



RESOURCE AND PATIENT MANAGEMENT SYSTEM

# Emergency Room System

(AMER)

## User Manual

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# Table of Contents

<b>1.0</b>	<b>Introduction.....</b>	<b>1</b>
<b>2.0</b>	<b>System Navigation .....</b>	<b>2</b>
<b>3.0</b>	<b>Package Management.....</b>	<b>7</b>
3.1	Table and Parameter Setup (PAR).....	7
3.1.1	Add/Edit ER Consultant Service List (CNS) .....	7
3.1.2	Add Local ER Facilities (LOC).....	9
3.1.3	ER Alerts Mail Group (MGRP).....	10
3.1.4	ER Options Transportation-Disposition-Procedures (OPT) .....	11
3.1.5	Facility Parameter Setup (SET).....	13
3.1.6	Run AMER Cleanup Utility (FIX).....	16
<b>4.0</b>	<b>Package Operation .....</b>	<b>18</b>
4.1	Admit to Emergency Room (IN).....	18
4.2	Triage Nurse Update Admission Record (TRI) .....	22
4.3	Batch Mode ER Admission/Discharge (BAT).....	26
4.4	Discharge from Emergency Room (OUT).....	32
4.5	Cancel Visit (DNA).....	39
4.6	DOA Admissions to ER (DOA) .....	42
4.7	Mini Registration of New Patients (REG).....	42
4.8	Registering a New Patient (REG) .....	42
4.9	Scanning Patient Names or Chart Numbers (SCAN).....	44
4.10	List Patients Currently Admitted to ER (HERE) .....	45
4.11	Patient Instruction Menu (INST) .....	45
4.11.1	Add Patient Education Material (ADD) .....	47
4.11.2	Print Patient Education Materials (PRT) .....	48
4.12	Reports Menu (RPTS) .....	49
4.12.1	ER System Pre-Defined Reports (CAN) .....	50
4.12.2	ER Visit Auditing Log Reports (AUD) .....	59
4.12.3	ER System Report Generator (LIST).....	66
4.12.4	Print ER Log (LOG) .....	77
4.12.5	Display ER Log Entry for a Single ER Visit (VIS).....	78
4.12.6	Display Data for a Specific Patient Visit (VV) .....	79
4.13	Edit ER Visits (UP).....	82
4.13.1	Selecting Visit and Patient to Edit.....	82
4.13.2	Specifying a Reason for the Change .....	85
4.13.3	Editing the Admission Summary (1) .....	85
4.13.4	Editing the Triage Information (2) .....	96
4.13.5	Injury Info (3) .....	102
4.13.6	Procedures (4).....	107
4.13.7	Diagnoses (5).....	110
4.13.8	Exit Assessment (6).....	110

4.13.9	Discharge Info (7).....	112
4.13.10	Follow Up Instructions (8).....	114
4.13.11	ER Consultants (9).....	116
4.13.12	All (10).....	118
4.13.13	Exiting UP.....	118
<b>5.0</b>	<b>Standard Nurse/Provider Entry .....</b>	<b>119</b>
5.1	Entering New Triage Nurse Information.....	119
5.2	Entering Additional Triage Nurse Information .....	121
5.3	Editing an Existing Triage Nurse Date/Time Seen.....	121
5.4	Deleting an Existing Triage Nurse .....	122
<b>6.0</b>	<b>ERS/PIMS Scheduling Interface .....</b>	<b>123</b>
<b>7.0</b>	<b>Configuring ERS for Sites with Multiple ER/Triage/Urgent Care Departments .....</b>	<b>129</b>
7.1	Introduction.....	129
7.2	Original Design .....	129
7.3	Current Design .....	130
7.4	New Configuration Descriptions.....	130
7.4.1	ER CLINIC/LINK TO HOSPITAL LOCATION.....	131
7.4.2	New DEFAULT ER CLINIC .....	131
7.5	Sample Configurations .....	131
7.5.1	Site with One Emergency Department Area (Combined Triage, Emergency Department or Urgent Care).....	132
7.5.2	Site with Separated (and Distinct) Emergency Department Functional Areas (Separate/Distinct Triage, Emergency Department, or Urgent Care Areas).....	133
7.5.3	Site with Multiple Emergency Department Areas (Two or More Physically Separated Emergency Departments or Other Areas).....	134
<b>8.0</b>	<b>NUBC Disposition Mapping Functionality.....</b>	<b>136</b>
8.1	Defining ERS to NUBC Disposition Mappings .....	136
8.1.1	Display a List of Current ERS Dispositions.....	136
8.1.2	Mapping the Current ERS Dispositions .....	137
8.1.3	Handling Special Cases .....	138
8.2	Displaying the NUBC Disposition.....	140
8.2.1	Displaying the NUBC Disposition in AMER .....	140
8.2.2	Displaying the NUBC Disposition in BEDD.....	141
8.2.3	Displaying the NUBC Disposition Code in PCC.....	141
8.2.4	NUBC Code Value Set .....	142
<b>9.0</b>	<b>LWOBS/Did Not Answer Functionality .....</b>	<b>146</b>
9.1	Introduction.....	146
9.2	AMER/BEDD LWOBS/DNA Functionality.....	146
9.3	Default Functionality .....	146
9.4	Site Specified LWOBS/DNA Functionality .....	147

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<b>Appendix A</b>	<b>RPMS Rules of Behavior</b>	<b>149</b>
A.1	All RPMS Users	149
A.1.1	Access	149
A.1.2	Information Accessibility	150
A.1.3	Accountability	150
A.1.4	Confidentiality	151
A.1.5	Integrity	151
A.1.6	System Logon	152
A.1.7	Passwords	152
A.1.8	Backups	153
A.1.9	Reporting	153
A.1.10	Session Timeouts	153
A.1.11	Hardware	153
A.1.12	Awareness	154
A.1.13	Remote Access	154
A.2	RPMS Developers	155
A.3	Privileged Users	155
<b>Glossary</b>		<b>158</b>
<b>Acronym List</b>		<b>159</b>
<b>Contact Information</b>		<b>160</b>

## Preface

This manual provides information necessary to understand and use the Emergency Room system (ERS) application (AMER). The ERS package is a tool that will help facilities run and manage Emergency Departments. This manual provides instructions for performing various ERS tasks and includes examples of its processes and procedures enabling you to perform the activities supported by the package.

<p><b>Note:</b> All patient names and information in this manual are fictitious.</p>
--

### Security

The ERS uses security keys to limit users' ability to change system set-up parameters and patient information. In other words, not all ERS options are available to all users. Contact your site administrator to determine or change your security keys.

### Rules of Behavior

All RPMS users are required to observe HHS and IHS Rules of Behavior regarding patient privacy and the security of both patient information and IHS computers and networks. This document provides both RPMS and AMER Rules of Behavior.

## 1.0 Introduction

The ERS captures patient data during an Emergency Room (ER) visit. Admission data is stored in the **ER ADMISSION (#9009081)** file, as well as the **VISIT (#9000010)**, **V POV (#9000010.07)**, **V PROVIDER (#9000010.06)**, **V NARRATIVE TEXT (#9000010.34)**, and **V EMERGENCY VISIT RECORD (#9000010.29)** files until the patient is discharged from the Emergency Room. Upon discharge, information stored in the **ER ADMISSION** file is moved to a new entry in the **ER VISIT (#9009080)** file.

The ERS enables facilities to register, admit, and discharge patients through their emergency rooms and create reports for viewing and managing the flow of patients and the staff workload.

### PIMS Interface

The AMER application interfaces with the **Patient Information Management System (PIMS)**, **Admission/Discharge/Transfer (ADT)**, **Scheduling**, **Scheduling**, and **Sensitive Patient Tracking** packages.

Note the following:

- Configuration information is provided in the *AMER Installation Guide and Release Notes*.
- Additional task instructions are provided to the user in those situations where information is passed to, or extracted from, the **PIMS**, **ADT**, and **Scheduling** packages or by a cross-reference to the specific **PIMS** user guide and section.
- PIMS recognizes temporary chart numbers. All temporary chart numbers start with a T. Be aware of the following:
  - In the **PIMS-Scheduling** package you can make an appointment, using the temporary chart number. However, you cannot CHECK IN a patient unless that patient has a CHART NUMBER. Patient Registration (AG) should handle this.
  - In the **PIMS ADT** package, you cannot admit a patient to the hospital with a temporary chart number. You must contact medical records for new chart number.
  - In the **PIMS Sensitive Patient Tracking** package, you can track a patient using a temporary chart number.

## 2.0 System Navigation

The ERS provides menu options that enable you to:

- Register, admit, triage and discharge patients through the Emergency Department.
- Edit information on discharged visits.
- Create reports for viewing and managing the flow of patients and the staff workload.

**Note:** The options that appear on the ERS Main Menu (Figure 2-1) depend on a user's assigned security keys. To determine or change the assigned security keys for a user, contact the Site Administrator.

The ERS Main Menu (Figure 2-1) serves as the front end to the ERS application. Each menu and submenu option are summarized below and described in further detail in Section 3.0 and Section 4.0.

```

*****
*           Emergency Room System           *
*           Indian Health Service           *
*           Version 3.0                     *
*****
                2016 DEMO HOSPITAL

IN      Admit to Emergency Room
TRI     Triage Nurse Update Admission Record
BAT     Batch Mode ER Admission/Discharge
OUT     Discharge from Emergency Room
DNA     Cancel Visit (did not answer or left AMA)
DOA     DOA Admission to ER
        **> Out of order:  Option is being redesigned
REG     Mini-Registration of New Patients
SCAN    Scan Patient Names or Chart Numbers
HERE    List Patients Currently Admitted to ER
INST    Patient Instruction Menu ...
RPTS    Reports Menu ...
UP      Edit ER VISITS
PAR     Table and Parameter Setup ...

You have PENDING ALERTS
        Enter "VA to jump to VIEW ALERTS option

Select Emergency Room System <TEST ACCOUNT> Option:

```

Figure 2-1: ERS Main Menu

The ERS Main Menu contains several submenus:

- **Patient Instruction Menu (INST)** (Figure 2-2)

```

*      Patient Instruction Material Menu      *
*              Indian Health Service        *
*              Version 3.0                  *
*****
                2016 DEMO HOSPITAL

You have PENDING ALERTS
      Enter "VA to jump to VIEW ALERTS option

Select Patient Instruction Menu <TEST ACCOUNT> Option:
    
```

Figure 2-2: ERS Patient Instruction Menu (INST)

- **Reports Menu (RPTS) (Figure 2-3)**

```

*****
*              Reports Menu                *
*              Indian Health Service        *
*              Version 3.0                  *
*****
                2016 DEMO HOSPITAL

AUD   ER VISIT AUDITING LOG REPORTS
LIST  ER System Report Generator
LOG   Print ER Log
CAN   ER System Pre-Defined Reports
VIS   Display ER Log entry for a single ER visit
VV    Display Data for a Specific Patient Visit
CLN   ER Record Cleanup Report

You have PENDING ALERTS
      Enter "VA to jump to VIEW ALERTS option

Select Reports Menu <TEST ACCOUNT> Option:
    
```

Figure 2-3: ERS Reports Menu (INST)

- **Table and Parameter Setup (PAR) (Figure 2-4)**

```

*****
*              Facility Setup Menu          *
*              Indian Health Service        *
*              Version 3.0                  *
*****
                2016 DEMO HOSPITAL

CNS   Add/Edit ER CONSULTANT SERVICE list
LOC   Add Local ER Facilities
MGRP  ER Alerts Mail Group Edit
OPT   ER Options Transportation-Disposition-Procedures
SET   Facility Parameter setup
FIX   Run AMER Cleanup Utility
    
```

```
You have PENDING ALERTS
      Enter "VA to jump to VIEW ALERTS option

Select Table and Parameter Setup <TEST ACCOUNT> Option:
```

Figure 2-4: Table and Parameter Setup (PAR)

Below are the ERS Main Menu options:

- **IN–Admit to Emergency Room**  
Use this option to admit an established patient to the Emergency Department. Additionally, you can register a new patient and add a patient to the **ER ADMISSION** file.
- **TRI–Triage Nurse Update Admission Record**  
This option enables the triage nurse/triage provider to edit the ER admission record before the transaction is processed, to capture the time the patient was seen by the triage nurse/triage provider, their assigned clinic and their **Emergency Severity Index (ESI)** assessment.
- **BAT–Batch Mode ER Admission/Discharge**  
Use this option to enter admission, triage, and discharge information for a patient as a single entry.
- **OUT–Discharge from Emergency Room**  
Use this option to discharge a patient from the Emergency Department. The information collected is stored in the **ER VISIT** file and other **PCC V** files. Additionally, you can print patient instructions, create a visit, and remove patients registered in error from the **ER Admission** file.
- **DNA–Cancel Visit (did not answer or left AMA)**  
Use this option to cancel a patient visit to the ER without using the discharge process.
- **DOA–DOA Admission to ER**  
This option is out of order and should not be used.
- **REG–Mini-Registration of New Patients**  
Use this option to register a new patient, by entering basic patient demographic information: name, sex, or date of birth.
- **SCAN–Scan Patient Names or Chart Numbers**  
User this option to search for a patient, before admitting the patient or creating a new account.

- **HERE–List Patients Currently Admitted to ER**

Use this option to display a list of those patients currently admitted to the Emergency Department.

- **INST–Patient Instruction Menu**

Use this option to create and print adult or pediatric patient instructions. Be aware that a previous AMER release removed the options from this menu.

- **RPTS–Reports Menu**

Use this option to generate predefined ER tracking reports, visit audit reports, statistical reports, and logs of patient admissions for previous day; and display the log entry for a particular patient/visit, and display Patient Care Component (PCC) details of a single patient visit. The Reports Menu currently contains the following options:

- **AUD**–ER VISIT AUDITING LOG REPORTS
- **LIST**–ER System Report Generator
- **LOG**–Print ER Log
- **CAN**–ER System Pre-Defined Reports
- **VIS**–Display ER Log entry for a single ER visit
- **CLN**–ER Record Cleanup Report

- **UP–Edit ER Visits**

Use this option to edit information about an ER visit. After selecting a visit and patient to edit, you can update information related to the:

- 1–Admission summary
- 2–Triage information
- 3–Injury information
- 4–Procedures
- 5–Diagnoses–This feature has been disabled
- 6–Exit Assessment
- 7–Discharge information
- 8–Follow-up instructions
- 9–ER consultants
- 10–ALL

The system tracks all changes and requires a reason for change.

- **PAR–Table and Parameter Setup**

Use this option to set up/maintain your local facility's ERS site parameters, ER tables and other files containing data, such as procedures and dispositions. The Table and Parameter Setup menu currently contains the following options:

- **CNS**—Add/Edit ER CONSULTANT SERVICE list
- **LOC**—Add Local ER Facilities
- **MGRP**—ER Alerts Mail Group Edit
- **OPT**—ER Options Transportation-Disposition-Procedures
- **SET**—Facility Parameter setup
- **FIX**—Run AMER Cleanup Utility

To select one of these menu options, type enough of the option synonym or name to uniquely identify it at the “Select Emergency Room System Option” prompt, and press **Enter**.

## 3.0 Package Management

### 3.1 Table and Parameter Setup (PAR)

The options on the Table and Parameter Setup Menu enables you to set up:

- Parameters for your local facility
- Tables for ER files, such as local ER facilities, procedures, and dispositions.

**Note:** This option is available only to those users who have the appropriate security key.

To access the Table and Parameter Setup menu, type **PAR** at the “Select Emergency Room System Option” prompt (Figure 3-1).

```

Select Emergency Room System <TEST ACCOUNT> Option: PAR  Table and Parameter Set
up
          *****
          *              Facility Setup Menu              *
          *      Indian Health Service                    *
          *              Version 3.0                      *
          *****
                    2016 DEMO HOSPITAL

CNS  Add/Edit ER CONSULTANT SERVICE list
LOC  Add Local ER Facilities
MGRP ER Alerts Mail Group Edit
OPT  ER Options Transportation-Disposition-Procedures
SET  Facility Parameter setup
FIX  Run AMER Cleanup Utility

You have PENDING ALERTS
      Enter "VA to jump to VIEW ALERTS option

Select Table and Parameter Setup <TEST ACCOUNT> Option:

```

Figure 3-1: Table and Parameter Setup (PAR)

The following sections describe the options available on the Facility Setup Menu.

#### 3.1.1 Add/Edit ER Consultant Service List (CNS)

Use the **Add/Edit ER Consultant Service List** option to add or remove an **ER Consultant** type from the **ER Consultant Service** list. List entries are used to record the different types of consultants providing care to the ER patient.

To add, edit or inactivate ER Consultant types:

1. To access the **ERS Table and Parameter Setup Menu**, type **PAR** at the “Select Emergency Room System Option” prompt. The system will display the Facility Setup Menu.

2. At the “Select Table and Parameter Setup Option” prompt, type **CNS**.
3. At the “Select ER CONSULTANT TYPE NAME” prompt, enter the type of **ER Consultant**.

**Note:** The ER Consultant type may be **1 to 30** characters in length. If there are similar matches, the system prompts you to select the one you want from a list and prompts you to confirm that selection by typing **Y** at the **OK?** prompt.

4. At the “Are you adding ‘XXXXXXX’ as a new ER CONSULTANT TYPE (the xxth)?” prompt, type **YES**.
5. At the “NAME” prompt press **Enter**.
6. At the “DELETE DATE” prompt press **Enter** (Figure 3-2).

```
Select Table and Parameter Setup <TEST ACCOUNT> Option: CNS  Add/Edit ER CONSULTANT
SERVICE list

Select ER CONSULTANT TYPE NAME: GERIATRICS
  Are you adding 'GERIATRICS' as a new ER CONSULTANT TYPE (the 57TH)? No// Y
  (Yes)
NAME: GERIATRICS// <enter>
DELETE DATE: <enter>

Select ER CONSULTANT TYPE NAME:
```

Figure 3-2: Add/Edit ER Consultant Service list–Add a new ER Consultant Type

7. If you need to edit an ER Consultant type, then enter the updated **ER Consultant** type at the “NAME” prompt after the double slash marks ‘//’ for that type (Figure 3-3).

```
Select ER CONSULTANT TYPE NAME: GERIATRICS
NAME: GERIATRICS// ENDOCRINOLOGY
DELETE DATE: <enter>

Select ER CONSULTANT TYPE NAME:
```

Figure 3-3: Add/Edit ER Consultant Service list–Edit an ER Consultant Type

8. While existing ER Consultant types cannot be deleted (since they may have been used and thus referenced in existing patient visit entries), entries can be inactivated so that they are no longer selectable. If you need to inactivate a current consultant type, at the “Delete Date” prompt, type the date to inactivate the ER Consultant type (Figure 3-4).

```
Select Table and Parameter Setup <TEST ACCOUNT> Option: CNS  Add/Edit ER CONSULTANT
SERVICE list

Select ER CONSULTANT TYPE NAME: ENDOCRINOLOGY
NAME: ENDOCRINOLOGY// <enter>
```

```
DELETE DATE: 5/2/2023 (MAY 02, 2023)
```

```
Select ER CONSULTANT TYPE NAME:
```

Figure 3-4: Add/Edit ER Consultant Service List–Inactivate an Existing ER Consultant Type

This completes the procedure for adding or inactivating an ER Consultant Type from the **ER Consultant Service** list. You may now select another set-up function or exit the **PAR** option.

### 3.1.2 Add Local ER Facilities (LOC)

Use the **Add Local ER Facilities** option to add a local facility to the **ER Local Facility** file. These entries are used with **Transferred from** and **Transferred to** prompts during the ER patient admission and discharge.

To access the Add Local ER Facilities Menu:

1. Type **PAR** at the “Select Emergency Room System Option” prompt. The system will display the **Facility Setup** Menu.
2. At the “Select Table and Parameter Setup Option” prompt, type **LOC**.
3. At the “Select ER Local Facility Name” prompt, type the name of the local ER facility.

**Note:** If there are similar matches, the system prompts you to select your facility from a list and prompts you to confirm that selection by typing **Y** at the **OK?** prompt.

4. At the “UID” prompt, type the **UID** for the local ER, or press **Enter** to continue. UID is a User ID number that is used for ordering/sorting purposes. This field is optional (Figure 3-5).

```
Select Table and Parameter Setup <TEST ACCOUNT> Option: LOC Add Local ER Facilities

Select ER LOCAL FACILITY NAME: ACUTE CARE HOSPITAL
Are you adding 'ACUTE CARE HOSPITAL' as
a new ER LOCAL FACILITY (the 5TH)? No// Y (Yes)
NAME: ACUTE CARE HOSPITAL//
UID:

Select ER LOCAL FACILITY NAME:
```

Figure 3-5: Add Local ER Facilities

This completes the procedure for adding a local ER facility to the list. You may now select another set-up function or exit the **PAR** option.

### 3.1.3 ER Alerts Mail Group (MGRP)

When v3.0 was installed, the **AMER ER PATIENT MERGE ALERTS Mail Group** was set up. Also, a Coordinator was specified during installation. When any **Edit ER Visits (UP)** option is used to change the patient associated with an ER visit, MailMan sends a notification message to the members of this Mail Group.

**Note:** This option requires Supervisor privileges. Use the **ER Alerts Mail Group** option to add or remove members of the **AMER ER PATIENT MERGE ALERTS Mail Group**.

**IMPORTANT:** Ensure that this group includes a member from Medical Records to carry over correct billing information.

To edit the ER Alerts Mail Group:

1. To access the **ERS Table and Parameter Setup** menu, type **PAR** at the “Select Emergency Room System Option” prompt. The system will display the **Facility Setup** menu.
2. At the “Select Table and Parameter Setup Option” prompt, type **MGRP**.
3. At the “Select New Person Name” prompt, type the **name** of the person to add or remove.
4. At the “Would you like to Add this user to the Mail Group?” prompt, press **Enter** (YES), or type **N** (NO) if you do not want to add this person to the mail group.
  - If the name entered is not valid, a message appears. If this happens, notify your ER application manager.
  - An example of adding a user to the mail group is shown here (Figure 3-6):

```
Select Table and Parameter Setup <TEST ACCOUNT> Option: MGRP  ER Alerts Mail Group
Edit
Select NEW PERSON NAME: DEMO,BRIAN E          BEE
Would you like to ADD this user to the Mail Group? YES// <enter>
Select NEW PERSON NAME:
```

Figure 3-6: ER Alerts Mail Group Edit

5. If the user entered is already in the mail group, you will be prompted to remove the user from the mail group (Figure 3-7).

```
Select Table and Parameter Setup <TEST ACCOUNT> Option: MGRP  ER Alerts Mail Group
Edit
Select NEW PERSON NAME: DEMO,BRIAN E          BEE

This user is already in the AMER ER PATIENT MERGE ALERTS Mail Group
```

```
Would you like to REMOVE this user from the Mail Group? YES// <enter>
Select NEW PERSON NAME:
```

Figure 3-7: ER Alerts Mail Group Edit–Removing a User From a Mail Group

This completes the procedure for adding or removing a mail group member. You can continue adding/removing people in the **ER Mail Group** or select another set-up function or exit the **PAR** option.

### 3.1.4 ER Options Transportation-Disposition-Procedures (OPT)

Use the **ER Options Transportation-Disposition-Procedures** option to add items in a pick list to one or more of the 27 categories or prompts, such as modes of transportation, dispositions, ER procedures, safety equipment, and causes of injury. The entries in this table are used in different prompts throughout the ER application.

To access the **ER Options Transportation-Disposition-Procedures** option:

1. At the “Select Emergency Room System Option” prompt, type **PAR**. The system will display the **Facility Setup** Menu.
2. At the “Select Table and Parameter Setup Option” prompt, type **OPT**.
3. At the “Select ER OPTIONS NAME” prompt, type the entry you want to add. For example, **UNDER CARE OF HOME HEALTH ORG**.
4. Confirm your entry at the “Are you adding ‘XXXXXXXX’ as a new ER Options?” prompt by pressing **Enter**.
5. At the “ER OPTIONS MNEMONIC” prompt, type the **mnemonic** for the ER option you want to add.
6. At the “NAME” prompt, press **Enter** to accept the default or type the name of the ER option you want to add.
7. At the “TYPE” prompt, type the prompt under which the ER option should appear (pick list) for the entered **Type**.

Examples:

- If you want to add **BLOOD TRANSFUSION** as a possible type of ER procedure, type **BLOOD TRANSFUSION** at the “ER OPTIONS NAME” prompt and type **ER PROCEDURES** at the “TYPE” prompt.
- If you want to add **MOUTH GUARD** as a possible SAFETY EQUIPMENT selection, type **MOUTH GUARD** at the “ER OPTIONS NAME” prompt and type **SAFETY EQUIPMENT** the “TYPE” prompt.

8. (Optional) If a **DISPOSITION** type, at the “MAP TO NUBC DISPOSITION” prompt, enter a valid **NUBC code** to map this DISPOSITION to or press **Enter** to bypass. The **NUBC code** entered for the DISPOSITION will ultimately be stored in the **VISIT (#9000010)** file **PATIENT STATUS CODE (NUBC) (#1110)** field upon a patient’s discharge from ERS. Refer to Section 8.0 for more information on mapping ERS dispositions to valid **NUBC codes**.
9. (Optional) At the “Brief Form” prompt, enter a value or press **Enter** to bypass. The value can be 1-to-16 characters.
10. (Optional) At the “HER Value” prompt, enter a value or press **Enter** to bypass. The value can be 1-to-240 characters.
11. (Optional) At the “Ancillary Services” prompt, type **??** to display a list of services, and then type the number of the service; or press **Enter** to bypass.
  - (1) CARDIOVASCULAR
  - (2) INTRAVENOUS
  - (3) LABORATORY
  - (4) RADIOLOGY
  - (5) RESPIRATORY
  - (6) OTHER
12. (Optional) At the “Mnemonic” prompt, type a mnemonic or press **Enter** to bypass. This value can be 1-to-30 characters.
13. (Optional) At the “Map to Place of Accident” prompt, enter a value or press **Enter** to bypass. This value can be 1-to-240 characters.
14. (Retired–no longer in use) At the “ICD9 Code” prompt, type the **ICD9** code if appropriate for the given **ER Option**.
15. Examples of a new AMER DISPOSITION entry and a new SAFETY EQUIPMENT entry are shown here (Figure 3-8).

```

Select Table and Parameter Setup <TEST ACCOUNT> Option: OPT ER Options
Transportation-Disposition-Procedures

Select ER OPTIONS NAME: UNDER CARE OF HOME HEALTH ORG
Are you adding 'UNDER CARE OF HOME HEALTH ORG' as
a new ER OPTIONS (the 134TH)? No// Y (Yes)
ER OPTIONS MNEMONIC: HHO
NAME: UNDER CARE OF HOME HEALTH ORG Replace <enter>
TYPE: DIS
1 DISCHARGE INFO
2 DISPOSITION
CHOOSE 1-2: 2 DISPOSITION
MAP TO NUBC DISPOSITION: 06 UNDER CARE OF HOME HEALTH ORG
BRIEF FORM: <enter>
HER VALUE: <enter>

```

```

ANCILLARY SERVICES: <enter>
MNEMONIC: HHO// <enter>
MAP TO PLACE OF ACCIDENT: <enter>
ICD9 CODE: <enter>

Select ER OPTIONS NAME: MOUTH GUARD
  Are you adding 'MOUTH GUARD' as a new ER OPTIONS (the 135TH)? No// Y (Yes)
  ER OPTIONS MNEMONIC: MG
NAME: MOUTH GUARD// <enter>
TYPE: SAFETY EQUIPMENT
BRIEF FORM: <enter>
HER VALUE: <enter>
ANCILLARY SERVICES: <enter>
MNEMONIC: MG// <enter>
MAP TO PLACE OF ACCIDENT: <enter>
ICD9 CODE: <enter>

Select ER OPTIONS NAME:

```

Figure 3-8: ER Options Transportation-Disposition-Procedures

This completes the procedure for adding options to one or more of the 27 ER categories. You can continue adding **ER category** options or select another set-up function or exit the **PAR** option.

### 3.1.5 Facility Parameter Setup (SET)

Use the **Facility Parameter Setup** option to edit the ER system parameters for a facility.

To access this option:

1. To access the **ERS Table and Parameter Setup** menu, type **PAR** at the “Select Emergency Room System Option” prompt. The system will display the **Facility Setup** menu.
2. At the “Select Table and Parameter Setup Option” prompt, type **SET**.
3. At the “Select ER PREFERENCES LOCATION” prompt (Figure 3-9), type the name of the facility where the ER is located. Then confirm the selection by typing **Y** at the “OK?” Prompt. If there are similar matches, the system prompts you to select your facility from a list, and then prompts you to confirm that selection by typing **Y** at the “OK?” prompt.

```

Select ER PREFERENCES LOCATION: 2016 DEMO HOSPITAL

```

Figure 3-9: Facility Parameter Setup (SET)—Entering the ER Preferences Location to modify

4. At the “Location” prompt (Figure 3-10), press **Enter** to accept the current location or type the location.

```
LOCATION: 2016 DEMO HOSPITAL// <enter>
```

Figure 3-10: Facility Parameter Setup (SET)–Accepting the location

5. At the “DEFAULT HOSPITAL LOCATION” prompt, press **Enter** to accept the current entry, or type the Walk-in clinic name, which is your main Emergency Room Clinic as set up in the **PIMS Scheduling** application. This value will be overridden by entries defined in the **ER CLINIC** property described later in this section. A sample value is shown here (Figure 3-11).

**Note:** This **Walk-In Clinic** field must be completed to access PIMS scheduling appointments. For more information, refer to Section 6.0.

```
DEFAULT HOSPITAL LOCATION: ED WALK-IN// <enter>
```

Figure 3-11: Facility Parameter Setup (SET)–Entering the DEFAULT HOSPITAL LOCATION

6. At the “LABEL PRINTER NAME” prompt, type the **Label Printer Name**.
7. At the “QUEUE LABELS” prompt, type **Y** or **N**, or press **Enter** to bypass this field.
8. At the “CHART PRINTER NAME” prompt, type the name of the chart printer, or press **Enter** to bypass this field.
9. At the “Send .9999 CODES TO PCC” prompt, press **Enter** (**YES**) to send uncoded diagnoses (.9999 codes) to the PCC record, or type **NO** to prevent uncoded diagnoses from being sent to PCC.
10. At the “DISABLE TRIAGE PROVIDER ENTRY” prompt, press **Enter** to accept the current value or **YES** to turn off prompting for the **Triage Provider** in the **ER TRI, BAT, OUT, and UP** options. Entering **NO** will allow the user to be prompted to enter the **Triage Provider**.
11. At the “ENABLE AUTOMATIC CHECK-OUT” prompt, press **Enter** to accept the current value or **YES** to automatically check a patient out of their ER appointment upon discharge from the ER. Entering **NO** will cause the patient to remain checked in to their ER appointment.
12. The next prompt, **Select ER CLINIC**, can be used to set up multiple ER locations (referred to as Clinic types in ERS) for areas such as triage, urgent care, and a second distinct ER section. Clinic types entered here can be mapped to separate HOSPITAL LOCATION areas.

For example, if a facility has four different distinct ER areas (Clinic type) defined (TRIAGE, URGENT CARE, EMERGENCY MEDICINE, and ED MAIN) they can link those ER areas to four different HOSPITAL LOCATION entries. To perform this linking, these separate areas must first be set up using the **ER Options Transportation-Disposition-Procedures (OPT)** option described in Section 3.1.4. Once the separate Clinic types are defined, this option can be used to specify which HOSPITAL LOCATION to link to each of the areas. In the following example, the TRIAGE Clinic type has been linked to the TRIAGE HOSPITAL LOCATION, the URGENT CARE Clinic type has been linked to the URGENT CARE HOSPITAL LOCATION, the EMERGENCY MEDICINE Clinic type has been mapped to the ED WALK-IN HOSPITAL LOCATION and the ED MAIN Clinic type has been linked to the ED MAIN HOSPITAL LOCATION (Figure 3-12).

For more information on setting up Clinic types and linking them to HOSPITAL LOCATIONS to best meet the set up at your site, refer to Section 7.0.

```
Select ER CLINIC: TRIAGE
...OK? Yes// <enter> (Yes)

ER CLINIC: TRIAGE// <enter>
LINK TO HOSPITAL LOCATION: TRIAGE// <enter>
Select ER CLINIC: URGENT CARE <enter>      80
...OK? Yes// <enter> (Yes)

ER CLINIC: URGENT CARE// <enter>
LINK TO HOSPITAL LOCATION: WALKIN// <enter>
Select ER CLINIC: EMERGENCY MEDICINE <enter>      30
...OK? Yes// <enter> (Yes)

ER CLINIC: EMERGENCY MEDICINE// <enter>
LINK TO HOSPITAL LOCATION: ED WALK-IN// <enter>
Select ER CLINIC: ED MAIN <enter>      30
...OK? Yes// <enter> (Yes)

ER CLINIC: ED MAIN// <enter>
LINK TO HOSPITAL LOCATION: ED MAIN// <enter>
Select ER CLINIC:
```

Figure 3-12: Facility Parameter Setup (SET)–Linking ERS Clinic types to HOSPITAL LOCATION entries

- At the “DEFAULT ER CLINIC” prompt, press **Enter** to accept the current value or enter a new value. This property should contain the default ER Clinic type that all new admissions to the ERS should be assigned to (Figure 3-13). If using the BEDD application this property will also control the default value showing up in the \*Clinic Type property.

```
DEFAULT ER CLINIC: EMERGENCY MEDICINE// <enter>
```

Figure 3-13: Facility Parameter Setup (SET)–DEFAULT ER CLINIC set up

14. At the “Select LWOBS/DNA DISPOSITIONS” prompt, enter one or more ERS dispositions that should be treated as Left Without Being Seen or Left Against Medical Advice (Figure 3-14). Entries defined in this property list will show in the BEDD application discharge screen as allowable dispositions to use when doing a LWOBS/AMA discharge. Refer to Section 9.4 for more information on populating this property.

```
Select LWOBS/DNA DISPOSITIONS: AMA
Select LWOBS/DNA DISPOSITIONS: LEFT WITHOUT BEING SEEN
Select LWOBS/DNA DISPOSITIONS: <enter>
```

Figure 3-14: Facility Parameter Setup (SET)–Select LWOBS/DNA dispositions

### 3.1.6 Run AMER Cleanup Utility (FIX)

This option will loop through the **AMER** application **ER ADMISSION** and **ER VISIT** files as well as the **BEDD BEDD.EDVISIT** class entries and identifies and attempts to fix any issues found with entries not lining up with PCC information.

1. To access the ERS Table and Parameter Setup menu, type **PAR** at the “Select Emergency Room System Option” prompt. The system will display the **Facility Setup** menu.
2. At the “Select Table and Parameter Setup Option” prompt, type **FIX**.
3. Choose **YES** to run the AMER record cleanup and select whether to run it in the foreground or background (Figure 3-15).

```
*****
*           Emergency Room System           *
*           Indian Health Service           *
*           Version 3.0                     *
*****

This option will loop through the AMER application ER ADMISSION and ER VISIT
files as well as the BEDD BEDD.EDVISIT class entries and identifies and
attempts to fix any issues found with entries not lining up with PCC
information.

Continue running the AMER record cleanup? Y// <enter> ES

This process could take some time to run. Would you like to queue
it off in the background or run it in the foreground?

Select one of the following:

      F           FOREGROUND
      B           BACKGROUND

Select one of the following: : BACKGROUND// <enter>
```

```
Kick off the background process now? Y// <enter> ES  
Kicking off the record cleanup utility background process...
```

Figure 3-15: Run AMER Cleanup Utility (FIX)

## 4.0 Package Operation

This section describes the functionality provided by the ERS application.

### 4.1 Admit to Emergency Room (IN)

Use the ERS Admit to emergency room menu option to admit an established patient to the emergency department. This option is a data collection session for patients who are admitted to the ER. Also, you can register a new patient, print a routing slip, and add a patient to the **ER admission** file.

**Note:** The options that appear on the ERS main menu depend on your security key. To determine or change your security keys, contact your site administrator.

To admit a patient to the ER:

1. From the “Select Emergency Room System Option” prompt, enter **IN** and press **Enter**.
2. From the “Enter the Patient’s NAME or LOCAL CHART NUMBER” prompt (Figure 4-1), type the patient’s name or chart number.

```
ER SYSTEM Ver 3.0: ADMISSION TO EMERGENCY ROOM      ^ = back up      ^^ = quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.

~~~~~

Enter the patient's NAME or LOCAL CHART NUMBER:
```

Figure 4-1: Admit to Emergency Room (IN) Option–Select Patient to Admit

**Note:** The system displays appointment information, if any, for the patient. It is important to note that if the patient has another appointment scheduled for a time close to the current time, that the system may prompt the user whether they want to check into that appointment. The user must always answer *no* to this question in order for a new ERS visit to be created.

3. From the “Date and time of admission to ER” prompt, type the date and time of admission or press **Enter** to select the default value of **NOW** (Figure 4-2).

```
~~~~~

*Date and time of admission to ER:  NOW//  <enter>
```

Figure 4-2: Admit to Emergency Room (IN) option–Enter the Date and Time of Admission to ER

4. From the “Presenting Complaint” prompt, enter the patient’s presenting complaint (Figure 4-3). You may enter up to 240 characters. The system displays a history of the patient’s previous registrations and demographic information. You may edit the registration information at this time.

```

No Pending Appointments
~~~~~
*Presenting complaint:
    
```

Figure 4-3: Admit to Emergency Room (IN) option–Enter the Presenting Complaint

5. The system displays a history of the patient’s previous registrations and demographic information (Figure 4-4). This information can be edited at this time.

```

~~~~~
Date of Last Registration Update: JUL 08, 2019
'
(home) (work)
Does patient's address or phone # need to be updated? NO//
    
```

Figure 4-4: Admit to Emergency Room (IN) Option–Edit Registration Information

6. From the “Visit Type” prompt (Figure 4-5), type one of the following:
  - Clinic referral
  - Hospital referral
  - Review
  - Scheduled
  - Unscheduled

```

~~~~~
*Visit type: UNSCHEDULED//
    
```

Figure 4-5: Admit to Emergency Room (IN) option–Enter the Visit type

7. If the Emergency Room Clinic is set up in your **Scheduling** package, respond to the prompts for appointment time, clinic, provider, and routing slips. You do not need to answer all questions. However, these responses set up the appointment in the Scheduling package and add information to the **Visit** file and **V Provider** file.
8. From the “Was this patient transferred from another facility?” prompt, type **Y** or **N**.

```

~~~~~
*Was this patient transferred from another facility? NO//

```

Figure 4-6: Admit to Emergency Room (IN) option–Was this patient transferred from another facility

**Note:** If you type **Y**, enter the name of the facility from which the patient was transferred and whether a medical attendant was present during transfer.

9. From the ER “Mode of transport to the ER” prompt, type how the patient arrived. Type ?? to view a list of available options.

```

~~~~~
*Mode of transport to the ER: PRIVATE VEHICLE/WALK IN//

```

Figure 4-7: Admit to Emergency Room (IN) option–Mode of Transport to the ER

**Note:** Depending on the selection chosen, additional information regarding the transportation method may be prompted for.

10. From the “Was the Trauma Team Activated for this visit” prompt, select **YES** if the Trauma Team was activated. Otherwise, select **NO**.

**Note:** If you type **YES**, you will also be prompted to enter the following required fields. Refer to Figure 4-8 for a display of the trauma related prompts.

- a. From the “Trauma Activated Provider” prompt, enter the provider that was activated for this visit.
- b. From the “Trauma Team Activation Date/Time” prompt, enter the time that the trauma provider was activated.

```

~~~~~
*Was the Trauma Team Activated for this visit? NO// YES
~~~~~
*Trauma Activated Provider: TEST, PROVIDER ONE      PTT
~~~~~
*Trauma Team Activation Date/Time: T@0545 (NOV 13, 2024@05:45)

```

Figure 4-8: Admit to Emergency Room (IN) option–Trauma Related Information Entry

11. From the Enter number of labels to print prompt, enter a value from 0 to 50 (Figure 4-9). The desired number of labels will print on the selected device.

- a. From the “LABEL PRINTER” prompt, enter the name of the printer.
- b. From the “Right margin” prompt, accept the default.

```
Enter number of labels to print: (0-50): 4// 4
LABEL PRINTER: PER// NULL NULL DEVICE NULL DEVICE Right Margin: 132//
```

Figure 4-9: Admit to Emergency Room (IN) option—Enter the number of labels to print

12. From the “Do you want to print a routing slip?” prompt (Figure 4-10), type **Y** or **N**. If you type **Y** (yes):
  - a. From the “FILE ROOM PRINTER” prompt, enter the name of the printer.
  - b. From the “Right margin” prompt, accept the default.

```
Do you want to PRINT a routing slip? YES// <enter>
FILE ROOM PRINTER: HOME// <enter>
FILE ROOM PRINTER: HOME// <enter> VIRTUAL Right Margin: 80// <enter>
```

Figure 4-10: Admit to Emergency Room (IN) option—Do you want to PRINT a Routine Slip

**Note:** If the **IHS Emergency Department Dashboard (BEDD)** application has been installed, depending on the enabled reports, the following additional prompts may be asked during the admission process

13. From the “Select printer for PATIENT MEDICATION WORKSHEET DEVICE” prompt (Figure 4-11), enter the device to print the report on. A “^” can be typed to skip printing this worksheet.

```
Select printer for PATIENT MEDICATION WORKSHEET...
DEVICE: HOME//<enter>
```

Figure 4-11: Admit to Emergency Room (IN) option—MEDICATION WORKSHEET DEVICE prompt

14. From the “Select the Printer for PATIENT ROUTINE SLIP DEVICE” prompt (Figure 4-12), enter the device to print the report on. A “^” can be typed to skip printing this slip.

```
Select printer for PATIENT ROUTING SLIP...
DEVICE: HOME//<enter>
```

Figure 4-12: Admit to Emergency Room (IN) option—PATIENT ROUTINE SLIP DEVICE prompt

15. From the “How many copies of the EMBOSSED CARD do you want?” prompt (Figure 4-13), enter a value between **1** and **5**. A “^” can be typed to skip printing the EMBOSSED CARD. From the “DEVICE” prompt, enter the device to print the EMBOSSED CARD on.

```

PATIENT REGISTRATION

2016 DEMO HOSPITAL

Print an EMBOSSED CARD

*** NOTE: IF YOU EDIT A PATIENT AND SEE THEIR NAME IN REVERSE VIDEO ***
*** WITH '(RHI)' BLINKING NEXT TO IT, IT MEANS THEY HAVE RESTRICTED ***
*** HEALTH INFORMATION ***

How many copies of the EMBOSSED CARD do you want? (1-5) 1// <enter>

DEVICE: HOME//<enter>

```

Figure 4-13: Admit to Emergency Room (IN) option—How many copies of the EMBOSSED CARD do you want prompt

When the admission is complete (Figure 4-14), the system displays the following message:

```
ER admission data collection is now complete. Thank you.
```

Figure 4-14: ER Admission complete message

## 4.2 Triage Nurse Update Admission Record (TRI)

The **Triage Nurse Update Admission Record Menu** option enables a triage nurse to edit the ER admission record before the transaction is processed. This option captures the time the patient was seen by the triage nurse, and the initial acuity of the patient.

To update the Admission Record, follow the instructions below:

1. From the “Select Emergency Room System Option” prompt (Figure 2-1), type **TRI**.
2. A list of patients currently admitted to the ED will display. From the “Select ER Patient” prompt, choose whether to sort by **ADMISSION time** or by **PATIENT NAME** and then type the number that matches the patient for whom you are adding triage information (Figure 4-15).

```

Select Emergency Room System <TEST ACCOUNT> Option: TRI Triage Nurse Update
Admission Record
The following patients are currently admitted to the ER =>

```

NAME	DOB	CHART	ADMISSION	PRESENTING COMPLAINT
1) DEMO,PATIENT ONE	11/27/15	123	11/13/24 06:00	TESTING
2) DEMO,PATIENT TWO	10/18/14	456	11/13/24 08:00	TESTING TW

Would you like to sort by ADMISSION time? N// **NO**

Select ER patient: **1**

Figure 4-15: Triage Nurse Update Admission Record (TRI)–Select the patient to triage

- From the “Clinic Type” prompt (Figure 4-16), select the appropriate clinic. For more information on setting up the clinics that should be selectable for this prompt, refer to Section 3.1.4. If a patient was admitted to the ERS using the **Admit to Emergency Room (IN)** option (Section 4.1), their Clinic type will default to the DEFAULT ER CLINIC property described in the **Facility Parameter Setup (SET)** option (Section 3.1.5). If a patient was admitted to the ERS using the **IHS Emergency Dept Dashboard (BEDD)** application BEDD IN option, then the Clinic type will match the Clinic type they chose when performing the admission.

```

~~~~~
ER ADMISSION FOR DEMO,PATIENT ONE ^=back up ^^=quit
Questions preceded by a '*' are MANDATORY. Enter '??' to see choices.
~~~~~

*Clinic type: EMERGENCY MEDICINE// <enter>
    
```

Figure 4-16: Triage Nurse Update Admission Record (TRI)–Sample Clinic Type selection choices

4. Entering the **Triage Nurse/Triage Provider:**

After entering the Clinic type, users will then be prompted to enter Triage information for the patient visit. The user will first be prompted to enter information for the Triage nurse. Depending on the value of the DISABLE TRIAGE PROVIDER ENTRY property described in the **Facility Parameter Setup (SET)** option (Section 3.1.5), the user may then be prompted to enter information for the Triage Provider. At least one triage nurse or provider must be entered to complete the **TRI** option.

With the release of AMER v3.0 p13, users can enter more than one triage nurse, triage provider, primary nurse and ED provider. For each nurse/provider entry, a corresponding date/time seen value must also be recorded. A consistent method to enter this information across the four nurse/provider roles has been developed and is described in Section 5.0.

- Enter the **Triage nurse information** (if applicable) to the patient visit (Figure 4-17).

```

ER ADMISSION FOR DEMO,PATIENT ONE ^=back up ^^=quit
Questions preceded by a '*' are MANDATORY. Enter '??' to see choices.
    
```

```

~~~~~
TRIAGE NURSE ENTRY
~~~~~

Triage nurse: TEST,NURSE ONE          NOT
*Enter the date/time that this patient was seen:  11/13/24@1001// T@0900   (NOV 13,
2024@09:00)
    
```

Figure 4-17: Triage Nurse Update Admission Record (TRI)–Sample Triage nurse entry

- b. The Triage nurse will now show as populated (Figure 4-18). An additional Triage nurse can be entered at this time, the existing Triage nurse date/time seen can be adjusted or the existing Triage nurse information can be deleted.

```

ER ADMISSION FOR DEMO,PATIENT ONE ^=back up ^^=quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

TRIAGE NURSE ENTRY

Current entry/entries on file for visit:

#      Nurse/Provider                Date/Time Seen
-----
1      TEST,NURSE ONE                 11/13/24@09:00

(A)dd new, (E)dit existing, (D)elete existing Triage nurse: <enter>
    
```

Figure 4-18: Triage Nurse Update Admission Record (TRI)–Entered Triage nurse display

- c. Enter the **Triage provider information** (if applicable and the DISABLE TRIAGE PROVIDER ENTRY property is not set to YES) to the patient visit (Figure 4-19).

```

ER ADMISSION FOR DEMO,PATIENT ONE ^=back up ^^=quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

TRIAGE PROVIDER ENTRY

~~~~~

Triage Provider: TEST,PROVIDER ONE          PTT
*Enter the date/time that this patient was seen:  11/13/24@1001// T@0930   (NOV 13,
2024@0930)
    
```

Figure 4-19: Triage Nurse Update Admission Record (TRI)–Sample Triage provider entry

- d. The Triage provider will now show as populated (Figure 4-20). An additional Triage provider can be entered at this time, the existing Triage provider date/time seen can be adjusted or the existing Triage provider information can be deleted.

```

ER ADMISSION FOR DEMO,PATIENT ONE      ^ = back up      ^^ = quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

TRIAGE PROVIDER ENTRY

Current entry/entries on file for visit:

#      Nurse/Provider                      Date/Time Seen
-----
1      TEST,PROVIDER ONE                    11/13/24@09:30

(A)dd new, (E)dit existing, (D)elete existing Triage Provider: <enter>
    
```

Figure 4-20: Triage Nurse Update Admission Record (TRI)–Entered Triage provider display

- e. At the “Enter the Emergency Severity Index assessment” prompt (below), enter a value from 1 to 5.

```

~~~~~
*Enter the Emergency Severity Index assessment:  (1-5): // 1
    
```

Figure 4-21: Triage Nurse Update Admission Record (TRI)–Entered the Emergency Severity Index assessment

- f. The information entered will now be displayed. Note that only the most recent Triage nurse or Triage provider will be shown. At the “Do you want to make any changes?” prompt, enter **YES** to make changes or **NO** to conclude the Triage Nurse Update Admission Record data entry process.

**Note:** If the user answers **YES** at the “Do you want to make any changes” prompt, they will be able to modify the fields listed in the summary, including the new Trauma related fields introduced in AMER v3.0 p16.

```

Summary of this ER data entry session for DEMO,PATIENT ONE =>
---  ADMISSION SUMMARY  ---
Patient: DEMO,PATIENT ONE                Arrival time: NOV 13,2024@06:00
Presenting Complaint: TESTING              Visit type: UNSCHEDULED
Transferred from:
Transport to ER: PRIVATE VEHICLE/WALK IN
Ambulance ID:                             Ambulance billing #:
Ambulance company:                         Clinic type: EMERGENCY MEDICINE
ED Provider:                               Triage nurse: TEST,NURSE ONE
Emergency Severity Index: 1
Seen by triage nurse at: NOV 13,2024@09:00
Medical Screening Exam Time:               Triage Provider: TEST,PROVIDER ONE
Seen by triage provider at: NOV 13,2024@09:30
Decision to admit at:                      Trauma Team Activation: YES
Trauma Activated Provider: TEST,PROVIDER ONE
Trauma Team Activation DTM: NOV 13,2024@05:45
ED Provider Time:                          Primary Nurse:
Primary Nurse Time:
    
```

```
*Do you want to make any changes? No// <enter>
```

Figure 4-22: Triage Nurse Update Admission Record (TRI)–Verify changes

### 4.3 Batch Mode ER Admission/Discharge (BAT)

The **Batch Mode ER Admission/Discharge Menu** option enables you to enter admission, triage, and discharge information.

**Note:** This option is available only to those users who have the appropriate security key.

To use the Batch Mode option:

1. From the “Select Emergency Room System Option” prompt, type **BAT**.
2. From the “Enter the patient's Name or Local Chart Number” prompt, type the patient’s name or chart number.

The series of prompts displayed next, depends on whether you are admitting or discharging this patient.

- For Admission information, refer to Section 4.1.
- For Triage information, refer to Section 4.2.
- For discharge information, refer to Section 4.4.

From the end of the **BAT** process, the system displays a summary of the input and asks if you want to make any changes. After prompts for printing labels, patient medication worksheet, routing slips and embossed cards, ERS adds specific visit data to **PCC V POV**, **V EMERGENCY VISIT RECORD**, and **V PROVIDER** files. The following example (Figure 4-23) displays the prompts and responses for the BAT option.

```
ER SYSTEM Ver 3.0: ADMISSION TO EMERGENCY ROOM      ^ = back up      ^^ = quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.

~~~~~

Enter the patient's NAME or LOCAL CHART NUMBER: DEMO,PATIENT THREE
                                         F 01-01-1985 XXX-XX-5456   DB 92343

~~~~~

*Date and time of admission to ER:  // N (NOV 13, 2024@16:05)
No Pending Appointments

~~~~~

*Presenting complaint: TESTING

~~~~~
```

```

*****
Date of Last Registration Update: SEP 25, 2024

Additional Registration Information:
*****

Want to Edit this Registration Record? NO// <enter>

~~~~~

*Visit type: UNSCHEDULED// <enter>

~~~~~

*Was this patient transferred from another facility? NO// <enter>

~~~~~

*Mode of transport to the ER: PRIVATE VEHICLE/WALK IN// <enter>

~~~~~

*Was the Trauma Team Activated for this visit? NO// YES

~~~~~

*Trauma Activated Provider: TEST,PROVIDER ONE          PTT

~~~~~

*Trauma Team Activation Date/Time: N (NOV 13, 2024@16:05)
Enter number of labels to print: (0-50): 4// ^
LABEL PRINTER: PER// ^
Do you want to PRINT a routing slip? YES// NO
Setting data for Dashboard...

Select printer for PATIENT MEDICATION WORKSHEET...

DEVICE: HOME// ^

Select printer for PATIENT ROUTING SLIP...

DEVICE: HOME// ^

Select printer for Patient WristBand/Embossed Card...

                PATIENT REGISTRATION

                2016 DEMO HOSPITAL

                Print an EMBOSSED CARD

*** NOTE: IF YOU EDIT A PATIENT AND SEE THEIR NAME IN REVERSE VIDEO ***

```

\*\*\* WITH '(RHI)' BLINKING NEXT TO IT, IT MEANS THEY HAVE RESTRICTED \*\*\*  
\*\*\* HEALTH INFORMATION \*\*\*

2016 DEMO HOSPITAL

Emergency Room System

\*\*\* NOTE: IF YOU EDIT A PATIENT AND SEE THEIR NAME IN REVERSE VIDEO \*\*\*  
\*\*\* WITH '(RHI)' BLINKING NEXT TO IT, IT MEANS THEY HAVE RESTRICTED \*\*\*  
\*\*\* HEALTH INFORMATION \*\*\*

~~~~~  
\*Clinic type: EMERGENCY MEDICINE// <enter> 30

~~~~~  
ER ADMISSION FOR DEMO,PATIENT THREE ^=back up ^=quit  
Questions preceded by a '\*' are MANDATORY. Enter '??' to see choices.  
~~~~~

TRIAGE NURSE ENTRY

~~~~~  
Triage nurse: **TEST,NURSE ONE** NOT  
\*Enter the date/time that this patient was seen: 11/13/24@16:05// <enter> (NOV 13,  
20

ER ADMISSION FOR DEMO,PATIENT THREE ^=back up ^=quit  
Questions preceded by a '\*' are MANDATORY. Enter '??' to see choices.  
~~~~~

TRIAGE NURSE ENTRY

Current entry/entries on file for visit:

| # | Nurse/Provider | Date/Time Seen |
|---|----------------|----------------|
| 1 | TEST,NURSE ONE | 11/13/24@16:05 |

(A)dd new, (E)dit existing, (D)etele existing Triage nurse: <enter>

~~~~~  
ER ADMISSION FOR DEMO,PATIENT THREE ^=back up ^=quit  
Questions preceded by a '\*' are MANDATORY. Enter '??' to see choices.  
~~~~~

TRIAGE PROVIDER ENTRY

~~~~~  
Triage Provider: TEST,PROVIDER ONE PTT  
\*Enter the date/time that this patient was seen: 11/13/24@16:06// (NOV 13, 20

ER ADMISSION FOR DEMO,PATIENT THREE ^=back up ^=quit  
Questions preceded by a '\*' are MANDATORY. Enter '??' to see choices.  
~~~~~

TRIAGE PROVIDER ENTRY

```

Current entry/entries on file for visit:

#      Nurse/Provider                Date/Time Seen
-----
1      TEST, PROVIDER ONE             11/13/24@16:06

(A)dd new, (E)dit existing, (D)elete existing Triage Provider: <enter>

~~~~~

*Enter the Emergency Severity Index assessment:  (1-5): // 1

~~~~~
ER ADMISSION FOR DEMO, PATIENT THREE ^=back up ^^=quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

PRIMARY NURSE ENTRY

~~~~~

Primary Nurse:  TEST, NURSE ONE          NOT
*Enter the date/time that this patient was seen:  11/13/24@16:06// <enter>  (NOV 13,
20
ER ADMISSION FOR DEMO, PATIENT THREE ^=back up ^^=quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

PRIMARY NURSE ENTRY

Current entry/entries on file for visit:

#      Nurse/Provider                Date/Time Seen
-----
1      TEST, NURSE ONE                11/13/24@16:06

(A)dd new, (E)dit existing, (D)elete existing Primary Nurse: <enter>

~~~~~

ER ADMISSION FOR DEMO, PATIENT THREE ^=back up ^^=quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

ED PROVIDER ENTRY

~~~~~

ED Provider:  TEST, PROVIDER ONE          PTT
*Enter the date/time that this patient was seen:  11/13/24@16:06// <enter>  (NOV 13,
20
ER ADMISSION FOR DEMO, PATIENT THREE ^=back up ^^=quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

ED PROVIDER ENTRY

Current entry/entries on file for visit:

#      Nurse/Provider                Date/Time Seen
-----

```

```
1 TEST, PROVIDER ONE 11/13/24@16:06
(A)dd new, (E)dit existing, (D)elete existing ED Provider: <enter>
~~~~~
*Enter Medical Screening Exam Time: 11/13/24@16:06// <enter> (NOV 13, 2024@16:06)
~~~~~
Enter the decision to admit date/time: <enter>
~~~~~
*Was this ER visit caused by an injury? NO// <enter>
~~~~~
*Was this ER visit WORK-RELATED? NO// <enter>
~~~~~
*Was an ER CONSULTANT notified? NO// <enter>
~~~~~
Enter procedure: NONE// <enter>
~~~~~
*Enter Purpose of Visit Information
Enter ZZZ.999 to log an uncoded diagnosis
Enter PURPOSE OF VISIT: ZZZ.999
PRESENT ON ADMISSION?: Y YES
PRIMARY/SECONDARY: P PRIMARY
PROVIDER NARRATIVE: NARRATIVE FOR POV
CAUSE OF DX:
ENCOUNTER PROVIDER:
Enter PURPOSE OF VISIT: <enter>
~~~~~
*Enter final acuity assessment from provider: (1-5): // 1
~~~~~
*Disposition: HOME
~~~~~
Select one of the following:
1 RTC PRN, INSTRUCTIONS GIVEN
2 APPT AND INSTRUCTIONS GIVEN
3 REF MADE, INSTRUCTIONS GIVEN
Follow up instructions: RTC PRN, INSTRUCTIONS GIVEN// <enter>
~~~~~
```

```

*(PRIMARY)Provider who signed PCC form: : TEST,PROVIDER ONE// <Enter>      PTT
~~~~~
*Discharge nurse: TEST,NURSE ONE          NOT
~~~~~

Summary of this ER data entry session for DEMO,PATIENT THREE =>
      --- ADMISSION SUMMARY ---
Patient: DEMO,PATIENT THREE          Arrival time: NOV 13,2024@16:05
Presenting Complaint: TESTING        Visit type: UNSCHEDULED
Transferred from:
Transport to ER: PRIVATE VEHICLE/WALK IN
Ambulance ID:                       Ambulance billing #:
Ambulance company:                  Clinic type: EMERGENCY MEDICINE
ED Provider: TEST,PROVIDER ONE      Triage nurse: TEST,NURSE ONE
Emergency Severity Index: 1
Seen by triage nurse at: NOV 13,2024@16:05
Medical Screening Exam Time: NOV 13,2024@16:06
Triage Provider: TEST,PROVIDER ONE
Seen by triage provider at: NOV 13,2024@16:06
Decision to admit at:               Trauma Team Activation: YES
Trauma Activated Provider: TEST,PROVIDER ONE
Trauma Team Activation DTM: NOV 13,2024@16:05
ED Provider Time: NOV 13,2024@16:06 Primary Nurse: TEST,NURSE ONE
Primary Nurse Time: NOV 13,2024@16:06
      --- CAUSE OF VISIT ---
Occupation related: NO
      --- INJURY INFORMATION ---
Injury related visit: NO           Location:
Time of injury:                   Cause of injury:
Setting:                          Safety equipment:
      --- ER PROCEDURES ---
Procedures: NONE
      --- ER CONSULTANT ---
1:
      --- EXIT ASSESSMENT ---
Diagnoses: [P] NARRATIVE FOR POV [ZZZ.999]
Discharge acuity: 1
      --- DISPOSITION ---
Disposition: HOME                 Transfer to:
      --- DISCHARGE INFO ---
Provider who signed PCC form: TEST,PROVIDER ONE
Discharge nurse: TEST,NURSE ONE    Departure time: NOV 13,2024@16:06
      --- FOLLOW UP INSTRUCTIONS ---
Discharge instructions: RTC PRN, INSTRUCTIONS GIVEN

*Do you want to make any changes? No// <Enter> No

```

Figure 4-23: Batch Mode ER Admission/Discharge (BAT)–Sample BAT visit entry

## 4.4 Discharge from Emergency Room (OUT)

Use the discharge from emergency room menu option to discharge a patient from the emergency room. This is a data collection session for patients who are discharged from the ER. The information collected is stored in the ER visit file. From the end of the OUT process, specific data is synched with PCC files.

In addition, this option enables you to print patient instructions, create a visit, and delete a patient from the ER admission file.

**Note:** The options that appear on the ERS main menu depend on your security key. Contact your site administrator to determine or change your security keys.

**REQUIRED:** You must answer all questions marked with an asterisk (\*).

1. To discharge a patient from the ER, from the Select emergency room “System Option” prompt, enter OUT. The system lists all patients currently admitted to the ER.
2. Choose whether to sort by ADMISSION time or not and, from the “Select ER patient” prompt, enter the number that matches the patient you are discharging (Figure 4-24).

```
The following patients are currently admitted to the ER =>
```

| NAME                   | DOB      | CHART | ADMISSION      | PRESENTING COMPLAINT |
|------------------------|----------|-------|----------------|----------------------|
| 1) DEMO, PATIENT ONE   | 11/27/15 | 123   | 11/13/24 06:00 | TESTING              |
| 2) DEMO, PATIENT THREE | 01/01/85 | 92343 | 11/15/24 08:00 | TESTING              |
| 3) DEMO, PATIENT TWO   | 10/18/14 | 456   | 11/13/24 08:00 | TESTING TW           |

```

Would you like to sort by ADMISSION time? N// <enter> O

Select ER patient:  1
                    DEMO, PATIENT ONE
    
```

Figure 4-24: Discharge from Emergency Room–Select patient to discharge

3. From the “Clinic type” prompt, accept the default or select the correct Clinic type from the list of available choices (Figure 4-25 ).

```

~~~~~
                ER ADMISSION FOR DEMO, PATIENT ONE ^=back up ^^=quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~
    
```

```
*Clinic type: EMERGENCY MEDICINE//          <enter>          30
```

Figure 4-25: Discharge from Emergency Room–Select the Clinic type

- From the **TRIAGE NURSE ENTRY** data entry method, add, edit or remove the Triage Nurse information (Figure 4-26).

```
ER ADMISSION FOR DEMO,PATIENT ONE ^=back up ^^=quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

TRIAGE NURSE ENTRY

Current entry/entries on file for visit:

#      Nurse/Provider                Date/Time Seen
-----
1      TEST,NURSE ONE                11/13/24@09:00

(A)dd new, (E)dit existing, (D)elete existing Triage nurse: <enter>
```

Figure 4-26: Discharge from Emergency Room–Triage Nurse add/edit/delete data entry method

- If enabled, from the **TRIAGE PROVIDER ENTRY** data entry method, add, edit or remove the Triage provider information (Figure 4-27).

```
ER ADMISSION FOR DEMO,PATIENT ONE ^=back up ^^=quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

TRIAGE PROVIDER ENTRY

Current entry/entries on file for visit:

#      Nurse/Provider                Date/Time Seen
-----
1      TEST,PROVIDER ONE            11/13/24@09:30

(A)dd new, (E)dit existing, (D)elete existing Triage Provider: <enter>
```

Figure 4-27: Discharge from Emergency Room–Triage Provider add/edit/delete data entry method

- At the “Enter the Emergency Severity Index assessment” prompt, accept the value, if already entered, or enter a new value (Figure 4-28).

```
~~~~~
*Enter the Emergency Severity Index assessment:  (1-5): 1// <enter>
```

Figure 4-28: Discharge from Emergency Room – Enter the Emergency Severity Index Assessment

- From the **PRIMARY NURSE ENTRY** data entry method, add, edit or remove the **Primary Nurse** information (Figure 4-29).

```

PRIMARY NURSE ENTRY

~~~~~

Primary Nurse: TEST,NURSE ONE          NOT
*Enter the date/time that this patient was seen: 11/15/24@11:18// 11/13@1100 (
ER ADMISSION FOR DEMO,PATIENT ONE ^=back up ^^=quit
Questions preceded by a '*' are MANDATORY. Enter '??' to see choices.
~~~~~

PRIMARY NURSE ENTRY

Current entry/entries on file for visit:

#      Nurse/Provider                      Date/Time Seen
-----
1      TEST,NURSE ONE                      11/13/24@11:00

(A)dd new, (E)dit existing, (D)elete existing Primary Nurse: <enter>
    
```

Figure 4-29: Discharge from Emergency Room–Primary Nurse add/edit/delete data entry method

8. From the **ED PROVIDER ENTRY** data entry method, add, edit or remove the ED Provider information (Figure 4-30).

```

~~~~~
ER ADMISSION FOR DEMO,PATIENT ONE      ^=back up      ^^ = quit
Questions preceded by a '*' are MANDATORY. Enter '??' to see choices.
~~~~~

ED PROVIDER ENTRY

~~~~~

ED Provider: TEST, PROVIDER ONE        PTT
*Enter the date/time that this patient was seen: 11/15/24@11:19// 11/13@1200 (
ER ADMISSION FOR DEMO,PATIENT ONE ^=back up ^^=quit
Questions preceded by a '*' are MANDATORY. Enter '??' to see choices.
~~~~~

ED PROVIDER ENTRY

Current entry/entries on file for      Nurse/Provider                      Date/Time
Seen
-----
1      TEST,PROVIDER ONE                  11/13/24@12:00

(A)dd new, (E)dit existing, (D)elete existing ED Provider: <enter>
    
```

Figure 4-30: Discharge from Emergency Room–ED Provider add/edit/delete data entry method

9. From “Enter the Medical Screening Exam Time” prompt, enter the date/time the patient was first seen by the ED Provide (Figure 4-31).

```

~~~~~
*Enter Medical Screening Exam Time: 11/13/24@12:00// <enter> (NOV 13, 2024@12:00)
    
```

Figure 4-31: Discharge from Emergency Room–Enter the Medical Screening Exam Time

10. From “Enter the decision to admit date/time” prompt, enter the date/time it was determined to admit the patient (Figure 4-32).

```

~~~~~
Enter the decision to admit date/time: <enter>
    
```

Figure 4-32: Discharge from Emergency Room–Enter the decision to admit date/time

11. From the “Was This ER Visit Caused by an Injury?” prompt, do one of the following:

- **Enter Y (Yes)** and press **Enter**. Go to step 10.
- **Enter N (No)** and press **Enter**. Go to step 16.

12. **Optional:** From the “Town/Village Where Injury Occurred” prompt, enter the town where the injury occurred, or press **Enter** to bypass this field.

13. **Optional:** From the “Enter the exact time and date of Injury” prompt, enter the date and time the injury occurred, or press **Enter** to bypass this field.

14. From the “Cause of Injury” prompt, enter the cause of the injury. Enter a partial entry to get a list of applicable ICD-10 codes to choose from.

15. After the cause of injury has been entered, the system displays specific prompts. Respond to the prompts as they appear on your screen (Figure 4-33).

```

~~~~~
*Was this ER visit caused by an injury? NO// YES
Town/village where injury occurred: // INJURY TOWN
Enter the exact time and date of injury: 11/12@0800 (NOV 12, 2024@08:00)
*Cause of injury: MOTOR V

1 X82.2XXS Intentional collision of motor vehicle with tree, sequela
2 X82.1XXS Intentional collision of motor vehicle with train, sequela
3 X82.8XXS Oth self-harm by crashing of motor vehicle, sequela
4 X82.2XXA Intentional collision of motor vehicle w tree, init encntr
5 X82.1XXA Intentional collision of motor vehicle w train, init encntr
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 1
Setting of accident/injury: HIGHWAY OR ROAD
Safety equipment used: B
1 BELT (LAP)
2 BELT (SHOULDER)
    
```

CHOOSE 1-2: **2** BELT (SHOULDER)  
 Location of MVC (if applicable): **123 PARK AVENUE**

Figure 4-33: Discharge from Emergency Room—Entering injury information

16. From the “Was this ER visit Work-Related?” prompt, enter **Y** or **N**.
17. From the “Was an ER Consultant notified?” prompt, **Enter Y** or **N**. If you enter **Yes**, the system displays additional prompts as shown in Figure 4-34. Respond to those prompts as appropriate.

```

~~~~~
*Was an ER CONSULTANT notified? NO// y YES
~~~~~
*CONSULTANT SERVICE: INTERNAL MEDICINE
*What time did the patient see this CONSULTANT: 11/13@1300 (NOV 13, 2024@13:00)
*CONSULTANT NAME: DEMO, ADAM AA 119 SYSTEMS ANALYST *Was another
CONSULTANT notified? NO// <enter>
    
```

Figure 4-34: Discharge from Emergency Room—Entering ER Consultant information

18. From the “Enter Procedure” prompt, enter the procedure the patient’s procedure. Enter **??** to display a list of available options or press **Enter** to accept the default, **NONE**.
19. From the “Enter Another Procedure” prompt, enter another procedure, or press **Enter** if there are no other procedures.
20. From the Enter “PURPOSE OF VISIT” prompt, enter an ICD-10 code or ICD-10 code description to look up a specific diagnosis (Figure 4-35).

```

~~~~~
*Enter Purpose of Visit Information
  Enter ZZZ.999 to log an uncoded diagnosis
Enter PURPOSE OF VISIT: ELBOW FRACTURE

  6 term matches found.

1)  Periprosthetic fracture around internal prosthetic left elbow joint,
    sequela (ICD-10-CM M97.42XS)
2)  Periprosthetic fracture around internal prosthetic right elbow joint,
    sequela (ICD-10-CM M97.41XS)
3)  Periprosthetic fracture around internal prosthetic left elbow joint,
    initial encounter (ICD-10-CM M97.42XA)
4)  Periprosthetic fracture around internal prosthetic right elbow joint,
    initial encounter (ICD-10-CM M97.41XA)
5)  Periprosthetic fracture around internal prosthetic left elbow joint,
    subsequent encounter (ICD-10-CM M97.42XD)
    
```

```
Type "^" to STOP or SELECT 1-5: (1-5): // 1
```

Figure 4-35: Discharge from Emergency Room–Entering the Purpose of Visit

21. After selecting a diagnosis, respond to whether the diagnosis was **PRESENT ON ADMISSION (YES/NO)**, **PRIMARY/SECONDARY**, enter the **PROVIDER NARRATIVE**, **CAUSE OF DX**, and the **ENCOUNTER PROVIDER**. Choose whether to enter an additional **PURPOSE OF VISIT** (Figure 4-36).

```
PRESENT ON ADMISSION?: Y YES
PRIMARY/SECONDARY: P PRIMARY
PROVIDER NARRATIVE: BROKE LEFT ELBOW IN MVC
CAUSE OF DX: <enter>
ENCOUNTER PROVIDER: <enter>
Enter PURPOSE OF VISIT: <enter>
```

Figure 4-36: Discharge from Emergency Room–Entering the remaining purpose of visit information

22. From the **Enter Final Acuity Assessment from Provider** prompt, enter the number of the patient’s final acuity assessment.
23. From the **Disposition** prompt, enter the patient’s disposition. Enter **??** to display a list of available dispositions (Figure 4-37).
- If the disposition is transferred to another facility, the “Where is patient being transferred to” prompt is displayed for you to enter the facility to which the patient was transferred.
  - If you need to change a disposition because it was entered in error, use the **REGISTERED IN ERROR** disposition. The system displays messages alerting you to the consequences of entering the **REGISTERED IN ERROR** disposition and asks if you still want to use the specified disposition.

```
~~~~~
*Enter final acuity assessment from provider: (1-5): // 3
~~~~~
*Disposition: HOME
```

Figure 4-37: Discharge from Emergency Room–Entering the final acuity assessment and Disposition

24. From the “Follow up Instructions” prompt, enter the follow-up instructions.
25. From the “(PRIMARY) Provider who Signed PCC Form” prompt, enter the name of the Provider who signed the PCC form. The default is the latest ED Provider, if previously entered.
26. From the “Discharge Nurse” prompt, enter the name of the discharge nurse.

27. From the “What time did the patient depart from the ER” prompt, enter the date and time the patient left the ER. The time must be after the time of the triage for the computer to accept your response (Figure 4-38).

```

~~~~~
Select one of the following:

1          RTC PRN, INSTRUCTIONS GIVEN
2          APPT AND INSTRUCTIONS GIVEN
3          REF MADE, INSTRUCTIONS GIVEN

Follow up instructions: RTC PRN, INSTRUCTIONS GIVEN// <enter>

~~~~~

*(PRIMARY)Provider who signed PCC form: TEST,PROVIDER ONE// <enter>          PTT

~~~~~

*Discharge nurse: TEST,NURSE ONE          NOT

~~~~~

*What time did the patient depart from the ER:  NOW// 11/13@2000  (NOV 13, 2024@
20:00)

```

Figure 4-38: Discharge from Emergency Room—Entering the Follow-Up Instructions Primary Provider, Discharge Nurse, and Discharge Date/Time

28. The system displays a summary of the patient’s discharge information. Review the summary for accuracy.
29. From the “Do you want to make any changes?” prompt, enter **Y** or **N**.

- If you enter **No**, the discharge is complete, and the system displays the message, **Data entry session successfully completed. Thank you.**

```

Summary of this ER data entry session for DEMO,PATIENT ONE =>
---  ADMISSION SUMMARY  ---
Patient: DEMO,PATIENT ONE          Arrival time: NOV 13,2024@06:00
Presenting Complaint: TESTING       Visit type: UNSCHEDULED
Transferred from:
Transport to ER: PRIVATE VEHICLE/WALK IN
Ambulance ID:                      Ambulance billing #:
Ambulance company:                  Clinic type: EMERGENCY MEDICINE
ED Provider: TEST,PROVIDER ONE      Triage nurse: TEST,NURSE ONE
Emergency Severity Index: 1
Seen by triage nurse at: NOV 13,2024@09:00
Medical Screening Exam Time: NOV 13,2024@12:00
Triage Provider: TEST,PROVIDER ONE
Seen by triage provider at: NOV 13,2024@09:30
Decision to admit at:                Trauma Team Activation: YES
Trauma Activated Provider: TEST,PROVIDER ONE
Trauma Team Activation DTM: NOV 13,2024@05:45
ED Provider Time: NOV 13,2024@12:00  Primary Nurse: TEST,NURSE ONE
Primary Nurse Time: NOV 13,2024@11:00

```

```

          --- CAUSE OF VISIT ---
Occupation related: NO
          --- INJURY INFORMATION ---
Injury related visit: YES          Location: INJURY TOWN

Time of injury: NOV 12,2024@08:00
Cause of injury: X82.2XXS - Intentional collision of motor vehicle with tree,
sequela
Setting: HIGHWAY OR ROAD          Safety equipment: BELT (SHOULDER)
          --- ER PROCEDURES ---
Procedures: NONE
          --- ER CONSULTANT ---
1: INTERNAL MEDICINE @ NOV 13,2024@13:00 DEMO,ADAM
          --- EXIT ASSESSMENT ---
Diagnoses: [P] BROKE LEFT ELBOW IN MVC [M97.42XS]
Discharge acuity: 3
          --- DISPOSITION ---
Disposition: HOME          Transfer to:
          --- DISCHARGE INFO ---
Provider who signed PCC form: TEST,PROVIDER ONE
Discharge nurse: TEST,NURSE ONE          Departure time: NOV 13,2024@20:00
          --- FOLLOW UP INSTRUCTIONS ---
Discharge instructions: RTC PRN, INSTRUCTIONS GIVEN

*Do you want to make any changes? No// <enter> (No)
Do you want to print patient instructions? No//<enter> (No)

```

Figure 4-39: Discharge from Emergency Room—Reviewing the Discharge Information and Completing the Discharge

- If you enter **Yes**, enter the number of the section that you want to edit from the “Which section do you want to edit” prompt, to re-enter responses to the prompts in the chosen section.
- When you finish typing responses to the prompts, the system redisplay the patient’s discharge summary, for your review. If further edits are necessary, enter the section you want to edit from the prompt.
- When you finish making changes to the patient discharge, enter **NO** from the “Do you want to make any changes?” prompt.

## 4.5 Cancel Visit (DNA)

Use the **Cancel Visit** menu option to cancel a patient visit without using the discharge process.

**Note:** The options that appear on the ERS main menu (Figure 2-1) depend on your security key. Contact your site administrator to determine or change your security keys.

To cancel a visit:

1. From the “Select Emergency Room System Option” prompt, type DNA. The system displays a list of patients currently admitted to the ER.
2. Select whether to sort by ADMISSION time and, at the “Select ER patient” prompt, type the number that matches the patient visit you want to cancel.
3. From the “Disposition” prompt, enter the applicable disposition from the list of available choices.
4. From the “Follow up Instructions” prompt, press **Enter**.
5. From the “(PRIMARY) Provider who signed PCC form” prompt, type the name of the provider who signed the PCC form.
6. From the “Discharge nurse” prompt, type the name of the discharging nurse. The system displays the patient’s admission summary.
7. Review the summary for accuracy.
8. From the “Do you want to make any changes?” prompt, type **Y** or **N** (Figure 4-40).
  - a. If you type **No**, the visit is cancelled, and the system displays the message, **Data entry session successfully completed. Thank you.**
  - b. If you type **Yes**,
    - Type the number of the section that you want to edit at the “Which section do you want to edit” prompt, to re-enter responses to the prompts in the chosen section.
    - When you finish typing responses to the prompts, the system redisplay the patient’s discharge summary, for your review. If further edits are necessary, enter the section you want to edit at the prompt.
    - When you finish making changes to the patient discharge, type **NO** at the “Do you want to make any changes?” prompt.

```

Select Emergency Room System <TEST ACCOUNT> Option: DNA Cancel Visit
(did not a

***** PROCESS PATIENT WHO LEFT BEFORE VISIT WAS COMPLETED *****

The following patients are currently admitted to the ER =>

NAME                                DOB      CHART  ADMISSION  PRESENTING
                                     COMPLAINT
1) DEMO, PATIENT FIVE                09/23/15 165    11/15/24 09:00 TESTING DN

```

```

2) DEMO,PATIENT THREE                01/01/85 92343  11/15/24 08:00 TESTING
3) DEMO,PATIENT TWO                   10/18/14 456   11/13/24 08:00 TESTING TW

Would you like to sort by ADMISSION time? N// NO

Select ER patient:  3 DEMO,PATIENT TWO
  DEMO,PATIENT TWO      <D>   M 10-18-2014 XXX-XX-1234   DB 456
~~~~~

*Disposition: LEFT
  1  LEFT AFTER INSURANCE DENIAL
  2  LEFT WITHOUT BEING DISCHARGED
  3  LEFT WITHOUT BEING SEEN
CHOOSE 1-3: 3 LEFT WITHOUT BEING SEEN
~~~~~

      Select one of the following:

          1          RTC PRN, INSTRUCTIONS GIVEN
          2          APPT AND INSTRUCTIONS GIVEN
          3          REF MADE, INSTRUCTIONS GIVEN

Follow up instructions: RTC PRN, INSTRUCTIONS GIVEN// <enter>
~~~~~

*(PRIMARY)Provider who signed PCC form: TEST,PROVIDER ONE      PTT
~~~~~

*Discharge nurse: TEST,NURSE ONE      NOT
~~~~~

*What time did the patient depart from the ER:  NOW// 11/13@1500 (NOV 13, 2024@
15:00)

This means a really long delay since the time of admission: NOV 13,2024@08:00
Are you sure? No// Y (Yes)
Summary of this ER data entry session for DEMO,PATIENT TWO =>
      ---  ADMISSION SUMMARY  ---
Patient: DEMO,PATIENT TWO                Arrival time: NOV 13,2024@08:00
Presenting Complaint: TESTING TWO        Visit type: UNSCHEDULED
Transferred from:
Transport to ER: PRIVATE VEHICLE/WALK IN
Ambulance ID:                            Ambulance billing #:
Ambulance company:                       Clinic type:
ED Provider:                             Triage nurse: TEST,NURSE ONE
Emergency Severity Index: 1
Seen by triage nurse at: NOV 13,2024@14:00
Medical Screening Exam Time:             Triage Provider:
Seen by triage provider at:              Decision to admit at:
Trauma Team Activation: YES
Trauma Activated Provider: TEST,PROVIDER ONE
Trauma Team Activation DTM: NOV 13,2024@07:50
ED Provider Time:                        Primary Nurse:
Primary Nurse Time:
      ---  CAUSE OF VISIT  ---
Occupation related:

```

```

          --- INJURY INFORMATION ---
Injury related visit:                Location:
Time of injury:                      Cause of injury:

Setting:                             Safety equipment:
          --- ER PROCEDURES ---
Procedures:
1:                                   --- ER CONSULTANT ---
          --- EXIT ASSESSMENT ---
Diagnoses:                           Discharge acuity:
          --- DISPOSITION ---
Disposition: LEFT WITHOUT BEING SEEN  Transfer to:
          --- DISCHARGE INFO ---
Provider who signed PCC form: TEST,PROVIDER ONE
Discharge nurse: TEST,NURSE ONE      Departure time: NOV 13,2024@15:00
          --- FOLLOW UP INSTRUCTIONS ---
Discharge instructions: RTC PRN, INSTRUCTIONS GIVEN

*Do you want to make any changes? No// <enter> (No)

```

Figure 4-40: Cancel Visit (did not answer or left AMA)

## 4.6 DOA Admissions to ER (DOA)

Use the **DOA Admissions to ER** menu option to enter information about a patient that dies before arriving at the ER.

**Note:** This menu option was never implemented and should not be used.

## 4.7 Mini Registration of New Patients (REG)

Use the Mini Registration of New Patients menu option to register a new patient by entering basic patient demographic information.

**Note:** The options that appear on the ERS main menu (Figure 2-1) depend on your security key. To determine or change your security keys, contact your site administrator.

## 4.8 Registering a New Patient (REG)

To register a new patient:

1. From the “Select Emergency Room System Option” prompt, type **REG** and press **Enter**.
2. From the “Select Patient Name” prompt, type the patient’s name.

**Note:** When typing the name, do not use any spaces after the comma, use the LAST,FIRST format.

If the patient is not found, press **Enter** at the “Select Patient Name” prompt.

- From the “Enter the patient’s full name” prompt, type the patient’s **name** in **LAST,FIRST** format.

If the new patient’s name includes a (first or) middle initial, enter the complete name or press **Enter** to continue (Figure 4-41).

```
Select Emergency Room System <TEST ACCOUNT> Option: REG Mini-Registration of Ne
ADD a new patient.....

You must first SCAN FOR SIMILAR NAMES or CHART NUMBERS NOW...
Select PATIENT NAME: DEMO,PATIENT SIXTEEN
??
Select PATIENT NAME:
Enter the NEW PATIENT'S FULL NAME.....
(EXAMPLE: Demo, Patient, JR (no space after commas))

Entering NEW Patient for 2016 DEMO HOSPITAL

Enter the PATIENT'S NAME: DEMO,PATIENT SIXTEEN
ARE YOU ADDING 'DEMO,PATIENT SIXTEEN' AS A NEW PATIENT (THE 7294TH)? No// Y
(Yes)
```

Figure 4-41: Mini-Registration of New Patients—Steps 1 - 3

- From the “PATIENT SEX” prompt, type the patient’s **sex**.
- From the “PATIENT DATE OF BIRTH” prompt, type the patient’s **date of birth**.
- From the “PATIENT SOCIAL SECURITY NUMBER” prompt, type the patient’s **Social Security number**. The system searches for possible duplicates, if none are identified, the patient is added.
- From the “Do you need a temporary chart number for this patient?” prompt, enter **Y** or **N**.
  - If you enter **Y** (Yes), RPMS creates a temporary chart number for this patient, and displays the temporary number.
  - If you enter **N** (No), everything you entered previously into the patient file is deleted.
- From the “DATE OF BIRTH” prompt, press **Enter** to accept the displayed **DOB**, or type the correct **DOB**.
- From the “SEX” prompt, press **Enter**, to accept the displayed **sex**, or enter a different **sex**.

```
PATIENT SEX: F FEMALE
PATIENT DATE OF BIRTH: 1/1/1980 (JAN 01, 1980)
PATIENT SOCIAL SECURITY NUMBER: 4349434345 ??
SSN
```

```

Enter 9-digit SSN or 'P' for pseudo-SSN.
PATIENT SOCIAL SECURITY NUMBER: 854347656

...searching for potential duplicates.....

...adding new patient

Do you need a temporary chart number for this new patient? (Y/N)  N// Y

The new patient's TEMPORARY chart number is T00001

Press RETURN...

DATE OF BIRTH: 01/01/1980// <enter>

SEX: FEMALE// <enter>

```

Figure 4-42: Mini-Registration of New Patients—Steps 1–3

## 4.9 Scanning Patient Names or Chart Numbers (SCAN)

Use the **Scan Patient Names or Chart Numbers** menu option to search for a patient, before you admit the patient or create a new account. There are several methods you can use to find a patient, such as entering a partial name like DOE,JO instead of DOE,JOHN. You can also search for other first names and married names.

Additionally, you can limit birth date searches by entering a date of birth in the format 9/9/99 to reduce the list of choices.

**Note:** This option is available only to those users who have the appropriate security key.

To scan for patients already in the system:

1. From the “Select Emergency Room System Option” prompt, Type **SCAN** and press **Enter**.
2. From the “Enter Patient Name, DOB, or Local Chart Number” prompt, type the patient’s **name, date of birth, or chart number**.

```

Select Emergency Room System <TEST ACCOUNT> Option: SCAN Scan Patient
Names or Chart Numbers

There are several tricks you can use to find this patient. Try entering a
partial name like 'DOE,JO' instead of 'DOE,JOHN'. Ask about other first
names and married names. Try entering a date of birth in the format 9/9/99.
This should narrow down the list of possible choices.

Enter patient NAME, DOB, or LOCAL CHART NUMBER: DEMO,PATIENT F
1. DEMO,PATIENT FIVE F 09-23-2015 XXX-XX-1564 DB 165
2. DEMO,PATIENT FOUR <A> F 09-23-2015 XXX-XX-5555 DB 143
3. DEMO,PATIENT FOUR F 01-01-1980 DB 65687
CHOOSE 1-3: 3

```

```

DEMO,PATIENT FOUR                F 01-01-1980                DB 65687

Press 'Return to continue:

```

Figure 4-43: Scan Patient Names or Chart Numbers (SCAN)

## 4.10 List Patients Currently Admitted to ER (HERE)

Use the **List Patients Currently Admitted to the ER** menu option to display a list of those patients currently admitted to the emergency room.

**Note:** The options that appear on the ERS main menu (Figure 2-1) depend on your security key. To determine or change your security keys, contact your Site Administrator.

To list patients currently admitted, From the “Select Emergency Room System Option” prompt (Figure 4-44), type **HERE** and press **Enter**. The system displays a list of the patients currently admitted to the ER. If there are multiple screens of patients, press **Enter** to browse through the pages.

```

Select Emergency Room System <TEST ACCOUNT> Option: HERE List Patients Currently
The following patients are currently admitted to the ER =>

      NAME                                DOB      CHART  ADMISSION      PRESENTING
      NAME                                DOB      CHART  ADMISSION      COMPLAINT
1) DEMO,PATIENT FIVE                    09/23/15 165    11/15/24 09:00 TESTING DN
2) DEMO,PATIENT FOUR                    09/23/15 143    11/18/24 14:00 TESTING
3) DEMO,PATIENT THREE                   01/01/85 92343  11/15/24 08:00 TESTING

Would you like to sort by ADMISSION time? N//

```

Figure 4-44: List Patients Currently Admitted to ER (HERE)

## 4.11 Patient Instruction Menu (INST)

The **Patient Instruction menu** option enables you to create, edit, and print patient instruction materials.

**Note:** In a previous AMER release, the options in this menu were removed. If you would like to re-add the previous options to this menu, follow the instructions listed here. Also note that the **Print Patient Education Materials (PRT)** option described in this section requires the user to hold the **AMERZBATCH** security key.

The following instructions have been provided to re-add the **Patient Instruction Menu** options back into the menu. As shown in the instructions, this requires FileMan to be kicked off from programmer mode (Figure 4-45).

```

Select IHS Kernel <TEST ACCOUNT> Option: 6 Programmer Options

KIDS Kernel Installation & Distribution System ...
PG Programmer mode
Delete Unreferenced Options
Error Processing ...
Global Block Count
List Global
Routine Tools ...

You have PENDING ALERTS
Enter "VA to jump to VIEW ALERTS option

Select Programmer Options <TEST ACCOUNT> Option: PG Programmer mode

F2Q1T>D P^DI

VA FileMan 22.0

Select OPTION: 1 ENTER OR EDIT FILE ENTRIES

INPUT TO WHAT FILE: OPTION// 19 OPTION (13176 entries)
EDIT WHICH FIELD: ALL// MENU
1 MENU (multiple)
2 MENU TEXT
CHOOSE 1-2: 1 MENU (multiple)
EDIT WHICH MENU SUB-FIELD: ALL// ITEM
THEN EDIT MENU SUB-FIELD: SYNONYM
THEN EDIT MENU SUB-FIELD: <enter>
THEN EDIT FIELD: <enter>

Select OPTION NAME: PATIENT INSTRUCTION MENU AMER PATIENT INSTRUCTION MENU
Patient Instruction Menu
Select ITEM: ADD PATIENT EDUCATION MATERIAL AMER PATIENT INSTRUCTIONS ADD Add
Patient Education Material
Are you adding 'AMER PATIENT INSTRUCTIONS ADD' as
a new MENU (the 1ST for this OPTION)? No// Y (Yes)
MENU SYNONYM: ADD
SYNONYM: ADD// <enter>
Select ITEM: PRINT PATIENT EDUCATION MATERI AMER PATIENT INSTRUCTIONS PRT Print
Patient Education Materials
Are you adding 'AMER PATIENT INSTRUCTIONS PRT' as
a new MENU (the 2ND for this OPTION)? No// Y (Yes)
MENU SYNONYM: PRT
SYNONYM: PRT// <enter>
Select ITEM:

```

```
Select OPTION NAME:
```

Figure 4-45: Patient Instruction Menu (INST)–Adding menu options back to menu

After performing the above instructions, the Patient Instruction Menu should now have two options to choose from (Figure 4-46).

```

*****
*   Patient Instruction Material Menu   *
*           Indian Health Service      *
*                   Version 3.0        *
*****
                2016 DEMO HOSPITAL

ADD   Add Patient Education Material
PRT   Print Patient Education Materials

You have PENDING ALERTS
      Enter "VA to jump to VIEW ALERTS option

Select Patient Instruction Menu <TEST ACCOUNT> Option:

```

Figure 4-46: Patient Instruction Menu (INST)–Menu display after options have been re-added

The following sections describe how to add and print patient instruction materials.

#### 4.11.1 Add Patient Education Material (ADD)

Use the **Add Patient Education Material** option to add new or edit existing patient instruction materials. To add new patient education materials:

1. From the “Select Patient Instruction Menu Option” prompt, type **ADD**.
2. From the “Select ER Instructions Topic” prompt, type the **name** of the new topic.
3. From the “Are you adding ‘topic-name’ as a new ER Instructions?” prompt, type **Y**.
4. From the “ER Instructions Category” prompt, type the following:
  - **A** for adult instructions
  - **P** for pediatric instructions
5. From the “Topic” prompt, press **Enter** to accept the new topic name.
6. From the “Category” prompt, press **Enter** to accept the new topic category.

7. From the “Description Edit?” prompt, select whether to enter a description. Type **Y** to enter a description for the topic. The system opens the RPMS word processing tool. You can type the text in the area provided, or you can use another word processing tool like MS Word, then cut and paste the text into this field (Figure 4-47).

```
Select Patient Instruction Menu <TEST ACCOUNT> Option: A Add Patient Education
Material

Select ER INSTRUCTIONS TOPIC: NEW TOPIC
Are you adding 'NEW TOPIC' as a new ER INSTRUCTIONS (the 1ST)? No// Y (Yes)
ER INSTRUCTIONS CATEGORY: ??

Choose from:
A ADULT
P PEDIATRIC
ER INSTRUCTIONS CATEGORY: A ADULT
TOPIC: NEW TOPIC// <enter>
CATEGORY: ADULT// <enter>
Description:
No existing text
Edit? NO// <enter>
Instruction Material:
No existing text
Edit? NO//Y
```

Figure 4-47: Patient Instruction Menu (INST)–Add Patient Education Material option

8. From the “Instruction Material Edit?” prompt, type **Y** to enter the patient instructions. The system opens the RPMS word processing tool. You can type the text in the area provided, or you can use another word processing tool like MS Word, then cut and paste the text into this field (Figure 4-48).

```
==[ WRAP ]==[ INSERT ]=====< Instruction Material >===== [ <PF1>H=Help ]====
Type the instructions here.

<=====T=====T=====T=====T=====T=====T=====T=====T=====T>=====
```

Figure 4-48: Patient Instruction Menu (INST)–Add Patient Education Material option – Add Instructions

**Note:** The type of word processing tool/editor depends on the Preferred Editor field in Edit an Existing User in the User Management kernel option. This field should be set to **Screen editor - VA Fileman**.

#### 4.11.2 Print Patient Education Materials (PRT)

Use the **Print Patient Education Materials** option to print patient instructions.

To print patient education materials:

1. From the “Select Patient Instruction Menu Option” prompt, type **PRT**.
2. From the “Print Instructions for which age group” prompt, type:
  - **A** to print adult instructions
  - **P** to print pediatric instructions
3. From the “Enter the number of copies you would like to print” prompt, type a number between 1 and 10.
4. From the “Enter patient education topic” prompt, type the name of the education topic. Type **??** to display a list of available topics.
5. To print additional topics, type the name of another topic you want to print at the “Enter another patient education topic” prompt. Once complete, press **Enter**.
6. From the “Print patient instructions on which device” prompt, type the name of a printer, or press **Enter** to view the instructions on the screen.

```

Select Patient Instruction Menu <TEST ACCOUNT> Option: PRT Print Patient Educat
ion Materials

      Select one of the following:

          A          ADULT
          P          PEDIATRIC

Print instructions for which age group: ADULT
Enter patient education topic:      NEW TOPIC      ADULT
Enter the number of copies you would like to print: (1-10): 1// <enter>

If you choose to send the output to your slave printer, print 1 copy at a time.

Print patient instructions on which device: HOME// <enter> VIRTUAL

Type the instructions here.

Press RETURN to continue or '^' to exit.

```

Figure 4-49: Patient Instruction Menu (INST)–Add Patient Education Material option – Print Instructions

## 4.12 Reports Menu (RPTS)

The options on the reports Menu (Figure 4-50) enable you to create ER related reports, print the ER log, and to view the ER log for a single patient.

**Note:** The options that appear on the ERS main menu (Figure 2-1) depend on your security key. To determine or change your security keys, contact your site administrator.

```

*****
*                               *
*           Reports Menu         *
*           Indian Health Service *
*           Version 3.0          *
*                               *
*****
                2016 DEMO HOSPITAL

AUD   ER VISIT AUDITING LOG REPORTS
LIST  ER System Report Generator
LOG   Print ER Log
CAN   ER System Pre-Defined Reports
VIS   Display ER Log entry for a single ER visit
VV    Display Data for a Specific Patient Visit
CLN   ER Record Cleanup Report

You have PENDING ALERTS
      Enter "VA to jump to VIEW ALERTS option

Select Reports Menu <TEST ACCOUNT> Option:

```

Figure 4-50: Reports Menu (RPTS)

#### 4.12.1 ER System Pre-Defined Reports (CAN)

Use the **ER System Pre-Defined reports** option to create reports for tracking Patients by Triage Category, by Triage Nurse, or by Consultant Type:

- Transfers from outside facilities
- Patients arriving by ambulance or by flight services

To generate pre-defined ERS reports:

1. To access the ERS reports menu, type **RPTS** at the “Select Emergency Room System Option” prompt. The system displays the reports menu.
2. At the “Select reports Menu Option” prompt, type **CAN**. The system displays the list of reports (Figure 4-51).

```

Select Reports Menu <TEST ACCOUNT> Option: CAN ER System Pre-Defined Reports

Select one of the following:

1          PATIENTS BY TRIAGE CATEGORY
2          PATIENTS BY TRIAGE NURSE
3          PATIENTS BY CONSULTANT TYPE
4          TRANSFERS FROM OUTSIDE FACILITIES
5          ARRIVE TO ER BY AMBULANCE
6          ARRIVE TO ER BY FLIGHT SERVICES
7          TRANSFERRED TO OTHER FACILITIES

Select Report:

```

Figure 4-51: Reports Menu (RPTS)–Canned report listing

#### 4.12.1.1 Patients by Triage Category (1)

Use the **Patients by Triage Category** option to display or print a report that sorts ERS information by triage category patient's last name time of patient admission in the ER. To print or display the Patients by Triage Category report:

1. At the "Select report" prompt, type **1**.
2. At the "Start Date" prompt, enter a date, or press **Enter** to begin the report with the very first ER visit.
3. At the "End Date" prompt, enter a date, or press **Enter** to end the report with the very first ER visit. The system displays the following prompt and choices:

```
Select Report: 1 PATIENTS BY TRIAGE CATEGORY
~~~~~

***** TIME FRAME *****
Start Date: t-1
End Date: t
FINISHED SYNCHING ERS WITH CURRENT PCC DATA FROM MAY 1,2023 TO MAY 2,2023

Select one of the following:

1          SORT BY TRIAGE CATEGORY
2          SORT BY PATIENT LAST NAME
3          SORT BY ADMIT TIME

Select sort option:
```

Figure 4-52: Reports Menu (RPTS)–Canned report listing – Patients by Triage Category (1)

4. At the "Select sort option" prompt (Figure 4-52), type the number that matches how you want to sort this report.
5. At the "Device" prompt, type the number that matches your printer, or press **Enter** to display the report on the screen.
6. At the "Right Margin" prompt, press **Enter** to accept the default value of 80 or type the size of the right margin. The system prints your report or displays it on the screen.

The following example (Figure 4-53) displays a triage category report sorted by initial acuity. You can also sort by the patient's last name or by the admission time.

```
Sort by: 1
DEVICE: 0;80;9999 VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****ER
VISIT TRIAGE CATEGORY REPORT BY CATEGORY FROM: MAY 1,2023 TO: MAY 2,2023
MAY 2,2023 14:55 PAGE 1
Sort Criteria: EMERGENCY SEVERITY INDEX to 5 (includes nulls)
```

```

ADMISSION TIMESTAMP from May 1,2023 to May 2,2023@24:00
TRGE CAT  PATIENT          CNO          DOB          ARRIVAL TIME
-----
2          DEMO,PATIENT FO  102590      DEC  9,1965  MAY  2,2023  01:20
-----
SUBCOUNT 1
3          DEMO,PATIENT TH  109886      SEP 21,1960  MAY  2,2023  01:00
-----
SUBCOUNT 1
5          DEMO,PATIENT TH  109886      SEP 21,1960  MAY  1,2023  09:06
-----
SUBCOUNT 1
-----
COUNT 3

Enter RETURN to continue or '^' to exit:
    
```

Figure 4-53: Reports Menu (RPTS)–Canned report listing – Patients by Triage Category (1) - Display

#### 4.12.1.2 Patients by Triage Nurse (2)

Use the **Patients by Triage Nurse** option to print or display a report that sorts ERS information by:

- Triage nurse
- Patient’s last name
- Triage category

To print or display the Patients by Triage Category report:

1. At the “Select report” prompt, type **2**.
2. At the “Start Date” prompt, enter a date, or press **Enter** to begin the report with the very first ER visit.
3. At the “End Date” prompt, enter a date, or press **Enter** to end the report with the very first ER visit. The system displays the following prompt (Figure 4-54) and choices:

```

Select Report: 2 PATIENTS BY TRIAGE NURSE

~~~~~

***** TIME FRAME *****
Start Date: T
End Date: T
FINISHED SYNCHING ERS WITH CURRENT PCC DATA FROM MAY 2,2023 TO MAY 2,2023

Select one of the following:

1          SORT BY TRIAGE NURSE
2          SORT BY PATIENT LAST NAME
3          SORT BY TRIAGE CATEGORY
    
```

```
Select sort option:
```

Figure 4-54: Reports Menu (RPTS)–Canned report listing – Patients by Triage Nurse (2)

4. At the **Select sort** option, type the number that matches how you want to sort this report.
5. At the “Device” prompt, type the number that matches your printer, or press **Enter** to display the report on the screen.
6. At the “Right Margin” prompt, press **Enter** to accept the default value of 80, or type the size of the right margin. The system prints your report or displays it on the screen (Figure 4-55).

```
Select sort option: 1  SORT BY TRIAGE NURSE

Start Date: MAY 2,2023          End Date: MAY 2,2023

Sort by: 1
DEVICE: 0;80;999  VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****ER
VISIT TRIAGE NURSE REPORT BY NURSE  FROM: MAY 2,2023  TO: MAY 2,2023
                                  MAY 2,2023  15:01    PAGE 1

PATIENT          CNO          ARRIVAL TIME                                TRGE
PRESENTING COMPLAINT                                CAT
-----
      TRIAGE NURSE: TEST,NURSE ONE
DEMO,PATIENT FO 102590      MAY  2,2023  01:20
      TESTING                                                    2

      TRIAGE NURSE: TEST,NURSE TWO
DEMO,PATIENT TH 109886      MAY  2,2023  01:00
      Testing                                                    3

Enter RETURN to continue or '^' to exit:
```

Figure 4-55: Reports Menu (RPTS)–Canned report listing – Patients by Triage Nurse (2) - Display

#### 4.12.1.3 Patients by Consultant Type (3)

Use the **Patients by Consultant Type** option to display or print a report that sorts ERS information by the type of provider the patient saw.

To print or display the Patients by Consultant Type report:

1. At the “Select report” prompt, type **3**.
2. At the “Start Date” prompt, enter a date, or press **Enter** to begin the report with the very first ER visit.

3. At the “End Date” prompt, enter a date, or press **Enter** to end the report with the very first ER visit.
4. At the “Device” prompt, type the number that matches your printer, or press **Enter** to display the report on the screen.
5. At the “Right Margin” prompt, press **Enter** to accept the default value of 80, or type the size of the right margin. The system prints your report or displays it on the screen.

The following example displays Patients by Consultant Type report (Figure 4-56).

```

Select Report: 3 PATIENTS BY CONSULTANT TYPE

~~~~~

***** TIME FRAME *****
Start Date: T
End Date: T
FINISHED SYNCHING ERS WITH CURRENT PCC DATA FROM MAY 2,2023 TO MAY 2,2023

Start Date: MAY 2,2023 End Date: MAY 2,2023
DEVICE: 0;80;999 VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****ER
VISITS BY ER CONSULTANT TYPE FROM: MAY 2,2023 TO: MAY 2,2023
MAY 2,2023 15:13 PAGE 1

CONSULTANT TYPE CONSULTANT NAME CONSULT TIME
PATIENT CNO ADMISSION
PRIMARY DX
NARRATIVE
-----
FAMILY PRACTICE TEST, PROVIDER FOUR MAY 2,2023 07:00
DEMO, PATIENT FIVE 112691 MAY 2,2023 05:00
ZZZ.999 {}
NARRATIVE FOR DX
INTERNAL MEDICIN TEST, PROVIDER THREE MAY 2,2023 14:00
DEMO, PATIENT SIX 101082 MAY 2,2023 10:00
M97.42XS{}
NARRATIVE FOR M97.42XS
MENTAL HEALTH TEST, PROVIDER THREE MAY 2,2023 08:00
DEMO, PATIENT FIVE 112691 MAY 2,2023 05:00
ZZZ.999 {}
NARRATIVE FOR DX
ORTHOPEDIC TEST, PROVIDER FIVE MAY 2,2023 13:00
DEMO, PATIENT SIX 101082 MAY 2,2023 10:00
M97.42XS{}
NARRATIVE FOR M97.42XS

Enter RETURN to continue or '^' to exit:

~~~~~
    
```

Figure 4-56 Reports Menu (RPTS)–Canned report listing–Patients by Consultant Type (3)

#### 4.12.1.4 Transfers from Outside Facilities (4)

Use the **Transfers from Outside Facilities** option to display or print a report that sorts ERS information by the facility from which the patient transferred.

To print or display the Transfers from Outside Facilities report:

1. At the “Select report” prompt, type **4**.
2. At the “Start Date” prompt, enter a date, or press **Enter** to begin the report with the very first ER visit.
3. At the “End Date” prompt, enter a date, or press **Enter** to end the report with the very first ER visit.
4. At the “Device” prompt, type the number that matches your printer, or press **Enter** to display the report on the screen.
5. At the **Right Margin**, press **Enter** to accept the default value of 80 or type the size of the right margin. The system prints your report or displays it on the screen.

The following example displays the Transfers from Outside Facilities report (Figure 4-57) sorted by the facility:

```
Select Report: 4 TRANSFERS FROM OUTSIDE FACILITIES
~~~~~

***** TIME FRAME *****
Start Date: t
End Date: t
FINISHED SYNCHING ERS WITH CURRENT PCC DATA FROM MAY 2,2023 TO MAY 2,2023

Start Date: MAY 2,2023                      End Date: MAY 2,2023
DEVICE: 0;80;999 VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****ER
VISIT TRANSFERS FROM OUTSIDE FACILITIES FROM: MAY 2,2023 TO: MAY 2,2023
MAY 2,2023 15:16 PAGE 1

TRANSFERED FROM      PATIENT          ARRIVED BY          CNO
PRESENTING COMPLAINT          ARRIVAL TIME
-----

GENERAL HOSPITA      DEMO,PATIENT FO      LOCAL AMBULANCE          102590
TESTING                                     MAY 2,2023 01:20
-----
SUBCOUNT 1

NURSING HOME         DEMO,PATIENT FI      PRIVATE VEHICLE          112691
Testing                                     MAY 2,2023 05:00
-----
SUBCOUNT 1
-----
COUNT 2
```

```
Enter RETURN to continue or '^' to exit:
```

Figure 4-57 Reports Menu (RPTS)–Canned report listing–Transfers from Outside Facilities (4)

#### 4.12.1.5 Arrive to ER by Ambulance (5)

Use the **Arrive to ER by Ambulance** option to display or print a report that is sorted by the name of the ambulance company that transported the patient, then by patient name. To print or display the Arrive to ER by Ambulance report:

1. At the “Select report:” prompt, type **5**.
2. At the “Start Date” prompt, enter a date, or press **Enter** to begin the report with the very first ER visit.
3. At the “End Date” prompt, enter a date, or press **Enter** to end the report with the very first ER visit.
4. At the “Device” prompt, type the **number** that matches your printer, or press **Enter** to display the report on the screen.
5. At the “Right Margin” prompt, press **Enter** to accept the default value of 80 or type the **size of the right margin**. The system prints your report or displays it on the screen (Figure 4-58).

```
Select Report: 5 ARRIVE TO ER BY AMBULANCE

~~~~~

***** TIME FRAME *****
Start Date: T
End Date: T
FINISHED SYNCHING ERS WITH CURRENT PCC DATA FROM MAY 2,2023 TO MAY 2,2023

Start Date: MAY 2,2023           End Date: MAY 2,2023
DEVICE: 0;80;999 VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****
*****ARRIVE TO ER BY AMBULANCE FROM: MAY 2,2023 TO: MAY 2,2023
                MAY 2,2023 15:22 PAGE 1
AMBULANCE          COMPANY          PATIENT          CNO          ADMISSION          TRIAG
COMPANY          PATIENT          CNO          TIMESTAMP          CAT
PRESENTING COMPLAINT

-----

MODE OF TRANSPORT: AMBULANCE

LOCAL AMBULANCE DEMO,PATIENT SE 101046          MAY 2,2023 04:00          2
TESTING

-----
SUBCOUNT 1
-----

COUNT 1
```

```
Enter RETURN to continue or '^' to exit:
```

Figure 4-58: Reports Menu (RPTS)–Canned report listing–Arrive to ER by Ambulance (5)

#### 4.12.1.6 Arrive to ER by Flight Services (6)

Using the **Arrive to ER by Flight Services** option to display or print a report that is sorted by the name of the air ambulance company that transported the patient, then by patient name.

To print or display the Arrive to ER by Air Ambulance report:

1. At the **Select report**, type **6**.
2. At the “Start Date” prompt, enter a date, or press **Enter** to begin the report with the very first ER visit.
3. At the “End Date” prompt, enter a date, or press **Enter** to end the report with the very first ER visit.
4. At the “Device” prompt, type the number that matches your printer, or press **Enter** to display the report on the screen.
5. At the “Right Margin” prompt, press **Enter** to accept the default value of 80 or type the size of the right margin. The system prints your report or displays it on the screen.

The following example (Figure 4-59) shows an Arrive to ER by Air Ambulance report:

```
Select Report: 6 ARRIVE TO ER BY FLIGHT SERVICES
~~~~~

***** TIME FRAME *****
Start Date: T
End Date: T
FINISHED SYNCHING ERS WITH CURRENT PCC DATA FROM MAY 2,2023 TO MAY 2,2023

Start Date: MAY 2,2023 End Date: MAY 2,2023
DEVICE: 0;80;999 VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****
*****ARRIVE TO ER BY AIR AMBULANCE FROM: MAY 2,2023 TO: MAY
2,2023

MAY 2,2023 15:25 PAGE 1
AMBULANCE ADMISSION TRIAG
COMPANY PATIENT CNO TIMESTAMP CAT
PRESENTING COMPLAINT
-----

MODE OF TRANSPORT: AIR AMBULANCE
```

```

LOCAL AMBULANCE DEMO,PATIENT SI 101082      MAY  2,2023  10:00      3
      TESTING AMER
-----
SUBCOUNT 1
-----
COUNT 1

Enter RETURN to continue or '^' to exit:

```

Figure 4-59: Reports Menu (RPTS)–Canned report listing–Arrive to ER by Flight Services (6)

#### 4.12.1.7 Transferred to Other Facilities (7)

Use the Transferred to Other Facilities option to display or print a report that is sorted by facility to which the patient was transferred, then by patient name.

To print or display the Transferred to Other Facilities report:

1. At the **Select** report prompt, Type 7.
2. At the “Start Date” prompt, enter a date, or press **Enter** to begin the report with the very first ER visit.
3. At the “End Date” prompt, enter a date, or press **Enter** to end the report with the very first ER visit.
4. At the “Device” prompt, type the number that matches your printer, or press **Enter** to display the report on the screen.
5. At the “Right Margin” prompt, press **Enter** to accept the default value of 80, or type the size of the right margin. The system prints your report or displays it on the screen.

The following example (Figure 4-60) shows a Transferred to Other Facilities report:

```

Select Report: 7  TRANSFERRED TO OTHER FACILITIES

~~~~~

*****  TIME FRAME  *****
Start Date:  T
End Date:  T
FINISHED SYNCHING ERS WITH CURRENT PCC DATA FROM MAY 2,2023 TO MAY 2,2023

Start Date: MAY 2,2023                      End Date: MAY 2,2023
DEVICE: 0;80;999  VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****
*****TRANSFERRED TO OTHER FACILITIES FROM: MAY 2,2023 TO: MAY
2,2023

                                MAY  2,2023  15:31    PAGE 1
                                ADMISSION    TRIAG
PATIENT                          CNO          TIMESTAMP    CAT
      PRESENTING COMPLAINT

```

```

-----
          TRANSFERED TO: GENERAL HOSPITAL
DEMO, PATIENT EIGHT          108936      MAY  2, 2023  11:15  4
          Testing transfer
-----
COUNT 1

Enter RETURN to continue or '^' to exit:

```

Figure 4-60: Reports Menu (RPTS)—Canned report listing—Transferred to Other Facilities (7)

#### 4.12.2 ER Visit Auditing Log Reports (AUD)

The **ER Visit Auditing Log reports** option enables you to create reports that:

- Track ER activity
- Provide statistics
- Show workload

To generate ER Visit Auditing Log reports:

1. To access the ERS reports menu, type **RPTS** at the “Select Emergency Room System Option” prompt. The system displays the reports menu.

At the “Select reports Menu Option” prompt, type **AUD**. The system displays the list of reports (Figure 4-61).

```

Select Reports Menu <TEST ACCOUNT> Option: AUD ER VISIT AUDITING LOG REPORTS

Select one of the following:

1          DAILY ER AUDIT LOG
2          SINGLE ER VISIT ER AUDIT LOG
3          DATA ENTERER ER AUDIT LOG
4          VISIT FIELD ER AUDIT LOG
5          EDIT REASON ER AUDIT LOG
6          ER AUDIT LOG BY VISIT DATE

Select Report:

```

Figure 4-61: Reports Menu (RPTS)—ER Visit Auditing Log Reports

##### 4.12.2.1 Daily ER Audit Log report (1)

Use the **Daily ER Audit Log** option to display or print the ER log for the current or a specified day.

To display or print the Daily ER Audit Log report:

1. At the “Select report” prompt, type **1**.
2. At the “Report for what day” prompt, enter a date, or press **Enter** to use today’s date.

3. At “Device” prompt, type the number that matches your printer, or press **Enter** to display the report on the screen.
4. At the “Right Margin” prompt, press **Enter** to accept the default value of 80 or type the size of the right margin. The system prints your report or displays it on the screen (Figure 4-62).

```

Select Report: 1  DAILY ER AUDIT LOG
~~~~~

***** TIME FRAME *****
Report for what day:  MAY 2,2023// <enter>

Log Date: MAY 2,2023
DEVICE: 0;80;999  VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****ER
VISIT DAILY EDIT LOG REPORT  FROM: MAY 2,2023
   MAY 2,2023  15:45    PAGE 1

VISIT TIME          EDITED BY
  FIELD NAME          REASON          COMMENT
  ORIGINAL
  CHANGED TO
-----
MAY 2,2023  11:15    DEMO,BRIAN E
DISCHARGE PROVIDER  Data entry erro  TESTING EDIT
  TEST, PROVIDER ONE
  TEST, PROVIDER FOUR
DEPARTURE TIME      Administrative    TESTING EDIT FUNCTION
  MAY 02, 2023@15:30
  MAY 02, 2023@15:35
MAY 2,2023  01:20    DEMO,BRIAN E
TRIAGE NURSE        Other            OT COMMENT

  TEST,NURSE TWO (05/02/23 02:18)
TRIAGE NURSE TIME   Other            OT COMMENT

  TEST,NURSE TWO (05/02/23 02:18)
~~~~~
    
```

Figure 4-62: Reports Menu (RPTS)–ER Visit Auditing Log Reports–Daily ER Audit Log (1)

#### 4.12.2.2 Single ER Visit ER Audit Log (2)

Use the **Single ER Visit ER Audit log** option to report a single patient’s ER visit.

To display or print a Single ER Visit ER Audit Log report:

1. At the “Select report” prompt, Type **2**.

2. At the “Enter ER Visit” prompt, type the **date** of the ER visit. The system displays a list of visits for the date entered.
3. At the “Choose N” prompt, type the **number** that matches the visit you want to review.
4. At “Device” prompt, type the **number** that matches your printer, or press **Enter** to display the report on the screen.
5. At the “Right Margin” prompt, press **Enter** to accept the default value of 80 or type the size of the right margin. The system prints your report or displays it on the screen (Figure 4-63).

```

Select Report: 2 SINGLE ER VISIT ER AUDIT LOG

~~~~~
Enter ER VISIT: T@1115 MAY 02, 2023@11:15 DEMO,PATIENT EIGHT

ER EDIT LOG FOR VISIT: 3230502.1115
DEVICE: 0;80;999 VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****ER
VISIT LOG ENTRY
   MAY 2,2023 15:56 PAGE 1
-----

          ERVSIT IEN: MAY 2,2023 11:15

TIMESTAMP: MAY 02, 2023@15:44:09          ERVSIT IEN: MAY 02, 2023@11:15
  DATA ENTERER: DEMO,BRIAN E
EDITED FIELD: 6.3                        EDIT TIME: MAY 02, 2023@15:44:18
  OLD VALUE: TEST,PROVIDER ONE           NEW VALUE: TEST,PROVIDER FOUR
  EDIT REASON: Data entry error          COMMENT: TESTING EDIT
  EDITED FIELD NAME: DISCHARGE PROVIDER

EDITED FIELD: 6.2                        EDIT TIME: MAY 02, 2023@15:44:31
  OLD VALUE: MAY 02, 2023@15:30         NEW VALUE: MAY 02, 2023@15:35
  EDIT REASON: Administrative            COMMENT: TESTING EDIT FUNCTION
  EDITED FIELD NAME: DEPARTURE TIME

Enter RETURN to continue or '^' to exit:

~~~~~

```

Figure 4-63: Reports Menu (RPTS)–ER Visit Auditing Log Reports–Single ER Visit ER Audit Log (2)

#### 4.12.2.3 Data Enterer ER Audit Log report (3)

Use the **Data Enterer ER Audit Log** option to list the date and time changes made to the ER Log and the person (Data Enterer) who made those changes:

To display or print the Data Enterer ER Audit Log report:

1. At the “Report Type” prompt, type **3**.
2. At the “Enter starting date” prompt, enter a date, or press **Enter** to begin the report with the very first ER visit.

3. At the **Enter** ending date prompt, enter a date, or press **Enter** to end the report with the very last ER visit.
4. The resulting report will display (Figure 4-64).

```

Select Report: 3 DATA ENTERER ER AUDIT LOG

~~~~~

***** TIME FRAME *****
Start Date: T
End Date: T

Start Date: MAY 2,2023          End Date: MAY 2,2023
DEVICE: 0;80;999 VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****ER
VISIT DATA ENTERER AUDIT LOG REPORT FROM: MAY 2,2023 TO: MAY 2,2023
                                  MAY 2,2023 15:59 PAGE 1

  DATA ENTERER                TIMESTAMP                ERVSIT IEN
-----
  DEMO,BRIAN E                 MAY 2,2023 15:44                MAY 2,2023 11:15
  DEMO,BRIAN E                 MAY 2,2023 15:45                MAY 2,2023 01:20

Enter RETURN to continue or '^' to exit:

```

Figure 4-64: Reports Menu (RPTS)–ER Visit Auditing Log Reports–Data Enterer ER Audit Log (3)

#### 4.12.2.4 Visit Field ER Audit Log Report (4)

Use the Visit Field ER Audit Log option to review the edits performed based on the time the ER Visit Field was edited. This report includes the:

- Time of the edit
- Time of the visit
- Reason for the edit
- Name of the person who edited the log

To print or view the Visit Field ER Audit Log report:

1. At the “Report Type” prompt, type **4**.
2. At the “Enter starting date” prompt, enter a **date** or press **Enter** to begin the report with the very first ER visit.
3. At the “Enter ending date” prompt, enter a **date** or press **Enter** to use today’s date.
4. At “Device” prompt, type the **number** that matches your printer, or press **Enter** to display the report on the screen.

- At the “Right Margin” prompt, press **Enter** to accept the default value of 80 or type the size of the right margin (Figure 4-65).

```
Select Report: 4 VISIT FIELD ER AUDIT LOG

~~~~~

***** TIME FRAME *****
Start Date: T
End Date: T

Start Date: MAY 2,2023           End Date: MAY 2,2023
DEVICE: 0;80;999
```

Figure 4-65: Reports Menu (RPTS)–ER Visit Auditing Log Reports–Visit Field ER Audit Log (4)

The system prints your report or displays it on the screen (Figure 4-66).

```
***** CONFIDENTIAL PATIENT INFORMATION *****ER
VISIT FIELD AUDIT LOG REPORT FROM: MAY 2,2023 TO: MAY 2,2023
MAY 2,2023 16:04 PAGE 1
FIELD NAME            ORIGINALLY            CHANGED TO
-----
DATA ENTERER: DEMO,BRIAN E
TIMESTAMP: MAY 2,2023 15:44
DISCHARGE PROVIDER   TEST,PROVIDER ONE       TEST,PROVIDER FOUR
DEPARTURE TIME      MAY 02, 2023@15:30     MAY 02, 2023@15:35
TIMESTAMP: MAY 2,2023 15:45
TRIAGE NURSE        TEST,NURSE TWO (05/02/23
TRIAGE NURSE TIME   TEST,NURSE TWO (05/02/23

Enter RETURN to continue or '^' to exit:
```

Figure 4-66: Reports Menu (RPTS)–ER Visit Auditing Log Reports–Visit Field ER Audit Log (4)-Display

#### 4.12.2.5 Edit Reason ER Audit Log Report (5)

Use the **Edit Reason ER Audit Log** option to review the reason the ER log was edited. The report is grouped by the reasons for the edits and includes:

- Time of the edit
- Time of the visit
- Name of the person who edited the log

To display or print the Edit Reason ER Audit Log report:

- At the “Select report” prompt, type **5**.
- At the “Enter starting date” prompt, enter a **date** or press **Enter** to begin the report with the very first ER visit.

3. At the “Enter ending date” prompt, enter a **date** or press **Enter** to use the very last ER visit. The system displays the starting and ending dates for the report.
4. At “Device” prompt, type the **number** that matches your printer or press **Enter** to display the report on the screen.
5. At the “Right Margin” prompt, press **Enter** to accept the default value of 80 or type the size of the right margin. The system prints your report or displays it on the screen (Figure 4-67).

```

Select Report: 5  EDIT REASON ER AUDIT LOG

~~~~~

***** TIME FRAME *****
Start Date: T
End Date: T

Start Date: MAY 2,2023          End Date: MAY 2,2023
DEVICE: 0;80;999 VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****EDIT
REASON AUDIT LOG REPORT FROM: MAY 2,2023 TO: MAY 2,2023
                                MAY 2,2023 16:06 PAGE 1
TIMESTAMP          ERVSIT IEN          DATA ENTERER
-----
          EDIT REASON: Administrative
MAY 2,2023 15:44  MAY 2,2023 11:15  DEMO,BRIAN E

          EDIT REASON: Data entry error
MAY 2,2023 15:44  MAY 2,2023 11:15  DEMO,BRIAN E

          EDIT REASON: Other
MAY 2,2023 15:45  MAY 2,2023 01:20  DEMO,BRIAN E

Enter RETURN to continue or '^' to exit:

```

Figure 4-67: Reports Menu (RPTS)–ER Visit Auditing Log Reports–Edit Reason ER Audit Log (5)

#### 4.12.2.6 ER Audit Log by Visit Date Report (6)

Use the **ER Audit Log by Visit Date** option to review the reason the ER log was edited. The report is grouped by date of the ER visit and includes all information about all visits that occurred during the range of dates entered.

To display or print the Edit Reason ER Audit Log report:

1. At the “Select report:” prompt, type **6**.
2. At the “Enter starting date” prompt, enter a **date** or press **Enter** to begin the report with the very first ER visit.

3. At the “Enter ending date” prompt, enter a **date** or press **Enter** to use the very last ER visit. The system displays the starting and ending dates for the report.
4. At the “Device” prompt, type the **number** that matches your printer or press **Enter** to display the report on the screen.
5. At the “Right Margin” prompt, press **Enter** to accept the default value of 80 or type the **size** of the right margin.

The system prints your report or displays it on the screen (Figure 4-68).

```

Select Report: 6 ER AUDIT LOG BY VISIT DATE

~~~~~

**** TIME FRAME ****
Start Date: T
End Date: T

Start Date: MAY 2,2023 End Date: MAY 2,2023
DEVICE: 0;80;999 VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****ER
VISIT EDIT LOG REPORT BY ER VISIT FROM: MAY 2,2023 TO: MAY 2,2023
MAY 2,2023 16:09 PAGE 1
-----

ERVSIT IEN: MAY 2,2023 01:20

TIMESTAMP: MAY 02, 2023@15:45:03 ERVSIT IEN: MAY 02, 2023@01:20
DATA ENTERER: DEMO,BRIAN E
EDITED FIELD: .07 EDIT TIME: MAY 02, 2023@15:45:21
NEW VALUE: TEST,NURSE TWO (05/02/23 02:18)
EDIT REASON: Other COMMENT: OT COMMENT
EDITED FIELD NAME: TRIAGE NURSE

EDITED FIELD: 12.2 EDIT TIME: MAY 02, 2023@15:45:21
NEW VALUE: TEST,NURSE TWO (05/02/23 02:18)
EDIT REASON: Other COMMENT: OT COMMENT
EDITED FIELD NAME: TRIAGE NURSE TIME
ERVSIT IEN: MAY 2,2023 11:15

TIMESTAMP: MAY 02, 2023@15:44:09 ERVSIT IEN: MAY 02, 2023@11:15
DATA ENTERER: DEMO,BRIAN E
EDITED FIELD: 6.3 EDIT TIME: MAY 02, 2023@15:44:18
OLD VALUE: TEST,PROVIDER ONE NEW VALUE: TEST,PROVIDER FOUR
EDIT REASON: Data entry error COMMENT: TESTING EDIT
EDITED FIELD NAME: DISCHARGE PROVIDER

EDITED FIELD: 6.2 EDIT TIME: MAY 02, 2023@15:44:31
OLD VALUE: MAY 02, 2023@15:30 NEW VALUE: MAY 02, 2023@15:35
EDIT REASON: Administrative COMMENT: TESTING EDIT FUNCTION
EDITED FIELD NAME: DEPARTURE TIME

```

```
Enter RETURN to continue or '^' to exit:
```

```
~~~~~
```

Figure 4-68: Reports Menu (RPTS)–ER Visit Auditing Log Reports–ER Audit Log By Visit Date (6)

### 4.12.3 ER System Report Generator (LIST)

The **ER System Report Generator** option enables you to create reports that track ER activity, statistics, and workload.

To use the ER System Report Generator option:

1. To access the ERS Reports menu, type **RPTS** at the “Select Emergency Room System Option” prompt. The system displays the Reports menu.
2. At the “Select Reports Menu Option” prompt, type **LIST**. The system displays the list of reports options (Figure 4-69).

```

          ***** REPORT OPTIONS *****

Select one of the following:

1          STANDARD ER LOG REPORT
2          BRIEF ER LOG REPORT
3          STATISTICAL REPORTS
4          HOURLY WORKLOAD REPORT

Report type: 1//

```

Figure 4-69: Reports Menu (RPTS)–ER System Report Generator (LIST)

3. At the “Report type” prompt, type the number that matches the report you want to create.

#### 4.12.3.1 Standard ER Log Report (1)

Use the **Standard ER Log Report** option to generate a report that contains all ER information about patient visits. For example, you can create a report that provides visit data for a specified Provider for the last 30 days.

To print the Standard ER Log report:

1. At the “Report type” prompt, type **1**. The system displays the following display options and prompt (Figure 4-70):

```

          ***** DISPLAY OPTIONS *****

Select one of the following:

1          VISITS IN INVERSE ORDER OF DATES
2          PATIENTS IN ALPHABETICAL ORDER
3          VISITS IN CHRONOLOGICAL ORDER

```

```
Your choice: 3//
```

Figure 4-70: Reports Menu (RPTS)–ER System Report Generator (LIST)–Standard ER Log Report (1)

2. At the “Your choice” prompt, type the **number** that matches how you want to display the report.
3. At the “Enter starting date” prompt, enter a **date**.
4. At the “Enter ending date” prompt, enter a **date**.

The system displays the following sort options and prompt (Figure 4-71):

```
Your choice: 3// <enter> VISITS IN CHRONOLOGICAL ORDER

          ***** TIME FRAME *****
Enter starting date: 11/13 (NOV 13,2024)
Enter ending date: 11/13 (NOV 13,2024@23:59)
FINISHED SYNCHING ERS WITH CURRENT PCC DATA FROM 3241113 TO 3241113

          ***** SORT OPTIONS *****

Patient attributes =>
  1) AGE ON DAY OF VISIT          2) SEX

Visit attributes =>
  3) ACUITY                      11) OCCUPATION RELATED
  4) DISPOSITION                 12) PHYSICIAN
  5) FIRST OR REVISIT           13) PROCEDURE
  6) FOLLOW UP                   14) REVOLVING DOOR
  7) ICD CODE                   15) TOTAL VISIT DURATION
  8) INJURY CAUSE               16) WAITING TIME FOR THE DOCTOR
  9) INJURY TIME LAG           17) WAITING TIME FOR TRIAGE
 10) NURSE

10) NURSE

Sort by: (1-17):
```

Figure 4-71: Reports Menu (RPTS)–ER System Report Generator (LIST)–Standard ER Log Report (1)–Sort Options

5. At the **Sort by** prompt, type the number that matches how you want the report sorted.
  - Depending on the selected **sort** option, the system displays additional prompts that are specific to the sort criteria you selected. Type **your responses** at the prompts, as they are displayed.
  - Some sort criteria attributes can have multiple values. If prompted, select the **specific value** you want in your report at the **Your choice** prompt.

- If prompted, select the additional sort criteria within the selected criteria as prompted by the system.
6. When finished selecting sort criteria, press **Enter** at the “Then sort by” prompt.
  7. At the “Device” prompt, type **HOME** to display the report on the screen or type the name of the printer.
  8. At the “Right Margin” prompt, press **Enter** to accept the default value of 80 or type the size of the right margin. The system prints your report or displays it on the screen.

The following example shows the first two pages of a report containing all visits by female patients (Figure 4-72).

```
Sort by: (1-17): 2 (SEX)

This attribute can have multiple values

Select one of the following:

    1          Sort by all values of this attribute
    2          Limit output to one particular value of this attribute
    3          Display entries where attribute value is 'null'

Your choice: 1// 2 Limit output to one particular value of this attribute

Select one of the following:

    F          FEMALE
    M          MALE

Your choice: FEMALE

Patient attributes =>
    1)  AGE ON DAY OF VISIT          2)  SEX

Visit attributes =>
    3)  ACUITY                      11)  OCCUPATION RELATED
    4)  DISPOSITION                 12)  PHYSICIAN
    5)  FIRST OR REVISIT            13)  PROCEDURE
    6)  FOLLOW UP                   14)  REVOLVING DOOR
    7)  ICD CODE                    15)  TOTAL VISIT DURATION
    8)  INJURY CAUSE                16)  WAITING TIME FOR THE DOCTOR
    9)  INJURY TIME LAG             17)  WAITING TIME FOR TRIAGE
   10)  NURSE

Then sort by: <enter> (1-17):
DEVICE: 0;80;9999 VIRTUAL
Please note: the following criteria were used to screen entries:

    1)  SEX = "FEMALE"

***** CONFIDENTIAL PATIENT INFORMATION *****
*****STANDARD ER LOG REPORT FROM: NOV 13, 2024 TO: NOV 13,
2024@23:59
NOV 18,2024 16:06 PAGE 1
```

```

-----
ADMISSION TIMESTAMP: NOV 13,2024 06:00
PATIENT: DEMO,PATIENT ONE
PCC VISIT: NOV 13,2024 06:00
  DOB: NOV 27,2015          AGE AT VISIT: 8
  CHART #: 123              SEX: FEMALE
CLINIC TYPE: EMERGENCY MEDICINE
MODE OF TRANSPORT: PRIVATE VEHICLE/WALK IN
  AMBULANCE CO:
  AMBULANCE #:              AMB INVOICE #:
TRAUMA TEAM ACTIVATION: YES TRAUMA TEAM ACTIVATION DTM: NOV 13,2024 05:45
TRAUMA TEAM ACTIVATION BY: TEST,PROVIDER ONE
PRESENTING COMPLAINT: TESTING
  OCCUPATION RELATED: NO          INJURED: YES
  CAUSE OF INJURY: X82.2XXS      SCENE OF INJURY: HIGHWAY OR ROAD
  TIME OF INJURY: NOV 12,2024 08:00
  SAFETY EQUIPMENT: BELT (SHOULDER)
  TOWN OF INJURY: INJURY TOWN
  EXACT MVC LOCATION: 123 PARK AVENUE
PROCEDURES:
  NONE
PRIMARY DIAGNOSIS: M97.42XS {Periprosth fx around internal prosth l elbow joint,
sequela}
  PRIMARY DX NARRATIVE: BROKE LEFT ELBOW IN MVC
DIAGNOSIS:                      DX NARRATIVE:
  M97.42XS {Periprosth fx around internal prosth l elbow joint, sequela}
  BROKE LEFT ELBOW IN MVC
ED PROVIDER: TEST,PROVIDER ONE
  ED PROVIDER TIME: NOV 13,2024 12:00
PRIMARY NURSE: TEST,NURSE ONE
  PRIMARY NURSE TIME: NOV 13,2024 11:00
MEDICAL SCREENING EXAM TIME: NOV 13,2024 12:00
TRIAGE NURSE: TEST,NURSE ONE
  TRIAGE NURSE TIME: NOV 13,2024 09:00
TRIAGE PROVIDER: TEST,PROVIDER ONE
  TRIAGE PROVIDER TIME: NOV 13,2024 09:30
INITIAL TRIAGE BY: TEST,NURSE ONE
  INITIAL TRIAGE TIME: NOV 13,2024 09:00
DECISION TO ADMIT TIME:
EMERGENCY SEVERITY INDEX: 1          FINAL ACUITY: 3
DISPOSITION: HOME
PATIENT STATUS CODE (NUBC): DISCHARGED HOME (01)
  TRANSFERED TO:
DEPARTURE TIME: NOV 13,2024 20:00
  DISCHARGE (PRIMARY) PROVIDER: TEST,PROVIDER ONE
  DISCHARGE NURSE: TEST,NURSE ONE
DISCHARGE INSTRUCTIONS: RTC PRN, INSTRUCTIONS GIVEN
ER CONSULTANTS:
  INTERNAL MEDICINE NOV 13,2024 13:00          DEMO,ADAM
TOTAL VISIT DURATION: 840
  WAITING TIME FOR TRIAGE : 180
  WAITING TIME FOR PROVIDER: 360
  DATA ENTERER: DEMO,BRIAN E
ADMISSION TIMESTAMP: NOV 13,2024 16:05
PATIENT: DEMO,PATIENT THREE
PCC VISIT: NOV 13,2024 16:05
  DOB: JAN 1,1985          AGE AT VISIT: 39
  CHART #: 92343          SEX: FEMALE
CLINIC TYPE: EMERGENCY MEDICINE
MODE OF TRANSPORT: PRIVATE VEHICLE/WALK IN
  AMBULANCE CO:

```

```

AMBULANCE #:                               AMB INVOICE #:
TRAUMA TEAM ACTIVATION: YES TRAUMA TEAM ACTIVATION DTM: NOV 13,2024  16:08
TRAUMA TEAM ACTIVATION BY: TEST,PROVIDER ONE
PRESENTING COMPLAINT: TESTING
OCCUPATION RELATED: NO                     INJURED: NO
CAUSE OF INJURY:                           SCENE OF INJURY:
TIME OF INJURY:
SAFETY EQUIPMENT:
TOWN OF INJURY:
EXACT MVC LOCATION:
PROCEDURES:
NONE
PRIMARY DIAGNOSIS: ZZZ.999 {Uncoded diagnosis}
PRIMARY DX NARRATIVE: NARRATIVE FOR POV
DIAGNOSIS:                                 DX NARRATIVE:
ZZZ.999 {Uncoded diagnosis}               NARRATIVE FOR POV
ED PROVIDER: TEST,PROVIDER ONE
ED PROVIDER TIME: NOV 13,2024  16:06
PRIMARY NURSE: TEST,NURSE ONE
PRIMARY NURSE TIME: NOV 13,2024  16:06
MEDICAL SCREENING EXAM TIME: NOV 13,2024  16:06
TRIAGE NURSE: TEST,NURSE ONE
TRIAGE NURSE TIME: NOV 13,2024  16:05
TRIAGE PROVIDER: TEST,PROVIDER ONE
TRIAGE PROVIDER TIME: NOV 13,2024  16:06
INITIAL TRIAGE BY: TEST,NURSE ONE
INITIAL TRIAGE TIME: NOV 13,2024  16:05
DECISION TO ADMIT TIME:
EMERGENCY SEVERITY INDEX: 1                FINAL ACUITY: 1
DISPOSITION: HOME
PATIENT STATUS CODE (NUBC): DISCHARGED HOME (01)
TRANSFERED TO:
DEPARTURE TIME: NOV 13,2024  16:06
DISCHARGE (PRIMARY) PROVIDER: TEST,PROVIDER ONE
DISCHARGE NURSE: TEST,NURSE ONE
DISCHARGE INSTRUCTIONS: RTC PRN, INSTRUCTIONS GIVEN
ER CONSULTANTS:
TOTAL VISIT DURATION:                      1
WAITING TIME FOR TRIAGE :                  0
WAITING TIME FOR PROVIDER:                 1
DATA ENTERER: DEMO,BRIAN E

Press 'Return to continue:

```

Figure 4-72: Reports Menu (RPTS)–ER System Report Generator (LIST)–Standard ER Log Report (1)–Sort Options (Continued)

#### 4.12.3.2 Brief ER Log Report (2)

The **Brief ER Log Report** option, a condensed version of the Standard ER Log Report, provides the same sort options as the Standard ER Log Report, but contains less information about the ER visit. For example, you can use this report to sort by community, providing the number of visits by community. In addition, you can generate wait time reports, injury reports, and many others with this option.

To print a Brief ER log report:

1. At the “Report Type” prompt, type **2**. The system displays the following display options and prompt (Figure 4-73):

```

***** DISPLAY OPTIONS *****

Select one of the following:

1          VISITS IN INVERSE ORDER OF DATES
2          PATIENTS IN ALPHABETICAL ORDER
3          VISITS IN CHRONOLOGICAL ORDER

Your choice: 3//

```

Figure 4-73: Reports Menu (RPTS)–ER System Report Generator (LIST)–Brief ER Log Report (2)

2. At the “Your Choice” prompt, type the number of the option you want.
3. At the “Enter starting date” prompt, type the starting date for your report.
4. At the “Enter ending date” prompt, type the ending date for your report. The system displays the following sort options and prompt (Figure 4-74):

```

Your choice: 3//  VISITS IN CHRONOLOGICAL ORDER

***** TIME FRAME *****
Enter starting date:  T  (MAY 2,2023)
Enter ending date:   T  (MAY 2,2023@23:59)
FINISHED SYNCHING ERS WITH CURRENT PCC DATA FROM 3230502 TO 3230502

***** SORT OPTIONS *****

Patient attributes =>
1)  AGE ON DAY OF VISIT          2)  SEX

Visit attributes =>
3)  ACUITY                      11) OCCUPATION RELATED
4)  DISPOSITION                 12) PHYSICIAN
5)  FIRST OR REVISIT           13) PROCEDURE
6)  FOLLOW UP                   14) REVOLVING DOOR
7)  ICD CODE                    15) TOTAL VISIT DURATION
8)  INJURY CAUSE               16) WAITING TIME FOR THE DOCTOR
9)  INJURY TIME LAG            17) WAITING TIME FOR TRIAGE
10) NURSE

Sort by:  (1-17):

```

Figure 4-74: Reports Menu (RPTS)–ER System Report Generator (LIST) – Brief ER Log Report (2) – Sort Options

5. At the “Sort by” prompt, type the number that matches how you want the report sorted.
  - Depending on the sort option selected, the system displays additional prompts that are specific to the sort criteria you selected. Type your responses at the prompts, as they are displayed.
  - Some sort criteria attributes can have multiple values. If prompted, select the specific value you want in your report at the Your choice prompt.
  - If prompted, select the additional sort criteria within the selected criteria as prompted by the system.
6. When finished selecting sort criteria, press **Enter** at the “Then sort by” prompt.
7. At the “Device” prompt, type **HOME** to display the report on the screen or type the name of the printer.
8. At the “Right Margin” prompt, press **Enter** to accept the default value of 80 or type the size of the right margin. The system prints your report or displays it on the screen (Figure 4-75).

```
Sort by: (1-17): 7 (ICD CODE)

This attribute can have multiple values

Select one of the following:

    1          Sort by all values of this attribute
    2          Limit output to one particular value of this attribute
    3          Display entries where attribute value is 'null'

Your choice: 1// <enter> Sort by all values of this attribute

Patient attributes =>
    1)  AGE ON DAY OF VISIT          2)  SEX

Visit attributes =>
    3)  ACUITY                      11) OCCUPATION RELATED
    4)  DISPOSITION                 12) PHYSICIAN
    5)  FIRST OR REVISIT            13) PROCEDURE
    6)  FOLLOW UP                   14) REVOLVING DOOR
    7)  ICD CODE                    15) TOTAL VISIT DURATION
    8)  INJURY CAUSE                16) WAITING TIME FOR THE DOCTOR
    9)  INJURY TIME LAG             17) WAITING TIME FOR TRIAGE
   10) NURSE

Within ICD CODE sort by: (1-17): <enter>
DEVICE: 0;80;999 VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****
*****BRIEF ER LOG REPORT FROM: MAY 02, 2023 TO: MAY 02,
2023@23:59
                                MAY 2,2023 16:31 PAGE 1
                                PRIMARY DX
DATE      TIME      PATIENT      CHART  DOB      PHYSICIAN  NARRATIVE
-----
```

```

DIAGNOSIS: J02.0
05/02/23 1:00 AM DEMO,PATIENT T 109886 09/21/60 TEST,P NARRATIVE FOR J0
05/02/23 10:00 AM DEMO,PATIENT S 101082 12/10/76 TEST,P NARRATIVE FOR M9
05/02/23 11:15 AM DEMO,PATIENT E 108936 07/08/75 TEST,P NARRATIVE FOR DX
DIAGNOSIS: M97.42XS
05/02/23 10:00 AM DEMO,PATIENT S 101082 12/10/76 TEST,P NARRATIVE FOR M9
DIAGNOSIS: ZZZ.999
05/02/23 1:20 AM DEMO,PATIENT F 102590 12/09/65 TEST,P NARRATIVE FOR ZZ
05/02/23 5:00 AM DEMO,PATIENT F 112691 09/23/54 TEST,P NARRATIVE FOR DX
05/02/23 4:00 AM DEMO,PATIENT S 101046 10/29/35 TEST,P NARRATIVE FOR DX

Press 'Return to continue:

```

Figure 4-75: Reports Menu (RPTS)–ER System Report Generator (LIST)–Brief ER Log Report (2)–Sample Report

### 4.12.3.3 Statistical Reports (3)

The **Statistical Reports** option provides statistics for a given sort value. These reports provide the same 25 sort options as the other LIST reports. For instance, if you sort by Provider wait time, the report shows an overview of the length of time patients have to wait to see the Provider. This report could be reviewed for staffing issues.

To print statistical reports:

1. At the “Report Type” prompt, type **3**.
2. At the “Enter starting date” prompt, type the starting date for your report.
3. At the “Enter ending date” prompt, type the ending date for your report.
4. The following sort options will display (Figure 4-76).

```

Report type: 1// 3 STATISTICAL REPORTS

***** TIME FRAME *****
Enter starting date: T (MAY 2,2023)
Enter ending date: T (MAY 2,2023@23:59)
FINISHED SYNCHING ERS WITH CURRENT PCC DATA FROM 3230502 TO 3230502

***** SORT OPTIONS *****

Patient attributes =>
1) AGE ON DAY OF VISIT          2) SEX

Visit attributes =>
3) ACUITY                       11) OCCUPATION RELATED
4) DISPOSITION                  12) PHYSICIAN
5) FIRST OR REVISIT             13) PROCEDURE
6) FOLLOW UP                     14) REVOLVING DOOR
7) ICD CODE                      15) TOTAL VISIT DURATION

```

```

8)   INJURY CAUSE           16)  WAITING TIME FOR THE DOCTOR
9)   INJURY TIME LAG       17)  WAITING TIME FOR TRIAGE
10)  NURSE

Sort by:  (1-17):
    
```

Figure 4-76: Reports Menu (RPTS)–ER System Report Generator (LIST)–Statistical Reports (3)

5. At the “Sort by” prompt, type the number that matches how you want the report sorted.
  - Depending on the **sort** option selected, the system displays more prompts that are specific to the sort criteria you selected. Type your responses at the prompts, as they are displayed.
  - Some sort criteria attributes can have multiple values. If prompted, select the specific value you want in your report at the “Your choice” prompt.
  - If prompted, select the additional sort criteria within the selected criteria as prompted by the system.
6. When finished selecting sort criteria, press **Enter** at the “Then sort by” prompt.
7. At the “Device” prompt, type **HOME** to display the report on the screen or type the name of the printer.
8. At the “Right Margin” prompt, press **Enter** to accept the default value of 80 or type the size of the right margin. The system prints your report or displays it on the screen.

The following example shows an ER Statistical Report for patients’ final acuity from May 2, 2023 through May 2, 2024 and subtotals for each acuity level, as well as the total number of patients with a final acuity (Figure 4-77).

```

Sort by:  (1-17): 3  (ACUITY)

Select one of the following:

1          Do statistical analysis of patient acuities now
2          Limit analysis to patients in a certain acuity range

Your choice: 1// <enter> Do statistical analysis of patient acuities now
DEVICE: 0;80;999 VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****ER
STATISTICAL REPORT FROM: MAY 02, 2023 TO: MAY 02, 2023@23:59
                                MAY 2,2023 16:43 PAGE 1

FINAL
ACUITY
-----
SUBCOUNT  FINAL ACUITY: 1
2
SUBCOUNT  FINAL ACUITY: 3
1
SUBCOUNT  FINAL ACUITY: 4
    
```

```

SUBCOUNT   3
COUNT      6

Press 'Return to continue:

```

Figure 4-77: Reports Menu (RPTS)–ER System Report Generator (LIST)–Statistical Reports (3)–Sample Report

#### 4.12.3.4 Hourly Workload Report (4)

Use the **Hourly Workload Report** option to review the workload of the Providers and Triage. This report provides timeframes and can be used to sort by specific Providers. The timeframe values are minimum, maximum, and average. The maximum timeframe for this report is 30 days.

To print the Hourly Workload Report:

1. At the “Report Type” prompt, type **4**.
2. At the “Enter starting date” prompt, type the starting date for your report.
3. At the “Enter ending date” prompt, type the ending date for your report. The system displays the following choices and prompt (Figure 4-78):

```

Report type: 1// 4 HOURLY WORKLOAD REPORT

          ***** TIME FRAME *****
Enter starting date: T (MAY 2,2023)
Enter ending date: T (MAY 2,2023@23:59)
FINISHED SYNCHING ERS WITH CURRENT PCC DATA FROM 3230502 TO 3230502

Select one of the following:

    1          SORT BY A SPECIFIC PROVIDER
    2          SORT BY ALL PROVIDERS
    3          DO NOT SORT BY PROVIDER

Sort option: 3//

```

Figure 4-78: Reports Menu (RPTS)–ER System Report Generator (LIST)–Hourly Workload Report

4. At the “Sort by” prompt, type the number that matches how you want the report sorted. Depending on your choice, the system may display the following message and prompt (Figure 4-79):

```
Sort option: 3// <enter> DO NOT SORT BY PROVIDER
```

```
Some of the times recorded in the database may be invalid; i.e., negative or
excessively long intervals.
```

```
Want to FILTER out data which is likely to be invalid? No// <enter>
```

Figure 4-79: Reports Menu (RPTS)–ER System Report Generator (LIST)–Hourly Workload Report–Filtering Screen

5. Type your answer to this prompt and any additional prompts.
6. At the “Device” prompt, type HOME to display the report on the screen or type the name of the printer.
7. At the “Right Margin” prompt, press **Enter** to accept the default value of 80, or type the size of the right margin.

The system prints your report or displays it on the screen.

The following report (Figure 4-80) example shows hourly statistics for the selected reporting period (May 2, 2023).

```
Report daily totals only? YES// NO
Enter STARTING hour: (1-24): 24// 1
Enter ENDING hour: (1-24): 24// <enter>
```

```
Reporting from: 0100 to: 2359
```

```
Print HOURLY WORKLOAD TOTALS on which device: HOME// 0;80;999 VIRTUAL
```

```
***** HOURLY WORKLOAD REPORT *****
```

```
MAY 2, 2023
```

| VISIT TIME | # PTS | MINS TO TRIAGER |     |     | MINS TO PROVIDER |     |     | AGE<14 | ETOH | INJURY |
|------------|-------|-----------------|-----|-----|------------------|-----|-----|--------|------|--------|
|            |       | MIN             | MAX | AVE | MIN              | MAX | AVE |        |      |        |
| 0100-0159  | 3     |                 |     |     |                  |     |     |        |      |        |
| 0200-0259  | 0     |                 |     |     |                  |     |     |        |      |        |
| 0300-0359  | 0     |                 |     |     |                  |     |     |        |      |        |
| 0400-0459  | 1     |                 |     |     |                  |     |     |        |      |        |
| 0500-0559  | 1     |                 |     |     |                  |     |     |        |      |        |
| 0600-0659  | 0     |                 |     |     |                  |     |     |        |      |        |
| 0700-0759  | 0     |                 |     |     |                  |     |     |        |      |        |
| 0800-0859  | 0     |                 |     |     |                  |     |     |        |      |        |
| 0900-0959  | 0     |                 |     |     |                  |     |     |        |      |        |
| 1000-1059  | 0     |                 |     |     |                  |     |     |        |      |        |
| 1100-1159  | 1     |                 |     |     |                  |     |     |        |      |        |

| VISIT TIME | # PTS | MINS TO TRIAGER |     |     | MINS TO PROVIDER |     |     | AGE<14 | ETOH | INJURY |
|------------|-------|-----------------|-----|-----|------------------|-----|-----|--------|------|--------|
|            |       | MIN             | MAX | AVE | MIN              | MAX | AVE |        |      |        |
| 1200-1259  | 0     |                 |     |     |                  |     |     |        |      |        |
| 1300-1359  | 0     |                 |     |     |                  |     |     |        |      |        |
| 1400-1459  | 0     |                 |     |     |                  |     |     |        |      |        |
| 1500-1559  | 0     |                 |     |     |                  |     |     |        |      |        |
| 1600-1659  | 0     |                 |     |     |                  |     |     |        |      |        |
| 1700-1759  | 0     |                 |     |     |                  |     |     |        |      |        |

|           |   |    |    |    |     |     |     |   |   |
|-----------|---|----|----|----|-----|-----|-----|---|---|
| 1800-1859 | 0 |    |    |    |     |     |     |   |   |
| 1900-1959 | 0 |    |    |    |     |     |     |   |   |
| 2000-2059 | 0 |    |    |    |     |     |     |   |   |
| 2100-2159 | 0 |    |    |    |     |     |     |   |   |
| 2200-2259 | 0 |    |    |    |     |     |     |   |   |
| 2300-2359 | 0 |    |    |    |     |     |     |   |   |
| TOTALS    | 6 |    |    |    |     |     | 0   | 0 | 1 |
| AVERAGES  |   | 30 | 40 | 32 | 108 | 141 | 134 |   |   |

Figure 4-80: Reports Menu (RPTS)–ER System Report Generator (LIST) Hourly Workload Report–Sample Report

### 4.12.4 Print ER Log (LOG)

Use the **Print ER Log** option to print a list of ER patients. This report uses a default date of the previous day’s admissions to the ER and includes:

- Date and time the patient was admitted
- Patient name
- Chart number
- Date of birth
- Physician
- Primary diagnosis

To print the ER log:

1. At the “Select Reports Menu Option:” prompt, type **LOG**.
2. At the “Device” prompt, type **HOME** to display the report on the screen or type the **name** of the printer.
3. At the “Right Margin” prompt, press **Enter** to accept the default value of 80, or type the size of the right margin.

The system prints your report or displays it on the screen.

The following example shows an ER Daily Log Report for May 1, 2023. This report includes the date and time the patient was admitted, the patient’s name, chart number, and date of birth, the physician, and the primary diagnosis (Figure 4-81).

```
Select Reports Menu <TEST ACCOUNT> Option: LOG Print ER Log
FINISHED SYNCHING ERS WITH CURRENT PCC DATA FROM MAY 01, 2023 TO MAY 01, 2023
DEVICE: 0;80;999 VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****ER
DAILY LOG REPORT FROM: MAY 01, 2023 TO: MAY 01, 2023
                                MAY 2,2023 17:13 PAGE 1
                                PRIMARY DX
DATE      TIME      PATIENT      CHART DOB      PHYSICIAN  NARRATIVE
-----
```

```
05/01/23 9:06 AM DEMO,PATIENT T 109886 09/21/60 TEST,P          PATIENT HEALTH I
Press 'Return to continue:
```

Figure 4-81: Reports Menu (RPTS) – Print ER Log (LOG)

#### 4.12.5 Display ER Log Entry for a Single ER Visit (VIS)

Use the **Display ER Log Entry for a Single ER Visit** option to display the ER log for a particular patient and visit.

To display a single ER visit:

1. At the “Select Reports Menu Option” prompt, type **VIS**.
2. At the “Enter name, DOB or chart number” prompt, type the patient’s name, DOB, or chart number. If the patient has more than one visit on record, the system displays all visits (Figure 4-82).

```
Select Reports Menu <TEST ACCOUNT> Option: VIS Display ER Log entry for a single ER
visit
Enter name, DOB or chart number: DEMO,PATIENT THREE
                                F 01-01-1985 XXX-XX-5456      DB 92343
1 7623 9-23-2024@14:00:00      DEMO,PATIENT THREE
2 7623 11-13-2024@16:05:00      DEMO,PATIENT THREE
CHOOSE 1-2: 2 11-13-2024@16:05:00      DEMO,PATIENT THREE
FINISHED SYNCHING ERS WITH CURRENT PCC DATA
DEVICE: 0;80;9999 VIRTUAL
***** CONFIDENTIAL PATIENT INFORMATION *****ER
LOG ENTRY FOR SINGLE PATIENT
                                NOV 18,2024 16:10      PAGE 1
-----
ADMISSION TIMESTAMP: NOV 13,2024 16:05
PATIENT: DEMO,PATIENT THREE
PCC VISIT: NOV 13,2024 16:05
  DOB: JAN 1,1985      AGE AT VISIT: 39
  CHART #: 92343      SEX: FEMALE
CLINIC TYPE: EMERGENCY MEDICINE
MODE OF TRANSPORT: PRIVATE VEHICLE/WALK IN
  AMBULANCE CO:
  AMBULANCE #:      AMB INVOICE #:
TRAUMA TEAM ACTIVATION: YES TRAUMA TEAM ACTIVATION DTM: NOV 13,2024 16:08
TRAUMA TEAM ACTIVATION BY: TEST,PROVIDER ONE
PRESENTING COMPLAINT: TESTING
  OCCUPATION RELATED: NO      INJURED: NO
  CAUSE OF INJURY:      SCENE OF INJURY:
  TIME OF INJURY:
  SAFETY EQUIPMENT:
  TOWN OF INJURY:
  EXACT MVC LOCATION:
PROCEDURES:
  NONE
PRIMARY DIAGNOSIS: ZZZ.999 {Uncoded diagnosis}
```

```

PRIMARY DX NARRATIVE: NARRATIVE FOR POV
DIAGNOSIS:                                DX NARRATIVE:
  ZZZ.999 {Uncoded diagnosis}             NARRATIVE FOR POV
ED PROVIDER: TEST,PROVIDER ONE
ED PROVIDER TIME: NOV 13,2024  16:06
PRIMARY NURSE: TEST,NURSE ONE
  PRIMARY NURSE TIME: NOV 13,2024  16:06
MEDICAL SCREENING EXAM TIME: NOV 13,2024  16:06
TRIAGE NURSE: TEST,NURSE ONE
  TRIAGE NURSE TIME: NOV 13,2024  16:05
TRIAGE PROVIDER: TEST,PROVIDER ONE
  TRIAGE PROVIDER TIME: NOV 13,2024  16:06
INITIAL TRIAGE BY: TEST,NURSE ONE
  INITIAL TRIAGE TIME: NOV 13,2024  16:05
DECISION TO ADMIT TIME:
EMERGENCY SEVERITY INDEX: 1             FINAL ACUITY: 1
DISPOSITION: HOME
PATIENT STATUS CODE (NUBC):  DISCHARGED HOME (01)
  TRANSFERRED TO:
DEPARTURE TIME: NOV 13,2024  16:06
  DISCHARGE (PRIMARY) PROVIDER: TEST,PROVIDER ONE
  DISCHARGE NURSE: TEST,NURSE ONE
DISCHARGE INSTRUCTIONS: RTC PRN, INSTRUCTIONS GIVEN
ER CONSULTANTS:
TOTAL VISIT DURATION:                   1
  WAITING TIME FOR TRIAGE   :           0
  WAITING TIME FOR PROVIDER:           1
  DATA ENTERER: DEMO,BRIAN E
Press 'Return to continue:

```

Figure 4-82: Reports Menu (RPTS)–Display ER Log Entry for a Single ER Visit (VIS)

#### 4.12.6 Display Data for a Specific Patient Visit (VV)

Use the **Display Data for a Specific Patient Visit** option to display the details of a single patient visit.

To display data for a specific patient visit:

1. At the “Select Reports Menu Option” prompt, type **VV**.
2. At the “Select Patient Name” prompt, type the name of the patient whose record you want to view.
3. At the “Enter Visit date” prompt, type the date of the visit.

The system displays the PCC record for the selected patient on the selected date (Figure 4-83).

```

Select Reports Menu <TEST ACCOUNT> Option: VV Display Data for a Specific Patient Visit

Enter PATIENT NAME:
  DEMO, PATIENT FOUR                                F 12-09-1965 XXX-XX-8047    DB 102590
PCC VISIT DISPLAY          May 02, 2023 17:22:03          Page: 1 of 7
-----
-----

```

Patient Name: DEMO,PATIENT FOUR  
 Chart #: 102590  
 Date of Birth: DEC 09, 1965  
 Sex: F  
 Visit IEN: 247225

===== VISIT FILE =====

VISIT/ADMIT DATE&TIME: MAY 02, 2023@01:20  
 DATE VISIT CREATED: MAY 02, 2023

TYPE: IHS  
 PATIENT NAME: DEMO,PATIENT FOUR  
 LOC. OF ENCOUNTER: 2016 DEMO HOSPITAL  
 SERVICE CATEGORY: AMBULATORY  
 CLINIC: EMERGENCY MEDICINE  
 DEPENDENT ENTRY COUNT: 6

DATE LAST MODIFIED: MAY 02, 2023  
 WALK IN/APPT: WALK IN  
 CHECK OUT DATE&TIME: MAY 02, 2023@05:50  
 HOSPITAL LOCATION: ED MAIN

+-----Enter ?? for more actions-----

HOSPITAL LOCATION: ED MAIN

+-----Enter ?? for more actions-----

Select Action: +// PL PL

DEVICE: HOME// 0;80;9999 VIRTUAL

PCC VISIT DISPLAY May 02, 2023 17:22:09 Page: 1 of 1

Patient Name: DEMO,PATIENT FOUR  
 Chart #: 102590  
 Date of Birth: DEC 09, 1965  
 Sex: F  
 Visit IEN: 247225

===== VISIT FILE =====

VISIT/ADMIT DATE&TIME: MAY 02, 2023@01:20  
 DATE VISIT CREATED: MAY 02, 2023

TYPE: IHS  
 PATIENT NAME: DEMO,PATIENT FOUR  
 LOC. OF ENCOUNTER: 2016 DEMO HOSPITAL  
 SERVICE CATEGORY: AMBULATORY  
 CLINIC: EMERGENCY MEDICINE  
 DEPENDENT ENTRY COUNT: 6

DATE LAST MODIFIED: MAY 02, 2023  
 WALK IN/APPT: WALK IN  
 CHECK OUT DATE&TIME: MAY 02, 2023@05:50  
 HOSPITAL LOCATION: ED MAIN

CREATED BY USER: DEMO,BRIAN E

OPTION USED TO CREATE: SD IHS PCC LINK

APPT DATE&TIME: MAY 02, 2023@01:20

USER LAST UPDATE: DEMO,BRIAN E

VCN: 1594.1X

OLD/UNUSED UNIQUE VIS: 5054300000247225

DATE/TIME LAST MODIFI: MAY 02, 2023@15:45:37

PATIENT STATUS CODE (: 09

NDW UNIQUE VISIT ID (: 999990000247225

CHIEF COMPLAINT: TESTING

WHERE SEEN SNOMED CT: 255327002

WHERE SEEN PREFERRED : Ambulatory

WHERE SEEN SNOMED CT: 440655000

WHERE SEEN PREFERRED : Outpatient environment

FACE TO FACE SNOMED C: 308335008

FACE TO FACE PREFERRE: Patient encounter procedure

FACE TO FACE SNOMED C: 4525004

FACE TO FACE PREFERRE: Emergency department patient visit  
 VISIT ID: 5HPP-HOX

===== PROVIDERs =====

PROVIDER: TEST,NURSE ONE  
 PRIMARY/SECONDARY: SECONDARY  
 EVENT DATE AND TIME: MAY 02, 2023@02:20  
 DATE/TIME ENTERED: MAY 02, 2023@14:44:06  
 ENTERED BY: DEMO,BRIAN E  
 DATE/TIME LAST MODIFI: MAY 02, 2023@14:44:06  
 LAST MODIFIED BY: DEMO,BRIAN E  
 V FILE IEN: 365279

PROVIDER: TEST,PROVIDER ONE  
 PRIMARY/SECONDARY: SECONDARY  
 EVENT DATE AND TIME: MAY 02, 2023@02:25  
 DATE/TIME ENTERED: MAY 02, 2023@14:44:20  
 ENTERED BY: DEMO,BRIAN E  
 DATE/TIME LAST MODIFI: MAY 02, 2023@14:44:20  
 LAST MODIFIED BY: DEMO,BRIAN E  
 V FILE IEN: 365280

PROVIDER: TEST,NURSE TWO  
 PRIMARY/SECONDARY: SECONDARY  
 EVENT DATE AND TIME: MAY 02, 2023@03:30  
 DATE/TIME ENTERED: MAY 02, 2023@14:44:37  
 ENTERED BY: DEMO,BRIAN E  
 DATE/TIME LAST MODIFI: MAY 02, 2023@14:44:37  
 LAST MODIFIED BY: DEMO,BRIAN E  
 V FILE IEN: 365281

PROVIDER: TEST,PROVIDER THREE  
 PRIMARY/SECONDARY: PRIMARY  
 EVENT DATE AND TIME: MAY 02, 2023@05:00  
 DATE/TIME ENTERED: MAY 02, 2023@14:44:47  
 ENTERED BY: DEMO,BRIAN E  
 DATE/TIME LAST MODIFI: MAY 02, 2023@14:44:47  
 LAST MODIFIED BY: DEMO,BRIAN E  
 V FILE IEN: 365282

===== POV's =====

POV: ZZZ.999  
 ICD NARRATIVE: Uncoded diagnosis  
 PROVIDER NARRATIVE: NARRATIVE FOR ZZZ.999  
 PRIMARY/SECONDARY: PRIMARY  
 PRESENT ON ADMISSION?: YES  
 PRIMARY SNOMED: 63161005  
 PRIMARY SNOMED PREFER: Principal  
 DATE/TIME ENTERED: MAY 02, 2023@14:45:06  
 ENTERED BY: DEMO,BRIAN E  
 DATE/TIME LAST MODIFI: MAY 02, 2023@14:45:06  
 LAST MODIFIED BY: DEMO,BRIAN E  
 V FILE IEN: 370827

===== EMERGENCY VISIT RECORDs =====

FORM ID: IHS-114 ER  
 INITIAL ACUITY: EMERGENT (2)  
 MEANS OF ARRIVAL: AMBULANCE  
 ENTERED ER BY: AMBULATORY  
 DISPOSITION OF CARE: ADMIT  
 DISPOSITION IF OTHER: ADMIT

```

DEPARTURE DATE&TIME:    MAY 02, 2023@05:50
DATE/TIME ENTERED:     MAY 02, 2023@14:43:05
ENTERED BY:            DEMO,BRIAN E
DATE/TIME LAST MODIFI: MAY 02, 2023@15:45:37
LAST MODIFIED BY:     DEMO,BRIAN E
PROVIDERS:             TEST,PROVIDER ONE
PROVIDER TYPE:         TRIAGE PROVIDER
PROVIDER TIME:        MAY 02, 2023@02:25
PROVIDERS:            TEST,PROVIDER THREE
PROVIDER TYPE:        ED PROVIDER
PROVIDER TIME:        MAY 02, 2023@05:00
PROVIDERS:            TEST,PROVIDER THREE
PROVIDER TYPE:        DISCHARGE PROVIDER
PROVIDER TIME:        MAY 02, 2023@05:50
NURSES:               TEST,NURSE TWO
NURSE TYPE:           TRIAGE NURSE
NURSE TIME:           MAY 02, 2023@02:18
NURSES:               TEST,NURSE ONE
NURSE TYPE:           TRIAGE NURSE
NURSE TIME:           MAY 02, 2023@02:20
NURSES:               TEST,NURSE TWO
NURSE TYPE:           PRIMARY NURSE
NURSE TIME:           MAY 02, 2023@03:30
NURSES:               TEST,NURSE TWO
NURSE TYPE:           DISCHARGE NURSE
NURSE TIME:           MAY 02, 2023@05:50
V FILE IEN:           6427

```

Figure 4-83: Reports Menu (RPTS)–Display Data for a Specific Patient Visit (VV)

## 4.13 Edit ER Visits (UP)

Use the **Edit ER Visits** menu option to edit information about an ER visit after the patient has been discharged using the **OUT-menu** option.

**Note:** This option is available only to those users who have the appropriate security key.

Be aware that changing the patient’s name or the visit date (or time) may also change the patient’s PCC or PIMS information. ERS-to-PCC is a two-way interface. Once data is entered, data in ERS will be checked against data in PCC. If a difference is found, you are prompted to accept either the PCC data or the ERS data.

### 4.13.1 Selecting Visit and Patient to Edit

Before you can edit a patient visit, you must first identify the visit date and patient you want to edit. The sections that follow provide instructions for selecting a visit and editing various parts of the ER visit. To edit an ER visit:

1. To access the **Edit ER Visits (UP)** option, type **UP** at the “Select Emergency Room System Option” prompt.
2. At the “Start with date” prompt, enter a **visit date** to begin your search.

3. At the “Enter name, DOB, or chart number” prompt, enter a **patient name, date of birth, or chart number**.
4. At the “Device” prompt, enter the **printer name** or enter **HOME** to display the report on the screen.
5. At the “Right Margin” prompt, press **Enter** to accept the default value of 80 or type the size of the right margin. The patient visit detail will display (Figure 4-84).

```

*****
*           Editing Interface           *
*           Indian Health Service      *
*           Version 3.0                *
*****
                2016 DEMO HOSPITAL

Start with date:  NOV 21,2024// 11/13
Enter name, DOB or chart number:  DEMO,PATIENT TWO
  1   DEMO,PATIENT TWO                <D>   M 10-18-2014  XXX-XX-1234   DB 456
  2   DEMO,PATIENT TWO                F 01-01-1980                DB 12343
CHOOSE 1-2:  1
  DEMO,PATIENT TWO                <D>   M 10-18-2014  XXX-XX-1234   DB 456  1
1-13-2024@08:00:00      DEMO,PATIENT TWO
DEVICE:  0;80;9999  VIRTUAL

ADMISSION TIMESTAMP:  NOV 13,2024  08:00
PATIENT:  DEMO,PATIENT TWO
PCC VISIT:  NOV 13,2024  08:00
  DOB:      OCT 18,2014                AGE AT VISIT:  10
  CHART #:  456                        SEX:           MALE
CLINIC TYPE:  EMERGENCY MEDICINE
MODE OF TRANSPORT:  PRIVATE VEHICLE/WALK IN
  AMBULANCE CO:
  AMBULANCE #:                          AMB INVOICE #:
TRAUMA TEAM ACTIVATION:  YES  TRAUMA TEAM ACTIVATION DTM:  NOV 13,2024  07:50
TRAUMA TEAM ACTIVATION BY:  TEST,PROVIDER ONE
PRESENTING COMPLAINT:  TESTING TWO
  OCCUPATION RELATED:                    INJURED:  NO
  CAUSE OF INJURY:                      SCENE OF INJURY:
  TIME OF INJURY:
  SAFETY EQUIPMENT:
  TOWN OF INJURY:
  EXACT MVC LOCATION:
PROCEDURES:
PRIMARY DIAGNOSIS:          {}
  PRIMARY DX NARRATIVE:
DIAGNOSIS:                  DX NARRATIVE:
ED PROVIDER:
  ED PROVIDER TIME:
PRIMARY NURSE:
  PRIMARY NURSE TIME:
MEDICAL SCREENING EXAM TIME:
TRIAGE NURSE:  TEST,NURSE ONE
  TRIAGE NURSE TIME:  NOV 13,2024  14:00
TRIAGE PROVIDER:
  TRIAGE PROVIDER TIME:
INITIAL TRIAGE BY:  TEST,NURSE ONE

```

```

INITIAL TRIAGE TIME: NOV 13,2024 14:00
DECISION TO ADMIT TIME:
EMERGENCY SEVERITY INDEX: 1          FINAL ACUITY:
DISPOSITION: LEFT WITHOUT BEING SEEN
PATIENT STATUS CODE (NUBC): LEFT AMA (07)
TRANSFERED TO:
DEPARTURE TIME: NOV 13,2024 15:00
DISCHARGE (PRIMARY) PROVIDER: TEST, PROVIDER ONE
DISCHARGE NURSE: TEST, NURSE ONE
DISCHARGE INSTRUCTIONS: RTC PRN, INSTRUCTIONS GIVEN
ER CONSULTANTS:
TOTAL VISIT DURATION:                420
WAITING TIME FOR TRIAGE :            360
WAITING TIME FOR PROVIDER:
DATA ENTERER: DEMO, BRIAN E

Do you want to EDIT this ER VISIT? YES//

```

Figure 4-84: Edit ER VISITS (UP)–Select visit and display detail

6. At the “Do you want to Edit this ER Visit?” Prompt:

- If this is the correct patient, press **Enter** to display the editing options.
- If this is not the correct patient, type **N** (No) and press **Enter**. Then at the “Would you like to Edit another ER Visit?” prompt, select another patient or return to the UP menu. The list of edit options will display (Figure 4-85).

```

Select one of the following:

1      ADMISSION SUMMARY
2      TRIAGE INFO
3      INJURY INFO
4      PROCEDURES
5      DIAGNOSES (OPTION DISABLED)
6      EXIT ASSESSMENT
7      DISCHARGE INFO
8      FOLLOW UP INSTRUCTIONS
9      ER CONSULTANTS
10     ALL

ENTER NUMBER OF SECTION TO EDIT (OR '<return>' TO QUIT):

```

Figure 4-85: Edit ER VISITS (UP)–Edit Choices

7. At the “Enter Number of Section to Edit?” Prompt:

- Type the **number** that matches the section to edit, and press **Enter**.
- To QUIT at this point, press **Enter**. You may be prompted with the following:
  - Correct data from PCC or ERS
  - Print the ER Visit
  - Edit another ER Visit

### 4.13.2 Specifying a Reason for the Change

Once the change has been made, the system displays the time the change was made, and the old and new values. If you change the patient's name, chart number, or DOB, the system gives you the opportunity to print new chart labels and routing slips. If you change any ERS visit information, the system displays the following **Primary Reason for Change** codes and prompts you to enter the **code** that best describes the reason for the change (Figure 4-86):

```

Select one of the following:

DE      Data entry error
ADM     Administrative
ID      Mistaken patient ID
PT      Patient corrected
OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM//

```

Figure 4-86: Edit ER VISITS (UP)–Reason for Change Choices

**Note:** You must enter a reason code.

After you enter the code for changing the patient record, you may type an explanation at the “Comment” prompt. The Comment is optional.

### 4.13.3 Editing the Admission Summary (1)

The **Admission Summary (1)** option enables you to update a patient visit after the patient is discharged from the ER, with the following options:

- Replace a patient entered in error with a patient in the system.
- Update an Admission Date/Time entered in error with the correct date/time.
- Update the following patient visit data fields:
  - Clinic Type
  - Presenting Complaint
  - Visit Type
  - Was this patient transferred from another facility?
  - Transferred from
  - Mode of transport to the ER
  - Was the Trauma Team Activated for this visit?
  - Trauma Activated Provider
  - Trauma Team Activation Date/Time
  - Ambulance Number
  - Ambulance HRCN/Billing#

- Ambulance Company
- Medical attendant present during transfer

The actual prompts vary, depending on the patient data.

**Warning:** Be aware that changing the patient’s name can also change the chart number, age, and other fields, which then creates a new PCC visit. The original information stays in the database until it is marked deleted.

**Note:** If you change any admission summary information, the system prompts for a **Primary Reason for Change** code. You must enter one of the codes. You can also add an explanation at the **Comment** prompt.

#### 4.13.3.1 Changing a Patient within the Admission Summary (1)

To change a patient within the **Admission Summary** option:

1. Select a **visit date** and **patient**, as described in Section 4.13.1.
2. At the “Enter Number of Section to Edit” prompt, type **1**.
3. At the “Change Patient?” Prompt:
  - Press **Enter** (No) to leave the patient’s name unchanged.
  - Type **YES** to change the patient.
4. At the “Enter the patient’s NAME or LOCAL CHART NUMBER” prompt, enter the name of the patient to change to.
5. At the “Change patient from xxx,xxx to yyy,yyy” prompt type **YES** to change the patient.
6. At the “Enter number of labels to print” prompt enter the number of labels to print.
7. At the “Do you want to PRINT a routing slip” prompt, type **YES** or **NO**.
8. Enter the **primary reason** for change and comment.

An example of changing a visit patient is shown below (Figure 4-87):

```

**Changing the PATIENT will change chart number, age and other fields**
*** AND will also cause a new PCC VISIT to be created ***
Change Patient? NO// YES
Enter the patient's NAME or LOCAL CHART NUMBER: DEMO,PATIENT TWO//456
DEMO,PATIENT TWO          <D>    M 10-18-2014 XXX-XX-1234    DB 456
Do you want to register a new patient for this visit ? NO// NO

```

```

Change patient from DEMO,PATIENT TWO to DEMO,PATIENT TWO? NO// YES
  ***THIS PATIENT HAS AN APPOINTMENT IN THIS CLINIC TODAY***
      ED WALK-IN                FOR : Nov 13, 2024@08:00

Enter number of labels to print: (0-50): 4// 0
Do you want to PRINT a routing slip? YES// NO

MESSAGE NUMBER 6000 CREATED AND SENT

EDIT DATE: NOV 21, 2024

EDIT TIME: 11:09:01

FIELD NAME BEING EDITED: PATIENT

OLD VALUE: DEMO,PATIENT TWO

NEW VALUE: DEMO,PATIENT TWO

    Select one of the following:

        DE      Data entry error
        ADM     Administrative
        ID      Mistaken patient ID
        PT      Patient corrected
        OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM//  Administrative
Comment: TESTING

```

Figure 4-87: Edit ER VISITS (UP)–Admission Summary (1)–Changing the patient on a visit

#### 4.13.3.2 Changing Admission Time within the Admission Summary

To Change Admission Time within the Admission Summary option:

1. At the “Change Admission Time” prompt:

- Press **Enter** to leave the Admission Date/Time unchanged

Or

- Type **YES** to change the Admission Date/Time.

The following example (Figure 4-88) shows how to change the Admission Date/Time of MAY 02, 2023@01:20 that was entered incorrectly to the correct Admission Date/Time MAY 02, 2023@01:40. Other date/time data will also be displayed for the user to update, if appropriate. The user will also be prompted to enter the primary reason for change and a comment.

```

**Changing the ADMISSION TIME can cause other time related data to be deleted**
Change Admission Time? NO// YES
Date and time of admission to ER: NOV 13, 2024@08:00// 11/13@0801 (NOV 13, 202
4@08:01)

EDIT DATE: NOV 21, 2024

```

```

EDIT TIME: 11:15:18

FIELD NAME BEING EDITED: ADMISSION TIMESTAMP

OLD VALUE: NOV 13, 2024@08:00

NEW VALUE: NOV 13, 2024@08:01

    Select one of the following:

        DE          Data entry error
        ADM         Administrative
        ID          Mistaken patient ID
        PT          Patient corrected
        OT          Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM//  Administrative
Comment: TESTING

```

Figure 4-88: Edit ER VISITS (UP)–Admission Summary (1)–Changing the admission date/time

#### 4.13.3.3 Updating the Remaining Admission Summary (1) Options

To update the remaining Admission Summary options:

1. At the “Clinic type” prompt, press **Enter** to accept the displayed information, accept the current value by pressing Enter or select another clinic from the available choices. If you select a new entry:
  - At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - **Enter** additional information at the “Comment” prompt, if necessary (Figure 4-89).

```

*Clinic type: EMERGENCY MEDICINE// ?
Answer with ER OPTIONS NAME
Do you want the entire ER OPTIONS List? Y (Yes)
Choose from:
EMERGENCY MEDICINE      30
TRIAGE                   79
URGENT CARE              80

*Clinic type: EMERGENCY MEDICINE// TRIAGE      79

EDIT DATE: NOV 21, 2024

EDIT TIME: 11:20:20

FIELD NAME BEING EDITED: CLINIC TYPE

OLD VALUE: EMERGENCY MEDICINE

NEW VALUE: TRIAGE

    Select one of the following:

        DE          Data entry error
        ADM         Administrative

```

|    |                     |
|----|---------------------|
| ID | Mistaken patient ID |
| PT | Patient corrected   |
| OT | Other               |

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// Administrative  
 Comment: TESTING

Figure 4-89: Edit ER VISITS (UP)–Admission Summary (1)–Changing the Clinic type

2. At the “Presenting complaint” prompt, press **Enter** to accept the displayed information or enter the correct **Presenting complaint**. If you change the presenting complaint:
  - At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - **Enter** additional information at the “Comment” prompt, if necessary (Figure 4-90).

```

Presenting complaint: TESTING TWO// NEW PRESENTING COMPLAINT

EDIT DATE: NOV 21, 2024

EDIT TIME: 11:21:25

FIELD NAME BEING EDITED: PRESENTING COMPLAINT

OLD VALUE: TESTING TWO

NEW VALUE: NEW PRESENTING COMPLAINT

Select one of the following:

DE      Data entry error
ADM     Administrative
ID      Mistaken patient ID
PT      Patient corrected
OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// Administrative
Comment: TESTING
  
```

Figure 4-90: Edit ER VISITS (UP)–Admission Summary (1)–Changing the Presenting complaint

3. At the **Edit more admission data?** Prompt type **YES** or **NO** to edit additional admission information (Figure 4-91).

```

ERS PCC Data Entry is complete for this option
Edit more admission data? NO// YES
  
```

Figure 4-91: Edit ER VISITS (UP)–Admission Summary (1)–Selecting to edit additional admission information

4. If you chose to edit more admission data, at the “Visit Type” prompt, press **Enter** to accept the displayed information, or type one of the following:

- **C**(linic referral)
- **H**(ospital referral)
- **R**(eview)
- **S**(chedule)
- **U**(nscheduled)

If you type **C, H, R, S** or **U**:

- Type the **code** that matches your reason for the update at the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt.
- **Enter** additional information at the “Comment” prompt, if necessary (Figure 4-92).

```

Visit Type: UNSCHEDULED// ?
Answer with ER OPTIONS NAME
Do you want the entire ER OPTIONS List? Y (Yes)
Choose from:
CLINIC REFERRAL
HOSPITAL REFERRAL
REVIEW
SCHEDULED
UNSCHEDULED

Visit Type: UNSCHEDULED// CLINIC REFERRAL

EDIT DATE: NOV 21, 2024

EDIT TIME: 11:23:05

FIELD NAME BEING EDITED: VISIT TYPE

OLD VALUE: UNSCHEDULED

NEW VALUE: CLINIC REFERRAL

Select one of the following:

DE      Data entry error
ADM     Administrative
ID      Mistaken patient ID
PT      Patient corrected
OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// Administrative
Comment: TESTING

```

Figure 4-92: Edit ER VISITS (UP)–Admission Summary (1)–Updating the Visit Type

5. At the “\*Was this patient transferred from another facility?” prompt, press **Enter** to accept the displayed information, or type **Y**(Yes) or **N**(No). If you change the response:

- At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - **Enter** additional information at the “Comment” prompt, if necessary.
6. At the “\*Transferred from” prompt, press **Enter** to accept the displayed information or type the correct facility name. If you change the **transferred from** facility:
- At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - **Enter** additional information at the “Comment” prompt, if necessary (Figure 4-93).

```

*Was this patient transferred from another facility? NO// YES
EDIT DATE: NOV 21, 2024
EDIT TIME: 11:24:07
FIELD NAME BEING EDITED: TRANSFERED
OLD VALUE: NO
NEW VALUE: YES

    Select one of the following:

        DE      Data entry error
        ADM     Administrative
        ID      Mistaken patient ID
        PT      Patient corrected
        OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM//  Administrative
Comment: TESTING
*Transferred from: ?
    Answer with ER LOCAL FACILITY NAME
    Choose from:
    BANNER GOOD SAMARITAL REGIONAL
    DESERT SAMARITAL MEDICAL

*Transferred from: DESERT SAMARITAL MEDICAL
EDIT DATE: NOV 21, 2024
EDIT TIME: 11:24:32
FIELD NAME BEING EDITED: TRANSFERED FROM
OLD VALUE:
NEW VALUE: DESERT SAMARITAL MEDICAL

    Select one of the following:

        DE      Data entry error
        ADM     Administrative

```

|    |                     |
|----|---------------------|
| ID | Mistaken patient ID |
| PT | Patient corrected   |
| OT | Other               |

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// Administrative  
 Comment: TESTING

Figure 4-93: Edit ER VISITS (UP)–Admission Summary (1)–Updating the Transferred from

7. At the “\*Mode of Transfer transport” prompt, press **Enter** to accept the displayed information, or type the correct mode of transport. If you change the Mode of Transfer transport:
  - At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - **Enter** additional information at the “Comment” prompt, if necessary.
8. At the “\*Was the Trauma Team Activated for this visit?” prompt, press **Enter** to accept the displayed information, or type the correct responses. If you change the response:
  - a. If the response is **YES** or was changed to **YES**, the user will be prompted to enter or change the **Trauma Activated Provider**. If an update is performed the user will be prompted to enter:
    - At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
    - **Enter** additional information at the “Comment” prompt, if necessary.
  - b. If the response is **YES** or was changed to **YES**, the user will be prompted to enter or change the **Trauma Team Activation Date/Time**. If an update is performed the user will be prompted to enter:
    - At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
    - **Enter** additional information at the “Comment” prompt, if necessary (Figure 4-94).

```
*Was the Trauma Team Activated for this visit? YES//
*Trauma Activated Provider: DEMO,ADAM// TEST,PROVIDER ONE      PTT

EDIT DATE: NOV 21, 2024

EDIT TIME: 11:27:01

FIELD NAME BEING EDITED: TRAUMA TEAM ACTIVATED PROVIDER

OLD VALUE: 1

NEW VALUE: 6364
```

```

Select one of the following:

    DE      Data entry error
    ADM     Administrative
    ID      Mistaken patient ID
    PT      Patient corrected
    OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM//  Administrative
Comment: TESTING
*Trauma Team Activation Date/Time: NOV 13,2024@08:01// 11/13@0745 (NOV 13, 202
4@07:45)

EDIT DATE: NOV 21, 2024

EDIT TIME: 11:27:10

FIELD NAME BEING EDITED: TRAUMA TEAM ACTIVATION DTM

OLD VALUE: 3241113.0801

NEW VALUE: 3241113.0745

Select one of the following:

    DE      Data entry error
    ADM     Administrative
    ID      Mistaken patient ID
    PT      Patient corrected
    OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM//  Administrative
Comment: TESTING

```

Figure 4-94: Edit ER VISITS (UP)–Admission Summary (1)–Updating the Trauma Information

9. At the “\*Ambulance number” prompt (if applicable), press **Enter** or type a new **Ambulance number**. If you change the Ambulance number:
  - At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - **Enter** additional information at the “Comment” prompt, if necessary (Figure 4-95).

```

*Ambulance number: // 12345

EDIT DATE: NOV 21, 2024

EDIT TIME: 11:33:55

FIELD NAME BEING EDITED: AMBULANCE NUMBER

OLD VALUE:

NEW VALUE: 12345

Select one of the following:

```

|     |                     |
|-----|---------------------|
| DE  | Data entry error    |
| ADM | Administrative      |
| ID  | Mistaken patient ID |
| PT  | Patient corrected   |
| OT  | Other               |

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// Administrative  
 Comment: TESTING

Figure 4-95: Edit ER VISITS (UP)–Admission Summary (1)–Updating the Ambulance number

10. At the “\*Ambulance HRCN/billing number” prompt (if applicable), press **Enter** to accept the displayed information or enter in the correct value. If you change the Ambulance HRCN/billing number:

- At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
- **Enter** additional information at the “Comment” prompt, if necessary (Figure 4-96).

```
*Ambulance HRCN/billing number: // 454545
EDIT DATE: NOV 21, 2024
EDIT TIME: 11:34:56
FIELD NAME BEING EDITED: AMBULANCE INVOICE NUMBER
OLD VALUE:
NEW VALUE: 454545

Select one of the following:

DE      Data entry error
ADM     Administrative
ID      Mistaken patient ID
PT      Patient corrected
OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// Administrative
Comment: TESTING
```

Figure 4-96: Edit ER VISITS (UP)–Admission Summary (1)–Updating the Ambulance HRCN/billing number

11. At the “\*Ambulance company” prompt (if applicable), press **Enter** to accept the displayed information or enter the correct value. If you change the Ambulance company:

- At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
- **Enter** additional information at the “Comment” prompt, if necessary (Figure 4-97).

```

*Ambulance company: LOCAL AMBULANCE COMPANY      AMB
EDIT DATE: NOV 21, 2024
EDIT TIME: 11:35:21
FIELD NAME BEING EDITED: AMBULANCE COMPANY
OLD VALUE:
NEW VALUE: LOCAL AMBULANCE COMPANY

  Select one of the following:

      DE      Data entry error
      ADM     Administrative
      ID     Mistaken patient ID
      PT     Patient corrected
      OT     Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM//   Administrative
Comment: TESTING

```

Figure 4-97: Edit ER VISITS (UP)–Admission Summary (1)–Updating the Ambulance company

12. At the “\*Medical Attendant present during transfer” prompt, press **Enter** to accept the displayed information or type **Y**(Yes) or **N**(No). If you change the \*Medical Attendant present during transfer value:

- At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
- **Enter** additional information at the “Comment” prompt, if necessary.

```

*Medical attendant present during transfer? NO// YES
EDIT DATE: NOV 21, 2024
EDIT TIME: 11:36:40
FIELD NAME BEING EDITED: TRANSFER ATTENDANT
OLD VALUE: NO
NEW VALUE: YES

  Select one of the following:

      DE      Data entry error
      ADM     Administrative
      ID     Mistaken patient ID
      PT     Patient corrected
      OT     Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM//   Administrative
Comment: TESTING

```

Figure 4-98: Edit ER VISITS (UP)–Admission Summary (1)–Updating the \*Medical Attendant present during transfer information

#### 4.13.4 Editing the Triage Information (2)

The **Triage Info (2)** option enables you to edit the triage information of an ER visit. The actual process can vary, depending on the patient record and your responses to the prompts.

**Note:** If you change any admission summary information, the system prompts for a **Primary Reason for Change** code. You must enter one of the codes. You can also add an explanation at the “Comment” prompt.

To edit Triage Information:

1. Select a **visit date** and **patient**, as described in Section 4.13.1.
2. At the Enter “Number of Section to Edit” prompt, Type **2**.
3. The **TRIAGE NURSE ENTRY** method will display. A new Triage Nurse can be entered, the date/time for an existing Triage Nurse can be updated or an existing Triage Nurse can be deleted. Refer to Section 5.0 for instructions on how to perform these updates. The following example shows the date/time being modified for an existing Triage Nurse (Figure 4-99).

```
ER ADMISSION FOR DEMO,PATIENT EIGHT      ^ = back up      ^^ = quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

TRIAGE NURSE ENTRY

Current entry/entries on file for visit:

#      Nurse/Provider                      Date/Time Seen
-----
1      TEST,NURSE FIVE                      05/02/23@12:00

(A)dd new, (E)dit existing, (D)elete existing Triage nurse: e Edit
Enter the entry # to edit: : (1-1): 1

Triage nurse: TEST,NURSE FIVE

*Enter the date/time that this patient was seen: 05/02/23@12:00// 5/2@1202 (MAY 02, 2023@12:02)

EDIT DATE: MAY 03, 2023

EDIT TIME: 09:20:27

FIELD NAME BEING EDITED: TRIAGE NURSE TIME

OLD VALUE: TEST,NURSE FIVE (05/02/23 12:00)

NEW VALUE: TEST,NURSE FIVE (05/02/23 12:02)

Select one of the following:
```

```

DE      Data entry error
ADM     Administrative
ID      Mistaken patient ID
PT      Patient corrected
OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: TESTING
    
```

Figure 4-99 Edit ER VISITS (UP)–Triage Information (2)–Updating the Triage Nurse

4. If applicable, the **TRIAGE PROVIDER ENTRY** method will display. A new Triage Provider can be entered, the date/time for an existing Triage Provider can be updated or an existing Triage Provider can be deleted. Refer to Section 5.0 for instructions on how to perform these updates. The following example shows the date/time being modified for an existing Triage Nurse (Figure 4-100).

```

ER ADMISSION FOR DEMO,PATIENT EIGHT      ^ = back up      ^^ = quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

TRIAGE PROVIDER ENTRY

~~~~~

Triage Provider: TEST,PROV
 1 TEST,PROVIDER FIVE      BAU
 2 TEST,PROVIDER FOUR      KB
 3 TEST,PROVIDER ONE      ALT      HEALTH SYST. SPEC.
 4 TEST,PROVIDER THREE     BAK
 5 TEST,PROVIDER TWO      AMU
CHOOSE 1-5: 1 TEST,PROVIDER FIVE      BAU
*Enter the date/time that this patient was seen: 05/03/23@09:27// T-1@1245 (MAY 02, 2023@12:45)

EDIT DATE: MAY 03, 2023
EDIT TIME: 09:27:13

FIELD NAME BEING EDITED: TRIAGE PROVIDER

OLD VALUE:

NEW VALUE: TEST,PROVIDER FIVE (05/02/23 12:45)

Select one of the following:

DE      Data entry error
ADM     Administrative
ID      Mistaken patient ID
PT      Patient corrected
OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: TESTING
    
```

Figure 4-100: Edit ER VISITS (UP)–Triage Information (2)–Updating the Triage Provider

5. The **PRIMARY NURSE ENTRY** method will display. A new Primary Nurse can be entered, the date/time for an existing Primary Nurse can be updated or an existing Primary Nurse can be deleted. Refer to Section 5.0 for instructions on how to perform these updates. The following example shows the existing Primary Nurse being removed from the visit (Figure 4-101).

```

ER ADMISSION FOR DEMO,PATIENT EIGHT      ^ = back up      ^^ = quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

PRIMARY NURSE ENTRY

Current entry/entries on file for visit:

#      Nurse/Provider                      Date/Time Seen
-----
1      TEST,NURSE FOUR                      05/02/23@13:00

(A)dd new, (E)dit existing, (D)elete existing Primary Nurse: Delete
Enter the entry # to delete: : (1-1): 1
Are you sure you want to remove this entry: ? NO// YES

EDIT DATE: MAY 03, 2023

EDIT TIME: 09:30:26

FIELD NAME BEING EDITED: PRIMARY NURSE

OLD VALUE: TEST,NURSE FOUR (05/02/23 13:00)

NEW VALUE:

    Select one of the following:

        DE      Data entry error
        ADM     Administrative
        ID      Mistaken patient ID
        PT      Patient corrected
        OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: testing

```

Figure 4-101: Edit ER VISITS (UP)–Triage Information (2)–Updating the Primary Nurse

6. The **ED PROVIDER ENTRY** method will display. A new ED Provider can be entered, the date/time for an existing ED Provider can be updated or an existing ED Provider can be deleted. Refer to Section 5.0 for instructions on how to perform these updates. The following example shows how an additional ED Provider can be added to a patient visit (Figure 4-102).

```

ER ADMISSION FOR DEMO,PATIENT EIGHT      ^ = back up      ^^ = quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

ED PROVIDER ENTRY

```

```

Current entry/entries on file for visit:

#      Nurse/Provider                      Date/Time Seen
-----
1      TEST, PROVIDER ONE                  05/02/23@14:00

(A)dd new, (E)dit existing, (D)elete existing ED Provider: Add
~~~~~

ED Provider: TEST, PROV
1  TEST, PROVIDER FIVE      BAU
2  TEST, PROVIDER FOUR     KB
3  TEST, PROVIDER ONE      ALT      HEALTH SYST. SPEC.
4  TEST, PROVIDER THREE    BAK
5  TEST, PROVIDER TWO      AMU
CHOOSE 1-5: 2  TEST, PROVIDER FOUR      KB
*Enter the date/time that this patient was seen: 05/03/23@09:34// T-1@1400 (MAY 02, 2023@14:00)

EDIT DATE: MAY 03, 2023

EDIT TIME: 09:34:17

FIELD NAME BEING EDITED: ED PROVIDER

OLD VALUE:

NEW VALUE: TEST, PROVIDER FOUR (05/02/23 14:00)

    Select one of the following:

        DE      Data entry error
        ADM     Administrative
        ID      Mistaken patient ID
        PT      Patient corrected
        OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: TESTING

```

Figure 4-102 Edit ER VISITS (UP)–Triage Information (2)–Updating the ED Provider

7. At the “\*Enter the Initial ED Provider Medical Screening Exam Time” prompt, accept the displayed value by pressing **Enter** or type in the **correct value**. If the value is updated, enter the **PRIMARY REASON FOR CHANGE** and a **Comment** (Figure 4-103).

```

*Enter the Initial ED Provider Medical Screening Exam Time: MAY 2,2023@14:00// t-1@1401
(MAY 02, 2023@14:01)

EDIT DATE: MAY 03, 2023

EDIT TIME: 09:36:09

FIELD NAME BEING EDITED: INITIAL ED PROVIDER TIME

OLD VALUE: MAY 02, 2023@14:00

```

```

NEW VALUE: MAY 02, 2023@14:01

  Select one of the following:

      DE      Data entry error
      ADM     Administrative
      ID      Mistaken patient ID
      PT      Patient corrected
      OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: testing

```

Figure 4-103: Edit ER VISITS (UP)–Triage Information (2)–Updating the Initial ED Provider Medical Screening Exam Time

8. At the “Enter the decision to admit date/time” prompt, press **Enter** to accept the displayed value or enter in the correct value. If the value is updated, enter the **PRIMARY REASON FOR CHANGE** and a **Comment** (Figure 4-104).

```

Enter the decision to admit date/time: t-1@1500 (MAY 02, 2023@15:00)

EDIT DATE: MAY 03, 2023

EDIT TIME: 09:39:16

FIELD NAME BEING EDITED: DECISION TO ADMIT DT

OLD VALUE:

NEW VALUE: MAY 02, 2023@15:00

  Select one of the following:

      DE      Data entry error
      ADM     Administrative
      ID      Mistaken patient ID
      PT      Patient corrected
      OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// ot Other
Comment: testing

```

Figure 4-104: Edit ER VISITS (UP)–Triage Information (2)–Updating the decision to admit date/time

9. At the “Edit more TRIAGE data” prompt, enter **YES** or **NO**. If **YES**, at the “Enter the Emergency Severity Index Assessment” prompt, press **Enter** to accept the displayed value or enter in the correct value. If the value is updated, enter the **PRIMARY REASON FOR CHANGE** and a **Comment** (Figure 4-105).

```

ERS PCC Data Entry is complete for this option
Edit more TRIAGE data? NO// YES
Enter the Emergency Severity Index assessment: (1-5): 4// 3

EDIT DATE: MAY 03, 2023

```

```

EDIT TIME: 09:43:53
FIELD NAME BEING EDITED: INITIAL ACUITY
OLD VALUE: 4
NEW VALUE: 3

    Select one of the following:

        DE      Data entry error
        ADM     Administrative
        ID      Mistaken patient ID
        PT      Patient corrected
        OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: testing

```

Figure 4-105: Edit ER VISITS (UP)–Triage Information (2)–Updating the Emergency Severity Index Assessment

10. At the “Was this ER visit WORK-RELATED?” prompt, press **Enter** to accept the displayed value or enter in the correct value. If the value is updated, enter the **PRIMARY REASON FOR CHANGE** and a **Comment** (Figure 4-106).

```

Enter the Emergency Severity Index assessment: (1-5): 3// <enter>
Was this ER visit WORK-RELATED? NO// YES

EDIT DATE: MAY 03, 2023
EDIT TIME: 09:45:59
FIELD NAME BEING EDITED: WORK RELATED
OLD VALUE: NO
NEW VALUE: YES

    Select one of the following:

        DE      Data entry error
        ADM     Administrative
        ID      Mistaken patient ID
        PT      Patient corrected
        OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// de Data entry error
Comment: testing

```

Figure 4-106: Edit ER VISITS (UP)–Triage Information (2)–Was this ER visit WORK-RELATED information

This completes the procedure for editing triage information. You may now select another editing function or exit the **UP** option.

### 4.13.5 Injury Info (3)

The **Injury Info (3)** option enables you to edit the injury information of an ER visit. The actual process can vary, depending on the patient record and your responses to the prompts.

**WARNING:** Be aware that changing the patient’s name can also change the chart number, age, and other fields, which then creates a new PCC visit. The original information stays in the database until it is marked deleted.

**Note:** If you change any admission summary information, the system prompts for a **Primary Reason for Change** code. You must enter one of the codes. You can also add an explanation at the “Comment” prompt.

To edit information about a patient’s injury:

1. Select a **visit date** and **patient**, as described in Section 4.13.1.
2. At the “Enter Number of Section to Edit” prompt, type **3**. The system displays the following warning (Figure 4-107):

```

~~~~~
**Setting the following field to No will cause all injury data to be deleted*
    
```

Figure 4-107: Edit ER VISITS (UP)–Injury Info (3)

3. At the “Was this ER visit caused by an injury?” prompt, press **Enter** to accept the default and go to Step 5 or type **NO** or **YES** to change the cause for the visit. If you change the response:
  - At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - Enter additional information at the “Comment” prompt, if necessary (Figure 4-108).

```

Was this ER visit caused by an injury? NO// YES

EDIT DATE: MAY 03, 2023

EDIT TIME: 10:02:16

FIELD NAME BEING EDITED: INJURED

OLD VALUE: NO

NEW VALUE: YES

    Select one of the following:
    
```

```

DE          Data entry error
ADM         Administrative
ID         Mistaken patient ID
PT         Patient corrected
OT         Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: TESTING

```

Figure 4-108: Edit ER VISITS (UP)–Injury Info (3)–Updating Was this ER visit caused by an Injury information

4. At the “Cause of injury” prompt, press **Enter** to accept the displayed value or enter the **correct value** for the visit. If you change the response:
  - At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - Enter additional information at the “Comment” prompt, if necessary (Figure 4-109).

```

**Changing this Cause of Injury value can cause injury data to be deleted**
*Cause of injury: BALLOON

1  V96.04XS Balloon fire injuring occupant, sequela
2  V96.01XS Balloon crash injuring occupant, sequela
3  V96.03XS Balloon collision injuring occupant, sequela
4  V96.05XS Balloon explosion injuring occupant, sequela
5  V96.04XA Balloon fire injuring occupant, initial encounter
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 2

EDIT DATE: MAY 03, 2023

EDIT TIME: 10:05:13

FIELD NAME BEING EDITED: CAUSE OF INJURY

OLD VALUE:

NEW VALUE: Balloon crash injuring occupant, sequela

    Select one of the following:

DE          Data entry error
ADM         Administrative
ID         Mistaken patient ID
PT         Patient corrected
OT         Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: TESTING

```

Figure 4-109: Edit ER VISITS (UP)–Injury Info (3)–Updating the Cause of injury

5. At the “\*Setting of accident/injury” prompt, press **Enter** to accept the displayed value or enter the **correct value** for the visit. If you change the response:
  - At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - Enter additional information at the “Comment” prompt, if necessary (Figure 4-110).

```

*Setting of accident/injury: ?
Answer with ER OPTIONS NAME
Do you want the entire ER OPTIONS List? y (Yes)
Choose from:
HIGHWAY OR ROAD
HOME
INDUSTRIAL PLACE
MINE/QUARRY
OTHER SCENE OF INJURY
PUBLIC BUILDING
RANCH OR FARM
RECREATIONAL/SPORT PLACE
RESIDENTIAL INSTITUTION
UNSPECIFIED

*Setting of accident/injury: RECREATIONAL/SPORT PLACE

EDIT DATE: MAY 03, 2023
EDIT TIME: 10:10:22
FIELD NAME BEING EDITED: SCENE OF INJURY
OLD VALUE:
NEW VALUE: RECREATIONAL/SPORT PLACE

Select one of the following:

DE      Data entry error
ADM     Administrative
ID      Mistaken patient ID
PT      Patient corrected
OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: TESTING

```

Figure 4-110: Edit ER VISITS (UP)–Injury Info (3)–Updating the Setting of Accident/Injury

6. At the “\*Safety equipment used” prompt, press **Enter** to accept the displayed value or enter the **correct value** for the visit. If you change the response:
  - At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - Enter additional information at the “Comment” prompt, if necessary (Figure 4-111).

```

*Safety equipment used: HELMET
EDIT DATE: MAY 03, 2023
EDIT TIME: 10:12:47
FIELD NAME BEING EDITED: SAFETY EQUIPMENT
OLD VALUE:
NEW VALUE: HELMET

    Select one of the following:

        DE      Data entry error
        ADM     Administrative
        ID      Mistaken patient ID
        PT      Patient corrected
        OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: TESTING

```

Figure 4-111: Edit ER VISITS (UP)–Injury Info (3)–Updating the Safety equipment used

7. At the “\*Enter the exact time and date of injury” prompt, press **Enter** to accept the displayed value or enter the **correct value** for the visit. If you change the response:
  - At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - Enter additional information at the “Comment” prompt, if necessary (Figure 4-112).

```

*Enter the exact time and date of injury: t-5@1200 (APR 28, 2023@12:00)
EDIT DATE: MAY 03, 2023
EDIT TIME: 10:15:22
FIELD NAME BEING EDITED: TIME OF INJURY
OLD VALUE:
NEW VALUE: APR 28, 2023@12:00

    Select one of the following:

        DE      Data entry error
        ADM     Administrative
        ID      Mistaken patient ID
        PT      Patient corrected
        OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// de Data entry error
Comment: testing

```

Figure 4-112: Edit ER VISITS (UP)–Injury Info (3)–Updating the exact time and date of injury

8. At the “Town/village where injury occurred” prompt, press **Enter** to accept the displayed value or enter the **correct value** for the visit. If you change the response:
  - At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - Enter additional information at the “Comment” prompt, if necessary (Figure 4-113).

```
Town/village where injury occurred: injury town
EDIT DATE: MAY 03, 2023
EDIT TIME: 10:17:42
FIELD NAME BEING EDITED: TOWN OF INJURY
OLD VALUE:
NEW VALUE: injury town

    Select one of the following:

        DE      Data entry error
        ADM     Administrative
        ID      Mistaken patient ID
        PT      Patient corrected
        OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: testing
```

Figure 4-113: Edit ER VISITS (UP)–Injury Info (3)–Updating the Town/village where injury occurred

9. At the “Location of MVC (if applicable)” prompt, press **Enter** to accept the displayed value or enter the **correct value** for the visit. If you change the response:
  - At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - Enter additional information at the “Comment” prompt, if necessary (Figure 4-114).

```
Location of MVC (if applicable): MVC location
EDIT DATE: MAY 03, 2023
EDIT TIME: 10:20:27
FIELD NAME BEING EDITED: EXACT MVC LOCATION
OLD VALUE:
```

```

NEW VALUE: MVC location

  Select one of the following:

      DE      Data entry error
      ADM     Administrative
      ID      Mistaken patient ID
      PT      Patient corrected
      OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: testing

```

Figure 4-114: Edit ER VISITS (UP)–Injury Info (3)–Updating the Location of MVC

10. At the remaining “driver’s insurance” and “owner’s insurance” prompts, press **Enter** to accept the displayed value or enter the correct value for the visit. If you change the response:
- At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - Enter additional information at the “Comment” prompt, if necessary (Figure 4-115).

```

Driver's insurance company (if applicable): <enter>
Driver's insurance policy number (if applicable): <enter>
Owner of vehicle, if different than driver (if applicable): <enter>
Owner's insurance company (if applicable): <enter>
Owner's insurance policy number (if applicable): <enter>

```

Figure 4-115: Edit ER VISITS (UP)–Injury Info (3)–Updating the driver and owner insurance

This completes the procedure for editing injury information. You may now select another editing function or exit the **UP** option.

#### 4.13.6 Procedures (4)

The **Procedures (4)** option enables you to edit information about procedures performed on a specific patient. The actual process can vary, depending on the patient record and your responses to the prompts.

**WARNING:** Be aware that changing the patient’s name can also change the chart number, age, and other fields, which then creates a new PCC visit. The original information stays in the database until it is marked deleted.

**Note:** If you change any admission summary information, the system prompts for a **Primary Reason for Change** code. You must enter one of the codes. You can also add an explanation at the “Comment” prompt.

To edit procedural information:

1. Select a **visit date** and **patient**, as described in Section 4.13.1.
2. At the “Enter Number of Section to Edit” prompt, type **4**.
3. A list of current procedures for the patient will display. If the patient does not have any procedures, they will have the default procedure of NONE entered. If a new procedure is going to be added and **NONE** is on file the **NONE** procedure must first be removed.
4. To remove **NONE**, type **NONE** at the “Enter another procedure” prompt.
5. At the “Delete this procedure?” Prompt type **YES**.
6. Enter a **PRIMARY REASON FOR CHANGE** value and a **Comment** value (Figure 4-116).

```

ENTER NUMBER OF SECTION TO EDIT (OR '<return>' TO QUIT): 4 PROCEDURES
~~~~~
The following procedure(s) have been entered:

NONE

Enter another procedure: NONE
Delete this procedure? ? NO// YES

EDIT DATE: MAY 03, 2023

EDIT TIME: 10:56:29

FIELD NAME BEING EDITED: PROCEDURE

OLD VALUE: NONE

NEW VALUE:

    Select one of the following:

        DE      Data entry error
        ADM      Administrative
        ID      Mistaken patient ID
        PT      Patient corrected
        OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: TESTING

```

Figure 4-116: Edit ER VISITS (UP)–Procedures (4)–Deleting the NONE procedure

7. To enter an additional procedure, at the “Enter another procedure:” prompt, type the **name** of a new procedure or **?** to see a list of valid procedures.
8. Enter a **PRIMARY REASON FOR CHANGE** value and a **Comment** value (Figure 4-117).

```

Enter another procedure: ?
Answer with ER OPTIONS NAME
Do you want the entire ER OPTIONS List? y (Yes)
Choose from:
ARTHROCENTESIS
BLOOD TRANSFUSION
CASTING AND SPLINTING
CATHETERIZATION, URETHRAL
CENTRAL VENOUS CATHETERIZATION
CHEST TUBE INSERTION
CODE BLUE
CULDOCENTESIS
CURRETTAGE OF UTERUS
CUTDOWN, VENOUS
DEFIBRILLATION/CARDIOVERSION
DRESSING CHANGE
EAR IRRIGATION
EKG
ENDOTRACHEAL INTUBATION
GASTRIC LAVAGE
INCISION AND DRAINAGE
INTRAVENOUS FLUIDS
LUMBAR PUNCTURE
NASAL PACKING
NASOGASTRIC INTUBATION
NONE
PARACENTESIS
REDUCTION DISLOCATION/FRACTURE
SIGMOIDOSCOPY
SUTURING
THORACENTESIS
WOUND IRRIGATION

Enter another procedure: DRESSING CHANGE

EDIT DATE: MAY 03, 2023

EDIT TIME: 11:03:28

FIELD NAME BEING EDITED: PROCEDURE

OLD VALUE:

NEW VALUE: DRESSING CHANGE

    Select one of the following:

        DE      Data entry error
        ADM     Administrative
        ID      Mistaken patient ID
        PT      Patient corrected
        OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: TESTING

```

Figure 4-117: Edit ER VISITS (UP)–Procedures (4)–Adding a new procedure

This completes the procedure for editing injury information. You may now select another editing function or exit the **UP** option.

### 4.13.7 Diagnoses (5)

The **Diagnoses (5)** option has been disabled. To modify patient Diagnosis information, use the PV mnemonic found in the **PCC Date Entry Module Modify Data** option.

### 4.13.8 Exit Assessment (6)

The Exit Assessment (6) option enables you to change the exit assessment information.

**WARNING:** Be aware that changing the patient's name can also change the chart number, age, and other fields, which then creates a new PCC visit. The original information stays in the database until it is marked deleted.

**Note:** If you change any admission summary information, the system prompts for a **Primary Reason for Change** code. You must enter one of the codes. You can also add an explanation at the "Comment" prompt.

To edit an exit assessment:

1. Select a **visit date** and **patient**, as described in Section 4.13.1.
2. At the "Enter Number of Section to Edit" prompt, type **6**.
3. At the "Enter final acuity assessment from provider" prompt, press **Enter** to accept the default or type the **number** of the final acuity assessment.

**Note:** Each site determines the numeric range and the meaning of the acuity assessment values.

If you change the final acuity assessment:

- At the "PLEASE ENTER A PRIMARY REASON FOR CHANGE" prompt, type the **code** that matches your reason for the update.
  - Enter additional information at the "Comment" prompt, if necessary.
4. If you edit this information, the system displays messages similar to the following example (Figure 4-118):

```
ENTER NUMBER OF SECTION TO EDIT (OR '<return>' TO QUIT): 6 EXIT ASSESSMENT
~~~~~
Enter final acuity assessment from provider: (1-5): 1// 2
EDIT DATE: MAY 03, 2023
```

```

EDIT TIME: 11:13:04

FIELD NAME BEING EDITED: FINAL ACUITY

OLD VALUE: 1

NEW VALUE: 2

    Select one of the following:

        DE      Data entry error
        ADM     Administrative
        ID      Mistaken patient ID
        PT      Patient corrected
        OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: TESTING

```

Figure 4-118: Edit ER VISITS (UP)–Exit Assessment (6)–Entering the final acuity assessment from provider

- At the “Disposition: Transfer to Another Facility” prompt, press **Enter** to accept the displayed information or type the **correct disposition**.

If you change the disposition:

- At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
- Enter additional information at the “Comment” prompt, if necessary (Figure 4-119).

```

Disposition: TRANSFER TO ANOTHER FACILITY// ?
Answer with ER OPTIONS NAME
Do you want the entire ER OPTIONS List? y (Yes)
Choose from:
ADMIT
AMA
CLINIC
ELOPED
EXPIRED
HOME
LEFT AFTER INSURANCE DENIAL
LEFT WITHOUT BEING DISCHARGED
LEFT WITHOUT BEING SEEN
OBSERVATION
POLICE CUSTODY
REGISTERED IN ERROR
TRANSFER TO ANOTHER FACILITY

Disposition: TRANSFER TO ANOTHER FACILITY// ADMIT

EDIT DATE: MAY 03, 2023

EDIT TIME: 11:18:55

FIELD NAME BEING EDITED: DISPOSITION

```

```

OLD VALUE: TRANSFER TO ANOTHER FACILITY
NEW VALUE: ADMIT

  Select one of the following:

      DE      Data entry error
      ADM     Administrative
      ID     Mistaken patient ID
      PT     Patient corrected
      OT     Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: TESTING

```

Figure 4-119: Edit ER VISITS (UP)–Exit Assessment (6)–Entering the Disposition

This completes the procedure for editing exit assessment information. You may now select another editing function or exit the **UP** option.

### 4.13.9 Discharge Info (7)

The **Discharge Info (7)** option enables you to edit discharge information.

**WARNING:** Be aware that changing the patient’s name can also change the chart number, age, and other fields, which then creates a new PCC visit. The original information stays in the database until it is marked deleted.

**Note:** If you change any admission summary information, the system prompts for a **Primary Reason for Change** code. You must enter one of the codes. You can also add an explanation at the “Comment” prompt.

To edit discharge information:

1. Select a **visit date** and **patient**, as described in Section 4.13.1.
2. At the “ENTER NUMBER OF SECTION TO EDIT” prompt, type **7**.
3. At the “(PRIMARY) Provider who signed PCC form” prompt, press **Enter** to accept the displayed information or type the **name** of a new provider. If you change the provider:
  - At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - Enter additional information at the “Comment” prompt, if necessary (Figure 4-120).

```

ENTER NUMBER OF SECTION TO EDIT (OR '<return>' TO QUIT): 7 DISCHARGE INFO

```

```

~~~~~
*(PRIMARY)Provider who signed PCC form: : TEST,PROVIDER FOUR// TEST, PROVIDER FIVE
  BAU
EDIT DATE: MAY 03, 2023
EDIT TIME: 11:23:13
FIELD NAME BEING EDITED: DISCHARGE PROVIDER
OLD VALUE: TEST,PROVIDER FOUR
NEW VALUE: TEST,PROVIDER FIVE

  Select one of the following:

      DE      Data entry error
      ADM     Administrative
      ID      Mistaken patient ID
      PT      Patient corrected
      OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: TESTING

```

Figure 4-120: Edit ER VISITS (UP)–Discharge Info (7)–Updating the (PRIMARY) Provider who signed PCC form

4. At the “Discharge nurse” prompt, press **Enter** to accept the displayed information, or type the **name** of the correct Discharge nurse.

If you change the discharge nurse:

- At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
- **Enter** additional information at the “Comment” prompt, if necessary (Figure 4-121).

```

Discharge nurse: : TEST,PROVIDER ONE// TEST,NURSE THREE      TRN      STUDE
NT
EDIT DATE: MAY 03, 2023
EDIT TIME: 11:27:40
FIELD NAME BEING EDITED: DISCHARGE NURSE
OLD VALUE: TEST,PROVIDER ONE
NEW VALUE: TEST,NURSE THREE

  Select one of the following:

      DE      Data entry error
      ADM     Administrative
      ID      Mistaken patient ID
      PT      Patient corrected
      OT      Other

```

```
PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: TESTING
```

Figure 4-121: Edit ER VISITS (UP)–Discharge Info (7)–Updating the Discharge nurse

- At the “\*What time did the patient depart from the ER” prompt, press **Enter** to accept the displayed information, or type a new **date, time, or both**.

If you change the date and/or time:

- At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
- Enter additional information at the “Comment” prompt, if necessary (Figure 4-122).

```
*What time did the patient depart from the ER: MAY 2,2023@15:35// 5/2@1540 (MAY 02, 2023@15:40)

EDIT DATE: MAY 03, 2023

EDIT TIME: 11:30:33

FIELD NAME BEING EDITED: DEPARTURE TIME

OLD VALUE: MAY 02, 2023@15:35

NEW VALUE: MAY 02, 2023@15:40

    Select one of the following:

        DE      Data entry error
        ADM      Administrative
        ID       Mistaken patient ID
        PT       Patient corrected
        OT       Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// PT Patient corrected
Comment: TESTING
```

Figure 4-122: Edit ER VISITS (UP)–Discharge Info (7)–Updating the time that the patient departed from the ER

This completes the procedure for editing discharge information. You may now select another editing function or exit the **UP** option.

#### 4.13.10 Follow Up Instructions (8)

The **Follow Up Instructions (8)** option enables you to edit follow-up instructions.

**WARNING:** Be aware that changing the patient’s name can also change the chart number, age, and other fields, which then creates a new PCC visit. The original information stays in the database until it is marked deleted.

**Note:** If you change any admission summary information, the system prompts for a **Primary Reason for Change** code. You must enter one of the codes. You can also add an explanation at the “Comment” prompt.

To edit follow-up instructions:

1. Select a **visit date** and **patient**, as described in Section 4.13.1.
2. At the “ENTER NUMBER OF SECTION TO EDIT” prompt, type **8**.
3. At the “\*Follow up instructions” prompt, press **Enter** to accept the default or type the new follow-up instructions. If you change the follow-up instructions:
  - At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.
  - Enter additional information at the “Comment” prompt, if necessary (Figure 4-123).

```

~~~~~
Select one of the following:

    1      RTC PRN, INSTRUCTIONS GIVEN
    2      APPT AND INSTRUCTIONS GIVEN
    3      REF MADE, INSTRUCTIONS GIVEN

Follow up instructions: RTC PRN, INSTRUCTIONS GIVEN// 2 APPT AND INSTRUCTIONS G
IVEN

EDIT DATE: MAY 03, 2023

EDIT TIME: 11:35:12

FIELD NAME BEING EDITED: DISCHARGE INSTRUCTIONS

OLD VALUE: RTC PRN, INSTRUCTIONS GIVEN

NEW VALUE: APPT AND INSTRUCTIONS GIVEN

Select one of the following:

    DE      Data entry error
    ADM     Administrative
    ID      Mistaken patient ID
    PT      Patient corrected
    OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: testing

```

Figure 4-123: Edit ER VISITS (UP)–Follow Up Instructions (8)–Change the follow up instructions

This completes the procedure for editing discharge information. You may now select another editing function or exit the **UP** option.

### 4.13.11 ER Consultants (9)

The **ER Consultants (9)** option enables you to edit the name of the ER consultant.

**WARNING:** Be aware that changing the patient's name can also change the chart number, age, and other fields, which then creates a new PCC visit. The original information stays in the database until it is marked deleted.

**Note:** If you change any admission summary information, the system prompts for a **Primary Reason for Change** code. You must enter one of the codes. You can also add an explanation at the **Comment** prompt.

To edit the name of the ER consultant:

1. Select a **visit date** and **patient**, as described in Section 4.13.1.
2. At the “ENTER NUMBER OF SECTION TO EDIT” prompt, type **9**.
  - The system displays the types of consultants that attended the selected patient on the selected date, for example the following visit has one consultant defined for the visit (Figure 4-124):

```

ENTER NUMBER OF SECTION TO EDIT (OR '<return>' TO QUIT): 9 ER CONSULTANTS
~~~~~
The following ER CONSULTANT types and times have been entered
PHYSICAL THERAPY @ MAY 02, 2023@16:00 TEST, PROVIDER FIVE
Edit/Enter ER CONSULTANT TYPE:

```

Figure 4-124: Edit ER VISITS (UP)–ER Consultants (9)–Visit showing one ER Consultant currently entered

3. At the “Edit/Enter ER CONSULTANT TYPE” prompt, press **Enter** to return to the **UP** menu or select a **consultant type** from the list.

**Note:** Each site determines its consultant types. A patient visit can have several consultants; however, these consultants cannot be the same consultant type. If you attempt to add another consultant to a consultant type that was already used, the following message is displayed: **Do you want to delete this ER CONSULTANT?**

If you edit/enter an **ER CONSULTANT TYPE**:

- At the “PLEASE ENTER A PRIMARY REASON FOR CHANGE” prompt, type the **code** that matches your reason for the update.

- Enter additional information at the “Comment” prompt, if necessary (Figure 4-125).

```

Edit/Enter ER CONSULTANT TYPE: ?
Answer with ER CONSULTANT TYPE NAME
Do you want the entire ER CONSULTANT TYPE List? y (Yes)
Choose from:
ANESTHESIOLOGY
AUDIOLOGIST
DENTAL
DIABETIS&METABOLISM
FAMILY PRACTICE
INFECTIOUS DISEASE
INTERNAL MEDICINE
MENTAL HEALTH
NEUROLOGY
OBSTETRICS & GYNECOLOGY
OPHTHALMOLOGY
OPTOMETRY
ORTHOPEDIC
OTOLARYNGOLOGY
PEDIATRICS
PHYSICAL THERAPY
PODIATRY
PSYCHIATRIC
PSYCHIATRIC-CHILD&FAMILY
PSYCHOLOGY
PULMONARY DISEASE
RADIOLOGY
SOCIAL WORKER
SURGEON - OTHER
UROLOGY
WOUND CARE NURSE SPECIALIST

Edit/Enter ER CONSULTANT TYPE: FAMILY PRACTICE

EDIT DATE: MAY 03, 2023

EDIT TIME: 11:47:05

FIELD NAME BEING EDITED: ER CONSULTANTS

OLD VALUE:

NEW VALUE: FAMILY PRACTICE

    Select one of the following:

        DE      Data entry error
        ADM     Administrative
        ID      Mistaken patient ID
        PT      Patient corrected
        OT      Other

PLEASE ENTER A PRIMARY REASON FOR CHANGE: ADM// <enter> Administrative
Comment: TESTING

```

Figure 4-125: Edit ER VISITS (UP)–ER Consultants (9)–Entering a new ER CONSULTANT TYPE

4. At the “Date and time of ER CONSULTANT” prompt, press **Enter** to accept the displayed information, or type a new date, time, or both.
5. At the “ER CONSULTANT Name” prompt, enter the new **consultant’s name** (Figure 4-126).

```

Date and time of ER CONSULTANT:  T-1@1554  (MAY 02, 2023@15:54)
ER CONSULTANT Name:  TEST, PROV
1  TEST, PROVIDER FIVE          BAU
2  TEST, PROVIDER FOUR         KB
3  TEST, PROVIDER ONE          ALT          HEALTH SYST. SPEC.
4  TEST, PROVIDER THREE        BAK
5  TEST, PROVIDER TWO          AMU
CHOOSE 1-5:  5  TEST, PROVIDER TWO          AMU

```

Figure 4-126: Edit ER VISITS (UP)–ER Consultants (9)–Entering a new Date and time of ER CONSULTANT and ER CONSULTANT Name

This completes the procedure for editing consultant types and names. You may now select another editing function or exit the **UP** option.

#### 4.13.12 All (10)

The **ALL (10)** option enables you to change any or all information about a specific patient. Be aware that all changes you make are tracked and you are identified as the person who made the change.

#### 4.13.13 Exiting UP

When you exit from the **UP menu** option, some data points that were changed in ERS will be compared against PCC. If there are differences between ERS and PCC, the user is prompted to specify which set of data should be corrected.

At the “Which would you like to do” prompt:

- Selecting **1** will change PCC data so that it matches that in ERS.
- Selecting option **2** will change ERS data so that it matches that in PCC, for example.

## 5.0 Standard Nurse/Provider Entry

With the AMER v3.0 p13 release, sites now have the ability to enter multiple triage nurses, triage providers, primary nurses and ED providers. Each of these nurse/provider types uses a similar method to enter/edit/remove information. The following instructions describe how to enter/edit/remove multiple triage nurse and triage nurse date/time values. The same instructions can be followed to enter/edit/remove multiple triage providers, primary nurses and ED providers.

### 5.1 Entering New Triage Nurse Information

A new triage nurse can be entered by following these instructions:

1. From the “Triage Nurse” prompt, type the name of the triage nurse (Figure 5-1).

```
ER ADMISSION FOR DEMO,PATIENT ONE      ^ = back up      ^^ = quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~
TRIAGE NURSE ENTRY
~~~~~
Triage nurse: TEST,NURSE ONE          TRN
```

Figure 5-1: Entering New Triage Nurse Information—Enter the Triage nurse name

- You can also enter a “?” at the “Triage nurse” prompt and then type **YES** at the “Do you want the entire NEW PERSON List?” prompt to see a list of allowable nurses/providers (Figure 5-2).

```
Triage nurse: ?
Answer with NEW PERSON NAME, or INITIAL, or SSN, or VERIFY CODE, or
NICK NAME, or SERVICE/SECTION, or DEA#, or VA#, or CODE, or
IHS LOCAL CODE, or IHS ADC INDEX, or ALIAS, or NPI
Do you want the entire NEW PERSON List? Y (Yes)
Choose from:
DEMO,B MD          ABB          DENTIST
DEMO,J MD          ABB          PHYSICIAN
DEMO,ARLIS L      ALA
DEMO,ADAM          AA          119     SYSTEMS ANALYST
DEMO,JOSEPH       AHL          PHYSICIAN
DEMO,KIM           AHL
DEMO,JOSEPHINE    AHS

DEMO,KELVIN N     ARU
DEMO,MICHAEL      ARU
```

Figure 5-2: Entering New Triage Nurse Information—Displaying a list of all nurses/providers

- If **NO** is entered at the “Do you want the entire NEW PERSON List?” prompt, a “Would you like to see a list of nurses assigned to the ED?” prompt will display. Entering **YES** will display a list of all users who hold the **AMERZNURSE** security key (Figure 5-3).

```

Triage nurse: ?
  Answer with NEW PERSON NAME, or INITIAL, or SSN, or VERIFY CODE, or
  NICK NAME, or SERVICE/SECTION, or DEA#, or VA#, or CODE, or
  IHS LOCAL CODE, or IHS ADC INDEX, or ALIAS, or NPI
Do you want the entire NEW PERSON List? NO (No)

Would you like to see a list of nurses assigned to the ED? YES// <enter>

NURSE                               INI      TITLE
-----
TEST,NURSE FIVE                     BOW
TEST,NURSE FOUR                      BAU
TEST,NURSE ONE                       TRN      STUDENT
TEST,NURSE THREE                     TRN      STUDENT
TEST,NURSE TWO                       TRN      STUDENT
Enter RETURN to continue or '^' to exit:

Triage nurse:
    
```

Figure 5-3: Entering New Triage Nurse Information–Displaying a list of all nurses with the AMERZNURSE security key

**Note:** For provider related fields a list of all users holding the AMERZPROVIDER security key will be displayed.

- After entering a triage nurse at the “\*Enter the date/time that this patient was seen” prompt (Figure 5-4) enter the date/time that the patient saw this triage nurse. The default date/time will be the current date/time.

```
*Enter the date/time that this patient was seen: 04/28/23@15:39// <enter>
```

Figure 5-4: Entering New Triage Nurse Information–Entering the date/time the patient was seen

- The **TRIAGE NURSE ENTRY** information will now display with the added information (Figure 5-5).

```

ER ADMISSION FOR DEMO,PATIENT ONE      ^ = back up      ^^ = quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

TRIAGE NURSE ENTRY

Current entry/entries on file for visit:

#      Nurse/Provider                      Date/Time Seen
-----
1      TEST,NURSE ONE                       04/28/23@15:39
    
```

```
(A)dd new, (E)dit existing, (D)elete existing Triage nurse:
```

Figure 5-5: Entering New Triage Nurse Information–Display of the TRIAGE NURSE ENTRY Information

## 5.2 Entering Additional Triage Nurse Information

Additional triage nurses can be entered for a patient visit. To add another triage nurse, enter “A” at the “(A)dd new, (E)dit existing, (D)elete existing Triage nurse” prompt (Figure 5-6). You will then be prompted to enter an additional triage nurse and the date/time that they were seen.

```
(A)dd new, (E)dit existing, (D)elete existing Triage nurse:
```

Figure 5-6: Entering New Triage Nurse Information–Entering Additional Triage Nurse Information

## 5.3 Editing an Existing Triage Nurse Date/Time Seen

To edit an existing triage nurse date/time seen information follow these instructions:

1. Enter **E** at the “(A)dd new, (E)dit existing, (D)elete existing Triage nurse” prompt (Figure 5-7).
2. You will then be prompted to **Enter the entry # to edit**.
3. The selected triage nurse’s **current date/time seen** information is displayed and the user can change the value to a new date/time seen (Figure 5-7).

```
ER ADMISSION FOR DEMO,PATIENT ONE      ^ = back up      ^^ = quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

TRIAGE NURSE ENTRY

Current entry/entries on file for visit:

#      Nurse/Provider                      Date/Time Seen
-----
1      TEST,NURSE ONE                      04/28/23@15:39

(A)dd new, (E)dit existing, (D)elete existing Triage nurse: Edit
Enter the entry # to edit: : (1-1): 1

Triage nurse: TEST,NURSE ONE

*Enter the date/time that this patient was seen: 04/28/23@15:39//
```

Figure 5-7: Entering New Triage Nurse Information–Editing an existing triage nurse date/time seen

**Note:** Only the date/time seen by the triage nurse can be edited.  
To change the triage nurse name, remove the existing entry  
and add a new entry with the correct triage nurse name.

## 5.4 Deleting an Existing Triage Nurse

To delete an existing triage nurse entry follow these instructions:

1. Enter **D** at the “(A)dd new, (E)dit existing, (D)elete existing Triage nurse” prompt (Figure 5-8).
2. You will then be prompted to **Enter the entry # to edit**.
3. The selected triage nurse’s **current date/time seen** information will be displayed and the user can change the value to a new date/time seen (Figure 5-8).
4. At the “Are you sure you want to remove this entry” prompt, enter **YES** to remove the entry.

```

ER ADMISSION FOR DEMO,PATIENT ONE      ^ = back up      ^^ = quit
Questions preceded by a '*' are MANDATORY.  Enter '??' to see choices.
~~~~~

TRIAGE NURSE ENTRY

Current entry/entries on file for visit:

#      Nurse/Provider                      Date/Time Seen
-----
1      TEST,NURSE ONE                      04/28/23@15:39

(A)dd new, (E)dit existing, (D)elete existing Triage nurse: Delete
Enter the entry # to delete: : (1-1): 1
Are you sure you want to remove this entry: ? NO// YES

```

Figure 5-8: Entering New Triage Nurse Information–Deleting an existing triage nurse entry

## 6.0 ERS/PIMS Scheduling Interface

The following example provides instructions for setting up an ERS/PIMS scheduling interface. In this example:

- Emergency Room clinic hours are Monday through Friday from 6am to 8pm and Saturday 8am to Noon, with five appointments available for each 15-minute interval.
- Appointment lengths are variable and can be increased in multiples of 15 minutes.

Use this example to create your interface based on your site's parameters.

Modifying PIMS Scheduling:

1. Access the PIMS Scheduling application (Figure 6-1).

```
Select IHS Kernel <TEST ACCOUNT> Option: 1 Core Applications

ABM   Third Party Billing System ...
ADT   ADT Menu ...
AG    Patient registration ...
ALL   Adverse Reaction Tracking ...
AMER  Emergency Room System ...
AMH   Behavioral Health Information System ...
ANS   Nursing Acuity System ...
AQAO  QAI MANAGEMENT System Menu ...
ATX   Taxonomy System ...
AWAY  REMOTE LOGIN USER MENU ...
BAR   A/R MASTER MENU ...
BCSV  CSV UPDATE MAIN MENU ...
BDP   Designated Specialty Prov Mgt System ...
BDW   Data Warehouse Export Menu ...
BGP   IHS Clinical Reporting System (CRS) Main Menu ...
BILL  Business Office Master Menu ...
BPM   IHS Patient Merge ...
BVP   View Patient Record
BW    Women's Health Menu ...
BYIM  Immunization Interchange Management Menu ...
CASE  Case Management System ...
CD    Chemical Dependency Menu ...

          Press 'RETURN' to continue, '^' to stop:
CHMS  Contract Health System ...
CHR   Community Health Representative System ...
CMOP  CMOP Site Manager Menu ...
CRED  CREDENTIALS Tracking System ...
DDS   Dental Data System Menu ...
DM    Diabetes Management System ...
EHR   EHR MENU ...
GFM   FileMan (General) ...
GIS   GIS Interface Menu ...
LAB   IHS Short Lab Main Menu ...
LR    Laboratory DHCP Menu ...
MCH   Immunization Menu ...
NDF   National Drug File Menu ...
NUT   Nutrition and Dietetics Menu ...
PCC   Patient Care Component ...
PCCM  PCC Manager Menu ...
```

```

PDM   Pharmacy Data Management ...
PHAR  PHARMACY MENU ...
PIHS  IHS-Specific Pharmacy Options ...
POS   Pharmacy Point of Sale ...
PSM   Outpatient Pharmacy Manager ...
PST   Pharmacy Technician's Menu ...

      Press 'RETURN' to continue, '^' to stop:
PSU   Pharmacist Menu ...
QMAN  Q-Man (PCC Query Utility)
QMON  Q-Man Site Manager's Utilities
RA    Rad/Nuc Med Total System Menu ...
RCIS  Referred Care Information System ...
ROI   RELEASE OF INFORMATION SYSTEM ...
SCH Scheduling Menu ...
SEC   Sensitive Patient Tracking ...
TIUC  TIU Menu for Clinicians ...
TIUM  TIU Menu for Medical Records ...

```

```

You have PENDING ALERTS
      Enter "VA to jump to VIEW ALERTS option

```

```

*****
*          INDIAN HEALTH SERVICE          *
*          CLINIC SCHEDULING SYSTEM      *
*          VERSION 5.3                   *
*****
                2016 DEMO HOSPITAL

```

```

AL    Appointment List
AM    Appointment Management
CR    Chart Requests
CHK   List Patient Check In Status
DA    Display Patient's Appointments
MB    Multiple Appointment Booking
MC    Multiple Clinic Display/Book
MD    Month-at-a-glance Display
PL    Print Scheduling Letters
PS    View Provider's Schedule
WL    Waiting List Enter/Edit
PCP   Primary Care Provider Menu ...
PMR   Patient Mini Registration
SCR   Reports Menu (Scheduling) ...
SCS Supervisor Menu (Scheduling) ...

```

```

You have PENDING ALERTS
      Enter "VA to jump to VIEW ALERTS option

```

```

                Supervisor Menu (Scheduling)

```

```

                (2016 DEMO HOSPITAL)

```

```

ACM   Application Coordinator Menu ...
CPF   Clinic Profile
CRA   Cancel/Restore Clinic Availability
DSU   Display Scheduling User
EEL   Enter/Edit Letters
IWL   Wait List Activate/Inactivate

```





```

AVAILABILITY DATE: 5/5 (MAY 05, 2023)

FRIDAY

TIME: 0600-2000 NO. SLOTS: 1// 5
TIME:
[5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5
|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5]
...PATTERN OK FOR FRIDAYS INDEFINITELY? Y (Yes)
...SORRY, LET ME THINK ABOUT THAT A MOMENT...
PATTERN FILED!
    
```

```

AVAILABILITY DATE: 5/6 (MAY 06, 2023)

SATURDAY

TIME: 0600-2000 NO. SLOTS: 1// 5
TIME:
[5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5
|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5]
...PATTERN OK FOR SATURDAYS INDEFINITELY? Y (Yes)
...EXCUSE ME, HOLD ON...
PATTERN FILED!
    
```

```

AVAILABILITY DATE: 5/7 (MAY 07, 2023)

SUNDAY

TIME: 0600-2000 NO. SLOTS: 1// 5
TIME:
[5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5
|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5]
...PATTERN OK FOR SUNDAYS INDEFINITELY? Y (Yes)
...EXCUSE ME, LET ME PUT YOU ON 'HOLD' FOR A SECOND...
PATTERN FILED!
    
```

```

AVAILABILITY DATE: 5/8 (MAY 08, 2023)

MONDAY

TIME: 0600-2000 NO. SLOTS: 1// 5
TIME:
[5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5
|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5]
...PATTERN OK FOR MONDAYS INDEFINITELY? Y (Yes)
...SORRY, LET ME PUT YOU ON 'HOLD' FOR A SECOND...
PATTERN FILED!
    
```

```

AVAILABILITY DATE: 5/9 (MAY 09, 2023)

TUESDAY

TIME: 0600-2000 NO. SLOTS: 1// 5
TIME:
[5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5
|5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5]
    
```

```
...PATTERN OK FOR TUESDAYS INDEFINITELY? Y (Yes)
...SORRY, JUST A MOMENT PLEASE...
PATTERN FILED!
```

```
AVAILABILITY DATE:
```

Figure 6-1: Defining the PIMS Clinic

## 2. Setting Up ERS Preferences:

- Refer to Section 3.1.5 for information on setting up the ERS Preferences.

## 7.0 Configuring ERS for Sites with Multiple ER/Triage/Urgent Care Departments

### 7.1 Introduction

AMER v3.0 p10 and BEDD v2.0 p3 contained new functionality that allows sites with separate triage areas, urgent care or emergency departments (ED) to better track patient movements. Sites are now able to define a default clinic for patient admission and then transfer patients between Emergency Room (ER) related clinics. This is accomplished by linking ER clinics with Resource and Patient Management System (RPMS) hospital locations. By linking these entities together, patient orders, labs and other information will print to the hospital location associated with the ER clinic.

### 7.2 Original Design

Prior to AMER v3.0 p10/BEDD v2.0 p3, sites only had the ability to link their ER clinics to one hospital location. This was accomplished by entering a hospital location in the WALK-IN CLINIC property in the Facility Parameter setup option (Figure 7-1).

|                                                     |                          |
|-----------------------------------------------------|--------------------------|
| Select OPTION NAME: <b>Facility Parameter setup</b> | Facility Parameter setup |
| Facility Parameter setup                            |                          |
| Select ER PREFERENCES LOCATION:                     | 2016 DEMO HOSPITAL       |
| LOCATION:                                           | 2016 DEMO HOSPITAL//     |
| <b>WALK-IN CLINIC:</b>                              | <b>ED WALK-IN//</b>      |
| LABEL PRINTER NAME:                                 | PER//                    |
| QUEUE LABELS:                                       | YES//                    |
| CHART PRINTER NAME:                                 | PER//                    |
| SEND .9999 CODES TO PCC:                            | YES//                    |

Figure 7-1: Original Facility Parameter Setup Properties

This setup posed a problem for sites that had separate areas for triage, emergency or urgent care. Documents, such as labels, orders and labs, printed off in one location (the hospital location specified as the WALK-IN CLINIC). As these areas are often physically separated from each other, it is sometimes a major inconvenience to require staff to travel back and forth to retrieve the printed patient documents. An additional problem with the original design is that all admissions in AMER were automatically assigned to the Emergency Department clinic. In the BEDD IN option, the default clinic would show as Emergency Department, but sites could change to something else. This limitation made it more tedious for sites that utilized a triage area as users would have to change the clinic in AMER (after admission) or manually change the BEDD IN clinic value for every admission.

## 7.3 Current Design

With the release of AMER v3.0 p10 and BEDD v2.0 p3, sites now have the ability to link their ER clinics to different hospital locations. This is accomplished by populating the ER CLINIC and associated LINK TO HOSPITAL LOCATION fields in the Facility Parameter setup option. Sites also can specify what ER clinic to use as the default clinic by populating the new DEFAULT ER CLINIC field. One final change was to rename the existing WALK-IN CLINIC property to now be called DEFAULT HOSPITAL LOCATION. A display of the current Facility Parameter setup properties is shown here (Figure 7-2).

```
Select Table and Parameter Setup <TEST ACCOUNT> Option: SET Facility Parameter
setup
Select ER PREFERENCES LOCATION:      2016 DEMO HOSPITAL
LOCATION: 2016 DEMO HOSPITAL//
DEFAULT HOSPITAL LOCATION: ED WALK-IN//
LABEL PRINTER NAME: PER//
QUEUE LABELS: YES//
CHART PRINTER NAME: PER//
SEND .9999 CODES TO PCC: YES//
DISABLE TRIAGE PROVIDER ENTRY: NO//
ENABLE AUTOMATIC CHECK-OUT: YES//
Select ER CLINIC: ED MAIN//
  ER CLINIC: ED MAIN//
  LINK TO HOSPITAL LOCATION: ED MAIN//
Select ER CLINIC: TRIAGE
  ...OK? Yes//    (Yes)

  ER CLINIC: TRIAGE//
  LINK TO HOSPITAL LOCATION: TRIAGE//
Select ER CLINIC: URGENT C ARE      80
  ...OK? Yes//    (Yes)

  ER CLINIC: URGENT CARE//
  LINK TO HOSPITAL LOCATION: WALKIN//
Select ER CLINIC: EMERG ENCY MEDICINE  30
  ...OK? Yes//    (Yes)

  ER CLINIC: EMERGENCY MEDICINE//
  LINK TO HOSPITAL LOCATION: ED WALK-IN//
Select ER CLINIC:
DEFAULT ER CLINIC: EMERGENCY MEDICINE//
Select LWOB/DNA DISPOSITIONS: LEFT WITHOUT BEING SEEN
//

Select ER PREFERENCES LOCATION:
```

Figure 7-2: New Facility Parameter Setup Properties

## 7.4 New Configuration Descriptions

As referenced above, the following new properties are now available that sites can use to tailor the Emergency Department software to best meet their specific setup.

### 7.4.1 ER CLINIC/LINK TO HOSPITAL LOCATION

As mentioned in the Section 7.2 Original Design section, sites used to have to point all of their ER clinics to the same hospital location. This design was inconvenient for sites that have separate areas for triage or urgent care that were each capable of printing orders, labs, etc. For sites having setups like this, they can use the ER CLINIC/LINK TO HOSPITAL LOCATION property to assign a separate hospital location, if desired, to each ER clinic. Doing so will allow orders, labs, etc. to be printed off in the area where the patient is physically located. As an example of this new feature, the site has chosen to map their EMERGENCY MEDICINE ER clinic to the ED WALK-IN hospital location, their URGENT CARE ED clinic to the WALKIN hospital location, their ED MAIN clinic to their ED MAIN hospital location and their TRIAGE ED clinic to their TRIAGE hospital location (Figure 7-3). Thus, if a patient has been sent to the URGENT CARE, any orders, labs, etc. for that patient will print off in that hospital location.

```
Select ER CLINIC: EMERGENCY MEDICINE//
ER CLINIC: EMERGENCY MEDICINE//
LINK TO HOSPITAL LOCATION: ED WALK-IN
Select ER CLINIC: URGENT CARE 80
LINK TO HOSPITAL LOCATION: WALKIN
Select ER CLINIC: TRIAGE
LINK TO HOSPITAL LOCATION: TRIAGE
Select ER CLINIC: ED MAIN 30
LINK TO HOSPITAL LOCATION: ED MAIN
Select ER CLINIC:
```

Figure 7-3: Assigning ED Clinics to Separate Hospital Locations

### 7.4.2 New DEFAULT ER CLINIC

Sites can now choose to specify the default ER clinic to admit patients into. This is accomplished by entering the desired ER clinic into the new DEFAULT ER CLINIC property shown (Figure 7-4). This property is especially useful for a site that has a central triage that all patients first enter (and then get later transferred to the emergency department or urgent care).

```
DEFAULT ER CLINIC: EMERGENCY MEDICINE 30
```

Figure 7-4: New DEFAULT ER CLINIC Property

## 7.5 Sample Configurations

The Facility Parameter setup option properties can be adjusted to optimally work for a number of site setups. The following examples provide different setups to demonstrate how these new settings can be utilized.

### 7.5.1 Site with One Emergency Department Area (Combined Triage, Emergency Department or Urgent Care)

For sites that have an emergency department that does not separate out triage, OB triage or urgent care into separate areas and where all printing is done in one central area, the original configuration can be utilized. In this scenario, all ER clinics will map to the hospital location stored in the DEFAULT HOSPITAL LOCATION property. Printing of patient information will occur at the assigned hospital location as well. Refer to Figure 7-5 for an example of this property.

```
Select ER PREFERENCES LOCATION: 2016 DEMO HOSPITAL
LOCATION: 2016 DEMO HOSPITAL//
DEFAULT HOSPITAL LOCATION: ED WALK-IN//
```

Figure 7-5: DEFAULT HOSPITAL LOCATION Use

While not required, sites could also utilize the new ER CLINIC/LINK TO HOSPITAL LOCATION properties to get the same results. In the Facility Parameter setup option, at the “Select ER CLINIC” prompt make sure the ER clinics are all set up to map to the same HOSPITAL LOCATION property. In Figure 7-6, each of the ER clinics has been mapped to the same ED WALK-IN hospital location.

```
Select ER CLINIC: ED MAIN//
ER CLINIC: ED MAIN//
LINK TO HOSPITAL LOCATION: ED WALK-IN//
Select ER CLINIC: URGENT CARE 80
...OK? Yes// (Yes)

ER CLINIC: URGENT CARE//
LINK TO HOSPITAL LOCATION: ED WALK-IN//
Select ER CLINIC: TRIAGE
...OK? Yes// (Yes)

ER CLINIC: TRIAGE//
LINK TO HOSPITAL LOCATION: ED WALK-IN//
Select ER CLINIC:
```

Figure 7-6: Entering ER CLINIC/LINK TO HOSPITAL LOCATION Information

## 7.5.2 Site with Separated (and Distinct) Emergency Department Functional Areas (Separate/Distinct Triage, Emergency Department, or Urgent Care Areas)

Some sites have separated their emergency departments into distinct areas such as a main emergency department, triage area, OB triage or urgent care. Each of the areas have their own hospital locations (defined in the HOSPITAL LOCATION, #44 file), each with designated printers utilized for printing labels, orders, labs, etc. In order to get this information to print to the appropriate printer, links have to be established between the ER clinics and the associated hospital locations. Figure 7-7 shows how to link each ER clinic with a separate hospital location. The figure also shows how a site can set the default clinic that a patient initially gets admitted to (in this case the TRIAGE ER clinic).

```

Select ER PREFERENCES LOCATION: 2016 DEMO HOSPITAL
LOCATION: 2016 DEMO HOSPITAL//
DEFAULT HOSPITAL LOCATION: ED WALK-IN//
LABEL PRINTER NAME: PER//
QUEUE LABELS: YES//
CHART PRINTER NAME: PER//
SEND .9999 CODES TO PCC: YES//
Select ER CLINIC: TRIAGE//
  ER CLINIC: TRIAGE//
  LINK TO HOSPITAL LOCATION: TRIAGE//
Select ER CLINIC: EMERGENCY MEDICINE    30
  ...OK? Yes// (Yes)

  ER CLINIC: EMERGENCY MEDICINE//
  LINK TO HOSPITAL LOCATION: ED WALK-IN//
Select ER CLINIC: URGENT CARE    80
  ...OK? Yes// (Yes)

  ER CLINIC: URGENT CARE//
  LINK TO HOSPITAL LOCATION: WALKIN//
Select ER CLINIC:
DEFAULT ER CLINIC: TRIAGE//

```

Figure 7-7: Setting up the ED to Accommodate Separated Emergency Department Areas

### 7.5.3 Site with Multiple Emergency Department Areas (Two or More Physically Separated Emergency Departments or Other Areas)

Some sites have broken up their emergency departments into separate areas. That is, they may have two or more actual emergency department locations. Since each area is part of the emergency department, they often have HOSPITAL LOCATION entries that share the same STOP CODE NUMBER value – typically EMERGENCY MEDICINE (30). Since the STOP CODE NUMBER is the same value used for the AMER OPTIONS FILE option MNEMONIC field, special mapping has to be done to properly associate the ER clinics with their respective HOSPITAL LOCATION entries. Figure 7-8 shows an example of two ER clinics, both with a MNEMONIC of 30.

```
Select OPTION NAME: AMER OPTIONS FILE  ER Options Transportation-
Disposition-Procedures
ER Options Transportation-Disposition-Procedures

Select ER OPTIONS NAME: EMERGENCY MEDICINE  30
NAME: EMERGENCY MEDICINE//
TYPE: CLINIC TYPE//
BRIEF FORM:
HER VALUE: 4//
ANCILLARY SERVICES:
MNEMONIC: 30//
MAP TO PLACE OF ACCIDENT:
ICD9 CODE:

Select ER OPTIONS NAME: ED MAIN  30
NAME: ED MAIN//
TYPE: CLINIC TYPE//
BRIEF FORM:
HER VALUE:
ANCILLARY SERVICES:
MNEMONIC: 30//
MAP TO PLACE OF ACCIDENT:
ICD9 CODE:
```

Figure 7-8: ED Clinics that Share the Same STOP CODE NUMBER

In order to handle ER clinics with matching MNEMONIC values, ER CLINIC/LINK TO HOSPITAL LOCATION links *must* be defined for each of the ER clinics. This is done the same way that other links are created (refer to Section 7.5.2). ER CLINIC/LINK TO HOSPITAL LOCATION entries must be defined in the Facility Parameter setup option. Refer to Figure 7-9 for an example on how to set up the separate emergency department entries.

```
Select OPTION NAME:  Facility Parameter setup  Facility Parameter setup
Facility Parameter setup

Select ER PREFERENCES LOCATION:  2016 DEMO HOSPITAL
LOCATION: 2016 DEMO HOSPITAL//
DEFAULT HOSPITAL LOCATION: ED WALK-IN//
LABEL PRINTER NAME: PER//
QUEUE LABELS: YES//
CHART PRINTER NAME: PER//
SEND .9999 CODES TO PCC: YES//
Select ER CLINIC: ED MAIN//
  ER CLINIC: ED MAIN//
  LINK TO HOSPITAL LOCATION: ED MAIN//
Select ER CLINIC: EMERGENCY MEDICINE    30
  ...OK? Yes// (Yes)

  ER CLINIC: EMERGENCY MEDICINE//
  LINK TO HOSPITAL LOCATION: ED WALK-IN//
Select ER CLINIC:
DEFAULT ER CLINIC: TRIAGE//
```

Figure 7-9: Sample Scenario with Multiple Emergency Departments

## 8.0 NUBC Disposition Mapping Functionality

The AMER v3.0 p12 and BEDD v2.0 p6 releases contain new functionality that allows sites to map their custom ERS Disposition codes to standard NUBC Discharge Status codes and then report the **NUBC codes** in AMER/BEDD reports.

### 8.1 Defining ERS to NUBC Disposition Mappings

Follow these instructions to map your site's ERS dispositions to the appropriate **NUBC code**.

#### 8.1.1 Display a List of Current ERS Dispositions

The first step in mapping the ERS dispositions is to display a list of the current dispositions that are in use. Figure 8-1 shows how to run a FileMan search to display a list of the ERS dispositions.

```
Select OPTION: 3  SEARCH FILE ENTRIES

OUTPUT FROM WHAT FILE: ER OPTIONS//

-A- SEARCH FOR ER OPTIONS FIELD:      TYPE
-A- CONDITION:      EQUALS
-A- EQUALS ER CATEGORIES:      DISPOSITION

-B- SEARCH FOR ER OPTIONS FIELD:

IF: A//      TYPE EQUALS 19 (DISPOSITION)

STORE RESULTS OF SEARCH IN TEMPLATE:

SORT BY: NAME//
START WITH NAME: FIRST//
FIRST PRINT FIELD: .01 NAME
THEN PRINT FIELD:
Heading (S/C): ER OPTIONS SEARCH//
DEVICE: 0;80;999 VIRTUAL
ER OPTIONS SEARCH                                DEC 14,2021  13:51    PAGE 1
NAME
-----
ADMIT
AMA
CLINIC
ELOPED
EXPIRED
HOME
LEFT AFTER INSURANCE DENIAL
LEFT WITHOUT BEING DISCHARGED
LEFT WITHOUT BEING SEEN
OBSERVATION
POLICE CUSTODY
```

```

REGISTERED IN ERROR
TRANSFER TO ANOTHER FACILITY
TRANSFER TO MAIN HOSPITAL

```

Figure 8-1: Displaying a List of ERS Dispositions

## 8.1.2 Mapping the Current ERS Dispositions

The **AMER ER Options Transportation-Disposition-Procedures (OPT)** option has been updated to allow sites to map their ERS dispositions to **NUBC discharge status codes**. For each ERS disposition identified in Figure 8-1, try to find a suitable **NUBC code** from the list found in Section 8.2.4 to map the disposition to. Once a match has been identified, use the **OPT** option to establish the map as shown in Figure 8-2.

```

*****
*           Facility Setup Menu           *
*           Indian Health Service         *
*           Version 3.0                   *
*****
                2016 DEMO HOSPITAL

CNS   Add/Edit ER CONSULTANT SERVICE list
LOC   Add Local ER Facilities
MGRP  ER Alerts Mail Group Edit
OPT   ER Options Transportation-Disposition-Procedures
SET   Facility Parameter setup
FIX   Run AMER Cleanup Utility

Select Table and Parameter Setup <TEST ACCOUNT> Option: OPT   ER Options
Transportation-Disposition-Procedures

Select ER OPTIONS NAME: POLICE CUSTODY
NAME: POLICE CUSTODY//
TYPE: DISPOSITION//
MAP TO NUBC DISPOSITION: 21           TRANSFERRED COURT/LAW ENFORCE
BRIEF FORM:
HER VALUE:
ANCILLARY SERVICES:
MNEMONIC:
MAP TO PLACE OF ACCIDENT:
ICD9 CODE:

Select ER OPTIONS NAME:

```

Figure 8-2: Mapping ERS Dispositions to NUBC Discharge Status Codes

### 8.1.3 Handling Special Cases

In reviewing your site defined ERS dispositions, you may find that some do not match up to a specific **NUBC code**. For example, in the example shown in Figure 8-1, an ERS disposition of TRANSFER TO ANOTHER FACILITY is defined. The **NUBC codes**, however, are more specific. In order to better document patient visit outcomes therefore, you may want to consider creating new ERS dispositions to reflect the specific transfer type. For example, some facilities may provide services in multiple capacities (general, psychiatric, inpatient rehabilitation, etc.). Instead of having a disposition called TRANSFER TO ST. LUKE for example, it would be more descriptive to create new ERS dispositions such as TRANSFER TO ST. LUKE–MAIN, TRANSFER TO ST. LUKE – PSYCH, and TRANSFER TO ST. LUKE–IRF. As a note, the maximum field length can only be 30 characters so some abbreviations of the text may be necessary. Figure 8-3 shows how to add new ERS dispositions.

```

*****
*           Facility Setup Menu           *
*           Indian Health Service         *
*           Version 3.0                   *
*****
                        2016 DEMO HOSPITAL

CNS   Add/Edit ER CONSULTANT SERVICE list
LOC   Add Local ER Facilities
MGRP  ER Alerts Mail Group Edit
OPT   ER Options Transportation-Disposition-Procedures
SET   Facility Parameter setup
FIX   Run AMER Cleanup Utility

Select Table and Parameter Setup <TEST ACCOUNT> Option: OPT   ER Options
Transportation-Disposition-Procedures

Select ER OPTIONS NAME: TRANSFER TO ST LUKE - MAIN
Are you adding 'TRANSFER TO ST LUKE - MAIN' as
a new ER OPTIONS (the 135TH)? No// Y   (Yes)
ER OPTIONS MNEMONIC:
NAME: TRANSFER TO ST LUKE - MAIN   Replace
TYPE: DISPOSITION
MAP TO NUBC DISPOSITION: 02           TRANSFERRED GEN HOSPITAL
BRIEF FORM:
HER VALUE:
ANCILLARY SERVICES:
MNEMONIC:
MAP TO PLACE OF ACCIDENT:
ICD9 CODE:

Select ER OPTIONS NAME: TRANSFER TO ST LUKE - PSYCH
Are you adding 'TRANSFER TO ST LUKE - PSYCH' as
a new ER OPTIONS (the 136TH)? No// Y   (Yes)
ER OPTIONS MNEMONIC:
NAME: TRANSFER TO ST LUKE - PSYCH   Replace
TYPE: DISPOSITION
MAP TO NUBC DISPOSITION: 65           TRANSFERRED TO PSYCH HOSP
BRIEF FORM:
HER VALUE:

```

```

ANCILLARY SERVICES:
MNEMONIC:
MAP TO PLACE OF ACCIDENT:
ICD9 CODE:

Select ER OPTIONS NAME: TRANSFER TO ST LUKE - IRF
  Are you adding 'TRANSFER TO ST LUKE - IRF' as
    a new ER OPTIONS (the 137TH)? No// Y (Yes)
  ER OPTIONS MNEMONIC:
NAME: TRANSFER TO ST LUKE - IRF  Replace
TYPE: DISPOSITION
MAP TO NUBC DISPOSITION: 62          TRANSFERRED TO IRF
BRIEF FORM:
HER VALUE:
ANCILLARY SERVICES:
MNEMONIC:
MAP TO PLACE OF ACCIDENT:
ICD9 CODE:

Select ER OPTIONS NAME:

```

Figure 8-3 Adding new ERS dispositions

If the decision is made to add new dispositions that are more descriptive, it also may be desired to no longer allow users to select the original less descriptive disposition code. To accomplish this, it is important to note that the existing disposition should never be deleted. Since there are existing visits which point to this entry, in order for them to show up properly, the entry has to remain defined. The solution is to therefore mark the entry so that it is no longer a DISPOSITION type. Doing this will prevent the entry from being selectable in any future visits. Figure 8-4 shows how to modify an entry so that it is inactive and longer selectable.

```

*****
*           Facility Setup Menu           *
*           Indian Health Service         *
*           Version 3.0                   *
*****
                2016 DEMO HOSPITAL

CNS   Add/Edit ER CONSULTANT SERVICE list
LOC   Add Local ER Facilities
MGRP  ER Alerts Mail Group Edit
OPT   ER Options Transportation-Disposition-Procedures
SET   Facility Parameter setup
FIX   Run AMER Cleanup Utility

You have PENDING ALERTS
      Enter "VA to jump to VIEW ALERTS option

Select Table and Parameter Setup <TEST ACCOUNT> Option: opt  ER Options
Transportation-Disposition-Procedures

Select ER OPTIONS NAME: TRANSFER TO ANOTHER FACILITY
NAME: TRANSFER TO ANOTHER FACILITY  Replace
TYPE: DISPOSITION// @
      SURE YOU WANT TO DELETE? Y (Yes)
MAP TO NUBC DISPOSITION: ^

```

```
Select ER OPTIONS NAME:
```

Figure 8-4 Marking an existing disposition as inactive

## 8.2 Displaying the NUBC Disposition

When an ERS disposition is mapped to a **NUBC discharge status code**, the new code will be visible from a number of locations.

### 8.2.1 Displaying the NUBC Disposition in AMER

Figure 8-5 shows how the **NUBC Disposition code** is now visible in the AMER Standard ER Log. The field is referred to as the **PATIENT STATUS CODE (NUBC)**.

```
***** CONFIDENTIAL PATIENT INFORMATION *****
*****
STANDARD ER LOG REPORT FROM: DEC 15, 2021 TO: DEC 15, 2021@23:59
                                DEC 15, 2021 10:30 PAGE 1
-----
ADMISSION TIMESTAMP: NOV 13,2024 06:00
PATIENT: DEMO,PATIENT ONE
PCC VISIT: NOV 13,2024 06:00
  DOB: NOV 27,2015 AGE AT VISIT: 8
  CHART #: 123 SEX: FEMALE
CLINIC TYPE: EMERGENCY MEDICINE
MODE OF TRANSPORT: PRIVATE VEHICLE/WALK IN
  AMBULANCE CO:
  AMBULANCE #: AMB INVOICE #:
TRAUMA TEAM ACTIVATION: YES TRAUMA TEAM ACTIVATION DTM: NOV 13,2024 05:45
TRAUMA TEAM ACTIVATION BY: TEST,PROVIDER ONE
PRESENTING COMPLAINT: TESTING
  OCCUPATION RELATED: NO INJURED: YES
  CAUSE OF INJURY: X82.2XXS SCENE OF INJURY: HIGHWAY OR ROAD
  TIME OF INJURY: NOV 12,2024 08:00
  SAFETY EQUIPMENT: BELT (SHOULDER)
  TOWN OF INJURY: INJURY TOWN
  EXACT MVC LOCATION: 123 PARK AVENUE
PROCEDURES:
  NONE
PRIMARY DIAGNOSIS: M97.42XS {Periprosth fx around internal prosth l elbow
joint, sequela}
  PRIMARY DX NARRATIVE: BROKE LEFT ELBOW IN MVC
DIAGNOSIS: DX NARRATIVE:
  M97.42XS {Periprosth fx around internal prosth l elbow joint, sequela}
  BROKE LEFT ELBOW IN MVC
ED PROVIDER: TEST,PROVIDER ONE
  ED PROVIDER TIME: NOV 13,2024 12:00
PRIMARY NURSE: TEST,NURSE ONE
  PRIMARY NURSE TIME: NOV 13,2024 11:00
MEDICAL SCREENING EXAM TIME: NOV 13,2024 12:00
TRIAGE NURSE: TEST,NURSE ONE
  TRIAGE NURSE TIME: NOV 13,2024 09:00
TRIAGE PROVIDER: TEST,PROVIDER ONE
  TRIAGE PROVIDER TIME: NOV 13,2024 09:30
INITIAL TRIAGE BY: TEST,NURSE ONE
```

```

INITIAL TRIAGE TIME: NOV 13,2024 09:00
DECISION TO ADMIT TIME:
EMERGENCY SEVERITY INDEX: 1          FINAL ACUITY: 3
DISPOSITION: HOME
PATIENT STATUS CODE (NUBC):  DISCHARGED HOME (01)
TRANSFERED TO:
DEPARTURE TIME: NOV 13,2024 20:00
DISCHARGE (PRIMARY) PROVIDER: TEST, PROVIDER ONE
DISCHARGE NURSE: TEST, NURSE ONE
DISCHARGE INSTRUCTIONS: RTC PRN, INSTRUCTIONS GIVEN
ER CONSULTANTS:
INTERNAL MEDICINE  NOV 13,2024 13:00          DEMO, ADAM
TOTAL VISIT DURATION:          840
WAITING TIME FOR TRIAGE :      180
WAITING TIME FOR PROVIDER:     360
DATA ENTERER: DEMO, BRIAN E

Press 'Return to continue:
    
```

Figure 8-5 Viewing the NUBC Disposition in the AMER Standard ER Log Report

### 8.2.2 Displaying the NUBC Disposition in BEDD

Figure 8-6 shows how the **NUBC Disposition Code** will be visible in the **BEDD Central Log** report. If no mapping is defined for the ERS disposition, the new column will be blank.

| Central Log                    |                  |               |           |     |     |            |           |           |           |         |                    |                  |                    |      |         |      |      |         |          |         |         |         |             |                      |
|--------------------------------|------------------|---------------|-----------|-----|-----|------------|-----------|-----------|-----------|---------|--------------------|------------------|--------------------|------|---------|------|------|---------|----------|---------|---------|---------|-------------|----------------------|
| Between the Admission Dates of |                  |               |           |     |     |            |           |           |           |         |                    |                  |                    |      |         |      |      |         |          |         |         |         |             |                      |
| 11/13/2024 And 11/13/2024      |                  |               |           |     |     |            |           |           |           |         |                    |                  |                    |      |         |      |      |         |          |         |         |         |             |                      |
| Check-In                       | Arrival          | Patient       | Admission | Age | Sex | DOB        | Class     | Emergency | Diagnosis | Primary | Transfer           | Admitted         | Primary            | ESD  | Medical | ESD  | ESD  | Primary | Admitted | Initial | Initial | Initial | Disposition |                      |
| Time                           | Time             | Name          | Complete  | Yr  |     |            |           | Code      | ICD-10    | Code    | Code               | Time             | Code               | Code | Code    | Code | Code | Code    | Code     | Code    | Code    | Code    | Code        |                      |
| 11/13/2024 08:00               | 11/13/2024 08:00 | DEMO, BRIAN E | 01        | 45  | M   | 11/13/1979 | EMERGENCY | 0         | S07.0XXA  | 01X     | TEST, PROVIDER ONE | 11/13/2024 09:00 | TEST, PROVIDER ONE | 01X  | 01X     | 01X  | 01X  | 01X     | 01X      | 01X     | 01X     | 01X     | 01X         | DISCHARGED HOME (01) |
| 11/13/2024 08:00               | 11/13/2024 08:00 | DEMO, BRIAN E | 01        | 45  | M   | 11/13/1979 | EMERGENCY | 0         | S07.0XXA  | 01X     | TEST, PROVIDER ONE | 11/13/2024 09:00 | TEST, PROVIDER ONE | 01X  | 01X     | 01X  | 01X  | 01X     | 01X      | 01X     | 01X     | 01X     | 01X         | DISCHARGED HOME (01) |
| 11/13/2024 08:00               | 11/13/2024 08:00 | DEMO, BRIAN E | 01        | 45  | M   | 11/13/1979 | EMERGENCY | 0         | S07.0XXA  | 01X     | TEST, PROVIDER ONE | 11/13/2024 09:00 | TEST, PROVIDER ONE | 01X  | 01X     | 01X  | 01X  | 01X     | 01X      | 01X     | 01X     | 01X     | 01X         | DISCHARGED HOME (01) |

Figure 8-6: Displaying the NUBC Disposition Code on the BEDD Central Log Report

### 8.2.3 Displaying the NUBC Disposition Code in PCC

Figure 8-7 shows how the **NUBC Disposition Code** is visible in PCC. The field is referred to as the **PATIENT STATUS CODE (NUBC)**. Only the code itself is visible and, depending on the display, only PATIENT STATUS CODE could be visible as the field name.

```

*****
*                               Reports Menu                               *
*                               Indian Health Service                       *
*                               Version 3.0                                 *
*****
                                2016 DEMO HOSPITAL

AUD  ER VISIT AUDITING LOG REPORTS
LIST ER System Report Generator
LOG  Print ER Log
CAN  ER System Pre-Defined Reports
    
```

```

VIS      Display ER Log entry for a single ER visit
VV       Display Data for a Specific Patient Visit
CLN      ER Record Cleanup Report

Select Reports Menu <TEST ACCOUNT> Option: VV  Display Data for a Specific
Patient Visit

Enter PATIENT NAME:
  DEMO,PATIENT                      M 08-05-1958 XXX-XX-5435    DB
100974
PCC VISIT DISPLAY                    Dec 15, 2021 11:12:27      Page:    1 of
5

Patient Name:          DEMO,PATIENT
Chart #:              100974
Date of Birth:        AUG 05, 1958
Sex:                  M
Visit IEN:           247976

===== VISIT FILE =====
VISIT/ADMIT DATE&TIME: DEC 15, 2021@01:00
DATE VISIT CREATED:   DEC 15, 2021
TYPE:                 IHS
PATIENT NAME:         DEMO,PATIENT
LOC. OF ENCOUNTER:   2016 DEMO HOSPITAL
SERVICE CATEGORY:   AMBULATORY
CLINIC:              EMERGENCY MEDICINE
DEPENDENT ENTRY COUNT: 4
DATE LAST MODIFIED:  DEC 15, 2021
WALK IN/APPT:        WALK IN
HOSPITAL LOCATION:   ED WALK-IN
CREATED BY USER:    DEMO,BRIAN E
+      Enter ?? for more actions
CREATED BY USER:    DEMO,BRIAN E

CREATED BY USER:     DEMO,BRIAN E
OPTION USED TO CREATE: SD IHS PCC LINK
APPT DATE&TIME:      DEC 15, 2021@01:00
USER LAST UPDATE:    DEMO,BRIAN E
VCN:                 478.2X
OLD/UNUSED UNIQUE VIS: 5054300000247976
DATE/TIME LAST MODIFI: DEC 15, 2021@10:21:02
PATIENT STATUS CODE (: 02
NDW UNIQUE VISIT ID (: 999990000247976
    
```

Figure 8-7 Displaying the NUBC Disposition in PCC

### 8.2.4 NUBC Code Value Set

Table 8-1 contains a listing of valid **NUBC codes** and their descriptions.

Table 8-1: NUBC Codes and Descriptions

| NUBC CODE | DESCRIPTION              |
|-----------|--------------------------|
| 01        | DISCHARGED HOME          |
| 02        | TRANSFERRED GEN HOSPITAL |
| 03        | TRANSFERRED SNF          |

| <b>NUBC CODE</b> | <b>DESCRIPTION</b>             |
|------------------|--------------------------------|
| 04               | TRANSFERRED CUST/SUPP CARE     |
| 05               | TRANSFERRED CANCER CHILD       |
| 06               | UNDER CARE OF HOME HEALTH ORG  |
| 07               | LEFT AMA                       |
| 08               | UNDER CARE OF HOME IV THERAPY  |
| 09               | ADMITTED TO THIS HOSPITAL      |
| 10               | DISCHARGE DEFINED BY STATE     |
| 11               | DISCHARGE DEFINED BY STATE     |
| 12               | DISCHARGE DEFINED BY STATE     |
| 13               | DISCHARGE DEFINED BY STATE     |
| 14               | DISCHARGE DEFINED BY STATE     |
| 15               | DISCHARGE DEFINED BY STATE     |
| 16               | DISCHARGE DEFINED BY STATE     |
| 17               | DISCHARGE DEFINED BY STATE     |
| 18               | DISCHARGE DEFINED BY STATE     |
| 19               | DISCHARGE DEFINED BY STATE     |
| 20               | EXPIRED                        |
| 21               | TRANSFERRED COURT/LAW ENFORCE  |
| 22               | EXPIRED DEFINED BY STATE       |
| 23               | EXPIRED DEFINED BY STATE       |
| 24               | EXPIRED DEFINED BY STATE       |
| 25               | EXPIRED DEFINED BY STATE       |
| 26               | EXPIRED DEFINED BY STATE       |
| 27               | EXPIRED DEFINED BY STATE       |
| 28               | EXPIRED DEFINED BY STATE       |
| 29               | EXPIRED DEFINED BY STATE       |
| 30               | STILL A PATIENT                |
| 31               | STILL PATIENT DEFINED BY STATE |
| 32               | STILL PATIENT DEFINED BY STATE |
| 33               | STILL PATIENT DEFINED BY STATE |
| 34               | STILL PATIENT DEFINED BY STATE |
| 35               | STILL PATIENT DEFINED BY STATE |
| 36               | STILL PATIENT DEFINED BY STATE |

| <b>NUBC CODE</b> | <b>DESCRIPTION</b>             |
|------------------|--------------------------------|
| 37               | STILL PATIENT DEFINED BY STATE |
| 38               | STILL PATIENT DEFINED BY STATE |
| 39               | STILL PATIENT DEFINED BY STATE |
| 40               | EXPIRED AT HOME (HOSPICE ONLY) |
| 41               | EXPIRED SNF, ICF, FS HOSPICE   |
| 42               | EXPIRED, PLACE UNKNOWN         |
| 43               | TRANSFERRED FEDERAL HOSPITAL   |
| 44               | RESERVED NATIONAL ASSIGNMENT   |
| 45               | RESERVED NATIONAL ASSIGNMENT   |
| 46               | RESERVED NATIONAL ASSIGNMENT   |
| 47               | RESERVED NATIONAL ASSIGNMENT   |
| 48               | RESERVED NATIONAL ASSIGNMENT   |
| 49               | RESERVED NATIONAL ASSIGNMENT   |
| 50               | DISCHARGED TO HOSPICE - HOME   |
| 51               | DISCHARGED TO HOSPICE FACILITY |
| 52               | RESERVED NATIONAL ASSIGNMENT   |
| 53               | RESERVED NATIONAL ASSIGNMENT   |
| 54               | RESERVED NATIONAL ASSIGNMENT   |
| 55               | RESERVED NATIONAL ASSIGNMENT   |
| 56               | RESERVED NATIONAL ASSIGNMENT   |
| 57               | RESERVED NATIONAL ASSIGNMENT   |
| 58               | RESERVED NATIONAL ASSIGNMENT   |
| 59               | RESERVED NATIONAL ASSIGNMENT   |
| 60               | RESERVED NATIONAL ASSIGNMENT   |
| 61               | TRANSFERRED TO HOSP SWING BED  |
| 62               | TRANSFERRED TO IRF             |
| 63               | TRANSFERRED TO LTCH            |
| 64               | TRANSFERRED TO MCD CERT SNF    |
| 65               | TRANSFERRED TO PSYCH HOSP      |
| 66               | TRANSFER TO CAH                |
| 67               | RESERVED NATIONAL ASSIGNMENT   |
| 68               | RESERVED NATIONAL ASSIGNMENT   |
| 69               | TRANSFER DISASTER ALTER CARE   |

| <b>NUBC CODE</b> | <b>DESCRIPTION</b>             |
|------------------|--------------------------------|
| 70               | TRANSFER TO OTHER HEALTH CARE  |
| 71               | DELETED                        |
| 72               | DELETED                        |
| 73               | RESERVED NATIONAL ASSIGNMENT   |
| 74               | RESERVED NATIONAL ASSIGNMENT   |
| 75               | RESERVED NATIONAL ASSIGNMENT   |
| 76               | RESERVED NATIONAL ASSIGNMENT   |
| 77               | RESERVED NATIONAL ASSIGNMENT   |
| 78               | RESERVED NATIONAL ASSIGNMENT   |
| 79               | RESERVED NATIONAL ASSIGNMENT   |
| 80               | RESERVED NATIONAL ASSIGNMENT   |
| 81               | DISCHARGED HOME W/READMIT      |
| 82               | TRANSFER GEN HOSP W/READMIT    |
| 83               | TRANSFER SNF W/READMIT         |
| 84               | TRANSFER CUS/SUP CAREW/READMIT |
| 85               | TRANSFER CANCER CHLDW/READMIT  |
| 86               | DISC HOME CARE SVCS W/READMIT  |
| 87               | TRANSFER COURT/LAW W/READMIT   |
| 88               | TRANSFER FED HTH FAC W/READMIT |
| 89               | TRANSFER HOSP SWING W/READMIT  |
| 90               | TRANSFER TO IRF W/READMIT      |
| 91               | TRANSFER TO LTCH W/READMIT     |
| 92               | TRNS MDCAID CERT SNF W/READMIT |
| 93               | TRANSFER PSYCH HOSP W/READMIT  |
| 94               | TRANSFER CAH W/READMIT         |
| 95               | TRANSFER TO OTHER W/READMIT    |
| 96               | RESERVED NATIONAL ASSIGNMENT   |
| 97               | RESERVED NATIONAL ASSIGNMENT   |
| 98               | RESERVED NATIONAL ASSIGNMENT   |
| 99               | RESERVED NATIONAL ASSIGNMENT   |

## 9.0 LWOBS/Did Not Answer Functionality

### 9.1 Introduction

This guide provides the Clinical Applications Site Coordinator instructions on implementing new functionality available in the BEDD application.

AMER v3.0 p11 and BEDD v2.0 p4 contain new functionality that allows sites to quickly discharge patients who have left the emergency department (ED) without being seen or who did not answer when called. In order to gain the most benefit from this new functionality, sites should tailor their AMER settings to align with their custom site definition.

### 9.2 AMER/BEDD LWOBS/DNA Functionality

The BEDD v2.0 p4 release contains new functionality that allows LWOBS/DNA patients to be quickly discharged from the ED. Prior to this functionality sites had to enter (possibly incorrect or inaccurate) data in the BEDD application to get past the required information checks to complete the discharge or they had to use the AMER **Cancel Visit (did not answer or left AMA)** option to discharge the patients from the ED. AMER v3.0 p11 contains new site property definitions that sites can also use to adjust their settings to further customize the BEDD to their site's specific setup. This customization involves identifying which (site defined) AMER dispositions should be allowed for LWOBS/DNA discharges. Without this customization, the application utilizes built in logic to identify what dispositions to use.

The following sections describe the new functionality, as installed and customized to meet each site's needs.

### 9.3 Default Functionality

The LWOBS/DNA functionality determines what dispositions are LWOBS/DNA related by predefined logic delivered with AMER v3.0 p11. Any AMER dispositions that meet the following criteria will show up in the list of dispositions available in the **BEDD LWOBS/DNA discharge** option:

- The disposition contains the string LEFT WITHOUT
- The disposition contains the string LWOBS
- The disposition contains the string DNA
- REGISTERED IN ERROR will always be included in the list

For example, if a site has the following dispositions defined:

- ADMIT
- AMA

- CLINIC
- DNA
- ELOPED
- EXPIRED
- HOME
- LEFT AFTER INSURANCE DENIAL
- LEFT WITHOUT BEING DISCHARGED
- LEFT WITHOUT BEING SEEN
- LWOBS
- OBSERVATION
- POLICE CUSTODY
- REGISTERED IN ERROR
- TRANSFER TO ANOTHER FACILITY

The corresponding BEDD LWOBS/DNA dispositions that will display are shown in Figure 9-1. Only those dispositions are available as LWOBS/DNA dispositions.

The screenshot shows a form titled "Disposition Information" with several fields and a dropdown menu. The fields include "Final Acuity" (dropdown), "Follow up Instructions" (text input), "(PRIMARY) Provider who signed" (dropdown), and "\*Departure Date/Time" (text input). The "\*Disposition" field is a dropdown menu that is currently open, showing a list of options: DNA, LEFT WITHOUT BEING DISCHARGED, LEFT WITHOUT BEING SEEN, LWOBS, and REGISTERED IN ERROR. Other fields include "Where Transferred" (dropdown) and "Discharge Nurse" (dropdown).

Figure 9-1: Sample LWOBS/DNA Dispositions

## 9.4 Site Specified LWOBS/DNA Functionality

With AMER v3.0 p11, sites also have the ability to specify what dispositions should appear as LWOBS/DNA dispositions (along with REGISTERED IN ERROR, which will automatically appear). This is accomplished through new settings in the AMER Facility Parameter setup option. Figure 9-2 shows how to specify which dispositions to include in the LWOBS/DNA discharge.

**Note:** Once something has been entered in this new section, the default logic described in the last section will no longer be utilized. Only dispositions appearing in this section (along with REGISTERED IN ERROR) will display.

In the following example notice how the disposition LEFT WITHOUT BEING DISCHARGED from the last section was not entered here as a LWOBS/DNA disposition.

```
Select Table and Parameter Setup <TEST ACCOUNT> Option: SET Facility Parameter
setup

Select ER PREFERENCES LOCATION:      2016 DEMO HOSPITAL
LOCATION: 2016 DEMO HOSPITAL//
DEFAULT HOSPITAL LOCATION: ED WALK-IN//
LABEL PRINTER NAME: PER//
QUEUE LABELS: YES//
CHART PRINTER NAME: PER//
SEND .9999 CODES TO PCC: YES//
DISABLE TRIAGE PROVIDER ENTRY: NO//
ENABLE AUTOMATIC CHECK-OUT: YES//
Select ER CLINIC: ED MAIN//
  ER CLINIC: ED MAIN//
  LINK TO HOSPITAL LOCATION: ED MAIN//
Select ER CLINIC:
DEFAULT ER CLINIC: EMERGENCY MEDICINE//
Select LWOBS/DNA DISPOSITIONS: AMA
Select LWOBS/DNA DISPOSITIONS: LWOBS
Select LWOBS/DNA DISPOSITIONS: LEFT WITHOUT BEING SEEN
Select LWOBS/DNA DISPOSITIONS:

Select ER PREFERENCES LOCATION:
```

Figure 9-2: Specifying LWOBS/DNA Dispositions

Based on the above settings, the following dispositions will display in the LWOBS/DNA option (refer to Figure 9-3).

**Note:** The LEFT WITHOUT BEING DISCHARGED disposition is not displaying even though it contains LEFT WITHOUT because the default logic has been superseded by the new parameter settings.

The screenshot shows a 'Disposition Information' form with several fields: 'Final Acuity' (dropdown), '\*Disposition' (dropdown menu), 'Where Transferred' (dropdown), 'Follow up Instructions' (text input), '(PRIMARY) Provider who signed PCC form' (dropdown), 'Discharge Nurse' (dropdown), and '\*Departure Date/Time' (text input). At the bottom are 'Complete Discharge' and 'Cancel' buttons. The '\*Disposition' dropdown menu is open, showing the following options: DNA, LEFT WITHOUT BEING SEEN, LWOBS, and REGISTERED IN ERROR. 'LEFT WITHOUT BEING SEEN' is highlighted.

Figure 9-3: Site Specified LWOBS/DNA Disposition Display

## Appendix A RPMS Rules of Behavior

The Resource and Patient Management (RPMS) system is a United States Department of Health and Human Services (HHS), Indian Health Service (IHS) information system that is FOR OFFICIAL USE ONLY. The RPMS system is subject to monitoring; therefore, no expectation of privacy shall be assumed. Individuals found performing unauthorized activities are subject to disciplinary action including criminal prosecution.

All users (Contractors and IHS Employees) of RPMS will be provided a copy of the Rules of Behavior (RoB) and must acknowledge that they have received and read them prior to being granted access to a RPMS system, in accordance IHS policy.

- For a listing of general Rules of Behavior for all users, see the most recent edition of IHS General User Security Handbook (SOP 06-11a).
- For a listing of system administrators/managers rules, see the most recent edition of the IHS Technical and Managerial Handbook (SOP 06-11b).

Both documents are available at this IHS website, <https://security.ihs.gov/>

The Rules of Behavior listed in the following sections are specific to RPMS.

### A.1 All RPMS Users

In addition to these rules, each application may include additional RoBs that may be defined within the documentation of that application (e.g., PCC, Dental, Pharmacy).

#### A.1.1 Access

RPMS users shall:

- Only use data for which you have been granted authorization.
- Only give information to personnel who have access authority and have a need to know.
- Always verify a caller's identification and job purpose with your supervisor or the entity provided as employer before providing any type of information system access, sensitive information, or non-public agency information.
- Be aware that personal use of information resources is authorized on a limited basis within the provisions Indian Health Manual Part 8, "Information Resources Management," Chapter 6, "Limited Personal Use of Information Technology Resources."

RPMS users shall not:

- Retrieve information for someone who does not have authority to access the information.
- Access, research, or change any user account, file, directory, table, or record not required to perform your OFFICIAL duties.
- Store sensitive files on a PC hard drive, or portable devices or media, if access to the PC or files cannot be physically or technically limited.
- Exceed their authorized access limits in RPMS by changing information or searching databases beyond the responsibilities of their job or by divulging information to anyone not authorized to know that information.

### A.1.2 Information Accessibility

RPMS shall restrict access to information based on the type and identity of the user. However, regardless of the type of user, access shall be restricted to the minimum level necessary to perform the job.

RPMS Users Shall

- Access only those documents they created and those other documents to which they have a valid need-to-know and to which they have specifically granted access through an RPMS application based on their menus (job roles), keys, and FileMan access codes. Some users may be afforded additional privileges based on the function they perform such as system administrator or application administrator.
- Acquire a written preauthorization in accordance with IHS policies and procedures prior to interconnection to or transferring data from RPMS.

### A.1.3 Accountability

RPMS Users Shall

- Behave in an ethical, technically proficient, informed, and trustworthy manner.
- Logout of the system whenever they leave the vicinity of their PC.
- Be alert to threats and vulnerabilities in the security of the system.
- Report all security incidents to their local Information System Security Officer (ISSO)
- Differentiate tasks and functions to ensure that no one person has sole access to or control over important resources.
- Protect all sensitive data entrusted to them as part of their government employment.

- Shall abide by all Department and Agency policies and procedures and guidelines related to ethics, conduct, behavior, and IT information processes.

#### A.1.4 Confidentiality

##### RPMS Users Shall

- Be aware of the sensitivity of electronic and hardcopy information and protect it accordingly.
- Store hardcopy reports/storage media containing confidential information in a locked room or cabinet.
- Erase sensitive data on storage media, prior to reusing or disposing of the media.
- Protect all RPMS terminals from public viewing at all times.
- Abide by all HIPAA regulations to ensure patient confidentiality.

##### RPMS Users Shall NOT

- Allow confidential information to remain on the PC screen when someone who is not authorized to that data is in the vicinity.
- Store sensitive files on a portable device or media without encrypting.

#### A.1.5 Integrity

##### RPMS Users Shall

- Protect your system against viruses and similar malicious programs.
- Observe all software license agreements.
- Follow industry standard procedures for maintaining and managing RPMS hardware, operating system software, application software, and/or database software and database tables.
- Comply with all copyright regulations and license agreements associated with RPMS software.

##### RPMS Users Shall NOT

- Violate Federal copyright laws.
- Install or use unauthorized software within the system libraries or folders
- Use freeware, shareware, or public domain software on/with the system without your manager's written permission and without scanning it for viruses first.

### A.1.6 System Logon

RPMS Users Shall

- Have a unique User Identification/Account name and password.
- Be granted access based on authenticating the account name and password entered.
- Be locked out of an account after 5 successive failed login attempts within a specified time period (e.g., one hour).

### A.1.7 Passwords

RPMS Users Shall

- Change passwords a minimum of every 90 days.
- Create passwords with a minimum of eight characters.
- If the system allows, use a combination of alpha, numeric characters for passwords, with at least one uppercase letter, one lower case letter, and one number. It is recommended, if possible, that a special character also be used in the password.
- Change vendor-supplied passwords immediately.
- Protect passwords by committing them to memory or store them in a safe place (do not store passwords in login scripts, or batch files.
- Change password immediately if password has been seen, guessed, or otherwise compromised; and report the compromise or suspected compromise to your ISSO.
- Keep user identifications (ID) and passwords confidential.

RPMS Users Shall NOT

- Use common words found in any dictionary as a password.
- Use obvious readable passwords or passwords that incorporate personal data elements (e.g., user's name, date of birth, address, telephone number, or social security number; names of children or spouses; favorite band, sports team, or automobile; or other personal attributes).
- Share passwords/IDs with anyone or accept the use of another's password/ID, even if offered.
- Reuse passwords. A new password must contain no more than five characters per 8 characters from the previous password.
- Post passwords.
- Keep a password list in an obvious place, such as under keyboards, in desk drawers, or in any other location where it might be disclosed.

- Give a password out over the phone.

### A.1.8 Backups

RPMS Users Shall

- Plan for contingencies such as physical disasters, loss of processing, and disclosure of information by preparing alternate work strategies and system recovery mechanisms.
- Make backups of systems and files on a regular, defined basis.
- If possible, store backups away from the system in a secure environment.

### A.1.9 Reporting

RPMS Users Shall

- Contact and inform your ISSO that you have identified an IT security incident and you will begin the reporting process by providing an IT Incident Reporting Form regarding this incident.
- Report security incidents as detailed in the IHS Incident Handling Guide (SOP 05-03).

RPMS Users Shall NOT

- Assume that someone else has already reported an incident. The risk of an incident going unreported far outweighs the possibility that an incident gets reported more than once.

### A.1.10 Session Timeouts

RPMS system implements system-based timeouts that back users out of a prompt after no more than 5 minutes of inactivity.

RPMS Users Shall

- Utilize a screen saver with password protection set to suspend operations at no greater than 10-minutes of inactivity. This will prevent inappropriate access and viewing of any material displayed on your screen after some period of inactivity.

### A.1.11 Hardware

RPMS Users Shall

- Avoid placing system equipment near obvious environmental hazards (e.g., water pipes).
- Keep an inventory of all system equipment.

- Keep records of maintenance/repairs performed on system equipment.

RPMS Users Shall NOT

- Eat or drink near system equipment

### A.1.12 Awareness

RPMS Users Shall

- Participate in organization-wide security training as required.
- Read and adhere to security information pertaining to system hardware and software.
- Take the annual information security awareness.
- Read all applicable RPMS Manuals for the applications used in their jobs.

### A.1.13 Remote Access

Each subscriber organization establishes its own policies for determining which employees may work at home or in other remote workplace locations. Any remote work arrangement should include policies that:

- Are in writing.
- Provide authentication of the remote user through the use of ID and password or other acceptable technical means.
- Outline the work requirements and the security safeguards and procedures the employee is expected to follow.
- Ensure adequate storage of files, removal, and non-recovery of temporary files created in processing sensitive data, virus protection, intrusion detection, and provides physical security for government equipment and sensitive data.
- Establish mechanisms to back up data created and/or stored at alternate work locations.

Remote RPMS Users Shall

- Remotely access RPMS through a virtual private network (VPN) whenever possible. Use of direct dial in access must be justified and approved in writing and its use secured in accordance with industry best practices or government procedures.

Remote RPMS Users Shall NOT

- Disable any encryption established for network, internet, and web browser communications.

## A.2 RPMS Developers

### RPMS Developers Users Shall

- Always be mindful of protecting the confidentiality, availability, and integrity of RPMS when writing or revising code.
- Always follow the IHS RPMS Programming Standards and Conventions (SAC) when developing for RPMS.
- Only access information or code within the namespaces for which they have been assigned as part of their duties.
- Remember that all RPMS code is the property of the U.S. Government, not the developer.
- Shall not access live production systems without obtaining appropriate written access, shall only retain that access for the shortest period possible to accomplish the task that requires the access.
- Shall observe separation of duties policies and procedures to the fullest extent possible.
- Shall document or comment all changes to any RPMS software at the time the change or update is made. Documentation shall include the programmer's initials, date of change and reason for the change.
- Shall use checksums or other integrity mechanism when releasing their certified applications to assure the integrity of the routines within their RPMS applications.
- Shall follow industry best standards for systems they are assigned to develop or maintain; abide by all Department and Agency policies and procedures.
- Shall document and implement security processes whenever available.

### RPMS Developers Shall NOT

- Write any code that adversely impacts RPMS, such as backdoor access, "Easter eggs," time bombs, or any other malicious code or make inappropriate comments within the code, manuals, or help frames.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Not release any sensitive agency or patient information.

## A.3 Privileged Users

Personnel who have significant access to processes and data in RPMS, such as, system security administrators, systems administrators, and database administrators have added responsibilities to ensure the secure operation of RPMS.

### Privileged RPMS Users Shall

- Verify that any user requesting access to any RPMS system has completed the appropriate access request forms.
- Ensure that government personnel and contractor personnel understand and comply with license requirements. End users, supervisors, and functional managers are ultimately responsible for this compliance.
- Advise the system owner on matters concerning information technology security.
- Assist the system owner in developing security plans, risk assessments, and supporting documentation for the certification and accreditation process.
- Ensure that any changes to RPMS that affect contingency and disaster recovery plans are conveyed to the person responsible for maintaining continuity of operations plans.
- Ensure that adequate physical and administrative safeguards are operational within their areas of responsibility and that access to information and data is restricted to authorized personnel on a need-to-know basis.
- Verify that users have received appropriate security training before allowing access to RPMS.
- Implement applicable security access procedures and mechanisms, incorporate appropriate levels of system auditing, and review audit logs.
- Document and investigate known or suspected security incidents or violations and report them to the ISSO, CISO, and systems owner.
- Protect the supervisor, superuser, or system administrator passwords.
- Avoid instances where the same individual has responsibility for several functions (i.e., transaction entry and transaction approval).
- Watch for unscheduled, unusual, and unauthorized programs.
- Help train system users on the appropriate use and security of the system.
- Establish protective controls to ensure the accountability, integrity, confidentiality, and availability of the system.
- Replace passwords when a compromise is suspected. Delete user accounts as quickly as possible from the time that the user is no longer authorized system. Passwords forgotten by their owner should be replaced, not reissued.
- Terminate user accounts when a user transfers or has been terminated. If the user has authority to grant authorizations to others, review these other authorizations. Retrieve any devices used to gain access to the system or equipment. Cancel logon IDs and passwords and delete or reassign related active and back up files.
- Use a suspend program to prevent an unauthorized user from logging on with the current user's ID if the system is left on and unattended.

- Verify the identity of the user when resetting passwords. This can be done either in person or having the user answer a question that can be compared to one in the administrator's database.
- Shall follow industry best standards for systems they are assigned to; abide by all Department and Agency policies and procedures.

Privileged RPMS Users Shall Not

- Access any files, records, systems, etc., that are not explicitly needed to perform their duties.
- Grant any user or system administrator access to RPMS unless proper documentation is provided.
- Not release any sensitive agency or patient informatio

## Glossary

### **Emergency Department Dashboard**

Refers to the RPMS EDD application (in the BEDD namespace). The ERS is integrated with the EDD application so information gets transferred back and forth between the two applications.

### **RPMS Patient Care Component**

Refers to functions within RPMS as a clinical data repository, storing visit-related data about a patient

## Acronym List

| <b>Acronym</b> | <b>Meaning</b>                         |
|----------------|----------------------------------------|
| DOB            | Date of Birth                          |
| ED             | Emergency Department                   |
| EDD            | Emergency Department Dashboard         |
| EHR            | Electronic Health Record               |
| ER             | Emergency Room                         |
| ERS            | Emergency Room System                  |
| HHS            | Health and Human Services              |
| HRN            | Health Record Number                   |
| IHS            | Indian Health Service                  |
| LWOBS/DNA      | Left Without Being Seen/Did Not Answer |
| NUBC           | National Uniform Billing Committee     |
| OIT            | Office of Information Technology       |
| RPMS           | Resource and Patient Management System |

## Contact Information

If you have any questions or comments regarding this distribution, please contact the IHS IT Service Desk.

**Phone:** (888) 830-7280 (toll free)

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