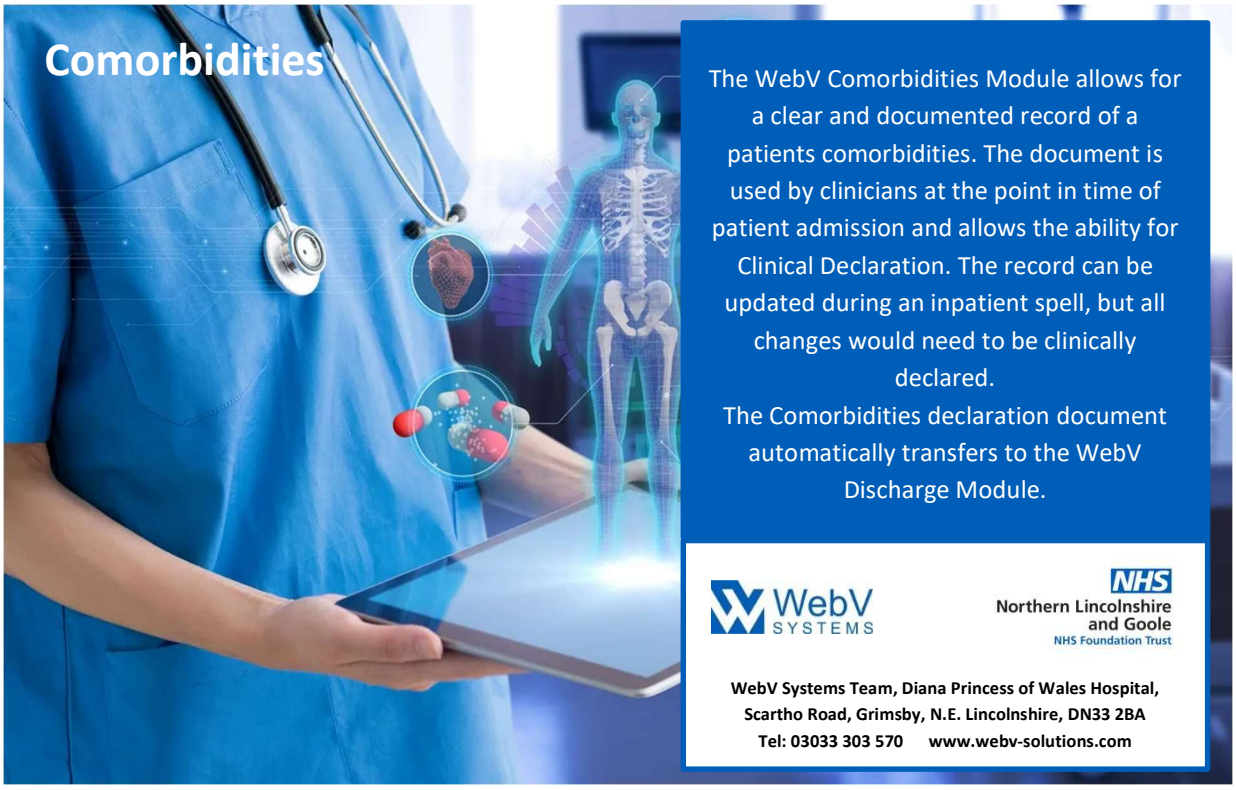

Module Origin

The Problem

As with many older processes, comorbidities has been a paper based system which includes documentation of patient comorbidities on admission. Patient notes are then reviewed following discharge by clinical coders to extrapolate the required comorbidities data for submission to the appropriate reporting body.

In order to improve the process the following problems would need to be addressed:

- Inaccuracy of data in relation to lack of documentation of patient comorbidities
- Inaccuracy of data in relation to visibility of patient comorbidities documented within the current Patient Health Record
- Data retrieval from multiple paper documents
- Time allocated to paper process
- Financial loss for the organisation

The WebV Solution:

To provide an electronic module which, provides the clinician with a selection of options, which facilitate the accurate recording of the patient's comorbidities.

Benefits Realisation:

- Comorbidities remain on the patient electronic record and are visible on subsequent admissions and provide clinicians with an accurate resume of their pre-existing conditions
- Documented comorbidities are automatically transposed into the patient's discharge summary providing valid data to GPs Reduction in time required for documentation of comorbidities by preventing unnecessary duplication of records
- Enhancement of patient safety and risk reduction in respect of high quality patient health data
- Financial savings in respect of time saved by single documentation process
- Appropriate remuneration for the organisation for types of patient treated
- Financial savings associated with process digitisation
- Provide assurance to external stakeholders
- SHMI index – linked to Comorbidities

Where the module can be used

Primarily at point of Admission

Comorbidities Module	• Ability to add comorbidities to the patient record by selecting from a list of chapters. • Prompt displayed to declare the patient's comorbidities before navigating away from the module if the comorbidities have not been signed. If the comorbidities have been signed, the prompt will not display. • Added comorbidities can be viewed in a table, including comorbidity name, chapter, ICD10 code, Summary Hospital Mortality Indicator (SHMI) status, recorded details (if any) and status of the comorbidity • Recorded comorbidities are automatically populated in to the patient's discharge summary • Functionality to mark a comorbidities as inactive with a recorded reason • The same comorbidity cannot be added to the patient's record twice • Message displayed to clearly advise when there are no comorbidities added to the patient's record. • Full search functionality at the chapter level