Purpose

This document serves as a reference guide to the overall use of the Santa Clara County EMS System’s electronic patient care record (ePCR) system. Currently the EMS Agency utilizes Image Trend Elite Field as its ePCR solution for all 911 EMS Responses occurring within Santa Clara County.

This guide will cover topics such as sign on and access to both the online and offline versions of Elite, how to interface with CAD and external devices, patient information transfer between responding agencies, and procedures used to complete documentation. The sections, panels, values and other associated tools have been assembled and streamlined to ensure compliance National and State reporting requirements and to collect data specific to our county guidelines.

This document is expected to continuously evolve as changes are made to improve the Santa Clara County EMS Documentation Systems. Items expressed and explained in this document are not intended to override any part of the policies governing documentation.

Documentation Overview

A Patient Care Record has many purposes, the most important being, the ability to rapidly and efficiently provide patient care information throughout the chain of medical providers. The PCR accounts for all patient care and assessment provided by each responding unit, from each agency. The PCR also serves as a retrospective Quality Improvement tool to analyze the effectiveness of the provider’s adherence to treatment protocols and the effectiveness of the treatment protocols in the patient’s overall outcome.

The Santa Clara County EMS Agency hosts the EMS Data Task Force, which enables EMS managers and EMS providers to collaborate on the construction of the ePCR template and forms. This group continually strives to find new efficiencies in the documentation process. Please visit the EMS Agency website for further information or to contact the EMS Data Task Force.

Santa Clara County Policy 500: ePCR Documentation, defines a patient as any individual for whom emergency medical assessment, care, or emergency ambulance transportation has been requested and who: has a chief complaint or is deceased; ss accompanied by a witness, or someone with personal knowledge of the individual, who states that the individual has a chief complaint, or who makes a request for examination or treatment on the individual’s behalf; has an obvious symptom or signs of injury or illness; has been involved in an event with a mechanism that the average EMS Responder would believe could cause injury; appears to be disoriented, have impaired psychiatric function, or suicidal intentions.
Santa Clara County Policy 500: ePCR Documentation, requires an ePCR record to be completed for every EMS response by each responding agency. Each responding unit is responsible for collecting patient assessment information while at the patient’s bedside when scene safety and patient acuity allows. EMS providers shall document only what their crew performs.

This guide is using the assumption that there are “normal” conditions during flow of an EMS call. One assumption is the standard sequence of events that occur on a call, such as:

- Each tablet has a functioning cellular or Wi-Fi connection most all the time.
- The first arriving unit begins to document at the patient’s bedside.
- The first arriving unit prepares to transfer the patient data to the next arriving unit.
- The second arriving unit prepares to accept the patient data download while at the patient bedside.
- The transport unit will select a destination and post the chart.
- Each unit will post as often as possible.
- The record will be completed within 24 hours from the time of the call or the end of the crew’s working shift, whichever is less.

Table of Contents

Purpose........................................................................................................................................................................ 1
Documentation Overview............................................................................................................................................. 1
The Basics of Image Trend Elite................................................................................................................................. 4
Sign In to Elite Online and Elite Field ...................................................................................................................... 4
Syncing Elite Field....................................................................................................................................................... 5
Standard Symbols Throughout Elite ...................................................................................................................... 5
Elite Field Dashboard - Screen Layout ..................................................................................................................... 6
Incident Form Navigation............................................................................................................................................... 7
Top Header Overview.................................................................................................................................................. 7
Right Side: Slide Out Panel Overview..................................................................................................................... 7
Times Panel................................................................................................................................................................. 8
Mileage Panel ............................................................................................................................................................ 8
Timeline Panel.......................................................................................................................................................... 9
Situations Panel......................................................................................................................................................... 9
Timeline.................................................................................................................................................................. 9
Power Tools ............................................................................................................................................................ 10
Sections and Panels Overview.................................................................................................................................... 10
Form Footer: Patient Name, Validation Score, Record Status.................................................................................. 10
Patient Care Report (PCR) Form.................................................................................................................................. 12
ePCR: Start Here: Start Incident .............................................................................................................................. 12
ePCR: Import CAD .................................................................................................................................................. 12
ePCR: Start Here: Patient Interview........................................................................................................................ 13
ePCR: Repeat Patient Search...................................................................................................................................... 15
ePCR: Start Here: Transfer Notes .......................................................................................................................... 15
In the Field Patient Data Transfer.......................................................................................................................... 16
ePCR: Start Here: Rapid Transport .......................................................................................................................... 18
ePCR: Start Here: Refusal of Care........................................................................................................................... 18
ePCR: Dispatch: Unit and Crew .............................................................................................................................. 20
ePCR: Dispatch: Dispatch........................................................................................................................................ 20

20191001 Page 2 of 49
The Basics of Image Trend Elite

<table>
<thead>
<tr>
<th>Elite Online</th>
<th>Elite Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>Considered the online version of Elite</td>
<td>Considered the offline version of Elite</td>
</tr>
<tr>
<td>Requires constant internet connection.</td>
<td>After initial sync, internet may be disabled.</td>
</tr>
<tr>
<td>After log in, the user must navigate within the incident tab to start a PCR.</td>
<td>After log in, the user clicks on the “new” button to start a PCR.</td>
</tr>
<tr>
<td>Syncing occurs as a part of the opening of the PCR template.</td>
<td>The user must allow the Elite software to process through the sync process prior to using it.</td>
</tr>
<tr>
<td>Post button is not needed due to the constant save via the internet connection.</td>
<td>Post button must be used to upload data from the device to the database, when internet connection is available. This will be performed frequently.</td>
</tr>
<tr>
<td>The internal messaging system is available to the user while online.</td>
<td>The user will be redirected to Elite Online to use the internal messaging system.</td>
</tr>
</tbody>
</table>

Sign In to Elite Online and Elite Field

- Notice that the login panel has an orange border around the “sign in” text
- Login with your username
- Enter your password
- Click “Sign In”

https://imagetrendelite.com/Elite/Organizationxscemsa/ • Notice that the login panel has a blue border around the “sign in” text
• Login with your username
• Enter your password
• Click “Sign In”

https://imagetrendelite.com/Elite/Organizationxscemsa/RunForm/Login
Syncing Elite Field

Upon initial “Sign In” to Elite Field a “Sync” will be performed. This “Sync” is a download of vital information into the web browser’s cache (or memory) to construct the offline version of this complex software. Interrupting this “Sync” will cause fatal errors and or will prevent the software from loading. The user may be asked to allow your browser cache to expand the browser cache. The user should always select “yes.”

Standard Symbols Throughout Elite

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Add" /></td>
<td>“Add” an item (Crew Member, Exam, Intervention, etc.).</td>
</tr>
<tr>
<td><img src="image" alt="X" /></td>
<td>“X” button. Closes the current screen or panel; Removes a field entry.</td>
</tr>
<tr>
<td><img src="image" alt="Arrow Down" /></td>
<td>Arrow Down button. Click to scroll through Field Values, “Arrow” button next to a field indicates a single value is to be selected for the field.</td>
</tr>
<tr>
<td><img src="image" alt="Multi Value" /></td>
<td>Multi Value button. Click to scroll through Field Values, “Multi” button next to a field indicates one or more values can be selected for the field.</td>
</tr>
<tr>
<td><img src="image" alt="Field Values" /></td>
<td>Field Values Button. Opens a list of values for a field in the section index on the left margin navigation area.</td>
</tr>
<tr>
<td><img src="image" alt="Null Value" /></td>
<td>Null Value button. Click the “Null Value” button to select allowable “None Reported”, “Not Applicable”, and “Unable to Obtain” values.</td>
</tr>
<tr>
<td><img src="image" alt="Exclamation marks" /></td>
<td>Exclamation marks warn of required input to a field based on validation rules.</td>
</tr>
<tr>
<td><img src="image" alt="Time/date autofill" /></td>
<td>Time/date autofill button. Use to auto fill the current date/time into the associated data field.</td>
</tr>
<tr>
<td></td>
<td>Incident Search Field (incidents not posted)</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>2</td>
<td>Number of incidents attributed to the current user in the browser’s cache</td>
</tr>
<tr>
<td>3</td>
<td>Add crew member(s) and provider role. The crew member assignment, shift, and role will remain assigned until updated or removed, and will auto-populate in the incident document</td>
</tr>
<tr>
<td>4</td>
<td>Remove crew members and/or their associated provider roles</td>
</tr>
<tr>
<td>5</td>
<td>Add the response unit’s call sign and add the assigned shift for this crew (if applicable).</td>
</tr>
<tr>
<td>6</td>
<td>Choose your unit’s EKG medical device. Doing so will auto populate the device in the filter area of the EKG download window.</td>
</tr>
<tr>
<td>7</td>
<td>Image Trend mail “Inbox” link. This field will update every time you log in or sync and will show unopened messages with a red number. Clicking on this link will take you to the online version of Elite and will open the messages solution.</td>
</tr>
<tr>
<td>8</td>
<td>Settings, About, Logout buttons will allow the user to, Sync the form and solution data, Obtain the software version number, or Log out the current user.</td>
</tr>
<tr>
<td>9</td>
<td>The “new incident” bar. Clicking on this bar will initiate a new PCR form using the agency’s default template.</td>
</tr>
<tr>
<td>10</td>
<td>Shows “All” Incidents assigned to you, or show “None”</td>
</tr>
<tr>
<td>11</td>
<td>Clicking this post button while an incident is highlighted will post that incident to the server. Online connectivity is required.</td>
</tr>
<tr>
<td>12</td>
<td>Clicking this button will delete the highlighted incident from the browser’s cache and the device.</td>
</tr>
<tr>
<td>13</td>
<td>Switch between three different views, each showing different amount of detail.</td>
</tr>
</tbody>
</table>
Incident Form Navigation

Top Header Overview

01 **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.

02 **Save Button:** Click to *Save* changes to the local drive. Additionally, information auto-saves when switching panels.

03 **Post Button:** In Field, this button *Posts* the incident to the server.

04 **Print Button:** Generate a printable HTML report of the incident while online or offline. The report opens in a new browser tab.

05 **PDF Button:** Click the *PDF* button to view a printable PDF report of the incident in a new tab.

06 **CAD Import:** Importing CAD incidents imports specific information from the incident into the incident form.

07 **Import EKG Button:** Click *EKG* to import EKG cases into your incident. This functionality requires that your agency has set up EKG cloud data transfer.

08 **Transfers:** Click this button to initiate the incident data transfer functionality of Elite. Select PCR data may be transferred, and thus shared, with other responding units or agencies that are part of the care of the patient being documented.

09 **Close Button:** Click *Close* to close the incident and return to the dashboard.

Right Side: Slide Out Panel Overview

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

**Times Panel:** The Time slide out panel opens revealing all response time fields. 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. To close the panel, click either the X or the Times button again.

**Mileage Panel:** select the Mileage button to open this slide out panel.

**Timeline Panel:** 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 patient data history through multiple contacts

**Situations Panel:** The Situations Panel allows the user to quickly document procedures and medications administered during an event. Click the Situations panel to view a menu of situation options for Adult Care and Pediatric Care (organized along the Weight and Color Codes based on the Broselow Tape System).

**JotPad:** The Jot Pad allows the user to make handwritten notes using a stylus. The JotPad data is not part of the legal patient care record.

### Times Panel
Selecting **Times** button in the right-side view of the screen and a table will show all event times. If the CAD has been downloaded, the values will be displayed, will show in the times fields. Times may be added using the time stamp or clicking on the field and entering the times with the device’s keyboard or the software keypad next to the times fields.

### Mileage Panel

Click the **Mileage Button** to open the mileage table shown. Enter the numeric odometer reading, including tenths of a mile for beginning odometer, on-scene odometer, patient destination odometer. The total mileage calculation will be automatically calculated and will show next to incident total mileage.
The **Timeline** panel combines information from the times table and events or procedures from the situations table or those entered using dynamic power tools. The timeline Panel is the most efficient way to navigate the form, once times and procedures have been entered. To access the form for any event in timeline, click the arrow button, next to the entry and the user will be navigated to the entry field and form for the event. Events that have validation issues can be selected to make revisions in the form as needed.

The **Situation** panel allows the user a simple way to time stamp events and record relevant assessment values as they occur at the bedside. Situation tools are organized as adult and pediatric.

Each situation group shows buttons titled to the specifics of the protocol or procedure. Pressing the button creates a line in timeline to document the event as well as prepopulates that item into the ePCR. Some of the buttons, such as “Vital Signs” will open a Power tool allowing the author to complete the values for that item.
Power Tools

The Elite solution also allows for rapid data entry for a specific set of common procedure, medications, and assessments.

Click on a **Power Tool Button** to open a form that will allow the author to enter the specifics associated with that topic. Power tools are designed primarily to allow the user to capture as much data as possible in a reduced amount of time. That said, most fields that require data entry can be accomplished using a keypad that will open when the user opens the field for the data, such as the Table for GCS Scoring shown below.

**Sections and Panels Overview**

**Sections:** A section is the main header that is collection of panels. Selecting a section expands it to view the panels that are contained in the section. Some sections may be hidden until certain values are selected in an element. Upon beginning an incident form, only the “Start Here” section is visible. When the section is selected the header will open the attached panels below and bold the section name.

**Panels:** A panel is the child to the parent section header. The panel contains the various elements that are related. When the panel is selected it will highlight white and bold the panel name.

**Form Footer:** Patient Name, Validation Score, Record Status
Menu: Click Menu to add Attachments, view the Incident Audit Report, send a Messages, Delete the chart, or Lock the incident. The use of Addendums is prohibited in this data system. The function of Associate Fire Incident is only applicable to those services utilizing the County’s Fire RMS System Image Trend. Users can select to add Attachments of many types, including incident photos and supporting documentation.

Validation Score: The current validation score for the incident form. To easily Navigate to the validation errors, click on the Validation Score, center of footer, for a list of linked errors. Click the right arrow to move directly to that field/form.

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.

Validation Highlight: Elements that are required by various rules will have a red highlight ribbon. Select the exclamation point to learn the rule behind the highlight. Achieving the highest point value is the goal of every user but, it is not always possible given the variety of complexities of documentation. The user should concentrate more on proper documentation versus the assigned point value.

The Status area displays the current status of the PCR document. Authors may utilize this drop down box to change from “in progress by crew” to “completed by crew” status once documentation for this incident has completed.

Patient Name: name of the patient as recorded for the record will be displayed here if entered.
Patient Care Report (PCR) Form

A patient is defined as per Policy 500: (ePCR) Documentation. A patient care report (ePCR) shall be completed by each responding unit from each responding agency for every patient encounter that occurs. This ePCR solution is configured to expand and collapse panels based on the Primary Role of the Response Unit and values chosen by the user throughout the creation of the chart.

**ePCR: Start Here: Start Incident**

START HERE: Start Incident – The first section and panel that are visible after creating an “New Incident” from the “Dashboard”.

- **Primary role of my unit** – This panel will “Show or Hide” other sections and panels based the values selected.
- **I am completing a (choose one)** – This panel will “Show or Hide” other sections and panels based the values selected.
  - “Cancelled Call” is used when no patient contact has occurred.
- **My event number** – Enter your agency’s event or incident number. CAD downloadable.
- **Time of dispatch** – Enter date/time the dispatch occurred. CAD downloadable.
- **Arrived at patient time** – Enter date/time the user arrived at the patient’s side.

**Data transferred from Agency ID:** non-editable field that will populate when an appropriate download is complete.

**Transferred call sign:** non-editable field that will populate when an appropriate download is complete.

**ePCR: Import CAD**

- **CAD** – It is recommended the user downloads CAD early and often throughout the creation of the PCR.
  - **Import CAD Incident** – CAD information may be imported from a CAD record into the PCR. Any data that was entered manually into a field that CAD data will import, will be overwritten by the download. Multiple CAD imports will update the most recent CAD record. If downloading while in a current incident, this dialog box will open:
    - **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.
**START HERE: Patient Interview** – this panel is intended to be used to collect most all patient information while at the patient’s bedside on scene.

### Encounter Specific Patient Number

- **Encounter Specific Patient Number:** is a number associated on scene to the patient, EX: 1 of 3.

### Driver’s License Scanner

- **Driver’s License Scanner:** uses an iOS app that scans the barcode of an ID, imports various fields. This field will remain non-selectable until the app is installed on the device. The user shall validate all data with the patient upon import.

### Add Patient to Incident

- **Add Patient to Incident:** creates a new chart with the non-patient identifiable data that has been entered at that point.

### Patient’s First Name

- **Patient’s First Name:** only the patient’s actual name is to be entered, a “Null” value of “Unknown” or “Refused”, is acceptable.

### Patient’s Last Name

- **Patient’s Last Name:** only the patient’s actual name is to be entered, a “Null” value of “Unknown” or “Refused”, is acceptable.

### Find a Repeat Patient

- **Find a Repeat Patient:** (see page 16)

### Date of Birth

- **Date of Birth:** only the patient’s actual DOB is to be entered, a “Null” value of “Unknown” or “Refused”, is acceptable.

### Age

- **Age:** enter numeric value, populated from the DOB.

### Age Units

- **Age Units:** select the appropriate value.

### Gender

- **Gender:** select the appropriate value.

### Length Based Tape Measure (Broselow)

- **Length Based Tape Measure:** the applicable color of the pediatric patient, a “Null” value of “Not Applicable” or “Unable to Complete”.

### Estimated Body Weight

- **Estimated Body Weight:** enter the patient’s weight, a “Null” value of “Unable to Complete” is acceptable.

### Race

- **Race:** select all that apply.
**Patient Complaints** (grid)—**Add**: select to create more than one complaint.

**Complaint Type**: Select Primary or Secondary, a “Null” value of “None” or “Unable to Obtain” is acceptable.

**Complaint**: enter in free text the complaint the patient states.

**Duration of Complaint**: enter the numerical value of time, a “Null” value of “Crew unable to obtain” or “Not Applicable” is acceptable.

**Time Units of Duration of Complaint**: select the unit of time to measure.

Select **OK** when finished.

**Time of Symptom Onset**: record when the patient noted the complaint began.

**Does the Patient Have an Injury Related to this incident**: select No, if there is not an associated injury present. Select Yes, if any injury is present.

**Cardiac Arrest**: was the patient at any point during this EMS Response in cardiac arrest.

**Medication Allergies**: was select all the medications the patient is or has been allergic to.

**Current Medication**: select all the medications the patient is currently prescribed and/or taking.

**Medical / Surgical History**: this is free text box to document all the relevant medical and surgical history the patient has had.

**Advance Directives**: Select all that apply, a “Null” value of “Unable to Determine” is acceptable.

**Alcohol / Drug Use Indicators**: Select all that apply, a “Null” value of “None Found” or “Refused” is acceptable.
Initial Patient Acuity Upon Arrival: Select the applicable descriptor of the patient’s status upon the initial encounter, a “Null” value of “No Acuity (patient without medical compliant).

**ePCR: Repeat Patient Search**

The **Find Repeat Patient** button opens a table that the author may use to add patient information from previous patient contacts. Patient Information can be located by entering the patient’s last name, patient birthdate, social security number, last four number of SSN, or the patient’s address. Clearly the more information the user can provide the more accurate the search will be.

Once the patient has been identified and selected, all information that is available within the Elite database is automatically entered to the current PCR form. This may include information such as name, address, date of birth, current medications, allergies, as well as billing information. It should be the practice of the author to verify that the information is current, particularly medications and allergies, and make any changes as necessary.

**ePCR: Start Here: Transfer Notes**

**Transfer Notes**: The information captured in this free text box is just for reference note taking only. None of the data entered here shall take the place of a data value required to complete a chart. This note box will be part of the “Transfer” to other units. This notes box will be saved in the charting process but is not part of the legal PCR.
In the Field Patient Data Transfer

Once the user on the first arriving unit has completed the “Start Here: Patient Interview” there is enough information to perform an in the field data transfer to the second arriving unit. This is a requirement of Policy 500, so long as scene safety and patient acuity allow for this activity. These steps do require both units to have a cellular or Wi-Fi signal from their device in order to successfully transfer and download.

The first arriving EMS unit, fire or ambulance, shall “Post” the collected data while at the patient’s bedside. The first arriving unit shall “Transfer” the data collected to the second arriving unit. The second arriving unit shall “Download” the collected data. Both units should ensure that the correct patient information was transferred and downloaded.

If the second arriving unit discovers the incorrect patient data has been downloaded into their chart, the user must “Delete” the entire chart. The second arriving unit must create a new chart and ensure the first arriving unit “Transfers” the data again. Failure to do so may result in a potential patient data breach.

The “Transfer” and “Download” process binds the two separate charts into one “Unified PCR”. Prior to departing from the scene, or while immediately at the beginning of the transport, the ambulance will select a destination in the chart and “Post” the chart. This will enable the receiving facility to view the “Unified PCR” from the Hospital Hub.

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**Required Transferable Patient Data**

- My incident number
- Unit call sign
- Incident address
- Patient’s full name (first, last)
- Age
- Gender

**Additional Transferable Patient Data**

- Date of birth
- Weight
- Chief complaint(s)
- Medication allergies
- Current medications
- Medical surgical history
- Transfer notes
- Patient encounter number

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After collecting the on-scene patient data, the first arriving unit will:

1. “Post” the chart
2. Select “Transfers”
3. Select “Upload Transfer”

4. Choose the correct “Agency Name”
5. Choose the correct “Call Sign”
6. “Select Transfer and Post” – this is the preferred method

If the user did not meet the minimum data required to “Transfer” this error message will appear. The user should return to the “Validation List” and ensure all required data is entered. The required minimum data points are listed above.
The minimum data required for a Transfer are denoted in the Validation List by the symbol that looks like a red equal sign. By selecting the arrow to the right of this red symbol, the user will be directed to the location in the chart where the data is needed to be entered.

This dialogue box will appear to confirm a successful “Post” and “Transfer” was completed.

The second arriving unit will:

1. Create a chart
2. Downloaded CAD
3. “Post” chart
4. Select “Transfers”
5. Select “Download Transfer”
6. Locate and download the correct transfer
7. Ensure the correct information was downloaded

Both units will continue to work to accurately document the incident. As each separate PCR is updated and “Posted”, the “Unified PCR” will also update, thus always providing the Hospital Hub with the most up to date “Unified PCR”.

Post & Transfer Complete

Incident was successfully posted and transferred.

Download Transfer

The second arriving unit will:

1. Create a chart
2. Downloaded CAD
3. “Post” chart
4. Select “Transfers”
5. Select “Download Transfer”
6. Locate and download the correct transfer
7. Ensure the correct information was downloaded

Both units will continue to work to accurately document the incident. As each separate PCR is updated and “Posted”, the “Unified PCR” will also update, thus always providing the Hospital Hub with the most up to date “Unified PCR”.
This is visible only if “Primary Role of My Unit” equals “Transport”. Choose the appropriate **Destination Name** and enter the Date/Time your **Unit Left Scene Time**. The user shall “POST” the chart to allow this chart to be visible by the Hospital Hub Users. If a change of destination occurs during transport, simply repeat the process, and “POST”. **Destination Code** is a non-editable field.

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**ePCR: Start Here: Refusal of Care**

Select a **Refusal of Care Type**

Select a **Reason for Refusal of Care**

**Patient Explanation** – a free text field, the user should document what the patient states is their plan to mitigate the complaint.

Does the **Patient or Legal Representative have the capacity to refuse care?** – select yes, no, if unknown, consider cancelling refusal.

**Areas refused and/or accepted**: select all that apply.

Use the **List Specific Items Refused** text field to include any specific care that has been declined by the patient during treatment and or transport.

Select the appropriate **Interventions by EMS** taken to resolve the refusal.
Instructions Provided by EMS - select all appropriate that apply

Select the value(s) for Patient’s or Legal Representative’s alternative plan as they have been explained by the Patient or Legal Representative

Who Was the Patient Left with - select all that apply

Select the appropriate choice for Have the risks and complications of refusal been discussed

Click the “Add” button in Refusal of Care Signatures to select the type of signatures added to the Document

Click the “Add” button, select the appropriate signature for whom will be signing. This may be repeated as many times as needed.

Add Another – select to save current signature form and add one additional.

OK – select to save and close current signature form.

Language – currently is non-editable.

Signature Status – select the best descriptor of outcome.

Signature box – collect the signature by using a mouse, stylus or finger on the screen.

Date / Time – Enter the date and time the signature was collected.

Get Patient Name – this will import the patient’s name if previously entered in the ePCR.

First Name – Enter the patient’s first name

Last Name – Enter the patient’s last name
ePCR: Dispatch: Unit and Crew

**DISPATCH – Unit and Crew** – This panel may be auto-populated with the values entered from the Elite Field Dashboard prior to creating this new incident.

**Unit Call Sign** – select the radio identifier the unit and crew identify with in CAD.

**Level of Care** – select the highest level of care the unit is permitted and equipped.

**My Unit’s Crew Members** – select Add to populate other Crew Member Names and Certification Level. A crew member may have multiple Roles. A PCR shall record every crew member present on the incident.

ePCR: Dispatch: Dispatch

**DISPATCH – Dispatch** – This panel collects further information regarding dispatch. Most information is populated by most CADs. Not all CADs send the same information and in cases of CAD failure this panel allows for the manual collection of the data.

**My Agency’s Event Number**: enter your agency’s incident number, auto-populated by CAD.

**EMD Card Number**: auto-populated by CAD and is non-editable by the user.

**Complaint Reported by Dispatch**: Select the single complaint as per Dispatch, auto-populated by CAD

**Dispatch Priority**: Select the single level of acuity as identified by Dispatch Information, auto-populated by CAD
**Incident Street Address:** enter the actual incident address, does auto-populate, but must be verified and changed by user if incorrect.

**Scene Street Address:** used to add relevant information such as an apartment number or cross street, auto-populated by CAD.

**Incident Zip Code:** must be entered, auto-populate by some CADs.

**Set from Postal Code:** This button will assign the city, county and state by the entered zip code.

**Incident City, County State:** where the response occurred.

**Mile Post or Major Roadway:** enter any additional information such as mile marker.

**Set Scene GPS Location:** for iOS only – this button will populate Latitude and Longitude below, by using the devices GPS signal.

**Type of Service Requested:** select the most appropriate value.

**ePCR: Dispatch: Response**

DISPATCH – Response – This panel collects data reading how the user’s unit responded to the scene.

**Response Mode to Scene:** Select response the appropriate response.

**Additional Response Mode Descriptors:** Select values for additional information to clarify the Response Mode above.

**Type of Response Delay:** Select a factor in delayed response (if any). None/ No delay is a possible choice.
DISPATCH – Scene – This panel collects data related to the overall location and type of the scene, as well as the others on that scene.

**Incident Location Type**: Select Incident Location from Dropdown

**First EMS Unit on Scene**: Select the status of your unit on arrival

**Other Agencies on Scene**: Add Button allows user to select any multiple of additional units from separate agencies on scene.

**Type of Scene Delay**: Allow user to select multiple options which caused a delay in accessing the patient

**Number of Patients on Scene**: None, Single, Multiple (Mass Casualty becomes mandatory).

**Mass Casualty Incident**: Select Yes or No for multiple patient scenarios. Select “Null” Value of “Not Applicable” for cancellations.
PATIENT CARE — Symptoms / Impressions — This panel contains two main elements that are mandated by CEMSIS and California EMSA. The accuracy of the impression is essential for the reporting on the collected data.

**Provider’s Primary Impression** — the provider’s single most significant or critical impression that the patient was assessed or treated for while in the care of EMS. There is a total of 65 impressions from the State mandated list to choose from. There is not an acceptable null value.

**Provider’s Secondary Impression(s):** the provider’s other impressions that the patient was assessed or treated for while in the care of EMS. There is a total of 66 secondary impressions from the State mandated list to choose from. A “Null” value of “No Secondary Impression” is acceptable.

**Example:** If a patient is suffering from an obstructed airway and then subsequently goes into cardiac arrest; the most appropriate Primary Impression is “Cardiac Arrest – Non-Traumatic”; the most appropriate Secondary Impression is “Airway Obstruction”.

If the same patient does not enter cardiac arrest, and with a simple maneuver dislodges the obstruction and is now dyspneic; the most appropriate Primary Impression is “Airway Obstruction”; the most appropriate Secondary Impression is “Respiratory Distress / Other”.

**Patient’s Primary Symptom:** select the single most relevant symptom the patient is complaining of from the State mandated list. A “Null” value of “No Symptom” is acceptable.

**Other Associated Symptoms:** add multiple other symptoms from the State mandated list. A “Null” value of “No Other Associated Symptom” is acceptable.

**Chief Complaint Anatomic Location:** select a single value, a “Null” value of “Not Applicable” is acceptable.

**Chief Complaint Organ System Location:** select a single value, a “Null” value of “Not Applicable” is acceptable.

**Type of Patient:** as defined by Policy 602.

**Barriers to Patient Care:** select multiple values if any apply.
PATIENT CARE – Injury / Accidents – This panel serves an important process in delineating what type of injury the patient has suffered. The values collected on this page are consistent with NHTSA and OSHA data values. These elements will be collected for all patients. Certain values the user selects on this panel will “show/hide” the next panel “Major Trauma”.

**Does this patient meet the Santa Clara County major trauma triage criteria?:** Selecting “Yes” will show the next panel, “Major Trauma”. Select “No” if patient does not meet any of Policy 605 Trauma Triage criteria.

**Work Related Illness/Injury:** Select “Yes” if this is a related to a workplace injury.

**Cause of Injury:** select all that apply. A “Null” value of “Not Applicable” is acceptable.

**Mechanism of Injury:** Select a single mechanism that best describes the injury. A “Null” value of “Not Applicable” is acceptable.

**OSHA Personal Protective Equipment Used:** Select all that apply or applicable.

**Height of Fall:** (if applicable) enter the estimated height of the fall in feet.

**Number of Vehicles:** single or multiple.

**Motor Vehicle Type:** select a single type of vehicle that was involved in the injury.

**Location of Patient in Vehicle:** select the best location of where the patient was in the vehicle.

**Exterior Damage:** select the best estimate of damage to the vessel.

**Airbag Deployment:** select all that apply or applicable.

**Use of Occupant Safety Equipment:** select all that apply or applicable.
Major Trauma – This Specialty Patient Care panel is used to include specific data to qualify this patient for entry into the Trauma System. These values are written to be consistent with Policy 605 Trauma Triage.

### Major Trauma Physiologic and Anatomic Criteria:
- Select all that apply. A “Null” value of “Not Applicable” is acceptable.

### Major Trauma Mechanisms and Considerations:
- Select all that apply. A “Null” value of “Not Applicable” is acceptable.

### Major Burn Criteria:
- Select all that apply.

### Central Nervous System changes:
- Select all that apply.

### EMS Discretion:
- Enter the user’s rationale to enroll the patient as a major trauma victim.
PATIENT CARE – STEMI – This Specialty Care panel is used to provide data to qualify this patient for entry into STEMI System, according to Protocol 700-A08. This panel is also utilized to chart patient’s that have ROSC. It is acceptable to not enter values in this panel if the patient does not have applicable complaints.

STEMI: The user may “Add” multiple entries of the grid described below, as the patient condition changes.

Date/Time Last Known Well: enter the last date and time that the patient was known to be well.

STEMI Probable?: Does the user believe this patient is suffering from a probable a STEMI, select the single appropriate value.

STEMI Activation: This patient meets the criteria according to Protocol 700-A08, select the single appropriate value.

12 Lead ECG Used?: Did the user use a 12 Lead to determine this patient is a STEMI patient, select the single appropriate value.

12 Lead ECG Interrupted By: Who determined the 12 Lead was a STEMI, select the single appropriate value.

12 Lead ECG Transmitted for Interpretation: Was the 12 Lead sent to the receiving STEMI center prior to the patient’s arrival, select the single appropriate value.

OK: Select the button when completed to save
**PATIENT CARE – Stroke** – This Specialty Care panel is used to provide data to qualify this patient for entry into the Stroke System, according to Protocol 700-A13.

The GFAST vital sign slows for the user to record multiple assessments performed during patient care. It is acceptable to not enter values in this panel if the patient does not have applicable complaints.

<table>
<thead>
<tr>
<th><strong>Is the patient’s blood glucose within normal limits (80-300)?</strong></th>
<th>select the appropriate value.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Is the patient without seizure activity?</strong></td>
<td>select the appropriate value.</td>
</tr>
<tr>
<td><strong>Stroke Symptoms Resolved:</strong></td>
<td>select appropriate value.</td>
</tr>
<tr>
<td><strong>Symptoms Onset:</strong></td>
<td>enter the date/time of onset.</td>
</tr>
<tr>
<td><strong>Last Time Known Well:</strong></td>
<td>enter the date/time of when the patient was last known to be well.</td>
</tr>
</tbody>
</table>

**This is a critical clinical assessment value.**

<table>
<thead>
<tr>
<th><strong>Is the patient taking anticoagulants (other than aspirin)?</strong></th>
<th>enter the appropriate value.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Is this a stroke alert?</strong></td>
<td>enter the appropriate value, according to Protocol 700-A13.</td>
</tr>
<tr>
<td><strong>This patient was transported to a:</strong></td>
<td>enter the appropriate value, if Comprehensive is selected GFAST Score must = 4.</td>
</tr>
</tbody>
</table>

**Historian full name:** enter the patients’ historian name

**Historian phone number:** enter the phone number where the historian may be emergently reached.

**The following assessment is located in the Stroke Situational Tool.**

**Date/Time GFAST taken:** auto-populates with the date/time the grid was opened, change as appreciate.

**Stroke Scale Gaze:** select appropriate value.

**Stroke Scale Facial Droop:** select appropriate value.

**Stroke Scale Arm Drift:** select appropriate value.

**Stroke Scale Speech:** select appropriate value.

**Stroke Scale Score** – manually add the points from the above four elements and enter value of 0-4.

**The GFAST assessment may be repeated.**
**PATIENT CARE – CPR Prior to Arrival** – This Specialty Care panel is used to collect data that the user will learn upon arriving on scene of a patient in CPR and the care that was provided by those that were present prior to arrival. It is acceptable to not enter values in this panel if the patient does not have applicable complaints.

<table>
<thead>
<tr>
<th>Patient Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impressions / Symptoms</td>
</tr>
<tr>
<td>Injury/Accidents</td>
</tr>
<tr>
<td>Major Trauma</td>
</tr>
<tr>
<td>STEMI</td>
</tr>
<tr>
<td>Stroke</td>
</tr>
<tr>
<td>CPR Prior to Arrival</td>
</tr>
</tbody>
</table>

**Was CPR Care Provided Prior to a 911 Unit’s Arrival:**
- [ ] No
- [ ] Yes

**Who Provided CPR Prior to a 911 Unit’s Arrival:**
- Family Member
- Lay Person (Non-Family)
- Law, Park, Stagger, Lifeguard
- EMS Professional (On-Duty)
- EMS Professional Not On Duty

**Estimated Time of First CPR:**
- [ ]
- [ ]

**Type of CPR Provided Prior to Arrival:**
- [ ] Compression (No ventilation)
- [ ] Compressions and Ventilation
- [ ] Use of External Defibrillator
- [ ] Use of External AED

**Was an AED Used Prior to a 911 Unit’s Arrival:**
- [ ] No
- [ ] Yes, without Defibrillation
- [ ] Yes, With Defibrillation
- [ ] Unknown

**Was CPR care provided prior to a 911 unit’s arrival:** enter the appropriate value, based on observations and bystander history.

**Who provided care prior to a 911 unit’s arrival:** Select all that apply, that were not part of the EMS Response.

**Estimated time of first CPR:** Enter the actual or estimated date/time that CPR begun.

**Type of CPR provided Prior to Arrival:** Select all that apply, a “Null” value of “Not Applicable/ No CPR Preformed” is acceptable.

**Was an AED used prior to a 911 unit’s arrival?:** enter the most appropriate value, based on observations or bystander history.
### ePCR: Patient Care: Cardiac Arrest

**PATIENT CARE – Cardiac Arrest**—This Specialty Care panel is used to collect cardiac arrest data to measure the effectiveness of County protocols, community education programs, and study patient outcomes in large datasets.

**Last time known well:** Enter the actual or estimated date/time the patient was last seen normal.

**Estimated time of cardiac arrest:** Enter the actual or estimated date/time the patient went into cardiac arrest.

**Arrest witnessed by:** Select all that apply. A “Null” value of “Not Recorded” is acceptable.

**First monitored arrest rhythm of the patient:** Select the rhythm that the first arriving EMS Unit found the patient. A “Null” value of “No Monitor Attached” is acceptable.

**Cardiac arrest etiology:** Select the most appropriate reason that the patient may be in cardiac arrest.

**Resuscitation attempted by my crew:** Select all the care provided by your crew.

**Any Return of Spontaneous Circulation:** Select all that apply.

**ROSC time:** Enter the date/time ROSC was obtained.

**Time resuscitation stopped:** Enter the date/time resuscitation was terminated, not to be used if ROSC, a “Null” value of “Not Applicable” is acceptable.

**Reason resuscitation stopped:** Select the most appropriate reason that resuscitation was terminated, a “Null” value of “Was Not Discontinued” is acceptable.

**Crew who pronounced death:** Select the crew name who determined death.

**Cardiac rhythm on arrival at destination:** Select all cardiac rhythms that apply, a Null” value of “Not Applicable” is acceptable.

**Patient outcome at the end of the call:** Select the value that best describes the outcome.
PATIENT CARE – OB/GYN—The OB/GYN panel is used to collect additional information relative to obstetrics and gynecology. This panel should be used to list pertinent negatives of women of childbearing years. This panel is hidden if “Gender” equals “Male”.

<table>
<thead>
<tr>
<th>Last Menstrual Period:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy:</td>
<td>No</td>
</tr>
<tr>
<td>Gravida:</td>
<td></td>
</tr>
<tr>
<td>Para:</td>
<td></td>
</tr>
<tr>
<td>Estimated Date of Delivery:</td>
<td></td>
</tr>
</tbody>
</table>

**Last menstrual period:** Enter the actual or estimated date the patient had a menstrual cycle.

**Pregnancy:** Select the value that best describes the patient’s pregnancy status, a “Null” value of “Refused” is acceptable.

**Gravida:** Enter the total number of confirmed pregnancies.

**Para:** Enter the number of births.

**Estimated date of delivery:** Enter the expected due date.
PATIENT CARE – Behavioral Crisis – This panel is used to specify the circumstances for management of a patient in behavioral crisis. Specifically, around the application of physical restraints and the role of law enforcement in the care of the patient. Any medications used in addition to physical restraint should be documented in the medication’s sections of the ePCR. This panel was added to improve the study of EMS involvement in behavioral crisis.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Is this a new onset of psychosis?</strong></td>
<td>Yes, No</td>
</tr>
<tr>
<td><strong>Is the patient on a 5150 involuntary psychiatric hold?</strong></td>
<td>Yes, No</td>
</tr>
<tr>
<td><strong>Which agency executed the hold?</strong></td>
<td><a href="#">Enter the name of the organization that placed the hold on the patient.</a></td>
</tr>
<tr>
<td><strong>What was the probable cause category for the 5150 placement?</strong></td>
<td><a href="#">Select the most appropriate.</a></td>
</tr>
<tr>
<td><strong>Was the 5150 hold written prior to EMS arrival on the scene?</strong></td>
<td>Yes, No</td>
</tr>
<tr>
<td><strong>Was the patient destination requested by law enforcement agency?</strong></td>
<td>Yes, No</td>
</tr>
<tr>
<td><strong>Describe the circumstances leading to the law enforcement 5150 hold placement:</strong></td>
<td><a href="#">Start typing here...</a></td>
</tr>
<tr>
<td><strong>Describe the circumstances leading to the law enforcement encounter:</strong></td>
<td><a href="#">Start typing here...</a></td>
</tr>
<tr>
<td><strong>Was the patient in restraints prior to EMS arrival on scene?</strong></td>
<td>Yes, No</td>
</tr>
<tr>
<td><strong>What type of restraints were used?</strong></td>
<td><a href="#">Select the most appropriate restraints used.</a></td>
</tr>
<tr>
<td><strong>Was law enforcement present in the ambulance transport?</strong></td>
<td>Yes, No</td>
</tr>
<tr>
<td><strong>Did law enforcement follow the ambulance during transport?</strong></td>
<td>Yes, No</td>
</tr>
<tr>
<td><strong>Has Law enforcement encountered this patient before?</strong></td>
<td>Yes, No</td>
</tr>
</tbody>
</table>
PATIENT CARE – Abuse / Neglect – This panel is used to collect necessary data regarding suspected patient abuse, neglect, or domestic violence. This panel is linked to these values from the element “Cause of Injury”: Accidental Injury (hit, struck, other) by another person, Asphyxiation - Mechanical Suffocation, Injury from Blunt Object (assault), Stabbing/Cut/Laceration (assault), Firearm injury, Maltreatment/Abuse, Sexual abuse

**Are there signs or symptoms of abuse present?** select the appropriate value.

**If Yes, list signs and symptoms:** enter all symptoms present.

**Do you suspect any Abuse, or Neglect, or Violence:** select the appropriate value.

**Did you complete appropriate mandatory reporting requirements to APS or CPS?** select the appropriate value.

**If Yes, what is the report number?** enter the numeric value.

**Did you report the information to Law Enforcement?** select the appropriate value.

**If Yes, what Law Enforcement Agency?** enter the appropriate name of the law enforcement agency.

**Do you feel safe at home?** select the appropriate value.

**If No, patient comments:** enter what the patient states as to why they may feel unsafe.

**Do you feel safe in your relationship, or with your family?** select the appropriate value.

**If No, patient’s comments:** enter what the patient states as to why they may feel unsafe.

**Additional patient comments:** enter any other specific details observed or reported.
ePCR: Ringdown / Base: Hospital Ringdown

RINGDOWN / BASE – Hospital Ringdown – This panel collects the data regarding notifying the receiving facility of a routine or specialty care patient’s impending arrival.

Hospital Ringdowns (grid) Add: select to add multiple ringdowns.

Time of Ringdown/Activation: enter the date/time the ringdown was delivered.

Type of Notification: select the type of ringdown the user is providing to the facility.

ePCR: Ringdown / Base: Base Contact

RINGDOWN / BASE – Base Contact – This panel is used to record the data required while making Base Contact for “online medical direction”.

Was Base Contact made for this patient? Select yes or no.

Base Hospital Contacted: Select the base hospital.

Base Hospital Contact Date: enter the date/time the contact was made.

Add Another: the user may add multiple procedures.

OK: select to save when complete.

Cancel: the user may delete all data entered.

Date/Time: enter the date and time the order was given.

Procedure Ordered: select the procedure ordered.

Procedure Ordered Comments: enter any relative comments to the order given.

Add Another: the user may add multiple medications.

OK: select to save when complete.

Cancel: the user may delete all data entered.

Date/Time: enter the date and time the order was given.

Medication Ordered: select the procedure ordered.

Dosage: enter the dose ordered.

Dosage Units: select the unit of measure for the dose.

Route: select the route the medication is to be delivered.

Medication Ordered Comments: enter any relative comments to the order given.
NARRATIVE – Narrative – This panel is a free text box that allows the user the opportunity to illustrate the incident in a detailed paragraph format. The user should use caution and avoid contradictions in the data entered above and the description given in the narrative. The user should use this opportunity to describe procedures that others on the care team have preformed that were not recorded in the data above. The user should avoid entering data here that was not entered a data field. The user should avoid abbreviations that are not found in Taber’s Encyclopedia.

**Enlarge:** select to enter full screen mode.

**Clear:** select to erase all data entered.

**My Narrative:** enter the narrative for this incident. There are many methods to assist the user in presenting the narrative in an organized format, examples include: Sequential, SOAP, CHART.

---

PCR DISPOSITION – Field Disposition – This panel is only visible if “Non-Transport” or “Chief / Supervisor” were selected on the Start Here – Start Incident panel.

**Incident disposition:** Select a disposition that best describes how the incident was closed. Logic and validation rules are based around each disposition type.

**Fire agency disposition code:** enter the appropriate NFIRS code, if desired.

**I transferred patient care to which (agency)?** Select the appropriate agency.

**Transfer to Call Sign:** enter the call sign of the unit.

**Transfer of patient care date/time:** enter the date and time care was transferred.

**Final Patient Acuity:** select the patient’s acuity level at the time of transferring care.
**Incident disposition**: select a disposition that best describes how the incident was closed. Logic and validation rules are based around each disposition type.

**Number of patients transported in my EMS unit**: enter the total number of patients in your ambulance.

**EMS transport method**: select the appropriate value.

**Transport mode from scene**: select the appropriate value.

**Additional transport mode descriptors**: select all that apply.

**Transfer to Call Sign**: enter the call sign of the unit.

**Type of transport delay**: select all that apply.

**Type of turn-around delay**: select all that apply.

**Patient Destination**: select the destination name.

**Destination Code**: non-editable field.

**Destination street address**: will populate from Destination value above.

**Destination zip code**: will populate from Destination value above.

**Set from postal code (button)**: will auto-populate below.

**Destination city**: will populate from zip code.

**Destination state**: will populate from zip code.

**Destination county**: will populate from zip code.

**Type of destination**: select the appropriate value.

**Hospital capability needed for this patient**: select the appropriate value.

**Reason for choosing destination**: select all that apply.
**External Patient Record Number(s)**

<table>
<thead>
<tr>
<th>Grid</th>
<th>Add</th>
</tr>
</thead>
</table>

**Patient ID Number:** enter a numerical value

**ID number type:** select the appropriate value.

**OK:** select to save and close grid.

**Condition of patient at destination:** select the patient’s acuity level at the time of transferring care.

**Was your unit diverted from your intended hospital ED?**
Select yes or no.

**ED diversion time:** enter the date and time the diversion occurred.

**ED diverted from:** select the ED that diverted your unit.

**ED diversion reason:** select the appropriate value.

**Patient transport assessment:** select the appropriate value.

**How patient was moved to ambulance:** select the appropriate value.

**Position of patient during transport:** select the appropriate value.

**How patient was transported from ambulance:** select the appropriate value.

**Patient belongings left with:** select the appropriate value.

**Patient belongings left with other:** free text box.

**Patient belongings:** select the appropriate value.

**Patient belongings description:** free text box.
PCR DISPOSITION – Signatures – This panel allows the user to collect a variety of signatures for various reasons. Although not every signature is described here, the process remains the same for each. It is important to note that a PCR must contain a signature form the author of the chart. Other signature types are required for various billing and QI reasons. The user should take steps to prevent forgery of signatures.

- **Crew member completing this report**: select the crew member’s name whom authored this report.
- **Signatures – Add**: select the appropriate signature type.

  - PCR author signature:
  - Patient signature:
  - Patient representative signature:
  - Emergency department signature:
  - Controlled substance waste signature:
  - Airway verification signature:

- **PCR Author signature(grid) – Add Another**: will save the current and add another.
  - **OK**: select to save.
  - **Cancel**: select to delete.

- **Language**: non-editable.

- **Signature box**: collect the signature by using a mouse, stylus or finger on the screen.

- **Enlarge**: select for full screen
- **Reset**: select to clear.

- **Date / Time**: enter the date / time signature was obtained.

- **Crew member**: select the crew members name.

Both fields are preset by choosing Signature type above and therefore are non-editable.
**PCR DISPOSITION – Consumables** – This panel serves two main purposes. First, it is used by the transport providers to list the supplies used for the call. Second, the items not restocked on scene by the transport provider will be listed by the fire first responders.

Non-transport units shall document only those items that were not restocked on scene by County Ambulance.

**County Ambulance units shall document all items used for the call.**

Do any supply items need to be documented for this call? Select yes or no.

Patient supply items (grid):  
Supply item used name: select the name of the item.  
Number used: enter numerical value.  
Add: select to save and move to next item.
PCR DISPOSITION – Controlled Substances – This panel collects data related to the use of controlled substances. Complete a controlled substances report for each vial of medication. A crew signature must be added when controlled substances are used, see PCR Disposition: Signatures.

All controlled substance administrations must also have a crew signature which may be performed under the signature panel.

**Controlled Substances (grid) – Add:** Select to add.

**Add Another:** Select to save current and add another.

**OK:** select to save.

**Cancel:** to erase.

**Broken seal number:** enter the discarded seal number.

**Medication name:** select the correct medication used.

**Amount administered:** enter a numerical value.

**Amount units:** select the unit of measure.

**Amount wasted:** enter a numerical value.

**Amount returned:** (if any) enter a numerical value.

**Crew that administered:** select the crew member that gave the medication.

**Crew that witnessed:** enter the signature of the crew member that witnesses the waste or return.
PCR DISPOSITION – Exposures – This panel is used to log occupational exposures that may have occurred during this incident. This is a requirement of CEMSIS. Each crew member must have this form completed for every ePCR. This report form does not replace any department or company policy of reporting workplace injuries.

**Exposures: (grid)**

*Add*: Select to add just one crew.

Add all crew: select to add all crew previously entered.

**EMS professional (crew member ID)**: select the crew member’s name to save current and add another.

**Suspected work-related exposure, injury, or death**: select yes or no.

**The type of work-related, injury, death, or suspected exposure**: select all that apply.

**OK**: select to save.
**DATA CLEANUP – All Monitor Data Downloads**

This panel will not be visible until EKG data has been downloaded into the chart. The user will edit the imported EKG files once added to this panel.

### Medical Device Downloads (grid)

Each added EKG file will be listed once imported. Double click to open the file. 

“X”: select to delete that file.

### EKG Waveforms (grid)

The other elements are non-editable; scroll to EKG Waveform, double click to open to review attached waveform.

“X”: select to delete that file.

### Medical Device Waveform Graphic:

Select “Browse” to find another file. The user should review each attached EKG to ensure the correct waveform has been attached. 

“X”: select to delete that file.

**DATA CLEANUP – All Vitals Data**

This panel will not be visible until EKG data has been downloaded into the chart. The user will edit the imported vitals sign data files once added to this panel.

### Vitals (grid)

Each Vital taken by the monitor will be visible once imported. Double click to open the file to edit. 

“X”: select to delete that file.

### Vital (grid)

Used to edit the values of the import.

**OK**: select to save any additions to the grid.

**Cancel**: select to exit grid without saving.

**General Note**: The user shall validate all imported monitor data. The user is required to add additional descriptor information that was not collected by the heart monitor.

**Waveform graphic**: The user shall review all attached EKG attachments.
**ePCR: Data Cleanup: All Procedure Data**

DATA CLEANUP – All Procedure Data – This panel will not be visible until EKG data has been downloaded into the chart. The user will edit the imported procedure data files once added to this panel.

**Procedures (grid):** each Procedure added to the monitor will be visible once imported. Double click to open the file to edit.

“X”: select to delete that file.

**General Note:** the user shall validate all imported monitor data. The user is required to add additional descriptor information that was not collected by the heart monitor.

---

**ePCR: Data Cleanup: All Medication Data**

DATA CLEANUP – All Medication Data – This panel will not be visible until EKG data has been downloaded into the chart. The user will edit the imported medication data files once added to this panel.

**Medications (grid):** each medication added to the monitor will be visible once imported. Double click to open the file to edit.

“X”: select to delete that file.

**General Note:** the user shall validate all imported monitor data. The user is required to add additional descriptor information that was not collected by the heart monitor.
BILLING – Patient Data – This panel is visible to transport units. Billing Data is used to bill for services provided to the patient. The information in this table is critical to successful claims processing.

<table>
<thead>
<tr>
<th>Social Security number:</th>
<th>enter numeric values.</th>
</tr>
</thead>
<tbody>
<tr>
<td>State issuing driver’s license:</td>
<td>select the appropriate value.</td>
</tr>
<tr>
<td>Driver’s license number:</td>
<td>enter the alpha numeric values.</td>
</tr>
<tr>
<td>Patient phone numbers - (grid):</td>
<td>use this grid to enter the patient’s various phone numbers, if any.</td>
</tr>
<tr>
<td>Patient email addresses numbers - (grid):</td>
<td>use this grid to enter the patient’s various emails, if any.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Same as incident address:</th>
<th>select this to import the incident address for the patient’s address.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient homeless:</td>
<td>select yes or no.</td>
</tr>
<tr>
<td>Patient’s home address:</td>
<td>enter address.</td>
</tr>
<tr>
<td>Patient street address 2:</td>
<td>used for additional information.</td>
</tr>
<tr>
<td>Patient’s home zip code:</td>
<td>enter numerical postal code, a “Null” value of “Not Recorded” is acceptable.</td>
</tr>
<tr>
<td>Set from postal code:</td>
<td>allows fields below to be populated.</td>
</tr>
<tr>
<td>Patient’s home city:</td>
<td>enter the city.</td>
</tr>
<tr>
<td>Patient’s home state:</td>
<td>enter the state, a “Null” value of “Not Recorded” is acceptable.</td>
</tr>
<tr>
<td>Patient’s home county:</td>
<td>enter the county, a “Null” value of “Not Recorded” is acceptable.</td>
</tr>
</tbody>
</table>
**ePCR: Billing: Closest Relative Data**

<table>
<thead>
<tr>
<th>Relationship to Patient:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Closest Relative First Name:</td>
<td></td>
</tr>
<tr>
<td>Closest Relative Last Name:</td>
<td></td>
</tr>
<tr>
<td>Street Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td></td>
</tr>
<tr>
<td>State:</td>
<td></td>
</tr>
<tr>
<td>ZIP Code:</td>
<td></td>
</tr>
</tbody>
</table>

**Relationship to patient:** select a value that describes how this person is related to the patient.

**Closest relative first name:** enter the first name.

**Closest relative last name:** enter the last name.

**Same as patient address:** select if relative’s address and patient’s address are equal, enter the alphanumeric values.

**Street address:** enter the relative’s address.

**City:** enter the city.

**State:** enter the state.

**Zip Code:** enter the postal code.

**Relative phone numbers (grid):** use this grid to enter the relative’s various phone numbers, if any.

---

**ePCR: Billing: Billing Data**

<table>
<thead>
<tr>
<th>ALS Assessment performed and warranted:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALS Assessment performed by:</td>
<td>Paramedic-Fire Dept. Unit</td>
<td>Paramedic-Transport Unit</td>
</tr>
<tr>
<td>Primary Method of Payment:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ALS Assessment performed and warranted:** select yes or no.

**ALS Assessment performed by:** select the appropriate value of whom completed the ALS assessment.

**Primary method of payment:** select the appropriate value.

**Billing insurance information (grid):** Add: to enter into the grid. Ok to save. Cancel to exit without saving.
**General note:** the user should enter as much information as possible as required by their department’s standard.

**Insurance company ID:**

**Insurance company name:**

**Insurance company address:**

**Insurance company address 2:**

**Insurance company zip code:**

**Set from postal code:**

**Insurance company city:**

**Insurance company state:**

**Insurance company county**

**Get SSN:**

**Insured SSN:**

**Insurance group ID:**

**Insurance policy ID number:**

**Get patient name:**

**First name of the insured:**

**Last name of the insured:**

**Insurance effective date:**

**Relationship to the insured:**

**Transport authorization code:**

**Prior authorization code payer:**

**Physician certification statement:**

**Date PCS signed:**

**Reason for PCS:**

**Healthcare provider type signing PCS:**

**First name of physician:**

**Last name of physician:**
Cancelled Call Record

The Cancelled Call Record is an ePCR that is used to display only the necessary sections, panels, and values that are required for an EMS response that did not encounter a patient. This guide will only list the sections and panels required for cancelled calls. This chapter will not explain any previously illustrated sections, panels, and values. Only new relevant sections, panels, and values will be illustrated and explained.

Cancelled Call: Start Here: Start Incident

START HERE: Start Incident – The first section and panel that are visible after creating an “New Incident” from the “Dashboard”.

I am completing a (choose one) – This panel will “Show or Hide” other sections and panels based the values selected. “Cancelled Call” is used when no patient contact has occurred.

Arrived at patient time – Enter date/time the user arrived at the patient’s side, validation rules will apply if a time at patient’s side is entered.

Unit and Crew: (see pages 21 & 22 for details)
Dispatch: (see pages 21 & 22 for details)
Response: (see pages 21 & 22 for details)

Cancelled Call: (described below)

Incident disposition: select the appropriate description of the cancellation.

Fire agency disposition code: use if required by your agency, enter the corresponding NFIRS code for this type of cancellation.

Was your unit cancelled prior to patient contact? Select yes or no.

Crew member completing this report: select the member that is responsible for this chart.

Unit dispatch time: downloaded by CAD.
Arrived on scene time: downloaded by CAD.
Cancelled time: enter date/time of cancellation
Back in service time: enter date/time unit went back into service

Enlarge: select to enter full screen mode.
Clear: select to erase all data entered.

Narrative: enter the narrative for this incident. There are many methods to assist the user in presenting the narrative in an organized format, examples include: Sequential, SOAP, CHART.
MCI Quick Triage Form

The MCI Quick Triage form is designed to mimic the data collected on a MCI tag. This form is not intended to replace the MCI tag when required for use by another EMS Policy. However, it may be used at any time to rapidly collect patient information and assessment. The MCI form can easily be transitioned into a complete Patient Care Report at any time and the data collected remains.

MCI: Start Here: Start Incident

**START HERE: Start Incident** – The first section and panel that are visible after creating an “New Incident” from the “Dashboard”.

*I Am Completing a... (choose one):*  
- Patient Care Record (PCR)  
- MCI Quick Collect Form  
- Canceled Call Record

**My Event Number:** enter the incident number,

**Time of Dispatch:**

**Arrived at Patient Time:**

**My agency’s incident number:** enter the incident number,

**My call sign:** select the user’s radio unit identifier.

**Arrived at patient time:** enter the date and time the user arrived at the patient.

**Triage Tag Number (grid):**

**Triage Tag #:** enter the numeric tag number.

**Type:** non-editable field

**START Triage classification:** select the appropriate classification of the patient according to the START triage process.
**Add patient to incident:** select the button to add an additional patient and open another MCI Quick Triage.

**First name:** only the patient’s actual name is to be entered, a “Null” value of “Unknown” or “Refused”, is acceptable.

**Last name:** only the patient’s actual name is to be entered, a “Null” value of “Unknown” or “Refused”, is acceptable.

**Gender:** select the appropriate gender.

**Age:** enter a numeric value of age.

**Age units:** enter the appropriate unit of measure for age.

**Patient phone numbers (grid):** enter the patient’s various phone numbers, if any.

**SLUDGE triage:** select all that apply.

**Auto injector doses given:** select the total doses given, this does not replace the need to record the medication administered in the appropriate power tool.

**Decontamination applied:** select the appropriate value.

**Decontamination solution:** describe the type of solution used for decontamination, if any.

**MCI rapid findings:** select all that apply.

**Patient complaints (grid): Add:** select to enter patient complaints.

**Complaint Type:** Select Primary or Secondary, a “Null” value of “None” or “Unable to Obtain” is acceptable.

**Complaint:** enter in free text the complaint the patient states.

**Duration of Complaint:** enter the numerical value of time, a “Null” value of “Crew unable to obtain” or “Not Applicable” is acceptable.

**Time Units of Duration of Complaint:** select the unit of time to measure.

Select **OK** when finished.
**I transferred to (agency):** select the agency that accepted the patient.

**I transferred to call sign:** enter the call sign of the unit that accepted the patient.

**Patient destination:** select which hospital the patient was to be transported to.

**Relative/ guardian first name:** enter the first name.

**Relative/ guardian last name:** enter the last name.

**Relative/ guardian relationship:** select the appropriate.

**Relative phone numbers (grid): Add:** select to enter any phone numbers of the relative.