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This manual is plagiarized from Grand Teton National Park's 4/4/14EMS Charts User Guide Version 2.0.

This guide is designed to help you become familiar with using EMS Charts. We have tried to streamline EMS Charts as much as possible to represent that which is applicable to GRTE. That being said, a lot of the language and some of the functions in EMS Charts are not always intuitive, and some we just can't get rid of.

Please make sure the pop-up blocker on the internet server you are using is **disabled** in order to fully complete your chart.

Notes:

- Many fields contain defaults, or are able to have defaults entered. This is especially applicable on page 1 (Dispatch), page 3 (Neuro, Airway), and page 5 (Secondary Survey). Carefully read each field. Providers can easily skip over a default field, and end up with a charting error (Ex. "Loss of Consciousness: No", when there may have been an LOC).
- You must enter a referring location on page 1. "Unknown" doesn't cut it.

Home Page information

Logging In:

- If you are having issues logging into EMS Charts, please make sure that you are a credentialed EMS provider for Grand Teton National Park. If you *are* a credentialed provider and cannot login or do not have login information or your account is locked email Park EMS Coordinator for password reset.
- Confirm you are in Grand Teton National Park in the Service Login
- Enter BTNF for the **Base**
- Enter On Foot for the Unit

ems	Charts.com	Cu
 > home > Configuration > Patient Records > Special Reports > Forums > Continuing Ed. > Phone Messages > Reports > Human Resources > Calendar > Links > Summark 	At a Glance Incomplete Charts: 0 (Service: 5) Charts Flagged for QA: 0 Unanswered QA Flags: 0 New Special Reports: 63 Calendar (08/10/2014 - 09/07/2014) New Special Reports: 63 Calendar (08/10/2014 - 09/07/2014) No Events Found System Messages Command Facility Announcements Service Announcements Service Announcements	Mar Service Login Change Login: Grand Teton National Park ▼ Base: BTNF ▼ Unit: On Foot ▼ On Foot Crew ∭ No Crew Listed
» Training » Security Settings	01/02/09: Welcome to emsCharts. Please go to configuration/user to enter your demographics and certification information.	

Creating a New Patient Record:

• To create a new PCR click on Patient Records and Create Blank Chart

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Page 1: Dispatch Information

	Create new	chart	Times (MST)
Patient Record ID: Ne	w Record Case Number:		Onset: 06/22/2013 12:36
	General	Referring	Dispatched: 06/22/2013 12:36
Basesite: Unit: Response: EMD: Type of Svc.: Category: Dispatched As: Outcome: Amb. Transport	Moose Medic 1 Alpha Scene Unsched. Not Recorded	Type: Hosp EMS Other Other Type: Location: Zip: County: Requester: Pt. Classification	Enroute: 06/22/2013 12:36 First Resp: On Scene: 06/22/2013 12:36 Leave Ref: 06/22/2013 12:36 Arv Rec: 06/22/2013 12:36 Xfer Care: 06/22/2013 12:36 Available: 06/22/2013 12:36
Code:	Crew Members	Type: Hosp EMS Other Name: Unit: Emergency Department Rec. MD: Dest.Basis:	Edit Times Odometer At Ref: At Rec: Mileage Loaded:
Other:		Comment: Patients Click button below to add patient Add Patient >>	
Create new c	hart		

• Enter your case number. This should be in format: BTYY00000X (YY is the 2-digit year and X is the sequential chart number (ie 1, 2, 3, 4...). No hyphens/spaces.

General

- Basesite—BTNF
- Unit—"On Foot", imported from the very first screen and select BLS (First Responder/EMT). The BTNF Medical Direction only covers BLS with expanded scope of practice.
- EMD if there were any significant instructions from dispatch to the patient, you can document it here.
- Response Leave blank (This is used for the dispatch code on the Billing Sheet which the BT doesn't use)
- **Type of Svc** The type of service will be **scene**, **unscheduled**.
- **Category**—nature of injury/illness. Sometimes the options don't fit your patient's complaint. In that case, pick the closest one, or "Not Applicable." This ought to be charted in your narrative anyway.
- Dispatched As: Self-explanatory. (FYI the Park uses this code to indicate the Dispatch Code on the Billing Sheet).
- **Outcome**—final disposition of patient contact; lots of options here. Most of the time, it will be:
 - **01- Treated, transported by ALS**—any patient that **YOU** transported in an ambulance where you initiated ALS assessment/interventions.
 - **02- Treated, transported by BLS**—any patient that **YOU** transported in an ambulance (or GOV) where you initiated BLS assessment/interventions.
 - 03- Treated and Refused Transport any patient who has received BLS or ALS treatment, but has refused transport.
 - 04- Patient Refused Care A patient who does not wish to receive any care and care has not been administered.
 - **05- Treated, transferred care to Air Ambulance**—patient was treated and transferred to another caregiver and transported in a certified Air Ambulance
 - **06- ALS Assessment, Transported by BLS** the patient was assessed by an ALS provider and the call was appropriate to be turned over to a BLS provider. (the ALS provider must document their assessment in the chart)
 - 07- Canceled Prior to Arrival the ambulance was requested, but was stood down prior to reaching the scene.
 - **08 Dead at Scene –** when you get to the scene and the patient is dead. No resuscitation.

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- **09-** No Patient when you get to the scene and there is no patient to be found, or the person calling decided they don't need that ambulance and no assessment or care has been administered.
- Amb. Transport Code—Don't worry about it.

Crew Members

- If you are the primary provider, ensure you have added yourself to the provider list. If you don't, you won't be able to complete the chart.
 - If you were NOT involved in the response at all but you are completing the chart, add yourself as an 'other' so you can complete the chart. Include a remark that you are just completing the chart.
- Select the crew members' names from the drop down list BT folks with White Cards (and therefore EMS Charts logins) might not show up in the list if they haven't ever logged in. Just add them in the 'other' box.
- Designate their role as D, P, S, or T (these letters stand for <u>D</u>river, <u>P</u>rimary Provider, <u>S</u>econdary Provider, and <u>T</u>ertiary Provider)
- Use the Other box for providers without credentials or whose name you cannot locate in the system
- Don't worry about the '*Please select'* to the right of their name.

Referring—where the patient contact took place/where you were dispatched to

- Туре—
 - Hosp—you received the patient from clinic or hospital
 - EMS—you received the patient from other ambulance (example: Yellowstone transfer)
 - Other—you received the patient at some other location (default) this will be the most likely scenario.
- Location—click the kit is the select-address-box-will-pop-up
 - Don't worry about the "other type" box.
 - In the **Common** box, start typing the name of where the patient contact took place and a list of common locations in GRTE will display in a drop down list. Select the location. The address of this location should auto-populate.
 - Since BT calls, especially the ones on wildfires, will likely NOT be in GRTE, just, manually type in the address. This can be a general geographic location, "West Kelley Lookout, Kelley Fire, ID" for example.
- **Requester**—This is the person who requested assistance or called 911 (i.e. patient, family member, supervisor, DIVS, crewboss, crew member etc.)

Receiving-where/to whom the care of the patient was transferred

- If the patient refuses care/transport, you do not need to fill out this section
- If you are transferring care of the patient, select whether you transferred to a hospital or EMS (ambulance)
 - Name—click the vill often be "Other" – you can describe other in the Location field (next one)
 - Location—(if you transferred to EMS) where the transfer of care took place (i.e. Colter Bay C-Store, Lupine Meadows LZ).
 - **Rec. MD** this is the physician you transferred to.
 - **Destination Basis**—why the patient was taken to that specific location.
 - **Comment**—enter miscellaneous information here. If you transferred to a hospital or EMS agency not listed under the dropbox, type it in here. Definitely describe who took over patient care here (ie MEDL).

Times

- Edit times to enter the time for each field. Note the date! The chart will auto-generate the date as when you began writing your chart, so you may have to change it.
- These are important! Try to have folks be diligent about recording times.

Odometer

Ignore

Patients—Click Add New Patient to enter Patient Information and proceed to next page.

- Ensure Dispatch page has been completed before clicking "Add New Patient." After you click this, it will take you to next page.
 - Choose No Patient for entering documentation for Fire Standby and Special Events where no patient contact was made.

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Patient Information

When you advance to Patient Information, the following box will appear. Click the **Add New Patient** box, unless you know that this patient has received care/transport from us before or you do not know the patient's name.



Patient Information

- Enter all known patient information
 - At a minimum, get a home unit address and phone number
- Use Barriers to care to identify any hindrances to delivering patient care (ex. language barriers, physical impairments, etc.)
- Patient Driver's License or Race information do not need to be filled out

Billing Information

Leave all of this blank.

Medical History, Current Medications, and Current Allergies

- Click the ¹ icon to display alphabetically organized lists of Med Hx, Medications, and Allergies
- Once you have located your entry, click on it (will appear in the blank field at the top of the pop-up window); click add
- If you can't locate an item in the preset list, you can manually type in the name of the item in the field at the top of the pop-up
- When you have "added" all entries, click done; This will take you back to the main patient information screen
- If you need to delete an entry, highlight it in the white box and then click the K icon
- Obtained from—from whom you obtained this information (patient, family member, etc)
- Emergency Inf. Form—don't worry about this box

Patient Information							
PTID: 15903937 Triage Color/#:							
Last: doe First: john	Viddle: Unknown SSN: 123-45-6789						
Address:	nknown Address Sex: Male						
City/St/Zip:	Weight: kg 💌						
County: O Country:	Height: IBW: 💡						
Census Tract:	Barriers to Care: Not Recorded						
Phone: DOB: S Age	40 Yr 💌 Race:						
DL State: DL Number: DNR:	Immunizations Employer Physicians Ema	ils					
	Billing Information						
Consent Form Signed: No 💌	PCS / Medical Necessity Signed: No						
Prior Authorization Payer:	C Transport Auth. Code: Primary Me	thod					
Relationships / Guarantors Edit	Billing Information Edit						
No relatives / guarantor listed	No billing information prese	nt					
	CMS / Payment Information						
CMS Trans Reason: 👔	Date PCS Signed: PCS Signatory Last	Name:					
Amb. Condition Indicator: 👔	PCS Reason: 👔 PCS Signatory First	Name:					
	PCS Provider Type: Mileage to Closest H	ospital:					
Medical History 🚫 🐩 🗱	Current Medications 🚫 🗊 🛛 🗶 Current Alle	rgies 🚫 🏂 🛛 🗶					
*	^	^					

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Impression / Diagnosis	Scene Description
System: 👔	AB _C
Symptoms: 👔	
Impression: 📆	
Initial Patient Acuity:	# Patients at Scene: 1
Condition At Dest:	First Assess Unit On Second?
Chief Complaint	First Agency Unit On Scener:
Duration of Complaint:	Exposure
	Patient Movement
	Moved to Vehicle Via:
History of Present Illness	Position in Vehicle:
B _C	Moved From Vehicle Via:
	Transport Assessment: 👔
	Stretcher Purpose:
	Factors Affecting Care
	Factors: 👸
Reason for Encounter:	Set All Factors to None
Drugs/Alcohol: None	
Cardiac Arrest	
<< Bac	k Next Page >>

Page 2: PT, Chief Complaint, History of Present Illness

Impression/Diagnosis

- System—the primary body system affected. Click the ¹ icon to display a list of body systems. You can only select ONE Primary system. You can select multiple secondary systems in the Other column.
- **Symptoms** same primary/other parameters as above.
- **Condition at Dest**—select the patient's condition at the termination of the call

Chief Complaint-State patient's chief complaint in 50 characters or less

History of Present Illness

• Narrative of history of present illness. This is where you will write your narrative. Use a contemporaneous format such as CHARTE or SOAP. For PCRs received from other providers, just transcribe their narrative in this box.

Scene Description—Narrative of scene and how you found your patient. General impression of patient.

• **Exposure**— If you had a true exposure, click on the exposure button to bring up pop-up window below. Fill in appropriate/applicable boxes and click **Save**. Blood/vomit/urine/etc on closed skin? Not an exposure.

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	Exposure/Bioterrorism
Prote	ective Equipment: 1
Contact v	with Blood/Fluids:
т	ype of Exposure: 🚺
Expos	ed To (primary):
Pe	rsonnel Exposed:
	Save Reset

Patient Movement, Reason for Encounter, Drugs/Alcohol—Enter appropriate information.

Factors Affecting Care—Enter appropriate information. By selecting Set All Factors to None you will auto-populate the factors to None. Was the call in the backcountry? Was the weather bad?

Cardiac Arrest—Clicking on the **Cardiac Arrest** button will display the following pop-up window. Click and complete if appropriate/applicable.

Care	diac Arrest Registry	
		<u>Unknown</u>
Witnessed:		
Who Witnessed:	N/A 💌	
Cardiac Etiology:	•	
Initial Rhythm:		
CPR Started:	۵	
CPR By:	N/A 💌	
Resuscitation:	1	
First Defib:		
Defib Type:	N/A	
Defib By:	N/A	
ALS Initiated:		
CPR Discontinued:		
Reason Terminated:		
Circulation Returned:		
Ventilation Returned:	Sector 1	
Dest. Rhythm:	1	
	Save Cancel	

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	Page 3: Neuro/Airway				
	Neuro				
Level of Alert		Pupils Size:	Left Nomai	Right Normal	•
Mental: 📷		React	Reactive	Reactive	-
Comments:			Motor	Senso	ny
Stroke Scale:	•	LA: RA:	Normal Normal	 Normal Normal 	
Patient		LL	Nomai	 Normal 	-
chemically No 💌 Loss of Cons paralyzed:	sciousness: No 💌	RL:	Normal	 Normal 	-
Was Pt. Immobilized:					
I	nitial Glasgow Coma Score				
Eye Opening Verb	al Motor TOTAL:	15	Qualifier:	5	
	Airway				
Status: Patent	•				
Comments:					
Performed By:	• (Dutco	me:	•	
Defaults Cancel Changes			<< Back	Next Pag	e >>

Fill in the fields as necessary. Be sure to note that there are several fields that automatically default to **Normal** (ex: Pupils and Motor and Sensory).

Mental

• Click on the ticon. The box below will appear. If you click normal, you can't click anything else (the chart won't lock).



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Page 4: Resp/Cardio

Respiratory Cardio page is pretty self-explanatory.

Oxygen should be documented if you found the patient on O2. If you give O2 to the patient, that should be documented in the activity log on page 8.

		RES	SPIRATOR	Y			
	Effort: Normal	Breath Soun	ds: L: Clear	. [Clear	-
	02:	Via:	come:	Performe	d By:		
	Resp. 👔 📃						
Con	nments:						
		CARD	IOVASCUL	AR			
	Pulses						
	<u>Left</u>	<u>Right</u>					
	Carotid:	•					
	Radial: Strong 💌	Strong 💌					
	Femoral:	•					
	Dorsalis:	-					
	JVD: Not Checked 💌	Cap Refill: Les	s than 2 Seco	nds 💌	Edema	a: Not Che	ecked 💌
	Comments:						
De	efaults Cancel Changes					< Back	Next Page >>

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Page 5: Secondary Survey

Head	Neck
Assessment: 👔	Findings:
Chest	GU/Pelvic
Assessment: 👔	Assessment: 🛐
Findings:	Findings:
Abdomen	Back
Left Upper: 👔 Right Upper: 👔 Left Lower: 👔 Right Lower: 🐔	Spine: 📆 Thoracic: 🔂 Lumbar: 📆 Findings:
	Extremities
Appearance: Palpation: Comments:	Extremities LA: Image: Comparison of the
Appearance: Palpation: Comments: Additional Information	Extremities LA: Image: Colspan="2">Image: Colspan="2" Findings: Colspan="2">Image: Colspan="2"
Appearance: Palpation: Comments: Additional Information Burns	Extremities LA: Image: Colspan="2">Image: Colspan="2" Findings: Image: Colspan="2">Image: Colspan="2" Restraints: Image: Colspan="2"
Appearance: Palpation: Comments: Additional Information Burns	Extremities LA: Image: Colspan="2">Image: Colspan="2" Findings: Image: Colspan="2" Image: Colspa=""2" Image: Colspan="2"
Appearance: Palpation: Comments: Additional Information Burns	Extremities LA: Image: Constraint in the second
Appearance: Palpation: Comments: Additional Information Burns	Extremities LA: Image: Colspan="2">Image: Colspan="2" Colspan="2">Image: Colspan="2"

• If you click "Normal" in any dropbox, you can't click anything else in the box (chart won't lock if you do).

Burns—If the patient is a burn patient, select the Burn icon to display a separate burn information box.

There will be several options in which you can enter information.

- The **Total Body Surface Area** will allow you to enter information in percentages of body area burned. There is an **Anterior** and a **Posterior** option for entering in information.
- The **Rule of 9's** will allow you to enter in the burned area based on the location(s) of the burn(s). There is an **Anterior** and a **Posterior** option for entering in information.
- Both options will calculate out the total percentage of the body that has been burned. You **DO NOT** need to enter information into both **Total Body Surface Area** and the **Rule of 9's** section, you only need to choose one.

Page 6 is automatically skipped.

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Page 7: Meds, IV's, PTA

Vascular Access Initiated Prior to Assessment								
IV#	Gauge Site	Solution	Rate (ml/hr)	Performed By	Outcome			
1					-	▼ Add		
		Medications	/ Infusions Prior to A	ssessment				
Time	Medication 🗵	Concentration Dose/Rate	IV#/Other Route	Performed By	Outcome	Drip?		
					•	- 🗌 🗛		
			🗖 🔍					
		<	< Back Next Page >>					

• This page is for treatment prior to your arrival. For example, on Yellowstone transfers, you would chart if the YELL medic started an IV or gave meds here. Not the place to chart your treatment. That's Page 8.

Page 8: Patient Activity Log

The Activity Log is one of the most important parts of your PCR. This is where a lawyer, family member, physician, etc, will find mistakes. So, please, do your best to ensure accuracy of times, treatments, and vitals.



Vitals

- Record all vitals taken
- If you are **NOT** monitoring/recording heart rhythms, select the **Not Applicable** option in the drop-down menu underneath **Rhythm**
- Enter Glu (blood glucose), Temp, LOC, and GCS
- Remember to click "Save/Add Line" after each time entry.

Comments –This box is where you can enter a narrative for each time stamp, if you want to. Some prefer to write their narrative in completion on Page 2. Either way is acceptable.

Protocol—The protocol under which your care/actions are justified

Add Action (turn off pop-up blocker)

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- Clicking on Add Action will give you a drop-down list of possible actions/interventions, including Medication, Intubation, Airway, Cardiac, Initiate IV, Immobilization, Medical Consult, Hosp. Notify, and Operations. THIS IS IMPORTANT FOR STATISTICS!
- If you performed one of these actions, click on it in the drop-down list and it will appear in the Add Action field
- When you click **SAVE/Add Line**, a pop-up window will appear requesting details for that specific action.
- Similar boxes will pop-up depending on the action you have selected.
- When you complete these boxes, the information will appear in the Patient Activity Log along with the other information entered for each specific timestamp.
- These action boxes help complete your narrative. They also document much of the 6 R's of medication administration.
- When you are finished entering all information, actions taken, and your narrative of the patient contact, click Next Page.

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Page 9: Misc Forms



Attached Files

- This is where you will upload all additional documentation that you have scanned into a computer. This includes the PCR, field notes, etc.
- Please rename file with case incident #, so it is easy to identify without having to open it
- Select the appropriate **category** if applicable
- Feel free to scan and upload all documents as one file, naming it "Patient Demographics", or something similar.

Signatures—You will need to enter your EMS Charts password and SSN/pin in order to sign your chart. Primary provider must sign chart before locking it.

Quality Assurance—In order to finalize your chart and submit for quality assurance review you must click complete/lock chart

- **Current**—the current level of QA your chart is at. S0 is initial entry, S1 is initial QA.
- Next—the next level your chart will be sent to after it passes the current level
- Once your chart has been locked, you can only view a Read Only version. You can no longer make changes. If you lock your chart accidentally or need to change/add information after clicking complete/lock chart, please contact the EMS coordinator requesting to have your chart demoted back to you.
- Once you submit your chart for **QA**, it will go through several levels of approval, ultimately being reviewed by our medical director for **final QA**.
- If the person responsible for reviewing your chart at any level finds something missing or has questions, you will receive a message via email with his/her concerns.
- **First**, you MUST acknowledge the **QA flag**. **Second**, you need to correct your chart. **Third**, you need to re-lock and re-submit the chart for QA review. When you have responded to the QA flag your chart will show up as green instead of red.

Addendums

- Addendums can be used for additional crew members to add narratives or information about the call that you may have not witnessed (ex. another credentialed provider was on scene prior to your arrival and has pertinent information they want to document)
- An addendum can be added before AND after a chart has been locked
- An addendum may also be used to make corrections to a chart after the chart has been locked.