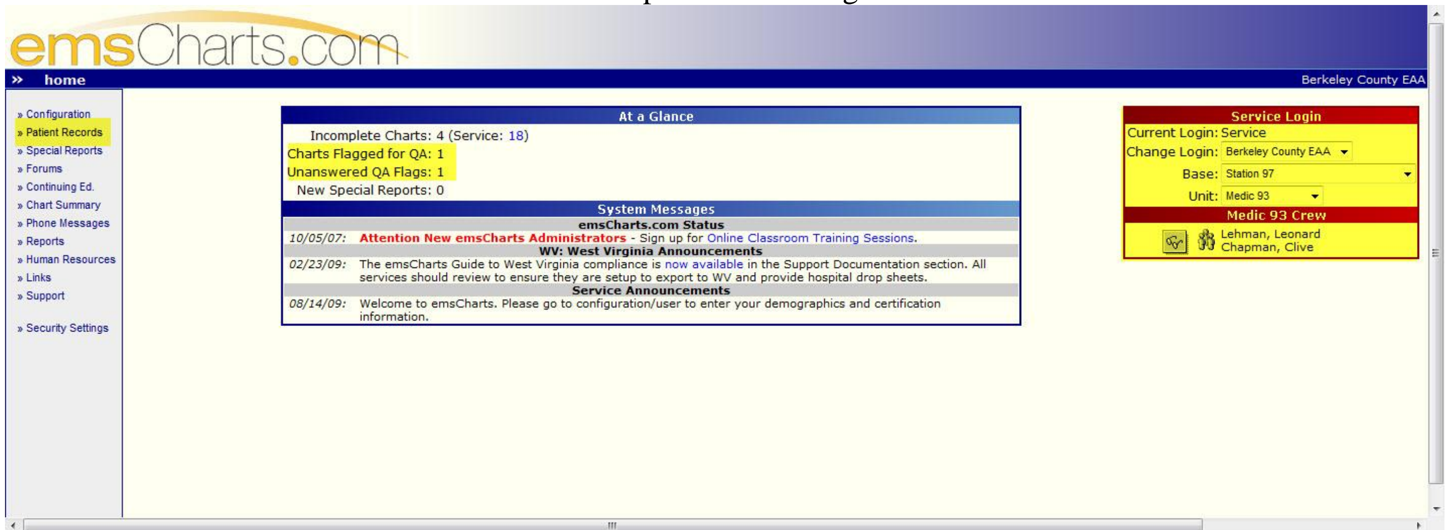
**BCEAA**
**Instructional Guide for EMS Charts Data Entry**

Go to web site: [www.emscharts.com](http://www.emscharts.com)
Login: first and last name, no caps, no spaces
Password: password you selected
Click Login Button

Example of Home Page




Go to the service login on the right

Enter the “base” (station) you are responding from.
Unit – Unit number of Ambulance you responded to call in.

Don’t do anything to “Medic 98 crew” box.

If you have any run sheets with Q/A flags on them you would click on these and correct them accordingly via the three methods that will be stated. Once completed, they will go to the Q/A supervisor.

Click “Patient Records” to advance Patient Records page.

Click on incomplete chart to finish a previously started chart.

Example of Patient Records Page

emsCharts.com

» home — Berkeley County EAA - ed

» Patient Records
» Search
» QA/RD Search
» MD Consults
» Procedure Logs
» Response Times
» QA Flag Search
» Export/Import
» F/U Letter Queue
» Patient Management

» Open Support

**Incomplete Charts**

Berkeley County EAA

| | Date | Location | Unit |
|---|---|---|---|
| 6721684 | 2009-10-21 | Unknown | Medic 98 |

Penn Care - Demo Service

| | Date | Location | Unit |
|---|---|---|---|
| 4989254 | 2009-03-05 | Pike County EMS | Medic 101 |
| 5612986 | 2009-06-01 | Jane Doe | Medic 101 |
| 5747696 | 2009-06-19 | Residence | Medic 101 |

**Service Incomplete Charts**

Berkeley County EAA

| | Date | Location | Unit |
|---|---|---|---|
| 6612252 | 2009-10-07 | Gertrude Glick | Ambulance 33 |
| 6619415 | 2009-10-08 | Berkeley County EMS | Ambulance 33 |
| 6628478 | 2009-10-09 | Applebys | Medic 98 |
| 6644567 | 2009-10-12 | john cober | Ambulance 33 |
| 6648571 | 2009-10-12 | Berkeley County EMS | Ambulance 33 |
| 6648701 | 2009-10-12 | Unknown | Ambulance 33 |
| 6648729 | 2009-10-12 | Unknown | Ambulance 33 |
| 6650334 | 2009-10-12 | *See Parent Chart: 6650280* | |
| 6650280 | 2009-10-12 | Berkeley County EMS | Ambulance 33 |
| 6650459 | 2009-10-12 | Berkeley County EMS | Ambulance 33 |
| 6661414 | 2009-10-14 | Unknown | Ambulance 33 |
| 6666602 | 2009-10-14 | Carrie Underwood | Medic 98 |
| 6674772 | 2009-10-15 | Unknown | Ambulance 692 |
| 6680411 | 2009-10-16 | dd donaldson | Ambulance 33 |
| 6722196 | 2009-10-21 | Jim Brown | Medic 95 |
| 6722162 | 2009-10-21 | 354 specks run rd. | Medic 95 |
| 6721457 | 2009-10-21 | Unknown | Medic 98 |
| 6721684 | 2009-10-21 | Unknown | Medic 98 |

**Create Chart**

Create blank chart

Click "Create blank chart" to create a new chart. The Dispatch screen will appear

**Example of Dispatch Screen**

Create TEST chart

Times (EST)

Patient Record ID: New Record Dispatch Number:

Received: 10/21/2009 13:28
Dispatched: 10/21/2009 13:28
Enroute: 10/21/2009 13:28
On Scene: 10/21/2009 13:28
Dep Ref: 10/21/2009 13:28
Arv Rec: 10/21/2009 13:28
Available: 10/21/2009 13:28

Edit Times

Odometer
At Ref: At Rec:
Mileage
Loaded:

General
Basesite: Station 98
Unit: Medic 98 ALS
Type of Svc.: Scene Unsched.
Category:
Dispatched As: Not Recorded
Outcome: Treated, Transported by EMS
Mass Casualty: Not Recorded

Crew Members
D Brown, Ed EMT Basic
P Scheuch, Karen EMT Paramedic
S
T
Other:

Referring
Type: Hosp EMS Other
Other Type:
Location:
Zip:
County:
Requester:
Mode: Lights / Sirens
Moved Via:
Position:

Receiving
Type: Hosp EMS Other
Name:
Unit: Emergency Department
Mode: No Lights/Sirens
Dest.Basis:
Moved From:
Condition:
Comment:

Patients
Click button below to add patient

Add Patient >>

***Some info is already entered for you; make sure it applies to your specific run, use drop down boxes to make any changes. The required fields to enter are hi-lighted on the Example of Dispatch Screen.**

**Dispatch Number:** The full CAD system number assigned by Berkeley dispatch, example: 0910-01234. You may cut and paste directly from the CAD page.

**General**
Base site: Station you are responding from.
Unit: Ambulance you responded to Call on and whether your crew is ALS or BLS.
Type of Svc: Select "Scene" and "Unsched." For all calls except those with another Agency. I.e. if you intercept a Morgan County, City of Martinsburg, or JCEAA unit then you will select 'Intercept' instead of 'Scene'.
Category: problem you were dispatched for
Dispatched as: same as the "category" NOTE: we know this is a repeat but both fields are required by PREMIS.
Outcome: "treated and transported", "refused services", "DOA", etc.
Mass Casualty: Yes or No

**Crew Members**
D – Driver
P – Primary attendant
S – Secondary attendant
T – Tertiary attendant
Other – student, third person, etc.

**Referring (Scene)**

**Type**: Should always be defaulted to “other”
**Other Type**: may be called to Residence, Dr’s office, nursing home, Farm, etc.
**Location:** Enter address of scene location. Name field is used for business name i.e. Wal-Mart - **(This is not the Patient’s Name)**
**Requester**: who called 911 – i.e. Bystander, Patient, Law Enforcement, or 3rd Party Caller
**Mode**: How you responded, which may be lights/sirens most of the time.
**Moved Via**: How you moved your patient
**Position**: How you positioned them for transport.

**Receiving (Facility)**
**Type**: Will always be hospital
**Name**: Which hospital – select from drop down list
**Unit:** Which department in the hospital you took PT too, will be emergency department most of the time, could be OB.
**Mode**: Your response mode to the hospital – normally no lights, no sirens
**Dest. Basis**: Pt. choice, closest facility, etc.
**Moved From**: How you moved your patient at the facility.
**Condition**: What the status of your patient was when you reached the hospital.

**Times**
*Click on edit times and you must fill in all blanks from “received through available” changing the time accordingly using military time format.

**Odometer**
**At ref:** Mileage at scene
**At Rec:** Mileage at Hospital
Place mileage at scene and at hospital, the system will calculate loaded mileage.

**To add a Patient**

Click ‘Add Patient >>’ button to add patient.
Click on ‘Search for Existing Patient’ button.

**Enter selection criteria - Patient:**
Last Name: First Name: SSN: DOB: Search

If patient exists, click on Patient's name to add patient to your chart.

If patient doesn't exist, click 'Add New Patient' button.

Note: You must search to see if the patient exists in the system before adding them as a new patient. If your patient is a "frequent flyer" you can locate them and just click and add them to your chart. All previous patient info will be displayed and you can verify or update any new patient information.

Items hi-lighted in yellow on the 'Patient Information' page are all required for billing. If you have a 'minor' patient, use the "relationship/guarantor" box to enter Parent/Legal Guardian information. If patient is an emancipated minor and they will need documentation for same, then place in this box "emancipated" for the name of the relationship/guarantor.

Click 'Next >>' to advance to Chief Complaint/HPI page

## Page 2 - Chief Complaint/History Page

**All required fields are hi-lighted in yellow.**

**System**: Use drop down box to select Body system(s).
**Symptoms**: Use drop down box to select Symptom(s).
**Impression**: Use drop down box to select your Impression(s).
**Anatomic Location**: Use drop down box to select Specific location(s) affected.

**Note: Chief complaint, Secondary complaint, History of Present Illness, Scene Description, And Patient Belongings are all free text field that you can type information. The ABC box beside these will spell check your text. Chief complaint limited to 50 characters or less.**

**Chief complaint and History of Present Illness are required**. You must place pertinent information in these from your assessment. Use the **OPQRST mnemonic** when writing your History of Present Illness, which will provide consistency among our providers and hopefully prohibit missed information. Although, the electronic form generates a pretty detailed run report you must provide this information.

**Factors Affecting Care**: Response, scene and transportation factors need completed if applicable.

**Reason for Encounter**: Injury or Non-Injury
**Drugs/Alcohol**: Enter if applicable, but if you enter these fields you must put in the **Indicators** for them, meaning how you came to this conclusion, be careful unless you document in a narrative "patient states" you can't assume someone is under the influence by smell or behavior. You can suspect and treat accordingly.

Click 'Next Page>>' to advance to Neuro and Airway Page

**Page 3 - Neuro and Airway**

Neuro
Level of Consciousness: Alert
Orientation: Oriented
Pupils Left Right
Size:
React:
Neuro Exam:
Neurologic Deficit:
Comments:
Motor Sensory
LA:
RA:
LL:
RL:
Patient chemically paralyzed: No
Loss of Consciousness: No
Was Pt. Immobilized: No
Initial Glasgow Coma Score
Eye Opening Spontaneous Verbal Oriented Motor Obeys Command TOTAL: 15
Airway
Status: Patent
Secured Via: Tube Size: mm Depth: cm
Comments:
Performed By: Outcome:
Defaults Cancel Changes << Back Next Page >>

Hi-Lighted fields are required and are defaulted with normal values. You will need to change these accordingly based on your assessment findings.

**Level of Consciousness**: AVPU Scale
**Orientation**: Alert, Disoriented, Confused
**Neuro Exam:** Check all that apply
**Neurologic Deficit:** Check all that apply based on your assessment
**Comments:** Enter any pertinent comments on Patient’s Neurologic assessment findings
**Pupils:** Enter Pupil Size and Pupil Reactivity for each eye.
**Motor/Sensory:** Enter assessment findings for each extremity. Select Not Assessed if no assessment was performed.
**Initial Glasgow Coma Score**: Enter patients GCS
**Status of Airway**: Status of Patient’s airway upon initial contact with patient

Click ‘Next >>’ to advance to Respiratory/Cardiovascular Page

**Page 4 - Respiratory/Cardiovascular**

RESPIRATORY

Effort: Breath Sounds: L: R:

O2: l/min Via: Performed By: Outcome:

Comments:

CARDIOVASCULAR

| Pulses | Left | Right |
|---|---|---|
| Carotid: | | |
| Radial: | | |
| Brachial: | | |
| Femoral: | | |
| Dorsalis: | | |

Temp: °C

JVD: Cap Refill: Edema:

Comments: Pacemaker

Defaults Cancel Changes << Back Next Page >>

Hi-Lighted fields are required. Fill in fields with your initial assessment findings of the patients Respiratory and Cardiovascular systems. If patient on O2 prior to EMS arrival, please note here. All EMS interventions should be noted on Page 8 – Activity Log.

**Effort:** Indicate respiratory effort.
**Breath Sounds:** Indicate assessments findings for each lung.
**O2:** rate in LPM
**Via:** route administered
**Performed By:** Person who performed action (prior to EMS arrival)
**Outcome:** Select from drop down box
**Comments:** Note any comments pertinent to patients respiratory status

**Cardiovascular**:

**Pulses:** Note Pulse location and quality assessed
**Temp:** Note temp and route taken
**JVD:** "not appreciated" medical terminology for assessed and none noted.
**Cap Refill:** Note Cap Refill if assessed.
**Edema**: "not appreciated" medical terminology for assessed and none noted.
**Comments:** Note any pertinent comments on cardiovascular assessment findings

Click 'Next >>' to advance to Secondary Survey Page

## Page 5 - Secondary Survey

External/Skin
Unspecified

**Current Injuries**

| Area | Injury |
| --- | --- |
| | *-- no injuries recorded --* |

**Current Assessments**

| Area | Assessment |
| --- | --- |
| | *-- no assessments recorded --* |

**General Comments**

*-- no comments recorded --*

Assess Date: 10/21/2009 13:28 Save

**Additional Exam Information**

Obstetrics Burns Drains & Tubes

Defaults

<< Back Next Page >>

*Click on body area and drop down boxes will appear for you to check appropriate assessments and make comments.

**External/Skin:** Enter Skin Assessment findings
**Obstetrics:** Enter pertinent findings if applicable
**Burns:** Enter pertinent findings if applicable
**Drains & Tubes:** Normally not used. Use only if patient has drain/chest tube/Foley in place prior to your arrival

Click 'Next >>' to advance to Activity Page

## Page 8 – Activity Log

At Ref: 13:28 Lv Ref: 13:28 At Rec: 13:28

Time | H.R. | B.P. | SaO2 | EtCO2 | Resp | Rhythm

Action | Comment

Date | Time | HR | BP | SaO2 | EtCO2 | RESP | Resp Effort | Rhythm

10/21/09

Glu | Temp

°C

Comments:

Repeat Vital Signs

No Change

GCS: E: V: M: Pain:

Protocol: Assessed By:

SAVE / Add Line And Action:

Notes:
Place the mouse over the vitals and click to edit/delete.
Place the mouse over the 'action' name and click to edit/delete

Next Page >> Graph

***All EMS interventions are entered here!** Indicate vital signs ( all vitals including glucometer checks, pulse oximetry, IV's, Medications, heart rhythms, Spinal Immobilizations, Intubations, placed oxygen on your patient, etc. )

***Make sure you list all EMS Interventions on this page because billing needs this info on this specific page!!**

### Example of Entering Patient Vital Signs

At Ref: 08:52 Lv Ref: 08:52 At Rec: 08:52

Time | H.R. | B.P. | SaO2 | EtCO2 | Resp | Rhythm

Action | Comment

Date | Time | HR | BP | SaO2 | EtCO2 | RESP | Resp Effort | Rhythm

10/26/09 | 08:52 | 80 | 120 / 80 | 98 | | 14 | Normal | Normal Sinus Rhythm | REG

Glu | Temp

128 | °C

Comments:

Repeat Vital Signs

No Change

GCS: E: 4:Spontaneous V: 5:Oriented M: 6:Obeys Command Pain: 0

Protocol: Abdominal Pain Assessed By: Ed Brown

SAVE / Add Line And Action:

Notes:
Place the mouse over the vitals and click to edit/delete.
Place the mouse over the 'action' name and click to edit/delete

Next Page >> Graph

**Date:** Date vital signs were assessed
**Time:** Time vital signs were assessed
**HR:** Patient's Heart Rate
**BP:** Patient's Blood Pressure
**SaO2:** Patient's Pulse Oximetry reading

**Resp:** Patient’s Respiratory Rate
**GCS:** Patient’s Glasgow Coma Score
**Glu:** Patient’s blood glucose level
**Comments:** Enter any comments necessary pertaining to vital signs
**Protocol:** Enter protocol that you are following from drop down list
**Assessed by:** Select crew member from drop down list

Once all vital signs are entered, click 'SAVE/Add Line' button to add vitals.

To add a line for your IV or Meds, simply put in your time next to your vital signs, go to “And Action” drop down the box, chose your procedure, then click “Save/Add Line”. Complete the info in the box that appears.

If you have entered a procedure or vital sign and you realize you entered a wrong value, simply follow the directions on the bottom of the page to edit what you did. As you will note, your times at the Ref(scene), Lv Ref(left scene) and at Rec(at the hospital) are all at the top of your page to help you figure out when you did the action.

## Example of Entering Oxygen Administration as a Medication

Enter a time and select Medication from the 'and Action' drop down list. Then click the ‘Save/Add Line’ button. The appropriate data entry window will appear and you can enter the info required.

10-26-09 Medication Log
Crew ID#
Ed Brown
Medication | Dose | Route
Oxygen | 15 LPM | Non Re-breather Mask
Comp: Response: Improved Lot #
Authorization
Via Protocol
Comments
Submit Information

Note: Oxygen is considered a medication and is documented under Medications

**Crew ID#:** Enter the crew member who administered the Oxygen
**Medication:** Select Oxygen from the drop down lists
**Dose:** Enter Flow Rate and select LPM from drop down list.
**Route:** Select route from drop down list (i.e. Non Re-Breather Mask or Nasal Prongs)
**Authorization:** select ‘Via Protocol’ from drop down list
Comments: Enter any pertinent comments concerning oxygen administration

Then click ‘Submit Information’ button to submit

**Note:** Use of Bag Valve Mask, Suction, Oral and Nasal Airways can be documented under Airway-Other

**Note:** 12-Lead EKG, Cardioversion, Defibrillation, Pacing and CPR can be documented under Cardiac

## Example of Entering a Medication

Enter a time and select Medication from the 'and Action' drop down list. Then click the ‘Save/Add Line’ button. The appropriate data entry window will appear and you can enter the info required.

10-28-09 Medication Log
Crew ID#
Thomas E Gorman
Medication | Dose | Route
Epinephrine 1:10,000 | 1 MG | IV - Push
Comp: Response: Unchanged Lot #
Authorization
Via Protocol
Comments
Submit Information

**Crew ID#:** Enter the crew member who administered the medication
**Medication:** Select the medication given from the medication drop down list

**Dose:** Enter dosage rate and select units from the drop down list.
**Route:** Select the route the medication was administered from drop down list (i.e. IV-Push)
**Authorization:** select 'Via Protocol' from drop down list
**Comments:** Enter any pertinent comments concerning the medication administration

Then click 'Submit Information' button to submit

## Example of Entering an Intubation

Enter a time and select Intubation from the 'and Action' drop down list. Then click the 'Save/Add Line' button. The appropriate data entry window will appear and you can enter the info required.

10-28-09 Intubation Log
Crew ID# | Successful | Attempts
Yes | 1
Size | CM at Lips | Method
Orotracheal
Verification | Comments
Auscultation
Capnography
Chest Rise
Direct Visualization
Esophageal Detection
ETCO2 Detector (Eas
Mallampati | Sellick Man. | Laryngoscopic Grade
Stylet Used | Cuff Fill/Qty. | Larynogoscope Blade
Complication | Response
Authorization
Submit Information

**Crew ID#:** Enter the crew member who performed the intubation
**Successful:** Yes or No
**Attempt:** Number of Attempts
**Size:** Size of tube
**CM at Lips:** Note CM at lips
**Method:** Orotracheal, CombiTube, King Airway
**Verification:** Verification of tube placement performed
**Comments:** Enter any pertinent comments about the intubation
**Authorization:** Enter Authorization

Then click 'Submit Information' button to submit

## Example of Entering a Spinal Immobilization

Enter a time and select Immobilization from the 'and Action' drop down list. Then click the 'Save/Add Line' button. The appropriate data entry window will appear and you can enter the info required.

10-28-09 Immobilization Log
Crew ID# Option
Thomas E Gorman Applied
Devices Used
Long Board
Pediatric Immob Device
Cervical Immobilization Device
Traction Splint
Cervical Collar
Splint
KED
MAST - Applied
Short Board
MAST - Inflated
Manual C-Spine Stabilzation
Physical Restraints
Complication Response Authorization
Via Protocol
Assessment Site
Comments
Good PMS X 4 prior to and after immobilization
Submit Information

**Crew ID#:** Enter crew member who performed immobilization
**Option:** Applied
**Devices Used:** Check the devices used – Note: Cervical Immobilization Device = Head Blocks
**Authorization:** Via Protocol
**Assessment:** Note assessment
**Site:** Note extremities checked for PMS
**Comments:** Enter pertinent comments

## Page 9 – Misc Forms

**Note:** On this page, you will attach the Run Sheet, Hospital Face Sheet, Signature Form, and Rhythm Strips plus any other documents pertaining to the patient record

**To Attach Files**: Click the 'Attached Files' button to upload the scanned files.

**Signatures**: Only the person that entered the run report will need to electronically sign the form by clicking the 'Sign Chart' button. There will be a place to enter your password and your Social Security number. The system will check to see if you are a provider.

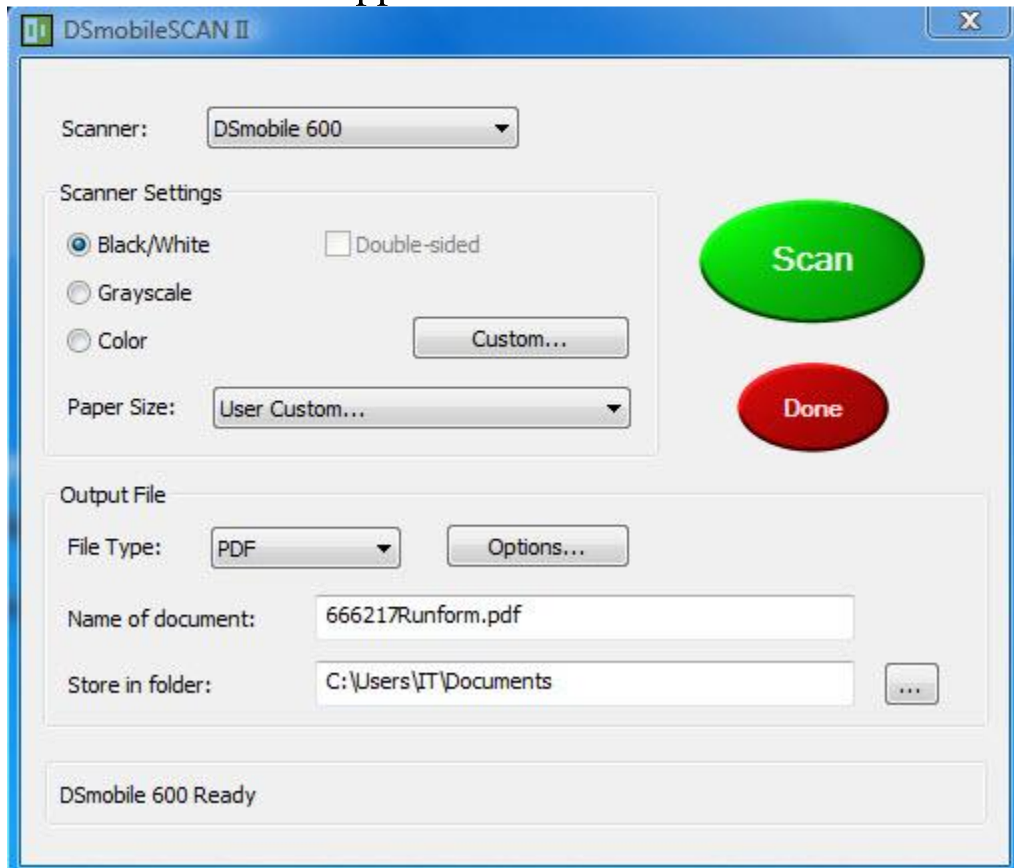
**Quality Assurance**: Once the attachments have been uploaded and the chart has been signed. Click the "Complete/Lock Chart" button to complete your chart. When this is clicked the system will check to see if all required fields for PREMIS has been completed. If so, you will get a report that states all criteria "passed" and the form was forwarded to the next Q/A level. If not, there will be a red hi-lighted error and when you click on this it will tell you which box and page number to correct. Once you correct this "complete/lock chart" again and it should accept your run. Once the chart is locked you will not be able to change anything on this run report. The only way to add is by addendum.

Note: If you are in the middle of the form and are toned out for another call, if you log out of the system your report will be saved at the point you left it and when you come back to it you can pick up where you left off to finish your report.

While we have tried to make this as user friendly as possible, some things we simply cannot change. If there are questions or suggestions, please direct them to either Ed Brown at ebrown@bceaa.com, Karen Scheuch at kscheuch@bceaa.com, or Jenna Mulligan at jmulligan@bceaa.com via email and we can see what we can and cannot do to accommodate.

## Scanning in Documents for uploading into emsCharts

1) Click DsmobileSCAN icon on Task Bar
2) DSmobileSCAN screen will appear.




3) Enter name of document (prid number and what page you are scanning.
Examples:

666217Runform.pdf (for run sheet)
66217Signatureform.pdf (for signature form)
66217Facesheet.pdf (for face sheet)

PRID Number can be obtained from the Pt's Chart at the top of the page. Example:

Pt: Gertrude Glick PRID: 6612252

| Print | Miscellaneous Forms | |
|---|---|---|
| ☐ | Supplies Used: | Completed |
| ☐ | Reason for Transport: | Optional |
| ☐ | Activity Audit: | Optional |
| ☐ | Utilization Review: | Optional |
| | Pt. Followup Log: | None |
| | Special Reports: | None |

**Attached Files**

Attached Files

(Number of Attached Files: 0)

**Signatures**

View

(Number of Signatures: 2)

**Print Chart**

Chart | Forms | Chart & Forms

**Quality Assurance**

Complete / Lock Chart

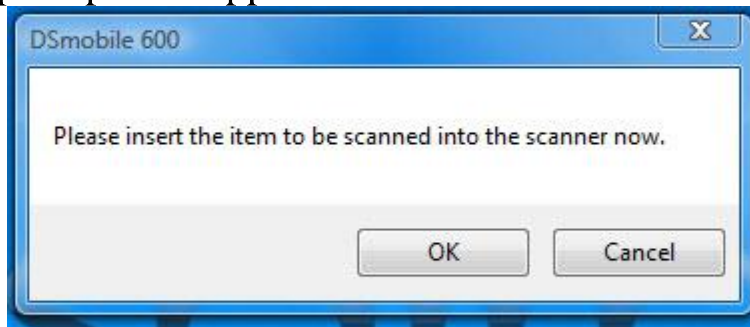
Current: Initial Entry (S0)
Next: Q/A Followup Crew (S1)

**Addendums**

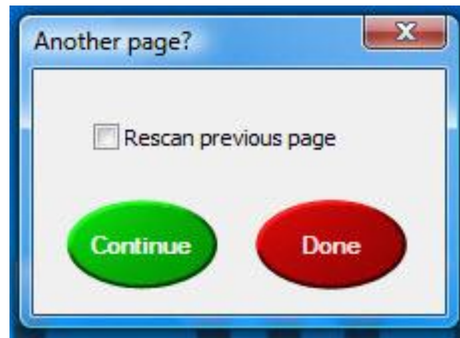
Addendums

(Current Number of Addendums: 0)

4) Verify folder that scanned document will be saved in.
   Example: c:\Users\Medic98\Documents
5) Click Scan Button
6) Insert document prompt will appear



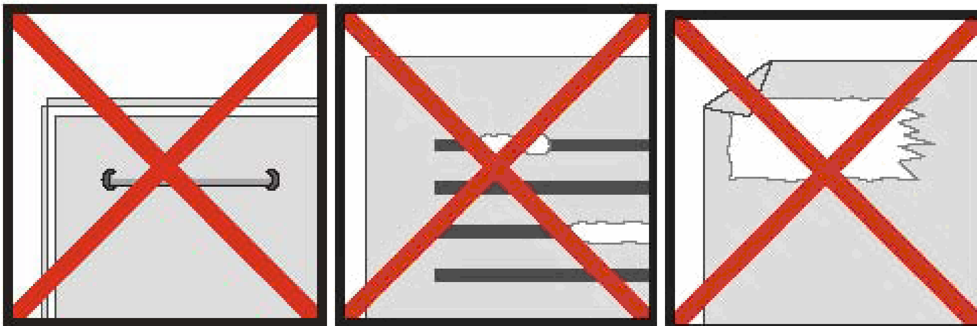

7) Insert document to be scanned into scanner face down
8) Click OK to scan document
9) Scanning progress screen will display until scanning completed
10) ‘Another page?’ prompt will appear




11) Click Done to continue
12) Scanned document will appear in Adobe Acrobat Reader. Verify that the document was scanned in properly. If so, scan next document or close DSmobileSCAN. If not, rescan document.
13) Once scanning is completed, documents are ready to be uploaded into emsCharts as attachments.

***Tips & Cautions …………………………………***

- **Please do not load stapled items or pages into the DSmobile600.**
- **Please do not scan documents that have chipped or un-dried Wite-Out®.**
- **Please do not insert documents with any type of adhesive material, even POST-IT® notes.**



**Make sure the leading edge of your documents is very straight (not wrinkled or having folded corners) and is inserted level with the intake slot.**