Sandoval County Fire Department

Patient Care Reporting Manual

Rescue Bridge/Field Bridge Version

January 2014

Version 1.0

Dear Sandoval County Emergency Medical Services Provider,

This manual is the result of a vision to make EMS reporting easier for our personnel. Quality EMS report writing is an important component in our provision of high quality EMS services. EMS reporting is critically important and helps us maintain our current levels of funding. Most of the information from our incident reporting system is uploaded into a National Database called NEMSIS (National EMS Information System). NEMSIS allows EMS researchers to evaluate the types of calls we respond to and their outcome. This manual has been designed for ease of use and to make your life easier when completing reports. This manual will especially help you if you do not write EMS reports on a regular basis. I would like to thank Lieutenant Charlie Molinari for his help in the concept phase of this manual and Deputy Chief/ Fire Marshal, Eric Masterson writing and completing this manual.

If you have feedback on this manual please e-mail emasterson@sandovalcountynm.gov

Sincerely,

James Maxon
Fire Chief
Sandoval County

Introduction

Beginning in 2009, Sandoval County Fire Department (SCFD) transitioned all Fire Districts Fire and EMS reporting to its own Rescue Bridge in conjunction with the City of Rio Rancho. Sandoval County and the City of Rio Rancho split the cost of the system setup allowing for significant savings for each agency. Sandoval County Fire Department Career Staff converted to the Rescue Bridge July 1, 2012. This software is an Image Trend product purchased by SCFD with the intention of improving all reporting system-wide. This document covers patient care reporting. Fire reporting is covered in a separate document.

The Rescue Bridge (covered in this manual) is comprised of two distinct functions. Primarily, the Rescue Bridge is an internet-based software that can be accessed by visiting https://www.rescuebridge.com/riorancho/. From this website, users can log in using their issued credentials to check messages, create new fire and/or EMS reports, inventory equipment, capture activity and training hours, and run agency reports. The Rescue Bridge, as it is referred, is the primary method of completing all SCFD Fire Incident Reports.

Secondly, Field Bridge (covered in a different manual) is a function of the Rescue Bridge that has been loaded onto laptop computers strategically placed throughout SCFD for in-the- field use. The Field Bridge is software that is loaded onto these machines so that EMS reports can be completed while outside of Internet connectivity, on incident scenes, while transporting patients and while at hospital facilities. The Field Bridge is the primary method for capturing all SCFD EMS Incident Reports for career staff and a few of its districts.

It is the responsibility of the provider to synchronize the Field Bridge computer after an incident report has been captured in order load the incident information into the Rescue Bridge database. This SCFD Patient Care Report Manual is intended to walk a member through the steps necessary to create and complete a patient care report using the Field Bridge with all required information. All sections are separated by "Tab" noting the different sections of information to be documented by the software.

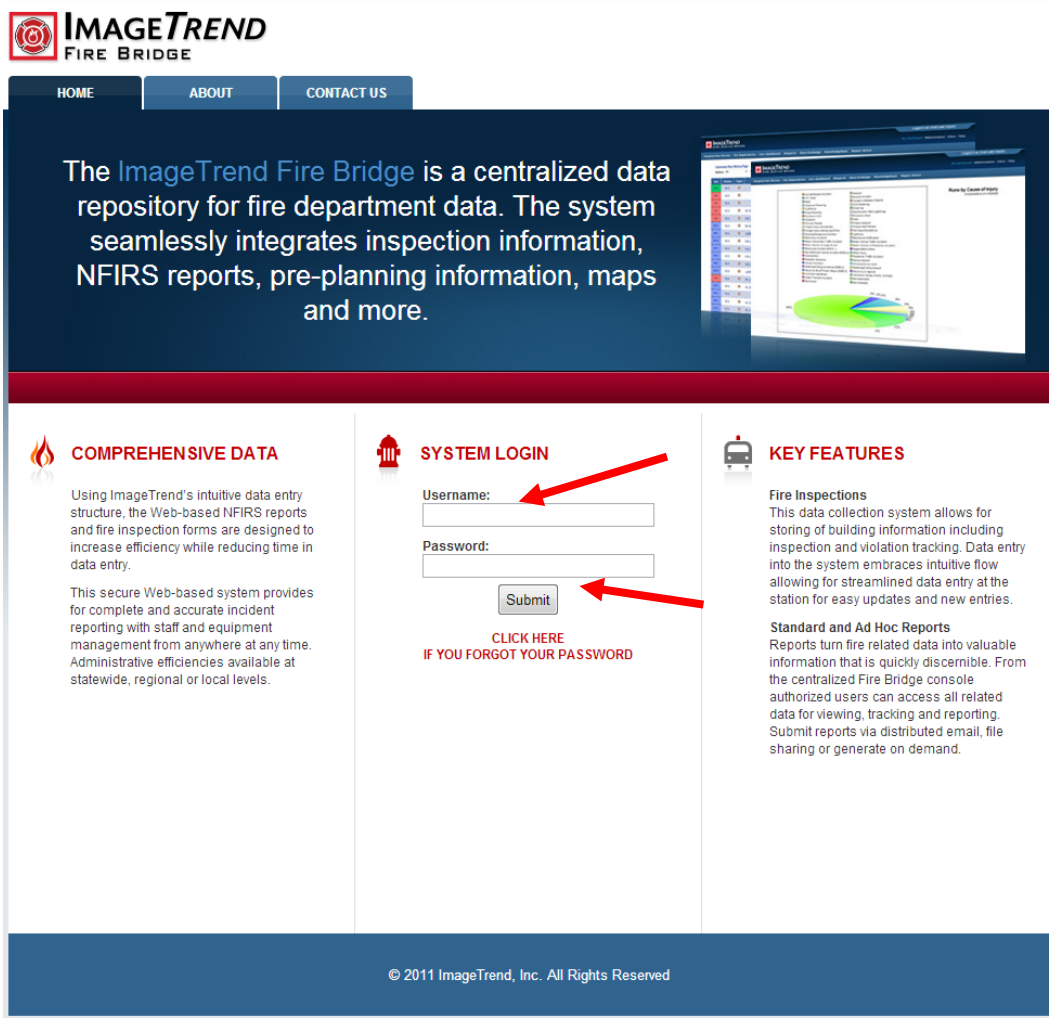
How to use this manual

- This manual is designed for patient care reporting on the online system
- Each member shall be familiar with all pages of this document
- The first few pages are for anytime a member logs into the system to generate a report
- Once a disposition has been selected in the Dispatch info page, only the requirements for that disposition will be visible.
- Refer to page 13 – 15 as they will show the user what tabs are required for each disposition
    - Each tab will have a page number associated with it that will direct the user to the page with instructions on that section of the patient care report
- Always ensure to Save your reports as often as possible
- Should you ever encounter any issues, use helpdesk or email emasterson@sandovalcountynm.gov
    - **Do not contact Image Trend Directly**

LOGGING IN AND USING RESCUE BRIDGE

- Two ways to get to Image Trend Rescue Bridge
  - https://www.rescuebridge.com/riorancho/default.cfm?page=login
    - Direct Link
  - Or Two; Google Rio Rancho Fire Bridge and click the first option
- The main page is displayed with some information as well as the System Login
  - Across the top, there are three tabs
    - HOME – This is the Login Page
    - ABOUT – Gives users an overview of Image Trend
    - CONTACT US – Allows users to contact Image Trend
      - This shall not be used by any field personnel
        - Follow your chain of Command with any issues
        - Send a helpdesk with issues if possible
        - Or, email emasterson@sandovalcountynm.gov with issues
          - Use email as last resort
  - **Login using your username and password**.
    - Use the 'CLCIK HERE' icon if you cannot remember your password and follow the prompts
      - If you continue to have issues logging in, use your chain of Command, Helpdesk, or, as last resort, email emasterson@sandovalcountynm.gov

- Once logged in, a privacy form from Image trend is presented, read the document and select '**Yes**' to agree to the document and proceed.
  - This document will display each time the user logs in.


IMAGETREND
FIRE BRIDGE
HOME
ABOUT
CONTACT US
The ImageTrend Fire Bridge is a centralized data repository for fire department data. The system seamlessly integrates inspection information, NFIRS reports, pre-planning information, maps and more.
COMPREHENSIVE DATA
Using ImageTrend's intuitive data entry structure, the Web-based NFIRS reports and fire inspection forms are designed to increase efficiency while reducing time in data entry.
This secure Web-based system provides for complete and accurate incident reporting with staff and equipment management from anywhere at any time. Administrative efficiencies available at statewide, regional or local levels.
SYSTEM LOGIN
Username:
Password:
Submit
CLICK HERE
IF YOU FORGOT YOUR PASSWORD
KEY FEATURES
Fire Inspections
This data collection system allows for storing of building information including inspection and violation tracking. Data entry into the system embraces intuitive flow allowing for streamlined data entry at the station for easy updates and new entries.
Standard and Ad Hoc Reports
Reports turn fire related data into valuable information that is quickly discernible. From the centralized Fire Bridge console authorized users can access all related data for viewing, tracking and reporting. Submit reports via distributed email, file sharing or generate on demand.
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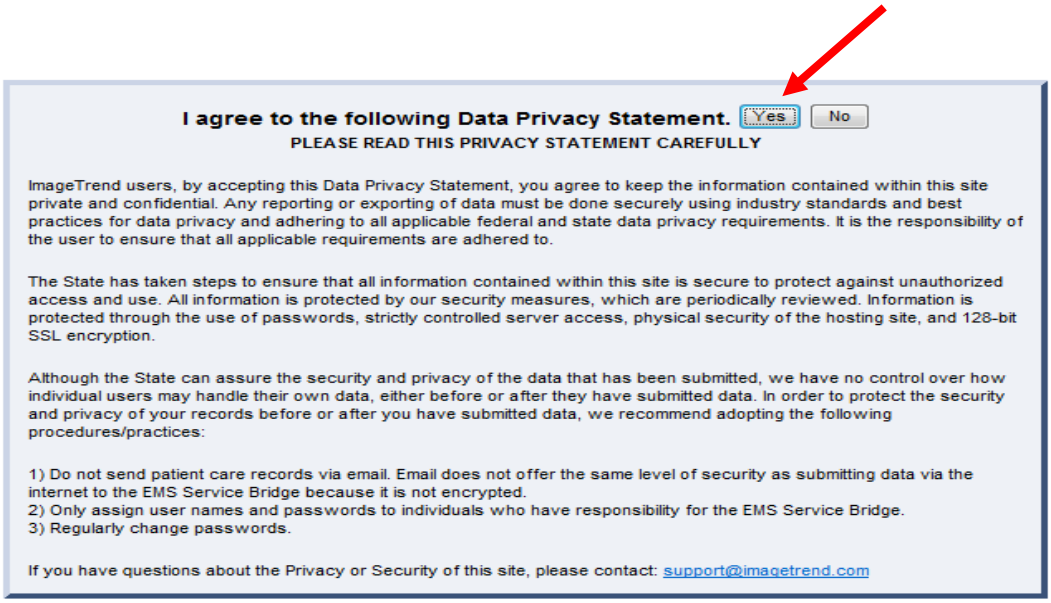
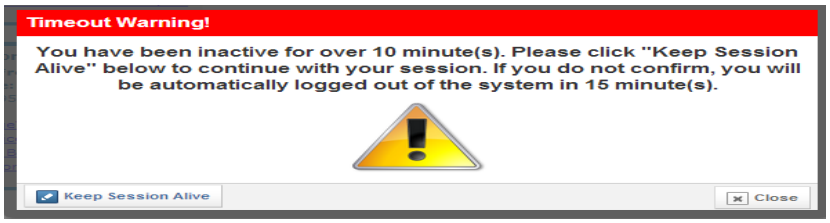
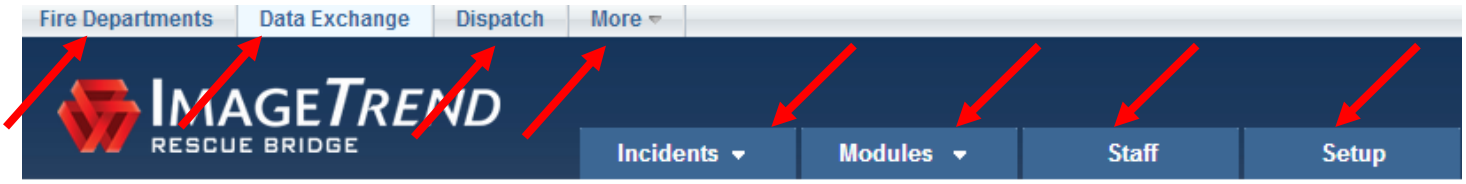

I agree to the following Data Privacy Statement.
Yes
No
PLEASE READ THIS PRIVACY STATEMENT CAREFULLY
ImageTrend users, by accepting this Data Privacy Statement, you agree to keep the information contained within this site private and confidential. Any reporting or exporting of data must be done securely using industry standards and best practices for data privacy and adhering to all applicable federal and state data privacy requirements. It is the responsibility of the user to ensure that all applicable requirements are adhered to.
The State has taken steps to ensure that all information contained within this site is secure to protect against unauthorized access and use. All information is protected by our security measures, which are periodically reviewed. Information is protected through the use of passwords, strictly controlled server access, physical security of the hosting site, and 128-bit SSL encryption.
Although the State can assure the security and privacy of the data that has been submitted, we have no control over how individual users may handle their own data, either before or after they have submitted data. In order to protect the security and privacy of your records before or after you have submitted data, we recommend adopting the following procedures/practices:
1) Do not send patient care records via email. Email does not offer the same level of security as submitting data via the internet to the EMS Service Bridge because it is not encrypted.
2) Only assign user names and passwords to individuals who have responsibility for the EMS Service Bridge.
3) Regularly change passwords.
If you have questions about the Privacy or Security of this site, please contact: support@imagetrend.com

- The Main page is then displayed
  - Once Logged in, an internal timer begins to work, if the user becomes dormant and does not utilize the program, it will automatically sign out at the 15 minute marker of no use; a **warning** is given at the 10 minute mark. As long as the user is active, this will not occur.



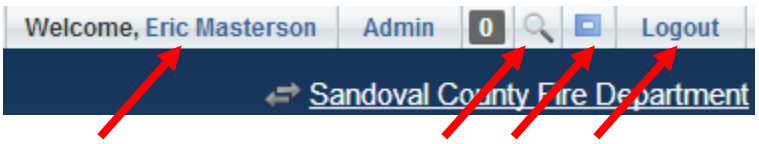
  - Numerous options, tabs, dropdowns and information is presented
    - Along the Top of the Page

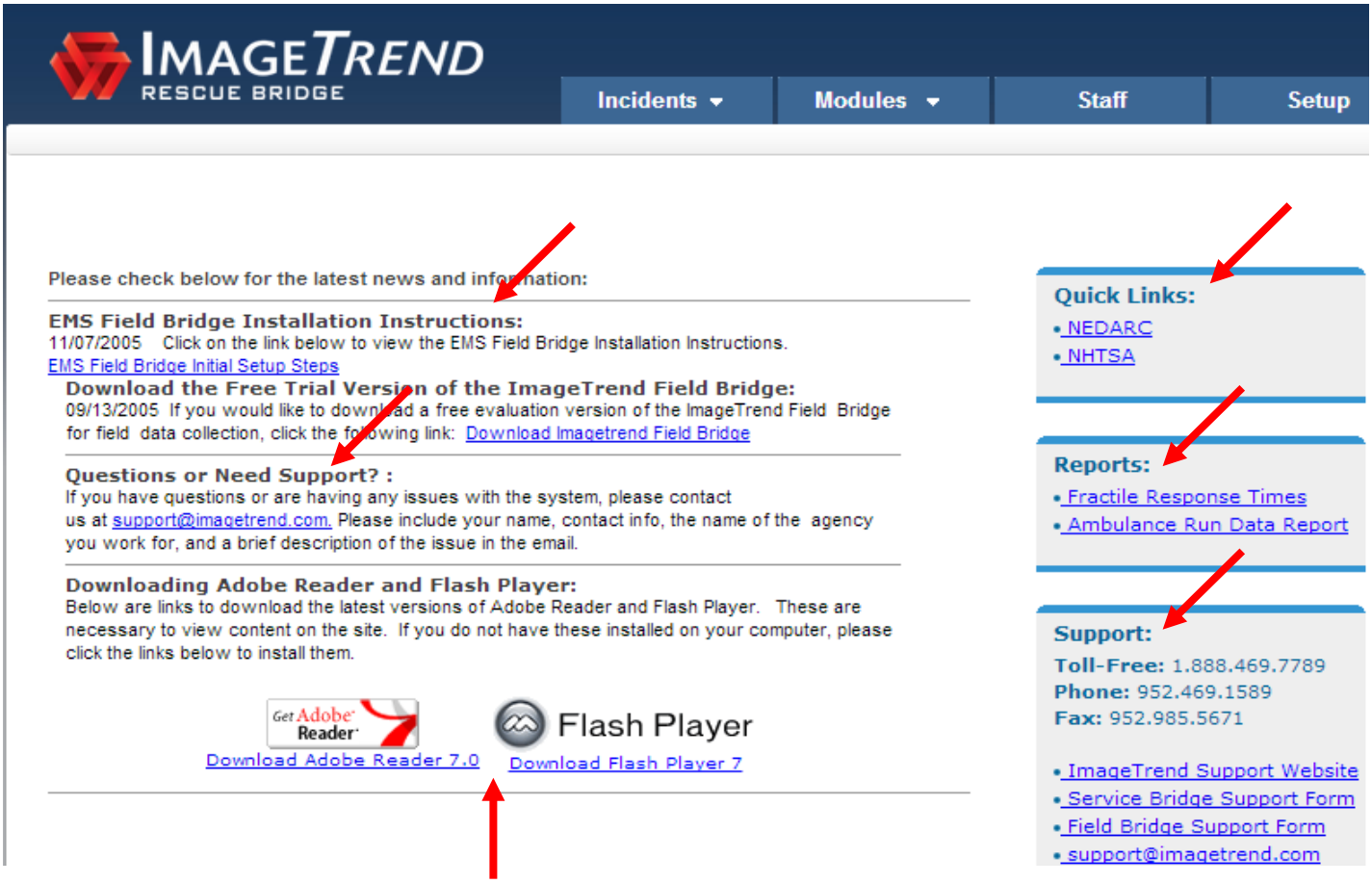


- **Fire Departments**
  - For use by Image Trend Personnel only, does not work for our users, will only return you to the home page
- **Data Exchange**
  - May be utilized in the future but is currently not in use by field personnel
- **Dispatch**
  - Will pull up CAD information from dispatch for the user to reference if needed
    - Cannot change any information on this page
- **More**
  - Numerous selections present themselves for the user to utilize
    - Please see Appendix _____ for direction on this section

  - The Next Row, tabs next to the Image Trend Logo
    - Two to Four dropdowns are presented (depending on permissions that have been set for you)
      - **Incidents** – See below for direction
      - **Modules**
      - **Staff** (if applicable)
      - **Setup** (if applicable)
    - For Directions involving the Modules, Staff and Setup tab, see Appendix _____

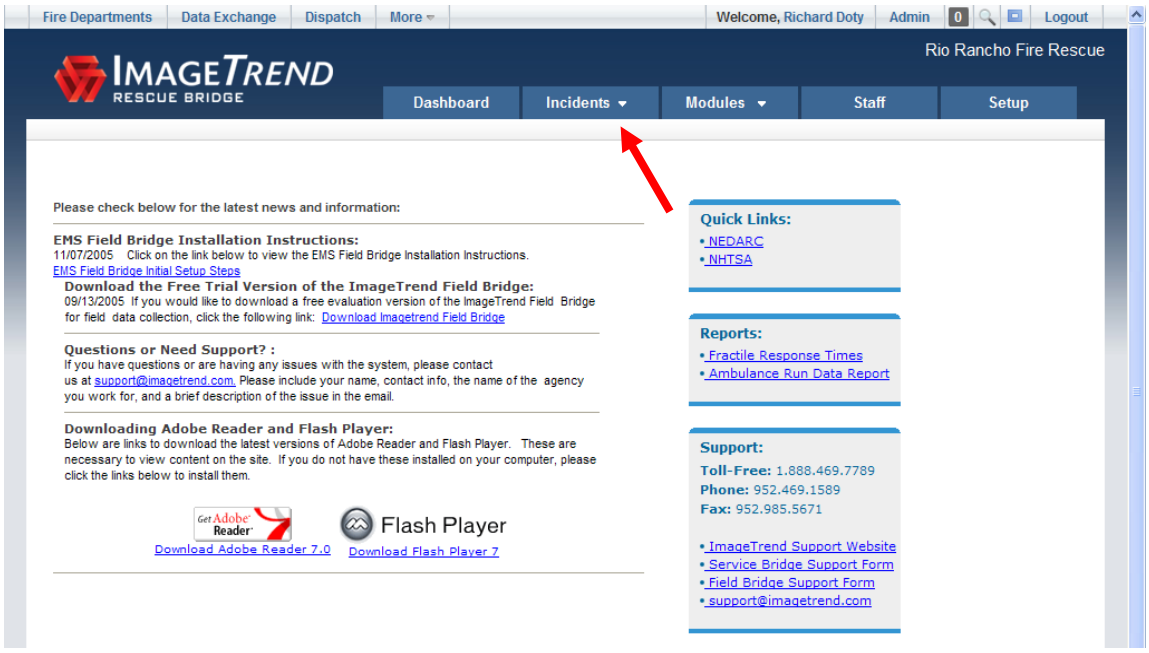
  - Additional options presented
    - Far upper right displays your **name**, a **magnifying glass** for search options, **a square icon** which removes some tabs on the page and the **Logout** tab to be utilized when the user is finished with utilization of the current session.

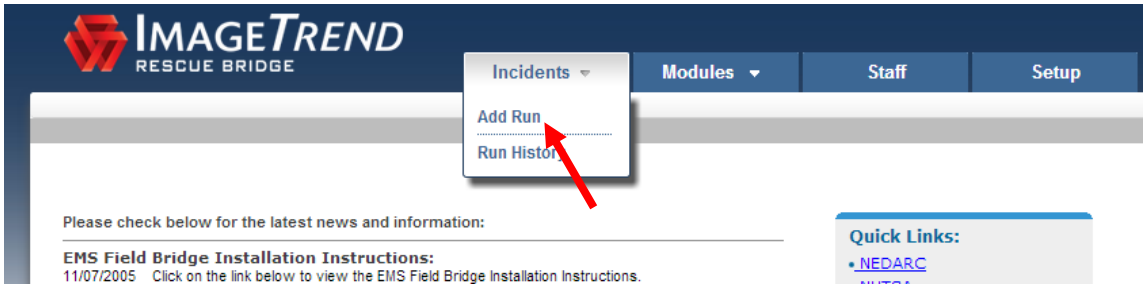


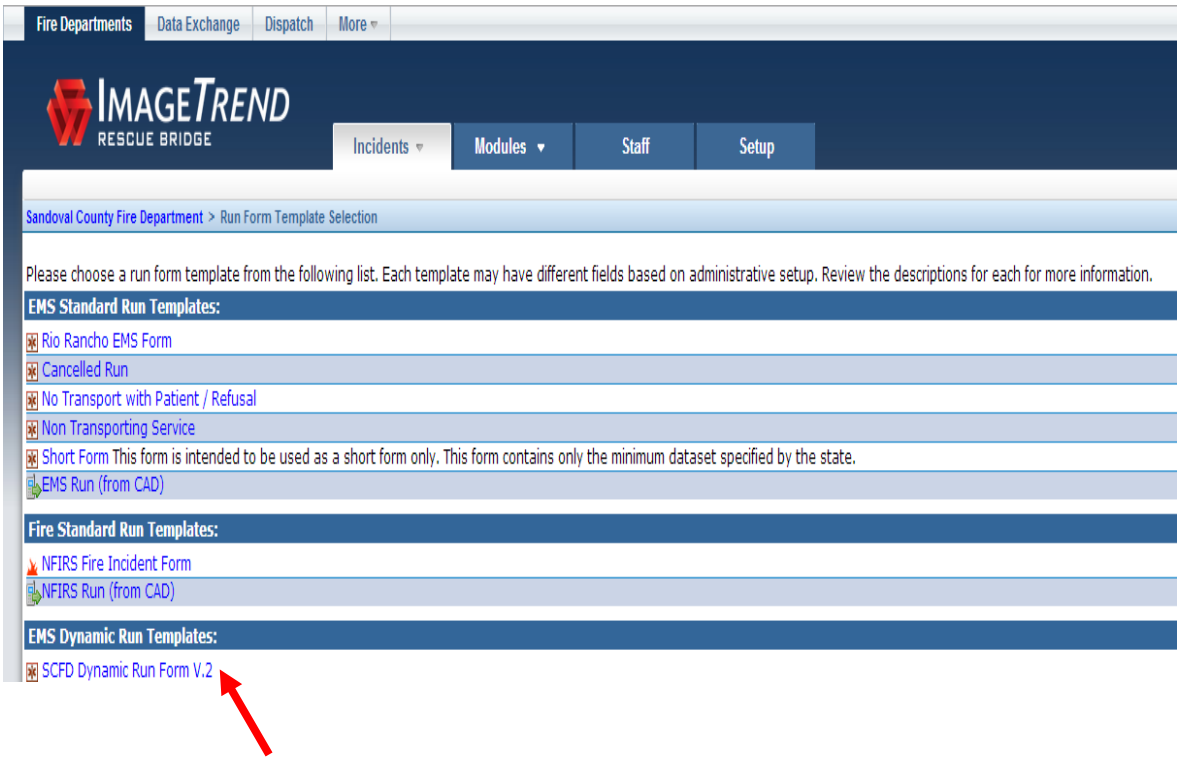


- **Quick Links**
  - NEDARC – A resource for Child EMS resource site for users to explore if they wish
  - NHTSA – National Highway Traffic Safety Administration website for users if they wish
- **Reports**
  - Fractile Response Times
    - Can be used to gather statistics for users if needed
  - Ambulance Run Data Report
    - Can be used to gather statistics for users if needed
- **Support**
  - Gives users phone and email options to contact Image trend with concerns or issues
    - Do not use this option
      - Use your chain of command, helpdesk or email emasterson@sandovalcountynm.gov
- Along the left
  - **EMS Field Bridge Instructions**
    - Gives users options to download Field Bridge on a device
      - Utilize chain of command before downloading as licenses may need to be purchased for additional usages with this format.
  - **Questions or Need Support**
    - Gives users the option to send an email with concerns to Image Trend
      - Do not use this option
        - Use your chain of command, helpdesk or email emasterson@sandovalcountynm.gov
  - **Downloading Adobe Reader and Flash Player**
    - Gives the User a direct link to free downloads of those two software programs that are needed to utilize Image Trend

To ENTER A NEW EMS RUN



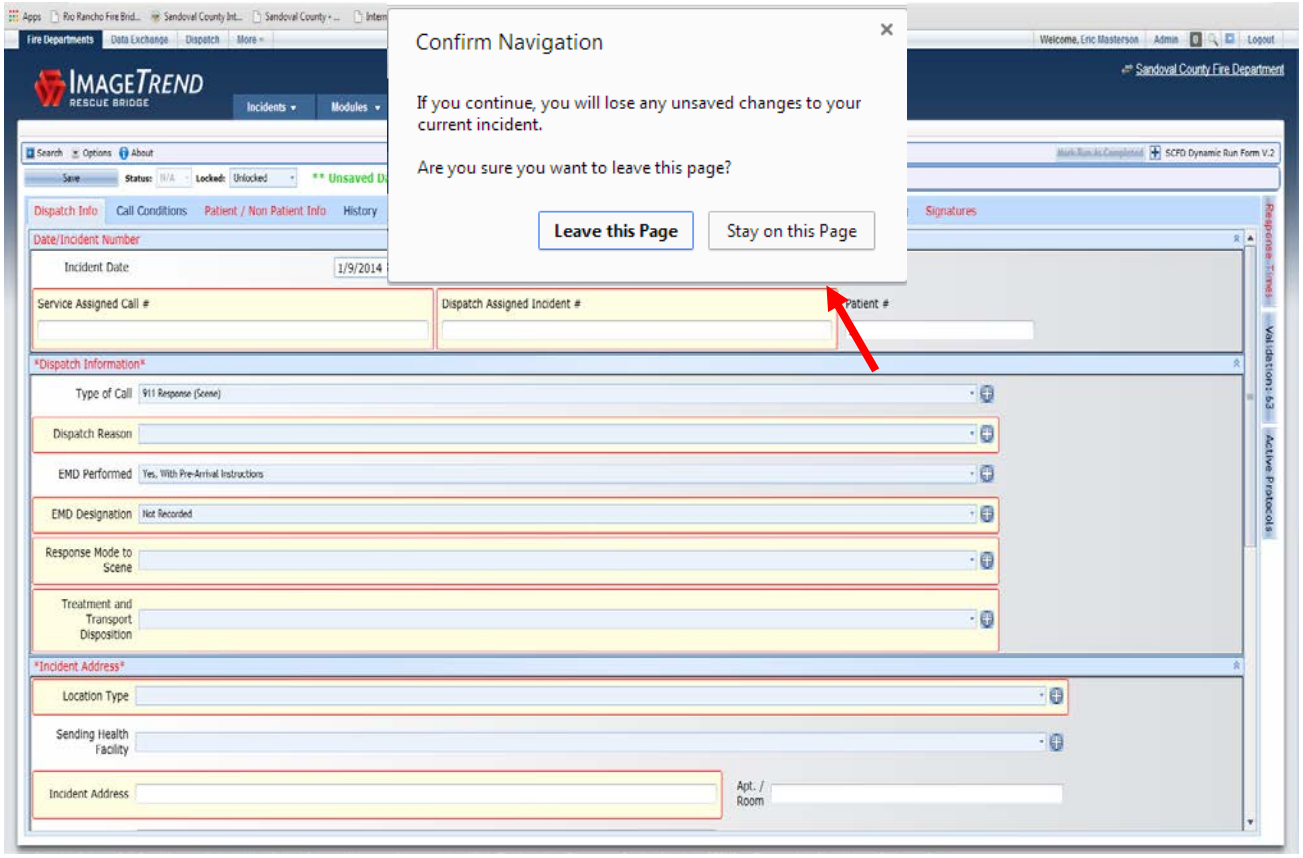


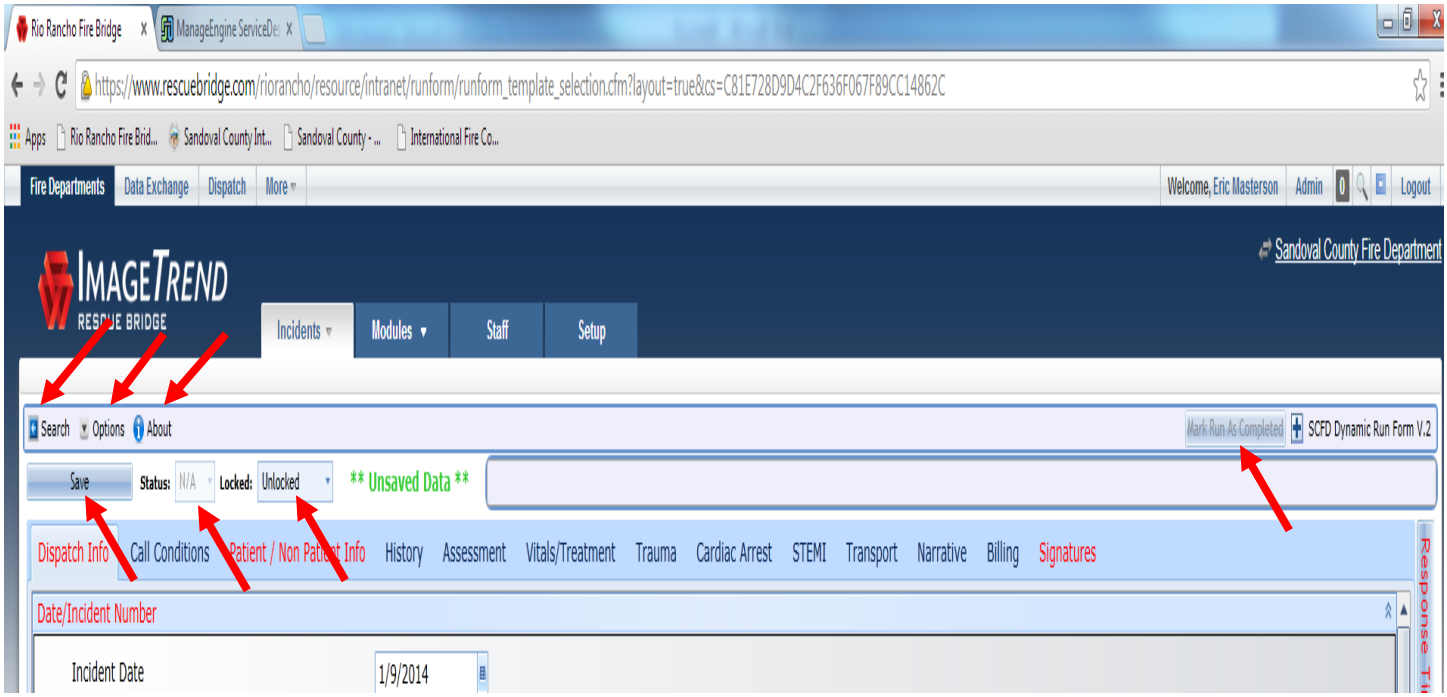


✱ From the Main Home Page drag the cursor over the **Incidents** tab

- Select **Add Run**
  - Run History can by utilized by the user if a call needs to be referenced or changed at a later date
- Select **SCFD Dynamic Run Form V.2** for **ALL EMS CALLS**
  - If additional options for EMS reporting are present, such as 'Short Form' or 'Cancelled Run', do not use them, the SCFD Dynamic Run Form encompasses these forms to ensure all users are using the same form
  - Refer to the Image Trend Fire Manual for directions on using the Fire reporting systems

- Once the New Run loads, numerous options are presented above the ePCR
  - Any option that requires the user to move away from the ePCR will **prompt the user to confirm that request** before leaving the page with potentially unsaved data.
    - Always ensure your data is saved before moving to another section
      - There is an 'Auto Save' Feature that will save your information as you go from one tab to another, however, if you leave your computer and do not save the information prior to leaving, the system may log you out and any info that was on that page may be lost.

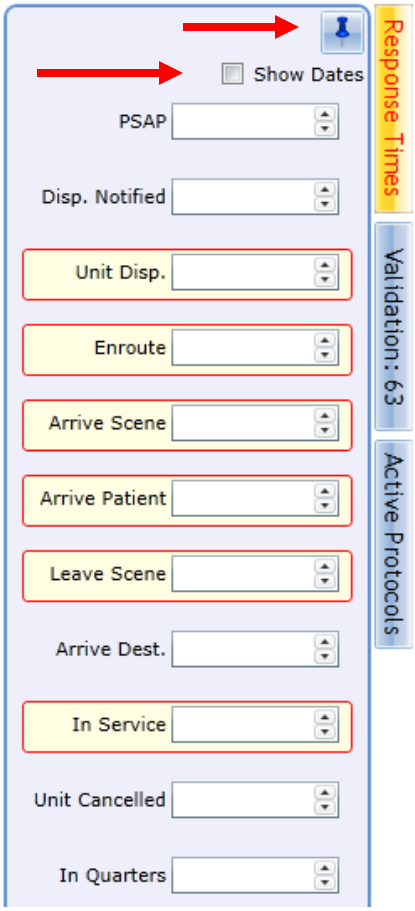




- Along the top of this page
  - **Search**
    - This tab takes you to the search runs page and will prompt you to leave the current page.
  - **Options**
    - Gives the user the option to display single panel behavior which will only allow one panel to be open at a time
    - Gives the user the option to expand all Panels if needed.
  - **About**
    - Gives the user brief information about the dynamic run form
  - Mark Run As Complete (Far Right in red)
    - To be used by Chief Officers only to mark the run completed to the full extent
  - **Save**
    - This needs to be used as often as possible by the user to ensure the information that is being input into the ePCR does not get lost or erased.
  - **Status**
    - No need for the user to use this button
  - **Locked**
    - Tab is defaulted to Unlocked, this should not be changed unless it is by a Chief Officer or QA/QI officer

✱ Continue to the next page to begin entering EMS run information

DISPATCH INFORMATION

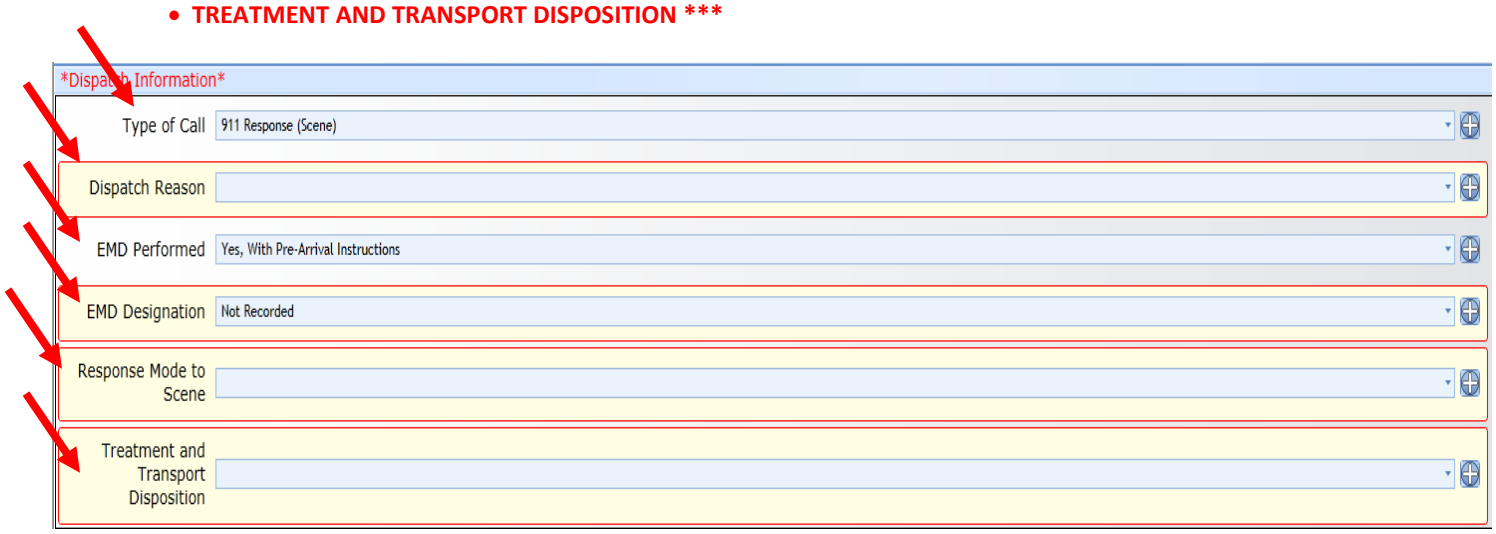


✱ Dispatch Tab – This information shall be filled out for **EVERY** call

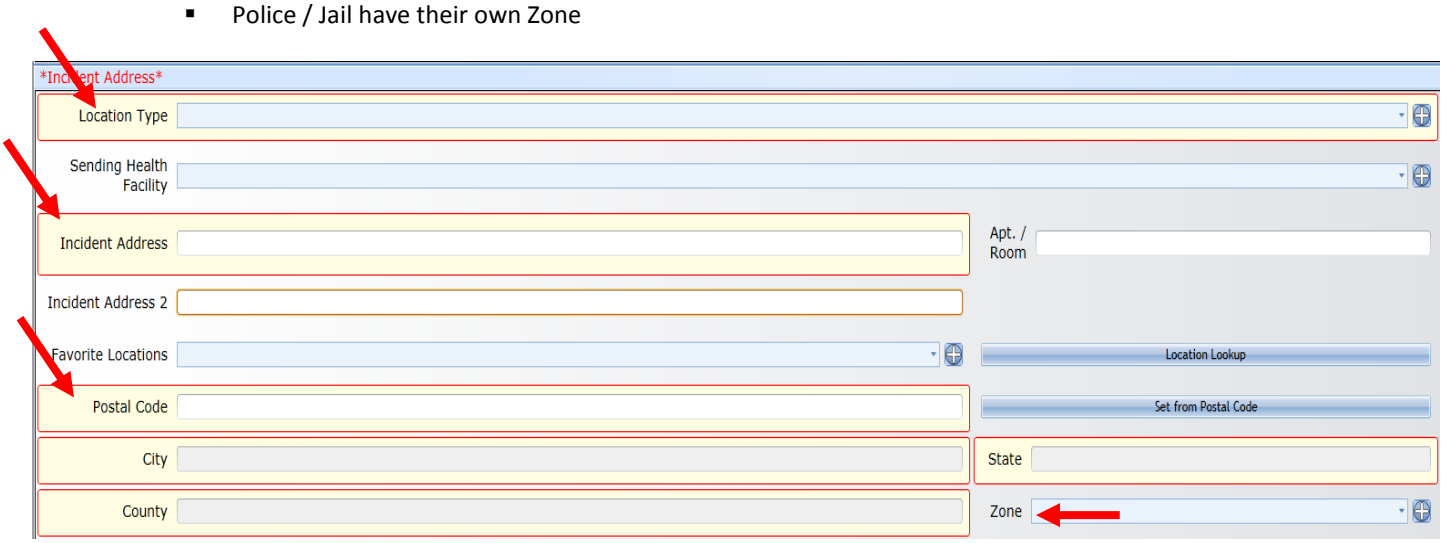
- ➢ Response Times – Located on the upper right hand side of the ePCR in a vertical fashion
  - Click on the button to open the response times
    - A **blue image of a thumbnail** is at the top, when selected it will take the dispatch time and put them next to the tabs in its own section so that the times are not sitting on top of any information
      - Use the blue thumbnail as needed
    - A **button** at the top can be checked that will show the dates associated with the response times
      - Should be selected if the call runs into another day
        - i.e. 2330 dispatch on 6/1/2025 but back in service at 0030 on 6/2/2025
    - The provider must type in the times
      - Fill in as many as applicable
      - Disp. Notified Time can be the same time or just before the Unit Disp. Time
    - If a time is being required that is not applicable but the validation is not at 100%, leave the time blank, post the chart when completed and advise a supervisor.

- ➢ DATE / INCIDENT NUMBER
  - Ensure **Date** is accurate
  - **Service Assigned Call #**
    - Other than the south district, this shall be a unique number specific to the district
      - It shall be the responsibility of the District Chief to determine the numbering schedule and enforce this item
  - **Dispatch Assigned Number**
    - County Run Number given to the responding personnel by dispatch or by the CAD
    - For South District and Career Staff, this number shall be the same as the Incident Number
  - **Number of Patients** – Only needs to be changed if more than one patient is being assessed on that scene with the same run number

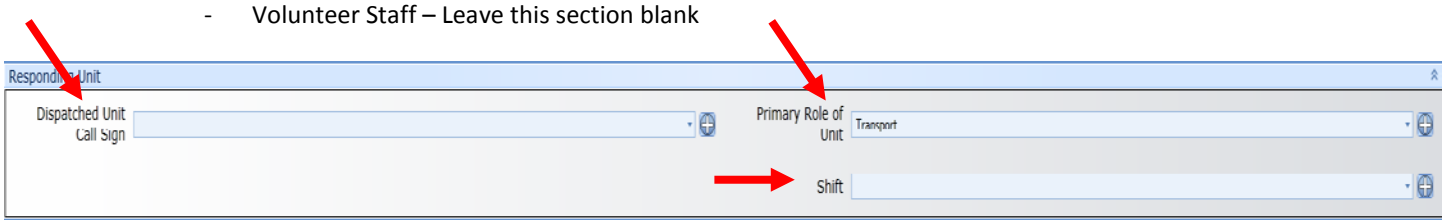
- DISPATCH INFORMATION
  - **Type of Call** – Is this a 911 emergency or a standby for example
  - **Dispatch reason** – Why was the unit dispatched (choices relate to Clawson codes)
  - **EMD Preformed** – If the call originated through dispatch, select "yes, with pre-arrival instructions".
  - **EMD Designation** – Immediate (Bravo – Echo) or Non-Immediate (Alpha & Omega)
    - Unless otherwise designated through Dispatch Guidelines
  - **Response Mode to Scene** – Lights and Siren; No Lights and Siren (also includes whether the unit was upgraded or downgraded)
  - **TREATMENT AND TRANSPORT DISPOSITION *****



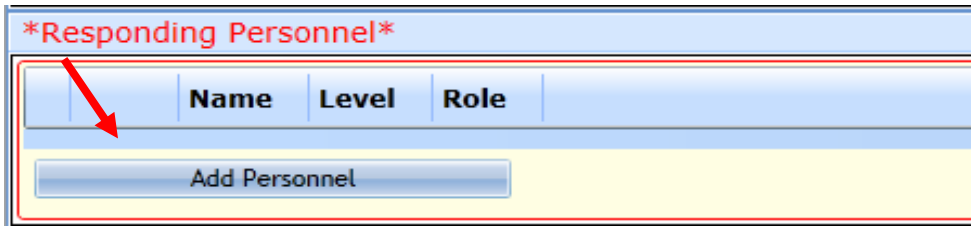
- INCIDENT ADDRESS
  - **Location Type** – Choose most appropriate heading
    - If Location Type is Health Care Facility, another tab will then present itself titled 'Sending Health Facility'.
      - Select the Clinic that is requesting the transfer
  - **Incident Address** – Use the first line – Address Dispatch gave
  - Apt # / Room – As Needed
  - **City / State / etc** – Select from Favorite Locations Drop Down where applicable
    - All City / State / Zip information will be automatically added
    - If not available – manually input.
  - **Zone** – This is important for statistically tracking number or calls in each zone
    - Select where the call originated
    - All Casinos have their own Zone
    - Police / Jail have their own Zone



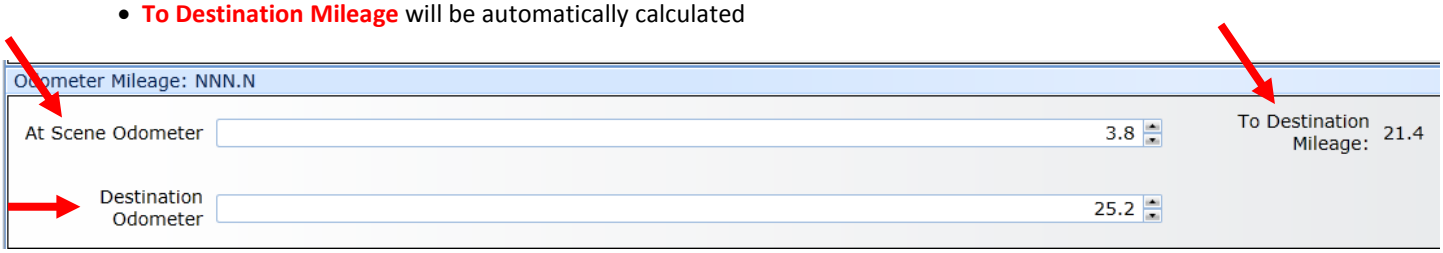
- Responding Unit
  - Select from the dropdown the **EMS unit that responded** to the EMS call. If additional units responded, add to the narrative
  - **Primary Role of Unit**
    - Select from dropdown
  - **Shift**
    - As applicable, A,B,C shift, special event, etc
      - Volunteer Staff – Leave this section blank



- Responding Personnel
  - Use the **Add Personnel** button to add Personnel to the call and their qualifications
    - Career Staff – Ensure to Add Placitas and Algodones Members to your chart
      - Use the Add button to add first responder members from Algodones and Placitas – **Use language per Chief Maxon**



- Odometer Mileage
  - Beginning Mileage is always 0.0
  - **At scene** may include 10th's of a mile (i.e. 3.2)
  - **Destination Mileage**
    - Only applicable to units that transport to an ED
  - **To Destination Mileage** will be automatically calculated



***** THE FOLLOWING DISPOSITIONS WILL REFERENCE PAGE NUMBERS IN THIS MANUAL TO REFERENCE FOR EACH CALL AND DISPOSITION SELECTION**

Treated, Transported by EMS (ALS)

- **Required tabs:**
  - **Dispatch Info** **Page: 10**
  - **Call Conditions** **Page: 16**
  - **Patient/ Non Patient info** **Page: 18**
  - **History** **Page: 20**
  - **Assessment** **Page: 22**
  - **Vitals/Treatment** **Page: 25**
  - **Transport** **Page: 36**
  - **Narrative** **Page: 38**
  - **Billing** **Page: 41**
  - **Signatures** **Page: 45**

✱ **The Trauma, Cardiac Arrest, and STEMI tabs use as applicable in the call conditions – Pages: 31, 33, 35**

Treated, Transported by EMS (BLS)

- **Required tabs:**
  - **Dispatch Info** **Page: 10**
  - **Call Conditions** **Page: 16**
  - **Patient/ Non Patient info** **Page: 18**
  - **History** **Page: 20**
  - **Assessment** **Page: 22**
  - **Vitals/Treatment** **Page: 25**
  - **Transport** **Page: 36**
  - **Narrative** **Page: 38**
  - **Billing** **Page: 41**
  - **Signatures** **Page: 45**

✱ **The Trauma, Cardiac Arrest, and STEMI tabs use as applicable in the call conditions – Pages: 31, 33, 35**

Treated and Released

- **Required tabs:**
  - **Dispatch Info** **Page: 10**
  - **Call Conditions** **Page: 16**
  - **Patient/ Non Patient info** **Page: 18**
  - **History** **Page: 20**
  - **Assessment** **Page: 22**
  - **Vitals/Treatment** **Page: 25**
  - **Narrative** **Page: 38**
  - **Billing** **Page: 41**
  - **Signatures** **Page: 45**

✱ **The Trauma, Cardiac Arrest, and STEMI tabs use as applicable in the call conditions – Pages: 31, 33, 35**

(Continues next page)

NON-Patient

- **Required tabs:**
  - **Dispatch Info** **Page: 10**
  - **Call Conditions** **Page: 16**
  - **Patient/ Non Patient info** **Page: 18**
  - **Narrative** **Page: 38**
  - **Signatures** **Page: 45**

Treated, Transferred Care

- **Required tabs:**
  - **Dispatch Info** **Page: 10**
  - **Call Conditions** **Page: 16**
  - **Patient/ Non Patient info** **Page: 18**
  - **History** **Page: 20**
  - **Assessment** **Page: 22**
  - **Vitals/Treatment** **Page: 25**
  - **Transport** **Page: 36**
  - **Narrative** **Page: 38**
  - **Billing** **Page: 41**
  - **Signatures** **Page: 45**
  -

    ✱ **The Trauma, Cardiac Arrest, and STEMI tabs use as applicable in the call conditions – Pages: 31, 33, 35**

No Patient Found

- **Required tabs:**
  - **Dispatch Info** **Page: 10**
  - **Call Conditions** **Page: 16**
  - **Narrative** **Page: 38**
  - **Signatures** **Page: 45**

Cancelled

- **Required tabs:**
  - **Dispatch Info** **Page: 10**
  - **Call Conditions** **Page: 16**
  - **Narrative** **Page: 38**
  - **Signatures** **Page: 45**

(Continues next page)

Treated, Transported by Private Vehicle

- **Required tabs:**
  - **Dispatch Info** **Page: 10**
  - **Call Conditions** **Page: 16**
  - **Patient/ Non Patient info** **Page: 18**
  - **History** **Page: 20**
  - **Assessment** **Page: 22**
  - **Vitals/Treatment** **Page: 25**
  - **Narrative** **Page: 38**
  - **Billing** **Page: 41**
  - **Signatures** **Page: 45**

    ✱ **The Trauma, Cardiac Arrest, and STEMI tabs use as applicable in the call conditions – Pages: 31, 33, 35**

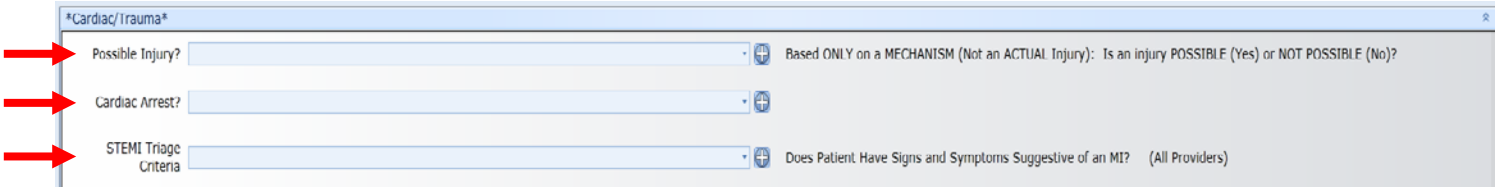
Dead at Scene

- **Required tabs:**
  - **Dispatch Info** **Page: 10**
  - **Call Conditions** **Page: 16**
  - **Patient/ Non Patient info** **Page: 18**
  - **History** **Page: 20**
  - **Assessment** **Page: 22**
  - **Vitals/Treatment** **Page: 25**
  - **Narrative** **Page: 38**
  - **Billing** **Page: 41**
  - **Signatures** **Page: 45**

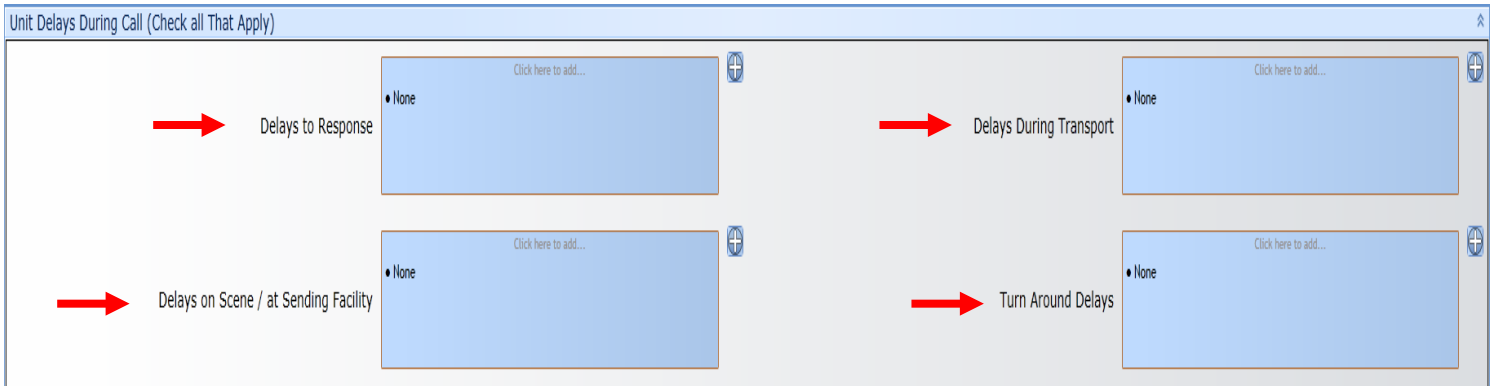
    ✱ **The Trauma, Cardiac Arrest, and STEMI tabs use as applicable in the call conditions – Pages: 31, 33, 35**

CALL CONDITIONS INFORMATION

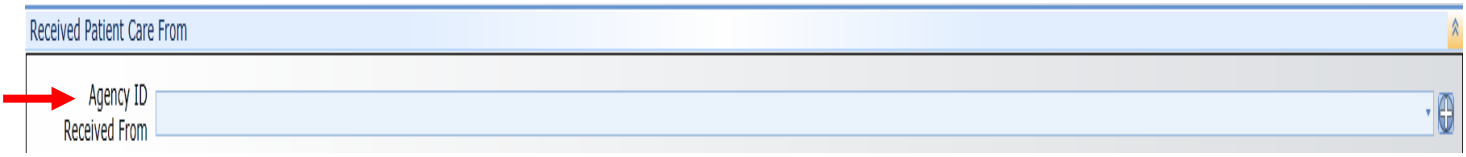
- CALL CONDITIONS TAB
  - CARDIAC / TRAUMA
    - **Possible Injury** – Yes / No
      - Based on mechanism, was an injury possible or not
    - **Cardiac Arrest** – Yes / No
      - If yes, did it happen before EMS or after arrival
    - **STEMI triage criteria** – Yes / No
      - If the patient is complaining of signs and having symptoms of cardiac related issues suggested of an Acute Myocardial Infarction (Heart Attack)



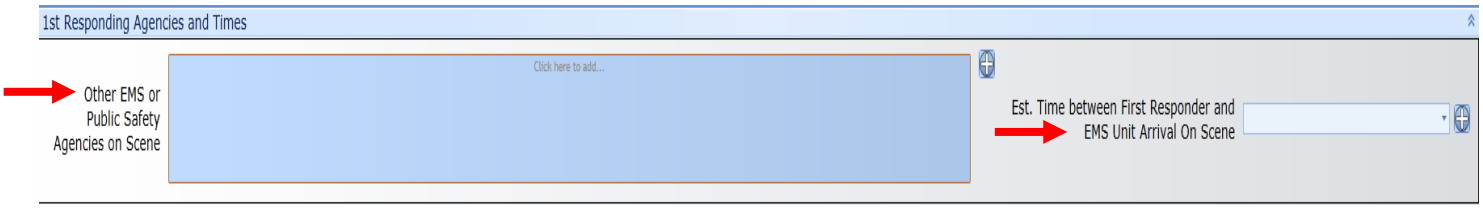
  - UNIT DELAYS – Choose appropriate answers for each section as applicable
    - **Delays to response**
      - Auto-selected to 'None'
      - Use the + encircled in Blue to open a list of potential delays such as weather or traffic
        - Any selections shall be described in E of the Narrative
    - **Delays on scene**
      - Auto-selected to 'None'
      - Use the + encircled in Blue to open a list of potential delays such as weather or traffic
        - Any selections shall be described in E of the Narrative
    - **Delays during transport**
      - Auto-selected to 'None'
      - Use the + encircled in Blue to open a list of potential delays such as weather or traffic
        - Any selections shall be described in E of the Narrative
    - **Turnaround delays**
      - Auto-selected to 'None'
      - Use the + encircled in Blue to open a list of potential delays such as staff delay or overcrowding
        - Any selections shall be described in E of the Narrative



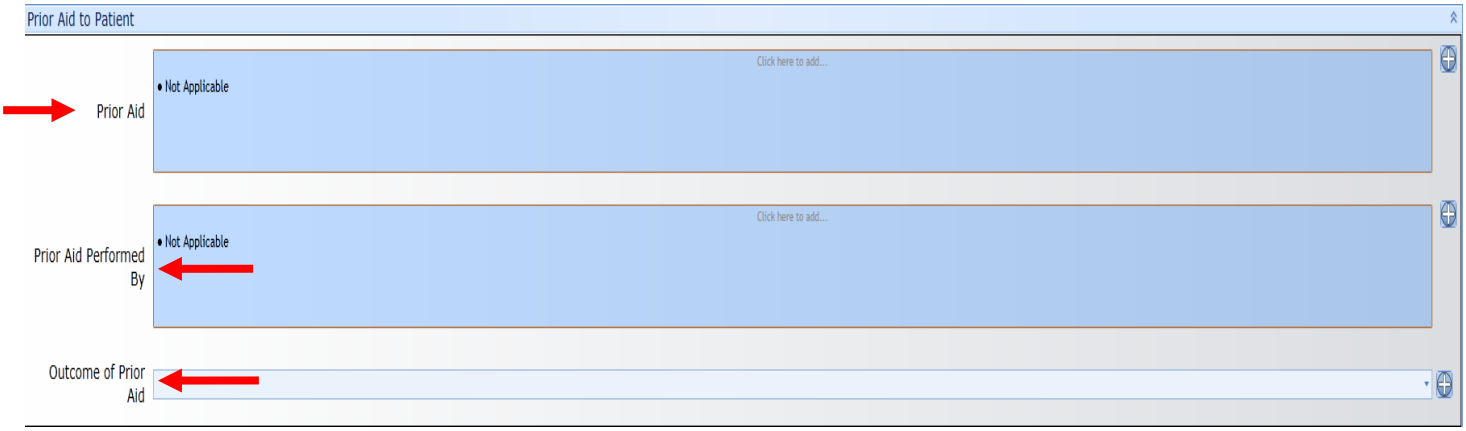
- RECEIVED PATIENT CARE FROM
  - Use this section if another unit is intercepting with your unit
  - **Agency ID** Received From
    - Pick from applicable list



- 1st RESPONDING AGENCIES AND TIMES
  - **Other EMS** or Public Safety Agencies on Scene
    - Choose from the list including Law Enforcement
      - Applicable to all responders
    - **Est. Time** between First Responder and EMS Unit Arrival On Scene
      - As applicable



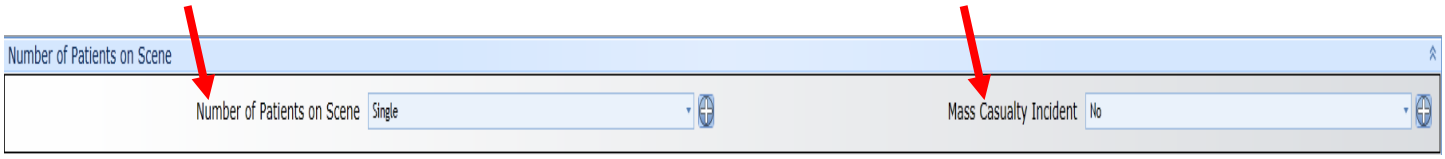
- PRIOR AID TO PATIENT
  - **Prior Aid** – Select any Treatment provided to the patient prior to your arrival
  - **Prior Aid Preformed By**
    - Choose category of person giving the aid.
  - **Outcome of prior aid**
    - Select appropriate from drop down



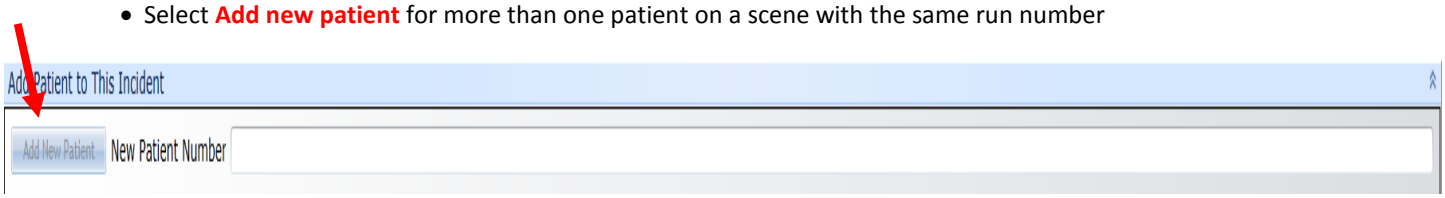
PATIENT / NON PATIENT INFORMATION

✱ PATIENT / NON-PATIENT INFO

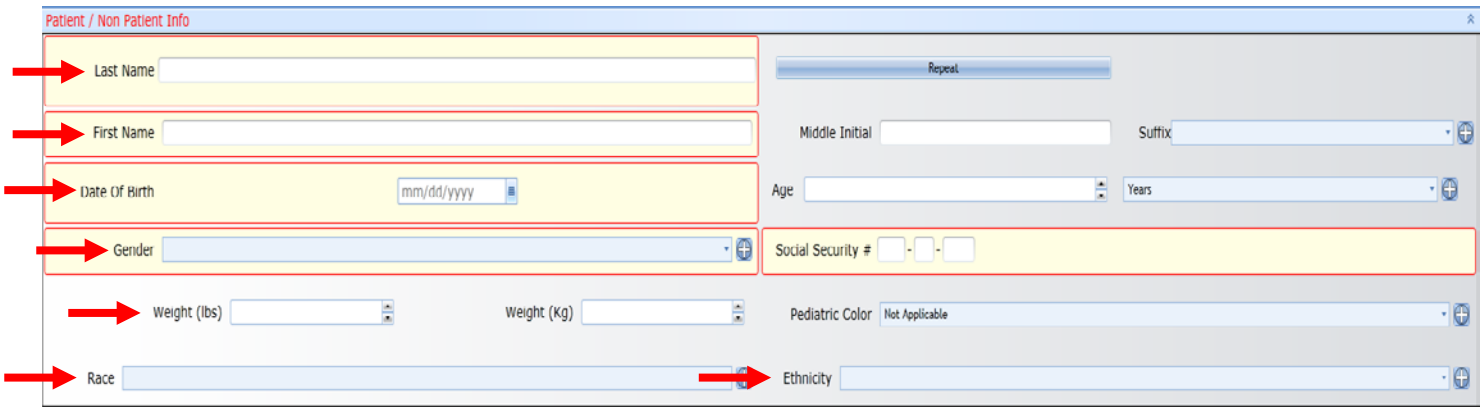
- Number of Patients on Scene
  - **Number of pts on scene**
    - Defaulted to Single
  - **Mass Casualty Incident** – Reference SCFD Protocol for definition
    - Defaulted to No



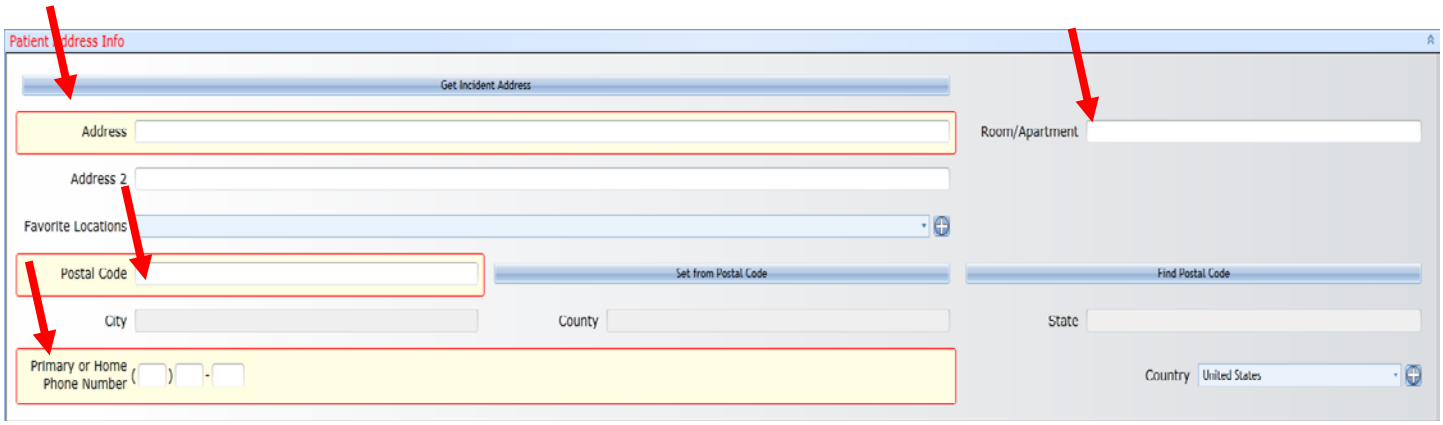
- Add Patient to This Incident
  - Select **Add new patient** for more than one patient on a scene with the same run number



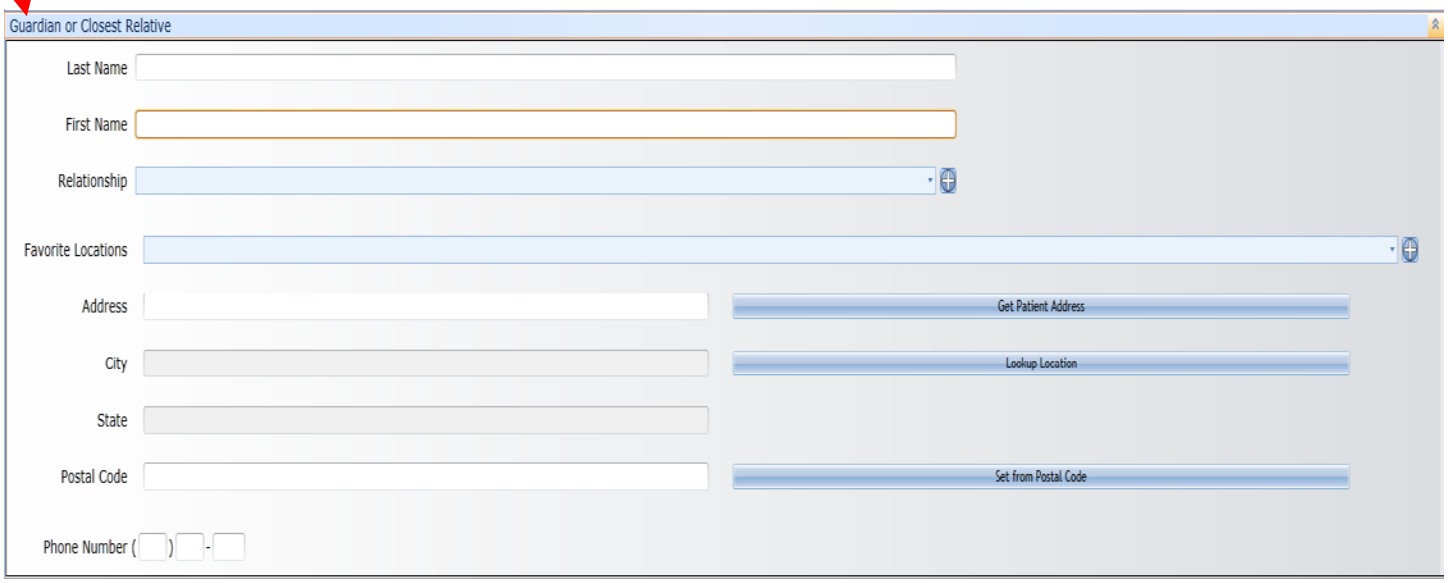
- PATIENT / NON PATIENT INFO – Fill in all
  - **Last Name**
    - Select the repeat button to check if the patient is already in the system; once selected, the other demographics will auto populate
      - Ensure the information is current
    - If the patient is not in the system, continue with the other information outlined below.
  - **First Name**
  - **Date of Birth**
    - Age should auto-populate
  - **Gender**
  - **Social Security Number**
    - If unknown or patient does not have one, **leave blank**
  - **Weight in pounds or kilograms**
    - The other will populate
  - **Race** – Do Not Leave Blank – Ask your patient
    - Choose From Dropdown
  - **Ethnicity** – Do Not Leave Blank – Ask your patient
    - Choose From Dropdown



- Patient Address Info
  - If incident address is same as mailing address – select the "Get Incident Address"
    - The demographical information will auto-populate
    - If it is not the same – Follow below
  - **Incident Address** – Use the first line – <u>USE PATIENT MAILING ADDRESS</u>
  - **Apt # / Room** – As Needed
  - **City / State / etc** – Select from Favorite Locations Drop Down where applicable
    - All City / State / Zip information will be automatically added
    - If not available – manually input.
  - **Primary or Home Phone Number** – Which ever the patient prefers
    - If unknown or patient does not have – **<u>leave blank</u>**



- **Guardian or Closest Relative**
  - If the patient is a minor or the patient has a power of attorney, enter the patients Guardian or Closest Relative information in this section as complete as possible

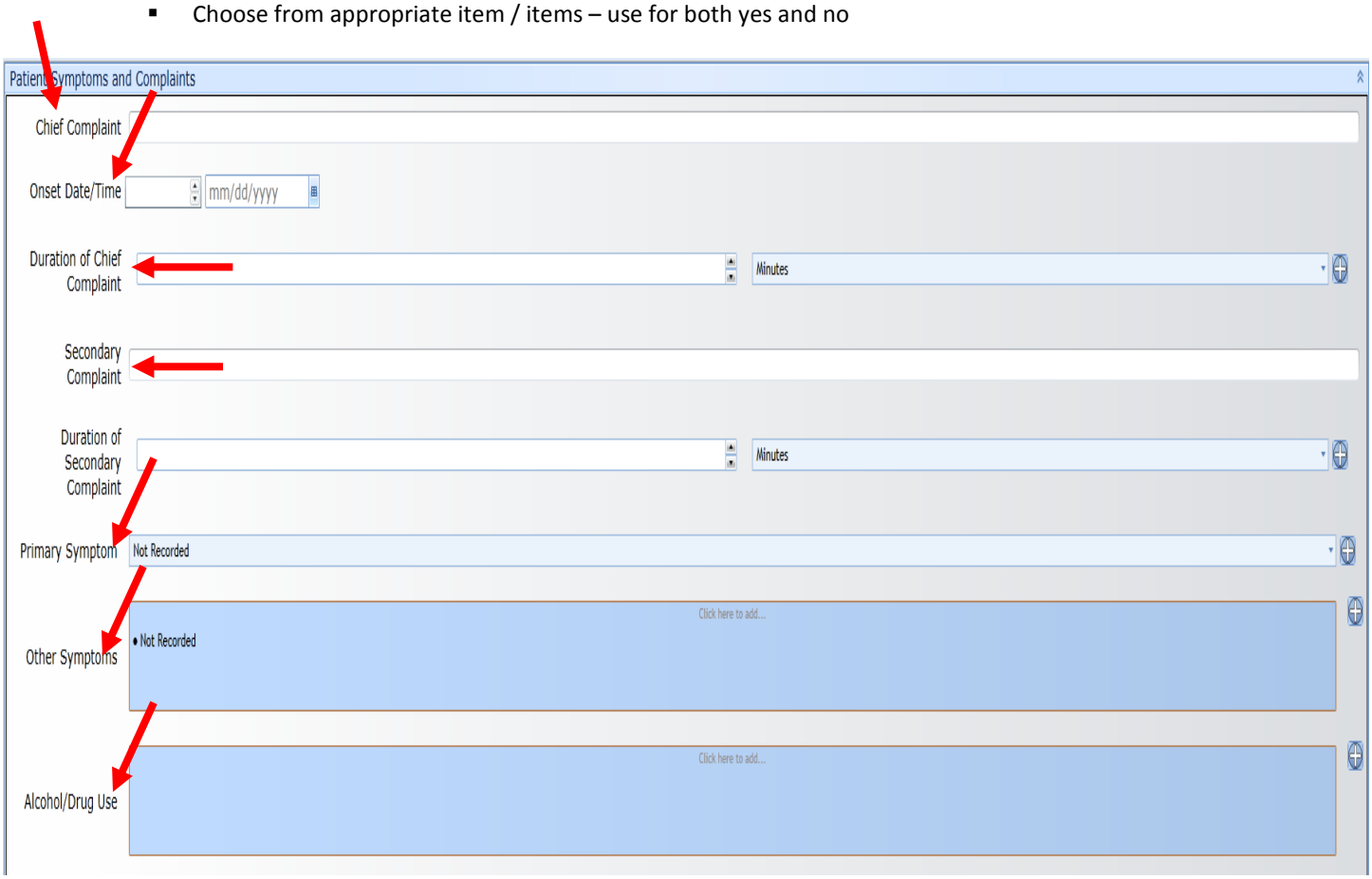


HISTORY INFORMATION

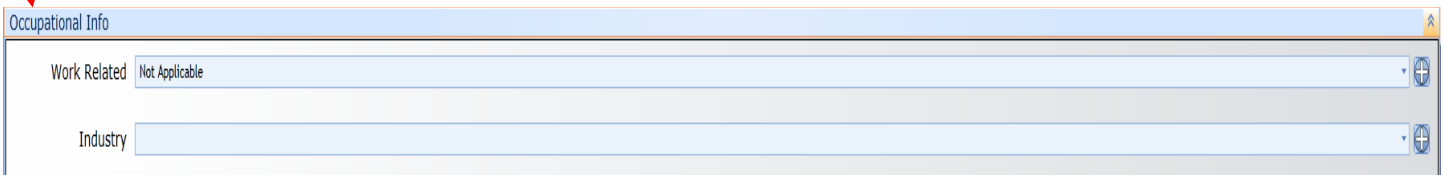
✱ HISTORY TAB

➢ Patient Symptoms and Complaints

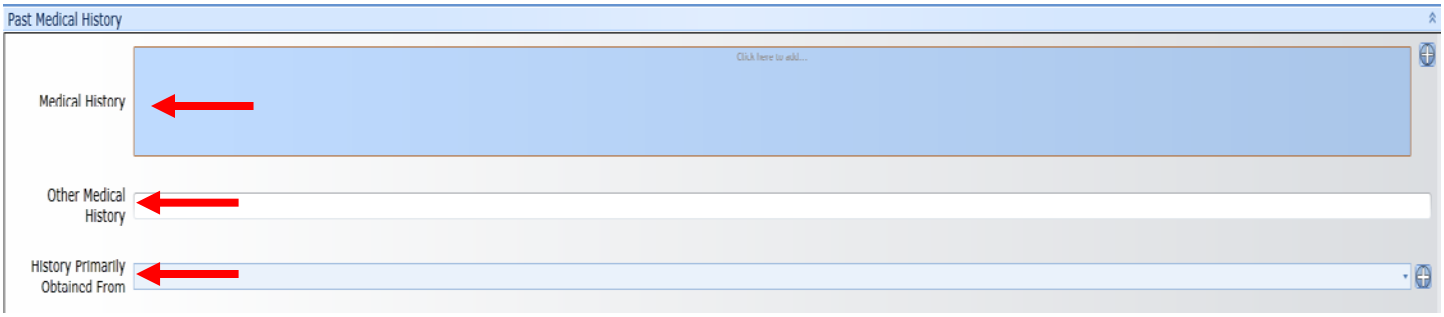
- **Chief Complaint** – Type patient complaint in the patient's own words, or describe patient condition in appropriate medical terminology if there are no verbal complaints (i.e. pulseless and apenic; or altered mentation; etc.)
- **Onset Date / Time** - Select the time the patient began feeling their symptoms or began presenting with the complaint
  - If the complaint / symptoms are chronic and have been an issue for greater than 48 hours – select the time that the patients complaint / symptoms changes that made the patient activate 911
    - Unless the patient knows the exact time of onset even though it may be greater than 48 hours – use that time.
- **Duration of Chief Complaint** – **<u>From onset of patient complaint to the time 911 was called</u>**
- **Secondary Complaint** – Only applicable if the patient has more than one complaint / symptom
  - Type patient complaint in the patient's own words, or describe patient condition in appropriate medical terminology if there are no verbal complaints (i.e. pulseless and apenic; or altered mentation; etc.)
    - Onset Date / Time - Select the time the patient began feeling they symptoms or began presenting with the complaint
  - If the complaint / symptoms are chronic and have been an issue for greater than 48 hours – select the time that the patients complaint / symptoms changes that made the patient activate 911
    - Unless the patient knows the exact time of onset even though it may be greater than 48 hours – use that time.
  - Duration of Secondary Complaint – **<u>From onset of patient secondary complaint to the time 911 was called</u>**
- **Primary Symptom** – Choose the Most Appropriate from the dropdown
- **Other Symptoms** – May choose multiple options as needed
- **Alcohol / Drug Use**
  - Choose from appropriate item / items – use for both yes and no



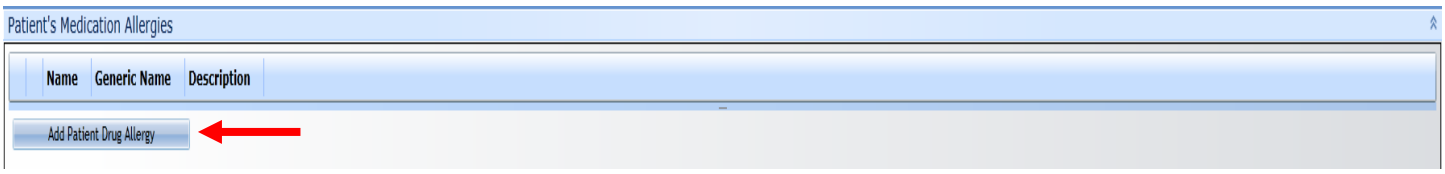
- **Occupational Info** – Is the incident work related – yes or no
  - If yes – select from the dropdown



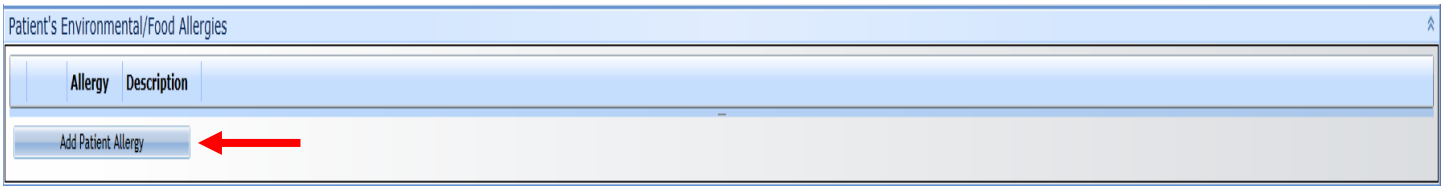
- Past Medical History
  - **Medical History**
    - Select as many items as possible
      - Use + encircled in blue to show list and make selection
  - **Other Medical History** – Free Text for additional items not in selectable items above
    - **History Primarily Obtained From** – Select From Dropdown



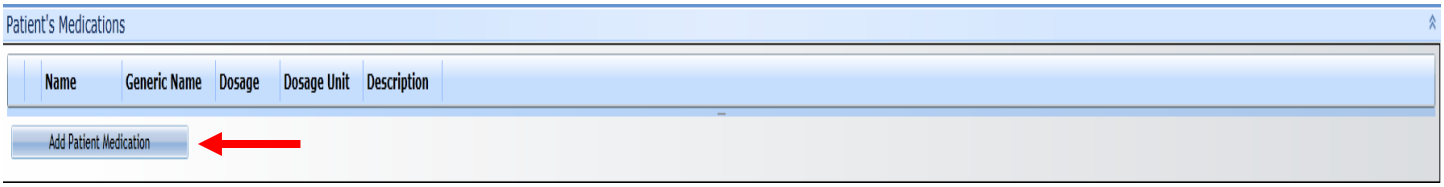
- Patients Medication Allergies
  - Choose **Add Patient Drug Allergy** and select as appropriate
    - Can Select NKDA
      - If not available in the selection, can add free text as needed



- **Patient Environmental / Food Allergies**
  - Use if applicable

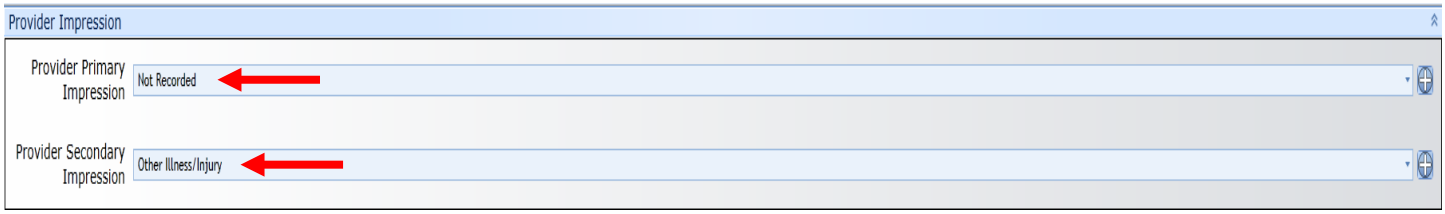


- Patient Medications
  - Choose **Add Patient Medication** and select as appropriate or use free text if not available

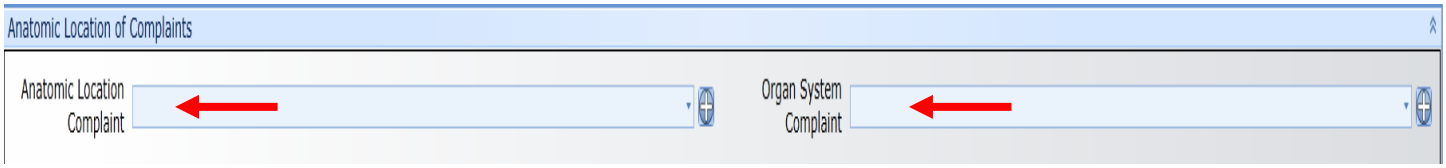


ASSESSMENT INFORMATION

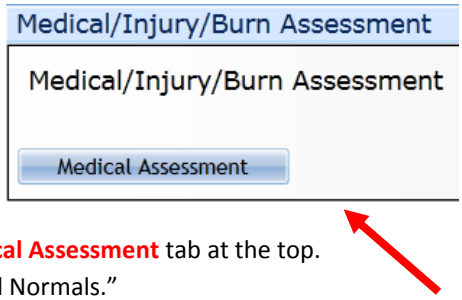
- ASSESSMENT TAB
  - Provider Impression
    - Provider Primary Impression – Select what is main symptom that is harming the patient from the drop down
    - Provider Secondary Impression – Use as needed if additional symptoms are present



  - Anatomic Location of Complaints
    - Anatomic Location of Complaint – Select where on the body the patient is experiencing the symptom (i.e. select "Chest" for Chest pain)
    - Organ System Complaint – Use this section to define which body organ is being affected by the symptom (i.e. select "Cardiovascular" for Chest Pain"



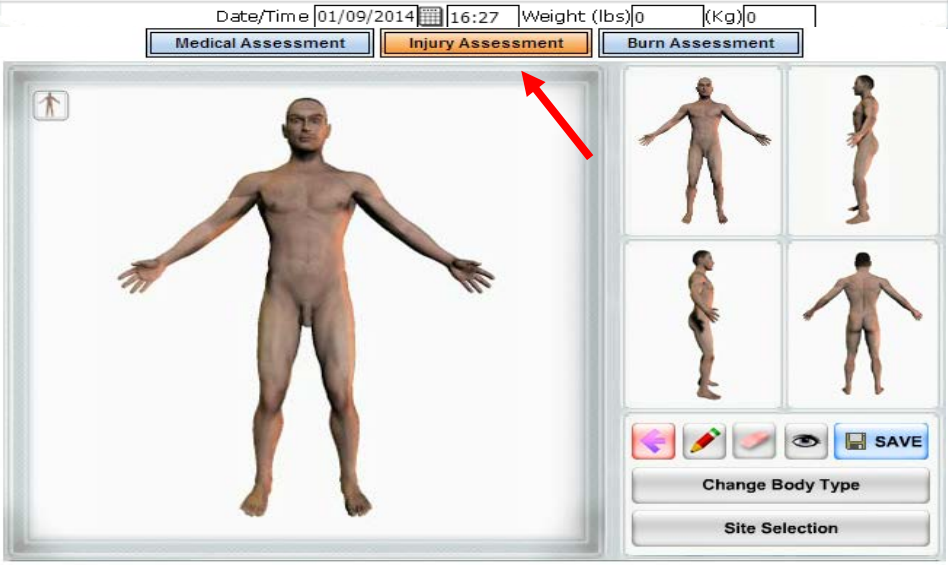
(Continues Below)



- Medical/Injury/Burn Assessment
  - Select the **Medical Assessment** button to access all three assessments
    - The window that opens is the assessment Power Tool. This displays a picture of the patient relevant to the age of the patient listed in the Patient/Non Patient Info Tab.
      - The easiest way to utilize this Power Tool is to begin with the **Medical Assessment** tab at the top.
      - Select "**Site Selection**" on the right hand side, then select "Select All Normals."
      - This will select the entire body as a normal assessment, simply select from the list the areas that are abnormal, click on them, and either free type the abnormalities or choose from the detailed list that pertains to each body part
      - When Finished, CLICK **SAVE** – then select Close
      - If needed, you may re-open this tool and update it as needed; just be sure to select "**UPDATE EXAM**" before closing
      - The Provider may also utilize the **Injury Assessment** Tab at the top of this Power Tool.
        - Here, the provider can select any area of the body by placing the cursor over the body and clicking the mouse.
          - This will bring up a list of potential injuries for that location that can be selected as needed, or, free text can be utilized
      - The Provider may also utilize the **Burn Assessment** Tab at the top of this Power Tool.
        - Here, simply click an area of the body that has been burned.
          - Click once for first degree burns, or superficial
            - Blue in color
          - Click twice for second degree burns, or partial thickness
            - Yellow in Color
          - Click three times for third degree burns, full thickness
            - Red in Color
        - This will automatically calculate the percentage of the body that has been burned total, and in each degree.
      - ENSURE TO RETURN TO THE MEDICAL ASSESSMENT TAB AND SELECT "SAVE" or "UPDATE EXAM" PRIOR TO CLOSING THE TOOL
  - The Provider may elect to skip this step and write a detailed head to toe in the narrative as outlined under the Narrative Tab

(Images on next page)

Medical Assessment
Injury Assessment
Burn Assessment
SAVE
Change Body Type
Site Selection
Time
Description
Date/Time 01/09/2014 16:27 Weight (lbs) 0 (Kg) 0


Medical Assessment
Injury Assessment
Burn Assessment
SAVE
Change Body Type
Site Selection

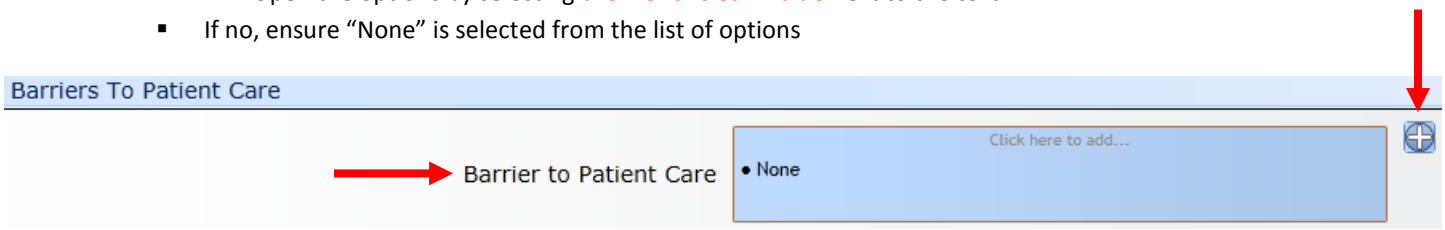
Medical Assessment
Injury Assessment
Burn Assessment
Total BSA
1st Degree: 0%
2nd Degree: 0%
3rd Degree: 0%
Total: 0%
SAVE
Change Body Type
Site Selection

VITAL SIGNS – PROCEEDURES – MEDICATIONS – EKG

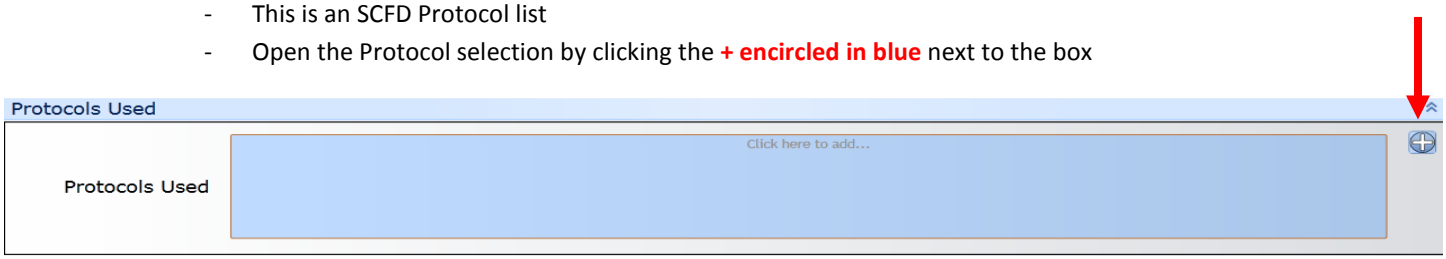
✱ VITALS/TREATMENT TAB

➢ **Barriers To Patient Care**

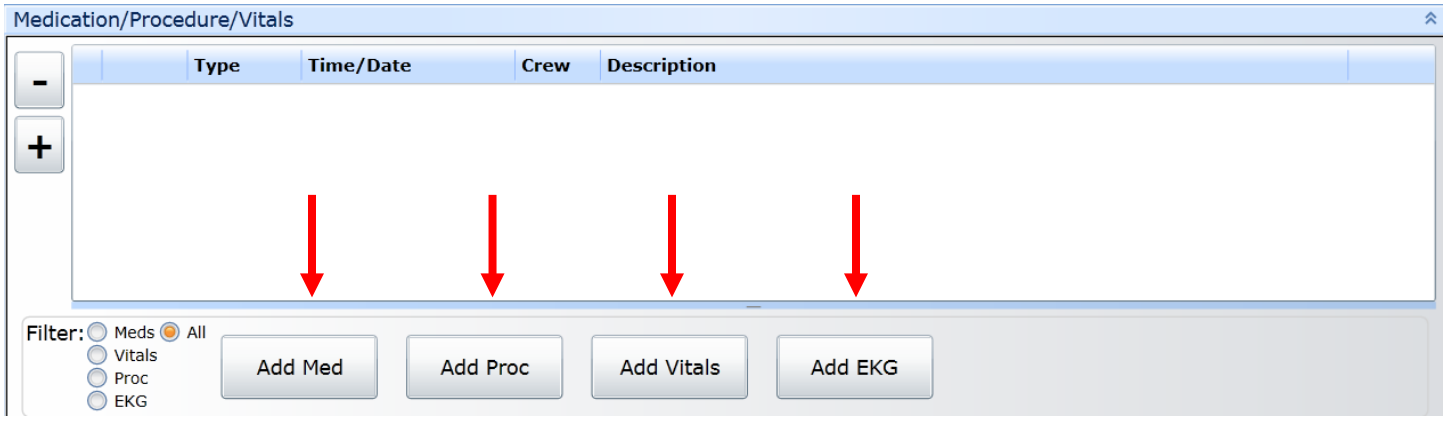
- Was there an issue communicating or gaining access to the patient's information due to a particular reason?
  - If yes, select from the detailed list of options, ensure to deselect "None" which is auto populated each time
    - Open the options by selecting **the + encircled in blue** next to the text
  - If no, ensure "None" is selected from the list of options



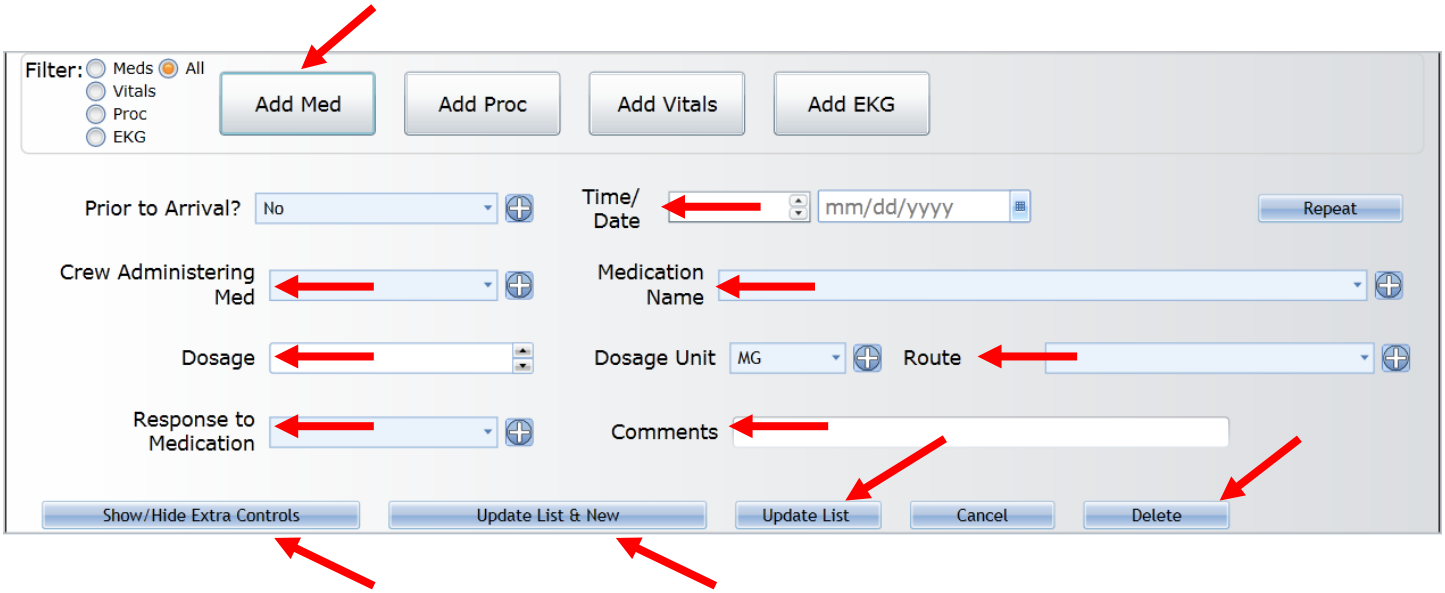
- Protocols Used
  - Select the Protocol that was followed to treat this patient
    - This is an SCFD Protocol list
    - Open the Protocol selection by clicking the **+ encircled in blue** next to the box



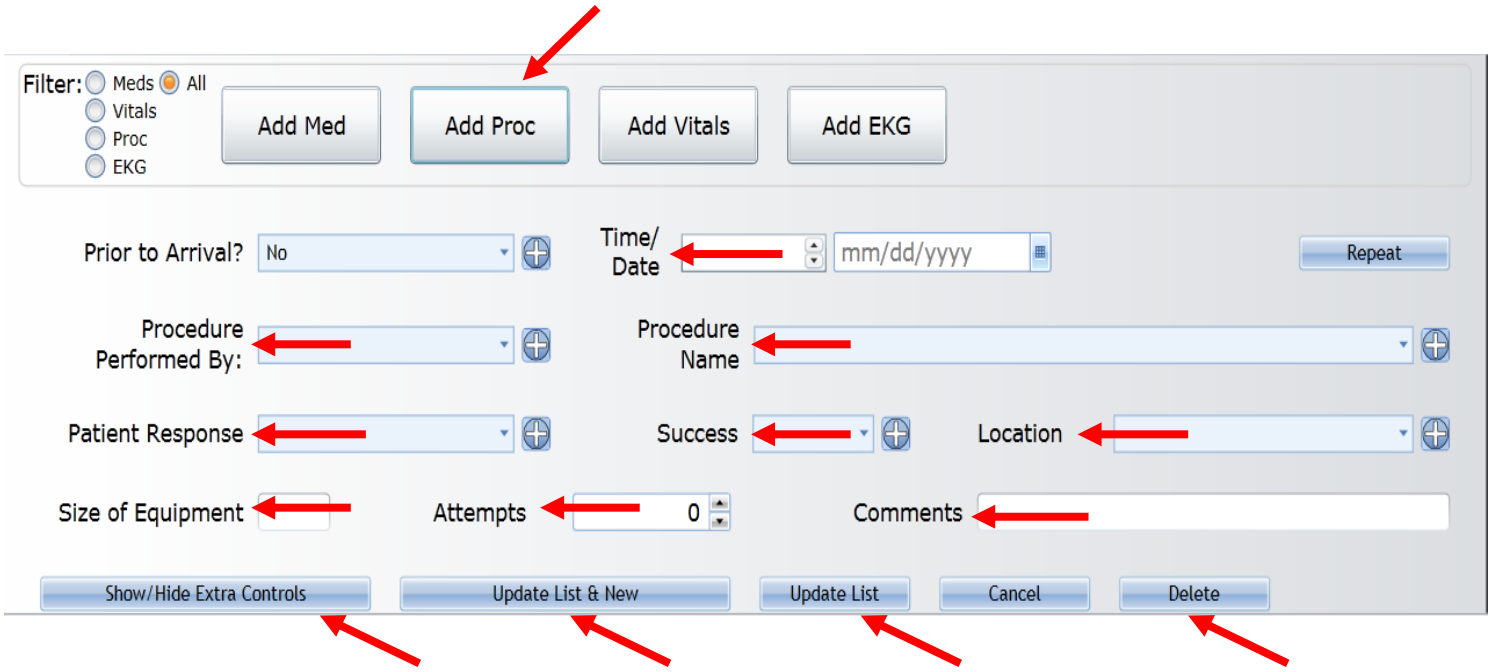
- Medication/Procedure/Vitals
  - All **medications, procedures, vital signs** and **EKG**'s shall be recorded here for data collection purposes.
    - Some medications, procedures and vital signs may be required to be repeated in other areas of the chart as this manual states (i.e. Narcotic usage)
      - Some medications, procedures and vital signs may be listed elsewhere in the chart at the discretion of the providers
  - For all these options, the provider will be given the option to select procedures, medications and vitals that were obtained prior to the arrival of the unit filing the report
    - This should only be selected "Yes" when inputting vital signs and EKG's that were obtained prior to arrival.
      - All Procedures and Medications that were administered prior to your arrival shall be input in the CALL <u>CONDITIONS TAB</u> under the Prior Aid to Patient heading
        - ❖ Exception for South District – If South District Personnel are on scene and have done any medications, procedures, vitals, etc, that information shall be collected here in this tab, in this section.



- To enter a medication that has been administered to the patient, select the "**Add Med**" button.
  - Ensure the **date/time** are correct
  - Ensure the Person administering the drug is correctly listed under "**Crew Administering Med**"
  - Select the **Medication**
    - (Oxygen is a Medication)
    - (Normal Saline is a Medication)
  - Ensure the **dose** is correct including the units as most meds will auto populate a dose once selected
  - Enter the **Route** and **Response to Medication**
  - The Comments box is for free text at the discretion of the provider
  - There is a **Show/Hide Controls** button on the bottom that may be utilized at the discretion of the provider
    - Information includes:
      - Authorization – who or what allowed you to administer the med
      - Authorizing Physician - only applicable if an MCEP has given an order to administer a medication
      - Complications – Select as many as needed at the discretion of the provider
  - Once all information has been input and ensured to be accurate, press the "**Update List**" button at the bottom.
    - The **Update List & New** button can also be used if you want to add another medication immediately following the current entry
  - Once the medication has been saved, it will show up in the list above the data entry. Here, the provider can "Open" the medication and edit as needed, or, select the "Repeat" button which will open a new area for data entry but will already have the information auto populated from the selection used.
  - If the provider wishes to delete an entry from the list, open the selected entry and click the "**Delete**" button at the bottom of the data entry space



- To enter a procedure that has been preformed, select the "**Add Proc**" button
  - Ensure the **date/time** are correct
  - Ensure the Person performing the procedure is correctly listed under "**Procedure Performed By**:"
  - Select the **Procedure** from the extensive list
    - Providers should take some time getting used to what is in this list, it can be very specific and detailed which helps with data collection and billing, so please use as much as possible
  - Select a **Patient Response**, if the Procedure was **Successful**, and **Location** the procedure was performed (as applicable) from the appropriate dropdown selections.
  - The **Size of Equipment** box, **Attempts** box and **Comments** box is for free text at the discretion of the provider
    - The Size and Attempts box shall be utilized when placing airways or starting IV's
  - There is a **Show/Hide Controls** button on the bottom that may be utilized at the discretion of the provider
    - Information includes:
      - Authorization –who or what allowed you to perform the procedure
      - Authorizing Physician – only applicable if an MCEP has given an order to perform a procedure
      - Complications – Select as many as needed at the discretion of the provider
  - Once all information has been input and ensured to be accurate, press the "**Update List**" button at the bottom.
    - The **Update List & New** button can also be used if you want to add another procedure immediately following the current entry
  - Once the procedure has been saved, it will show up in the list above the data entry. Here, the provider can "Open" the procedure and edit as needed, or, select the "Repeat" button which will open a new area for data entry but will already have the information auto populated from the selection used.
  - If the provider wishes to delete an entry from the list, open the selected entry and click the "**Delete**" button at the bottom of the data entry space



- To enter vital signs that have been preformed, select the "**Add Vitals**" button (See Image Next Page)
  - Ensure the **date/time** are correct
  - Ensure the Person taking the vitals is correctly listed under "**Provider Taking Vitals**
  - Enter the following information:
    - **Pulse, Systolic and Diastolic Blood Pressure, Respiratory Rate, SpO2 %, Blood Glucose and Pain Scale** as free text
    - Select a **SpO2 qualifier**
      - Was the patient on oxygen or not
    - Select a **Responsiveness** level
      - AVPU
  - There is a **Show/Hide** Controls button on the bottom that may be utilized at the discretion of the provider
    - Information includes:
      - Patient position at the time of the taking of the vitals
      - BP Location – Right vs Left; Arm vs Thigh, etc
      - Stroke Scale
        - Has selections for both Cincinnati and LA stroke screen
      - Temp
        - Free text, if a number is put into the F (Fahrenheit) box, it will automatically convert to a number in the C (Celsius) box and vise-versa
      - Temp Method – As applicable depending on device
      - Airway – Status of the patient airway
      - Breathing – Status of the patient breathing
      - Electronic CO2 – if your equipment has this ability to capture
      - APGAR – Only applicable for newborns
      - GCS – Eye; Verbal; Motor – Numerical from dropdown
        - GCS Score Qualifier – is anything interfering with the total score
        - GCS Total will be auto populated as the numbers are selected
  - Once all information has been input and ensured to be accurate, press the "**Update List**" button at the bottom.
    - The **Update List & New** button can also be used if you want to add another vital sign immediately following the current entry
  - Once the vital signs have been saved, they will show up in the list above the data entry. Here, the provider can "Open" the vital signs and edit as needed, or, select the "Repeat" button which will open a new area for data entry but will already have the information auto populated from the selection used.
  - If the provider wishes to delete an entry from the list, open the selected entry and click the "**Delete**" button at the bottom of the data entry space

Filter: Meds All
Vitals
Proc
EKG

Add Med | Add Proc | Add Vitals | Add EKG

Prior to Arrival ? No

Time/ Date mm/dd/yyyy

Provider Taking Vitals

Repeat

Pulse

Blood Pressure Sys / Dia.

Resp

SpO2 %

SpO2 Qualifier

Responsiveness

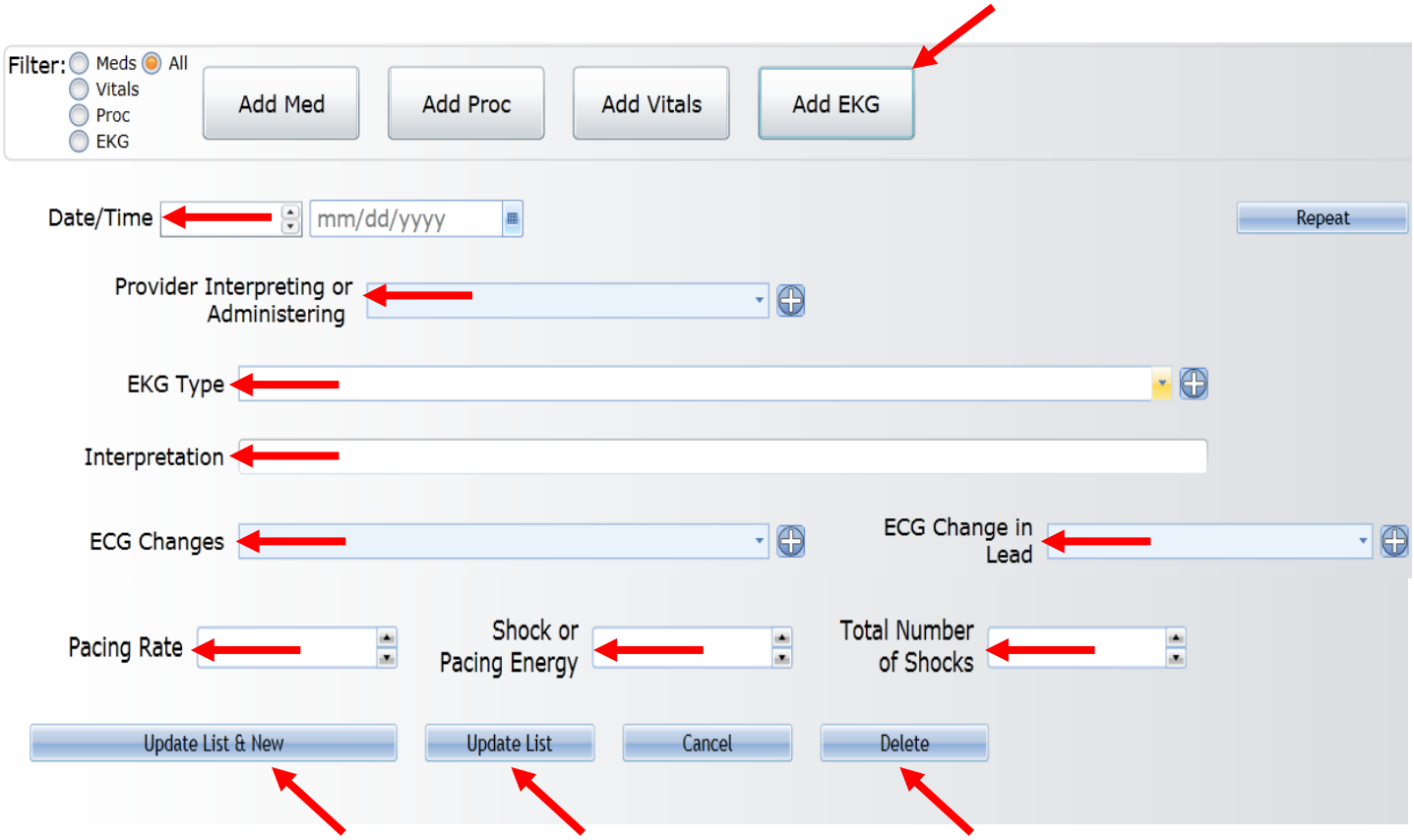
Blood Glucose Hi Lo

Pain Scale (0-10)

Show/Hide Extra Controls | Update List & New | Update List | Cancel | Delete

To enter an EKG that has been obtained but is not able to be transferred to the ePCR, select the **Add EKG** button

- Ensure the **date and time** are correct
- Ensure the **Provider Interpreting** the EKG is accurate
- Select the **EKG Type** as appropriate
- Enter a **Interpretation** as free text using medically accepted terminology
- Enter **ECG Changes** from the dropdown if there are abnormalities
- Enter the **ECG Change in Lead** from the drop down box that indicate which lead(s) the abnormalities are found in
- If transcutaneous **pacing**, synchronized **cardioversion**, or **defibrillation** is used, enter the appropriate information in the text boxes in the appropriate location.
- Once all information has been input and ensured to be accurate, press the "**Update List**" button at the bottom.
  - The **Update List & New** button can also be used if you want to add another EKG immediately following the current entry
- Once the EKG has been saved, it will show up in the list above the data entry. Here, the provider can "Open" the EKG and edit as needed, or, select the "Repeat" button which will open a new area for data entry but will already have the information auto populated from the selection used.
- If the provider wishes to delete an entry from the list, open the selected entry and click the "**Delete**" button at the bottom of the data entry space



TRAUMA INFORMATION

- ✱ TRAUMA TAB – This tab will only be visible if an answer of "Yes" was provided in the "Call Conditions" Tab, *Cardiac/Trauma* section, 'Possible Injury?' dropdown box
  - ➢ Trauma (See Image Next Page)
    - **Mechanism of Injury** – what caused the injury to occur
      - Choose from the extensive dropdown list
    - **Height of fall** (feet)
      - Only applicable if the patient fell from a distance greater than standing position
    - **Injury intent**
      - Select as appropriate from the dropdown list
    - **Type of Injury**
      - Select as many as needed by using the + encircled with blue next to the list box
    - **Trauma Referral Center Notified**
      - Was a trauma center notified of the incoming patient
    - **Trauma Triage Criteria**
      - Use the + encircled in blue next to the list box to select as many obvious traumatic injuries as needed that categorized the particular trauma patient
    - **Patient Safety Equipment Used**
      - Use the + encircled in blue next to the list box to select as many devices (i.e. seat belt) that the patient was using at the time of injury to attempt to prevent harm (use as needed)
  - ➢ Motor Vehicle Info – Shall only be utilized if the patient was involved in a car crash
    - **Vehicle Injury Indicators**
      - Use the + encircled in blue next to the list box to select as many vehicle indicators as applicable that would or that have increased the severity of injuries sustained to the patient
    - **Area of the Vehicle Impacted**
      - Use the + encircled in blue next to the list box to select as many areas as applicable that the vehicle sustained damage
    - **Airbag deployment**
      - Use the + encircled in blue next to the list box to select if airbags
    - **Seat Row Location of Patient**
      - Select from Dropdown
        - Row 1 is the driver row
    - **Position of Patient**
      - Select from dropdown where the pt was located at the time of incident in the vehicle

Trauma

Mechanism of Injury

Height of fall (feet)

Injury Intent Not Recorded

Type of Injury Click here to add...

Trauma Referral Center Notified

Trauma Triage Criteria Click here to add...

Patient Safety Equipment Used Click here to add...

Motor Vehicle Info

Vehicular Injury Indicators Click here to add...

Area of the Vehicle Impacted Click here to add...

Seat Row Location of Patient

Position of Patient

Airbag Deployment Click here to add...

PATIENT CARDIAC ARREST INFORMATION

- CARDIAC ARREST TAB – This tab will only be visible if an answer of "Yes" was provided in the "Call Conditions" Tab, *Cardiac/Trauma* section, 'Cardiac Arrest?' dropdown box
  - Cardiac Arrest Info (See Image Next Page)
    - **Cardiac Arrest Etiology**
      - Select from the dropdown what caused the cardiac arrest
    - **Cardiac Arrest Witness**
      - Select from the dropdown if the arrest was witnessed and by whom
    - **Resuscitation Attempted**
      - Use the + encircled in blue to select any and all Cardiac Arrest treatment that has been attempted or was provided prior to your arrival
        - This includes lay persons and other healthcare providers that may be listed under the "Call Conditions" tab
    - **Time of Arrest Prior to EMS Arrival**
      - Select from the dropdown how long it has been since the time the pt was found or witnessed going into arrest, until the time you arrive on scene to provide care
    - **Pre-Ambulance AED**
      - Select from the dropdown if an AED was used prior to your arrival and by whom
    - **Pulse with Pre-Ambulance Defib**
      - Was there ever a pulse or was the AED successful in resuscitation of the patient prior to your arrival.
    - **Return of Circulation**
      - If the patient has had a return of circulation prior to your arrival or obtains one due to your efforts on scene, select the appropriate response from the dropdown.
    - **Date/Time CPR Discontinued**
      - Only applicable if MCEP orders providers to stop all efforts to resuscitate the patient.
        - Ensure to record the date and time of the order.
      - **Rhythm at Destination**
        - Use the + encircled in blue to select the appropriate cardiac rhythm the patient is presenting with upon arrival of the ED.

Cardiac Arrest Info

Cardiac Arrest Etiology

Cardiac Arrest Witness

Resuscitation Attempted

Click here to add...

Time of Arrest Prior to EMS Arrival

Pre-Ambulance AED

Pulse with Pre-Ambulance Defib

Return of Circulation

Date/Time CPR Discontinued

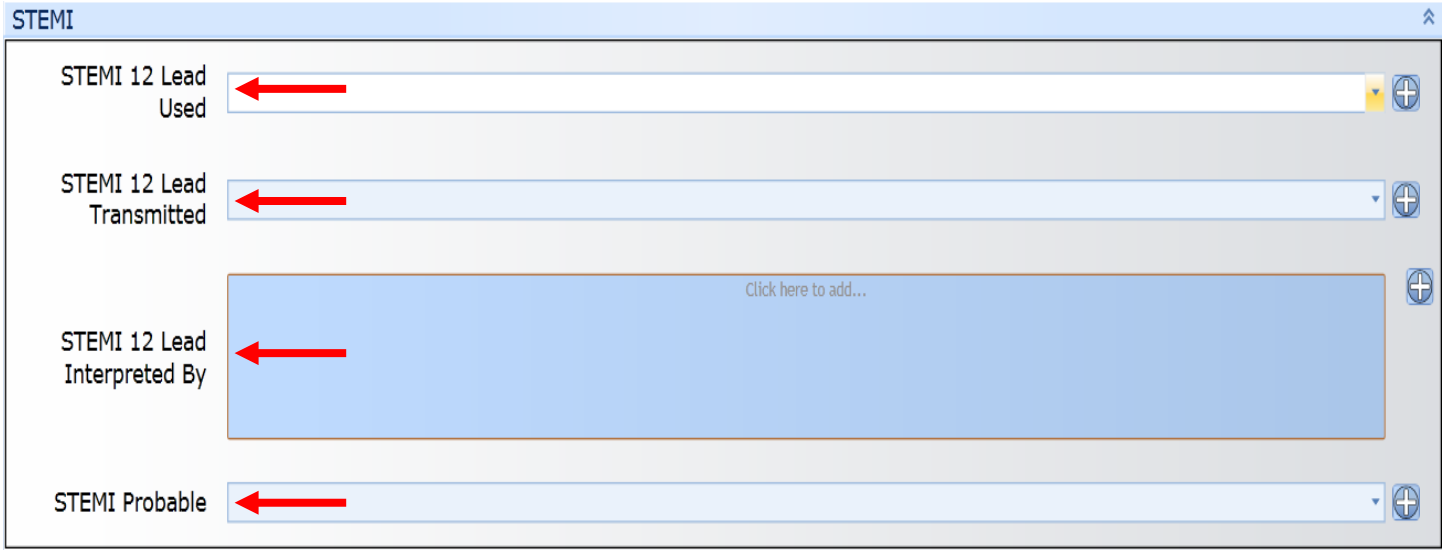
mm/dd/yyyy

Rhythm at Destination

Click here to add...

PATIENT HEART ATTACK INFORMATION (AMI, STEMI, ACS)

- STEMI TAB – This tab will only be visible if an answer of "Yes" was provided in the "Call Conditions" Tab, *Cardiac/Trauma* section, 'STEMI Triage Criteria' dropdown box
  - STEMI
    - **STEMI 12 Lead Used**
      - Select from the dropdown if a 12 lead EKG was performed
    - **STEMI 12 Lead Transmitted**
      - Select from the dropdown if the 12 lead EKG that has been captured was sent to the receiving facility
        - Only applicable for providers who have the capabilities to send the EKG
    - **STEMI 12 Lead Interpreted By**
      - It is auto populated with EMT-Paramedic
        - The provider may select additional medical personnel who have provided an interpretation by clicking the + encircled in blue and selecting as appropriate
          - For example, if a doctor is on scene and has provided an interpretation
    - **STEMI Probable**
      - Select from the drop down if the provider feels that the patient is in fact suffering from an ST Elevation Myocardial Infarction (STEMI)



TRANSPORT INFORMATION

✱ TRANSPORT TAB (See Image Next Page)

- Life Threat & Transport Mode
  - **Life Threat**
    - Select from the dropdown if the complaint / injury could cause the patient to lose their life
      - If you and your crew were not there at that moment, would the patient have died?
  - **Transport Mode From Scene**
    - Select from the dropdown if the patient was transported code 1 or code three and if the unit was required to upgrade / downgrade
      - Code 1 – No Lights or Sirens
      - Code 3 – Lights and Sirens
- **Destination Information**
  - Destination Determination
    - Select from the dropdown who made the decision to transport where you did
  - **Destination Type**
    - Select from the dropdown if you transported all the way to a hospital or did you intercept
  - **Destination Name**
    - Select from the dropdown the name of the receiving hospital you transported to
      - If you intercepted, select the destination name that the other unit transported to.
      - If the hospital that the patient was transported to is not in the list, please notify your supervisor to notify the EMS Chief so that it can be added.
  - **Facility Diverted From**
    - Only needs to be completed if the original receiving facility has diverted your unit to another hospital.
    - Select from the dropdown when applicable
      - Ensure to document in your narrative (P.18) that a diversion has occurred and any orders or reasons why
- **Transfer of Care for Transport**
  - If your unit is transporting to, or turning over care to another EMS transport service, select that service from the dropdown
- **Transport Mileage** – Only applicable for transporting units – first response rescues that are not providing an intercept or transport are exempt from this section
  - All text boxes are free text entry
  - The "Loaded Trip Meter Mileage" will auto populate once the 'At Scene Odometer' and 'Destination Odometer' have been entered.
    - The two most important mileages to enter are the 'At Scene Odometer' and 'Destination Odometer' as this calculated transport mileage is what is used for billing purposes
    - The starting mileage will auto populate with 0.0
      - First Response Rescues, if at times you are providing transport or intercept, set your on scene mileage to 0.0 and record the mileage when you get to the hospital or intercepting unit.
- Patient Outcome Linkage (Admin Use)
  - All field providers are exempt from entering data in this section as this is for Administrative ONLY to use

Life Threat & Transport Mode

Life Threat

Transport Mode From Scene

Destination Information

Destination Determination

Destination Type

Destination Name

Facility Diverted From

Transfer of Care for Transport

Agency ID Transferred To

Call Number Transferred To

Transport Mileage

Mileage From Trip Meter

Loaded Trip Meter Mileage: 21.4

OR Mileage from Odometer Readings

Starting Odometer 0.0

At Scene Odometer 3.8

Destination Odometer 25.2

Ending Odometer 25.2

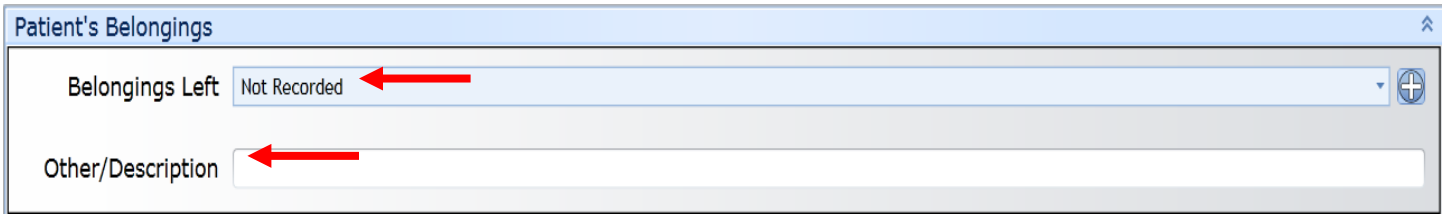
Total Mileage: 25.2

Patient Outcome Linkage (Admin Use)

NARRATIVE INFORMATION

✱ NARRATIVE TAB

- Patient's Belongings
  - **Belongings Left**
    - Select from the drop down where and who you left any patient belongings with
  - **Other / Description**
    - Free Text any additional information about who and where you left the belongings (if needed
      - Enter what the belongings were that were left with the above person



- Service Defined Questions (Not Visible)
  - If SCFD wished to add any questions specific to our usage, they will be listed here and an update to this manual will be provided with explanation
- Narrative
  - **Condition of Patient at Destination**
    - Only applicable for transport services that have transported all the way to the receiving facility
    - Select appropriate language from the dropdown
  - **Narrative**
    - Can be input two different ways
      - Free Text can be utilized and the provider can manually enter the DCHARTE information – see Appendix A
        - D – Dispatch Information – What did dispatch give to you as call information
          - i.e. 29B2, two vehicle motor vehicle accident with injuries, airbags deployed
        - C – Age and sex of the patient along with the patients Chief Complaint in their own words
          - i.e. "59 year old male complaining of chest pain and shortness of breath"
        - H – History information (Requires two pieces, History of Present Illness and Past Medical History)
          - History of Present Illness (HPI) What were the events leading up to the complaint, what happened, what is the patient felling and reporting to you. What have others (Police, Lay persons, etc) told you about what is happening, etc. Use direct quotes as needed.
          - OPQRSTU
            - i.e. Pt reports he was relaxing on the couch when he suddenly felt a pressure in his chest, 8/10 radiating to his left arm, does not change with movement or palpation, does not report feeling this any other time today, this has never happened to him before.
          - PMH – What is the patients past medical history.
            - Because the information has been listed under the 'History' Tab, the provider can simply state here, "History as above in History Tab"
            - If there is additional information about the history that was not listed in the History Tab, include that information here (i.e. Pt reports he is compliant with all medications)
        - A – Assessment
          - What did you see, smell, hear observe, etc.
          - What position was the patient in
          - Most of the assessment will be listed above, the provider can elect here to free text a head to toe assessment or, simply state "See assessment Tab above."
        - Rx – Treatment
          - What treatment was provided for the patient

        - Treatment includes all medication administration and patient response to the medication
        - Treatment includes all procedures performed
    - T – Transport
        - What mode of transport was used, code 1 (no lights / sirens), or code 3 (lights / siren)
        - Any reassessments or major changes that occurred during transport
        - Who was the patient left with, who was the turnover report given to (nurse or above)
        - Document if HIPAA was given and if there were any questions or concerns
        - Document if billing signatures were obtained and if there were any questions or concerns.
    - E – Exceptions
        - Were there any exceptional issues that caused delay or anything out of the ordinary that needs to be documented or may be able to assist you in remembering the call.
            - Some exceptions may be a repeat or an explanation of the information provided under the Call Conditions Tab, Unit Delays During Call.
- Or, user can use the Auto Narrative Option
    - To do this, on the lower right hand side is a blank dropdown, select one of the two options, dCHARTE Transport if you transported the patient (including transport to intercept) or dCHARTE non-transport if you are not the transporting agency
        - Click the Set Narrative button next and then follow the prompts and answer the questions as completely as possible
        - When finished, the entire dCHARTE will populate in the Narrative section
            - It is the responsibility of the user to read through the auto narrative to ensure accuracy, flow and well composed
- If the user wished to completely delete the narrative and redo the document, click the Clear button on the far lower right side.

- The next item just below the Narrative gives the user the option to '**Attach AMA to this Incident**'.
    - Once selected, the remaining information below becomes available to be filled out
        - This Shall only be done for Patient Refusals
            - First, select one of the three options for type of refusal
                - Against Medical Advise
                    i. To be used for patients who refuse to be treated/transported against the advice of the medical provider or medical direction
                    ii. These may require MCEP consult
                - Refuse Specific Care
                    i. For the patient that is refusing certain care, advice, recommendations, transport, etc
                - Request Release
                    i. For the patient who does not feel his/her condition requires EMS care or transport
            - Next, four free text boxes are presented
                - List Specific Items Refused
                    i. This defines the selection above (i.e. Pt refuses transport to ED)
                - Patient/Guardian reason for AMA
                    i. If the patient is refusing AMA, state why here
                - Patient/Guardian alternative plan
                    i. For example, 'Pt will stay home and monitor' or 'Pt going to ED POV.'
                - Who (Family/Friends) with patient now?
                    i. List family and/or friends that will remain with the patient, type NA if not applicable and explain any exceptions here
            - Then, the next seven questions are simple Yes/No responses to the questions
                - Any NO answer to one of these questions requires MCEP consult

Narrative

Condition of Patient at Destination: Not Recorded

Narrative

Spell-Check | Save | Set Narrative | Clear

☑ Attach AMA to this Incident

- AGAINST MEDICAL ADVICE, refuse medical care, transportation, and/or advice by this agency.
- REFUSE SPECIFIC care, advice, or recommended destination as provided by this agency.
- REQUEST RELEASE, as I do not feel my condition requires emergency care and/or transportation by this agency.

List Specific Items Refused

Patient/Guardian reason for AMA

Patient/Guardian alternative plan

Who (family/friends) with patient now?

AMA/Release Checklist

Is Patient (or Guardian) oriented to person, place, time & event?

Is Patient Unimpaired by drugs or alcohol?

Is Patient (or Guardian) competent to refuse care?

Has patient (or Guardian) been advised that 911 can be reassessed?

Have the risks and complications of refusal been discussed?

Is the patient 18 YEARS OF AGE or emancipated?

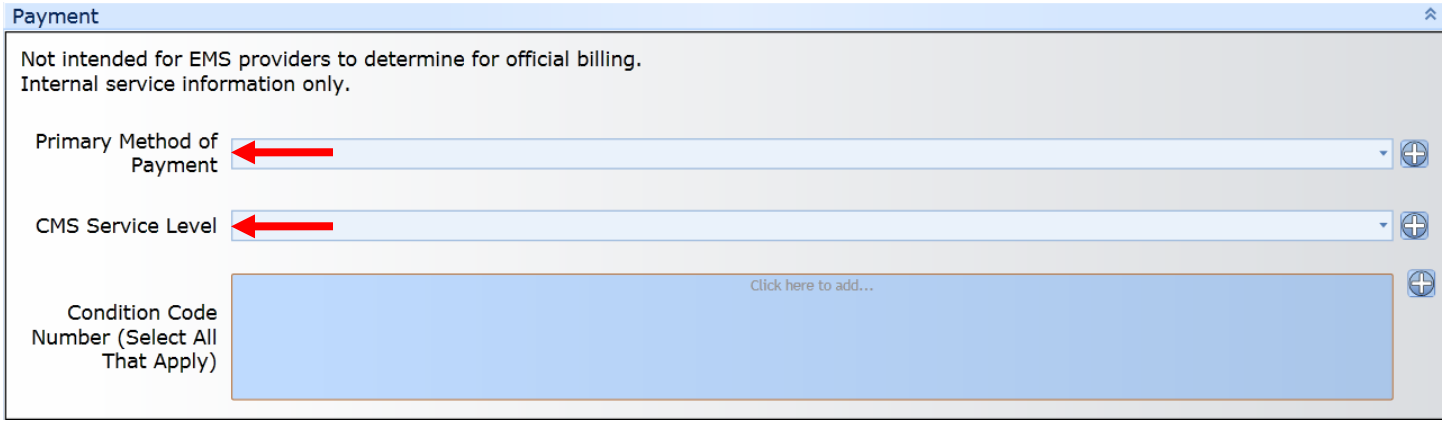
No medical care or only BLS care rendered?

*Any NO answer requires: Base Hospital Contact for ALL personnel

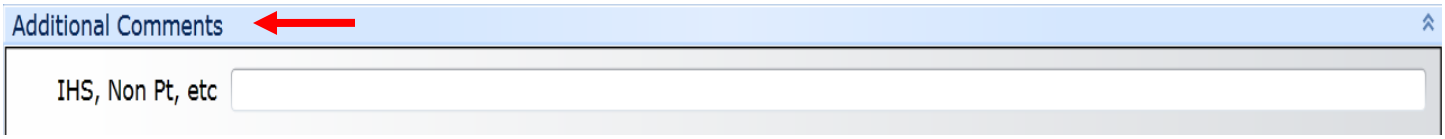
BILLING INFORMATION

✱ BILLING TAB – Official Billing will be used with the information providers provide on this tab

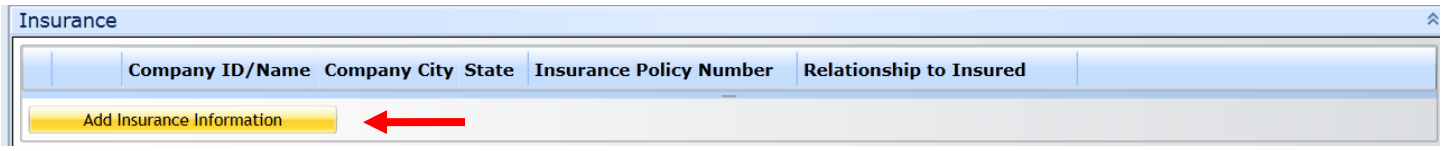
- Payment
  - **Primary Method of Payment**
    - Select from the dropdown
      - Not Reporting – The patient refuses to provide any information
      - Insurance – The patient has insurance that is their primary form of payment
      - Medicaid – The patient has Medicaid and is used for their primary form of payment
      - Medicare – The patient has Medicare and is used for their primary form of payment
      - Not Billed (for any reason) - must be very specific if a patient is not to be billed and must be thoroughly documented in the narrative
      - Other Government – Used if the patient uses an alternative form of federal funds as payment
        - i.e. Indian Health Services (IHS)
      - Self Pay – The patient does not have insurance or wishes to pay the bill out of pocket
      - Workers Compensation – Did the patient sustain an injury while at work and the company is now responsible for the payment
      - Not Known – No information was obtainable due to patient mentation
  - **CMS Service Level**
    - Patient Evaluation
      - Used for patient refusals where an assessment was provided but no transport was provided
    - BLS
      - Used when the patient being transported required only basic level interventions and assessments
        - Oxygen is considered a basic level treatment
    - ALS, Level 1
      - Used when at least one ALS intervention is provided by an Intermediate or Paramedic
        - i.e. IV was initiated or the cardiac monitor was used for a baseline EKG / 12 lead EKG
    - ALS Level 2
      - Used when at least three different ALS medications by IV bolus or continuous infusion were administered (including the ILS medications) or; when the same ALS medication is administered three or more times or; when "one or more of the following ALS procedures are provided: manual defibrillation/cardioversion, endotracheal intubation, central venous line, pacing, chest decompression, surgical airway, advanced invasive airway, or intraosseous access.
        - Advanced invasive airway includes Combitube, LMA, and King Airways
  - Condition Code Number (Select All That Apply) – **all providers are exempt from this information at this time**



- **Additional Comments**
  - This is to be used by providers that have exceptions with the billing info
    - For example, what IHS contacted and when they were contacted; is the patient not receiving a bill due to being a non-patient; why the provider selected 'Not Billed for Any Reason'; etc



- Insurance
- Click the tab titled **'Add Insurance Information'** which will open additional text boxes that shall be filled out as outlined below with information obtained from the patient



(Continues next page)

- **Insurance Company ID / Name** – What is the name of the insurance provided (image next page)
  - Relist Medicaid, Medicare here and fill out additional information
  - Define Other Government here
  - Define Workers Compensation information here
    - Name of employer
  - If the injury is due to motorized vehicle incident – the provider shall also list the vehicle insurance company to this section
  - Can free text the information or use the + encircled in blue to pull up a list of common insurance companies
    - If the patient does not have insurance and is a resident of Sandoval or Bernalillo County, select the **"AAAA Indigent"** option and the patient will receive information from the county on assistance to medical payments
- **Insurance Company Billing Priority**
  - Is this Company ID/Name the patients primary, secondary, or other
    - The Insurance Company Address, City, State and Zip may auto populate. If they do not, leave the information blank and the billing company will finish
- **Insurance Company Address**
  - If available, fill in the address of the insurance company, if unavailable, leave blank
- **Insurance Group ID / Name**
  - If the patient is able to show you an insurance card, input the Group number that is on the card
    - If not available, leave blank
- **Insurance Policy ID / Number**
  - If the patient is able to show you an insurance card, input the ID number that is on the card
    - If not available, select the 'Get SSN' button on the bottom of the screen, the SSN number will then be auto populated in the ID slot
- **Last Name, First Name and Middle Initial of the Insured**
  - Can be typed in
    - Preferred if the name of the insured is different than the patients name (i.e. minors)
  - Can be auto populated with the patient information by selecting the 'Get Name' button on the far right hand side next to the Middle Initial of the Insured box
- **Date of Birth – provider may fill in if needed**
- **Relationship to the Insured**
  - Select from the dropdown or use the + encircled in blue to select the appropriate response
    - Other – someone who is not the patient or related to the patient but provides insurance for the patient
    - Self – The information is the patient's own information and is listed as the insured
    - Son / Daughter – Is the patient the son / daughter of the insured (the patients parent)
    - Spouse – The patients spouse is listed as the primary insured
- Click **Save Insurance Information**

Insurance

Company ID/Name	Company City	State	Insurance Policy Number	Relationship to Insured

Insurance Company ID/ Name

Insurance Group ID/Name

Insurance Company Billing Priority

Insurance Policy ID Number

Insurance Company Address

Last Name of the Insured

Insurance Company City

First Name of the Insured

Insurance Company State

Lookup

Middle Initial of the Insured

Get Name

Insurance Company Zip

Set from Zip

Date of Birth

mm/dd/yyyy

Relationship to the Insured

Get SSN

Save Insurance Information

Cancel

SIGNATURE INFORMATION

- ✱ SIGNATURES TAB (For Transporting Ambulances Only)
  - ➢ The following information refers to all potential signatures that a provider may need depending on the disposition selected.
  - ➢ Once a disposition is selected on the Dispatch Info page, only the signatures that apply to that disposition will be visible to the user in this section.
  - ➢ Clicking on the title will expand the section
    - Hospital Receiving Agent ID and Signature
      - This is for units that have transported a patient to an Emergency Department
        - The NURSE or MD that is taking the turnover from the provider shall sign in the **yellow signature box**
          - o Ensure that the nurse or MD agrees to receiving the patient and select '**I Agree**' above the signature
          - o Print the name of the nurse or MD in the free text box titled '**Printed Name**'
            - ❖ Ensure to Print First and Last name and title of that provider
          - o Ensure to Fill out the **Date and Time** of the signature in the boxes next to the name

- Advanced Airway Signature
  - This is for units that have transported a patient to an Emergency Department
    - An MD shall verify the placement of the tube and sign in the **yellow signature box**
      - o **This is required for any advanced airway placement**
    - Ensure the '**I Agree**' selection is checked, select the **placement**, **findings**, **method** of verification, and any **comments** from the doctor. **Print** the MD name and ensure the **date** is accurate.

Advanced Airway

I acknowledge that I have checked the placement of the advanced airway and have caused my findings to be documented on the electronic patient care report.

I Agree I Disagree Not Applicable

X Please Sign Here

Placement

Findings Click here to add...

Method Click here to add...

Comments

Printed Name

Date mm/dd/yyyy

- Medical Control/Physician signature
  - If the transporting unit called an MCEP for orders, the MCEP shall be located once the patient has been turned over and the following information shall be documented
    - The MCEP shall sign in the **yellow signature box**
    - Print the MCEP name in the **Printed Name** area and ensure the **date** is accurate
    - Ensure the '**I Agree**' selection is made
    - Ensure to document and expand on what orders were given in your narrative

Medical Control/Physician

I acknowledge that I have authorized the use of controlled medications/procedures for this patient.

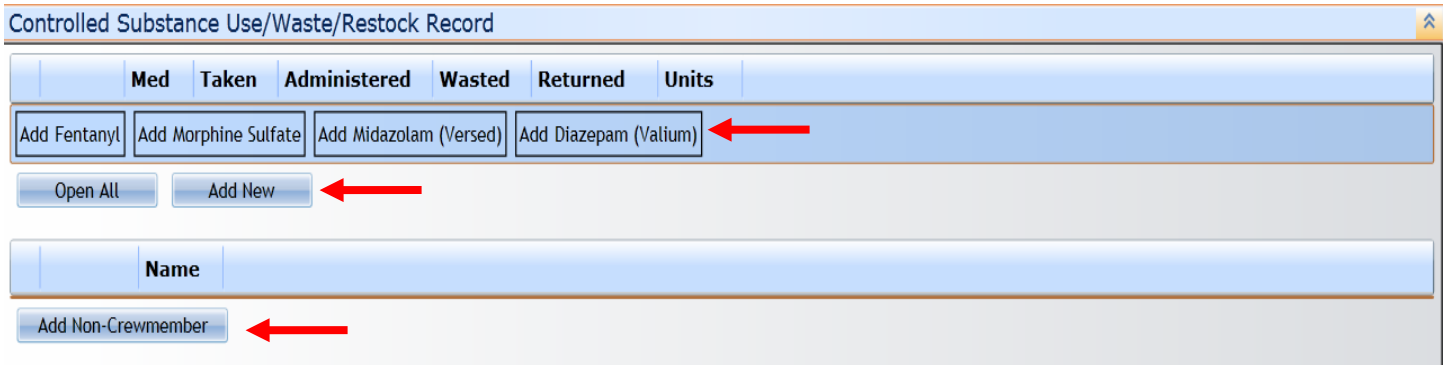
I Agree I Disagree Not Applicable

X Please Sign Here

Printed Name

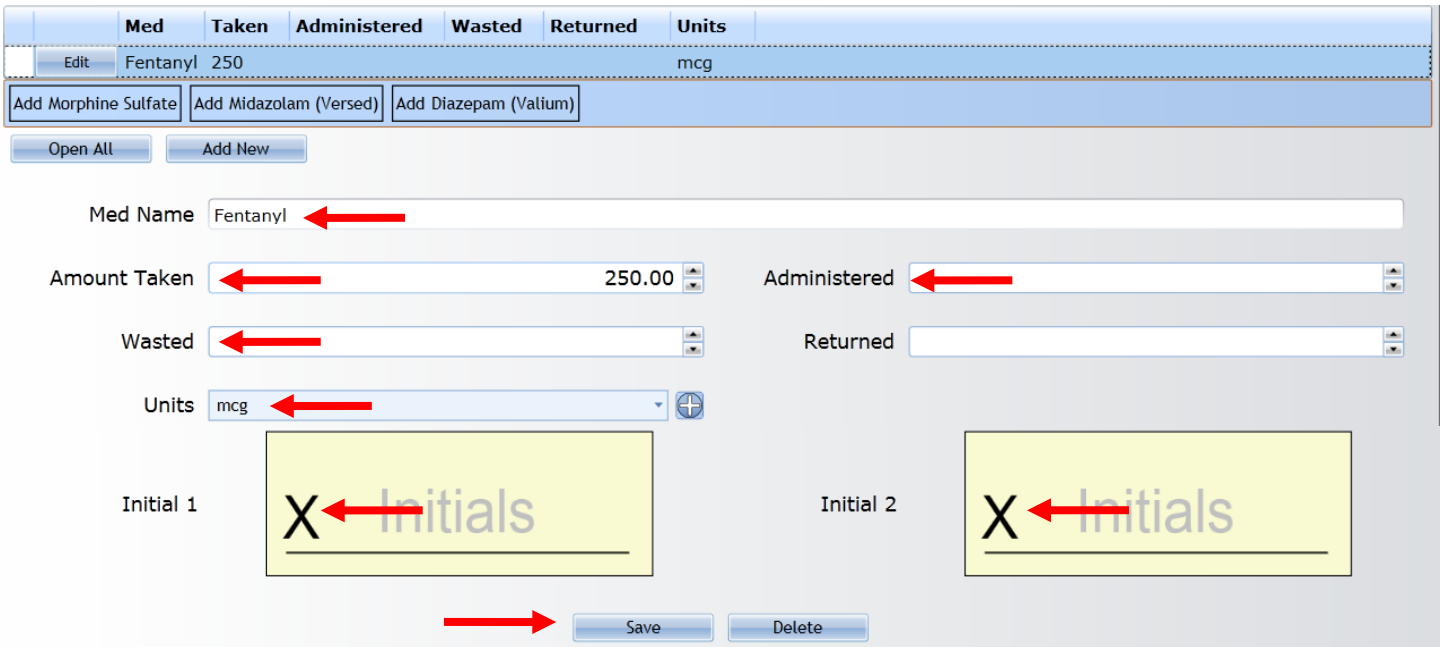
Date mm/dd/yyyy

- Controlled Substance Use/Waste/Restock Record
  - To be used anytime a controlled substance has been administered to a patient
  - Once the window is open, the following will display

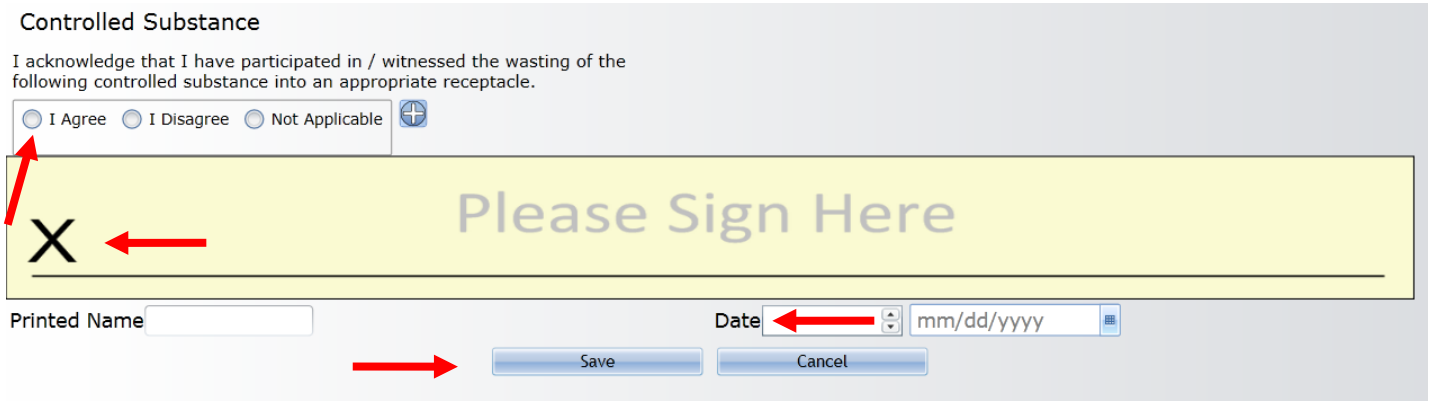


  - Select the appropriate medication that has been administered by selecting the '**Add** ___' button
  - Ensure the **Med Name** is correct
  - If the medication was appropriately added to the chart in the Vitals/Treatment tab, the **administered** dosage will already be filled in. Ensure the amount is correct, if not, ensure the correct documentation in the vitals/treatment tab and try again.
  - Ensure the **amount taken** is correct (what was the size of the vial)
  - Ensure or type in the amount **wasted**
  - Ensure the **units** of measurement are correct
  - Leave the Returned area blank
  - The two **initial boxes** are for the providers that were with the patient when the medication was administered. These verify the provider administering the medication and a second provider (on scene or with the pt, ie driver) that the medication was given
  - Ensure to click **Save**
  - Each vial used must be documented this way
    - In the event two vials of the same medication were used, the provider shall log the first one and then, for the second one, select '**add new**' and free text the name of the second vial being used. Ensure to complete all required documentation as outlined above.

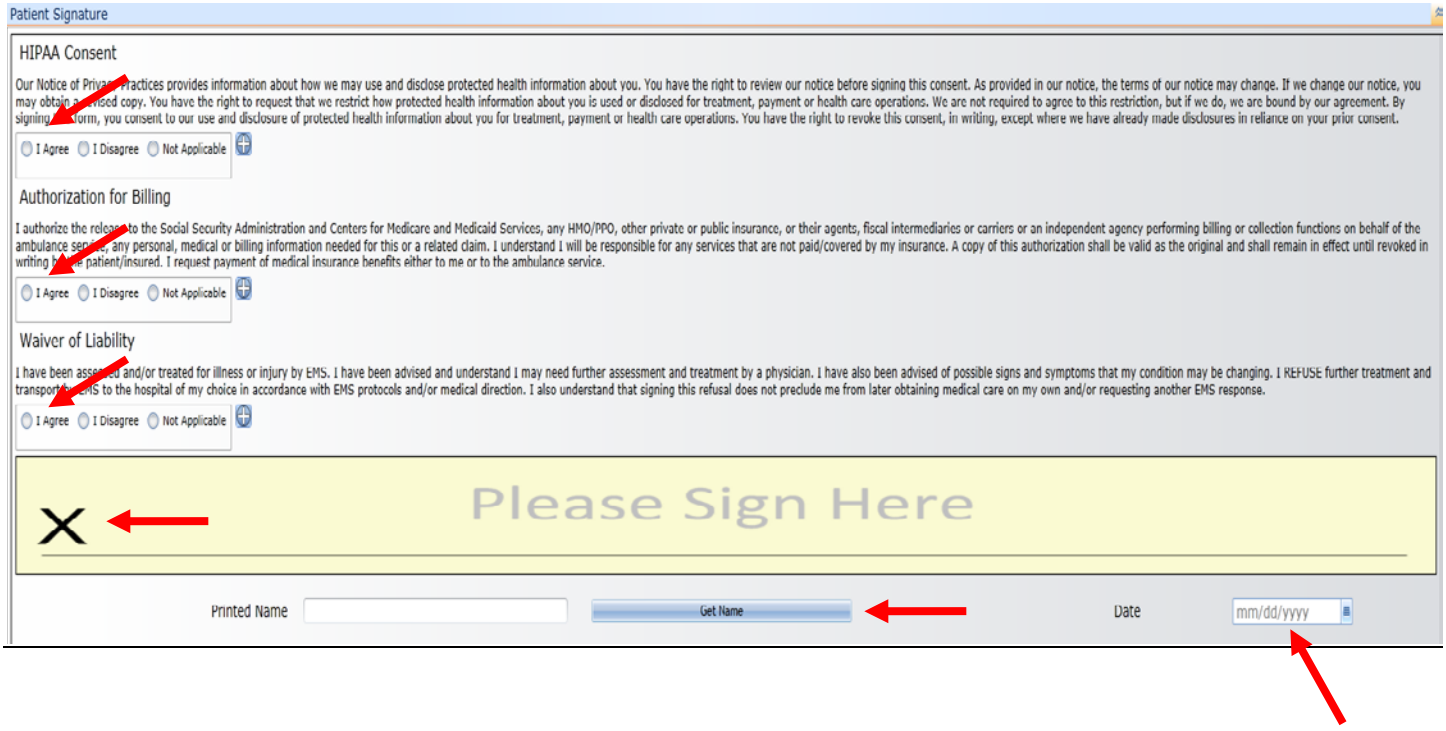
(Images next page)

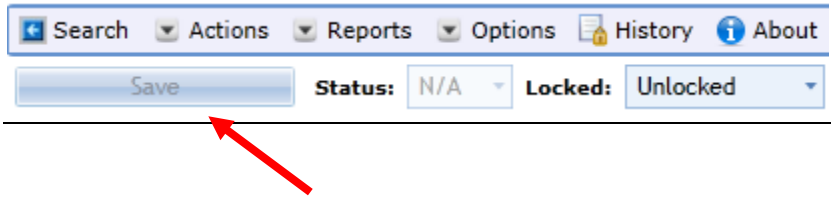


- Once the **Add Non-Crewmember** box has been selected, the following will appear
  - If a nurse or MD is not available to witness the waste, crew shall try to utilize a Chief Officer or Career Lt.
    - As a last resort, crew may use their partner
- Ensure the '**I Agree**' button is selected, a signature is in the **yellow signature box**, the **date and time** is accurate
- Type in the witness full name and credentials in the **Printed Name** box
- Click '**Save**'

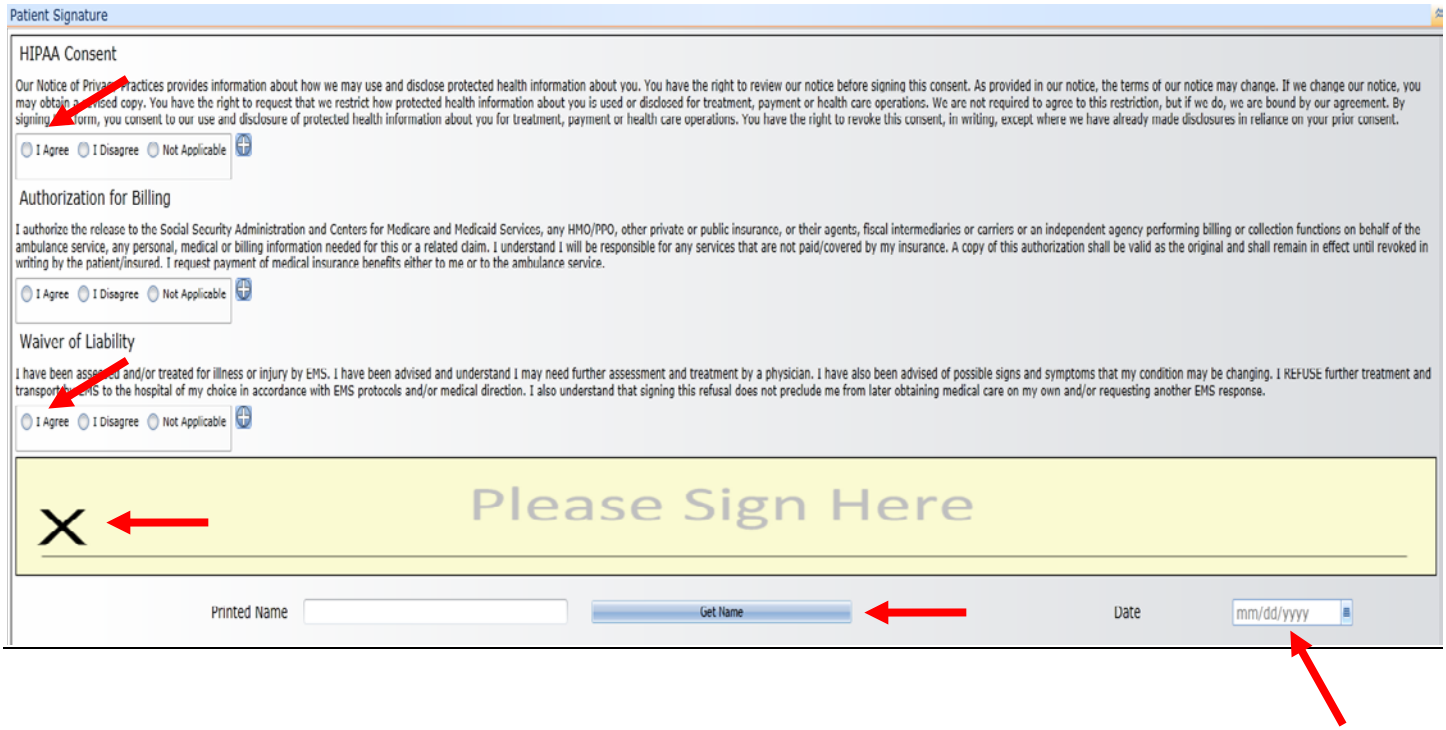


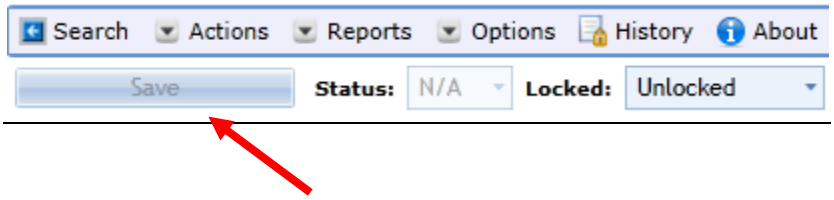
- Patient Signature
  - This section is soon to be updated as refusals will be in their own signature area
  - All Patients shall receive HIPAA paperwork, ensure to select '**I Agree**'
  - For units that are transporting, ensure to explain billing procedures to the patient, ensure the patient agrees and select '**I Agree**'
  - For Refusals, **READ** the Waiver of Liability portion to the patient, ensure they agree and select '**I Agree**'
  - Ensure the Patient signs in the **yellow signature box**
  - If the patients name has already been input under patient info, the user may select the **Get Name** tab and the **Printed Name** will auto generate. Otherwise, manually input the name
  - Ensure the **Date** is accurate
  - Click **Save** at the top left of the screen



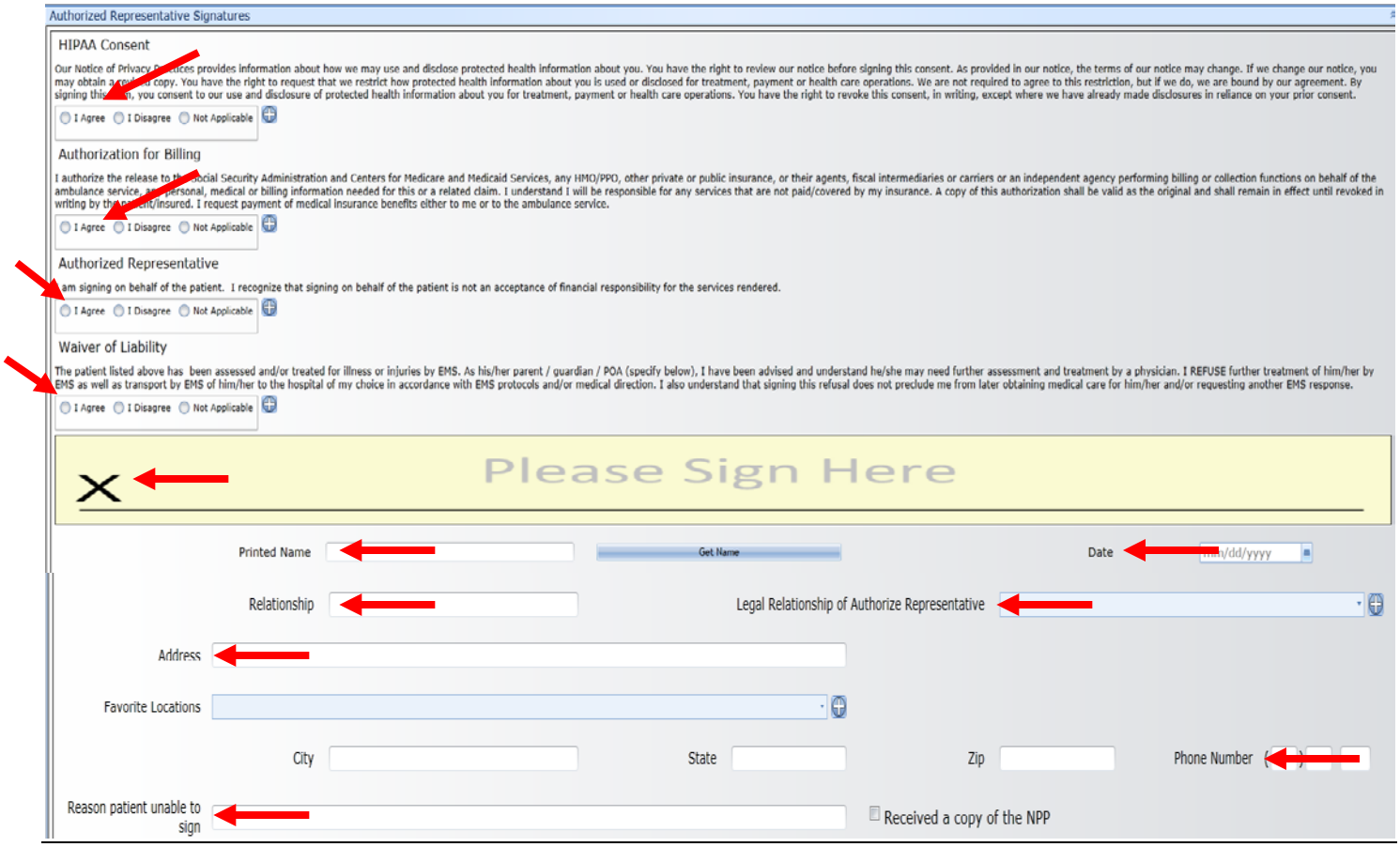


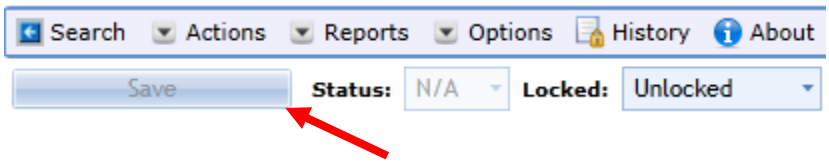
- Non Patient Signature (for non pt refusal only)
  - This section is soon to be updated as refusals will be in their own signature area
  - All Patients shall receive HIPAA paperwork, ensure to select '**I Agree**'
  - Authorization for billing, leave blank
  - For Refusals, read the Waiver of Liability portion to the patient, ensure they agree and select '**I Agree**'
    - Some providers may elect to still use paper refusals for this section. If that occurs, the paper must be scanned in and attached to the chart
  - Ensure the Patient signs in the **yellow signature box**
  - If the patients name has already been input under patient info, the user may select the **Get Name** tab and the **Printed Name** will auto generate. Otherwise, manually input the name
  - Ensure the **Date** is accurate
  - Click **Save** at the top left of the screen



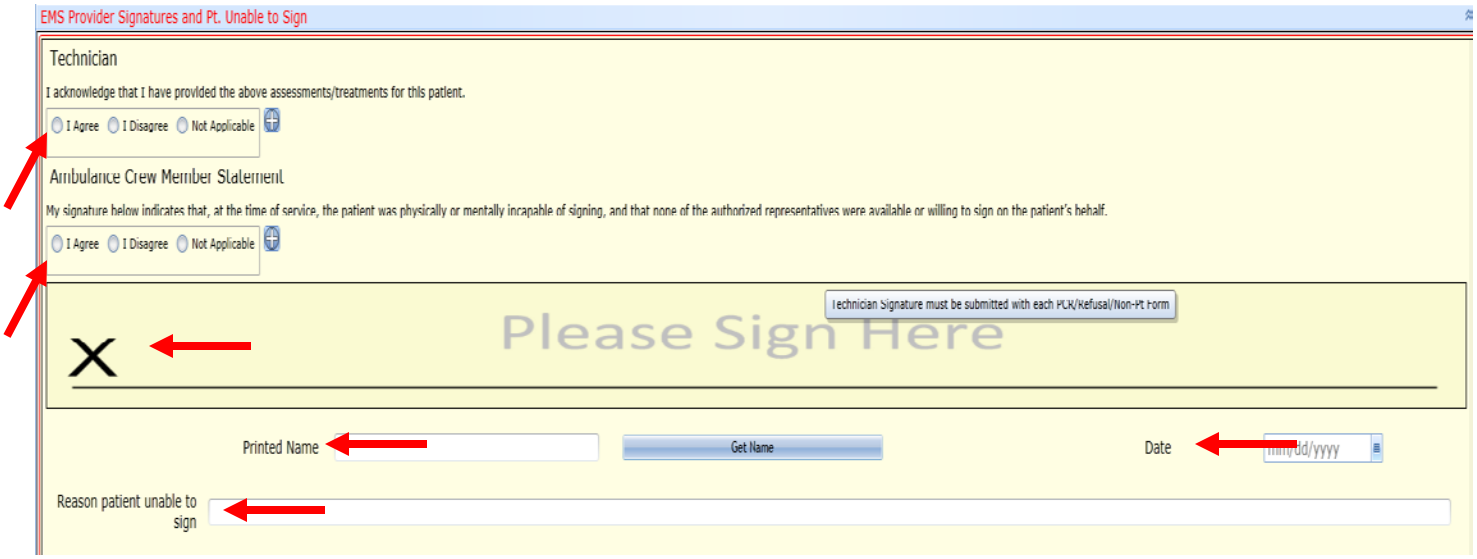


- Authorized Representative Signature
  - This section is for patients that are minors who's parent is signing; or a patient with a power of attorney; or if a patient is not able to sign but there is a family member that can sign on their behalf
    - Any of the above shall be briefly explained in the narrative
  - All Patients shall receive HIPAA paperwork, ensure to select '**I Agree**'
  - For units that are transporting, ensure to explain billing procedures to the representative, ensure the representative agrees and select '**I Agree**'
  - Ensure the representative understands they are signing on behalf of the patient, select '**I Agree**'
  - For Refusals, read the Waiver of Liability portion to the patient, ensure they agree and select '**I Agree**'
  - Ensure the Patient signs in the **yellow signature box**
  - Manually type the representatives name in the Printed Name box
  - Ensure the **Date** is accurate
  - Type in the **relationship** to the patient (Parent, POA, etc.)
  - Select from the dropdown the **Legal Relationship of Authorize Representative**
  - If available, get the representatives **address** and **phone number**
  - Ensure to type the Reason **patient was unable to sign**
  - Click **Save** at the top left of the screen

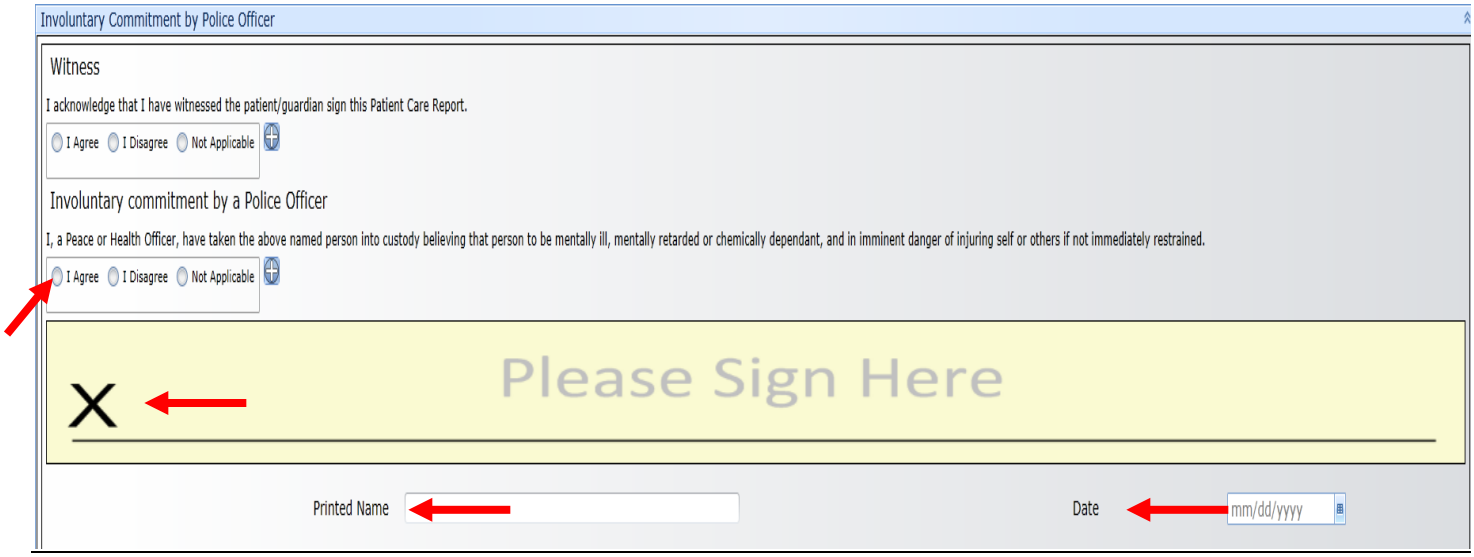




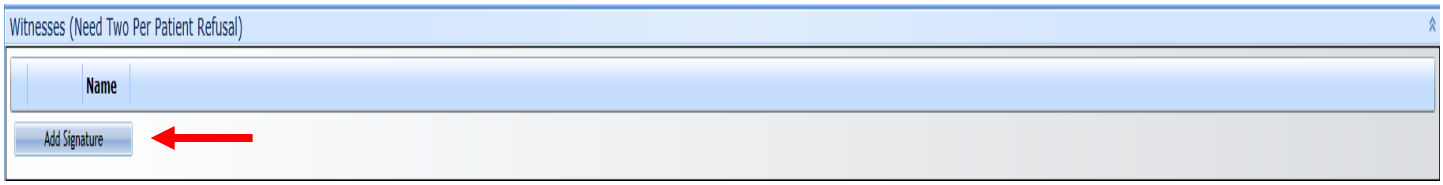
- EMS Provider and Pt. Unable to Sign
  - This section is required anytime an EMS provider writes a chart
  - Technician
    - The provider filling the chart shall read this statement and select '**I Agree'**
  - Ambulance Crew Member Statement
    - If the patient was unable to sign for any reason and there was not a representative to sign for them, read this statement as well and select **'I Agree'**
  - Ensure to sign in the **yellow signature box**
  - Print your **name** and ensure the **date** is correct
  - If the patient was unable to sign and a representative did not sign, type the **reason the patient was unable to sign** and expand on it as needed in the narrative



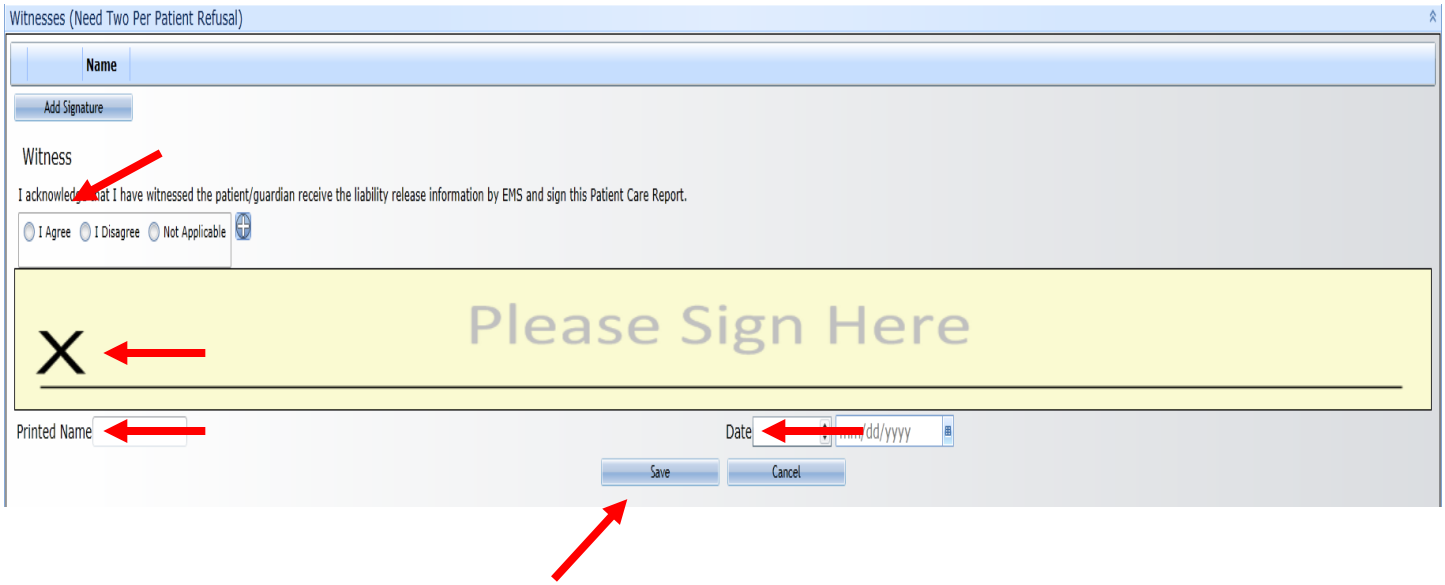
- Involuntary Commitment by Police Officer
  - If a law enforcement or Health Officer has taken a patient into custody so as to ensure the patient is transported by our agency for the safety of the patient, the following signature is required
    - The Witness area of this section will be non visable in the near future
    - All witness signatures shall go in the Witness area of the signatures (next page)
  - Ensure the officer reads the section Involuntary commitment by a Police Officer and agrees, select '**I Agree**'
  - Have the officer sign in the **yellow signature box**
  - Print the **name** and credentials of the officer
  - Ensure the **Date** is accurate



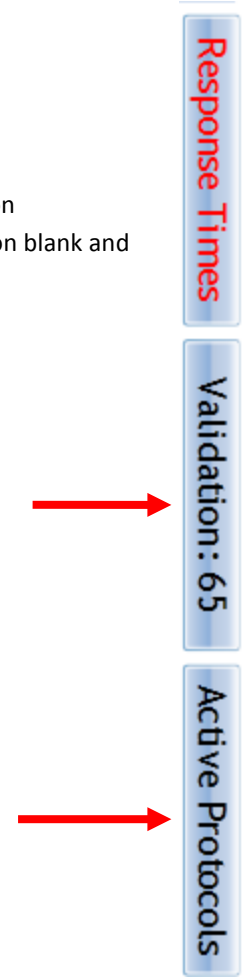
- Witnesses
  - This section is to be used anytime a refusal has been obtained
    - Two witnesses are required for each refusal per SCFD protocol
    - Always attempt to get others to witness, such as family members, law enforcement, other agencies
      - As a last resort, use SCFD personnel
  - Once the Witnesses tab is selected, the following is displayed, click **Add Signature**



  - Once the **Add Signature** page is selected, the following is displayed
  - Ensure to read the statement to the witness and select '**I Agree'**
  - Ensure the witness signs in the **yellow text box**
  - Ensure to type the **name** of the witness and credentials
  - Ensure the **Date and Time** is accurate
  - Click **Save**
  - Repeat for the second witness



ADDITIONAL BUTTONS AT THE SIDE OF THE CHART



- Far Right Side Buttons Under Response Times
  - **Validation**
    - This button keeps track of the percentage of completion for the chart based on the disposition.
      - All charts shall be completed as close to 100 % as possible **without falsifying** any information
        - If information is not obtainable, such as a phone number or Social, leave the information blank and post the chart even though validation may not be 100.
    - The button can be selected at any time and a list of items that still require validation will appear
      - Any of the items can be selected and the provider will be taken to the appropriate tab
  - **Active Protocols**
    - Not being utilized by us at this time

This concludes the instructions for the EMS Manual. Additional manuals are to be forthcoming and shall include, Field Bridge and Fire Bridge Manual for inputting Fire Charts, Training Manual for entering trainings, and appendices for all additional information. This Manual is a living document and subject to change. Any change to the document shall be explained and forwarded to all personnel.

Any questions please use Helpdesk or email emasterson@sandovalcountynm.gov

Appendix A

How to handwrite an EMS chart using DCHARTE format

The following is an example as outlined above in the Narrative section of the Manual (this is to serve as an example only, if you have a different style of using DCHARTE that has been approved by SCFD Medical Direction, you may use in place of this example)

D- 10D4, 60 year old male with Chest Pain

C- 60 year old male patient complaining of chest pain to the anterior left portion of his chest.

Hx- HPI- Pt reports that about an hour ago, while watching TV, he began experiencing chest pain. Pt reports the pain has gradually increased since onset. Pt reports the pain is a pressure pain, 8/10, radiates to his left arm type pain. The pt states nothing makes it better or worse and that he has never felt this pain before. Pt denies any activity prior to onset; pt denies any recent trauma to his chest. Pt does feel nauseated and sweaty, denies shortness of breath. Pt reports he did self administer 81mg of Baby Aspirin per the dispatcher's recommendation. Pt denies any headache, changes in vision, neck or back pain, abdomen pain, numbness or tingling in extremities, pt denies any recent trauma, pt denies any recent illness or fever.

PMH- Pt has a medical history as outlined under the History section of the chart. Pt is compliant with medications.

A- Pt is awake, alert, tracking, sitting upright on chair, appears diaphoretic and in moderate pain, holding his chest. No obvious trauma noted, GCS 15, pain does not change with palpation. See complete assessment under assessment section of this chart.

Rx- Pt transferred to gurney, position of comfort, primary assessment and history obtained. 15 liters of O2 applied via NRB. 162 mg ASA administered. IV established, monitor shows a sinus rhythm with ST segment depression in V1. 12 lead EKG shows sinus with 3+mm of ST segment elevation in V1-V4. Nitro administered at appropriate intervals. Fentanyl administered at appropriate intervals as listed above to a total of 200mcg.

T- Transported code 3 to UNMH per pt request. Pt continually monitored, with treatment, pain reduced to a 4/10. Additional assessments found no other significant changes, serial 12 lead EKG's taken without change. Pt turnover to nurse and MD staff in resuscitation room without event. Hipaa left with pt, pt signed billing without question or concern.

E- There was a delay getting to the scene due to weather.