

MCATS

BIRTHING OUTCOMES SYSTEM

VERSION 6.3



SUPER USER ADMINISTRATION NOTES

Contents:

Section I	Introduction
Section II	Data flow diagram
Section III	Administration <ul style="list-style-type: none">a) System Control Filesb) System Reference Filesc) Record Maintenanced) Delete Duplicate Usere) Maintain Record Locksf) System Messages
Section IV	Reporting <ul style="list-style-type: none">a) System Reportsb) Adhoc Reports
Section IV	Reporting
Section V	Data Collection <ul style="list-style-type: none">a) Neonatal Results Processingb) VPDC Processingc) BDM Birth Notifications
Appendix	<ul style="list-style-type: none">a) User Access Levelsb) Super User Checklist

Section I Introduction

Welcome to Users of the Birthing Outcomes System (BOS) !

These notes are designed for administration *Super Users* of the MCATS **Birthing Outcomes System (BOS)** version 6 and are for distribution to attendees of the *BOS Super-User Education Session*.

The contents are couched in non-technical terms wherever possible, however some higher-level concepts and technical details are necessary given the intended participants.

The nature of the administrative role requires some understanding of the application from a user perspective, and the conceptual framework underlying the application.

The Super-User Education Session and these accompanying notes are not intended to be a *step by step* guide, but rather to provide the participant with a level of understanding about the system, that will maximise the benefits of a successful implementation.

BOSv6 is a dynamic *Clinical Information Management System* designed to capture obstetric, intrapartum, birthing and neonatal data relating a complete pregnancy episode.

The application is currently used in a variety of hospital maternity service agencies. It interfaces with various Patient Registration systems and records a comprehensive set of data to satisfy clinical documentation needs, statutory reporting requirements (including VPDC submissions), Clinical Indicator and Obstetric Audit.

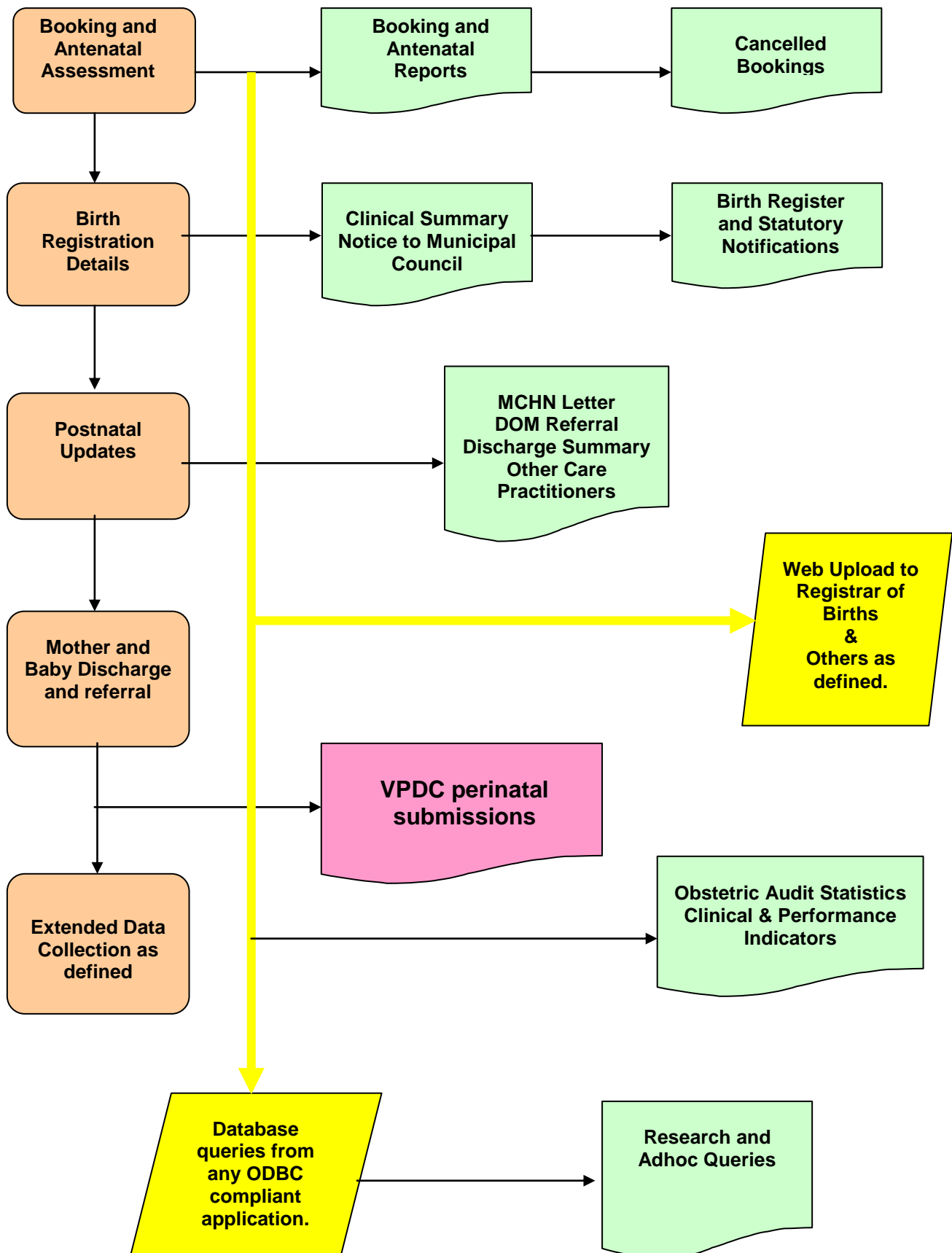
Computerized output from BOS replaces manual documentation and has been approved by all receiving agencies.

BOSv6 was created by the MCATS development team in conjunction with the BOS User Group. It embodies all existing concepts and functions from previous BOS versions and combines newer features to provide an enhanced, more user friendly system. BOSv6 has been developed using current Microsoft tools and uses standard Microsoft Office features.

BOSv6 includes the following functional areas:

- Booking, Antenatal and Risk Assessment
- Antenatal Events
- Birthing Process
- Birth Registration
- Baby Details
- Special Care Nursery
- Postnatal, Discharge and Follow-up
- Periodic and Per-Birth Reporting
- Clinical Indicator Reporting
- Statutory Reporting
- Adhoc Reporting

Section II Data Flow Diagram



Section III Administration

The Administration menu group contains the following options :

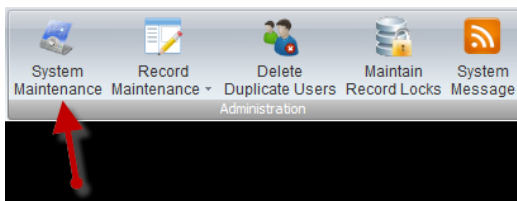


CONTENTS :

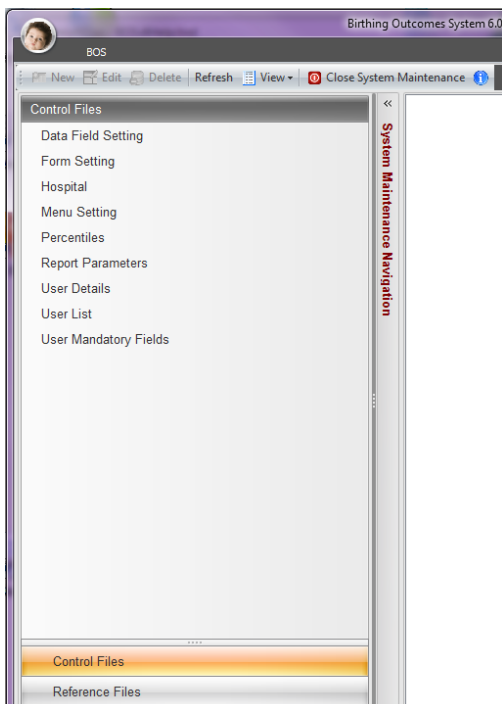
- [System Maintenance](#)
- [Record Maintenance](#)
- [Delete Duplicate Users](#)
- [Maintain Record Locks](#)
- [System Messages](#)

System Maintenance

The menu provides access to high level System Control items and the BOS Reference tables.



Click the **System Maintenance** icon to access the System Maintenance Menu :



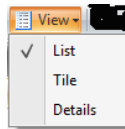
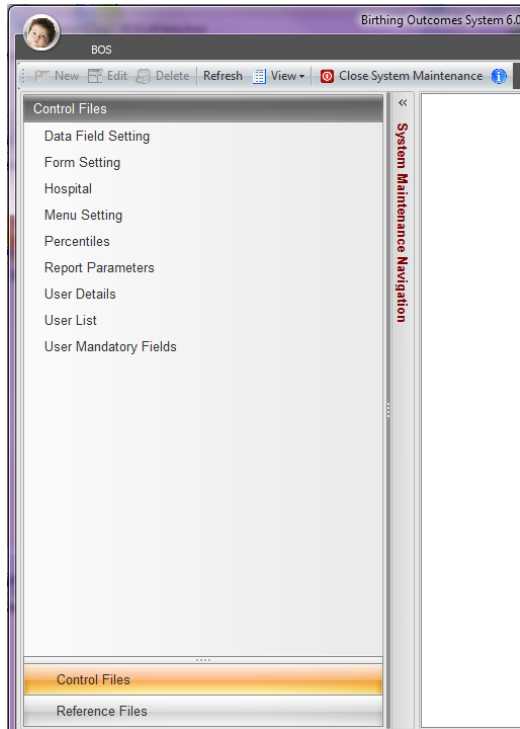
The default sub-menu displayed is the **Control Files** menu.

Click **Reference Files** in the Left hand Navigation pane to switch to the **Reference files** menu.

Click **Close System Maintenance** to close the System Maintenance menu.

System Control Files

The System Control Files menu provides access to high level controls and settings that govern the way BOS operates in your environment.



Click on any item in the left hand Navigation pane to display the contents in the right hand pane.

Click to change the view of the items listed in the Right Hand pane, to suit your personal requirement.

CONTENTS :

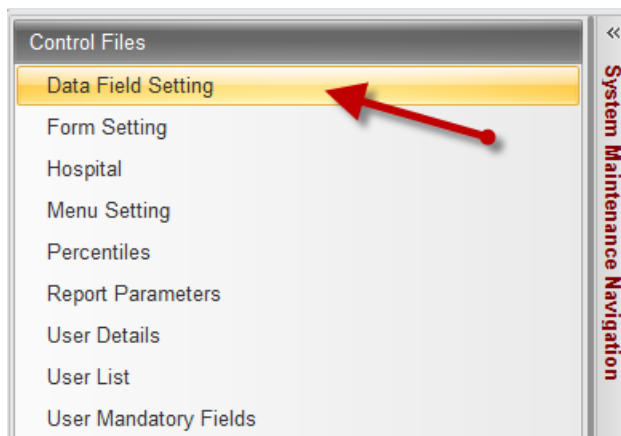
- [Data Field Setting](#)
- [Form Setting](#)
- [Hospital](#)
- [Menu Setting](#)
- [Report Parameters](#)
- [User Details](#)
- [User List](#)
- [User Mandatory Fields](#)

Data Field Setting

The Data Field Setting option allows you to Enable/Disable specific fields in BOS for your implementation of the system.

The default setting is for all fields to be *Enabled*.

There may be a requirement to disable a field that will not be used in your BOS implementation.



Click **Data Field Setting** in the Navigation pane to display the contents of this table in the right hand pane.

The list of BOS fields are grouped in Screen order.

New entries cannot be added to the list.

Double click on any entry you wish to change, and display the Data Field Setting screen thus :

Form - field is for display purposes only, and cannot be changed.

Data - field is for display purposes only, and cannot be changed.

Data Collection Status - to Enable/Disable this Menu Icon, click the required button.

- saves changes to the record.

- closes the record. If changes have been made you will be prompted to Save as required.

The effect of setting a field status to *Disabled* will be to remove it from it's corresponding Screen in the Patient Episode Record. No data can be saved to a field whilst it is disabled.

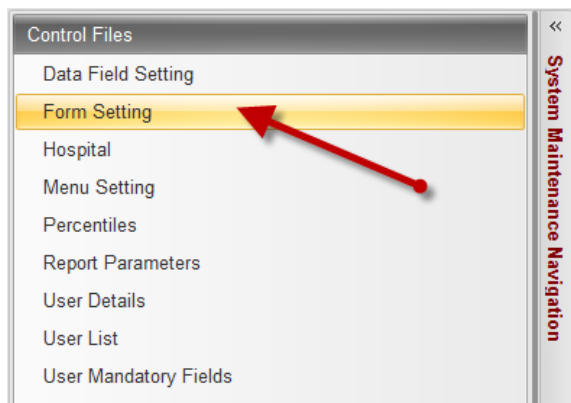
The field can be set to *Enabled* again at any time.

Form Setting

The Form Setting option allows you to Enable/Disable specific Screens in BOS for your implementation of the system.

The default setting is for all screens to be *Enabled*.

There may be a requirement to disable a screen that will not be used in your BOS implementation.



Click **Form Setting** in the Navigation pane to display the contents of this table in the right hand pane.

The list is grouped by Navigation bar.

New entries cannot be added to the list.

Double click on any entry you wish to change, and display the Form Setting screen thus :

NavBar - field is for display purposes only, and cannot be changed.

Form - field is for display purposes only, and cannot be changed.

Status - to Enable/Disable this Screen, click the required ☐ Enable ☒ Disable button.



- saves changes to the record.



- closes the record. If changes have been made you will be prompted to Save as required.

The effect of setting a screen status to *Disabled* will be to remove it from its corresponding Navigation Bar in the Patient Episode Record. No data can be saved to a screen whilst it is disabled.

No data can be saved to this screen whilst it is disabled.

Disabled screens entries are displayed thus in the Form Setting list :

- Mother Postnatal, Care Model
- Mother Postnatal, Discharge
- Mother Postnatal, Postnatal
- Mother Postnatal, Postnatal Events
- Antenatal Assessment, Share Care

The screen can be set to *Enabled* again at any time.

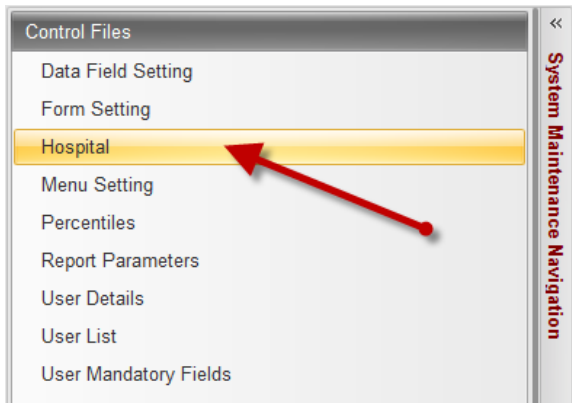
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Hospital

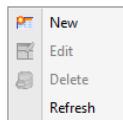
The Hospital option allows you to set specific global controls in your hospital's entry, and maintain limited information on other listed hospitals. Your Hospital entry is usually configured at the time of installation, but may be adjusted as required.

The contents of the Hospital list is usually maintained automatically as part of periodic updates to your system.



Click **Hospital** in the Navigation pane to display the contents of this table in the right hand pane.

The list of Hospitals are grouped in [Sequence](#)/Alphabetical order.



Right Click anywhere in the Hospital list and click **New** to create a new entry.

Double click on any entry you wish to change, and display the Hospital screen thus :

NB - the *System Parameters* and *Comments Boxes Setting* Tabs will be disabled for all entries except your own hospital.

A screenshot of the 'Hospital' configuration window in the MCATS Super User Admin interface. The window title is 'Hospital'. It contains several input fields for hospital information: Hospital Code (1360), Hospital Name (MCATS District Memorial Hospital), Address (193 Red Road), Suburb (Bellingham), PostCode (3456), State (VIC), Phone (9076 1233), Phone Nursery (9076 1572), Sequence Num (0), and Tertiary Hospital (N). Below these fields are two tabs: 'System Parameters' and 'Comment Boxes Setting'. The 'System Parameters' tab is active and shows various settings: Reports Template Location, Reports Audit Location, Registrar Report Location, BOS Update Location, Report Output Location, VPDC Report Output Location, Default Public Class Code, BMI Alert Level, Grand Multi, Post Discharge Edit Days, 1st Stage Max Hrs, 2nd Stage Max Hrs, 3rd Stage Max Hrs, Gender Code, Minimum Age, and Maximum Age. At the bottom right of the window are 'Save' and 'Close' buttons.

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Hospital Code	- DoH Identifier Code.
Hospital Name	- Hospital's Incorporated name.
Address	- details should be completed as required.
Sequence Num	- default is 0, enter a number to re-sequence in the list the display as required.
Tertiary Hospital	- Yes/No, set as appropriate.

System Parameters Tab :

All fields in this Tab are Mandatory, and must contain a value.

The 6 location fields allow BOS to access templates, files and documents required for correct operation of the system.

Click the  button to browse for the required directory.

Reports Template Location	- directory where BOS report templates are stored.
Reports Audit Location	- directory where BOS report audit copies are written/stored.
Registrar Report Location	- directory where the BDM notification files are written.
BOS Update Location	- directory where updated BOS files may reside.
Report Output Location	- directory where BOS alternative report formats are written/stored.
VPDC Report Output Location	- directory where VPDC submission files are written.
Default Public Class Code	- determines the default value used for the Account Class field in the Patient Episode Record.
BMI Alert Level	- is the value above which an automatic Alert will be posted to the Alerts window in the Patient Episode Record.
Grand Multi	- definition of Grand Multi (Gravida = n or above) for use in statistical Reporting.
Post Discharge Edit Days for after the discharge date.	- determines the number of days up to which a discharged Record may be edited
1st Stage Max Hours value.	- effects a warning when the entered length of 1st Stage is greater than this
2nd Stage Max Hours value.	- effects a warning when the entered length of 2nd Stage is greater than this
3rd Stage Max Hours value.	- effects a warning when the entered length of 3rd Stage is greater than this
Gender Code message if the Patient is not Female.	- Identifies the gender code expected fro the hospital PMI, and effects a warning
Minimum Age	- effects a warning if the Patient's age is less than this value.
Maximum Age	- effects a warning if the Patient's age is more than this value

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Comments Boxes Setting Tab :

Click the Tab heading to display the fields.

The screenshot shows the 'Comment Boxes Setting' tab. It contains a grid of checkboxes for various medical conditions. A summary box on the right, titled 'Report the following comments to PDCU:', lists the selected conditions.

Field	Selected
Maternal Medical Conditions	<input checked="" type="checkbox"/>
Obstetric Complications	<input checked="" type="checkbox"/>
Investigations/Procedures	<input checked="" type="checkbox"/>
Operative Delivery Indications	<input checked="" type="checkbox"/>
Family History	<input checked="" type="checkbox"/>
Birth Trauma	<input checked="" type="checkbox"/>

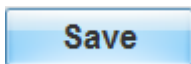
This is a fixed list of Referenced Fields in the BOS Patient Episode Record that have an (optional) associated Text Field.

The BOS System Administrator determines which fields will have it's Text Field made available.

Check the required field heading ☒ **Obstetric Complications** in the list to *Activate* it's Text Field. Uncheck to remove it.

Activated *Text Field* buttons appears above the respective field in the Patient Episode Record screen.

The white box to the right is no longer functional, please ignore it.



- saves changes to the record.



- closes the record. If changes have been made you will be prompted to Save as required.

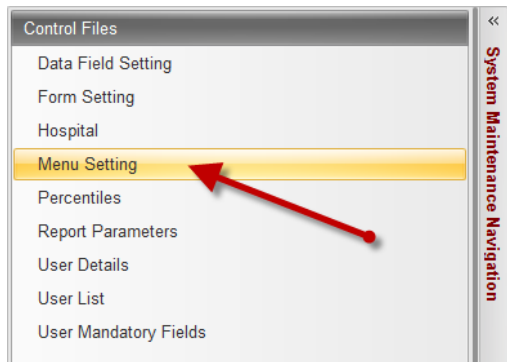
Menu Setting

The Menu Setting option allows you to :

- Enable/Disable specific Menu Icons,
- determine a User Access Level for a specific Menu Icon.

The default setting is for all Menu Icons to be *Enabled*.

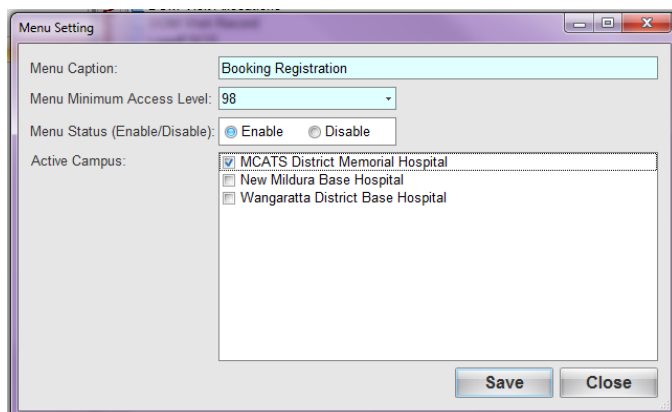
There may be a requirement to disable a Menu Icon that will not be used by anyone in your BOS system.



Click **Menu Setting** in the Navigation pane to display the contents of this table in the right hand pane.

New entries cannot be added to the list.

Double click on any entry you wish to change, and display the Menu Setting screen thus :



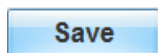
Menu Caption

Menu Minimum Access Level

Menu Status

Active Campus

- field is for display purposes only, and cannot be changed.
- set as required for Users with appropriate Access.
- to Enable/Disable this Menu Icon, click the required button.
- Select the Campus for which the Menu Icon will be available.



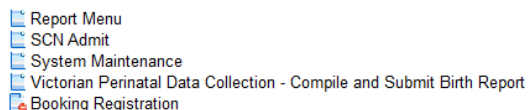
- saves changes to the record.



- closes the record. If changes have been made you will be prompted to Save as required.

The effect of setting a Menu Icon status to *Disabled* will be to remove it the from the BOS Main Menu Bar for all Users.

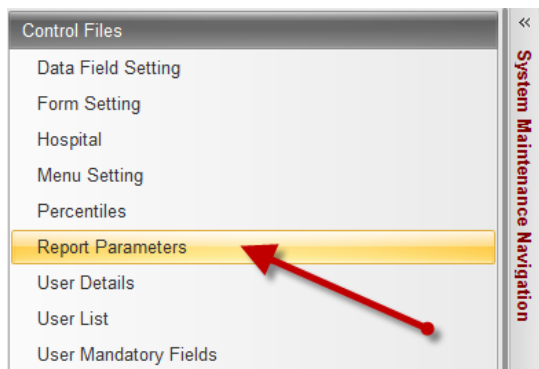
Disabled Menu Icons entries are displayed thus in the Menu Setting list :



The Menu Icon can be set to *Enabled* again at any time.

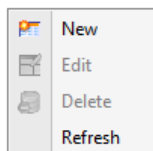
Report Parameters

The Report Parameters option allows you to maintain reports settings for your implementation of the system.



Click **Report Parameters** in the Navigation pane to display the contents of this table in the right hand pane.

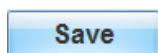
The list of Reports are grouped in [Sequence](#)/Alphabetical order.



Right Click anywhere in the Report Parameters list and click **New** to create a new entry.

Double click on any entry you wish to change, and display the Report Parameters screen thus :

- Report Name** - select the assigned report template from the drop-down list.
- Report Menu Heading** - name of the report as it appears on the report menu.
- Report Group** - select the required report group from the drop-down list.
- Minimum Access Level** - enter the minimum access level to be assigned to this report.
- Allow Future Start Date** - enter Yes/No as required. Antenatal reports may be allowed a future start date.
- Allow Printing of Incomplete Records** - field active only for Per Birth reports. Default is No.
- Alternative Output Required** - field active only for Per Birth reports. Enter Yes for reports with an alternative Output to a Scanned Medical Record system or Fax Server.
- Sequence Number** - enter a [sequencing](#) number as required.
- Suspended Date** - select the required report group from the drop-down list.



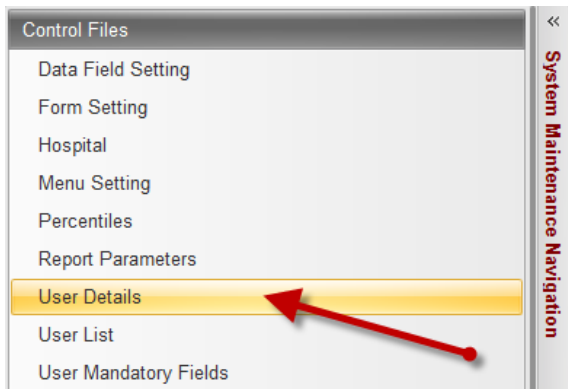
- saves changes to the record.



- closes the record. If changes have been made you will be prompted to Save as required.

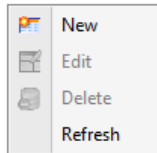
User Details

The User Details option allows you maintain User Details including Logon settings for access to the BOS system.



Click **User Details** in the Navigation pane to display the contents of this table in the right hand pane.

The list of Users are grouped in Alphabetical order.



Right Click anywhere in the User Details list and click **New** to create a new entry.

Double click on any entry you wish to change, and display the User Details screen thus :

User Details	
Surname:	Smith
First Name:	John
Hospital:	MCATS District Memorial Hospital
Rank:	Registered Midwife
Specialty:	Obstetrics
Employee Number:	
Share Care Review Date:	
Resign Date:	

Practice/Address Details	
Practice Name:	
Alternate ID:	MPG149702
Address:	
Suburb:	
State:	
Postcode:	
Provider No:	0
Fax:	
Phone:	
Email:	

Logon Details	
Login Allowed:	Yes
User Level:	98
TimeOut:	10
Discharge Edit:	Yes
User ID:	fleg
Birth Record Access Level:	Update
Password:	*****
Confirm Password:	*****

Save Close

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User Details :

Mandatory fields must be completed.

Surname	- User Surname.
First Name	- User First Name(s).
Hospital	- Select the Hospital this User is assigned to, from the drop-down list.
Rank	- Select the Rank for this User, from the drop-down list.
Specialty	- Select the Specialty for this User, from the drop-down list.
Share Care Review Date	- Optional - enter a review date.
Employee Number	- Optional, as required.
Resign Date	- Enter a Resign Date. Maybe entered in advance.

Practice/Address Details :

Fields in this section are optional, and are for reference purposes only.

Alternative ID - Optional. This is the ID that this User is know by in the Hospitals Main System.

Login Details :

Fields in this section are conditional on the *Login Allowed* setting.

Login Allowed - if set to **No**, all the remaining fields in this section are inactive.

Login Details			
Login Allowed:	No	User ID:	
User Level:	1	Birth Record Access Level:	No Access
TimeOut:	3	Password:	
Discharge Edit:	Yes	Confirm Password:	

Login Allowed - if set to **Yes**, remaining fields in this section are mandatory.

Login Details			
Login Allowed:	Yes	User ID:	fleg
User Level:	98	Birth Record Access Level:	Update
TimeOut:	10	Password:	*****
Discharge Edit:	Yes	Confirm Password:	*****

User Level - allocates the User an Access Level that determines their Menu and Report options.

TimeOut - is the number of minutes of keyboard inactivity, after which the User is logged out of BOS.

Discharge Edit - if set to Yes, overrides the *Post Discharge Edit* restriction.

User ID - User Login ID.

Birth Record Access - select the appropriate Birth Record access for this User.

Password - may be left blank, to enable a new User to create their own password at first login.

Confirm Password - may be left blank, or mandatory if Password field is entered.



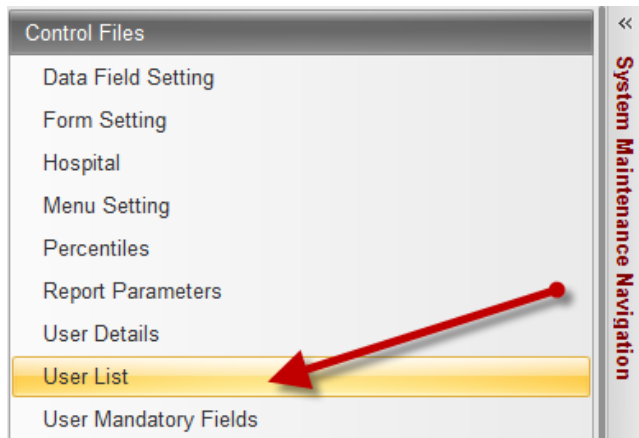
- saves changes to the record.



- closes the record. If changes have been made you will be prompted to Save as required.

User List

The User List option allows you maintain Specialty assignments for designated fields in the BOS system that reference the User Details table.

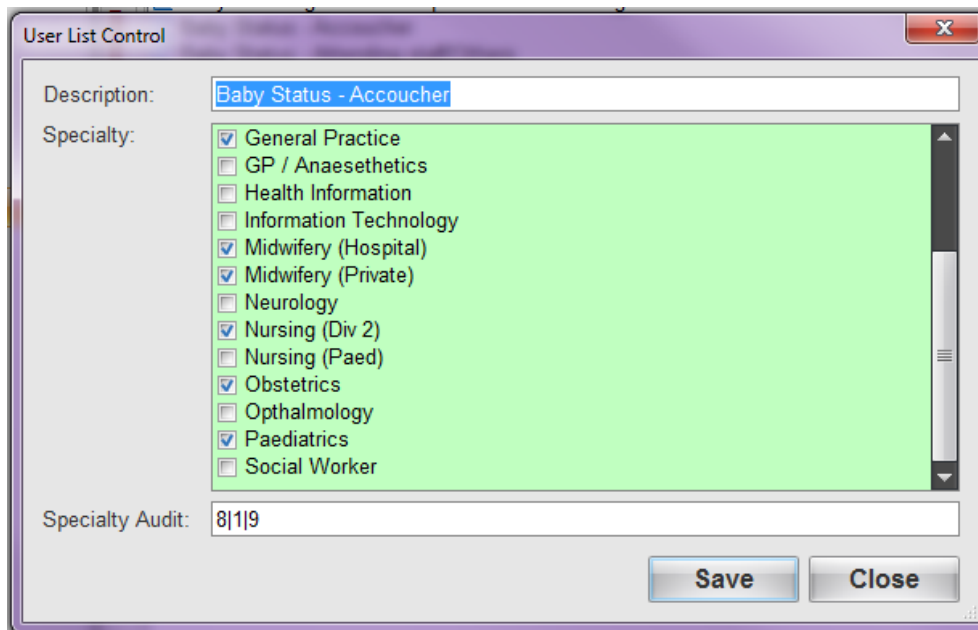


Click **User List** in the Navigation pane to display the contents of this table in the right hand pane.

The list of User Fields are grouped in Alphabetical order.

New entries cannot be added to the list.

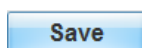
Double click on any entry you wish to change, and display the User List screen thus :



Description Specialty

- Display only field.
- check the Specialties required for this field.

The effect of selecting Specialties for individual fields (populated with User Names) is to customize the contents of the drop-down list with only those Users assigned the selected Specialty.



- saves changes to the record.



- closes the record. If changes have been made you will be prompted to Save as required.

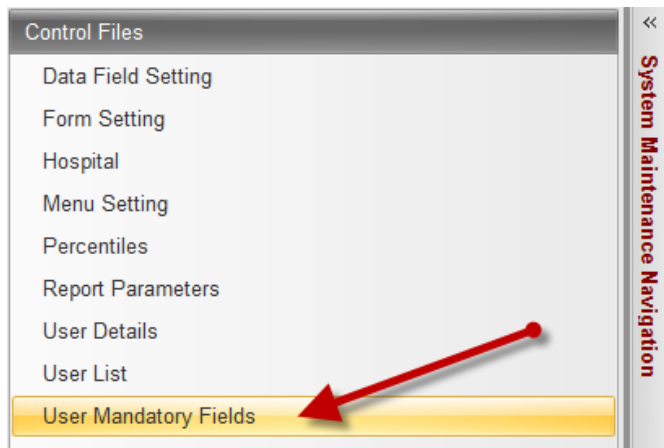
User Mandatory Fields

The User Mandatory Field option allows you maintain User-Defined Mandatory fields for your implementation of the BOS system table.

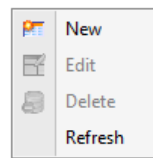
The system has a default set of standard Mandatory fields (as agreed by the BOS User Group).

In addition to the standard mandatory fields, you may make other fields Mandatory as required.

The system default is no User-Defined Mandatory fields.



Click **User Mandatory Fields** in the Navigation pane to display the contents of this table in the right hand pane.



Right Click anywhere in the User Mandatory Fields list and click **New** to create a new entry.

Double click on existing entry you wish to change, and display the User Mandatory Field screen thus :

Form - click the drop-down list and select the required screen name.

Field - populates with the fields associated with the selected *Screen*. Select the required field name.

Suspended Date - Effectively de-activates User Mandatory Field when a date is entered.



- saves changes to the record.

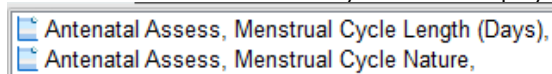
On <save> of a new entry, the User Mandatory Field list will display the new entry.

The newly created User-Defined Mandatory field will appear and be treated as a Mandatory field in the Patient Episode Record.

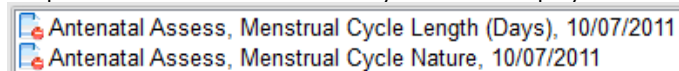


- closes the record. If changes have been made you will be prompted to Save as required.

Current User-Defined Mandatory fields are displayed in the list thus :



Suspended User-Defined Mandatory fields are displayed in the list thus :



System Reference Files

The System Reference Files menu provides access to customize the contents of drop-down lists in defined fields of the Patient Episode Record.

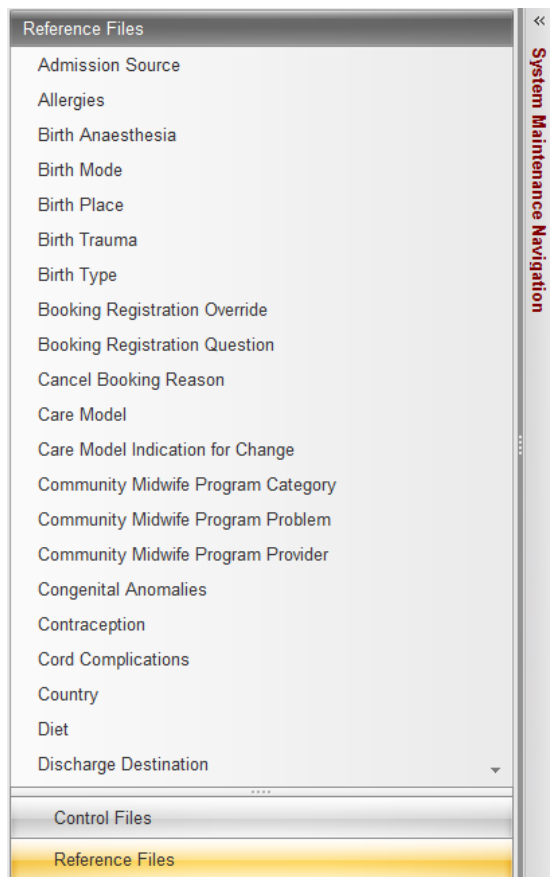
Some of these also require additional settings, controls and mappings to :

- associate the entry to a pre-determined code (VPDC, ICD10 AM, etc.)
- align with other reporting code such as ACHS Clinical Indicators
- provide a trigger for a dependent function or control
- facilitate sequencing

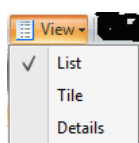
There are some fixed option drop-down lists (as agreed by the BOS User Group) used in the BOS which include :

- Placenta/Membranes
- Placenta Delivery Mode
- Placenta Abnormality
- Cord Insertion
- Forceps Type
- Blood Group

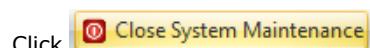
Reference File Navigation Pane :



Click on any item in the left hand Navigation pane to display the contents in the right hand pane.



Click to change the view of the items listed in the Right Hand pane, to suit your personal requirement.



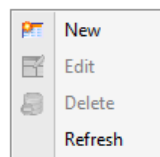
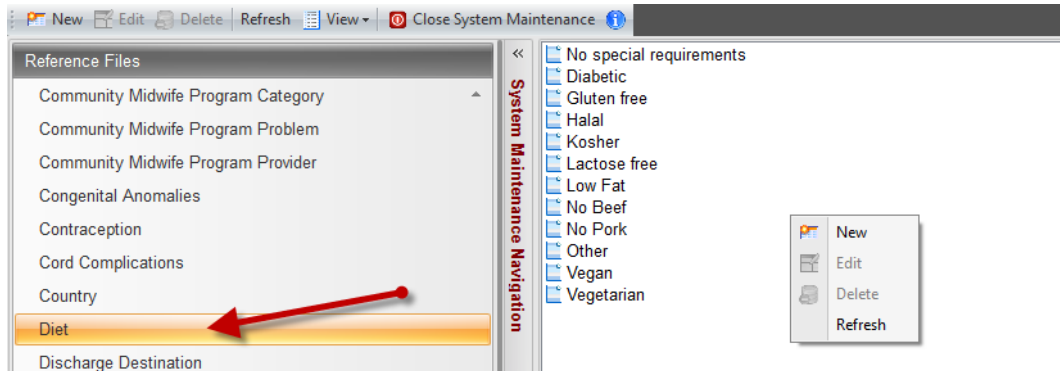
Click to close the System Maintenance menu.

Create/Amend/Delete Reference File entries

The System Reference Files menu options enable the BOS System Administrator to Create, Amend and *Delete* entries in all Reference Tables.

Creating a Reference file entry :

Click on the Reference File Name in the Navigation Pane, to display the contents in the right hand pane.



Right Click anywhere in the list and select **New** to in the pop-up window to create a new entry.

Alternately you may click the  button on the menu bar.

Description - the descriptive text for this entry.

Definition - the Definition text for this entry.

Sequence Number - enter a number to [sequence](#) this entry as required in the listing.

Suspended Date - enter a Date to virtually [Delete](#) this entry.



- saves changes to the record.



- closes the record. If changes have been made you will be prompted to Save as required.

Amending a Reference file entry :

Double click the required entry in the listing pane, to display the maintenance screen thus :

Reference Files Maintenance

Diet

Description:

Definition:

Sequence Number:

Suspended Date:

Save Close

Make the required changes and click  to update the record.

Deleting a Reference file entry :

Double click the required entry in the listing pane, to display the maintenance screen thus :

Reference Files Maintenance

Diet


Description:

Definition:

Sequence Number:

Suspended Date:

Save Close

Enter a Date in the *Suspended Date* field, and click  to update the record.

The effect of entering a Suspended Date is to *virtually delete* this item.

- ☐ No special requirements
- ☐ Diabetic
- ☐ Gluten free
- ☐ Halal
- ☐ Kosher
- ☐ Lactose free
- ☐ Low Fat
- ☐ No Beef
- ☐ No Pork
- ☐ Other
- ☐ Vegan
- ☒ Vegetarian

The item will flagged and moved to the end of the list thus :

A Suspended Item will no longer be available for use in the corresponding field of the Patient Episode Record.

A Suspended Item may be opened, but it's contents (excepting Suspended Date) cannot be changed :

Reference Files Maintenance

Diet

Description:

Definition:

Sequence Number:

Suspended Date:

Save Close

☐ **Hint** – if a *Suspended* item is to be reinstated, simply remove the *Suspended Date*.

A reinstated item becomes immediately available in the corresponding field of the Patient Episode Record.

Sequencing

The default sort order of Reference File lists is Alphabetical. If an alternative sequence is required, the Sequence Number field can be used to effect this.









Select the Reference File to be Sequenced.

Amend the **Sequence Number:** field for individual items.









The default Sequence Number is zero. An item with a Sequence Number of zero will appear at the top of the list.

Items with the same Sequence Number will be sorted in Alphabetical order within the Sequence Number group.

Example - The Liquor reference table showing the default (alphabetical) sequencing :

	Blood Stained
	Clear
	Green (not meconium)
	Meconium
	Nil Seen
	Offensive
	Pink
	Yellow

The Liquor reference table after sequencing to place most commonly used items at the top of the list :

	Clear
	Pink
	Blood Stained
	Meconium
	Green (not meconium)
	Yellow
	Offensive
	Nil Seen

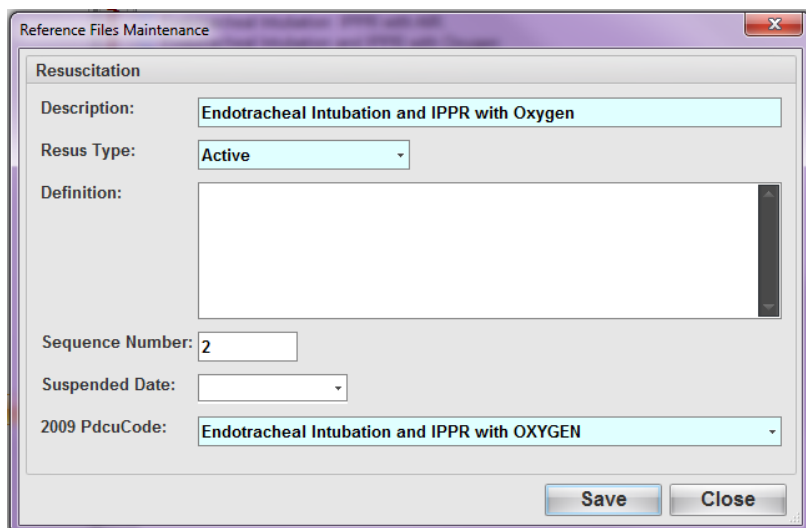
VPDC Mapping

Many referenced fields in the Patient Episode Record require selected items to be flagged with VPDC report and ICD10 AM codes.

These report codes are used when compiling Submission files for VPDC data collection.

Refer to Appendix 2 - [Super User Checklist](#) for a full list of the Reference files and the VPDC reporting fields.

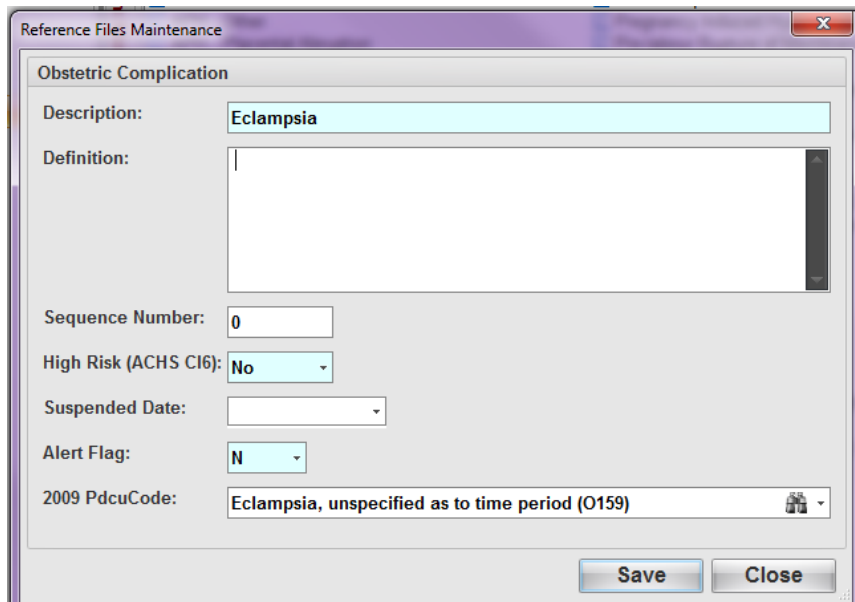
Example - Resuscitation :



The screenshot shows the 'Reference Files Maintenance' window with the 'Resuscitation' tab selected. The 'Description' field contains 'Endotracheal Intubation and IPPR with Oxygen'. The 'Resus Type' dropdown is set to 'Active'. The 'Definition' field is empty. The 'Sequence Number' is '2'. The 'Suspended Date' dropdown is empty. The '2009 PdcuCode' dropdown is set to 'Endotracheal Intubation and IPPR with OXYGEN'. At the bottom are 'Save' and 'Close' buttons.

2009 PdcuCode - select a value from the drop-down list that best aligns with the Description and meaning of this entry for VPDC reporting requirements.

Example - Obstetric Complication :



The screenshot shows the 'Reference Files Maintenance' window with the 'Obstetric Complication' tab selected. The 'Description' field contains 'Eclampsia'. The 'Definition' field is empty. The 'Sequence Number' is '0'. The 'High Risk (ACHS Cl6)' dropdown is set to 'No'. The 'Suspended Date' dropdown is empty. The 'Alert Flag' dropdown is set to 'N'. The '2009 PdcuCode' dropdown is set to 'Eclampsia, unspecified as to time period (O159)'. At the bottom are 'Save' and 'Close' buttons.

2009 PdcuCode - select an ICD10 AM Description/Code from the drop-down list that corresponds with the Description and meaning of this entry for VPDC reporting requirements.

☐ **Hint** – click on the  button to search for entries in the BOS ICD10 AM library file.

Refer to the VPDC documentation for specific conditions that are required to be ICD10 AM coded.

Field Controls

A number of referenced fields in the Patient Episode Record provide for selected items to be flagged with conditional controls. These controls will trigger a defined action in a screen, when the flagged item is selected for the record.

The following Reference files have conditional controls :

- ☐ Discharge Destination
- ☐ Birth Type
- ☐ Substance Use

Example - Substance Use :

The screenshot shows the 'Reference Files Maintenance' window with the 'Substance Use' tab selected. The form contains the following fields:

- Description: Smoking
- Tobacco?: Yes
- Alcohol: No
- Definition: (Empty text area)
- Sequence Number: 1
- Suspended Date: (Empty date field)
- Alert Flag: N
- 2009 PdcuCode: Not Reportable (9999)

Buttons at the bottom: Save, Close.

Tobacco - set to Yes if this item is Tobacco Use and required to trigger the additional Smoking fields in the Substance Use window of the Patient Episode Record.

Alcohol - set to Yes if this item is Alcohol Use and required to trigger the additional Drinking fields in the Substance Use window of the Patient Episode Record.

Example - Discharge Destination :

The screenshot shows the 'Reference Files Maintenance' window with the 'Discharge Destination' tab selected. The form contains the following fields:

- Description: Transfer - Mother
- Pdcu Code: Transfer
- Description Required: Y
- NICU or SCN: N
- Dom Referral: N
- Definition: (Empty text area)
- Sequence Number: 0
- Suspended Date: (Empty date field)

Buttons at the bottom: Save, Close.

Description Required - set to Yes if this item is a Transfer Type and required to trigger the associated Hospital field in the Patient Episode Record.

Nil Item Flag

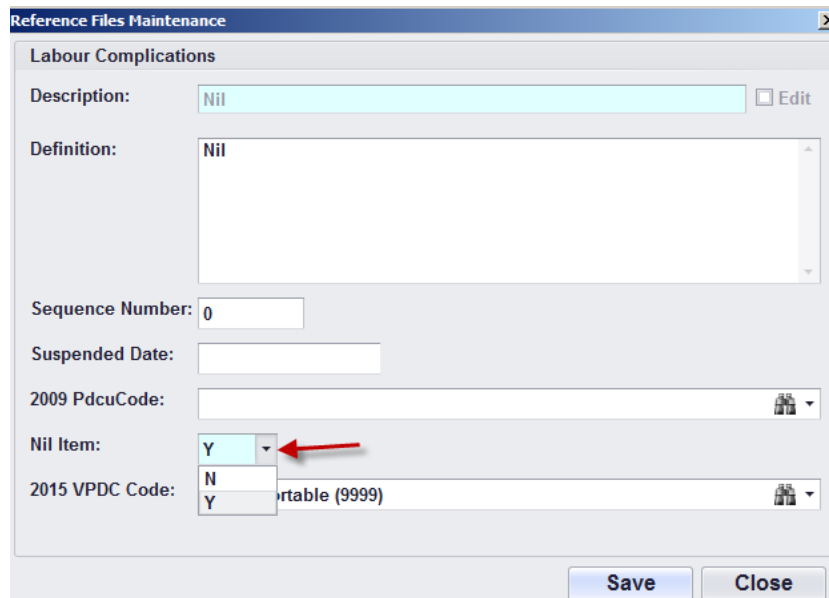
The following Reference files have the ability to flag an item meaning 'Nil' for reporting :

1. ObBirthTrauma
2. ObCongenital
3. ObCordComps
4. ObDischPlan
5. ObDischQuestions
6. ObDomViolence
7. ObFamHistory
8. ObLabourComp
9. ObMatMed
10. ObMedication
11. ObNeoMorb
12. ObObsComp
13. ObPersonalHist
14. ObPostComp
15. ObProcedure
16. ObRiskFactors
17. ObSubstance
18. ObTreatment

To ensure that a Nil item is interpreted correctly by reporting functions, please set the nil Item flag to 'Y'.

Setting the flag correctly will also ensure that Nil items are automatically removed from a field in the Patient Episode Record if non-Nil items are selected.

Example – Labour Complications :



The screenshot shows the 'Reference Files Maintenance' window for 'Labour Complications'. The 'Description' field contains 'Nil' and has an 'Edit' button. The 'Definition' field is empty. The 'Sequence Number' is '0'. The 'Suspended Date' is empty. The '2009 PdcuCode' is empty. The 'Nil Item' dropdown is set to 'Y' and is highlighted with a red arrow. The '2015 VPDC Code' dropdown is set to 'N' and has a 'table (9999)' button next to it. At the bottom are 'Save' and 'Close' buttons.

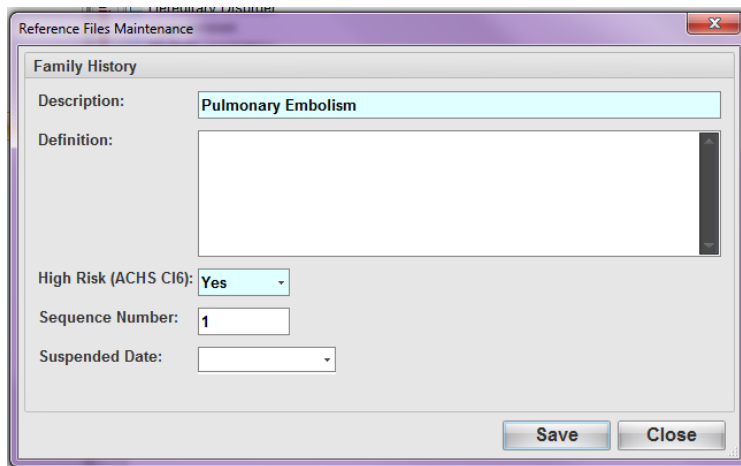
Report Mapping

A number of referenced fields in the Patient Episode Record provide for selected items to be flagged with various report codes. These report codes are used in a range of ACHS Obstetric Clinical Indicator and Audit reports.

The following Reference files have specific report mapping fields :

- ☐ Family History
- ☐ Personal History
- ☐ Obstetric Complications
- ☐ Maternal Medical Conditions
- ☐ Procedures & Investigations

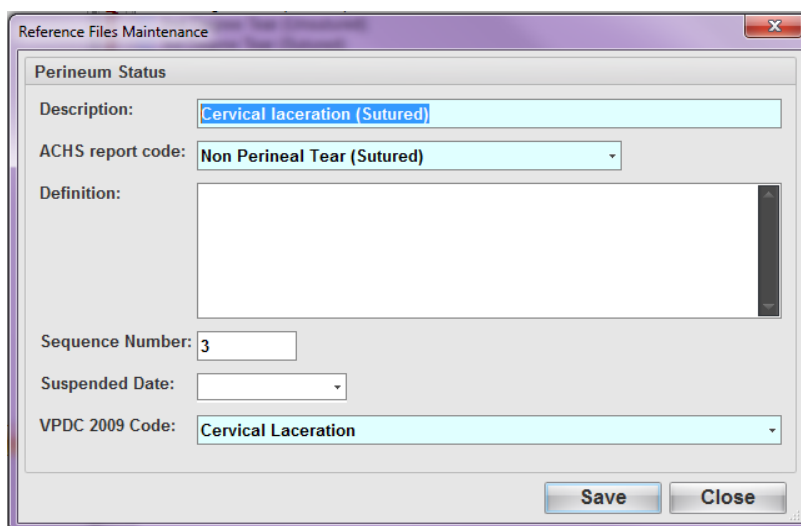
Example - Family History :



The screenshot shows the 'Reference Files Maintenance' window with the 'Family History' tab selected. The 'Description' field contains 'Pulmonary Embolism'. The 'Definition' field is empty. The 'High Risk (ACHS CI6)' dropdown is set to 'Yes'. The 'Sequence Number' is '1'. The 'Suspended Date' dropdown is empty. At the bottom are 'Save' and 'Close' buttons.

High Risk (ACHS CI6) - set to Yes if this item is a criteria in the ACHS Clinical Indicator Area 6 report.

Example - Perineum Status :



The screenshot shows the 'Reference Files Maintenance' window with the 'Perineum Status' tab selected. The 'Description' field contains 'Cervical laceration (Sutured)'. The 'ACHS report code' dropdown is set to 'Non Perineal Tear (Sutured)'. The 'Definition' field is empty. The 'Sequence Number' is '3'. The 'Suspended Date' dropdown is empty. The 'VPDC 2009 Code' dropdown is set to 'Cervical Laceration'. At the bottom are 'Save' and 'Close' buttons.

ACHS report code - select a value from the drop-down list that best aligns with the Description and meaning of this entry for ACHS reporting requirements.

Lookup Controls

A number of referenced fields in the Patient Episode Record source contents of the drop-down list from the same reference file :

- [Procedures](#)
- [Medications](#)
- [Care Model Indication for Change](#)

The Reference file screen for each of these have a special control fields that facilitate the assignment of each entry to the appropriate screen in the Patient Episode Record.

Procedures & Investigations :

Reference Files Maintenance

Procedure and Investigations

Description: Abdominal Hysterectomy

Antenatal Procedures: N

High Risk (ACHS C16): Yes

Additional Procedures: Y

Postnatal Procedure: Y

Definition:

Sequence Number: 0

Suspended Date:

2009 PdcuCode: Sterilisation (Z302)

Save Close

The Procedures and Investigations reference file is used to populate the drop-down list in the following fields.

Antenatal Procedures - set to Yes if the item is required for the list in this field (Maternal Details 1).

Additional Procedures - set to Yes if the item is required for the list in this field (3rd Stage).

Postnatal Procedures - set to Yes if the item is required for the list in this field (Postnatal Events).

Patient Alerts

A number of referenced fields in the Patient Episode Record provide for selected items to be flagged as Patient Alerts.

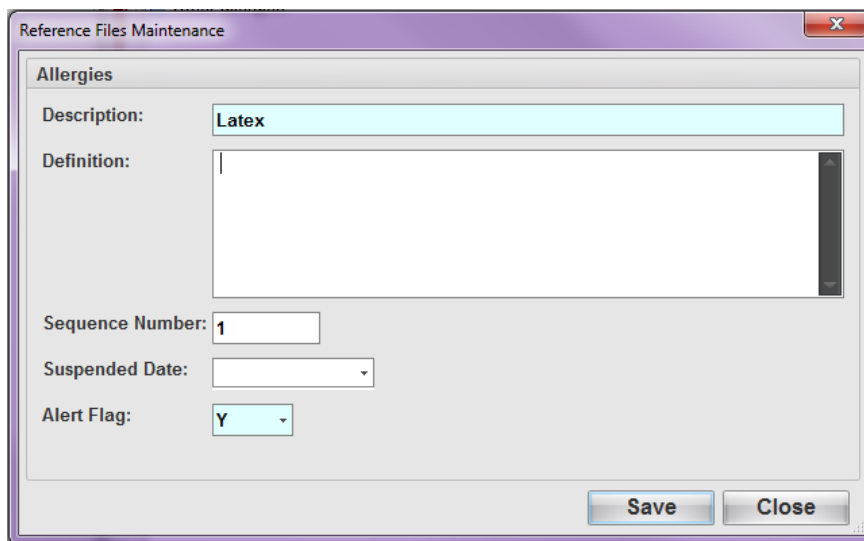
These are automatically added to the Patient Alert screen and Antenatal Summary for individual patients.

The following Reference files have the ability to flag Alerts :

- ☐ Allergies
- ☐ Obstetric Complications
- ☐ Maternal Medical Conditions
- ☐ Substance Use
- ☐ Birth Type (Past Birth Types)
- ☐ Outcomes (Past Outcomes)
- ☐ Personal History

The Reference file screen for these has a special control field to assign the alert :

Example - Allergies :



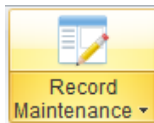
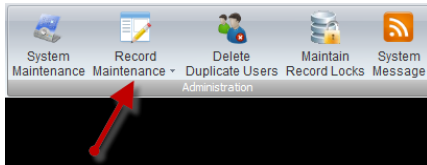
The screenshot shows a software window titled "Reference Files Maintenance" with a close button (X) in the top right corner. Inside the window, there is a tab labeled "Allergies". Below the tab, there are several input fields: "Description:" with a text box containing "Latex", "Definition:" with a large empty text area, "Sequence Number:" with a text box containing "1", "Suspended Date:" with a date picker, and "Alert Flag:" with a dropdown menu showing "Y". At the bottom right of the window, there are two buttons: "Save" and "Close".

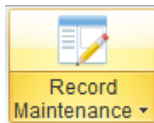
Alert Flag - set to Yes if the item is required as an Alert when selected in the Patient Episode Record.

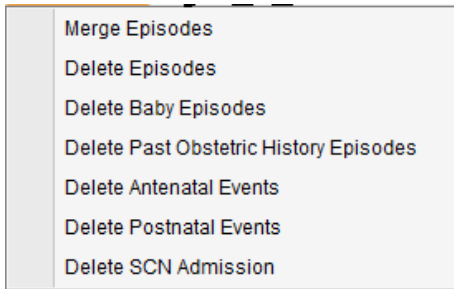
Record Maintenance

The Record Maintenance option allows an Authorized User to manage Patient Episode records in the system.

These options should be used with caution, as they will effect the merge or deletion of selected record elements and/or whole records.



Click the  icon on the Administration Menu to display the Record Maintenance sub menu thus :



CONTENTS :

[Merge Episodes](#)

[Delete Episodes](#)

[Delete Baby Episodes](#)

[Delete Past Obstetric History](#)

[Delete Antenatal Events](#)

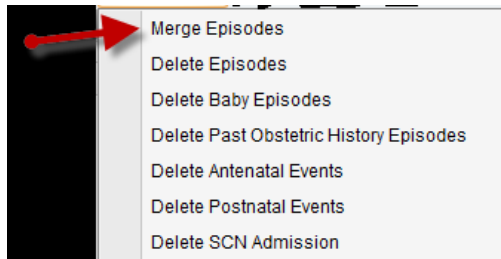
[Delete Postnatal Events](#)

[Delete SCN Admission](#)

Merge Episodes

The Merge Episode option allows an Authorized User to merge Patient Episode records in the system.

This option is generally used in conjunction with a corresponding merge of URNO's in the hospitals patient registration system.



Click the Merge Episode option in the Record Maintenance sub menu to display the Merge Episode screen thus :

Merge UrNo

FROM UrNo: 111111 TO UrNo: 111113

Summary of Urno:

UrNo: 111111 Name: Frederico, Freda Fredo Date of Birth: 18/08/1971

Episode ID	Surname	Firstname	Date Of Birth	Plurality	EBD	Cancel Date	Mother Discharge Date	Baby Number	Birth Date	Baby Discharge Date
<input type="checkbox"/> 11665	Frederico	Freda Fredo	18/08/1971	1	08/08/2010			1	22/08/2010	

Summary of Urno:

UrNo: 111113 Name: Duck, Daisy Date of Birth: 17/08/1961

Episode ID	Surname	Firstname	Date Of Birth	Plurality	EBD	Cancel Date	Mother Discharge Date	Baby Number	Birth Date	Baby Discharge Date
<input type="checkbox"/> 11667	Duck	Daisy	17/08/1961	2	09/09/2010		01/01/0001 1	2	01/09/2010	
<input type="checkbox"/> 11667	Duck	Daisy	17/08/1961	2	09/09/2010		01/01/0001 1	1	03/09/2010	10/09/2010

Merge Close

FROM URNO - enter the Mother URNO to be merged from.



Click the button to view the patients details.

TO URNO - enter the Mother URNO to be merged to.

A summary of the patients current episodes will be displayed in the screen.

Click the checkbox of episodes you wish to be merged :

Summary of Urno:

UrNo: 111111 Name: Frederico, Freda Fredo

Episode ID	Surname	Firstname
<input checked="" type="checkbox"/> 11665	Frederico	Freda Fredo

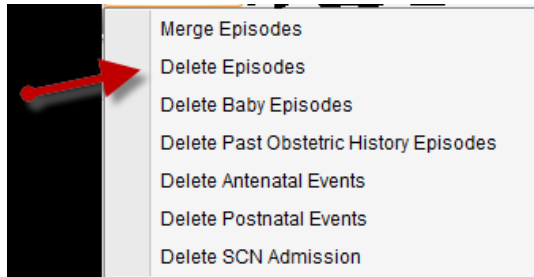
Click the **Merge** button to effect the merge of the selected records.

If multiple episodes are to be merged these can all be selected to effect the simultaneous merging.

Delete Episodes

The Delete Episode option allows an Authorized User to delete a Patient Record in the system.

This option is generally used to clear a duplicate or incorrect entry in the system.



Click the Delete Episode option in the Record Maintenance sub menu to display the Delete Episode screen thus :

The 'Delete Maternal Episode' screen displays the following information:

UrNo: 111111

Summary of Urno:

UrNo:	Name	Date of Birth
111111	Frederico, Freda Fredo	18/08/1971

Episode ID	UrNo	Plurality	EBD	Cancel Date	Mother Discharge Date	Baby Number	VPDC Batch ID	VPDC Error	VPDC Status
<input checked="" type="checkbox"/> 11665	111111	1	08/08/2010			1	0	Y	0

At the bottom right, there are two buttons: **Delete** (green) and **Close** (red).

URNO - enter the Mother URNO with episode to be deleted.



Click the button to view the patients details.

A summary of the patients episodes will be displayed in the screen.

Click the checkbox of episode you wish to be deleted :

The 'Summary of Urno' screen displays the following information:

UrNo: 111111 **Name:** Frederico, Freda Fredo

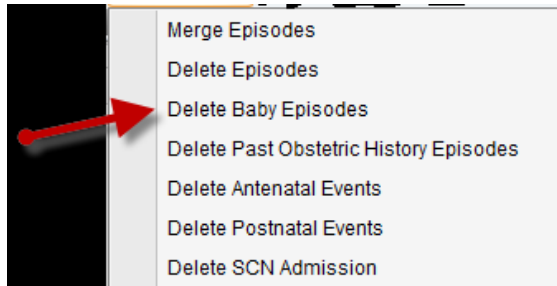
Episode ID	UrNo	Plurality	EBD	Ca
<input checked="" type="checkbox"/> 11665	111111	1	08/08/2010	

Click the  button to effect the deletion of the selected record.

Delete Baby Episodes


The Delete Baby Episode option allows an Authorized User to delete a Baby Record in the system.

This option is generally used to clear a duplicate or incorrect entry for a multiple birth in the system.



Click the Delete Baby Episode option in the Record Maintenance sub menu to display the Delete Baby Episode screen thus :



Delete Baby Episode(s) for a maternal episode

UrNo: 4313774 

Summary of Urno:


UrNo:	Name	Date of Birth
4313774	Frederico, Freda Fredo	18/08/1971

Episode ID	Plurality	EBD	Mother Discharge Date	Baby Number	Birth Date	Baby Discharge Date	Baby UrNo	VPDC Batch ID	Allow Deletion Flag	VPDC
<input checked="" type="checkbox"/> 10660	2	22/12/2010	26/08/2010	2	01/09/2...		43137742	1	Y	Y
<input type="checkbox"/> 10660	2	22/12/2010	26/08/2010	1	30/08/2...	11/08/2010	476654	1	N	Y
<input type="checkbox"/> 10659	1	31/10/2008		1	31/10/2...		4313774	0	N	

URNO - enter the Mother URNO with the Baby episode to be deleted.



Click the  button to view the patients details.

A summary of the patients episodes will be displayed in the screen.


Click the checkbox of baby episode you wish to be deleted :

Summary of Urno:

UrNo:	Name
4313774	Frederico, F

Episode ID	Plurality	EBD
<input checked="" type="checkbox"/> 10660	2	22/12/2010
<input type="checkbox"/> 10660	2	22/12/2010
<input type="checkbox"/> 10659	1	31/10/2008

Delete

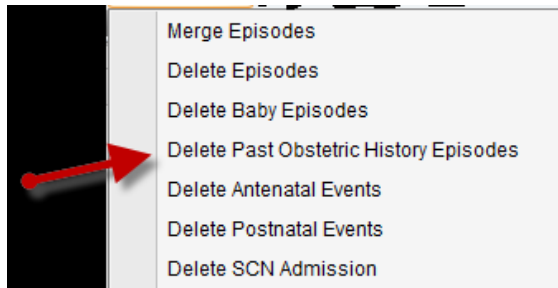
Click the  button to effect the deletion of the selected record.

NB - Baby Number 1 cannot be deleted in this screen - use [Delete Episode](#) for this.

Delete Past Obstetric History

The Delete Past Obstetric History option allows an Authorized User to delete selected Past Obstetric entries from a Patient Episode Record in the system.

This option is generally used to clear a duplicate or incorrect entry in the system.



Click the Delete Past Obstetric History option in the Record Maintenance sub menu to display the Delete Past Obstetric History screen thus :

Year	Month	Gestation	BabyNum	Outcome	Birth Type	Weight	Gender	Feeding	Birt...	Plurality	Seqnum	Print	Comment
<input type="checkbox"/>	2007	2	41	1	Livebirth	Normal Vaginal	3500	Male	Breast	Abb...	1	6	Yes
<input type="checkbox"/>	1990	3	37	2	Neonatal ...	Elective Caesar...	2100	Male	0	Abb...	2	8	
<input type="checkbox"/>	1994	5	36	1	Livebirth	Elective Caesar...	2670	Female	Breast	Abb...	2	9	
<input type="checkbox"/>	1998	1	41	1	Livebirth	Forceps	3000	Male	Breast	Abb...	1	10	Yes
<input type="checkbox"/>	1994	5	36	2	Neonatal ...	Elective Caesar...	1260	Male	0	Abb...	2	12	No
<input type="checkbox"/>	1990	3	37	1	Livebirth	Normal Vaginal	3233	Female	Breast	Abb...	2	23	Yes

URNO - enter the Mother URNO with Obstetric History to be deleted.



Click the button to view the patients details.

A summary of the patients Past Obstetric History will be displayed in the screen.

Year	Month	Gestation	BabyNum
<input type="checkbox"/>	2007	2	41
<input checked="" type="checkbox"/>	1990	3	37
<input checked="" type="checkbox"/>	1994	5	36
<input type="checkbox"/>	1998	1	41
<input type="checkbox"/>	1994	5	36
<input type="checkbox"/>	1990	3	37

Click the checkbox of History you wish to be deleted :

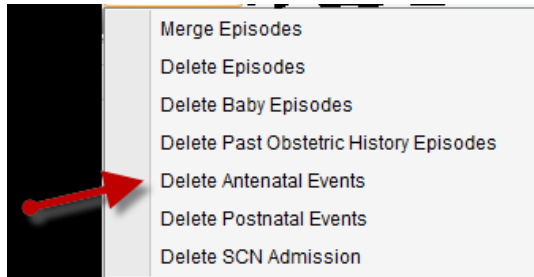


Click the button to effect the deletion of the selected Past Obstetric History.

Delete Antenatal Events

The Delete Antenatal Events option allows an Authorized User to delete selected Antenatal Events from a Patient Episode record in the system.

This option is generally used to clear a duplicate or incorrect entry in the system.



Click the Delete Antenatal Events option in the Record Maintenance sub menu to display the Delete Antenatal Events screen thus :

ObAnteEventID	EpisodeID	Attendance Date	Attendance Time	Appointment Time	Gestation	Fundal Height	BP	Urine	Foetal Heart Rate	Foetal Movements
<input type="checkbox"/> 5311	11665	21/09/2010	18:14	15:32	46.0				0	
<input type="checkbox"/> 5335	11665	08/06/2010	15:31	15:32	31.2				0	

URNO - enter the Mother URNO with Antenatal Events to be deleted.



Click the button to view the patients details.

Antenatal Events - select the required Event Type from the drop-down list, or select "All" :

A summary of the patients Events will be displayed in the screen.

Click the checkbox of Event you wish to be deleted :

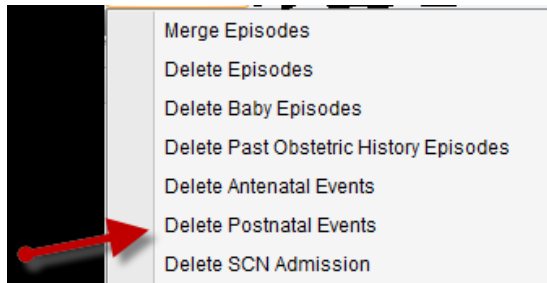
ObAnteEventID	EpisodeID	Attendance Date
<input checked="" type="checkbox"/> 5311	11665	21/09/2010
<input type="checkbox"/> 5335	11665	08/06/2010

Click the **Delete** button to effect the deletion of the selected record.

Delete Postnatal Events

The Delete Postnatal Events option allows an Authorized User to delete selected Postnatal Events from a Patient Episode record in the system.

This option is generally used to clear a duplicate or incorrect entry in the system.



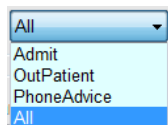
Click the Delete Postnatal Events option in the Record Maintenance sub menu to display the Delete Postnatal Events screen thus :

URNO - enter the Mother URNO with Postnatal Events to be deleted.



Click the button to view the patients details.

Postnatal Events - select the required Event Type from the drop-down list, or select "All" :



A summary of the patients Events will be displayed in the screen.

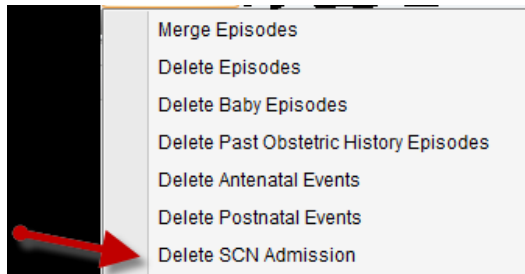
Click the checkbox of Event you wish to be deleted :

Click the **Delete** button to effect the deletion of the selected record.

Delete SCN Admission

The Delete SCN Admission option allows an Authorized User to delete an SCN Admission Record in the system.

This option is generally used to clear a duplicate or incorrect entry for a SCN admission.




Click the Delete SCN Admission option in the Record Maintenance sub menu to display the Delete SCN Admission screen thus :

The screenshot shows a window titled 'Delete SCN Baby Admission Records'. At the top, there is a field for 'UrNo:' with the value '222223' and a small icon button. Below this is a 'Summary of Urno:' section with fields for 'UrNo:', 'Name', and 'Date of Birth'. A table displays admission records with columns: ID, Admit #, Admit Date, Admit Time, Disch Date, Disch Time, and LOS. The table contains three rows of data. At the bottom right, there are two buttons: 'Delete' (green) and 'Close' (red).

ID	Admit #	Admit Date	Admit Time	Disch Date	Disch Time	LOS
<input type="checkbox"/> 2				01/01/00...		0
<input type="checkbox"/> 1		01/09/2010	06:00	10/09/20...	13:23	10
<input type="checkbox"/> 1						0

URNO - enter the Baby URNO with SCN Admits to be deleted.



Click the  button to view the patients details.

A summary of the patients episodes will be displayed in the screen.

Click the checkbox of baby episode you wish to be deleted :

The screenshot shows the 'Summary of Urno:' section of the software. It includes fields for 'UrNo:' and 'Name'. Below these is a table with columns: ID, Admit #, Admit Date, Admit Time, and Disch Date. The table contains three rows of data. The first row has a checked checkbox next to the ID '2'. The second and third rows have unchecked checkboxes next to the IDs '1' and '1' respectively.

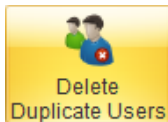
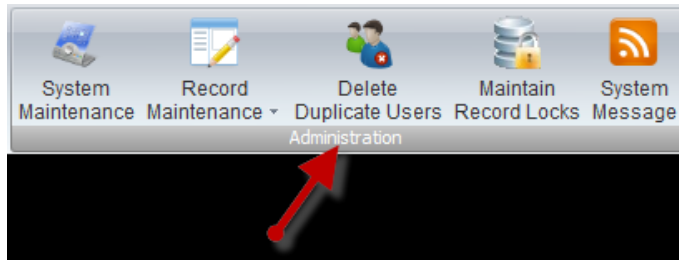
ID	Admit #	Admit Date	Admit Time	Disch Date
<input checked="" type="checkbox"/> 2				01/01/00...
<input type="checkbox"/> 1		01/09/2010	06:00	10/09/20...
<input type="checkbox"/> 1				

Click the  button to effect the deletion of the selected record.

Delete Duplicate Users

The Delete Duplicate Users option allows an Authorized User to remove Duplicate Users from the system.

Where a User has been entered twice in the system User table, this can be corrected by employing this option. The Delete Duplicate Users process will merge the User into one record, and update any Patient Episode Records accordingly.



Click the **Delete Duplicate Users** icon on the Administration Menu to display the Delete Duplicate Users window thus :

 A screenshot of the 'Delete Duplicate Users' window. The window has a purple title bar and a light gray background. It contains two dropdown menus: 'User to be DELETED:' and 'User to be MERGED:'. Below these menus is a text box with the message: 'Please be aware that using this facility while there is a lot of activity on BOS may result in long running time.' At the bottom right, there are three buttons: 'Delete', 'Close', and 'Help'.

User to be DELETED - select the User name to be deleted.

☐ **Hint** – start typing the name of the user in the field to quickly locate in the drop-down list.

User to be MERGED - select the User name to be merged.



Click the **Delete** button to run the process.

NB - the process could take a while to run if the Database is large. All records have to be scanned to find any occurrence of the duplicate, and make the required updates.

The deleted User will be retired from the User List at the end of the process.

Maintain Record Locks

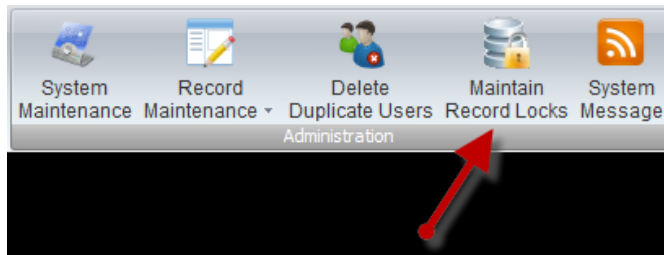
The Maintain Record Locks option allows an Authorized User to remove Record Locks from the system.

A record lock is present when a Patient Episode Record is been accessed by a User. This prevents more than one user accessing and updating the same record at any time.

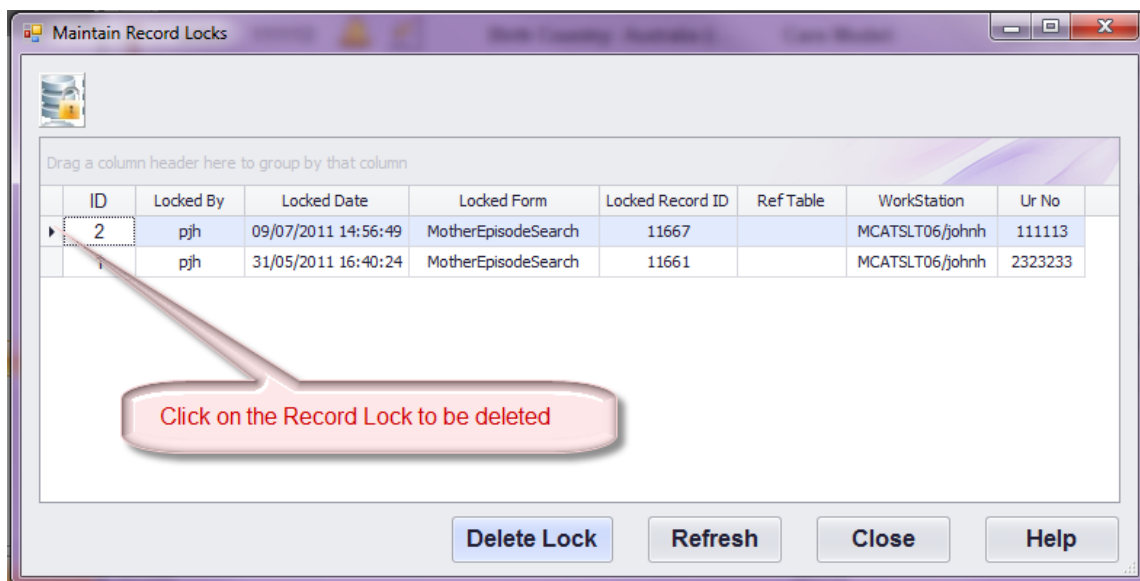
The record lock is released when the record is exited gracefully, ie. By **Save**, **Close**, or **Time-out** from the Record.

It is possible on occasion, due to a sudden and unexpected system failure, (eg. PC or server crash), that a record lock can be left in situ.

In this case, the lock may be manually cleared using this option.

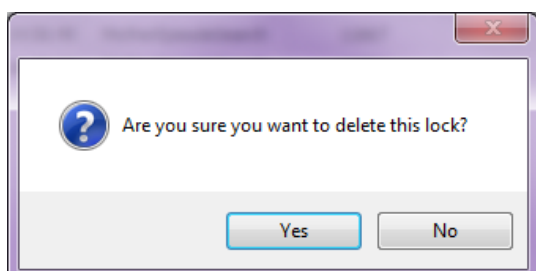


Click the **Maintain Record Locks** icon on the Administration Menu to display the Maintain Record Locks window thus :



Click on the record lock to be deleted, and click the **Delete Lock** button.

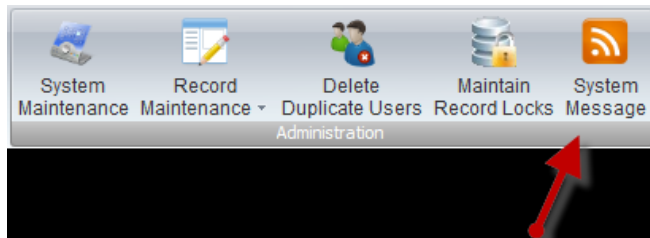
The following confirmation window will be displayed :



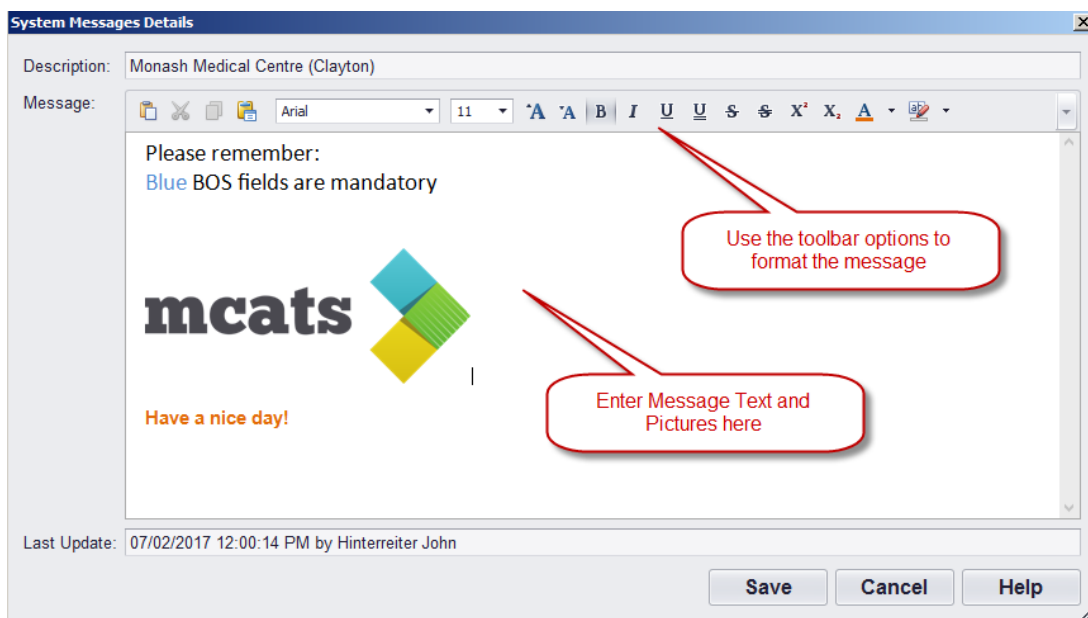
Click the **Yes** button to proceed, or click **No** to return to the Maintain Record Locks window. Locks are removed from the listing in real-time.

System Message

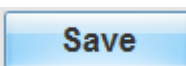
The System Message option allows an Authorized User to update the system message which is displayed to all BOS Users on the main BOS menu screen.



Click the **System Message** icon on the Administration Menu to display the System Message Details window thus :



The *Description* and *Last Update* fields contain default information, and cannot be updated.



Enter your message text in the Message field, and click **Save** to update the system message.

Apply fonts, colours and other formatting to make you message stand out.

The message will be seen by all BOS Users when the BOS Main Menu screen is displayed.

If 'Automatic' font colour is chosen, the text colour will change each time the message is updated, as a visual alert to Users.

Section IV Reporting

The Reporting menu group contains the following options :



BOS provides many standard and statutory reports.

BOS Clinical Reports (Per Birth) are generated as a standard MS Word document.

BOS Periodic reports are generated as a standard MS Excel spreadsheet.

Reports are generated from a pre-formatted templates, and these may be copied and changed on a site specific basis as required.

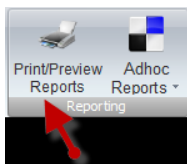
Reports can be output to:

- Any windows/local/networked printer
- A fax server
- Saved to a file
- As an email attachment

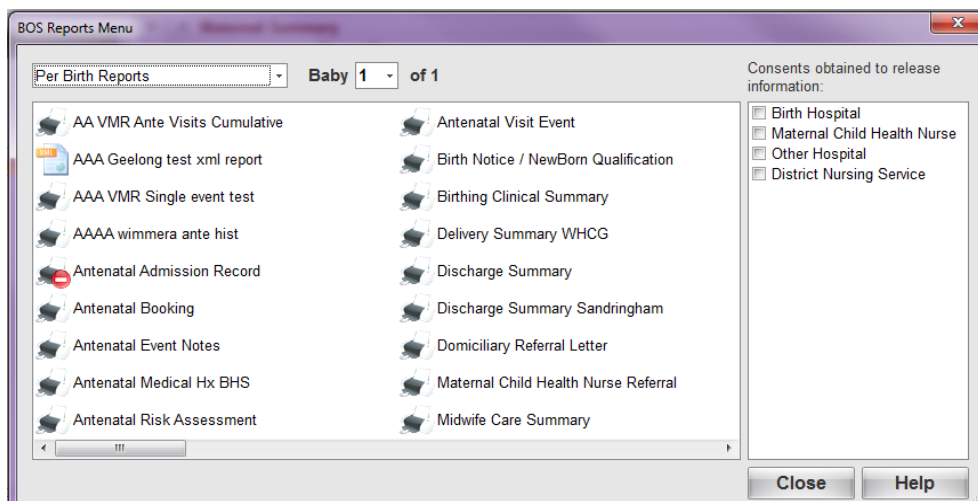
Print/Preview Reports

The Print/Preview option provides access to the BOS report menus.

NB - Reports displayed on your menu depend on the User Access Level you have been allocated by the BOS System Administrator.



Click the **Print/Preview Reports** icon on the Reporting Menu to display the Reporting menu thus :



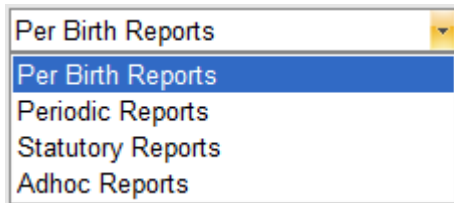
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Note - The *Per Birth Reports* Menu will be displayed if the Print/Preview icon is selected whilst a Patient Episode Record is currently open. Otherwise the default report sub-menu is *Periodic Reports*.

The reports listed in the ***Per Birth*** report menu are specific Clinical reports relating to the Patient Record you are currently working on.

Click on the drop-down to display the list of report sub-menus :



In the case of a multiple birth, select the Baby Number to report on :

Baby 1 of 1

Notes on Report indicators :



Antenatal Admission Record

usually occurs for *Event Type* reports and indicates that the current record has none of these type of Event Types to be reported.



AAX Discharge Summary

indicator to signify this report has an alternative output - usually to the hospitals Scanned Medical Record, or a Fax system. When running this type of report, the User is prompted to finalize the report before it's transfer to the receiving system.

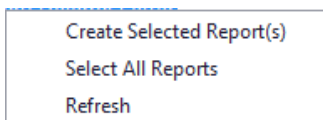
Report sub-menus :

Various reports are organized into sub menus on a User Defined basis for each site.

The Adhoc Report menu is populated with reports created by an authorized User at the hospital and the contents will vary from site to site.

Multiple reports may be printed at the same time - in any report menu, hold down the <ctrl> key and click the reports to be printed.

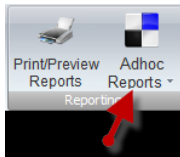
Right-click on any of the selected reports to display the following window :




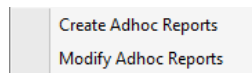
Click **Create Selected Report(s)** to run.

Adhoc Reports

This option enables authorized Users to create and amend Adhoc Reports. Your User Access Level allocated by the BOS System Administrator will determine if you see this menu icon.



Click the  icon on the Reporting Menu to display the Adhoc Report options thus :



Create Adhoc Reports - Click this option to display the Adhoc Report screen :


Start Date - Enter a Start Date for this report.

☐ **Hint** – Click the drop-down on any date field to display the calendar. Default date is today.

End Date - Enter an End Date for this report.

Filter Report By - select the filter method required.

Report Type - select the type required.

Report Data - click the  button to display a list of all fields available, grouped by Screen Name. Check the fields required.

Sort By - this field is populated with the list of fields selected for this report. Select one from the drop-down list to sort this report by.

Select Required Campus - defaults the User location site, but may be changed for Multiple campus sites.

The screen will be populated as per overleaf :

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Adhoc Report

Start Date: 01/04/2011 End Date: 30/06/2011

Filter Report By:

☐ EBD (Interim or Agreed)

☒ Birth Date

Report Type:

☒ Per Birth Episode

☐ Per Baby Episode

Report Data:

1st Stage - 1st Stage Onset Date

1st Stage - Augmentation

1st Stage - Labour Analgesia

History - Comments

Sort By:

1st Stage - Labour Analgesia

Select Required Campus:

MCATS District Memorial Hospital

☐ Save as permanent report

Report Settings

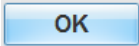
Report Menu Heading:

Minimum Access Level: 1

Allow Future Start Date: N

Sequence Number: 0

OK Close Help

If the report is a one-off, and not required again, then click the  button to generate the report.

If the report is to be saved, and/or added to selected User's Adhoc Report menu, complete the remaining fields by checking ☒ **Save as permanent report** - this will activate the additional fields :

☒ Save as permanent report

Report Settings

Report Menu Heading:

Minimum Access Level: 1

Allow Future Start Date: N

Sequence Number: 0

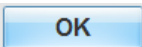
OK Close Help

Report Menu Heading - Enter the name for your report here.

Minimum Access Level - enter the appropriate Access Level for this report.

Allow Future Start Date - Yes/no response.

Sequence Number - enter the number required.

Click the  button to save and generate the report.

The report will appear on the Adhoc Report Menu for Users with a corresponding Access Level.

The report entry may be found in the [Report Parameters](#) option in the System Control Menu.

User Defined Per Birth Reports

Proficiency in editing Microsoft Word templates is a pre-requisite for this feature.

An updated guide is available on the BOS User Group Forum at the following URL:

<http://www.mcats.com.au/bosforum/viewtopic.php?f=13&t=10>

(It will require that you sign up as a member, which is highly recommended for all Super Users!)

BOS facilitates the generation of user-defined reports, in addition to the standard reports supplied with the system.

Any of the standard BOS report templates may be copied and modified for the hospital's own use as required.

Any user-defined report should be renamed to include the hospital initials in the filename.

NB - BOS standard reports should NOT be changed, as these may be overwritten from time to time, when subsequent update patches are installed.

Introduction to the creation of user defined per birth reports :

Reports of a clinical nature, ie. reports printed for an individual Maternity Episode are generated in BOS via MS Word. There are 2 components to the creation of a user defined Per-Birth report :

1. Document template – these are standard MS Word documents with the required layout, text and formatting, and *bookmarks* placed where data from the Maternity Record is required within the document.

Bookmarks used in the document template have the same naming convention as the corresponding field name in the BOS system database. (Please refer to the BOS Data Dictionary).

It is important that the bookmark name for the field required is exactly as it appears in the Data Dictionary – case sensitive and no spaces.

It is recommended to start with a copy of an existing standard BOS report template, and customise this to the new requirements.

A link to the hospital logo file can be added if not already present, and resized as required. (Insert a link to BOS5HospitalLogo.jpg)

The newly created document template (.dot) should be placed in the shared BOS Templates directory, when ready for use.

2. Reports setup – Report Parameters option, System Control menu :

Replacement Report - Amend the report's entry in the [Report Parameters](#) option. Select the new document template filename from the drop-down list.

New Report - create a new entry and set the required fields.

Section V Data Collection

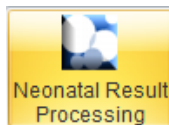
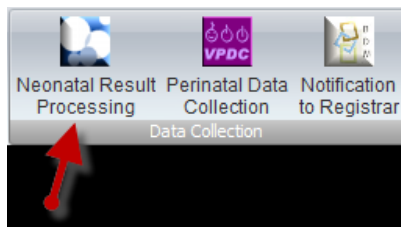
The Data Collection menu group contains the following options :

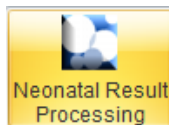


Neonatal Results Processing

The Neonatal Results Processing option allows an Authorized User to load and post Neonatal Results to matched Baby records in the system.

This is an optional process, and requires Neonatal Screening results to be sent from the Central Laboratory in a pre-formatted extract file.



Click the  icon on the Data Collection Menu to display the Neonatal Results Processing screen thus :

 A screenshot of the 'Neonatal Screening Result' window. At the top, there are four statistics: 'Total Processed' (0), 'Posted Successfully' (0), 'Not Posted' (0), and 'Abnormal Results' (0), each in an orange box. Below these are three radio button options: 'Upload New results file' (selected), 'Re-process results file', and 'Result Maintenance'. The 'Upload New results file' option has a text field for 'Result File Location:' and a browse button (...). The 'Re-process results file' option has a text field for 'Select Required:' and a dropdown arrow. At the bottom are four buttons: 'Clear', 'Process NNS Result', 'Close', and 'Help'.

Upload New results file - click on the  button to browse for the required file to upload.

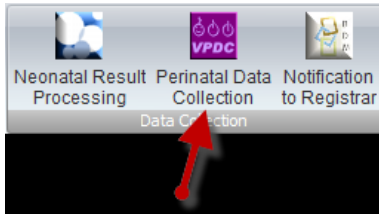
Click the  button to process the selected file.

Perinatal Data Collection (VPDC)

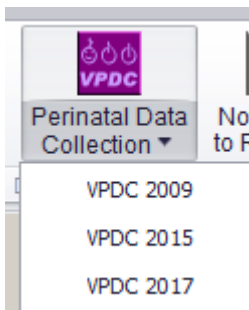
The Perinatal Data Collection option allows an Authorized User to process records and submit extract files to VPDC via the HealthCollect Portal.

This is a mandatory process, and requires all birthed records to be edit checked, compiled and sent to VPDC.

Click on the icon on the Data Collection Menu:



Then select the appropriate version to display the Perinatal Data Collection processing screen for that version:



Contents :

- [Create New Run](#)
- [Recompile Existing Run](#)
- [Submit a Compiled Run](#)
- [Upload Files to VPDC](#)

Create New Run

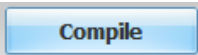
Perinatal Data Collection - Create New Run :

Click **Create New Run**

Record Limit - (optional field) if a number is entered, then this run will include n records. If left blank, then all new records due to be reported (not previously reported) will be compiled into the run.

Select Required Campus - defaults the User location site, but may be changed for Multiple campus sites.

Report Output Location - not required.

Click the  button to process any pending records.

NB - the compilation process applies a number of edit checks on each record. These error checks are based on VPDC requirements for submission.

Where records are found and compiled into the new run, the following window will confirm the Batch number assigned, and indicate if any errors were found :

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If the batch has errors, then an Excel Spreadsheet will automatically display listing the errors found as per overleaf :

	A	B	C	D	E	F
1		Batch number :	4			
2						
3	URNO	Mother's Surname	Baby Number	Baby UrNo	Birth Date	Error Messages
4	4277445	Frederico	1	4277445	16102009	Warning - Admission Date is later than Birth Date Gravidity is not consistent with Past History. Gravidity is 3 whereas Past History indicates 4 (inclusive of current pregnancy).
5	4277445	Frederico	1	4277445	16102009	
6	4277445	Frederico	1	4277445	16102009	No Discipline of Antenatal Care Provider
7	4277445	Frederico	1	4277445	16102009	Warning - No Admitted to HDU/ICU - Mother
8	4277445	Frederico	1	4277445	16102009	Warning - No Admission to SCN/NICU – Baby
9	4277445	Frederico	1	4277445	16102009	Warning - No Hepatitis B Vaccine Received
10	4277445	Frederico	1	4277445	16102009	No Last Feed Since Birth
11	4277445	Frederico	1	4277445	16102009	Warning - Mother Separation Date (Discharge Date) and Mother Separation Status (Discharge Destination) are both blank.

Errors listed in a **red font** are error messages which must be reviewed and the associated record amended.

NB - a batch may NOT be submitted to VPDC with these type of Errors. These errors will cause the records to be rejected by VPDC.

Errors listed in a black font are Warning messages - these should be reviewed and amended as required.

A batch file may be submitted to VPDC with current Warning messages.

Following review of any Warning and Error messages, and corresponding updates to the affected Patient Episode Record(s), the batch must be recompiled, in order to reassess it's status.

Recompile Existing Run

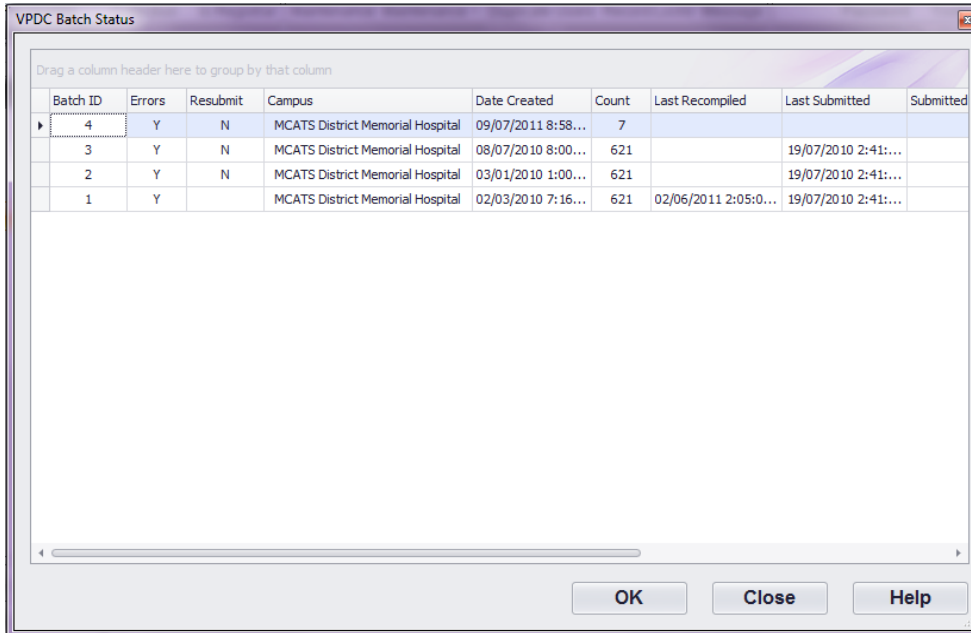
Perinatal Data Collection - Recompile Existing Run :

Click **Recompile an Existing Run**

Click the **View Batch Status** button to display the list of available batches :

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VPDC Batch Status

Drag a column header here to group by that column

Batch ID	Errors	Resubmit	Campus	Date Created	Count	Last Recompiled	Last Submitted	Submitted
4	Y	N	MCATS District Memorial Hospital	09/07/2011 8:58...	7			
3	Y	N	MCATS District Memorial Hospital	08/07/2010 8:00...	621		19/07/2010 2:41:...	
2	Y	N	MCATS District Memorial Hospital	03/01/2010 1:00...	621		19/07/2010 2:41:...	
1	Y		MCATS District Memorial Hospital	02/03/2010 7:16...	621	02/06/2011 2:05:0...	19/07/2010 2:41:...	

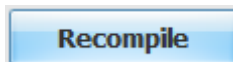
OK Close Help

Double click the batch to be recompiled, which returns the selected batch number to the *Compile Perinatal Data* screen.

Record Limit - not required, field is inactive.

Select Required Campus - defaults to the site in the original batch.

Report Output Location - not required.



Click the **Recompile** button to re-process the selected batch.

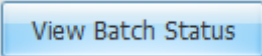
The re-compilation process will apply all edit checks again to each record in the batch.

Where records in the batch have errors, these are automatically displayed in an Excel Spreadsheet.

Submit a Compiled Run

Perinatal Data Collection - Submit a Compiled Run :

Click **Submit a Compiled Run**

Click the  button to display the list of available batches :

Drag a column header here to group by that column									
Batch ID	Errors	Resubmit	Campus	Date Created	Count	Last Recompiled	Last Submitted	Submitted	
4	N	N	MCATS District Memorial Hospital	09/07/2011 8:58...	7	09/07/2011 9:26:0...	09/07/2011 9:32:...		pjh
3	Y	N	MCATS District Memorial Hospital	08/07/2010 8:00...	621		19/07/2010 2:41:...		
2	Y	N	MCATS District Memorial Hospital	03/01/2010 1:00...	621		19/07/2010 2:41:...		
1	Y	N	MCATS District Memorial Hospital	02/03/2010 7:16...	621	09/07/2011 9:23:4...	19/07/2010 2:41:...		

Double click the batch to be submitted, which returns the selected batch number to the *Compile Perinatal Data* screen.

The selected batch must be flagged as error free, otherwise an error will be advised. The batch cannot be submitted until it is error free.

Record Limit - not required, field is inactive.

Select Required Campus - defaults to the site in the original batch.

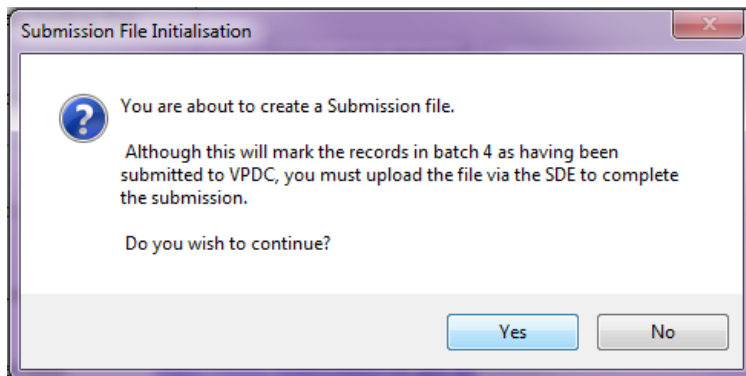
Report Output Location - will display the default location where the extract file is written. May be changed as required - click on the drop-down to display the browse window.

Click the  button to process the selected batch.

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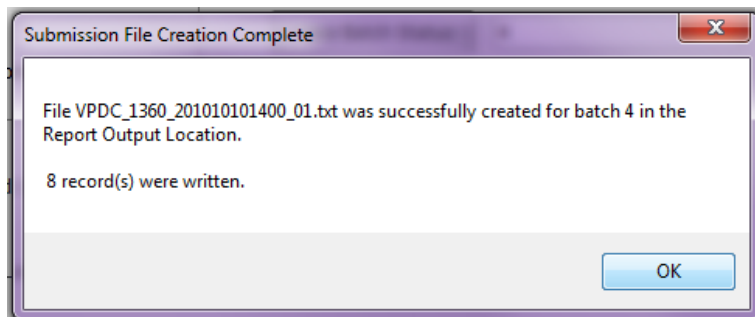
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If the batch is error free, then the submission process will create the extract file for this batch.



Confirm this by clicking **Yes**.

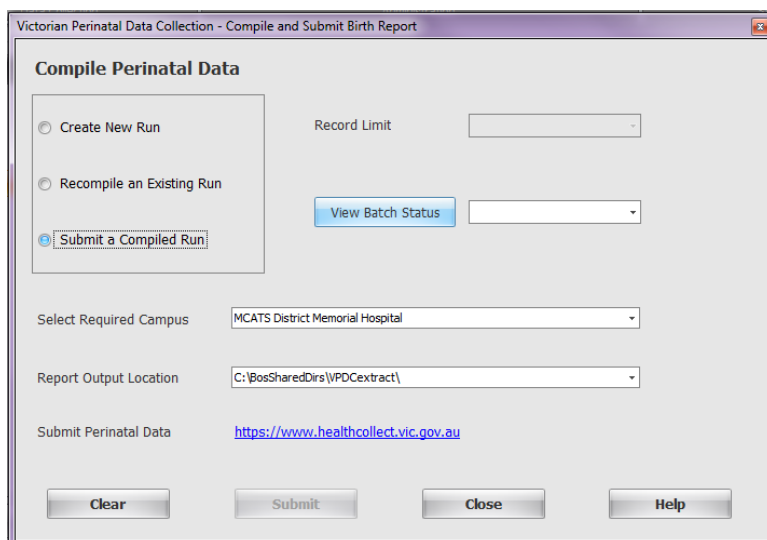
If the file is successfully created, the following window will be displayed to confirm the details :



The file is now ready for [Upload to VPDC](#).

Upload files to VPDC

Perinatal Data Collection - Upload a Submission File :



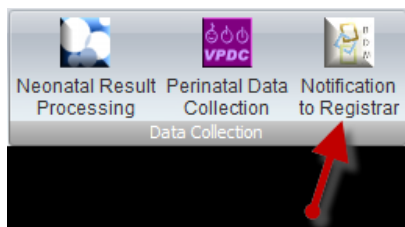
Submit Perinatal Data - Click on the url <https://www.healthcollect.vic.gov.au/>

Login to the HealthCollect portal using your assigned credentials.

Notification to Registrar

The Notification to Registrar option allows an Authorized User to process records and submit extract files to BDM via their Secure Web site.

This is a mandatory process, and requires all birthed records to be compiled and sent to BDM.



Click the **Notification to Registrar** icon on the Data Collection Menu to display the Notification to Registrar processing screen.

Create New Run

Notification to Registrar - Create New Run :

Click **Create New Run**

Select Required Campus - defaults the User location site, but may be changed for Multiple campus sites.

Report Output Location - will display the default location where the extract file is written. May be changed as required - click on the drop-down to display the browse window.

Click the **Compile Data** button to process any pending records.

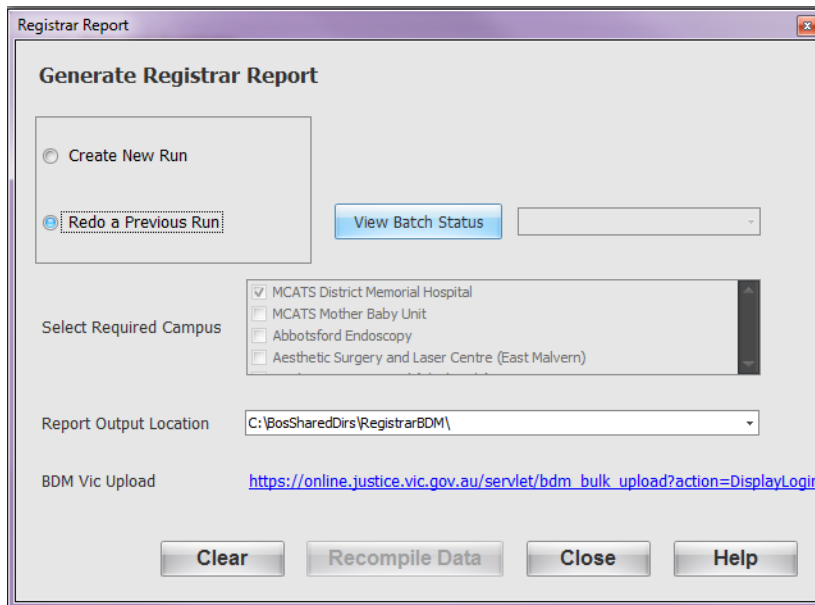
NB - the compilation will automatically process new records, not previously notified.

A new batch is created and the file written to the Report Output Directory.

The file may now be [Uploaded to BDM](#).

Redo Previous Run

Notification to Registrar - Redo Previous Run :



Registrar Report

Generate Registrar Report

☐ Create New Run
☒ Redo a Previous Run

View Batch Status

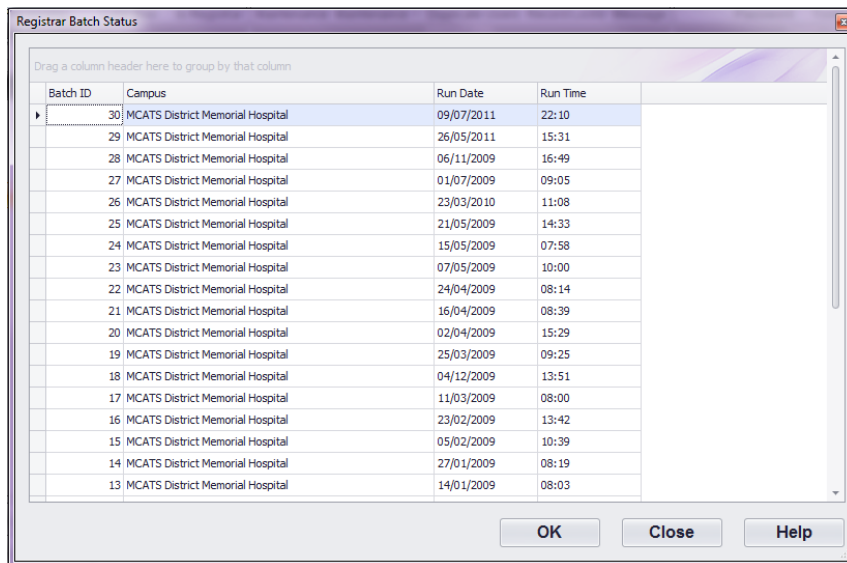
Select Required Campus

- ☒ MCATS District Memorial Hospital
- ☐ MCATS Mother Baby Unit
- ☐ Abbotsford Endoscopy
- ☐ Aesthetic Surgery and Laser Centre (East Malvern)

Report Output Location: C:\BosSharedDirs\RegistrarBDM\

BDM Vic Upload: https://online.justice.vic.gov.au/servlet/bdm_bulk_upload?action=DisplayLogin

Click Redo Previous **Run**, then click the **View Batch Status** button to display the list of available batches :



Registrar Batch Status

Drag a column header here to group by that column

Batch ID	Campus	Run Date	Run Time
30	MCATS District Memorial Hospital	09/07/2011	22:10
29	MCATS District Memorial Hospital	26/05/2011	15:31
28	MCATS District Memorial Hospital	06/11/2009	16:49
27	MCATS District Memorial Hospital	01/07/2009	09:05
26	MCATS District Memorial Hospital	23/03/2010	11:08
25	MCATS District Memorial Hospital	21/05/2009	14:33
24	MCATS District Memorial Hospital	15/05/2009	07:58
23	MCATS District Memorial Hospital	07/05/2009	10:00
22	MCATS District Memorial Hospital	24/04/2009	08:14
21	MCATS District Memorial Hospital	16/04/2009	08:39
20	MCATS District Memorial Hospital	02/04/2009	15:29
19	MCATS District Memorial Hospital	25/03/2009	09:25
18	MCATS District Memorial Hospital	04/12/2009	13:51
17	MCATS District Memorial Hospital	11/03/2009	08:00
16	MCATS District Memorial Hospital	23/02/2009	13:42
15	MCATS District Memorial Hospital	05/02/2009	10:39
14	MCATS District Memorial Hospital	27/01/2009	08:19
13	MCATS District Memorial Hospital	14/01/2009	08:03

Double click the batch to be recompiled, which returns the selected batch number to the *Generate Registrar Report* screen.

Select Required Campus - defaults to the site in the original batch, field is inactive.

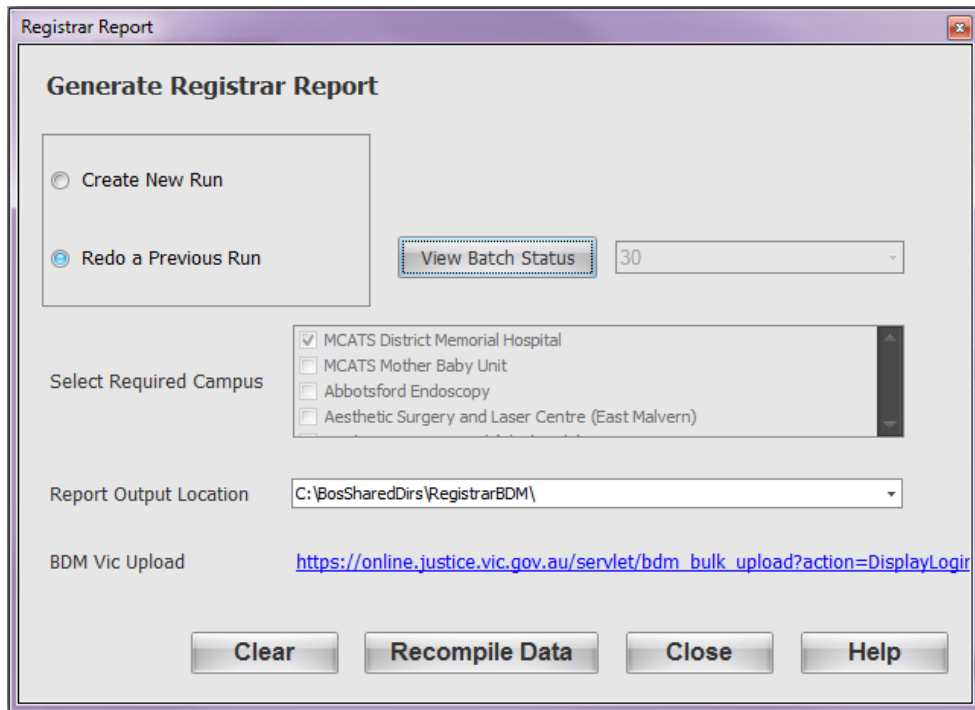
Report Output Location - will display the default location where the extract file is written. May be changed as required - click on the drop-down to display the browse window.

Click the **Recompile Data** button to re-process the selected batch. The re-compilation process will create a new file version of the selected batch.

The file may now be [Uploaded to BDM](#).

Upload files to BDM

Notification to Registrar - Upload a BDM File :



The image shows a software window titled "Registrar Report". Inside, there is a section "Generate Registrar Report" with two radio buttons: "Create New Run" and "Redo a Previous Run". The "Redo a Previous Run" option is selected. To the right of these buttons is a "View Batch Status" button and a dropdown menu showing the number "30". Below this is a "Select Required Campus" section with a list of checkboxes: "MCATS District Memorial Hospital" (checked), "MCATS Mother Baby Unit", "Abbotsford Endoscopy", and "Aesthetic Surgery and Laser Centre (East Malvern)". Below the campus list is a "Report Output Location" dropdown menu showing "C:\BosSharedDirs\RegistrarBDM\". At the bottom left is a "BDM Vic Upload" label and a URL: https://online.justice.vic.gov.au/servlet/bdm_bulk_upload?action=DisplayLogin. At the bottom right are four buttons: "Clear", "Recompile Data", "Close", and "Help".

BDM Vic Upload - Click on the url <https://online.justice.vic.gov.au/bdm/bulkuploadlogin.doi>

Login to the BDM Secure site using your assigned credentials.

Appendix

User Access Levels Summary

User Access to BOS is controlled by setting various Access Levels for individual components of BOS, and matching each User to a corresponding level.

User Access Control levels are User Defined.

The system is initially setup with the following defaults (as determined by the User Group), and may be adjusted to suit the individual needs of sites.

- Maintain Record Locks minimum Access Level = 70
- Maintain System Messages minimum Access Level = 70
- Record Maintenance minimum Access Level = 80
- System Maintenance minimum Access Level = 80

User Access levels can be set for :

- Any Menu Item
- Individual Reports
- Access to Reference File maintenance

In addition to User Access Levels, there are other Access Settings that may be employed to determine the scope of access for an individual User.

- **Log on Allowed** - if set to "Y" then allows this user to log on to BOS. A number of additional control fields are required when *Log on Allowed* is set to "Yes".
- **User Level** - a numeric value that determines the User's Menu and Reporting access.
- **Discharge Edit** - if set to "Y", allows the User access to change Birth Records after the system cut-off date.
- **Birth Record Access Level** - this can be set to No Access, Read Only and Update.

Super User Checklist

Reference Table :	Field	Requirement
Birth Defect	Congenital PdcuCode	Flag any item describing “None”, and any non-reportable minor defect.
Admission Source	Pdcu Code	Map any item describing “No Antenatal Care”
Care Model	Pdcu Code	Map all items
Birth Place	PDCU code	Map items as required, as per VPDC code list
Birth Type	Pdcu Code	Map items as required.
Cord Complications	2015 PdcuCode	Map all items as per VPDC code list.
Country	SACC Code	Map to current SACC code set
Feed Mode	Feed Type	Map all items
Foetal Monitoring	Pdcu Code	Map all items as per VPDC code list.
Foetal Presentation	Pdcu Code	Map all items
Induction Indication	2015 PdcuCode	Map selected items as per VPDC code list
Labour Complications	2015 PdcuCode	Map selected items as per VPDC code list
Indigenous Status	VPDC 2015 Code	Map all items as per VPDC code list.
Maternal Medical Conditions	2015 PdcuCode	Map selected items as per VPDC code list
Birth Mode	2015 PdcuCode	Map “Water Birth” <u>only</u> , as per VPDC code list.
Neonatal Morbidity	2015 PdcuCode	Map selected items as per VPDC code list.
Obstetric Complications	2015 PdcuCode	Map selected items as per VPDC code list
Operative Birth Indication	2015 PdcuCode	Map selected items as per VPDC code list
Oxytocic	2015 PdcuCode	Map all items as per VPDC code list
Perineum Status	2015 PdcuCode	Map all items as per VPDC code list.
Post Natal Complications	2015 PdcuCode	Map selected items as per VPDC code list
Procedures	2015 PdcuCode	Map selected items as per VPDC code list
Resuscitation	Resus Type AND 2015 Pdcu Code	Map all items as per VPDC code list.
Substance Use	2015 PdcuCode	Map selected items as per VPDC code list