



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Emergency Room System

(AMER)

User Manual

Version 3.0
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Office of Information Technology (OIT)
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Preface

This manual provides information necessary to understand and use the Emergency Room system (ERS). The ER package is a tool that will help facilities run and manage Emergency Rooms.

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

Security

The ERS uses security keys to limit user’s 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.

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1.0 Introduction

The IHS Emergency Room System (ERS) captures patient data during an ER visit. Admission data is stored in the ER Admission file until the patient is discharged from the Emergency Room. Discharge information is stored in the ER Visit file. Once the visit has been created, the visit data is passed to the Visit, V POV, and V Provider files. There is also a triage function that can be used to track the patient through the Emergency Room process.

The IHS Emergency Room System 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.

1.1 PIMS Interface

Starting with this version, ERS interfaces with the Patient Information Management System (PIMS), Admission/Discharge/Transfer (ADT), Scheduling, Scheduling, and Sensitive Patient Tracking packages. Please note the following:

- Configuration information is provided in the *Emergency Room System 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. Please 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 (PCC) should handle this.
 - In the PIMS Admission/Discharge/Transfer (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 ERS Main Menu

The Emergency Room System (ERS) provides menu options that enable you to

- Register, admit, and discharge patients through the Emergency Room.
- 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 your security keys. To determine or change your security keys, contact your Site Administrator.

```

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

                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
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 ...

Select Emergency Room System Option:

```

Figure 2-1: Emergency Room System (ERS) Main Menu options

These are the ERS main menu options:

- **IN - Admit to Emergency Room**

Use this option to admit an established patient to the Emergency room. 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 to edit the ER admission record *before* the transaction is processed, to capture the time the patient was seen by the triage nurse or admitting provider and initial patient acuity.

- **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 Room. The information collected is stored in the ER Visit file. 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**
Use this option to enter information for a patient, who dies before arriving at the ER.
- **REG - Mini-Registration of New Patients**
Use this option to register a new patient, by entering basic patient demographic information: name, gender, date of birth, and social security number.
- **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 Room.
- **INST - Patient Instruction Menu**
Use this option to create and print adult or pediatric patient instructions.
- **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 details (PCC record) of a single patient visit.

- **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

- Admission summary
- Triage information
- Injury information
- Procedures
- Diagnoses
- Exit Assessment
- Discharge information
- Follow-up instructions
- ER consultants

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

- **PAR - Table and Parameter Setup**

Use this option to set up/maintain you local facility's ERS site parameters and ER tables/files containing data, such as procedures and dispositions.

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 Admit to Emergency Room (IN)

Use the ERS **Admit to Emergency Room** menu option to admit an established patient to the Emergency room. 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 (Figure 2-1) depend on your security key. To determine or change your security keys, contact your site administrator.

To admit a patient to the ER, follow these steps:

1. At the “Select Emergency Room System Option” prompt, type **IN** and press Enter.
2. At the “Enter the Patient’s Name or Local Chart Number” prompt, type the patient’s name or chart number.

The system displays appointment information, if any, for the patient.

3. At the “Date and Time of Admission to ER” prompt, type the date and time of the admission. If the admission is now, press Enter to accept the default, **NOW**.

```
Select Emergency Room System Option: IN <Enter> Admit to Emergency Room

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

Enter the patient's NAME or LOCAL CHART NUMBER:  DOE,JOHN <Enter>  M 01-01-
1950 000748159
          33123

NO PENDING APPOINTMENTS

~~~~~

Date and time of admission to ER:  NOW// <Enter>  (MAY 27, 2008@11:58)
```

Figure 3-1: Admitting an ER patient (steps 1-3)

4. At the “Presenting Complaint” prompt, type the patient’s presenting complaint. This field is free text and can take up to 80 characters.

The system displays a history of the patient's previous registrations and demographic information. You may edit the registration information at this time.

5. At the "Visit Type" prompt: type one of the following:
 - Clinic Referral
 - Hospital Referral
 - Review
 - Scheduled
 - Unscheduled
6. 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.
7. At the "Was this patient transferred from another facility?" prompt, type **Y** or **N**.

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.
8. At the ER at the "Mode of transport to the ER" prompt, type how the patient arrived. Type ?? to view a list of available options.

Depending on the option you select, you may be prompted for additional information regarding the transportation method.
9. At the "Want to print PCC+ forms?" prompt, type Y or N.

If you type Y (yes),

 - a. At the "Enter number of labels to print." prompt, enter a value from 1 to 10.
 - b. At the "Label printer" prompt, enter the name of the printer.
 - c. At the "Right margin" prompt, accept the default.
11. At the "Do you want to print a routing slip?" prompt, type Y or N.

If you type Y (yes),

 - a. At the prompt "File room printer", enter the name of the printer.
 - b. At the "Right margin" prompt, accept the default.

When the admission is complete, the system displays the message, "ER admission data collection is now complete. Thank you."

```

Presenting complaint: HEART ATTACK <Enter>

~~~~~

*****
Date of Last Registration Update: FEB 10, 2002 <Enter>

Additional Registration Information:
*****

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

~~~~~

Visit type: FIRST VISIT// <Enter>

~~~~~

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

~~~~~

Mode of transport to the ER: PRIVATE VEHICLE/WALK IN// <Enter> (MAY 27, 2008@11:58)

Want to print PCC+ forms? Yes// NO <Enter>
Enter number of labels to print: (1-10): 4//1 <Enter>
LABEL PRINTER: SCR// HOME <Enter> VIRTUAL Right Margin: 80// <Enter>
03-31-23 M
DOE,JOHN
01/01/1950 MAHNOMEN
PRIV INS

Do you want to PRINT a routing slip? YES// <Enter>

FILE ROOM PRINTER: HOME// <Enter> VIRTUAL Right Margin: 80// <Enter>

FACILITY: NOT A REAL FACILITY
**Confidential Patient Data**
PAGE 1 OUTPATIENT ROUTING SLIP
NAME: DOE,JOHN HRCN: 33123
DOB: 01/01/1950 APPT DT: 5/27/2008@11:58

**CURRENT APPOINTMENTS**
TIME CLINIC
11:58 AM WI EMERGENCY ROOM

DATE PRINTED: May 27, 2008@11:58:49
Requested by: LASTNAME,FIRST

ER admission data collection is now complete. Thank you.

```

Figure 3-2: Admitting an ER patient (steps 4-8)

4.0 Triage Nurse Update Admission Record (TRI)

The **Triage Nurse Update Admission Record** menu option enables the 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.

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

To update the Admission Record, follow these steps:

1. At the “Select Emergency Room System Option” prompt, type **TRI**.
The system displays a list of all patients currently admitted to the ER.
2. At the “Select ER Patient” prompt, type the number that matches the patient for whom you are adding triage information.
3. At the “Clinic Type” prompt, type **EMERGENCY MEDICINE** or **URGENT**.
4. At the “Triage Nurse” prompt, type the name of the triage nurse.
Type ?? to view a list of providers, or press Enter to bypass this field.

```

Select Emergency Room System Option: TRI <Enter> Triage Nurse Update
Admission Record

The following patients are currently admitted to the ER =>

  NAME          DOB          CHART    ADMISSION          PRESENTING
COMPLAINT
-----
-
1) DOE,JOHN     JUN 01,1950  33574    MAY 30,2008@10:45  PAIN
2) RABBITT,BUD JAN 01,1950   123     MAY 27,2008@12:13  HEART ATTACK
3) FUDD,ELMER  DEC 01,1950  84877    MAY 27,2008@14:33  HEART

Select ER patient: 1 <Enter>  DOE,JOHN
DOE,JOHN          M 06-01-1950  000748159      33574

~~~~~
ER ADMISSION FOR DOE,JOHN   ^ = back up   ^^ = quit
The answers to ALL questions, except those marked with a '*', are MANDATORY!
~~~~~
*Clinic type (EMERGENCY or URGENT): EMERGENCY <Enter>  EMERGENCY MEDICINE
30
~~~~~
*Triage nurse: ADAM,ADAM <Enter>   AA
~~~~~

```

Figure 4-1: Updating the Admission Record (steps 1-4)

5. At the “Enter initial triage assessment from RN” prompt, type the number that matches the initial triage assessment from the triage nurse.
6. At the “What time did the patient see the triage nurse” prompt, type the date and time the patient saw the triage nurse, or press Enter bypass this field.

If the time was several hours after the time of admission, the system asks you to confirm the time.

```

Enter initial triage assessment from RN: (1-5): // 1 <Enter>

~~~~~
*What time did the patient see the triage nurse: 5P <Enter> (JUN 03, 2008@17:00)

This means a really long delay since the time of admission: MAY 30,2008@10:45
Are you sure? No// Y <Enter> (Yes)

~~~~~

```

Figure 4-2: Updating the Admission Record (steps 5-6)

The system displays a summary of the patient’s admission and triage information. Review the summary for accuracy.

7. After reviewing the summary, type **Y** or **N** at the “Do you want to make any changes?” prompt.
 - If you type **N** (No),
Type **Y** or **N** at the “Do you want to print patient instructions?” prompt.

The discharge is complete, and the system displays the message, “Data entry session successfully completed. Thank you.”
 - If you type **Y** (Yes), change admission information in response to the prompts, as necessary. When you finish making changes,
 - Type **NO** at the “Do you want to make any changes?” prompt
 - Respond to the “Do you want to print patient instructions?” prompt.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 JOHN DOE =>
      ---  ADMISSION SUMMARY  ---
Patient: DOE,JOHN                Arrival time: MAY 30,2003@10:45
Presenting Complaint: PAIN        Visit type: FIRST VISIT
Transferred from:
Transport to ED: PRIVATE VEHICLE/WALK IN
Ambulance ID:                    Ambulance billing #:
Ambulance company:                Clinic type: EMERGENCY MEDICINE
Admitting provider: PROVIDER,JOE  Triage nurse: ADAM,ADAM
Initial triage category: 1
Seen by triage nurse at: JUN 3,2003@17:00

Do you want to make any changes? No// NO <Enter> (No)
```

Figure 4-3: Updating the Admission Record (step 7)

5.0 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, follow these steps:

1. At the “Select Emergency Room System Option” prompt, type **BAT**.
2. At 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, see Section 3.0, “Admit to Emergency Room (IN).”
- For Triage information, see Section 4.0, “Triage Nurse Update Admission Record (TRI).”
- For Discharge information, see Section 6.0, Discharge from Emergency Room (OUT).”

At the end of the BAT process, the system displays a summary of the input and asks if you want to may any changes. After prompts for printing PCC forms, labels, and routing slip, ERS adds specific visit data to PCC V POV and V PROVIDER files.

The following example (Figure 5-1) 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 optional.  Enter '??' to see choices.
~~~~~
Enter the patient's NAME or LOCAL CHART NUMBER: DOE,JANE <Enter>
~~~~~
*Date and time of admission to ER:  // T-1@10AM <Enter> (AUG 08, 2008@10:00)
No Pending Appointments
~~~~~
*Presenting complaint: HEART ATTACK <Enter>
~~~~~
```

```

*****
Date of Last Registration Update: OCT 09, 2001

Route 3 Box 465
Maynard, MN 56591
555-555-1372 (Home)
          (Work)
Press ENTER to Continue: <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>
~~~~~
*Clinic type (EMERGENCY or URGENT): EMERGENCY MEDICINE// <Enter> 30
~~~~~
*Admitting physician: PROVIDER,JOE <Enter> JAC
~~~~~
*Triage nurse: ADAM,EVE <Enter> AE
~~~~~
*Enter initial triage assessment from RN: (1-5): // 1 <Enter>
~~~~~
*What time did the patient see the triage nurse: T-1@1001 <Enter> (AUG 08,
2008@10:01)
~~~~~
*What time did the patient see the admitting doctor: T-1@1002 <Enter> (AUG 08,
2008@10:02)
~~~~~
*Was this ER visit caused by an injury? NO// <Enter>
~~~~~
*Was this ER visit WORK-RELATED? NO// <Enter>
~~~~~
*Was an ER CONSULTANT notified? NO// YES <Enter>
*CONSULTANT SERVICE: INTERNAL MEDICINE <Enter>
*What time did the patient see this CONSULTANT: T-1@1005 <Enter> (AUG 08,
2008@10:05)
*CONSULTANT NAME: KING,W F <Enter> FEL
*Was another CONSULTANT notified? NO// <Enter>
~~~~~
Enter procedure: NONE// DEFIBRILLATION/CARDIOVERSION <Enter>
Enter another procedure: <Enter>
~~~~~
*Enter narrative description of the PRIMARY diagnosis: HEART MURMUR <Enter>
*Enter ICD9 code: .9999// <Enter> .9999 UNCODED DIAGNOSIS
...OK? Yes// <Enter> (Yes)
Enter another diagnosis: <Enter>
~~~~~
*Enter final acuity assessment from provider: (1-5): // 2 <Enter>
~~~~~
*Disposition: ADMIT <Enter>
Where is patient being transferred: <Enter>
~~~~~
Follow up instructions: RTC PRN, INSTRUCTIONS GIVEN// <Enter>
~~~~~
Provider who signed PCC form: PROVIDER,JOE <Enter> JAC
~~~~~
*Discharge nurse: JOHNSON,CURTIS <Enter> ASP
~~~~~
*What time did the patient depart from the ER: NOW// T-1@1030 <Enter> (AUG 08,
2008@10:30

```

```

Summary of this ER data entry session for JANE DOE =>
      --- ADMISSION SUMMARY ---
Patient: DOE,JANE                      Arrival time: AUG 8,2007@10:00
Presenting Complaint: HEART ATTACK      Visit type: UNSCHEDULED
Transferred from:
Transport to ER: PRIVATE VEHICLE/WALK IN
Ambulance ID:                          Ambulance billing #:
Ambulance company:                      Clinic type: EMERGENCY MEDICINE
Admitting provider: PROVIDER,JOE        Triage nurse: ADAM,EVE
Initial triage category: 1
Seen by triage nurse at: AUG 8,2008@10:01
Seen by admitting provider at: AUG 8,2008@10:02
      --- 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: DEFIBRILLATION/CARDIOVERSION
      --- ER CONSULTANT ---
1: INTERNAL MEDICINE @ AUG 8,2009@10:05 KING,W F
      --- EXIT ASSESSMENT ---

Diagnoses: HEART MURMUR [.9999]         Discharge acuity: 2
      --- DISPOSITION ---
Disposition: ADMIT TO ICU                Transfer to:
      --- DISCHARGE INFO ---
Provider who signed PCC form: PROVIDER,JOE
Discharge nurse: JOHNSON,CURTIS         Departure time: AUG 8,2009@10:30
      --- FOLLOW UP INSTRUCTIONS ---
Discharge instructions: RTC PRN, INSTRUCTIONS GIVEN

Do you want to make any changes? No// <Enter> (No) (AUG 08, 2009@10:00)

Want to print PCC+ forms? Yes// N <Enter> (No)
*Enter number of labels to print: (1-10): 4// <Enter>
LABEL PRINTER: LER// <Enter> SLAVE PC PTR Right Margin: 80// <Enter>
Do you want to PRINT a routing slip? YES//<Enter>
FILE ROOM PRINTER: HOME// <Enter> SLAVE PC PTR Right Margin: 80// <Enter>

** PRIMARY V PROVIDER ADDED TO PCC VISIT **

** SECONDARY V PROVIDER ADDED TO PCC VISIT **

** SECONDARY V PROVIDER ADDED TO PCC VISIT **

** SECONDARY CONSULTANT V PROVIDER ADDED TO PCC VISIT **

** V POV DX ADDED TO PCC VISIT **

~~~~~

```

Figure 5-1: Example of using the Batch Mode ER Admission/Discharge (BAT) option

6.0 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. At 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 (Figure 2-1) depend on your security key. Please contact your site administrator to determine or change your security keys.

To discharge a patient from the ER, follow these steps:

1. At the “Select Emergency Room System Option” prompt, type **OUT**.

The system lists all patients currently admitted to the ER.

Note: You must answer all questions marked with an asterisk (*) as they are **REQUIRED**.

2. At the “Select ER Patient” prompt, type the number that matches the patient you are discharging.
3. At the “Clinic type” prompt, type **EMERGENCY MEDICINE** or **URGENT**.
4. At the “Admitting Physician” prompt, type the name of the admitting provider.
Type ?? to view a list of providers, or press Enter to bypass this field.
5. At the “Triage Nurse” prompt, type the name of the triage nurse. If the name was entered during the triage session, it is displayed at this prompt.
Type ?? to see a list of triage nurses.
6. At the “Enter initial triage assessment from RN” prompt, type the number that matches the initial triage assessment of the triage nurse. If information was entered during the triage session, it is displayed at this prompt.

7. At the “What time did the patient see the triage nurse” prompt, type the date and time the triage nurse saw the patient, or press Enter to bypass this field.
 - If the information was entered during the triage session, it is displayed at this prompt.
 - If the time was several hours after the time of admission, the system asks you to confirm the time.
8. At the “What time did the patient see the admitting doctor” prompt, type the date and time that doctor saw the patient, or press Enter to bypass this field.
 - If the time was several hours after the time of admission, the system asks for confirmation.

```

Select Emergency Room System Option:      OUT <Enter>  Discharge from Emergency Room

The following patients are currently admitted to the ER =>

  NAME                DOB                CHART        ADMISSION        PRESENTING COMPLAINT
-----
1) DOE,JOHN          JUN 01,1950    33574        MAY 27,2008@11:58  HEART ATTACK
2) DOE,JANE          SEP 01,1951    65441        MAY 27,2008@14:34  PAIN
3) RABBITT,BUD       JAN 01,1950    12123        MAY 27,2008@12:13  heart attack
4) FUDD,ELMER        DEC 01,1954    84877        MAY 27,2008@14:33  HEART

Select ER patient: 1 <Enter>  DOE,JOHN
DOE,JOHN                M 06-01-1950  000748159      33123

~~~~~
ER ADMISSION FOR DOE,JOHN    ^ = back up    ^^ = quit
The answers to ALL questions, except those marked with a '*', are MANDATORY!
~~~~~
Clinic type (EMERGENCY or URGENT): EMERGENCY MEDICINE// <Enter>
~~~~~
*Admitting Physician: PROVIDER,JOE <Enter>          Physician
~~~~~
*Triage nurse: ADAM,ADAM <Enter>    AA
~~~~~
Enter initial triage assessment from RN: (1-5): // 1 <Enter>
~~~~~
*What time did the patient see the triage nurse: 5P <Enter> (MAY 27, 2008@17:00)

This means a really long delay since the time of admission: MAY 27,2008@11:58
Are you sure? No// YES <Enter> (Yes)
~~~~~
*What time did the patient see the admitting doctor: 6P <Enter> (MAY 27,
2008@14:00)

```

Figure 6-1: Discharging an ER patient (steps 1-8)

9. At the “Was This ER Visit Caused by an Injury?” prompt, do one of the following:
 - Type **Y** (Yes) and press Enter. Then go to step 10.
 - Type **N** (No) and press Enter. Then go to step 13.

10. (Optional) At the “Town/Village Where Injury Occurred” prompt, type the town where the injury occurred, or press Enter to bypass this field.
11. (Optional) At the “Enter the exact time and date of Injury” prompt, type the date and time the Injury Occurred, or press Enter to bypass this field
12. At the “Cause of Injury” prompt, type the cause of the injury.

Type ?? to see a list of available options.
13. For each cause of injury, the system displays specific prompts. Respond to the prompts as they appear on your screen.

```
*Was this ER visit caused by an injury? NO// Y <Enter> YES
Town/village where injury occurred: // DULCE <Enter>
Enter the exact time and date of injury: 052708@10a <Enter> (MAY 27, 2008@10:00)
Cause of injury: MOTOR VEHICLE <Enter>

Setting of accident/injury: HIGHWAY OR ROAD <Enter>
Safety equipment used: AIR BAG <Enter>
Location of MVC: 1ST AND MAIN <Enter>
```

Figure 6-2: Discharging an ER patient (steps 9-13)

14. At the “Was this ER visit Work-Related?” prompt, type Y or N.
15. At the “Was an ER Consultant notified?” prompt, Type Y or N.

If you type Yes, the system displays additional prompts as shown in Figure 6-3. Respond to those prompts as appropriate.

```
~~~~~
*Was this ER visit WORK-RELATED? NO// YES <Enter>
~~~~~
*Was an ER CONSULTANT notified? NO// YES <Enter>
*CONSULTANT SERVICE: INTERNAL MEDICINE <Enter>
*What time did the patient see this CONSULTANT: NOW <Enter> (MAY 27, 2008@14:40)
*CONSULTANT NAME: MILLER,GARY <Enter> ASP
*Was another CONSULTANT notified? NO// <Enter>
```

Figure 6-3: Discharging an ER patient (steps 14-15)

16. At the “Enter Procedure” prompt, type the procedure the patient had.

Type ?? to display a list of available options or press Enter to accept the default, NONE.
17. At the “Enter Another Procedure” prompt, type another procedure, or press Enter if there are no other procedures.

18. At the “Enter Narrative Description of the Primary Diagnosis” prompt, type a description of the Primary diagnosis. This is an 80- character text field.
19. At the “Enter ICD9 Code” prompt, enter the correct ICD9 code or accept the default .9999 code.
20. At the “Enter Another Diagnosis” prompt, type another diagnosis, or press Enter if there are no further diagnoses.
21. At the “Enter Final Acuity Assessment from Provider” prompt, type the number of the patient’s final acuity assessment.
22. At the “Disposition” prompt, type the patient’s disposition.

Type ?? to display a list of available dispositions.

```

~~~~~
Enter procedure: NONE// BLOOD TRANSFUSION <Enter>
Enter another procedure: <Enter>
~~~~~
*Enter narrative description of the PRIMARY diagnosis: CAR ACCIDENT <Enter>
*Enter ICD9 code: 234.0 <Enter>
~~~~~
Enter another diagnosis: <Enter>
~~~~~
*Enter final acuity assessment from provider: (1-5): // 2 <Enter>
~~~~~
*Disposition: HOME <Enter>

```

Figure 6-4: Discharging an ER patient (steps 16 -22)

- a. If the disposition is “Transferred to another facility,” the “Where is patient being transferred to” prompt is displayed for you to type the facility to which the patient was transferred.
- b. 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. For example,

```

*Disposition: HOME// REGISTERED IN ERROR <Enter>
Using this DISPOSITION will cause the entire VISIT to be deleted!!
This DISPOSITION can not be changed!!
Do you still wish use this DISPOSITION? YES// <Enter>
PCC Visit deleted...
PIMS Scheduling appointment was not deleted.

```

If you press Enter to indicate Yes, the system deletes the PCC visit, (but not the PIMS scheduling appointment), and returns you to the main menu.

23. At the “Follow up Instructions” prompt, type the follow-up instructions.
24. At the “Provider who Signed PCC Form” prompt, type the name of the Provider who signed the PCC form. The default is the Admitting provider.
25. At the “Discharge Nurse” prompt, type the name of the discharge nurse.
26. At “What time did the patient depart from the ER” prompt, type 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.

```

Follow up instructions: RTC PRN, INSTRUCTIONS GIVEN// <Enter>
~~~~~
Provider who signed PCC form: PROVIDER,JOE// <Enter>           Physician
~~~~~
*Discharge nurse: ADAM,ADAM <Enter>  AA
~~~~~
*What time did the patient depart from the ER:  NOW// 4P <Enter>  (MAY 27,
2008@16:00)

```

Figure 6-5: Discharging an ER patient (steps 23 -26)

The system displays a summary of the patient’s discharge information.

27. Review the summary for accuracy.
28. At the “Do you want to make any changes?” prompt, type **Y** or **N**.
 - If you type No, the discharge is complete, and the system displays the message, “Data entry session successfully completed. Thank you.”
 - If you type Yes,
 - a. 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.
 - b. 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.
 - c. When you finish making changes to the patient discharge, type **NO** at the “Do you want to make any changes?” prompt.

```
Summary of this ER data entry session for JOHN DOE =>
      --- ADMISSION SUMMARY ---
Patient: DOE,JOHN                Arrival time: MAY 27,2008@11:58
Presenting Complaint: HEART ATTACK      Visit type: UNSCHEDULED REVISIT
Transferred from:
Transport to ER: PRIVATE VEHICLE/WALK IN
Ambulance ID:                    Ambulance billing #:
Ambulance company:                Clinic type: EMERGENCY MEDICINE
Admitting provider: PROVIDER,JOE      Triage nurse: ADAM,ADAM
Initial triage category: 1
Seen by triage nurse at: MAY 27,2008@13:00
Seen by admitting provider at: MAY 27,2008@14:00
      --- CAUSE OF VISIT ---
Occupation related: YES
      --- INJURY INFORMATION ---
Injury related visit: YES           Location: DULCE
Time of injury: MAY 27,2008@10:00    Cause of injury: MOTOR VEHICLE
Setting: HIGHWAY OR ROAD             Safety equipment: AIR BAG
      --- ER PROCEDURES ---
Procedures: BLOOD TRANSFUSION
      --- ER CONSULTANT ---
1: INTERNAL MEDICINE @ MAY 27,2008@14:40  CONSULT1,FIRSTNAME
      --- EXIT ASSESSMENT ---

Diagnoses: R ANKLE SPRAIN [845.00]      Discharge acuity: 3
      --- DISPOSITION ---
Disposition: HOME                    Transfer to:
      --- DISCHARGE INFO ---
Provider who signed PCC form: PROVIDER,JOE
Discharge nurse: ADAM,ADAM           Departure time: MAY 27,2008@16:00
      --- FOLLOW UP INSTRUCTIONS ---
Discharge instructions: RTC PRN, INSTRUCTIONS GIVEN

Do you want to make any changes? No//
```

Figure 6-6: Discharging an ER patient (steps 27 and 28)

The following example shows editing a section of the ER patient discharge session.

```

Do you want to make any changes? No// Y <Enter> (Yes)

  Select one of the following:

      1      ADMISSION SUMMARY
      2      CAUSE OF VISIT
      3      INJURY INFO
      4      PROCEDURES
      5      EXIT ASSESSMENT
      6      DISPOSITION
      7      DISCHARGE INFO
      8      FOLLOW UP INSTRUCTIONS
      9      ER CONSULTANTS

Which section do you want to edit: 8 <Enter> FOLLOW UP INSTRUCTIONS
~~~~~
Follow up instructions: RTC PRN, INSTRUCTIONS GIVEN// APPT AND INSTRUCTIONS GIVEN
Summary of this ER data entry session for JOHN DOE =>
      --- ADMISSION SUMMARY ---
Patient: DOE,JOHN                      Arrival time: MAY 27,2008@11:58
Presenting Complaint: heart attack      Visit type: UNSCHEDULED REVISIT
Transferred from:
Transport to ER: PRIVATE VEHICLE/WALK IN
Ambulance ID:                          Ambulance billing #:
Ambulance company:                      Clinic type: EMERGENCY MEDICINE
Admitting provider: PROVIDER,JOE        Triage nurse: ADAM,ADAM
Initial triage category: 1
Seen by triage nurse at: MAY 27,2008@13:00
Seen by admitting provider at: MAY 27,2008@14:00
      --- CAUSE OF VISIT ---
Occupation related: YES
      --- INJURY INFORMATION ---
Injury related visit: YES                Location: DULCE
Time of injury: MAY 27,2008@10:00        Cause of injury: MOTOR VEHICLE
Setting: HIGHWAY OR ROAD                 Safety equipment: AIR BAG
      --- ER PROCEDURES ---
Procedures: BLOOD TRANSFUSION
      --- ER CONSULTANT ---
1:
      --- EXIT ASSESSMENT ---

Diagnoses: R ANKLE SPRAIN [845.00]       Discharge acuity: 3
      --- DISPOSITION ---
Disposition: HOME                        Transfer to:
      --- DISCHARGE INFO ---
Provider who signed PCC form: PROVIDER,JOE
Discharge nurse: ADAM,ADAM              Departure time: MAY 27,2008@16:00
      --- 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// Y <Enter> (Yes)
Enter the number of copies you would like to print: (1-10): 1 <Enter>
I will print a set of follow up instructions for the patient and provider.
You can also print patient education materials...

Select one of the following:
  A  Adult
  P  Pediatric
Print instructions for which age group: A <Enter>
Enter patient education topic SPRAINED ANKLE <Enter> 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// SLAVE <Enter> PC PTR
~~~~~
Data entry session successfully completed...Thank you
```

Figure 6-7: Example of editing the Follow Up section of an ER patient discharge

7.0 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. Please contact your site administrator to determine or change your security keys.

To cancel a visit, follow these steps:

1. At the “Select Emergency Room System Option” prompt, type **DNA**.

The system displays a list of patients currently admitted to the ER.

2. At the “Select ER patient” prompt, type the number that matches the patient visit you want to cancel.
3. At the “Disposition” prompt, press Enter to accept the default disposition, Left Without Being Seen.
4. At the “Follow up Instructions” prompt, press Enter.
5. At the “Provider who signed PCC form” prompt, type the name of the provider who signed the PCC form.
6. At 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. At the “Do you want to make any changes?” prompt, type **Y** or **N**.
 - If you type No, the visit is cancelled, and the system displays the message, “Data entry session successfully completed. Thank you.”
 - If you type Yes,
 - a. 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.
 - b. 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.

- c. 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 Option: DNA <Enter> Cancel Visit (did not answer or
left AMA)

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

The following patients are currently admitted to the ER =>

NAME          DOB          CHART      ADMISSION      PRESENTING COMPLAINT
-----
1) RABBITT,BUD  JAN 01,1951  123        MAY 27,2008@12:13  HEART ATTACK
2) DEMO,P       AUG 01,1951  22222     MAY 27,2008@12:13  PAIN IN NECK

Select ER patient: 2 <Enter> DEMO,P
DEMO,P          F 08-01-1951 000351866      22222

~~~~~

Disposition: LEFT WITHOUT BEING SEEN// <Enter>

~~~~~

Follow up instructions: <Enter>

~~~~~

(Primary)Provider who signed PCC form: CHASE,R <Enter>

~~~~~

Discharge nurse: ADAM,ADAM <Enter> AA

~~~~~

What time did the patient depart from the ER: NOW// <Enter> (MAY 27, 2008@12:22)
Summary of this ER data entry session for JANE DOE =>
--- ADMISSION SUMMARY ---
Patient: DOE,JANE          Arrival time: MAY 27,2008@12:13
Presenting Complaint: PAIN IN NECK      Visit type: UNSCHEDULED REVISIT
Transferred from:          Transport to ER or Private Vehicle/Walk-in:
Ambulance ID:              Ambulance billing #:
Ambulance company:         Clinic type:
Admitting provider:        Triage nurse:
Initial triage category:    Seen by triage nurse at:
Seen by admitting provider at:

--- 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: CHASE,R   Discharge nurse: ADAM,ADAM
Departure time: MAY 27,2008@12:22
          --- FOLLOW UP INSTRUCTIONS ---
Discharge instructions:

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

~~~~~

Data entry session successfully completed...Thank you
```

Figure 7-1: Example of canceling an ER patient visit

8.0 DOA Admissions to ER (DOA)

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

Note: This menu option is currently under construction and not available as of January 2009.

9.0 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.

9.1 Registering a New Patient (REG)

To register a new patient, follow these steps:

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

Note: When typing the name, do not use any spaces after the comma; for example, LAST,FIRST

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

3. At the “Enter the patient’s full name” prompt, type the patient’s name in the sequence LAST,FIRST.

If the new patient name includes a (first or) middle initial, you are prompted to enter the complete name, or press Enter to continue.

```
Select Emergency Room System Option:   REG <Enter>  Mini-Registration of New
Patients

ADD a new patient.....

You must first SCAN FOR SIMILAR NAMES or CHART NUMBERS NOW...
Select PATIENT NAME: SMITH
  ?? <Enter>

Select PATIENT NAME:
Enter the NEW PATIENT'S FULL NAME.....
  (EXAMPLE:   MORGAN,JAMES PAUL,JR   (no space after commas))

Entering NEW Patient for NOT-A-REAL FACILITY

Enter the PATIENT'S NAME: SMITH,JOANN <Enter>
  ARE YOU ADDING 'SMITH,JOANN' AS A NEW PATIENT (THE 9291ST)? No// Y <Enter>  (Yes)
```

Figure 9-1: Adding a new patient (steps 1-3)

4. At the “Patient Sex” prompt, type the patient’s gender.
5. At the “Patient DOB” prompt, type the patient’s date of birth.
6. At 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.

7. At the “Do you need a temporary chart number for this patient?” prompt, enter Y or N.
 - If you type Y (Yes), RPMS creates a temporary chart number for this patient, and displays the temporary number.
 - If you type N (No), everything you entered previously into the patient file is deleted.
8. At the “Date of Birth” prompt, press Enter to accept the displayed DOB, or type the correct DOB.
9. At the “Sex” prompt, press Enter, to accept the displayed sex, or type the correct gender.

```
Enter complete middle name if known,  
  or press <return> to add as entered: <Enter>  
PATIENT SEX: M <Enter>  MALE  
PATIENT DOB: 110101 <Enter>  (NOV 01, 1901)  
PATIENT SSN: 000412365  
  
...searching for potential duplicates  
  
No potential duplicates have been identified.  
  
...adding new patient  
  
Do you need a temporary chart number for this new patient? (Y/N)  N// Y <Enter>  
  
The new patient's TEMPORARY chart number is T00008  
  
Press RETURN <Enter>  
DATE OF BIRTH: 11/01/1901// <Enter>  
  
SEX: MALE// <Enter>
```

Figure 9-2: Adding a new patient (steps 4-8)

9.2 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.

In addition, 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. At the “Select Emergency Room System Option” prompt, Type **SCAN** and press Enter.
2. At 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 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:
```

Figure 9-3: Scanning for patients(SCAN)

10.0 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:

At the “Select Emergency Room System Option” prompt, 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 Option: HERE <Enter> List Patients Currently Admitted
to ER

The following patients are currently admitted to the ER =>

  NAME          DOB          CHART    ADMISSION          PRESENTING COMPLAINT
-----
1) Doe,John     AUG 01,1902  22222    MAY 27,2003@12:13  pain in neck
2) RABBITT,BUD  JAN 01,1901  123      MAY 27,2003@12:13  Heart Attack

Press the 'RETURN' key to go on <>
```

Figure 10-1: Displaying a list of currently admitted patients (HERE)

11.0 Patient Instruction Menu (INST)

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

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 create patient instruction materials:

1. At the “Select Emergency Room System Option” prompt, type **INST**.
2. At the “Select Patient Instruction Menu Option” prompt, type
 - **ADD** to add patient education material
For instructions see Section 11.1, “Add Patient Education Material (ADD).”
 - **PRT** to print patient education materials
For instructions see Section 11.2, “Print Patient Education Materials (PRT).”

```

Select Emergency Room System Option: INST <Enter> Patient Instruction Menu

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

ADD Add Patient Education Material
PRT Print Patient Education Materials

Select Patient Instruction Menu Option:

```

Figure 11-1: Displaying the Patient Instruction Material (INST) menu options

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, follow these steps:

1. At the “Select Patient Instruction Menu Option” prompt, Type **ADD**.
2. At the “Select ER Instructions Topic” prompt, type the name of the new topic.
3. At the “Are you adding ‘*topic-name*’ as a new ER Instructions?” prompt, type **Y**.
4. At the “ER Instructions Category” prompt. type
 - **A** for Adult instructions
 - **P** for Pediatric instructions

```
Select Patient Instruction Menu Option: ADD <Enter> Add Patient Education Material
Select ER INSTRUCTIONS TOPIC: NEW TOPIC <Enter>
Are you adding 'NEW TOPIC' as a new ER INSTRUCTIONS (the 1ST)? No// Y <Enter>
(Yes)
ER INSTRUCTIONS CATEGORY: ?? <Enter>

Choose from:
A      ADULT
P      PEDIATRIC
ER INSTRUCTIONS CATEGORY: A ADULT
```

Figure 11-2: Adding new patient education materials (steps 1-4)

5. At the “Topic” prompt, Press Enter to accept the new topic name.
6. At the “Category” prompt, Press Enter to accept the new topic category.
7. At the “Edit?” prompt, type **Y** to enter the topic description.

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.

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.”

When you are done, press **F1** to save your text and type **E** to exit the word processing tool.

8. At the next “Select ER Instructions Topic” prompt,
 - Press Enter to return to the Patient Instruction menu
 - Repeat steps 2-7 to add another set of patient instructions.

```

TOPIC: NEW TOPIC// <Enter>
CATEGORY: ADULT// <Enter>
Description:
  No existing text
  Edit? NO// Y <Enter> (Yes)

==[ WRAP ]==[ INSERT ]===== < Description >===== [ <PF1>H=Help ]=====
                                     Type the new patient instructions here

<====T=====T=====T=====T=====T=====T=====T=====T=====T>=====
Select ER INSTRUCTIONS TOPIC:

```

Figure 11-3: Adding new patient education materials (steps 5-8)

11.2 Print Patient Education Materials (PRT)

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

To print patient education materials, follow these steps:

1. At the “Select Patient Instruction Menu Option” prompt, type **PRT**.
2. At the “Print Instructions for which age group” prompt, type
 - **A** to print Adult instructions
 - **P** to print Pediatric instructions
3. At the “Enter the number of copies you would like to print” prompt, type a number between 1 and 10.
4. At 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.

When done, Press enter at the prompt.

- At 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 Option: PRT <Enter> Print Patient Education
Materials

      Select one of the following:

          A          ADULT
          P          PEDIATRIC

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

Enter another patient education topic: <Enter>
Print patient instructions on which device: HOME// <Enter>
```

Figure 11-4: Printing patient education materials (PRT)

12.0 Reports Menu (RPTS)

The options on the **Reports Menu** 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.

1. To access the Emergency Room System Reports menu, type **RPTS** at the “Select Emergency Room System Option” prompt.

The system displays the Reports menu; for example,

```
Select Emergency Room System Option: RPTS <Enter> Reports Menu ...

*****
*                Reports Menu                *
*          Indian Health Service              *
*                Version 3.0                  *
*****
                        NOT-A-REAL FACILITY

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

Select Reports Menu Option:
```

Figure 12-1: Displaying the ERS Reports menu (RPTS)

The following table lists the ERS Reports menu options and their corresponding section of instructions.

Option	Action	For details see Section
CAN	Create predefined reports for tracking patients by triage category or nurse, or by consultant type; transfers from outside facilities; and patient arrivals by ambulance or by flight services.	12.1
AUD	Create audit reports of ER visits	12.1.7
LIST	Create statistical reports	12.3
LOG	Print the ER log	12.4
VIS	Display a patient's gender, date of birth (DOB), Social Security number (SSN), and chart number.	12.5
VV	Display the details of a patient visit	12.6

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, follow these steps:

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 **CAN**.

The system displays the list of reports; for example,

```
Select Reports Menu Option: CAN <Enter> 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 12-2: List of CAN (predefined) reports

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

The following table lists the reports and their corresponding section of instructions:

Number	Report	For details see Section
1	Patients by Triage Category	12.1.1
2	Patients by Triage Nurse	12.1.2
3	Patients by Consultant Type	12.1.3
4	Transfers from outside facilities	12.1.4
5	Arrive to ER by ambulance	12.1.5
6	Arrive to ER by flight services	12.1.6
7	Transferred to other facilities	12.1.7

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 Patients by Triage Category Report, follow these steps:

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 one of the following:
      1          SORT BY TRIAGE CATEGORY
      2          SORT BY PATIENT LAST NAME
      3          SORT BY ADMIT TIME
Select sort option:
```

4. At the "Select sort option" prompt, 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 12-3) displays a triage category report sorted by initial acuity. You can also sort by the patient's last name or by the admission time.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
ER VISIT TRIAGE CATEGORY REPORT BY CATEGORY FROM: DEC 25,2008 TO: DEC
31,2008
JAN 26,2009 11:13 PAGE 1
Sort Criteria: INITIAL ACUITY to 5 (includes nulls)
ADMISSION TIMESTAMP from Dec 25,2008 to Dec 31,2008@24:00
TRGE CAT PATIENT CNO DOB ARRIVAL TIME
-----
2 TUWNSAND, CHARLE 105425 APR 29,1982 DEC 30,2008 06:58
2 NESUN, LOIS M 102369 MAY 9,1926 DEC 30,2008 13:11
-----
SUBCOUNT 2
3 MORREI, CECELIA 110543 FEB 3,1955 DEC 30,2008 12:03
3 LASLYA, BRIAN DU 107258 DEC 30,1987 DEC 30,2008 14:10
3 HANRI, KAREN R 101768 FEB 2,1962 DEC 31,2008 11:11
-----
SUBCOUNT 3
4 FALT, JOSEPH A 105118 AUG 7,1957 DEC 29,2008 15:34
4 NETTRASS, YVONNE 105845 APR 26,1955 DEC 31,2008 11:11
-----
SUBCOUNT 2
COUNT 7
Enter RETURN to continue or '^' to exit:

```

Figure 12-3: Example of Patients by Triage Category Report sorted by initial acuity

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, follow these steps:

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 and choices:

```
***** TIME FRAME *****
Start Date: 12/15/08
End Date: 12/31/08
FINISHED SYNCHING ERS WITH CURRENT PCC DATA FROM DEC 15,2008 TO DEC 31,2008

Select one of the following:

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

Select sort option:
```

4. At the “Select sort option” prompt, 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.

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, follow these steps:

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.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
ER VISITS BY ER CONSULTANT TYPE FROM: AUG 21,2006 TO: AUG 22,2006
                                AUG 23,2006 13:04 PAGE 1
CONSULTANT TYPE      CONSULTANT NAME      ADMISSION      CONSULT TIME
PATIENT              CNO
PRIMARY DX
NARRATIVE
-----
GASTROENEROLOGY      HOLT,VIRGIL      AUG 21,2006    04:30
WANTLEND,RICHARD      AUG 21,2006    03:00
DEAN
536.9 {STOMACH FUNCTION DIS NOS}
stomach pains undetermined
PAIN MEDICINE        WILSON,RUPERT O      AUG 22,2006    11:00
JONES,CHIP            654356            AUG 22,2006    10:00
380.53 {STENOSIS EAR D/T INFLAM}
R INNER EAR INFLAMMATION

***** CONFIDENTIAL PATIENT INFORMATION *****
ER VISITS BY ER CONSULTANT TYPE FROM: AUG 21,2006 TO: AUG 22,2006
                                AUG 23,2006 13:04 PAGE 2
CONSULTANT TYPE      CONSULTANT NAME      ADMISSION      CONSULT TIME
PATIENT              CNO
PRIMARY DX
NARRATIVE
-----
SURGEON - TRAUMA      MILLER,GARY        AUG 21,2006    16:30
MIRMAL,LINDA M        104047            AUG 21,2006    14:00
873.59 {OPEN WND FACE NEC-COMPL}
mauled on right side of arm and face by pit-bull

Enter RETURN to continue or '^' to exit:

```

Figure 12-4: Example of Patients by Consultant Type Report

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.

- 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 the Transfers from Outside Facilities report sorted by the facility.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
ER VISIT TRANSFERS FROM OUTSIDE FACILITIES FROM: JAN 1,1995@00:01 TO: AUG 24,2
006@23:59
                                AUG 24,2006 06:01 PAGE 2
TRANSFERED FROM PATIENT ARRIVED BY CNO
PRESENTING COMPLAINT ARRIVAL TIME
-----
UNM Hospital CRANBERRY,MARY CHARTER AIR T00003
DISLOCATED R SHOULDER AUG 17,2006 12:53
-----
SUBCOUNT 1
-----
COUNT 1

```

Figure 12-5: Example of Transfers from Outside Facilities Report

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, follow these steps:

- At the “Select Report:” prompt, type 5.
- At the “Start Date” prompt, enter a date, or press Enter to begin the report with the very first ER visit.
- At the “End Date” prompt, enter a date, or press Enter to end the report with the very first ER visit.
- At the “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.

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

The following example shows the Arrive to ER by Ambulance report.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
ARRIVE TO ER BY AMBULANCE FROM: AUG 1,2006@00:01 TO: AUG 24,2006@23:59
                                AUG 24,2006 06:08 PAGE 2
AMBULANCE COMPANY          PATIENT          CNO          ADMISSION          TRIAG
PRESENTING COMPLAINT          TIMESTAMP          CAT
-----
TRANSCARE          RENDBARG,HAZEL  102408          AUG 1,2006 09:20          3
  stroke
TRANSCARE          TEILUR,JOEL G.  102800          AUG 4,2006 16:00          2
  stroke
TRANSCARE          WADE,ROBERT L   T00001          AUG 4,2006 07:03          2
  stroke
TRANSCARE          WITESKA,IRENE O 108556          AUG 1,2006 13:44          3
  stroke
-----
SUBCOUNT 4
-----
COUNT 4

```

Figure 12-6: Example of an Arrive to ER by Ambulance Report

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, follow these steps:

1. At the “Select Report:” prompt, 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 shows an Arrive to ER by Air Ambulance report.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
ARRIVE TO ER BY AIR AMBULANCE FROM: AUG 1,2006@00:01 TO: AUG 24,2006@23:59
                                AUG 24,2006 06:48 PAGE 1
AMBULANCE COMPANY          PATIENT          CNO          ADMISSION          TRIAG
PRESENTING COMPLAINT          TIMESTAMP          CAT
-----
                                MODE OF TRANSPORT: AIR AMBULANCE
TRANSCARE          WEDA,LINDA S          105413          AUG 17,2006 14:09          3
R WRIST FRACTURE
-----
SUBCOUNT 1
-----
COUNT 1

```

Figure 12-7: Example of Arrive to ER by Air Ambulance Report

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, follow these steps:

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 shows a Transferred to Other Facilities report.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
TRANSFERRED TO OTHER FACILITIES FROM: DEC 15,2008 TO: JAN 20,2009
                                JAN 26,2009 11:23 PAGE 1
                                ADMISSION      TRIAG
PATIENT                          CNO          TIMESTAMP      CAT
  PRESENTING COMPLAINT
-----
          TRANSFERED TO: LOCAL MENTAL HEALTH
ALLAGEERD,LAVONNE C              108536      JAN  8,2009  15:42  2
  BROKEN LEG
REDAR,GEORGE H                   110893      DEC 16,2008  08:02  2
  HEART ATTACK
THUMPSUN,CELESTE L              107851      JAN  8,2009  13:21  3
  MIGRAINE HEADACHE

***** CONFIDENTIAL PATIENT INFORMATION *****
TRANSFERRED TO OTHER FACILITIES FROM: DEC 15,2008 TO: DEC 31,2008
                                JAN 26,2009 11:23 PAGE 2
                                ADMISSION      TRIAG
PATIENT                          CNO          TIMESTAMP      CAT
  PRESENTING COMPLAINT
-----
          TRANSFERED TO: LOVELACE MEDICAL CENTER
TREETNAR,LAWRENCE J              111697      JAN 16,2009  08:00  3
  SHORTNESS OF BREATH
          TRANSFERED TO: UNIVERSITY EMERGENCY ROOM
CALLATTA,ROBERT                  103652      JAN 20,2009  08:00  2
  HEADACHES
-----
COUNT 5

Enter RETURN to continue or '^' to exit:

```

Figure 12-8: Example of Transferred to Other Facilities Report

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, follow these steps:

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 **AUD**.

The system displays the list of reports; for example,

```
Select Reports Menu Option: AUD <Enter> ER System Pre-Defined 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 12-9: ER Visit Auditing Log Reports (AUD)

3. Type the number that matches the report you want to create.

The following table lists the reports and their corresponding section of instructions:

Number	Report	For details see Section
1	Daily ER Audit Log	12.2.112.1.1
2	Single ER Visit ER Audit Log	12.2.2
3	Data Enterer ER Audit Log	12.2.3
4	Visit Field ER Audit Log	12.2.4
5	Edit Reason ER Audit Log	12.2.5
6	ER Audit Log by Visit Date	12.2.6

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, follow these steps:

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.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
ER VISIT DAILY EDIT LOG REPORT FROM: AUG 22,2006
                                         OCT 20,2006 10:06 PAGE 2
VISIT TIME          EDITED BY
FIELD NAME          REASON          COMMENT
ORIGINAL
CHANGED TO
-----
.9999 {UNCODED DIAGNOSIS}
873.59 {OPEN WND FACE NEC-COMPL}
DIAGNOSIS           Administrative   CODING AFTER CHANIGNG PATIENT NAME
.9999 {UNCODED DIAGNOSIS}
873.59 {OPEN WND FACE NEC-COMPL}
AUG 21,2006 03:00   RANDOLPH,STEPHANIE
PRIMARY DIAGNOSIS   Administrative   updating a primary narrative
.9999 {UNCODED DIAGNOSIS}
536.9 {STOMACH FUNCTION DIS NOS}
DIAGNOSIS           Administrative   not sure what to make of this
.9999 {UNCODED DIAGNOSIS}
536.9 {STOMACH FUNCTION DIS NOS}

```

Figure 12-10: Example of the Daily ER Audit Log Report

12.2.2 Single ER Visit ER Audit Log Report (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, follow these steps:

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.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
ER VISIT LOG ENTRY
                                     AUG 22,2006  12:16   PAGE 1
-----

          ERVSIT IEN: AUG  1,2006  08:46

TIMESTAMP: AUG 02, 2006@15:47:52      ERVSIT IEN: AUG 01, 2006@08:46
  DATA ENTERER: RANDOLPH,STEPHANIE
EDITED FIELD: 5.2.1                    EDIT TIME: AUG 02, 2006@15:48:27
  OLD VALUE: .9999 {UNCODED DIAGNOSIS}
  NEW VALUE: 389.04 {COND HEAR LOSS INNER EAR}
  EDIT REASON: Data entry error        COMMENT: heh
  EDITED FIELD NAME: PRIMARY DIAGNOSIS
EDITED FIELD: 5-01.1                  EDIT TIME: AUG 02, 2006@15:48:09
  OLD VALUE: .9999 {UNCODED DIAGNOSIS}
  NEW VALUE: 389.04 {COND HEAR LOSS INNER EAR}
  EDIT REASON: Other
  COMMENT: system failure
  EDITED FIELD NAME: DIAGNOSIS
EDITED FIELD: 5-01.2                  EDIT TIME: AUG 02, 2006@15:48:58
  OLD VALUE: .9999 {UNCODED DIAGNOSIS}
  NEW VALUE: 259.9 {ENDOCRINE DISORDER NOS}

***** CONFIDENTIAL PATIENT INFORMATION *****
ER VISIT LOG ENTRY
                                     AUG 22, 2006@12:16   PAGE 2
-----

  EDIT REASON: Data entry error        COMMENT: an un specified disorder
  EDITED FIELD NAME: DIAGNOSIS
EDITED FIELD: 5-1.2                    EDIT TIME: AUG 02, 2006@15:49:13
  OLD VALUE: endocrine sufferage
  NEW VALUE: unspecified endocrine disorder
  EDIT REASON: Data entry error        COMMENT: that was it all along
  EDITED FIELD NAME: PROVIDER NARRATIVE
EDITED FIELD: .03                      EDIT TIME: AUG 02, 2006@15:49:24
  NEW VALUE: 3060801.0846             EDIT REASON: Data entry error
  COMMENT: entered previous patient info
  EDITED FIELD NAME: PCC

Enter RETURN to continue or '^' to exit:

```

Figure 12-11: Example of Single ER Visit ER Audit Log Report

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, follow these steps:

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.

```
Select Report: 3 <Enter> DATA ENTERER ER AUDIT LOG

~~~~~

**** TIME FRAME ****
Enter starting date: AUG21 <Enter>
Enter ending date: AUG22

Start Date: AUG 21,2006                End Date: AUG 22,2006@23:59
```

Figure 12-12: Single ER Visit ER Audit Log Report (steps 1-3)

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.

```
***** CONFIDENTIAL PATIENT INFORMATION *****
ER VISIT DATA ENTERER AUDIT LOG REPORT FROM: AUG 21,2006 TO: AUG 22,2006
                                     AUG 22,2006 12:46 PAGE 1

DATA ENTERER                TIMESTAMP                ERVSIT IEN
-----
RANDOLPH,STEPHANIE          AUG 21,2006 16:10          AUG 21,2006 16:08
RANDOLPH,STEPHANIE          AUG 22,2006 07:05          AUG 21,2006 03:00
RANDOLPH,STEPHANIE          AUG 22,2006 07:07          AUG 21,2006 14:00

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

Figure 12-13: Data Enterer ER Audit Log Report example

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, follow these steps:

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.
5. At the “Right Margin” prompt, press Enter to accept the default value of 80, or type the size of the right margin.

```
Select Report: 4 <Enter> VISIT FIELD ER AUDIT LOG
~~~~~
***** TIME FRAME *****
Enter starting date: AUG21 <Enter>
Enter ending date: AUG22 <Enter>

Start Date: AUG 21,2006           End Date: AUG 22,2006
DEVICE: <Enter> VIRTUAL           Right Margin: 80// <Enter>
```

Figure 12-14: Single ER Visit ER Audit Log Report (steps 1-5)

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

```

***** CONFIDENTIAL PATIENT INFORMATION *****
ER VISIT FIELD AUDIT LOG REPORT FROM: AUG 21,2006 TO: AUG 22,2006
                                         OCT 20,2006 12:51 PAGE 1
FIELD NAME                               ORIGINALLY                               CHANGED TO
-----
DATA ENTERER: RANDOLPH,STEPHANIE
TIMESTAMP: AUG 21,2006 16:10
PRIMARY DIAGNOSIS .9999 {UNCODED DIAGNOSIS} 989.5 {TOXIC EFFECT VENOM
PRIMARY DX NARRATIVE allergic reaction to bee- allergic reaction to bee
DIAGNOSIS .9999 {UNCODED DIAGNOSIS} 989.5 {TOXIC EFFECT VENOM
PROVIDER NARRATIVE allergic reaction to bee- allergic reaction to bee
TIMESTAMP: AUG 22,2006 07:05
PRIMARY DIAGNOSIS .9999 {UNCODED DIAGNOSIS} 780.6 {FEVER}
DIAGNOSIS .9999 {UNCODED DIAGNOSIS} 780.6 {FEVER}
TIMESTAMP: AUG 22,2006 07:07
PATIENT MIRMAL,DEBRA M MIRMAL,LINDA M
PRIMARY DIAGNOSIS .9999 {UNCODED DIAGNOSIS} 873.59 {OPEN WND FACE NEC
DIAGNOSIS .9999 {UNCODED DIAGNOSIS} 873.59 {OPEN WND FACE NEC
TIMESTAMP: AUG 22,2006 15:49
PRIMARY DIAGNOSIS .9999 {UNCODED DIAGNOSIS} 536.9 {STOMACH FUNCTION D
DIAGNOSIS .9999 {UNCODED DIAGNOSIS} 536.9 {STOMACH FUNCTION D
Enter RETURN to continue or '^' to exit:

```

Figure 12-15: ER Visit Field ER Audit Log Report example

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 the

- 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, follow these steps:

1. At the “Select Report” prompt, type **5**.
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 “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.

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

```

***** CONFIDENTIAL PATIENT INFORMATION *****
ER VISIT FIELD AUDIT LOG REPORT FROM: AUG 21,2006 TO: AUG 22,2006
                                     AUG 23,2006 06:23 PAGE 1
EDIT TIME          VISIT TIME          REASON          DATA ENTERER
-----
AUG 21,2006 16:10  AUG 21,2006 16:08 Administrative  RANDOLPH,STEPHANIE
AUG 22,2006 07:05  AUG 21,2006 03:00 Administrative  RANDOLPH,STEPHANIE
AUG 22,2006 07:07  AUG 21,2006 14:00 Administrative  RANDOLPH,STEPHANIE
AUG 22,2006 15:49  AUG 21,2006 03:00 Administrative  RANDOLPH,STEPHANIE
AUG 22,2006 07:07  AUG 21,2006 14:00 Administrative  RANDOLPH,STEPHANIE

AUG 21,2006 16:10  AUG 21,2006 16:08 Administrative  RANDOLPH,STEPHANIE
AUG 22,2006 07:05  AUG 21,2006 03:00 Administrative  RANDOLPH,STEPHANIE
AUG 22,2006 07:07  AUG 21,2006 14:00 Administrative  RANDOLPH,STEPHANIE
AUG 22,2006 15:49  AUG 21,2006 03:00 Administrative  RANDOLPH,STEPHANIE

***** CONFIDENTIAL PATIENT INFORMATION *****
ER VISIT FIELD AUDIT LOG REPORT FROM: AUG 21,2006 TO: AUG 22,2006
                                     AUG 23,2006 06:23 PAGE 2
EDIT TIME          VISIT TIME          REASON          DATA ENTERER
-----
AUG 21,2006 16:10  AUG 21,2006 16:08 Administrative  RANDOLPH,STEPHANIE
AUG 21,2006 16:10  AUG 21,2006 16:08 Administrative  RANDOLPH,STEPHANIE

Enter RETURN to continue or '^' to exit:

```

Figure 12-16: Example of Edit Reason ER Audit Log Report

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, follow these steps:

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

```

***** CONFIDENTIAL PATIENT INFORMATION *****
ER VISIT EDIT LOG REPORT BY ER VISIT FROM: AUG 21,2006 TO: AUG 22,2006
                                     AUG 23,2006 07:31 PAGE 1
-----

      ERVSIT IEN: AUG 21,2006 03:00

TIMESTAMP: AUG 22, 2006@07:05:28      ERVSIT IEN: AUG 21, 2006@03:00
  DATA ENTERER: RANDOLPH,STEPHANIE
  EDITED FIELD: 5.2.2                  EDIT TIME: AUG 22, 2006@07:06:39
    OLD VALUE: .9999 {UNCODED DIAGNOSIS} NEW VALUE: 780.6 {FEVER}
    EDIT REASON: Administrative          COMMENT: DX CODE PRIMAR
    EDITED FIELD NAME: PRIMARY DIAGNOSIS
  EDITED FIELD: 5-01.2                EDIT TIME: AUG 22, 2006@07:06:30
    OLD VALUE: .9999 {UNCODED DIAGNOSIS} NEW VALUE: 780.6 {FEVER}
    EDIT REASON: Administrative          COMMENT: DX CODING
    EDITED FIELD NAME: DIAGNOSIS

TIMESTAMP: AUG 22, 2006@15:49:06      ERVSIT IEN: AUG 21, 2006@03:00
  DATA ENTERER: RANDOLPH,STEPHANIE
  EDITED FIELD: 5.2.2                  EDIT TIME: AUG 22, 2006@15:50:28
    OLD VALUE: .9999 {UNCODED DIAGNOSIS} NEW VALUE: 536.9 {STOMACH FUNCTION DIS NOS}
    NEW VALUE: 536.9 {STOMACH FUNCTION DIS NOS}
    EDIT REASON: Administrative          COMMENT: updating a primary narrative
    EDITED FIELD NAME: PRIMARY DIAGNOSIS
  EDITED FIELD: 5-01.2                EDIT TIME: AUG 22, 2006@15:50:19
    OLD VALUE: .9999 {UNCODED DIAGNOSIS} NEW VALUE: 536.9 {STOMACH FUNCTION DIS NOS}
    NEW VALUE: 536.9 {STOMACH FUNCTION DIS NOS}
    EDIT REASON: Administrative          COMMENT:
    EDITED FIELD NAME: DIAGNOSIS
      ERVSIT IEN: AUG 21,2006 14:00

TIMESTAMP: AUG 22, 2006@07:07:52      ERVSIT IEN: AUG 21, 2006@14:00
  DATA ENTERER: RANDOLPH,STEPHANIE
  EDITED FIELD: .02                   EDIT TIME: AUG 22, 2006@07:08:05
    OLD VALUE: MIRMAL,DEBRA M           NEW VALUE: MIRMAL,LINDA M
    EDIT REASON: Administrative
    COMMENT: CHANGING A PATIENT WITH NEW PCC LOOKUPS
    EDITED FIELD NAME: PATIENT

  EDITED FIELD: 5.2.1                 EDIT TIME: AUG 22, 2006@07:09:25
    OLD VALUE: .9999 {UNCODED DIAGNOSIS} NEW VALUE: 873.59 {OPEN WND FACE NEC-COMPL}
    NEW VALUE: 873.59 {OPEN WND FACE NEC-COMPL}
    EDIT REASON: Administrative          COMMENT: CODING PRIMARY NARRATIVE
    EDITED FIELD NAME: PRIMARY DIAGNOSIS
  EDITED FIELD: 5-01.1                 EDIT TIME: AUG 22, 2006@07:09:15
    OLD VALUE: .9999 {UNCODED DIAGNOSIS}

```

Figure 12-17: Example of ER Audit Log by Visit Date report

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; for example,

```

***** 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:

```

Figure 12-18: ER System Report Generator (LIST)

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

The following table lists the reports and their corresponding section of instructions:

Number	Report	For details see Section
1	Standard ER Log Report	12.3.1
2	Brief ER Log Report	12.3.2
3	Statistical Reports	12.3.3
4	Hourly Workload Report	12.3.4

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, follow these steps:

1. At the “Select Report” prompt, type **1**.

The system displays the following display options and prompt:

```

***** 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//

```

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:

```

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

Patient attributes =>
  1) AGE ON DAY OF VISIT          4) ELIGIBILITY
  2) CURRENT COMMUNITY           5) SEX
  3) DOA                         6) TRIBE

Visit attributes =>
  7) ACUITY                      17) INJURY TIME LAG
  8) BENEFICIARY CLASS           18) NURSE
  9) DIAGNOSTIC CATEGORY         19) OCCUPATION RELATED
 10) DISPOSITION                 20) PHYSICIAN
 11) EMERGENCY TRANSPORT         21) PROCEDURE
 12) FINAL CONDITION             22) REVOLVING DOOR
 13) FIRST OR REVISIT           23) TOTAL VISIT DURATION
 14) FOLLOW UP                   24) WAITING TIME FOR THE DOCTOR
 15) ICD9 CODE                  25) WAITING TIME FOR TRIAGE
 16) INJURY CAUSE

Sort by: (1-25):

```

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 a blank “Then sort by” prompt.
7. At “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.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
STANDARD ER LOG REPORT FROM: JAN 01, 1995@00:01 TO: SEP 20, 2006@23:59
                               SEP 20,2006 11:31 PAGE 1
-----

ADMISSION TIMESTAMP: JUN 23,2006 08:14
PATIENT: BOCK,KAREN S PCC VISIT: JUN 23,2006 08:14
DOB: SEP 19,1978 AGE AT VISIT: 27
CHART #: 109360 GENDER: FEMALE
MODE OF TRANSPORT: PRIVATE VEHICLE/WALK IN
AMBULANCE CO:
AMBULANCE #: AMB INVOICE #:
PRESENTING COMPLAINT: shock
OCCUPATION RELATED: NO INJURED: NO
CAUSE OF INJURY: SCENE OF INJURY:
TIME OF INJURY:
SAFETY EQUIPMENT:
TOWN OF INJURY:

***** CONFIDENTIAL PATIENT INFORMATION *****
STANDARD ER LOG REPORT FROM: JAN 01, 1995@00:01 TO: SEP 20, 2006@23:59
                               SEP 20,2006 11:31 PAGE 2
-----

EXACT MVC LOCATION:
DRIVERS INSURANCE CO: DRIVER POLICY NUMBER:
OWNER INSURANCE CO: OWNER POLICY NUMBER:
OWNER NAME:
PROCEDURES:
NONE
PRIMARY DIAGNOSIS: .9999 {UNCODED DIAGNOSIS}
PRIMARY DX NARRATIVE: shock
DIAGNOSIS: DX NARRATIVE:
.9999 {UNCODED DIAGNOSIS} shock
ADMITTING PROVIDER: SMITH,TIM
ADMITTING PROVIDER TIME: JUN 23,2006 08:15
TRIAGE NURSE: RICHARDS,MARIE
TRIAGE TIME: JUN 23,2006 08:15
INITIAL ACUITY: 2 FINAL ACUITY: 2
DISPOSITION: HOME
TRANSFERRED TO:
DEPARTURE TIME: JUN 23,2006 08:16

```

Figure 12-19: Example of Standard ER log report

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, follow these steps:

1. At the “Report Type” prompt, type 2.

The system displays the following display options and prompt:

```

***** 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//

```

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:

```

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

Patient attributes =>
  1) AGE ON DAY OF VISIT          4) ELIGIBILITY
  2) CURRENT COMMUNITY           5) SEX
  3) DOA                          6) TRIBE

Visit attributes =>
  7) ACUITY                       17) INJURY TIME LAG
  8) BENEFICIARY CLASS           18) NURSE
  9) DIAGNOSTIC CATEGORY         19) OCCUPATION RELATED
 10) DISPOSITION                 20) PHYSICIAN
 11) EMERGENCY TRANSPORT        21) PROCEDURE
 12) FINAL CONDITION            22) REVOLVING DOOR
 13) FIRST OR REVISIT           23) TOTAL VISIT DURATION
 14) FOLLOW UP                   24) WAITING TIME FOR THE DOCTOR
 15) ICD9 CODE                  25) WAITING TIME FOR TRIAGE
 16) INJURY CAUSE

Sort by: (1-25):

```

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 a blank “Then sort by” prompt.
 7. At “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 the Brief ER Log Report for August 1, 2006 through September 1, 2006.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
BRIEF ER LOG REPORT FROM: AUG 01, 2006 TO: SEP 01, 2006@23:59
                               SEP 20,2006 13:07 PAGE 1
DATE      TIME      PATIENT          CHART  DOB      PHYSICIAN        PRIMARY DX
-----
08/01/06  8:46 AM  RUARYNG,PAUL E  111757 05/08/57 THOMAS,M        problems in the
08/01/06  8:51 AM  RIEN,ROBERTA J  107896 02/06/48 POWERS,D        open wounds mult
08/01/06  8:53 AM  ROA,LETA M      103210 11/22/73 EVERSON,T       multiple dog bit
08/01/06  9:20 AM  RENDBARG,HAZEL  102408 07/30/19 RODENBIKER,Z    broken right leg
08/01/06  9:53 AM  WYAMAR,LORETTA  102328 05/03/58 TUHY,J          HEART ATTACK
08/01/06  1:00 PM  SMERT,NONA L    105472 08/21/84 CLUTTER,R       HEADACHE
08/01/06  1:44 PM  WITESKA,IRENE  108556 06/07/40 ERICKSON,J      OPTIC NERVE DAMA
08/02/06  3:44 PM  VUNDEL,LARISSA  103377 02/16/74 ENGBERG,D       BLOOD POISONING
08/03/06  9:31 AM  DEHRYNG,AUDRA  108397 02/11/58 MACKEN,J        LACK OF FOOD

***** CONFIDENTIAL PATIENT INFORMATION *****
BRIEF ER LOG REPORT FROM: AUG 01, 2006 TO: SEP 01, 2006@23:59
                               SEP 20,2006 13:07 PAGE 2
DATE      TIME      PATIENT          CHART  DOB      PHYSICIAN        PRIMARY DX
-----
08/03/06  9:54 AM  DEHRYNG,AUDRA  108397 02/11/58 WALK,T          stroke
08/03/06  10:41 AM OPHEM,UDELL J.  109694 03/17/47 THOMAS,M        headache
08/03/06  10:49 AM EWANDAR,GALEN  106821 03/01/82 HENKE,J         heart attack
08/03/06  10:52 AM TYBBATTS,EMILY 111209 05/14/87 TONI,B          heart murmur
08/04/06  6:03 AM  WEDA,ROBERT L  101368 07/06/21 WALK,T          broken leg
08/04/06  8:30 AM  OREN,BEN J     105489 01/07/86 TRAYNOR,T       Kidney damage
08/04/06  4:00 PM  TEILUR,JOEL G.  102800 08/14/31 TONI,D          BLOCKAGE OF INST
08/07/06  10:00 AM  TEILUR,GALEN J  108451 01/16/54 HOODY,E         broken forearm
08/08/06  8:16 AM  ALLAGEERD,GEOR 104967 01/30/80 WENGER,B        brain tumor
08/09/06  2:04 PM  PADARSAN,LINDA 104096 09/29/78 RICHARDSON,Z    BROKEN HIP WITH
08/16/06  12:53 PM  JO,PHYLLIS R   102492 03/03/67 BULLWINKLE,R    SOB
08/17/06  12:53 PM  CRANBERRY,MARY T00003 01/01/58 BULLWINKLE,R    DISLOCATION R SH
08/17/06  2:09 PM  WEDA,LINDA S   105413 01/24/44 ,
08/21/06  2:00 PM  MIRMAL,LINDA M 104047 03/01/82 MOORE,S         bruise on arm and

```

Figure 12-20: Example of Brief ER log report

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, follow these steps:

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.

The system displays the following sort options and prompt:

```

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

Patient attributes =>
  1) AGE ON DAY OF VISIT          4) ELIGIBILITY
  2) CURRENT COMMUNITY          5) SEX
  3) DOA                          6) TRIBE

Visit attributes =>
  7) ACUITY                      17) INJURY TIME LAG
  8) BENEFICIARY CLASS          18) NURSE
  9) DIAGNOSTIC CATEGORY        19) OCCUPATION RELATED
 10) DISPOSITION                20) PHYSICIAN
 11) EMERGENCY TRANSPORT        21) PROCEDURE
 12) FINAL CONDITION            22) REVOLVING DOOR
 13) FIRST OR REVISIT          23) TOTAL VISIT DURATION
 14) FOLLOW UP                  24) WAITING TIME FOR THE DOCTOR
 15) ICD9 CODE                 25) WAITING TIME FOR TRIAGE
 16) INJURY CAUSE

Sort by: (1-25):

```

4. 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.
5. When finished selecting sort criteria, press Enter at a blank “Then sort by” prompt.

6. At “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 example shows an ER Statistical Report for patients’ final acuity from August 1, 2006 through September 1, 2006 and subtotals for each acuity level, as well as the total number of patients with a final acuity.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
ER STATISTICAL REPORT FROM: AUG 01, 2006@00:01 TO: SEP 01, 2006@23:59
                               SEP 20,2006 13:30 PAGE 1

      FINAL
      ACUITY
-----
SUBCOUNT  FINAL ACUITY:  1
           6
SUBCOUNT  FINAL ACUITY:  2
           23
SUBCOUNT  FINAL ACUITY:  3
           18
SUBCOUNT  FINAL ACUITY:  4
           28
SUBCOUNT  FINAL ACUITY:  5
           4
COUNT     79

```

Figure 12-21: Example of a Statistical Report

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, follow these steps:

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:

```

Select one of the following:

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

Sort option:

```

- 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:

```

Note: 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//

```

- Type your answer to this prompt and any additional prompts.
- At “Device” prompt, type HOME to display the report on the screen or type the name of the printer.
- 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 example shows hourly statistics for the selected reporting period (October 13, 2006).

***** HOURLY WORKLOAD REPORT *****											
OCT 13, 2006											
VISIT TIME	#	PTS	MINS TO TRIAGER			MINS TO PROVIDER			AGE<14	ETOH	INJURY
-----			MIN	MAX	AVE	MIN	MAX	AVE	-----	-----	
0800-0859		1									
1200-1259		1									
TOTALS		2							1	0	
AVERAGES			3	3	1	23	23	23			

Figure 12-22: Example of the Hourly Workload Report

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 the

- 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 "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 August 17, 2006. This report includes the date and time the patient was admitted, the patient name, chart number, and date of birth, the physician, and the primary diagnosis.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
ER DAILY LOG REPORT FROM: AUG 17, 2006 TO: AUG 17, 2006
                                AUG 18,2006 09:16 PAGE 1
                                PRIMARY DX
DATE      TIME      PATIENT      CHART  DOB      PHYSICIAN  NARRATIVE
-----
08/17/06 12:53 PM CRANBERRY,MARY T00003 01/01/58 BULLWINKLE,R DISLOCATION R SH
08/17/06 2:09 PM WEDA,LINDA S 105413 01/24/44 ASP,B STROKE
Press 'Return to continue:

```

Figure 12-23: Example of an ER Daily Log Report

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.

3. At the “Choose 1-?” prompt, type the number of the visit you want to view.

The system then displays the patient’s ER log. To scroll through the pages, press Enter.

```

***** CONFIDENTIAL PATIENT INFORMATION *****
ER LOG ENTRY FOR SINGLE PATIENT
                                     SEP 21,2006  07:39   PAGE 1
-----
ADMISSION TIMESTAMP:  AUG 23,2006  10:19
  PATIENT: CRANBERRY,MARY ANN      PCC VISIT:    AUG 23,2006  10:19
  DOB:      JAN  1,1958             AGE AT VISIT:    48
  CHART #:  T00003                 GENDER:        FEMALE
MODE OF TRANSPORT: PRIVATE VEHICLE/WALK IN
  AMBULANCE CO:
  AMBULANCE #:                    AMB INVOICE #:
PRESENTING COMPLAINT: LOWER BACK PAIN
  OCCUPATION RELATED: NO           INJURED: YES
  CAUSE OF INJURY:  E884.9         SCENE OF INJURY: HOME
  TIME OF INJURY:   AUG 23,2006  10:00
  SAFETY EQUIPMENT:
  TOWN OF INJURY:  HARLEM
  EXACT MVC LOCATION:
  DRIVERS INSURANCE CO:           DRIVER POLICY NUMBER:
  OWNER INSURANCE CO:            OWNER POLICY NUMBER:

```

```

***** CONFIDENTIAL PATIENT INFORMATION *****
ER LOG ENTRY FOR SINGLE PATIENT
                                     SEP 21,2006  07:40   PAGE 2
-----

OWNER NAME:
PROCEDURES:
  NONE
  SUTURING
PRIMARY DIAGNOSIS: 847.9  {SPRAIN OF BACK NOS}
  PRIMARY DX NARRATIVE: LOWER BACK PAIN
DIAGNOSIS:                                     DX NARRATIVE:
  847.9    {SPRAIN OF BACK NOS}                LOWER BACK PAIN
ADMITTING PROVIDER:  POWERS,DAVID
ADMITTING PROVIDER TIME:  AUG 23,2006  10:25
TRIAGE NURSE: GORDEN,GEORGE
  TRIAGE TIME:                AUG 23,2006  10:25
INITIAL ACUITY:  3                FINAL ACUITY:  3
DISPOSITION: HOME
  TRANSFERED TO:
DEPARTURE TIME: AUG 23,2006  10:48
  DISCHARGE PROVIDER: POWERS,DAVID
  DISCHARGE NURSE: GORDEN,GEORGE

***** CONFIDENTIAL PATIENT INFORMATION *****
ER LOG ENTRY FOR SINGLE PATIENT
                                     SEP 21,2006  07:42   PAGE 3
-----

DISCHARGE INSTRUCTIONS: RTC PRN, INSTRUCTIONS GIVEN
ER CONSULTANTS:
TOTAL VISIT DURATION:                29
  WAITING TIME FOR TRIAGE  :          6
  WAITING TIME FOR PROVIDER:          6
  DATA ENTERER: JARAMILLO,JOANN

Press 'Return to continue:

```

Figure 12-24: Example of an ER Log Entry For Single Patient

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.

```

PCC VISIT DISPLAY                Sep 13, 2006 09:10:39                Page:    1 of  2

Patient Name:                    SALINGER,JON
Chart #:                         T00005
Date of Birth:                   JUN 06, 1952
Sex:                             M
Visit IEN:                       8356

===== VISIT FILE =====
VISIT/ADMIT DATE&TIME:          AUG 31, 2006@08:27
DATE VISIT CREATED:             AUG 31, 2006
TYPE:                           IHS
PATIENT NAME:                   SALINGER,JON
LOC. OF ENCOUNTER:              NOT-A-REAL FACILITY
SERVICE CATEGORY:              AMBULATORY
CLINIC:                         URGENT CARE
DEPENDENT ENTRY COUNT:          0
DATE LAST MODIFIED:             SEP 05, 2006
WALK IN/APPT:                  WALK IN
CHECK OUT DATE&TIME:            AUG 31, 2006@09:55
HOSPITAL LOCATION:              EMERGENCY ROOM

+          Enter ?? for more actions
+   Next Screen          -   Previous Screen          Q   Quit
Select Action: +//

PCC VISIT DISPLAY                Sep 13, 2006 09:12:38                Page:    2 of  2
+
CREATED BY USER:                HAMEL,MARY
OPTION USED TO CREATE:          SD IHS PCC LINK
APPT DATE&TIME:                 AUG 31, 2006@08:27
USER LAST UPDATE:              HAMEL,MARY
VCN:                           9293.2B
UNIQUE VISIT ID:               1135100000008356
DATE/TIME LAST MODIFI:         SEP 05, 2006@08:20:10
CHIEF COMPLAINT:              HIGH FEVER AND COUGH
VISIT ID:                      10F2-WEX

```

Figure 12-25: PCC visit example

13.0 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 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.

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, follow these steps:

1. To access the ERS Reports menu, 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 "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 following example shows how to select a visit date, patient name and an ER Visit record.

```

Start with date:  JAN 14,2009// 10/25/06 <Enter>
Enter name, DOB or chart number:  T00007 <Enter>
NEW,TODAY                M 06-03-1963 XXX-XX-4312    WE 101149
1-8-2009@14:56:00      ANNU,BEN J
DEVICE:  HOME <Enter>  VIRTUAL    Right Margin: 80//  <Enter>
ADMISSION TIMESTAMP:  OCT 25,2006  09:29
  PATIENT:  NEW,TODAY                PCC VISIT:      OCT 25,2006  09:29
  DOB:      JUN  3,1963                AGE AT VISIT:   43
  CHART #:  T00007                      GENDER:        FEMALE
MODE OF TRANSPORT:  AMBULANCE
AMBULANCE CO:      TRANSCARE
AMBULANCE #:       2                    AMB INVOICE #:
PRESENTING COMPLAINT: SHOCK
OCCUPATION RELATED: NO                  INJURED: NO
CAUSE OF INJURY:      SCENE OF INJURY:
TIME OF INJURY:
SAFETY EQUIPMENT:
TOWN OF INJURY:
EXACT MVC LOCATION:
DRIVERS INSURANCE CO:  DRIVER POLICY NUMBER:
OWNER INSURANCE CO:   OWNER POLICY NUMBER:

OWNER NAME:
PROCEDURES:
DEFIBRILLATION/CARDIOVERSION
PRIMARY DIAGNOSIS:  .9999 {UNCODED DIAGNOSIS}
PRIMARY DX NARRATIVE: cardiac arrest
DIAGNOSIS:
.9999 {UNCODED DIAGNOSIS}          DX NARRATIVE:
.9999 {UNCODED DIAGNOSIS}          cardiac arrest
.9999 {UNCODED DIAGNOSIS}          low oxygen in blood
ADMITTING PROVIDER:  TONI,STEPHEN
ADMITTING PROVIDER TIME:  OCT 25,2006  10:00
TRIAGE NURSE:  ERICKSON,PHILLIP
TRIAGE TIME:      OCT 25,2006  10:31
INITIAL ACUITY:  3                    FINAL ACUITY:  3
DISPOSITION:  TRANSFER TO ANOTHER FACILITY
TRANSFERED TO:  UNM Hospital
DEPARTURE TIME:  OCT 25,2006  11:00
DISCHARGE PROVIDER:  TONI,STEPHEN
DISCHARGE NURSE:  NELSON,WADE
DISCHARGE INSTRUCTIONS:  RTC PRN, INSTRUCTIONS GIVEN
ER CONSULTANTS:
TECHNICIAN, CARDIOLOGY
OCT 25,2006  10:45                    BERG,JANET
TOTAL VISIT DURATION:  91

```

Figure 13-1: Example of an ER visit record

6. Press Enter to display additional information about this patient's visit; for example,

```

WAITING TIME FOR TRIAGE   :      2
WAITING TIME FOR PROVIDER:     31
DATA ENTERER:  RANDOLPH,STEPHANIE

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

```

Figure 13-2: Example of additional ER visit information

7. At the “Do you want to Edit this ER Visit? prompt,
- If this is the correct patient, press Enter to display the editing options (Figure 13-3).
 - 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.

```

Select one of the following:

1      ADMISSION SUMMARY
2      TRIAGE INFO
3      INJURY INFO
4      PROCEDURES
5      DIAGNOSES
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 13-3: Edit ER Visit (UP) editing options

8. At the “Enter Number of Section to Edit”? prompt,
- Type the number that matches the section you want 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
 - Code uncoded ICD9 entries
 - Print the ER Visit
 - Edit another ER Visit

The following table lists the ERS Edit Section options and their corresponding section of instructions.

Number	Section to Edit	See Section
1	Admission Summary	13.3
2	Triage Info	13.4
3	Injury Info	13.5
4	Procedures	13.6
5	Diagnoses	13.7
6	Exit Assessment	13.8
7	Discharge Info	13.9
8	Follow Up Instructions	13.10
9	ER Consultants	13.11
10	All	13.12

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 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:

```

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 13-4: Specifying a reason for an edit to the ER visit

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.

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?
 - Mode of transport to the ER
 - Ambulance Number
 - Ambulance HRCN/Billing#
 - Ambulance Company.

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.

Remember: 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.

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 13.1 "Selecting Visit and Patient to edit."

2. At the “Enter Number of Section to Edit” prompt, type **1**.

The system displays the following warning message:

```

ENTER NUMBER OF SECTION TO EDIT (OR <return> TO QUIT): 1 <Enter> *ADMISSION
SUMMARY

  **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//

```

3. At the “Change Patient?” prompt,
 - Press Enter (No) to leave the patient’s name unchanged.
 - Type YES to change the patient.

The following example shows how to change the patient **JONES,CHIP** that was entered incorrectly to the correct patient **JOE,PANDA**. For more details, see Section 13.3.1.

```

**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>
Enter the patient's NAME or LOCAL CHART NUMBER:
JONES,CHIP//JOE,PANDA <Enter>           M 09-10-1958 XXX-XX-1140   WE
T00005
Change patient from JONES,CHIP to JOE,PANDA? NO// YES <Enter>
  ***THIS PATIENT HAS AN APPOINTMENT IN THIS CLINIC TODAY***
                EMERGENCY ROOM           FOR : Jan 16, 2009@10:00

PATIENT IS SCHEDULED FOR: Jan 16, 2009@10:00
COMMENTS :
Check-in to this scheduled visit? YES// <Enter> (JAN 16,
2009@10:00)

Want to print PCC+ forms? Yes// N <Enter> (No)

CREATED PCC VISIT 8500 FOR ER APPOINTMENT : Jan 16, 2009@10:00
Enter number of labels to print: (1-10): 4// 1 <Enter>
LABEL PRINTER: SCR// HOME <Enter> VIRTUAL   Right Margin:
80//<Enter>
      T0-00-05           M
      JOE,PANDA
      09/10/58

Do you want to PRINT a routing slip? YES// NO <Enter>

```

```

MESSAGE NUMBER 5838 CREATED AND SENT
EDIT DATE: JAN 16, 2009
EDIT TIME: 17:59:40
FIELD NAME BEING EDITED: PATIENT
OLD VALUE: JONES,CHIP
NEW VALUE: JOE,PANDA

    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: ENTERED THE WRONG PATIENT <Enter>

```

Figure 13-5: Example of changing a patient within the Admission Summary option

13.3.2 Changing Admission Time within the Admission Summary

To Change Admission Time within the Admission Summary option:

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 13-6) shows how to change the Admission Date/Time of **JAN 16, 2009@14:00** that was entered incorrectly to the correct Admission Date/Time **JAN 16,2009@15:00**. Other date/time data will also be displayed for the user to update, if appropriate.

```
**Changing the ADMISSION TIME can cause other time related data to be
deleted**
Change Admission Time? NO// YES <Enter>
Date and time of admission to ER:  JAN 16, 2009@14:00// 1/16@1500  (JAN 16,
2009@15:00)
```

```
EDIT DATE: JAN 16, 2009
```

```
EDIT TIME: 18:11:20
```

```
FIELD NAME BEING EDITED: ADMISSION TIMESTAMP
```

```
OLD VALUE: JAN 16, 2009@14:00
```

```
NEW VALUE: JAN 16, 2009@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// <Enter>  Administrative
Comment: ENTERED WRONG ADM TIME
```

```
*What time did the patient see the triage nurse:  JAN 16,2009@14:05//
1/16@1505  (JAN 16, 2009@15:05)
```

```
EDIT DATE: JAN 16, 2009
```

```
EDIT TIME: 18:11:50
```

```
FIELD NAME BEING EDITED: TRG NURSE TIME
```

```
OLD VALUE: JAN 16, 2009@14:05
```

```
NEW VALUE: JAN 16, 2009@15:05
```

```
    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: MUST ADJUST TRG NURSE TIME <Enter>
```

```
*What time did the patient depart from the ER:  JAN 16,2009@11:00//
1/16@1600  (JAN 16, 2009@16:00)

EDIT DATE: JAN 16, 2009

EDIT TIME: 18:12:48

FIELD NAME BEING EDITED: DEPARTURE TIME

OLD VALUE: JAN 16, 2009@11:00

NEW VALUE: JAN 16, 2009@16:00

    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: MUST ADJUST DEPARTURE TIME <Enter>
```

Figure 13-6: Example of changing the Admission Time within the Admission Summary

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, or type either **EMERGENCY** or **URGENT**.

If you type Emergency or Urgent:

- 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.
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.

The system displays the following message and prompt:

```
ERS PCC Data Entry is complete for this option
Edit more admission data? NO//
```

3. At the “Edit more admission data?” prompt, press Enter, if no more changes are required for this patient visit, or type **Y** to continue editing information about this patient visit.
4. At the “Visit Type” prompt, press Enter to accept the displayed information, or type on 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.
5. At the “*Was this patient transferred from another facility?” prompt, press Enter to accept the displayed information, or type **Y**(es) or **N**(o).

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.
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 “*Medical Attendant present during transfer” prompt, press Enter to accept the displayed information, or type Y(es) or N(o).
 9. At the “Enter number of section to edit” prompt,
 - Enter the number of section you would like to continue to edit.
 - To Quit at this time, press Enter.

These are the possible prompts that may appear after you press Enter.

```
***INSUFFICIENT DATA AVAILABLE FOR COMPLETE PCC VISIT***
primary diagnosis is not coded
***PLEASE CORRECT THESE PROBLEMS ***
**This PCC Visit contains uncoded ICD9 entries **
Would you like to update them now? YES//
```

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.

Remember: 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, follow these steps:

1. Select a visit date and patient, as described in Section 13.1, “Selecting Visit and Patient to edit.”
2. At the “Enter Number of Section to Edit” prompt, Type **2**; for example,

```
ENTER NUMBER OF SECTION TO EDIT (OR <return> TO QUIT): 2 <Enter> Triage Info
```

3. At the “Admitting Provider” prompt, press Enter to leave the Admitting Provider’s name unchanged, or type the correct name.
 - If the Admitting and Discharge providers are the same person, the system displays the following message:

```

ADMITTING provider is same as DISCHARGE provider
cannot remove ADMITTING provider until DISCHARGE provider is updated

```

- If you changed the name of the Admitting Provider, the system displays the information and prompts for a reason for the change; for example,

```

EDIT DATE: NOV 01, 2006

EDIT TIME: 08:46:25

FIELD NAME BEING EDITED: ADMITTING PROVIDER

OLD VALUE: ASSEL,JANICE M

NEW VALUE: ASP,RICKY E

    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:

```

Figure 13-7: System responses and change codes

- At the “Please Enter a Primary Reason for Change” prompt, type the code that matches your reason for updating this patient.
 - Enter additional information at the “Comment” prompt, if necessary.
4. At the “*What time did the patient see the admitting provider” prompt, press Enter to accept the displayed information, or type the correct time.

If you change the 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.

- At the “*Triage nurse” prompt, press Enter to accept the displayed information, or type the correct name.

If you change the 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.

The system displays the following message and prompt:

If you change the name, type Y or N at the “Do you want to REMOVE this Triage nurse from this visit?” prompt.

```
*Triage nurse: SKRUTVOLD,VERN// ERICKSON,JOHN <Enter>
EDIT DATE: FEB 09, 2009
EDIT TIME: 12:54:29
FIELD NAME BEING EDITED: TRIAGE NURSE
OLD VALUE: SKRUTVOLD,VERN
NEW VALUE: ERICKSON,JOHN

    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:
*What time did the patient see the triage nurse: DEC 18,2008@08:10//
```

- At the “*What time did the patient see the triage nurse:” prompt, press Enter to accept the displayed information, or type the correct time.

If you change the 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.

The system displays the following message and prompt:

```
ERS PCC Data Entry is complete for this option
Edit more TRIAGE data? NO// Y <Enter> Yes
```

7. At the “Edit more Triage data?” prompt,
 - Press Enter to end your editing session, or
 - Type **Y** (Yes) and press Enter to continue editing triage information.
8. At the “Enter initial triage assessment from RN” prompt, press Enter to accept the displayed information, or type a number between 1 and 5 for the new assessment code.

Note: This is the initial acuity assessment code. Each site determines the numeric range and the meaning of the acuity assessment values.

If you change the initial triage 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.
9. At the “Was this ER visit Work-Related?” prompt, press Enter to accept the displayed information, or type **Y** or **N**

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.

This completes the procedure for editing triage information. You may now select another editing function or exit the UP option.

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.

Remember: 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, follow these steps:

1. Select a visit date and patient, as described in Section 13.1, "Selecting Visit and Patient to edit."
2. At the "Enter Number of Section to Edit" prompt, type **3**.

The system displays the following warning:

****Changing CAUSED BY INJURY can cause injury data to be deleted****

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 N or Y 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.

The system displays the date and time of the edit, the field edited, the old and new values for the field, and the codes for the reason you changed the cause of injury; for example,

```
EDIT DATE: AUG 29, 2006
EDIT TIME: 08:43:48
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:
```

Figure 13-8: Editing injury information

4. If you are specifying or changing the cause of injury,
 - a. At the “Cause of injury” prompt, type the revised cause of injury.
To display a list of causes, type ?? at the prompt and then type the cause at the prompt; for example,

```

Was this ER visit caused by an injury? YES// <Enter>

Cause of injury: FALL (ACCIDENTAL)// ?? <Enter>

Choose from:
ANIMAL BITE/STING
ANIMAL KICK/GORE
ASSAULT (NO WEAPON)
ASSAULT (WEAPON)
BICYCLE
CHEMICALS (CAUSTIC OR TOXIC)
DOMESTIC VIOLENCE
DROWNING
ELECTRICITY
EXPLOSION
EXPOSURE HYPOTHERMIA
FALL (ACCIDENTAL)
FIRE FLAME
FIREARM (ACCIDENTAL)
HEATSTROKE DEHYDRATION
HOUSEHOLD OBJECT
INHILATION (GAS/SMOKE)  should be INHALATION
MOTOR VEHICLE
OTHER CAUSE
POISONING (ACCIDENTAL)
RAPE
SELF INFLICTED
SUFFOCATION
TOOLS JOB EQUIP.
UNDETERMINED

Cause of injury: FALL (ACCIDENTAL)// SELF INFLICTED <Enter>

```

Figure 13-9: Editing cause of injury

If there is no ICD9 code associated with the revised injury, the following message is displayed and injury information is not recorded.

```

No ICD9 code associated to Cause of Injury!

Cause of injury will be lost

```

- b. At the “Please Enter a Primary Reason for Change” prompt, type the code that matches your reason for the update.
- c. Enter additional information at the “Comment” prompt, if necessary.

- At the “*Setting of accident/injury” prompt, press Enter to accept the displayed information, or type the location where this injury occurred.

To display the list, type ?? at the prompt.

If you change the location:

- 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.

The system displays the date and time the record was edited, the field edited, the old and new values for that field, and then displays the Reason for Change prompt; for example,

```
*Setting of accident/injury: HOME// ?? <Enter>

Choose from:
HIGHWAY OR ROAD
HOME
INDUSTRIAL PLACE
MINE/QUARRY
OTHER
PUBLIC BUILDING
RANCH OR FARM
RECREATIONAL/SPORT PLACE
RESIDENTIAL INSTITUTION
UNSPECIFIED

*Setting of accident/injury: HOME// RANCH OR FARM <Enter>

EDIT DATE: AUG 29, 2006

EDIT TIME: 10:00:54

FIELD NAME BEING EDITED: SCENE OF INJURY

OLD VALUE: HOME

NEW VALUE: RANCH OR FARM

    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: PT <Enter> Patient
corrected
Comment: <Enter>
*Enter the exact time and date of injury:
```

Figure 13-10: Editing Setting of accident/injury information

6. At the “Enter the exact time and date of injury” prompt, press Enter to accept the displayed information, or type the revised date, time, or both.

The system displays the date and time the record was edited, the field edited, and the old and new values for that field.

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.
7. At the “Town/village where injury occurred” prompt, press Enter to accept the displayed information, or type a different location.

If you change the location:

- 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.

This completes the procedure for editing injury information. You may now select another editing function or exit the UP option.

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.

Remember: 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, follow these steps:

1. Select a visit date and patient, as described in Section 13.1, “Selecting Visit and Patient to edit.”
2. At the “Enter Number of Section to Edit” prompt, TYPE 4.

The system displays the procedures performed on this patient; for example,

```
The following procedure(s) have been entered:
NONE
INTRAVENOUS FLUIDS
Enter another procedure:
```

Figure 13-11: Editing procedural information

3. At the “Enter another procedure:” prompt, type the name of a new procedure, or type the name of a procedure listed for this patient.
4. At the “Delete this procedure?” prompt, press Enter.
5. Type the code that matches your reason for the update at the “Please Enter a Primary Reason for Change” prompt, and enter additional information at the “Comment” prompt, if necessary.
6. At a blank “Enter another procedure” prompt, continue adding or deleting procedures for this patient as necessary, or press Enter to exit.

This completes the procedure for editing injury information. You may now select another editing function or exit the UP option.

13.7 Diagnoses (5)

The **Diagnoses (5)** option enables you to edit information about diagnoses.

! 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.

Remember: 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 diagnostic information, follow these steps:

1. Select a visit date and patient, as described in Section 13.1, “Selecting Visit and Patient to edit.
2. At the “Enter Number of Section to Edit” prompt, type **5**.

The system displays this patient’s diagnosis and a prompt for the diagnoses code; for example,

```
The following DX : Narratives have been entered
  Primary DX is marked with '***'

**850.9  CONCUSSION NOS : CONCUSSION

ENTER ICD9 DX CODE to Edit or Add:
```

Figure 13-12: Current diagnostic information example

3. At the “Enter ICD9 DX Code to Edit or Add” prompt,
 - a. Type the code of the diagnosis you want to edit.
 - b. Verify that the code you entered is OK.

Note: If you do not know the ICD9 code, enter the DX narrative and select the appropriate match from the displayed list, and respond any additional prompts.

4. At the “Do you want to change DX code?” prompt, press Enter to change the code, or type N (No).

If you change the DX code:

- 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.

For example:

```

EDIT DATE: SEP 05, 2006

EDIT TIME: 07:15:46

FIELD NAME BEING EDITED: DIAGNOSIS

OLD VALUE: 850.9 {CONCUSSION NOS}

NEW VALUE: 989.5 {TOXIC EFFECT VENOM}

    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:
Comment:

```

Figure 13-13: Editing diagnostic information example

- At the “Do you want to change narrative?” prompt, press Enter to accept the default, Yes, or type N (No).

The system displays the date and time edited, the field edited, as well as the old and new values for this field; for example,

```

Do you want to change narrative? Yes//
The following DX : Narratives have been entered
    Primary DX is marked with '**'

**850.9  CONCUSSION NOS : CONCUSSION

ENTER ICD9 DX CODE to Edit or Add: 850.9 <Enter>  850.9      CONCUSSION NOS
    ...OK? Yes// <Enter>  (Yes)

Narrative: CONCUSSION
**This is currently the Primary DX**

Do you want to change DX code? YES// <Enter>
ENTER CORRECT DX: BEE STING <Enter>
( BEE/BEEF/BEES STING )

989.5 (TOXIC EFFECT VENOM)
TOXIC EFFECT OF VENOM

OK? Y// <Enter>

```

```

EDIT DATE: SEP 26, 2006
EDIT TIME: 13:55:24
FIELD NAME BEING EDITED: DIAGNOSIS
OLD VALUE: 850.9 {CONCUSSION NOS}
NEW VALUE: 989.5 {TOXIC EFFECT VENOM}

  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: DE <Enter>  Data entry error
Comment: TESTING <Enter>
Do you want to change narrative? YES// <Enter>
Provider Narrative: PT STUNG 100 TIMES <Enter>

EDIT DATE: SEP 26, 2006
EDIT TIME: 13:55:47
FIELD NAME BEING EDITED: PROVIDER NARRATIVE
OLD VALUE: CONCUSSION
NEW VALUE: PT STUNG 100 TIMES

  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: DE <Enter>  Data entry error
Comment: TESTING <Enter>

The following DX : Narratives have been entered
  Primary DX is marked with '*'

**989.5 TOXIC EFFECT VENOM : PT STUNG 100 TIMES
ENTER ICD9 DX CODE to Edit or Add: ^

```

Figure 13-14: Editing ICD9 diagnostic codes example

This completes the procedure for editing diagnostic information. You may now select another editing function or exit the UP option.

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.

Remember: 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, follow these steps:

1. Select a visit date and patient, as described in Section 13.1, "Selecting Visit and Patient to edit."
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.

If you edit this information, the system displays messages similar to the following example:

```

EDIT DATE: SEP 05, 2006

EDIT TIME: 09:56:08

FIELD NAME BEING EDITED: FINAL ACUITY

OLD VALUE: 2

NEW VALUE: 1

    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 :
Comment :
```

Figure 13-15: Editing exit acuity information example

- At the “Disposition: Transfer to Another Facility” prompt, press Enter to accept the displayed information, or type the facility name.

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.

If an ERS patient visit needs to be deleted because it was entered in error, type “REGISTERED IN ERROR” for the disposition. The system displays prompts as shown below.

```

*Disposition: HOME// REGISTERED IN ERROR <Enter>
Using this DISPOSITION will cause the entire VISIT to be deleted!!
This DISPOSITION can not be changed!!
Do you still wish use this DISPOSITION? YES// <Enter>
PCC Visit deleted...
PIMS Scheduling appointment was not deleted.
```

This completes the procedure for editing exit assessment information. You may now select another editing function or exit the UP option.

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.

Remember: 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, follow these steps:

1. Select a visit date and patient, as described in Section 13.1, "Selecting Visit and Patient to edit."
2. At the "Enter Number of Section to Edit" prompt, type **7**.
3. At the "Provider who signed PCC form" prompt, press Enter to accept the displayed information, or type the name of a new provider.

The system displays messages similar to the ones in the following example:

```
EDIT DATE: SEP 05, 2006
EDIT TIME: 12:49:46
FIELD NAME BEING EDITED: DISCHARGE PROVIDER
OLD VALUE: OLSEN,NOBODY
NEW VALUE: CORDOVA,C H
```

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.

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: DE <Enter> Data entry error	
Comment :	

- 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.
- 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.

This completes the procedure for editing discharge information. You may now select another editing function or exit the UP option.

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.

Remember: 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, follow these steps:

1. Select a visit date and patient, as described in Section 13.1, “Selecting Visit and Patient to edit.”
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,

- The system displays messages similar to the ones in the following example:

```
EDIT DATE: SEP 05, 2006
EDIT TIME: 13:26:32
FIELD NAME BEING EDITED: DISCHARGE INSTRUCTIONS
OLD VALUE: APPT AND INSTRUCTIONS GIVEN
NEW VALUE: RTC PRN, INSTRUCTIONS GIVEN
```

- 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.

```
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: DE <Enter> Data entry error
Comment:
```

This completes the procedure for editing discharge information. You may now select another editing function or exit the UP option.

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.

Remember: 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 13.1, "Selecting Visit and Patient to edit."
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 ER CONSULTANT types and times have been entered
INFECTIOUS DISEASE @ AUG 31, 2006@08:49 BELKNAP,CURTIS
NURSE PRACTITIONER @
Edit/Enter another ER CONSULTANT TYPE:
```

Figure 13-16: Consultant types example

If there are no ER consultants for this visit, the system displays the following message and prompts:

```
There are currently no ER CONSULTANTS associated to this visit
Do you want to add an ER CONSUTLANT?
Edit/Enter ER CONSULTANT TYPE:
```

3. At the "Edit/Enter ER Consultant Type" prompt, press Enter to return to the UP menu, or type a consultant name.

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:

- 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. At the “Date and time of ER Consultant” 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.
5. At the “ER Consultant Type” prompt, press Enter to accept the displayed information, or type a new consultant name.

If you change the 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.

This completes the procedure for editing consultant types and names. You may now select another editing function or exit the UP option.

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.

To Edit	See Section
Admission Summary	13.3
Triage Info	13.4
Injury Info	13.5
Procedures	13.6
Diagnoses	13.7
Exit Assessment	13.8
Discharge Info	13.9
Follow Up Instructions	13.10
ER Consultants	13.11

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,

```

**The PRIMARY DX in the PCC VISIT file is different from ERS PRIMARY DX**
PCC VISIT VALUE: .9999 - FOOD POISONING
ERS ENTERED VALUE: 005.1 - FOOD POISONING

Select one of the following:

1          Correct PCC data using ERS data
2          Correct ERS data using PCC data

Which would you like to do: 2 <Enter> Correct ERS data using PCC data

```

14.0 Table and Parameter Setup (PAR)

The options on the **Table and Parameter Setup Menu** enable 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:

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

The system displays the Facility Setup Menu; for example,

```

*****
*           Facility Setup Menu           *
*           Indian Health Service         *
*           Version 3.0                   *
*****
                NOT-A-REAL FACILITY

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

Select Table and Parameter Setup Option:

```

Figure 14-1: Table and Parameter menu options (PAR)

The following table lists the ERS Facility Setup Menu options and their corresponding section of instructions.

Option	Action	See Section
CNS	Add or remove a Consultant Type from the ER Consultant Service list, which are used in the tracking the different types of providers who are consulted for patient care.	14.1
LOC	Add local facility to the ER Local Facility file, which are used in the transferred from/to prompts at Admission and Discharge.	14.2
MGRP	Edit the MGRP (ER Alerts Mail Group Edit) mail group to add/remove members, which is sent an email notification whenever an Editing option is used to change the patient associated with an ER Visit.	14.3
OPT	Add/modify the list of available options (pick lists) used by different prompts throughout the ER application.	14.4
SET	Edit the parameter setup for an ER facility	14.5

14.1 Add/Edit ER Consultant Service List (CNS)

Use the **Add/Edit ER Consultant Service List** option to add or remove a 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 or edit consultant groups, follow these steps:

1. To access the ERS Table and Parameter Setup menu, type **PAR** at the “Select Emergency Room System Option” prompt.

The system displays 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 consultant.

The consultant type may be 1-30 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 “Delete Date” prompt, type the date to remove or inactivate the consultant type, or press Enter to add this Consultant type now.
5. If you need to edit a Consultant type, then enter the updated Consultant type at the NAME prompt after the double slash marks ‘//’ for that type.

6. If you need to remove the Consultant type, then enter “@” at the NAME prompt.

```

*****
*           Facility Setup Menu           *
*           Indian Health Service         *
*           Version 3.0                   *
*****
                NOT-A-REAL FACILITY

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

Select Table and Parameter Setup Option:  CNS <Enter>  Add/Edit ER CONSULTANT
SERVICE list
Select ER CONSULTANT TYPE NAME:  AUDIOLOGIST <Enter>
Are you adding 'AUDIOLOGIST' as a new ER CONSULTANT TYPE (the 57TH)? No// YES
<Enter>
NAME: AUDIOLOGIST// <Enter>
DELETE DATE:  <Enter>

Select ER CONSULTANT TYPE NAME:

```

Figure 14-2: Adding a Consultant Type

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

14.2 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, follow these steps:

1. To access the ERS Table and Parameter Setup menu, type **PAR** at the “Select Emergency Room System Option” prompt.

The system displays 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.

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.

```

*****
*           Facility Setup Menu           *
*           Indian Health Service         *
*           Version 3.0                   *
*****
                                NOT-A-REAL FACILITY

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

Select Table and Parameter Setup Option:  LOC <Enter>  Add Local ER Facilities
Select ER LOCAL FACILITY NAME:  FIRST NATIONS HOSPITAL
Are you adding 'FIRST NATIONS HOSPITAL' as a new ER LOCAL FACILITY (the 7TH)?
No// Y <Enter>  (Yes)
NAME:  FIRST NATION HOSPITAL  Replace
UID:  <Enter>

Select ER LOCAL FACILITY NAME:

```

Figure 14-3: Adding a facility location.

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.

14.3 ER Alerts Mail Group (MGRP)

When version 3.0 is installed at your facility, the AMER ER PATIENT MERGE ALERTS Mail Group is set up. Also, a Coordinator is specified during installation. When any ERS Edit (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, follow these steps:

1. To access the ERS Table and Parameter Setup menu, type **PAR** at the “Select Emergency Room System Option” prompt.

The system displays 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.
 - If you type the name of an existing mail group member, the following message appears:

```
This user is already in the AMER ER PATIENT MERGE ALERTS Mail Group
Would you like to REMOVE this user from the Mail Group?
```

To remove the existing name, type Yes at the prompt.

```
*****
*           Facility Setup Menu           *
*           Indian Health Service         *
*           Version 3.0                   *
*****
                NOT-A-REAL FACILITY

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

Select Table and Parameter Setup Option:  MGRP <Enter>  ER Alerts Mail Group Edit
Select NEW PERSON NAME:  KELLEY,ZZZ <Enter>
Would you like to add this person to the mail group? YES// <Enter>  (Yes)
Select NEW PERSON NAME:
```

Figure 14-4: Example of adding a user to the 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.

14.4 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, follow these steps:

1. at the “Select Emergency Room System Option” prompt, type **PAR**.
The system displays 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, Murder NOS.
4. Confirm your entry at the “Are you adding *ER-Option* 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, you would type BLOOD TRANSFUSION at the “ER Options Name” prompt and type ER PROCEDURES at the “Type” prompt.
 - If you wanted to add “SKATE BOARD” as a possible Cause of Injury, you would type SKATEBOARD at the “ER Options Name” prompt and type CAUSE OF INJURY at the “Type” prompt.
8. (Optional) At the “Brief Form” prompt, enter a value or press Enter to bypass. The value can be 1-to-16 characters.
 9. (Optional) At the “HER Value” prompt, enter a value or press Enter to bypass. The value can be 1-to-240 characters.

10. (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

11. (Optional) At the “Mnemonic” prompt, type a mnemonic or press Enter to bypass. This value can be 1-to-30 characters.

12. (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.

13. At the “ICD9 Code” prompt, type the ICD9 code if appropriate for the given ER Option.

Note: If you do not know the ICD9 code, enter the DX narrative and select the appropriate match from the displayed list, and respond any additional prompts.

14. If the information is correct press Enter (Yes) at the “OK” prompt.

```
Select ER OPTIONS NAME:  MURDER NOS <Enter>
Are you adding 'MURDER NOS' as a new ER OPTIONS (the 131ST)? No// Y <Enter>  (Yes)

ER OPTIONS MNEUMONIC:  <Enter>
NAME: MURDER NOS// <Enter>
TYPE: CAUSE OF INJURY <Enter>
  1  CAUSE OF INJURY
  2  CAUSE OF VISIT
CHOOSE 1-2: 1 <Enter>  CAUSE OF INJURY
BRIEF FORM:  <Enter>
HER VALUE: <Enter>
ANCILLARY SERVICES: <Enter>
MNEUMONIC: <Enter>
MAP TO THE PLACE OF ACCIDENT: <Enter>
ICD9 CODE: MURDER <Enter>
(MURDER).
E968.9 (ASSAULT NOS)
ASSAULT BY UNSPECIFIED MEANS

OK? Y// <Enter>

Select ER OPTIONS NAME:
```

Figure 14-5: Using the OPT option (steps 3-14)

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.

14.5 Facility Parameter Setup (SET)

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

To use the Facility Parameter setup option, follow these steps:

1. To access the ERS Table and Parameter Setup menu, type **PAR** at the “Select Emergency Room System Option” prompt.

The system displays the Facility Setup menu.

2. At the “Select Table and Parameter Setup Option” prompt, type **SET**.
3. At the “Select ER Preferences Location” prompt, type the name of the facility where the ER is located. Then confirm the selection by typing **Y** at the “OK?” prompt. For example,

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.

4. At the “Location” prompt, press Enter to accept the current location, or type the location.

```
Select ER PREFERENCES LOCATION: SSM TRIBAL HEALTH CENTER      BEMIDJI NON-IHS
      EASTERN MICHIGAN      10
      ...OK? Yes// <Enter> (Yes)
LOCATION: NOT-A-REAL FACILITY// <Enter>
```

Figure 14-6: Selecting the ER Preferences Location (steps 3-4)

5. At the “Walk-In Clinic” prompt, press Enter to accept the current entry, or type the Walk-in clinic name, which is your Emergency Room Clinic, as set up in the PIMS Scheduling application.

Note: This Walk-In Clinic field *must* be completed to access PIMS scheduling appointments.

For more information, see Appendix A: ERS/PIMS Scheduling Interface.

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 **N** to prevent uncoded diagnoses from being sent to PCC.
10. At the “Select ER Preferences Location” prompt press Enter to exit.

```
WALK-IN CLINIC: EMERGENCY ROOM// <Enter>
LABEL PRINTER NAME: HFS// <Enter>
QUEUE LABELS: <Enter>
CHART PRINTER NAME: <Enter>
SEND .9999 CODES TO PCC: YES// <Enter>
Select ER PREFERENCES LOCATION: <Enter>
```

Figure 14-7: Using the SET option (steps 5-10)

15.0 Appendix A: 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.

15.1 Modifying PIMS Scheduling

Step 1: Access the PIMS Scheduling application.

```

ACCESS CODE: ***** <Enter>
VERIFY CODE: ***** <Enter>

Good afternoon JARAMILLO,JOANN
  You last signed on today at 12:05
Select DIVISION: DEMO HOSPITAL// <Enter>      OKLAHOMA      LAWTON      30      NM      505530
Site set to DEMO HOSPITAL

  CORE   Core Applications ...
  FM     VA FileMan ...
         Manage Mailman ...
         Menu Management ...
         Programmer Options ...
         Taskman Management ...
         User Management ...
  KIDS   Kernel Installation & Distribution System ...

Select Systems Manager Menu Option: CORE <Enter>  Core Applications

  ADT    ADT Menu ...
  AG     Patient registration ...
  BW     Women's Health Menu ...
  ERS    Emergency Room System ...
  FILE   FileMan (General) ...
  SCH    Scheduling Menu ...
  SEC    Sensitive Patient Tracking ...
  WH     WOMEN'S Health Care ...

Select Core Applications Option: SCH <Enter>  Scheduling Menu

```

```

*****
*          INDIAN HEALTH SERVICE          *
*          CLINIC SCHEDULING SYSTEM      *
*          VERSION 5.3                   *
*****
                                DEMO HOSPITAL

AL      Appointment List
AM      Appointment Management
CR      Chart Requests
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) ...

Select Scheduling Menu Option: SCS <Enter> Supervisor Menu (Scheduling)

                                Supervisor Menu (Scheduling)
                                (DEMO HOSPITAL)

ACM     Application Coordinator Menu ...
CPF     Clinic Profile
CRA     Cancel/Restore Clinic Availability
DSU     Display Scheduling User
EEL     Enter/Edit Letters
LAM     List Appts Made By Clinic
MON     Month-at-a-glance Display
SET     Set Up a Clinic

Select Supervisor Menu (Scheduling) Option: SET <Enter> Set Up a Clinic

    Use this option to create clinics, modify their parameters,
    and set up their appointment slots.
*****Screen 1 of 4*****

                                SET UP A CLINIC                                Page 1 of 4

CLINIC NAME: EMERGENCY ROOM                ABBREVIATION: ER
DIVISION: CARNEGIE INDIAN HEALTH CE        FACILITY: ALBUQUERQUE INDIAN H

    MEETS AT THIS FACILITY?: YES
NON-COUNT CLINIC? (Y OR N): N
INCLUDE ON FILE ROOM LISTS?:
PRINCIPAL CLINIC:
PHYSICAL LOCATION:                        TELEPHONE:
    CLINIC CODE: EMERGENCY MEDICINE
HOSPITAL SERVICE:

CLINIC OWNERS (responsible for setup)
JARAMILLO,JOANN

Exit      Save      Next Page      Refresh
-----
Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND: Next                                Press <PF1>H for help      Insert
    
```

*****Screen 2 of 4*****
SET UP A CLINIC Page 2 of 4

SPECIAL INSTRUCTIONS for make appt. (3 lines max.)

PROHIBIT ACCESS TO CLINIC?: OVERBOOK USERS & LEVEL
SCHEDULE ON HOLIDAYS?:
HOUR CLINIC DISPLAY BEGINS: 6
LENGTH OF APPOINTMENT: 15
VARIABLE APPOINTMENT LENGTH: YES
DISPLAY INCREMENTS PER HOUR: 15-MIN
OVERBOOKS/DAY MAXIMUM: 20
MAX # DAYS FOR FUTURE BOOKING: 365
START TIME FOR AUTO REBOOK: 11
MAX # DAYS FOR AUTO-REBOOK: 365

Exit Save Next Page Refresh
Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND: Next Press <PF1>H for help Insert

*****Screen 3 of 4*****
SET UP A CLINIC Page 3 of 4

PRE-APPOINTMENT LETTER:
CLINIC CANCELLATION LETTER:
APPT. CANCELLATION LETTER:
NO SHOW LETTER:
ALLOWABLE CONSECUTIVE NO-SHOWS: 10
WAITING PERIOD FOR NO-SHOWS:

PRINT HEALTH SUMMARY?: HEALTH SUMMARY TYPE:
PRINT ADDRESS/INSURANCE UPDATE?:
PRINT RX PROFILES?:
REQUIRE X-RAY FILMS?:

Exit Save Next Page Refresh
Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND: Next Press <PF1>H for help Insert

*****Screen 4 of 4*****
 SET UP A CLINIC Page 4 of 4

ASK FOR CHECK IN/OUT TIME: **YES**
 CREATE VISIT AT CHECK-IN?: **YES**
 VISIT SERVICE CATEGORY: **AMBULATORY**
 MULTIPLE CLINIC CODES USED?: **YES**
 VISIT PROVIDER REQUIRED: **YES**
 TRIAGE CLINIC?: **NO**
 PYXIS LOCATION:

CLINIC PROVIDERS DEFAULT

Exit Save Next Page Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND: **Save** Press <PF1>H for help Insert

COMMAND: **Exit**

AVAILABILITY DATE: **10/30** <Enter> (OCT 30, 2006)

MONDAY

TIME: 0600-2000 NO. SLOTS: 1// **5** <Enter>

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** <Enter> (Yes)

...SORRY, LET ME PUT YOU ON 'HOLD' FOR A SECOND...

PATTERN FILED!

AVAILABILITY DATE: **10/31** <Enter> (OCT 31, 2006)

TUESDAY

TIME: 0600-2000 NO. SLOTS: 1// **5** <Enter>

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** <Enter> (Yes)

...EXCUSE ME, HOLD ON...

PATTERN FILED!

AVAILABILITY DATE: **11/1** <Enter> (NOV 01, 2006)

WEDNESDAY

TIME: 0600-2000 NO. SLOTS: 1// **5** <Enter>

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 WEDNESDAYS INDEFINITELY? **Y** <Enter> (Yes)

...HMMM, HOLD ON...

PATTERN FILED!

AVAILABILITY DATE: 11/2 <Enter> (NOV 02, 2006)

THURSDAY

TIME: 0600-2000 NO. SLOTS: 1// 5 <Enter>

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]

...PATTERN OK FOR THURSDAYS INDEFINITELY? Y <Enter> (Yes)

...EXCUSE ME, THIS MAY TAKE A FEW MOMENTS...

PATTERN FILED!

AVAILABILITY DATE: 11/3 <Enter> (NOV 03, 2006)

FRIDAY

TIME: 0600-2000 NO. SLOTS: 1// 5 <Enter>

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]

...PATTERN OK FOR FRIDAYS INDEFINITELY? Y <Enter> (Yes)

...HMMM, JUST A MOMENT PLEASE...

PATTERN FILED!

AVAILABILITY DATE: 11/4 <Enter> (NOV 04, 2006)

SATURDAY

TIME: 0800-1200 NO. SLOTS: 1// 5 <Enter>

TIME:

| [5 5 5 5|5 5 5 5|5 5 5 5|5 5 5 5]

...PATTERN OK FOR SATURDAYS INDEFINITELY? Y <Enter> (Yes)

...HMMM, HOLD ON...

PATTERN FILED!

AVAILABILITY DATE: <Enter>

Select CLINIC NAME: <Enter>

ACM	Application Coordinator Menu ...
CPF	Clinic Profile
CRA	Cancel/Restore Clinic Availability
DSU	Display Scheduling User
EEL	Enter/Edit Letters
LAM	List Appts Made By Clinic
MON	Month-at-a-glance Display
SET	Set Up a Clinic

Select Supervisor Menu (Scheduling) Option: MON <Enter> Month-at-a-glance Display

Use this option to view a clinic's available appointments
or to view the first available date for each clinic under
a principal clinic.

```

Select CLINIC: EMERGENCY ROOM <Enter>

ENTER THE EARLIEST DATE DESIRED FOR THIS APPOINTMENT: TODAY// 10/30 <Enter> (OCT
30, 2006)

MONTH-AT-A-GLANCE                Oct 25, 2006 12:39:43                Page:    1 of    24
-----
                                EMERGENCY ROOM
                                Oct 2006

TIME | 6      | 7      | 8      | 9      | 10     | 11     | 12     | 1      | 2      |
DATE |        |        |        |        |        |        |        |        |        |
MO 30 | [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 |
TU 31 | [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 |
                                Nov 2006

TIME | 6      | 7      | 8      | 9      | 10     | 11     | 12     | 1      | 2      |
DATE |        |        |        |        |        |        |        |        |        |
WE 01 | [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 |
TH 02 | [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 |
FR 03 | [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 |
SA 04 |          |          | [5 5 5 5 | 5 5 5 5 | 5 5 5 5 | 5 5 5 5 |          |          |          |
MO 06 | [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 |
TU 07 | [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 |
+-----Enter ?? for more actions----->>>
AL Appointment List      SL Short Appt List      Q Quit
Select Action:Next Screen// <Enter>  NEXT SCREEN
MONTH-AT-A-GLANCE                Oct 25, 2006 12:39:55                Page:    2 of    24
-----
WE 08 | [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 |
TH 09 | [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 |
10   |          |          |          |          |          |          |          |          |          |
    VETERANS DAY
SA 11 |          |          | [5 5 5 5 | 5 5 5 5 | 5 5 5 5 | 5 5 5 5 |          |          |          |
MO 13 | [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 |
TU 14 | [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 |
WE 15 | [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 |
TH 16 | [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 |
FR 17 | [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 |

TIME | 6      | 7      | 8      | 9      | 10     | 11     | 12     | 1      | 2      |
DATE |        |        |        |        |        |        |        |        |        |
SA 18 |          |          | [5 5 5 5 | 5 5 5 5 | 5 5 5 5 | 5 5 5 5 |          |          |          |
MO 20 | [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 |
TU 21 | [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 |
WE 22 | [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 |
23   |          |          |          |          |          |          |          |          |          |
    THANKSGIVING
+-----Enter ?? for more actions----->>>
AL Appointment List      SL Short Appt List      Q Quit
Select Action:Next Screen// Q <Enter>

Select CLINIC: <Enter>

ACM   Application Coordinator Menu ...
CPF   Clinic Profile
CRA   Cancel/Restore Clinic Availability
DSU   Display Scheduling User
EEL   Enter/Edit Letters
LAM   List Appts Made By Clinic
MON   Month-at-a-glance Display
SET   Set Up a Clinic

Select Supervisor Menu (Scheduling) Option: <Enter>
    
```

15.2 Setting Up ERS Preferences

This section provides instructions for setting up the Emergency Room System application.

```

*****
*           Emergency Room System           *
*           Indian Health Service           *
*           Version 3.0                     *
*****
NOT-A-REAL FACILITY

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
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
EXP     Export data Menu ...
PAR     Table and Parameter Setup ...

Select Emergency Room System Option: PAR <Enter> Table and Parameter Setup

*****
*           Facility Setup Menu             *
*           Indian Health Service           *
*           Version 3.0                     *
*****
NOT-A-REAL FACILITY

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

Select Table and Parameter Setup Option: SET Facility Parameter setup

Select ER PREFERENCES LOCATION: NOT-A-REAL FACILITY           BEMIDJI           WHITE EARTH
10      MC(M)           516
...OK? Yes// <Enter> (Yes)
LOCATION: NOT-A-REAL FACILITY// <Enter>
WALK-IN CLINIC: EMERGENCY ROOM <Enter>           < Enter the exact name of your
                                                    < Emergency Room Clinic

LABEL PRINTER NAME: HFS// <Enter>
QUEUE LABELS: <Enter>
CHART PRINTER NAME: <Enter>
SEND .9999 CODES TO PCC: YES// <Enter>

Select ER PREFERENCES LOCATION: <Enter>

Select Table and Parameter Setup Option: <Enter>

Select Emergency Room System Option: <Enter>

```

16.0 Appendix B: Patient with Appointment Check In

The following example provides instructions for checking in a patient, who has a scheduled Emergency Room Clinic appointment.

```

*****
**                               PIMS - SCHEDULING                               **
*****

Appt Mgt Module           Aug 14, 2007 09:24:57           Page:    1 of    1
Clinic:  EMERGENCY ROOM
Total Appointment Profile           08/14/07 thru 08/21/07

Patient      Appt Date/Time      Status
1  100355 Mydbu, Timothy M      08/14/2007@09:45  No Action Taken/Tod
2  102530 Huben, Carol J        08/14/2007@11:30  No Action Taken/Tod
3  111348 Martans, Sidney L     08/14/2007@11:45  No Action Taken/Tod
4  109504 Mehar, Frances I     08/14/2007@12:00  No Action Taken/Tod
5  109344 Mirmal, Debra M      08/14/2007@12:15  No Action Taken/Tod
6  108130 Morrei, Wayne E      08/14/2007@12:30  No Action Taken/Tod
7  101687 Muss, Myron W.       08/14/2007@12:45  No Action Taken/Tod

Enter ?? for more actions
CI Check In           OI Add/Edit Other Info   HS Health Summary
WI Unscheduled Visit  AT Ancillary Tests       OR Other Reports
PR Patient Registration CO Check Out           PT Change Patient
MA Make Appointment  DE Delete Check Out      CL Change Clinic
NS No Show           PC PCP Update           CD Change Date Range
CA Cancel Appointment EX Expand Entry        AP Appt Profiles
Select Action:Quit// QUIT <Enter>

*****
**                               EMERGENCY ROOM SYSTEM                               **
*****

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

~~~~~

Enter the patient's NAME or LOCAL CHART NUMBER: 100355 <Enter>
MYDBU, TIMOTHY M           M 08-20-1954 665921872   WE 100355

~~~~~

Date and time of admission to ER:  NOW// <Enter>  (AUG 14, 2007@09:27)

          **** APPOINTMENTS FROM TODAY FORWARD ****
Aug 14, 2007@09:45  EMERGENCY ROOM           TESTING

~~~~~

Presenting complaint:  ER FOLLOW-UP <Enter>

~~~~~

```

```

*****
Date of Last Registration Update: FEB 21, 1991 <Enter>

Additional Registration Information:
*****

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

~~~~~

Visit type: UNSCHEDULED// SCHEDULED <Enter>

~~~~~

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

~~~~~

Mode of transport to the ER: PRIVATE VEHICLE/WALK IN// <Enter>
***THIS PATIENT HAS AN APPOINTMENT IN THIS CLINIC TODAY***
EMERGENCY ROOM          FOR : Aug 14, 2007@09:45

PATIENT IS SCHEDULED FOR: Aug 14, 2007@09:45 <Enter>
COMMENTS : TESTING <Enter>
Check-in to this scheduled visit? YES// <Enter> (AUG 14, 2007@09:45)

Want to print PCC+ forms? Yes// N <Enter> (No)

CREATED PCC VISIT 8503 FOR ER APPOINTMENT : Aug 14, 2007@09:45
*Enter number of labels to print: (1-10): 4// 1 <Enter>
LABEL PRINTER: LER// SLAVE <Enter> PC PTR    Right Margin: 80// <Enter>

Do you want to PRINT a routing slip? YES// <Enter>

FILE ROOM PRINTER: HOME// SLAVE <Enter> PC PTR    Right Margin: 80// <Enter>

ER admission data collection is now complete. Thank you.

*****
**                               PIMS - SCHEDULING                               **
*****

Appt Mgt Module          Aug 14, 2007 09:30:19          Page: 1 of 1
Patient: MYDBU,TIMOTHY M (100355) WHITE EARTH          Outpatient
Age: 52 YRS Pcp/Team: None/None
Total Appointment Profile          IHS          08/09/07 thru 05/09/10
Clinic          Appt Date/Time          Status
1  Emergency Room          08/14/2007@09:45  Checked In          09:27
    Not currently on a Waiting List.

Last Registration Update: FEB 21, 1991
CI Check In          OI Add/Edit Other Info          HS Health Summary
WI Unscheduled Visit          AT Ancillary Tests          OR Other Reports
PR Patient Registration          CO Check Out          PT Change Patient
MA Make Appointment          DE Delete Check Out          CL Change Clinic
NS No Show          PC PCP Update          CD Change Date Range
CA Cancel Appointment          EX Expand Entry          AP Appt Profiles
Select Action:Quit//

```

17.0 Appendix C: Deleting an ERS Patient Visit

If a patient's ER visit was entered in error and needs to be deleted, use the Disposition prompt in OUT *or* UP. At the "Disposition" prompt, enter "Registered in Error".

OUT option messages/and prompt

For the OUT option, the system displays the following messages and prompt:

```
*Disposition: HOME// REGISTERED IN ERROR
Using this DISPOSITION will cause the entire VISIT to be deleted!!
This DISPOSITION can not be changed!!
Do you still wish use this DISPOSITION? YES// <Enter>
PCC Visit deleted...
PIMS Scheduling appointment was not deleted.
```

UP option prompts/messages

For the UP option, the system displays the following prompts and messages:

```
Do you want to EDIT this ER VISIT? YES// <Enter>
  Select one of the following:
    1      ADMISSION SUMMARY
    2      TRIAGE INFO
    3      INJURY INFO
    4      PROCEDURES
    5      DIAGNOSES
    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): 6 <Enter>
~~~~~
Enter final acuity assessment from provider: (1-5): 2// <Enter>
Disposition: ADMIT// REGISTERED IN ERROR <Enter>
This DISPOSITION will cause this entire VISIT to be deleted!!
Do you still wish to keep this DISPOSITION? YES// <Enter>.....
UNABLE TO CANCEL THE SCHEDULED PIMS APPOINTMENT!

EDIT DATE: JAN 14, 2009

EDIT TIME: 11:41:34

FIELD NAME BEING EDITED: DISPOSITION

OLD VALUE: ADMIT

NEW VALUE: REGISTERED IN ERROR

  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: ENTERED IN ERROR <Enter>
~~~~~
```

18.0 Appendix D: 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 web site,

<http://security.ihs.gov/>

The Rules of Behavior listed in the following sections are specific to RPMS.

18.1 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).

18.1.1 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.

18.1.2 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.

18.1.3 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.

18.1.4 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.

18.1.5 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.

18.1.6 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).

18.1.7 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.

18.1.8 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.

18.1.9 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

18.1.10 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.

18.1.11 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

18.1.12 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.

18.1.13 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) when ever 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.

18.2 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.

18.3 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 information.

19.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk (IHS).

Phone: (505) 248-4371 or (888) 830-7280 (toll free)

Fax: (505) 248-4363

Web: <http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm>

Email: support@ihs.gov