



SilhouetteCentral v3.22

User's Guide

Note: This system is developed for use only by qualified medical professionals trained and experienced in its use. Do not use the system before reading and understanding this user's guide.

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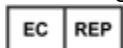
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Introduction to SilhouetteCentral

Throughout this user's guide, screen, menu, and field names in SilhouetteCentral are displayed in a **bold font**. Series of actions are referred to as follows:

Admin > Organization > Settings

which means to click on the **Settings** option in the **Organization** menu in the SilhouetteCentral Admin section.

The Silhouette Product Suite

The Silhouette™ Product Suite is a computerized wound imaging, analysis, and documentation system designed for wound care professionals. As part of this suite, SilhouetteCentral™ acts as a centralized database and data management tool that stores and organizes wound assessment information collected from SilhouetteConnect™ and SilhouetteStar™. SilhouetteStar is a specialized wound camera that connects to a Windows device, such as a PC or tablet. SilhouetteStar is controlled by SilhouetteConnect, a software applications that resides on the Windows device.

SilhouetteCentral

SilhouetteCentral is a web based application for storing wound information. The SilhouetteCentral application is developed using Microsoft .NET 4.5.2 and is hosted by Microsoft Internet Information Services (IIS) on Windows Server 2008 or later machines. Patient demographic and assessment data is stored in a Microsoft SQL Server 2008 or later database (although images and reports are stored outside of the database).

SilhouetteCentral is divided into three parts:

- Desktop - Provides access to the patient medical data stored in the SilhouetteCentral database for reviewing, editing, and updating. Reports, images, and wound measurement data can also be exported for further processing and importing into other applications.
- Reporting - Provides access to population level reporting, i.e. allows the generation of reports that summarize and collate assessment data across multiple patients. This is an optionally licensed feature which may not be present in your installation.
- Admin - Provides facilities to manage units, groups, patients, and system users. SilhouetteConnect and SilhouetteCentral can also be configured and customized.

Getting Started

This chapter describes how to get started with SilhouetteCentral. It is divided into the following sections:

- [System Requirements](#)
- [Logging On to SilhouetteCentral](#)
- [Navigating in SilhouetteCentral](#)
- [Identifying Patients](#)
- [My Account](#)
- [Logging Off SilhouetteCentral](#)
- [About Screen](#)

System Requirements

SilhouetteCentral is accessed via a web browser and does not install any additional software. It is possible to use multiple tabs to view SilhouetteCentral (however we advise caution to ensure the correct patient data is being reviewed when using multiple tabs).

The screens your browser displays may differ slightly from the screen captures shown in this document. However, such differences are minor and do not affect the performance of SilhouetteCentral.

Logging On to SilhouetteCentral

The default method of logging in is Manual Sign-on only, if you have LDAP integration turned on you have two extra modes Automatic and manual sign-on and Automatic sign-on only.

Manual sign-on only

To log on to SilhouetteCentral, navigate to the website address of your SilhouetteCentral instance. The log on screen will appear. Enter the **User Name** and **Password** supplied to you. Select Log on. If your user account has access to **patients** in multiple units you will be prompted to select a **unit**.

Please select which unit you wish to log on to.

Unit

It is important to log on using the **User Name** and **Password** assigned to you. Silhouette records the names of users viewing, creating, and modifying patient records, and using the correct user name ensures accurate auditing. Next time you log on, your last selected unit will be remembered and it will be automatically selected from the list. You can select a different unit if you want.

If you are logged into different units in multiple devices or **SilhouetteConnect** and **SilhouetteCentral** at the same time, it will select the last synchronized unit among those at your next logon.

Once you are logged on to SilhouetteCentral, the **Patient Select** screen will be displayed (see [Selecting a Patient](#)). Many browsers will prompt you to save a **User Name** and **Password** for websites you log on to. It is recommended that you do not permit the browser to do so for SilhouetteCentral as doing so means that anyone using your computer can log on, access and potentially modify patient medical records that will be recorded as having been actioned by you.

While logging on to SilhouetteCentral you may occasionally be prompted to change your password if a system administrator has made use of the password expiry features. In this case you will need to pick a new password that meets the password complexity requirements and enter it before SilhouetteCentral will allow you to log on.

Automatic and manual sign-on

You can log into SilhouetteCentral the same way as in Manual sign-on. You can also use your Windows domain user credentials by clicking the link. "Logon using Microsoft Windows domain".

User Name

Password

[Logon using Microsoft Windows domain](#)

Automatic sign-on only

If this option is enabled you will not be prompted to enter your username and password. If you are using SilhouetteCentral on a machine running Windows the credentials of the logged in user will be used to log in. To log on as a different user then you need to switch which user is logged into Windows. If your user account has access to patients in multiple units you will be prompted to select a unit.

Next time you access SilhouetteCentral, your last selected unit will be remembered and it will automatically select from the list. You can select a different unit if you want. To select a different unit at any time click the current unit name in the top right of the screen.

If you are logging into different units in multiple devices of SilhouetteConnect and SilhouetteCentral at the same time, it will select the last synchronised unit among those at your next logon.

Once you are logged on to SilhouetteCentral, the patient select screen will be displayed.



If Automatic sign-on is enabled the link to My Account and Log Off will be unavailable. If you want to switch units, click on the current unit in the top right and SilhouetteCentral will navigate back to the unit selection screen.

Recovering Forgotten Password

If you have forgotten your password, click on "Forgot your Password?" link on the log on screen. If you do not see this link, your administrator may have chosen to disable this feature, in which case contact your system administrator for further advice on how to regain access to your account.

User Name

Password

[Forgot your password?](#)

Log On

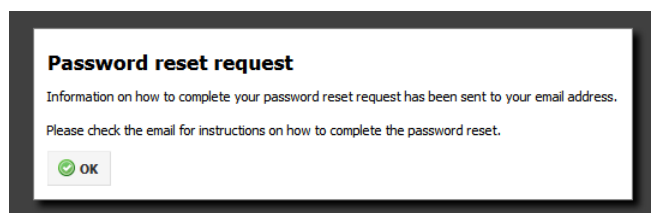
Once the "Forgot your password?" link is selected you will be prompted to enter your email address. You should enter the email address that is associated with your SilhouetteCentral user name.

In order to reset your password please enter your email address.

Email Address

Cancel Send Password Reset

You will get a message that an email with instructions to reset your password has been sent to the email address you specified.



When you check your email account and receive the email sent by SilhouetteCentral you will find a link that can be clicked to reset your password. Clicking the link will load the SilhouetteCentral website and prompt you to enter a new password.

Please enter the new password for 'donald'.

The password must match the following criteria:

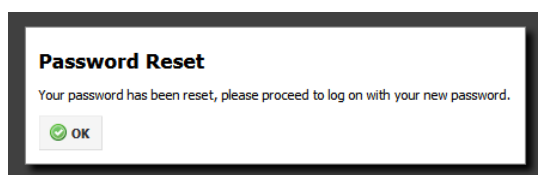
- A minimum of 3 characters.
- A maximum of 20 characters.

New Password *

Confirm Password *

Cancel Reset Password

You will receive a confirmation that your password has been changed and you can now proceed to log on with the new password.




If you receive a password reset request email and do not remember requesting it, an additional link in the email may (depending upon system configuration) be provided that allows you to cancel the password reset request so any other person who manages to view the email can not reset your password.

Password reset request canceled. The link can no longer be used to reset your password.

User Name

Password

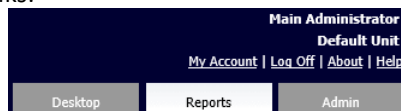
[Forgot your password?](#)

 Log On

In some circumstances you may get a password reset email that indicates your user account is not able to have its password reset via email. In this scenario contact your system administrator for further instructions on how to reset your password.

Navigating in SilhouetteCentral

Once you have logged on to SilhouetteCentral, your name and unit is shown in the top right-hand corner, and immediately underneath are a set of links:



My Account

Change your account settings such as your name, email address and password. See [My Account](#).

Log Off

Log off from SilhouetteCentral. See [Logging Off SilhouetteCentral](#).

About

View information about the application. See [About Screen](#).

Help

View information to help you use SilhouetteCentral.

Desktop, Reports and Admin tabs

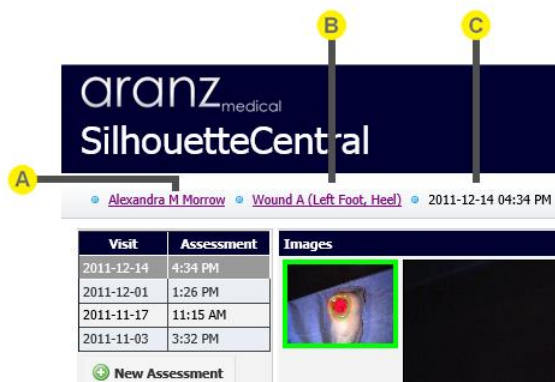
SilhouetteCentral is divided into a number of distinct sections that allow you to perform different kinds of tasks. Once logged on each section is represented as a tab in the top right hand corner of the browser window.

The main sections are

- Desktop - allows review, creating or editing of patient data
- Reports - allows population level aggregate reporting across all patient data
- Admin - allows system administration activities to be performed

Note: Different users may see a different sub set of tabs. The tabs that are visible depend upon the security permissions associated with your user account and/the which features of SilhouetteCentral have been licensed.

Some SilhouetteCentral screens have breadcrumbs made up of hyperlinks. The hyperlinks in the breadcrumb allow you to move quickly from one part of the application to another. An example is when viewing patient records:



- A** Clicking on the patient name hyperlink returns you to the **Patient Select** screen. See [Selecting a Patient](#).
- B** Clicking on the wound hyperlink returns you to the **Wound Manager** for the selected patient. See [Using the Wound Manager](#).
- C** The last part of the breadcrumb indicates the currently selected assessment within the **Wound Details** screen. This is typically not clickable, however while editing notes you will see a 4th part to the breadcrumb indicating the type of notes being edited, and clicking the assessment date will then return you to the **Wound Details** screen.

Note that it is possible to use multiple tabs to view SilhouetteCentral, however care should be taken to ensure the correct patient data is being reviewed when using this feature.

Identifying Patients

Within the context of a hospital environment there may be two or more patients with the same name or date of birth. Silhouette uniquely identifies each patient via use of a personal identifier, which by default is called the patient's Patient ID.

Within Silhouette it is not possible to create a new patient record without assigning a Patient ID to the patient. Although Patient ID is the default name for a patient's personal identifier, it is possible to change this to a term that will be more familiar in your environment: [Organization](#).

Searching for Patients

In some SilhouetteCentral screens, you can search for patients by their first name, middle name, last name, or Patient ID. You can also restrict the search to patients that have had an assessment performed within a specific range of dates. All screens with such search functionality operate in a consistent manner as outlined below.

A

Search box

Enter part of the patient's name or Patient ID, then click on the **Search** button.

For example, searching for the letters "an" filters the list so that it displays patients whose name or Patient ID contains the letter sequence "an".

Narrow the search further by entering more of a patient's name or Patient ID. If your user account has access to patients in more than one unit and a search does not find the patient you are looking for, you may need to select "Any Unit" within the **Within** drop down in order to look for patients in units other than the one you logged on to.

B

Assessments from and to

Select the from and to dates from the popup calendars, then click on the **Search** button.

You can also type in the date. Specifying a date range will search for patients that have had an assessment made within the specified range. The from and to dates are inclusive.

C

Search button

Once search criteria have been entered, click to search.

D

Clear Search button

Click to clear search criteria and display the full list of patients. If visible, the **Within** drop down will keep its current value.

Alternative Work-flow: Multi-Unit Organizations

For user accounts that have access to patients in more than one unit, the patient search will be restricted to the unit you are currently logged on to. If you wish to view patients in another unit, you must select that unit when you log on. Alternatively, you may set the **Within** drop-down box to **Any Unit**. This will display all patients you have access to irrespective of which unit they are currently assigned to. For more on users, groups and units configuration, see [Groups, Users, and Units in Silhouette](#).

My Account

In the **My Account** screen, you can:

- Change the password you use to log on to SilhouetteCentral. See [Changing Your Password](#).
- Change other account settings, such as your name, contact details or email address.

NOTE: You may not be able to access the My Account screen if your user account is administered centrally via your IT infrastructure. In this case you should contact your systems administrator if you need to change any details of your user account displayed within SilhouetteCentral.

Changing Your Password

To change your SilhouetteCentral password:

1. Navigate to the **My Account** screen.
2. Select the **Reset Password** button.
3. Enter your existing password in the **Current Password** box.
4. Enter your new password in both the **New Password** and **Confirm Password** boxes.
5. Select the **Reset Password** button to update the system with your new password.

Note that user names and passwords are used across the Silhouette Product Suite, so you will also need to use the new password when logging onto SilhouetteConnect.

You can also manage and change passwords for other users via the [User Administration](#) screen.

If you are unable to see the link to **My Account** screen, you are possibly logged into an account controlled by [LDAP Integration](#).

Logging Off SilhouetteCentral

You can log off SilhouetteCentral from any screen by clicking on the **Log Off** option from the upper right-hand corner.

Note that you will be automatically logged off SilhouetteCentral after a certain period of inactivity. This period is configurable, but by default is 10 minutes.

Please note that with the authentication mode **Automatic sign-on only** the user does not have the ability to log off.

About Screen

The **About** screen displays information about SilhouetteCentral, including the SilhouetteCentral version and customer support information.

You can also download some items from the **About** screen to your computer:

- The latest version of the SilhouetteConnect software is available for download by selecting the **Download Page** link. While SilhouetteCentral will deploy SilhouetteConnect application updates automatically upon synchronization, it might still be useful to download this software manually, for example if you wish to install SilhouetteConnect on a new computer.
- You can view or save the **End User License Agreement**. Select the link to export the information.

Using SilhouetteCentral Desktop

This chapter describes how to use SilhouetteCentral Desktop. It is divided into the following sections:

- [Selecting a Patient](#)
- [Assessment Orders](#)
- [Using the Wound Manager](#)

Selecting a Patient

Following log on, the **Patient Select** screen is displayed:

The screenshot shows the 'Patient Select' interface. At the top, a breadcrumb (A) shows 'Steven A Dallas'. Below it, patient details (B) are listed: Domain ID TF310983, Name Steven A Dallas, Date of birth 1951-02-18 (61 years old), and Gender Male. A search bar (C) contains 'Name or Patient ID' and 'Within Default Unit'. Below the search bar is a table (D) of patients. The table has columns: Last Name, First Name, Middle Name, Domain ID, D.O.B., First Assessment, Last Assessment, and # Assessments. The table lists 13 patients, with Steven A Dallas highlighted. Below the table are page links (E) '1 2 3 4 5'. At the bottom are action buttons: Create (F), Edit (G), Delete (H), Wound Manager (I), and Export Records (J).

Last Name	First Name	Middle Name	Domain ID	D.O.B.	First Assessment	Last Assessment	# Assessments
Allen	Maria		TF023578	1957-09-14	2011-10-11 18-52	2011-10-11 18-52	1
Ashworth	Susan	Diane	ZW984390	1939-03-06	2008-10-13 10-59	2008-10-13 10-59	1
Berry	Clare	Judith	TF326703	1975-12-21			0
Bloom	Meredith	Cooper	TF320147	1959-03-19	2011-11-15 20-12	2011-12-14 10-01	6
Caldwell	Jacqueline		TF329234	1960-09-14			0
Cook	Lucy		ZW906802	1946-01-14	2008-10-13 10-15	2008-10-13 10-19	2
Cooke	Albert		PQ958825	1946-11-23	2009-08-17 15-47	2009-08-23 20-17	5
Cooper	Elizabeth		ZW123250	1953-11-19	2008-10-02 17-03	2008-10-13 12-42	4
Dallas	Steven	Arthur	TF310983	1951-02-18	2011-10-10 15-38	2011-10-19 17-04	13
Davidson	Peter		TF319472	1955-12-14			0

- A Breadcrumb**
When a patient is selected, their name is displayed to start the breadcrumb.
In the **Wound Manager**, you can return to the **Patient Select** screen by clicking on the patient's name in the breadcrumb.
See [Navigating in SilhouetteCentral](#).
- B Patient details**
This summarizes the currently selected patient's details.
If no information is displayed, click on a patient in the patient table.
- C Patient search fields**
Search for a patient by their name or Patient ID or view all assessments in a specific range of dates. See [Searching for Patients](#).
- D Patient table**
The patient table lists patients found in the SilhouetteCentral database.
You can sort the list by clicking on any of the column titles.
- E Page links**
When there are too many patients to display on one screen, the page links at the bottom of the screen allow you to navigate through the patient table.
- F Create button**
See [Adding a New Patient](#).
- G Edit button**
See [Editing an Existing Patient's Details](#).
- H Delete button**
See [Deleting a Patient](#).
- I Wound Manager button**
See [Using the Wound Manager](#).
- J Export Records button**
See [Exporting Patient Records](#).

Adding a New Patient

To add a new patient, in the **Patient Select** screen click on the **Create** button. The **Create Patient** screen is displayed, with compulsory fields marked with an asterisk. When you have entered the patient's details, clicking on the **Save** button at the bottom of the screen saves the patient's information and returns you to the **Patient Select** screen.

Alternative Work-flow: Multi-Unit Organizations

You can only create a patient belonging to the unit that you are logged on to. If you wish to create a patient belonging to a different unit, you will need to log off and log on to the other unit. Once a patient has been created you can change the unit they are associated with by [Editing an Existing Patient's Details](#).

Editing an Existing Patient's Details

To edit an existing patient's details, select that patient in the **Patient Select** screen and click on the **Edit** button. The **Edit Patient** screen is displayed, with compulsory fields marked with an asterisk. When you have finished editing the patient's details, clicking on the **Save** button at the bottom of the screen saves the patient's information and returns you to the **Patient Select** screen.

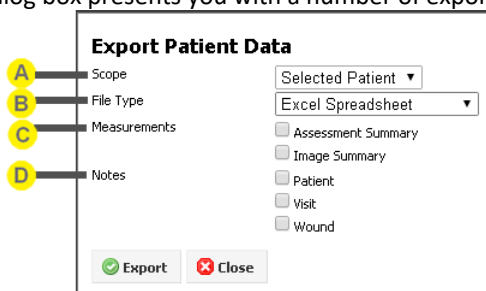
Deleting a Patient

To delete a patient from SilhouetteCentral, select that patient in the **Patient Select** screen and click on the **Delete** button. You will be asked to confirm your choice.

If you accidentally delete a patient, contact an administrator who can reactivate the patient on your behalf using the [Reactivate Patients](#) screen.

Exporting Patient Records

To export patient data for use in an external application, on the **Patient Select** screen click the **Export Records** button. The **Export Patient Data** dialog box presents you with a number of export options:



A

Scope

Choose to export patient data for the currently selected patient, or for all patients in the units you have permission to access.

B

File type

You can export the data in one of the following file types:

- Excel 2003 Spreadsheet (.xml): the data is formatted to be read by Microsoft Excel 2003 or later, or prior versions with the Microsoft Office Compatibility Pack for Word, Excel and PowerPoint File Formats installed.
- Comma (,) Delimited (.csv): text file, with a comma (,) used to separate patient data fields in the exported file
- Pipe (|) Delimited (.csv): text file, with a pipe (|) used to separate patient data fields in the exported file
- Underscore (_) Delimited (.csv): text file, with an underscore (_) used to separate patient data fields in the exported file
- Asterisk (*) Delimited (.csv): text file, with an asterisk (*) used to separate patient data fields in the exported file



Measurements

Choose between exporting Assessment Summary and/or Image summary measurement. See Measurement and Note Options.



Notes

Choose whether to export patient, Visit, and Wound Level notes. See Measurement and Note Options.

Measurement and Notes Options

You need to select at least one of the measurement or notes options in order to export data. If you select more than one option, the different options will appear as different sheets in the Excel file; or, if you selected a delimited file, the different options will be contained in a zip file containing one .csv file for each export option.

Assessment Summary

The **Assessment Summary** option exports a wound assessment level summary of all assessments captured with SilhouetteStar. For each wound assessment the export contains:

- Patient details, such as name, address, Patient ID, date of birth, and gender
- The wound label, anatomical site, assessment number, assessment date and time, and state (open or healed)
- The wound's area, area reduction, island area, perimeter, depth (max and mean), volume, and tissue types
- Wound notes, if enabled via the **Include Wound Notes in Summary Export** organization setting
- The axes (length and width) of each fragment and each ruler measurement

Note that the **Assessment Summary** present the wound measurements at the *assessment* level. For example, when two or more images are required to assess the area of a large wound, a single area measurement figure is displayed.

Image Summary

The **Image Summary** option exports an image level summary of all assessments captured with SilhouetteStar. For each image the export contains:

- Patient details, such as name, address, Patient ID, date of birth, and gender
- The wound label, anatomical site, assessment number and assessment date and time
- The image number, capture date and time, the number of fragments, the number of islands, and state (open or healed)
- The wound's area, area reduction, island area, perimeter, depth (max and mean), volume, and tissue types
- The axes (length and width) of each fragment and each ruler measurement

So in contrast to the **Assessment Summary** which presents measurements at the *assessment* level, the **Image Summary** presents measurements at the *image* level.



Customizing the Displayed Measurements

The types of measurements displayed is configurable via the SilhouetteCentral **Organization Settings**. Any number of measurement types can be chosen (or hidden) from the following list: time, area, area reduction, island area, perimeter, axes (length and width), rulers, maximum depth, mean depth, volume, and tissue types. For the measurement type to be included in the exported data file, it must be displayed somewhere within the Silhouette user interface.

For details on how the individual image and assessment level measurements are calculated, refer to the **How Silhouette Works** document.

Patient Notes

The **Patient Notes** option exports information extracted from the patient notes fields. In addition to the patient identity fields (name, address, Patient ID, date of birth, and gender), there are four columns:

- Group
- Item
- Value
- Changed

Each entry in the patient notes will appear as a row in the exported report, with the note's section label in the **Group** column, the label for the note in the **Item** column, the note's selected option or measurement in the **Value** column, and the date of the last update in the **Changed** column.

Visit Notes

The **Visit Notes** option exports information extracted from the visit notes fields. In addition to the patient identity fields (name, address, Patient ID, date of birth, and gender), there are five columns:

- Visit
- Group
- Item
- Value
- Changed

Each entry in the visit notes will appear as a row in the exported report. The date of each visit is listed in the **Visit** column, the note's section label in the **Group** column, the label for the note in the **Item** column, the note's selected option or measurement in the **Value** column, and the date of the last update in the **Changed** column.

Wound Notes

The **Wound Notes** option exports information extracted from the wound notes fields. In addition to the patient identity fields, there are seven columns:

- Wound
- Assessment
- Visit
- Group
- Item
- Value
- Changed

Each entry in the wound notes will appear as a row in the exported report. Each wound is identified in the **Wound** column, and alongside in the **Assessment** column is the date and time for each assessment. The note's section label appears in the **Group** column, the label for the note in the **Item** column, the note's selected option or measurement in the **Value** column, and the date of the last update in the **Changed** column. Note that the **Wound Notes** can also appear in the **Assessment Summary** if enabled via the **Include Wound Notes in Summary Export** organization setting.

Managing Assessment Orders

Assessment Orders

Optional Feature: Assessment Orders

Depending on the licensed features and configuration of your system, you may see an **Orders** button on the **Patient Select** screen. This feature is described in the following section.

Assessment orders are instructions to obtain one or more wound assessments for a specific wound on a specific patient. An assessment order contains a unique order number that can be used to uniquely identify the order, a scheduled date when the assessment(s) should occur and a description field containing details provided by the EMR which describe what needs to be assessed.

To action an assessment order, first perform the required assessments with Silhouette. Next the assessment(s) are assigned to their respective assessment order. This can be done either on SilhouetteConnect or SilhouetteCentral (once the data has been synchronized). To perform the assignment on SilhouetteCentral, select the patient and then click the **Orders** button on the **Patient Select** screen.

The **Assessment Orders** screen shows the orders for the patient, with a filter that defaults to displaying all currently active orders. Each order that has not been completed will display a drop down list containing suitable assessments that can be used to fulfill the order.

Assessment Orders screen for patient Roger Smith. The screen displays a table of assessment orders with the following columns: Order, Description, Unit, Scheduled Date, and Assessments. The table shows one order: Order 5178924, Description Urgent assessment, Unit Default Unit, Scheduled Date 2013-11-12 15:56, and Assessments 2013-11-12 16:03 - Wound A (Sacrum). The Assessments column has a dropdown menu. The screen also includes a 'Filter orders' button, a 'Show Active orders' dropdown, a 'Search' button, a 'Clear Search' button, and an 'Add' button. Callouts indicate the following actions: 'Free-form text or instructions sent with the order' (points to the Description field), 'Dropdown list of assessments performed' (points to the Assessments dropdown), 'Link assessment to order' (points to the 'Assign' and 'Close' hyperlinks), 'Mark order as completed' (points to the 'Close' hyperlink), and 'Create an Assessment Order' (points to the 'Add' button).

Find the appropriate assessment for the order in the drop-down list then click the **Assign** hyperlink to link the assessment to the order. The hyperlink will change to a disabled **Sending...** hyperlink, indicating that the assessment is being sent to the institution's electronic medical record system. As soon as the order results have been confirmed as received by the EMR system the disabled **Sending...** hyperlink will change to a **Resend** hyperlink.

When an assessment order has been satisfied click **Close** hyperlink to mark the assessment order as completed. No more assessments can be added after the assessment order is closed. Note that it is possible to close an assessment order without assigning any assessment to it. It would be appropriate to close an assessment order in this way if the assessment order was generated in error. It is also possible that such assessment orders may automatically be closed by your institution's electronic medical record system when the order is canceled elsewhere.

Other filter options on the **Assessment Orders** screen allow the user to display:

- All Orders - irrespective of their status.
- Active Orders - orders which are "new" or "in progress".
- New Orders - active orders which have been received from the EMR but have not yet had a wound assessment assigned to them.
- In Progress Orders - active orders which have had 1 or more wound assessments assigned to them, but have not been marked as closed (completed).
- Closed Orders - orders which have been marked as closed by a user in Silhouette, or canceled by the EMR.

Creating an Assessment Order

To Create an Assessment Order Click on the **Add** button and fill in the details in the dialog box that appears: Order Id, Scheduled Date, Wound, and Description.

Create Assessment Order

Order Id *

Scheduled Date *

Wound

Description *

Click **Create** to add the Assessment Order.

Assigning Multiple Assessments to an Order

Depending upon the configuration of your system it may be possible to assign multiple assessments to a single assessment order. For example an assessment order may have a description requesting 1 assessment be made each week for the following 3 weeks. First, select and assign the first wound assessment as described in the previous section. Additional unassigned assessments for the same wound will then automatically be listed below the assigned assessment, each with an **Assign** hyperlink. Click the **Assign** hyperlink for each assessment you want to associate with the assessment order.

Note that when a wound assessment has been assigned to an active assessment order, all subsequent assessments for the same wound must be assigned to the same order. If future wound assessments for the wound need to be assigned to a different order, the current order must first be closed.

• [Roger Smith](#) Domain ID 359878 Name Roger Smith Date of Birth 1959-06-25 (54 years old)

Assessment Orders

Show containing

Order	Description	Unit	Scheduled Date	Assessments	
5178924	Urgent Assessment	Default Unit	2013-11-12 15:56	2013-11-12 16:03 - Wound A (Sacrum) 2013-11-12 16:27 - Wound A (Sacrum) 2013-11-12 16:31 - Wound A (Sacrum)	Sending... Assign Assign Close

Additional assessments of same wound, each with its own **Assign** button

Resending an Assessment


In some cases you may wish to change information or generate an updated report for a wound assessment that has already been assigned to an assessment order and hence already sent through to your institutions electronic medical record system. Once you have edited the assessment using the standard Silhouette editing tools, navigate to the **Assessment Orders** screen. On the orders screen, the modified assessment will appear with a **Resend** hyperlink. Click the **Resend** hyperlink to have the updated assessment order results re-sent to the electronic medical record system.

Note if a change has been made to an assessment and the **Resend** hyperlink is not pressed this may mean that out of date results will be displayed within the EMR when the assessment order is reviewed. Always ensure that after a change is made in Silhouette that the **Resend** hyperlink is used.

• [Roger Smith](#) Domain ID 359878 Name Roger Smith Date of Birth 1959-06-25 (54 years old)

Assessment Orders

Show containing

SilhouetteConnect 
Mary Jones

Order	Description	Unit	Scheduled Date	Assessments	
5178924	Urgent assessment	Default Unit	2013-11-12 15:56	2013-11-12 16:03 - Wound A (Sacrum) 2013-11-12 16:27 - Wound A (Sacrum) 2013-11-12 16:31 - Wound A (Sacrum)	Resend Resend Resend Close

Modified assessments have **Resend** buttons alongside

Using the Wound Manager

The **Wound Manager** displays information about all the wounds for a selected patient.

A

B

Steven A Dallas

Wound A (Left Medial Malleolus)

Patient ID

TF310983

Name

Steven A Dallas

Date of Birth

1951-02-18 (63 years old)

Gender

Male

Anatomical Site	Wound	Number of Assessments	Baseline Assessment	Most Recent Assessment	Days Between	Area Reduction	Wound State
Left Medial Malleolus	Wound A	4	2011-10-10 03:38 PM	2011-10-19 05:04 PM	9	39.6%	Open
Left Foot, Medial	Wound B	3	2011-10-10 03:38 PM	2011-10-12 10:57 AM	2	49.6%	Open
Left Foot, Heel	Wound C	4	2011-10-11 12:49 PM	2012-07-31 03:17 PM	294	-23.3%	Open
Left Foot, Sole	Wound D	1	2011-10-12 11:34 AM	2011-10-12 11:34 AM	0	0.0%	Open
Left Gaiter, Circumferential	Wound E	1	2011-10-12 12:35 PM	2011-10-12 12:35 PM	0	0.0%	Open
Left Foot, Lateral	Wound F	1		2011-10-12 04:02 PM		-	Open
Left Thigh, Anterior	Wound G	0					Open

D

New Wound

E

View Assessments

- A Breadcrumb**
Click on the patient's name to return to the **Patient Select** screen.
See [Navigating in SilhouetteCentral](#).
- B Patient details**
This summarizes the currently selected patient's details.
- C Wound table**
The **Wound** table lists the wounds for the currently selected patient, together with the number of assessments and anatomical site label.
Click on a wound, then on **View Assessments** to view the [Wound Details](#).
- D New Wound**
Click the **New Wound** button to add a wound for the selected patient. While wounds are generally created on SilhouetteConnect, there are some situations where it can be useful to create them on SilhouetteCentral, for example, if you are setting up a new patient for another user.
- E View Assessments**
Click the **View Assessments** button to view details for the currently selected wound. The [Wound Details](#) screen will be displayed. Clicking the **View Assessments** button will also allow you to edit patient notes prior to the first assessment being captured.

The columns visible within the wound manager table include:

Anatomical Site

The anatomical region of the body that the wound is located on.

Wound

The wound identifier for the wound. This is used to uniquely identify multiple wounds on the same anatomical site.

Number of Assessments

The total number of assessments that have been performed for this wound. This will not include assessments with images, but also those that contain wound notes only.

Baseline Assessment

Baseline assessment by default, is the first assessment with an area. This can, however, be changed. For instructions to set an assessment as baseline, see [Wound Details](#).

Most Recent Assessment

This is the latest assessment done for the patient in that particular wound.

If the most recent assessment does not contain an area measurement (for example it contains assessment notes only) a star will indicate that the area reduction value shown is not taken from this latest assessment.

Days Between

It is the number of days between baseline assessment and the most recent assessment.

Area Reduction

This is the reduction in area of the wound when the most recent assessment is compared to the baseline assessment.

If your system administrator has turned off the display of the area reduction measurement feature, then the *Baseline Assessment*, *Days Between*, and *Area Reduction* columns will be hidden as shown in the image below.

		Main Administrator Level 101 My Account Log Off About Help				
		Desktop Reports Admin				
Meredith C Bloom Wound A (Right Upper Arm, Anterior)		Patient ID TF320147 Name Meredith C Bloom Date of Birth 1959-03-19 (55 years old) Gender Female				
Anatomical Site	Wound	Number of Assessments	Most Recent Assessment	Wound Last Opened	Wound Last Healed	Wound State
Right Upper Arm, Anterior	Wound A	4	2015-01-04 23:36	2014-03-02	2014-10-11	Healed
Right Upper Arm, Circumferential	Wound B	1	2014-02-02 20:13	2014-03-01		Open
Left Forearm, Anterior	Wound C	2	2014-03-02 16:28	2014-03-02		Open
Left Foot, Medial	Wound D	2	2014-10-11 14:26	2014-10-04		Open
New Wound View Assessments						

Wound Details

The **Wound Details** screen is divided into a series of panels, as shown below.

- A Breadcrumb**
The breadcrumb displays the currently selected patient and the anatomical site. Click on the patient's name to return to the **Patient Select** screen or on the wound to return to the **Wound Manager**. If you edit a note and return to **Wound Details** screen by clicking on a breadcrumb, the note tab will remain selected.
- B Patient details**
This summarizes the currently selected patient's details.
- C Assessments panel**
Here is a list of assessments, organized by visit, for the currently selected wound. Visits and assessments are displayed with the most recent visit at the top of the panel. Click on an assessment to display images for that assessment. See [Assessments Panel](#) for more information. You can also create a new assessment by clicking the **New Assessment** button. This can be useful if you wish to enter new wound notes for the patient.
- D Images panel**
This displays the images from the assessment currently selected in the **Assessments** panel. You can also export images to a file for viewing in another application. See [Images Panel](#) for more information.

- E Graphs panel**
This displays graphs for the currently selected wound across all assessments. Click on the tabs to view **Area**, **Area Reduction**, **Depth**, **Volume**, **Perimeter**, and **Tissue Type** graphs. You can also export graphs to a file for viewing in another application. See [Graphs Panel](#) for more information.
- F Notes panel**
This displays notes for the currently selected assessment. Click on the tabs to view **Patient**, **Visit**, and **Wound** notes. You can edit notes by clicking on the **Edit** button at the top or bottom of each tab. See [Notes Panel](#) for more information. If you edit one of these notes and click **Cancel**, it returns you to **Wound Details** screen with the tab still selected.
- G Reports panel**
This displays reports that have been created for the currently selected wound and the currently selected assessment. To view a report, click on a document link. These are identified by the date on which the report was created. You can create new reports by clicking on the **New Report** button. See [Reports Panel](#) for more information.
- H Wound panel**
This displays the selected wound identifier (A, B, etc) and the anatomical site. If the wound is healed the wound panel turns gray. See [Wound Panel](#) for more information.
- I Baseline Assessment**
This asterisk(*) denotes that the assessment is baseline. For more information, see [Assessment Panel](#).
- J Wound Gear**
This is a wound gear. If you click on it, you will see an option to heal this wound. For more information, see [Wound Panel](#).

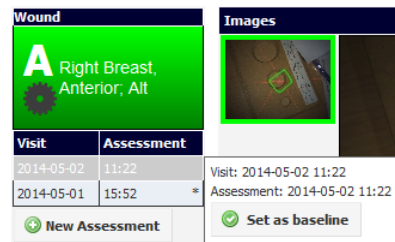
Assessments Panel

The **Assessments** panel shows the list of visits and assessments for the currently selected wound.

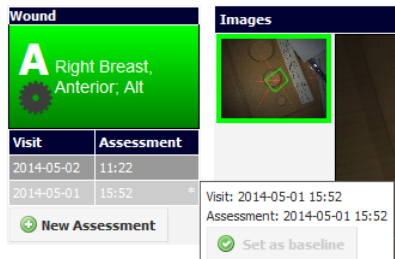
Visit		Assessment
A	2011-12-14	04:34 PM
		01:26 PM
	2011-11-17	11:15 AM
	2011-11-03	03:32 PM *

- A Visit**
The **Visit** column displays the list of visits for the currently selected wound. The visit and assessment highlighted in gray determine the images shown in the **Images** panel and the notes displayed in the **Notes** panel (**Visit** and **Wound** tabs).
- B Assessment**
When multiple assessments are made on the same visit, the last assessment of the visit is displayed higher in the list. In the example above, there are two assessments made on 2011-12-14.
- C Baseline Assessment**
The baseline assessment is indicated by the asterisk beside the assessment in the assessments panel. To change which assessment is currently selected as the baseline assessment, hover the

mouse cursor over an assessment row in the assessments panel. This will pop up a panel, as shown below, containing a button which will set that assessment as the baseline assessment.

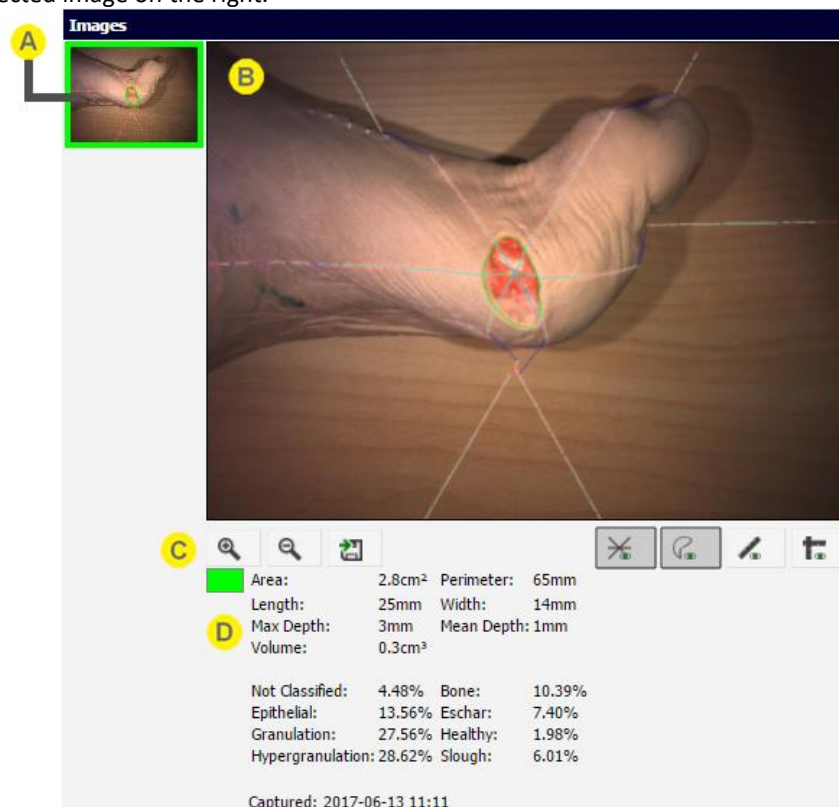


If the assessment is already a baseline assessment, the button will be grayed out.



Images Panel

The **Images** panel shows the images that belong to the assessment that is currently selected in the [Assessments Panel](#). A list of small thumbnails of each image captured in the assessment is shown on the left beside a larger view of the currently selected image on the right.









A **Thumbnails**
The left side of the panel displays thumbnails of the images for the currently selected assessment. The selected image is surrounded by a box in the wound's outline color.

B **Captured image**
A larger view of the currently selected image is shown on the right side of the panel

C Image controls

You can:

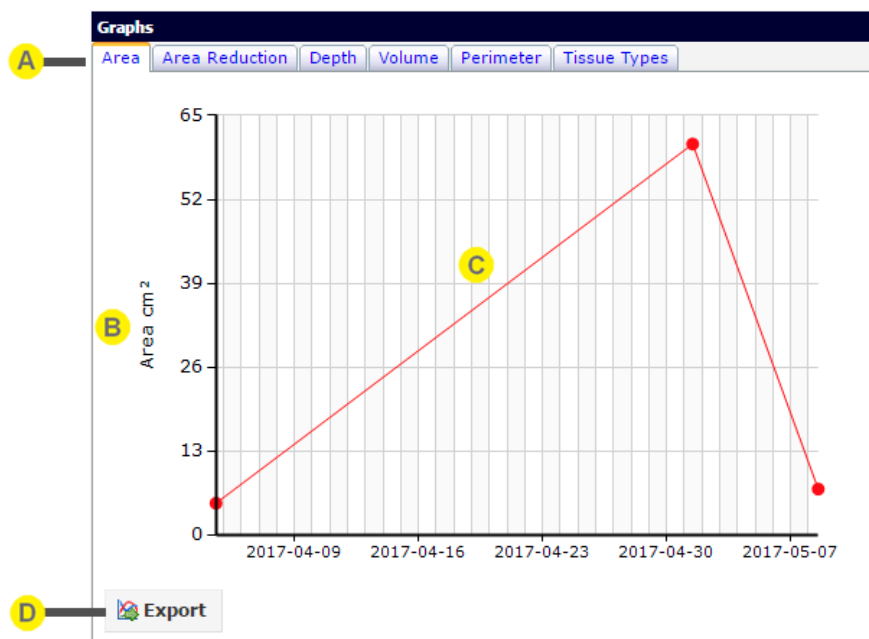
- Zoom in. Select the **Zoom In** button .
- Zoom out. Select the **Zoom Out** button .
- Pan the image. Select, hold and move the image to pan.
- Export the image. A high resolution version of the image currently displayed will be exported. The appearance of wound boundaries, laser lines, etc, on the exported image will be determined by what is currently displayed on screen. In other words, if they appear on the main image then they will appear in the exported file. Therefore select your desired configuration before exporting.
- Show or hide the lasers. Select the **Show/Hide Lasers** button . A gray background to the button indicates lasers will be drawn.
- Show or hide the wound outline. Select the **Show/Hide Outline** button . A gray background to the button indicates wound outlines will be drawn.
- Show or hide the rulers. Select the **Show/Hide Rulers** button . A gray background to the button indicates rulers will be drawn.
- Show or hide the axes. Select the **Show/Hide Axes** button . A gray background to the button indicates axes will be drawn.

D The measurements as pertain to the image

Displayed here are the wound measurements that have been calculated for the selected image.

Graphs Panel

The **Graphs** panel shows the graphs of wound area, area reduction, depth, and volume for the currently selected wound.



A Graph types

There are up to six tabs, one for each of the types of graph available, namely area, area reduction, depth, perimeter, volume, and tissue types.

The graphs available depend on the information available for the wound, and any organization settings that may prevent certain measurements from being displayed.

B Legend

The legend indicates the units for the values plotted on the graph.

C Graph

The graph plots data for the currently selected wound across all assessments.

If there is no data for the graph type selected, no image will be displayed.



Export

Click on the **Export** button to export the graph.

Notes

Notes Panel

The **Notes** panel shows the notes that have been entered for the currently selected wound assessment. It is divided into three tabs. Depending upon system configuration one or more of these tabs may not be present.

Notes

Patient Visit **Wound**

Edit

Wound Appearance

Etiology	Pressure Ulcer: Stage 4
Epithelializing (island) (%)	0
Granulating (%)	65
Sloughy (%)	20
Necrotic (%)	15
Hypergranulating (%)	0
Underlying structures	Bone

Exudate

Volume	Low
Type	Purulent

Treatment

Goal of treatment	Absorb exudate; Peri-wound protection
Technique	Clean
Primary dressing type	Antimicrobial - Silver
Primary dressing product	
Secondary dressing type	Dry absorbent
Re-evaluation date	2013-11-30
Treatment outcome	

Risk Assessment at Admission

Sensory Perception	2. Very Limited
Moisture	3. Occasionally Moist
Activity	2. Chairfast
Mobility	2. Very Limited
Nutrition	2. Probably Inadequate
Friction & Shear	2. Potential Problem
Total Score	13
Image Capture Reference	

Edit



Patient tab

The **Patient** tab displays patient information. This information typically does not change from visit to visit.



Visit tab

The **Visit** tab displays information specific to a visit but not specific to a particular wound assessment. Selecting a different wound assessment may change the information displayed on the **Visit** tab, as the new assessment could belong to a different visit.



Wound tab

The **Wound** tab displays information specific to an individual wound assessment. When a different wound assessment is selected, the information in this tab will be updated to reflect information collected for that wound assessment.



Edit button

Click the **Edit** button to edit the information in the current tab.

Click on fields to enter and edit information. When you are finished editing notes, click on the **Update** button to save your changes. You can also discard changes made by clicking on the **Cancel** button.



Group

The notes are categorized into groups.

Groups and items can be customized using the **Organizations** menu in Admin.

See [Notes Administration](#).



Notes item

Item names and how data is entered in SilhouetteCentral Desktop and SilhouetteConnect can be customized using the **Organization > Notes** menu in Admin. See [Notes Administration](#).



Data entered

Data entered against a notes item is displayed to the right-hand side of the tab. For note items that contain one or more SilhouetteStar image (most likely captured via use of a protocol within SilhouetteConnect) thumbnails are shown. The thumbnails can be clicked and will change the selected image within the [Images Panel](#).



Notes audit history

An icon displayed against a notes item indicates that data has been changed.

Move the cursor over the icon to display the audit history.

Treatment			
	Date	New Value	User
	2013-11-13	Aseptic	Alison Smith
	2013-11-11	Clean	Mary Jones

Information displayed includes the date changes were made, the old and new values, and the user who made the change.

Date Entry

A date entry note appears on screen as three drop-down boxes, in an order as defined in the organization settings. For example, year-month-day order will appear as follows:

2012 ▾	July ▾	27 ▾
--------	--------	------

Date and Time Entry

A date and time entry note appears on screen as five drop-down boxes, in an order as defined in the organization settings. For example year-month-day order and hour-minutes in 24 hour format will appear as follows:

2012 ▾	July ▾	27 ▾
15 ▾	:	24 ▾

Text

An expanding text box appears on screen as a box:

Medicines: Other	
Sensitivities: Medicines	
Sensitivities: Dressings and adhesives	
Sensitivities: Other	
Comments	

Type in the information required. If the content is long, the text box expands to create additional space.

Medicines: Other	This is a note for medicines. This is a note for medicines. This is a note for medicines. This is a note for medicines. This is a note for medicines.
Sensitivities: Medicines	
Sensitivities: Dressings and adhesives	
Sensitivities: Other	
Comments	

Decimal and Integer

A numeric entry box appears on screen as a simple box:

Height (cm)	
Weight (kg)	
Blood pressure, systolic (mmHg)	

When you click on the box, a cursor will appear in it. Enter the number required.

Boolean (yes/no)

Radio buttons are used to present a set of options when a notes field is intended to have a yes, or no answer, as in the example below of a field called **Recurrent wound**:

Recurrent wound ☒ NA ☐ Yes ☐ No

Click on the button for the option required. NA means not applicable (or not answered) and will be recorded as no answer being provided for this notes field.

Single Select Lists

A single select list presents a set of options, from which one can be chosen. The screen below shows a series of select lists:

Epithelializing (island) (%)	20%
Granulating (%)	30%
Sloughy (%)	25%
Necrotic (%)	25%
Hypergranulating (%)	
Underlying structures	Fascia

Clicking on the arrow next to **Underlying Structures** reveals the options for that field:

Epithelializing (island) (%)	20%
Granulating (%)	30%
Sloughy (%)	25%
Necrotic (%)	25%
Hypergranulating (%)	
Underlying structures	Fascia
Underlying structures: Other	<div> Fascia Muscle Tendon Ligament Bone </div>
Wound Margins	

Only one option can be selected. Click on the option required to select it.

You can also close the list without changing the current setting by clicking on the arrow.

You will see a blank option among other options. If you select blank option for a list that previously had a value, it will delete the old value and set it to blank. You cannot select blank option for a required field. For details, see

[Validation Errors.](#)

[Notes](#) and [reports](#) will not show old data in the note when you set it to blank.

Multiple Select Lists

Multiple select lists are used when several values are possible for a particular setting. In the example below, a number of different options are possible for the field **Medicines**:

Medicines

☐ NSAIDS ☐ Cytotoxics ☐ Anti-coagulants
☐ Beta blockers ☐ Immune suppressants ☐ Steroids
☐ Antibiotics

Click on a box to select that option.

Images

When viewing wound notes any images captured within the wound assessment should also be presented as small thumbnail sized images. The screen below shows a set of images thumbnails:



Assessment

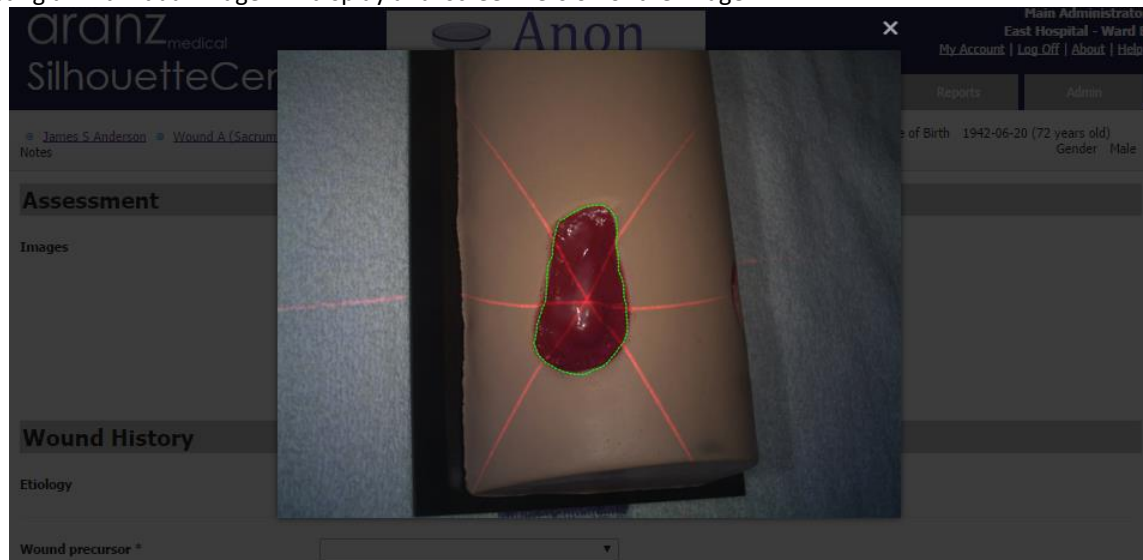
Images

Wound History

Etiology: Deep Tissue Injury

Wound precursor *

Selecting an individual image will display a fullscreen version of the image:



NOTE: For a normal wound assessment the images will appear in a group titled "Assessment" located at the top of the wound notes. However if the assessment was captured via use of the SilhouetteConnect protocol engine the images will be dispersed in between the other notes fields used to record the answers provided during use of the protocol.

Validation Errors

If you attempt to save a note that doesn't meet the requirements, you will see a validation error in red text next to that note.

Some notes may be dependant on others. In this example, if the patient is not a smoker, it is mandatory that the cigarette consumption option be left blank.

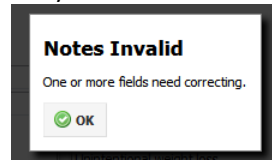
Smoking History

Current cigarette consumption

Update Cancel

Smoker
Past smoker
Never smoked

If you choose the "Never smoked" or "Past Smoker" option along with a value for cigarette consumption, and click on **Update**, you will see a pop-up message that says some fields need correcting.



When you click **Ok** the page will automatically scroll to the field that needs correcting and you will see an error message in red text.

Smoking History

Current cigarette consumption

Update Cancel

Never smoked

1-10 per day

A non smoker must leave this question unanswered

Another trigger for validation error could be required fields. If the note has an asterisk (*) next to its name, it means that you must enter a data for it.

Etiology

Wound precursor *

Required field.

For boolean notes, "N/A" is equal to a blank value.

Recurrent Wound

Wound on amputated body part? *

NA Yes No

NA Yes No

If a note has an asterisk (*) and gives N/A, "Yes" and "No" as options, you will have to choose either "Yes" or "No". If you set it to "N/A", it will give you an error.

Recurrent Wound

Wound on amputated body part? *

NA Yes No

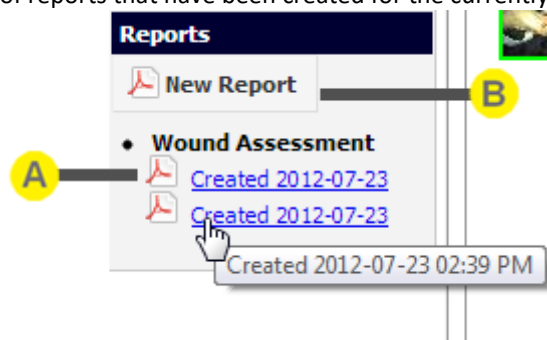
NA Yes No

Required field.

If you want to make a note field compulsory, follow the instructions on [Notes Management](#).

Reports Panel

The **Reports** panel shows the list of reports that have been created for the currently selected assessment.

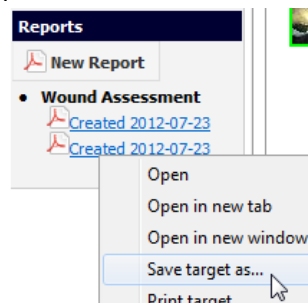


A

Existing reports

Under the **Reports** heading a list of different report types will be displayed. For each report type a list of reports than have been generated will be shown. The most recent report is displayed at the top of the list. If multiple reports have been created on the same date, hold the mouse over a report to see the creation time of the report in a tooltip, to differentiate between reports. Click on a link to view the report. This will open the report inside the browser window. To navigate back to the assessment details page when viewing the report, click the back button in the browser. Alternatively, you can navigate to assessment details, wound manager page or patient select page by clicking on the breadcrumbs on top of the page.

You can also save a report to your computer by right-clicking on the link, then selecting **Save target as...** from the popup menu:



A PDF viewer must be installed on your computer to view the downloaded PDF report file. If a report that you created in SilhouetteConnect does not appear in the list, check that the SilhouetteConnect that captured the data for the patient's assessment has been synchronized with SilhouetteCentral.

B

New Report

Create new reports by selecting the **New Report** button. The **Create Assessment Report** dialog will appear with a separate tab for each type of assessment report available to you. You will be asked what information you want to include in the report.

For the standard Wound Assessment report, options are grouped into three categories: **Images**, **Graphs**, and **Notes**, with the currently selected options listed. Click on the options to view check boxes letting you choose from the available options.

Create Assessment Report

A screenshot of the 'Create Assessment Report' dialog box. The 'Wound Assessment' tab is selected. The dialog contains the following fields and options: 'Assessment:' with the value '2017-05-08 13:20'; 'Wound:' with the value 'Wound A'; 'Images:' with a link 'All'; 'Graphs:' with a link 'All' and three checked checkboxes: 'Area', 'Depth', and 'Perimeter'; 'Notes:' with a link 'All' and three checked checkboxes: 'Area Reduction', 'Volume', and 'Tissue Type'. At the bottom, there is a message: 'There already exists a report for this assessment. It was created on 2017-05-08 13:32 (3 minutes ago)'. At the very bottom are 'OK' and 'Cancel' buttons.

Some options may be grayed out and cannot be ticked. For example, the **Wound** option under **Notes** will only be available if wound notes have been created.

When you select the **OK** button, the report will be saved to your *Files* folder, and opened in the browser.

Wound Panel

This displays the selected wound identifier (A, B, etc) and the anatomical site. If the wound is currently open, then the wound panel will display in the wound color. If the wound is healed the wound panel turns gray. To edit the wound healed status, click on the gear on the lower left part of the wound panel. This will bring up a dialog as shown below, which allows the wound open date and healed date to be set. To mark a wound as healed, enter the healed date. If the healed date is left blank then only the opened date is updated.

Heal Wound

History	Date
Opened	2014-04-04

Heal Wound	Date
Heal	

Save

Cancel

This dialog will also display the full healing history for the wound. Each time the wound has been healed and reopened will be listed, but only the last record will be editable as shown in the image below.

Reopen Wound

History	Date
Opened	2014-04-04
Healed	2014-04-06
Reopened	2014-04-07
Healed	2014-04-08

Reopen Wound	Date
Reopen	

Save

Cancel

Wound Reopen or healed date should be at least a day later than last healed/reopened date. If you enter a date older than last state of the wound, you will get a message.

Reopen Wound

Healing Status

Wound Reopen date must be later than the previous Heal date.

OK

Save

Cancel

Using SilhouetteCentral Reporting

The population reporting module of SilhouetteCentral is an optionally licensed feature that allows reports to be run across all patient data stored within an organizations SilhouetteCentral database. These reports can be used to perform tasks such as:

- Aggregating data from multiple patients, wounds and assessments into a single summary for reporting or regulatory needs
- Reporting details of each individual patient, wound or assessment that match a specified criteria (e.g. patients admitted within a certain time frame, wounds of a certain size or etiology)

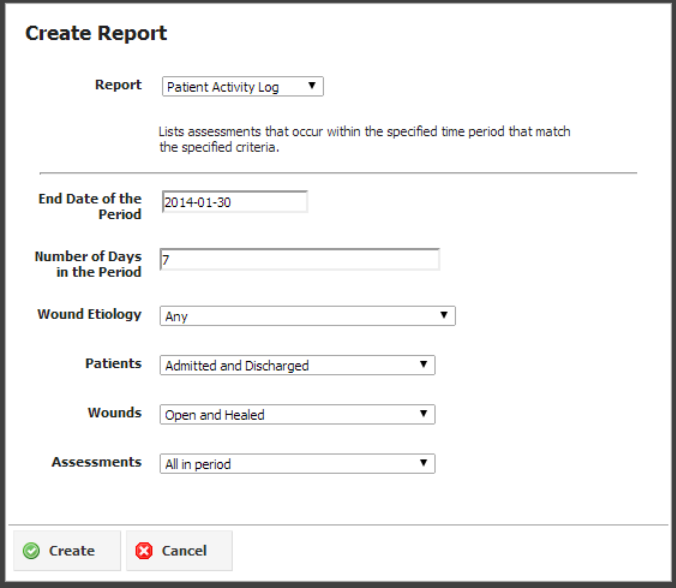
Note that this functionality differs to that of the [reports panel](#) accessible in [Silhouette Desktop](#) which can only be used to produce a report for a single wound assessment.

The population reporting functionality is controlled by report templates. Custom report templates can be designed by ARANZ Medical Support staff in order to satisfy your unique reporting and regulatory needs.

Creating a report

If the population reporting module is licensed for your organization you will have access to a Reports tab. To create a new report click on the **Create Report** button located at the far left of the menu at the top of the Reports tab. This will display a create report dialog that allows you to select a report template via the report drop down list. Please note that the list of reports displayed to you are based on the security permissions assigned to your user account, i.e. different users may have access to a different subset of report templates.

Once a report template is selected, a brief description of the report will be displayed underneath. Each report template may also have one or more parameters that can be used to filter which patients or assessments are included in the report and/or alter the behavior of calculations or display of data within the report. The purpose and meaning of each report parameter is by nature report specific.



Create Report

Report: Patient Activity Log ▼

Lists assessments that occur within the specified time period that match the specified criteria.

End Date of the Period: 2014-01-30



Number of Days in the Period: 7

Wound Etiology: Any ▼

Patients: Admitted and Discharged ▼

Wounds: Open and Healed ▼

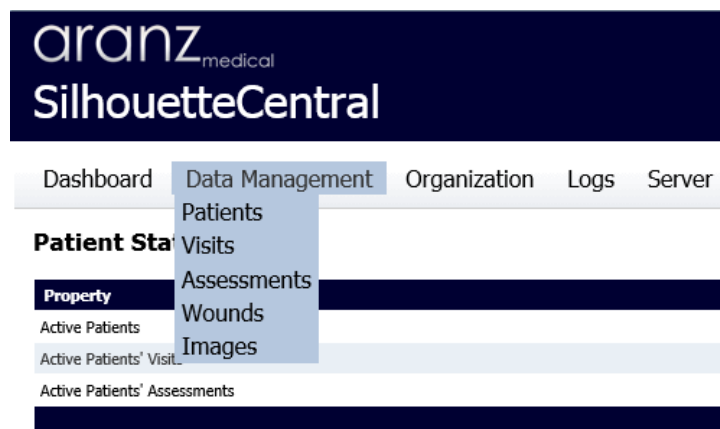
Assessments: All in period ▼

 Create  Cancel

Once a report template has been selected, and suitable values entered for each report parameter (most will initially default to a sensible default value such as today's date) you can query the SilhouetteCentral database and generate a PDF report by clicking the **Create** button. Once SilhouetteCentral has generated the report it will be displayed in a pdf viewer inside the browser, or you will be prompted to save the PDF file.

Using SilhouetteCentral Admin

SilhouetteCentral Admin is organized into five main sections, which are displayed in a menu at the top of each screen:



For more information on the options available in each menu, see:

- [The Dashboard](#)
- [Data Management Tools](#)
- [Organization Management Tools](#)
- [Logs](#)
- [Server](#)

Note that what is displayed to the user will depend upon the group that the user is assigned to, and the permissions that have been configured for that group.

The Dashboard

The **Dashboard** displays an overview of SilhouetteCentral activities, and is divided into three tables:

- [Patient Statistics](#)
- [Latest Synchronizations](#)
- [Latest Camera Calibrations Checks](#)

Patient Statistics

The Patient Statistics table displays an overview of the patient data currently stored on SilhouetteCentral:

Patient Statistics

Property	Number
Active Patients	56
Active Patients' Visits	49
Active Patients' Assessments	100

The **Active Patients** data shows the number of patients and the number of assessments and visits for those patients. The active patients statistics exclude any deleted patients and their count of visits and assessments.

Latest Synchronizations

The **Latest Synchronizations** graph shows the number of successful (in green) and failed (in red) synchronizations between SilhouetteCentral and SilhouetteConnect over the last seven days. You can click and drag on the graph to move backwards (and forwards) in time to see events prior to the last seven days. You can also click on a red or green bar to automatically navigate to the synchronizations log page, with the filter controls pre-populated to view matching synchronization attempts (including the date and success/failure status).

To view the full list of synchronizations select **Logs > Synchronizations**. See [Synchronizations](#).

Latest Camera Calibrations Checks

The **Latest Camera Calibration Checks** table displays the most recent SilhouetteStar camera calibration checks that have been performed by users within SilhouetteConnect. You can view the full list of camera calibrations by selecting **Logs > Camera Calibration Check**. See [Camera Calibration Checks](#).

Data Management Tools

The tools in the **Data Management** menu allow you to change, create, combine, move, delete, undelete, and check various parts of the Silhouette data. You can:

- Undelete and check the data as pertains to the patients. See [Patient Administration](#).
- Change, create, combine, move the data as pertains to the visits. See [Visit Administration](#).
- Change, create, combine, move the data as pertains to the assessments. See [Assessment Administration](#).
- Change, delete, and undelete the data as pertains to the wounds. See [Wound Administration](#).
- Move the images. See [Image Administration](#).

Patient Administration

The tools in the **Patient Administration** screen allow you to manage patient data. You can:

- Reactivate patients that have been deleted previously. See [Deleted Patients](#).
- Review a list of errors in the patient data record. See [Data Consistency Errors](#).

Reactivate Patients

When patients are deleted from the SilhouetteCentral database via SilhouetteCentral Desktop or SilhouetteConnect, the records for that patient are retained and can be restored to the working database. This is useful when a SilhouetteCentral Desktop or SilhouetteConnect user accidentally deletes a patient from the database. In the **Reactivate Patients** screen, you can reactivate patients that have been marked as deleted. Note that patients deleted via SilhouetteConnect before they are synchronized cannot be recovered as they will not appear in the **Reactivate Patients** list; it will be necessary for the SilhouetteConnect user to first synchronize with SilhouetteCentral.

In Admin, select **Data Management > Patients > Reactivate Patient**. The **Reactivate Patients** screen will be displayed:

Reactivate Patient

Step 1 / 3: Select patient to reactivate

Select the deleted patient to reactivate.

A Search: Within Assessments from to

Last Name	First Name	Middle Name	Patient ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
Adams	Angela		DP094387	Unit A	1990-02-20	2011-09-26 01:11 PM	2011-09-26 01:11 PM	1
Aldwin	Bruce		ZW340989	Unit A	1970-05-14			0
Allen	Roberta		JA1298	Unit A	1950-10-07			0
Allison	Melva		ZW981007	Unit A	2011-12-14			0
Ashworth	Susan		AD4390	Unit A	1973-02-23			0
Ashworth	Susan	Diane	ZW984390	Unit A	1939-03-06			0
Austin	Steve		EX4276	Unit A	1937-02-21			0
Barlow	Clinton		DP235423	Unit A	1958-10-06	2011-10-06 12:04 PM	2011-10-06 02:26 PM	16
Benson	Edith		PX3498	Unit A	1926-03-27			0
Benson	Edith		ZE093498	Unit A	2011-12-14			0

C 1 2 3 4 5 6 7

E **D**

A Search for patients
Enter part of the patient's name or Patient ID, or search by assessment date as described in [Selecting a Patient](#).

B Deleted Patients table
This table lists the patients that have been deleted from SilhouetteCentral. This table operates in the same manner as described in [Selecting a Patient](#).

C Page links
When there are too many patients to display on one screen, the page links at the bottom of the screen allow you to navigate through the patient table.

D**Next button**

Once a patient is selected in the table, click **Next** to reach the second step of reactivating a patient.

Reactivate Patient**Step 2 / 3: Select units**

Select the unit the patient should be assigned to.

In this step, you can select the unit patient should be assigned to. If the patient's original unit still exists in the working database, it will be selected in the dropdown by default.

If the unit doesn't exist anymore, the dropdown will be empty and you will have to assign the patient to an existing unit.

After assigning the patient to desired unit, click **Next** to proceed to the final step. A summary of the changes made will be displayed.

Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to restore the patient.

Once you click **Finish**, you will be asked to confirm your choice.

E**Cancel button**

If you wish to cancel reactivating a patient, click **Cancel** to stop the canceling process. The patient will remain deleted from the working database.

Data Consistency Errors

Viewing this page will run a consistency check over all patient data present in the SilhouetteCentral database. A list of wound assessments with identified issues will then be displayed with hyperlinks that direct the user to the page within SilhouetteCentral Desktop where the data can be corrected.

Dashboard Data Management Organization Logs Server

Data Consistency Errors

Last Name	First Name	Middle Name	Patient.LocalDomainIdLabel	Item	Error
Smith	Joan			Visit at 2013-11-12 11:23	Admitted date (2013-11-07 11:57) is incorrect - it should be after the prior visit (2013-11-12 11:19)

Over time additional consistency checks will be added. The current checks that are performed by this tool include:

1. Checks the admission date occurs on or prior to the visit in which it is recorded
2. Checks the discharge date occurs on or after the visit in which it is recorded

When the hyperlink beside a particular data consistency error is clicked the user will be navigated to the correct page within SilhouetteCentral Desktop to allow the inconsistency to be corrected. When this page is displayed a yellow banner will appear at the top of the page outlining the details of the error that needs to be fixed.

As an example the below screen shot demonstrates the user being directed to correct an error within the visit notes.

When the data consistency error banner is displayed on a screen, pressing the **Update** or **Cancel** buttons will return the user to the **Data Consistency Errors** page within SilhouetteCentral Admin instead of the SilhouetteCentral Desktop **Wound Manager** screen.

Visit Administration

The tools in the **Visit Administration** screen allow you to manage visit data. You can:

- Change the date of a visit. See [Change Visit Date](#).
- Create a visit. See [Create Visit](#).

- Combine two visits for a single patient into one visit. See [Combine Visits](#).
- Move a visit from one patient to another. See [Move Visit to Another Patient](#).
- Delete a visit from a patient. See [Delete Visit](#).

Change Visit Date

If the incorrect date has been recorded for a patient visit, it can be changed using the **Change Visit Date** option. You can change either only the visit date, or the visit date and the date of all the assessments associated with that visit. If you need to change an assessment date but not the visit date, use the [Change Assessment Date](#) option. If you need to change the visit date but only some assessment dates, change the visit date first without applying the change to assessments (Step 4). Then use the [Change Assessment Date](#) option for each assessment that needs to change.

Changing a visit date involves five steps, and the process can be canceled at any time before the last step. To change a visit date, select **Data Management > Visits**, then select **Change Visit Date**. The first **Change Visit Date** screen will be displayed:

Change Visit Date

Step 1 / 5: Select patient

Select the patient whose visit you wish to change.

Search: Within Assessments from to

Last Name	First Name	Middle Name	Domain ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
a	a		A111	Default Unit	1998-02-02			0
a	aada	a	A099	Default Unit	1990-03-02			0
ABe	CDf		123456789	Default Unit	1956-01-01			0
Acharya	Radha		RW120	Default Unit	1979-01-01			0
Ani	Maya		131623	Default Unit	1979-01-01			0
b	b		B111	Default Unit	1991-03-02			0
Bob	Marley		1242343	Default Unit	1983-02-05			0
branch	olive		22121	Default Unit	1985-02-02	2014-05-06 16:50	2014-05-22 16:48	3
Caa	Paewnt		183181	Default Unit	1987-01-03			0
Check	Patient		183181	Default Unit	1987-01-02			0

1234

Click on the required patient, then on the **Next** button. The second step will be displayed:

Dashboard Data Management Organization Logs Server

Change Visit Date

Step 2 / 5: Select visit

Select the visit you wish to change.

Visit
 2014-05-06 16:51:34
 2014-05-06 16:50:05

Select the visit you wish to change from the drop-down box, then click **Next**. The third step will be displayed:

Dashboard Data Management Organization Logs Server

Change Visit Date

Step 3 / 5: Specify Date

Update the visit to reflect the correct date.

Visit Date and Time :

Change the visit date and time, then click **Next**. The fourth step will be displayed:




Dashboard Data Management Organization Logs Server

Change Visit Date

Step 4 / 5: Update Assessments

Specify if you would like all the assessments to be updated to reflect this date.

Assessments ☒ Update the date on assessments.

If you wish to update the date and time for all assessments associated with the visit, select the **Update the date on assessments** check box.

Click **Next** to proceed to the final step. A summary of the changes made will be displayed, including what assessments will be affected by the change.

Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to update the visit. Once you click **Finish**, you will be asked to confirm your choice.

Create Visit


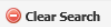
Creating a visit involves three steps, and the process can be canceled at any time before the last step. To create a new visit for a patient, select **Data Management > Visits**, then select **Create Visit** from the **Visit Administration** screen. The first **Create Visit** screen will be displayed:

Dashboard Data Management Organization Logs Server

Create Visit



Step 1 / 3: Select patient for new Visit

Select the patient to create a new visit for.

Search: Within Assessments from to  

Last Name	First Name	Middle Name	Domain ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
a	a		A111	Default Unit	1998-02-02			0
a	aada	a	A099	Default Unit	1990-03-02			0
ABe	CDf		123456789	Default Unit	1956-01-01			0
Acharya	Radha		RW120	Default Unit	1979-01-01			0
Ani	Maya		131623	Default Unit	1979-01-01			0
b	b		B111	Default Unit	1991-03-02			0
Bob	Marley		1242343	Default Unit	1983-02-05			0
branch	olive		22121	Default Unit	1985-02-02	2014-05-06 16:50	2014-05-06 16:51	2
Caa	Paewnt		183181	Default Unit	1987-01-03			0
Check	Patient		183181	Default Unit	1987-01-02			0

1234

Click on the required patient, then on the **Next** button. The second step will be displayed:



Dashboard Data Management Organization Logs Server

Create Visit

Step 2 / 3: Visit Details

Enter the data for the visit.

Visit Date and Time :

Use the date selection tool to select a visit date and the drop-down boxes to specify a visit time, then click **Next**. A screen will be displayed summarizing the changes that will be made.

Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to create the visit. Once you click **Finish**, you will be asked to confirm your choice.

Combine Visits

If information has been recorded in two visits that should be recorded as a single visit, those visits can be combined using the **Combine Visits** option. This may occur if a new visit was accidentally created, for example, after an interruption during treatment.

If you need to move a visit to another patient, use the [Move Visit to Another Patient](#) option.

If you need to combine two assessments, use the [Combine Assessments](#) option.

Combining two visits involves four steps, and the process can be canceled at any time before the last step. To combine two visits, select **Data Management > Visits**, then select **Combine Visits**. The first **Combine Visits** screen will be displayed:

Dashboard Data Management Organization Logs Server

Combine Visits

Step 1 / 4: Select patient

Select the patient whose visits you wish to combine.

Search: Name or Domain ID Within Default Unit Assessments from to

Last Name	First Name	Middle Name	Domain ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
a	a		A111	Default Unit	1998-02-02			0
a	aada	a	A099	Default Unit	1990-03-02			0
ABe	CDf		123456789	Default Unit	1956-01-01			0
Acharya	Radha		RW120	Default Unit	1979-01-01			0
Ani	Maya		131623	Default Unit	1979-01-01			0
b	b		B111	Default Unit	1991-03-02			0
Bob	Marley		1242343	Default Unit	1983-02-05			0
branch	olive		22121	Default Unit	1985-02-02	2014-05-06 16:50	2014-05-06 16:51	2
Caa	Paewnt		183181	Default Unit	1987-01-03			0
Check	Patient		183181	Default Unit	1987-01-02			0

1234

Click on the required patient, then on the **Next** button. The second step will be displayed:

Dashboard Data Management Organization Logs Server

Combine Visits

Step 2 / 4: Select visit to combine

Select the first visit that you wish to combine. This visit will be removed after it has been combined with the visit selected in the next step.

Visit

Please select...

2014-05-06 16:51:34

2014-05-06 16:50:05

If the patient you selected in Step 1 has only one visit, you will be prompted to select another patient.

For Step 2, select the first of the visits you wish to combine from the visits in the drop-down list. This is the visit that will be deleted once the two visits have been combined. Click **Next** to move on to the next step. The third step will be displayed:

Dashboard Data Management Organization Logs Server

Combine Visits

Step 3 / 4: Select assessment to combine into

Select the second visit that you wish to combine. The first visit will be merged into this visit.

Visit

Please select...

2014-05-06 16:51:34

2014-05-06 16:50:05

Select the second of the visits you wish to combine from the drop-down list, then click **Next** to proceed to the final step.

A summary of the changes made will be displayed. Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to combine the visits. Once you click **Finish**, you will be asked to confirm your choice.

Move Visit to Another Patient

If a visit has been assigned to the wrong patient, it can be moved to the correct patient using the **Move Visit to Another Patient** option.

If an assessment needs to be moved to another patient, use the [Move Assessment to Another Patient](#) option.

Moving a visit to another patient involves five steps, and the process can be canceled at any time before the last step. To move a visit to another patient, select **Data Management > Visits**, then select **Move Visit to Another Patient**. The first **Move Visit to Another Patient** screen will be displayed:

Dashboard Data Management Organization Logs Server

Move Visit to Another Patient

Step 1 / 5: Select patient to move visit from
Select the patient whose visit you wish to move.

Search: Within Assessments from to

Last Name	First Name	Middle Name	Domain ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
Come	Well		b01	Default Unit	1983-01-01	2014-05-06 11:44	2014-05-06 11:45	2
Cup	One	t	123452368df	Default Unit	1987-01-01			0
Da	Sa		ID1200	Default Unit	1975-02-02	2014-05-01 13:23	2014-05-01 14:33	18
Day	Nice		ab012	Default Unit	1984-01-01	2014-05-02 11:31	2014-05-02 12:10	6
Doe	John		12333	Default Unit	1983-01-01			0
Doe	John34		123336546	Default Unit	1983-01-01	2014-05-06 12:40	2014-05-06 12:40	3
Dough	Jane		12333	Default Unit	1956-04-07	2014-05-06 12:50	2014-05-06 12:50	1
Durkin	Jesenia		40597	Default Unit	1974-06-07			0
Eve	Good		b014	Default Unit	1985-01-01	2014-05-06 11:54	2014-05-06 11:57	3
Frank	Lampard		10291	Default Unit	1986-12-05			0

1234

Click on the required patient, then on the **Next** button. The second step will be displayed:

Dashboard Data Management Organization Logs Server

Move Visit to Another Patient

Step 2 / 5: Select visit to move
Select the visit that you wish to move to another patient.

Visit

2014-05-06 12:40:52
2014-05-06 12:39:57

If the patient you selected in Step 1 has no visits, you will be prompted to select another patient. For Step 2, select the visit you wish to move from the drop-down box, then click **Next**. The third step will be displayed:

Dashboard Data Management Organization Logs Server

Move Visit to Another Patient

Step 3 / 5: Select patient to move visit to
Select the patient that you wish to move the visit to.

Search: Within Assessments from to

Last Name	First Name	Middle Name	Domain ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
Come	Well		b01	Default Unit	1983-01-01	2014-05-06 11:44	2014-05-06 11:45	2
Cup	One	t	123452368df	Default Unit	1987-01-01			0
Da	Sa		ID1200	Default Unit	1975-02-02	2014-05-01 13:23	2014-05-01 14:33	18
Day	Nice		ab012	Default Unit	1984-01-01	2014-05-02 11:31	2014-05-02 12:10	6
Doe	John		12333	Default Unit	1983-01-01			0
Doe	John34		123336546	Default Unit	1983-01-01	2014-05-06 12:40	2014-05-06 12:40	3
Dough	Jane		12333	Default Unit	1956-04-07	2014-05-06 12:50	2014-05-06 12:50	1
Durkin	Jesenia		40597	Default Unit	1974-06-07			0
Eve	Good		b014	Default Unit	1985-01-01	2014-05-06 11:54	2014-05-06 11:57	3
Frank	Lampard		10291	Default Unit	1986-12-05			0

1234

For Step 3, select the patient you wish to move the visit to. Once a patient is selected, click **Next**. As long as there are images or wound notes associated with the visit, the fourth step will be displayed, otherwise it will be skipped:

Dashboard Data Management Organization Logs Server

Move Visit to Another Patient

Step 4 / 5: Assign Wounds

Please match the existing wound labels to the wound labels on the destination patient.

A - Right Buttock, Superior A - Left Shoulder, Superior
B - Right Calf B - Left Calf

For Step 4, match the wound labels according to the wound position descriptions available for the patient the visit is being moved to.

Click **Next** to proceed to the final step. A summary of the changes made will be displayed. Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to move the visit. Once you click **Finish**, you will be asked to confirm your choice.

Delete Visit

If a visit has been incorrectly created, it can be deleted using the Delete Visit option.

Deleting a visit involves three steps, and the process can be canceled at any time before the last step. To delete a visit, select **Data Management > Assessments**, then select **Delete Visit**. The first **Delete Visit** screen will be displayed:

Dashboard Data Management Organization Logs Server

Delete Visit

Step 1 / 3: Select Patient

Select the patient with the visit to be deleted.

Search: Within Assessments from to

Last Name	First Name	Middle Name	Domain ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
Come	Well		b01	Default Unit	1983-01-01	2014-05-06 11:44	2014-05-06 11:45	2
Cup	One	t	123452368df	Default Unit	1987-01-01			0
Da	Sa		ID1200	Default Unit	1975-02-02	2014-05-01 13:23	2014-05-01 14:33	18
Day	Nice		ab012	Default Unit	1984-01-01	2014-05-02 11:31	2014-05-02 12:10	6
Doe	John		12333	Default Unit	1983-01-01			0
Doe	John34		123336546	Default Unit	1983-01-01	2014-05-06 12:40	2014-05-06 12:40	3
Dough	Jane		12333	Default Unit	1956-04-07	2014-05-06 12:50	2014-05-06 12:50	1
Durkin	Jesenia		40597	Default Unit	1974-06-07			0
Eve	Good		b014	Default Unit	1985-01-01	2014-05-06 11:54	2014-05-06 11:57	3
Frank	Lampard		10291	Default Unit	1986-12-05			0

Click on the required patient, then on the **Next** button. The second step will be displayed:

Dashboard Data Management Organization Logs Server

Delete Visit

Step 2 / 3: Select Visit

Select the visit that is to be deleted.

Visit

For Step 2, select the visit you wish to delete from the drop-down box, then click **Next** to proceed to the final step. A summary of the changes made will be displayed. Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to delete the visit. Once you click **Finish**, you will be asked to confirm your choice.

Assessment Administration

The tools in the **Assessment Administration** screen allow you to manage assessment data. You can:

- Change the date of an assessment. See [Change Assessment Date](#).
- Create a new assessment. See [Create Assessment](#).
- Combine two assessments of a single patient into one assessment. See [Combine Assessments](#).

- Move an assessment to another visit on the same patient. See [Move Assessment to Another Visit](#).
- Move an assessment to another patient. See [Move Assessment to Another Patient](#).
- Delete an assessment from a patient. See [Delete an Assessment](#).

Change Assessment Date

If the incorrect date has been recorded for an assessment, it can be changed using the **Change Assessment Date** option in Admin.

If you need to change all assessment dates for a single visit, use the [Change Visit Date](#) option and tick the box for **Update the date on assessments** in Step 4.

Changing an assessment date involves four steps, and the process can be canceled at any time before the last step. To change an assessment date, select **Data Management > Assessments**, then select **Change Assessment Date**. The first **Change Assessment Date** screen will be displayed:

Dashboard Data Management Organization Logs Server

Change Assessment Date

Step 1 / 4: Select patient

Select the patient whose assessment date you wish to change.

Search: Within Default Unit Assessments from to

Last Name	First Name	Middle Name	Domain ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
milyo			P3428	Default Unit	1989-10-12			0
patient	default	name	a110	Default Unit	1996-02-03	2014-05-05 14:24	2014-05-05 14:24	1
Rai	Sita		39213	Default Unit	1994-10-07	2014-05-12 14:00	2014-05-12 14:00	1
teri	ho	mary	A842	Default Unit	1985-11-15	2014-05-01 15:52	2014-05-02 11:22	2
test	test		18232	Default Unit	1987-01-03			0
test2	test2		18232r	Default Unit	1987-01-03			0
test3	test3		182323	Default Unit	1987-01-03			0
Tree	Oak		1002032	Default Unit	1974-01-05	2014-05-12 15:08	2014-05-21 13:44	2
Wills	Robbie		ID1232	Default Unit	1976-02-11			0

1234

Click on the required patient, then on the **Next** button. The second step will be displayed:

Dashboard Data Management Organization Logs Server

Change Assessment Date

Step 2 / 4: Select assessment

Select the assessment you wish to change.

Assessment

Please select...
2014-05-21 13:44:13
2014-05-12 15:08:41

Select the assessment you wish to change from the drop-down box, then click **Next**. The third step will be displayed:

Dashboard Data Management Organization Logs Server

Change Assessment Date

Step 3 / 4: Specify Date

Specify the correct date for the selected assessment.

Assessment Date and Time 2014 May 21 13 : 44

Change the assessment date and time, then click **Next** to proceed to the final step. A summary of the changes made will be displayed.

Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to update the assessment. Once you click **Finish**, you will be asked to confirm your choice.

Create Assessment

Creating an assessment involves three steps, and the process can be canceled at any time before the last step. To create a new assessment for a patient, select **Data Management > Assessments**, then select **Create Assessment** from the **Patient Data Administration** screen. The first **Create Assessment** screen will be displayed:

Dashboard Data Management Organization Logs Server

Create Assessment

Step 1 / 3: Select Patient for new Assessment

Select the patient to create a new assessment for.

Search: Within Assessments from to

Last Name	First Name	Middle Name	Domain ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
a	a		A111	Default Unit	1998-02-02			0
a	aada	a	A099	Default Unit	1990-03-02			0
ABe	CDf		123456789	Default Unit	1956-01-01			0
Acharya	Radha		RW120	Default Unit	1979-01-01			0
Ani	Maya		131623	Default Unit	1979-01-01			0
b	b		B111	Default Unit	1991-03-02			0
Bob	Marley		1242343	Default Unit	1983-02-05			0
branch	olive		22121	Default Unit	1985-02-02	2014-05-06 16:50	2014-05-06 16:51	2
Caa	Paewnt		183181	Default Unit	1987-01-03			0
Check	Patient		183181	Default Unit	1987-01-02			0

1234

Click on the required patient, then on the **Next** button. The second step will be displayed:

Dashboard Data Management Organization Logs Server

Create Assessment

Step 2 / 3: Select Visit

Select the visit that the assessment will be added to.

Visit

2014-05-12 15:07:53
2010-10-17 05:00:00

Use the drop-down tool to select a visit date, then click **Next**. A screen will be displayed summarizing the changes that will be made.

Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to create the assessment. Once you click **Finish**, you will be asked to confirm your choice.

Combine Assessments

If information has been recorded in two assessments that would be better covered by a single assessment, those assessments can be combined using the **Combine Assessments** option. For example, this may occur if wound notes were accidentally created in a different assessment to the images that were captured.

If you need to move an assessment to another patient, use the [Move Assessment to Another Patient](#) option.

If you need to move an assessment to another visit without changing the patient, use the [Move Assessment to Another Visit](#) option.

Combining two assessments involves four steps, and the process can be canceled at any time before the last step. To combine two assessments, select **Data Management > Assessments**, then select **Combine Assessments**. The first **Combine Assessments** screen will be displayed:

Dashboard Data Management Organization Logs Server

Combine Assessments

Step 1 / 4: Select patient

Select the patient whose assessments you wish to combine.

Search: Within Assessments from to

Last Name	First Name	Middle Name	Domain ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
a	a		A111	Default Unit	1998-02-02			0
a	aada	a	A099	Default Unit	1990-03-02			0
ABe	CDf		123456789	Default Unit	1956-01-01			0
Acharya	Radha		RW 120	Default Unit	1979-01-01			0
Ani	Maya		131623	Default Unit	1979-01-01			0
b	b		B111	Default Unit	1991-03-02			0
Bob	Marley		1242343	Default Unit	1983-02-05			0
branch	olive		22121	Default Unit	1985-02-02	2014-05-06 16:50	2014-05-06 16:51	2
Caa	Paewnt		183181	Default Unit	1987-01-03			0
Check	Patient		183181	Default Unit	1987-01-02			0

1 2 3 4

Click on the required patient, then on the **Next** button. The second step will be displayed:

Dashboard Data Management Organization Logs Server

Combine Assessments

Step 2 / 4: Select assessment to combine

Select the first assessment that you wish to combine. This assessment will be removed after it has been combined with the assessment selected in the next step.

Assessment

2014-05-21 13:44:13
2014-05-12 15:08:41

If the patient you selected in Step 1 has only one assessment, you will be prompted to select another patient. For Step 2, select the first of the assessments you wish to combine from the assessments in the drop-down list. This is the assessment that will be deleted once the two assessments have been combined. Click **Next** to move on to the next step. The third step will be displayed:

Dashboard Data Management Organization Logs Server

Combine Assessments

Step 3 / 4: Select assessment to combine into

Select the second assessment that you wish to combine. The first assessment will be merged into this assessment.

Assessment

2014-05-12 15:08:41

Select the second of the assessments you wish to combine from the drop-down list, then click **Next** to proceed to the final step. A summary of the changes made will be displayed. Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to combine the assessments. Once you click **Finish**, you will be asked to confirm your choice.

Move Assessment to Another Visit

If an assessment has been assigned to the wrong visit, it can be moved to the correct visit using the **Move Assessment to Another Visit** option.

If you need to move the assessment to another patient, use the [Move Assessment to Another Patient](#) option.

If you need to combine assessments withing the same visit, use the [Combine Assessments](#) option.

Moving an assessment to another visit involves four steps, and the process can be canceled at any time before the last step. To move an assessment to another visit, select **Data Management > Assessments**, then select **Move Assessment to Another Visit**. The first **Move Assessment to Another Visit** screen will be displayed:

Dashboard Data Management Organization Logs Server

Move Assessment to Another Visit

Step 1 / 4: Select patient

Select the patient whose assessment you wish to move.

Search: Within Default Unit Assessments from to

Last Name	First Name	Middle Name	Domain ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
milyo			P3428	Default Unit	1989-10-12			0
patient	default	name	a110	Default Unit	1996-02-03	2014-05-05 14:24	2014-05-05 14:24	1
Rai	Sita		39213	Default Unit	1994-10-07	2014-05-12 14:00	2014-05-12 14:00	1
teri	ho	mary	A842	Default Unit	1985-11-15	2014-05-01 15:52	2014-05-02 11:22	2
test	test		18232	Default Unit	1987-01-03			0
test2	test2		18232r	Default Unit	1987-01-03			0
test3	test3		182323	Default Unit	1987-01-03			0
Tree	Oak		1002032	Default Unit	1974-01-05	2014-05-12 15:08	2014-05-12 15:08	1
Wills	Robbie		ID1232	Default Unit	1976-02-11			0

1234

Click on the required patient, then on the **Next** button. The second step will be displayed:

Dashboard Data Management Organization Logs Server

Move Assessment to Another Visit

Step 2 / 4: Select assessment to move

Select the assessment that you wish to move.

Assessment

Please select...
2014-05-21 13:44:13
2014-05-12 15:08:41

If the patient you selected in Step 1 has no assessments, you will be prompted to select another patient. For Step 2, select the assessment you wish to move from the drop-down box, then click **Next**. The third step will be displayed:

Dashboard Data Management Organization Logs Server

Move Assessment to Another Visit

Step 3 / 4: Select destination visit

Select the visit that you wish to move the assessment to.

Visit

Please select...
2014-05-12 15:07:53

Select the visit you wish to move the assessment to, then click **Next** to proceed to the final step.

A summary of the changes made will be displayed. Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to move the assessment. Once you click **Finish**, you will be asked to confirm your choice.

Move Assessment to Another Patient

If an assessment has been assigned to the wrong patient, it can be moved to the correct patient using the **Move Assessment to Another Patient** option. The patient you are moving an assessment to must have an anatomical site defined before you can move the assessment.

Note that often it will be more appropriate to move the whole visit, rather than just the assessment. In which case use the [Move Visit to Another Patient](#) option.

If you need to move the assessment to another visit but the patient does not need to be changed, use the [Move Assessment to Another Visit](#) option.

Moving an assessment to another patient involves five steps, and the process can be canceled at any time before the last step. To move an assessment to another patient, select **Data Management > Assessments**, then select **Move Assessment to Another Patient**. The first **Move Assessment to Another Patient** screen will be displayed:

Dashboard Data Management Organization Logs Server

Move Assessment to Another Patient

Step 1 / 5: Select patient to move assessment from

Select the patient whose assessment you wish to move.

Search: Within Assessments from to

Last Name	First Name	Middle Name	Patient ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
Andrews	Maria		TF023578	Unit A	1957-09-14	2011-10-11 06:52 PM	2011-10-11 06:52 PM	1
Berry	Clare	Judith	TF326703	Unit A	1975-12-21	2012-08-01 04:11 PM	2012-08-01 05:33 PM	5
Bloom	Meredith	Cooper	TF320147	Unit A	1959-03-19	2011-11-15 08:12 PM	2012-07-23 02:26 PM	8
Dallas	Steven	Arthur	TF310983	Unit A	1951-02-18	2011-10-10 03:38 PM	2012-07-31 03:17 PM	14
Davidson	Peter		TF319472	Unit A	1955-12-14	2012-07-23 02:52 PM	2012-07-23 02:52 PM	1
Goodwin	Mark		TF320923	Unit A	1956-06-15	2012-07-23 03:00 PM	2012-07-31 03:48 PM	10
Gow	Hilda		DF2368203	Unit A	1930-09-17	2011-09-23 03:20 PM	2011-09-26 09:35 AM	7
Grayson	Richard		TF009024	Unit A	1963-12-11	2012-08-27 10:17 AM	2012-08-27 10:17 AM	1
Jones	Oliver	Wendell	ZW802345	Unit A	1954-12-13	2011-10-07 01:07 PM	2011-10-10 12:16 PM	12
Morrow	Alexandra	Mary	TF320072	Unit A	1965-07-12	2011-11-03 03:31 PM	2011-12-14 04:39 PM	13

1 2 3 4

Click on the required patient, then on the **Next** button. The second step will be displayed:

Dashboard Data Management Organization Logs Server

Move Assessment to Another Patient

Step 2 / 5: Select assessment to move

Select the assessment that you wish to move to another patient.

Assessment

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Please select...

- 2012-07-31 03:17:14
- 2011-10-19 05:04:22
- 2011-10-12 04:02:42
- 2011-10-12 12:35:26
- 2011-10-12 11:34:57
- 2011-10-12 10:57:58
- 2011-10-12 10:57:51
- 2011-10-12 10:57:44
- 2011-10-11 12:49:27
- 2011-10-11 12:49:13
- 2011-10-11 12:48:55
- 2011-10-10 03:38:28
- 2011-10-10 03:38:11
- 2011-10-10 03:38:04

For Step 2, select the assessment you wish to move from the drop-down box, then click **Next**. The third step will be displayed:

Dashboard Data Management Organization Logs Server

Move Assessment to Another Patient

Step 3 / 5: Select patient to move assessment to

Select the patient that you wish to move the assessment to.

Search: Within Assessments from to

Last Name	First Name	Middle Name	Patient ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
Andrews	Maria		TF023578	Unit A	1957-09-14	2011-10-11 06:52 PM	2011-10-11 06:52 PM	1
Berry	Clare	Judith	TF326703	Unit A	1975-12-21	2012-08-01 04:11 PM	2012-08-01 05:33 PM	5
Bloom	Meredith	Cooper	TF320147	Unit A	1959-03-19	2011-11-15 08:12 PM	2012-07-23 02:26 PM	8
Dallas	Steven	Arthur	TF310983	Unit A	1951-02-18	2011-10-10 03:38 PM	2012-07-31 03:17 PM	14
Davidson	Peter		TF319472	Unit A	1955-12-14	2012-07-23 02:52 PM	2012-07-23 02:52 PM	1
Goodwin	Mark		TF320923	Unit A	1956-06-15	2012-07-23 03:00 PM	2012-07-31 03:48 PM	10
Gow	Hilda		DF2368203	Unit A	1930-09-17	2011-09-23 03:20 PM	2011-09-26 09:35 AM	7
Grayson	Richard		TF009024	Unit A	1963-12-11	2012-08-27 10:17 AM	2012-08-27 10:17 AM	1
Jones	Oliver	Wendell	ZW802345	Unit A	1954-12-13	2011-10-07 01:07 PM	2011-10-10 12:16 PM	12
Morrow	Alexandra	Mary	TF320072	Unit A	1965-07-12	2011-11-03 03:31 PM	2011-12-14 04:39 PM	13

1234

Select the patient you wish to move the assessment to. The patient chosen must have a wound defined. Once a patient is selected, click **Next** to proceed to the fourth step:

Dashboard Patients Organizations System

Move Assessment to Another Patient

Step 4 / 6: Select anatomical site for assessment

Select the anatomical site on the destination patient that the assessment will be assigned to.

Anatomical Site

Right Forearm, Anterior

Select the wound on the patient that the assessment data will be assigned to. If a wound in the assessment being moved is a different wound from those defined for the patient, then you must first create a new wound. Click **Next** to proceed to the final step. A summary of the changes made will be displayed. Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to move the assessment. Once you click **Finish**, you will be asked to confirm your choice.

Delete Assessment

If an assessment has been incorrectly created, it can be deleted using the Delete Assessment option.

Deleting an assessment involves three steps, and the process can be canceled at any time before the last step. To delete an assessment, select **Data Management > Assessments**, then select **Delete Assessment**. The first **Delete Assessment** screen will be displayed:

Dashboard Data Management Organization Logs Server

Delete Assessment

Step 1 / 3: Select Patient

Select the patient with the assessment to be deleted.

Search: Within Default Unit Assessments from to

Last Name	First Name	Middle Name	Domain ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
a	a		A111	Default Unit	1998-02-02			0
a	aada	a	A099	Default Unit	1990-03-02			0
ABe	CDf		123456789	Default Unit	1956-01-01			0
Acharya	Radha		RW120	Default Unit	1979-01-01			0
Ani	Maya		131623	Default Unit	1979-01-01			0
b	b		B111	Default Unit	1991-03-02			0
Bob	Marley		1242343	Default Unit	1983-02-05			0
branch	olive		22121	Default Unit	1985-02-02	2014-05-06 16:50	2014-05-06 16:51	2
Caa	Paewnt		183181	Default Unit	1987-01-03			0
Check	Patient		183181	Default Unit	1987-01-02			0

1234

Click on the required patient, then on the **Next** button. The second step will be displayed:

Dashboard Data Management Organization Logs Server

Delete Assessment

Step 2 / 3: Select Assessment

Select the assessment that is to be deleted.

Assessment

Please select...
2014-05-06 16:51:34
2014-05-06 16:50:05

For Step 2, select the assessment you wish to delete from the drop-down box, then click **Next** to proceed to the final step.

A summary of the changes made will be displayed. Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to delete the assessment. Once you click **Finish**, you will be asked to confirm your choice.

Wound Administration

The tools in the **Wound Administration** screen allow you to manage wound data. You can:

- Edit the wound's anatomical site. See [Change Anatomical Site](#).
- Delete a patient's wound. See [Delete Wound](#).
- Undelete a previously deleted wound. See [Undelete Wound](#).
- Combine two wounds into one. See [Combine Wounds](#).

If you wish to add a new wound to a patient, this can be done in the [Wound Manager](#).

Change Anatomical Site

If a wound's anatomical site has been described incorrectly, it can be changed using the **Change Anatomical Site** screen. This may occur if, for example, a wound near an elbow is described as occurring on the elbow but would be more accurately described as occurring on the forearm.

Changing an anatomical site involves four steps, and the process can be canceled at any time before the last step. To change an anatomical site, select **Data Management > Wounds**, then select **Change Anatomical Site** from the **Wound Administration** screen. The first **Change Anatomical Site** screen will be displayed:

Dashboard Data Management Organization Logs Server

Change Anatomical Site

Step 1 / 4: Select patient
Select the patient whose anatomical site you wish to change.

Search: Within Assessments from to

Last Name	First Name	Middle Name	Domain ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
Come	Well		b01	Default Unit	1983-01-01	2014-05-06 11:44	2014-05-06 11:45	2
Cup	One	t	123452368df	Default Unit	1987-01-01			0
Da	Sa		ID1200	Default Unit	1975-02-02	2014-05-01 13:23	2014-05-01 14:33	18
Day	Nice		ab012	Default Unit	1984-01-01	2014-05-02 11:31	2014-05-02 12:10	6
Doe	John		12333	Default Unit	1983-01-01			0
Doe	John34		123336546	Default Unit	1983-01-01	2014-05-06 12:40	2014-05-06 12:40	3
Dough	Jane		12333	Default Unit	1956-04-07	2014-05-06 12:50	2014-05-06 12:50	1
Durkin	Jesenia		40597	Default Unit	1974-06-07			0
Eve	Good		b014	Default Unit	1985-01-01	2014-05-06 11:54	2014-05-06 11:57	3
Frank	Lampard		10291	Default Unit	1986-12-05			0

Click on the required patient, then on the **Next** button. The second step will be displayed:

Dashboard Data Management Organization Logs Server

Change Anatomical Site

Step 2 / 4: Select Anatomical Site
Select the anatomical site that you wish to change.

If the patient selected in Step 1 has no wound defined, you will be prompted to select another patient. For Step 2, select the wound whose anatomical site you wish to change from the drop-down box, then click **Next**. The third step will be displayed:

Dashboard Data Management Organization Logs Server

Change Anatomical Site

Step 3 / 4: Update Anatomical Site
Select the anatomical site that you wish to change it to.

Group

Gross Division

Handedness

Region

Aux. Text

Use the drop-down boxes to set a new anatomical site, then click **Next**. A screen will be displayed summarizing the changes that will be made.

Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to update the anatomical site. Once you click **Finish**, you will be asked to confirm your choice.

Combine Wounds

If the same physical wound has two records created for it, then these can be combined using the **Combine Wounds** screen.

Combining wounds involves four steps, and the process can be canceled at any time before the last step. To combine wounds, select **Data Management > Wounds**, then select **Combine Wounds** from the **Wound Administration** screen. The first **Combine Wounds** screen will be displayed:

Dashboard Data Management Organization Logs Server

Combine Wounds

Step 1 / 4: Select patient

Select the patient whose wounds you wish to combine.

Search: Within Assessments from to

Last Name	First Name	Middle Name	Patient ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
Andrews	Maria		TF023578	Unit A	1957-09-14	2011-10-11 06:52 PM	2011-10-11 06:52 PM	1
Berry	Clare	Judith	TF326703	Unit A	1975-12-21	2012-08-01 04:11 PM	2012-08-01 05:33 PM	5
Bloom	Meredith	Cooper	TF320147	Unit A	1959-03-19	2011-11-15 08:12 PM	2012-07-23 02:26 PM	8
Dallas	Steven	Arthur	TF310983	Unit A	1951-02-18	2011-10-10 03:38 PM	2012-07-31 03:17 PM	14
Davidson	Peter		TF319472	Unit A	1955-12-14	2012-07-23 02:52 PM	2012-07-23 02:52 PM	1
Goodwin	Mark		TF320923	Unit A	1956-06-15	2012-07-23 03:00 PM	2012-07-31 03:48 PM	10
Gow	Hilda		DF2368203	Unit A	1930-09-17	2011-09-23 03:20 PM	2011-09-26 09:35 AM	7
Grayson	Richard		TF009024	Unit A	1963-12-11	2012-08-27 10:17 AM	2012-08-27 10:17 AM	1
Jones	Oliver	Wendell	ZW802345	Unit A	1954-12-13	2011-10-07 01:07 PM	2011-10-10 12:16 PM	12
Morrow	Alexandra	Mary	TF320072	Unit A	1965-07-12	2011-11-03 03:31 PM	2011-12-14 04:39 PM	13

1 2 3 4

Click on the required patient, then on the **Next** button. The second step will be displayed:

Dashboard Data Management Organization Logs Server

Combine Wounds

Step 2 / 4: Select the wound to combine

Select the first wound that you wish to combine. The wound will be removed after it has been combined with the wound selected in the next step.

If the patient selected in Step 1 has no wounds or only a single wound, you will be prompted to select another patient.

For Step 2, select the wound that you wish to combine, then click **Next**. The third step will be displayed:

Dashboard Data Management Organization Logs Server

Combine Wounds

Step 3 / 4: Select the wound to combine into

Select the second wound that you wish to combine. The first wound will be merged into this wound.

Select the wound that you want to merge the wound selected in step 2 into, then click **Next**. This is the wound that will remain after the merge is completed. A screen will be displayed summarizing the changes that will be made. Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to merge the wounds. Once you click **Finish**, you will be asked to confirm your choice.

Delete Wound

Deleting a patient's wound will remove the wound from that patient on SilhouetteCentral, and on any SilhouetteConnect that subsequently synchronizes with SilhouetteCentral. Note that the deleted wound label will not be re-used if a new wound is subsequently created.

Deleting a wound involves three steps, and the process can be canceled at any time before the last step. To delete a wound for a patient, select **Data Management > Wounds**, then select **Delete Wound** to begin the process. The steps are as follows:

1. Select patient: The first **Patient Select** screen will be displayed. You can use the page links to choose a different page, or you can search for a particular patient in the search box. Once you have selected the required patient, click on the **Next** button.

Dashboard Data Management Organization Logs Server

Delete Wound

Step 1 / 3: Select Patient

Select the patient with the wound to be deleted.

Search: Within Assessments from to

Last Name	First Name	Middle Name	Domain ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
Come	Well		b01	Default Unit	1983-01-01	2014-05-06 11:44	2014-05-06 11:45	2
Cup	One	t	123452368df	Default Unit	1987-01-01			0
Da	Sa		ID1200	Default Unit	1975-02-02	2014-05-01 13:23	2014-05-01 14:33	18
Day	Nice		ab012	Default Unit	1984-01-01	2014-05-02 11:31	2014-05-02 12:10	6
Doe	John		12333	Default Unit	1983-01-01			0
Doe	John34		123336546	Default Unit	1983-01-01	2014-05-06 12:40	2014-05-06 12:40	3
Dough	Jane		12333	Default Unit	1956-04-07	2014-05-06 12:50	2014-05-06 12:50	1
Durkin	Jesenia		40597	Default Unit	1974-06-07			0
Eve	Good		b014	Default Unit	1985-01-01	2014-05-06 11:54	2014-05-06 11:57	3
Frank	Lampard		10291	Default Unit	1986-12-05			0

- Select wound: Use the drop-down box to select the patient's wound to delete, then click **Next**.

Dashboard Data Management Organization Logs Server

Delete Wound

Step 2 / 3: Select Wound

Select the wound that is to be deleted.

- Confirmation: A screen will be displayed summarizing the changes that will be made. Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to delete the wound. Once you click **Finish**, you will be asked to confirm your choice.

Undelete Wound

Undeleting a patient's wound will add back a previously delete wound on SilhouetteCentral, and on any SilhouetteConnect that subsequently synchronizes with SilhouetteCentral.

Undeleting a wound involves three steps, and the process can be canceled at any time before the last step. To undelete a wound for a patient, select **Data Management > Wounds**, then select **Undelete Wound** to begin the process. The steps are as follows:

- Select patient: The first **Patient Select** screen will be displayed. You can use the page links to choose a different page, or you can search for a particular patient in the search box. Once you have selected the required patient, click on the **Next** button.

Dashboard Data Management Organization Logs Server

Undelete Wound

Step 1 / 3: Select Patient

Select the patient with the wound to be undeleted.

Search: Within Assessments from to

Last Name	First Name	Middle Name	Domain ID	Unit	Date of Birth	First Assessment	Last Assessment	# Assessments
milyo			P3428	Default Unit	1989-10-12			0
patient	default	name	a110	Default Unit	1996-02-03	2014-05-05 14:24	2014-05-05 14:24	1
Rai	Sita		39213	Default Unit	1994-10-07	2014-05-12 14:00	2014-05-12 14:00	1
teri	ho	mary	A842	Default Unit	1985-11-15	2014-05-01 15:52	2014-05-02 11:22	2
test	test		18232	Default Unit	1987-01-03			0
test2	test2		18232r	Default Unit	1987-01-03			0
test3	test3		182323	Default Unit	1987-01-03			0
Tree	Oak		1002032	Default Unit	1974-01-05	2014-05-12 15:08	2014-05-21 13:44	2
Wills	Robbie		ID1232	Default Unit	1976-02-11			0

- Select deleted wound: Use the drop-down box to select the patient's wound to undelete, then click **Next**.

Dashboard Data Management Organization Logs Server

Undelete Wound

Step 2 / 3: Select Deleted Wound

Select the deleted wound that is to be undeleted.

A - Sternum, Inferior ▼

Cancel Back Next

- Confirmation: A screen will be displayed summarizing the changes that will be made. Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to undelete the wound. Once you click **Finish**, you will be asked to confirm your choice.

Image Administration

The tools in the **Image Administration** screen allow you to manage the images. You can:

- Move an image from one assessment to another. See [Move Image to Another Assessment](#).

Move Image to Another Assessment

If an image has been captured in the wrong assessment, it can be moved to the correct assessment using the **Move Image to Another Assessment** option.

Moving an image to another assessment involves seven steps, and the process can be canceled at any time before the last step. To move an image to another assessment, select **Data Management > Images**, then select **Move Image to Another Assessment**. The first **Move Image to Another Assessment** screen will be displayed:

Step 1 / 7: Select patient to move image from

Select the patient whose image you wish to move.

Search Assessments from to

Last Name	First Name	Middle Name	Domain ID	Date of Birth	First Assessment	Last Assessment	# Assessments
Andrews	Maria		TF023578	1957-09-14	2011-10-11 18-52	2011-10-11 18-52	1
Ashworth	Susan	Diane	ZW984390	1939-03-06	2008-10-13 10-59	2008-10-13 10-59	1
Berry	Clare	Judith	TF326703	1975-12-21	2012-08-01 16-11	2012-08-01 16-11	1
Bloom	Meredith	Cooper	TF320147	1959-03-19	2011-11-15 20-12	2012-07-23 14-26	8
Boscoe	Michael	James	AN883910	1951-05-04			0
Caldwell	Jacqueline		TF329234	1960-09-14			0
Cook	Lucy		ZW906802	1946-01-14	2008-10-13 10-15	2008-10-13 10-19	2
Cooke	Albert		PQ958825	1946-11-23	2009-08-17 15-47	2009-08-23 20-17	5
Cooper	Elizabeth		ZW123250	1953-11-19	2008-10-02 17-03	2008-10-13 12-42	4
Dallas	Steven	Arthur	TF310983	1951-02-18	2011-10-10 15-38	2012-07-31 15-17	14

1 2 3 4 5 6

Cancel Next

Click on the required patient, then on the **Next** button. The second step will be displayed:

Step 2 / 7: Select assessment to move image from

Select the assessment that contains the image you wish to move

Assessment

Please select... ▼

2012-08-01 16-18-11

2012-08-01 16-11-59

Cancel Back Next

For Step 2, select the assessment you wish to move the image from, using the drop-down box, then click **Next**. The third step will be displayed:

Step 3 / 7: Select image to move

Select the image that you want to move.

2012-08-01 16-18

Cancel Back Next

If there are no images in the assessment selected, you will be advised there are no images to display, and you will have the option to go **Back** and select a different patient or assessment, or **Cancel**.

For Step 3, select the image you wish to move, then click **Next**. The fourth step will be displayed:

Step 4 / 7: Select patient to move image to

Select the patient that you wish to move the image to.

Search Assessments from to

Last Name	First Name	Middle Name	Domain ID	Date of Birth	First Assessment	Last Assessment	# Assessments
Andrews	Maria		TF023578	1957-09-14	2011-10-11 18-52	2011-10-11 18-52	1
Ashworth	Susan	Diane	ZW984390	1939-03-06	2008-10-13 10-59	2008-10-13 10-59	1
Berry	Clare	Judith	TF326703	1975-12-21	2012-08-01 16-11	2012-08-01 16-18	2
Bloom	Meredith	Cooper	TF320147	1959-03-19	2011-11-15 20-12	2012-07-23 14-26	8
Boscoe	Michael	James	AN883910	1951-05-04			0
Caldwell	Jacqueline		TF329234	1960-09-14			0
Cook	Lucy		ZW906802	1946-01-14	2008-10-13 10-15	2008-10-13 10-19	2
Cooke	Albert		PQ958825	1946-11-23	2009-08-17 15-47	2009-08-23 20-17	5
Cooper	Elizabeth		ZW123250	1953-11-19	2008-10-02 17-03	2008-10-13 12-42	4
Dallas	Steven	Arthur	TF310983	1951-02-18	2011-10-10 15-38	2012-07-31 15-17	14

1 2 3 4 5 6

For step 4, select the patient the image will be moved to, then click **Next**. The fifth step will be displayed:

Step 5 / 7: Select assessment to move image to

Select the assessment to move the image to

Assessment

Please select...
Please select...
2012-07-31 15-17-14
2011-10-19 17-04-22
2011-10-12 16-02-42

For step 5, select the patient's assessment the image will be moved into, then click **Next**. The sixth step will be displayed:

Move Image to Another Assessment

Step 6 / 7: Wound Selection

The selected assessment is already linked to a wound. The image will be assigned to this same wound.

Wound F - Left Foot, Lateral

For step 6, if the image is being assigned to an assessment that already has data, then the wound will already be defined and is not able to be changed as is shown above. If, however, the assessment has no existing wound data then select the wound location the image is specific to.

Move Image to Another Assessment

Step 6 / 7: Wound Selection

The selected assessment is not linked to a wound. Please select the wound to assign the image to.

A - Left Clavicular Region

Click **Next** to proceed to the final step. A summary of the changes made will be displayed. Click **Cancel** to cancel the process, **Back** to go back and make changes or **Finish** to move the image. Once you click **Finish**, you will be asked to confirm your choice.

Organization Management Tools

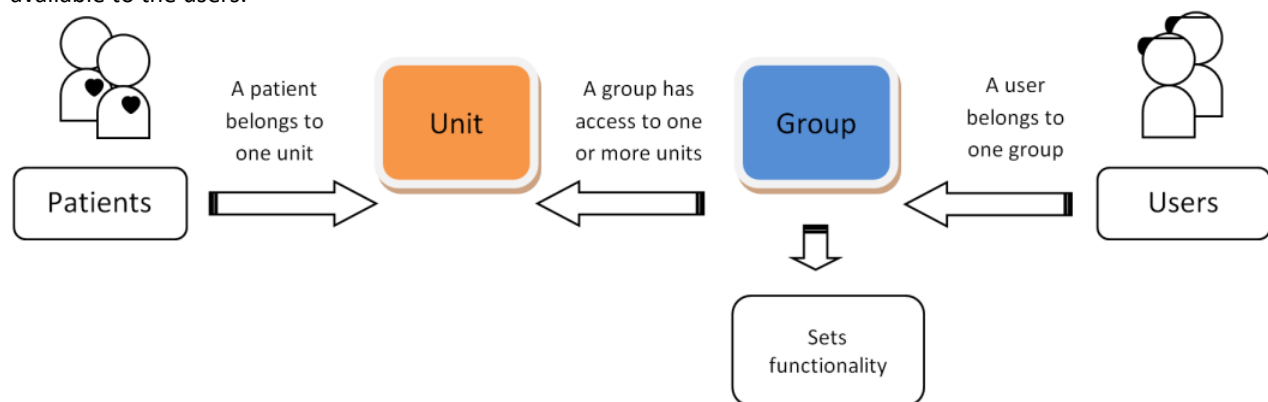
The tools in the **Organization** menu allow you to configure SilhouetteCentral and SilhouetteConnect in a variety of ways to suit your organization. You can:

- Create, edit and delete users. See [User Administration](#).
- Create, edit and delete groups. See [Group Administration](#).
- Create, edit and delete units. See [Unit Administration](#).
- Configure the documentation notes that appear in the **Notes** screens in Silhouette. See [Notes Administration](#).
- Upload and remove report templates. See [Report Administration](#).
- Upload and remove protocol templates. See [Protocol Administration](#).
- Manage the settings of SilhouetteCentral and SilhouetteConnect. See [Organization Settings](#).

For an overview of the interrelation between groups, users and units, see [Groups, Users, and Units in Silhouette](#).

Groups, Users, and Units in Silhouette

Access to the Silhouette data is managed through units and groups. Additionally, the group controls functionality available to the users.



Where:

- Every patient belongs to a single unit. While a patient can only belong to one unit at a time, this can change over time.
- Each user belongs to a single group.
- A group can be associated with one, several, or all units of the organization.

In summary, a user has access to those patients that belong to the unit(s) which the user's group is associated with; additionally, the group defines the actions a user can perform.

Silhouette users can log on to only one unit at a time. In a multi-unit organization that uses different Patient ID identifiers for patients in different units, selection of a unit will control which IDs are displayed on screen and which Patient ID is used in the creation of patient records.

As an example, your organization might have a set of users who belong to the same group that can only log on to a specific unit in the organization. A user might also be limited in what changes they can make to patient records or might be prevented from creating new patients in the system. At the same time, there may be a set of users who belong to a different group that has access to every unit and can use any Silhouette feature available in the system. Note that different organizations use units in different ways, depending upon how the organization is structured. For example, an organization may use units to differentiate different departments, wards, or facilities.

Units can be defined in the [Unit Administration](#) screen. Group settings, including which units members of a group can access, are defined in the [Group Administration](#) screen. Users can be created and edited in the [User Administration](#) screen, which allows assignment of a user to one of the groups defined in the [Group Administration](#) screen.

User Administration

Users must have a user account to access SilhouetteConnect or SilhouetteCentral. The User Administration screen allows you to add and manage Silhouette user accounts. To define and manage users, select **Organization> Users**.

Dashboard Data Management Organization Logs Server

User Administration

A Search: Belonging to: Any Group

User Name	First Name	Middle Name	Last Name	Phone Number	Email Address	Group	Status
swift	swift		grey		swift.grey@address.com	Default	Enabled
valeria	valeri		admas		valerie.adams@address.com	Admin	Enabled
warren	warren		brothers		warren.brothers@address.com	Default	Enabled
weva	eva		jones		eva.jones@address.com	Default	Enabled
yason	bob		jason		bob.jason@address.com	Default	Enabled
zlaura	laura		paul		laura.paul@address.com	Default	Enabled

B

1 2

C **D** **E** **F** **G**

H

Upload users

- A Filter options**
Limit the users shown in the table using these options.
- B User table**
The table displays the users defined for the selected organization. See [Creating a User](#) for more information about the fields in this table.
- C Create button**
See [Creating a User](#).
- D Edit button**
See [Editing a User](#).
- E Delete button**
Click the **Delete** button to delete the currently selected user. You will be prompted to confirm your action.
- F Reset Password button**
The **Reset Password** button resets the password for the currently selected user. You will be prompted to enter and verify a new password. Click on the **Change Password** button to confirm the new password. Password can also be [reset via email](#).
- G Export button**
Click the **Export** button to export a list of all users that match the current filter options.
- H Upload users**
A csv file containing a list of users can be uploaded to import these users to SilhouetteCentral. This file should be in the same format as the csv file generated through the export function. If an existing user is found in SilhouetteCentral then this user will be updated (users are determined as existing or new through the user name). An additional column labeled "Password" may be included, in which case if a value is specified the user's password will be set to the specified value. If no password value is specified the user's original password will be retained. It is an error to attempt to create a new user without specifying a password.

LDAP Integration

Some of the functionality described in this section, such as the ability to delete user accounts, or reset passwords may be disabled for certain user accounts if your system is configured with **LDAP Integration** enabled.

When LDAP integration is enabled an additional **Source** column will be shown in the user table to indicate user accounts that are controlled via LDAP. If user maintenance is required for these user accounts the actions should be performed via LDAP (or Active Directory). Silhouette will automatically detect the changes and update the user accounts as required.

Creating a User

To add a new user to SilhouetteCentral, in the **User Administration** screen click on the **Create** button. The **Create User** screen is displayed, with compulsory fields marked with an asterisk. Enter the required information.

Note that every user within the organization must have a unique **User Name**.

The **Group** a user is assigned to determines what Silhouette features and patients the user has access to. See [Group Administration](#) for more information.

When a user belongs to a group that can view device synchronizations in the SilhouetteCentral Admin section the time of each synchronization attempt is displayed in the user's specified timezone. When creating a new user account ensure that the correct timezone is selected. For convenience a system wide default can be specified to control which timezone is selected by default when creating a new user account, see [Organization](#).

When you have entered the patient's details, select the **Update** button at the bottom of the screen to save the user's information, and you will be returned to the [User Administration](#) screen.

Editing a User

To edit an existing user's details, select that user in the **User Administration** screen and click on the **Edit** button. The **Edit User** screen is displayed, with compulsory fields marked with an asterisk. When you have finished editing the user's details, clicking on the **Update** button at the bottom of the screen saves the user's information and returns you to the [User Administration](#) screen.

The status drop-down controls if a user can log on to SilhouetteCentral or SilhouetteConnect (subject to their group permissions). A user will be able to log on when their status is "Enabled". To temporarily stop a user from logging on you can set their status to "Disabled". The system may also automatically disable an account, in which case the status will be "Locked". This distinction can be used to determine which user accounts have been explicitly disabled by a system administrator, and those which a user has accidentally disabled due to entering the incorrect password too many times.

If you wish to change the user's password, use the **Reset Password** button in the [User Administration](#) screen.

Send Password Reset Email

[Email Integration](#) has to be enabled in SilhouetteCentral for a setting to "Allow users to reset password via email" to be seen on [Organization Settings](#) page. If this setting is enabled, "Send password reset email" link will be seen on clicking "Reset Password" button for users having email addresses. On clicking this link, an email will be sent to the user's email address, with content as specified in the [Email Template](#) for resetting a Password.

Reset Password

Enter the new password below. The password must match the following criteria:

- A minimum of 3 characters.
- A maximum of 20 characters.

[Send password reset email](#)

New Password *

Confirm Password *

Group Administration

To ease support burdens, individual user accounts are assigned to groups based upon similar needs with respect to the features and patients they are allowed to access. This allows the permissions to be configured once and applied immediately across a number of user accounts.

As an example you may create a group to allow data correction tools to be utilized by research staff, while another group containing your clinical staff would not have access to these tools. Groups can also be used to restrict users to interacting with a subset of patients (via units).

To define and manage groups, select **Organization> Groups**.

Dashboard Data Management Organization Logs Server			
Group Administration			
Name	Description	User Count	Source
Admin	Users with full administrator access	2	corp.rochester.com
Default		5	corp.rochester.com
Default Group		20	corp.rochester.com
Hospital1Admin		2	corp.rochester.com
Hospital1User		20	corp.rochester.com
Hospital2Admin		2	corp.rochester.com
Hospital2User		20	corp.rochester.com
<div> <div>Create</div> <div>Edit</div> <div>Delete</div> <div>Export</div> </div>			

A Groups table
This table lists the groups defined.

B Create button
See [Creating a Group](#).

C Edit button
See [Editing a Group](#).

D Delete button
The **Delete** button deletes the currently selected group.
You will be asked to confirm your choice.

Note that you are not able to delete a group that has user accounts assigned to it. Likewise you can not delete groups that are automatically created as part of LDAP Integration. If you want to delete such a group the change must be made to the LDAP server. SilhouetteCentral will then detect the change.

E Export button
Click the **Export** button to save a CSV report of the groups that match the current filter options.

Creating a Group

To create a new group, in the **Group Administration** screen click the **Create** button. The **Create Group** screen is displayed, with compulsory fields marked with an asterisk. Enter a **Group Name** and **Description**.

If you tick the check box **Force Password Reset**, new users who are assigned to this group will be required to change their password the first time they log on.

This allows you to create all new user accounts with an easily entered password such as "password" or "1234" and ensure users provide a new password only known to themselves when they initially log on.

The settings in this screen are divided into two main parts:

- The left hand side defines what **Silhouette Product Features** users who belong to this group have permission to use. The **Administration** settings primarily relate to Silhouette system configuration, and should only be enabled for groups that require high-level access to the system.
- The right hand side defines what patients users who belong to the new group can access. Patients are always assigned a single unit at a specific point in time, and the new group can be assigned permission to interact with patients associated with one or more specified units.

To defined which units the new group has access to, click Change, which reveals a list of all available units the current system administrator has access to. Select the check boxes which represent the units that hold patients the new group should have access to:

For the following units

☐ all and future units

☒ Level 101

☒ Level 102

☒ Level 103

☒ Level 201

☒ Level 202

☒ Level 203

[Close](#)

If you select the **all and future units** check box then the unit check boxes will be hidden.

Having the **all and future units** check box enabled means that as new units are created within SilhouetteCentral permission to access the patients in the newly created units will automatically be assigned to the new group. If the **all and future units** check box was left unchecked a system administrator would need to manually edit each group to add permission to access each new unit.

If you don't select the global access (all units) check box the Administration section on the left side of the screen is removed so they can not be enabled. This is because the permissions in this section control the ability to access functionality which allows interaction with any patient within the system, or affects all users. Due to this, these permissions are only assignable to a group if the group has global access to all patients and user accounts. Below you will find a description of each permission that can be assigned to a group.

SilhouetteConnect

- **can log on** - controls if users assigned to this group can log on to SilhouetteConnect.
- **can access admin** - controls if users assigned to this group can access the Licensing and Synchronization tabs within the SilhouetteConnect admin dialog. If this permission is not assigned to a group the respective tabs will not be visible.
- **can synchronize** - controls if users assigned to this group can synchronize a SilhouetteConnect device with SilhouetteCentral. The Sync button on the patient selection screen within SilhouetteConnect will be disabled if this permission is not assigned.
- **can add patients** - controls if users assigned to this group can add additional patients currently stored within SilhouetteCentral to a SilhouetteConnect device.
- **can remove patients** - controls if users assigned to this group can remove patients from a SilhouetteConnect device (once the patient data has successfully been synchronized with SilhouetteCentral for storage).
- **can perform camera calibration checks** - controls if users assigned to this group can perform a SilhouetteStar camera calibration check. If this permission is not assigned to a group the Calibration Check tab within the SilhouetteConnect admin dialog will not be visible.

Note: **can add patients** and **can remove patients** permissions also requires the user have the can synchronize permission. If users have neither **can add patients** or **can remove patients** permissions the manage patients button on the patient selection screen within SilhouetteConnect will be disabled.

SilhouetteCentral

- **can log on** - controls if users assigned to this group can log on to SilhouetteCentral.
- **can access admin** - controls if users assigned to this group have access to the Admin tab within SilhouetteCentral.
- **can access desktop** - controls if users assigned to this group have access to the Desktop tab within SilhouetteCentral.
- Population Reporting
 - **can access population reporting** - controls if users assigned to this group have access to the Reports tab within SilhouetteCentral.
 - **can create reports** - controls if users assigned to this group can generate a new population report. A separate permission is provided for each available population report template such that access to certain report types can be restricted to a subset of groups.

Note: **can access admin**, **can access desktop** and **can access population reporting** also require the **can log on** permission. All groups must have at least one of the **can access admin**, **can access desktop** or **can access population**

reporting permissions assigned. If all are disabled, users will be immediately returned to the log on screen after they successfully log on.

Administration

- **can manage clinical data** - controls if users assigned to this group have access to the data correction tools available underneath the Data Management menu in SilhouetteCentral's admin section. It also controls access to the Audit Log menu item available in Logs > Audit Log and whether holding down the CTRL key while exporting an image in either SilhouetteConnect or SilhouetteCentral will result in an SDR file being exported (designed for advanced ARANZ Medical support needs) instead of the typical JPEG or PNG file.
- **can manage notes** - controls if users assigned to this group have access to the Organization > Notes menu item in SilhouetteCentral's admin section.
- **can manage protocols** - controls if users assigned to this group have access to the Organization > Protocols menu item in SilhouetteCentral's admin section.
- **can manage reporting** - controls if users assigned to this group have access to the Organization > Reports menu item in SilhouetteCentral's admin section.
- **can manage organization settings** - controls if users assigned to this group have access to the Organisation > Settings menu item in SilhouetteCentral's admin section.
- **can perform SilhouetteCentral maintenance** - controls if users assigned to this group have access to the License Details, Logs of SilhouetteCentral and SilhouetteConnect, and Error Messages menu items located in the Server menu within SilhouetteCentral's admin section.
- **can create units** - controls if users assigned to this group can use the Create button on the Unit Administration screen, and on the Patient Identifier Administration screen in SilhouetteCentral's admin section.
- **can edit units** - controls if users assigned to this group can use the Edit button on the Unit Administration screen, and on the Patient Identifier screen in SilhouetteCentral's admin section.
- **can delete units** - controls if users assigned to this group can use the Delete button on the Unit Administration screen, and on the Patient Identifier screen in SilhouetteCentral's admin section.

Note: If **can create units**, **can edit units** and **can delete units** are all unchecked the Unit Administration screen, and Patient Identifier screen will be inaccessible to users assigned to this group.

Note: All permissions listed in this section also require the SilhouetteCentral **can access admin** permission.

Otherwise features controlled by the permissions listed in this section will be inaccessible.

Clinical Data

- **can create patients on SilhouetteConnect** - controls if users assigned to this group can use the Create button on the Patient Select screen within SilhouetteConnect.
- **can create patients on SilhouetteCentral** - controls if users assigned to this group can use the Create button on the Patient Select screen within SilhouetteCentral.
- **can edit patient demographics** - controls if users assigned to this group can use the Edit button on the Patient Select screens within SilhouetteConnect and SilhouetteCentral.
- **can delete patients** - controls if users assigned to this group can use the Delete button on the Patient Select screens within SilhouetteConnect and SilhouetteCentral.
- **can edit patient notes** - controls if users assigned to this group can create new, or edit existing patient, visit or wound notes within SilhouetteConnect or SilhouetteCentral.
- **can capture images** - controls if users assigned to this group can use the Capture Images button within SilhouetteConnect to create new wound assessments by capturing one or more SilhouetteStar images.
- **can trace images at time of capture** - controls if users assigned to this group see the Trace Images step of the Image Capture wizard while capturing new images in SilhouetteConnect. If disabled, users will be able to assign new images to a wound, but after this they will be returned to the patient dashboard rather than given the opportunity to trace wound outlines or draw rulers.
- **can reassign images** - controls if users assigned to this group are able to click the Edit Image button within the Patient Dashboard of SilhouetteConnect to reassign an image to a different wound, or discard an image.
- **can trace/retrace images** - controls if users assigned to this group see the Trace Images step of the Image Capture Wizard while editing an existing image. This permission also requires the **can reassign images** permission (in order for the user to be able to access the edit image wizard). If disabled, users will be able to

reassign images to a different wound, but they will not be able to alter wound boundaries, or rulers while editing an image.

- **can create a wound** - controls if users assigned to this group can use the Create Wound button within SilhouetteCentral's wound manager, and SilhouetteConnect's patient dashboard screens.
- **can change an anatomical site** - controls if users assigned to this group can use the Change Anatomical Site menu item within SilhouetteConnect is enabled.
- **can heal or re-open wounds** - controls if users assigned to this group can use the Heal / Re-open wound menu item within SilhouetteConnect and SilhouetteCentral's wound manger screen.
- **can create assessment reports** - controls if users assigned to this group can generate a new wound assessment report. A separate permission is provided for each available report type such that access to certain report types can be restricted to a subset of groups.
- **can run protocols** - controls if users assigned to this group can run protocols within the SilhouetteConnect protocol engine feature. A separate permission is provided for each available protocol, as installed via the [Protocol Administration](#) screen.
- **can create a new visit** - controls if users assigned to this group can use the Create Visit button within SilhouetteConnect's patient dashboard screen and the Create Assesment button in SilhouetteCentral's Wound Manager screen.
- **can split/merge assessments** - controls if users assigned to this group can use the split and merge feature within SilhouetteConnect's image capture wizard to split multiple images into different assessments.
- **can view assessment orders** - controls if users assigned to this group can view assessment orders (or DICOM worklists) associated with a patient in both SilhouetteCentral and SilhouetteConnect.
- **can assign assessments to orders** - controls if users assigned to this group can assign additional assessments to an assessment order within SilhouetteCentral and SilhouetteConnect.
- **can close assessment orders** - controls if users assigned to this group can mark an assessment order as closed within SilhouetteCentral and Silhouetteconnect.
- **can export patient information** - controls if users assigned to this group can export patient data. If this permission is not assigned the Export button on the Patient Selection screens within SilhouetteConnect and SilhouetteCentral will be hidden.

Note: The **can run protocols** section will only be present if the **Protocol Engine** feature has been licensed.

Note: If a group only has permission to utilize a single protocol they will not get prompted to select a protocol when the Run Protocol button is selected in SilhouetteConnect.

Note: If **can view assessment orders**, **can assign assessments to orders** and **can close assessment orders** are all unchecked, users will not see the Orders button within the Patient Selection screen within SilhouetteCentral, or the Patient Dashboard screen within SilhouetteConnect.

Users

- **can create users** - controls if users assigned to this group can use the Create button on the User Administration screen.
- **can edit users** - controls if users assigned to this group can use the Edit button on the User Administration screen.
- **can delete users** - controls if users assigned to this group can use the Delete button on the User Administration screen.

Note: if all three permissions are unchecked the User Administration screen will be inaccessible to users assigned to this group.

Groups

- **can create groups** - controls if users assigned to this group can use the Create button on the Group Administration screen.
- **can edit groups** - controls if users assigned to this group can use the Edit button on the Group Administration screen.
- **can delete groups** - controls if users assigned to this group can use the Delete button on the Group Administration screen.

Note: If all three permissions are unchecked the group administration screen will be inaccessible to users assigned to this group.

Devices

- **can manage SilhouetteConnect devices** - controls if administrators logged into SilhouetteCentral Admin see the camera calibration check table on the admin dashboard, the Logs > Synchronizations and Logs > Camera Calibration Check menu items. Within SilhouetteConnect controls if the user can see the Synchronization tab within the Admin dialog (this also requires the user to have the SilhouetteConnect can access admin permission).

To save the group's settings, click on the **Update** button at the bottom of the screen.

Editing a Group

To edit a group to SilhouetteCentral, in the **Group Administration** screen select the group from the groups table and click on the **Edit** button. Update the information, as required. To save the group's settings, click on the **Update** button at the bottom of the screen.

Patient Identifier Administration

The **Patient Identifiers Administration** screen is used to define the Patient Identifiers that are used by Silhouette. Each patient within Silhouette can have one or more of these identifiers assigned to them.

Access to the **Patient Identifier Administration** screen is controlled by the corresponding group permissions, namely 'can create units', 'can edit units', and 'can delete units'.

Name	Label	Unit Count
Medical Record Number	MRN	0
Patient Account Number	Account Number	0
Patient ID	Patient ID	2

Create Edit Delete Export

Upload Patient Identifier

- A Patient Identifiers table**
This table lists the patient identifiers that have been defined.
- B Create button**
Click the **Create** button to define a new patient identifier. This will launch the **Create Patient Identifier** screen
- C Edit button**
Click the **Edit** button to amend details for the currently selected patient identifier. When you are finished, click on the **Save** button to save your changes.
- D Delete button**
Click the **Delete** button to delete the currently selected patient identifier. You will be asked to confirm your choice. Note that you will not be able to delete a patient identifier if it is currently linked to a unit.
- E Export button**
Click the **Export** button export a CSV file of all patient identifiers.
- F Upload patient identifiers**
A CSV file in the same format as the exported CSV file can be uploaded to import patient identifiers into SilhouetteCentral. A file can be uploaded either by clicking the **Browse** button and locating the file, or by dragging and dropping the file onto the upload field that automatically appears.

Editing a Patient Identifier

To edit a patient identifier in SilhouetteCentral, in the **Patient Identifier Administration** screen, select the patient identifier from the patient identifiers table and click the **Edit** button.

Edit Patient Identifier

The screenshot shows the 'Edit Patient Identifier' form. It has five main input fields, each with a yellow circular label:

- A Name ***: A text box containing 'Patient ID'.
- B Label ***: A text box containing 'Patient ID'.
- C DICOM Assigning Authority**: An empty text box.
- D Regular Expression**: An empty text box.
- E Message**: An empty text box.

 Below these fields is a section labeled 'Validation'. At the bottom of the form are two buttons: a green 'Update' button with a checkmark icon and a red 'Cancel' button with an 'X' icon.

- A Name**
A unique name for this patient identifier. This value is used in HL7 configuration files and template macros.
- B Label**
This label will be shown in the user interface and on reports everywhere this patient identifier appears.
- C DICOM Assigning Authority**
This field is only visible if DICOM has been correctly licensed and allows the user to specify which DICOM Assigning Authority (Patient ID Issuer) Tag to match to this Patient Identifier within SilhouetteCentral.
- D Regular Expression**
This defines a regular expression that is used to validate the patient identifier when a patient record is being created or edited in SilhouetteCentral or SilhouetteConnect. It will not be used to validate identifiers that are set using the HL7 or DICOM interfaces.
If this is left blank then no additional validation, beyond it being a required field, will be performed.
For more information on developing a Regular Expression refer to the [Regular Expression Appendix](#).
- E Message**
This defines the error message that will be displayed if the user enters an identifier that does not match the regular expression defined above.

Patient Field Administration

The Patient Field Administration screen is used to configure the Patient Fields that appear in the **Create Patient** and **Edit Patient** screens. They can be renamed, hidden, or made mandatory.

Patient Field Administration

Details

Identifier A	Label B	Visible C	Required D	
Unit	Unit	✓	✓	
Last Name	Last Name	✓	✓	
First Name	First Name	✓	✓	
Middle Name	Middle Name	✓		
Date of Birth	Date of Birth	✓	✓	
Gender	Gender	✓	✓	

Address

Identifier	Label	Visible	Required	
Street	Street	✓		
Suburb	Suburb	✓		
City	City	✓		
State	State	✓		
Postcode	Postcode	✓		
Country	Country	✓		

Contact

Identifier	Label	Visible	Required	
Home Phone	Home Phone	✓		
Work Phone	Work Phone	✓		
Mobile Phone	Mobile Phone	✓		

 Edit **E**

A**Identifier column**

This is the name the field used to identify the field.

B**Label column**

This is the label that will be shown for the field in SilhouetteCentral and SilhouetteConnect.

C**Visible column**

Indicates whether the patient field will be visible in any part of Silhouette.

D**Required column**

Indicates whether the patient field will be a required field when editing or creating a patient. This will apply to both patients created through SilhouetteCentral or SilhouetteConnect, or through the DICOM or HL7 interface.

E**Edit button**

Click the **Edit** button to [make changes](#) to the patient fields.

Edit Patient Fields

Clicking the **Edit** button will switch the Patient Field Administration screen into edit mode as shown in the image below.

Patient Field Administration

Details **A**

Identifier	Label	Visible	Required	
Unit	Unit B	✓	✓	E
Last Name	Last Name	✓ C	✓ D	
First Name	First Name	✓	✓	
Middle Name	Middle Name	✓	<input type="checkbox"/>	
Date of Birth	Date of Birth	✓	✓	
Gender	Gender	✓	✓	

Address

Identifier	Label	Visible	Required	
Street	Street	✓	<input type="checkbox"/>	
Suburb	Suburb	✓	<input type="checkbox"/>	
City	City	✓	<input type="checkbox"/>	
State	State	✓	<input type="checkbox"/>	
Postcode	Postcode	✓	<input type="checkbox"/>	
Country	Country	✓	<input type="checkbox"/>	

Contact

Identifier	Label	Visible	Required	
Home Phone	Home Phone	✓	<input type="checkbox"/>	
Work Phone	Work Phone	✓	<input type="checkbox"/>	
Mobile Phone	Mobile Phone	✓	<input type="checkbox"/>	

A**Group Heading label**

This is the heading label that will appear on the **Create Patient** and **Edit Patient** screens.

B**Label**

This text will be shown in all places where the patient field is used.

C**Visible**

If this is unchecked, then the field will not be shown anywhere in Silhouette.

D**Required**

This determines whether this is a required field on the **Create Patient** and **Edit Patient** screens. This can only be edited if the field is visible.

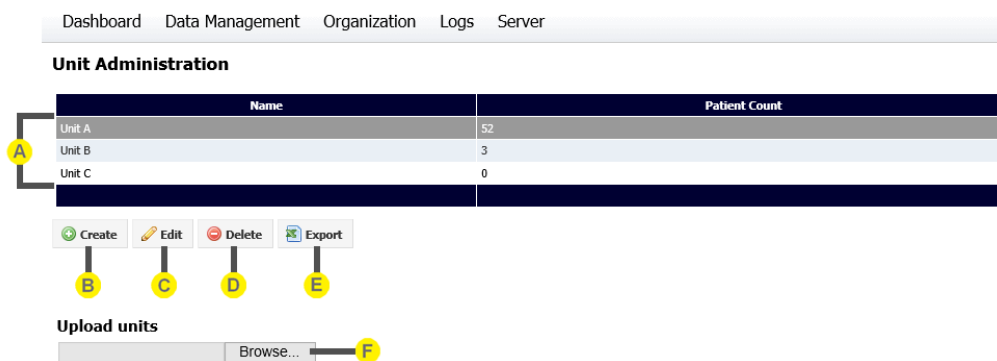
E**Unit Visible/Required**

The Unit field is always visible and required, and so is not able to be edited.

Unit Administration

A unit defines an entity which patients can be assigned to. Different organizations use units in different ways, depending upon how the organization is structured. For example, an organization may use units to differentiate different departments, wards, or facilities.

To define and manage units, select **Organization > Units**.



A

Units table

This table lists the units defined.

B

Create button

Click the **Create** button to define a new unit.

Enter a name for the new unit and configure the additional settings:

Patient ID - The Patient Identifier that this unit uses. See [Patient Identifier Administration](#) for how to configure the Patient Identifiers in Silhouette. See [Groups, Users, and Units in Silhouette](#) for more details on how the Patient ID works with multiple units.

Power Frequency - By default a newly created unit will have the power frequency setting set to **Organization Default** which means SilhouetteStar cameras make use of the setting defined on the [Organization Settings](#) screen. If you have a few units that are located in a different geographical region, when creating the unit, you can override the power frequency setting such that when a user logs into SilhouetteConnect and selects the unit the correct power frequency is utilized for their current location.

You can also select which groups of users have permission to access patients assigned to the new unit.

Note that these are the same settings that can be configured in the **Create** or **Edit Group** screens.

Click on **Update** to return to the **Unit Administration** screen.

C

Edit button

Click the **Edit** button to amend details for the currently selected unit.

When you are finished, click on the **Save** button to save your changes.

D

Delete button

Click the **Delete** button to delete the currently selected unit.

You will be asked to confirm your choice.

Note that you will not be able to delete a unit in three cases:

- If there are patients assigned to that unit, you will get a message that asks you to delete or reassign all patients to a different unit.
- If you are currently logged in to that unit, you will get a message that asks you to log off and log on to a different unit.
- If it is the last existing unit in the system, you will get a message that asks you to create another unit as there needs to be at least one existing unit in the system.

E

Export button

Click the **Export** button export a CSV file of all units that match the current filter options.

F

Upload units

A CSV file in the same format as the exported CSV file can be uploaded to import units into SilhouetteCentral. A file can be uploaded either by clicking the **Browse** button and locating the file, or by dragging and dropping the file onto the upload field.

Editing a Unit

To edit a unit in SilhouetteCentral, in the **Unit Administration** screen, select the unit from the units table and click the **Edit** button.

Edit Unit

A Unit Name *

B Patient ID Type

C Power Frequency

D Scheduled Station AE Title

E Accessible by these group(s)
[Change](#)

F **Assessment Email Templates**

Email Assessment Template to

To find where the email templates are defined, go to [Server\Integration\Email](#), section Assessment Email Templates.

A

Unit Name

This is the name of the unit being edited.

B

Patient ID

The Patient Identifier that this unit uses. See [Patient Identifier Administration](#) for how to configure the Patient Identifier. See [Units in Silhouette](#) for more details on how the Patient ID works with multiple units.

C

Power Frequency

This will override the [Organization Setting](#) for power frequency on a per unit basis.

D

Scheduled Station AE Title

Defines the Station AE title that SilhouetteLink should query for the DicomClientTask. Only visible if DICOM is licensed.

E

Accessible by these groups

From this area, we can view which groups have access to this unit. To override the access provided from [Group Edit](#) screen, click [Change](#).

Accessible by these group(s)

- ☒ Admin *
- ☒ ARANZ Medical Support *
- ☒ Default
- ☒ SilhouetteLink *
- ☒ Unit1
- ☐ Unit2

* Groups with access to all units, including future units, cannot be edited on this screen. The 'all and future units' setting is configured on the Edit Group screen.

[Close](#)

Some of these groups will be disabled and we cannot remove access from them. This is because these groups have access overridden on this screen. To change these group's access, go to [Group Edit](#) screen.

F

Assessment Email Templates

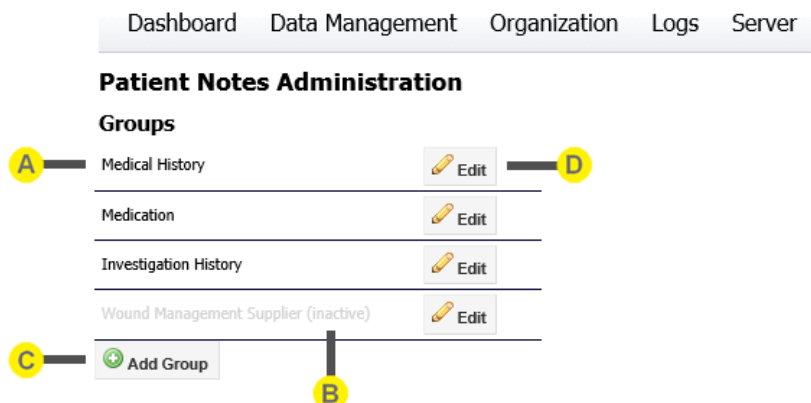
If [Email Integration](#) is enabled, you can set the email addresses of recipients for a unit by editing a unit. When actions are performed, recipients for that particular assessment template receive an email.

To find where the email templates are defined, go to [Server\Integration\Email](#), section Assessment Email Templates.

Notes Administration

The **Notes Administration** screen provides access to add, remove or edit notes fields that appear in the patient, visit, or wound notes within SilhouetteConnect and SilhouetteCentral Desktop.

To edit and organize notes, select the **Admin > Organization > Notes** menu, and then select the set of notes you wish to customize. The **Patient Notes Administration** screen is shown below and examples are taken from the **Visit Notes Administration** and **Wound Notes Administration** screens.



- A Group title**
Each group of notes is organized under a group title
The order in which groups are displayed is the order in which they will be displayed in SilhouetteConnect and SilhouetteCentral Desktop. To re-order click and drag the group titles and move them.
- B Inactive group**
Inactive groups of notes will be displayed in a gray font. These groups of notes will not be displayed in the SilhouetteConnect and SilhouetteCentral Desktop notes screens. In other words they will not be viewable or editable by clinical staff.
Items within an active group can be deactivated on an individual basis, however they will not appear in SilhouetteConnect and SilhouetteCentral Desktop unless their parent group is also active.
- C Add Group**
To add a new group to the list click on the **Add Group** button.
- D Editing Group**
To edit a group, see [Editing Notes Groups](#).

Changes you make in this screen will be uploaded to SilhouetteConnect the next time they synchronize and will appear in SilhouetteCentral Desktop the next time you switch to it.

Editing Notes Groups

To edit a group click on the **Edit** button to the right of the group you want to edit. The group's properties are displayed:

Group Admission and Discharge

Group Name

Active ☐ No ☒ Yes

Conditional Validation Rules

- If an admission status change date is recorded you must specify an admission status Edit Remove
- If an admission status is recorded the date the status change occurred on must also be recorded Edit Remove
- If an expected discharge date is recorded the patient must currently be admitted Edit Remove
- The expected discharge date must be on or after the admission date Edit Remove

+ Add Validation Rule

Save Cancel

Rename the group by entering a new name.

If you want to hide the group of notes you can set the active field to **No**. The group and its associated items will not appear in the SilhouetteConnect and SilhouetteCentral Desktop note screens.

Click on **Save** to save your changes.

Conditional Validation Rules

When a user enters notes within SilhouetteConnect or SilhouetteCentral validation rules can be applied to ensure that note items within a group are answered in a consistent manor. For example you may have a question that asks if the patient smokes, and another asking the total number of cigarettes smoked per day. A custom validation rule could be used to ensure if the first question is answered "No" that an answer isn't recorded for the second question. Other uses of custom validation rules could include scenarios such as:

- ensuring a set of individual percentages always add up to 100%.
- ensuring two values such as dates, or before and after measurements have expected correct order, i.e. the second value is always larger than the first.

To add a conditional validation rule to a group of notes click the Add Validation Rule button a Conditional Validation Rule dialog will appear.

Conditional Validation Rule

Display Item

Error Message

Expression

Save Cancel



Display Item

A drop-down list of note items within the current group will be displayed.

Select the note item a validation error should be displayed against if the conditional validation rule indicates the user made an error in their data entry.

**Error Message**

Specify the error message that should be displayed to the user when the validation rule indicates the user made an error in their data entry.

**Expression**

Specify an expression that should always evaluate to true assuming the user has entered their notes data correctly. If this expression evaluates to false using the current notes entered by the user the associated error message will be displayed to the user and the user will be stopped from saving their updated notes until the error is corrected.

The expression specified can only make use of note items within the current group that have been assigned a variable name ([Adding Items to Notes Groups](#)).

Once one or more conditional validation rules have been defined the order in which they are evaluated can be controlled by clicking and dragging the order of the rules around within the dialog. The conditional validation rule at the top of the dialog will be evaluated first, and evaluation will stop as soon as a rule evaluates to false. In other words as soon as one rule indicates the user has made an error, no additional validation rules will be checked until the user has corrected the current notes data entry error and attempted to save their changes again. If a conditional validation rule is no longer needed the **Remove** button can be pressed to delete it.

Conditional Validation Rule Expression Syntax

The expressions that can be specified within a conditional validation rule can refer to any notes item that has been assigned a variable name. If a variable name refers to a notes item that the user has not recorded a value in, a default value (0 for numbers, an empty string for text items) will be used for calculation purposes.

As well as referring to variables conditional validation rule expressions can contain constant values. Numbers must be written in decimal, or scientific notation and text must be enclosed in single quotes, e.g.

```
braden_score > 5
temperature <= 32.75
mass_of_planet_earth_in_kg == 5.98e24
approval_status == 'undecided'
```

as demonstrated in the previous sample expressions it is possible to compare two or more values in an expression. The following logical operators are available.

Operator	Description	Example Expression
<=	Less than or equal to	height <= 150
<	Less than	height > 145
>=	Greater than or equal to	weight >= 275
>	Greater than	temperature > 35
==	Equal to	smoking_history == 'never smoked'
!=	Not equal to	admission_status != 'admitted'
!	Negation	!edema_present
&&	And	impaired_sensation_left && impaired_sensation_right
	Or	palliative_care edema_present

Simple calculations can also be performed using the following mathematical operators

Operator	Description	Example Expression
+	Addition	left_area + right_area > 25

-	Subtraction	<code>Initial - final > 14</code>
*	Multiplication	<code>length * width == 45</code>
/	Division	<code>volume / depth == area</code>
%	Modulo	<code>x % 5 == 1</code>

There are also a number of functions available for use that can perform specialist operations:

Function	Description	Example Expressions
<code>Contains(x, y)</code>	Returns true if 'x' contains the string 'y'. NOTE: This function requires both arguments to be strings and can be useful when comparing the user's selection within a multilist notes item.	<code>Contains('pointer', 'int')</code>
<code>HasValue(x)</code>	Returns true if variable 'x' contains a value. In other words it will return true if the user has recorded a value in the notes items within Silhouette. NOTE: The single argument to HasValue must be a name of a variable.	<code>HasValue(admission_status)</code>
<code>HasNoValue(x)</code>	Returns true if variable 'x' does not contain a value. This is a convenience instead of having to write <code>!HasValue(x)</code>	<code>HasNoValue(admission_status)</code>
<code>ListContains(x, y)</code>	Returns true if the multi-select list variable 'x' contains item 'y'. NOTE: The first argument to ListContains must be the name of a variable.	<code>ListContains(contributing_factors, 'Shearing')</code>
<code>ListLength(x)</code>	Returns the number of items selected in a multi-select list variable 'x'. NOTE: The single argument to ListLengthH must be the name of a variable.	<code>ListLength(contributing_factors)</code>
<code>IsNull(x, y)</code>	Returns the value of variable 'x' if the user has recorded a value in the notes field within Silhouette, otherwise returns the value 'y'. NOTE: The first argument to IsNull must be the name of a variable.	<code>IsNull(contributing_factors, 'Unspecified')</code>
<code>Abs(x)</code>	Returns the absolute value of a number	<code>Abs(-1) == Abs(1)</code>
<code>Acos</code>	Returns the angle whose cosine is the number	<code>Acos(1)</code>
<code>Asin</code>	Returns the angle whose sine is the number	<code>Asin(1)</code>
<code>Atan</code>	Returns the angle whose tangent is the number	<code>Atan(0)</code>
<code>Ceiling</code>	Returns the smallest integer greater than or equal to the number	<code>Ceiling(1.5) == 2</code>
<code>Cos</code>	Returns the cosine of the angle	<code>Cos(0)</code>
<code>Exp</code>	Returns e raised to the power	<code>Exp(1)</code>

Floor	Returns the largest integer less than or equal to the number	Floor(1.5)
Log10	Returns the base 10 logarithm of a number	Log10(1)
Log	Returns the logarithm of a number in a specified base	Log(1, 10) == Log10(1)
Max	Returns the larger of two numbers	Max(2, 5) == 5
Min	Returns the smaller of two numbers	Min(2, 5) == 2
Pow	Returns a number raised to the specified power	Pow(3, 2) == 9
Round	Rounds a value to the nearest integer or specified number of decimal places	Round(3.222, 2) == 3.22
Sign	Returns a value indicating the sign of a number	Sign(-10) == -1
Sin	Returns the sine of the angle	Sin(0)
Sqrt	Returns the square root of a number	Sqrt(4)
Tan	Returns the tangent of the angle	Tan(0)
Truncate	Returns the integral part of a number	Truncate(1.7) == 1
In	Returns whether an element specified by the first parameter, is in a set of values	In(x, 1, 2, 5)
If	Returns a value based upon a condition	If(x > 5, 'true', 'false')
ParseInt	Converts a string argument into an integer value. Causes an error if the argument is not correctly formatted.	ParseInt('5') + 3 == 8
ParseDecimal	Converts a string argument into a decimal value. Causes an error if the argument is not correctly formatted.	ParseDecimal('5.25') + 3 == 8.25

Expressions are evaluated with standard precedence of operators. You can place sub-expressions in brackets, or parenthesis to alter the precedence if required.

Note: All references to variables and function names are case insensitive, e.g. "admission_status", "ADMISSION_STATUS" and "AdMiSiOn_StAtUs" all refer to the same variable.

Adding Items to Notes Groups

To add items to a notes group:

1. Click on the group title to select it, the right hand side of the screen will display the current list of items within this group:

Dashboard Data Management Organization Logs Server

Patient Notes Administration

Groups

Medical History	Edit
Medication	Edit
Investigation History	Edit
Wound Management Supplier	Edit
Add Group	

Notes in Group Medical History

Current conditions	Type: MultiList (Select values from the List Items)	Edit
Current conditions: Other	Type: Text (e.g. normal, no problems)	Edit
Past medical history	Type: Text (e.g. normal, no problems)	Edit
Contributing factors	Type: MultiList (Select values from the List Items)	Edit
Contributing factors: Other	Type: Text (e.g. normal, no problems)	Edit
Comment	Type: Text (e.g. normal, no problems)	Edit
Add		

Save Order

- Click the Add button at the bottom to display a Note Details dialog. The new item's details are displayed.

Note Details

Item Name	<input type="text" value="Weight"/>	A
Variable Name	<input type="text"/>	B
Data Type	<input type="text" value="Decimal (e.g 6.7, 4.56)"/>	C
Comment	<input type="text"/>	D
Is Percentage	<input checked="" type="radio"/> No <input type="radio"/> Yes	
Units	<input type="text" value="kg"/>	E
Min Value	<input type="text"/>	
Max Value	<input type="text"/>	F
Step	<input type="text"/>	
Is Active	<input type="radio"/> No <input checked="" type="radio"/> Yes	
Is Required	<input checked="" type="radio"/> No <input type="radio"/> Yes	G
Is Visible	<input type="radio"/> No <input checked="" type="radio"/> Yes	
Is Read-only	<input checked="" type="radio"/> No <input type="radio"/> Yes	
Persist Value	<input checked="" type="checkbox"/>	H
Persist Value Condition	<input type="text"/>	

Save
 Cancel

I

A

Item Name

The item name identifies the label that appears within the notes screen within SilhouetteConnect and SilhouetteCentral Desktop as well as within PDF reports or CSV patient data exports.

B

Variable Name

A notes field can be utilized in a number of scenarios as part of a conditional expression. For example conditional validation rules within a notes group may refer to a notes item to determine if the user has correctly filled out the note items. SilhouetteLink can also use a notes item when determining if a wound assessment report should be generated.

In order to be utilized within a conditional expression a notes item must be assigned a unique variable name. A variable name is case insensitive and must start with a letter.



Datatype

Select a data type from the drop-down list.

The best datatype to choose depends on the type of information users will be entering.

Choices are:

- Text Items - a free form text box that allows one or more lines of text to be entered by the user.

Note Details

Item Name	<input type="text" value="Comments"/>
Variable Name	<input type="text"/>
Data Type	<input type="text" value="Text (e.g. normal, no problems)"/>
Multi-Line	<input checked="" type="checkbox"/>
Units	<input type="text"/>
Min Length	<input type="text"/>
Max Length	<input type="text" value="3000"/>
Is Active	<input checked="" type="checkbox"/>
Is Required	<input type="checkbox"/>
Is Visible	<input checked="" type="checkbox"/>
Is Read-only	<input type="checkbox"/>
Persist Value	<input type="checkbox"/>

If Data Type = Text, then Multi-Line is the default with a Max Length of 3000. Click the check box to make Single-Line.

- Boolean Items - a set of radio buttons that allow the user to record "yes" or "no" answers.
- Integer Items - a text box that allows a whole number (e.g. -1, 0, 1, 2 or 3) to be entered.
- Decimal Items - a text box that allows a decimal number (e.g. -1.23, 0, 1.435, 99.99999) to be entered.
- Date and Date & Time Items - a date (or date/time) picker that allows the user to select a date.
- List Items - a drop down list that allows the user to select a single item from a list of pre-determined options.
- MultiList Items - a set of check boxes that allows the user to select one or more items from a list of pre-determined options.

Different fields are required for each of the different datatypes.



Comment

A free form text field that can be used to enter a description to help system administrators determine what the intended purpose of this item is.

E**Units**

If the item is a value measured in units, enter the units in the form they are to be displayed. The value entered in this field will be appended to the **Item Name** when it is displayed. For example, when an item such as height is defined, the units required are entered in the **Units** field:

Note Details

Item Name

Variable Name

Data Type

Multi-Line ☒

Units

Min Length

Max Length

Is Active ☒

Is Required ☐

Is Visible ☒

Is Read-only ☐

Persist Value ☐

The resulting field is displayed as follows:

Vital signs

Height (cm)

F**Min Value, Max Value, Step, Min Length and Max Length**

Depending upon the data type selected certain parameters will be able to be set that ensure the user enters a reasonable value into a field during the data entry process.

- **Min Value / Max Value** - Present for integer or decimal items. If specified these control the minimum and maximum values that will be accepted as valid data.
- **Step** - Present for integer or decimal items. If specified instead of a text box a drop down list of options will be displayed that the user can pick from. Used in conjunction with min value, max value and unit. For example a Min Value of 10, a Max Value of 50, with unit "%" and a step of 5 would display 10%, 15%, 20%, 25%, 30%, 35%, 40%, 45% and 50% options for the user to pick from.
- **Min Length / Max Length** - Present for text items only. If specified these control the minimum and maximum number of characters that will be accepted as valid input. E.g. if Min Length is set to 7 this means the user must enter at least 7 characters.

G**Availability controls**

Is Active: If you do not wish the field to appear during the data entry process, click the **No** button. This can be used to delete an unused item.

Is Required: If you wish the field to be compulsory when entering patient data, click the **Yes** button.

Is Visible: If you do not wish the field to appear during the data entry process, click the **No** button.

Is Read-only: When **Yes** is selected, the note is displayed but is not editable.

H**Persistence controls**

Visit and Wound level note items can optionally be made persistent. This means when a new set of notes is created instead of starting off blank the notes item will by contain the previous value recorded by a user in the previous visit or assessment.

To make a visit or wound level note item persistent enable the Persist Value check box. Optionally a conditional expression can be entered to determine if the previous value should be copied across into the new set of notes. As an example an expression such as "admission_status == 'Admitted'" would

copy the notes value across to new set of notes, as long as the admission status notes item had the value Admitted.

[Editing Notes Groups](#) for details on the expression syntax.



Update button

Click the **Update** button to save changes.

List Items

If you create a notes item of type List or Multilist a second panel will appear on the right hand side of the Note Details dialog to allow you to define the list of items that the user should be able to pick from when filling out the notes form within SilhouetteCentral or SilhouetteConnect.

The screenshot shows the 'Note Details' dialog. On the left, there are fields for 'Item Name' (Status), 'Variable Name' (admission_status), 'Data Type' (List), 'Comment', 'Units', and several boolean options: 'Is Active' (Yes), 'Is Required' (No), 'Is Visible' (Yes), 'Is Read-only' (No), and 'Persist Value' (checked). At the bottom are 'Save' and 'Cancel' buttons. On the right, the 'List Items' section displays a list of items: 'Admitted', 'Discharged', 'Lost to follow-up', and 'Deceased'. Each item has an 'Edit' button next to it. Below the list is an 'Add Lookup Item' button.

To alter the order the list items are displayed in simply click and drag the items as required.

To add a new list item use the **Add Lookup Item** button, or to edit an existing list item use the **Edit** button beside the relevant item. Both buttons will display the Lookup Item dialog, as shown below:

The screenshot shows the 'Lookup Item' dialog. It has three main fields: 'Text*' (Admitted), 'Value' (admitted), and 'Active' (Yes). Each field has a corresponding label 'A', 'B', or 'C' next to it. There is a 'Close' button at the bottom.



Text

The label that will be displayed to the user when they create notes within SilhouetteCentral or SilhouetteConnect. This is only editable when a new list item is created, once a list item has been added it can not be modified in case the value has already been used within a set of patient notes.

If you make a typo or for some other reason need to replace an existing lookup item, mark the current one as inactive, and create a new replacement lookup item.



Value

The value that will be used within any conditional expression that makes use of this notes item when the user selects this lookup item. If unspecified, i.e. left blank, the value will be the same as the text value entered above.

This feature can be used when multiple distinct values should be selectable by the user but should all be considered similar from the point of view of conditional validation rules etc. For example you may

define a notes item to keep track of the patient's admission status and have multiple types of discharge (e.g. sent home, lost to follow-up, deceased) , these could all share the same value "discharged" so validation rule expressions such as

```
admission_status == 'discharged'
```

could be written instead of requiring

```
admission_status == 'sent home'
|| admission_status == 'lost to follow-up'
|| admission_status == 'deceased'
```

which would need to be constantly updated as new lookup items were introduced etc.



Active

Select **No** if this list item should no longer be listed as an option when users create new notes.

If the value has been used in previously captured notes when a user edits the notes the value will still appear, however the user will not be able to select it again if they attempt to edit the value of this note item.

Editing Notes Items

To edit an item, click on the **Edit** button for that item. The item's properties will be displayed.

Edit the item as described in [Adding Items to Notes Groups](#), then click on **Update** to save your changes.

Tissue Type Classification

A tissue type defines an extra way that wound outlines can be assigned. They will be used to divide wounds into outlines, which can then have a tissue type assigned (so a wound can be part necrotic and part granulating). The default list defined is *Not Classified*, *Bone*, *Epithelial*, *Eschar*, *Granulation*, *Healthy*, *Hypergranulation*, and *Slough*. To define and manage tissue types, select **Organization >Tissue Types**.

The order in which the tissue types appear in the list, is the order in which they will be shown in on the Trace Tissue screen in SilhouetteConnect. To change this order, drag-and-drop the items to reposition them.

Tissue Type Classification

Tissue Types					
A	B	C	D	E	
Label	Colour	Order In Graph	Is Active	Is Default	
Not Classified		1	✓	✓	F
Bone		2	✓		
Epithelial		3	✓		
Eschar		4	✓		
Granulation		5	✓		
Healthy		6	✓		
Hypergranulation		7	✓		
Slough		8	✓		

G



Label

The name defined for the Tissue Type.



Colour

The colour for the tissue types. This defines how its displayed on the graphs, in the reports, etc.



Order in Graph

The index of where in the graph the tissue type will display. Lowest number at the top, highest at the bottom.

- D Is Active**
Determines whether the tissue type can be selected by the user. Only 10 tissue types can be active at a time.
- NOTE:** Tissue types cannot be deleted. Inactive types will still be shown for any assessments that they have been added to.
- E Is Default**
If a tissue type is marked as default, then that will be the one that gets automatically assigned to any new tissue outline in SilhouetteConnect. Only one tissue type can be marked as default.
- F Edit button**
Click the **Edit** button to amend details for the tissue type.
When you are finished, click on the **Save** button to save your changes.
- G Add Tissue Type**
Click the **Add Tissue Type** button to define a new tissue type.

Editing a Tissue Type

To edit a Tissue Type in SilhouetteCentral, in the **Tissue Type Administration** screen, click the **Edit** button for the relevant Tissue Type.

Tissue Type Details

A **Label***

B **Colour***

C **Order In Graph***

D **Is Active** ☒

E **Is Default** ☐

- A Label**
The name defined for the Tissue Type.
- B Colour**
The colour for the tissue types. This defines how its displayed on the graphs, in the reports, etc. Click on the bar to open a colour picker.
- C Order in Graph**
The index of where in the graph the tissue type will display. Lowest number at the top, highest at the bottom.
- D Is Active**
Determines whether the tissue type can be selected by the user. Only 10 tissue types can be active at a time.
- NOTE:** Tissue types cannot be deleted. Inactive types will still be shown for any assessments that they have been added to.
- E Is Default**
If a tissue type is marked as default, then that will be the one that gets automatically assigned to any new tissue outline in SilhouetteConnect. Only one tissue type can be marked as default.

Report Administration

The **Report Administration** screen allows you to upload new and updated report templates for the wound assessment report and population reporting module (if licensed).

For example, if customization is required to the layout or contents of the reports, contact ARANZ Medical Support who can provide you with a customized template to be uploaded via this page.

To upload a new report template drag and drop the template file into the browser window. When the file is over top of the browser window a border and prompt text will show you where to drop the file. Alternatively click the **Browse** button, select the report template file provided by ARANZ Medical Support and press the upload button.

Protocol Administration

The **Protocol Administration** screen allows you to upload new protocols or update existing protocols that are used by the SilhouetteConnect protocol engine feature.

To upload a protocol file, drag and drop the new protocol file into the browser window. When the file is over top of the browser window a border and prompt text will show you where to drop the file. Alternatively click the **Choose File** button, select the protocol file provided by ARANZ Medical and press the upload button.

Note: This page will only be present if you have licensed the Protocol Engine.

Organization Settings

The settings in the **Organization Settings** screen control the appearance and type of information displayed in SilhouetteConnect and SilhouetteCentral.

Change the settings as required, then click the **Update** button at the bottom of the screen to save the changes.


For SilhouetteConnect applications that synchronize with SilhouetteCentral, these organization settings will be applied the next time the SilhouetteConnect application synchronizes.

The **Organization Settings** screen is divided into:

- [Organization](#)
- [Display and Measurements](#)
- [Assessment](#)
- [Reports/Image Export](#)
- [Password](#)
- [Account Lockout](#)
- [Application Lock](#)

Organization Settings

<h4>Organization</h4> <p>Name <input type="text" value="Default Organization"/></p> <p>Logo Configure</p> <p>Default Power Frequency <input type="text" value="Auto"/></p> <p>Default Timezone <input type="text" value="(UTC+12:00) Auckland, Wellington"/></p> <p>Support Statement Configure</p> <p>Log on Statement Configure</p>	<h4>Reports / Image Export</h4> <p>Use anonymous file names <input type="checkbox"/></p> <p>Filename Template <input type="text" value="(Patient,LastName)"/></p> <p>Image Export file format <input type="text" value="PNG"/></p> <p>Show Wound Outlines in Reports <input checked="" type="checkbox"/></p> <p>Show All Notes in Report <input checked="" type="checkbox"/></p> <p>Rounding of measurements in CSV exports <input type="text" value="Match Silhouette Display"/></p>
<h4>Display and Measurements</h4> <p>Date <input type="text" value="Year, Month, Day"/></p> <p>Time <input type="text" value="Hours, Minutes (24 hour)"/></p> <p>Wound Label Format <input type="text" value="Alphabetical"/></p> <p>Display Configure</p> <p>Area Units <input type="text" value="cm²"/></p> <p>Depth Units <input type="text" value="mm"/></p> <p>Length Units <input type="text" value="mm"/></p> <p>Volume Units <input type="text" value="cm³"/></p> <p>Axis Method <input type="text" value="Longest Axis"/></p> <p>Show Axes by default on image tracing screen <input type="checkbox"/></p> <p>Ignore Islands in Area Computations <input type="checkbox"/></p> <p>Ignore Islands in Perimeter Computations <input type="checkbox"/></p> <p>Enable Tissue Types editing <input type="checkbox"/></p>	<h4>Password</h4> <p>Enforce Password Expiration <input type="checkbox"/></p> <p>Days Until Password Expires <input type="text" value="14"/></p> <p>Password Min Length <input type="text" value="3"/></p> <p>Password Max Length <input type="text" value="20"/></p> <p>Must Contain Alpha and Numeric Characters <input type="checkbox"/></p> <p>Must not match User Name <input type="checkbox"/></p> <p>Enforce Password History <input type="checkbox"/> 0 passwords remembered</p> <p>Allow password resets via email <input checked="" type="checkbox"/></p>
<h4>Assessment</h4> <p>Visit Length <input type="text" value="12"/> hours <input type="text" value="0"/> mins.</p>	<h4>Account Lockout</h4> <p>User Lockout Enabled <input type="checkbox"/></p> <p>Failed Log on Attempts Before Locking Account <input type="text" value="6"/></p> <p>Failed Log on Check Interval <input type="text" value="10"/> mins.</p>
<h4>Application Lock</h4> <p>Timeout Before Logon Required <input type="text" value="10"/> mins.</p>	

 Save

Organization

Name

The organization name appears on the footer of each page in a PDF wound assessment report. Enter your organisation's name in the text box.

Logo

A custom PNG logo that is 266x75px can be uploaded by clicking the configure link. This logo will be displayed beside the ARANZ Medical logo at the top of each SilhouetteCentral page. It will also appear on the header of the first page of PDF wound assessment reports.

Patient ID Label

By default Silhouette refers to the patient's unique patient identifier as their "Patient ID". If you use a different term, such as Medical Record Number (MRN), or Enterprise Master Patient Index (EMPI), enter your desired label in the **Patient ID Label** text box. Changing this value will make the user interface more familiar to your clinical users.

Default Power Frequency

If horizontal banding is observed on captured images, the **Default Power Frequency** setting can be changed to adapt to regional lighting conditions. There are three options:

- **Auto.** When this setting is used, the Power Frequency is determined by the Windows operating system locale setting.
- **50Hz.** Use this setting when capturing images under 50Hz lighting.
- **60Hz.** Use this setting when capturing images under 60Hz lighting (USA and Canada).

Note that individual units within the organization can override the default power frequency if required. See [Unit Administration](#).

Default Timezone

When a new user account is created the timezone the user is located in can be specified. This setting controls the timezone that will be assigned by default. It is suggested that you set this setting to the timezone the majority of your users will be located in.

Note: If LDAP Integration is enabled this setting will also be used to specify the timezone of any users created via LDAP.

Support Statement

A statement is displayed to the user on the About screen of SilhouetteCentral, and as a tab within the about dialog of SilhouetteConnect. Click the configure link to specify the text you would like to display in these locations. It is suggested you update the default support text to provide details of your own IT support desk, etc. If you don't want any text displayed, leave the text box blank and the relevant sections will be removed from the user interface. SilhouetteConnect will update when it is next synchronized.

Privacy Statement

Similar to the support statement a message can be displayed to all users on the log on and application lock screens. Click the configure link to specify the text you would like to display in these locations. SilhouetteConnect will update when it is next synchronized.

Display and Measurements

The **Display and Measurements** settings configure how the date and time is displayed, and how various measurements are calculated and displayed.

Date

Specifies how dates should be displayed through out Silhouette. The options are:

- year, month, day e.g. 2013-12-31
- month, day, year e.g. 12-31-2013
- day, month, year e.g. 31-12-2013

Time

Specifies how times should be displayed through out Silhouette. The options are:

- Hours, Minutes (am/pm) e.g. 3:59 pm
- Hours, Minutes, Seconds (am/pm) e.g. 3:59:27 pm
- Hours, Minutes (24 hours) e.g. 15:59
- Hours, Minutes, Seconds (24 hours) e.g. 15:59:27

Display

Clicking the **Configure** button will show a Measurement Display dialog as follows:

Measurement Display			
	Dashboard		Tracing
	Image Summary	Assessment Summary	Assessment Summary
Timestamp	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Area	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Area Reduction		<input checked="" type="checkbox"/>	<input type="checkbox"/>
Island	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perimeter	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Axes	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rulers	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Max Depth	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Mean Depth	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Volume	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Tissue Types	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

 Close

This dialog can be used to control which measurements are displayed in specific areas of Silhouette's user interface. Each column represents a different area of the user interface:

- Dashboard Image Summary - The display of measurements underneath an individual image within SilhouetteCentral's **Wound Manager** screen and SilhouetteConnect's **Patient Dashboard** screen.
- Dashboard Assessment Summary - The display of measurements within the assessment summary panel shown in the top right of SilhouetteConnect's **Patient Dashboard** screen.
- Tracing Assessment Summary - The display of measurements underneath the wound label within SilhouetteConnect's **Trace Images** screen.

If a particular check box is enabled then the respective measurement will be displayed in the specified area of the user interface.

The settings in this dialog also affect what measurements are reported within PDF wound assessment reports or while [Exporting Patient Records](#). If a particular measurement type is not displayed anywhere within the user interface of Silhouette (for example, Island Area in the screen shot above) then the respective measurement will not

be displayed within the PDF wound assessment reports. It also means that the respective graph will not be visible (for measurement types such as max depth, or area reduction).

This dialog can be used to hide measurements SilhouetteStar is capable of measuring but are not important, or monitored by your clinical staff. Removing unneeded measurement types will reduce confusion and the potential to record erroneous values.

The Tissue Types options will *not* be visible if **Enable Tissue Types Editing** is not checked.

Area, Depth, Length, Volume Units

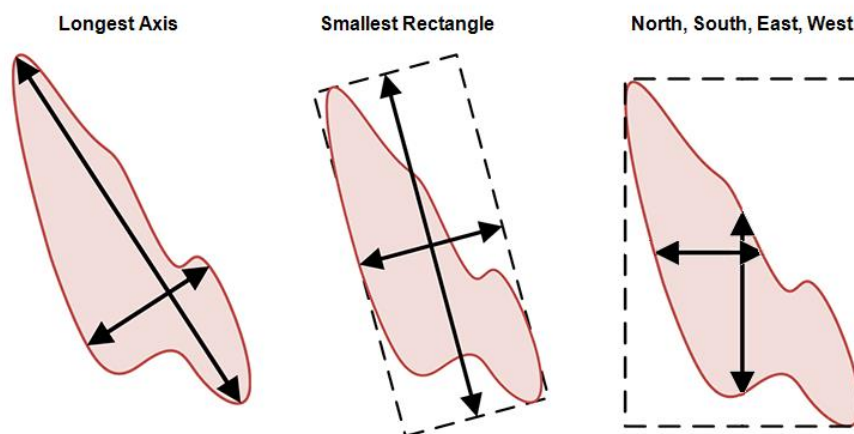
Specifies which units the respective measurements should be displayed throughout Silhouette.

Axis Method

The axes are two perpendicular rulers automatically drawn on each wound outline drawn on an image. The **Axis Method** setting defines the technique used to orient the axes. The options available are:

- **Longest Axis.** The axes are oriented such that one of the pair of rulers transects the wound at the longest point across the wound. The second ruler is drawn perpendicular to the first, where the greatest width is found.
- **Smallest Rectangle.** The orientation of the smallest rectangle that can completely enclose a wound is calculated, and the axes are oriented across the middle of the rectangle, perpendicular to the rectangle's edges.
- **North South East West (East/West is length).** A rectangle is drawn completely enclosing the wound, with the edges of the rectangle being vertical and horizontal as seen on the wound image. The axes are oriented across the middle of the rectangle, perpendicular to the rectangle's edges and constrained to fit within the wound outline. The measurement from east to west is considered as length of the axis and the measurement from north to south is considered its width.
- **North South East West (North/South is length).** A rectangle is drawn completely enclosing the wound, with the edges of the rectangle being vertical and horizontal as seen on the wound image. The axes are oriented across the middle of the rectangle, perpendicular to the rectangle's edges and constrained to fit within the wound outline. The measurement from north to south is considered as length of the axis and the measurement from east to west is considered its width.

These different methods are illustrated for a wound outline as follows:



Show Axes by default in Image Tracing Screen

This setting controls within SilhouetteConnect whether or not axes are automatically displayed after tracing a wound, or the user must first click the show/hide axes button to display them.

Ignore Islands In Area Computations

When the check box is ticked, parts of a wound that are marked as an island will not be subtracted from the total wound area. Note that this setting will **not** influence the tissue type percentages. Islands are always ignored for those calculations.

Ignore Islands In Perimeter Computations

When the check box is ticked, parts of a wound that are marked as an island will not be added to the total wound perimeter.

Enable Tissue Types Editing

When the check box is ticked, the tissue types will be enabled in SilhouetteCentral (and in SilhouetteConnect after synchronizing). This means that the options can be enabled/disabled in the Measurements Display dialog, and the types can be modified on the [Tissue Types admin](#) page. For SilhouetteConnect, it means that the tissue type outlines can be added on the Trace Tissue screen, which comes after the Trace Images screen, and that the measurements belonging to Tissue Types (graph, percentages, etc.) will be displayed on the Patient Dashboard.

Assessment

The **Visit Length** setting defines the length of time in hours and minutes after which a new visit will automatically be created whenever a new assessment is created. The default visit length is 12 hours 0 minutes. Prior to the **Visit Length** duration occurring the user would need to manually select the **Add New Visit** button to place subsequent assessments into a new visit.

Reports/Image Export

The **Reports/Image Export** settings configure how images and reports are exported from Silhouette.

Use anonymous file names

When the check box is ticked, exporting an image, PDF report or CSV export will use file names such as "EE05F604-C33C-4E75-8FCF-7B69891B19A7.pdf"

If disabled, a textbox appears allowing the file name for pdf reports to be described in the required format. Macros can be used in this field, such as "{Patient, LastName}_{Patient,FirstName}" (data exports use the same filename format "{Patient, PatientId}_{Patient, LastName}_{Patient, FirstName}_DataExport"). Extensions do not need to be specified as the correct one will be appended to the filename when it is generated. For a list of usable macros, refer to the table provided in [Assessment Email Templates](#)

Image Export file format

High resolution exports of SilhouetteStar captured images will by default be exported in PNG file format to ensure the sharpness of overlaid wound boundaries or rulers. If desired images can be exported in JPEG file format which will reduce file sizes, but may decrease the quality of overlays.

Show wound outlines in reports

When the check box is ticked PDF Wound Assessment reports will display wound outlines on the right hand image. If disabled only axes and rulers will be drawn on this image.

Show All Notes in Report

When the check box is ticked, all notes items are included in PDF Wound Assessment reports, regardless of whether or not data has been recorded against them. When the box is unticked, only those notes items that have data recorded against them are included.

If this setting is changed, reports created before the change are not updated.

Rounding of Measurements in CSV Exports

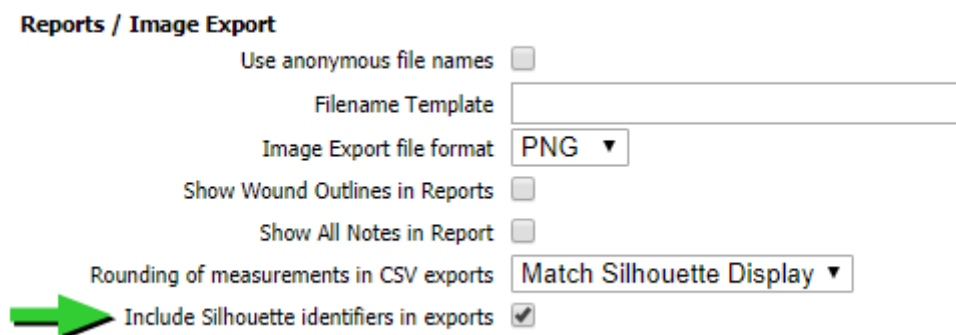
The **Rounding of Measurements in CSV Exports** setting defines how many decimal places are used when exporting patient data. The options available are:

- **One Decimal Place.** All numbers exported are given to one decimal place precision.
- **Match Silhouette Display.** Numbers are exported with the decimal place precision shown on screen. Measurements in cm, cm², and cm³ are all exported to one decimal place. Measurements in mm, mm², and mm³ are all displayed as whole numbers.

Note: When exporting data in a Microsoft Excel file format this setting controls presentation only, i.e. if set to 1 decimal place values displayed in Excel will only show 1 decimal place, however the full un-rounded number will be utilized if that cell is used in a calculation. I.e. although an area measurement may display as 1.2, it could be 1.175 when used in a calculation. This ensures similar results to those displayed by Silhouette are obtained when measurements from more than one image or assessment are totaled.

Including Silhouette Identifiers in Exports

When the check box is ticked, the data exports will include columns with the Silhouette Identifiers (i.e database primary keys) for the Patients, Visits, Assessments, Images, Notes Groups, and Note Fields. This is useful when trying to join data from the different tables in the export. This setting effects both file exports (e.g csv) and database export, see [Database export Integration](#).



Reports / Image Export

Use anonymous file names ☐


Filename Template

Image Export file format **PNG** ▼

Show Wound Outlines in Reports ☐

Show All Notes in Report ☐

Rounding of measurements in CSV exports **Match Silhouette Display** ▼

 Include Silhouette identifiers in exports ☒

Password

The **Password** settings relate to the password Silhouette users are required to enter before logging on to Silhouette.

LDAP Integration

The settings described in this section are only relevant to user accounts which are created directly within SilhouetteCentral Admin. If a user is created / controlled via LDAP integration these settings are not applicable and it is the responsibility of the LDAP server to define and implement password reset functionality.

Enforce Password Expiration

When the check box is ticked, users are prompted to change their password a fixed number of days after their last password change.

Days Until Password Expires

This setting determines how often a user's password expires. Set a value between 1 and 365 days. This setting is only available when **Enforce Password Expiration** is enabled.

Password Min Length

This setting determines the minimum number of characters a Silhouette user is required to include when setting a password. Set a value between 3 and 10 characters.

To promote more secure passwords on the system, choose longer minimum lengths.

Password Max Length

This setting determines the maximum number of characters a Silhouette user can include when setting a password. Set a value between 8 and 30 characters.

Must Contain Alpha and Numeric Characters

This setting determines whether or not a Silhouette user is required to enter a password that contains at least one number and letter. Requiring both numbers and letters in passwords increases the security of the password.

Tick the box to require users to enter both numbers and letters when setting their passwords.

Note: Irrespective of this setting the user is allowed to make use of other characters such as \$, %, ^, &, _ etc in their passwords.

Must not Match User Name

Users may try to use their user name as their password. This may be easy to remember, but it is a security risk.

Tick the box to forbid passwords that match user names.

Enforce Password History

Users sometimes try to reuse passwords, but this practice is a security risk. To prevent a user changing their password to a previously used password, the system can check to see if the new password matches a previously used password. To enable this, tick the check box next to the **Enforce Password History** field, then in the adjacent box specify how many previous passwords are checked when the user changes their password. The maximum number of passwords stored is 9.

Allow Users to Reset Password via Email

If [Email Integration](#) is enabled, passwords can be reset via email by configuring this setting on Organization Settings page. This setting can be disabled if this functionality is not desired in which case users would need to contact a system administrator to manually reset their password.

Account Lockout

The **Account Lockout** settings determine how the system responds when incorrect passwords are entered. Having Silhouette lock out a user that enters a password incorrectly is a security measure that prevents "brute force" attacks by someone entering a series of passwords, hoping one is correct. It creates a potential inconvenience for legitimate users who accidentally mis-enter their passwords, but this situation can be limited by allowing a reasonable number of failed attempts within a certain time period before locking the user out. Once locked out, a user will need to request an administrator to unlock their account.

LDAP Integration

The settings described in this section are only relevant to user accounts which are created directly within SilhouetteCentral's admin user interface. If a user is created / controlled via LDAP integration these settings are not applicable and it is the responsibility of the LDAP server to define and implement account lock out functionality.

User Lockout Enabled

When the check box is ticked, users will be locked out of their account according to the settings in **Failed Log on Attempts Before Locking Account** and **Failed Log on Check Interval**.

Failed Log on Attempts Before Locking Account

This setting determines how many failed log on attempts the system tolerates. Once the user has failed to login the specified number of times the user's account will automatically be locked.

Permit a reasonable number of failed attempts to allow for users mistyping their passwords, or accidentally leaving the Caps Lock on.

Failed Log on Check Interval

The number of failed log on attempts does not accumulate indefinitely. It will be reset whenever the user manages to successfully log on, or a system administrator unlocks a locked user account. Additionally it will be reset once the number of minutes specified via the **Failed Log on Check Interval** setting have passed since the last invalid log on attempt. This setting allows occasional failed log ons due to the user miss typing their password, while sufficiently delaying attackers from trying to "brute force" a password by continually guessing.

Application Lock

The **Application Lock** protects patient data by automatically locking SilhouetteConnect or SilhouetteCentral after inactivity, requiring the user to log on again.

Timeout Before Logon Required

The **Timeout Before Logon Required** defines the length of time in minutes after which Silhouette will require the user to log on again. After this time period expires with no user activity SilhouetteConnect will display a lock screen which provides the user the option to re-enter their password and resume from where they left off, or to log off losing any unsaved changes. SilhouetteCentral on the other hand will simply return the user to the log on screen automatically, losing any unsaved changes.

Note: This feature can be disabled for SilhouetteConnect by setting a timeout of 0 minutes. Note however that SilhouetteCentral will interpret 0 to mean 30 minutes, i.e. this feature can not be disabled for SilhouetteCentral.

Note: When the authentication mode **Automatic sign-on only** is enabled the application will not lock the screen

Automated Installation

If you have access to the physical server running SilhouetteCentral, as an alternative to using the various file upload options within the administration user interface to configure additional users, units or report templates etc, you can alternatively make use of a more direct import process.

Files with the following special filenames can be placed in the Files\Setup folder of SilhouetteCentral's installation folder and will be automatically detected and processed during the next application pool restart. If successfully processed the file will be deleted from the Files\Setup folder to indicate its successful import.

- Units.csv - a list of units to import into SilhouetteCentral.
- Users.csv - a list of users to import into SilhouetteCentral.
- Report Templates - create a subfolder within Files\Setup called ReportTemplates and place any population report or wound assessment report templates within this folder for import into SilhouetteCentral.
- Email Templates - create a subfolder within Files\Setup called EmailTemplates and place any assessment email templates within this folder for import into SilhouetteCentral.
- File Templates - create a subfolder within Files\Setup called FileTemplates and place any file integration settings within this folder for import into SilhouetteCentral.
- Protocols - create a subfolder within Files\Setup called Protocols and place any protocol templates within this folder for import into SilhouetteCentral.

As an example if you wanted to quickly add 50 additional units to a SilhouetteCentral installation you could create a Units.csv file describing the details of the 50 additional units and then place this file in the Files\Setup folder. Once the file is in place, restarting the IIS application pool would cause the 50 units to be imported into the system, without needing to even log on to the SilhouetteCentral application.

Logs

The tools in the **Wound Administration** menu allow you to review various logged activities. You can:

- Review who has been synchronizing with SilhouetteCentral. See [Synchronizations](#).
- Review the SilhouetteStar camera calibration checks. See [Camera Calibration Checks](#).
- Review who has been attempting to log onto SilhouetteCentral or SilhouetteConnect. See [Logon Attempts](#).
- Review the audit log containing a record of each modification, view or export of patient data. See [Audit Log](#).
- Review the SilhouetteCentral log files. See .

Synchronizations

The **Synchronizations** screen displays the full list of users that have synchronized SilhouetteConnect devices with SilhouetteCentral.

The table displays the date and time of each synchronization, together with the user who performed it and whether or not there were any errors. The most recent synchronization is displayed at the top of the table.

You can navigate through pages of synchronizations using the links at the bottom of the screen.

Click the **Export** button to save a CSV report of the synchronizations that match the currently selected filter options.

Camera Calibration Checks

The **Camera Calibration Checks** screen displays a list of the calibration checks that have been performed on SilhouetteStar cameras.

The table displays the date and time of each calibration, together with the user who performed the calibration check, and whether or not the camera passed. Expected and actual measurements, a calculated relative error, the camera model and serial number are also displayed. Click on the **Calibration Image** link to see the image recorded by the camera during the calibration check process.

You can navigate through pages of calibration reports using the links at the bottom of the screen.

Click the **Export** button to save a CSV report of the calibration checks that match the currently selected filter options.

Logon Attempts

The **Logon Attempts** screen displays a list of logon attempts for both SilhouetteConnect and SilhouetteCentral.

The table displays the date and time each attempt occurred. If an attempt at logging on failed, the reason for the failure will be displayed. The most recent attempt is displayed at the top of the table.

You can navigate through pages of logon attempts using the links at the bottom of the screen.

Click the **Export** button to save a CSV report of the logon attempts that match the currently selected filter options.

Note: Recent SilhouetteConnect log on attempts may not appear on this page. A user needs to successfully synchronize SilhouetteConnect to SilhouetteCentral in order for log on attempts to appear on this page.

Audit Log

The **Audit Log** screen allows you to view the list of changes made against a patient's data. It also displays a record of users who have viewed or exported a patient's information. Select **Admin > Logs > Audit Log**. The **Audit Log** screen will be displayed:

Dashboard Data Management Organization Logs Server

Audit Log

Search: Within Assessments from to

Last Name	First Name	Middle Name	Domain ID	Date of Birth	First Assessment	Last Assessment	# Assessments	Is Deleted
Adams	Angela		DP094387	1990-02-20	2011-09-26 13-11	2011-09-26 13-11	1	Yes
Aldwin	Bruce		ZW340989	1970-05-14	2008-10-10 14-07	2008-10-10 14-07	1	Yes
Allen	Roberta		JA1298	1950-10-07			0	Yes
Allison	Melva		ZW981007	2011-12-14	2007-03-21 11-36	2008-09-24 19-43	6	Yes
Andrews	Maria		TF023578	1957-09-14	2011-10-11 18-52	2011-10-11 18-52	1	No
Ashworth	Susan	Diane	ZW984390	1939-03-06	2008-10-13 10-59	2008-10-13 10-59	1	No
Ashworth	Susan		AD4390	1973-02-23			0	Yes
Austin	Steve		EX4276	1937-02-21			0	Yes
Barlow	Clinton		DP235423	1958-10-06	2011-10-06 12-04	2011-10-06 14-26	16	Yes
Benson	Edith		ZE093498	2011-12-14	2008-10-17 13-52	2008-10-19 15-37	2	Yes

1 2 3 4 5 6 7 8 9 10

- A Search fields**
Search by patient name, Patient ID, or assessment date, as described in [Selecting a Patient](#).
- B Patient table**
Select the required patient.
- C Page links**
When there are too many patients to display on one screen, the page links at the bottom of the screen allow you to navigate through the patient table.
- D Logs button**
Click the **Logs** button to display the logs for the selected patient.
Two types of information are displayed:
- The **Changes** tab displays the users who have made changes to the patient's data. For each change, old and new values are displayed, together with the date and time the change was made.
 - The **Views** tab displays users who have viewed the patient's data and the date and time it was viewed. It also displays a record of any data exports that have occurred that have included the patient's data.
- Both of these are able to be exported in csv format simply by clicking the **Export** button.
- E Is Deleted column**
This column indicates if the patient record has been deleted.
The **Patient Logs** table shows both existing and deleted patients, so that it is possible to see when patients are deleted. This column identifies the current status of the patient's record.

SilhouetteCentral Logs

The **SilhouetteCentral Logs** screen provides access to all the log files for SilhouetteCentral. By default, a new log file is created daily.

Dashboard Data Management Organization Logs Server

SilhouetteCentral Log Files

Select log file:

```

2014-04-08 10:01:40,676 [3] INFO Silhouette.Central.WebApplication.Global [(null)] - Application_Start
2014-04-08 10:01:44,951 [3] INFO Silhouette.DataAccess.Implementation.SchemaUpgrade.V110_120_Upgrade [(null)] - No errors found in BodyPart data
2014-04-08 10:01:46,370 [3] INFO Silhouette.Central.WebApplication.Global [(null)] - Software Update: Looking for application update
2014-04-08 10:01:46,370 [3] INFO Silhouette.Central.WebApplication.Global [(null)] - Software Update: No application update found
2014-04-08 10:01:47,166 [20] INFO Silhouette.Central.WebApplication.Global [(null)] - Session_Start ktrkt5eb3jz05bq4dillzn46
2014-04-08 10:01:47,182 [20] INFO Silhouette.Central.WebApplication.Global [(null)] - User IP: 131.203.63.230 Port 61214
2014-04-08 10:02:31,688 [12] INFO SilhouetteCentral.AdminPages.ClientLogFile.ClientLogFileHandler [(null)] - Loading Connect log file contents: ''
2014-04-08 10:02:31,720 [12] DEBUG SilhouetteCentral.AdminPages.ClientLogFile.ClientLogFileHandler [(null)] - Length of JSON output: '2065'
2014-04-08 10:02:34,387 [14] INFO SilhouetteCentral.AdminPages.ClientLogFile.ClientLogFileHandler [(null)] - Loading Connect log file contents: ''
2014-04-08 10:02:34,387 [14] DEBUG SilhouetteCentral.AdminPages.ClientLogFile.ClientLogFileHandler [(null)] - Length of JSON output: '780'
2014-04-08 10:02:49,036 [12] INFO SilhouetteCentral.AdminPages.ClientLogFile.ClientLogFileHandler [(null)] - Loading Connect log file contents: ''
2014-04-08 10:02:49,285 [12] DEBUG SilhouetteCentral.AdminPages.ClientLogFile.ClientLogFileHandler [(null)] - Length of JSON output: '2694085'
2014-04-08 10:02:54,714 [14] INFO SilhouetteCentral.AdminPages.ClientLogFile.ClientLogFileHandler [(null)] - Loading Connect log file contents: ''
2014-04-08 10:02:54,714 [14] DEBUG SilhouetteCentral.AdminPages.ClientLogFile.ClientLogFileHandler [(null)] - Length of JSON output: '2065'
  
```


To access this log, your group should have permission to "perform SilhouetteCentral maintenance", which can be enabled in [Group permissions](#).

SilhouetteConnect Logs

The **SilhouetteConnect Logs** screen provides access to all the log files for all the SilhouetteConnect devices that have synced to this SilhouetteCentral instance. You can filter the results by user, device and log file.

Dashboard Data Management Organization Logs Server

SilhouetteConnect Log Files

Filter By User: Filter By Device:

Select log file:

Log for Device F0:BF:97:5C:51:3E,BFEBFBFF000206A7,A03BC7DC on 2013-10-31

```

2013-10-31 13:45:13,278 [1] INFO Silhouette.Connect.Log [(null)] - Logging started
2013-10-31 13:45:13,363 [1] INFO Silhouette.Connect.Log [(null)] - Starting up Silhouette Connect
2013-10-31 13:45:19,580 [1] INFO Silhouette.Connect.Log [(null)] - Attempting SimpleInitialise
2013-10-31 13:45:19,584 [1] INFO Silhouette.Connect.Log [(null)] - Attempting Repair
2013-10-31 13:45:19,604 [1] INFO Silhouette.Connect.Log [(null)] - Attempting SyncIfSyncEnabledSilhouetteLogin
2013-10-31 13:55:21,300 [1] INFO Silhouette.Connect.Log [(null)] - Attempting SimpleInitialise
2013-10-31 13:55:21,301 [1] INFO Silhouette.Connect.Log [(null)] - Attempting Repair
2013-10-31 13:55:21,301 [1] INFO Silhouette.Connect.Log [(null)] - Attempting SyncIfSyncEnabledSilhouetteLogin
2013-10-31 13:57:39,085 [12] INFO Silhouette.Connect.Log [(null)] - Logging stopped
2013-10-31 14:08:12,799 [1] INFO Silhouette.Connect.Log [(null)] - Logging started
2013-10-31 14:08:12,839 [1] INFO Silhouette.Connect.Log [(null)] - Starting up Silhouette Connect
2013-10-31 14:08:31,183 [1] INFO Silhouette.Connect.Log [(null)] - Attempting SimpleInitialise
2013-10-31 14:10:07,081 [1] INFO Silhouette.Connect.Log [(null)] - Attempting SimpleInitialise
2013-10-31 14:14:32,651 [1] INFO Silhouette.Connect.Log [(null)] - Attempting SimpleInitialise
  
```

To access this log, your group should have permission to "perform SilhouetteCentral maintenance", which can be enabled in [Group permissions](#).

Server

The tools in the **Server** menu relate to the SilhouetteCentral database, synchronization, and deployment of SilhouetteConnect software. You can:

- License your software, and review the license details including expiry dates and licensed features. See [License Details](#).
- Configure how SilhouetteCentral synchronizes with SilhouetteConnect. See [Synchronization Settings](#).
- Configure SilhouetteCentral integration. See [Integration](#).

License Details

The **License Details** screen allows you to update the license for your SilhouetteCentral. The following license details are displayed:

1. **Created:** The creation date of your license.
2. **Expires:** This is the expiry date of your license. If you have purchased a perpetual license, 'Never' will be displayed.
3. **Features:** Any optional software features that have been licensed will be listed here.

Licensing SilhouetteCentral

Underneath the license details there is a relicensing section that displays a client code. If there is no client code in the text box, then the SilhouetteCentral instance is unlicensed, and operating in a trial mode (which can be confirmed by a yellow bar appearing at the top of each page). To license SilhouetteCentral for the first time, enter your client code and select the **Check for License** button. To subsequently update your license, for example if you have purchased additional features or extended your warranty, it is only necessary to select the **Check for License** button.

In order for the automatic license update process to function, access to the Internet is required. If there is no Internet access, instructions on obtaining the license file manually will be provided once the **Check for License** button is pressed.

HTTP Proxy Configuration

The ARANZ Medical licensing server is hosted on the internet at www.silhouettecentral.com. When attempting communication with the licensing server SilhouetteCentral will use .NET's default proxy settings. If your network environment requires SilhouetteCentral to use a different proxy server this can be specified by updating the defaultProxy setting within SilhouetteCentral's web.config file.

As an example if you desire SilhouetteCentral to make use of a proxy server located at 192.168.2.1 port 8888 you could update the relevant section of the web.config file as follows:

```
<system.net>
<defaultProxy enabled="true">
<proxy proxyaddress="http://192.168.2.1:8888"/>
</defaultProxy>
</system.net>
```

Please refer to Microsoft's online .NET framework configuration documentation for further details.

Synchronization Settings

The **Synchronization Settings** screen configures how information is transferred between SilhouetteConnect and SilhouetteCentral during synchronization.

Dashboard Data Management Organization Logs Server

Synchronization Settings

General Settings

Automatic sync at log off ☐

Proxy URL

Data Retention

Remove patients after ☐ 0 days

Remove patients without active assessment orders ☐

Database Backups

Backup Create daily ▼

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Automatic Synchronization

A SilhouetteConnect user can always initiate a synchronization process when the **Sync** button is selected in the SilhouetteConnect **Patient Selection** screen. However, this process can also be automated in certain circumstances.

- **At log off.** SilhouetteConnect will automatically synchronize with SilhouetteCentral when the user logs off.

Data Retention

The **Data Retention** settings relate to how long patient information remains on devices running SilhouetteConnect.

- **Remove Patients After.** Tick this check box to enable the feature, and specify a number in the **days** field. Subsequently, if there is no record of a patient having data captured or edited in the specified number of days, that patient will be removed from the synchronizing SilhouetteConnect. Note that when the check box is unticked, patients will only be removed manually from SilhouetteConnect via **Manage Patients**, selectable on the SilhouetteConnect **Patient Selection** screen.
- **Remove patients without active assessment orders.** Tick this check box to enable the feature, if there are patients that have been automatically added to SilhouetteConnect that currently have no active assessment orders attached to them that patient will be removed from the synchronizing SilhouetteConnect.

Database Backups

Database Backups only relates to the backing up of SilhouetteConnect data, and has no relationship to the backup of SilhouetteCentral data.

- **Backup.** This setting controls the backup of SilhouetteConnect databases that are synchronizing to this SilhouetteCentral. It has four options:
 1. **Never create.** No backups are made.
 2. **Create on start up.** A backup is made whenever SilhouetteConnect is started.
 3. **Create daily.** A backup is made when SilhouetteConnect is started and the system detects that a backup has not yet been made for that day.
 4. **Create weekly.** A backup is made when SilhouetteConnect is started and the system detects that a backup has not yet been made in the last seven days.

Root URL

The Root URL should be the URL at which SilhouetteCentral is located. This is used for automatically configuring the SilhouetteConnect software updates so they synchronize to the correct SilhouetteCentral instance.

Proxy URL

If SilhouetteConnect requires the use of an HTTP proxy to communicate with SilhouetteCentral or the ARANZ Medical licensing server (hosted on the internet at www.silhouettecentral.com) this should be specified here. SilhouetteConnect installers downloaded from SilhouetteCentral or existing installations which successfully synchronize will automatically make use of the specified proxy server.

If this setting is not set SilhouetteConnect will attempt to use the default proxy settings stored in the computer's Internet Explorer installation.

Integration

The integration menu provides access to a number of different integration features that allows SilhouetteCentral to interface with other systems such as an Electronic Medical Record system. The exact features present within the integration menu will depend upon your SilhouetteCentral license.

- Configure SilhouetteCentral email integration to allow password resets to be performed via email and potentially automatically send assessment reports. See [Email Integration](#).
- Configure SilhouetteCentral to make use of an LDAP or ActiveDirectory server to administer user accounts and staff groups. See [LDAP Integration](#).
- Configure SilhouetteCentral to automatically generate wound assessment reports and save a copy to a pre-determined file location. See [File Integration](#).
- Configure SilhouetteCentral to automatically export patient data to an external database. See [Database Export Integration](#).
- Configure SilhouetteCentral to import a CSV file of medical practice data from the United Kingdom's National Health Service (NHS). See [General Medical Practices](#).

Email Integration

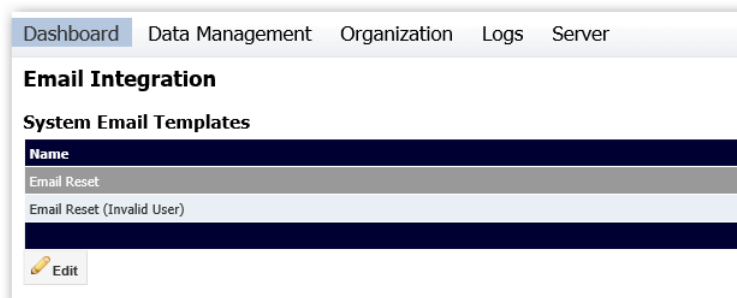
The email integration screen allows you to manage the email templates that SilhouetteCentral will use when sending various notifications.

If SilhouetteCentral is not being hosted by ARANZ Medical Ltd this page can also be used to configure the SMTP server settings that will be utilized to send emails.

System Email Templates

This section of the page lists a number of emails that SilhouetteCentral may generate and enables the contents to be customized. As an example you may like to modify the Email Reset email template to include details such as the contact phone number of an IT Support Desk etc.

To change any of these templates, select the template from the list, and click the **Edit** button below.



This will bring up the Edit Email Template dialog as shown below. Here you can change the details and click Save to apply those changes. Both the Subject and Body fields all the use of macros which provide the ability to insert targeted text into the email. For example in the image below, the {User,Login} macro will be replaced by the login name for the user that the reset request is being emailed to. For a full list of the available macros see section [Template Macros](#).

Edit Email Template

Name: Email Reset

Subject: Silhouette password reset request

Body:

You have been sent this email because you (or someone else) has requested that your Silhouette password be reset.

Your user name is: {User,Login}.

To reset your password click the link below and follow the instructions provided:

{User>PasswordResetUrl}

If you did not make this request please click the following link to cancel the password reset request:

{User>PasswordResetCancelUrl}

Save Cancel

Assessment Email Templates

If SilhouetteCentral is licensed to allow assessment report emailing, the Email Integration page will display a list of **Assessment Email Templates**.

Each **Assessment Email template** defines the subject and body of an email to be automatically generated whenever a specified set of trigger conditions (such as creation of an assessment, capture of additional images, modification of wound notes, etc) occurs. More than one Assessment Email template can be specified to allow different emails to be sent under specific conditions.

Assessment Email Templates

Name
Assessment Change

Create Edit Delete Export

In order to define the recipients for each Assessment Email Template, go to [Organisation\Units](#) and add the addresses in each separate unit.

Upload email template

Choose file No file chosen E

A

Create button

Click the **Create** button to define a new email template. See [Create/Edit Assessment Email Template](#).

B

Edit button

Click the **Edit** button to edit the selected email template. See [Create/Edit Assessment Email Template](#).

C

Delete button

Click the **Delete** button to delete the selected email template.

D

Export button

Click the **Export** button to export the selected email template. This will download a zip file containing the email template definition. In order to define the recipients for each assessment email template go to Organisation\Units and add the addresses in each separate unit.

E

Upload email template

An existing email template can be imported into SilhouetteCentral by uploading the zip file created by the export feature. If the email template already exists then it will be updated, otherwise a new email template will be created. The zip file can be uploaded by clicking the **Browse** button and navigating to the file location, or by dragging and dropping the file onto the browser window.

Create/Edit Assessment Email Template

Either creating or editing an assessment email template will bring up a screen like the following:

This will allow you to set the following:

- A Name**
The name of the assessment email template. This will be used for identifying it on the **Email Integration** and **Unit Edit** screen.
- B Conditions for Activating Template**
Configures which events cause the assessment email to be generated and sent. The individual events represented by check boxes are "ORed" together. E.g. if both the "Visit notes change" and "Wound notes change" checkboxes are checked an email will be generated if either the visit or wound notes associated with the assessment are updated. You can also select the check box "**And a condition evaluates to true**" to enter a conditional expression that must evaluate to true in order to trigger an email to be generated. The expression can reference any note field that has been assigned a variable name. This feature can be used to setup scenarios such as only generating an email for "stage 1 pressure ulcers" or "patients weighing over 120 kg".
- C Email Subject and Body**
Provides the templates to be used for the subject and body fields of the email. These fields can use macros. To see a full list of available macros see section [Template Macros](#). Whenever the trigger conditions are satisfied SilhouetteCentral will trigger the email template and send the email to the [recipients defined for that unit](#).
- D Attach a Report**
Check the check box to automatically generate a copy of the specified assessment report and attach a copy to the email.
Define Recipients
Check the check box to send the email to all recipients at once (instead of using individual emails).

SMTP Configuration

If SilhouetteCentral is not hosted by ARANZ Medical Ltd the email integration screen will show a check box to enable or disable email integration.

When email integration is enabled, it will show additional options to configure the SMTP settings that SilhouetteCentral will use for sending emails. If email integration is left disabled, certain system functionality, such as the "Forgotten Password" link on the login screen will be hidden.

SMTP configuration settings will not be present for SilhouetteCentral instances hosted by ARANZ Medical Ltd. Such installations use email server configuration details managed by ARANZ Medical Ltd. Please contact your Account Manager if you are a hosted SilhouetteCentral customer and wish to customize your email settings such as the email address the user will see if they attempt to reply to an assessment email.

Template Macros

Some fields allow for macro expansion to allow the actual value to include details dynamically retrieved from the patient, assessment, or order that is being processed.

A macro is indicated by a set of curly braces, and the general form of a macro is {source,path,empty}. Source describes where to obtain the value, and path further clarifies exactly which value is desired. If the value obtained is NULL or an empty string an optional third parameter to the macro can provide an alternative value to be substituted.

The sources and paths available depend upon the context in which the format string will be utilized. Currently supported sources and paths are listed below:

Password Reset Emails

The following macros are available for the password reset emails.

Source	Description							
System	Info associated with the SilhouetteCentral environment that is processing the current request							
	<table> <tr> <th>Path</th><th>Description</th></tr> <tr> <td>Date</td><td>The current date and time of the server processing the request.</td></tr> </table>	Path	Description	Date	The current date and time of the server processing the request.			
Path	Description							
Date	The current date and time of the server processing the request.							
User	Info associated with the user requesting the password be reset							
	<table> <tr> <th>Path</th><th>Description</th></tr> <tr> <td>Login</td><td>The login name for the current user.</td></tr> <tr> <td>Email</td><td>The email address for the user.</td></tr> <tr> <td>FirstName</td><td>The user's first name</td></tr> </table>	Path	Description	Login	The login name for the current user.	Email	The email address for the user.	FirstName
Path	Description							
Login	The login name for the current user.							
Email	The email address for the user.							
FirstName	The user's first name							

Source	Description
	<div> <div>LastName</div> <div>The user's last name.</div> </div> <div> <div>MiddleName</div> <div>The user's middle name.</div> </div> <div> <div>FullName</div> <div>The user's full name.</div> </div> <div> <div>Phone</div> <div>The user's phone number.</div> </div> <div> <div>PasswordResetUrl</div> <div>The URL the user will have to visit to reset their password.</div> </div> <div> <div>PasswordResetCancelUrl</div> <div>The URL that will allow the user to cancel the password reset request. Once this is visited, then the password reset URL will no longer be usable.</div> </div> <div> <div>ForgotPasswordUrl</div> <div>The URL that the user should visit if they have forgotten their password</div> </div>

Assessment Email Templates

The following macros are available for the assessment email templates.

Source	Description
System	<div>Info associated with the SilhouetteCentral environment that is processing the current request</div> <div> <div>Path</div> <div>Description</div> </div> <div> <div>Date</div> <div>The current date and time of the server processing the request.</div> </div>
Patient	<div>Info associated with the patient the current action is associated with</div> <div> <div>Path</div> <div>Description</div> </div> <div> <div>PatientId</div> <div>Patient ID for the unit the patient is currently assigned to (could be blank). See below for including additional ID types.</div> </div> <div> <div>FirstName</div> <div>The patient's first name.</div> </div> <div> <div>MiddleName</div> <div>The patient's middle name.</div> </div> <div> <div>LastName</div> <div>The patient's last name.</div> </div> <div> <div>DateOfBirth</div> <div>The patient's date of birth.</div> </div> <div> <div>Gender</div> <div>The text "Female" or "Male" based upon the gender recorded in the patient's demographics.</div> </div> <div> <div>Unit</div> <div>The name of the unit the patient is currently assigned to.</div> </div> <div> <div>Street</div> <div>Current address information for the patient as recorded in their demographics.</div> </div> <div> <div>Suburb</div> </div> <div> <div>City</div> </div> <div> <div>State</div> </div> <div> <div>Postcode</div> </div>

Source	Description
	<p>Country</p> <p>WorkPhone HomePhone MobilePhone</p> <p>DashboardUrl</p> <p>Current phone numbers as recorded in the patients demographics.</p> <p>A datalink to the wound dashboard within SilhouetteCentral for the patient</p>
Visit	<p>Info associated with the visit the current action is associated with</p> <p>Path Date</p> <p>Description The date (and time) the visit was originally created on</p>
Assessment	<p>Info associated with the assessment the current action is associated with</p> <p>Path Date</p> <p>Description The date (and time) the assessment was originally created on</p> <p>AssessmentUrl</p> <p>Datalink to the wound assessment dashboard within SilhouetteCentral for this assessment</p> <p>ReportFilename</p> <p>Internal filename of the PDF wound assessment report (useful only if SilhouetteCentral is configured to place reports on a network share etc)</p> <p>ReportUrl</p> <p>Datalink to the PDF wound assessment report within SilhouetteCentral.</p>
Wound	<p>Info associated with the wound the current action is associated with</p> <p>Path Label</p> <p>Description The wound label e.g. Wound "A" or Wound "1". The option to set Wound Labels to numeric or alpha is found in Organization > Settings</p> <p>AnatomicalSite</p> <p>A description of the anatomical site the wound is associated with.</p>
Order	<p>Info associated with the HL7 order associated with the current action</p> <p>Path Id</p> <p>Description The placer order number obtained from the ORM^O01 message</p> <p>ScheduledDate</p> <p>The date/time the wound assessment was requested to be performed at.</p> <p>Description</p> <p>The description of the order as it will appear within the SilhouetteCentral and SilhouetteConnect user interfaces.</p>
Notes	<p>Provides access to all patient, visit and wound assessment level notes recorded against the assessment currently being processed.</p> <p>'Path' should be the name of a valid variable name associated with a notes field and the current value for that notes field will be returned.</p> <p>If an unknown variable name is requested an empty string will be returned.</p>

Note: If you want to include an explicit curly brace within your text value you need to escape it e.g. `{{foo}}` turns into `{foo}`.

Note: Within a macro, if the empty parameter is not specified a blank string will be assumed. Likewise if a macro refers to an unknown source or path an empty string will be substituted.

Some example macros and the resultant text string they produce are described in the table below:

Format String	Resultant Text
Hello, World	Hello, World
Please view the report at {Assessment,ReportUrl}	Please view the report at http://server-name/SilhouetteCentral/datalink/3D916AD2-92D8-4D8E-B5FB-BC2D0D1B12B4
Please dress the wound using {Notes,DressingType}	Please dress the wound using Gauze
{Patient,PatientId} was assessed at {Assessment,Date}. Their admission status is "{Notes,Admission_Status,not recorded}"	PX1234 was assessed at 2009-10-12 19:53 Their admission status is "Lost to follow up".
Hello {{world}}	Hello {world}
Dressing Type: {Notes,DressingType,Unknown}	Dressing Type: Unknown

Data Links

A data link is a unique URL that can be used to access a specific page related to a specific patient or assessment within the SilhouetteCentral website.

Macros which generate data links such as `{Patient,DashboardUrl}` and `{Assessment,ReportUrl}` by default will generate data links that do not expire. However if you wish the links to only be active for a fixed period of time you can add optional parameters as explained below:

Example Macro	Description
{Patient,DashboardUrl}	Non expiring link - always usable
{Patient,DashboardUrl:days=20}	Link will expire after 'n' days from today
{Patient,DashboardUrl:months=1}	Link will expire after 'n' months from today
{Patient,DashboardUrl:years=1}	Link will expire after 'n' years from today

When a user attempts to view a data link that has expired instead of the webpage or PDF report being presented they will be shown an error message stating the data link has expired. This feature is useful if the URLs are being sent for consultation or review purposes and you want to control how long the user has access to the information.

Date Values

Any of the macros outlined in the previous tables that return date/time values are by default formatted using the current organizational settings. If you wish the timestamps to be formatted in a different manor you can add an optional parameter to specify the date format explicitly:

Example Macro	Description
{Assessment,Date}	Format date using current organisation settings
{Assessment,Date:format=dd-MM-yyyy}	Format date as day-month-year, e.g. 31-12-2014
{Assessment,Date:format=D}	Format date in long format, e.g. Wednesday, December 31, 2014

The format string parameter can be any valid date/time format string understood by Microsoft .NET's System.DateTime class. For further reference refer to Microsoft's documentation.

Standard Date and Time Format Strings

[http://msdn.microsoft.com/en-us/library/az4se3k1\(v=vs.110\).aspx](http://msdn.microsoft.com/en-us/library/az4se3k1(v=vs.110).aspx)

Custom Date and Time Format Strings

[http://msdn.microsoft.com/en-us/library/8kb3ddd4\(v=vs.110\).aspx](http://msdn.microsoft.com/en-us/library/8kb3ddd4(v=vs.110).aspx)

Patient Identifiers

A patient may have several different identifiers assigned. These identifiers can be obtained using overloads of the PatientId macro

Example Macro	Description
{Patient,PatientId}	Display the identifier assigned to the unit that the patient belongs to
{Patient,PatientId:name=MRN}	Display the "MRN" patient identifier for the patient. The name argument (MRN) must match exactly the name of the patient identifier you want to display as defined in SilhouetteCentral.

LDAP Integration

LDAP integration is a licensed feature that when enabled allows SilhouetteCentral to sync users and groups with an LDAP server. SilhouetteCentral should be compatible with both Active Directory and Posix LDAP implementations. For details of the LDAP directory structure that is required for SilhouetteCentral integration see section [LDAP Requirements](#).

LDAP Configuration

When LDAP is available the LDAP configuration screen is accessed through the LDAP option under the Server -> Integration menu on the admin pages .

Dashboard Data Management Organization Logs Server

LDAP Integration

☒ Enable LDAP Integration

LDAP Settings

Authentication mode: Automatic and manual sign-on

Sync Interval (mins): 20

Save

LDAP Directories

Server	OU	User Name
coleburn2:389	Silhouette	cn=Manager,dc=maxcrg,dc=com
lq.aronmedical.com	TestSilhouetteImport	test@aronmedical.com

Sync Add Edit Delete

- A Enable LDAP Integration**
Configures whether LDAP integration is enabled in SilhouetteCentral. If this is disabled, then any associated users and groups that have been created will be disabled.
- B Authentication mode**
There are three modes available Manual sign-on, Automatic and manual sign-on, Automatic sign-on only.
- C Sync Interval**
If SilhouetteCentral should query the Active Directory on a regular basis, then set the Sync Interval to the number of minutes it should wait between synchronizations. To disable this feature set it to 0.
- D Save**
Saves the settings described in A, B, and C above. Does not save anything below this button.
- E LDAP Directories**
This will display a list of all the currently configured LDAP directories. Click on a row on the grid to select that record, then click the buttons
- F Sync Button**
Click to sync the selected directory record. This will first display a preview of the sync and ask for confirmation before it is performed. See [Preview Sync](#).
- G Add Button**
Click this to add a new directory record. See [LDAP Integration Options](#).
- H Edit Button**
Click to edit the selected directory record. See [LDAP Integration Options](#).
- I Delete Button**
Click to delete the selected directory record. Once deleted, the associated users and groups will be removed from SilhouetteCentral.

Authentication Modes

When Ldap integration is enabled there are three authentication options.

- Manual sign-on only
- Automatic and manual sign-on
- Automatic sign-on only.

Manual sign-on only

The user is always prompted for their username and password. User accounts can be LDAP accounts or accounts administered within SilhouetteCentral.

Automatic and manual sign-on

Users can log on with either LDAP accounts or accounts administered within SilhouetteCentral. The behaviour of SilhouetteCentral and SilhouetteConnect is different.

When SilhouetteConnect is started, it will automatically attempt to log on using the users Windows domain credentials already authenticated to Windows (Windows Integrated Authentication). If that user account does not have access to Silhouette (or the subsequently log off) then the log on screen is shown and the user can enter a username and password manually.

When a user browses to the SilhouetteCentral instance, they are presented with the normal log on page with an additional link allowing them to use their Microsoft Windows domain credentials instead of typing them in. See [Logging On to SilhouetteCentral](#).

Automatic sign-on only

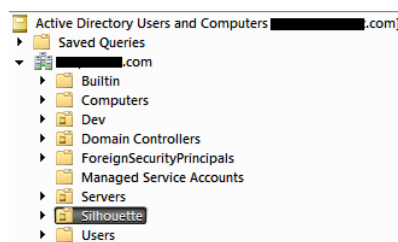
Both SilhouetteConnect and SilhouetteCentral attempt to log the user in using the currently authenticated Windows domain credentials (Windows Integrated Authentication). If those user credentials don't have access to Silhouette then a different user must log in to Windows to access Silhouette.

LDAP Requirements

This section details the list of requirements that SilhouetteCentral has for the LDAP server it is connecting to.

Organizational Units

The Silhouette LDAP interface for Active Directory expects all the groups that it is going to import to be contained within a single Organizational Unit (OU), henceforth referred to as the Silhouette Root OU. The suggestion for this is "Silhouette", e.g.



Note: Unlike the example above, the Silhouette Root OU does not have to be a top level OU.

Security Groups

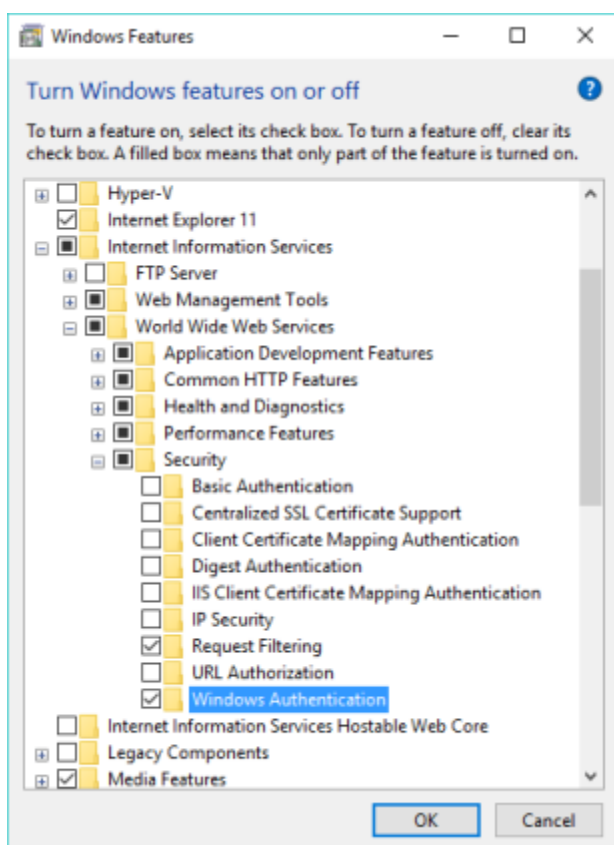
Within the Silhouette Root OU, create one or more Security Groups. These groups should be directly under the Silhouette Root OU. SilhouetteCentral will not scan any child OUs of the Silhouette Root OU searching for groups. Each of the created Security Groups will have a matching group created within SilhouetteCentral. Once created, add users to these groups as required. The users should already exist in your AD structure (probably under the global Users Container). Each of these users will be imported into SilhouetteCentral and assigned to the matching SilhouetteCentralgroup.

Note: Users can only belong to a single group in SilhouetteCentral. Various LDAP servers, however, allow you to add the same user to many groups. But inside Silhouette, the users will only be assigned to the first group the Silhouette import tool finds. To avoid any confusion, you should ensure that the users are only assigned to a single Security Group inside Active Directory.

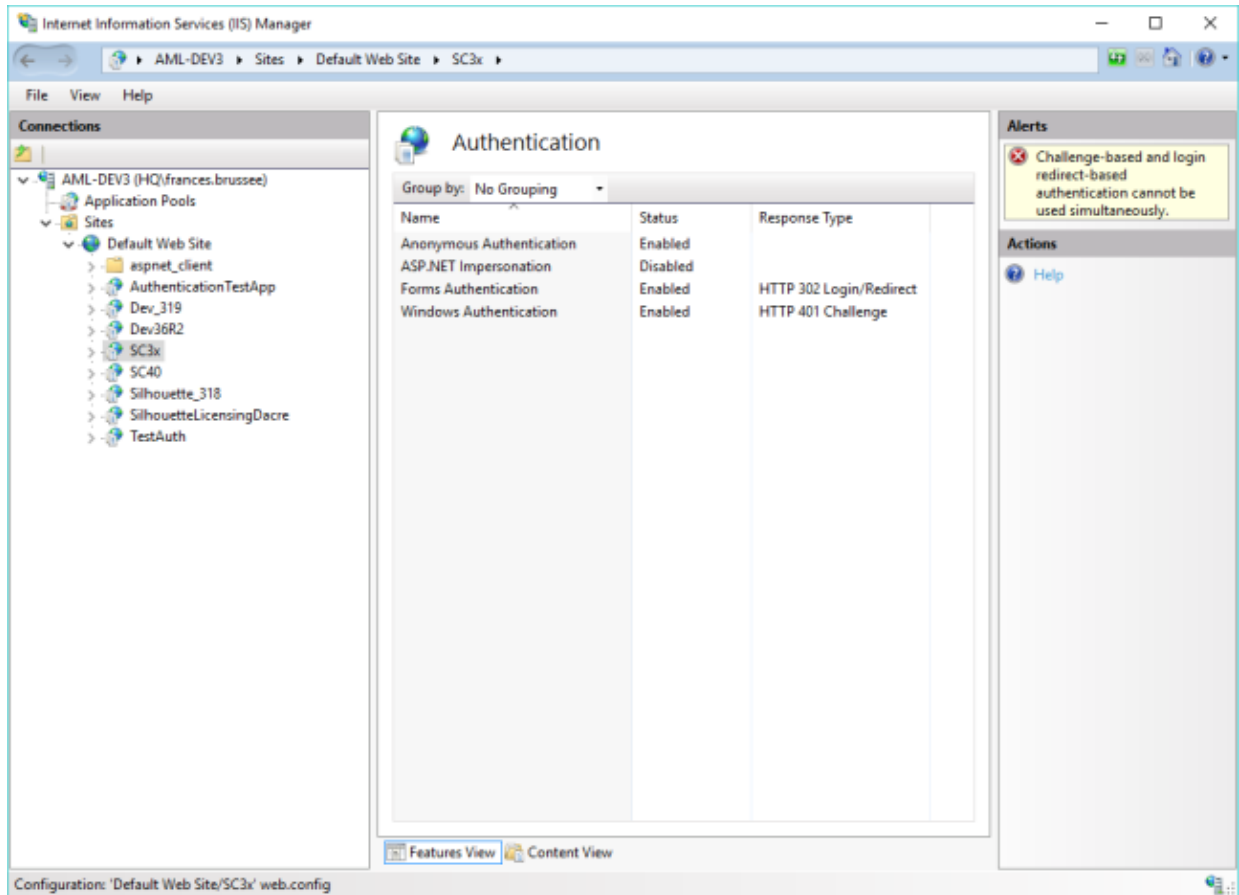
Setting up Central for single sign-on

If either "Automatic sign-on only" or "Automatic and manual sign-on" is the selected authentication mode in LDAP integration, some changes need to be made in IIS in order for this functionality to work correctly.

- Enable 'Windows Authentication' for IIS



- In IIS Manager, for the website, click 'Authentication' and enable 'Windows Authentication'. The resulting error shown can be ignored



LDAP Integration Options

Delete this text and replace it with your own content.

LDAP Integration Options

A Server:

B Authentication:

C Username:

Password:

D Base DN:

E Organizational Unit:

F Login Attribute:

- A Server**
Displays the list of SilhouetteCentral groups that will be changed when the sync is performed.
- B Authentication**
Sets the authentication mode that SilhouetteCentral will use when querying the LDAP server. Can be one of the following:
- Anonymous
 - Basic
 - Digest

C**Username and Password**

The username and password are the credentials that SilhouetteCentral will use to query the LDAP server. This is only available when the authentication mode is set to basic or digest

D**Base DN**

The Base DN specifies the node in the LDAP server where SilhouetteCentral will begin the search for users.

E**Organizational Unit**

The Organizational Unit that SilhouetteCentral will scan for groups. (Referred to as the Silhouette Root OU).

F**Login Attribute**

Configures which LDAP attribute SilhouetteCentral will assign as the Username for the created SilhouetteCentral users. This can be set to one of the following:

- SAM Account Name
- User Principal Name
- Other (you will be required to enter the attribute value when this is selected)

Preview Sync

This dialog provides a preview of the changes that will be made to the SilhouetteCentral users and groups when the LDAP server is synced with SilhouetteCentral.

LDAP Preview

A Groups

Name	Synced	Result
TestGroup1	Yes	Added
TestGroup2	Yes	Added

B Users

User Name	Name	Group	Synced	Result
testuser1	Test, User 1	TestGroup1	Yes	Added
testuser2	Test, User 2	TestGroup2	Yes	Added

C Sync **D** Cancel

A**Groups**

Displays the list of SilhouetteCentral groups that will be changed when the sync is performed.

B**Users**

Displays the list of SilhouetteCentral users that will be changed when the sync is performed.

C**Sync Button**

Performs the LDAP sync. All changes as shown will be made to the SilhouetteCentral users and groups.

D**Cancel Button**

Closes the dialog without making any changes to the Silhouette users and groups.

File Integration

SilhouetteCentral can be configured to automatically generate a new wound assessment report whenever specific changes are detected to an assessment and save a copy to a pre-determined folder location.

Note: This feature is currently only available for self-hosted installations of SilhouetteCentral, i.e. this feature is not present for SilhouetteCentral installs hosted by ARANZ Medical Ltd on www.silhouettecentral.com.

File Integration

Assessment Report Templates

Name
Assessment Report Template

Create **A**
Edit **B**
Delete **C**
Export **D**

Upload report template

E
A**Create button**

Click the **Create** button to define a new template. See [Create/Edit Assessment Report Templates](#).

B**Edit button**

Click the **Edit** button to edit the selected template. See [Create/Edit Assessment Report Templates](#).

C**Delete button**

Click the **Delete** button to delete the selected template.

D**Export button**

Click the **Export** button to export the selected template. This will download a zip file containing the report template definition.

E**Upload report template**

A report template can be imported to SilhouetteCentral by uploading the zip file created by Export process. If the uploaded report template already exists, then it will be updated, otherwise a new report template will be created. The zip file can be uploaded by clicking the **Browse** button and navigating to the file location, or by dragging and dropping the file onto the browser window.

Create/Edit Assessment Report Templates

Either creating or editing an Assessment Report Template will show a screen similar to the screenshot shown below:

A

B

C

D

Edit Assessment Report Template

Name:

Whenever:

<input checked="" type="checkbox"/> Assessment change	<input type="checkbox"/> Patient details change
<input checked="" type="checkbox"/> Image change	<input type="checkbox"/> Patient notes change
<input checked="" type="checkbox"/> Wound change	<input checked="" type="checkbox"/> Visit notes change
<input checked="" type="checkbox"/> Wound Status change	<input checked="" type="checkbox"/> Wound notes change
<input type="checkbox"/> And a condition evaluates to true	

Generate a report and store it in the following location:

Filename:

This screen will allow you to set the following:

A**Name**

The name of the assessment report template.

B**Conditions for Activating Template**

Configures which events cause the assessment report to be generated and saved to disk.

The individual events represented by checkboxes are "ORed" together, i.e. if both the "**Visit notes change**" and "**Wound notes change**" check boxes are checked an email will be generated if either the visit or wound notes associated with the assessment are updated.

You can also select the check box "**And a condition evaluates to true**" to enter a conditional expression that must evaluate to true in order to trigger a report to be generated. The expression can reference any notes field that has been assigned a variable name. This feature can be used to setup scenarios such as only generating a report for "stage 1 pressure ulcers" or "patients weighing over 120 kg".

C

Report Type

This combo box allows the type of PDF assessment report to be specified.

In most cases this will only have one option (Wound Assessment), however [protocols](#) can provide alternative options.

D

Filename and location

When SilhouetteCentral generates a new wound assessment report it will store a copy in the main clinical data store (where all patient demographic, assessment and image data are stored). However a copy will also be stored in a folder location of your choosing.

One use of this functionality would be to use a cold-feed import utility to import the PDF wound assessment report into an Electronic Medical Record (EMR) system, or for an automatic report printing mechanism.

[Macros](#) can be used in the path to allow patient demographics or assessment details to be included in the generated path or filename.

NOTE: It is important to ensure the generated filename structure results in a unique location for each report. If all reports for a single patient generated an identical filename for example SilhouetteCentral would overwrite previous reports so only the most recently generated one would be present in the folder location specified. Techniques to ensure unique filenames are always generated could include

- Including the report generation time stamp e.g. {System,Date}
- Including the wound label and assessment date e.g. {Assessment,Date}_{Wound,Label}

NOTE: Filenames can include all characters except `\/:?*<>`. If a macro expansion results in a character which can not be part of a filename, the invalid characters will be replaced with underscores.

Create/Edit Image Export Templates

Either creating or editing an Image Export Template will show a screen similar to the screenshot shown below:

Edit Image Export Template

A Name: **Generate WinDIP:** ☐

B ☒ Whenever an image changes
☐ Whenever an image changes and a condition

C Full Size Image: ☒

With ☒ Outlines ☒ Axes ☒ Rulers

Generate a **D** **JPG** image and store it in the following location:

Filename:

☒ Save ☐ Cancel

This screen will allow you to set the following:

- A Name**
The name of the Image Export template.
- B Conditions for Activating Template**
Configures which events cause the Image to be exported to disk.
The options are to export the image whenever it changes, or
Export the image if it changes and a specific scenario has been met .
- C Full Sized Image and options**
These tickboxes allow the image to be exported at full size, and have the Outlines, Axes, or Rules displayed on them.
- D Filename and type**
When SilhouetteCentral generates a new image export it will store a copy in the main clinical data store (where all patient demographic, assessment and image data are stored). However a copy will also be stored in a folder location of your choosing.
The file type dropdown can be set to output either JPG or PNG image types.
[Macros](#) can be used in the path to allow patient demographics or assessment details to be included in the generated path or filename.
NOTE: Filenames can include all characters except `\.:\?*<>`. If a macro expansion results in a character which can not be part of a filename, the invalid characters will be replaced with underscores.

WinDIP File Export Feature

SilhouetteCentral is able to export wound assessment reports in WinDIP format through a separate optional license feature. From the **Edit Assessment Report Template**, or **Edit Image Export Template** screens shown in the previous sections, a tickbox labelled **Generate a WinDIP file** will be present if this feature is licensed.

☒ Generate a WinDIP file + Add Item

Id: Surname	Value: {Patient,LastName}
Id: First Name	Value: {Patient,FirstName}
Id: Hospital Number	Value: {Notes,HospitalNumber}

Setup the Assessment Report Template as required and use the **Add Item** button to add indexes to the WinDIP file, when it is created and fill in the **Id** names and **Value** in [macro](#) format.

The WinDIP file (extension .wif) will be created in the same directory as the images/pdf reports (as set in the Report Templates Window) when SilhouetteLink is run.

Database Export Integration

The Database Export is a licensed feature that allows SilhouetteCentral to automatically run the patient data exports ([Exporting Patient Records](#)) with the results stored in an external database.

The Database Export Integration screen allows you configure which of the available exports should be exported, and how often SilhouetteCentral should run these exports.

Database Export Integration

A ☒ Enable database export integration

B Interval (mins)

E Patient Identifier

C **Summary Measurements**

Enabled ☒

Connection String

Table Name

Detailed Measurements

Enabled ☐

Patient Notes

Enabled ☐

Visit Notes

Enabled ☐

Wound Notes

Enabled ☐

D

A Enable database export integration
Toggle this check box to enable or disable the feature.

B Interval
This is the number of minutes between each export run. This must be between 1 and 10080 minutes (7 days).

C Export Details
Each available export can be enabled or disabled.
To enable the export, check the check box and fill in the Connection String and Table Name fields. The Connection String defines the external database to connect to, and the Table Name defines the name of the Table inside the database where the export will store the data.
The Connection String must connect to the desired database with sufficient permissions within the external database to be able to create tables.
The table will be dropped (deleted) and recreated each time the export runs.

There are two options for the Connection String (replace brackets <> with required values)

Integrated Security: The connection to the database is made using the users account hosting the SilhouetteCentral website. The Connection string will then be in the form:
DataSource=<name of database server>; Initial Catalog=<name of database>; Integrated Security=True

SQL Server Login: The Connection to the database is made using a SQL Server login with sufficient permissions to create tables. The Connection string will then be in the form:
DatabaseSource=<name of database server>;Initial Catalog=<name of database>;User ID=<username>;Password=<password>

D Save button
Click the **Save** button to save your changes.

E Patient Identifier
When configuring a database export, select the required patient identifier from the dropdown list. This will be used for all database exports and is dependant on the Patient Identifiers defined within SilhouetteCentral.

Exporting Silhouette Identifiers (primary keys)

To include Silhouette Identifiers (i.e database primary keys) in the database exports, see [Include Silhouette Identifiers in Exports](#)

DICOM Configuration

The DICOM configuration is a licensed feature that allows SilhouetteCentral to receive and resolve DICOM worklists. This page replaces the old DicomClientSettings.xml file, and allows DICOM to be configured in a user-friendly way.

DICOM Configuration

When DICOM is available the DICOM configuration screen is accessed through the DICOM Configuration option under the Server -> Integration menu on the admin pages . To set the Scheduled Station AE Title for each Unit, go to the [Unit Edit](#) page.

DICOM Integration

Connectivity

A Association Timeout *

B **Silhouette Modality**

AE Title *

Station Name *

Two Stage Workflow Trigger Condition

C **Modality Worklist Server**

Enabled ☒

IP Address *

Port *

AE Title *

D Worklist Query Mode

E **Storage Server**

Enabled ☒

IP Address *

Port *

AE Title *

F Send Images ☒

Full Size Image ☐

Image Height *

Image Width *

G Send Reports ☐

- A Association Timeout**
The timeout value of the DICOM association.
- B Silhouette Modality**
- AE Title: the AE title to use for this modality
 - Station Name: the value that will be set for the StationName tag of any generated DICOM images or PDF reports.
- C Worklist Modality Server**
The IP address, port number and AE Title of the DICOM Modality Worklist (MWL) Server Silhouette should poll to fetch worklists from.
- D Worklist Query Mode**
Determines whether the modality server will be queried whenever SilhouetteConnect syncs with SilhouetteCentral, or on a periodic basis, typically every 60 seconds. If set to On SilhouetteConnect Sync, the worklist server will also be queried whenever a user navigates to the orders page in SilhouetteCentral.

**Server Storage**

The IP address, port number and AE Title of the DICOM Storage Server Silhouette should submit generated images and PDF reports to.

**Image Settings**

If **Send Images** is selected, image files will be sent to the DICOM storage server whenever a modality stored procedure step is marked as completed. If **Full Size Image** is not selected, use **Image Width** and **Image Height** to set the image size. Image size needs to retain a 4 by 3 ratio.

**Send Reports**

If selected, PDF wound assessment reports will be generated and sent to the DICOM storage server whenever a modality stored procedure step is marked as completed.

General Medical Practices

The General Medical Practices is a licensed feature that allows SilhouetteCentral to import a CSV formatted General Medical Practice file from the UKs NHS.

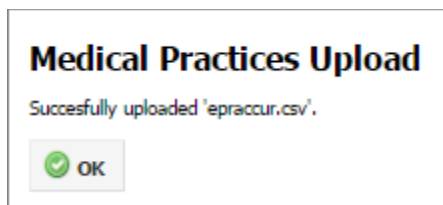
The data is imported into a new database table, within the SilhouetteCentral database (and replaces any existing data that table may have).

Import is restricted to the following types of fields:

- National Practice Code
- Name
- Address
- Phone Number

To use this feature either drag and drop the General Medical Practice file onto the page and the upload will begin, or click the **Browse** button and navigate to the file that has been downloaded from the NHS.

Once the file has been successfully imported the following dialog will be displayed:



The data will now be available within SilhouetteCentral.

If there are errors present in the data, the file will not be uploaded and the error will be reported to the user.

Appendices

Appendix A: Regular Expressions

Regular Expressions are patterns used to match character combinations in strings, for example a phone number or email address can be checked against a Regular Expression pattern to validate they conform to a certain format. Regular Expressions use a definition language where characters have special meaning. There are many special characters, the ones used in the examples that follow are:

- Square brackets [], to specify the range of characters that are allowed.
- Curly brackets {}, to specify the number of times the previous pattern must match.
- Caret ^, to specify the pattern match must occur at the beginning of the string.
- Dollar sign \$, to specify that the pattern match must occur at the end of the string
- Using ^ and \$ specifies that the whole input string must match the pattern.

Patient Identifier Examples for SilhouetteConnect

Example A

A 5 digit patient number would be written as:

- `^[0-9]{5}$`
- Values satisfying this regular expression include 12345 and 75319

Example B

A 3 digit unit ID, a dash, then a 3 digit patient number would be written as:

- `^[0-9]{3}-[0-9]{3}$`
- Values satisfying this regular expression include 147-963 and 456-321

Example C

Two upper-case alphabetic character unit ID, then 4 digit patient number would be written as:

- `^[A-Z]{2}[0-9]{4}$`
- Values satisfying this regular expression include ZK1648 and VT7642

Example D

A three-digit unit ID, a dash, a patient number comprising 4, 5 or 6 numeric digits, and the last character being an upper-case A, B, or C to indicate three different study groups would be written as:

- `^[0-9]{3}-[0-9]{4,6}[ABC]{1}$`
- Values satisfying this regular expression include 010-01934A and 110-50012C

Through the simple use of regular expressions you can control the accuracy of information entered into a system and hence improve reliability and reduce errors.

Further reading and an interactive tutorial can be found here: <http://regexone.com/>

Using Regular Expressions the following types of structures can be specified:

- A character from a group of characters, e.g.:
 - A lower-case alphabetic character [a-z]
 - An upper-or-lower case alphabetic character [a-zA-Z]
 - A numeric digit [0-9]
 - Alphanumeric characters comprising lower-case alphabetic or numeric digits [0-9a-z]
 - Commonly occurring punctuation characters such as dash "-", comma ",", period ".", brackets "[", and braces "{", etc.
- A character can occur a fixed number of times, e.g.:

Three characters which can be either a, b or c would be written as: `[abc]{3}`
- A single optional character is indicated by the question mark "?", e.g.:

An optional uppercase alphabetic character would be written as: `[A-Z]?`
- 1 upper-case alphabetic or 2 numeric digits could be required using the special or operator "|":

such as: `[A-Z]|[0-9]{2}`

Things to Note

- The special treatment of the “(” and “)” characters –these have special meaning within Regular Expression language so when they need to be used as normal characters this needs to be indicated. Preceding special characters with the “\” (“slash”) character tells the computer to treat the character as regular text - this is referred to as “escaping” a character. Other characters that may need escaping include “[”, “]”, even the slash itself requires escaping using a slash. “\\”.
- The dash “-” character generally doesn’t require escaping, although it does have special meaning when used to designate a character range within the square brackets. If a dash is used outside a character range statement then it will be interpreted as a normal character.
- If you want to ensure the regular expression only matches if the pattern covers the entire input you need to explicitly specify this by using ^ and \$, which mean match the start of the input and end of the input respectively.
- Regular Expressions can become very complex and testing them carefully to ensure they both accept and reject the correct input is important. It is also recommended to test the regular expressions on all applications used for data entry (i.e. both SilhouetteCentral and SilhouetteConnect).