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Doccla RPM
Clinician Portal - Clinician Manual

UDI (01)57450002100174(11)20251202(17)20271202(10)RPM21150

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Introduction

This user manual of Doccla RPM Clinician Portal has been written for clinicians. It has been written in a way so that it is understandable for all clinicians, and no prior teaching or workshop participation is necessary to understand it. All clinicians must read this entire user manual before using the Doccla RPM Clinician Portal.

Intended use

Doccla Remote Patient Monitoring (RPM) is a medical device software composed of a clinician portal and mobile applications (for patients and caregivers) that supports healthcare professionals in their remote monitoring and management of non-critical patients.

For the purpose of this document, non-critical patients are defined as adult (18 years and older) and paediatric patients (1 month to 17 years) with clinically stable chronic or post-operative conditions that do not present a risk of rapid or serious deterioration, and for whom remote monitoring is considered clinically appropriate and safe by the responsible healthcare professional.

Doccla RPM has a medical purpose to support the monitoring and management of disease, injury, or disability by enabling healthcare professionals to remotely collect, review, and assess physiological and non-physiological health data for clinical decision support.

Doccla RPM is intended to be used by patients (with caregiver assistance when required) via the mobile application to enter or transmit data, while healthcare professionals use the clinician portal to:

- Configure monitoring parameters and alert thresholds;
- Review submitted physiological and non-physiological data;
- Receive alerts when parameters deviate from thresholds set by healthcare professional-defined inputs

Doccla RPM supports clinical decision-making by providing timely information on patient status but does not perform diagnosis, prognosis, or therapeutic decision-making.

The system is intended for use with patients in non-clinical environments (e.g., patient homes, community clinics, rehabilitation centres) and low-acuity clinical environments (e.g., nursing homes, step-down facilities, outpatient follow-up units) under the supervision of qualified healthcare professionals.

Medical indications

Doccla RPM is indicated to support the remote monitoring of physiological and non-physiological parameters across the following categories, either through compatible third party medical devices, manual entry or questionnaires. Each category includes examples (in brackets) without restricting the scope of use.

Categories of Physiological parameters

- Cardiovascular parameters (e.g., blood pressure, heart rate, pulse waveform)

- Electrophysiological parameters (spot readings) (e.g., single-lead ECG, rhythm strips)
- Respiratory parameters (e.g., oxygen saturation (SpO_2), respiratory rate)
- Metabolic and biochemical parameters (e.g., glucose, ketones — where supported by compatible third party medical devices)
- Thermoregulatory parameters (e.g., body temperature)
- Anthropometric parameters (e.g., weight, BMI-related inputs)
- Neurological parameters (e.g., cognitive screening scores, neuropathic symptom questionnaires)
- Musculoskeletal parameters (e.g. mobility, frailty, pain evaluation)

Categories of Non-Physiological parameters

- Patient-reported outcomes (e.g., symptom scores, pain scales, functional assessments)
- Questionnaire-based metrics (e.g., condition-specific surveys, general health questionnaires, daily check-ins)
- Behavioural or contextual data (e.g., activity indicators, self-reported medication adherence, wellbeing checklists)

Main functionalities

Data Collection and Integration: Acquisition of physiological and non-physiological data through compatible third party medical devices, manual entry, or connected systems.

Alert Configuration and Generation: Allows healthcare professionals to configure thresholds and/or validated algorithms that generate alerts when patient data deviate from predefined criteria. Alerts are based solely on clinician-defined inputs and do not interpret, diagnose, or recommend treatment.

Data Visualisation and Trend Analysis: Presentation of historical and current patient data to support clinical interpretation and prioritisation.

Doccla RPM supports intermittent monitoring only and is not intended for real-time monitoring.

Benefit claims

Doccla RPM is intended to enable the early recognition of physiological changes in non-critical patients, thereby supporting timely clinical assessment, continuity of care outside hospital settings, and efficient use of healthcare resources. In short, the benefit claims for Doccla RPM are as follows:

- Doccla RPM can improve patient outcomes.
- Doccla RPM can reduce unnecessary healthcare utilisation.

These benefit claims are supported by clinical evaluation data, which demonstrate that Doccla RPM performs safely and effectively within its intended scope of use.

Patient population

As defined in the Intended Use section, Doccla RPM is intended for use with non-critical adults (18 years and older) and paediatric patients (1 month to 17 years) who are clinically stable and able to participate in remote monitoring, independently or with caregiver support.

The target population includes individuals with chronic or post-operative conditions where remote data submission and periodic review are deemed clinically appropriate and safe by the healthcare professional.

Intended users

Doccla RPM is intended to be used by:

- Healthcare professionals: For configuring monitoring parameters, reviewing patient data, and responding to alerts through the clinician portal.
- Patients and caregivers: For entering or transmitting data via the patient or carer mobile application.

All users must receive appropriate training in the safe operation of the software and any connected medical devices.

Contra-indications

Doccla RPM must not be used for patients outside the defined non-critical population (see Section 1). The system is contraindicated for patients who are clinically unstable, at risk of rapid deterioration, or who require real-time physiological monitoring.

These contraindications apply where a patient is clinically unstable or requires real-time monitoring. A patient with a chronic or post-operative condition who develops a temporary intercurrent illness remains eligible for use, provided the responsible healthcare professional determines the patient to be clinically stable and suitable for remote monitoring.

Unstable physiological parameters

Patients with instability in any monitored physiological domain, including:

- Cardiovascular instability (e.g., severe/symptomatic BP fluctuations, hypertensive crisis, decompensated heart failure, unstable arrhythmias)
- Electrophysiological instability (e.g., acute rhythm disturbances requiring real-time ECG/ telemetry)
- Respiratory instability (e.g., acute respiratory distress)
- Metabolic or biochemical instability (e.g., recurrent severe hypoglycaemia, significant DKA risk, metabolic derangements requiring inpatient titration)
- Thermoregulatory instability (e.g., active sepsis, high-grade fever needing continuous observation)
- Anthropometric instability (e.g., rapid unexplained weight change, severe dehydration requiring close inpatient monitoring)
- Neurological instability (e.g., real-time neurological monitoring or emergency neurological intervention)
- Musculoskeletal instability (e.g., acute musculoskeletal emergencies or severe functional impairment needing intensive supervision)

Need for real-time monitoring

Doccla RPM must not be used where real-time monitoring is required, including:

- ICU, HDU, CCU or similar high-acuity settings
- Emergency or acute presentations (e.g., unstable vital signs)
- Any environment requiring real-time review of physiological parameters
- Doccla RPM is not intended to support monitoring of neonates (<1 month old) because their monitoring requirements typically necessitate real-time or high-acuity clinical observation

Functional, cognitive, or environmental unsuitability

Use is contraindicated where safe remote monitoring cannot be ensured (unless supported by a caregiver), including:

- Cognitive or communication barriers (e.g., inability to understand/apply instructions)
- Physical limitations (e.g., inability to operate devices or collect measurements independently)
- Insufficient caregiver support (e.g., paediatric users without responsible adult supervision)
- Technical or connectivity limitations (e.g., no mobile/internet/landline access or inability to sustain regular data submission)

General exclusions

- Doccla RPM does not diagnose, detect serious deterioration, or provide treatment recommendations.
- It must not replace emergency services or clinician-led acute assessment.
- Suitability must always be assessed and periodically reviewed by the responsible healthcare professional.

These contraindications have been established based on clinical evaluation and risk management considerations.

Warnings and Precautions

⚠ Warning

- The product may only be used by patients/and or the patient’s caregivers/next of kin, and healthcare personnel.
- Doccla RPM is not to be used for any purpose outside of the scope of the intended use defined in the Instructions For Use - this includes the specific patient population that the device is indicated for use with. Use of the Doccla RPM outside of the scope of the intended use is subject to the requirements of applicable regulatory legislation regarding misuse, off-label use and obligations of importers, distributors and other persons.
- No modification of the Doccla RPM software is allowed.
- The user must keep login information confidential to others to avoid unauthorized access.
- The user must have received appropriate and adequate training from either a representative from Doccla Denmark or a colleague who has been trained by a Doccla Denmark representative.
- The user must read and fully understand the instructions for use for the medical equipment.
- Doccla RPM does not provide real-time alerts and is not intended to provide automated treatment decisions or diagnosis.
- Doccla RPM must not be used for real-time monitoring of time-critical data and emergency intervention.
- Doccla RPM platform is an information tool and must not be used as a substitute for the clinician’s professional judgment when diagnosing and treating patients.
- In the case of Doccla RPM being unavailable or not working as intended, please email support@doccla.com.

Doccla RPM software installation and update

There are no installation or updates required for the Doccla RPM client, since the software is accessed through a browser.

An up-to-date version of Google Chrome, Mozilla Firefox or Microsoft Edge is recommended when using the Doccla RPM platform to ensure proper operation.

An internet connection that provides access to the relevant server installation is required.

For accurate display of visualisations, including graphs and charts, the browser should be used at 100% zoom. Use at any other zoom level may result in inaccurate data representation.

General Navigation

Logging into the system

1. Visit the Doccla RPM clinician portal web site in your internet browser. URL is provided upon installation. The Doccla RPM clinician portal is a web based application and can be used anywhere as long as you have access to a web browser. The website functions best with Google Chrome, Mozilla Firefox or Microsoft Edge.
2. Input your username and password. Your username and initial temporary password will be provided by the administrator. Upon initial login, you will be asked to change your password. Passwords must be at least 10 alphanumeric characters in length and must contain 1 number.
3. Click “Login”.

Menus and page layout

The Overview page displays patients assigned to you that have pending alerts.

General navigation features are described below:

1. Overview page; this is the default page that is displayed upon login. It shows the patients with pending alerts for your organization.
2. Main Menu panel allows access to the submenus: Overview, Calendar (optional), Patient group messages (optional), Find Patient, Create Patient and All Notes for My Team pages.
3. In the drop down it is possible to choose a which patient group will display.
4. Top menu bar displays the username you are logged in with; Administrator Menu button to access the Administrator Menu; Round button with the initials of the signed in user to access the drop-down User Menu. The User Menu drop-down includes the Profile page, for changing password and editing personal message snippets, a logout button to logout of the system, an about button to display the product label and a help button with access to a help site.

Profile page

1. Click the round button with user initial in the top right corner and select “Profile”.

Changing my password

2. Type in the current password.
3. Type in your new password and repeat the password. Passwords must be at least 10 alphanumeric characters in length and must contain 1 number.
4. Click Update
5. A confirmation message will display when your password is successfully changed.

Edit personal message snippets

2. **Enter** snippet title and content in the “Add snippet” form to the far right, and click **Add**. The snippet is now available inside the “Messages” patient menu.

3. Click on **Edit** or **Delete** buttons in the “Message snippets” table to the left to update existing snippets. Sorting can be done by clicking on the different table column headers.

Logging out

1. When ready to log out of the system, click on Log out in the top right dropdown menu.

After a period of inactivity (no keyboard or mouse interaction) you will be logged out automatically.

Patient Enrollment

Evaluate patient suitability

Before enrolling a patient in Doccla RPM the patient's suitability must be evaluated.

A patient should:

- Have a diagnosis for one or more chronic diseases, **non-acute condition**.
- Or have a **non-acute** clinical condition/state of temporary character (i.e. pregnancy, post-op etc.)
- Or be unencumbered by any known condition of disease.
- Be able to read.
- Have the cognitive abilities required to operate a simple app and the required medical devices.

Patient Creation Options

The experience you have when creating a patient will depend on how your organisation has been configured by your administrator – you will see either **"Create patient"** or **"Create patient NEW"** in the main menu.

Creating a Patient with a Demographics Look-Up Service

This form allows you to create a new patient by making a call to a look-up service to auto-populate their demographic data or by manually inputting their data.

Steps:

1. Click **'Create patient NEW'** in the main menu.
2. Choose an organization to create the patient into (if you have access to more than one).
3. If a lookup service has been configured by your administrator:
    - Look up a patient using their unique healthcare identifier.
    - This will auto-populate the form with the patient's basic data.
    - Alternatively, fill the form out manually if there isn't a look-up or if preferred.
4. Continue by filling out the **contact information** for the patient.
5. Optionally add a **next of kin** for the patient.
6. Set the **pathway patient group** for the patient (this is used to automatically set thresholds).
7. Set any other **patient groups** the patient should be included in. _Note: Only patient groups without thresholds can be added at this stage.
8. Provide any other **organisation-specific information** requested in the form.
9. Click **'Create'**.

After Creation:

10. Upon successful creation, you will see a confirmation page.
11. Click **'Go to patient page'** to:
    - Update the patient's personal thresholds.
    - Add organisation-specific metadata.

Creating a Patient Manually

This form allows you to create a new patient by manually inputting their data.

1. Click Create patient in the main menu.
2. Enter the new patient information in the Basic data form.

A red asterisk* indicates that a field is mandatory and must be filled out. The patient Health care ID is the unique patient identifier. Likewise, the Username must also be unique. You can either use the automatically generated temporary password or enter one manually; passwords must be at least eight characters in length and contain at least one number.

3. Once all fields have been filled out, the form will indicate whether the data is valid by either coloring the border green, or red if some data is missing or invalid.
4. Once the Basic data form has been filled out, continue by filling out the Contact information form in a similar fashion.
5. Add any relatives, guardians or contact persons to the patient's Circle of care by filling out the form below and click Add.

If a guardian is added a user will be created and the information associated can be found on the Basic data page of the patient.

7. Verify that all relevant persons have been added to the Circle of care.
8. Choose the desired patient group(s) the patient should be assigned. Optionally select which of the chosen patient groups should be marked as data-responsible.
9. After choosing the relevant patient groups, fill out any relevant patient metadata that may be associated with the organizations the patient will be enrolled within. Note that all metadata is optional by nature.
10. Adjust any loaded thresholds associated with the chosen patient group's values.
11. Click Save.
12. After saving you will be redirected to the patient's Basic data page and the main menu will change to the patient context. When in a patient context, the patient menu will display the patient's information at a quick glance (e.g. patient name, health care ID, date of first enrollment, comments, contact information and their relative's contact information).

Setting a patient's monitoring plan and schedule

1. Click Monitoring plan on the left patient menu.
2. The monitoring plan page for the patient will display.
3. Start date will default to the date the patient profile was created.

4. Click Edit to change the date as required.
5. Click the calendar icon. The calendar will pop up. Select the date you would like the plan to begin.
6. Click Update.
7. Click Assign Questionnaire.
8. Select the questionnaire for the patient by clicking on the drop down menu.
9. Select/Click the frequency/schedule for completing the questionnaire. See more information about schedule setup chapter Edit monitoring plan/schedule.
10. Once frequency is selected, additional options will appear on the screen below. See more information about schedule setup chapter Edit monitoring plan/schedule. Complete the information in the field as shown.
11. Click Assign.
12. The monitoring plan page will display with the inputted monitoring plan and schedule.

Assigning questionnaire groups

It is also possible to link a questionnaire group to the patient, thus automatically assigning each questionnaire, using the questionnaire's standard schedule in that questionnaire group, to the patient.

Any changes made to the list of questionnaires in the questionnaire group is then reflected in the patient's monitoring plan.

1. Click Assign/remove questionnaire groups from the Monitoring plan page.
2. The 'Assign/remove questionnaire groups' page will display showing the questionnaire groups the patient is already assigned to.
3. Select a Questionnaire group in the drop down menu, which will show the questionnaires of the group in a table below. Click the +Add button to add the questionnaire group to the monitoring plan.
4. Added questionnaire groups are shown here along with the names of the questionnaires in each group.
5. Click Update.
6. The Monitoring plan will be updated with the new list of assigned questionnaire groups.

Ongoing patient care

Finding a patient

Searching by patient name

1. Click Find Patient from the main menu panel.
2. Type in the patient's first name and last name.
    - In France, this will find patients with the provided value as either their current name or their birth name.
3. Ensure that the status is set to Active in the drop down menu where available.
4. If you want to blank out the form: Click Reset form and type new information as required.
5. Click Find Patient.
6. Patient search results will display. Click on the patient's name to pull up the patient chart.

Other search options

Outside of France, you can also search for a patient by:

1. Health Care ID
2. Phone number
3. Username and/or
4. Patient group

In France, you can also search for a patient by:

1. Date of birth
2. INS Number

Simply click on the field on the find patient page, type in the information and click "Find Patient". Patient search results will display.

Reviewing all notes for my team

1. Click All notes for my team from the main menu panel.
2. All notes for your team/patients will display. Each row displays the patient name, note documented, type (e.g. normal or important), reminder date, whether it's been seen by you and whether it's been seen by another member of the team. Notes can be sorted by each column simply by clicking on the title. You can move up and down the list by clicking on the up and down arrows.
3. Click on the patient's name to view the patient chart.

4. Click directly on the note to view additional details of the note.

5. Click Mark As Read to indicate you have read the message. Once the note has been acknowledged by a user it cannot be edited.

6. Return to the note page. You will now see that the note has been seen by you.

See more information on notes under Viewing, creating and marking notes as read.

See and schedule upcoming video conferences with patients

The Calendar menu gives you an overview of any upcoming video conferences. The drop-down menu at the top of the screen provides the option to filter these meetings based on patient groups as well as by all meetings or just yours.

- Click the Create video conference button to schedule a video conference
- Click the Start video conference button to start an already scheduled video conference (see Conducting a video conference), or
- Click the Show conference to edit an existing scheduled video conference.

Overview screen

The overview screen is the default page displayed when the user logs into the system. This screen shows patients who have either:

1. Responded to the questionnaire,
2. have not carried out the questionnaire on time,
3. have an unread message, or
4. have a reminder note.

This is not the complete list of all your patients.

Patients are listed by severity of the alert color. Red alerts are shown at the top, then yellow, blue, orange, green and gray. The alert descriptions are shown based on data retrieved from the questionnaire. The colors signal the following:

1. **Red:** alert exceeded by one or more values which fall outside of the normal range.
2. **Yellow:** one or more values to be observed which fall outside of the normal range.
3. **Blue:** data not received before expected deadline.
4. **Orange:** clinical attention to review data within questionnaire.
5. **Green:** no alert limits are exceeded (however, it’s important to note that a patient’s condition may gradually worsen before an alert is triggered).
6. **Gray:** no new measurements, but an unread message either to or from patient.

You can view the overview screen by patient groups by using the filter feature. Additional actions include acknowledging alerts and responding to the various icons and alerts mentioned below:

- **Filter screen view**
    - Click on the drop down menu and select the patient group you would like to view. Depending on your access you may have one or more patient groups.
- **Alert icon** shows the alert triggered based on measured values and/or responses to the patient's questionnaire. Alerts may appear in red, yellow, blue, orange, green or gray.
    - Hover over the icon to see which questionnaire may have triggered the alert.
- **Unread messages from patient** will be previewed in bold next to a speech bubble icon.
    - Hover over the message to see the number of unread messages and the date/time of the last unread message.
- **Unread messages to patient** will be previewed in grey text next to a checkmark icon. Read messages will be previewed in grey text without any icon.
- **Patient name and ID**. Click on the patient's name or health care ID to view patient chart and profile. You will be brought to the completed questionnaire page for the patient.
- **Notes and Reminders**. A note or bell icon indicates whether there are any notes with or without reminders for the patient.
    - Hover over the icon to see the status on unread notes and/or reminders.
    - Click the icon to view unread notes/reminders and respond to them accordingly.

When hovering the mouse cursor over a specific patient, more information and actions are available.

- Unacknowledged questionnaires. Next to the alert counter, the total number of unacknowledged questionnaire replies is displayed.
- Clear alerts. A dropdown menu for acknowledging all green (or blue) alerts for the patient.
- Add note. Click to add a new note for the patient

When clicking anywhere else on the patient row, an overview of any unacknowledged questionnaire replies is shown. See "Reviewing completed questionnaires" for more information.

By default, data on the Overview page updates only when the page is refreshed. If you have the appropriate permissions (at the moment it's a beta feature), a toggle button will be displayed. This button allows the data to refresh automatically at regular intervals, provided no patient row is expanded. When the patient row is expanded, it is assumed a clinician is actively working on the patient and so to not disrupt the work a dismissable message will be displayed asking clinician if they wish to refresh the screen.

Navigating the patient menu

Reviewing completed questionnaires

1. Click on a patient name in the overview.

2. The Completed questionnaires page displays. This page is the default page when navigating to the patient menu context. Alternatively, click Completed questionnaires from the patient menu to access the page.

3. You will notice the following on the completed questionnaire page (see sections below for additional details):

    - **Period selection** displays the timeframe of completed questionnaires.
    - **Drop down labeled 'All questionnaires'** allows you to select a measurement/question to view at the top row.
    - **Column header** indicates the date and time the questionnaire was completed. When hovering over a column, various options to respond to results are shown in a drop down box above the column. Each column displays the patient's responses to each question (one question per row) within the questionnaire.

4. Review patient questionnaire responses by using the scroll bar to the right. You will notice responses are flagged yellow or red based on thresholds set per question. Respond to questionnaire accordingly.

Period selection

1. Click on the period/timeframe of choice to view completed questionnaires from the top menu.
2. The completed questionnaire results will display.
3. Click Choose period to specify the period you would like to see.
4. Click the calendar icon and select the preferred from and to date on the calendar.
5. Click Adjust.
6. The questionnaires will display for your specified timeframe.

Drop-down labeled 'All questionnaires'

1. Click on the drop down menu.
2. Select the questionnaire you would to see results from.
3. The table will now hide all completed questionnaire results that are not from that questionnaire.
4. Selecting the All questionnaires option from the drop-down will show all completed questionnaires as before.

Column header

Each column displays the patient's responses to each question within the questionnaire. The column header displays the date and time the patient completed the questionnaire along with the:

- Alert icon displaying the color triggered. Hovering over the icon reveals a summary of what threshold(s) has triggered the alert(s) in the questionnaire.

- Hover over the date and click link to View questionnaire result.
- Acknowledge icon. When hovering the column header for a questionnaire reply, click the Acknowledge drop-down and select this icon to acknowledge the questionnaire.
- Acknowledge and send receipt to patient icon. When hovering over the column header for a questionnaire reply, click the '**Acknowledge**' drop-down and select this icon to acknowledge the questionnaire and send receipt to the patient.

Blue alerts

If you want to remove all blue for the actual patient, hover over the Clear button in the top right corner and select the option Clear all Blue Alerts.

View questionnaire result

1. Click the date link to view questionnaire/ignore questionnaire/add comment.
2. The patient's questionnaire will display.
3. Review the questionnaire and add acknowledgement note as needed.
4. Type Acknowledgement note
5. Click Ignore if you would like to skip the measurement and exclude it from graphs/tables.
6. Click Acknowledge to acknowledge the questionnaire.

Acknowledging questionnaires with closure notes

Please note: The closure notes functionality is an optional add-on to the Doccla RPM system. If you cannot find the functionality on your Doccla RPM installation, and believe it should be present, please contact your local administrator. If you are the local administrator, contact support@doccla.com.

Acknowledge a completed questionnaire in the completed questionnaires overview

When closure notes are enabled and you click the **Acknowledge** icon as described in the previous section, you are now met with a popup asking you to select any relevant closure notes and write an acknowledgement note for the completed questionnaire to be acknowledged:

As before, the questionnaire is acknowledged when clicking on the 'Acknowledge' button.

Acknowledge a completed questionnaire when reviewing a single completed questionnaire

When closure notes are enabled and you are reviewing a single completed questionnaire then the 'view completed questionnaire' menu contains an extra 'closure notes' menu, where you have to select any relevant closure notes for the completed questionnaire to be acknowledged:

When clicking the 'acknowledge' button, the completed questionnaire is then acknowledged and the 'acknowledge note' and 'closure notes' values have been filled out in the 'view completed questionnaire' menu.

Adding measurements

Adding measurements is used when the hospital staff are adding measurements for the patient, e.g. in a video conference or a personal meeting in the hospital.

> ⚠ **Warning**
>
> Note that alerts are not generated for manually entered measurements. Please make sure that the values are reviewed by a qualified clinician.

1. Click Add measurements from the patient menu.

2. The Add measurement page will be displayed.
3. Select the measurement you would like to add from the drop down menu.
4. Click Add measurement.
5. The measurement field will be displayed.
6. Type the values manually based on information the patient provides you.
7. Click delete to delete the measurement if required.
8. Repeat steps 2-6 to add a measurement as needed.
9. Click Save when complete.
10. The measurement will now appear in the completed questionnaires section. Click on Completed questionnaires to view the added measurement(s).

Uploading, downloading and deleting patient files

> **Note:** This functionality is only available if the Patient Files feature has been enabled for your installation.

The Patient Files feature allows you to store .pdf files up to 20MB for a particular patient.

Uploading patient files

1. Select ‘Patient files’ from the patient menu.
2. Press ‘Select a file’.
3. Select the file you want to upload in your computer’s file explorer.
4. Confirm that you are uploading the correct file to the correct patient.
5. You will see an upload progress bar.
6. Once completed you will see an ‘Upload complete’ message and the file will be available to download.

Downloading patient files

You can download files that have been previously uploaded by you or other clinicians.

1. Select ‘Patient files’ from the patient menu.
2. Find the file you want to download in the table of available files.
3. Press ‘Download’ and choose a location in your computer to download the file to.
4. You will see an indication the file is downloading and download confirmation in your browser.

> ⚠ **Warning**
>
> Files are scanned for malware when uploaded to Doccla. Before downloading files ensure your device is secure and uses a reputable antivirus software.

Deleting patient files

You can delete files that have been previously uploaded by you or other clinicians.

1. Select ‘Patient files’ from the patient menu.

2. Find the file you want to delete in the table of available files.
3. Press the trash icon.
4. Confirm that you want to delete the file (once you've done this it cannot be undone).
5. Provide a reason for deleting the file (this will be made available in the audit log).

Viewing and changing patient basic data

1. Click Basic data in the patient menu.
2. The patient information will be displayed.
3. Scroll to the bottom of the page.
4. Click Edit.
5. Enter any new patient information as needed.
6. Choose the patient group(s) you would like to add.
7. Enter any relevant patient metadata.
8. Update any of the assigned contact persons in the Circle of care by adding new ones or changing existing ones.
9. Click Save. The patient information will be update and you will be brought back to the basic data page.

Edit/add patient thresholds

1. Click Basic data from the patient menu.
2. The patient information will be displayed.
3. Scroll to the bottom of the page.
4. Click Edit.
5. Scroll to the bottom of the page and click Add threshold to create/add a threshold measurement.

Add threshold

1. Select the Measurement type for the new threshold.

2. Select the Threshold type for the new threshold. Depending on the selected measurement type there are up to four possibilities:

    - Absolute
    - Relative latest
    - Relative period
    - Lag

    each of these will be described in the following.

Absolute thresholds

An absolute threshold compares a new measurement value with a fixed set of value limits when determining its severity.

3. Enter the relevant limits of the thresholds:

    - Red alert (high): Values greater than this trigger a red alert.
    - Yellow alert (high): Values greater than this trigger a yellow alert.
    - Yellow alert (low): Values lower than this trigger a yellow alert.

    - Red alert (low): Values lower than this trigger a red alert.

Example if a patient submits a blood pressure measurement where the systolic value is greater than 130 mmHg, then trigger a red alert, if it is less than 130 mmHg but greater than 110 mmHg, then trigger a yellow alert, and finally if it is lower than 110 mmHg then don't trigger any alert.

4. Press Create to create the threshold for the patient.

Relative latest threshold

A relative latest threshold compares a new measurement with the latest measurement received by looking at the change in value between the two measurements when determining its severity.

3. Select whether to define the threshold limits for the measurement value change as a percentage or an absolute value.
4. Enter the relevant limits of the threshold.
5. Press "Create" to create the threshold for the patient.

Example: if a patient submits a weight measurement where the change in value compared to the previous measurement is greater than 2.5 kg, then trigger a red alert, if it is less than 2.5 kg but greater than 1.5 kg then trigger a yellow alert, and finally if it is lower than 1.5 kg, don't trigger any alert.

> Because the relative latest threshold calculates the severity based on a previously submitted measurement, the very first measurement submitted by the patient will always trigger an orange alert, as the patient will have no prior measurements to compare it to. If an orange alert is shown, the clinician will need to assess the patient measurement manually.

Relative period thresholds

A relative period threshold compares a new measurement to the measurement received previously within a given time period that has the highest or lowest value, and then looks at the change in value between the two measurements when determining its severity.

3. Select whether to define the threshold limits for the measurement value change as a percentage or an absolute value.
4. Select whether to compare the measurement with the highest or lowest value received within the time period.
5. Select whether the time period should be the whole time the patient has been enrolled or a period of the last number of days. If the latter, then enter the number of days to look back in time.
6. Enter the relevant limits of the threshold.
7. Press Create to create the threshold for the patient.

Example: if a patient submits a weight measurement where the change in value compared to the lowest measurement received within the last 5 days is greater than 2.5 kg then trigger a red alert, if it is less than 2.5 kg but greater than 1.5 kg, then trigger a yellow alert, and finally if it is lower than 1.5kg don't trigger any alert.

Note: Because the relative period threshold calculates the severity based on a previously submitted measurement, the very first measurement submitted by the patient will always trigger an orange alert, because the patient will have no prior measurements to compare it to. If an orange alert is shown, the clinician will need to assess the patient measurement manually.

Aggregate thresholds

When adding a new patient threshold, of one of the above types, it is possible to make it aggregate. This means that a measurement value has to exceed the threshold for at least a certain percentage of the latest received measurements. For example, if an aggregate threshold is set to 40% of the last 5 measurements, it means that at least 2 of the latest 5 measurements, including the latest one, must exceed the threshold (be it absolute or relative). If there are not enough previous measurements to evaluate an aggregate measurement, the measurement will trigger an orange alert.

Example

If we have an **absolute** weight threshold with a **Red alert (high)** set to 100 kg with aggregation set to 40% of the latest 5 measurements we get the following set of severities:

Measurement sequence (kg)					Severity
95	95	98	99	101	OK
95	98	99	101	99	OK
98	99	101	99	102	RED ALERT
99	101	99	102	98	OK

Adding aggregate thresholds

On the Add threshold page:

1. Select the Measurement type for the new threshold.
2. Select the Threshold type for the new threshold.
3. Check the Aggregation checkbox to enable aggregation.
4. Enter the percentage of the looked at measurements that need to exceed a limit, and the enter the number of measurements to look at.
5. Enter the relevant limits of the threshold.
6. Press “Create” to create the threshold for the patient.

In the above example, the threshold should be read as a normal absolute threshold except that it now requires 3 (60%) of the 5 latest received measurements to exceed a limit before the measurement triggers a yellow or red alert.

Lag

In contrast to the previous threshold types that are used for calculating the severity of a measurement attached to a questionnaire or an external measurement. The lag threshold is used for calculating the severity of a stream of measurements being continuously submitted by a patient, e.g. in a Virtual Ward

scenario where a patient has a measurement device attached to them that continuously monitor and submits their vitals. The **lag** threshold works by looking at all measurements received within the last number of minutes and then calculates whether the trend of the patient's severity is changing, thus minimizing any false alerts in the case where a patient has a very brief spike.

3. Enter the number of minutes back in time the threshold should compare measurements.

4. Enter the relevant limits of the thresholds:

    - Red alert (high): values greater than this trigger a red alert.
    - Yellow alert (high): values greater than this trigger a yellow alert.
    - Yellow alert (low): values lower than this trigger a yellow alert.
    - Red alert (low): values lower than this trigger a red alert.

Example: if all pulse measurements submitted by the patient within the last 5 minutes have a value greater than 100 BPM then trigger a red alert, if all pulse measurements submitted by the patient within the last 5 minutes have a value greater than 90 BPM then trigger a yellow alert, etc.

5. Press Create to create the threshold for the patient.

Resetting a patient's password

1. Click Basic data from the patient menu.
2. Scroll to the bottom of the page.
3. Click Reset Code.

Printing patient basic information

1. Click Basic data from the patient menu.
2. Scroll to the bottom of the page.
3. Click Print.
4. Click OK when the printer pop-up displays.

Patient messages

To access patient messages, click Messages from the patient menu. If there are any unread messages from the patient, the number of unread messages will be shown in the menu item.

Alternatively, the messages feature can be accessed by clicking a message from the patient overview.

Choosing an organization

Patient messages are grouped into conversations by organizations. If the selected patient and the current clinician are both in a multiple patient groups, belonging to two or more organizations, you have to choose which organization to talk to the patient on behalf of.

This is done either by choosing one when accessing the messaging page or by using the organization drop down at the top right corner of the messaging interface.

The messages interface

The messages page for your patient contains:

- Most recent messages are displayed at the bottom of the page. Scroll up to view previous messages/history.
- Clinician messages are displayed on the right. Patient messages on the left.
- When hovering over a message bubble, the date/time and sender of the message will be shown.
- Unread messages from patients will have a “mark read” button next to them. Click Mark read to mark them as read.
- The small check mark icon next to sent messages indicates whether they have been seen by the patient. A thin, circled check mark indicates an unread message. A solid check mark indicates a read message.

Creating/sending a new message

Use the text field at the bottom of the screen to type a new message. Press Enter or click “Send” to send the message.

To enter a line break, press **Shift + Enter**.

Optional: if the patient has a mobile phone numbered in its basic data, it is possible to send a message as an SMS / text message by clicking on the small mobile phone icon on the right side of the “Send” button.

> **Note:** messages send as text messages won’t show up in the chat history.

Notice: There is no guarantee that SMS / text messages will be received by the patient and the confidentiality of SMS messages is also not to be guaranteed. Therefore critical or sensitive information must not be sent via the SMS message functionality.

Clicking on the speech bubble icon, to the left of the text field, displays a drop-down list of message snippets that can be inserted into the text field for common responses or clinician signatures. The list of message snippets can be configured on the clinician “Profile” page and in the “Message snippets” administration menu.

By clicking the paper clip icon, it is possible to attach images to a message. A preview of the image will be shown. Note that the image file will be attached as-is, so make sure that the resolution and/or file size is appropriate. The maximum file size is 8 MB.

Images in sent messages will be shown as thumbnails in the conversation. Click to enlarge.

When enlarged, an option to delete the attachment appears.

Click “Yes” to confirm the deletion of the attachment. This will cause the image to be deleted entirely from the server.

Patients can delete their own attachments. Clinicians can delete attachments belonging to both patients and clinicians.

Viewing, creating and marking notes as read

General notes

1. Click Notes from the patient menu.
2. The notes for your patient will display. Each row displays:
    - Patient Note. This displays the note documented for patient.
    - Type. This will be displayed as normal or important.
    - Reminder date. A date will display if a reminder has been set to perform an item requested in the note.
    - Seen by me? This will be displayed as yes or no.
    - Seen by another user? This will be displayed as yes or no.
3. The notes in your display view can be sorted by each column title based on your preference. Simply click the title you would like to sort by. Text fields will be sorted by A-Z, dates by most recent. You can also sort/move rows by clicking the arrows up/down.

Viewing notes and marking notes as read

1. Click the note you would like to view from the notes page.
2. The note will display along with type, the date of when the note was created, last edited and who it was created by. Notes cannot be edited once they have been acknowledged by a user.
3. Click Mark As Read to mark the note read.
4. The last edited time will be updated to the date/time “Mark As Read” was clicked.
5. Click on Notes from the patient menu to return to the notes page. You will notice “Seen by me?” now displays “yes”.

Creating a new note

1. Click Create from the notes page.
2. The Create Patient Note page will display.
3. Enter your patient note.
4. Select the type (normal or important) from the drop down menu.
5. Set the reminder date and time as needed.
6. Click Create.
7. The new patient note will display. Click Edit to edit note, Delete to delete note, and/or Mark As Read to mark your note as read.

Placing a pause on a patient’s monitoring schedule

To mark patient vacations or when a patient is away, use the “Monitoring pauses” page in the patient menu. Though patient is marked on vacation in the system, they can still perform scheduled questionnaires as needed. The nurse will advise on the patient monitoring plan which questionnaire to perform on vacation.

1. Click “Monitoring pauses” from the patient menu.
2. The “Monitoring pauses” pages will display with all past vacations and/or absence periods documented.

3. Click “Add”.
4. Click icon and select the “First day paused” date from the calendar. The “First day paused” is the date the patient will be away on vacation and/or unable to complete the questionnaire.
5. Click the date picker icon and select the “Unpause on” date from the calendar. The “Unpause on” date is when the patient will be able available to complete the questionnaire again.
6. Enter comment as required.
7. Click “Add”.
8. The following page will display. Click “Edit” if you need to edit the interval or click “Delete” to delete.

Viewing graphs

1. Click Graphs from the patient menu.
2. The graphs for each patient measurement will display. Scroll to view each graph.
3. Each graph will display the date on the x-axis, the measurement on the y-axis, graph title, legend and data.
4. To change the date selection and amount of data on the graph, click the preferred period you would like to view on the top navigation menu or click Choose period to select your own.

Viewing patient results

1. Click Measurements from the patient menu.
2. The patient measurements will display. Scroll down to view all measurements.
3. Each row will indicate the date/time the measurement was taken, the value, and unit of measure. You will notice the values will also be flagged yellow or red based on the set of thresholds for the measurement type.
4. To change the date selection and amount of measurement data displayed, Click the preferred period you would like to view on the top navigation menu or Click Choose period to select your own.
5. Thresholds colors will be displayed if measurement values have exceeded their thresholds.

Editing a patient’s monitoring plan and adding/removing a questionnaire

1. Click Monitoring plan from the patient menu.

2. The monitoring plan for your patient will display.

3. From the page you can complete the following (see instructions by referring to the highlighted sections below):

    - **Edit the start date for the patient to complete questionnaires.**
    - **View, edit, and delete assigned questionnaires.**
    - **Assign questionnaire.**
    - **Edit assigned questionnaire groups.**

Edit start date for patient to complete questionnaires

1. Click Edit from the Monitoring plan page.
2. Click and select the new date from the calendar.
3. Click Update.

4. If you want the patient to only be able to answer this questionnaire on the day of the scheduled deadline, mark the field indicating this.
5. You will be brought back to the monitoring plan page. Notice the monitoring plan start date has been updated.

Edit monitoring plan/schedule

1. Click Edit.
2. The patient's monitoring plan/schedule will display.
3. Update the information you would like to update on the monitoring plan.
4. Click Update.
5. You will be brought back to the Monitoring plan page and the information will be updated.

Delete monitoring plan/schedule

1. Click the trash can icon to delete the monitoring plan.
2. A confirmation pop-up will display.
3. Click OK to delete.
4. Click Cancel to exit the page if you have decided not to delete the monitoring plan.

Assigning questionnaire

1. Click Assign Questionnaire from the Monitoring plan page.
2. Select the questionnaire for the patient by clicking on the drop down menu.
3. Select the frequency/schedule for completing the questionnaire.
4. Once frequency is selected, additional options will appear on the screen below.
5. Complete the information in the field as shown.
6. Click Assign

Explanation of the different schedules:

- **Unscheduled:** The questionnaire can be completed at any time and as many times as you wish.
- **Weekdays - several daily measurements:** The questionnaire can be completed on specific days of the week and it is possible to make several measurements per day.
- **Weekdays - one daily measurement:** The questionnaire can be completed on specific days of the week with a single measurement per day.
- **Date(s) of the Month:** The questionnaire can be completed on specific dates of the month, e.g. the 1st and 15th of the month.
- **Every nth day:** The questionnaire can be completed on every nth day, e.g. a measurement every 3 days.
- **Specific date:** The questionnaire can be completed on a specific date.
- **Deadline at:** Questionnaire should be completed at the specified time of day. If a measurement frequency is selected with several measurements per day, multiple measurement times can be specified by clicking on the '+' button.

- **Reminder at:** Reminder sent a specified number of minutes before the deadline for the questionnaire.
- **Schedule window:** Used to indicate how long before a deadline a sent in questionnaire result is registered as being the result of a questionnaire. This is used to indicate a period in which a delayed questionnaire result is not counted as an in-time result for the next questionnaire deadline.
- **Weekdays:** First, select which weeks the first measurement frequency should be, e.g. 2 weeks. Next, choose which days of the week the patient should answer the questionnaire in the first period e.g. Monday, Wednesday and Friday. Then, which weekdays in the second period, e.g. Monday and Friday, for which the patient should answer the questionnaire. The second measurement period is valid as long as this questionnaire is valid for this patient.

Edit assigned questionnaire groups

1. Click Edit Questionnaire Groups from the Monitoring plan page.
2. The ‘Assign/remove questionnaire groups’ page will display showing the questionnaire groups the patient is already assigned.
3. Select a Questionnaire group in the drop down menu, which will shown the questionnaires of the group in the table below. Click the “+ Add” button to add the questionnaire group to the monitoring plan.
4. Added questionnaire groups are shown here along with the names of the questionnaires in each group.
5. Click Update.
6. The Monitoring plan will be updated with the new list of assigned questionnaire groups.

Conducting a video conference

In order to conduct a video conference:

1. Click on Video call in the patient menu.
2. Click on the Start Video Conference button to start a video conference with the patient. Note: when starting the video conference, the browser will open an embedded video app on the page and pop up an incoming call on the patient’s mobile or tablet.
3. Once the video conference is over you can click Leave video conference to close the video conference on the patient’s phone/tablet.

Downloading summary of recent patient data

1. Click on the Work log patient menu item
2. Enter a title of the work log summary
3. Select the date range from which to fetch measurements and messages
4. Click Retrieve Work Log
5. The text area now contains summary data of the most recent measurements and messages for the patient
6. Click Select text to copy the content of the text area to your clipboard so it can be entered into another system.

Using the Administrative button

Note: This feature is only available if the Administrative button has been enabled for your installation.

1. Click on Administrative in the patient menu.
2. Choose one of the following options:
    - **Copy pathway contact details** – copies the contact information for the patient's care team to your clipboard.
    - **Download discharge log** – downloads the discharge log for the patient's most recent stay as a PDF.
    - **Download patient log** – enter a From and To date to download a PDF containing the patient's activity within that period.

Dashboard screen

The ‘Dashboard’ is a page provided to see a list of all active patients in particular patient groups. Visibility of this screen is controlled by a user permission that admin users can apply or remove per user.

You can filter to any selection of patient groups you have access to and see a list of all the patients within them. By default, patients are listed by severity of the alert color.

Identifying patients

Each patient in the patient list is represented by name, surname, healthcare ID and username. On click of the info button you are also able to see patient’s date of birth and all the patient groups that the patient is in.

Seeing recent questionnaire submission

When a patient submits the questionnaire, the user interface displays an indication of a new questionnaire and its severity:

- **High**: alert exceeded by one or more values which fall outside of the normal range.
- **Low**: one or more values to be observed which fall outside of the normal range.
- **Unknown**: clinical attention to review data within questionnaire.
- **Within thresholds**: no alert limits are exceeded (however, it’s important to note that a patient’s condition may gradually worsen before an alert is triggered).

You can click on the indication and see the details of the questionnaire alerts. You can also click on the “Go to completed questionnaires page”button which will take you to the ‘Completed Questionnaires’ page which has all the questionnaire answers to review and acknowledge.

Seeing missing questionnaire submission

When the questionnaire submission is overdue, the interface displays a due icon indicating the length of time it has been overdue. The patient’s row is highlighted in blue unless there are other alerts indicating higher severity, in which case the color will change accordingly. For example, if a patient has unanswered questionnaires with high or low severity, a different color will be used to reflect the urgency.

You can click on the indication and see details of the overdue questionnaire. You can also clear the indication as you see fit.

Seeing new messages

When a patient has not read a clinician’s message or when a patient sends a message that has not been marked as “read” by a clinician, the interface displays an indication of a new message. You can click on the message indication and will be taken to the patient Messages page.

Seeing new notes

When there are notes left by other clinicians, the interface will display an indication of a new note. You can click on the note indication and will be taken to the patient Notes page.

Seeing NEWS2 Score

You can see the latest NEWS2 score generated for a patient in the NEWS2 column. Hovering on the NEWS2 score will show the measurements that contributed to the overall score and the number of points contributed by each measurement. It's also indicated what SpO2 Scale has been used to calculate the NEWS2 score.

In order for a NEWS2 score to be calculated, a questionnaire must be submitted with the following measurements completed:

- Respiratory rate
- Saturation
- Blood pressure and pulse
- Oxygen therapy
- Temperature
- Consciousness

An **SpO2 Scale 2** piece of metadata should be set in the patient's basic data. If this is not set, a NEWS2 calculation is made with SpO2 Scale 1 used (by default).

See https://www.rcp.ac.uk/improving-care/resources/national-early-warning-score-news-2/ for further information on NEWS2.

Ordering the patient list

You can select how you would like patients in the patient list to be ordered:

- **Alert severity:** the most urgent questionnaire results to least urgent (time awaiting acknowledgement where this is equal)
- **Latest questionnaire**: the most recent questionnaire respondent to least recent
- **Oldest questionnaire**: the least recent questionnaire respondent to most recent
- **Next due questionnaire**: the earliest due questionnaire time to latest

Filtering on patient status

As well as filtering by patient group and organization, you can also limit how many patients you see using the dashboard tabs:

- **Awaiting attention:** only patients with unacknowledged results, unread messages and unread patient notes (important or reminder)
- **Overdue:** only patients who have an unacknowledged alert for a missing questionnaire response

Passive monitoring

The Passive Monitoring dashboard provides a list of patients and their submitted vital signs such as pulse, saturation, respiratory rate, blood pressure, temperature and consciousness as well as a NEWS2 score. Access to this dashboard is controlled by a user permission that admin users can apply or remove per user.

For these observation types, it is possible for a patient to submit vitals either passively or intermittently via a scheduled questionnaire (daily, hourly etc.) in the patient app. The dashboard updates every minute with the latest values.

Dashboard Tabs

The Dashboard consists of two primary tabs:

- **All:** Displays all active patients filtered by selected patient groups. By default, previously selected patient groups remain selected in the filter dropdown. By default, patients are ordered by the most recently created patient at the top. Multiple groups can be selected simultaneously.
- **Needs Attention:** Displays only patients with unacknowledged or silenced alerts, filtered by selected patient groups. The list is ordered by patients who have been in an alerting state the longest. If patients appear in this tab, a red circle indicates the number of patients needing attention.

Hovering over each tab provides a tooltip with ordering information.

Viewing patient observations

1. Each patient row contains:
    - the patient’s name
    - healthcare ID
    - the most recent observation(s) they have submitted
    - an indicator for any patient submitted questionnaires
    - NEWS2 calculated value
    - if a patient is using SPO2 Scale 2
2. Each observation contains the latest value with its unit and when it was submitted.
3. Each observation is displayed alongside a severity indicator based on the alert thresholds configured for that patient.
4. On hover of NEWS2 value a modal of the contributing observations is displayed.
5. If a patient’s observations have triggered an alert, the alert (bell) button will be displayed before the patient’s name and the patient row will be highlighted in red.
    - On hover of an Alert (bell) button a modal of the contributing observations is displayed.
6. If the patient alert is silenced, a Silenced (crossed bell) icon will be displayed before the patient’s name.
    - On hover of a Silenced (crossed bell) icon a modal with the contributing observations, when the alert was silenced and who silenced the alert, is displayed.
7. If the patient is late with their scheduled questionnaire or if they have stopped sending their passive observations for longer than 15 minutes, a blue clock icon will be displayed below the missing observation timestamp.

8. By default, the dashboard displays all patients from “All” patient groups. On the top right hand side of the dashboard you can filter the groups by selecting one or more patient groups.

Filtering patients

You can filter to any selection of patient groups you have access to and see a list of all the patients within them. By default, patients are listed by severity of the alert color.

Device status

The status of the device is shown in the Device column - the statuses displayed (in order of priority) are:

- Not connected to the app
    - If it was ever connected (and when) is visible in the popover
- Battery charging
- Not being worn / Wearing issue detected
- Not optimised
- Battery level

NEWS2

The NEWS2 scoring system is based on six physiological parameters: respiratory rate, saturation, systolic blood pressure, pulse rate, temperature and level of consciousness. The NEWS2 value is calculated according to the specification found here.

NEWS2 calculation

A NEWS2 score is calculated based on the following criteria:

1. Within the last 15 minutes a new observation for each of the following types must have been received:
    - Respiratory rate
    - Saturation
    - Pulse
    - Systolic blood pressure
    - Temperature
    - Oxygen (is the patient receiving supplementary oxygen)
    - Consciousness indication
2. In the patient basic data for all patients, the following custom basic data should be configured and set:
    - SpO2 Scale 2 (does the patient suffer from hypercapnic respiratory failure, usually due to COPD)
3. The NEWS2 calculation is triggered only when all observations are received within the 15 minute window.

The NEWS2 value displayed will always be the most recently generated score, but there is also historical data in the form of a graph.

Severity indicators

The level of the abnormal observations is indicated by a 2-level Yellow and Red severity indicator icon displayed next to the observation value. The severity indicator will only be displayed if the most recent reading for that observation type is outside of the “Normal” threshold. If it returns to “normal” the indication will disappear.

Patient alerts

An Alert button is presented to the user when a patient has triggered an alert by submitting a single observation that is outside of their thresholds. Underneath the Alert button, the length of time the patient has been in an alerting state will be displayed (from the moment an alert is triggered until it is acknowledged or set silence time elapses).

An alert persists even if the observation value that triggered it returns to “normal”.

Alert context

On hover over the alert button, the Alert context is displayed: observations that triggered the alert (or observation ranges for vital signs measured passively) and any observations that occurred after the trigger but before the acknowledgment are displayed together with the severity indicators and breached thresholds. This allows the user to understand the cause of the alert even when observations are back to normal. When the alert is silenced, the Alert context is displayed on hover over the Silence icon together with the silence time, notes and the username of the clinician who silenced the alert.

Acknowledging alerts

To acknowledge the alert you need to click the Alert button - this will open up a modal with:

- the contributing observations to the alert
- a multiple selection list of preset notes
- free text area to input custom notes
- silence time select box
- ‘Acknowledge’ button
- ‘Close’ button

After clicking the Acknowledge button the alert button on patient row disappears and an acknowledgment is created and saved with:

- quick note
- custom note
- timestamp
- author of the note
- details of all observations at the time clinician opened the modal

Acknowledging an alert will silence it for a default of 10 minutes or the selected time. When an alert is acknowledged the Silence icon is displayed for the selected silence time or until the silence is broken.

Silencing alerts

Alerts can sometimes be “false alerts”, meaning that often the values that trigger alerts are normal for patients or can be caused by physical activity. This can introduce two risks:

1. alert fatigue
2. alert complacency

To avoid that, when acknowledging, clinicians can set a silence time - similar to the one used in monitoring machines in hospitals.

Alerts can be silenced for:

- 10min (default)
- 20min
- 30min
- 1 hour

When the silence time elapses either:

1. the patient observations are no longer out of thresholds and they return to a non-alerting state
2. at least one of the observations remains outside of the configured thresholds therefore the dashboard displays the Alert button again.

When a patient alert is silenced, a new alert will be triggered if:

- the alert severity of the silenced measurement type increases from Yellow to Red
- a different observation starts to alert. For example, if the Saturation is out of thresholds and returns to normal while Respiratory Rate increases outside of thresholds an alert will still be triggered to inform clinicians of new circumstances.

Missing observations

If a patient doesn’t submit their readings on time we display a blue clock icon and a lighter colour of the observation value. There is a different logic for intermittent and passive observations:

- For passive, the observation is considered missing if a patient does not submit a new reading in 20 minutes.
- For intermittent, the observation is considered missing if the patient does not submit a reading on time according to their schedule windows.

Patient detailed view

The patient detailed view presents more data about the patient:

- Name
- Healthcare ID
- Row of most recent observations
- Date of birth
- Age
- Historical data of patient observations
- Alerts log

Table

A table view provides readings at regular intervals for each observation type and step count.

- The table displays passive and questionnaire-based observations grouped by type
- Readings are displayed at 15-minute intervals. If more than one reading has been recorded in the time interval, a median value is displayed (with the exception of step count, where a sum is displayed for each interval).
- If no data was received for a particular time period this is displayed as '-' (for passive observations) or a blank cell (for questionnaire-based observations)
- A time period for readings can be selected. Choosing a number of hours will display all the readings from the current time backwards that number of hours. If a date range is selected, it will show all readings midnight to midnight for the date range, starting at the oldest date.
- The table does not update real time, you will need to refresh or select a time filter to see the latest values plotted. Threshold alerts are not displayed in the table view.

Graphs

The graphs are shown for each observation type, steps and the NEWS2 score.

1. For each observation type, a graph shows the trendline and the latest value is displayed
2. When hovering in the graph area, the corresponding observation value and timestamp are shown. Additionally, for the NEWS2, contributing observations are displayed.
3. The Steps are shown in the form of a bar graph, where each bar represents the amount of steps made every 15min. Additionally, above each day, the total of steps made each day is displayed.
4. The time filter buttons choose which data to plot, all graphs will use the same timeline. By default, "3 hours" is presented the user can select
    - 3 hours
    - 6 hours
    - 12 hours
    - 24 hours
    - Custom range, a date range with a maximum of 7 days at a time
5. The graphs do not update real time, you will need to refresh or select a time filter to see the latest values plotted

Alerts log

When clicking on the "Alerts log" tab, a history of alerts is displayed. The most recent acknowledgements are at the top of the list.

For each incident is shown:

1. The alerting observations with thresholds breached and timestamp of the alerting observation being submitted.
2. The acknowledgement consists of:
    - pre-set note(s)
    - custom note
    - silence time period
    - username of the clinician
    - timestamp

3. It is possible to filter incidents by time period. By default, “Last week” is presented the user can select:
    - Last 24 hours
    - Last week
    - All

Clinician app

The Clinician app is designed to be used on a tablet or phone in a context where the clinician is located in the field and doesn't have access to a stationary desktop. The Clinician app can be accessed by opening the corresponding app or by any browser. The best functioning browsers for this purpose is Google Chrome, Mozilla Firefox or Microsoft Edge.

Logging into the app

1. Open the OTH Clinician app on your Android or iOS device of choice.
2. Type your clinician username and password. Your username and initial temporary password will be provided by the administrator. Upon initial login, you will be asked to change your password. Passwords must be at least 10 alpha numeric characters in length and must contain 1 number.
3. Click the 'Login'-button.

Clinician menu

Upon login, the Clinician menu is displayed, which is divided into two halves. The first section, **Patient(s)**, is a form where patient search criteria can be entered, while the last section, **Results**, shows the corresponding search results.

> If a warning is shown about missing permissions, you will need to contact an administrator.
> If this warning is present you can't expect to create or act on behalf of patient(s).

Searching and acting on behalf patient(s)

1. Enter the relevant patient search criteria or none at all to request all patients.
2. Click the 'Search'-button and wait for the results to load.
3. Find the desired patient in the scrollable result list.
4. Click on the patient you want to act on behalf of and wait for the patient menu to load.

You should now be able to act on behalf of the chosen patient and see which patient you are acting on behalf of.

Completing questionnaires the patient has not been assigned

Because you are acting on behalf of another patient you should be able to complete questionnaires apart from the ones the patient has been assigned.

When in the Patient menu:

1. Click the 'Start visit'-button to see the assigned questionnaires.
2. Click the 'Other questionnaires'-button.

The page containing the Other questionnaires menu should now be displayed.

3. Pick one or more questionnaire groups or none at all to request all questionnaires.
4. Click the 'Search/Search all'-button and wait for the results to load.

5. Find the questionnaire you want the patient to complete.
6. Click on the chosen questionnaire and the questionnaire should be rendered.

Creating a patient

When in the Clinician menu:

1. Click the ‘Create’-button.

The Create patient page should be shown.

2. Enter the new patient information in the Basic data form.

A red asterisk* indicates that a field is mandatory and must be filled out. The patient Health care ID is the unique patient identifier. Likewise, the Username must also be unique. You can either use the automatically generated temporary password or enter one manually; passwords must be at least eight characters in length and contain at least one number.

⚠ Warning

If the chosen patient groups contain thresholds they will be inherited. In case of overlapping thresholds, the thresholds of the first chosen patient group will be applied

3. Once the Basic data form has been filled out, continue by filling out the Contact information form in a similar fashion.
4. Click the ‘Create patient’-button.

The app should now create the patient and navigate to the Patient menu of the newly created patient.

Addendum

Reporting patient incident

Any serious incident that occurred in connection with the use of Doccla RPM must be reported to Doccla Denmark via support@doccla.com and the competent authority of the Member State where the user and/or patient is established.

Precautions

The information in this document are subject to change without notice.

Legal Notices

Doccla Denmark declares that the Doccla RPM software application is a medical device and is CE-marked in conformity with Regulation (EU) 2017/745 (MDR). The device complies with the applicable General Safety and Performance Requirements of the MDR. Conformity assessment was carried out by Kiwa Assurance B.V, NB no. 1912.

Manufacturer

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Manufacturer responsibility

The manufacturer is only responsible for the software of Doccla RPM itself. No parts of this document may be reproduced or translated without the prior written permission of the manufacturer.

End of life (EOL)

The product’s End of life (EOL) is 2 years after release. After EOL there is no product support. The date for EOL can be found on the product label.