



Charting Standardization Guide

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Home Page

- When you first log in set your base to your working location. It will stay defaulted to that base location after being set the first time. At the beginning of your shift if you set your unit and crew it will default to that unit and crew for the remainder of your shift.
- From your home page you have a quick view of charts outstanding and any charts you have flagged for QA. As a reminder, Patient Care Reports MUST be completed within Twenty-Four (24) hours of Time of Dispatch pursuant to MedTrust Policy and State Regulations.
- To begin charting click on - Patient Records.
- If you ever need to change your password, pin number, or email you can do so in Security Settings which is highlighted in yellow.

ZOLL | emsCHARTS Current Login Type: Service MedTrust Medical Transport (S4620) LOGOUT

HOME medtrustcrew (965362) 09/24/23

Configuration

Patient Records

Special Reports

Forums

Human Resources

Calendar

Links

Support

Training

Security Settings

PCR

Incomplete Charts	Charts Flagged for QA	Unanswered QA Flags	New Special Reports	Open Support Cases	Go to PATIENT RECORDS
0	0	0	0	0	

Click to review

Current Login and Shift Settings

Last Login 7/11/2023

Change Login MedTrust Medical Transport

Base Grandstrand

Unit

Agency

Calendar (09/24/2023 - 10/22/2023)

No Events Found

Service Announcements

06/14/23

[Go to ZOLL Data Systems](#)

Charts must be completed within 24 hours. If you cannot complete your chart please contact your ops team!

MORE

emsCharts, Inc. - 1-800-663-3911 - ec-www21-green.aws.emscharts.com (prod) - 8.12.09

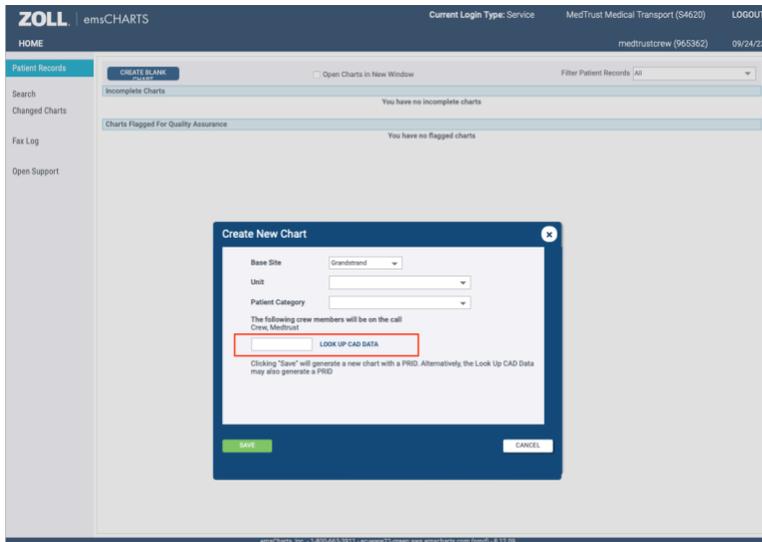
Patient Records

- To begin charting, click on - Create Blank Chart.
- Any incomplete/outstanding charts you have, and any charts flagged for QA, will also appear on this page. Again, as a reminder, Patient Care Reports MUST be completed within Twenty-Four (24) hours of Time of Dispatch pursuant to MedTrust Policy and State Regulations.
- QA flags shall be answered within 72 hours.

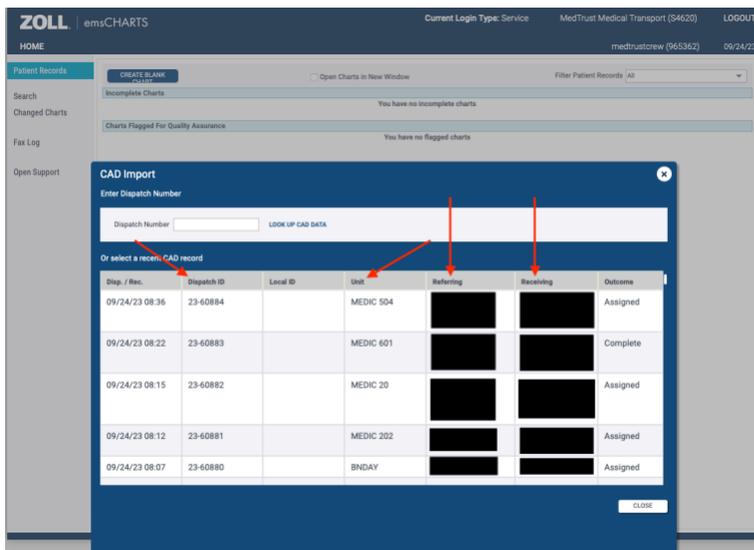
The screenshot shows the ZOLL emsCHARTS interface. At the top, the header includes the ZOLL logo, 'emsCHARTS', and user information: 'Current Login Type: Service', 'MedTrust Medical Transport (S4620)', and 'LOGOUT'. Below the header, there is a navigation bar with 'HOME' and 'medtrustcrew (965362) 09/24/23'. The main content area is titled 'Patient Records' and features a sidebar with links for 'Search', 'Changed Charts', 'Fax Log', and 'Open Support'. The main content area contains a 'CREATE BLANK CHART' button (highlighted with a red box), a checkbox for 'Open Charts in New Window', and a 'Filter Patient Records' dropdown menu set to 'All'. Below these controls, there are two sections: 'Incomplete Charts' with the message 'You have no incomplete charts' and 'Charts Flagged For Quality Assurance' with the message 'You have no flagged charts'. At the bottom of the page, there is a footer with the text: 'emsCharts, Inc. - 1-800-663-3911 - ec-www21-green.aws.emscharts.com (prod) - 8.12.09'.

Creating a Chart

- If you know your run number, you can type it in or click on – Look Up CAD Data. Run numbers can be obtained from the dispatch phone and should be entered into emsCHARTS with the two (2) digit year followed by a dash and then the run number. Example: 23-12345. In this example 23 represents 2023 and 12345 represents your run number obtain from dispatch.



- If you do not know your run number and you clicked on – Look Up CAD Data, the next screen will come up. From here select your call matching your MedTrust Unit, Referring, and Receiving. Please be mindful you select your Unit, as multiple calls can be going out at the same facility at once.



- Once you have entered your run number or selected your call, the details and patients name will come up. Confirm this is the correct information for the call you were dispatched to, scroll down, and select – Import Data
- If you import the wrong call or start a chart by accident or want to do a test chart; simply type “delete” next to the run number in the run number box on the chart and it will be deleted by your manager.

ZOLL emsCHARTS Current Login Type: Service MedTrust Medical Transport (04620) LOGOUT
HOME medtrustcrew (965362) 09/24/23

Patient Records CREATE BLANK Open Charts in New Window Filter Patient Records All

Search Incomplete Charts You have no incomplete charts

Changed Charts Charts Flagged For Quality Assurance You have no flagged charts

Fax Log

Open Support

CAD Import CAD Import Data

Map To: Hospital [redacted] Bath [redacted]

Rec. Mode No Lights/Strm

Rec. Address [redacted]

Rec. City CHARLESTON

Rec. State SC

Rec. ZIP 29425

Rec. Coordinates 32.785517 N / -79.946621 E

Patient Import Previous Patients (max 10 shown)

Name [redacted]

Name	DOB	Age	SSN
[redacted]	[redacted]	[redacted]	[redacted]

Phone (000) 000-0000

DOB [redacted]

SSN [redacted]

Import Note 2023-09-23 19:05:17.0 [redacted]

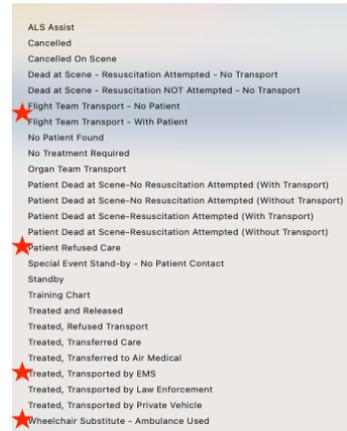
Import Note 2023-09-23 21:01:29.0 [redacted]

Import Note 2023-09-22 10:11:41.0 [redacted]

IMPORT DATA

Page 1 – Dispatch

- Most items on page 1 will populate for you when you import the call from the CAD.
- The open box next to your unit number is there for you to designate the level of care of that unit. Not the level of care of that patient, but of that entire unit. BLS or ALS.
- Make sure you are listed as a crew member, that your role on the call is documented correctly, and that your level of certification is listed.
- Most of our transports occur under the “Treated and Transported by EMS,” disposition, but for those occasions when you arrive on scene and the patient refuses, or you transport a flight team, or your ambulance is used as a wheelchair sub because no wheelchair vans were available; you must make sure you are selecting the appropriate applicable disposition.
- If you select “Patient Refused Care,” Reason for Refusal will become a required field.
- Under the Referring Section – Response Mode and Mode Descriptors are required.
- Under the Receiving Section – Transport Mode, Mode Descriptors, and Dest. Basis are required.
- Times are required.
 - *In Georgia, an “At Pt” and “Lv w/Pt” are required.*
- Again, confirm you are listed as a crew member on this chart.
- Once you have confirmed that and are ready to go to the next page, click – next page.



Event	Time	Date
Onset		
Received	09:27:24	09/05/2023
Dispatched	09:28:00	09/05/2023
EnRoute		
Staging On Scene	09:32:00	09/05/2023
At Pt		
Lv w/Pt		
Leave Ref	09:40:00	09/05/2023
Arrive Rec	10:12:00	09/05/2023
Transfer Care Dest	10:15:00	09/05/2023
Available	10:20:00	09/05/2023
Completed		

Patient Page

- If dispatch has the patient’s information: the patients name and demographics will populate here. If we have taken this patient before, the past medical history, medications, and allergies will also populate here. If no name is given for the patient or if the name is incorrectly spelled, please add all required information here.
- EVERY patient contact requires demographic information. This requirement includes all transports, refusals, and wheelchair sub calls.
- Unless attached on page 9, document pertinent past medical history, medications, and allergies on this page. Typing medical history into the narrative section can be helpful at times, but it does not replace documenting it on the patient page as well.
- Identifying a Primary Method of Payment is a new NEMESIS V3.5 requirement.
- Obtaining a Middle Name and a SSN is not required but strongly encouraged.
- Obtaining a Height and Weight on your patient is not required but strongly encouraged.
- When you are ready to go to the next page, click – next page.

The screenshot displays a web-based patient information form. On the left is a vertical navigation menu with options like 'Patient Records', 'Page 1: Dispatch', 'Patient', 'Page 2: CC, HPI', 'Page 3: Neuro, Airway', 'Page 4: Resp., Cardio', 'Page 5: SecondarySurvey', 'Page 6: Labs, Fluid', 'Page 7: Meds, IVs PTA', 'Page 8: Activity Log', 'Narrative', 'Page 9: Misc. Forms', 'Patient Follow-up: Hospital Notes', 'Entire Chart', 'Print Preview', 'Attachments', 'Special Report', 'Chart Toolbox', and 'Open Support'. The main content area is titled 'Patient Information' and includes sections for 'Address', 'Demographics', 'Medical History', 'Current Medications', 'Current Allergies', and 'Billing Information'. Red and yellow boxes highlight specific fields: 'Last', 'Suffix', 'First', 'Middle', 'SSN', 'DOB', 'Age', 'Gender', 'Weight', 'Height', 'IBW', 'Race', 'DNR', 'Subscriber', 'Barriers to Care', 'Medical History', 'Current Medications', 'Current Allergies', 'Consent Form Signed', 'Prior Authorization Payer', 'Transport Auth. Code', 'Primary Method of Payment', 'Reason for Interfacility Transfer', and 'Justification for Transfer'. A 'Replace Patient' button is located above the address section. At the bottom, there are status indicators for 'Relationships / Guarantors' and 'Billing Information'.

Page 2 – CC, HPI

This page begins the patient assessment portion of the chart.

- Impression/Diagnosis – The System, Symptoms, Impression, Anatomic Location, Initial Patient Acuity, and Final Acuity are all required fields.
- Chief Complaint – This is the reason why the patient called the ambulance today or, in the case of interfacility transfers, it is acceptable to use the patient’s medical diagnosis and contributing medical history from the referring facility.
- In the case of an ALS patient, an ALS assessment should be noted as completed.
- History of Present Illness – This can be obtained by asking questions like symptom Onset, does anything Provoke it or make it better or worse, what is the Quality of what you’re feeling, does it Radiate anywhere, and what is the Severity of this incident; to help gain a better understanding of what is going on with this patient. These questions are commonly referred to simply as OPQRST questions. In the case of interfacility transfers this section can be used to document the events that led the patient into the facility.
- Reason for Encounter – This field is not required unless you select “Injury/Trauma,” then you must fill out the “Add’l Injury Details” tab.
- Scene Description – This should be where you found your patient.
- Level of Care per Protocol is a new NEMSIS V3.5 requirement.
- Patient Movement – This is how you moved the patient out to the ambulance, how they were positioned in the ambulance, and how you moved them into the receiving facility.
- Stretcher Purpose – This is not the reason why the patient physically needed a stretcher, but the place to document why the patient was being transferred by ambulance.
- All other fields on this page are optional. It is good habit to document things like patient belongings that you bring with you or any paperwork that you took with you, but not required.
- Cardiac Arrest, Exposure and Factors Affecting Care are highlighted as optional but will become required if you select a “yes” answer within those tabs. For instance: if you click exposure and then select yes to a TB exposure, it will ask you if you were wearing PPE and it will be required you answer that question.
- When you are ready to go to the next page, click – next page

- Patient Records
- Page 1: Dispatch
- Patient
- Page 2: CC, HPI
- Page 3: Neuro, Airway
- Page 4: Resp., Cardio.
- Page 5: Secondary Survey
- Page 6: Labs, Fluid
- Page 7: Meds, IVs PTA
- Page 8: Activity Log
- Narrative
- Page 9: Misc. Forms
- Patient Followup: Hospital Notes
- Entire Chart
- Print Preview
- Attachments
- Special Report
- Chart Toolbox
- Open Support

Impression/Diagnosis

System	Abdominal
Symptoms	Pain - Pelvic / Abdominal
Impression	Abdominal pain / problems
Anatomic Location	Abdomen
Initial Patient Acuity	Lower Acuity (Green) ▼
Final Acuity:	Lower Acuity (Green) ▼

Condition At Dest

Chief Complaint

Abdominal pain AB

Duration of Complaint Days

ALS Assessment

ALS Assessment Rationale

Patient Activity

History of Present Illness

Patient is being transferred today for abdominal pain secondary to bowel perforation AB

Reason for Encounter

Drugs/Alcohol

Drug/Alcohol Indicators

-
-
-

Scene Description

Bed 10 Tidelands ED. AB

First Agency Unit On Scene?

Other EMS/Public Safety on Scene

Other Agencies on Scene (Generic)

Level of Care per Protocol

Patient Belongings

bag of clothes AB

Patient Movement

Moved to Vehicle Via	Stretcher
Position in Vehicle	Semi-Fowlers
Moved From Vehicle Via	Stretcher

Transport Assessment

Stretcher Purpose

Pt is going to MUSC for inpatient admission and surgical services not available at referring facility. AB

Forms Received/Delivered

Discharge Paperwork	Received	<input type="checkbox"/>	Delivered	<input type="checkbox"/>
Transfer Paperwork (PCS/Medical Necessity)	Received	<input checked="" type="checkbox"/>	Delivered	<input checked="" type="checkbox"/>

Factors Affecting Care

Dispatch Factors	None
Response Factors	None
Scene Factors	None
Transport Factors	None
Turn-Around Factors	None

BACK

NEXT PAGE

Page 3 – Neuro, Airway

- Pages 3-7 focus on what you found when you arrived on scene. You will notice this page mentions level of consciousness and initial GCS, if that changes during transport you will document that change on page 8 and in your narrative. Alternatively, if you document the patient is Alert and A&Ox4 on page 3 and then put in your narrative the patient is not alert, has a GCS of 5 due to multiple strokes, and that is why he is going by ambulance back to his residence, you should expect a chart flag asking for clarification.
- Level of Consciousness, initial Pupils assessment, initial Motor and Sensory function, and initial GCS, are all required fields.
- If applicable to the type of call you are on, or if you select “Stroke/CVA” on the impressions list located on page 2; a Stroke Scale, Stroke Score, and Time Last Know Well will be required elements. *In SC, you must use the RACE Stroke Scale.*
- If you arrived on scene to find a patient who had been chemically paralyzed, lost consciousness, or has been already immobilized, you will document your findings on this page in the section highlighted in yellow.
- If you arrived on scene to find a patient who has an airway adjunct or a secured airway already in place, you would document that on this page under the airway section highlighted in yellow.

Airway

Status: Secured / Intubated Verification Method(s): Auscultation, Capnograph...

Secured Via: Endotracheal Tube Size: 7.5 mm Depth: 24 cm

Comments:

Performed By: Other Healthcare Provider Outcome: Improved

- When you are ready to go to the next page, click – next page.

Patient Records

Page 1: Dispatch

Patient

Page 2: CC, HPI

Page 3: Neuro, Airway

Page 4: Resp., Cardio.

Page 5: Secondary Survey

Page 6: Labs, Fluid

Page 7: Meds, IVs PTA

Page 8: Activity Log

Narrative

Page 9: Misc. Forms

Patient Followup: Hospital Notes

Entire Chart

Print Preview

Attachments

Special Report

Chart Toolbox

Open Support

Neuro

Level of Consciousness: Alert

Time Last Known Well:

Comments:

Stroke Scale:

Stroke/CVA Symptoms Resolved:

Patient chemically paralyzed: No Loss of Consciousness: No

Was Pt. Immobilized: No

Initial Glasgow Coma Score

E: 4 Spontaneous V: 5 Oriented M: 6 Obeys Commands Total 15 Qualifier: ADD +

Pupils

	Left	Right
Size	Normal	Normal
React	Reactive	Reactive

Comments:

	Motor	Sensory
LA	Normal	Normal
RA	Normal	Normal
LL	Normal	Normal
RL	Normal	Normal

Sensory:

Motor:

Airway

Status: Patent

Secured Via:

Comments:

Verification Method(s): ADD +

Tube Size: mm Depth: cm

Performed By: Outcome:

Page 4 – Resp, Cardio

- Pages 3-7 focus on what you found when you arrived on scene.
- Respiratory Effort, Breath Sounds, and at least one (1) Carotid, Radial, or Femoral pulse check from both the right and left side of the patient are required.
- If you arrived on scene to find a patient who is on oxygen, you will document your findings on this page in the O2 section highlighted in yellow.
- Paramedics – If you have a patient who is already on a Ventilator, already being externally paced, or already has an Art. Line in place; you will document that here. Once you move them over to our MedTrust equipment, you will document that as an action on page 8.
- When you are ready to go to the next page, click – next page.

Respiratory

Effort: Normal

Breath Sounds: Left: Clear, Right: Clear

O2: /min

FIO2:

Air Temperature: °F

Humidity (Air): %

Via:

Performed By:

Comments:

Ventilator

Cardiovascular

Pulses: Left, Right

Carotid: Left, Right

Radial: Normal, Normal

Femoral:

Temp: °F

Invasive Monitoring

Art. Line: ADD +

PA Line:

JVD: Not Appreciated, Cap Refill: , Edema: Not Appreciated

Comments:

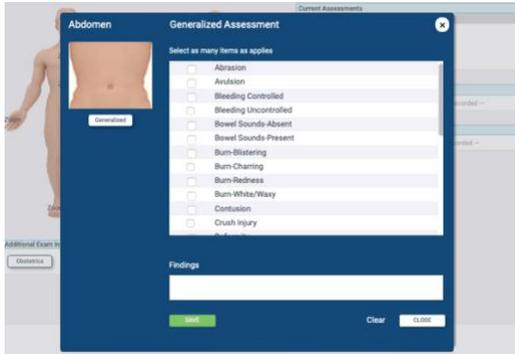
Pacemaker

Defaults, Cancel Changes

BACK, NEXT PAGE

Page 5 – Secondary Survey

- Pages 3-7 focus on what you found when you arrived on scene.
- At a minimum, a basic external/skin assessment are required for each patient contact.
- If applicable to the patient, a detailed assessment and thorough secondary survey should be completed.
- To complete a more detailed assessment, click on the body part you would like to comment on, and then select the items that apply.



- When you are ready to go to the next page, click – next page.

The interface includes a sidebar with navigation options: Patient Records, Page 1: Dispatch, Patient, Page 2: CC, HPI, Page 3: Neuro, Airway, Page 4: Resp., Cardio, **Page 5: Secondary Survey**, Page 6: Labs, Fluid, Page 7: Meds, IVs PTA, Page 8: Activity Log, Narrative, Page 9: Misc. Forms, Patient Followup: Hospital Notes, Entire Chart, Print Preview, Attachments, Special Report, Chart Toolbox, and Open Support.

At the top, there are tabs for 'External/Skin' (highlighted), 'General Extremities', 'Neurological', 'Mental', and 'Heart'. The 'Assess Date' is 09/05/2023 at 09:27. There are 'SAVE' and 'Add' buttons.

The central area shows a 3D human model with 'Zoom' labels. A red box highlights the 'External/Skin' area on the front view.

The right-hand panel displays 'Current Assessments' with the following data:

Area	Assessment
Generalized Ab	Pain Rebound Tenderness Tenderness
Mental Status	Oriented-Event Oriented-Person Oriented-Place Oriented-Time
Skin	Clammy Warm

Below this is a 'Findings/Comments' section with the text '-- no comments recorded --' and an 'Assessment Images' section with the text '-- no images recorded --'.

At the bottom, there is an 'Additional Exam Information' section with buttons for 'Burns', 'Drains & Tubes', and 'Defaults'. At the very bottom, there are 'BACK' and 'NEXT PAGE' buttons.

Page 6

- This page is no longer in use and was previously used to record results of imaging tests and lab work done during transport.

Page 7 – Meds, IV's PTA

- Pages 3-7 focus on what you found when you arrived on scene.
- If the patient has Vascular Access already in place, that will stay in place during transport, you will document that here.
- If the patient received medications pertinent to their care prior to your arrival, or will be receiving medication infusions during the transport, you will document that here.
- There is no minimum amount of information you need to enter in the vascular access or medication section on this page, for it to save. Example: If you are unable to obtain the concentration but know the dose/rate that is acceptable, and the system will still let you save it.
- When you are ready to go to the next page, click – next page.

Patient Records

Page 1: Dispatch

Patient

Page 2: CC, HPI

Page 3: Neuro, Airway

Page 4: Resp., Cardio.

Page 5: Secondary Survey

Page 6: Labs, Fluid

Page 7: Meds, IVs PTA

Page 8: Activity Log

Narrative

Page 9: Misc. Forms

Patient Followup: Hospital Notes

Entire Chart

Print Preview

Attachments

Special Report

Chart Toolbox

Open Support

Vascular Access Initiated Prior to Assessment

IV#	Gauge	Site	Solution	Rate (mL/hr)	Performed by	
2	<input type="text"/>	<input type="button" value="Add"/>				

Medications / Infusions Prior to Assessment

IV#/Other Route	Time	Medication	Concentration	Dose/Rate	Unit	Performed by	Drip	
<input type="text"/>	<input type="checkbox"/>	<input type="button" value="Add"/>						

Prior Aid Procedures

Blood Product Administration

Time/Date <input type="text"/>	Pt. ID Verified <input type="text"/>				
Clinical Indicator <input type="text"/>	Cross matched <input type="text"/>	Transfusion Consent <input type="text"/>	Transfusion Consent Time/Date <input type="text"/>		
Product Blood Type <input type="text"/>	Product <input type="text"/>	Product ID <input type="text"/>	Unit Exp. Time/Date <input type="text"/>		
Site Administered <input type="text"/>	Transfusion Start Time/Date <input type="text"/>	Transfusion End Time/Date <input type="text"/>	By Whom <input type="text"/>		
Volume Infused (mL) <input type="text"/>	Unit Completed <input type="checkbox"/>	Warmer Used <input type="checkbox"/>			

Page 8 – Activity Log – Vitals Section

- This page is where you document vitals and any actions you or your crew performed during the call.
- At a minimum you must have two (2) complete sets of vital signs.
 - Unless patient refuses. If patient refuses you must document why (i.e. combative, contractures, agitated)
- A complete set of vital signs includes:
 - Date and Time the vitals were taken
 - Heart Rate and Rhythm
 - Blood Pressure and Blood Pressure Method
 - Pulse Oximetry Reading, on Room Air (RA) or on Oxygen.
 - Respiratory Rate and Effort.
 - Level of Consciousness
 - Current GCS
 - Pain: **Scale and Quality**
 - Protocol Used (Default protocol is Universal Patient Care)
 - Name of Crew Member who took vitals
- If applicable to the nature of the call, Crew Members should also document:
 - ETCO2
 - Cardiac Monitor Rhythm including an EKG import
 - Stroke Scale
 - Sedation Score
- Directions on how to upload the cardiac monitor to emsCHARTS can be found in this manual.
- When you are ready to go to the next page, click – next page.

Table of Recorded Vitals:

Time	Assessed By	H.R.	REG	R.P.	BP	MAP	RA SpO2	ETCO2	Resp	Rhythm	GCS	ECG Method	Prctd	Pain
09/05/23 09:45:00	Scott Worcester	110	REG	144 / 76	99	Y 98	20	Lead_Sinus	4	Manual Interpretation	Universal Care	8		
09/05/23 10:00:00	Scott Worcester	124	REG	148 / 62	91	Y 98	20	Lead_Sinus	4	Manual Interpretation	Universal Care	8		
09/05/23 10:02:00	Scott Worcester													
09/05/23 10:10:00	Scott Worcester	110	REG	126 / 74	91	Y 98	18	Lead_Sinus	4	Manual Interpretation	Universal Care	3		

Form Fields (Bottom Section):

- Date:** 09/05/23
- Time:** 10:10
- Prior to Arrival:**
- Vitals:** H.R. (110), REG, H.R. Method (Electric Monitor - Cardiac), BP (126/74), BP Method (Auto. Cuff), MAP (91), RA SpO2 (91)
- ETCO2/ETCO2 Type:** ETCO2 (18), ETCO2 Type (None)
- Resp:** Resp Effort (4), Glucose (None), Rhythm (Normal), ECG Method (None)
- Stroke Scale:** (None)
- Temp:** (None)
- Comments:** (None)
- Repeat Vitals:** (No Change), (EKG Import)
- GCS:** (3), Qualifier (None)
- Sedation:** (None)
- Protocol:** (None)
- Assessed By:** Scott Worcester
- Buttons:** Add Action, Save/Add, Graph

Page 8 – Activity Log – Add Action Section

- emsCHARTS calls any care, procedures, assessments, moves, or treatments provided by your crew “Actions,” and to document those “Actions” provided you will utilize the “Add Action” button at the bottom of the set of vitals.

The screenshot shows the emsCHARTS interface with various vital signs and assessment fields. At the bottom, there is an 'Add Action' dropdown menu and a 'SAVE / Add Line' button. A red arrow points to the 'Add Action' dropdown menu.

- Choose which Action you would like to add from the drop-down menu. Some of the common actions are: Oxygen admin, patient lifts/moves, medications given, and procedures performed, like placing the patient on a cardiac monitor, starting an IV, or placing the patient on the ventilator.

The screenshot shows the 'Add Action' dropdown menu with a list of actions including: Assessments, Medication, Titrate, Intubation, Airway - Other, Initiate IV, Cardiac, Immobilization, Medical Consult, Labs, Drains, Ventilator, Extrication, Rescue, Childbirth/OB, Wound Care, Ventricular Assist Device, Imaging/Ultrasound, Hosp. Notify, Critical Care, Blood Product Administration, Operations, Pertinent Negative - Procedure, and Pertinent Negative - Medication.

The screenshot shows the 'Medication Log' form with the following fields: Crew ID (Medtrust Crew), Role Performing (EMT/Paramedic), Medication (Fentanyl), Dose (100 MCG), Rate (100 Slow IV Push), Route (IV - Push), Concentration (100mcgs/2ml), Wasted (checkbox), Lot # (N9019), Comp. (None), Response (Improved), Authorization (Via Protocol), and Comments.

- Example, Fentanyl Administration, Select Medication from drop down menu and enter required fields. You must select “None” if there were no complications during administration. Simply leaving it blank is not permitted.

Narrative Section

- A legal document that, next to providing good patient care, is your best protection from liability. Bad narratives are the leading cause of unfavorable results during litigation. If you didn't document it, it didn't happen.
- There are many different methods of narrative writing but in general you must include:
 - A detailed description of your patient assessment, Chief Complaint, treatment and response to treatment, any care provided, how you moved the patient, and anything that occurred during the transport.
- During an interfacility call it is important to document:
 - The reason for transport to a facility or a second hospital. Including what specific services were not available at the first hospital.
 - How you moved the patient to the stretcher.
 - Noting bed confined – please include why or what condition makes the patient bed confined (like deficits from a CVA and list them or weakness from being hospitalized for the past 15 days and not using the muscles, etc.)
 - Documenting a “Higher Level of Care” alone is not specific enough. Detail about the specific treatment should be on the PCR.
 - The PCR MUST be able to stand on its own without a PCS to justify ambulance transport and medical necessity. Simply having a PCS without an appropriately filled out PCR is not acceptable.
- It is important during this page to go back and see the dispatch notes that populate into the HPI section on page 2. If the notes say “patient requires oxygen 4lpm” and then you document spo2 of 99% on RA; noting in the narrative the patient doesn't require oxygen will help to explain the disconnect.
- All patient contacts require a narrative section. That includes, refusals and wheelchair sub calls.
- When you are ready to go to the next page, click – next page.

Patient Records

- Page 1: Dispatch
- Patient
- Page 2: CC, HPI
- Page 3: Neuro, Airway
- Page 4: Resp., Cardio
- Page 5: Secondary Survey
- Page 6: Labs, Fluid
- Page 7: Meds, IVs PTA
- Page 8: Activity Log
- Narrative**
- Page 9: Misc. Forms
- Patient Followup: Hospital Notes

Narrative

Please add a narrative

Medic 21 was dispatched to respond to TGMH for ALS transport to TWCH. Medic 21 responded non-emergent to the call. Upon arrival to the scene to receive report from the sending nurse. He reported a 72 y/o female patient that was being transferred back to TWCH for continuation of care following cardiac catheterization. The nurse reported that the patient's cardiac cath was unremarkable with no blockages found. The patient had a RIGHT radial insertion with compression bracelet in place. The air can be released intervalley starting at 1530. Orders for transport were cardiac/hemodynamic monitoring and continuation of IV NSS at KVO rate. Upon arrival to the patient to find a 72 y/o female patient with the complaint of being hungry. She denied chest pains or shortness of breath. Denied abdominal pain or discomfort. Denied weakness or dizziness. Denied known infections or fevers per report from the sending nurse.

PE-CAOX4; HEENT- ATRAUMATIC; PUPILS-PERL; (-)JVD; TRACHEA MIDLINE; CHEST- SYMMETRICAL; LS- CLEAR EQUAL BILATERAL; ABD- SNT, NON-DISTENDED, NO MASSES OR PULSESPALPABLE;BACK-ATRAUMATIC;PELVIS-STABLE;EXTREMITIES- SKINWASNORMALWARMANDDRY:(+)RADIALANDPEDALPULSES:(-)PEDALEDEMA; MOVEDALL EXTREMITIES WITHIN NORMAL LIMITS, COMPRESSION BRACELET ON RIGHT RADIAL FROM CATH INSERTION.

TREATMENT- The patient was assessed and monitored by Paramedic .The patient's VS were established and monitored every 15 minutes. She was placed on the cardiac monitor and was in Atrial Fibrillation with occasional PVCs. #20g cath saline lock with 500ml NSS running at KVO rate was continued throughout transport. The patient was stable and required no medical interventions. The patient care report was given to the receiving nurse at bedside.

TRANSPORT- The patient was transferred to the stretcher by x3 person sheet slide. She was placed in a semi-Fowlers position. The patient was secured to the stretcher by x5 safety straps and x2 rails. Patient was loaded and secured into the ambulance. Transport was non-emergent to TWCH. The patient was off loaded and taken into the hospital by stretcher. The stretcher was lowered to a safe position. The patient transferred herself unassisted to the hospital bed. Patient transport was completed without incident. Medic 21 was placed available with Dispatch.

Characters: 0/10,000

[BACK](#) [NEXT PAGE](#)

Page 9 – Misc Forms

- Before you finish on Page 9, go back to Page 1 and click on CAD Import to make sure all of your times come over, then return back to Page 9.

Run Number TEST CHART **CAD IMPORT**

Disposition

Disposition: Treated, Transported by EMS

Unit Disposition: Patient Contact Made

Patient Evaluation/Care: Patient Evaluated and Care Provided

Crew Disposition: Initiated and Continued Primary Care

Transport Disposition: Transport by This EMS Unit (This Crew O

Reason for Refusal/Release: ADD +

Referring / Scene

Type: Hosp EMS Other

Name: Tidelands - Waccamaw Communit LOOK UP

Unit: Emergency Department

ZIP: 29576

Times (EST)

Event	Time	Date
Onset		
Received		
Dispatched	09:27:24	09/05/2023
EnRoute	09:28:00	09/05/2023
Staging		
On Scene	09:32:00	09/05/2023
At Pt		
Lv w/Pt		
Leave Ref	09:40:00	09/05/2023
Arrive Rec	10:12:00	09/05/2023
Transfer Care Dest	10:15:00	09/05/2023
Available	10:20:00	09/05/2023

- Next, obtain a Standard Signature, a Receiving Facility Signature, and upload any documents from that call like a face sheet and PCS.

Patient Records

Page 1: Dispatch

Patient

Page 2: CC, HPI

Page 3: Neuro, Airway

Page 4: Resp., Cardio.

Page 5: Secondary Survey

Page 6: Labs, Fluid

Page 7: Meds, IVs PTA

Page 8: Activity Log

Narrative

Page 9: Misc. Forms

Patient Followup: Hospital Notes

Entire Chart

Print Preview

Attachments

Special Report

Chart Toolbox

Complete / Lock Chart

Status: GA Oply

Page 1: Required Times: Completed

State V3 Custom Elements: Optional

Billing Signatures: Optional

Special Reports: None

COMPLETE / LOCK CHART

QA Status

Current Initial Entry (S0)

Next QA (S1)

Signatures

Sign Chart

View Signatures

Number of Signatures: 1

Attached Files

Attached Files

Number of Attached Files: 2

NEMSIS v3 Status

Addendums

Addendums

Current Number of Addendums: 0

Print & Complete Miscellaneous Forms

Print	Select Form	Status
<input type="checkbox"/>	Reason for Transport	Optional
<input type="checkbox"/>	Activity Audit	Optional
<input type="checkbox"/>	Utilization Review	Optional
<input checked="" type="checkbox"/>	Standard Signatures	
<input checked="" type="checkbox"/>	Custom Forms	ADD
	Receiving Facility Signature Form 1	

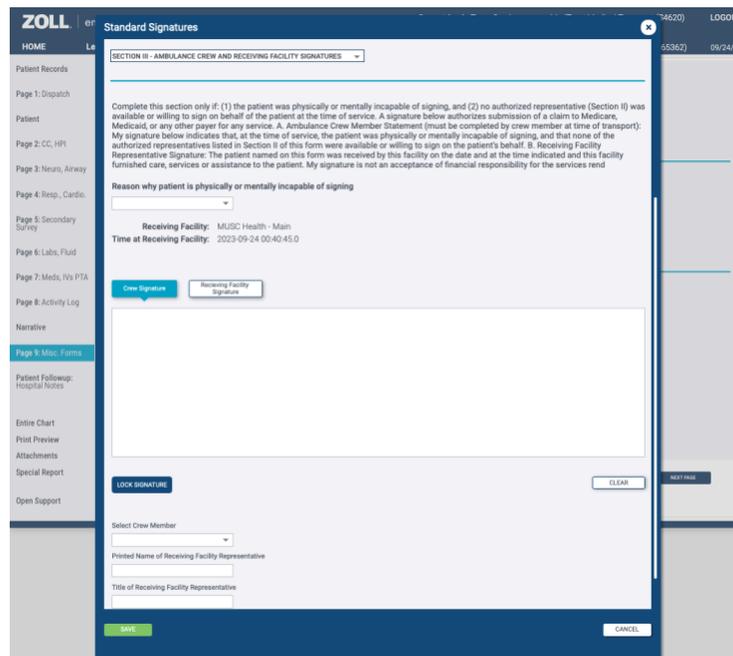
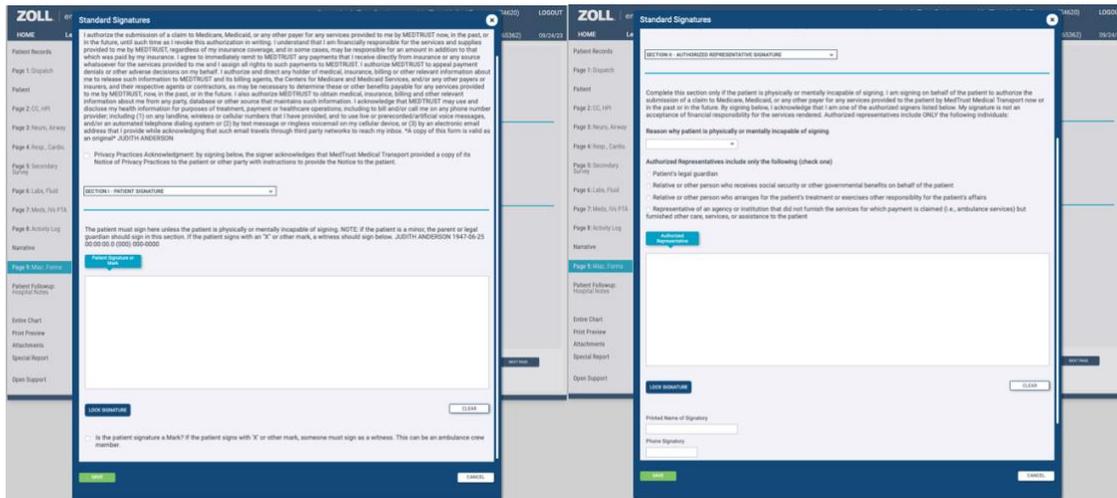
Print Actions

Chart Forms Chart & Forms

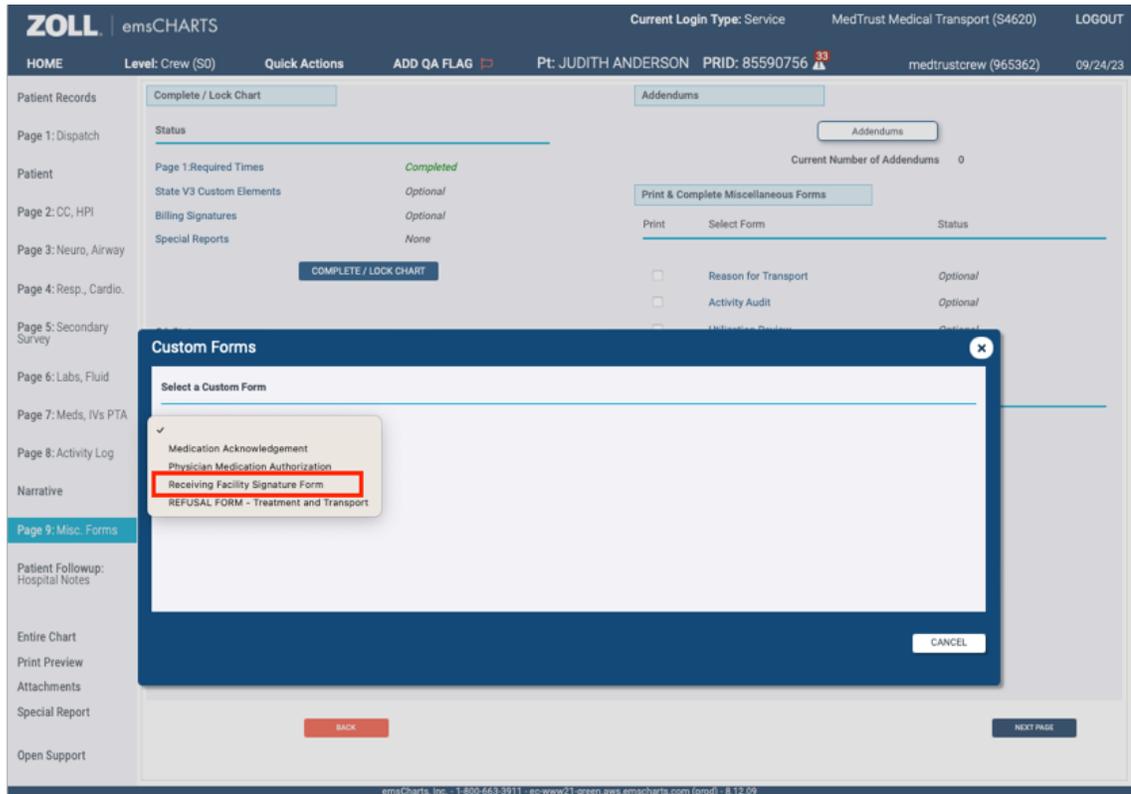
BACK NEXT PAGE

Page 9 – Signatures

- The patient should be signing the PCR using the Standard Signature Form for ambulance transport. The patient signs the Standard Signature Form in Section 1.
- If the patient is physically or mentally incapable of signing, then it should be documented why, and you should proceed first to Section 2 for an Authorized Representative and then to Section 3 for the Facility to sign.
- It is important to remember that if you are using Section 2 or Section 3 of the Standard Signature form then you MUST have the full name AND relationship or title of the person signing.



- Once you have obtained a Standard Signature you must click Lock Signature and then Save.
- To obtain a receiving facility signature accepting clinical responsibility of your patient: go to Custom Forms and then to Receiving Facility Signature Form.
- ***Note*** This is also where you will find the Patient Refusal Form.



Page 9 – Attachments/Complete and Lock Chart

- To attach documents to this chart including things like a PCS and a Face Sheet, go to Attached Files. Click Choose File, then pick a Category.
- *Note* You must pick a category of the document/picture you are attaching for it to go through.

The screenshot shows the 'Attach File' section of the ZOLL emsCHARTS interface. The 'File name' field is highlighted with a red box, and the 'Choose File' button is also highlighted. The 'Category' dropdown menu is open, showing options like 'Consent for Transfer', 'EKG', 'Medical Necessity', 'Other', 'Patient Demographics', 'Refusal', and 'Sepsis Checklist'. The 'UPLoAD' button is visible below the category dropdown. The interface also shows a sidebar with navigation options and a top navigation bar with user information.

- The last step is to sign your chart and then “Complete/Lock” your chart.

The screenshot shows the 'Complete / Lock Chart' section of the ZOLL emsCHARTS interface. The 'COMPLETE / LOCK CHART' button is highlighted with a red box. The 'Sign Chart' button is also highlighted. The 'Attached Files' section shows 2 files attached. The 'NEMSIS v3 Status' section is visible at the bottom. The interface also shows a sidebar with navigation options and a top navigation bar with user information.

QA Flags

- QA flags assigned to you, or your crew, will appear on the patient records page. You shall respond to a QA flag within 72 hours.

Charts Flagged For Quality Assurance					
MedTrust Medical Transport					
QA	Status Details	ID	Date	Location	Unit
S0	Response Required	test123	10-04-2023	MUSC Health - Orangeburg	Medic 404

- To answer a QA flag, click:

ZOLL emsCHARTS | Current Login Type: Service | MedTrust Medical Transport (S4620) | LOGOUT

HOME | Level: Crew (S0) | Quick Actions | **ADD QA FLAG** | PRID: 85793709 | medtrustcrew (965362) | 10/04/23

Patient Records

PRID: 85793709 | Service: MedTrust Medical Transport | Run Number: test123 | Date: October 4, 2023

Base: Orangeburg | Unit: Medic 404 | Team: ALS

Tail/Reg: 128 | Crew 1*: Worcester, Scott (EMT - Paramedic) | Crew 2*: Crew, Medtrust (EMT - Paramedic)

EMT: No | * designates an ALS Provider

Dispatched As: Transfer / Interfacility / Palliative Care | Transport Mode: Non-Emergent

Veh. Disp. GPS: 33.5404829,-80.8288691

Type of Service: Routine Medical Transport Scheduled

Dispatch Priority: Priority 3

Response Mode: Non-Emergent

Disposition: Treated, Transported by EMS

Unit Disposition: Patient Contact Made

Patient Evaluation/Care: Patient Evaluated and Care Provided

Crew Disposition: Initiated and Continued Primary Care

Transport Disposition: Transport by This EMS Unit (This Crew Only)

Reason for Refusal/Release:

Referring / Scene: MUSC Health - Orangeburg (F00024809) | Receiving / Destination:

3000 Saint Matthews Road | Orangeburg, SC 29118-1442 | Orangeburg County | 803-533-2290

Ref. Zip: 29118-1442 | Ref. County: Orangeburg | Ref. GPS: 33.542017,-80.832132

Last Name: EVANS | First Name: ZACHERY | SF: SC | Country: United States | DOB: 12/21/1992 | SM: 403-65-1641 | Age: 30y | Gender: | Weight: | Height: | Subscriber: No

Times: Dispatch: 14:15:46 | Available: 14:15:46

Consent Signed: No | PCS / Medical Necessity Signed: No

QA Flags for record 85793709 | Select row to view details

Date	Status Details	Flagged By	Referenced Page	Assigned To
10/04/2023	Response Required	Scott Worcester	Page 1	All Crew

CANCEL

QA Flag Details	
Date/Time	10/04/2023 21:18
PRID	85793709
Created By	sworcester762
Flag Type	Clinical Care
Response Type	Email
Assigned To	All Crew Members
Referenced Page	Page 1
Comments	This is a test



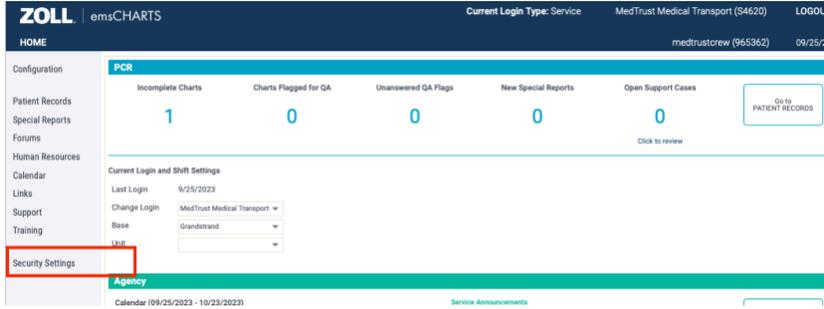
Billing QA Flags and Addendums

- Billing QA Flags will be requested solely via an addendum. An addendum is meant to supplement narratives about the patient’s condition during transport.
- Role of MedTrust Billing Team is to review the chart non-clinically, focusing on accurate ambulance transport billing. They determine “Medical Necessity” by evaluating: “Why was alternative transportation contraindicated, today?”
- Identifying “Medical Necessity”
 - Patients may fulfill this through one/more conditions.
 - Severe muscle weakness, altered LOC, decubitus ulcers necessitating specific positioning, paralysis, severe contractures.
 - Need for specialized monitoring: seizures, cardiac, hemodynamics.
 - IV medications, cardiac monitoring, ventilator dependence.
 - Non-healed fractures, requisite orthopedic devices.
 - Oxygen regulation inability or airway monitoring required.
 - Potential danger to self/others or need for restraints.
- All conditions mandate comprehensive, accurate documentation.
- Understanding Medical Necessity: Not all patients will qualify and that is ok. If unsure why alternative transport is contraindicated during an addendum request, admitting uncertainty is acceptable.

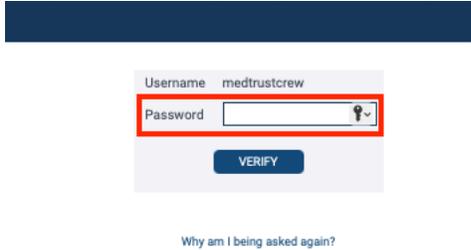
Charting Standardization Guide Supplements

How to change your email and pin in emsCHARTS

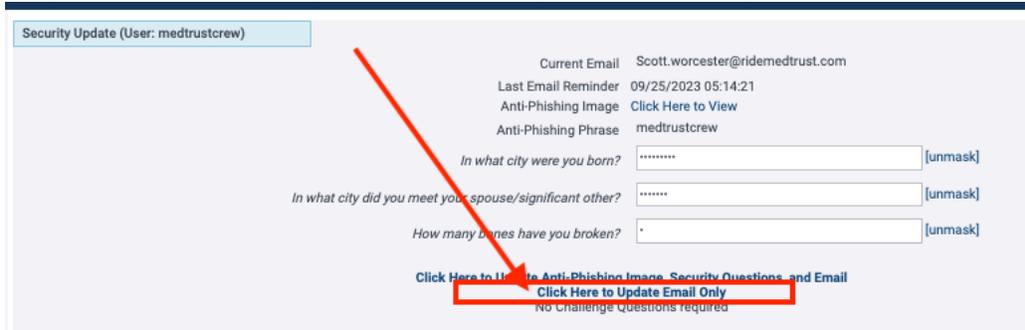
Step 1: Log into emsCHARTS and go to Security Settings on the bottom left.



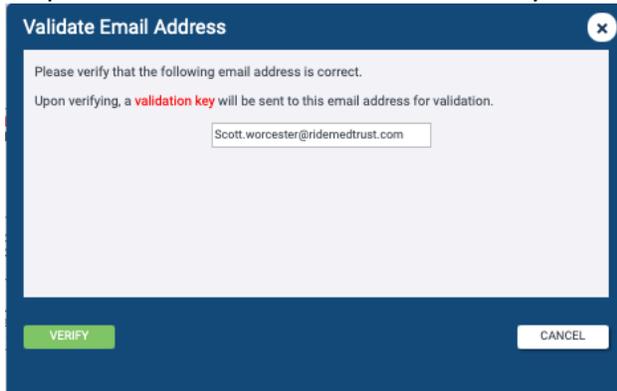
Step 2: Enter in your password again.



Step 3: Click where is says Click Here to Update Email Only



Step 4: Enter in new email and click Verify.



How to upload your monitor data to emsCHARTS

WIFI:

To set Wi-Fi up:

1. On the tablet, activate the hotspot.
2. On the monitor scroll up to the network symbol at the top of the screen and press the enter key. Scroll down to temporary profile/edit.
3. Enter the hotspot information from your tablet and save. If active your network symbol will turn green.

Ensure you have selected the temporary profile that you entered the information into. Ensure the hotspot is on. Information from the tablet HAS TO MATCH, it is case sensitive.

Monitor

1. Use the monitor to obtain vital signs
2. When the call is complete go to the monitor and select "Page Two", using the quick access/soft
3. Select "Log" soft key.
4. Select "Envelope" soft key.
5. Select "close case" using enter button, If the monitor has been off for more than 2 minutes, "continue".
6. "Select Case" will be highlighted. Select enter button to view cases. Using the arrow buttons, select the case(s) you wish to upload, (up to 15 cases can be chosen). Top case is the newest
7. Once you have highlighted the case select the display/home button.
8. Transfer will be highlighted. Select enter button to start transfer.
9. Case will automatically transfer to the cloud if Wi-Fi is available.

Tablet

1. Log on to your EMS chart
2. It may take a few minutes for your upload to reach the cloud
3. Go to activity log screen on page 8. Select "EKG Import" on the screen.
4. Click "Device" and choose the name of the monitor that your patient information is on.
5. Choose your vitals, EKG, ETCO2, SP02 etc.
8. Click "Import".
- 9. Complete any missing information in these vital signs!**
10. DO NOT omit information because you don't want to bother with it.
11. Multiple providers can download the same information.
12. It is critical that you verify that the correct information was downloaded.

EMS Charts

How to add patient to chart

How to add a patient to your EPCR when dispatch had no patient information.

- There are times when you'll not have patient information when a call is dispatched to you.
- This short slide show will help you upload the information.
- You will also need to contact dispatch to give them the patient information, name and date of birth.

Start with search for patient.

The screenshot displays the ZOLL emsCHARTS web application interface. At the top, the browser address bar shows the URL `zoll.emscharts.com`. The application header includes the ZOLL logo, the text "emsCHARTS", and user information: "Current Login Type: Service", "MedTrust Medical Transport (S4620)", and a "LOGOUT" link. Below the header, a navigation bar contains "HOME", "Level: Crew (50)", "Quick Actions", "ADD QA FLAG", "PRID: 85470143", "tbouthiller1 (946129)", and "09/18/23". A "MedTrust Mail" notification and a "Select Patient" button are also visible. The main content area features a sidebar on the left with menu items: "Patient Records", "Page 1: Dispatch", "Patient", "Page 2: CC, HPI", "Page 3: Neuro, Airway", "Page 4: Resp., Cardio.", "Page 5: Secondary Survey", and "Page 6: Labs, Fluid". The central panel shows "No Patient Selected" and a "Search for Existing" button. A large red arrow points to this button, indicating the starting point for patient search.

First, search for the patient. If they are in the system, they will pull up.

The screenshot shows the ZOLL emsCHARTS interface. At the top, there's a navigation bar with "ZOLL | emsCHARTS", "Current Login Type: Service", "MedTrust Medical Transport (S4620)", and "LOGOUT". Below this is a secondary bar with "HOME", "Level: Crew (50)", "Quick Actions", "ADD QA FLAG", "PRID: 85470143", "tbouthiller1 (946129)", and "09/18/23".

The main content area is titled "No Patient Selected" and has a "Search for Patient" button. A "Patient Lookup" dialog box is open in the foreground. It contains the following fields and elements:

- Last Name**: Text input field.
- First Name**: Text input field.
- SSN**: Text input field.
- DOB**: Text input field with a calendar icon and a placeholder "MM/DD/YYYY". A red arrow points to this field.
- SEARCH**: A green button.
- SEARCH TIPS**: A link.
- Clear**: A button.
- CANCEL**: A button.

At the bottom of the dialog, there is a note: "Search must include 1 or more Pt. Identifiers". A second red arrow points to the "SEARCH" button.

Click on add new.

emsCHARTS

Level: Crew (S0) Quick Actions

No Patient Selected

Search for Existing

Patient Lookup

Enter selection criteria

Last Name First Name SSN DOB

Play MM/DD/YYYY

Search must include 1 or more Pt. Identifiers SEARCH TIPS SEARCH

Search Results

Select a Patient

No records found

Add New

Clear CANCEL

Fill out information and save.

No Patient Selected

Search for Existing

Patient Records

Page 1: Dispatch

Patient

Page 2: CC, HPI

Page 3: Neuro, Airway

Page 4: Resp., Cardio.

Page 5: Secondary Survey

Page 6: Labs, Fluid

Page 7: Meds, IVs PTA

Page 8: Activity Log

Narrative

Page 9: Misc. Forms

Patient Followup:

Add New Patient

Last Suffix First Middle Unknown SSN

Address

Google Unknown Address

Street Address

Apt, Suite, Unit, Building

City/State/ZIP ENTER MANUALLY

County All, Home Residence

Country

Census Tract LOOK UP

DOB

Age

Gender

Weight

Height IBW

Race ADD +

DNR ADD +

Subscriber