# Clinical Portal

DMF Systems have developed a fully integrated clinical information system that enables clinicians and users access to all required patient information from one single login using an active directory password.

The GeneCIS Clinical portal suite is available as a fully inclusive package or on a modular basis as shown below. It is also easily integrated with 3rd party systems for direct access to files, providing the Clinician with direct access to the patient record in context.


# Integration with 3rd Party Vendors

3rd party vendors have invested heavily in delivering browser based result reporting and web based GUI's. Hospital users are trained and are familiar with the systems they need to access. Why reinvent and lose all this investment when delivering a fully functional clinical portal?

Our approach is to develop a connection model that integrates with the 3rd party's presentation layer. It's key to work with the 3rd party so that when we provide the specific identifiers for the patient and /or identifiers for a specific episode of care that the 3rd party system will present the patient record in context. Most vendors will support this facility, we simply formulate the connectivity to re-use this available technology.

Where the vendor cannot facilitate URL/Desktop integration supporting this level of connectivity, we utilise the DMF MediViewer technology to present results. We simply implement a HL7 based interface with the 3rd party and deliver the results on the MediViewer platform.

# eDischarge®

## Web Based Electronic Discharge Solution.

Paper based discharge summaries are often illegible, incomplete or received too late for the information to be considered clinically useful. Electronic discharge summaries can address known deficiencies and improve the continuity of care, communication and accuracy of data in discharge summaries.

Our web-based eDischarge solution enables doctors to rapidly record all diagnoses, treatments & medications at the point of care. Consultants can review & approve discharge summaries even after the patient has left the hospital. If the consultant sees any omissions or errors, these can be added or corrected to the updated summary filed and sent to the patients GP instantaneously on approval.

### Benefits

Minimum training required as system is simple and intuitive.

Improvement of patient outcomes due to controlled accessible & controlled continuation of care.

The delivery of complete and accurate records of care at discharge.

The creation of an instantly accessible record of care. Available on all workstations to authenticated users

Billing information can immediately be retrieved from the database.

If patients are re-admitted, all previous history is available

Medication Management Functionality reduces prescription errors and re-admission rates

The discharge letter when approved is immediately sent to the GP via email or in a HL7 format

Zero footprint on a PC, tablet or PDA means hospital wide deployment is simple & secure

### Process

On admission, a central repository is created that includes a Shared Patient Index and the Episodes of Care for each patient.

Once the episode is created the NCHD (Non Consultant Hospital Doctor) may commence the creation of the electronic summary.

The discharge coordinator will finalise the data capture and will print the summary on Patient discharge.

The printed summary may be filed in the patients chart and a hard copy handed to the patient. It's the printing of the summary that will trigger the delivery of the summary to the patients' GP electronically.

The consultant can either approve or can update the summary to provide some specific additional information. The consultant review typically occurs after the patient has been discharged and after the summary has been printed and transferred to the GP.

# MediViewer®

## Results Online, On time.

Not having the ability to easily access results scans and/or files for patients at any one time or place can become a very timely and costly process. Valuable time spent looking for patient's results in different computers and different departments have a huge knock-on effect on the remaining duration of the patients stay. Being able to access patient files via a web based single login portal ensures you save valuable time and enabling your facility to become more efficient. If a hospital cannot access a web interface to access lab results for example, Medilink, another module of Clinical Portal can be used instead.

MediViewer provides a safe and secure means of displaying inpatient and outpatient results that can be accessed anytime, anywhere. MediViewer currently processes in excess of 10,000 profile results and images per month for disciplines including Biochemistry, Haematology, Immunology, Histology, Blood Bank and Coag, Radiology, Cardiology, MRI & CT Scans, EEG, ECG, PTCA and ECO.

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# eReferrals®

## Multi-Speciality Patient Referral System.

The current process of referring patients for speciality or follow-up care is notably a disjointed process. Typically, all participants in the referral process must rely on paper, telephone calls and faxes for communication and coordination. Often the onus is on the patient to organise the referral appointment.


The result of this process presents numerous opportunities for miscommunication, delays in follow-up care, loss of hard copy referrals, and there is no viable method for referring providers to assess the referrals process. Current paper based solutions are also unable to trace the patients journey at any given time and high administration costs apply also.

DMF have developed a multi-speciality patient referral system that facilitates referral processes agreed between the hospitals & referring doctors. Patients can be referred internally and externally for: Consultations, Tests, Examinations, Diagnostic Procedures & Minor Surgeries...

via our eReferral System

### Benefits

- Direct referral to clinicians work list bypasses patient outcomes.
- Greater control over quality of data provided.
- Standard, predictable and monitored referral process.
- Improved timeliness and referral intervention
- Patient tracking results in reduced DNA's.
- The necessity of the referral is ensured.
- Enables higher referral volume that can be managed by smaller staff.
- Full management reporting functionality.

### Process...

The referring doctor can either refer the patient directly onto the consultants work list or through admissions, depending on the requirements. The consultant later reviews the referral and either accepts or rejects each referral. Appointments for accepted referrals are booked in the hospital and details are sent to the patient.

Alternatively the referring doctor has access to the consultant's diaries and can book an appointment directly for the patient from their surgery. The patient is given the appointment details in the GP's surgery.

The eReferrals product is a module of the clinical portal package or can be supplied as a standalone product that can be easily integrated into an existing hospital system. It can also be configured for multiple hospitals; each hospital having its own view of the data. As it is also a web based product, it can be accessed from anywhere with a functioning internet browser, from any device.

# ePrescription

## Reducing MEs and ADEs.

Studies have shown that medication errors (MEs) affect 5% of in-patients. Although this may seem like a small percentage, it's quite a significant number of patients to be effected (1 in every 20) and errors like these can ultimately result in adverse drug events (ADEs). Our ePrescription solution has been developed to add additional functionality to the eDischarge workflow and ultimately the Clinical Portal Suite to help reduce medication errors and ADEs. Our solution will allow you to print and submit a script to the pharmacy following the decision support analysis. This will create a legible and digitally recorded script that can be issued immediately and now forms part of the patients' medical record.

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# Clinical Summaries®

## Facilitating the communication of current clinical notes between clinical team personnel.

During a period of care, a patient can potentially be treated by a number of health-care practitioners and specialists in multiple settings, including emergency care, surgical care, intensive care, and rehabilitation. Patients will often move between areas of diagnosis, treatment, and care on a regular basis - introducing a safety risk to the patient at each interval.

The handover care between shifts is a vital and timely process for all medical staff concerned but might not include all the essential information, or information may be misunderstood. These gaps in communication can cause serious breakdowns in the continuity of care, inappropriate treatment, and potential harm to the patient. It is paramount that all patient details are carefully transferred from one care provider to another.

DMF have developed an electronic solution that considerably improves both the expediency of the handover of care and reducing interpretation errors. Our solution enables teams of doctors to view their specific patient's lists. These patients' lists are updated automatically from the hospital PAS system, detailing a real-time account of each patient's location.

Clinical Summaries significantly reduces the hand-over of care time, transcription errors and provides accurate information for the continuation of patient care. Clinical Summaries are completed at the point of care and is easily accessed through a password-protected portal from any PC or Tablet.

## Benefits

Clinical Summaries will reduce the duration of patient care and the timeliness of handover care.

Team-specific patient lists are freely accessible to authorised parties.

Information is backed up regularly to ensure its security and availability.

Significant reduction in errors transcribing patient information during the handover of care during shifts.

Patient location is instantly available and updated in real-time, allowing you to find the whereabouts of the patient at any particular time and keep you informed of any recent updates, dramatically reducing the time it takes to observe and treat patients, allowing more time to be spent on others.

## Process

Each doctor inputs patient data into a workstation during or upon completion of their rounds. The previously entered information from other personnel is readily available for viewing by those parties directly related to the patient. Approved staff can access patient information specific to their team or group of patients. The bed number and the location of each patient is available and can be utilised during rounds.

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