ESO Documentation Instructions

Electronic Health Record (EHR)

Version 1.0

4/12/2022

Current ESO Administrator is:

IT Division - BioTech

Contact the Biotech On Call number with technical needs.

This document is for use by Unified Fire Authority for Quality and Education purposes.

Additional ESO software instructions, including software screenshots, can be found by clicking on the "Product Training" link on your ESO Dashboard or at https://www.esosuite.net/EsoSuite/TrainingMaterials/Training.html.

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GENERAL INSTRUCTIONS

Acknowledgement: The following instructions are intended to be used by field care providers of **UFA** for patient care documentation in ESO software. This is a living document and will be updated periodically as technology and best practices dictate. The original document was developed by combining documents from UFA and documents used with permission from ESO and other agencies.

- **Fiscal responsibility:** UFA operates as an independent fire authority under the direction of the UFA Board of Directors. Each of the municipalities appoints one elected official from their municipality to serve on the UFA Board of Directors except for Salt Lake County who can appoint two officials. UFA has a commitment to the municipalities we serve to be fiscally responsible, and monies received are used to improve the services we provide to these communities. These services are supported by our ability to bill and collect reasonable user fees. Every effort should be made to collect information for billing to continue our efforts of helping people county-wide.

- **Reporting Requirements:** UFA is required to report incident information to the State of Utah in accordance with Utah Code 26-8a-203. This information is also reported to the National EMS Information System (NEMSIS). Records are shared with hospitals through Patient Tracker, an online portal service by ESO. Hospitals using Patient Tracker can see your draft documentation as soon as you enter the hospital in the destination field. All **critical** patient information should be documented in the draft with the hospital selected before leaving the hospital. The state requires accessible documentation for all dispatched calls within 1 hour, and **UFA policy dictatates all documentation will be completed by the end of shift.**

- **Accuracy requirements:** Information supplied in the EHR, including all attached forms and documents, are used to document medical/legal information about the patient and to generate billing invoices for the services rendered. For medical and legal reasons, it is imperative that all information supplied by UFA's medical personnel is accurate, verified, and solidly based on fact. All information supplied must be **accurate, legible, and in accordance with UFA Patient Care Reporting policy.**

- **All records in your possession shall be kept private:** ANY paperwork containing patient information (for example, hospital face sheets or records) must always be secured and kept private. Supplemental documentation received related to patient care should be scanned and attached to the ESO record. After attachment, the documentation should be returned to the facility or destroyed in an appropriate document shredding receptacle. Any photographs taken of a scene **must comply with UFA IT acceptable use policy (can't remember the name of this policy but I'll find it)**

- **Patient confidentiality:** All information obtained during your employment or while working for UFA must not be shared, disseminated, or otherwise released to other company employees, other agencies, news agencies, or the public except through an authorized Public Information Officer appointed by UFA. Special protection should be given to the confidentiality of employees, their family members, or prominent members of the community or nation. **Replace with UFA HIPAA policy reference**

- **Retention and security of records:** By law, the company is required to maintain records of the services provided for ten (10) years or a minimum of 21 years of age for minors. Copies of these official records may not be made for any reason without express written approval of management. Upon request of management, in the case of a court subpoena or for educational purposes, records may be viewed, in the

company offices, to refresh your memory of the services provided. Therefore, it is important to fully document, at the time of service, all impressions and actions taken.

- **Obtaining Billing information:** While it is acceptable to obtain medical information, medication history, and the patient's medical history prior to arrival at the patient's destination. Billing information should be obtained after assessment and treatment of services has been fully provided.

- **Requirement for personal contact with patient and/or family:** All billing and patient information should be obtained directly from the patient where possible or if not, a family member. To expedite this process, go directly to the patient or family member; identify yourself by name as the person who just provided their ambulance transportation. Ensure that everything went satisfactorily, they are as comfortable as possible, and then obtain the information necessary to document medical/legal issues and billing information. Establishing this personalized contact with the patient or family member is a requirement of the job and will allow you to develop a good rapport with the patient and/or their family. Be proud of the service you have just provided; it is of great value to them. Don't be tentative or hesitate to obtain the necessary billing and patient information. The patient and/or family understand the need for us to obtain this information.

- **When information on the EHR is not available:** If you are unable to obtain a piece of information, please leave that field blank and list the reason the information was not available at the bottom of the narrative section. Obtain as much information as possible from the hospital, including the Hospital Chart Number (This is the unique number assigned for this specific visit, not the medical record number (MRN) and can usually be found on the patient’s wrist band or chart sticker.

- **Your effect on the billing process:** As a patient care advocate, the quality of information obtained in the EHR has an impact on the patient and family well into the future. EMS providers can contribute to patient health long after our initial care and transport by reducing patient stress through complete and accurate care documentation, collection of demographic and financial information, and a seamless billing process. The less financial burden we leave for our patients to worry about, the more they can focus on healing.

Special Circumstances Documentation

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Refusal of Service: It is the expressed direction of UFA Administration that we do not "refuse service" to any individual who requests assessment, necessary treatments or transport to an emergency department. Refer to UFA EMS Protocol – Scene Release of Patients for specific guidelines that shall be followed in every situation where emergency medical service or transport is not provided.

Out of Country Patients: When transporting an out of country patient, the crew must do the following:

- gather as much demographic and insurance information as possible
- collect a patient **e-mail address**

Flight Team and Medical Team Transports:

- When called to transport a medical team or transporting with nursing or physician staff maintaining patient care, the team should provide you with patient demographics, chief complaint, and a set of vital signs.
- You should document any, and all, witnessed treatments provided by the team during transport.
- You should also document your assessment of the patient. If the team is reluctant or unwilling to provide you with additional information, please contact the on-duty captain.
- Ensure the incident location is documented as the location where the patient was picked up.

Standby Events:

- A standby event will be assigned an incident number, so an EHR can be completed for the event itself.
- The run type will be stand-by.
- The disposition will be "Standby-No Service or Support Provided" for routine standby service at events such as health fairs, schools, etc. For standby events providing medical service for fire or law enforcement, use the disposition of "Standby - Public Safety, Fire, or EMS Operational Support Provided".
- The narrative will consist of a list of patients treated and/or transported with associated incident numbers. The narrative will also include issues or abnormal events which occurred at the stand-by.
- All patients encountered will be assigned a separate incident number for individual EHR documentation purposes. You should contact dispatch for the additional incident numbers.

Wildland Single Resource EMT/AEMT/Paramedic Service:

- Any patient care provided by a UFA EMT, AEMT or Paramedic during a wildland single resource deployment, where a patient was treated or transported requires an individual EHR.
- …..add more details
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Transfer of Care between UFA Responders

- Transfer of patient care may occur when (1) a UFA heavy apparatus initiates patient care and then transfers care to a UFA transport unit or (2) a UFA transport unit is unable, due to mechanical or other reasons, to deliver a patient to the destination hospital.
- In the case of a transfer of patient care, follow direction provided in UFA Operational Guideline 550-15 EMS Prehospital Patient Care Transfer Reporting.
- There are two ways to transfer
- In the case of transfer of care from a non-transporting UFA apparatus to a transporting UFA apparatus, there should be 2 patient care reports. The first report should be initiated and completed by the first arriving unit (typically a heavy apparatus) which includes documentation of care from the time of initial patient contact to the time that care was transferred. In this scenario, crews should utilize the “mobile-to-mobile" transfer feature.
    - The initial arriving engine should start an EHR by importing the engine assignment from the CAD and utlize the disposition “Patient Treated, Transferred Care to Another EMS Professional/Unit.”
    - After the EHR has been transferred, the transport unit should import the ambulance assignment from the CAD.
    - Each unit should document the findings, observations, and treatments relevant to the time that each had primary care of the patient.

EHR Instructions

ESO Pro Mobile Dashboard Buttons

Button	Directions
Log In	● Enter username and password. User names are typically first initial and last name. If you forgot your password, contact On Call UFA IT Representative. ● DO NOT hit "Let's Go" button; hit system update button at the beginning of your shift daily. ● Now you can hit the "Let's Go" button to access the EHR. ● Use ONLY your personal credentials. All other providers must document for themselves under their personal log in. Documentation under another providers log in is fraudulent documentation!
Top Bar Menu	● Home returns you to the dashboard. ● Records displays a list of open records on this device which have not been synced to the web version of ESO. You can sync records from this page or open a record in progress. You can also open a new record from the CAD incident list here. ● This area displays messages sent to you from the clinical, quality, and billing departments. You can only review the messages from the mobile version of ESO. You must log in to the **ESO web version** to reply to the messages. You are required to reply to each message sent. Please check and reply to the messages on the web version of ESO every shift.
Set Shift	● Enter all providers "crew members on unit". Any students or trainees will be added later as "non-crew".

	● Enter the Unitname ● Enter Unit's Level of Care (ALS or BLS). ● Leave the vehicle number field blank ● Enter your Platoon for the shift. ● Choose the cardiac monitor from the "Device" dropdown that you will be using during your shift.
Quick Links	● The "Import from CAD" button should be used as the primary way to start an EHR. ● A window will open with calls that have been assigned to your unit. ● Select the incident #, date, unit, and address assigned to you. ● The "New Record" button should be used if the link between CAD and ESO is down or when a call does not show up in the CAD window. ● If you start a new record, you must later match it to the CAD import from the Incident tab inside the EHR you created. ● If you accidentally select the wrong CAD incident, you can update with the correct CAD incident inside the EHR Incident tab. If you are unable to find your CAD incident or overwrite an incorrect incident, contact the On-Call Biotech number for assistance.
Agency Alerts	● Check this area regularly for important agency messages regarding documentation or clinical updates.
Fax Status	● This section is not used.
Status Center	● This button is used to synchronize EHRs in ESO Mobile (GETAC Devices) to ESO Suite (Web). ● You should synchronize all locked EHRs as soon as possible and you are REQUIRED to finish all reports before the end of your shift in accordance with UFA Policies and Procedures. ● All EHRs showing in the list should be synchronized even if they are not your calls.

General Instructions about EHR

- Once you have opened an EHR, you will notice a bar across the top of the page.
  - House Icon- This takes you back to the dashboard page.
  - Patient- The default is “UNNAMED PATIENT”. This lists the patient's name once entered on the patient tab. It also gives you an option to add a new patient to this record. **Never select this option.** Each patient must be assigned a new CAD incident through dispatch. When you have multiple patients, you need to request additional incident numbers from the dispatch center and start a new record for each additional patient.
  - ↑↓ Transfer or Receive Patient allows you to import or export your record to and from another ESO user’s mobile device. Select if you are transferring or receiving the patient, and the system will assign you a code to enter to complete the import or give you a code to export.
  - Keyboard Icon- This enables the on-screen keyboard.
  - Checkmark Icon- This is used to run the validation routine and lock the record.
  - Timeline Icon- This will pull up the call times in a timeline for reference when you are working in other areas of the EHR.
  - Camera Icon – This allows you to use the device camera to attach a picture to the EHR
  - 3 Line Icon (Hamburger Menu)-This allows you to add/view attachments or view cardiac monitor data. There is also a link here to these documentation instructions.
  - Lightning Bolt- This opens the quick treat menus, including alerts, which allows you to quickly document time sensitive meds, treatments, and vitals. Use this menu to quickly time stamp interventions performed on scene without having to enter details or navigate through tabs.
- The page tabs are listed across the page below the top black bar in a blue menu row. To navigate between page tabs, just click on the tab for the section you need.
- Down the left side of each page is a section bar. To navigate between sections on each page, you can scroll or select the section you would like.
- When responding on calls where the patient is treated but not transported, documentation of the call is no different than if the patient was transported and should follow UFA Scene Release of Patients protocol and Patient Care Reporting Policies.

  Any care that is provided should be documented and as much demographic and billing information as possible should be obtained. Regarding demographic information, the minimum information required is: a name, date of birth (DOB), weight, social security number (SSN), address, phone number, and insurance information.

Incident tab

This tab is used to document the following elements of an incident: response, scene, personnel, disposition, destination, times, mileage and additional factors.

Field	Directions for field
CAD Import	• This button is located next to the incident number. Throughout an incident our CAD sends time and destination updates to ESO. By clicking on the button, the new information will populate. You must have the correct incident number and unit number • Any previously entered information in the fields identified above will be overridden by the latest CAD Import. • If the link between CAD and ESO is down or you do not have an internet connection, you will have to manually enter all of the following data: Incident Number, Run Type, EMD Card Number, TIMES, all location information, all destination information, Zone, and any other information that normally pre-populates. Alternatively, you can wait until you can connect to the internet and use the CAD import button to populate these fields. You will not be able to lock the report until these fields are completed either through manual entry or CAD import.
Incident Number (eResponse.03)	Enter the Incident Number assigned by VECC for this specific call. *If adding a new record with no CAD info, leave the prepopulated incident number until the correct CAD details can be attached.*
Run Number (eResponse.04)	This is a CAD number to link the CAD record to the incident. This number populates with the CAD import and is the same as the Incident Number.
Run Type (Type of service requested) (eResponse.05)	Select the appropriate run type: 911 Response - All runs that originate from a 911 center Nearly all EHRs completed by UFA personnel should use this run type. Mutual Aid – Selected when requested for mutual aid to another neighboring agency outside of the VECC or Central Dispatch Centers. Public Assist/Other Not Listed – This run type should be rarely used. Responses where patients refuse treatment or transport, or no transport required should be a 911 response with the appropriate disposition identified. Law Enforcement Assist – Used for TEMS team responses or other law enforcement standby requests. Emergency Interfacility Transfer – This is selected when transferring emergent patients out of a freestanding ED or a clinic.
Priority (eResponse.23)	The mode of response to the scene should be selected. If responding with Lights and Sirens, “Emergent” should be selected. If responding nwithout the use of lights and sirens, “Non-Emergent” should be used. “Downgraded” or “Upgraded” can also be utilized when indicated.

Shift	Select your current Platoon. This field will typically autofill I you set your shift on the EHR home screen
Unit (eResponse.14)	Select your assigned unit for that shift. This field will typically autofill if you set your shift on the EHR home screen
Unit's Level of Care (eResponse.15)	Select your unit's level of care: ALS-Paramedic – This should be used on nearly all UFA responses BLS- Basic/EMT - This should only ever be selected in the case of an event EMT that does not have a paramedic.
Vehicle (eResponse.13)	Leave this field blank
EMD Complaint (eDispatch.01)	Select the appropriate complaint based on the dispatch details received. This field should be automatically imported from CAD data.
EMD Card Number (eDisptach.03)	This field should be automatically imported from CAD data, it represents the dispatch center's call categorization
Requested by	Select the appropriate option for the person or agency requesting the response only if known. This information may be present in the CAD details.
First Unit on Scene	Mark "yes" or "no" to answer if you were the first unit on scene.
Location Type (eScene.09)	The appropriate location type should be selected. The "PREDEFINED" locations should be used as much as possible and are typically automatically imported from the CAD. You may select the "ADDRESS" button to manually enter the scene information if necessary.
Location Name	Choose the specific location name in the list, if applicable.
Address 1 (eScene.15)	Enter the complete street address. This should be automatically imported from the CAD
Apt/Suite/RM (eScene.16)	Enter any additional address information, if applicable (Apartment #, Room #, Suite #, etc.).
City (eScene.17)	This field is populated based on the selection in zip code
Zip Code	Enter the proper zip code for the address and hit the magnifying glass. Then select the proper city, state and county.

(eScene.19)	
State and County (eScene.19 and .21)	These fields will populate based on the selection in zip code. If this field is blank, delete the city name and then select the search magnifying glass to enter the correct county and city based on the selected zip code.
Zone	Select the battalion in which the incident is located. This should be automatically imported from the CAD. If the incident is located in another agency's zone, select the battalion that the responding heavy apparatus is located in, or if only an ambulance responds, the battalion in which the ambulance is stationed should be selected.
Mass Casualty (eScene.07)	Used to identify mass casualty events
Triage Classification (eScene.08)	Select the most appropriate classification: Red-Critical Yellow-Potentially Unstable Green-Walking Wounded Grey-Expectant Black-Deceased
Personnel (eCrew.01-.03)	The crew members assigned to the unit/vehicle should be listed in this section as Lead or Driver. The lead is generally the person responsible for all patient care but is mostly responsible for the EHR documentation. **<u>A UFA provider must always be listed as the Lead</u>**. All UFA providers involved with patient care should be listed on the EHR as dictated in UFA policy. Individuals who were on scene but did not participate in patient care (i.e. vehicle extrication crew) will be listed in the Fire/Incident report but do not need to be listed on the EHR. Students and observers should be listed as "Non-Crew". To properly assign treatments in the flowchart, the individual providing treatment needs to be listed in the personnel section. You can add them under the first responder/other tab. You can list other agencies as providers of the treatments by selecting the department you are working with from the personnel list and use that to show they provided the treatment in the Flow Chart. It is not necessary to list the individual provider. <u>Other agency personnel should never be listed as the Lead Provider</u>. In the personnel list, type Fire into the search, and the other departments will pop up to allow for quick selection. When importing data through the mobile to mobile link, other agency personnel will automatically be added and marked as "other". Click on each provider to document PPE used or any exposures during the call.

PPE	
Disposition (eDisposition.12,.17,.18)	The proper disposition should be selected based on situation, patient care, or assessment performed. **Patients Transported:** ***Transported No Lights/Siren, Lights /Siren, No Lights/Siren Upgraded, Lights/Siren Downgraded*** *One of these two outcomes should be used any time a patient is transported from a scene to a receiving facility in a UFA ambulance.* ***Patient Treated, Transferred Care to another EMS Professional*** This should be used when a patient has been evaluated and/or treated, and care is turned over to another provider (i.e. helicopter crew), other agency transport unit, or UFA ambulance for transport to a hospital. ***Patient's Not Transported:*** ***Patient Treated, Released (AMA)*** This is used when a patient is treated and refuses transport against the recommendation of responding UFA EMS Providers. ***Patient Treated, Released (per protocol)*** This should be used when a patient is assessed and treated, but is not transported in strict accordance with UFA EMS Protocol "Scene Release of Patients." If ALL criteria of this protocol are not met, a different outcome should be used. ***Patient Evaluated, No Treatment/Transport Required*** This should be used when an assessment and vital signs have been completed but no treatment is necessary and EMS Providers do not recommend transport to a facility by ambulance. If any treatments are administered, use the disposition "Patient Treated, Released (per protocol). This disposition requires patient information and a documented evaluation of the patient. ***Cancelled on Scene/No Patient Found*** This is used when there is no patient found, or you arrived on scene and are cancelled by other responders who performed all patient care and evaluation. If you provided any care or had contact with the patient, you must use a different disposition. This disposition is appropriate for a motor vehicle accident where vehicle occupants are already out of the vehicles and indicating that they are not injured and do not wish to be evaluated. Any time a patient in this scenario asks to be evaluated, a different dispostion should be used based on the patient encounter.

	<u>Cancelled (Prior to Arrival at Scene)</u> This is used when you are cancelled prior to your arrival by the dispatch center or another unit If you arrive on scene and another UFA unit cancels you, there is no need for you to complete an EHR. The unit on scene will complete the EHR for that patient encounter. If you arrive on scene and are cancelled by another agency, use the "assist agency" disposition.. ***<u>Patient Dead on Scene- No Resuscitation Attempted (Without Transport)</u>*** This is used when resuscitation was not attempted by bystanders, another agency, or a UFA provider. When this outcome is used, providers should clearly document why no resuscitation was attempted per UFA EMS protocols. ***<u>Patient Dead on Scene- Resuscitation Attempted (Without Transport)</u>*** This is used when resuscitation was attempted unsuccessfully, and the deceased patient was left in the custody of law enforcement or the State Medical Examiner. ***<u>Patient Refused Evaluation/Care (Without Transport)</u>*** This should be used when a patient refuses assessment, treatment, and transport. In multiple patient scenarios, the "Refusal of Service Log" can be completed. ***<u>Patient Treated, Transported by Law Enforcement</u>*** This should be used when a patient is assessed and treated, but is being transported by law enforcement. This outcome is typically used for behavioral health transports or transport of intoxicated individuals to a facility other than a hospital. Any patient with a medical condition should ***<u>Patient Treated, Transported by Private Vehicle</u>*** This should be used when a patient is assessed and treated, but is being transported by private vehicle. If EMS Providers on scene recommend transport by ambulance, the disposition "Patient Treated/Released (AMA) should be used even if the patient goes to the hospital via POV. ***<u>Assist, Agency</u>*** This is used when you are assisting another agency, but neither participating in patient assessment or care or transporting the patient in a UFA ambulance. An example of appropriate use of this outcome is a UFA firefighter drives another agency ambulance to a hospital while patient care is provided exclusively by that agency. This disposition should be rarely used.
Transport Method (eDisposition.16)	Choose the method the patient was transported from the provided list. Most of our patients will be Ground-Ambulance.
Transported Due To	The most appropriate reason should be selected. Multiple reasons should be selected if they apply.
Refusal Reason	When applicable, the most appropriate reason should be selected.

Destination	Use the "PREDEFINED" selections. If you transport to a location not in the predefined list, you can select "ADDRESS" and manually enter the information. If you need to enter a manual address, please contact BioTech to have the new location atted to the predefined list.
Destination Type (eDisposition.01)	The location name should be selected from the list (i.e. hospitals, clinics, public buildings, etc.). UFA transports patients to hospitals. Any other destination should be rarely, if ever used and should include specific, clearly documented online medical direction and the EMS Division Captain should be notified via email. Transport to a destination other than hospital may be a violation of UFA's 911 service license.
Destination Name (eDisposition.01	The appropriate location type should be selected. The predefined locations should be used as much as possible.
Department	Enter the department the patient was released to. In almost all situations this will be Emergency Department. Some hospitals may allow direct delivery to labor and delivery or in some rare instances a behavioral health facility. If the department is anything other than an ED, the reason(s) should be clearly documented and include specific online medical direction.
Address (eDisposition.03)	This address will be automatically filled from the facility chosen in the predefined list.
Apt/Suite/RM (eDisposition.03)	Enter any additional address information, if applicable. (ER, Clinic Name, Room #).
City (eDisposition.04)	Enter the city name (unabbreviated).
Zip Code (eDisposition.07)	Enter the proper zip code for the address and city.
State and County (eDisposition.05-.06)	These fields will populate based on city and/or zip code.
Zone	The proper zone should be entered based on the location where the patient is transported (North, South, and East).
Chart Number	The patient encounter number or hospital account number should be entered in this field. This is not the medical record number. This is the number on the patient's arm band or unique visit sticker. UFA EMS Providers should use the scan option to scan the patient's encounter number on their wristband or registration paperwork. This field will allow us to link our record to the patient's hospital record in the Health Data Exchange.
"Patient Number" and "Trauma Registry ID"	Leave these fields blank
Reportable Condition	Mark "yes" or "no" if this patient's condition needs to be reported to authorities due to disease, abuse, or other mandatory reporting requirements.

Request for Review	Mark this box if you would like your call reviewed by a member of the quality team. Please be aware, the team will not know who marked the box or why, so if you want more specific feedback, please e-mail Brooke Burton with your request at bburton@unifiedfire.org. We prefer you e-mail your request and not use this button.
Times (eTime.01-.16)	These fields should be entered either manually by requesting them from the communications center, clicking on "Set to current date & time" throughout the call, or through the CAD import link. The CAD import link should be used primarily. At patient and transfer of patient times are always manually entered as these are not times tracked in dispatch. Transfer of patient time is when you pass off to a RN or MD in the receiving facility.
Delays (eResponse.08-.12)	Below the times, you should document any delays which occurred during the incident. Delays are broken down as follows: Dispatch, Response, Scene, Transport, and Turn Around Delays.
Mileage (eResponse.20-.21)	Mileage is calculated with the odometer in the ambulance and may be manually entered in this field or auto-calculated if a scene address and destination address are provided.
Additional Agencies	Select the agencies from the list who responded with you when applicable.
Additional Responders (eResponse.24)	List Bystanders, other healthcare providers, first responders, and police officers.
Additional Comments	This section is used to document any other comments about the incident, not patient care related.

Patient Tab:

When collecting demographic information from the patient, at a minimum, the following information should be obtained; Last Name, First Name, SSN, Weight, DOB, Gender, Address, City, Zip Code, Phone Number, and Email Address. If you are obtaining the information from another document (i.e. face sheet, medical record or chart), be sure to have the patient or family member verify the name and information, including correct spelling.

Field	Directions for field
First Name (ePatient.03)	Enter the patient's legal first name. If the name is unknown, use the alias name given to the patient at the hospital so the records can be matched later when the patient is identified. Do NOT use any other alias like "John Doe", unless it is the exact alias given by the hospital documentation.
Middle Name (ePatient.04)	Enter the patient's legal middle name. If the name is unknown, use the alias name given to the patient at the hospital so the records can be matched later when the patient is identified. Do NOT use any other alias like "John Doe", unless it is the exact alias given by the hospital documentation.

Last Name (ePatient.02)	Enter the patient's legal last name. If the name is unknown, use the alias name given to the patient at the hospital so the records can be matched later when the patient is identified. Do NOT use any other alias like "John Doe", unless it is the exact alias given by the hospital documentation.
SSN (ePatient.12)	Enter the patient's Social Security Number (SSN). If the patient does not want to give the number or does not know it, leave the field blank and document after your narrative why the SSN was unobtainable. **However, when the parents do not know the SSN number for their child, enter a parent's or legal guardian's SSN.** Non-resident patients do not have an SSN; you should leave the SSN field blank.
Date of Birth (DOB) (ePatient.15-.17)	Enter the patient's date of birth in MM/DD/YYYY format. If DOB is not known, click the "Estimated" button and enter the estimated age in the "Age" field.
Drivers License Scan	This feature is the preferred "best practice" for entering patient demographic information. Once all of the information is scanned and entered, UFA EMS Providers should verify with the patient that the information is correct.
Patient Import	This field will allow you to import previous historical information about patients transported in the last 150 days. You can access some patient demographic and history information which will be directly uploaded into your EHR. Be sure to verify that any imported information is still current. You need to have two of the following three pieces of info: Last Name, SSN, or DOB.
Weight	A patient weight should be entered in either pounds or kilograms. This can be estimated but shoud be entered for all patients encountered by EMS. This field aids in determining any interventions (e.g. medication doses) that are weight-based
Gender (ePatient.13)	Select the patient's biological gender.
Race (ePatient.14)	Select the patient's race.
Ethnicity	This field does not need to be used.
Pediatric Color Coding	This optional field is for you to document the color of the Dose by Growth chart used for your patient. UFA EMS Providers should complete this field on ALL pediatric patients who fit on a length-based tape.
Contact	Select the "UTO" button, if you are unable to obtain patient info and select the reason.
Country	Select the appropriate country.
Address 1 (ePatient.05)	Enter the patient's mailing address. If the patient is homeless, ask if the patient has a PO Box for mailing or type "Homeless" in the field if no address is available and choose "Homeless" from the list in the Resident Status field.
Apt/Suite/Room	Enter additional mailing address information, if applicable (Apartment #, Room #).

(ePatient.05)	
City (ePatient.06)	Enter the city, do not abbreviate.
Zip Code (ePatient.09)	Enter the zip code for the address.
State/county (ePatient.07-.08)	These will populate based on city and/or zip code information.
Resident Status	If the patient is homeless, this field must be selected with "Homeless" selected from the list.
Phone Number (ePatient.18)	Enter the patient's phone number including the area code. Phone number is used for a variety of follow up reasons, and should be collected, if possible.
Personal Email (ePatient.19)	Enter an email for the patient.
Driver's License Information (ePatient.20-.21)	These fields can be completed, if information is available.
Physician First Name (eHistory.03)	Enter the patient's private physician information if relevant
Physician Last Name (eHistory.02)	Enter their private physician's last name.
Advanced Directives (eHistory.05)	Select the most appropriate type of advanced directives.
History (eHistory.08-.11)	All medical problems must be selected from the list. Do not select "other" and type the problems in the comments section. **"See list"** or **"list given to nurse"** is not appropriate either. Do not leave this section blank if the patient denies history or they are unknown; choose the appropriate field. Also, select whom the history was obtained from.
Allergies (eHistory.06-.07)	All allergies should be selected from the list. Do not select "other" and type an allergy in the comments section if the allergy is included in the list. "See list" or "list given to nurse" is not appropriate either. Do not leave this section blank if the patient denies allergies or they are unknown. Select the appropriate field. There may be times selecting "other" is appropriate when it is not listed, but the other allergy should be clarified in the comments.
Medications (eHistory.12-.15)	All medications should be selected from the list. Do not select "other" and type a medication in the comments section if the medication is included in the list. "See list" or "list given to nurse" is not appropriate either. Do not leave this section blank if the patient denies medications or they are unknown. Select the appropriate field. There may

	be times selecting “other” is appropriate when it is not listed, but the other medication should be clarified in the comments.
Belongings	This section should be completed to document patient personal items present during transport and care. This section should be used on non-transports as well. Be sure to document where the items were last seen and to whom (name, not title) they were given.

Vital Signs Tab:

Vital sign trending is important in future care of the patient. There should be at a minimum two complete sets of vital signs obtained on all transports. For stable patients, the vital signs should be obtained every 15 minutes at a minimum. For unstable patients, the vital signs should be obtained every 5 minutes at a minimum. Vital signs should also be taken after the administration medications that affect blood pressure, pulse, or respirations. UFA monitors are equipped with upload capabilities and field crews are required to upload vital sign and EKG data on every call where it is obtained.

You will see two green buttons at the bottom of the page. Select “Add Vitals” to document a new set of vitals or “Monitor Import” to upload from a monitor. You will also see any imported vitals from Mobile to Mobile data transfer.

Field	Directions for field
Add Vitals	Select this button to manually add a new set of vitals to the record.
Monitor Import (eDevice.01-.12)	Select this button to upload your monitor data to the EHR. Choose Cloud and select the case you wish to import. Utilizing a monitor import is the best practice and provides increased reporting efficiency for patient care providers. All monitor records should be uploaded from the monitor to the cloud.
Date and Time (eVitals.01)	Enter the date and time the set of vital signs was obtained. Any vital signs obtained prior to a UFA EMS Provider arriving on scene should be marked as PTA.
AVPU (eVitals.26)	Select the appropriate AVPU level.
Side	Select the appropriate side of the body where the vital signs were obtained.Note that if you take a blood pressure on one side of the body and a pulse or SPO2 on the other, you will need to have a separate vital signs entry for the signs that were registered on the other side of the body.
Position	Select the appropriate patient position for the set of vital signs when they were obtained.
UTO	Select this button if you are unable to obtain vitals and write a detailed reason in the narrative.
Blood Pressure (eVitals.06-.09)	Enter the systolic and diastolic blood pressure as well as the method used to obtain the BP. MAP will be calculated for you.
Pulse (eVitals.10-.11,.13)	Enter the pulse rate, method, rhythm, and strength.

Respirations (eVitals.14-.15)	Enter the respiration rate, rhythm, and quality.
SPO_2, $ETCO_2$, CO (eVitals.12,.16-.17)	Enter the SPO_2, $ETCO_2$, and CO quantities, if measured. Mark to indicate if readings were obtained on Oxygen or Room Air.
Glucose (eVitals.18)	Enter the blood glucose level and select high or low if applicable. .
Temperature (eVitals.24-.25)	Enter the temperature value in either F° or C° and method obtained.
ECG (eVitals.03-.05)	Select the type of ECG performed. Select the Rhythm. Select the method of interpretation used. Notes: Enter any special notations about the ECG performed. If a 12 lead is obtained, mark "YES" if an MI is suspected based on interpretation.
Scoring (eVitals.19-.23,.33)	Enter the Glasgow Coma Score (GCS) in this section. Qualifiers should be used when applicable. The RTS will be calculated automatically if you have a complete set of vital signs documented on the same line. Complete the Pediatric Trauma scoring for pediatric patients. These scores may be reported to the hospital to aid them in determining appropriate alert levels (i.e. Trauma 1)
Pain Scales (eVitals.27-.28)	Enter the level of pain or discomfort. You must also complete this field with any change in pain status.

Flowchart Tab:

All interventions should be documented in the flowchart. Include every attempt whether successful or unsuccessful. Also include interventions performed by other agencies and healthcare providers.

All interventions should be properly associatd with the provider who actually performed the intervention. This should, at all times, match current UFA EMS Protocols and scope of care. For example, an EMT-B should never be listed as having started an IV.

All ALS patients should have the "ALS Assessment" marked as an intervention. This assessment can be found in the "critical care" portion of the flowchart tab.

***In cases of STEMI, Stroke, Trauma, Sepsis, or Cardiac Arrest, the time you alerted the hospital (either by radio or EKG transmission) must be documented in the flow chart by using the appropriate alert entries found in the list or the quick treats. Proper documentation of alert times in these cases is essential. ***
Treatments you perform or performed in your presence should be documented in the flowchart tab. Any treatments performed PTA that are relevant to UFA patient care or the current patient condition should also be documented.

This includes treatments performed by a first responder, other healthcare provider, law enforcement, lay person, or the patient. If applicable the agency should be documented as having performed the intervention(s). As much relevant information about the treatment performed should be documented in the comments section. Any known treatments performed prior to your arrival can be listed with PTA as the time.

Treatment Details	Treatments Available

Special Instructions for certain treatment tabs:

Advanced Airways: An attempt is defined as any passage of the laryngoscope blade, tube, or other approved device beyond the patient's lips with the intent to establish an invasive airway (excludes direct laryngoscopy with the intent to remove a foreign body). ETI Verification is required for any patient with an advanced airway in place, for each movement of the patient (i.e. moving from hospital bed to gurney, after loading the patient into the ambulance, etc.). Any patient with an advanced airway in place is required to have ongoing End Tidal CO2 monitoring.

12-Lead ECG: Anytime you obtain a 12-Lead ECG, you must document this in the vital signs tab, flow chart, and specialty patient Form tab: ACS.

Involuntary Psychiatric Hold: Remember to add this choice to the Flow Chart when transporting a patient under a 5150 or any type of psychiatric hold.

IV Therapy: An attempt is anytime an IV catheter punctures the skin. IV Therapy is used when you start the IV or saline lock.

IV Bolus: Used when a fluid bolus is administered during the care of the patient.

Suctioning: When suction is provided to a patient, document where and what type of suction was performed on the patient in the comments box.

General instructions for treatments administered fields:

Field	Directions for field
Not Performed	Use this button to document when an treatment which is indicated or expected in UFA EMS Protocol is not performed. Document the reason in detail in the comments.
Date and Time	Enter the date and time the intervention was attempted or performed or select the button if the treatment was performed Prior to Arrival.
Dose or Quantity	Enter the amount or dose of the intervention, if applicable.
Measure	Enter the proper measure for the amount or dose given, if applicable.
Route	Enter the route used to administer intervention, if applicable.
Comments	Free text box to note any special comments about the treatment.
Provider	Enter the provider who administered the intervention. Note that the intervention must be within the scope of care for that provider level as specified in UFA EMS Protocol
Successful	Select whether intervention was successful or not.
Pt Response	Select the patient's response to the intervention.
Complication	If any complications occur from your intervention, select the most appropriate one from the list.
Medical Control	Select either standing order or on-line medical control. On-Line meaning you have called the receiving facility and either asked for permission to do or was told to perform the procedure. Online medical direction should include details either in the intervention notes/narrative section or in the EHR narrative to indicate any direction or interventions that are outside of current UFA EMS Protocol.
Physician	If on-line medical control was used, list the physician who gave the order.

Assessments Tab:

Complete assessments are required as a part of the mandatory reporting requirements.

A **pertinent negative** is a sign or symptoms that might be expected, based on the chief complaint, that the patient denies having.

Field	Directions for the field
Initial/Ongoing Assessment (eExam.01-.21)	An initial assessment is required anytime patient contact is made. The date and time of the assessment is required to be documented. The most detail should be listed in the area of chief complaint, and pertinent negatives should be marked. An ongoing assessment is required for all transports. The date and time of the ongoing assessment is required to be documented. An ongoing assessment is also required for signed releases where treatment/care was performed (i.e. diabetic emergencies, heroin overdose, seizure, etc.) or cardiac arrest resuscitations that were terminated in the field.
Quick Assessment	This tab can be used to quickly access a section of the assessment and mark areas of no abnormality or jump to a detailed assessment of that area.
Anatomical Figures (eExam.01-.21)	The anatomical figures should be used to document injuries for trauma patients in addition to the medical assessment section. The figures are also helpful for burn patients or anyone complaining of pain to pinpoint the location.

Narrative Tab:

Field	Directions for field
Clinical Impressions (eSituation.11-.12)	Select the appropriate Primary Impression: The EMS personnel's impression of the patient's primary problem or most significant condition which led to the management given to the patient (treatments, medications, or procedures). Select the appropriate secondary impression if applicable: The EMS personnel's impression of the patient's secondary problem or most significant condition which led to the management given to the patient (treatments, medications, or procedures).
Chief Complaint System	Select the body system primarily involved in the patient's chief complaint.
Medical/Trauma	Select whether this is a Medical, Trauma, or both.
Supporting Signs/Symptoms (eSituation.09-.10)	As many applicable entries should be completed to support the primary and secondary impressions and/or chief complaint.
Patient Complaint (eSituation.04)	Enter the chief complaint stated by the patient (this may be the same or different from your impression). Enter the secondary complaint, if applicable. Use the menu to select the duration of the complaints.
Initial Patient Acuity	Select the most appropriate classification: Critical (Red) Emergent (Yellow) Lower Acuity (Green) Dead Without Resuscitation Efforts (Black)
Final Patient Acuity (eDisposition.19)	Select the most appropriate classification: Critical (Red) Emergent (Yellow) Lower Acuity (Green) Dead Without Resuscitation Efforts (Black)
Patient Activity	If the patient was participating in a specific activity when becoming ill or injured, select the activity from the list.
Anatomic Location	Enter the anatomic location of the complaint.
Possible Patient Injury	Select the button Yes or No for patient injured.

(eInjury.01-.29)	This section should be completed for all patients who suffered an injury. • Primary injury • Injury details • Place of injury • Date of Injury
Factors Affecting Care (eHistory.01,.17,.18)	This section should be completed for every transport. ● Barriers to care ● Alcohol/Drugs ● Pregnancy
Patient Transport	Select how patient was moved TO ambulance. Select how patient was moved FROM ambulance. Select patient position during transport. Select the patient condition at the destination.
Narrative (eNarrative.01)	The narrative should consist of a chronological description of what happened during the incident describing details not documented in other areas of the EHR. The narrative "paints the picture" of circumstances. Narratives should be detailed enough to explain information to future care providers. Narratives also serve as a legal document which may provide a valuable reminder during legal proceedings which could occur several years later. This section at a minimum should contain: ● Additional information about scene (i.e. location of the patient upon arrival) ● Additional details about the condition not captured in the assessment ● An overview of what happened with the patient during transport ● More detailed response to interventions ● The disposition of the patient (i.e. patient was delivered to the ED room 22) If you are unable to obtain required information in your EHR, you should document the reason after your narrative. Items clearly documented in other portions of the EHR do not necessarily need to be re-stated in the narrative.
Appended Narrative (eNarrative.01)	This section is used to document any clinical information that was not initially in the EHR prior to locking and syncing. It is also used to document additional information requests resulting from a Quality Department audit or billing denial/review.

Forms Tab:

The Forms tabs are required for ensuring accurate and complete documentation of specific call types; refer to the directions for each field.

Field	Directions for field
Acute Coronary Syndrome (eVitals.31)	Complete the section when a call is cardiac related, whether a 12-lead is obtained or not; it has OPQRST. This section is required whenever a 12-lead is obtained or performed. It provides fields to document ST segment abnormalities.
Advanced Airway (eAirway.01-.11)	This section is required anytime an advanced airway device is placed or attempted. If an attempt was unsuccessful, click on the tab to the right "Reasons for Failed Intubation."
Burns	This section should be used when treating a burn patient.
CDC 2011Trauma Criteria	This should be used on suspected multisystem trauma patients.
Cardiopulmonary Resuscitation-CPR (eArrest.01-.19)	This section is required on all cardiac arrests when resuscitation is attempted.
C-STAT Stroke Score (eVitals.29-.30 eExam.21))	This section is required anytime a stroke is suspected, or the assessment was performed. The full scale must be completed along with times documented. Most receiving hospitals will request the C-Stat score when receiving a stroke or suspected stroke patient.
Motor Vehicle Collision (eInjury.05-.29)	This section should be used when treating a patient from an MVC.
Obstetrical	This should be used when treating a pregnancy problem.
Outbreak Screening	Use this field to screen for any suspected outbreak. The only current outbreak in the list is COVID-19.
Sepsis Screening	Complete as many of the boxes as possible. Once your patient has met the screening threshold for Sepsis Alert, the Circles will turn to green and state "Yes". If you get a "Yes" in the screening tool, you should be alerting the receiving facility for Sepsis.
Spinal Immobilization Screening Tool	This section should be used when the selective spinal immobilization protocol is used.

Syndromic Surveillance - Overdose	The form should be completed when responding to an overdose patient.

Billing Tab:

If you are unable to obtain billing information for any reason, document the reason at the end of your narrative.

Field	Directions for field
Unable to Obtain and No Payment Info	"Unable to Obtain" should only be marked if the patient is altered and there is no historical information available from the hospital. "No Payment Info" should not be use.
Method of Payment (ePayment.01)	Select the appropriate payer: Insurance: This is used when the patient has a private insurance plan (HMO, PPO, HSA, Etc.) as Primary. Medicaid: This is used when a patient has Medicaid as Primary. Medicare: This is used when a patient has Medicare as Primary. Self-Pay: This is used when the patient states they do not have insurance, or any other payer info is not available. Workers Compensation: This is used when a patient has a work-related injury or illness. Not Billed (for any reason): NEVER Used Other Government: This is used for VA, FEMA, or other government payers. Payment by Facility: This is used when a hospital or other facility is the payor. Contracted Payment: Not currently used Community Network: Not currently used Other Payment Option: Not currently used
Medicare (ePayment.10)	Enter the patient's Medicare number. (Use this field whether it is primary or secondary insurance).
Medicaid (ePayment.10)	Enter the patient's Medicaid number. (Use this field whether it is primary or secondary insurance.)
Primary Insurance (ePayment.10)	Select the patient's primary insurance provider even if the patient does not know the policy number. (Medicare and Medicaid should be documented in the above fields only.)
Primary Policy Number (ePayment.17)	Enter the policy number, if unknown leave blank.
Primary Group Number (ePayment.18)	Enter the group number of the primary insurance provider.

Secondary Insurance (ePayment.10	Select the patient's secondary insurance provider even if the patient does not know the policy number. (Medicare and Medicaid should be documented in the above fields only.)
Secondary Policy Number (ePayment.17)	Enter the policy number, if unknown leave blank.
Secondary Group Number (ePayment.18)	Enter the group number of the secondary insurance provider.
Relationship to Insured (ePayment.22)	Select the appropriate relationship. (Whose insurance is it?)
First name (ePayment.20)	If different from the patient, enter the legal first name of the responsible individual.
Middle Name (ePayment.21)	If different from the patient, enter the legal middle name of the responsible individual.
Last Name (ePayment.19)	If different from the patient, enter the legal last name of the responsible individual.
Insured SSN	Enter the SSN of the insured individual.
Insured DOB	Enter the DOB of the insured individual.
Country	Select the appropriate country.
Same as Patient	This can be used to import information from the patient tab, if the patient is the insured.
Address 1	Enter the responsible individual's mailing address.
Apt/Suite/Room	Enter additional mailing address information, if applicable (Apartment #, Room #).
City	Enter the city; do not abbreviate.
Zip Code	Enter the zip code for the address.
State/county	These will populate based on city and/or zip code information.
Billing Details	We do not use the fields in this section. Please leave them blank.
Medical Necessity (CMS REQUIREMENT) (ePayment.46, .52)	This section is required on all transports. All applicable necessities should be marked. If additional clarification is needed, it should be documented in the comments field. Bed confined is defined as unable to get up without assistance, unable to ambulate, and unable to sit unsupported in a wheelchair. The patient must meet all three to meet the requirement. Special care includes any treatments performed (i.e. IV, EKG, monitor, or medications).
Transport (ePayment.42-.53)	We do not use the fields in this section, Please leave them blank

Work Related (eSituation.14-.16, ePayment.33-.39))	Mark “Yes” or “No” for work related incident. If you mark “Yes”, complete the additional information fields.
Next-of-Kin (ePayment.23-.32)	Enter the information for the next-of-kin. This information helps us locate a patient who may not return home after transport and treatment at the hospital in addition to other notifications.
Consumables	This section is not currently used. Any treatments using consumables should be documented in the Flow Chart.

This document is for use by Unified Fire Authority for Quality and Education purposes.

Signatures Tab:

Field	Directions for field
Billing Authorization Sect. 1-Patient Signature (eOther.18-.21)	The patient should sign this section. They should also mark the billing authorization, Notice of Privacy Practices and HIPAA acknowledgement.
Witness (eOther.18-.21)	This section is only used if the patient signs with an “x”, other mark or illegible signature. You sign as a witness to their signature. Always list your address as “28333 Industrial Blvd., Hayward, CA 94545”.
Billing Authorization Sect. 2- Authorized representative signature	If the patient is unable to sign due to physical or mental condition, or the patient is a minor, then this section should be completed by an authorized representative for the patient.
Notice of Privacy Practices Provided	Each patient or family member signing should be offered a copy of the HIPAA privacy notice. Mark this box if you provided a HIPAA privacy notice to the patient or instructed them on how to obtain one. Note that the notice of privacy practices is available on the UFA Website. Your may also mark the box if you offered a copy and the patient or family declined.
Authorized Representative (eOther.12,.14)	Mark the appropriate authorization of the representative signing.
Signature (eOther.18-.21)	The signature should be as legible as possible.
Printed Name of Authorized Representative (ePayment.20-21)	Type the first and last name of the representative that signed.
Reason unable to sign (ePayment.13)	If the patient is unable to sign due to physical or mental condition, a reason must be documented; unconscious, incompetent, in great pain, or otherwise in such a condition that he/she is unable to sign (CMS, 2014). You should not just type physically unable or mentally unable or patient unable to sign. List the specific condition/reason. Documentation in other areas of the EHR must also verify the reason listed.
Billing Authorization Section III- EMS and Facility Signature	If the patient is unable to sign due to physical or mental condition, and an authorized representative for the patient is not present or available, then the lead provider and a facility representative need to complete this section. Both signatures are required.
EMS Personnel Signature (ePayment.18-21)	The Lead Provider should sign legibly here.
Printed Name (ePayment.20-21)	The Lead provider should type his or her full name here.
Reason unable to sign	If the patient is unable to sign due to physical or mental condition, a reason must be documented; unconscious, incompetent, in great pain, or otherwise in such a condition

(ePayment.13)	that he/she is unable to sign (CMS, 2014). You should not just type physically unable or mentally unable or patient unable to sign. List the specific condition/reason. Documentation in other areas of the EHR must also verify the reason listed.
Facility Representative Signature (eOther.18-.21)	The facility representative should sign legibly here.
Printed Name (ePayment.20-21)	Type the full name (first and last) of the representative that signed. Medicare requires this name to be "identifiable", so if you are not able to get a full name, you must list the employee ID number or explain in your narrative.
Title of Representative (ePayment.14)	The title of the facility representative should be typed here.
Controlled Substances	List the medication, amount, and document the full first and last name of the witness to the waste disposal of any unused narcotic. You must also document the lot number and expiration date in the Flow Chart medication comments.
Notice of Privacy Practices Provided	A notice of practices should be provided regardless of whether the patient can sign.
Receiving Signature (eOther.18-.21)	The MD or Nurse receiving the patient and report need to sign this section. This is your protection against abandonment.
Acknowledgement of Paperwork (eOther.18-.21)	The individual receiving any paperwork regarding the transport needs to sign here. Due to privacy and HIPAA concerns, all paperwork should be digitally transferred, if possible. If you must transport paperwork, it must be documented and accounted for.
Airway Confirmation (eOther.18-.21)	This section is required if an advanced airway was placed or in place during the transport. MD confirming airway is preferred, then RT, followed by the patient's nurse.
Providers (ePayment.08, .18-.21)	The lead provider is required to sign here. All other providers should review and sign prior to locking the document.
Refusal (eOther.11, .18-.21)	Refusals have some of the highest liability in EMS and should be documented as well as, or better than, any other patient contact. In addition to all other required documentation, refusals also must specify: • Capacity Assessment- This assessment documents your patient's legal ability to refuse care as well as their capacity to understand the situation and consequences of a refusal. • Medical Command- This section allows you to document your base hospital medical control contact and instructions. • Patient Notifications- This is where you can document the suggestions or warnings provided to the patient. • Patient Refusals- This section has the UFA refusal language and sections for your patient and a witness to sign affirming refusal of transport.

	Remember, a patient with capacity has the right to refuse any part or all offered assessment and treatment. The refusal form has an area to mark exactly what was refused • Assessment • Treatment (a single treatment or all treatments) • Transport by EMS • Recommended Destination Check all that apply and write a detailed description in the comments. Obtain the patient's signature. For additional protection against liability, a witness signature (preferably a third party like law enforcement or a relative) should be obtained. If the patient refuses to sign and there is no other witness, the provider may sign as the witness.
Custom Forms	

APPENDIX A

This document is for use by Unified Fire Authority for Quality and Education purposes.