Vermont EMS
SIREN
(**S**tatewide **I**ncident **RE**porting **N**etwork)

Creating an Electronic Patient Care Report (ePCR)

VERMONT
DEPARTMENT OF HEALTH

Introduction

This guide will take you through how to document an incident in SIREN Elite. The workflow listed in this guide is that of the required fields for what's anticipated to be an "average call" for First Response as of November 2022. This guide will review of the NEMIS 3.5 patient care report.

This guide is not a comprehensive review of every section/field and the documentation requirements are subject to change. Some sections/fields will display information that is specific to an agency and in these sections, this guide will not precisely match what will show for you. These areas have been noted.

This guide primarily reviews the fields that are mandatory for most First Response patient care reports. Not all of the available fields that display in SIREN will be discussed in this guide. Additionally, what information is required will be dependent on the responses that are documented in the report. As information is entered in the report, the system will automatically guide you through which details are needed by flagging the required fields in red.

> *Example: If a responding unit is canceled by Dispatch prior to arrival on scene, the number of required fields will decrease from approximately 45 to approximately 9.*

Navigating this Guide

This guide follows the order in which an average provider documents an incident.

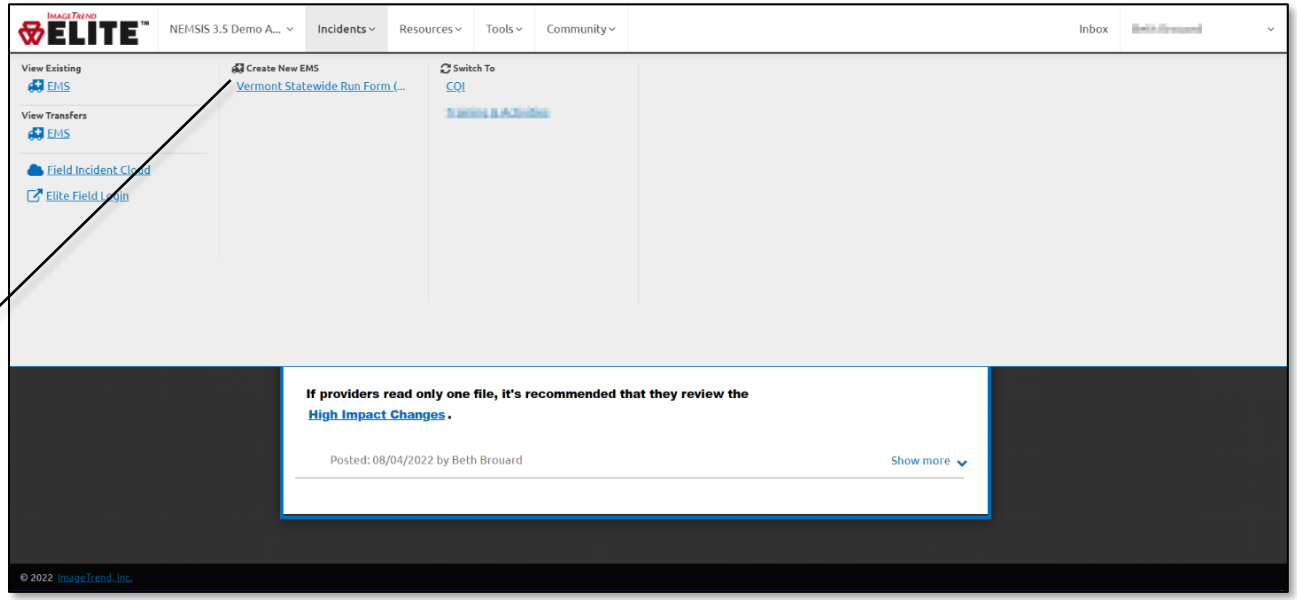
Each page of this file will include an overall view of how your screen will display, with areas of interested magnified.

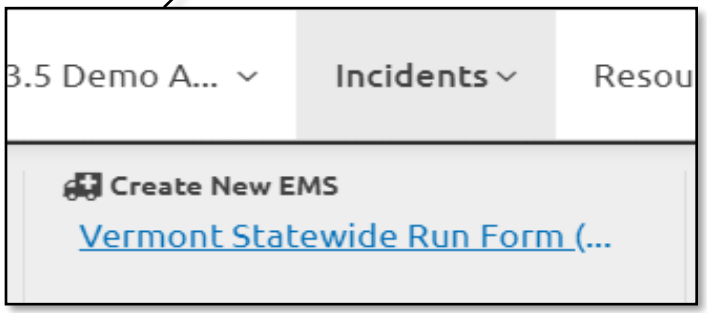
Recommendations for making documentation easier and more efficient for providers have been included throughout this guide, and these suggestions will display on the page that discusses the applicable section.

Finally, each page of this guide will include information in the upper right-hand corner, detailing what type of data is being collected on the page in question. The information will fall into one of three categories: Operations, Clinical and Reimbursement.

Table of Contents

Creating a New Form





Steps

After logging in, click:

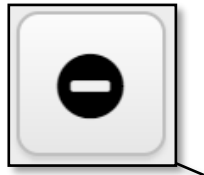
- Incidents
- Vermont Statewide Run Form

Additional Information

If you click on View Existing EMS, you will be able to view all incident records that you have created.

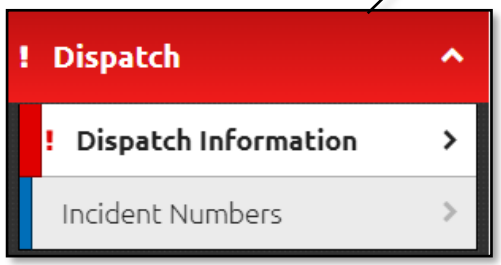
Navigating Through the Patient Care Report

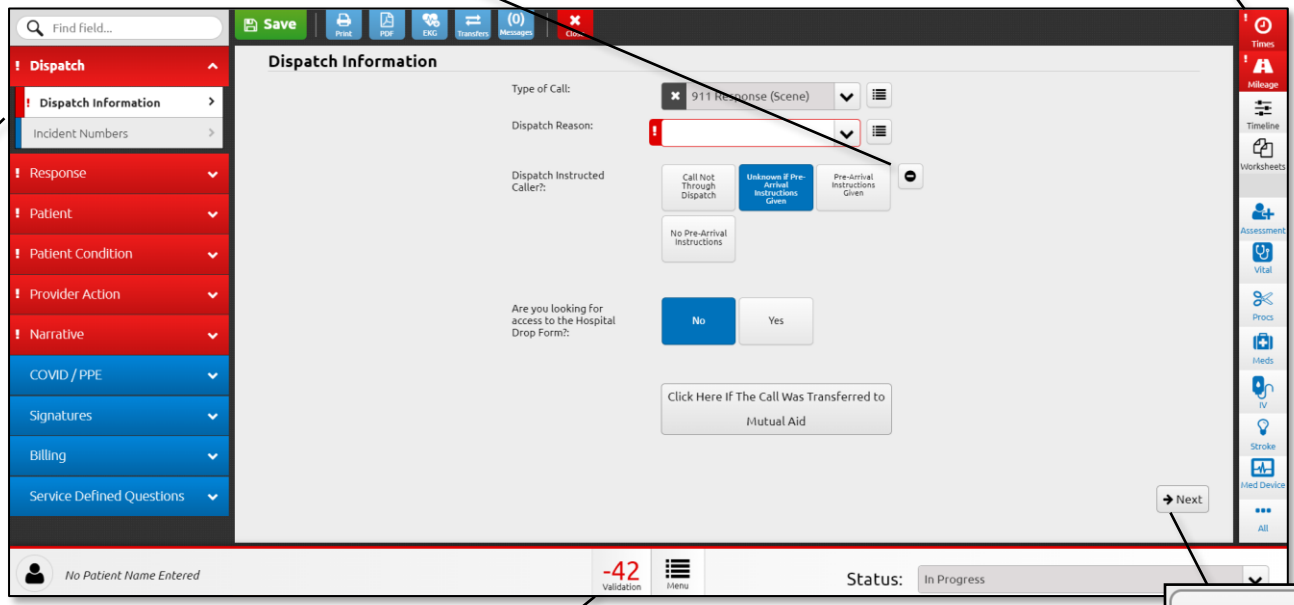
If you're unable to obtain a name or other information, there is a prohibition sign (circle with a line through it) that you can click on. You can then choose define why this information isn't being reported. You will see these prohibition signs in many areas of the system and they're there in case you don't have data that's listed as required or the requested information is not applicable.



The Times button will need to be chosen in order to enter information in that section—SIREN won't automatically take you to that area.

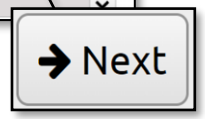
You can "jump around" by selecting any section on the left





The Validation Score shows on the bottom of the screen and currently reads of -42. With each entry into a red (aka required) field, this brings you closer to a perfect 100. The red fields will also turn to blue, making it easy to see what's left.

You can navigate through the form in order by clicking on Next. Unfortunately, there is not a "Back" button and if you need to revisit a previous section, you will need to select the Section (example: Dispatch) and Panel (example: Dispatch Information) on the left.



Additional Information

What's entered in some fields will affect others. For example if you select "Patient Treated, Transferred Care to Another EMS Unit", the Times section will require a "Patient Contact" date and time, which wasn't required previously. If you choose "Patient Treated, Transported by this EMS Unit", you will need to add in the Patient Contact time, the En Route Hospital/Left Scene time and Arrived Destination time, in addition to what may have previously been required.

Flagged Concerns: Validation Rules

When a required field is blank or there is an issue, it will have an exclamation mark next to it and be outlined in Red. If you click on the exclamation mark, details will list on where to go to fix the problem.

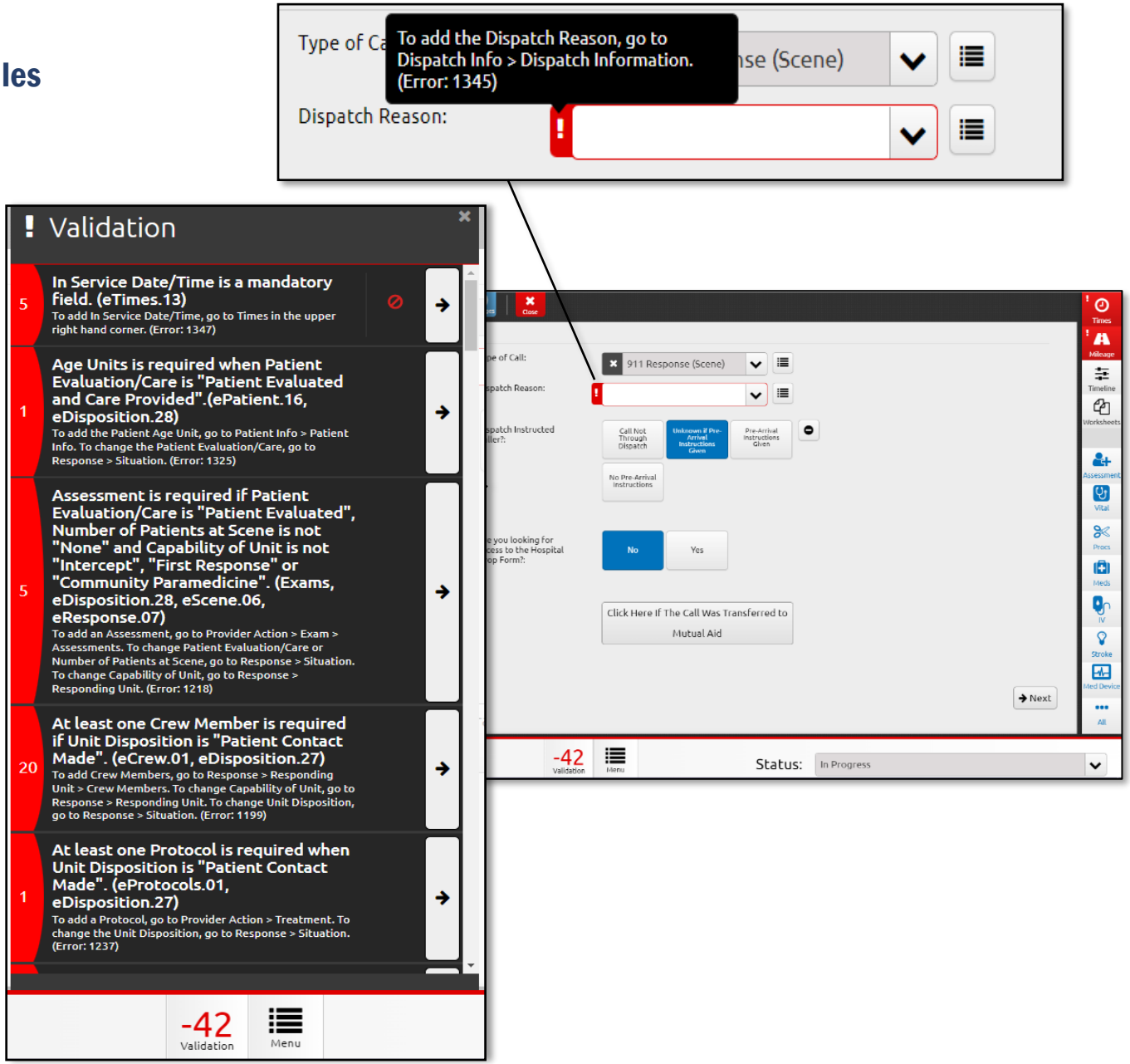
More information can be found if you click on the number in Red (or Yellow) at the bottom of the page. This will open a list of violations to the Validation Rules, along with the reason for the problem and instructions on where to go to fix the problem.

Validation Rules in Yellow are recommended. If these are not resolved, your score will not be impacted.

Validation Rules in Red are required. If these are not resolved, points will be subtracted from your total score.

Validation Rules with a red circle and a line through it,  are mandated items that must be added in order to close the patient care report.

Your incident's validation score must be a minimum of **85** in order to close the incident.



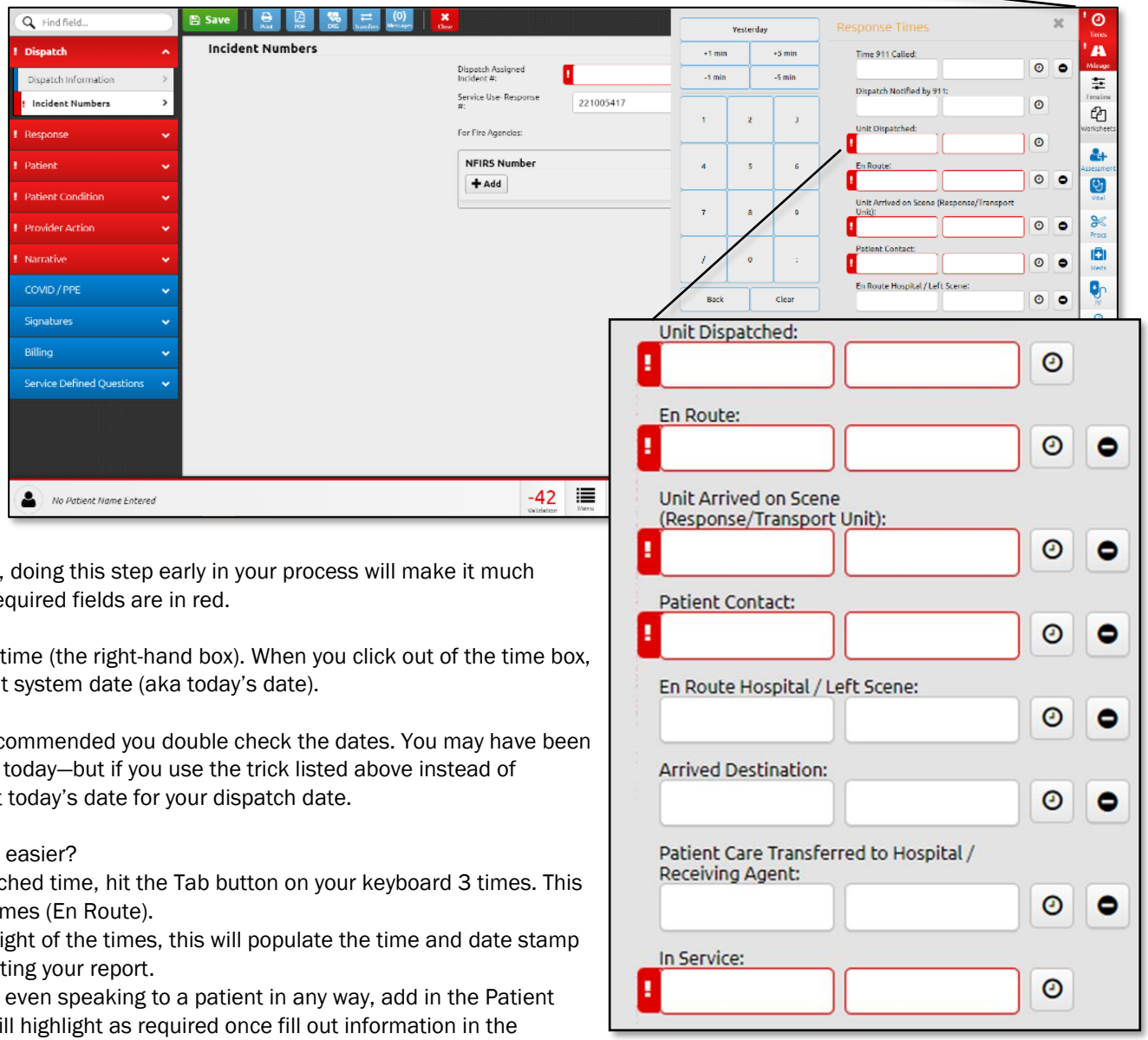
Type of Data: Operations, Reimbursement

Response and Incident Times

Steps

Under Times, enter:

- Unit Dispatched
- En Route
- Unit Arrived on Scene
- Patient Contact
- In Service



Additional Information

It's recommended that the Times be entered early. If for some reason the website closes, or your computer crashes, doing this step early in your process will make it much easier to pick up where you left off. The required fields are in red.

To easily enter the date, only enter in the time (the right-hand box). When you click out of the time box, the date will auto populate as your current system date (aka today's date).

Caution: If you run a call overnight, it's recommended you double check the dates. You may have been dispatched yesterday and back in service today—but if you use the trick listed above instead of manually entering the date, SIREN will list today's date for your dispatch date.

Want to make the dates and times a little easier?

- After entering in your Unit Dispatched time, hit the Tab button on your keyboard 3 times. This will move you to the next set of times (En Route).
- If you click the little clock to the right of the times, this will populate the time and date stamp for the exact moment you are writing your report.
- If you ended up providing care or even speaking to a patient in any way, add in the Patient Contact time at this point. This will highlight as required once fill out information in the Response > Situation section.

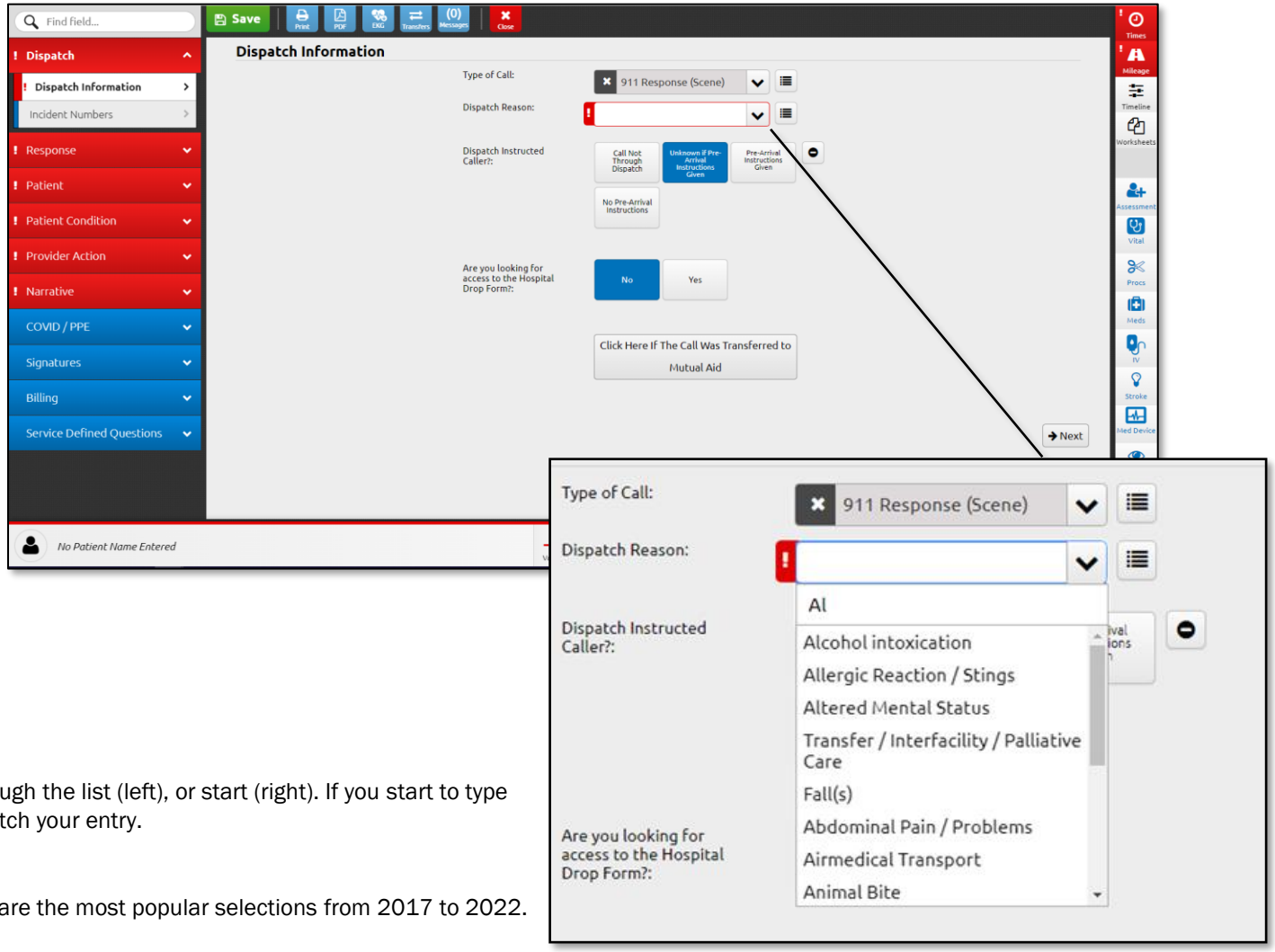
Type of Data: Operations, Reimbursement

Dispatch Information

Steps

Under Dispatch > Dispatch Information:

- Confirm the Type of Call is correct
  - This will automatically populate as "*911 Response (Scene)*.
  - If you are being sent to help in another agency's primary service area, change this drop down to "Mutual Aid".
- Enter the Dispatch Reason



Additional Information

For any drop-down menu, you can scroll through the list (left), or start (right). If you start to type something, the list of options will filter to match your entry.

The first six items listed in Dispatch Reason are the most popular selections from 2017 to 2022.

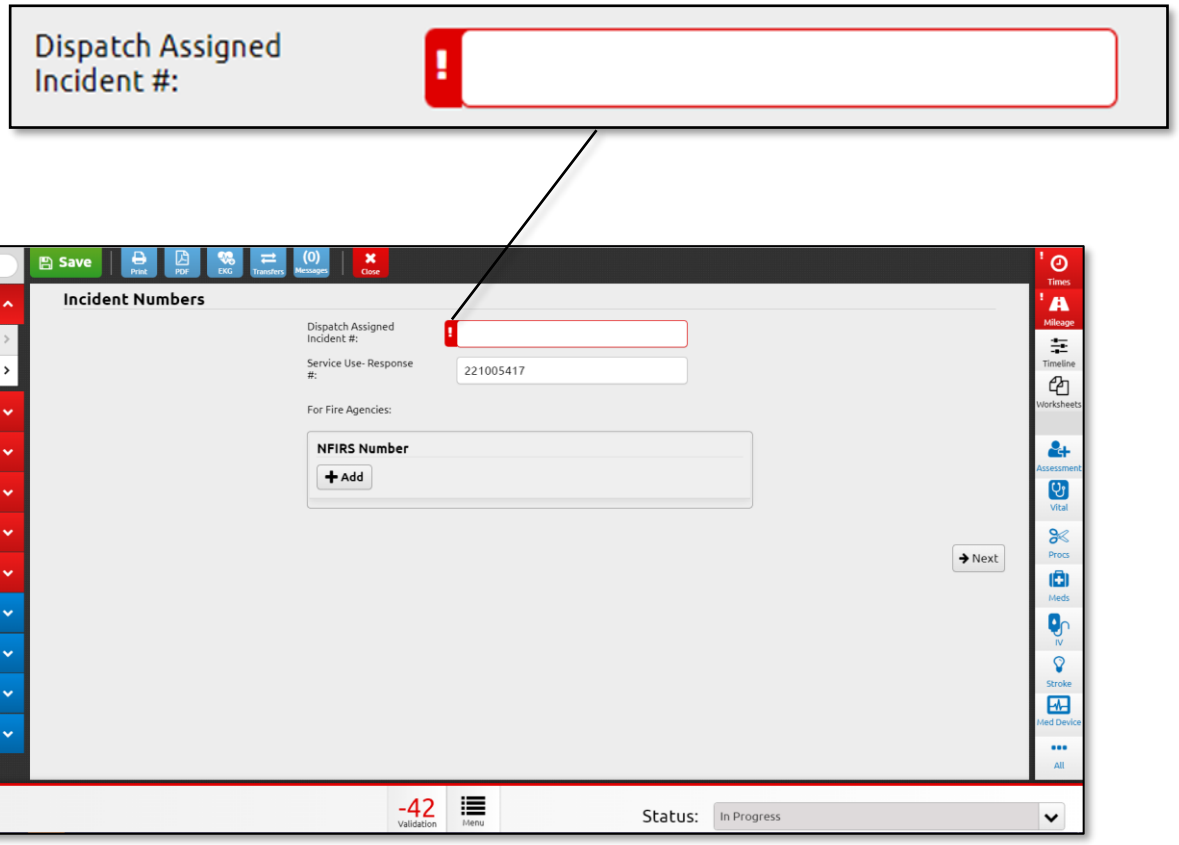
Type of Data: Operations

Incident Number

Steps

Under Dispatch > Incident Numbers:

- Enter the Dispatch Assigned Incident #, if this does not automatically default
- Enter the Service Use-Response #, if this does not automatically default



Additional Information

It's recommended that these numbers be different for every call you respond to so if you ever need to find a record in the future, it's easier to locate.

The Dispatch Assigned Incident # is obtained from Dispatch.

Some agencies have this area set up to automatically fill in a predetermined number. What displays and what is required for the Dispatch Assigned Incident # and the Service Use Response #, will be service-specific.

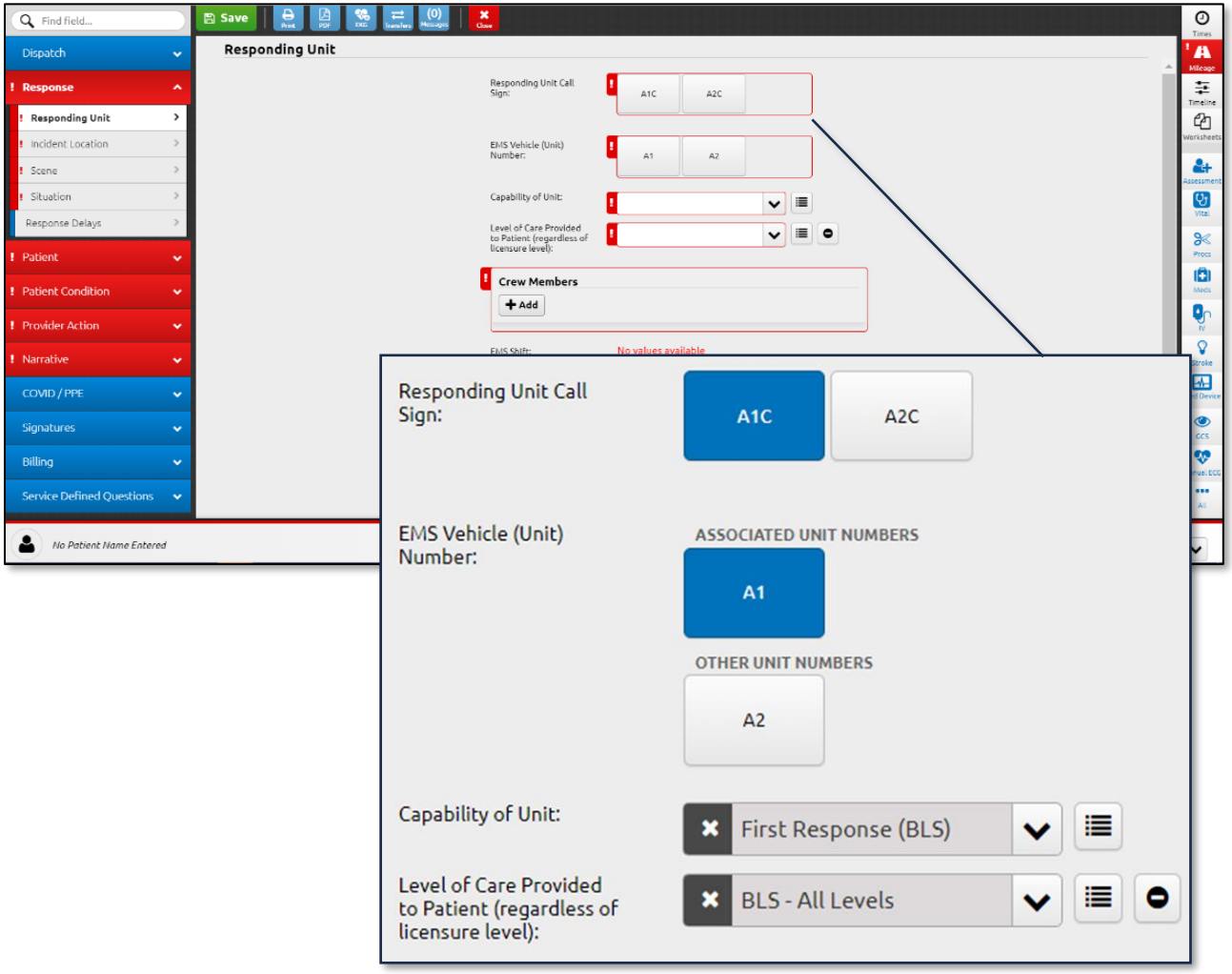
Type of Data: Operations, Reimbursement

Responding Unit

Steps

Go to Response > Responding Unit and enter:

- Responding Unit Call Sign
- EMS Vehicle (Unit) Number
    - Depending on your Agency's set up, this may default for you based on the Responding Unit Call Sign.
- Capability of Unit
- Level of Care Provided to Patient (regardless of licensure level)



Additional Information

Adding Crew Members will be reviewed on the next page.

This section will show different options for Responding Unit Call Sign, EMS Vehicle (Unit) Number and Crew Members information, based on your agency's set up. The available selections are designed to be service-specific.

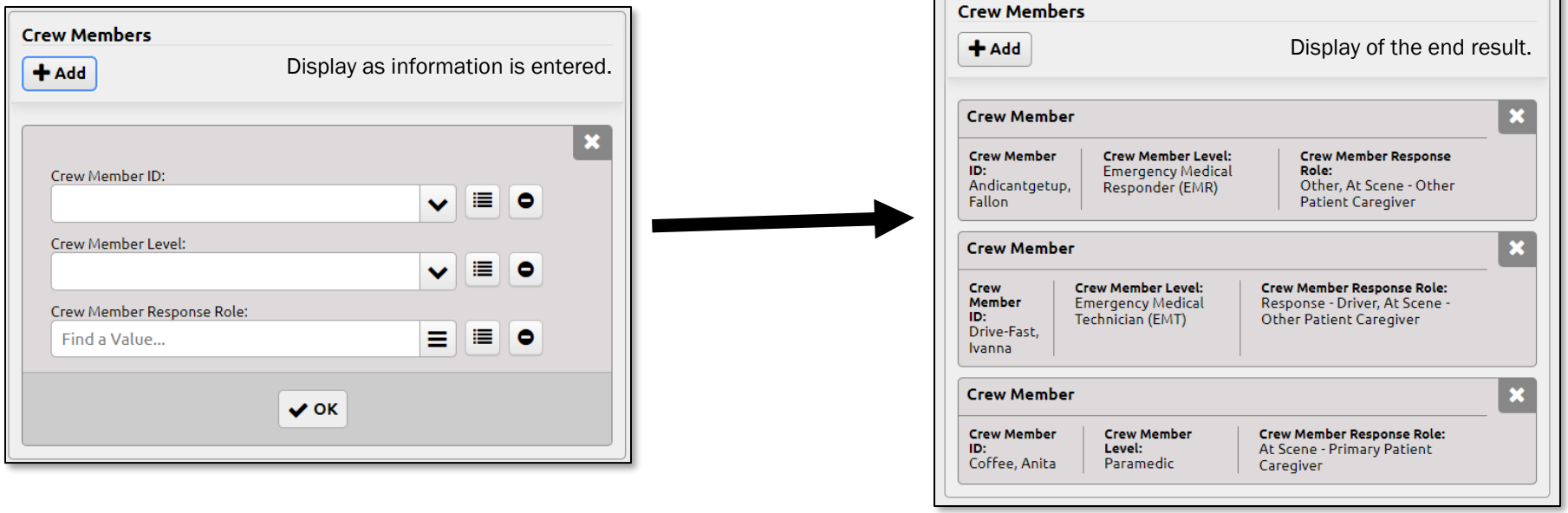
Type of Data: Operations, Reimbursement

Responding Unit: Crew Members

Steps

Under Response > Responding Unit:

- Click *Add* under Crew Members
- Locate the first crew member's name by either scrolling or typing in a part of their first or last name, then select them
- Confirm that the Crew Member Level is correct
  - This may default to the provider's level, depending on your agency's set up.
- Define their role(s) for the incident
  - This may display one or more roles, depending on your agency's set up for this crew member.
- Repeat as needed for all crew members that responded to the incident



Additional Information

Once a member has been added to your run form, and assuming they have rights to do this, they will be able to log into SIREN and view and/or edit the incident.

It's strongly recommended that every crew member that was on the call, is added to your run form—this could impact reimbursement rates, help with later reviewing staffing needs, and ensuring that providers receive "credit" for their work.

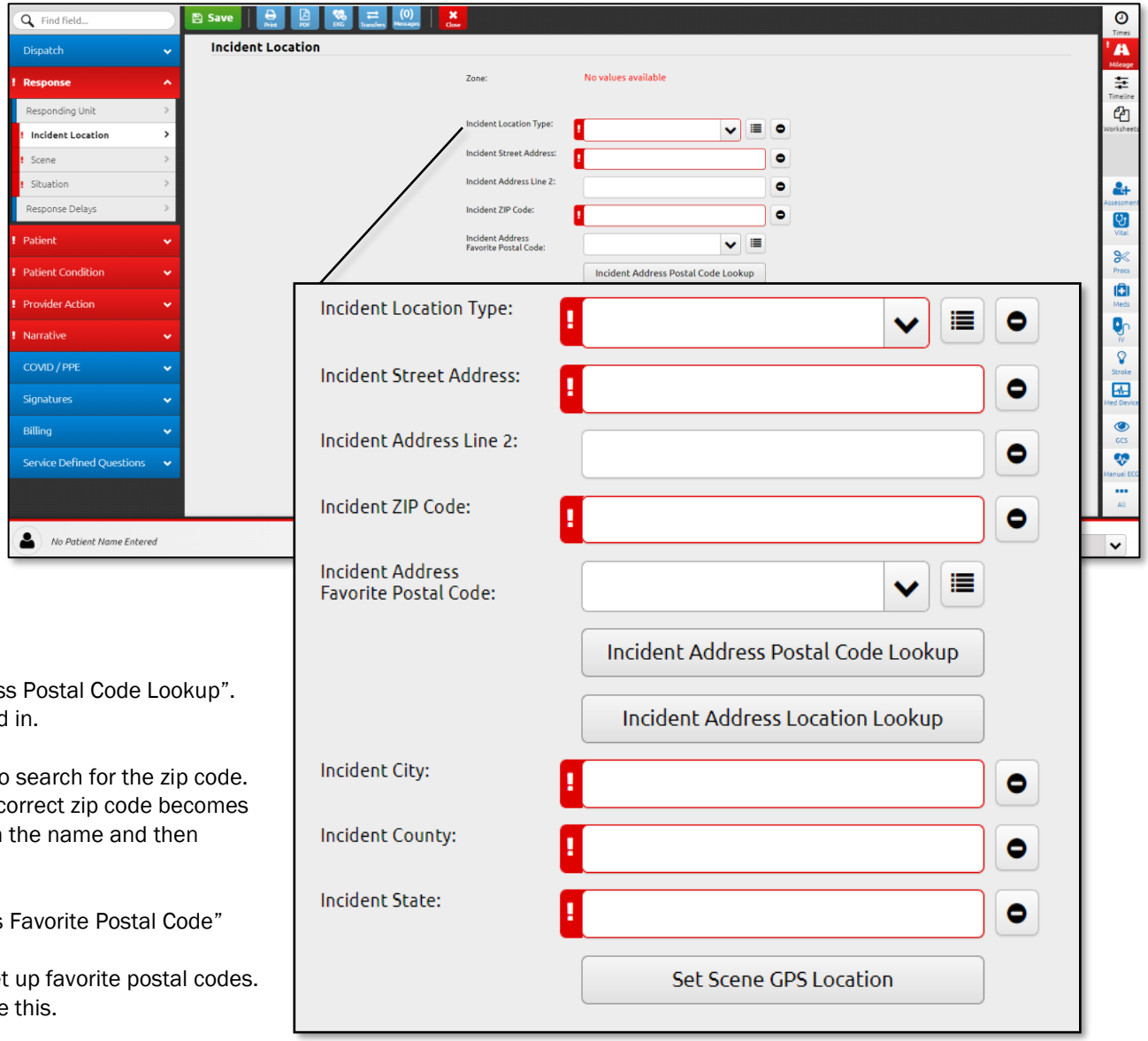
Type of Data: Operations

Incident Location

Steps

Under Response > Responding Unit:

- Select the Location Type from the drop-down menu
  - Like with all other drop-down selections, the list will shorten if you begin to type
- Enter the first two lines of the address
- Enter the Zip Code
  - The City, State and County will auto-populate based on the Zip Code



Additional Information

There are three options for entering the zip code:

Option 1: Enter the zip code and click "Incident Address Postal Code Lookup". You can then click on whichever town the call occurred in.

Option 2: Select "Incident Address Location Lookup" to search for the zip code. As you type in the city name and select the state, the correct zip code becomes easier to find. When you have the correct one, click on the name and then click OK.

Option 2: Click on the drop down for "Incident Address Favorite Postal Code" and select the correct option.

Note: This will only work if your agency has set up favorite postal codes. Your Rescue Service Administrator can enable this.

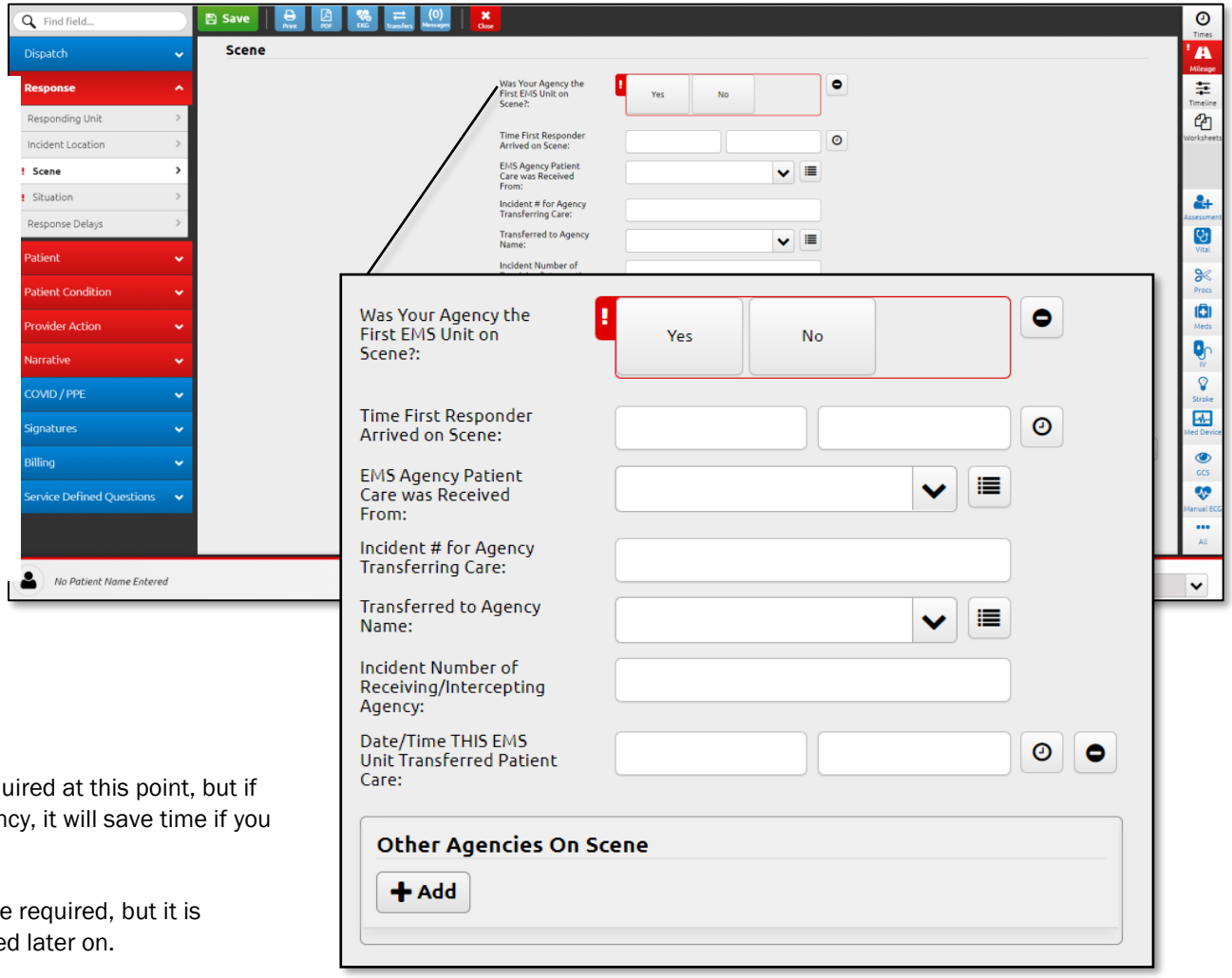
Type of Data: Operations

Scene

Steps

Under Response > Scene:

- Define if your agency was the first one on scene
- If patient care was handed over to another agency, enter this information under “Transferred to Agency Name”
- Add in any additional details regarding the scene



Additional Information

The “Transferred to Agency Name” is not required at this point, but if patient care was turned over to another agency, it will save time if you add the details at this point.

The field “Other Agencies On Scene” is not be required, but it is enormously helpful if the records are reviewed later on.

Type of Data: Operations

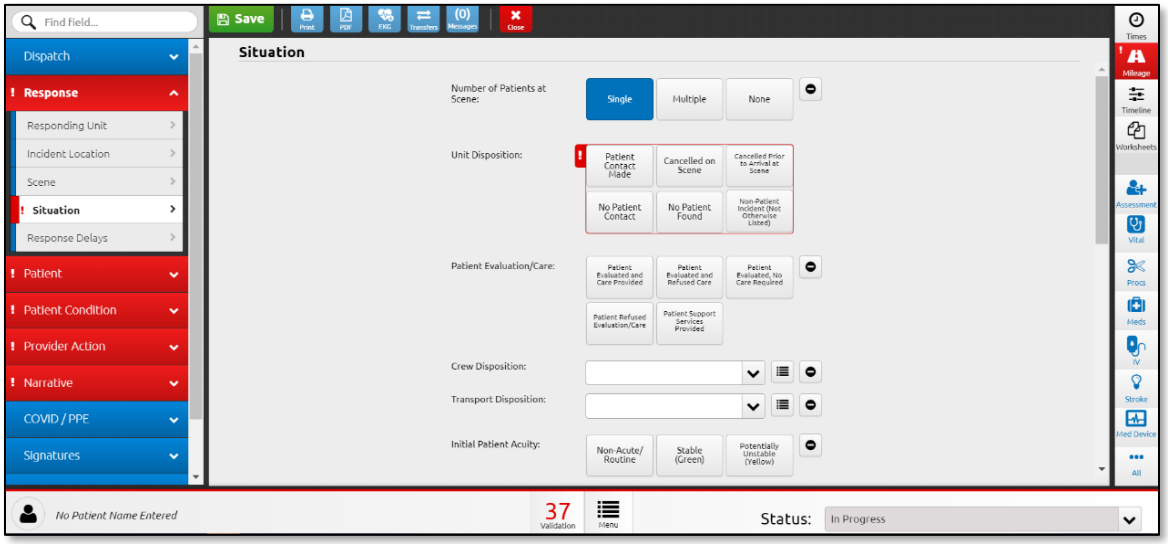
Situation

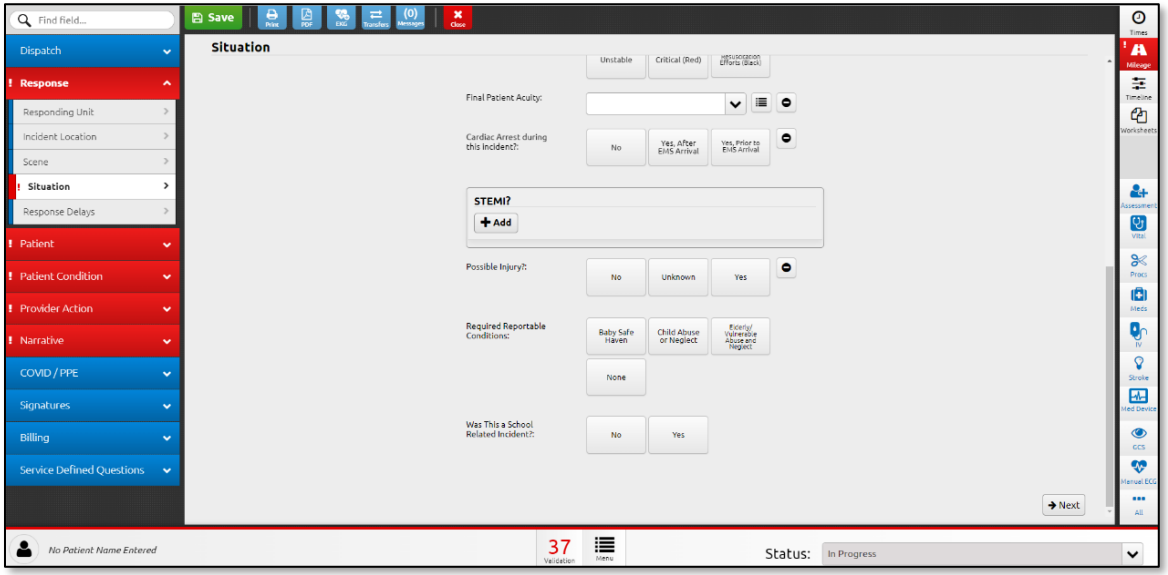
Steps

Document what occurred overall for the incident under Response > Situation. These fields will most likely be required:

- Number of Patients at Scene
  - This will default to Single but should be manually changed as needed.
- Unit Disposition
- Patient Evaluation/Care
- Crew Disposition
- Transport Disposition
- Initial Patient Acuity
- Final Patient Acuity
- Cardiac Arrest during this incident?
  - This will be required if there was patient contact.
- Possible Injury?
  - This will be required if there was patient contact.

Exactly which fields are required will be dependent on what responses have been entered so far.





Additional Information

Reason for Refusal/Release may display as a recommended field, depending on the responses selected for the other fields. If it does show, it will be directly below Transport Disposition.

See the next page for a screenshot of how this will display.

The Initial Patient Acuity and Final Patient Acuity should be defined by how the patient presented when the author of the report met them, and at the end of the author's encounter with the patient—regardless of if the patient was seen by a provider that's with another EMS agency.

Disposition Fields Additional Details

Type of Data: Operations

The five fields listed here are all new to the Patient Care Report. As they are new, the definitions for each have been listed:

Unit Disposition: The patient disposition for an EMS event identifying whether patient contact was made.

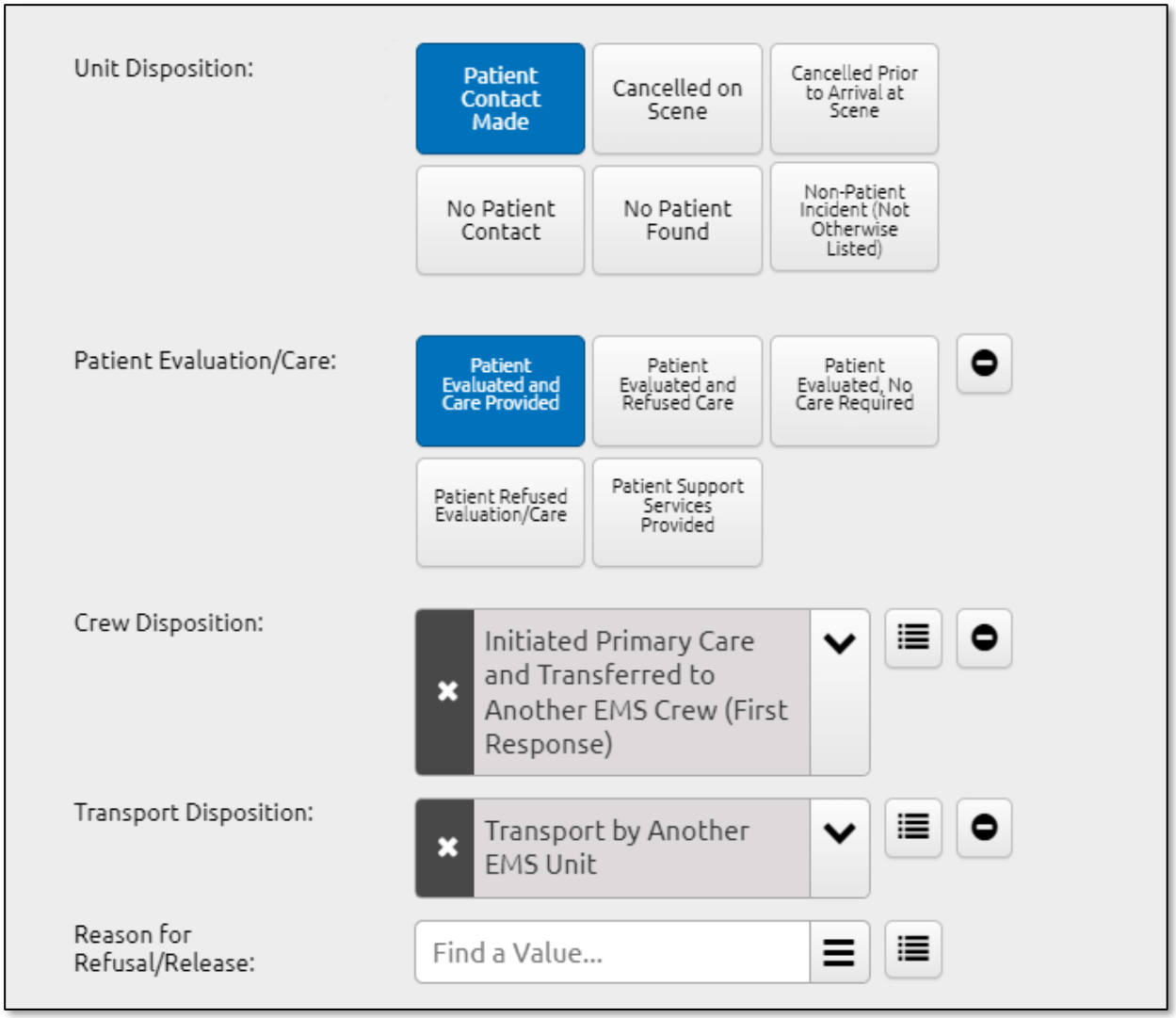
Patient Evaluation/Care: The patient disposition for an EMS event identifying whether a patient was evaluated and care or services were provided.

Crew Disposition: The crew disposition for this EMS event identifying which crew provided primary patient care or whether support services were required.

Transport Disposition: The transport disposition for an EMS event identifying whether a transport occurred and by which unit.

Reason for Refusal/Release: Describes reason(s) for the patient's refusal of care/transport OR the EMS clinician's decision to release the patient.

> **Note**: The *Reason for Refusal/Release* will only show if there are indications that the patient denied transport.



Additional Information

If you are looking for definitions on the possible responses for these fields, they can be found at https://nemsis.org/media/nemsis_v3/release-3.5.0/DataDictionary/PDFHTML/EMSDEMSTATE/Extended%20Data%20Definitions.pdf, from page 6 to 11.

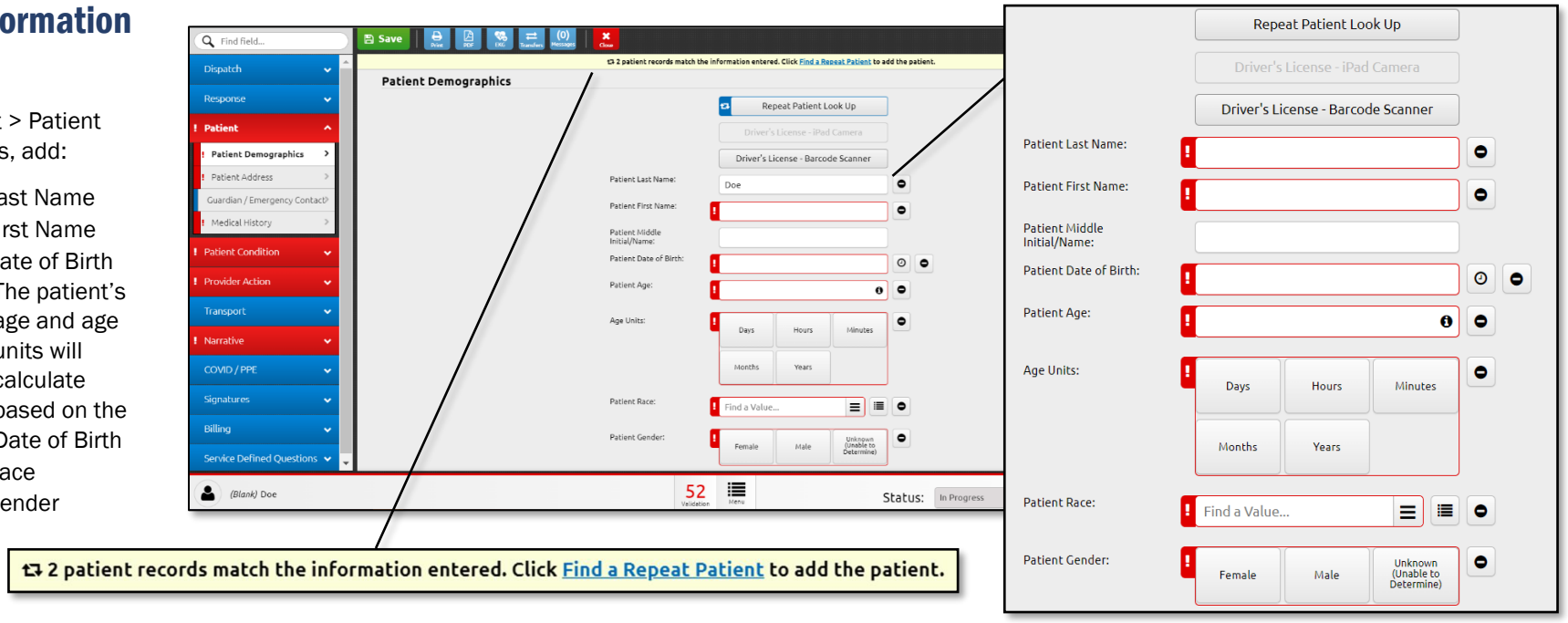
Type of Data: Reimbursement

Patient Information

Steps

Under Patient > Patient Demographics, add:

- Patient Last Name
- Patient First Name
- Patient Date of Birth
  - The patient's age and age units will calculate based on the Date of Birth
- Patient Race
- Patient Gender

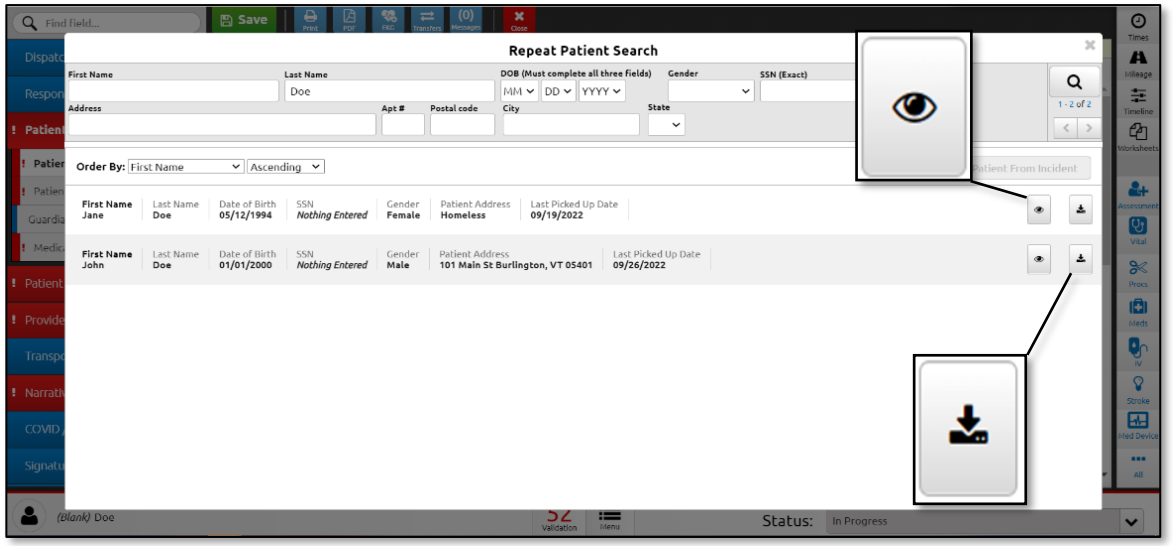


Additional Information

As patient details are added, a banner may show at the top of the page. If your agency has treated the patient before, you will be able to download the patient's details and medical history.

In "Repeat Patient Lookup", you can preview the person by clicking on the eye icon. You can select the person by clicking on the download icon. Downloading the patient information will save you significant time when it comes to documenting the call!

Caution: The Patient Race and Patient Gender should be defined by the patient, not the provider. If the patient did not state their race and/or gender, select the "Unknown" option(s).



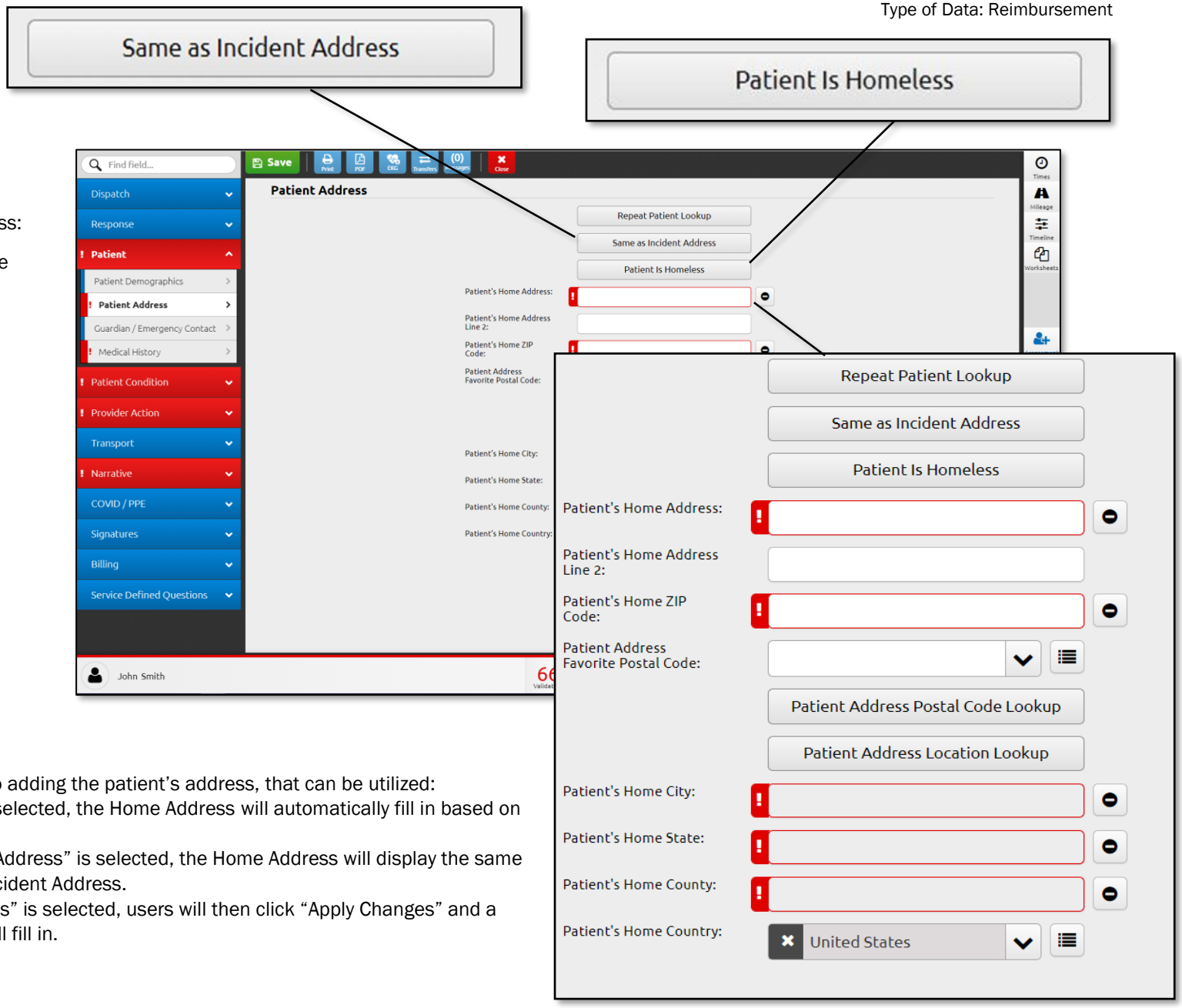
Type of Data: Reimbursement

Patient Address

Steps

Under Patient > Patient Address:

- Enter Lines 1 and 2 for the Patient's Home Address
- Define the Zip Code, City, State and County



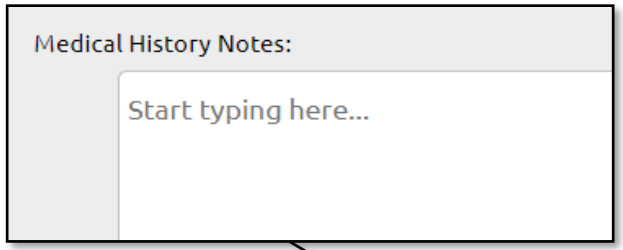
Additional Information

There are three alternatives to adding the patient's address, that can be utilized:

1. If a repeat patient is selected, the Home Address will automatically fill in based on previous incidents.
2. If "Same as Incident Address" is selected, the Home Address will display the same information as the Incident Address.
3. If "Patient is Homeless" is selected, users will then click "Apply Changes" and a Homeless address will fill in.

Medical History

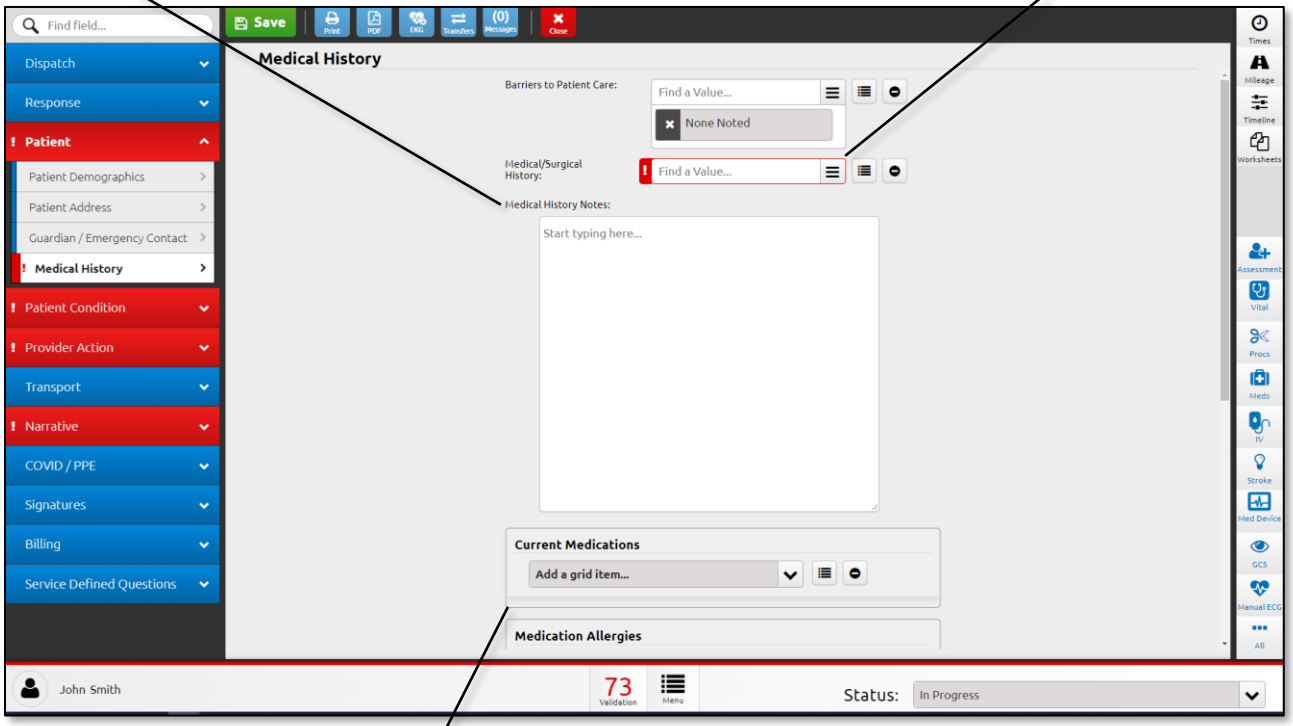
Type of Data: Clinical

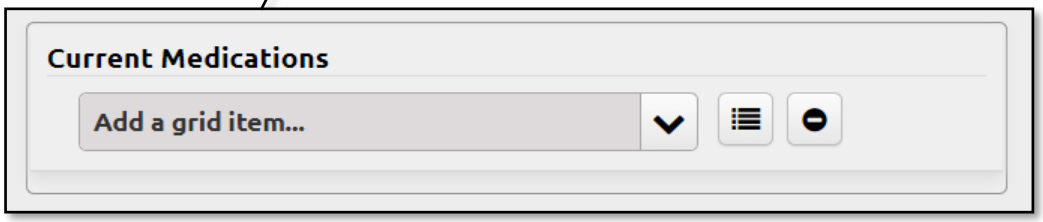


Steps

Under Patient > Medical History:

- Enter the patient's Medical/Surgical History.
  - If no information can be entered, click on the Null value (circle with a horizontal line) and select the reason.
- Any details on the following can also be entered on this page:
  - Medical History Notes (this is a free text field)
  - Current Medications
  - Medication Allergies
  - Environmental/Food Allergies
  - Response to Drug Use Screening Test
  - Medical History Obtained From
  - Advanced Directives





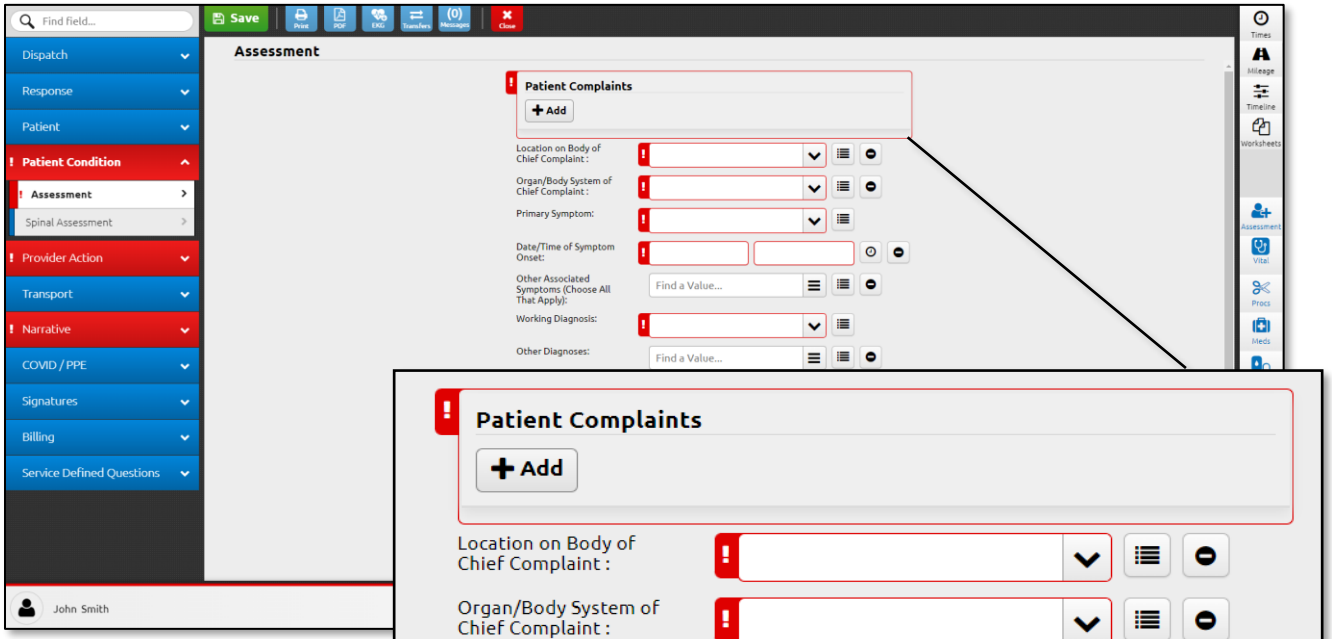
Additional Information

At a minimum, providers should add any details obtained that could be related to the patient's current illness or injury.

It is recommended that as much information as possible is entered. The details added here will carry forward when a repeat patient is chosen, saving time on future documentation.

Type of Data: Clinical

Patient Condition



Steps

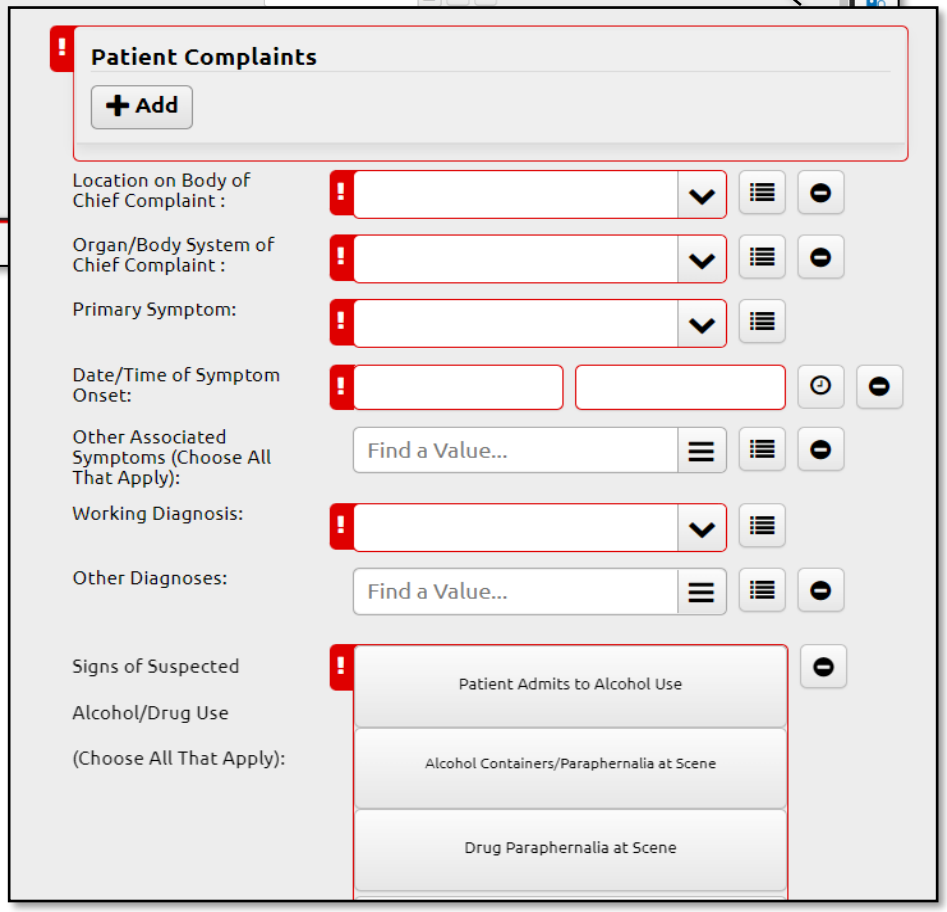
Under Patient Condition > Assessment:

- Add the Patient Complaint:
  - Click +Add
  - Select the Complaint Type
  - Enter the Complaint
  - (Optional) Add in the Duration of Complaint and the Duration of Complaint Time Units
  - Click Ok
- Enter the Organ/Body System of Chief Complaint
- Define the Primary Symptom
- Enter the Date/Time of Symptom
- Select the provider's current Working Diagnosis
- Enter any details regarding Signs of Suspected Alcohol/Drug Use
  - If this question is Not Applicable, the patient states they have not used drugs or alcohol, the patient refuses to answer, or you are unable to complete this, click on the Null button (the black circle with the line) and choose the correct response.

Additional Information

The Date/Time of Symptom Onset is defined as, "The date and time the symptom began (or was discovered) as it relates to this EMS event. This is described or estimated by the patient, family, and/or healthcare professionals".

Other Associated Symptoms and Other Diagnoses are both optional fields. If drug use is indicated under Signs of Suspected Alcohol/Drug Use, two optional, additional fields will display and allow providers to give details on the suspected or confirmed drug(s) taken by patient and who the drug information was obtained from.



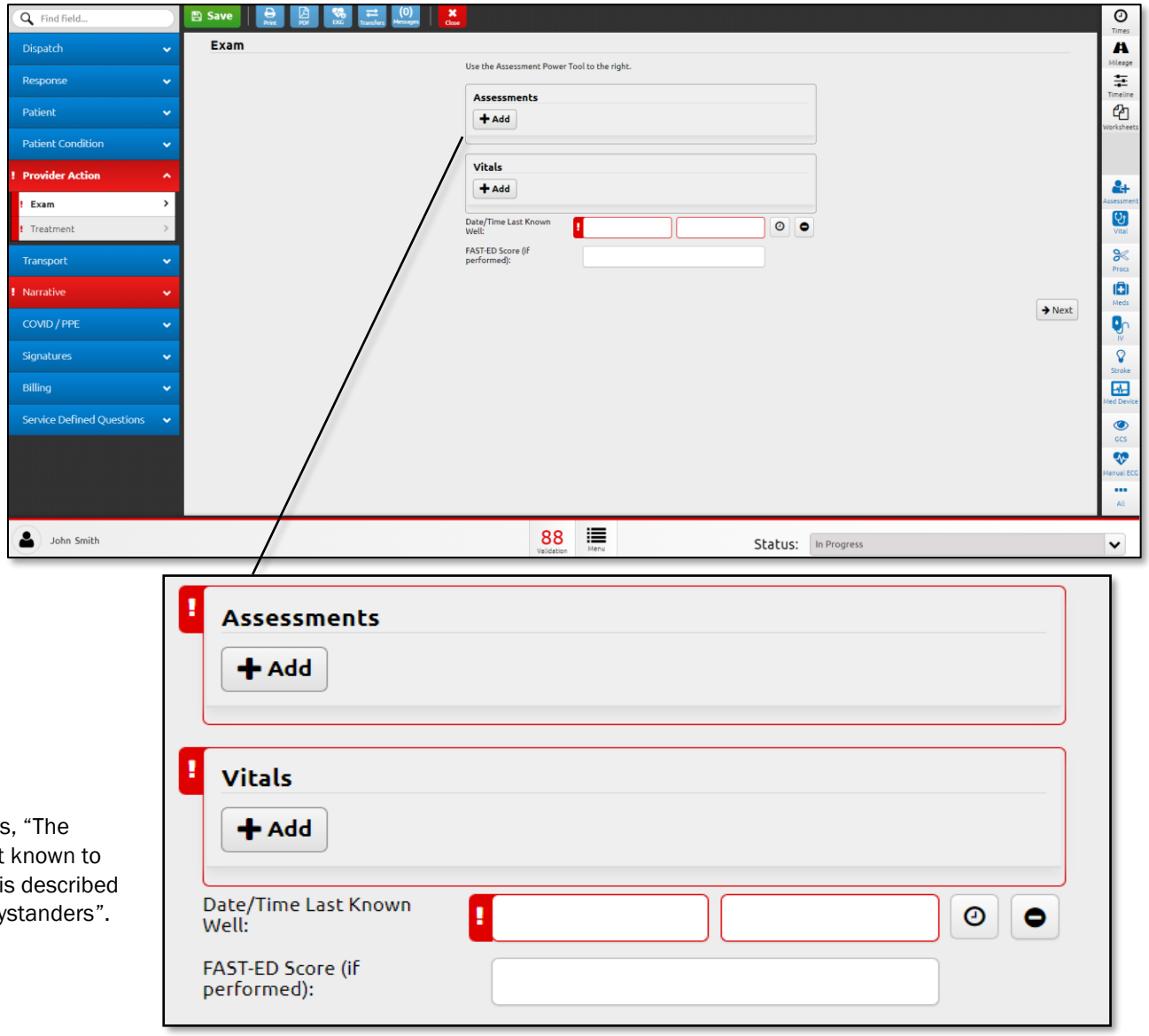
Type of Data: Clinical, Reimbursement

Provider Action

Steps

Under Provider Action > Exam:

- Add the Date/Time Last Known Well for the patient.
- If you have completed any assessments or obtained any vitals, this information is entered on this page. Additional details are on the next two pages.



Additional Information

The Date/Time Last Known Well is defined as, “The estimated date and time the patient was last known to be well or in their usual state of health. This is described or estimated by the patient, family, and/or bystanders”.

Type of Data: Clinical, Reimbursement

Exam

Steps

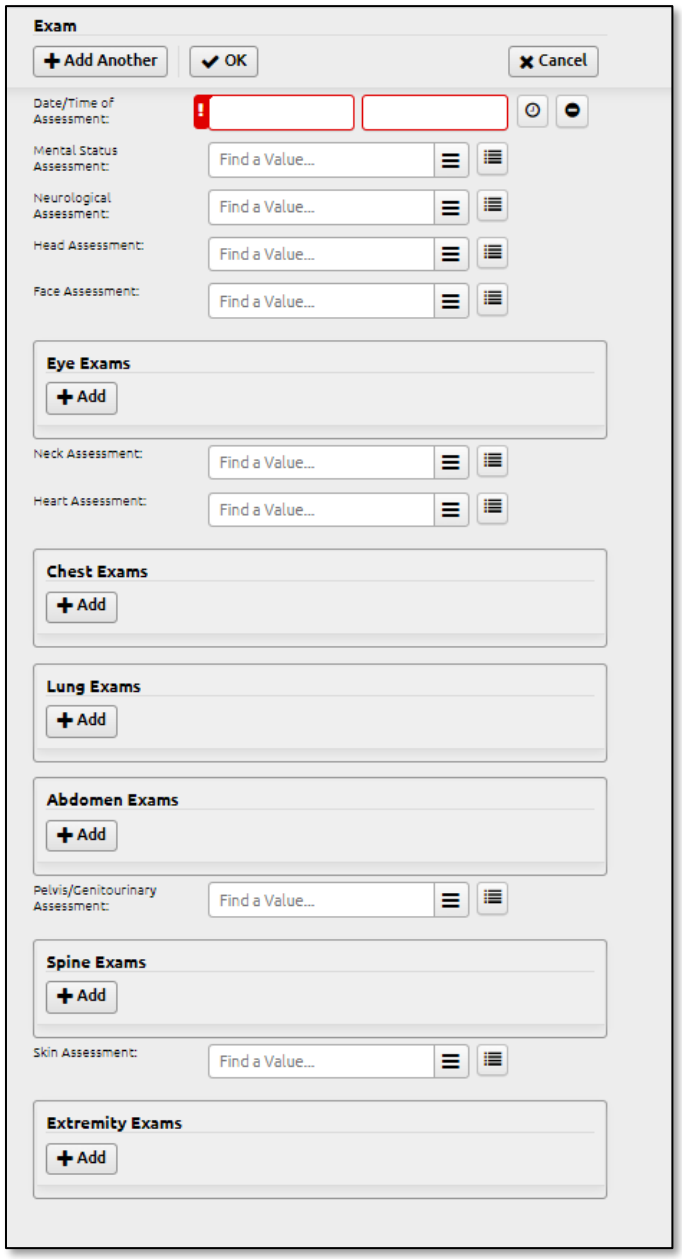
Under Provider Action > Exam > Assessments:

- Enter the Date and Time the assessment was completed
- Add all assessment findings for that time
- Click Ok or Add Another
- Repeat as needed

Available Exam Fields

The following assessments can be entered on this page:

1. Mental Status
2. Neurological
3. Head
4. Face
5. Eye
6. Neck
7. Heart
8. Chest
9. Lungs
10. Abdomen
11. Pelvic/Genitourinary
12. Spine
13. Skin
14. Extremities



Additional Information

These are available as options on every entry so that providers have the flexibility to document what was obtained. At this time, it is not the expectation that providers will review every item in this list for every patient on every Exam.

Vitals

Type of Data: Clinical, Reimbursement

Steps

Under Provider Action > Exam > Vitals:

- Enter the Date and Time the assessment was completed
- Add all assessment findings for that time
- Click “Ok” or “Add Another”
- Repeat as needed

Additional Information

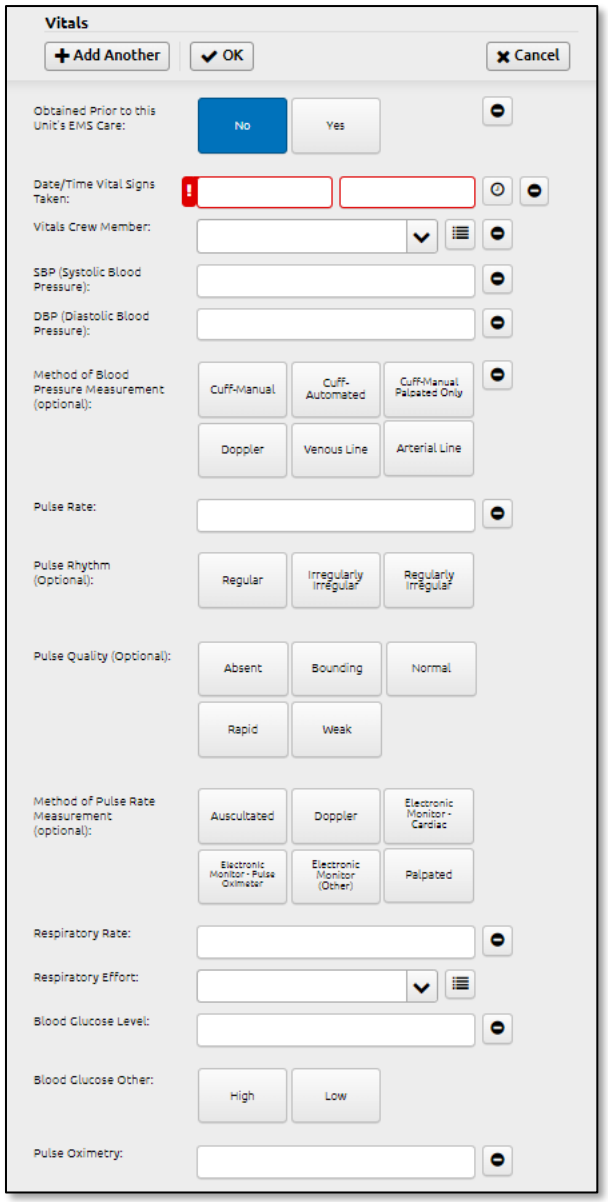
These are available as options on every entry so that providers have the flexibility to document what was obtained. At this time, it is not the expectation that providers will review every item in this list for every patient on every Vitals assessment.

Caution: The Vitals Crew Member will default to the name and license level of the Primary Provider on Scene. If this wasn’t the person who obtained the information, this drop down should be changed to reflect the correct provider.

Available Exam Fields

The following vitals can be entered on this page:

1. Systolic Blood Pressure
2. Diastolic Blood Pressure
3. Method of Blood Pressure
4. Pulse Rate
5. Pulse Rhythm
6. Pulse Quality
7. Method of Pulse Rate Measurement
8. Respiratory Rate
9. Respiratory Effort
10. Blood Glucose Level
11. Blood Glucose Other (High / Low)
12. Pulse Oximetry
13. Pulse Oximetry Qualifier
14. Carbon Dioxide (CO2/ETCO2)
15. Carbon Monoxide (CO)
16. Pain Scale Score
17. Pain Scale Type
18. Level of Responsiveness (AVPU)
19. Temperature
20. Temperature Method
21. Stroke Scale Type
    a. Facial Palsy
    b. Arm Weakness
    c. Speech Changes
    d. Eye Deviation
    e. Denial Neglect
    f. LVO / FAST-ED Score (this will auto-calculate)
22. Stroke Scale Score
23. GCS - Eye
24. GCS – Verbal
25. GCS – Motor
26. GCS – Qualifier
27. Total GCS (this will auto calculate)
28. Revised Trauma Score
29. Vital Comments



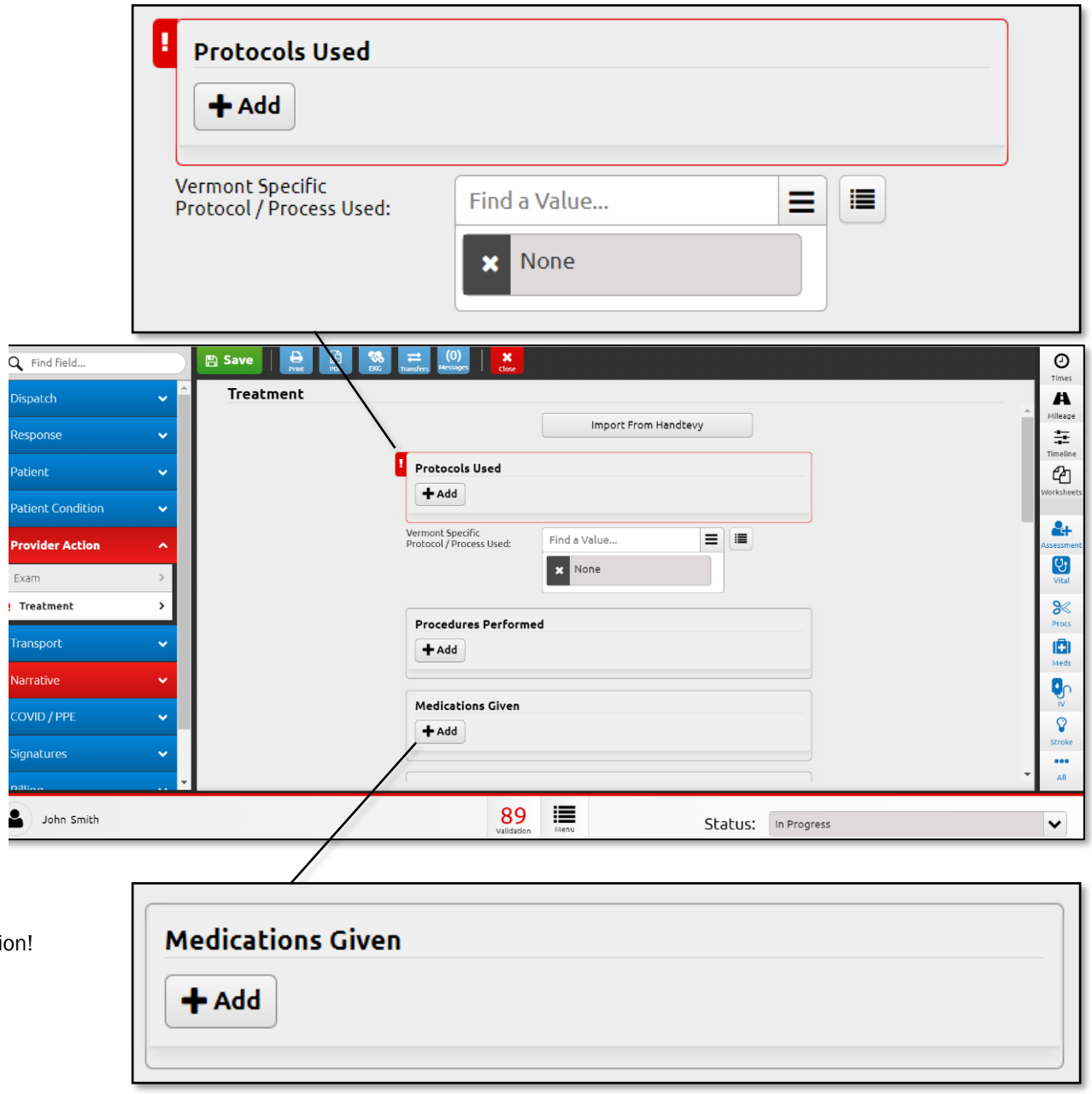
Type of Data: Clinical, Reimbursement

Treatment

Steps

Under Provider Action > Treatment:

- Add the Protocol(s) Used:
  - Click +Add
  - If you leveraged more than the "General – Routine Patient Care/Initial Patient Contact" protocol during your care of the patient, click +Add a second time. You will then change the drop down to the protocol used and confirm the Protocol Age Category.
- Add any medications given, it should be entered here. Additional details are on the next page.



Additional Information

Remember: Even Oxygen counts as a medication!

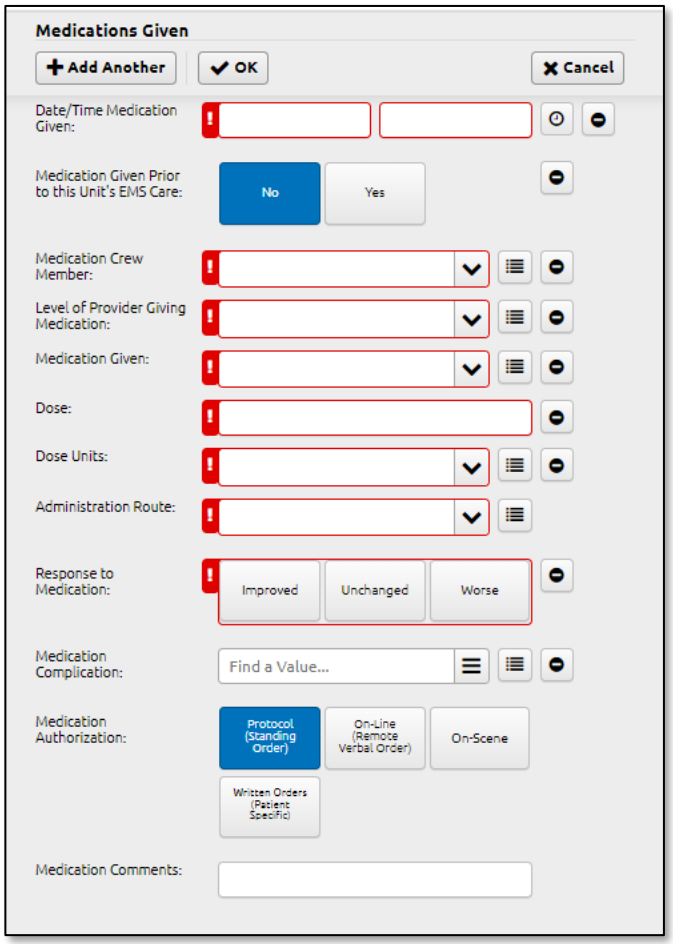
Type of Data: Clinical, Reimbursement

Medications Given

Steps

Under Provider Action > Treatment > Medications Given:

- Add the Date/Time the Medication was given
- Confirm if the medication was given prior to the EMS unit's care
- The Medication Crew Member and Level of Provider Giving Medication will default to the name and license level of the Primary Provider on Scene. If the medication was given by another provider, this should be updated
- Define the Medication Given
    - The list of available options will adjust based on the Medication Crew Member's license level.
- Enter the Dose, Dose Units and Administration Route, if this information does not automatically populate
    - Some medications have these details set up with default values, which can be changed.
- Enter the Response to Medication
- If applicable, add any Medication Complications or Medication Comments, and adjust the Medication Authorization if needed.
- Click Ok or Add Another.

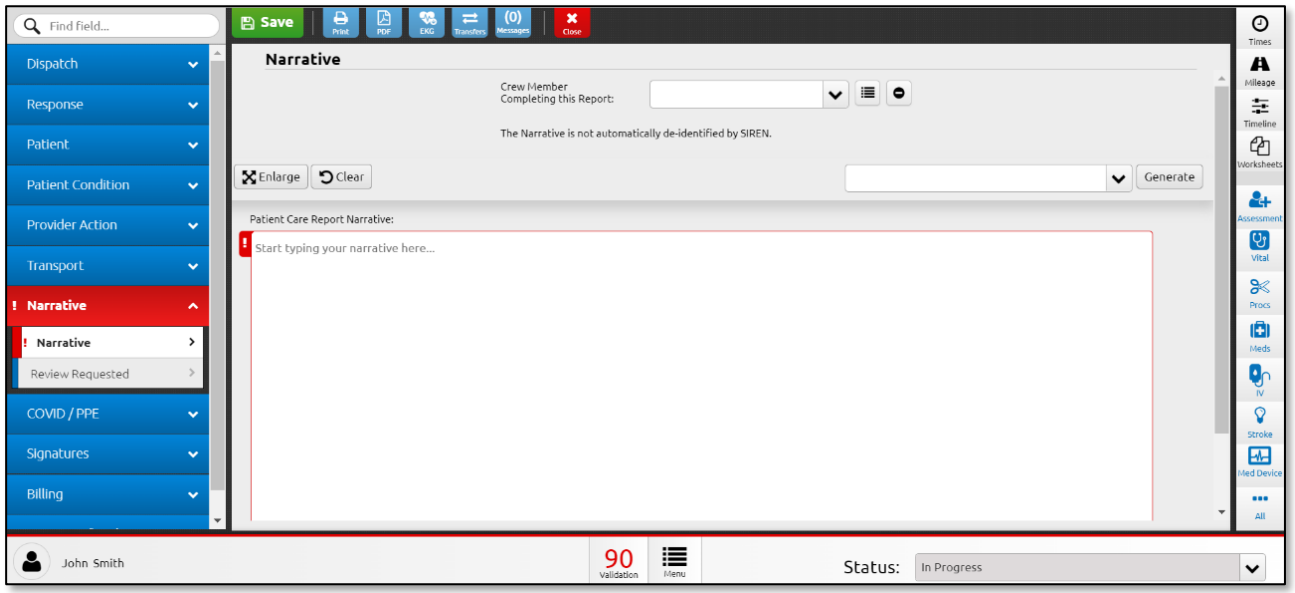


Type of Data: Clinical, Reimbursement

Narrative

Steps

Under Narrative > Narrative, document the details of the call and the information obtained from the patient by using the **CHART** template.



C – Chief Complaint

- The patient's primary physical complaint

H – History of Present Illness/Injury (HPI)

- Events leading up to incident
- SAMPLE
- OPQRST
- Medications
- Significant medical history

A – Assessment

- Initial patient presentation
- Assessments (primary and secondary)
- Physical findings
- Associated symptoms
- Pertinent negatives and positives
- Vital signs

R – Rx, Treatment and Response

- Interventions
- Patient's response to interventions

T – Transport / Transfer of Care

- How the patient was moved from where EMS first met the patient, to where the patient was at the end of the encounter.
- Any changes during transport
- To whom patient care was transferred and any additional details related to this.

Additional Information

The Narrative should reflect what occurred during the incident and the information collected by the provider.

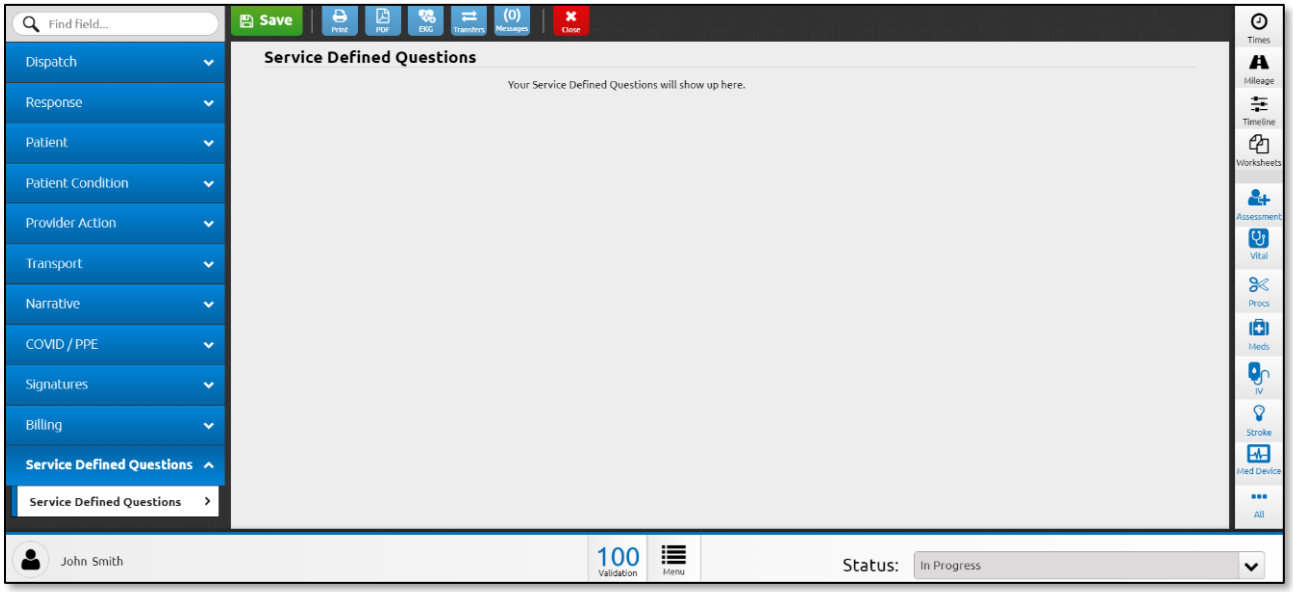
Type of Data: Operations

Service Defined Questions

Steps

Under Service Defined Questions > Service Defined Questions:

- Answer any questions your agency may have listed here. These requirements will vary from service to service and will be reflective of what your specific agency is looking to collect.



Additional Information

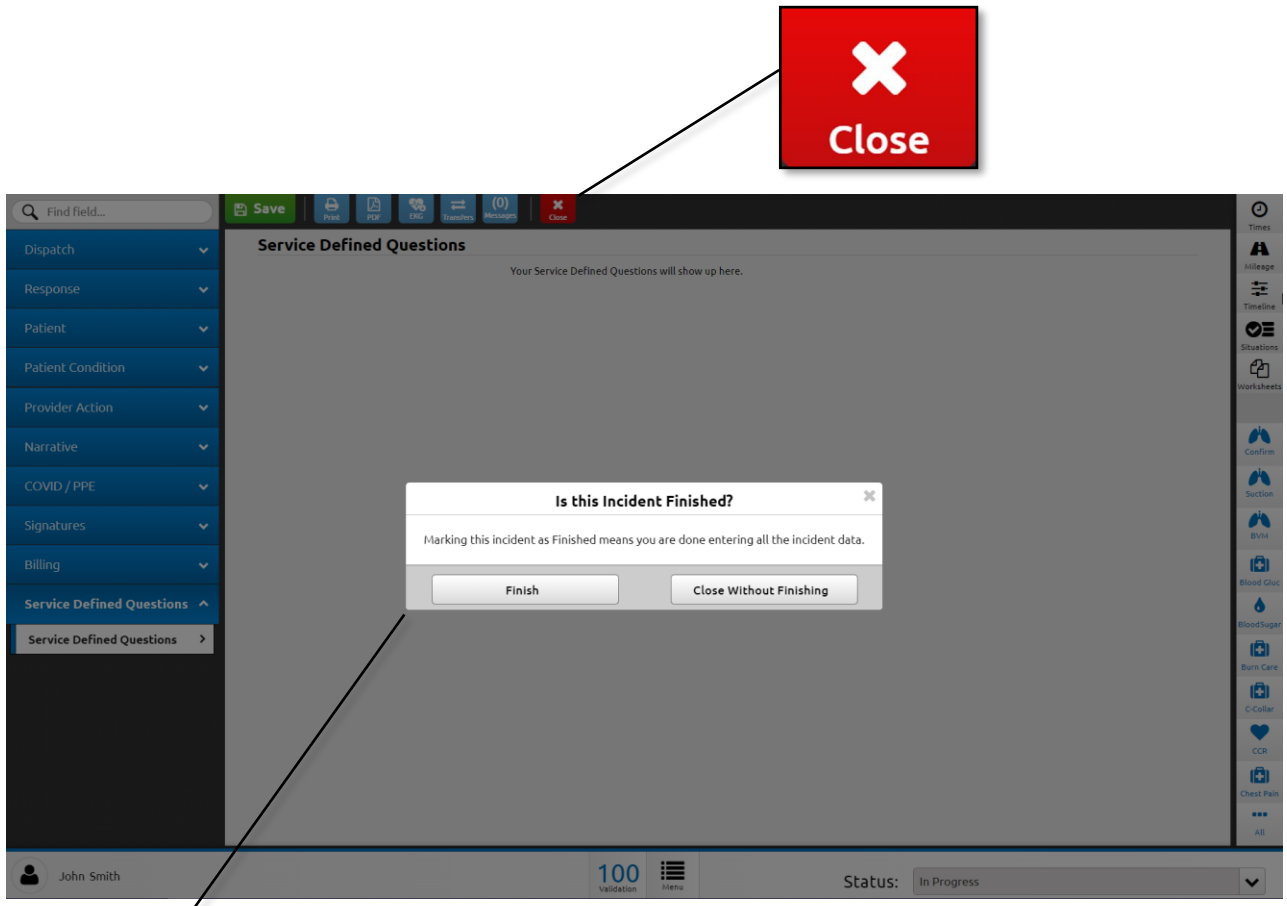
Not all agencies will have Service Defined Questions. If an agency does have them, these will vary from service to service.

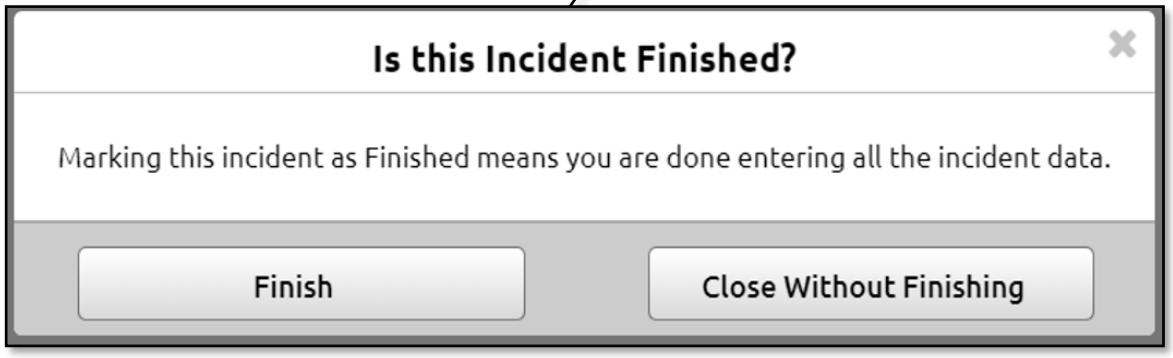
Close the Incident

Steps

At the top of the page:

- Click Close
  - If the report is completely done, click Finish
  - If you may need to go back and update details within 24 hours of starting the report, click Close Without Finishing





Additional Help

If you're having any issues at all, there are several resources available:

- Your Agency's SIREN Administrator
- The Data Management Team:
  - Email: Siren@Vermont.gov
- Beth Brouard, AEMT, EMS Data Manager:
  - Email: Bethany.Brouard@Vermont.gov
  - Phone (802) 495-8762