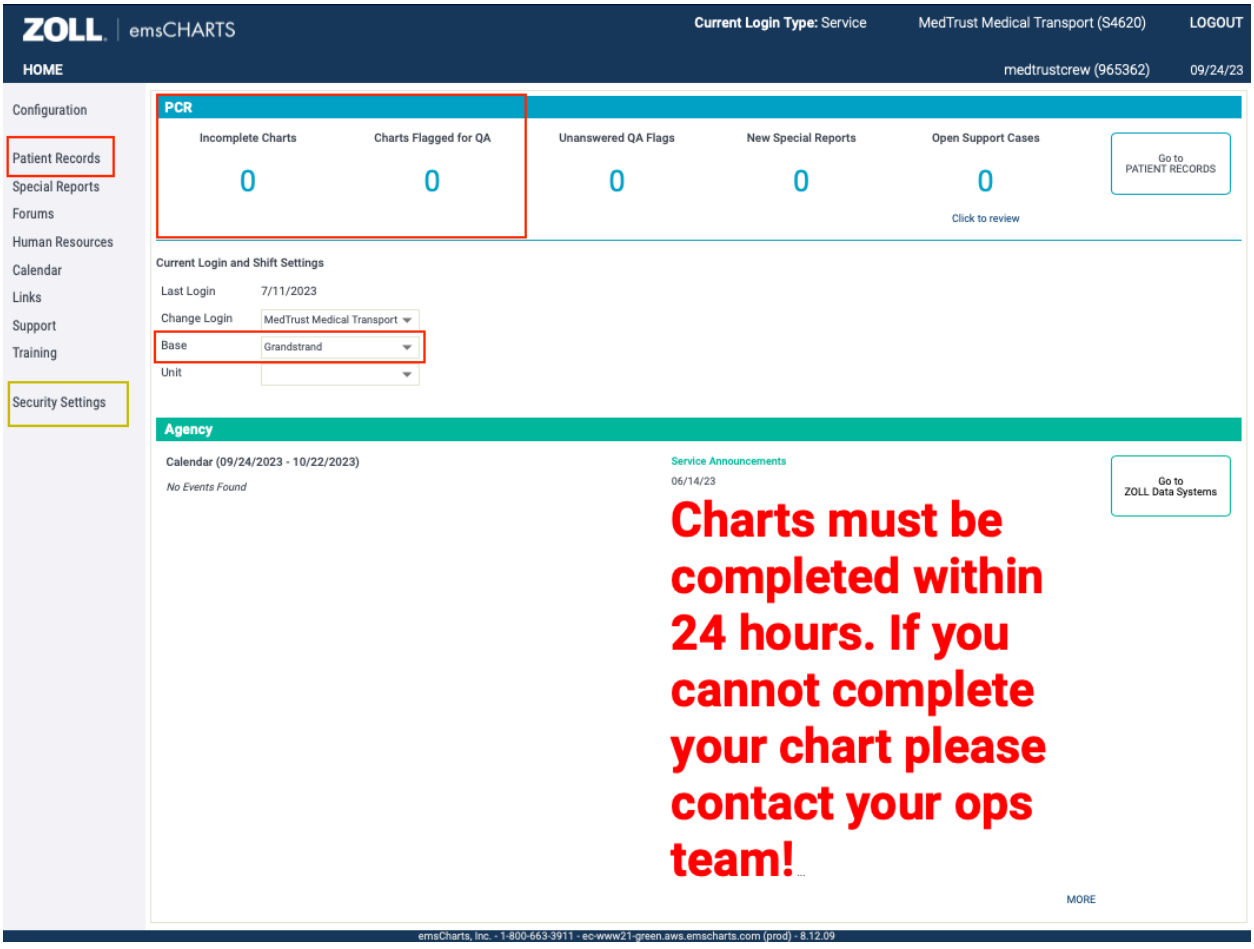
Charting Standardization Guide

Table of Contents

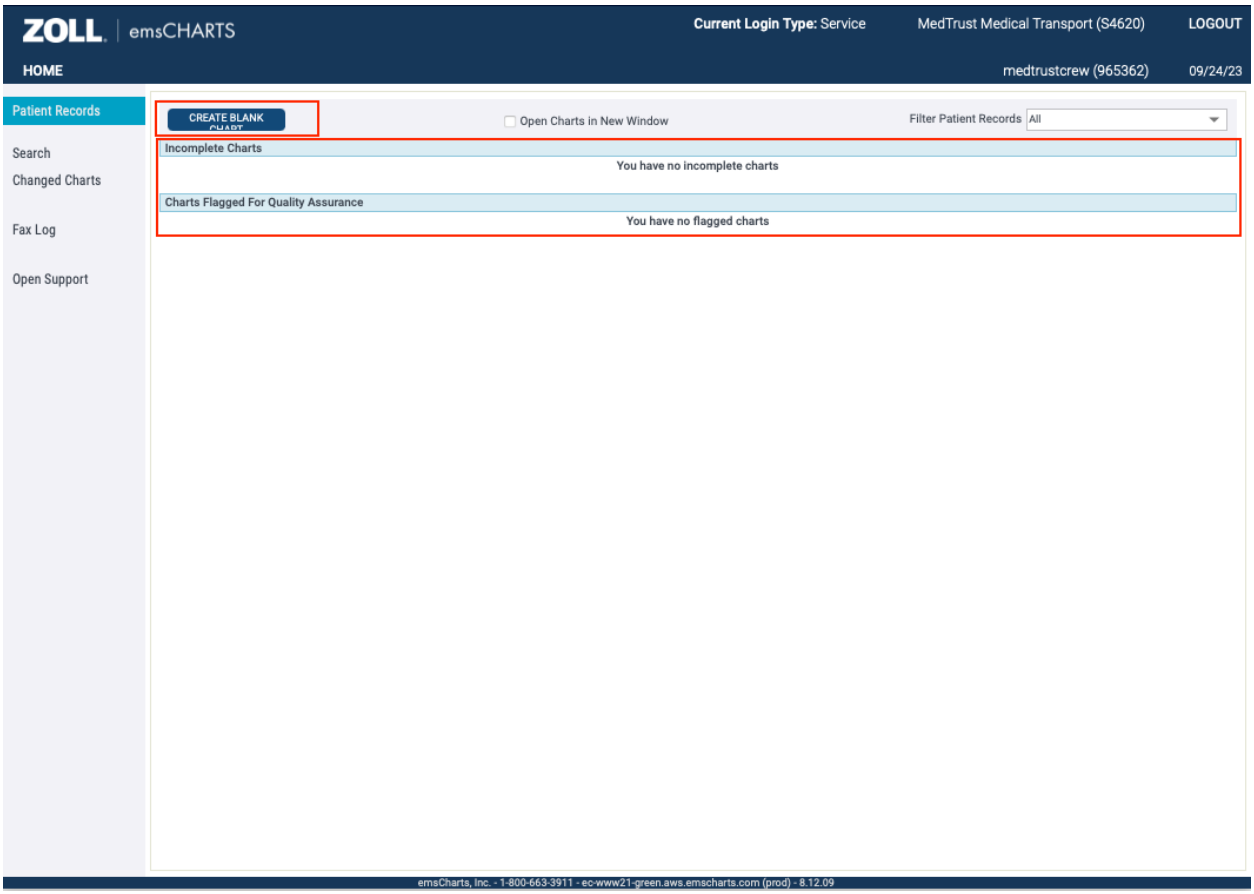
Home Page

- 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.



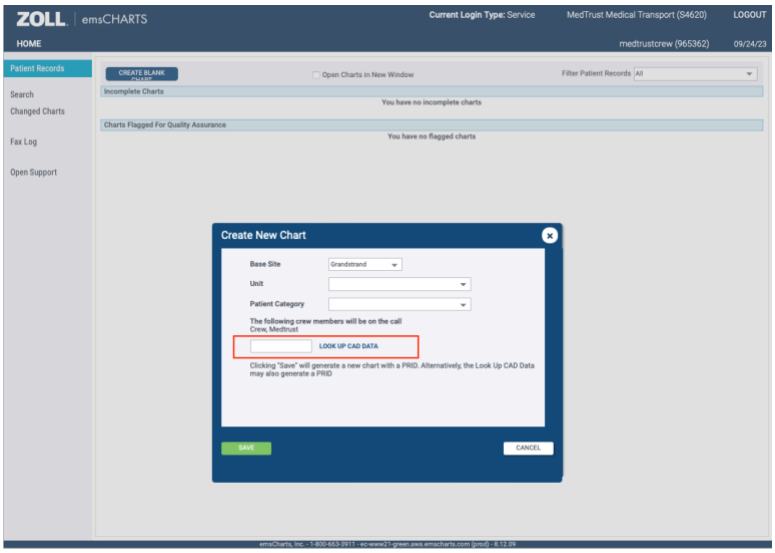
Patient Records

- 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.

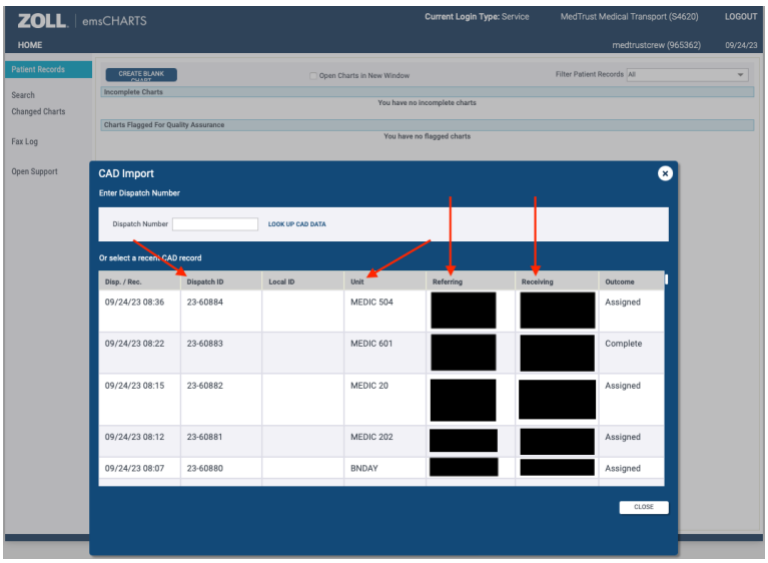


Creating a Chart

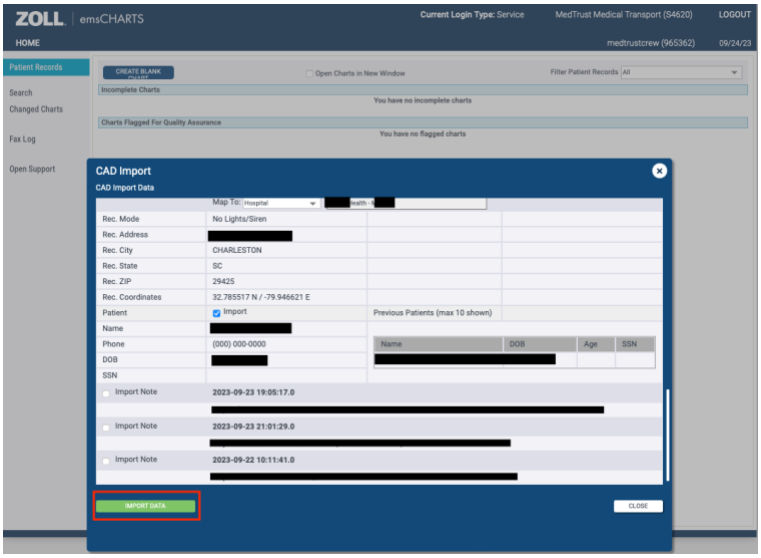
- If you know your run number, you can type it in or click on – Look Up CAD Data. Run numbers can be obtained from the dispatch phone and should be entered into emsCHARTS with the two (2) digit year followed by a dash and then the run number. Example: 23-12345. In this example 23 represents 2023 and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

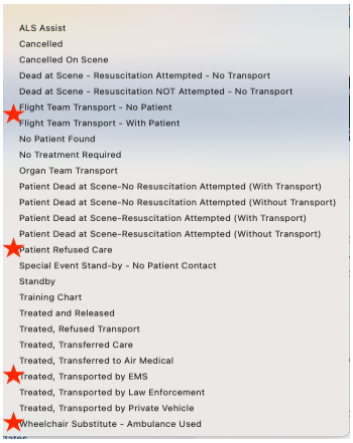


- Once you have entered your run number or selected your call, the details and patients name will come up. Confirm this is the correct information for the call you were dispatched to, scroll down, and select – Import Data
- If you import the wrong call or start a chart by accident or want to do a test 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.

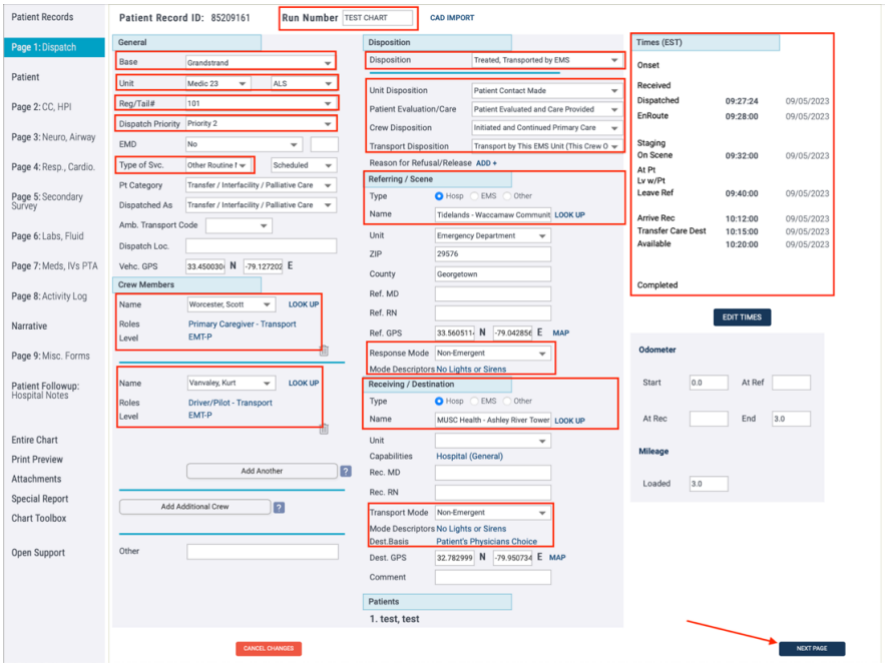


Page 1 – Dispatch

- 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.

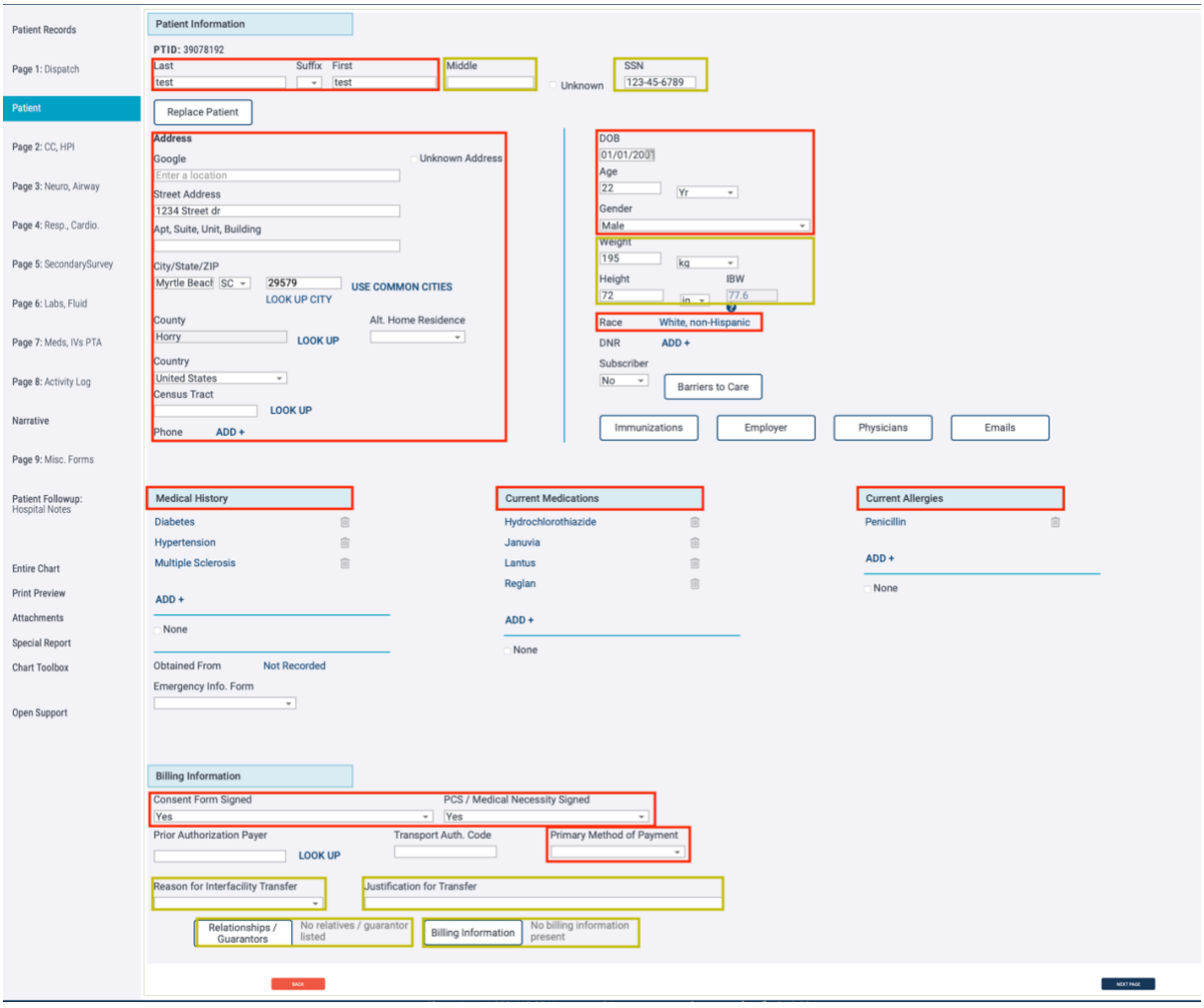


- If you select "Patient Refused Care," Reason for Refusal will become a required field.
- Under the Referring Section – Response Mode and Mode Descriptors are required.
- Under the Receiving Section – Transport Mode, Mode Descriptors, and Dest. Basis are required.
- Times are required.
    - *In Georgia, 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.



Patient Page

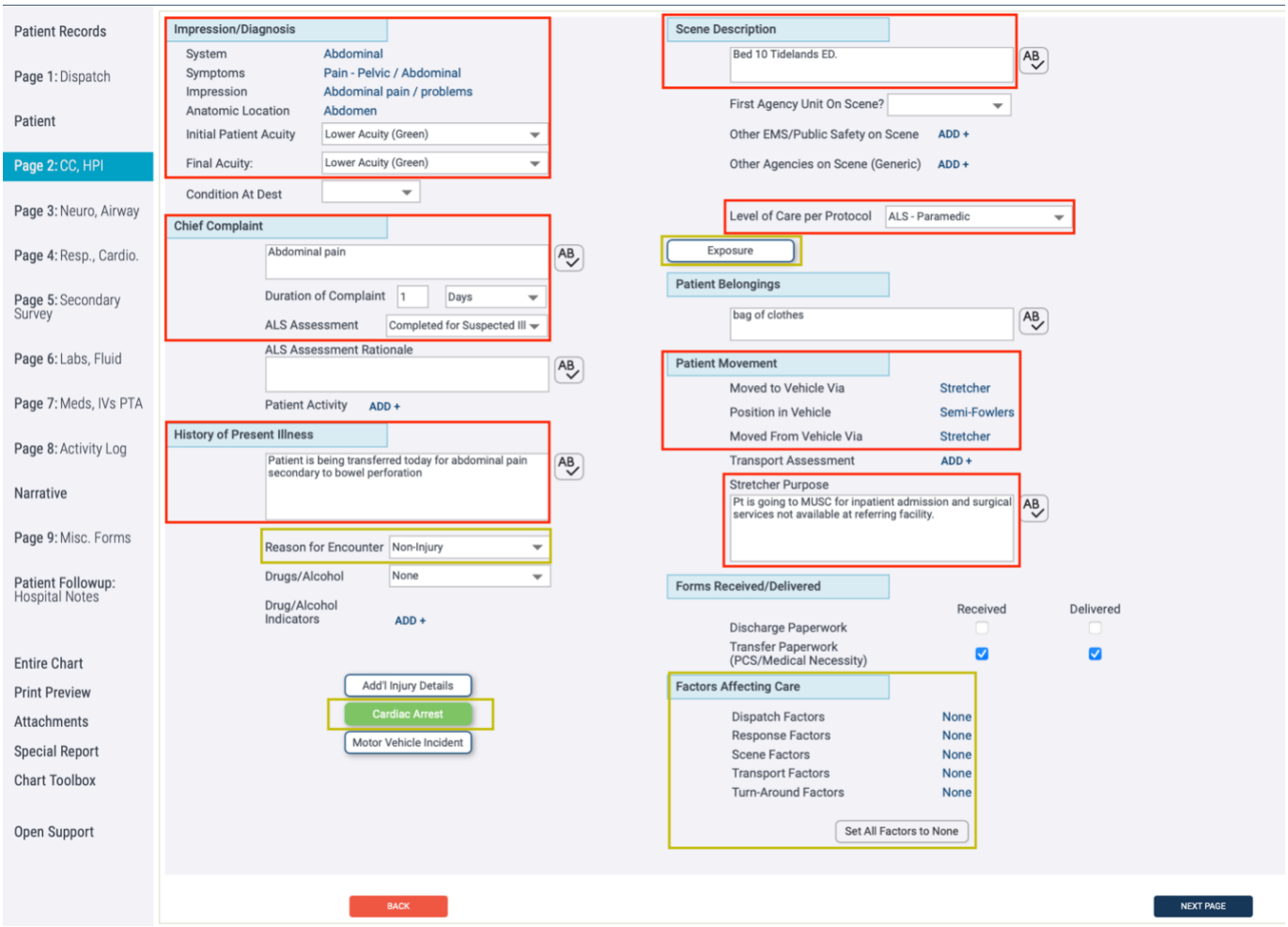
- If dispatch has the patient's information: the patients name and demographics will populate here. If we have taken this patient before, the past medical history, medications, and allergies will also populate here. If no name is given for the patient or if the name is incorrectly spelled, please add 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 NEMSIS 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.



Page 2 – CC, HPI

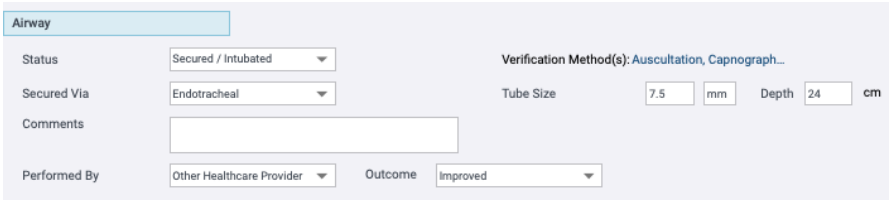
This page begins the patient assessment portion of the chart.

- Impression/Diagnosis – The System, Symptoms, Impression, Anatomic Location, Initial Patient Acuity, and Final Acuity are all required fields.
- Chief Compliant – 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

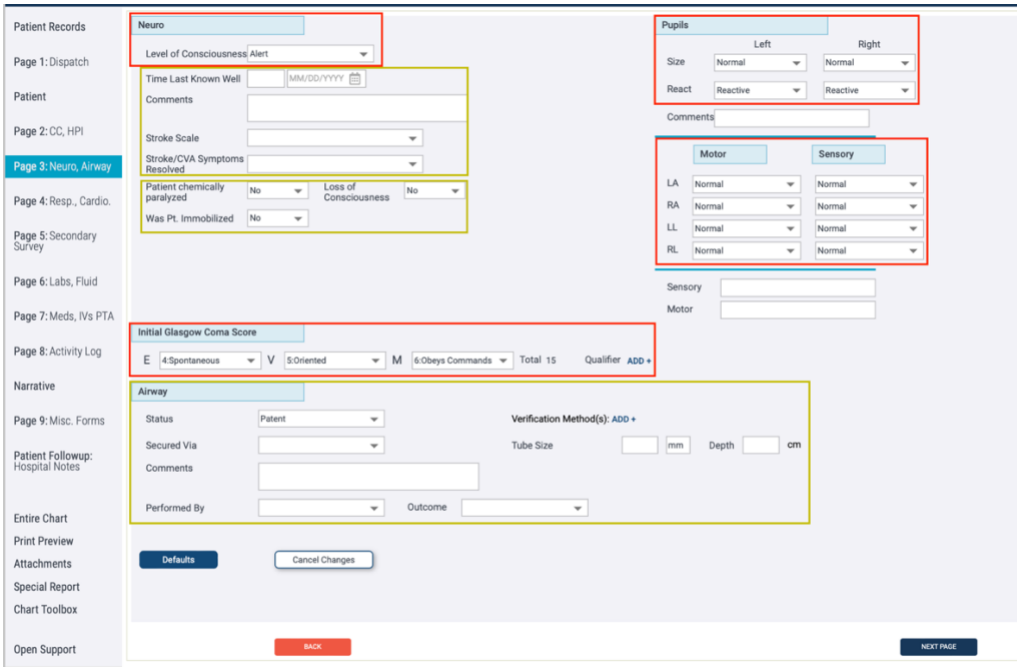

Patient Records
Page 1: Dispatch
Patient
Page 2: CC, HPI
Page 3: Neuro, Airway
Page 4: Resp., Cardio.
Page 5: Secondary Survey
Page 6: Labs, Fluid
Page 7: Meds, IVs PTA
Page 8: Activity Log
Narrative
Page 9: Misc. Forms
Patient Followup: Hospital Notes
Entire Chart
Print Preview
Attachments
Special Report
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
Duration of Complaint 1 Days
ALS Assessment Completed for Suspected Ill
ALS Assessment Rationale
Patient Activity ADD +
History of Present Illness
Patient is being transferred today for abdominal pain secondary to bowel perforation
Reason for Encounter Non-Injury
Drugs/Alcohol None
Drug/Alcohol Indicators ADD +
Add'l Injury Details
Cardiac Arrest
Motor Vehicle Incident
Scene Description
Bed 10 Tidelands ED.
First Agency Unit On Scene?
Other EMS/Public Safety on Scene ADD +
Other Agencies on Scene (Generic) ADD +
Level of Care per Protocol ALS - Paramedic
Exposure
Patient Belongings
bag of clothes
Patient Movement
Moved to Vehicle Via Stretcher
Position in Vehicle Semi-Fowlers
Moved From Vehicle Via Stretcher
Transport Assessment ADD +
Stretcher Purpose
Pt is going to MUSC for inpatient admission and surgical services not available at referring facility.
Forms Received/Delivered
Received
Delivered
Discharge Paperwork
Transfer Paperwork (PCS/Medical Necessity)
Factors Affecting Care
Dispatch Factors None
Response Factors None
Scene Factors None
Transport Factors None
Turn-Around Factors None
Set All Factors to 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.

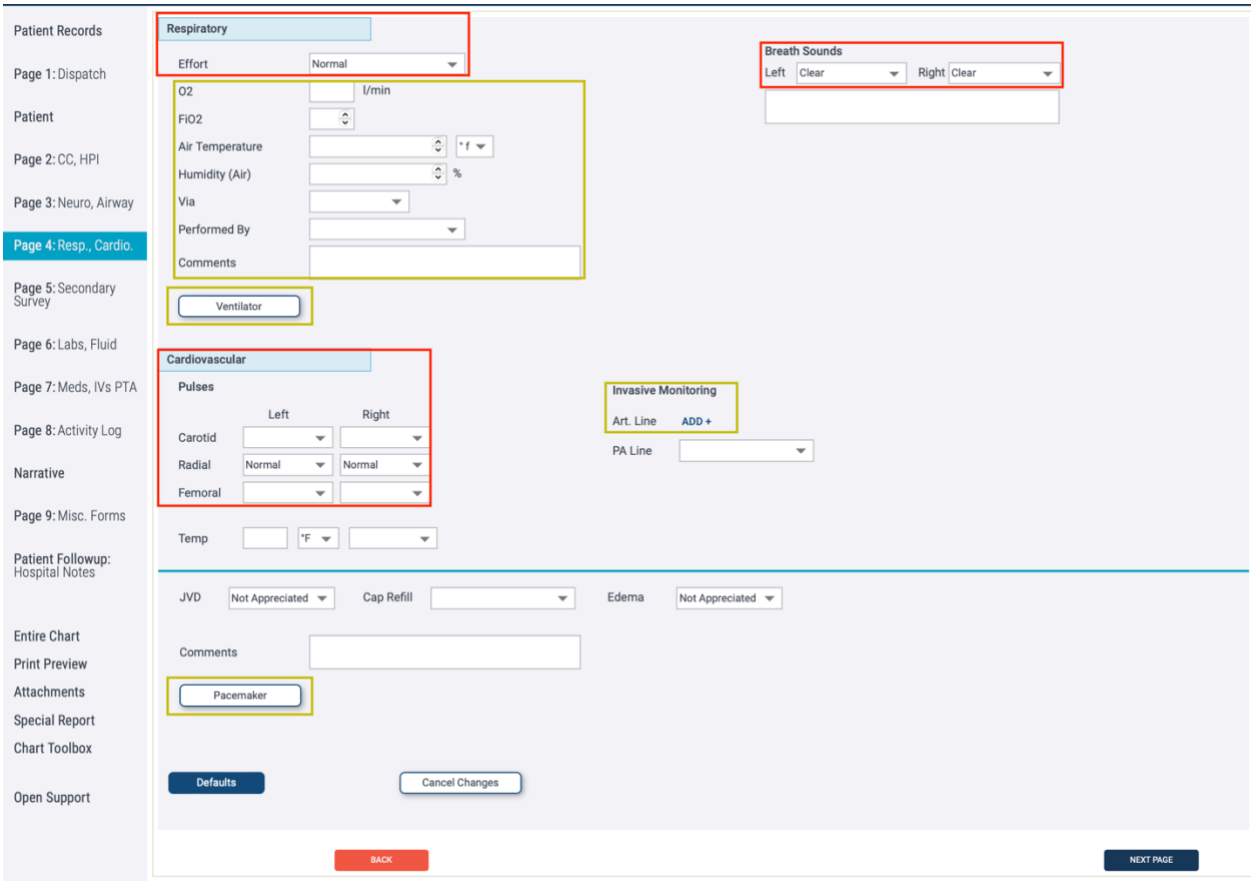


- When you are ready to go to the next page, click – next page.



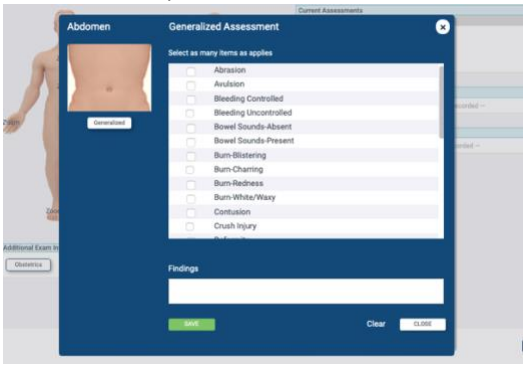
Page 4 – Resp, Cardio

- 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.

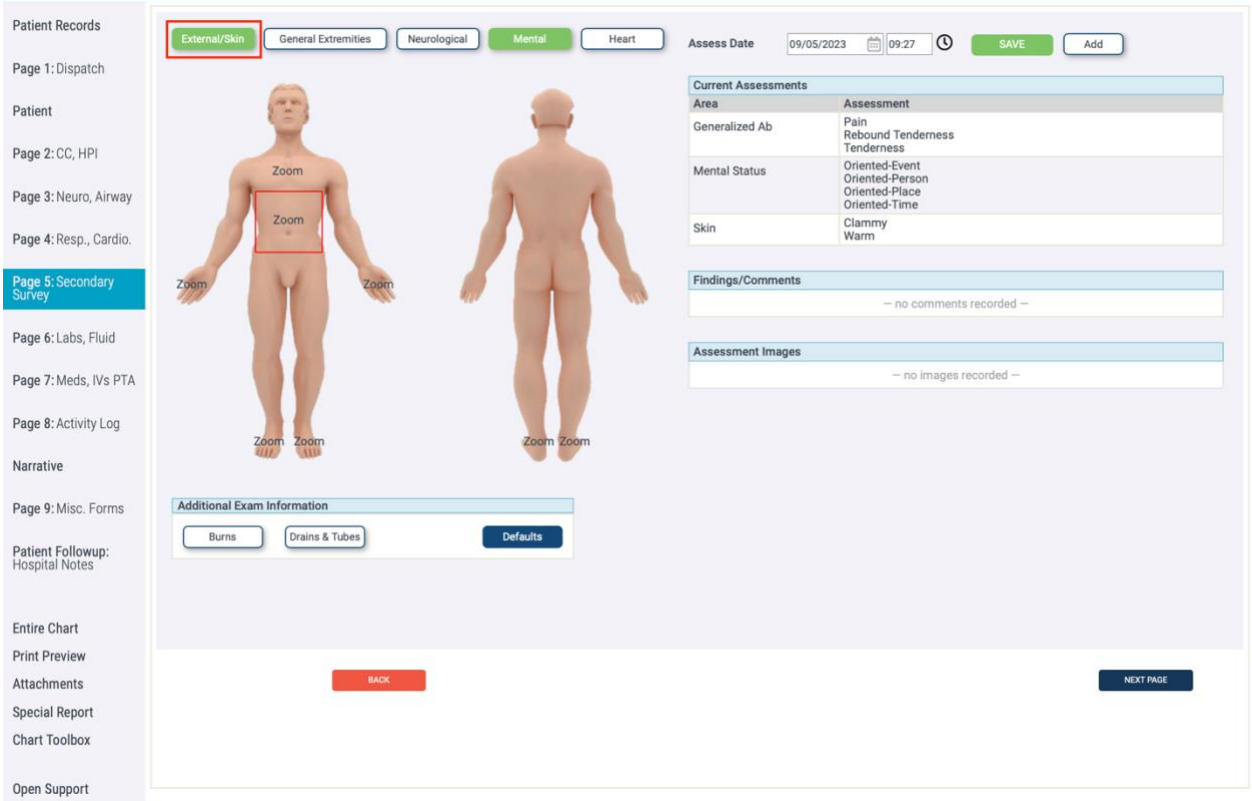


Page 5 – Secondary Survey

- 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.

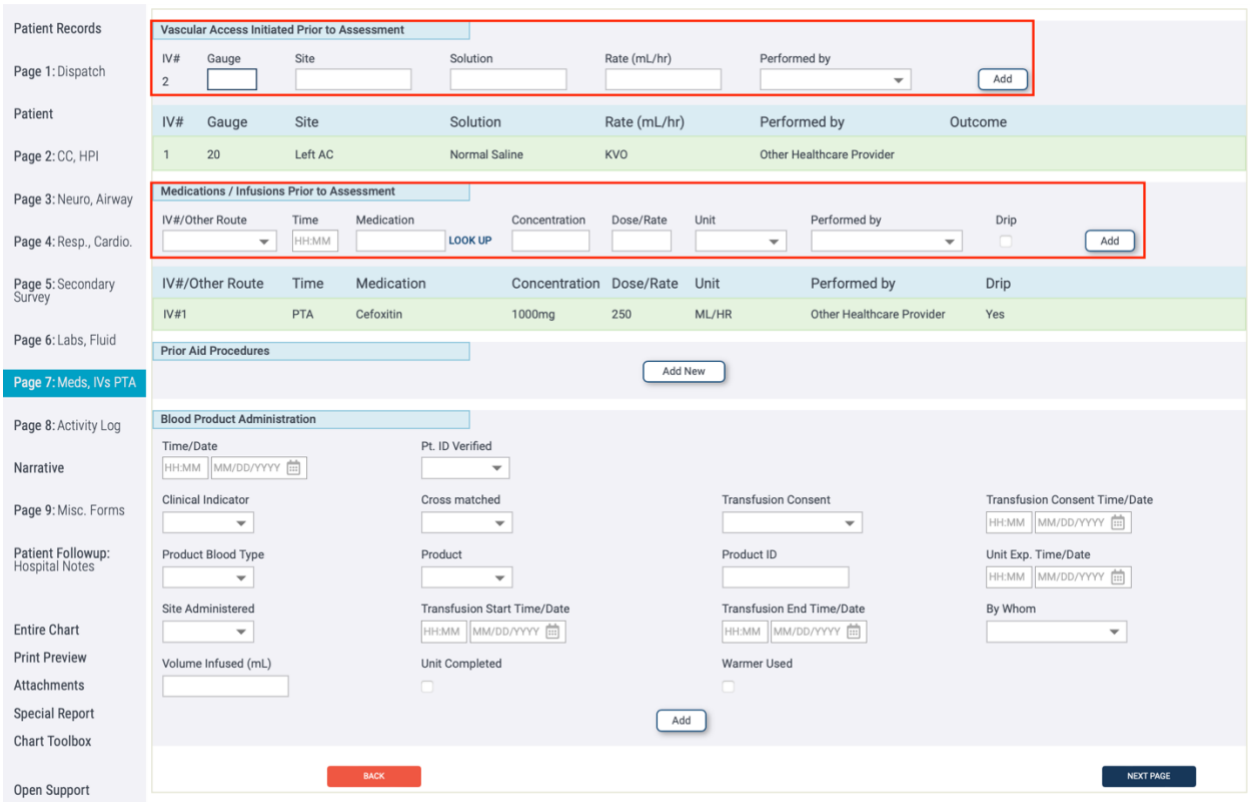


Page 6

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

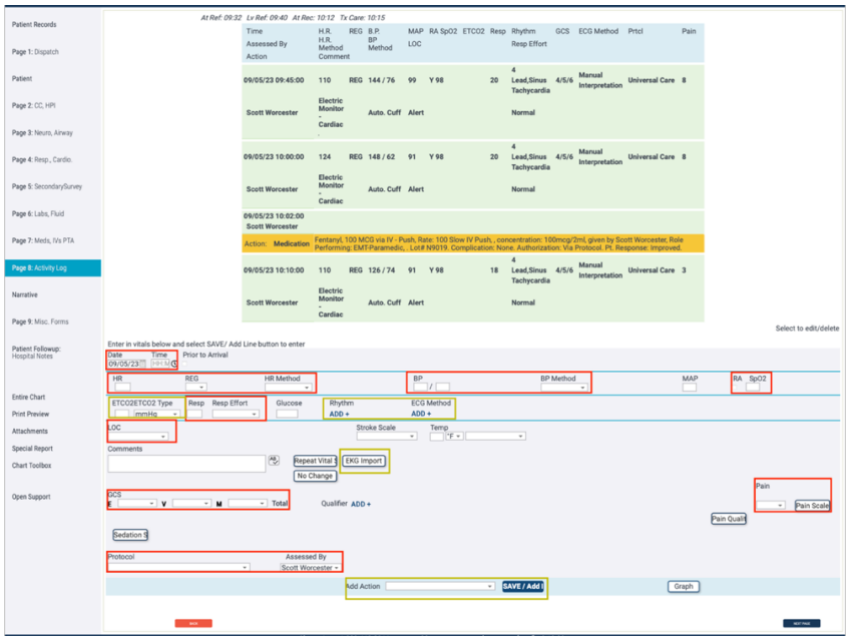
Page 7 – Meds, IV's PTA

- 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.



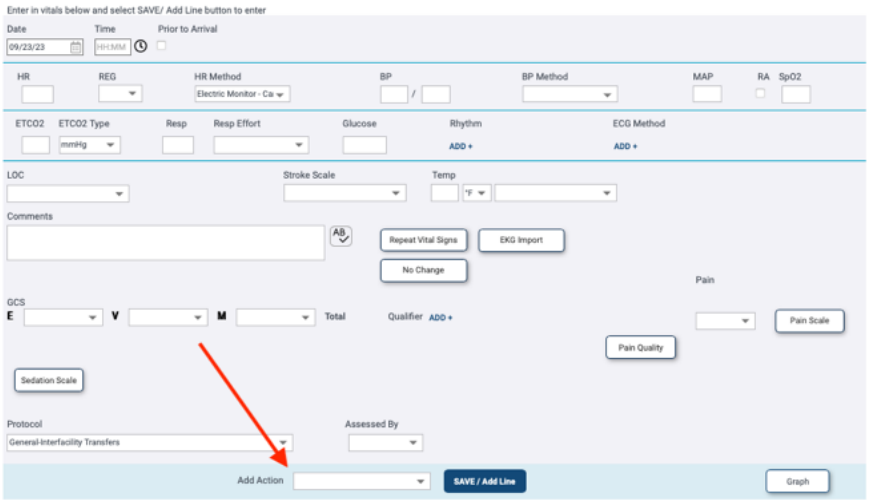
Page 8 – Activity Log – Vitals Section

- 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.

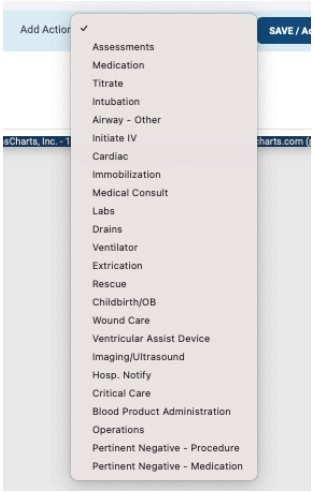


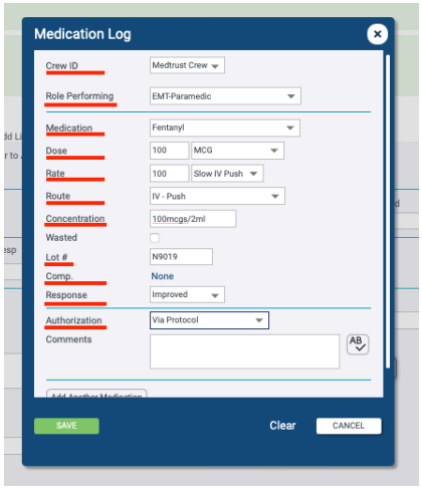
Page 8 – Activity Log – Add Action Section

- 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.



- 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.

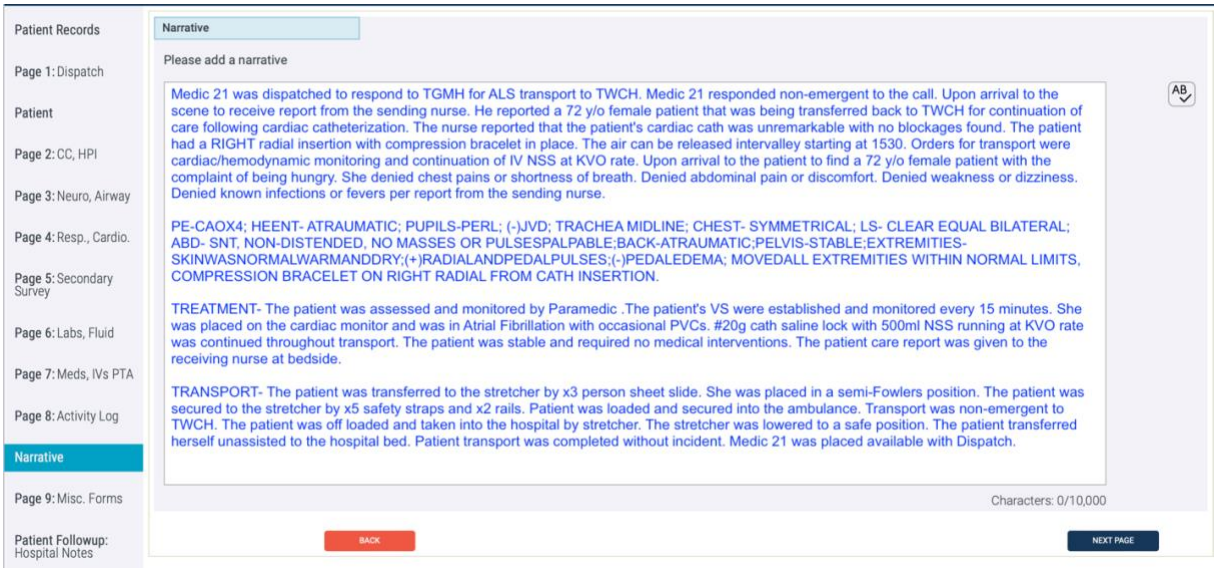




- Example, Fentanyl Administration, Select Medication from drop down menu and enter required fields. You must select “None” if there were no complications during administration. Simply leaving it blank is not permitted.

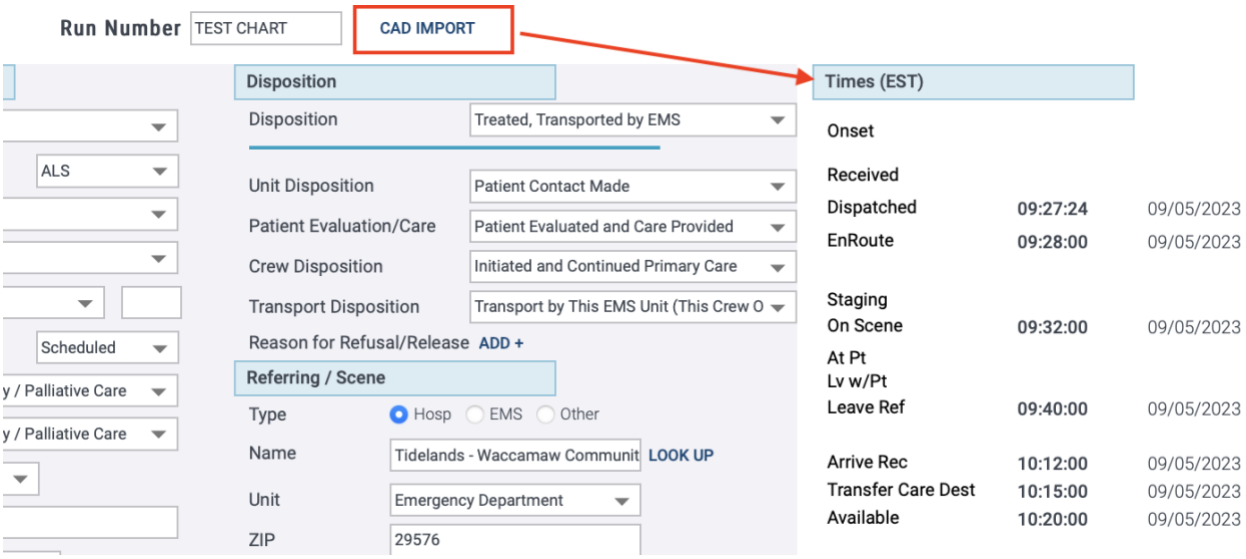
Narrative Section

- 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 import 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 <u>on its own</u> 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.
- <u>All patient contacts require a narrative section. That includes, refusals and wheelchair sub calls</u>.
- When you are ready to go to the next page, click – next page.

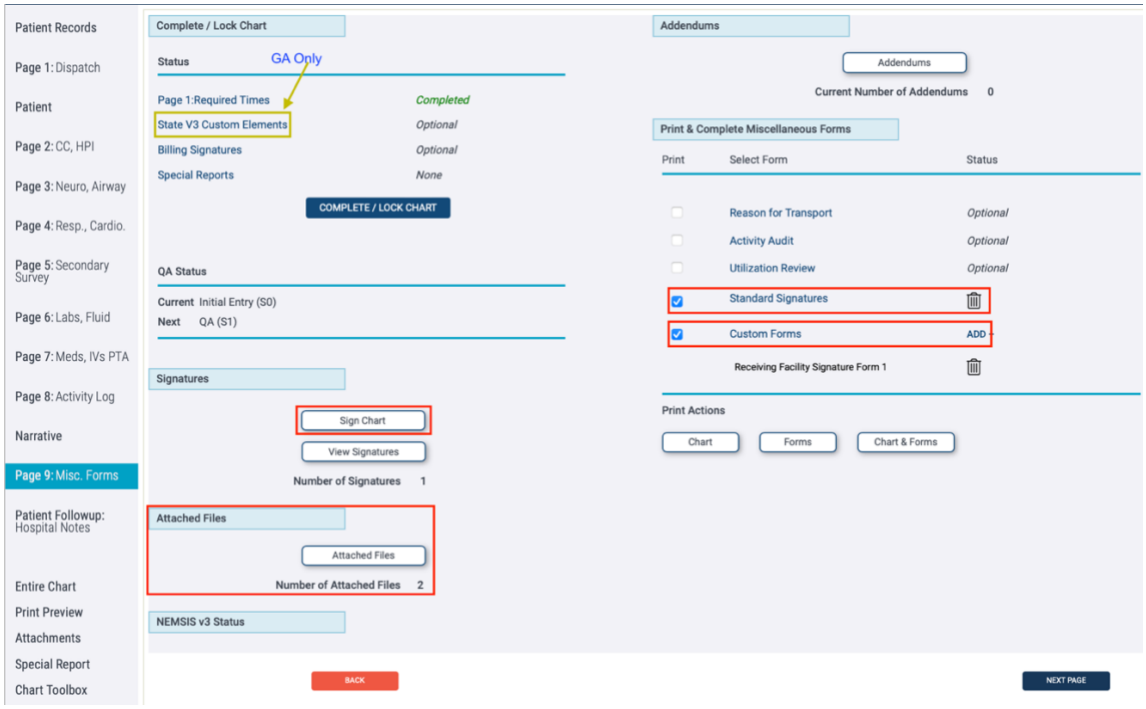


Page 9 – Misc Forms

- 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.

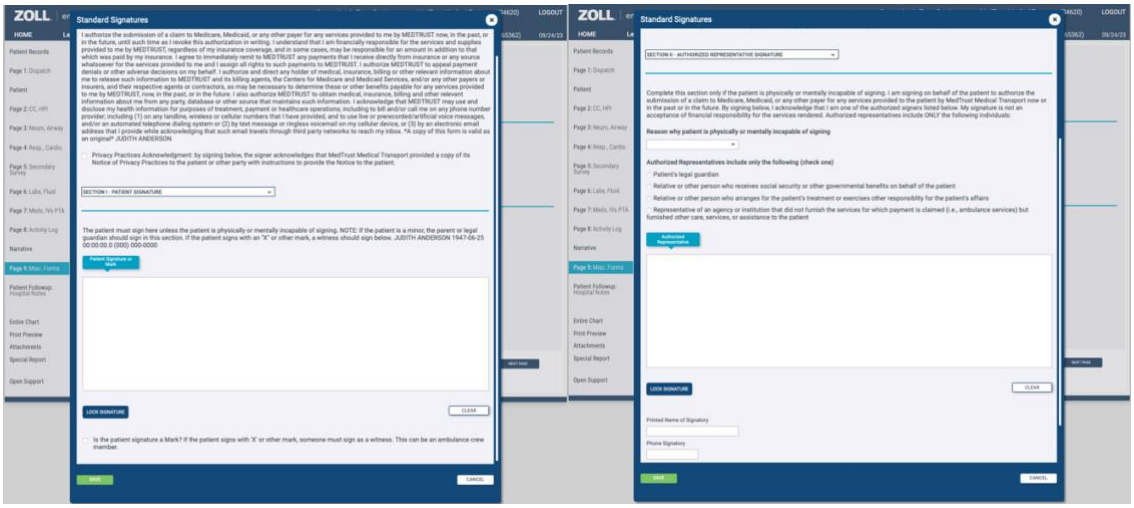


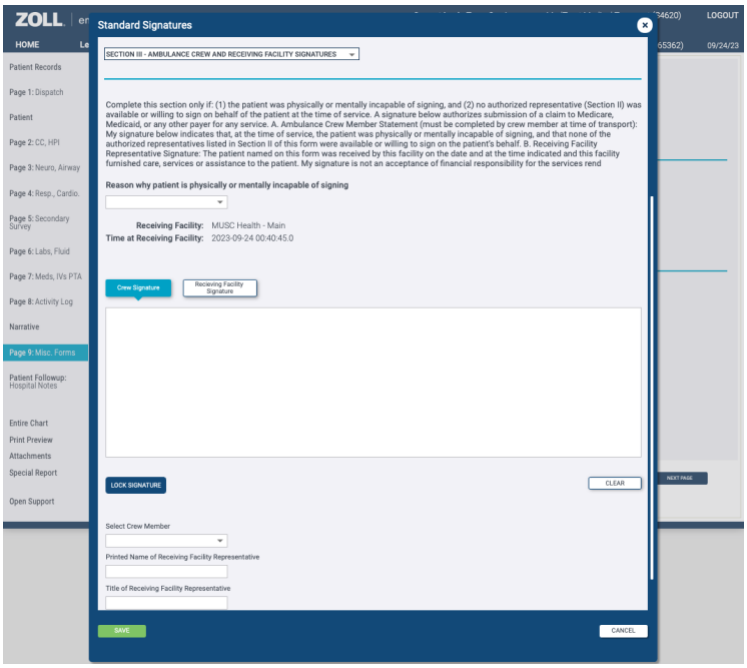
- Next, obtain a Standard Signature, a Receiving Facility Signature, and upload any documents from that call like a face sheet and PCS.



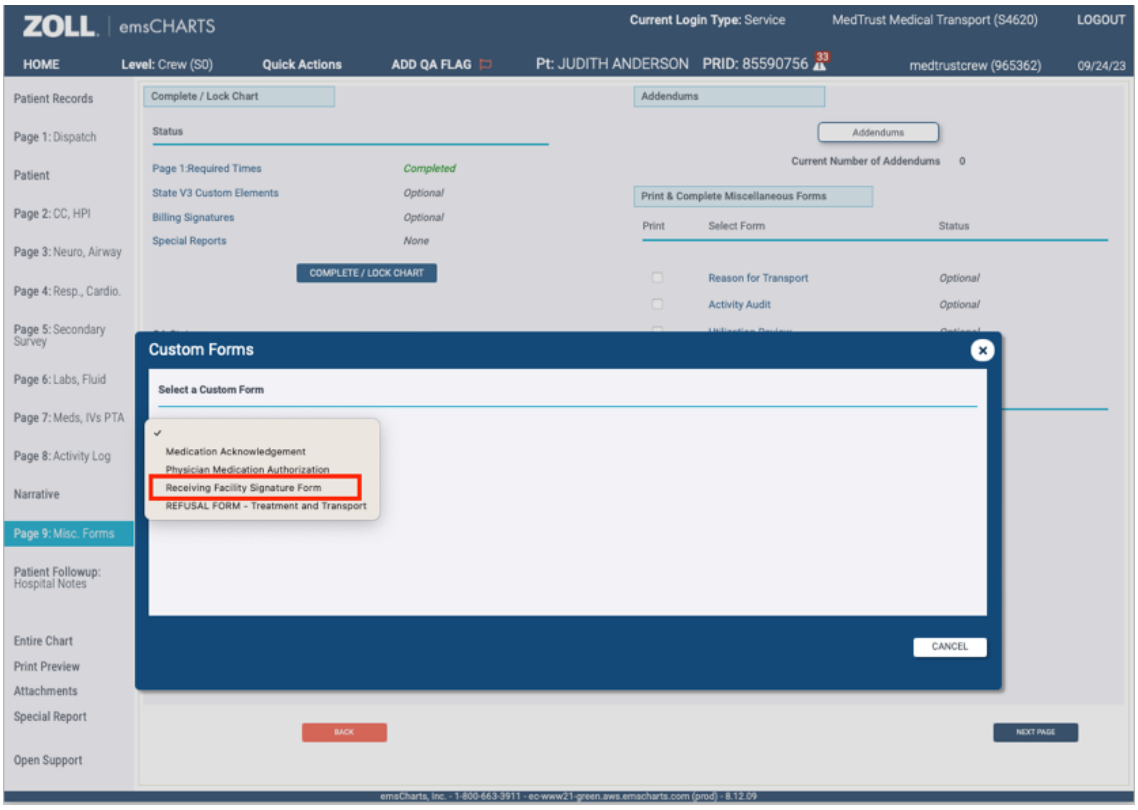
Page 9 – Signatures

- 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.



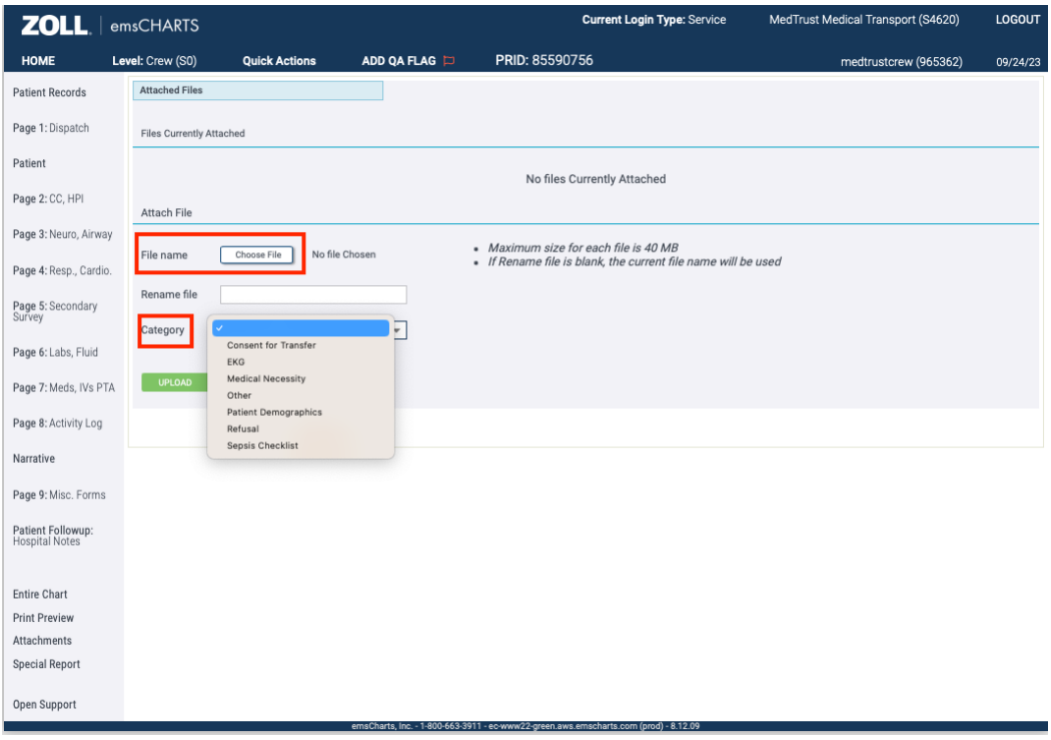


- Once you have obtained a Standard Signature you must click Lock Signature and then Save.
- To obtain a receiving facility signature accepting clinical responsibility of your patient: go to Custom Forms and then to Receiving Facility Signature Form.
- *Note* This is also where you will find the Patient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

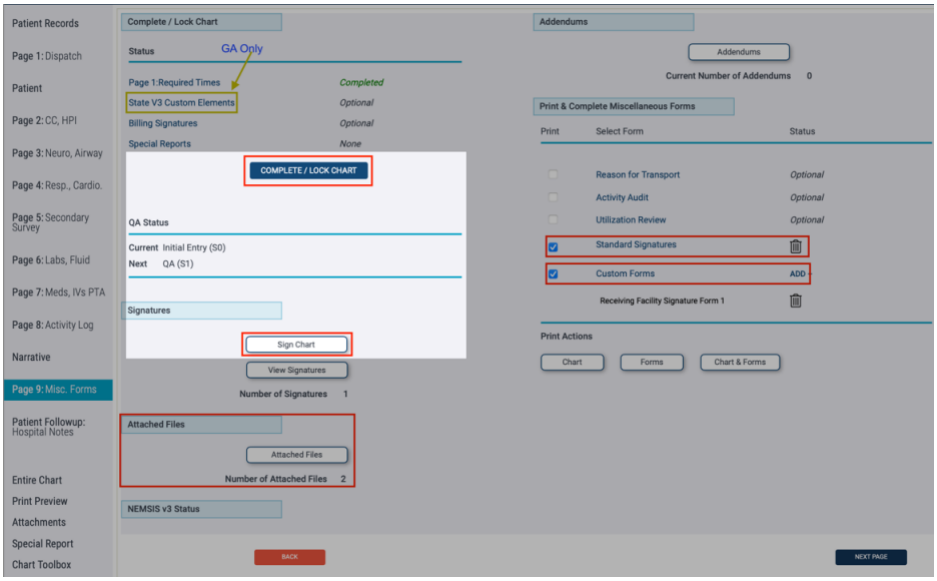


Page 9 – Attachments/Complete and Lock Chart

- 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.

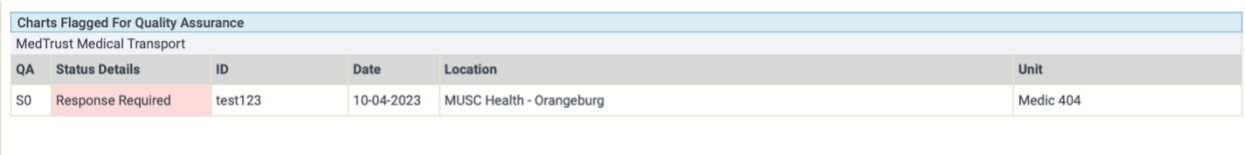


- The last step is to sign your chart and then “Complete/Lock” your chart.



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.

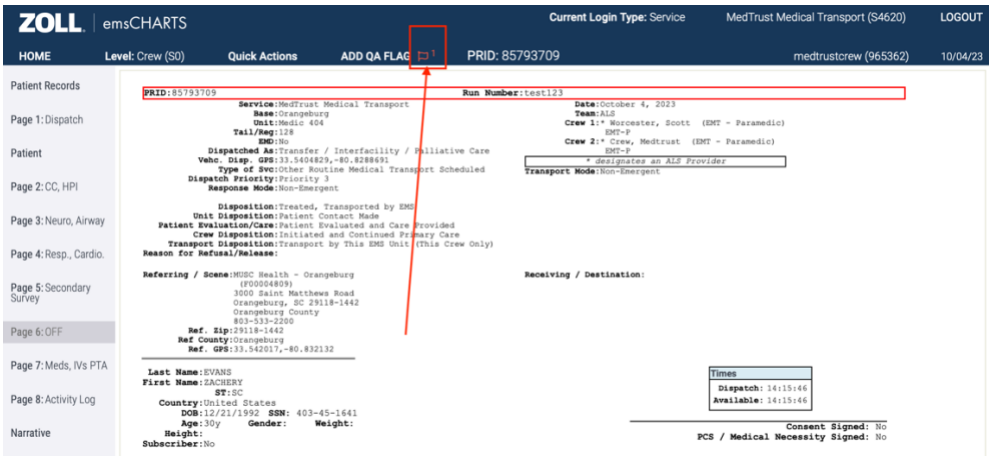


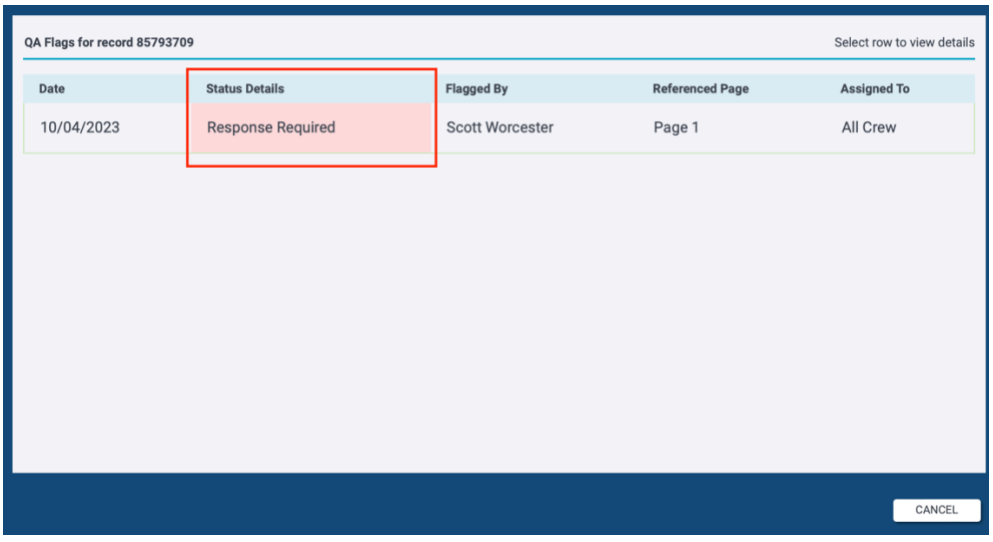
Charts Flagged For Quality Assurance

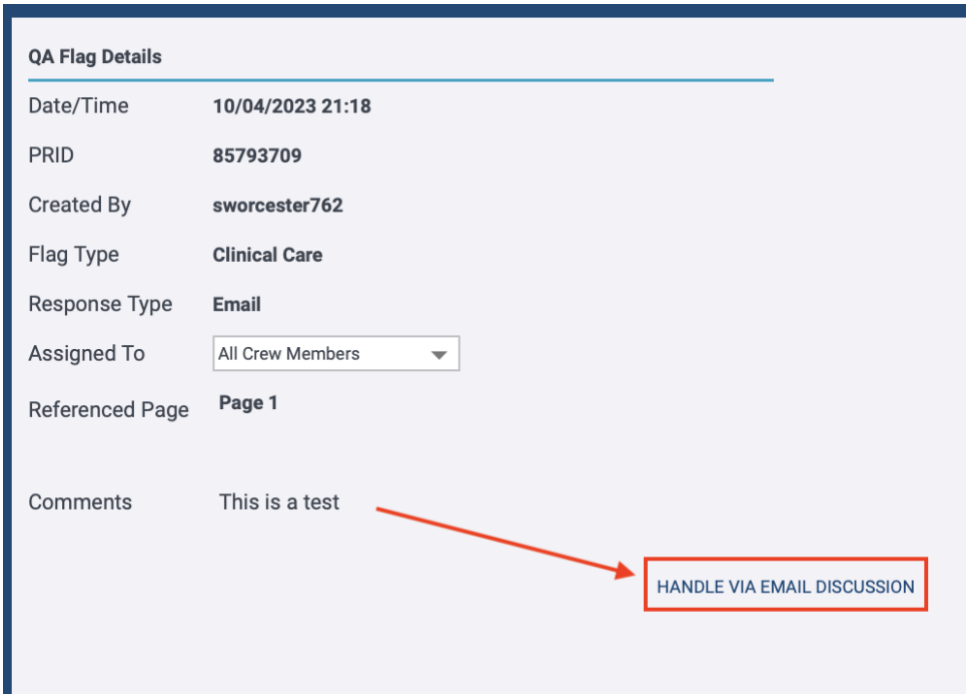
MedTrust Medical Transport

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:







Billing QA Flags and Addendums

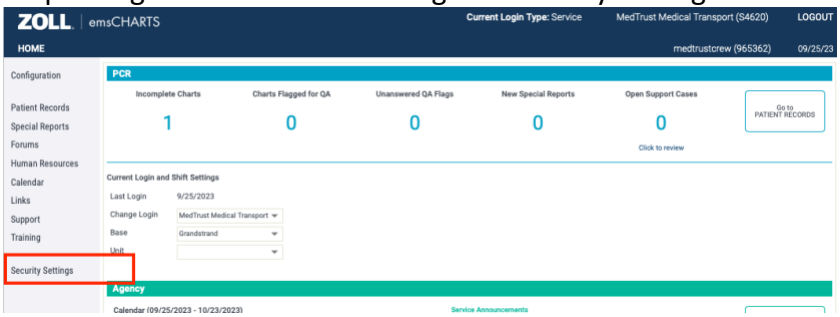
- Billing QA Flags will be requested solely via an addendum. An addendum is meant to supplement narratives about the patient's condition during transport.
- Role of MedTrust Billing Team is to review the chart non-clinically, focusing on accurate ambulance transport billing. They determine "Medical Necessity" 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.

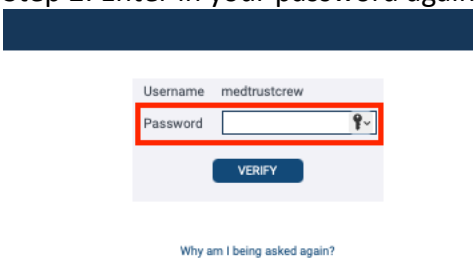
Charting Standardization Guide Supplements

How to change your email and pin in emsCHARTS

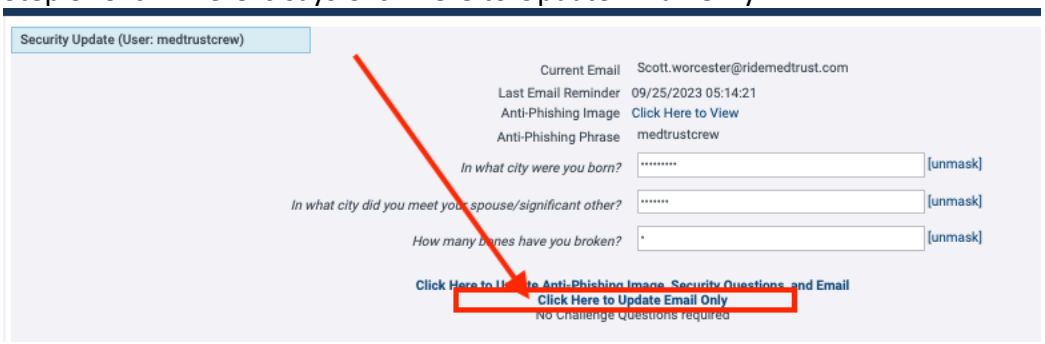
Step 1: Log into emsCHARTS and go to Security Settings on the bottom left.



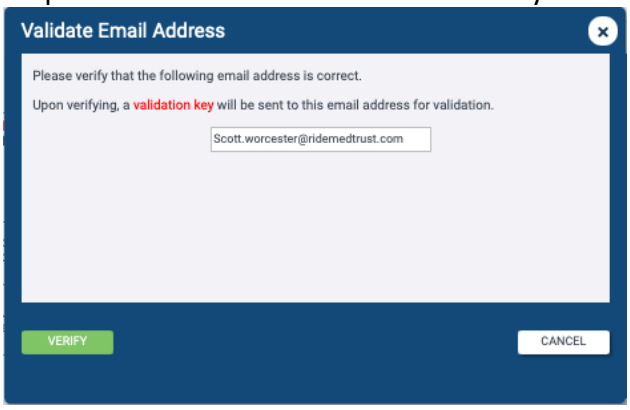
Step 2: Enter in your password again.



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, ETC02, 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.

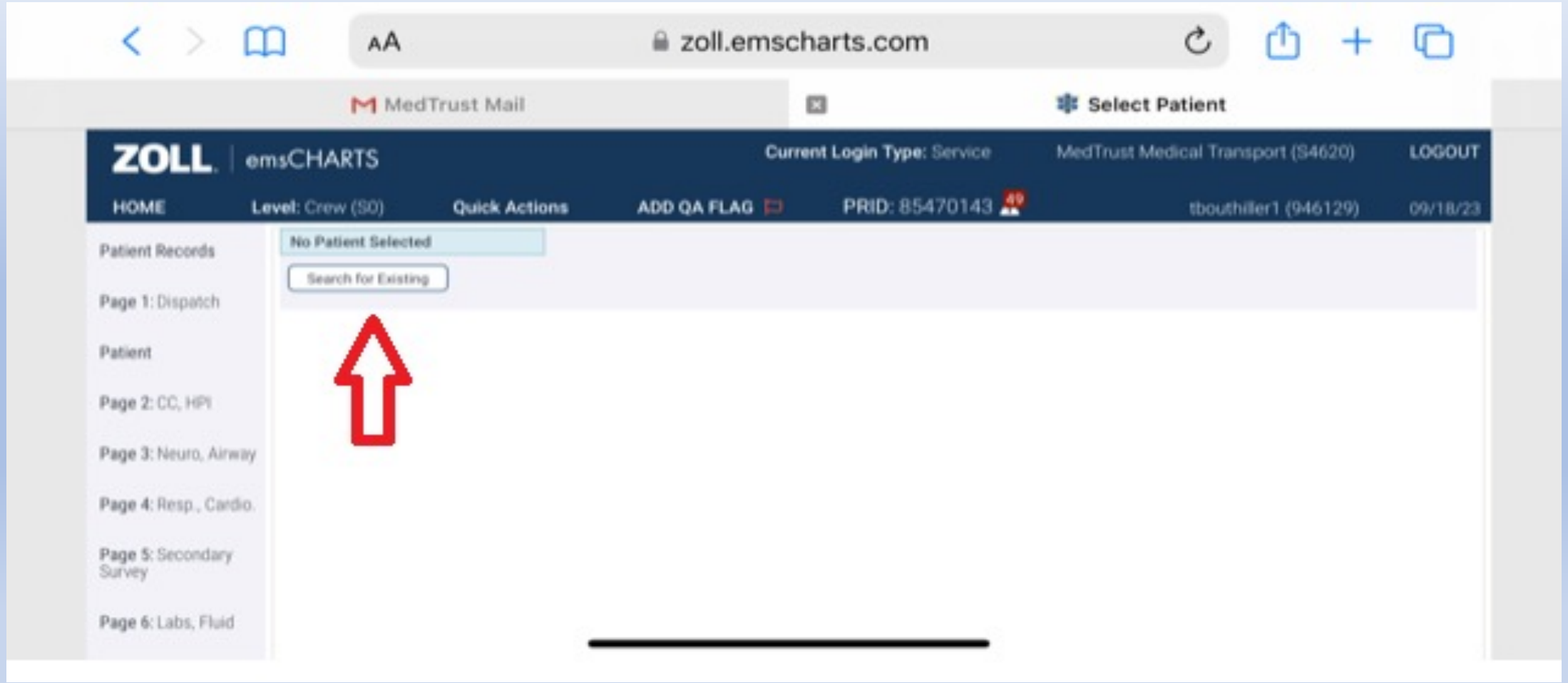
EMS Charts

How to add patient to chart

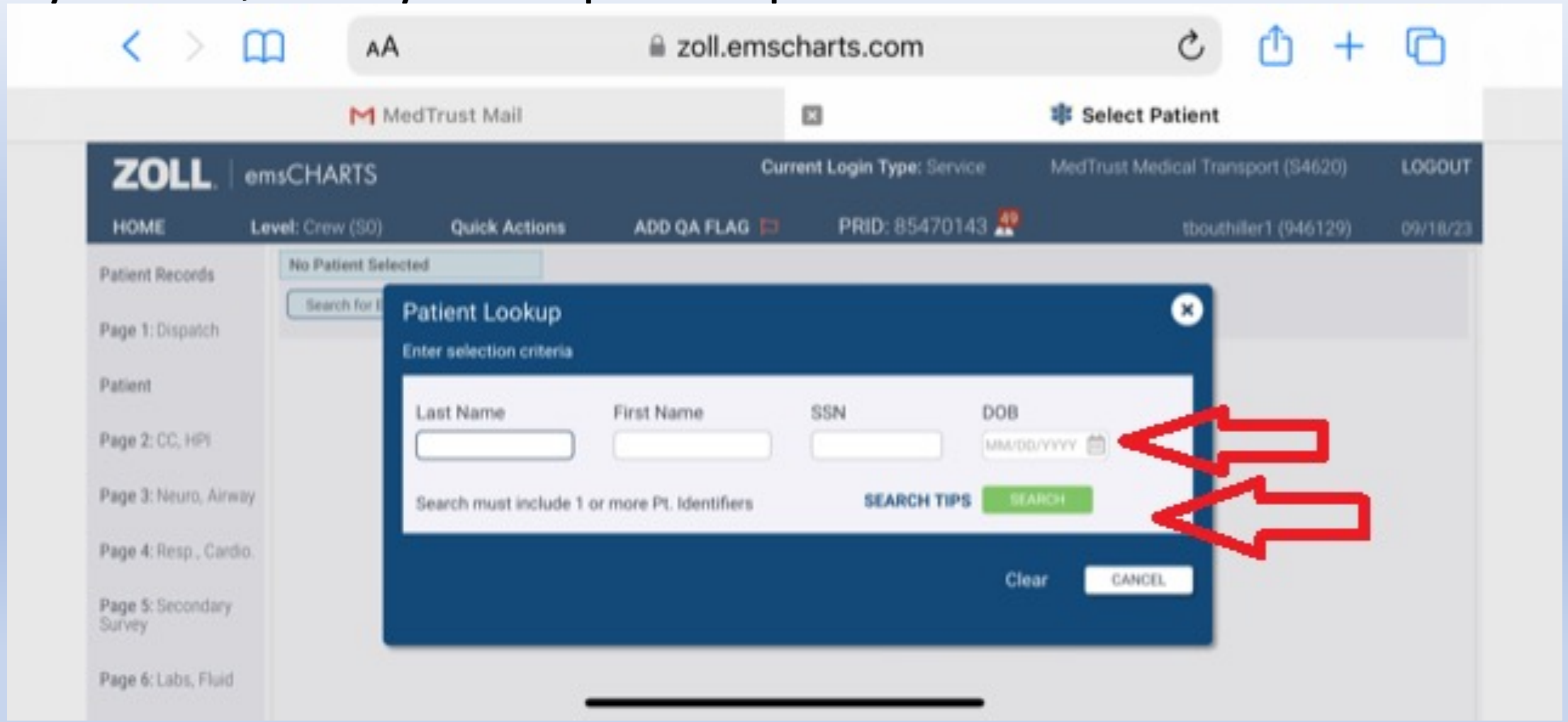
How to add a patient to you EPCR when dispatch had no patient information.

- 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.

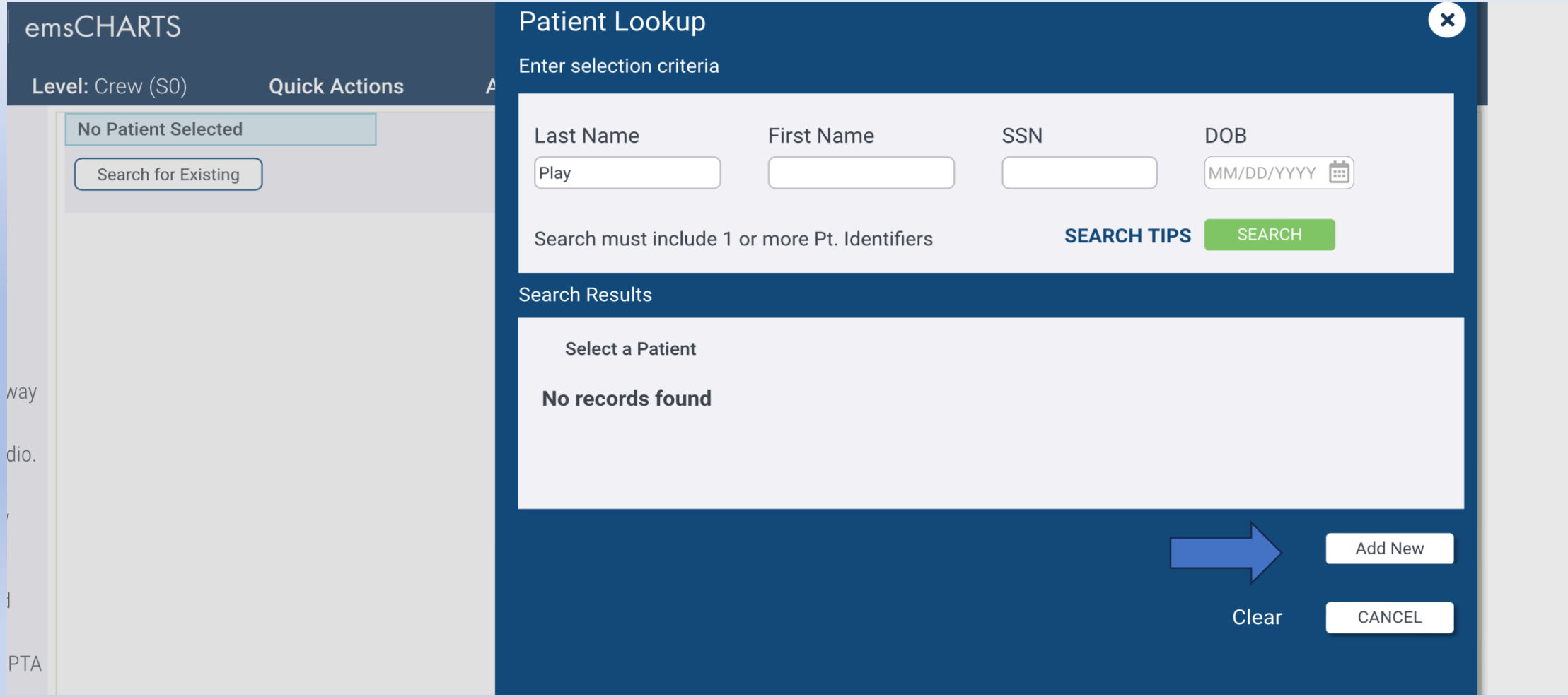
Start with search for patient.



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



Click on add new.



Fill out information and save.