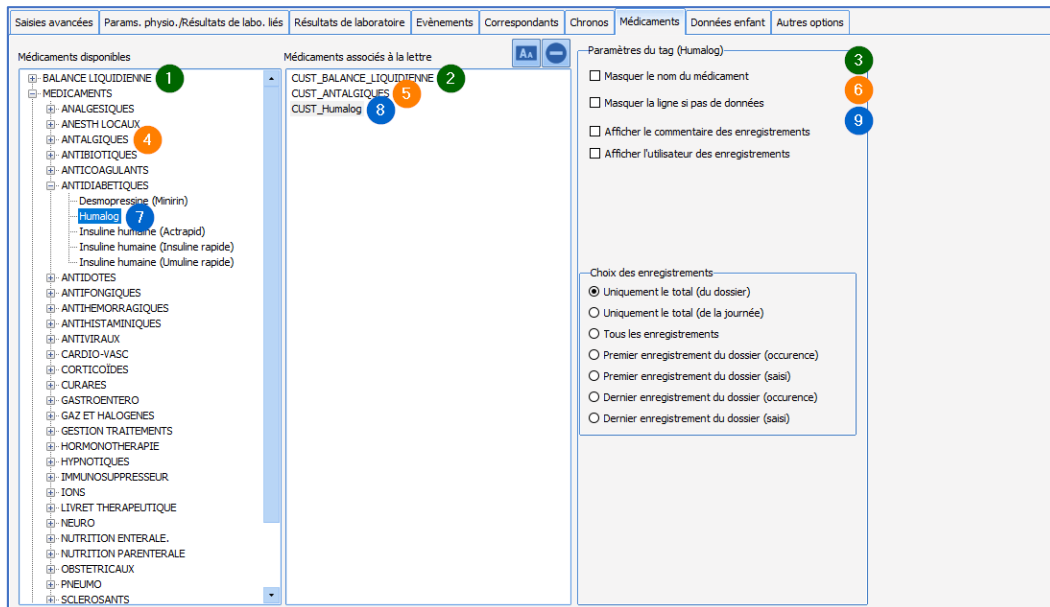
Timer custom tags have the following settings options:

- **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.



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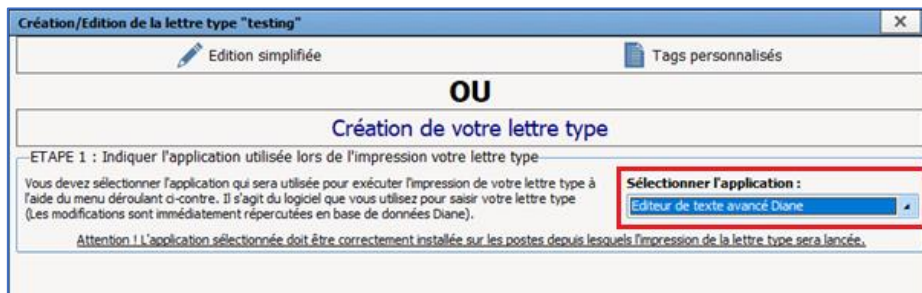


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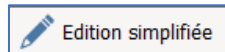
- Responsiveness is superior to **Word** and **OpenOffice**. This is because there is no external application to launch.
- The formatting options are basic to ensure that form letter set-up is as stable as possible.
- The presence of a tag search engine facilitates form letter creation.
 - **Disadvantages:**
- 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 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.

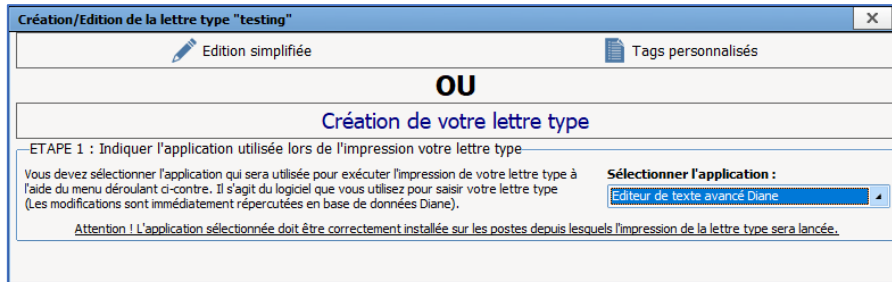
3.12.2.3.3 Modify a form letter

To modify 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.

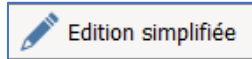


Once this has been done, the Create/edit the form letter window opens to select the required format from the drop-down menu.





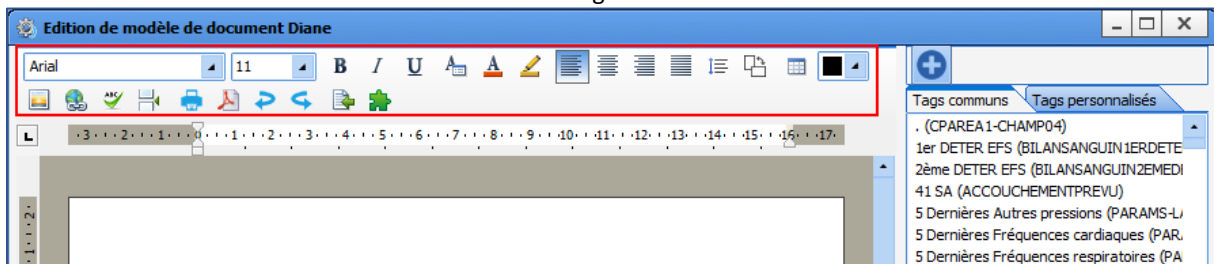
To modify an **Integrated form letter**, click the Simplified editing button.



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 typography options available on the DIANE expert's computer. Defines the typography of the selected text in the editor or changes the editing to this new typography from the cursor.
	Defines the size of the typography of the selected text in the editor or changes the editing to this new size from the cursor.
	Makes the selected text in the editor bold or changes the editing to bold from the cursor.
	Italicises the selected text in the editor or changes the editing to italics from the cursor.
	Underlines the selected text in the editor or changes the editing to underlined from the cursor.
	Opens the typography editor to change the appearance of the selected text in the editor or change editing to the new text appearance.
	Defines the colour of the selected text in the editor or changes the editing to this new colour from the cursor.
	Defines the highlighting of the selected text in the editor or changes the editing this new highlighting from the cursor.
	Defines the justification of the selected lines in the editor OR defines the justification for the text from the cursor.
	Defines paragraph spacing .
	Defines the document page orientation 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.



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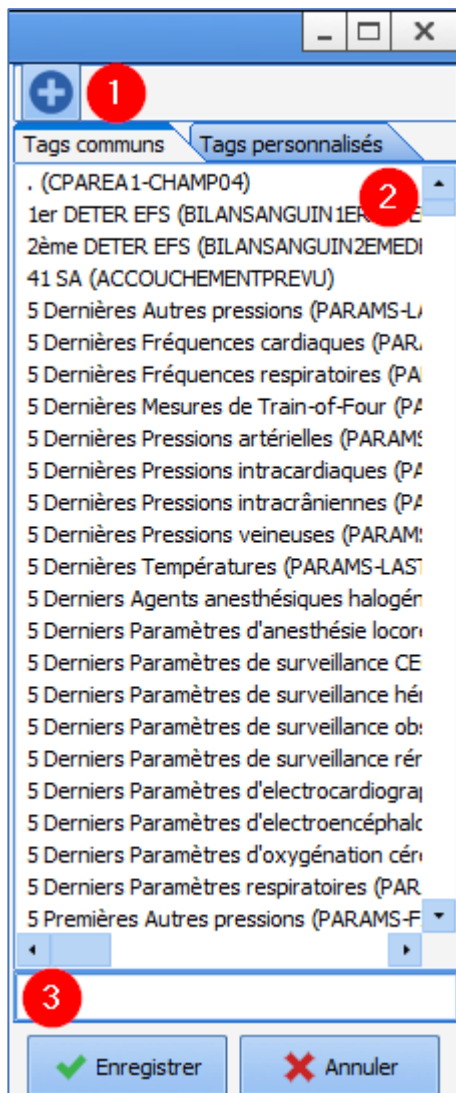


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	Insert a hyperlinked word into the form letter
	Spell check
	Page break
	Printing Send print without preview to the default printer of the user's computer.
	Create a PDF file to be saved on the user's computer.
	These two functions, go to a previous version and return to present, are also accessed with the keyboard shortcuts CTRL + Z and CTRL + MAJ + Z
	Import a copy of content from another form letter
	Show a checkbox. 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

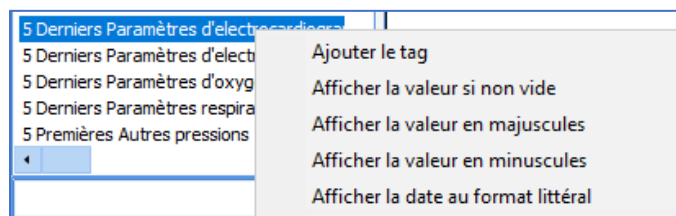
To insert custom tags in a document, they must first be created (see Creation of custom tags). Once this has been done, previously created tags can be inserted into a document in the integrated **DIANE** editor.



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**.

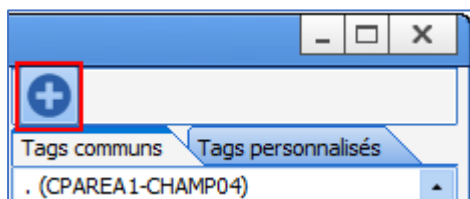


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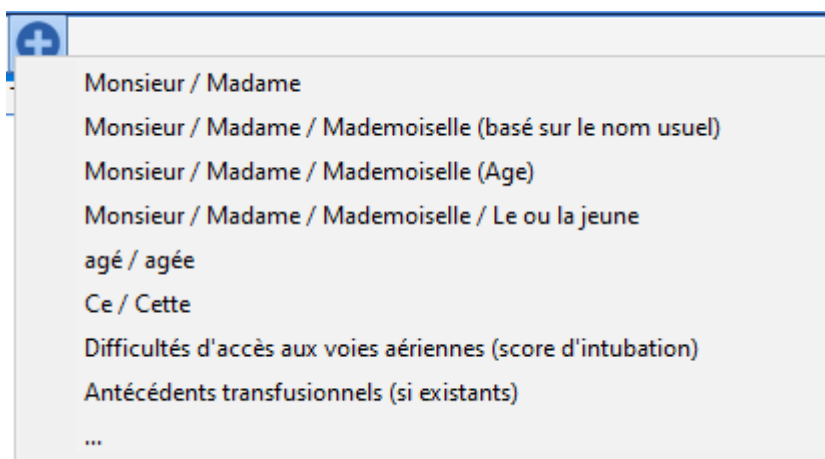


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3.12.2.3.5.1 Creating a tag with simple conditions



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

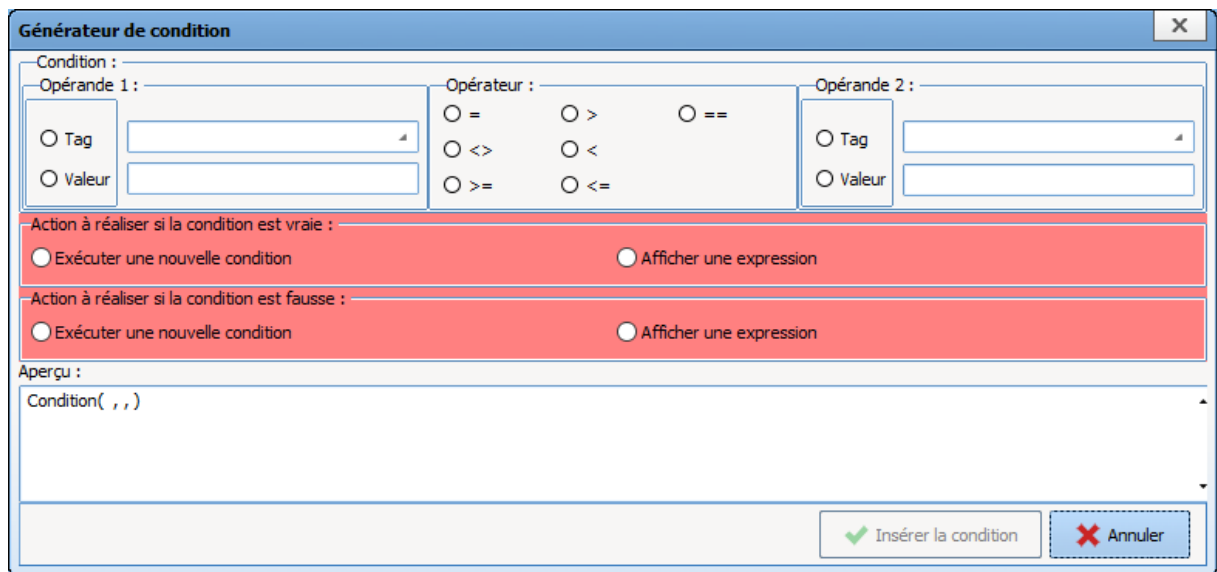


The list of forms of address is as follows:

- **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
- **This**
According to gender
- **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 “Juvenile patient” will be shown in the form letter if the patient is under 18 years of age.





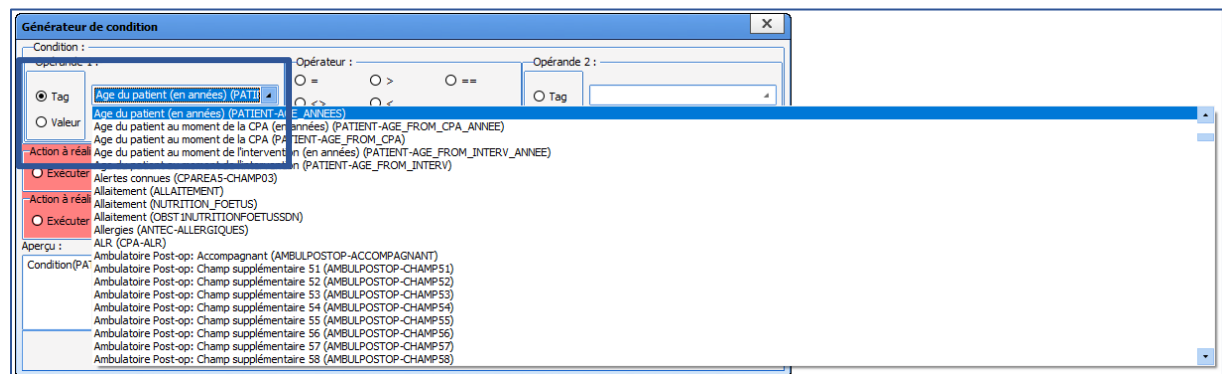
The condition builder comprises three horizontal panes:

- 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:

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, ,)

Insérer la condition Annuler

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 *Juvenile patient* must be shown. When **View an expression** is selected, the expression builder is used to select the tag or text to be displayed.

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

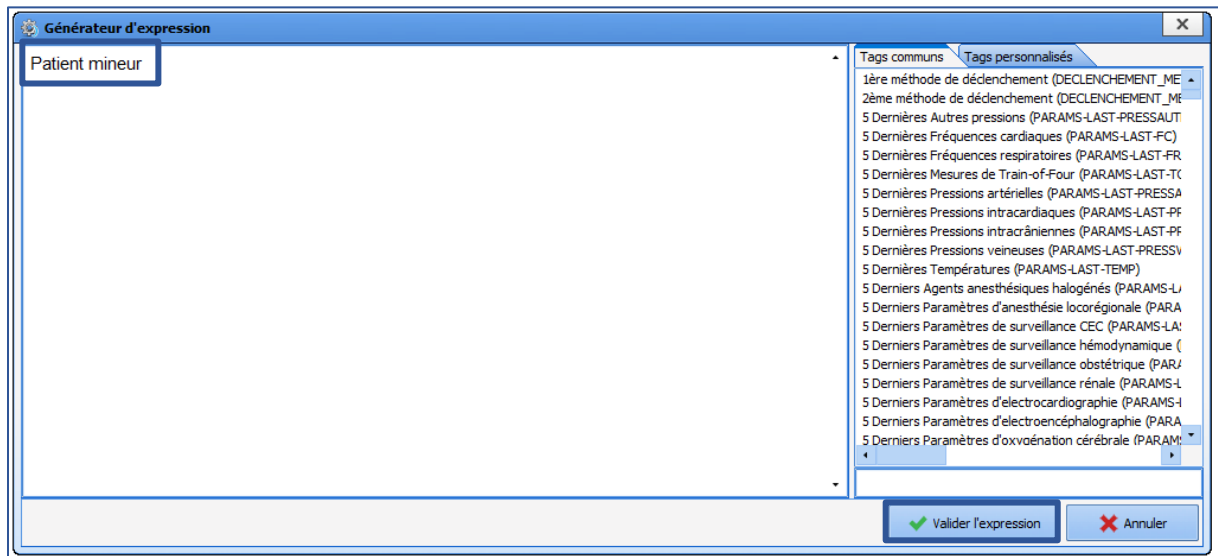
Action à réaliser si la condition est fausse :
 Exécuter une nouvelle condition Afficher une expression

Aperçu :
Condition(PATIENT-AGE_ANNEES < 18, ,)

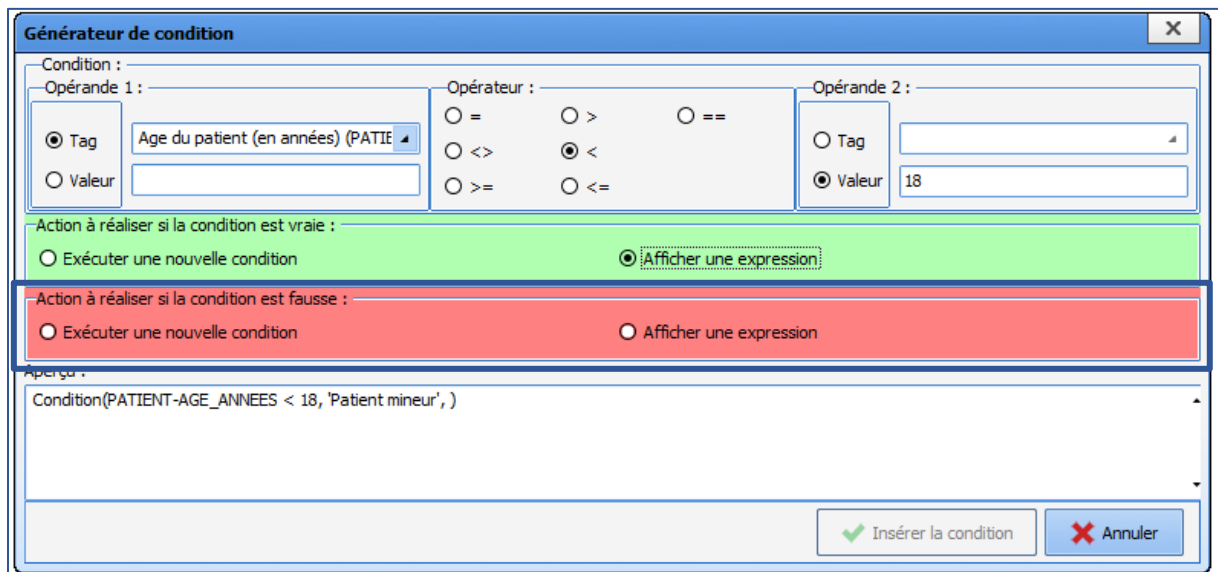
Insérer la condition Annuler



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: *Juvenile patient*.
Confirm expression.

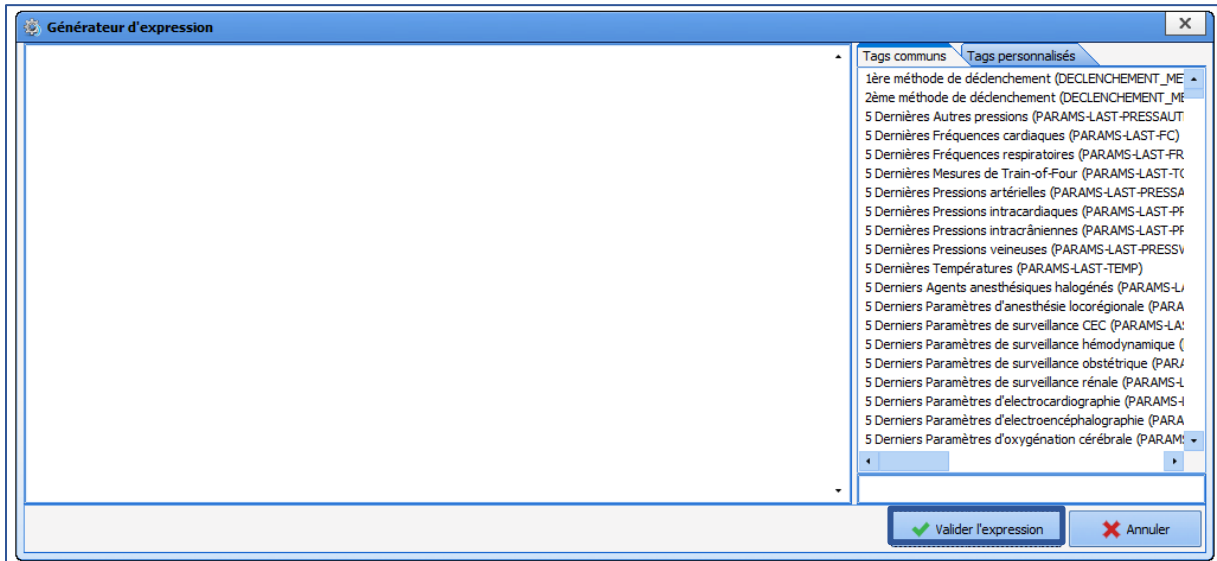


If the condition is false, i.e. the **PATIENT-AGE-YEARS** tag is higher than **18**, nothing is shown. **View an expression** must therefore be selected in **Action to take if condition is false**.



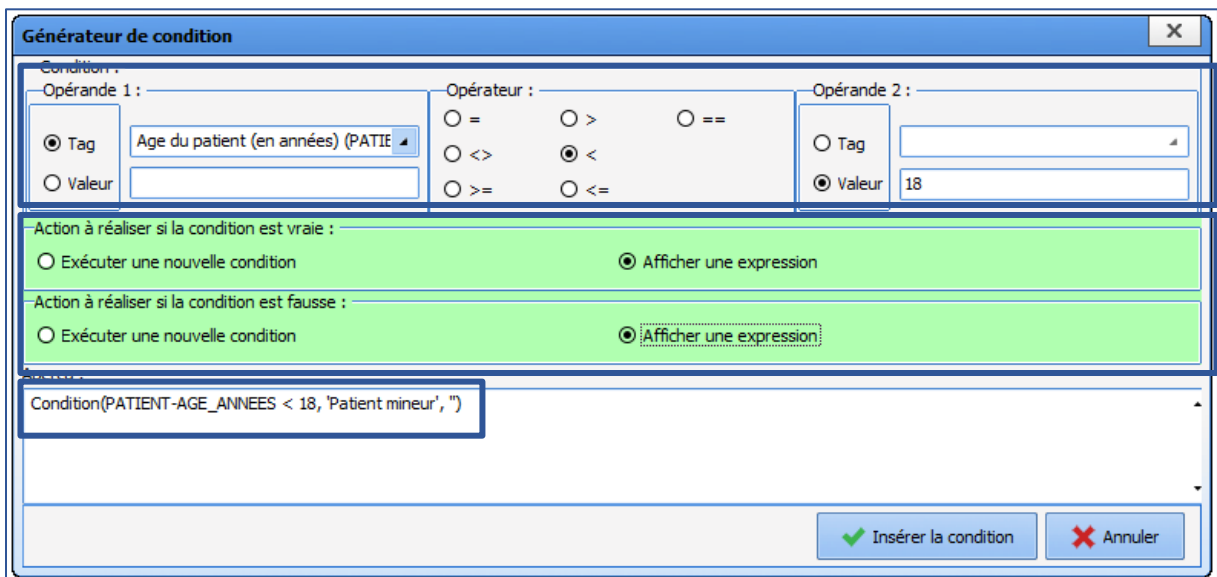
The expression builder window opens again.





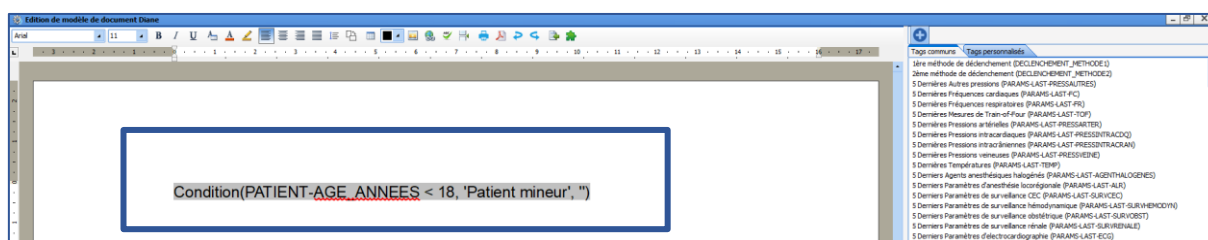
In this example, no other information must be added to the letter if the **PATIENT-AGE-YEARS** tag is higher than **18**. The expression can be confirmed without entering text or selecting tags.

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, "Juvenile 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).

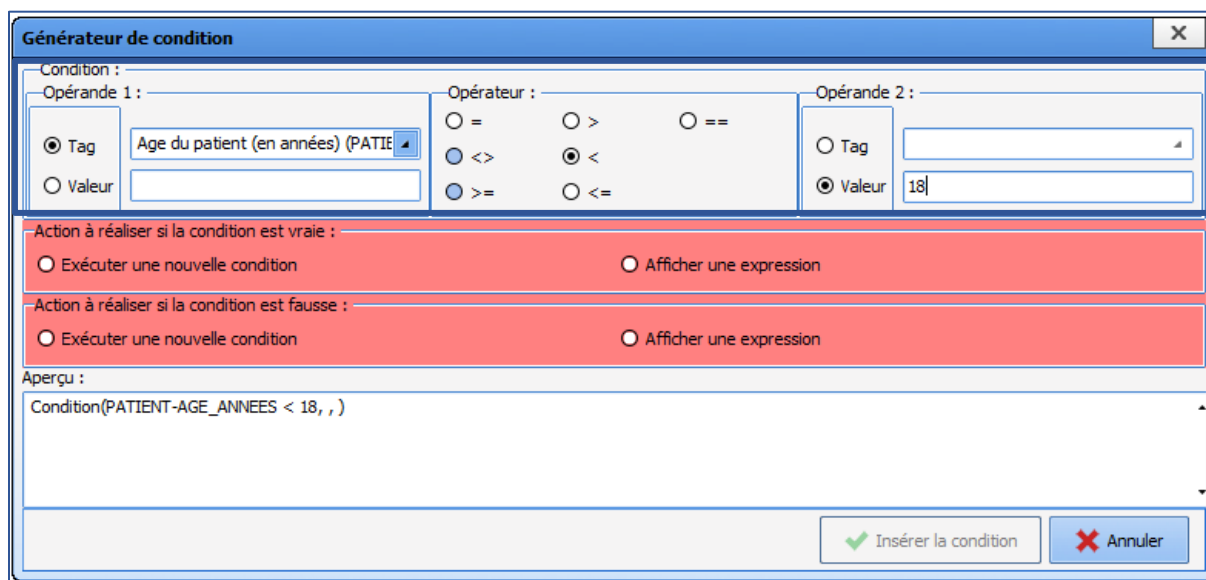
This condition is then used to automatically enter the term "Juvenile patient" in the form letter when the component PATIENT-AGE-YEARS is lower than 18 and enter nothing when the patient is an adult.

3.12.2.3.5.2 Creating a tag with advanced conditions

It is often useful to create a tag in a form letter, which nests multiple various conditions and actions. Example: the term *Juvenile male patient* will be used for a male patient under 18 years of age and *Juvenile female patient* for a female patient under 18 years of age. Likewise, *Adult male patient* will be used for a male patient aged 18 years or over and *Adult female patient* for a female patient aged 18 years or over.

In this example, three conditions are nested: the patient's age followed by two conditions configured using the **PATIENT-SEX** component.

The first step is to define the **PATIENT-AGE_YEARS** tag, as shown above. The following two conditions will be inserted using the **Execute a new condition** option.



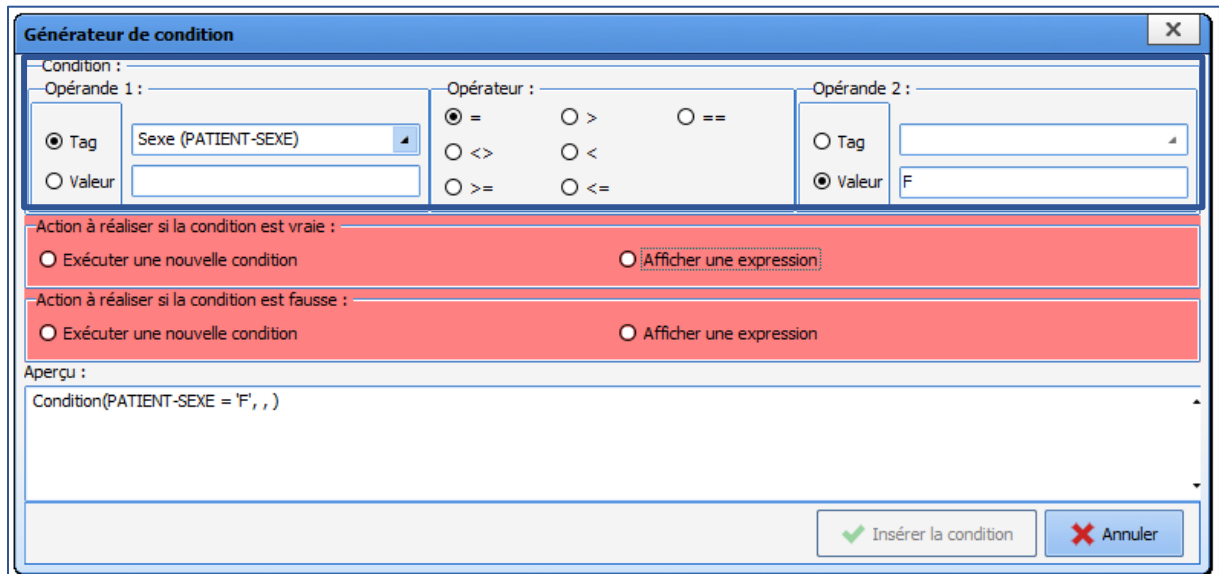
Click **Execute a new condition**. The condition builder reopens to let you configure this second condition. In this example, the nested condition is based on the **PATIENT-SEX** tag, which is equal to F (possible value of the patient's sex component).



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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

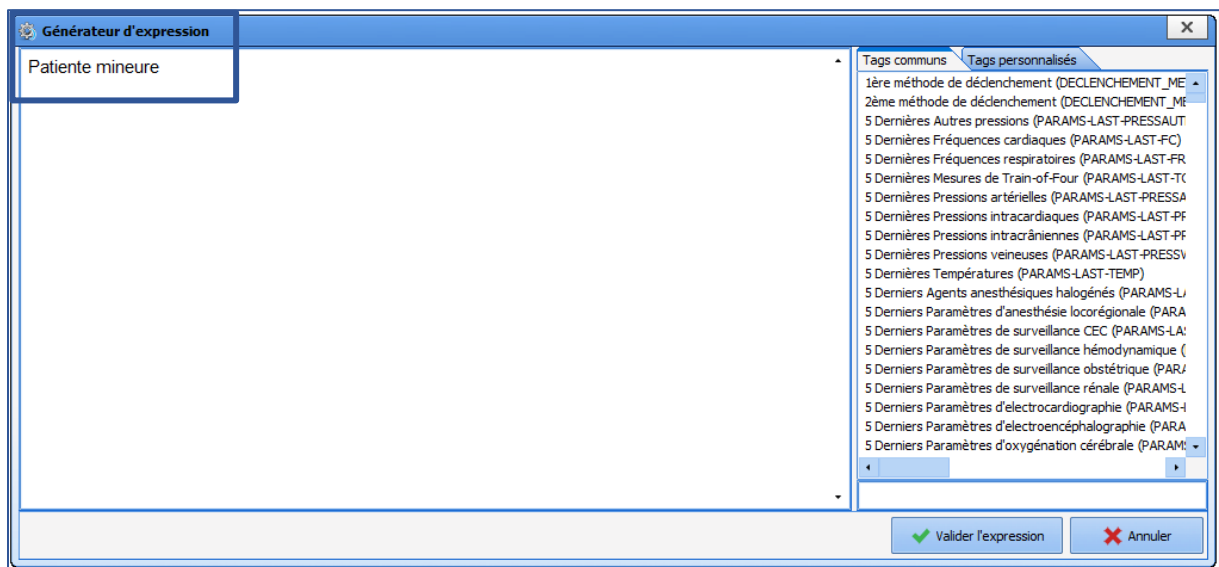
Action à réaliser si la condition est fausse :

Exécuter une nouvelle condition Afficher une expression

Aperçu :

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

Then select **View an expression** and enter the desired expression or tag. In this example, if the patient's sex is equal to **F**, then *Juvenile female patient* must be displayed.



Générateur d'expression

Patiente mineure

Tags communs Tags personnalisés

1ère méthode de déclenchement (DECLENCHEMENT_ME...
 2ème méthode de déclenchement (DECLENCHEMENT_MF...
 5 Dernières Autres pressions (PARAMS-LAST-PRESSAUT...
 5 Dernières Fréquences cardiaques (PARAMS-LAST-FC)
 5 Dernières Fréquences respiratoires (PARAMS-LAST-FR)
 5 Dernières Mesures de Train-of-Four (PARAMS-LAST-TX)
 5 Dernières Pressions artérielles (PARAMS-LAST-PRESSA...
 5 Dernières Pressions intracardiaques (PARAMS-LAST-PF...
 5 Dernières Pressions intracrâniennes (PARAMS-LAST-PF...
 5 Dernières Pressions veineuses (PARAMS-LAST-PRESSV...
 5 Dernières Températures (PARAMS-LAST-TEMP)
 5 Derniers Agents anesthésiques halogénés (PARAMS-LU...
 5 Derniers Paramètres d'anesthésie locorégionale (PARA...
 5 Derniers Paramètres de surveillance CEC (PARAMS-LA...
 5 Derniers Paramètres de surveillance hémodynamique (...
 5 Derniers Paramètres de surveillance obstétrique (PAR...
 5 Derniers Paramètres de surveillance rénale (PARAMS-L...
 5 Derniers Paramètres d'electrocardiographie (PARAMS-H...
 5 Derniers Paramètres d'electroencéphalographie (PARA...
 5 Derniers Paramètres d'oxygénation cérébrale (PARAM...

If the condition is false, *Juvenile male patient* must be used instead (**Actions to be performed if condition is false**).



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 fautive : Exécuter une nouvelle condition Afficher une expression

Aperçu :
Condition(PATIENT-AGE_ANNEES < 18, 'Patient mineur',)

Insérer la condition Annuler

Générateur d'expression

Patient mineur|

Tags communs Tags personnalisés

- 1ère méthode de déclenchement (DECLENCHEMENT_ME
- 2ème méthode de déclenchement (DECLENCHEMENT_ME
- 5 Dernières Autres pressions (PARAMS-LAST-PRESSAUT
- 5 Dernières Fréquences cardiaques (PARAMS-LAST-FC)
- 5 Dernières Fréquences respiratoires (PARAMS-LAST-FR)
- 5 Dernières Mesures de Train-of-Four (PARAMS-LAST-TOF)
- 5 Dernières Pressions artérielles (PARAMS-LAST-PRESSA
- 5 Dernières Pressions intracardiaques (PARAMS-LAST-PFI
- 5 Dernières Pressions intracrâniennes (PARAMS-LAST-PFI
- 5 Dernières Pressions veineuses (PARAMS-LAST-PRESSV
- 5 Dernières Températures (PARAMS-LAST-TEMP)
- 5 Derniers Agents anesthésiques halogénés (PARAMS-LU
- 5 Derniers Paramètres d'anesthésie locorégionale (PARA
- 5 Derniers Paramètres de surveillance CEC (PARAMS-LA:
- 5 Derniers Paramètres de surveillance hémodynamique (
- 5 Derniers Paramètres de surveillance obstétrique (PAR/
- 5 Derniers Paramètres de surveillance rénale (PARAMS-L
- 5 Derniers Paramètres d'électrocardiographie (PARAMS-I
- 5 Derniers Paramètres d'électroencéphalographie (PARA
- 5 Derniers Paramètres d'oxygénation cérébrale (PARAM:

Valider l'expression Annuler

This second condition is now configured. Select **Insert condition**.



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The condition builder for the first condition is now open to complete the setup.

The **Action to be performed if condition is false** must now be configured. In this example, *Adult male patient* and *Adult female patient* are to be indicated for a man and a woman, respectively. A third function, i.e., **Execute a new condition**, must now be nested in **Action to be performed if condition is false**.



In the same way as above, select operand 1, the operator, operand 2, and then the actions to be performed if true/false ('Adult female patient ' , 'Adult male patient' in this example). The third condition is then inserted. The generator then returns to the first condition. All three conditions are nested in it and are visible in the preview, as illustrated above.

Select **Insert condition** to display the condition in the form letter.

The result of the conditions is as follows:

- If the patient is under 18 and female = write *Juvenile female patient*
- If the patient is under 18 and not female = write *Juvenile male patient*
- If the patient is aged 18 or over and female = write *Adult female patient*
- If the patient is aged 18 or over and not female = write *Adult male patient*

All nested conditions are displayed in the **Preview pane**.

Be sure to save the form letter before closing the editor window, otherwise your changes will be lost.

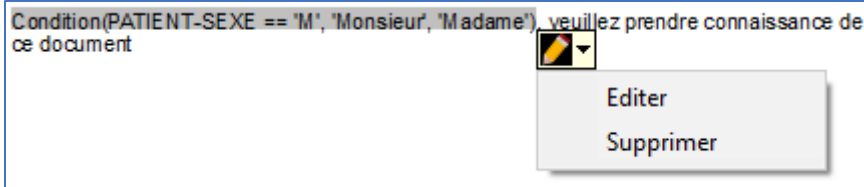


3.12.2.3.5.3 Modifying a conditioned tag

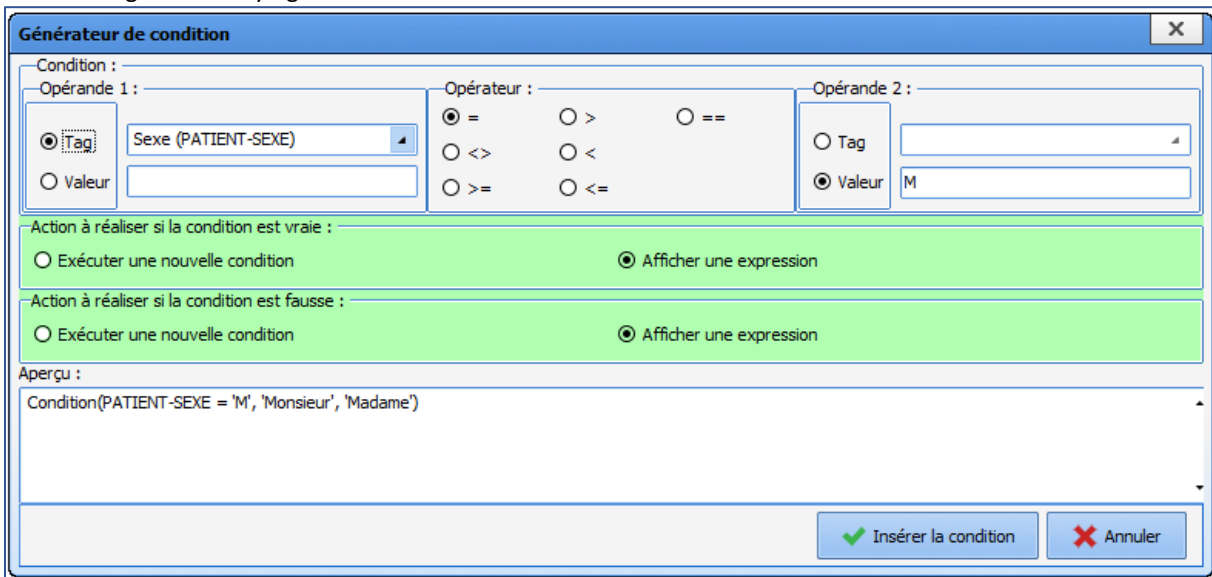
Demonstration of the Mr/Mrs/Ms/ formula result in the editor.

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

A condition is always shown as a single grey box. It is not possible to delete any part of it or modify the contents. To modify 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.



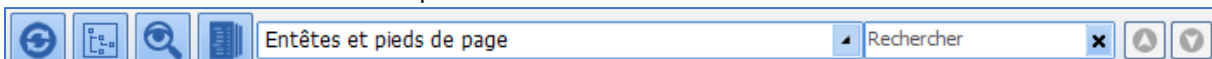
3.12.2.3.6 Adding a header to a form letter

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



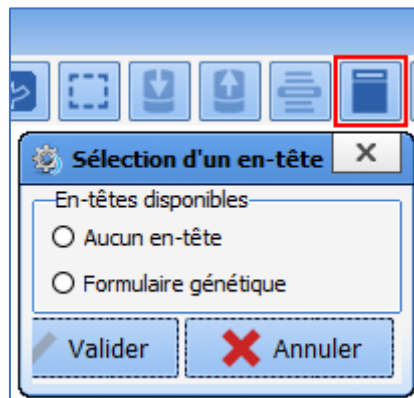
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NOTE: Headers must also be toggled in the Visible form letters in the selected area column.

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. 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.

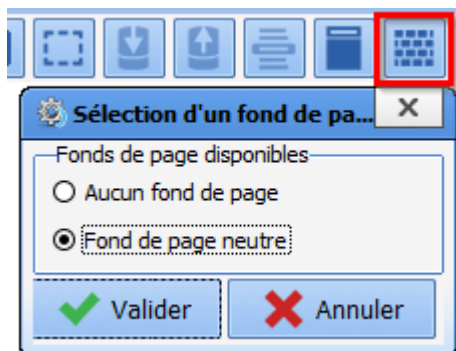
NOTE: The background and form letter with which it is linked can be considered as layers. It is important to check that the page set up gives the expected result.

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 computers 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 checkboxes). This function is questionable as potentially important information may not be present in the **DIANE** patient record.

○ **Disadvantages:**

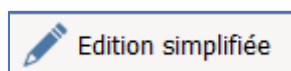
- The lack of a Tag engine makes searching for tags more complicated.
- Loading documents for editing takes longer than with the integrated **DIANE** editor.

3.12.2.4.2 Creating a Word form letter

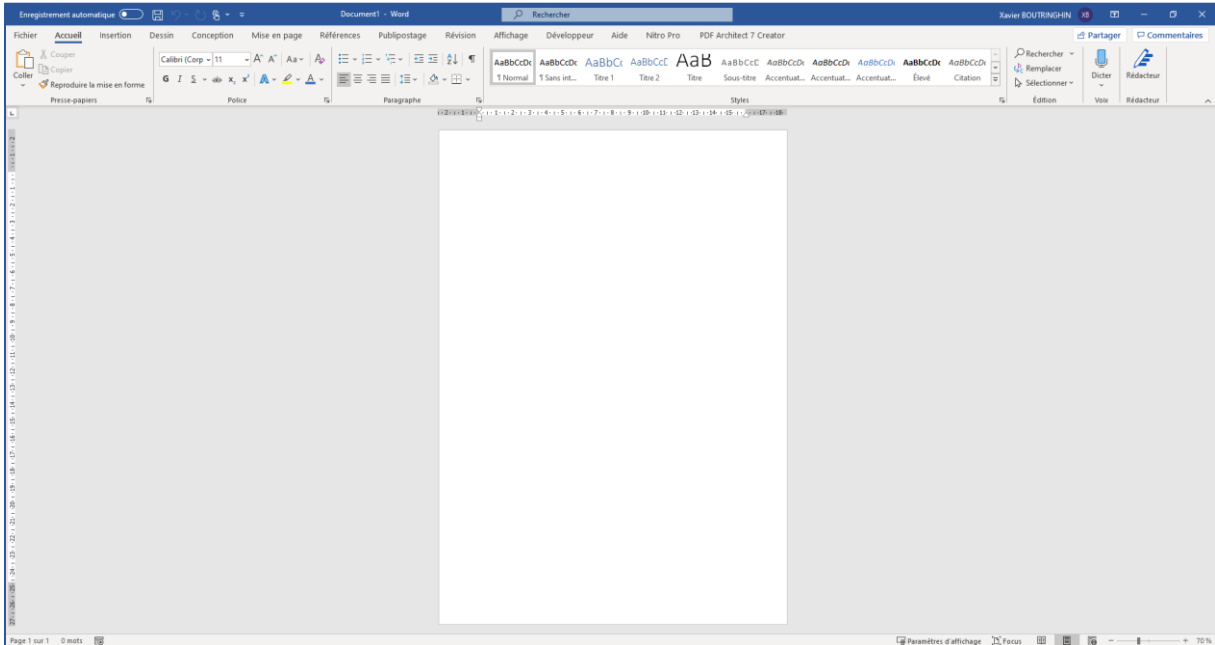
To create a form letter, in the application configuration select the **Form letter** tab, then in the drop-down menu select the category of document required, then see Section 3 for creating a form letter. Once this has been done, the Create/edit the form letter window opens to select the required format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



To create a **Word form letter**, select **Word 97 or later**. Click 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 checkboxes and the modification of **DIANE** documents on a computer that doesn't have the software.



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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.

Édition 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 computer:

- Create or edit a **Word** document on the computer 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 (checkboxes, free text...)
*Use **Word** help if difficulties arise.*
- Protect the document if necessary
*Use **Word** help if difficulties arise.*
- Import the document into **DIANE**

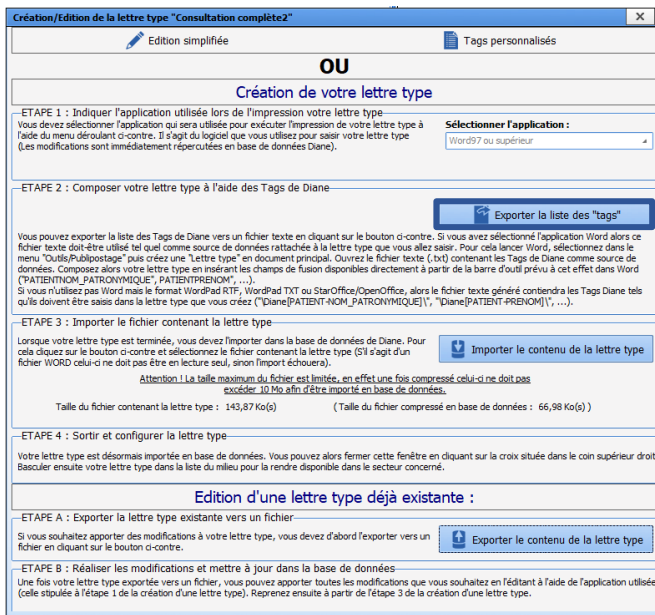


3.12.2.4.4 Linking the tag list to a Word document

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.

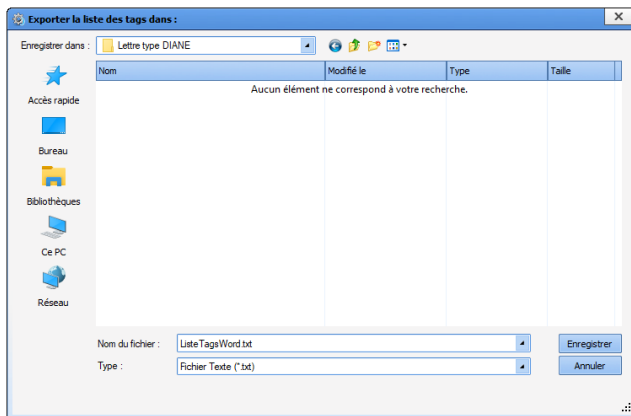
When working on the formatting of a form letter, with the exception of simplified editing (i.e. when **DIANE** is not used), the tag list must be linked to the relevant form letter. To do this, please proceed as follows:



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 computer. 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**)





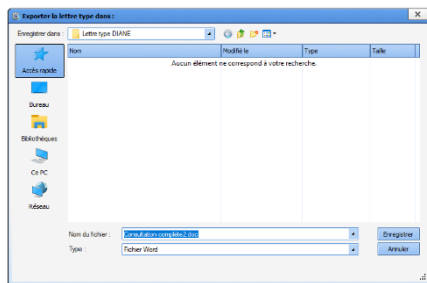
3a - First case:

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.

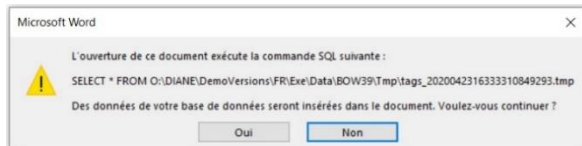


In the first situation, select the required location using the icons on the right and/or the drop-down menu.

Select **Save**.

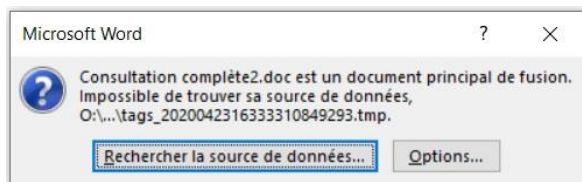
At this stage, the form letter can be opened using **Word**. The document can be found in the previously chosen location. In this example, the document is saved in the folder named **DIANE form letter**.

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**.



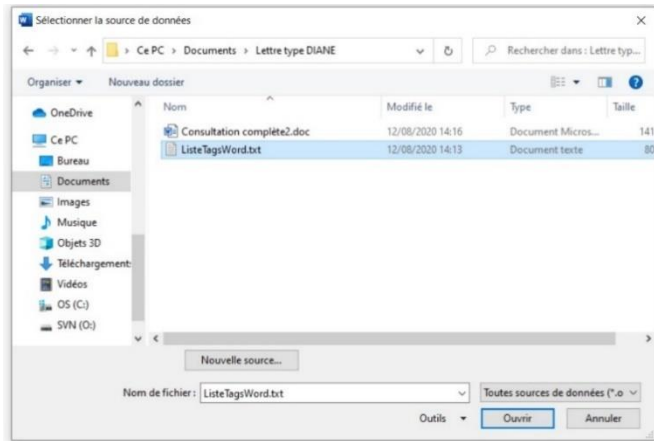
Then in the next window, select **Search for data source**.



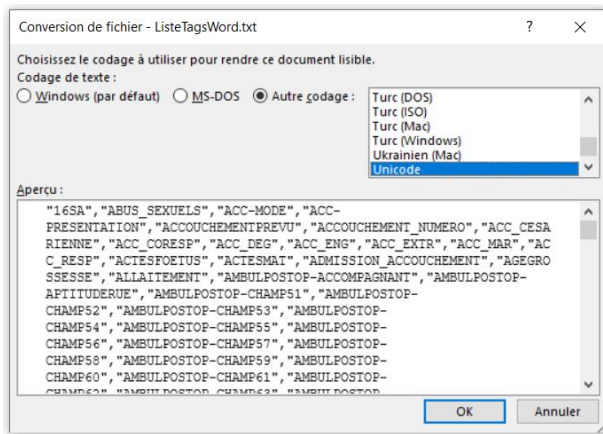
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The data source selection window is used to select the location in which the list of tags was previously saved (in this example, in the folder named **DIANE form letter**). Then click **Open**.



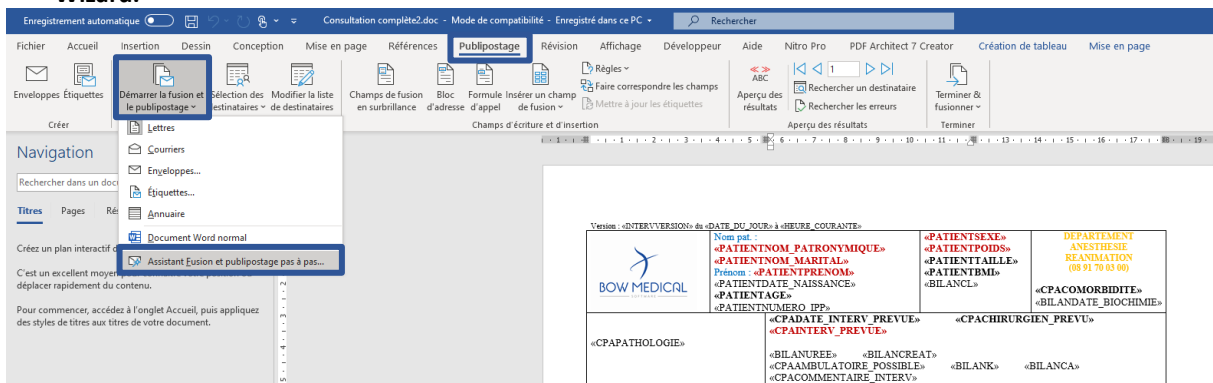
Finally, select **OK** in the file conversion window, with no modifications.

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**.



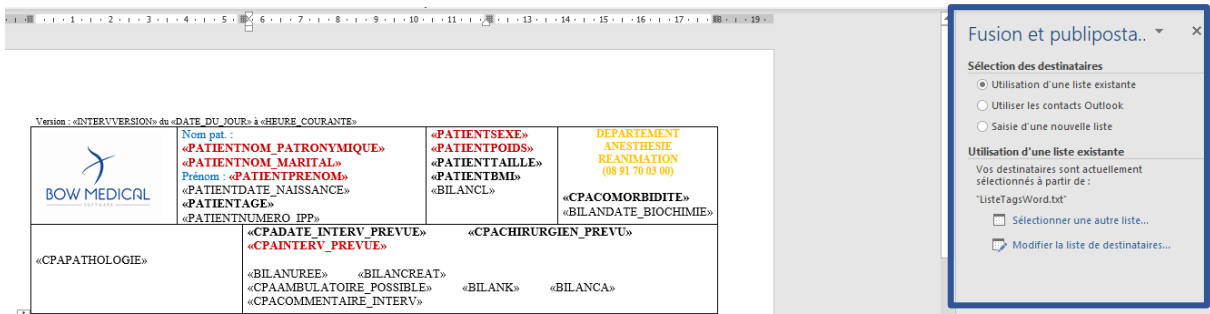
Depending on the version of **Word**, the program will open a help window or a help pane on the right. In this example, **Word** opens a browser to the right of the document.



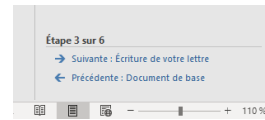
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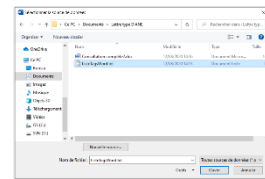
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At the bottom of the merge pane, select **Next: Write your letter**



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



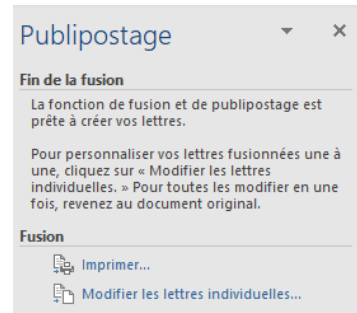
Select **Next: Preview your letters**



Select **Next: Complete the merge**



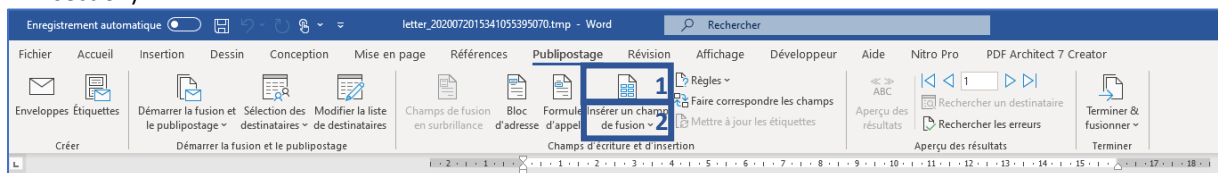
The list of tags is now linked to the form letter. It is now possible to start formatting the **Word** document.



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 computer, 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.

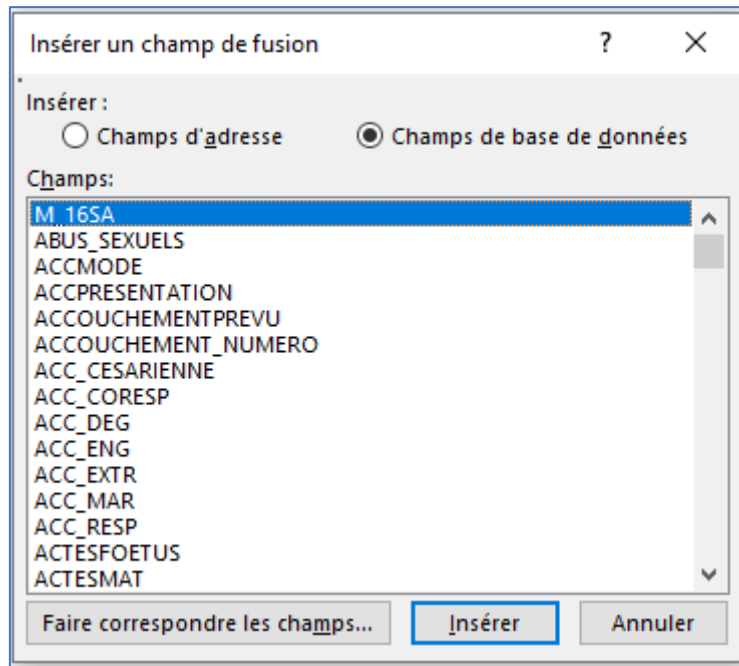
Clicking the lower part (2) opens a drop-down menu showing the list of tags. Quick entry is not available for this section.



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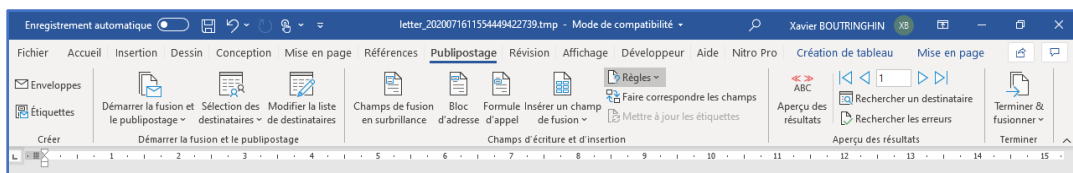
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3.12.2.4.6 Creating a tag with simple conditions (rules)

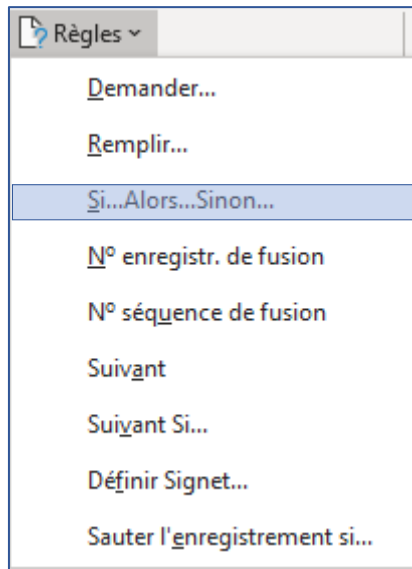
Example: creating a rule to automatically write Mr or Mrs depending on the gender given in the patient record.

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

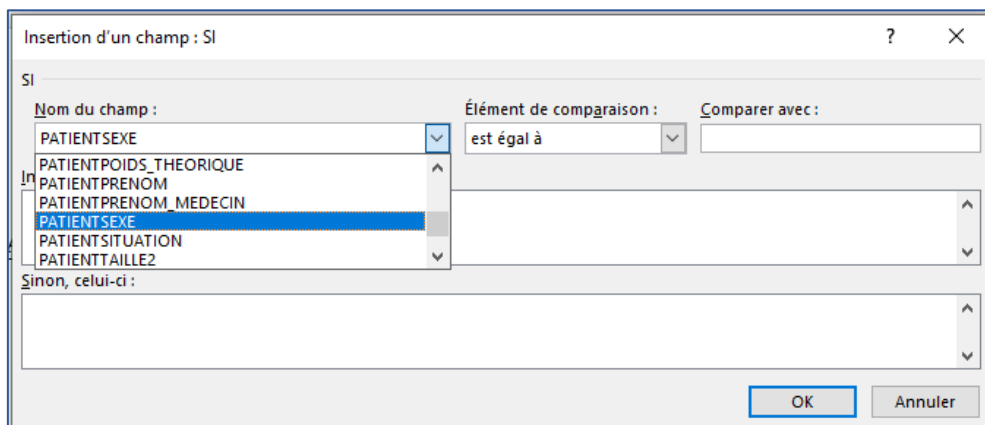


- Clicking the **Rules** button makes it possible to choose the type of rules to apply.
- Use the function: If... Then... Otherwise...





- The Field insertion window opens. The drop-down menu is used to select the reference field. Here, the **PATIENTGENDER** 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.



Insertion d'un champ : SI

SI

Nom du champ : PATIENTSEXE Élément de comparaison : est égal à Comparer avec : M

Insérer le texte suivant :
Monsieur

Sinon, celui-ci :
Madame

OK Annuler

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 full tag diagram in **Word**. Spacing out quotation marks ("" "") is recommended to avoid errors and improve readability.

The logic behind how a tag with advanced conditions is written can be illustrated as follows:

{Si {TAG}="to be compared with TAG" "action if true" "action if false"}

- **Example for name:**

«PATIENTNOM_MARITAL»

This is what this looks like in ALT+F9 mode:

{ IF { MERGEFIELD PATIENTNOM_MARITAL }="" "" "Nom marital : " } MERGEFIELD PATIENTNOM_MARITAL }

Translation: The condition corresponds to: if PATIENTNOM_MARITAL field is empty, write nothing, otherwise insert merge field PATIENTNOM_MARITAL.



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

View not in Alt+F9 mode:

«PATIENTDATE_NAISSANCE»
«PATIENTAGE»

View in Alt+F9 mode:

```
{ 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 PATIENTDATE_NAISSANCE merge field is not entered, then nothing, otherwise write DOB:

Translation:

If the date of birth is empty, nothing is written. Otherwise, DOB: is written, the “date of birth” field is inserted and if the age = 0, write nothing, otherwise write age: insert “age” field while respecting the font rules. (bold)

Result: no text is written if the information is lacking. 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 checkboxes and input boxes



The **DEVELOPER** tab is needed to add checkboxes to a **Word** document. If this is not how Word is configured, click **FILE**.

Select **OPTIONS** at the bottom left of the window.

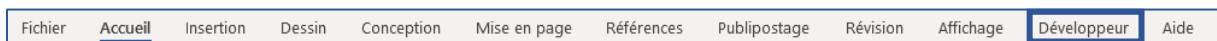
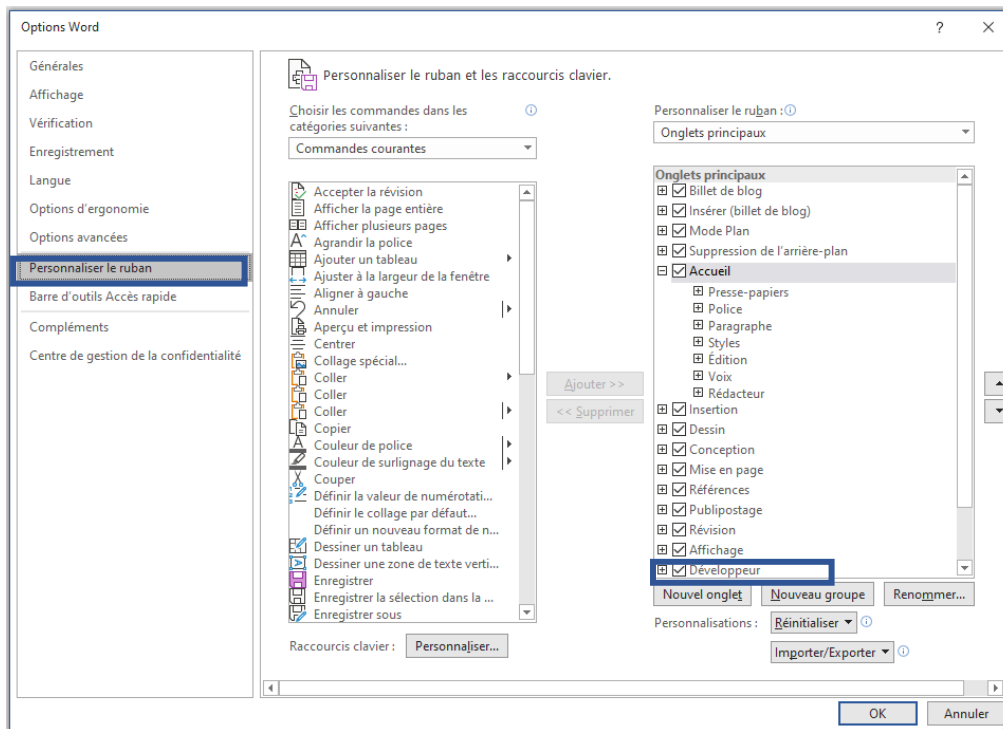
Then select **CUSTOMIZE RIBBON** in the new window. Select the Developer tab then click **OK**. The **Developer** tab then appears in the Word ribbon.



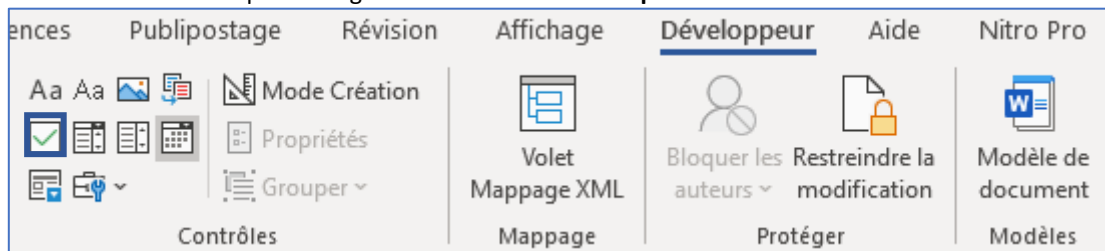
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When the Developer tab is visible, select the location in the document where a checkbox is to be entered, then select the icon representing a checkbox in the **Developer** tab.



The checkbox will appear at the location selected with a click:



Click the checkbox to tick and untick.

Example:

Prescriptions on 01/02/2020:

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

3.12.2.4.9 Protecting the document

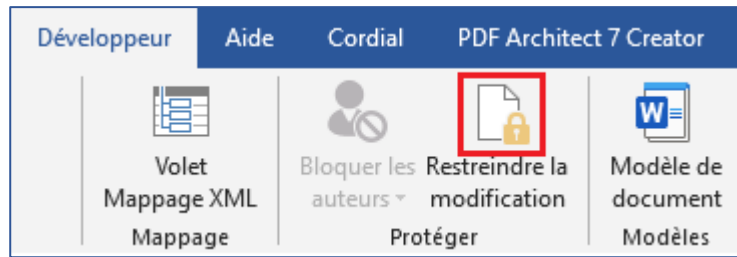
A document with checkboxes or input boxes must be protected so that users can use these parts of the form. It is also possible to protect a document so that it is no longer modifiable by the user once integrated into **DIANE**.



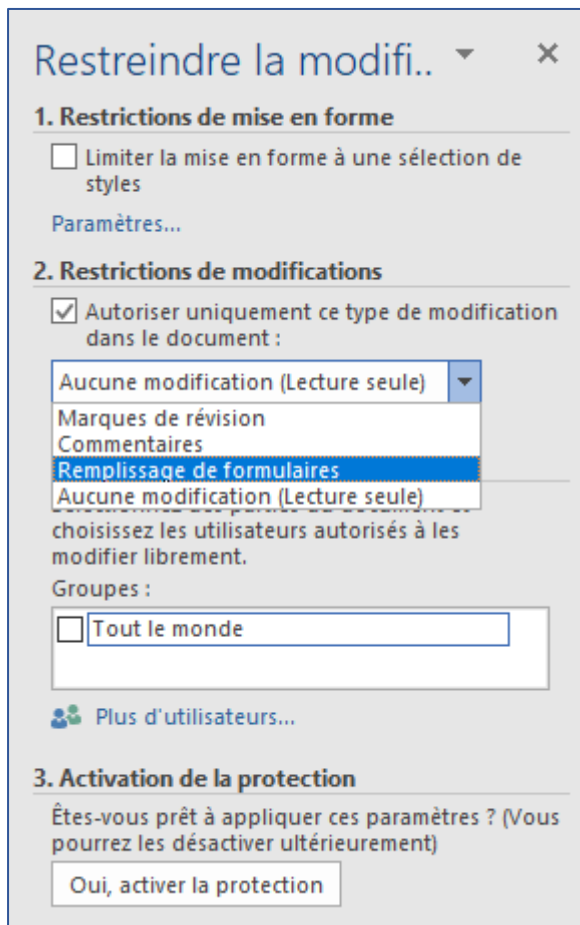
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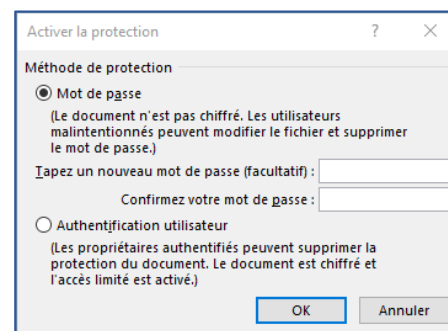


Click Restrict editing as shown above.



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



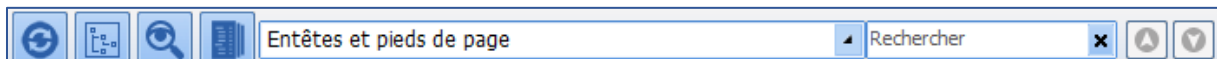
3.12.2.4.10 Adding a header to a Word form letter

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.

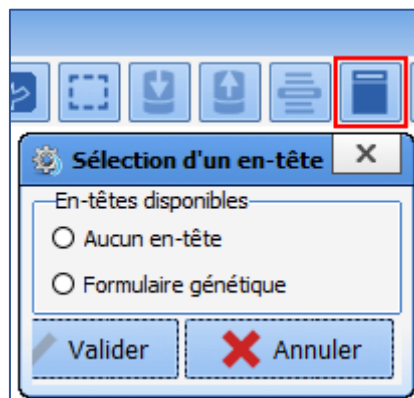
To create or modify a header, select the **FORM LETTER** tab in the application configuration, then select **Headers and footers** from the drop-down menu:



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. 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.

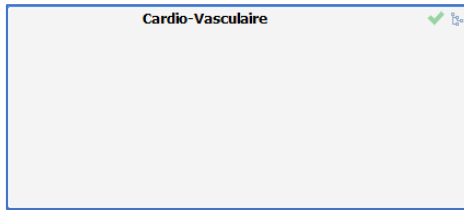
Radio buttons only allow one item to be selected from the available choices. Click **Generic form** and confirm to link the document. To unlink a document so that it no longer has a header, click **No header** and confirm.


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.





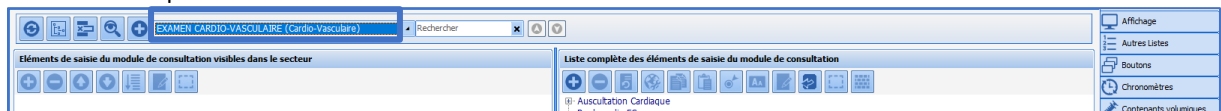
This is the list called up on clicking  or typing the first letters of the word. It is possible to:

- 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 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.




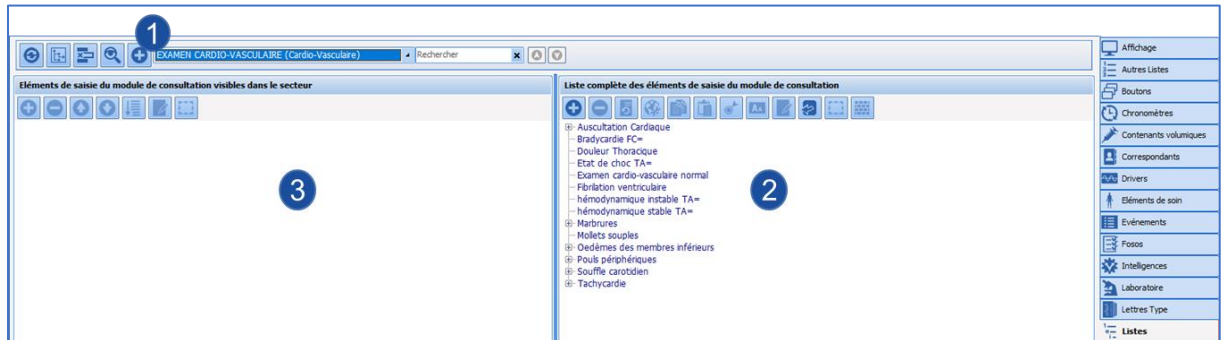
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An item configured as a selector (underlined) is not repeated when the user selects one of its child items. In this example, “Colon” is configured as a selector, unlike “colitis”. If the user selects “pseudomembranous”, this is written as “pseudomembranous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

Multiple formularies can be used on the same database (e.g., one formulary for the anaesthesia department and another for the ICU). Different drug databases may be used in cases where a database is shared by multiple facilities.



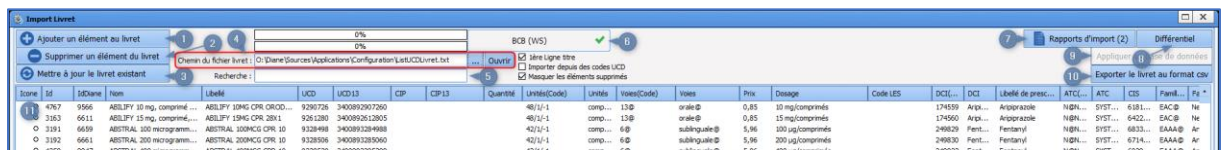
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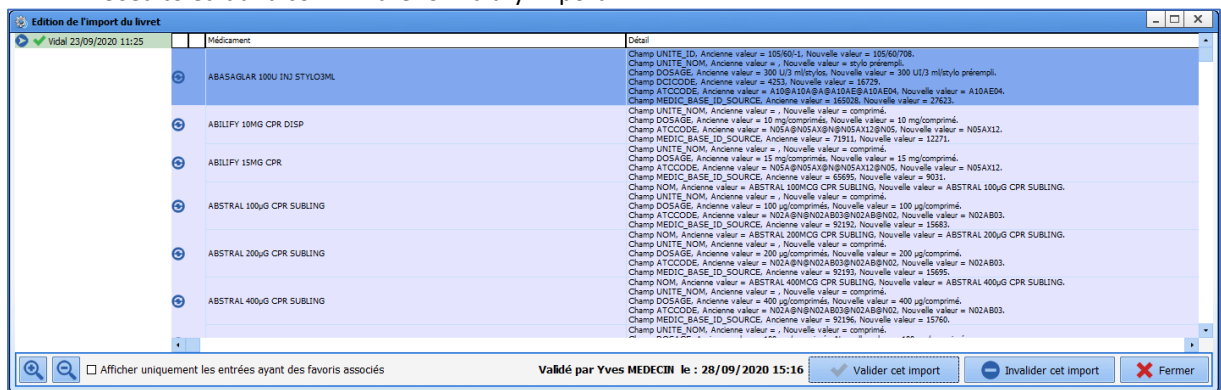
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3.14.1 Importing the formulary

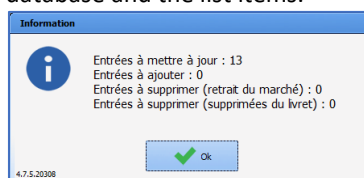
Formulary configuration is accessed via the **Formulary** tab.



1. Used to add an item to the formulary.
2. Used to delete an item from the formulary or recover a deleted item (visible if **Hide deleted items** is not selected).
3. Update the existing formulary from the configured drug database (**Pane 6**).
4. 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.
5. Used to search for an element in the formulary.
6. Name of configured drug database (BCB or Vidal) and connection status.
7. Used to edit and confirm the formulary import.



8. Shows differences between the database and the list items.



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

3.14.2 Editing the formulary

It is possible to add, edit and delete items from the formulary.

Items can be added using the **Drug search** field: entering the name of a product, active ingredient or UCD, UCD13, CIP or CIP13 code allows information to be retrieved directly from the configured drug database.



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Édition d'un élément du livret thérapeutique

ID Livret 5797	ID Diane 19586	Quantité 	Unités(Code) -1/60/164	Unité(UCD) poche	Quantité d'azote par contenant 0
CIP	CIP13	Prix GLUCOSE 10%	Voies(Code) 33	Voies intraveineuse (en perfusion)	Voir la monographie
UCD 9179035	UCD13 3400891790351	CIS 62408126	DCI(Code) 3148	DCI GLUCOSE 10 % sol inj	Base de médicament configurée : Vidal
Nom GLUCOSE 10% BBM INJ P.E1000ML			ATC(Code) B05BA03	ATC HYDRATES DE CARBONE	Base de médicament de l'élément : Vidal
Libellé GLUCOSE 10% (LABO B BRAUN), SOL PR PERF, POCHE 1 L			Famille(Code) 28	Famille Anesthésie - Réanimation	Ré-importer depuis la BdM
Dosage 400 kcal/1000 ml/poche			Forme(Code) 531	Forme solution pour perfusion	Quantité Max. (/J/Kg) <input type="text"/> Quantité Max. (/J) <input type="text"/>
Dilution Aucun paramétrage				Libellé de prescription GLUCOSE 10 %	Valeur létale (/J/Kg) <input type="text"/> Valeur létale (/J) <input type="text"/>
Commentaires pour prescripteurs	Commentaires pour IDEs			Codes LES	Poids patient (utilisé pour le calcul des valeurs maximales et létales) <input type="text"/> 70 Kg
Recherche de médicament <input type="text" value="Rechercher..."/>	CIP trouvés				<input type="button" value="OK"/> <input type="button" value="Annuler"/>

DIANE identifies the corresponding CIP code(s) and shows the relevant products:

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

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



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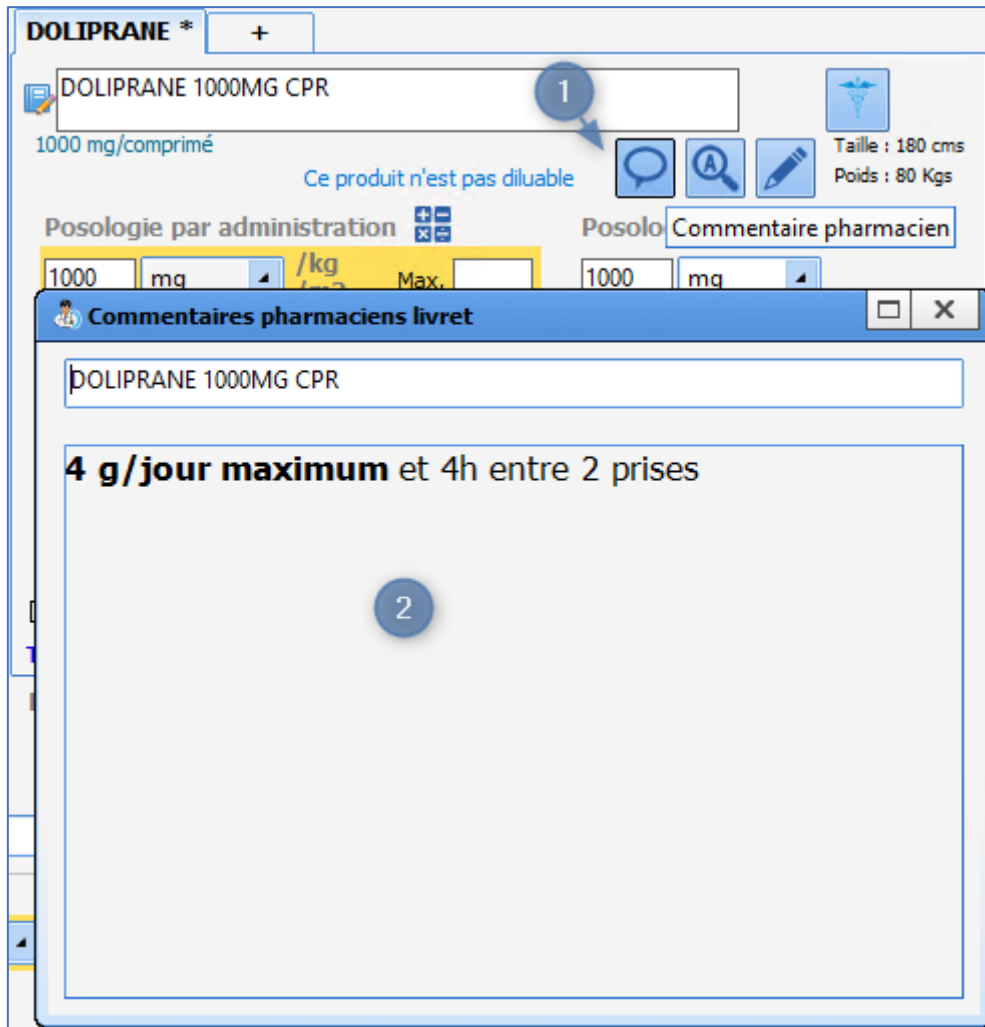
The **Reimport from DDB** button is used to update item information.

It is possible to update the whole formulary by clicking **Update the existing formulary**.

The **Delete an item from the formulary** button is used to delete an item from the formulary. Deletion is not permanent: a deleted item can be added back. To do this, untick **Hide deleted items** (1). Deleted items can be identified by the value 0 in the **Visible** column (2). To add the item back in, select it then click **Add an item back in the formulary** (3).

The fields **Comments for prescribers** and **Comments for nurses** allow pharmacists to enter information visible to prescribers in the medication order entry form (1 and 2) and nurses on the care plan (3).





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	

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



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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 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 **Mandatory dilution** is enabled, 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** subtab. 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.



Édition d'un élément du livret thérapeutique

ID Livret 6689	ID Diane 20484	Quantité	Unités(Code) 57/60/138	Unité(UCD) flacon	Quantité d'azote par contenant 0
CIP 2675601	CIP13 3400926756017	Prix 115,53	Voies(Code) 33	Voies intraveineuse (en perfusion)	Voir la monographie
UCD 9389270	UCD13 3400893892701	CIS 68011537	DCI(Code) 1641	DCI ACIDE ZOLEDRONIQUE 4 mg/:	Base de médicament configurée : Vidal
Nom ACID.ZOLEDRONIQ.MYL 4MG/5ML			ATC(Code) M05BA08	ATC ACIDE ZOLEDRONIQUE	Base de médicament de l'élément : Vidal
Libellé ACID.ZOLEDRONIQ.MYL 4MG/5ML			Famille(Code) 269	Famille Cancérologie - Hématologie	Ré-importer depuis la BdM
Dosage 4 mg/5 ml/flacon			Forme(Code) 453	Forme solution à diluer pour perfusio	Quantité Max. (/J/Kg) <input type="text"/>
Dilution Aucun paramétrage				Libellé de prescription ACIDE ZOLEDRONIQUE	Valeur létale (/J/Kg) <input type="text"/>
Commentaires pour prescripteurs	Commentaires pour IDEs			Codes LES	Valeur létale (/J) <input type="text"/>
					Poids patient (utilisé pour le calcul des valeurs maximales et létales) <input type="text" value="70"/> Kg
Recherche de médicament <input type="text" value="Rechercher..."/>	CIP trouvés				

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



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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 Lf" (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.)

Dilution




Concentration minimale mg/ml

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

Nouveau dosage : 4 mg/5 ml/flacon

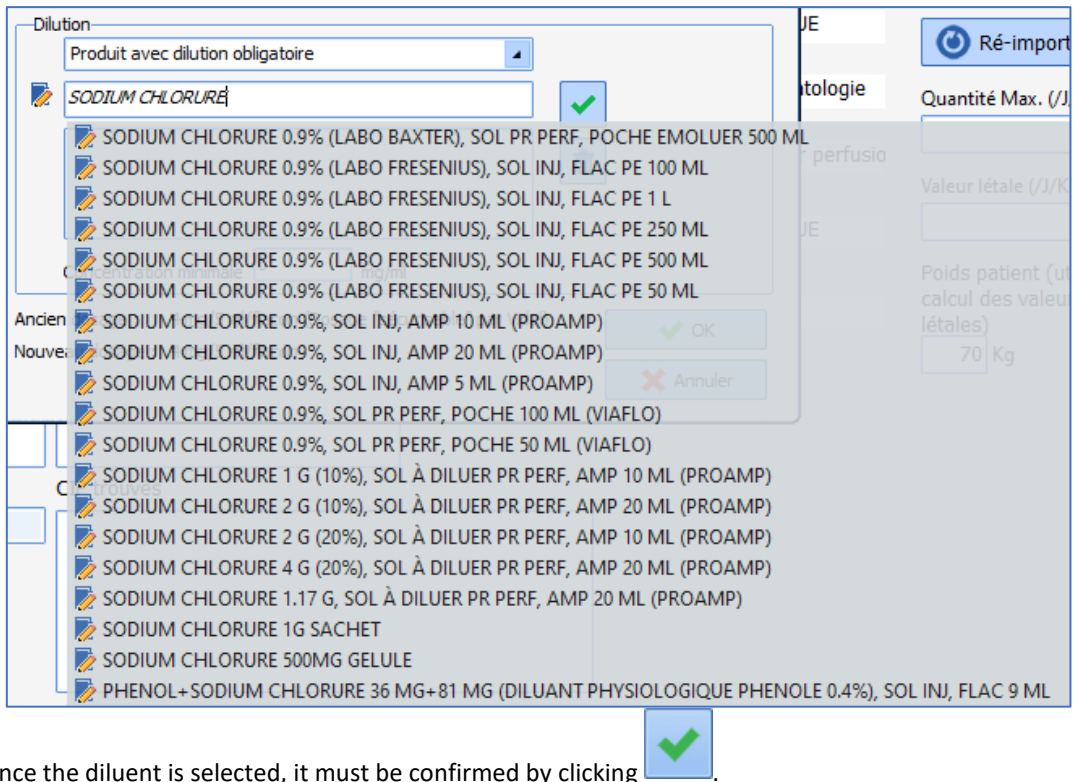
Product with mandatory dilution must then be selected from the drop-down menu. Word completion can be used to quickly find the diluents in the formulary items.


Dilution

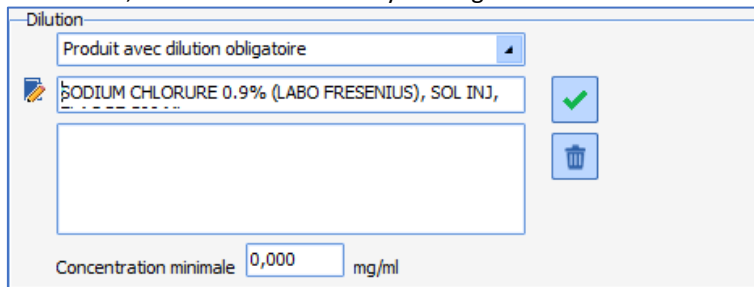


Concentration minimale mg/ml

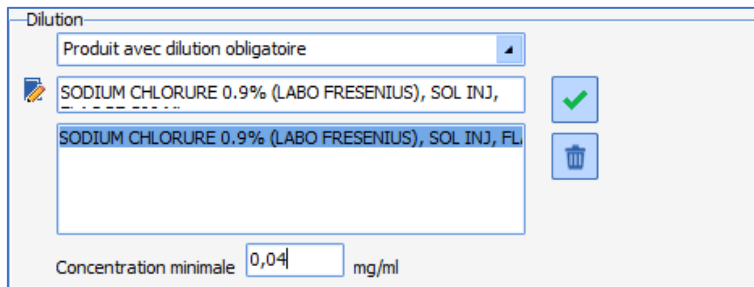




Once the diluent is selected, it must be confirmed by clicking .



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



As many mandatory diluents as required can be set up.



Dilution

Produit avec dilution obligatoire


GLUCOSE 5% (LABO FRESENIUS KABI FRANCE), SOL PR

SODIUM CHLORURE 0.9% (LABO FRESENIUS), SOL INJ, FL

GLUCOSE 5% (LABO FRESENIUS KABI FRANCE), SOL PR PE

Concentration minimale 0,030 mg/ml



Click  to remove the diluent from the list.

3.14.5 Products marked as diluents

The option **Product marked as diluent** is used to propose items in the formulary as diluents when completing dilutions from the care plan or drug label editing window.

Modification du dosage/dilution/conditionnement du produit

GLUCOSE 5% FKF INJ FP500ML

Quantité de produit exprimé par conditionnement

Veillez saisir une valeur et une unité

exemple : "250 mg" (par cp), "200 Uli" (pour 10 ml), "5 mol" (par ml)

25000 mg

Conditionnement ou volume exprimé par conditionnement

Veillez saisir une valeur (par défaut 1) et une unité

exemple : "10 ml", "(1) cp", "(1) dose", "(1) bouffée"...

500 ml

Marquer ce produit comme diluable sans volume de préparation associé

Conditionnement

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

flacon

Dilution

Produit marqué comme diluant

Ancien dosage : 25000 mg/500 ml/flacon (Dosage "sécurisable" par Vida)

Nouveau dosage : 25000 mg/500 ml/flacon

OK

Annuler

Note: if there is one or more product marked as diluent, only products in this list can be used in the care plan if the medication order does not specify a diluent.

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**



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(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.

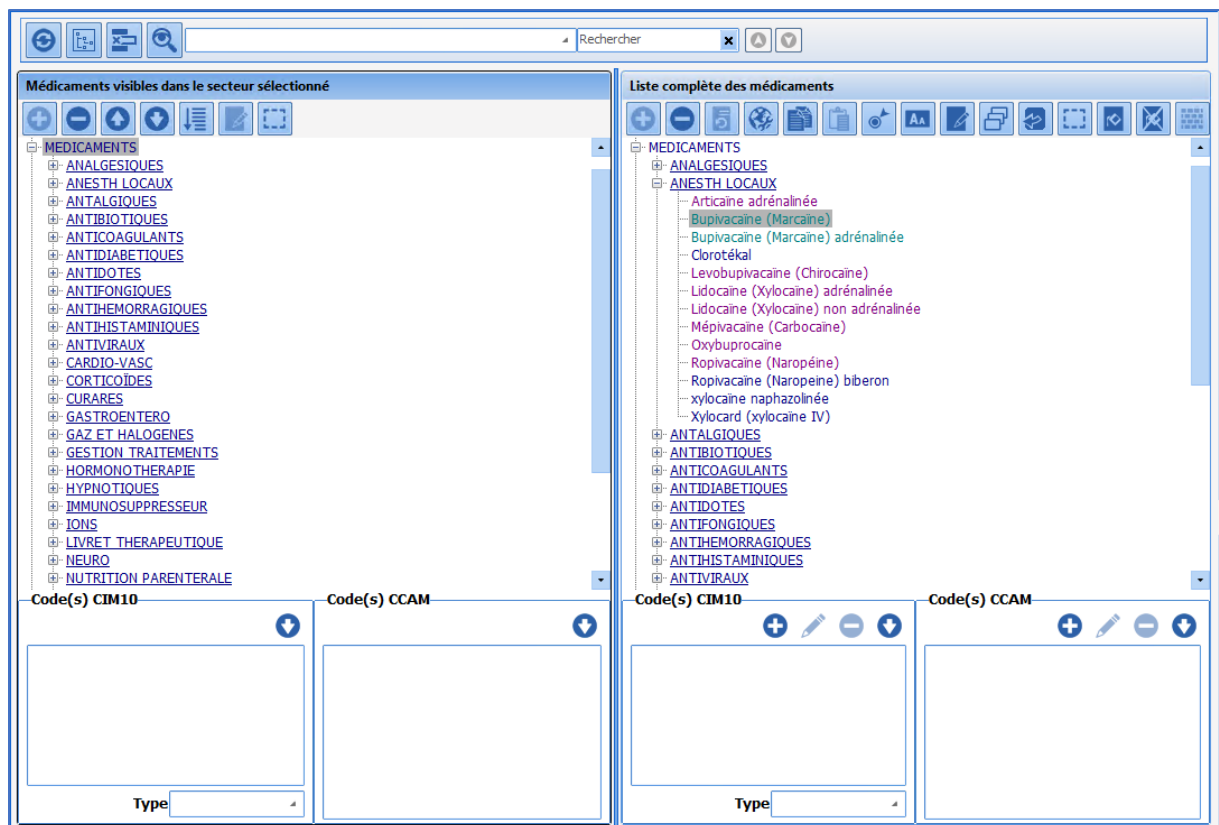
These names cannot and should not be changed! The same applies for categories (analgesics, antibiotics, etc.).

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 modify all items by adding, modifying or deleting dosages.

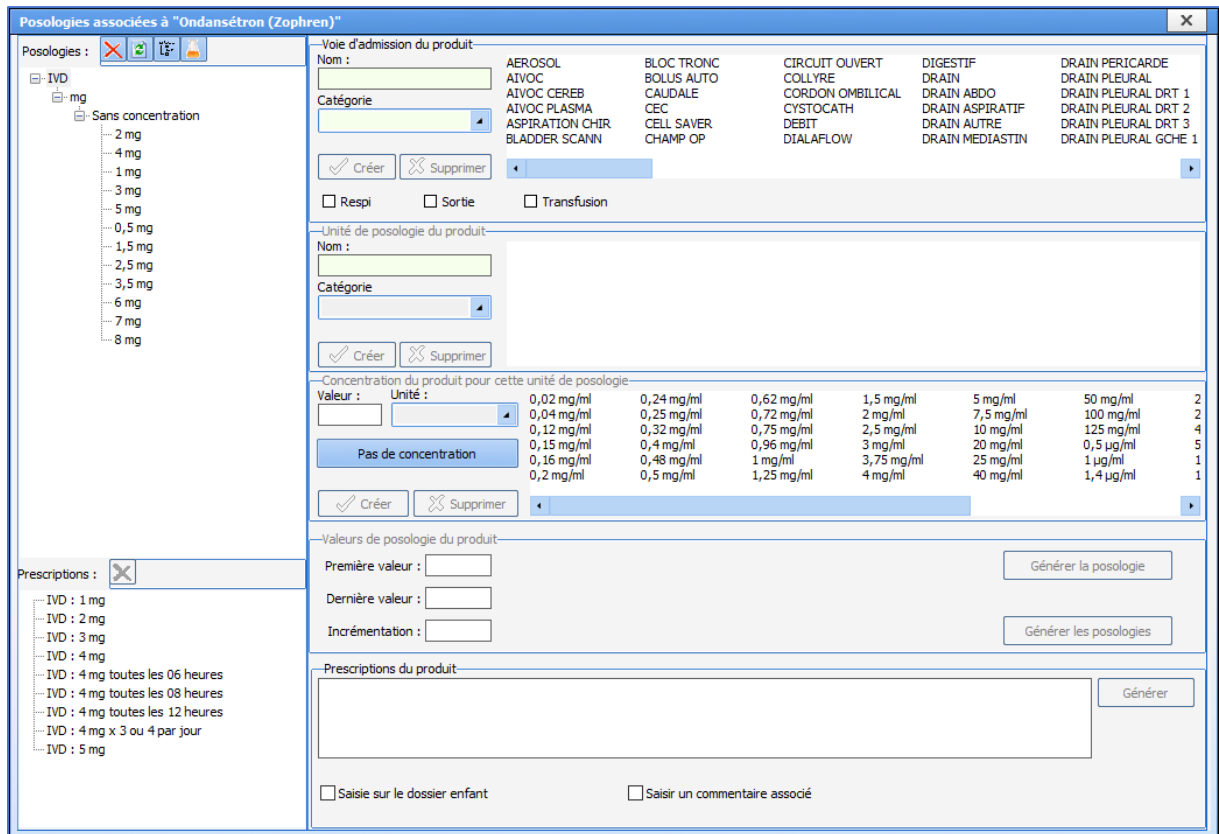
Please note that it is impossible to rename the categories **Analgesics**, **Antibiotics**, **Anticoagulants**, **Ions** and **Solutions** as these lists are used to create post-op medication orders in **Visual**. It is also impossible to duplicate a drug.



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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 categories 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), 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:




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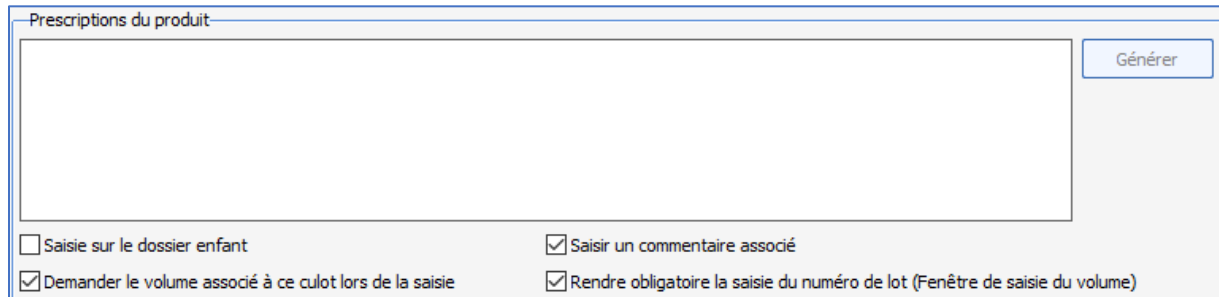
To delete a **Route of administration**, a **Dosage unit** or a **Concentration**, select the item to be deleted and click the corresponding **Delete** button.

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.

Setup options:



The screenshot shows a window titled "Prescriptions du produit" with a large empty text area on the left and a "Générer" button on the right. Below the text area are four checkboxes:

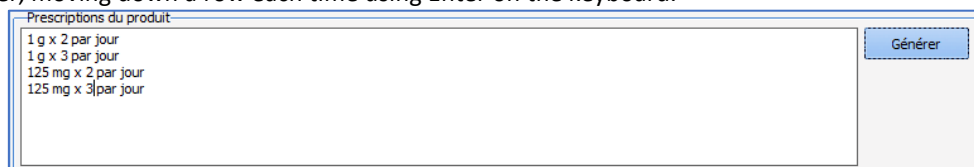
- Saisie sur le dossier enfant
- Saisir un commentaire associé
- Demander le volume associé à ce culot lors de la saisie
- Rendre obligatoire la saisie du numéro de lot (Fenêtre de saisie du volume)

Several setup options are available in the lower part of the window.

- **Enter on child record** is used in obstetrics.
- **Enter an associated comment:** for products that require traceability, it is possible to have a comment window that opens automatically after entry.
- **Request associated volume when entered:** for products administered in bags (blood bags or other) with several possible volumes, a window can be used to enter the bag volume.
- **Make batch number mandatory (volume entry window):** for products administered in bags, the **Batch No.** field of the bag volume entry window is mandatory (this requires the option **Request associated volume when entered** to be enabled).

3.15.3 Creation, modification 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.

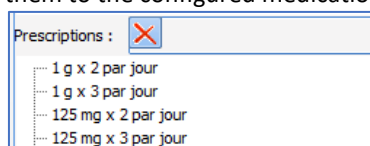


The screenshot shows the "Prescriptions du produit" window with the following text entered in the left column:

- 1 g x 2 par jour
- 1 g x 3 par jour
- 125 mg x 2 par jour
- 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 smaller window titled "Prescriptions" with a close button (X) in the top right corner. The text inside is:

- 1 g x 2 par jour
- 1 g x 3 par jour
- 125 mg x 2 par jour
- 125 mg x 3 par jour



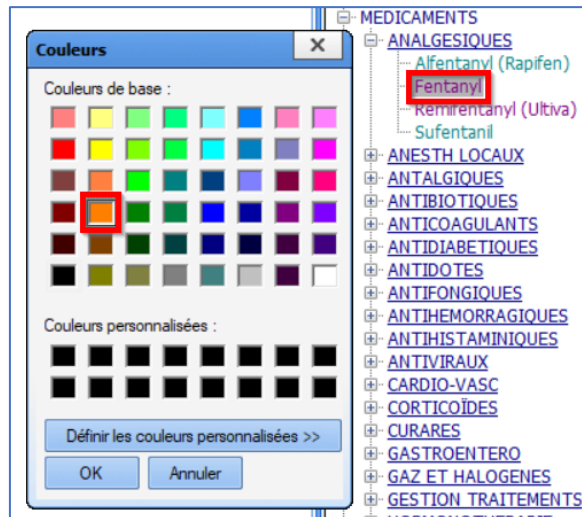
3.15.4 Associate a volume with a blood bag

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 checkbox **Request associated volume when entered** 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 **fantanyl**.





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



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3.16 Setups

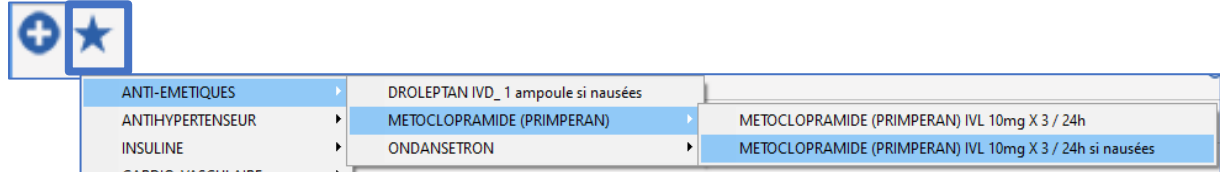
See chapter: *Setups*

3.17 MO/Pres./Medic. favourites

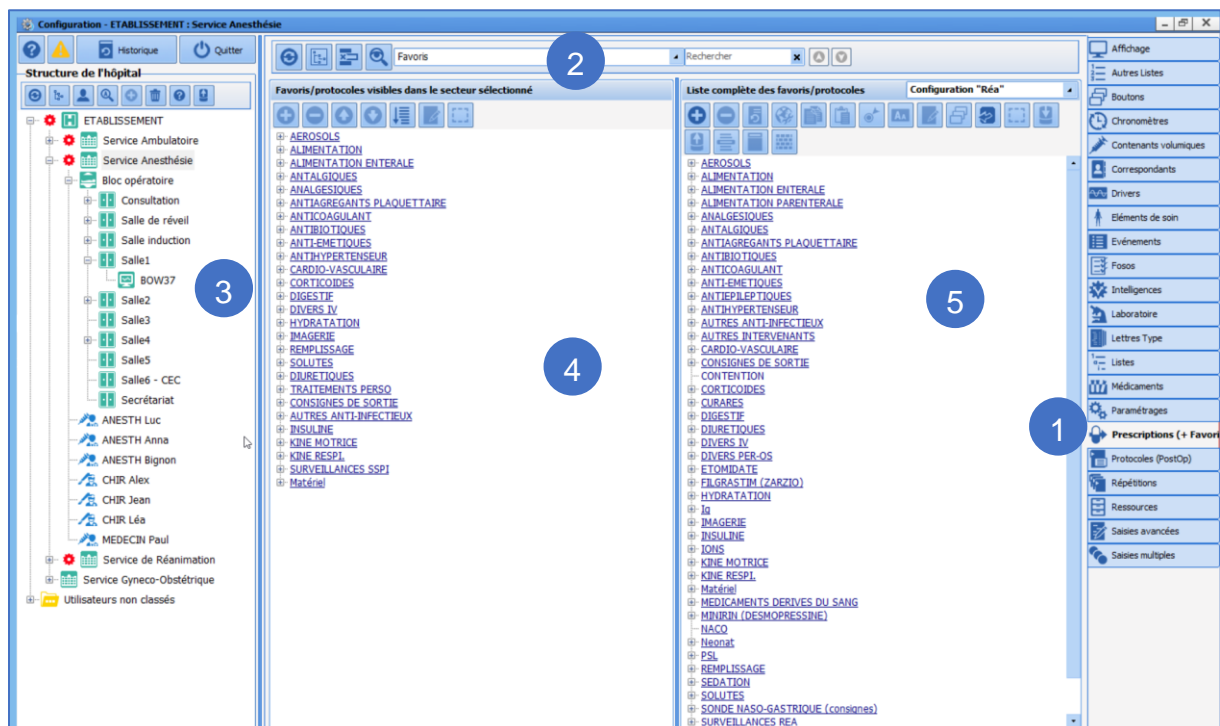
To set up medication order favourites, it is possible to modify existing favourites or create new ones.


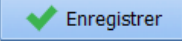
! The formulary must be imported before favourites are created. When formulary updates are carried out, it is essential to check whether any favourites have been affected.

In use, favourites are accessible via the star  in the selected drug category in the **Medication order** tab.



3.17.1 Favourites



1. To add favourites, select the **MO/Pres./Medic. favourites** tab.
2. Select **Favourites** from the drop-down menu.
3. Select the sector in which the favourites should be applied (gear).
4. The column on the left shows the configured favourites in the selected sector.
5. To modify a favourite, select and edit it. To create a favourite, select a category and click . Then, create the medication order (as in use) then click .

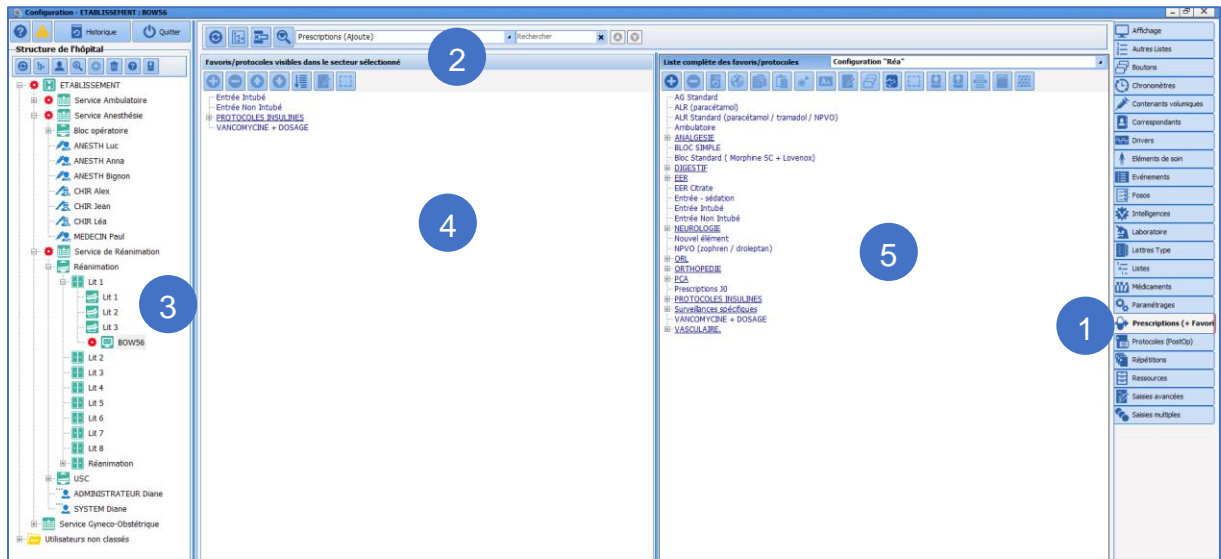



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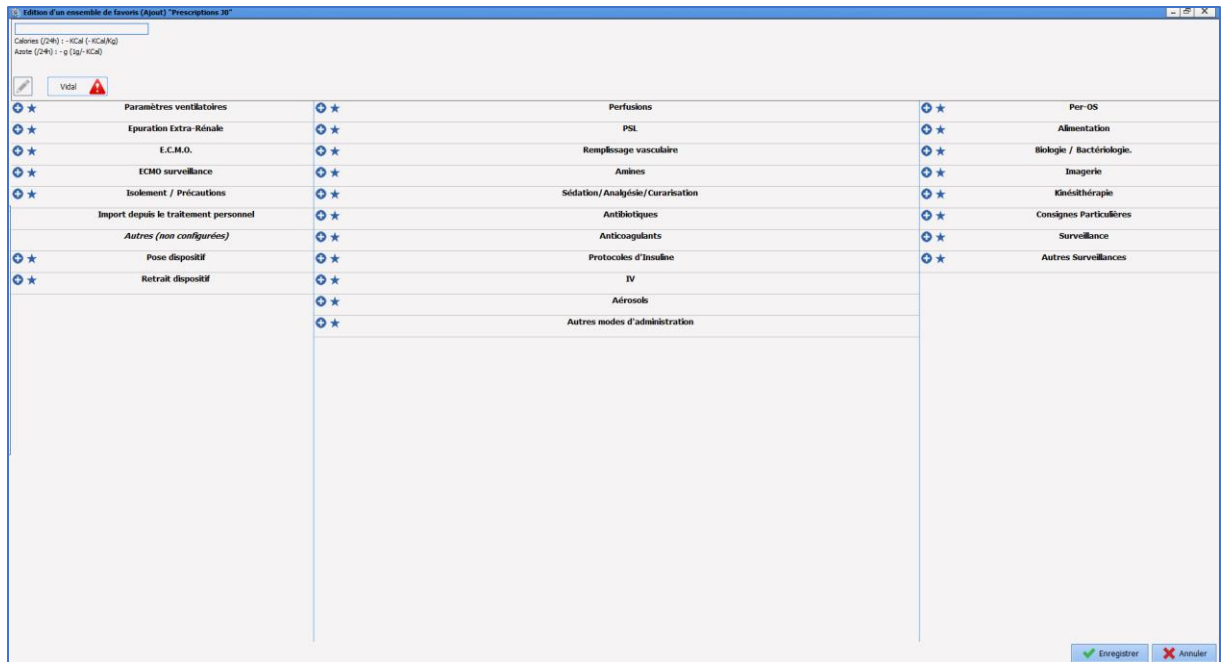


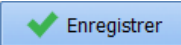
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3.17.2 Protocols



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).



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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 checked="" type="checkbox"/> Droits logiciels	<input checked="" type="checkbox"/> Droits applicatifs	<input checked="" type="checkbox"/> Droits administratifs
Consultation		
<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		
RDV		
<input checked="" type="checkbox"/> Créer/Modifier des rendez-vous		
Visual / Liste des patients / DianeObst		
<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"/> FILGRASTIM (ZARZIO)
<input checked="" type="checkbox"/> Gaz du sang : x1 à 22h, x1 à 8h
<input checked="" type="checkbox"/> Glucose 5 %+ potassium chlorure 0,2 %+ sodium chlorure 0,4 % : 1000 ml en continu
<input checked="" type="checkbox"/> HYDRATATION
<input checked="" type="checkbox"/> Hydroxyethylamidon 130 000 6 %+ sodium chlorure 0,9 % : 500 ml; D=1h 2x/j
<input checked="" type="checkbox"/> Ig
<input checked="" type="checkbox"/> ...

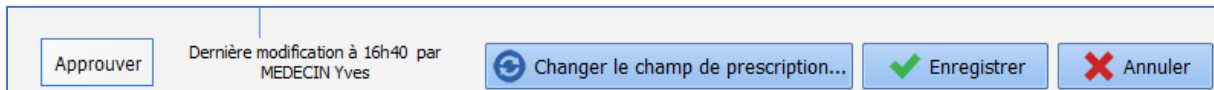


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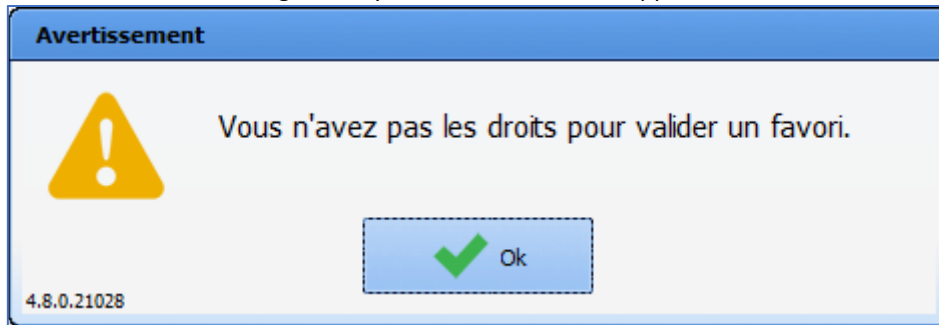


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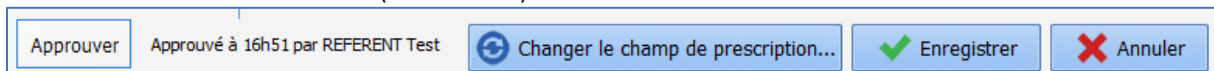
If the protocol/favourite has not yet been approved, the date of the last modification and the user who made this modification are specified. An **Approve** button is used to approve the medication order protocol or favourite.



If the user does not have these rights, they are not authorised to approve.



Once approved, the date 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 modifying user has approval rights, the protocol/favourite is automatically approved.

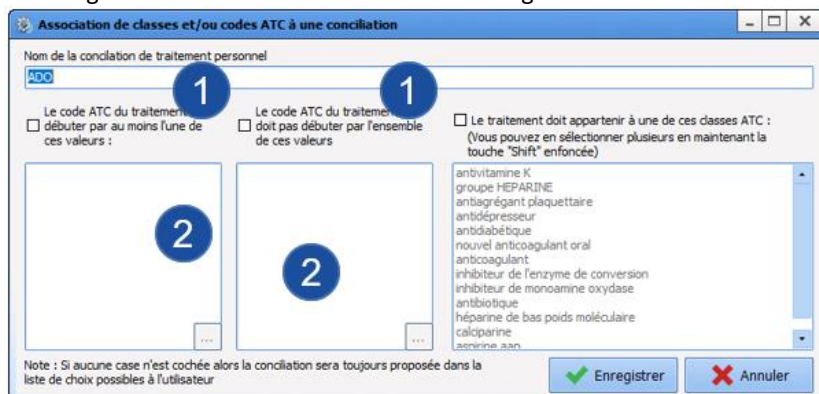
3.17.4 Conversion (treatment) // Stoppage (treatment)

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

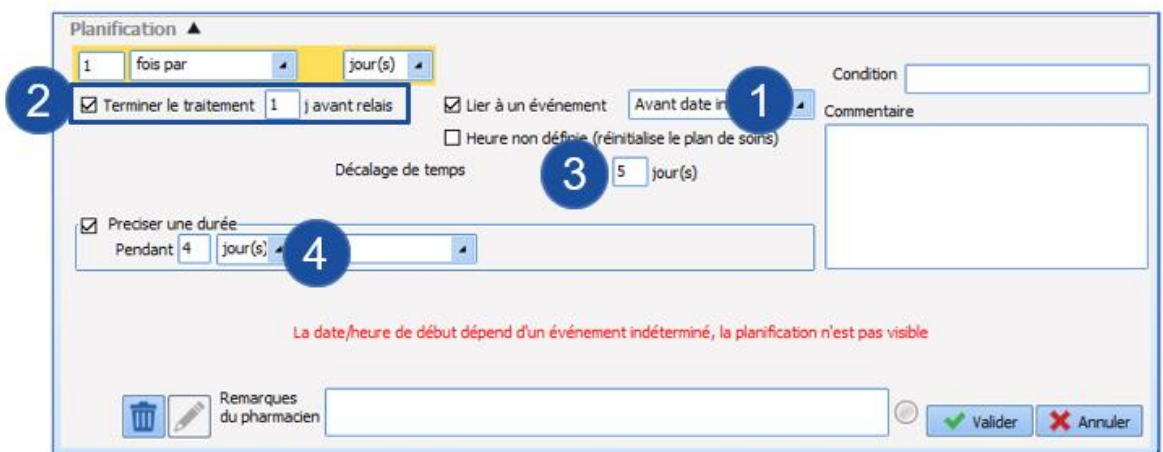


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- The button at the bottom of pane 2 is used to access the existing classes and select those concerned by the current settings.
- **Save**
- Edit the form using the  button
- Click  to access the drug settings window
- In the top part, enter the drug 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.



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.

3.17.5 Directly administered substances

This tab lets you configure formulary drugs to be used in anaesthesia.



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Paramétrage associé à "FENTANYL"

Composition (non modifiable car présence d'au moins une posologie)

Produit principal
FENTANYL 0.5 MG (LABO MYLAN), SOL INJ, AMP 10 ML 500 µg

Concentration finale du produit principal : 50 µg/ml

Voie d'administration : intraveineuse

Type d'administration : Injection directe, Injection lente, Injection pédiatrique, CEC, Débit contrôlé, Débit contrôlé ciblé

Génération des posologies

µg /kg /m2 Première valeur : Dernière valeur : Incrémentation :

Génération de la (ou des) posologie(s)

Posologie(s) générée(s)

- intraveineuse (ID) 50 µg/ml
 - 25 µg - 0,5 ml
 - 50 µg - 1 ml
 - 75 µg - 1,5 ml
 - 100 µg - 2 ml
 - 125 µg - 2,5 ml
 - 150 µg - 3 ml
 - 175 µg - 3,5 ml
 - 200 µg - 4 ml
 - 225 µg - 4,5 ml
 - 250 µg - 5 ml
 - 275 µg - 5,5 ml
 - 300 µg - 6 ml
 - 325 µg - 6,5 ml
 - 350 µg - 7 ml
 - 375 µg - 7,5 ml
 - 400 µg - 8 ml

Saisir un commentaire associé Ne pas prendre en compte pour la balance liquidienne

3.17.5.1 Composition

The **Composition** field lets you configure the substance(s) contained in a drug.

Composition

Produit principal

Rechercher...

+

The **Main product** field lets you select the main product from the items listed in the drug formulary.



Composition

Produit principal

ALFENTANIL 1 MG (RAPIFEN), SOL INJ, AMP 2 ML 1000 µg

Concentration finale du produit principal : 500 µg/ml

+

The units associated with the main product are retrieved directly from the drug formulary and populated into the unit field.

Clicking the **+** button adds a **Additional product** line.

Produit additionnel

Rechercher...

-

This line works in the same way as the main product, but lets you choose a secondary product. Click the **+** button as many times as you like to associate as many products as necessary. Each line added is preceded by the label **Additional product** and includes a **Diluent** checkbox for identifying which of the additional products is the diluent (only one product can be considered a diluent).

Produit additionnel Diluant

GLUCOSE 10% (LABO B BRAUN), SOL PR PERF, POCHE 1 L 1000 ml

-

The **Final concentration of the main product** is displayed at the bottom of this area. The final concentration can be edited, which will modify the diluent volume.

3.17.5.2 Route of administration

Voie d'administration

intraveineuse

intraveineuse

péridurale

intraveineuse (en perfusion)

intramusculaire

Autre

The routes are those configured for the main product in the drug formulary. If you select the option **Other**, a window will prompt you to specify the route of administration.

Autre voie d'administration :

Veuillez saisir la voie d'administration (valeur actuelle = "intraveineuse (ID)") intraveineuse (ID)

OK Annuler

3.17.5.3 Type of administration

There are six types of administration: Direct Injection (DI), Slow Injection (SI), Paediatric Injection (IPed), CPB, Controlled Flow (SP) and Targeted Controlled Flow (Targeted SP).



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3.17.5.4 Generating dosages

The number of products and the administration type determine the generation of dosages in the following step (target and/or flow rate).

If only one main product is to be administered, the available units are those that are compatible with the main product.

- Direct injection (**DI**): dosage in quantity per administration, target per kg or m² is possible.
- Slow injection (**SI**): dosage in quantity per hour or per minute, target per kg or m² is possible
- Paediatric injection (**IPed**): dosage in quantity per administration, target per kg or m² is possible.
- **CBC**: dosage in quantity per administration, target per kg or m² is possible.
- Controlled flow (**SP**): dosage in quantity per hour or per minute, target per kg or m² is possible.
- Targeted controlled flow (**Targeted SP**): dosage in quantity per hour or per minute, target per kg or m² possible.

If multiple products are to be administered, the unit is the millilitre (mL) or drops.

- Direct injection (**DI**): dosage in mL of mixture.
- Slow injection (**SI**): dosage in mL or drops of mixture per hour or per minute.
- Paediatric Injection (**IPed**): dosage in mL of mixture.
- **CBC**: dosage in mL of mixture.
- Controlled Flow (**SP**): dosage in mL or drops of mixture per hour or per minute.
- Targeted controlled flow (**Targeted SP**): dosage in quantity per hour or per minute, target per kg or m² possible.

Values may be individually created by filling in the **First value** field and then clicking **Generate dosage(s)**.

To create a series of dosages, enter the lowest value in the **First value** field, the highest value in the **Last value** field, the interval in the **Increment** field, and then click **Generate dosage(s)**. The values are created starting from the lowest to the highest value and at the interval entered.

3.17.6 On-demand administration favourites

Entry of administrations requested verbally by a doctor may be restricted to certain favourites configured in the **On-demand administration favourites** subtab of the **MO/Pres./Medic. favourites** tab.



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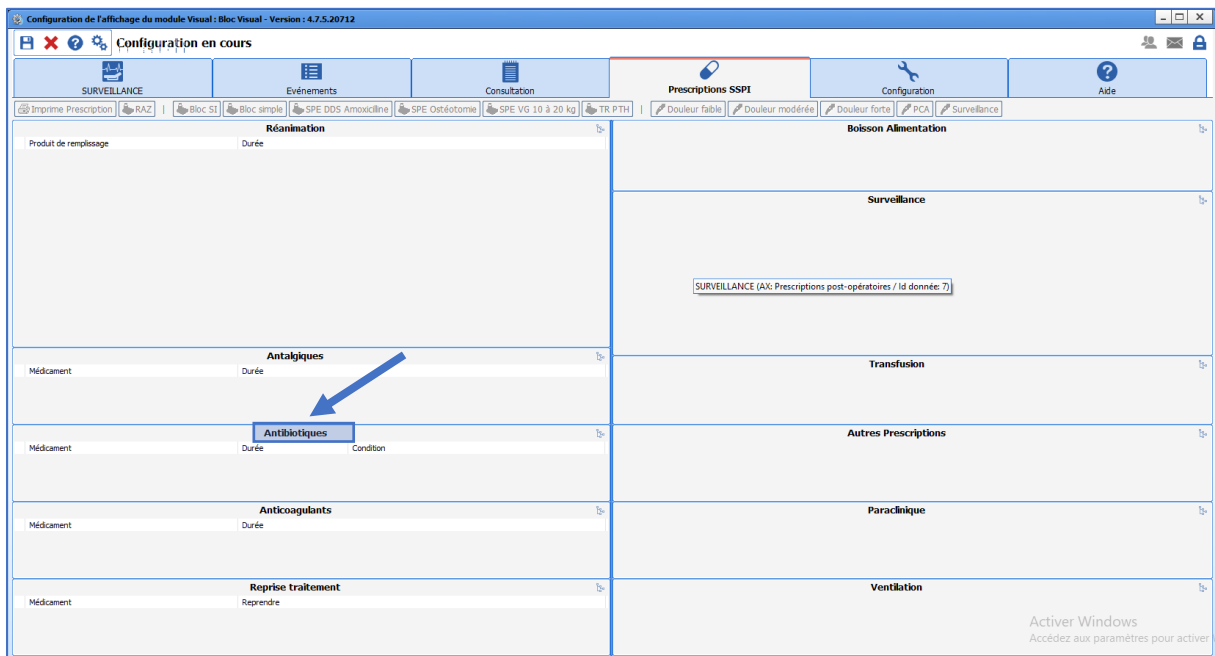
By default, the full list of favourites (on the right) includes all medication order favourites. On-demand administration are created, edited and deleted in a similar manner as for medication order favourites. Only the favourites toggled to the left in the list of favourites list can be used in the selected area.

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**.

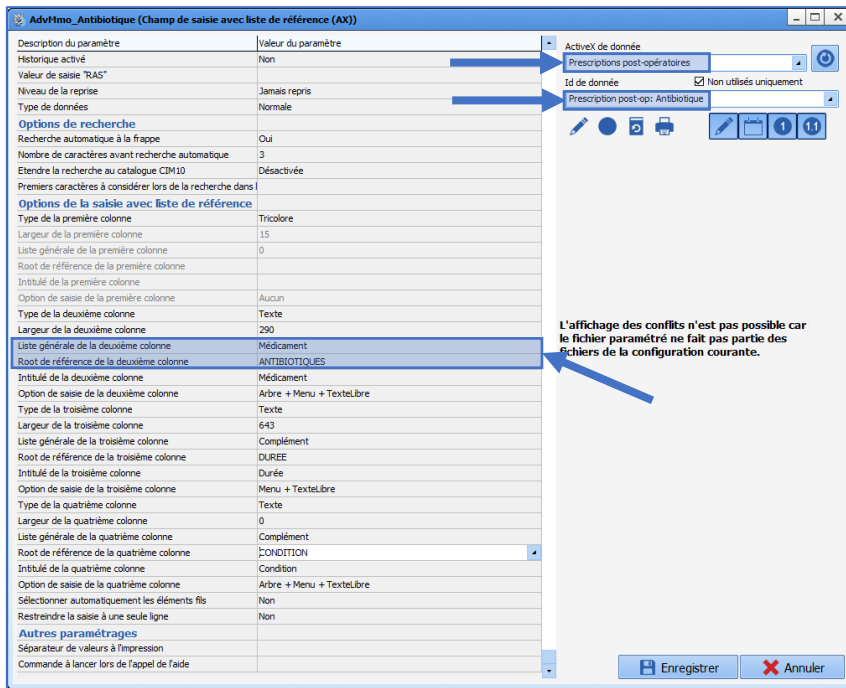
3.18.1 Create a new medication order configuration

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.



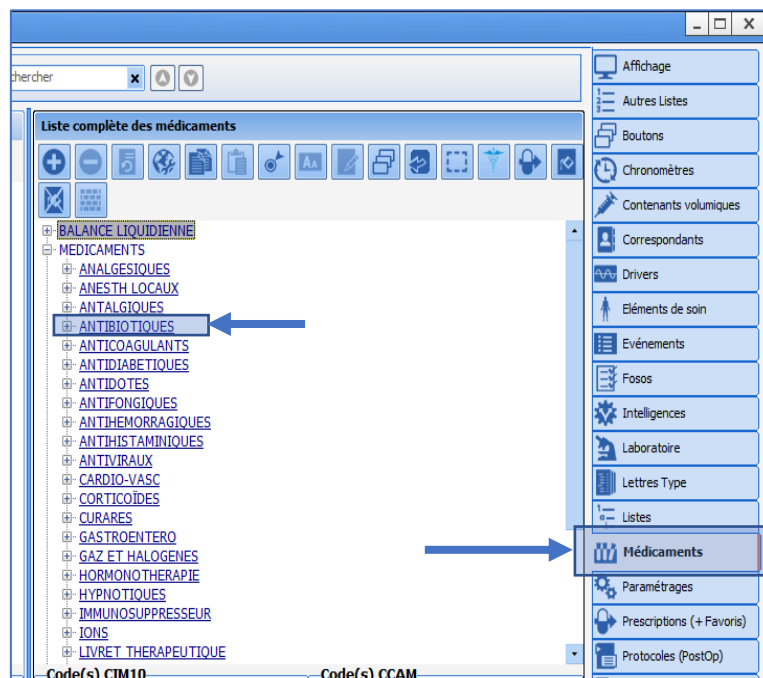
In this example, the configured item is the **Antibiotics** field. Right-clicking brings up a menu to access the component configuration.





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.**



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AdvTmo_Surveillance (Champ de saisie avec liste de référence (AX))


Description du paramètre	Valeur du paramètre
Taille de la police de l'intitulé	10
Intitulé en gras	Oui
Options d'affichage du contenu	
Couleur de la police de l'intitulé	0
Couleur quand une valeur est saisie	16309708
Couleur quand le composant est vide	16119285
Couleur de fond du composant	16053493
Taille de la police	8
Texte au survol de l'aide	
Options des données associées	
Accès en écriture du champ	Ecriture
Niveau d'importance du champ	Élément normal
Historique activé	Non
Valeur de saisie "RAS"	
Niveau de la reprise	Jamais repris
Type de données	Normale
Options de recherche	
Recherche automatique à la frappe	Oui
Nombre de caractères avant recherche automatique	3
Étendre la recherche au catalogue CIM10	Désactivée
Premiers caractères à considérer lors de la recherche dans	
Options de la saisie avec liste de référence	
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	Aucun
Type de la deuxième colonne	Texte
Largeur de la deuxième colonne	795
Liste générale de la deuxième colonne	Consultation
Root de référence de la deuxième colonne	SURVEILLANCE
Intitulé de la deuxième colonne	
Option de saisie de la deuxième colonne	Arbre + Menu + TexteLibre
Sélectionner automatiquement les éléments fils	Non
Restreindre la saisie à une seule ligne	Non
Autres paramètres	
Séparateur de valeurs à l'impression	
Commande à lancer lors de l'appel de l'aide	

ActiveX de donnée
 Prescriptions post-opérateurs
 Id de donnée Non utilisés uniquement
 Prescription post-op: Surveillance

L'affichage des conflits n'est pas possible car le fichier paramétré ne fait pas partie des fichiers de la configuration courante.

Enregistrer Annuler

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.


Création d'un nouvel élément

Saisissez le nom pour cet élément :


OK Annuler



Édition d'un Protocole/Prescription										
Configuration Nom : <input type="text" value="Bloc SI"/> <input type="button" value="✓ Enregistrer"/> <input type="button" value="✗ Annuler"/>										
Réanimation 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>pd 24 h</td> </tr> <tr> <td>Ringer Lactate : 1000 cc/j</td> <td>pd 24 h</td> </tr> <tr> <td>Hydroxyéthylamidon + Chlorure de sodium (Voluven) 500 ml x 2/j sur 1 heure</td> <td>pd 24 h</td> </tr> </tbody> </table>	Produit de remplissage	Durée	815 2000 cc/j	pd 24 h	Ringer Lactate : 1000 cc/j	pd 24 h	Hydroxyéthylamidon + Chlorure de sodium (Voluven) 500 ml x 2/j sur 1 heure	pd 24 h	Boisson Alimentation	
Produit de remplissage	Durée									
815 2000 cc/j	pd 24 h									
Ringer Lactate : 1000 cc/j	pd 24 h									
Hydroxyéthylamidon + Chlorure de sodium (Voluven) 500 ml x 2/j sur 1 heure	pd 24 h									
Antibiotiques <table border="1"> <thead> <tr> <th>Médicament</th> <th>Durée</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> </tbody> </table>	Médicament	Durée			Surveillance 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										
Anticoagulants 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>pd durée de l'hospitalisation</td> </tr> </tbody> </table>	Médicament	Durée	Enoxaparine sodique (Lovenox) SC : 40 mg 1 fois par jour	pd durée de l'hospitalisation	Transfusion					
Médicament	Durée									
Enoxaparine sodique (Lovenox) SC : 40 mg 1 fois par jour	pd durée de l'hospitalisation									
Antalgiques 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>pd 24 h</td> </tr> </tbody> </table>	Médicament	Durée	Paracétamol Perfalgan Perfusette : 1 g x 4 par jour	pd 24 h	Autres Prescriptions 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	pd 24 h									
Kinésithérapie respiratoire 1 fois par jour										
Kinésithérapie de mobilisation 1 x par jour										
Reprise traitement <table border="1"> <thead> <tr> <th>Médicament</th> <th>Reprendre</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> </tbody> </table>	Médicament	Reprendre			Paraclinique 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										
Ventilation 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).

Création d'un nouveau bouton pour l'élément "Bloc SI"

 Création d'un nouveau bouton pour l'élément "Bloc SI"

Choisissez le mode à utiliser pour la prescription :
 Prescription (Ajout de contenu) ou Protocole (Remplacement de contenu)

4.7.5.20665

3.18.3 Creating a POST OP protocol

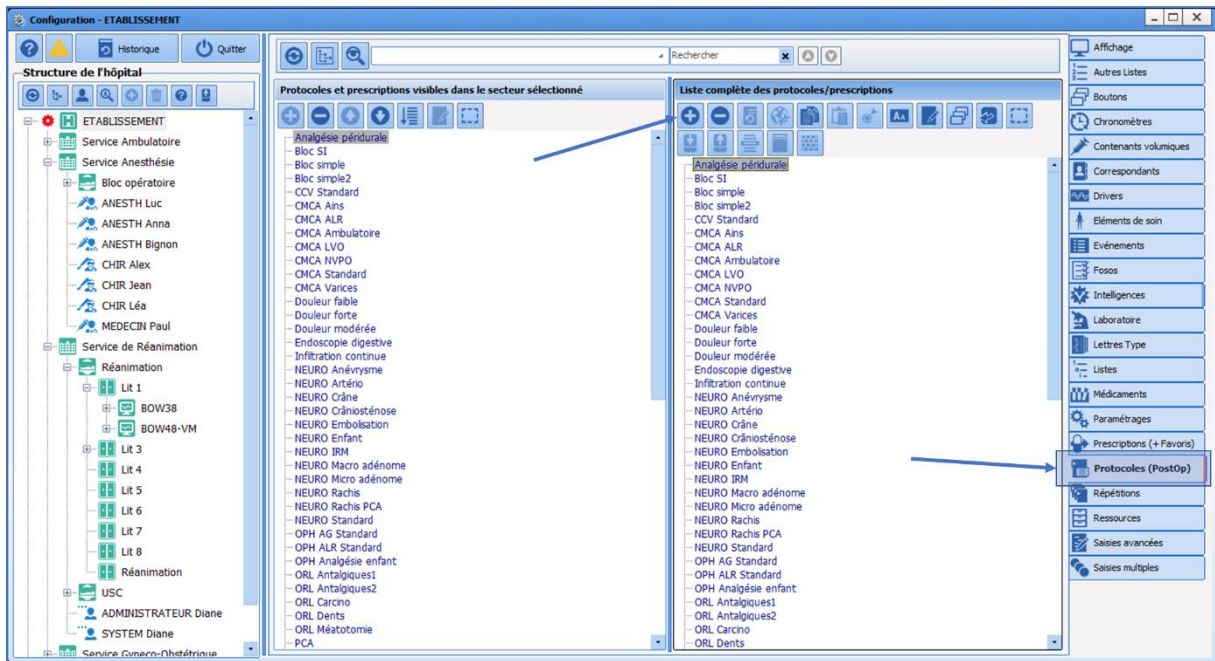
In the **Protocols (PostOp)** tab, click : this brings up the form as configured in the **VISUAL** tab.




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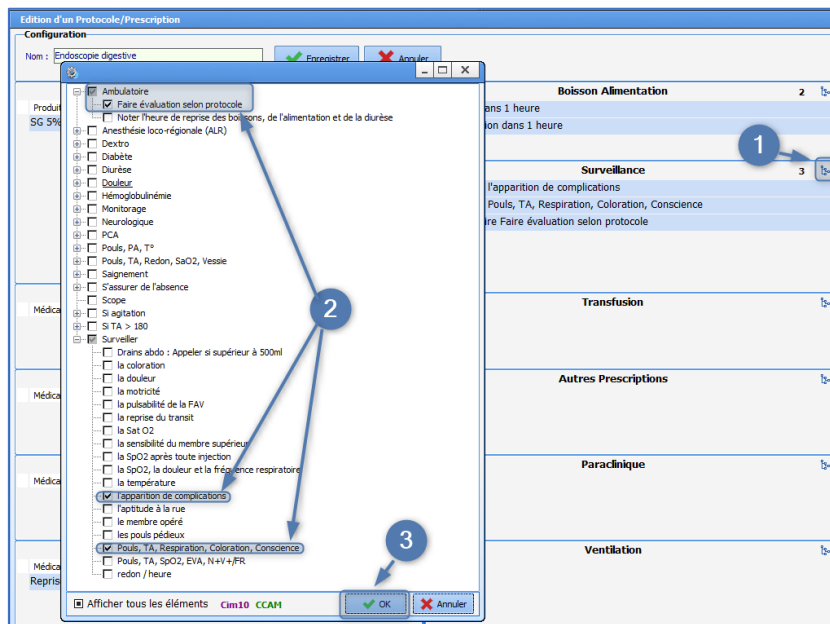


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To create the protocol or medication order, the various medication order fields must be completed. There are several ways to do this:

- 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**




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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 modify items in a protocol or medication order. After modifying or creating a protocol or medication order, click **Save**.

Réanimation		1
Produit de remplissage	Durée	
SG 5% 250ml	jusqu'à reprise alim	

Boisson Alimentation		2
Boisson dans 1 heure		
Alimentation dans 1 heure		

Surveillance		3
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

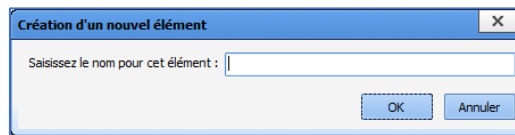
This tab contains all the images, models, procedures, nursing and medical protocols, print templates and videos set up in the program:

- **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)

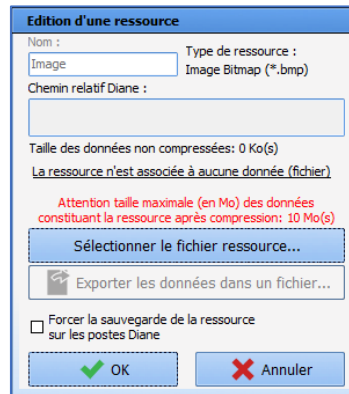


To import a new file, select the file type to be inserted from the drop-down list:

- Click  (Create a new resource).
- Enter the name of the new item.

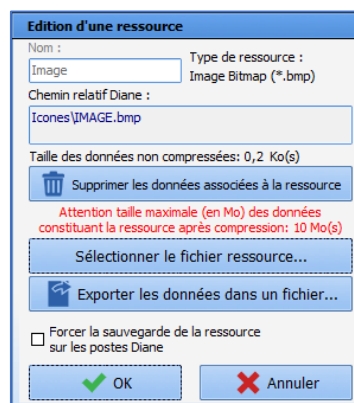


- Click **Select the resource file.**



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).



3.20.1 Enable a custom header for HTML prints

It is possible to enable a custom header for “HTML” prints. For this, an XSL file with the required changes to the default header is required.

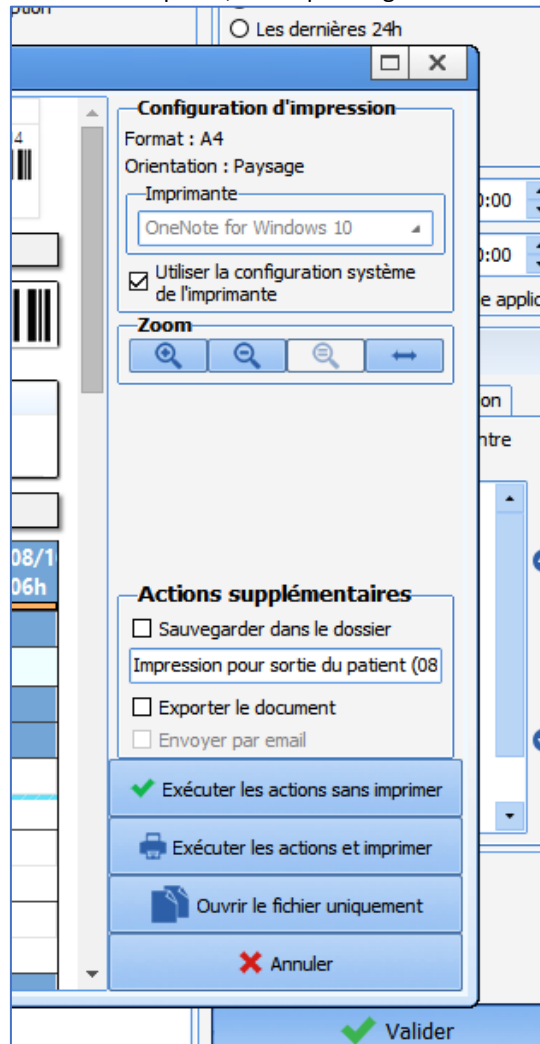


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This principle is applicable to all “HTML” prints, corresponding to the use of this window:

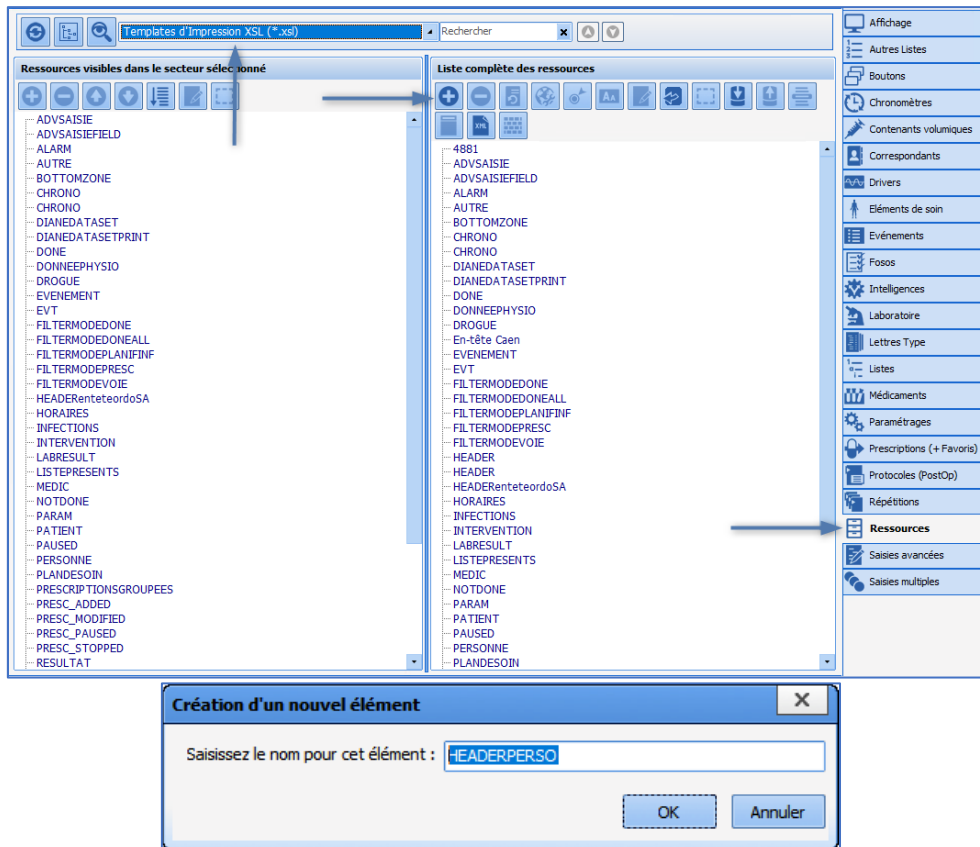


In this example, the XSL file provided is named “headerperso.xsl”, but the name can be different and more specific, e.g. “headerprescription.xsl”). Note: the file name is important for subsequent set-up. All the following steps must be carried out in the configuration tool.

- **Importing the resource**

Go to the **Resources** tab, **XSL print templates** category and create a new resource.

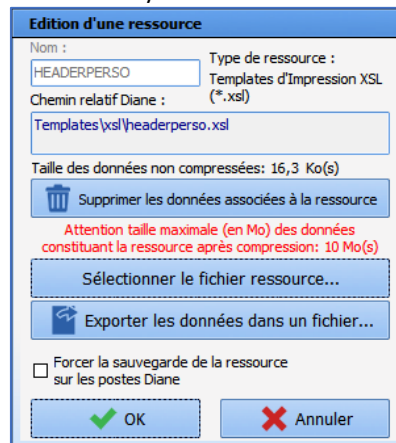




It is important to ensure consistency with the file name provided (here “headerperso.xml”) to avoid confusion later. For this example, the resource is therefore named “HEADERPERSO”.

Ensuring consistency between the resource name and the file name is strongly recommended. Most 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 enabled.

- **Header activation**

Activation is set up in the **Settings** tab, **Printing** category.

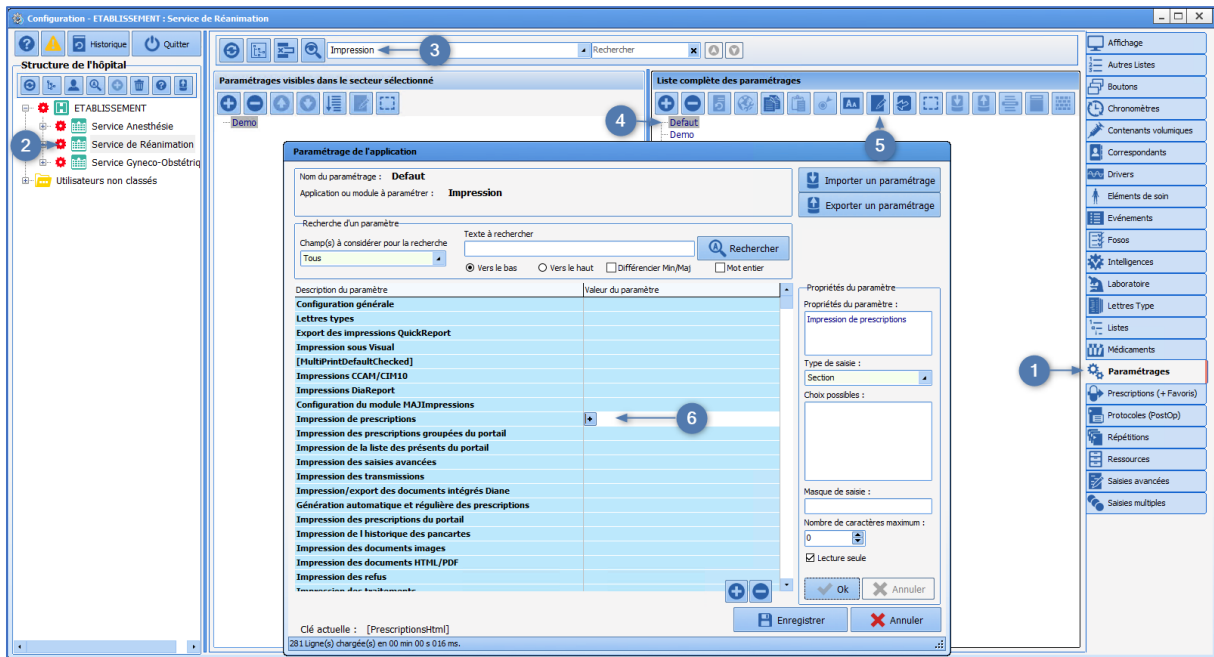
Edit the corresponding configuration at the required location in the tree structure.



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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 enabled (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
Impressions DiaReport	
Configuration du module MAJImpressions	
Impression de prescriptions	
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
Impression des prescriptions groupées du portail	

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 enabled (in this example, a medication order).



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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


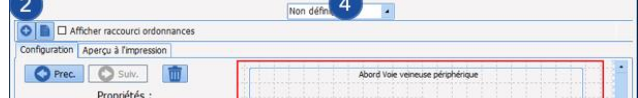
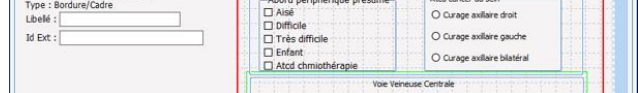
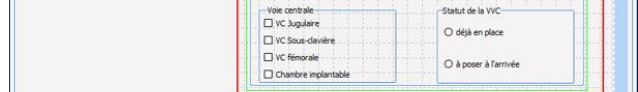

1. Input box for description of the detailed entry	
2. Addition of a new component	




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3. Associate the detailed entry with an icon	
4. Determine whether the entry is restricted to a specific role	
5. Advanced settings button for selected component	
6. "Parent" detailed entry: integration of a pre-existing detailed entry into the detailed entry currently being edited	
7. Ability to: <ul style="list-style-type: none"> - Select the position of the title of the selected component - Hide the title of the selected component 	

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 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
- Checkbox
- One-line input field
- Multi-line input field
- Drop-down menu
- Radio button group
- Checkbox 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



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Libellé

For adding **text**.
Text is entered in the **Label** portion.

Score permettant d'évaluer la probabilité
de nausées / vomissements post- opératoires (NVPO)

Case à cocher

Adds a **checkbox**.
Enter its name in the Urgence
Label checkbox.

Menu déroulant

Adds a **drop-down menu**.
Enter its name in the **Label** checkbox.

type de respirateur
Primus
Perseus

The various
values are
defined as
follows:
1=...
2=...

Liste de choix possibles :
1=Primus
2=Perseus

Bordure/Cadre

Creates a **border/frame** (appearance)
A title (*label*) must be associated.

Bouton

Adds a **button** with which a behaviour can be
associated (context-based information retrieval,
printing, etc.)

Impressions

Bouton (AX)

Do not use this button.

Bouton de valeurs prédéfinies

Adds a **button** that can be associated with **default**
values.

Donnée Diane

Displays data entered in a record (lab, vital signs).

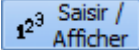
Saisie d'évènement via bouton

Equivalent to an **event entry button** (like
shortcuts).

Affichage des dossiers du patient sous forme de texte

Displays patient **records** in **text** format.



Champ de saisie avec liste de référence (AX)	Used to enter data from reference lists .
Sous-score	This component makes it easy to enter a score in a detailed entry . Simply select the desired score and size the component. Click the  button to display the score entry window.
Sous-score (affichage intégré)	Like above, this component makes it easy to enter a score in a detailed entry. Simply select the desired score and size the component. Unlike with the previous component, scores are entered directly in this one .

3.21.1.4 Change a detailed entry

A detailed entry used in production can no longer be modified. 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 for editing all the detailed entries of this component: "bilanspecifiques". This tag is used to edit only the checkboxes 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.



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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 the detailed entries used is “examenspecifique”.

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"> - Hide label - Include value in a calculation - Set the field to read-only and result of calculation - Mandatory field - Child data (OB-GYN module) 	
<p>9. Access to calculation settings and score legend 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.

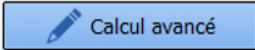
For drop-down menus, checkbox groups and radio buttons, these have been written as:

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 checkboxes can have several selections in the same component.

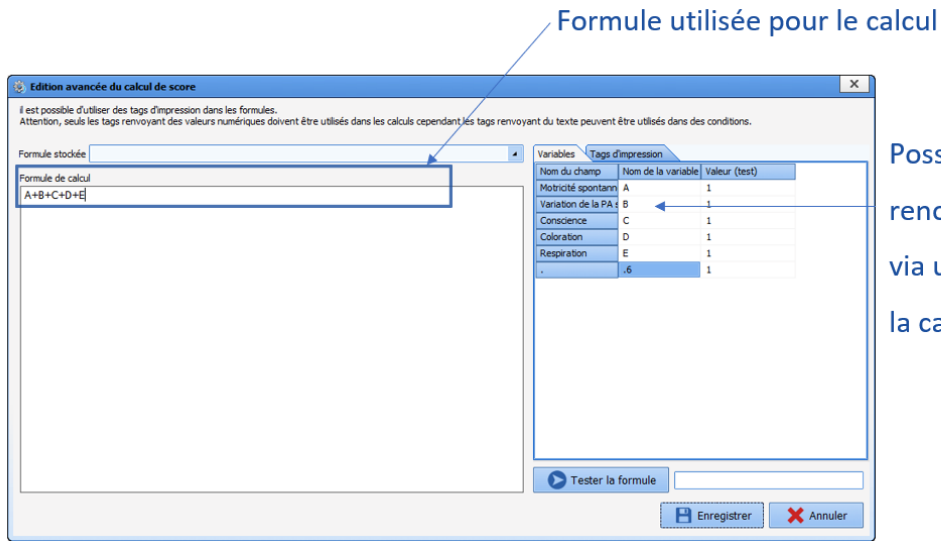
- Use  to access the calculation formula settings
- The name of the variables includes the title of the components by default. They can be rewritten to simplify writing the formula in the dedicated pane.
- Write calculation formula
- Test formula



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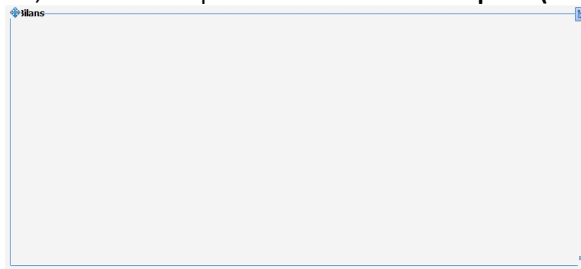
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3.21.5 Display modes for detailed entries in consultation


3.21.5.1 Viewing Laboratory tests detailed entries

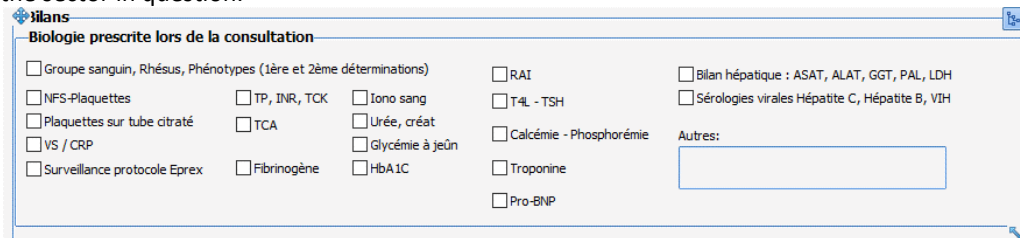
In the consultation module, there is a component named **BilanGroupBox (Test)**.



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 Tags 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.



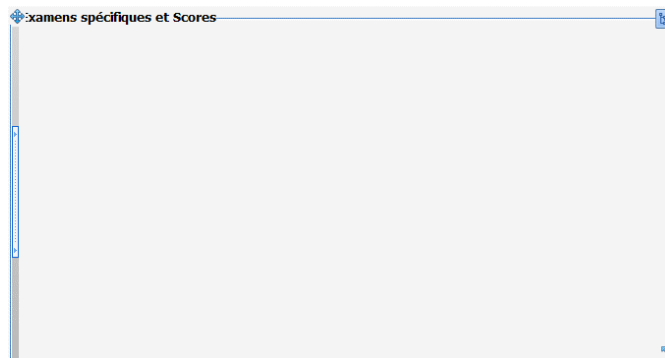
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3.21.5.2 Viewing Specific examinations detailed entries

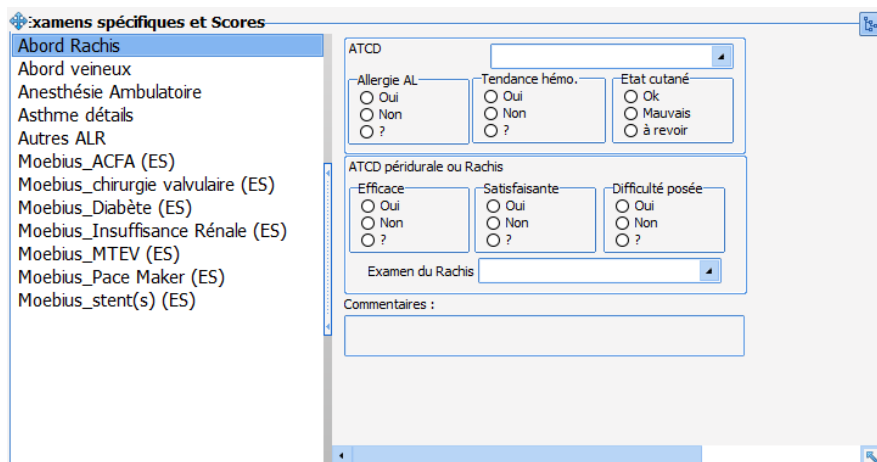
In the consultation module, there is a component named **ExamenGroupBox (Examination)**.



Right-click to access the settings window and determine the **parent tab**, **title** and various additional functions.

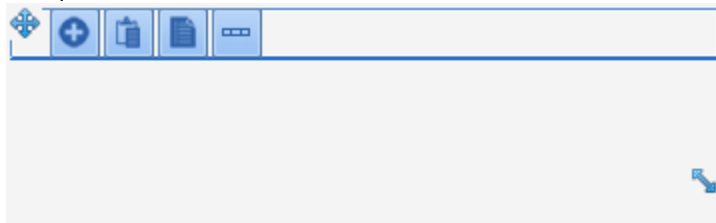
To position it in the tab, move it and click a second time in the required place. The arrow found bottom right is used to change the height and width of the component.

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 **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.



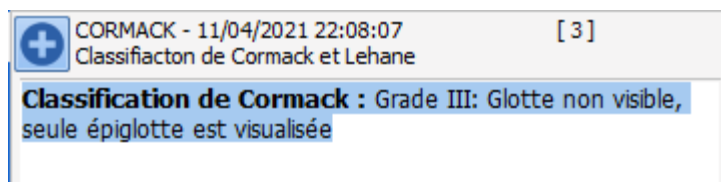
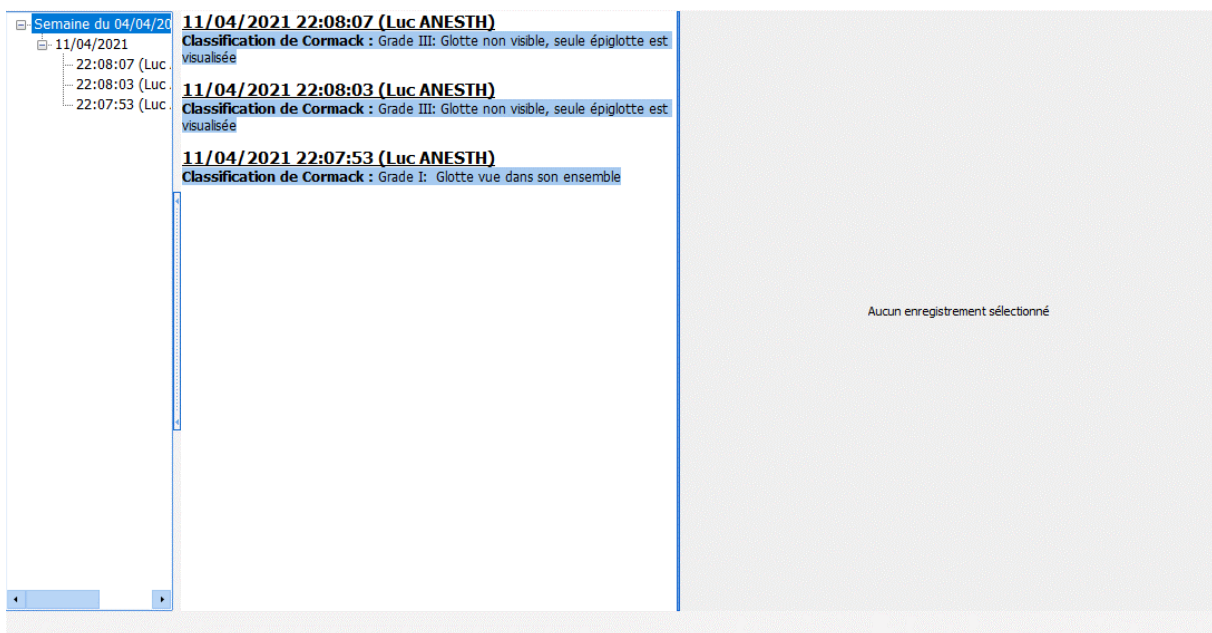
The container is used to view **Detailed entries** and **Scores** detailed entries. A single detailed entry can be viewed per tab. It is possible to add as many tabs as detailed entries required.

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 **Doctor** or **Paramedical** type tabs and in **Dispo 3** type tabs, in three different forms.



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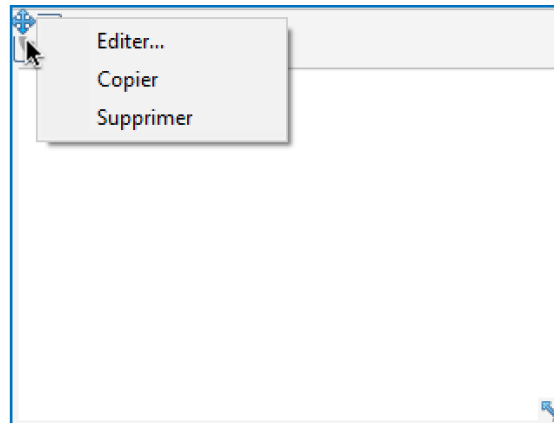


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3.21.6.1 Basic view (Detailed entry basic view)

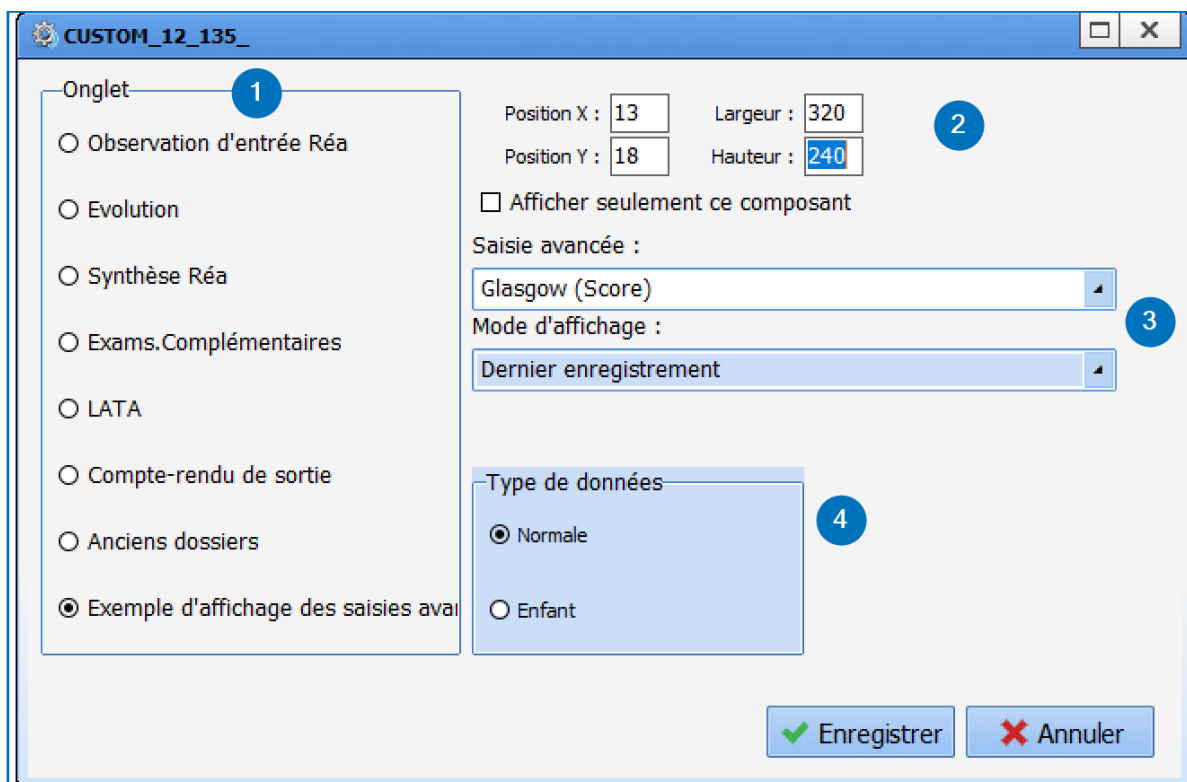
In this view, only one **detailed entry** can be selected. This is used to show a summary of data entered but also to restrict the display so that only the score result is seen, for example.

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 **View this component only** option is used to adjust to the size of the screen automatically.
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**.

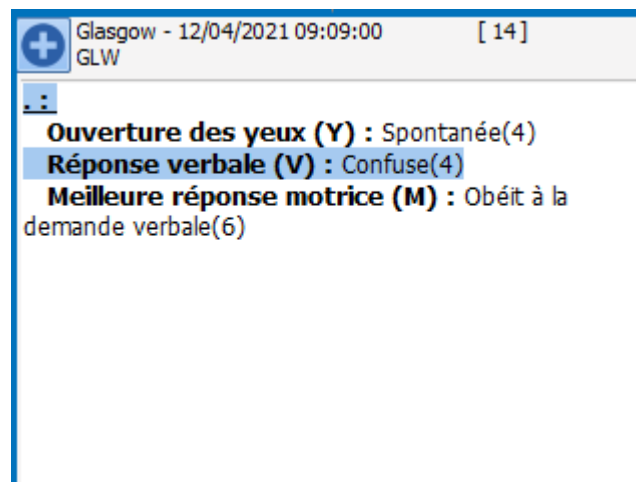


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Preview of view:



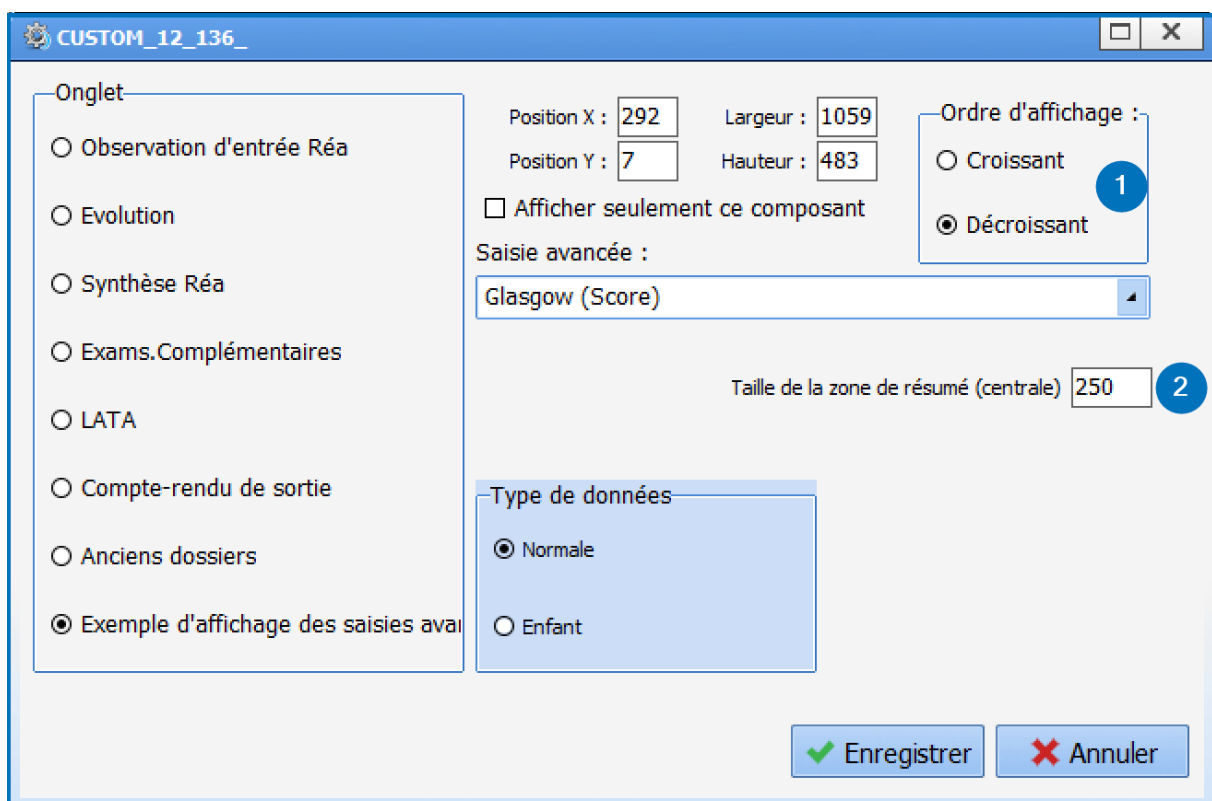
3.21.6.2 Multiple view (Detailed entry multi-view)

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.



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Preview of view:

The screenshot shows a software interface for entering Glasgow Coma Scale data. On the left, a sidebar displays a calendar view for the week of 11/04/2021 to 18/04/2021, with a selected entry for 12/04/2021 at 09:09:00 (Luc ANESTH). The main area shows the entry details for '12/04/2021 09:09:00 (Luc ANESTH)'. The patient name is 'Glasgow GLW', and the entry was made by 'Luc ANESTH'. The date and time of occurrence are '12/04/2021' and '09:09:00'. The total score is '14'. The entry is categorized as 'Ouverture des yeux (Y) : Spontanée (4)', 'Réponse verbale (V) : Confuse(4)', and 'Meilleure réponse motrice (M) : Obéit à la demande verbale(6)'. Below this, there is a section titled 'SCORE DE GLASGOW' with three columns of radio button options: 'Ouverture des yeux (Y)' (Spontanée(4), A la demande(3), A la douleur(2), Aucune(1)), 'Réponse verbale (V)' (Orientée(5), Confuse(4), Inappropriée(3), Incompréhensible(2), Aucune(1)), and 'Meilleure réponse motrice (M)' (Obéit à la demande verbale(6), Orientée à la douleur(5), Evitement(4), Décortication(3), Décérébration(2), Aucune). A 'Modifier' button is located at the bottom right.

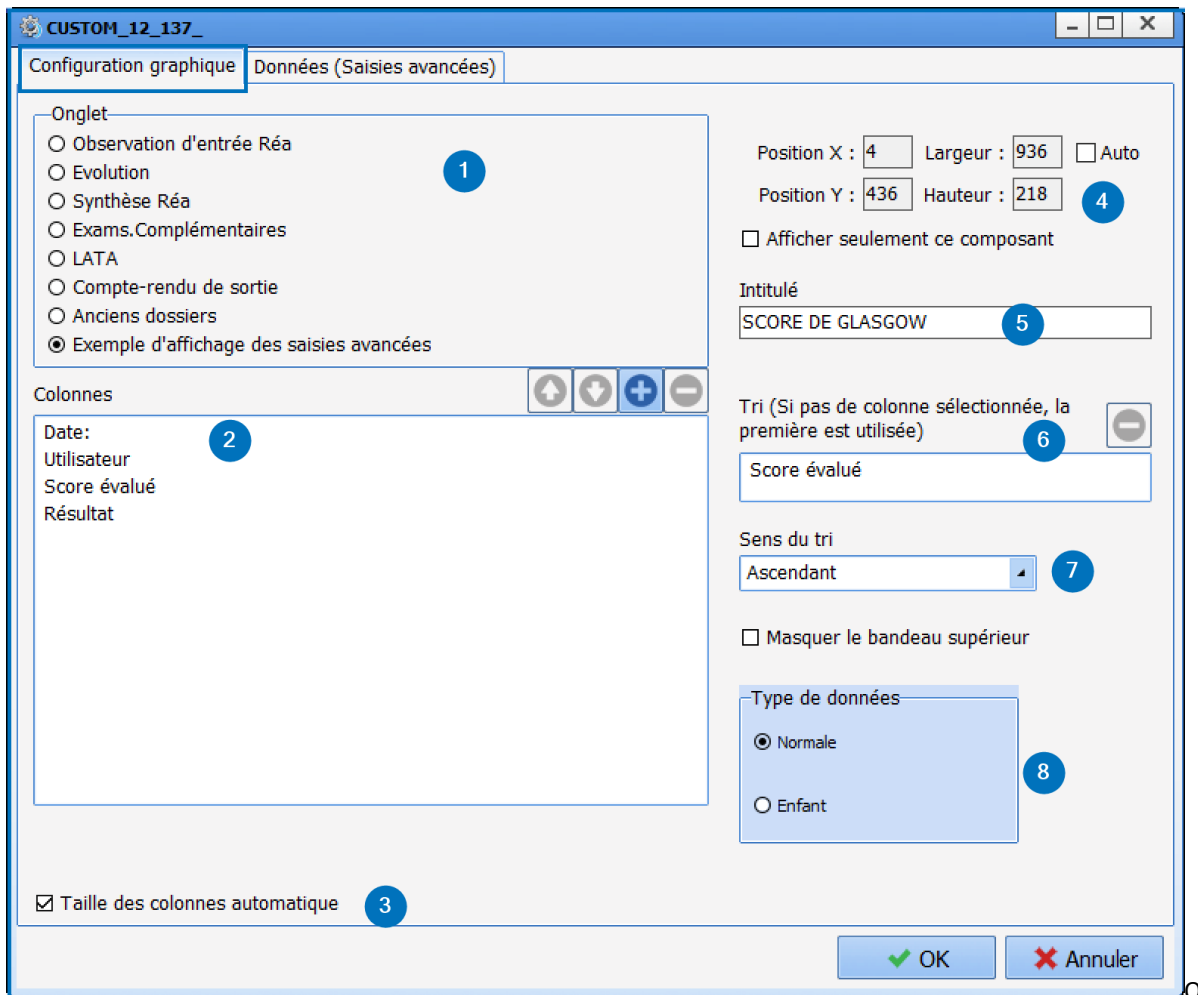
3.21.6.3 Detailed entry table (Display detailed entries as list)

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](#)

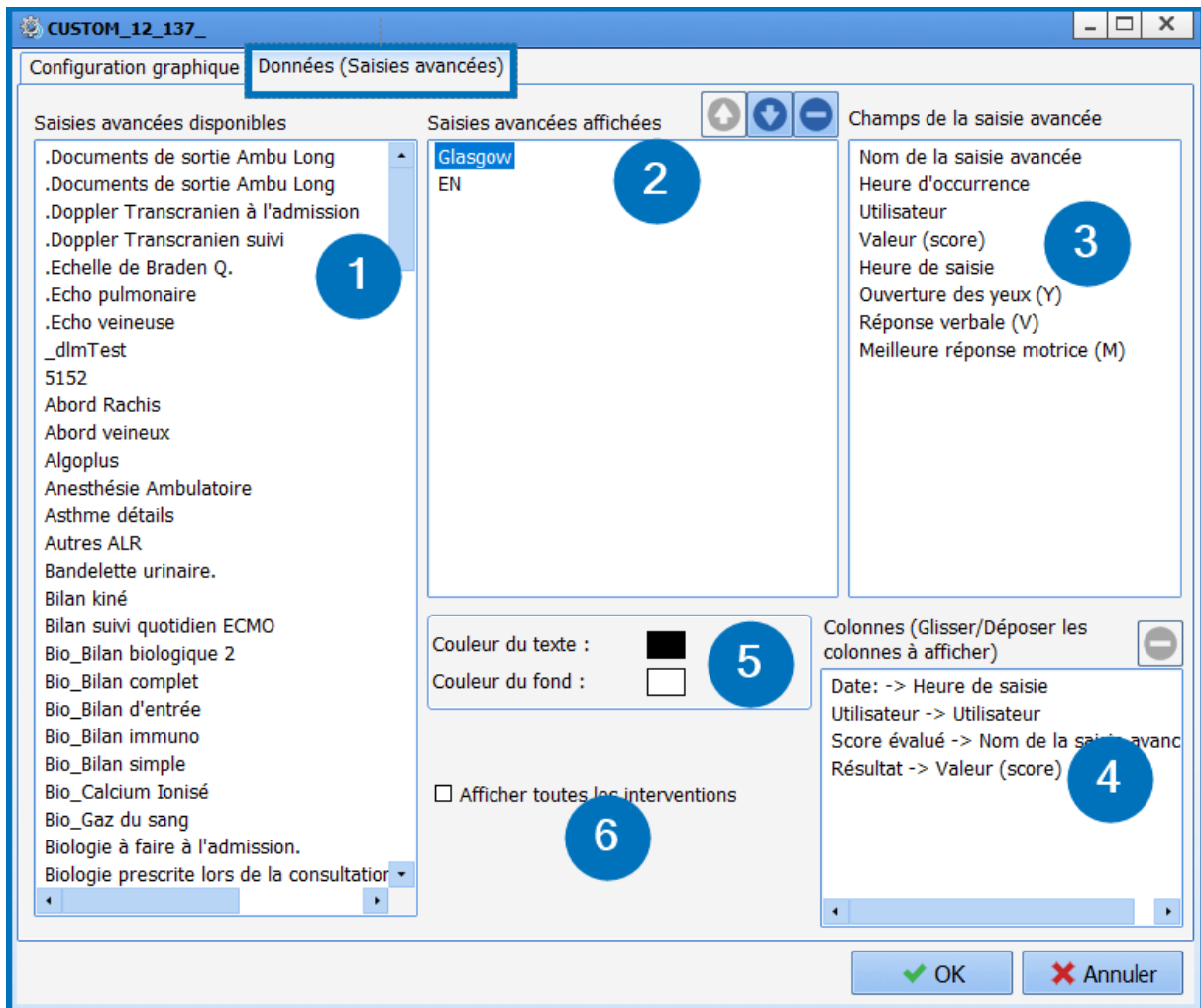




The settings window has two subtabs:

- **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 chose 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 surgeries:** this option is used to repeat all entries, not only for the current record but for all patient records.

Preview of view:

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



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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.



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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 search bar for 'Nom Saisie Multiple' with the value 'SM Perfusion'. Below this is a menu with 11 tabs: Médicament, Environnement, Prélèvement, Saisie avancée, Séparateur, Consommable, Evénement, Complication, Saisie Multiple, Donnée manuelle, and Élément de soin. To the right of these tabs are buttons for 'RAZ temps', 'Enregistrer', and 'Annuler'. The main area contains a list of items, each with a checkbox, a text field for the item name, and a time slider. 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), 'Obtuteur' (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:

Médicament	Add a drug, fluid balance or blood product from the Drugs 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.
Environnement	Add an item from the Environment tree structure on the Events tab.
Prélèvement	Add an item from the Sample tree structure on the Events tab.
Saisie avancée	Add a Detailed entry or Score from the Detailed entries tab.
Séparateur	Add a separator row between blocks to improve readability.
Consommable	Add an item from the Consumables tree structure on the Events tab.
Evénement	Add an item from the Events tree structure on the Events tab.
Complication	Add an item from the Complications tree structure on the Events tab.



Saisie Multiple	Add an existing multiple entry.
Donnée manuelle	Add a manual entry.
Élément de soin	Add an item from the Care items 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.

- Reset scheduling (see 9).
- Save and quit multiple entry editing.
- Quit multiple entry editing without saving.
- 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

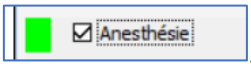
In the case of an **Undetermined** item, the box is replaced by a black square: in use, the box will be selected when the item has been specified.

- Types of item added to the multiple entry.
- Names of items added to the multiple entry. If only the category of the item is entered, the item **Undetermined** is shown. The user must enter it when entering the multiple entry.
- Route and quantity for drugs.
- 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** key is used to move all items at once. The change in time is shown to the right of the cursor.
- Settings for chained multiple entries (proposal(s) done 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.
- 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 Setups

4.1 Key principles of settings

4.1.1 Consultation

Paramétrage de l'application

Nom du paramétrage : **Demo 1280x800 EMed Optim**
Application ou module à paramétrer : **Consultation**

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
Configuration générale	+
Configuration de l'envoi des traitements en relais ou prescription d'	
Interaction avec le module RDV	
[DEBUG]	
Impressions	
Fenêtre de sélection de patient	
Informations obligatoires à la création d'intervention	
[COLOR]	
[Pnl_Tricolore]	
[Lst_Sejours]	
[DiaLabResultListe]	
[Bvl_TopIntervention]	
[Bvl_TopPatient]	
[Btn_CPA_Enreg]	
[Btn_CPA_Cancel]	
[Btn_CPA_Print]	
[Btn_Options]	
[Btn_CPA_Nouvelle_interv]	
[Edt_CPA_NOM]	
[Edt_CPA_NOMSecond]	
[Edt_CPA_...]	

Propriétés du paramètre

Propriétés du paramètre :
Configuration générale

Type de saisie :
Section

Choix possibles :

Masque de saisie :

Nombre de caractères maximum :
0

Lecture seule

Ok Annuler

Enregistrer Annuler

Clé actuelle : [GENERAL]
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 computer location on starting consultation (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)	
Clé actuelle : [GENERAL]	

This setting requests confirmation that the computer is in the right location: it 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)	



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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 launch automatic resumption when creating a new operation (AskForRepriseAuto)

Demander pour lancer la reprise automatiquement lors de la création d'une nouvelle intervention	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 resumption strategy when creating 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

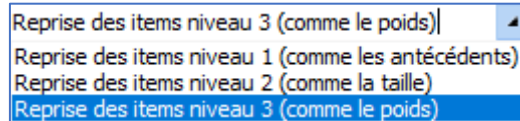
4.1.1.1.7 Resumption level from which items are copied in the consultation (DefaultNivReprise)

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 resumption level (1, 2 or 3) from which items are copied to the consultation



when a new consultation is created.



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 (Antécédents obstétricaux à l'ille	0

This setting determines the **Word** printing used by default. If the setting is set to 1 (yes), the document configured using **Configuration, Form letters** tab/**Print the entire POA** is used.

4.1.1.3 Patient selection window

Date RDV	Statut...	IPP :	Nom de naissance	Nom usuel	Prénom	Date naissance
DIA	inconn...	7510174	ANGELO		Marc	07/09/1953
DIA	inconn...		ANGELIN		Francis	01/01/1970

4 patient(s) trouvé(s)

The patient selection window for the consultation can be configured via setup keys.



Description du paramètre	Valeur du paramètre
Fenêtre de sélection de patient	-
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

This setup can also be done on the graphic display, accessed via **Advanced configuration/Patient selection**

4.1.1.3.1 Configuration of columns

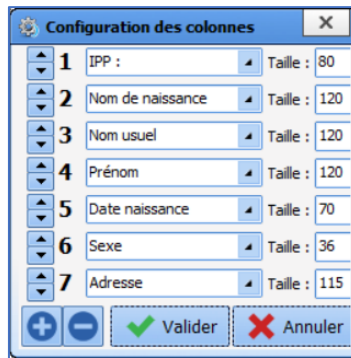
This interface makes column configuration easier:



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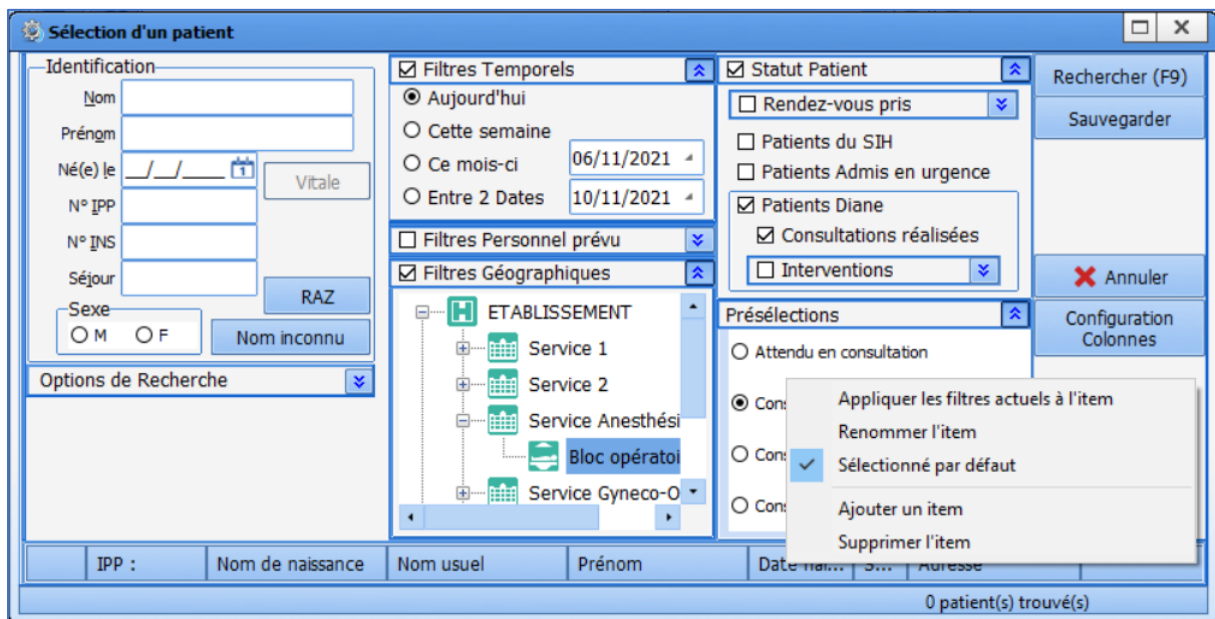


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4.1.1.3.2 Preset configuration

It is possible to configure presets (filter favourites).

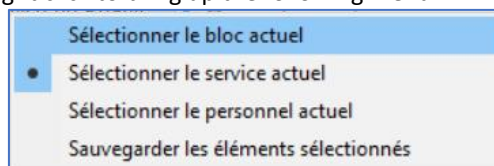


Right-clicking a preset item shows a menu to:

12. Apply the current search criteria to the item: used to modify an existing preset or apply filters to a new preset.
13. Rename item: used to modify/correct the name of a preset.
14. Selected by default: used to select the preset that is applied on opening the patient selection window.
15. Add an item: used to create a new preset.
16. Delete item: used to delete the selected preset.

Specific case: location filter

To save the location filter, right click to bring up the following menu:



Once the location filter has been configured, select the appropriate option:

17. Select the current OT: selects the OT in which the computer is located
18. Select the current unit: selects the unit in which the computer is located
19. Select current staff: shows patients for whom the consultation was carried out by the current user
20. Save the selected items: selects the configured OT(s) or unit(s), regardless of computer location.

4.1.1.4 Mandatory information for surgery creation

4.1.1.4.1 Make entering date of birth mandatory for authorising creation request (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 Make entering patient's sex mandatory for authorising creation request (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 Make entering scheduled surgery type mandatory for authorising creation request (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 Make entering scheduled surgery date mandatory for authorising creation request (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 Make entering hospitalisation date mandatory for authorising creation request (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)	

This setting makes entering the scheduled admission date mandatory for authorising a surgery creation.

4.1.1.4.6 Make entering scheduled surgeon for authorising creation request (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 Make entering scheduled anaesthetist mandatory for authorising creation request (NeedPreviousAnesth)

Rendre obligatoire la saisie de l'anesthésiste prévu pour autoriser la demande de création	0
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 Hospitalisation date in "Scheduling of new surgery" window (UseNormalDateHosp)

Date d'hospitalisation dans la fenêtre "Programmation d'une nouvelle intervention"	0
UseNormalDateHosp (Date d'hospitalisation dans la fenêtre "Programmation d'une nouvelle intervention")	

4.1.1.4.9 Make entering requesting unit mandatory for authorising creation request (NeedServiceDemandeur)

Rendre obligatoire la saisie du service demandeur pour autoriser la demande de création	0
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
Configuration générale de DianeRéa	
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'informations prévue par interface	1

Clé actuelle : [GENERAL]

328 Ligne(s) chargée(s) en 00 min 00 s 016 ms.



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4.1.2.1 DIANEICU general configuration

4.1.2.1.1 Request confirmation of computer location on starting application (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: it is important in particular for emergency stations.

4.1.2.1.2 Time in minutes to wait before the application 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)	

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 Upper ribbon display mask (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 verification bar in DIANE ICU.

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

Setup keys are found in *Information tags shown in ribbon of Visual/DIANE ICU/ DIANE OB-GYN.*



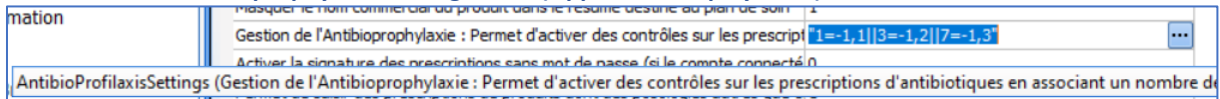
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4.1.2.2 Medication order

4.1.2.2.1 Antibiotic prophylaxis management (UpperBandDisplayMask)



This setting is used to enable controls on antibiotic medication orders by associated a number of days with a DIANE template ID and/or internal form ID to be associated with the entry.

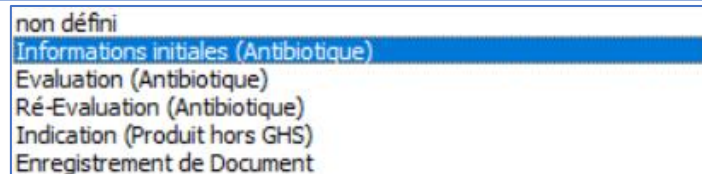
Paramétrage des saisies complémentaires de prescription

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.

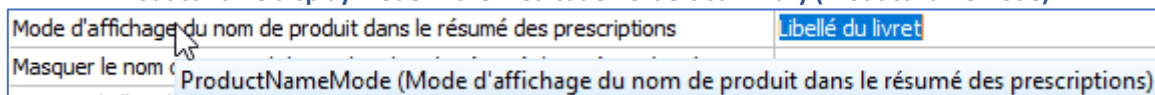
Note : Vous pouvez éditer/ajouter des modèles de document via l'onglet des lettres types dans l'outil de configuration (section "Lié à une prescription (Réa)")

	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)

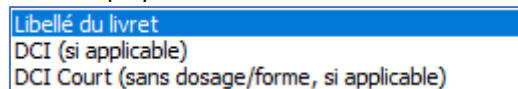
OK Annuler



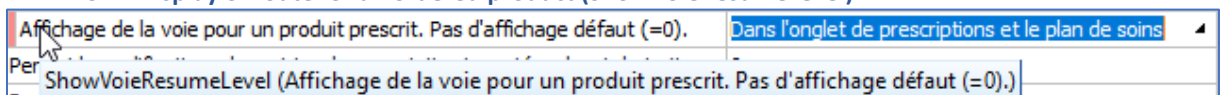
4.1.2.2.2 Product name display mode in the medication orders summary (ProductNameMode)



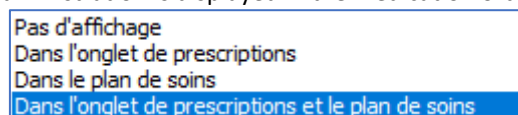
Defines how the product name is displayed in the medication orders summary.



4.1.2.2.3 Display of route for an ordered product (ShowVoieResumeLevel)



Defines how the route of administration is displayed in the medication orders summary and/or care plan.



4.1.2.2.4 Drip rate coefficient limitation on care plan relative to initial medication order (LimitRateChangeAfterPrescriptionCoef)

Limitation en coefficient de débit de perf sur le plan de soins par rapport à la pr	2	Nombre Entier
LimitRateChangeAfterPrescriptionCoef (Limitation en coefficient de débit de perf sur le plan de soins par rapport à la prescription initiale (2 par défaut))		

Defines the coefficient between the flow rate ordered by the doctor and the flow rate entered by the registered nurse during administration. The coefficient is set to **2** by default, but it can be changed to **1** to prevent entry of a flow rate different from that entered by the doctor.

4.1.2.2.5 Request signature of medication orders on tab change (RequestSignOnTabChange)

Demander la signature des prescriptions au changement d'onglet : 0=non, 1 = 1	<input checked="" type="checkbox"/>
RequestSignOnTabChange (Demander la signature des prescriptions au changement d'onglet : 0=non, 1 = oui (1 par défaut))	

Defines whether the application will display a message when a user exits the **Medication order** tab although the day's medication order has not been signed. It is highly recommended to leave key set to **1** so as to prevent a doctor from forgetting to sign the medication order.

4.1.2.2.6 Internally reset the care plan schedule when an undefined time is applied (=similar to 'urgent' but with the possibility of moving the occurrence). Enabled by default (=1) (FreeStartOrApplyDateTimeResetCarePlanSchedule)

L'application d'une heure non définie réinitialise en interne la planification du pl	<input checked="" type="checkbox"/>
FreeStartOrApplyDateTimeResetCarePlanSchedule (L'application d'une heure non définie réinitialise en interne la planification du plan de soins (=fonctionnement similaire à "urgent" mais avec la possibilité de déplacer l'occurrence). Activé par défaut (=1).)	

Determines what a signed medication order does when it is edited and the **Undefined time** box is ticked. If the key is enabled, signing the medication order resets the care plan and generates a new care plan occurrence at the current time. If the key is disabled, signing the medication order does not generate a new care plan occurrence at the current time. The first occurrence that has not yet happened may be moved.

4.1.2.2.7 Restrict on-demand administration to authorized favourites. Disabled by default (=0) (UseOnlyAuthorizedShortcutsForAdministrationOnDemand)

Restreindre l'administration à la demande aux favoris autorisés. Désactivé par 1	<input type="checkbox"/>
UseOnlyAuthorizedShortcutsForAdministrationOnDemand (Restreindre l'administration à la demande aux favoris autorisés. Désactivé par défaut (=0))	

Determines which products may be administered following a verbal request from a doctor. If the key is disabled, any substance in the drug formulary or drug database may be entered in the window. If the key is enabled, only on-demand administration favourites may be entered.

4.1.2.2.8 Prohibit direct administration of drugs that are not listed in either the formulary or the drug database (anaesthesia drugs listed in the formulary). (ForbidLiteralMedicsForDirectAdmin)

Interdire les médicaments n'appartenant ni au livret, ni à la banque médicament	<input checked="" type="checkbox"/>
ForbidLiteralMedicsForDirectAdmin (Interdire les médicaments n'appartenant ni au livret, ni à la banque médicament pour les "médicaments en administration directe" (médicaments structurés destinés à l'anesthésie))	

Determines whether drugs used for direct administration must be listed in the drug database or in the facility's drug formulary.

4.1.2.2.9 Use guided medication order for favourites (UseGuidedPrescriptionForShortcuts)

Utiliser la prescription guidée pour les favoris	<input checked="" type="checkbox"/>
UseGuidedPrescriptionForShortcuts (Utiliser la prescription guidée pour les favoris)	

Determines which medication order window (guided or expert) will be used when entering medication order favourites.



4.1.2.2.10 Open medication orders in guided mode by default (OpenGuidedPrescriptionByDefault)

Ouvrir par défaut les prescriptions en mode guidé	1
Section de la banque de médicaments	
OpenGuidedPrescriptionByDefault (Ouvrir par défaut les prescriptions en mode guidé)	

Determines which prescription window (guided or expert) will open when a medication order is entered.

4.1.2.3 Care plan

4.1.2.3.1 Limit in minutes for validating 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 1	
FutureCarePlanValidLimitTime (Limite (en minutes) de validation des éléments futurs du plan de soin)	
Nombre de jours de génération du plan de soin (2 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 at scheduled 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 allows manual infusions scheduled to end 'x' minutes ago to be stopped automatically on the care plan or not: x=0 disable autostop, 1 = stop at scheduled time, otherwise stop at current time when after scheduled end.

4.1.2.3.3 Number of days of care plan generation (default = 2) (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 on the care plan.

4.1.2.3.4 Show dosage in product header on 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 dosages in product headers.

4.1.2.3.5 Syringe pump connection: disable strict checking that dilution is the same on medication order and device to be associated with a care plan occurrence (without this strict control, connection is simpler but this can lead to inconsistencies on the care plan) (DisabledCheckDeviceDilutionCompleteApplication)

Liaison au PSE : désactiver le contrôle strict de la correspondance de dilution et	<input checked="" 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 entraîner des incohérences sur le plan de soins) (1=oui, 0=non, Oui par défaut))		

This setting is used, where this is a care plan occurrence associated with a syringe pump, to disable strict checking that the dilution on the medication order is the same of that on the device to be associated with a care plan occurrence. Without this strict control, connection is simpler but this can lead to inconsistencies on the care plan. (1=yes=control disabled, 0=no=control enabled. Default=yes).



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	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	3 6
Afficher la signature de sortie de réveil comme action importante (0=Non, 1=A	Avertissement Bouton
Afficher la signature des prescriptions comme action importante (0=Non, 1=A	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	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=A	3 2
Afficher la saisie de l'IADE présent (0=Non, 1=Avertissement Bouton, 2=Avert	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=Av	0 8
Afficher la saisie de l'aide soignant présent (0=Non, 1=Avertissement Bouton,	0 8
Afficher la saisie du risque ASA (0=Non, 1=Avertissement Bouton, 2=Avertisse	0 2
Afficher la saisie du type d'anesthésie (0=Non, 1=Avertissement Bouton, 2=Av	0 2
Afficher la saisie du type d'intervention (0=Non, 1=Avertissement Bouton, 2=A	3 2
Afficher la saisie des allergies (0=Non, 1=Avertissement Bouton, 2=Avertisse	0 2
Liste des événements (ou catégorie) importants (A configurer comme suit : Com	
Liste des scores importants (A configurer comme suit : Comportement(0=Non,	
Afficher la saisie de l'IGS2 (0=Non, 1=Avertissement Bouton, 2=Avertissement	0 8

Important actions are used to make certain entries in patient records mandatory. How to set up important actions is covered in *Configuring important actions*.

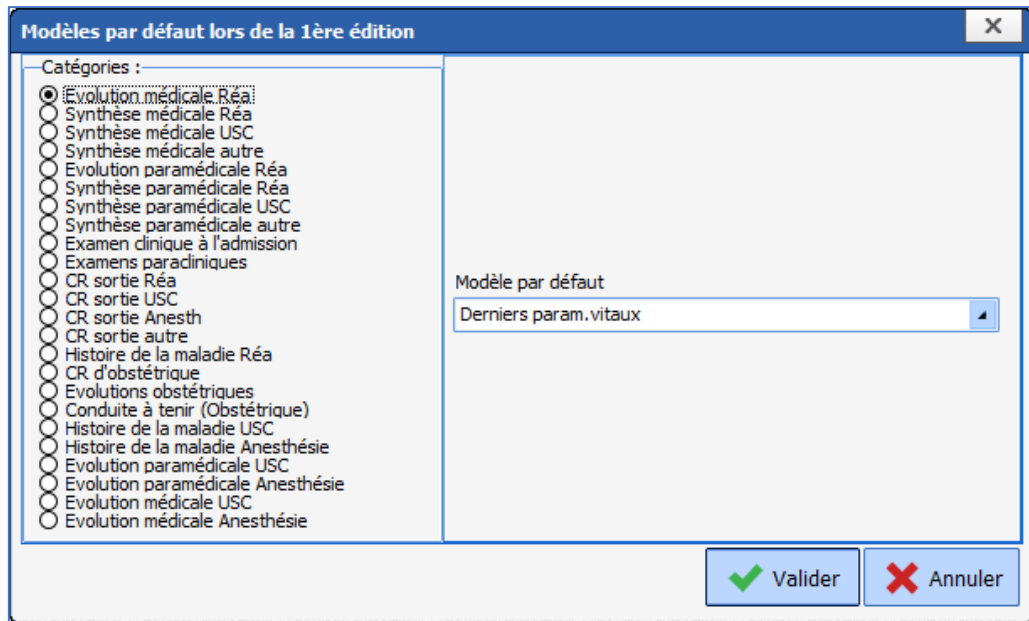
4.1.2.5 Integrated documents

4.1.2.5.1 Setting up integrated documents in DianeRea.ini

Documents intégrés	
Intervalle (en secondes) entre chaque sauvegarde locale du contenu en cours	15
Masque de l'entête ajouté automatiquement lors de l'édition	*<NEWLINE><NEWLINE><USERPRENOM> <USERNC
Modèles par défaut lors de la première édition	1028=212 1031=219 1032=229 1027=228 * ...

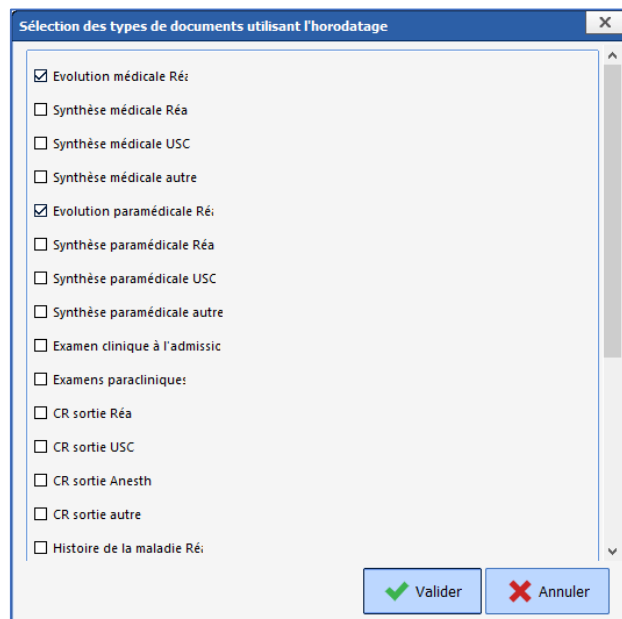
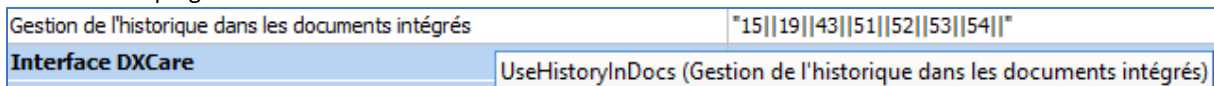
- **Interval (in seconds) between each local save of content being edited:** determines the interval at which content is autosaved on the computer to limit data loss in case of disconnection.
- **Header mask automatically added during editing:** used to modify the header added automatically when an integrated document is edited.
- **Default template during first edition:** determines the template to be integrated into the document when it is first opened for editing.





4.1.2.5.2 Setting up integrated documents in Misc.ini

This setting (in the **General configuration** section) determines the integrated documents for which timestamping is enabled.



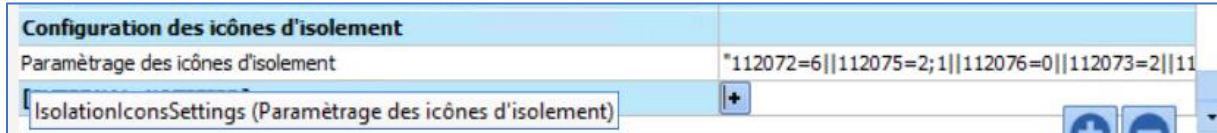
The setup key **UseHistoryInDocs** is used to enable or disable timestamping for integrated documents in **DIANE**. By default, the key is enabled for the following categories:

- Medical developments ICU
- Paramedical developments ICU
- Obstetric developments
- Paramedical developments CCU

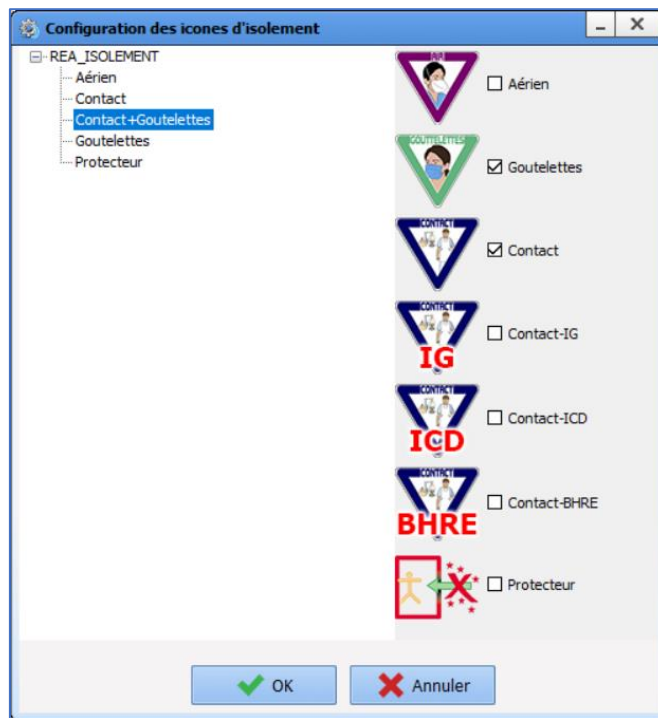


- Paramedical developments Anaesthesia
- Medical developments CCU
- Medical developments Anaesthesia

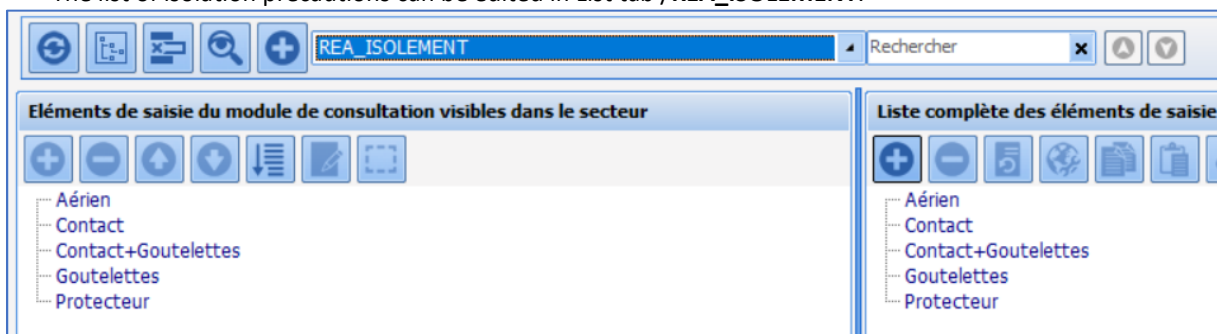
4.1.2.6 Configuration of isolation icons



Setting up isolation icons (IsolationIconsSettings) allows one or more icons to be assigned according to the type of isolation.



The list of isolation precautions can be edited in List tab /**REA_ISOLEMENT**.



4.1.2.7 Configuration of to-do list

Paramétrage de l'application

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

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
Onglet navigation	
Feuille d'ouverture et fiche inter patient	
Plan de soin	
Transmissions ciblées	
Documents intégrés	
CCAM/CIM10	
Fiche de sortie/fermeture de dossier	
Actions importantes	
Configuration du portail de réanimation	
Configuration des paramètres des fréquences cardiaques	
Configuration des icônes d'isolement	
Configuration de la liste des tâches	
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 1"
[EXTERNAL_NOTIFIER]	

Clé actuelle : [TODOLIST]

343 Ligne(s) chargée(s) en 00 min 00 sec 024 ms.

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

This setting determines the default time slot:

- **Rolling time slot** shows items for the next X hours.
- **Fixed time slot** shows items within a given time slot.

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)	5

This setting determines the start time for fixed time slots.

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 for fixed time slots.



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 Website : www.bowmedical.com



DEV-EN-035 Settings Guide **DIANE**
DIANE version: 4.12
 Medical device version: 3.38
 UDI: (01)3760404900005(10)0338
 Document version : 1

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 slot to be shown when a rolling time slot is used.

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 to be shown when a rolling time slot is used.

4.1.2.7.6 Care statuses to include (TodoFilterEtatSoin)

Etat des soins à inclure	Tous les soins
Type de soins à inclure (elements de soin planification infirmière Plan de soin)	"1 1 1 "
TodoFilterEtatSoin (Etat des soins à inclure)	

This setting is used to select the **Care statuses** filter used:

- 0=all care items
- 1=Only overdue items
- 2=Only urgent items

4.1.2.7.7 Care types to include (TodoFilterTypeSoin)

Type de soins à inclure (elements de soin planification infirmière Plan de soin)	"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 scheduling**||Care plan(=**Medication orders**)" and the value **1** to select a care type and **0** to not select a care type.



4.1.3 Visual

Paramétrage de l'application

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

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
Configuration générale de Visual	+
Gestion des pousses-seringue	
[DEBUG]	
Fiche de sortie/fermeture de dossier	
Position et taille de la fenêtre, utilisé si la clé Maximized <> 1	
Feuille d'ouverture et fiche inter patient	
Signatures	
Avertissements	
Actions importantes	
Configuration des couleurs de Visual	
[PRESCRIPTION]	
Mouvement du personnel	
Évènements automatiques lors de l'ouverture et la fermeture d'un dossier	
Graphique des médicaments	
Configuration de la fenêtre de sélection d'intervention	
Configuration de la fenêtre de sélection de patient	
Configuration de la fenêtre de sélection de patient en salle de réveil	
Configuration de la fenêtre de saisie manuelle de paramètre de ventilation	
Configuration de la fenêtre de saisie de donnée manuelle	
[COULEUR]	
Connexion à distance	
[CIM10CCAM]	

Clé actuelle : [GENERAL]
 313 Ligne(s) chargée(s) en 00 min 00 s 022 ms.

4.1.3.1 Visual general configuration

4.1.3.1.1 Request confirmation of computer location on starting intra and /or post-op (ConfigurePoste)

Demander la confirmation de l'emplacement du poste au démarrage du per et/o	1
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: it is important in particular for emergency stations. This is requested if the Visual shortcut is used to open the application (without going via the **DIANE** portal).

4.1.3.1.2 Time in minutes before the intra and /or post-op application of 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 rooms, but rooms requiring longer periods of inactivity must be taken into account.



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. Useful in recovery rooms as it encourages 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) Création 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) Modification autorisée si IPP non renseigné	
Case "Imprimer le dossier" cochée par défaut en sortie de salle	

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 the 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)	
Case "Imprimer le dossier" cochée par défaut en sortie de salle	

This setting automatically selects the **Print record** box on departure from the room.

4.1.3.1.7 Maximum duration, in hours, of an operation (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 an operation: traditionally this is less than 24 hours, but it must be modified for delivery rooms.



4.1.3.1.8 Maximum duration, in hours, of reoperation (RepriseTimeLimit)

Délai maximum en heures d'une reprise d'intervention	24
Co RepriseTimeLimit (Délai maximum en heures d'une reprise d'intervention)	

This setting determines the time during which a completed surgery can be resumed. The countdown starts from when the record is closed.

Note: this key and the previous key may be incompatible. For example, a record is closed after 12 hours of presence (OT + RR). If reoperation takes place 13 hours after closing the record, i.e. 25 hours after the start of the operation, this cannot take place as the duration of an operation on a single record would exceed the 24 hours set by the **Maximum duration, in hours, of an operation** key.

In this case, creating a new record is strongly recommended.

4.1.3.1.9 Tick the extended search in the drug search window by default (SearchDrogueEtendue)

Cocher la recherche étendue par défaut dans la fenêtre de recherche de drogu	0
C SearchDrogueEtendue (Cocher la recherche étendue par défaut dans la fenêtre de recherche de drogues)	

This setting is traditionally set to 0.

4.1.3.2 Discharge form/closing the record

4.1.3.2.1 Available rooms transfer choice (ConfigurePoste)

Choix de transfert de salle disponibles	"1 3 5,5"
Der 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 scope of **DIANE**):


Cloturer le dossier

Transférer : Réveil

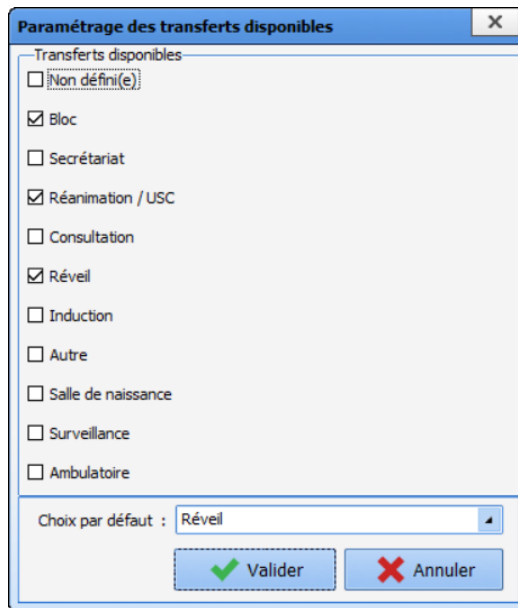
Bloc

Réanimation / USC

Réveil

Clicking the  button opens the following Setup window:





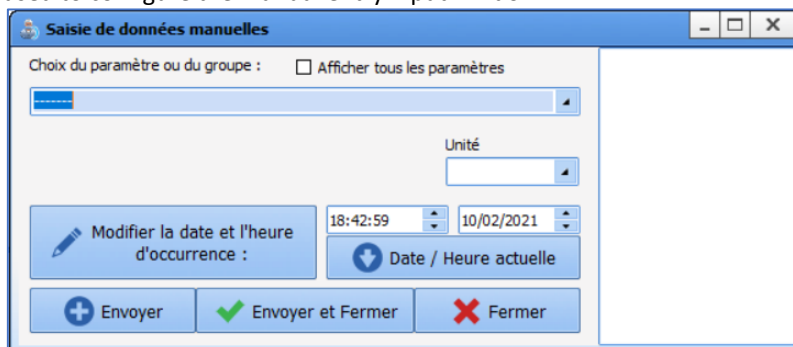
4.1.3.3 Signatures

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=non, 1=oui	0
Supprimer l'autorisation de sortie de réveil lors de la modification des prescriptions	0

4.1.3.4 Configuring the manual data 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 input window:

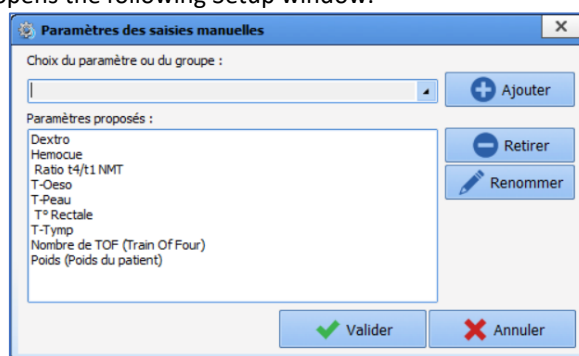


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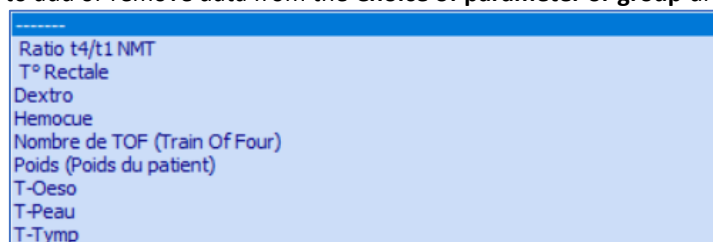


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Clicking the  button opens the following Setup window:



It is then possible to add or remove data from the **Choice of parameter or group** drop-down menu:



If **View all parameters** is selected, this is no longer taken into account and all parameters are displayed.

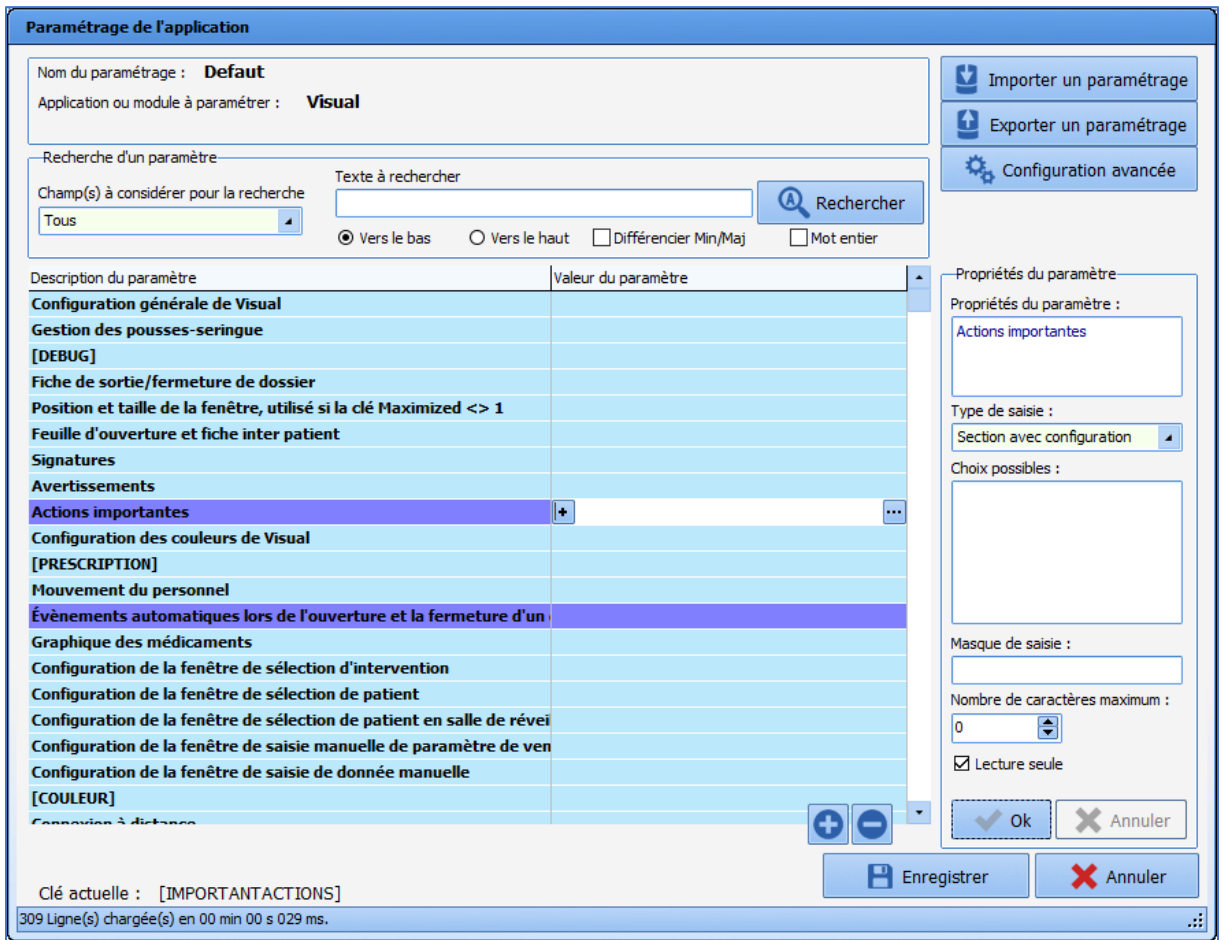
4.2 Configuring important actions

Managing mandatory and important items is essential for finding a balance between the legal obligations of some items and ease of use of the software.

To define **mandatory and important items** in **DIANE ANAESTHESIA**, open configuration and select **Settings/ Visual**. The same settings are possible for **DIANE ICU** (Settings/ DianeICU)

This settings window opens:

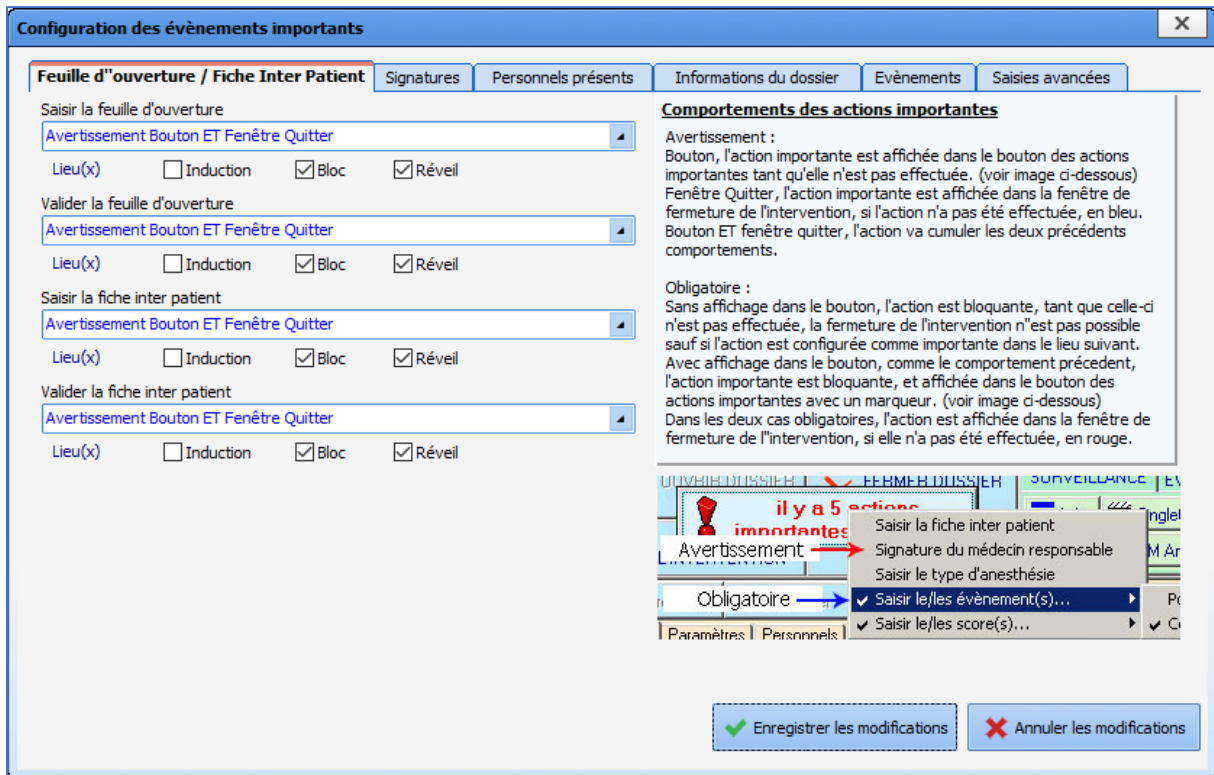




Select the first purple row, **Important actions**, and click  to the right of the row.

The **Important event configuration** window opens.





For each item, there are six possible options for level of importance (only one option can be selected):

Disabled	The item is not important or mandatory: it has no impact on the closing of the record
Button Warning	The important item appears in the red flashing button on the top ribbon of the box but does not prevent closure
Exit Window Warning	The importance of the item is mentioned on the patient discharge window but does not prevent closure
Button and Exit Window warning	Both of the previous warnings appear but do not prevent closure
Mandatory without display in the button	The item is mandatory. Not displayed in the red flashing button on the top ribbon of the box. The need to complete the item is mentioned on the patient discharge window.
Mandatory with display in the button	The item is mandatory. This is mentioned in the red flashing button and the patient discharge window.

4.2.1 Safety checklist/Inter-patient checklist

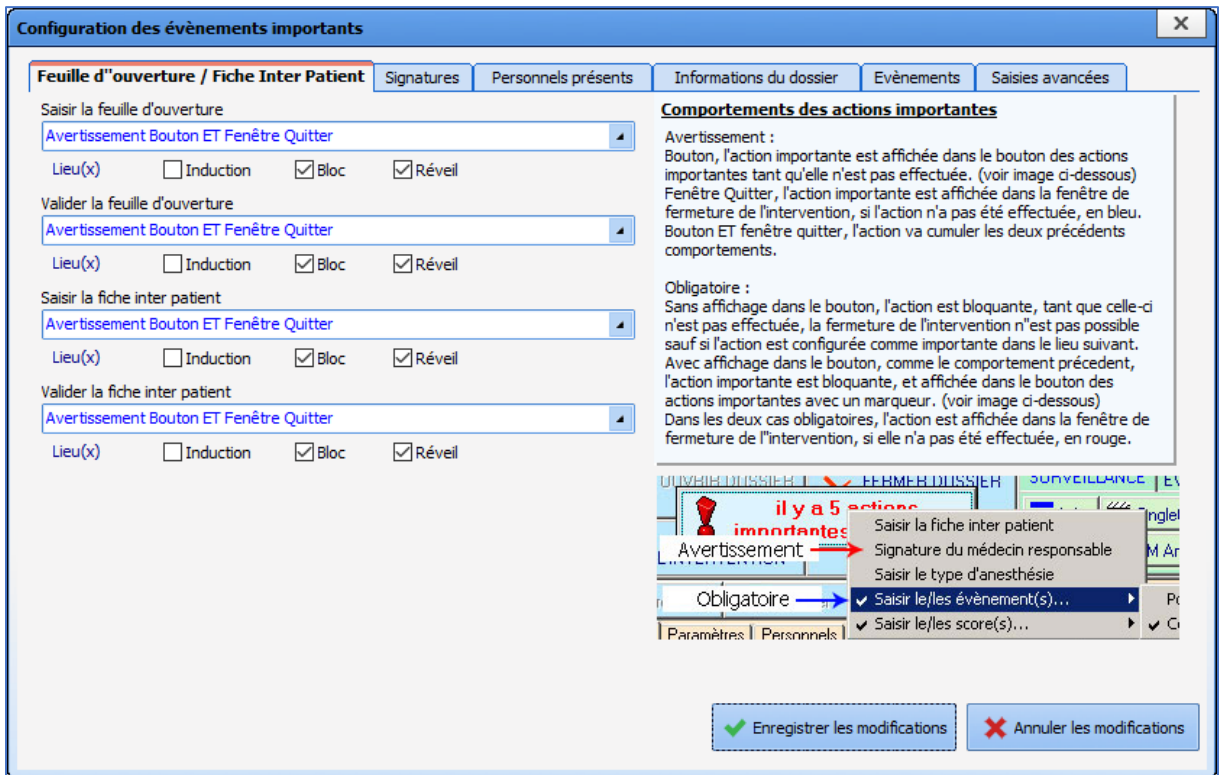
This tab concerns safety checklists and interpatient checklists



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There are four items to be configured:

Safety checklist entry	Signature of the person checking the room and equipment on opening the room
Safety checklist validation	Signature of the doctor taking responsibility
Inter-patient checklist entry	Signature of the person checking the room and equipment between two patients
Inter-patient checklist validation	Signature of the doctor taking responsibility

For each item, the level of importance must be selected (only one option can be selected): **Disabled**, **Button Warning**, **Exit Window Warning**, **Button and Exit Window warning**, **Mandatory without display in the button** or **Mandatory with display in the button**

It is then possible to select the location(s) - room type(s) - to which this setting is applied:

Induction

OT

Recovery

4.2.2 Signatures

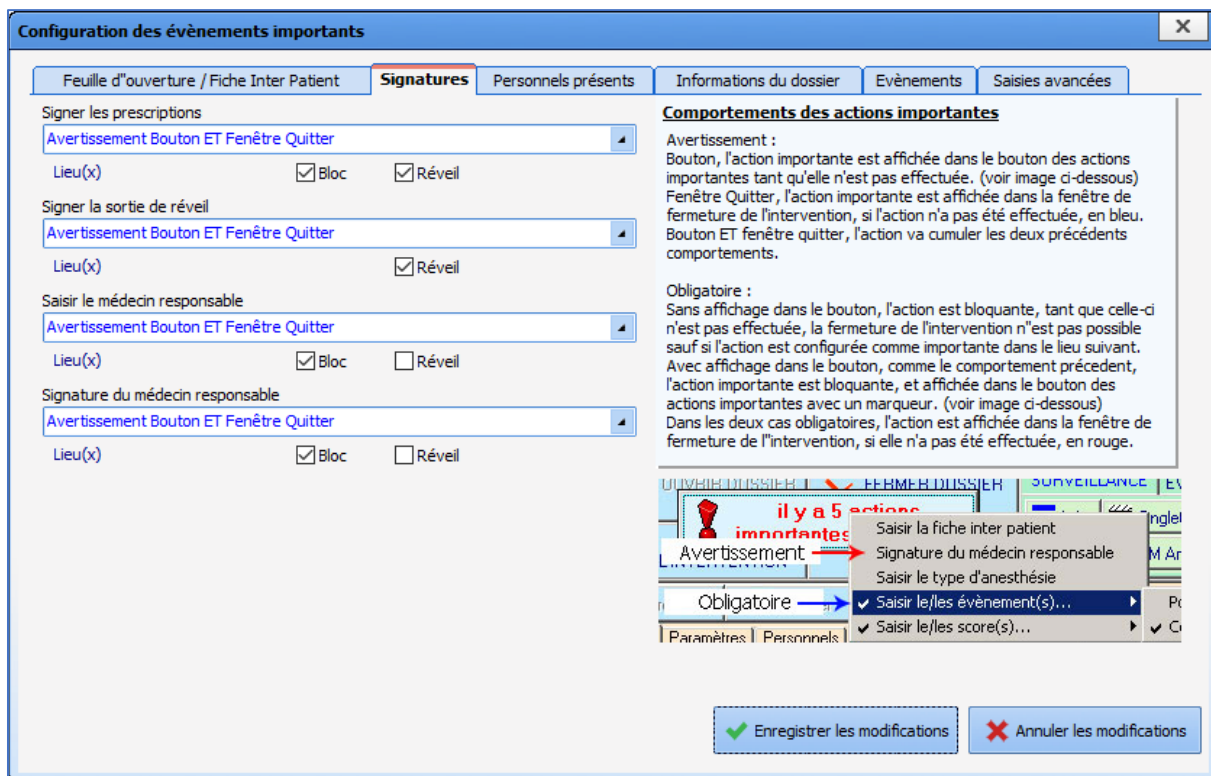
This tab is used to configure legal medical obligations.



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It is possible to configure four items:

Sign medication orders	Suggest or require signing of medication orders
Sign RR release	Suggest or require an anaesthetist's signature for recovery room discharge
Enter doctor in charge	Suggest or require that an anaesthetist is defined for the operation See: Anaesthesia responsibility
Signature of doctor in charge	Suggest or require the signature of doctor in charge

For each item, the level of importance must be selected (only one option can be selected): **Disabled**, **Button Warning**, **Exit Window Warning**, **Button and Exit Window warning**, **Mandatory without display in the button** or **Mandatory with display in the button**

It is then possible to select the location(s) - room type(s) - to which this setting is applied:

OT

Recovery

4.2.3 Staff members present

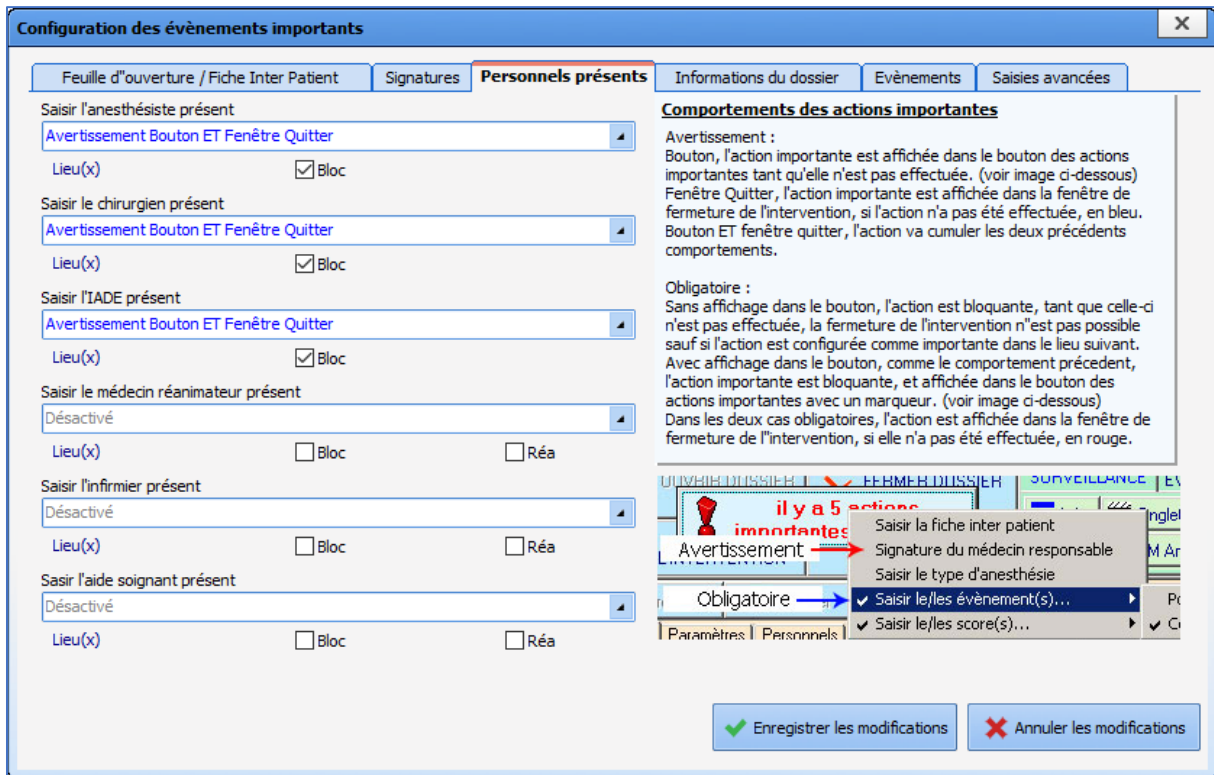
This tab is used to configure the staff who should be entered in a patient record.



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It is possible to configure six items:

<i>Enter anaesthetist present</i>	Suggest or require entry of an anaesthetist present during surgery
<i>Enter surgeon present</i>	Suggest or require entry of a surgeon present during surgery
<i>Enter nurse anaesthetist present</i>	Suggest or require entry of a nurse anaesthetist present during surgery
<i>Enter intensivist present</i>	Suggest or require entry of an intensivist present during surgery or resuscitation
<i>Enter nurse present</i>	Suggest or require entry of a nurse present during surgery or resuscitation
<i>Enter nursing assistant present</i>	Suggest or require entry of a nursing assistant present during surgery or resuscitation

This is used to cover cases where this information was not entered previously in a consultation, or emergencies.

For each item, the level of importance must be selected (only one option can be selected): **Disabled**, **Button Warning**, **Exit Window Warning**, **Button and Exit Window warning**, **Mandatory without display in the button** or **Mandatory with display in the button**

It is then possible to select the location(s) - room type(s) - to which this setting is applied:

OT

ICU (ICU or CCU)

4.2.4 Record information

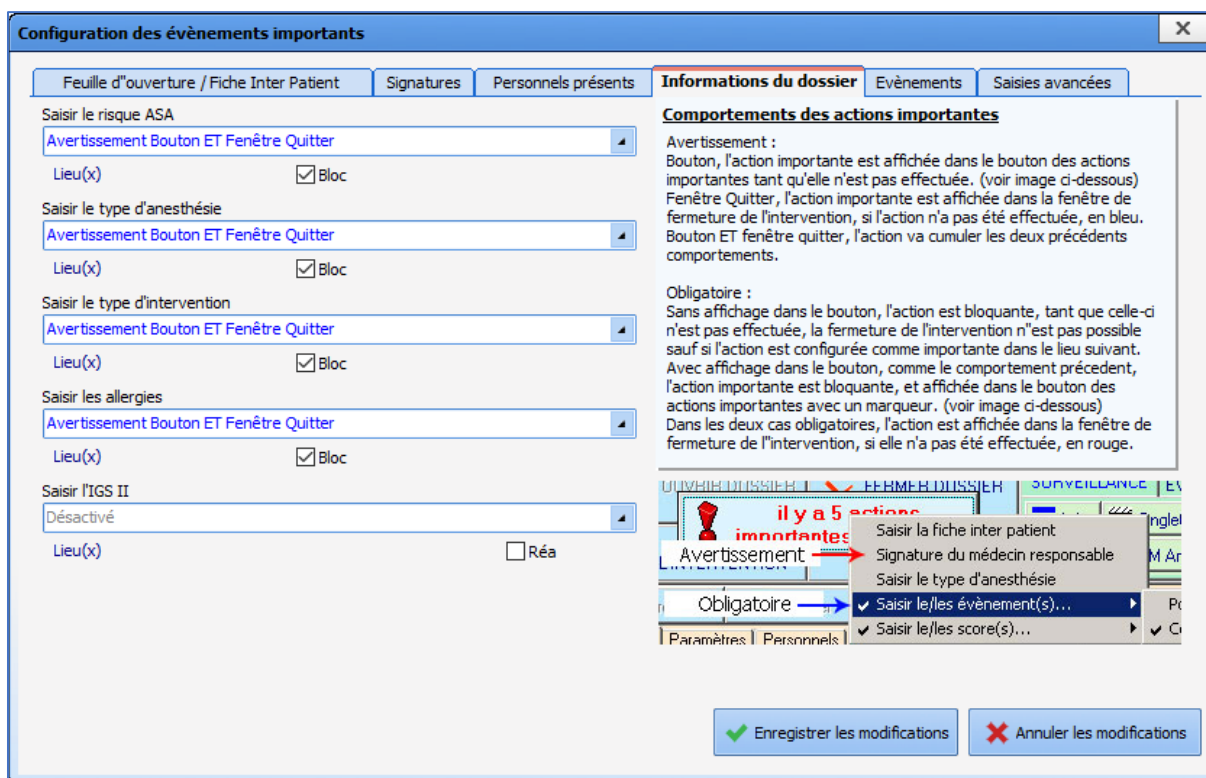
This tab is used to enter key information from the record.



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It is possible to configure five items:

Enter ASA score	Suggest or require entry of ASA score (ASA may be entered during the consultation)
Enter anaesthesia type	Suggest or require entry of type of anaesthesia (type of anaesthesia may be suggested during the consultation)
Enter procedure type	Suggest or require entry of type of operation (type of operation may be suggested during the consultation)
Enter allergies	Suggest or require entry of at least one allergy (include "no allergy" entry so users are not blocked)
Enter SAPS II	Suggest or require entry of SAPS II

For each item, the level of importance must be selected (only one option can be selected): **Disabled**, **Button Warning**, **Exit Window Warning**, **Button and Exit Window warning**, **Mandatory without display in the button** or **Mandatory with display in the button**

It is then possible to select the location(s) - room type(s) - to which this setting is applied:

OT	Except for Enter SAPS II
ICU (ICU or CCU)	Only for Enter SAPS II

4.2.5 Events

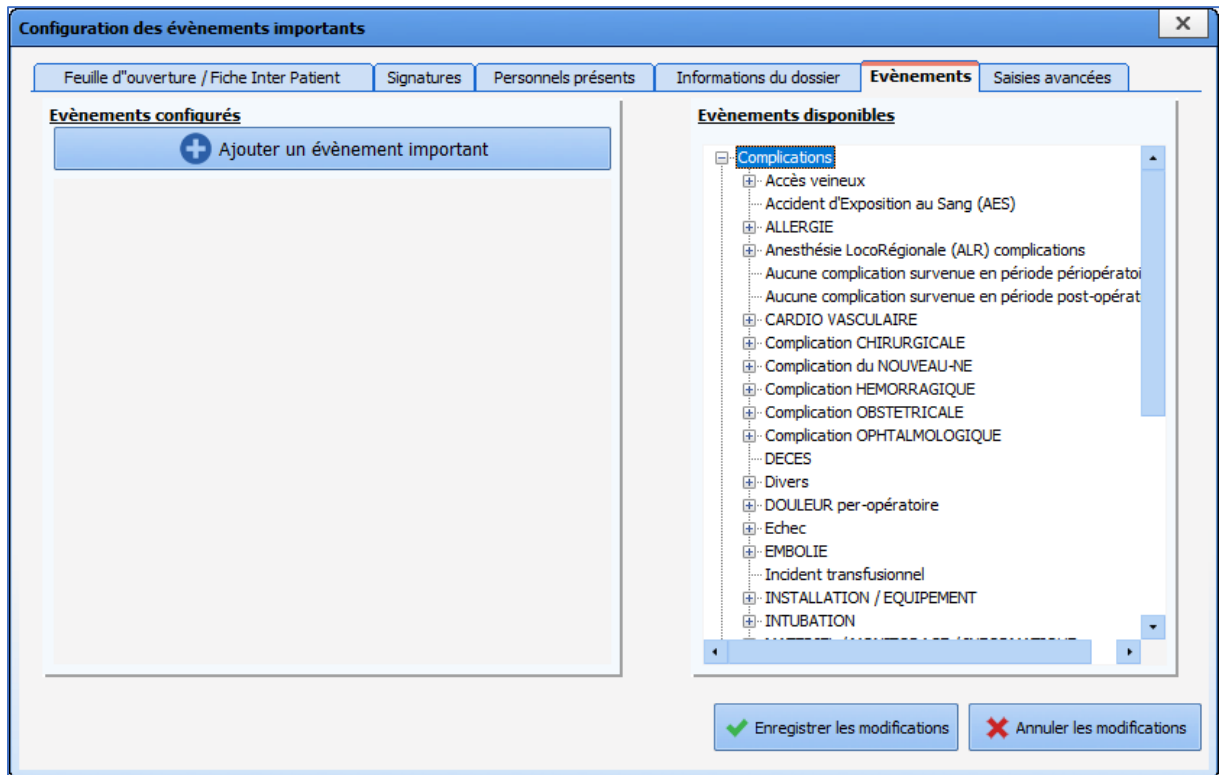
This tab is used to configure important or mandatory events.



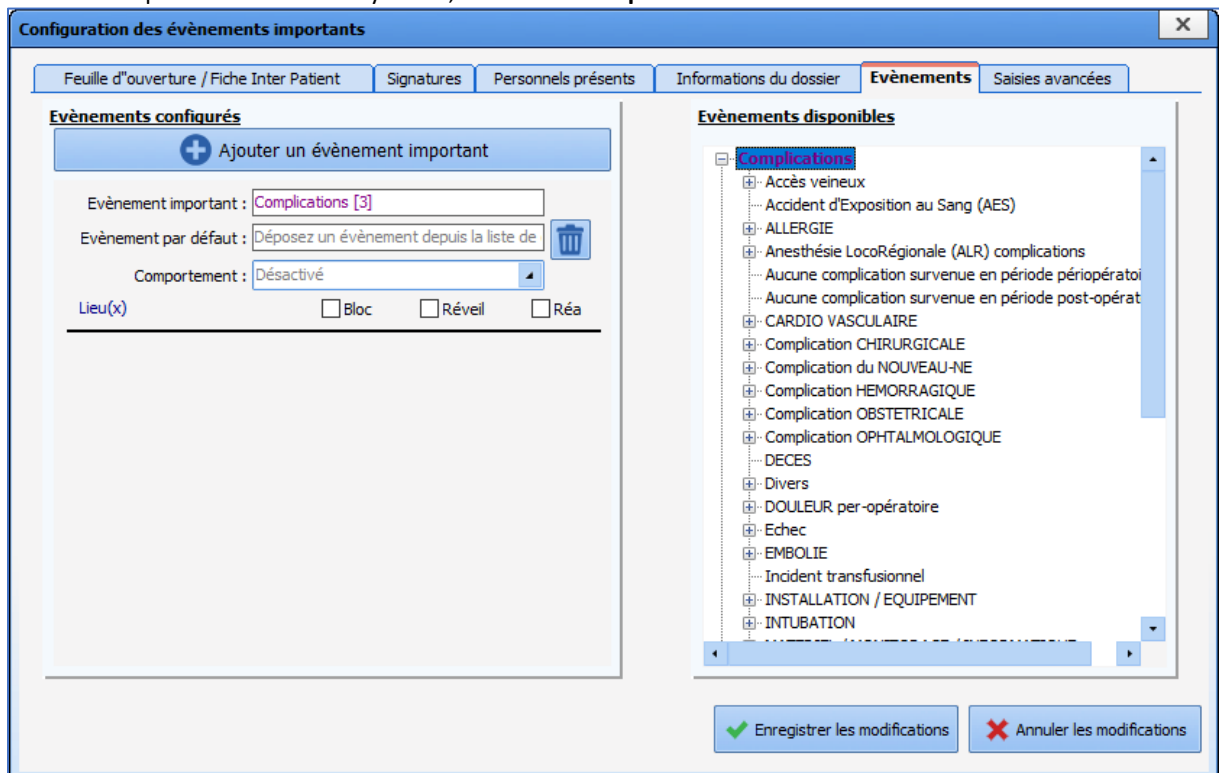
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To add an important or mandatory event, click **Add an important event**.



In the example below, the **Complications** event category has been dragged and dropped into the box on the left entitled **Important event** (the number 3 in brackets is an internal identifier to prevent duplicates with the same name).

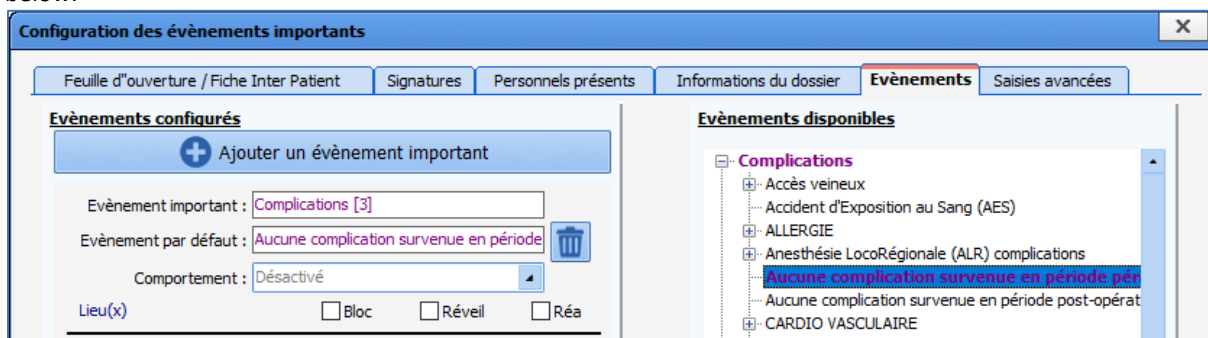


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To help users enter a complication quickly, it is possible to drag and drop one of the complications listed below.



For each item, the resulting action must be selected (level of importance): **Disabled, Button Warning, Exit Window Warning, Button and Exit Window warning, Mandatory without display in the button or Mandatory with display in the button**

It is then possible to select the location(s) - room type(s) - to which this setting is applied:

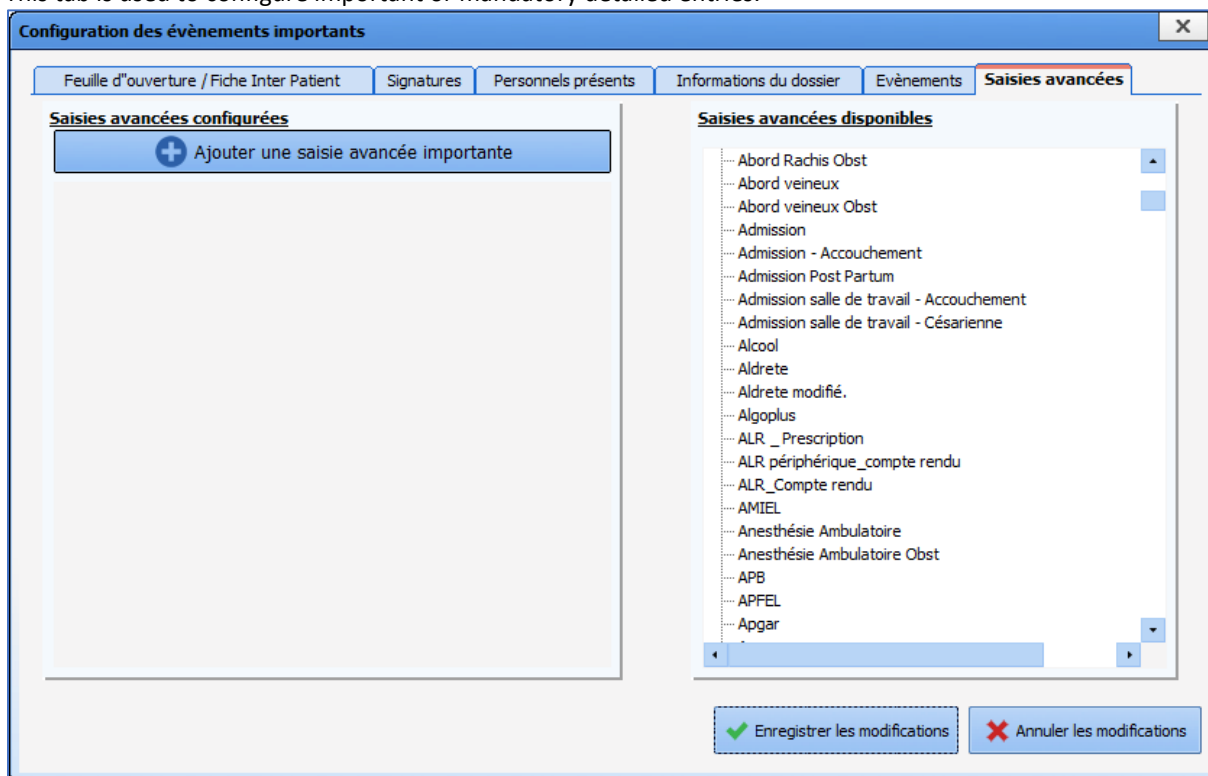
OT

Recovery

ICU (ICU or CCU)

4.2.6 Detailed entries

This tab is used to configure important or mandatory detailed entries.



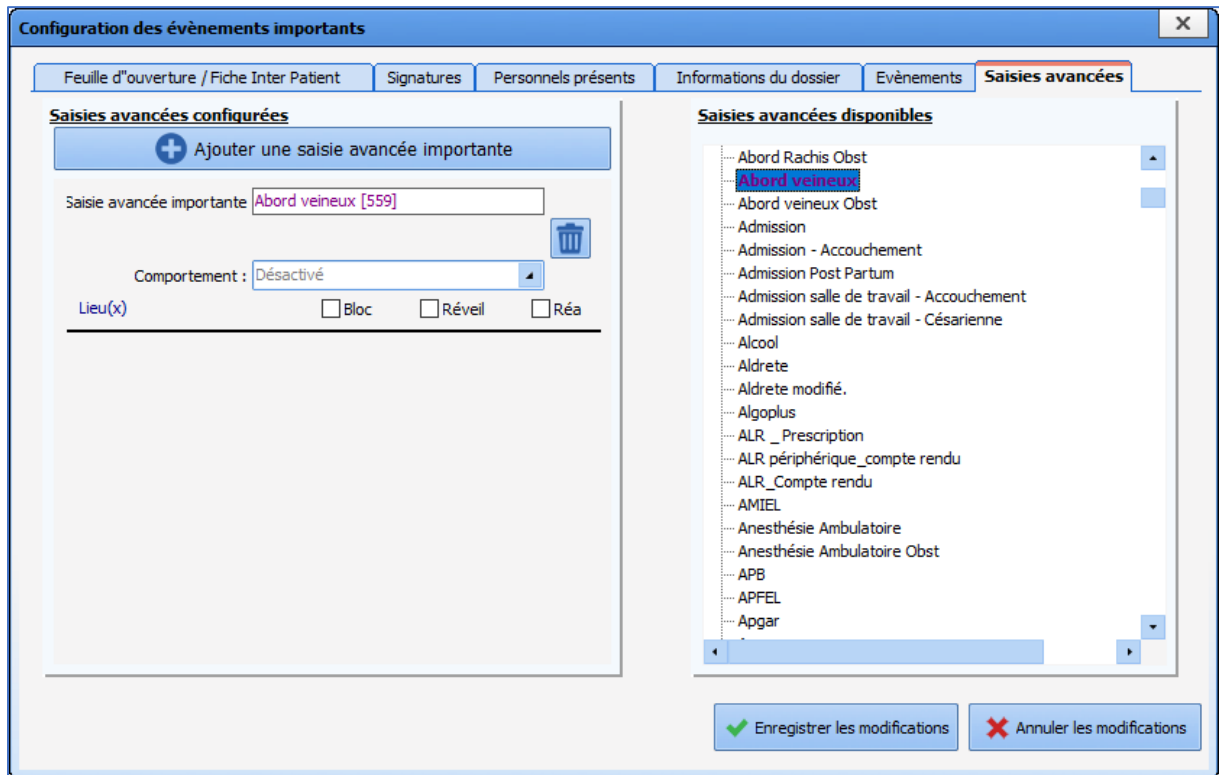
To add an important or mandatory detailed event, click **Add an important detailed entry**.



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In the example below, the **Venous access** detailed entry has been dragged and dropped into the box on the left entitled **Important detailed entry** (the number 559 in brackets is an internal identifier to prevent duplicates with the same name).

For each item, the resulting action must be selected (level of importance): **Disabled, Button Warning, Exit Window Warning, Button and Exit Window warning, Mandatory without display in the button** or **Mandatory with display in the button**

Two other actions are possible:

When the record is opened	The record cannot be opened unless the detailed entry has been completed.
When the record is opened (postponable)	The user is asked to complete the detailed entry before opening the record, but this can be postponed: the record can be opened but the detailed entry must be completed to close the record.

It is then possible to select the location(s) - room type(s) - to which this setting is applied:

OT

Recovery

ICU (ICU or CCU)

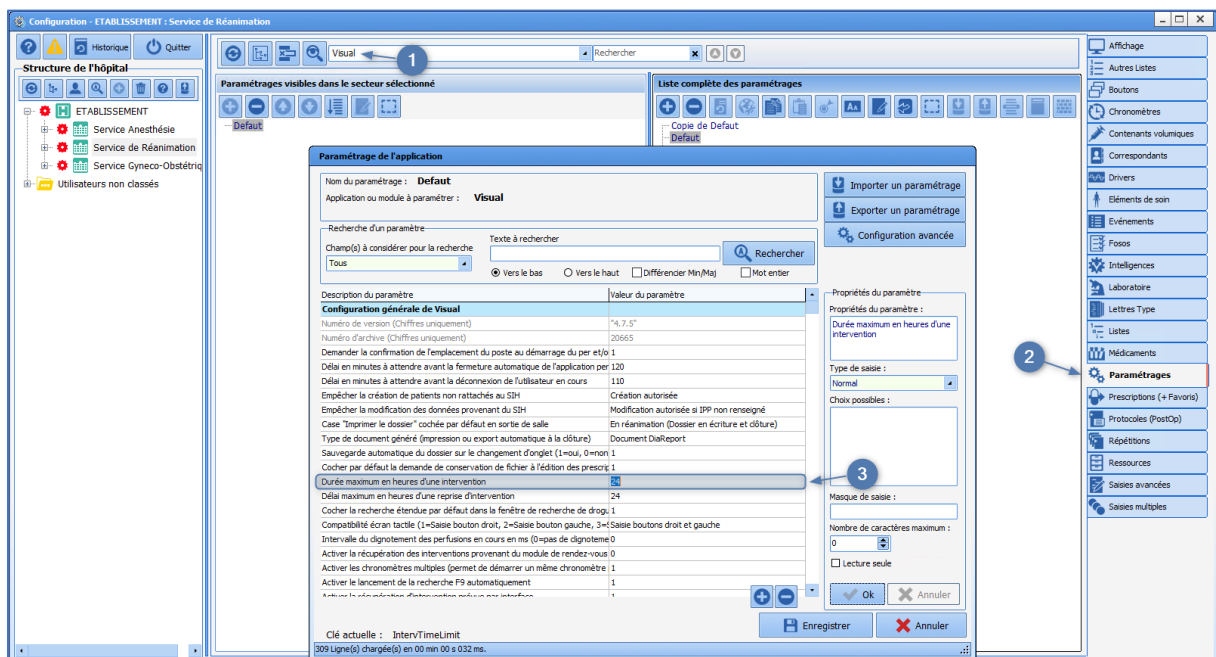
4.2.7 Saving changes

For changes to be implemented, they must be saved by clicking **Save changes** on the **Important item configuration** window.



4.3 Changing the maximum duration of an operation

Visual general configuration>> Maximum duration, in hours, of an operation -> Enter relevant duration.



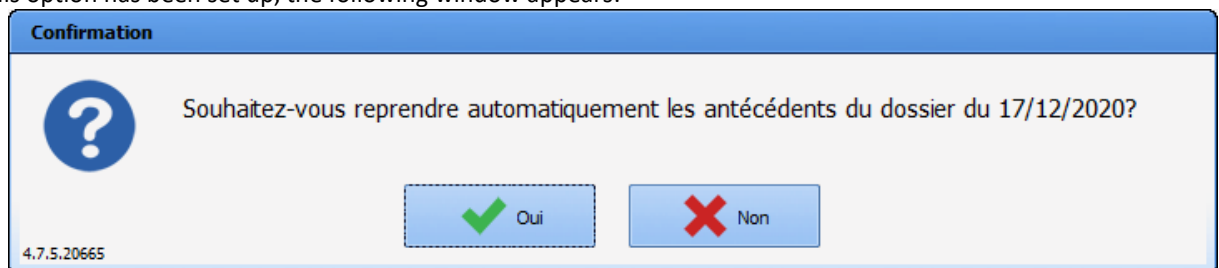
4.4 Configuring the resumption mechanism (Consultation)

Information from consultations can be copied (resumption) in different ways depending on the saved configuration. It can be manual, automated or separated into three levels. This flexibility optimises results.

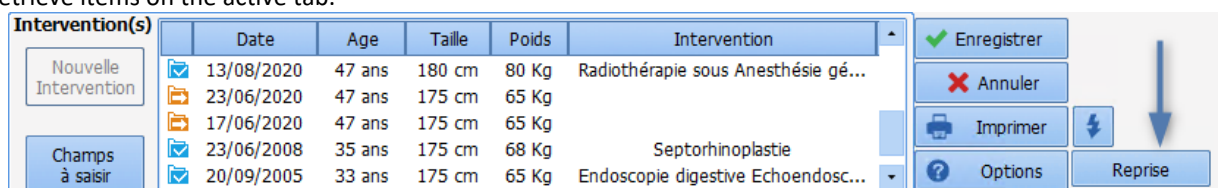
4.4.1 Resumption level and manual resumption

- **In use:**

If this option has been set up, the following window appears:



It is possible to retrieve information from old records using the **Resumption** button. This button can be used to retrieve items on the active tab.



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When **Resumption** is clicked, a selection window opens and is used to specify the consultation/operation from which information should be retrieved.

Sélectionnez l'intervention dont vous souhaitez récupérer les antécédents

Date	Age	Taille	Poids	Intervention
17/06/2020	47 ans	175 cm	65 Kg	
23/06/2008	35 ans	175 cm	68 Kg	Septorhinoplastie
20/09/2005	33 ans	175 cm	65 Kg	Endoscopie digestive Echoendoscopie voie haute

Une fois l'intervention sélectionnée, cliquez sur Ok pour réintégrer ces éléments dans le dossier en cours

Niveau de reprise : 1 2 3

1 2 3

Once the resumption level has been validated (as 1, 2 or 3), the current tab is modified and checkboxes are added to most of the page components.

In the example below, deselecting the box marked with the arrow deselects all Surgical history component boxes. None of the items will be included. If, for example, only the box for the **Septorhinoplasty** row is deselected, only this item will not be included.

← Antécédents chirurgicaux 4

<input checked="" type="checkbox"/>	Septorhinoplastie	23/06/2008
<input checked="" type="checkbox"/>	Radiothérapie sous Anesthésie générale (AG) crano-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 **Display** tab, the level of resumption sensitivity for the different consultation fields can be set up.

Description du paramètre	Valeur du paramètre
Positionnement / Affichage	
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
Intitulé	
Intitulé	Antécédents chirurgicaux
Taille de la police de l'intitulé	10
Intitulé en gras	Oui
Options d'affichage du contenu	
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	
Options des données associées	
Accès en écriture du champ	Ecriture
Niveau d'importance du champ	Élément normal
Historique activé	Oui
Valeur de saisie "RAS"	</1:77030>
Niveau de la reprise	Niveau 1(ex. Antécédents)
Type de données	Jamais repris
Options de recherche	
Recherche automatique à la frappe	Niveau 2(ex. Taille) Niveau 3(ex. Poids)
Nombre de caractères avant recherche automatique	4
Étendre la recherche au catalogue CIM10	Désactivée
Premiers caractères à considérer lors de la recherche dans	
Options de la saisie avec liste de référence	
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 should never be copied. 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 most often. Examples: weight, usual treatments and relays.

4.4.2 Setting up the Resumption Mechanism

In the **Setups** tab, three keys handle how resumption works in consultations.

“Authorise resumption of whole consultation”

“Ask to launch automatic resumption when creating a new operation”

“Resumption level from which items are copied in the consultation”



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Paramétrage de l'application

Nom du paramétrage : **Demo 1280x800 EMed Optim**
 Application ou module à paramétrer : **Consultation**

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
Configuration générale	
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 au réa

Propriétés du paramètre
 Propriétés du paramètre :
 Autoriser la reprise de toute la consultation
 Type de saisie : Oui / Non
 Choix possibles :
 Masque de saisie :
 Nombre de caractères maximum : 0
 Lecture seule

Clé actuelle : REPRISEALL
 13591 Ligne(s) chargée(s) en 00 min 01 s 469 ms.

- **“Authorise resumption of whole consultation”**: the value **0** represents **No**, and the value **1** represents **Yes**.
- **“Ask to launch automatic resumption when creating a new operation”**: Suggests (or not) copying the previous consultation. The following possible values are available:
 - Inactive
 - History tab only with request for validation
 - History tab only invisible
 - Whole consultation with request for validation
 - Whole consultation muted
 - Select record for history
 - Select record for copying whole consultation
- **“Resumption level from which items are copied in the consultation”**: Resumption level from which items are copied in the consultation, in order to refine how the first two keys mentioned above work. Possible values are 1, 2 and 3.



4.5 Configuration of the quick-entry module


The quick-entry module is used to extract consultation records on the basis of searches. These records are then presented as a list from which it is possible to:

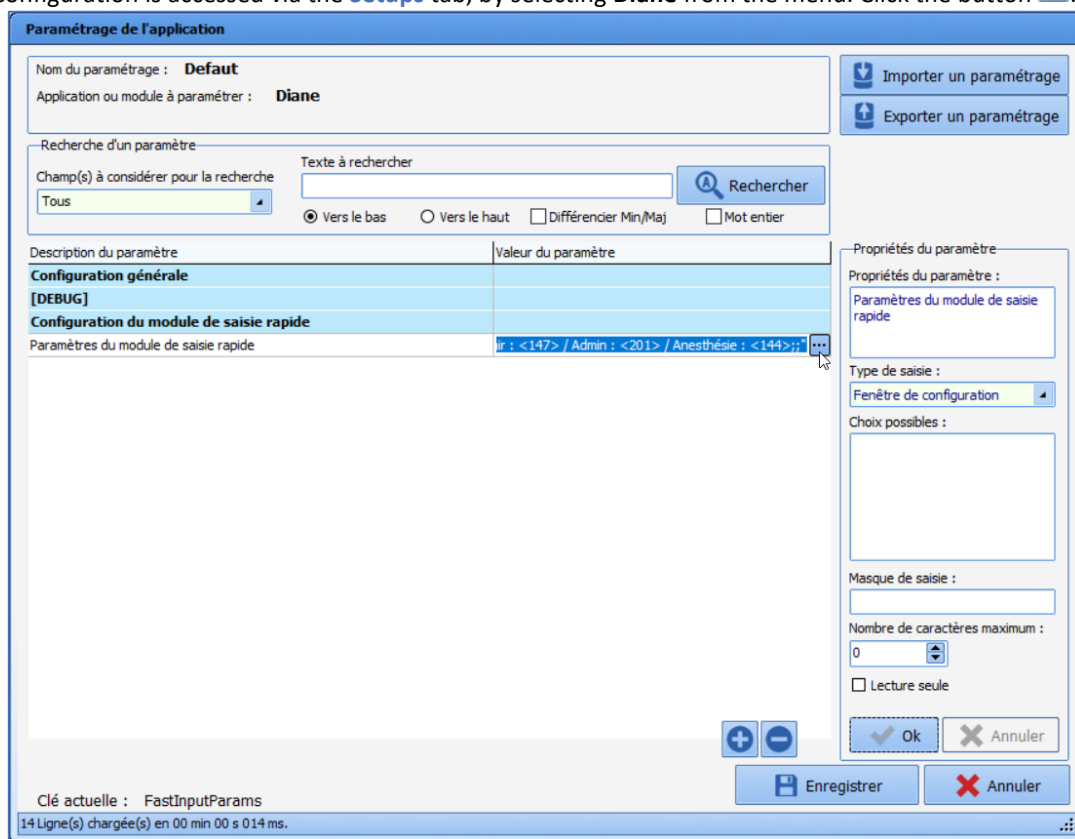
- Access the record directly
- Add information to the record without opening up, prioritising preset fields.

This module can be useful for facilitating the entry of the POA, accessing records to be staffed, and finding incomplete records.

Note that completing a record without opening it does not generate a new edition.

4.5.1 Opening configuration

Configuration is accessed via the **Setups** tab, by selecting **Diane** from the menu. Click the button .



Paramétrage de l'application

Nom du paramétrage : **Default**
Application ou module à paramétrer : **Diane**

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
Configuration générale	
[DEBUG]	
Configuration du module de saisie rapide	
Paramètres du module de saisie rapide	r : <147> / Admin : <201> / Anesthésie : <144>;;

Propriétés du paramètre
Propriétés du paramètre :
Paramètres du module de saisie rapide

Type de saisie : Fenêtre de configuration
Choix possibles :
Masque de saisie :
Nombre de caractères maximum : 0
 Lecture seule

Ok Annuler

Enregistrer Annuler

Clé actuelle : FastInputParams
14 Ligne(s) chargée(s) en 00 min 00 s 014 ms.

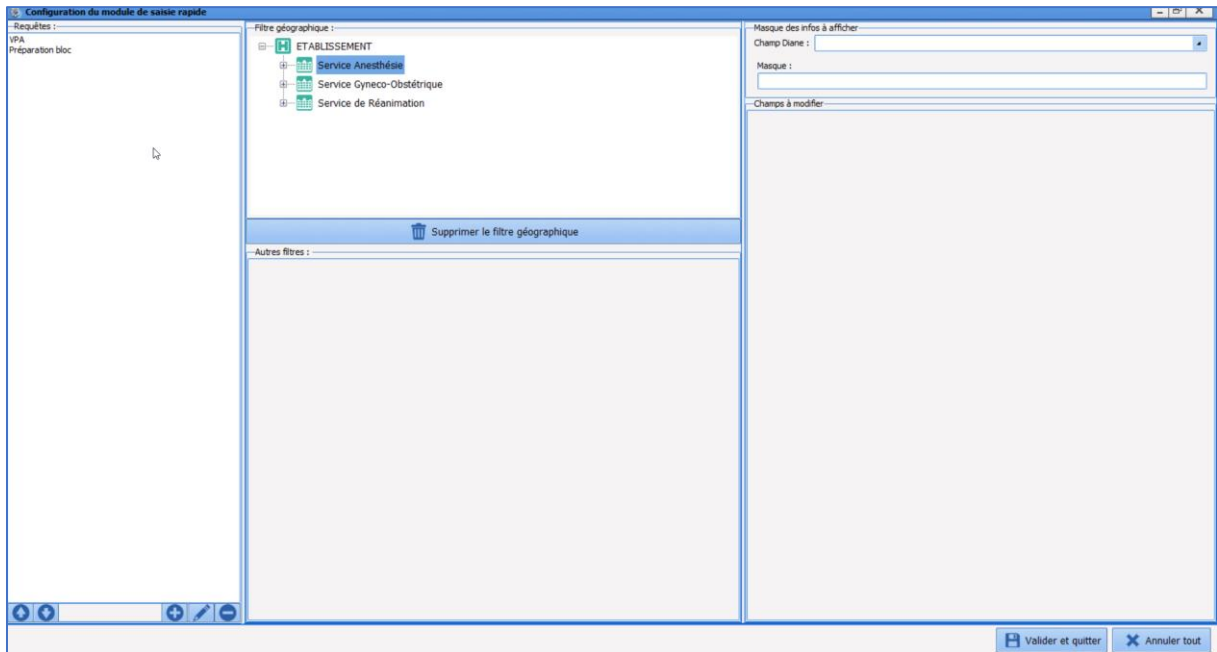
The following window opens:



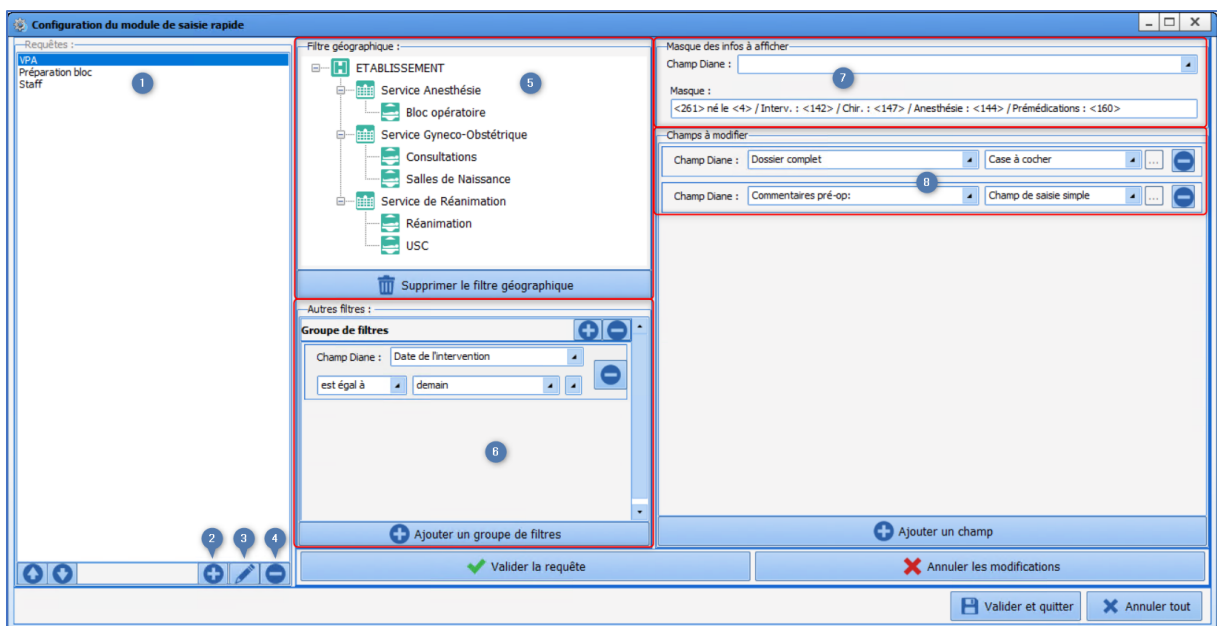
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4.5.2 The configuration window



1. List of queries
2. New query
3. Edit selected query
4. Delete selected query
5. Location filter
6. Record selection criteria
7. Selection of fields that appear on patient selection
 - Select the required information from the patient's record in the **Diane field** drop-down menu
 - Drag and drop to the **Hide** field (information appears as a number between brackets, e.g. <261>)
 - Type the text word for word if necessary (e.g. **DOB**)



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8. Selection of editable fields
 - Next click the 'Add field' button at the bottom right.
 - Select the DIANE field to edit
 - Select the component type of the selected field

Once the query is set up, click the **Confirm query** button.

The **Confirm and exit** button validates the configuration and closes the **Entry module configuration** window. The user must then click the **Save** button in the **Application setup** 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 'Recherche d'un paramètre', a 'Champ(s) à considérer pour la recherche' dropdown set to 'Tous', and a 'Texte à rechercher' input field. There are also radio buttons for search direction ('Vers le bas' selected), checkboxes for 'Différencier Min/Maj' and 'Mot entier', and a 'Rechercher' button. The main area is a table with columns 'Description du paramètre' and 'Valeur du paramètre'. The table contains two rows: '[DEBUG]' and 'Configuration du module de saisie rapide'. To the right is a 'Propriétés du paramètre' panel with 'Propriétés du paramètre : Configuration générale', 'Type de saisie : Section', 'Choix possibles' (empty list), 'Masque de saisie' (empty input), 'Nombre de caractères maximum : 0', and a checked 'Lecture seule' checkbox. At the bottom right are 'Ok' and 'Annuler' buttons. At the bottom center is an 'Enregistrer' button. At the bottom left, it shows '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 appear, records must be verified by at least one filter 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 appear will be those with a surgery date today **OR** tomorrow **AND** with ANESTH Anna as the anaesthetist in consultation **OR** scheduled anaesthetist.



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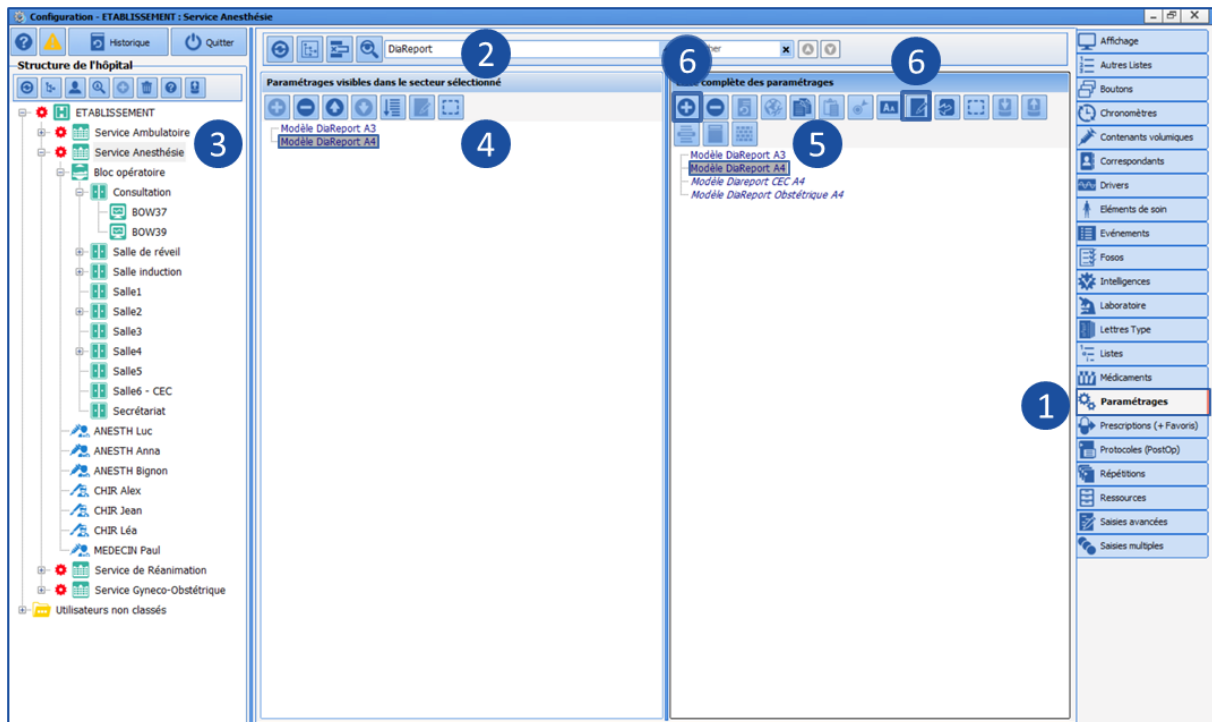


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4.6 Setting up the DiaReport

The DiaReport is used to set up the structure of the anaesthesia record. It is exported automatically when the **DIANE** record is closed. Reminder: When a patient is removed from DIANE, their record must be closed

Printer selection: the program uses the computer settings. Adding or changing the default printer must be done in **Windows**. **DIANE** will list the printers set up for the computer on a drop-down menu..



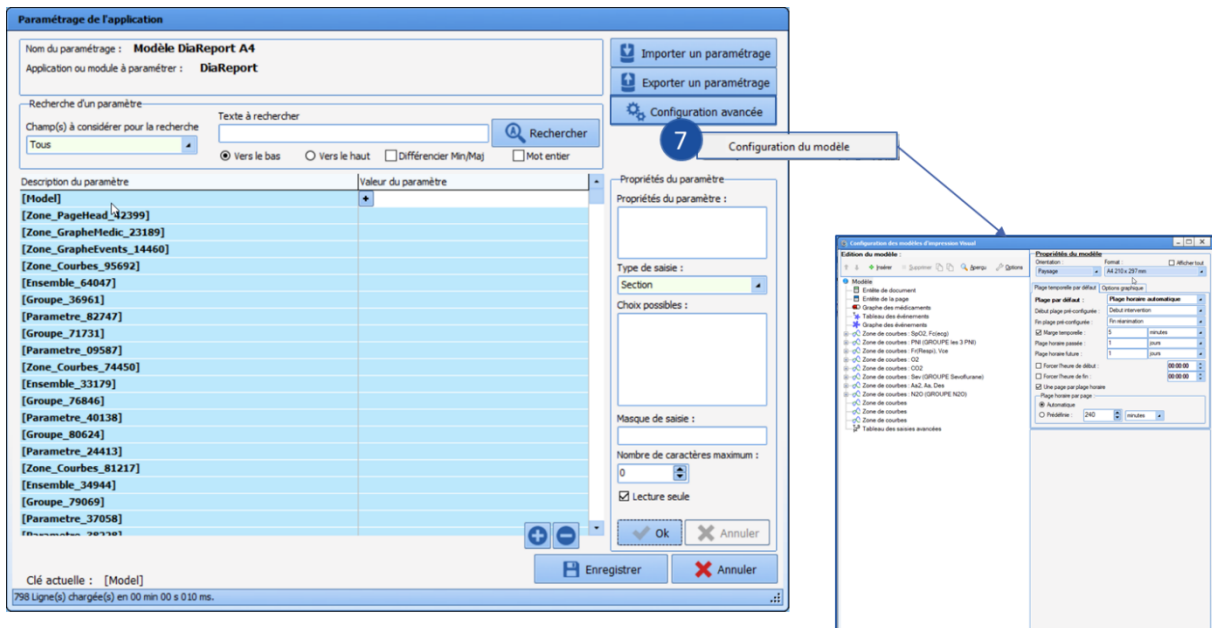
1. **Setups** tab
2. **DiaReport** section
3. Area selection (gear)
4. DiaReport applied to the area
5. DiaReport selection to be edited
6. Edit existing template or create a new template



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4.7 Locks management

4.7.1 Introduction

4.7.1.1 General information

Locks in **DIANE** are used to ensure that a patient record is not open in write-mode in two different locations.

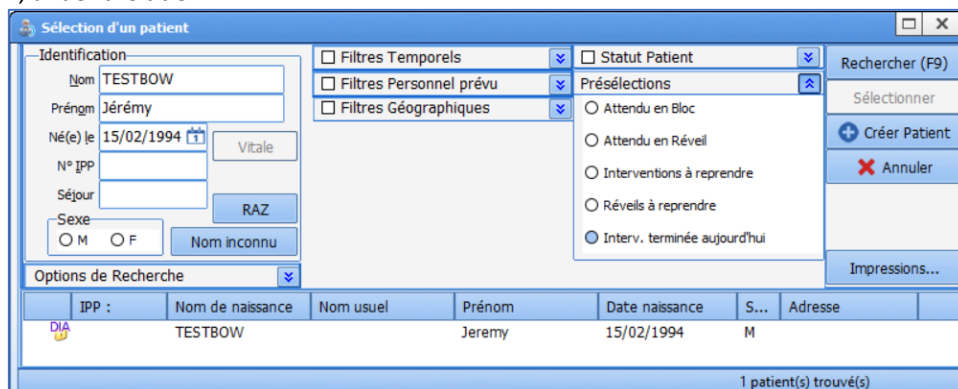
When a patient record is opened in Consultation, Induction, OT, RR or ICU, in write-mode (i.e. not read-only), the user has exclusive write permissions for the record on the computer where it has been opened.

DIANE locks work as follows: when a patient record is opened in write-mode, the whole patient record and its procedures are opened too, so that there are no data conflicts if another user attempts to access the record from another computer.

4.7.1.2 What do locks look like?

4.7.1.2.1 In search windows

When a patient record is locked elsewhere, a lock icon appears at the start of the row in the **Patient selection** window, under the title **DIA**:



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The same is true for patient procedures in the **Patient record selection** window:

Bloc	Date Interv	Date Consult	Type Interv Prév	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

4.7.1.2.2 Consultation

In Consultation, if a record locked elsewhere is opened without setting the lock (i.e. in read-only mode), the following message appears:



In the upper part of the window, in the patient record list, several possible icons can be seen 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			

If the icon is blue, the user does not have write permissions, usually because the record is locked elsewhere. It is thus possible to see these different icons showing that a visible consultation cannot be edited:

- 🔒 Dossier fermé
- 🔒 Dossier verrouillé
- 🔒 Réveil en cours
- 🔒 Bloc en cours
- 🔒 Induction en cours
- 🔒 Dossier non accessible



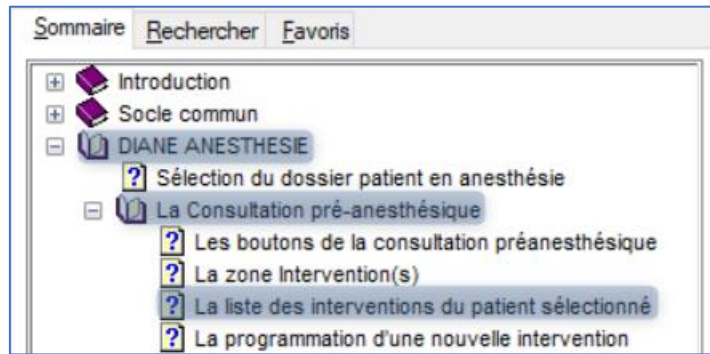
Use the **F1** key to see more information on the icons (when **DIANE Consultation** is open in the foreground. This opens a help window. Then go the relevant area of the help tree structure to find the appropriate information:



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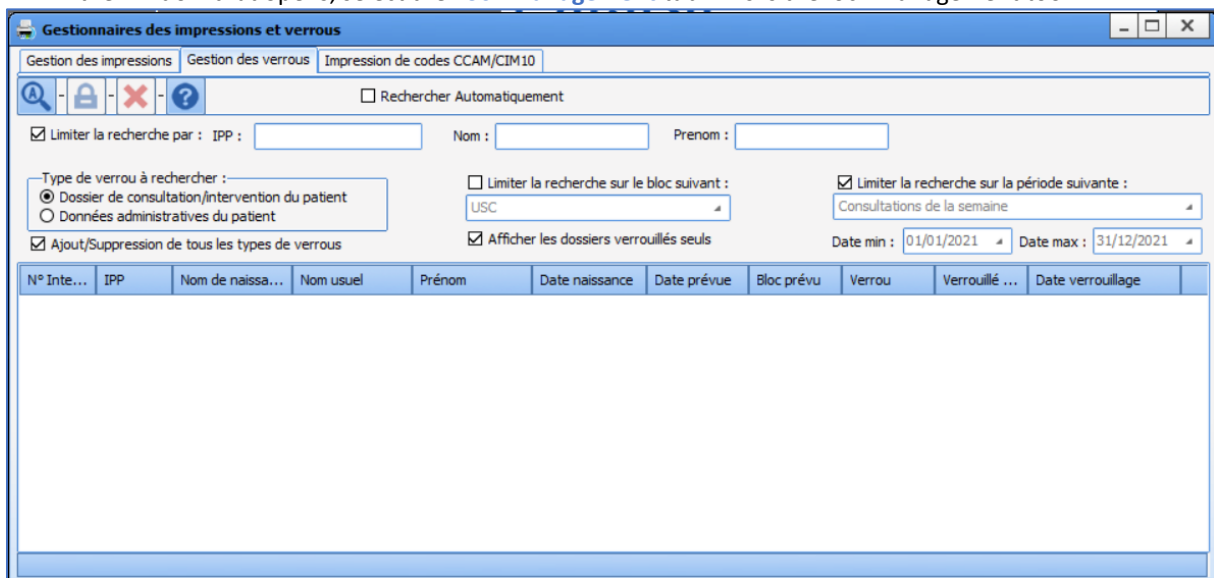


4.7.2 Lock management tool

4.7.2.1 Opening the tool

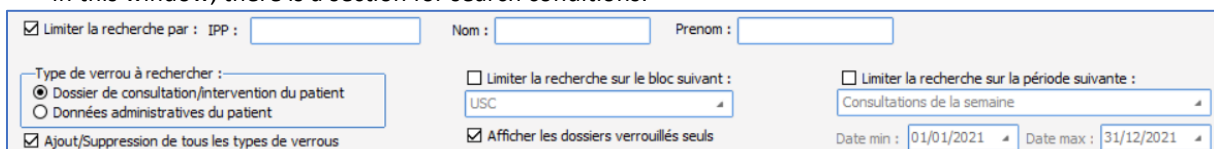
On the **DIANE** portal, click Printouts/Locks or execute MAJImpressions.exe.

In the window that opens, select the **Lock management** tab: This is the lock management tool.



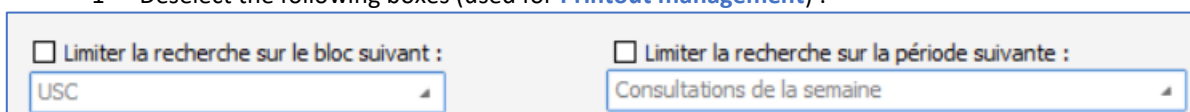
4.7.2.2 Carrying out a search

In this window, there is a section for search conditions:



When searching for a “locked patient to unlock”, the following is recommended:

- 1- Deselect the following boxes (used for **Printout management**) :




- 2- Select the following box: Limiter la recherche par :
- 3- Use the following fields for the search:

IPP : Nom : Prenom :

- 4- Select the box: Afficher les dossiers verrouillés seuls

When searching for a “patient to be locked to this user”, carry out the same actions but deselect Afficher les dossiers verrouillés seuls

After defining the search conditions as indicated above, click the search button  unless the following box is selected Rechercher Automatiquement.

4.7.2.3 Unlocking locks on a record

To unlock the locks on a patient record, ensure all the rows associated with the patient are displayed. Wherever possible, to avoid errors, avoid having several patients in the results. Otherwise, particular care must be taken to avoid making a record open elsewhere unusable.

In addition, all the rows for a single patient must be selected.

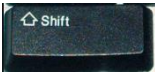

For example, as follows:

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 just select one row (for the procedure for which access is required), as this will only 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, while holding down , click the last row to select all the rows shown;
- Click all of the rows to be selected while holding down ;
- Click under the list of results and, without releasing the mouse button, slide up to select rows one at a time:



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

Clic avec le curseur

Once the rows to be unlocked have been selected, the  button is no longer greyed out. It is possible to click it to delete the locks and make the patient record and all its procedures available in write mode for another computer.

It is also possible to right-click the highlighted rows and click the yellow row:

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	Bow13	SYSTEM Di...	09/02/2021 11:46:16
36821		TESTBOW		Jeremy	15/02/1994	21/01/2021	Réanimation	Bow13	SYSTEM Di...	09/02/2021 11:46:16
34031		TESTBOW		Jeremy				Bow13	SYSTEM Di...	09/02/2021 11:46:16
36681		TESTBOW		Jeremy				Bow13	SYSTEM Di...	09/02/2021 11:46:16
36361		TESTBOW		Jeremy				Bow13	SYSTEM Di...	09/02/2021 11:46:16
36921		TESTBOW		Jeremy				Bow13	SYSTEM Di...	09/02/2021 11:46:16

Poser un(des) verrou(s) dans la sélection

Retirer le(s) verrou(s) dans la sélection

4.7.2.4 Taking write permissions for a record

In addition to unlocking a patient record and its procedures, it is also possible to add locks. This is used to take write permissions for a record.

However, this function must only be used in one case: where the user already had the patient record locked on the computer on which they are working, but the locks are no longer present due to an error or incorrect lock setting. It is possible to seize write permissions and avoid data loss by following the instructions below.

This operation can only be carried out on the computer that should have write permissions for the record. If it is done from another computer, the other computer will have the write permissions.

First, search for the patient and select all the corresponding rows (see previous chapter for best practice).

For example:

Limiter la recherche par : IPP : Nom : testbow Prénom : jeremy

Type de verrou à rechercher :
 Dossier de consultation/intervention du patient
 Données administratives du patient

Ajout/Suppression de tous les types de verrous


Limiter la recherche sur le bloc suivant : USC

Limiter la recherche sur la période suivante : Consultations de la semaine

Afficher les dossiers verrouillés seuls

Date min : 01/01/2021 Date max : 31/12/2021

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 greyed out: .

It is also possible to right-click the highlighted rows and click the yellow row:



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						
36361		TESTBOW		Jeremy						
36921		TESTBOW		Jeremy						

The write permissions for this patient record are then retrieved with the corresponding locks.

4.7.3 Configuration associated with locks

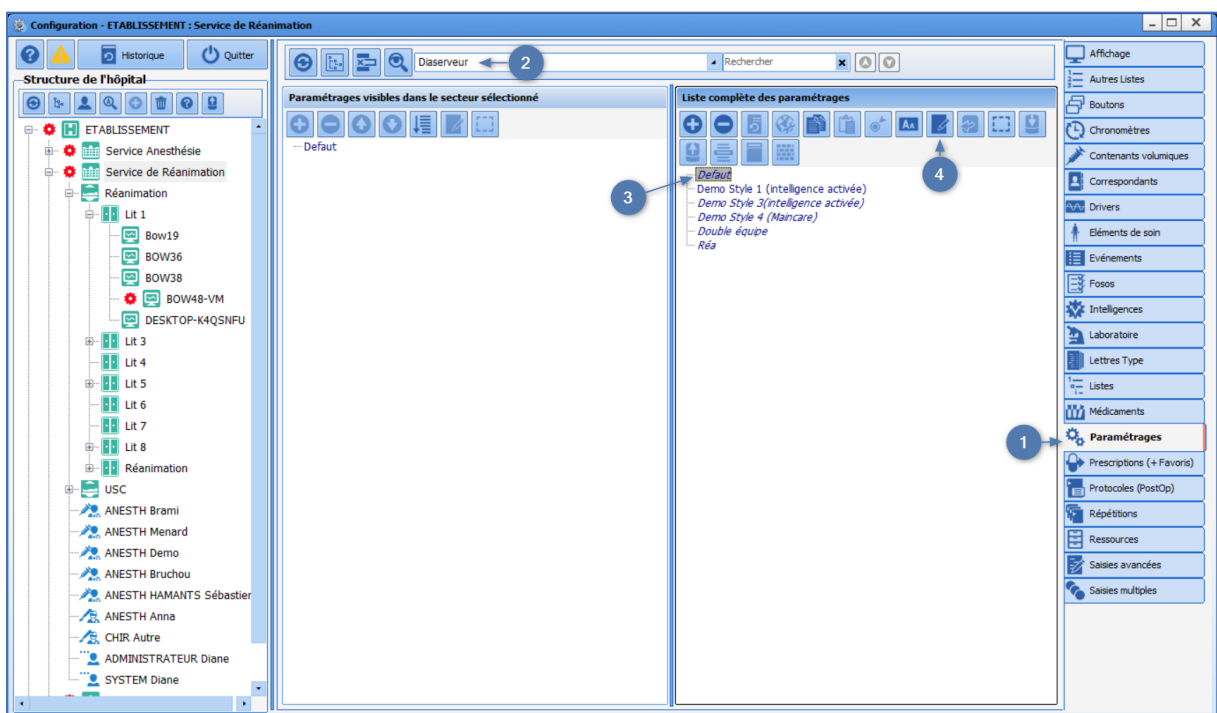
4.7.3.1 Lock prioritisation

If a user wants to open a record locked elsewhere, it is possible to seize the record locks to the detriment of the data being added on the other computer.

However, this can be configured in part. It is possible to define the room types (Induction, OT, RR, ICU and other) with priority over the others for setting locks.

To do this, go to **Application configuration**.

Select the **Setups tab (1)**, **DiaServeur menu (2)**, click the configuration to be modified **(3)**, click **Edit item (4)**:



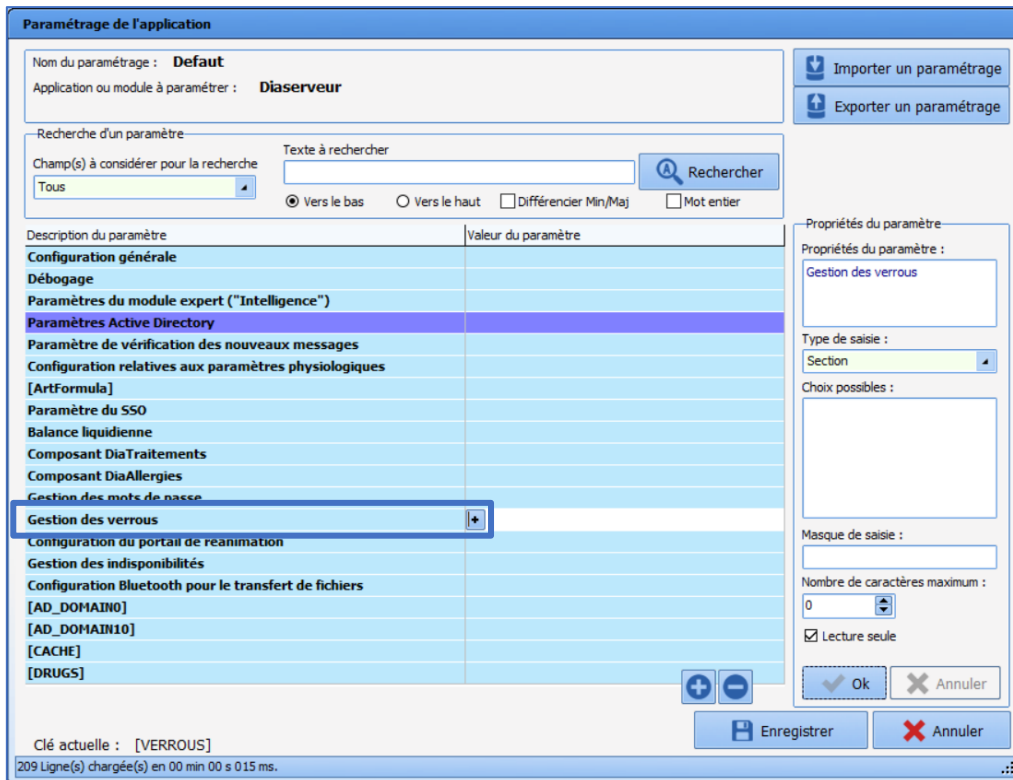
In the window that opens, select **Lock management** and click the  button to expand the row:




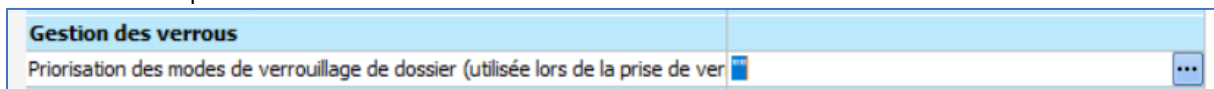
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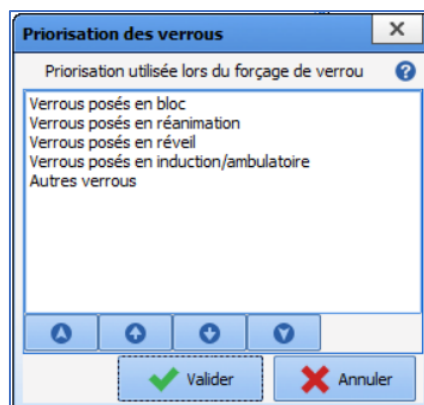
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Select the expanded row and click  at the end of the row:

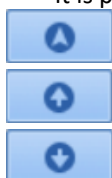


A window is displayed:



The rows inside the central block indicate from bottom to top the room types with priority over the others for lock prioritisation. This means, in this example, that the OT has priority for setting locks on a record, even if the record is currently open in a RR.

It is possible to modify this order by selecting a line and clicking the buttons above it as follows:



The first button is used to move an item straight to the first place.

The second button is used to move an item up one place.

The third button is used to move an item down one place.




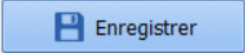
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The fourth button is used to move an item straight to the last place.

Once the order has been defined, click  at the bottom of the window, then  to save the new setup. **DIANE** must then be restarted on computers using this configuration.

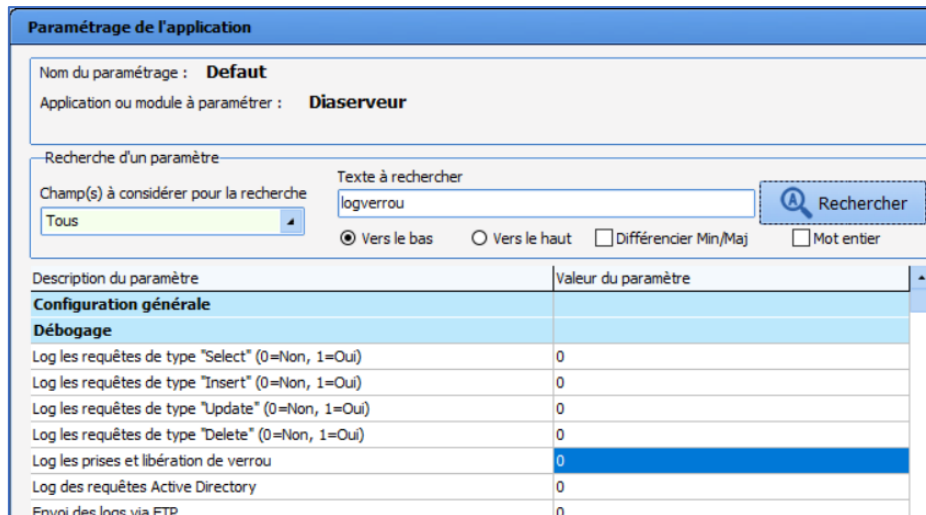
4.7.3.2 Activating logs to monitor changes to locks

It is possible to activate logs (text files used to analyse problems encountered in **DIANE**) to monitor the setting and releasing of locks. This can be useful for analysing what has happened on client computers when recurrent issues with locks are encountered. These logs are disabled by default.

Once activated, these logs are generated in the folder **Diane/Data/*computer name*/Log** of the computer and can be sent to **Bow Médical** for analysis.

To activate these logs, go to **Application Configuration, Setups** tab, **DiaServeur** menu to select and edit the configuration (see previous chapter for how to do this).

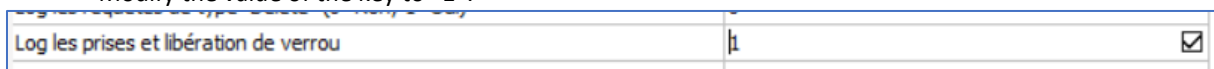
From the setup key window, search for **LogVerrou**:



The screenshot shows the 'Paramétrage de l'application' window. The search field contains 'logverrou'. The search results table is as follows:

Description du paramètre	Valeur du paramètre
Configuration générale	
Débogage	
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

Modify the value of the key to "1":



The screenshot shows a close-up of the parameter 'Log les prises et libération de verrou' with its value set to '1'.

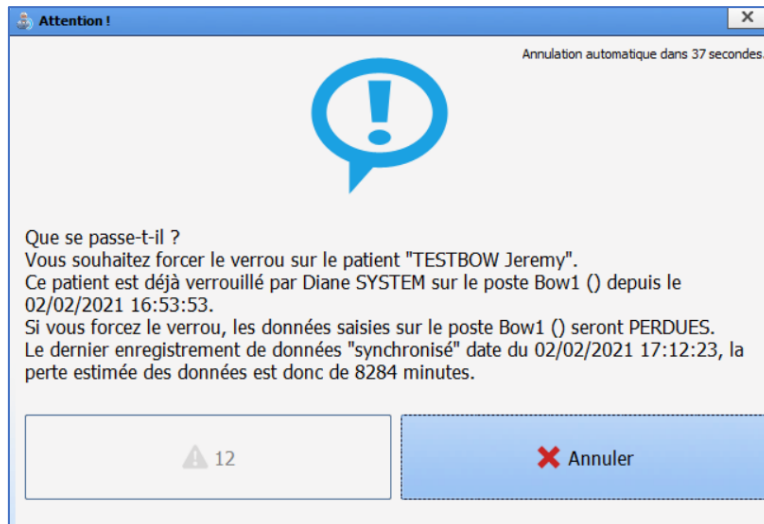
Then click  and restart **DIANE** on computers using this configuration.

4.7.4 Known issues

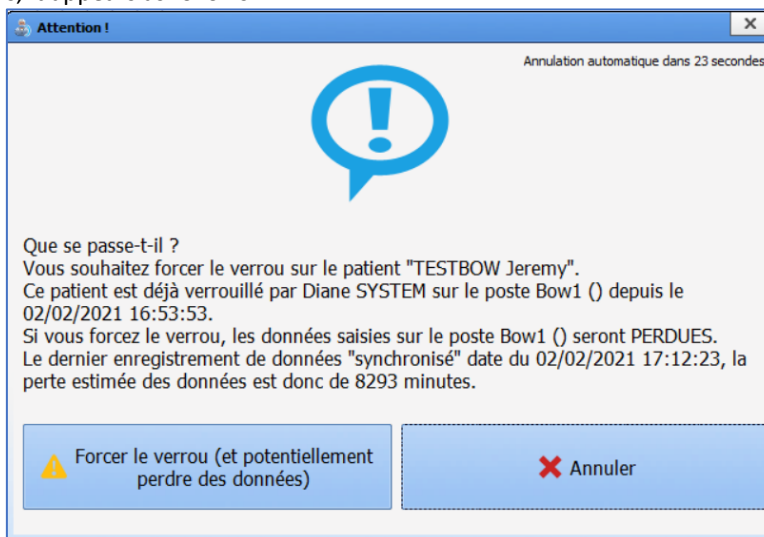
4.7.4.1 Locks seized by another user

When attempting to force a record to open in write-mode on a computer other than the one that holds the locks, the following message is shown:





After 15 seconds, it appears as follows:



Clicking the button with the yellow panel will seize the lock. If the record was being used elsewhere, other users will receive an error message and will no longer be able to work on the record.

If the record was blocked on another computer for no valid reason, this is a solution for retrieving the record. However, this may result in data loss.

4.7.4.2 Record locked to OT after transfer to RR

In some cases, following a transfer from OT to RR, the record cannot be opened in the RR as the previous lock has not been released correctly.

In this case, it must first be ensured that the record is no longer open on the OT computer. If the record has been properly closed or transferred from the OT computer, the locks must be seized. Otherwise, wait until the record has been closed and verify afterwards that the record can be opened in RR in write-mode.

If there is still an issue, go to **Lock management** to see if the locks can be released in this way. If this is possible, the record should then be available in write-mode after releasing the locks.

If the issue cannot be resolved or continues despite manual release of the locks, restart **DIANE** with a **DianeKiller, Stop** option, on the OT computer. **DIANE** can then be restarted on the OT computer with no issues. The record should then be available after the procedure.

If the issue is not resolved, please contact **Bow Médical**.



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4.8 Setting up ICD-10, Procedure Codes

4.8.1 Configuring ICD-10 and Procedure Codes

This is done in **Setups** tab – **Misc.**

The screenshot shows the 'Paramétrage de l'application' window. The 'Nom du paramétrage' is 'Default' and the 'Application ou module à paramétrer' is 'Misc'. There are buttons for 'Importer un paramétrage' and 'Exporter un paramétrage'. A search section includes a dropdown for 'Champ(s) à considérer pour la recherche' (set to 'Tous'), a 'Texte à rechercher' field, and a 'Rechercher' button. Below is a table of parameters:

Description du paramètre	Valeur du paramètre
Configuration des web services spécifiques à Maincare	
Configuration des appels contextuels avec MAINCARE	
Configuration de la CIM10 et de la CCAM	
Actes ajoutés automatiquement, à configurer comme suit : <Acte automatique>=<Acte déclencheur1>,<Acte déclencheur2>,...,<Acte déclencheurN>, <Acte automatique 2>=<Acte déclencheur1>,<Acte déclencheur2>,...,<Acte déclencheurN>	D15, GLLD008, GLLD004, GLLD007, GLLD009, GLJF010,
Onget 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 clotu	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"
Configuration du Webservice DopaSoins	
Configuration du Webservice Ambucare	
Configuration du Webservice Doctolib	
Configuration des appels contextuels et du Web Service Logipren	
Configuration du Webservice Moebius	
Configuration du simulateur	
Anamnèse	

At the bottom, there are buttons for '+', '-', 'Enregistrer', and 'Annuler'. The status bar shows 'Clé actuelle : CCAM_AutoAddedActes' and '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>

Example:

"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 Tab

This key determines the default tab shown on starting the **Procedure Code/ICD-10** module.

Possible values:

0=ICD-10

1=Procedure Codes

4.8.1.3 Enter the form opening time or record closing time (if closed) in the procedure entry date

By default 0, corresponding to 23:59.

Labels and recommendations for **Requesting CAM**, **Executing CAM**, and **Location of execution** panes.



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These keys are used to edit the titles and recommendations on hovering of the corresponding entry fields in the **CCAM** tab of the **Procedure Codes/ICD-10** tab.

N° de séjour	<input type="text"/>	Lieu de réalisation	Uf-124578
CAC demandeur	Cardiologie	CAC réalisateur	Uf-124578

If the keys are empty, the application shows the default values.

4.8.1.4 ATC codes used to trigger Procedure Codes associated with expanders

This setup indicates the ATC codes used to trigger code EQLF002 (when an expander is prescribed).

Example:

ATC codes used to trigger Procedure Codes associated with expanders

4.8.2 Setting up DIANE ICU (Procedure Codes)

This is done in **Setups** tab – **DianeICU**.

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

Rechercher

Description du paramètre	Valeur du paramètre
Configuration de la fenêtre de saisie de donnée manuelle	
Mouvement du personnel	
Configuration des couleurs de DianeRea	
[DEBUG]	
Avertissements	
Connexion à distance	
Graphique des médicaments	
Onglet navigation	
Feuille d'ouverture et fiche inter patient	
Plan de soin	
Transmissions ciblées	
Documents intégrés	
CCAM/CIM10	
Actes CCAM favoris	
Actes CCAM à prédéterminer	7 8 9 10 11 12 13 14 15 16 17 18 19* ...
Fiche de sortie/fermeture de dossier	
Actions importantes	
Configuration du portail de réanimation	
Configuration du calcul du score IGS2	
[EXTERNAL_NOTIFIER]	

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

Ok Annuler

Enregistrer Annuler

Clé actuelle : PredeterminedCCAMCodes
 318 Ligne(s) sauvegardée(s) en 00 min 00 sec 000 ms.



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4.8.2.1 Favourite procedures

Codes CCAM favoris

1: Acte:

2: Activité: 1: Acte principal

3: Ext. doc. 4: Phase: 0

5: Modificateurs

6: Association 7: Remboursement

Code généré: **GLLD019 0**

Informations complémentaires sur la saisie:

* OBLIGATOIRE
Topographie de l'acte : 2 lettres

Praticien:

CCAM Version 68.00 (applicable au 09/12/2021)

- SYSTÈME NERVEUX CENTRAL, PÉRIPHÉRIQUE ET AUTONOME
- OEIL ET ANNEXES
- OREILLE
- APPAREIL CIRCULATOIRE
- SYSTÈME IMMUNITAIRE ET SYSTÈME HÉMATOPOÏÉTIQUE
- APPAREIL RESPIRATOIRE
 - ACTES DIAGNOSTIQUES SUR L'APPAREIL RESPIRATOIRE
 - ACTES THÉRAPEUTIQUES SUR LES VOIES RESPIRATOIRES
 - ACTES THÉRAPEUTIQUES SUR LE POUMON, LA PLÈVRE ET LE MÉDIASTIN
 - ASSISTANCE RESPIRATOIRE
 - Adaptation d'une ventilation non effractive
 - Suppléance ventilatoire
 - GLJF001 | dialyse dioxyde carbone v. veineuse/24h
 - GLJF002 | dialyse dioxyde carbone v. veinoartérielle/24h
 - GLJF010 | dialyse dioxyde carbone/24h
 - GLLD001 | O2thér. hyperbare +ventil.
 - GLLD002 | ventil. discontinue masque/embout pr kinésithérapie/24h
 - GLLD003 | ventil. spontanée masque/canule sans aide inspiratoire +PEP/24h
 - GLLD004 | ventil. trach. +PEP >6 +/-FIO2 >60% +déclatib ventral alterné/24h
 - GLLD006 | ventil. spontanée sur sonde intub. pdt sevrage 1ventil/24h
 - GLLD007 | ventil. à poumons séparés/24h
 - GLLD008 | ventil. trach. +PEP sup. à 6+/- FIO2 sup. à 60%/24h
 - GLLD009 | ventil. oscillations à hte fréquence/24h
 - GLLD010 | ventil. liquide/24h
 - GLLD011 | ventil. à fréq. sup. à 80minute/24h
 - GLLD012 | ventil. continue au masque facial pr suppléance ventilatoire/24h
 - GLLD013 | ventil. spontanée sur trachéo pdt sevrage 1ventil/24h
 - GLLD015 | ventil. trach. +PEP < 6+FIO2 < 60%/24h
 - GLLD017 | O2thér. +surv. continue oxymétrie sf ventil/24h
 - GLLD019 | ventil. non invasive masque cumul. 2h/12h pr insuf. resp. aig.**
 - GLLD020 | O2thér. hyperbare sans utli. ventil.
 - Rééducation respiratoire
 - Appareillage de l'appareil respiratoire
 - Oxygénothérapie hyperbare
 - APPAREIL DIGESTIF

Actes CCAM favoris

- ventil. spontanée masque/canule sans aide inc
- ventil. oscillations à hte fréquence/24h
- ventil. non invasive masque cumul. 2h/12h pr

Double-clic pour sélectionner un acte

4.8.2.2 Procedures to predetermine

Some codes are automated in **DIANE**. The codes that are generated automatically are the ones selected in this window.

Codes CCAM à prédéterminer

<input checked="" type="checkbox"/> EQLF003	<input checked="" type="checkbox"/> DEQP004
<input checked="" type="checkbox"/> EQLF002	<input checked="" type="checkbox"/> DEQP007
<input checked="" type="checkbox"/> FELF004	<input checked="" type="checkbox"/> EQLF001
<input checked="" type="checkbox"/> FELF003	<input checked="" type="checkbox"/> GLQP004
<input checked="" type="checkbox"/> GLLD006	<input type="checkbox"/> GLLD003
<input checked="" type="checkbox"/> GLLD013	<input type="checkbox"/> GLLD019
<input checked="" type="checkbox"/> GLLD012	<input type="checkbox"/> ABQP001
<input checked="" type="checkbox"/> GLLD015	<input type="checkbox"/> EQLF005
<input checked="" type="checkbox"/> GLLD008	<input type="checkbox"/> FELF011
<input checked="" type="checkbox"/> GLLD004	<input type="checkbox"/> GLLD005
<input checked="" type="checkbox"/> GLLD007	<input type="checkbox"/> GLLD011
<input checked="" type="checkbox"/> GLLD009	<input type="checkbox"/> HSLF001



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4.8.3 Setting up ICD-10, Procedure and NGAP Codes

ICD-10 codes, Procedure codes and NGAP codes can be set up for automatic entry by **DIANE**. This is done by creating rules that generate one or more codes when the configured conditions are met. The conditions can be a **Record data**, an **Event** or a **Timer**.

Codes are generated automatically when a record is saved. In some cases, it may be useful to use a mandatory field "Full record" to the conditions in order to avoid generating codes each time the record is saved.

For ICD-10 and Procedure Codes, set up is carried out in the **Setups** tab – **DianeICU** for ICU (ReaCodeRules) or **Setups – Visual** for anaesthesia (VisualCodeRules).

For NGAP codes, set up is carried out in the **Setups** tab – **Misc** (MiscNGAPCodeRules).

Clicking the  button opens the following window:

A rule is set up in three steps:




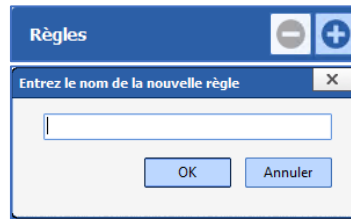
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4.8.3.1 Adding a rule

To add a new rule, click  and enter the name of the rule.

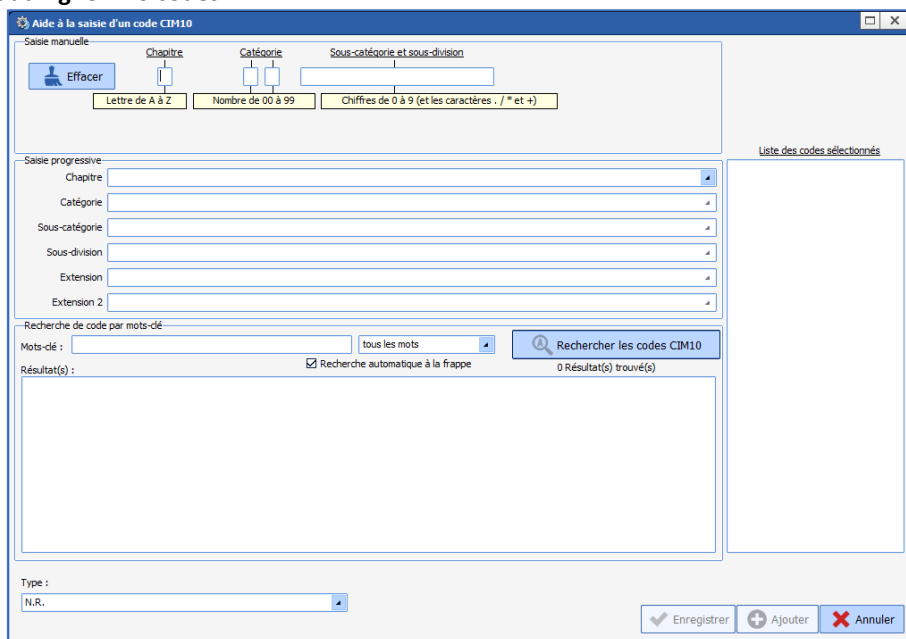


4.8.3.2 Adding a code

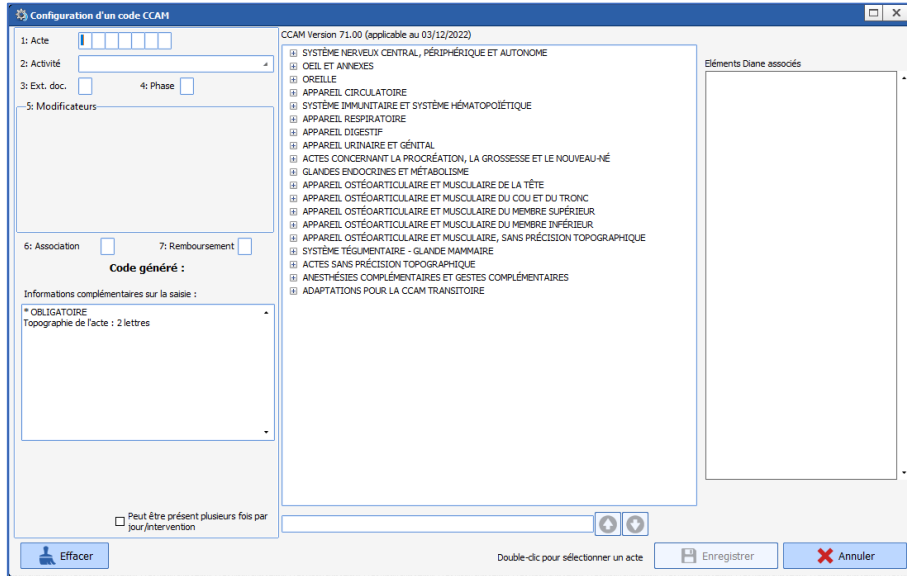
One or more associated codes must then be added by clicking  then the relevant code type.



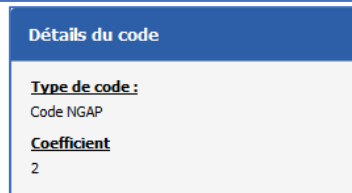
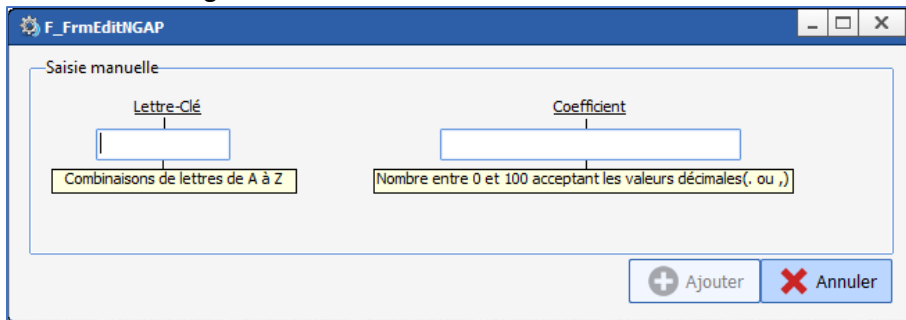
Window for adding ICD-10 codes:



Window for adding procedure codes:




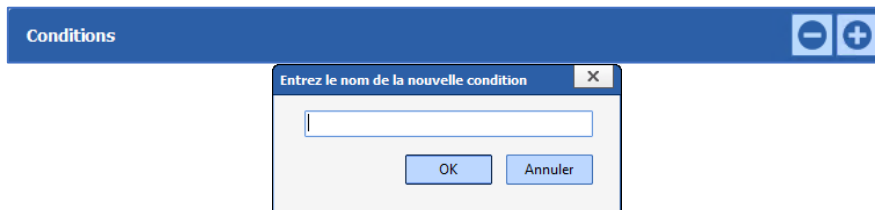
Window for adding NGAP codes:



The code details are shown:

4.8.3.3 Adding a condition

Finally, the condition(s) required for automatic entry of the code must be entered by clicking  and entering the name of the condition.



For each condition, the source of the required data must be selected. This can be a **Record data**, an **Event** or a **Timer**.



4.8.3.3.1 Record data (ICD-10, Procedure and NGAP Codes)

In the case of record data, the **Diane field** must be selected from the drop-down menu, then the **Operand** (variable depending on data type: Contains... Does not contain... Is equal to... Is different to... Is less than... Is more than... etc.).

Example for ASA score over 2:

Détails de la condition

Source: Données du dossier | Champ Diane: ASA [= Risque ASA]

Opérande: Contient un des éléments suivants

Valeurs possibles:

<input type="checkbox"/> 1	<input type="checkbox"/> 1U
<input type="checkbox"/> 2	<input type="checkbox"/> 2U
<input checked="" type="checkbox"/> 3	<input checked="" type="checkbox"/> 3U
<input checked="" type="checkbox"/> 4	<input checked="" type="checkbox"/> 4U
<input checked="" type="checkbox"/> 5	<input checked="" type="checkbox"/> 5U
<input checked="" type="checkbox"/> 6	<input checked="" type="checkbox"/> 6U

Example for age less than or equal to 2 years:

Détails de la condition

Source: Données du dossier | Champ Diane: Age du patient (années)

Opérande: Est inférieur ou égal à 2

Example for standard consultation:

Détails de la condition

Source: Données du dossier | Champ Diane: Type de consultation [= Téléconsultation]

Opérande: Contient un des éléments suivants

Valeurs possibles:

<input checked="" type="checkbox"/> Consultation en présentiel	<input type="checkbox"/> Consultation privée
<input type="checkbox"/> Consultation au lit du patient[<input type="checkbox"/> Téléconsultation



Example for lab result from POA:

Détails de la condition

Source: Données du dossier | Champ Diane: Examens cliniques [= Examens cliniques effectués en CPA en lien NGAP]

Opérande: Contient un des éléments suivants

Valeurs possibles:

- Bilan réalisé en CPA
- Bilan et ECG réalisés en CPA
- ECG réalisé en CPA

4.8.3.3.2 Event (Procedure Codes)

In the case of an event, the **root item** (Complication, Patient environment, Consumable or Event) must be selected, then the Operand (Has been entered or Has not been entered), and the events selected in the tree structure.

Détails de la condition

Source: Evénements | Element racine: Evénements

Opérande: A été saisi

- Anesthésie
- Surveillances
- Alimentation et Hydratation
- Artéfact monitoring
- Chirurgie
- Actes péri-anesthésiques
- Examen neurologique
- Stade de quedel
- Voie d'abord
- Imagerie
- REANIMATION
- Prélèvements Actes Réalisés

4.8.3.3.3 Timer (Procedure Codes)

In the case of a timer, the timer must be selected, then the Operand (**Duration >=**, **Duration <=** or **Duration between**) and the duration(s) in minutes.

Détails de la condition

Source: Chronomètres | Chrono: Chirurgie

Opérande: Durée >= | 15 | (en minutes)



4.9 Setting up warnings for remote modification of Ax fields

Warnings for modified fields are set up via **Setups – Misc.**

Description du paramètre	Valeur du paramètre
Configuration générale	-
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"
Interface DXCare	
Appel	
Avertissement lors de modifications des champs du dossier à partir d'autres pos	33 132 131 92 959 135 958 263 112 62"
Interface DXCare	

Clicking the  button opens the following window:

Paramétrage des alertes des champs modifiés X

<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Allergies (Allergiques) <input type="checkbox"/> ALR (ALR) <input type="checkbox"/> Ambulatoire (Eligible ambulatoire) <input type="checkbox"/> Anesthésiste en CS (Anesthésiste en consultation (complé <input type="checkbox"/> Anesthésiste en CS (Anesthésiste réalisant la consultation <input type="checkbox"/> Anesthésiste(s) prévu(s) (Anesthésiste(s)) <input checked="" type="checkbox"/> Antécédents anesthésiques (Anesthésiques) <input checked="" type="checkbox"/> Antécédents Chirurgicaux (Chirurgicaux) <input checked="" type="checkbox"/> Antécédents familiaux (Champ supplémentaire 3) <input checked="" type="checkbox"/> Antécédents familiaux (Médicaux inactifs) <input checked="" type="checkbox"/> Antécédents Médicaux (Familiaux) <input checked="" type="checkbox"/> Antécédents médicaux (Médicaux actifs) <input type="checkbox"/> Antécédents obstétricaux (Obstétricaux) <input type="checkbox"/> Antécédents obstétricaux (Suivi post-opératoire) <input type="checkbox"/> Antécédents Transfusionnels (Transfusionnels) <input type="checkbox"/> Antibiotiques (Antibiotique) <input type="checkbox"/> Anticoagulants (Anticoagulant) <input type="checkbox"/> ASA (Risque ASA) <input type="checkbox"/> ATB prophylaxie (Antioprophylaxie) <input type="checkbox"/> ATB prophylaxie (Na) <input type="checkbox"/> Autopsie (Champ 19) <input type="checkbox"/> Autorisation (Autorisation) <input type="checkbox"/> Autorisation d'opérer (Phosphore) <input type="checkbox"/> Autorisation d'opérer (Type naissance) <input type="checkbox"/> Autres examens cliniques (Champ 10) <input type="checkbox"/> Autres Prescriptions (Autres) 	<p>Utilisation du champ</p> <p>Visual Consultation -> Antécédents / traitements) Allergies</p> <p>Consultation 7 Résumé Antécédents allergiques 1 ATCD Allergies</p> <p>Réanimation Paramed. -> Macro cible d'entrée) Allergies Médecin -> Antécédents) Allergies</p>
<input checked="" type="checkbox"/> Afficher uniquement les champs utilisés	<div style="display: flex; justify-content: space-between; width: 100%;"> Valider Annuler </div>

The pane on the right displays the components using the Ax/ID selected and the tab in which they are found for each toggled display configuration (**Consultation, Visual, ICU and OB-GYN**).



4.10 Fluid balance settings

This is done in **Setups** tab – **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 :
Rechercher

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

Description du paramètre	Valeur du paramètre
Configuration générale	
Débogage	
Paramètres du module expert ("Intelligence")	
Paramètres Active Directory	
Paramètre de vérification des nouveaux messages	
Configuration relatives aux paramètres physiologiques	
[ArtFormula]	
Paramètre du SSO	
Balance liquidienne	-
Décalage (en minutes) pour la date/heure de début de calcul de la balance liquidienne	0
Décalage (en minutes) pour la date/heure de fin de calcul de la balance liquidienne	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 heures	24
Case à cocher "De la veille" cochée par défaut. 1 (activé) par défaut	1
Composant DiaTraitements	
Composant DiaAllergies	
Gestion des mots de passe	
Gestion des verrous	
Configuration du portail de réanimation	
Section des indisponibilités	

Propriétés du paramètre
Propriétés du paramètre :
Balance liquidienne
Type de saisie :
Section
Choix possibles :
Masque de saisie :
Nombre de caractères maximum :
0
 Lecture seule
Ok Annuler

Enregistrer Annuler

Clé actuelle : [BL]
214 Ligne(s) chargée(s) en 00 min 00 sec 012 ms.

4.10.1 Defining the fluid balance calculation start time

OffsetStartDateTimeInMin: Delay (in minutes) for the fluid balance calculation start date/time (used for ICU where fluid balance is based on the ICU day by default). 0 by default, e.g.: -60 → starts one hour earlier.

The setup key **OffsetStartDateTimeInMin** is used to define the fluid balance calculation start date/time in comparison to the start time of the ICU day. It is the difference, in minutes, from the start time of the ICU day. It must be a positive or negative whole number.

4.10.2 Defining the fluid balance calculation end time

OffsetEndDateTimeInMin: Delay (in minutes) for the fluid balance calculation end date/time (used for ICU where fluid balance is based on the ICU day by default). 0 by default, e.g.: -60 → ends one hour earlier.

The setup key **OffsetEndDateTimeInMin** is used to define the fluid balance calculation end date/time in comparison to the start time of the ICU day. It is the difference, in minutes, from the start time of the ICU day. It must be a positive or negative whole number.



4.10.3 Resetting the fluid balance on patient transfer to another unit

ConstrainedToLocationStartDateTime: Resets the fluid balance on patient transfer to another unit

The setup key **ConstrainedToLocationStartDateTime** is used to reset the fluid balance when the patient is moved to another unit. It is a **Yes/No** key.

4.10.4 Hiding the date and time of items in the fluid balance

HideDateTime: Hides the date and time of items in the fluid balance. 0 (disabled) by default.

The setup key **HideDateTime** is used to hide the date and time of the item. It is a **Yes/No** key.

4.10.5 Default value for showing fluid balance of last X hours

DefaultValueTimeFilter: Default value for showing fluid balance of last X hours. 24 by default.

The setup key **DefaultValueTimeFilter** is used to configure the default value of the **Of the X last hours** in the **Fluid balance display** of the **Fluid balance** tab. This setting also affects how fluid balance is displayed in the cockpit and information on the record history in the **Medication order** tab. It must be a positive whole number.

4.10.6 For yesterday checkbox selected by default

ShowDayBeforeChecked: For yesterday checkbox selected by default 1 (Enabled) by default.

The setup key **ShowDayBeforeChecked** is used to select the **For yesterday** checkbox by default in the **Fluid balance display** of the **Fluid balance** tab. It is a **Yes/No** key.

4.11 Password settings

This is done in **Setups** tab – **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
Composant DiaAllergies	
Gestion des mots de passe	-
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
Gestion des verrous	
Configuration du portail de réanimation	
Gestion des indisponibilités	
Configuration Bluetooth pour le transfert de fichiers	
[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 expiry

PasswordExpiration: Password expiry.

The setup key **PasswordExpiration** determines whether or not passwords have a limited duration. Three settings are possible:

- **Disabled:** passwords have no expiry date.
- **Enabled (warning message on expiry):** when a password expires, a message informs the user that it has expired.
- **Enabled (update mandatory on expiry):** when a password expires, the user must define a new password to log in.

4.11.2 Password duration

PasswordDuration: Password duration (in days, 365 by default).

The setup key **PasswordDuration** is used to define the duration, in days, of passwords.



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4.11.3 Minimum password length

PasswordMinLength: Minimum password length (in characters, 6 by default).

The setup key **PasswordMinLength** is used to define the minimum length of passwords.

4.11.4 Minimum number of digits in password

PasswordMinDigits: Minimum number of digits in password (-1=digits forbidden).

The setup 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 digits.

4.11.5 Minimum number of lowercase letters in password

PasswordMinSmallLetters: Minimum number of lowercase letters in password (-1=lowercase letters forbidden).

The setup key **PasswordMinSmallLetters** is used to define the minimum number of lowercase letters a password must contain. If this key is set to -1, passwords may not contain lowercase letters.

4.11.6 Minimum number of uppercase letters in password

PasswordMinCapitalLetters: uppercase number of uppercase letters in password (-1=uppercase letters forbidden).

The setup key **PasswordMinCapitalLetters** is used to define the minimum number of uppercase letters a password must contain. If this key is set to -1, passwords may not contain uppercase letters.

4.11.7 Minimum number of special characters in password

PasswordMinSpecialChar: Minimum number of special characters in password (-1= special characters forbidden).

The setup 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 modify password

CanModifyPassword: Allows the user to modify their password.

The setup key **CanModifyPassword** is used to define whether the users can change their own passwords or if this must be done by an administrator. It is a **Yes/No** key.

4.11.9 Number of attempts before account blocked

PasswordFailure: Number of attempts before account blocked (0=no limit).

The setup key **PasswordFailure** is used to set the number of password entry attempts that can be made before the account is temporarily blocked. The account is then blocked for one minute before another attempt. The duration for which the account is blocked doubles each time the limit is reached.





4.11.10 Password history

PasswordHistory: Password history.

The setup key **PasswordHistory** is used to define whether previous passwords are saved. If this is the case, it is not possible to reuse a password that has already been used. It is a **Yes/No** key.

4.12 Cockpit setup for anaesthesia

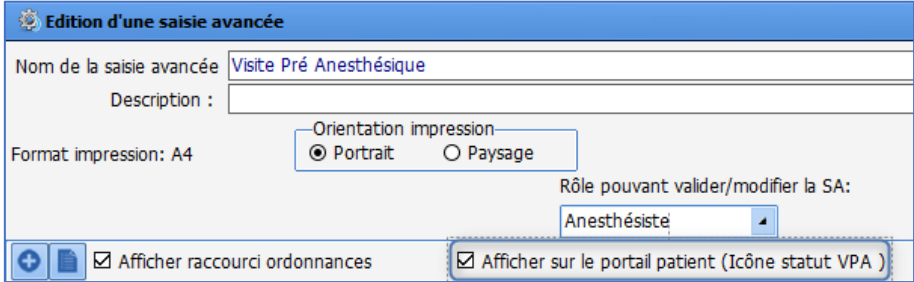
The cockpit (patients list) can be used to display an icon  if used in anaesthesia. The icon turns blue  when the POA is signed using a detailed entry set up to this effect.

4.12.1 Activation of the POA icon

The **DisplayVPAStatusOnPanel** setup key in **Dianerea.ini** must be enabled for this icon to be displayed.

4.12.2 Configuration of POA detailed entries

For a detailed entry to be used for signing a POA, the box **Display on patient portal (POA status icon)** must be checked when it is edited.



Edition d'une saisie avancée

Nom de la saisie avancée: Visite Pré Anesthésique

Description:

Format impression: A4

Orientation impression: Portrait Paysage

Rôle pouvant valider/modifier la SA: Anesthésiste

Afficher raccourci ordonnances Afficher sur le portail patient (Icône statut VPA)

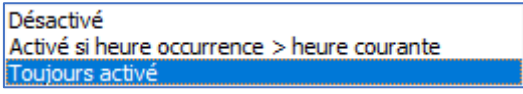
4.13 Setting up multiple entries

This is done in **Setups** tab – **Visual** tab.

4.13.1 Activation of synchronisation

SynchronizeNextSM: Activate synchronisation of a chained multiple entry with regard to the last time of occurrence of the previous multiple entry: disabled by default.

The setup key **SynchronizeNextSM** is used to activate the synchronisation of a chained multiple entry with regard to the last time of occurrence of the previous multiple entry. This key can have the following three values:



Désactivé
Activé si heure occurrence > heure courante
Toujours activé



4.13.2 Activation of the Keep this multiple entry checkbox

AfficheRepriseSM: Display the Keep Multiple Entry checkbox (default 1).

The setup key **AfficheRepriseSM** is used to define whether the **Keep this multiple entry** checkbox is shown in multiple entries. It is a **Yes/No** key.

4.13.3 Selection of default occurrence mode

SMOccurrenceMode: Indicates the default occurrence mode of a multiple entry item (0=single, 1=multiple. Simple by default).

The setup key **SMOccurrenceMode** is used to define whether or not elements in the multiple entry are single or multiple by default (if multiple, a window is used to schedule them).

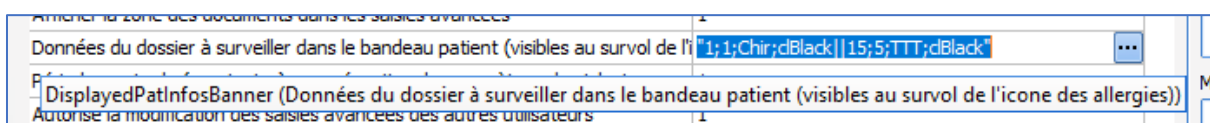
4.13.4 Allow modification of occurrence mode

SMCanSetOccurrenceMode: Indicates whether the occurrence mode of multiple entry items can be modified (1=yes, 0=no. No by default).

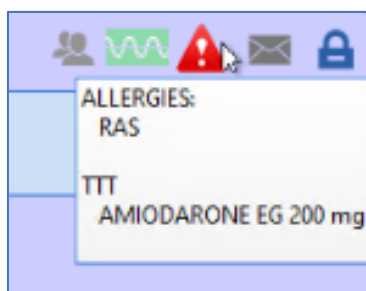
The setup key **SMCanSetOccurrenceMode** is used to define whether or not it is possible to change the occurrence mode of multiple entry items.

4.14 Setting up information on hovering over the allergy icon

This is done in **Setups** tab – **Visual** or **DianeICU** tab.

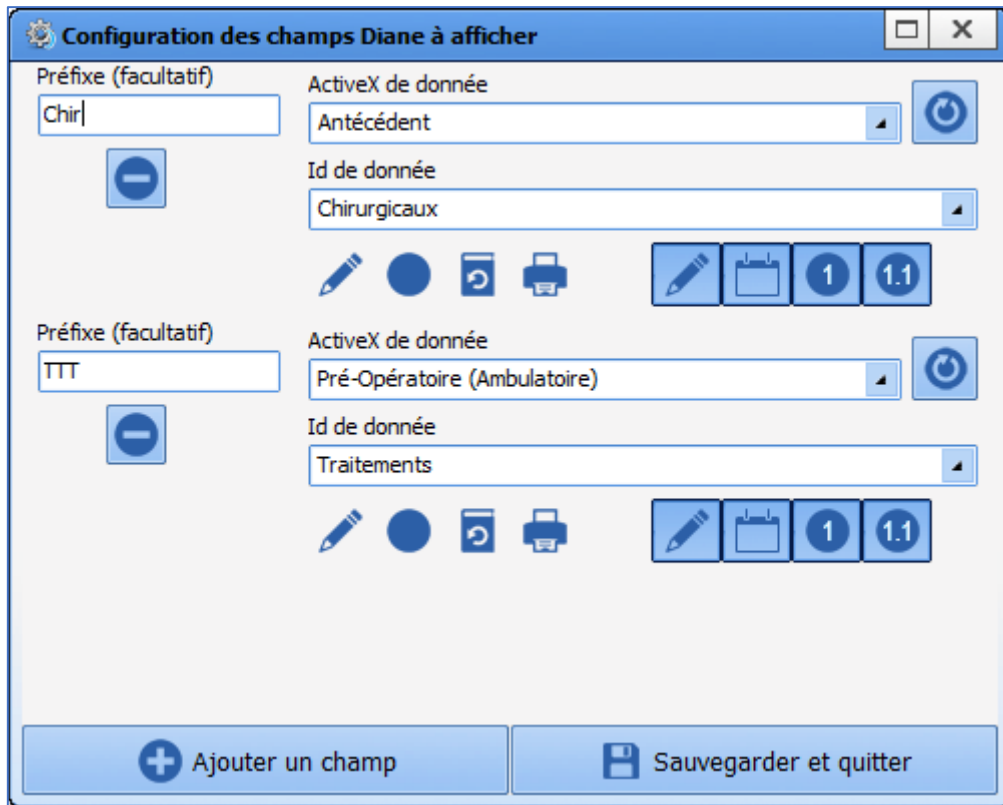


Hovering over the allergy icon can show other information in addition to the allergies entered in the relevant component.



This additional information can be selected from the various data ActiveX using the **Configuration of DIANE fields to view** window. This window can be accessed via the ... button at the end of the setup key row.

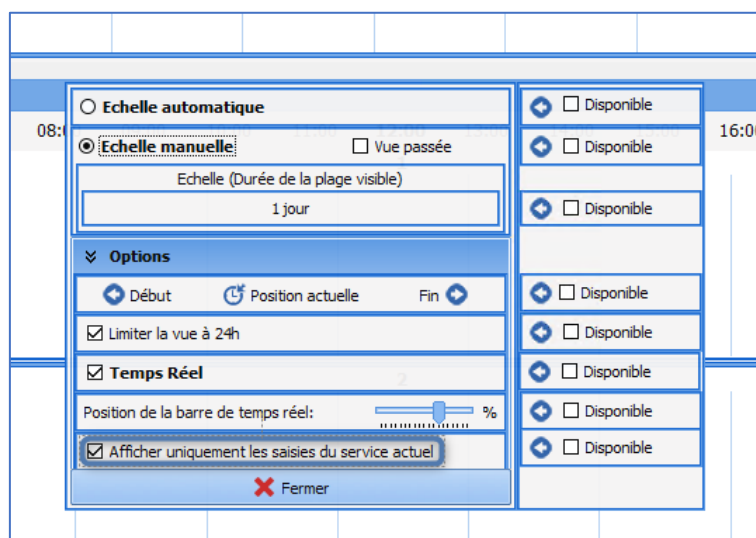




4.15 Setting up exclusions for data from other units

When a patient is transferred to another unit, for example a patient hospitalised in ICU who undergoes a procedure in anaesthesia, displaying the data associated with the ICU record can reduce the readability of the anaesthesia record.

It is possible to set up the display so that only data from the current unit is shown. This prevents overloading the display with issues from the patient's original unit. To do this, the Only show entries from current unit checkbox is used to configure the display of the **OT** or **Monitoring** tab or type 3 views.



4.16 Setting up treatments and premedications

This is done in **Setups** tab – **Diaserveur** tab.

Paramétrage de l'application

Nom du paramétrage : **Demo Style 1 (intelligence activée)**
 Application ou module à paramétrer : **Diaserveur**

Recherche d'un paramètre

Texte à rechercher

Champ(s) à considérer pour la recherche: Tous

Rechercher

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

Description du paramètre	Valeur du paramètre
Composant DiaTraitements	-
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>, <shortname> <dosage> (<principeactif>)	
Pattern pour le libellé personnalisé du médicament dans le composant (<default> <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 case à cocher "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 select the unit and route of the selected drug.
 It is a **Yes/No** key.

MinCharacterBeforeSearchInBase: Number of characters to be entered before automatic search in the drug database
 This must be a whole number.

DelayBeforeSearchInBase: Delay (in ms) before the drug database is searched when a drug is entered.
 This must be a whole number.

ListBoxMedicNamePattern: Pattern for personalised label in list box (<default>, <shortname>, <dosage>, <forme>, <atccode>, <atcname>, <principeactif>)
 This key is text.

ComponentMedicNamePattern: Pattern for the personalised label of the drug in the component (<default>=Drug database label <dosage>, <forme>, <atccode>, <atcname>, <medicname> = List box label, <cip>, <posology>)
 This key is text.

Jokerize: Whether jokers such as * can be used in searches (used in list box)
 Possible values: 0 = None



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1=Before
2=After
3=Before & After

ListBoxLV1: Level 1 (used in list box)

Possible values: <atcname>=ATC name
<atccode>=ATC code
<forme>=Form name
<dosage>=Dosage
<medicname>=Drug name

ListBoxLV2: Level 2 (used in list box)

Possible values: <atcname>=ATC name
<atccode>=ATC code
<forme>=Form name
<dosage>=Dosage
<medicname>=Drug name

ListBoxLV3: Level 3 (used in list box)

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 must be a whole number.

AntecMedicauxDataId: Data ID for mode of admission (by default "MEDICAUX" field in "ANTECEDENTS" table)
This must be a whole number.

AdmissionModePossibleValues: Possible values for "mode of admission" component
(default=A="Ambulatory" | H="Hospitalisation" |)
This key is text.

AdmissionModeRefDiaAX: Reference ActiveX for mode of admission (by default "CPA_INFO_INTERVENTION"
table)
This must be a whole number.

AdmissionModeDataId: Data ID for mode of admission (by default new "mode of admission" field)
This must be a whole number.

CommentairesRefDiaAX: Reference ActiveX for comments associated with usual treatments (by default
"CPA_INFO_INTERVENTION")
This must be a whole number.

CommentairesDataId Data ID for mode of admission (by default new "comments" field) Whole number

DPIPathToLaunch: Command line for accessing Electronic health record from personal treatments and
premedications tab.
This key is text.

NoTreatmentText: Text for indicating that the patient has no personal treatments (= "No treatment" by default
or if not entered)



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This key is text.

UnknownTreatmentText: Text for indicating that the patient's personal treatment is unknown (= "Unknown treatment" by default or if not entered)

This key is text.

SendSubstitutesToReaPrescription: Status of "Send to hospital medication orders" for conversions (disabled=0 by default)

It is a **Yes/No** key.

SendPremedsToRealPrescription: Status of "Send to hospital medication orders" for premedications (disabled=0 by default)

It is a **Yes/No** key.

TimeMorningTreatment: Default time for morning treatments.

This must be a whole number.

TimeMiddayTreatment: Default time for midday treatments.

This must be a whole number.

TimeEveningTreatment: Default time for evening treatments.

This must be a whole number.

TimeBedTimeTreatment: Default time for bedtime treatments.

This must be a whole number.

ReprisePremed: The "Resume treatment from previous record" button also includes premedications (disabled=0 by default)

It is a **Yes/No** key.

4.17 Setting up integrated scores (SAPS II, CRIB II)

This is done in **Setups** tab – **DianeICU**.

Paramétrage des scores intégrés	
Type d'admission par défaut des patients en réanimation pour le calcul du score	Valeur du champ Diane TYPE_ADMISSION
Alim [IGS2] (Paramétrage des scores intégrés) roniques" à partir de la saisie	1
Configuration des parametres des fréquences cardiaques	"1 2 3 157 174 270 271 272 280 "

4.17.1 Default admission type for patients in ICU for calculating SAPS II score

IGS2DefaultAdmissionType: Default admission type for patients in ICU for calculating SAPS II score

The setup key **IGS2DefaultAdmissionType** determines the type of admission used to calculate the SAPS II score. Five settings are possible:

- 0=Undefined (by default)
- 1=Scheduled surgery
- 2=Emergency surgery
- 3=Medicine
- 4=Value of DIANE field **TYPE_ADMISSION**




4.17.2 Automatically fill the “Chronic diseases” field using the Diane field MALADIES_CHRONIQUES (AX Patient Info/Data ID 38)

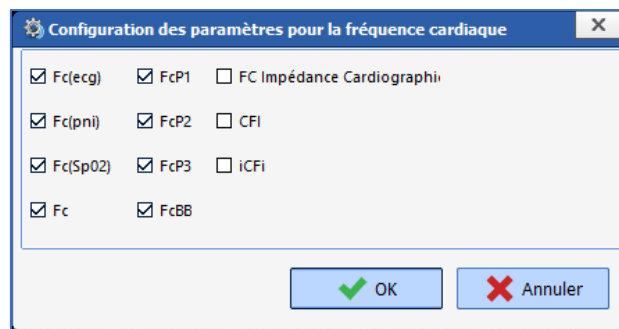
IGS2ChronicDiseaseFromCase: Automatically fill the “Chronic diseases” field using the Diane field MALADIES_CHRONIQUES (AX Patient Info/Data ID 38).

The setup key **IGS2ChronicDiseaseFromCase** determines whether the field **Maladies chroniques** is automatically filled using the contents of the DIANE field **MALADIES_CHRONIQUES**. It is a **Yes/No** key.

4.17.3 Configuring heart rate parameters

ParamFreqCard: Configuration of heart rate parameters.


The setup key **ParamFreqCard** determines the heart rates used to calculate the SAPS II score. Clicking  shows a window from which the heart rates taken into account can be selected.



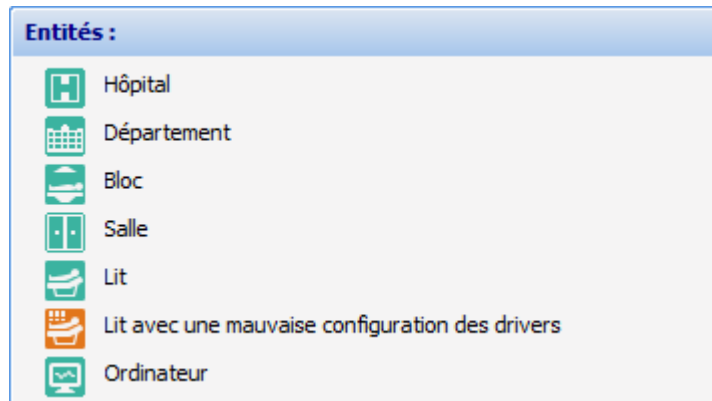
5 Configuring users (and facility organisation)

5.1 Glossary

Gear

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

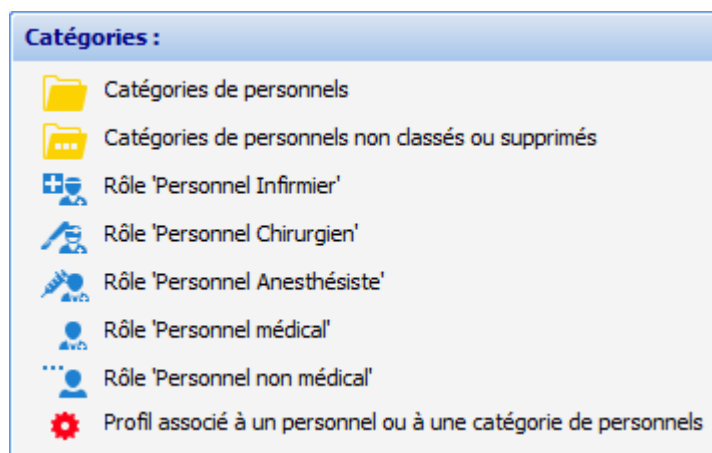
Facility entities





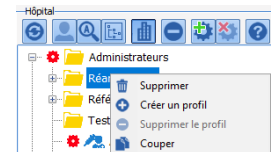
Each entity can have its own configuration (gear).

Any entity that does not have its own configuration will use the first configuration found when ascending the tree structure.

Staff categories and Roles



The categories segment possible users by job. Each first level category must have a gear . It is possible, if necessary, to create a profile for a row. To do this, select the row, then either click the right mouse button to see a menu (**Create a profile**) or select the button  in the toolbar below.



Properties pane

This pane contains all the information relevant to the **Category** or **Role**. Fields differ depending on if a **Staff category** or **Role** is selected.











Tools for Staff categories and Roles

The tools for **Staff category** and **Role** are as follows:



Used to refresh the list, close the tree structure and deselect the current computer or user



	Used to hide or show configured 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 the hospital entities or staff categories
	Used to show users
	Used to delete an entity, staff category or staff member
	Used to create a user account or facility entity
	Used to delete a user account or facility entity
	Shows icon meanings

Some buttons may be greyed out if they are not used in the current context.

Workstation connection information

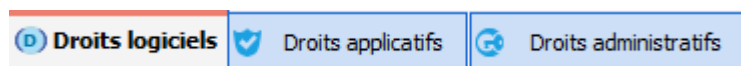
This pane only appears if a **Computer** is selected.

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 use of the computer.

Permissions associated with a gear

Each **Staff category** or **Role** is associated with **Permissions** broken down on three tabs



5.2 User configuration

This chapter explains how to create a new user account or modify an existing account.

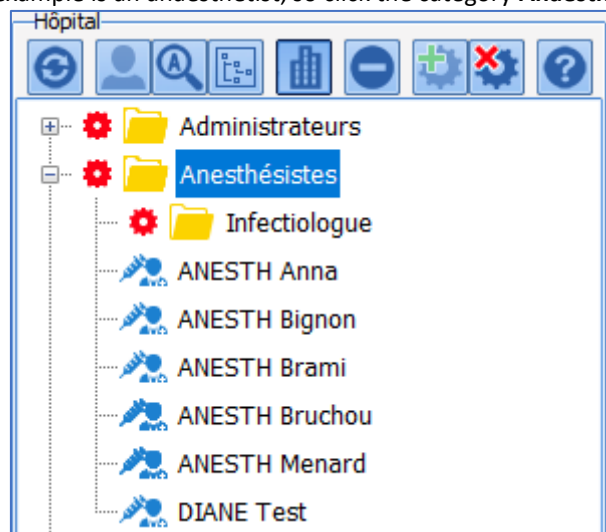
A user, category or entity can be deselected in the **UserConfiguration** application tree. To do this, right-click in the white pane at the bottom of the tree (after closing the submenu with a left-click outside the submenu), left-clicking in the white pane at the bottom of the tree, or pressing the **Esc** key.



5.2.1 Creating a user account

A user must be associated with a **Staff category** in **DIANE**. The staff category corresponds to a row on the left side of the configuration of a user.

The user created in this example is an anaesthetist, so click the category **Anaesthetists**:



Here, several anaesthetists are already configured, as is a subcategory: **Infectious disease specialist** with a specific configuration (gear).

The **right side** is used to create a user by clicking in the red-framed button below.

Last name and First name The user's name appears when using **DIANE** modules. In order to distinguish between the two accounts of DIANE experts, when they are also HCPs, writing **DIANE expert** before the **Last name** and **First name** is recommended. The two accounts have different permissions and purposes, so it is very important that they can be distinguished using the **Last name** and **First name**.

Role The role attributed to a user affects how some **DIANE** modules behave. The anaesthetist is the only user able to sign a recovery room discharge. Pharmacists and doctors have different functions when it comes to medication orders.

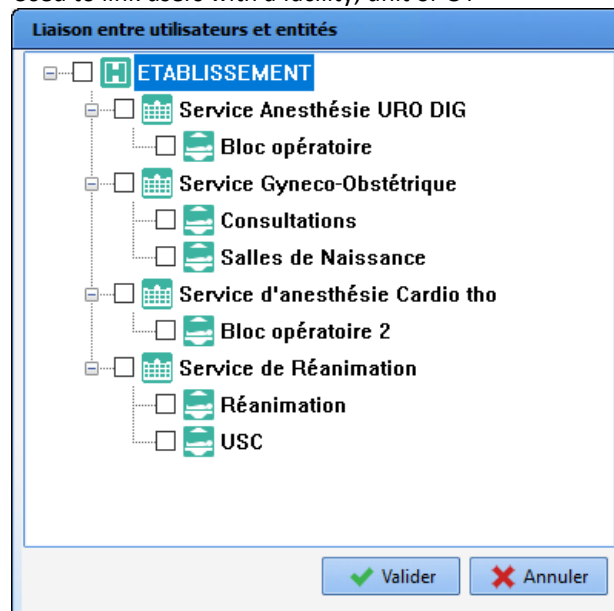
ID The **ID** and **Password** are necessary for accessing the software. The ID must be unique



	across the facility.
Password and Confirmation	The minimum complexity of the password with regard to uppercase letters and digits can be set up in Application configuration . The same password must be entered in Password and Confirmation .
Health professional registry number	This information can be added automatically to letters and prescriptions generated by DIANE .
HCP directory ID	This information can be added automatically to letters and prescriptions generated by DIANE .
CPS	Health Professional Code
Signature	The contents can be added to letters and prescriptions.
External ID	Used by interfacing service with IT department for creating context calls.
Email address	Used in setting up medication order emailing to set up the address from which emails are sent.
Title	User's title
Senior doctor	The senior doctors has the right to countersign the signatures of junior doctors. This permission is associated with a start date for this ability. It is not possible to generate a specific date. It starts on clicking Use today's date and stops on clicking Delete date .
Disabled account	Used to limit the duration of use of an account without having to disable it. Can be used for temporary contracts, for example.




Used to link users with a facility, unit or OT

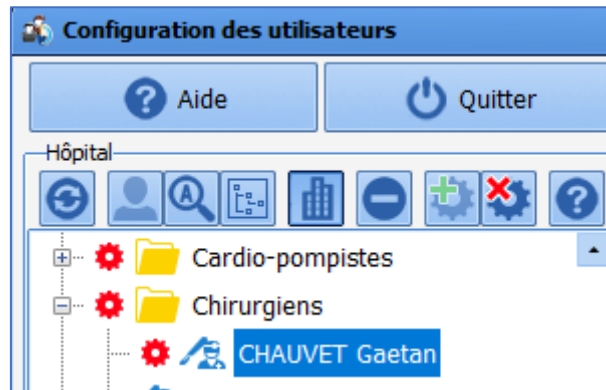


By default, if a user is not assigned to a specific entity, they will be assigned to all entities.



5.2.2 Modifying a user account

To modify a user account or a component of a user account, select the user from their category (or use the search tool .



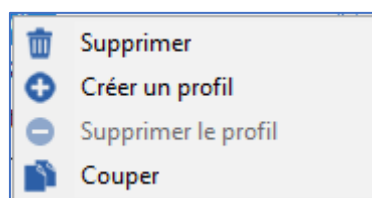
Click the name of the user to be modified.

The **Save** button must be clicked to save changes.

5.2.3 Deleting a user account

A user configured in **DIANE** does not fully disappear but is only disabled. Keeping disabled user accounts allows for records to be displayed and archived consistently.

To delete a user, right-click the user to be disabled.



From this menu, select **Delete**: a confirmation window appears to reduce the risk of error.





To reactivate an account, there are two possibilities:


- Drag and drop the user into the relevant **User category**.
- Right-click the user's name and select **Cut**. The user's name is greyed out and italicised. Right-click to copy it into the relevant category.

5.2.4 Using the User signature function

The signature function is used to construct a text and image-based (barcode, scanned handwritten signature, etc.) signature automatically added to the end of prescriptions.

To do this, for each user, construct a signature in **Wordpad** or **Word** (not possible with the integrated editor) and copy it into the open window after clicking **Signature...**



Once this has been confirmed, a logo  appears to the left indicating that this user has a signature.

It is also possible to import a signature in RichText format (.rtf).

5.2.5 Creating user categories

In this example, a category of perfusionists will be created.

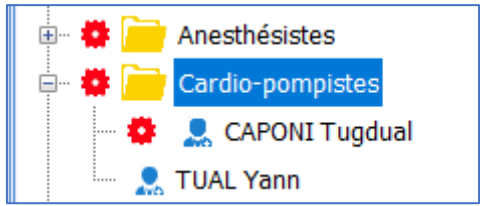
To create a new user category, select the parent user category.



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Création Imports Exports

Propriétés

Nom :

Définir comme profil Invité pour Active Directory / Interfaces intégration utilisateurs

Rôle par défaut pour ce profil

After clicking the create user category button outlined in red in the illustration above, this window is shown:

Création Imports Exports

Propriétés

Nom :

Définir comme profil Invité pour Active Directory / Interfaces intégration utilisateurs

Rôle par défaut pour ce profil

The name of the user category is entered under **Name**. The role associated with this user category is selected from the drop-down menu **Default role for this profile** from the following values:

- Anaesthetist
- Surgeon



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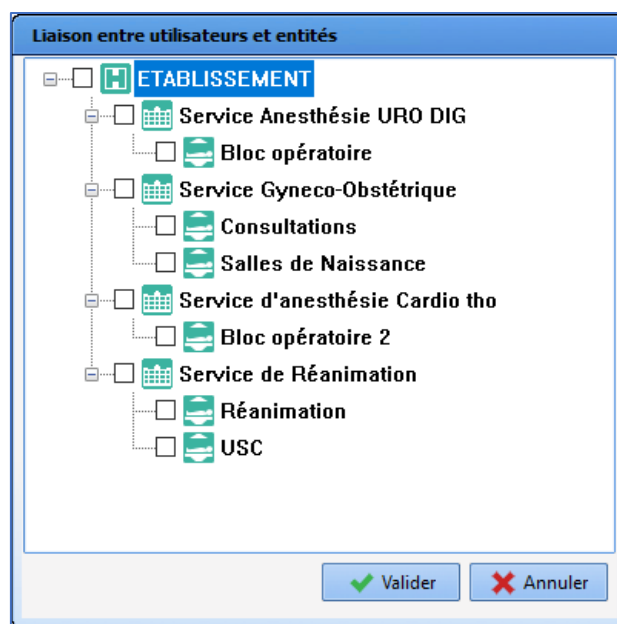


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- Nurse anaesthetist
- Medical
- Non-medical
- Intensivist
- Nurse
- Nursing assistant
- Obstetrician
- Midwife
- Gynaecologist
- Paediatrician
- Intensivist anaesthetist

It is possible to associate a user category with one of more entities using the following window, accessed by

clicking .



The list of **Hospital, Unit** and **OT** entities configured is suggested.

It is possible to select the entities for which the user category should be available with a click. The association is confirmed by clicking **Confirm**. By default, if a Staff category is not assigned to a specific entity, it will be accessible throughout the facility.

Warning: Deleting an entity updates the table where user/entity associations are saved. If a user was only assigned to the deleted entity, they will then be available throughout the facility again as they are not associated with a specific entity.

NOTE: The checkbox **Define as profile... user integration** is used to connect **DIANE** to the facility directory; this is the responsibility of the IT department.

5.2.6 Editing a user category

To modify a user category, right-click the category.



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Création Imports Exports

Propriétés

Nom :

Définir comme profil Invité pour Active Directory / Interfaces intégration utilisateurs

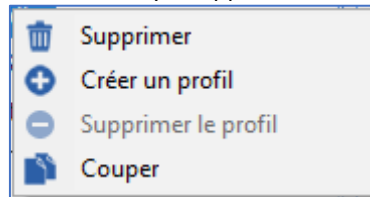
Rôle par défaut pour ce profil

Enregistrer Annuler

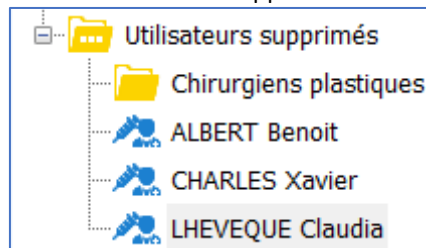
Edit the **Name** of the user category and save changes using the **Save** button.

5.2.7 Deleting a user category

A user category configured in **DIANE** does not fully disappear but is only disabled.




From this menu, select **Delete**: a confirmation window appears to reduce the risk of error.



To reactivate a category, there are two possibilities:

- Drag and drop the user into the relevant **User category**.
- Right-click the user's name and select **Cut**. The category name is greyed out and italicised. Right-click to copy it into the relevant category.

5.2.8 Gears

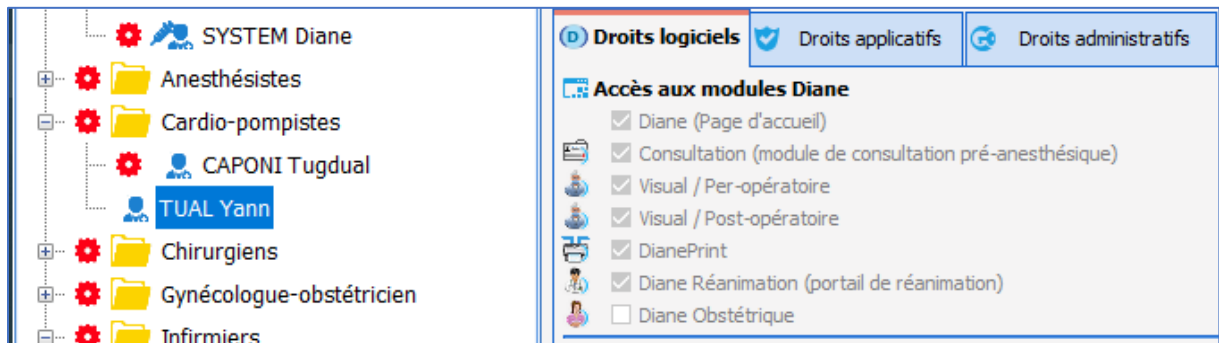
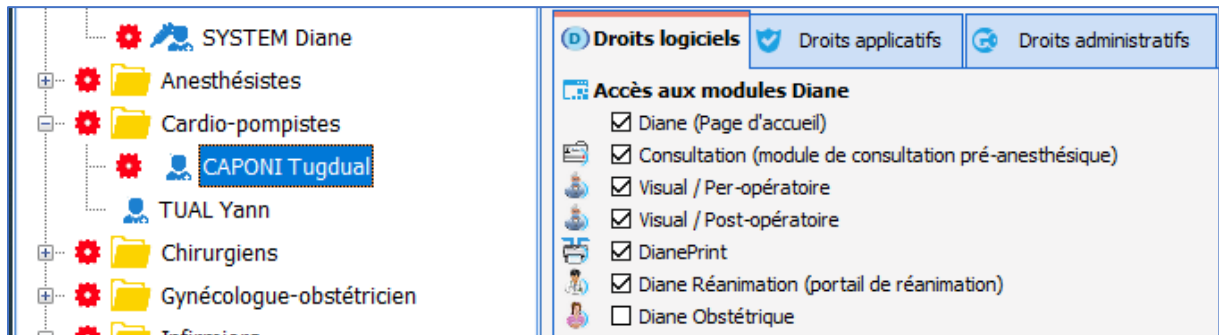
Permissions are managed using gears . It is not possible to modify permissions associated with a category or user if there is no gear associated with the row.



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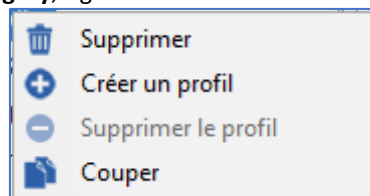
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In the example above, the permissions of Yann Tual are those set up for the Perfusionists **user category**.

If the Perfusionists **user category** settings are changed, only Yann Tual will be affected by the changes. Tugdual Caponi is not affected as he has his own configuration.

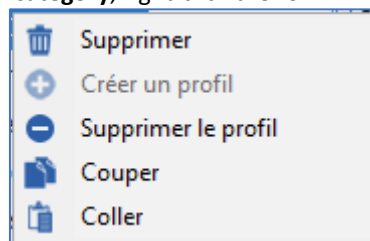
To **add a gear** to a **user** or **user category**, right-click the row.



Then select **Create a profile**: the setup for this new **gear** will be the same as the first row with a **gear** when going up the tree structure.

In the example above, if a gear is created for Yann Tual, it will have the same setup but can be modified. The setup is a “copy” of the setup for the Perfusionists **user category**.



To **delete a gear** from a **user** or **user category**, right-click the row.




Then select **Delete a profile**: the setup now associated with this row will be the same as the first row with a **gear** when going up the tree structure.

In the example above, if the **gear** associated with Tugdual Caponi is deleted, he will be given the same setup as that of Yann Tual, i.e. that of Perfusionists.




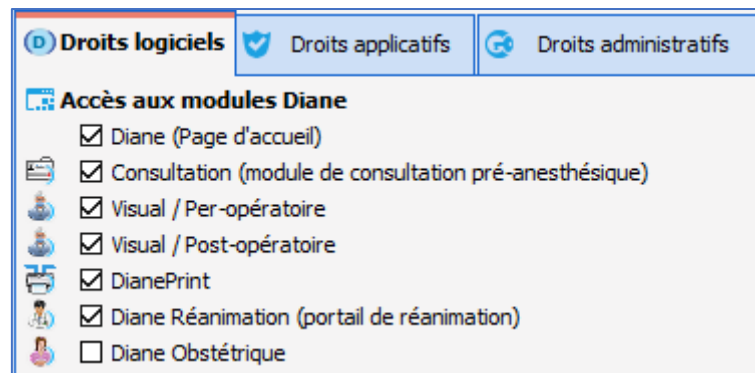
In addition to right-clicking to **Create a profile** or **Delete a profile**, it is also possible to use the relevant buttons:  and .

5.2.9 Managing permissions

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 checkbox.

The image below indicates that for the row with the gear , launching all modules is authorized, with the exception of **DIANE OB-GYN**.



To make launching **DIANE OB-GYN** possible, select the box and save the change.

Permissions are divided into three categories:

Software permissions:

These permissions restrict access to the various modules. The difference between user and Diane Expert accounts can be used as an example: the user cannot launch the two configuration tools, unlike the Diane Expert.



Droits logiciels	Droits applicatifs	Droits administratifs
Accès aux modules Diane		
<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)		
Fenêtre de selection de patient		
<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 restrict the actions that can be carried out in the modules, for example for **Consultation**:

Droits logiciels	Droits applicatifs	Droits administratifs
Consultation		
<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		

Administrator permissions:

These permissions restrict the scope of intervention of Diane Experts. This can be used to give them specific roles or avoid user errors.

Droits logiciels	Droits applicatifs	Droits administratifs
Droits de modification des listes complètes (listes sur la droite dans l'application Configuration)		
<input checked="" type="checkbox"/> Listes de CONSULTATION		
<input checked="" type="checkbox"/> Listes des EVENEMENTS		
<input checked="" type="checkbox"/> Listes des MEDICAMENTS		
<input checked="" type="checkbox"/> Listes des CHRONOMETRES		
<input checked="" type="checkbox"/> Listes des EXAMENS et des BILANS		
<input checked="" type="checkbox"/> Listes des SAISIES MULTIPLES		



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NOTE: the default permissions allow the different modules to work coherently. They can be modified but this should be done with caution: there are interactions between permissions.

5.3 Configuring the facility organisation

This facility configuration tool is used to modify how rooms are organized and the possible location of computers in the facility.

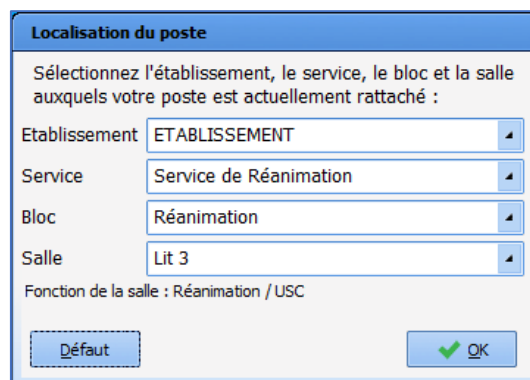
5.3.1 Organising the tree structure

The facility is sub-divided into the following 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 computers.

Note: gears have no relevance for this tool and therefore do not appear.

5.3.2 Adding a computer

This tool is not used to add a computer. When a computer must be configured for use in **DIANE**, it must be started and then **DIANE** launched. Once the connection is validated, the computer location is requested.



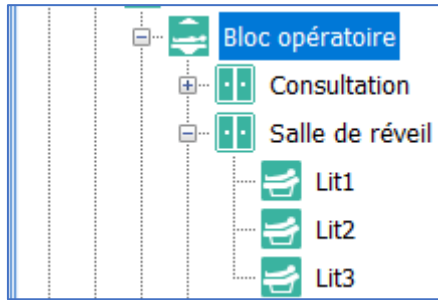
Once this initial location has been selected, the computer appears in the tool where it was set up.

5.3.3 Adding an entity to the facility tree structure

Adding an entity to the tree structure means that it can be kept up to date. It also enables some specific functions.

To add an entity, click the entity that will contain the new entity. In this example, a second **Recovery Room** will be added by clicking the **OT** row.





Select the Add entity button to the top right of the screen:



It is then possible to create the new entity:

Propriétés

Nom : Identifiant Externe : Couleur

Type : UF :

Fonction : Email :

Téléphone :

Finess :

The **name** appears in the facility tree structure.

The **type** corresponds to the entity's place in the hierarchy:

Hospital	Corresponds to the facility.
Unit	Covers several OTs .
OT	Covers all rooms in a patient pathway.
Room	Covers at least one Computer . Configurations often apply to a Room rather than a Computer .
Bed	To be taken into account, a bed must be associated with a computer.
Computer	Several beds can be assigned to a computer - for RR or CCU for example.

The **function** is used to classify the **Room**:

OT	Classic OT configuration.
Secretariat	Used to assign a patient to a computer.
ICU/CCU	Used to work in Primary - Mirror mode. A Mirror computer is used to access the record open on the Primary computer remotely.
Consultation	Used to automate, on creating a new consultation, setting of the logged in user



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	as the Anaesthetist in consultation and current date as Consultation date.
Recovery	Used to manage anaesthesia signatures for authorizing patient discharge. Ensure at least one recovery bed is assigned to the computer in the RR. Otherwise the portal considers it as an OT: the RR signature function is nevertheless retained.
Induction	Works as a recovery room with no RR discharge signature and must take place before OT: this means the patient can be found in the list of expected patients in the OT.
Other	
Delivery room	
Monitoring	Used to configure computers on mobile carts so that the user can take action on patients assigned to them without having to log in each time they change patient. A patient reception can be carried out.
Ambulatory	Used to discharge a patient remotely.

5.3.4 Searching for a computer, room or user

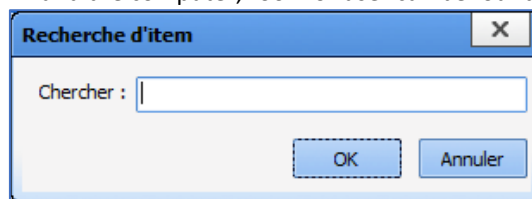
On opening, the tool selects the current computer. Clicking the update button finds the current computer:



To find a computer, it is possible to search for it in the facility tree structure.



The following window is shown and the computer, room or user can be found using part of their name.



If the row suggested by the search engine is not correct, press the **F3** key for a list of search engine suggestions.

NOTE: the presence of users in this tool is only useful for the **DIANE Appointments** module.

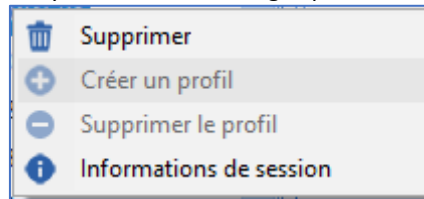
5.3.5 Adding a user for the Appointments module

It is possible to add a user in this part of the tool. Users created in user part of the 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. They can be found using their name via the search engine and drag-and-dropped or cut-and-pasted to the relevant unit .

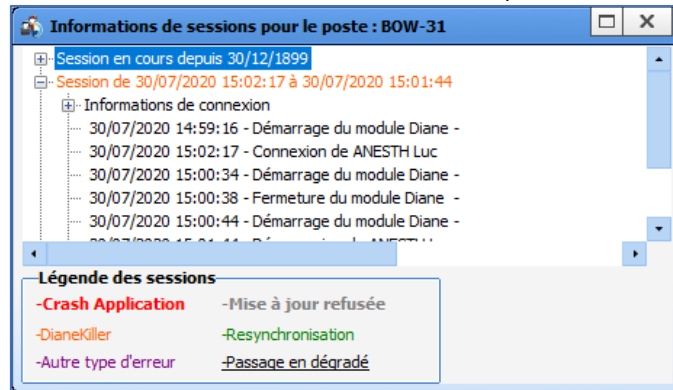


5.3.6 Inspecting a computer history

Right-clicking a computer in the facility tree structure brings up this menu:

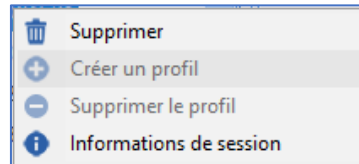


The **Session information** shows connection information for this computer in the following window:



5.3.7 Deleting a computer or room

Right-clicking a computer or entity in the facility tree structure brings up this menu:



Delete moves the computer or entity to the bottom of the tree structure in the **Deleted entities** category. These rows can be moved using the mouse (drag and drop) by following the instructions to **Move a computer, room or user**.

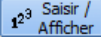
It is also possible to delete a computer or entity using the delete button in the button bar at the top of the facility tree structure:

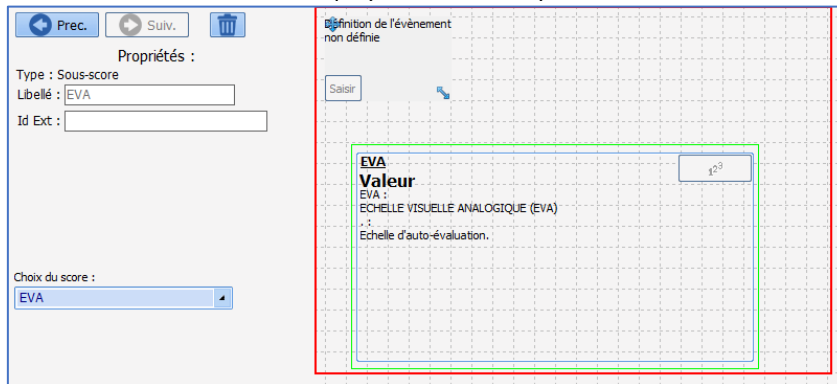


6 ANNEXES

6.1 Components only used in Detailed entries

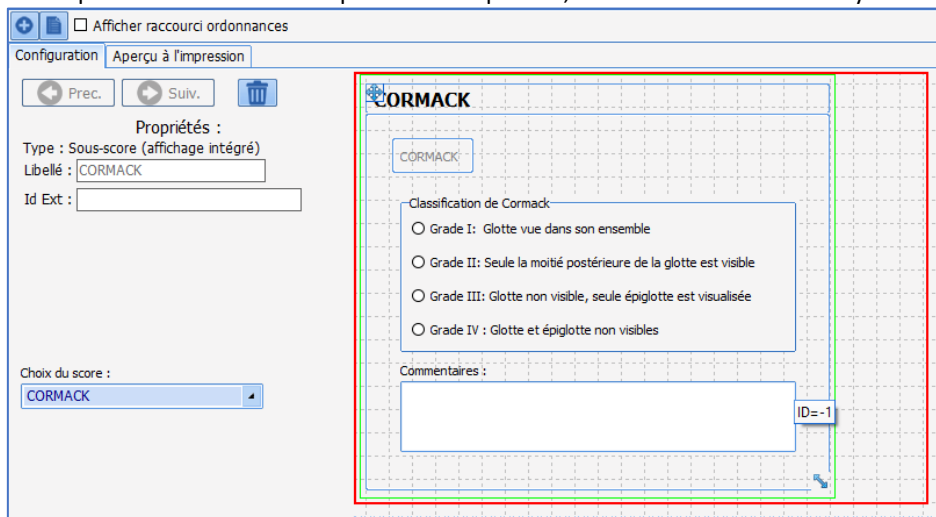
6.1.1 Subscore

This component makes it easy to enter a score in a detailed entry. Just select the desired score and size the component. Click the  button to display the score entry window.



6.1.2 Subscore (integrated display)

Like above, this component makes it easy to enter a score in a detailed entry. Just select the desired score and size the component. Unlike with the previous component, scores are entered directly in this one.





6.1.3 Predefined values button

This component is used to complete the various components (Checkboxes, radio button and/or checkbox groups, one-line and multi-line input fields, etc.) with the values set up in configuration. It is possible to determine whether or not data entered in components that remain empty when the component is edited should be deleted using the **Do not reset other fields** box.



ne pas RAZ autres champs

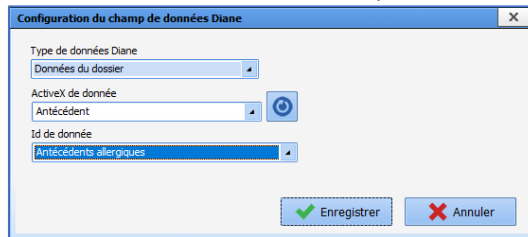
 Enregistrer les valeurs prédéfinies

 Annuler

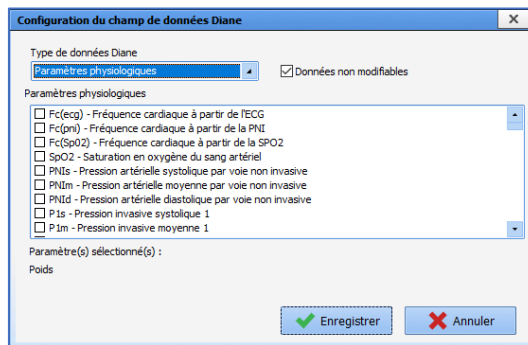
6.1.4 DIANE data

This component is used to display three types of **DIANE** data:

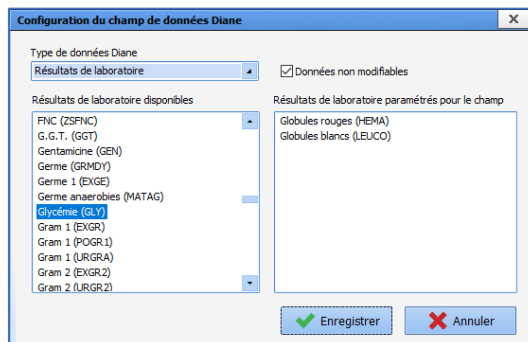
- **Record data** (associated with an ActiveX and a Data ID)



- **Vital signs:**



- **Lab results:**




6.1.5 Components only used in display configuration

6.1.5.1 Tab

This component is used in the configuration of the **DIANE ANAESTHESIA (Visual (IntraOp and PostOp))**, **DIANE OB-GYN** and **DIANE ICU** applications. It is used to add a subtab to tabs where this is permitted.

Description du paramètre	Valeur du paramètre
Positionnement / Affichage	
Visible	Oui
Intitulé	
Intitulé	Antécédents / traitements
Options d'affichage du contenu	
Couleur de fond du composant	0
Taille de la police	10

Enregistrer Annuler

6.1.5.2 Detailed entry (basic view)

This component is used to display items entered when a detailed entry is edited.

Onglet

- Administratif
- Antécédents / traitements
- Examen clinique
- Paracliniques
- Conclusion visite
- Ambulatoire

Position X : 0 Largeur : 320
Position Y : 0 Hauteur : 240

Afficher seulement ce composant

Saisie avancée :
Identitovigilance

Mode d'affichage :
Dernier enregistrement

Type de données

- Normale
- Enfant

Enregistrer Annuler

The two settings for this component are:

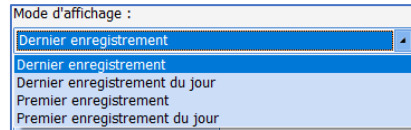
- **Detailed entry:**

Saisie avancée :

- Identitovigilance
- Identitovigilance 1
- Identitovigilance 2
- Identitovigilance 3
- Identitovigilance 4
- Identitovigilance 5
- Infirmiers Néonatal
- Informations nouveau né
- Initial PARSONNET. (Score)
- Intervention Kiné
- Isolement
- J+1 Césarienne
- J+1 Suspicion de chorioamniotite
- J0 César
- J1 Accouchement prématuré spontané - Postnatale
- J-1 César
- Kiné_ Bilans
- Kiné_Prescription
- Kinésithérapie
- Kremlin-Bicêtre(sortie SSPJ) (Score)



- **View mode:**



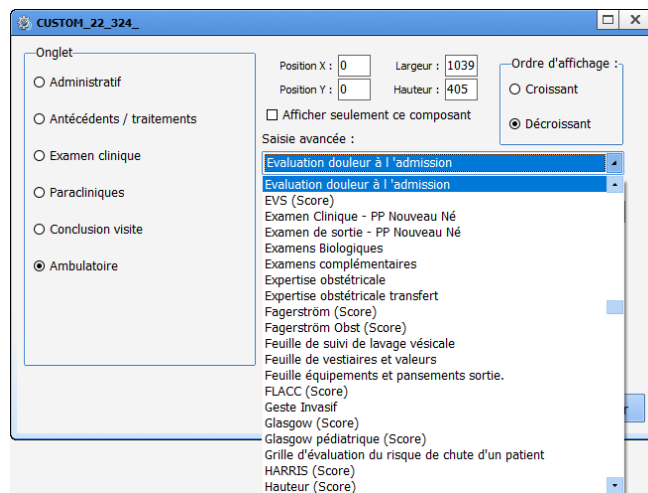
The **View this component only** checkbox changes the size of the component so it takes up the whole tab.

It is also possible to use non-toggled detailed entries.

6.1.5.3 Detailed entry (multi-view)

As with the previous component, this is used to display detailed entries. However, here, previous entries remain visible and can be displayed in full. 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** component (targeted and macro targeted) cannot be resized (it always takes up the whole subtab), moved from one subtab to another, or edited.

There are no settings to change, but a subtab must be allocated.

6.1.5.5 Treatments

This component is used to synchronise and retrieve usual treatments entered in Consultation.



Description du paramètre	Valeur du paramètre	ActiveX de donnée
Positionnement / Affichage		
Visible	Oui	Antécédent
Onglet parent	Traitements	<input type="checkbox"/> Non utilisés uniquement
Position horizontale en pixel	0	Antécédents: Traitements
Position verticale en pixel	0	
Largeur en pixel	468	<input type="checkbox"/> Cacher les boutons
Hauteur en pixel	315	<input type="checkbox"/> Forcer saisie voie et unité
Ordre de tabulation	0	
Nom du composant parent (Conteneur déployable)		
Intitulé		
Intitulé	Traitements	
Taille de la police de l'intitulé	10	
Intitulé en gras	Oui	
Options d'affichage du contenu		
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	
Options des données associées		
Accès en écriture du champ	Ecriture	
Niveau d'importance du champ	Elément normal	
Historique activé	Oui	
Valeur de saisie "RAS"		
Niveau de la reprise	Jamais repris	
Options de la saisie avec liste de référence		
Liste générale de la première colonne	Consultation	
Liste générale de la deuxième colonne	Consultation	
Root de référence de la deuxième colonne		

The ActiveX/Data ID pair used in the Consultation module must be used again.

NOTE: By default, the component connects to the Vidal or BCB drug database cache.

6.1.5.6 Deployable container

The deployable container is a component that can be used to streamline the display: other components can be inserted and are only visible when the container is expanded.

Closed container:

Informations patient						
Né(e) le	Lieu de naissance	N° IPP	N° de S.S.	Situation de famille	Profession	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Non renseigné	<input type="text"/>	
Adresse		Code postal	Ville	Téléphone	Mobile	Adresse email
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Médecin traitant						
<input type="text"/>						
Intervention						
Date de consultation	Date Prévus d'intervention	Anesthésiste en CS			Chirurgien(s) prévu(s)	
<input type="text"/>	04/11/2020	<input type="text"/>			<input type="text"/>	
Service demandeur	Durée chirurgie prévue					
<input type="text"/>	<input type="text"/>					

Expanded container:

Informations patient						
Né(e) le	Lieu de naissance	N° IPP	N° de S.S.	Situation de famille	Profession	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Non renseigné	<input type="text"/>	
Adresse		Code postal	Ville	Téléphone	Mobile	Adresse email
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Médecin traitant						
<input type="text"/>						
Médecin traitant						
Nom	Prénom	Adresse		Code postal	Ville	
<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	
<input type="text"/>						
Date de consultation	Date Prévus d'intervention	Anesthésiste en CS			Chirurgien(s) prévu(s)	
<input type="text"/>	04/11/2020	<input type="text"/>			<input type="text"/>	
Service demandeur	Durée chirurgie prévue					
<input type="text"/>	<input type="text"/>					

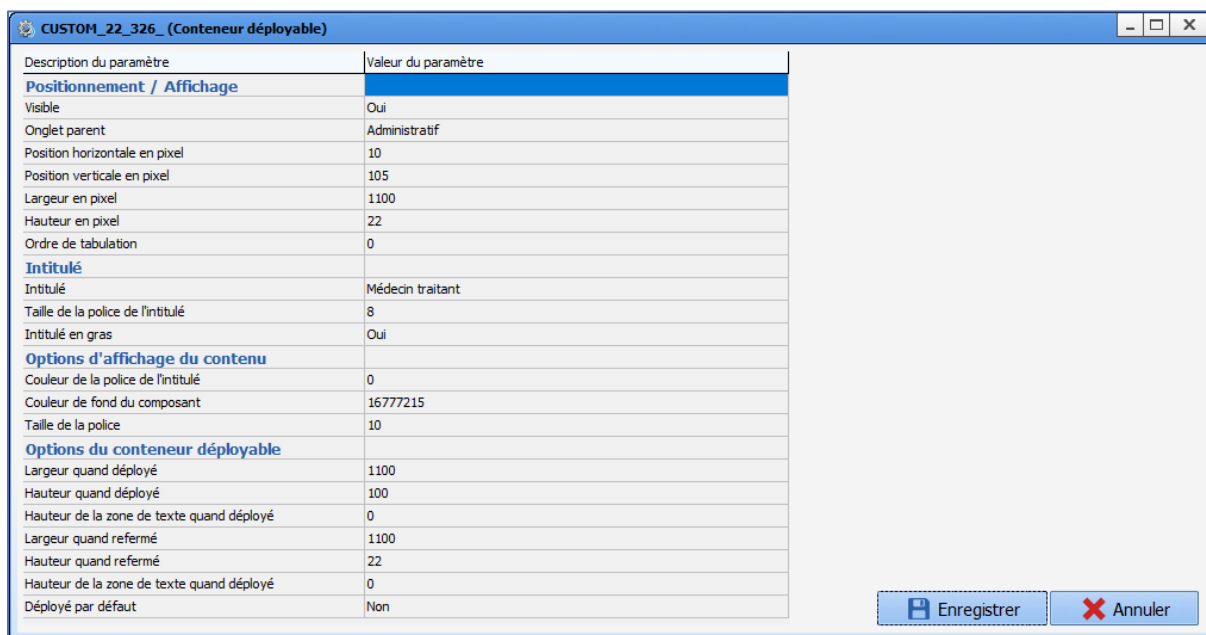


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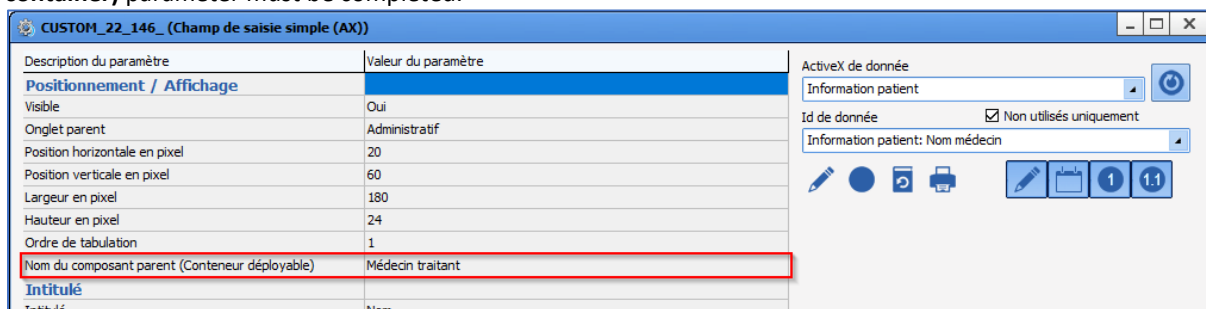
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The container is expanded using  and closed using .



The important settings for this component are the expanded and closed dimensions.

To add each component to be included in the container, the **Parent component name (deployable container)** parameter must be completed.



The placement of components within the container is done by modifying the **Horizontal position in pixels** and **Vertical position in pixels** parameters.

6.1.5.7 Display detailed entries as list

This component is used to display different detailed entry fields as a list. Setup is carried out from two tabs:

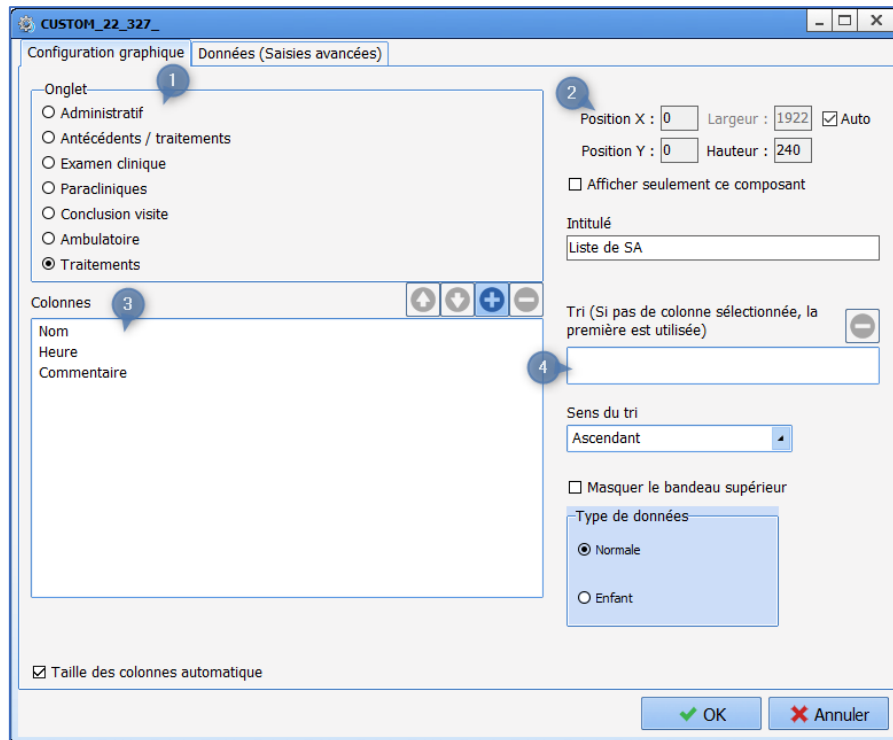
The **Chart configuration** tab is used to configure the component appearance:



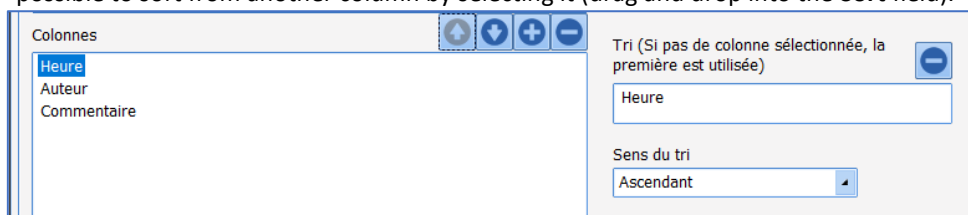
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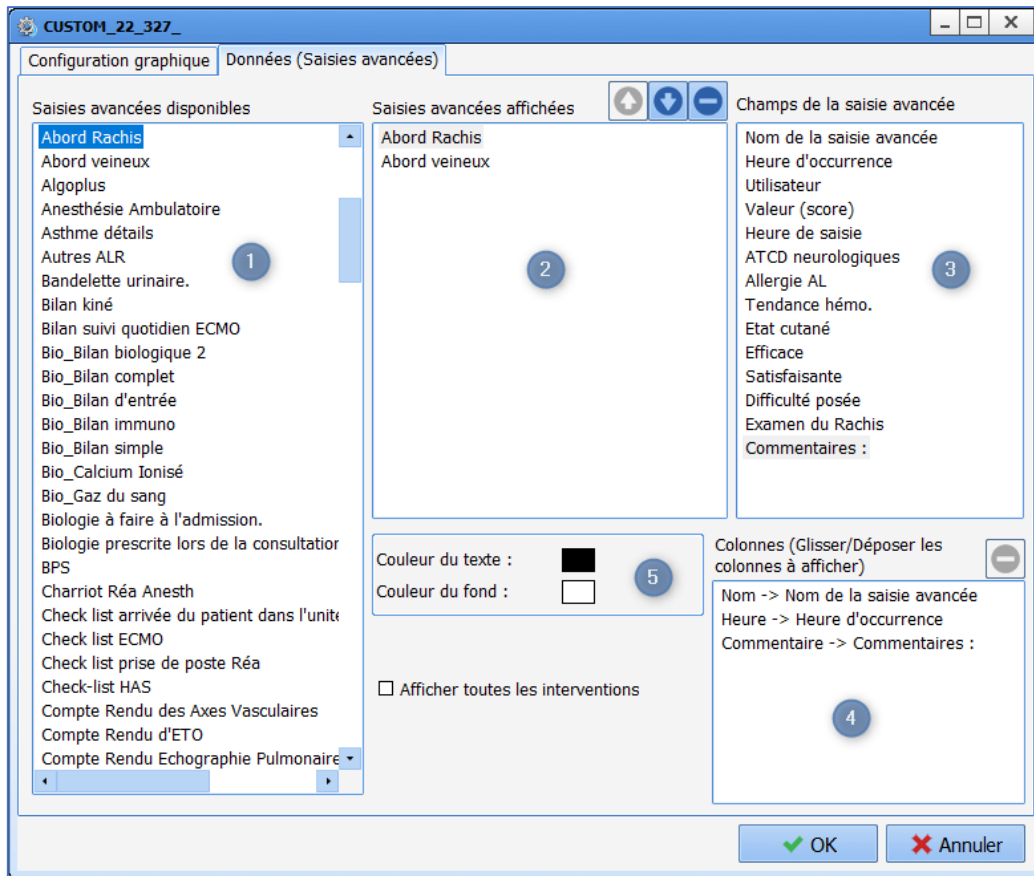
1. This pane is used to select the subtab in which the component appears.
2. This pane is used to select the position of the component in the subtab and its dimensions. The checkbox **View this component only** is used to only show this component in the subtab. It then takes up the whole area of the subtab. The title is the name of the component shown.
3. This pane is used to configure the table columns shown in the component:
The column content can be **Text**, **Date/Time** or **Number**.
The buttons are used to add or delete columns and change their order. The name can be modified: click the name to be changed twice (not quickly) to activate editing.
4. This pane is used to sort information: by default, the first column is used for sorting, but it is possible to sort from another column by selecting it (drag and drop into the **Sort** field).



To sort using another column, the column previously set up must be removed using .

The **Data (Detailed Entries)** tab is used to define the detailed entries the user can enter:





1. List of available detailed entries and scores (toggled or not).
2. Lists of detailed entries and scores shown in component.
3. Detailed entry field selected in pane 2.
4. Fields used by different 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 colour and background colour to facilitate 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 retrieve allergy history entered in Consultation.



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 Document version : 1

CUSTOM_18_120_ (Allergies)

Description du paramètre	Valeur du paramètre
Positionnement / Affichage	
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)	
Intitulé	
Intitulé	Allergies médicamenteuses
Taille de la police de l'intitulé	10
Intitulé en gras	Non <input type="checkbox"/>
Options d'affichage du contenu	
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
Options des données associées	
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
Options de la saisie avec liste de référence	
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

The ActiveX/Data ID pair used in the Consultation module must be used again.

NOTE: By default, the component connects to the Vidal or BCB drug database cache.

6.1.5.9 Display patient records as a list

This component is used to view information from the patient's previous records.

Nombre de dossiers : 1 (1)

Interventions précédentes				
Date	Anesthésiste	Chirurgien	Intervention	
18/12/2020	ANESTH Anna	CHIR Jean	Ablation du fil métallique	

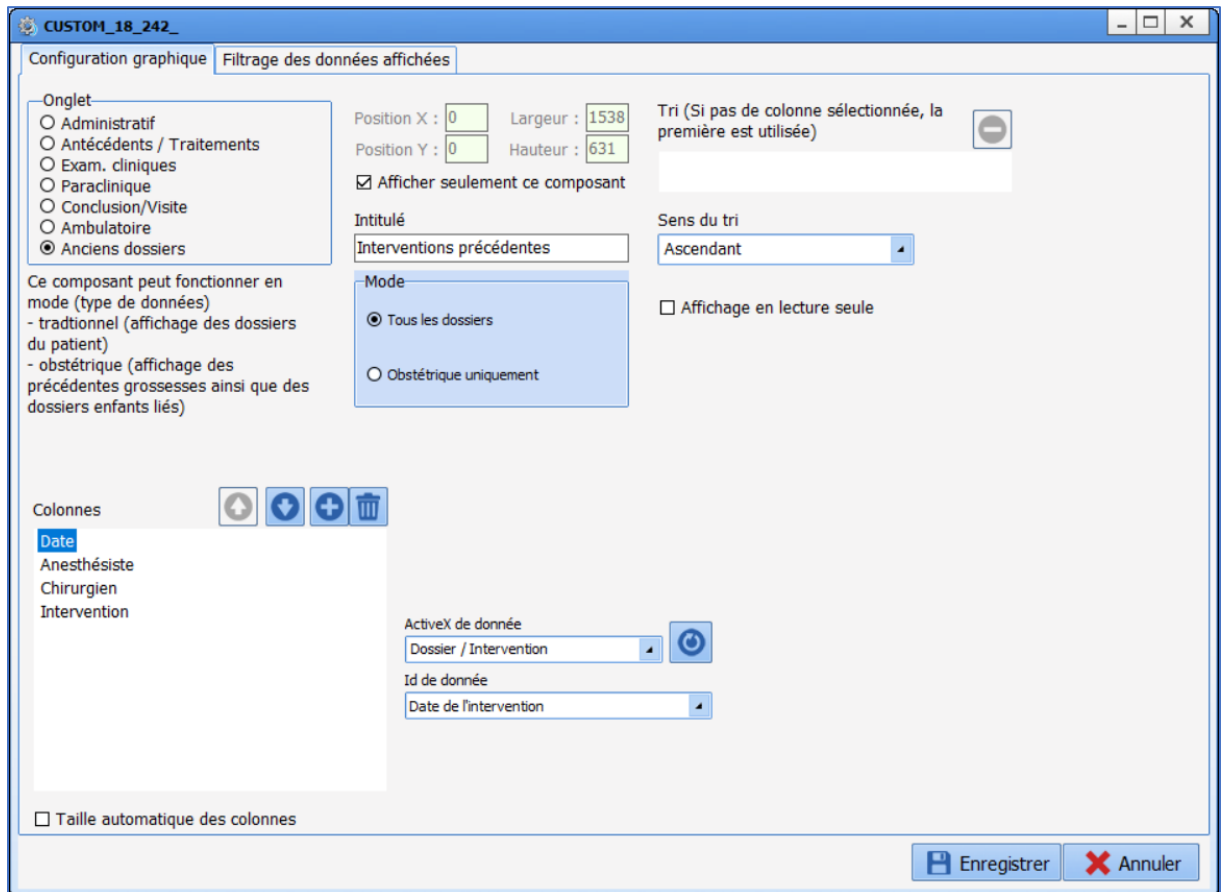
Columns can be configured (number, names, contents). The content is determined by the associated ActiveX/Data ID pair.



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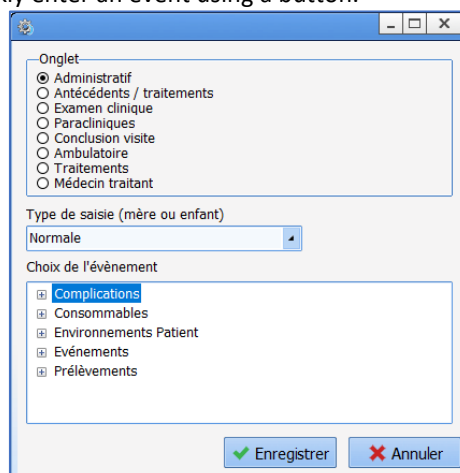


6.1.5.10 Selector of child records to be processed

This component is only useful in **DIANE OB-GYN**. No setup is necessary. The component size and position must be selected.

6.1.5.11 Event entry via button

This component is used to quickly enter an event using a button.



It is possible to select any event, whether or not it is toggled in the **Events** tab, from **Complications**, **Consumables**, **Patient Environments**, **Events** and **Samples**.



6.1.5.12 View (type 3)

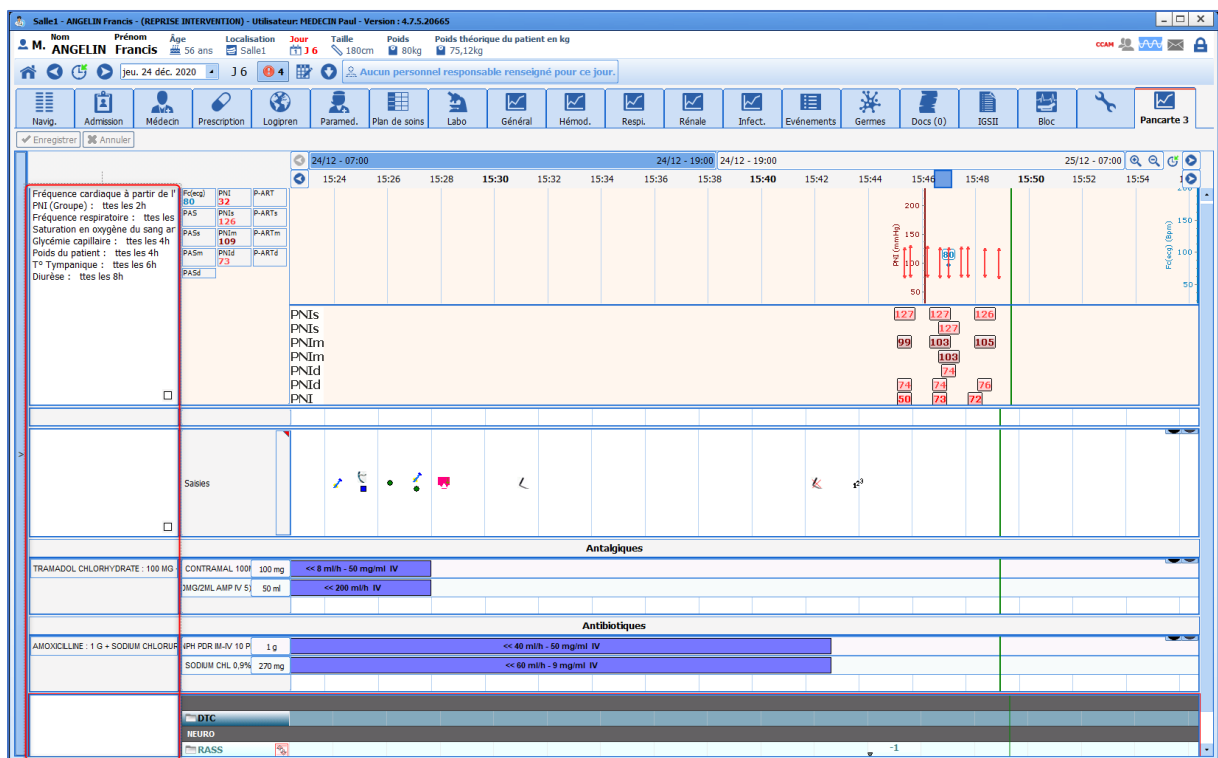
View 3 is a hybrid view combining the functions of the monitoring and care plan views.

It is possible to see all the data available in the patient record:

- Graphically for **parameters, scores and drugs, fluid balance and blood products.**
- In a table for **events, blood products, fluid balance and advanced entries.**

The **entry bar** found in the monitoring view is also available.

The pane on the left (outlined in red) is the area for **medication orders**. Once validated by the doctor, medication orders automatically appear in this pane.



The number of ribbons can be configured: A ribbon can contain:

- A **DIANE** grid.
- A prescribed drug chart.
- A vital signs chart.
- An events ribbon.
- A free comment pane.
- A non-prescribed drug chart.
- A drug chart.
- A field pane.

Specificities of prescribed drug chart:

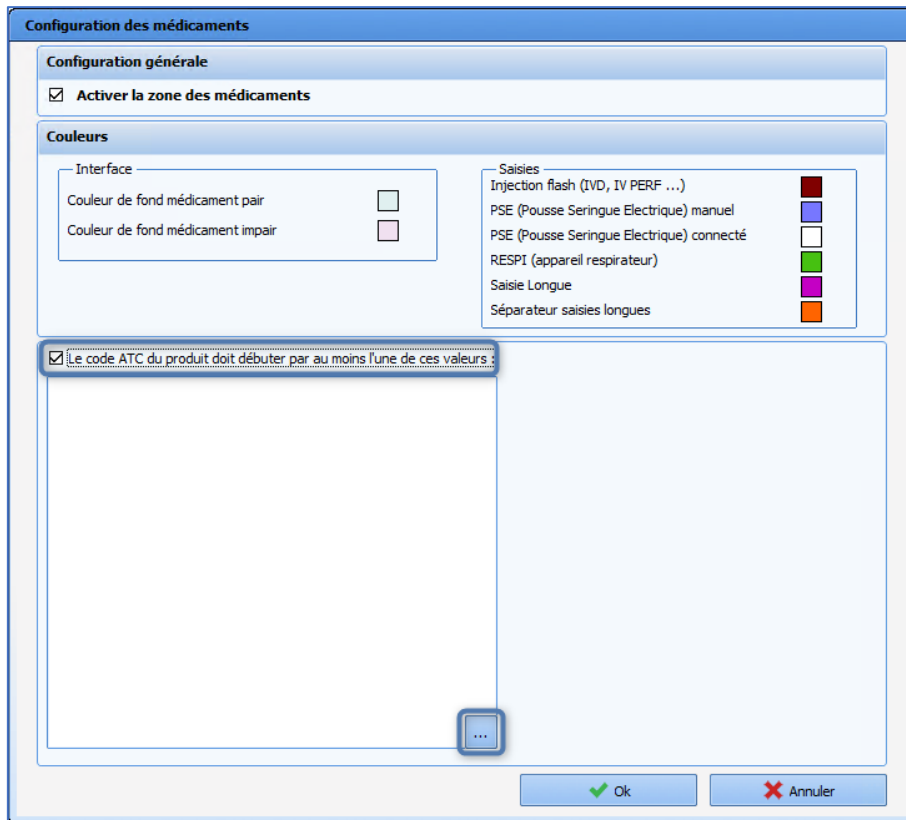
It is possible to filter prescribed drugs by their ATC code by selecting the **treatment's ATC code must start with at least one of these values** checkbox:



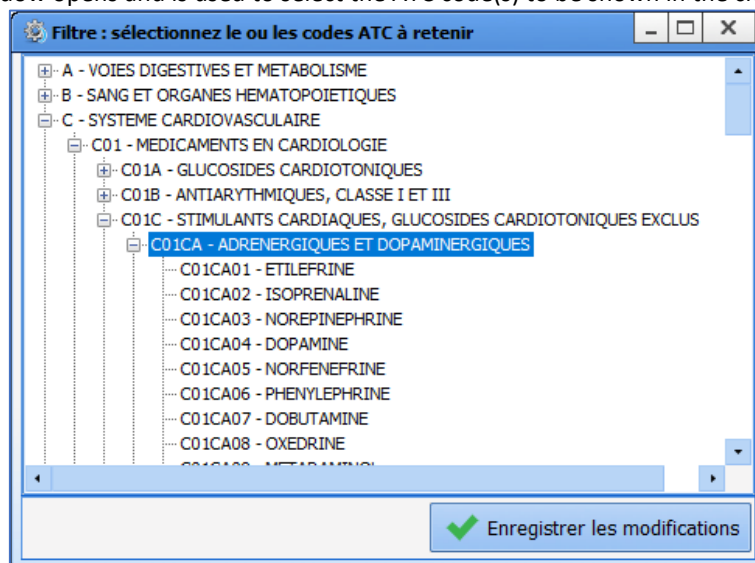
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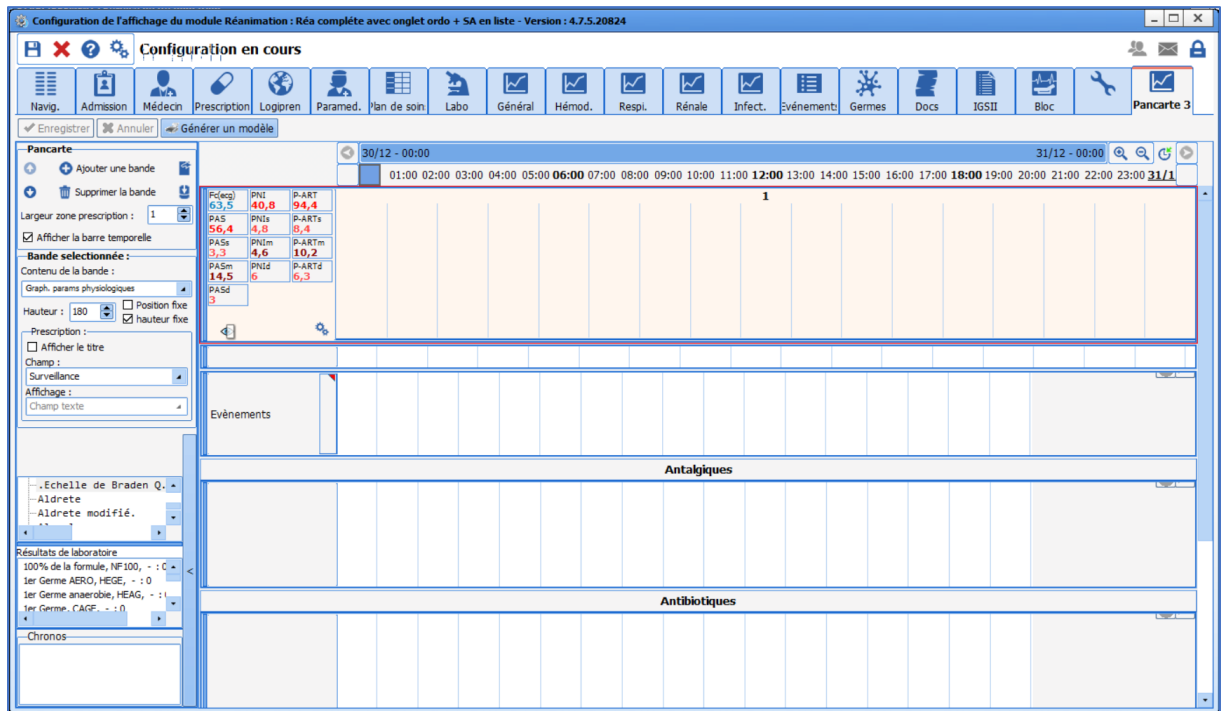


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The following window opens and is used to select the ATC code(s) to be shown in the chart.





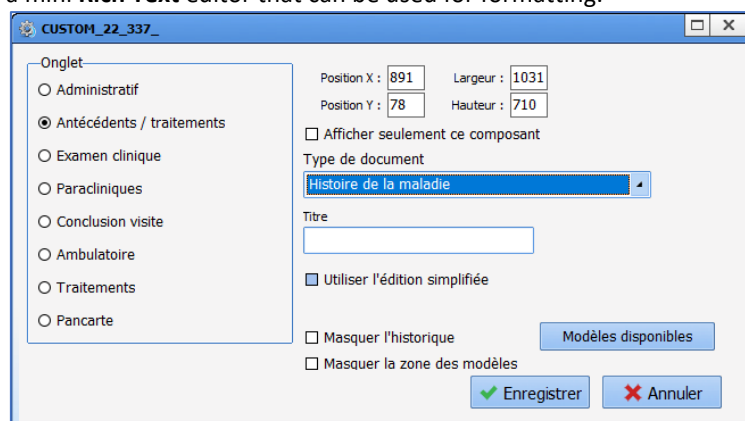
The display configuration of the settings is identical to that of the **Monitoring (DIANE ANAESTHESIA)/OT (DIANE ICU)** tab: *Setup of settings to be shown.*

6.1.5.13 Pregnancy type selection

This component is only useful in **DIANE OB-GYN**. No setup is necessary. The component size and position must be selected.

6.1.5.14 Document editing pane

This component is a mini **Rich Text** editor that can be used for formatting.



It can be used to edit several document types:

- What to do (Obstetrics)
- Obstetrics report
- Anaesth discharge report
- Other discharge report
- ICU discharge report
- CCU discharge report

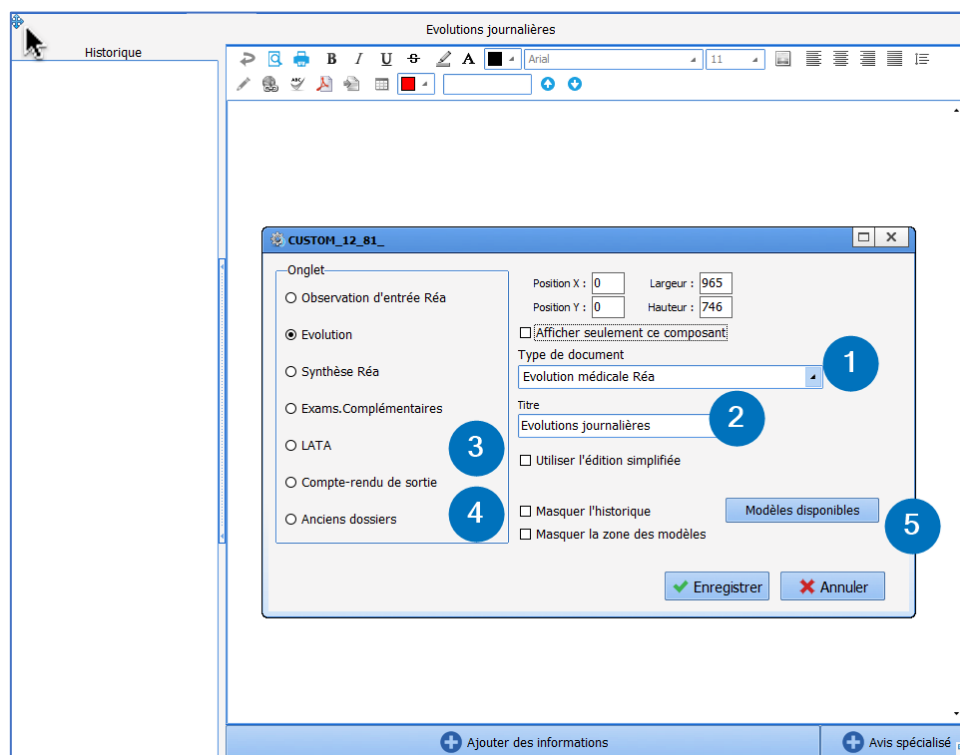


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- Medical developments Anaesthesia
- Medical developments ICU
- Medical developments CCU
- Paramedical developments Anaesthesia
- Paramedical developments ICU
- Paramedical developments CCU
- Obstetric developments
- Clinical examination at admission
- Paraclinical examinations
- History of the disease Anaesthesia
- History of the disease ICU
- History of the disease CCU
- Medical summary other
- 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.



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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

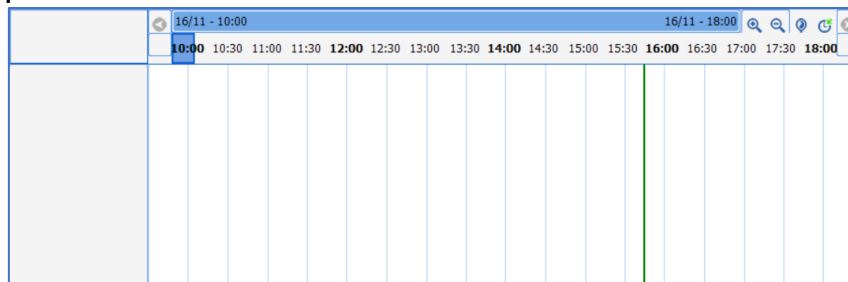
Liste des modèles	Modèles paramétrés
1er gaz du sang Admission Antécédents Balance Liqu. CR_Sortie de Réa Dernier gaz du sang Derniers param.vitaux Evol. jour. Résumé de Séjour Tansmissions	Antécédents Balance Liqu. Derniers param.vitaux Evol. jour. 1er gaz du sang Dernier gaz du sang

NB: It is possible to determine an automatic template on first editing the component.



6.1.5.15 Children drugs pane

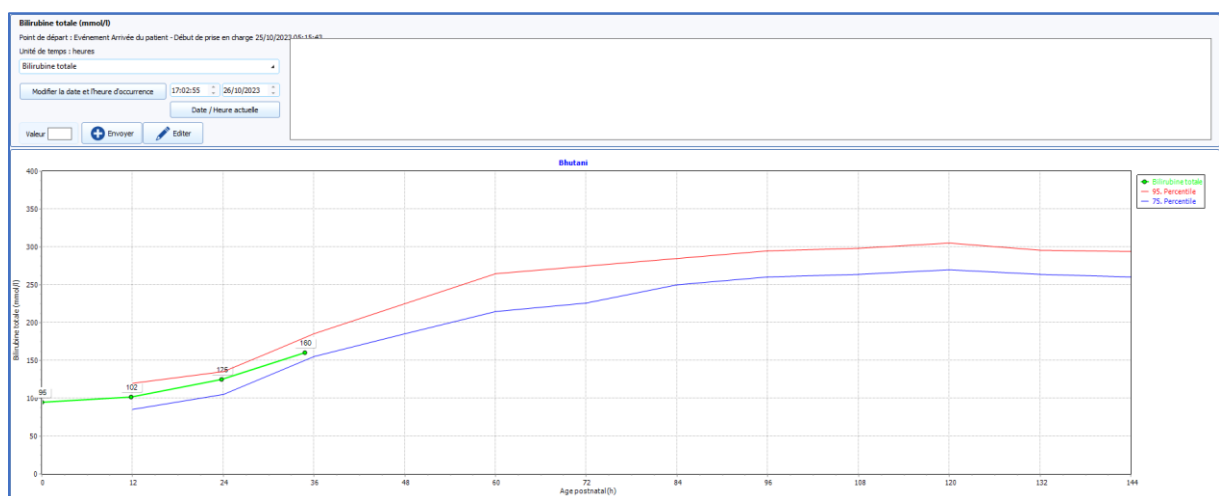
This component is used to add a drug pane (see illustration below) for each child using the **Selector of child records to be processed**.



It is possible to set the colours and filter drug entry and/or display.

6.1.5.16 Curve pane for manual parameters

This component is used to enter manual parameters and display them as a curve.



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To configure the component, first select the manual parameter (or group). The curve colour can be configured and it is possible to show values on the chart. . A second parameter may be displayed, but it must have the same unit as the first parameter. The data type must be **Normal**, except for obstetrical records (**Mother or Child**).

The X and Y axes can be configured. The time units available are hours, days and weeks. Start items can be the start of the procedure, date of birth, start of pregnancy or an event. Events must be chosen from all events (toggled or not).

Reference curves can be used to show percentile or mean curves, for example. To configure them, first click **Add a curve** then **Coordinates**. The following window is shown and it is possible to define a curve by entering the coordinates of its points, with the units defined in **General configuration** for the component for the parameter on the Y-axis and in **X-axis** for time.



Ajout de coordonnées

+ Ajouter une ligne...

X	Y
12	85
24	105
36	155
48	185
60	215
72	226
84	250
96	260
108	264
120	270
132	264

✓ Valider ✗ Annuler

6.1.5.17 List of documents from old records

This component is used to display documents entered in old 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



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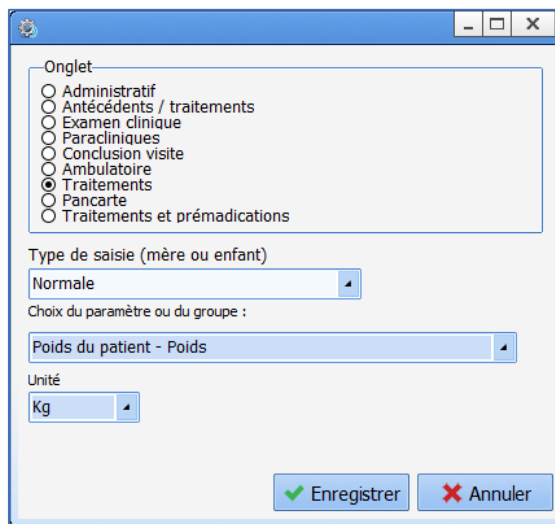
The available documents are:

- Doctor's notes
- Doctor summary
- Nursing notes
- Nurse summary
- Clinical examination at admission
- Paraclinical examinations
- Discharge report
- Disease history
- Obstetrics report
- Obstetric notes
- What to do (Obstetrics)

Only one document type can be configured per component.

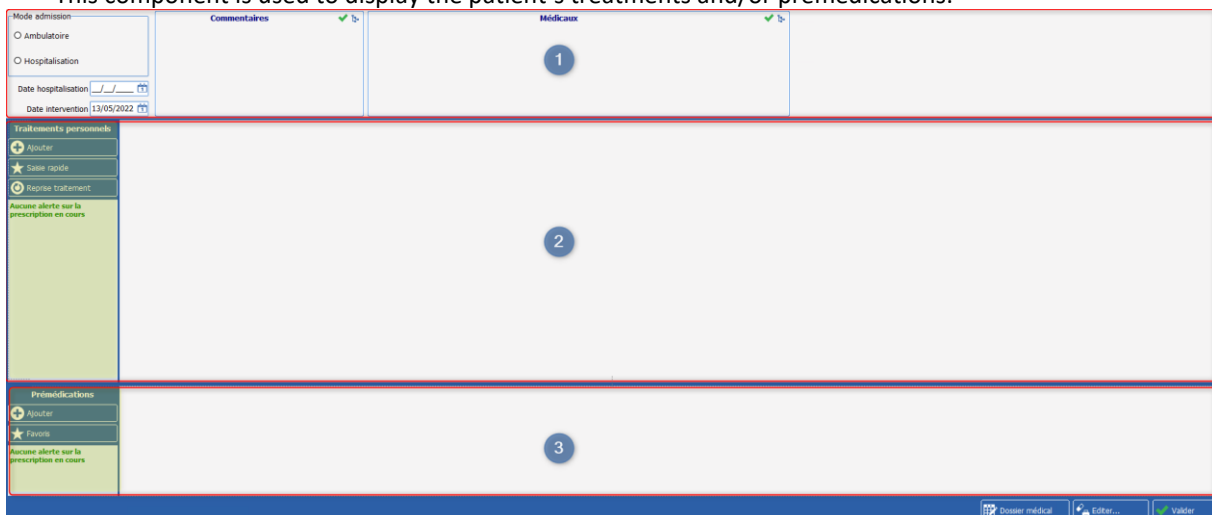
6.1.5.18 Button for adding manual vital signs

This component is used to enter and/or quick-edit manual data. Select the vital sign (or group of signs) and the unit.



6.1.5.19 Treatments and/or premedications pane

This component is used to display the patient's treatments and/or premedications.



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Seven view modes are available:

- **Full view** (treatments and premedications): panes 1, 2 and 3
- **Reduced treatments and premedications**: panes 2 and 3
- **Full treatments**: panes 1 and 2
- **Treatments with signature**: pane 2
- **Treatments in read-only**: pane 2 without the yellow pane or the lower ribbon
- **Premedications with signature**: pane 3
- **Premedications in read-only**: pane 3 without the yellow pane or the lower ribbon

In addition to these modes, conversions may be shown or hidden in the treatment area.

6.1.5.19.1 Configuring the tab in the consultation module

In the consultation, the component is presented as a tab. It is configured via the consultation setup keys.

Nom du paramétrage : Demo 1280x800 EMed Optim	
Application ou module à paramétrer : Consultation	
Recherche d'un paramètre	
Champ(s) à considérer pour la recherche	Texte à rechercher
Tous	<input type="text"/>
<input checked="" type="radio"/> Vers le bas <input type="radio"/> Vers le haut <input type="checkbox"/> Différencier Min/Maj <input type="checkbox"/> Mot entier	
Rechercher	
Description du paramètre	Valeur du paramètre
Configuration générale	
Configuration de l'envoi des traitements en relais ou prescription d'entrée	
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
Interaction avec le module RDV	Traitements complets
[DEBUG]	Traitements avec signature
Impressions	Traitements sans signature
	Prémédications avec signature
	Prémédications sans signature

6.1.5.19.2 Configuring the component in Visual or Diane ICU

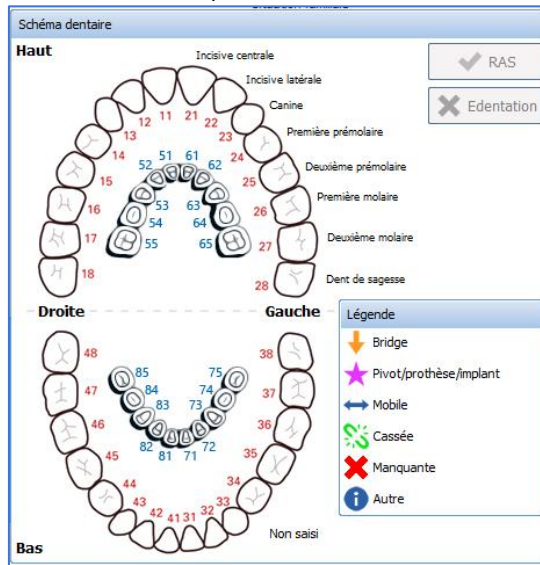
In **Visual** or **DIANE ICU**, the component can be placed in a subtab, alone or with other components.

CUSTOM_12_114_	
Onglet <input type="radio"/> Observation d'entrée Réa <input checked="" type="radio"/> Traitements et prémédications <input type="radio"/> Evolution <input type="radio"/> Synthèse Réa <input type="radio"/> Exams.Complémentaires <input type="radio"/> Engagement thérapeutique <input type="radio"/> Compte-rendu de sortie	Position X : <input type="text" value="0"/> Largeur : <input type="text" value="1920"/> Position Y : <input type="text" value="0"/> Hauteur : <input type="text" value="849"/> <input checked="" type="checkbox"/> Afficher seulement ce composant Mode d'affichage <input checked="" type="radio"/> Affichage complet <input type="radio"/> Traitements et prémédications réduits <input type="radio"/> Traitements complet <input type="radio"/> Traitements avec signature <input type="radio"/> Traitements en lecture seule <input type="radio"/> Prémédications avec signature <input type="radio"/> Prémédications en lecture seule
Affichage des traitements <input checked="" type="radio"/> Complet <input type="radio"/> Sans conciliation	<input checked="" type="checkbox"/> Ancré gauche <input checked="" type="checkbox"/> Ancré haut <input type="checkbox"/> Ancré droite <input type="checkbox"/> Ancré bas
<input type="button" value="✓ Enregistrer"/> <input type="button" value="✗ Annuler"/>	

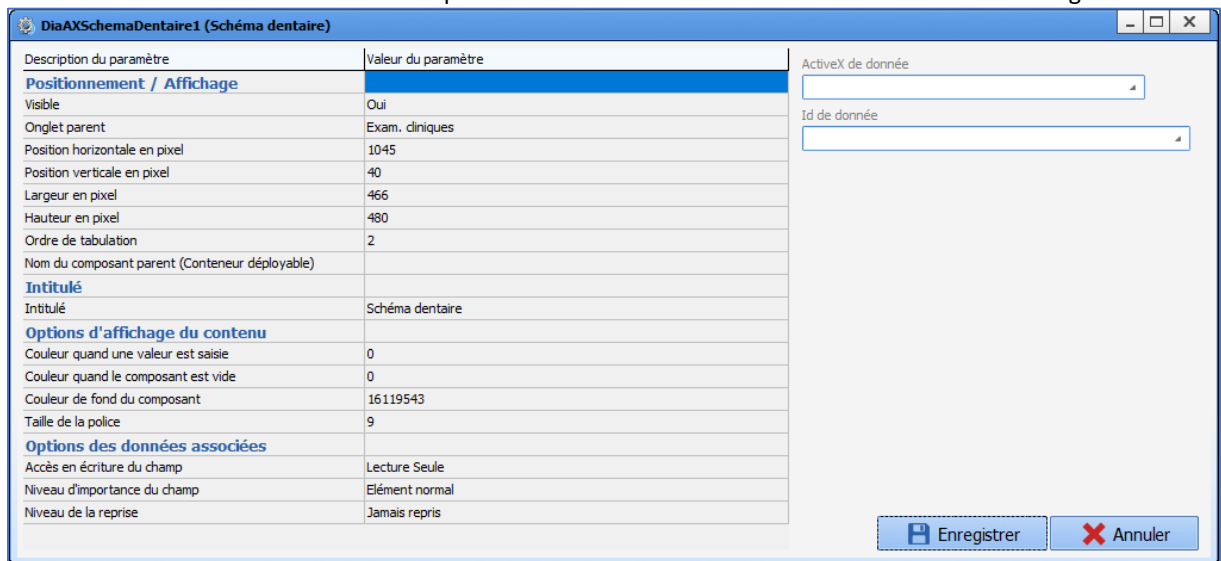


6.1.5.20 Tooth chart

This component is used to list the status of the patient's teeth.

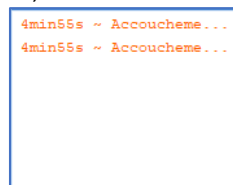


It can be moved with a left-click the component and cannot be resized. It can be modified with a right-click.



6.1.5.21 Editable timers

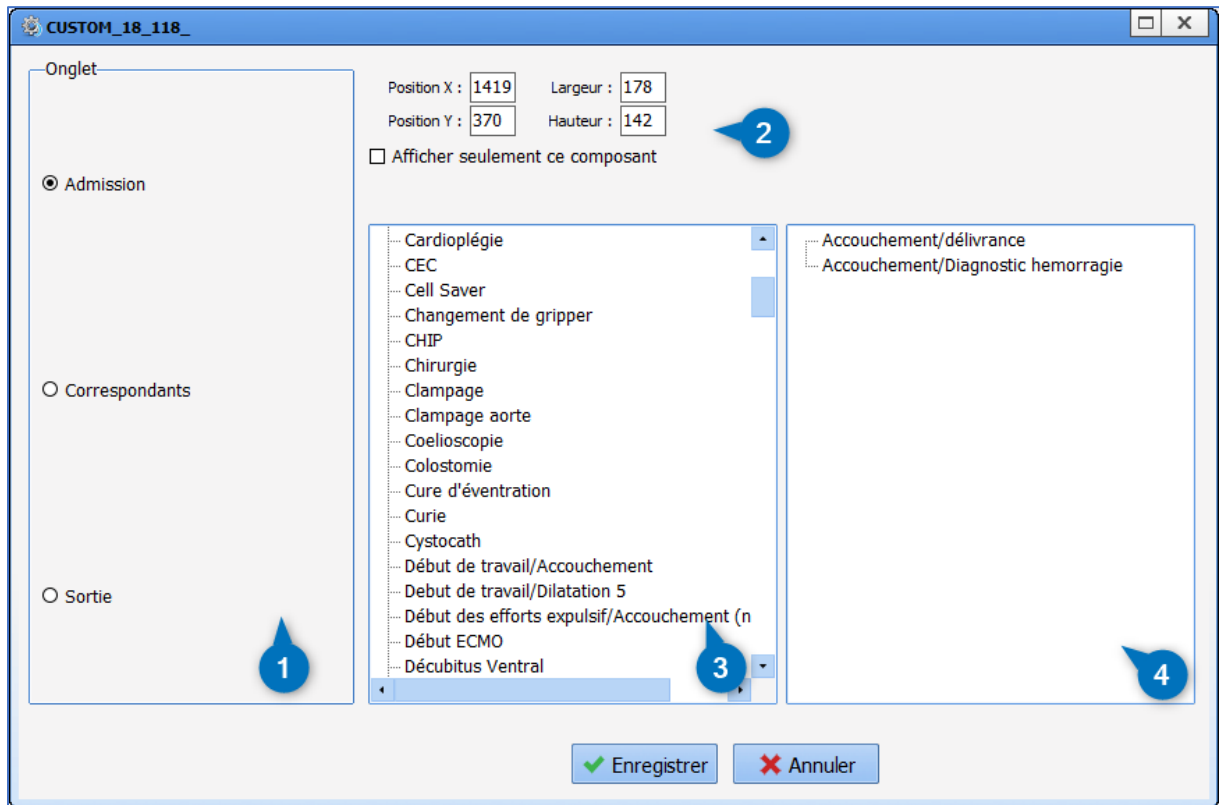
This component shows a window with timers, similar to that in the **MONITORING** tab of **Visual**.



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1. Tab in which the component appears.
2. Component position and size.
3. List of timers (toggled or not).
4. Configured timers (note: only toggled timers in configuration are shown).

6.1.5.22 Moebius

Moebius is a risk assessment tool. It proposes suitable patient management and risk mapping.



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MOEBIUS - Informations de mise à jour	
Evaluation	Scores
Suggestion de conciliation	

DiaAXMoebius1 (Moebius)	
Description du paramètre	Valeur du paramètre
Positionnement / Affichage	
Visible	Oui
Onolet parent	Conclusion/Visite
Position horizontale en pixel	445
Position verticale en pixel	195
Largeur en pixel	1120
Hauteur en pixel	610
Ordre de tabulation	2
Nom du composant parent (Conteneur déployable)	
Intitulé	
Intitulé	DiaAXMoebius1
Options d'affichage du contenu	
Couleur quand une valeur est saisie	0
Couleur quand le composant est vide	0
Couleur de fond du composant	16053493
Taille de la police	10
Options des données associées	
Accès en écriture du champ	Ecriture
Niveau d'importance du champ	Élément normal
Historique activé	Non
Valeur de saisie "RAS"	
Niveau de la reprise	Jamais repris
Autres paramétrages	
Liste des couples Ax/Id où transférer les données Moebius	6,1 6,1 4,1
Couple Ax/Id où transférer les données d'évaluation (Elemé 8,19	

ActiveX de donnée

 Id de donnée Non utilisés uniquement

6.1.5.23 3D annotation diagram (care plan)

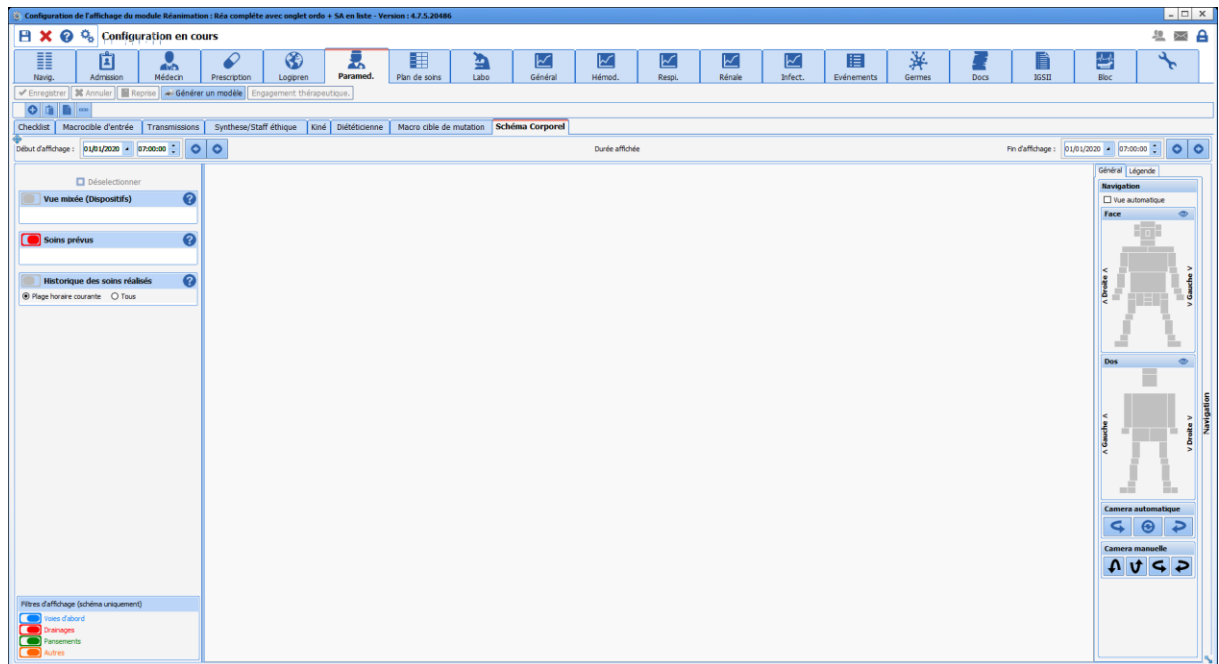
This component is used to locate treatments on a 3D representation of the patient.



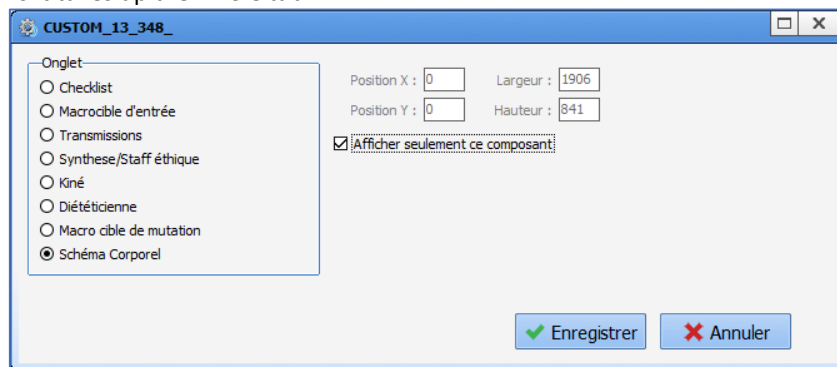
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The only settings for this component are its position and dimensions. The **View this component only** checkbox means it takes up the whole tab.



For this to be available for use, forms must be created in the **Care items** tab.



6.2 ActiveX/data ID list

Ax/ID pairs are used, in part, to save and, if relevant, print patient data. Some Ax/ID pairs must not be used for anything other than their preset role.

Below are lists of AX and lists of the IDs depending on these Ax. A comment is included for those with a specific role.

Caption:



: calculated data (click the icon for information on the calculation)



: data print tag




: read-only data

6.2.1 List of ActiveX

- *Medical history*
- *Cardiopulmonary examinations*
- *Intubation*
- *Biochemical testing*
- *Haematology test*
- *Instructions (and blood product order)*
- *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*
- *Obstetrics data*
- *Conclusion POA*
- *Clinical examination*
- *PED POA*
- *Obstetrics POA*
- *Stay field*
- *Other*

6.2.2 Data ID list

6.2.2.1 ActiveX: Medical history








- | | |
|----------------------|---|
| • Allergic |  ANTEC-ALLERGIQUES |
| • Anaesthesia |  ANTEC-ANESTHESIQUES |
| • Cardiac |  ANTEC-CARDIAQUE |











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• Surgical	 : ANTEC-CHIRURGICAUX
• Comment	 : ANTEC-COMPLICATIONS
• Surgical complications	 : ANTEC-COMPLICATION_OPERATOIRE
• Spouse: Habits, smoking, etc.	 : ANTEC-CONJOINT
• Digestive	 : ANTEC-DIGESTIF
• Misc.	 : ANTEC-COMPORT_DIVERS
• Endocrinology	 : ANTEC-ENDOCRINOLOGIE
• Family	 : ANTEC-MEDICAUX
• Gravity	 : ANTEC-GESTITE
• Active gynaeco	 : ANTEC-GYNECO_ACTIFS
• Resolved gynaeco	 : ANTEC-GYNECO_INACTIFS
• Gynaecology	 : ANTEC-GYNECOLOGIE
• Habits, smoking, etc.	 : ANTEC-HABITUS_TABAGISME
• Active medical	 : ANTEC-MEDICAUX_ACTIFS
• Resolved medical	 : ANTEC-MEDICAUX_INACTIFS
• Neurological	 : ANTEC-NEUROLOGIQUE
• Obstetric	 : ANTEC-OBSTETRICAUX
• Ophthalmology	 : ANTEC-OPHTALMOLOGIE
• Parity	 : ANTEC-PARITE
• Pulmonary	 : ANTEC-PULMONAIRE
• NTR	 : ANTEC-RAS
• Kidneys	 : 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
• Expert advice request	 : EXAMEN_CARDIO-DEMANDE_AVIS_SPECIALISE
• ECG	 : EXAMEN_CARDIO-ECG
• Cardio examination	 : EXAMEN_CARDIO-EXAMEN_CARDIO
• Further pre-op examination	 : EXAMEN_CARDIO-EXAMEN_COMPLEMENTAIRE_PRE_OP
• Lung examination	 : 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
• Mean arterial pressure	 : EXAMEN_CARDIO-PRESSION_ARTERIELLE_MOYENNE
• Systolic arterial pressure	 : EXAM-PA_SYSTO
• NTR	 : EXAMEN_CARDIO-RAS
• Summary cons other	 : EXAMEN_CARDIO-RESUME_CS_AUTRE
• Summary cons cardio	 : EXAMEN_CARDIO-RESUME_CS_CARDIO
• Summary cons pneumo	 : EXAMEN_CARDIO-RESUME_CS_PNEUMO
• RP	 : EXAMEN_CARDIO-RP
• Sat	 : EXAMEN_CARDIO-SAT
• ECG status	 : EXAMEN_CARDIO-STATUT_ECG
• Lung x-ray status	 : EXAMEN_CARDIO-STATUT_RP
• Temp	 : EXAMEN_CARDIO-TEMP
• Vein	 : EXAM-VEINE

6.2.2.3 ActiveX: Intubation

These Ax-ID pairs are all correlated. These components can be completed using the “normal” button (without Ax/ID). The 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: Biochemical testing




• 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



















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- **Protein**  : BILAN-PROT
- **Urea**  : BILAN-UREE
- **Confirmed**  : BILAN-VALID_BIOCHIMIE









6.2.2.5 ActiveX: Haematology testing

- **CAT**  : EXAMEN_HEMATO-CAT
- **Date/time**  : BILAN-DATE_HEMATOLOGIE
- **Scanned reports**  : EXAMEN_HEMATO-DOCS_BILANS_SCANNES
- **Reviewed reports**  : EXAMEN_HEMATO-DOCS_BILANS_VU
- **GB**  : BILAN-GB
Used by "NTR" advanced automation for anaesthesia consultations
- **WBC**  : EXAMEN_HEMATO-GBLANCS
- **RBC**  : BILAN-GR
- **HB**  : BILAN-HB
- **Hct**  : BILAN-HT
- **Platelets**  : BILAN-PLAQ
- **Lab test results**  : EXAMEN_HEMATO-RESULTATS_BILAN_BIO
- **Examination status**  : EXAMEN_HEMATO-STATIT_EXAMENS
- **TCA**  : BILAN-TCA
- **PT**  : BILAN-TP
- **TS**  : BILAN-TS
- **Confirmed**  : BILAN-VALID_HAMATOLOGIE

6.2.2.6 ActiveX: Instructions (and blood product order)

- **Command**  : CPA-COMMANDE_PRODUITS
- **Instructions**  : CPA-CONSIGNES
- **Premedication**  : CPA-PREMEDICATIONS
- **NON-HOSPITAL PREMEDITATIONS**  : CPA-PREMEDICATIONS_HORS_HOPITAL












6.2.2.7 ActiveX: Blood test

- **1ST EFS DETER**  : BILANSANGUIN1ERDETER
- **2ND EFS DETER**  : BILANSANGUIN2EMEDETER
- **Report brought by patient**  : BILAN_SANGUIN-BILAN_AMENE
- **Scanned report**  : BILAN_SANGUIN-BILAN_SCANNE
- **Reviewed report**  : BILAN_SANGUIN-BILAN_VU
- **CAT blood type**  : BILAN_SANGUIN-CAT_GROUPE
- **IAS CAT**  : BILAN_SANGUIN-CAT_RAI
- **Comment**  : BILAN-COMMENTAIRE



• IAS validity criteria	 : BILAN_SANGUIN-CRITERES_VALIDITE_RAI
• Date/time IAS	 : BILAN-DATE_RAI
• Last negative IAS	 : BILANSANGUINDERNIERRAINEGATIF
• Blood glucose 2	 : GLYCEMIE_POSTPRANDIALE
• Fasting blood glucose g/L	 : GLYCEMIE_A_JEUN
• Blood glucose H0	 : GLYH0
• Blood glucose H1	 : GLYH1
• Blood glucose H2	 : GLYH2
• Blood glucose H3	 : BILANSANGUINGLYH3
• Fasting blood glucose g/L	 : GLYCEMIE_A_JEUN
• 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
• Lab test result	 : BILAN_SANGUIN-RESULTAT_EXAMEN_BIO
• Complete test result	 : BILAN_SANGUIN-RESULTAT_EXAMEN_COMPLETER
• Rhesus	 : BILAN-RHESUS
• Blood type card status	 : BILAN_SANGUIN-STATUT_CARTE_GROUPE
• Covid status	 : BILAN_SANGUIN-STATUT_COVID
• RAI status	 : BILAN_SANGUIN-STATUT_RAI
• APTT ratio	 : BILAN_SANGUIN-TCA_RATIO

6.2.2.8 ActiveX: Patient information

• Doctor's address	 : PATIENT-ADRESSE_MEDECIN
• Patient's age (with unit)	 : PATIENTAGEWITHUNIT
• LRA	 : 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



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• BSA 	 : PATIENT-BSA
• Doctor's post code	 : PATIENT-CODE_POSTAL_MEDECIN
• Comments	 : ANTEC-RELAIS
• Non-hospital comments	 : CPA-RELAIS-HORS-HOPITAL
• Hospitalization 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
• Hepatic failure	 : INFOPATINSUFFHEPATIQUE
• Chronic diseases	 : MALADIES_CHRONIQUES
• Minor	 : INFOPAT-MINEUR
• Doctor's name	 : PATIENT-NOM_MEDECIN
• Room number	 : CPA-NUMERO_CHAMBRE
• Doctor's phone number	 : INFOPATTELEMEDECIN
• Private health insurance number	 : PATIENT-NUMERO_MUTUELLE
• Usual NIPd	 : PATIENT-PNID_HABITUELLE
• Usual NIPs	 : PATIENT-PNIS_HABITUELLE
• Adjusted patient weight in kg 	 : INFOPATPOIDSAJUSTE
• Patient weight in kg	 : PATIENT-POIDS2
• Theoretical patient weight in kg 	 : PATIENT-POIDS_THEORIQUE
• Doctor's first name	 : PATIENT-PRENOM_MEDECIN
• Parents present	 : INFOPAT-PRESENCE_PARENTS
• Weight gain/loss (%) 	 : PRISE_PERTE_POIDS_PAGE
• Weight gain/loss (kg) 	 : PRISE_PERTE_POIDS
• Weight gain/loss since last measurement 	 : PRISE_PERTE_POIDS_DEPUIS_DER_MESURE
• Weight gain/loss since admission 	 : PRISE_PERTE_POIDS_DEPUIS_ADMISSION
• 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's town/city	 : 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 assessment














These Ax/ID pairs are all correlated. Completing one component automatically implements the “Done by” and “On” components.

• Fasting	 : CPA-A_JEUN
• Comment	 : CPA-COMMENTAIRE_VISITE
• POA date/time  	 : VPADATETIME
• Full record	 : CPA-DOSSIER_COMPLET
• Full name of the user who did the POA  	 : VPAUSERNAME
• Preoperative assessment : NTR since POA	 : VPARASSINCEVPA





















6.2.2.10 ActiveX: Record information

• Anaesthesia	 : CPA-TECHNIQUE_ANESTHESIQUE
• Anaesthetist in consultation (completed automatically) Used to automatically complete the name of the anaesthetist carrying out the consultation	 : CPA-COMORBIDITE
• Anaesthetist performing the pre-op assessment	 : CPA-ANESTH
• Anaesthetist(s)	 : CPA-ANESTHESISTE_PREVU
• Surgeon(s)	 : CPA-CHIRURGIEN_PREVU
• Circumstances	 : INTERV-CIRCONSTANCES
• Comment	 : CPA-COMMENTAIRE_INTERV
• Comments associated with personal treatment	 : COMMENTAIRE_TRAITEMENT
• Anaesthesia consent	 : INTERV-CONSETEMENT_ANESTH
• Transfusion consent	 : INTERV-CONSETEMENT_TRANSFUSION
• Preoperative assessment date	 : DATE_CPA
• Scheduled date	 : CPA-DATE_INTERV_PREVUE
• Excess fees	 : INTERV-DEPASSEMENT_HONORAIRE
• Expected duration	 : INTERV-DUREE_PREVUE
• Disease history	 : HISTOIRE_MALADIE
• Nurse anaesthetist(s)	 : CPA-INFIRMIER_PREVU
• Room ID	 : CPA-SALLE_PREVUE
• OT ID	 : CPA-BLOC_PREVU
• RR bed ID	 : CPA-LIT_PREVU
• Surgery information: Admission type	 : TYPE_ADMISSION
• Information from EHR	 : INTERV-INFOS_PROVENANCE_DPI
• Location	 : INFOINTERVLOCALISATIONINFO
• Mode of admission (used for personal treatments)	 : MODE_ADMISSION
• Mode of admission confirmed	 : INTERV-MODE_ADMISSION_VALIDE



• Reason for admission ambulatory	 : MOTIF-HOSPI-AMBU
• Reason for admission postpartum	 : MOTIF-HOSPI-PP
• Reason for admission ICU	 : MOTIF-HOSPI-REA
• Reason for admission delivery room	 : MOTIF-HOSPI-SDN
• Reason for admission RR	 : MOTIF-HOSPI-SSPI
• Reason for admission monitoring	 : MOTIF-HOSPI-SURV
• Reason for admission CCU	 : 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


• Anaesthetist for surgery	
• Operating surgeon	
• Surgery date	 : CPA-DATE_INTERVENTION
• Surgery 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
• Discharge form date/time	 : INTERV-DATE_AUTORISATION_SORTIE
• Update date/time of consultation printout	 : INTERVDATEMAJIMPCPA
• RR medication order signature date/time 	 : INTERV- DATE_SIGNATURE_PRESCRIPTION
• Procedure status (ongoing, recovery, transit, etc.) 	
• Surgery start time	 : INTERV-HEURE_DEBUT
• Surgery end time	 : INTERV-HEURE_FIN
• Patient ID history 	
• Nurse anaesthetist during surgery	
• DIANE ID of the mother's associated pregnancy record	 : INTERVIDGROSSESSE
• Surgery OT ID	
• Surgery patient ID 	
• External surgery ID 	
• Internal ID of record 	
• Portal "to do" list	
• Surgery OT name	 : INTERV-BLOC
• Surgery record internal version number 	



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• Configuration customised portal view	
• Anaesthesia responsibility 	 : INTERV-RESPONSABILITE_ANESTHESIE
• Signer of RR discharge form	 : INTERV-AUTORISATION_SORTIE
• Signer of RR medication orders 	 : INTERV-SIGNATURE_PRESCRIPTION
• Obstetrics record type 	 : TYPEDOSSIER-
• Pregnancy type	 : INTERVTYPEGROSSESSE

6.2.2.12 ActiveX: Patient

These Ax/ID pairs are generally used by interfaces to retrieve administrative data.












• Patient's email address	 : PATIENT-EMAIL
• Patient's postal address	 : PATIENT-ADRESSE
• Patient's 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 death date	 : PATIENT-DATE_DECES
• Patient's birth date	 : PATIENT-DATE_NAISSANCE
• Patient's UPI history	
• DIANE ID of biological mother 	 : PATIENTIDMERE_BIOLOGIQUE
• 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-MEDECIN_TRAITANT
• Patient NHI type	 : PATIENT-INS_NATURE
• Patient's birth name	 : PATIENT-NOM_PATRONYMIQUE
• Name gone by	 : PATIENT-NOM_MARITAL
• Patient's national healthcare identifier	 : 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
• First name gone by	 : PATIENT-PRENOM_USUEL
• Profession of patient	 : PATIENTPROFESSION
• Patient's sex	 : PATIENT-SEXE










- Patient situation  : PATIENT-SITUATION
- Patient status  : PATIENT-INS_STATUS
- Patient town/city  : 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
- Intensive care  : 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 instructions  : AMBULPREOP-CONSIGNES_CONNUES
- Arrival time  : AMBULPREOP-HEURE_ARRIVEE
- Time of last food intake  : AMBULPREOP-HEURE_DERNIERE_ALILENTATION
- 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
- Snack  : AMBULPOSTOP-COLLATION
- Comments  : AMBULPOSTOP-COMMENTAIRES
- Consciousness  : AMBULPOSTOP-CONSCIENCE
- Difficulty  : AMBULPOSTOP-DIFFICULTE
- Diuresis  : 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
• Appointment with surgeon	 : AMBULPOSTOP-RDV_CHIRURGIEN
• Return	 : AMBULPOSTOP-RETOUR
• Return home	 : AMBULPOSTOP-RETOUR_A_DOMICILE
• Bleeding	 : AMBULPOSTOP-SAIGNEMENT
• Satisfaction	 : AMBULPOSTOP-SATISFACTION
• Signature	 : AMBULPOSTOP-PERSONNEL
• Sleep	 : AMBULPOSTOP-SOMMEIL
• Relief with treatments	 : AMBULPOSTOP-SOULAGE_PAR_TTT











6.2.2.16 ActiveX: ICU data

• Staff conclusions	 : CONCLUSION-STAFF
• Research protocol	 : CPAREA1-PROTOCOLE_RECHERCHE
• Medical transmissions	 : CPAREA1-TRANSMISSIONS_MEDICALES
• Sent by	 : PATIENT-MEDECIEN_ADRESSEUR

6.2.2.17 ActiveX: Additional patient information

• Spouse's age 	 : INFOPATSUPAGECONJOINT
• Spouse's medical history	 : SPOUSEMEDICHIST
• Mother's occupational code	 : MOTHERPROCEDURE
• Spouse's occupational code	 : SPOUSEPROCEDURE
• Spouse's birth date	 : SPOUSEBIRTHDATE
• Spouse's blood type	 : GRPSANGCONJOINT
• Mother's education level	 : NIVETUDEMERE
• Spouse's education level	 : NIVETUDECONJOINT
• Guardian's name	 : GUARDIANLASTNAME
• Name of person to notify	 : PERSONTONOTIFYNAME
• Trusted person's name	 : PERSONNECONFIANCENOM
• Guardian's last name	 : TUTORSHIPNAME
• 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	 : PERSONNECONFIANCETEL
• Tutorship/Guardianship	 : INFOPATSUPTUTELLECURATELLE






6.2.2.18 ActiveX: OB-GYN data

• 1: Field 194   	 : JOURSAMENORRHEE
• 16WA  	 : 16SA
• 1st method of delivery	 : DECLENCHEMENT_METHODE1
• 2nd method of delivery	 : DECLENCHEMENT_METHODE2
• Delivery: Date	 : DATE_ISSUE_GROSSESSE
• Delivery admission	 : ADMISSION_ACCOUCHEMENT
• Age in minutes at time of transfer	 : OBST1CHAMP08
• Corrected age (automatically formatted)	 : AGE-CORRIGE-AFFICHE
• Age of pregnancy	 : PREGNANCYAGE
• Patient's age (years)   	 : PATIENTAGEINYEARSINTEGER
• Delivery room supply	 : OBST1NUTRITIONFOETUSSDN
• Breastfeeding	 : BREASTFEEDING
• Breastfeeding foetus	 : NUTRITION_FOETUS
• AFP	 : OBST1ALPHA_FP
• Amniocentesis	 : OBST1AMNIOCENTESE
• Placental analysis	 : PLACENTA_ANALYSE
• Anaesthesia after delivery   	 : ANESTH_MODE_APRES
• Anaesthetists	 : ANESTH_ANESTHESISTE
• Pertussis vaccination year Mrs/Ms	 : PERTUSSISVACYEAR
• ARE	 : ACC_MAR
• Sick leave   	 : SICKLEAVE
• Allergy/Asthma/Eczema history	 : OBST1ATCDALLERGIEASTHMEECZEMA
• Surgical consent	 : OBST1CHAMP03
• Other samples	 : OBST1AUTRESPRELEVEMENT
• Other treatments	 : OBST1AUTRESTRAITEMENTS
• Trophoblast biopsy	 : OBST1BIOPSIETROPHOBLASTE



• Identification bracelet	 : BRACELET_IDENTIFICATION
• Calculation of pregnancy start date 	 : DDGALC
• C-section	 : ACC_CESARIENNE
• C-section: Complications	 : CESAR_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
• Field 120	 : OBST1EC_ECHOHANCHE
• Field 121	 : OBST1EC_TONUSAXIAL
• Field 122	 : OBST1EC_ORTHOPEDIQUE
• Field 123	 : OBST1EC_MALFORMATIONPATHO
• Field 124	 : OBST1EC_SORTIEPRECOCEENVISAGEE
• Field 125	 : OBST1EC_EXAMENSAPREVOIR
• Field 126	 : OBST1EC_CONSIGNES
• Field 127	 : OBST1EC_SURVEILLANCE
• Field 128	 : OBST1EC_CONSULTATIONULTERIEURE
• Field 129	 : OBST1ES_POULSFEMORAUX
• Field 130	 : OBST1ES_AUSCULTATIONCARDIAQUENORMALE
• Field 131	 : OBST1ES_EXAMNORMAL
• Field 132	 : OBST1ES_ICTERE
• Field 133	 : OBST1ES_CONCLUSIONICTERE
• Field 134	 : OBST1ES_ICTEREVALEURMAX
• Field 135	 : OBST1ES_ICTEREDATEVALEUR
• Field 136	 : OBST1ES_RISQUEINFECTIEUX
• Field 137	 : OBST1ES_ALIMENTATION
• Field 138	 : OBST1ES_SORTIE
• Field 139	 : OBST1ES_OEAPEA
• Field 140	 : OBST1ES_TRANSFERTNEONAT
• Field 141	 : OBST1ES_DEPISTAGEGUTHRIE
• Field 142	 : OBST1ES_DEPISTAGECARDIOCONG
• Field 143	 : OBST1ES_CONCLUSIONSEJOUR
• Field 144	 : OBST1ES_INFOCOURIERSORTIE































































• Field 145	 : OBST1ES_COMMENTAIRES
• Field 146	 : OBST1SEJOUR
• Field 147	 : OBST1PATHOPOSTPARTUM
• Field 148	 : OBST1ACCOUCHEMENTLIEU
• Field 149	 : OBST1ACCOUCHEMENTCOMMENTAIRE
• Field 150	 : OBST1IVGTYPE
• Field 151	 : OBST1ECHODATE
• Field 152	 : OBST1ECHOBIMETRIE
• Field 153	 : OBST1ECHOEXMORPHO
• Field 154	 : OBST1ECHOECHOGRAPHISTE
• Field 155	 : OBST1ECHOLA
• Field 156	 : OBST1ECHOPLACENTA
• Field 157	 : 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	 : BHCGTAUX2
• Field 244	 : BHCGTAUX3
• Field 245	 : BHCGTAUX4
• Field 246	 : OBST_DEPRECATED
• Field 248	 : HABITUS_MODEDEVIE
• Field 250	 : HABITUS_AUTREMODEVIE
• Field 252	 : NUMARCH
• Field 40	 : OBST1GLYCEMIECAPILAIRES
• Field 87	 : DEL_MODALITE
• Field T21	 : OBST1CHAMP404
• CN	 : OBST1CN
• Child comment	 : OBST1COMMENTAIREENFANT
• Complication	 : ANETH-COMPLICATION
• Uterine contractions: Registration	 : OBST1CUENREGISTREMENT
• Uterine contractions: Quality	 : OBST1CUQUALITE
• Umbilical cord: Anomalies	 : OBST1CORDONANOMALIES
• Umbilical cord: Insertion	 : CORDON_INSERTION
• CoResp	 : ACC_CORESP
• Postnatal care at home eligibility criteria child	 : OBST1PRADOENF
• Postnatal care at home eligibility criteria mother	 : OBST1PRADOMERE
• Cytomegalovirus	 : CYTOMEGALOVIRUS
• Scheduled delivery date 	 : SCHEDULEDELIVERY
• Breastfeeding start date	 : OBST1DEBUTALLAITEMENT
• Pregnancy start date	 : PREGNANCYSTART
• 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 Streptococcus bovis test start date 	 : DEBUTSTREPTOB
• Deadline: First trimester T21 screening 	 : DATEFINDEPISTAGET21T1
• Deadline: Second trimester T21 screening 	 : DATEFINDEPISTAGET21T2
• Deadline: Gestational diabetes test - 75g OGTT 	 : FINHPO75
• First-ultrasound deadline 	 : DATEFINECHOT1
• Second-ultrasound deadline 	 : DATEFINECHOT2
• Third-ultrasound deadline 	 : DATEFINECHOT3
• Streptococcus bovis testing deadline 	 : 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)	 : LASTPERIODENTRY
• Last menstrual period 	 : DERNIERESREGLES
• Death date	 : OBST1DATEDECES
• CRL Date	 : OBST1MESURELCC
• Deadline: Gestational diabetes test - fasting blood glucose 	 : DATEGLYCEMIEAJEUN
• Pregnancy declaration deadline 	 : DATELIMITEDECLARGROSSESSE
• EAB deadline 	 : EABDEADLINE
• Prenatal interview deadline 	 : PRENATALINTERVIEWDATE
• Rhophylac date	 : OBST1DATERHOPHYLAC
• Start of doctor-ordered leave	 : SICKLEAVESTART
• Delivery room death	 : OBST1CHAMP07
• OP/OA	 : ACC_DEG
• Placental delivery: Associated acts	 : 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: Method	 : DEL_DELAI
• Placental delivery: Transfusion	 : DEL_TRANSFUSION
• T21 screening	 : DEPISTAGE_T21
• DEPRECATED	 : OBST1CHAMP236
• Biparietal diameter in mm	 : DIAMETRE_BIPARIETAL
• Obstetrics data 1: Field 161	 : OBST1DATEDEBUTSUIVI
• Obstetrics data 1: Field 162	 : OBST1DATEFINSUIVI
• Obstetrics data 1: Field 237	 : DATEIVG
• DPNI	 : OBST1DPNI
• Duration of the active phase 	 : PHASE_ACTIVE
• Duration of latent phase 	 : PHASE_LATENCE
• Duration of doctor-ordered leave	 : DOCTORDEREDLEAVEDUR
• Stage 1 duration 	 : STADE1
• Stage 2 duration 	 : STADE2
• Stage 3 duration 	 : STADE3
• Time between ROM and start of labour 	 : PERTE_LA_DEBUT_TRAVAIL
• Carried out by	 : OBST1ACCOUCHEMENTEFFECTUEPAR
• Engagement	 : ACC_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	 : ACC_EXTR
• Foetus: Abnormal FHR	 : FOETUS_ANOMALIE_RCF
• Foetus: IUFD date	 : OBST1FOETUSMFIUDATE
• Foetus: Status (do not use)	 : FOETUS_ETAT
• Foetus: Scalp sample	 : FOETUS_SCALP
• Foetus: Monitoring	 : FOETUS SURVEILLANCE
• Genotyping	 : GENOTYPING
• Gravity 	 : GRAVIDITY
• Capillary blood glucose: time	 : OBST1GCHEURE
• Capillary blood glucose: value	 : OBST1GCVALEUR
• HBS	 : HBS
• HCG	 : HCG
• HEPATITISC	: HEPATITISC











































• HIV		: HIV
• Postnatal care at home eligibility indicator		: OBST1PRADOINDIC
• Gastric analysis or PCT indication		: INDICATION_PGPC
• Antenatal diagnosis follow-up indications		: OBST1INDICATIONSUIVIDAN
• Additional surgeries		: CESAR_INTERVCOMPL
• Pregnancy outcome		: PREGOUTCOME
• Pregnancy outcome?		: OBST1SAISIEJ
• Manually entered days of amenorrhoea		: OBST1JECHOT1
• Days of amenorrhoea based on 1st trimester ultrasound		: OBST1JECHOT1
• Is the patient a minor?		: IS-MINOR
• The patient is a minor		: ISMINOROLD
• Soft-tissue lesions		: LPM
• Soft-tissue lesions: Associated with		: OBST1LPM_ASSOCIEA
• Malformation Comment		: OBST1MOLFORMATIONCOMMENTAIRE
• Manoeuvre		: OBST1ACCOUCHEMENTMANOEUVRE
• Maturation?		: MATURATION_METHODE
• Meconium		: MECONIUM
• Pregnancy determination method		: DETERMINATIONTERME
• Maturation method		: MATURATION
• Urination		: URINATION
• Method of death		: OBST1CHAMP09
• Delivery type		: ACC-MODE
• Mode of anaesthesia		: ANESTH_MODE_AVANT
• Reason for procedure or C-section		: CESAR_MOTIF
• Reason for maturation		: MATURATION_MOTIF
• Reason for triggering		: DECLENCHEMENT_MOTIF
• NEONATOLOGIST		: NEONATOLOGIST
• Number of C-sections		: NB_CESAR
• Number of gynaecological surgery scars (excluding C-sections)		: NB-CICATRICES-GYNECO
• Number of molar pregnancies		: OBST1NBMOLE
• Number of pregnancies with diabetes		: OBST1NBDIABETE
• Number of pregnancies with HTN		: OBST1NBHTA
• Number of ectopic pregnancies		: OBST1NBGEU
• Number of days of amenorrhoea (if number of weeks is not ...		: OBST1JOURSAMENORRHEE
• Total number of days of amenorrhoea		: JOURSTOTALAMENORRHEE
• Number of premature births		: NOMBRE_PREMATURES

















• Number of weeks of amenorrhoea 	 : OBST1SEMAINESAMENORRHEE
• Number of children expected by patient 	 : NOMBRE_ENFANTS
• Number of hypotrophic children 	 : OBST1NBHYPO
• Number of children with malformations 	 : OBST1NBMALFORM
• Number of stillbirths 	 : NOMBRE_MORTSNES
• Number TABs < 22 WA 	 : OBST1NBIMGINF22
• Number TABs > 22 WA 	 : OBST1NBIMGSUP22
• Number EABs 	 : OBST1NBIVG
• Number of miscarriages 	 : OBST1NBFC
• Number	 : ACCOUCHEMENT_NUMERO
• Obstetrics: Date of T1 ultrasound	 : OBST-DATE-ECHO-T1
• Obstetrics: Free field 1	 : OBST-FREE-1
• Obstetrics: Free field 2	 : OBST-FREE-2
• Family planning: Confidentiality	 : ORTHO_COMPLICATIONS
• PAPP_A	 : OBST1PAPP_A
• Parity 	 : PARITE
• Pregnancy-related condition	 : PATHOPREGNANCY
• Conditions and complications during labour	 : PATHOLABOURCOMPLICATION
• Cord blood PCT	 : CORDPCT
• Pelvic ultrasound: BISPINOUS	 : OBST1BIEPINEUX
• Pelvic ultrasound: MAGNIN	 : OBST1MAGNIN
• Pelvic ultrasound: PRP	 : OBST1PRP
• Height percentile 	 : OBST1PERCTAILLE
• Head circumference percentiles 	 : OBST1PERCPC
• Weight percentiles 	 : OBST1PERCPOIDS
• Head circumference at birth (in cm)	 : PCCM-Naissance
• Head circumference in cm	 : PCCM
• Placenta: Anomalies	 : PLACENTA_ANOMALIES
• Newborn's weight (g)	 : POIDS-NN
• Gastric sample	 : PRELEVEMENT_GASTRIQUE
• Additional samples	 : OBST1PRLVTCOMMENTAIRES
• Preparation for birth and parenthood	 : PMP
• Presence of gynaecological 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	 : OCULARPROPHYL
• Birth rank	 : OBST1CHAMP195
• DR resuscitation: Procedures	 : OBST1REAACTES
• DR resuscitation: Comments	 : OBST1REACOMMENTAIRES
• DR resuscitation: Transfer	 : OBST1REATRANSFERT
• DR resuscitation: Paediatric call	 : OBST1REAAPPELPEDIATRIQUE
• DR resuscitation: Person in charge	 : OBST1REARESP
• Early acknowledgement of parenthood	 : RECOANTICIPEE
• Resp	 : ACC_RESP
• Full summary	 : OBST1CHAMP254
• Rubella	 : RUBELLA
• Rupture of membranes: Appearance	 : MEMBRANES_ASPECT_RUPTURE
• Rupture of membranes: Appearance AF	 : MEMBRANES_ASPECT_ULTERIEUR_C
• Rupture of membranes: Method	 : OBST1MEMBRANESMODALITERUPTURE
• Apgar score of 1	 : SCORE-APGAR1
• Apgar score of 5	 : SCORE-APGAR5
• Apgar score of 10	 : SCORE-APGAR10
• CRIB II score	 : SCORE-CRIB2
• Manually entered weeks of amenorrhoea	 : OBST1SAISIESA
• Weeks of amenorrhoea based on 1st trimester ultrasound 	 : OBST1SAECHOT1
• Patient discharge	 : SORTIEPATIENT
• Group B strep	 : BSTREP
• Antenatal diagnosis follow-up	 : OBST1SUIVIDAN
• Syphilis	 : SYPHILIS
• Temperature at birth	 : OBST1CHAMP304
• Birth size	 : TAILLE-NAISSANCE
• Term of pregnancy	 : TERMETHEORIQUEGROSSESSE
• Term of labour, number days amenorrhoea 	 : JOURS_AMENORRHEE
• Term of labour, number weeks amenorrhoea 	 : SEMAINES_AMENORRHEE
• Term of labour, number weeks + days amenorrhoea 	 : SEMAINES_JOURS_AMENORRHEE
• Complementary therapies	 : ANESTH_THERAPEUTIQUE_COMPLEMENTAIRE
• THROMBUS	 : OBST1THROMBUS
• TIU	 : TIU
• Toxoplasmosis	 : TOXOPLASMOSIS












• TPelvicUltrasound: TMU	 : OBST1TMU
• Immediate transfer	 : TRANSFERT_IMMEDIAT
• Reason for transfer	 : TRANSFERT_MOTIF
• Labour	 : MODALITE_TRAVAIL
• Labour during pregnancy	 : LABOURDURPREGNANCY
• Fertilization type, obtained by	 : OBST1CHAMP05
• Scarred uterus	 : SCARRED-UTERUS
• Flu vaccination	 : OBST1VACGRIPPE
• Pertussis vaccination Mr	 : PERTUSSISVACMRYEAR
• Pertussis vaccination Mrs/Ms	 : PERTUSSISVAC
• Pertussis vaccination Mr	 : PERTUSSISVACMR
• Vitamin D	 : OBST1CHAMP06
• Field 29	 : OBST2ATCDGYNINACTIF
• Field 30	 : OBST2ATCDMEDINACTIF















6.2.2.19 ActiveX: Conclusion POA

• Ambulatory validated	 : CONCLUSION_CPA-AMBULATOIRE_VALIDE
• Antibiotic prophylaxis	 : CONCLUSION_CPA-ANTIPPROPHYLAXIE
• Compression stockings	 : CONCLUSION_CPA-BAS-CONTENTION
• Personnel conclusion	 : CONCLUSION_CPA-CONCLUSION_STAFF
• Eligible ambulatory	 : CONCLUSION_CPA-ELIGIBLE_AMBULATOIRE
• Management companion	 : CONCLUSION_CPA-GESTION_ACCOMPAGNANT
• Monitoring scheduled	 : CONCLUSION_CPA-MONITORAGE_PREVU
• Reason personnel	 : CONCLUSION_CPA-MOTIF_STAFF
• Pain treatment	 : CONCLUSION_CPA-PEC_DOULEUR
• Post-op ICU	 : CONCLUSION_CPA-REA_POST_OP
• Post-op 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 condition	 : EXAMEN_CLINIQUE-ETAT_GENERAL
• Clinical examinations carried out during POA in connection with NGAP	 : EXAMEN_CLINIQUE-FAIT-EN-CPA-NGAP
• General	 : EXAMEN_CLINIQUE-GENERAL
• Lifestyle	 : EXAMEN_CLINIQUE-HABITUS
• Travel sickness	 : EXAMEN_CLINIQUE-MAL_DES_TRANSPORTS
• MTEA	 : EXAMEN_CLINIQUE-MTEA












• MTEV	 : EXAMEN_CLINIQUE-MTEV
• Neurology	 : EXAMEN_CLINIQUE-NEUROLOGIE
• NVPO	 : 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
• Respiratory	 : EXAMEN_CLINIQUE-RESPIRATOIRE
• Withdrawal	 : EXAMEN_CLINIQUE-SEVRAGE
• Heart function	 : EXAMEN_CLINIQUE-SIGNES_FONCTIONNELS_CARDIO
• Lung function	 : EXAMEN_CLINIQUE-SIGNES_FONCTIONNELS_NEURO
• Infection status	 : EXAMEN_CLINIQUE-STATUT_INFECTIEUX
• Virus status	 : EXAMEN_CLINIQUE-STATUT_VIRAL
• Vascular	 : EXAMEN_CLINIQUE-VEINEUX

6.2.2.21 ActiveX: PED POA

• Food	 : CPA_PED-ALIMENTATION
• APGAR birth	 : CPA_PED-APGAR_NAISSANCE
• Complications premature birth	 : CPA_PED-COMPLICATIONS_PREMATURITE
• Birth weight	 : CPA_PED-POIDS_NAISSANCE
• Suspicion stenosis	 : CPA_PED-SUSPICION_STENOSE
• Capillary refill time	 : CPA_PED-TEMSP_RECOLORATION_CUTANEE
• Type of birth	 : CPA_PED-TYPE_NAISSANCE

6.2.2.22 ActiveX: POA obstetrics

• Patient's 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_OBSTETRICAL
• 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






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DEV-EN-035 Settings Guide **DIANE**
DIANE version: 4.12
 Medical device version: 3.38
 UDI: (01)3760404900005(10)0338
 Document version : 1

- DATEIN
- DATEOUT
- TYPESEJOUR
- UF_MEDICALE
- UF_HEBERGEMENT
- CHAMBRE
- 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

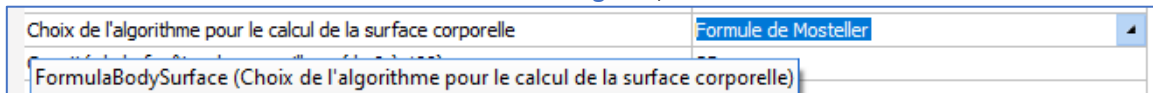
6.3.1 Consultation data

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.



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:

$\text{Weight in kg} / ((\text{Height in cm} / 100)^2)$

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) ²)

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 ≥ 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: **(Height in cm) – 35 - ((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: **(Height in cm) -100 - ((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: **(Height in cm) -100 - ((Height in cm – 125) *0.5)**
- The patient is under 18 years old, the following formula is used to determine the patient's



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Medical device version: 3.38
UDI: (01)3760404900005(10)0338
Document version : 1

theoretical weight: **(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: **(Height in cm) -100 - ((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: **(Height in cm) -100 - ((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 * (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 * (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 modified (**Patient/Sex**)
- The patient's height is modified (**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 updated.



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 (**Patient information/Weight**) is modified.

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 = (LN(PoidsNouveauNe) – moyenne)/Ecart_type

If the baby is a boy:

Ecart_type: $-4.3397226739 + 0.402861345256 * \text{AFFICHESA} - 0.01167844789 \text{AFFICHESA}(2) + 0.000109863095 \text{AFFICHESA}(3)$

Average: $11.06869318192 - 0.63463603736 * \text{AFFICHESA} + 0.025385311114 \text{AFFICHESA}(2) - 0.00028343446 \text{AFFICHESA}(3)$

Or: $-4.13667133974 + 0.382827233935 * \text{AFFICHESA} - 0.01101958925 * \text{AFFICHESA}(2) + 0.000102753287 * \text{AFFICHESA}(3)$;

Average: $10.57756060268 - 0.60716320319 * \text{SA} + 0.024851303008 * \text{AFFICHESA}(2) - 0.00028027298 * \text{AFFICHESA}(3)$

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 = (LN(Taille) – moyenne)/Ecart_type

If the baby is a boy:

Ecart_type: $-56.0552816179 + 5.194038268674 * \text{AFFICHESA} - 0.1506625261 \text{AFFICHESA}(2) + 0.001424420272 * \text{AFFICHESA}(3)$

Average: $50.06894254422 - 4.00572135523 * \text{AFFICHESA} + 0.186686129219 * \text{AFFICHESA}(2) - 0.00215574049 * \text{AFFICHESA}(3)$

Otherwise

Ecart_type: $-59.2880238464 + 5.39802559522 * \text{AFFICHESA} - 0.15428184703 * \text{AFFICHESA}(2) + 0.001437350107 * \text{AFFICHESA}(3)$

Average: $30.91419685296 - 2.42950191347 * \text{AFFICHESA} + 0.142594920869 * \text{AFFICHESA}(2) - 0.00175207738 * \text{AFFICHESA}(3)$

6.3.2.3 Head circumference percentile (DiafldObst1PercPC):

The newborn's head circumference percentile is calculated if head circumference (Obst1PCCM) and number of weeks of amenorrhoea (diafldObst1AFFICHESA) are entered.

Percentile = percentile (Score)

Score = (LN(PCCM) – moyenne)/Ecart_type

If the baby is a boy:

Ecart_type: $-24.3709774685 + 2.247143950431 * \text{AFFICHESA} - 0.06380758661 * \text{AFFICHESA}(2) + 0.000592765847$



* AFFICHESA(3)

Average: $2.527172432982 + 0.053793497931 * \text{AFFICHESA}(2) - 0.00083642534 * \text{AFFICHESA}(3)$

Otherwise

Ecart_type: $-31.7149671255 + 2.892529318957 * \text{AFFICHESA} - 0.08237590311 * \text{AFFICHESA}(2) + 0.000767371911 * \text{AFFICHESA}(3)$

Average: $1.722279782298 + 0.054867246533 * \text{AFFICHESA}(2) - 0.0008605794 * \text{AFFICHESA}(3)$

6.3.2.4 Date of last period (Obstetrics data 1: DERNIERESREGLESCALC):

This field takes the value of diafIdObst1DernieresReglesSaisie if this is entered manually, otherwise it is calculated by subtracting 14 days from the Pregnancy start date.

This field is updated on each modification to:

- Pregnancy start date (Obst1DebutGrossesse)
- Last menstrual period entry (Obst1DernieresReglesSaisie)
- Determination of term (Obst1DeterminationTerme)
- First trimester ultrasound date (ObstDateEchoT1)
- First trimester CRL measurement (Obst1MesureLCC)

6.3.2.5 Estimated due date (diafIdObst1AccouchementPrevu):

If the date of the last menstrual period (diafIdObst1DernieresReglesCalc) is entered, the due date is calculated as $\text{LMP} + 287 \text{ J}$. If the date of the last menstrual period is not entered, the estimated due date takes the value of the LMP, i.e. 0 (this is logical as “no LMP date” means “no pregnancy start date”). Data updated when the Date of last menstrual period (DernieresReglesCalc) field is updated.

6.3.2.6 Date of maternity leave (diafIdObst1ArretTravail) :

This date is calculated using the Estimated due date (diafIdObst1AccouchementPrevu) and parity (diafIdObst1Parite), which corresponds to the number of children already born.

The date of maternity leave is only calculated if the pregnancy type is entered in the record (never 0).

- If the pregnancy type (diafIdIntervTypeGrossesse) is 1 and parity is greater than or equal to two, the date of maternity leave is calculated as follows: [Estimated due date - 56 D](#)
- If the pregnancy type (diafIdIntervTypeGrossesse) is 1 and parity is equal to one, the date of maternity leave is calculated as follows: [Estimated due date - 42 D](#)
- If the pregnancy type (diafIdIntervTypeGrossesse) is between 2 and 4, the date of maternity leave is calculated as follows: [Estimated due date - 84 D](#)
- If the pregnancy type (diafIdIntervTypeGrossesse) is between 5 and 10, the date of maternity leave is calculated as follows: [Estimated due date - 168 D](#)

This data is updated if:

- Pregnancy start date is modified (Obst1AccouchementPrevu)
- Parity is modified (Obst1Parite)
- Type of pregnancy is modified (IntervTypeGrossesse)

6.3.2.7 Minor (diafIdObst1IsMinor):

The “Minor” checkbox found on the administrative tab is automatically selected if the patient is a minor. To verify this info, 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 checkbox is ticked, otherwise it is/remains unticked.

This data is updated if the patient’s date of birth is modified (Patient/DATENAIS).



6.3.2.8 Medical history: Number of children born: diafldObst1NbEnfantsNes:

How the number of children born is calculated depends on how Diane OB-GYN is set up. The section TOTAUXOBST key Foetus of Diane OB-GYN setup must be completed with data from the "Pregnancy outcome" DLM, associated with a birth of a living child (Child born alive. Postnatal death).

The number of children born calculation uses the patient's obstetric history to search for pregnancy outcomes associated with birth of a living child. A counter increases each time a value is found to then feed diafldObst1NbEnfantsNes.

Data updated on modification of obstetric history (diafldIntervINTERV_EC).

6.3.2.9 Medical history: Number of pregnancies with outcome as Intrauterine Foetal Death < 22 weeks amenorrhoea (diafldObst1NbMFIUInf22):

How the number of pregnancies with outcome as IUFD < 22WA is calculated depends on how Diane OB-GYN is set up. The section TOTAUXOBST key MFIUInf22 of Diane OB-GYN setup must be completed with data from the "Pregnancy outcome" DLM, associated with an IUFD < 22 weeks (IUFD < 22 WA). The number of intrauterine foetal deaths calculation uses the patient's obstetric history to search for pregnancy outcomes associated with an IUFD < 22 WA. A counter increases each time a value is found to then feed diafldObst1NbMFIUInf22.

Data updated on modification of obstetric history (diafldIntervINTERV_EC).

6.3.2.10 Medical history: Number of pregnancies with outcome as Intrauterine Foetal Death > 22 weeks amenorrhoea (diafldObst1NbMFIUSup22):

How the number of pregnancies with outcome as IUFD > 22WA is calculated depends on how Diane OB-GYN is set up. The section TOTAUXOBST key MFIUSup22 of Diane OB-GYN setup must be completed with data from the "Pregnancy outcome" DLM, associated with an IUFD > 22 weeks (IUFD > 22 WA). The number of intrauterine foetal deaths calculation uses the patient's obstetric history to search for pregnancy outcomes associated with an IUFD > 22 WA. A counter increases each time a value is found to then feed diafldObst1NbMFIUSup22

Data updated on modification of obstetric history (diafldIntervINTERV_EC).

6.3.2.11 Medical history: number of Medical terminations after 22 weeks of amenorrhoea (diafldObst1NbIMGSup22):

How the number of medical terminations > 22 WA is calculated depends on how Diane OB-GYN is set up. The section TOTAUXOBST key IMGSup22 of Diane OB-GYN setup must be completed with data from the "Pregnancy outcome" DLM, associated with a medical termination > 22 weeks (MAB > 22 WA).

Data updated on modification of obstetric history (diafldIntervINTERV_EC).

6.3.2.12 Medical history: number of Medical terminations before 22 weeks of amenorrhoea (diafldObst1NbIMGInf22):

How the number of medical terminations < 22 WA is calculated depends on how Diane OB-GYN is set up. The section TOTAUXOBST key IMGInf22 of Diane OB-GYN setup must be completed with data from the "Pregnancy outcome" DLM, associated with a medical termination < 22 weeks (MAB < 22 WA).

Data updated on modification of obstetric 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 Pregnancy start date and adding 112 days.

Data updated on modification of obstetric history (diafldIntervINTERV_EC).



6.3.2.14 Medical history: Number EABs (diafldObst1NbIVG):

Shows the number of pregnancies terminated with an elective abortion, if the section TOTAUXOBST key IVG of Diane OB-GYN is completed with the field corresponding to a history of EAB. The calculation is based on entries in the Pregnancy outcome T1 (ISSUEGROSSEold) DLM, found on the Obstetric History tab.
Data updated on modification of obstetric 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 DianeObst > TOTAUXOBST > C-section is set up correctly. The calculation is then verified if the DLM Pregnancy outcome (ISSUEGROSSESE) contains the data set up in C-section (C-section).
Data updated on modification of obstetric history (diafldIntervINTERV_EC).

6.3.2.16 Medical history: Number of Threatened preterm labour (diafldObst1NbMAP):

Requirements: Setup of the TOTAUXOBST section, Map key in Diane OB-GYN with a pathological pregnancy DLM data.
Data updated on modification of obstetric history (diafldIntervINTERV_EC).

6.3.2.17 Medical history: Gestational hypertension (diafldObst1NbHTA):

Requirements: Setup of the TOTAUXOBST section, Hta key in Diane OB-GYN with a pathological pregnancy DLM data.
The diafldObst1NbHTA field increases automatically based on the data entered in the patient's obstetric history.
Data updated on modification of obstetric history (diafldIntervINTERV_EC).

6.3.2.18 Medical history: Number of premature births (diafldObst1NbPrema):

Counts the number of children born alive between 22 and 37 weeks of amenorrhoea in the patient's history. (The section TOTAUXOBST key Foetus of Diane OB-GYN setup must be completed with data from the "Pregnancy outcome" DLM, associated with a birth of a living child (Child born alive. Postnatal death).)
Data updated on modification of obstetric history (diafldIntervINTERV_EC).

6.3.2.19 Medical history: Number of miscarriages (diafldObst1NbFc):

Requirements: Setup of the TOTAUXOBST section, FaussesCouches key in Diane OB-GYN with a ISSUEGROSSEold DLM data.
Data updated on modification of obstetric history (diafldIntervINTERV_EC).

6.3.2.20 Medical history: Number of pregnancies with diabetes (diafldObst1NbDiabete):

Requirements: Setup of the TOTAUXOBST section, Diabète key in Diane OB-GYN with a pathological pregnancy DLM data.
Data updated on modification of obstetric history (diafldIntervINTERV_EC).

6.3.2.21 Medical history: Number of molar pregnancies (diafldObst1NbMole):

Requirements: Setup of the TOTAUXOBST section, Mole key in Diane OB-GYN with a ISSUEGROSSEold DLM data.
The field diafldObst1NbMole is updated when pregnancy outcome is modified in the obstetric history.



6.3.2.22 Medical history: Number of hypotrophic newborns (diafldObst1NbHypo):

Counts the number of children with a weight percentile < 10 in the children born alive.
Data updated on modification of obstetric history (diafldIntervINTERV_EC).

6.3.2.23 Medical history: Number of children with malformations (diafldObst1NbMalform):

Counts the number of children born alive with a malformation (Malformation_presence=0). Data updated on modification of obstetric history (diafldIntervINTERV_EC).
Data updated on modification of obstetric history (diafldIntervINTERV_EC).

6.3.2.24 Medical history: Number of ectopic pregnancies (diafldObst1NbGeu):

Requirements: Setup of the TOTAUXOBST section, Geu key in Diane OB-GYN with a ISSUEGROSSEold DLM data. The field diafldObst1NbMole is updated when pregnancy outcome is modified in the obstetric history.
The field diafldObst1NbMole is updated when pregnancy outcome is modified in the obstetric history.

6.3.2.25 Postnatal care at home eligibility indicator (diafldObst1PradoIndic):

Used to automatically complete the "Postnatal care at home eligibility" drop-down list (Prado_Indic) on the Postpartum > Postnatal care at home/Early discharge tab.

The checkboxes 1 to 10 for Prado_mere must be selected and the checkboxes 1 to 10 for Prado_enfant must be selected for the drop-down list Eligible for postnatal care at home to change to Yes.

Field updated following changes to:

- diafldObst1PradoMere
- diafldObst1PradoEnf

6.3.2.26 Early discharge eligibility indicator (diafldObst1SortiePreIndic):

Automatic changing of the drop-down list Eligible for early discharge on the Postpartum > Postnatal care at home/Early discharge tab to Yes.

If the 15 checkboxes in the "Early discharge child" box and the 11 checkboxes in the "Eligibility criteria mother" box are selected, the list changes to Yes, otherwise it stays on No.

Field updated following changes to:

- diafldObst1SortiePrecMere
- diafldObst1SortiePrecEnf

6.3.2.27 DISPLAY WA (diafldObst1):

The DISPLAY WA (SAISIESA) field under birth monitoring shows, by default, the number of weeks of amenorrhoea (SemainesAmenorrhee) when the child was born. If a value is entered manually in the entry field **Enter WA** (SAISIESA), this value is automatically copied into the field DISPLAY WA.

Field updated if:

- Number of weeks of amenorrhoea (diafldObst1SemainesAmenorrhee or diafldObst1SAISIESA) is modified

6.3.2.28 DISPLAY DAYS (diafldObst1):

The DISPLAY DAYS (SAISIEJ) field under birth monitoring shows, by default, the number of days in addition to number of weeks of amenorrhoea (JoursAmenorrhee) when the child was born. If a value is entered manually in the entry field **Enter Days** (SAISIEJ), this value is automatically copied into the field DISPLAY DAYS.

Field updated if:

- Number of days of amenorrhoea (diafldObst1JoursAmenorrhee or diafldObst1SAISIEJ) is modified



6.3.2.29 Number of C-sections (diafldObst1Cesarienne):

This field is completed automatically using modalite_travail and acc_cesarienne.

If the type of labour (modalité_travail) is entered with a value of “e” (elective C-section) or if the incision type is specified (acc_cesarienne), C-section changes to Y, otherwise it remains N.

Field updated following changes to:

- diafldObst1AccouchementCesarienne
- diafldObst1Travail



6.3.2.30 Gravidity: (diafldObst1Gestite):

This field increases for each patient procedure listed under Obstetrics (1) or Pregnancy stopped (3).

Field updated following changes to:

- diafldIntervINTERV_EC
- diafldObst1TypeDossierDeprecated

6.3.2.31 Parity: diafldObst1Parite:

Terme	Parité
 41SA + 2J	 4








The parity field counts the number of children born alive, the number of MABs after 22 weeks (NB_IMG_>_22) and the number of IUFD (NB_MFIU_>22).

Field updated following changes to pregnancy outcome in the obstetric history.

Field updated following changes to:

- diafldIntervINTERV_EC
- diafldObst1IssueDeLaGrossesse

6.3.2.32 Scarred uterus (diafldObstUterusCicatriciel):

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 (diafldObst1NbCesar) and gynaecological scars (diafldObstCicatriceGyn).

The number of uterine scars displayed changes on the basis of this total:

- 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 modified (diafldObst1NbCesar)
- Number and type of gynaecological scars is modified (diafldObstCicatriceGyn/diafldObstNbCicatriceGyn)



6.3.2.33 Total days of amenorrhoea (diafldObst1JoursTotalAmenorrhee):

Total duration in days from patient's last menstrual period to birth of child. Corresponds to duration in weeks x 7 + duration in days.

Field updated if:

- Date of last period is modified (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafldObst1IssueGroDate)
- Term determination type is modified (diafldObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafldObstDateEchoT1)
- First trimester CRL measurement is modified (diafldObst1MesureLCC)

6.3.2.34 Number of weeks of amenorrhoea (diafldObst1SemainesAmenorrhee):

The number of weeks of amenorrhoea is calculated from the field JoursTotalAmenorrhee divided by 7.

Field updated following changes to diafldObst1JoursTotalAmenorrhee

6.3.2.35 Number of days of amenorrhoea in addition to number of weeks (diafldObst1JoursAmenorrhee):

The number of days of amenorrhoea is calculated from the field JoursTotalAmenorrhee modulo 7.

Field updated following changes to diafldObst1JoursTotalAmenorrhee

6.3.2.36 Start date 1st trimester ultrasound (diafldObst1DateDebutEchoT1):

Date calculated using Pregnancy start date + 63 days (9 weeks).

Field updated if:

- Pregnancy outcome date is modified (diafldObst1IssueGroDate)
- Term determination type is modified (diafldObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafldObstDateEchoT1)
- First trimester CRL measurement is modified (diafldObst1MesureLCC)

6.3.2.37 End date 1st trimester ultrasound (diafldObst1DateFinEchoT1):

Date calculated using Pregnancy start date + 83 days (11 weeks + 6 days)

Field updated if:

- Pregnancy start date is modified (diafldObst1DebutGrossesse)
- Term determination type is modified (diafldObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafldObstDateEchoT1)
- First trimester CRL measurement is modified (diafldObst1MesureLCC)

6.3.2.38 Start date for 1st trimester T21 screening (diafldObst1DateDebutDepistageT21T1):

Date calculated using Pregnancy start date + 63 days (9 weeks).

Field updated if:

- Pregnancy start date is modified (diafldObst1DebutGrossesse)
- Term determination type is modified (diafldObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafldObstDateEchoT1)
- First trimester CRL measurement is modified (diafldObst1MesureLCC)



6.3.2.39 End date for 1st trimester T21 screening (diafIdObst1DateFinDepistageT21T1):

Date calculated using Pregnancy start date + 83 days (11 weeks + 6 days)

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.40 Deadline for EAB (diafIdObst1DateLimiteIVG):

Date calculated using Pregnancy start date + 84 days.

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.41 End date fasting blood sugar detection (Obstétrique1/DateLimiteGlycemieAJeun):

Date calculated using Pregnancy start date + 97 days (13 weeks + 6 days)

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.42 Prenatal interview date (diafIdObst1DateEntretienPrenatal):

Date calculated using Pregnancy start date + 92 days (13 weeks)

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.43 Pregnancy declaration deadline (diafIdObst1DateLimiteDeclarationGrossesse):

Date calculated using Pregnancy start date + 98 days (14 weeks)

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.44 Start date for 2nd trimester T21 screening (diafIdObst1DateDebutDepistageT21T2):

Date calculated using Pregnancy start date + 84 days (9 weeks)

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)



6.3.2.45 End date for 2nd trimester T21 screening (diafIdObst1DateFinDepistageT21T2):

Date calculated using Pregnancy start date + 112 days (16 weeks)

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.46 Start date for 2nd trimester ultrasound (diafIdObst1DateDebutEchoT2):

Date calculated using Pregnancy start date + 126 days (18 weeks)

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.47 End date for 2nd trimester ultrasound (diafIdObst1DateFinEchoT2):

Date calculated using Pregnancy start date + 161 days (23 weeks)

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.48 Start date for oral glucose tolerance test (diafIdObst1DebutHPGO75):

Date calculated using Pregnancy start date + 154 days (22 weeks)

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.49 End date for oral glucose tolerance test (diafIdObst1FinHPGO75):

Date calculated using Pregnancy start date + 182 days (26 weeks)

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.50 Start date for 3rd trimester ultrasound (diafIdObst1DateDebutEchoT3):

Date calculated using Pregnancy start date + 196 days (28 weeks)

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)



6.3.2.51 End date for 3rd trimester ultrasound (diafIdObst1DateFinEchoT3):

Date calculated using Pregnancy start date + 231 days (33 weeks)

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)
- diafIdObst1MesureLCC

6.3.2.52 Start date for Strep B detection (diafIdObst1DebutStreptoB):

Date calculated using Pregnancy start date + 224 days (32 weeks)

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.53 End date for Strep B detection (diafIdObst1FinStreptoB):

Date calculated using Pregnancy start date + 252 days (36 weeks)

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.54 Patient age (Patient/AgeInYearsInteger)

Field calculated using the patient's date of birth (PatientDATENAISS). If this date is not zero, the Patient age field corresponds to the difference in years between the current date and the patient's date of birth.

Field modified following modification of Patient/DATENAISS.

6.3.2.55 Start date for 3-month consultation (diafIdObst1ConsultationTroisiemeMoisDebut):

Date calculated using Date of last period + 84 days (12 weeks)

Field updated if:

- Pregnancy start date is modified (diafIdObst1DebutGrossesse)
- Date of last period is modified (diafIdObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafIdObst1IssueGroDate)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.56 End date for 3-month consultation (DiafIdObst1ConsultationTroisiemeMoisFin):

Date calculated using Date of last period + 91 days (13 weeks)

Field updated if:

- Date of last period is modified (diafIdObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafIdObst1IssueGroDate)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)



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 modified (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafldObst1IssueGroDate)
- Term determination type is modified (diafldObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafldObstDateEchoT1)
- First trimester CRL measurement is modified (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 modified (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafldObst1IssueGroDate)
- Term determination type is modified (diafldObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafldObstDateEchoT1)
- First trimester CRL measurement is modified (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 modified (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafldObst1IssueGroDate)
- Term determination type is modified (diafldObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafldObstDateEchoT1)
- First trimester CRL measurement is modified (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 modified (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafldObst1IssueGroDate)
- Term determination type is modified (diafldObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafldObstDateEchoT1)
- First trimester CRL measurement is modified (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 modified (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafldObst1IssueGroDate)
- Term determination type is modified (diafldObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafldObstDateEchoT1)
- First trimester CRL measurement is modified (diafldObst1MesureLCC)



6.3.2.62 End date for 6-month consultation (diafIdObst1ConsultationSixiemeMoisFin):

Date calculated using Date of last period + 224 days (32 weeks)

Field updated if:

- Date of last period is modified (diafIdObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafIdObst1IssueGroDate)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.63 Start date for 7-month consultation (diafIdObst1ConsultationSeptiemeMoisDebut):

Date calculated using Date of last period + 224 days (32 weeks)

Field updated if:

- Date of last period is modified (diafIdObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafIdObst1IssueGroDate)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.64 End date for 7-month consultation (diafIdObst1ConsultationSeptiemeMoisFin):

Date calculated using Date of last period + 238 days (34 weeks)

Field updated if:

- Date of last period is modified (diafIdObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafIdObst1IssueGroDate)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.65 Start date for 7-month anaesthesia consultation (diafIdObst1ConsultationAnesthSeptiemeMoisDebut):

Date calculated using Date of last period + 196 days (28 weeks)

Field updated if:

- Date of last period is modified (diafIdObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafIdObst1IssueGroDate)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)

6.3.2.66 End date for 7-month anaesthesia consultation (diafIdObst1ConsultationAnesthSeptiemeMoisFin):

Date calculated using Date of last period + 224 days (32 weeks)

Field updated if:

- Date of last period is modified (diafIdObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafIdObst1IssueGroDate)
- Term determination type is modified (diafIdObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafIdObstDateEchoT1)
- First trimester CRL measurement is modified (diafIdObst1MesureLCC)



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 modified (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafldObst1IssueGroDate)
- Term determination type is modified (diafldObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafldObstDateEchoT1)
- First trimester CRL measurement is modified (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 modified (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafldObst1IssueGroDate)
- Term determination type is modified (diafldObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafldObstDateEchoT1)
- First trimester CRL measurement is modified (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 modified (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafldObst1IssueGroDate)
- Term determination type is modified (diafldObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafldObstDateEchoT1)
- First trimester CRL measurement is modified (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 modified (diafldObst1DernieresReglesCalc)
- Pregnancy outcome date is modified (diafldObst1IssueGroDate)
- Term determination type is modified (diafldObst1DeterminationTerme)
- First trimester ultrasound date is modified (diafldObstDateEchoT1)
- First trimester CRL measurement is modified (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 modified 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 (diafldObst1MeasureLCC)
- 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 (diafldObst1MeasureLCC)
- First trimester ultrasound date is modified (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 modified (diafldObst1DeterminationTerme)
- First trimester CRL measurement is modified (diafldObst1MeasureLCC)
- First trimester ultrasound date is modified (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 modified/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 modified/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 modified/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 (diafldObst1IssueGroDate) is modified
- If the dilation is modified/deleted

6.3.2.79 Stage 3 duration (diafldObstStade3):

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 Delivery entry time is modified
- the Delivery is deleted
- the Pregnancy outcome date is modified (diafldObst1IssueGroDate)



6.3.2.80 Term of labour (diafldObstTermeMiseTravailSAJ):

Terme

41SA + 1J

This calculated field is the result of the concatenation of two calculated fields:

- diafldObstTermeMiseTravailSA: calculated based on the difference between the Date of last period (DernieresReglesCalc) and the date of the Start of labour event divided by 7.
- diafldObstTermeMiseTravailJ: calculated based on the difference 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 modified (diafldObst1DernieresReglesCalc)
- 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: diafldObstPerteLADebutTravail

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 (diafldObstNbMortsNés):

Counts the number of stillbirths in the patient's obstetrical history. Calculated on the basis of the total of the calculated fields diafldObst1NbMFIUSup22 and diafldObst1NbIMGSup22.

The term is calculated if:

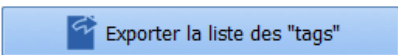
- The number of Intrauterine foetal deaths after 22 weeks is updated (diafldObst1NbMFIUSup22)
- The number of Medical terminations after 22 weeks is updated (diafldObst1NbIMGSup22)

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.



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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

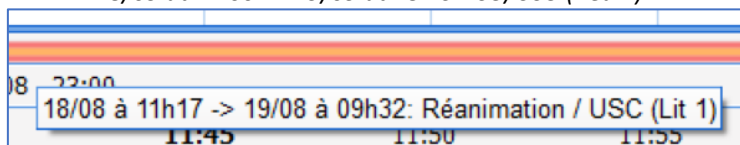
6.4.1.1 Print tags associated with traceability

A print tag **INTERV-TRACABILITE** (traceability of different patient movements during record) is used to show the timeline of the selected procedure, similar to hovering over **i** on the patient selection window.

There is also a print tag for each category of patient movement:

- INTERV-TRANSFERT**: Transfer period
- INTERV-INDUCTION**: Induction period
- INTERV-BLOC**: Transfer to OT period
- INTERV-REVEIL**: Recovery period
- INTERV-REA**: Period in ICU/CCU
- INTERV-CONSULTOBS**: Period in obstetrics consultation
- INTERV-SALLENAISS**: Period in delivery room
- INTERV-AMBU**: Period in ambulatory care
- INTERV-CLOTURE**: Closing the record

Example: **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 premedication signature date/time
- PREMEDICATIONS_PERSOS_SIGNES_PAR**: Full name of the doctor who signed the patient's premedications
- CPA-PREMEDICATIONS**: Premedication
- PRESCR-Premedications_ALD**: Premedications: Long-term condition
- PRESCR-Premedications_NonALD**: Premedications: Other than long-term condition
- PRESCR-REA_PREMEDICATIONS**: ICU medication orders: Import from premedications
- SIGNATURE_IMAGE_MEDECIN_PREMED**: Signature of the doctor who signed the patient's premedications
- TRAITEMENTS_PERSOS_SIGNES_LE**: Confirmation date/time of the patient's personal treatments
- COMMENTAIRE_TRAITEMENT**: Disease history
- TRAITEMENTS_PERSOS_SIGNES_PAR**: Full name of the doctor who confirmed the patient's personal treatments
- PRESCR-TraitementPersonnel_ALD**: Personal treatment: Long-term condition
- PRESCR-TraitementPersEtRelais_ALD**: Personal treatment: Other than long-term condition
- PRESCR-TraitementPersEtRelais_NonALD**: Personal treatment and conversion: Long-term condition
- PRESCR-TraitementPersonnel_NonALD**: Personal treatment and conversion: Other than long-term condition
- CPA-RELAIS-HORS-HOPITAL**: Personal treatment: Show substitutes associated with drug database
- CPA-PREMEDICATIONS_HORS_HOPITAL**: Premedications: Show substitutes associated with drug database



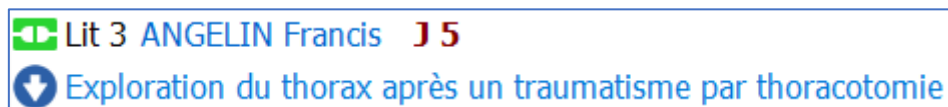
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6.4.2 Information tags shown in DIANE ICU (versions before V4.8)

Tags relating to the **DIANE ICU** portal:



“Patient name mask in list of patients present” key in DianeRea.ini (first line):

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):

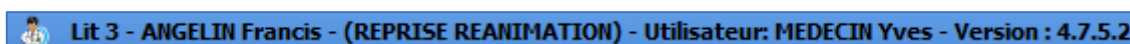
Tag	Action
<MOTIF_ADMISSION>	Value of ActiveX “CPAInterv”, “PATHOLOGIE”=2 data
<MOTIF_TYPE_INTERV> and <TYPE_INTERV>	Value of ActiveX “CPAInterv”, “TYPINTER”=5 data
<MOTIF_CHIRURGIEN>	Value of ActiveX “CPAInterv”, “CHIRURGIEN”=9 data
<MOTIF_REA_RESP>	Full name of doctor in charge of the current ICU time 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):



“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)



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<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, Inclusion, etc.)
<RESPONSABLE>	Full name of person in charge of procedure (only for OT/RR)

“Title appearing at top of application” key 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>	Current database alias
<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 service receiving the 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 ANGUERRAN	Prénom Charles	Âge  45 ans	Localisation:  Lit n°3	Jour  J 178	Taille  170cm	Poids initial  53kg	Poids  53kg	Poids théorique  66,02kg
---	--------------------------------	---------------------------------	--	---	--	--	--	--	---

This is the Top ribbon display mask.

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
<PATIENTAUTRESPRENOMS>	Other first names of patient
<PATIENTPRENOMUSUEL>	First name gone by
<PATIENTAGE>	Patient’s age (including unit)
<PATIENT_GESTATIONAL_AGE>	Gestational age
<PATIENT_REVISÉ_AGE>	Corrected age



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<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 the first day, D0 will be shown)
<PATIENT_HEIGHT>	Patient's height (not including unit)
<PATIENT_WEIGHT>	Patient's weight (not including unit)
<PATIENT_INITIAL_WEIGHT>	Patient's initial weight (on admission)
<PATIENT_THEORETICAL_WEIGHT>	Patient's theoretical weight according to the formula set up in DiaServeur.ini, "Choice of algorithm for calculating theoretical weight" (not including unit)
<PATIENT_ADJUSTED_WEIGHT>	Adjusted weight calculated according to the formula: $Theoretical\ weight + 0.4 \times (Current\ weight - Theoretical\ weight)$ (not including unit)
<PATIENT_BIRTH_WEIGHT>	Birth weight
<PATIENT_LAST_PRESC_WEIGHT>	Weight on last prescription
<PATIENT_WEIGHT_WITH_DATE>	Weight including date
<BMI>	IMC
<BSA>	Body surface area (not including unit)
<PATIENT_LAST_PRESC_BSA>	Body surface area on last prescription
<PATIENTSEXE>	Patient's sex (M or F)
<UF>	Functional unit for current entity (computer): The FU shown corresponds to the first FU found on parent entities recursively.
<IPP>	UPI
<INS>	Patient NHI
<PATIENTSTATUS>	Patient NHI status
<BILAN_GROUPE>	Patient's blood group (corresponds to data in ActiveX "Sanguin", Data "GROUPE"=1)
<IEP>	Stay number associated with record, found by searching using OT start date or ICU start date (as applicable)
<OBST_SAJ>	Week(s) and day(s) of amenorrhoea
<OBST_UT_CICAT>	Scarred uterus
<OBST_PARITE>	Parity
<USER>	Current user
<MOTIF_ADMISSION> <TYPE_INTERV> <MOTIF_CHIRURGIEN>	Reason for hospitalisation
<PATIENT_DATE_PRISE_EN_CHARGE>	ICU admission date (including date)
<PATIENT_GAIN_LOSS_SINCE_ADMISSION>	Weight gain or loss since admission
<PATIENT_GAIN_LOSS_SINCE_LAST_MEASURE>	Weight gain or loss since last measurement

6.4.5 Tags for integrated document headers (Developments, 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 username of logged-in user
<USERNOM>	Displays name of logged-in user



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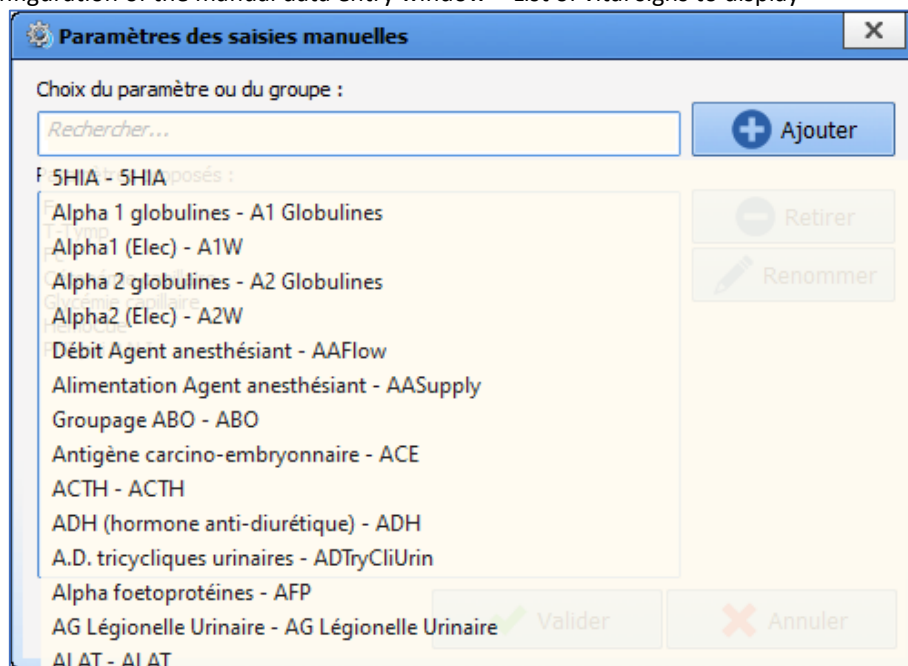
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<USERPRENOM>	Displays first name of logged-in user
<USERROLE>	Displays role of logged-in user
<USERPROFIL>	Displays profile/category of logged-in user
<USERADELI>	Displays health professional registry number of logged-in user
<USERIDEXT>	Displays external 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.

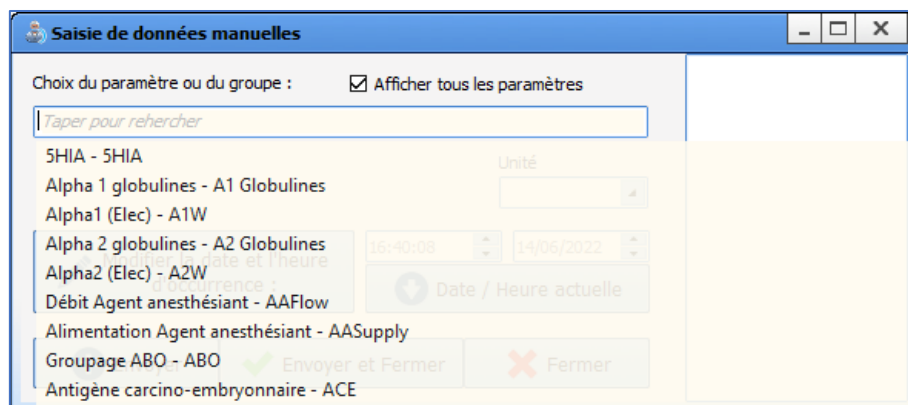


6.5 Vital signs lists

DIANE covers over 1,000 vital signs. The list is available during configuration via **Settings**, **Visual**, ParamList key – Configuration of the manual data entry window – List of vital signs to display



The list of vital signs is also available in use via the manual data entry window by selecting **View all vital signs**.





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2024-01-19



The **DIANE** prescribing system is a Class I Medical Device under Directive 93/42 and European Regulation 2017/745



Users must read all instructions carefully in order to ensure the medical device is used properly.

Training on the DIANE medical device is strongly recommended.

Most recent update 2024-01-19



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