SafetyPAD ePCR Instructions

Supersedes:
Effective: 09-24-10

CREW SETUP
NOTE: ePCR devices should be power cycled at the beginning of each shift to refresh the crew set-up and install any new software updates.

- UNIT -Select the correct unit designator as identified within CAD.
- SHIFT -Select the correct shift.
- SKILL -Select the appropriate unit skill level. ALS for all ALS units, BLS for BLS units.

CALL
DISPATCH

- DISPATCH -The time the unit was dispatched to the incident.
- ENROUTE - The time your unit departed its location and was en route to the scene of the incident.
- INCIDENT TYPE -Select the incident type.
- DATE DISPATCHED -Enter the date.
- INCIDENT # -Enter the nine digit incident (#ED) number.
- STREET -Enter the dispatched street address.
- AT SCENE -Enter the time your unit arrived at the scene.

  Note: Many of the fields will be automatically populated via a CAD "push". If the information is missing, it must be entered manually

PATIENT
IDENTIFY

- LAST NAME -Enter the patient's last name. If unknown, use the *"Unknown*?" button.
- FIRST NAME -Enter the patient's first name. If unknown, write unknown.
- SSN -Enter the patient's social security number on all patients transported by your unit.
- AT PATIENT -Enter the time first contact is made with patient.
- DOB -Enter the patient's date-of-birth. If DOB is unknown, approximate in the Age field.
- AGE -Enter the patient's age only if DOB is unknown, approximate if necessary or select the age in months/weeks/day's/hours -as appropriate, if less than 1 yr.
- SEX -Select the appropriate response.
- *ADDRESS*
  - STREET -Enter the patient's home mailing address.
  - CITY -Enter the patient's home mailing city.
  - STATE -Enter the patient's home mailing State.
  - POSTCODE -Enter the patient's home mailing zip-code.

FINDINGS

This section shall indicate the findings of the patient exam which will be supported by documentation in the narrative area of the report. Entries in these fields shall reflect the relevant clinical findings, or lack of findings, for the proper assessment and treatment of the patient.

VITALS

Record the time. Pulse - Only palpable pulses will be recorded, (no electronic readings will be placed in the pulse section). Respiration -Document the respiratory rate. Blood Pressure - Document systolic and diastolic. If palpated, select "Palp". Select the position the patient was in when the blood pressure and pulse were taken. Sp02%, select if the Sp02% was obtained at room air or with oxygen being delivered.

INITIAL

NOTE: The primary assessment will be documented in this section.

- PT FOUND -Select the appropriate response.
- LOC -Select the appropriate response to both questions.
- AIRWAY -Select the appropriate response.
- BREATHING -Select the appropriate response.
- CIRCUL -Select the appropriate response to each question.
- GCS -Select Adult or Pedi and answer appropriately.
- SKIN -Select the appropriate response.
- EYES -Select the appropriate response question.
- NEURO -Select the appropriate response to each question when a stroke assessment is completed.
- BLOOD SUGAR -Document the blood sugar, select High or Low if indicated on the Glucometer. Repeat Blood sugar documentation is required for a treat and release of a person treated for a hypoglycemic event.
- ECG -Select the appropriate response to each question as applicable. If an ECG is conducted, whenever possible a merge and attach with the LifePak and the ePCR must be completed.
- EtC02 -Required on all intubated patients.
- SCORES / PAIN -Required for any patient that complains of pain.
- SCORES / APGAR –if applicable.

PHYSICAL

This section is used to document those findings that are observed. You are required to document the areas which are positive for findings and those which are suspected due to the patent's complaint. This area is where pertinent negatives of a physical assessment would be recorded. Many physical findings have additional details that are required to fully document the assessment and shall be completed where appropriate.

IMPRESSION
This section is used to document your impression of the present illness or complaint. Many of the impressions have additional details that are required to fully document your findings.

HX PRESENT
COMPLAINT
This section is used to document what the patient tells you, or why others, such as family or a bystander, called. This is where the patient's “chief complaint" will be documented. Many of the complaints have additional details that are required to fully document the patient's history of present illness.

SYMPTOM
This section is used to document the symptoms that the patient and/or bystanders use to describe the associations with the chief complaint and secondary symptoms. Many of the symptoms have additional details that are required to fully document the patient's history of present illness. This area is where pertinent negatives of the present complaint will be recorded.

CAUSE
The cause is what you suspect is the origin of the present illness. Many of the causes have additional details that are required to fully document the patient's history of present illness.

HXPAST
ALLERGIES
Document the patient's allergies as appropriate.

MEDS
Document the patient's medications.

PREEXIST
Document the patient's preexisting medical conditions. Pertinent negatives of preexisting medical conditions may also be documented here.

TREAT
PROCEDURE
Document all treatments given to the patient in the order in which they were given as well as changes in the patient's condition that are observed following treatment. Many of the treatments require additional details. Below are some common procedures with mandatory documentation details.

OUTCOME
RESULT

- DEPARTED -Enter the time your unit left the scene.

- AT DESTINATION -Enter the time your unit arrived at the hospital.
- DISPOSITION -Check the factors that apply.
- CURRENT DISPOSITION -Select AFTER choosing all factors that apply to disposition.
- MEDICAL CONSULTANT -Select the appropriate response when applicable.

TRANSPORT

- DESTINATION -Choose the hospital the patient was transported to.
- REASON FOR TRANSPORT -Select the reason for transport.
- REASON FOR DESTINATION -Select the reason for destination
- HOSPITAL PT# -Record the patient's hospital number if available.

SIGNATURE

Capture the signature of crewmembers, patient, patient representative, or facility representative in accordance with the "Patient Signature Requirement" SOP as applicable.

NARRATIVE

TEXT

After reviewing the report, the NARRATIVE TEXT of the ePCR should be completed as the sequence of events took place, from arrival until the patient's transfer of care. All treatment initiated by BLS and ALS units on each patient will be documented on each report. When entering text in this section, choose the appropriate category from the drop-down.