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# BOOKLET NOVEMBER 2024



SmartCare **PRO**

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# INTRODUCTION

SmartCare Professional is a Zambian EHR enhanced from its predecessors SmartCare Legacy and SmartCare Plus. It is web-based with a centralized server and can be accessed through a URL, username and password. SmartCare Pro is a clinical workflow-centric EHR designed to help healthcare professionals do their work as opposed to being a data entry tool. Once a live version of SmartCare Pro has been setup at a facility, roles are assigned, and users start using the system



**1. Duties of an Administrator:** Once the facility In-Charge or the hospital administrator have been assigned, their duties would be as follows:

a. User Management

- i. Approving Login Requests by the HCWs.
- ii. Recovery Requests for those who forget their passwords.

The screenshot shows the 'User Management' interface. On the left, there is a sidebar with 'User Management' selected, and sub-options for 'Department' and 'Service Point'. The main area has a title 'User Management' and three tabs: 'Login Request (1)', 'Recovery Requests (0)', and 'Active Users (3)'. Below the tabs is a search bar labeled 'Search for name or cellphone'. A table displays user information with columns: Full Name, Username, Designation, Facility, Cellphone, and Contact Address. The first row shows 'Mit Bithy' with a cellphone number '+260 172394347' and address 'Bandhara, Dhaka'. There are 'Accept' and 'Reject' buttons for each user. At the bottom right, there is a 'Show' dropdown set to '10' and pagination controls.

Full Name	Username	Designation	Facility	Cellphone	Contact Address
Mit Bithy	Bithy	None	Bouleni Mini Hospital	+260 172394347	Bandhara, Dhaka

b. Departments Management

- i. Defining facility departments
- ii. Firms
- iii. Wards
- iv. Beds

c. Service Point Management

- i. Creating service queues

The screenshot shows the 'Departments' interface. On the left, the sidebar has 'Department' selected. The main area has a title 'Departments' and a search bar labeled 'Search' with the placeholder 'Enter Search'. There is a '+ Add Departments' button. A table lists departments with columns: '#', 'Department', and buttons for 'Edit' and 'Firms'. The table contains seven rows of departments. At the bottom right, there is a 'Show' dropdown set to '10' and pagination controls.

#	Department
1	OPD
2	cholera treatment centre
3	physiotherapy
4	MCH
5	PAEDIATRIC WARD
6	MALE WARD
7	FEMALE WARD

## 2. Duties of a Registry Clerk

- a. Searching and Registering
- b. Assigning to next service queue

The screenshot shows a user interface for a patient search and registration system. At the top, it says "Welcome Delight Kumwenda" on the left and "Tuesday, November 19, 2024" on the right. The main heading is "Search or Add New Patient". Below this, there are five search criteria buttons: "Biometrics" (highlighted in blue), "NRC", "NUPN", "Cellphone", and "Full Name". A prompt reads "Please select the finger and click on the icon to scan the fingerprint". Below the prompt are four buttons for finger selection: "Left Index", "Left Thumb", "Right Thumb", and "Right Index". At the bottom center, there is a large grey fingerprint scanner icon.

## 3. Duties of a Triage Nurse

- a. Reviewing a patient's file
- b. Entering vitals and anthropometry

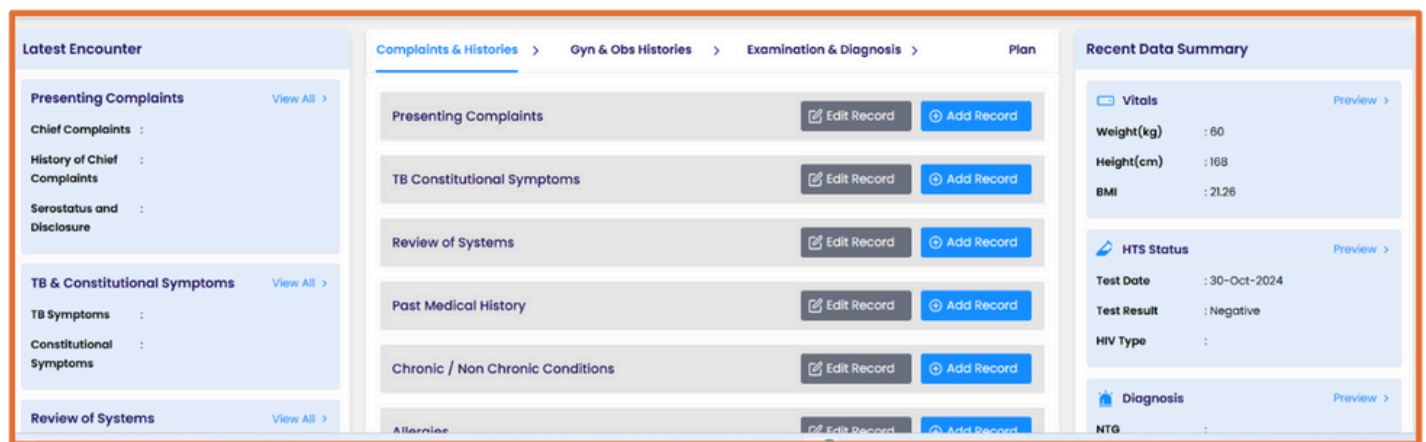
The screenshot shows a "Select Service Point for the Patient" interface. It features a grid of 20 service point buttons, each with a dropdown arrow. The buttons are: D-BLOCK LABORATORY, D-BLOCK SONOGRAPHY, B12 LABOUR WARD, B11 ANENATAL/POSTNATAL, B01 ANTENATAL/POSTNATAL, B13 HIGH COST ANTENATAL/POSTNATAL, TRIAGE B01 OSTETRIC EMERGENCY, B03 ANTENATAL/POSTNATAL, B12 EMERGENCY THEATRE, C-BLOCK THEATRE, C03 GYNEA EMERGENCY, C01 GYNAE WARD (highlighted in blue), C02 GYNAE WARD, C-BLOCK PHARMACY, B13 SATELLITE PHARMACY, D-BLOCK SATELLITE PHARMACY, OBSTETRIC ICU, C11 KMC, and C22 NHIMA ANTENATAL/POSTNATAL. Below the grid is a "Select Urgency" section with three buttons: "Standard", "Urgent" (highlighted in orange), and "Emergency". Underneath is a "Visit Purpose" text area containing the text "Vaginal bleeding". At the bottom right, there are "Cancel" and "Assign" buttons.

- c. Assessing the patient and determining the urgency of their treatment needs.
- d. Assigning to appropriate service queue.

# SERVICES PROVIDED BY SMARTCARE PRO

## 01. MEDICAL ENCOUNTER (OPD)

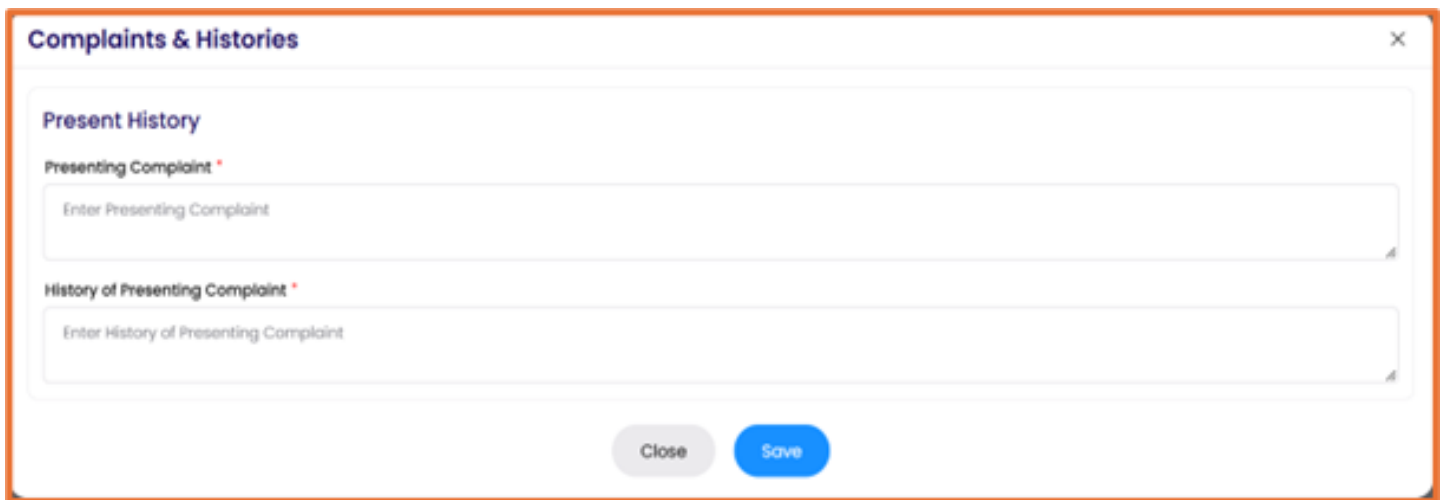
- First line of contact between the patient and the healthcare providers within the facility.
- The Reason for Encounter (RFE) will record patient notes using the popular approach, SOAP (Subjective, Objective, Assessment and Plan).
- Complaints and Histories including Obs and Gynae for female patients, and paediatric history for paediatric patients.
- Examinations and Diagnosis.
- Treatment Plan.



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**\*NEW IN SMARTCARE PRO\***

a. The clinician is provided with text boxes where they freely type their own notes enabling use of precise medical terminology, expressions and unique descriptions that predefined options may not cover.



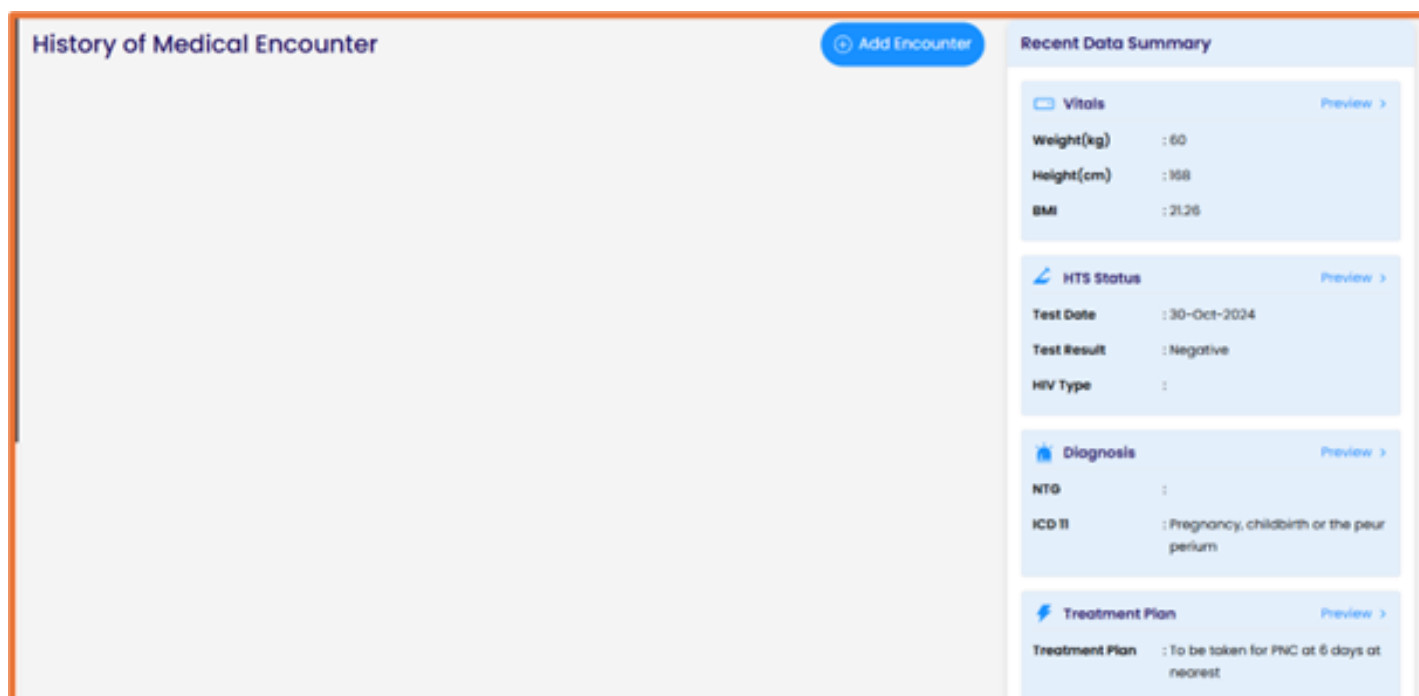
The screenshot shows a web form titled "Complaints & Histories". It features a "Present History" section with two text input fields. The first field is for the "Presenting Complaint" and the second is for the "History of Presenting Complaint". Both fields have placeholder text. At the bottom of the form, there are "Close" and "Save" buttons.

b. Diagnosis can be made in 2 ways:

1. Using NTG (National Treatment Guidelines)
2. Using ICD 11

c. Advantage of diagnosing using NTG is the availability of a suggested NTG which you may copy and use. This will result in standardization of care and improved patient outcomes because the guidelines are based on Evidence Based Practice.

d. Diagnosis, Treatment Plan, Medication Plan and Investigations will populate on the Dashboard, providing a bird's eye view of the patient's record.



## 02. VITALS AND ANTHROPOMETRY

Temperature, Pulse, Respiration, Blood Pressure, Weight, height, MUAC, Abdominal circumference, Head circumference, are provided with Clinical Decision Support showing when they are abnormal (above or below normal).

### \*NEW IN SMARTCARE PRO\*

- Once entered in one service point, will be seen in another service point.
- The provision of date and time of taking them will enable monitoring over time
- Graphs for TPR, BP can be plotted for admitted patients while Weight, Height and BMI can also be monitored in Nutrition and TB patients.
- Weight, Height and BMI will appear on the dashboard.

## 03. HTS – ENTRY POINT TO ART SERVICES

- Divided into 2 parts

-Part A: Pre-test assessment where the client type, visit type, service point, source of client, reason for testing, last test date and results, partner last test date and results, counselling and consent are entered.

-Part B: Test and Results where the test number, determine result, bioline result, HIV type, DNA PCR sample collection and date details are entered. Also entered are whether client received the results and whether they consent to SMS alerts.

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**\*NEW IN SMARTCARE PRO\***

- a. Once HTS is entered, it will be seen across all service points- no need of re-entering it.
- b. Only clients with a positive HTS will access ART services
- c. Only clients with negative HTS will access PEP and PrEP Services
- d. Test Date, Test Result and HIV Type will populate on the Dashboard.

## **04. PEP (POST EXPOSURE PROPHYLAXIS)**

- Management of short-term course of ARVs to reduce risk of HIV infection.
- Only applicable if HTS is negative.
- All components like for RFE in OPD will apply – complaints and histories, examination and diagnosis, treatment plan.
- ARVs are prescribed and dispensed for 28 days.
- Follow up is done with HTS results after 28 days. If still Negative – Discharge.

## **05. PREP (PRE-EXPOSURE PROPHYLAXIS)**

- ARVs taken to reduce risk of contracting HIV infection.
- Only applicable if HTS is negative.
- All components like for RFE in OPD will apply – complaints and histories, examination and diagnosis, treatment plan.
- ARVs are prescribed and dispensed for 30 days.
- Follow up with HTS results after 30 days – If positive initiate long-term ART.

## **06. TB SERVICES**

Services offered to a patient referred for TB Screening and management.

It has 4 Forms:

1. TB Screening – done in the same way as in RFE – Complaints and histories, examination and diagnosis and Treatment Plan.
2. TB Initial – Form used to initiate patient on ATT
  - It has the same components like on RFE (OPD) – Complaints and Histories, Examination and Diagnosis and Treatment Plan.
  - On Complaints and Histories is TB Service where the Patient Case ID Number, the patient category, and the patient type are entered.
  - Included On treatment plan are DOTs plan, TB Contact and treatment plan itself.
  - If you diagnose using NTG, a TB treatment plan is suggested which could be copied and used.
  - Prescribe and Diagnose ATT



### 3. TB Follow Up Form – Used for reviews.

- All components like for RFE in OPD will apply – complaints and histories, examination and diagnosis, treatment plan
- Included on the treatment plan is the TB Outcome/status entered at the end of the TB treatment.

### 4. TB Patient Locator – Used for Contact tracing

- Patient's entry, source, background, next of kin and address are captured.
- Updated regularly.

## 07. PAIN SCALING

A numeric pain rating scale which is a tool used to track how well a treatment plan is working to reduce pain measured on a scale of 1 to 10. 1 means no pain, 2 to 4, mild pain, 5 to 7, moderate pain, 8 to 10 means the worst possible severe pain.

**Pain Scaling Tool**

- 1-No pain
- 2-Pain is mild-barely noticeable. Most of the time you don't think about it
- 3-Minor pain, its annoying. You may have sharp pain now and then.
- 4-Noticeable pain. It may distract you, but you can get used to it
- 5-Moderate pain. If you are involved in an activity, you are able to ignore it for a while, but it is still distracting.
- 6-Moderately strong pain. You avoid some of your normal daily activities. You have trouble concentrating.
- 7-Strong pain. It keeps you from doing normal activities.
- 8-Very strong pain. It's hard to do anything at all.
- 9-Pain that is very hard to tolerate. You can't carry on a conversation.
- 10-Worst possible pain

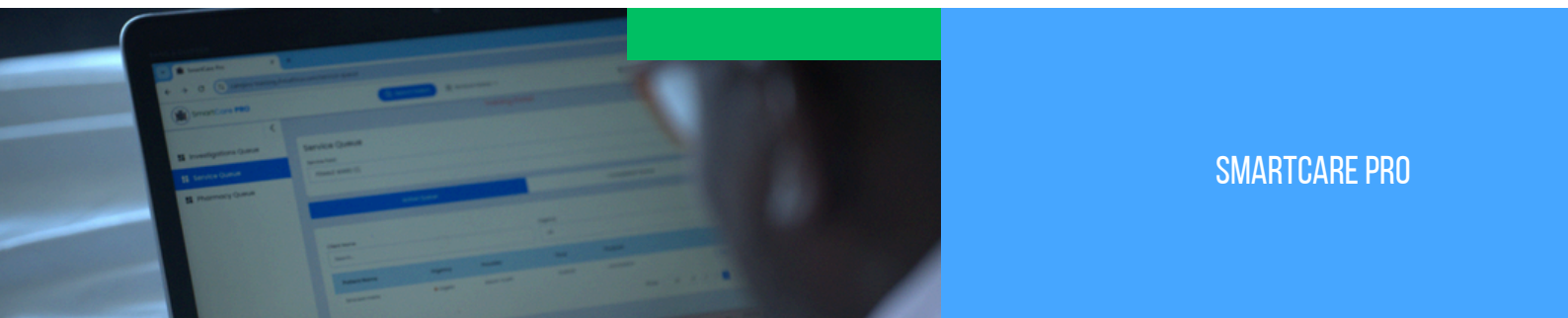
Close Save

## 08. VMMC SERVICE

Module used to manage Voluntary Male Medical Circumcision. It has 2 forms:

a. VMMC Initial – Form used to capture client information prior to circumcision. It includes client information, complaints and histories, examination and diagnosis and a treatment plan which includes surgery and pain scaling. Surgery includes booking, pre-operation, intra-operation, post-operation and the anaesthetic plan.

b. VMMC Review: Used for VMMC follow ups. It has 2 sections; Review Visit History which captures admin data and examination, history and complications if any and Pain Scaling.



## 09. INVESTIGATION

Module used for ordering investigations and entering of results. It has 2 sections: Single Test – Lab, pathology and radiology single tests and Composite tests – group lab tests such as Full Blood Count (FBC), Liver Function Test, Kidney Function Tests, Urinalysis etc

Interoperability – SmartCare Pro Investigations module is integrated with DISA such that investigations ordered in SmartCare Pro are able to be seen in DISA and results entered in DISA are able to be seen in SmartCare Pro.

## 10. SURGERY

Module used to manage patients referred for operations. It includes Booking, pre-operation, intra-operation, post-operation and anaesthetic plan.

## 12. VACCINATIONS

Module used to manage COVID 19 Vaccinations. A pre-assessment is done before vaccination. During vaccination, the type, date and batch number are entered. If the client suffered an adverse event post vaccination, it is also entered.

## 11. REFERRALS

Module used to refer a patient either internally or externally. If externally, the referral province, the district, the facility and the service referred for are entered.

## 13. BIRTH RECORDS

Module used to create a birth record. The components are:

- a.Particulars
- b.Reference Notes
- c.Informant Details

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## 14. DEATH RECORD

Module used to create a death record. The death record will include the immediate cause of death, the antecedent cause of death, the underlying cause of death and any other cause of death. The certificate handler will also have their details captured. The death record once created will produce the Notice of Death (NOD) and the Medical Certificate of the Cause of Death (MCCD).

## 15. PHARMACY

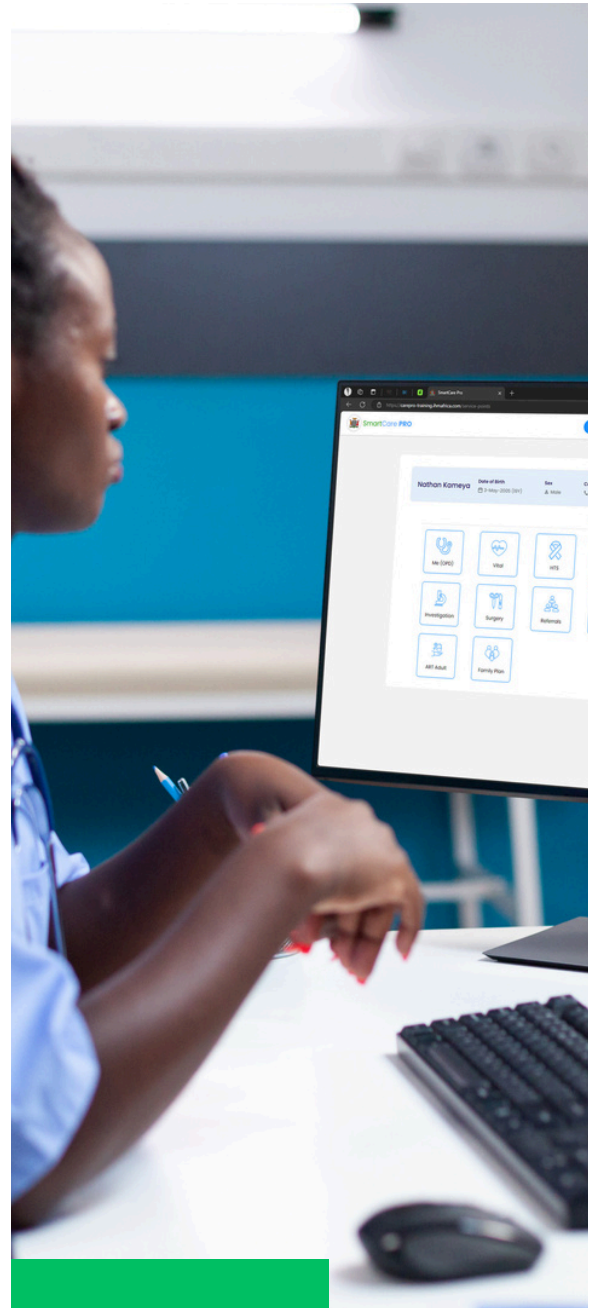
Module used for prescription and dispensation of drugs. Drugs are put into 3 categories:

- a. General Drugs – Essential medicines
- b. ARVs and ATT – ARVs and Anti-TB Drugs
- c. Custom Drugs – Drugs not in the system but are in the pharmacy can be prescribed.

The drugs can be searched for through different methods:

- a. Text Search
- b. Search by Physical Systems
- c. Search by Utility
- d. Search by Class
- e. Search by Indication

Once a prescription has been made, the patient is assigned to the dispensary for dispensation, or the drug is dispensed in the clinic using the dispensations module.





## 16. ADULT ART

Module used to manage adult clients on ARVs. Treatment eligibility requires a positive HTS status of the client. If client has no or negative HTS, the system would prompt the user to go to HTS. HTS is administered in 2 ways:

- a. Professional administered Test
- b. Self-test

Under Professional administered test, there is pre-test assessment and test and results. Under self-test, there is an indication as to whether the test was directly assisted or unassisted and whether the client is for key populations.

Adult ART in SmartCare Pro has the following forms:

- a. Adult Patient Locator – details are entered in the following sections:
  - i. Entry and source
  - ii. Households
  - iii. Next of Kin
  - iv. Disclosure, Index testing and partner notification services (IT&PNS)

The ART Number is on Disclosure, IT&PNS page. When the answer to the question, “Does the client have an ART number”, is Yes, the ART number is entered in the next box. If the answer is No, the system allocates an ART number to the client.

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- b Adult Patient Status – Form used if the client has a change in status e.g. trans-out, stopped ART, being inactivated, being reactivated, dead etc.
  - c .Adult IHPAI – (Initial History, Physical and Initiation) form used to initiate client on ART. Details entered include complaints and histories, gynae and Obs for female clients, examinations and diagnosis and treatment plan.
  - d. Adult Follow Up – Form used for clinical follow ups. Layout of the form is as for IHPAI form with complaints and histories, gynae and Obs for female clients, examinations and diagnosis and treatment plan.
  - e. Adult Stable on Care – Form used to manage ART clients that are stable on care and are on Differentiated Service Delivery (DSD). The form has Purpose of Visit to indicate whether it is a buddy pick up or patient is present, complaints and histories, gynae and Obs histories, examinations and diagnosis and treatment plan.

## **17. PAEDIATRIC ART**

Module used to manage paediatric clients on ART. Eligibility to ART requires a Positive HTS status. If the child has no HTS status or it is Negative, the system redirects the user to HTS Module. The HTS interaction is performed in the same way as for an adult client where you enter the visit type, the service point, last test results, consent, Determine Result, Bioline Result and HIV Type. Paediatric ART like Adult ART has similar forms:

- a. Patient Locator used for contact tracing with the following sections:
  - i. Entry & Source
  - ii. Households
  - iii. Next of Kin
  - iv. Disclosure, IT&PNS.
  
- b. Patient Status – used when the client has a change in patient status:
  - i. Trans-out
  - ii. Being made inactive
  - iii. Stopped ART
  - iv. Being Reactivated
  - v. Has died

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c. Paediatric Initial History, Physical and Initiation (IHPAI) – Form used to initiate client on ART. It is entered in the same way as for adult ART.

- i. Complaints & Histories
- ii. Paediatric Histories
- iii. Examination & Diagnosis
- iv. Plan

Drugs are prescribed and Dispensed in the normal way and investigations are ordered.

## **18. GBV**

Module used to manage clients who have suffered Gender Based Violence (GBV). Details entered include incident details and the type of GBV:

- a. Sexual Violence
- b. Physical Violence
- c. Emotional Violence
- d. Psychological

The plan is whether the client is linked to care and treatment or not.



## 19. ANTENATAL

Module used to manage expecting mothers from the start of the pregnancy until the day the baby is delivered. The module has the following forms:

- a. ANC Initial Visit – Includes ANC-related complaints and Histories, Gynae and Obs Histories, examination and diagnosis and treatment plan.
- b. ANC Follow Up – Form used for ANC Reviews. Layout of the form is the same as ANC Initial including ANC-related complaints and histories, Gynae and Obs Histories, Examinations and Diagnosis and Treatment Plans.
- c. Initial Already on ART – Form used for clinical follow ups for expecting mother on ART while at MCH. It has the following sections:
  - i. Patient Locator
  - ii. Patient Status
  - iii. Complaints and Histories
  - iv. Gynae and Obs Histories
  - v. Examination and Diagnosis
  - vi. Treatment Plans.
- d. ANC 1ST Time on ART – Form used to manage expecting mothers first time on ART. Form has the same sections as for Initial already on ART as follows:
  - i. Patient Locator
  - ii. Patient Status
  - iii. Complaints and Histories
  - iv. Gynae and Obs Histories
  - v. Examination and Diagnosis
  - vi. Treatment Plans.

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e. ANC Follow Up PMTCT – Form used for following up exposed expecting mothers for PMTCT. The layout of the form is the same:

- i. Patient Locator
- ii. Patient Status
- iii. Complaints and Histories
- iv. Gynae and Obs Histories
- v. Examination and Diagnosis
- vi. Treatment Plans.

## **20. LABOUR AND DELIVERY**

Module used to admit an expecting mother in labour ward and provide delivery services. It has the following Sub Modules:

a. History of Labour and Delivery with the following sections:

- i. Complaints and Histories
- ii. Gyn and Obs Histories
- iii. Examination and Diagnosis
- iv. Plan

Complaints and Histories will include:

- i. ANC Referrals
- ii .ANC Service
- iii. Presenting Complaints
- iv. ANC Screening
- v. TB Constitutional Symptoms
- vi. Review of Systems
- vii. Past Medical History
- viii. Drug Adherence
- ix. Chronic/non-chronic conditions
- x. Allergies
- xi. History of Blood Transfusion
- xii. Family and Social History



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Gyn & Obs Histories will include:

- i. Booking
- ii. Gyn & Obs
- iii. Mother Details
- iv. Child Details
- v. Past Antenatal Visits

Examination and Diagnosis will include:

- i. General Assessment
- ii. System Examination
- iii. Glasgow Coma Scale
- iv. Obstetric Examination
- v. Vaginal Examination
- vi. Diagnosis

Plan will include:

- i. Surgery
- ii. Counselling Service
- iii. Screening and Prevention
- iv. Treatment Plan

b. Labour and Delivery PMTCT – with the following sections:

- i. Patient Locator
- ii. Patient Status
- iii. Complaints and Histories
- iv. Gyn and Obs Histories
- v. Examination and Diagnosis
- vi. Plan

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Patient Locator will include:

- i. Entry and Source
- ii. Households
- iii. Next of Kin
- iv. Disclosure, IT&PNS

Patent Status will include

- i. Patent is being sent to another clinic
- ii. Patient is being made inactive
- iii. Patient has stopped ART
- iv. Patient is being reactivated
- v. Patient has died

Complaints and Histories will include:

- i. ANC Referrals
- ii. ANC Service
- iii. Presenting Complaints
- iv. ANC Screening
- v. TB Constitutional Symptoms
- vi. Review of Systems
- vii. Past Medical History
- viii. Drug Adherence
- ix. Chronic/non-chronic conditions
- x. Allergies
- xi. History of Blood Transfusion
- xii. Family and Social History

Gyn & Obs Histories will include:

- i. Booking
  - ii. Gyn & Obs
  - iii. Mother Details
  - iv. Child Details
  - v. Past Antenatal Visits
-

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Examination and Diagnosis will include:

- i. General Assessment
- ii. System Examination
- iii. Glasgow Coma Scale
- iv. Obstetric Examination
- v. Vaginal Examination
- vi. Diagnosis

Plan will include:

- i. Surgery
- ii. Counselling Service
- iii. Screening and Prevention
- iv. Treatment Plan

c. Partograph – This is a tool for monitoring maternal and foetal wellbeing during the active phase of labour and a decision-making aid when abnormalities are detected. To initiate the partograph, the following must be entered:

- i. Date of Admission
- ii. Time of Admission
- iii. Gravida
- iv. Parity
- v. LMP
- vi. EDD
- vii. Initiation Date
- viii. Initiation Time

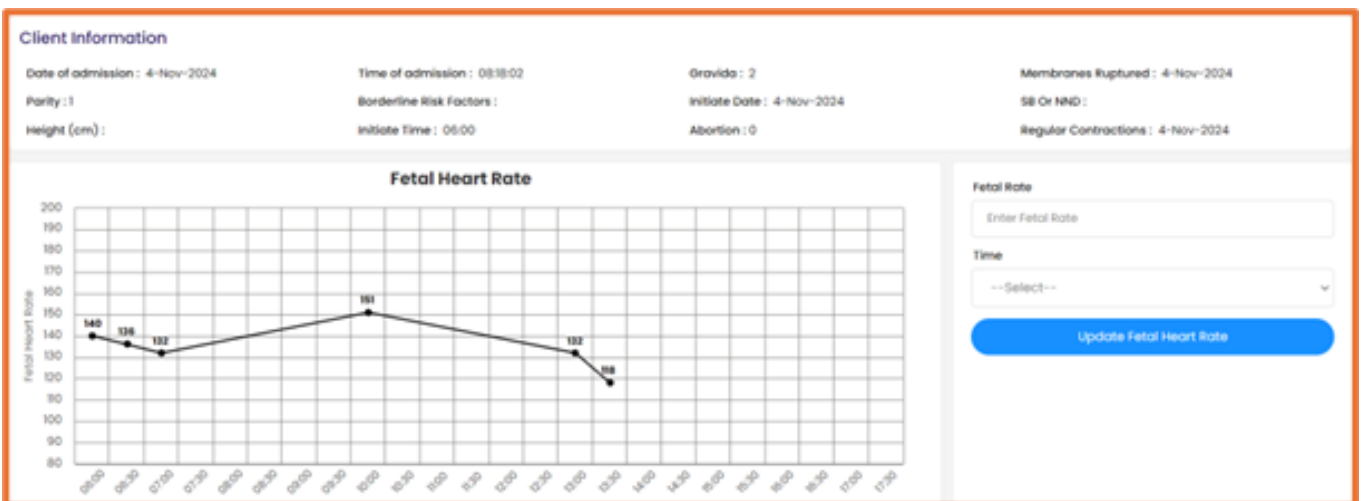
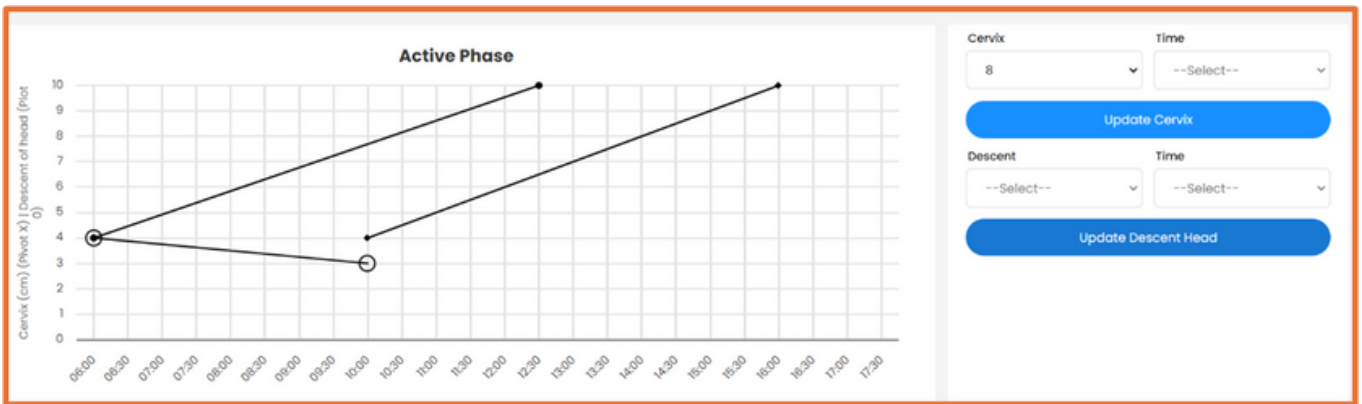
Parameters that need to be monitored and updated are as follows:

- i. Fetal Heart Rate
  - ii. Liquor and Moulding
  - iii. Cervix
  - iv. Descent
  - v. Contractions
  - vi. Oxytocin
  - vii. Drug given and IV Fluids
  - viii. Pulse and Blood Pressure
-

Once the delivery has been successful, the following information is captured:

- i. Gender
- ii. Weight
- iii. Type of Delivery:
  - (a) Vaginal Delivery
  - (b) Caesarian Section
  - (c) Vacuum Extraction
- iv. Birth Date
- v. Birth Time

The Partograph is then completed and can even be printed



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d. Summary – This is the labour and Delivery Summary. It will include:

- i. Delivery Summary: Mother
- ii. Newborn Details

Delivery Information will include:

- i. Third Stage Delivery
- ii. Treatment for PPH
- iii. Medical Treatment
- iv. Condition of Uterus
- v. Placenta Removal
- vi. Perineum Intact
- vii. Identified Perineum Intact

e. Delivery Discharge – This is the Delivery Discharge for both the mother and Baby after Delivery Services. It includes:

- i. Delivery Discharge Baby
- ii. Delivery Discharge Mother

Delivery Discharge Baby includes:

- i. Complaints and Histories
- ii. Paediatric and Histories
- iii. Examination and Diagnosis
- iv. Plan

Complaints and Histories includes:

- i. Baby (Discharge Metrix)

Paediatric and Histories includes:

- i. Immunization History
- ii. Feeding Method

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Examination and Diagnosis includes:

- i. General Assessment

Plan includes:

- i. Treatment Plan

Delivery Discharge Mother includes:

- i. Complaints and Histories
- ii. Examination and Diagnosis
- iii. Plan

Complaints and Histories includes:

- i. Presenting Complaints
- ii. Key Population Demographics
- iii. HIV and EMTCT

Examination and Diagnosis includes

- i. General Assessment

Plan includes:

- i. Treatment Plan

## 21. POSTNATAL CARE (PNC)

Module used to manage the health and wellbeing of both the mother and the newborn. It has 2 components:

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- a. Postnatal – Mother
  - b. Postnatal PMTCT – Mother

Postnatal – Mother includes:

- i. Visit Details
- ii. Complaints and Histories
- iii. Examination and Diagnosis
- iv. Plan

Postnatal PMTCT – Mother Includes:

- i. Visit Details
- ii. Complaints and Histories
- iii. Gyn and Obs
- iv. Examination and Diagnosis
- v. Plan



Postnatal Care for the newborn is performed by searching and retrieving the baby's file. Postnatal for the baby has 2 components:

- a. Postnatal – Baby
- b. Postnatal PMTCT – Baby

Postnatal – Baby includes:

- i. Visit Details
- ii. Examination and Diagnosis
- iii. Plan

Postnatal PMTCT – Baby includes:

- i. Visit Details
- ii. Examination and Diagnosis
- iii. Plan

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## 22. FAMILY PLANNING

Module used for timing of pregnancies and birth spacing. It includes the following components:

- a. Family Planning Register
- b. Complaints and Histories
- c. Gyn and Obs
- d. Examination and Diagnosis
- e. Plan

After this assessment a prescription is made, and a dispensation is made in the clinic or through the Dispensation module.





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## 23. UNDER FIVE

This is a module used to manage children younger than 5 years. It has 2 components:

- a. Under 5
- b. Paediatric Charts

Under 5 includes the following:

- i. Complaints and Histories
- ii. Paediatric and Histories
- iii. Examination and Diagnosis
- iv. Plan

Birth History, Immunization History, Feeding History, Developmental History and all that is going to be done on the child will fall under Paediatric and Histories. Anthropometric measurements like weight, height, circumference will be done through vitals.

Paediatric Charts includes the following:

- i. Weight for Age
- ii. Length/Height for Age
- iii. Head Circumference for Age

These must be captured in the Vitals Module whenever the child is brought for Under 5.

## 24. CACX

Module used to screen and manage women diagnosed with cervical cancer. It has the following components:

- a. Pre-screening
- b. Screening Modality
- c. Treatment

Pre-screening includes:

- i. Type of Visit
- ii. Obstetrics and Gynaecology

Screening Modality includes:

- i. Pap Smear (screening)
- ii. HPV Genotype
- iii. VIA
- iv. Enhanced Digital Imaging

Treatment includes:

- i. Thermo Ablation
- ii. LEEP
- iii. Cervical Plan

The screenshot displays the 'Cervical Cancer' module interface. At the top, patient information is shown: 004 (20y), Sex: Female, Cellphone: +260 777654321, NUPN: 5006-0334C-00032-5, NRC: 765894/24/1, and ART Number: 5050-334-00004-4. Below this, there are three tabs: 'Pre-Screening', 'Screening Modality', and 'Treatment'. The 'Treatment' tab is active, showing three options: 'Thermo Ablation', 'LEEP', and 'Cervical Plan'. Each option has an 'Edit Record' button and an 'Add Record' button. To the right, there is a 'Recent Data Summary' section with two sub-sections: 'Vitals' (Weight: 60kg, Height: 168cm, BMI: 21.26) and 'HTS Status' (Test Date: 28-Oct-2024, Test Result: Positive (Patient's ART record indicates HIV positivity), HIV Type: HIV-1 & HIV-2). At the bottom, there are 'Back' and 'Next' buttons.

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## 25. MEDICAL ENCOUNTER (IPD)

Module used to attend to a patient who has been admitted to the ward. Admission could either be through OPD or directly to the ward without passing through OPD. If patient is being admitted from OPD, the Green Action Button is clicked, and Admit Patient is selected. Admit Patient will have the following information captured:

- a. Admission Date
- b. Department
- c. Firm/Unit
- d. Ward
- e. Bed Number
- f. Additional Comments

Department, Firm/Unit, Ward and Bed Numbers should have been created in advance by the facility administrator. Once this information is captured, the patient is then assigned to IPD.

Medical Encounter (IPD) will include the following sections:

- a. Presenting Complaints and Examination
- b. Diagnosis
- c. Treatment Plan

Investigations and Prescriptions are done from the Green Action Button. At the end of the stay in hospital, the Discharge/Transfer Patient Date and any other notes are entered.

## 26. NURSING CARE

This is the formalized process used by Nurses to provide individualized and holistic care to patients admitted in the ward. It includes the following sections:

- a. Nursing Plan
- b. TPR and other charts/vitals
- c. TPR and other charts/Glasgow Coma Scale
- d. Turning Charts
- e. Fluids and Weight
- f. Blood Transfusion Monitoring/Pre-Transfusion Vitals
- g. Blood Transfusion Monitoring/Intra-Transfusion Vitals

Nursing Plan will include:

- a. Planning Date
- b. Planning Time
- c. Problem Need
- d. Goal Objective
- e. Nursing Diagnosis
- f. Nursing Intervention/Rationale
- g. Evaluation Post Intervention

The screenshot displays a user interface for nursing care. On the left, under 'Latest Encounter', there are three summary cards: 'Nursing Plan' (Planning Date: 18-Nov-2024, Planning Time: 10:02:47, Problem: Dehydration), 'TPR and Other Charts / Vitals' (Time: 08:07, Weight: 60 kg, Height: 168 cm), and 'TPR and Other Charts / Glasgow Coma Scale'. On the right, a vertical list of care sections is shown, each with an 'Edit Record' button and an 'Add Record' button. The sections are: Nursing Plan, TPR and Other Charts / Vitals, TPR and Other Charts / Glasgow Coma Scale, Turing Charts, Fluids and Weight, and Blood Transfusion Monitoring / Pre-Transfusion Vitals.

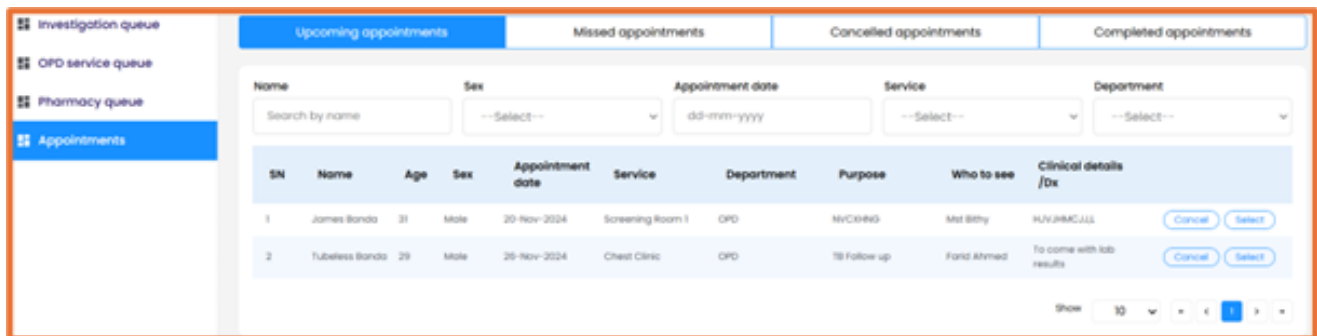
## 27. APPOINTMENTS

These are dates given to patients to come back for review or follow-up. They come out in form of lists of patients indicating the following:

- a. Appointment Date
- b. Service
- c. Department
- d. Purpose
- e. Who to See
- f. Clinical Details/Diagnosis

Listings would be generated for the following:

- a. Upcoming Appointments
- b. Missed Appointments
- c. Cancelled Appointments
- d. Completed Appointments



The screenshot displays a web application interface for managing appointments. On the left, there is a sidebar with navigation options: Investigation queue, OPD service queue, Pharmacy queue, and Appointments (highlighted in blue). The main content area has four tabs: Upcoming appointments (selected), Missed appointments, Cancelled appointments, and Completed appointments. Below the tabs, there are search filters for Name (with a 'Search by name' input), Sex (dropdown), Appointment date (calendar), Service (dropdown), and Department (dropdown). The main table lists appointments with columns: SN, Name, Age, Sex, Appointment date, Service, Department, Purpose, Who to see, and Clinical details /Dx. Two rows of data are visible. At the bottom right, there is a 'Show' dropdown set to 10 and a page indicator showing 1 of 1 pages.

SN	Name	Age	Sex	Appointment date	Service	Department	Purpose	Who to see	Clinical details /Dx	
1	James Banda	31	Male	20-Nov-2024	Screening Room 1	OPD	MVCHEG	Mal Bithy	HIV/RAC/LL	<a href="#">Cancel</a> <a href="#">Select</a>
2	Tubless Banda	29	Male	20-Nov-2024	Chest Clinic	OPD	TB Follow up	Fard Ahmed	To come with lab results	<a href="#">Cancel</a> <a href="#">Select</a>

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## **28. HISTORICAL VISIT**

This is where data is entered in e-Last Mode from paper to SmartCare Pro. The components include:

- a. The Previous Session Date
- b. The Service being captured

## **29. BINDING**

Refers to the process of linking or associating individuals for HIV testing based on their relationship to an index client. Binding is also used in linking a newly born baby to her mother. In the DFZ version of SmartCare Pro, Binding is also used to link or associate a dependent such as spouse or a child to a principal member of DFZ. It includes the following:

- a. Searching for the client
- b. Relationship
- c. Binding

## **30. COVID**

This is the module used to manage a patient suspected to have COVID-19. The components of the module are:

- a. Integrated Screening Form
- b. Symptom Screen
- c. Exposure Risk
- d. Case Report
- e. Clinical Assessment
- f. Co-Morbid Conditions

After completion of the assessments, investigations are ordered, Diagnosis is made and a treatment plan formulated.

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# THANK YOU

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