



This document gives an overview of Meddsystem clinical modules.

Medd_clinical_modules_v1.2



|MeddRecord:

Meddrecord Introduction

The clinical core of the health software service is Meddrecord. We have had to create a new concept of an “**online medical record**”, an **OMR**, because what we have created is the perfect solution to the age old problem of moving to paperless medical records. This is a “cloud based” solution, with security at the heart.

Data access

What this means is that when a person travels anywhere in the World they can have immediate access to the full medical information including all images, x-rays, scans and crucial information. Securely.

Data entry

All data that is added is through clinical wizards. This means that all doctors, nurses and professionals allied to medicine will all add information in a simple and standard manner. Everyone will be able to work to a common standard with no possibility of missing crucial information that should be added to a person’s record, not missing that important question about a symptom or examination.

Clinical specialities

Each specialty has its own wizards to add information from symptom checks (systematic enquiries) and examinations. Each specialist is able to have their top 10 symptoms that they record for patients, as well as the same top 10 examinations and top 10 diagnoses.

Accessing Meddrecord Online

There are simple secure channels for accessing a person’s Meddrecord.

These are:

- **Consultation: patient present** – patient registers at clinic → books for appointment → healthcare professional opens Meddrecord to start consultation
- **Emergency: patient present new Meddrecord** - Patient registered → registered to emergency healthcare professional → emergency doctor assesses using wizards adding new data.
- **Emergency: patient present & conscious with past Meddrecord** - Patient search, Meddrecord found → access code given by patient or security questions passed → duty of care given → registered to emergency healthcare professional → emergency doctor assesses using wizards adding new data and viewing old.
- **Emergency: patient present & unconscious with past Meddrecord** - Patient search, Meddrecord found → registered to emergency healthcare professional on call → duty of care given → emergency doctor assesses using wizards adding new data and viewing old data. **Post emergency access audit filed – notification of patient when conscious – or relatives**
- **Referral: patient not present** – patient referred for another opinion → referral received → duty of care transferred and logged → receiving healthcare professional views Meddrecord to action referral
- **Results returned: patient not present** – healthcare professional requesting test alerted to results available → Meddrecord results accessed → fully Meddrecord viewed as necessary → outcome created.
- **Inpatient ward round patient present** – ward round started → Meddrecord accessed → for ward round consultation



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Managing Meddrecord data during consultation

During a consultation or patient encounter the healthcare professional is able to view all the information required, including all multimedia information from imaging and laboratory tests and investigations. There are also specialist symptom checking and examinations that relate to diagnoses for all medical and surgical specialties.

These clinical modules are:

6.1 Recording history on patient online medical record(OMR)

- 6.1.01 Add symptoms
- 6.1.02 Add injury/accident
- 6.1.03 Add diagnosis
- 6.1.04 Add past medication
- 6.1.05 Run systematic enquiry
- 6.1.06 Add examination
- 6.1.07 Add allergy
- 6.1.08 Add investigation
- 6.1.09 Add vaccination
- 6.1.10 Add procedure
- 6.1.11 Add diet
- 6.1.12 Add care plan / care packages
- 6.1.13 Add social history
- 6.1.14 Record voice notes
- 6.1.15 Add family history
- 6.1.16 Put on hold
- 6.1.17 Add current care

6.2 Viewing history of patient online medical record(OMR)

- 6.2.01 View undiagnosed symptoms and each episode
- 6.2.02 View undiagnosed examination findings
- 6.2.03 View diagnoses
- 6.2.04 View symptoms of a diagnosis and their episodes
- 6.2.05 View treatments of symptoms
- 6.2.06 View examinations of diagnosis
- 6.2.07 View abnormal test results of diagnosis e.g. abnormal sugar in diabetes
- 6.2.08 View past medication
- 6.2.09 View all current medication
- 6.2.10 View systematic enquiry
- 6.2.11 View operations & procedure
- 6.2.12 View allergy – medication, contact, food allergies
- 6.2.13 View test & investigation
- 6.2.14 View vaccination
- 6.2.15 Make diagnosis
- 6.2.16 View medical diet
- 6.2.17 View care plan / care packages
- 6.2.18 View social history
- 6.2.19 Link symptom with diagnoses
- 6.2.20 View family history
- 6.2.21 View Appointments, admission & discharge summary
- 6.2.22 View current care & messages
- 6.2.23 View injury and accident
- 6.2.24 View referrals

6.3 Medrecord Online timeline views

- 6.3.01 Medrecord Online – timeline view
- 6.3.02 Current complete overview – health status now
- 6.3.03 Past health status – 1 hour, 2 hour, 6 hour, 12 hour, 24 hour, 48 hours,
- 6.3.04 1 week, 2 weeks, 1 month, 3 months, 6 months, 1 year, 5 year, life



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6.3.05 View how all health information relates in time to each other

6.4 Symptom – chief complaint, presenting complaint, complaining of..

- 6.4.01 Selecting the symptom to add
- 6.4.02 Find symptom to add
- 6.4.03 Type unusual symptom
- 6.4.04 Add symptom start date
- 6.4.05 Adding body area of symptom and add voice note to symptom
- 6.4.06 Add end of symptom
- 6.4.07 Add symptom details – history of presenting complaint, hpc
- 6.4.08 Add stop date to a previously ongoing symptom
- 6.4.39 Restart a symptom previously stopped
- 6.4.00 Linking a symptom to a diagnosis
- 6.4.11 Viewing a newly added, undiagnosed symptom
- 6.4.12 Update symptom
- 6.4.13 Remove symptom
- 6.4.14 Add telemedicine image to symptom
- 6.4.15 View telemedicine image
- 6.4.16 Annotate telemedicine image
- 6.4.17 Add voice note to telemedicine image
- 6.4.18 Link symptom to diagnosis

6.5 Adding an examination – observations and specialist examinations

- 6.5.01 Selecting examination to add
- 6.5.02 Add examination – automatic check of abnormal findings
- 6.5.03 View examination finding
- 6.5.04 Update examination finding
- 6.5.05 Re-examine examination finding
- 6.5.06 Record details of examination finding
- 6.5.07 Link examination finding to diagnosis
- 6.5.08 Confirm abnormal examination finding still present
- 6.5.09 Modify examination finding
- 6.5.10 Add telemedicine image to examination
- 6.5.11 View telemedicine image of examination

6.6 Recording Diagnoses – ICD10 current WHO classification

- 6.6.01 Adding a diagnosis
- 6.6.02 Adding diagnosis start date
- 6.6.03 Adding site of the diagnosis
- 6.6.04 Adding end of the diagnosis (past diagnoses) or current diagnosis
- 6.6.05 Viewing a past or ongoing (current) diagnosis
- 6.6.06 Viewing symptoms under a diagnosis
- 6.6.07 Viewing examinations under a diagnosis
- 6.6.08 Viewing test results under a diagnosis
- 6.6.09 Viewing medications under a diagnosis
- 6.6.10 Add differential diagnosis – likely, unlikely but important, to consider, possible
- 6.6.11 Viewing differential diagnosis
- 6.6.12 Update diagnosis
- 6.6.13 Remove symptoms from diagnosis
- 6.6.14 Remove examinations from diagnosis
- 6.6.15 Remove test results from from diagnosis
- 6.6.16 Remove view medications under diagnosis

6.7 Adding an Injury

- 6.7.01 Selecting injury to add
- 6.7.02 Adding the time of an injury
- 6.7.03 Adding the site of an injury



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6.7.04 View injury and accident

6.8 Prescriptions medications & therapies

6.8.01 View medication/therapy

6.8.02 Print prescription

6.8.03 Add dose taken

6.8.04 Stop medication

6.8.05 Add side effect of medication

6.8.06 Add haemodialysis – prescribe, plan sessions, manage session, manage access

6.9 Allergies

6.9.01 Medication allergies

6.9.02 Food allergies

6.9.03 Contact allergies

6.10 Dietary requirements

6.10.01 Daily food intake and deficiencies

6.10.02 Meat, vegetarian, vegan

6.10.03 Religious dietary requirements

6.10.04 Medical dietary requirements

6.11 Vaccinations

6.11.01 Vaccinations given in the past

6.11.02 Vaccinations due

6.12 Systematic enquiries – full symptom assessments

6.12.01 General & systemic symptoms

6.12.02 Respiratory system symptoms – from airways and lungs

6.12.03 Cardiovascular system symptoms – Heart and blood vessels

6.12.04 Alimentary, gastro-intestinal system symptoms – Stomach and bowel

6.12.05 Nervous system symptoms – central & peripheral

6.12.06 Locomotor System (bones and joints)

6.12.07 Genito-urinary Symptoms

6.12.08 Dermatological Symptoms

6.12.09 Dental, ear, nose and throat symptoms

6.12.10 Gynaecological symptoms

6.13 Examinations & observations

6.13.01 Positive findings

6.13.02 Negative findings

6.13.03 Observations

6.13.04 Cardiovascular examination – simple & complex

6.13.05 Respiratory examination – simple & complex

6.13.06 Alimentary examination – simple & complex

6.13.07 Neurology - Central nervous system

6.13.08 Neurology - Cranial nerves – I – XII

6.13.09 Neurology - Peripheral nervous system

6.13.10 Ear, nose & throat examination

6.13.11 Oral cavity examination – mucosae & dentition

6.13.12 Ophthalmology including optometry, prescription, dispensing

6.13.13 Skin examination – lesions, rashes, wounds & ulcers, infections

6.13.14 Rheumatology examination – joints, tendons, muscles

6.13.15 Gynaecology & obstetric examination

6.13.16 Urological examination

6.13.17 Dermatology examination



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6.14 Procedures & past operations

- 6.14.01 Past procedures
- 6.14.02 Future and planned procedures
- 6.14.03 Operation log & operation notes

6.15 Tests & investigations

- 6.15.01 Past procedures
- 6.15.02 Future and planned procedures
- 6.15.03 Operation log & operation notes

6.16 Social history – including care needs

- 6.16.01 Full social assessment
- 6.16.02 Religion ethnic & language
- 6.16.03 Household – carers who live and those cared for
- 6.16.04 Sexual history
- 6.16.05 Alcohol consumption
- 6.16.06 Tobacco intake
- 6.16.07 Drugs & illicit drug use
- 6.16.08 Mental state
- 6.16.09 Cooking & eating – ability to cook and feed
- 6.16.10 Self medication – ability to remember doses and to take
- 6.16.11 Mobility needs
- 6.16.12 Sleeping – special beds etc, pressure relief
- 6.16.13 Transport
- 6.16.14 Self caring needs – dressing, washing, toilet
- 6.16.15 Communication – sight, hearing & speech
- 6.16.16 Language – spoken languages
- 6.16.17 Occupation (Job risks to health) , exercise & travel

6.17 Family History

- 6.17.01 Adding children
- 6.17.02 Consent to view (child to adult & taking control of Medrecord Online)
- 6.17.03 Adding other family members

6.18 Child Health

- 6.18.01 Maternal health
- 6.18.02 Antenatal care
- 6.18.03 Labour and delivery
- 6.18.04 Post natal checks
- 6.18.05 Child health – development, illnesses, vaccinations

6.19 Care plans, referral appointment & admission

- 6.19.01 Plan new admission
- 6.19.02 Add past admission
- 6.19.03 Add care plan
- 6.19.04 View referrals

6.20 Notes and summary

- 6.20.01 Recording a voice message
- 6.20.02 Voice to text - typing a recorded message



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Conclusion

During the consultation all history taken and diagnoses made and every element of patient care or recorded clearly with a pdf printout automatically generated for a paper record, however Meddrecord means that everything is available in the cloud..24/7, wherever you travel worldwide..



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