EMSCHARTS.COM

emsCharts New User Handbook

EMSCHARTS.COM

emsCharts
New User Manual

---

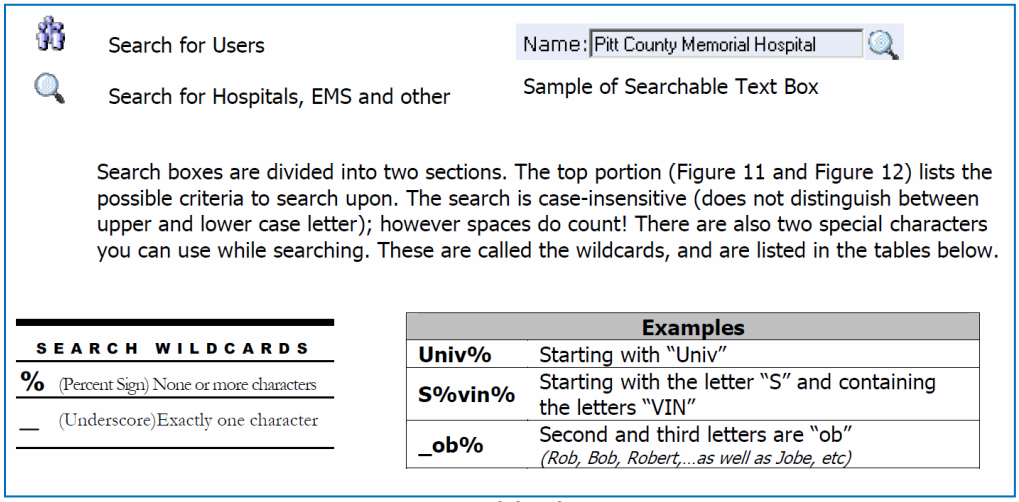
600 Mifflin Road, Suite 102
Pittsburgh, PA 15207
Phone 866.647.8282 • Fax 412.461.3270

v. 1.0.0, 7/17/2012

Content Provided by:
Deborah McCoy-Freeman
Linda Coene

1. **Introduction**
    a. This document is intended to serve as a guide to entering a patient record into emsCharts.
        i. The screen shots you see here may look different to the way your chart is or will be set up. Administrators may turn specific fields of or on and also control many lists shown.

2. **Basic emsCharts.com Navigation Information**
    a. Use of the Tab Key
        i. The most common way of moving around a web page is with the mouse. However, there is an alternate method in the Tab key. This key, located in the upper left-hand section of your keyboard, lets you move from one page element to the next.
        ii. Also, if you go past the element you were trying to reach, you can hold the Shift key and press Tab to move backwards through the page elements.
    b. Search Boxes
        i. Searches are used to look up hospital names, public safety agencies (EMS, Fire, Police, Communication Centers), users, services, and command facilities. The reason for these searches is so that the database can store the ID number associated with an object rather than the name.
            1. This will eliminate incorrect spellings, poor data entry, and provide the ability to search efficiently. For example, when a user changes their last name, only the displayed name will change. The number "behind" the name will remain the same, thus allowing searches across the time span when the name changed.
        ii. Fields in which searches are required are indicated by having the same color as the background immediately surrounding them. The text boxes will be read-only and will have an icon to their right. Clicking on this icon will display the search box.



(Fig. 1)

c. Text Boxes

i. Text boxes allow you to type information directly into the web page.

i. Some boxes enforce a maximum length to the amount of data that can be entered into them, if you are typing and no more text is appearing in the box, chances are that you have exceeded the amount of data the box can hold.

d. Type www.emscharts.com into your web browser to go to our home page

e. Enter your username and password

(Fig. 2)

3. **emsCharts Home Page**

a. Upon log-in, you will see the screen below. This page will be revealed once you complete the security setting for first-time log-ins.

b. **Red Service Login Box**

i. Use this box to change your login Service or Type

ii. Your current login **type** and **service** will always be visible in the upper **right hand** corner as you navigate through emsCharts

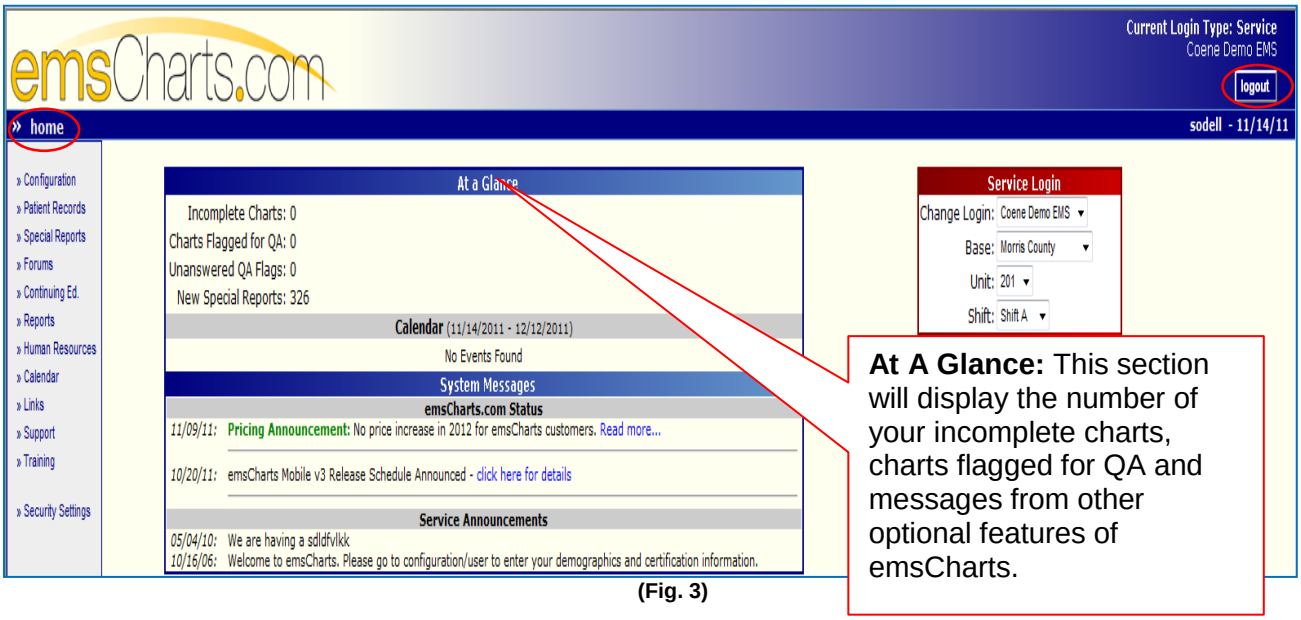
iii. If you work for multiple agencies using emsCharts, be sure that you are logged into the correct service to begin your chart

iv. Base and Unit should be entered for automatic entry when a chart is started.

c. **Logout Button (**upper **right hand** corner)
   i. This is a “kill switch” and will immediately log you off the system

d. **Home Button** (upper **left hand** corner under our logo)
   i. Clicking on “home” will bring you back to this page and the home page menu options in the column on the left
   ii. These home page menu options allow you to access a variety of functions for emsCharts. Your features may differ as many are customizable.

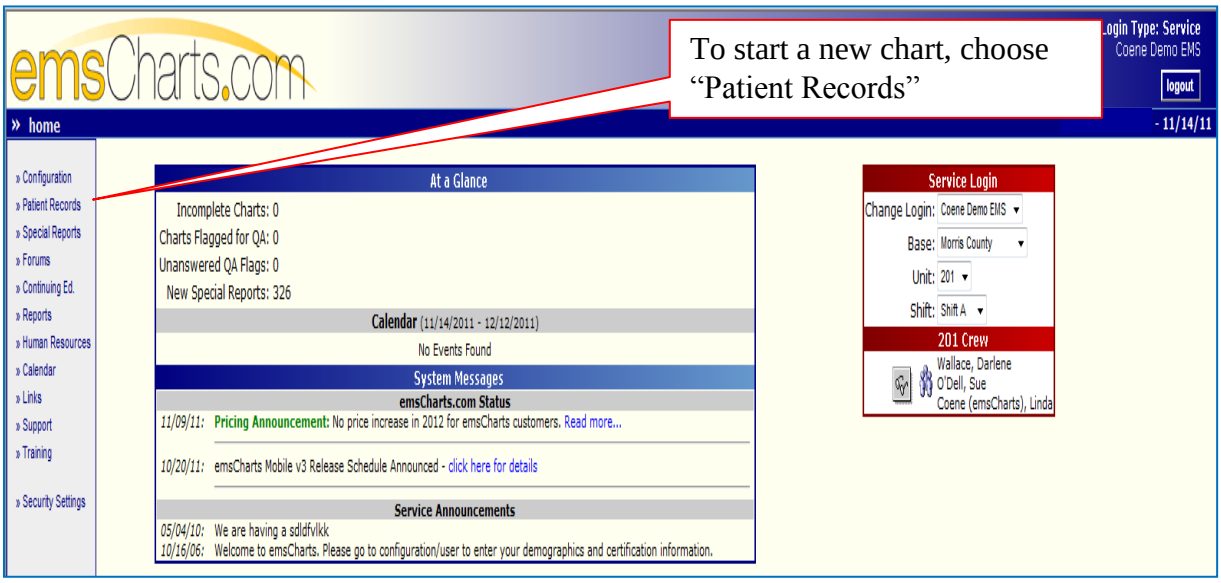
e. At a Glance
   i. See below



(Fig. 3)

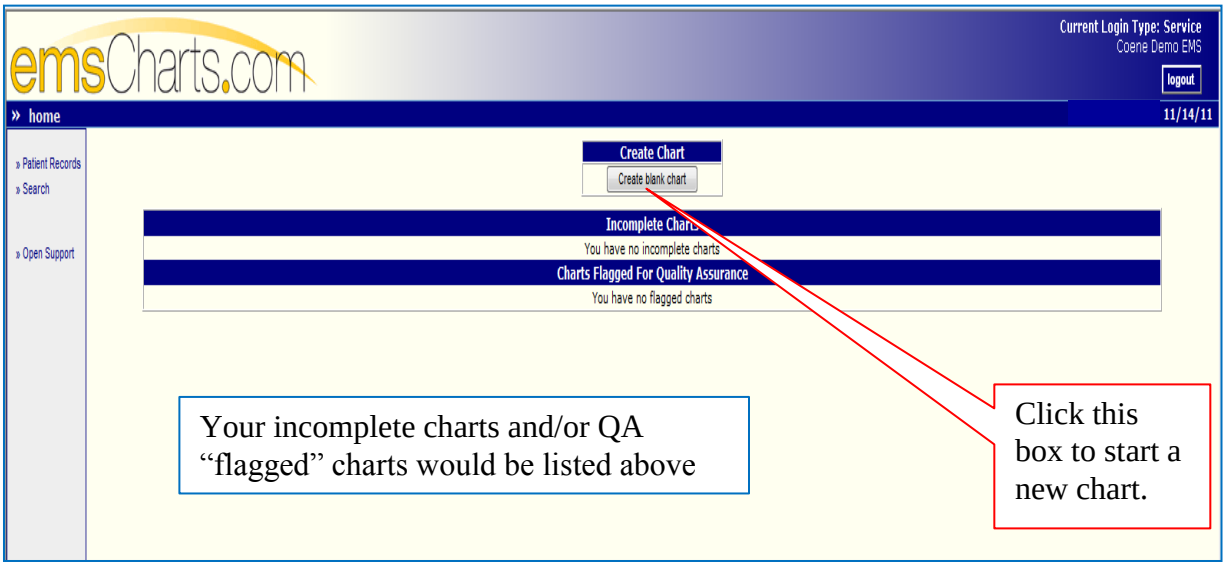
f. System Messages
   i. If messages appear here, they will always be in the following order:
      1. **emCharts Status**: anything we need to communicate to our users will be here
      2. **State/region**: If your state or region uses emsCharts to communicate with its users, those messages will come next
      3. **Command Facility (emsCharts):** will be next
      4. **Service Announcements** – Messages from your service

5. **Writing a Patient Care Report**
    a. Access the Patient Record menu option from the home page



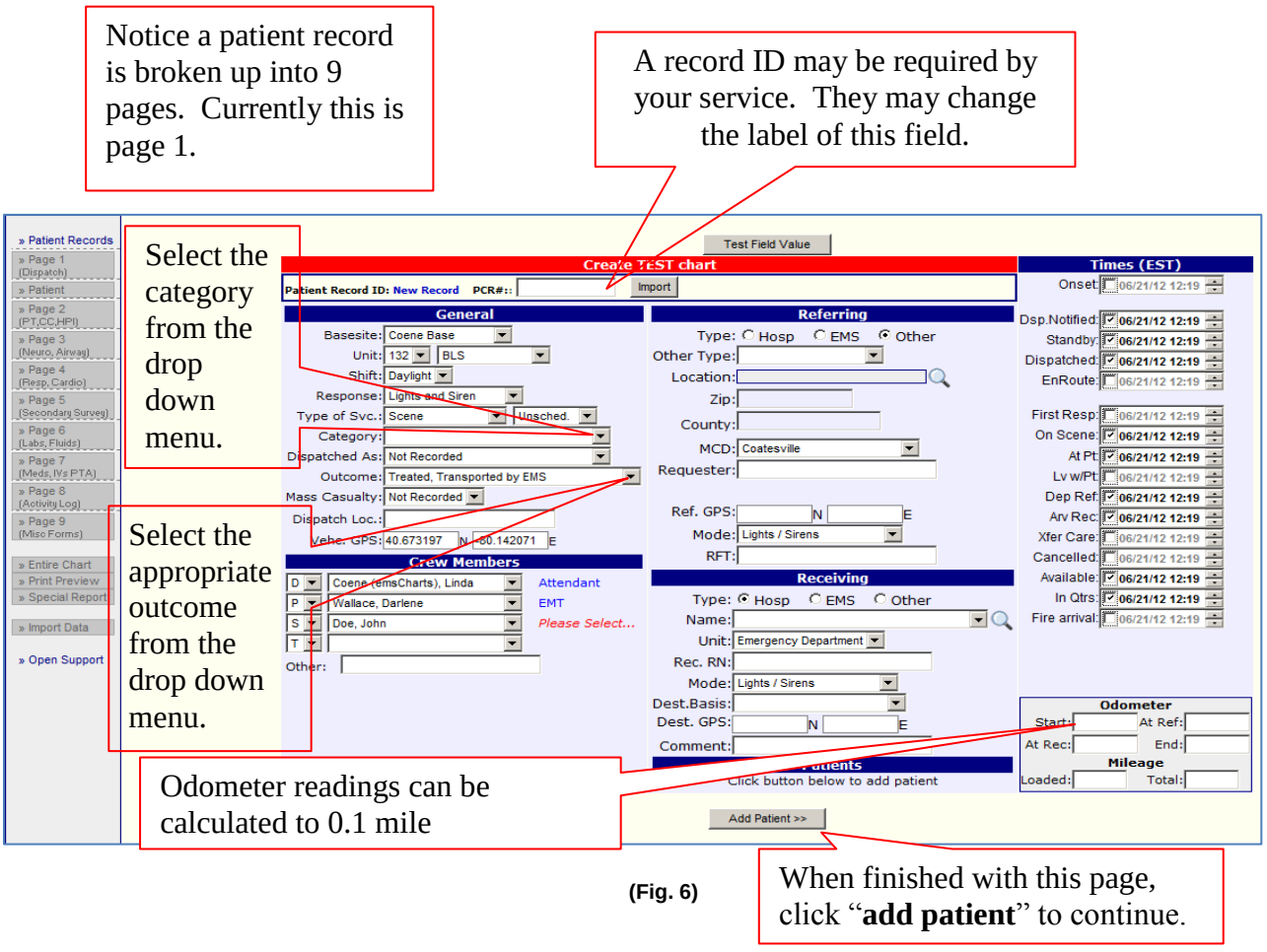
(Fig. 4)

    b. Creating a Blank Chart



(Fig. 5)

Page 1, Dispatch Page



(Fig. 6)

Referring: From whom/where did you receive this patient?

a. **EMS** if you are called to assume care of the patient from another ambulance or Quick Response Unit,
b. **Hosp** in the case of a transfer
c. **Other** for most other 911 calls.
d. This is commonly called the "Pick up" location

Receiving: To whom did you transfer care of your patient?

a. **Hosp** is the default here, so just choose the appropriate facility from the drop down menu.
b. If you transfer care to another EMS service, you should select **EMS** and then choose the appropriate service from the drop down.
c. If you transferred care to anyone other than a hospital or EMS, then choose **Other** and you may be able to choose from the looking glass, any common

address entered into your system for a common location in your response area. You may also type a complete address if not provided.

d. This is commonly called the “Taken to” location

Times

a. This area allows you to enter times. By clicking the box to the left of each time, you can select or deselect that time.
b. Some times will be required according to Outcome chosen

Page 1 Details

Fields at the top of page 1:	Some fields at the top of page 1 are customizable; you may or may not see them. Use whatever IDs your service requires.	**Crew Members**	Crew members entered in EMS charts will be found in the menu. You can manually enter other personnel from assisting services in the “other” box.
Basesite and unit	Customizable according to the service.	**Referring**	Referring is “who called”; most often you will select “other” and enter the address of the residence/location but for situations like an ALS assist or transfer you can select EMS or hospital.
Response	Customizable based on your local dispatch system	**Mode**	How you responded to the scene
Type of Service	“Scene” and “unscheduled” are the defaults for these fields. Other choices are available from the drop down. The most common, however for transfers “interfacility” or “other” can be selected. Scheduled or unscheduled can also be selected depending on a 911 call or scheduled transfer.	**Receiving**	Most often you will select “hospital” however if you transfer care to another EMS unit you could select “EMS” or “other” for a transfer.
Category	Category should be the condition most closely related to the patient’s condition.	**Comment**	This is the first of many opportunities to write comments and build a narrative.
Outcome	This should reflect the outcome of the call, choices can be customized depending on the needs of the service.	**Add Patient**	When page 1 is complete, click this button at the bottom of the page to add your patient information to the chart.

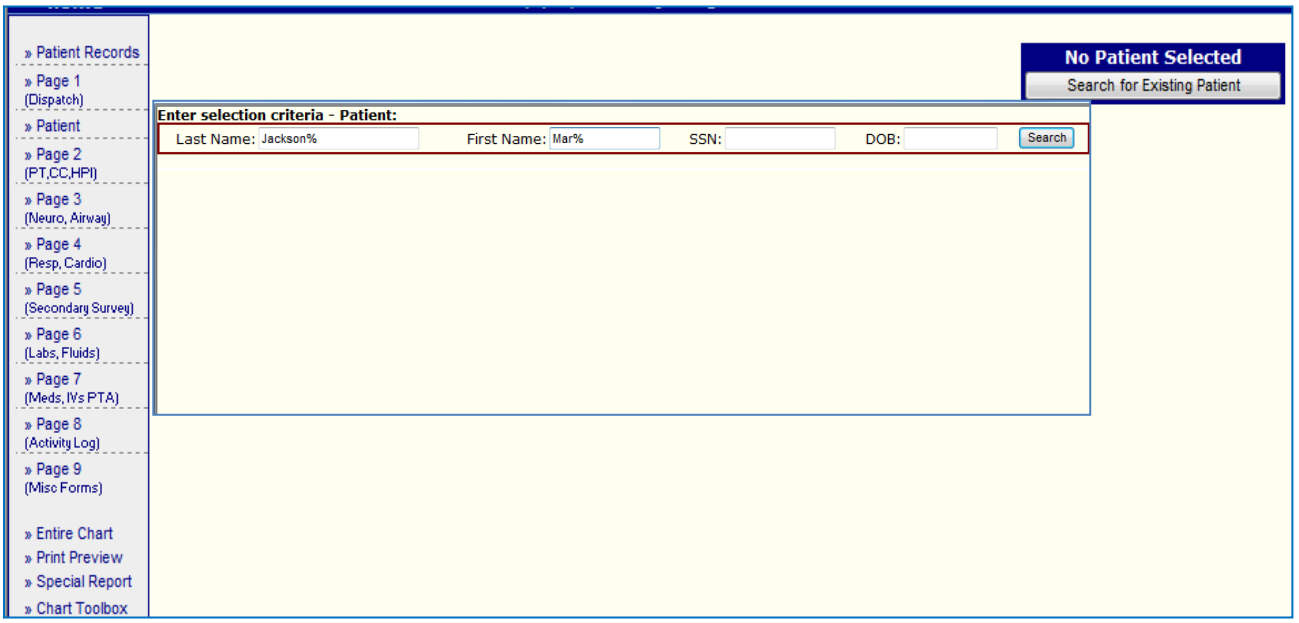
(Table 1)

Adding a Patient

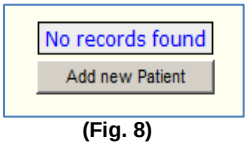
Click **Search for Existing Patient**

a. When searching for patients, be sure to use our program's "wild card code": the percent sign %, as shown below. It is helpful when you are not sure how to spell a name or how a name may have been originally entered in the system. (Fig. 7)

b. If **no** results are found, then choose **Add New Patient** button. (Fig.8)

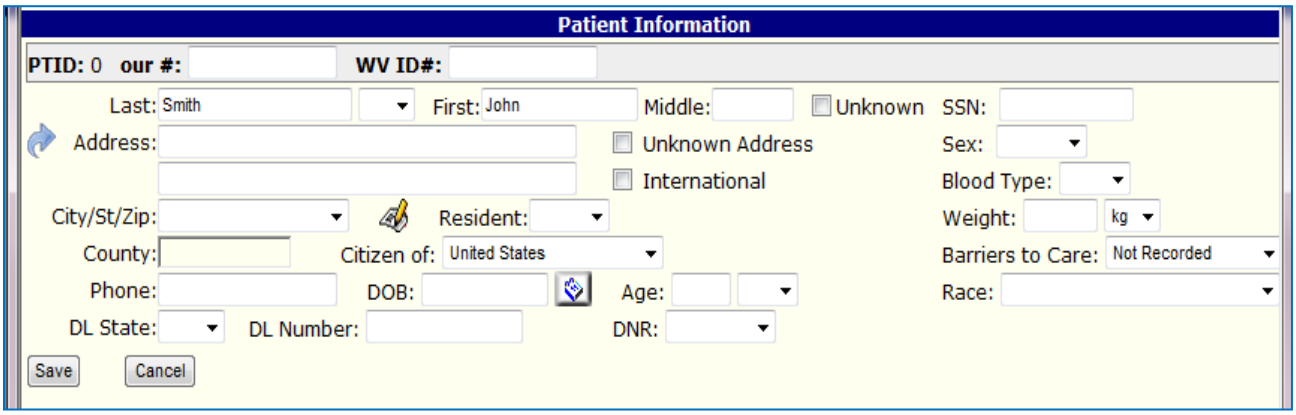


(Fig. 7)



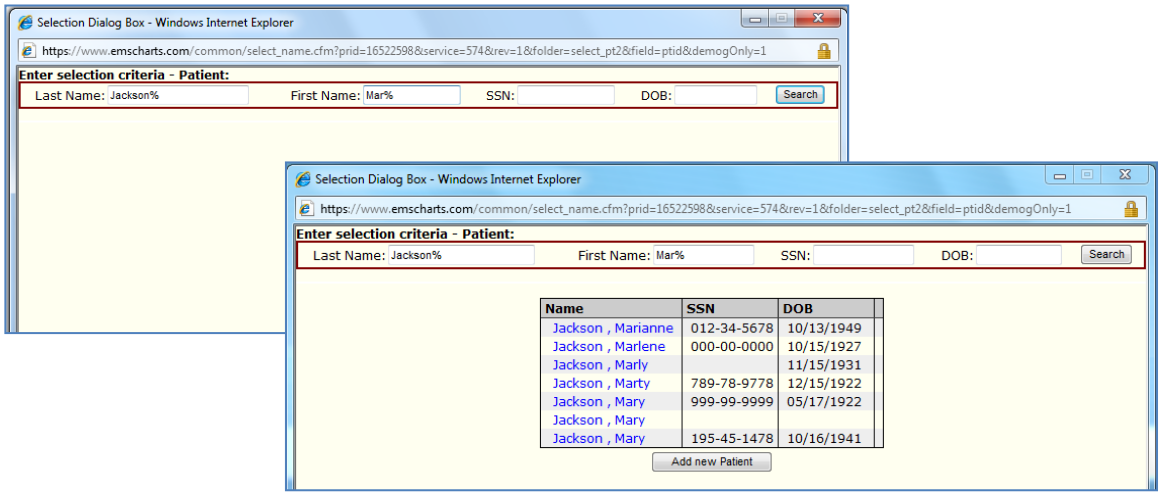
(Fig. 8)

c. Enter the **new patient**'s information in this window and **save. (Fig.9)**



(Fig. 9)

d. Note that the patient's name is Marianne Jackson and how the **%** was used in the search to retrieve all possible entries with last names beginning with "**Jackson**", whose first name begins with "**Mar**".
    I. This provides a more comprehensive search and a list from which to choose the correct patient.
    II. Once you have verified her SSN and/or DOB, you may choose the corresponding patient by clicking on the desired name in blue.
    III. This will result in the patient information, past medical history, current medications and allergies from their last record to be brought forth for you to use in this new patient care record.

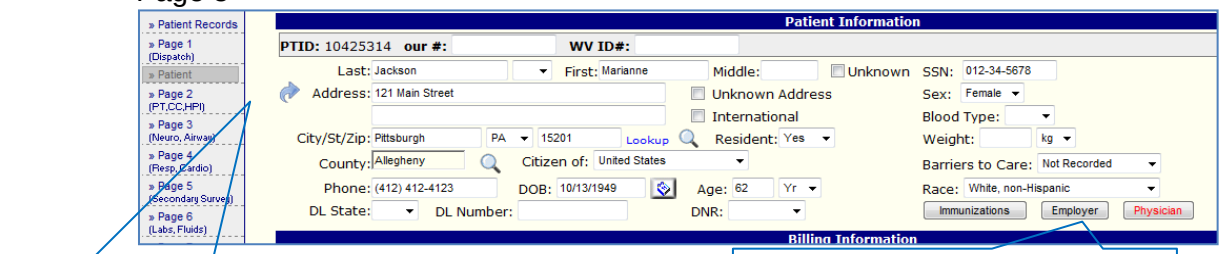


(Fig. 10)

The Patient Page

I. This page is divided into three sections for ease of display

1. **Demographics**
   - **i.** Not all fields may be turned on for your service
   - **ii.** Not all fields must be completed
   - **iii.** If name or address is not available, choose **Unknown**
   - iv. **Date of Birth**: When you tab away from this field, it auto-fills the age for you.
   - v. If the calculated age is less than 19, some pediatric assessment fields will be available.
   - vi. Choose **Female** as appropriate to open an OB/Gyne assessment box on Page 5

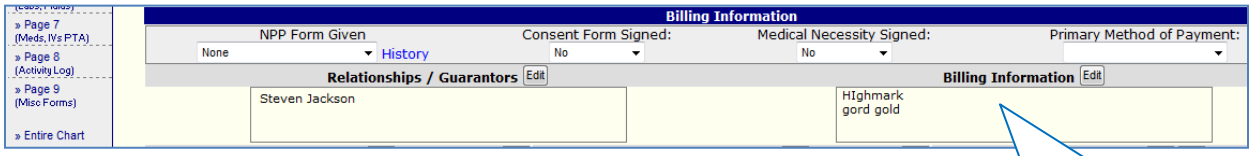


The patient demographics, billing information, PMHX, Meds and Allergies from the previous chart is imported into this chart to be validated

(Fig. 11)

These fields may be available as well. Note that if the text on the box is **red**, there is information already listed there and can be reviewed and/or edited

2. **Billing Information**
   - i. **NPP Form Given**: Choose from the drop down menu to document that the HIPPA form was signed and/or check the "history" link to verify when the patient last signed this form and what version it was.
   - ii. **Relationships/Guarantors**: Use this field to place next of kin or guarantors for insurance if other than patient
   - iii. **Primary Method of Payment**: choose from the drop down. Enter Billing Information below.



(Fig. 12)

Billing information such as insurances can be added or edited here.

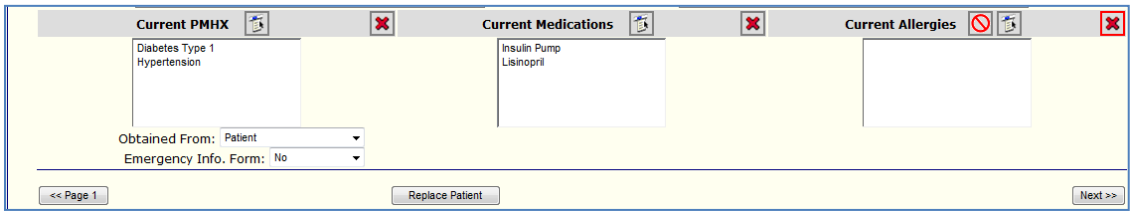
3. **Current PMHX, Medications and Allergies**

   i. a. Clicking the "chart" icons  will open a box (below) to allow you to **look up** Current PMHX, Current Medications and Current Allergies.

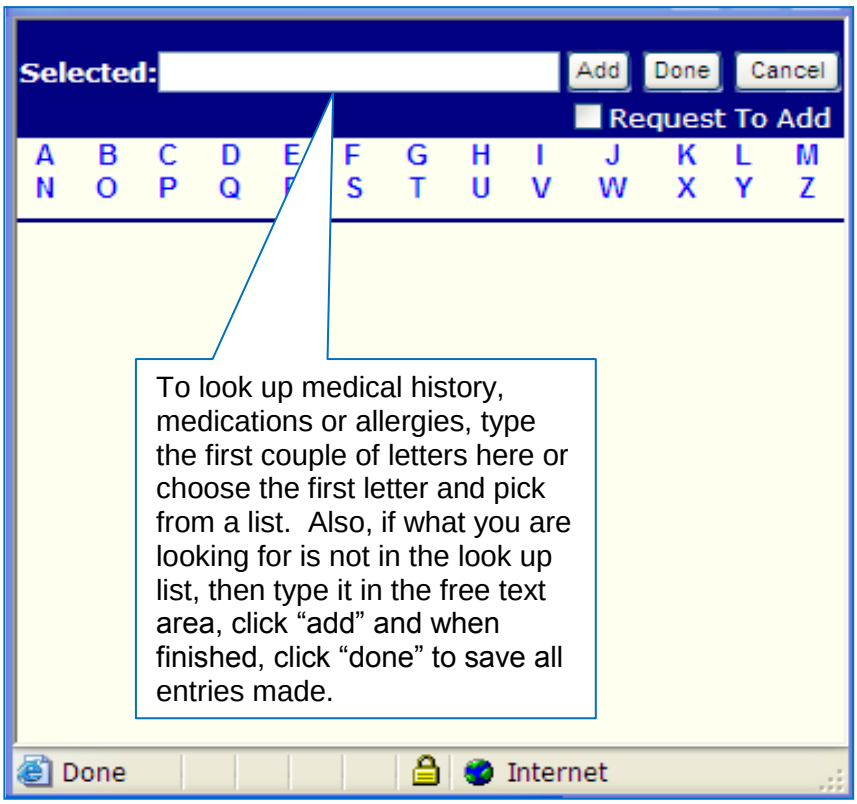
   ii. The "**X**" icon will delete entries after highlighting them

   iii. To document "none", choose the ⃠ icon

   iv. If you chose the wrong patient in the search window and need to replace it or add a new patient instead, click **Replace Patient**.



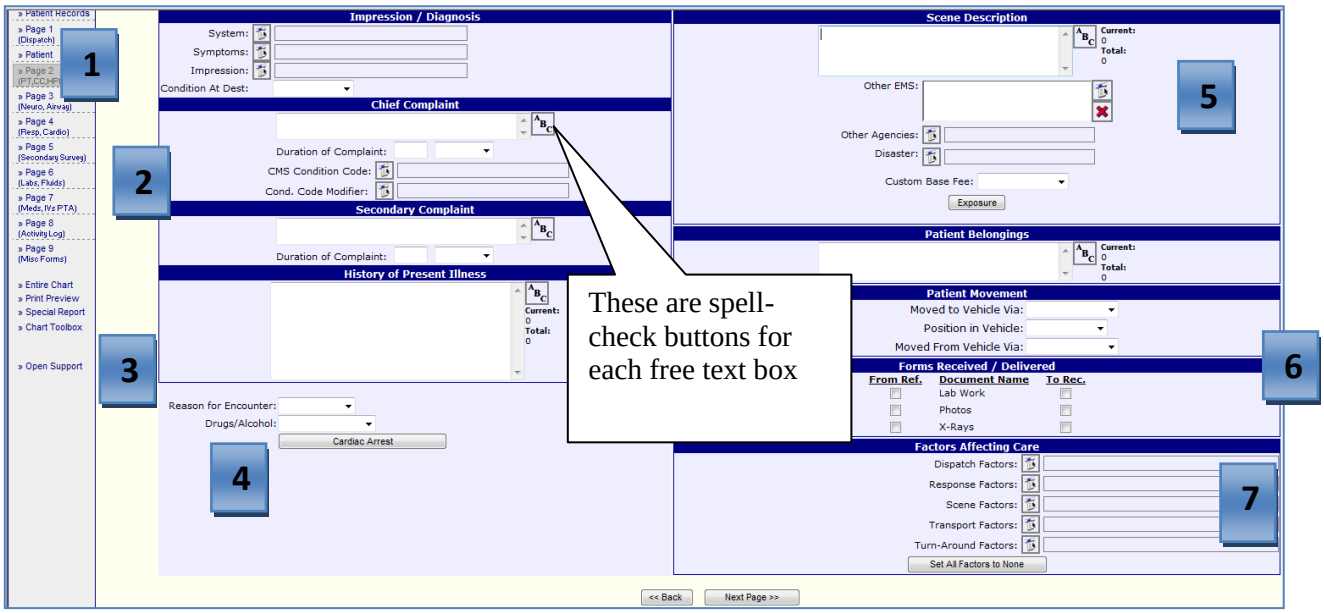
(Fig. 13)



(Fig. 14)

Page 2 (PT, CC, HPI)

1. **Impression/Diagnosis**
   - **a.** Choose the best description of the patient's problem from the drop down menus in each of these areas
   - **b.** Condition at Destination



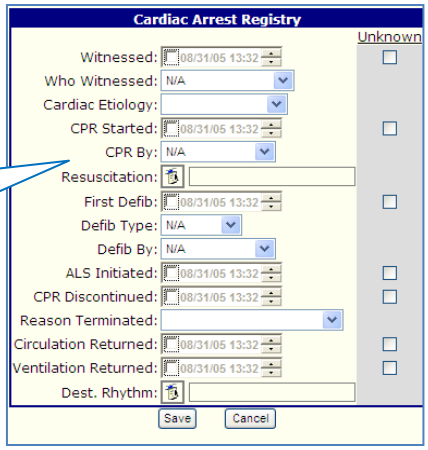
(Fig. 15)

2. **Complaints**
   - **a.** Enter Chief Complaint and Secondary Complaint (an optional field) using no more than 50 characters for each field. Notice you can also choose duration from the box below.

3. **History of Present Illness**
   - a. This free-text box allows up to 4000 characters (equivalent to 2 type written pages) for your description of the patient's history of present illness.

4. **Cardiac Arrest Button**
   - **a.** Information about the cardiac arrest that is in progress upon your arrival goes here. Other buttons may appear depending on the type of call in progress. Cardiac Arrest Button

This is a box to document the care that was given regarding the cardiac arrest that was in progress PRIOR to your arrival. Remember, we use page 8 to chart **our** actions, medications, and treatments for the patient!

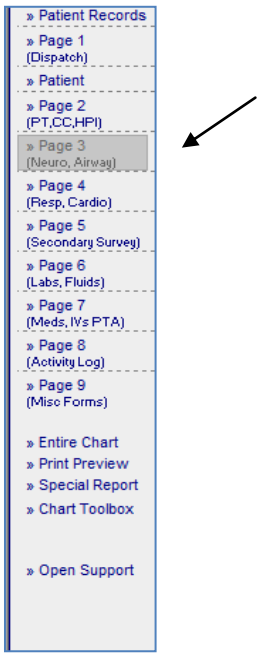


5. **Scene Description**
    - **a.** Use this box to describe the crash scenes. You should describe the damage to all the vehicles involved and any hazards on the scene. You can also document the condition of the house on routine medical calls. (4000 characters here also)

6. **Patient Belongings and Patient Movement**
    a. Free text box (2000 characters) to describe patients' belongings as well as a section below to choose how your patient was moved though out the call.

7. **Forms and Factors**
    a. The forms section is optional depending on the types of calls your service runs
    b. The factors affecting care section includes drop down menus with the most common factors affecting each part of the call.

Page 3, Neuro and Airway Assessment



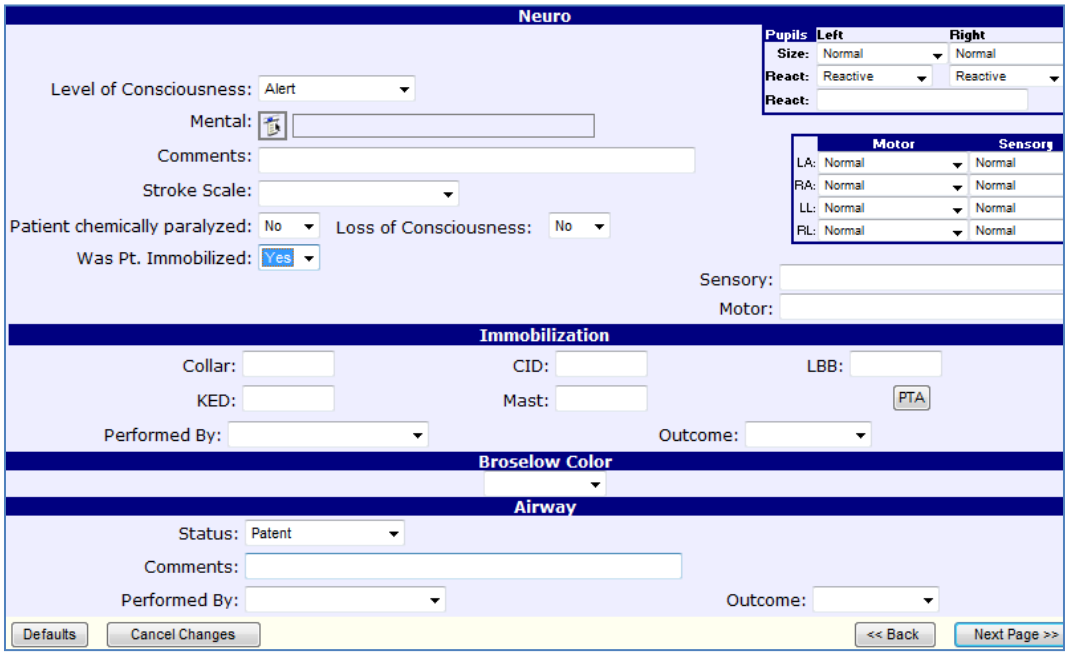
(Fig. 17)

1. **Neuro Assessment**
    a. Use the drop down menus, picklists and comment boxes for the patient's neuro assessment.
    b. If a Stroke Scale was used, indicate what type, and your result from that drop down menu.
    c. Pupillary, Motor and Sensory assessments.
    d. Upper right hand corner to document findings and brief comments for all.

2. **Immobilization**
    a. If you answered "yes" to, "Was Pt. Immobilized", the immobilization field will appear
    b. to document how/who immobilized the patient prior to your arrival. If "no" these fields do not show.
    c. You can choose "PTA" to auto fill (Prior to Arrival) for collar, CID and LBB; N/A will auto fill in the KED and Mast fields. You can then use the dropdown menu to choose who performed the immobilization and what they felt the outcome of that intervention was.

3. **Broselow Color**
    a. If a pediatric age is calculated on the patient page, this field will present itself to you to choose the color on the length based tape that you used for this patient.

4. **Airway**
    a. Airway assessment is done here. You can comment on how the airway was being managed and by whom, prior to your arrival
    b. This is NOT for any airway interventions your crew may have done. That is done on the activity log: Page 8

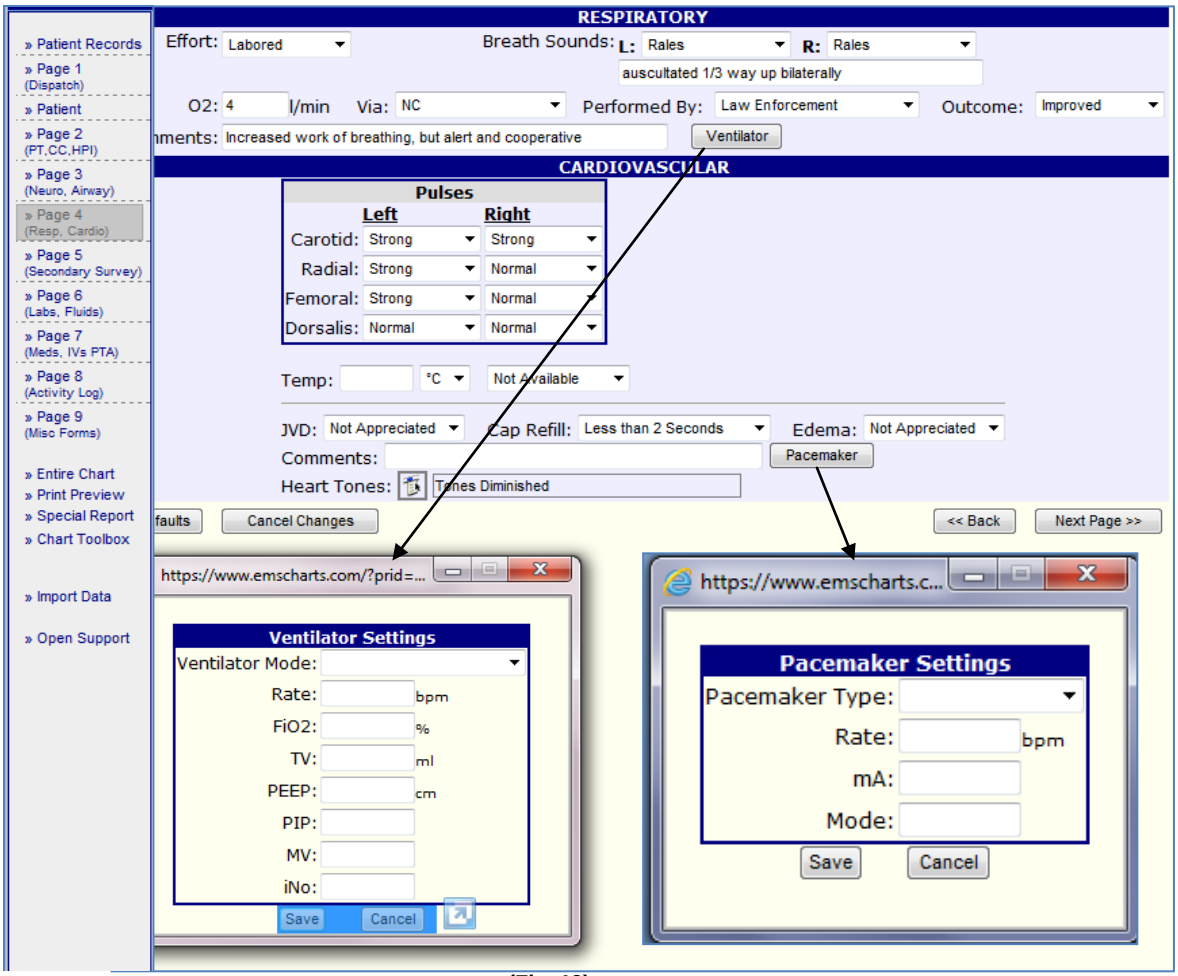

Neuro
Pupils Left Right
Size: Normal Normal
React: Reactive Reactive
React:
Level of Consciousness: Alert
Mental:
Comments:
Stroke Scale:
Patient chemically paralyzed: No
Loss of Consciousness: No
Was Pt. Immobilized: Yes
Motor Sensory
LA: Normal Normal
RA: Normal Normal
LL: Normal Normal
RL: Normal Normal
Sensory:
Motor:
Immobilization
Collar:
CID:
LBB:
KED:
Mast:
PTA
Performed By:
Outcome:
Broselow Color
Airway
Status: Patent
Comments:
Performed By:
Outcome:
Defaults
Cancel Changes
<< Back
Next Page >>

(Fig. 18)

Page 4, Respiratory and Cardiovascular Assessment

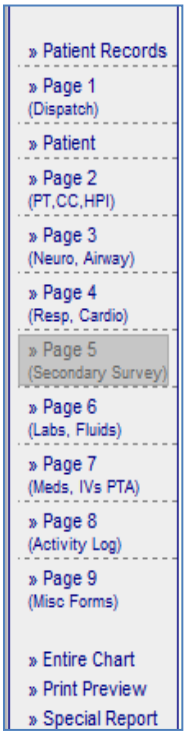
1. **Respiratory Assessment**
    a. Choose from drop down menus and comment fields to document the patient's respiratory assessment including any oxygen that might have been in place prior to your arrival.
    b. Note the Ventilator Settings button and associated box on the bottom left (will be available when the level of care of the chart is ALS).
    c. This is used for when the patient is ALREADY on a ventilator upon your arrival.

2. **Cardiovascular Assessment**
    a. Most of these fields are self-explanatory.
    b. Note the Pacemaker button and associated box on the bottom right (will be available when the level of care of the chart is ALS).
    c. This is used for when the patient is ALREADY being paced upon your arrival.



(Fig. 19)

Page 5, Secondary Survey



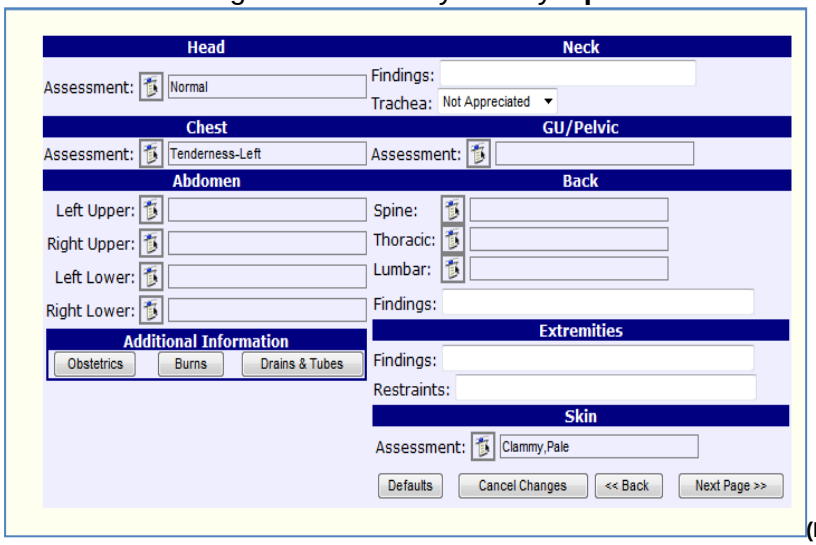
(Fig. 20)

Your service has chosen one of two available options for the Secondary Survey on page 5:

Option #1: Picklist/drop down and text box assessment

1. Clicking the “chart” icon will display common assessment findings under each category.
2. There are free text fields to document your assessment of the extremities in the example below

Page 5 - Secondary Survey **Option #1**



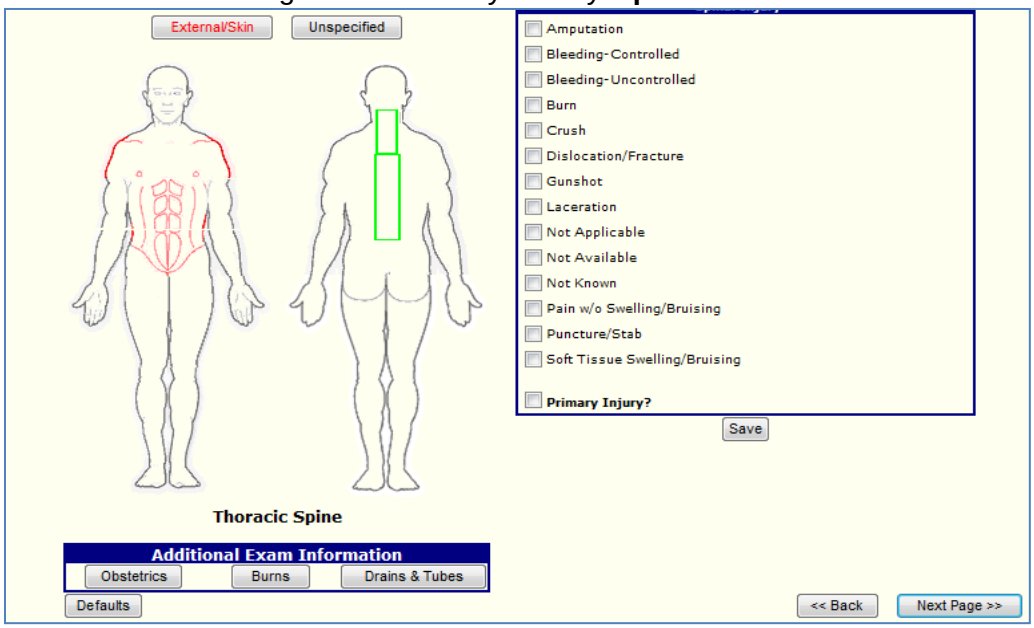
(Fig. 21)

Option #2: Anatomical Exam

1. Run your cursor over each anatomical area and it will turn it GREEN. Then click on it and an assessment box will open to the right with picklists and/or free text fields for injuries or assessment values. Once an area has been assessed, it will remain RED.

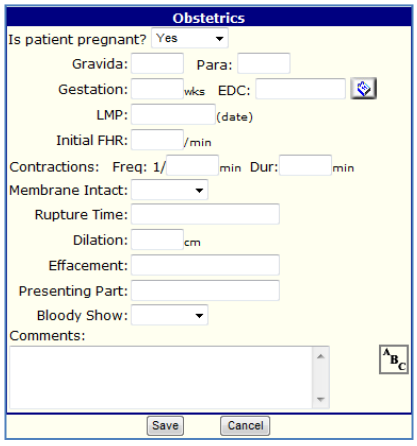
2. The RED text in the "External/Skin" assessment box means that there is data already documented there. The "Unspecified" box contains more assessment values.

Page 5 - Secondary Survey **Option #2**



(Fig. 22)

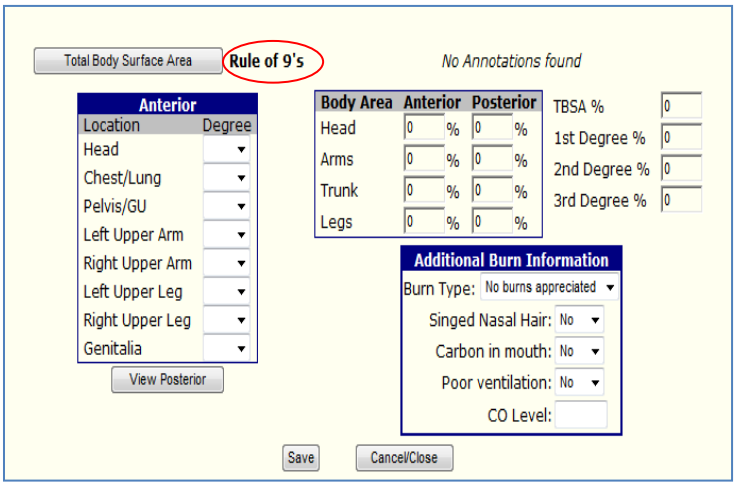
3. The Obstetrics assessment box is available if you chose Female on the patient page.



(Fig. 23)

4. The Burns assessment box has been enhanced to allow two different methods of calculating burns: Total Body Surface Area or Rule of 9's.

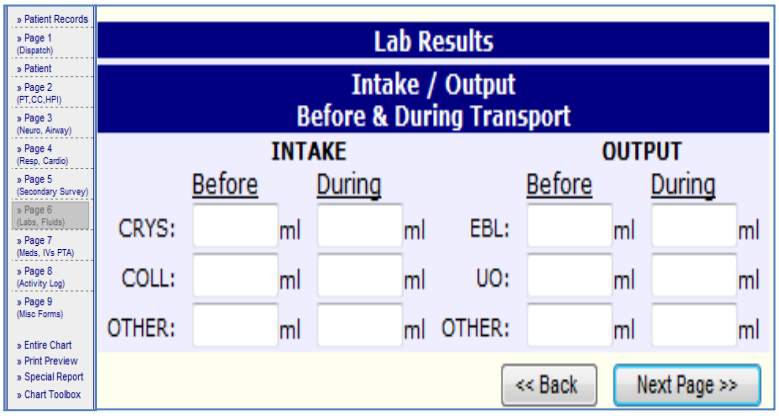
Burn Assessment



(Fig. 24)

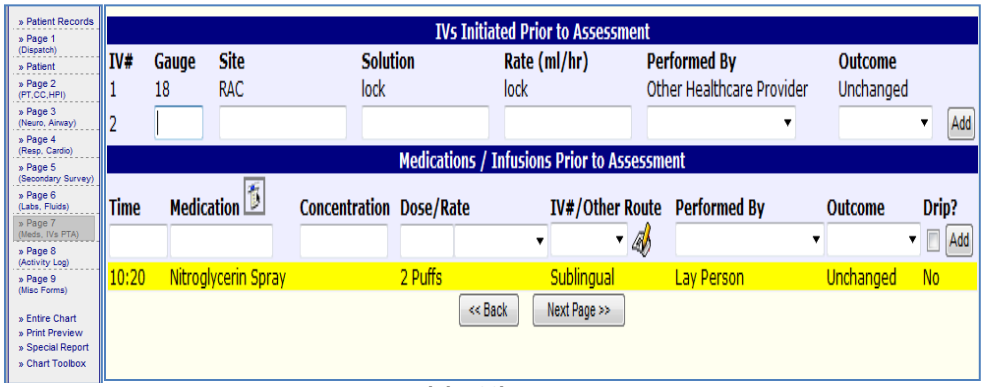
Pages 6 Labs; Intake and Output & 7 “Priors”

1. **Labs, I & O**
   a. Mostly used for critical care transport or long distance transport.
   b. Optional for most services NOT providing critical care



(Fig. 25)

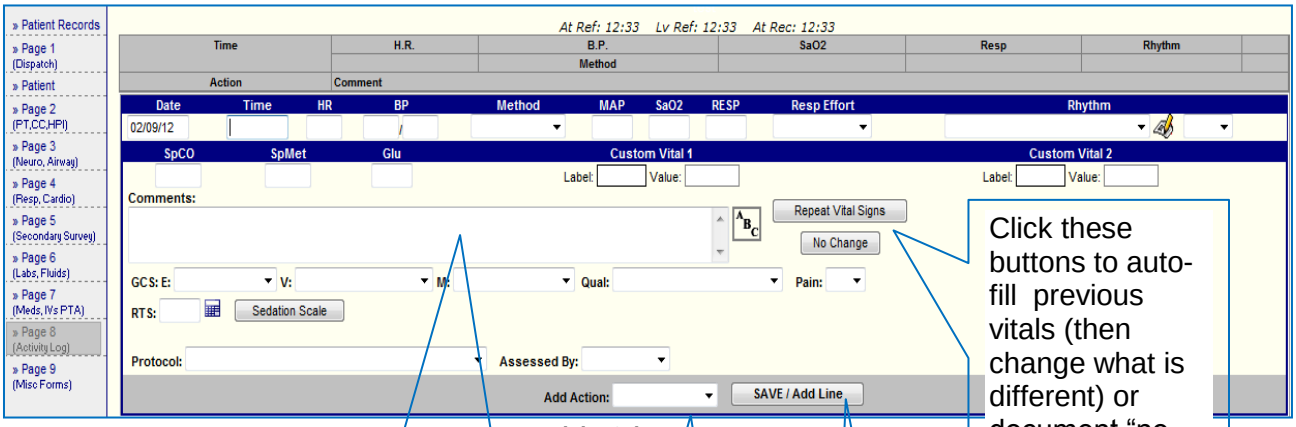
3. **Priors** (below)
   a. For those IVs and medications that were given to the patient PRIOR to your arrival.
   b. Able to document as much as you’re told about these interventions to have the information on the chart.
   c. NOT for medications and/or IVs YOU did for the patient (those go on Page 8: Activity Log)



(Fig. 26)

Page 8 Activity Log

4. **What goes on Page 8**?
   a. Everything about your patient encounter **after** their initial primary and secondary survey (chart pages 2-7) should be documented here
   b. You will document ALL medications, interventions and treatments you performed on your patient here.
   c. You can add comments individually or combine your comment with the documentation of other interventions
5. **Each comment** instance allows up to 4000 characters to continue your narrative, if necessary
6. **Times**
   a. Times are imported from the Dispatch page to assist you in accurately documenting your entries
   b. Each entry on the Activity Log MUST be accompanied by a time. We won't let you forget the time, as a reminder will appear when the time field is blank!



(Fig. 27)

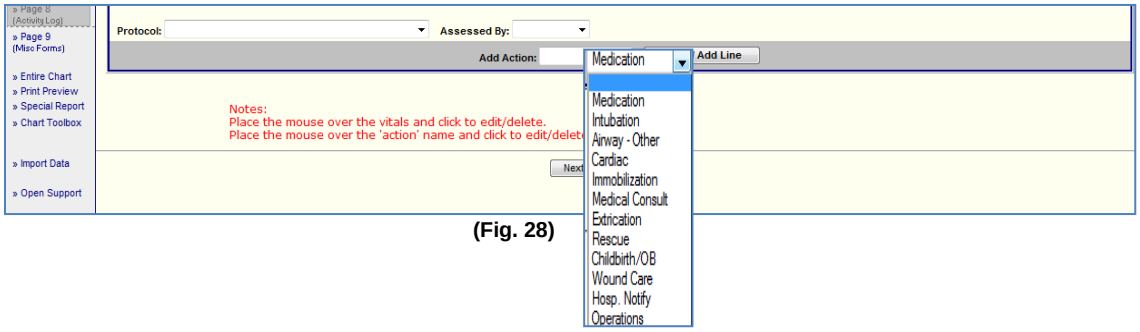
Note fields for blood glucose, GCS pain scale and customizable vitals/labs

Click these buttons to auto-fill previous vitals (then change what is different) or document "no change in patient condition"

"Add Action" is described in detail on the next page

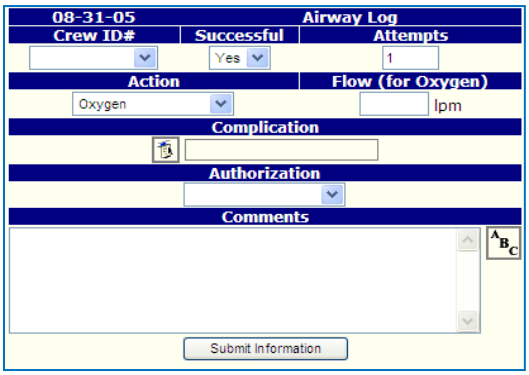
Save each item as you wish to add more detail lines

7. **Add Action:**
   a. Specific actions, medications and interventions are documented using the "Add Action" drop-down menu as shown below.
   b. Oxygen administration and immobilization are "actions" that can be documented by entering a time and documenting anything else you wish for that time.
   c. At the bottom of the log box, click the "Add Action" drop down menu to choose which action you are logging.
   d. Once you click "Save/Add Line" a new box will appear. This box is customized according to the action you chose and allows for quick documentation.

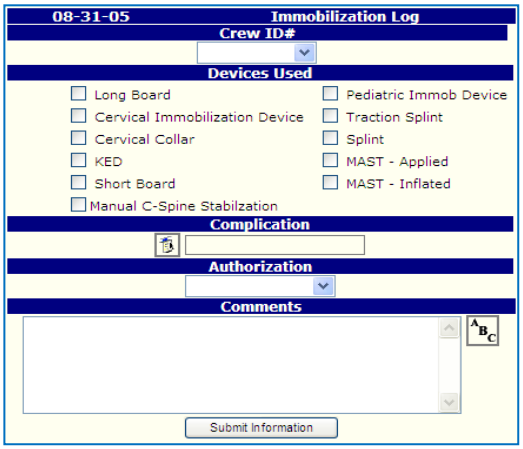


(Fig. 28)

   e. Selecting "Airway – Other" and clicking "Save/Add Line" will bring up the "Airway Log" box below (left)
   f. Selecting "Immobilization" and clicking "Save/Add Line" will bring up this "Immobilization Log" box below (right)



(Fig. 29)



(Fig. 30)

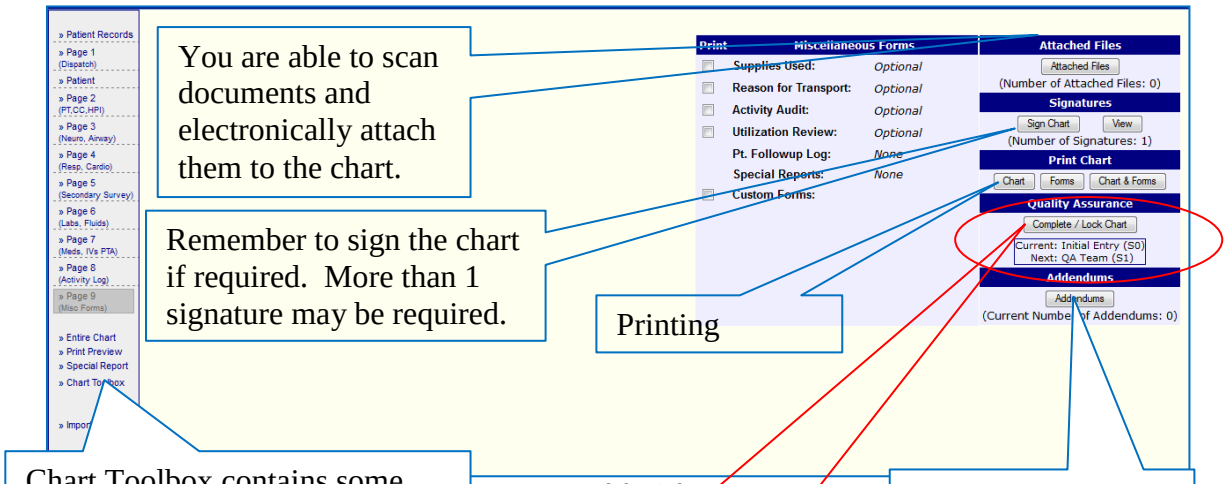
8. For each “Add Action” box, there are specific procedures. Please refer to the table below

Documentation of Specific Procedures on Page 8 – Activity Log

Add Action Menu Options	**Procedures that can be entered**
Medication	Medication Administration
Intubation	Any type of Intubation/Advanced Airway
Airway (Other)	Abdominal Thrusts Foreign Body Removal Bag Valve Mask Oxygen Suction Oral Airway Nasal Airway Impedance Threshold Device Respirator Operation CPAP BiPAP
Cardiac	CPR CPR/AED Mechanical CPR Cardiac Monitor Vagal 12-Lead EKG - Transmitted Defibrillation Chilled Saline Administration Patient Cooing – Post Resuscitation
Medical Consult	Contacting Command
Child Birth/OB	All procedures pertaining to Childbirth/OB
Rescue	Rescue Operation procedures
Extrication	Extrication types
Operations	Other issues
Wound Care	All procedures regarding care of wounds/bleeding
Hospital Notify	Hospital Notification

Page 9 Miscellaneous Forms

1. This is the "wrap-up" area of the chart
    a. There may be a variety of forms or options to complete here in addition to "locking" or advancing the chart to the next QA level when it is finished.



You are able to scan documents and electronically attach them to the chart.

Remember to sign the chart if required. More than 1 signature may be required.

Printing

(Fig. 31)

Chart Toolbox contains some utilities that may be useful, such as deleting a chart while it is still in the authoring stage (before it's locked)

Once the chart is locked, you can use the addendum feature to make your late entry. This will auto date/time stamp and adds your name to a 4000 character max notation box for each addendum instance.

Once the chart is finished, signed and considered to be "complete", it will be time to "Lock" the chart for QA. In this area, you can see at what QA level the chart is and what level it will go to once it is locked, in this case it will go to QA Level 1 QA Supervisor for review.

The locking procedure checks the chart for any data validations and then packages it for export.

The items on the left side of Page 9 are optional and may or may not be used by your service. They are "add in" items that they will train you on if they decide to use these functions of emsCharts.

Thank you for using emsCharts!