CareIT HMS

OFFICIAL USER GUIDE

Running your facility on one record — a guide for every role.

Step-by-step instructions for the front desk, clinicians, nurses, pharmacists, cashiers, and administrators — across all 29 modules of the CareIT Healthcare Management System, illustrated with the real product interface.

CareIT Healthcare Management System
User Guide · Edition 1.0

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About this guide

This guide explains how to use CareIT HMS day to day. It is organised the way the product is organised — by the sidebar areas you see on screen — and written for the people who actually operate a facility: front-desk staff, clinicians, nurses, diagnostic teams, pharmacists, cashiers, and administrators. Read your own chapters; skim the rest.

Every screenshot in this guide is the real product interface, captured from a live CareIT HMS instance seeded with realistic **sample data**. No name, result, or amount shown belongs to a real patient.

Conventions used in this guide

Bold text names a button, field, tab, or menu item exactly as it appears on screen.

`/appointments` is the address of a screen — every screen lists its own.

`Ctrl` + `K` marks a keyboard shortcut.

Numbered lists are steps to follow in order. Bulleted lists describe what a screen offers.

TIP

What you see depends on what you may do. Navigation, buttons, and whole modules appear only when your account holds the matching permission and your facility licenses the module — so your sidebar may show fewer entries than the screenshots here. That is by design, not an error.

PATIENT SAFETY

CareIT HMS enforces clinical safety rules in software: records are append-only, critical results escalate on deadlines, and worklists order by clinical priority. Where a rule changes how you work, this guide marks it with a box like this one — read those even when skimming.

Contents

1 **Getting started** 5

1.1 Signing in 5

1.2 The workspace 5

1.3 The identity banner 5

1.4 Time, records, and access — three rules to know 6

1.5 Dashboard & notifications 6

2 **Front desk & scheduling** 8

2.1 Finding a patient 8

2.2 Registering a new patient 9

2.3 The patient chart 10

2.4 Booking & the appointment board 11

2.5 The walk-in queue 12

2.6 Merging duplicate records 12

3 **The encounter chart** 14

3.1 Starting an encounter 14

3.2 Working the chart 14

3.3 Closing the encounter 15

4 **Inpatient, emergency & acute care** 17

4.1 Emergency department 17

4.2 Admissions & the bed board 18

4.3 The eMAR — medication rounds 19

4.4 Intensive care 20

4.5 Operating theatre 21

4.6 Maternity 22

5 **Specialty suites** 23

5.1 Dental — the odontogram 23

5.2 Optometry 24

5.3 Vaccination 25

5.4 Telemedicine 26

6 **Diagnostics & medication** 27

6.1 The order worklist 27

6.2 Critical results 28

6.3 Radiology 29

6.4 Pharmacy 30

7 Care coordination 4

7.1 Treatment plans 31

7.2 Messages 32

7.3 Patient portal administration 33

7.4 Mobile devices & offline sync 34

8 Billing & finance 4

8.1 From charges to an invoice 35

8.2 Invoice detail & discounts 36

8.3 The cashier desk 37

8.4 Insurance claims 38

8.5 Accounting exports 39

9 Operations 4

9.1 Inventory 40

9.2 Purchase orders 41

9.3 Workforce 42

9.4 Reports 43

9.5 Analytics 44

9.6 System health & backups 45

10 Administration & security 4

10.1 Modules & licensing 46

10.2 The audit log 47

10.3 Your account's security 48

A Appendices 4

A.1 Screen directory 49

A.2 Glossary 50

A.3 Getting help 51

CHAPTER 1

Getting started

Signing in, finding your way around, and the three ideas the whole system is built on: one record per patient, facility time, and permissions that shape what you see.

1.1 · Signing in `/login`

1. Open your facility's CareIT HMS address in a modern browser and enter your **work email** and **password**, then select **Sign in**.
2. If your account has two-factor authentication enabled, enter the six-digit code from your authenticator app when prompted. A one-time **recovery code** works here too if your phone is unavailable — each recovery code works exactly once.
3. You land on the **Dashboard**. If your session expires mid-shift, the system asks you to re-authenticate and returns you to where you were — unsaved form entries are kept where the screen supports it.

> **TIP**
> Changing your password signs out every other session and device on your account. If you suspect someone else has your password, changing it is the fastest way to cut them off.

1.2 · The workspace

Every screen shares the same frame:

- **Sidebar (left)** — modules grouped by area: Overview, Clinical, Specialties, Diagnostics & Meds, Coordination, Finance, Operations, and Settings. You only see the modules your facility licenses *and* your permissions allow.
- **Global search (top)** — press `Ctrl` + `K` anywhere to search patients, orders, and pages without touching the mouse.
- **Theme toggle** — switch between light and dark; your choice is remembered per device.
- **Notification bell** — critical results, critical findings, and published rosters arrive here. Notifications carry titles and references only, never clinical content, so a glanced-at screen never leaks patient data.
- **Profile menu** — your roles, security settings, and sign out.

1.3 · The identity banner

Every clinical screen pins the same **patient identity banner** above its content: name, age, sex, MRN, and — most importantly — **active allergies**, highlighted in red. Before you chart, order, prescribe, or administer anything, the banner is your confirmation that you are in the right chart. If the banner surprises you, stop.

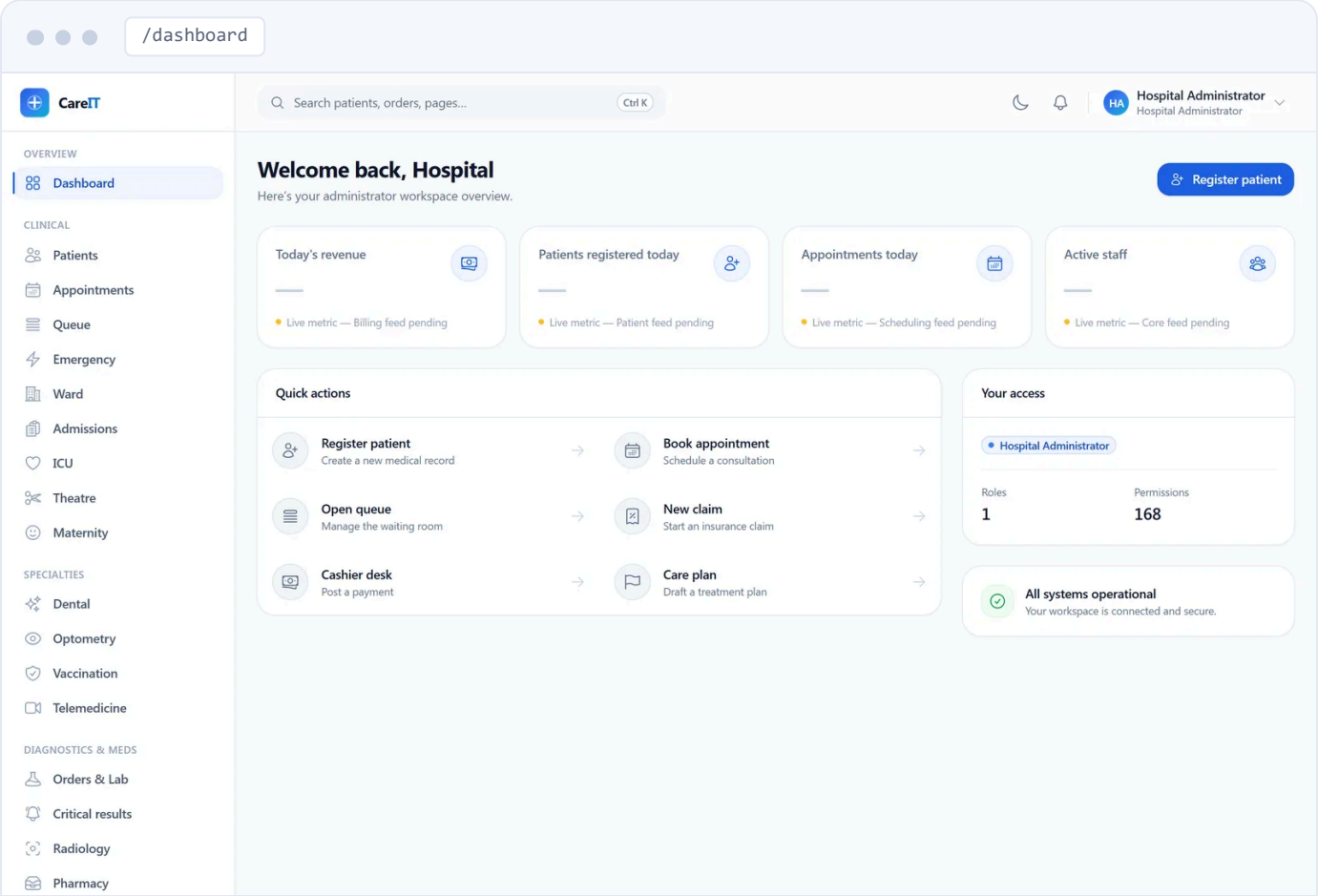
PATIENT SAFETY

The allergy chip in the banner is fed by the patient's active allergy list — and it survives record merges: when duplicate charts are merged, active allergies move to the surviving chart automatically so the prescriber always sees them.

1.4 · Time, records, and access — three rules to know

- **Every time you see is facility time.** Boards, schedules, and dose times display in your facility's own timezone — the "today" on the appointment board is your today, regardless of where the server runs.
- **Clinical records are append-only.** You can amend a note, correct a flowsheet entry, or supersede a prescription — but never silently edit or delete. The prior version stays readable with authorship, which is what makes the record defensible.
- **Access follows the action.** Permissions are per action (viewing a chart, signing a note, approving a discount). In an emergency, **break-glass** access is always available to those authorised for it — and always lands in the audit log.

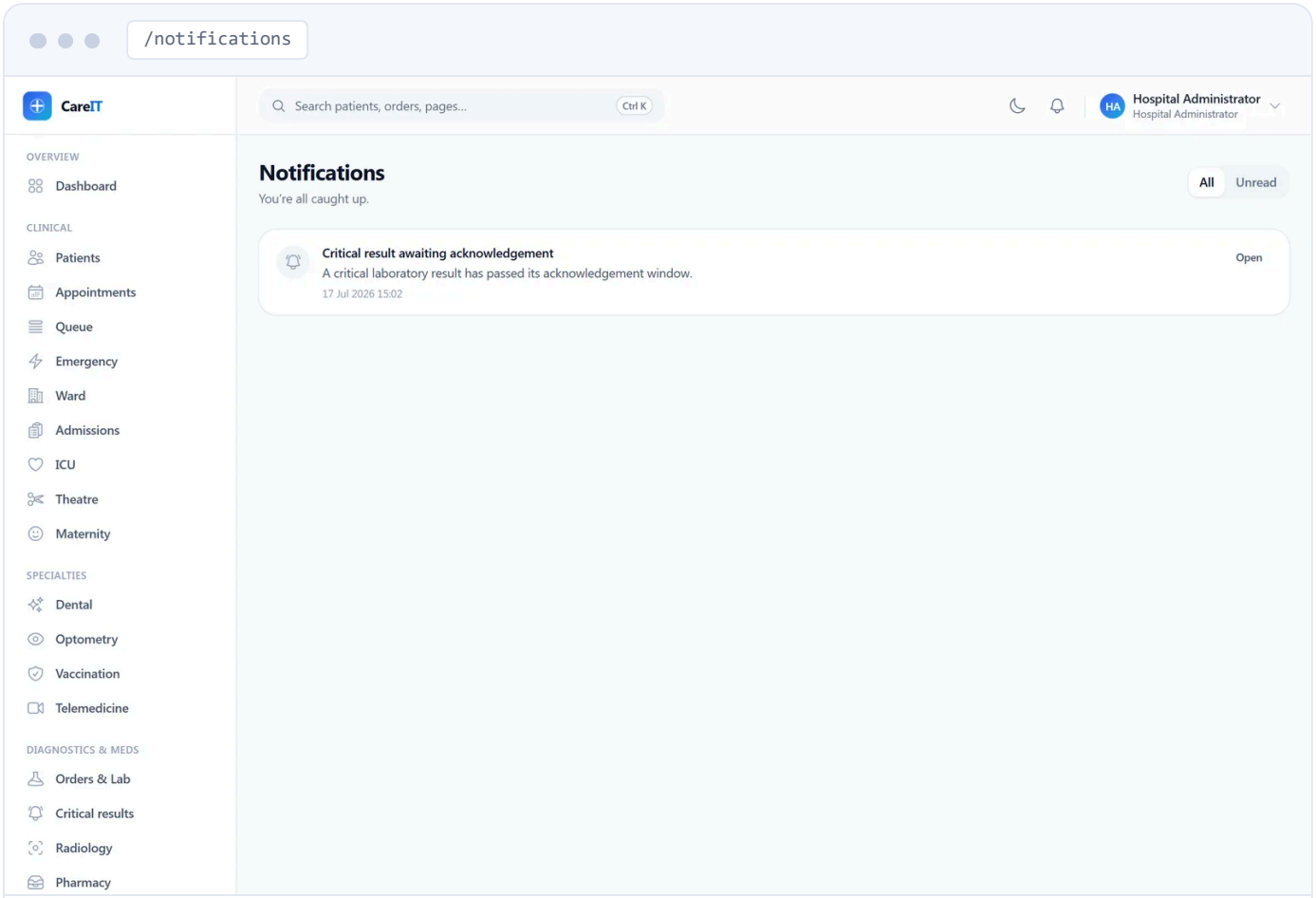
1.5 · Dashboard & notifications `/dashboard`



The dashboard — quick actions filtered to your permissions, your access summary, and system status.

- **Quick actions** jump straight into the flows you use most — register a patient, book an appointment, open the queue, start a claim, open the cashier desk. Only actions you are permitted to take appear.
- **Your access** lists the roles and permission count on your account — the first place to look when a screen you expect is missing.

- **Live metric cards** fill as their data feeds flow; a card that reads *feed pending* is being honest, not broken.



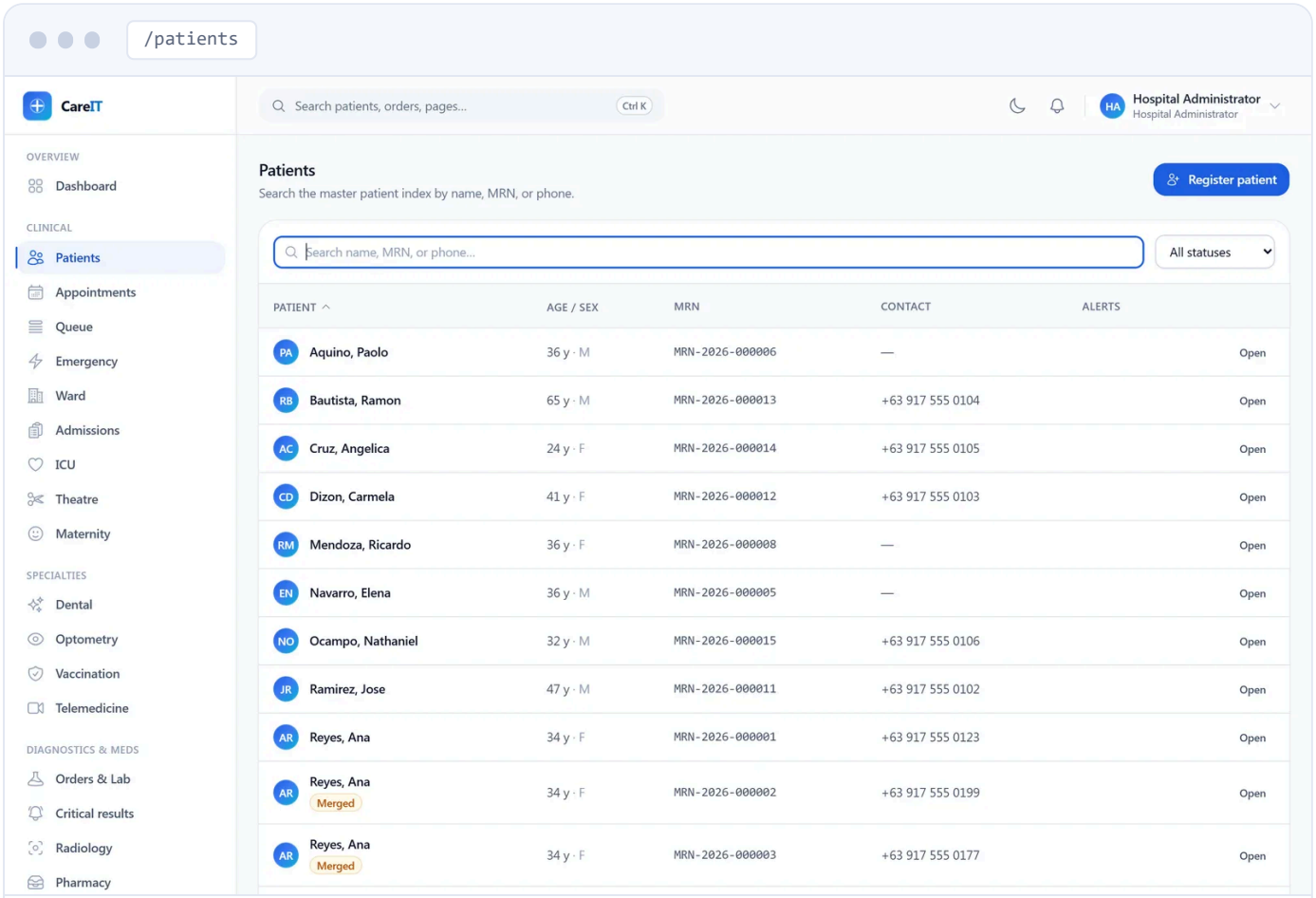
The notification inbox — every entry deep-links to the screen where you act on it.

CHAPTER 2

Front desk & scheduling

Finding the right chart, registering without creating duplicates, booking the day, and running an honest walk-in queue.

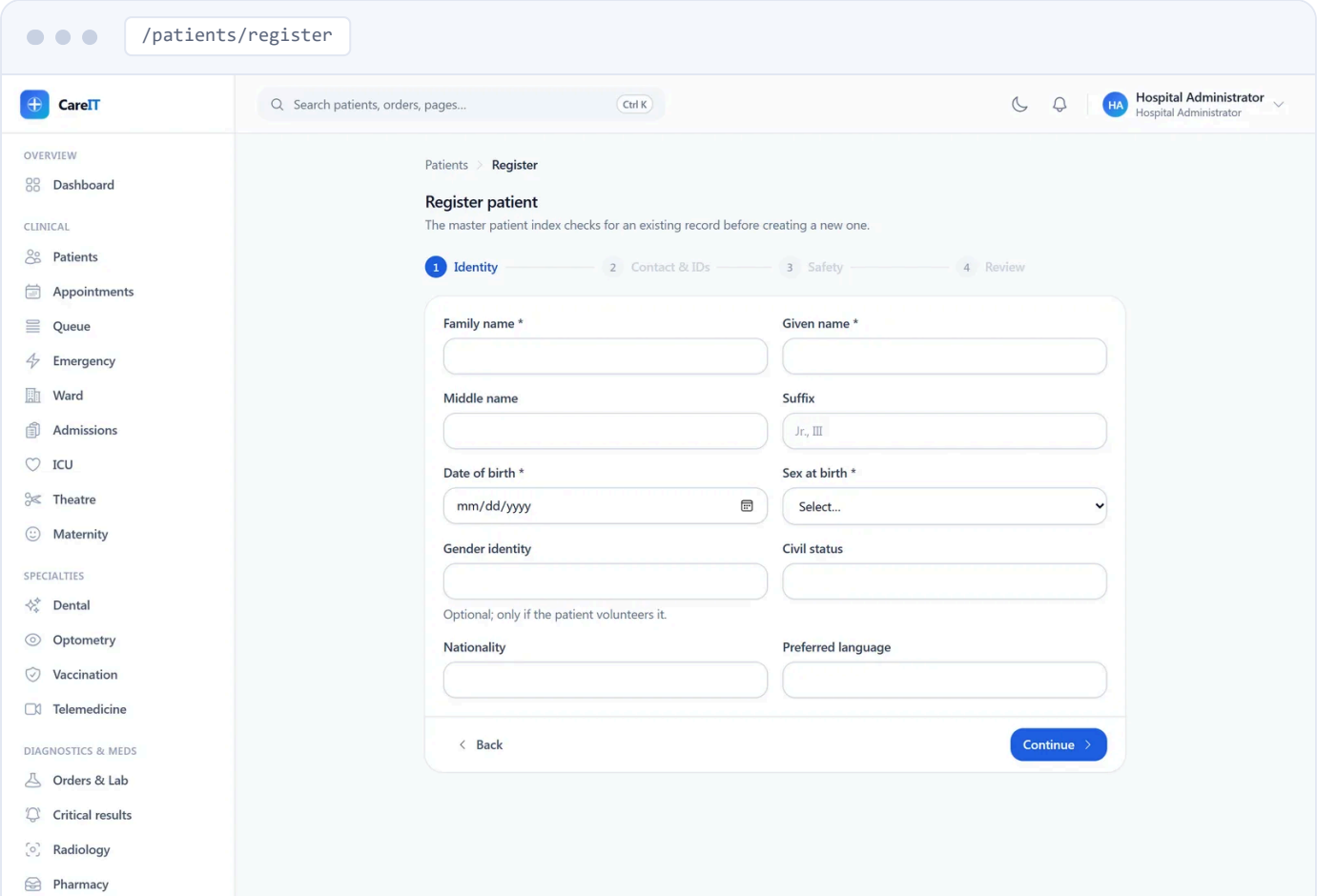
2.1 · Finding a patient `/patients`



The master patient index. Merged duplicates stay listed with a badge — history is never hidden.

1. Open **Patients** and press `/` to focus the search box.
2. Type a **name**, **MRN**, or **phone number** — results filter as you type, and the Alerts column flags charts with active allergies.
3. Select the row to open the patient's chart. If you see two candidates that are clearly the same person, don't pick either — flag it for a **merge** (§2.6).

2.2 · Registering a new patient `/patients/register`



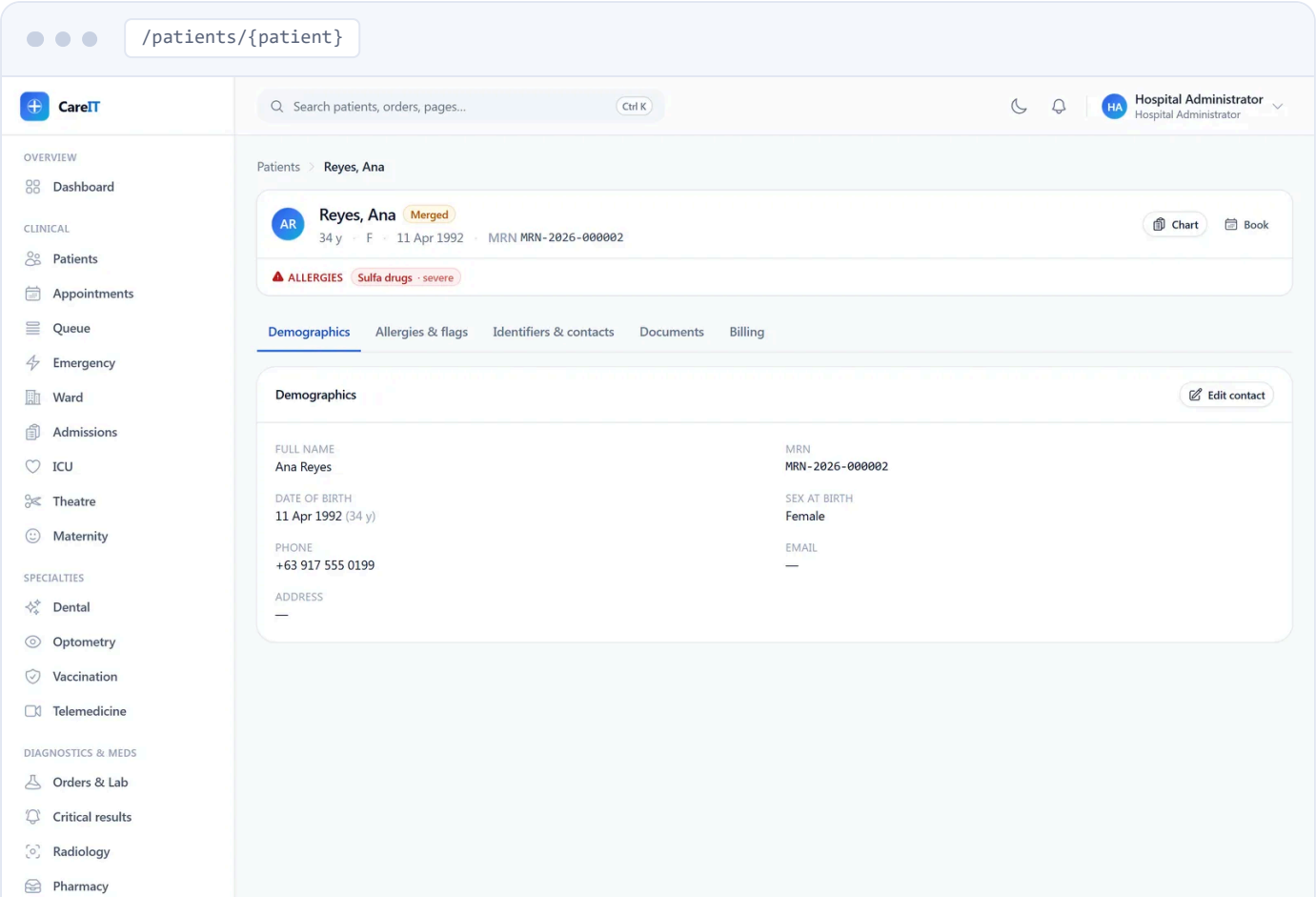
The four-step registration wizard — identity, contact, identifiers, review.

1. **Identity** — family name, given name, date of birth, and sex at birth are required; middle name, suffix, gender identity, civil status, nationality, and preferred language are captured here too. Select **Continue**.
2. **Contact** — phone, email, and address.
3. **Identifiers** — government IDs and other identifiers. These are encrypted at rest; staff later see only masked values.
4. **Review** — check the summary and select **Register**. The system assigns the next **MRN** from your facility's number series.
5. If the MPI finds a likely duplicate — same name and birth date, or a matching identifier — a **duplicate-resolution dialog** opens before anything is saved. Compare the candidates: open the existing chart if it's the same person, or confirm **Register as new** if it is genuinely someone else.

PATIENT SAFETY

Two charts for one person means allergies on one and prescriptions on the other. The duplicate check exists to stop that at the door — never bypass it just to save a queue a minute.

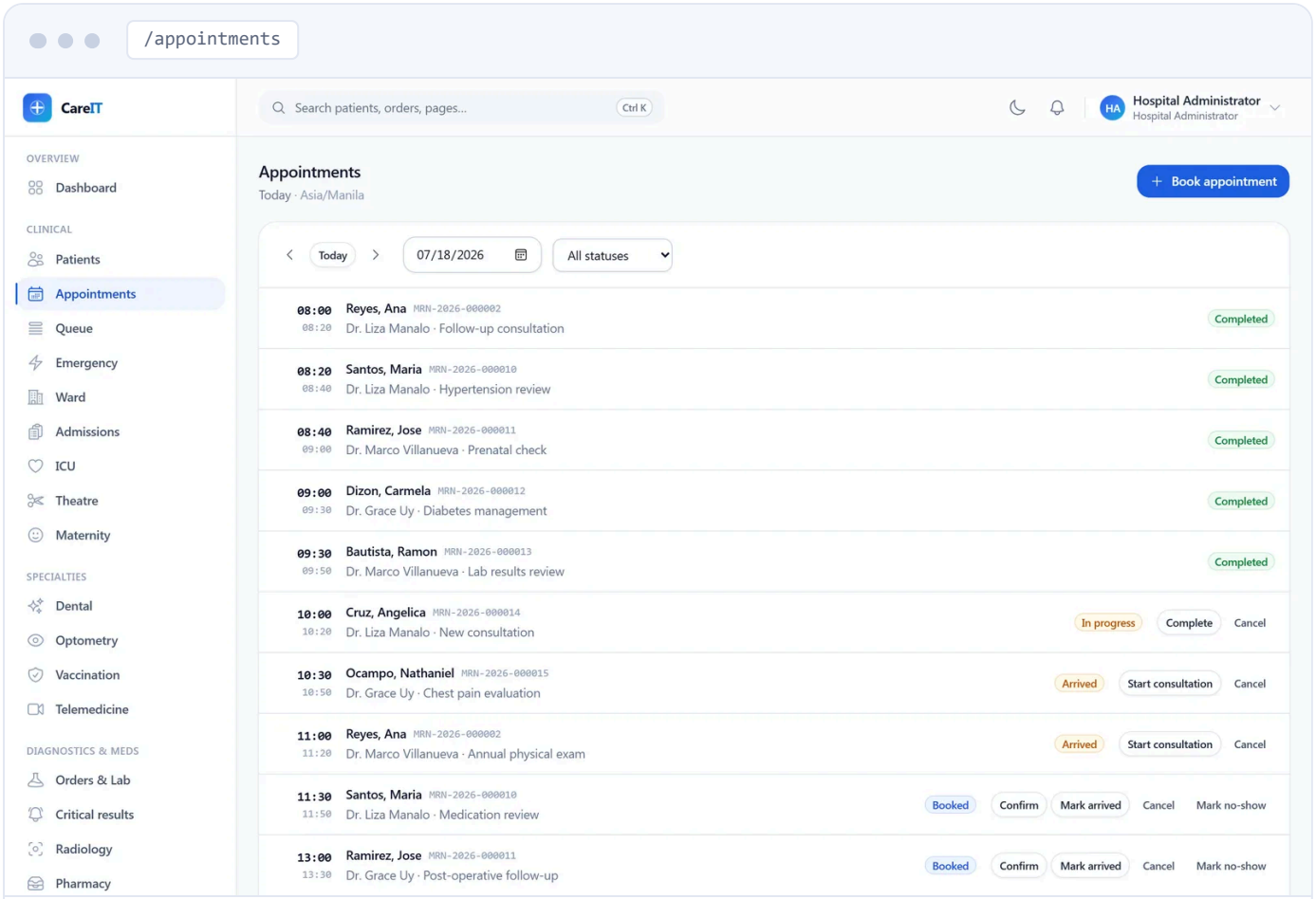
2.3 · The patient chart `/patients/{patient}`



One patient, one page — identity banner on top, everything else in tabs.

- **Demographics** — the registered details, with inline editing of contact information for staff with update rights.
- **Allergies & flags** — active and resolved allergies with severity and reaction. Entries here feed the red banner chip on every clinical screen.
- **Encounters** — the visit timeline, and where a new encounter starts (§3.1).
- **Documents** — upload referral letters, IDs, and results from outside. Files are stored under server-generated names, checksummed, and every download is logged as a PHI read.
- **Billing** — the charges captured against this patient, and the invoices they became (§8).

2.4 · Booking & the appointment board `/appointments`



The day board — each row offers exactly the actions its status allows.

Book an appointment

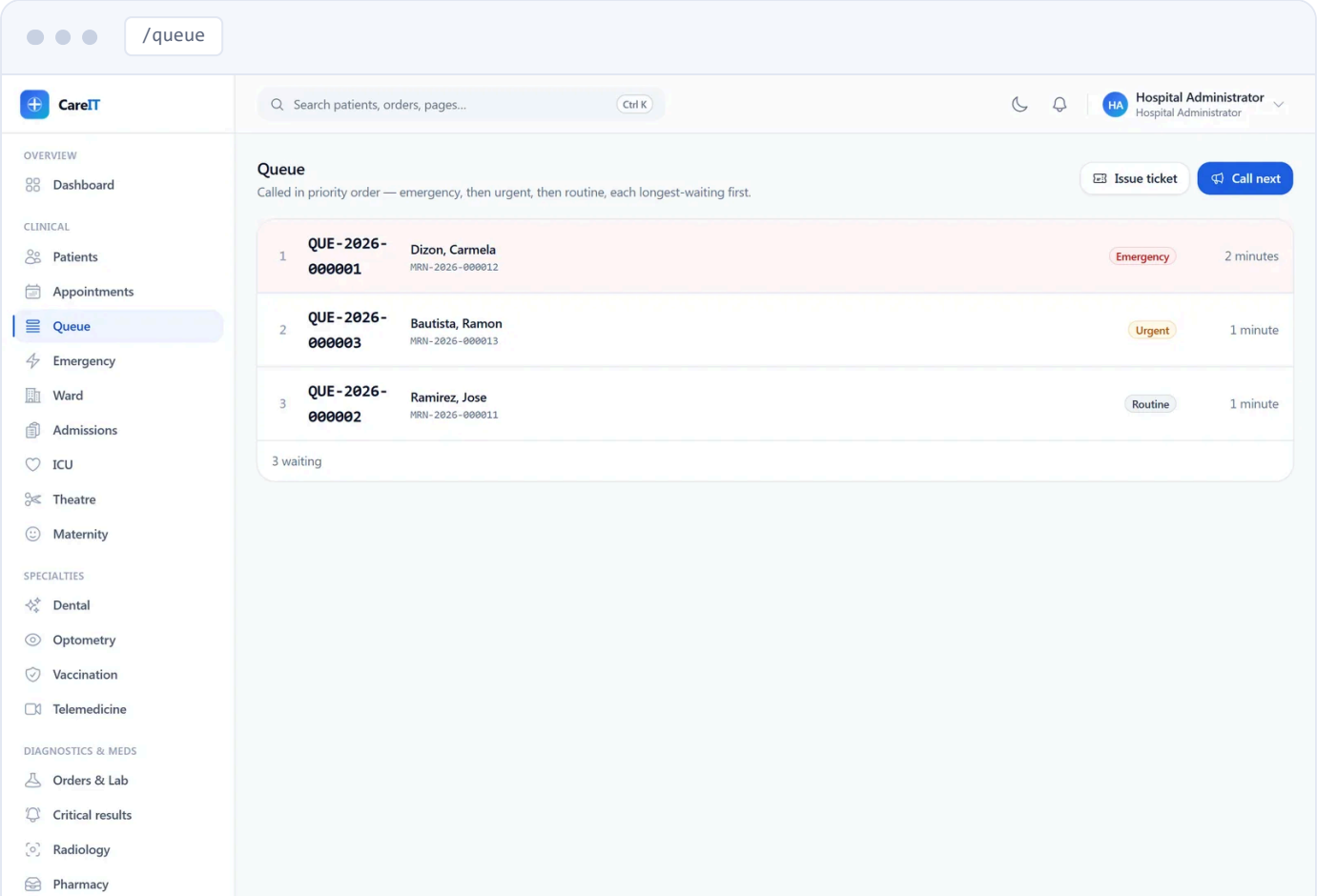
1. From the board, select **Book appointment**.
2. Search for and confirm the patient — their identity banner appears so you know you have the right chart.
3. Choose the **practitioner** and pick an open **slot** from their schedule. The slot is held for you while you finish, so two desks can't book it at once.
4. Add the reason for the visit and select **Book**.

Run the day

1. Use the date navigation (**Today**, arrows, or the date picker) and the status filter to work the list.
2. As patients arrive, select **Mark arrived**; when the consult begins, **Start consultation**; afterwards **Complete**. Use **Cancel** or **Mark no-show** when they apply.

> **TIP**
> The actions on each row come from the server's state machine. If a button isn't there, that transition isn't legal from the appointment's current state — not a display problem.

2.5 · The walk-in queue `/queue`



Queue tickets order emergency → urgent → routine, then by arrival — enforced by the server.

1. Select **Issue ticket**, find the patient (register them first if they're new), and choose a **priority class** — routine, urgent, or emergency.
2. The board lists tickets in calling order. An emergency ticket goes to the top regardless of when it was issued.
3. At the counter, select **Call next** — the system picks the correct ticket; you never choose by eye.

2.6 · Merging duplicate records `/patients/{patient}/merge`

1. Open the **duplicate** chart (the one to retire) and choose **Merge**.
2. Select the **surviving** chart. The screen shows both records side by side with conflicts called out — check names, birth dates, and identifiers carefully.
3. Pick an **approver** — merges need a second person, and the list won't offer you your own name.
4. Confirm. The duplicate is marked merged and stays visible with a badge; its **active allergies and contacts move** to the surviving chart automatically.

PATIENT SAFETY

A merge is one of the few actions that changes what a prescriber will see — which is exactly why it takes two people and shows its work. If anything about the pair looks wrong, stop and escalate rather than approve.

CHAPTER 3

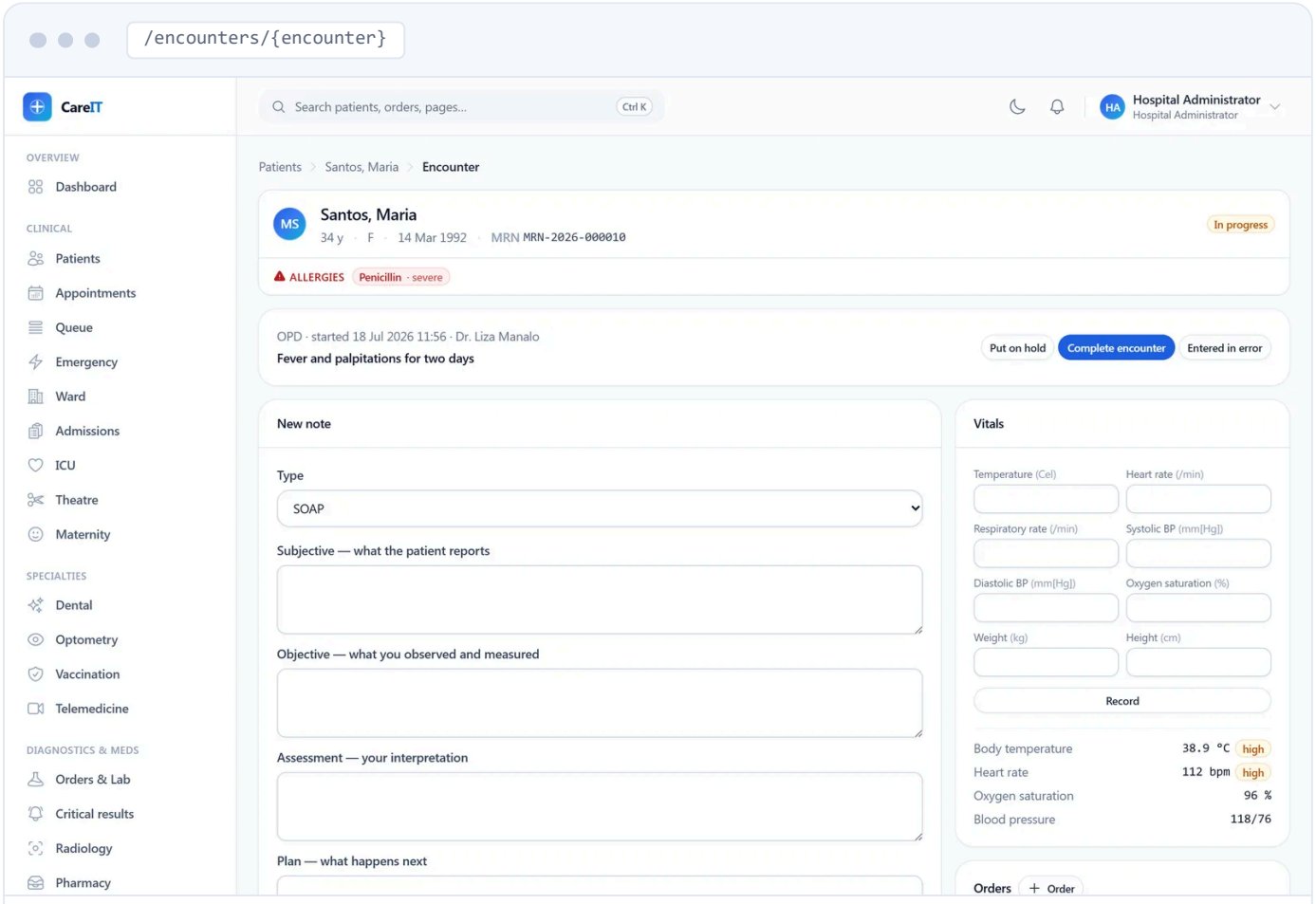
The encounter chart

The clinician's workspace: one screen for the whole consult — notes, vitals, diagnoses, orders, and prescriptions — built for the 90-second reality of a busy clinic.

3.1 · Starting an encounter

1. Open the patient's chart and go to the **Encounters** tab (`/patients/{patient}/encounters`) — the visit timeline.
2. Select **Start encounter**, choose the type — **OPD**, **ER**, **inpatient**, or **telemedicine** — the attending practitioner, and enter the chief complaint.
3. The encounter chart opens with the identity banner pinned on top. Front-desk flows can also start the encounter for the clinician with **Start consultation** on the appointment board.

3.2 · Working the chart `/encounters/{encounter}`



The whole consult on one screen — note composer, vitals with automatic interpretation, diagnoses, prescriptions, and orders. Note the allergy chip in the banner.

Record vitals

1. Enter temperature, heart rate, respiratory rate, blood pressure, oxygen saturation, weight, and height in the **Vitals** panel, then select **Record**.
2. Each value is interpreted against its reference range the moment it is saved — a 38.9 °C temperature shows **high** automatically. You never have to remember to flag it.

> **PATIENT SAFETY**
> Automatic interpretation marks values **low**, **normal**, or **high** — it never invents **critical**. Critical flags come only from explicit rules or a verifying clinician, so alarms stay meaningful.

Write the note

1. Pick the note **type** — SOAP, progress, nursing, operative, or discharge — and fill its sections. For SOAP: subjective, objective, assessment, plan.
2. **Save** keeps it as a draft; **Sign** locks it. Only the author can sign their own draft.
3. To change a signed note, use **Amend** — write the corrected text and a reason. The amendment supersedes the original, and both stay readable with authorship.

Record diagnoses

1. In **Diagnoses**, start typing a code or description — the ICD-10 typeahead matches both ("E11" or "diabet").
2. Set the verification status — **provisional** or **confirmed** — and the clinical status, then save.

Prescribe

1. In **Prescriptions**, enter the medication, dose, route, **frequency**, duration, and the **sig** (patient instructions).
2. Select **Sign**. A signed prescription becomes active — it appears on the pharmacy queue for validation and dispensing (§6.4), and on the ward it feeds the eMAR (§4.4).

> **TIP**
> Write frequency exactly as you mean it — "TID", "q8h", "at bedtime". The system shows your words verbatim everywhere, including the ward; it never converts them into clock times for you.

Order mid-consult

1. In **Orders**, select **+ Order**, choose the service (lab or imaging), set the **priority** — routine, urgent, or stat — and submit. The order joins the diagnostic worklist (§6.1) without you leaving the chart.

3.3 · Closing the encounter

- **Put on hold** — pause a consult you'll return to.
- **Complete encounter** — the normal close. The chart becomes **read-only**: every write control disappears, which is how you know it's closed.

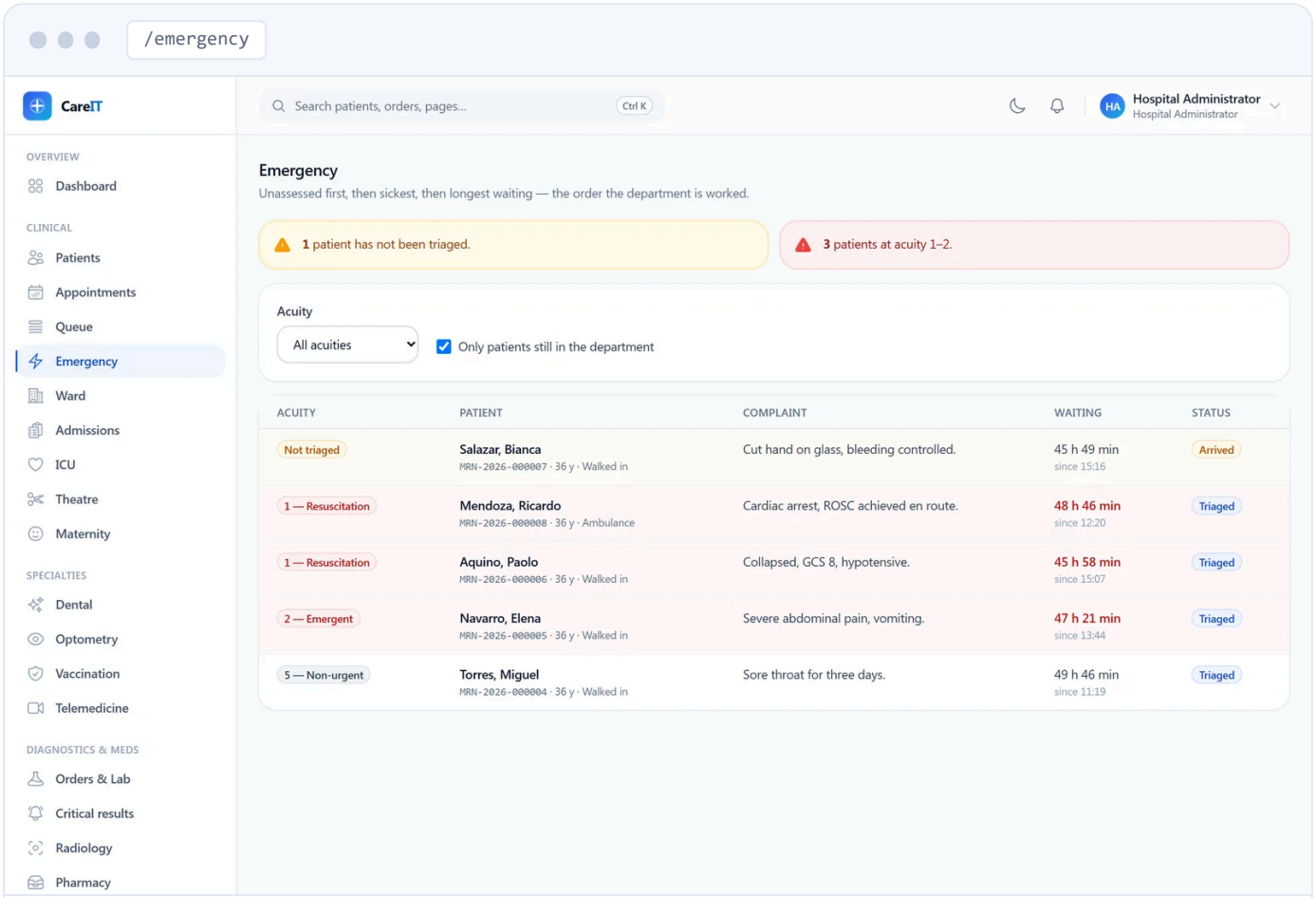
- **Entered in error** — for a chart opened on the wrong patient. The encounter is marked as such rather than deleted; nothing in CareIT HMS is ever silently removed.

CHAPTER 4

Inpatient, emergency & acute care

The ED board that triages, admissions and beds, the medication round on the eMAR, intensive care, the operating theatre, and maternity.

4.1 · Emergency department `/emergency`



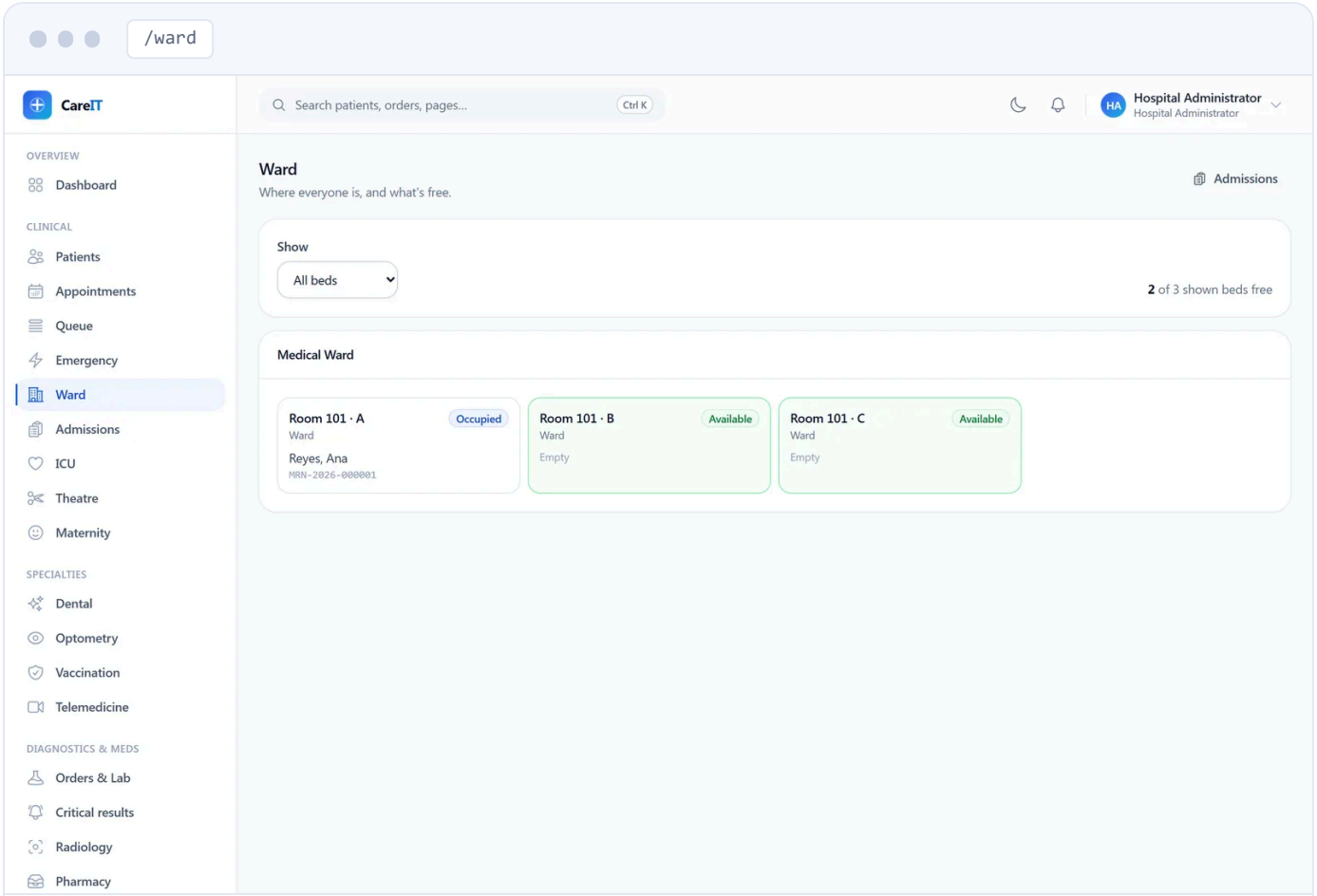
Untriaged arrivals pin to the top, then acuity 1→5, then longest wait — never arrival order.

1. **Register the arrival** — new visit, patient (or rapid-register an unknown), complaint, and mode of arrival. The visit appears on the board immediately, pinned to the top as **not triaged**.
2. **Triage** — record the assessment and assign an **acuity from 1 (resuscitation) to 5 (non-urgent)**. The board re-orders itself; you never sort it by hand.
3. **Re-triage** when the picture changes. Assessments are versioned — every earlier triage stays on record.
4. **Disposition** — discharge, admit (which hands over to §4.2), transfer, or other outcomes, recorded on the visit.

PATIENT SAFETY

Lowering a patient's acuity — deciding they are *less* sick than first thought — requires a stated reason. Raising it never does. The dangerous direction is the guarded one.

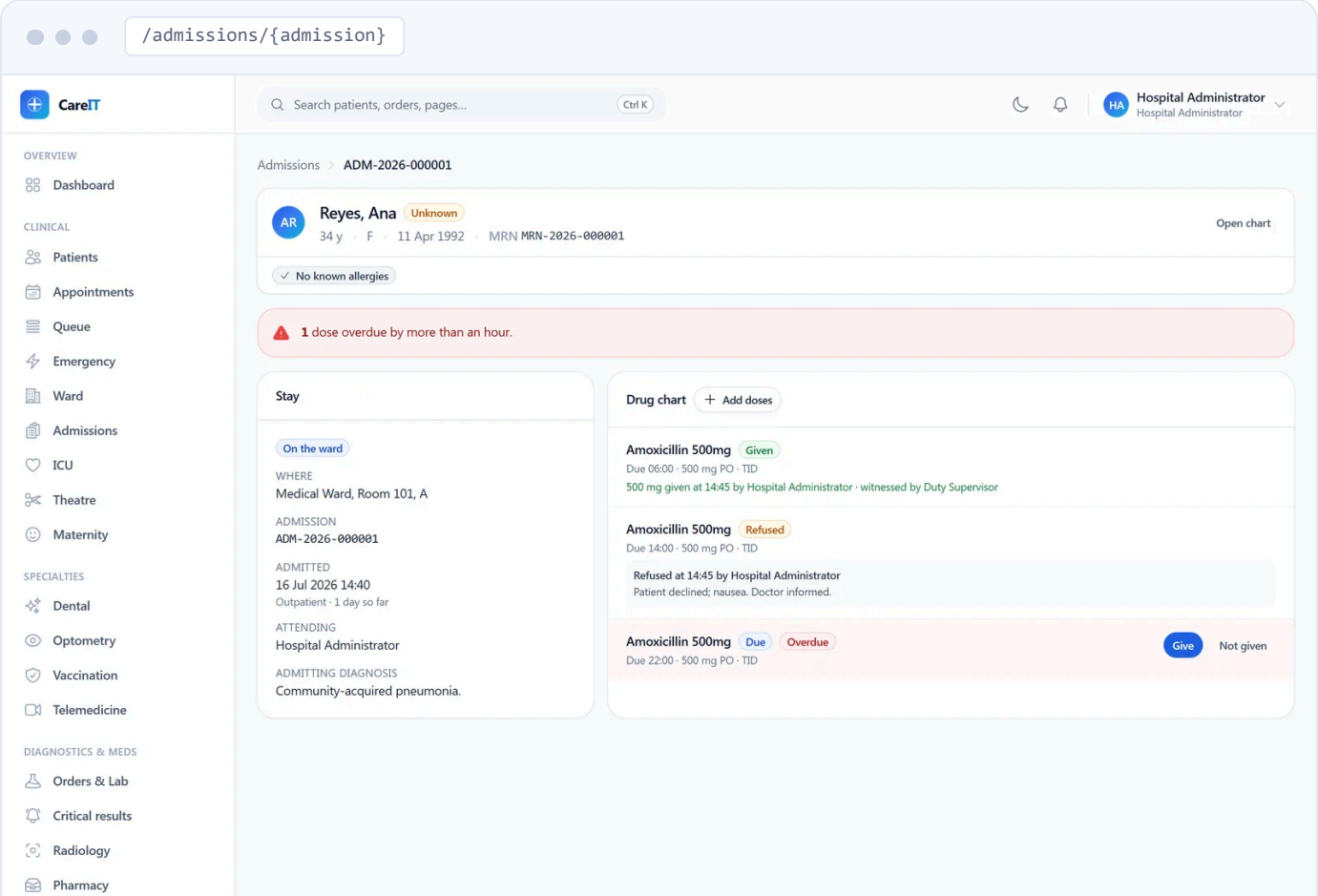
4.2 · Admissions & the bed board `/admissions · /ward`



The bed board — wards, rooms, and beds with live occupancy.

1. From **Admissions**, select **Admit patient**: choose the patient, the encounter, the attending, and a **free bed** from the board.
2. The stay appears in the admissions list and occupies the bed on the ward board.
3. To discharge, move the admission to **discharge-pending** — a second reviewer then confirms **Discharge**, or sends the patient back to **admitted** if they disagree. The two-step is deliberate: the reviewer's job is to be able to say no.

4.3 · The eMAR — medication rounds `/admissions/{admission}`



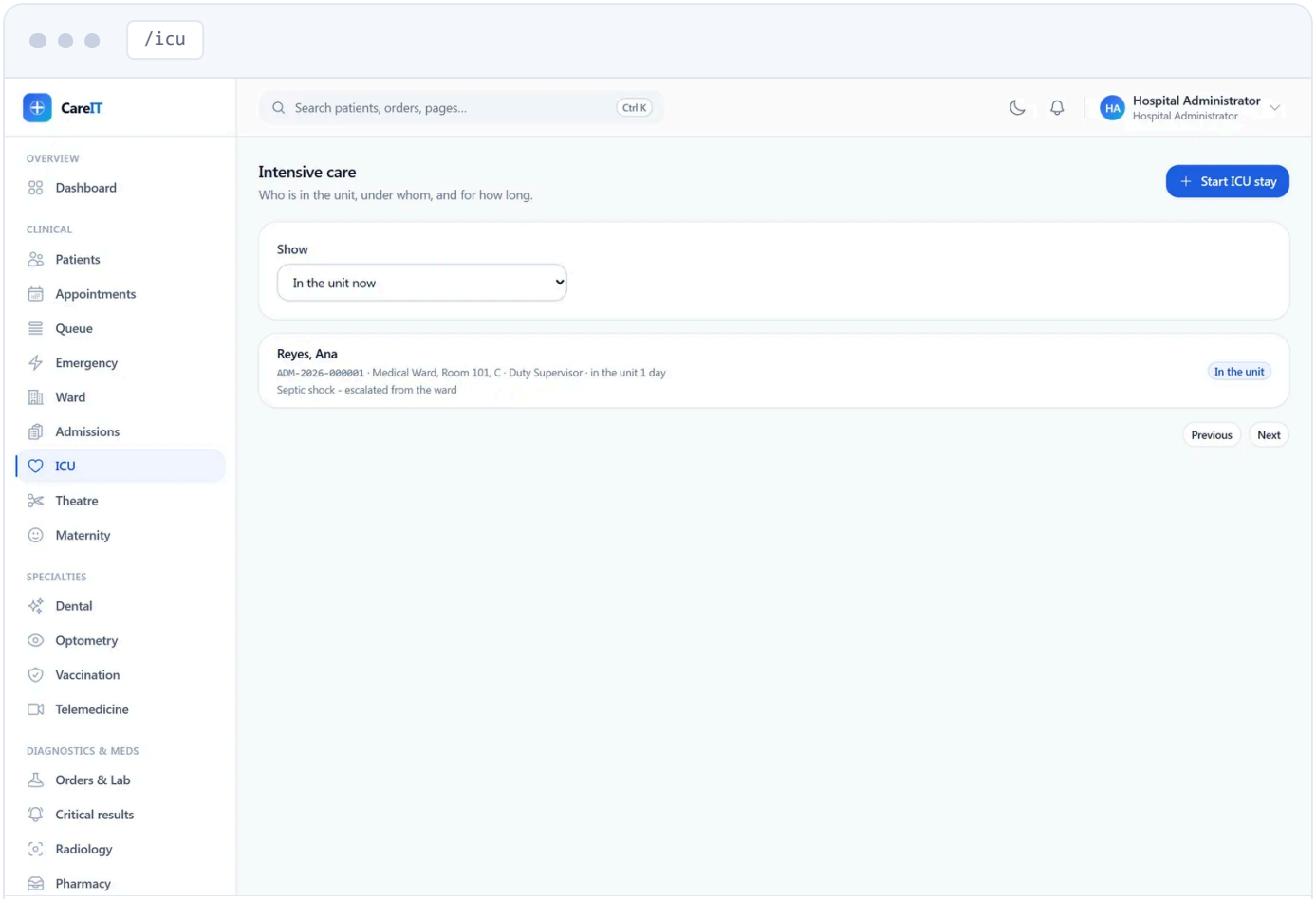
The drug chart: scheduled doses per prescription, each recorded as given, refused, or held.

1. Open the admission. The **drug chart** lists each active, signed prescription with its schedule.
2. **Schedule doses** by typing the ward's actual round times. The prescription's frequency ("TID") is shown verbatim beside them — the system never guesses clock times from it, because rounds differ per ward.
3. At each dose: select **Give** and confirm — or record **Refused** / **Held** with the reason. A dose that wasn't given must say so; it never sits as "still due" forever.
4. Overdue doses flag against **facility time**, so a 14:00 dose is late at 14:01 on the ward clock, not on a server clock somewhere else.

PATIENT SAFETY

Check the identity banner and the allergy chip before every administration. The eMAR sits under the same banner as every other clinical screen for exactly this moment.

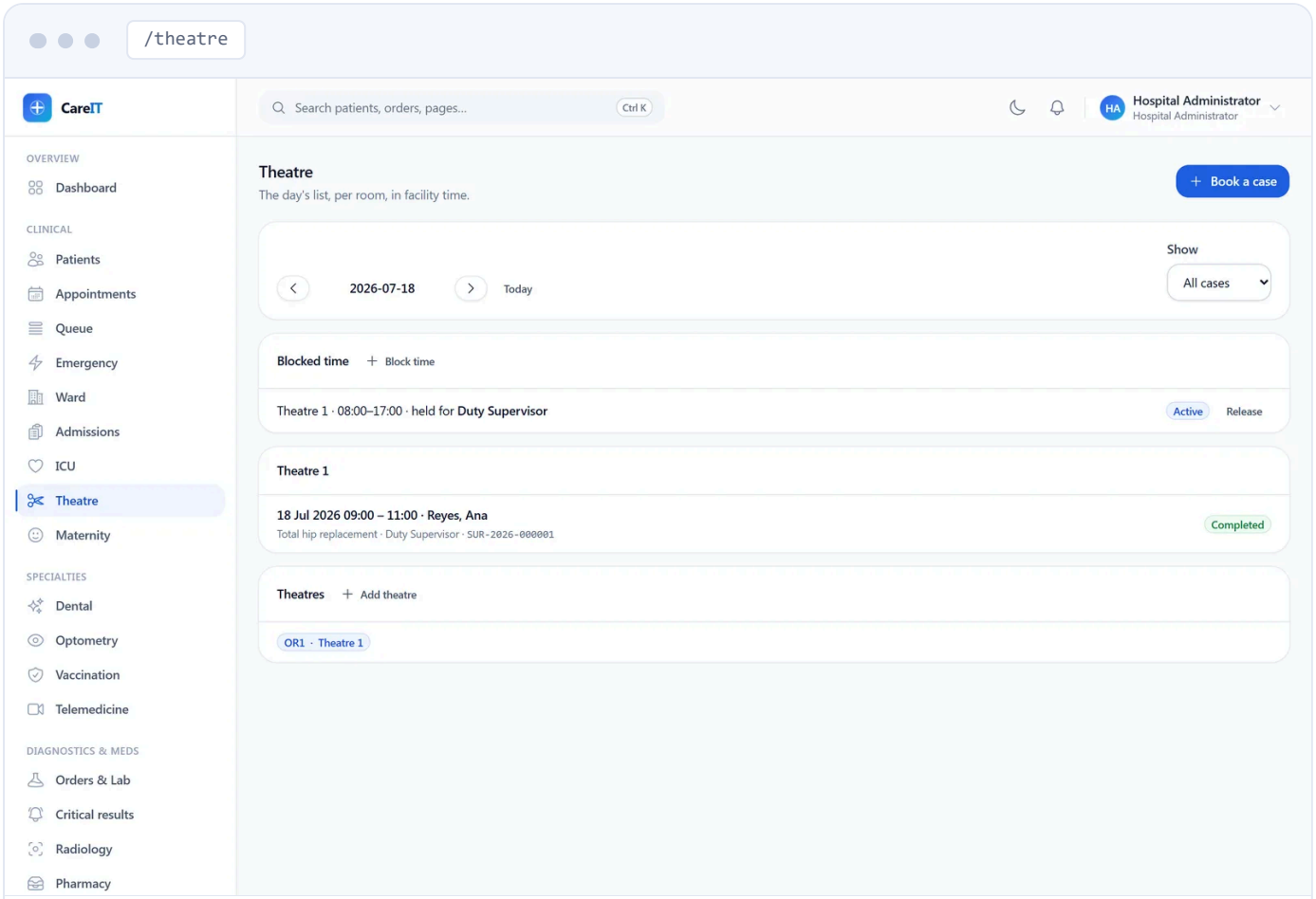
4.4 · Intensive care `/icu`



ICU stays — flowsheets, devices, and severity scores per stay.

- **Flowsheet** — hourly observations and fluid balance, with running totals per code. A wrong entry is **corrected**, not edited: the correction supersedes it and the original stays visible, struck through. A superseded entry can't be corrected again, so the chain never forks.
- **Devices** — lines and tubes with insertion dates and days-in-situ; a central line's day count turns amber at day 7 as an infection-risk prompt.
- **Severity scores** — recorded with their component values, so the number can always be checked against its parts.

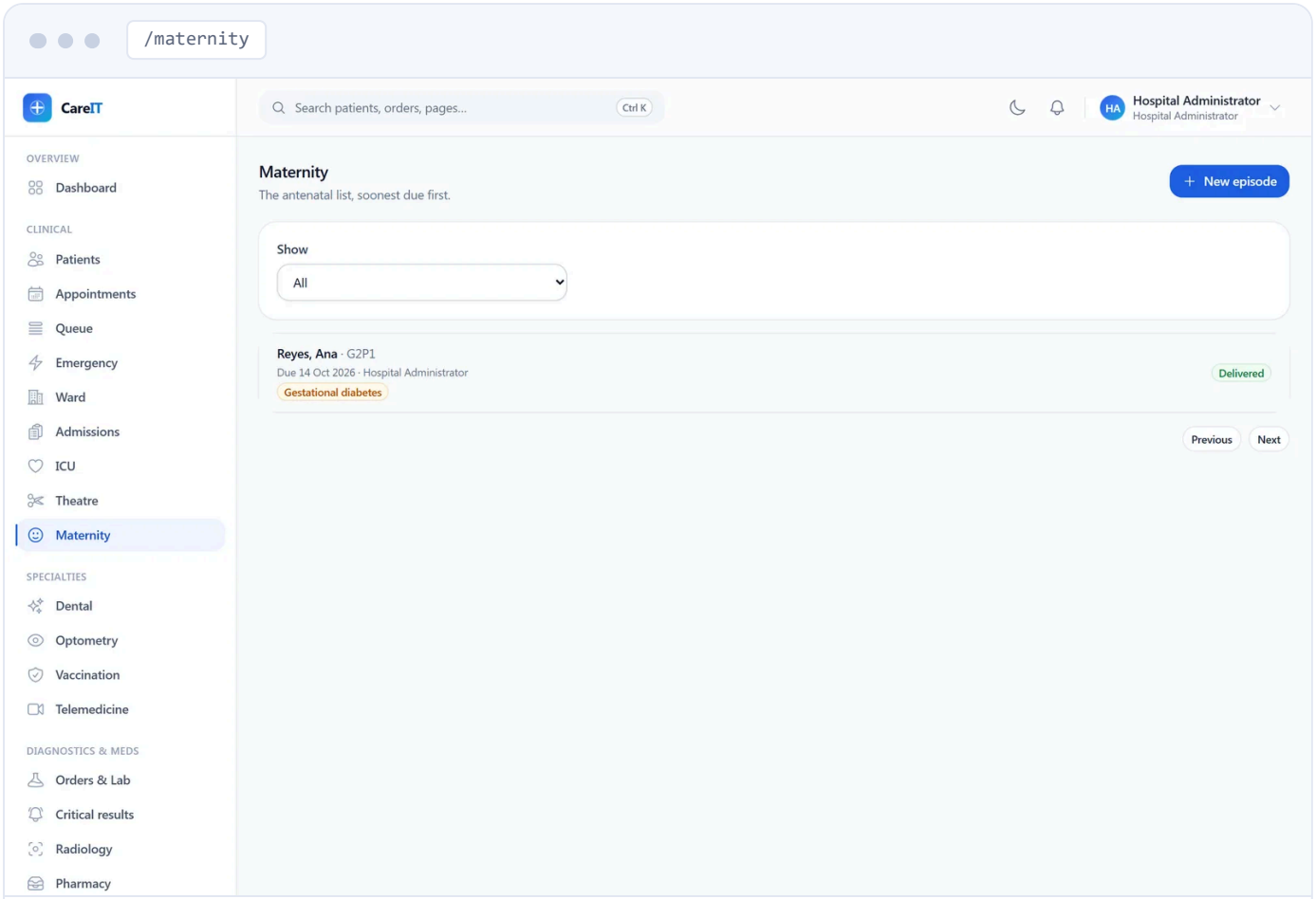
4.5 · Operating theatre `/theatre`



The surgical day — cases per theatre, with block time enforced.

1. **Book a case** — patient, encounter, procedure, theatre, schedule, and the surgical **team**. Booking inside another team's block time is refused.
2. Work the case through its pipeline. The **surgical safety checklist** gates it: **sign-in** before start, **time-out** before incision, **sign-out** before close — each recorded with any exceptions.
3. **Record implants** against the exact lot stated by the surgeon — this is the record a manufacturer recall depends on.
4. Complete the case; implants and theatre services capture their charges automatically (§8.1).

4.6 · Maternity `/maternity`



Pregnancy episodes — antenatal through delivery and postpartum.

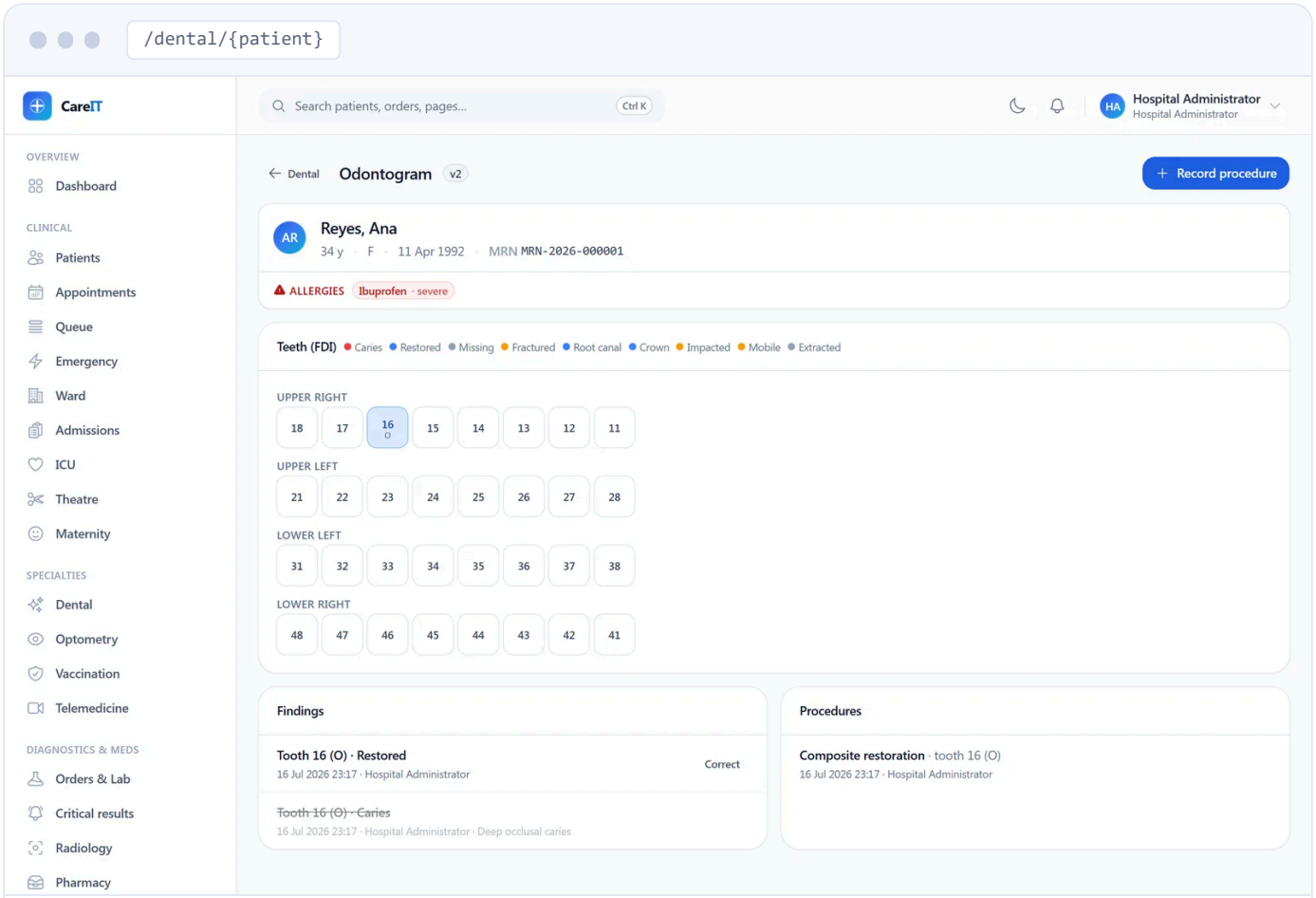
1. **Open an episode** for the mother with her LMP or EDD; risk factors (e.g. gestational diabetes) are badged on the list.
2. **Record antenatal visits** — gestational age is prefilled from the episode dates; adjust if the assessment says otherwise.
3. **Record the delivery** — method, outcomes, and the **newborn**, who is registered as their own patient with their own MRN, linked to the mother through the delivery.
4. **Postpartum** assessments follow on the same episode; close episodes that end without delivery with a reason.

CHAPTER 5

Specialty suites

Dental, optometry, vaccination, and telemedicine — purpose-built workspaces that write into the same patient record as everything else.

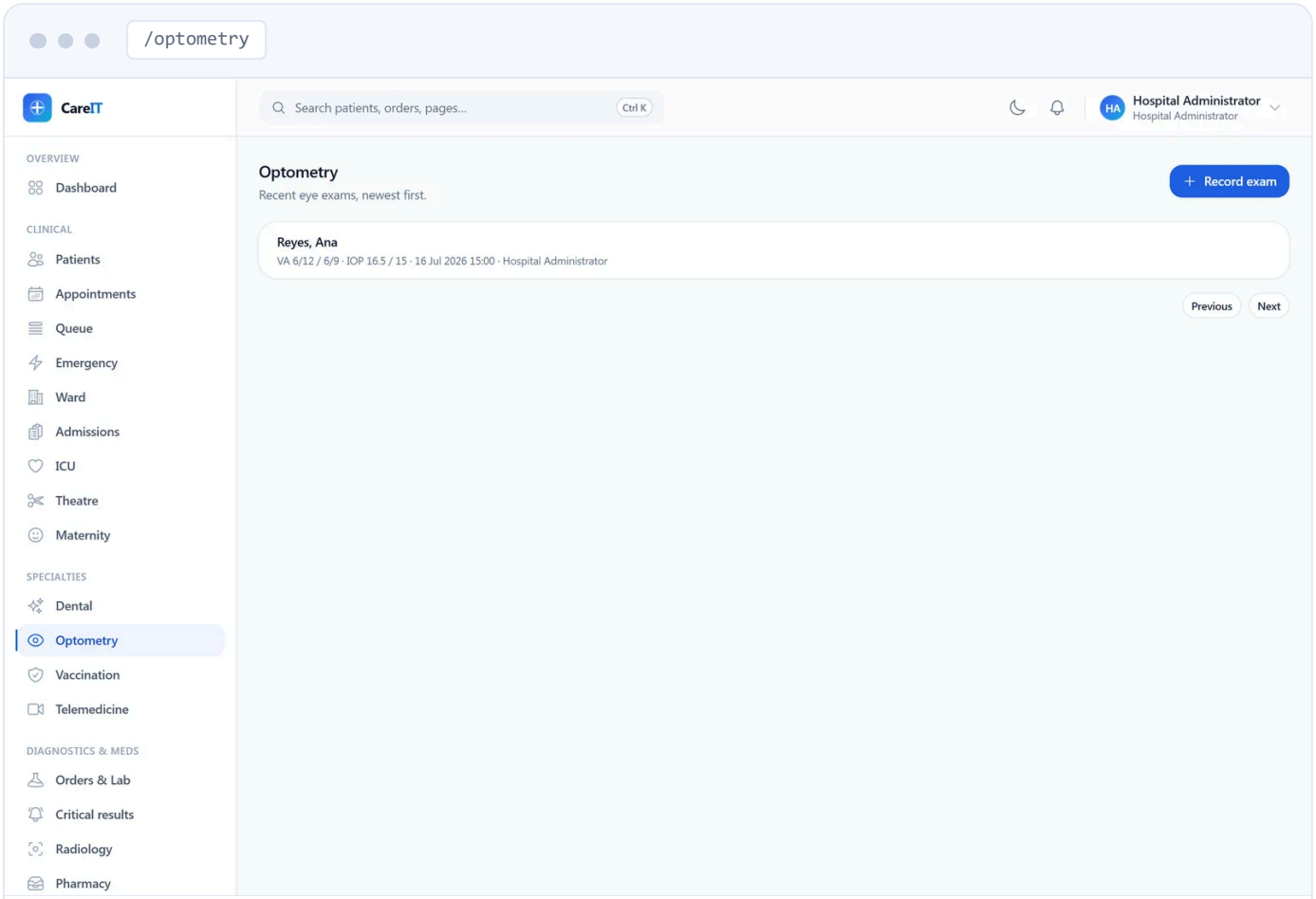
5.1 · Dental — the odontogram `/dental/{patient}`



The FDI tooth chart, painted by each tooth's current condition, with findings and procedures below.

1. Open **Dental** and find the patient. The odontogram shows all 32 teeth in FDI notation, coloured by their latest finding.
2. **Record a finding** — select the tooth, choose the condition (caries, restored, missing, and so on) and the surfaces involved, and save. The tooth repaints and the chart version increments.
3. Got it wrong? **Correct** the finding — the correction supersedes the old one on the same tooth; the history below the chart keeps both.
4. **Record procedures** against the service catalogue (e.g. composite restoration). Each procedure captures its charge automatically — it will appear on the patient's billing tab (§8.1).

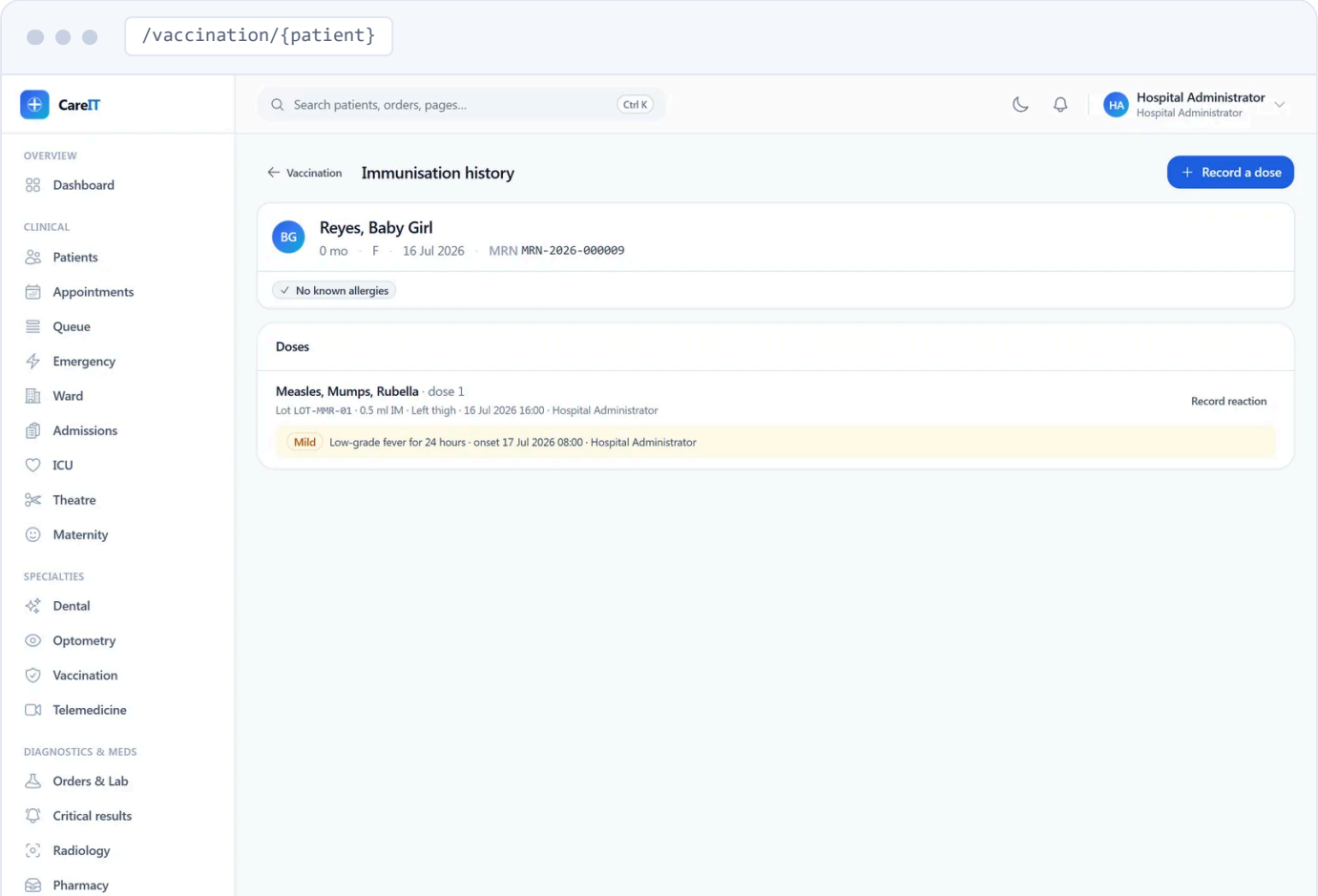
5.2 · Optometry `/optometry`



Eye exams with per-eye acuity and pressure; prescriptions sign once and supersede, never edit.

1. **Record an exam** — visual acuity and intraocular pressure per eye (OD/OS), plus assessment notes.
2. **Write the optical prescription** — sphere, cylinder, axis, and add, per eye — and **sign** it.
3. To change a signed prescription, **supersede** it: the form prefills from the current one, and signing the replacement retires it. There is never more than one current prescription — two "current" prescriptions is how the wrong lenses get ground.

5.3 · Vaccination `/vaccination/{patient}`



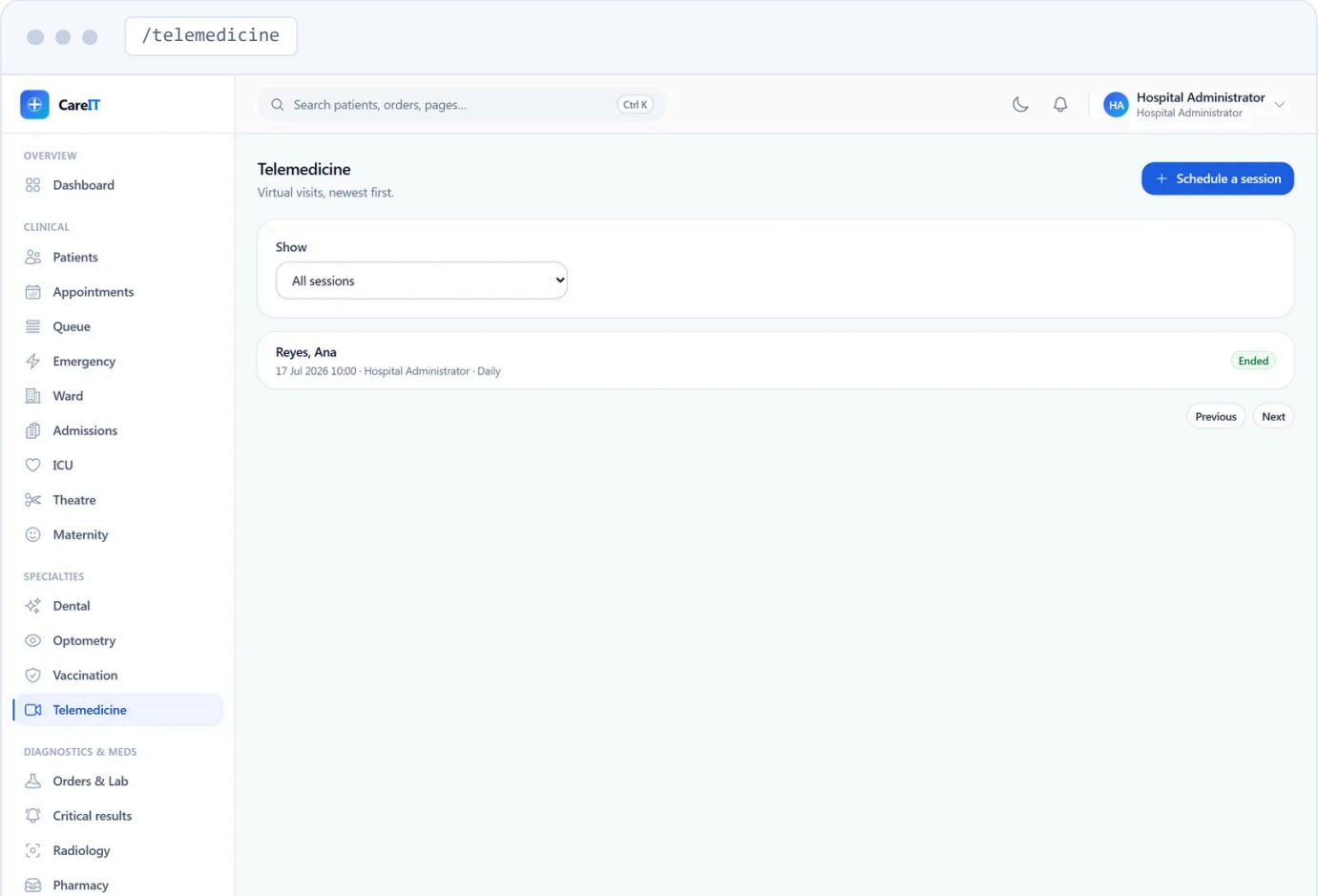
The immunization history — dose, lot, and any adverse events, per patient.

1. Open the patient's immunization history and select **Record a dose**.
2. Choose the **vaccine** and the **lot** — the picker shows expiry and on-hand stock from inventory. Pick the lot of the vial actually in your hand.
3. The system enforces **minimum dose intervals**: a dose given too soon after the last one is refused with the rule spelled out.
4. Record any **adverse event (AEFI)** against the dose it followed — reaction, severity, and outcome.
5. **Issue a certificate** when a schedule completes. Anyone can verify it later by its code — the public verification answers with the vaccine, dose count, and dates.

PATIENT SAFETY

The recorded lot is what an AEFI investigation traces. If the vial in your hand doesn't match the lot on screen, fix the pick before you inject — never after.

5.4 · Telemedicine `/telemedicine`



Remote consult sessions — consent gates the start; join tokens are shown exactly once.

1. **Schedule a session** from a telemedicine appointment.
2. Confirm the patient's **recorded consent** — a session will not start without it. Consents are versioned per patient.
3. **Start** the session and issue **join tokens** to participants. Each token is shown once; you can issue your own, and managing others' requires session-manage rights.
4. **End** the session, or **cancel** it with a fallback plan ("rebooked as in-person") so the patient is never simply dropped.

TIP

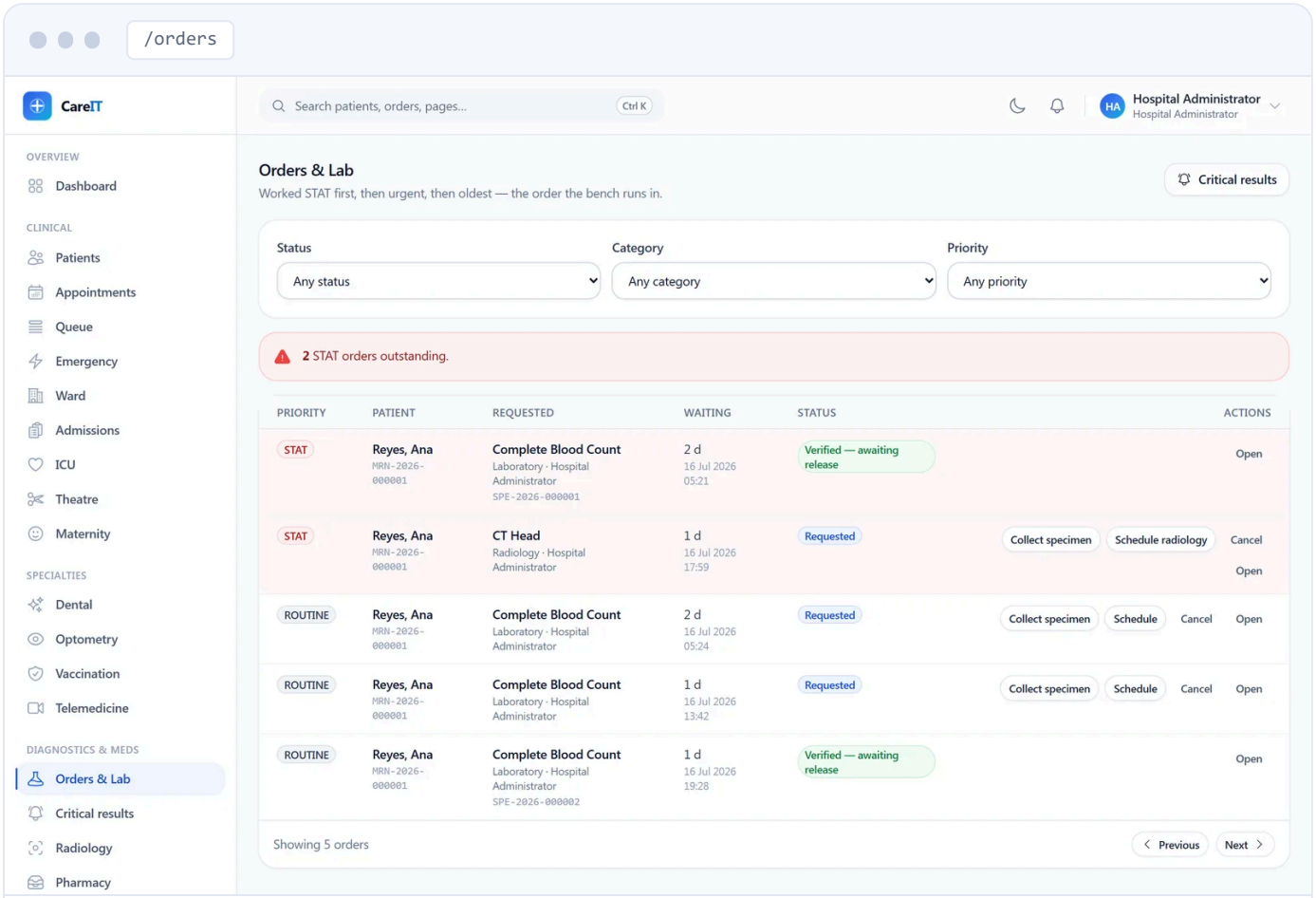
CareIT HMS governs the session — consent, lifecycle, tokens, documentation. The video call itself runs on your provider of choice; provider integrations are on the product roadmap.

CHAPTER 6

Diagnostics & medication

Orders and the laboratory pipeline, critical results, radiology reporting, and pharmacy dispensing with guardrails.

6.1 · The order worklist `/orders`



Stat rows are tinted and always on top. The list renders exactly as the server orders it.

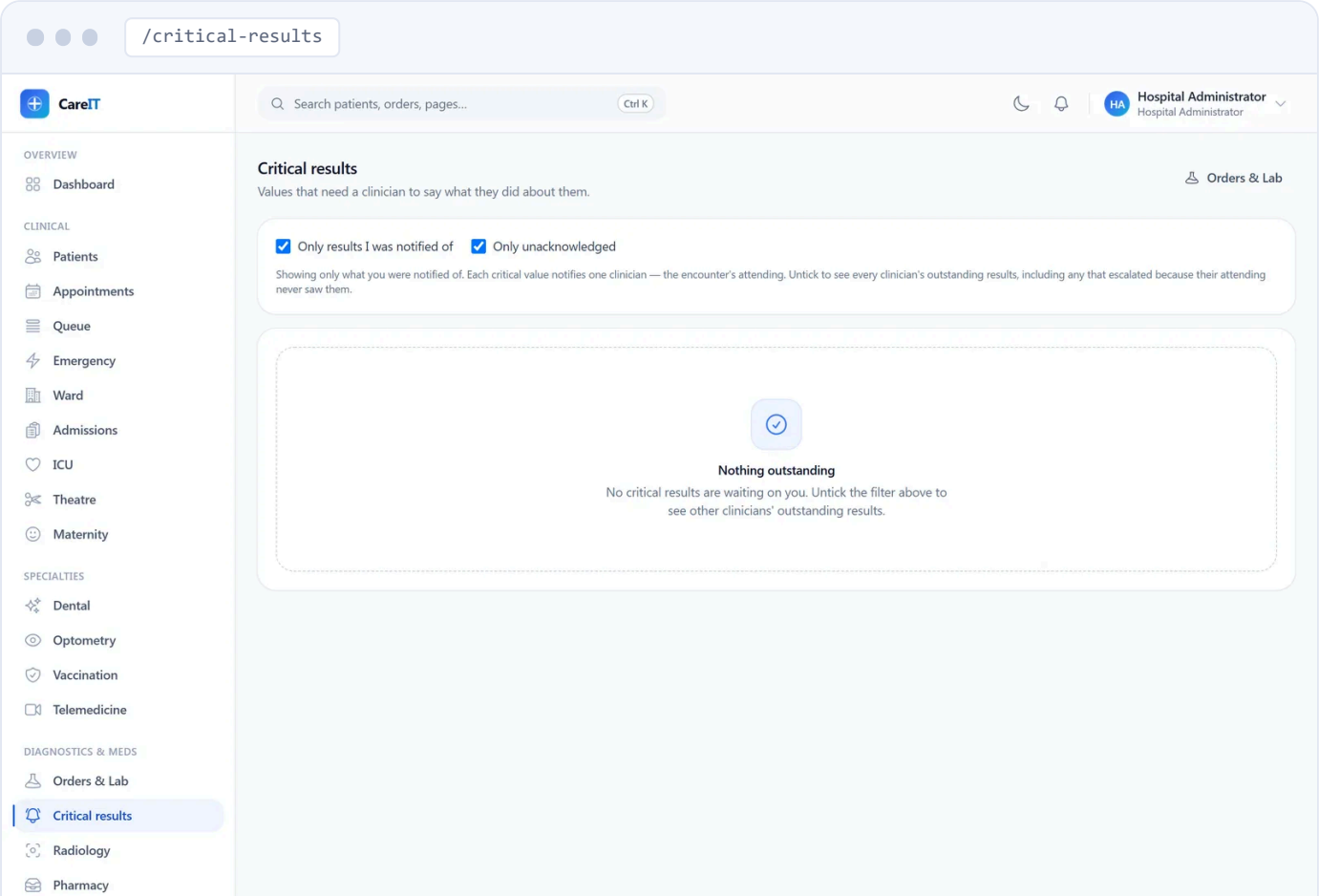
Orders arrive from encounter charts (§3.2) and land here ordered **stat** → **urgent** → **routine**, then longest-waiting first. Work top to bottom:

1. **Collect** — record specimen collection for lab orders.
2. **Enter results** — open the order, enter each analyte's value with its unit and reference range, and the **time it was effective**. Out-of-range values interpret automatically, exactly as vitals do.
3. **Verify** — a second look before anything leaves the lab. The verifier can flag a value **critical**; arithmetic never does that on its own.
4. **Release** — the verified report becomes visible on the patient's chart, and the order's charge is captured for billing.

PATIENT SAFETY

Never re-sort the worklist by hand or work it bottom-up "to clear the easy ones" — the ordering is clinical priority, and a stat sample buried under routine work is a patient at risk.

6.2 · Critical results `/critical-results`



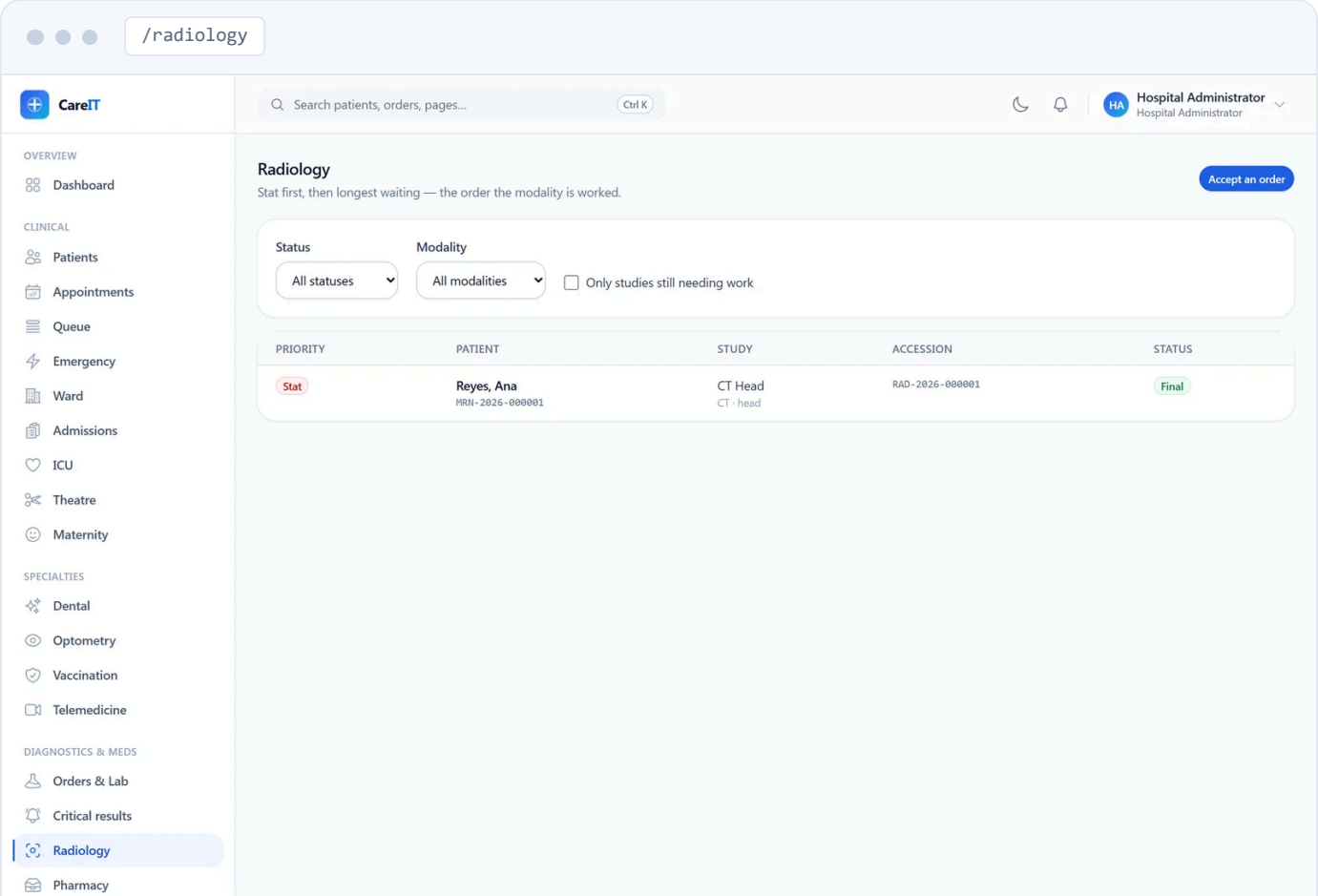
The escalation queue in its best state: empty. A cleared queue means every critical was answered.

1. When a result is flagged critical, everyone with acknowledge authority is **notified in-app** and a deadline starts running.
2. Open the queue, review the result, contact the responsible clinician, and select **Acknowledge** — your name and the time go on record.
3. If nobody acknowledges before the deadline, the system **escalates again**. It does not give up, and it does not assume someone saw it.

PATIENT SAFETY

Acknowledging is a claim that a human took responsibility — only acknowledge what you are actually acting on. The patient portal never auto-releases a critical result; the clinician conversation always comes first (§7.3).

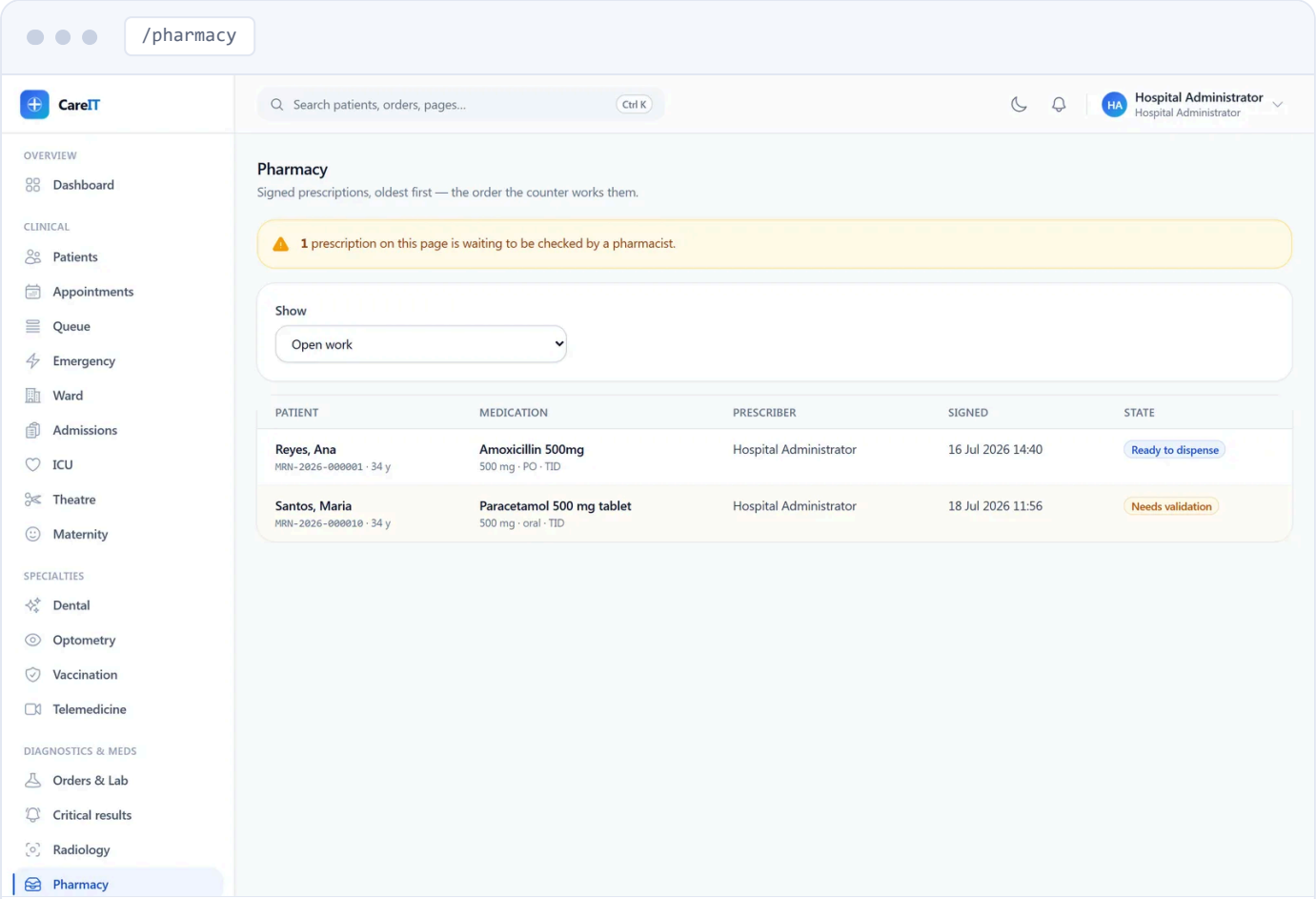
6.3 · Radiology `/radiology`



The imaging worklist — same stat-first discipline as the lab; a study is final only when signed.

1. **Accept an order** — imaging orders arrive from clinicians; accepting one creates the **study** with its modality and body site.
2. **Schedule** the study and mark the patient **arrived**; after the scan, record **acquisition** with the PACS system, study UID, and link.
3. **Report** — draft the findings and impression, then **sign**. Only signing makes the study final: a study is finished when a radiologist puts their name to it, not when the scanner ran. An attending may sign a resident's draft — the signature records who took responsibility.
4. **Amend** a signed report by issuing a new version with a reason — every prior version stays readable, so there is never doubt about what the referrer saw.
5. **Raise a critical finding** when the image shows something that can't wait. It escalates exactly like a critical lab value, pinned above the worklist until acknowledged with a note.

6.4 · Pharmacy `/pharmacy`



Signed prescriptions arrive oldest-first: validate, then dispense.

1. Open the queue — signed prescriptions appear **oldest first**, each showing its state: needs validation, ready, or dispensed.
2. **Validate** — review the prescription. If the system raises a blocking alert, overriding it requires a written reason that goes on record.
3. **Dispense** — choose the **location**, then the **product**: the picker shows live on-hand stock, and stock issues **first-expiry-first-out**. Enter the quantity.
4. For a **controlled drug**, a witness field appears — a second staff member must be selected before the dispense will save.
5. Made a mistake? **Reverse** the dispense with a reason — stock returns to the shelf and the charge is voided in the same step.

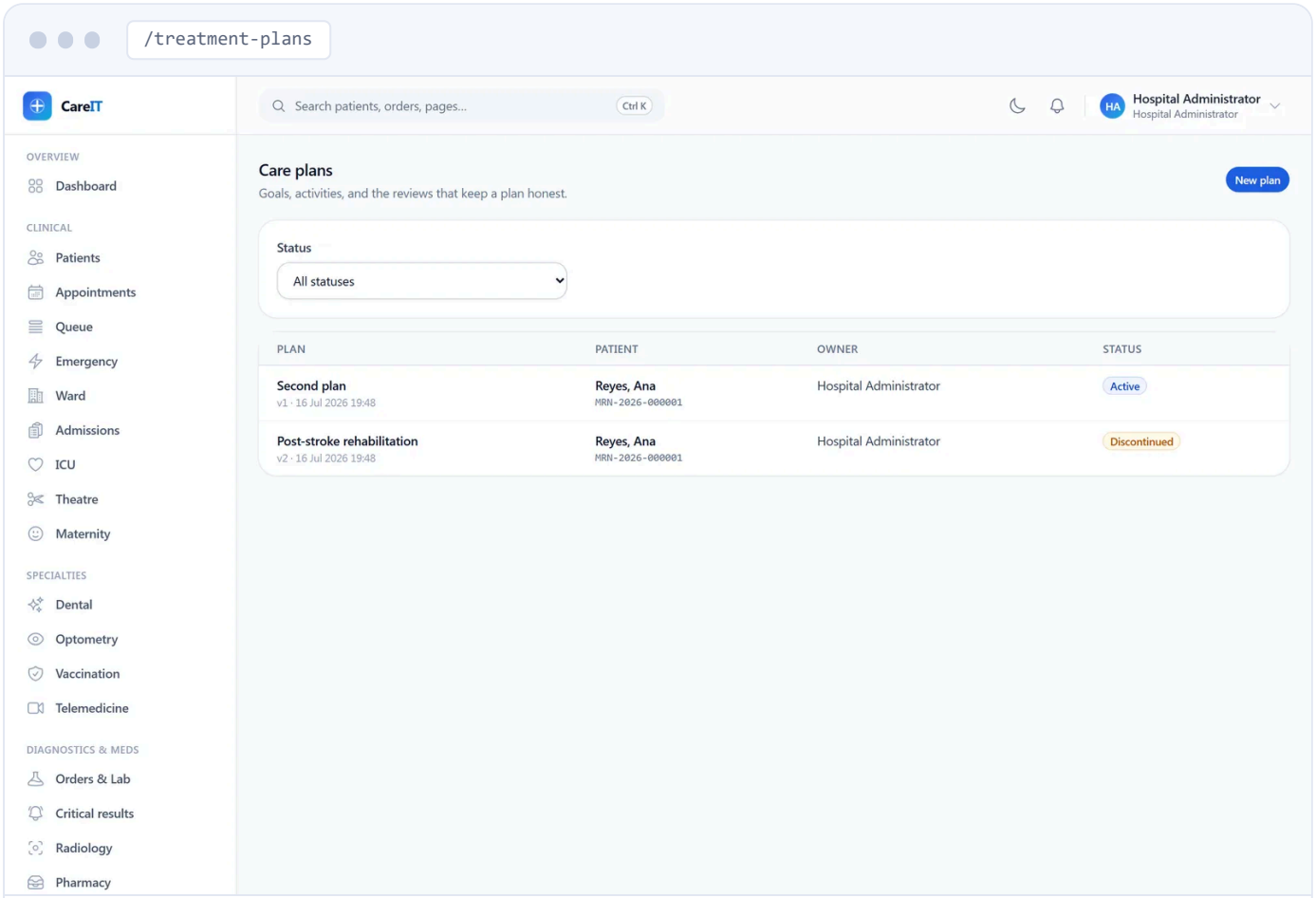
> **TIP**
>
> Dispensing and the stock board (§9.1) compute availability with the same rules — if the dispense screen says the stock isn't there, the shelf count screen will say the same thing.

CHAPTER 7

Care coordination

Longer-running care plans, secure staff messaging, the patient portal's controls, and mobile devices with offline sync.

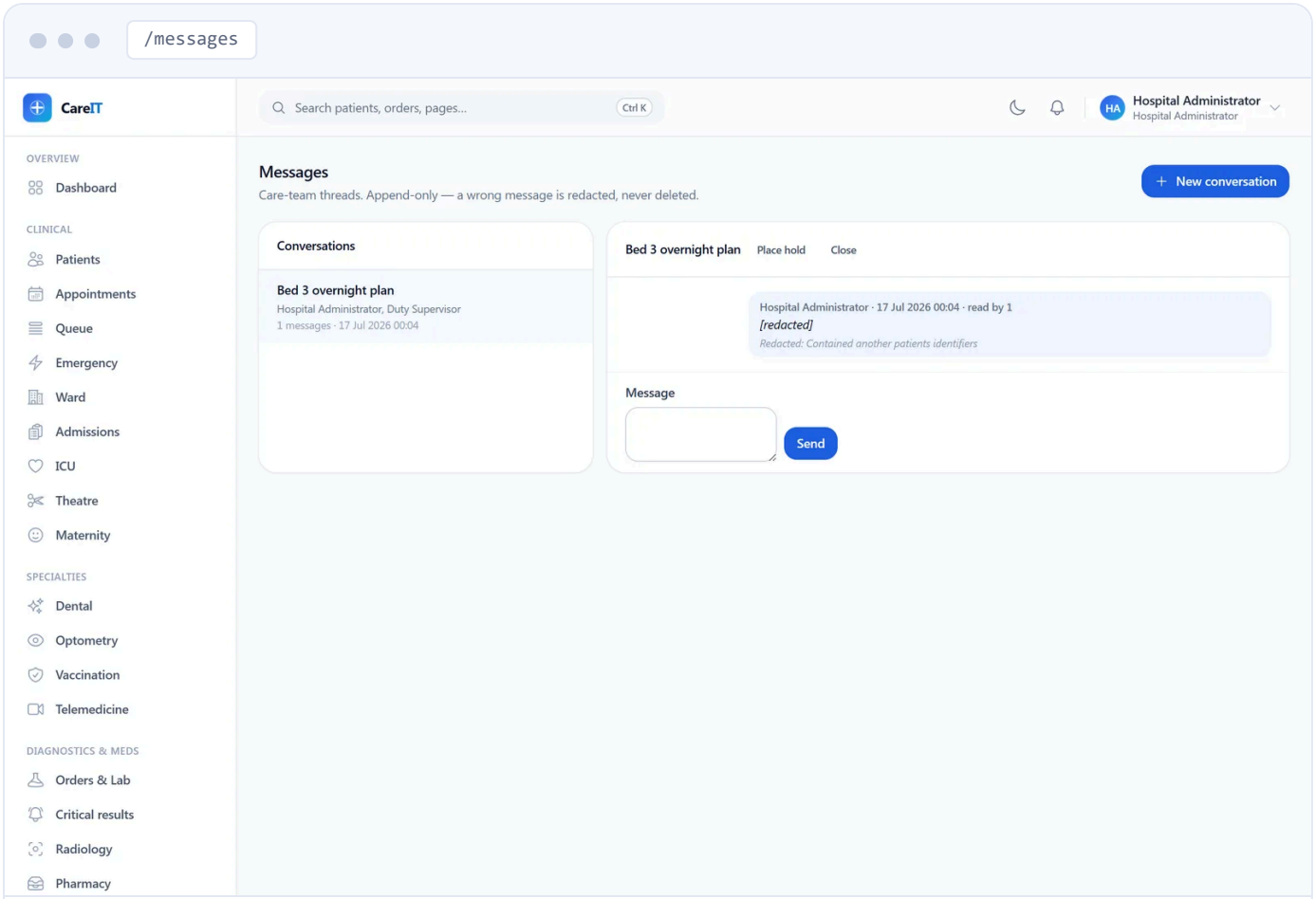
7.1 · Treatment plans `/treatment-plans`



Goal-driven care plans with activities, progress, and formal reviews.

1. **Create a plan** — patient, title, dates, and at least one **goal**; a goal-less plan is refused. New plans start as drafts — **activate** when care begins.
2. **Plan activities** — type, instructions, an optional owner, and a due time in facility-local time. Mark each **completed** or **cancelled** as the work happens.
3. **Record progress** against a goal — a value, a note, or both (an empty entry is refused). Progress can only be recorded against this plan's own goals.
4. **Resolve goals** as **achieved** or **abandoned**.
5. **Review** formally, with notes required: **continue** records the review, **revise** bumps the plan to a new version, **discontinue** ends it.

7.2 · Messages `/messages`



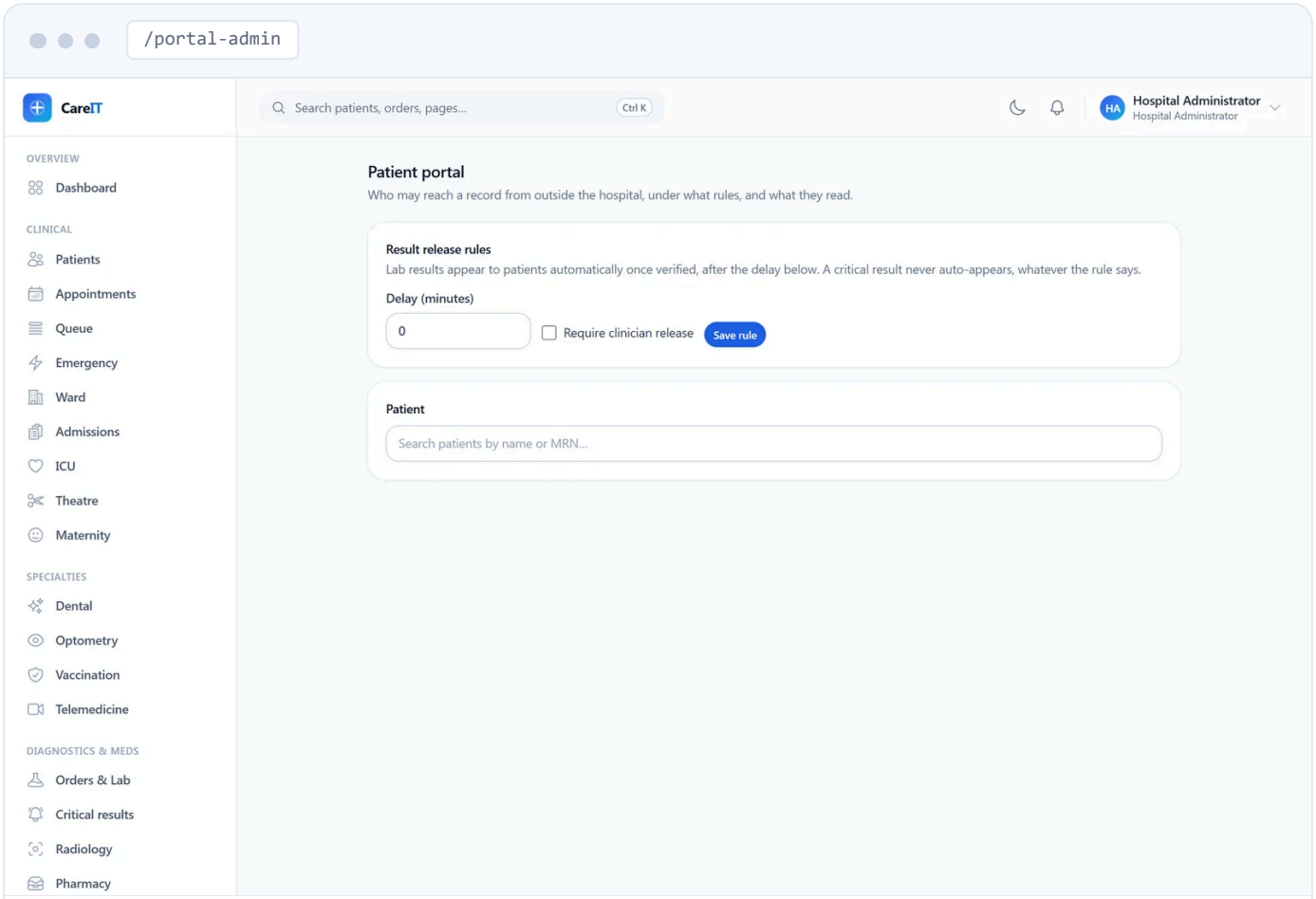
A care-team thread. Note the redaction tombstone — wrong messages are redacted with a reason, never deleted.

- **Threads have members** — you read only conversations you belong to; adding someone is how you share.
- **Read receipts** show who has seen each message.
- **Redaction, not deletion** — a message sent in error (say, another patient's identifier) is **redacted**: its content is removed but a visible tombstone with the reason remains. Nothing disappears silently.
- **Legal hold** freezes a conversation for an investigation — while a hold stands, even redaction is refused.

TIP

Messages are for coordination, not for the chart. Clinical facts belong in the encounter note, where they carry authorship and live with the record.

7.3 · Patient portal administration `/portal-admin`



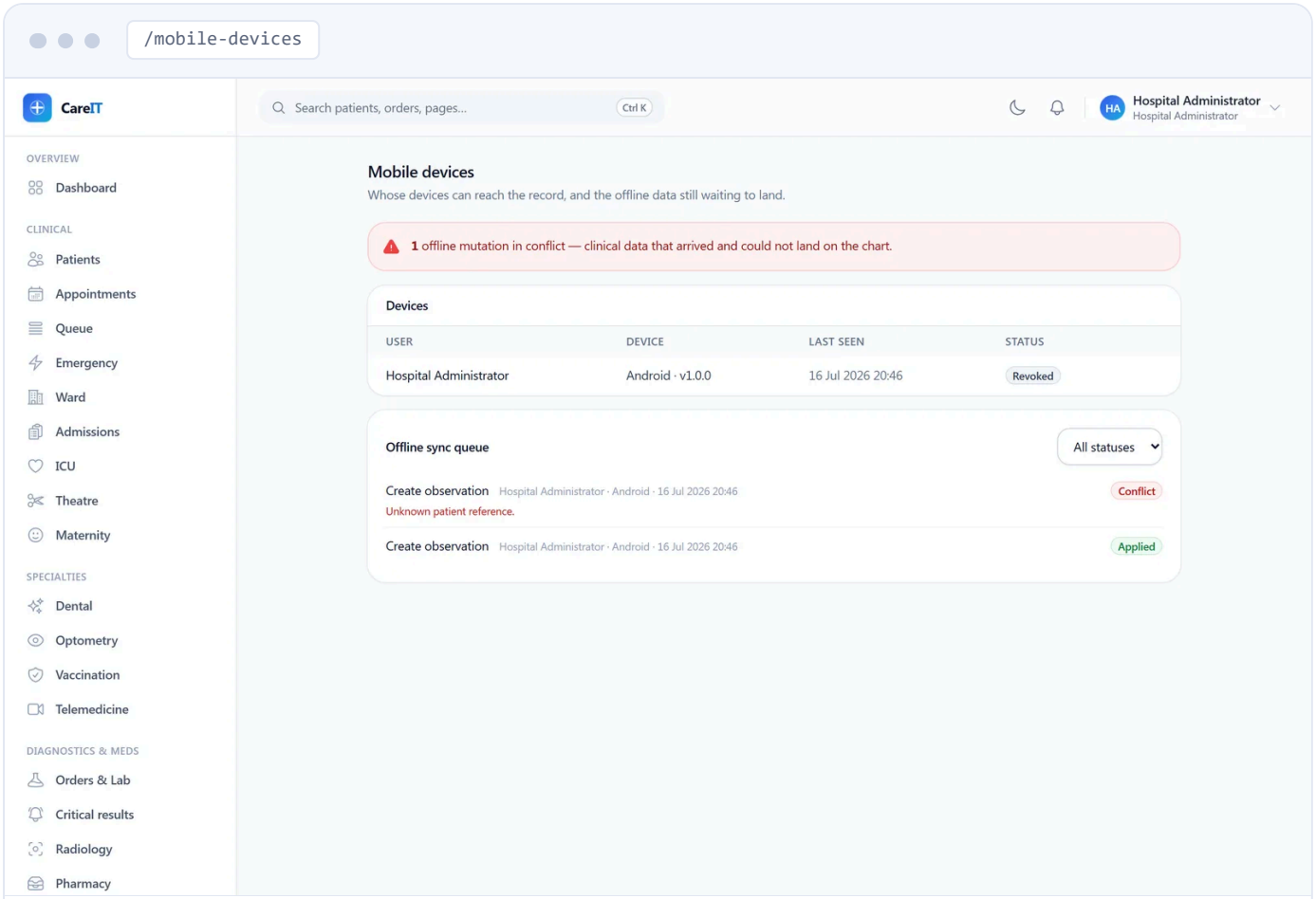
Release rules, portal accounts, proxy grants, consents, and the access log — the staff side of the portal.

1. **Invite a patient** — find them, create the portal account, and hand over the one-time invitation token (it is shown exactly once).
2. **Set release rules** — how long after verification a lab result becomes visible to the patient, and whether a clinician must release it explicitly.
3. **Grant proxy access** — a parent for a child, a carer for a dependent — with scopes and an expiry date. Grants are enforced, revocable, and their use is logged against the patient whose record was read.
4. **Record consents**, versioned per type.
5. **Review the access log** — every portal read of a patient's record, listed for the "who looked at my chart" question.
6. **Close access** — deactivating an account revokes all of its live tokens immediately.

PATIENT SAFETY

Whatever the release rule says, a **critical** result never auto-appears on the portal. Releasing it is a deliberate clinical act — the receipt of the conversation that must happen first.

7.4 · Mobile devices & offline sync `/mobile-devices`



Registered devices and the offline sync queue — conflicts surface honestly with their reason.

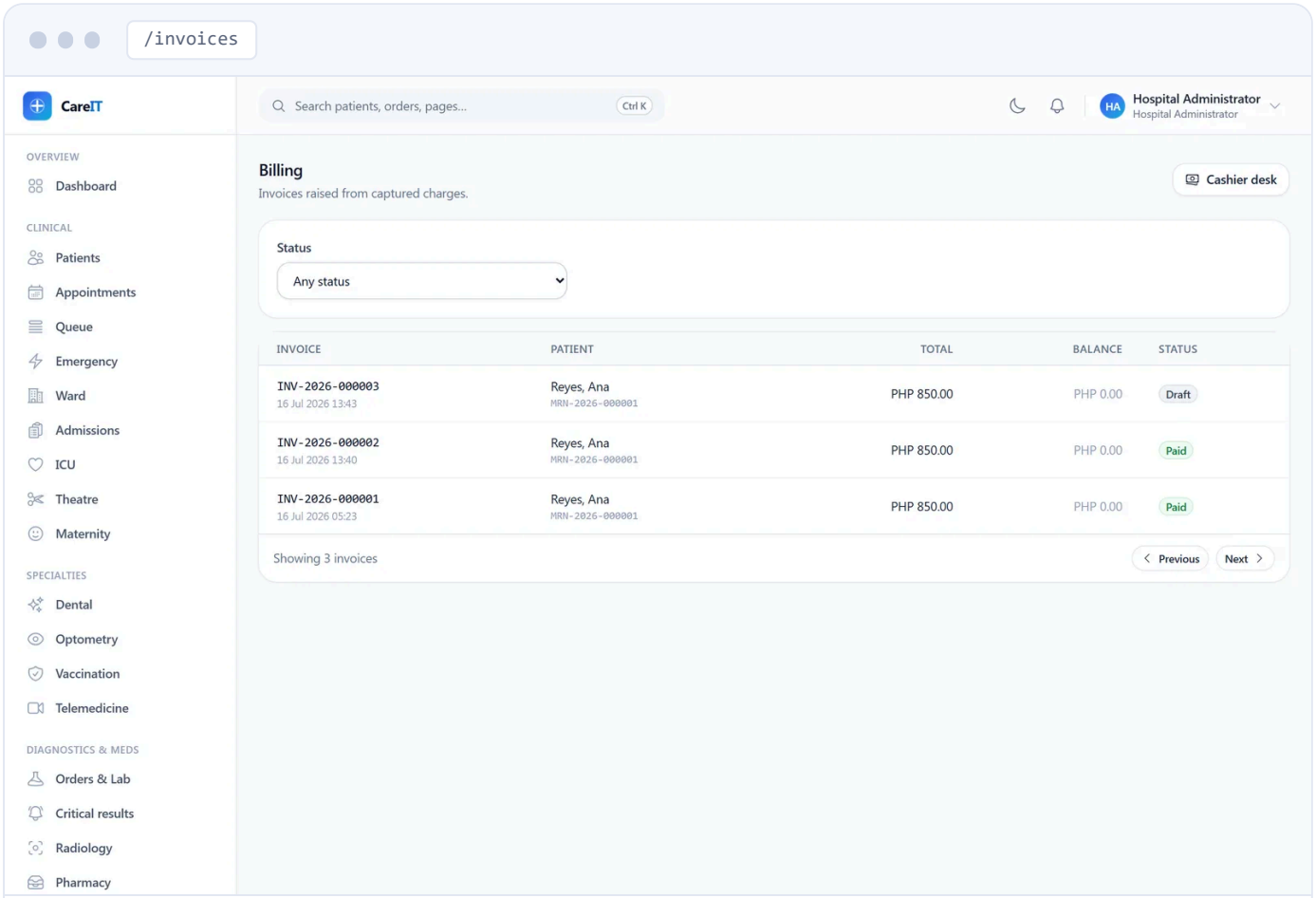
- **Devices** — each registered device is listed with its platform and last sync; administrators can **revoke** a lost device, which cuts off its access.
- **Sync queue** — vitals captured offline upload when the device reconnects and apply through the same interpreter as bedside entry. Each item shows **pending** → **applied**, or **conflict** with the reason (say, the encounter was closed in the meantime).
- **Conflicts need a human** — review the reason and re-enter the data where it now belongs. "Accepted and quietly dropped" does not exist here.

CHAPTER 8

Billing & finance

Charges are facts; invoices are presentations. Everything in this chapter flows from that one principle — through invoices, the cashier's drawer, payer claims, and the ledger.

8.1 · From charges to an invoice `/invoices`

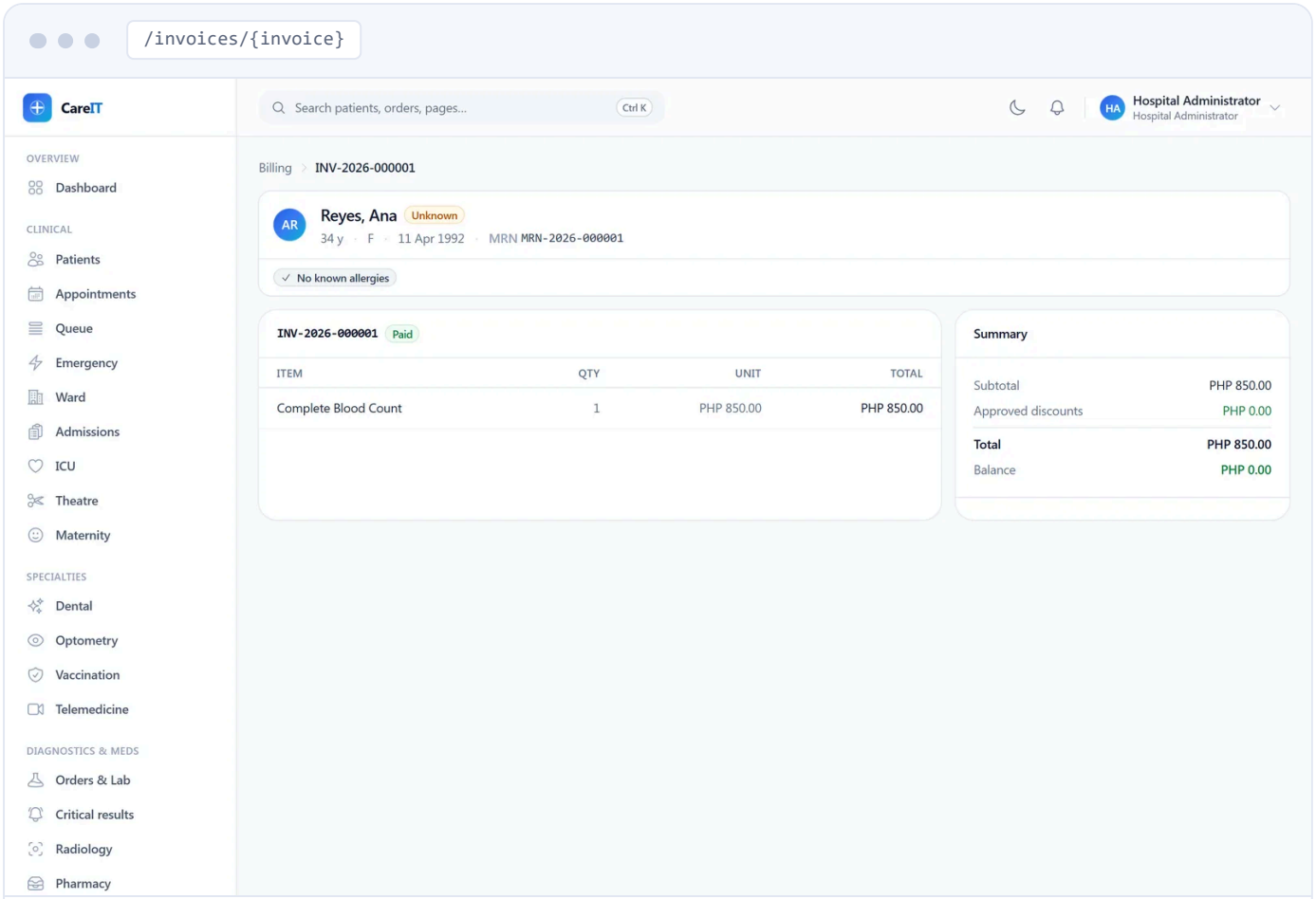


Invoices with their real states — a draft owes nothing until it is finalized.

You never type an invoice line. Consults, labs, imaging, dispensed drugs, procedures, and implants each **capture a charge at the point of care**; an invoice is assembled from those charges.

1. Open the patient's **Billing** tab to see their uninvoiced charges, and create the invoice from them.
2. The invoice starts as a **draft** — its balance is zero until you **finalize** it, because a draft is a working document, not a demand.
3. **Finalize** when it's ready to present; **void** (with the reason) if it was raised in error. Both are recorded transitions.

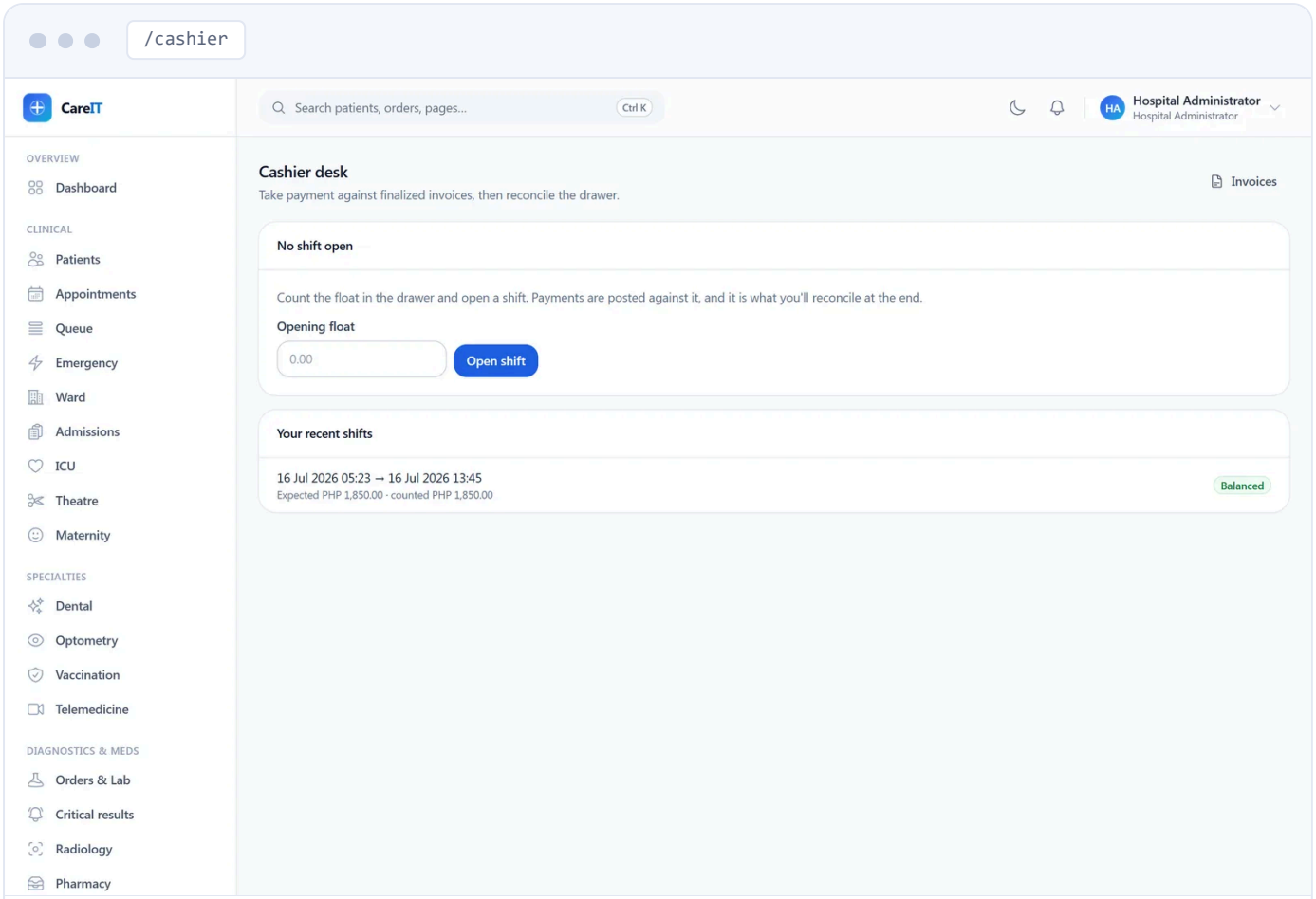
8.2 · Invoice detail & discounts `/invoices/{invoice}`



Lines traced to their charges, the discount trail, totals, and payments.

1. **Request a discount** (e.g. senior citizen) on the invoice with its basis.
2. A **different** staff member with approval rights reviews and **approves** it — the requester's own approval is refused. Separation of duties is enforced by the software, not by policy memo.
3. The approved discount appears on the invoice with its full trail: who asked, who approved, when.

8.3 · The cashier desk `/cashier`

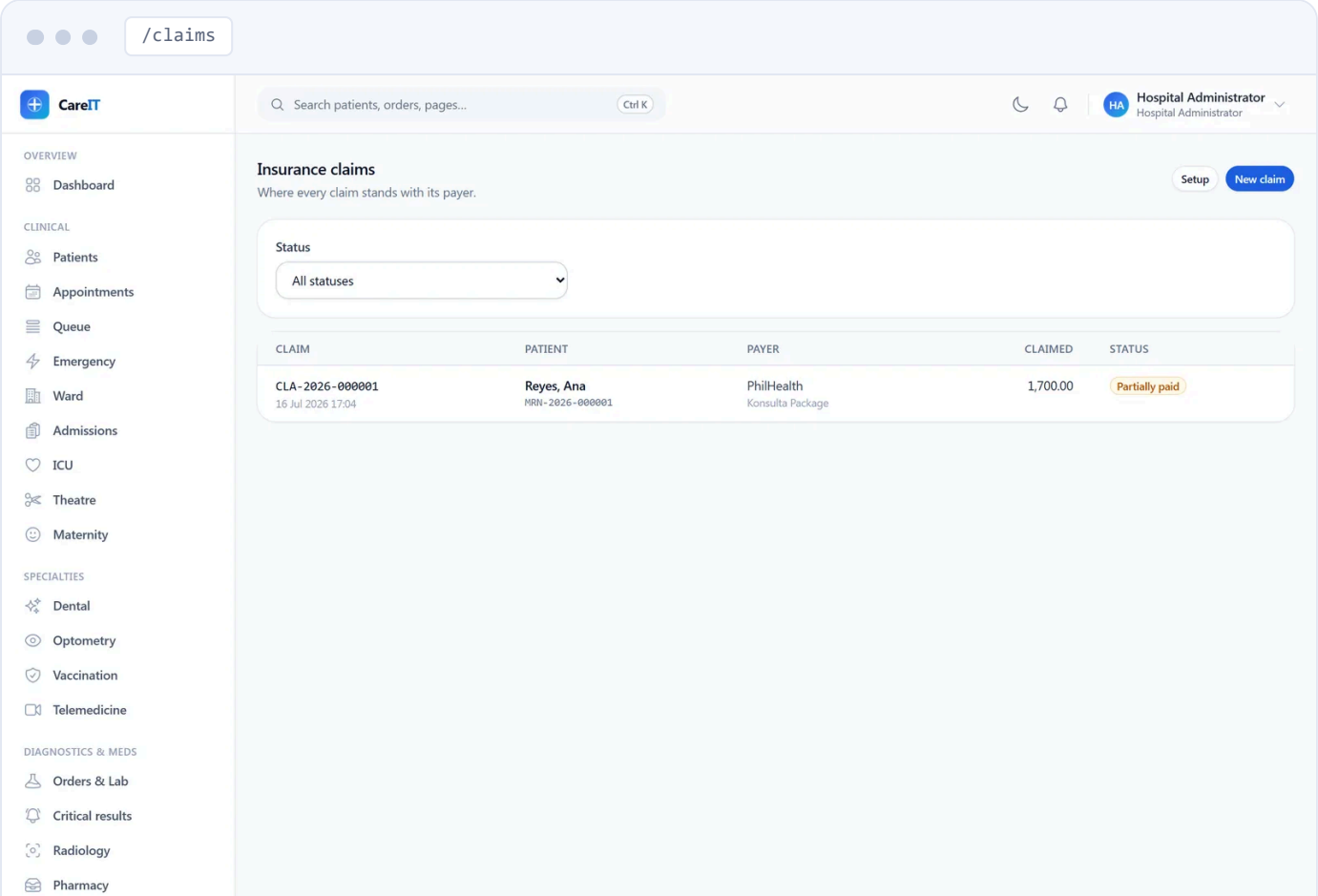


Shift-based cash management — open with a float, close by counting the drawer.

1. **Open a shift** with your starting **float**. Payments can only be posted inside an open shift.
2. **Post payments** against finalized invoices — cash, card, or other methods — and the invoice balance updates from the payments, never from hand arithmetic.
3. **Close the shift** by entering the **counted cash**. The drawer reconciles counted cash against *cash takings only*; card and e-wallet takings are reported separately per method.

> **TIP**
>
> Because non-cash methods are never folded into the drawer expectation, a variance always means something real — short cash is short cash, not a card payment hiding in the math.

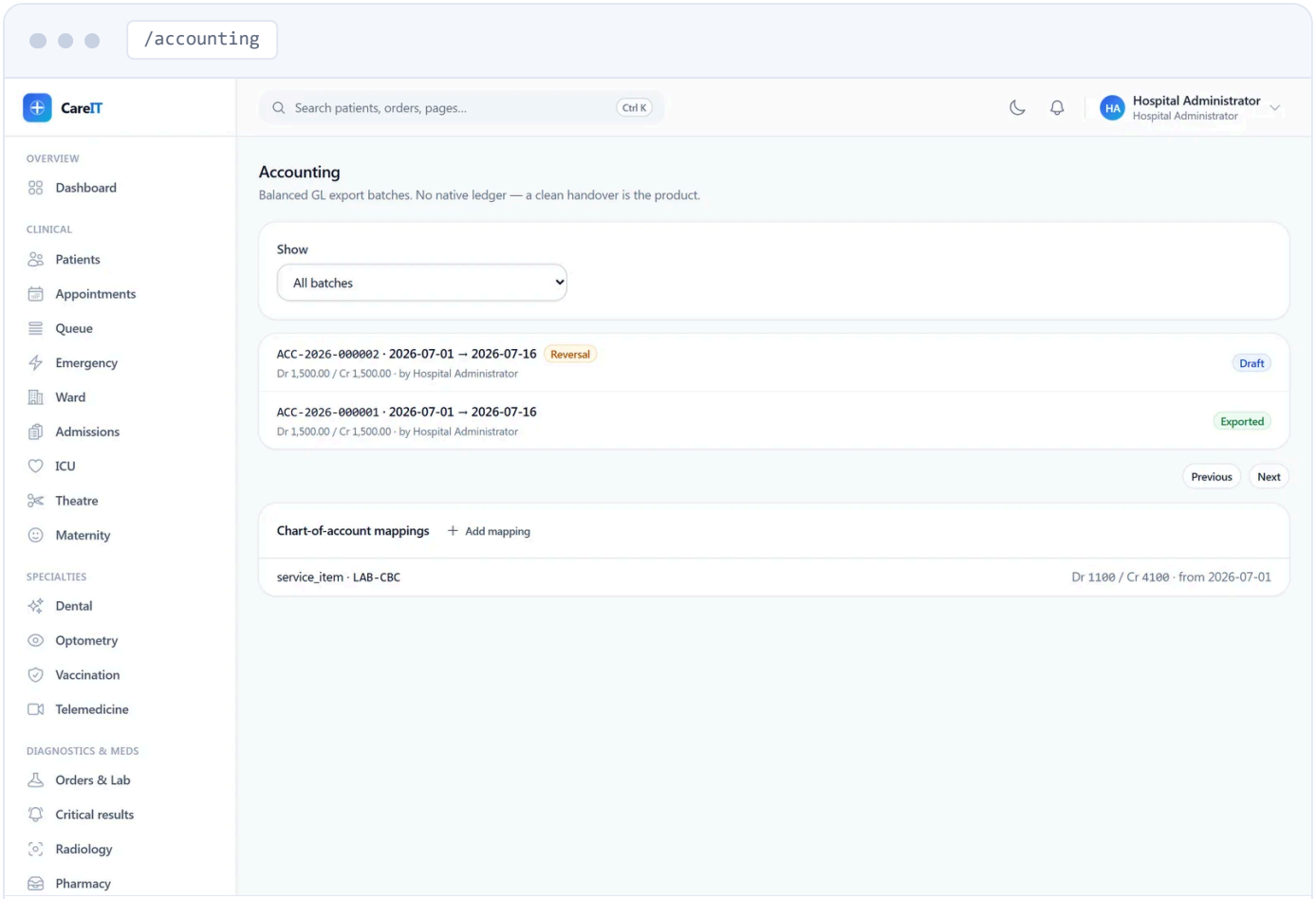
8.4 · Insurance claims `/claims`



Claims built from real charges, adjudicated line by line.

1. **Set up references once** — payers, their plans, and each patient's **policy** (member numbers are stored encrypted and always display masked). New policies can also be added inline while creating a claim.
2. **New claim** — pick the patient, their policy, the encounter, and the **claimable charges**. A charge already on another claim will not be offered — one service can never be billed to a payer twice.
3. **Validate**, then **submit** to the payer.
4. **Adjudicate** when the payer responds — record the approved amount per line (the form defaults each line to the claimed amount). The claim's outcome — adjudicated, partially paid, or denied — is computed from those numbers, never chosen by hand.

8.5 · Accounting exports `/accounting`



Balanced journal batches for your general ledger, with two-person approval.

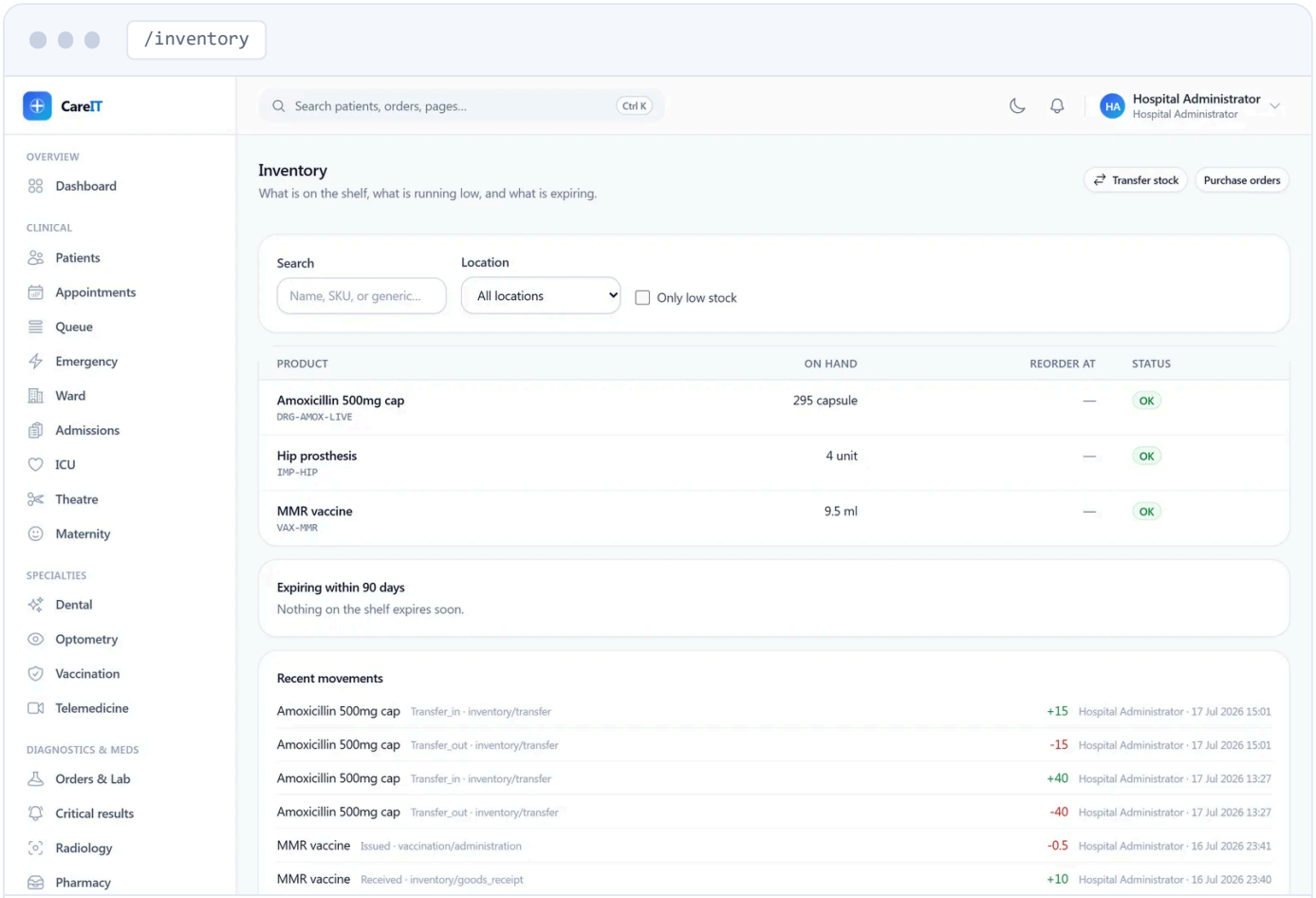
1. Maintain **account mappings** — which GL account each revenue and payment source posts to, with effective dates.
2. **Draft a batch** for a period; the system assembles balanced journal lines from the period's activity.
3. A second person **approves**; the batch is then **transmitted** and marked **exported** on acknowledgement. Failures can be retried.
4. An exported batch is immutable. To correct one, draft its **reversal** — debits and credits swapped — and put it through the same approval.

CHAPTER 9

Operations

Stock as a ledger, procurement with a paper trail, rosters and credentials, reporting, analytics, and the health of the system itself.

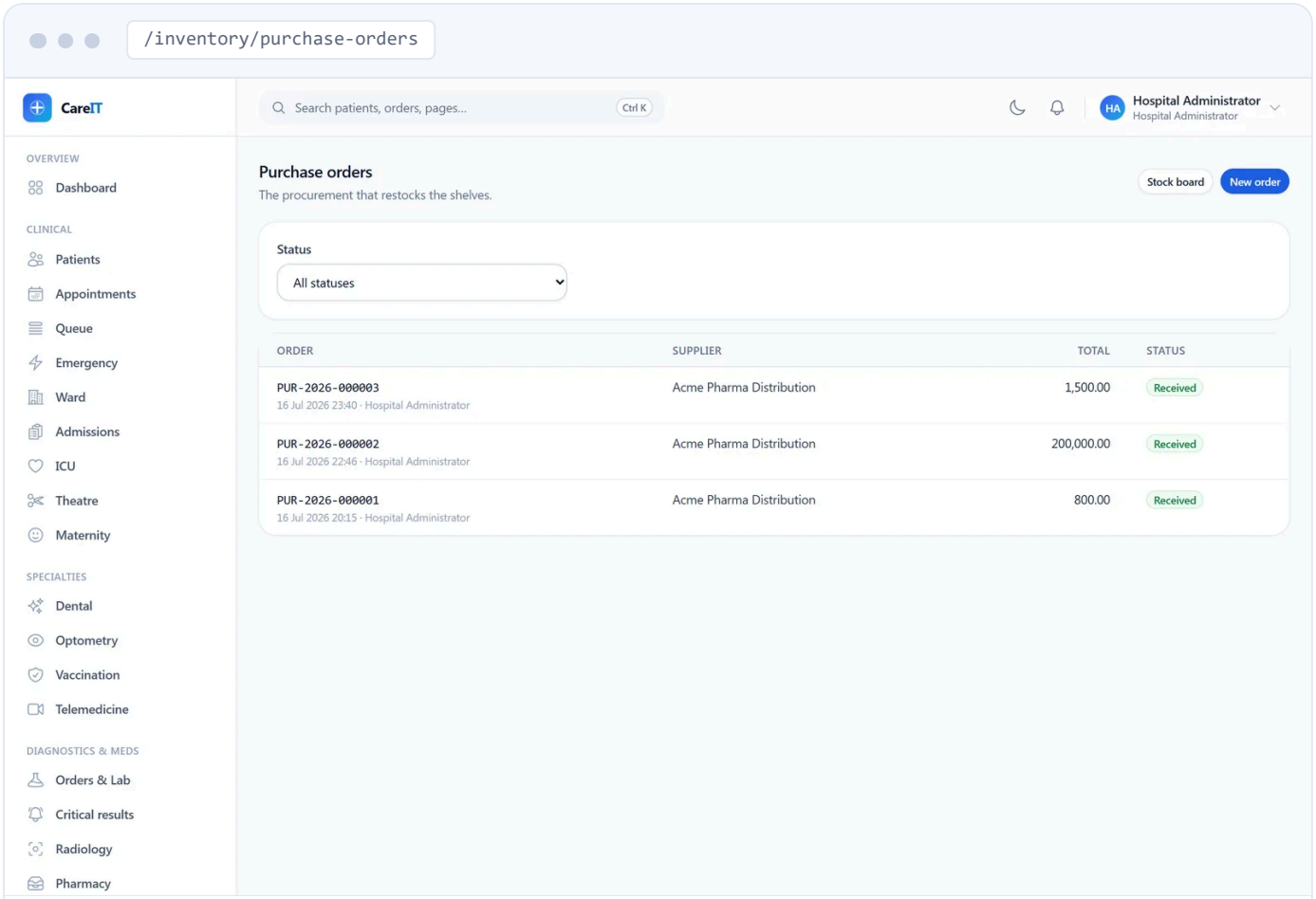
9.1 · Inventory `/inventory`



What's on the shelf, what's running low, what's expiring — and every movement, readable.

- **The stock board** shows on-hand per product and location at lot level, a low-stock view against reorder levels, and an expiring panel that includes anything already expired but still on the shelf.
- **Transfers** move stock between locations; both sides of the move land on the ledger.
- **Adjustments** record counts that disagree with the system — an adjustment always carries a reason, and a count that matches is simply not a movement.
- **The movement ledger** lists every receipt, issue, transfer, and adjustment with who and when — the answer to "where did it go" is always readable.

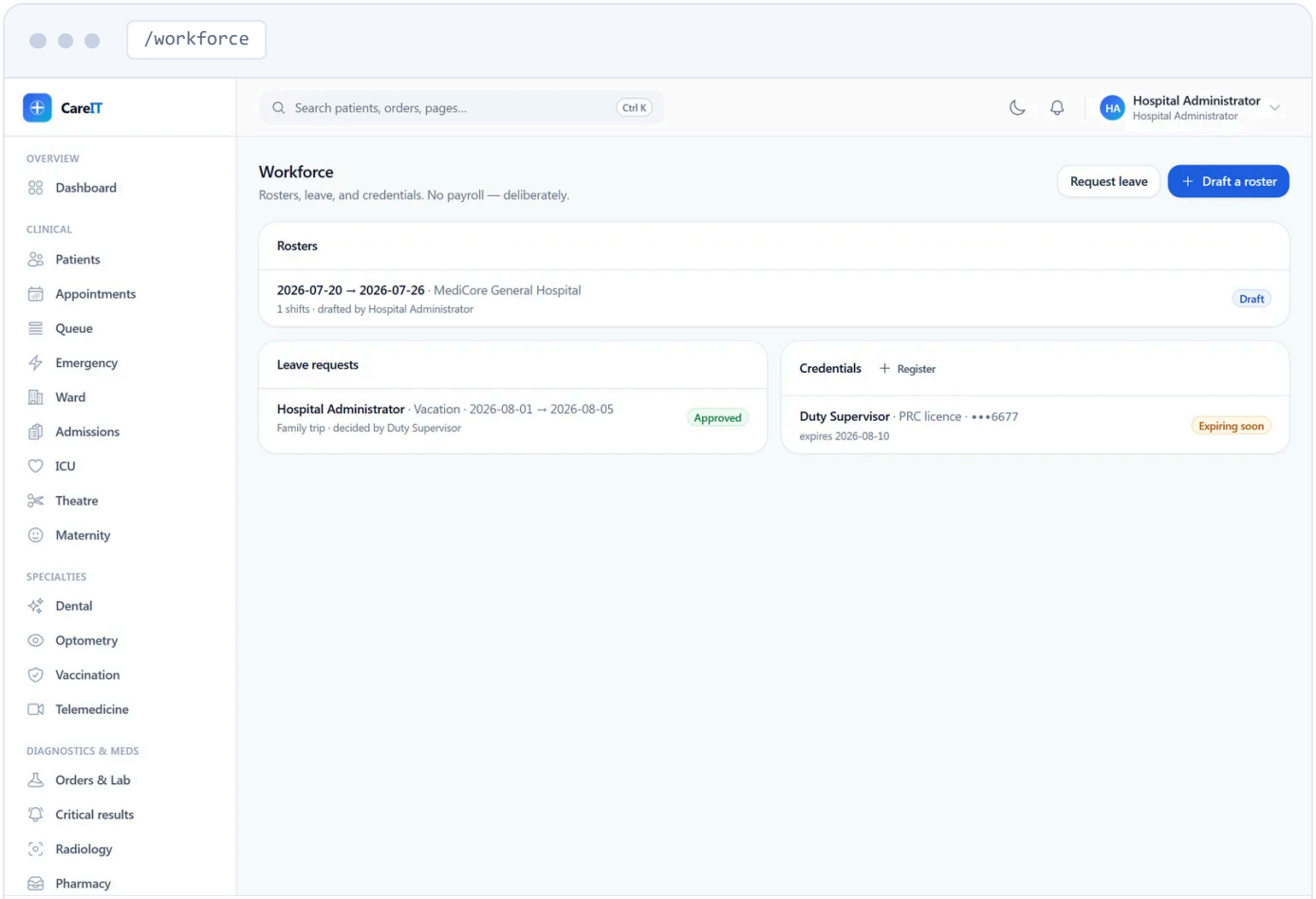
9.2 · Purchase orders `/inventory/purchase-orders`



Raise, approve (someone else), receive with lot and expiry.

1. **Raise a PO** — supplier, line items, quantities, and costs.
2. A **different** staff member approves it; the raiser's own approve button simply isn't there, with the reason stated.
3. **Receive** against the PO — quantities default to what's outstanding, and every received line demands its **lot and expiry**. Whether the PO closes as partial or full is decided by the numbers, not by a checkbox.
4. Received stock appears on the board and in the ledger immediately — and vaccination and dispensing pick lots from exactly this stock.

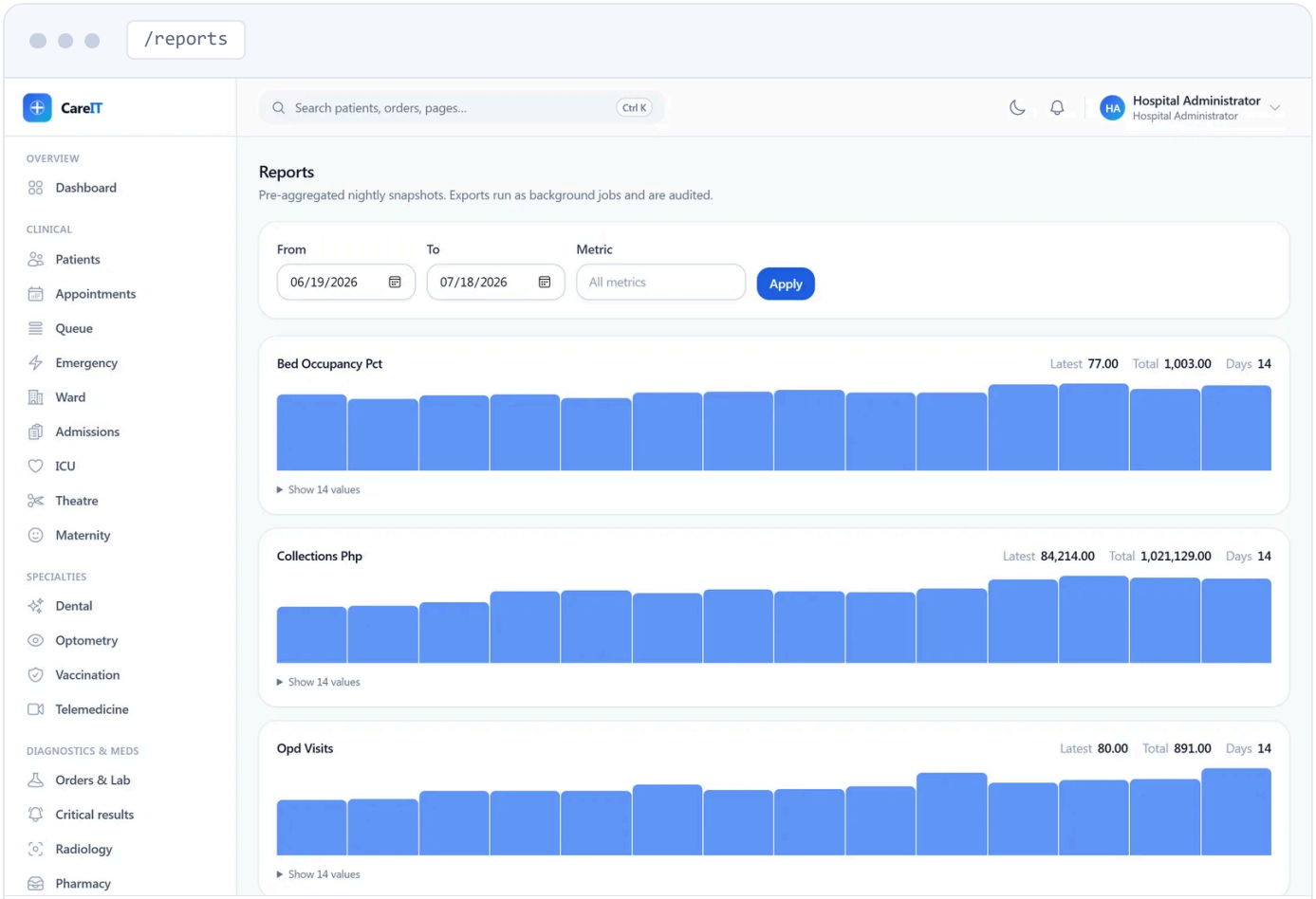
9.3 · Workforce `/workforce`



Rosters, leave, attendance, and credential expiry — with a minimum-staffing gate on publish.

- **Rosters** — draft shift patterns per period (night shifts roll past midnight correctly), then **publish**. Publishing runs the **minimum-staffing gate**: a ward that would fall below its required nurse count refuses to publish and says which shift is short. Staff are notified when a roster goes live.
- **Leave** — requests check for overlaps, and approval by the requester is refused.
- **Attendance** — clock events with corrections that keep the original visible.
- **Credentials** — professional licences are stored encrypted, display masked, and show amber warnings from 90 days before expiry. An expired licence is a rostering conversation *before* it is a compliance finding.

9.4 · Reports `/reports`

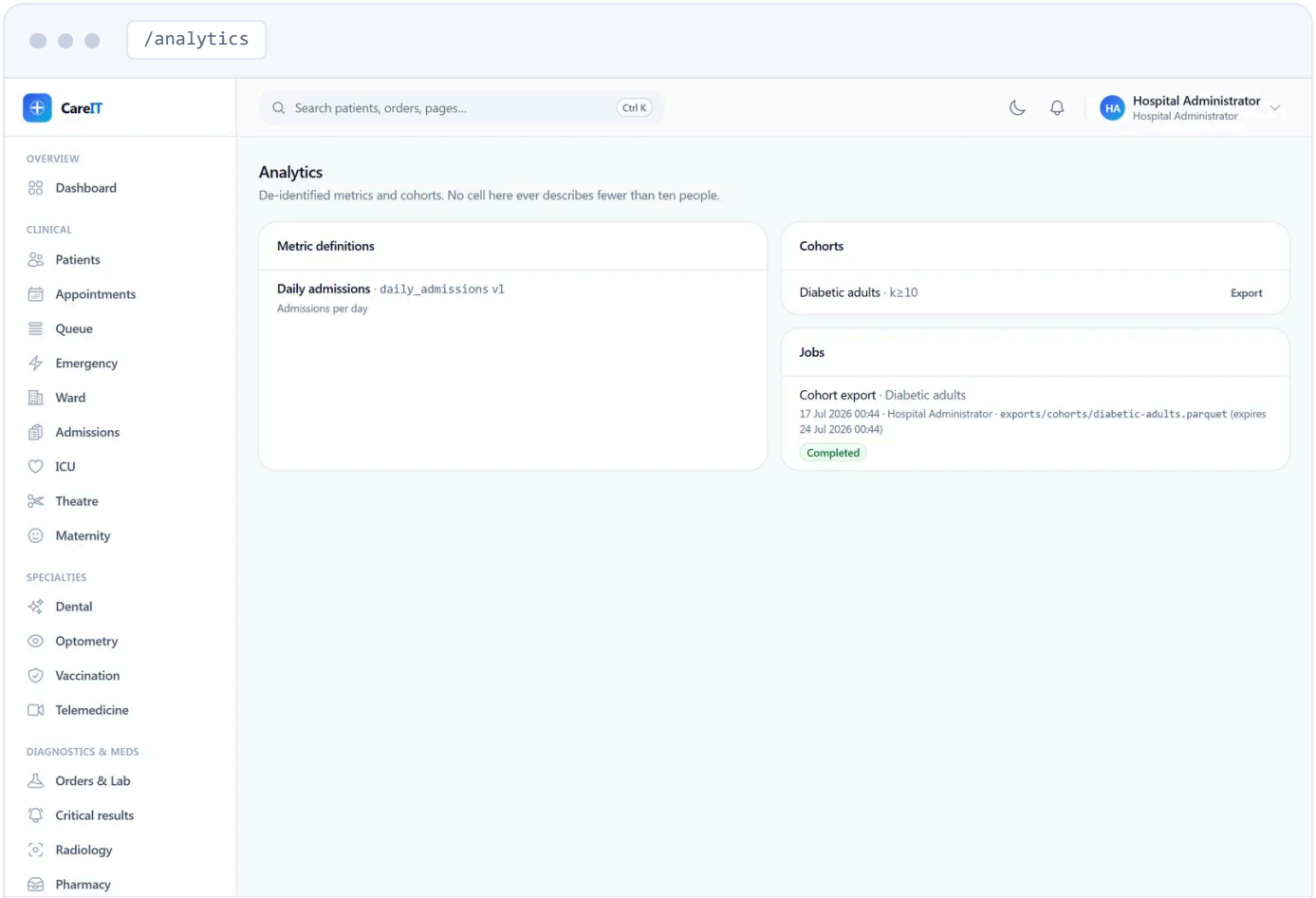


Nightly snapshot series per metric, and queued exports delivered through expiring links.

1. Pick a date range and, optionally, a metric — the page charts each metric's snapshot series over the period (visits, collections, occupancy, and so on).

2. **Export** queues a CSV in the background; the screen polls until it's ready and hands you a **signed download link that expires**. Every export is itself recorded in the audit trail.

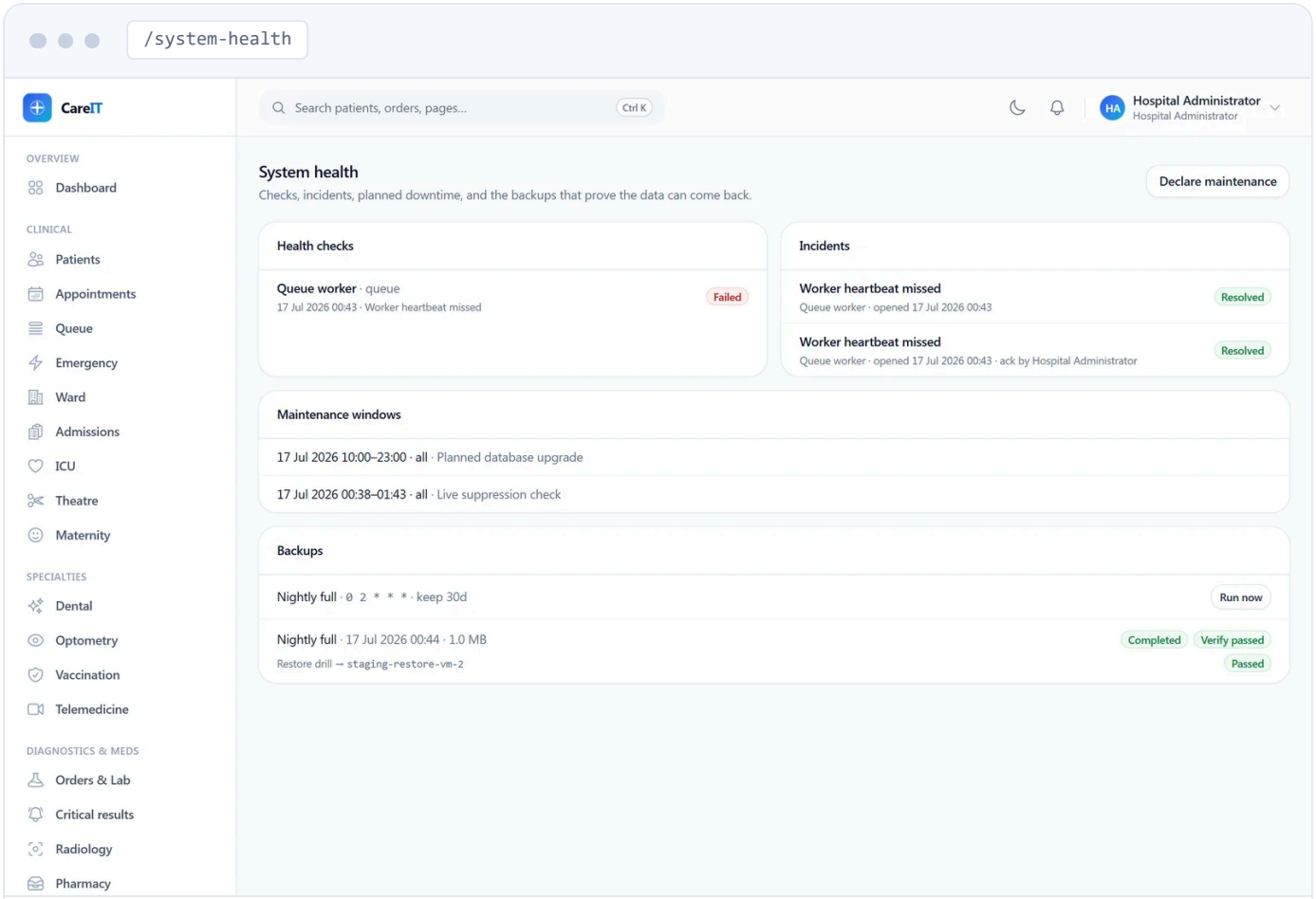
9.5 · Analytics `/analytics`



Metric definitions, cohorts with a k-anonymity floor, and the async job queue.

- **Metric definitions** are versioned — the number's meaning is part of the number.
- **Cohorts** define patient groups for analysis. A cohort that would identify fewer than 10 patients is refused at definition time — small groups can't leak into a spreadsheet.
- **Jobs** — snapshot refreshes and cohort exports run asynchronously; exports are permission-gated and their outputs expire.

9.6 · System health & backups `/system-health`



Checks, incidents, maintenance windows, and backup runs with verified restores.

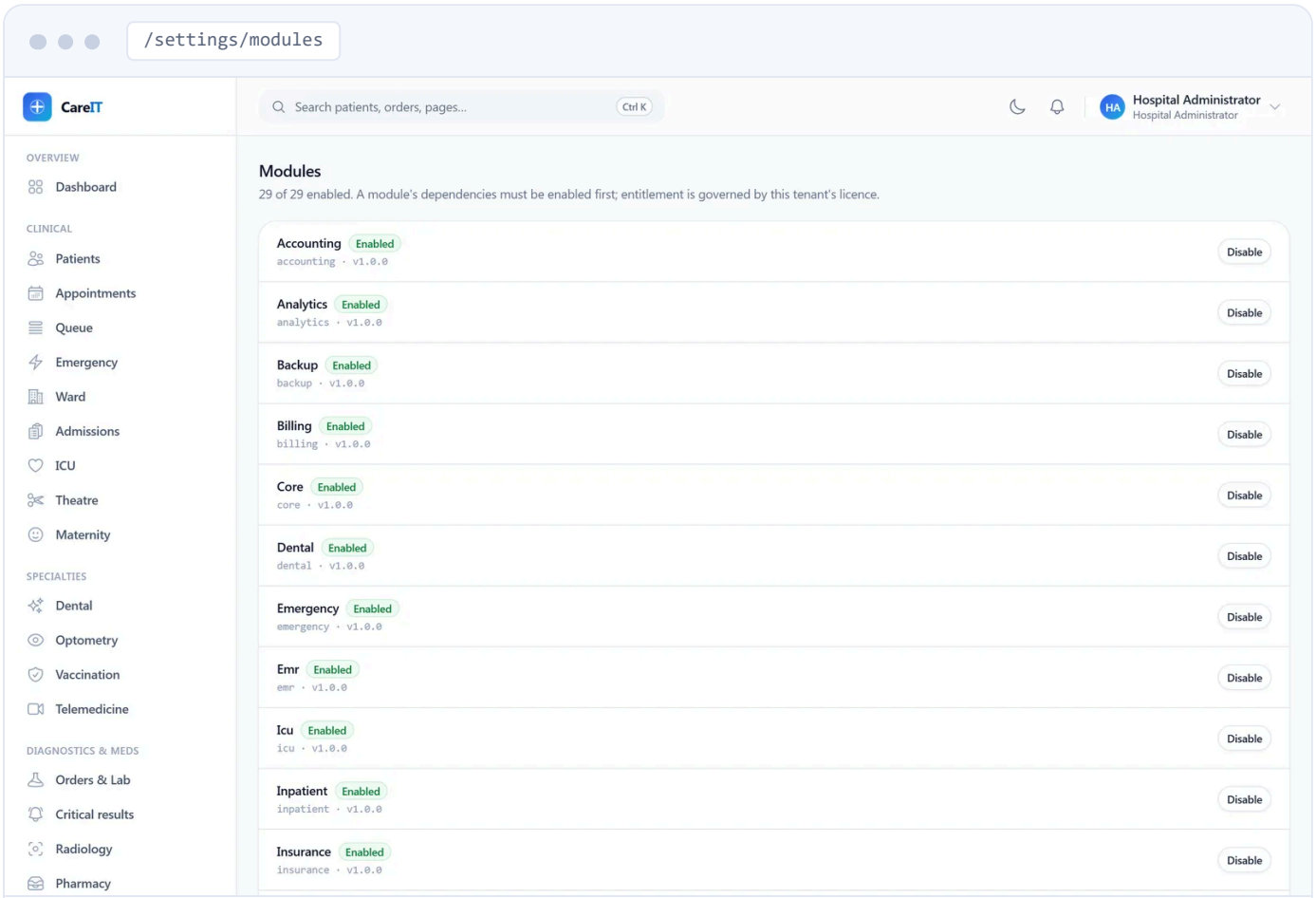
- **Checks** sample the platform's moving parts; failures open **incidents** that one person **acknowledges** — a second acknowledgement is refused, because ownership is singular.
- **Maintenance windows** declare planned downtime — failures inside a window never page anyone at 3 a.m. for work that was scheduled.
- **Backups** — every run is listed, and each wants a **restore test** with evidence. An unverified restore is a hope, not a backup; this screen is where hope is replaced with proof.

CHAPTER 10

Administration & security

Licensing by module toggle, the tamper-evident audit trail, and each account's own security.

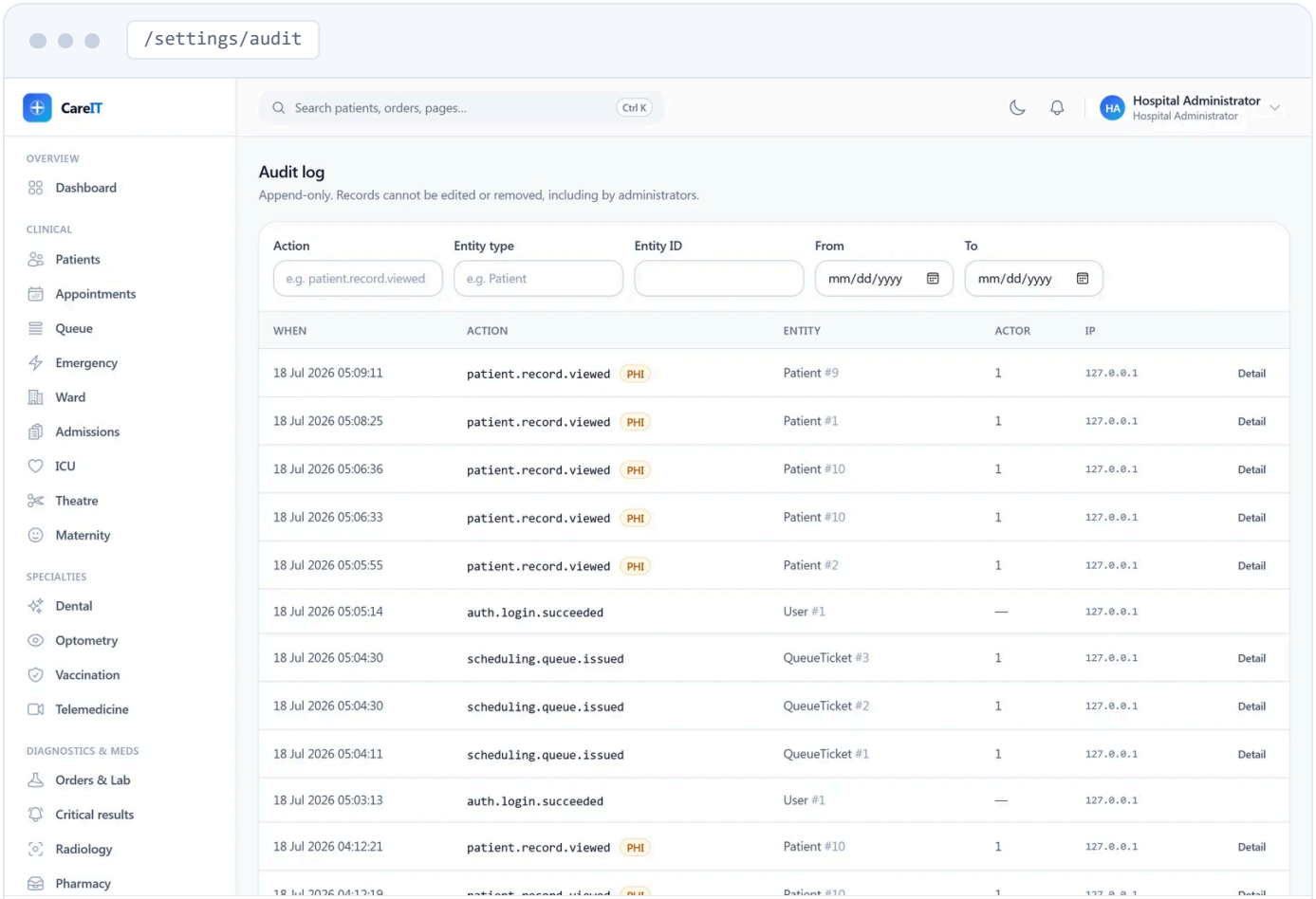
10.1 · Modules & licensing `/settings/modules`



All 29 modules with tiers and dependencies — toggles double as licensing.

- Enable the modules your facility licenses; sidebar entries appear and disappear with the toggle.
- The registry checks **dependencies** — enabling a module whose prerequisite is off is refused with the reason verbatim, and disabling something another module depends on is likewise refused.
- This is also how phased rollouts work: outpatient core first, wards later, specialties when each team is trained (your implementation plan follows the same toggles).

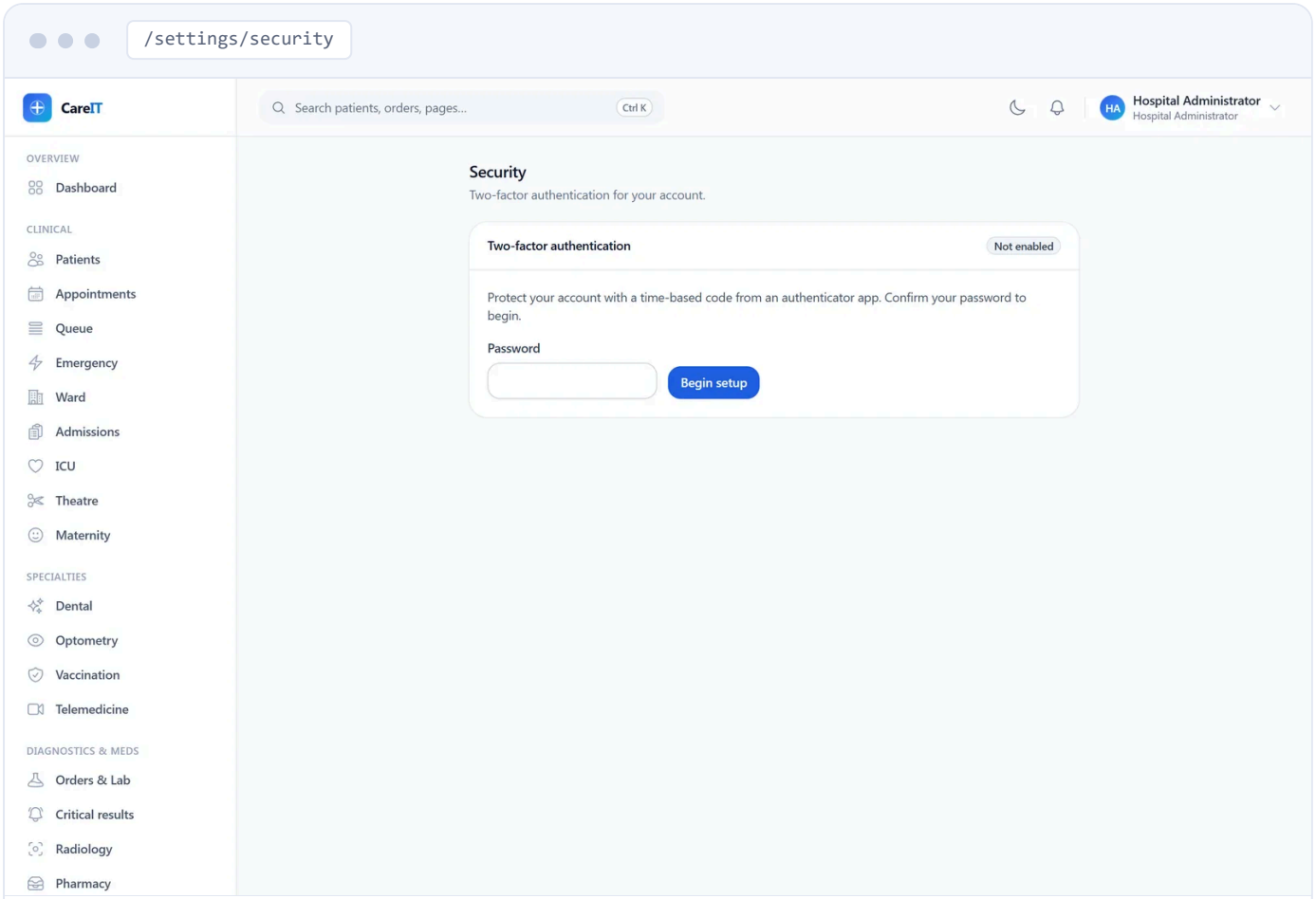
10.2 · The audit log `/settings/audit`



Append-only, hash-chained, PHI reads included — the answer to "who saw what, when".

- Filter by **actor**, **entity**, **action**, or **date**; expand an entry for its before/after diff.
- Entries that touched patient data are **PHI-tagged** — document downloads, chart reads, portal logins, break-glass access, all of it.
- The log is **hash-chained**: each entry carries a fingerprint of the one before it, so tampering breaks the chain visibly. Nobody — including administrators — edits this log.

10.3 · Your account's security `/settings/security`



Two-factor enrollment — recovery codes are shown exactly once.

1. **Enable two-factor** — scan the QR code with an authenticator app (or type the secret), confirm with a code.
2. **Store your recovery codes** somewhere safe the moment they appear — they are displayed once, then stored hashed and cannot be shown again. Each works one time.
3. **Disabling 2FA** requires re-authentication — a walk-away-from-your-desk moment can't quietly weaken your account.
4. **Changing your password** requires the current one, refuses passwords found in known breaches, and signs out your other sessions.

APPENDIX

Quick reference & glossary

Every screen at a glance, and the vocabulary the system uses.

A.1 · Screen directory

SCREEN	ADDRESS	WHAT IT'S FOR
Dashboard	`/dashboard`	Role-aware home with quick actions
Notifications	`/notifications`	Critical results, findings, roster notices
Patients	`/patients`	Master patient index — search, register, merge
Patient chart	`/patients/{patient}`	Demographics, allergies, encounters, documents, billing
Appointments	`/appointments`	Day board and booking
Queue	`/queue`	Walk-in tickets, emergency-first calling
Encounter chart	`/encounters/{encounter}`	Notes, vitals, diagnoses, orders, prescriptions
Emergency	`/emergency`	Acuity-first ED tracking board
Ward / Admissions	`/ward · /admissions`	Beds, stays, two-step discharge
eMAR	`/admissions/{admission}`	Scheduled doses — given, refused, held
ICU	`/icu`	Flowsheets, devices, severity scores
Theatre	`/theatre`	Cases, checklist gates, implants
Maternity	`/maternity`	Episodes, deliveries, newborn linking
Dental	`/dental/{patient}`	FDI odontogram, findings, procedures
Optometry	`/optometry`	Exams and optical prescriptions
Vaccination	`/vaccination/{patient}`	Doses from real lots, AEFI, certificates
Telemedicine	`/telemedicine`	Consent-gated remote sessions
Orders & Lab	`/orders`	Stat-first worklist, results, verification
Critical results	`/critical-results`	Acknowledge-with-deadline escalation queue
Radiology	`/radiology`	Studies, signed report versions, critical findings
Pharmacy	`/pharmacy`	Validation, FEFO dispensing, witnesses

Treatment plans	`/treatment-plans`	Goals, activities, progress, reviews
Messages	`/messages`	Care-team threads, redaction, legal hold
Portal admin	`/portal-admin`	Accounts, release rules, proxy, access log
Mobile devices	`/mobile-devices`	Device registry and offline sync queue
Invoices / Cashier	`/invoices · /cashier`	Charge-backed billing, shifts, drawer
Claims	`/claims`	Payer claims, per-line adjudication
Accounting	`/accounting`	GL export batches, reversals
Inventory	`/inventory`	Stock board, lots, movement ledger
Purchase orders	`/inventory/purchase-orders`	Procurement with two-person approval
Workforce	`/workforce`	Rosters, leave, attendance, credentials
Reports	`/reports`	Snapshot series, queued exports
Analytics	`/analytics`	Metrics, cohorts, jobs
System health	`/system-health`	Checks, incidents, windows, backups
Settings	`/settings/…`	Modules, audit log, account security

A.2 · Glossary

TERM	MEANING
MPI	Master Patient Index — the single registry of patients; one person, one record.
MRN	Medical Record Number — the patient's permanent identifier, issued from a per-facility series.
Encounter	One episode of care (a consult, an ER visit, an admission) — the unit clinical records hang from.
Append-only	Records are amended or superseded, never edited in place or deleted; every version stays readable.
Acuity	Triage severity, 1 (resuscitation) to 5 (non-urgent). Lower number = seen sooner.
eMAR	Electronic Medication Administration Record — the ward's drug chart of scheduled and recorded doses.
Stat	The highest order priority — before urgent, before routine, always at the top of the worklist.
Critical value	A result dangerous enough to demand acknowledged human attention on a deadline.
FEFO	First-Expiry-First-Out — dispensing consumes the earliest-expiring stock first.
Charge capture	Recording the billable fact at the moment of care; invoices are built from captured charges.
Adjudication	The payer's line-by-line decision on a claim; the claim's outcome is computed from it.

Break-glass	Emergency access outside normal permissions — always available to those authorised, always audited.
Hash chain	Each audit entry fingerprints the previous one, making tampering visible.
Proxy access	A portal grant letting one person view another's record (parent/child), scoped and expiring.
Legal hold	A freeze on a conversation or record during an investigation; destructive actions are refused.
K-anonymity	The analytics floor: no cohort smaller than 10 patients can be defined or exported.

A.3 · Getting help

Your facility's administrator is the first stop for access questions — they can see which roles and permissions your account holds. For product support, contact **CareIT Solutions** through the support channel in your service agreement. When reporting an issue, include the screen address (shown throughout this guide), what you did, and what you expected — the audit trail does the rest.

CareIT HMS User Guide · Edition 1.0 · July 2026. Interface captures show sample data only. Product capabilities described reflect the shipped system at time of writing; your facility's licensed modules may differ.