General Information

This guideline is provided as a learning and reference tool while using the Santa Barbara County ImageTrend Elite patient care reporting platform.

The first sections are general documentation guidelines, followed by general information about ImageTrend Elite.

Care providers can go to the section they most commonly use, depending on their agency’s level of care.

The three main options coincide with the most commonly used patient/incident dispositions. They are:

- Fire Assisted Ambulance with Treatment on Scene or During Transport
- Assessed/Treated/Transferred Care, and...
- Transport Agency: Additional Report Requirements

After these main sections, you will find other forms that are commonly and less commonly used.

Refer to the Table of Contents below for more information.

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The Importance of Quality Patient Care Documentation

Generally, your patient care documentation serves two critical roles:

● It provides a chain of events for the continuance of care from the onset of the patient’s complaint through their arrival to definitive care, and helps best inform the subsequent caregivers.
● Equally important, your report provides you and other responders with supporting documentation in the event of litigation. The more thorough and accurate your document, the easier it is to defend and respond proactively to inquiries in the future.

“If there is no documentation of an event, it didn’t happen.”

Documentation is:

● Professional accountability
● Legally recognized evidence
● A mechanism to help create credibility
● Transfers pertinent patient information to the people who need it
● Remains part of the patient’s permanent medical record

You, as the representative of the entire Santa Barbara County Emergency Medical Services System (System), and your Agency, are responsible for keeping a careful written record of every patient interaction. This record must be a professional, objective, factual rendering of the patient encounter.

The documentation will become part of the patient’s record and will be utilized by other medical professionals during the continuum of care. Accuracy, detail, and completeness are essentially important. Your record is a pivotal part of your agency’s and the System’s continuous process for quality assurance, data collection, legal record, and billing.

If you are called to court 10 years from now, will you be able to answer all questions asked of you based solely on your written documentation?
Could you do the following in court years from now?

- Determine the identity of all prehospital responders present
- Remember any other healthcare providers who may have rendered aid
- Recall the exact times related to the incident
- Describe the type of patient encountered by the pre-hospital providers
- Explain what precipitated the illness or injury
- Determine the patient’s medical history and medication regime at that time
- Remember the patient’s allergies to medication(s), food, or the environment
- Recall why you were dispatched to the scene
- Correctly identify the patient’s chief complaint
- Tell why the patient was being transferred
- Validate that the patient was competent to consent to or refuse treatment
- List the witnesses and family members at scene
- Describe your treatment path and ensure you gave proper medication(s) and dosage(s)
- Remember the drip concentration, dose, and rate you set up, delivered, and verified
- Recall the Emergency Department Doctor who concurred with/ordered the treatment
- Describe the protocol you engaged, and the reasons you chose it
- Confirm that the observed patient conditions warranted the treatment path decision
- Based on written documentation confirm that the provider adhered to the protocol and current treatment standards within their scope of practice
- Determine whether or not the provider deviated from the standard of care
- Recall what treatment and/or medications the patient received at scene versus during transport
- List the initial vital signs taken while at scene, as well as during transport
- Describe the patient’s response to treatment(s) provided
- Remember the time that patient care was transferred to the transport provider, and/or the receiving facility
- Tell who received the report and patient, and their qualifications
Electronic Patient Care Requirements within Santa Barbara County

General Information
Santa Barbara County Emergency Medical Services Agency (SBEMSA), through collaboration with all interested parties and agencies, has developed policy and procedure related to the documentation of patient care and contact. Those documents are generally found in Section 7 of the Policies and Procedures manual.

General patient care documentation policy can be found by clicking here, while specific electronic patient care reporting policy can be referred to here. If you, as the care provider, have questions regarding the requirement of patient documentation, first refer to these policies for guidance.

The remainder of this document will explain the process of logging in and completing an electronic patient care report using ImageTrend Elite.

ImageTrend Elite - The Basics
ImageTrend Elite is National EMS Information System 3 (NEMSIS) compliant. Santa Barbara County ImageTrend Elite “Web” interface access and login are found at this link (https://www.imagetrendelite.com/elite/organizationSantaBarbara/).

Elite offers two interface options available within either Google Chrome or iOS Safari browsers:
- ImageTrend Elite “Web” is the link above. This link requires a solid connection to the internet. You will note that there is no “Post” option in this site because it is constantly updating/saving as you complete the ePCR.
  - If you lose the internet connection and do not notice, information you enter can and will be lost unless you are using the “Field” interface (below)
- ImageTrend Elite “Field” can be found here:
  - https://www.imagetrendelite.com/Elite/Organizationsantabarbara/RunForm/Login
  - The “Field” version interface is essentially the same interface. However, it runs by using your internet browser cache to support the program. No software installation is necessary.
  - This is the preferred method of completing ePCRs because all information is stored inside your browser’s cache until you select “Post”, preventing any loss of information.
  - As long as you have an internet connection, the information will automatically update and save every 30 seconds.
  - The “Field” site must be saved as a bookmark inside your browser or on your desktop while you have connectivity. Once it is bookmarked and synced the first time, you can open the “Field” interface without internet service.
Logging in to ImageTrend Elite “Field” (preferred)

1. Go to this web address: [https://www.imagetrendelite.com/Elite/Organizationsantabarbara/RunForm/Login](https://www.imagetrendelite.com/Elite/Organizationsantabarbara/RunForm/Login)
2. Login with Username (Same as ImageTrend ver2.0 and ImageTrend Elite “Web”)
3. Password (Same as ImageTrend ver2.0 and ImageTrend Elite “Web”)
4. Click “Sign In”
   a. Notice that there is a small “Elite” symbol at the top center of the screen (image cropped)

Logging in to ImageTrend Elite “Web”

1. Go to this web address: [https://www.imagetrendelite.com/elite/organizationSantaBarbara/](https://www.imagetrendelite.com/elite/organizationSantaBarbara/)
2. Login with Username (Same as ImageTrend ver2.0)
3. Password (Same as ImageTrend ver2.0)
4. Click “Sign In”
   a. Click “Yes” on the next screen
   b. Notice that there is a large “ImageTrend” symbol at the top left of the screen
# The Differences - Elite “Web” vs. Elite Field

<table>
<thead>
<tr>
<th>Elite “Web”</th>
<th>Elite Field</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Navigation</strong> Incidents tab &gt; Create New or View Existing</td>
<td>Navigation Click New &gt; Select an incident form template or download a CAD incident</td>
</tr>
<tr>
<td>Requires Internet Loss of Internet connection may result in a loss of unsaved data</td>
<td>Internet Not Required Create incident while on or offline. Data saves if Internet connection is lost</td>
</tr>
<tr>
<td>No Post Button You are connected to the main system and your incident saves there</td>
<td>Post Button You can post incidents with or without Internet. Elite Field posts the incidents when connection is available</td>
</tr>
<tr>
<td>PDF Button You can generate a PDF report of the incident</td>
<td>No PDF Button PDF generation is not available on Elite Field. However, on some devices you can click the Print button to view a PDF version of the incident</td>
</tr>
<tr>
<td>Messages Button You can view and reply to incident related messages</td>
<td>No Messages Button Incident related messages are not accessible when on Elite Field. However, from the Elite Field Dashboard, when you have internet, clicking Messages takes you to your Inbox in Elite</td>
</tr>
<tr>
<td>No Syncing Required Syncing is not required to update resources (users, validation rules, etc)</td>
<td>Syncing Required Syncing is required to update resources such as users, vehicles, validation rules, etc</td>
</tr>
</tbody>
</table>

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The table above summarizes the differences between Elite “Web” and Elite Field. Elite “Web” is internet-dependent, while Elite Field allows incident creation while on or offline. Elite “Web” requires internet for data persistence, whereas Elite Field saves data even when offline. PDF generation is possible on Elite “Web” but not on Elite Field, although some devices offer a Print button as an alternative. Incident-related messages are accessible on Elite “Web” but not on Elite Field, with options to access messages via Elite Field Dashboard when internet is available.
ImageTrend Elite “Field” (Recommended Interface)

1  This is the startup screen as ImageTrend Elite “Field” is loading all information to your browser cache.

2  If you are confident there are no pending resource or information updates, you can choose to Close this process and move forward without it completing.

Standard Symbols Throughout Elite

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Add</td>
<td>Add an item (Crew Member, Exam, Intervention, etc.)</td>
</tr>
<tr>
<td>×</td>
<td>Closes the current screen/panel; Removes an entry</td>
</tr>
<tr>
<td>▼</td>
<td>Click to pull down for more options</td>
</tr>
<tr>
<td>□</td>
<td>Similar to above, but opens a list panel on the left margin</td>
</tr>
<tr>
<td>○</td>
<td>Click to select “None Reported”, “Not Applicable”, “Not Reported”, “Unable to Obtain”, etc.</td>
</tr>
<tr>
<td>!</td>
<td>Exclamation marks warn of required input for validation</td>
</tr>
<tr>
<td>☑</td>
<td>Use to auto fill using the current date/time stamp method</td>
</tr>
</tbody>
</table>
Elite Field Home Screen Layout

1. Incident search field (incidents not posted)
2. Number of incidents attributed to the current user in the Field cache
3. Add crew member(s) and provider roles
   a. Note: the crew member assignment, shift, and role will remain assigned until updated or removed, and will auto-populate in the incident document
4. Remove crew members and provider roles
5. Add the response unit
6. Add the assigned shift
7. Show “All” Incidents Assigned to you
8. Show “None”
9. Post an incident
10. Delete an incident
11. Switch between views
12. Enter a new incident using the default run form
13. Choose between run form options
14. ImageTrend mail “Inbox”
   a. This updates every time you log in or sync
   b. Unopened messages will show as a number
15. Settings
   a. Sync your incident data and form setup
16. About the ImageTrend software
17. Logout of the current user
1 Search Box: Search the incident form for a particular field. Search for fields based on the label given to the data element, this is not necessarily the field’s official name.

2 Save Button: Click to Save changes. Additionally, information auto-saves when switching panels

3 Post Button: In Field, this button Posts the incident to the server.

4 Print Button: Generate a printable HTML or PDF report of the incident while online or offline. The report opens in a new tab.

5 Buttons Not Shown:
   - PDF Button (Elite Web): Click the PDF button to view a printable PDF report of the incident in a new tab.
   - CAD Import: Importing CAD incidents imports specific information from the incident into the incident form.

   ○ WARNING: Importing a CAD incident after a new incident was created overwrites any duplicate information. Fields that have no information imported from the CAD incident keep the previously entered information.
If downloading while in a current incident form, the following dialog box will open. Once you select an incident, then you can choose one of the following options:

- **Download Other**: will download the new incident and overwrite the data for the current incident.
- **Reload Current**: will refresh and add any new data since your last CAD download.

### Import EKG Button

Click EKG to import EKG cases into your incident. If your agency uses a Zoll device, there will be a separate ZOLL EKG button that requires previous set up.

### Close Button

Click Close to close the incident.

### Slide Out Panels

Panels that slide out to reveal more options when clicked. Any field inside a slide out panel is flagged for validation, the entire slide out is flagged.

#### Response Times

1. Click the **Times** button. The Time slide out panel opens revealing all of the response time fields.
2. Enter the response times using the slide out panel’s keypad or your device’s keypad. The response times automatically complete the corresponding response time fields on the Response Times panel.
3. To Close the Panel, click either the **X** or the **Times** button again.

#### Mileage

1. Similar to the Times button, click the **Mileage** button to open this slide out panel.
Timeline:
1. The Incident Timeline shows all events and interventions entered into the report, in chronological order. To see/edit any event, click on the event.
2. The Patient Encounter Timeline will display patient data history through multiple contacts

9 Worksheets: Worksheets are questionnaires attached to the incident form template. Click Worksheets to display the worksheets and hide the power tools. This button is visible only if there are worksheets attached/available to this incident form template. Click Worksheets again to hide the worksheets list and show the power tools.

10 Power Tools: Click a power tool to open it.

11 Incident Status: Select the status of the incident from the drop down to change the incident status.

12 Menu: Click Menu to insert attachments, view the audit report, send messages, and delete or lock the incident.
   - Users can select to update attachments of many types, including incident photos and supporting documentation

13 Validation Score: The current validation score for the incident form.
   - To easily navigate to the validation errors, click on the validation score for a list of linked errors. Click the right arrow to move directly to that field/form.

14 Validation Bar: The thin bar directly above the information line and below the date entry section. The bar is red when there are invalid fields, and blue when all fields on the incident form are accurate.

15 Person: The patient’s name.

16 Data Entry Section: The center portion of the incident form where the fields for the currently selected panel appear.
17 **Validation Colors:** The red and blue bars on the left side of the sections and panels are visual indicators of validation. A red border and exclamation point indicates there are invalid fields. Blue indicates everything is accurate.

18 **Panels:** All fields for data entry appear in the panels. When selected, panels open in the center of the screen. The selected panel has bold text. In the data entry section the panel appears at the top.

19 **Sections:** Sections are headers containing panels. Selecting a section expands it to view the panels. Additional sections may appear below the last visible section. Scroll down to see all sections. Upon beginning an incident form, the first section and first panel are visible. The selected section has bold text.

(next page)
The Basic Report: All Providers

All patient documentation will have similar requirements for validation. BLS agencies making BLS level patient contact and interventions will generally require less inputs for validation than will ALS agencies making BLS contact, and ALS agencies making ALS assessments/interventions. This section pertains to non-transport agency units who do not act in a primary caregiver role during a single patient encounter. It will show the general requirements for documentation using the Incident Disposition where patient assessment documentation is not required: Fire Assisted Ambulance with Treatment on Scene or During Transport.

This section includes the required inputs for ALS and BLS providers.

Quick Report: Quick Report

The Quick Report is intended to be used at scene to capture critical information regarding patient care and disposition. The Quick Report will evolve throughout the life of the program, and therefore the diagrams provided within this document may not match the actual form. The first 12 items should be captured while at the bedside. All items in the Quick Report can be found elsewhere within the ePCR and the fields will cross-populate as they are completed. See the following pages for diagram descriptions(s).
Quick Report Screen Inputs - Quick data capture for use at scene while involved in patient care

1. Enter the Arrived at Patient Date/Time
2. Enter the Patient First Name
3. Enter the Patient Last Name
4. If available, use to Find a Repeat Patient
5. Enter the patient Date of Birth
6. Enter the patient Age (this will populate with D.O.B.)
7. Select the Age Units
8. Enter the patient Gender
9. Enter the Medical/Surgical History
10. Select the Current Medications
11. Choose any Medication Allergies

Quick Report: continued
12. Enter the patient’s Vitals
13. Enter the Patient Complaints
14. Enter the Provider’s Primary Impression
15. Select the Incident/Patient Disposition: In this case: Fire Assisted Ambulance With Treatment On Scene or During Transport (when BLS unit did not provide primary care)
16. Select the Level of Care of This Unit: BLS-EMT
17. Enter the Primary Role of the Unit: Non-Transport Rescue in this case
18. Enter the Estimated Body Weight
19. If pediatric, enter the Length Based Tape Measure
20. Enter any Procedures attempted and/or completed
21. Choose any Environmental Allergies
Incident: Personnel Inputs

1. Click to Add crew members. This will auto populate if you entered crewmembers on the home screen. If you did not enter crew member information in the home screen:
   2. Choose the crew member(s) name here
   3. Choose the crew member level of care
   4. Choose the crew member role (must always have 1 primary caregiver)

5. If not completed, choose the Crew Member Creating the Report
Incident: Incident Address

**Incident Address Screen Inputs (if not populated by C.A.D.)**

1. Enter the *Incident Street Address*
2. Enter *Incident City (or Set From Postal Code)*
3. Enter *Incident State (or Set From Postal Code)*
4. Enter *Incident Zip Code*
5. Click *Set From Postal Code* to auto fill other City/State fields
6. Enter *Incident County (or Set From Postal Code)*
7. Enter the *Incident Location Type*

(next page)
Incident: Response Info Screen Inputs (partially populated by C.A.D.)

1. Enter the Complaint Reported by Dispatch (dispatch reason)
2. Enter the Incident Number. Will populate from “Quick Report” screen
3. Enter the Type of Service Requested
4. Enter the Unit Number and Unit Call Sign. Will populate from the “Quick Report” screen
5. Select the Response Vehicle Type. Will populate from the “Quick Report” screen
6. Select the Level of Care of This Unit. Will populate from the “Quick Report” screen
7. Select the Response Mode to Scene
8. Select any appropriate Type of Response Delay(s)
9. Select the Response Disposition. Will populate from the “Quick Report” screen
Incident: Scene Info

### Incident: Scene Info Screen Inputs

1. Select if your unit is the *First EMS Unit on Scene*
2. Select if there are/were *Additional agencies on scene*? If so, complete the Other Agencies On Scene Form (see Other Commonly Used Forms section)
3. Select the *Number of Patients at Scene*
4. If you selected “Multiple” patients in #3, select whether or not this is/was a *Multi Casualty Incident*. If incident is an MCI, complete the *Triage Classification for (this) MCI Patient*
5. Select any appropriate *Type of Scene Delay(s)*
Patient: Patient Info

Patient: Patient Info Screen Inputs (many of these items will populate from previous screens)

1. Enter the patient’s Arrived at Patient Date/Time

Note: While it is not required to enter the other patient information when the disposition is “Fire Assisted Ambulance with Treatment on Scene or During Transport”, it is suggested to complete the patient information fields if possible.
Assess/Treat: Narrative

1. Type the appropriate narrative. See Appendix A: Sample Narratives

Signatures: Signatures

1. Click to Add crewmember signatures and then select Primary or Secondary Crew Signature
Signatures: Signatures Screen Inputs

1. If not populated, click to Select Crew Member
2. Enter the Signature Last Name
3. Enter the Signature First Name
4. Sign the Patient Care Record
5. Enter the Date/Time of Signature

Note: If additional signatures are desired, select “OK” and repeat the process
Times

Times: Time Inputs (located on top right edge)

1. Click to enter the *Dispatch Notified Date/Time* if not already populated by CAD
2. Click to enter the *Unit Notified by Dispatch Date/Time* if not already populated by CAD
3. Click to enter the *Unit En Route Date/Time* if not already populated by CAD
4. Enter the *Unit Arrived on Scene Date/Time* if not already populated by CAD
5. Enter the *Arrived at Patient Date/Time*
6. Enter the *Transfer of EMS Patient Care Date/Time*
7. Enter the *Date/Time of Symptom Onset*

At this time the basic patient documentation is completed and valid. Note that any deviation in basic disposition and/or additional patient documentation such as exams, assessments, and interventions will require additional information entered to create a fully valid, accurate patient care report.
The Common Report: All Providers

This section will show the general requirements for BLS and ALS documentation using the common Incident Disposition where patient assessment documentation is required: Assessed/Treated/Transferred Care.

This section of the manual will outline the required inputs for all ALS providers. BLS requirements are very similar, requiring much of the same information.

Quick Report: Quick Report

The Quick Report is intended to be used at scene to capture critical information regarding patient care and disposition. The Quick Report will evolve throughout the life of the program, and therefore the diagrams provided within this document may not match the actual form. The first 12 items should be captured while at the bedside. All items in the Quick Report can be found elsewhere within the ePCR and the fields will cross-populate as they are completed. See the following pages for diagram descriptions(s).
Quick Report Screen Inputs - Quick data capture for use at scene while involved in patient care

1. Enter the *Arrived at Patient Date/Time*
2. Enter the *Patient First Name*
3. Enter the *Patient Last Name*
4. If available, use to *Find a Repeat Patient*
5. Enter the patient *Date of Birth*
6. Enter the patient *Age* (this will populate with D.O.B.)
7. Select the *Age Units*
8. Enter the patient *Gender*
9. Enter the *Medical/Surgical History*
10. Select the *Current Medications*
11. Choose any *Medication Allergies*

**Quick Report: continued**

12. Enter the patient’s *Vitals*
13. Enter the *Patient Complaints*
14. Enter the *Provider’s Primary Impression*
15. Select the *Incident/Patient Disposition*
16. Select the *Level of Care of This Unit*
17. Enter the *Primary Role of the Unit*
18. Enter the *Estimated Body Weight*
19. If pediatric, enter the *Length Based Tape Measure*
20. Enter any *Procedures* attempted and/or completed
21. Choose any *Environmental Allergies*
Incident: Personnel Inputs

1. Click to Add crew members. This will auto populate if you entered crewmembers on the home screen. If you did not enter crew member information in the home screen:
   2. Choose the crew member(s) name here
   3. Choose the crew member level of care
   4. If not completed, choose the Crew Member Creating the Report (must always have 1 primary caregiver)

5. Choose the Crew Member Creating the Report

(next page)
Incident: Incident Address Screen Inputs (if not populated by C.A.D.)

1. Enter the Incident Street Address
2. Enter Incident City (or Set From Postal Code)
3. Enter Incident State (or Set From Postal Code)
4. Enter Incident Zip Code
5. Click Set From Postal Code to auto fill other City/State fields
6. Enter Incident County (or Set From Postal Code)
7. Enter the Incident Location Type

(next page)
Incident: Response Info

Incident: Response Info Screen Inputs (partially populated by C.A.D.)

- Many fields will populate from the Login and Quick Report forms
- **1** Enter the *Complaint Reported by Dispatch* (dispatch reason)
- **2** *Incident Number* should populate from the first screen
- **3** *EMS Response Number* should auto populate from the server
- **4** Enter the *Type of Service Requested* (9-1-1, Interfacility transfer, etc.)
- **5** Enter the *Responding Unit* (will auto populate if entered on the Home Screen when you logged in)
- **6** Enter the *Unit Call Sign* (will auto populate if entered on the Home Screen when you logged in)
- **7** Select the *Response Vehicle Type*
- **8** Enter the *Level of Care of This Unit* (may be selected from the Report screen)
- **9** Enter the *Response Mode to Scene*
- **10** Enter the *Type of Response Delay* (most common/auto fill: None/No Delay)
- **11** Enter the *Response Disposition*. In this case “Assessed, treated, transferred care.”
**Incident: Scene Info**

![Scene Info Screen](image)

**Incident: Scene Info Screen Inputs**

1. Select if your unit is the *First EMS Unit on Scene*.
2. Select if there are/were *Additional agencies on scene?* If so, complete the Other Agencies On Scene Form (see Other Commonly Used Forms section).
3. Select the *Number of Patients at Scene*.
4. If you selected “Multiple” patients in #3, select whether or not this is/was a *Multi Casualty Incident*. If incident is an MCI, complete the *Triage Classification for (this) MCI Patient*.
5. Select any appropriate *Type of Scene Delay(s)*.
Patient: Patient Info

Patient: Patient Info Screen Inputs (many of these items will populate from previous screens)

1. Enter the Arrived at Patient Date/Time
2. Enter the Patient’s First Name
3. Enter the Patient’s Last Name
4. Use to Find a Repeat Patient
5. Use the Same As Incident Address button to copy the incident address to the patient address
6. Enter the Patient’s Home Address
7. Complete the Patient’s Home City
8. Complete the Patient’s Home ZIP CODE
9. Select the Patient’s Home County
10. Enter the Patient’s Home State
11. Select the Patient’s Home Country
12. Complete the City/County/State fields by selecting Set From Postal Code
<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Click to Add Patient Phone Numbers</td>
</tr>
<tr>
<td>14</td>
<td>Select the patient’s Gender</td>
</tr>
<tr>
<td>15</td>
<td>Enter the Race</td>
</tr>
<tr>
<td>16</td>
<td>Enter/confirm the Date of Birth</td>
</tr>
<tr>
<td>17</td>
<td>Enter/confirm the patient Age</td>
</tr>
<tr>
<td>18</td>
<td>Enter/confirm the Estimated Body Weight</td>
</tr>
</tbody>
</table>
Patient: Patient Hx

**Patient: Patient Hx Inputs**

1. Select who the *Medical History Obtained From*
2. If you didn’t complete it in the previous sections then click to enter the patient’s *Medical/Surgical History*. You can select multiple options in this field
3. Select any *Alcohol/Drug Use Indicators* that were present. If none were present, select “Not Applicable”
4. Click *Add* to enter any *Patient Practitioners* (i.e. PMD)

Patient: Patient Medications

**Patient: Patient Meds Inputs (if captured, will populate from Quick Report)**

1. Add any noted *Current Medications* in this field. Multiple medications may be listed.
   - Click to select “None Reported”, “Not Applicable”, “Not Reported”, “Unable to Obtain”, etc.
Patient: Patient Allergies

Patient: Patient Allergies Inputs (if captured in Quick Report, will auto populate)

1. Add any noted Medication Allergies in this field. Multiple medications may be listed.
   - Click to select “No Known Drug Allergy”, “Not Applicable”, “Not Reported”, “Unable to Obtain”, etc.
2. Click to enter any Environmental/Food Allergies

Assess/Treat: Patient Conditions

Patient Condition: The Patient Condition form selections will dictate the requirements throughout the completion of the Patient Care Record. If specialty care conditions were present, selecting the appropriate scenario will adjust the validation requirements and will auto populate a number of fields to reflect those specialty care situations.

Also, with any Trauma or specialty care situations, additional sub forms will be required. See “Other, Less Common” Forms for more information.

1. Select whether this is a Trauma/Medical Patient
2. Select any appropriate Specialty Care
Assess/Treat: Complaint/Impression

Assess/Treat: Complaint/Impression Inputs

1. Enter the Date/Time of Symptom Onset/Last Normal
2. Click Add to add a patient complaint
   3. Select the appropriate hierarchy of the Complaint Type
   4. Type to enter a Complaint, select the Time units of Duration of Complaint
   5. Enter the Duration of Complaint and
   6. Select the correct Time Units of Duration of Complaint
   7. Click OK
8. Select the Chief Complaint Anatomic Location
9. Select the Chief Complaint Organ System
10. If not entered earlier, enter the Provider’s Primary Impression
11. Select the appropriate answer to whether or not this was a Work-Related Illness/Injury
Assess/Treat: Assess/Exam

Assess/Treat: Assess/Exam Inputs (Power Tool Available)

1. Enter the *Estimated Body Weight* if not already populated
2. If used, enter the Broselow *Length Based Tape Measure* findings
3. Click *Add* to enter exam findings (see below)

<table>
<thead>
<tr>
<th>Exam</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date/Time</td>
<td>Enter the <em>Date/Time of Assessment</em></td>
</tr>
<tr>
<td>Skin Assessment</td>
<td>Enter the <em>Skin Assessment</em> results (multiple). Normal and Not Done are available for all fields</td>
</tr>
<tr>
<td>Head Assessment</td>
<td>Enter the <em>Head Assessment</em> results (multiple)</td>
</tr>
<tr>
<td>Face Assessment</td>
<td>Enter the <em>Face Assessment</em> results (multiple)</td>
</tr>
<tr>
<td>Neck Assessment</td>
<td>Enter the <em>Neck Assessment</em> results (multiple)</td>
</tr>
<tr>
<td>Chest/Lung Assessment</td>
<td>Enter the <em>Chest/Lung Assessment</em> results (multiple)</td>
</tr>
<tr>
<td>Abdomen Exams</td>
<td>Click <em>Add</em> to enter <em>Abdomen Exams</em></td>
</tr>
<tr>
<td>Pelvic/Genitourinary Assessment</td>
<td>Click to enter <em>Pelvic/Genitourinary Assessment</em></td>
</tr>
<tr>
<td>Spine Exams</td>
<td>Click <em>Add</em> to enter <em>Spine Exams</em></td>
</tr>
<tr>
<td>Extremity Exams</td>
<td>Click <em>Add</em> to enter <em>Extremity Exams</em></td>
</tr>
<tr>
<td>Eye Exams</td>
<td>Click <em>Add</em> to enter <em>Eye Exams</em></td>
</tr>
<tr>
<td>Mental Status Assessment</td>
<td>Enter the <em>Mental Status Assessment</em> results (multiple)</td>
</tr>
<tr>
<td>Neurological Assessment</td>
<td>Enter the <em>Neurological Assessment</em> results (multiple)</td>
</tr>
</tbody>
</table>

1. Click to *Add Another*, OK, or Cancel
2. Enter the *Date/Time of Assessment*
Assess/Treat: Treatment/Vitals Inputs

1. If you made base contact enter the Base Hospital Contact Date/Time
2. Enter the Base Hospital Contacted
3. Select any/all Barriers to Patient Care
4. Click to Add Vitals (next page)
## Vital Signs

1. Click to Add Another, Cancel, or select OK
2. Enter the Date/Time Vital Signs Taken
3. Enter the ECG
4. Enter the ECG Type
5. Enter the Method of ECG Interpretation
6. Enter the Systolic Blood Pressure
7. Enter the Diastolic Blood Pressure
8. Select the Method of Blood Pressure Measurement
9. Enter the Heart
10. Optional: Enter the Pulse Rhythm
11. Enter the Pulse Oximetry measurement
12. Enter the Pulse Oximetry Qualifier
13. Enter the Respiratory Rate
14. Optional: Enter the Respiratory Effort
Vital Signs (continued)

15 If measured, enter ETCO2
16 Enter Blood Glucose Level
17 Optional: Enter GCS Score-Eye
18 Optional: Enter GCS Score-Verbal
19 Optional: Enter GCS Score-Motor
20 Optional: Enter GCS Score-Qualifier
21 Select the Level of Responsiveness (AVPU)
22 Optional: Enter the Pain Scale Score
Assess/Treat: Narrative

1 Type the appropriate narrative. See Appendix A: Sample Narratives

Signatures: Signatures

1 Click to Add crewmember signatures and then select the desired signature
Signatures: Signatures (Signature capture)

Signatures: Signatures Screen Inputs

1. If not populated, click to Select Crew Member
2. Enter the Signature Last Name
3. Enter the Signature First Name
4. Sign the Patient Care Record
5. Enter the Date/Time of Signature

Note: If additional signatures are desired, select “OK” and repeat the process
Times

**Times: Time Inputs (located on top right edge)**

1. Click to enter the *Dispatch Notified Date/Time* if not already populated by CAD
2. Click to enter the *Unit Notified by Dispatch Date/Time* if not already populated by CAD
3. Click to enter the *Unit En Route Date/Time* if not already populated by CAD
4. Enter the *Unit Arrived on Scene Date/Time* if not already populated by CAD
5. Enter the *Arrived at Patient Date/Time*
6. Enter the *Transfer of EMS Patient Care Date/Time*
7. Enter the *Date/Time of Symptom Onset*

At this time the basic patient documentation is completed and valid. Note that any deviation in basic disposition and/or additional patient documentation such as exams, assessments, and interventions will require additional additional information entered to create a fully valid, accurate patient care report.
Transport Agency: Additional Report Requirements

In addition to the Common Report standard forms, units involved in patient transportation will be required to complete the following forms.

Trans/Dest:Trans Info

Transportation Information
1. Select any/all applicable methods How Patient Was Moved to Ambulance (multiple selections available)
2. Select a EMS Transport Method
3. Select Transport Mode from Scene
4. Select Condition of Patient at Destination
5. Choose appropriate Position(s) of Patient During Transport (multiple selections available)
6. Choose Number of Patients Transported in this EMS Unit
7. If required, select the Type(s) of Transport Delay (multiple selections available) (default “None/No Delay”)
Destination Information

1. Enter the time that Receiving Hospital Contacted Date/Time
2. Choose the Destination/Transferred to Name
3. Enter the Destination Street Address (all fields can be set from Set From Postal Code button below)
4. If not auto-populated, complete the Destination City
5. Enter the Destination State
6. Enter the Destination County
7. Enter the Destination Zip
8. Enter all appropriate Reason(s) for Choosing Destination (multiple selections possible)
9. Select the Type of Destination
10. Select How Patient Was Transported from Ambulance
11. Enter all appropriate Type(s) of Turn-Around Delay (multiple selections possible)
Trans/Dest: Patient Valuables

Patient Belongings
1 Select all appropriate Patient Belongings
2 Choose where/who Patient Belongings Left With

Billing Information

Billing and Insurance
1 Click Add to open the Billing Insurances form
Billing Information (continued)

1. Enter/Select the **Insurance Company Name**
2. Enter the **Insurance Group ID**
3. Enter the **Insurance Policy ID Number**
   If appropriate, choose “Add Another” to enter secondary insurance

(next page)
Other Commonly Used Forms
Assess/Treat: Patient Procedure

**Patient Procedure; In the Treatment/Vitals Tab, Access this Form with the Procedures:Add Button.**

1. Enter the Date/Time Procedure Performed
2. Select whether or not the Procedure Performed Prior to this Unit’s EMS Care
3. Enter the Role/Type of Person Performing the Procedure. Note: this will limit the available procedures dependent upon the Crew Member’s scope.
4. Enter the Crew Member Performing the Procedure
5. Select the Procedure attempted and/or performed
6. Select whether or not the Procedure was Successful
7. Select the anatomical Procedure Location
8. If appropriate, enter (type entry) the Size of Procedure Equipment
9. Enter the Number of Procedure Attempts
10. Enter any/all (or “None”) Procedure Complication(s)
11. If appropriate, enter the CMS Intact Prior
12. If appropriate, enter the CMS Intact After
13. Select the Response to Procedure
14. Select the Procedure Authorization method
15. Optional: Add any Procedure Comments necessary to adequately document
Assess/Treat: Medications

Medication Administration; In the Treatment/Vitals Tab, Access this Form with the Medications: Add Button.

Note: It is more efficient to enter medication administration through the MEDS power tool

1. Enter the Date/Time Procedure Performed
2. Select whether or not the Medication Administered Prior to this Units EMS Care
3. Enter the Role/Type of Person Administering the Medication. Note: this will limit the available procedures dependent upon the Crew Member's scope.
4. Enter the Medication Administered By
5. Choose Medication Given
6. Choose Medication Administered Route
7. Enter Medication Dosage
8. Enter Medication Dosage Unit
9. Select the Response to Medication
10. Enter any/all (or “None”) Medication Complication(s)
11. Select the Medication Authorization
12. Enter any Medication comments
Other, Less Common Forms

Assess/Treat: Injury/Potential Injury

Assess/Treat: Injury/Potential Injury Form

1. Select any applicable *Cause of Injury*
2. Select any/all *Mechanism(s) of Injury*
3. Select the appropriate *Main Area(s) of the Vehicle Impacted by the Collision*. See #8
4. Enter the *Location of Patient in Vehicle*
5. Select all items that describe *Use of Occupant Safety Equipment*
6. Select all *Airbag Deployment* options
7. If the injury was due to a fall, enter the *Height of Fall (feet)*
8. When entering #3, this box will pop up on the left. Select the appropriate number coinciding with the *Main Area of the Vehicle Impacted by the Collision*
Assess/Treat: Trauma Triage Form

1. Choose the correct response to Meets Trauma Triage Criteria?
2. Select any/all applicable Trauma Center Criteria (multiple selections available)
3. Select a Additional Trauma Triage Criteria
4. Select any/all applicable Other Trauma Triage Criteria (multiple selections available)
Assess/Treat: 12 Lead ECG/STEMI

1. Click Add to include a 12 lead interpretation into the ePCR
2. Select whether or not a 12 Lead ECG Performed?
3. Select the STEMI Probable? response
4. Choose the method(s) the STEMI 12 Lead ECG Interpreted By (multiple entries possible)
5. Choose OK to accept
Assess/Treat: Stroke

1. Enter the *Date/Time Last Known Well*
2. Select the correct response to a *Speech* assessment
3. Select the correct result for a *Facial Droop* assessment
4. Select the result of the *Arm Drift* test
5. Select the *Scale Type*
6. Select whether or not the patient has a history of *Previous Stroke or Head Trauma*
7. If possible enter the *Contact Person Last Name*
8. If possible enter the *Contact Person First Name*
9. Enter/Select the *Contact Person Relationship*
10. Enter the pertinent *Relative Phone Numbers*
Assess/Treat: Advanced Airway

Advanced Airway; In the Treatment/Vitals Tab, Access this Form with the Advanced Airway Confirmation: Add Button.

1. Select if you need to Add Another, Cancel or OK to accept
2. Enter the Date/Time Airway Device Placement Confirmed
3. Choose the Airway Device Being Confirmed
4. Choose the Airway Device Placement Confirmation Method
5. Select the Crew Member ID
6. Select the Type of Individual Confirming Airway Device Placement
7. List any Airway Complications Encountered
8. If appropriate, select any Suspected Reasons for Failed Airway Procedure
9. Enter the Tube Depth
10. Select where the Airway Measured At
11. Select whether or not Gastric Sounds were present
12. Select whether or not Breath Sounds-Left were present
13. Select whether or not Breath Sounds-Right were present
Advanced Airway (continued)

14 Confirm Chest Rise-Left

15 Confirm Chest Rise-Right

16 Select Esophageal Detector Device result

17 Select ETT Placement Verification

(next page)
Assess/Treat: Medical Device

Assess/Treat: Medical Device (applies to electrical interventions; much information may be imported from the device); In the Treatment/Vitals Tab, Access this Form with the Medical Device: Add Button.

1. Select if you need to Add Another, Cancel or OK to accept
2. Enter the Date/Time of Event (per Medical Device)
3. Select the Medical Device Event Type
4. If applicable, upload any EKG Waveform Files
5. Select the Medical Device ECG Lead(s) (multiple selections possible)
6. Enter the Medical Device ECG Interpretation
7. Select the Type of Shock
8. Enter the amount of Shock or Pacing Energy
9. Enter the Total Number of Shocks Delivered
10. Enter the Pacing Rate
11. Select whether or not the device had Capture
Assess/Treat: Controlled Substance
Assess/Treat: Controlled Substance Administration; In the Assess/Treat Section, Access this Form with the Controlled Substances: Add Button.

1. Select the type of Controlled Substance Medication Name
2. Enter the Controlled Substance Amount Taken
3. Enter the Controlled Substance Amount Administered
4. Enter the Controlled Substance Amount Wasted
5. Enter the Controlled Substance Amount Returned
6. Select the Controlled Substance Amount Units
7. Enter the Narcotic Seal Number or Broken Seal Number (refer to your agency controlled substance policy)
8. Enter the New Seal Number (refer to your agency controlled substance policy)
9. Insert the Crew Initial #1 initials
10. Enter the Crew Initial #1 License ID
11. Enter the Crew Initial #1 initials
12. Enter the Crew Initial #2 License ID

(next page)
Assess/Treat: Cardiac Arrest

Cardiac Arrest Form

1. Select Cardiac Arrest status
2. Select Cardiac Arrest Etiology
3. Choose the Resuscitation Attempted by EMS
4. Select Arrest Witnessed By
5. Was CPR Care Provided Prior to EMS Arrival
6. If yes on #5, select Who Provided CPR Prior to EMS Arrival
7. Was there AED Use Prior to EMS Arrival
Cardiac Arrest Form (continued)

8 If “Yes” on #7, Select Who Used AED Prior to EMS Arrival
9 Select the Type of CPR Provided
10 Select the First Monitored Arrest Rhythm of the Patient
11 Was there Any Return of Spontaneous Circulation (ROSC)
12 Enter the Date/Time of Cardiac Arrest
13 Enter the Date/Time of First CPR
14 Enter the Date/Time of First Defib Shock
15 Enter the ROSC Time
16 Enter the Date/Time Resuscitation Discontinued
17 If appropriate, enter the Reason CPR/Resuscitation Discontinued or Not initiated
18 Enter the Cardiac Rhythm on Arrival at Destination
19 Select the Patient Condition at End of EMS Event
Power Tools

There are several Power Tools designed within the Santa Barbara County ePCR system. As the system evolves, those Power Tools may change, there may be other Power Tools added, and some or all may be removed depending on user feedback.

Below is an example of the Medications Power Tool. Most Power Tools have a similar interface and operation.

1 Power Tool Identification Label. In this case, showing the “Medication” Power Tool is open
2 Crew Member performing the intervention
3 Date/Time stamp. Like all date/time stamps throughout, the clock symbol will input the current date/time.
4 Record action buttons. OK saves, Cancel clears current form and closes the tool, and Delete is to remove unwanted or accidental entries
5 To record interventions that occurred Prior to Arrival, select “Yes”
6 Search tool. Enter any part of an intervention/action name to narrow the list
7 Common Medications. This list is narrowed by Crew Member provider qualifications
8 Favorites and alphabetical list. Use to narrow the visible list of interventions.

Notes regarding the Assessment Power Tool

1 The tool has buttons at the bottom to allow the provider to provide assessment information to multiple body systems simultaneously. Click to begin tagging multiple systems, click “Done Tagging” when complete.
2 When entering an assessment for a body system, click the system button. This will open the subform for that system on the right half of the screen. When complete, click the body system button again to close the subform.
Specialty Care: Trauma

**Patient Conditions**

1. Trauma/Medical Patient:
   - Medical
   - Trauma
   - Medical/ Trauma

2. Specialty Care:
   - Cardiac Arrest
   - STEMI
   - Trauma Triage
   - Stroke
   - Cardiac Arrest w/ ROSC
   - N/A

**Injury/Potential Injury**

3. Cause of Injury:
   - Find Value...

   - Mechanism of Injury:
     - Blunt
     - Burn
     - Penetrating

   - Main Area of the Vehicle
     - Impacted by the Collision:

   - Location of Patient in Vehicle:

   - Use of Occupant Safety Equipment:
     - Find Value...

   - Airbag Deployment:
     - Airbag Deployed Front
     - Airbag Deployed Side
     - Airbag Deployed Side
     - No Airbag Deployed
     - No Airbag Present

   - Was the patient forcibly extricated from the vehicle:
     - No
     - Yes

   - Height of Fall (Feet):

**Trauma Forms**

1. Select Trauma

2. Select Trauma Triage

3. Enter Cause of Injury and Mechanism of Injury, as well as all required and any pertinent fields into the Injury/Potential Injury form.
Specialty Care: Trauma Triage

Trauma Triage and Destination Forms Examples

1 Select the highest step applicable for Meets Trauma Triage Criteria
2 Then select all appropriate Trauma Triage Center Criteria
3 If you are transporting to a Trauma Center due to criteria: in Trans/Dest: Dest. Info. Always select “Specialty Center” for Reason for Choosing Destination, regardless of the distance to the Trauma center
4 Select the Type of Destination
5 If Diverted, enter the Facility Diverted From - Name
STEAMI Forms

1. Select Medical for Trauma/Medical Patient?
2. Then select STEMI for Specialty Care
   Select Add to add your 12 Lead information. Select the appropriate responses. In STEMI 12 Lead ECG
3. Interpreted By: choose Cardiac Monitor Program unless it was interpreted by an appropriate caregiver in the event of transporting from a facility. Click OK to accept.
Specialty Care: STEMI (2 of 4)

**STEMI Procedure Form**

1. On the Quick Report or Assess/Treat: Treatment/ Vitals form, select Add to add a procedure. Click OK when complete to accept.
2. Enter the Date/Time Procedure Performed.
3. Enter 12 Lead ECG Obtained for Procedure.
4. Select the answer for Procedure Successful.
5. Enter the Number of Procedure Attempts.
6. Select the appropriate Procedure Authorization.
Specialty Care: STEMI (3 of 4)

**STEMI Medication Form**

On the Assess/Treat: Treatment/Vitals tab, select Add to add a medication. Do this for each medication or choose Add Another to add additional meds. Select OK when complete.

1. Enter the Date/Time Medication Administered
2. Answer whether or not Medication Administered Prior to this Unit’s EMS Care
3. Select the Role/Type of Person Administering Medication
4. Select the Medication Administered
5. Choose the Medication Administered Route
6. Enter the Medication Dosage
7. Select the correct Medication Dosage Units
8. Choose the Response to Medication
9. Enter any Medication Complication
10. Select the Medication Authorization
11. Enter any Medication Comments
STEMI Destination Forms

1. If you are transporting to a Specialty/STEMI Center due to criteria: in Trans/Dest: Dest. Info. Always select "Specialty Center" for Reason for Choosing Destination, regardless of the distance to the center.

2. Select the Type of Destination.

3. If Diverted, enter the Facility Diverted From - Name.

(next page)
Stroke Forms
1 Select Medical for Trauma/Medical Patient?
2 Then select Stroke for Specialty Care
3 In the Assess/Treat: Complaint/Impression form enter the Date/Time of Symptom Onset/Last Normal
4 At Patient Complaints: select Add to add the complaint information.
5 Select/enter the appropriate responses, completing each field accurately
Specialty Care: Stroke (2 of 4)

**Stroke Complaint Example**

In the Assess/Treat: Complaint/Impression form enter the *Date/Time of Symptom Onset/Last Normal*

At Patient Complaints:
1. select *Add* to add the complaint information.
2. Select the *Complaint Type*
3. Enter the *Complaint*
4. Enter the *Duration of Complaint*
5. Select the *Time Units of Duration of Complaint*.
6. Click *OK* to accept
7. Enter the *Chief Complaint Anatomic Location*
8. Select the appropriate *Chief Complaint Organ System*
9. Select the *Primary Symptom*
10. Choose any *Other Associated Symptoms* (multiple selections allowed)
11. Select the *Provider’s Primary Impression*
12. Choose the correct response to *Work-Related Illness/Injury*
Stroke Specialty Care Form

1. Enter the Date/Time Last Known Well. This does not populate from the Complaint/Impression tab.
2. Select the Speech assessment result.
3. Choose the most correct response to the Facial Droop assessment.
4. Choose the result of the Arm Drift test.
5. Choose the appropriate stroke Scale Type used.
6. Select whether or not the patient has Previous Stroke or Head Trauma history.
7. Enter a Contact Person Last Name for Emergency Department follow up.
8. Enter the Contact Person First Name.
9. Select the Contact Person Relationship.
10. If possible, enter the contact person or Relative Phone Numbers.
Stroke Destination Forms

1. In the Assess/Treat: Treatment/Vitals tab, ensure you have entered the *Base Hospital Contact Date/Time*.

2. Choose the *Base Hospital Contacted*.

3. If you are transporting to a Specialty/Stroke Center due to criteria: in Trans/Dest: Dest. Info. *Always* select “Specialty Center” in *Reason for Choosing Destination*, regardless of the distance to the center.

4. Select the *Type of Destination*.

5. If Diverted, enter the *Facility Diverted From - Name*.

**Note:** Ensure you submit a minimum of 2 sets of vital sign assessments for all stroke patients.
Specialty Care: Determination of Death (DOD)

1. In the Incident:Response Info form, enter **Determination of Death (DOD)** in the Response Disposition field.

2. In the Assess/Treat:Patient Conditions form, select **Medical** to complete the Trauma/Medical Patient field.

3. Select **N/A** under Specialty Care?

   **Note:** Determination of Death includes scenarios where no resuscitation attempts were made due to determination criteria being present.

(next page)
Specialty Care: Termination of Resuscitation

1. In the Incident:Response Info form, enter **Determination of Death (DOD)** in the Response Disposition field.
2. In the Assess/Treat:Patient Conditions form, select **Medical** to complete the Trauma/Medical Patient field.
3. In the event of a Trauma Code scenario, select **Medical/Trauma**
4. Select **Cardiac Arrest** under Specialty Care?
5. Choose **General/Global** to complete Chief Complaint Anatomic Location
6. Complete Chief Complaint Organ System
7. Enter **Cardiac Arrest** to document the Provider’s Primary Impression
**Specialty Care: Inter-facility Transfers**

1. In the Incident:Response Info form, enter **Inter-facility Transport** in the *Type of Service Requested* field.

2. In the Assess/Treat:Patient Conditions form, select **Medical** to complete the *Trauma/Medical Patient* field.

3. Select **N/A** under *Specialty Care*?

   **Note:** Inter-facility transfers should ALWAYS include 2 sets of vital signs. Additionally, the narrative MUST include the reason for the IFT, who you received the report from, the final destination, whom you delivered the patient report to, and all other pertinent information.