

NeoCare

Integrated Information System for Neonatology and Paediatric Units





Software

NeoCare

The full and integrated
Suite for the computerized
management of NICU
and Paediatrics wards

NeoCare is the IT solution that fully supports all clinical and working processes in **Paediatrics wards NICU** and **Neonatology units.**

NeoCare meets all organizational and core needs on the ward by automating treatment procedures, information exchange among nurses and doctors as well as between families and the medical staf.

NeoCare was designed together with specialists and clinicians. **It has been certified as I° class Medical Device** according to EU Directive 93/42/EEC it is being used daily both in Italy and abroad in more and more hospitals.



Benefits

According to users' feedbacks, NeoCare is the most efficient application for communication among Neonatology medical staff.

- Easy to use
- Fully configurable and integrable
- Information always available
- Formalization of clinical data
- Activity check
- Reduction of clinical risk and activity tracking
- Disaster recovery and Business continuity
- Waste reduction, work optimization of medical staff



The assisted generation of treatment plans refines the preparation and dilution of drugs, thus minimizing unused quantities

Clinical records always on-line reduce the requests coming from laboratories

Paperless clinical records make access to information quicker and eliminate copying time

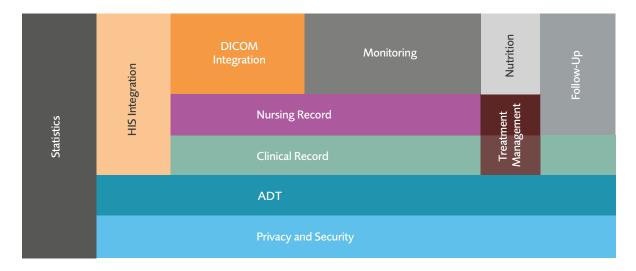
The time spent to drawing up the Hospital Discharge Register and the Hospital Discharge Letter is reduced

Optimize the use of follow-up and outpatient agendas

Compatible medical devices

- Multiparameter monitoring systems
- Infusion systems
- Ventilators
- Analyzers
- Incubators
- Oximeters
- ECMOs

NeoCare Modules



Privacy and Security

Authentication, authorization, ownership and traceability of information are guaranteed with the EU General Data Protection Regulation (2016/679) Even smartcard/badge and fingerprint readers are supported.

ADT

Manage the patient admission/discharge/ transfer, the automatic generation of discharge register and letter, including the ICD9 or ICD10 diagnosis, as well as other ward documentation. It is based on a problem oriented method for the collection and organization of clinical data.

Clinical Record

Manage the planning and execution of treatments according to a clinical model: the doctor prescribes the treatments, which are automatically copied in the nursing record, thus preventing nurses from rewriting them. Functions available on the clinical record enable to record

all data concerning treatments and care including medical history notes, monitoring and educational interventions and medical assessments.

Treatment Management

Automatic controls to support the medical staf in the drug management process, thus reducing clinical risks and increasing security in drug dispensing and administration. Moreover, the prescription of treatments is based on protocols that enable to check data previously typed in by doctors (minimum-maximum dosage, infusion and volume calculation, frequency calculation, check of the administration route, newborn-treatment-dosage control).

Nutrition

Management of enteral and parenteral nutrition. It enables to use one or more parenteral administration schemes, depending on the newborn's conditions, to view all previous administrations and compare them with the growth curves.

Nursing Record

Enable the registration of information acquired daily by nurses: procedures, infusion treatments, surgeries and vital signs detected by medical devices.

Monitoring

Enables the integration with medical devices in order to acquire, collect and register vital signs, for example: pulse oxymeters, cardiorespiratory monitor devices, incubator, ventilators and any other device for the monitoring of the newborn.

Follow Up

Manages outpatients and follow-up agendas. It enables to schedule medical examinations on more than one agenda, to record the results of visits, to view the figures of growth curves and rate.

HIS Integration

Integration with the hospital information system, specifically with the ADT (admission/discharge/transfer) module, LIS or RIS requests and results and the hospital clinical data repository.

DICOM Integration

Manages the view of DICOM images coming from electromedical devices (ultrasound scanner, electrocardiograph, etc.) and their uploading on the worklists linked to those devices. Moreover it enables the uploading of worklist on the medical records.

Statistics

For the customizable processing of statistics based on information available on the ward database.



Main Functions

Management of the newborn's personal details

Management of hospital admission, day hospital and follow-up

Management of medical history and assesments

Management of clinical and nursing diary



Recording of the newborn's problems

Recording of clinical notes

Prescription, execution and reporting of diagnostic procedures and referals

Prescription, preparation and administration of therapies

Vital sign monitoring

Food prescription and administration

Recording of educational interventions for the parents

Automatic recording of the daily planned care into the nursing diary

Display of growth curves and rate

Vital signs trend

Automatic generation of hospital discharge register including and ICD9-CM diagnosis and procedures

Automatic generation of personalized discharge letters

Customized reports

Generation of ward statistics



Reference

Italy

- LECCOOspedale Manzoni
- MILAN
 Fondazione IRCCS Cà Granda Ospedale
 Maggiore Policlinico
- BRESCIAPoliambulanza
- TREVISO
 Ospedale S. Maria di Ca' Foncello
- FERRARA Arcispedale Sant'Anna
- BARI
 ASL Bari Ospedale di Venere
 Policlinico di Bari
 CBH Mater Dei Hospital
- ACQUAVIVA DELLE FONTI (BA)
 Ospedale F. Miulli
- SAN GIOVANNI ROTONDO (FG)
 IRCCS Casa Sollievo della Sofferenza

Hungary

- NYÍREGYHÁZA
 Szabolcs-Szatmar Hospital
 Jósa András Hospital
- SZOLNOK
 Jász Nagykun Regional Hospital
- FEHÉRGYARMAT
 Kórházés Gyógyfürdő Hospital and
 Medicinal Bath

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