Ventura County EMS Agency

ePCR Documentation Guidelines

The Importance of Quality Patient Care Documentation

Generally, your patient care documentation serves two critical roles. Primarily, it provides a chain of events for the continuance of care from the onset of the patient's complaint through their arrival to definitive care, and helps best inform the subsequent caregivers. Equally important, your report provides you and other responders with supporting documentation in the event of litigation. The more thorough and accurate your document, the easier it is to defend and respond proactively to inquiries in the future.

"If there is no documentation of an event, it didn't happen."

Think of it this way:

Documentation is

- Professional accountability
- Legally recognized evidence
- A mechanism to help create credibility
- Transfers pertinent patient information to the people who need it
- Remains part of the patient's permanent medical record

You, as the representative of the entire Santa Barbara County Emergency Medical Services System (System), and your Agency, are responsible for keeping careful a written record of every patient interaction. This record must be a professional, objective, factual rendering of the patient encounter.

The documentation will become part of the patient's record and will be utilized by other medical professionals during the continuum of care. Accuracy, detail, and completeness are essentially important.

Additionally, your record is a pivotal part of your agency's and the system's continuous process for quality assurance, data collection, legal record, and billing.

If you are called to court 10 years from now, will you be able to answer all questions asked of you based solely on your written documentation?

Could you do the following in front of a jury years from now?

- Determine the identity of all prehospital responders present
- Remember any other healthcare providers who may have rendered aid
- Recall the exact times related to the incident
- Describe the type of patient encountered by the pre-hospital providers
- Explain what precipitated the illness or injury
- Determine the patient's medical history and medication regime at that time
- Remember the patient's allergies to medication(s), food, or the environment
- Recall why you were dispatched to the scene
- Correctly identify the patient's chief complaint
- Tell why the patient was being transferred
- Validate that the patient was competent to consent to or refuse treatment
- List the witnesses and family members at scene
- Describe your treatment path and ensure you gave proper medication(s) and dosage(s)
- Remember the drip concentration, dose, and rate you set up and delivered and verified
- Recall the Emergency Department Doctor who concurred with/ordered the treatment
- Describe the protocol you engaged, and the reasons you chose it
- Confirm that the observed patient conditions warranted the treatment path decision
- Based on ***written documentation*** confirm that the provider adhered to the protocol and current treatment standards within their scope of practice
- Determine whether or not the provider deviated from the standard of care
- Recall what treatment and/or medications the patient received at scene versus during transport to the hospital
- List the initial vital signs taken while at scene, as well as during transport
- Describe the patient's response to treatment(s) provided
- Remember the time that patient care was transferred to the transport provider, and/or the receiving facility
- Tell who received the report and patient, and their qualifications

ImageTrend Elite, NEMSIS v3, and CEMSIS

Laws, regulations, guidelines have changed, requiring all EMS providers to document to the new standard. California now requires all providers to submit v3 data electronically no later than January 1, 2017.

NEMSIS v3 aligns terms and definitions across numerous healthcare data languages such as Health Level 7 (HL7), ICD-10, SNOMED, RxNorm, etc. This creates a standardized picture for patient care documentation across the continuum of care. It may not seem like a big deal from our standpoint, but this does improve patient care by increasing efficiency, reducing cost through data integration and retrieval of outcomes, and standardization of healthcare delivery systems.

ImageTrend Elite is National EMS Information System 3 (NEMSIS) compliant. Santa Barbara County Image Trend Elite "Web" interface access and login are https://www.imagetrendelite.com/Elite/?OrganizationId=venturacounty/

Elite offers two interface options, available within either Google Chrome or iOS Safari browsers:

- ImageTrend Elite "Web" is the link above. This link requires a solid connection to the internet. You will note that there is no "Post" option in this site because it is constantly updating/saving as you complete the ePCR.
  - If you lose the internet connection and do not notice, information you enter can and will be lost unless you are using the "Field" interface (below)

- ImageTrend Elite "Field" can be found here: https://www.imagetrendelite.com/elite/organizationventuracounty/runform/login
  - The "Field" version interface is essentially the same interface. However, it runs by using your internet browser cache to support the program. No software installation is necessary.
  - This is the preferred method of completing ePCR's because all information is stored inside your browser's cache until you select "Post", preventing any loss of information.
  - As long as you have an internet connection, the information will automatically update and save every 30 seconds.
  - The "Field" site must be saved as a bookmark inside your browser or on your desktop while you have connectivity. Once it is bookmarked and synced the first time, you can open the "Field" interface without internet service.

Logging in to ImageTrend Elite "Web"
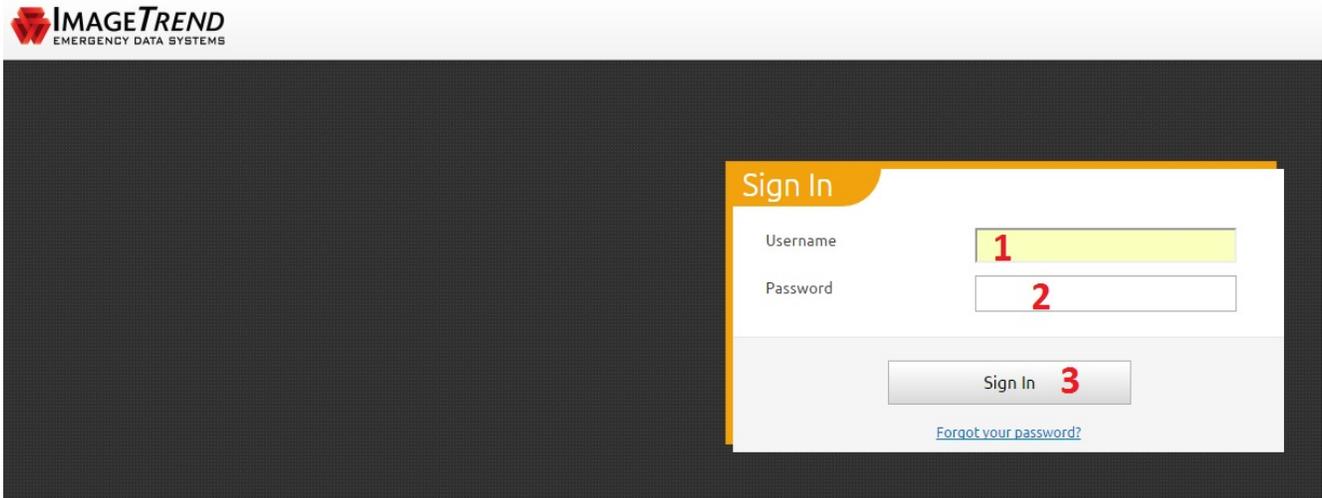
1. Go to this web address: https://www.imagetrendelite.com/Elite/?OrganizationId=venturacounty
2. Login with Username
3. Password
4. Click "Sign In"
   a. Click "Yes" on the next screen

Notice that there is a large "ImageTrend" symbol at the top left of the screen, and the gold color of the sign-in box. These indicate you are on the standard Elite "web" site

Logging in to ImageTrend Elite "Field"
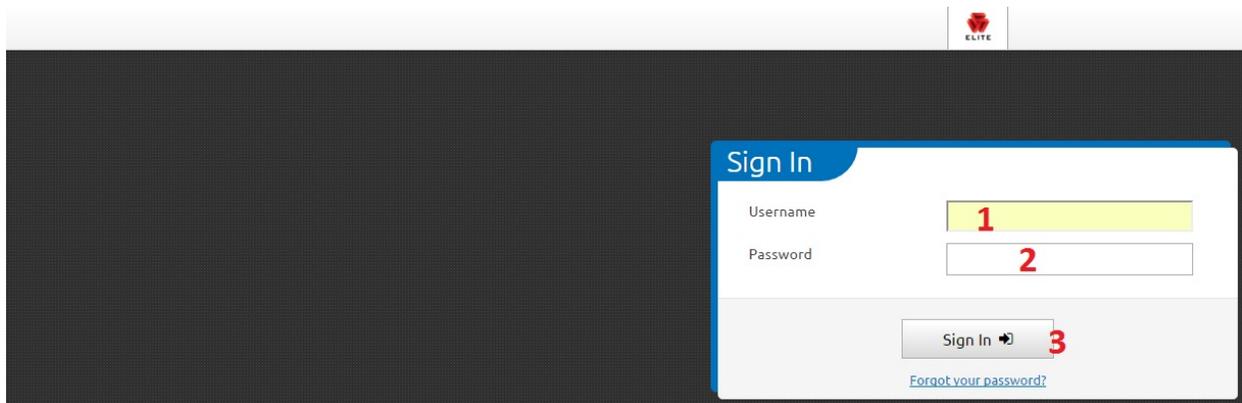
1. Go to this web address: https://www.imagetrendelite.com/elite/organizationventuracounty/runform/login
2. Login with Username (Same as ImageTrend ver2.0 and ImageTrend Elite "Web")
3. Password (Same as ImageTrend ver2.0 and ImageTrend Elite "Web")
4. Click "Sign In"

Notice that there is a small "Elite" symbol at the top of the screen, and the blue highlights of the sign-n box. These indicate you are in the Elite Field site.

Differences between Elite and Elite Field

Elite	Elite Field
Navigation Incidents tab > Create New or View Existing	**Navigation** Click New > Select an incident for template or download a CAD incident
Requires Internet Loss of Internet connection may result in a loss of unsaved data	**Internet Not Required** Create incident while on or offline. Data saves if Internet connection is lost
No Post Button You are connected to the main system and your incident saves there	**Post Button** You can post incidents with or without Internet. Elite Field posts the incidents when connection is available
PDF Button You can generate a PDF report of the incident	**No PDF Button** PDF generation is not available on Elite Field. However, on some devices you can click the Print button to view a PDF version of the incident
Messages Button You can view and reply to incident related messages	**No Messages Button** Incident related messages are not accessible when on Elite Field. However, from the Elite Field Dashboard, when you have internet, clicking Messages takes you to your Inbox in Elite
No Syncing Required Syncing is not required to update resources (users, validation rules, etc)	**Syncing Required** Syncing is required to update resources such as users, vehicles, validation rules, etc

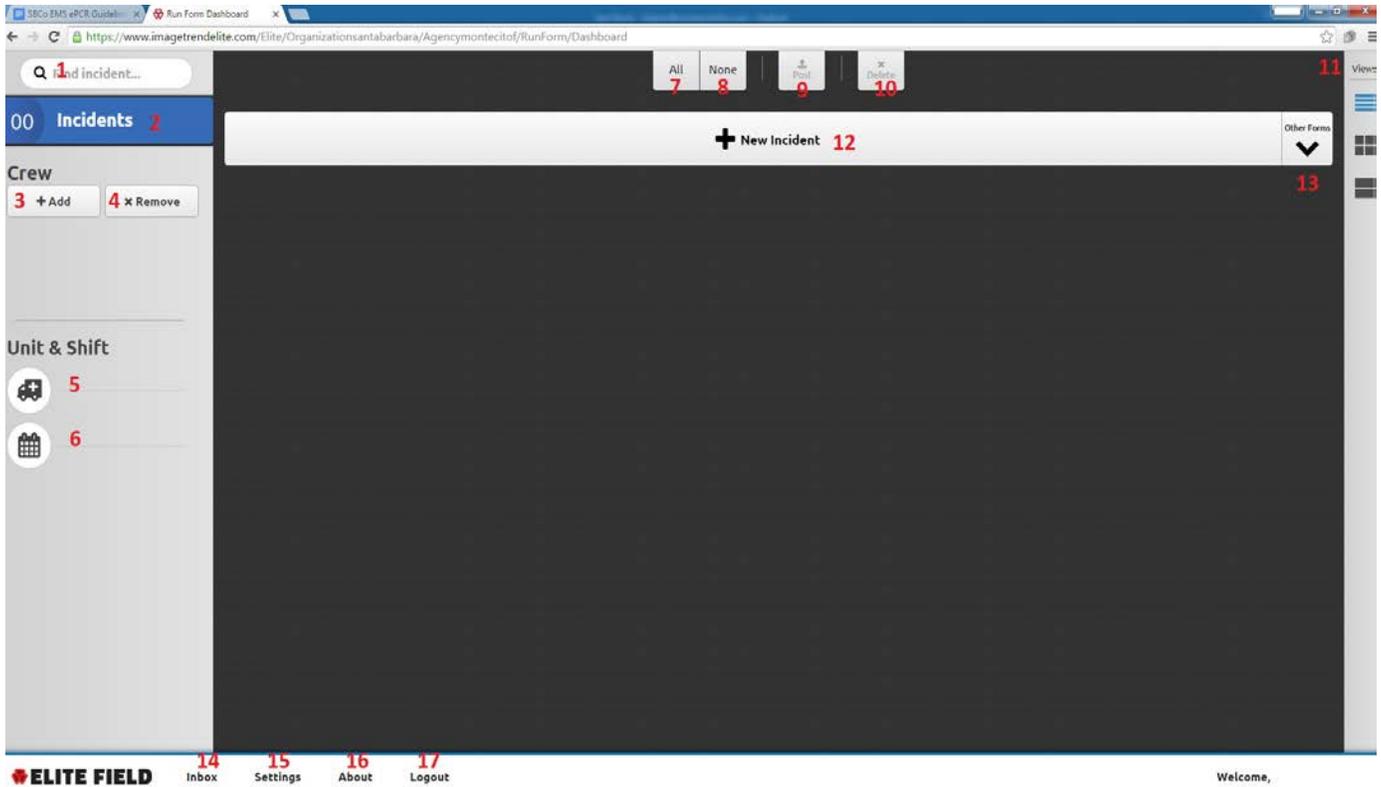## Recommended Interface – ImageTrend Elite Field
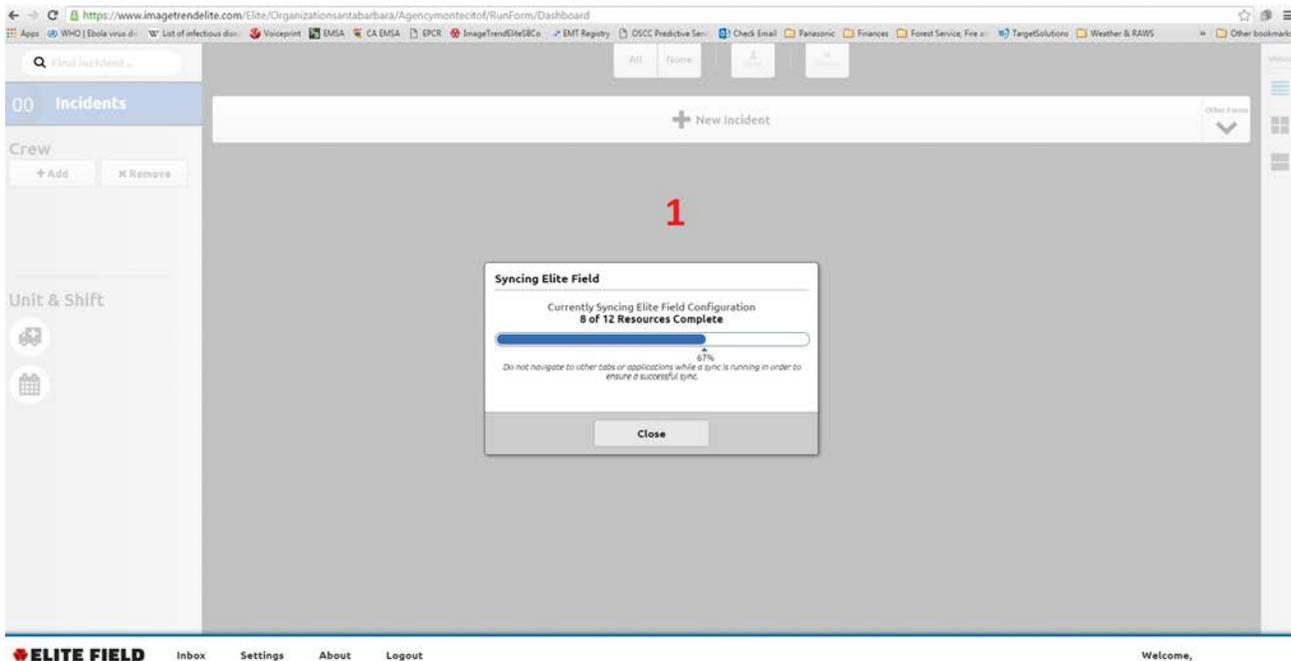
1   This is the startup screen as ImageTrend Elite "Field" is loading all information to your browser cache

2   **Do not click 'close' unless you are certain that any/all pending changes to your user/service information or system templates and validation have been applied.**

## Standard Symbols in the VCePCR Templates (Elite and Elite Field)

	Add an item (Crew Member, Exam, Intervention, etc.)
⊠	Closes the current screen/panel; Removes an entry
⌄	Click to pull down for more options
☰	Similar to above, but opens a list panel on the left margin
⊝	Click to select "None Reported", "Not Applicable", "Not Reported", "Unable to Obtain", etc.
	Exclamation marks warn of required input for validation
⊘	Use to auto fill using the current date/time stamp method

## Elite Field Home Screen Layout

|	
1. Incident search field (incidents not posted)	9. Post an incident
2. Number of incidents attributed to the current user in the Field Cache	10. Delete an incidents
3. Add crew member(s) and provider roles a. Note: the crew member assignment, shift, and role will remain assigned until updated or removed.	11. Switch between views
4. Remove crew members and provider roles	12. Enter a new incident using the default run form
5. Add the response unit	13. Choose between run form options

6. Add the assigned shift	14. ImageTrend messaging Inbox
	   a. This updates every time you login or sync
	   b. Unopened messages will show as a number

7. Show "All" incidents assigned to you	15. Settings a. Sync your incident data and form setup
8. Show "None"	16. About the ImageTrend Software
	17. Logout the current user

Incident Form Navigation
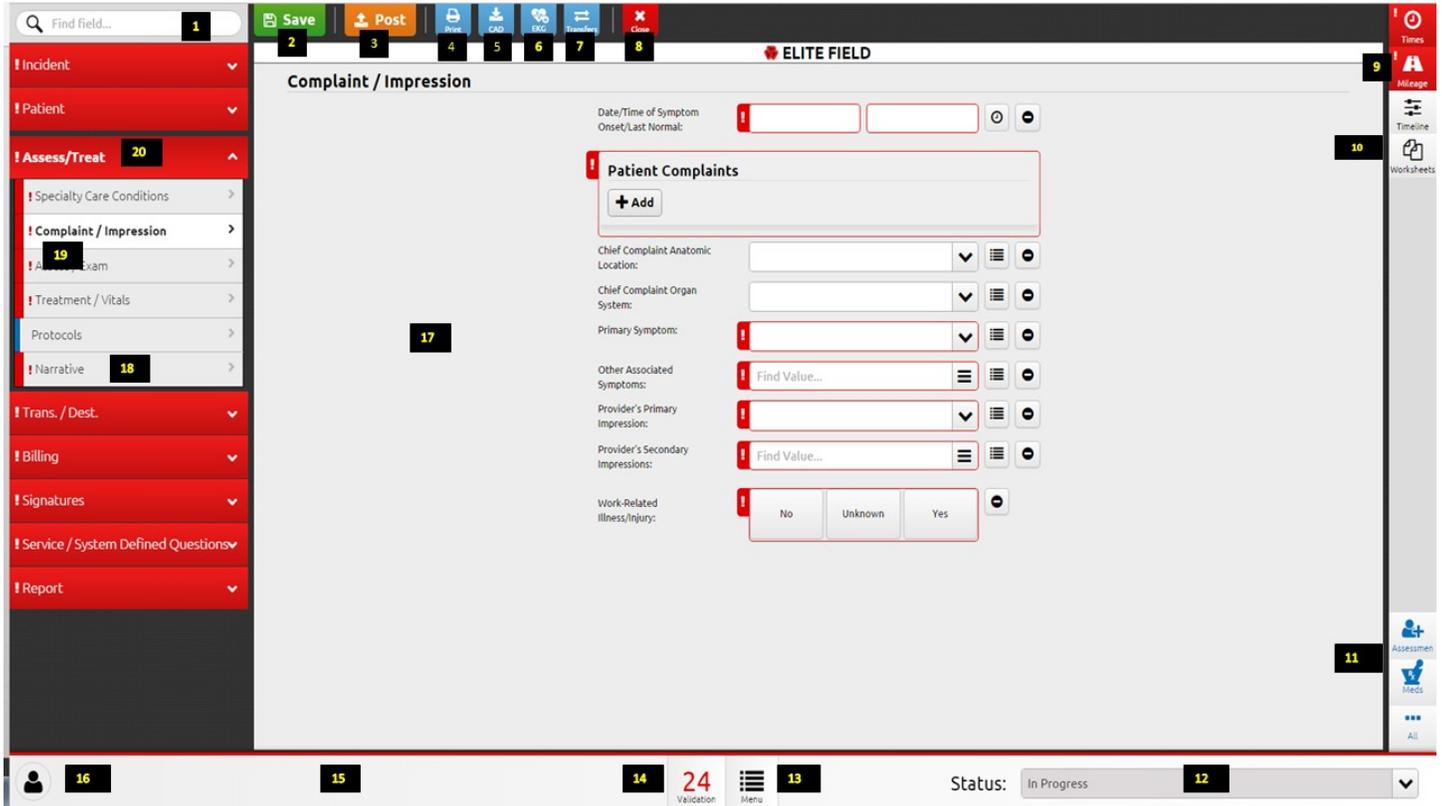
1. **Search Box:** Search the incident form for a particular field. Search for fields based on the label given to the data element, this is not necessarily the field's official name.
2. **Save Button:** Click to *Save* changes. Additionally, information auto-saves when switching panels.
3. **Post Button:** In Field, this button Posts the incident to the server.
4. **Print Button:** Generate a printable HTML or PDF report of the incident while online or offline. The report opens in a new tab.
5. **CAD Import:** Importing CAD incidents imports specific information from the incident into the incident form.
   - **WARNING:** Importing a CAD incident after a new incident was created overwrites any duplicate information. Fields that have no information imported from the CAD incident keep the previously entered information.
   - If downloading while in a current incident form, the following dialog box will open. Once you select an incident, then you can choose one of the following options:
     - *Download Other:* will download the new incident and overwrite the data for the current incident.
     - *Reload Current:* will refresh and add any new data since your last CAD download.
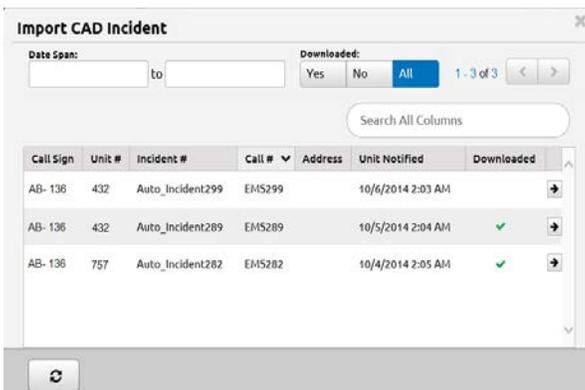
6. **Import EKG Button:** Click *EKG* to import EKG cases into your incident. If your agency uses a Zoll device, there will be a separate ZOLL EKG button that requires previous set up.

7. **Transfers:** Transfer your ePCR to another unit within your agency, or to a unit from an outside agency. You will be prompted at several points to select the type of transfer you desire.

Download means you are a unit that wants to download a transferred ePCR from another unit or agency.

Upload means you are a unit that wants to transfer or upload an ePCR to another unit or agency.
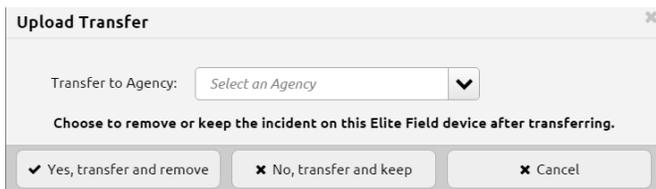
When uploading, you select the agency and unit number to whom you are transferring.

From here, you select how you want your ePCR handled in the transfer:

Yes, transfer and remove means that you are completely removing the ePCR from your device and transferring it to another unit or agency. This would typically be reserved for transfers within the SAME agency (e.g. engine to squad)

No, transfer and keep means that you are sending a copy to another unit or agency. This is typically used for transferring to units outside of your agency.

8. **Close Button:** Click *Close* to close the incident.

9. **Slide Out Panels:** Panels that slide out to reveal more options when clicked. When any field inside a slide out panel is flagged for validation, the entire slide out panel is flagged.

   Response Times:

   1. Click the *Times* button. The Time slide out panel opens revealing all of the response time fields.
   2. Enter the response times using the slide out panel's keypad or your device's keypad. The response times automatically complete the corresponding response time fields on the Response Times panel.
   3. To Close the Panel, click either the *X* or the *Times* button again.
   Mileage:

   1. Similar to the Times button, click the *Mileage* button to open this slide out panel.
   Timeline:

   - The *Incident Timeline* shows all events and interventions entered into the report, in chronological order. To see/edit any event, click on the event.
   - The *Patient Encounter Timeline* will display history patient data through multiple contacts

10. **Worksheets:** Worksheets are questionnaires attached to the incident form template. Click *Worksheets* to display the worksheets and hide the power tools. This button is visible only if there are worksheets attached/available to this incident form template. Click *Worksheets* again to hide the worksheets list and show the power tools.

11. **Power Tools:** Click a power tool to open it.

12. **Incident Status:** Select the status of the incident from the drop down to change the incident status.

13. **Menu:** Click *Menu* to insert attachments, view the audit report, send messages, and delete or lock the incident.
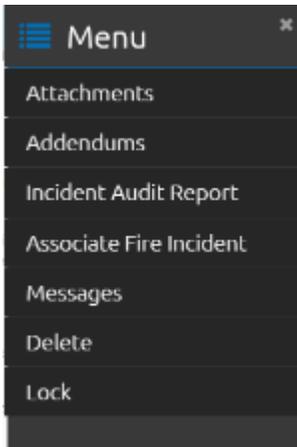
 Users can select to update attachments of many types, including incident photos and supporting documentation

14. **Validation Score:** The current validation score for the incident form.

- To easily navigate to the validation errors, click on the validation score for a list of linked errors. Click the right arrow to move directly to that field/form.
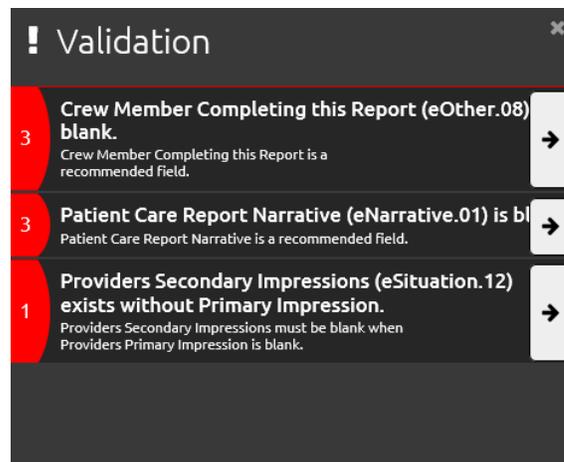
15. **Validation Bar:** The thin bar directly above the information line and below the date entry section. The bar is red when there are invalid fields, and blue when all fields on the incident form are accurate.

16. **Person:** The patient's name

17. **Data Entry Section:** The center portion of the incident form where the fields for the currently selected panel appear.

18. **Validation Colors:** The red and blue bars on the left side of the sections and panels are visual indicators of validation. A red border and exclamation point indicates there are invalid fields. Blue indicates everything is accurate.

19. **Panels:** All fields for data entry appear in the panels. When selected, panels open in the center of the screen. The selected panel has bold text. In the data entry section the panel appears at the top.

20. **Sections:** Sections are headers containing panels. Selecting a section expands it to view the panels. Additional sections may appear below the last visible section. Scroll down to see all sections. Upon beginning an incident form, the first section and first panel are visible. The selected section has bold text.

Documentation of Patient Care

Most ePCRs will have a similar starting point, in terms of validation. BLS agencies documenting a BLS level patient contact and interventions will generally require less inputs than an ALS agency documenting an ALS level of care. Transport providers will have an increased set of requirements due to the billing and transport fields. ***In all cases, the focus of an ePCR should be accurate documentation of patient care, and not just focusing on achieving a particular validity score.***

The Report Section

As in the previous version of ePCR, the Report section allows users to begin basic data entry and get an idea of what fields will be required for that particular patient encounter. Typically, requirements are driven by three elements: Primary Role of the Unit, Incident / Patient Disposition, and Level of Service Provided.

While certain elements are visible, they are not all required. This may be based on response disposition, primary role of the unit, or level of care of the unit. Eventually, visibility will help to guide the user (in addition to validity), but for now users can use the red boxes as a guide in documentation.

Completing the required elements outlined in the Report tab will help the user to establish a base report, upon which he/she can build later in the call or after the unit has cleared the call.

You will likely not be able to complete a full ePCR just using the Report section, but you should be able to complete enough fields to adequately document initial patient care. This is especially useful for fire personnel who seek to document initial care and then transfer the ePCR to the transport agency. Completing this section may also aid the user in documenting enough information (clinical and demographic) to aid during the base hospital contact and transfer of patient care at the destination.

The Incident Section

Within Incident lies basic information pertaining to the personnel (crew), incident response, and to the scene.

Personnel

This panel contains the Crew Members grid, as well as a place to document the name of the crew member completing the report.

When completing the ePCR on Elite Field, the crew member information will be auto-populated from the home screen, when crew information is completed there. The "Crew member completing report" field will not auto-populate.
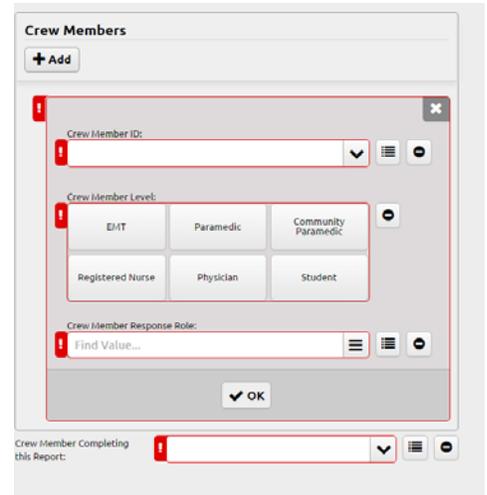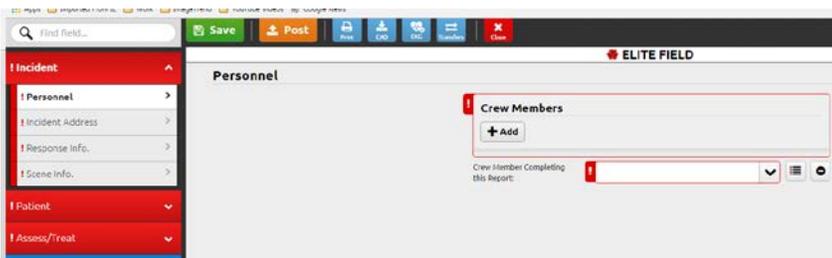

Incident Address

When downloading CAD data, the incident address should auto-populate with the dispatch data being downloaded. For cases not associated with a fire incident number generated by the Ventura County Regional Dispatch Center (FCC), users will need to complete this section by hand. This would typically occur during interfacility transports or other, non-fire incidents.

Response Info.

This panel contains much of the information related to incident response and disposition. Many elements found in this panel are also located in the Hospital Report panel, located in the Hospital section. Some of this data will be brought in during a CAD download (where applicable), but some will need to be entered manually. Many of the elements are self-explanatory, in regards to their meaning and intended use. In all cases, these fields help to paint an accurate picture of the response and conditions related to the incident.
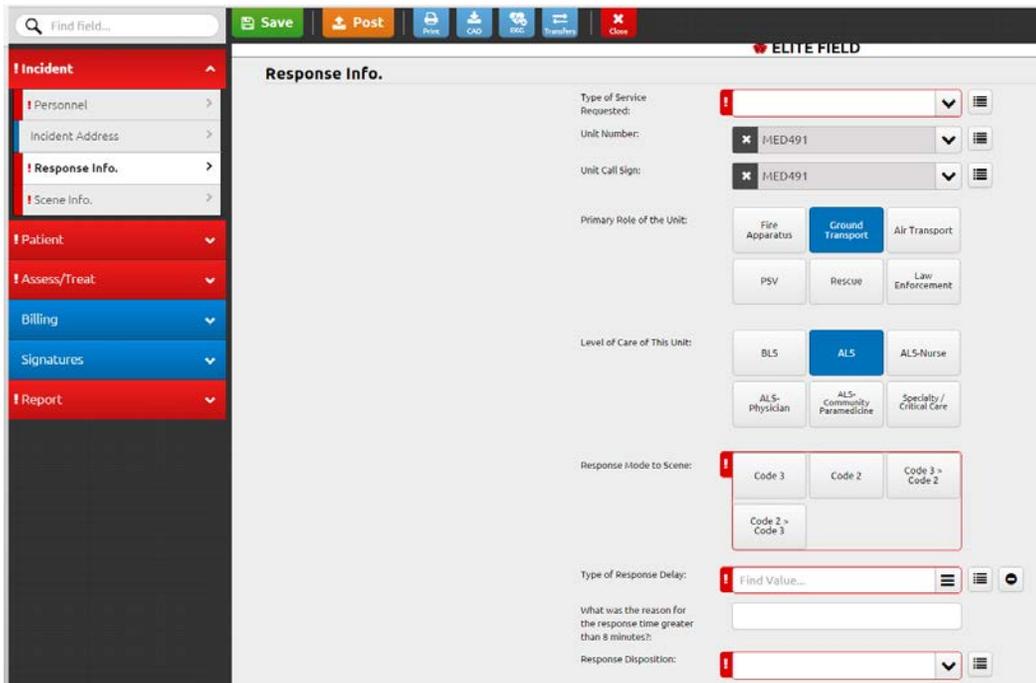
Remember: Response Disposition is an important element that outlines the outcome of the incident, as it relates to the clinical care you provided. Specific conditions for the use of each disposition are outlined in the VCEMS Data Standards – Appendix A

Scene Info.

This panel helps to provide information on the scene, and the number of patients involved. There are some specific details related to the fields located in this panel. These details are highlighted below:

Other Agencies on Scene: This field is not new, but several additional agencies have been added to aid personnel in highlighting partner / stakeholder agencies that were also involved in the incident somehow, such as the Medical Examiner or Law Enforcement. Some out-of-county fire agencies have also been included in this drop down list.
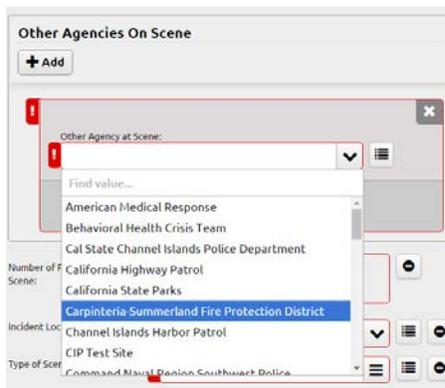
Please note: This is NOT a multi-select list. For each agency you want to document, you will need to select the agency from the drop down, click OK, and then click the +Add button within the grid to add another agency.

It's understood that this is not an ideal way to document multiple agencies. We are working with ImageTrend to develop this list into a multi-select tool at some point in the future.

Number of Patients at Scene: This is what is known as a "trigger field." For an MCI, "multiple" should be selected. At this point an Multi Casualty Incident field will appear. If the incident meets the threshold for ANY level MCI, per VCEMS policy, the 'Yes' field should be selected.

Then, select the appropriate level of declared MCI, based on policy, as well as the triage category of patient and the triage tag number for the patient.
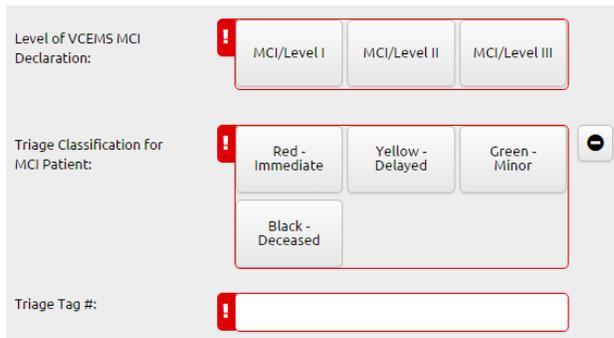
Please note: In some cases, users have accidentally clicked MCI yes when there are multiple patients…this should only occur when there are 2 patients. Regardless, clicking yes activates the MCI fields, resulting in validity requirements.

To undo this, simply change the MCI from 'Yes' to 'No' and the 3 additional MCI fields, along with the validity requirements will disappear.

The Patient Section

This section contains various elements surround the patient information, including HAM (history, allergies, and medications) and relative or guardian info (for minor patients and possible strokes or otherwise altered patients).

Patient Info:

Add Additional Patient to Incident: This button is identical in concept, but somewhat different in function when compared to the FieldBridge application. By clicking this button, you are basically opening an additional browser window on Chrome. Much of the data from the Incident Section will copy over into this new PCR that has been created in the additional browser window, with the exception of unit specific information (times unit number, disposition, etc) and any patient or clinical information.

Since an additional ePCR has been created, you will also be able to find the additional record on your Elite Field Dashboard, once the new ePCR has been saved at least one time.

| 65 | Incident #
16-0075915 | 1928 E Avenida De Los Arboles
Thousand Oaks, CA 91362 | Oct **13**
15:40 | → |
| 46 | Incident #
16-0075915 | 1928 E Avenida De Los Arboles
Thousand Oaks, CA 91362 | Oct **13**
15:40 | → |

Find a Repeat Patient: This tool is nearly identical in form and function to the button found in the FieldBridge application. Additional filters have been added to the search box to aid in finding a repeat patient within your agency's stored data. Remember…the repeat patient information is based on data stored in your agency only. The searchable information does not extend to other agencies within the system.

Repeat Patient Search

Find a Repeat Patient Button

Remember: DO NOT import the repeat patient data unless you are certain it is for the same patient. This will create the potential for protected health information from another person being merged with the patient contact you are documenting. To avoid potential problems/conflicts, verify certain key elements with your patient or a relative/guardian before clicking the import button.

Patient Hx:

Medical / Surgical History: Whereas in FieldBride (NEMSIS v2), the list of elements Medical and Surgical History were not based on any sort of standardized list, the elements now are based on a list that has been standardized through throughout all aspects of the medical community (ICD 10 codes). That being said, the list of available in Elite (NEMSIS v3) contains several thousand choices. In order to minimize the impacts of this new list, we have sorted some of the more common elements to the top of the drop down list.

Medical/Surgical History:
- Alzheimer's / Dementia
- Anxiety Disorder
- Asthma
- Cancer
- Cardiac - Angioplasty
- Cardiac - Congestive Heart Failure
- Cardiac - Coronary Artery Disease
- Cardiac - Dysrhythmia/Arrhythmia
- Cardiac - Heart Transplant

We matched the elements in the Medical / Surgical History *dropdown* to the elements in FieldBridge, from Alzheimer's / Dementia to tuberculosis. After that, the full ICD 10 list is visible.
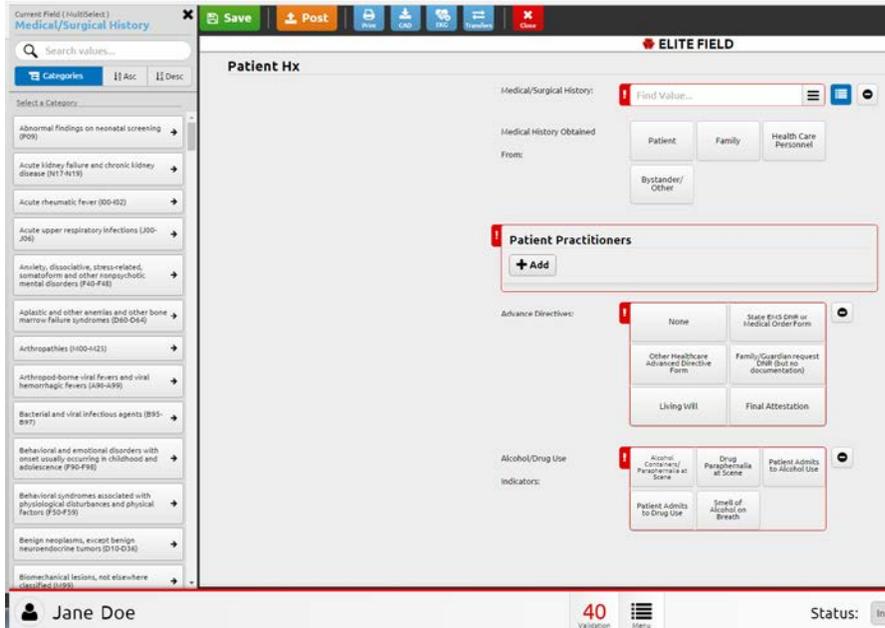
Note: If you click the "category view" button, a box will open. The sort that we have set up in the drop down list is NOT available in this category view. You will need to search for each value individually, based on its formal ICD 10 code name.

This list is very specific and complicated. For example, a search for aneurysm returns several hundred possible matches. *It is advisable to only use this tool if you have the exact condition as part of the patient's medical / surgical history.*

Null Values (NV) or Pertinent Negatives (PN): The use of NV or PN is permissable for this field, as there are conditions where they may apply. The best example would be for a patient that has No Medical History. This is no longer a choice in the dropdown list or cetegory view. Instead, you would use an NV or PN.
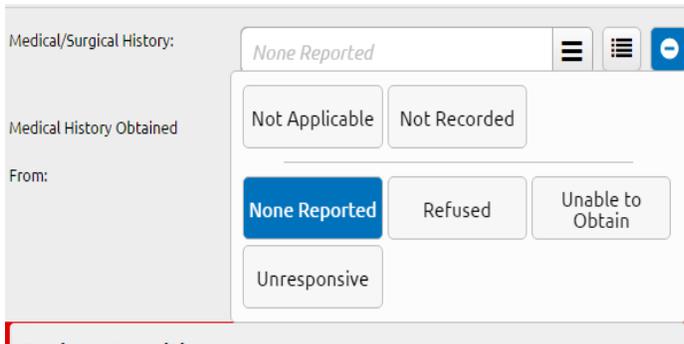

Technically, Not Applicable would work here because there is no applicable Medical / Surgical History to report on this ePCR.

More appropriate, however, would be the pertinent negative field "None Reported." By selecting this element, you are stating that the patient has reported he/she has no medical / surgical history to report.

Patient Meds:

Current Medications: Similar to Medical / Surgical History, the current medications list is based off of a standardized list. We are unable to sort this list, so users will need to search each medication to add it to the list. Also, there is no multi-select function associated with this field. Each medication needs to be selected and added individually.
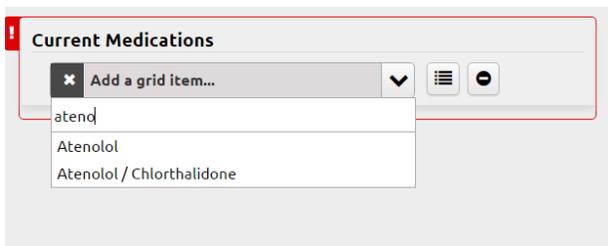

Users are able to seach for a specific medication simply by typing in the Find Value box, in order to begin narrowing down the list to a particular element.

Null Values and Pertinent Negatives: There are obviously conditions where current medications would not apply to a particular ePCR. Additionally, if there is only a list of medications available, there are some specific steps needed to document something like "see attached list."

Step 1: Click the NV / PN button to open the list of null values or pertinent negatives, select Not Recorded
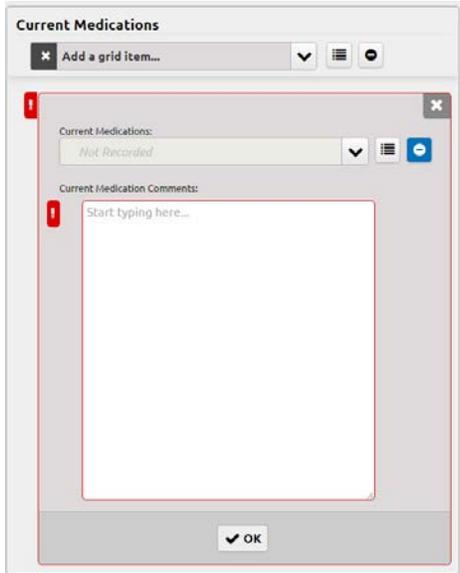

Step 2: Click on the Not Recorded box highlighted in red to open the medication comments field.

In the medication comments, you can type "See Attached List" or some other explanation as to why the medications were not recorded on this ePCR.

Click OK…The final product should look like this.

Patient Allergies: These fields are pretty self-explanatory. Like others, both are based off of standardized lists. One of the main differences, however, is that the Environmental / Food Allergies field does not allow Null Values or Pertinent Negatives. For this reason, No Known Allergies has been sorted to the top of the drop down list to document individuals that do not have any known environmental or food allergy.
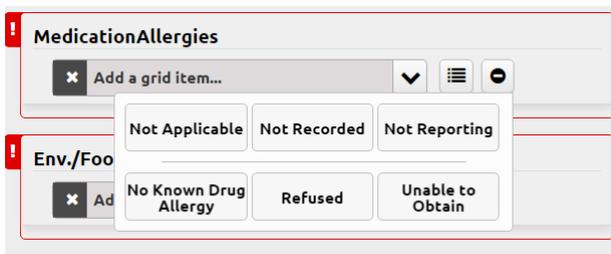
Closest Relative / Guardian Info: This information is required in two circumstances: patients that have been identified as a possible or confirmed stroke, and patients that are less than 18 years of age.

The Assess / Treat Section

The panels within this section contain the information related to clinical findigns and any/all treatment delivered by prehospital personnel. While many of the fields within these panels should be familiar, there are several new or re-formatted elements that will require some additional steps to complete.

Specialty Care Conditions: In FieldBridge, users answered a series of question to determine whether or not a patient met, or potentially met, to be included into the VCEMS Specialty Care System, users are now required to select from a single drop down list.

Due to development constraints, this list is only a single-select field (for now), so users will only be able to select the most critical condition the patient may present with. For example, if the patient suffers a cardiac arrest while driving and now also meets potential trauma criteria, only cardiac arrest should be selected because that is the most critical condition for that patient.

Please remember, this is for patients that meet OR potentially meet criteria to be included into the specialty care system.

- **Not Indicated** – No conditions exist that would require additional testing, procedures, or screening of patient for inclusion into a specialty care system. This means that none of the following exist:
  - The patient is not, or was not, in cardiac arrest at any point related to this specific incident.
  - 12 Lead ECG was not warranted, in accordance with VCEMS Policy 726
  - Patient was not exhibiting any sings/symptoms that would warrant assessment for a possible stroke/TIA, in accordance with VCEMS Policy 451
  - There was no traumatic mechanism, including minor incidents such as a slip/trip and fall.
  - The patient condition did not warrant any further assessment for signs/symptoms of sepsis.
- **Cardiac Arrest** – The patient is or was in cardiac arrest at some point related to this specific incident (prior to and/or after EMS arrival). This includes determination of death calls and situations involving advance directives or hospice patients.
- **ROSC with STEMI** – The patient was in cardiac arrest at some point during this incident (prior to or after EMS arrival), but now has/had a return of spontaneous circulation (ROSC) *AND* a 12 lead ECG was performed, in accordance with VCEMS Policy 726.
- **STEMI** – A 12 Lead was performed in accordance with VCEMS Policy 726. Selecting this does not necessarily indicate the patient has a STEMI, but rather the patient was screened for a possible STEMI (i.e. a 12 lead was performed). This is also referred to as STEMI Triage Criteria.
- **Stroke** – The patient has a complaint that warrants further stroke screening to include, or rule out, inclusion into the VCEMS stroke system, in accordance with VCEMS Policy 451. Selecting this does not necessarily indicate the patient meets prhospital stroke alert criteria, only that the patient was further assessed for signs and symptoms of stroke. This is also referred to as Stroke Triage Criteria.
- **Trauma** – The patient has a complaint related to some sort of traumatic mechanism. This could be due something very minor such as a small cut to the hand, or a trip/slip and fall. This would obviously also include patients that have significant trauma. Selecting this indicates the patient was involved in some type of event with a traumatic mechanism, AND the patient requires further assessment for trauma system inclusion or exclusion, in accordance with VCEMS Policy 1405. This is also referred to as Trauma Triage Criteria.

- **Sepsis** – The patient is exhibiting signs/symptoms of sepsis that may warrant a possible sepsis alert with VCEMS Policy 705.27. This does not necessarily mean that the patient is a Sepsis Alert, only that the patient required further screening. This is also referred to as Sepsis Triage Criteria.

Complaint / Impression: Many aspects of how we document compaints and provider impressions have changed, both in the values within each element, and in the function of the elements themselves.

Patient Compaints Grid: Elements realated to chief and secondary complaints have now been combined into a single grid.

Choose the type of complaint. If the patient is complaining of chest pain with shortness of breath, the chief complaint would be chest pain, as that is the primary reason 911 was called.

Note: This is a single select field. The process will be repeated if/when there is a secondary complaint also present.

As in FieldBridge, the complaint field is a write-in text box. The complaint being relayed by the patient should be entered in here.

Finish out the remaining information related to the particular complaint and click 'OK'

If/when there is a secondary complaint, click the 'Add' button and repeat the process.

Example: for a secondary complaint of Shortness of Breath, the user would click 'Secondary' under complaint type, and repeat the additional steps as outlined above. Final product should look like this…

Assess / Exam: When documenting a physical examination, it is best to use the Assessment Power Tool, located in the power tool section of the Elite / Elite Field application.

Some changes related to the Assessment Power Tool, compared to the tool used in the FieldBridge Application:

• The "All Normals" button has been removed from the assessment power tool
• Each individual section now needs to be tagged normal if there was a focused exam performed on that specific body area, AND nothing abnormal was discovered.
• If exam was not performed on a specific area, the section needs to be tagged as 'Not Done.' Remember, it is OK to document that you didn't do something, if that is truly the case.
  o An example of this would be clicking 'Not Done' for the wrist area for a patient that has an isolated complaint of Chest Pain. You can explain how/why you didn't examine a patient with an isolated complaint, versus why you dodcumented 'normal' for an area that you likely did not truly assess.

Step 1:

Complete the date and time of the assessment in the upper right corner of the assessment power tool.
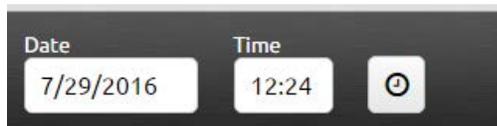
If you don't do this, the exam will remain red, and you will have to complete

the task in the exams grid, outside of the power tool. *Better to do everything all in one step*

Step 2:

• Tag your 'not dones' by selecting 'Tag Not Done' at the bottom of the tool, then by selecting the tile(s) that were not assessed.
• When clicked as not done, the tile(s) should be brown with an exclamation point in the upper left corner of each tile.
• Click 'done tagging' when you have completed marking your 'not dones'
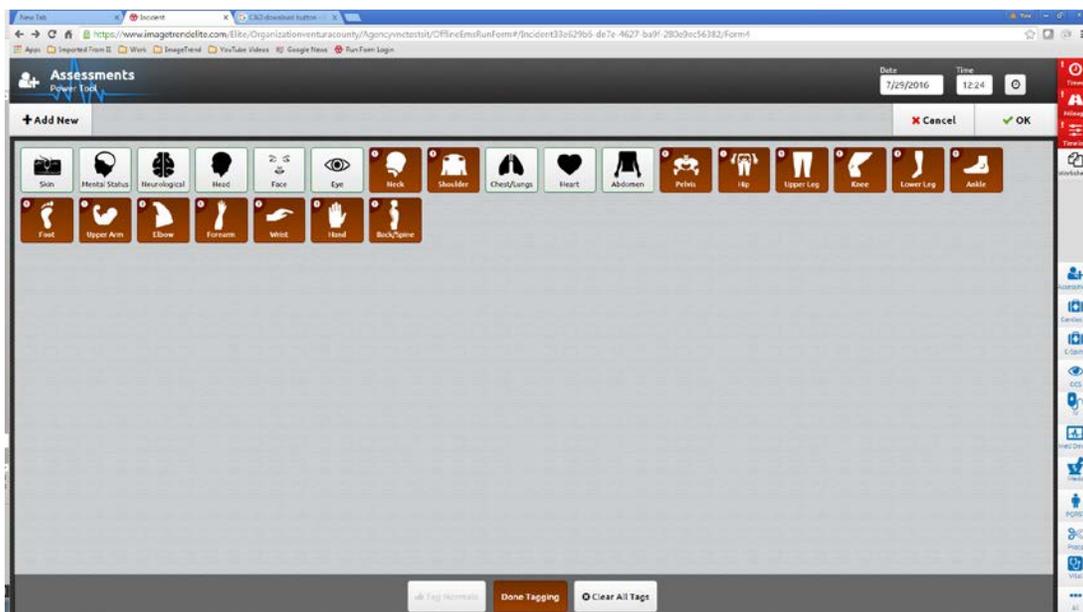
Step 3:

- Tag your 'normals' by clicking the 'Tag Normals' button.
- Remember that by clicking this, you are documenting that you have assessed ALL elements of that particular body section, and that ALL elements were within normal limits, based on your exam.
- When clicked as normal, the tile will turn blue with a thumbs up symbol in the upper right corner of each tile.
- Click 'Done Tagging' when you've completed marking your normals.
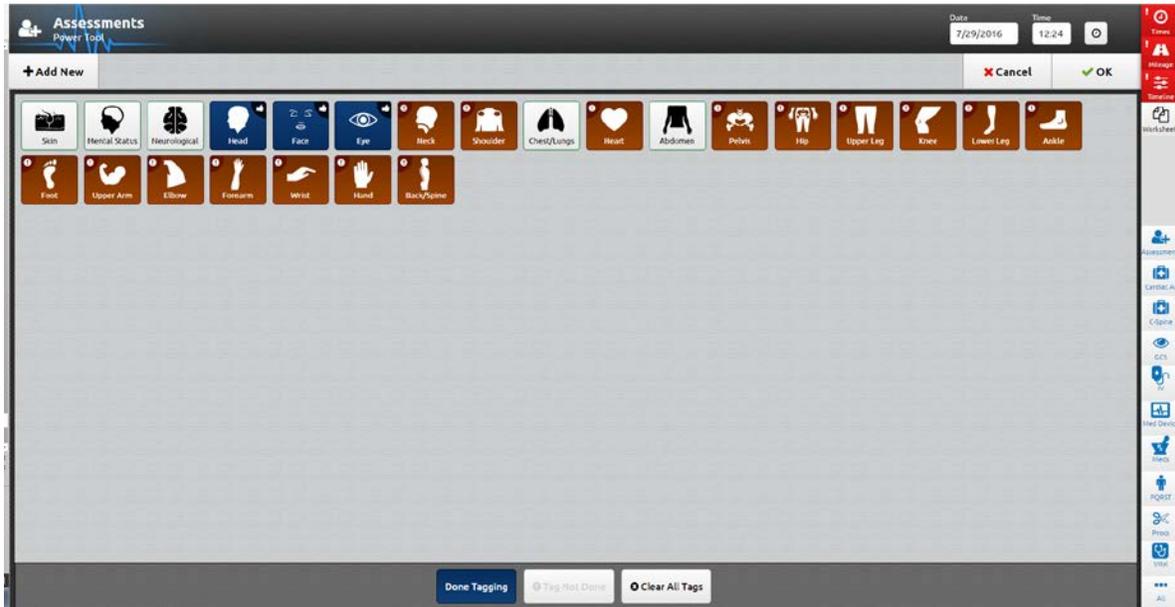
It's important to understand the difference between 'not done' and 'normal.' These terms are not interchangeable.

By clicking Not Done, you are (accurately) documenting that a specific assessment was not performed. This can be explained in the narrative, or to a lawyer or jury.

By clicking something as 'normal' when you in fact did not assess the area, you have now falsely documented your care for that patient. This would potentially open you up to liability if a case were to go to deposition or court.

Once again, tagging something as 'normal' means you have performed an assessment on a particular body area, and ALL elements of that assessment were normal.

ePCR Documentation Guidelines

Step 4:

- The remaining tiles are clicked individually to detail specific findings within each remaining body section.
- If you need to comment on a specific detail within that body section, click the details button and type in your findings.
- Once complete with a specific section, click the next tile.
- **DO NOT CLICK OK until you are completely done with the assessment.**
 - *Clicking OK will exit you out of the power tool before you are complete.*
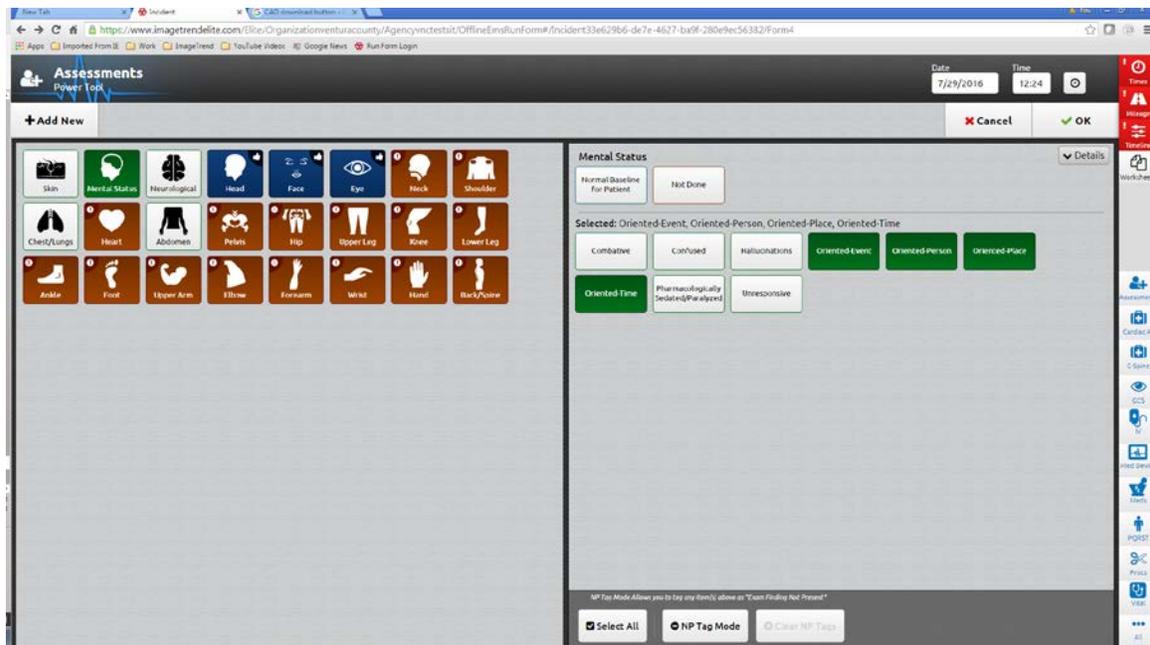
Step 5:

- Your assessment should be a combination of brown, blue and green tiles
- Once the assessment is complete, click 'OK' to save the assessment and exit the power tool.
- Once saved, this exam will reside as an exam grid in the Assess/Treat Section > Assess/Exam Panel.
  - You will not be able to click back into this assessment using the Assessment Power Tool. To make any corrections / additions / edits, you will need to use the exams grid.
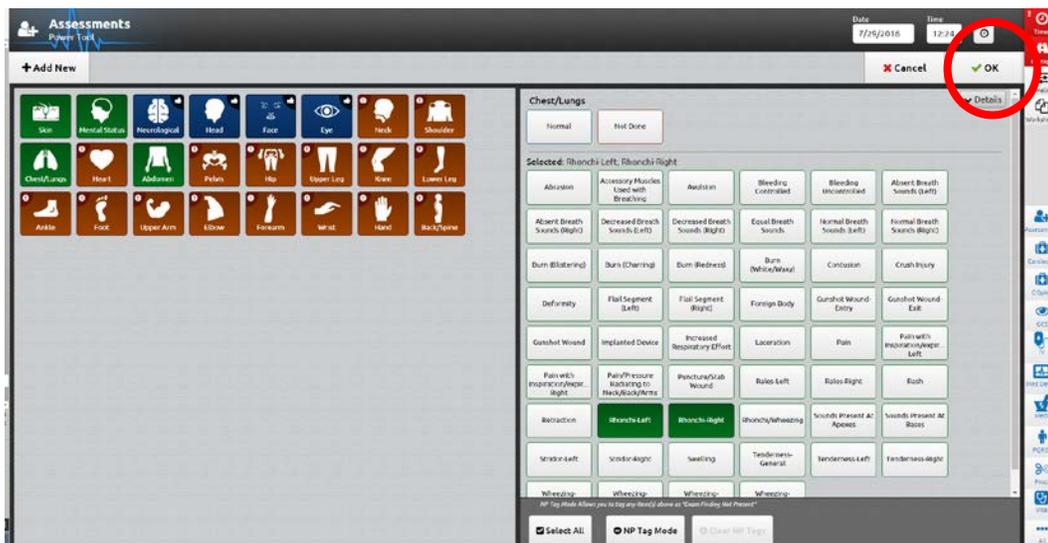
Treatment / Vitals:

Similar to the layout of FieldBridge, entering various treatments and procedures/meds is broken up into a series of functional grids. There are also several functional grids that are hidden, appearing only when certain criteria are met. For Now, these grids are: Advanced Airway and Controlled Substances. Medical Devices will also be tied to visibility rules, once the criteria for this rule has been established.
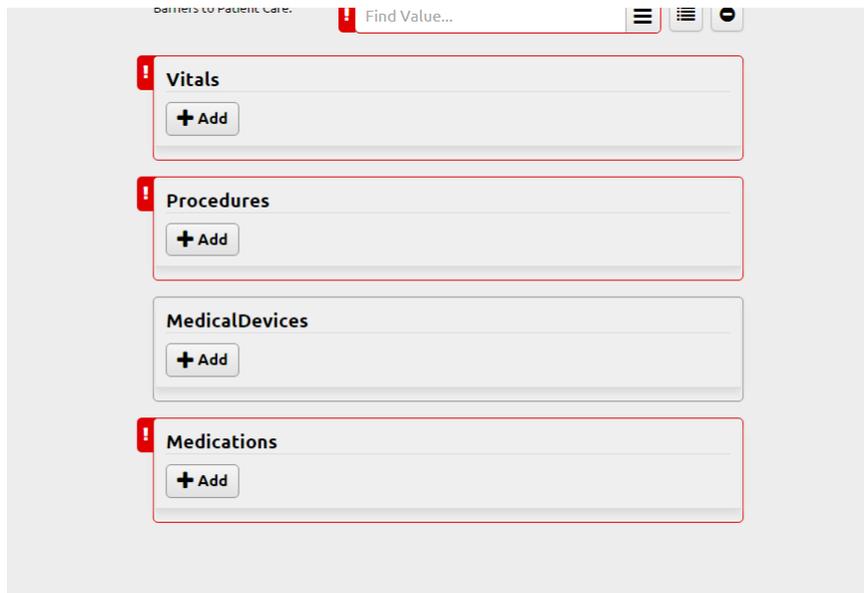
Vitals:

As you are accustomed to in FieldBridge, similar rules have been built into the vital signs grid that allow a user to account for situations where certain fields could not be completed. In Elite, however, those circumstances need to documented through the use of Pertinent Negatives (PN) whenever possible.

A good example is when a blood pressure is palpated. While there is no "palpated" choice in the pertinent negative field, there is an 'unable to complete.' The next field (Method of Blood Pressure Measurement) should also reflect the palpated measurement.
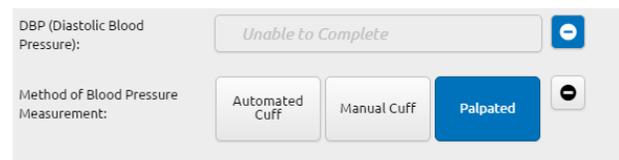
Several people have asked about the handling of EKG monitor data. On calls where the monitor was attached for an extended period, an import may trigger numerous data points, including vital signs and/or procedures, driving down validity scores. When asked how to handle this situation, the best answer is always "it depends on the patient."

- If the patient was very stable, but had a monitor attached due to an extended transport time, etc., then it is probably not necessary to have 20 lines of vital signs documented. Perhaps opting for a set of vital signs every 5 minutes.
- If the patient was highly unstable, then it would be necessary to document each set of vitals.

The bottom line is, you need to paint the most accurate picture possible in your documentation. The purpose of patient care documentation isn't to find the shortcuts, it is about accurately documenting your patient care encounter. Every time.

Procedures:

Documenting procedures is very similar in form and function to the documentation of vital signs. Certain fields will be required for all procedures, while some of the procedures will trigger other fields.

Selecting Spinal Immobilization, for example, will trigger the CMS assessment fields. These fields would not others be required for something like airway or Ice Pack Application.

Remember that use of Null Values or Pertinent Negatives is the most appropriate way to document that you *did not* perform something. If you did not perform any procedures, Not Applicable is an appropriate choice.

*Note: Patient Movement is a procedure, and needs to be documented as such…even in the case of a lift assist / public service.

Advanced Airway:

When an advanced airway (airQ, Endotracheal Tub, ETI through a tracheal stoma, or insertion of an ETT through an airQ) is documented in the procedures, a new functional grid will open, requiring detailed documentation related to the placement of that airway.

Medications:

The medications grid shares the same form and function as the other grids described above.

Controlled Substances:

When a controlled substance (Midazolam, Morphine Sulfate) is administered, a functional grid will appear, requiring detailed documentation surrounding the use of the particular medication.
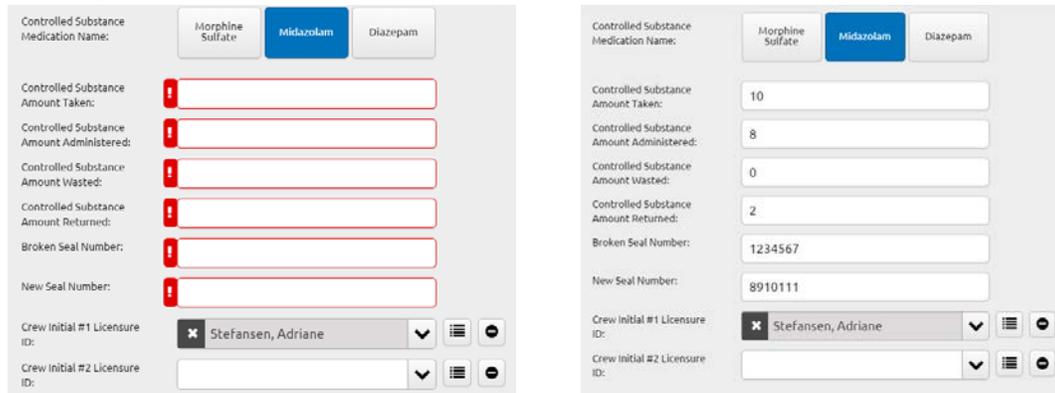
- Amount Taken is defined as the amount of the controlled substance taken for the purpose of administration.
- Amount Administered is the amount of the controlled substance administered to the patient.
- Amount Wasted is the amount (volume) of the controlled substance that was wasted after administration.
- Amount Returned is the amount (volume) of the controlled substance that was returned after use.
- * Broken Seal Number is the number of the seal or control tag that was on the controlled substance container prior to administration.
- * New Seal Number is the number of the seal or control tag that was placed on the controlled substance container when it was returned to its storage location.

    This process is likely defined by specific agency policy / procedure.

Protocols:

In certain circumstances (ALS Care or Evaluation provided), the documentation of guiding protocols is required. As this is a "single entry" grid, a new item needs to be opened for each protocol used. An example of this could be chest pain that progresses into cardiac arrest VF/VT. For this situation, at least 2 protocols would be documented: 705.08 and 705.09.
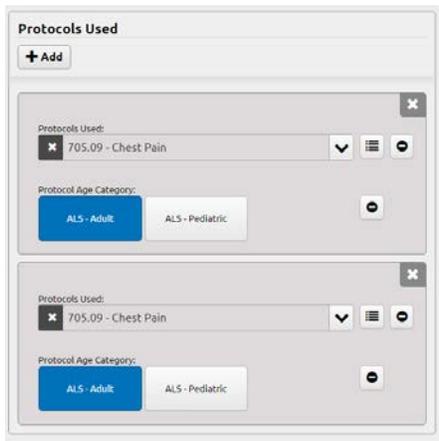
Step 1: Click Add

Step 2: Select desired protocol and age category

Step 3: If multiple protocols are used, click Add and repeat process until all desired protocols are selected.

Note: There are other policies included in this section beyond the 705 treatment guidelines. Examples include 131 – Multi Casualty Incident, 603 – AMA/Release of Liability, 606 – Determination of Death, and 732 – Use of Restraints.

Specialty Care System Sub-Panels

Cardiac Arrest:
This field appears when Actual / Potential Specialty Care Activations is equal to Cardiac Arrest or ROSC with STEMI. A series of questions based on the UTSTEIN cardiac arrest criteria will require documentation. With a few exceptions, these are the same questions users were required to answer in the FieldBridge application.

As specific fields are documented, other fields may become validated, based on user entry. These fields are very important in painting an accurate picture and building a timeline for every cardiac arrest patient. As visibility is not built into the fields within this panel, please rely on the validity (red boxes) to guide your documentation for each field.

12 Lead ECG / STEMI:
When a patient is documented as having a 12 lead performed, or as being a confirmed STEMI patient, this panel will open with a specific set of questions related to the acquisition of the 12 lead, and the confirmation of the STEMI.

This will be required for all patients where a 12 lead ECG was performed (STEMI Triage Criteria), or for patients in cardiac arrest with ROSC, where a 12 lead was performed, indicating STEMI.

Stroke:
As stroke fields are functionally classified as vital signs by NEMSIS and ImageTrend, this panel contains a functional grid contain stroke fields, in addition to some stroke fields that reside outside of the grid.

Stroke Assessment Grid:

Stroke Scale Fields – These are to be completed based on the Cincinnati Stroke Scale assessment you conduct on any patient with suspected stroke.

Stroke Scale Score – Remember that negative indicates all portions of the assessment are NORMAL. A positive score indicates the patient has *failed* one or more portions of the Cincinnati Stroke Scale.

Stroke Scale Type – As providers in Ventura County only perform the Cincinnati Stroke Scale, this field has been defaulted and marked as Read Only.

Prehospital Stroke Alert – This is answered based on the established Stroke Alert Criteria outlined in VCEMS Policy 451.

Once all fields have been answered, click **OK**.

After clicking OK, your stroke assessment grid should look like an empty vital signs grid.

That's alright! Your stroke assessment info has been saved within this grid.

Supplemental Stroke Fields:

Additional stroke fields have been added as a supplement for patients that may require neuro-intervention. These fields are required only when the patient is a confirmed VCEMS prehospital stroke alert.
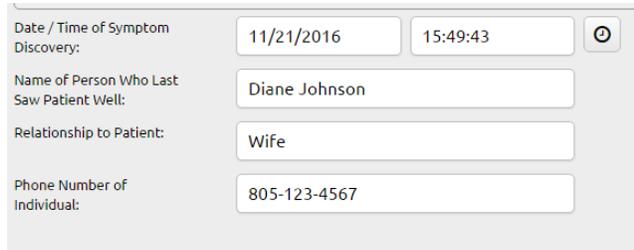
Date / Time of Symptom Discovery:	11/21/2016	15:49:43	🕐
Name of Person Who Last Saw Patient Well:	Diane Johnson		
Relationship to Patient:	Wife		
Phone Number of Individual:	805-123-4567		

Trauma:

As was in the case in FieldBridge, the functional grid for trauma contains several fields that help provide detailed documentation for patients that have a complaint with some type of traumatic mechanism, including VCEMS Trauma Step (ALS Only).

Ventura County Trauma Step:

This is a single-select list of the current VCEMS Trauma Steps, based on EMS Policy 1405. Because this list is single-select, only the "highest" trauma step will be selected. For example, if the patient has a SBP less than 90 (Step 1.2) AND a penetrating injury to the torso (Step 2.1), only the step 1.2 would be selected.

If the patient has been assessed per Policy 1405 and found not to meet trauma criteria, then Trauma Criteria Not Met should be selected.

Additional Trauma Questions:

There are additional questions related to trauma that will need to be completed, based on cause of injury:

- Main Area of the Vehicle Impacted by the Collision
    - This field utilizes a visual "clock" diagram to describe the primary impact site.

An 11 would be used to document the impact to the left front would.

ImageTrend has built an aide that opens when this field is selected.

- Location of Patient in Vehicle
- Use of Occupant Safety Equipment
- Airbag Deployment

Patient Care Report Narrative (Narrative):

Narrative (noun)

- A relating of events usually in the order in which they happened
  - Synonyms: chronicle, *chronology*, commentary, history, *narration*, account, record, report, *story*

Even with as much information collected in the ePCR, there are still gaps. These gaps aren't necessarily related to the specific clinical care provided, but rather in the overall situation/story related to the incident itself. As we have trained over the last several years, the narrative is not a "dumping ground" for every single piece of information related to the call. The narrative is the spot that would highlight the specific circumstances as to why something specifically occurred (or didn't) such as how the patient was found, why a specific treatment couldn't be performed, why the patient refused care and/or transport, etc. Basically, the narrative is the place where we describe the stuff that couldn't be made clear in the rest of the report (the story…AKA the NARRATIVE).

Trans. / Dest. Section: This section highlights the circumstances surrounding patient transport, including destination information and transfer of care to receiving hospital staff.

Trans. Info:

The fields in this panel highlight the broad circumstances surrounding the transport of the patient to a receiving location / facility.

Dest. Info:

This panel details the information related to the destination (receiving location / facility).

- **Destination/Transferred to, Name**: the name of the receiving location or facility. This is generally the hospital to which the patient was transported, but Helicopter Landing Zone is also listed as a destination for those cases where a patient was taken by air to an LZ for transfer to ground transport, or where the patient was taken by ground to an LZ for transport by air transport.
- When a hospital is selected, the address will auto-fill, but the boxes will remain red until the 'set from postal code' button is pushed. If multiple zip codes match the one provide, the user will need to choose the most appropriate. From here, the address fields should validate.
  - For an LZ destination, choose the established LZ designators (if applicable) for address and then enter a zip code to lock in city, state, and zip. If LZ is a mile marker or an intersection, etc., do your best to complete the info and zip in order to clear the validity.

- **Type of destination**: this field is pretty self-explanatory. When an LZ is selected as destination, the type of destination is Other EMS Responder (air) for a ground to air transfer, or Other EMS Responder (ground) for an air to ground transfer.
- **Reason for Choosing Destination**: transporting to a specific facility due to a special condition (STEMI, Trauma, etc.) is NOT considered diversion. For this type of situation, select specialty care (STEMI, Stroke, Trauma, ROSC). This specialty care choice should also be selected if the closest receiving facility is the desired specialty care center.
  - Diversion should be selected when the transporting unit is specifically diverted due to ED, ICU/CCU saturation, etc.
- **Type of Turn Around Delay**: this describes any reason there was a delay in the unit returning to service after arriving at the destination. A common situation would be decontamination of equipment. But ED overcrowding (bed delay) is also a possibility, as is documentation.

- **Encounter Number Info:** this is a functional grid that contains a write-in section where the *receiving facility's* encounter number (AKA account number, AKA visit number) is to be entered. The requirements for the encounter number were sent out in a previous training. This number is to be entered in for ANY patient that is transported to a receiving facility.

    This number is critical for patient tracking and receipt of outcome information after the patient has arrived at a destination.

Patient Valuables:

For patients that are transported (by air or ground), documentation of patient valuables / belongings is required. This is an important field related to customer service and protection from liability in the event there is ever a claim of lost or stolen belongings.

- **Pt. Belongings:** this is a multi-select field that is used to document specific belongings / valuables transported with the patient.

- **Pt. Belongings Left With:** this single-select field is used to document where and with whom the patient's belongings were left.

Billing: This section is reserved for ground transport providers that bill for their services. Non-transport units and air transport resources that do not bill will not see this section.

*Note: there are several fields within the Billing section that are customized based on agency specifications. The use of these fields will be determined by internal provider agency policy. As such, the guidelines in this document related to use of the billing section will be somewhat broad and generic. In all cases, these fields do not contain Null Values or Pertinent Negatives, meaning there is no way to answer a billing question with a "none/no" value.

Billing Info:

There is only one field in this panel. Guidance on terminology and when specific elements should be selected, based on the circumstances of an incident, can be obtained from transport agency management.

IFT Info:

When an interfacility transport (scheduled or unscheduled) is selected in the Response Info panel (Incident Section), IFT information will be required for collection in this panel within the Billing Section. Definitions and conditions of use for each of these fields are driven by transport agency policies. Further guidance can be obtained from transport agency management.

Insurance Info:

Your agency management maintains a list of insurance companies that will populate the insurance company name field.

When selected, the insurance Company ID will populate.

The user will need to enter the Insurance Group ID and Insurance Policy ID Number, based on the information found on the patient's insurance card.

In all cases, defer to transport agency policy for further guidance on how to complete these fields.

If there are multiple insurance companies applicable to this transport, add each new company by clicking the +Add button.

PCS Info:
Use of the fields within this panel will be dictated by transport agency policy.

Signatures: Pending further validity and visibility.

Report: As was the case in FieldBridge, the Report Section contains fields found elsewhere in the ePCR template. This section is intended to be used as an aide for the ePCR author to enter in some quick information that will help in the transfer of care process (fire/rescue to transport AND transport to destination).

Note: the information documented in the Report Section will back-fill the matching fields throughout the ePCR, so double-entry will not be required.

Miscellaneous:

Various elements of the ePCR are included in this section, which is located on the right side of the screen. Inclusive in this category are:

Times: this section includes most of the time fields found in the ePCR. Many of these fields will auto-populate when CAD data is downloaded, but some will require input from the user. Your agency controls the default settings for these fields (blank, at-patient time, or device time). For some time fields, there is logic programmed in that prevents the user from creating an implausible series of events (e.g. arrived at destination time before patient contact time).

Mileage: this is a requirement for ground transport providers that transport a patient. Defer to your agency management for specific policies on how to enter this information.

Timeline: this is intended to be an aide for the ePCR author, displaying a chronological sequence of events, based on CAD data, ECG import data, and vitals / procedures / medications entered by the ePCR author. The timeline will highlight red whenever there are outstanding validity requirements for a specific field.
- Clicking the arrow for each line item displayed in the timeline will take the ePCR author to that specific field.
- The Patient Encounter Timeline is useful for trending multiple encounters of the same patient. A good example would be the ability to graph blood glucose values of a patient encountered several times several days / weeks / months.

Power Tools and Worksheets: this button essentially functions as a toggle switch between worksheets and power tools.
- When the worksheet button is visible on the right side, you should be able to see the power tools in the lower right corner. When the power tools button is visible on the right side, you should see the worksheets in the lower right corner.
- Clicking the 'All' button will display all active power tools or worksheets, depending on which function you are in.