SOPEO NOW · ERNOW

Door to discharge, every minute accounted for.

ER NOW runs the emergency department against one number: **walk-in to walk-out.** Every step clocked, every queue visible, every report automatic — so the average visit shrinks by design, not by luck.

CHECK IN → TRIAGE → TREAT → DISCHARGE FASTER

CLOCKED
DOOR-TO-DOCTOR & DOOR-TO-DISCHARGE
Measured live, not at month-end

LIVE
EVERY PATIENT, QUEUE & ZONE
Command centre · board · zones

AUTO
DAILY & MONTHLY REPORTS
By email, raw data on demand

HOW IT SHORTENS THE VISIT

Start the clock at the door

Patients **check themselves in** and get a live queue number — triage sees them the moment they arrive.

Pre-triage the risk in seconds

A **rapid pre-triage screen** — TEWS and pain scoring built in — flags the deteriorating patient before a triage slot opens.

Keep every queue moving

Triage, treatment and transfer queues, **colour-coded by waiting time** — and the command centre shows the whole floor to whoever can unblock it.

ONE PATIENT · DOOR → DISCHARGE · EVERY STEP TIMED

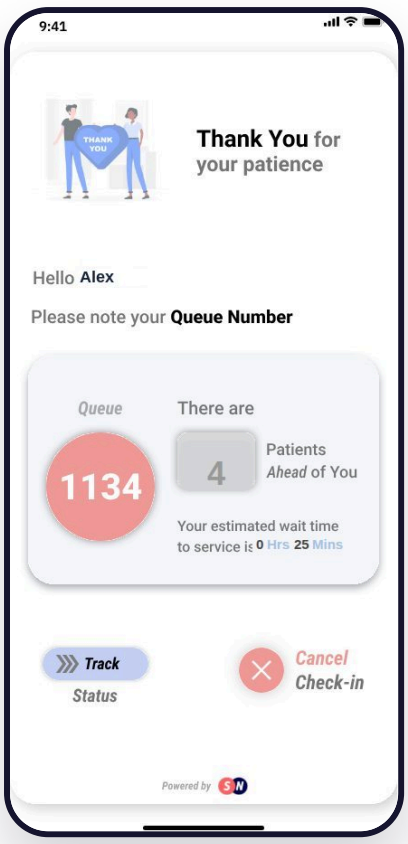
WALKS IN · CHECKED IN · TRIAGED · CONSULT · TREATMENT · DISPOSITION · DISCHARGED

S O P E O N O W · E R N O W

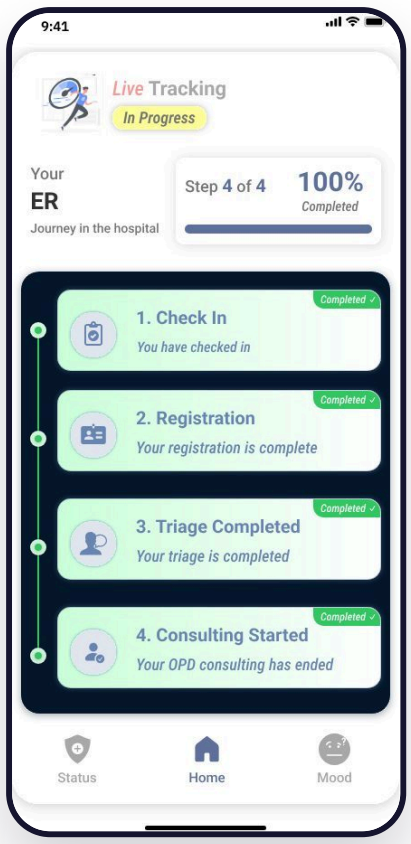
The visit clock starts at the door.
So does ER NOW.

An unregistered patient is still a waiting patient. ER NOW **starts the clock at minute one** — self check-in by phone, a live queue number, and triage that sees every arrival on sight.

SELF CHECK-IN & LIVE JOURNEY TRACKING



CHECK-IN · QUEUE Nº



TRACKING · STEP BY STEP

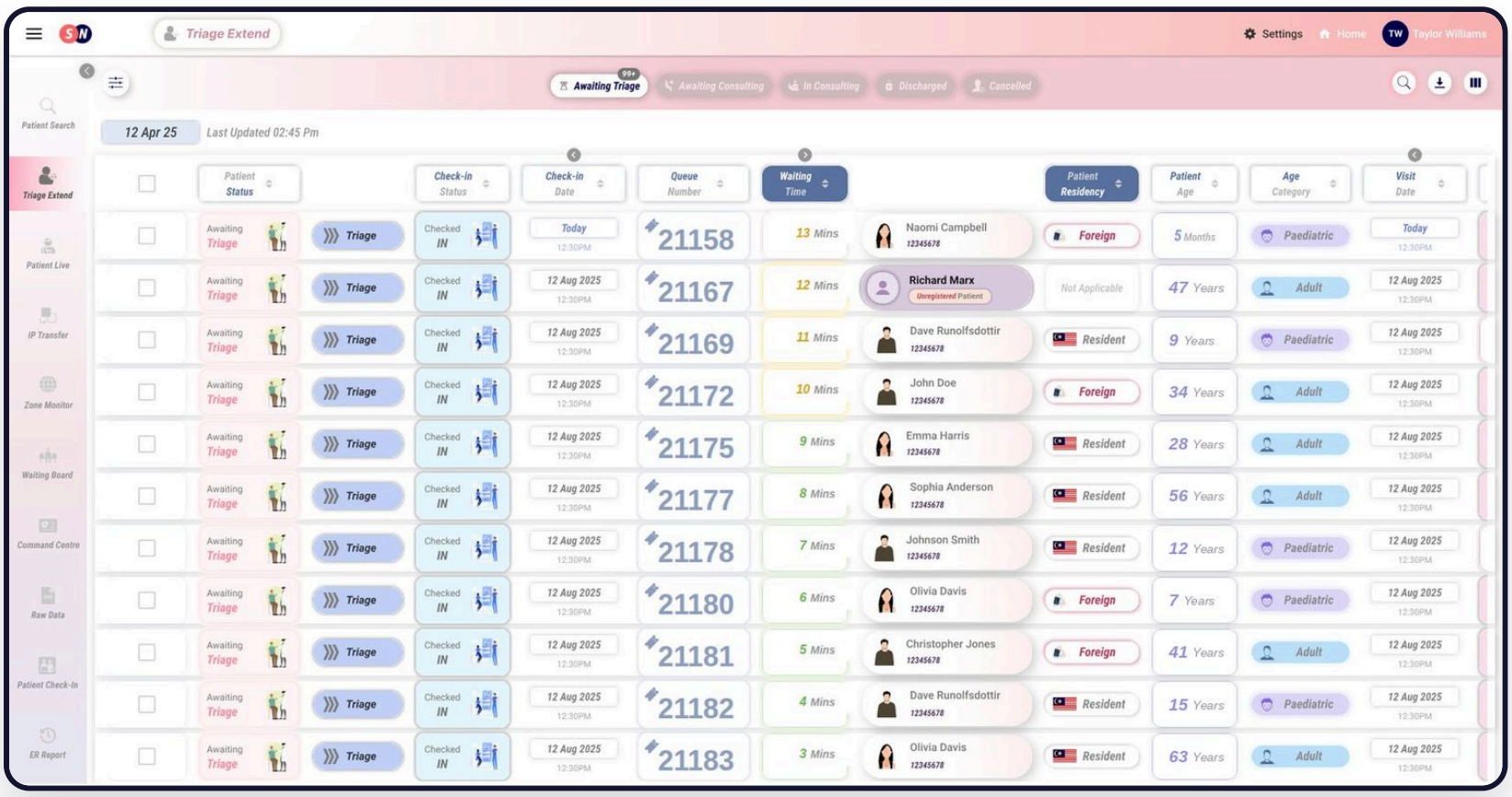
No desk. No clipboard. No mystery wait.

Walk-ins check in by phone and instantly see a **queue number, the patients ahead, and a live wait.** The app mirrors every step — so families stop asking "how much longer?" and the desk stops guessing.

SELF CHECK-IN
THE QUEUE STARTS BEFORE REGISTRATION DOES

LIVE WAIT
PATIENTS SEE THE SAME CLOCK THE ER RUNS ON

THE TRIAGE QUEUE



TRIAGE EXTEND · AWAITING TRIAGE · LIVE WAITING TIMES

Every arrival, one queue, zero blind spots.

The triage queue shows **who's waiting, how long, in what order** — waits that change colour as they grow. Unregistered walk-ins sit alongside registered patients, details ready before the nurse calls the name.

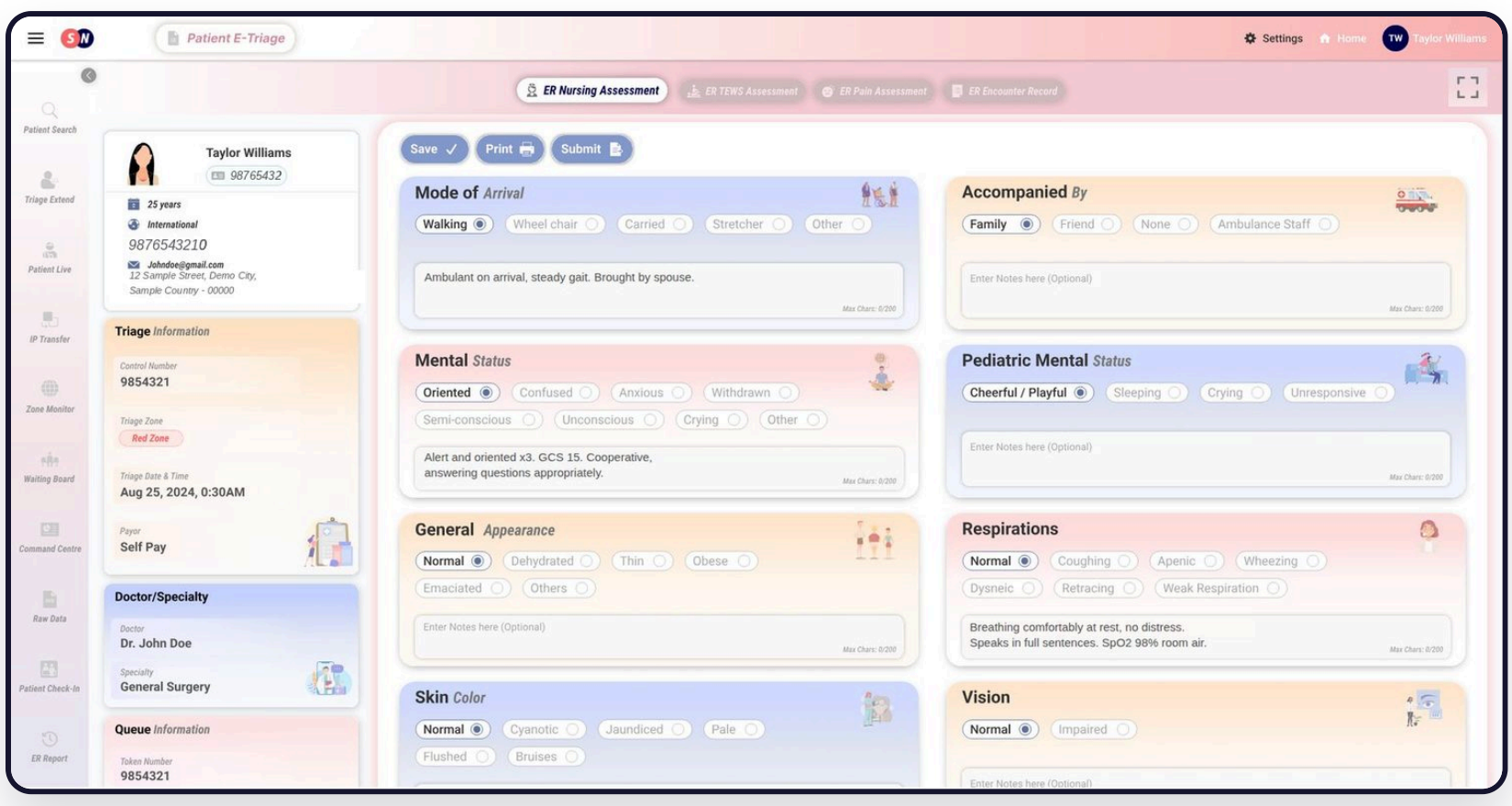
SLA → FLAGGED
WAITS PAST THE TRIAGE TARGET TURN RED — THEY CAN'T HIDE IN A LIST

SORT BY WAIT
THE LONGEST-WAITING PATIENT IS ALWAYS ON TOP

Sort the risk before the triage room is free. That's pre-triage.

The most dangerous minutes in an ER are the ones spent waiting to be triaged at all. **Pre-triage** is a fast, tap-through first look any nurse can run on the waiting room — the genuinely sick get flagged and bumped up the queue, so formal triage starts from a head-start, not a blank page.

PRE-TRIAGE · RAPID FIRST-LOOK ASSESSMENT



PRE-TRIAGE · RUN IT ON THE WAITING ROOM, BEFORE A TRIAGE SLOT OPENS

A 60-second screen that finds who can't wait.

Mode of arrival, mental status, respiration, skin — **each a single tap, so a whole waiting room screens in seconds per patient.** It flags the quiet emergency and re-orders the line, so the sickest patient isn't sitting fourth from the desk.

CATCH IT EARLY
SPOT THE DETERIORATING PATIENT BEFORE TRIAGE EVEN STARTS

HEAD-START
WHAT PRE-TRIAGE CAPTURES CARRIES STRAIGHT INTO FORMAL TRIAGE

TRIAGE EARLY WARNING SCORE (TEWS) · OBJECTIVE RISK SCORING

TEWS GRID · AGE- & HEIGHT-ADJUSTED · RED / YELLOW / GREEN ZONE

TEWS turns a hunch into a number.

The **Triage Early Warning Score** computes itself from the grid, age- and height-adjusted — so priority rests on an **objective score, not a gut call,** landing the patient in a colour-coded zone the whole floor reads the same way.

OBJECTIVE SCORE
THE GRID DOES THE MATH — NO TWO NURSES SCORE IT DIFFERENTLY

ZONE ASSIGNED
RED, YELLOW OR GREEN — ONE LANGUAGE THE WHOLE FLOOR READS

PAIN ASSESSMENT · WONG-BAKER FACES + NUMERIC SCALE

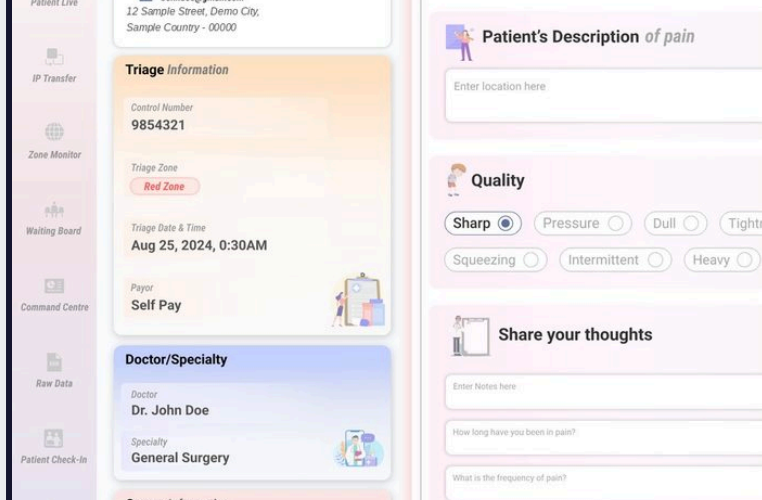
ONE PASS · WONG-BAKER FACES · 0–10 NUMERIC · QUALITY & HISTORY

Pain, captured in the same pass.

Wong-Baker faces and a numeric scale, side by side, with quality and history prompts — **a complete pain assessment in one pass,** signed by the RN and fed straight into the priority decision.

FACES + 0–10
WONG-BAKER AND A NUMERIC SCALE, SIDE BY SIDE

RN SIGNED
QUALITY AND HISTORY PROMPTS, CAPTURED IN THE SAME PASS



ONE-TAP HARDCOPY

And it all prints itself.

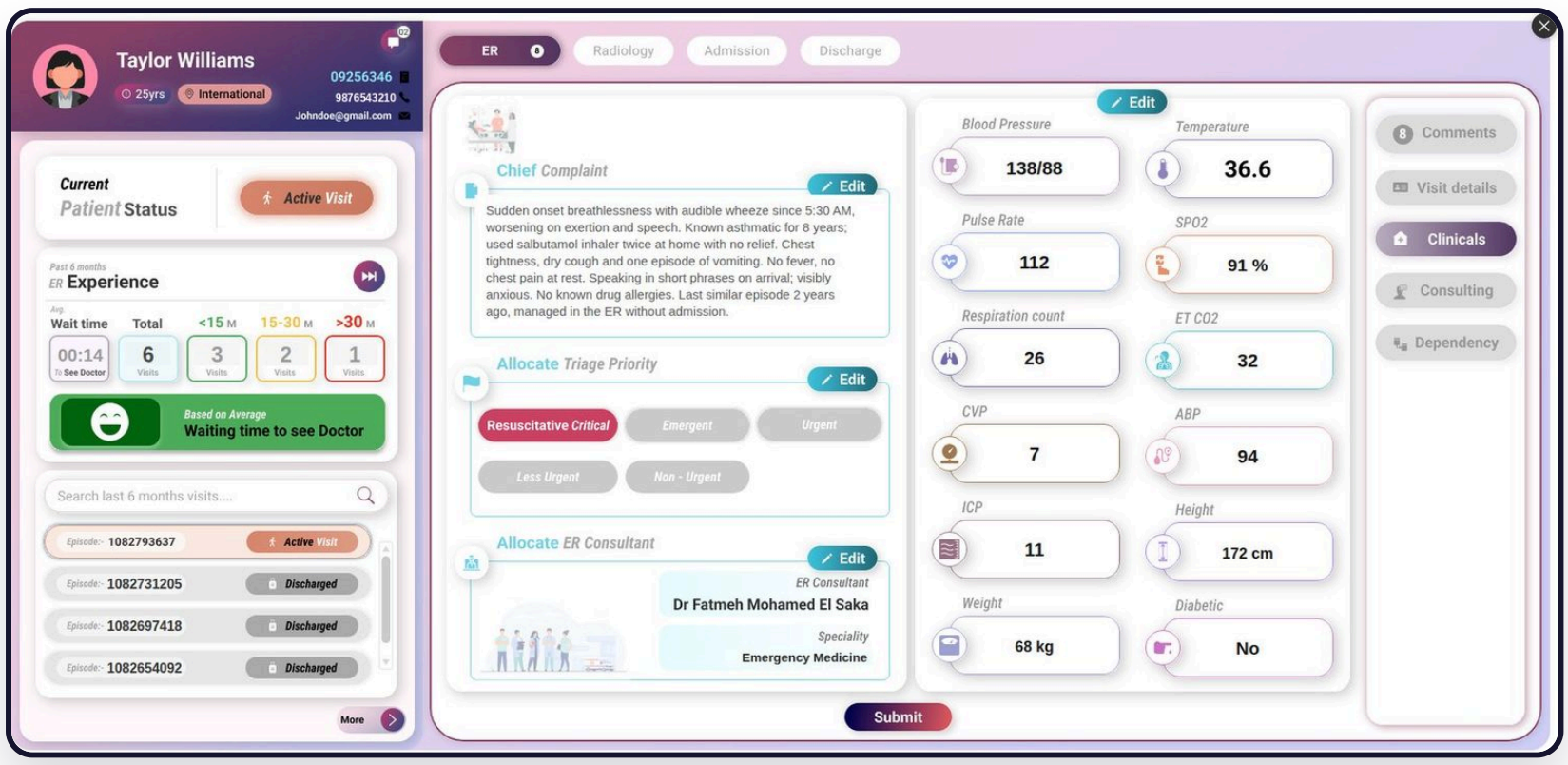
Every assessment — pre-triage, TEWS card, pain score — **prints as a clean, headed record in one tap,** ready for the file, the handover, or the payer. Captured once at the front gate, it carries into triage, consult and the daily report — **nobody re-types it at shift's end.**

The fast screen up front, the full paper trail to match.

While treatment runs, the chart keeps itself.

Once the consult starts, the visit usually disappears into verbal orders and memory. In ER NOW the console carries chief complaint, triage parameters and vitals to any device; consulting is **timestamped start to end;** and every order — radiology, lab — is tracked live from raised to closed.

THE PATIENT CONSOLE · CLINICALS



ANY DEVICE · CHIEF COMPLAINT · TRIAGE PRIORITY · VITALS

The story is on the screen before the doctor reaches the bed.

Chief complaint, triage priority, consultant and the full vitals panel — **readable on whatever the consultant is holding,** wall monitor, tablet or phone. The five-level priority re-allocates with one tap when the picture changes.

ANY DEVICE
THE CONSOLE FOLLOWS THE CONSULTANT, NOT THE DESK

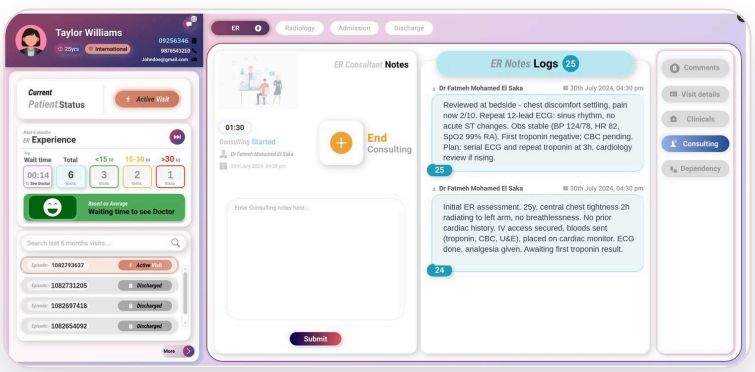
1-TAP PRIORITY
RESUSCITATIVE → NON-URGENT, EDITABLE AS THE PATIENT EVOLVES

CONSULT, CLOCKED

Start. Treat. End. All on the record.

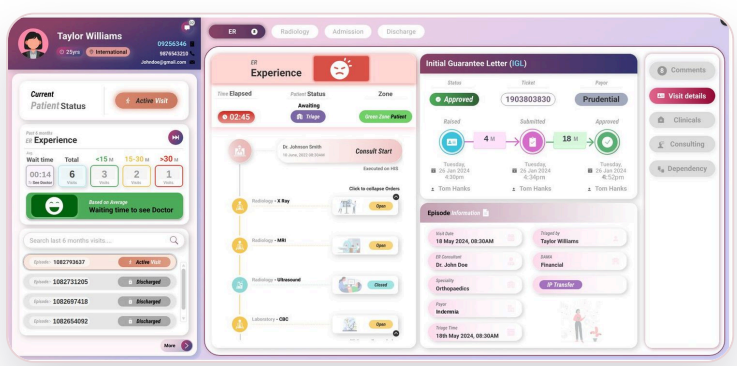
The consultant **starts and ends consulting with one button,** so door-to-doctor and consult duration become measured facts. Notes go into a running, timestamped log — every entry attributed and retrievable — not a paper scrap read at discharge.

25 notes on this visit? All of them in order, all of them signed.



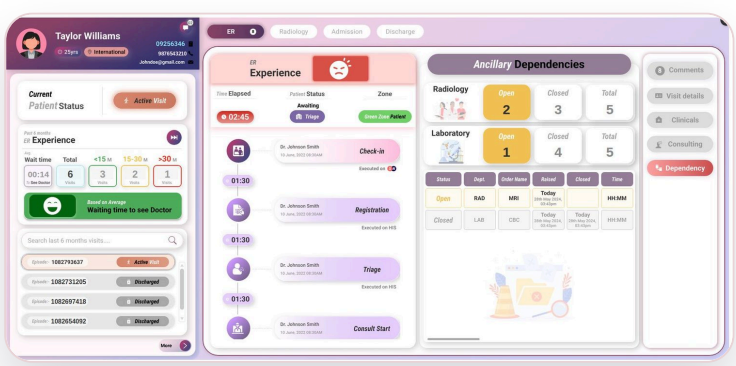
ER NOTES LOG · START / END CONSULTING

Every order on the visit timeline.



X-ray, MRI, ultrasound, CBC — every ancillary raised during treatment **appears on the patient's live timeline as open or closed,** next to check-in, triage and consult start. The consultant sees what the discharge is waiting on, at a glance.

Radiology & lab: open vs closed.

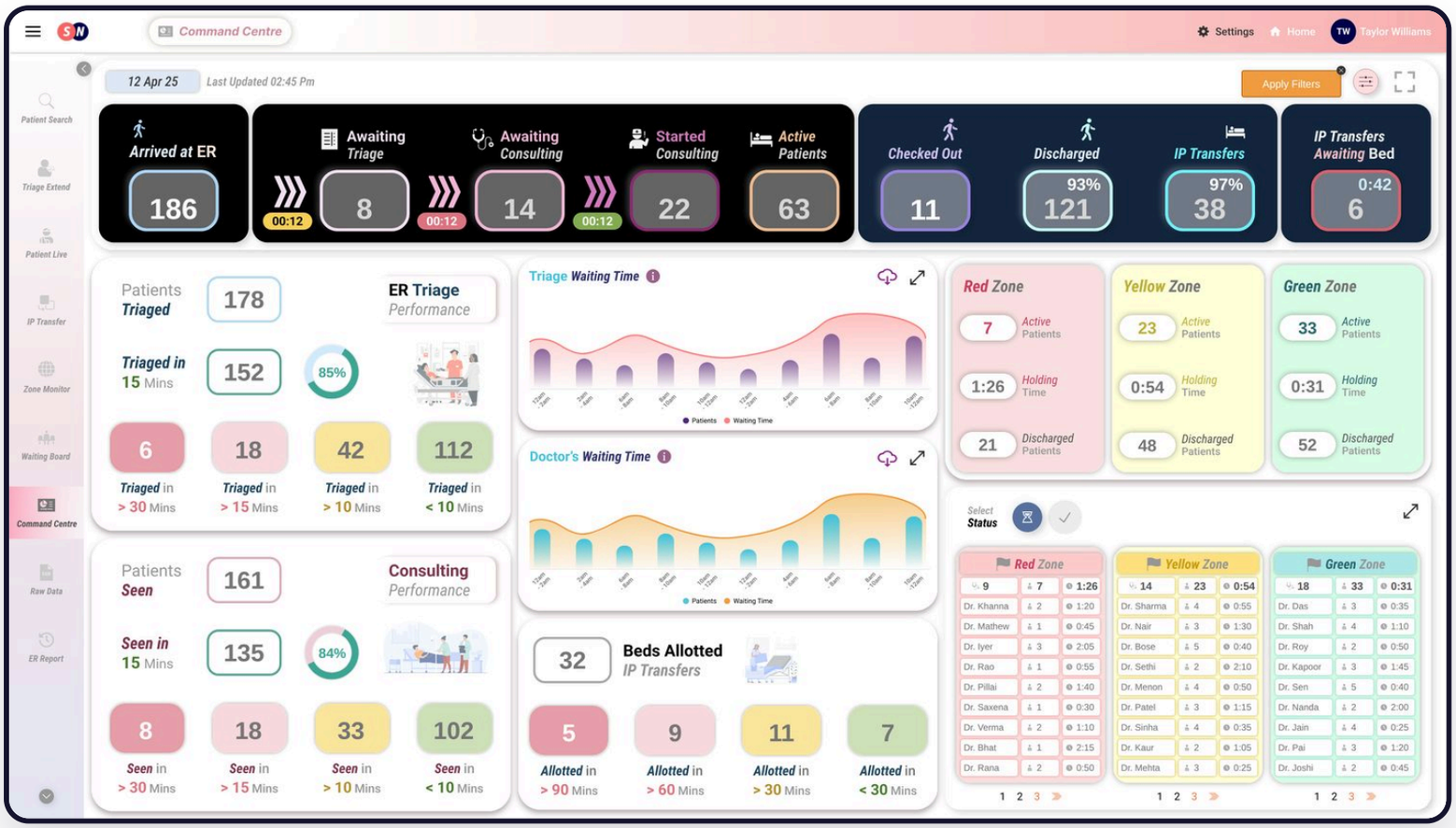


The dependency view totals it up: **how many radiology and laboratory orders are open, closed, and when each moved.** The longest pole in the tent stops being a surprise at hour three.

The whole ER, on one wall.

Average visit time is won and lost in the gaps between steps — invisible unless someone watches all of them. The command centre does, on one screen: arrivals, triage, consults, zones, discharges and transfers, live — with the curves and holding times that show *where* today's minutes are leaking.

ER COMMAND CENTRE · REALTIME OPERATIONS VIEW



ONE SCREEN · ARRIVED → TRIAGE → CONSULT → ZONES → DISCHARGE / IP TRANSFER

From "how's the ER doing?" to a number, instantly.

One screen carries the whole funnel — **arrived, awaiting triage, in consult, active, discharged, transferred** — with waiting-time curves, zone holding times and per-doctor loads. When triage starts slipping at 6 pm, it shows at 6 pm.

186 → 121
TODAY'S ARRIVALS AND DISCHARGES, LIVE ON THE BAND

RED / YEL / GRN
HOLDING TIME PER ZONE — THE BOTTLENECK HAS AN ADDRESS

Two boards for the wall.
Nobody waits unseen.

The command centre is the summary; these are the boards the floor lives on. The **waiting board** follows every patient through their lifecycle, escalating the ones running long. The **zone monitor** shows who's in red, yellow and green — how long, and whether a doctor is on them yet.

WAITING BOARD · LIFECYCLE, LIVE

AWAITING TRIAGE → CONSULT START → DISCHARGE · ELAPSED TIME ON EVERY CARD

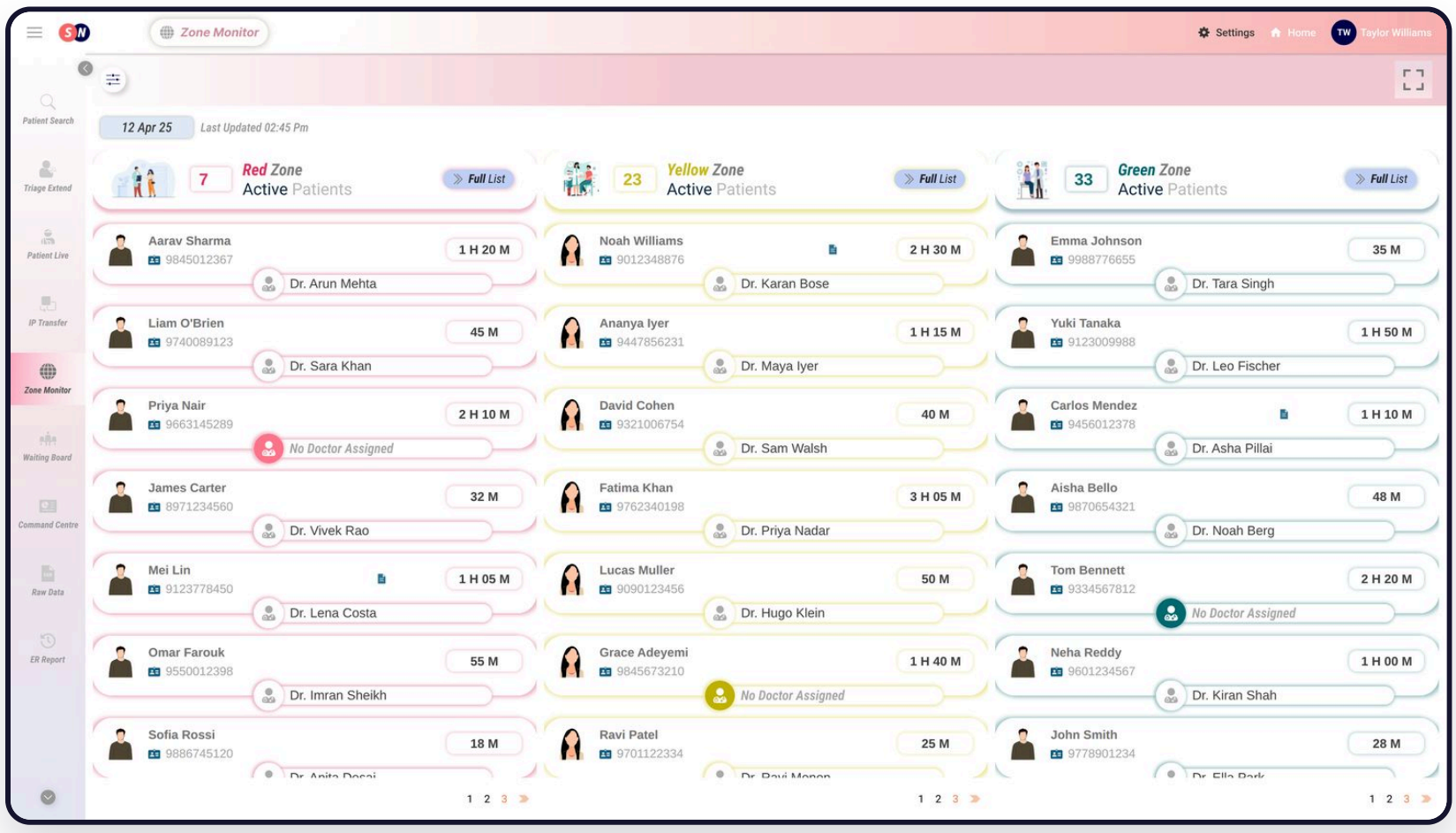
Every patient, every stage, with the clock running.

Three columns — awaiting triage, consult, discharge — each card carrying the patient and the **time spent at that stage.** The lifecycle bar fills as they move; patients running long **turn red and rise to the top,** so the board escalates them before anyone asks.

BREACH = RED
LONG WAITS SURFACE THEMSELVES — NO ONE HAS TO GO LOOKING

ALL 3 STAGES
ONE BOARD FROM ARRIVAL TO THE DOOR OUT

ZONE MONITOR · WHO, WHERE, HOW LONG



RED · YELLOW · GREEN · TIME-IN-ZONE + ASSIGNED DOCTOR ON EVERY PATIENT

NO DOCTOR?
AN UNMISSABLE FLAG WHEN A PATIENT HAS NO ONE ASSIGNED

TIME-IN-ZONE
HOW LONG EACH PATIENT HAS HELD A BED, PER ZONE

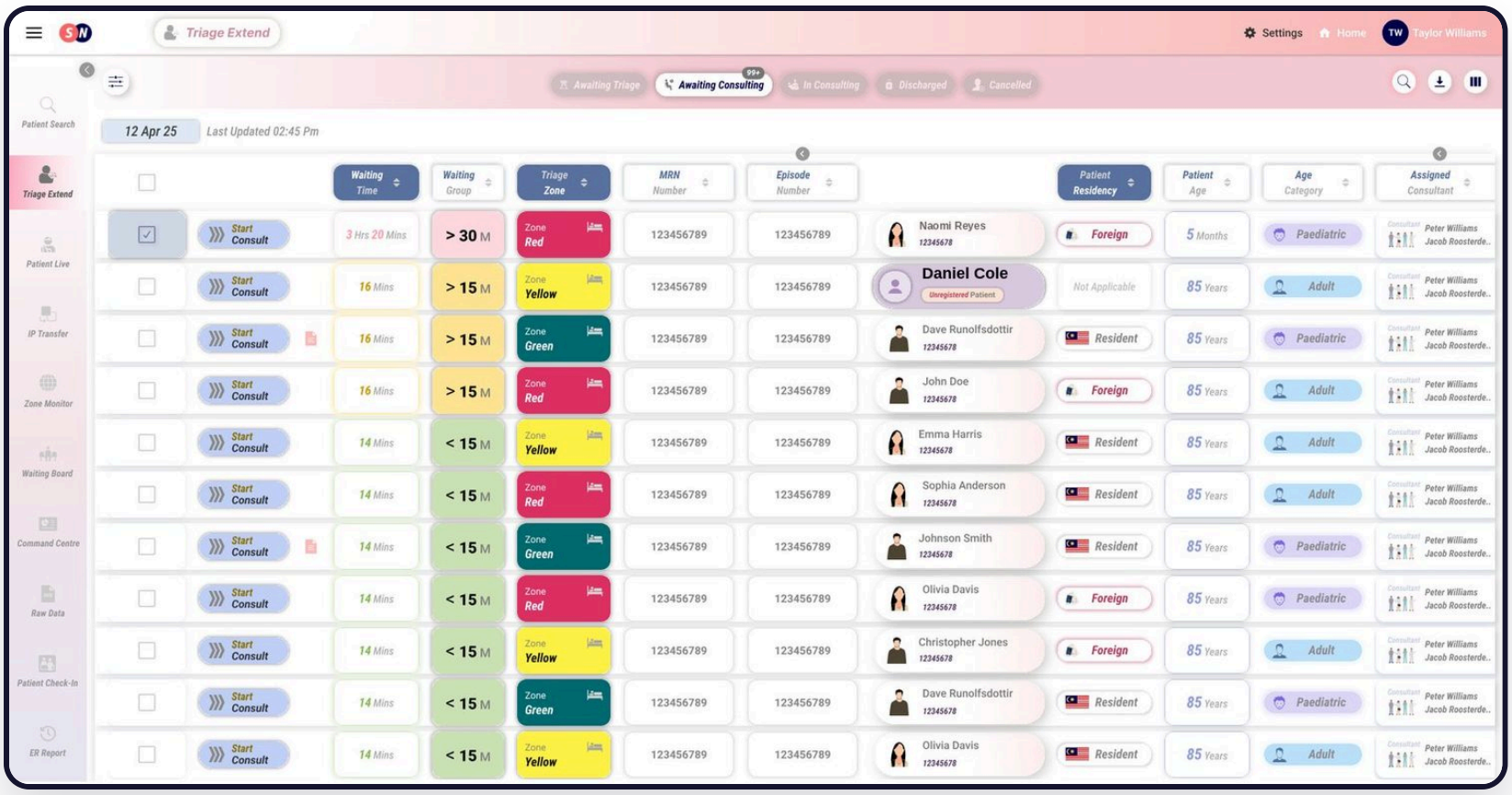
The acuity map, kept honest in real time.

Red, yellow and green zones, side by side, every patient showing **time-in-zone and the doctor assigned.** When someone sits with **no doctor assigned,** the card calls it out — so the gap that quietly stretches a visit is the one nobody can miss.

The exit is a queue too.
ER NOW runs it like one.

A patient waiting for a consultant, and a treated patient waiting for a bed, are the two longest silences in any ER. ER NOW gives both a visible, time-stamped queue — so boarding time stops being a quiet gap and becomes everyone's problem, because everyone can see it.

TREATMENT QUEUE · AFTER TRIAGE



AWAITING CONSULTING · START CONSULT IN ONE TAP · SORTED BY WAIT & ZONE

"Who's next?" answers itself.

On-duty consultants see everyone who's cleared triage, **sorted by waiting time and zone, with a Start Consult button on the row.** The 15-minute waiting-group flags make the next-patient call automatic — and auditable.

>15 MIN
WAITING GROUPS FLAGGED BEFORE THEY BECOME COMPLAINTS

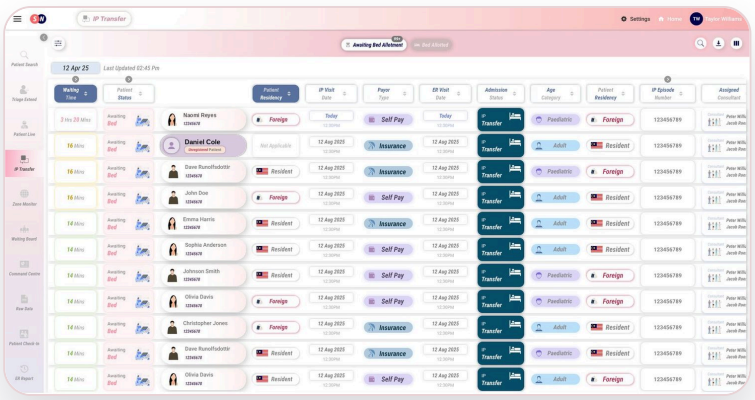
1 TAP
START CONSULT FROM THE QUEUE — THE CLOCK NOTES WHO AND WHEN

INPATIENT TRANSFER QUEUE

Boarding, with a stopwatch on it.

Every ER-to-inpatient transfer waits in one queue — **patient, payor, admission status and time waiting for a bed** — visible to the ER and the wards alike. When bed allotment is the bottleneck, the queue proves it in minutes, not anecdotes.

Beds allotted flow back onto the command centre, so the loop closes in real time.



AWAITING BED · TIME WAITING · PAYOR

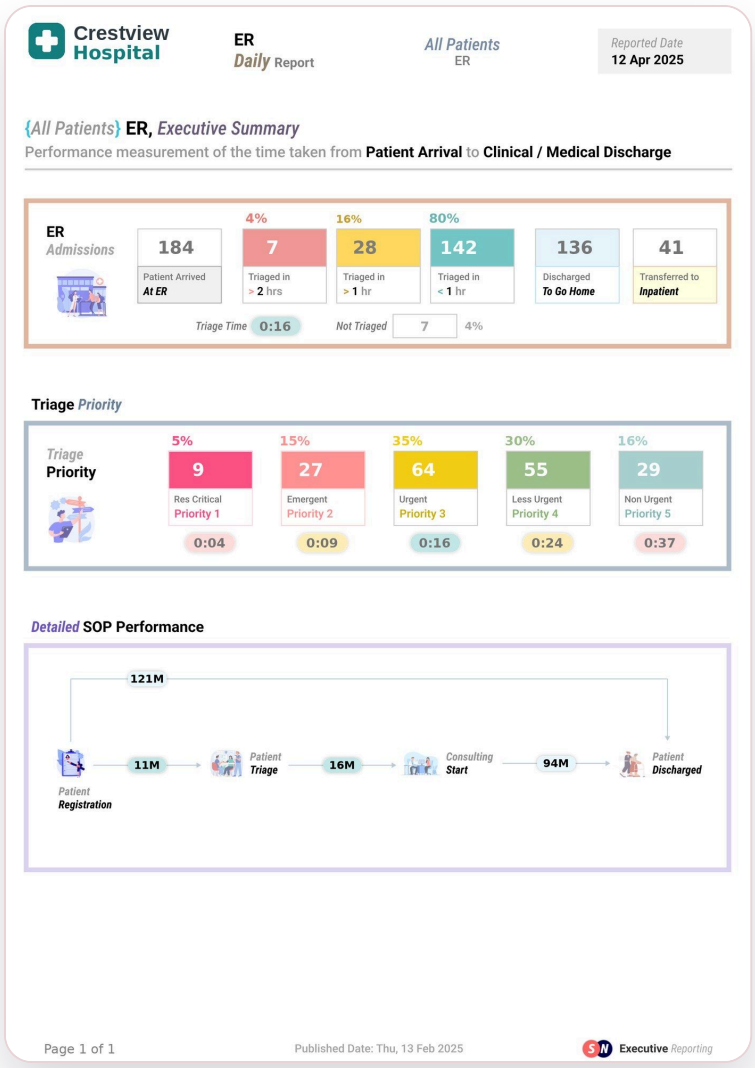
Discharged home
Medically cleared and out — the visit clock stops, and the minutes go into tonight's report.

Admitted to a bed
Into the transfer queue, tracked until allotment — boarding time measured, not estimated.

Every minute counted
Whichever way the visit ends, the full door-to-discharge timeline is already on the record.

Yesterday's ER in your inbox, before today's first patient.

What gets measured all day gets reported overnight. Stakeholders get the ER's performance automatically — daily for the past day, monthly for the past month — built around the one number this product exists to shrink: **arrival to clinical discharge.** Need more? The raw data is one click away.



DAILY E-MAIL · ARRIVAL → DISCHARGE · SOP TIMINGS

AUTOMATED REPORTS TO EMAIL

The executive summary writes itself.

Admissions, triage within 1 hour, discharges home vs inpatient, the five-priority mix, and the **step-by-step SOP timings — registration → triage → consult → discharge —** land in inboxes daily and monthly, with no one compiling a thing.

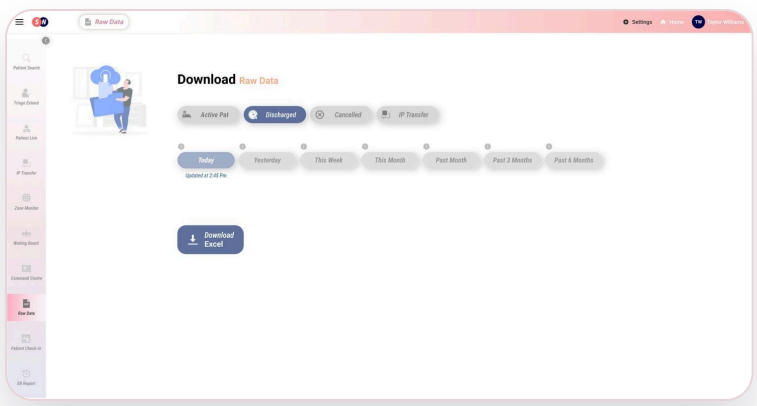
DAILY
YESTERDAY'S FULL ER PERFORMANCE, EVERY MORNING

MONTHLY
THE PAST MONTH, DELIVERED ON THE 1st — AUTOMATICALLY

RAW DATA, ONE CLICK

Your analysts get the whole table.

Active, discharged, cancelled and IP-transfer datasets export to Excel for **any window from today to the past six months** — your own dashboards, your own auditors, your own questions. ER NOW measures everything; it hides nothing.



One objective: get patients home sooner. Every feature here pulls in that direction.

From the front door to the morning report, the work is the same: find minutes — in the queue, in triage, in the consult, in the lab, at the bed desk — and give them back to the patient. Put the clock on the wall, and watch the average fall.

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